Hertfordshire and West Essex Integrated Care System

NHS
Hertfordshire and West Essex
Integrated Care Board

Hertfordshire and West Essex Joint Forward Plan: Delivery Plan 2024 - 2029

Working together
for a healthier future

Contents

Joint Forward Plan 2024-29: Delivery Plan

Introduction

This document outlines our specific plans in Hertfordshire and west Essex to support the delivery of our health and care systems strategic ambitions including our Medium-Term Plan and priorities for the next two years. Further details of these can be viewed in the overview of our Joint Forward Plan Hertfordshire_and_West_Essex_Joint_Forward_Plan_2024_2029.pdf (ics.nhs.uk)

A guide to this document:

Section 1: Delivering our priorities for 2024-2026

This section provides details of our plans to deliver our five system priorities, as agreed by our system leaders. These priorities have been identified as the five most important things that the ICB and its partners must deliver over the next two years to address our strategic challenges and support delivery of our long-term ambitions.

Under each of our priorities are specific plans for improvement along with the progress indicators for each plan, through which we will internally track our progress. Key indicators ('How will we know that we made a difference') show how we will demonstrate overall progress of this work, measure the impact for our population and evidence that we are making a positive difference. These plans, unless stated otherwise, are being delivered across our health and care system.

Section 2: Delivering our ambitions for 2024-2029

This section provides details of our plans to deliver our five-year strategic ambitions as set out in our Medium-Term Plan as well as supporting delivery of the systems Integrated Care Strategy. As per section 1, these plans, unless stated otherwise, are being delivered across our health and care system.

Under each ambition in this section there is a summary of the relevant strategic challenges relating to it, as well as patient and resident engagement findings that have informed and continue to inform our plans. Below this are our specific plans for delivering this ambition over the 2024-29 period along with the progress indicators for each plan, through which we will internally track our progress. Similarly to section 1, each ambition has a set of key indicators ('How will we know that we made a difference') that show how we will demonstrate overall progress of this work, measure the impact for our population and evidence that we are making a positive difference.

Section 3: Our workforce plan

Our health and social care workforce are an integral part of everything that we do and our workforce plans, that are detailed in this section, will help us to deliver our ambitions and priorities. Where appropriate our workforce plans are woven into our plans for each priority and ambition. However, this section provides an overview of our system workforce plans, these plans support delivery of the system's 2023-2025 People Plan that are working towards the requirements of the NHS Long-Term Workforce Plan.

In this section, similarly to sections 1 and 2, we provide a summary of our relevant strategic challenges relating to workforce, as well as staff engagement findings that have informed and continue to inform our plans and our specific plans for improvement. Besides our plans there are progress indicators, which are our internal mechanisms for tracking progress. Below our workforce plans are our key indicators ('How will we know that we made a difference') that show how we will demonstrate overall progress of this work, measure the impact for our population and evidence that we are making a positive difference.

Section 4: Key milestones

This section provides a summary of the key milestones for the projects that are included in this plan along with the expected date of completion. These are the most important things that we need to complete for us to deliver our plans and ambitions.

Section 5: Index

This section provides an index of where specific work areas are included in this document.

1. Delivering our priorities for 2024-2026

1.1 A reduction in the backlog for children's care

What will we do to make a difference:

2024-25	2025-26	Progress Indicators
Attention Deficit Hyperactivity Disorder (ADHD) / Autistic Spectrum Disorder (ASD): Implement our new clinical pathways, including revised staffing model to reduce diagnostic waits and ensure the right people are offered assessments through improved multi-agency support built around the child and family. These changes will initially focus on Hertfordshire, as in west Essex they have made significant service improvements and developments but there are plans for west Essex to be incorporated into the second phase of developments. The digital patient interface for referrals into west Essex community healthcare was launched and we are working across the Essex Southend and Thurrock Transforming Care Partnership to progress and deliver a pilot around accelerated autism assessments for children and young people at risk of admission	Undertake an evaluation of Autism Spectrum Disorder Psychoeducational Resource pilot across Essex, Southend and Thurrock and monitor and review pathways and support offered in line with changing needs and demand	Reduction in waiting times for a diagnosis (% of patients waiting less than 18 weeks, July 2024: East and North Hertfordshire NHS Trust (ENHT) – 16.9%, HCRG (Health Care Resourcing Group)19.6%, Hertfordshire Community NHS Trust (HCT) – 39.3%, Hertfordshire Partnership University NHS Foundation Trust (HPFT-ADHD only) 17.6%)
Family Services: Complete phase 1 of the Family Hub Service model delivering universal and targeted support for children, young people and families,	Complete phase 2 of the Family Hub Service model expanding the hub further to encompass support	An increase in the proportion of children accessing early help support.

including support with: parenting, helping parents and carers to manage their child's behaviour and respite support. It will also support adults with challenges that impact on children, including support with parental substance misuse, mental health, physical disabilities or domestic abuse. We will mobilise this new service with strong partner and community links within the Voluntary, Community, Faith and Social Enterprise (VCFSE) sector, schools, Hertfordshire County Council and districts/borough councils. We will work with these partners to drive a preventative approach with holistic whole family support, making every contact count and reduce duplication between our services.	for 0–25-year-olds and increase collaboration with partners and other services	An increase in the number of children accessing mental health support. A reduction in the proportion of 0–4-year-olds attending Emergency Departments (ED). An increase in the proportion of children under 5 years old who have had the required immunisations.

How will we know that we made a difference:

We will have:

- Reduced the wait for community paediatrics services to 65 weeks. by April 2026. This will include ASD, ADHD and speech and language assessments (wait times as of July 2024 are 179 weeks for ENHT, 156 for HCT and HCRG)
- Reduced the rate of ED attendance and admissions for children and young people by 5% by 2028.

1.2 Reduce inequality with a focus on outcomes for cardiovascular disease (CVD) and hypertension

What will we do to make a difference:

2024-25	2025-26	Progress Indicators
Cardiovascular Disease (CVD): Improve detection and control of hypertension (high blood pressure) through awareness raising (communications campaign) and community engagement events, increased access to blood pressure measurements in general practice, community pharmacy, outpatients and other community settings, as well as adopting a 'Making Every Contact Count' campaign across NHS providers and working with wider non-NHS organisations to use every opportunity to achieve health and wellbeing. Restore performance of local stroke services to pre-pandemic Sentinel Stroke National Audit Programme (SSNAP) standards and begin implementation of the Integrated Community Stroke Service specification (ICSS). Development of a local integrated lipid service and improving the delivery of core care for people with raised cholesterol in primary care.	Continued monitoring and improvements to hypertension detection and treatment, with a specific focus on tackling inequalities. Implementation of a community lipid clinic Working towards full implementation of an integrated community stroke service (ICSS) Development and delivery of integrated care models across the ICS for people with heart failure.	Increased identification of hypertension Increased proportion of people with hypertension who are treated to age specific thresholds. Increase in the identification of hypertension among people living in the 20% most deprived communities. Reduce the waiting time for Echocardiogram (ECHO).

Including integrated heart failure services with shared objectives and improve delivery of core care in primary care for people with heart failure. Primary care will continue to be funded to deliver core care processes and manage the health needs of people with heart failure atrial fibrillation and high cholesterol proactively.		
Obesity: We will continue to maximise use of nationally and locally commissioned weight management services for children and adults, ensuring all commissioned capacity is utilised. We will support the mobilisation and integration into local system of a new Herts-wide, integrated tier 2 and tier 3 weight management service for adults. We will embed early weight management support into clinical pathways (e.g. sleep apnoea, non-alcoholic fatty liver disease, diabetes) and optimise appropriate access to new anti-obesity medications. Whilst continuing to explore options for addressing unmet needs where people have been unable to achieve weight loss with tier 2 services. In west Essex we plan to work with Essex County Council to review all weight management tiers including arrangements in Hertfordshire.	Continue to embed early weight management support into additional clinical pathways (e.g. elective surgery, cardiology, fertility). Utilise a Population Health Management approach and the Core20PLUS5 model to identify priority groups for targeted intervention.	An increase in the number of people referred to and accessing weight management services who go on to lose weight.

Medicines Optimisation: Reducing the harm from medicines prescribed: System wide plan to reduce overprescribing and medicines waste. Sharing best practice across the system. Develop effective communication methods at place and within Integrated Neighbourhood Teams. Empower patients to know about the medicines they take, the expected outcome, potential side effects and the criteria for discontinuation	Embed a culture of shared decision making	

How will we know that we made a difference:

We will

- increase the hypertension diagnosis rate for patients in our GP practices by hypertension by 2% by March 2026 (QOF prevalence)
- increase in percentage of patients with GP recorded hypertension in whom the last blood pressure reading was within target range to 77%
- Increase the age standardised prevalence of diagnosed hypertension in the most deprived 20% of the ICB population from 17.6% to 19% by March 2026.
- Activity at >90% of commissioned monthly capacity for each locally and nationally commissioned weight management service for children and adults

1.3 Elective care recovery

What will we do to make a difference:

2024-25	2025-26	Progress Indicators
To complete the building work and mobilise the Community Diagnostic Centre (CDC) spoke site at St. Albans City Hospital (SACH) offering additional capacity for MRI and CT scans. Outpatients: embedding the Shared Decision Making campaign and to reduce the number of people who do not attend appointments without prior notice (DNAs). Continue to increase the number of people on a patient initiated follow up pathway and work towards supporting people through the functionality of the new patient portals. Increase the use of triage, specialist advice and guidance, implement 'Get it Right First Time (GIRFT), through: • standardisation and streamlined clinical pathways. • increasing our capacity to undertake elective care, support the reduction in variations in access time. • improved clinical outcomes and overall waiting times in accordance with the national standards by March 2025.	Diagnostics: To complete the building work and mobilise the endoscopy unit at St Albans City Hospital and complete and mobile Clinical Diagnostic Centre (CDC) hub in Epping offering a range of diagnostic tests.	Reduce the size of the elective waiting list. Theatre utilisation equal to or greater than 85%. Day case rates equal to or greater than 85%. By March 2025; 95% of patients needing diagnostic tests seen within six weeks.

Increase specialist advice activity and scope potential opportunities for one stop clinics, to support the backlog of people waiting for their first outpatient appointment including optimisation of remote consultations and reduce variation in pathways and processes. Increase Multi-Disciplinary Team (MDT) working (utilising the different workforce skill mix accordingly), to enable a single outpatient appointment with multiple healthcare professionals, to reduce pressure on estates and increase capacity. Increase Patient Initiated Follow Ups (PIFU).		

How will we know that we made a difference:

We will have:

- Reduced the number of patients waiting more than 65 weeks for treatment, to 0 by 30 September 2024.
- Ensured that 85% of surgery across HWE is consistently undertaken as a day case by March 2026
- Reduced the number of patients waiting more than six weeks for diagnostic services year on year and by March 2025 ensure that 95% of patients have their diagnostic within six weeks.
- Maximised the productivity of our operating theatres and outpatient's services.

1.4 Improve urgent and emergency care (UEC) through more anticipatory and more same day emergency care

What will we do to make a difference:

2024-25	2025-26	Progress Indicators
Same Day Emergency Care (SDEC) for frailty: Identify and quickly acknowledge people's frailty at the front door of ED so that they can be swiftly referred to alternative services closer to home if most appropriate to meet their urgent care needs. If they require emergency care, we will endeavour to provide this on the same day, either through same day emergency care (SDEC) or acute frailty services with swift comprehensive geriatric assessment and frailty expertise to turn patient's diagnosis and treatment around promptly and avoid unwanted or unnecessary admission to hospital. To support the ambition to provide greater same day emergency care, efficient direct referral pathways between our ambulance service and acute trust SDEC services will be developed with a focus on increasing the proportion of frail patients seen and treated on the same day. We will develop direct referral pathways from primary care and NHS 111 and continue to develop pathways between SDEC and hospital at home and other community services supporting frailty.	We will continue to make frailty everybody's business and embed digitally enabled (direct booking) referral pathways to ensure SDEC is accessible across all parts of the healthcare system (primary care, community care and hospital at home, 111 and 999), including from a single point of access. We will establish remote clinical support from senior clinical decision-makers in our acute trust to support 'call before convey' and direct access to SDEC.	Increase percentage of patients at risk of frailty (aged 85+ or over 65+with conditions) who have a clinical frailty score (CFS) recorded and accessing support. Increase proportion of frail patients who receive same day emergency care.
Frailty and End-of-Life: Systematic identification of patients who are likely to be approaching the end of their life and support	Continue to embed sustainable and robust digital advanced care plans accessible across	Increase proportion of people who are routinely identified as

clinicians to undertake person-centred discussions about preferences and priorities for future care to develop advance care plans. Scope proposals for a digital advanced care plan with wide stakeholder engagement and implementation of the digital advance care plans in Q4 which will ensure consistent documentation that it is shared, and understood by all staff, across the health and care system.	the health and care system, use continuous quality improvement methodologies. Continue to strengthen our care coordination for those at end-of-life to facilitate care closer to home, learning from discharge facilitator pilots, and embedding end of life skills in our hospital at home workforce with clear pathways to specialist palliative support so that those at the end of their life who experience acute illness or exacerbation of long-term conditions can be supported and cared for closer to home.	likely to be in the last 12 months of life and who have an advance care that has been reviewed in the last 12 months. Reduce rate of emergency admissions for people on the End-of-Life register Increase proportion of palliative and end of life care (PEoLC) patients who die in their place of choice.
Falls Prevention and Deprescribing (including reduction in anticholinergic medicines) Across HWE, map our falls prevention and rehabilitation services, and the pathways for people who have fallen and whose care and treatment could be provided in the community to avoid unnecessary conveyance to hospital. Identify opportunities to scope new, or maximise existing, commissioned services and clinical pathways to improve patient care. A system-wide review by pharmacy and medicines optimisation team to identify individuals prescribed more than 10 medications and to identify those older	Continue to develop our proactive approach to preventing falls, using continuous quality improvement methodology and learning from pilots, such as use of sensor devices in peoples' own homes to predict falls or early decline in functioning. Increase identification of those at risk of falls and promote self-referral into falls prevention services. Ensure patients at various falls risk receive best practice care and interventions, continue to develop strong links between community falls prevention services and the voluntary sector.	Reduction in prescribing for individuals on 10 or more medications Reduce rate of emergency admissions for falls within the community for people aged 65+ Increase the proportion of people aged 75+ accessing falls services within the community. Reduce hip fracture rate in people aged 65 and over.

people at risk of the cumulative effect of taking medications with anticholinergic activity (the 'anticholinergic burden' (ACB)) and support clinicians in assessment and deprescribing as necessary to reduce the risk of falls.	Development of a fracture liaison service to identify those at risk of osteoporosis and proactively manage them to avoid falls-related injuries.	
Care Closer to Home for more proactive, anticipatory care: A consistent high-level model of 'Care Closer to Home' will be developed and reflected in our community provider contract specifications, agreed by September 2024 to support a greater proportion of frail, older population to receive urgent and emergency care in the community. A proactive approach to managing chronic disease and complex care through integrated neighbourhood team (INT) working will be embedded at scale. Using population health management INTs identify and prioritise specific cohorts, those prioritising complex and frail cohorts at risk, or rising risk, of deterioration and future unplanned care will be supported to design and target delivery of proactive and anticipatory care models, to predict deterioration earlier, prevent escalation of need and deliver timely urgent response closer to home before patients reach crisis point.	Implement new 'Care Closer to Home' model reflected in community provider contracts from April 2025. Continuous improvement and evaluation of the impact of our INT proactive care. Further support anticipatory care using remote monitoring and health technology data to identify patients at high risk of acute deterioration, and predict future hospitalisation, and target earlier community care, enhanced monitoring and oversight, to prevent deterioration and avoid unplanned hospital admission. Scope expansion of our hospital at home to include other conditions and capabilities, driven by data in relation to population need in planned care and for children and young people.	INTs delivering a collaborative service and continue to refine and develop new models of care with system partners. Reduce rate of unplanned hospitalisation for chronic ambulatory care sensitive conditions Reduce emergency readmissions within 30 days of discharge from hospital. Reduce readmission rates from reablement. Increase the proportion of older people (65+) who were still at home 91 days after discharge from hospital into reablement/ rehabilitation services.

The ‘Care Closer to Home’ model will support integration of our Urgent Community Response (UCR) and Hospital at Home services with other community specialist services, primary care, hospital-based services and social care for seamless care and escalation purposes. We will boost our capacity for, and maximise referrals to, Urgent Community Response (UCR) to respond rapidly to urgent needs such as falls, decompensation of frailty, reduced mobility, or palliative care. Our hospital at home services will continue to provide safe and effective treatment to people living with frailty in their own home when acutely unwell. Care Coordination Centres (CCCs) will closely align to the unscheduled care hub to ensure swift MDT coordinated response to safely navigate patients to the right care. CCCs effectively coordinate delivery of Care Closer to Home, preventing admission and facilitating rapid, safe, and appropriate discharge to avoid harms of hospital stays in those who are frail or older. A clear understanding of the demand for intermediate care and alignment to Discharge to Assess to ensure appropriate capacity and	Develop our Care Coordination Centres (CCCs) to be digitally enabled to manage daily flow and care coordination of patients. Use data to map our population’s short and long-term care needs to ensure both intermediate care and long-term care services are fit for future ageing population and supports flow through the UEC pathway. Continuous quality improvement approach to evaluate the impact of our ‘Care Closer to Home’ model, monitoring success of alignment of Discharge to Assess/Intermediate Care and the impact on personalisation and reduced ‘unrecoverable’ failed starts.	Increase rate of patients discharged to usual place of residence following an acute admission.

maximise timely access to support in the most suitable community setting for patient needs.		

How will we know that we made a difference:

- Reduction in the rate of emergency admissions for falls within the community for people aged 65+ by 5% by March 2027.
- Reduce the percentage of deaths with 3 or more emergency admissions in last 90 days of life (all ages) from 6% to 5% across HWE by March 2027.
- An increase in care for frail patients taking place at home or in the community
- Develop a local workforce pipeline in line with workforce clinical expansion targets, support better retention of our workforce and reduce agency spend.
- A decrease in the amount of money we need to spend on non-elective admissions for frail older people

1.5 Better care for mental health crises

What will we do to make a difference:

2024-25	2025-26	Progress Indicators
Crisis Services: We will undertake a system wide review of alternative crisis services with the voluntary, community, faith and social enterprise (VCFSE) sector and clinical services. We will also enhance crisis cafes and sanctuaries and develop collaborative partnership working to ensure mobilisation of mental health ambulance response vehicles. We will also develop and monitor the impact of the system wide Mental Health Urgent Care Centre (18+) at Lister Hospital and explore options for increasing the offer to other acute trusts. Develop a joint response car supporting community-based mental health crisis and need. Integration of mental health expertise in unscheduled care hubs and review support to those substance misuse and mental health, including expansion of the alcohol care support team service. Continue to map coverage of mental health crisis care to understand the gaps, including emergent neurodiversity. We plan to continue to develop our community services to improve the prevention of mental health crisis	To provide comprehensive coverage across the system of an integrated urgent care response to support people experiencing mental health crisis, including those simultaneously suffering substance misuse. To build on the improvements in 2024-25 and continue to develop our community services to support the prevention of mental health crisis.	Increase the number of crisis beds available. Increase ‘see and treat’ for patients in mental health crisis. Reduced ambulance conveyances for mental health crisis. Improved patient experience. Reduce emergency department (ED) presentations for those with a mental health condition. Improved pathways for those with a mental health condition presenting at ED.

Right crisis care, in the right place, with the right person: Continue to monitor (as appropriate) the mobilisation of capital developments and evaluate the benefits of them to enhance accessibility to adult crisis services, improving quality of the environment as well as people's experience. We will work with all partners to implement the Right Care, Right Person Programme (RCRP) which is a partnership approach aimed to ensure that the people in mental health crisis are seen by the right professional. Work with partners to reduce out of area bed placements, monitor the impact and outcomes of the RCRP approach and explore system options/proposals to support inpatient needs.	2025-2026: Increase access for children and young people (CYP) and improve outcomes, listening to their feedback, addressing waiting times and tackling health inequalities. Continue to increase access to Herts CYP mental health services in line with NHSE targets, improved navigation, and awareness. Ensuring offers are informed by data, effective, and can support preventative actions. Understand Herts CYP/F user experience and professional confidence in services to support any system improvement. Monitor and understand demand and capacity of CYP mental health services. In west Essex, alongside expanding access, the focus will be on developing and improving core services, particularly in the areas of early intervention, prevention, community health, reducing inequalities, improving quality. With more of an emphasis on improving outcomes and experience of service for our CYP, families, and carers. 2026-2029: Work towards 100% of children and young people achieving access to specialist mental health care. Build on THRIVE methodology (i-THRIVE | Implementing the THRIVE Framework	Reduction in out of area bed placements and length of inpatient stay. Reduction in police handover time for S136 detentions.

	(implementingthrive.org) and principles, ensure Herts CYP are involved in shared decision making and feel empowered to have an active role around their own mental health and wellbeing.	
Long-Term Plan ambitions for Children and Young People (CYP) mental health services: Continue to increase mental health support teams working with schools to embed effective whole school approach to the emotional wellbeing of students. Hertfordshire focus: Continue to develop our Equity Equality Diversity and Inclusion (EEDI) practice and policy, to tackle health inequality enabling open and accessible services regardless of additional vulnerabilities (Core24Plus5). Increase access through improved system awareness and navigation, with clear accessible clinical pathways. Evaluate service delivery and activity to ensure it remains outcome focused, seek to develop a systematic approach with stakeholders to grow, retain and align the workforce to meet the Herts children and young people population needs. Develop crisis support, ensuring continuation of 24/6 access and develop approaches to prevent crisis triggers using evidence informed data. Develop, grow, and embed co-production with children, young people, and families to ensure they are involved in shared	Increase access for children and young people (CYP) and improve outcomes, listening to their feedback, addressing waiting times and tackling health inequalities. Continue to increase access to Herts CYP mental health services in line with NHSE targets, improved navigation, and awareness. Ensuring offers are informed by data, effective, and can support preventative actions. Understand Herts CYP/F user experience and professional confidence in services to support any system improvement. Monitor and understand demand and capacity of CYP mental health services. In west Essex, alongside expanding access, the focus will be on developing and improving core services, particularly in the areas of early intervention, prevention, community health, reducing inequalities, improving quality. With more of an emphasis on improving outcomes and experience of service for our CYP,	Improve service user experience of CYP mental health services.

decision making and feel empowered to have an active role in their own mental health and wellbeing. West Essex focus: Continue to ensure that children and young people (CYP) aged 0-25 have access to mental health services via adult mental health pathways and school/college based mental health support teams. Maintain 24/7 access to community crisis response and intensive home treatment as an alternative to acute inpatient admissions; sustain the target of 95% of CYP with eating disorders accessing treatment within 1 week for urgent cases and 4 weeks for routine cases. Ensure CYP mental health plans align with those for CYP with learning disability, autism, (Transforming Care cohort) special educational needs and disability (SEND), CYP's services, health, and justice.	families, and carers. Work towards 100% of children and young people achieving access to specialist mental health care. Build on THRIVE methodology and principles, ensure Herts CYP/F are involved in shared decision making and feel empowered to have an active role around their own mental health and wellbeing.	
Increasing and improving access to digital interventions: Continue to maintain early help and support by providing innovative digital therapies as well as efficient digital platform gateway for all mental health services; with focus on empowerment/self-care for Herts CYP/families/Carers, providing guidance, information, self-help and tailored support. In west Essex, continue to develop digital support offer for CYP Mental Health (MH); balancing digital offer with face-to-face provision, responding to feedback from CYP. Ensure there are digital leads across all North East London Foundation Trust (NELFT) Southend Essex Thurrock (SET) Child and Adolescent Mental Health Services (CAMHS). Development of		Increase the use of digital support, advice, and guidance in CYP mental health services. Improve service user experience of CYP mental health services digital support.

comprehensive offer (web, social media, treatment options).		
Digital: Continue to review and monitor the 'all age digital intervention offers' including impact, outcomes data and experience feedback. To support those who are digitally engaged and motivated to use online mental health self-help tools and 'AI' based therapeutic interventions to gain quicker access to support. Develop and embed the CYP mental health 'front door' triage team and the digital gateway portal and support improved navigation, increasing access, automated referrals, brief and single session interventions, advice, guidance to improve both the experience and journey of CYP. Enhance mental health data available on the Shared Care Record to provide greater information sharing across the system to enable greater visibility of patient needs at other care settings i.e. Emergency Department/Primary care.	Increase deployment of the online library of self-care apps that can support community mental health models. Enable electronic access to appointments, letter, care plans to help primary care networks and community working. Use automation for common tasks to increase capacity and provide more time to care. Implement systems to make it easier to book, track and manage rooms, equipment and resources to support new models of care in community and primary care networks. Herts CYP mental health services 'front door' triage team functioning; with outcomes and benefits realisation expected in the summer of 2025. Undertake a review of the Herts CYP mental health triage team to understand the impact and consider growth.	Increased Mental Health data on Shared Cared record use. Reduce missed appointments. Increase access to electronic services i.e. appointments, letters. Improve patient satisfaction.

Essex Child and Adolescent Mental Health Services (CAMHS): In west Essex the focus will be on prevention and early intervention, acute and crisis, supporting recovery. Key priorities will include the expansion of the CYP mental health primary care roles to increase access. Expand Mental Health Support Teams in educational settings; expand access to First Episode Rapid Early Intervention for Eating Disorders (FREED) and Avoidant/ Restrictive Food Intake Disorder (ARFID), CYP Eating Disorder (CYPEDs) Pathways. Maintenance of CYPEDs community intensive support services; improving access to infant mental health service and increasing access to health and justice mental health provision. Ensure continuity of early intervention and prevention (non-clinical services) designed to complement the core CAMH service offer. Extend the Mental Health Liaison Nurse roles in acute settings to assist paediatric teams to respond to mental health needs of CYP. Roll out of self-harm management toolkit in education settings, expanding the community mental health and children and young people learning disability neurodevelopment team. Mobilising at risk mental health (ARMS) teams; maintain pathways to support the Young Adults transition (18-25) and embed the principles of THRIVE to ensure services are needs led. In Hertfordshire evaluating the paediatric mental health liaison model for children and young people with mental health needs who present in acute paediatric settings	Consider the implementation of new combined clinical model for ASD/ADHD across NHS providers in Hertfordshire.	70% Service users reporting satisfaction with services received. 92% Referral to Treatment (RTT), incomplete pathways, CYP waiting to start treatment <18 weeks. 95% RTT (completed pathways) – CYP seen <18 weeks. Reduce the number of missed appointments to the target rate,10%.

as part of the wider crisis model. Design a new clinical model and pathways for ASD/ADHD services and explore potential shared learning from west Essex regarding ASD support hub pilots. Continue to reduce Out of Area placements and explore alternative options to maximise our local bed base. Continue with the Quality Transformation Programme for Mental Health, Learning Disability and Autism Inpatient Services under the Commissioning Framework for Mental Health Inpatient Services.		

How will we know that we made a difference:

We will have:

- Increased our response to Urgent Referrals to Community Crisis Services (CCS) in 2024/25 from 64% to 67%.
- Reduced the use of out of area inappropriate beds for adults requiring a mental health inpatient stay across the ICS from 16 people to four by March 2025.
- 75% of inpatient discharges to have 72-hour post discharge follow up by March 2025.

2. Delivering our ambitions for 2024-2029

2.1 Give every child the best start in life

Also supporting our Integrated Care Strategy Priority “Give every child the best start in life”.

Our ambition	Our Challenges:	What our residents say:
All children will have the best start and be supported to live as healthily as possible	Health concerns linked to social disadvantage, increasing social and emotional difficulties in young children, mapping through to school exclusions (including primary), youth justice entrants and increasing numbers of children with social and communication difficulties. Children aged four to five years old in Essex (22.3%) and in Hertfordshire (20.1%) are classified as being overweight or obese. This increases for 10–11-year-olds in Essex to 33.1% and in Hertfordshire to 30% (2019/20 data). Emergency hospital admissions for children aged under 18 years are significantly higher in East and North Hertfordshire and rates of Emergency Department (ED) attendances are higher in west Essex for children aged under five years than the national average. There are increasing numbers of children needing crisis intervention, with numbers of children in the care of their local authority and those	We established a youth council in September 2023 with 10 youth ambassadors representing the voices of children and young people from across Hertfordshire and west Essex. We have been meeting with the youth ambassadors, to learn what young people want from services, and how best we engage them. This results in a co-production project to produce a number of videos and The Patient Association and the Youth Ambassadors gave their opinions and views on what is it like to access a GP surgery and the top health concerns for children and young people today. A summary of the key findings are outlined below: • Young individuals expressed a preference for engaging with health services through online platforms, such as apps. • When seeking medical assistance, they indicated a desire to communicate with healthcare professionals who are more relatable in age, fostering a greater sense of understanding. • To enhance outreach, it was suggested that health services should utilise social media platforms that

	needing mental health specialist hospital provision increasing.	resonate with the younger demographic, like Instagram and Snapchat. • Young people with Special Educational Needs and Disabilities (SEND) require additional time for communication to ensure their voices are adequately heard. • Some participants were unaware of the services provided by pharmacies, particularly for advice and contraceptives. They emphasised the need for increased promotion of these services in schools and on social media. Concerns were raised about the perceived lack of privacy in pharmacies. • There is a demand for more education on overcoming mental health challenges among young individuals, as they feel current educational efforts are insufficient. • To make informed decisions about their health, young people expressed a need for more information on the long-term effects of vaping and drug consumption.

Our Plans:

2024-25	2025-29	Progress Indicators
SEND: Continuing the Children's Therapies Transformation Programme across Essex, ongoing local implementation of the Delivery Framework, staff engagement, resource modelling around local schools and density of need. Formalising our commissioning strategy at place to facilitate further integration of therapy services, alignment of guidance and information resources for parents, carers and young people and continued engagement to identify new opportunities.	Full integration of Special Educational Needs and Disabilities (SEND) and core therapy services in west Essex	Achievement of The Balanced System® framework Reduction in therapy waiting times for early support and specialist intervention
Mental Health and Obesity: Working in partnership to tackle and reduce the number of children aged four to five and ten to eleven years old who are overweight and improve awareness and access to emotional wellbeing and mental health support services (school years 1-3) to reduce the number needing specialist mental health hospital provision. We will utilise the Primary Care Networks & Integrated Neighbourhood Teams to deliver health inequalities projects to support levelling up and achieve health equity.		

Epilepsy: Work with partners to deliver the national bundle of care for children and young people, and the national 'Epilepsy12' programme to improve outcomes for children and families living with epilepsy. We will monitor and evaluate the regional pilot to increase access to epilepsy nurses.	Following the regional pilot evaluation, we'll work with our regional colleagues to support a system wide approach for sustainable Children's Epilepsy Services. We will review and continue to identify deliverables in the epilepsy bundles. share good practice and continue to make improvements where gaps are identified.	Reduction in Accident and Emergency attendances and admissions for children and young people with epilepsy
Engagement: Build on the current success of the youth council, recruit more young people to join and increase the youth council reach across our system, provide opportunities for more children and young people participation and co-production. Explore all possibilities to capture the voices and lived experiences of young adults aged between 19-25 years old, including parents and carers, resulting in a fully established participation and co-production function in the children and young people teams.		An increase in the number of co-production projects
Maternity: Ensuring pregnant women and new mothers have access to pelvic health services by 2024. Working closely with regional workforce colleagues to monitor improvements in growing, retaining and supporting our workforce through recruitment and retention leads. Our strong recruitment plans are having a noticeable reduction in the number of midwifery vacancies, empowering our teams to continue working with professionalism, kindness,	We will ensure that we have the right numbers of the right staff available to provide the best care for women and babies, by regular local workforce planning to meet staffing levels and reducing the number of vacancies for midwifery posts by 2027/28. By 2025 we will begin to deliver the national maternity early warning score tool developed by the Royal College of	Delivery of our 5-year equity and equality action plan

compassion and respect at all times accessing practical guidance and training through the perinatal culture and leadership programmes by 2024. We will continue to implement the 'Saving Babies Lives Care Bundle version 3' which provides evidence-based practice for providers and commissioners of maternity care across England to reduce perinatal mortality; including interventions to reduce stillbirths, neonatal brain injury, neonatal death and preterm births by 2024.	Physicians which improves the detection and response to clinical deterioration in adult patients and is a key element of patient safety and improving patient outcomes Ensure full delivery of the Three-Year Delivery Plan for Maternity and Neonatal Services	
Undertake a system wide approach to improve access for children and young people (CYP) to ensure 'No Wrong Door' approach and ensure smooth transfer between services with a focus on health inequalities through CYP mental health services triage team. Understand service gaps and identify hard to reach groups work with providers to deliver solutions.	Continue to improve access, waiting times and outcomes for children and young people and reduce health inequalities through peoples lived experience to understand if health inequalities are reducing and access is improving. Continue to improve access to services and promote good mental health for all, with an additional focus on children and young people who are more vulnerable to poor mental health.	Increase in baseline data for access to groups facing health inequalities across Herts CYP mental health services. Improvement in service user surveys for Herts CYP mental health services.

How will we know that we made a difference:

We will have:

- A reduction in the numbers of stillbirths and deaths in the first week of life
- Reduced waiting lists for neurodiversity services
- Decreased waiting times across all community paediatric services
- Reduced emergency admissions for all children under 18.
- Increased utilisation of hospital at home and other approaches to support children to have hospital level care in their own home.

2.2 Increasing healthy life expectancy and reducing inequality

Also supporting our Integrated Care Strategy Priorities “Improve support to people living with life-long conditions, long term health conditions, physical disabilities and their families” and “Support our residents to maintain healthy lifestyles”.

Our ambition	**Our Challenges:**	**What our residents say:**
Reduce under 75 mortality from long-term conditions	Whilst the HWE population is (in general) less deprived than the national average, there are communities within each of our three place areas with much more significant deprivation, where health and other outcomes are not at the same level as other parts of the system. Our populations life expectancy is reducing through conditions including heart disease and obesity with wide variation between our place areas. Around 1 in 5 adults across our geography are physically inactive, which means around 20% of the adult population are at increased risk of a range of health conditions and diseases which are preventable through increased physical activity. In 2022, the median age of death for people with learning disabilities in Hertfordshire was 61 years old (males and females). The national LeDeR Learning from Lives and Deaths Annual Report (2022) indicates that the median age of death of	Our ICS commissioned online focus group sessions in early November 2022, to hear from stakeholders who work with or represent seldom heard communities. Each group brought together representatives who work closely with specific groups including BAME; Children and Young People; People Living in Poverty; and a General Inclusion Group. This qualitative work brought these issues to light: “Those people from deprived backgrounds on low-income jobs who are not able to afford appointments [as they are] working very long hours, very scared to take time of work, in terms of not getting time off work or would lose money to get appointments by GPs.” “We need to be aware of the physical barriers like public transport and the cost of getting to these locations for these appointments”. “The built environment has a huge influence on people's health in the long term, can we get a better built environment? Can we do better in terms of our housing stock? Can we do better in terms of, I mean, with the financial crisis coming along? How are we helping our residents in terms of economic support, jobs and so forth?” “We do a lot of work with families with children who are under five in one of, if not, the most deprived neighbourhoods in Hertfordshire and you know what we're seeing there is, we're trying to kind of marry together, health

	autistic adults is 55. This is considerably lower than the median age for the general population at 82.3 for males and 85.8 years for females (2018/20). 4.9% of our population take 10 or more medicines often for more than one long term condition. All medicines cause adverse effects and sometimes the cause is not recognised. By effectively regularly reviewing medicines with patients and carers these effects and some of their harmful outcomes can be reduced.	and well-being education and learning and development of skills and your kind of trying to work against a centralised kind of mechanisms and it does make it quite challenging. So one thing is whilst looking at priorities, it's also about looking at the place's priorities alongside those overarching ones and being able to be a little bit more flexible." "The doctors don't live in the communities where the people live and they don't understand that you're having a choice between paying for the bus to go to the food bank or pay for the bus to go to see the doctor, and then you get a snotty note saying why didn't you turn up your appointment?" In 2023, as part of the JFP Healthwatch report we found that 16% (84) of respondents said they would like more information about the side effects of medication, particularly the long-term effects, and 7% (37) want more information about any contra-indications or interactions between medications. 11% (55) of respondents said they would like more direct and precise information about what their medication is for, and how best to take it.

Our plans:

2024-25	2025-29	Progress Indicators
West Essex: Pilot interventions adapted according to need; to include learning from Core20Plus5 Connectors wave 2, Levelling Up in Harlow, Proactive Social Prescribing, Community Agents in Essex and other models. Further develop and implement the Neighbourhood Network developing tool designed to help primary care networks to build on community assets and address health inequalities (years 1 and 2). Share draft Social Prescribing (SP) strategy and a new vision for social prescribing for children and young people with Health Creation Strategy Group and Primary Care Networks as the basis for further development as part of the No Wrong Door strand of the Health Creation Strategy (years 1 and 2).	Understand the full impact of social prescribing on individuals, community development, capacity and commissioning of the voluntary, community, faith and social enterprise sector (VCFSE). Work with VCFSE to digitally embed and integrate activities and outcomes in improving analysis to address wider determinants of heath. Identify some of the five Core20Plus5 clinical areas of focus and take a targeted approach concentrating on the most deprived district/ borough councils to address health inequalities (Stevenage, Harlow, Broxbourne, Watford and Welwyn Hatfield (Years 1-3)).	Social value created in communities and preventing crisis/ill health. Proportion of residents reporting satisfaction for local area as place to live and work, access to and use of green space, housing quality.
Specialist Commissioning To integrate the Med Tech Funding Mandate and Specialised Services Devices Programme into our contract management and research teams. We will continue to develop our Targeted Lung Health Check Programme focussing on areas of deprivation and high smoking prevalence, as well as armed forces veterans who are known to be smokers. We will develop an integrated approach to our personalised care programme for patients with complex co- morbidity receiving specialised services,	We will implement transformation plans through specialist clinical network and provider collaboratives as agreed through the East of England Joint Commissioning Committee	

to develop personalised Shared Care Records and integrated personalised care plans. Priority areas include patients with sickle cell disease and patients, carers, veterans, children and young people with specialist needs. Maintain robust and safe cancer services at Mount Vernon Cancer Centre; seeking capital to deliver the strategic re-provision plan. Identify services which can be delivered closer to home in outpatients and diagnostics. Continuing to work closely with East of England Joint Commissioning Committee for Specialist Services to manage and report on the 59 delegated service and develop robust transition plans for the Amber services due for delegation in April 2025. and report on the delegates specialist service. We will collaborate and co-commission with cross boundary specialist services. Working collaboratively with our colleagues in the 5 East of England Integrated Care Boards to develop a 5-year strategic plan for specialist services. Ensuring priority focus on planning the future re-location of Mount Vernon Cancer Centre (MVCC).		
Digital: Implementation of a shared data platform including population health management (PHM), to level-up data access, intelligence and analytics. Complete and increase utilisation of Resident Access	In west Essex digital inclusion activity will be progressed with County and District Council involvement, by implementing a personalised approach require reasonable adjustments	

platforms and report on primary care digital response to Health Inequalities. During 2026/29 we will increase the use of the NHS App based prescribing.	and targeted resources to ensure those experiencing digital exclusion are not further disadvantaged	
Embed all age suicide prevention and postvention into business as usual: Working with the voluntary sector agree a 5-year strategic plan focussed on suicide prevention, including the development of agreed metrics for system wide prevention monitoring. Implement suicide prevention training for the Armed Forces Community (AFC) working closely with our two County Suicide Prevention Boards. Reduce suicide, suicide attempts and self-harm rates working in partnership with health partners.	Utilise the population health data; national, regional and local suicide prevention strategy and needs analysis including the 3-year Coroners Audit of suicides to identify high risk groups; trends; clusters of our population. In West Essex we will continue to support the west Essex Suicide Prevention Strategy linking plans with priorities which result in better outcomes for those experiencing poor mental health and are at risk of self-harm or suicide. This will include a range of partners including the voluntary sector.	Report on the suicide numbers per Hertfordshire and West Essex population Agree 5-year plan as part of the system wide Better Care Fund including the voluntary sector.
Voluntary, Community, Faith and Social Enterprise (VCFSE): Improve the identification of carers in acute and community NHS services. Working to agree a 5-year strategic plan for social prescribing services; focus on health inequalities, data, impact and asset-based community development through the prevention lens. Utilise the Assura Foundation process to support grass root charities to address health inequalities in partnership with primary care networks.		Increased identification of friend and family carers. Monitor acute provider delivery of section 91 of Health and Care Act

Diabetes: Improvement in the delivery of core care for people with diabetes and implement the integrated care systems framework for diabetes care. ICS-wide roll out of the pathway to remission, including training, webinars for GPs. Implementation of early onset type 2 diabetes programme aimed at 18- to 39-year-olds. Primary care will continue to be funded to deliver core care processes and manage the health needs of people with non-diabetic hyperglycaemia and diabetes proactively.	The ICS will implement an integrated model of diabetes care that will ensure that there is equitable access to care adopting a population health management approach that delivers care according to need.	Improve of diabetic 8 care processes and three treatment targets. Increase in the number of people receiving a urine Albumin to Creatinine (ACR) care process. Increase the take up rates of diabetic structured education classes.
Respiratory: The ICS will continue our implementation of the asthma diagnosis hubs and to improve the delivery of core care for people with chronic obstructive pulmonary disease (COPD) in primary care. Further respiratory hubs to go live and join up diagnostic hubs with secondary care. Primary care will continue to be funded to deliver core care processes and manage the health needs of people with COPD proactively.	Continue to improve access to respiratory diagnostics, at PCN and Place level (e.g. sleep studies). Development of existing integrated respiratory services.	Improve accredited members of staff to deliver spirometry. Increase the number of Pulmonary Rehabilitation classes delivered face to face. Increase the proportion of people with a long-term respiratory condition who have a diagnosis confirmed by appropriate tests.

		Reduce prescription of high dose corticocortical steroid inhalers in ENH
Learning Disability and Autism Health Inequalities: Continue to deliver and improve the quality of Learning Disability Annual Health Checks (target 75%), including health action plans. Ongoing monitoring of LeDeR 3-year action plan taking into account our population health needs and identification of future priorities and planning. Sharing learning from the LeDeR reviews across the system to improve quality. Continue to develop access to preventative and proactive support as an identified theme from LeDeR and safety incidents for autistic adults and adults who have a learning disability. Respond to the national implementation of the digital reasonable adjustment flag and how this can be utilised to support learning disability and autistic people, families and organisations in understanding what may be needed and how to implement. Explore the options for practices to hold an Autism diagnosis register and make the necessary reasonable adjustments for autistic people to access health services. Embed the Integrated Care Board (ICB) Enhanced Commissioning Framework for Primary	Contract review with all commissioned services to ensure integrated models of care, continue to embed learning from the national LeDeR programme across health and care partners locally. Review learning from the national Autism Annual Health Check pilot and continue to explore how this can be implemented locally. Continue to improve access to services, exploring further training on reasonable adjustments. Develop system roadmaps to meet learning disability and autism population needs at local level, to ensure sustainable services in line with the expansion of communities.	**Learning Disability and Autism Health Inequalities:** Continue to deliver and improve the quality of Learning Disability Annual Health Checks (target 75%), including health action plans. Ongoing monitoring of LeDeR 3-year action plan taking into account our population health needs and identification of future priorities and planning. Reducing overprescribing in people with learning disabilities.

Care, continue to reduce waiting times for autism assessments and explore the different models of autism diagnosis pathways, ensuring compliance with NICE guidelines.		
Addressing health inequalities - mental health: We will continue to invest in employment support for people with a Severe Mental Illness aligned to Individual Placement and Support (IPS). Work to improve the uptake of Physical health Checks for people with an SMI. We will work to improve access to clinical pathways and support for people with autism and learning disabilities to support their health needs. Health system alignment, including pathways commissioned services such as reducing smoking rates among people with severe mental illness.		Increase the number of people accessing employment support. Increase the % of people with an SMI receiving an Annual Physical health Check.

How will we know that we made a difference:

- An increase in life expectancy across our system
- A lower rate of mortality from all cardiovascular disease
- An increase in the number of GP recorded hypertension patients with a blood pressure reading within the target range
- A fall in the rate of suicide across Hertfordshire and West Essex
- Targeted work to identify patients with hypertension in our most deprived communities.
- A reduction in high dose inhaled corticosteroid inhaler prescribing.
- A reduction in high carbon inhaler use
- A reduction in overprescribing in people with learning disabilities

2.3 Improving access to health and care services

Also supporting our Integrated Care Strategy Priorities “Support our communities and places to be healthy and sustainable” and “to improve our residents’ mental health and outcomes for those with learning disabilities and autism”:

Our ambition	**Our Challenges:**	**What our residents say:**
Reduction in the numbers waiting for elective activity and diagnostics	Post the pandemic patient health needs have increased and require more complex diagnosis and treatment. The current size of the waiting list is greater than the current capacity will allow. The numbers of patients waiting for elective treatment has fallen over the last 6 months but remains high. Outpatient and theatre productivity is currently below national standards and is inconsistent across the system, currently 80%, below the required 85% (Theatre productivity). We are finalising our elective strategy to increase capacity and improve productivity to ensure that patients are seen more quickly and waiting lists continue to fall. There are inconsistent pathways for the same conditions across our system providers leading to unwanted variation.	A survey into **Joint Forward Plan priorities, carried out in 2023** by the ICB and thematically analysed by Healthwatch Hertfordshire heard from 1,124 respondents, predominantly aged 50+. • When asked whether they would be prepared to travel to have non-urgent treatment more quickly, 70% said that they would be prepared to travel to another location in Hertfordshire or west Essex, and 59% said that they would be prepared to travel to a neighbouring area. • 77% of respondents agreed that they would be happy to receive initial healthcare advice from a telephone appointment. • 15% (60) of respondents suggested that the NHS could do more to support people by improving access to services. For example, a large proportion felt that the NHS needs to shorten waiting times, particularly in relation to GP services, secondary care and mental health services. • 90% of people surveyed said that they would be happy to see other professionals, such as a

		physiotherapist, social prescriber or practice nurse if this person had the skills required to help them, rather than wait to see a GP.
Everyone is able to easily and rapidly access the right urgent and emergency care	Many people are accessing services that are not best suited to their urgent care needs. One third of emergency department (ED) attendances in HWE resulted in no investigation or treatment suggesting these needs could have been addressed by alternative same day access in primary care or integrated urgent care, to free up capacity to deal with true emergencies within ED. Currently, there are delays in responding to ambulance calls across HWE, but many of these calls could be appropriately responded to by another service in primary or community care and would protect ambulance capacity to respond faster to the more serious emergencies**.**	A local survey to understand the views and experiences from people who had used our urgent and emergency care services in the past 12 month found the most cited suggestions for improvements related to primary care access, many citing difficulties in obtaining a same day GP appointment which often related to the 8am rush for appointments or about obtaining a face-to-face appointment. Almost one third of respondents reported they didn't know where to seek help for urgent or same day care, and 1 in 10 respondents felt services were confusing or hard to understand.
Increase in the provision of early help to prevent mental illness and support the health and wellbeing of those with a Severe Mental Illness (SMI), learning disabilities or autism	In Hertfordshire, the excess mortality rate for adults with a severe mental illness is above the regional average and in Essex, the rate of premature mortality is similar for cancer, cardiovascular disease, and respiratory illnesses *(Source: Health Needs Analysis Overview 2022)*. Mental health is a contributor to the gap in life expectancy between the most and least deprived areas, 6.9% for males in Hertfordshire and 2.9% in west Essex and 10.3% for females 7.6% in west Essex, *(Source: Hertfordshire Public Health Evidence and Intelligence, 2022 and Essex Joint Strategic Needs Assessment 2021-22).*	A survey into **Joint Forward Plan priorities by the ICB was, carried out in 2023** and thematically analysed by Healthwatch Hertfordshire heard from 1,124 respondents, predominantly aged 50+. 30% (136) of respondents said easier, quicker access to GP services would support them in getting the help they need for their mental health. Of these respondents, some also suggested that GP services should be more proactive in asking patients about their mental health and should be more aware of mental health issues.

	There has been a yearly increase over the last 3 years of adults reporting a long-term mental health condition. In 2022, the median age of death for people with learning disabilities in Hertfordshire was 61 years old compared to the national Learning from Lives and Deaths Annual Report (LeDeR) (2022) which indicates the median age of death of autistic adults is 55 years old. This is considerably lower than the median age for the general population at 82 years old for men and 85 years for women (2018/20). Autistic people are up to three times more likely to experience mental ill health and for many ill health can be more difficult to recognise, this can cause delays in diagnosis and led to delays in accessing appropriate support or treatment. The relationship between drug use and mental health problems among young people is of particular concern. Research shows that mental health problems are experienced by 70% of drug users in community substance misuse treatment. Deaths by suicide are also common among those with a history of drug misuse, between 2008 and 2019 34% of deaths from suicide were amongst people known to be experiencing mental health problems	24% (108) of respondents suggested waiting lists are too long, with many noting they have had to wait months before they were offered an appointment or treatment. Some respondents would like interim support while waiting for treatment. 10% (41) of respondents suggested that NHS staff need more training, particularly around how to support and interact with people with autism, people with learning disabilities, and people with sensory needs.

Our plans to improve access to Health and Care services:

2024-25	2025-29	Progress Indicators
Same Day Urgent Care: We will undertake a system-wide review of urgent treatment centres (UTCs) and minor injuries units (MIUs), including same day access hubs, to ensure we are providing the right level of access for our populations' same day urgent care needs. We will ensure consistency in pathways of care, assess the optimum locations and opening times to ensure equitable access and outcomes. We will further develop integrated pathways between both locally led models of same day access and UTCs and other urgent and emergency care services (NHS 111, ED, SDEC, hospital at home) to support referrals, diagnostics, treatment, and monitoring. Continued development of primary care led Integrated Urgent Assessment and Treatment Centre (IUATC) including optimising opportunities for hub and spoke model and developing them into business-as-usual services.	We will share learning across the system in relation to different models of UTCs and same day access hubs and spread best practice across HWE. Enable virtual networking of our emergency departments, same day emergency care (SDEC) services and urgent treatment centres to ensure patients have appropriate and timely access to diagnostics regardless of where they access the system.	Reduce low acuity presentations at type 1 emergency departments. Reduce emergency admissions for acute conditions that should not usually require hospital admission.
Urgent and Emergency Care – managing demand: We will work to develop an innovative demand management (NHS111 and unscheduled care hub) model to manage our urgent and emergency care demand from NHS 111 and 999 calls and explore potential for these UEC access points to be effectively integrated into a single assessment service (supported by a comprehensive and up-to-date directory of services [DoS]). We will increase clinical assessment of calls and proactively manage ambulance 999 call lists, expanding the 999 calls that	Expand the category of ambulance calls that can be automatically redirected and proactively managed by the unscheduled care hub, so that people dialling 999 with non-time critical presentations can be supported to directly access alternative pathways.	Reduce number of clinical assessments, referrals, and wait times for patients (reduce % abandoned calls, mean 999 call answering times)

can be proactively managed by the hub. We will maximise opportunities for ambulance crew to 'call before convey' to increase direct referrals to alternative sources. Integration with our Care Coordination Centres will enable patients to benefit from multidisciplinary senior clinical decision-maker assessment to find and streamline referral to the most appropriate urgent and emergency care closer to home (e.g. urgent community response, hospital at home, mental health, primary care, or direct access hospital pathways.)	Continue development of the model to become a single point of access across the system with no boundary restrictions. Enable access to multidisciplinary teams, to include acute consultants, with specialty clinical advice lines for guidance to support 'call before convey', and both mental health and drug and alcohol expertise. Continue to embed a trusted assessor approach across our urgent care pathways and digital interoperability to share records to ensure patients do not have to repeat their medical information.	Reduce ambulance conveyances. Reduced category 2 mean response times
Urgent and emergency care: system coordination Evolving and developing the System Coordination Centre (SCC) ensuring oversight of system pressures and supporting patient access to the safest and highest quality of care possible. The SCC will continue to develop true system coordination, with real-time clinical input into decisions made by the system to keep patients safe. Continued implementation of the Operating Pressure Escalation Level (OPEL) Framework with specified agreed incremental actions to support interventions across the ICS on key issues influencing patient flow.	Continued development of the System Coordination Centre to enable true system coordination. Ongoing development of a dashboard (SHREWD) to support whole system near-live monitoring of demand and system impacts and interdependencies.	Reduced category 2 mean response times Improved ED all-type 4-hour performance
Primary Care – Access Recovery Plan/Implementation of modern General Practice: Further implementation of cloud-based telephony and digital access including effective triage and signposting to more efficiently utilise available appointments and	Strengthen professional development and career pathways for Allied Health Professionals (AHPs) working in primary	To deliver over 8.1m GP appointments for 24/25

improve access, especially improving same/next day assessment and appointments with 2 weeks. We will monitor the impact of this and respond to any unintended consequences that may arise. Integrated neighbourhood team & PCN collaborative models, especially on same day hubs, to handle demand more effectively. NHS App & wider digital access implementation to empower patients & reduce need to contact practices directly We will scope the role of optometrists in the delivery of eye care ophthalmology pathway across primary care, community and hospital services. In addition to these, we are exploring expansion to improve same day access to optometrists for a range of minor eye conditions which is a service currently commissioned across west Essex and Stort valley in East and North Hertfordshire	care and continue to embed new models into business as usual. Referral optimisation – develop a referral management service/process improving patients access to planned care specialities	To deliver c89% of appointments within 2 weeks (for those appts where patient would request the first available) Increasing year-on-year numbers of completed online consultations from April 2024 to March 2028 Greater access to optometry diagnostic tests and investigations by April 2025
Integrated Neighbourhood Teams (INT): Continue to establish Integrated Neighbourhood Teams (INTs) with clarity of purpose and clear governance arrangements. By July 2024 Hertfordshire and west Essex will have INT coverage at primary care network level with establishment of locality leadership board, recruitment of overall lead and documents to support establishment of INTs (such as: Terms of reference, Memorandum of Understanding, risk sharing agreements) will be drafted for INTs to use.	Ongoing evaluation to understand impact and using quality improvement methodologies to continually show improvement.	All INTs delivering a collaborative service or health intervention from by May 2024 onwards in a phased way. Improved health and wellbeing outcomes in those clinical domain(s) identified, March 2025

The Primary Care CPD programme for 2023-24 has been reviewed and refreshed to ensure that the training provided is aligned to the ICS' strategic priorities. As part of this review the intention is to increase the number of funded leadership courses for primary care managers. In addition to the universal training offer, there is some scope in the programme to address support individual development needs of individual staff, practices, PCNs or INTs; all INTs will have identified a population group that would benefit from a joined-up approach. Population Health Management data will continue to be shared with INTs and each INT through a collaborative approach will identify the interventions including delivery, with the Health and Care Partnership.		Ongoing during 2024/25 – continue to refine and develop new models of care with system partners to improve access
Dental: Implementation of dental workforce, recruitment and retention plan, extend current urgent in and out of hours dental service contracts, preparing the commissioning model of care aligned to the urgent, emergency care strategy outcomes and primary care objective of same day access or urgent primary care (dental needs). Commission urgent dental care providing equality access, whilst addressing the health inequalities in deprived areas and supporting vulnerable and hard-to-reach groups. A review of secondary care dental pathways will be undertaken to identify opportunities for treatment to be delivered in the community improving equity of access. Evaluation of access and care home pilots to develop the longer-term commissioning model. Secure long-term Orthodontic services following completion of Orthodontic Needs Assessment. Implementation of national Dental Access Recovery Plan to secure and improve access and to improve oral health outcomes.	Development of one single specification for a Special Care Dental Service which will be commissioned from April 2026. Continued development of dental workforce recruitment and retention plan.	Increase delivery of units of dental activity to 1.9million for 24/25.

Pharmacy integration: Explore and develop integrated service delivery models for community pharmacy, review demand against current provision to identify and address problems with accessing pharmacy services. We will include community pharmacy leads in system leadership, strategic planning and pathway design, embed Pharmacy First into Primary Care service delivery, integrate community pharmacy as part of the Integrated Neighbourhood Teams (INT's). Map current community pharmacy provision incorporating this into wider system resilience and capacity planning. Develop local independent prescribing community pharmacy pathfinder programme Develop local pharmacy workforce plans, scoping local needs and ensuring workforce plans are as aligned as far as possible. and support to increase number of independent prescribers via greater availability of Designated Prescribing Practitioners (DPPs), multi-sector placements. Increase the number of referrals from GP practices and NHS 111 to community pharmacists through the Pharmacy First service (formally Community Pharmacy Consultation Service (CPCS)) and expand the number of pathways that offer patient self-referral and conditions that can be seen. The local communications approach and support for Pharmacy First is a mixture of targeted work to reach those least likely to receive their news through mainstream channels, members of the public, stakeholder groups and primary care and ICB staff.	Embed pharmacy delivery in primary care services with noticeable improved patient experience and outcomes, continuing to support independent prescribers	Increase utilisation of pharmacy workforce (e.g. accredited checking technicians/ pharmacist roles) Increase number of independent prescribers Increase number of trainee placement providers in general practice Increase referrals from GP practices to community pharmacies for the NHS Pharmacy First service to approx. 14,983 referrals from April 2024 to March 2025. Increase referrals for NHS 111 to approx. 9,940

Primary Care: Our ambition is for each primary care network to have a Children and Young People's Social Prescriber / Personalised Care Practitioner in place by March 2025. Continue to work with GP practices supporting them in becoming Royal College of GPs (RCGP) accredited as Veteran Friendly.		Increased recruitment of Allied Health Professionals and non-registered workers. Increase the number of Children and Young People's Social Prescriber/personalised care practitioner in GP Practices. Increase in the number of veteran friendly GP practices across HWE
2024-2025: Improved cancer operational performance: Continue to assess performance at tumour site level to highlight areas of underperformance and where improvement plans will deliver a faster and earlier diagnosis. **Improved screening update:** Continue delivery for the East and North Hertfordshire population. Commence roll out of a Targeted Lunch Health Check (TLHC) programme for a proportion of practices within the Southwest Herts area, starting April 24 for 4-year programme, priority practices and population size to be identified. Develop plans for further roll out within the west Essex locality in 2025/26.	Improved stage 1 and 2 diagnosis (75% by 2028) measured against 2023/24 baseline: Ongoing awareness sessions and activities to support cancer information, awareness and understanding. Assess position of stage at diagnosis to see where a shift from stage 3 and 4 to stage 1 and 2 is not demonstrated. Identify areas where further work and improvement will be required.	Improved screening uptake Targeted Lunch Health Checks 80% of bowel cancer referrals are accompanied by a FiT result. 100% population coverage of non-specific symptoms pathway (NSSP)

Improved extended use and implementation of cancer screening innovation tools and techniques: Continue to monitor the use of Faecal Immunochemical Testing (FIT) used as a screening test for colon cancer. Within East and North Hertfordshire a 'smart' referral form is being used within GP practices, allowing GP to provide advice and signposting at the time of referral. Cytosponge, is a single use device used to collect cells from the lining of the oesophagus, transition pilots into business as usual and develop opportunities for primary care and community-based models of delivery. Primary Care Network (PCN) in Stevenage South are participating in a pilot focused on early identification of people at risk of Barrett's Oesophagus or oesophageal cancer, which is receiving positive feedback. Extend the provision of tele-dermatology services and community spot clinics supporting earlier and faster interventions. Evaluate current tele-dermatology pilots and implement services for patients referred for a suspected skin cancer. **Breast pain Clinics:** Transition the East and North Hertfordshire Trust community-based breast pain clinic pathway into business-as-usual pathways. Develop a community-based breast pain clinic pathway and commence transition to a community-based model for The Princess Alexandra Hospital and West Hertfordshire Teaching Hospital.		

Transition the Non-Site-Specific Pathway Service (NSSP) pilots to business-as-usual models, exploring the potential of a system wide pathway/model.		
West Essex/Essex mental health: Implement system mapping of inpatient beds in collaboration with partners across Essex. Move from Care Programme Approach to personalised tailored care with new ways of working/care co-ordination across Essex and the Integrated Care Board (ICB)	Consolidate and review community mental health transformation (in line with the national roadmap and mental health strategy direction of travel). Review of Right Care, Right Person with system partners in line with police strategies.	Reduction in out of area placements
National mental health and learning disabilities strategy: The (ICB) will respond to the expected national strategy and continue to embed and consolidate and work with partners to support our population, such as employment, physical health checks, understanding the housing needs of the population, working though community mental health transformation across primary care networks.	Ensure our local strategies and workstreams are refreshed to implement the national strategy.	
Mental health, learning disability and autism inpatient quality programme: Finalise and publish our three-year strategy, and move to implement our plans in 24/25 with partners.	Implement years two and three of the plan.	Strategy implementation milestones met.
Older adult mental health transformation: Continue implementing the Hertfordshire Dementia Strategy 2023-2028, which sets out the broad priorities for health and care services in Hertfordshire, based on what people affected by dementia and their support networks say is most important to them. Improve dementia diagnosis rates to reduce unwarranted variation and continue to embed older adult mental health offer within frailty and physical health pathways to offer holistic long-term conditions/ mental health offer. Develop and implement Dementia and	Maintain a fully integrated older adult mental health and community health teams; in west Essex provide intensive support at place (including care homes) and explore development of services in west Essex that meets the needs of people with mild-cognitive impairment to ensure they have access to the correct health support.	Increase dementia diagnostic rate across Herts and west Essex

Delirium Strategy, west Essex secondary care to support transfer of care into and out of hospital.		
Improving the pathways for young adult mental health services: Focus on improvement of transitions between CYP mental health services and adult services with support from system-wide “transition” navigator and care leaver navigation roles. Ensure those CYP who need support can access adult mental health support effectively, efficiently and are involved in shared decision making, feeling empowered to have an active role around their own mental health and wellbeing.	Embed Herts Young Adult transition workers across CYP and adult mental health services and undertake an evaluation to understand the impact and effectiveness of transition workers. Key Indicators: to be confirmed.	Continual review and patient feedback.
Learning disabilities and autism Transforming Care: Continue to reduce the number of people in long stay placements, implement and embed the requirements of the new Dynamic Support Register (DSR) and Care Education and Treatment Reviews (CETRs) for autistic people embedding our DSR oversight processes with key partners to provide preventative support and prevent admission to a mental health hospital and support discharge with appropriate support. Work with partners to publish Hertfordshire All-Age Autism Strategy with implementation taking place in 2025/26. Undertake a contract review of all services to ensure they support integrated models of care. Continue to reduce waiting times for Autism Assessments and raise awareness of annual health checks for those with a diagnosis of Autism. Improve access to preventative and practical support for autistic adults and adults with a learning disability.	Undertake a full review of contracts and services to ensure future services are sustainable and meet the needs of our local population. Implementation of the Hertfordshire All Age Autism Strategy by 2029.	Reduce the number of patients in long stay placements. Reduce the number of people waiting for an adult Autism Assessment. Strategy implementation milestone.

How will we know that we made a difference:

- Faster access and delivery of cancer services in line with the cancer standards

- Quicker access to diagnostic tests
- Shorter waits for planned care
- Easy and rapid access to same day or urgent care as needed.
- Fewer emergency hospital admissions for intentional self-harm across the system
- An enhanced response to urgent referrals to community crisis services
- A reduced use of inappropriate out of areas placements for mental health patients
- Reduced emergency hospital admissions for intentional self-harm across the system

2.4 Increasing the number of residents taking steps to improve their wellbeing

Also supporting our Integrated Care Strategy Priorities “Support our communities and places to be healthy and sustainable” and “Support our residents to maintain healthy lifestyles”.

Our ambition	Our Challenges:	What our residents say:
	Falling life expectancy through conditions including heart disease and obesity and the number of adults who are overweight was similar to that of England in 2020/21, and still notably high at 62%, with wide variation between districts. Around 1 in 5 adults across our geography are physically inactive, which means around 20% of the adult population are at increased risk of a range of health conditions and diseases which are preventable through increased physical activity. Smoking in adults is similar or better than the England average for all our districts; however, there is some variation between the areas with the lowest rates (St Albans at 5.4%) and the highest (Harlow at 18.9%).	A survey into Joint Forward Plan priorities, carried out in 2023 by the integrated care board and analysed by Healthwatch Hertfordshire heard from 1,124 respondents, predominantly aged 50+. Showed that 10% of respondents suggested that the NHS could focus more on prevention to help improve the health of the population, particularly those in the most need. Of this 10%, some felt that the NHS could work more closely with other services, including councils, Public Health and the voluntary sector to improve health outcomes. Respondents also suggested that prevention could focus on providing more education and practical support about how to live a how to live a healthy lifestyle with considerable support for more preventative interventions and early diagnosis through health checks. They recommended; GPs awareness, education and training to signpost people to support services, particularly for gambling addiction, also addiction awareness in schools, colleges, universities and for parents to educate about soft socialisation to gambling including related harm and alcohol within families as well as for drug and alcohol addiction.

2024-25	2025-29	Progress Indicators
Tobacco Dependency: Expand the national Tobacco Dependency Programme acute inpatient pathway to all specialties and all inpatients and increase the number of patients offered support through this programme across all pathways i.e. maternity, community inpatients and mental health inpatients	Continue the progress to increase the number of patients offered support through the NHS Tobacco Dependency Programme across all pathways. Implement the national Tobacco Dependency Programme outpatient pathway and continue to work with providers across our system to achieve the national ambition of a Smoke Free England by 2030.	Achieve 100% coverage of this pathway by year 1 in Maternity; acute inpatients; mental health inpatients. Achieve 40% coverage of this pathway by year 1 in community outpatient services
Sustainability – Green Plan Focus on implementing and delivering against agreed action plans, launching system wide campaigns to co-ordinate communications on progress. System carbon reduction targets will be fully embedded across all partners with supporting policies and procedures. Review of the Green Plan to reflect on changes and new guidance, such as strategic estates, travel and transport strategy and bio-diversity net gain, creating a new 5-year plan with our partners. Supported by ongoing communications and engagement, which will include training and carbon literacy as part of mandatory training programme.	Focus on those hard to deliver actions; and reflect on what is working and identify areas that need further improvement.	Leads assigned to each work-stream. System wide campaign launched. Reduction in harmful emissions across the HWE NHS footprint
Primary Care: Commission enhanced oral (Dental) support; scope our plans with education and public health. Scope and commission outreach to care homes and undertake targeted interventions through the	Continue training and development of the 3 personalised care roles (social prescribing link worker, health and wellbeing coach and care coordinators). Strengthen the relationships and	Identified and deliver interventions through INTs

development of Integrated Neighbourhood teams (INT) using population health data to inform plans form May ’24 onwards. Implementation of Pharmacy First to enable integration of primary care services. **Medicines Optimisation:** Reduce medicines waste and maximise use of inhalers with a lower carbon footprint.	alignment between our integrated neighbourhood teams (INTs) and the voluntary, community, faith and social enterprise (VCFSE) sector and, supporting prevention and reducing inequalities, including digital; provide additional funding (within the available resource envelope) for initiatives aimed at reducing avoidable variation in the health status across different groups within our local population. Offer training in ‘healthy conversations’ through our public health teams to enable both clinical and non-clinical staff to develop their skills in behaviour change to support the wider prevention agenda. Support patients to self-manage a wider range of health concerns (where appropriate) by providing clear and prominent information, correct signposting to sources of help through either the NHS App, healthcare professionals and useful websites.	
Vaccinations: Work with regional and community colleagues to improve the uptake of vaccinations by supporting the roll out of the regional call and recall service for patients who have not received a dose of MMR. MMR is viewed as a good marker for uptake of a number of immunisations and vaccinations so the service will attempt to tackle low uptake for other vaccinations at the same time.		Improved uptake in MMR compared to April 2024 Maintain current uptake of covid vaccines (52% as of 3 June 2024 but this may

Continue to provide practice level data to enable GPs to target vaccination offers to cohorts with low uptake and improve health inequalities. Continue to work with public health and community colleagues to improve vaccinations in those people who are currently seeking asylum by targeting deployment of vaccination teams to asylum seeker hotels. Support roll out of annual flu programme across primary care in late 2024 and implement Autumn booster programme for Covid as defined by Joint Committee on Vaccination and Immunisation (JCVI). Roll out new RSV vaccination in late 2024 to over 75s and infants once defined by JCVI in conjunction with Regional, CSAIS and primary care colleagues. Complete project on behaviour change to improve uptake of covid vaccinations in patients who are immunosuppressed - late 2024.		increase as programme doesn't end until end of June 24) – noting that eligible cohorts frequently change. Continue to work towards meeting the national flu vaccination targets across eligible cohorts. Complete Spring covid booster programme by end of June 2024 including all care home residents and eligible housebound patients.

How will we know that we made a difference:

- A reduction in the smoking prevalence in Hertfordshire and West Essex
- An increase in those who are on low incomes receiving targeted support.
- An increase in our residents accessing information that will help them stay healthy and improve their wellbeing.

2.5 Ensuring financial sustainability

Also supporting our Integrated Care Strategy Priority “Enable our residents to age well and support people living with dementia”.

Our ambitions	**Our Challenges:**
1. Achieve a balanced financial position annually and efficiency and productivity targets achieved. 2. Frail older people will receive urgent and emergency care as close to home as possible to avoid harm of hospital stays and minimise disruption to their lives.':	Demographic changes in Hertfordshire and West Essex mean that our older population will be growing rapidly, with an expected increase in the next 10 years of those aged 65 in Hertfordshire by 23% and 28% in Essex. We also expect the number of over 85-year-olds to grow by 55% during this period. We expect demand for our services to increase in line with these demographic changes. The older members of our population are typically the most intensive users of health and care services. For instance, 50% of people aged 65 years and over with a hospital admission are estimated to be living with frailty. The median average cost of admission for those aged 65 years and over is currently £3,309. Unless action is taken to reduce the anticipated demand and also to provide more efficient healthcare our costs will increase and it will become increasingly challenging to achieve financial balance. Medicines spend is also increasing year on year, as we have people living for longer, identify more people who have conditions that need treatment and identify more treatments for different conditions, getting best value from our spend on medicines is essential and this can be achieved by using the best value medicine first, having an agreed outcome and criteria for discontinuation. Measuring the health outcomes of the medicines prescribed is a challenge and we are trying to do this taking a system population health approach.

Our plans to support our changing demographics and financial challenges:

Financial Recovery: A range of high-impact schemes have been identified to help address our financial challenges in 2024-5, these broadly fall into 5 workstream areas:

1. Initiatives that will improve productivity
2. Initiatives that will manage workforce growth and reduce agency spend
3. A whole system transformative approach to managing frailty and EOL care
4. A whole system transformative approach to managing growth in mental health, learning disabilities and autism in the system
5. Initiatives that will secure better value from contracts and increase efficiency

These are currently being developed into **detailed projects with phasing of savings, including potential impact in 24/25 being quantified.**	
Workstream	**Ambition for 2024- 25**
Workstream 1 - Improving Productivity *Our system aims are to adopt good practices and use a data driven approach to improve the productivity of elective care pathways, focussing on our five high impact changes based on a 'Best in HWE Benchmark'. These tools will be used to drive up productivity, reduce variation and create room for maximisation of elective recovery fund (ERF) income. By delivering more services at a reduced cost e.g. by maximising use of available theatre time and by delivering Outpatient first appointments using a one-stop model. The specific areas of focus for this work are:*	**Outpatients Optimisation:** • Make first appointment count • Reduce cancellations /DNAs <5% • Increase virtual appointments >25% • Increase advice and guidance diversion rate >20% • Increase PIFU • Reduce follow up appointments • Increase number of cases >23/24 activity plan • Improve average cases per 4-hour session >2.8 • Improve utilisation - capped >85% • Improve average late starts (minutes) <15 • Improve average inter case downtime (minutes) <15 • Improve average early finish (minutes) <30 • Improve average unplanned extensions (minutes) <30 • Improve % of emergency surgery conducted within elective lists <1% • Improve number of additional cases there is capacity to treat <10 • Improve additional capacity as a % of current activity <10% • Improve additional capacity (%) including 5% on the day cancellation rates <5% **Day Cases:** • Increase day case rates >85% • Reduce day case to patient <5% **Reduced Length of Stay (LoS):** • Reduce Elective Length of Stay <2 days • Reduce Non-elective Length of Stay <5 days

	Outpatients Optimisation: • Make first appointment count • Reduce cancellations /DNAs <5% • Increase virtual appointments >25% • Increase advice and guidance diversion rate >20% • Increase PIFU • Reduce follow-up appointments **Hospital at home Optimisation:** • Maximise utilisation of current capacity • Increase capacity in successful and new specialties • Share and implement best practice success across HWE
Workstream 2 - Manage workforce growth and reduce agency spend *our aim is to improve the productivity of our workforce; employ fewer people more cost effectively through the development of the primary and community workforce; through digital innovations and performance processes to provide assurance around operational use of workforce data.*	Using system workforce data and analysis of growth in workforce to at least deliver our 24/25 plan requirements: an overall reduction of workforce of -534 WTE (2.6%) made up of substantive staff reduce by -135 WTE (-1%) and temporary staffing by -398 WTE (-16%). We will achieve this by: • Initiate changes in workforce skills mix, • reduce workforce to safer staffing ratios, • improve job planning, • review roles added during COVID for value add, • drive harder on reducing agency staffing levels, • initiate more robust vacancy control processes, • manage turnover better and make use of lower cost Apprenticeships where appropriate.
Workstream 3 - Transformative approach to managing frailty and elderly care	**See pages 12-16**.
Workstream 4 - Transformative approach to managing growth and costs in mental health & learning disability and autism services The increased growth for these services needs a focused coordinated approach from across	We will adopt an integrated approach to carry out a review of pathways and capacity required; the challenge of developing services to meet the growth in demand hasn't allowed time for review of both capacity and pathways; through an integrated approach we need to tackle demand and capacity issues that are highlighted within our system. *Initial areas of focus for this work are:* • Implement a range of initiatives to manage growth in services and address historical

multiple service providers to support mental health integration, ensuring a coordinated support for physical health, mental health and wider social needs.	cost pressures: • Address issue of historical bed base and use of premium contracted beds ensuring we have the correct number and mix of beds to meet the population need into the future. • Agree a system approach to investing in backlog clearance and managing to agreed waiting times for neuro diversity services • Realising the financial and non-financial benefits of the new Mental health Urgent Care Centre. • Use the national utilisation tool to review staffing growth and link to Safe Staffing levels • Explore opportunities for more efficient group consultation models • Review bed flow and target blockages to discharge
Workstream 5 - Secure better value from contracts and increase efficiency	**Commissioning and contract Optimisation** • continue our ongoing review of all commissioned contracts • review of the decision-making process around high-cost complex cases • review of clinical thresholds to improve outcomes i.e. fitness and readiness for surgery optimisation • review of all contracted and non-contract activity (NCA) that the ICB has with the private sector and out of the ICS to look for opportunities to appropriately repatriate **Back-office benchmarking** • Use regional benchmarking data to review the opportunities for sharing back-office functions e.g. across acute trusts or between trust and local authorities within a Place • Consider previously untested services **Estates optimisation** • Use current Estates Strategy refresh to identify best use of estate • Identify excess estate for disposal

How will we know that we made a difference:

We will have:

- More care taking place at home or in the community.
- Develop a local workforce pipeline in line with workforce clinical expansion targets, support better retention of our workforce and reduce agency spend.
- Decreased our spend on urgent and emergency care.

3. Our workforce plan

Supporting delivery of the system's 2023-2025 People Plan and working towards the requirements of the NHS Long-Term Workforce Plan, applied, where feasible to the whole health and care system in Hertfordshire and west Essex.

Our ambition	Our Challenges:	What our staff say:
An integrated workforce that operates seamlessly through positive collaboration across Hertfordshire and west Essex delivering high-quality, person-centred care for our population	Hertfordshire and west Essex shares common challenges relating to workforce as the wider regional and national health and care sector. These include: • Vacancies within key clinical and care professional staff groups • There is ongoing anecdotal concern for staff wellbeing particularly from burnout and mental health concerns, with reducing resources and increasing demand on services. • While there are projections of increased demand on health and care services, training and education pipelines have been continually reducing. • The systems' perceived productivity gap has increased since 2019, and more work is required to understand this in relation to complexity of care required and other issues. • Industrial action has had an impact on productivity, and increased costs through agency usage.	As a system our main method of capturing views on the staff experience within the system is via the NHS national staff survey. There are also alternative surveys and methods of monitoring staff experience in primary care, social care and the voluntary, community, faith and social enterprise sectors. It is our ambition to improve our understanding of staff experience in Hertfordshire and west Essex, and where appropriate ensure there are concerted actions to make Hertfordshire and west Essex the best possible place to work, study and live. This year's NHS staff survey results broadly showed areas of progress and improvement across the system. This is particularly clear in the areas of staff engagement (with the exception of HWE ICB, potentially due to the amount of changes that have been undertaken across that organisation), as well as consistent improvements to staff morale across the system. We know that there are consistent concerns across staff groups in Hertfordshire and West Essex, regardless of the sector. However, there are a number of differences between organisations in their areas of focus for improvement as a result of the staff survey feedback, and we will look to support those activities through the *Retain* area of the

	• The system is also subject to higher rates of staff turnover across a number of staffing groups, this is particularly caused by the area's high cost of living.	system workforce transformation plan as part of this programme going forwards.

2024-2026 priority: TRAIN

What will we do to make a difference:

2024-25	2025-29	Progress Indicators
Clinical Education: • We will develop clinical workforce education plans to improve our local pipeline of registered staff to key clinical professionals. This will include revised governance routes and closer partnership working with higher and further education partners. • We will seek to establish effective links with the Local Skills Improvement body and Local Enterprise Partnership to improve wider awareness and planning for health and care sector roles. • We will develop service-based workforce modelling to understand long-term workforce needs.	• We will work towards the ambitious targets set by the Long-Term Workforce Plan for clinical education within Hertfordshire and West Essex. • We will support the development of the University of Hertfordshire Medical School.	• UCAS Applications to University of Hertfordshire • Clinical Placement monitoring • Retention of students into locally based employment

• We will support the development of advanced clinical practice pathways and review skill mixes required for the best possible care.		
Supply: • We will seek to work through and incorporate the overhauling recruitment toolkit across the system. • We will introduce a talent pool ensuring talent is retained within the sector. • We will promote key areas of workforce vacancy through innovative campaigns, specifically for care worker and learning disability roles. • We will limit our use of temporary staffing, reducing our agency spend and improving our agency cap compliance rates. • We will complete the procurement of collaborative bank to support harmonised recruitment and rates.	• We will have developed a system approach to staff recruitment enhancing recruitment services across health and care and ensuring that applications are representative of our whole population and talent is effectively supported into the sector. • We will continue to reduce agency usage across the system and encourage an appropriate substantive and temporary staffing mix.	• Provider workforce returns reviewed at People and Performance Committees • System and organisational vacancy rates. • Temporary staff usage and % of pay bill
Apprenticeships and T-levels • Develop and launch four new apprenticeships with the University of Hertfordshire, addressing key workforce shortages. • We will improve system-wide data collection of apprenticeship and levy use with regular monitoring. • We will continue to promote diversification of the apprenticeship offer as well as the gifting of levy	• Development and delivery of system integrated apprenticeship programmes that support delivery of care across the sector. • Work towards full utilisation of the apprenticeship levy within Hertfordshire and West Essex. • Introduce placement opportunities	• Apprenticeship take up across providers. • Apprenticeship levy spend across the system. • T-level placement utilisation

to key stakeholder partners within the system.	across the sector for T-level learning and development.	
Health and Care Academy • The Health and Care Academy will engage with all schools and colleges within Hertfordshire and West Essex, promoting health and care careers to our community. • The Academy will continue to seek to provide innovative means of promoting career opportunities within the sector. • We will further expand and develop our work experience programme and increase the number of active career outreach ambassadors.	• Have work experience programmes in all key providers as well as wider areas of the sector. • Developed effective pathways between Schools, FE, HEIs and employment.	• Engagement contacts with school/colleges • Entry level position vacancies
Volunteering • We will empower and connect our volunteers and encourage career development pathways for volunteers. • Encourage our workforce to volunteer and be aware of and support the broader volunteer, community, faith and social enterprise (VCFSE) sector.	• We will develop further career pathways that support volunteer to employment.	

How will we know that we made a difference:

We will have:

- Turned around the decline in applications for clinical education to local and regional higher education institutions.
- Developed effective domestic and local community pipelines across school, further education, higher education into health and

care employment and be able to monitor progress of employment from local communities.
- Be able to monitor apprenticeship levy spend and improve levels of spending through apprenticeship route development.

2024-2026 priority: REFORM

What will we do to make a difference:

2024-25	2025-29	Progress Indicators
Productivity: • We will further improve our understanding of workforce productivity across the system. • We will pilot programmes across the system reviewing job planning activities across the system. • We will continue to engage with the national team to review and refine the productivity diagnostic tool and expand its purpose to community and mental health providers.	• We will support service developments and innovation in identifying and developing the appropriate workforce and encourage movement to preventative measures and community care.	• Improvements to productivity and efficiency data reported to performance committee.
Skills Capacity and Modelling: • Our research partnership with the University of Hertfordshire will provide improved modelling and analytics on service delivery. • We will look to work with the ICB's project management office to identify an appropriate system-wide service to undertake a system-based skill-mix review and understand the impact of more efficient working.	• We will continue to explore new role opportunities. • Support development and skills experience of MDT teams working across the system	• Skill mix and staff establishment review processes increasingly undertaken on system and integrated basis.

• We will continue to support the development and uptake of new roles across clinical settings, including nursing associates and anaesthesia associates. • Support the primary care training hub with role development, training requirements and data modelling.		
Digital and Technological Innovation • We will establish improved engagement with digital transformation leads working across the system. • Continued focus on improving digital literacy of all staff. • We will continue to support innovation across service delivery such as virtual wards. • We will support the development of Artificial Intelligence and activity/workforce modelling with the University of Hertfordshire, encouraging exploratory thinking and working in this area. • We will continue to explore back-office efficiencies with digital and technological innovations with partners and key stakeholders. • Prepare for initial implementation of digital staff passport.	• Understand and review opportunities for shared procurement for digital solutions on a system basis. • Maximise and be delivering appropriate shared functions on a system basis. • Support full system implementation of the NHS Digital Staff Passport	• Improvements to productivity and efficiency data reported to performance committee.

Medical Transformation and Education • We will support the University of Hertfordshire in their application to become a medical school • We will work closely with our medical transformation committee to support key areas of development including the medical support worker role. • We will develop a medical training academy supporting trainees throughout their placement rotation. • Review wider requirements for medical training development and expansion, particularly within primary care and dental services. • Support development of the clinical educator strategy, providing practical support to organisations for expansion of placement support. • Continued expansion of the Oliver McGowan training across the system.	• Successful recruitment and delivery of the University of Hertfordshire medical school. • Full system uptake of Oliver McGowan Training.	• Reduced reliance on agency spend in key areas of medical workforce. • Reduced vacancies in key shortage areas of medical staffing • Improved turnover and leaver rates of medical workforce • Sustained improvements to system productivity and efficiency.

How will we know that we made a difference:

We will have:

- Improved service and workforce productivity across the system
- Supported the establishment of the University of Hertfordshire medical school.
- Have system-wide workforce modelling and design processes in place for delivery of the most effective and efficient care.

2024-2026 priority: RETAIN

What will we do to make a difference:

2024-25	2025-29	Progress Indicators
Talent and Leadership • Recruitment of a system talent lead in process to review existing programmes and further refine leadership talent management processes. • Review existing best practice in talent and leadership development across the system with provision mapped and gaps being addressed. • Review progress from culture transformation programme undertaken within the system and any associated actions resulting from it. • Provision of practical financial advice and guidance to staff. • System-wide mentoring and coaching services in place with sharing of resource and best practice. • Review of key 'hygiene' factors in team management as part of broader culture review being undertaken across the system.	• Host a consistent approach to leadership pathways and review.	• System turnover rate • System leaver rate and destination • Staff survey data and pulse surveys • Student retention and application rates
Culture, Equality, Diversity and Inclusion: • Complete the Healthwatch Hertfordshire review of international recruits experience and share that learning with quality team.	• Continued development and delivery of the anti-racism strategy across the system.	• System Turnover rate • System leaver rate and destination • Staff Survey data and pulse surveys • WRES and WDES data returns

• Participation in the 90-day project reviewing inclusive recruitment and staff development practices. • Delivery of the equality high impact actions identified. • Regular production of a system equality dashboard to identify further areas of action required. • Delivery of a range of tools and techniques to ensure staff voice is represented and heard as part of that process – including review sharing of freedom to speak up best practice, reciprocal mentoring, Schwartz rounds. • Review of staff networks across the system and how to best utilise those going forwards. • Development of a student placement evaluation tool for the system.	• Delivery of system culture proposals highlighted above, with improved links to VCFSE and students within the system. • Undertake a review of system culture and develop proposals for key areas of progress	
Health and Wellbeing • Review staff wellbeing conversations and practices across the system and seek to share areas of common concern or best practice. • Audit of practices related to wellbeing guardians and activities required for the system to progress. • Continued delivery of key wellbeing activities such as menopause awareness sessions and mental health first aid schemes.	• Development of detailed wellbeing plan to support reductions in sickness/absence across the system and reduce absence. • Effective monitoring of wellbeing conversations across the system, with support mechanisms in	• Staff sickness/absence rates • System turnover rate • System leaver rate and destination • Staff survey data and pulse surveys

• Review of pilot programmes undertaken as part of the retention pathfinder programme, including the e-rostering pilot and shared approach to flexible working. • West Hertfordshire Teaching Hospital Trust to continue delivery of flexible working leadership development programme and share outcomes with wider system. • Review of late-stage career activities and recommendations to be taken forward.	place and accessible • E-rostering and team management available across the system	

How will we know that we made a difference:

We will have:

- Reduced staff turnover rates across the system and particularly within key staff groups.
- Reduce staff leaver rates, particularly within the first year of joining.
- Continued improvements to staff survey response and engagement.
- Effective monitoring and understanding of flexible working proposition.

4. Key milestones

Area	Activity	Date for completion
Autism Spectrum Disorder (ASD) and Attention Deficit Disorder (ADHD)	Launch of digital interface to support referrals into community paediatrics in West Essex (including ASD/ADHD). Publish the Hertfordshire All Age Autism Strategy 2024-2029. Hertfordshire Support hub for children and young people pilot expansion to March 2025 – (HCC/ICB). A pilot for support interventions for CYP diagnosed or awaiting diagnosis, providing post diagnostic support and 'waiting well' interventions. The interventions will provide direct support to children and young people to help them to understand their condition. Develop a new model for children and young people autism and ADHD assessment, including redeveloping the clinical pathways to form a single-entry pathway across Hertfordshire with alignment and oversight across the ICS.	September 2024 September 2024 March 2025 March 2025 Clinical pathway implementation by 31 Jan 2025
Cancer	Achievement of the Faster Diagnosis Standard (FDS) and 62-day standard Targeted Lung Health Checks: • ENH partial coverage achieved • SWH and WE mobilisation commenced Faecal Immunochemical Testing (FIT) –delivery of 80% of all LGI Urgent Suspected Cancer referrals being made informed by a FiT result. Move to sustainable models of funding for current Cytosponge pilots. Delivery of 75% of improved stage 1 and 2 cancer diagnosis.	March 2025 March 2025 March 2025 March 2025 March 2025 March 2028

Cardiovascular Disease	**Hypertension** • Delivery of hypertension insights packs to general practices/PCNs • Completion of local communications campaign • Implementation of dental and optometry hypertension case finding pilot • Delivery of Trust hypertension plans, including implementation of blood pressure machines in outpatient waiting rooms, adopting Making Every Contact Count and awareness raising across staffing groups **Heart failure** • Development of an ICS model for heart failure care • Delivery of enhanced annual reviews in general practice • Implementation of ICS model of heart failure care and adoption of clinical pathways **Lipid management** • Delivery of training to general practice on national pathways for lipid management • Development of a business case for a lipid management service • Implementation of lipid management service	July 2024 September 2024 October 2024 March 2025 November 2024 March 2025 June 2025 January 2025 March 2025 March 2026
Dental	The following areas of dental transformation will be undertaken to address health inequalities and gaps in provision: • Improved domiciliary care – housebound and residential nursing homes services – pilot expanded across further care homes and evaluation to be done • Level 1 Endodontic and Periodontal services and the East of England Trauma Pathway • Level 2 minor oral surgery – planned review of services to ensure current provision is meeting the needs of the population • Improved dental access for asylum seekers/ migrants	March 2025 March 2025 March 2025 April 2025

	• Completion of 12-month alternative therapies pilot with Guys and St Thomas' NHS Hospital Trust to reduce the need for sedation or referrals into secondary care • Completion of a dental training needs analysis • Review of the current special care dental contracts (SCDC) across Herts and west Essex for new contract start date 1 April 2026 Further key dental priorities include: • Review enhanced access pilot and commission substantive service to address health inequalities in deprived areas • Development of a recruitment and retention plan aligned to the Dental Recovery "Golden Hello" to attract and retain dental workforce in the local area. • Scope and commission integrated out of hours dental service within the wider out of hours pathway	August 2025 December 2025 April 2026 December 2024 March 2025 April 2026
Diabetes	Implementation of national path to remission programme. Review of community diabetes services and development of an ICS wide integrated model of care for diabetes. Delivery of health checks and enhanced support to young people with type 2 diabetes ('Type 2 in the Young'). Completion of home testing pilot of urine ACR testing across general practice for people. Restoration and improvement in 8 care process completion.	August 2024 November 2024 March 2025 April 2025 April 2025
Digital	PAH electronic patient record (EPR) deployment.	October 2024

	Advanced care plans added to some pathways. Complete and increase utilisation of Resident Access platforms. Advanced care plans added to additional pathways. Shared Care Records for all pathways Single Cancer Patient Tracking List (PTL) Shared Care Records across all our health & care providers Data and analytical maturity	March 2025 March 2025. March 2026 March 2026 March 2026 March 2027 March 2029
Frailty and End of Life	To have consistent and up to date falls pathways across HWE, including identification and management of osteoporosis. To increase our identification of those at risk of falls. To increase utilisation of falls services. To have a digital advanced care plan in place across HWE to increase utilisation and completion of advanced care plans for our end-of-life patients. To have osteoporosis services across HWE	March 2025 March 2025 March 2025 March 2026 March 2029
HMHLDA HCP	Integrated older adults and frailty workplan in development for 2024/25 Implement Milestones as per Hertfordshire Dementia Strategy 2023-2028 Hertfordshire Dementia Strategy 2023-2028	End Q1 2024/25 December 2028
Integrated Neighbourhood Teams (INT)	Hertfordshire and west Essex will have INT coverage at PCN level through: • Establishment of locality leadership board • Recruitment of overall lead • Documents to support establishment of INTs All INTs to have identified a population cohort that would benefit from a joined-up approach and through collaboration and utilisation of population	July 2024 July 2024

	health management data, will identify the interventions and deliver with their HCP. Review of primary care continuous professional development programme to ensure availability of relevant and appropriate leadership training	 July 2024
Maternity	Finalise our transition from MVP (Maternity Voices Partnership) to include the Neonatal Voice and become a MNVP (Maternity and Neonatal Voices Partnership). Continue implementation of our digital strategy with implementation of electronic health records/ Improve our governance structures to enable clarity on reporting of progress with the single delivery plan. Agree key deliverables with clear progress measures and timescales. Ensuring the availability of bereavement services 7 days a week. Better alignment of neonatal cot availability.	July 2024 October 2024 March 2026. December 2024 December 2024
Mental Health	Mental Health Urgent Care Centre (UCC) full facility launched. Implementation of year 1 priorities of the Southend, Essex and Thurrock mental health strategy for 2023-2028.	September 2024 March 2025
Obesity	New integrated Herts-wide tier 2 and tier 3 weight management service for adults contract in place and mobilisation complete. Early prevention support embedded into relevant clinical pathways including: • Non-alcoholic fatty liver disease • Sleep apnoea • Diabetes • Elective surgery • Cardiology • Fertility	September 2024 March 2026

Pharmacy Integration	Implementation of local independent prescribing community pharmacy pathfinder programme. Ensure actions to reduce inappropriate polypharmacy and reduce medicines wastage are included in integrated neighbourhood teams and place-based teams plans. Increase referrals from GP practices to community pharmacies for the NHS Pharmacy First service to Approximately 14,983 referrals from April 2024 to March 2025. Ensure that all foundation pharmacist trainees allocated within HWE for 2025/26 have access to a Designated Prescribing Practitioner (DPP)	March 2025 March 2025 April 2025 July 2025
Planned Care	Elective Hub building in St Albans to be completed and treating patients. To build and mobilise remaining CDC sites: • St Albans Hospital CDC • St Albans Hospital Endoscopy • Epping CDC	September 2024 November 2024 April 2025 September 2025
Primary Care Access Recovery Plan/Implementation of modern General Practice	Implement Modern General Practice Access, including implementation of better digital telephony; highly usable and accessible online journeys for patients; faster care navigation, assessment, and response - Percentage of PCN practices meeting Capacity and Access Improvement Payment (CAIP) criteria (>90%). Further progress (from April 24 baseline) on implementation of four Primary Care Secondary Care Interface Academy of Medical Royal Colleges (AoMRC) recommendations – improve implementation at six- and twelve-month points. Make online registration available in all practices - More than 90% of practices using the on-line registration system	March 2025 September 2024 and March 2025 December 2024

Sustainability	Creation and ratification of refreshed ICS green plan	March 2025
Therapies	**West Essex** Launch of shared and centralised set of online information, guidance and education resources for schools and settings, followed by resources for parents and carers. Implement workforce integration (in shadow form, remodelled workforce allocation based on need and greater school-based delivery. Commissioning integrated workforce for CYP therapies. **Hertfordshire** Improved waiting times for speech and language therapy in line with the statutory requirements for education, health and care needs assessments. Recruitment of education leads who support schools to develop 'Communication Champions' to enhance the universal and targeted offer available in settings. Workforce strategy to be implemented in full. To include apprenticeships, rotational posts, progressive posts, training leads and international recruitments. Full implementation of prioritisation framework across Hertfordshire for all referrals into the speech and language service. Families to be kept up dated and support materials to be made available, whilst waiting. 'Waiting Well' strategy to be developed and implemented.	July 2024 September 2025 April 2027 July 2024 31 July 2024. Recruitment ongoing, first wave to be completed by 2026. All children to be risk assessed by December 2024 30 April 2025
Tobacco Dependency	Expansion of national tobacco dependency programme acute inpatient pathways to cover all specialities. Implementation of national tobacco dependency programme outpatient pathway	April 2025 April 2027
Urgent and emergency care	Care Closer to Home: • Finalise system-wide vision and high-level model of care for 'Care Closer to	July 2024

	Home' services for our adult population • Complete 'Care Closer to Home' financial modelling • Revised Community Services Contracts in place. Unscheduled care coordination development: - pass low acuity health care professional heralded calls via access to the stack (A2S) - to clinically validate certain NHS 111 calls that would normally receive a Category 2 level response from the ambulance service where clinically appropriate and provide an alternative pathway of care - expand 999 calls that can be proactively managed by the unscheduled care hub and community providers - simplifying opportunities for ambulance crews to call before convey/handover at home - innovative demand management model to manage NHS 111 and 999 calls - development of a single point of access with access to multidisciplinary teams (including acute consultants, mental health, drug and alcohol specialists), and trusted assessor approach System Coordination Centre (SCC) - implementation of enhanced National OPEL Framework (including consistent primary care, community, NHS 111 parameters) - development of a single ICS wide system resilience framework - development of an ICS capacity dashboard to ensure all available system capacity is correctly utilised - procurement of SCC dashboards and reporting mechanisms to evolve wider system pathway overview and linked to patient outcomes Finalise UTC and MIU review and recommendations. Maximise use of Same Day Emergency Care (SDEC) with direct referral pathways from ambulance service, primary care and NHS 111. Develop SDEC for frailty and	September 2024 April 2025 June 2024 September 2024 March 2025 March 2025 March 2026 March 2026 October 2024 March 2025 March 2025 March 2025 September 2024 March 2026

	pathways between acute frailty services and links with frailty care in the community.	
Vaccinations	Complete Spring covid booster programme by end of June 2024 including all care home residents and eligible housebound patients. Support roll out of annual flu programme across primary care in late 2024 and implement Autumn booster programme for Covid as defined by Joint Committee on Vaccination and Immunisation (JCVI).	July 2024 Autumn 2024
Veterans	Herts Suicide Prevention Board to update suicide data to include Armed Forces Community. To increase focus on prevention and training for the armed forces community with training to be rolled out to GP practices and NHS Trusts in 2024/25.	March 2025 March 2025
Workforce	Launch and further development of system workforce planning tool, including Equality, Diversity and Inclusivity dashboard through QlikSense. Revised governance and programme management approach to meet ICB priorities in a consistent manner, with more effective support for place-based development. Establishment of talent pool processes within the system Completion and implementation of associated actions of the 'overhauling recruitment' toolkit Completion of 'people promise' exemplar site at Hertfordshire Partnership Foundation Trust System participation in digital staff passport Establish system 'Medical Academy'. University of Hertfordshire medical school accepting up to 70 students in its first year of operation.	July 2024 June 2024 September 2024 April 2025 March 2025 April 2025 March 2025 September 2026

	Completion of 90 Day Challenge with nursing profession looking at inclusive recruitment Concerted system approach to volunteering and integration to wider VCFSE	August 2024 June 2025

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