NHS
Hertfordshire and
West Essex
Integrated Care Board

ICB Board Meeting [Public Session] Friday 23 September 2022

Conference Suite, Epping Forest District Council, Civic Offices, 323 High Street, Epping CM16 4BZ
and Microsoft Teams

NHS
Hertfordshire and
West Essex
Integrated Care Board

Meeting Book - ICB Board Meeting [Public Session] Friday 23 September 2022

HWE ICB Board Meeting Held in Public Friday 23 September 2022

12:30	1. Welcome, apologies and housekeeping		Chair
	2. Declarations of Interest		Chair
12:35	3. Minutes of last meeting held on Wednesday 27 July 2022	Approval	Chair
	4. Action Tracker and Matters Arising	Approval	Chair
12:40	5. Questions from the public	Discuss	Chair
	LIVED EXPERIENCE		
12:50	6. Patient / Carer Story	Discuss/Information	Chief of Staff
13:10	7. Board Deep Dive	Assurance	Director of Performance and Delivery /Medical Director
	CHAIR, CHIEF EXECUTIVE, QUALITY AND PERFORMANCE REPORTS		
13:30	8. Chair's Update	Information	Chair
13:35	9. Chief Executive Officer's Report	Information	Chief Executive Officer
13:40 - 13:50	COMFORT BREAK		
13:50	10. Nursing and Quality Report	Assurance	Director of Nursing
	10.1 National Patient Safety Strategy Update	Information	Director of Nursing
14:05	11. Performance Report	Assurance	Director of Performance and Delivery
	FINANCE AND STRATEGY		
14:20	12. Finance Report for Month 2022/23	Assurance	Chief Finance Officer
	GOVERNANCE AND COMPLIANCE		
14:35	13. Governance Report	Approval	Associate Director of Integrated Governance and

14:40	**14. Committee Summary Reports**	Information	Organisational Alignment Committee Chairs
14:45	**15. EPRR Annual Report**	Approval	Director of Operations
14:50	**16. UEC Assurance Framework**	Information	Director of Operations
	OTHER BUSINESS		
14:55	**17. What would service users, patients, carers and staff take away from our discussions today?**		Chair
	18. Any other business		Chair
15:00	**19. Close of meeting**		Chair
	Date of Next Meeting: Friday 18 November 2022		

The Nolan Principles

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

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

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

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

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

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

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

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

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

Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

DRAFT MINUTES

Meeting:	**NHS Herts and West Essex Integrated Care Board** **Board meeting held in Public**			
	Meeting in public	☒	*Meeting in private (confidential)*	☐
Date:	**Wednesday 27 July 2022**			
Time:	**09:30 – 11.52**			
Venue:	**Council Chambers, County Hall, Pegs Lane, Hertford**			

MINUTES

Name	**Title**	**Organisation**
Members present:		
Paul Burstow (PB) **(Meeting Chair)**	ICB Chair	Herts and West Essex ICB
Jane Halpin (JH)	Chief Executive Officer	Herts and West Essex ICB
Elliot Howard-Jones (EHJ)	Partner Member (NHS Community Trust)	Herts and West Essex ICB
Rachel Joyce (RJ)	Medical Director	Herts and West Essex ICB
Jane Kinniburgh (JK)	Director of Nursing	Herts and West Essex ICB
Owen Mapley (OM)	Partner Member (Local Authority, HCC)	Herts and West Essex ICB
Alan Pond (AP)	Chief Finance Officer	Herts and West Essex ICB
Gurch Randhawa (GR)	Non-Executive Member	Herts and West Essex ICB
Nicolas Small (NS)	Partner Member (Primary Medical Services)	Herts and West Essex ICB
Karen Taylor (KT)	Partner Member (NHS Mental Health Trust)	Herts and West Essex ICB
Members in attendance via Microsoft Teams:		
Ian Perry (IP)	Partner Member (Primary Medical Services)	Herts and West Essex ICB
Thelma Stober (TS)	Non-Executive Member	Herts and West Essex ICB
In attendance:		
Elizabeth Disney (ED)	Director of Operations	Herts and West Essex ICB
Beverley Flowers (BF)	Director of Strategy	Herts and West Essex ICB
Iram Khan (IK)	Corporate Governance Manager	Herts and West Essex ICB
Adam Lavington (AL)	Director of Digital	Herts and West Essex ICB

	Transformation	
Tania Marcus (TM)	Chief People Officer	Herts and West Essex ICB
Joanna Marovitch (JM)	VCFSE Representative	Herts and West Essex ICB
Avni Shah (AS)	Director of Primary Care Transformation	Herts and West Essex ICB
Frances Shattock (FS) Via Microsoft Teams	Director of Performance	Herts and West Essex ICB
Simone Surgenor (SS)	Associate Director of Integrated Governance and Organisational Alignment	Herts and West Essex ICB
Michael Watson (MW) Via Microsoft Teams	Chief of Staff	Herts and West Essex ICB
Tracey Norris (TN)	Clerk (minutes)	Herts for Learning
Apologies:		
Lucy Wightman	Partner Member (Local Authority ECC)	Herts and West Essex ICB
Ruth Bailey	Non-Executive Member	Herts and West Essex ICB
Catherine Dugmore	Non-Executive Member	Herts and West Essex ICB
Lance McCarthy	Partner Member (NHS Acute Trust)	Herts and West Essex ICB
Prag Moodley	Partner Member (Primary Medical Services)	Herts and West Essex ICB
Phil Turnock	Managing Director of HBL ICT Shared Services	Herts and West Essex ICB

ICB/08/22	**Welcome, apologies and housekeeping**
8.1	The Chair welcomed all to the meeting. This was the first meeting of the ICB Board in person and introductions were made. Joining via MS Teams were: ▪ Thelma Stober ▪ Frances Shattock ▪ Ian Perry ▪ Michael Watson Thelma Stober noted she would need to leave the meeting at 10am from which point the meeting would no longer be quorate. It was agreed to take agenda item 6 first as this required a decision by the Board.
8.2	Apologies for absence had been received from: ▪ Catherine Dugmore ▪ Ruth Bailey ▪ Lance McCarthy ▪ Lucy Wightman ▪ Prag Moodley ▪ Phil Turnock
ICB/09/22	**Declarations of interest**
9.1	The Chair invited members to update any declarations relating to matters on the agenda: ▪ None declared. All members declarations are accurate and up to date with the register available on the website: Declaration of interests – Hertfordshire and West Essex NHS ICB
ICB/10/22	**Minutes of the previous meeting**
10.1	The minutes of the previous meeting held on 1 July 2022 were approved as an accurate record.
ICB/11/22	**Action Tracker**
11.1	There was one item on the action tracker which had been completed: ▪ ICB 4.12/22: SS to circulate list of 62 policies to Board members: completed on 12 July 2022.
ICB/12/22	**Patient and lived experience stories**
12.1	Michael Watson (MW) presented the report (see pages 12 – 36 of the document pack) and explained that this concept had been in development for a while, and he hoped the creation of the ICB would provide the opportunity to explore lived experience stories in a new way.
12.2	The Board emphasised the importance of lived experience being a key part of the decision-making process and asked for this to be built into the governance framework. The board asked for the approach to be widened to citizens/carers to ensure a focus on prevention from the start and incorporating good practice from elsewhere.
12.3	**The Board approved the proposed approach to patient and lived experience stories**
12.4	***ACTION: Ensuring patient and lived experience stories are built into the ICB Governance Framework and ensuring that learning from best practice and across the system is incorporated.***
ICB/13/22	**Questions from the public**
13.1	Four questions from members of the public had been submitted in advance of the meeting. For the purposes of the meeting, the Chair summarised these questions and the

	responses from the ICB, noting that the full questions and answers would be recorded in the minutes. Consideration would be given to the most effective way to respond to questions in future meetings.
13.2	Question 1: Justine Jewitt “Given that patients are allowed E-access to their primary care medical records, are the board intending to mandate that every practice, covered by the ICS, allows access to the patient’s full records rather than summary records only (which many practices restrict their patient to)?”
13.3	HWE ICB response: “From this coming November E-access will automatically be turned on for patients who have appropriate accounts on NHS App (or some other Apps) so there is no need to mandate. Whilst guidance is still pending, it is covered via the national ‘Accelerating Access to Patient Records’ programme. We will be working with practices to ensure they know how to do this ready for November. There is planned to be a follow up programme in 2023 around granting access to historical records again managed at a national level.”
13.4	Question 2: Justine Jewitt “E consultation has developed well in a majority of practices in the ICS geography, is there any intention to mandate that all GP practices use E consult? And to set out the hours within which this service might be provided?”
13.5	HWE ICB response Practices should offer online consultation tools for patients to submit information and requests, as part of the ‘core digital offer’ set out in Annex C of the 2021/22 contract letter C1054-supportinggeneral-practice-in-21-22.pdf (england.nhs.uk) - https://www.england.nhs.uk/wp-content/uploads/2021/01/C1054-supporting-general-practice-in-21-22.pdf Within the HWE ICB we have two tools available to practices to choose from to delivery this functionality which are eConsult and Accurx. NHSE state “the definition of the core digital offer which all practices must provide to patients, including the offer and use of video and online consultations, ability to do online prescriptions, and online appointment booking There are not set hours in which consultations is mandated at present. We are awaiting National Guidance regarding the hours which this service should be provided, but we expect it to be within core GP hours (Monday to Friday 08:00 to 18:30).
13.6	Question 3: Paul Lambert “St Elizabeth’s have given their 85 residents 4 months’ notice of closure. What provision is being made to help find new placements, for the 30 plus Hertfordshire residents; bearing in mind that it took 6+ months, to secure the original St Elizabeth’s places. A task force run by social services will be insufficient, some direct intervention by you (sic) governing bodies is required.”
13.7	HWE ICB response Over the last 6 months there have been concerns raised about the care and quality of services at St Elizabeth’s which has resulted in two inadequate rating from the Care Quality Commission (CQC). In partnership with HCC and St Elizabeth’s we have set up a Task and Finish multi-agency group to support the safe closure of the service in the Best Interests of people residing at the home, working collaboratively with their families and carers. The ICB Continuing Health Care team have already commenced the work to re- assess all residents individually in terms of their current needs, focussing on safety and to ensure that we have up to date care plans in place. We have also arranged for a dedicated member of staff to be the point of contact for families contacting the ICB.

	The Continuing Health Care team will continue to work closely with patients and their families to ensure that their care needs are met, at St Elizabeth's and with new providers.
13.8	Question 4: David Foreman "As a supporter of the campaign groups 'Keep Our NHS Public' and 'We Own It' I wish to ask that the Board commits to rebuilding our NHS for people over profit. This means making: 1. A public commitment to ban people who work for private companies or have a financial interest in private companies likely to benefit from outsourcing being members of your Integrated Care Board or any of its committees; 2. A public commitment never to delegate any of your ICB's duties to commission NHS services to any bodies or committees that include people who work for or have a financial interest in private companies likely to benefit from outsourcing; 3. A public commitment not to outsource or privatise any further NHS services and to produce a plan for a systematic programme for insourcing (into NHS Trusts, Foundation Trusts or local authorities) services currently outsourced when their contracts expire; 4. An acknowledgement that outsourcing during the COVID-19 pandemic by the Conservative government wasted billions of pounds of public money as evidenced by Parliament's Public Accounts Committee report of March 2021. In that report they were critical of the £37billion allocated to the Test and Trace contract over a two period and stated".
13.9	HWE ICB response Thank you for your interest in this meeting. These are exciting times in a new era of integrated working, and therefore we look forward to welcoming members of the public to our second Integrated Care Board for Hertfordshire and West Essex. In response to the queries raised, pledges made by this ICB are included in our Constitution [available on the ICB's website]. The ICB cannot delegate its legal duties. Finally, as has been made public this week, the formal Covid public inquiry has started and therefore we do not propose to comment on areas covered by that.
13.10	**The Board noted the questions and the responses**
ICB/14/22	**Chair's update**
14.1	The Chair referred to his update (see pages 37-39 of the document pack). There were no questions arising.
14.2	**The Board noted the Chair's update**
ICB/15/22	**Chief Executive Officer's report**
15.1	Jane Halpin (JH) referred to her report (see pages 40-49 of the document pack) and highlighted the following points: ▪ Primary Medical Contracting has now been delegated to HWE and further work was underway with NHSEI to prepare for the delegation of other primary care services; dental, pharmacy and optometry. This was a large and complex piece of work and regular updates would be shared with the Board. ▪ Planning was underway for the autumn covid and flu vaccination programme with guidance being updated but the prime cohorts had now been designated. ▪ Within performance, operations and commissioning there were a number of challenges and areas for success (JH highlighted the following): o Challenges: Urgent care o Achievements: improved access to specialist in-patient case for young people with mental health issues.
15.2	Questions and comments were invited: ▪ Q When would an urgent care strategy be presented to the Board?

	▪ Elizabeth Disney was leading this work stream; the main component of the strategy would be developed at a meeting on 9 August with a view to presenting to the Board in the early autumn in preparation for winter. ▪ The reported challenges were consistent across the CEO's, performance and quality reports; the Board would need to put in place the appropriate governance structure to ensure deep dives into pathways were well chosen to ensure the Board's discussions/agenda items addressed these challenges and achieved the necessary improvement in service delivery. ▪ It was agreed that reports to the Board should contain high level strategic oversight and assurance rather operational detail.
15.3	**The Board noted the CEO's report.**
Thelma Stober left the meeting and it was noted that the Board was no longer quorate, items requiring approval would be taken at this meeting for discussion and again at the private meeting for approval which would be quorate.	
ICB/16/22	**Quality report**
16.2	Jane Kinniburgh (JK) presented the quality report (see pages 50-68 of the document pack) drawing the Board's attention to: ▪ The need for this report to continue to evolve, and to balance the scrutiny of detail at Quality committee with board level oversight ▪ Key challenges in the areas of Infection prevention, maternity care, mental health care and several aspects of safeguarding ▪ The CQC rating for EEAST moving from inadequate to RI.
16.3	The following points were raised in discussion: ▪ The importance of focusing on workforce. It was agreed a deep dive would take place on this subject at Quality Committee. The People Board will also consider integrated planning across health and care. ▪ The Board requested that the quality data dashboard is further developed to be a tool to cut through the detail and ensure the board received the information it required. ▪ The Board also noted the importance of engaging lived experience in discussions around quality to ensure decisions are informed by lived experience. ▪ The Board discussed the need for reporting to identify key drivers of quality and to triangulate with People and Finance on an exception basis and by means of an escalation from Board Committees. ▪ The Board noted the importance of engaging lived experience in discussions around quality to ensure decisions are informed by lived experience. This will allow for the Board to understand directly from its citizens who they would prefer to receive care from in the community (eg voluntary sector, social prescribers, healthcare vs social care etc).
16.4	**The Board noted the Quality Report**
16.5	***ACTION: Development session to be arranged to agree the format of future quality (and performance) reports to the Board***
16.6	***ACTION: The Board requested that the quality data dashboard is further developed.***
ICB/17/22	**Performance report**
17.1	Frances Shattock (FS) presented the Performance Report (see pages 49-93 of the document pack) drawing the Board's attention to: ▪ ICB performance in cancer 62-day and two-week standards were comparatively good. ▪ The number of patients waiting more than two years for elective care was falling with only 35 patients waiting more than 104 weeks as of 30 June; and of these, 33 had elected to continue to wait for local treatment. ▪ The cancer backlog had been stabilised.

	▪ Challenges were noted in urgent care, ED attendance was high and performance against the four-hour standard was poor. ▪ Mental health: high volume of patients with high acuity. Out of area placements had stabilised but were still high. ▪ Demand for Children & Young Peoples’ eating disorder care continued to be under pressure.
17.2	The Board noted the variation in Stroke Performance. It requested that future reports provide an overview of up-to-date outcome metrics in key areas such as stroke. The ICB should also consider who it is benchmarking itself against- both in the region and beyond. It also requested that future meetings receive an overview of symptoms and causes of key performance issues.
17.3	**The Board noted the Performance Report.**
17.4	***ACTION: Future report(s) to provide an overview of outcomes following a stroke and other long-term conditions, and also to seek to provide an overview of drivers underlying key performance issues.***
17.5	***ACTION: Future reports to include appropriate benchmarking.***
ICB/18/22	**HWE Integrated Care Board Finance Report 2022/23 & HWE Integrated Care System Finance Report 2022/23**
18.2	Alan Pond (AP) presented the ICB finance report (see pages 94-104 of the document pack) highlighting the below points: ▪ The draft accounts for 2021/22 outturn position show an underspend of £4.5m, due to allocations not being spent because of staff capacity issues or because the allocation had actually been received after the year end (ie in April 2022). ▪ The financial balances of the three CCGs have been transferred to the ICB for the remaining nine-month financial period; NHS England would enact a retrospective allocation to bring each CCG to a breakeven position ▪ Known financial risks: ○ Cost and volume contracts with acute providers ○ Continuing healthcare placement expenditure ○ Inflationary pressures ▪ In the days since the report had been written, the government has responded to the pay review body and accepted all recommendations. However, the pay award was higher than had been expected and no new money would be made available to cover this - requiring efficiency savings to be made in other areas. This would also impact 2023/24.
18.3	Although the system may be financially balanced, individual partners are under financial pressure due to the cost-of-living crises. The Board noticed the potential impact of the cost of living crisis on staff and residents.
18.4	**The Board noted the ICB and ICS finance reports 2022/23**
ICB/19/22	**Governance Report**
19.1	Simone Surgenor presented the ICB Governance Report (see pages 105-158 of the document pack) Adoption of ICP committee The ICB were required to approve the creation of the ICP (the inaugural meeting would take place on 28 July 2022); a paper was in the public domain setting out the remit of the ICP and its membership.
19.2	**The Board approved the creation of the ICP and would ratify this decision during the private session (when quorate).**
19.3	Interim delegation of policy approval to the Executive and Commissioning Board At its inaugural meeting on 1 July 2022, the ICB Board approved the temporary delegation of approval of ICB policies to the Executive and Commissioning Board. It was proposed

	that this delegation be extended until the next meeting of the ICB Board in September. This was agreed.
19.4	**The Board approved the extension of delegation of policy approval to the Executive and Commissioning Board and would ratify this decision during the private session which followed this meeting (when quorate).**
19.5	Policies The ICB was asked to ratify policies previously approved by Quality Committee (listed on page 114)
19.6	**The Board approved the policies listed above and would ratify this decision during the private session which followed this meeting (when quorate).**
19.7	Risk Register The ICB considered the risks presented in the papers (see pages 111-113 of the document pack).
19.8	The board recognised that further work is required to develop its approach to risk and to establish its risk appetite and ensure that risks are considered at the appropriate level.
19.9	**The Board noted the risk register**
19.10	The Board was asked to note the policies approved by the Executive Committee of the ICB listed on page 115.
19.11	**The Board noted the policies which had been ratified by the Executive and Commissioning Board**
19.12	Committee summaries Two committee summaries (Quality Committee and Population, Outcome & Improvements Committee) had been included in the document pack (see pages 151 –158). Going forward, each sub-committee of the Board would produce a high-level overview of the decisions and actions taken at each meeting.
19.13	The Board requested that each committee submit a one-page summary of its work, focusing on action taken rather than minutes of meetings. A common format will be developed. It also asked each committee Chair to review the terms of reference of their committee to avoid gaps and ensure responsibilities are aligned.
19.14	**The Board noted the committee summaries**
ICB/20/22	**Reflections and feedback from the meeting**
20.1	The following was raised: ▪ The intention to have “lived experiences” to inform the Board. ▪ Board discussions needed to balance the strategic and operational. ▪ Balance was needed on reviewing past performance/quality as well as looking forward to identifying what needs to improve. ▪ Alignment in attitude and thinking about risk was needed, including both ▪ Workforce and board / executive level training
ICB/21/22	**Any other business**
21.1	The chair noted that cost of living pressures had been a theme during the meeting. Cost of living pressures on the wider population and the knock-on impact on health and care as well as those on staff and providers and CVFSE services were highlighted. The ICB had a part to play along with local government and other partners in responding to these pressures and the Board should keep the matter in its sights. The increase in Primary Care workload relating to changes in methods of GP access (via e-solutions etc) was raised. Elements of this change were good but there needed to be recognition that the system was struggling to cope with increasing demand in all areas – and that this was in part due to consumer expectation.
Date of next meeting: Friday 23 September 2022	
The meeting closed at 11.52	

Hertfordshire and West Essex Integrated Care System

NHS
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Integrated Care Board

Herts and West Essex Integrated Care Board Board Meeting Action Tracker Last updated on 14 September 2022

Private / Public	Action Tracker Ref No	Date of Meeting	Subject	Action	Responsible Lead	Deadline Date	Comments and Updates	Status
PUBLIC	ICB/12.4/22	27/07/2022	Patient and lived experience stories	**Ensuring patient and lived experience stories are built into the ICB Governance Framework and ensuring that learning from best practice and across the system is incorporated.**	M Watson	**Ongoing**		**Open**
PUBLIC	ICB/16.5/22	27/07/2022	Quality Report	**Development session to be arranged to agree the format of future quality (and performance) reports to the Board**	M Watson / J Kinniburgh	**21/10/2022**	**13/09/2022 -** Development session scheduled for 21 October to discuss Board reports	**Open**
PUBLIC	ICB/16.6/22	27/07/2022	Quality Report	**The Board requested that the quality data dashboard is further developed.**	J Kinniburgh	**23/09/2022**	**14/09/2022 -** Discussions have taken place with the national data analytic lead to explore the development of the ICB Quality dashboard. We are linking to work undertaken in the southwest which have been flagged as an example of good practice. The development of quality reporting has been raised at the Regional ICB Directors of Nursing and Chief Nurse forum with the Regional DoN with the aim of developing a shared set of metrics across the region to enable benchmarking/shared approach. There have also been discussions at an Executive level to move to a more integrated reporting format, and the proposal for feedback from Board development sessions to shape the content the Board wishes to see. Progress will be made over the coming months.	**Open**
PUBLIC	ICB/17.4/22	27/07/2022	Performance Report	**Future report(s) to provide an overview of outcomes following a stroke and other long-term conditions, and also to seek to provide an overview of drivers underlying key performance issues.**	F Shattock/ R Joyce	**Ongoing**	**14/09/2022 -** S Williamson updated: **Providing an explanation of drivers of stroke performance:** Place based commissioning leads for stroke continue to work with local providers of stroke services to improve outcomes and performance. A summary of current service status, performance, local projects and issues will be provided. **Appendix 1 attached - Stroke Update**	**Open**
PUBLIC	ICB/17.4/22	27/07/2022	Performance Report		F Shattock/ R Joyce	**Ongoing**	**14/09/2022 -** S Williamson updated: **Overview of outcomes**. The Population health management and medical directorate are developing a series of information packs assessing health and care needs for the population. Health needs and outcomes from stroke will form part of the cardiovascular information pack. Once completed, this will be shared with the relevant teams as well as the ICB Board for information.	**Open**
PUBLIC	ICB/17.5/22	27/07/2022	Performance Report	**Future reports to include appropriate benchmarking.**	F Shattock	**~~23/09/2022~~** **18/11/2022**	**13/09/22 -** On-going work to establish where we source the data for regional/national benchmarks	**Open**

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

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Update on Stroke

Dr Sam Williamson
Katherine Cremins
Lisa Kennedy
Jo Batrick

Working together
for a healthier future

South & West Herts

Current service status	In South and West Herts (S&WH) and in particularly in West Herts Teaching Hospitals Trust (WHTHT) the Stroke teams have endeavoured to provide a high level of service, despite recent challenges around workforce and capacity which include issues around patient hand over and flow in the emergency department.
Service performance	80% of patients treated for stroke in S&W Herts are treated by WTHHT and the most recently published SNAPP data shows a **B** level rating for overall performance at WHTHT (Jan- March 2022) At WHTHT admission to the stroke unit within 4 hours continues to be a primary area of concern, as it is nationally. Performance has increased in this metric since IPC measures have been altered, however, it remains below standard. We have continued assurance that patients receive stroke consultant input and specific recommendations for their care while they are waiting for admission to the stroke unit. Our community provider (CLCH) reports continued challenges around ESD capacity, and workforce pressures however previously reported delays in contacting patients after discharge have improved and patients are now contacted within 1 -2 days of discharge. The numbers of patients receiving a 6 month review within the SNAPP specified time parameters are low due to a backlog created during the pandemic, however we have assurance that this is improving and it will be reflected in SNAPP performance going forward.
Actions and projects	A high number of breaches of admission to the stroke unit within 4 hours domain are due to limited bed and side room capacity therefore ringfencing of stroke bed capacity is being reviewed in support of improvement of this domain. WHTHT have developed a SSNAP improvement plan in response to their ISDN SSNAP review. This focuses on improving KPI's around access to MRI, reporting of CT Angio and workforce issues. CLCH are continuing to work on their new service models in line with ICSS model. ESD and NETT services have been implemented and the Living with Stroke pathway will commence in early October 2022 . 6 day working is now in place across ESD.
Issues and challenges	Workforce and capacity issues are reported across all providers, predominantly in the therapy workforce. An ongoing challenge at WHTHT is the use of the rehabilitation gym as a surge area. Gym space is limited and this is impacting on the levels of rehabilitation available for patients in the acute trust. This has been escalated within the trust and will continued to be monitored.

East & North Herts

Current service status	It is recognised that the stroke performance position in ENH requires improvement and activity is underway to address this. Some of the challenges of wider pressures across the system have had an impact on stroke performance, including ambulance response times (e.g. Cat 2 ambulance response times); general urgent and emergency care pressures including access at A&E / ambulance handover waits for stroke patients; covid-related infection prevention control measures; and wider bed pressures impacting the available bed base for stroke patients. Stroke-specific workforce pressures have also contributed to the decline in performance especially within the therapy workforce.
Service performance	. **SSNAP** - Stroke performance position in ENH requires improvement, current SSNAP data for ENH shows ENHT with a D rating. The target of a SSNAP A rating is required by April 2023. . **Thrombectomy rates** (0.3% performance in the East of England) - We endeavour to work towards an improvement in thrombectomy rates for our population and recognise the low performance, however also recognise that ENH patients requiring thrombectomy are transferred to Charing Cross the performance of which will not be reflected in this indicator.
Actions and projects	Stroke performance mitigations are being identified and progressed through Task and Finish groups. ENHT has a stroke action plan, with progress monitored regularly by Divisional teams, supported through the T&F groups. Our broader improvement work requires cross-organisational engagement across the ICS, including acute, community, ambulance and commissioning stakeholder partners and engagement with our ISDN South regional leads. Provider engagement (resource and time) is key to getting the SSNAP rating back on track and delivering improvements for stroke performance. Engagement from ENHT is good and there is activity to engage EEAST. ENH Stroke Programme Board is well established with the next meeting taking place on 05/10/2022. There is also a scheduled deep dive on neuro / stroke at the November ENH Clinical and Professional Group (previously CPEX) meeting. Task and Finish groups: . **TIA Pathways / prevention / pre-stroke care** – TIA Pathways T&F group has been established with most recent meeting taking place on 09/09/2022. Activity underway to address known problem areas including rapid access to MRI; referral analysis / audit to inform potential changes to booking slots / access in line with performance targets; pathways changes / implementation of best practice to support patients with normal ECG and streamline of referrals; possible adoption of ERS as well as education and communication activity to streamline referral pathways and address data quality issues; refresh of TIA pathways including SOP and guidance to promote the one-stop clinic model, streamline imaging and the appropriate discharge of patients from the service. . **Community** – T&F group (lead by HCT) being established and activities to be identified to improve access to Life After Stroke Services and increase the percentage of patients receiving 6 month reviews to 60% by 2024 as well as improvements to Early Supported Discharge (ESD). New stroke community indicators identified with HCT following comparison of existing service provision against the new Integrated Community Service Specification (ICSS) for Stroke. NHSE has given an opportunity to all ICSs to bid for funding that can be put towards planning for local improvements to meet the new ICSS. This funding provides a secondment opportunity for a local resource to work on this planning activity 2 days per week. Activity underway with clinical leads to identify resources to put forward for secondment opportunity, the output of which will be an aligned ICS-wide plan by April 2023 to address any delivery gaps in adhering to the ICSS. . **Workforce** - Stroke workforce improvements in place with ENHT, including approval for additional consultant, 4 x therapy posts and a stroke performance analyst. It is anticipated that the investment in workforce will support performance improvement in stroke care. Workforce T&F is being established and draft Terms of reference in place. . **Acute Stroke Care** - ENHT has developed a stroke action plan that is being progress monitored regularly by Divisional teams. Activity includes providing local improvements in addressing workforce and training needs as well as early identification of patients requiring thrombectomy (as well as identification of mimics and associated training programme) and onward treatment at a thrombectomy centre. Action is already underway to implement trauma pre-alert pathways for inbound ambulances so that ED, medical team and radiology can make advance preparation to request scans for inbound emergency patients requiring access to MRI. Work also underway to move to use of LFDs to improve flow to ward. Workforce T&F being established. Terms of reference to be agreed.
Issues and challenges	. **Stroke performance** - ENHT is current rated at a SSNAP D, with the target of a SSNAP A required by the end of the financial year 22/23. Mitigations are being identified and progressed through Task and Finish groups. ENHT has a stroke action plan that is being progress monitored regularly by Divisional teams . **Stroke programme commissioner resourcing** - Programme management resource changes. ENH Stroke Programme Lead left the organisation and there is a vacancy for this position. Lisa Kennedy has been covering core elements of the role currently. Stroke activity will be picked up by Rachel Fulton from end Sept until vacancy is filled.

West Essex CCG

Current service status	Acute SSNAP action plans – progress and delivery of these with your trusts Senior Transformation Manager for Stroke is new and learning a great deal. Making new working relationships with Trust and community providers to understand Stroke services. ICSS Service Improvement -
Service performance	Queens – The stroke service has transformed from being "D" rated to "B" rating, with ambition to regain "A" rating. The reduction in the rating was due to the challenges throughout covid19
Actions and projects	• Current service spec is being reviewed at EPUT. • Current contract with Stroke Association is being extended. • Tendering process is to begin for Stroke Community services. • Squire QI bid being discussed between the clinical team across the ICB and the Transformation Managers, paperwork to be submitted.
Issues and challenges	• Pathway concerns have been escalated by Queens • Pathway from PAH to Queens to be reviewed with the Trusts, E&NH patients are being referred to Queens also, rather than Lister. • Follow up pathway - Patients DNA rates at Queens increasing, as patients not wanting to travel for diagnostic follow up testing. • Increase in Staffing levels at Queens is required to meet HASU standards • Pathway concerns have been raised by Stroke re-hab centre in regards to the lack of patients 6 month review appointments. To be further investigated in our new meeting. • Community Neuro pathway gap – to be reviewed. • EPUT – workforce concerns reviewing staffing levels along with staffing levels required. • The service is only provided Monday – Friday, not 7 days.
Celebrations	• Monthly programme meeting to be set up • EPUT – Early supported discharge team confirm they have a dedicated AP completing the 6 month review service and are happy with the successful service being provided at present. Therapy gym is fully functioning and working well with patients.

HWE ICS Governance and structure

- South & West Herts– Stroke Leadership Group – with commissioning, provider and clinical representation across all parts of S&W Herts
- East & North Herts – Stroke Programme Board - with commissioning, provider and clinical representation across all parts of East & North Herts
- West Essex – WE are setting up meeting to start in October to include local Princess Alexandra Hospital Trust, Queens, EPUT – Beech ward, ESD team, Stroke Association and Stroke Re-hab centre.
- ICS – evolving long Term Condition governance. Stroke embedded within the disease specific sub-groups.
- The Place based leads are beginning to work collaboratively on stroke, with priority to the development of the Integrated Community Stroke Service specification.

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ICB Board

Patient Initiated Follow Up - Deep Dive

Friday 23rd September 2022

Working together
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What is Patient Initiated Follow Up (PIFU)

What is PIFU?

- Patient initiated follow up provides patients with **direct access** to guidance and treatment when **they** most need it
- Scheduling of follow-up appointments is set by the **patient's clinical need** as and when they need it
- **Patients** can personally contact their hospital team via telephone, email or a web-based patient portal
- At the point of request, patients can receive advice, teleconsultation or F2F apt
- **Removes unnecessary follow-up***

Evidence shows it maintains patient safety
would not include the necessary scheduled appointments, monitoring and investigations

Why PIFU?

- The current outpatient follow-up model is based largely on **clinician-ordered** appointments
- This can lead to **less meaningful appointments**, higher DNA rates, increased anxiety and more time taken off work, school and caring roles
- The majority of patients with long term conditions, or following hospital treatment, **do not require** regular follow up by the hospital team
- Patients do however require **prompt access** to medical care when their condition changes

It is used in a lot of places already but sometimes called different things:

✓ Open access follow-up
✓ Patient led follow-up
✓ Patient triggered follow-up
✓ See on symptom
✓ Open appointments
✓ Open self-referral appointments
✓ Direct Access

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The benefits of PIFU

PIFU benefits to patients

- Empowers people to book appointments when they need them, based on their symptoms and individual needs.
- Reduces inconvenience, time, cost and stress associated with hospital appointments that do not benefit them.
- Improves patient experience and satisfaction.
- Improves people’s engagement with their health (patient activation).
- Services are more responsive due to improved management of waiting lists.

PIFU benefits to clinicians

- Gives confidence that they are seeing the patients who need them the most.
- Gives confidence that patients know how to contact services if they need to.
- Provides a way to jointly develop plans and ‘what if’ scenarios with patients, and share the clinical risk.
- Helps manage caseloads and waiting lists in a safe and effective way.

PIFU benefits to providers and systems

- Reduces waiting times and waiting lists due to net reduction in follow up appointments.
- Reduces unmet need and clinical risk from patients waiting for follow up appointments.
- Reduces DNAs as patients can decide when they need an appointment.
- Enables delivery of the NHS Long Term Plan aim of reducing unnecessary face-to-face Outpatient appointments by 1/3.
- The associated reduction in travel will reduce CO2 emissions and support the ambition of delivering a ’Net Zero’ NHS.

The national PIFU ask for 2022/23…

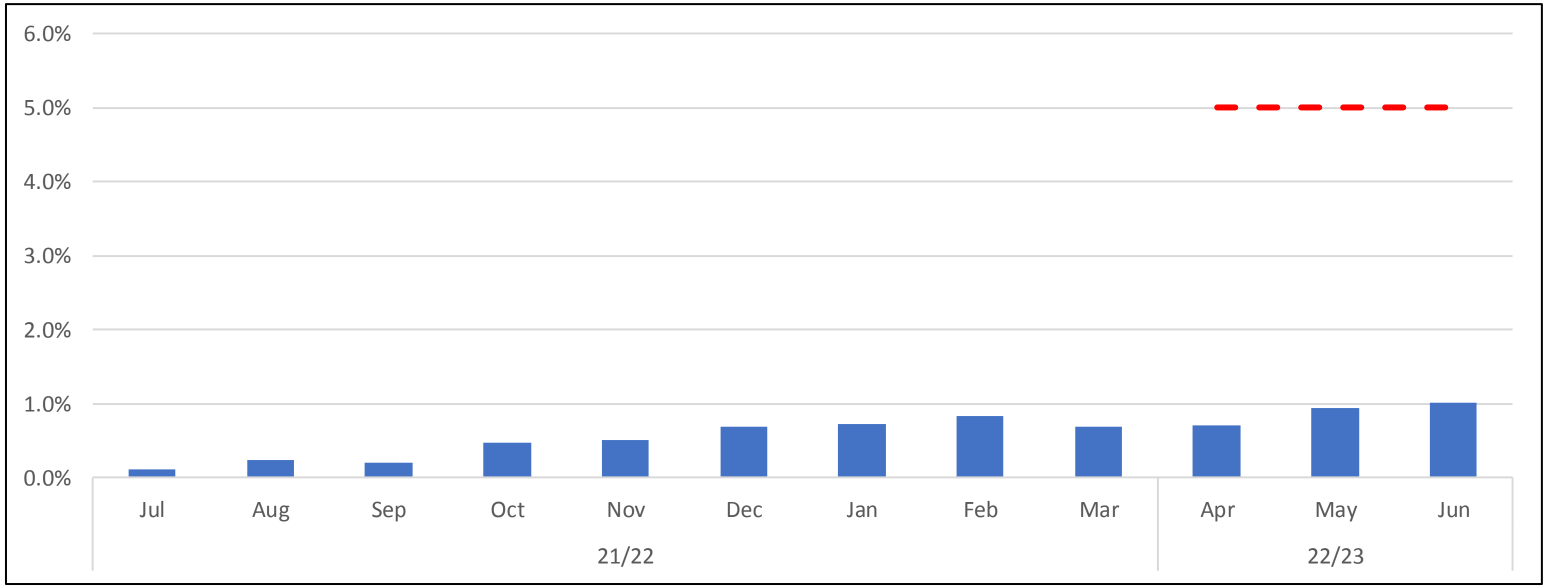
Expanding the uptake of PIFU to all major outpatient specialties, moving or discharging **5%** of all Outpatient attendances to PIFU pathways by March 2023.

PIFU plans for further roll-out and development

Provider	**PIFU live specialities**		**PIFU further roll out planned**
Princess Alexandra Hospital	Breast Neurology T&O Physio & Hand Therapy Cardiology ENT Dermatology Urology	Endocrinology Diabetes Gastroenterology Paediatrics General Surgery Colorectal Rheumatology	• Non-discharge pilot specialties and pathways identified; Neurology MS service (with a plan to expand into epilepsy at a later date) and Gastro IBD pathway. Pathway mapping has been drafted for comments, the SOP is in progress along with the patient outcome letters. Testing and reporting is the next phase of test before a confirmed start date for the pilot. Estimated pilot start date - November 22.
West Herts Hospital Trusts	Rheumatology Cardiology Dermatology Diabetes Ophthalmology	Physio Breast Prostate Colorectal CMDU	• Specialties that have expressed a clinical interest to implement PIFU • Targeting specialities with the longest waiting lists and largest DNA rates • To pilot in 3 specialties; placing all DNA rebooks on PIFU pathways
East & North Herts Trust	Breast ENT Urology Neurology Cardiology	T&O Pain Gynaecology Elderly Care Plastic dressing	• Ophthalmology • Oral • Sleep Study (Respiratory) • General Surgery • PIFU PLUS – implementing in Gastro • Streamlining the generic PIFU pathway and recording processes for PCFU cancer pathways. • PIFU in Cardiology & Elderly Care for patients following an inpatient spell
Community Providers	PIFU pathways to be identified and coded		

	21/22									22/23		
HWE Providers	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
Patients Moved /Discharged to PIFU	147	280	260	599	672	684	812	909	857	769	1169	1139
as % of Total OP Attendances	**0.1%**	**0.2%**	**0.2%**	**0.5%**	**0.5%**	**0.7%**	**0.7%**	**0.8%**	**0.7%**	**0.7%**	**0.9%**	**1.0%**
Target										**5%**	**5%**	**5%**

Trust Split												
ENHT	0.1%	0.2%	0.2%	0.3%	0.2%	0.3%	0.4%	0.5%	0.5%	0.6%	0.7%	0.7%
PAH	0.2%	0.3%	0.2%	0.5%	0.8%	1.0%	1.0%	1.1%	0.9%	0.9%	1.4%	1.5%
WHHT	0.0%	0.2%	0.2%	0.7%	0.7%	1.2%	1.2%	1.2%	0.8%	0.6%	0.9%	1.0%



The % is the number of patients moved/discharged onto PIFU pathways as a function of the total Outpatient attendances within the same period – although the values are low, the trend is moving steadily upwards over time.

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How PIFU “creates” capacity, efficiency and increased productivity

- Appointments are based on individual clinical need instead of being at routine intervals or “just in case” - this reduces unnecessary Outpatient appointments which are a waste of resource and optimises productivity in Outpatient clinics.

- Puts patients in control of their own Outpatient follow up and reduces the number of DNAs and Outpatient visits that do not add any value.

- Freeing up appointments releases capacity which helps towards reducing waiting times for other patients who really need an appointment by re-allocating appointments between long wait follow ups and 1st Outpatient appointments.

- Stops patients wasting time and money by attending appointments that are of little or no benefit.

- Reduces unnecessary patient transport and travel costs, which reduces the number of unnecessary journeys to help reduce our carbon footprint.

- Supports the recovery of the elective backlog following the Covid-19 pandemic.

- Utilising remote monitoring tools to support PIFU pathways will help patients and clinicians decide on the need for follow ups or optimise care remotely.

- Supports effective Outpatient discharge, when it is clinically safe and appropriate to do so, at the earliest agreed time for patients.

What it takes to deliver PIFU

Workforce

- Resources required to implement and roll out PIFU at scale
- Identify opportunity and patient cohorts suitable for PIFU
- Set KPIs, success criteria and performance reporting
- Booking process and management of clinic slots
- Review of patients on the waiting list for each PIFU specialty/pathway

Comms, Engagement and Project Documentation

- Comms and engagement plan
- Clinical engagement
- Patient engagement
- Patient comms to support them with the new PIFU processes and assist patients at risk of digital exclusion to participate in PIFU pathways
- Integrate Personalised Care to enable patients to make informed decisions
- Comms tools and materials such as guidance, key messages, FAQs to support teams when communicating about Outpatient follow up services
- Complete a Health Inequalities Impact Assessment (HIIA)
- Create implementation and benefit realisation plan
- Produce SOPs, clinical protocols, criteria, guidance, triage process, timescales, and safety nets
- Identify, report and mitigate any risks

Training

- Providing appropriate training for staff:
  - Train clinical staff in how to log patients in the system & how to discuss PIFU with patients
  - Train administrative staff in how to manage PIFU clinics and queries from patients

IT and Data

- Review data to estimate how many patients will be impacted for the chosen PIFU specialties
- Analyse baseline activity and performance
- Estimate the impact of PIFU on service appointments and waiting list
- Log and track patients on PIFU pathways and embed PIFU in PAS
- Implement data collection requirements for key PIFU metrics
- Test PIFU safety nets and recording and reporting
- Record and report PIFU as part of national data submissions to Provider EROC
- Use digital technology to implement and support PIFU pathways

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PIFU Patient Survey –Free text comments

Support for PIFU:

“It feels like I am in control, I can book a f/up appointments as I need rather than when one is due whether or not I need it.”
“It makes total sense, not wasting NHS money.”
“Rather than clogging up the system with potentially unnecessary appointments, I was happy to call the hospital to discuss my condition when it arose and an appointment was then booked.”
“It makes sense given limited NHS resources to offer this.”
“I think it gives a patient the freedom to choose for their own good.”
“I liked the fact I had time to make my own decision and instructions were sent to me in the post, easy to follow.”
“This allowed me to bypass the GP Surgery for a referral and made the process significantly more efficient.”

Q15: Please share any service suggestions or comments you would like to make about PIFU.

“The criteria for requesting a follow-up consultation wasn't entirely clear. The concept is good.”
“Principle is good but practice was poor, better monitoring of consultants diary needed.”
“It wasn't explained very well and I was concerned that I needed a follow up but didn't know how to book.”
“The PIFU thing is good if only one can get appointment on time instead of having to wait for too long.”
“Patients may feel that they do not want to follow up as they may feel there are others worse off than them with Covid-19 etc.”

PIFU Patient Survey –Conclusions

- Response rate of 16.5% was quite good
- Relatively small sample -117 responses and 40 patients who had booked a PIFU appointment
- Overall, results are positive
- Only 10% of patients said PIFU wasn't good for patients
- The free text comments show support for PIFU as a concept
- PIFU is reducing the number of outpatient appointments booked. (Current overall conversion rate for PIFU is 7%)
- The survey results highlight issues with communication around PIFU –many patients didn't know they had one

PIFU Risks & Mitigations

Risk	Mitigation
• There is a risk that the IT issues and lack of resourcing to support technical aspects of PIFU which could lead to activity under performance; contributing risk factor having IT barriers to recording PSFU activity and therefore unable to extract the correct level of PSFU activity to contribute towards the overall PIFU target.	• Escalate to Heads of IT to identify additional resource to expedite project delivery. Working with relevant BI, Operational and Transformation Leads across the ICS to identify what recording and reporting can be made available to submit to Provider EROC.
• There is a risk that the ICS PIFU roll out plans are not sufficient in meeting the 2022/23 PIFU target of 5% of all Outpatient activity, therefore not releasing sufficient FU Outpatient capacity.	• Regular monitoring of Place-based partnership PIFU plans.
• There is a risk in clinical confidence to move/discharge patients to PIFU.	• Clinical engagement supported by evidence from Royal Colleges, NICE and ‘real-world’ examples. • Shared learned experiences between providers. • Provision of training and development to ensure that junior doctors are confident in their ability to move/discharge patients to PIFU. • Development of SOPs for PIFU and clinical agreement to standardise PIFU process at a pathway level.
• There is a risk that additional clinical and admin time is required to monitor patients on a PIFU pathway.	• Use of other clinical professionals (e.g. AHPs) may be able to support PIFU pathways and remote monitoring.
• There is a risk we will see a reduction in discharges due to patients being inappropriately added to PIFU.	• Monitor the proportion of patients who are discharged without being put on a PIFU pathway, to identify any change in practice around discharging patients. • Address risk as part of clinical guidance. • Clinical education on true meaning of PIFU pathway and ongoing monitoring.
• There is a risk in identifying patients on PIFU pathway may mean that PIFU patients are not able to access services quickly and services are not able to easily contact patients if they need to.	• Tracking and reporting on the no of patients on PIFU pathway for each specialty. • Ensure patients are discharged appropriately at the end of their time on the PIFU pathway. • Develop comms resources e.g. patient info leaflets and videos for patients to have a good understanding of the PIFU processes and its objectives.
• There is a risk that some patients may not get in touch with services, even when they experience symptoms that meet the criteria agreed with the clinician.	• Develop comms resources such as patient information leaflets and videos for patients to have a good understanding of the PIFU processes and its objectives. SMS text reminders about when to contact services. • Provide a patient portal to support with objectives clinical measures and automatic triggers of clinical review. • Set guidelines for which patients PIFU is suitable for, so that patients are not put on the PIFU pathway if it is not right for them. Communicate with patients’ GPs to ensure they are kept informed.
• There is a risk that it might take too long for patients to access an appointment with the service because of service pressures which will result in a clinical risk to patient/harm.	• Put robust processes in place to ensure quick access for urgent PIFU appointments. • PIFU appointments prioritised in line with other waiting list targets.
• There is a risk that patients may lose track of their PIFU information.	• Send information both digitally (e.g. via email, SMS) and hard copy (e.g. leaflet posted to patients) • Monitor whether patients have clicked on links on emails/SMS and re-send if the links have not been accessed as expected. • Send information to patients’ GPs. • Provide a patient portal to support with objectives clinical measures and automatic triggers of clinical review

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ICS Board

Virtual Ward – Deep Dive

Friday 23rd September 2022

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Virtual Ward – Definitions

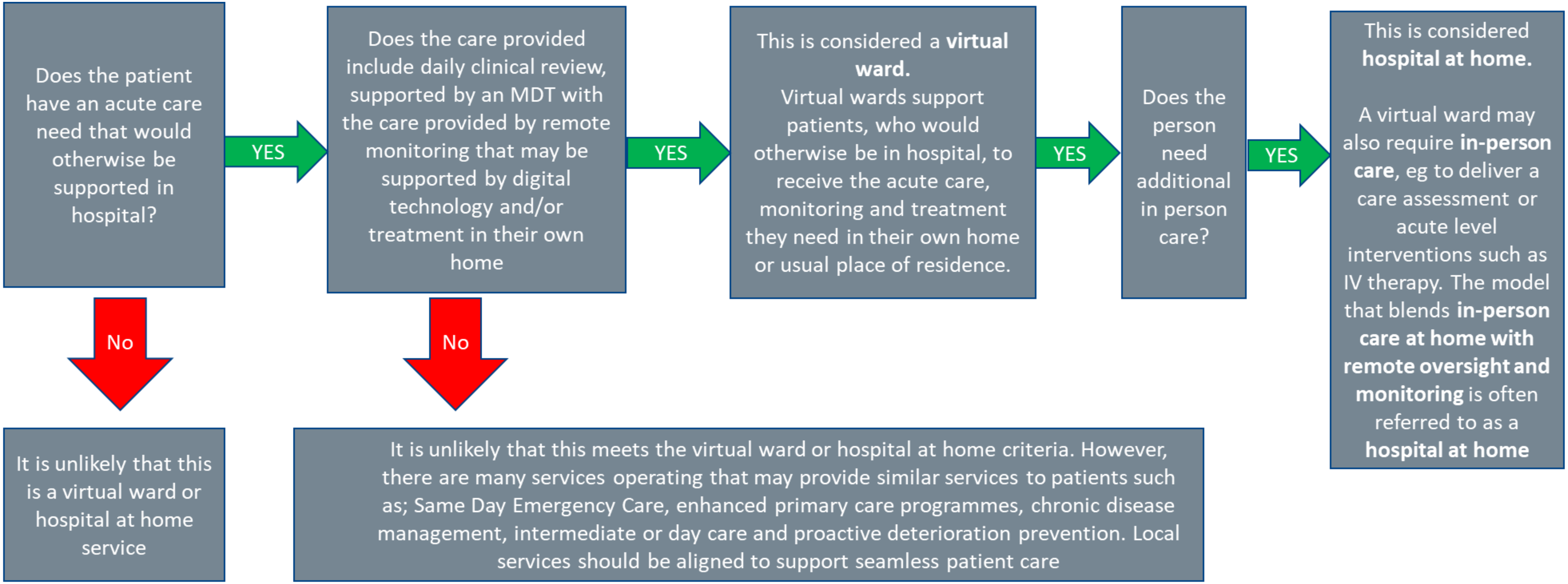
- **Virtual Ward**: A virtual ward is a safe and efficient **alternative to NHS bedded care** that is enabled by technology. Virtual wards support patients who would **otherwise be in hospital** to receive the acute care, monitoring and treatment they need in their own home. This includes either **preventing avoidable admissions** into hospital, or **supporting early discharge** out of hospital.

- **Hospital at Home**: Hospital at home is a type of virtual ward. A virtual ward may also require **face-to-face** care, e.g. to deliver a care assessment or acute level interventions such as IV therapy. The model that blends **in-person care at home with remote oversight and monitoring** is often referred to as a hospital at home.

- **Remote monitoring**: gathers patient data (e.g. images, symptoms, physiological observations) to give clinicians and patients information that would normally only be obtainable in a face to face assessment, to **improve clinical decision making, provide reassurance and enable the early detection of deterioration**. This may include solutions that are enabled by digital technology e.g. wearable devices

- ***Please note:*** *A virtual ward* ***is not*** *a mechanism intended for enhanced primary care programmes; chronic disease management; intermediate or day care; safety netting; proactive deterioration prevention; or social care for medically fit patients for discharge*

Virtual Ward or Hospital@Home?



Does the patient have an acute care need that would otherwise be supported in hospital?

Does the care provided include daily clinical review, supported by an MDT with the care provided by remote monitoring that may be supported by digital technology and/or treatment in their own home

This is considered a **virtual ward.**
Virtual wards support patients, who would otherwise be in hospital, to receive the acute care, monitoring and treatment they need in their own home or usual place of residence.

Does the person need additional in person care?

This is considered **hospital at home.**

A virtual ward may also require **in-person care**, eg to deliver a care assessment or acute level interventions such as IV therapy. The model that blends **in-person care at home with remote oversight and monitoring** is often referred to as a **hospital at home**

It is unlikely that this is a virtual ward or hospital at home service

It is unlikely that this meets the virtual ward or hospital at home criteria. However, there are many services operating that may provide similar services to patients such as; Same Day Emergency Care, enhanced primary care programmes, chronic disease management, intermediate or day care and proactive deterioration prevention. Local services should be aligned to support seamless patient care

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Virtual Ward – Benefits

- Virtual ward models cover a wide range of conditions, including frailty, COPD, heart failure, and infections

- Published research for frailty Hospital-at-Home demonstrates that:
    - patient outcomes can be better than those in hospital – eg decompensation
    - patients prefer being cared for at home rather than in hospital
    - patients experience less delirium
    - it is highly likely to be more cost-effective than its hospital equivalent

- Similarly, other virtual ward settings have realised significant benefit so far, with local evaluations concluding:
    - patients are admitted into hospital less frequently
    - patients prefer being cared for at home
    - mortality can be lower for those patients supported at home
    - Reduction in need for subsequent care home admission

- National modelling has also supported these studies, with initial analysis indicating a strong likelihood that there is an opportunity to realise a net 12% increase in national general and acute capacity

Virtual Ward – Funding

- Funding is available from the Service Development Fund (SDF) in 2022/23, along with some smaller pots of money, to help support the implementation and development of virtual wards.

- A further contribution will be available in 2023/24 from SDF, on a match-funded basis, but the funding release will be dependent on achieving the target 'bed' number by December 2022.

- It has been agreed that HWE will match-fund on growth from acute trusts.

Virtual Ward – (HWE early/ first adopters but not a national ambition)

Ambition for FY22/23:

AMBITION

ICSs are asked to develop comprehensive, multi-year plans and deliver virtual ward capacity equivalent to:

40-50 virtual ward 'beds' per 100k population

Successful implementation will require systems to:

- maximise their overall bed capacity to include virtual wards
- prevent virtual wards from becoming a new, community-based 'safety-netting' service; they should only be used for patients who would otherwise be admitted to an NHS acute hospital bed, or to facilitate early discharge
- maintain the most efficient, safe staffing and caseload model
- manage length of stay by establishing clear criteria to admit and to reside for services
- fully exploit remote monitoring technology and wider digital platforms to deliver effective and efficient care

CONSIDERATIONS

- This is not a mandatory target, but is proposed as an ambition in recognition of the work that many systems already have at least one non-Covid-19 virtual ward in their footprint
- This ambition was set following the national development of ARI and frailty pathways, which included defining the approach, the enabling technology, and the resources required to support the scale of virtual wards
- There is now a two-year transformation programme being initiated nationally, which will support regional and local development

Virtual Ward – Workforce Requirements

WORKFORCE REQUIREMENTS

- To assess the total workforce required to staff the number of virtual wards needed to realise the size of the prize, NHSE took the following approach:
    - Developed a generalised staffing structure for both virtual ward models, reflecting FTE and core functions
    - Analysed the estimated workforce requirements across disciplines
    - Calculated the potential benefit in net staffed bed capacity
- Calculated that the **maximum workforce requirement** would be for **~10k staff**, compared to the ~13k staff required in traditional bedded units
- This analysis indicated that fewer staff are required to support patients on a virtual ward when compared to similar patient numbers in bedded hospital settings, largely as a result of enabling technology

NET STAFFED BED BENEFITS

- We then carried out sensitivity analysis on two key variables – mean patient **length of stay**, and the **proportion of staff** supporting virtual wards who would be coming from existing acute settings
- Calculating the benefit of realising the size of the prize equated to a net **increase of 12%** in national general and acute bed capacity
- Additionally, when compared to setting up temporary physical units, virtual wards were a more cost-effective alternative that promoted better patient experiences and health outcomes

Virtual Ward – Type of Ward

Organisation	Ward Type	Ward Name	Capacity	Type of Monitoring	Technology Provider
HERTFORDSHIRE COMMUNITY NHS TRUST	Hospital at Home	E&N Hertfordshire Hospital at Home/Virtual Ward	100	Face to Face & Remote Monitoring	TPP
ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST	Virtual Ward	West Essex Virtual Wards	40		TPP
THE PRINCESS ALEXANDRA HOSPITAL NHS TRUST	Hospital at Home	Hospital at Home	24		Cambio
WEST HERTFORDSHIRE TEACHING HOSPITALS NHS TRUST	Virtual Ward	COVID	110		CIVICA
WEST HERTFORDSHIRE TEACHING HOSPITALS NHS TRUST	Virtual Ward	Respiratory/COPD	5	Continual monitoring	CIVICA
WEST HERTFORDSHIRE TEACHING HOSPITALS NHS TRUST	Virtual Ward	Heart Failure	15	Spot monitoring	CIVICA
WEST HERTFORDSHIRE TEACHING HOSPITALS NHS TRUST	Hospital at Home	WH Hospital at Home 001	20		Cerner

- Virtual
- Face to Face
- Different pathways eg COPD, HF, UTI, other IV needs, falls, post surgery
- Step down from hospital – SDEC/A&E/ shortening length of stay
- Prevention of Admission

Virtual Ward – HCT Case Study

Virtual Ward (inc. Hospital@Home) Reporting - Sitrep

VW Sitrep – Data submitted weekly on:

- **Type of model(s) in place**
- **Capacity**
- **Current occupancy** of the virtual ward – number of patients – by clinical cohort (essentially the primary diagnosis at point of admission to the virtual ward at ICD-10 chapter level) and of these how many are using a technology-enabled service
- **Admissions** to the virtual ward – number of patients – per week by clinical cohort, as above, and
  - referral/admission route
  - age group
  - ethnicity
  - person-stated gender
- **Discharges** from the virtual ward – number of patients – per week by clinical cohort and
  - discharge destination
  - length of stay (categorised)
  - local estimate of acute bed days saved from those patients

Please note: The national team is working on rolling out a dashboard soon to support the Sitrep collection/data flow.

Virtual Ward – Reported Capacity and Occupancy by ICS

Region	ICS	No of Virtual Ward Services	Total VW Capacity	Total VW Activity	VW capacity per 100k population	VW Occupied per 100k population
East of England	Bedfordshire, Luton and Milton Keynes	0	0	0	0.0	0.0
East of England	Cambridgeshire and Peterborough	5	94	29	11.2	3.4
East of England	Hertfordshire and West Essex	7	314	180	24.1	13.8
East of England	Mid and South Essex	4	245	128	24.1	12.6
East of England	Norfolk and Waveney Health and Care Partnership	3	70	65	7.7	7.1
East of England	Suffolk and North East Essex	1	30	0	3.4	0.0

Notes:

A) Per 100k population calculated on adult (16+) GP registered population as at April 2022
B) Capacity – the number of patients who can be managed simultaneously on a virtual ward
C) Activity – the number of patients who are being managed on a virtual ward.

Virtual Ward –

Organisation	No of Virtual Ward Services	Total VW Capacity	Total VW Activity	VW capacity per 100k population	VW Occupied per 100k population
Hertfordshire and West Essex	**7**	**314**	**180**	**24.1**	**13.8**
West Hertfordshire Teaching Hospital NHS Trust	4	150	41		
Hertfordshire Community NHS Trust	1	100	117		
Essex Partnership University NHS Foundation Trust	1	40	5		
The Princess Alexandra Hospital NHS Trust	1	24	17		

- Prevention of admission = more bed days and clinical engagement
- Handover at home and rapid community response
- Acute trust engagement including in evaluation

Evaluation and Place within Wider Urgent and Emergency Care Plans

(and Place in the Planned Care Space)

Meeting:	*Meeting in public* ☒	*Meeting in private (confidential)* ☐		
	HWE ICB Board meeting held in Public		**Meeting Date:**	**23/09/2022**
Report Title:	**Chair's Update Report**		**Agenda Item:**	**08**
Report Author(s):	Michael Watson, Chief of Staff			
Report Signed off by:	Paul Burstow, ICB Chair			
Purpose:	**Approval** ☐	**Decision** ☐	**Discussion** ☒	**Information** ☒
Report History:	Not applicable			
Executive Summary:	This report provides the ICB Board with a high-level update of the range of key operational & transformational workstreams across the organisation and wider system.			
Recommendations:	The Board are asked to note the contents of this report.			
Potential Conflicts of Interest:	***Indirect*** ☐	***Non-Financial Professional*** ☐		
	Financial ☐	***Non-Financial Personal*** ☐		
	None identified ☒			

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

Chairs Report to the Integrated Care Board- September 23rd

The death of Her Majesty Queen Elizabeth II

I have expressed on behalf of the Board, our deep saddness at the passing of Her Majesty the Queen and extended our heartfelt sympathy and condolences to the Royal Family. They are in our thoughts at this difficult and painful time.

As we reflect on and give thanks for the Queen's life-long commitment to public service, we should also recall her connections to the NHS in Hertfordshire and west Essex. Queen Elizabeth II had links to our area which go back to the early years of her reign. Her Majesty opened the QEII Hospital named in her honour in Welwyn Garden City in 1963, the country's first general hospital to be built after the Second World War, and more recently visited the Diamond Jubilee Maternity Unit at Lister Hospital in Stevenage in 2012. As evidenced by the public reaction her loss will be felt profoundly across the country.

Governance Approach

With the Integrated Care Board now in its third month, much of our focus has necessarily been on implementing ways of working which will enable us to achieve our key objectives as an organisation. Given the significant operational challenges facing the NHS in all systems, especially as we move into the winter months, it is essential that we have governance arrangments in place that support us to have informed discussions and take decisions at the right place and time, and that we identify and manage risk effectively.

This is particularly true in relation to the Board itself – where we need to maintain our focus on the long-term strategic challenges facing the NHS, for example workforce shortages, improving the NHS interaction with the social care system, working with our partners to address the drivers of poor health, realising the benefits of digital and the use of data to drive improvement in services and outcomes and the need for capital investment in critical NHS estate to improve the quality and experience of care and unlock opportunities for service transformation.

However, whilst keeping our focus on those strategic challenges, we also must work as a Board to ensure the ICB plays its leadership role in managing the here and now impacts that those strategic challenges are already having – in particular in relation to Urgent & Emergency Care, elective recovery and access to primary care.

To ensure we can strike that balance between shaping the future and managing the present we have made some changes to our approach to the Board today. This includes shortened committee reports, a deep dive into Virtual Wards and Patient Initiated Follow-up (PIFU) including the perspective of service users, and time on the agenda for us to reflect on what service users, patients, carers and staff would take away from our discussions. I am sure our approach will require further iteration at future meetings and I welcome constructive feedback.

Key to enabling the Board to maintain a focus on both the immediate and strategic challenges will be a need for our Committees and other parts of our governance to shoulder the responsibility for deliberating and deciding much of the business of the ICB. Again this will continue to develop as we set the drum beat of business and I appreciate the support of all Board colleagues, and especially those that chair committees, in helping to make sure that this is the case.

Another critical factor in the Board being able to fulfil the purpose of ICBs and address those challenges will be the extent to which we act as a truly unitary board- with Partner Members playing the same role as Non-Executive Members. I recognise that there are some concerns about demands on the time of board members at this time- and this will form an important part of our Board development discussions in the months to come.

Our Development as a Board

A comprehensive board development programme is in place for 2022/23, and designated time throughout the year for us to focus on development. We have appointed TPC to work with us as we establish ourselves as a high challenge, high support Board.

I am grateful to everyone that participated in the recent TPC interviews, in which TPC spoke to all members and named attendees of the board. I look forward to discussing the outcome and implications of those interviews at our next development session.

We are also currently finalising proposals to engage an external provider to support the development of the ICBs vision- especially in relation to Population Health. We hope that work will begin this month.

July-September Activity

In addition to attending and chairing Board Committees and holding regular 121s with ICB Executive colleagues and weekly catch-ups with the Chief Executive and Chief of Staff I list below a sampling of my activities on behalf of the Board.

Integrated Care Partnership (ICP): I attended the first meeting of the ICP in July- which was a great start in bringing together system partners to identify and tackle our shared challenges. As Vice-Chair of the ICP I am working with its Chair (Cllr Richard Roberts) on a development programme between now and Christmas which will support the establishment of the ICP and its approach to formulating and finalising the ICS 10-year strategy. The first development session takes place on 16th September.

Meeting with Members of Parliament: I have arranged meetings with all the Members of Parliament for our area. These will focus on their current constituency concerns and the actions we are taking as an ICB and as a system to address them. Some of the planned meetings have had to be postponed during the period of National Mourning.

Supporting NHS England as it develops its proposed operating framework: I have been asked by the NHS Confederation to Chair an national ICB reference group on regulation and recently chaired a session with Mark Cubbon, Director of Delivery at NHS England to discuss the proposed operating framework. It is anticipated that NHSE will publish the final version shortly.

Meetings with System Colleagues: In August I met with our NHS Trust Chairs and updated them on the strategy work being undertaken by the ICP. We will be meeting in person on the 16th September.

Meeting with Regional Colleagues: In July I had an introductory meeting with the new Regional Director, Clare Panniker. Along with the other East of England ICB Chairs I met with Clare in September to discuss the plans for NHSE to delegate of Dentistry, Pharmacy and Optometry commissioning to ICB from next April and Specialist Commissioning thereafter. At the start of September I met with Simon Wood, NHS England’s Regional Director link for the ICB, to discuss several areas of collaboration and our future ways of working together.

Meeting:	*Meeting in public*	☒	*Meeting in private (confidential)*	☐
	HWE ICB Board meeting held in Public	**Meeting Date:**	**23/09/2022**	
Report Title:	**Chief Executive Officer's Report**	**Agenda Item:**	**09**	
Report Author(s):	With contributions from the ICB Executive Team			
Report Signed off by:	Jane Halpin, Chief Executive Officer			
Purpose:	**Approval** ☐	**Decision** ☐	**Discussion** ☒	**Information** ☒
Report History:	Not applicable			
Executive Summary:	This report provides the ICB Board with a high-level update of the range of key operational & transformational workstreams across the organisation and wider system.			
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	Helping the NHS support broader social and economic development	☒
	Successfully complete and embed the transition of staff and functions from the three clinical commissioning groups into the Integrated Care Board	☒
	Develop the ways of working and profile of the Integrated Care System to ensure that its operating model is capturing the opportunities presented by closer system working	☒

Chief Executive Officer's Report

In the months since the establishment of the Integrated Care Board at the start of July, we have made some significant process as an organisation across our key areas of focus- working with system partners to further strengthen our joint approach to tackling the ongoing unprecedented demand on Urgent and Emergency Care, to reduce the elective waiting lists, improve performance against our cancer targets, coordinate delivery of the autumn booster programme and improve access to Primary Care. Further detail on all of this work is in the key updates section of this report.

Two crucial enablers of improvement across those areas will be our workforce and ensuring we grasp the opportunities presented by digital transformation. We have developed system wide strategies in both these areas- with the Digital Transformation Strategy and the People Strategy are expected to our meeting in November.

As well as the necessary focus on these immediate challenges, the creation of the Integrated Care Board also enables us to take steps to tackle health inequalities and deliver improvements in Population Health across Hertfordshire and West Essex. There are a number of examples of our work in this space in my report this month- with just one example being the excellent work to pilot targeted approaches to tacking inequalities in West Essex. Several members of the ICB team are also supporting partners to develop the Integrated Care Partnership strategy, which will set out our future vision for the system.

It has also been our pleasure to welcome senior leaders from NHS England to Hertfordshire and West Essex over the last few weeks- with separate visits from Clare Panniker, Regional Director for the East of England and Sir David Sloman, Chief Operating Officer of the NHS. Clare and I visited the Hertfordshire Community Trust “hub” at Robertson House in Stevenage, and had the opportunity to meet with team members from several different services. Clare also met with the ICB executive to discuss a number of areas.

David visited Watford General Hospital to see for himself the urgent need for redevelopment of that site, and to observe their Virtual Hospital Hub. We also visited Vicarage Road (home of Watford FC) to find out more about the ‘Shape Up Together’ physical activity and education programme, and the ‘Man On’ sessions funded by Watford FC Community Trust & Herts County Council, in conjunction with referring GPs and mental health services, before meeting with leaders from across the system.

Both David and Clare were highly complimentary of the services they visited and the work of the Hertfordshire & West Essex ICS.

I have also been able to visit some of our local services. I spent an interesting morning at Kingfisher Court (Hertfordshire Partnership FT) meeting staff and patients, and seeing services including neuromodulation, acute assessment and the mother and baby unit. I was also able to visit the Lister hospital (E&NH Trust) Surgicentre and Emergency Department. Staff in both Trusts were very welcoming and took great pride in their services, and the amount of innovation and adaptation was impressive.

In the coming months we will continue our focus on putting in place some of the key building blocks of our approach as a system- finalising our own internal ICB structures, making significant progress with the development of our strategy, progressing our plans for a system elective hub, holding an event on the 4th of October to bring system leaders together to agree our approach to place based partnerships and implementing our winter plans to support colleagues through what will be a difficult period for the entire NHS.

I would like to thank all of our system partners, and staff across the system, for all of their support for the organisation over the first two months of its existence, and for their hard work and dedication in the months ahead.

Jane Halpin
CEO

Appendix A: Key updates

1. Strategy Development

1.1 An initial presentation scoping the process for developing and agreeing the Integrated Care Strategy was shared at the first meeting of the Integrated Care Partnership in late July. (Presentation available on website). During August three strands of work have been underway. Firstly, a range of potential priority areas have been worked up based on early feedback to form the basis of a wider engagement exercise with key stakeholders and the wider public during October and November. This work is led by a small muti-agency task and finish group. A communications and engagement working group has been established and has begun to scope out the engagement process and work has commenced to develop the outline strategy document itself. A detailed update on progress will be shared with the ICP at its September meeting and will be made available to ICB Board members.

1.2 We have recently been awarded some short notice funding from the national cancer team as part of East of England Lung Health Check programme to run a lung health check pilot in the Harlow area, delivered in partnership between PAH, InHealth and primary care to screen 700 ex-smokers. The focus will be on the local community and veterans aged 55-75 who are ex-smokers. It will involve 5 to 6 days of a mobile CT in supermarket car park, with face to face nurse specialist appointments for high-risk patients following telephone triage. The team are now working to identify a suitable site for the mobile CT, patient details for invitations and follow up capacity for further diagnostics & treatment. It is expected that subject to evaluation we will have further opportunities to run similar schemes across the wider ICB area.

2. Primary Care Update

A) Delegation of Pharmacy, Optometry and Dental (POD) contracts

2.1 Following on from the update at the last ICB Board, work is progressing to take on delegated responsibility for NHS England’s community pharmacy, optometry and dental (POD) commissioning functions under powers set out in the Health and Care Act 2022. This provides an opportunity to remove organisational silos and integrate pathways of care for the benefit of patients.

2.2 Work to date has focussed on the agreement of the operating model for the 3 contractor groups. Each ICB will take on fully the commissioning of Dental services for their patients, this will include a proposed TUPE of staff from the EoE NHSE Dental Team to each ICB following national moderation.

2.3 For Pharmacy and Optometry contracts there will be a hosting arrangement for the contractual aspects of commissioning, with HWE taking on this function as host on behalf of the other 5 EoE ICBs. Responsibility for Transformation for Pharmacy and Optometry will remain with each ICB. This reflects the transactional nature of the contracting function and the practicalities of aligning a small team with specialist skills to each ICB.

2.4 As is the case for Primary Medical Services, the Medical Directorate at NHSE will retain responsibility for practitioner performance for POD.

b) Hosting of Pharmacy and Optometry (P&O) Contracting Function

2.5 HWE has been working with NHSE and EoE ICBs to progress the preferred model for the hosting arrangement. There is agreement that the function will move as it is currently configured to

HWE, to enable continuity. The P&O Contracting Team will form part of the primary care contracting team under the Executive lead for Primary Care Transformation. The team will host the Pharmaceutical Services Regulations Committee, which will report at least 6 monthly as prescribed in the Regulations to each ICB Primary Care Commissioning Committee or equivalent.

2.6 HWE has been working closely with NHSE and the other 5 ICBs to develop a draft Memorandum of Understanding (MOU) between HWE and the other ICBs within the Region to set out the responsibilities and expectations for each of the signatories. In addition, NHSE are developing an MOU to describe the interface between the ICBs and the retained functions at NHSE.

b) Pre-Delegation Assessment Framework (PDAF)

2.7 Completion of the PDAF is a requirement of the NHSE National team to determine whether each ICB will be approved to proceed with the full delegation of POD. The PDAF asks the ICB to RAG rate themselves against 4 domains; with a brief description of the work underway to ensure system readiness for the transfer in April. The domains are Transformation and Quality, Leadership and Governance, Finance and Workforce, Capability and Capacity. In addition, each ICB should identify the key risks and issues with their proposed mitigations and any support they require from Region or National NHSE teams. ICBs are also asked to rate as current and what they predict their RAG status as at March 2023 following mitigating the identified risks. These must be signed off by the Chief Executive of the ICB.

2.8 HWE have completed this, alongside a first draft Safe Delegation Checklist and supporting documents setting out the proposed Governance and Team structures., using a multidisciplinary approach including, Primary Care, Finance, Quality, Medical and Governance teams.

C) Key Risks

2.9 To note, the PDAF process has highlighted several key risks including, a lack of knowledge within the system and gaps at NHSE in information, risks associated with quality with the current quality and medical functions retained by NHSE for POD as well as the financial risk which is seeking for detailed information to be shared over the next months to continue progressing with the due diligence. This is an issue across all systems and has been raised through the PDAF and through the ongoing meetings with NHSE. The PDAF has identified a number of areas which are required to be understood between now and end of March to enable the ICB to progress to delegation.

D) Next Steps

As outlined in the timelines at the last board report, we are on track for NHSE to review our PDAF by 16th of September for it to be then submitted to national team on the 3rd of October. It is proposed for NHSE to make final decision in December 2022.
Internally to progress the due diligence and build the intelligence, the team are recruiting a project management resource to support this. This resource will continue the MDT approach taken to date to ensure that a task and finish group comprising a wider range of stakeholders can work to effectively operationalise the transfer of the P&O Contracting, Pharmacy Transformation and Dental Commissioning functions, identify and mitigate against risks.

3) Covid Vaccination Update

3.1 JCVI has recommended that for the 2022 autumn booster programme, the following groups should be offered a COVID-19 booster vaccine:

- residents in a care home for older adults and staff working in care homes for older adults
- frontline health and social care workers
- all adults aged 50 years and over
- persons aged 5 to 49 years in a clinical risk group, as set out in the Green Book (chapter 14a, tables 3 and 4)
- persons aged 5 to 49 years who are household contacts of people with immunosuppression
- persons aged 16 to 49 years who are carers, as set out in the Green Book (chapter 14a, table 3).

3.2 The programme has begun the week commencing 5 September, with visits to care homes and housebound patients. Formal launch of the programme took place on 12 September with a number of locally agreed sites i.e. high volume sites commencing vaccinations. With effect from 19 September all sites will be actively vaccinating at full operational capacity.
The opening of cohorts is expected to be phased with cohorts 1-3 opening from 5 September, and cohorts 4-9 opening in October.
The programme end date is currently 15 December 2022.
Co-administration of flu and Covid is encouraged, and most providers have indicated that they will co-administer where possible.

3.3 In order to ensure this programme is sustainable with the changes in the funding and contracting, teams have working in partnership with all stakeholders to propose an enhanced accessible model through primary care via Primary Care Networks (PCN) and Community Pharmacies (CP) whilst reducing the number of vaccination centres and repurposing the workforce from the vaccination centres to roving models.

3.4 For the autumn programme, across HWE we have a total of 30 PCNs and 68 CPs participating. In addition, 2 out of 5 vaccination centres will take part in the Autumn booster programme- Harlow Leisurezone and Stevenage. Harlow Leisurezone will close 31st October 22 (lease end date).
The following vaccination centres have closed:

- Watford Town Hall
- Argos Letchworth
- Hemel Hempstead Hospital

Hospital Hubs

3.5 The main providers Princess Alexandra Hospital, West Herts Trust, Hertfordshire Partnership Foundation Trust (HPFT) and East and North Herts Trust will all be vaccinating their own staff, again co-administrating covid and flu were possible. HPFT will be vaccinating some of their long-term/stay patients whilst encouraging staff to be immunised via local vaccination centre or community pharmacy using the national booking system.

Social Care

3.6 Hertfordshire and west Essex social care including adult and children services have been working in partnership with the system to ensure that communication and uptake of the booster campaign is maximised. In addition to the joined up work to ensure vulnerable patients including care homes residents; learning disability and mental health are prioritised, a letter has been produced for the wider social care workforce to prove their eligibility for the booster in the absence of an ID card. Overall, there is enough capacity and mostly good geographical coverage to give great access across all areas of HWE. However, in areas where geographical gaps have been identified the pop up model will be put in place.

4. Primary Care Access

4.1 Work continues within primary care on improving access to general practice. Since the last Board report, the GP Patient Survey (GPPS) results were published end of July 2022. The ICB results are in line with the national averages which has seen a drop in patient experience as expected with the Covid Pandemic and increased demand across the Health and Social Care system. Although the ICB is in line with the national picture, there is significant variance amongst PCNs and GP Practices which will need to be addressed.

4.2 In summary:

Question	**National Average**	**ICS Average**	**Observation**
Overall experience of GP Practice	72% (Good) 14% (Poor)	72% (Good) 14% (Poor)	Almost 50% of PCNs achieved or exceeded the national & ICS average
Ease of getting through on phone	53% (Easy) 47% (Not Easy)	48% (Easy) 52% (Not Easy)	The % of patients finding it easy getting through on the phone ranged from 28% up to 71% across PCNs
Experience of making an appointment	56% (Good) 26% (Poor)	54% (Good) 27% (Poor)	This was a similar picture for “Satisfaction of appointment times offered” with an average of 70% of patients accepting the appointment offered
Perceptions of Care	83% (Good) 5% (Poor)	83% (Good) 5% (Poor)	Although marginally worse in relation in recognising/understanding Mental Health Needs.
Use of services when GP Practice closed	50% (Good) 30% (Poor)	50% (Good) 31% (Poor)	60% of patients called NHS111 and 31% attended A&E. The remaining 9% used another physical or online service.

4.3 It was clear from the results that there is further work to do to support both patients and GP Practices to improve access and experience of primary care.

4.4 Practices have been able to access funding to support the improvement or upgrade to their telephony systems this year and 97 out of the 135 practices have submitted their bids; 25 practices have now completed their upgrade and the remainder are in progress so it is expected that the patient experience will improve in the next round of the survey.

4.5 A Multidisciplinary Team led by Primary Care Contracting leads to pull together all the work programmes that are currently underway, or planned, to identify appropriate actions that will support practices in improving access and patient experience where needed and also share best practice.

4.6 Examples of work underway:

- Upgrade to telephony systems
- Reinstating Practice Patient Participation Groups with support from National Patient Association. This will include PCN patient participation groups as requested by a number of PCNs.
- Deep dive patient engagement with patients in 3 localities across HWE with a view to understanding needs of the population on access and the impact some of the changes are making or not
- Review of the Practice websites underway
- Negotiation and mobilisation of contracts for online consultations, video consultations, batch text messaging before winter- October 2022
- Initiation of the series of Practice Quality Visits across HWE

4.7 A detailed discussion will take place the Primary Care Board and agree the next steps which will support transformation of primary care.

4.8 Enhanced Access – From 1 October 2022, the current “Extended Access” and “Extended Hours” services are being combined and commissioned through the PCN Directed Enhanced Service (DES) under the new guise of “Enhanced Access”; this will provide appointments every weekday evening up until 8pm and 9 – 5 on Saturdays. PCNs have developed their models following a patient engagement process and may decide to provide additional sessions on a Sunday or early morning where their patient feedback evidences this.
There will be a mix of delivery models; majority of PCNs choosing to deliver the service themselves, however a small number of PCNs have agreed to sub-contract the service to the GP Federation currently providing the service.

4.9Winter Pressures – working in partnership with urgent care leads, primary care leads are currently developing the framework for general practice to support for winter. Building on the experience from last year, it is proposed for PCNs to build on their patient engagement/need of their population to ensure they have the right additional capacity in general capacity. With the implementation of OPEL framework from October across all practices with the launch of the enhanced commissioning framework, general practices are asked to accelerate their recruitment plans for the Additional Roles, increasing the use of social prescribers or provide additional appointments to meet the demand at peak times to reduce pressures on NHS111 and A&E.

5. Performance, Operations and Commissioning

5.1 Key successes to note:

- Bids for funding for Community Diagnostics Centres in West Essex and South West Herts were submitted to NHSE. These are currently being reviewed and we expect an outcome imminently. The Community Diagnostic Centre which is already operational in East and North Herts at the QE2 has had approval to expand the number of modalities to include cardiology and respiratory and has been confirmed as a full specification Community Diagnostic Hub.

- We continue to focus on initiatives that will identify and treat people's cancer quickly and ensure a less invasive and less stressful diagnostic process. Our ambition is that 75% of patients will be diagnosed while their disease is at stage one or two. These are some examples of how our clinical teams are aiming to meet that challenge:
  - Cytosponge is now being trialled in two of our hospitals as a less invasive alternative to an endoscopy. This procedure is more comfortable for patients and is used to find early oesophageal cancers as well as managing conditions like reflux
  - NHSE/Cancer Alliance have just confirmed £117k worth of funding to come to the ICB to support a pilot of 200 scans to be delivered to a targeted patient cohort within the one of the most deprived areas within West Essex. The objective of the Pilot is to identify the cohort of patients at high risk of developing lung cancer, patients within the 55-74yrs and 364 days age range who have smoked, or are smokers, perform a Targeted Lung Health Check with them and for those identified as high risk invite them to have a low dose CT scan. The aim is to identifying lung cancers at an earlier stage which is evidenced to result in better outcomes for the patient. Planning meetings are just about to launch and it is anticipated that the pilot will run in November 2022.

- Our ICB revised EPRR team structure is now fully recruited to on an interim basis. This will enable us to confirm we have the necessary roles in place to be compliant for the national core standards assurance process.
- The UEC Board agreed to the proposed framework for an ICS UEC Strategy at their August meeting. The first stage of this work – a full UEC needs analysis – is now underway. It is anticipated that a first draft of the Strategy should be available for the ICB Board before Christmas.
- Our system bid for winter funding has been successfully submitted and our ICS Winter Task and Finish Group, reporting to the UEC Board, is overseeing the mobilisation of the winter schemes and initiatives and the required UEC Assurance Framework.

5.2 Upcoming opportunities, key events and challenges:

- We are continuing to develop our plans around a system elective hub, which will add elective capacity to our system to enable us to reduce waiting times for patients. This work involves operational, clinical and financial teams from across the system and learning from best practice from other areas.
- Delivering the standards set out in the national elective plan continues to be a challenge. We have met the first target to treat patients who have been waiting for 2yrs for treatment and are now focussing on ensuring the cohort of patients who have waited 18mths are treated by 31 March 2023 and the numbers of patients who have waited a year are reduced. More detail is set out in the Performance report.
- We are holding a HCP Development Workshop on the 4th October, bringing ICS system leaders together to discuss how we continue to support the development of place-based partnerships.
- Whilst our UEC performance position remains highly challenged with demand across the summer exceptionally high, we are now successfully bringing this together in an ICS-wide programme of work governed by the UEC Board. The programme includes daily operational oversight processes between partners, tactical management of capacity, revised surge and escalation protocols, additional capacity and a focus on flow, and place-based and system level transformation projects. We are leading the current tranche of work nationally on the HARIS model (a revised process for managing ambulance demand) where we anticipate

aspects of the model to be able to support our system during winter. This includes additional capacity for early upfront clinical support conversations through a true single point of entry (#Handover@Home), access to the 999 ambulance stack for diverting demand to alternative community-based services including 2 hour community response and virtual wards, and local tactical management of ambulance usage.

6. Place-based updates

East and North Herts

Key recent successes:

6.1 Over the last few months, we have undertaken a refresh of our Clinical and Professional and Transformation Groups, revised the membership, and developed a joint work plan aligned to our strategic priorities. To support this work, we have consolidated our high-priority strategic transformation programmes, ensuring each programme has a Senior Responsible Officer, programme plan and the resources in place to ensure delivery. There has been significant progress across the portfolio including the agreement of the model for the Integrated Heart Failure Service, receiving NHSE approval for respiratory clinics and a direct access holter service at the New QEII as part of Community Diagnostics Hub developments, and developed Joint priorities with the Mental Health Learning Disabilities and Autism Collaborative.

6.2 Public Health have supported the development of a needs analyses for each of our priority areas, having completed the heart failure work earlier this year, the analysis on people living with diabetes has now been completed.

6.3 In other areas:

- The Heart Failure Steering Group have agreed a bid for up to £100k from NHSE to enhance the development of our planned new model of care.
- The fourth Community Assembly has been held, and a model of involvement has been agreed, which will include linking patients with our priority projects.
- The Health Inequalities Group has agreed an action plan to ensure addressing inequalities is embedded across the partnership.
- The inaugural Quality Group has been held which will initially focus on addressing quality improvements across our integrated pathways.
- The Research and Innovation Group has agreed its development approach for the future, including agreeing a research strategy for our ‘place’.

Upcoming opportunities, events, and challenges

6.4 The partnership:

- will hold its fourth executive development session in October; the focus of the event will be on partnership culture, the emerging financial framework, and scenario planning for winter.
- has started developing an out of hospital strategy which will provide the overarching strategic direction for a range of transformations.
- has started exploring the enhancement of our Virtual Transformation Team (VTT), where transformation leads work seamlessly across organisational boundaries with the aim of improving consistency and building transformation capacity.

- is reviewing its relationship with both the Local Enterprise Partnership and the Chamber of Commerce to explore how it can enhance its role in supporting wider economic and social development in ENH.
- is increasingly starting to focus on mitigation of strategic issues and risks (e.g., changing our culture, investing in our priorities, and developing flexible workforce models).

South & West Hertfordshire:

6.5 There has been further positive progress with South and West Hertfordshire Health and Care Partnership (SWHHCP). The transformation programme has been confirmed for a range of projects, including ones from each locality. Two key pilot programmes are launching this autumn - a system approach to advanced care planning and a pilot of a proactive programme to manage care needs for people with multiple long-term conditions. Other HCP updates:

- Last month, the South West Herts HCP was announced as a finalist for a Health Service Journal (HSJ) Award in the Place-Based Partnership Category for their work on the integrated virtual hospital. There will be a presentation to the judging panel on 27 September, with the winner announced on 17 November. Chief Operating Officer of NHS England David Sloman has also recently praised the virtual hospital following a visit on 2 September to West Hertfordshire Teaching Hospital NHS Trust.
- The interim coproduction board for the HCP will launch on 28 September, with the full board due to launch in April 2023. This board will oversee and provide guidance on how best to use coproduction and other forms of engagement to drive and deliver service improvements led by SWHHCP.

6.6 WHTHT has been working with the national New Hospital Programme on their hospital redevelopment plans. In early September they were allocated funding by the Department of Health and Social Care (DHSE) to help them progress these. This includes geological and ecological surveys and preparation for groundworks on the Watford General Hospital site. Work continues to progress plans for the Hemel Hempstead and St Albans sites, with planning applications submitted where there are plans for some new buildings and overall refurbishment. In August, WHTH ran engagement events at Hemel Hempstead and St Albans hospitals to talk to patients, carers, residents and councilors about the plans. WHTH is working towards submitting its redevelopment outline business case later this year. Expanded diagnostics and more services running on a ‘one stop’ model are at the heart of the plans, and a business case has been submitted for a new community diagnostics centre based across St Albans City and Hemel Hempstead hospitals. If granted, this would provide earlier diagnostic tests closer to home for local patients.

6.7 Other local updates:

- Herts Urgent Care (HUC) is preparing to provide a new urgent care service based at St Albans Hospital caring for minor illnesses and minor injuries. It is due to open in October for 9 hours a day, 7-days a week with capacity to see up to 70 patients a day. The Integrated Urgent Care Hub will support patients across south and west Hertfordshire and will also provide a safe alternative to A&E, thus relieving some of the pressure on the acute front door.
- The ICB is also working with AJM Healthcare to launch a new Hertfordshire wheelchair service from 1 October once the contract of the current provider, Millbrook Healthcare, ends on 30 September. The service will offer wheelchair assessments as well as supplying and

repairing wheelchairs. It will operate out of two new bases in Hertford and Watford but will also provide appointments in people's homes and in other locations such as special schools where feasible.

- On 8 September, the Commissioning Board evaluated and approved a business case for allocation of funds to enable development of the Attention Deficit Hyper Active Disorder (ADHD) Diagnosis and Primary Care Medicines Treatment Service. The board recognised the innovative and cross-system approach between mental health and primary care services and was fully supportive of the clinical model designed to address the immediate identified demand and waiting list for ADHD services in south and west Hertfordshire. We will return to the Committee in 6-9 months time to report on progress and to further refine the model such that it considers wider children's and young people's services and how we work together as a system.

West Essex:

Development of the Health Care Partnership

6.8 The PHM and Place Development Programme concluded with the "End Well" session on 2nd August. Overall the programme has strengthened the partnership relationships, strengthened the delivery of shared outcomes and objectives and the commitment to build on the Harlow PHM pilot with further targeted approaches to addressing health inequalities across the west Essex population. ECC have outlined a framework for how adult social care would like to take forward place – based working with partnerships including shared outcomes, delivery plans and priorities supported by developing place leadership and governance.

6.9 This framework along with the learning from the Place Development Programme is to be discussed by the WEHCP Board in September with outcomes shared at the ICB HCP Development session in October.

Addressing health inequalities

6.10 The West Essex HCP Health Inequalities & Prevention Committee is continuing to progress priorities around the wider determinants of health. It is adopting the Robert Wood Johnson model based on healthy behaviours, clinical care, the built environment and socio-economic factors. The socio-economic workstream includes joint action on the impact of the cost of living. Various organisations/agencies and the voluntary sector have held two summit meetings, organised by the HCP, to focus on income maximisation and debt management support, as well as better intelligence and information sharing between service providers. The summits have also strengthened support for community hubs, which are playing a key part in meeting the growing demand for emergency food provision and help with rising energy costs. The two Harlow PCNs are allowing Citizens Advice staff into their surgeries to help with this too, and 'warm places' are being established across Essex for those unable to heat their homes. The HCP is looking to see if the latter could link in with health MOTs and vaccination programme.

6.11 The West Essex HCP continues to play a pivotal role in the development of Levelling Up activity in Harlow. It is currently working with Harlow District Council and Essex County Councils to map out the many different schemes and projects underway in the town and link them closer together. A task force is being established to drive ideas and proposals forward. One of the first initiatives to benefit will be the Harlow population health management programme. Work continues with the Harlow pilot for the population cohort on the PAHT waiting lists with a focus on the coordination of proactive support for individuals and their families.

Delivery objectives

6.12 Focus continues on the delivery of key programmes to support short term and longer-term priorities for improving access to urgent on the day services, supporting the shift to proactive management of our patients in the community, planning for winter and recovery.

- A second workshop was held with clinical leads and PCN clinical directors on 8th September with a particular focus on winter planning and the role of PACTs (PCN Aligned Community Teams) to increase admission avoidance and supporting people in the community.
- The Care Coordination Centre (CCC) is now implementing Phase 2 of its programme with a focus on community MDT and triage. A four-week pilot has been undertaken with EEAST testing CCC ability to take directly from the ambulance stack those patients deemed suitable for community services i.e. Urgent Community Response. The West Essex CCC has also been put forward by the ICB as an example of good system working to the NHS Confederation ICS Network.
- The Strategic Case for Change for the future operating model of intermediate care in west Essex has been completed. Outcome to be shared at the WEHCP Board in September.
- The Integrated Virtual Hospital model with EPUT and PAHT has been supported by WEHCP Transformation Committee. Implementation of core national requirements is already underway to secure benefit from increased capacity for winter as part of ICB winter plans.
- Final outcomes from the national and regional team for the development of the West Essex Community Diagnostic Centre on the St Margaret's site is expected in September.
- To support the elective recovery West Essex has been piloting an advanced telephone advice and guidance solution alongside an image sharing solution. This provides GPs with rapid access to A&G, from October 2021 to June 2022 feedback from GPs stated in 56% of telephone A&G cases, a referral was avoided. With 4% of admissions avoided and 54% of teledermatology cases resulting in a potential referral being avoided. Work is underway with ICB colleagues to complete the full evaluation ready for October 2022 decision on future intentions.
- Following ICB approval in 2021, PAHT have recruited to a Physicians Associate post working across PAHT and Old Harlow Health Surgery(started in July 2022). The aim is for this role to integrate teams particularly community nurses with a focus on Respiratory conditions.

7.Our People

Hertfordshire and West Essex ICS Workforce Update

7.1 The following report provides an update on areas of transformational work taking place across the Integrated Care System (ICS) supported by the workforce transformation team within the Integrated Care Board (ICB). It aims to provide a narrative update on progress in meeting the 10 designated functions of the ICB as designated by NHS England.

7.2 One of our current core areas of focus is on supporting our staff through the cost-of-living crisis. Organisations have introduced a wide range of initiatives to support their staff, including one-off payments, additional reimbursement on mileage, introduction of essentials shops and discounted items. The issue is continually reviewed, and best practice shared at our fortnightly HRD Network.

Supporting System Design and Development

- We are in the process of developing a new People Plan for the system. Extensive engagement has been undertaken with key stakeholders, alongside key research and policies within this area. Workforce has also been identified as an initial priority and enabler for delivery of the wider Integrated Care Partnership strategy. As part of this process the People Board has been under further development and the governance and reporting structure beneath the system's People Board will be updated to better support delivery of the priorities identified.

Supporting the Health and Wellbeing of our Staff

- The latest data shared within the Health Education England (HEE) e-portal shows that sickness absence has steadily risen in the first six months of 2022. Mental health and musculoskeletal issues are still the largest reason, although respiratory conditions are also a significant contributor.
- The enhanced health and wellbeing service went live in June. Long covid, menopause and sleep therapy sessions triaged over 100 staff in the first 10 days. Service reviews are underway of therapies and data collection of service user experiences to build an accurate picture of the greatest benefit to the workforce.
- Phase 2 evaluation of the *My Health, My Way* platform is being compiled and service has been extended to March 2023. Nearly 600 people registered across the system and over 70 requests for 1:1 coaching. Google analytics being used to identify popular areas of the platform.
- The ICS has been named as a finalist in the Menopause Friendly Employer Awards. The system has been shortlisted for the Best Training Initiative Award, with the winner being announced on the 22 September.

Growing the workforce and ensuring workforce supply

- Staff turnover continues to rise, and we are seeking to address some of the key factors to address this through the retention pathfinder programme. Four key workstreams have been identified: Flexible working, E-rostering, Onboarding and Career Development. Objectives and work plans are currently being developed.
- An extensive recruitment campaign is currently being developed to promote opportunities for health and care support workers, including social media, radio and transport advertising. Staff have attended a range of careers events with schools and colleges to promote opportunities. Links have been made to the agency Indeed to provide additional support for winter pressures.
- Workshop held with key staff to develop key activities to provide support in addressing the vacancies within imaging and diagnostics, as part of this a successful careers awareness session has been hosted by the Health and Care Academy.
- The reservist model has recruited over 500 members of staff to the model, and Herts Community Trust continue to engage with stakeholders to inform them of the resource available and the processes for utilisation.

Supporting inclusion and belonging for all and creating a great experience

- The system has been successful in receiving a bid from NHSE/I for the development of a programme of support in relation to civility and respect, improving issues relating to bullying and harassment. A project plan has now been shared with EDI leads and HR contacts for implementation.
- Following engagement with the system and identification of best practice a draft inclusive development programme has been developed and shared with partners for feedback. The first cohort has been publicised and applicants are now being prepared to pilot the programme.

Valuing and supporting leadership at all levels

- The Scope for Growth programme has been refreshed and restarted following the pause during the second pandemic wave.
- The HCPA succession planning pilot programme is now complete, with two cohorts delivered, and good qualitative feedback from course attendees and indicative evidence of an improvement to staff retention within care homes.
- The next cohort of graduate management trainees are about to begin their induction and we have sought to ensure an engaging system-based offer.

Leading workforce transformation and new ways of working

- The system is currently engaging with providers to identify staff interested in enhanced role or Nursing Associate post, enabling greater share of skills and understanding between social care and health provision and to be based within care homes.
- The first pilot of staff knowledge and experience transfer between physical and mental health is in the process of being developed.
- A task and finish group is being established to review the NHS England Digital Covid passport, supporting staff mobility between organisations, and it's suitability for the system.

Education, training and developing people and managing talent

- Organisations have successfully completed their CPD review with HEE. In addition, the system's CPD Portal is now in place, with all NHS organisations participating. Procurement now collaborating on joint initiatives to share approach to commissioning and purchasing of CPD, and the system is exploring opportunities to collaborate in use of CPD funds for more efficient and effective use.
- The system has completed the demand scoping exercise for HEE – and going forwards will seek to immerse this process into it's forward planning provision.

Driving and supporting broader social and economic development

- The University of Hertfordshire is further developing it's proposal to support the development of anchor institutions within Hertfordshire and West Essex, supported by funding from HEE. Further details are to be shared at the next People Board.

Transforming people services and supporting the people profession

- The system already has a number of shared services and areas of joint working and cooperation, including occupational health and temporary staffing, but we are planning a half-day workshop to explore the opportunities and possibilities for progression to scale up people services.

Leading coordinated workforce planning using analysis and intelligence

- Two work force planning and analytical posts have now been appointed and will shortly be in position and being inducted. Additionally, East and North Herts Trust have started to undertake the HEE Workforce Planning Masterclass and will share intelligence and resources when appropriate.
- HEE have also announced the requirement for a multi-year planning submission to be prepared towards the end of the year.

8. National Review

Children with disabilities and complex health needs placed in residential settings. Urgent action required

The Child Safeguarding Practice Review Panel wrote to Director's of Children Services on 23rd of August 2022 advising of a review being undertaking nationally into safeguarding and children with disabilities and complex health needs in residential settings. This was in relation to the experiences of children placed in three specialist independent residential settings located in the Doncaster area (Fullerton House, Wilsic Hall and Wheatley House) and operated by the Hesley Group.

The letter advised that the review will be conducted in two phases. The first phase will focus on understanding the children affected. These children have all now been moved to safe placements elsewhere, but the review team needs to establish how they came to be placed at the facilities being investigated, and how they were supported while in residence. The review will capture a range of information on all of the children and their individual needs. The first phase of the review will be completed by the summer of 2022.

The second phase of the review will seek to understand whether what happened to these children is indicative and typical of practice more generally, and, if this is the case, set out what should be in place to prevent children with disabilities and complex health needs from harm. Work on Phase Two will commence in late autumn and conclude by March 2023.

It is estimated that there are around 1,700 children nationally who would meet these criteria. The review is considering allegations of widespread abuse (which are subject to a live criminal and associated investigation). The panel particularly expressed concern that they expect that families of children living in similar settings may rightly be concerned about the safety and welfare of their children. Children in care with disabilities and complex health needs in specialist residential settings should be living in safe and good quality placements. However, the serious abuse and neglect revealed by this Review and the related criminal and associated investigation means that there is a need for additional assurance about the safety and well-being of children living in similar types of placements.

The letter now asks Directors of Children's Services to complete 2 urgent actions and provide an overview report on key findings:

1. *Directors of Children's Services to ensure that Quality and Safety Reviews are completed for all children with complex needs and disabilities currently living within placements with the same registrations (i.e., residential specialist schools registered as children's homes) to ensure they are in safe, quality placements.*

2. *That the host authority LADO for each individual establishment reviews all information on any LADO referrals, complaints and concerns over the last 3 years relating to the workforce in such establishments to ensure these have been appropriately actioned.*

There is an expectation that this work will be done collaboratively with ICS and wider NHSE and DFE partners. It must be completed within a 3-month deadline. The Panel have notified ICBs and have also asked that the LA Chief Executive be notified of this activity.
The letter has been widely shared and discussed through our Safeguarding Partnership arrangements in both Hertfordshire and Essex with meetings undertaken or scheduled to agree our approach to completing the reviews and the actions as required.

Meeting:	*Meeting in public*	☒	*Meeting in private (confidential)*	☐
	HWE ICB Board meeting held in Public	**Meeting Date:**	**23/09/2022**	
Report Title:	**Nursing and Quality Report**	**Agenda Item:**	**10**	
Report Author(s):	David Wallace/Hayley Mounsey - West Essex, Mary Emson- East & North Hertfordshire, Clare Molloy/Shazia Butt- South and West Hertfordshire			
Report Signed off by:	Jane Kinniburgh, Director of Nursing and Quality			
Purpose:	**Approval** ☐	**Decision** ☐	**Discussion** ☒	**Information** ☐
Report History:	This report is a concise version of the Quality Escalations report presented to the ICB Quality Committee on 1st September 2022.			
Executive Summary:	This paper provides the current position in relation to quality and safety for Quarter 1, across the Hertfordshire and West Essex system.			
Recommendations:	The Board is asked to note the report for discussion and advise regarding any areas where further detail would be helpful in future reports.			
Potential Conflicts of Interest:	***Indirect***	☐	***Non-Financial Professional***	☐
	Financial	☐	***Non-Financial Personal***	☐
	None identified			☒

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

Hertfordshire and
West Essex Integrated
Care System

NHS
Hertfordshire and
West Essex
Integrated Care Board

HWE ICB Board

Nursing and Quality Summary Report

23 SEPTEMBER 2022

Report Contents

Patient Safety Report	Slide 3-4
1. Learning from Lives and Deaths – LeDeR Quality Summary	Slide 5-6
Safeguarding Adults and Children	Slide 7-10
Children, Young People and Maternity	Slide 11-12
Care Home Quality Summary	Slide 13-14
Primary Care	Slides 15-16
CQC Inspection Summary Update	Slide 17-20
Mental Health Quality Summary Update	Slide 21-23
Infection Prevention and Control Quality Summary	Slide 24-26
Other Areas for Noting	Slide 27-28

Assurance Report – Patient Safety/Experience (Reporting period Q1)

Summary description:

Locality	Complaints	PALS	MP	Comments/ compliments	Totals
ENH	3	19	4	0	26
HV	32	36	6	0	74
WE	4	116	8	77	205
Totals	39	171	18	77	305
Themes	Funding process Vaccinations for housebound persons Access to services Medications Communication Care pathways				

Serious Incidents

Locality	Reported Q1	Never events	Themes
ENH	56	0	Slips/trips/falls Self-harm Treatment delay
HV	34	2 -retained foreign object -misplaced nasogastric tube At different providers	Self-harm
WE	11	0	Nil specific
Totals	101	2	

Quality review System/GP queries

Locality	Reported in Q1	Identified as incidents	total practices
ENH	232	37	50
HV	114	Not differentiated	55
WE	62	17	32
Totals	408		147
Themes	Referrals, Care pathways, Communication Discharge issues, Inappropriate request for GP action, Medications, Access to services, Care and treatment		

Next steps and ongoing monitoring

Patient Experience

From 1st July the three locality teams have been working together, agreeing revised processes to ensure consistency of approach and support across the ICB. The difference between complaints and PALs within localities should become less pronounced with a uniform approach. The team are supporting Directorates as we transition to adopt a consistent process in regards to all Complaints including those from MPs

Datix

The ICB are now using one Datix system for patient experience and patient safety. The coding for the categorisation of all patient experience queries, SI and Quality Review System (GP queries) has been changed so the same taxonomy is being used across all areas. This will enable effective comparison of all types of feedback, over time.

Serious Incidents

All providers have overdue SI investigations, some have significant numbers. Locality teams are working with relevant providers to identify a pragmatic process for addressing this backlog and a trajectory for their completion.

Two Never Events reported one at RFL- misplaced nasogastric tube. One at West Herts Trust-retained swab . This provided a partial focus for a Quality Assurance visit to West Herts. Further visits will take place to seek assurance over actions taken and quality improvements made.

Quality Review System (QRS) from 1st July – feedback has been received from ENH GPs to the changes. Action- agreed to review the feedback over the next 3 months.

All localities have queries from primary care relating to secondary care providers, one locality has routinely also had queries from secondary care about primary care – this reciprocal process is starting in the other two localities.

Learning from all queries will be shared as needed, to reduce the risk of similar issues being repeated

HWE ICB policies- both the Complaints, Concerns and Patient Feedback policy and Serious Incident policy have been completed and sent for approval. Action - awaiting final approval.

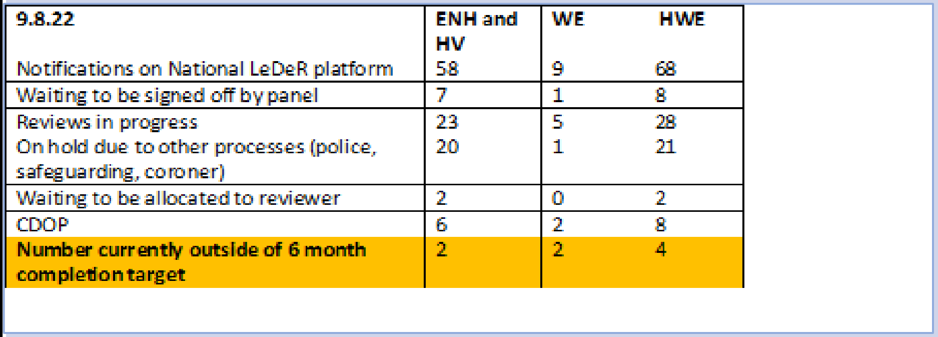
Escalation Report Patient Safety

Subject	Key issue summary/Risk	Mitigating actions and timelines	Next steps
No Items for Escalations for Patient Feedback and Herts and West Essex Localities			
East & North Herts Trust (ENHT)- Complaints and Serious Incidents (SI) Backlog	Complaints - Delays with completing investigations and reduction in complaints being closed due to staffing - Due to high volume and capacity PALS enquiries have extended their turn around to 21-day response time. - 12 Serious Incidents were declared in Q1 - Throughout the pandemic there has been an increased number of overdue serious incident investigations due for completion. In Q1 2022/23 there are 28 overdue SI's	- Regular review of overdue cases and escalation to individual leads. - Early resolution conversations to reduce complaints where possible. - NHSP funding agreed for 1-2 months, part time PALS member to work on backlog. - Continuous improvement works within the Emergency Department such as redeveloping the departments environment and reviewing shift patterns for staff. - Open SIs are being reviewed on a twice weekly basis. An escalation report to the Divisional triumvirate's are being trailed to ensure full support is provided to the divisional quality team and to progress escalations of specific cases. The use of round table meetings have also embedded to discuss incidents.	- ENHT complaints team are now working with the Transformation Team on an Improvement plan to present to Trust Board in August 2022. - Regular meetings have been arranged with the Trust and HWE ICB (ENH) to review the SI backlog and progress updates. Commencing from August 2022. - NHSE/I will be sharing regular reports of open SIs. These will be shared and reviewed with the Trust.
ENHT- Emerging risk. Risk of patient safety due to overcrowding and waiting room care in Emergency Department	- Increasing OPEL 4 status and ambulance delays. - Themes noted around ED overcrowding compromising IPC, high acuity patients in waiting room, staff :patient ratio, deterioration in triage times, inefficiencies as specialty Doctors queue to use GP/triage room for Same day Emergency Care (SDEC)type patients - the ability for patients to be assessed, diagnosed and start treatment on the same day, improving patient experience and reducing hospital admissions - Ongoing increase of incidents relating to Violence and Aggression within Children's ED. - Emerging risk to supplier resilience and supply of key clinical products.	- Discharger Assessment Referral Team (DART) process partially mitigating but not available 24/7 - Electronic prescribing and medicines administration (ePMA) risk mitigation is being supported by the ePMA team and the nursing digital lead. - Incidents related to violence and aggression- Patient Flow and Mental health are sighted and supporting the team. Use of Body Cams are being explored, in the process of piloting link workers from MIND to be in ED to provide psychological/emotional support to patients while waiting for Mental Health Liaison Team , this only for >18 currently. - Discussions with MIND to see if they can provide similar support for children. A meeting is being organised with the Team and safeguarding to discuss further. - Product supply- governance process for oversight and management is being revised/strengthened.	
HCT- negative assurance. The CQC Insight Data report has highlighted a discrepancy between HCT and CQC data relating to the percentage of patient incidents resulting in harm.	- The usual monthly upload of patient incidents to the National Reporting and Learning System has not taken place since December 2021 due to a number of factors which may have impacted on the data reported by the CQC. - HCT have moved from Datix to Radar incident reporting system and the transition could have contributed to the discrepancy.		- The CQC Lead will work with the risk team and the CQC Analyst team to gain understanding of this discrepancy

Assurance report : Learning from Lives and Deaths(LeDeR)

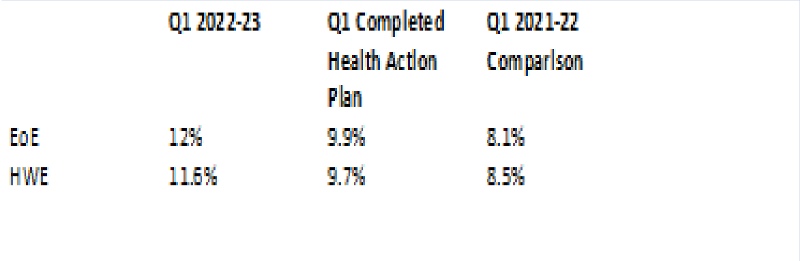
Summary description please be concise:

Summary of performance and activity for LeDeR .
Current monitoring by NHSE of local performance is focused on completion of reviews within 6 months of notifications. Data from HWE is as follows:



9.8.22	ENH and HV	WE	HWE
Notifications on National LeDeR platform	58	9	68
Waiting to be signed off by panel	7	1	8
Reviews in progress	23	5	28
On hold due to other processes (police, safeguarding, coroner)	20	1	21
Waiting to be allocated to reviewer	2	0	2
CDOP	6	2	8
Number currently outside of 6 month completion target	2	2	4

Emerging themes from reviews and Learning into Action is described in the local LeDeR Annual Reports due for reporting Sept/Oct 2022.
Annual Health Check (AHC) performance is also monitored by the national NHSE team. Target for 2022-23 is 75%, however there is a national request for all patients who did not receive an AHC in the last 12 months to be contacted in Q2 2022-23. Q1 data for AHC is as follows,



	Q1 2022-23	Q1 Completed Health Action Plan	Q1 2021-22 Comparison
EoE	12%	9.9%	8.1%
HWE	11.6%	9.7%	8.5%

Next Steps:
Reviews: Plans in place for sign off of reviews outside of 6 months and regional NHSE lead aware of local position and has no issues.

Annual Health Check(AHC): Herts communication circulated to GP practices re: Q2 invites for those who have not attended within last 12 months. Learning Disability (LD) Health Equality Nurses contacted all GP practices with **offer of support to contact those patients that are 'hard to reach'.**

West Essex: By end of Q4 last year, 316 people had not had health checks – West Essex was low for Essex, the Region and England @ 66%. **Additional funding to support health checks** to be completed by end Q2 22/23
By end of Q1 104 were complete, equivalent to 10.9% of total on registers (954) 5 of these were for young people age 14-17, out of a possible 99, equivalent to 5%.

Ongoing Monitoring: In Hertfordshire the LeDeR Leadership group oversees Learning into action from recommendations from reviews and is chaired by Operations Director Adult Disability and Mental Health Services. This group reports into the Learning Disability and Autism Strategic Partnership Board.

In West Essex there is a pan Essex steering group and associate groups; the Local Area Contact chairs, and then circulates the recommendations the group has agreed on, plus any amendments to the review itself, and submits after the panel members confirm the recording of the discussions. ALL reviews are then overseen by the Steering group, a multi-agency group overseen via Director of Public Health. This group monitors actions against recommendations.

Overall for HWE: The programme is also monitored by the local NHSE health inequalities lead with fortnightly meetings with regional lead and HWE leads. In addition, any emerging issues are flagged to the NHSE leads at monthly TCP operational support meetings.

Escalation Report Patient Safety /Experience/LeDeR

Subject	Key issue summary/Risk	Mitigating actions and timelines	Next steps
LeDeR	• To date no notifications of deaths for people with autism have been notified. Notification of deaths in people with autism was introduced in January 2021 under the new policy. • Annual Health Check (AHC) data and LeDeR review evidence shows that not all patients received a Health Action Plan following AHC	• The criteria for in scope of review is an adult with a clinical diagnosis of autism which may present barriers • Herts Leadership Group sending out comms for HWE partner organisations to increase awareness. • WE linked with local autism support organisation and families • Herts Learning Disability Nurses promoting Stay Healthy at Home checklist to include as 1 action on every HAP with tailored advice from GP • Regional data identified data on practice level. LDNS will make contact with practices where there are gaps between AHC and HAP to offer support	• Communications to be circulated Aug/Sept across HWE • New Autism Commissioning Manager (Herts) joining LeDeR Leadership Group (Sept). • Ongoing promotion and support by Learning Disability Nurse specialist(LDNS)

Assurance report : Safeguarding Children Q1

Summary description	**Next steps and ongoing monitoring**
West Essex Child Safeguarding Practice Reviews (CSPR) The Child Safeguarding Practice Report(CSPR) publication will occur following conclusion of legal proceedings. A Rapid Review was completed following Essex Safeguarding Childrens Board (ESCB) escalation for persistent inability to safeguard a child. **Children of concern taken abroad** A thematic review has been requested to consider learning and multi-agency working following 3 recent cases. **Non-accidental injuries (NAI) to infants** Since January 2022, there has been a rise in incidents of NAIs identified in West Essex. **Initial Health Assessments (IHA)** Due to on-going paediatrician capacity issues, the IHAs are not completed within the statutory timeframes.	The Essex Safeguarding Children Board (ESCB) will continue to disseminate learning. The outcome and multi-agency action plan is awaited. Await further update from ESCB Multi-agency Thematic Audit Professional Standards and Audit Service Quality Assurance and Safeguarding team. Local learning events have been held to reinforce multi-disciplinary pathways. The Southend, Essex and Thurrock (SET) Suspicious Injuries protocol has been reviewed, strengthened and shared widely. Changes to commissioning arrangements are supporting improvements. Work is in progress with Essex Local Authority to reduce non-attendance
Hertfordshire National Safeguarding Practice Review (2022) (SPR) panel and Hertfordshire SPR identified practice gaps whereby fathers/Co-Habiting partners (FCHP) are not included in safeguarding risk assessment, information sharing and safety planning. East & North Hertfordshire(ENHT)- gaps in compliance and assurances for safeguarding training and supervision. Maternity safeguarding concerns linked to system and process change as well as current practice model. Significant number of cases sitting outside recommended timescale of 6 months for Child Death Overview Panel (CDOP)review. Late review of cases increases the risk that trends/risks are not identified and the opportunity for timely intervention is missed. The Corporate Parenting Board has been revised to include a new executive Board, that will include representatives from looked after children and business and commerce sector. Increased number of children placed as Looked After with complex risk factors placing increased demand on the Provider's service to meet additional requirements. Impact of out of area placements to fulfil their statutory requirements in a timely manner impacts on Hertfordshire local capacity	*(*1.) Safeguarding Supervision access to all frontline staff is in place. (2) Safeguarding Learning event to raise awareness of the issue is completed. (3) Risk recorded on both ICB and HCC risk registers. An ICS project is underway to implement a new service model across ICSs change in practice, policies and processes to raise awareness. The anticipated implementation date is not yet agreed. Flagged on ENHT risk register for monitoring with improvement plan. Planned QA visit by HWEICB safeguarding team. Regular oversight of performance in safeguarding committee and DASH-Board. Delivery of regular safeguarding supervision to lead professionals. Risk recorded on both ICB and HCC risk registers Additional clinical support provided from within the Designated Team Additional meetings planned to support meeting 6month compliance Revised model of delivery proposed to increase capacity and reduce inequity between unexpected and expected deaths awaiting agreement. •Provider work taking place to understand current capacity within service – what is statutory and relates to in county placements •Provider working towards business case to support increased activity – Autumn 2022. •Looking at ways to improve collection of information in systems for the older cohort which will also support transition process.

Assurance report : Safeguarding Children Q1

Summary description	Next steps and ongoing monitoring
HWE ICB **Safeguarding Accountability and Assurance Framework** Safeguarding children, young people and adults at risk in the NHS: assurance and accountability framework (SAAF) was published by NHS England in July 2022 which sets out expectations for safeguarding within the ICB it outlines the safeguarding roles and responsibilities of all individuals and identifies how NHS England regional and national teams work with ICB leaders	• The SAAF strengthens the Health and Care Act 2022, how health and other systems work at both strategic and operational levels • The SAAF acknowledges the changes to the Mental Capacity Act and the introduction of Liberty Protection Safeguards. • Safeguarding on babies, children and young people and vulnerable adults. • The ICB leadership is engaging with Local Authorities and the system to work together
The National Child Safeguarding Practice Review Panel recently published the Findings from the Child Protection in England report into the deaths of Arthur Labinjo-Hughes and Star Hobson together with The Independent Review of Children Social Care by Josh Macallister. This led to a Multiagency Safeguarding Hub (MASH) review by the Independent Scrutineer of Hertfordshire Safeguarding Childrens Partnership (HSCP)	• MASH review led to a business case for increased health capacity for 6 months. Challenges in recruitment to posts plus longer term requirements will require additional business case to HWE ICB. • The Safeguarding team hosted a learning event- three key recommendations include: • The quality of safeguarding training and supervision • Increased exposure to safeguarding training to pre and post registration professionals. • Supporting respectful challenge, difficult conversations and professional curiosity. The report asserts that the child protection system must be strengthened to ensure that leadership and management has a powerful enabling impact on child protection practice, underpinned by specialist multi-agency expertise that creates and protects the optimum organisational /system context for undertaking this complex activity.
Ukraine refuges and unaccompanied children Preparation is in progress to support the safe placement of unaccompanied children from the Ukraine into Private Fostering Arrangements across the ICB. Oversight of arrangements is via the Essex Tactical Coordination Group and the Hertfordshire Health Needs Coordination Group.	

Assurance report : Safeguarding Adults Q1

Summary description	**Next steps and ongoing monitoring**
West Essex Domestic Abuse: There is significant work being undertaken by relevant agencies and Boards around domestic abuse- with Essex-wide Domestic Abuse Board-(Southend Thurrock Essex Domestic abuse Board (SETDAB) working towards a campaign' Reflect' that will be asking people to focus and reflect on their behaviour in as far as Domestic Abuse is concerned. Essex Domestic Abuse Local Partnership Board has highlighted the need for future multi-agency financial contribution to develop services in line with the Domestic Abuse Act 2021. They currently are working on a Discovery project to identify Domestic abuse needs of the local population. Health continues to play an important part in attending these meetings as well as where feasible seeing that the actions needed come to fruition. **Safeguarding Adult Reviews (SARs) and Domestic Homicide Reviews (DHRs)** In West Essex there is 1 SAR and 2 DHRs in progress. Obtaining information from general practices for the reviews requires persistence to meet set timescales **Provider performance:** PAH: work continues to reach compliance with safeguarding training requirements.	• The revised Safeguarding Assurance and Accountability 2022 has reiterated the essence of provision and of sharing of information as per statutory requirements to enable reviews to take place. Work is being undertaken by SETDAB with practice managers and from Safeguarding Team to promote adherence to timescales via emails and in Safeguarding training updates. Where it is required escalation to the Director of Nursing. • PAH: training compliance is discussed at the PAH Joint Safeguarding Performance and Quality Meeting that is attended by the Designated Nurse for Adult Safeguarding who provides oversight.The feedback from PAH is centred around Medical Staff figures impacting on whole training figures. Medical staff priority has been drawn towards meeting waiting lists.
Hertfordshire Domestic Abuse: The newly recommissioned Hertfordshire Independent Domestic Violence Advisor Service (IDVA) has commenced. The Named Nurse for Adult Safeguarding is playing an active role in this process to oversee the provision for health and ensure support and presence within primary care is developed. **Safeguarding Adult Reviews (SARs) and Domestic Homicide Reviews (DHRs)** In Hertfordshire there are 3 SARs in progress and 4 SAR reports awaiting agreement. There are 4 DHRs in progress and 5 waiting to commence A multi-agency rapid review of the 5 pending DHRs took place to identify immediate learning whilst awaiting the full DHR. **Provider Performance:** **ENHT:** work continues to reach compliance with adult safeguarding training requirements.	• The development of a Domestic Abuse and Sexual Violence policy for GP practices to adapt and adopt is being led by the Named Nurse and will be presented to the primary care commissioning committee for sign off. • The Adult Safeguarding Team has commissioned further primary care Domestic Abuse webinars to be delivered in the Autumn by a subject matter expert. This year the focus will be on intrafamilial abuse in response to learning from DHRs. • ENHT: this is reported at the providers' Safeguarding Committees attended by the Named Nurse who provides oversight and challenge.
HWE ICB **Mental Capacity (Amendment) Act (2019):** The Adult Safeguarding Team compiled and submitted an ICB response to the Code of Practice and Regulations consultation closed on 14th July. and participated in multi-agency responses for both counties. It is anticipated that the Government response to the consultation will be published in winter 2022/23 and an indication of implementation date for Liberty Protection Safeguards (LPS) will be given at this time, it is envisaged that the date of implementation may be in 2024. **Home office publication of Domestic Abuse Act Statutory guidance (July 2022)** emphasises the role of Health in identifying and responding to DA and the need for an integrated approach across the ICS.	• Work to ensure a strong foundation in the knowledge and use of the Mental Capacity Act (MCA) continues within the ICB and providers. • The Safeguarding Team and relevant ICB colleagues are active members of the Hertfordshire and Essex local authority Liberty Protection Safeguards (LPS) Programme and Implementation Boards and the NHSE&I LPS Implementation Steering Group. • The ICB LPS Operational Group works together in preparation for an implementation date and to ensure the Executive Team are kept informed. • Safeguarding and CHC colleagues are undertaking a review of provisional templates of LPS forms disseminated from DHSC; ese are being analysed by different work streams to be able to feedback to the DHSC. The Safeguarding Adult Team is engaged in these at local level.

Escalation Report Safeguarding Adults and Children

Subject	Key issue summary/Risk	Mitigating actions and timelines	Next steps
Annual safeguarding update for the HWE ICB Hertfordshire	The Board is to receive their annual training in line with Intercollegiate Documents (2018 and 2019). Dates are being arranged.	Level 1, Level 2 Safeguarding, MCA and Prevent training is accessible to the board on ESR.	Agree date for the Board safeguarding training being arranged
Children's Safeguarding Initial Health Assessments in West Essex	Initial Health Assessments (IHA) are not being completed within the statutory timeframe of 20 working days.	Change in commissioning arrangements in place with provider to increase resource within the system. Work continues for an Essex-wide provision and for a digital platform to track the timeframe for IHAs. Oversight of the challenges for timely IHA has been escalated at both regional and national levels.	• Continue to monitor local outcomes through Key Performance Indicators • Continue discussion at the Health Executive Forum to progress the Essex-wide systems. • Ensure the challenges are repeatedly heard at regional and national levels

Assurance Report – Children, Young People and Maternity Q1

Summary description:	Next steps and ongoing monitoring
Community Paediatrics - Hertfordshire Community NHS Trust (HCT); Waiting List Backlog Gap in Paediatrician capacity leading to increased referrals and backlog. The trajectory for improvements and timelines are currently being forecast by HCT. A Clinical Harm Review (CHR) for long waiters identified patient specific and service-wide actions; these have formed part of the transformational plan to support patient safety and experience. Complaints into the service remain low and no SIs have been declared. **West Essex PAHT Maternity Staffing** is monitored against a RAG status. Shortages in staffing have led to delays in induction of labour and the inability for the co-ordinator to be supernumerary as they work clinically to ensure women and birthing people receive 1-1 care in line with national guidance. Figures for June 2022 indicated that the compliance was as follows Green 60%, Amber 34%(short of up to 2 midwives) and Red 6% (short of more than 2 midwives). **Maternity Incentive Scheme (MIS)** operated by NHS Resolution known as the Clinical Negligence Scheme for Trusts (CNST) support the delivery of safer maternity care. • PAHT are largely on track to achieve compliance however there are concerns relating to safety action 2 that relates to coding and data. Non-compliance with all 10 safety actions could result in a funding loss for PAHT. • WHTH have concerns in implementing safety action 8 relating to multi professional day training due to the inclusion of GP rotational doctors. Non-compliance would result in funding loss **Maternity Serious Incidents (SI)** Information presented at the July PAHT Maternity Oversight Committee relating to serious incidents indicated that there are currently 6 SI's under investigation, 1 of which is being investigated by HSIB. 4 of these were declared in Quarter 1 of 2022/23. **Special Educational Needs & Disability (SEND)** Ofsted and the Care Quality Commission have published their final report confirming that significant progress has been made in Essex to address the areas of weakness previously identified in the 2019 inspection. Key highlights from the report include: • Better partnership working between health and education organisations, as well as increased oversight of joint SEND commissioning arrangements. • Improvements in the accurate identification of SEND for children and young people. • Progress made in the co-production of Education Health and Care plans across health, social care and education. **Autism Diagnosis Waiting Times** Significant sustained increases in autism diagnosis referrals (75% increase over the past 6 months) is placing further pressure on the ability to recover waiting times following additional recurrent investment by West Essex CCG.	**Community Paediatrics:** HCT funds have been secured for the recruitment of 4wte locum Paediatric Consultants. Non recurrent funding to be decided. HWE ICB will monitor improvements in backlog against projected milestones and delivery of transformation plan through the ICB Contract and Quality Review Meetings and continue to work collaboratively with the Trust. **Staffing:** Work has commenced to strengthen the escalation model in the service to include an additional band 6 midwife on a voluntary basis to the on-call rota. 14 newly qualified midwives were recruited in June and have agreed to work clinically as Band 4 while they await their PIN. PAHT are managing the risk internally through the use of Bank and Agency staff and the leadership team undertakes clinical work where required. A detailed staffing report will be presented at PAHT Quality Safety Committee part 2 Maternity Oversight Committee in September, monitoring will continue by West Essex Quality Team **Maternity SI's:** Serious incidents reports are reviewed by West Essex serious incident assurance panel. Learning points and actions have been defined and how these are being embedded will be monitored through peer reviews and quality visits the next of which is being undertaken on 11th August 2022. **Autism Diagnosis Waiting Times** The service is working with commissioners to implement business continuity plans in the interim to longer term adjustments to the pathway. Quarter 1 reporting noted 213 referrals received, waiting list of 1074 children and waiting times of 130 weeks to completion of a full autism assessment.

Escalation Report Children, Young People and Maternity Q1

Subject	Key issue summary/Risk	Mitigating actions and timelines	Next steps
Workforce	High vacancy rates and lack of midwives to recruit to these positions may have a number of impacts; • Midwifery lead unit or homebirth services may need to be suspended to maintain safety across the unit • Units may close or divert • Services may not be able to achieve the National deliverables within currently expected timeframes. • Training may be cancelled. There are also vacancies in the obstetric and anaesthetic rotas that are resulting in low levels of attendance at training by medical staff. Full compliance with the Core Competency Framework may not be achieved. • Continuity of Carer may not roll out at the required rate to meet the national deliverable • There is a risk that Ockenden Immediate and Essential Actions are not achieved in full.	• Recruitment and retention plans in place. • Support offers for psychological support from various agencies and platforms • Funds allocated through a bidding process to support capacity between establishment and birth rate +, all trusts successful in securing funding. • Birthrate + review completed • Regional lead to build capacity across the East of England • International recruitment • Support from ICB workforce leads • Redeployment of seconded and specialist Midwives to improve clinical capacity • Implementation of Regional divert and closure policies • Redeployment of Senior and Specialist Midwives to improve clinical capacity. • Use bank and locum staff to backfill. • Forward planning for medical staff attendance at training • Senior teams meet regularly to monitor workstreams re key actions from the Immediate and Essential Actions and local GAAP/SWOT analysis. • Ongoing audits of compliance and action plans where indicated	• As a system consider tasks that are not required to be completed by a midwife. Continue with actioning Trust based workforce plans and providing assurance to Local Maternity and Neonatal System Partnership Board on a 6 monthly basis
Finance	Due to funding allocation agreement via the ICB, there is a risk that we may not be able to achieve the National deliverable to provide 46% of maternal smokers a NHS smoke free pregnancy pathway by March 2023	• Delivery Plan in place • Spending Plan in place • All maternal smokers continuing to be offered an existing smoke-free pathway	**Current risk score of 12** • Review at Local Maternity and Neonatal System Partnership Board September

Assurance Report – Care Homes (Reporting period Q1)

Summary description:

- Admissions to secondary care (place based South & West Hertfordshire)

Increase in avoidable admissions seen compared to Q1 2021-22. Main theme remains as falls.

- Hertfordshire Admission Avoidance Response Car (HAARC) place based South & West Hertfordshire)

There were 731 calls from care homes to the HAARC service of which 108 were sent to ED, main themes were falls, head injury and respiratory.
Capacity issues due to sickness/EEAST wider pressures on services.

- Non-Commissioned Activity (NCA) place based South & West Hertfordshire)

Increase seen in referrals for non-neurology patients since the decommissioning of DTA funding. 1 nurse manages the caseload and has capacity for a maximum of 12 patients. Currently 11 patients on the caseload 3 are non-neurology.

- Enhanced Care Home Practitioner (ECHP) (place-based East & North Hertfordshire)

Engagement/information sharing needs to be more robust. Teams managed by 3 different providers, no consistency in training offer.

- Covid- ICB wide Outbreaks in care homes increased slightly during April and May, however, are now seeing a reduction. Communications have been sent to the care homes in preparation for the autumn booster campaign.
- Quality Monitoring – ICB wide Planned contract monitoring ICB/County council monitoring continues a risk-based approach. See escalation report for information homes with quality concerns. Some homes have identified have seen a low resident intake which may be a future financial viability risk.

Next steps and ongoing monitoring

See escalation report for actions.

6 weekly contract monitoring for oversight/assurance. Immediate escalation where risks identified for capacity issues - see escalation report.

Escalation within planned care and Nursing & Quality team where capacity is reached.

Review service requirements as part of ICB merge.

Twice weekly Outbreak cell for oversight/assurance on outbreaks in Hertfordshire homes/provide update for West Essex homes

Continues as proactive planning with capacity for urgent as needed. Any concerns discussed at support to care homes meetings (Hertfordshire) and monthly Multi Agency Care Provider Hub meetings in West Essex. See escalation report for homes with quality concerns..

CQC ratings June 22 – ICB wide

Inadequate	Requires Improvement	Good	Outstanding	Not yet rated	Total
5	51	229	11	9	305

Homes rated Inadequate and Requires Improvement are offered enhanced support and training. Oversight and monitoring through CQC processes.

Escalation Report Care Homes

Subject	Key issue summary/Risk	Mitigating actions and timelines	Next steps
HAARC (Hertfordshire Admission Avoidance Response Car). Place based South & West Hertfordshire	Capacity challenges due to sickness. Also linked to the wider challenges faced by EEAST's demand on their ambulance service. **Risk** Longer waits to for non urgent care home residents to be seen. Additional pressure on 999 services with care homes calling direct where unable to access HAARC. Increase in avoidable secondary care admissions.	Ensure other admission avoidance pathway partners are aware that may be able to support. Stand down general care home education sessions temporarily. Where pressure is identified on the service communication to be sent to the homes and utilisation of other admission avoidance pathways.	Review training stepdown in 4 weeks. Case by case discussion where intensive support/training is required. Escalation where risk of no car availability.
Avoidable secondary care admissions. Place based South & West Hertfordshire	2% increase of care home avoidable admissions during Q1 2022-23 compared to the same quarter 2021-22 **Risk** Poor resident outcomes. Reduced care home staff confidence. Increased pressure on ambulance service and secondary care.	Face to face visits by CHIT nurse to discuss admissions training /advice/support provided where required. Reminder of use of admission avoidance pathway. Identification of key themes of avoidable admissions and plan training /support to ensure care home staff confidence to manage. Engage system partners to offer additional support where beneficial.	Discuss and planning for further actions at weekly CHIT meeting. Escalate immediately where risk continues/increases.
Safety Improvement (SIP)/Quality monitoring Process ICB wide St. Elizabeth's Centre	12 care homes currently in a SIP/quality monitoring process. 3 homes with an admission embargo. **Risk** Poor resident outcomes due to, management/leadership oversight, documentation, care planning, governance, staff culture, Infection Prevention & Control (IPC). CQC inspection –inadequate, concerns raised in regards to care and quality of services. St Elizabeth's gave notice to close adult services due to recruitment & retention	Visits by quality improvement leads and county council colleagues undertaken for action plan and improvement oversight and assurance. CHIT nurses in South & West Hertfordshire/ECHP in East & North Hertfordshire/provider quality team in West Essex to support with advice and training. 6 weekly formal strategic management meetings within Hertfordshire to ensure assurance, improvement and sustainability. Hertfordshire County Council (HCC) and HWE ICB are working with the senior team from St Elizabeth's to ensure measures are in place to prioritise safety of patients. HWE ICB Assistant Director for Continuing Health care is leading on the work. CHC Team are re-assessing needs with a focus on safety, plus provided a single point of contact for families Task and Finish multiagency to support closure in best interests of people living at the centre.	6 weekly SIP meetings. Where risk is identified between SIP meetings, escalated at the weekly support to care homes meeting, Hertfordshire and Multi Agency Care Provider Hub meeting in West Essex. Continue to work with HCC in partnership to achieve a safe solution for people.

Assurance Report – Primary Care (Reporting period Q1)

Summary description:

Recommencement of CQC inspections to General Practices

Place	Outstanding	Good	Requires Improvement	Inadequate	Inspected awaiting publication	Total
East & North Herts	0	48	1	0	2	**51**
Herts Valleys	1	54	0	0	0	**55**
West Essex	1	28	0	1	0	**30**
Totals	**2**	**130**	**1**	**1**	**2**	**136**

- 4 practices across HWE have recently received routine inspections following the CQC pause during the pandemic. Whilst not all reports have been published, themes are already emerging – for example, gaps in training, poor incident reporting, medicines management issues, monitoring of all staff competencies and Do Not Attempt Cardio Pulmonary resuscitation (DNACPR)record keeping. Many of these themes have previously been highlighted through support visits
- The 2 practices in ENH were offered support to prepare for their CQC inspection, however these offers have been declined

Practice rated Inadequate- Lister Medical Centre, Harlow, West Essex
CQC report published June 2022 – practice rated as inadequate, placed in special measures and 3 warming notices received -***Please refer to escalation slide for further details***

Next steps and ongoing monitoring

- Training is available on the ENH Training hub in a series of 5 webinars on how to achieve CQC Outstanding – consider making available across Herts and West Essex
- CQC developments and inspection preparation is/will continue to be discussed at Practice Manager Meetings and GP Bulletins where practices are encouraged to take up the ICB offer of support
- Development of a rolling programme of supportive quality/contract
- Use of CQC reports to further identify themes and learning for all practices
- Development of a risk resilience dashboard across the whole ICB so that practices can eb provided with support in a timely and proactive manner
- Discussion of practices identified as high risk at placed based risk and information sharing groups to enable proactive timely support – as required
- Consider how emerging themes will be disseminated to practices and consider training/ communications to support practices

- See escalation slide

Escalation Report Primary Care

Subject	Key issue summary/Risk	Mitigating actions and timelines	Next steps
Lister Medical Centre, Harlow- Inadequate CQC rating (June 2022)	The practice was rated as 'inadequate' for Well-led, Safe, Responsive and Effective. Caring was rated as 'good'. The practice have been placed in special measures and received 3 warning notices (Regulation 12 (safe care & treatment), Regulation 17 (good governance) and Regulation 18 (staffing) and will be inspected again by the CQC within 6 months. There is a risk that the practice may not meet the standards required when the CQC re-inspect. Impact- the practice is one of the largest within the ICB with approximately 20,000 registered patients and is within an area of high deprivation	• The primary care and quality team are working with the practice as they develop a single combined action plan to address the issues raised by the CQC, issues raised at the mock CQC support meeting, actions within the whistleblowing report and actions from the access support meeting • Progress against the action plan is being closely monitored by the ICB with an expectation that a robust body of evidence is provided by the practice in order to demonstrate that the issues are being addressed • The practice has received a formal letter & fortnightly meetings with the ICB which define expectations • Fortnightly support meetings are provided by ICB • Support, advice & guidance is provided from ICB specialist teams e.g. medicines, Infection, prevention & control • Practice has commissioned an experienced independent primary care consultant to support • Independent clinical support is being identified	• Practice have received a letter requesting assurances against the areas considered to be of highest risk, as identified during the mock CQC support meeting- 28 days given for this (by 22 August 2022)- outcome awaited • Full contract/ quality visit will be conducted by ICB - mid September 2022
GP practices meeting the CQC standards during /following the pandemic	• There is a risk that there are practices that have not yet been identified as meeting the required CQC standards • There is a risk that practices haven't yet fully integrated new models and ways of working (that arose during the pandemic) into their day to day working and written policies/ protocols	• **Risk and information sharing-** currently all 3 place areas capture concerns/ issues which are shared between primary care team, quality team, medicines optimisation team, NHS England, Local Medical Committee. • **Risk Resilience Dashboard Development** so that there is 1 dashboard across HWE • **Development of a rolling Quality/ Contractual Programme Visits to provide support-** Q2/3 2022 • **Ongoing collaborative working with the CQC** with a consistent approach across HWE. • **Review themes emerging from CQC inspections** • **Consideration of training requirements** in conjunction with workforce team	• Identification of practices most at risk of instability, reduced resilience or sustainability and who require additional support- prioritise these for a contract/ quality visit

Assurance Report – CQC Summary Inspections Update

Summary description:

West Hertfordshire Teaching Hospitals NHS Trust (WHTH) - Maternity Services
The Trust continues to respond to the remaining open actions from the CQC inspection in October 2021 which resulted in the downgrading of maternity services to 'Requires Improvement'. The two key areas within the action plan remain on track and focus on:

- Nitrous oxide monitoring; demand valves, monitors, scavenger units, personal monitors and remote monitoring all in place and this risk will now be closed on the WHTH risk register.
- Staffing aspects – linked to maternity workforce escalation of this report on page 17.

EEAST Inspections held in April and May led to an Overall Trust Rating of Required Improvement (Safe – Requirements Improvement, Effective – Requires Improvement, Caring – Good, Responsive – Requires Improvement, Well Led – Requires Improvement). The overall rating is an improvement from the previous rating of Inadequate. Details are in the CQC report published in July which covers actions the Trust must take including mandatory training, staffing levels and skill mix, staff engagement, clinical risk assessments and access to the service and response times.

Princess Alexandra Hospital NHS trust CQC Section 31 has been reviewed as part of internal round-table comprising Urgent Emergency Care Triumvirate Executive team . Acknowledged conditions on licence, team commended for progress made. Trust continue to report weekly to the CQC in terms of ED (adult and paediatric) workforce, clinical observations, risk assessments and time to triage. To date improvements had been consistent and sustained. Engagement through clinical effectiveness groups and support delivery of action plans through peer review and planned quality assurance visits to clinical areas. Trust is making good progress and have shared July ED audit data set submitted to CQC. Formal request approved to not submit data in Aug to allow ED Nerve centre model to be embedded.

Quality Improvement - Joint Improvement Work

- **Quality First Team** Developing Clinical Vision for Unplanned Emergency Care – working with the trust and wider system to support clinical vision for unplanned emergency care, which will help inform medium and long-term improvement programme supporting IN and OUT workstreams
- **Acute Assessment Unit Quality Improvement** – performance is high when unit functions as assessment – following on from recent Improvement Quality Assurance visit recommendation to optimise Same Day Emergency Care and review of pathways to improve flow – continue to support improvement work through Urgent Emergency Care programme board/Clinical Workstream. Re-set of Acute Assessment Unit as a priority – Ico-design Improvement Methodology to progress work alongside Quality First/Ian Sturgess/Clinical Teams
- Trust went LIVE with successful implementation of Nerve centre Module in Emergency Department 27 July to support trust-wide implementation of electronic patient record / Manchester Triage Tool embedded as part of this system

Next steps and ongoing monitoring

- **Quality Assurance** Supportive quality visits being undertaken by Nursing and Quality teams across Herts and West Essex Health Care Partnerships - targeted support and opportunities for improvement identified.
- Maternity Quality Assurance Visit to be undertaken in Q3 jointly with WHTH to triangulate quality intelligence.
- Monitoring the actions associated with the improvement areas will be undertaken in regional and place-based groups.

- **Table-top Peer Reviews** Working alongside trust to focus on CQC Must and Should Do Actions as part of Table-Top Peer Review meetings. Alongside the Trust's internal improvement tracker, this insight is used to understand themes, issues, and risks to further support the Trust to address key gaps. Oversight, assurance and compliance data is presented, and Business As Usual reports – broader suite across Key lines of enquiry framework around data, intelligence, peer review to ensure we have oversight of quality compliance

Escalation Report CQC Summary Inspections

Subject	Key issue summary/Risk	Mitigating actions and timelines	Next steps
Urgent Care – Current Pressures in ED and Impact on Patient Flow	Increased attendances in Emergency Dept(ED) and Impacts of EEAST system pressures and additional ambulance demand. Long waits in ED – 12-hour breach, data Backlog from Nov 21 – May 22 is now complete **4-hour standard Type 1 Activity** – PAH are 39/116 nationally. 19th June 2022 trust achieved 77% compliance with 4-hour standard. Work within the team to establish what went well and what can be learned	Real-time Harm Reviews are taking place at daily regular Safety Huddles in ED Oversight/assurance of process in place to recover backlog and governance through Joint Safety Performance Quality meeting/Patient Safety Group/Incident Management Group • Introduction of the electronic system NERVE CENTRE implemented 28 July • Digital Kiosk Streaming (streaming and triage) - business case submitted • Pilot - Improvement of non-admitted 4-hour performance and management of overnight long-waits (awaiting sign-off finance)	Introduction of NERVECENTRE is seen as a critical step before removal of section 31 request is made. Electronic driven pathways and implementation go live in July 2022. Agreement to review position in September
IT configuration and compatibility with Message exchange for Social care & Health digital system (MESH) affecting communication between PAHT and Primary Care	Nerve centre implementation and IT interoperability issues with GP has resulted in a backlog of electronic discharge summaries not being received	• All practices in West Essex contacted directly to establish areas affected • Of the 29 practices, 10 are not having any issues, but for the remaining 19, they were either not sure, don't like the system or there are some issues still to resolve. • PAH have identified patient level information to individual practice who have attended ED so these can be cross-referenced with practices and ensure discharge summaries are being correctly received • Rapid resolution is being led by multidisciplinary team comprising PAHT, Transformation, Contracts and Patient Safety Team	Trust will address small backlog and will be cleared over the weekend – continuing to target those practices that still have issues and hopefully find a resolution.

Assurance Report – CQC Summary Inspections Update

Summary description:	**Next steps and ongoing monitoring**
HPFT : **Forest house-** Care Quality Commission (CQC) conducted 2 follow up visits to Forest house following recently issues 29A Warning Notice. (6th and 7th July- 3 inspectors visited the ward. 24th July- 2 inspectors visited the ward). Following initial verbal update form HPFT it has been noted there was one identified immediate action for the ward, which involved having a clock in an isolation room. CQC noted overall improvement of the service.	Ongoing monitoring by HPFT whilst improvement work is being carried out throughout the service. CQC report is awaited for final recommendations. Complaints, SI's, feedback triangulated by HWE ICB
CMHT reliance on telephone or virtual contact. Increase acuity in all services. Challenging level of workforce. Risk assessment and care plans require strengthening	**Quality assurance visits (QAV).** QAV has been focused on community mental health services (CMHT), Crisis services and single point of access (SPA) Themes from QAV. Reports provided to the Trust to implement actions with planned review visits. Close monitoring of data and contact to service user. Task and finish group to address the concerns. Following quality improvement pilot- there has been an improvement of updated risk assessments. Further monitoring through QAV.
Serious Incidents themes- Early analysis indicates learning regarding safety plans for service users whilst awaiting an initial assessment. Discharge following non engagement with services or after repeated 'did not attend' (DNA) without being seen or proactive follow up. Communication between the Trust and CGL regarding dual diagnosis, self-referrals to Change Grow Live (CGL) (Drug and alcohol service) and follow up by the Trust.	A learning note was disseminated to all services for discussion at their Patient (service user) safety meetings and Quality and Risk meetings to raise awareness of these themes and actions to take to reduce risk. Quality lead to join Bi-monthly Integrated Governance Meeting between HPFT and CGL in September.
West Essex- Inpatient incident Inpatient incident- Death of a 18 years old patient in Derwent Centre. Patient was registered with Mid and South Essex. Service user was open to EPUT and HPFT. Learning from investigation will be brought to future quality committee.	Investigation is being carried out by EPUT. HPFT will participate in the review. Staff and service users are being supported. Visit to be carried out by Mental health Quality manager.

Escalation Report CQC Summary Inspections

Subject	Key issue summary/Risk	Mitigating actions and timelines	Next steps
HPFT- Workforce	- High vacancy rate throughout the services- - 25% Vacancy – nurses - 19 % Vacancy- health care worker	There is an agreed escalation process for reporting any safety concerns associated with nurse staffing. If a shift remained unfilled, this is reported to the Heads of Nursing (HoN) and recorded as a safety incident on DATIX. Reliance on bank and agency usage to support safe delivery of care across the services.	Review of the recruitment processes is currently underway regards to staff onboarding as part of a continuous quality improvement (CQI) project.
CQC Inspection Forest house. 29A Warning Notice	- Forest house was rated as inadequate by CQC and issues with 29A Warning Notice. - 2 recent follow up visited took place in July, CQC reported no immediate concerns.	- Focused resources implemented in Forest house. - Weekly meeting with the team. - New staff have been recruited and block booking of agency staff to support the acuity implemented.	- Awaiting report from recent CQC inspection. - The trust is working towards agreed improvement plan. - Scrutiny and reporting in the Quality review meeting.
CG L &HPFT Pathway. Communication and joint working with Care Grow Live (CGL)	Themes from serious incident has noted an increase in concern with communication and joint working between CGL and HPFT.	Currently there is an agreed joint working protocol between HPFT and CGL.	- Taskforce is being explored for this quarter. - Upcoming meeting between CGL/ HPFT and ICB in September. - Further monitoring upon quality assurance visits to services.
West Essex- EPUT Workforce	Vacancy rate currently at 20.2% for the month of June. Vacancy Rate (%) April 18.1% May 19.4% June 20.2%	EPUT recently invested in overseas recruitments. Services are covered with agency and bank staff. Daily safety huddles throughout the services to identify risk and implement risk management plans.	The new Mental Health ARRS (Additional Roles Reimbursement Scheme) are starting together with other positions across the Trust. The trust plan to explore different employment solutions and utilising existing roles – apprenticeships, associate practitioners etc.

Assurance Report Mental Health Quality Summary

Summary description please be concise:

Hertfordshire CAMHS

Crisis presentations:

- Presentations to acute hospitals continue to have high levels of complexity, and need for medical treatment, those needing Mental Health assessment Act (MHAA), social care interventions meaning further work and support within hospital over a more longitudinal assessment/intervention period is necessary.
- Children –Crisis Assessment Team (C-CATT) staffing has remained 95-100% at capacity (utilising permanent, bank and agency staffing) with additional twilight shift being added to the team – effective from August. This will support assessing CYP in a timely and efficient way
- Demand to access support for Eating Disorder (ED) remains high
- The new Early Help Eating disorder service commenced in June, initially they will support HPFT Community ED Team to support a reduction in the current waiting list.

West Essex SET CAMHS Community

- Recruitment remains challenging particularly in Mid and West Essex,
- There is increasing pressure from secondary care with requests to support CYP who have presented to acute settings with eating disorders and disordered eating.
- There has been a significant rise in demand for Care Education Treatment Reviews (CETR) with the team (2 people) undertaking 8 reviews in the week commencing 18/07/2022.
- Tier 4 - Discussion on progress and status of CYP within Tier 4 beds is monitored monthly with multi-agency attendance inclusive of the provider collaborative.
- The Tier 4 bed position for Hertfordshire and Essex is monitored weekly. Demands for tier 4 beds continues nationally.

Next steps and ongoing monitoring

Hertfordshire CAMHS

- In addition to the regular contract review meetings, HPFT have developed action plans that have commissioner oversight.
- These have focused on recovery across C-CATT and the CYP Community Eating Disorder team.
- For C-CATT these will focus on 4 elements to achieving 95% target: Staffing recruitment & Retention, Retaining quality, wellbeing/burnout, Diversion from A & E to community Services.
- To further address demand, C-CATT have established Saturday clinics, currently held every other week but planned to run weekly every Saturday from September in line with expected influx of referrals post school holidays
- For Children and Young People ED Team the focus will be on reducing the waiting list and improving service User(SU) experience and overall performance.

West Essex SET CAMHS Community

- 2 quality visits have been undertaken to West and Mid Essex, further visits are planned for the coming months.
- Following identification of additional funding for the Eating Disorder (ED) service, commissioners are in the process of putting in place the synergy sub clinical threshold model as a pilot project which offers 121 and family support for under 18's with an emerging Eating Disorder as an additional element to existing ED support.
- Expansion of the CETR team has been agreed and posts will go out to recruitment.
- Tier 4 bed position for week commencing 24/7/22 outlined below.

6 county Bed Position	Beds closed	Beds Occupied	Beds Vacant	Planned admission & Assess ments	Beds available	CYP waiting
5/09/22	38	104	24	4	20	18

Assurance Report Mental Health Quality Summary

Summary description	Next steps and ongoing monitoring
Mental Health Adults • The community eating disorder service has seen a 133% increase in referrals since 2020. 85% of routine referrals were seen within 28 days. • Significant rise in referrals for community mental health services since the last wave of COVID, reflected across the country. • Increased pressure on services, higher caseloads and people waiting longer for assessment has affected the 18-week waiting time. Workforce challenges are also impacting on the waiting times for treatment • HPFT to look at how treatment pathways can be supported by other organisations, such as Herts Mind Network Complex Needs or social prescribing . • A delay in transfers of care has increased further at 12.09% due to the high levels of delay in Adult Acute services caused by insufficient placements available for people with complex care needs. • Out of Area Placements (OAP) trajectory has not been achieved against NHSE target. Recovery plan submitted to NHSE	• Capacity issues within the community mental health team. Recovery action plan in development. Additional agency staff have been recruited to community teams in the West • Actions taken by the HPFT to address the backlog of Initial Assessments, which was a result of demand coming into the service outstripping capacity within the current service configuration and because of the known workforce challenges. • Additional clinics have been provided during evenings and weekends, which will continue • Technical contract meetings monitoring the 28 day wait to treatment • Multi-Agency Discharge Events (MADE) have commenced and will be held regularly to support DTC and complex care. Commissioners attend for oversight purposes • OAPS recovery plan completed and overseen by MH Commissioners

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

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

Adult Mental Health Workforce challenges OAPs	• Staffing capacity is a significant risk to service delivery • The refurbishment of Kingfisher Court adult mental health wards will reduce bed capacity and may increase OAPs	• Recruitment continues and bank staff utilised • Recovery action plan will be updated to reflect refurbishment plans.	• Progress monitored through contract management meetings • HPFT will confirm timeline for refurbishment

Assurance Report – Infection, Prevention and Control HCAI Data

Summary description:

Healthcare Associated Infection (HCAI) Data:

- **Clostridioides difficile infection (CDI)** – Although all 3 CCGs have a rate below that of the EoE region, at the end of Q1 each of the 3 acute trusts are above the rate for acute trusts within the region.
- **MRSA blood stream infection -** No cases were reported by any of the 3 acute trusts during Q1. Only 2 CCG cases were reported, and these are currently being reviewed to identify any learning.
- **MSSA blood stream infection –** During 21-22 PAHT experienced a high rate of MSSA BSI, but this reduced significantly after the establishment of a task and finish group to address IV access practices. During Q1 both PAHT and ENHT now have rates below region. This was also reflected in the WECCG and ENHCCG data. However, both WHTHT and HVCCG both now have a rate above region.
- **E. coli blood stream infection –** although all 3 CCGs were below their thresholds and below regional rates for Q1, all 3 acute trusts had exceeded their thresholds. However, only PAHT was slightly above the regional rate.
- **Klebsiella spp blood stream infection –** All 3 CCGs exceeded their thresholds for cases during Q1. In particular, WECCG infection rate was significantly above the regional rate. During Q1 WHTHT exceeded their threshold and significantly exceeded the regional rate.
- **Pseudomonas aeruginosa blood stream infection –** During Q1 all 3 CCGs were below threshold, and only WECCG was slightly above the regional rate. All 3 acute trusts were below their thresholds, although ENHHT had a rate slightly above that for EoE.

Next steps and ongoing monitoring

The ICB IPC team produce a monthly HCAI report and comparative data analysis that facilitates discussion with individual service providers.

There is currently a process for RCA of HCAIs and identification of learning. However, a review and overhaul of this process is included within draft integrated HWE IPC 5 Year Strategy and agreement will be sought regarding the best way forward to maximise quality improvements at the strategy workshop on 17th August 222

The strategy also prioritises key areas that will positively impact on rates of HCAIs locally such as programmes to strengthen IV access practice, Aseptic Non-Touch Technique (ANTT), urinary catheter management etc. A more detailed integrated plan will be produced following the strategy workshop.

Assurance regarding the implementation of identified learning from case reviews is reported and monitored via each trust IPC Committee. This includes reporting of Trust audit programmes and results.

Learning and challenges are disseminated more widely and discussed at the monthly system IPC network group meetings.

Assurance Report – Infection, Prevention and Control – Outbreaks

Summary description:

Outbreaks and Incidents:

- **COVID 19** - The number of reported outbreaks/clusters steadily increased in Q1
- In total, 37 outbreaks relating to Covid were reported
- 13 in West Herts Teaching Hospital Trust (WHTHT)
- 6 in ENHT
- 1 in Hertfordshire Community Hospital
- 3 in PAHT
- 6 in Hertfordshire Partnership University NHS Foundation Trust (HPFT), 2 in hospices, 5 in independent hospitals and 1 in primary care. In addition, there were 11 clusters relating to Covid – 2 in HPFT, 1 in an independent hospital, 2 in hospices and 6 in primary care.

- **Norovirus** - 1 reported outbreak of Norovirus in Princess Alexandra Hospital, in the Acute Admissions Ward (AAU). Incident Management Team (IMT) meetings were implemented, to monitor and manage the situation.

- **Monkeypox** The incidence of monkeypox cases increased steadily during Q1. Most cases were reported in London and in gay, bisexual men and other men who have sex with men. Extraordinary meetings with all provider settings were arranged to ensure that national guidance was implemented.

- Adult and children's care pathways were developed covering responsibilities of the clinical risk assessment, safe swabbing procedures, treatment and follow up of possible/probable and positive cases.

- A major challenge was the development of a pathway for the under 18's where it is not appropriate for them to attend the sexual health clinics. A variation of contract through Commisceo was investigated and at the time of writing this report (8th August), this contract is being finalised.

- Although reported in quarter 2, there has been 2 separate incidents in schools which involved confirmed, positive individuals being in contact with large numbers of children. Some of these children required screening, and some were offered vaccination.

Next steps and ongoing monitoring

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

Affected units develop, implement action plans and progress of the action plans are monitored at these meetings. Outbreaks are also regularly discussed at the following meetings and progress of the action plans are monitored:-

- Monthly Infection Prevention and Control ICS network meetings Quarterly IPC ICS meetings
- Provider IPC committees
- Webinars

Continue with the system Monkeypox meetings
Liaise with the contracts team to agree and confirm the contract of variation with Commisceo across the ICS.
Continue to offer and implement filtering face piece (FFP3) fit testing in primary care.
Provide updates regarding Monkeypox and FFP3 fit testing in the monthly IPC webinars

To continue to support UK Health Security Agency (UKHSA)with these investigations; To attend the IMT meetings that are scheduled and follow up regarding finances for screening

Assurance Report – Infection, Prevention and Control outbreaks continued

Summary description:

Outbreaks and Incidents:

- **Tuberculosis -**2 separate incidents involving Tuberculosis, both in East and North Hertfordshire. Incident one involved 2 positive cases working in a Packaging Company (20 – 30 staff required screening). Incident two involved a worker employed in a food processing warehouse (8 colleagues were screened).

- **Legionella -** Legionella was detected in two side room showers and a 4 bedded bay in Avocet Ward (Saffron Waldron). Previous works had been carried out in 2021 to replace pipes by NHSPS. Full risk assessments were completed, and all patients and staff were monitored.

- Patients were decanted to another ward whilst remedial actions were carried out. Further dead legs were identified that had not been removed in earlier works. Ward reopened after a complete decontamination of system completed. Filters also applied to outlets.

- **Primary Care:** The IPC team has been supporting colleagues within primary care with issues relating to IPC. This has been achieved via several available routes including the implementation of an RCN accredited IPC training session for the designated IPC link practitioners.

- Monthly webinars continue to be carried out and have been well attended with positive feedback being received from those who have joined the sessions. Filtering face piece (FFP3) training sessions have also been available for primary care staff across the system.

Next steps and ongoing monitoring

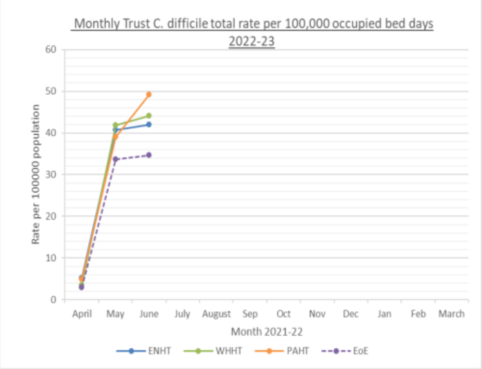
To continue to support UK Health Security Agency (UKHSA)with these investigations; To attend the IMT meetings that are scheduled and follow up regarding finances for screening

Water systems continue to be monitored via the Water Safety Committee. Legionella still being identified in the water system - found to be more widespread in the unit. All mitigations remain in place. EPUT have requested a declaration from NHSPS.

Further IPC training sessions have been scheduled for September and the implementation of an IPC audit programme is to be introduced in Primary Care which will raise awareness of IPC within the GP practices.

The audit tool (ICAT) will encourage the GP practices to be proactive in implementing IPC as part of good, effective and safe practice which will minimise the risk of infection within this setting. The monthly webinars will continue to be carried out and further FFP3 fit testing sessions have been scheduled for September.

Escalation Report IPC

Subject	Key issue summary/Risk	Mitigating actions and timelines	Next steps
Clostridioides difficile infection (CDI) rates at WHTHT, ENHHT & PAHT are currently above the EoE regional rate per 100,000 occupied bed days. Includes a period of increased incidence of CDI on Sarratt Ward at WGH.	 Monthly Trust C. difficile total rate per 100,000 occupied bed days 2022-23 • Extended hospital stays due to CDI • Risk of increased mortality from CDI • Risk of outbreaks of CDI resulting in loss of bed days • Negative impact on the patient	• All cases subject to root cause analysis and antibiotic review • Review of themes in learning identified through RCA – documentation of stool, use of laxatives, PPI usage • Discussion of cases at divisional governance meetings • Ribotyping of all positive samples – no links identified to date • Structured peer reviews undertaken involving key internal and external stakeholders • Action plan developed including a staff training plan – includes mock CDI RCA at acute trust IPC study day on 16th August 22 • Monthly trust-wide antibiotic usage data continues to be reviewed • HWE Antimicrobial Stewardship SRO now nominated – ICB Director of Nursing and Quality	• Draft HWE IPC 5 year strategy includes the review of the process for HCAI case review and dentification of learning – workshop to agree way forward booked for 17th August 22 • HWE ICS AMR group being established in next several months
Increase in the number of COVID outbreaks and clusters being reported	• Incidence increasing in Q1 and the beginning of Q2. • Risk of increasing the pressures on bed within the system – may result in bays/ward closures • Possible increase in the number of ITU beds being blocked • High numbers of staff being involved which may have an effect on business continuity and patient safety	• Regular attendance at the IMTs • Discussion at the monthly network meeting – reassessing the risks associated with the hierarchy of controls – particularly, regarding mask usage • Ensuring appropriate development and implementation of risk assessment in terms of Living with Covid guidance and monitoring the impact on patient's and services • Monitoring IIMARCH submission data • Review and update internal outbreak spreadsheet on a weekly basis	• Continue supporting staff at the monthly IMT meetings • Continue to identify learning per outbreak and to disseminate the learning across the system via the system monthly network meetings • Continuing to promote collaborative working across the system to encourage patient flow. This will be done via the draft HWE 5 year IPC strategy

Assurance Report – Other Areas for Noting

Summary description:	**Next steps and ongoing monitoring**
EEAST • Significant delays in arrival to handover times at all acute hospitals continue to increase. This is also a significant driver for increasing delays in ambulance response times. Although there were fewer SIs in Q1 – 3 in total (ENH – 2, HV – 1, WE – 0) early indications for July show this isn't continuing, and most SIs are related to delays. Delays feature in complaints and Friends and Family scores have dropped to 92% in April to 86% in May. • Safeguarding referrals increased from 2500 in April to 2850 in June.	• EEAST attend the daily system calls and are working with partners to improve flows and review of escalation procedures. The Hospital Ambulance Liaison Officer role continues in 2022/23 to help manage ambulance handovers. • SI's are reviewed by each place based SI panel.
HUC • Higher numbers of Out of Hours cases in Q1 than the previous quarter. • 29% of complaints include the theme of call back delays. • 60% of reported incidents relate to service delays.	• Monitored through Contractual and Quality Review Meetings

Meeting:	*Meeting in public*	☒	*Meeting in private (confidential)*	☐
	HWE ICB Board meeting held in Public	**Meeting Date:**	**23/09/2022**	
Report Title:	**National Patient Safety Strategy Update**	**Agenda Item:**	**10.1**	
Report Author(s):	Rosie Connolly, ICB Associate Director Quality Improvement and Patient Safety			
Report Signed off by:	Jane Kinniburgh, ICB Director of Nursing and Quality			
Purpose:	**Approval** ☐	**Decision** ☐	**Discussion** ☒	**Information** ☒
Report History:	Updates on progress with the implementation of the National Patient Safety Strategy have previously been provided to the 3 CCG’s Quality Committees, Primary Care Commissioning Committees and Boards.			
Executive Summary:	The slides provide a brief overview of the National Patient Safety Strategy, originally published in July 2019. The strategy sets out what the NHS will do to achieve its vision to continuously improve patient safety. It builds on two key areas; patient safety culture and a patient safety system. National timelines have been adjusted throughout the Covid-19 period due to the impact of the pandemic. Additionally, a new element was added to the Strategy during the refresh in February 2021 to ensure a commitment to address inequalities. This presentation provides an update on key areas within the strategy, including previous work within the CCGs, current position from an ICB perspective, and next steps. A key area for the Board to be aware of is the publication of the new Patient Safety Incident Response Framework (PSIRF). The ICB will be working with providers across the system to implement the new framework over the next 12 months.			

Recommendations:	The Board is being asked to note the strategy and support the local work required for implementation.			
Potential Conflicts of Interest:	***Indirect***	☐	***Non-Financial Professional***	☐
	Financial	☐	***Non-Financial Personal***	☐
	None identified			☒

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

Hertfordshire and
West Essex Integrated
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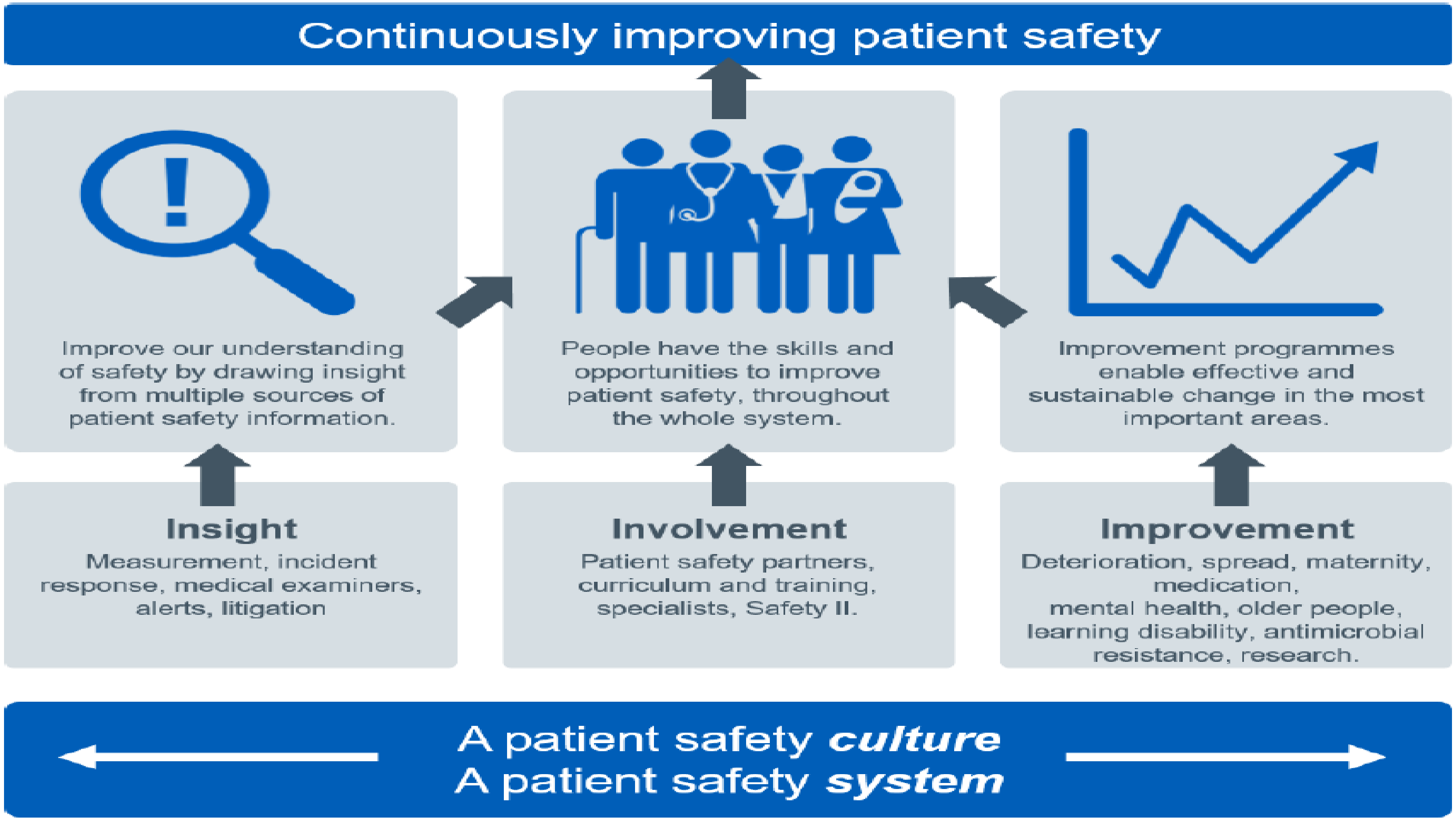
National Patient Safety Strategy Update

Friday 23rd September 2022

Rosie Connolly, ICS Associate Director Quality Improvement and Patient Safety

Working together
for a healthier future

Overview of National Patient Safety Strategy



Continuously improving patient safety

Improve our understanding of safety by drawing insight from multiple sources of patient safety information.

People have the skills and opportunities to improve patient safety, throughout the whole system.

Improvement programmes enable effective and sustainable change in the most important areas.

Insight
Measurement, incident response, medical examiners, alerts, litigation

Involvement
Patient safety partners, curriculum and training, specialists, Safety II.

Improvement
Deterioration, spread, maternity, medication, mental health, older people, learning disability, antimicrobial resistance, research.

A patient safety ***culture***
A patient safety ***system***

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Background: Previous CCG Work Undertaken

- Progression of the National 9 key priorities (see next slide for current position)
- Requirement to take paper to Board regarding role and expectations of Patient Safety Specialists completed
- Patient Safety Specialist role established in each CCG
- Implementation of ICS Patient Safety Specialist Network
- Preparing for roll out of Medical Examiner System for Community Deaths
- Roll out of Level 1 patient safety training to all CCG staff
- Development of business case for Patient Safety Partners within the ICB
- Supporting EPUT as early adopters of Patient Safety Incident Response Framework
- Participation in national workshops

Summary of Current Position Against Key Priorities

Priority area	Current position	Status (for Herts and West Essex ICB)
Just Culture	Ongoing work with HR within ICB (eg staff survey results), and working with providers regarding psychologically safe and just culture across system.	In progress, significant ongoing work required
National Patient Safety Alerts	Robust processes within ICB and across main NHS Trusts to review and act upon alerts.	On track
Involving Patients in Patient Safety	Funding approved by ICB Exec for Patient Safety Partners within the ICB. Recruitment pack developed with roles to be advertised in September with support of Healthwatch in both Herts and Essex.	In progress, ongoing work following recruitment to develop the role.
Transition from NRLS and STEIS to Learning from Patient Safety Events (LFPSE)	Assurance being sought from providers regarding transition plans. ICB developing plans for transition of STEIS to LFPSE. (transition required by April 2023)	On track, will be working with primary care to introduce LFPSE over coming months
Improving quality of patient safety incident reporting	Robust processes for oversight of provider incident reporting, ongoing work with primary care	On track, focus to be on primary care incident reporting
Patient safety education and training	Level 1 training made mandatory within ICB with good uptake, planning roll out of Level 2 and Board training (August data 81% compliance for L1)	On track (NHSE requirement for all staff to be trained in L1 by Q1 22/23)
Patient Safety Incident Response Framework (PSIRF)	Final guidance published 16th August 2022, ICS implementation plans being developed	In progress, significant ongoing work required. Have been national delays
National Patient Safety Improvement Programmes	All programmes led by local Patient Safety Collaboratives, await publication of local plans for the 5 key programmes.	On track, await Patient Safety Collaborative update
Covid-19 recovery planning	Ongoing wider work across ICB and ICS, with Nursing and Quality Team input as required	On track from patient safety strategy perspective, significant system work ongoing.
Medical Examiner System for community deaths	All 3 local Medical Examiner Offices on track with plans to ensure statutory requirement for all non-coronial deaths to be reviewed by Medical Examiner by April 2023 is achieved.	On track locally, some national delays impacting on delivery

Patient Safety Incident Response Framework (PSIRF)

- NHS England has published the new Patient Safety Incident Response Framework (PSIRF) outlining how NHS organisations should respond to patient safety incidents for the purpose of learning and improvement.

- The framework will replace the current Serious Incident Response Framework by Autumn 2023, and represents a significant shift in the way the NHS responds to patient safety incidents, centring on compassion and involving those affected; system based approaches to learning and improvement; considered and proportionate responses; and supportive oversight.

- PSIRF is a major step towards improving safety management across the healthcare system in England and will greatly support the NHS to embed the key principles of a patient safety culture. It will ensure the NHS focuses on understanding how incidents happen, rather than apportioning blame on individuals; allowing for more effective learning and improvement, and ultimately making NHS care safer for patients.

- PSIRF removes the requirement that all/only incidents meeting the criteria of a 'serious incident' are investigated, allowing for other incidents to be investigated and for learning response resource to focus on areas with the greatest potential for patient safety improvement.

- Alongside the framework, a 'Guide to engaging and involving patients, families and staff following a patient safety incident' has also been published, setting out expectations for how those affected by a patient safety incident should be treated with compassion and involved in any investigation process.

- PSIRF makes the leaders of provider organisations accountable for high quality incident responses while Integrated Care Boards will consider their providers' overall approach rather than each individual response.

- The framework has been developed following widespread consultation and informed by the experience of early adopters who piloted an introductory version of PSIRF from March 2020 – June 2022

Successes and Next Steps

Successes

- Herts and West Essex ICS seen as exemplar by NHSE regional team for establishment of ICS Patient Safety Specialist Network
- Success of Medical Examiner Webinar has been shared regionally and recording is available on the Futures Platform (East of England Patient Safety)
- Roll out of Patient Safety Level 1 training to all staff with good uptake (approx. 65% compliance in March 22, no data currently available due to transition of HR systems).
- Ongoing work with EPUT as part of the PSIRF early adopters pilot
- One of the first ICBs to have Patient Safety Partner Business Case approved, with good progress being made towards recruitment.

Next Steps

- NHSE will be republishing refreshed Patient Safety Priorities for all NHS organisations
- ICB Nursing and Quality Team ongoing structure review to create capacity to drive work forward
- Development of ICS Quality Strategy, with key focus on Patient Safety and Quality Improvement
- Focus on Just Culture and supporting our Acutes to improve CQC rating from Requires Improvement to Good
- Progression of system implementation of PSIRF and recruitment of Patient Safety Partners
- Progressing patient safety work within Primary Care

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Meeting:	*Meeting in public*	☒	*Meeting in private (confidential)*	☐		
	HWE ICB Board meeting held in Public			**Meeting Date:**	**23/09/2022**	
Report Title:	**Performance Report**			**Agenda Item:**	**11**	
Report Author(s):	Stephen Fry, Assistant Director of Performance West Essex, Hertfordshire & West Essex ICB Shazia Butt, Acting Associate Director of Quality & Performance Improvement, South West Herts, Hertfordshire & West Essex ICB Jo O'Connor, Assistant Director of Performance East and North Herts, Hertfordshire & West Essex ICB					
Report Signed off by:	Frances Shattock, Director of Performance and Delivery, Herts & West Essex ICB					
Purpose:	**Approval** ☐	**Decision** ☐	**Discussion** ☒	**Information** ☒		
Report History:	ICB Performance Committee					
Executive Summary:	The ICS Performance report provides an overview of the performance and quality of services being delivered by the system against key standards and benchmarks. Issues are escalated by exception with a focus on actions and next steps being taken to address.					
Recommendations:	The ICB Board are asked to note the contents of the report.					
Potential Conflicts of Interest:	***Indirect***	☐	***Non-Financial Professional***	☐		
	Financial	☐	***Non-Financial Personal***	☐		
	None identified			☒		
	N/A					

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

Hertfordshire and West Essex Integrated Care System Performance Report
September 2022

Hertfordshire and West Essex
Integrated Care System

Essex County Council

Hertfordshire

NHS

Executive Summary

URGENT CARE, Slides 6-11:

- Decline in 111 performance and call volumes answered within 60 seconds in June with continued high levels of demand;
- Increase in ambulance response times and number of handovers over 60 minutes;
- Continued decline in ED 4 hour performance with attendances remaining at increased levels. Improvements have been seen in the % of patients spending more than 12 hours in department however;
- Data does not yet suggest plans are delivering overall improvement for UEC.

CANCER, Slide 16-17:

- Increased number of 2 week wait referrals following significant spike in May;
- Decline in 62 day first performance however breaches are in line with mitigating action plans to treat the longest waiting patients;
- The number of patients waiting >62 days has improved but remains high and behind operational plan trajectory; ENHT and WHTHT are currently in Tier 1 for 62 day recovery, receiving the highest level of NHSEI regional support;
- Improvement over the last two months against 28 day Faster Diagnosis Standard, with mitigating actions across pathways improving performance.

PLANNED CARE, Slide 12-14:

- Continued improvement in number of patients waiting over 104 weeks in line with recovery plan; HWE ICS remain on plan to achieve the target of zero capacity breaches by end of August;
- System is now focused on reducing the number of patients waiting over 78 weeks to zero by the end of March 23 and is ahead of the operational plan trajectory. ENHT and WHTHT are currently in Tier 1 for 78 week recovery, receiving the highest level of NHSEI regional support;
- The number of patients waiting over 52 weeks continues to increase.

DIAGNOSTICS, Slide 15:

- The number of patients waiting over 6 weeks for a diagnostic test remains fairly static and whilst performance is ahead of regional average, is not meeting standard;
- Not yet assured that plans are sufficient to deliver the operational activity targets and return performance to target.

MENTAL HEALTH, Slide 19-20:

- Dementia diagnosis remains challenged in Hertfordshire together with the number of patients accessing IAPT;
- Pressure for Mental Health Assessments and acute beds continues, with Out of Area Bed placements remaining high;
- CYP eating disorder performance continues to decline with increasing referrals and higher levels of patient acuity and complexity;
- Data does not yet suggest plans are delivering improvement for MH Out of Area Placements and CYP ED;
- Working group involving the ICB, EPUT and HPFT to further develop the MH data set to better understand demand, complexity of need and acuity across the ICS.

PRIMARY CARE AND CONTINUING HEALTHCARE, Slides 21-22:

- Total number of GP appointments declined in June following an increase seen in May, however remain higher than pre-pandemic levels;
- Proportion of face to face appointments continue to increase, reaching 65% in June;
- The number of CHC assessments completed within 28 days remains a challenge, driven by South West Herts.

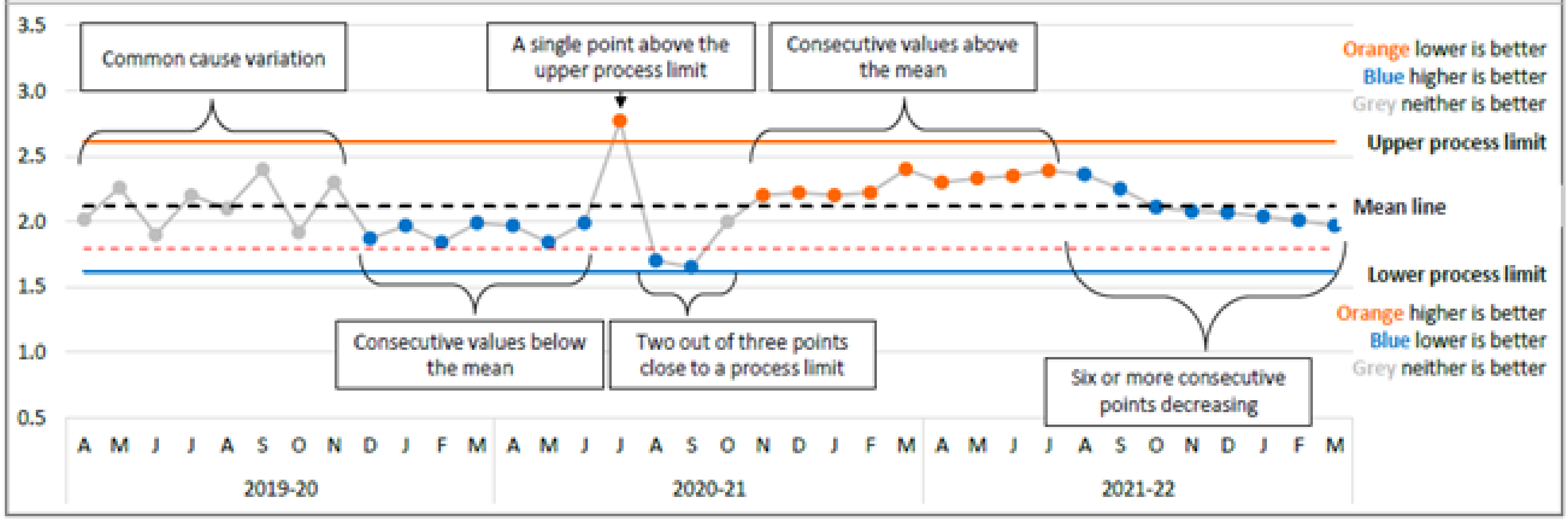
Executive Summary – Performance Overview

Metric	**Latest month**	**Measure**	**Target**	Variation	Assurance	Mean	Lower process limit	Upper process limit
A&E - 4 Hour Standard	Jul 22	61.4%	95.0%	L	F	69.2%	64.3%	74.0%
A&E - % spending more than 12 Hours in Dept	Jun 22	6.7%	-	H		5.8%	4.5%	7.1%
A&E - ED Average Attendance	Jul 22	41545	-	○		40258	33985	46531
Trolley Waits	Jul 22	368	-	H		158	-6	322
2 Hour Community Response	Jun 22	90.3%	-	○		83.0%	63.6%	102.4%
14 day LOS	Jul 22	12.4%	-	H		12.1%	9.8%	14.3%
Ambulance - Handover >60 Mins	Jun 22	1059	-	○		825	522	1128
EEAST: Cat 1 - Mean (<7min)	Jun 22	00:10:06	00:07:00	H	F	00:09:15	00:07:35	00:10:55
EEAST: Cat 2 - Mean (<18 Mins)	Jun 22	00:56:46	00:15:00	H	F	00:45:54	00:25:00	01:06:48
RTT - 18 Weeks	Jun 22	58.4%	92.0%	L	F	63.1%	59.8%	66.4%
RTT - 52 Week Waits	Jun 22	8903	-	H		8006	6339	9673
RTT - PTL Size	Jun 22	186538	-	H		156283	145446	167120
RTT - 104 weeks	Jun 22	9	-	L		100	61	139
Diagnostics - 6 Week Wait	Jun 22	67.4%	99.0%	○	F	70.9%	63.9%	78.0%
Diagnostics - PTL Size	Jun 22	36916	-	○		35553	28434	42672
Cancer - 2 Week Wait Standard	Jun 22	76.5%	93.0%	○	F	80.8%	69.7%	91.9%
Cancer - 2 Week Wait Referrals	May 22	6114	-	○		4951	3781	6121
Cancer - 62 Day Standard	Jun 22	64.3%	85.0%	L	F	73.3%	65.6%	81.0%
Cancer - 62 Day Total Waiting	Jul 22	706	-	H		602	369	835
Cancer - 104 Day Total Waiting	Jul 22	172	-	H		144	88	199
Cancer - 28 Day Faster Diagnosis Standard	Jun 22	67.4%	-	L		69.6%	59.7%	79.6%
Mental Health - Out of Area Placements	Jun 22	2254	-	H		952	380	1523
Mental Health - Dementia Diagnosis	Jun 22	61.4%	66.6%	○	F	61.3%	61.0%	61.7%
Mental Health - IAPT Entering Treatment	Jun 22	2291	-	○		2428	1701	3156
			-					

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

Statistical Process Control (SPC)

How to interpret a Statistical Process Control (SPC) Chart



Common cause variation

A single point above the upper process limit

Consecutive values above the mean

Consecutive values below the mean

Two out of three points close to a process limit

Six or more consecutive points decreasing

Orange lower is better
Blue higher is better
Grey neither is better

Upper process limit

Mean line

Lower process limit

Orange higher is better
Blue lower is better
Grey neither is better

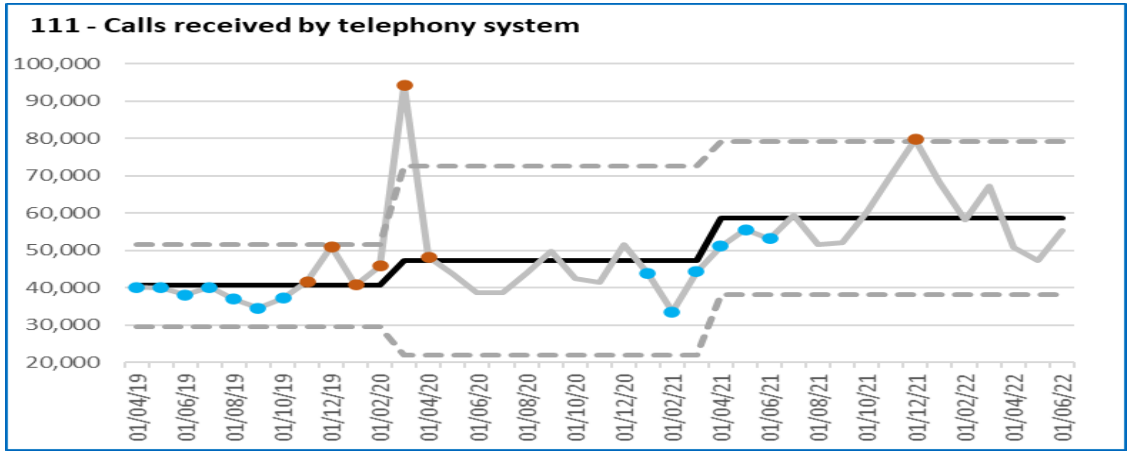
	Variation
H L	Special cause variation of concerning nature due to Higher or Lower values
H L	Special cause variation of improving nature due to Higher or Lower values
	Common cause variation No significant change

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

Performance by Work Programme

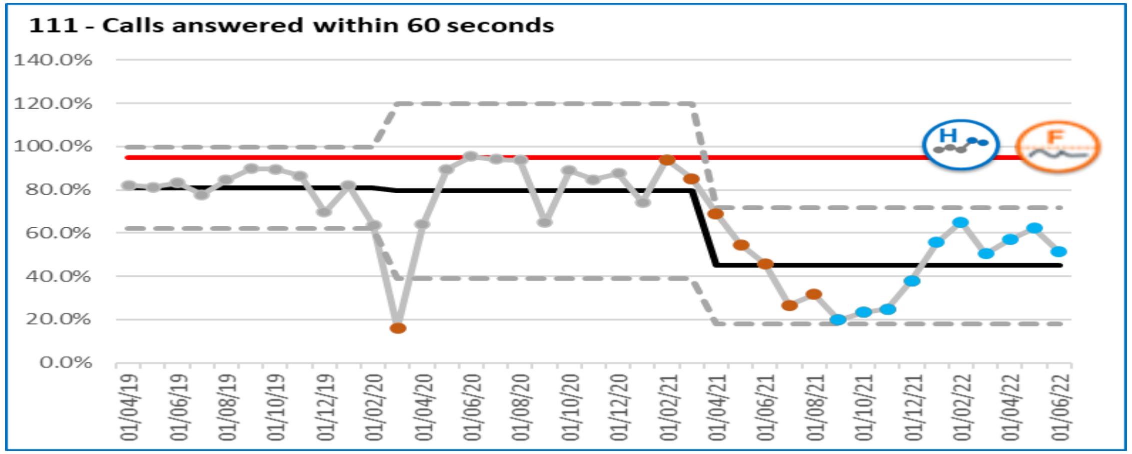
Slide 6: NHS 111
Slide 7: Urgent & Emergency Care (UEC)
Slide 11: Urgent 2 Hour Community Response
Slide 12: Performance against Operational Plan
Slide 14: Planned Care – 52 & 104 Week Breaches
Slide 15: Planned Care Diagnostics
Slide 16: Cancer
Slide 18: Stroke
Slide 19: Mental Health
Slide 21: Continuing Health Care
Slide 22: Primary Care

NHS 111



	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20
Hertfordshire	31,71	31,69	30,27	31,95	29,62	27,73	30,12	33,34	41,11	32,85	37,12	75,77	38,47	35,15	31,51	31,16	35,55	40,33	34,00	33,32
West Essex	8,460	8,368	7,903	8,208	7,409	6,831	7,084	8,333	9,938	7,972	8,788	18,48	9,752	8,593	7,090	7,572	8,586	9,523	8,378	8,229
ICS	40,17	40,05	38,17	40,16	37,03	34,56	37,20	41,67	51,05	40,82	45,90	94,25	48,22	43,74	38,60	38,74	44,14	49,85	42,38	41,55

	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22
Hertfordshire	41,20	35,15	26,87	35417	40,96	44,29	42,71	47,28	41,15	41,25	48,10	59,03	67,42	58,72	50,28	58011	40,99	38,10	44,67
West Essex	10,30	8,718	6,717	8877	10,19	11,29	10,45	12,19	10,59	10,78	12,17	10,98	12,41	9,549	8,013	9377	9,904	9,165	10,64
ICS	51,51	43,86	33,58	44,29	51,16	55,58	53,17	59,47	51,74	52,04	60,27	70,01	79,84	68,27	58,29	67,38	50,89	47,26	55,32

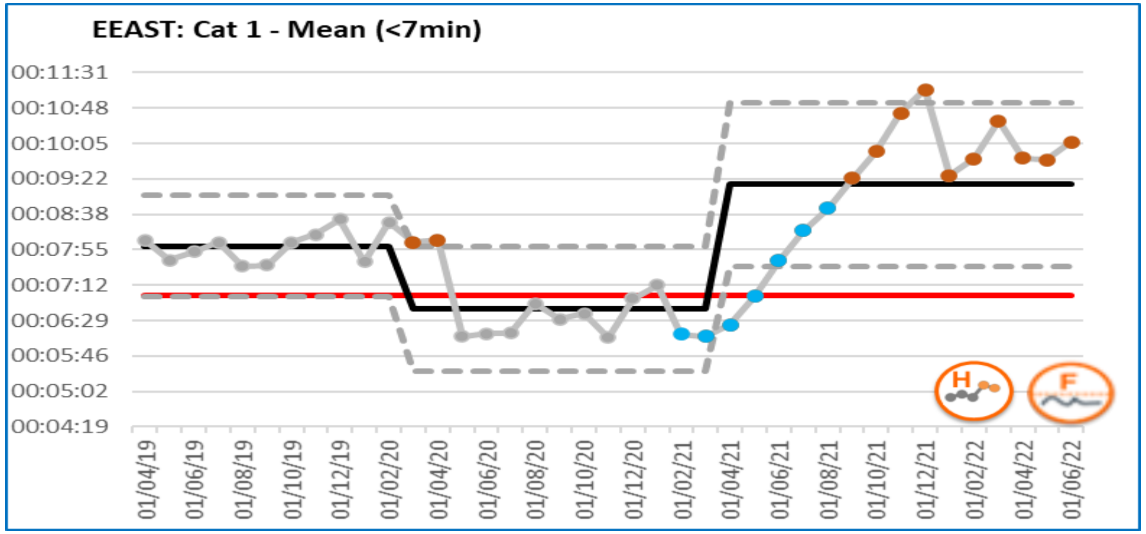


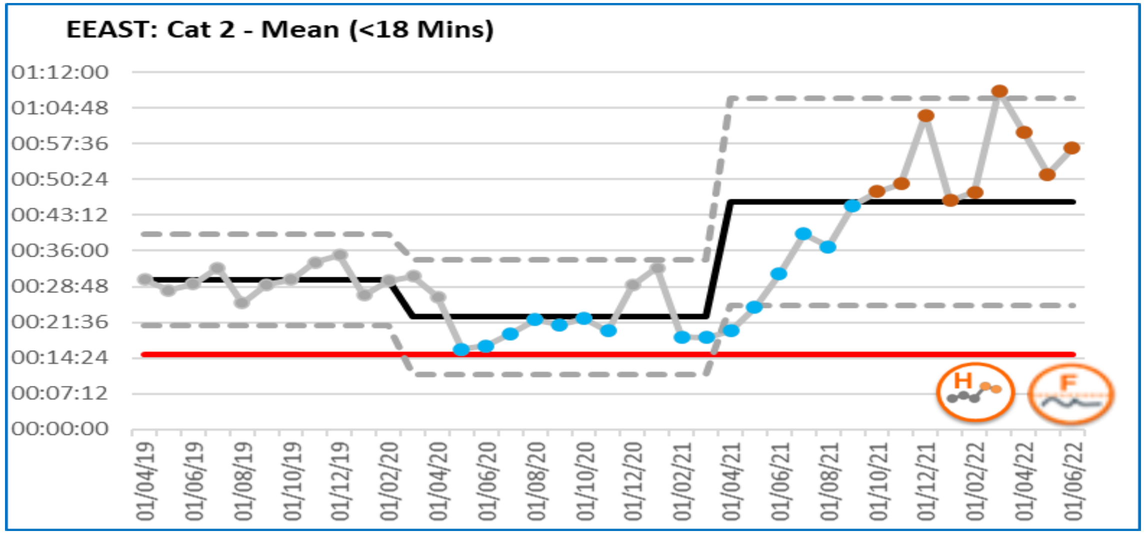
	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20
Hertfordshire	83.0%	81.6%	84.1%	78.4%	84.6%	89.7%	89.8%	86.9%	70.1%	82.1%	64.3%	16.2%	64.2%	89.6%	95.2%	94.3%	93.9%	65.0%	88.8%	84.8%
West Essex	78.4%	79.8%	79.6%	75.6%	83.9%	90.4%	88.4%	84.7%	68.1%	81.1%	61.8%	15.8%	62.7%	89.5%	96.3%	94.3%	93.5%	64.7%	88.9%	84.3%
ICS	82.0%	81.2%	83.2%	77.8%	84.4%	89.8%	89.5%	86.5%	69.7%	81.9%	63.8%	16.1%	63.9%	89.6%	95.4%	94.3%	93.8%	64.9%	88.8%	84.7%
Target	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%

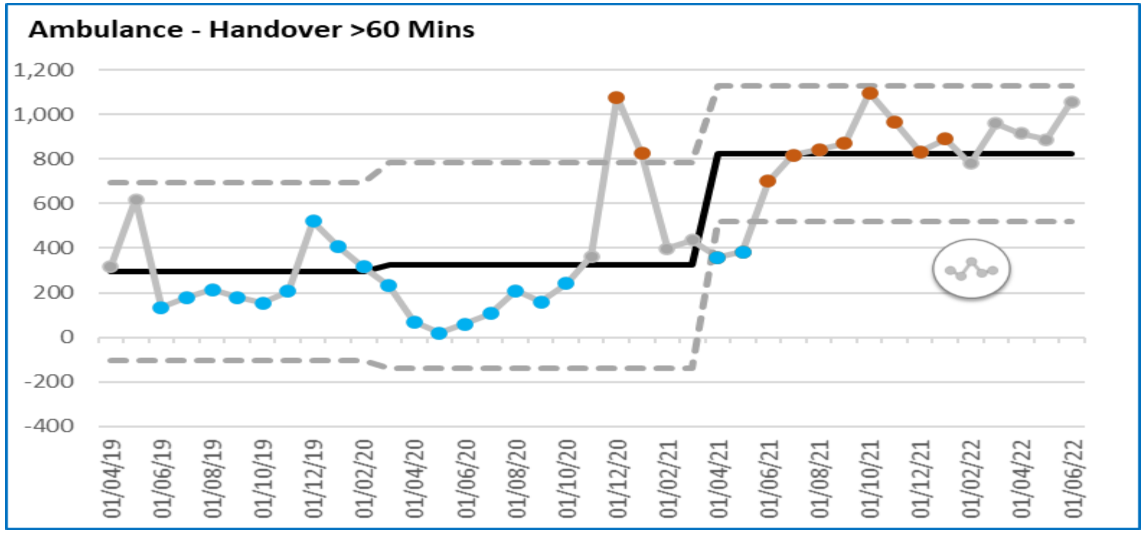
	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22
Hertfordshire	87.7%	74.3%	94.0%	85.2%	69.4%	54.9%	45.8%	26.6%	31.5%	19.7%	23.4%	25.0%	38.2%	55.7%	65.4%	50.4%	56.9%	62.2%	51.6%
West Essex	87.6%	74.2%	93.5%	85.2%	67.7%	53.1%	45.5%	26.3%	31.8%	20.2%	23.2%	24.4%	37.2%	55.5%	63.8%	50.8%	57.0%	62.1%	50.2%
ICS	87.7%	74.2%	93.9%	85.2%	69.1%	54.5%	45.8%	26.6%	31.6%	19.8%	23.4%	24.9%	38.0%	55.6%	65.1%	50.4%	56.9%	62.2%	51.3%
Target	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%

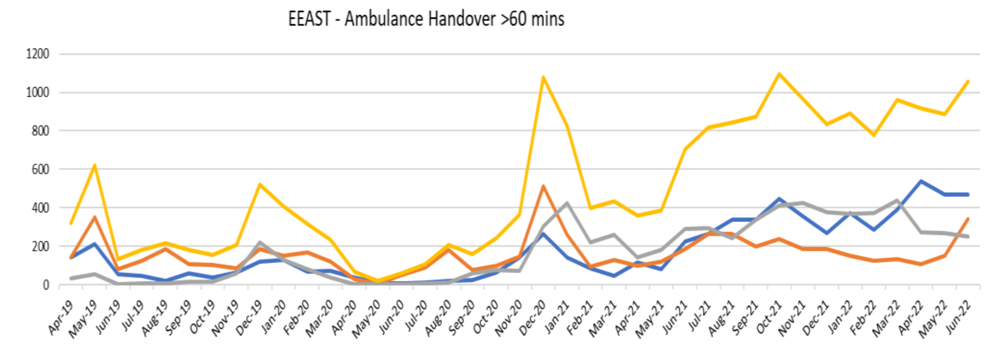
ICB Area	What the charts tell us	Issues	Actions	Mitigation
HUC	• Sustained increase in call volumes with HWE patients making over 130k calls during Qtr 1 • Overall improving trend in number of calls answered within 60 seconds however not meting target and slight deterioration in June • 8.7% of patient calls were abandoned before being answered, against the 3% expected standard	• High call volumes (including specific types, such as Dental and Repeat Prescriptions) • High sickness rates, including short term absences and COVID-related absence • Recruitment of clinical staff • In August, Adastra outage has impacted service delivery.	• Fortnightly IUC meetings to discuss issues and escalations (until September) • Monthly HUC T&F Group in place from September to discuss regional issues and unified approach • Weekly IUC Overview Reports from the Provider • Two recruitment companies engaged to fill vacancies • Range of staff support and welfare measures in place • Increased home working for Health Advisors and GPs to increase capacity and encourage shift fill • Provider delivering GP engagement events to speak directly to clinical colleagues regarding engagement with the service • Working groups in place to discuss Dental Calls and Repeat Prescription Calls • In response to Adastra outage, Business Continuity Plan enacted and Provider meetings with NHSEI and Commissioners in place	Actions are starting to improve performance and address issues, however the data does not suggest that the improvement plan is sufficient to restore performance to target at this stage.

UEC - Ambulance Response Times



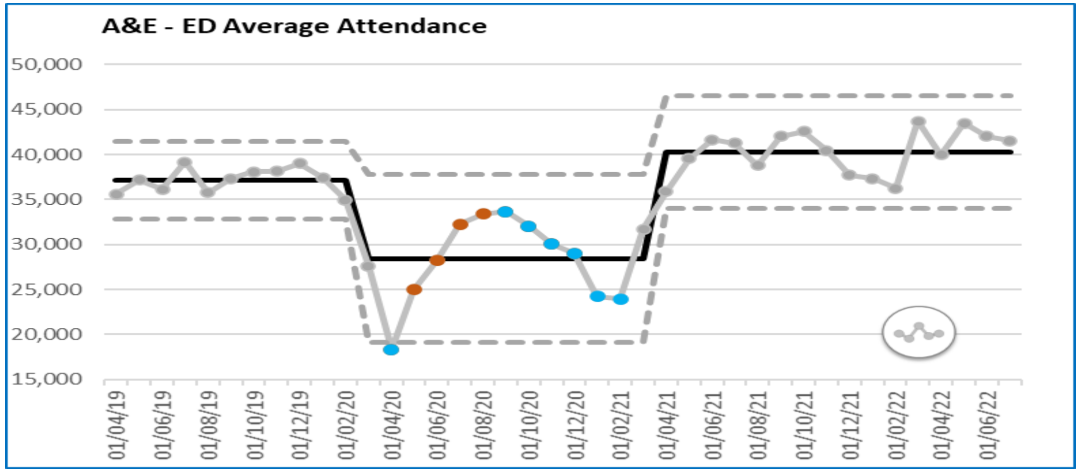




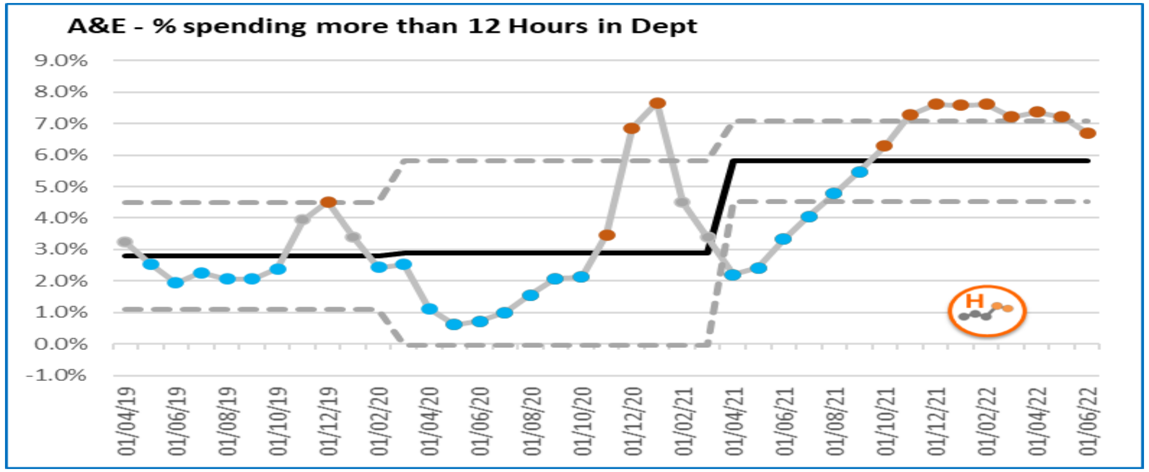


	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22
NHS East and North Hertfordshire	142	211	54	48	22	57	38	62	119	130	69	73	38	10	6	10	19	24	64	142	264	144	85	44	117	81	224	262	338	338	446	356	270	372	286	391	537	470	469
NHS Herts Valleys	144	353	79	126	187	108	101	84	184	149	169	122	27	6	52	89	179	77	99	148	511	259	93	131	100	120	186	264	264	197	238	186	185	150	123	132	105	150	341
NHS West Essex	34	55	1	5	6	15	15	61	219	128	79	37	3	4	1	8	11	57	78	73	303	423	220	260	142	183	292	293	242	337	414	423	379	369	371	437	274	268	249
Hertfordshire and West Essex	320	619	134	179	215	180	154	207	522	407	317	232	68	20	59	107	209	158	241	363	1078	826	398	435	359	384	702	819	844	872	1098	965	834	891	780	960	916	888	1059

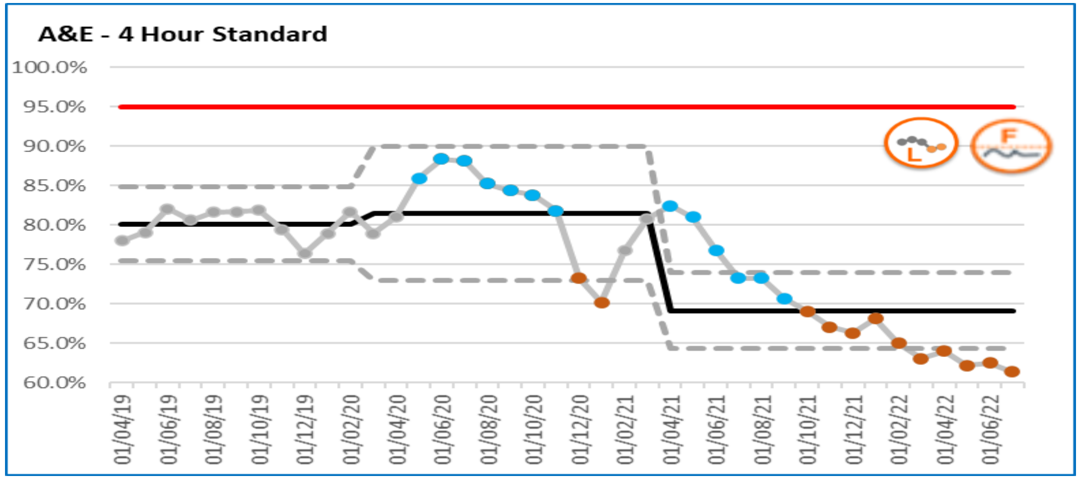
Urgent & Emergency Care (UEC)


A&E - ED Average Attendance

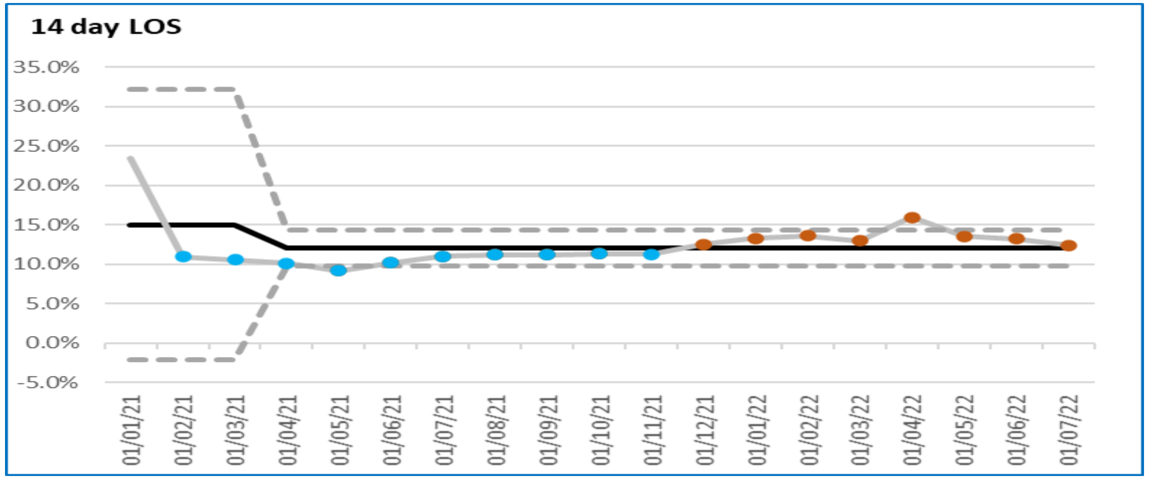
	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22
East And North Hertfordshire NHS Trust	13,44	14,30	13,67	14,82	13,67	14,04	14,64	14,55	14,84	14,24	13,22	10,45	7,228	9,838	11,09	12,28	12,57	12,81	12,15	11,38	10,88	9,319	9,072	11,95	13,47	14,72	15,85	15,63	14,92	16,38	16,59	15,61	14,67	14,16	14,01	16,70	14,72	16,40	15,45	15,65
West Hertfordshire Hospitals NHS Trust	13,12	13,70	13,52	14,54	13,16	13,83	13,88	13,95	14,37	13,56	12,81	10,22	6,619	8,854	9,991	11,74	12,31	12,00	11,38	10,65	10,72	8,864	8,689	11,43	13,20	14,41	15,17	15,22	13,94	14,97	15,20	14,52	13,42	13,53	13,02	15,53	14,73	15,63	15,63	15,14
The Princess Alexandra Hospital NHS Trust	9,008	9,152	8,932	9,822	8,926	9,428	9,555	9,622	9,756	9,636	8,903	6,945	4,484	6,299	7,150	8,210	8,475	8,826	8,506	7,990	7,400	6,034	6,155	8,348	9,223	10,42	10,58	10,39	9,892	10,66	10,78	10,30	9,592	9,636	9,231	11,45	10,48	11,45	10,92	10,74
ICS	35,57	37,16	36,12	39,18	35,76	37,30	38,08	38,13	38,97	37,44	34,94	27,62	18,33	24,99	28,23	32,24	33,36	33,65	32,04	30,02	29,01	24,21	23,91	31,73	35,89	39,56	41,62	41,25	38,76	42,02	42,57	40,44	37,69	37,33	36,27	43,69	39,94	43,49	42,01	41,54


A&E - % spending more than 12 Hours in Dept

	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22
NHS EAST AND NORTH HERTFORDSHIRE CCG	3.1%	2.2%	2.0%	2.5%	1.5%	2.3%	2.3%	3.8%	4.5%	3.8%	2.9%	3.7%	1.7%	0.7%	0.6%	0.9%	1.3%	2.7%	2.4%	4.1%	6.3%	7.2%	4.4%	2.7%	2.7%	2.7%	4.1%	5.1%	6.4%	7.4%	9.1%	9.6%	9.7%	10.5%	10.4%	10.1%	9.4%	8.5%	9.1%
NHS HERTS VALLEYS CCG	2.0%	2.2%	1.7%	1.7%	2.3%	1.8%	2.5%	2.1%	2.2%	2.0%	2.0%	2.2%	1.3%	0.7%	0.7%	0.8%	1.5%	1.3%	1.3%	1.8%	6.4%	6.9%	2.0%	1.3%	1.1%	1.4%	1.7%	2.2%	2.4%	2.5%	3.1%	3.7%	5.0%	5.1%	4.9%	5.0%	4.8%	4.9%	5.4%
WEST ESSEX CCG	3.2%	2.6%	2.0%	1.7%	1.8%	2.3%	3.2%	5.4%	6.3%	4.8%	3.0%	2.7%	0.8%	0.4%	0.9%	1.1%	1.9%	2.4%	3.0%	4.3%	7.3%	7.9%	5.8%	4.7%	3.2%	3.2%	4.5%	5.7%	5.7%	7.6%	8.3%	9.8%	9.0%	7.9%	8.1%	9.3%	9.5%	9.6%	8.9%
ICS	2.8%	2.3%	1.9%	2.0%	1.9%	2.1%	2.7%	3.7%	4.3%	3.5%	2.6%	2.9%	1.3%	0.6%	0.7%	0.9%	1.6%	2.1%	2.3%	3.4%	6.7%	7.3%	4.1%	2.9%	2.1%	2.3%	3.2%	4.0%	4.6%	5.4%	6.4%	7.1%	7.5%	7.6%	7.6%	7.8%	7.4%	7.1%	7.0%


A&E - 4 Hour Standard

	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22
East And North Hertfordshire NHS Trust	80.5%	81.6%	84.5%	81.5%	86.1%	85.1%	85.8%	81.5%	78.9%	81.5%	85.3%	80.2%	78.0%	83.4%	88.1%	90.1%	87.1%	84.8%	84.5%	82.4%	78.2%	75.2%	78.8%	85.2%	82.8%	84.1%	78.6%	74.8%	73.3%	69.5%	70.1%	68.8%	69.5%	69.8%	67.1%	66.6%	66.0%	66.4%	65.2%	62.4%
West Hertfordshire Hospitals NHS Trust	81.2%	79.9%	82.1%	81.3%	80.5%	83.0%	83.1%	82.2%	79.4%	81.7%	80.7%	77.1%	78.9%	83.9%	87.1%	85.9%	83.0%	84.3%	83.4%	82.1%	68.4%	65.3%	78.9%	83.1%	86.0%	83.0%	79.1%	73.9%	76.1%	77.6%	73.6%	70.5%	63.3%	65.7%	62.7%	58.8%	62.1%	58.2%	60.5%	63.2%
The Princess Alexandra Hospital NHS Trust	69.6%	74.0%	78.2%	78.3%	76.5%	74.9%	74.2%	72.2%	68.2%	71.2%	77.7%	79.7%	88.9%	92.9%	90.7%	88.3%	85.8%	83.9%	83.4%	80.7%	73.2%	69.8%	70.8%	71.4%	76.9%	73.9%	71.0%	70.0%	69.4%	62.9%	61.1%	59.6%	65.7%	69.1%	65.1%	63.8%	64.1%	61.7%	61.6%	57.5%
ICS	78.0%	79.1%	82.1%	80.6%	81.7%	81.7%	81.9%	79.4%	76.4%	78.9%	81.7%	78.9%	81.0%	86.0%	88.4%	88.1%	85.3%	84.4%	83.9%	81.8%	73.3%	70.2%	76.8%	80.8%	82.5%	81.0%	76.8%	73.3%	73.3%	70.7%	69.1%	67.1%	66.3%	68.1%	65.0%	63.1%	64.0%	62.2%	62.5%	61.4%
Target	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%


14 day LOS

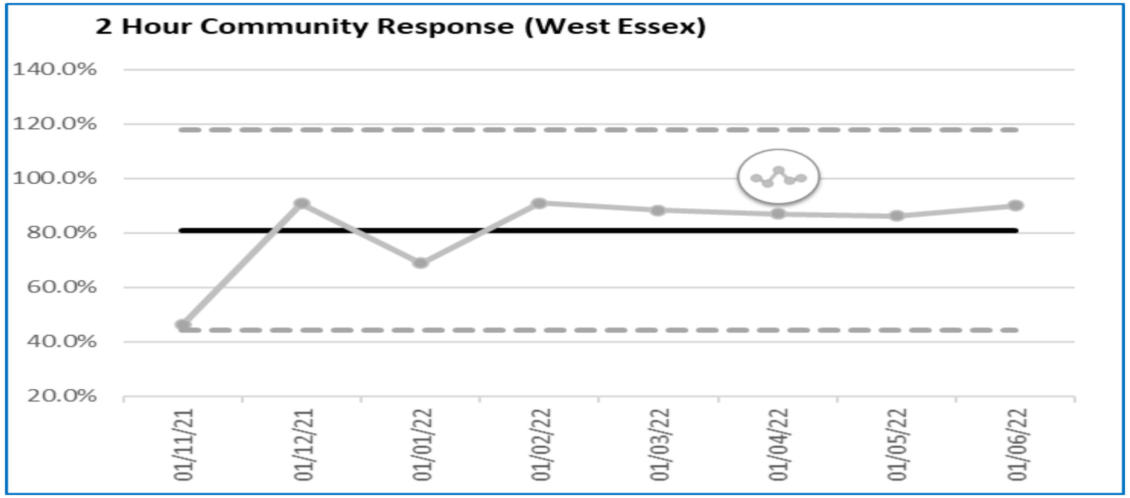
Urgent & Emergency Care (UEC)

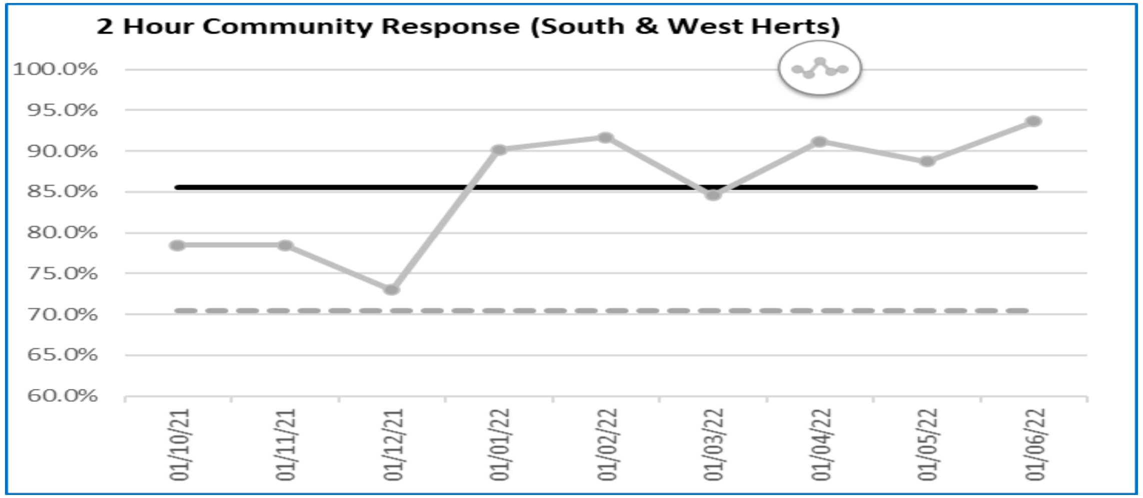
ICB Area	What the charts tell us	Issues	Actions
ICB	• Following a two month improvement, Category 1 & 2 ambulance response times increased in June • The numbers of ambulance handovers over 60 minutes also saw an increase in June at ICS level, predominantly driven by WHTHT • ED attendances have remained consistently above historical averages over the last 12mths coinciding with a continuing deterioration in performance against the 4hr standard; attendances have seen a decline in the last two months however • The percentage of patients spending more than 12 hours in the ED department remain high but have also seen a decline in the last two months • 14 day LoS remains consistently higher than historical average however has started to improve across the last three months • Above data points suggest EDs are experiencing exit block due to issues with discharge from wards	• Continued high demand for UEC services • Continued increased 111 demand • Acute capital build in some areas impacting on the management of current and future demand • Increased Covid admissions • Workforce availability and impact of Covid on the UEC workforce • MH assessment delays and bed shortages	**Alternatives to ED/reducing attendances:** • Implementation of the HARIS/Unscheduled Care Co-ordination to provide health care professionals working within our system access to appropriate clinical support to make the best use of services across the system and to reduce delays and improve performance. This program will start with support to EEAST Ambulance service (East of England Ambulance service) **System Strategy:** • Participation in the integrated Urgent and Emergency Care (iUEC programme) supported by the National Improvement team. The ICB is one of two systems that are participating in the pilot programme. The aim of the programme is to support development of a UEC strategy, support UEC recovery and reduce overcrowding in the EDs through diagnostics based on population health needs and service redesign; • Identification and monitoring of system UEC commitments for 2022 which include; - Reducing ambulance handover delays over 60 minutes- trajectories agreed - Reducing the numbers of patients spending 12 hours or more in ED - Improving the numbers of in-patients staying more than 14 and 21 days • Strengthening of ICB and CCG oversight and assurance arrangements linked to local escalation surge plans, and quality and performance frameworks • Currently developing plans to increase HWE bedbase by 141 beds in preparation for Winter • Each acute provider has its own internal Urgent care improvement plan.

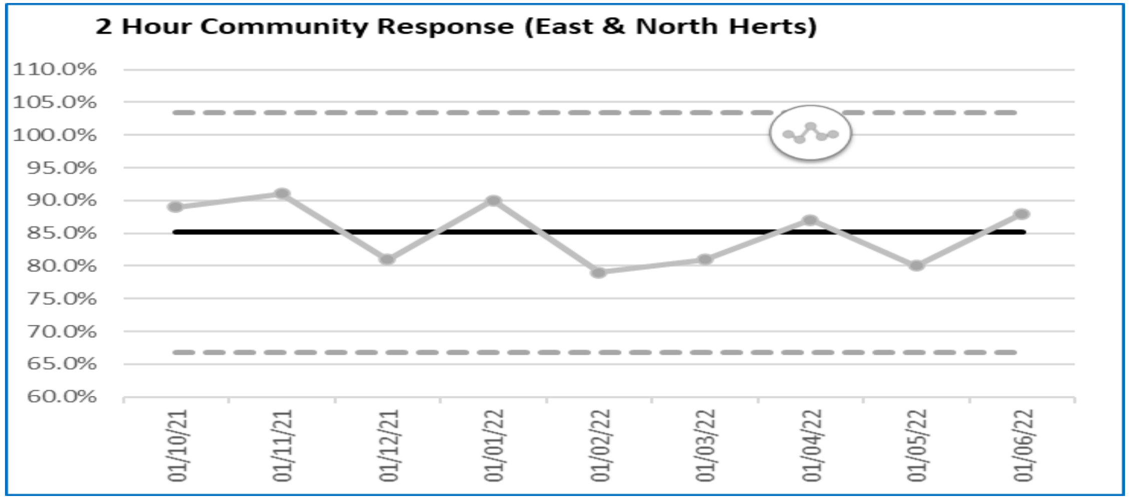
Urgent & Emergency Care (UEC)

ICB Area	What the charts tell us	Issues	Actions	Mitigation
West Essex / PAH	• High number of patients presenting at ED, but comparable to recent months • The number of patients arriving by ambulance and waiting over 60 minutes to be transferred to ED improved for the 3rd consecutive month • 9% of patients spent over 12 hours in ED in July, continuing a 12 month above average trend • The number of patients treated, admitted or discharged in under 4 hours continues to decline. Only 57.5% was achieved in July	• Continued high demand in number of attendances • Estate footprint and size of department • ED staffing, sickness and isolation • Increased Covid patients within the Trust impacting bed capacity • Flow into ED and out of hospital (Discharge) • MH assessments and bed shortages	• Daily joint working with all system partners to create ED capacity aligned to local oversight arrangements • Daily calls and CCG support with discharges and Transport • Daily calls with EEAST to review pressures across local Trusts and enact "load levelling" • Urgent Treatment Centre (UTC) – further expansion of services and hours • Nightingale Ward (18 beds) available as escalation as per escalation plans and staffing availability • Continue with established safety huddles and harm review arrangements • National, Regional & Internal Discharge Programmes to improve flow and length of stay • National 100 Day Challenge	Actions in place to ensure that patient safety is maintained. HWE selected for National IUEC Transformation Programme SRG work plans agreed in line with NHSE planning guidance
South West Herts / WHTHT	• A&E attendances have increased by 41% over the past year with an increase in walk-in attendees of 68.15% • The number of patients treated, admitted or discharged in under 4 hours improved from June (60.4%) to 63.2% in July • 12 hour total time in ED – deterioration from 4.9% in May to 5.4% in June 22.	• High number of patients conveyed by ambulance • A continued high number of mental health presentations, both in ED and on the wards • MH bed shortages (national issue) • Workforce issues across all providers (vacancies/sickness) • Regularly having 70+ surge beds open at WHTHT	• Daily joint working with all system partners to create ED capacity aligned to local oversight arrangements. Establishment of an integrated urgent treatment centre at St Albans from October 22 • NHS 111 direct booking to UTC. Implemented a new EPR system across the entire Trust • All ambulance arrivals are immediately assessed in Senior Team Assessment Rapid Response (STARR) area and investigations and Treatment commenced if appropriate • Identified additional area for walk-in patients that separates them from ambulance arrivals • Provided additional assessment trollies. Reviewed the workforce model for the UTC • Increased the use of SDEC pathways. Current data shows better usage of this pathway than previous 2 years .Direct access for GPs into the frailty unit • Executive led confirm and challenge sessions . Continue with established safety huddles and harm review arrangements	
East & North Herts / ENHT	• Improvement in handover delays over 60 minutes following spike in April • Reduced number of ED attendances over June and July following spike in May, however remain at increased levels • Decline in ED 4 hour performance across June and July, sitting at just over 62% • Following an improvement in May, the % of patients spending more that 12 hours in department increased in June to 9.1%	• Continued high demand in number of attendances • Internal critical incident in June with 29 IP beds closed for a number of days reducing capacity and impacting ED and patient flow • ED staffing, sickness and isolation • Increased Covid admissions • MH assessments and bed shortages	• Interim proposal to support increased cubicle and triage capacity ahead of the UEC transformation project completion being reviewed • Implementation of COVID cohort bed model • Trust wide UEC workshop held on 14 July to pool improvement ideas to improve patient safety and flow; agreed key actions expected to reduce LOS within ED and improve performance • Re-set week held end of July, with focus on flow and discharge; targets of 100 discharges a day, 3 discharges per ward by 11am and to stop bedding SDEC/discharge lounge. Redeployed Ops and Senior nursing staff and cancelled all non-essential meetings. Staff challenged decisions and put large focus on moving patients through hospital. • ECIST spent time with site team and on site – recommendations are due shortly	

UEC - Urgent 2 Hour Community Response







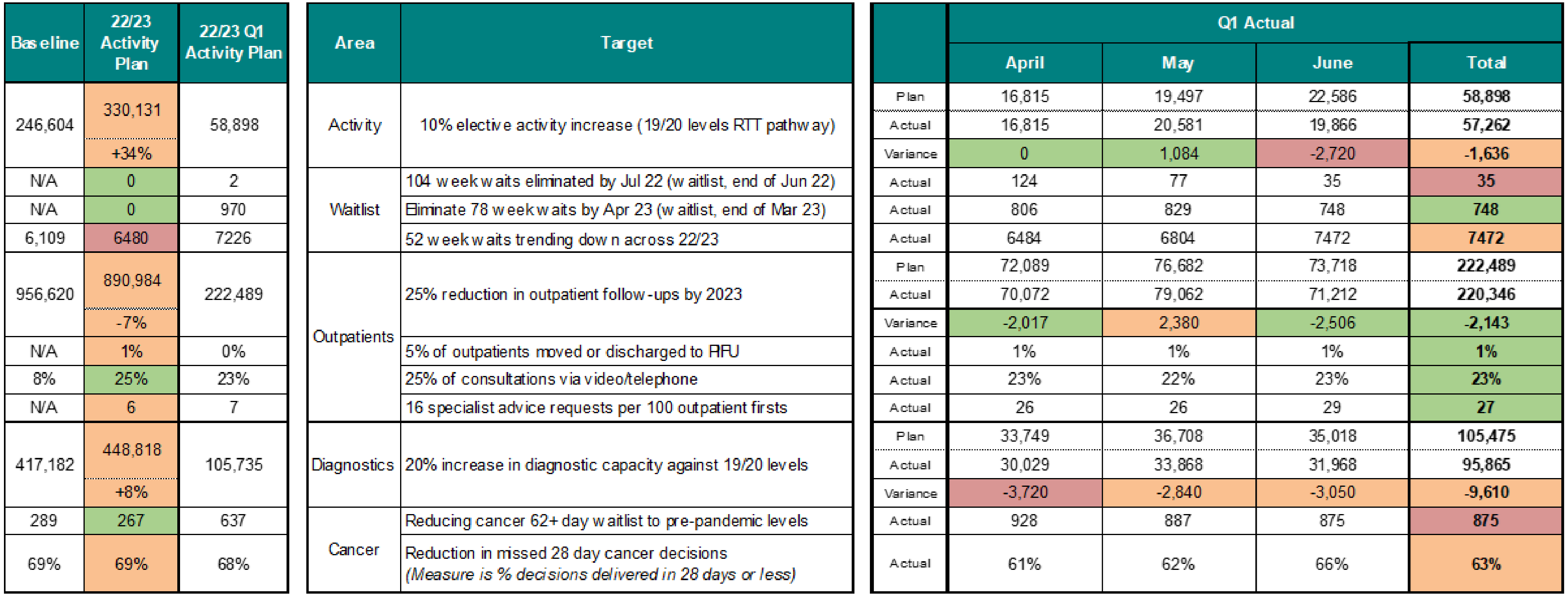
ICB Issues, escalation and next steps

ICB:

- Common Cause Variation – no significant change
- 80% being achieved in all three Places

Performance v. 22/23 Operational Plans

Herts and West Essex Providers (please see Appendix B, slide 24 for performance by Place)

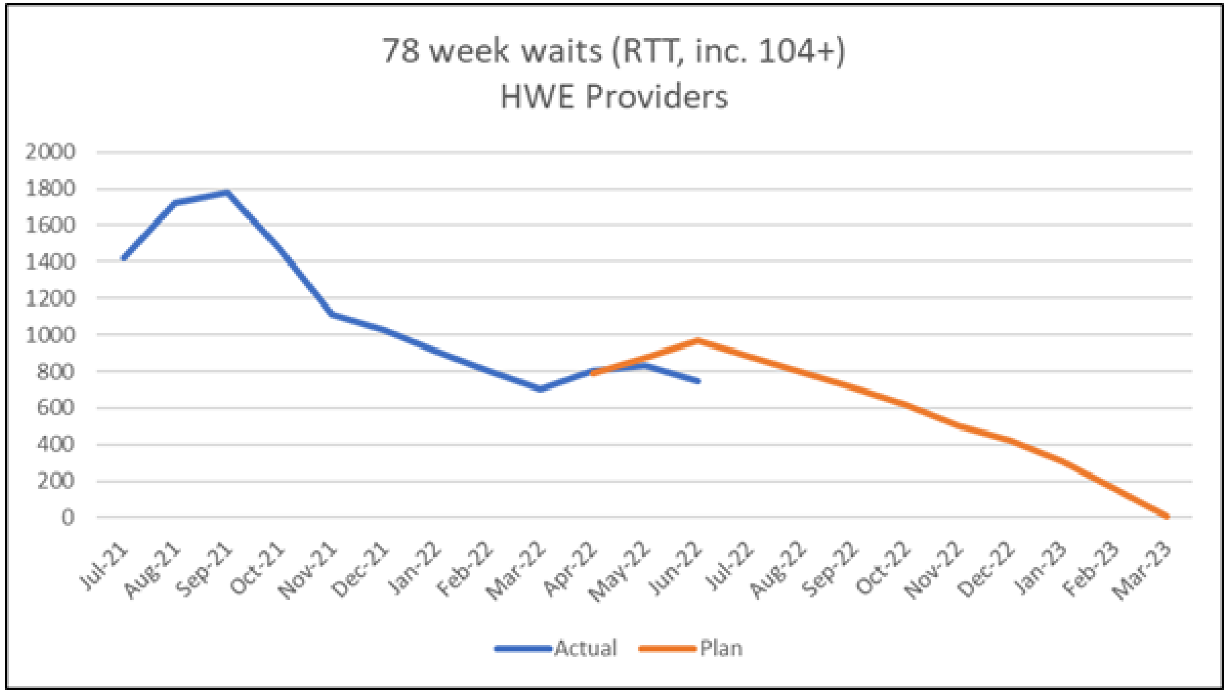


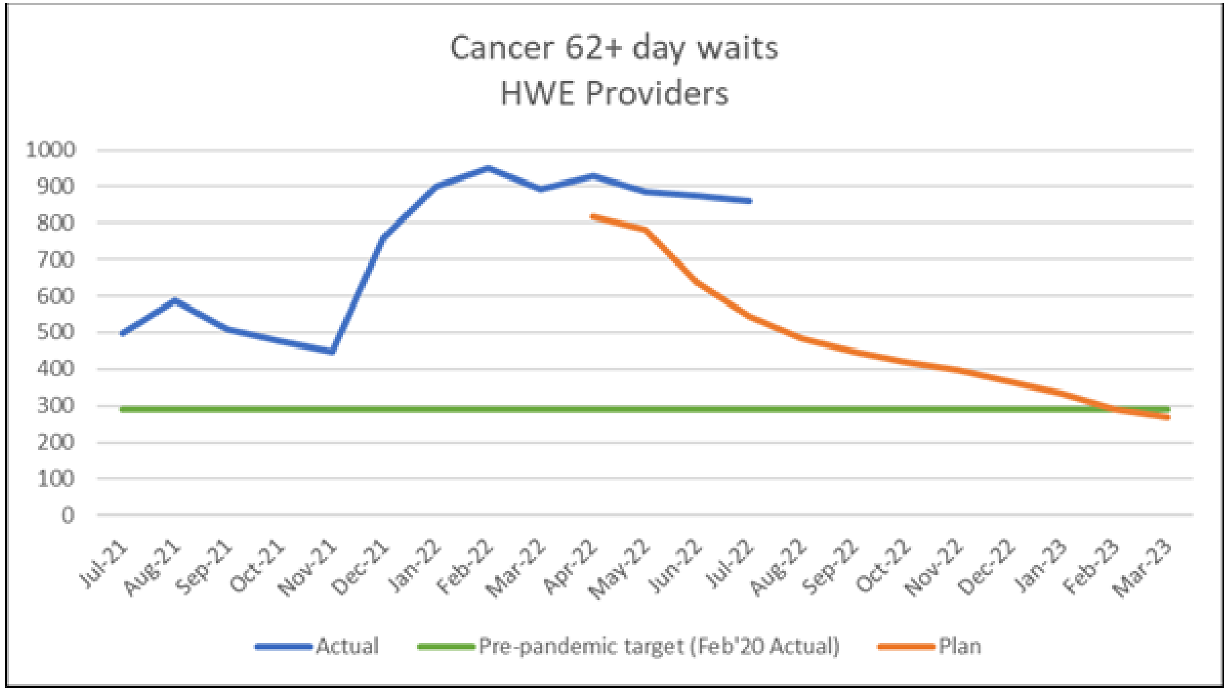
Baseline	22/23 Activity Plan	22/23 Q1 Activity Plan	Area	Target		Q1 Actual			
						April	May	June	Total
246,604	330,131	58,898	Activity	10% elective activity increase (19/20 levels RTT pathway)	Plan	16,815	19,497	22,586	**58,898**
					Actual	16,815	20,581	19,866	**57,262**
	+34%				Variance	0	1,084	-2,720	**-1,636**
N/A	0	2	Waitlist	104 week waits eliminated by Jul 22 (waitlist, end of Jun 22)	Actual	124	77	35	**35**
N/A	0	970		Eliminate 78 week waits by Apr 23 (waitlist, end of Mar 23)	Actual	806	829	748	**748**
6,109	6480	7226		52 week waits trending down across 22/23	Actual	6484	6804	7472	**7472**
956,620	890,984	222,489	Outpatients	25% reduction in outpatient follow-ups by 2023	Plan	72,089	76,682	73,718	**222,489**
					Actual	70,072	79,062	71,212	**220,346**
	-7%				Variance	-2,017	2,380	-2,506	**-2,143**
N/A	1%	0%		5% of outpatients moved or discharged to PIFU	Actual	1%	1%	1%	**1%**
8%	25%	23%		25% of consultations via video/telephone	Actual	23%	22%	23%	**23%**
N/A	6	7		16 specialist advice requests per 100 outpatient firsts	Actual	26	26	29	**27**
417,182	448,818	105,735	Diagnostics	20% increase in diagnostic capacity against 19/20 levels	Plan	33,749	36,708	35,018	**105,475**
					Actual	30,029	33,868	31,968	**95,865**
	+8%				Variance	-3,720	-2,840	-3,050	**-9,610**
289	267	637	Cancer	Reducing cancer 62+ day waitlist to pre-pandemic levels	Actual	928	887	875	**875**
69%	69%	68%		Reduction in missed 28 day cancer decisions *(Measure is % decisions delivered in 28 days or less)*	Actual	61%	62%	66%	**63%**

ICB Issues and escalations

- Activity significantly off planned levels for both elective and diagnostics (as seen across the country);
- Good delivery against reduction to the number of patients waiting over 104 and 78 weeks, but 52 week waits are increasing, which is a risk;
- Overall, on track with the Out Patient programmes of work;
- Cancer backlogs are reducing but not at the rate anticipated in the plan; we are currently still forecasting to reach the March 23 target of zero.

Performance v. 22/23 Operational Plans





ICB Issues and escalations

- Activity significantly off planned levels for both elective and diagnostics (as seen across the country);
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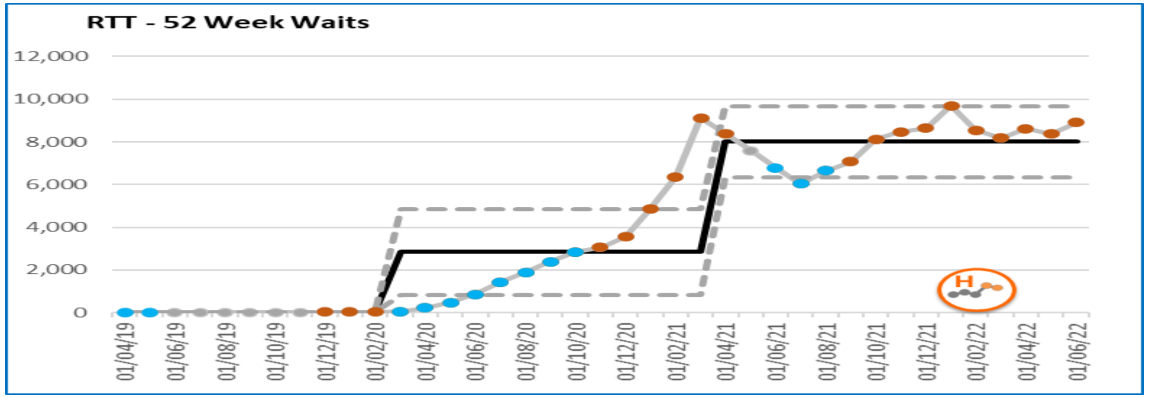
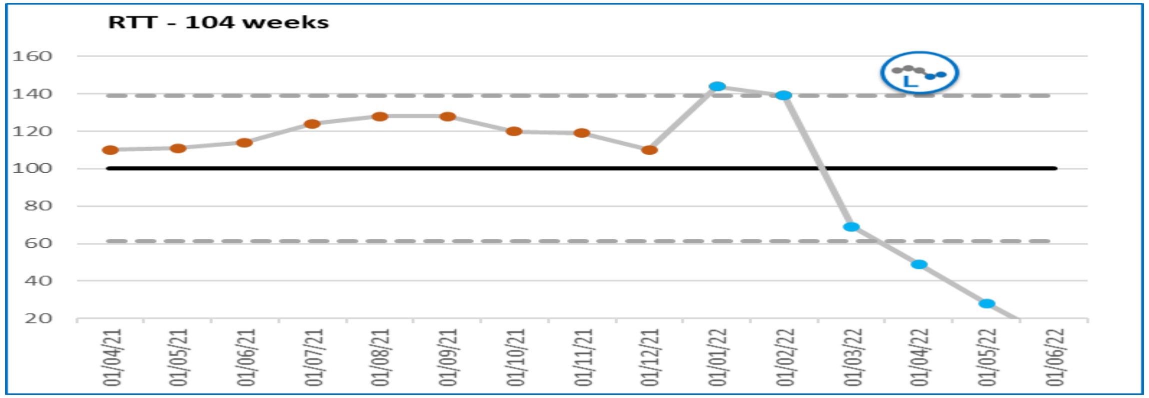
- Overall, on track with the Out Patient programmes of work;
- Cancer backlogs are reducing but not at the rate anticipated in the plan; we are currently still forecasting to reach the March 23 target of zero.

Planned Care – 52 & 104 Week Breaches



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12
	201920												202021											
🟨 Other	8	4	5	2	3	4	6	9	8	9	11	17	101	179	391	564	741	917	1021	1068	1197	1577	2004	4082
⬜ THE PRINCESS ALEXANDRA HOSPITAL NHS TRUST	0	0	0	0	0	0	0	0	0	0	0	2	27	60	140	213	272	363	420	467	657	914	1177	1286
🟧 WEST HERTFORDSHIRE HOSPITALS NHS TRUST	2	3	4	4	1	3	0	0	0	0	1	3	53	135	302	484	669	855	1075	1112	1131	1463	1733	1702
🟦 EAST AND NORTH HERTFORDSHIRE NHS TRUST	4	5	21	19	21	18	16	15	25	22	24	37	90	209	190	483	604	735	931	987	1158	1724	2499	3221

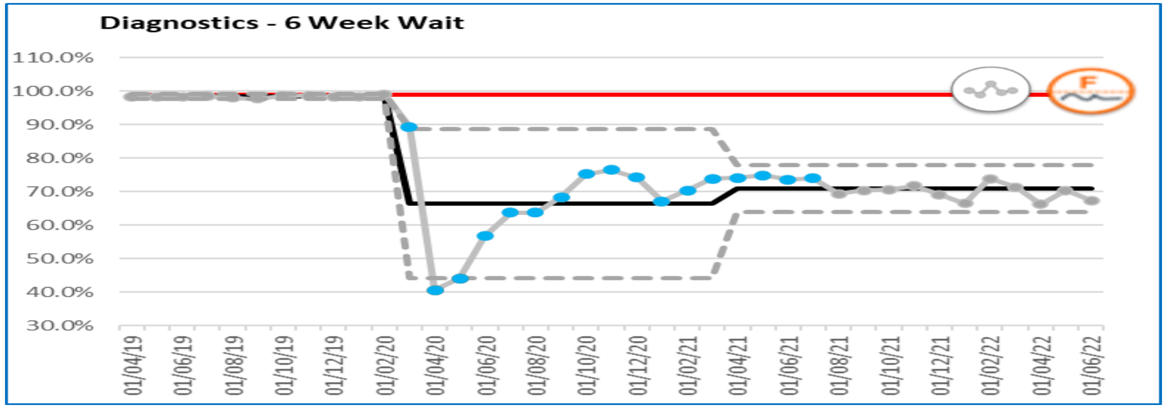
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3
	202122												202223		
🟨 Other	3740	3162	2782	2578	2447	2441	2394	2296	2321	3348	2853	2868	3033	2496	2412
⬜ THE PRINCESS ALEXANDRA HOSPITAL NHS TRUST	1302	1249	1143	1269	1394	1536	2141	2321	2486	2613	2221	1737	1818	1674	1785
🟧 WEST HERTFORDSHIRE HOSPITALS NHS TRUST	1462	1162	898	789	800	838	878	862	927	1006	1103	1059	1193	1431	1660
🟦 EAST AND NORTH HERTFORDSHIRE NHS TRUST	2936	2791	2785	2095	2910	3259	3818	4102	4016	3739	3184	3313	3473	3699	4027



	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22
⬜ THE PRINCESS ALEXANDRA HOSPITAL NHS TRUST	0	17	19	26	32	43	43	38	25	19	28	11	14	12	10
🟧 WEST HERTFORDSHIRE HOSPITALS NHS TRUST	3	12	18	28	34	42	38	46	39	55	40	26	14	9	4
🟦 EAST AND NORTH HERTFORDSHIRE NHS TRUST	43	53	67	65	57	65	72	76	105	159	144	123	96	56	21

ICB Area	What the charts tell us	Issues	Actions	Mitigation
HWEICB	• Continued improvement and reduction in number of patients waiting over 104 weeks • The latest data for 104+ week waits shows 0 capacity breaches across the ICS, meeting the delivery target. There are 10 breaches due to patient choice, clinical complexity or the patient being clinically unfit. • The number of patients waiting over 52 weeks has been increasing and there is not yet a consistent trend of improvement.	• Whilst we have been successful in the reduction of the longest waiting patients and are meeting the asks in the 22/23 operating plan, we are not delivering enough activity to get on top of our backlog • "Pop-ons" of long waiting patients identified through increased validation • High referral volumes in early 21/22 now reaching their 52 week wait • UEC pressures impacting operating and bed capacity • Trauma and Orthopaedics and Gastroenterology remain the main areas of pressure for long waiters • Staffing remains a challenge, particularly around anaesthetics	**Management of waiting lists:** • The systems focus is now on reducing the number of patients waiting over 78 weeks, with national oversight and focus; • ENHT and PAH are currently in Tier 1 for 78 week recovery, receiving the highest level of regional NHSEI support; • Recovery plans and trajectories in place by specialty to track and deliver the national target of zero >78 week waits by end of March 2023; • ENHT PTL management continues with a focus on individual patient plans, **Increasing Capacity and Improving productivity:** • National ISP capacity support; • Ongoing work to increase system elective capacity through mobilisation of Elective Hub(s) across the ICB to ringfence capacity for high volume / low complexity procedures • Mapping of elective programme in the UEC Winter Plan • PAH Theatre Utilisation Programme – 90% utilisation ambition and aim to return to full operating capacity in August • WHTHT long waits plan in place including maximising ISP capacity and additional inhouse sessions • All ENHT theatres (17) now open with two new procedure rooms to open in September and a third in Oct to increase capacity • Anaesthetist recruitment	• Actions delivering reductions in long waiting patients • National emphasis on prioritising patients in order of clinical need resulting in longer waits for routine patients. • Clinical harm reviews and regular patient contact to manage patient safety and experience.

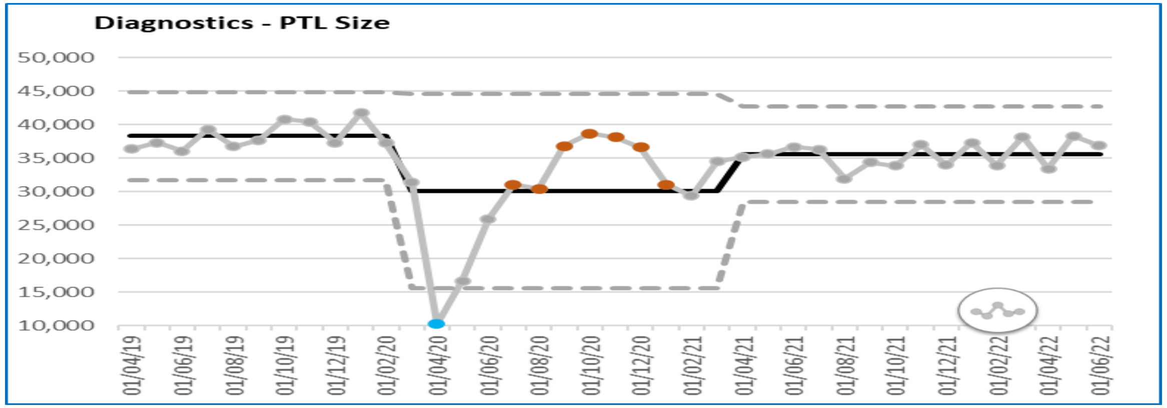
Planned Care – Diagnostics



	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20
EAST AND NORTH HERTFORDSHIRE NHS TRUST	98.4%	99.0%	99.6%	99.4%	99.4%	99.8%	99.8%	99.8%	99.5%	99.7%	99.8%	94.4%	38.2%
WEST HERTFORDSHIRE HOSPITALS NHS TRUST	99.8%	99.8%	100.0%	99.8%	99.7%	99.7%	99.9%	99.6%	99.7%	98.9%	99.9%	88.9%	26.5%
THE PRINCESS ALEXANDRA HOSPITAL NHS TRUST	99.6%	99.2%	99.2%	99.2%	99.5%	99.6%	99.5%	99.1%	98.4%	99.2%	99.1%	82.0%	40.9%
ICS	99.1%	99.2%	99.6%	99.5%	99.5%	99.7%	99.7%	99.6%	99.3%	99.3%	99.6%	89.2%	36.5%
Target	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%

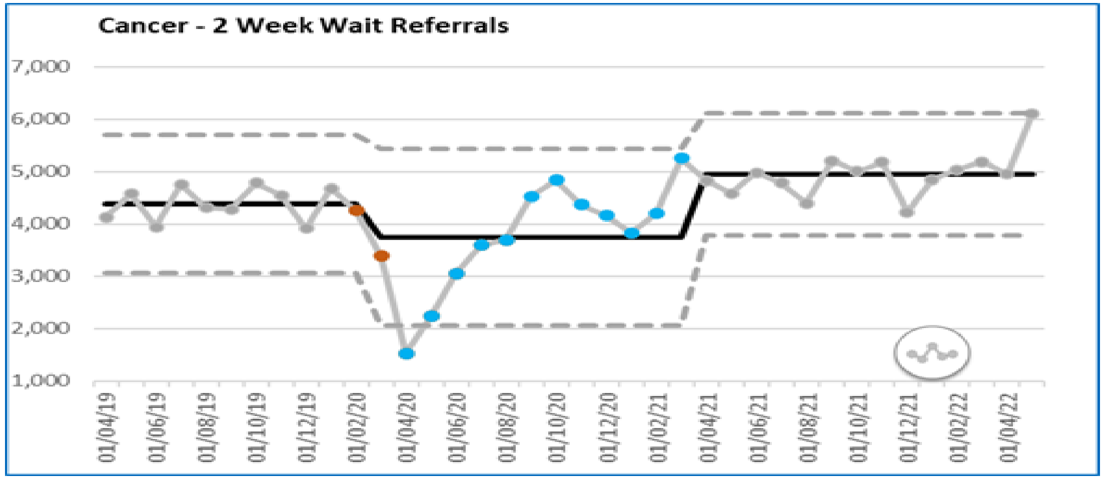
	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21
EAST AND NORTH HERTFORDSHIRE NHS TRUST	38.8%	51.0%	59.8%	61.8%	70.6%	80.3%	82.6%	79.0%	70.4%	70.6%	66.9%	69.5%	69.6%
WEST HERTFORDSHIRE HOSPITALS NHS TRUST	39.7%	64.7%	73.4%	68.5%	69.4%	71.8%	74.3%	72.5%	69.1%	78.3%	82.5%	81.5%	83.5%
THE PRINCESS ALEXANDRA HOSPITAL NHS TRUST	48.5%	64.4%	68.5%	65.6%	64.4%	68.7%	64.6%	62.2%	51.1%	54.2%	66.8%	69.2%	71.9%
ICS	42.1%	57.1%	65.3%	64.6%	68.3%	74.2%	74.8%	72.3%	64.5%	67.9%	70.9%	72.3%	73.7%
Target	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%

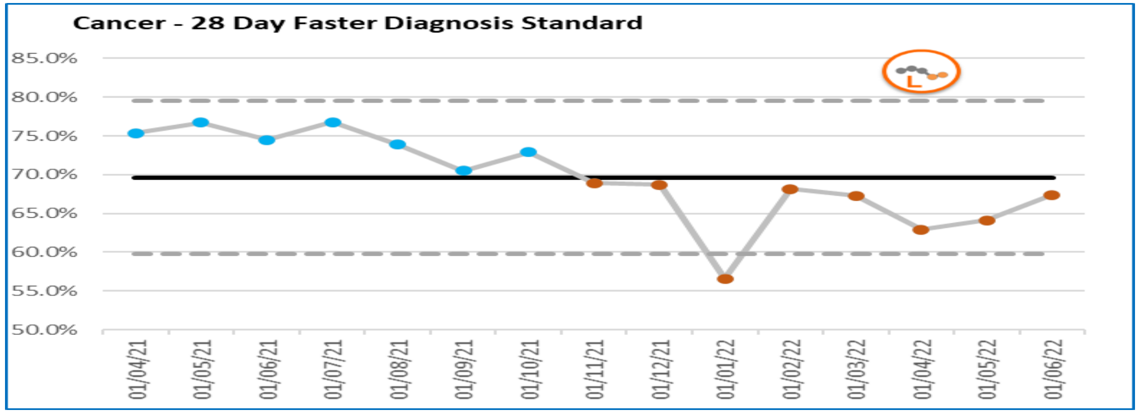
	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22
EAST AND NORTH HERTFORDSHIRE NHS TRUST	66.7%	70.5%	62.6%	63.0%	60.4%	61.0%	54.7%	50.9%	60.0%	54.9%	45.9%	53.0%	52.2%
WEST HERTFORDSHIRE HOSPITALS NHS TRUST	77.6%	77.6%	75.2%	73.8%	75.4%	71.6%	63.4%	67.5%	73.8%	72.5%	66.6%	67.6%	65.4%
THE PRINCESS ALEXANDRA HOSPITAL NHS TRUST	71.5%	70.6%	64.2%	67.3%	68.7%	72.9%	69.4%	71.8%	79.9%	82.0%	81.3%	86.9%	76.7%
ICS	70.7%	72.3%	66.2%	67.0%	66.5%	66.8%	60.5%	60.1%	68.4%	65.7%	58.9%	64.3%	61.4%
Target	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%



ICB Area	What the charts tell us	Issues	Actions	Mitigation
West Essex / PAH	• The proportion of patients waiting >6 weeks for a diagnostic test increased by 10% in June	• Continued high referrals, particularly in Ultrasound and MRI • Ultrasound workforce / capacity • Cystoscopy recovery has plateaued	• Further extension of MRI mobile scanner • Ultrasound business case for additional staffing • Echocardiography insourcing continues to reduce backlogs • Refresh of Cystoscopy recovery plan • ICB diagnostics strategy including yr2 -5 CDC programme	• Current actions in place are delivering improvements across most modalities. • Patients receiving a D code to prioritise & treat in clinical order
South West Herts / WHTHT	• 6 week diagnostic performance deteriorated to 65.4% in June	• Prioritising the most clinically urgent patients results in longer waits for more routine patients • Overall increase in demand • DQ issues associated with implementation of EPR are affecting the position in some modalities.	• Outsourcing in place for MRI, CT & US • Non-obstetric ultrasound outsourcing commenced June 2022 • Extension of mobile scanner at Hemel Hempstead and outsourcing (prostate MRI and plain MRI) • Additional in house sessions to increase capacity • ICB diagnostics strategy including yr2 -5 CDC programme	• MRI recovery supported through insourcing and outsourcing • Patients receiving a D code to prioritise & treat in clinical order
East & North Herts / ENHT	• Proportion of patients waiting >6 weeks for diagnostic test remains at just over 50% in June, declining marginally from May	• Continued increase in cancer demand month on month for CT, MRI & Ultrasound and for Gastroenterology • Workforce shortages (vacancy & sickness) • National supply issue with CT contrast • Risk to echo compliance due to backlog	• Additional MRI van confirmed from August • Additional Gastroenterology consultants to start Aug and Sept • Echo funding approved for 7 day services from Oct • ICB collaboration and mutual aid • Workforce group reviewing skill mix and recruitment • Clinical Decision meeting to support demand management • Weekly contrast meetings to review protocols, booking profile & stock • ICB strategy including yr2 -5 CDC programme to improve access	• Two reset weeks for Breast reduced waiting lists by 45% & 18% • Clinical review of requests and backlog • Gastroenterology Consultant vetting referrals • Patients receiving a D code to prioritise & treat in clinical order

Cancer

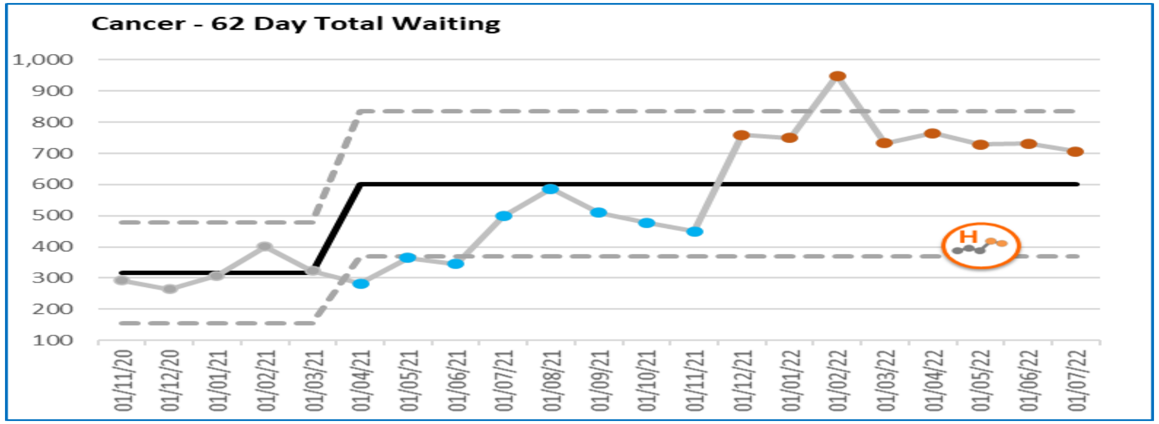




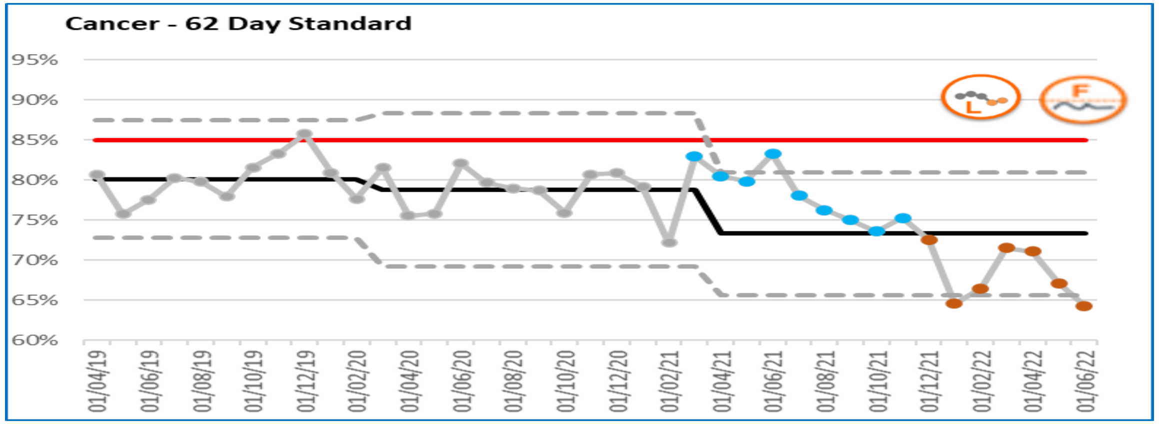
	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22
EAST AND NORTH HERTFORDSHIRE NHS TRUST	72.1%	75.6%	76.2%	76.7%	72.0%	71.8%	76.5%	74.8%	74.1%	64.2%	72.9%	74.6%	68.0%	64.2%	70.6%
WEST HERTFORDSHIRE HOSPITALS NHS TRUST	81.3%	79.8%	81.4%	82.1%	77.8%	77.2%	77.7%	71.9%	64.7%	47.0%	59.2%	54.6%	51.3%	57.7%	55.6%
THE PRINCESS ALEXANDRA HOSPITAL NHS TRUST	72.3%	74.6%	66.8%	77.1%	75.9%	62.9%	65.1%	60.6%	66.8%	50.9%	69.4%	69.3%	64.1%	65.9%	74.3%
ICS	75.6%	76.9%	75.4%	78.9%	75.3%	71.1%	73.8%	69.3%	68.9%	54.4%	67.3%	65.6%	60.8%	62.4%	66.4%

ICB Area	What the charts tell us	Issues	Actions	• Mitigation
West Essex / PAH	• 2 week wait cancer referrals remain at increased levels with a significant spike seen in May • 28d FDS showing an improved trend in performance for May and June	• Cancer management, tracking and coding capacity • Tele-dermatology rollout delayed due to lead consultant pulling out • Urology, Breast and Skin capacity	• Cancer Recovery & Improvement Plan in place from 31/8 • Permanent Head of Cancer in post from September • Actively recruiting to tracking and coding posts • Improved and consistent application of coding guidance • Identification of alternative Tele-derm. lead consultant	• System support and oversight in place with bi-weekly meetings • Weekly Key Lines of Enquiry (KLOE) process in place with Cancer Alliance
South West Herts / WHTHT		• Some recovery noted in May but decline in June linked to new high levels of 2ww referrals (WHTHT report that pre covid average 1600 vs May 22 2300) • Outpatient and diagnostics capacity continues to be a challenge	• Place based system work to ensure demand increase is NG12 compliant new forms launched in May/June • Divisional accountability to Elective Care Programme Board. • Two 'spotlight on cancer' weeks conducted where trust run intensive improvement programmes ran end of run • Tier 1 oversight meetings in place (bi weekly)	• Weekly Key Lines of Enquiry (KLOE) process in place with Cancer Alliance • Weekly patient reviews and oversight where pathways failing to progress • Harm reviews with oversight from DON and MD of WHTHT (no serious harms noted to date) reported monthly to ICS
East & North Herts / ENHT		• Increase in 2 week wait referrals and growth in PTL • Diagnostic imaging and histopathology challenges • Delays in communication of non-cancer diagnosis	• Deep dives for tumour sites continue with actions plans being updated weekly • Radiology and histopathology prioritising cancer patients from urgent and routine to avoid delays and also offering WLI work to increase capacity	• Weekly Key Lines of Enquiry (KLOE) process in place with Cancer Alliance • Fortnightly Tier 1 meetings in place with support from NHSEI

Cancer



	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22
WEST HERTFORDSHIRE HOSPITALS NHS TRUST	73	76	96	105	79	83	109	88	132	179	130	128	129	331	347	374	307	261	297	297	277
THE PRINCESS ALEXANDRA HOSPITAL NHS TRUST	129	118	200	187	127	107	141	161	212	224	201	190	127	175	176	303	194	182	156	128	125
EAST AND NORTH HERTFORDSHIRE NHS TRUST	90	70	120	106	117	92	114	96	155	184	178	160	193	253	226	272	232	322	275	306	304

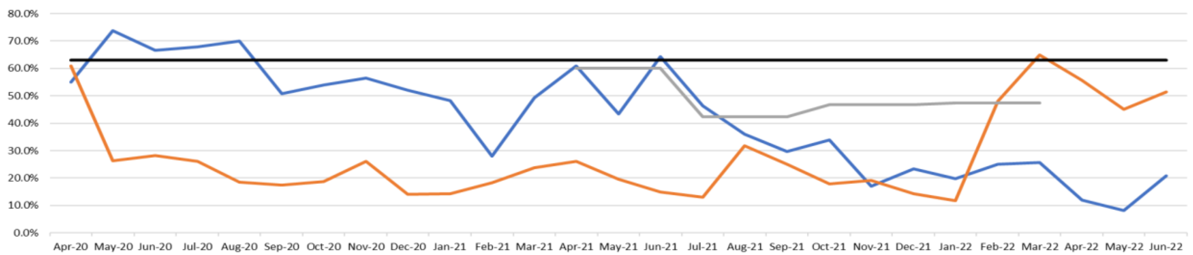


	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20
EAST AND NORTH HERTFORDSHIRE NHS TRUST	80.6%	75.4%	75.5%	79.8%	74.5%	69.6%	81.1%	85.4%	87.6%	83.5%	77.0%	87.4%	87.3%	85.9%	87.3%	89.2%
WEST HERTFORDSHIRE HOSPITALS NHS TRUST	77.8%	83.3%	81.2%	72.8%	81.7%	86.7%	78.2%	78.9%	81.9%	83.0%	76.0%	80.0%	68.8%	73.9%	86.4%	74.7%
THE PRINCESS ALEXANDRA HOSPITAL NHS TRUST	78.7%	74.7%	76.5%	82.6%	78.9%	85.2%	85.2%	85.3%	87.2%	77.3%	76.7%	79.7%	68.1%	63.1%	75.6%	75.0%
ICS	79.3%	77.6%	77.9%	77.8%	77.6%	78.7%	81.0%	83.3%	85.5%	82.0%	76.6%	83.2%	76.5%	77.9%	84.6%	80.8%
Target	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%

	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22
EAST AND NORTH HERTFORDSHIRE NHS TRUST	85.3%	80.1%	86.9%	86.6%	87.0%	86.9%	83.4%	87.4%	91.1%	88.2%	85.0%	90.3%	86.1%	87.5%	86.1%	89.9%	86.2%	79.5%	87.6%	84.1%	86.0%	81.1%	82.4%
WEST HERTFORDSHIRE HOSPITALS NHS TRUST	85.7%	83.7%	80.0%	83.1%	81.1%	83.1%	73.4%	84.5%	84.9%	75.0%	86.8%	80.1%	79.8%	70.9%	75.0%	77.2%	75.1%	57.3%	62.5%	72.6%	60.2%	61.4%	66.1%
THE PRINCESS ALEXANDRA HOSPITAL NHS TRUST	69.3%	66.3%	64.9%	67.3%	68.4%	65.4%	48.6%	68.3%	63.1%	68.9%	78.4%	66.1%	68.4%	69.8%	64.1%	62.5%	63.8%	47.7%	41.4%	68.1%	61.7%	49.2%	45.0%
ICS	80.6%	79.5%	77.3%	81.7%	80.8%	80.7%	72.7%	82.8%	83.1%	80.0%	85.1%	80.0%	79.3%	78.0%	77.7%	79.0%	77.2%	67.6%	71.4%	74.4%	72.8%	68.0%	65.5%
Target	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%

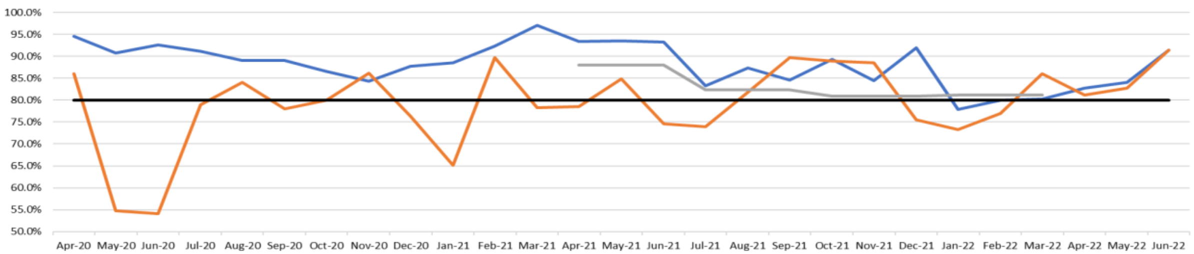
ICB Area	What the charts tell us	Issues	Actions	• Mitigation
West Essex / PAH	• 62 day backlog position has stabilised at a level significantly higher than pre-pandemic levels • Further work required to reduce the 62 day backlog to the pre-pandemic level of 289 in line with agreed 22/23 operating plans • 62 day performance has fallen, but this is a positive indication that the longest waiting patients are being treated	• Return to full theatre capacity delayed • Recruitment to key cancer posts • Notable proportion of longest waiters are at tertiary centres	• Plan to return to full theatre capacity in September • Interim Head of Cancer will dual run alongside the substantive Head from September for a number of months • Support with tertiary centres from Cancer Alliance	• Clinical harm reviews • Rapid Access Pathways maintained and safety netting in place
South West Herts / WHTHT		• High number of 2 week wait referrals, above pre Covid Scarcity of outpatient slots for diagnostics and OPAs main reason for delay followed by lack of elective capacity in theatres • Breast and Urology breaches due to OP /Diagnostic capacity • Head of Cancer leaving post at the end of September • Delays in clinic letters	• Updated trajectories received in July; supporting actions to reduce backlog areas • 62 and 104 day weekly reports indicate reduction- WHTHT no longer in red/amber nationally • Tier 1 assurance and support process in place • Extra clinics, workforce reviews, further potential to outsource and recruitment continue to try and meet increased demand	• Continued Clinical Harm Reviews • Weekly patient reviews and oversight where pathways failing to progress– oversight from Director of Nursing WHTHT • Interim lead with plans around long term recruitment in place (Cancer Lead)
East & North Herts / ENHT		• High number of patients waiting over 62 days as a proportion of total PTL (currently 15.5%) • Diagnostic imaging and histopathology challenges • Delays in communication of non-cancer diagnosis • Challenges with late referrals to ENHT as a tertiary centre impacting PTL waits >62 days	• Tier 1 assurance and support process in place • Recovery plans in place and trajectory in development • MRI and CT capacity to increase across next few months • Histopathology processes under review to reduce delays • Work with Cancer Alliance on tertiary pathways	• Robust weekly PTL management in place; clinical and operational review of patients waiting >62 and 104 days with clinical harm reviews in place

Stroke



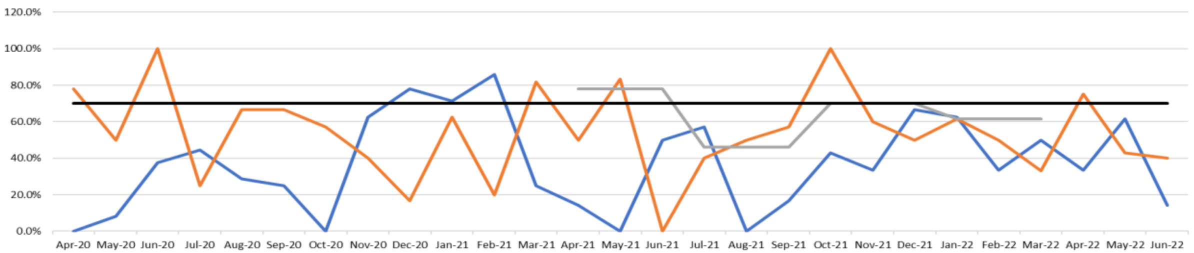
4 hours direct to Stroke unit from ED

	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22
East & North Hertfordshire Trust	55.0%	73.8%	66.7%	67.9%	69.9%	50.7%	54.0%	56.5%	52.0%	48.3%	28.1%	49.3%	61.0%	43.5%	64.4%	46.4%	36.1%	29.7%	33.9%	17.1%	23.3%	19.7%	25.0%	25.7%	12.0%	8.2%	20.9%
West Hertfordshire Trust	60.9%	26.4%	28.3%	26.1%	18.5%	17.4%	18.8%	26.1%	14.0%	14.3%	18.4%	23.8%	26.2%	19.6%	15.0%	13.0%	31.8%	25.0%	17.8%	19.2%	14.3%	11.8%	48.1%	65.0%	55.6%	45.1%	51.4%
West Essex													60.0%	60.0%	60.0%	42.3%	42.3%	42.3%	46.8%	46.8%	46.8%	47.4%	47.4%	47.4%			
Target	63%	63%	63%	63%	63%	63%	63%	63%	63%	63%	63%	63%	63%	63%	63%	63%	63%	63%	63%	63%	63%	63%	63%	63%	63%	63%	63%



Percentage of patients who spent at least 90% of their stay on stroke unit

	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22
East & North Hertfordshire Trust	94.6%	90.8%	92.6%	91.1%	89.0%	89.0%	86.5%	84.3%	87.7%	88.5%	92.3%	97.1%	93.4%	93.5%	93.2%	83.3%	87.3%	84.6%	89.3%	84.4%	91.9%	77.9%	80.0%	80.3%	82.7%	84.0%	91.4%
West Hertfordshire Trust	86.0%	54.8%	54.1%	78.9%	84.1%	78.0%	80.0%	86.2%	76.3%	65.1%	89.7%	78.3%	78.5%	84.8%	74.6%	73.9%	81.8%	89.7%	88.9%	88.5%	75.5%	73.3%	76.9%	86.0%	81.1%	82.7%	91.4%
West Essex													88.0%	88.0%	88.0%	82.3%	82.3%	82.3%	80.9%	80.9%	80.9%	81.1%	81.1%	81.1%			
Target	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%



Percentage of patients who were thrombolysed within 1 hour of clock start

	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22
East & North Hertfordshire Trust	0.0%	8.3%	37.5%	44.4%	28.6%	25.0%	0.0%	62.5%	77.8%	71.4%	85.7%	25.0%	14.3%	0.0%	50.0%	57.1%	0.0%	16.7%	42.9%	33.3%	66.7%	62.5%	33.3%	50.0%	33.3%	61.5%	14.3%
West Hertfordshire Trust	77.8%	50.0%	100.0%	25.0%	66.7%	66.7%	57.1%	40.0%	16.7%	62.5%	20.0%	81.8%	50.0%	83.3%	0.0%	40.0%	50.0%	57.1%	100.0%	60.0%	50.0%	61.5%	50.0%	33.0%	75.0%	42.9%	40.0%
West Essex													78.0%	78.0%	78.0%	46.2%	46.2%	46.2%	70.0%	70.0%	70.0%	61.5%	61.5%	61.5%			
Target	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%

ICB Issues, escalation and next steps

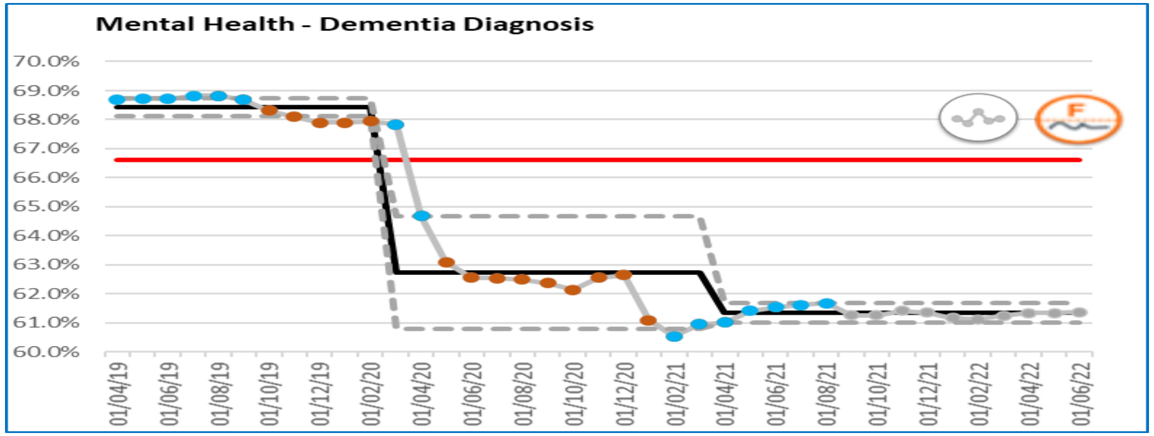
Barking, Havering and Redbridge Trust (BHRT) are the main providers of Stroke for West Essex patients. Reporting remains on a quarterly basis and we are reliant on publication of national SSNAP data. Q4 results have just been published and the Trust's overall rating has reduced from B, to D. Commissioners have met with the Trust to review, and the drop in rating was as a result of significant sickness impacting the upload of data to SSNAP. Only 192 records were uploaded, compared to an average of 250-280. Operationally the Trust is still performing at a B level.

Performance across Hertfordshire continues to meet target for percentage of patients who spend at least 90% of their stay on a stroke unit, improving to 91% for both ENHT and WHTHT in June. Herts performance has declined against the percentage of patients who were thrombolysed within 1 hour of clock start, most significantly at ENHT achieving 14% in June, with WHTHT achieving 40%. Both Trusts also continue below standard for 4 hours direct to stroke unit from ED, however did see an improvement in performance in June with WHTHT achieving 51% and ENHT 21%; the pandemic has had a significant impact on performance driven primarily by IPC factors and bed capacity. Both WHTHT and ENHT are implementing mitigation and action plans.

Next Steps: Overall concerns with June performance are due to high level of COVID related sickness, ongoing IPC challenges and delays in handover and ED flow. Actions include:

- Direct to Stroke unit within 4 hours is a priority for review and action plan development. Assurance that patients continue to receive stroke consultant input and specific recommendations for their care while they await admission and lateral flow devices are being implemented in ENHT RAG green patients. 4hr performance is a national issue with all Trusts recording C or below;
- High number of breaches due to limited bed and side room capacity; ringfencing of Stroke bed capacity is being reviewed. ENHT continue to ringfence Stroke beds and monitor adherence;
- WHTHT have developed a SSNAP improvement plan focusing on improving KPIs; access to MRI, reporting of CT Angio and workforce issues;
- ENHT action plan includes improvements to CT to improve door to needle time;
- Ongoing monthly reviews for all domains are supported with improvements plans.

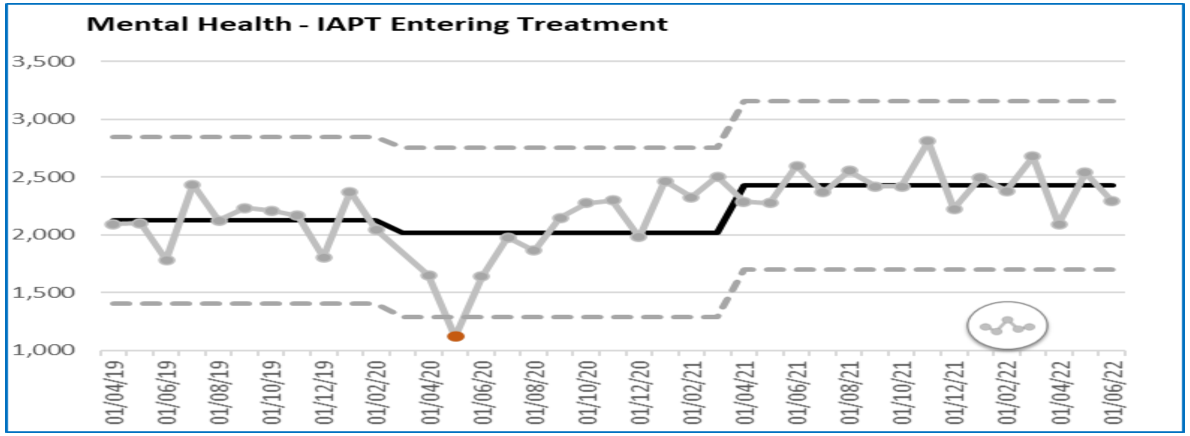
Mental Health – Dementia Diagnosis and IAPT



	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20
NHS EAST AND NORTH HERTFORDSHIRE CCG	66.6%	66.6%	66.7%	66.9%	67.1%	67.0%	67.4%	66.9%	66.8%	66.6%	66.6%	66.4%	64.1%
NHS HERTS VALLEYS CCG	69.4%	69.4%	69.3%	69.1%	69.3%	69.1%	68.1%	68.2%	68.0%	67.7%	67.9%	67.6%	63.2%
NHS WEST ESSEX CCG	71.2%	71.2%	71.4%	71.7%	71.0%	71.0%	70.3%	70.0%	69.7%	70.7%	70.6%	71.0%	68.6%
ICS	68.7%	68.7%	68.7%	68.8%	68.8%	68.7%	68.3%	68.1%	67.9%	67.9%	68.0%	67.8%	64.7%
Target	66.6%	66.6%	66.6%	66.6%	66.6%	66.6%	66.6%	66.6%	66.6%	66.6%	66.6%	66.6%	66.6%

	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21
NHS EAST AND NORTH HERTFORDSHIRE CCG	62.5%	61.7%	61.8%	62.0%	61.5%	61.3%	61.6%	61.1%	59.5%	59.2%	59.6%	59.4%	59.7%
NHS HERTS VALLEYS CCG	61.4%	61.0%	60.4%	60.1%	60.4%	59.8%	60.2%	61.0%	59.3%	58.4%	58.9%	59.2%	59.6%
NHS WEST ESSEX CCG	67.5%	67.2%	67.9%	68.1%	67.8%	68.1%	68.9%	68.7%	67.5%	67.0%	67.4%	67.6%	68.0%
ICS	63.1%	62.6%	62.5%	62.5%	62.4%	62.1%	62.6%	62.6%	61.1%	60.5%	61.0%	61.0%	61.4%
Target	66.6%	66.6%	66.6%	66.6%	66.6%	66.6%	66.6%	66.6%	66.6%	66.6%	66.6%	66.6%	66.6%

	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22
NHS EAST AND NORTH HERTFORDSHIRE CCG	60.2%	60.2%	60.2%	59.5%	59.3%	59.5%	59.2%	59.0%	58.8%	59.2%	59.2%	59.2%	59.0%
NHS HERTS VALLEYS CCG	59.6%	59.8%	60.0%	59.8%	60.1%	60.3%	60.6%	60.5%	60.6%	60.4%	60.6%	60.8%	60.7%
NHS WEST ESSEX CCG	67.7%	67.7%	67.6%	67.3%	67.1%	67.0%	66.7%	66.4%	66.5%	66.6%	66.6%	66.5%	66.9%
ICS	61.5%	61.6%	61.7%	61.3%	61.3%	61.4%	61.4%	61.2%	61.1%	61.2%	61.3%	61.3%	61.4%
Target	66.6%	66.6%	66.6%	66.6%	66.6%	66.6%	66.6%	66.6%	66.6%	66.6%	66.6%	66.6%	66.6%



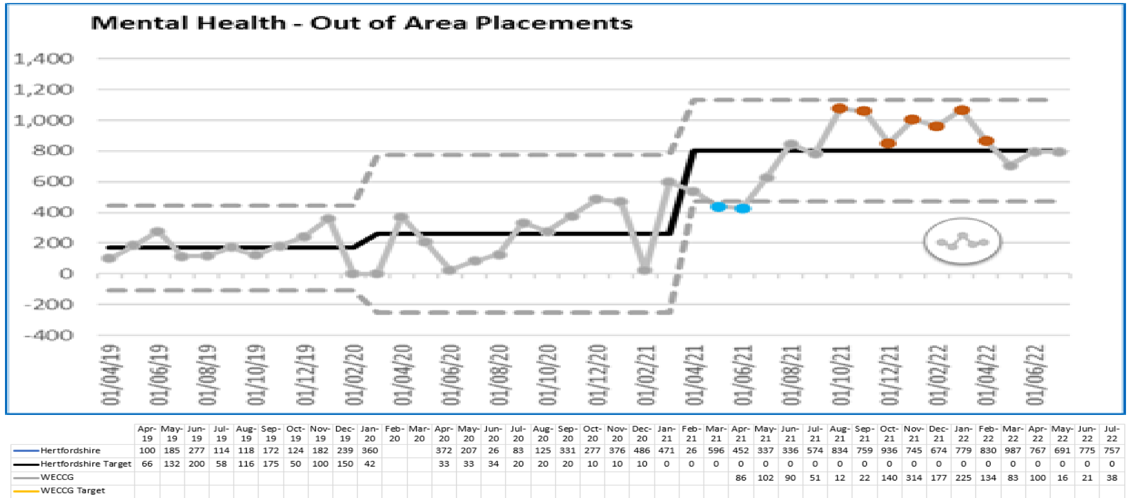
	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20
ENHCCG	816	688	650	899	824	977	704	652	647	842	798		671
HVCCG	927	1051	899	1095	900	939	1184	1233	832	1213	936		603
WECCG	350	363	234	440	401	318	321	281	327	319	312	358	377
ICS	2093	2102	1783	2434	2125	2234	2209	2166	1806	2374	2046		1651

	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21
ENHCCG	454	669	892	766	919	938	994	861	1,027	952	991	921	941
HVCCG	490	675	811	772	804	866	895	833	1,039	954	1,068	962	1,002
WECCG	175	293	273	327	424	472	408	288	398	420	445	405	332
ICS	1119	1637	1976	1865	2147	2276	2297	1982	2464	2326	2504	2288	2275

	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22
ENHCCG	1,169	1,074	984	903	916	1,047	740	930	1015	888	933	957	974
HVCCG	1,165	1,056	978	1,058	1,098	1,165	881	1,052	826	1,271	830	1,050	867
WECCG	263	237	592	457	406	598	602	513	540	518	328	531	450
ICS	2597	2367	2554	2418	2420	2810	2223	2495	2381	2677	2091	2538	2291

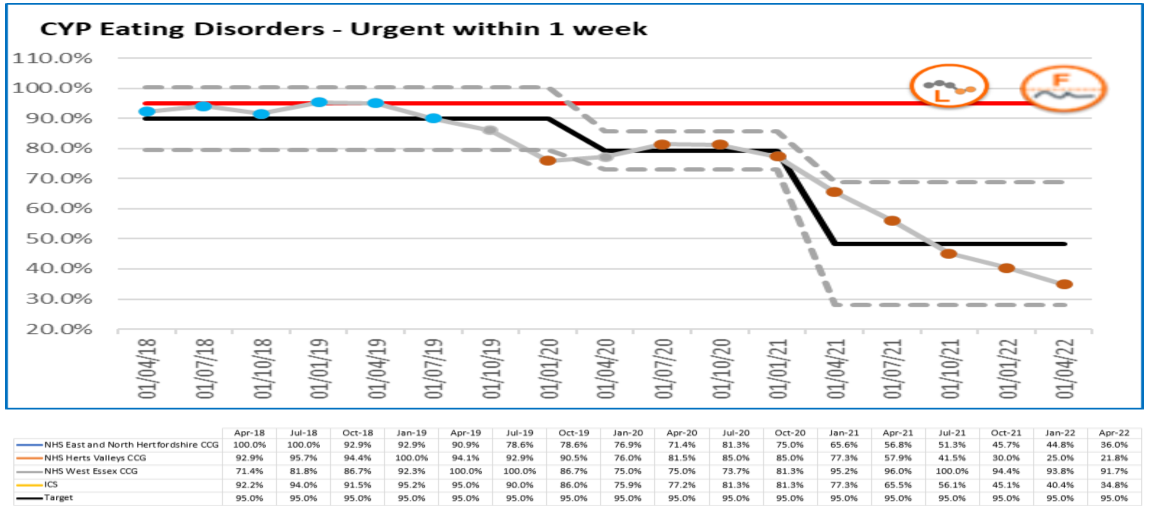
ICB Area	What the charts tell us	Issues	Actions	Mitigation
West Essex / PAH	• Diagnosis of patients with Dementia has improved and is now compliant with the national standard • The number of patients accessing IAPT services remains below plan	• Ongoing under-establishment within the core IAPT service and some resignations • High levels of patient cancellations and non-attendance of booked appointments (DNAs) • Therapist sickness and cancellations	• Use of third-party IAPT resource to support assessments • Recruitment of new IAPT staff (4 new candidates due to start in July and August) • Diversion of resource from other regional IAPT services	• Recovery rates are compliant with the 50% national standard • The 6 week and 18 week waiting time standards both continue to be routinely achieved
Herts	• Dementia Diagnosis rate for Herts is 59.9% remaining significantly below National Target • Sustained improvement in the number of IAPT patients entering treatment over period	• The current recovery plan and actions have not fully commenced therefore the true impact to be realised • IAPT referrals into service are reducing in the summer season. Lower referrals in Herts Valleys, especially mild to moderate presentations. Cases are becoming more complex impacting and increasing wait times	Actions still relevant although some not yet commenced: • Enhanced Commissioning Framework (ECF) for GPs to complete coding exercise to capture true diagnosis rate. Admin role in Primary Care Diagnosis Service to free Nurse Specialists . Practice Data reviewed monthly to target support . Provision of 700 GPs IAPT prescription pads to surgeries . Admin role in Primary Care Diagnosis Service to free Nurse Specialists . Focus on physical LTC - respiratory, MSK and older people Communication plan in place & public engagement events. Review of GP websites to enable patient direct access . Review and update primary care materials and distribute new materials. Service to deliver increase in step 3 interventions where vacancies cannot be recruited to.	• Continue with current actions to increase access to Dementia Diagnosis and IAPT services • Bring Recovery Action Plans into one forum to ensure central oversight • CQUIN IAPT ADSMs is fully embedded into therapist practice

Mental Health – Out of Area Placements and CYP Eating Disorders



	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20
Hertfordshire	100	185	277	114	118	172	124	182	239	360			372	207	26	83	125	331	277	376
Hertfordshire Target	66	132	200	58	116	175	50	100	150	42			33	33	34	20	20	20	10	10
WECCG																				
WECCG Target																				

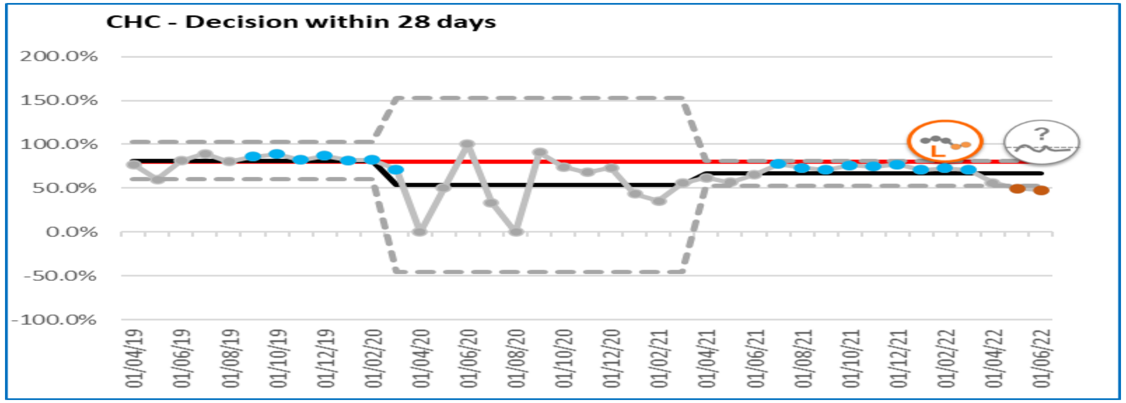
	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22
Hertfordshire	486	471	26	596	452	337	336	574	834	759	936	745	674	779	830	987	767	691	775	757
Hertfordshire Target	10	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
WECCG					86	102	90	51	12	22	140	314	177	225	134	83	100	16	21	38
WECCG Target																				



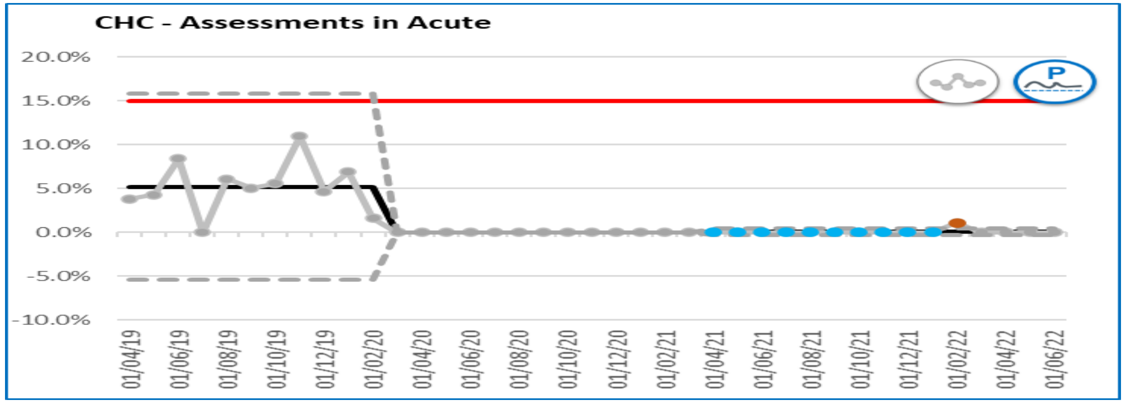
	Apr-18	Jul-18	Oct-18	Jan-19	Apr-19	Jul-19	Oct-19	Jan-20	Apr-20	Jul-20	Oct-20	Jan-21	Apr-21	Jul-21	Oct-21	Jan-22	Apr-22
NHS East and North Hertfordshire CCG	100.0%	100.0%	92.9%	92.9%	90.9%	78.6%	78.6%	76.9%	71.4%	81.3%	75.0%	65.6%	56.8%	51.3%	45.7%	44.8%	36.0%
NHS Herts Valleys CCG	92.9%	95.7%	94.4%	100.0%	94.1%	92.9%	90.5%	76.0%	81.5%	85.0%	85.0%	77.3%	57.9%	41.5%	30.0%	25.0%	21.8%
NHS West Essex CCG	71.4%	81.8%	86.7%	92.3%	100.0%	100.0%	86.7%	75.0%	75.0%	73.7%	81.3%	95.2%	96.0%	100.0%	94.4%	93.8%	91.7%
ICS	92.2%	94.0%	91.5%	95.2%	95.0%	90.0%	86.0%	75.9%	77.2%	81.3%	81.3%	77.3%	65.5%	56.1%	45.1%	40.4%	34.8%
Target	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%

ICB Area	What the charts tell us	Issues	Actions	Mitigation
West Essex / PAH	• Out of Area Bed Days for West Essex mental health patients improved further in Quarter 1 • 97.1% of patients referred for urgent eating disorders were seen within 1 week	• Pressure for Mental Health beds has increased substantially over the Covid period leading to a national shortage of beds, high occupancy rates and use of OOA beds.	• SMART (Surge Management and Resilience Toolset) - providing real time ward data • Essex review of bed model - numbers, type & location • Out of Area Placement (OOAP) Elimination & Sustainability Impact System Group (Essex wide) in place to monitor the impact of the NHSE OOAP Action Plan	Working with EPUT and HPFT to further develop the MH data set to better understand demand, complexity of need and acuity across the ICS which will be brought the next performance committee and Board. **MH Out of Area Placements:** MADE methodology implemented to support discharge and repatriate OAPS. NHSE support for OOA beds pressures engaged. Bring Recovery Action Plans into one forum to ensure central oversight. Review Herts bed base numbers **CYP Eating Disorders:** Early Help ED service commissioned to initially support the CYP Community ED team, reduce the waiting list and provide safe step down to improve through put. Recovery plans in place. Medical monitoring service to support primary care, also offering brief interventions.
Herts	• Continuing increased levels of Out of Area Beds compared to last year, although a reduction has been seen since March. CYP requiring support for ED continue to increase. Numbers being referred for support have not yet stabilised and the levels of complexity and acuity remain significant.	• DTOC challenges. Higher admissions to discharges. Increased use of MHA • Refurbishment of bedrooms has begun with 3 rooms at time being decorated – planned end mid-December 2022. • The number, complexity and acuity of CYP presenting with ED and staffing has impacted on patient throughput • Access re specialist beds due to co-morbidities (wait times have improved)	• Reduce admission through gatekeeping. • Adopt purposeful Inpatient Admission Model • Daily OAP reviews /dedicated clinical ownership for OAPs • Reviewing what other areas are doing I.e. voluntary service input to pathways. Review community demand and capacity, to avoid admissions • Share agreed actions with PCN leadership linked to neighbourhood level MDT development. New Early Help Service Commissioned . HPFT recovery plans in place. Medical Monitoring service implemented to support primary care and also offering brief interventions	

Continuing Health Care (CHC)



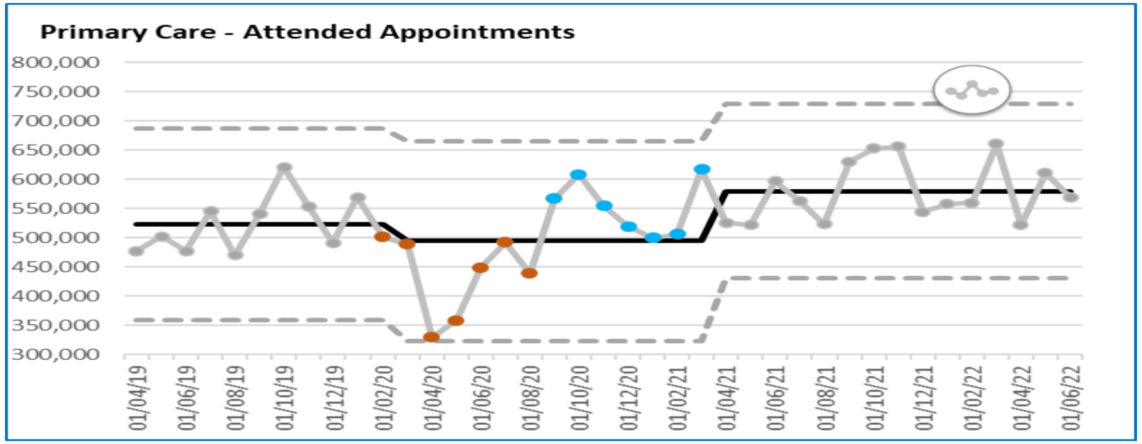
	Apr-19	May -19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May -20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May -21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May -22	Jun-22
East & North Hertfordshire CCG	55.0	33.3	72.0	91.2	57.1	68.0	71.4	68.4	75.0	53.3	57.9	71.4	0.0%	50.0	100.	33.3	0.0%	57.1	21.1	34.2	30.8	21.1	18.4	25.6	38.7	23.3	50.0	58.3	50.0	66.7	77.4	70.4	47.8	52.6	72.0	69.0	70.8	74.2	94.9
Herts Valleys CCG	84.5	69.6	84.3	88.3	88.5	91.9	92.1	87.0	89.7	87.5	93.0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.	91.4	87.7	86.6	69.7	66.7	75.8	47.2	65.7	74.4	81.5	80.4	66.7	61.1	72.3	85.7	80.5	71.2	72.5	47.2	35.2	23.4
West Essex CCG	58.3	39.4	54.0	55.6	58.3	50.0	34.5	63.2	57.1	52.2	88.2	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.	87.0	71.0	83.0	80.0	88.0	100.	93.0	92.3	68.4	80.0	70.0	88.9	89.5	85.0
ICS	76.9	60.2	81.1	89.4	80.5	85.9	88.9	82.2	86.9	81.6	82.3	71.4	0.0%	50.0	100.	33.3	0.0%	90.6	74.0	68.0	73.1	43.7	35.6	56.0	62.0	56.8	65.4	77.3	73.0	71.0	76.3	74.8	77.2	70.9	72.8	71.0	56.2	49.7	47.6
Target	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%

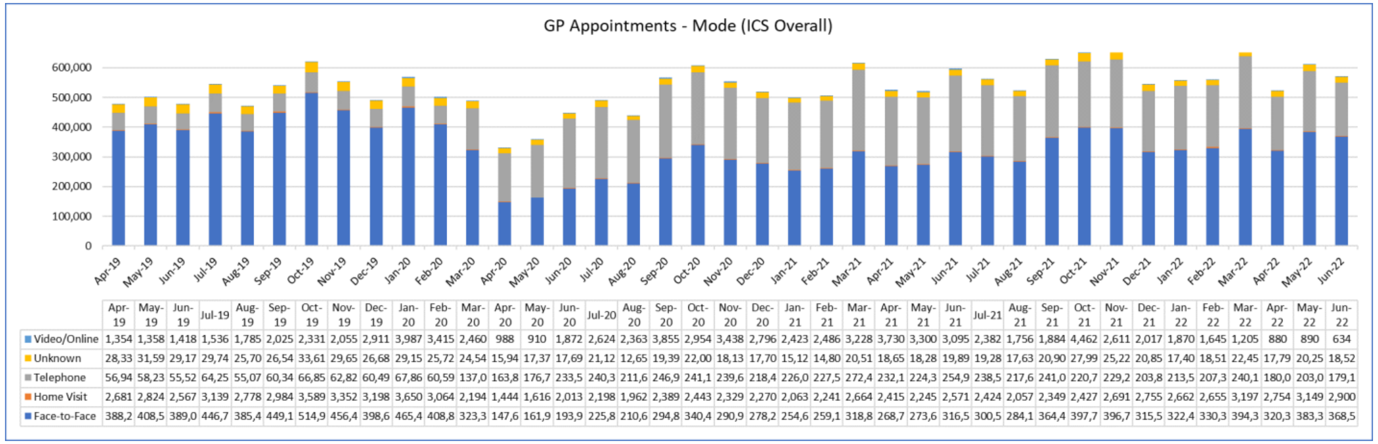


	Apr-19	May -19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May -20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May -21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May -22	Jun-22
East & North Hertfordshire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

ICB Area	What the charts tell us	Issues	Actions	Mitigation
West Essex / PAH	• 85% of CHC referrals in West Essex resulted in a decision within 28 days, achieving the standard • No patients received assessments in an acute setting	• Performance in July is expected to deteriorate as a result of staffing issues in the CHC and Community Teams	• The West Essex CHC Team continues to work alongside EPUT to provide additional resource and support • The teams are confident that Quarter 2 performance will be achieved, despite the decline forecast for July	• SWH action plan in place, supported by NHSEI • Performance standards continue to be monitored, issues escalated and risks mitigated • Agency cover requested for vacancies whilst recruitment continues • Setting trajectory and drive on clearing cases over 28 days
South West Herts / WHTHT	• SWH remain an outlier with performance against decisions within 28 days not achieved; in June performance was 23% compared to the 85% target being achieved at other Places, however improved in July to 36% • No patients received assessments in an acute setting	• Workforce issues, recruitment & induction • Backlog of CHC & FNC reviews due to prioritising high numbers of new DSTs. • Referrals continue to be high in numbers. 54 positive checklist in July. • Challenges of receiving signatures from social workers following assessment; raised in weekly meetings with Social Worker and has improved.	• Recruitment drive continues • Prioritisation of fast track and patients receiving 1:1 • Allocation and weekly tracking of assessments remains a priority • Case management for all cases over 6 weeks • Collaborative working with system partners; weekly meetings with LA • Face to face Nursing needs assessments are completed and evidence is gathered at this time. • Reduction of open cases >28 days QP from 57 in May to 13 in July.	
East & North Herts / ENHT	• Performance against decision within 28 Day improved significantly in June, returning to meet standard • Continued achievement of 0% of assessments in an acute setting	• Workforce issues such as sickness and annual leave • Ongoing delays receiving signed assessment paperwork from community, particularly Mental Health, may impact performance going forward	• The Team is confident that Quarter 2 performance will be achieved. • Weekly tracking of referrals over 28 days by caseload and CHC manager • Performance levels expected to be achieved in July	

Primary Care





	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20
Video/Online	1,354	1,358	1,418	1,536	1,785	2,025	2,331	2,055	2,911	3,987	3,415	2,460	988
Unknown	28,33	31,59	29,17	29,74	25,70	26,54	33,61	29,65	26,68	29,15	25,72	24,54	15,94
Telephone	56,94	58,23	55,52	64,25	55,07	60,34	66,85	62,82	60,49	67,86	60,59	137,0	163,8
Home Visit	2,681	2,824	2,567	3,139	2,778	2,984	3,589	3,352	3,198	3,650	3,064	2,194	1,444
Face-to-Face	388,2	408,5	389,0	446,7	385,4	449,1	514,9	456,4	398,6	465,4	408,8	323,3	147,6

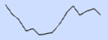
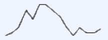
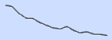
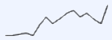
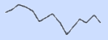
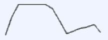
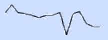
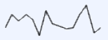
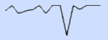
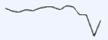
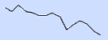
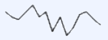
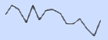
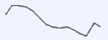
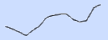
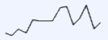
	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21
Video/Online	910	1,872	2,624	2,363	3,855	2,954	3,438	2,796	2,423	2,486	3,228	3,730	3,300
Unknown	17,37	17,69	21,12	12,65	19,39	22,00	18,13	17,70	15,12	14,80	20,51	18,65	18,28
Telephone	176,7	233,5	240,3	211,6	246,9	241,1	239,6	218,4	226,0	227,5	272,4	232,1	224,3
Home Visit	1,616	2,013	2,198	1,962	2,389	2,443	2,329	2,270	2,063	2,241	2,664	2,415	2,245
Face-to-Face	161,9	193,9	225,8	210,6	294,8	340,4	290,9	278,2	254,6	259,1	318,8	268,7	273,6

	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22
Video/Online	3,095	2,382	1,756	1,884	4,462	2,611	2,017	1,870	1,645	1,205	880	890	634
Unknown	19,89	19,28	17,63	20,90	27,99	25,22	20,85	17,40	18,51	22,45	17,79	20,25	18,52
Telephone	254,9	238,5	217,6	241,0	220,7	229,2	203,8	213,5	207,3	240,1	180,0	203,0	179,1
Home Visit	2,571	2,424	2,057	2,349	2,427	2,691	2,755	2,662	2,655	3,197	2,754	3,149	2,900
Face-to-Face	316,5	300,5	284,1	364,4	397,7	396,7	315,5	322,4	330,3	394,3	320,3	383,3	368,5

ICB Area	What the charts tell us	Issues	Actions	Mitigation
ICB	• Total number of GP appointments increased in May, falling slightly in June, remaining higher than pre-pandemic levels. • Proportion of face to face appointments continue to increase, reaching 65% of total attended appointments in June.	• General Practice continues to see increases in demand against a backdrop of working through the backlog, workforce pressures and negative media portrayal.	• Full funding from ICB Winter Access Fund (WAF) has been spent. While some impact such as additional capacity is immediate, as we saw in March, we also expect to see benefits from infrastructure investment over the medium term. • We continue to implement actions funded through the WAF including advanced telephony and offsite storage of notes. • WAF visits have been completed across the ICB providing each practice with an tailored plan to support the improvement of access; • Follow up visits and monitoring of action plans underway in areas of high risk/poor access. • Patients Association has been engaged to support practices to restart and maximise engagement with their Patient Participation Groups following the disruption of the Pandemic. • Healthwatch have been engaged to support developing patient engagement in key programmes across the ICB. • An MDT group has been established to review the National GPPS data and to develop an access framework and work programme • The ICS Primary Care team is beginning development of the 22/23 Winter Plan for Primary Care	• Review the inputs funded through the WAF for impact and return on investment to inform future winter planning. • Continue to support return of business as usual to general practice through the relaunch of the Enhanced Commissioning Framework (ECF) across the ICB, supported by investment. • Continue to monitor access trends in the 3 places and to pick up individual practices with poor access through complaints and patient contacts • PCCC and PC Board oversight of the GPPS results and action plan developed through the Access MDT Group.

Appendix A – Performance Dashboard

June 2022

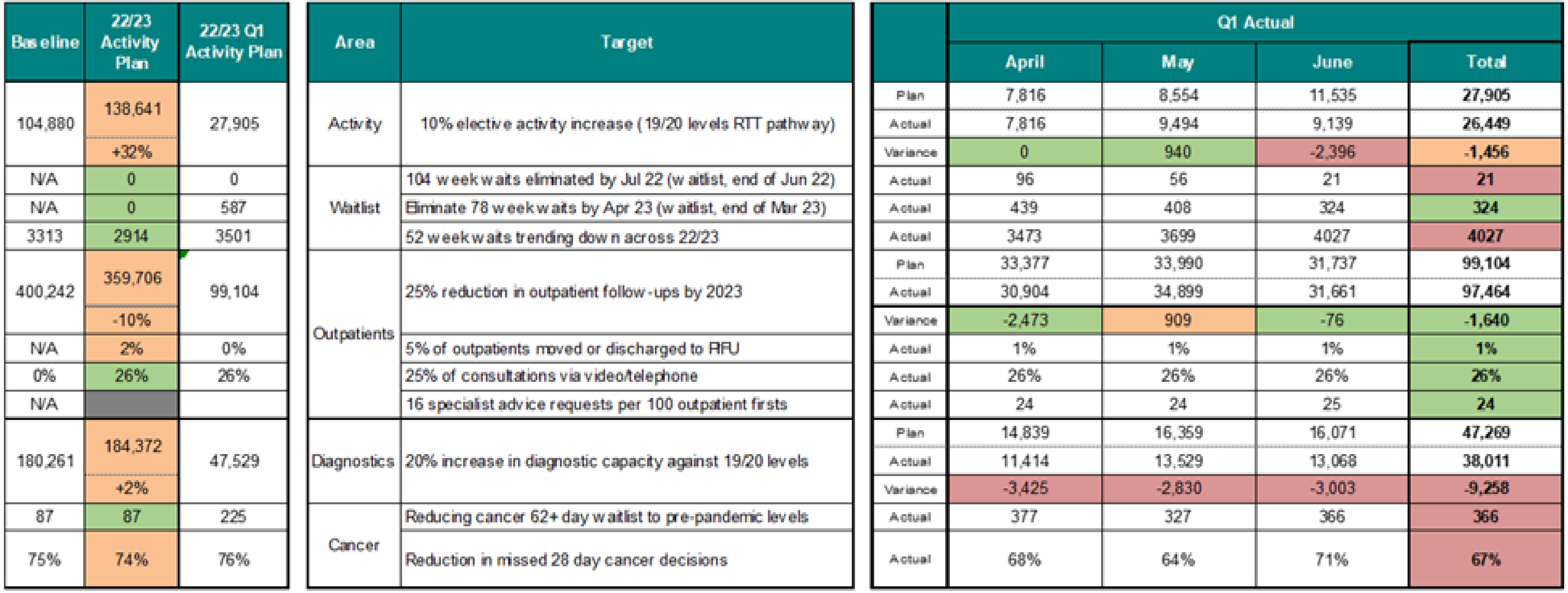
			Herts & West Essex ICS (Commissioner)							Individual Trust					
Area	**Activity**	**Target**	**Latest published data**	**Data published**	**Trend ***	**Assurance**	**Variation**	**ICS Aggregate Provider**	**Trend**	**ENHT**	**Trend**	**PAH**	**Trend**	**WHTHT**	**Trend**
111	Calls answered < 60 seconds	95%	○ **51.3%**	**June 22**	✗ -21.22%	F	~	○ **51.3%**	✗ -21.22% 	See individual CCG performance in the table below					
	Calls abandoned after 30 seconds	5%	○ **9.7%**	**June 22**	✗ 27.64%	?	~	○ **9.66%**	✗ 27.64% 						
A&E	% Seen within 4 hours	95%	○ **61.4%**	**July 22**	✗ -1.79%	F	L	○ **61.42%**	✗ -1.79% 	○ **62.42%**	✗ -4.48%	○ **57.48%**	✗ -7.15%	○ **63.19%**	✓ 4.23%
	12 Hour Breaches	0	○ **368**	**July 22**	✗ 58.97%	?	H	○ **368**	✗ 58.97% 	○ **170**	✗ 69.41%	○ **198**	✗ 50.00%	● **0**	▬ 0.00%
Cancer	2ww All Cancer	93%	○ **76.5%**	**June 22**	✗ -8.53%	?	~	○ **75.61%**	✗ -9.36% 	**93.50%**	✗ -2.48%	○ **73.40%**	✗ -20.07%	○ **59.96%**	✗ -11.81%
	2ww Breast Symptoms	93%	○ **51.4%**	**June 22**	✗ -24.37%	?	L	○ **51.21%**	✗ -27.00% 	● **96.97%**	✓ 5.17%	○ **66.90%**	✗ -42.90%	○ **6.72%**	✓ 3.25%
	31 day First	96%	○ **92.5%**	**June 22**	✓ 0.34%	?	~	○ **93.28%**	✗ -0.13% 	● **96.23%**	✓ 0.03%	○ **80.23%**	✗ -1.75%	● **96.32%**	✓ 0.22%
	31 day Sub Surgery	94%	○ **84.7%**	**June 22**	✓ 3.91%	?	~	○ **84.29%**	✗ -3.26% 	○ **82.50%**	✗ -6.95%	● **100%**	✓ 50.00%	○ **84.62%**	✗ -10.80%
	31 day Sub Drug	98%	● **100%**	**June 22**	▬ 0.00%	?	~	● **100%**	▬ 0.00% 	● **100%**	▬ 0.00%	● **100%**	▬ 0.00%	● **100%**	▬ 0.00%
	31 day Sub Radiotherapy	94%	● **96.6%**	**June 22**	✓ 3.75%	P	~	● **98.81%**	✓ 0.78% 	● **98.81%**	✓ 0.78%	N/A		N/A	
	62 day First	85%	○ **64.3%**	**June 22**	✗ -4.41%	F	L	○ **65.47%**	✗ -3.81% 	○ **82.35%**	✓ 1.48%	○ **45%**	✗ -9.32%	○ **56.11%**	✗ -9.36%
	62 day Screening	90%	○ **65.7%**	**June 22**	✗ -7.21%	?	~	○ **61.11%**	✗ -9.09% 	○ **42.86%**	✗ -49.33%	○ **25%**	✗ -33.33%	○ **80.95%**	✗ -23.53%
	62 day Upgrade	85%	○ **80.2%**	**June 22**	✓ 15.04%	?	~	○ **81.40%**	✓ 16.01% 	○ **70.45%**	✗ -9.76%	● **92.19%**	✓ 35.59%	○ **71.43%**	✓ 7.89%
RTT	Incomplete Pathways <18 weeks	92%	○ **58.4%**	**June 22**	✗ -2.48%	F	L	○ **55.06%**	✗ -2.58% 	○ **55.43%**	✗ -2.73%	○ **51.41%**	✗ -2.15%	○ **56.38%**	✗ -2.78%
	52 weeks	0	○ **8,903**	**June 22**	✗ 6.07%	F	H	○ **7,472**	✗ 8.94% 	○ **4,027**	✗ 8.15%	○ **1,785**	✗ 6.22%	○ **1,660**	✗ 13.80%
Diagnostics	6 week wait	1%	○ **32.6%**	**June 22**	✗ 9.43%	F	~	○ **38.64%**	✗ 7.58% 	○ **47.79%**	✗ 1.71%	○ **23.30%**	✗ 43.61%	○ **34.57%**	✗ 6.17%

			Herts & West Essex ICS (Commissioner)							Individual CCGs					
Area	**Metric**	**Target**	**Latest published data**	**Data published**	**Trend ***	**Assurance**	**Variation**	**ICS Aggregate Provider**	**Trend**	**East & North Herts**	**Trend**	**Herts Valleys**	**Trend**	**West Essex**	**Trend**
111	Calls answered < 60 seconds	95%	○ **51.3%**	**June 22**	✗ -21.22%	F	~	N/A		○ **51.59%**			✗ -20.59%	○ **50.15%**	✗ -23.88%
	Calls abandoned after 30 seconds	5%	○ **9.7%**	**June 22**	✗ 27.64%	?	~			○ **9.40%**			✗ 29.76%	○ **10.72%**	✗ 20.06%
Mental Health	Dementia Diagnosis rate	66.6%	○ **61.4%**	**June 22**	✓ 0.04%	F	~			○ **58.99%**	✗ -0.27%	○ **60.74%**	✗ -0.02%	● **66.91%**	✓ 0.63%
	OOA placements	0	○ **2,254**	**June 22**	✗ 34.61%	F	H			○ **2233**			✗ 34.71%	○ **21**	✗ 23.81%
CHC	% of eligibility decisions made within 28 days	80%	○ **47.6%**	**June 22**	✗ -4.39%	?	L			● **94.87%**	✓ 21.80%	○ **23.36%**	✗ -50.82%	● **85.00%**	✗ -5.26%
	% of assessments carried out in acute	15%	● **0.0%**	**June 22**	▬ 0.00%	?	~			● **0%**	▬ 0.00%	● **0.00%**	▬ 0.00%	● **0%**	▬ 0.00%

** Against last month's performance ●n/above target ○elow target I✓rovement on previous month's performance De✗ase on previous month's performance No ▬nge on previous month's performance*

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

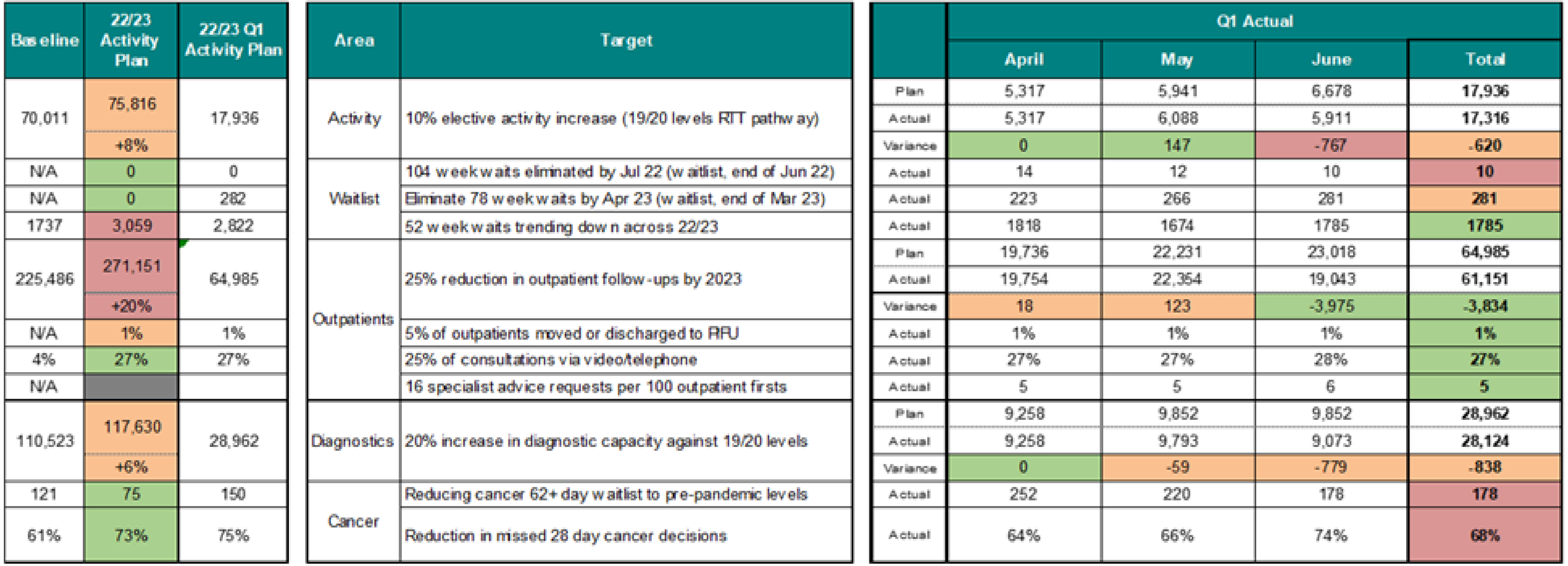
East and North Herts Trust



Baseline	22/23 Activity Plan	22/23 Q1 Activity Plan	Area	Target		Q1 Actual			
						April	May	June	Total
104,880	138,641	27,905	Activity	10% elective activity increase (19/20 levels RTT pathway)	Plan	7,816	8,554	11,535	27,905
					Actual	7,816	9,494	9,139	26,449
	+32%				Variance	0	940	-2,396	-1,456
N/A	0	0	Waitlist	104 week waits eliminated by Jul 22 (waitlist, end of Jun 22)	Actual	96	56	21	21
N/A	0	587		Eliminate 78 week waits by Apr 23 (waitlist, end of Mar 23)	Actual	439	408	324	324
3313	2914	3501		52 week waits trending down across 22/23	Actual	3473	3699	4027	4027
400,242	359,706	99,104	Outpatients	25% reduction in outpatient follow-ups by 2023	Plan	33,377	33,990	31,737	99,104
					Actual	30,904	34,899	31,661	97,464
	-10%				Variance	-2,473	909	-76	-1,640
N/A	2%	0%		5% of outpatients moved or discharged to PIFU	Actual	1%	1%	1%	1%
0%	26%	26%		25% of consultations via video/telephone	Actual	26%	26%	26%	26%
N/A				16 specialist advice requests per 100 outpatient firsts	Actual	24	24	25	24
180,261	184,372	47,529	Diagnostics	20% increase in diagnostic capacity against 19/20 levels	Plan	14,839	16,359	16,071	47,269
					Actual	11,414	13,529	13,068	38,011
	+2%				Variance	-3,425	-2,830	-3,003	-9,258
87	87	225	Cancer	Reducing cancer 62+ day waitlist to pre-pandemic levels	Actual	377	327	366	366
75%	74%	76%		Reduction in missed 28 day cancer decisions	Actual	68%	64%	71%	67%

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

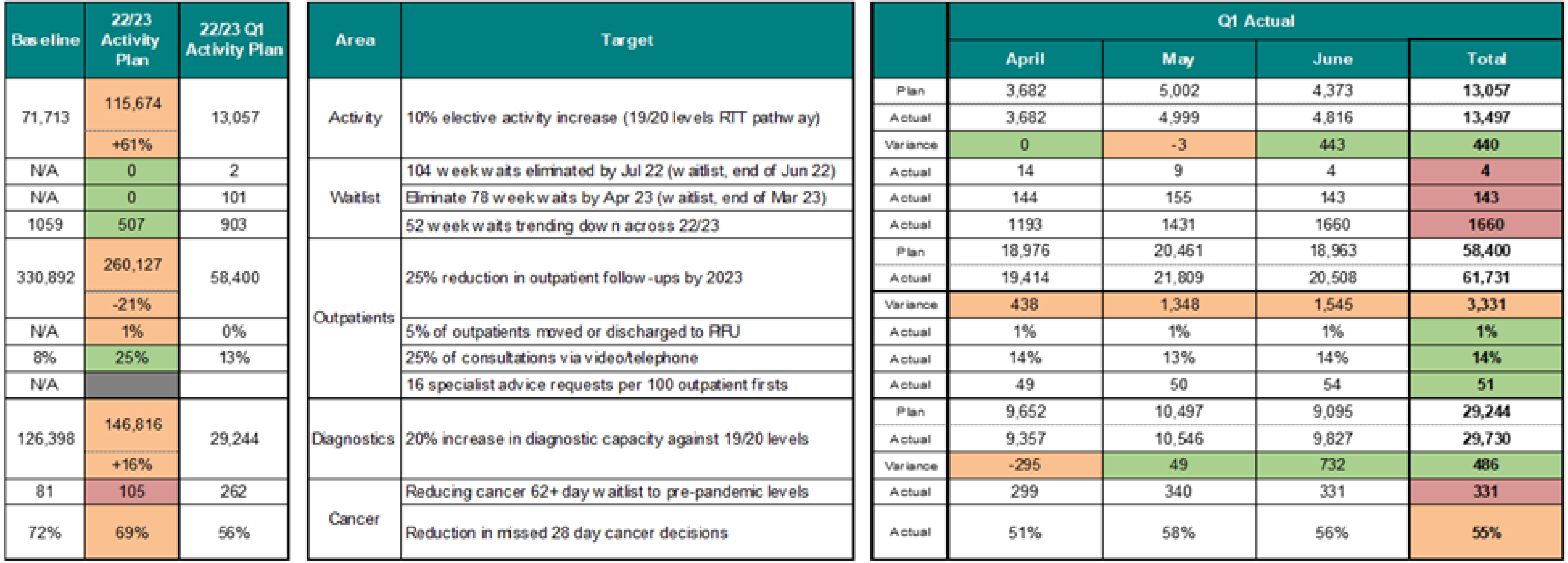
PAH



Baseline	22/23 Activity Plan	22/23 Q1 Activity Plan	Area	Target		Q1 Actual			
						April	May	June	Total
70,011	75,816	17,936	Activity	10% elective activity increase (19/20 levels RTT pathway)	Plan	5,317	5,941	6,678	**17,936**
					Actual	5,317	6,088	5,911	**17,316**
	+8%				Variance	0	147	-767	**-620**
N/A	0	0	Waitlist	104 week waits eliminated by Jul 22 (waitlist, end of Jun 22)	Actual	14	12	10	**10**
N/A	0	282		Eliminate 78 week waits by Apr 23 (waitlist, end of Mar 23)	Actual	223	266	281	**281**
1737	3,059	2,822		52 week waits trending down across 22/23	Actual	1818	1674	1785	**1785**
225,486	271,151	64,985	Outpatients	25% reduction in outpatient follow-ups by 2023	Plan	19,736	22,231	23,018	**64,985**
					Actual	19,754	22,354	19,043	**61,151**
	+20%				Variance	18	123	-3,975	**-3,834**
N/A	1%	1%		5% of outpatients moved or discharged to PIFU	Actual	1%	1%	1%	**1%**
4%	27%	27%		25% of consultations via video/telephone	Actual	27%	27%	28%	**27%**
N/A				16 specialist advice requests per 100 outpatient firsts	Actual	5	5	6	**5**
110,523	117,630	28,962	Diagnostics	20% increase in diagnostic capacity against 19/20 levels	Plan	9,258	9,852	9,852	**28,962**
					Actual	9,258	9,793	9,073	**28,124**
	+6%				Variance	0	-59	-779	**-838**
121	75	150	Cancer	Reducing cancer 62+ day waitlist to pre-pandemic levels	Actual	252	220	178	**178**
61%	73%	75%		Reduction in missed 28 day cancer decisions	Actual	64%	66%	74%	**68%**

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

West Herts Teaching Hospitals Trust



Baseline	22/23 Activity Plan	22/23 Q1 Activity Plan	Area	Target		Q1 Actual			
						April	May	June	Total
71,713	115,674	13,057	Activity	10% elective activity increase (19/20 levels RTT pathway)	Plan	3,682	5,002	4,373	**13,057**
					Actual	3,682	4,999	4,816	**13,497**
	+61%				Variance	0	-3	443	**440**
N/A	0	2	Waitlist	104 week waits eliminated by Jul 22 (waitlist, end of Jun 22)	Actual	14	9	4	**4**
N/A	0	101		Eliminate 78 week waits by Apr 23 (waitlist, end of Mar 23)	Actual	144	155	143	**143**
1059	507	903		52 week waits trending down across 22/23	Actual	1193	1431	1660	**1660**
330,892	260,127	58,400	Outpatients	25% reduction in outpatient follow-ups by 2023	Plan	18,976	20,461	18,963	**58,400**
					Actual	19,414	21,809	20,508	**61,731**
	-21%				Variance	438	1,348	1,545	**3,331**
N/A	1%	0%		5% of outpatients moved or discharged to PIFU	Actual	1%	1%	1%	**1%**
8%	25%	13%		25% of consultations via video/telephone	Actual	14%	13%	14%	**14%**
N/A				16 specialist advice requests per 100 outpatient firsts	Actual	49	50	54	**51**
126,398	146,816	29,244	Diagnostics	20% increase in diagnostic capacity against 19/20 levels	Plan	9,652	10,497	9,095	**29,244**
					Actual	9,357	10,546	9,827	**29,730**
	+16%				Variance	-295	49	732	**486**
81	105	262	Cancer	Reducing cancer 62+ day waitlist to pre-pandemic levels	Actual	299	340	331	**331**
72%	69%	56%		Reduction in missed 28 day cancer decisions	Actual	51%	58%	56%	**55%**

Glossary
# of Acronyms

>104 days	Cancer backlog greater than 104 days
>104 weeks	Elective Care backlog greater than 104 weeks
>62 days	Cancer backlog greater than 62 days
A&E	Accident & Emergency
AAU	Ambulatory Assessment Unit
AHC	Annual Health Check
BAME	Black Asian & Minority Ethnic
BAU	Business As Usual
CAMHS	Children & Adolescent Mental Health Service
CCATT	Children Crisis Assessment & Treatment Team
CCG	Clinical Commissioning Group
CDC	Cancer Diagnostic Centre
CEO	Chief Executive Officer
CHC	Continuing Healthcare
CISS	Community Intensive Support Service
CLCH	Central London Community Healthcare NHS Trust
CMO	Chief Medical Officer
CO	Carbon Monoxide
CQC	Care Quality Commission
CT	Computerised Tomography (scan)
CYP	Children Young People
D2A	Discharge to Assess
DQ	Data Quality
DST	Decision Support Tool
DSX	DSX Systems (Digital Health Solutions)
DWP	Department for Work & Pensions

EAU	Emergency Assessment Unit
ECHO	Echocardiogram
ED	Emergency Department
EEAST	East of England Ambulance Service NHS Trust
EMIS	Supplier of GP Practice systems and software
ENHCCG	East & North Herts Clinical Commissioning Group
ENHT	East & North Herts NHS Trust
EPR	Electronic Patient Record
EPUT	Essex Partnership University NHS Foundation Trust
F2F	Face-to-Face
FHAU	Forest House Adelescent Unit
FNC	Funded Nursing Care
GP	General Practice
HALO	Hospital Ambulance Liaison Officer
HCA	HealthCare Assistant
HCT	Hertfordshire Community Trust
HEG	Hospital Efficiency Group
HPFT	Hertfordshire Partnership NHS Foundation Trust
HVCCG	Herts Valley Clinical Commissioning Group
IAG	Inspection Action Group
IAPT	Improving Access to Psychological Therapies
ICP	Integrated Care Partnership
ICS	Integrated Care System
IPC	Infection prevention and control
IS	Independent Sector
IUC	Integrated Urgent Care

JSPQ	Joint Service, Performance and Quality Review Meeting
LA	Local Authority
LAC	Look After Children (team)
LD	Learning Disability
LeDeR	Learning Disability Mortality Review Programme
LFT	Lateral Flow Test
LMNS	Local Maternity Neonatal System
LMS	Local Maternity System
LoS	Length of Stay
MH	Mental Health
MOU	Memorandum Of Understanding
MRI	Magnetic Resonance Imaging
MSE	Mid & South Essex NHS Foundation Trust
NHSE / I	NHS England & Improvement
NICE	The National Institute for Health & Care Excellence
NO	Nitrous Oxide
NOK	Next Of Kin
OHCP	One HealthCare Partnership
OOAP	Out of Area Placements
OT	Occupational Therapy
PAH / PAHT	The Princess Alexandra Hospital NHS Trust
PCN	Primary Care Network
PCR	Polymerase Chain Reaction (test)
PEoLC	Palliative & End of Life Care

PIFU	Patient Initiated Follow-Up
PMO	Project Management Office
PRISM	Primary Integrated Service for Mental Health
PTL	Patient Tracking List
RCA	Root Cause Analysis
REAP	Resource Escalation Action Plan
RESUS	Resuscitation
RTT	Referral to Treatment (18-week elective target)
SACH	St Albans City Hospital
SAFER	Tool to reduce patient flow delays on inpatient wards
SDEC	Same Day Emergency Care
SLT	Speech & Language Therapist
SMART	Surge Management and Resilience Toolset
SSNAP	Sentinel Stroke National Audit Programme
T&O	Trauma and Orthopaedic
TTA	Take Home Medication (To Take Away)
UEC	Urgent Emergency Care
US	Ultrasound Scan
UTC	Urgent Treatment Centre
WAF	Winter Access Fund
WECCG	West Essex Clinical Commissioning Group
WGH	Watford General Hospital
WHHT	West Herts Hospital Trust
WW	Week Waits

Hertfordshire and West Essex Integrated Care System

NHS
Hertfordshire and West Essex
Integrated Care Board

<table>
<tr><td rowspan="2">Meeting:</td><td colspan="4"><i>Meeting in public</i></td><td>☒</td><td colspan="3"><i>Meeting in private (confidential)</i></td><td>☐</td></tr>
<tr><td colspan="4">HWE ICB Board meeting held in Public</td><td colspan="2">Meeting Date:</td><td colspan="3">23/09/2022</td></tr>
<tr><td>Report Title:</td><td colspan="4">Finance Report for Month 4 2022/23</td><td colspan="2">Agenda Item:</td><td colspan="3">12</td></tr>
<tr><td>Report Author(s):</td><td colspan="9">Debbie Griggs, Deputy Chief Finance Officer</td></tr>
<tr><td>Report Signed off by:</td><td colspan="9">Alan Pond, Chief Finance Officer</td></tr>
<tr><td>Purpose:</td><td>Approval</td><td>☐</td><td>Decision</td><td>☐</td><td colspan="2">Discussion</td><td>☒</td><td>Information</td><td>☒</td></tr>
<tr><td>Report History:</td><td colspan="9">N/A</td></tr>
<tr><td>Executive Summary:</td><td colspan="9">This report provides the Board with information on the financial position of the Herts and West Essex (HWE) Integrated Care Board (ICB) for Month 4 2022/23.

At Month 4, the ICB is reporting a year to date and forecast outturn position of breakeven.

Continuing Healthcare (CHC) continues to experience cost pressures, despite the remedial actions being taken by the Team. This particularly affects the South and West Herts (SWH) Healthcare Partnership (HCP) and is a continuation of the pressures experienced in the legacy Clinical Commissioning Group (CCG) of Herts Valleys.

Following the move away from the Emergency Financial Regime covering 2020/21 to 2021/22, most of the Acute Services contracts are based on the Aligned Payment Incentive (API) agreements, which blocks the emergency and non-elective services and leaves the elective services on a cost and volume basis. Any over performance on elective services will be reimbursed by NHS England and Improvement (NHSE/I) retrospectively through the Elective Service Recovery Fund (ESRF). There are three contracts that are based on cost and volume and any urgent or non-elective services over performance against the plan is a risk to the ICB.</td></tr>
<tr><td>Recommendations:</td><td colspan="9">It is recommended that the Board:
▪ Note the Month 4 forecast financial position of breakeven
▪ Note the risks to the financial position specifically linked to CHC and the three cost and volume contracts
▪ Note the delivery of the financial performance targets for the year</td></tr>
</table>

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

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

1. Executive summary

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

This report provides the Board with information on the financial position of the ICB for its first month, Month 4 (July) 2022/23. At Month 4, the ICB is reporting a year to date and forecast outturn position of breakeven.

2. Background

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

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

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

3. Financial Performance

Allocations notified

The table below shows the notified allocations that the ICB has received in Month 4 2022/23 and reflects the value of allocations attributable to the nine-month financial period for the ICB.

HWE ICB Financial Plan	CCGs Q1 £'000	ICB Q2-4 £'000	TOTAL £'000
ICB Programme allocation	593,692	1,781,075	**2,374,766**
ICB Primary Medical Care Services	59,350	178,051	**237,401**
ICB Running Costs	7,249	21,746	**28,995**
ICS Ockenden Funding	686	2,059	**2,745**
ICS Health Inequalities Funding	997	2,991	**3,988**
ICS Elective Services Recovery Funding	11,344	34,031	**45,375**
ICS COVID Funding	9,236	27,708	**36,944**
ICS Service Development Funding	10,903	32,708	**43,610**
Balance of CCG Allocations at end of Q1 - transferred to ICB	(26,414)	26,414	**0**
Cancer Alliance		797	**797**
LDA Autism and Keyworkers		388	**388**
Audit and Salary costs for double running in 22/23 Q1		328	**328**
Treatment and care, recovery and implementation costs		327	**327**
Partnership Awards - Digital Care Models		190	**190**
Tobacco (Maternity and Inpatient)		163	**163**
NHS 111 Webchat pilot		144	**144**
PCT Flexible Staff Pools		120	**120**
Digitising Social Care		69	**69**
CGM Allocation		52	**52**
ICS Integrated Care Board Development		50	**50**
Children and Young People Hospice		40	**40**
Personalised Care ARRS		30	**30**
Embedding the VCSE in ICS Programme (Cohort 3) Funding 22/23		10	**10**
Total Allocation	**667,042**	**2,109,490**	**2,776,532**

The ICB submitted the final financial plan for 2022/23 on 20 June 2022 with the value of £2.774bn. There was an expectation that the three CCGs would spend one quarter of the annual allocation, totalling £0.694bn, which would leave a balance of £2.080bn for the remaining 9 months with the ICB. However, the vast majority of the reserves identified below were not required in the first quarter of this financial year and were carried forward into the ICB:

Reserve	Qtr 1 Plan £'000	Purpose of reserve
Service Development Funding (SDF	12,454	The phasing of the SDF schemes has always been in the latter half of the financial year, which reflects the time taken to plan and implement these scheme specific and non-recurrent funding streams
Elective Services Recovery Fund (ESRF)	11,334	Where NHS Providers itemised their estimated ESRF values in the June 2022 Agreement of Balances (AoB) statements, the CCGs accrued for the expected liability; the balance was carried forward into the ICB
Low Value Agreements (LVA) with NHS Providers	4,439	The LVA payments were not due to be paid to providers until Quarter 2, where it is expected that an annual payment will be made by the ICB
Total	**28,227**	

Expenditure as at Month 4 2022/23

The summary position of the ICB at Month 4 2022/23 is a year to date and forecast outturn position of breakeven.

Summary Expenditure Position as at Month 4 (July) 2022/23

	Year to Date				Forecast		
	Budget £'000	Actual £'000	Variance £'000	Expenditure Category	Total Budget Mths 4 to 12 £'000	Outturn £'000	Variance £'000
1	123,840	123,840	0	Acute Services	969,808	969,808	0
2	11,234	12,613	1,379	Continuing Healthcare Services	100,251	100,251	0
3	2,560	2,560	0	Corporate Services	22,671	22,671	0
4	21,995	21,995	0	Mental Health Services	194,164	194,164	0
5	41,598	41,597	0	Primary Care Services	380,119	380,119	0
6	21,866	21,866	0	Community Services	187,950	187,950	0
7	1,657	1,656	0	Other Commissioned Services	6,080	6,081	0
8	218	218	0	Other Programme Services	37,874	37,874	0
10	2,497	1,119	(1,379)	Reserves	210,574	210,574	0
	227,464	**227,464**	**0**	**Total Expenditure**	**2,109,490**	**2,109,490**	**0**

The Year-to-Date budget for Month 4 reflects the phasing of Service Development Funding (SDF) and Reserves into the latter part of the financial year, to align with the timing of the expected spend. The variances in the other categories is impacted by the transition of budgets between the CCGs and the ICB.

4. Financial Control

Better Payment Practice Code

The ICB is required to pay 95% of invoices within 30 days of receipt of a valid invoice. This was achieved in July 2022.

BPPC Paid Period	Invoice Count	Invoice Count (Passed)	% Passed	BPPC Amount	Invoice Amount (Passed)	% Amount Passed
Jul-22	2,207	2,204	**99.86%**	198,395,267.62	198,391,180.92	**100.00%**
YTD	2,207	2,204	**99.86%**	198,395,267.62	198,391,180.92	**100.00%**

Year To Date						
Period Covered	**Jul-22**	**to**	**Mar-23**			
	Number of Bills Paid			**Value of Bills Paid**		
	In Total	**Within**		**In Total**	**Within**	
	Period	**Target**	**%**	**Period**	**Target**	**%**
				£'000	**£'000**	
Non NHS	2,171	2,168	**99.86%**	64,236,321.62	64,232,234.92	**99.99%**
NHS	36	36	**100.00%**	134,158,946.00	134,158,946.00	**100.00%**
Total	**2,207**	**2,204**	**99.86%**	**198,395,267.62**	**198,391,180.92**	**100.00%**

5. Identified Issues

The Board is asked to note the following identified risks:

Continuing Healthcare

Continuing Healthcare (CHC) continues to experience cost pressures, despite the remedial actions being taken by the CHC Team. This particularly affects the South and West Herts (SWH) Healthcare Partnership (HCP) and is a continuation of the pressures experienced in the legacy Clinical Commissioning Group (CCG) of Herts Valleys.

Previously the SWH CHC spend remained above budget throughout the year and a deep dive review was undertaken and monitored by the Herts Valleys CCG's Finance Committee during the year. The main reasons for the increased costs were recognised to be due to both volume and price increases, with the average cost per patient increasing for Fast Track and Homecare services. A comparison of bed rates within the ICB also showed that SWH CHC was not as competitive on price as East and North Herts CCG or West Essex CCG. It is expected that combining the three CHC Teams together will allow harmonisation of process, including bed rates.

Cost and Volume Contracts

Following the move away from the Emergency Financial Regime covering 2020/21 and 2021/22, most of the Acute Services contracts for 2022/23 are based on the Aligned Payment Incentive (API) agreements.

These contracts have a block basis for the emergency and non-elective services and leaves the elective services on a cost and volume basis. Any over performance on elective services will be reimbursed by NHS England and Improvement (NHSE/I) retrospectively through the Elective Service Recovery Fund (ESRF). Although the risk of overperformance is mitigated through the ESRF, it is not completely eliminated, as the reimbursement is based on how the system performs and not individual providers.

There are three contracts that are based on cost and volume and any urgent or non-elective services over performance against the plan is a financial risk to the ICB. The activity for Months 1 and 2 has been verified (freeze), however, this is a small sample and the activity seen each month remains volatile.

Name of Organisation	Annual Contract Value	Forecast Outturn
Moorfields Eye Hospital NHS FT	£12.429m	Currently within plan
North Middlesex University NHS Trust	£12.713m	Currently within plan
Oxford University Hospitals NHS FT	£1.066m	Currently above plan

6. Other Areas to Note

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

Financial Framework Governance

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

The checklist, comprising an initial assessment and 72 questions over 7 domains, is expected to be reviewed by the Internal Auditors, who will report individually against 12 of the questions to the ICB's Audit Committee.

Controls on Agency Spend

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

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

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

7. Recommendations

The Board are asked to note the following:

- The ICB's year to date and forecast outturn position of breakeven
- The potential risks to the financial position linked to the Continuing Healthcare (CHC) costs and the overperformance against the Cost and Volume contracts
- The delivery of financial performance targets for the year

Appendix A

HWE ICB Risk Register
(Extract from Datix Current Risk Scores 12 and above)

ID	Opened	Risk Owner	Description	Risk Score (current)	Controls	Gaps in controls
318	17/05/2022	Shah, Avni	If points of participation and influence for primary care in the new ICB and HCP structures are not made clear during the transitional period then meaningful engagement with primary care may not be sustained into the new ICB arrangements resulting in challenges enacting ICB plans for delivery at place	20		
333	18/05/2022	Shah, Avni	If Transfer of the GP Extended Access Service from the IUC Contract to PCNs - Cost pressure CCG may be required to fund PCNs at a higher value Then- can be disaggregated from the HUC Integrated Urgent Care (IUC) contract, Resulting in- a cost pressure Extracting the equivalent PCN value from the IUC contract may destabilise the remaining NHS111, Out of Hours and CASservices(Primary Care but specific to WECCG only)	20		
468	24/08/2022	Kinniburgh , Jane	There is a risk that poor data quality is leading to a significant lack of oversight of patients waiting to access services including patients waiting for more services. This is due to the introduction of a new Electronic Patient Record (EPR) at WHHT. The Trust have outlined the key risks of EPR implementation that are affecting services as: Data quality, configuration, awareness, hardware issues. There is potential unless action is taken of delays in assessment and treatment, increased waiting times, national waiting time targets will not be achieved, patient harm and poor patient experience. Risk to be reviewed at the West Herts Place discussion and proposal for next steps will be reported to Quality Committee in November	20	Exceptions reporting of implementation of EPR and remedial actions to be shared at routine joint quality and performance oversight meetings. Recruiting additional administrative staff to improve PTL management and accuracy of data reported. commissioner are supporting recovery plans with WHHT and trajectories for return to baseline. Partnership working to monitor the trusts improvement plan and trajectory. The trust has an established clinical harm review process built into their governance and outcomes from clinical harm reviews will continue to be shared by the Trust. Monitoring of serious incidents by SI panel. Monitoring of complaints via the Patient experience team. Monitoring of GP concerns via the quality alert system. 21/06/2022 Trust have agreed to develop a SitRep to track divisional impacts and impacts on performance. Escalation processes in place. CEO and EPR lead continue to meet weekly to review progress. The potential impact of EPR underpins the Quality assurance visits processes and actions.	WHHT have a weekly director-level oversight group and actions progress is reported via this route. This reports into the Trust Executive. Formal monthly quality and performance meetings with WHHT are in place, in line with the ICS arrangements.
469	24/08/2022	Kinniburgh , Jane	There is an increased risk of severe and moderate patient harm as a result of poor performance in cancer pathways. There is a deterioration of all cancer 2 week wait pathways alongside increased total numbers of people waiting above 62 days resulting in increasing 104 day breaches therefore delays to patient treatment. Key factors impacting this risk: Increased numbers of patient referrals particularly within breath and LGI Administration issues within the trusts resulting in a lack of timely removal of patients from the PTL-EPR system - recovery from multi system issues that affected many areas of clinic administration and capacity.	20	A process has been developed that will ensure all patients who receive a cancer diagnosis who have waited 4 weeks or more for their first appointment, will have a harm review. These reviews will be reported fortnightly at the Trusts Clinical Harm Review Panel. Updates are being made to the harm review standard operating procedure accordingly. WHHT are recruiting additional administrative staff to improve PTL management and accuracy of data reported. Exceptions reporting will be requested via HV locality /WHHT Quality and Performance Review Meetings. This includes routine updates with regards to the Trust Clinical Harm Review Process. Ongoing triangulation of patient safety and assurance intelligence including via Serious Incidents process. Ongoing assurance and oversight of EPR implementation and actions progress to address areas of affected performance as per NQ59. 21/06/2022 Monthly exception meetings in place with the Trust. The Cancer Improvement Plan is being taken to the Finance and Performance meeting on June 30th.The Cancer Alliance reviews progress fortnightly. KLOE 62 Days oversight is aligned to clinical harm reviews and serious incident processes to monitor progress	WHHT have provided cancer deep dive which incorporates key actions to improve performance and provide quality assurance alongside trajectory, HV locality MDT to review and collate feedback to WHHT
477	08/09/2022	McLaren, Alex	Project HCQ: IF.. patients on Hydroxychloroquine medication cannot access annual screening after 5 years on this medication due to there being no commissioned service in ENH place. THEN.. there is a clinical risk to patients of sight loss and reduction in quality of life as patients would not be able to have medication stopped in a timely manner. RESULTING IN.. risk to quality of life, reputation of the ENH Place	20	Negotiating interim agreement with local organisations to accept patients being newly referred. ENHT will continue to offer service to the 150 patients currently open to them .ICS working group established to address the issue	No identified alternative organisations to direct patients too. Limited understanding of the cohort size due to multiple patient groups/prescribers
6	05/06/2019	Joyce, Rachel	IF the Medical Directorate do not deliver their portfolio of improvement/ transformation projects THEN activity and demand on current services will continue to grow (i.e. aging/frail population)RESULTING IN increased demand for services which would mean that the current level of services will be inadequate for the needs of the population and little or no improvement in patient outcomes. This would also likely cause financial pressure for the CCG and/or providers and may result in cuts to services.	16	ICP LTC and Planned Care Boards setup to support system wide transformation. Each project allocated a Director and AD to provide executive oversight. Each project allocated a project manager. Monthly Organisation Performance Delivery meetings. Sub-teams within the Medical Directorate to focus on specific projects relating to key programmes	Population Health Management approach is still being developed.Project Resource gaps impacting upon capacity and project delivery
123	28/10/2019	Joyce, Rachel	IF GPs or doctors within the Trust prescribe high doses of opioid analgesics for chronic pain (especially above 120mg oral morphine equivalent) which are not regularly reviewed in line with uptodate national guidance (also due to long waiting times for referral to specialist services), THEN there is a risk that patients would continue to be prescribed very high doses of opioid analgesics, sometimes inappropriately which do not provide any additional clinical benefit and can increase patient harm and mortality . RESULTING IN potentially serious harm to patients including dependency, reduction of quality of life and reputational damage to the CCG	16	Investigating consultant connect. The 2022/3 QOF and PCN DES quality improvement sets targets including structured medication reviews in order to optimise the quality of prescribing of medicines which can cause dependency and the use of non pharmacological alternatives to potentially addictive pain management medication. Enhanced Commissioning Framework approved at Primary Care Commissioning Committee for 2022/3 with targets on opioid reduction in ENH and SWH for practices to identify patients taking high dose opioids and taper their dose. (Work has already been completed in W Essex place and prescribing of high dose opioids in primary care is very low) A locally multidisciplinary developed opioid reduction tool was approved at the Area Prescribing Committee in July 2022 to support practices in identifying and managing patients Working with PMO team on primary care pathways, training and options for commissioning of services to support patients addicted to prescribed medicines (as agreed at Area Prescribing Committee July 2022) Opioid discussions at locality prescribing meetings and with individual practices Discussion with others at CD LIN to enable us to learn from good practice	To roll out opioid elements of Enhanced Commissioning Framework in ENH and SWH and monitor prescribing changes. To discuss with the PMO team and Comms, and consider options at MSK group in September 2022. Waiting times for referrals to secondary care have not reduced. To extend the mapping of services ICS wide. Lack of consistent referral options across the ICS for patients addicted to prescription medicines
209	11/06/2020	Connolly, Rosie	If there is insufficient capacity in the team due to vacancies, redeployment of staff, covering additional covid-19 functions including the ICC and core cells, and the significant volume of care home work such as supporting IPC outbreaks, training and mutual aid requests, Then this will impact on core functions and the ability to deliver business as usual within the Nursing and Quality team. Resulting in reduced visibility and identification of quality and safety issues, and potential for negative impact on wellbeing of staff.	16	1. ICS SMT and N&Q SMT meeting regularly to review priorities 2. Development of business case for additional resource achieved, recruitment in progress 3. AD role for Nursing and Quality now substantive, with oversight from ICS Director of N&Q	2. Gaps remain as the team continue to have reduction by 2 WTE 2. Some vacancies recruited to however other vacancies remain with 2 staff members on secondment
282	23/08/2021	Pond, Alan	If Mental Health activity demand exceeds plan there is a risk that beds are full and there being insufficient capacity resulting in patients having to be placed in expensive private facilities and/or remaining in acute hospital leading to increased cost within acute and CCG Mental Health.	16	1. The financial plan approved by the GB delivered mandated level of growth in investment within Mental Health 2. Additional non recurrent financial support was made available to funding services where significant growth is being experienced 3. Contract is in place with HPFT and performance is monitored to highlight variances from plan 4. NHSE monthly non ISFE returns tracks investments to ensure funding released are spent within Mental Health	
324	18/05/2022	Shah, Avni	If there are not consistent and rigorous processes for monitoring quality and performance of contracts and investments then there is potential for variable outcomes in improvements across the three geographical areas resulting in inequalities in the quality and performance of ICB primary care services and disparities in costs for the same services in different locations	16		
325	18/05/2022	Shah, Avni	If the processes for recruitment of social prescribing link workers in primary care are not aligned then- availability of social support in primary care will be uneven across the ICS resulting in- inequalities in outcomes for local populations	16		
346	19/05/2022	Kinniburgh , Jane	If- East and North Herts NHS Trust (ENHT) fail to address the ongoing quality and safety issues (e.g. sepsis, VTE and IPC). Then- the quality of care may be compromised potentially. Resulting in patient harm Propose to change to: If-the ICB is ineffective in supporting our acutes to progress from RI to Good, and the Trusts fail to adequately address current and emerging quality issues. Then- there is a risk relating to the quality and safety of care provided. Resulting in- harm to patients(N&Q)	16	Robust programme of quality monitoring and assurance visits - Programme to monitor requirements of quality schedules and information schedules in contracts - Patient Network Quality meetings where quality issues are discussed (as well as patient participation groups (PPGs) etc) - Annual visits of children's safeguarding section 11 visits and quarterly monitoring of providers - Provider CQC action plan in place - Dedicated IPC resource - Annual visits of adult safeguarding review visits to all providers - Mortality review process in place - Ongoing monitoring of staffing returns - Ward level quality indicators analysed (safer staffing information and safety metrics)	
351	19/05/2022	Burlingham, Jo	If- there is a pandemic flu/Influenza type disease (pandemic), infectious outbreak or disease including - Localised legionella or meningitis outbreak - Major outbreak of a new or emerging infectious disease Then- this will cause additional pressure on healthcare services and organisational business continuity issues Resulting in- the increased potential for compromised patient care and safety and organisational business continuity failures(EPRR)	16	Hertfordshire Pandemic Flu Framework. BIAs completed for each team / department. Place based business continuity plans. Place based incident response plans.Director / Senior Manager on call systems / packs. MoU for the Mobilisation of NHS Resources in the event of a significant Health protection Incident in place. Staff and community vaccination programmes in place for flu / COVID. Arrangements in place for Monkeypox vaccines to be deployed as and when required (specific criteria to be met). EPRR training and exercise programmes in place. Outbreak plans and pathways in place	Current Herts Flu Pandemic Framework is out of date and require review by NHSE/I. Specific Infectious Disease Framework required. BIA template requires review so that it is consistent across the whole ICB. This may delay the annual review of some team / departmental BIAs, although leads have been asked to just check that these remain fit for purpose in the meantime. ICB emergency plans are required to replace the place based version. These are currently being drafted for sign off. Place based on call systems require review following ICB transition. MoU for the Mobilisation of NHS Resources in the event of a significant Health protection Incident in place
387	12/07/2022	Kinniburgh , Jane	Increased demand for EHCPs in Community Paediatric services across ICB due to 2015 & 2018 SEND reforms. (Around 40-50% increase in demand). This is resulting in long waiting times throughout the community paediatric services and if additional resource (staff and investment) are not made available these waits will continue to increase. There is a risk that children will not receive the support required in both health and education environments which will impact on their health, well being and educational attainment.	16	S&W-HCT business case for additional staff clinically approved at HVCCG Commissioning Exec - HCT completed clinical harm review for Community Paediatrics and recommendations to be implemented by HCT in collaboration with commissioners. - Commissioners monitoring monthly data on RTT, referrals and quality data. ENH- E&N Herts ICBcontracts team are working to obtain waiting list data for all CYP Community Services so that there is clear awareness of the waiting list and any associated risks. West Essex- ECC continue to work on developing a more streamlined electronic process for EHCPs. - Process in place to ensure all plans are available on the child's PB19 record to support holistic approaches to care. - Increase capacity of the current designated officer function for SEND with administration support. - Commissioning manager returns from maternity leave in December. Workplan to include more of the Essex SEND agenda to support capacity of the team. _ -Extensive programme of work in train across Essex on therapies transformation and neuro pathway alignment	

Appendix A

HWE ICB Risk Register
(Extract from Datix Current Risk Scores 12 and above)

ID	Opened	Risk Owner	Description	Risk Score (current)	Controls	Gaps in controls
391	13/07/2022	Kinniburgh , Jane	Special school nursing - The number of special school places has increased in Hertfordshire alongside the acuity of the children and yet in E&N Hertfordshire the nursing establishment has not increased. The establishment is 41% under the required number of nurses needed to provide the service required. Local Authority planning of new special schools does not take account of additional capacity required of health services to effectively support children attending the school. The resulting issue is that some elements of the service cannot be provided, and this is adversely impacting children, families, and schools. It is also putting significant strain on the existing workforce.	16	E& N Herts -Specification being developed for current special school service - Business case is being developed by health CYP commissioning team in collaboration with ENHT & HCC setting out current and future needs for special school nursing. This will review skill mix and nursing need alongside required establishment - There is a targeted piece of work on Lonsdale REP cover as part of this working in partnership with ENHT, health commissioners and HCC - Proforma developed by Health CYP commissioning team/HCC and ENHT to ensure clinical data and educational needs is shared with clinical team before child starts school - Cross system programme board established - Presented to ENH HCP Exec and support to progress. S&W and E&N - to review additional school places to ensure that capacity meets demand. West Essex- Current commissioned SSN capacity is sufficient for supporting the 3 special schools in WE. - New SEMH school planned in Harlow, requiring additional capacity - SSN commissioning limited in the rest of Essex, prompting an Essex wide review; potential risk of changes being imposed to current commissioning and provision.	
455	12/01/2021	Kinniburgh , Jane	IF there is a lack of information from NHSE&I regarding delegation of functions to the ICB including timescales and expectations, THEN there is a risk that relevant Teams will have inadequate time to prepare for the delegation of primary care quality oversight and improvement, primary care complaints, additional safeguarding and IPC requirements etc, RESULTING IN a lack of robust processes being in place to maintain oversight of quality and safety, and provide a responsive services. Transition Workstream Risk Register Ref: R029	16	Awaiting further guidance from NHSE/I on the full delegation of primary care and other specialist commissioning functions, including timeframes, level of expectation and confirmation of transferring resource. Development of business case for identified additional resource once guidance and transferring resource confirmed and requirements fully scoped.	Guidance from NHSE/I delayed until 2022 impacting on any potential planning and recruitment. Staff capacity planning may be impacted by potential redeployment of staff to manage COVID-19 outbreaks across the health system.
124	28/10/2019	Pond, Alan	If - NICE guidance (e.g. diabetes and anticoagulants) is implemented rapidly and external factors cause prices of medicines to increase (for example due to national medicines shortages, price increases, national recommendations, higher cost new drugs, increased prevalence through diagnosis, and more elderly population with many co-morbidities), or there is a lack of clinical engagement then - the CCG may overspend on the annual prescribing budget (despite QIPP targets being met) resulting in - an additional significant financial burden on the ICB	15	Matrix working using ICB clinical specialists to improve clinical engagement Staying informed of national decisions to identify cost pressures and horizon scanning Awareness of internal decisions affecting the prescribing budget Monthly monitoring of prescribing items and costs using electronic prescribing data Planning and prioritising work agenda to take account of related challenges Regular feedback to practices through Pharmaceutical Advisers at locality prescribing meetings Monthly monitoring of agreed QIPP targets and investigating changes Medicine optimisation targets in ECF Biannual feedback to the Quality Committee through the PMOT Prescribing Report	Other changes in prescribing practices in acute and primary care and as a result of national decisions New NICE guidance for example around diabetes drugs and devices which will need introduced with a phased approach in order to be affordable. Medicine shortages, for example due to NCSO cost pressures, recalls, safety alerts. External price rises including unexpected Category M risks which nationally will raise generic prices. To negotiate an appropriate budget with finance based on forecast issues for the following year
157	17/12/2019	Kinniburgh , Jane	IF requirements for health checks for adults with severe mental illness (SMI) is not met, THEN there are risks of unsafe or poor quality care for patients, poor patient experience RESULTING in poor health outcomes including reduced life expectancy, double the risk of obesity, diabetes, and increased risk of a range of long term conditions. Risk description revised 22-08-22	15	1. Monthly emails to Practices and monitoring of physical health checks being delivered 2. Attendance at GP Leads, JCPCC and continual discussion with Practice Managers and GP's about requirements and performance 3. Ardens template available to all Practices 4. Practice Support Packs live on CCG intranet to support delivery in primary care includes template letters, best practice guidance, GP video, local and national resources and information, NHS toolkit 5. Dedicated email address for help and support for primary care 6. QOF for 22/23 has greater focus on SMI health checks 7. Pilot commencing in Stort Valley with HPFT physician associates working in primary care aiming to increase take ups of checks and improve outcomes 8. Delivery of these checks now included in the CFF for primary care	1. Issue raised by some Practices that HCA's and/or others do not want to work with this cohort due to lack of experience or understanding. Commissioners are currently implementing a mental health awareness training programme to support delivery of these checks in primary care 2. Working on resolving data issues in primary care to ensure the reporting includes all checks being completed (having to estimate at the moment) 3. Impact of Covid on primary care capacity (IPC measures, staffing and mass vaccination)
302	30/09/2021	Kinniburgh , Jane	Due to significant pressures as a result of COVID-19 and other operational pressures, there is a risk that ENHT Maternity services may not be able to achieve National deliverables, impacting workforce and also patient experience and safety. Key risks include: - Increase in stillbirth rates and neonatal deaths; - Increase in pre-term babies; - A deterioration in workforce and team culture; - increase in unit closures and patient diversion	15	Fortnightly maternity assurance meeting in place. Discussed at SQG -system oversight. Newly qualified midwives due to start in ENHT	Newly qualified midwives require supervision from a reduced pool of senior staff
362	20/05/2022	Burlingham, Jo	If- an unexpected situation causes an inability to maintain Business Continuity planning. Then- organisational services / areas may not be able to continue. Resulting in- compromised business functions which, dependent on the service / area, may lead to compromised patient / staff safety and care and business continuity failures(EPRR)	15	Place based Business Continuity plans. Place based incident response plans. BIA template requires review so that it is consistent across the whole ICB. This may delay the annual review of some team / departmental BIAs, although leads have been asked to just check that these remain fit for purpose in the meantime. Business continuity training offered to appropriate staff as part of the overall EPRR training programme. Place based on call systems	ICB emergency plans required to replace place based versions. BIAs for all teams / departments require standardisation and review. Place based on call system requires review following transition to ICB
244	08/09/2020	Fairhurst, Holly	If there is a lack of access to dental services then this will impact on a patient's treatment and care resulting in a potential deterioration of health	15	Discussion will take place with the Commissioner NHSE&I to understand if the routine backlog is being reviewed and they are assured all patients are being risk stratified appropriately to mitigate the risk of harm. Once confirmed, Contracts will recommend the risk is officially closed. Communication links are in place with NHSE&I to obtain information is needed. HUC Dental call activity is regularly reviewed, including complexity of cases across the dispositions. Processes are in place with the Provider, to flag potential clinical/pathway concerns.	CCG is not the commissioner of dental services. Assurance not received from NHS E/I on actions and mitigations to improve dental access. Additional demand at HUC not currently commissioned
164	19/02/2020	Burlingham, Jo	IF the CCG does not continue to respond to the current COVID-19 (Corona virus) pandemic, there is a risk that delivery of essential services could be compromised resulting in poor outcomes for patients and staff welfare.	15	Place based business continuity plans in place. ICB Incident Response plan in place. BIAs in place for all team / departments. Placed based on call systems in place to manage incident our of hours. 1 - National Public Health England (PHE) guidance being given regularly as the one source of truth for all stakeholders, based on best evidence at the time. This is being developed by central government nationally. 2 - Health system conference calls chaired by NHSE Regional, declared as level 4 incident. 3 – The Local Resilience Forum (LRF) are meeting weekly (Mon) through the Strategic Coordination Group (SCG) which brings together all Category 1 & 2 responders. This has stepped down from daily meetings in line with the National COVID alert level . 4 - A Health Economy Tactical Coordination Group (HETCG) has been established with all the acute, community, mental health & 111 providers, in addition to West Essex & Herts Valley CCG's, NHSE, East Of England Ambulance Service Trust (EEAST) and Hertfordshire county council (Social care and public health). This is led by East & North Hertfordshire CCG (ENHCCG) and is used to coordinate the health system. 5 - NHSE are setting out the national strategy. The Local Health Resilience Partnership (LHRP), through HETCG which consists of providers across all of Hertfordshire (not just East and North Hertfordshire), are coordinating the health response at a local level and also acts as the tactical coordinating group in response to any local outbreaks and lockdowns reporting into the Strategic Coordination Group (SCG). 6 - NHSE weekly webinars to discuss guidance and operational concerns have now been stood down but guidance is passed down national through the EPRR route via the ICC. 7 - Swabbing and testing programmes being implemented in line with Government guidance (localised health staff swabbing solutions, access to regional swabbing across Hertfordshire for the, Organisation of the Military Mobile units, Swabbing Cell, Primary Care Outbreak cell, Health Protection Board). 8 - Existing Pandemic Flu Plan has informed the strategy for this evolving incident along with national guidance. 9 - 111 Pathways have been created nationally specifically for COVID-19. 10 - Primary care being updated by the CCG with relevant information and asked to review business continuity plans in case of a practice closure. 11 - Cell's created within ENHCCG to pick up all the key work streams (ICC, Communications, Primary Care & Localities, Unplanned Care, Contracts & Performance Service Change, HR & Governance, Pharmacy, Recovery). 12 - All covid-19 expenditure to support the response is being tracked and reported locally to NHSE	Place based on call system requires review following transition to ICB ICB emergency plans are required to replace the place based version. These are currently being drafted for sign off. ICB business continuity plan required to replace placed based version 1 - Rapidly evolving situation, therefore some time lag in PHE update of guidance on line. 2 - Primary care Business Continuity Plans may not have been exercised thoroughly enough
259	09/02/2021	Fairhurst, Holly	If the 18 week referral to treatment waiting times are not being met and the number of people waiting longer than 52 weeks is not monitored with mitigations / risk stratification put in place. Then there will be delays to treatment for patients. Resulting poor outcomes for the patient and possible harm	15	Continued contact with patients throughout pandemic directly from consultants. Plans in place to carry out full PTL Prioritisation again when no longer in incident response. Performance & monitoring in place via Clear PTL. Cancer 2wws and 62day wait report being produced weekly for Planned Care board to consider mutual aid offers. Exploring wait well as an option for patients on the waiting list. Patient initiated follow ups. National guidance produced and being followed regarding clinical reviews to reduce and avoid harm for people waiting for treatment.	The mandate from NHSE takes some of the ability to control this risk away from the providers. NHSE directive is to cancel planned/routine operations. This will increase the number of patients waiting more than 52 weeks.
303	14/10/2021	Kinniburgh , Jane	ENHT Children's community nursing team (CCN) are currently only operating Monday to Friday 9-5pm. This is resulting in a lack of service in the evenings and weekends preventing timely discharge from acute hospitals and increasing footfall through the Children's ED departments. There is an impact across the ICS in terms of equitable service, particularly on discharges from PAH. WE &HV localities operate a 7 day service 8-8. ENH CYP equate to about 40% of attendances/ admissions to PAH, therefore this is impacting on hospital flow.	15	Children who are regular attenders have direct access to Paediatric Team. 111 can be accessed out of hours as required for Children Out of hours GP can be accessed as required for children	Children who are regular attenders have direct access to Paediatric Team . although not ideal E&N CYP have access to Childrens ED
307	18/10/2021	Fairhurst, Holly	If there is not a new provider in place when the anti-coag service ends at Buntingford and Puckeridge in December 2021, there is a risk that there will be no service in place resulting in an impact on patients care.	15	Discussions are ongoing with the Provider, and includes support from Execs.	Unclear on the extent of potential impact for patients, until the practice's final stance on the matter is understood. Patient numbers have been requested from the provider.

Appendix A

HWE ICB Risk Register
(Extract from Datix Current Risk Scores 12 and above)

ID	Opened	Risk Owner	Description	Risk Score (current)	Controls	Gaps in controls
349	19/05/2022	Kinniburgh , Jane	IF a child's death process is not being reviewed within recommended 6 month period, THEN there is a risk the HWE ICB will not be compliant with the national guidance RESULTING in a backlog, delay in learning, potential to miss incidents, and impact on parents and carers.	15	Extraordinary meeting arranged to facilitate review of cases. Revised process for Designated Dr's to complete Form C prior to CDOP to support concise discussion. Arrangement for Neonatal deaths to be reviewed with Neonatologist at specific meetings. Workshop arranged with all Child Death Overview Panel (CDOP) attendees 24.09.2021 to change process. Compare Hertfordshire service to w Essex model Service specification is in development with a business case worked up to present to ICB and HCC commissioning committees Dedicated neonatal death panels in place to review neonatal deaths	Acute organisations are not returning form Bs in a timely manner; ongoing review of processes in Hertfordshire compared with West Essex. Designated Drs supporting the neonatal panels whilst Neonatologists and Obstetricians are sought to support panels
350	19/05/2022	Burlingham, Jo	If- the impact of Covid19 on system resilience across HWE (declared as a level 3 incident) causes (a) Incident Management of the Coronavirus Pandemic diverts significant resource from CCG business as usual; (b) Pandemic incident increases the likelihood of absence from work due to sickness among CCG staff, GP membership and board and committee members; (c) Pandemic response in recovery and restoration phase reduces capacity of providers i.e. social distancing, PPE, swabbing, staff isolating Then- there is the potential for a failure to robustly carry out HVCCG and NHS England's statutory responsibilities: - failure to meet statutory targets, - failure to meet patient needs. Resulting in- the potential for compromised patient and staff care and safety, together with an increased potential for organisational harm from unfulfilled statutory duties and assurances(EPRR)	15	LHRP / LHRP subgroup / HETCG / SCG meetings. Regular UKHSA guidance received. Daily teleconferences in place with providers to manage capacity and demand. Regular liaison with NHSE/I via MS Teams e.g. RHRF, EPRR leads meetings, UEC/EPRR tactical calls Place based incident response and business continuity plans. Team / departmental BIAs. Incident Control Centre stood up	ICB emergency plans required to replace place based versions
392	13/07/2022	Kinniburgh , Jane	Children's Community Nursing – ENH The community nursing provision in ENH is Mon to Fri 9am to 5pm and up to 16. West Essex and Herts Valleys offer a 7-day service from 8am to 6pm in HV, 8am to 8pm in WE. The risk is that children attend or are admitted to hospital to meet their needs when they could be better cared for at home and in addition that children cannot be discharged to a community nursing team and therefore spend additional time in hospital. Impact on hospital avoidance, pressures in ED and NEL/EL care, admission/ readmission, length of stay. Inequity of access and patient experience for Herts children attending PAH.	15	Draft business case has been developed by ENHT. The case is being updated to include current data and option of provision from 16-18. -ENH HCP agreed fit with hospital at home priority and are supportive of moving this work forwards - Cross system programme board established - Position paper drafted by CYP health commissioners. - Development of joined-up service provision between WE CCN and PAH HAH to improve pathways and process. Potential for WE CCN to be commissioned to expand the service to include the majority of the Herts catchment along the border. Cost estimations have been provided and will be incorporated into options going forward.	
1	15/04/2019	Joyce, Rachel	If the CCG fails to implement its medium term initiatives, which are designed to improve patient outcomes, then there is a risk that efficiency and effectiveness improvements will not be delivered, resulting in higher costs and the need to cut other services impacting on the achievement of improved patient outcomes and other objectives.	12	1. Strategic plan agreed including project work streams, finance requirements and projected savings. 2. Operational plan agreed together with high level projects required to deliver strategy and medium term initiatives. 3. Organisation Performance and Delivery (OPD) Days in place to oversee and provide direction on agreed work streams and to monitor progress. 4. Impact of initiatives are reviewed to test objectives have been delivered, including outcome measures. 5. Locality involvement in developing plans and ideas - discussion at locality meetings.	4 Ensuring the contract challenge processes and data quality issues are resolved
2	01/11/2013	Connolly, Rosie	IF East and North Herts NHS Trust fail to address the ongoing quality and safety issues (e.g. sepsis, VTE, IPC), THEN the quality of care may be compromised potentially RESULTING IN in patient harm.	12	1.Robust programme of quality monitoring and assurance visits 2.Programme to monitor requirements of quality and information schedules in contracts. 3aPatient network quality (PNQ) meetings.3b Patient Participation Group (PPG) involvement in quality monitoring and use of patient stories 4.Annual visits Programme of children's safeguarding Section 11 visits and quarterly monitoring to providers. 5.Provider CQC action plans. 6.Dedicated CCG IPC resource. 7.Annual visits Programme of adult safeguarding review visits to providers. 8.Mortality review process in place. 9.Ongoing monitoring of staffing returns. 10.Ward level indicators analysed (safer staffing information and safety metrics from all providers monthly now in place).	CQUINs had been paused nationally, now recently recommenced. QAVs limited due to covid, now reinstated but risk focused
5	01/10/2014	Turnock, Phil	IF there is a vulnerability in the existing cyber-security protection THEN there could be a successful cyber-attack potentially RESULTING IN loss of access to ICT systems, data loss/corruption, installation of malware/ransomware, data breaches, legal action from clients/regulators. This could lead to loss of knowledge, temporary inability to carry out the CCG's functions in a timely manner and unplanned costs.	12	HBLICT have signed off to NCSC Early Warning System. Additional staff on support 1 Backups in place for key systems (SQL, File and Print) 2 2 N+1 datacentres housing infrastructure (duplicated) 3 Recovery software (Intercept X) in place on key servers 4 Patching carried out on end points and servers no less than monthly 5 Technical staff with coverage skills sets to support service 6 Monitoring and response to CareCERT 7 Rapid failover between datacentres for key systems and network 8 Antivirus and ATP in place on all end points and servers 9 Automated monitoring 24x7 with alerting in place 10 N+1 datacentres at more than 30 miles apart 11 Only supported software and hardware is deployed by HBL ICT 12 DR, MIM and BC Plans in place 13 Standard builds in place across Infrastructure and End User Devices 14 Shared knowledge within Tech Services with reduced risk of single point of failure 15 Annual Pen Test carried out across technical environment and action plan and reporting to Stakeholders in place 16 Business Continuity / DR desktop exercises carried out annually (Jan 2022) 17 Umbrella deployed to ICBs 17 Additional Resources within the DS team focused on Cyber	Known and unknown issues impacting the environment (inc any open items identified in Pen Test). Log4J ongoing updates in progress. Complete Deployment of Umbrella across partnership (part of SDWAN) Agreement to enrol users into 2FA for public cloud, and then deployment. Completion of work to move SCCM to Cloud Gateway
9	05/06/2019	Emson, Mary	If there continues to be a shortage of appropriately skilled staff, then there is a risk that the HWE ICB will not be able to effectively commission new services or provide existing services potentially. Resulting in diminished services, poor outcomes for patients and failure to deliver core services.	12	1.Peoples Board DoN represented 2.Requirement for providers to report workforce vacancies, attrition and sickness levels. Main providers report establishment by ward and team (agency cap in place). 3.Primary care workforce programme in place 4. DDoN will lead on workforce	1. awaiting outcomes from action boards 2.awaiting outcomes from action boards 3.awaiting outcomes from action boards
10	05/06/2019	Kinniburgh , Jane	IF providers for ENH commissioners are associates to the contract (e.g. PAH and RF) fail to address quality issues THEN quality of care may be compromised RESULTING in harm to patients.	12	1.Programme of Quality monitoring and assurance in place with HVCCG as host commissioner for RF, and WECCG for PAH 2.Provider CQC action plans in place for all providers. 3. Patient Network Quality Meetings where quality issues regarding PAH and RF are discussed 4. Dedicated IPC resource 5. Mortality review process in place 6. Programme to monitor requirements of quality and information schedules in contracts. 7. Dedicated support to PAH maternity services from NHSE&I 8. - Closer working across the HWE ICB, and alignment of processes as part of wider work to transition	1. Quality assurance processes currently disrupted due to covid, particularly for RF and HVCCG
12	05/06/2019	Connolly, Rosie	IF we don't achieve/make reasonable adjustments in healthcare settings and/or offer regular GP health checks to patients with learning disabilities THEN we may fail to identify serious underlying health conditions potentially RESULTING IN detrimental health outcomes including reduced life expectancy patients with learning disabilities.	12	1. Improving Health Outcomes working group (IHOG) meets regularly to review learning disability health priority areas and put in place actions to address gaps in service 2.Annual questionnaire of people with learning disabilities to ask about their experiences of health services. 3.Learning Disability Mortality Review Process (LeDeR) reviews the quality of patient healthcare retrospectively. Key issues and themes are passed to IHOG for action 4. LeDeR and wider health inequalities work is a standing item on the Learning Disability and Autism Board agenda.	1. Lag in data available from national NHS digital on AHC performance. Local IT systems do not support the availability of regular information on performance of AHCs carried out. 2. Due to Covid19 GP practices have had reduced capacity to deliver AHCs face to face. There is a risk that this will impact on the quality of AHCs completed.
25	25/06/2019	Joyce, Rachel	If the directorate does not have sufficient staff then we may not be able to deliver all of our portfolio of projects as required which means that some projects maybe delayed resulting in reduced benefits/reduction in potential savings.	12	Subtream structure enables other members to cover staff absence or shortages PDP and staff development within the team supports staff retention	
28	08/07/2019	Emson, Mary	If the CCG does not implement systems and processes to ensure that any CHC funded clients who are deprived of their liberty are done so lawfully, through the authorisation process Liberty Protection Safeguards (LPS), which will come into force in April 2022 (replacing the Deprivation of Liberty Safeguards (DoLS) following the Mental Capacity (Amendment) Act (2019)). Then there is a risk of eligible clients having their human rights unlawfully breached, leading to patient harm and reputational damage; resulting in the CCG being fined.	12	1.The Adult and Children Safeguarding Teams, CHC and N&Q Teams are represented at the Multi-agency LPS Implementation Board led by the Local Authority. The Board has been formed to work in partnership to address processes, legal support and training needs. 2. The Associate Director of Adult Safeguarding is an active member of the NHSE LPS Forum chaired by the Head of Safeguarding at NHS England to drive implementation. The Hertfordshire Safeguarding Adults Board will support partnership agencies in implementing the LPS. 3. A scoping tool from NHS Futures has been completed by the CHC Team providing greater detail regarding the impact of LPS for the CCG. 4. Named Nurse for Adult Safeguarding will work with the Safeguarding Children and Continuing Healthcare Teams to complete a training needs analysis for CCG staff in response to the Code of Practice.	2.The implementation of the LPS relies heavily on the Code of Practice which will not be published until winter 2021

As at 14/09/2022

Appendix A

HWE ICB Risk Register
(Extract from Datix Current Risk Scores 12 and above)

ID	Opened	Risk Owner	Description	Risk Score (current)	Controls	Gaps in controls
116	11/10/2019	Surgenor, Simone	If there are failures in the management and monitoring of declaration of interest, then there is a risk that undeclared interests would cause potential conflicts, resulting perceived reputation risk and breach of statutory requirements.	12	1. Policies and Procedures: Managing COI policy states that declaration of interests should be reported upon appointment; at the start of meetings; when circumstances change. The policy also states how they should be monitored and decision making when a conflict arises. 2. Register of Interests: The Revised Statutory Guidance for Conflicts of Interests 2017 states that 'as a minimum the CCGs should publish the register of interests and gifts and hospitality of decision-making staff (band 8C and above) on a prominent place on their website'. 3. The clinical procurement strategy outlines how the CCG manages conflicts within the procurement process. 4. Declarations of Interest form has a counter fraud declaration. 5. Annual Refresh of the Declaration of Interest Register: The CCG ensured that all agenda for change bands were refreshed for 2019/20 in regards to declarations.	
239	13/10/2020	Elton, Sharn	If there is no progress/KPI plan in place by the trust to allow for sufficient monitoring of the number of Type 1 patients awaiting a follow up appointment as part of their annual review, then patients may not be seen resulting in potential harm to patients.	12	1) Risk mitigation plan 2) Numbers of patients awaiting follow up confirmed as 1,936 following validation by administration team for duplicates etc. 3) Clinical validation taking place to ensure clinical risk is assessed and patients are prioritised accordingly. 4) Appt slots now being raised on Trust system to enable patient follow up to be monitored as previously held on standalone database. 5) Waiting list initiatives (WLIs) in place with additional weekend sessions in place with Consultant and Specialist Nurse input. 6) Additional £50K identified by NHSE to support recovery. Bid being compiled by CCG and ENHHT for additional sessions using locum consultants as no further resource available over and above existing WLIs. 7.) Funding requested from ENH CCG Finance team to go out to recruit to Locum Consultant position (as could not recruit additional locum in time using 50K from NHSE).	6) Timescales for submission and funding period to be confirmed by regional team when known.
253	12/01/2021	Fairbrother, Keith	IF 3rd party suppliers are connecting IT equipment to the corporate networks across the partnership without putting in place controls aligned to DSPT/CE+ THEN this could significantly increase the chances of a cyber security attack across the partnership RESULTING IN loss of access to critical IT systems to support the delivery of healthcare services	12	Implementation of Port Based Security 8021X at all remote sites (in progress of rollout - on 10+ sites). Working with supplier to identify solution/software in scope and level of risk - quote in process. Pilot of software to hunt issues on the network (e.g. firmware/versions) Completed. Identified 8021X better solution. Dedicated role within HPFT in progress of recruitment. Firewalls present across all external links (Internet/HSCN). Systems in place to monitor network activity (Solarwinds). Web filtering in place (barracuda). Networks configured with VLANs to separate traffic. Audit tools in place to help identify all IT assets on corporate networks	Port blocking exercise to be completed and Partners to engage to ensure devices remain on network Agree solution for potential dirty network - at SSG/ Stakeholder. Statement from each partner that they have confirmation from their 3rd parties. Limited partner buy in to support management of 3rd party contracts No formal policy to enforce standards for 3rd party vendors using corporate networks. Gaps in audit tools to identify and report on rogue network connected devices. No formal process to ensure that all requests are being captured across the partnership. End to End visibility of Contracts
263	21/04/2021	Milbourn, Nuala	IF… staff across the ICB are not kept informed of and engaged with developments, including staffing structures and the ways in which the ICB will meet its operational responsibilities in a timely, meaningful and reassuring way... THEN… staff may not feel sufficiently well informed about and connected to the wider work of the ICB and how their role fits in and may not feel they have enough of a voice to influence ...RESULTING IN… low morale, negative behaviours, anxiety and a potential increase in stress-related absence or staff turnover, loss of organisational memory and additional pressures on teams.	12	1) Monthly ICB-wide staff briefings and monthly briefings by 'Place' directors on a rota basis (i.e.. one per quarter for each 'Place') 2) ICB staff intranet in place with work underway to incorporate HR ODL intranet to create single information platform for ICB staff 3) Weekly ICB update 4) Staff Partnership Forum in process of being established 5) 'Staff Survey' newsletter picking up wellbeing issues raised in 2021 staff survey 6) ICB-wide all staff emails as needed 8) Active workstream in Comms and Engagement team focused on delivering and developing internal comms. 9) Survey conducted in June to gather staff views on internal communications. 10) Chief of Staff email to senior managers summarising issues from Exec meeting 11) Monthly senior manager meetings led by CEO, Jane Halpin	Internal communications and engagement plan yet to be developed and agreed. New ICB staff Partnership Forum is yet to be established and have its first meeting. Groups that had been in place to support and hear from staff in the lead up to transition to the ICB - a Pathfinders group of senior managers and an Explorers group of staff interested in leading and supporting colleagues through the transition - have now ceased. With many team structures yet to be decided or put in place, and the ICB still in development there is still some uncertainty and concern among staff and currently limited organised support and listening mechanism in place beyond line managers.
266	23/08/2021	Pond, Alan	If activity across all urgent and emergency care settings increased more than planned partly due to the continued effect of COVID 19, then there is a risk of insufficient funding to match the pace in changes to services to meet the required level of increase in both bed capacity and critical care capacity, resulting in delays in care, cancellation of elective admissions, compromising patient experience and safety and increased financial cost.	12	1. Balanced financial plan and budgets approved by the GB 2. Additional investments allocated to fund increased capacity within UEC services 3. NHSE UEC Daily report highlighting the level of demand and performance sent to each CCG for action 4. CCG working with system partners to manage increased demand	
314	27/01/2022	Sterling, Miss Jamie-Lee	If no funding is transferred from ENHT to HCT, following the transfer of some routine skin health activity from ENHT to HCT, this may result in a financial risk for ENHCCG, and the possibility of ENHCCG exceeding its overall commissioning budget.	12	Discussions are ongoing between ENHT and ENHCCG, to seek agreement on the Skin Health routine funding to be transferred from ENHT to HCT. Discussions are to take into account that some of the routine activity will still need to be onward referred to ENHT.	f no agreement is reached, this potentially creates a financial risk for ENHCCG, as ENHT is still receiving funding for the service via the monthly block payments.
316	20/04/2022	McLaren, Alex	If patients do not receive a Spirometry test, then patients may not receive a confirmed COPD Diagnosis resulting in the patient being left untreated or inappropriately treated.	12		
320	18/05/2022	Shah, Avni	If- pressures in general practice, exacerbated by the Covid-19 pandemic and pent up non-Covid demand, remain at the current high level Then- there may be insufficient capacity for GP practices, primary care networks and federations to deliver against transformation of care priorities in a way that demonstrates tangible improvements for patients Resulting In- sub-optimal patient experience due to continued pressures across the system and especially in acute services	12		
321	18/05/2022	Shah, Avni	If Primary Care is not supported to optimise capacity and address variation then- patients may not experience improved access to urgent, same day primary care resulting in negative impact on patient experience, patient safety, system resilience and commissioner reputation.	12		
326	18/05/2022	Shah, Avni	If Primary Care sustainability is not robust enough then we may not be able to ensure continued delivery of primary medical services resulting in- a reduction in quality, patient safety and experience.	12		
327	18/05/2022	Shah, Avni	If primary care recovery and prioritisation of workload is not adequately supported then meeting of primary care contractual requirements may be affected, particularly relating to routine and preventative work resulting in negative impact on patient access, care and experience, QOF outcomes and wider system pressures	12		
328	18/05/2022	Shah, Avni	If the quality of data available to practices and Primary Care Networks is not adequate then this will limit the ability for primary care to meet new responsibilities relating to population health management resulting in- failure to achieve forecast outcomes in population health and healthcare and tackle inequalities in outcomes, experience and access	12		
331	18/05/2022	Shah, Avni	If the transfer of the GP Extended Access Service to PCNs is not proactively supported then workforce challenges are likely resulting in a.Staff may leave the incumbent provider due to uncertainty caused by the GP Extended Access transfer, resulting in a risk for future provision b.Incumbent providers may lose experienced staff through TUPE which could destabilise their remaining services(Primary Care)	12		
336	19/05/2022	Joyce, Rachel	If-functions where NHS England are transferring services to the ICB are not clearly defined in terms of scope, funding and staffing. Then - the ICB will not have the resources to deal with these areas, Resulting in-insufficient capacity and lack of robust processes for effectively managing community pharmacy contracts and specialised commissioning and/or a knock on effect on other services provided by PMOT and other departments	12	Awaiting further guidance from NHSE/I on the full delegation of primary care and other specialist commissioning functions, including timeframes, level of expectation and confirmation of transferring resource. Development of business case for identified additional resource once guidance and transferring resource confirmed and requirements fully scoped. Sharing of local projects, plans, best practice and avoiding duplication works well. Implementation and reporting is at a local ICP level. Ongoing discussions between primary care and NHSE/I about the transfer of responsibilities and the establishment of a System Community Pharmacy Clinical Lead	Awaiting further guidance from NHSE/I on the full delegation of primary care and other specialist commissioning functions, including timeframes, level of expectation and confirmation of transferring resource. Staff capacity planning may be impacted by potential redeployment of staff to manage COVID-19 outbreaks across the health system.
347	19/05/2022	Kinniburgh , Jane	IF we don't achieve/ make reasonable adjustments in healthcare settings and/ or offer timely or poor-quality GP health checks to patients with learning disabilities THEN we may fail to identify serious underlying health conditions potentially RESULTING in detrimental health outcomes including reduced life expectancy for patients with learning disabilities. Risk description revised 22-08-22	12	Improving health outcomes working group (IHOG) meets regularly to review learning disability health priority areas and put in place actions to address gaps in service - Annual questionnaire of people with learning disabilities to ask about their experiences of health services - LeDeR reviews The quality of patient healthcare retrospectively, key issues and themes are passed to IHOG for action - LeDeR and wider health inequalities work is A standing item on The learning disability and Autism Board agenda	Lag in data available from national NHS Digital on AHC performance. Local IT systems do not support the availability of regular information on performance of AHCs carried out - Due to Covid-19 GP practices have had reduced capacity to deliver AHCs face to face. There is a risk that this will impact on the quality of AHCs completed
354	19/05/2022	Burlingham, Jo	If-extreme temperatures are experienced including: - Low temperatures and heavy snow; - Heatwave Then- these events could cause pressure on healthcare services and organisational business continuity issues Resulting in- compromised patient care and safety and failure of business continuity arrangements through staffing shortages(EPRR)	12	Place based Severe Weather plans. Place based incident response plans. Place based business continuity plans. BIAs for each team / department. ICB on call systems. LHRP 3 year exercise plan. National cold weather and heat wave plans	ICB emergency plans required to replace place based versions. BIAs for all teams / departments required standardisation and review. Place based on call system requires review following transition to ICB

As at 14/09/2022

Appendix A

HWE ICB Risk Register
(Extract from Datix Current Risk Scores 12 and above)

ID	Opened	Risk Owner	Description	Risk Score (current)	Controls	Gaps in controls
390	13/07/2022	Kinniburgh , Jane	Waiting time ASD assessments are a long way short of the expected 18 week target. The risk is that without a diagnosis children will not get appropriate support and may not develop competent skills with regards to learning, speech, or social interactions. There is a risk that children / families are not fully supported while they are waiting for a formal diagnosis.	12	S&W and E&N - Waiting time ASD assessments are a long way short of the expected 18 week target. The risk is that without a diagnosis children will not get appropriate support and may not develop competent skills with regards to learning, speech, or social interactions. There is a risk that children / families are not fully supported while they are waiting for a formal diagnosis. West Essex - Investment in capacity. HCRG sub-contracting additional capacity with Mind Professionals; has been slow in being initiated and yet to see impact. - Remodelling of the JADES pathway – planning initiated. - Enhanced reporting for improved transparency and monitoring of recovery.	
411	11/08/2022	Joyce, Rachel	IF...PAH send separate clinical summaries and discharge medicines letters by email...THEN...they do not meet national standards and letters could arrive on different days ...RESULTING IN...duplication of action or no action, plus time delays and safety risks. (Note there is a duplicate risks now closed ID 410).	12	Issue was identified at Medicines Optimisation Programme Board (MOPB) by GP prescribing leads. Raised at the PAH Interface Meeting. Electronic Prescribing Lead from PAH attended MOPB to understand the risks. Reviewed discharge process with PAH Chief Pharmacist to identify a practical solution. Flagged as a concern to the CCG contracting team to raise with PAH. Communication with practices (W Essex and relevant ENH practices) in ... suggesting systems in place in practices to manage this	Major patient safety risk Lack of consistency with other Trusts in ICS and nationally Identified in February 2019, Nov 2019 review of process with PAH
442	15/08/2022	Watson, Michael	IF the governance substructures required under the new delegation arrangements are not understood and put in place for April 2023, THEN requisite assurance and decision structure will not have been established, RESULTING in the ICB breaching its delegation responsibilities and legal duties. Linked to the previous transition risk R026 (394). Transition Workstream Risk Register ID: R041	12	12.08.22 - an initial ICB internal meeting took place regarding delegation and what it would entail on 10.08.22. This is part of an ongoing programme. Entries are also due to be included in ICB sub-committee work plans. Links also to be made with mirroring areas adopting the same. NHS E support anticipated.	
464	03/12/2020	Kinniburgh , Jane	Risk that the East of England Ambulance Service Trust (EEAST) will not deliver on their quality and safety responsibilities, as set out with the NHS Constitution and also within the contract they have agreed to. Following a CQC visit undertaken in June/July 2020 the Trust have been rated as Inadequate and placed into Special Measures therefore the Trust will be required to have sufficient resource to implement the Quality Improvement Plan that has been developed. Key issues relate to: Safeguarding adults & children Workforce & cultural concerns. Lack of processes in place to manage allegations against staff. 21/06/2022 The Trust continues to experience significant operational pressures impacting performance. Further concerns have been raised by CQC in relation to workforce, staff safety and medicines management. There were staff concerns around lack of training, appraisals, one to one support and career progression. In addition to this staff reported a worsening culture rather than an improving one following the initial concerns raised by the CQC.	12	EEAST, with the support of NHSE/I have developed a Quality Improvement Plan (QIP) EEAST have undertaken a review of the governance arrangements in place to ensure all elements of the QIP are monitored, with clear escalation processes in place. A copy of the outcome of the review has been shared. Regular progress reports are shared with all commissioners. ICS Director of Nursing attends the Oversight & Assurance Group (OAG). Monthly local meetings are attended by HV and EEAST to monitor and discuss the local impact. Pre-meets are also arranged to ensure the effectiveness of the meetings Serious incidents process in place. 21/06/2022 EEAST have implemented initial actions as recommended by CQC and will continue to address further issues highlighted by the CQC.	The EEAST Localities meeting for April 2022 has been stood down due to operational pressures and an escalation meeting has been put in place on 8 April 2022
465	15/07/2020	Kinniburgh , Jane	There is a risk of increased complaints, CHC appeals, PHSO complaints, NHSEI Independent Reviews and Judicial Reviews as a result of re-establishing CHC assessments where people are not happy with the outcome of a funding decision. All deferred assessments have now been completed however some appeals will still be in progress	12	To mitigate and plan for this risk an integrated ICS meeting is being arranged with partners to make recommendations for agreement within each organisation 08-22> The ICB Continuing HealthCare team has been reconfigured. Appeals and retrospective claims are now managed and co-ordinated through a single process. The appeals process is mandated as part of the National Framework for CHC and NHS Funded Care. Appropriate policies and procedures are in place. Risk can be closed.	Business case seeking approval for increased establishment within the CHC team. HV locality staff supporting the discharge process within the Acute Trust. All referrals scrutinised to ensure appropriateness of referrals Fortnightly meeting with HCC to monitor progress and discuss emerging issues. Maintenance on D2A tracker to ensure assessments are booked in within timeframes and assessments completed field
470	30/12/2021	Kinniburgh , Jane	Consumables- CLCH are no longer providing the supply of consumables for CHC patients and handing the responsibility to CHC. HV locality does not have suitable pathway in place to allow for this service handover. Current contract with CLCH does not include the supply of consumables for patients that are not on a CLCH pathway including CHC patients Issue still persists and has not been resolved. One ongoing case that requires specialist equipment to be provided.	12	Escalated to senior managers and contact managers to review CLCH contract to allow them to recharge consumables to a separate CHC budget line for the complex CHC patients be agreed. Corporate staff supporting and ordering consumables via Oracle. This is not sustainable and no proper pathway is in place. Delivery has to be arranged to patient's home. CHC does not provide hands on care so there is no clinical oversight. 21/06/2022 All patients are receiving their equipment so assurance that risks currently being managed. 08-22> A CHC and CYPCC Taks and finish group has been established to scope both the amount of equipment supplied and the process for how this is to be managed. This group will also ensure there is clear oversight of the management of consumables, and the supply of all specialist equipment for CHC and CYPCC Patients. This risk is now recommended for closure.	Escalated to senior managers and contact managers to review CLCH contract to allow them to recharge consumables to a separate CHC budget line for the complex CHC patients be agreed. Corporate staff supporting and ordering consumables via Oracle. This is not sustainable, and no proper pathway is in place. Delivery has to be arranged to patient's home.
472	26/08/2022	Milbourn, Nuala	IF we are not able to extend the current provider contract for the ICB and ICS websites beyond the agreed two year period (ending July 2024)... THEN we will not have time to achieve the development of the web ecosystem that we aspire to and will not be able to give teams the stability and continuity of service that they require given the time investment needed to populate content ....RESULTING in ineffective use of resources, lack of buy-in from services and the ICB not being able to maximise the potential of the web platform to significantly develop and enhance our web offering.	12	Taking forward discussions with digital primary care team, with the aim of identifying external primary care-related website functionality which could attract funding streams which could help to fund the contract extension beyond its current length. Discussions initiated and advice obtained from Contracts team with regards to contract extension	
473	01/09/2022	Milbourn, Nuala	IF the ICB does not actively and meaningfully involve and engage people and communities, so that they can truly shape and influence the development and commissioning of services, and work with all ICS partners to achieve this, THEN it will not meet its constitutional commitments and statutory requirements to hear and put the voices of people and communities (particularly those facing health inequalities), at the centre of decision-making and governance, RESULTING IN an insufficient understanding of communities' needs and their experience and aspirations for health and care, less effective services caused by less informed planning and decision-making, a reduction of public confidence, and an increased risk of legal challenge.	12	People and Communities Strategy sets out principles and a mechanism for the ICB to follow in meeting its statutory and constitutional responsibilities around involvement and engagement.. Task and finish group of patient voice volunteers, who have supported the NHS system for several years, have supported work to develop an ICB engagement and involvement approach. This is being drafted and will be shared with ICB Executive for consideration and sign-off. Co-production boards are in place in some ICS organisations and are being further developed across the ICS system. Partners such as Herts County Council and West Herts Teaching Hospitals Trust have co-production boards that will support the people and communities approach. South and West Herts Health and Care Partnership is establishing a co-production board with Healthwatch Hertfordshire. Networks of active patients across the ICB who are part of GP practice patient groups and other community groups. They regularly take part in information and engagement sessions. They also participate, as volunteers, in procurement processes, project groups and task and finish activities. Patients also lead on developing activities such as the Herts and West Essex Diabetes support group and Cancel out Cancer. ICB Board has endorsed a proposal for Patient Stories coming to Board. Numerous engagement projects in place across the ICB. Working group in the comms and engagement team meet fortnightly to oversee and ensure continued progress with each. A working group has been established (August 2022) to develop an ICP strategy engagement and communications plan.	People and Communities Strategy agreed but need to work to fully embed the principles of involvement, co-production and engagement into organisation practice across the ICB and translate these commitments into action and tangible outcomes. The ICB needs to widen its engagement reach beyond the group of interested patients who have formed the backbone of participation and involvement to date, particularly to increase connections communities experiencing health inequalities and/or digital exclusion.
474	06/09/2022	Turnock, Phil	IF Third-party prices rise due to increasing energy costs THEN HBL ICT will incur additional/unplanned costs from Third-party companies RESULTING IN increased costs for the HBL ICT partnership	12		
476	06/09/2022	Turnock, Phil	IF supply chain delays increase due to global distribution challenges THEN HBL ICT will not receive IT equipment in timely manner RESULTING IN delays to HBL ICT partner projects and users	12		

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:**	**23/09/22**	
Report Title:	**Governance Report**	**Agenda Item:**	**13**	
Report Author(s):	Simone Surgenor – Associated Director of Integrated Governance & Organisational Alignment Iram Khan – Corporate Governance Manager Shirley Potter – Programme Manager Leon Adeleye – Corporate Governance Manager Jas Dosanjh – Corporate Governance Manager Gay Alford – Governance & Senior Business Support Officer Anna Cason – Corporate Governance and Risk Manager			
Report Signed off by:	Michael Watson – Chief of Staff			
Purpose:	**Approval** ☒	**Decision** ☒	**Discussion** ☒	**Information** ☒
Report History:	The paper will take the Board through a sequence of governance related items, clearly referencing what actions are being sought from NHS Hertfordshire and West Essex Integrated Care Board.			
Executive Summary:	1.1 This is the third meeting of NHS Hertfordshire and West Essex Integrated Care Board. 1.2 The Board will be asked to consider the following: a) ICB Constitution update, for approval and final sign-off by NHS England. b) ICB Governance framework. c) Risk Register 1.3 No changes are proposed to the current ICB Governance Handbook, or delegation approved at Board in July, pending revisions due to be tabled at November's Board.			

Recommendations:

For approval –

- **ICB Constitution** – for the Board to support changes to the ICB Constitution as detailed in paragraph 2.1, and approve adoption following approval by NHS England.
- **ICB Governance Framework** –
    - In respect of demands on NEM time - that over the next course of all sub-committee meetings, frequency and quoracy requirements will be reviewed and agreed for updated Terms of Reference to be approved at November Board. This will include whether quoracy is based on the number of Non-Executive Members (NEM) and Partner Members being present, rather than just the NEMs as is at present.
    - Remuneration Committee – for Dr Ian Perry to become a member of the Remuneration Committee.
    - The Finance and Investment Committee – for Owen Mapley to become a member, and chair, of the Finance and Investment Committee.
-

For noting –

- **Risk Register** – for noting, alongside the development work.

Potential Conflicts of Interest:

Indirect	☐	***Non-Financial Professional***	☐
Financial	☐	***Non-Financial Personal***	☐
None identified			☐

*Paragraph 2.2.2 – Recommended revision to the ICB governance framework. Neither of the following with have their votes counted for:

Option 4 - Dr Nicolas Small

Option 5 - Owen Mapley

Further and in addition to the above, the items referenced cover a large core section of this Board and governance within the ICB. Therefore, conflicts have been addressed up to this point however members are asked to declare any conflicts prior to the meeting, in line the declaration sought at the beginning of this meeting, and through the course of this meeting should conflicts be identified. For any queries concerning Conflict, colleagues are asked to refer to the ICBs Conduct of Business (including Conflicts of Interest) Policy and/or contact the ICB governance team.

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

1. Executive summary

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

1.2 The Board will be asked to consider the following:

1) ICB Constitution update, for approval and final sign-off by NHS England.
2) ICB Governance framework.
3) Risk Register and updates.

1.3 No changes are proposed to the current ICB Governance Handbook, or delegation approved at Board in July, pending revisions due to be tabled at November's Board.

1.4 The points referenced above will be addressed in turn.

2 Items for Consideration

2.1 NHS Hertfordshire and West Essex ICB Constitution update – for support by the Board

2.1.1 Further to Schedule 2 of the Health and Care Act 2022, an Integrated Care Board must have a Constitution.

2.1.2 On 1st July 2022, HWE ICB adopted its Constitution having received formal approval for this document from NHS England on 1st June 2022.

2.1.3 On 13th September 2022, the ICB received notification that the following amendments be made to its Constitution:

- Section 1.4.7 (f) – Health and Care Act reference 'section 14Z44' corrected to read 'section 14Z45'
- Section 3.2.4 – Reference to the 'sections 56A to 56K of the Scottish Bankruptcy Act 1985' replaced with 'Part 13 of the Bankruptcy (Scotland) Act 2016'.
- Section 3.2.7 – 'A health care professional (within the meaning of section 14N of the 2006 Act)….'. First line updated to remove reference to section 14N of the 2006 Act and capital letters for 'Health Care Professional'. Line to read as follows 'A Health and Care Professional or other professional……..'.
- Section 7.1.1 – Reference to 'paragraph 11(2)' amended to 'paragraph 12(2)'
- Appendix 1 – Add definition of 'Health Care Professional' to the table. Definition to be added: 'An individual who is a member of a profession regulated by a body mentioned in section 25(3) of the National Health Service Reform and Health Care Professions Act 2002.

2.1.5 The Board is asked to support these amendments, for a submission highlighting the changes to be with NHS England by Friday 30th September. This submission, following guidance received by NHS England will be in the form of an email from the ICB's Chief Executive

Officer Dr Jane Halpin, confirming awareness of the changes. Not further documentation is sought bar a version of the Constitution with all changes highlighted.

2.1.6 Once formal approval of the Constitution is received the Board is asked to support its adoption for uploading on the ICB's public facing website.

2.1.7 A draft version of the Constitution will be placed on the ICB's website at https://hertsandwestessex.icb.nhs.uk/us/constitution-1

2.2 ICB Governance Framework

2.2.1 As referenced to the Board during its first formal meeting on 1st July 2022, there will be a need to continuously review and adapt the ICBs governance framework during its first year of operation. This section sets out the current challenges and gaps within the framework, with a series of options to be considered:

2.2.2 Current challenges

a) **Demand on NEMs Time**
Several of the NEMs have raised concerns about the current demands on their time- and in particular the number of meetings they have to attend. It is likely in coming months that this demand will increase as they begin to carry out more activity in relation to the committees they chair.

b) **Quoracy**
Quoracy of almost all of the sub-committees is predicated on NEM attendance, meaning that some committees which have two NEM members rely on 100% attendance from NEMs at all times to be quorate. This has already led to challenges in several sub-committees.

c) **Committee Chairs**
The Finance and Investment Committee is currently chaired by the Chair of the ICB. However, the committee has reached a view that it would be more appropriate for the committee to be chaired by a different member of the board, to maintain the chairs independence.

d) **Remuneration Committee Membership**
We had originally planned for a local authority partner member to be a member of this committee - however they have both suggested that they will not be attending this committee. One of the current NEM members has also indicated that they do not have the capacity to be a member of this committee. This leads to potential difficulties in ensuring quoracy.

2.2.3 Recommendations for the Board:

a) In respect of demands on NEM time - that over the next course of all sub-committees meetings, frequency and quoracy requirements will be reviewed and agreed for updated Terms of Reference to be approved at November Board. This will include whether quoracy is based on the number of Non-Executive Members (NEM) and Partner Members being present, rather than just the NEMs as is at present.

b) Remuneration Committee – for Dr Ian Perry to become a member of the Remuneration Committee.

c) The Finance and Investment Committee – for Owen Mapley to become a member, and chair, of the Finance and Investment Committee.

2.3 Risk Report and updates

2.3.1 Following the last report to this Board, work has continued in undertaking a route to branch check on all risks to:

1) Ensure historic risks that originally sat in the Clinical Commissioning Group registers and remained, with none being have been lost.
2) to bring all new risks into the new world providing an ICB perspective.
3) Map all risks and their progress through from Health Care Partnerships/Place to the ICB, and mitigate against the patient’s voice being lost; and
4) Support a programme of organisations development not just at Board level, surrounding Risk Appetite.
5) The ICB will also look to implement “heat mapping” against risks, to provide a clear visual presentation of how the risks is progressing with the mitigations in place; and
6) Where possible, to ensure the number of risks are reduced as following the transition of Clinical Commissioning Groups to the ICB, one observation made is that we have too many with some of these risks possibly needing to sit at project/working group level.

2.3.2 It should be stressed that this work is ongoing and includes checks and structures being mapped throughout the Hertfordshire and West Essex system, to support full transparency and assurance.

2.3.3 All operational risks with a score about 12 can be found at **appendix A.** The Board will note that following adoption of the ICBs Strategic Objectives, and Board Assurance Framework (BAF) will be produced for the November Board, encompassing Corporate Risks – the latter of which is pending final approval, for support and adoption by the ICB.

Hertfordshire and
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West Essex
Integrated Care Board

<table>
<tr><td rowspan="2">Meeting:</td><td colspan="2"><i>Meeting in public</i></td><td>☒</td><td colspan="4"><i>Meeting in private (confidential)</i></td><td>☐</td></tr>
<tr><td colspan="4">HWE ICB Board meeting held in Public</td><td colspan="2">Meeting Date:</td><td colspan="2">23/09/2022</td></tr>
<tr><td>Report Title:</td><td colspan="4">Committee Summary Reports</td><td colspan="2">Agenda Item:</td><td colspan="2">17</td></tr>
<tr><td>Report Author(s):</td><td colspan="8">Governance Leads, ICB</td></tr>
<tr><td>Report Signed off by:</td><td colspan="8">Simone Surgenor, Associate Director of Integrated Governance and Organisational Alignment</td></tr>
<tr><td>Purpose:</td><td>Approval</td><td>☐</td><td>Decision</td><td>☐</td><td>Discussion</td><td>☒</td><td>Information</td><td>☒</td></tr>
<tr><td>Report History:</td><td colspan="8">Not applicable</td></tr>
<tr><td>Executive Summary:</td><td colspan="8">Each ICB Committee has produced a summary document providing an update from their last meeting.

Audit and Risk Committee – Catherine Dugmore
Commissioning Committee – Gurch Randhawa
Population Outcomes and Improvement Committee – Gurch Randhawa
Finance and Investment Committee – Paul Burstow
Primary Care Board – Nicolas Small
People Board – Ruth Bailey
Performance Committee – Thelma Stober
Quality Committee – Thelma Stober</td></tr>
<tr><td>Recommendations:</td><td colspan="8">The ICB Board are asked to discuss and note the content of the committee summary reports</td></tr>
<tr><td rowspan="4">Potential Conflicts of Interest:</td><td colspan="2"><i>Indirect</i></td><td>☐</td><td colspan="4"><i>Non-Financial Professional</i></td><td>☐</td></tr>
<tr><td colspan="2"><i>Financial</i></td><td>☐</td><td colspan="4"><i>Non-Financial Personal</i></td><td>☐</td></tr>
<tr><td colspan="7"><i>None identified</i></td><td>☒</td></tr>
<tr><td colspan="8">Not applicable</td></tr>
</table>

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

Hertfordshire and
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Hertfordshire and
West Essex
Integrated Care Board

ICB Committee Summary Document

Audit and Risk Committee **Tuesday 2 August 2022**	
Key items discussed: ***(From agenda)***	• Purpose and orientation • Terms of Reference • CCG Legacy items and handover documents • CCG 3 month 22/23 accounts • Assurance Framework and Corporate Risk Register • External audit timetable and audit plan • Internal audit plan, progress report and recommendation • Local counter fraud workplan and progress report • Use of seal • Review of tender waivers, losses and special payments • Workplan
Key points made / Decisions taken:	• The Committee discussed the Terms of Reference, key areas included membership, including non-Execs and partner members, and quoracy. • The Committee reviewed and discussed the legacy document that had been handed over by the CCGs to the ICB. The document included key areas of risk to be taken forward including CHC, Risk Management, Cyber Security, Conflicts, and increasing requirements of ICBs in respect of IG and sustainability. • The Committee discussed and noted the current high level work relating to risk management including strategic and corporate objectives and the executive level input relating to risk appetite. Risk registers are being reviewed and this work will be informed by the objective setting and a shared understanding of risk appetite. Transition risk registers are being reviewed and discussions also focused on how the ICB will be working with system partners to ensure a shared understanding of current and emerging system risks. Process agreed relating to triangulating with other committees. The next committee will receive an update on risk management. • The committee discussed the outstanding internal audit (IA) recommendations handed over from the 3 CCGs which are progressing well. The IA plans for 22/23 were presented and discussed. • External audit requirements include some areas for which ICB duties and responsibilities continue to emerge from the centre, timetable and plan will come to the next committee. • Committee was not quorate and therefore the IA plan for 22/23 could not be approved, although work will continue in the interim until such time as the plan is approved.
Committees to note: **As example of information sought:** ***(Positive progress on numbers waiting***	• The points referenced above

for specialist CAMHS in-patient care (for MHLDA collab to note, for cross-ref by performance committee)	
Board to note: ***(Highlight quality oversight and identify where further work is required)***	No items required escalation to the Board. As agreed, the Terms of Reference will be circulated to Committee members for comment. A revised terms of reference will be presented to Board as NEM and partner membership needs further consideration.
Forward plan issues:	• None identified.
Date of next meeting	Tuesday 20 September 2022

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ICB Committee Summary Document

Commissioning Board **Thursday 08 September 2022**	
Key items discussed: ***(From agenda)***	• ADHD Backlog Business Case • Urgent and Emergency Care Dashboard (UEC) - Procurement Evaluation Report • Children and Young Person (CYP) Autistic Spectrum Disorder (ASD) Post Diagnostic Support • Hertfordshire and West Essex Area Prescribing Committee Report • Register of Healthcare Contracts Subject to Procurement Regulations and Guidelines. • Workplan
Key points made / Decisions taken:	• ADHD Backlog Business Case – approved on a non-recurrent basis pending further evaluation and work from the team on a sustainable funding source. • UEC Dashboard – recommendations approved, and proposed award. • CYP ASD Post Diagnostic Support - approved the decision to undertake an Invitation to Tender for the project in order to award a single-provider contract for the design, development, pilot and evaluation of an ASD post-diagnostic psychoeducational resource • The Committee approved: ○ The recommendations of HWE Area Prescribing Committee (APC) on mandatory NICE Technology Appraisal (TA) treatments and highlighted cost impact/pressures. ○ The recommendations on mandatory NICE TA fast track treatments and highlighted cost impact/pressures. ○ The recommendations of HWE APC for treatments not included in the NICE work programme and highlighted cost impact/pressures. • The Committee agreed to form a subgroup to look in more detail at the Contracts register, form a commissioning plan, and develop our ICS strategic commissioning function. • The Committee agreed to defer the November meeting from being held in public – this is to be kept under review in compliance with the ICB Constitution and duties.
Committees to note: **As example of information sought:** ***(Positive progress on numbers waiting for specialist CAMHS in-patient care (for MHLDA collab to note, for cross-ref by performance committee)***	• The Committee is to note the discussions and decisions above.

Board to note: ***(Highlight quality oversight and identify where further work is required)***	- The Committees revised Terms of Reference remain under review - The Committees Workplan is also pending final agreement but is in a developed state.
Forward plan issues:	- No forward plan issues identified.
Date of next meeting	10th November 2022

Hertfordshire and
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ICB Committee Summary Document

Population Outcomes and Improvement Committee **Wednesday 07 September 2022**	
Key items discussed: ***(From agenda)***	• Terms of Reference and Scope • Workplan • Strategic Priorities – Health Needs Analysis - Overview • Business intelligence and Population Health Management Platform

Key points made / Decisions taken:	• This Committee:
	  • Agreed – to meet on alternate months and use the intervening months to look at development and wider engagement. The workplan was revised to reflect this and circulated for comment.
	  • Discussed:
	  ○ Review of the Terms of Reference and scope – with suggested amendments for comment. This included reference to oversight of Anchor Institutions.
	  ○ The interpretation of data is telling us, specifically in the ways it can support this committee and the ICS. It was acknowledged that we do not have all data and cannot cover everything in one meeting.
	  ○ The Committee looked at how we develop a process to agree which parts of the system are already working on, or leading on, specific areas and how we can understand better our potential relationship with the Integrated Care Partnership.
	  ○ The Committee recognised that wider partner members will be present at future meetings, and it was suggested that there is a focus on inequalities work, linked to the role of the Voluntary Community Faith Social Enterprise sectors (VCFSE), and priorities identified, to give a shared understanding of the overall responsibilities of this Committee.
	  ○ It was agreed that work programmes need to be checked and challenged to provide assurance they are focusing on the right areas to deliver what is required.
	  ○ Challenges in Hertfordshire & West Essex and their differences, but equal importance. Equality and equity are important to everyone, especially those living in vulnerable circumstances.

Committees to note:
As example of information sought:
(Positive progress on numbers waiting for specialist CAMHS in-patient care (for MHLDA collab to note, for cross-ref by performance committee)
	• A summary was shared describing the demographic features of the population in Hertfordshire & West Essex and high-level health profiles and outcomes for different segments within the population.
	  • Compared to the national average:
	    • A lower proportion of the population are living in the most deprived 20% nationally.
	    • A higher proportion of the population is aged over 85 years
	  • A higher proportion of the population are of white or mixed ethnicity
	    • High level population health outcomes show that:

	• The average life expectancy is approximately 81 years of age for males and 84 years for females. Healthy life expectancy for males is 65.4 years and 65.7 years for females. • Variation exists between and within our communities, with people living in higher levels of deprivation experiencing higher levels of disability, disease, frailty and poorer health outcomes.
Board to note: ***(Highlight quality oversight and identify where further work is required)***	• The issues identified above:
Forward plan issues:	No forward plan issues have been identified.
Date of next meeting	Wednesday 02 November 2022

Hertfordshire and
West Essex Integrated
Care System

ICB Committee Summary Document

Hertfordshire and West Essex
Integrated Care Board

Finance and Investment Committee **Tuesday 9 August 2022**	
Key items discussed: ***(From agenda)***	• Declarations of interest • Meeting purpose & orientation • Membership and attendees • Risk Register • Terms of Reference • Reflections and feedback from the meeting
Key points made / Decisions taken:	• It was noted that the business of ICB committees and subcommittees has been discussed, especially to ensure they are well aligned. As part of this work, the FIC committee would reaffirm the Terms of Reference (ToR) and make suggestions to the ICB Board about any changes that might be needed to make its work fit with that of other ICB committees. • The FIC's role is to help the ICB achieve its goals by keeping an eye on and making sure that a strong, viable, and long-term financial plan for the system is made. • The Performance, Quality, Commissioning, and FIC committees need to work together to make sure there is enough oversight and to avoid having the same conversations twice. • FIC should get a report on how our organisation is doing in terms of its efficiency, productivity, and results. • As a committee, we do not see the distinction between stable and non-stable as set out in the ToR. Therefore, for it not to be defined in terms of "stable" and "not-stable," the ToR would need to be rewritten so that it has only one list. • Therefore, work needs to be done to look at the rhythm of the committee over the course of the coming year and how we can shift it during this year to align with the financial reporting dates. • There will be further discussions about who will take on the role of FIC chair, as the chair is to be independent. • Further work is to take place across all committees to consider the balance of non-executive and partner members. • A financial plan must be developed alongside a 5-year plan for the ICB. This will be aligned with the workforce plan to get plans delivered by March 2023. • The 10-year forward view on capital would come to the FIC, as well as the 5-year plan for revenue.
Committees to note: **As example of information sought:** ***(Positive progress on numbers waiting for specialist CAMHS in-patient care (for MHLDA collab to note, for cross-ref by***	• Positive progress on the committee’s forward planner (draft) was made. It includes it annual cycle of business. • It was agreed that some items on the forward planner will be fed into the Audit committee around how we are managing financial risks. Some audit reports will come to the FIC.

performance committee)	
Board to note: ***(Highlight quality oversight and identify where further work is required)***	• The ToR is being re-drafted, and committee members are being reviewed, including the chair of the FIC committee.
Forward plan issues:	None identified
Date of next meeting	14 September 2022

Hertfordshire and West Essex Integrated Care System

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Integrated Care Board

ICB Committee Summary Document

People Board
Tuesday 05 July 2022

Key items discussed: ***(From agenda)***	• Workforce Transformation Programme • People Board - Future Direction – Part 1 (Innovate For Action)
Key points made / Decisions taken:	**Board expectations and priorities;** the committee discussed the national 10 people function outcomes and worked to identify the shared critical priorities of the system to focus on creating the most significant difference. These areas were agreed to be critical as part of the developing People Strategy, and members agreed that the Board will be responsible for leading and contributing to transformational work in these areas. 1. System workforce planning 2. Workforce supply including attraction 3. Staff retention 4. Equality, Diversity and Inclusion **Board development and impact** 1. Building on current achievements and partnerships 2. Developing membership and roles that drive impact 3. Developing metrics to measure impact at a system level 4. Alignment to the 4 priorities of the ICB
Committees to note: **As example of information sought:** ***(Positive progress on numbers waiting for specialist CAMHS in-patient care (for MHLDA collab to note, for cross-ref by performance committee)***	• Initial operational planning tracker shared – and to be updated for September meeting • Sickness absence amongst secondary care providers continuing to rise month on month – last reported figures at 4.8% • HWE an outlier relating to turnover within the region – this could partially be caused by contracting requirements of the Mass Vaccination campaign within Herts Community Trust. • Social Care provider and staff survey published across the Eastern region giving improved insight to staff and provider motivations.
Board to note: ***(Highlight quality oversight and identify where further work is required)***	• People Strategy and Board to be further refined to be fit for purpose in addressing workforce performance related issues and achieve strategic transformation. • Further engagement across the system to be undertaken to feed into the strategy • Draft people strategy to be shared at next People Board
Forward plan issues:	• Develop a clear understanding of the current and currently foreseeable future workforce – through robust workforce intelligence. • Build and develop workforce capacity and capability to enable the region to meet population health needs. • Develop innovative ways to ensure the supply of the right workforce, with the right skills and knowledge at the right

	time to deliver high quality patient care. • Support implementation of the priorities set out in both the national and local People Plans – forward planner requirements will be aligned to workstream priorities identified within the People Plan.
Date of next meeting	Thursday 29 September 2022

Hertfordshire and
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Integrated Care Board

ICB Committee Summary Document

HWE ICB Primary Care Board (PCB) Thursday 11 August 2022	
Key items discussed: ***(From agenda)***	• Terms of Reference • Primary Care Commissioning Committee Legacy Document • Outline of published GP Patient Survey results • Reflections of the Clare Fuller Report • Primary Care Highlight report • Risk Register
Key points made / Decisions taken:	• Amendments were made to the Terms of Reference noting the role of the PCB and shaping its direction of travel. It is important to align with Population Health Management and how sub-groups of the PCB have clear remit to support the objectives of the PCB. It was agreed for this to be names PCB and to meet bimonthly in public and private. Membership is evolving with work underway to identify patient representatives as attendees of the board; further discussions on opportunities to consider Public Health as commissioner of services from primary care board and as each place primary care leadership is established to include them. • PCB discussed the high level summary GP Patient Survey results which were published end of July noting that a detailed discussion report including an outline an action plan will be presented to the committee in September. • Clare Fuller Report – PCB discussed the findings of the report and noted how this should be discussed with the CDs/practices and primary care providers over the next few months following appointments of the Primary Care transformation leads. • Highlight report – providing an oversight of governance structure, remit of PCB and PCCC, clinical leadership appointments, development of Primary Care Strategy, delegated functions and commissioning. • Current risk registers are a mixture of issues and risks therefore the primary care team are working through identifying the issues and risks and working through mitigations.
Committees to note: **As example of information sought:** ***(Positive progress on numbers waiting for specialist CAMHS in-patient care (for MHLDA collab to note, for cross-ref by performance committee)***	• GP Patient Survey results in line with national and East of England average in most areas. However, key is not to be complacent and a multidisciplinary approach to develop the action plan as to how we build on improving access and patient experience across HWE; learning from areas within and HWE and outside on good practice. • Work underway on the submission of Pre-delegation assessment framework for Dental, Optometry and Pharmacy to NHSE/I for submission early September 2022. • Committee to note Herts and West Essex ICB will be the host community pharmacy and optometry contracts on behalf of East of England. •

Board to note: ***(Highlight quality oversight and identify where further work is required)***	• Proposed revised Terms of Reference; though to note further discussion with public health and recruitment of patient • Submission of Pre-delegation assessment framework for Dental, Optometry and Pharmacy to NHSE/I by 9/9/22 • Committee to note Herts and West Essex ICB will be the host community pharmacy and optometry contracts on behalf of East of England.
Forward plan:	• Set up of the subgroups with remit • Discussion on Primary Care Access Action Plan • Deep Dive in Primary Care to inform further action plan
Date of next meeting	Thursday 22 September 2022

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Integrated Care Board

ICB Committee Summary Document

Performance Board **Wednesday 13 September 2022**	
Key items discussed: ***(From agenda)***	- Terms of Reference - Performance Overview - Primary Care Deep Dive - Committee Workplan
Key points made / Decisions taken:	- The Committee has agreed to move the sequence of meetings from monthly to every other month – thus supporting performance reporting across the system. - The Committee sought further assurance around improvement plans in Urgent and Emergency Care. Further assurance will be sought through: ○ a discussion of the Hertfordshire and West Essex ICB winter plan – this plan is currently being finalised; ○ proposed trajectories for improvement; and ○ a self-assessment of the plan at its next meeting in November. - The Committee agreed to escalate pressures in respect of activity and acuity in Mental Health. Whilst there are improvements plans in place, the committee
Committees to note: **As example of information sought:** ***(Positive progress on numbers waiting for specialist CAMHS in-patient care (for MHLDA collab to note, for cross-ref by performance committee)***	- Primary Care Deep Dive – key points: - The Committee received a comprehensive deep dive around the services provided within primary care, workforce issues and pressures, primary care access, digital and estates, and places for improvement. - Further deep dives will be structured around the inclusion of: context; issues to be highlighted to the Committee; and, the support required.
Board to note: ***(Highlight quality oversight and identify where further work is required)***	- The items referenced above.
Forward plan issues:	- None identified.
Date of next meeting	9th November 2022

Hertfordshire and
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Integrated Care Board

ICB Committee Summary Document

Quality Committee – Thursday 1 September 2022	
Key items discussed: ***(From agenda)***	• Quality Committee Governance update including terms of reference • ICS Quality Strategy • ICB Escalation Report • National Patient Safety Strategy update • Safeguarding Adults Annual Report Herts and West Essex • Safeguarding Children’s Annual Report Herts • Pharmacy and Medicines Optimisation Annual Report Herts and West Essex • Minutes from sub-groups • Joint ICB Risk Register
Key points made / Decisions taken:	• Appointment of the Vice Chair to the committee was formally ratified. • Quality committee terms of reference were agreed and recommended for ICB Board approval. • In line with the National Quality Boards guidance, the committee noted that there needs to be clear and credible strategy for improving quality, centered on patient involvement. The committee will seek assurance and note progress. • Risk register was discussed in detail with a number of risks recommended for closure. Some risks have been re-drafted with those relevant to system partners.
Committees to note: **As example of information sought:** ***(Positive progress on numbers waiting for specialist CAMHS in-patient care (for MHLDA collab to note, for cross-ref by performance committee)***	• Safeguarding Children (Hertfordshire): Significant number of cases outside recommended timescale of 6 months for Child Death Overview Panel (CDOP) review. A late review of cases increases that trends or risks could be missed and reduce opportunity for timely intervention. This has been recorded on both the ICB and Hertfordshire County Council risk registers. Additional clinical support is place from within the Designated team to support compliance within 6 months. A revised delivery model has been proposed to increase capacity and reduce inequity between unexpected/expected deaths awaiting agreement. • Multiagency Safeguarding Hub) (MASH review by the Independent Scrutineer of Hertfordshire Safeguarding Children’s Partnership (HSCP) following the publication of Findings from the Child Protection in England report into the deaths of two young people. The MASH review identified a business case for increased health capacity for 6 months. Challenges in recruitment to posts plus longer-term requirements will require additional business case to HWE ICB.

	- The recurring theme of workforce related risks (recruitment, retention and vacancy rates) across a range of service settings within the quality reports including Maternity services, Community and inpatient mental health, and Hospice settings. The Committee discussed the range of settings affected and noted that whilst individual organisations were taking proactive steps to manage the impact on service delivery, further consideration is needed at ICB/Regional level.
Board to note: ***(Highlight quality oversight and identify where further work is required)***	- ICB risks that have been recommended for closure.
Forward plan issues:	Not applicable
Date of next meeting	Thursday 03 November, 13:00

Hertfordshire and West Essex Integrated Care System

NHS
Hertfordshire and West Essex
Integrated Care Board

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<tr><td rowspan="2">Meeting:</td><td colspan="3"><i>Meeting in public</i></td><td>☒</td><td colspan="3"><i>Meeting in private (confidential)</i></td><td>☐</td></tr>
<tr><td colspan="4">HWE ICB Board meeting held in Public</td><td colspan="2">Meeting Date:</td><td colspan="2">23/09/2022</td></tr>
<tr><td>Report Title:</td><td colspan="4">EPRR Annual Report</td><td colspan="2">Agenda Item:</td><td colspan="2">15</td></tr>
<tr><td>Report Author(s):</td><td colspan="8">Amanda Yeates, Head of EPRR</td></tr>
<tr><td>Report Signed off by:</td><td colspan="8">Elizabeth Disney, Director of Operations</td></tr>
<tr><td>Purpose:</td><td>Approval</td><td>☒</td><td>Decision</td><td>☐</td><td>Discussion</td><td>☐</td><td>Information</td><td>☒</td></tr>
<tr><td>Report History:</td><td colspan="8">N/A</td></tr>
<tr><td>Executive Summary:</td><td colspan="8">This paper contains the annual report to Board in public on organisational Emergency Preparedness, Resilience and Response (EPRR). The report includes the results of our self-assessment against NHSE Core Standards for EPRR for 2022 which show us to be “substantially compliant.”
This reflects the ICB’s transition to new responsibilities as a category 1 responder.
*All embedded documents are available separately</td></tr>
<tr><td>Recommendations:</td><td colspan="8">The Board is being asked to:
▪ Note the information in relation to Emergency Preparedness, Resilience and Response (EPRR) for annual assurance and the work undertaken during the last 12 months
▪ Note the planned work for 2022/23
▪ Approve the EPRR core standards and deep dive assurance self - assessment recommendation of ‘substantially compliant’ for 2022</td></tr>
<tr><td rowspan="4">Potential Conflicts of Interest:</td><td colspan="3"><i>Indirect</i></td><td>☐</td><td colspan="3"><i>Non-Financial Professional</i></td><td>☐</td></tr>
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Impact Assessments (completed and attached):	***Equality Impact Assessment:***	N/A
	Quality Impact Assessment:	N/A
	Data Protection Impact Assessment:	N/A
Strategic Objective(s) / ICS Primary Purposes supported by this report:	***Improving outcomes in population health and healthcare***	☒
	Tackling inequalities in outcomes, experience and access	☐
	Enhancing productivity and value for money	☐
	Helping the NHS support broader social and economic development	☐
	Successfully complete and embed the transition of staff and functions from the three clinical commissioning groups into the Integrated Care Board	☐
	Develop the ways of working and profile of the Integrated Care System to ensure that its operating model is capturing the opportunities presented by closer system working	☒

1. Executive summary

This paper provides annual assurance to the Board that the HWE Integrated Care Board (ICB) meets the NHS Emergency Preparedness, Resilience and Response (EPRR) statutory requirements outlined in the Civil Contingencies Act (2004) and the NHS Act (2006) as amended by the Health and Social Care Act (2012) and the Health and Care Act (2022), as required by the NHS England EPRR Framework (2022). It also outlines the results of the ICB's initial self-assessment against the annual NHSE/I Core Standards for EPRR of "substantially compliant" and details the work that will be undertaken over the next 12 months to achieve full compliance against these standards next year.

2. Background

EPRR is a core function of the NHS and is a statutory requirement of the Civil Contingencies Act (CCA) 2004. Responding to emergencies is also a key function within the NHS Act (2006) as amended by the Health and Social Care Act (2012) and the Health and Care Act (2022).

The EPRR framework being embedded at HWE ICB ensures that we are prepared for any service interruption or emergency that may occur, which threatens our ability to exercise our civil protection and/or statutory functions, as required as a Category 1 Responder by the Civil Contingencies Act 2004. The role of HWE ICB relates to responding to potentially disruptive threats and the need to take command of the local NHS system, as required, during emergency situations. These are wide ranging and may be anything, including, for example, extreme weather conditions, an outbreak of an infectious disease, a major transport accident or a terrorist incident; this is not an exhaustive list. HWE ICB must ensure that it can continue to deliver critical services, support the local community and partner organisations before, during and after an emergency.

This report summarises the EPRR work that has been carried out in 2021/22 by Herts Valleys, East and North Herts and West Essex CCGs prior to transition, and also by the ICB post-transition, to ensure that HWE ICB meets its legal obligations in relation to EPRR.

In addition to this, HWE ICB is required to self-assess against the NHSE/I Core Standards for EPRR annually (as were the 3 CCGs prior to transition) in order to assure NHSE/I that the ICB has appropriate EPRR arrangements in place. Details of our self-assessment are included within section 6 of this report

3. Incidents

The response to the coronavirus pandemic has remained the priority. Although the COVID-19 response reduced to level 3 in March 2022, HWE has remained in command and control maintaining situational awareness and oversight. In addition to this, there have been a number of other incidents within the past 12 months running concurrently which have required a response from the CCGs and the newly formed ICB. Details of these are included in appendix A, together with information about lessons learned from formal debriefings and how changes to address these will be embedded to improve resilience in the future.

4. Risks / mitigation measures

Individual CCG EPRR risks were reviewed, amalgamated and incorporated into a single EPRR team risk register using DATIX, following transition. These risks will be reviewed on a regular basis going forward to ensure that they continue to be appropriately managed.

In addition to this work, the Hertfordshire Local Health Resilience Partnership (LHRP) has signed off the following in order to ensure appropriate EPRR risk mitigation and emergency preparedness in relation to key health risks logged on the Local Resilience Forum Community Risk Register, which score high and very high:

- LHRP 3 year exercise plan (2022/4) – see section 4.2
- LHRP ICS Training plan (2022/3) – see section 4.3
- LHRP 3 year strategy (2022/4)

Hertfordshire LHRP 3
year Strategic Plan 20

4.1 EPRR Plans

Following transition on 1 July 2022, the following HWE ICB plans are being implemented to ensure emergency preparedness; these plans replace those previously in place for the 3 individual CCGs

- HWE ICB EPRR policy
- HWE ICB Business Continuity policy and plan
- HWE ICB Incident Response plan
- HWE ICB Severe Weather plan
- HWE ICC plan

4.2 EPRR Exercising

One of the ways in which we can ensure staff are capable and aware of their roles and responsibilities during an incident is to regularly exercise emergency plans.

Planned exercises this year have been limited due to the ongoing corona virus pandemic and the fact that key EPRR staff have been involved with the response in some way, either directly or indirectly. However, the incident response itself negates the need for exercising those areas which are covered by that response. Having said that, West Essex, Herts Valleys and East and North Herts CCGs have participated in a number of exercises during the past 12 months in order to ensure compliance with statutory exercise requirements as they are routinely using emergency plans and involved in an incident response. Please see appendix B for specific details of the exercises undertaken, the learning taken from these and how changes have been implemented and embedded as a result of this to improve future responses.

The LHRP has now approved a full 3 year exercise plan which will help to ensure that HWE ICB continues to meet it's statutory exercise obligations until 2024. This is a live document and additional exercises will continue to be added as appropriate.

LHRP 3 year exercise
plan and tracker 22-2

In addition to the exercise plan, HWE ICB has an internal communications testing plan to test internal communications at regular intervals. As part of this plan, an out of hours communications test was carried out at East and North Herts place base at 6pm on 25 July 2022 and the report below outlines the results. Similar out of hours communications testing is planned for both West Essex and Herts Valleys place bases later this year. Regular external testing of our communications channels is carried out by NHSE/I, with the last test being an in-hours test carried out on 21 July 2022.

ENH Place - Excercise
Moonlight FINAL V1.0

Furthermore a "SITREP" test was conducted internally by the HWE ICB EPRR team on 18 August 2022.This test was conducted essentially to test the effectiveness of the new SBAR situational reporting system and the results of this testing are currently being collated into a short report.

4.3 EPRR Training

The ICB co-ordinates the annual training plan across the Integrated Care System (ICS) and, following the annual training needs assessment, the plan for 2022/23 now incorporates the requirements of the Minimum National Occupational Standards for EPRR. Specific details of training currently available for ICB staff are outlined in the plan itself (see attached) and the staff log indicates individual compliance with mandatory training.

ICS Training Plan
2022-23 V6.xlsx

On-call, duty manager and ICC training are in-house training sessions and are run throughout the year as needed and can be adapted to be delivered remotely if needed.

5. ICB transition check list

HWE ICB was required by NHSE/I to complete the ICB transition checklist for submission in June 2022. This required the ICB to self-assess against a list of criteria to provide assurance that relevant arrangements for EPRR were in place to facilitate the CCGs transition to an ICB on 1 July 2022. HWE ICB was able to provide total assurance that all criteria would be met, see below.

B1355_ii_EPRR
Transition to ICBs EP

6. NHSE/I Core Standards for EPRR self-assessment

HWE ICB has self-assessed its current emergency planning arrangements against the NHS Core Standards for EPRR as “partially” compliant for 2022.

Compliance against each standard has been assessed by the EPRR team and signed off by the Director of Operations (Accountable Emergency Officer). The statement below provides an overview of HWE ICB compliance for the NHS Core Standards for 2022/23.

Compliance Statement

The Core Standards with which the ICB has to comply have been updated this year following the COVID response. In addition, the ICB needs to demonstrate additional compliance as a new category 1 responder this year, and therefore full compliance was not anticipated.

HWE ICB currently fully meets 42 requirements of the 47 core standards across the nine domains applicable in this year’s (2021-22) core standards submission and was partially compliant with 5 of the standards. However, work is being undertaken at the moment to ensure that 4 of the standards marked as partially compliant can be changed to fully compliant at the peer review of our self-assessment with NHSE/I on 20 October 2022. While full compliance with 4 more of the core standards provides increased assurance around the ICB’s EPRR activities, it will not improve our overall score from “substantially” compliant. This is because, to achieve an overall score of “fully” compliant, organisations must be compliant with 100% of the individual core standards. .

Of the 5 core standards where we have only been able to demonstrate partial compliance, 3 of these are because NHSE/I region emergency plans / agreements require updating. This has been highlighted to NHSE/I as part of our submission.

Domain	**Self-assessment rating**
Governance	FULL
Duty to assess risk	FULL
Duty to maintain plans	PARTIAL
Command and Control	FULL
Training and exercise	FULL
Response	FULL
Warning and informing	PARTIAL
Co-operation	PARTIAL
Business Continuity	FULL
Overall rating	PARTIAL

This year's "Deep Dive" was in relation to Shelter and Evacuation. HWE ICB was fully compliant with 8 of the 8 deep dive criteria and therefore we can demonstrate full compliance in relation to this. However, it should be noted that the results of the "Deep Dive" do not affect the ICB's overall core standards self-assessment rating.

Full details of the HWE ICB core standards submission can be found below

B1069_ii_NHS core standards for EPRR_Ju

An action plan has been put in place to ensure that the ICB achieves full compliance against the NHSE/I Core Standards for EPRR next year. Please see appendix C.

7. Recommendations

Based on the evidence that the ICB is able to provide, as detailed in the submission spread sheet, it is recommended that the ICB self-assesses against the NHSE/I Core Standards as "substantially" compliant for 2022.

8. Conclusion / Next Steps

Next steps in relation to the NHSE/I core standards submissions will be to:

- Peer review the core standards self-assessments submitted by providers and agree their scoring in order to produce an overall core standards submission for NHSE/I which represents the overall position of the ICS. The LHRP will be asked to approve this before it is submitted to the NHSE/I regional team on 4 November 2022.
- Progress our core standards action plan over the next 12 months with a view to achieving full compliance for 2022 2023.

In relation to EPRR generally, key priorities going forward are:

- The Accountable Emergency Officer (AEO) and the EPRR team for the HWE ICB will focus on amending/standing down existing COVID command and control arrangements in line with NHSE/I requirements. This will reflect a hybrid approach of business as usual and some Command and Control to maintain situational awareness and oversight as COVID continues to circulate.
- Transitioning the Incident Control Centre (ICC) to a permanent system operations centre (SOC) for the HWE ICB; we are still awaiting direction from NHSE/I on the operational requirements for this.
- Reviewing the on-call functions across the HWE ICB.
- Moving the current interim EPRR team structure to a permanent structure.
- Reviewing best practice across the 3 previous CCGs and implementing this into HWE ICB EPRR processes and procedures
- Ongoing preparation work required for the upcoming COVID public inquiry; we are still awaiting further information about the inquiry to understand the level of evidence, if any, that will be required at ICB

level. The ICB will need to appoint a COVID-19 public inquiry lead, details of this role will be established once the requirements of the inquiry are clear for ICBs.

- Reviewing business continuity arrangements, aligning to new team structures within the ICB and enhancing arrangements due to the heightened risk of cyber security incidents and our reliance on Microsoft Teams.
- Continuing to ensure that all ICB EPRR plans/policies/arrangements align to the new NHSE EPRR framework
- Ensuring lessons from incidents and exercises are learned and any necessary changes to processes and procedures are implemented
- Maintaining a watching brief of ongoing and potential incidents, such as Monkeypox outbreak, potential strikes in all sectors, fuel protests, supply chain issues, cost of living rises and COVID, infection increase, other high consequence infectious diseases, geopolitical instability, UK political instability and cyber security incidents.

Appendix A – Incidents

3.1 COVID – January 2019 (ongoing)

On 31 December 2019 a novel coronavirus which caused serious respiratory infection was identified and referred to as Coronavirus or COVID19. The first cases of COVID19 were diagnosed in the UK in late January 2020. The NHS has been in incident response mode since this time, with fully functioning command and control and fully operational Incident Coordination Centres responsible for coordinating the day to day incident response.

Underpinning all efforts to manage the incident has been a co-ordinated communications response, managing incoming requests for information from stakeholders and media interest, as well as ensuring a constant flow of consistent information both internally and externally. HWE ICB has worked with both Herts and Essex Local Resilience Forums and the local health economy via Strategic Co-ordination and Tactical Co-ordination groups and regional calls chaired by NHSE/I to assist with managing the response to the COVID19 pandemic.

The 3 individual CCGs conducted a number of debriefs and subsequent action plans (available on request) during this time to establish the aspects of the response that went well and those that didn't go so well so that we could implement learning for the future. These fed into a wider ICS debrief (see below) which was then discussed at the Herts and Essex Local Health Resilience Partnerships (LHRP). The Herts LHRP subgroup is now in the process of co-ordinating an actions list across the system so that we can show how COVID learning has been embedded. A working group has also been established from across the ICS to discuss the results of the debrief and identify what might be done differently in future now that the ICS is established.

LHRP Debriefing
Slides v6.pptx

3.2 Afghan Evacuation - August 2021

In August 2021 the UK supported the relocation of people from Afghanistan. These people were a mix of Afghan Nationals returning under the Afghan Relocations and Assistance Policy ARAP (Interpreters and their families), UK Passport Holders/British citizens, British Embassy employees, Military Personnel and Third Country Nationals. As Afghanistan was a Red List Country, all arrivals - other than those who qualified for an exemption – were required to quarantine in one of the Managed Quarantine Service (MQS) facilities.

The nominated CCG EPRR and primary care leads for this were part of the Tactical Coordinating Groups convened to discuss the specific support that relocated people may need on arrival in the UK. In collaboration with local providers we were able to ensure that appropriate mental health, maternity, routine vaccination, GP, prescription and safeguarding services (amongst many other things) were put in place. The EPRR place based leads for Herts and west Essex produced separate geographically centred Standard Operating Procedures for MQS hotels which detailed local pathways and services (not just restricted to health) and contacts. CCG staff also took part in the Hertfordshire TCG debrief led by police. This has yet to be signed off by the police and distributed but once received, we will look at any lessons that can be learned by the local health system and ensure that these are implemented via robust action plans.

3.3 Fuel

(a) Shortages – October 2021 and March 2022

In September 2021 and March 2022 there were issues around fuel supply disruption. These did not directly affect HWE ICB but did have some impact on service providers (more so in west Essex, impacts in Hertfordshire were very limited and were effectively managed by providers implementing their business continuity plans). In Hertfordshire, the CCG ensured communication with our providers via the Heath Economy Tactical Coordination Group so that we maintained oversight of any potential difficulties and could offer support if required.

In west Essex, the fuel supply disruption was more significantly affecting partner service delivery, particularly for Health & Social Care so a formal Fuel Advisory Group was convened in September 2021.

In West Essex, the Fuel Advisory Group closed in October 2021 and the Essex Resilience Forum (ERF) formal debrief was undertaken. The following recommendations were made as a result of this debrief and are being taken forward by the ERF:

1. Create an ERF Fuel Supply Forum, similar to that of the COMAH Forum.
2. Production of an ERF Fuel Disruption Plan that covers the continuum from BC, ERF and the National Fuel Plan.
3. Define processes to trigger ERF response arrangements.
4. Review the garages that are listed in the national fuel plan, are they still current and viable? *Creating hard plans for each location so if required they can be activated quickly.*
5. Peer review of ERF partners BC plans and provide recommendations for them to update their plans.
6. Run an exercise to validate the new process.

(b) Just Stop Oil Protests – February 2022 (ongoing)

Essex Police held TCGs to brief Resilience Forum members to ensure that partners were aware of the potential difficulties which could be caused and to share the latest intelligence. In Hertfordshire, this information is shared at routine scheduled Buncefield Safety Group Meetings which are chaired by Herts Local Resilience Forum (LRF). Just Stop Oil has so far taken direct action against art galleries and the Buncefield Oil depot, as well as protesting at the Silverstone racetrack during F1 weekend. Historically, neither the 3 CCGs or now currently HWE ICB have been required to take any action in relation to the protests. However, HWE ICB will continue to monitor intelligence received in case this situation changes and action is required.

3.4 Storm Eunice – February 2022

The CCGs were directly involved in local system preparations for Storm Eunice and attended various preparation meetings including the Regional Health Resilience Forum chaired by NHSE/I and Strategic or Tactical Coordinating Groups, in order to share situational awareness and identify any ongoing risks to public safety so impacts associated with this could be minimised. Local health system conversations in relation to preparation for the storm also took place and the CCG Incident Control Centres coordinated the distribution of communications and information from the Met office to service providers. The 3 CCGs, together with service providers were able to manage this incident without any significant disruption by implementing business continuity plans where required. Command and control arrangements were stood up to maintain oversight of the incident response and the CCG sent an email to all staff recommending that they work from home on the day of the storm if possible to minimise any risk to staff safety. Subsequently, Storm Eunice did not have any significant impact on the CCGs.

3.5 Ukraine – February 2022

On 24 February, Russia began military action against Ukraine and a large number of the population were displaced. The Home Office announced changes to visa rules to allow those fleeing Ukraine to come to the UK via the Home Office Visa Sponsorship and Family schemes. In Hertfordshire, work to accommodate the health needs of people arriving from Ukraine has been mainly led by primary care team in line with the work they already undertake as business as usual for refugees, without significant EPRR input. Regular planning meetings are held, chaired by Herts County Council, with representatives from across the ICS attending.

In west Essex, a weekly TCG was set up under the ERF chaired by Essex County Council’s Consultant in Public Health. Health continues to be represented by Essex ICB members from EPRR, primary care, children’s safeguarding and UKHSA. Sub-groups for ports of entry, health, welcome, wellbeing & welfare, housing assurance, finance and communications are established. With services following the primary care guidance, in that any new registration at a GP practice acts as a gateway onwards with enhanced new patient assessment, there has been no requirement for the health sub-group to meet for some time now; this is however regularly monitored by the TCG.

3.5 Lassa Fever – April 2022

A regional major incident was declared in response to positive Lassa Fever cases in the East of England. This resulted in the closure of critical care beds at Cambridge University Hospitals and the Neonatal Intensive Care Unit at Luton and Dunstable hospital. This meant there was a need to divert services to other acute trusts in the region. The CCG's Incident Coordination Centre managed the coordination of the distribution of information from NHSE/I and UK Health Security Agency (UKHSA) to providers and command and control was stood up to maintain oversight and situational awareness. However, HWE ICB was not directly impacted by this incident.

3.6 Monkeypox – May 2022 (ongoing)

An initial outbreak of Monkeypox occurred in the UK in May 2022, initially linked with travel to Africa. Since then, further cases have been identified with no such link. UKHSA have been working to stop the virus spreading widely because a small number of people who get infected will be seriously unwell and the disruption and pain it cases can be significant. Command and control is currently in place and the Incident Coordination Centre is managing the distribution of situational awareness, guidance and appropriate patient pathways to service providers across the health system. The ICB's Infection Control team has been working in conjunction with UKHSA as part of the response to Monkeypox, arranging for GP testing for paediatric close contacts / suspected cases and for post exposure vaccination of a nursery in east Hertfordshire, developing and implementing new paediatrics pathways in conjunction with Commisceo as a consequence of this.

As this incident is still ongoing, a post-incident debrief has not yet been undertaken.

3.7 Heatwave – July 2022

In July temperatures broke previous known records, recording 40 degrees Celsius in many areas. According to the Met Office, no fewer than 34 locations around the United Kingdom exceeded the country's previous highest temperature of 37.8 Celsius, set in 2019.

Command and control was put in place, Strategic Coordinating Group meetings held to prepare for the heatwave and an extraordinary LHRP subgroup was stood up to coordinate the local health system response. As a result of this meeting a resilient system communications plan was implemented to mitigate against the potential loss of ICT due to concern about a number of IT servers overheating. HWE ICB Incident Control Centre coordinated the distribution of communications from the Met Office, Herts County Council and NHSE/I to service providers. The ICB also liaised closely with acute trusts to address capacity issues in Urgent and Emergency Care, which were already an issue due to COVID and exacerbated by the excessive heat.

HWE ICB EPRR team is currently communicating with those ICB staff involved with the heatwave response to facilitate a debrief so that we can ensure we capture any learning from the response appropriately. It is planned that this will feed into a wider system debrief so that we can ensure any necessary improvements to future heatwave responses are implemented for the future.

3.8 Operation Silver Puncture – July 2022 (ongoing)

Advanced, a third-party software supplier, advised that they had been subject to an external cyber incident as a result of a ransomware attack. While an investigation was carried out Advanced isolated all services and took them offline to mitigate the risk of further impact. This meant that users (including the 111 service and some urgent care centres) were not able to access the Adastra clinical patient management system. There was no immediate cyber security threat to NHS systems identified as a result of this ransomware attack. The attack was not targeted against the NHS, rather the third-party software provider.

While Advanced worked to resolve their software problems, the NHS immediately put in robust defences to protect its own networks, in line with cyber security advice that had been widely circulated to data leads, digital and cyber security teams. The National Cyber Security Centre supported Advanced with the investigation and response to the cyber-attack. The priority for the NHS was the knock-on impact of the Adastra system being offline, particularly as this related to referrals and access to patient records and several community providers were unable to use e-financials software for purchasing/payroll.

The services within Herts and west Essex that have been impacted have embedded tried and tested business continuity measures to ensure that services to patients are still available. Unfortunately, these measures are more labour intensive and as a result services, including NHS 111, GP out of hours and Urgent Care services, have been heavily impacted and therefore extremely busy. This incident has been managed nationally by NHSE/I, with HWE ICB maintaining local oversight.

NHS digital teams have worked with Advanced to bring services back online, with NHS 111 and Urgent Care Centres being prioritised. This has required NHS organisations to balance the potential operational And clinical impact of continuing with business continuity arrangements against the potential cyber security risks of re-connecting to systems and guidance was issued by NHSE/I in relation to reconnection. Recovery plans are being put into place by affected organisations to enable them to move from business continuity arrangements back to business as usual.

There is an ongoing investigation into the incident both looking at the cause and potential impacts around cyber and data security.

Appendix B – Exercises undertaken 2021/22

4.2.1 Exercise Extremis

Exercise Extremis was a resilience tabletop exercise designed to test absolute worst case scenarios and rehearse the responses, with the following objectives:

- to ensure that on-call managers understand local and ICS escalation triggers, and how and when to activate them
- to ensure that 'in extremis'/'OPEL 4+' actions can be appropriately implemented should the need arise
- to clarify activation triggers and governance requirements for different 'in extremis' actions
- to assess whether current surge and escalation frameworks can fulfil Major/Level 3 Incident command & control and governance requirements

A summary of lessons learned and actions identified as being required following the exercise are outlined in the attached documents. The completion of these actions is being coordinated by the systems resilience teams.

Exercise Extremis report - Master v1.do

Winter 21-22 HWE extremis actions v2.pp

4.2.2 Exercise Walker

Exercise Walker was a tabletop exercise held on 11 May 2022 to test the ability of the NHS East of England Region to respond to a catastrophic building collapse caused by the failure of buildings constructed using Reinforced Autoclaved Aerated Concrete (RAAC). It allowed a wide range of health organisations, along with multi-agency partners and other stakeholders, to rehearse the evacuation of a hospital. The exercise was used to test the new ICB Incident Response plan, which has subsequently been updated. A summary of lessons learned from this exercise and subsequent actions required are outlined in appendix A of the below document. NHSE/I will be leading the co-ordination of actions required across the system, supported by HWE ICB.

Exercise Walker Report FINAL v1.0.pdf

4.2.3 Exercise Enigma

This exercise was run by NHSE/I and based around an infectious disease scenario. It was attended by the CCG EPRR leads and the Director of Operations and the objectives were to:

- Confirm and challenge command and control in the ICB and region with its key stakeholders
- Ensure that as a region we are working collaboratively to manage a level 2/3 incident
- Identify potential roles and responsibilities going forward

The Exercise was split into the following three phases: -

1. Risk Assessment. Consolidate and test the command, control and initial coordination
2. Incident Management
3. Recovery

The ICB Incident Response Plan was updated following learning from this exercise and the attendees also provided post-exercise feedback as requested by NHSE/I. The ICB is currently waiting for the post-exercise report to be issued to see what the further learning is and whether any more changes need to be made to improve existing processes and procedures.

4.2.4 Cyber Attack

West Essex CCG undertook a cyber attack exercise in conjunction with the Essex Resilience Forum (ERF). However, the scenario was aimed heavily at Local Authorities (LAs) and their systems and processes which meant that “health” were not heavily involved until health systems became infected. There also seemed to be some confusion around health service internal structures and a lack of Strategic Coordinating Group objectives included within the exercise, which created difficulties for planning the health response. It was therefore suggested that, in future, a representation from health was involved with exercise planning. The exercise did, however, provide good networking opportunities and offered West Essex CCG the chance to understand the response arrangements with HBLICT for HWE ICB and within other organisations. It provided a useful starting point and highlighted how such an event can impact and affect healthcare and the different emphasis on LAs. The following actions were agreed based on the learning from this exercise:

- Essex Council Duty Officer contact details held in Framework to be confirmed (now complete)
- Exercise materials to be shared (now complete)
- Further similar exercises to occur to build relationships within the ICS
- Health structure briefing to be given to the ERF (now complete)
- Liaison between ERF, Essex Online Partnership (EOLP) & Health and ICT colleagues to be improved
- ERF Framework to capture appropriate Health ICT arrangements
- Awareness of Vulnerable Identification of Persons in an Emergency Response (VIPER) to be raised and added to Vulnerable Persons Framework & Common Operating Procedures for Essex (COPE)
- Generic cyber planning awareness to be raised
- C3 structures and awareness to be raised with EOLP

Appendix C - Core Standards Action Plan 2022/23

Action Required	Responsible Owner	Due Date
ICB Countermeasures procedures to be included in the Incident Response Plan	Maxine Hazle	1/12/2023
Information Governance Toolkit Action plan to be completed when due	Ruth Boughton	31/3/2023
Supplier business continuity Framework to be drafted and signed off	Maxine Hazle	20/10/2022
Liaise with NHSE/I to ensure MASCAS plan is signed off and circulated	Amanda Yeates	20/10/22
LHRP documentation to be discussed and signed off by MSE ICB/ LRFs	Grainne Stephenson	20/10/2022
Liaise with NHSE/I to ensure the Mutual Aid agreement is signed off	Amanda Yeates	20/10/2022
Social Media strategy to be updated to cover the management of incidents and signed off	Nuala Milbourn	20/10/2022
Liaise with NHSE/I and UKHSA to ensure that the Pandemic Flu Framework is appropriately updated	Amanda Yeates	20/10/2022
Fire risk assessment and updated evacuation plan required for Kao Park	Kelly Taylor	20/10/2022

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<tr><td colspan="4">HWE ICB Board meeting held in Public</td><td colspan="2">Meeting Date:</td><td colspan="2">23/09/2022</td></tr>
<tr><td>Report Title:</td><td colspan="4">UEC Assurance Framework</td><td colspan="2">Agenda Item:</td><td colspan="2">16</td></tr>
<tr><td>Report Author(s):</td><td colspan="8">Jo Burlingham, Head of Resilience and Response, HWE ICB</td></tr>
<tr><td>Report Signed off by:</td><td colspan="8">Elizabeth Disney, Director of Operations, HWB ICB</td></tr>
<tr><td>Purpose:</td><td>Approval</td><td>☐</td><td>Decision</td><td>☒</td><td>Discussion</td><td>☐</td><td>Information</td><td>☐</td></tr>
<tr><td>Report History:</td><td colspan="8">N/A</td></tr>
<tr><td>Executive Summary:</td><td colspan="8">On the 12th August 2022, NHS England (NHSE) published the next steps in increasing capacity and operational resilience in Urgent and Emergency Care (UEC). This paper sets out the expectations for the Hertfordshire and West Essex (HWE) Integrated Care Board (ICB) and the HWE system providers to increase capacity and resilience ahead of winter and the proposed arrangements for UEC assurance monitoring for HWE ICB for 2022/23.</td></tr>
<tr><td>Recommendations:</td><td colspan="8">The Board is asked to note the arrangements being put in place for winter 2022/23.</td></tr>
<tr><td rowspan="4">Potential Conflicts of Interest:</td><td colspan="3"><i>Indirect</i></td><td>☐</td><td colspan="3"><i>Non-Financial Professional</i></td><td>☐</td></tr>
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Impact Assessments (completed and attached):	***Equality Impact Assessment:***	In progress
	Quality Impact Assessment:	To be reviewed and completed, as applicable
	Data Protection Impact Assessment:	To be reviewed and completed, as applicable
Strategic Objective(s) / ICS Primary Purposes supported by this report:	***Improving outcomes in population health and healthcare***	☒
	Tackling inequalities in outcomes, experience and access	☒
	Enhancing productivity and value for money	☐
	Helping the NHS support broader social and economic development	☐
	Successfully complete and embed the transition of staff and functions from the three clinical commissioning groups into the Integrated Care Board	☐
	Develop the ways of working and profile of the Integrated Care System to ensure that its operating model is capturing the opportunities presented by closer system working	☐

1. Executive summary

On the 12th August 2022, NHS England (NHSE) published the next steps in increasing capacity and operational resilience in Urgent and Emergency Care (UEC). This paper sets out the expectations for the Hertfordshire and West Essex (HWE) Integrated Care Board (ICB) and the HWE system providers to increase capacity and resilience ahead of winter and the proposed arrangements for UEC assurance monitoring for HWE ICB for 2022/23.

The Board is asked to note these arrangements being put in place for winter 2022/23.

2. Background

Urgent and Emergency Care is currently under significant pressure. This is not isolated to HWE but across the country. Staff have faced one of their busiest summers ever with record numbers of A&E attendances and the most urgent ambulance call outs, whilst continuing to deal with COVID-19. Scenario planning for this winter expects UEC pressure to increase and we have therefore begun planning for the coming winter earlier than usual, recognising pressure on the NHS is likely to be substantial, particularly in UEC.

The following core objectives have been set out for operational resilience for ICBs for Winter 2022/23:

1. Prepare for variants of COVID-19 and respiratory challenges, including an integrated COVID-19 and flu vaccination programme.
2. Increase capacity outside acute trusts, including the scaling up of additional roles in primary care and mental health throughout winter.
3. Increase resilience in NHS 111 and 999 services, through increasing the number of call handlers.
4. Target higher acuity ambulance response times and ambulance handover delays, including improved utilisation of urgent community response and rapid response services.
5. Reduce crowding in A&E departments and target the longest waits in ED, through improving use of the NHS directory of services, and increasing provision of same day emergency care and acute frailty services.
6. Reduce hospital occupancy, through increasing capacity through a mix of new physical beds, virtual wards, and improvements elsewhere in the pathway.
7. Ensure timely discharge, across acute, mental health, and community settings, by working with social care partners and implementing the 10 best practice interventions through the ‘100-day challenge’.
8. Provide better support for people at home, including the scaling up of virtual wards and additional support for High Intensity Users with complex needs.

The Health and Care Act 2022 has outlined a new approach to how organisations in the NHS work together. The creation of Integrated Care Systems (ICSs) offers an opportunity for all partners in a local system to work together to develop new ways of working to make a real difference to patients and join up the entire urgent and emergency care pathway in ways we’ve been unable to do before. The actions outlined above will help HWE ICB manage pressure across the UEC pathway, supporting improved flow for patients across the system.

The new way of working also means a new approach to accountability. ICBs are accountable for ensuring that their system providers and other partners deliver their agreed roles in their local plans and work together effectively for the benefit of the populations they serve. Section 3 outlines how we plan to do this across the UEC pathway for Winter 2022/23 in HWE ICB.

3. Issues

HWE ICB has been tasked with developing a single winter plan that includes:

- ICB wide Demand and Capacity plans that are based on realistic assumptions, including how many staff can be recruited and at what speed. Initial submissions to NHSE were made on 29th August 2022 and mobilisation plans including the implementation of monthly monitoring of their impact are in progress (see appendix 1).

- Undertaking a self-assessment against 10 Key Lines of Enquiry (KLOE) ahead of winter (See appendix 2) in order to agree a system wide UEC Action Plan (see appendix 3) with agreed improvement trajectories against any partially compliant or non-compliant domains (see appendix 4) as well as the following priority metrics:

    - 111 call abandonment
    - Mean 999 call answering times
    - Category 2 ambulance response times
    - Average hours lost to ambulance handover delays per day
    - Adult general and acute type 1 bed occupancy (adjusted for void beds)
    - Percentage of beds occupied by patients who no longer meet the criteria to reside

- Ensuring that system providers and other partners deliver their agreed role in their local winter and UEC action plans and work together effectively for the benefit of the populations they serve, putting mechanisms in place to problem solve and intervene should providers be unable to deliver their agreed role.

- Monitoring performance against the agreed priorities and metrics using the UEC Assurance Framework and the development of a HWE UEC dashboard. Appendix 5 outlines the metrics that will be monitored monthly to demonstrate performance across the UEC system, covering pre-hospital, in-hospital and out of hospital. These metrics include the 6 NHSEI priority areas defined as key to the provision of safe and effective UEC, for which improvement trajectories will be agreed (highlighted yellow). There will be uniform reporting across all ICS and Place meetings (SRG/LDBs, UEC Board Meetings), utilising consistent sources of data which will be validated, published data where possible.

- A robust surge and escalation framework across the ICS to respond to unprecedented increases in system pressure and provide mechanisms for mutual aid and support to ensure patient safety.

4. Options

There are no options for the board to consider.

5. Resource implications

The actions outlined in section 3 will be progressed by a system wide winter planning task and finish group represented by all HWE providers, commissioners (UEC, Finance, Primary Care, Performance, Communications etc) and the voluntary sector and chaired by the ICB Head of Resilience and Response and UEC team leads.

A single winter plan will be developed that will incorporate the mandated asks from NHSE outlined above as well as learning from last winter and our system response to Covid-19. The plan will bring together organisational level plans and current plans from other forums into a single integrated plan for HWE e.g. Mental health pathway review, primary care capacity, social care and joint commissioned services, Voluntary Sector Organisations.

A key element of the plan will be the revision of existing escalation frameworks to ensure they are fit for purpose and to integrate Emergency Preparedness, Resilience and Response (EPRR) and UEC operating models to support operational oversight and tactical day to day management of the system.

Implementation of the ICB winter plan, UEC action plans and improvement trajectories will be managed at place and overseen by the Systems Resilience Groups and Local Delivery Boards. The plan will be monitored on a monthly basis by the ICB UEC Performance dashboard which will include individual performance at place as well as an aggregated ICB level.

6. Risks/Mitigation Measures

Overarching governance and assurance will be maintained through the ICB UEC Board via the Board Assurance Framework (BAF) outlined in appendix 4. This will be submitted to NHSE monthly and is a helpful tool will be used to both support and hold the system to account on the commitments we have made to support winter.

7. Recommendations

The Board is asked to note the plans being put in place to support the management of winter 2022/23 across the ICS.

8. Next Steps

The UEC and EPRR teams led by the ICB Director of Operations will continue to progress the tasks outlined in the paper to meet the deadlines stated to ensure a single ICB Winter Plan is in place across the ICS ahead of winter.

Appendix 1

Additional ICB Demand and Capacity Schemes commissioned to support winter

Winter Resilience 2022/23

Lead Org	Schemes and KPIs	Target	Total Performance	Average Performance	RAG
Acute					
WHTHT	Shrodells Refurb				
WHTHT	SMART (Specialist review at the front door) - Cardiology, Respiratory, Gastro				
HCC	Acute discharge runners				
PAH	Nightingale Ward				
PAH	OPAL (Frailty) beds				
PAH	Additional DF in IHDT				
EPUT	MH Band 7 (inpatient support/Dx out of hospital pathway)				
Community					
CLCH	NWB community beds				
CLCH	DTA Therapy provision (HCC & CLCH)				
CLCH	Extended bridging service				
CLCH	SPOC extension to manage dx flow				
HPFT	MH beds Shared (S&W and E&N)				
HCT	IMC				
HCT	Bridging Service				
EPUT	Avocet beds				
EPUT	Increased Bridging capacity (care at home) Oct - Mar x 6 posts				
EPUT	MH Band 3 IS dementia x 3 (admission avoidance)				
HPFT	MH - 24/7 expand crisis alternatives to 24/7				
HPFT	MH - 24/4 Drug & Alcohol - ED alternative				

Appendix 1 Continued

Lead Org	Schemes and KPIs	Target	Total Performance	Average Performance	RAG
Social Care					
HCC	**DTA Shared (S&W and E&N)**				
HCC	**Staffing (HCC) to support additional beds (DTA)**				
ECC	**ARC (West Essex)**				
HCC	**GP wrap around provision to support additional D2A beds**				
Voluntary Sector					
Herts	**VSE - Prevention cost of living infrastructure**				
WE Place	**VSE acute social prescribing, CVS Hospital Discharge Proposal**				
ICB					
ICB	**6 x additional NEPTS Vehicles (2 per trust) providing 36 additional discharge journeys per day**				
WE Place	**WHZAN digital kit for care homes**				
Herts	**Internal case management to reduce NMCTR (Non-long Meet Criteria to Reside)**				

Appendix 2

HWE ICB Self-Assessment Against KLOE

#	Good Practice Basics			
	Out of Hospital	**Y**	**N**	**Partial**
1	Directory of services reviewed monthly by ICB executives and with clinical service leads			
2	Co-located urgent treatment centre operating as the front door to the hospital (or streaming) (or equivalent primary and urgent care service)			
3	111 clinical contact > 50%			
4	Abandoned 111 call rate			
5	Ambulance conveyance to ED <49%			
6	Virtual wards in place that support admission avoidance and length of stay reduction			
7	Ensuring primary care have extended hours for evenings and weekends			
8	Urgent community response within 2 hours			
	Site/Operational Discipline	**Y**	**N**	**Partial**
9	Focused site/bed management 24/7 with minimum 3 times per day site meeting following a structured FOCUS model (or equivalent) with appropriate accountable actions			
10	Site management support & presence within ED to deliver timely flow and support to ED team			
11	Daily Executive Director oversight responsible for all escalation and delivery of mitigations			
12	Bed/site management function should ideally be clinical or as a minimum has access to clinical colleagues 24x7. Site function should have annualised competency/training.			
13	Senior Clinical and Management Directorate staff 24/7 rota to support min twice daily meetings			
14	Full capacity protocol in place – infection, prevention and control (IPC) compliant Along with BCPs for every acute service so that no service functions stops or defaults to ED			
15	Exec signed off internal professional standards in place appropriately managed with escalation for non-compliance			
	Emergency Department	**Y**	**N**	**Partial**
16	Streaming of all patients who could be appropriately managed by a co-located urgent/primary care service in place at times matching the demand.			
17	Minimum Consultant management > 16 hours a day (or as required by other specialist centres)			
18	Speciality and acute call down within 1 hour of referral. For tertiary units, acute physician presence in ED > 16 hours a day			
19	ED are granted one way referral rights with no patient being given back to ED at any time			
20	Mental health 24/7 liaison service			
21	SDEC > 12 hours a day/ 7 days a week at least but ideally open at times of demand. Open access criteria to be in place for all system partners. These units should never be bedded. Capacity cap shouldn't be in place.			
22	Acute frailty service > 70 hours over 7 days At least but ideally open at time of demand			
23	Dedicated, separate to adults, Paediatric ED / secure area in place			
24	All Minor illness streamed to GPs			
25	All Minor injuries streamed to an emergency nurse practitioner (ENP)			

Appendix 2 Continued

	Emergency Department Environment	Y	N	Partial
26	Required capacity (numbers of cubicles and Fit to sit) in place to meet demand			
27	CDU adjacent or equivalent short stay Emergency patient area			
28	GIRFT data should be used to effectively plan against demand and capacity			
	Emergency Department IT	**Y**	**N**	**Partial**
29	ED system in place to enable patient flow against national standards			
	Inpatient Management	**Y**	**N**	**Partial**
30	Minimum of twice Daily Consultant Led MDT Board Rounds in every ward			
31	Acute Medical Unit should be in place for maximum 72 hours length of stay. All other specialty patients should be bedded in alternative appropriate areas.			
32	Daily senior medical review (by a person able to make management and discharge decisions) seven days a week			
33	Red to Green Process or equivalent in place and audited weekly			
34	All patients reviewed by a senior decision maker 7 days a week			
35	Trust IPS clearly communicated, adhered to, escalated and audited.			
36	IPC protocol in place that adheres to the latest national guidance and balances IPC risk with flow and delays related harm risks			
	Discharge	**Y**	**N**	**Partial**
37	Expected Date of Discharge set within first 24 hours of admission. Patients should clearly have an acute reason to reside within the acute provider.			
38	Discharge is profiled against admission demand with a focus on early in the day discharge and weekend discharges.			
39	Identify patients in ED or at admission who are likely to need complex discharge support and highlight for early intervention			
40	Where in place, protect discharge lounge capacity from being bedded			
41	7-day Transfer of Care Hub in place			
	System and Trust Oversight	**Y**	**N**	**Partial**
42	Trust and ICB executive review weekly as a minimum (taking into account variance by provider in an ICB)			
43	ED Performance: Over 4 hours in department + 12 hour DTAs + Over 12 hours in department			
44	Ambulance Performance: Response times + Hospital Handover delays + Longest handover + Any identified patient harm including SUI			
45	Potential patient harm: Overview of all patient related incidents and serious incidents with regards to ambulance delays			
46	Overview of all incidents and serious incidents for patients in ED over extended periods			
47	Right to reside/delayed discharges			
48	In and out of hours clear bronze, silver and gold escalation with recorded actions and outcomes with appropriate training & support programme. Reflective practice should be used to inform future ways of working.			
49	Monthly review of agreed data sets and this checklist at trust and ICB boards			

Appendix 3

HWE ICB UEC Action Plan

RP#	Strategic Objective	Action
1.1	**Aligning Demand & Capacity**	**1.1 Ensure sufficient capacity to meet expected demand for this winter**
1.1.1	Aligning Demand & Capacity	Implement the additional capacity identified through the demand and capacity planning to effectively deliver against expected winter demand. Nationally this amounts to an additional 6,000 G&A beds.
1.4	**Aligning Demand & Capacity**	**1.4 Managing demand and aligning capacity**
1.4.1	Aligning Demand & Capacity	UTC provision operating at top of specification with capacity matched to local demand.
1.4.2	Aligning Demand & Capacity	Ensure all Emergency Departments have appropriate streaming services in place to redirect all appropriate patients to Type 3 services.
1.4.3	Aligning Demand & Capacity	Increase the provision of High Intensity Use services (HIU) from current position of approx. 50% of A&E departments having access to services
1.5	**Aligning Demand & Capacity**	**1.5 Community health care at home services**
1.5.1	Aligning Demand & Capacity	Urgent Community Response – increase 2-hour UCR provision by maximising referrals from the ambulance service and other appropriate providers, with the ambition of at least 70% of 2-hour UCR demand to be seen within two hours in each ICB.
1.5.2	Aligning Demand & Capacity	Rapidly scale virtual wards to support patients who would otherwise be in a hospital bed to receive acute care at home –with a focus on ARI and frailty. The VW system plans will likely create an additional 1,146 VW 'beds' of capacity by September 2022 and 2,514 Virtual Ward beds by December 2022.

Appendix 3 Continued

RP#	Strategic Objective	Action
1.6	**Aligning Demand & Capacity**	**1.6 Primary Care**
1.6.1	Aligning Demand & Capacity	ICB to resource a dedicated primary care team to actively engage and support General Practices and Community Pharmacies with seasonal preparedness and operational.
1.6.2	Aligning Demand & Capacity	ICBs to complete system framework for supporting General Practice to rapidly prioritise practical interventions to improve patient experience of access and staff workload locally and engage in national process to secure potential funding for technology/estates solutions
1.6.3	Aligning Demand & Capacity	Consider and support PCNs working with each other and other providers to develop collaborative models to manage specific winter pressures (for example oximetry monitoring for COVID; winter hubs; community and VCS led support for vulnerable)
1.6.4	Aligning Demand & Capacity	Rapid recruitment of up to: 1000 additional SP Link Workers and health and wellbeing coaches, each to boost staff numbers who target and work with stepping down from High Intensity User services with non-medical needs where social and lifestyle issues are a significant risk factor 1000 additional Care Coordinators to support the development of PCSPs for high risk individuals with MLTC, within the Anticipatory Care prioritised cohorts, with use of Personal Health Budgets where appropriate.
1.6.5	Aligning Demand & Capacity	ICBs to offer intensive hands-on quality improvement support to practices working in the most challenging circumstances (such as areas of high deprivation, areas with highest need or workforce challenges) via the national 'Accelerate' support programme available to 400 practices for 22/23 alongside addressing barriers outside the scope of the support
1.6.6	Aligning Demand & Capacity	Technology and Telephony to digitally enable Primary Care - **Cloud Based Telephony in General Practice:** Expand number of practices on cloud-based telephony, supporting transition from analogue to cloud-based through expanded scope and pace of current pilots in advance of the national cloud-based telephony framework going live in April 2023. **Business Intelligence tools roll out to General Practice:** Expand availability of Business Intelligence tools (to understand demand and capacity). Provide support to build capability to use them for improvement Use of a **unified directory of services** across ICS to direct patients to the right services and communicate clearly on primary care pathways and processes
1.6.7	Aligning Demand & Capacity	Promote use of the following community pharmacy services the expansion of CPCS to divert demand away from general practice into community pharmacies aligned to metrics outlined in the Primary Care Investment and Impact Fund the Discharge Medicines Service to community pharmacies to help prevent readmissions to hospital

Appendix 3 Continued

RP#	Strategic Objective	Action
1.8	**Aligning Demand & Capacity**	**1.8 Elective Recovery**
1.8.1	Aligning Demand & Capacity	Maintaining and increasing elective capacity to eliminate waits of over 18 months by April 2023
1.8.3	Aligning Demand & Capacity	Reducing the cancer 62-day backlog back to pre-pandemic levels
1.8.4	Aligning Demand & Capacity	Reducing the number of 78-week elective long waiters to zero
1.8.5	Aligning Demand & Capacity	Ensure inclusive recovery of elective services through use of data on health inequalities, children and young people and other population factors
1.10	**Aligning Demand & Capacity**	**1.10 Diagnostics**
1.10.1	Aligning Demand & Capacity	Enable over 89 CDC sites which are currently operational to deliver nearly 3 million tests to patients. These are located away from acute secondary care hospital sites and into the community health care settings. This supports improved access and timeliness for reprioritisation of key diagnostic modalities CT, MRI and Endoscopy for in-patient urgent testing and discharge prioritisation.
2.1	**Discharge**	**2.1 Building on best practice**
2.1.3	Discharge	Continue and expand use of small, one-off Personal Health Budgets (PHBs) to facilitate early discharges
2.2	**Discharge**	**2.2 Increase capacity on discharge pathways**
2.2.1	Discharge	Increase capacity of pathway one discharge teams to match demand and supply for this winter
2.2.2	Discharge	Reduce length of stay in community rehab wards/units and bed days lost for each delayed discharge in every community rehabilitation ward/unit and shift from bedded to home models of rehab for lower acuity people.
2.2.3	Discharge	Monitor P0 discharges at weekend to maintain flow 7 days a week.
3.4	**Improvements in Ambulance service performance**	**3.4 Ambulance Fleet**
3.4.1	Improvements in Ambulance service performance	Ambulance trusts to model their optimal fleet requirements to improve performance, including the use of Rapid Response Vehicles by August 2022 and implement in line with identified need by November 2022
3.6	**Improvements in Ambulance service performance**	**3.6 Improve the ambulance response to mental health**
3.6.1	Improvements in Ambulance service performance	All ICBs to use Long Term Plan ambulance and mental health funding in full to: • Deploy mental health professionals in 999 emergency operation centres (EOCs) and clinical assessment services (CAS) • Enable a joint on-scene response to mental health patients • Provide mental health education and training to the ambulance workforce

Appendix 3 Continued

RP#	Strategic Objective	Action
4.5	**Improving NHS 111 performance**	**4.5 Improve the ambulance response to mental health**
4.5.1	Improving NHS 111 performance	All ICBs to profile and update details of 24/7 urgent mental health helplines on the local Directory of Services (DOS)
4.5.2	Improving NHS 111 performance	All ICBs to seek to increase local comms to ensure people are aware of local 24/7 urgent mental health helpline numbers, or it can be promoted at www.nhs.uk/urgentmentalhealth
4.5.3	Improving NHS 111 performance	Increase the use of specialist vehicles to support mental health
5.1	**Avoiding admission and alternative 'in hospital' pathways to Improve Flow**	**5.1 Increase the number and breadth of services profiled on the DoS**
5.1.3	Avoiding admission and alternative 'in hospital' pathways to Improve Flow	Ensure only patients with an emergency need are directed to ED, through ensuring alternative services are available on the DoS
5.2	**Avoiding admission and alternative 'in hospital' pathways to Improve Flow**	**5.2 Standardise appropriate alternatives to inpatient care to avoid admissions and reduce pressure on beds**
5.2.2	Avoiding admission and alternative 'in hospital' pathways to Improve Flow	Improve Acute Frailty service provision including delivery of MDT assessment to ensure that treatment plans support transition from hospital to home4, where admission is not appropriate
5.2.3	Avoiding admission and alternative 'in hospital' pathways to Improve Flow	Review non-emergency patient transport services to transport patients who do not need to be admitted back to their homes and avoid unnecessary overnight admissions
5.3	**Avoiding admission and alternative 'in hospital' pathways to Improve Flow**	**5.3 Standardise specialist input and subsequent management at the earliest appropriate point in the patient's journey**
5.3.1	Avoiding admission and alternative 'in hospital' pathways to Improve Flow	Speciality in reach within 60 minutes of referral from an emergency portal for the main admitting medical specialities (Cardiology, Respiratory and Care of the Elderly) Delivery of care within speciality where appropriate through provision of direct speciality admission
5.3.2	Avoiding admission and alternative 'in hospital' pathways to Improve Flow	7-day provision of services which support acute care

Appendix 3 Continued

RP#	Strategic Objective	Action
5.4	**Avoiding admission and alternative ‘in hospital’ pathways to Improve Flow**	**5.4 Out of hospital services**
5.4.1	Avoiding admission and alternative ‘in hospital’ pathways to Improve Flow	Implement ‘out of hospital’ home-based pathways (including virtual wards) to improve flow by reducing hospital attendances through Urgent Integrated Care approaches for patients who need same day urgent clinical assessment and would otherwise attend or be conveyed to an urgent appointment in primary care or an emergency department.
5.4.2	Avoiding admission and alternative ‘in hospital’ pathways to Improve Flow	Reduce unnecessary primary and secondary care attendances for patients with mild coughs, colds, flu, and Covid by publishing revised NHS @home COVID pathways that incorporate broader Acute Respiratory Infections (including Flu, RSV etc) with accompanying patient self-management and escalation pack including patient diaries, oximeters, thermometers and safety netting advice.
6.2	**Preparing for new COVID-19 variants/respiratory challenges**	**6.2 Infection Prevention and Control**
6.2.1	Preparing for new COVID-19 variants/respiratory challenges	Implement UKHSA IPC guidance and develop strategies to minimise the impact of ‘void’ beds to maximise capacity. Embed reservist model in each ICS to increase capacity and capability to respond to surge and major incidents
7.1	**Workforce**	**7.1 Wellbeing**
7.1.1	Workforce	All ICBs to sustain, develop and promote staff MH hubs in line with guidance
7.2	**Workforce**	**7.2 Recruitment and retention**
7.2.1	Workforce	Implement recruitment and retention plans which include: • Staff sharing arrangements and maximising collaboratives banks • Embed reservist model in each ICS to increase capacity and capability to respond to surge and major incidents • Develop and launch managing attendance challenge toolkit • International Support to support UEC recovery plans - identify shortages for key roles & skills and implement recruitment programme targeting towards shortages to support UEC and winter pressures • Ensure plans to maximise the use of the national protocol and reduce the pull-on registered healthcare professionals to deliver this autumn’s COVID-19 and flu vaccination programme.
7.3	**Workforce**	**7.3 Utilisation of VCS and Volunteers**
7.3.1	Workforce	Enhancing resilience through identifying and scaling high impact roles for volunteers that reduce pressure on services, enhance patient experience and support staff wellbeing. (for example, Community First Responders, Discharge Support, ED support)

Appendix 3 Continued

RP#	Strategic Objective	Action
8.2	**Improved data and performance management**	**8.2 Ensure real-time system monitoring**
8.2.1	Improved data and performance management	Work with cross-system partners to put provisions in place to monitor data and pressures across the system and patient pathway, including primary care, acute and mental health services, and workforce pressures
9.2	**Communications**	**9.2 Campaigns**
9.2.1	Communications	Deliver the ‘Help Us, Help You’ NHS 111 (October 22) and GP Access (February 23) campaigns; to increase the number of people using NHS 111 when they have an urgent, but non-life-threatening medical need and of people using online access routes to contact their practice. ICBs to deliver local campaigns including messaging on triage, prioritisation and MDTs/ARRS staff by December 2022.

Appendix 4

Improvement Action Plan - 111 Service (IUC)

111 Service (IUC)		
Ambition - Patients are signposted to the most appropriate service for their needs every time, all the time.		
Key lines of enquiry (KLOEs)	**Implementation Questions**	**Implementation Answers**
IUC - 1. Are services within the Directory of Service correctly profiled and what is your assurance process to ensure the right patients are being directed to the right service? DoS returns the most appropriate, lowest acuity services, based on time of day, service capacity, and the patient's location. If alternative services to ED are available these should be given higher order and ED should be profiled last.		
IUC - 2. Are 111 services undertaking revalidation of primary care, urgent care, emergency department and ambulance dispositions?		
IUC 3 - Does 111 service redirect patients to CPCS for community pharmacy needs via online and telephony and what are the total numbers redirected per month?		

Appendix 4 continued

Improvement Action Plan - Ambulance (AMB)

Ambulance (AMB)		
Ambition - Patients receive timely emergency and urgent ambulance care and conveyance, with minimal delays.		
Key lines of enquiry (KLOEs)	**Implementation Questions**	**Implementation Answers**
AMB - 6. Accessible system-wide capacity with activity to each per month, to reduce unnecessary ambulance conveyance to ED, including an updated Directory of Services for ambulance service referral to e.g. UCR; frailty services; mental health; SDEC and UTCs		
AMB - 7. Escalation processes to reduce excessive handover delays (>60), including the use of Hospital Ambulance Liaison Officers (HALOs) and how are you assured that minimum care standards are provided to any patient delayed in an ambulance?'		
AMB - 8. Is current demand / opportunity for clinical capacity being met in EOCs to optimise Hear and Treat rates.		
AMB - 9. Outline activity per month to enhance current paramedic access to clinical advice to improve See and Treat and time on scene e.g. through Clinical Assessment Service; 'call before convey' and ED virtual consultation models.		
AMB - 10. Improve the integration of NEPTS as part of discharge planning to reduce the time spent 'waiting for transport'.		
AMB - 11. Increase awareness of the Healthcare Travel Cost Scheme to support patient discharge.		
AMB - 12. How does the NEPTS service in the local systems meet the requirements of the NEPTS Review?		

Appendix 4 Continued

Improvement Action Plan - High Intensity Users (HIU)

High Intensity Users (HIU)		
Ambition - Patients receive consistent care at all times, minimising the need to access acute and emergency services unless clinically needed**.**		
Key lines of enquiry (KLOEs)	**Implementation Questions**	**Implementation Answers**
HIU - 13. Does the Emergency department have access to a High Intensity Use scheme, supporting frequent users of A&E through a non-clinical approach to coach through issues, signpost, etc and is this scheme ICS owned/engaged with?		
HIU - 14. For commissioned HIU services, who provides this (organisation & Contact details) and to what date is it commissioned?		
HIU - 15. Are evaluation results re cost of delivery for HIU and impact of the service available?		

Appendix 4 Continued

Improvement Action Plan - Alternative Acute and Community Pathways/Services (AAP)

Alternative Acute and Community Pathways/Services (AAP)		
Ambition - Patients are treated in the right care setting, at the right time, by the right person. This includes access to alternative acute pathways and the appropriate voidance of attendance to the Emergency Department.		
Key lines of enquiry (KLOEs)	**Implementation Questions**	**Implementation Answers**
AAP - 16. Complete a system exercise to ascertain available alternatives to ED attendance and admission e.g. Alternative to ED and hospital admission tool (AtED and AtA) and Missed Opportunities tool.		
AAP - 17. Agreed pathways available to support a safe reduction in ambulance conveyance to ED - improving access to the wider health & socail care service, including access to clinical advice. what are the pathways and what is the activity currently versus ambition activity.		
AAP - 18. All acute alternative pathways accept direct referrals from system wide healthcare professionals. What is the activity per month per service? And is the access criteria open and in line with the CQC Patient First ideology: the patient goes to the right care setting for their need and that ED should not be a default for assessment.		
AAP - 19. ED streamers and triage nurses empowered to stream to all hospital services (e.g. all SDECS, AMU, SAU, GAU, Ortho, ENT, Paeds etc) and with streaming activity to each of these areas a month outlined.		
AAP - 20. Regularly reviewed Directory of Service in place to support accurate service profiling and re-direction.		
AAP - 21. SDEC Services with rapid diagnostic access are operational to meet patient demand profile.		
AAP - 22. Acute Frailty Services are operational to meet patient demand profile.		
AAP - 23. Hot clinic capacity is aligned to patient demand.		
AAP - 24. Virtual wards are operational to support admission avoidance and LOS reduction and are led by a relevant specialist and delivered by the Community.		

Appendix 4 Continued

Improvement Action Plan - Emergency Department (ED)

Emergency Department (ED)		
Ambition - Patients with an emergency need will be managed in a timely manner within the Emergency Department.		
Key lines of enquiry (KLOEs)	**Implementation Questions**	**Implementation Answers**
ED - 25. All Emergency Departments have a comprehensive streaming model so all non-emergency patients are directed from the ED with a structured competency programme, and outline % of patients are streamed per month OUT of the ED.		
ED - 26. The ED shop floor+A5:A13 team. - regular board rounds, walk-throughs and active progress chasing in line with the 4-hour performance standard. - senior support (silver or above) should be provided for ED decompression during times of excessive (over 1hour) ambulance handover delays and patients in the department exceeding 12 hours as well as a defined & tested escalation process should be in place.		
ED - 27. Patient assessed by the emergency department team as needing specialty assessment are accepted directly by that team and reviewed within 1 hour. There will be no ED hand backs (unless clinically required) The specialty teams should have time scheduled to make sure this is feasible. An agreement drawn up and signed by all clinical leads and the medical director. Specialty clinicians do not physically review patients in the emergency department - helping to improve flow, social distancing and infection control.		
ED - 28. Direct admission to hospital assessment area (e.g. AMU, SAU, GAU) or other specialty area from GPs etc. available 24/7		
ED - 29. Direct access to “hot” clinics e.g. ENT, Max-fax, orthopaedics, Obs & gynae, ophthalmology (from GP, NHS-111 or ED) 24/7 availability and bookable access without discussion and activity per month for each one.		
ED - 30. Direct referral to frailty, falls service from NHS-111, ambulance service or ED, available: 10 hours a day, 7 days a week with activity per month outlined.		
ED - 31. Direct to specialty referral 24/7 (from NHS-111, ambulance service or ED) (streamer, traiger, navigator or clinician) if the patient is under active specialty care or has a problem relating to that care e.g. post-op complications, or a complaint that is best managed by that specialism.		
ED - 32. Specialty advice / guidance available 24/7 by telephone with consultants for GPs, paramedics etc. (A-tED 2021) A single point of access which external healthcare professionals can contact directly 24/7 GPs to ‘call before they send’ patients to ensure the patient is seeing the right specialty first time. (Patient FIRST 2021)		
ED - 33. Using Non-clinical navigators / coordinators within emergency departments and GPs to make sure patients have a GP, support them through the GP registration process and chase/check diagnostic results when flagged ready to view. (Patient FIRST 2021)		

Appendix 4 Continued

Key lines of enquiry (KLOEs)	Implementation Questions	Implementation Answers
ED - 34. Pathways in place for specific groups of patients whose needs may best be met elsewhere e.g. percutaneous endoscopic gastrostomy (PEG) tube problems; catheter problems; peripherally inserted central catheter (PICC) line problems. (Patient FIRST 2021) List all pathways available and the activity per month each pathway sees.		
ED - 35. Emergency departments has 24/7 liaison mental health services to ensure that people of all ages presenting with acute mental health needs receive timely assessment by a skilled mental health professional, including direct referral to adult mental health and CAHMS service e.g. on-site MH ambulatory unit (from NHS-111, ambulance service or ED). 24/7 availability. Escalation process in place to ensure mental health admissions are completed in a timely manner, within 1 hour of streaming or referral and do not utilise an acute bed unless clinically required. Access to in-house psychiatric liaison team (Mental health practitioner review within 1 hour) that is safe, responsive, transparent with clear escalation processes. (Patient FIRST 2021)		
ED - 36. Urgent treatment centre (UTC) with GP presence co-located with ED, with bookable access from ED, GP or NHS-111 and available 12 hours a day, 7 days a week (A-tED 2021) and available at times of urgent care demand (i.e. no primary care or urgent care issue is seen in ED).		
ED - 37. External – urgent treatment appointments via GP, dental, pharmacy, optometry available 8am to 6pm,5 days a week and activity per month to each outlined.		
ED - 38. External - General practice appointments available 24/7 from NHS111, with these practices listed by how many appts per month?		
ED - 39. All staff to actively encourage patients to call GPs or NHS 111 first and to only 'go to A&E' in an emergency, with assurance and monitoring process outlined (Patient FIRST 2021).		
ED - 40. Regular review of the staffing of the emergency department so that capacity meets variation in demand, rather than average demand.		

Appendix 4 Continued

Improvement Action Plan - Treatment in the Emergency Department (TiED)

Treatment in the Emergency Department (TiED)		
Ambition - Clinical care and treatment will be delivered on time - aligned with best practice. Safety is never compromised.		
Key lines of enquiry (KLOEs)	**Implementation Questions**	**Implementation Answers**
TiED - 41. All emergency department staff telephonic or messaging platform for teaching, training, regular communication and escalation of pressure. All staff have access to the group to receive information, though only a few staff can post information - limiting less important information. Requires systems to manage risk of non-receipt and changes to on-call rotas etc. (Patient FIRST 2021)		
TiED - 42. A full, locally led and delivered MDT quality governance which will regularly review: performance, quality, risks, incidents, mortality, safety alerts, complaints and audit. (Patient FIRST 2021). Process measures (Patient FIRST 2021) include: time to diagnostics, time to antibiotics for sepsis (Sepsis 6 - delivered in first hour), time to ECG electrocardiogram) and sign off for chest pain, frailty/ dependency score in ED, reporting medication errors and near misses, left without being seen (LWBS), time to definitive treatment length of wait for specialty review , NEWS2, hip X-ray for patients with fracture neck of femur (NOF) - performed in first hour, CT for possible stroke - performed within an hour, Time to pathology, senior sign off for RCEM recommended clinical presentations.		
TiED - 43. Effective delivery of time critical medication - including new prescriptions (antibiotics) and medication that the patient is already taking - for example medication for Parkinson's disease, epilepsy, diabetes, with assurance and monitoring process outlined.		
TiED - 44. Urgent care standard operating procedures in place and regularly reviewed. (Patient FIRST 2021) along with Business continuity plans for all services that deliver flow out of ED so that no service 'defaults' to ED when capacity or business continuity issues occur.		
TiED - 45. Active use of National Safety Standards for Invasive Procedures in place, with assurance process outlined. (NatSSIPs). (Patient FIRST 2021)		
TiED - 46. Use of an adult mental health triage tool that includes recording of 15-minute observations. (Patient FIRST 2021)		
TiED - 47. ECG for patients presenting with chest pain - performed and reviewed by ST3 or above clinician within 30 minutes of arrival (Patient FIRST 2021)		
TiED - 48. Immediate review and sign off of point of care blood results so that timely management can begin. (Patient FIRST 2021)		
TiED - 49. Senior clinician review of patients with high (eg NEWS >3) or increasing NEWS (Patient FIRST 2021)		
TiED - 50. Early senior review (as soon as the red flag identified and no later than one hour from arrival) of infants, children and young people presenting with red flags for sepsis, with complex needs or safeguarding concerns. (Patient FIRST 2021)		

Appendix 4 Continued

Key lines of enquiry (KLOEs)	Implementation Questions	Implementation Answers
TiED - 51. Regular review of diagnostic standards e.g. time to CT and time to Pathology. (Patient FIRST 2021)		
TiED - 53. Adherence to nationally agreed clinical standards with regular compliance auditing eg standards from NICE, the British Thoracic Society (BTS) and the Royal College of Emergency Medicine (RCEM). (Patient FIRST 2021)		
TiED - 54. Timely diagnosis and treatment of patients with acute pain to include regular audit of: assessment, treatment and continuing reassessment to be carried out monthly. (Patient FIRST 2021)		

Appendix 4 Continued

Improvement Action Plan - Staffing (STF)

Staffing (STF)		
Ambition - Staff will be in the right place, at the right time with the appropriate skills to care for patients and keep them safe.		
Key lines of enquiry (KLOEs)	**Implementation Questions**	**Implementation Answers**
STF - 54. Staffing models for at least the next 12 months in place to enhance the urgent care pathway with increased staffing where appropriate, and new roles such as: redirection, streaming, early senior decision makers, specialty support. (Patient FIRST 2021) Recognised standards and regional benchmarking in place, such as the baseline emergency staffing tool (BEST-RCN) for staffing and assessing the skills mix throughout the department. (Patient FIRST 2021)		
STF - 55. For new joiners (including locums) a clear induction programme in place that includes infection prevention and control as well as wellbeing support, regular teaching and communication.		
STF - 56. All EDs where children attend have in place: a paediatric emergency medicine (PEM) consultant, at least two children's nurses per shift, and a play specialist in a dedicated secure area separate to adult patients. (Patient FIRST 2021)		
STF - 57. Consider new or extended practitioner roles in emergency departments such as: AHPs, paramedics, physician's assistants etc. (Patient FIRST 2021)		
STF - 58. Review existing models and job plans for non-ED consultants and workforce. For example, to place appropriate value on generalists and medical on call and support specialists to provide 'in-reach' and senior specialty review to ED. (Patient FIRST 2021)		
STF - 59. Support staff by providing robust, clearly signposted ways to report and manage moral injury and support wellbeing. (Patient FIRST 2021)		
STF - 60. Support staff by providing robust ways to manage their wellbeing at work. Including: ways to regularly give and collect feedback to all staff; 100% of leavers should be offered an exit interview. Results should be formally monitored, actioned upon where appropriate and shared; undertake regular reviews of the establishment for all staff groups; provide mandatory training for all staff and this should be formally monitored and actioned. (Patient FIRST 2021)		
STF - 61. Undertake regular reviews of establishment requirements for all staff groups at least yearly pre-winter. (Patient FIRST 2021)		

Appendix 4 Continued

Improvement Action Plan - Urgent Treatment Centres (UTC)

Urgent Treatment Centres (UTC)

Ambition - Patients with urgent and minor ailments/illnesses will be managed in Urgent Care settings everytime, at all times.

Key lines of enquiry (KLOEs)	Implementation Questions	Implementation Answers
UTC - 62. Do all your UTCs meet or, have plans in place to meet, the UTC standards? This as a minimum should include: - In line with local demand, open for at least 12 hours a day, 7 days a week for both walk-in and booked appointments. Booked appointments for UTCs should be available from ED, GP or NHS111. - Provide minor illness and injury treatments to patients of all ages. - Access to bedside diagnostics and plain x-ray facilities. Where facilities are not available on site, clear access protocols should be in place. - Receive ambulance conveyed patients (including stretcher) where clinically appropriate. - the ICS needs to ensure that there is an urgent care service available as alternative to EDs available 24/7		
UTC - 63. Are plans in place to designate any remaining type 3 or 4 services as a UTC, or as an alternative service where more appropriate?		
UTC - 64. Has a co-located UTC at the front door of the ED been considered to support streaming and diversion? If no, outline reason, alternatives and review processes in place.		
UTC - 65. Where a UTC at the front door is not possible / appropriate, enhanced streaming should be in place for example use of GP streaming or a digital streaming and redirection tool, with % of patients are streamed away from ED outlined. *Pending approval of UTC standards approval*- *All Type 1 EDs should have in place, or robust plans in place to enact, a UTC at the front door by March 2024 where it is clinically appropriate for the local health economy. Where this is not cost-effective or appropriate, this should be discussed with regional teams and ICBs are asked to explore forms of enhanced streaming that could maximise opportunities to divert low acuity patients away from ED.*		
UTC - 66. Each ED should review what % of attendees are primary or urgent care patients who are then seen by an ED clinician rather than an UTC. The system should monitor and create plans to reduce this % as part of their UEC strategy.		

Appendix 4 Continued

Improvement Action Plan - Flow

Flow		
Ambition - No patient will reside in an acute hospital bed once their clinical care has been completed. Everyday (7-days a week) spent in the acute trust should be free from delay with clinical led by a senior clinical decision maker		
Key lines of enquiry (KLOEs)	**Implementation Questions**	**Implementation Answers**
Flow - 67. Minimise handover delays between ambulance and hospital in line with 22/23 operational planning guidance e.g. eliminating handover delays >60mins - contribute towards achieving the ambulance response standards. No patient should wait in an ambulance outside of ED when they could be streamed to another service for their needs.		
Flow - 68. Acute takes are owned by the relevant specialities with a Senior Decision Maker in place 7 days a week.		
Flow - 69. Red 2 Green (or alike) is embedded with an escalation process to overcome delays.		
Flow - 70. 7-day a week ward / board rounds operational in line with RCP guidelines. With all patients receiving a senior review (ST4 or above) every day.		
Flow - 71. Internal professional standards are adhered to in a clear and unambiguous manner with description of values and behaviours expected in the organisation (Patient FIRST) for diagnostics and speciality review. (within 24hours of referral as a maximum - 7 days a week)		
Flow - 72. Weekend discharges maintain patient flow over 7 days including usage of Criteria Led Discharge.		

Appendix 4 Continued

Improvement Action Plan - Mental Health (MH)

Mental Health (MH)		
Ambition - Patients receive timely services and treatment as needed, with a greater focus on early intervention services that can prevent mental health crises.		
Key lines of enquiry (KLOEs)	**Implementation Questions**	**Implementation Answers**
MH - 73. (MH Trust specific) Systems should ensure anyone admitted to an adult mental health acute ward has a clearly documented purpose for admission and an estimated discharge date.		
MH - 74. (MH Trust specific) The average length of stay for mental health hospital spells is no more than the current national average of 40 days.		
MH - 75. (MH Trust specific) Systems should drive local reductions in long length of stay in mental health adult acute wards - this should include a focus on reducing the number of working age adults in acute care with a length of stay (LoS) over 60 days and older adults with a length of stay over 90 days, and below the current set threshold of 8 people per 100k population.		
MH - 76. (MH Trust specific) Systems must use baseline funding increases for therapeutic and purposeful mental health inpatient admissions e.g. through expanding the staff skill mix (focusing on psychologists, occupational therapists, peer support workers and other Allied health Professionals), the type of interventions and activities offered to patients, and ensuring the inpatient environment is therapeutic.		
MH - 77. (MH Trust specific) Systems should continue to focus on delivering timely and effective discharge following the additional funding made available for enhanced post-discharge mental health support during 2021/22. Where new schemes proved successful in reducing length of stay, waits in A&E, inappropriate OAPs, and preventing further admissions, they should be continued in 2022/23. [using baseline funding increases where required]		
MH - 78. (MH Trust specific) Systems should continue to deliver and maintain the ambition to eliminate all inappropriate mental health adult acute out of area placements (OAPs) and continue delivering the 72-hour post discharge follow-up standard.		
MH - 79. AAP Local Winter plans include demand and capacity analysis for mental health, inclusive of the following service areas for all ages: i. Community mental health team referrals and capacity ii. Capacity in primary care to support mental health needs, via Mental Health Practitioner ARRS roles iii. Open access crisis care, i.e. crisis lines and SPA's as well as CRHTT iv. VCSE sector capacity inclusive of alternatives in community, i.e. sanctuaries, crisis houses, etc. (e.g. patients seen vs anticipated need) v. Acute MH inpatient capacity (e.g. number of bed days available and anticipated bed days required) vi. Emergency Department (e.g. number of MH attendances at ED and % of MH patients waiting over 12 hours)		

Appendix 4 Continued

Key lines of enquiry (KLOEs)	Implementation Questions	Implementation Answers
MH – 80. Consider the workforce required to deliver and maintain commissioned service capacity across all age mental health pathways this winter, drawing on guidance available regarding new ways of working and the use of new roles in mental health.		
MH - 81. All ICBs to sustain, develop and promote staff Mental Health hubs in line with guidance.		

Appendix 4 continued

Improvement Action Plan - Operational Management & Escalation (OME)

Operational Management & Escalation (OME)		
Ambition - Patients on an urgent and emergency pathway are managed in the right care setting at the right time to maximise their health outcomes with operational processes in place to deliver this.		
Key lines of enquiry (KLOEs)	**Implementation Questions**	**Implementation Answers**
OME - 82. Handover framework/ actions in place (i.e rapid handover protocol) to be enacted when ambulance pressures, (i.e hospital handover delays, Cat 2 calls, lost hours) exceed a pre-agreed (ICS and ambulance service jointly) tolerance.		
OME - 83. Minimum twice daily site meetings, with senior leadership (executive level Opel 3&4). These are action focussed and conducted in line with a recognised framework – working example ECIST FOCUS model.		
OME - 84. Fit for purpose and regularly reviewed full hospital protocol is in place that is compliant with the latest IPC guidance and enables capacity to be created to meet surge needs.		
OME - 85. In and out of hours clear bronze-silver-gold line of escalation with recorded actions and outcomes.		
OME - 86. Weekly board level review and identified improvement actions of: - Ambulance waits and root cause. - Patient harm because of excessive waits at any point across the UEC pathway. - Over 12hrs in ED and 12hour DTA patients - 4hr performance and breach rational.		

Appendix 4 Continued

Improvement Action Plan - Integrated Care Boards (ICB)

Integrated Care Boards (ICB)		
Ambition - Integrated Care Boards take responsibility for oversight of UEC recovery, improvement and transformation through the implementation of robust governance arrangements across the ICS and place-based systems		
Key lines of enquiry (KLOEs)	**Implementation Questions**	**Implementation Answers**
ICB - 87. ICB responsibilities - ICBs should ensure they have aligned with national guidance (as provided in the links)		
ICB - 88. ICB to establish an UEC improvement steering group/board or equivalent with senior membership from all partners across system and place. *Recommendation for ICB executive to chair this board with support from ICS UEC clinical and operational leads Responsibilities include : - To review membership to include health, social care and system partners representative of system and place - To ensure system and place based improvement groups report to the board to enable oversight of all UEC improvement efforts, challenges and constraints to enable system wide solutions and sharing of good practice. - To receive and review national and local data to inform priority deliverables and opportunities for improvement across UEC. - To complete a review of current progress and opportunities for improvement using data and local intelligence to prioritise areas of focus as outlined within this improvement framework		
ICB - 89. Process measures (Patient FIRST 2021) include: Admission conversion rates, Re-attendance rates to ED, Proportion of patients clinically assessed and directed to SDEC, Proportion of patients clinically assessed and directed to another service off-site (for example urgent primary care/urgent treatment centres) or on-site (co-located urgent treatment centre, specialty assessment units, clinics) , Proportion of patients sent to the emergency department by GP or other community provider without prior communication; To be monitored, discussed and acted upon at each ICS UEC Board.		
ICB - 90. Agreed assurance process in place across all ICSs to support a rapid return to sustainable ambulance performance, focused on C1 and C2. What is the agreed assurance process and trajectory across all ICSs to achieve and maintain C1 and C2 performance?		
ICB - 91. Agreed assurance process in place with the role of the ICBs outlined in challenging whether a co-located UTC at the front door would be beneficial.		

Appendix 4 Continued

Key lines of enquiry (KLOEs)	Implementation Questions	Implementation Answers
ICB - 92. Each ICB has appointed a lead SRO for NEPTS across the system. This requirement is a recommendation from the review, with guidance awaiting approval which includes what is expected from the Lead SRO, such as: - Oversight of all NEPTS for patients for whom the relevant commissioner has responsibility - Oversight and co-ordination of all commissioning of NEPTS with the region / ICB / place, where applicable - Promoting the benefits of integrated working across the ICS that encompasses the key role of NEPTS in wider provision.		
ICB - 93. External: Use of regional level system risk assessment tools or apps that work in real time. An agreed set of associated actions and responsibilities can be triggered from this data (Please outline triggers and actions). These actions could then be filtered to the appropriate services. (Patient FIRST 2021)		

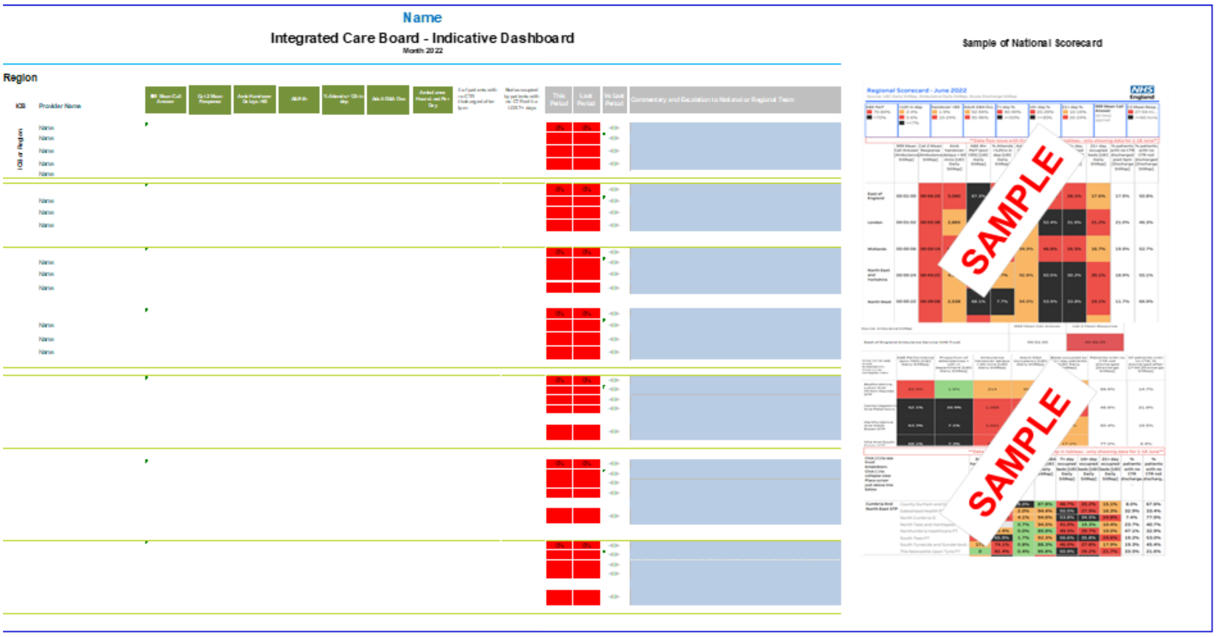
Appendix 5

NHSE Board Assurance Framework and HWE UEC Dashboard Metrics

Domain	Patient Journey	Area	Indicator
Priority 1	Pre Hospital	Covid	Prevalence
	At Hospital	Hospital flow/Covid	Beds Occupied
	TBA	TBA	Generic respiratory conditions
Priority 2	Pre Hospital	Primary Care	GP Appts: Attended/DNA
	Pre Hospital	Primary Care	GP Appts: Mode (F2F, Video, Telephone, HV)
	Out of Hospital	Community	Number of POA and % 2 hour urgent community response
	Out of Hospital	Community	Community bed capacity/occupancy
	Out of Hospital	Mental Health	CAMHS – Access and Crisis response
	Out of Hospital	Mental Health	Out of area placements
	Out of Hospital	Community	Virtual ward capacity /occupancy
	Out of Hospital	Community	Total hours available v total hours provided (dom care county/council)
	Out of Hospital	Community	Nursing/Residential home capacity v usage
	Out of Hospital	Community	D2A capacity v usage
	Out of Hospital	Homecare	Bridging capacity
	Hospital	Mental Health	Waits for CAMHS beds
	Hospital	Mental Health	MH waits longer than 12 hours in ED
	Hospital	Mental Health	MH Bed capacity
Priority 3/4	Pre Hospital	IUC	No of calls received by telephony system
	Pre Hospital	IUC	% abandoned calls after 30 seconds
	Pre Hospital	IUC	Calls Answered
	Pre Hospital	IUC	% calls answered <60 seconds
	Pre Hospital	IUC	% ED cases given disposition other than ambulance or ED
	Pre Hospital	IUC	% of ED revalidated by CAS
	Pre Hospital	IUC	% of revalidated cases diverted away from ambulance service
	Pre Hospital	999	Mean 999 Call answering times
	Pre Hospital	999	CAT 1 90% percentile and mean response times
	Pre Hospital	999	CAT 2 90% percentile and mean response times
	Pre Hospital	999	Cat 3 90% percentile and mean response times
	Pre Hospital	999	Cat 4 90% percentile and mean response times
	Pre Hospital	999	Hear & Treat rate
	Pre Hospital	999	See & Treat rate
	Pre Hospital	999	Conveyance rate
	At Hospital	999/A&E	Average hours lost to handover
	Pre Hospital	999	Utilisation from EEAST to other services
	Pre Hospital	999	Access to STACK
Priority 5	At Hospital	999/A&E	Ambulance Handover >60 mins (numbers)
	At Hospital	A&E	ED Attendances (all types)
	At Hospital	A&E	4-hour standard
	At Hospital	A&E	Emergency Admission via A&E
	At Hospital	A&E	Emergency Admission - SDEC performance
	At Hospital	A&E	Conversion rates (against all attendance - not just Type 1)
	NEW		SDEC
	Hospital	A&E	SDEC Frailty
Priority 6	At Hospital	Hospital flow	Bed occupancy (G&A)
	At Hospital	Hospital flow	LOS 7/>14/21 days
	At Hospital	RTT	> 52 /78/104 week waits
Priority 7	At Hospital	In-hospital dx	Percentage of beds occupied by patients who no longer meet the criteria to reside
	At Hospital	In-hospital dx	Not meeting criteria to reside: dx pathways 0-3
	At Hospital	In-hospital dx	% dx before noon
	At Hospital	In-hospital dx	% dx before 5pm
Priority 8	Out of Hospital	CHC	CHC wait for FastTrack - % FT applications validated within 24 hours
Priority 9	At Hospital	A&E	High intensity users

Appendix 5 Continued

NHSE Board Assurance Framework and HWE UEC Dashboard Metrics



Name

Integrated Care Board - Indicative Dashboard

Month 2022

Region

ICB	Provider Name	This Period	Last Period	Vs Last Period	Commentary and Escalation to National or Regional Team
ICB or Region	Name	0%	0%		
	Name				
	Name				
	Name				
	Name				
	Name	0%	0%		
	Name				
	Name				
	Name	0%	0%		
	Name				
	Name				
	Name	0%	0%		
	Name				
	Name				

Sample of National Scorecard

Regional Scorecard - June 2022

NHS England
SAMPLE
SAMPLE