Hertfordshire and West Essex Integrated Care System

NHS
Hertfordshire and West Essex
Integrated Care Board

**Working together**
for a healthier future

# Hertfordshire and West Essex Joint Forward Plan 2025 - 2030

# Foreword

Welcome to the annual update of Hertfordshire and West Essex Integrated Care Board's Joint Forward Plan for 2025-2030.

This plan, which supports the delivery of our Medium Term Plan, is based on the changes the NHS needs to make to help people in our area live healthier lives for longer:

- reducing health inequalities
- putting in place a more community-based, anticipatory model of care that prioritises early help
- delivering true integration of health and care services
- involving and supporting patients to manage and plan their health and care in collaboration with the staff and carers who support them
- delivering on our priorities for improving the health and wellbeing of our population in a financially sustainable way.

We have made progress across a number of these areas, some of which are set out in this plan.

For example, more than 5,000 people aged over 40 are now having their blood pressure checked each month – helping them to avoid the potentially devastating health consequences of undiagnosed hypertension. More than 200 pharmacies across Hertfordshire and west Essex are supporting our drive to improve access to this quick and pain-free test.

The uptake of the NHS app has increased significantly, with our patients logging into the app 1.5 million times in October 2024 – a doubling in use compared with the same period in 2023, with 121,000 repeat prescriptions ordered in this way during that month. This is a significant improvement in convenience for patients and productivity for GP practice and pharmacy staff.

We are proud that in the last year, 3.5% more GP appointments were held in our area when compared to 23-24. This increase has been supported by more primary care staff working in a variety of roles, which has enabled patients to access the right care first time.

For those experiencing serious ill health, more than 506 'virtual ward' beds are now available across Hertfordshire and west Essex, enabling people with a wide range of health needs to be expertly cared for by integrated neighbourhood teams at home, where we know that their recovery is usually quicker and more comfortable. This is just one of the ways in which we are prioritising delivering care in people's own homes or local neighbourhoods, with teams of professionals from different organisations working together for patients.

We have added more mental health help in emergency departments in peak times, funded the extended opening of mental health 'crisis houses', and supported more than 700 people at the new Mental Health Urgent Care Centre at the Lister Hospital between January and December 2024. More than 80% of people using the Urgent Care Centre did not need to be admitted to hospital and were supported to return home or on to other help. Now the Urgent Care Centre is fully open, people can walk-in to the service directly and get help without a referral.

These steps forward in preventative healthcare, community-based help and harnessing the power of digital technology are very much in line with the principles of the developing national NHS 10 Year Plan, and we look forward to the publication of that document.

However, as a system there is still a lot more to do to provide consistently timely, high-quality NHS care with the funds and infrastructure we have available.  It is disappointing that our hospitals are not included in wave 1 of the national New Hospitals Programme, although it is positive that they will be next in line to begin construction between 2032 and 2034. The news will give our Trusts more time to develop their proposals with their communities.

As we plan ahead, we are facing the challenge of meeting the growing health needs of our increasingly ageing population within the financial constraints of a very tight budget. To help to close the gaps which some patients experience between GP, hospital, and community-based services, our Integrated Care Board is working to begin the process of delegating some of our responsibilities for planning, paying for and monitoring the quality of health services to our established Health and Care Partnerships. These are the local partnerships made up of health and care organisations, local government and the voluntary and community sector.

Health and Care Partnerships will work together more closely than ever to ensure that the care they provide is centred around the needs of patients and delivered effectively and efficiently. We look forward to seeing the benefits of these plans in improved patient care across Hertfordshire and west Essex.

Thank you for reading this Joint Forward Plan, which has been endorsed by both Essex and Hertfordshire Health and Wellbeing Boards.

Our Joint Forward Plan was created prior to government announcements concerning the future of NHS England and ICB's and we may update our plan during the coming year to reflect the impact of these changes.
With the collective commitment and expertise of the Hertfordshire and West Essex Integrated Care System, we are confident that we can deliver on our ambition to help build a brighter and healthier future for everyone who lives and works in our area.

**Dr Jane Halpin, Chief Executive**
Hertfordshire and West Essex
Integrated Care Board (ICB)

**Rt. Hon. Paul Burstow, Chair**
Hertfordshire and West Essex
Integrated Care Board (ICB)

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# 1. About us

The Hertfordshire and West Essex Integrated Care Board (ICB) was established on 1 July 2022, following the introduction of the Health and Care Act 2022.

Our role is to plan and oversee how NHS money is spent to support our 1.66 million residents. We have a budget of £3.8 billion and our role is to join up health and care services, improve health and wellbeing and reduce health inequalities across our area.

The board is one of two key components of our area's 'Integrated Care System' (ICS). The second is the Integrated Care Partnership (ICP), a statutory joint committee, established jointly by Hertfordshire County Council, Essex County Council and the ICB. It was formally constituted on 1 July 2022 and is made up of representatives from the following organisations:

- Elected members and executive directors from Hertfordshire and Essex County councils
- Chief executive and Chair of the Integrated Care Board
- Council leaders and Chief Executives from district and borough councils
- Directors and Chairs of the Health and Care Partnerships
- Leads from the Voluntary, Community, Faith and Social Enterprise (VCFSE) Alliance
- The Care Providers' Association
- Healthwatch
- Police, Fire and Crime Commissioners.

Our vision for Hertfordshire and west Essex is one in which ***all of our residents can live better, healthier and longer lives.*** Critical to this will be ensuring that:

- our whole system delivers high quality, fully integrated care that is accessible in a timely manner
- no patient is treated in a hospital setting when it would have been possible for them to receive their treatment at home or in the community
- the health experience and outcomes of all Hertfordshire and west Essex residents matches the experience and outcomes of those who with the best outcomes
- we are a proactive system that is as focused on interventions to prevent illness and reduce the risk of hospitalisation, as we are on the management of illness
- decisions about health and care services are based on the needs of the population and are taken as locally to the patient who uses them as possible, except for where there is a clear benefit to doing something at scale.

We have a number of statutory duties that the ICB and its partner trusts are required to fulfil by law. Throughout this document we demonstrate how we are fulfilling these duties, Appendix 1 provides further details of these duties and compliance.

The NHS Long Term Plan (2019) (LTP) set the direction for NHS organisations delivering care to patients across the country. The plan's ambition is to ensure that the NHS can achieve the improvements needed for patients over the next ten years. It sets out how the challenges that the NHS faces, such as staff shortages and growing demand for services, can be overcome by:

**Doing things differently:** we will give people more control over the health and the care they receive, encourage more collaboration between GP practices, their teams and local community-based health services – so that they increase the services they provide jointly - and increase the focus on NHS organisations working with their local partners, to plan and deliver services which meet the needs of their communities.

**Preventing illness and tackling health inequalities:** the NHS will increase its contribution to tackling some of the most significant causes of ill health, including new action to help people stop smoking, overcome drinking problems and avoid Type 2 diabetes, with a particular focus on the communities and groups of people most affected by these problems.

**Backing our workforce**: we will train and recruit more professionals, including thousands more clinical placements for undergraduate nurses, hundreds more medical school places, and more routes into the NHS, such as apprenticeships. We will also make the NHS a better place to work, so more staff stay in the NHS and feel able to make better use of their skills and experience to benefit patients.

**Making better use of data and digital technology:** we will provide more convenient access to services and health information for patients, with the NHS App as a digital 'front door', better access to digital tools and patient records for staff, and improvements to the planning and delivery of services based on the analysis of patient and population data.

**Getting the most out of taxpayers' investment in the NHS**: we will continue working with doctors and other health professionals to identify ways to reduce duplication in how clinical services are delivered, make better use of the NHS' combined buying power to purchase commonly used products for less, and reduce spend on administration.

The delivery of our Joint Forward Plan by the ICB and our partners will support the delivery of the NHS Long Term Plan.

In response to the 2024 Darzi review, the government is developing a new 10-year plan for health and care, based on three 'big shifts' they want to see in health and care, moving from:

**Hospital to Community Services:** The biggest improvements to health and care will come from prioritising services outside of hospital. That means greater investment in the primary and community services that support people before they need hospital treatment, or so that they can avoid hospital treatment if that's right for them

**Treating sickness to preventing it:** political focus on public health strategies that keep people healthy and prevent illness in the first place.

**Analogue to digital:** Using digital technology to improve patient experience and outcomes and help deliver the ambition of moving care closer to home.

Whilst the East of England (EoE) will receive multi-billion-pound investment under the nationally funded New Hospital Programme (NHP) to rebuild hospitals, the overall increase in acute patient beds of these new hospitals will be modest, with a planned increase of 5% by 2034. However, the projected population growth, coupled with increased demand, means that even with this growth, there will be a significant acute care gap by 2036. To address this, a different model of care is needed that provides an alternative, safe and sustainable option and there is agreement across the EoE for all six ICBs to come together on a joint approach that:

- maximises the use of digital to build the hospitals of the future
- learns from global good practice on models of care
- is radical in how we envisage future pathways
- reimagines workforce models.

This shared ambition has resulted in a focus on a new model of care that addresses the capacity, workforce and financial challenges we are experiencing today, alongside those we can expect in the future. This transformative approach shifts from traditional acute care to a community-based model that enhances accessibility, patient satisfaction, and operational efficiency. Our priority is to empower people by placing access to care directly in their hands, offering user-friendly digital platforms and personalised support to navigate their healthcare journey with ease. A regional approach, owned by all ICBs, sets out a New Care Model covering four areas of delivery and implementation:

1. **Digital enablement**: Utilises electronic health records (EHRs) and telemedicine to enhance patient care, streamline data sharing, and reduce costs. Digital tools will improve efficiency, accessibility, personalised care, and patient outcomes, while also allowing patients to manage appointments and access health records online.
2. **Health optimisation**: Focuses on prevention, early detection, and management of chronic conditions. It targets high-risk populations with personalised interventions to improve health outcomes and reduce healthcare utilisation.
3. **Acute illness management**: Integrates multi-disciplinary teams (MDTs), case managers, and a virtual hospital infrastructure to streamline patient care, reduce delays, and ensure seamless transitions. This model emphasises community-based acute care and reduces unnecessary hospital admissions.
4. **Advanced illness care**: Enhances quality of life for individuals in their last two years by providing personalised support, managing end-of-life care, and reducing hospital admissions through better community care.

In 2025/26, five workstreams have been established to co-ordinate design, delivery and test approaches that can be applied at scale across all six ICBs in the NHS East of England area:

- Cardiovascular Disease (CVD)
- Urgent Care Co-Ordination Hubs
- Care in the last two years of life
- Digital transformation
- Standardisation and Efficiency

# 2. Our population

Our Integrated Care System provides health and social care to the 1.66 million people living in Hertfordshire and west Essex.

A high proportion of our residents are in good health and life expectancy is longer than the national average.

However, although the health and wellbeing of our population is similar or better than in England as a whole, there is considerable variation within our area. In some communities, life expectancy is relatively low, with people struggling to live with the health and wellbeing impacts of deprivation. Based upon the most recent nationally published data, the average healthy life expectancy for our residents, which is the average number of years that a person can expect to live in good health, is 64.2 years for men (Essex 63 years and Hertfordshire 65.4 years) and 64.65 years for women (Essex 63.3 years and Hertfordshire 66 years) compared with a total life expectancy of 81.1 for men and 84.8 for women.

Key partner organisations across our system recognise that the main factors affecting deprivation, such as social, economic and environmental factors, sit outside direct health and social care provision, and that health and care services need to do more to support our more deprived populations.

In addition, we know that changes to the demographics of our population will further test both the services we provide and the budget which we have to provide them with, in the latter part of this decade. Our area, which already has a higher proportion of residents aged over 85 than many others, will see a further steep growth in our older population over the next five years.

This is welcome news, but it does mean that our services and approach will need to change to match the changing demographics of our residents.

We also recognise that pockets of deprivation and health inequalities exist in Hertfordshire and west Essex. Any plan that covers the remainder of this decade must consider the role that the Integrated Care Board should have in bringing the experience and outcomes of the residents currently experiencing our worst outcomes to the level of those in our communities with the best outcomes.

The combination of health inequalities and an ageing population mean that the demand faced by our health and care services outstrips their capacity, and this will only worsen without action.

This plan has been informed by detailed information about our population including our local Joint Strategic Needs Assessments (JSNA) and the health and social care needs of our communities. We have used this information to assess the

health of our communities in comparison with each other, and against the national average, identifying the areas where the needs are greatest.

A health overview of our Integrated Care System population can be found here: Health needs of the Hertfordshire and west Essex (HWE) population. Assessments of the needs of the whole of Hertfordshire and Essex can be accessed using these links: Hertfordshire Joint Strategic Needs Assessment Essex Joint Strategic Needs Assessment

## 2.1 Learning from people and communities

The views of our residents, patients, staff and communities have informed and shaped the development of this plan.

Using an approach guided by our policy and best practice - we have explored what makes healthy living tough, particularly for people facing health inequalities and those whose protected characteristics put them at great risk from poor health and wellbeing.

More than 1,100 people from across Hertfordshire and west Essex shared their personal experiences and recommendations for action in a survey specifically commissioned to support this plan, which was supported by our Healthwatch partners. Our formal and informal ongoing engagement with residents; whether through our Patient Engagement Forum, Youth Council, GP practice-based groups or via Next Door, social media, our fortnightly newsletter or targeted survey work, helps to keep us informed about their needs and concerns with regard to local health services. There was also extensive engagement with our residents and key stakeholders to support the development of our Integrated Care Strategy. This included consultations, surveys, workshops and focus groups.

## 2.2 Supporting our places

Our system includes most of the county of Hertfordshire, with its 10 district and borough councils (with the exception of Royston in the north of Hertfordshire) and the three district and borough councils in the west of Essex.

The Integrated Care System also falls under two county council areas (Essex and Hertfordshire) and is a key partner of both Essex and Hertfordshire Health and Wellbeing Boards, delivering their health and wellbeing strategies that cover 2022/26.

- Essex Joint Health and Wellbeing Strategy 2022 - 2026
- Hertfordshire Health and Wellbeing Strategy 2022 – 2026

Our area has a number of hospitals and in-patient units to meet people's physical and mental health needs. Watford General Hospital, Lister Hospital in Stevenage and Princess Alexandra

Hospital (PAH) in Harlow are our three biggest 'acute' hospitals. Both Watford General and PAH are part of the nationally funded New Hospital Programme with new hospitals to be put in place by 2034, which will transform the services provided by these hospitals.

Residents in our area can also access care and support from mental and community health organisations, including:

- Essex Partnership University Foundation NHS Trust (EPUT),
- Hertfordshire Community NHS Trust (HCT)
- Central London Community Healthcare NHS Trust (CLCH) and
- Hertfordshire Partnership University NHS Foundation Trust (HPFT).

Figure 1 provides an overview of the geographic coverage of our three place-based HCPs.

Within Hertfordshire and West Essex we have four Health Care Partnerships (HCPs). Three of these are based around geographical areas (places) covering west Essex, south and west Hertfordshire and east and north Hertfordshire. These partnerships are a collaboration of NHS, local authority and voluntary and community organisations that help to design and deliver services together in a way that meets the needs of their local communities.

An overview of the main providers of our Healthcare services is provided in Figure 2 on the next page.

*Figure 1: A map showing our geographically based Health and care Partnership areas*

| Provider | East and North Hertfordshire | South and West Hertfordshire | West Essex |
| --- | --- | --- | --- |

| | | | |
|---|---|---|---|
| Acute services | East and North Hertfordshire NHS Trust (ENHT) | West Hertfordshire Teaching Hospitals NHS Trust (WHTHT) | Princess Alexandra Hospital NHS Trust (PAH) |
| Community Services | Hertfordshire Community NHS Trust (HCT) | Central London Community Healthcare NHS Trust (CLCH) | Essex Partnership University NHS Foundation Trust (EPUT) |
| Mental Health Services | Hertfordshire Partnership University NHS Foundation Trust (HPFT) | | Essex Partnership University NHS Foundation Trust (EPUT) |
| 111/Integrated Urgent Care | HUC | | |
| Emergency and non-emergency transport services (including 999 services) | East of England Ambulance Service Trust (EEAST) | | |
| GPs; Pharmacy; Opticians; Dentists | 126 GP practices serving our communities, working in groups of 35 ‘Primary Care Networks’ (PCNs)<br>267 community pharmacies providing medicines expertise and advice on minor ailments<br>183 optometrists (opticians) working across Hertfordshire and west Essex<br>204 dental practices providing NHS dental care across Hertfordshire and west Essex | | |

*Figure 2: A summary of the main commissioned providers of healthcare in our area.*

The Hertfordshire Mental Health, Learning Disability and Autism Health and Care Partnership (HMHLDA HCP) brings together the local organisations with a responsibility for supporting people living with a mental illness, autism and learning disabilities in Hertfordshire, to support them to live longer, happier and healthier lives. Essex is served by three Integrated Care Boards, and an integrated adult mental health strategy is currently being developed to serve the greater Essex area.

The local Voluntary, Community, Faith, and Social Enterprise sector (VCFSE) consists of many thousands of organisations, from small volunteer-led charities and community-based faith groups to large social enterprises employing hundreds of staff and serving thousands of people. Our VCFSE Alliance is a network of these organisations which works closely with the NHS, councils, and other partners within the Integrated Care System to help make sure everyone can find the right support, when and where they need it. The Alliance has recently developed a strategy to value, promote and enhance the VCFSE sector in promoting health and wellbeing and addressing the wider determinants of health across our system.

## 2.3 Building our operating model

Our system will see significant change to our operating approach in 25/26. We will retain HCPs as the key organising principle of our approach but plan to further evolve and strengthen their governance through the delegation of further responsibilities from the ICB to South and West Herts HCP, West Essex HCP and the Mental Health, Learning Disability and Autism HCP. This delegation will be underpinned by a host provider model.

The approach of East and North Herts HCP will remain as at present.

We have also created two new collaboratives across our system, for acute and community providers. They will work to set common approaches and standards across the system, helping to drive improvement by identifying good practice and supporting its spread.

# 3. The principles that underpin the shift in care we will see over the next decade

Collaboration within and between local and national organisations and working towards an agreed number of shared priorities is widely agreed as being fundamental for any system that wants to achieve a healthier future for its population.

We recognise that to meet the changing needs of our population and create a sustainable health and care system, we need to build our model of care around the following principles:

## 3.1 The integration of health, care, and wellbeing services

We will prioritise **opportunities for integrated planning, commissioning and delivery of health, care, and wellbeing services** so that people's experience of support and services is more joined up. We recognise that it is already routine for health and care staff to work together across teams and between organisations.

This strategy is about the big strategic changes where a more joined-up approach will bring local authority, NHS, and voluntary sector services much closer together to improve health and wellbeing at every opportunity.

In addition to this and to support the ambitions of our Medium-Term Plan, we will encourage a shift in our care model to an improved model of continuous integrated NHS care, with a strong emphasis on joining up NHS services to provide our residents with the best possible outcomes.

See sections 4 and 5 for further detail.

## 3.2 Moving from reactive, urgent care to preventative, anticipatory and community-based care

We will prioritise **prevention and early intervention**, learning from evidence that shows it is better to identify and deal with needs earlier rather than to respond when difficulties have become complex, which will then require intensive action by services.

Preventative services are particularly effective in improving the longer-term life chances of children, young people, and their families.

We will look at how we can shift investment across our system so that we can support the priorities we have set ourselves for early intervention and prevention, while still striving to improve services for those who need help now.

As a key partner of the Integrated Care Strategy, the ICB is focussed on prevention and early intervention.

See sections 4 and 5 for further details.

## 3.3 Targeted work to reduce health inequalities

We will prioritise targeted work to reduce health inequalities across our population and across all services and settings, reducing avoidable and unfair differences in health between different groups in society. We will use local intelligence, including population health management systems, to enable health and care staff to identify people who are most at risk of ill health. We will identify areas where health inequalities are greatest to ensure that resources are targeted at people with the greatest needs.

See section 5 and 6 for further details.

## 3.4 Involving our residents and our workforce

We will involve our residents, their carers, our communities, and our staff - engaging with them at the earliest stages of service design, development, and evaluation. We recognise that those with 'lived experience' of a particular issue or condition, their families and carers, and the staff that support them are often best placed to advise on what support and services will make a positive difference to their lives. We will listen to what they tell us and respond to their needs.

*See Section 2.1 for further detail.*

We will refresh our JFP in the future to address the new Long Term 10-year NHS plan, as we do this, we will include details of some of the wider strategic plans in our system, such as the future of the Mount Vernon cancer service, which will be woven into our operational plans over the next five years.

# 4. Our priorities

In accordance with our principles, this Joint Forward Plan is aligned to the six priorities of our Integrated Care System (ICS) and our local health and wellbeing strategies. The ICS comprises different organisations from across Hertfordshire and West Essex including both Essex and Hertfordshire County Councils, healthcare providers and the Voluntary, Community, Faith, and Social Enterprise sector (VCFSE) Alliance.

The Integrated Care System brings together these organisations to design and implement joined up health and care services, and to improve the lives of its residents. The six priorities for the Hertfordshire and West Essex ICS, which are shared by all partners, are:

**Priority 1: give every child the best start in life:**
We will ensure that children in Hertfordshire and west Essex have the best opportunity to be safe and well and to reach their potential at school and beyond.

**Priority 2: support our communities and places to be healthy and sustainable:**
We will work with our communities to improve our residents' health and wellbeing by reducing health inequalities and taking action on the wider determinants of health including housing, employment and the environment.

**Priority 3: support our residents to maintain healthy lifestyles:**
We will support people to be physically active, eat healthily and maintain a healthy weight, and we will provide support and advice to prevent tobacco, alcohol and substance misuse.

**Priority 4: enable our residents to age well and support people living with dementia:**
We will ensure our residents are supported to age healthily, with access to advice and services that enable them to live well and independently for as long as possible.

**Priority 5: improve support to people living with life- long conditions, long term health conditions, physical disabilities, and their families:**
We will support people living with lifelong conditions, long term health conditions, physical disabilities and their families, assisting them to take more control of their health and have a good quality of life.

**Priority 6: improve our residents' mental health and outcomes for those with learning disabilities and autism:**
We will provide early help to our residents to prevent mental illness and support the health and wellbeing of those with a Severe Mental Illness (SMI), learning disabilities or autism.

**Vision**

A healthy Hertfordshire and west Essex, enabling everyone to live their best lives with the greatest possible independence

**Principles**

- Involving our residents and staff
- Targeted work to reduce health inequalities
- Priority towards prevention and early intervention
- Integration of health, care and wellbeing services

**Strategic Priorities**

- Support our communities and places to be healthy and sustainable
- Support our residents to maintain healthy lifestyles
- Give every child the best start in life
- Enable our residents to age well and support people living with dementia
- Improve support to people living with life-long conditions, long term health conditions, physical disabilities and their families
- Improve our residents' mental health and outcomes for those with learning disabilities and Autism

**Enablers**

- Our workforce
- Data and insight
- Digital and technology
- Research and innovation
- Collaborative and joint working
- Delivery at the right place

*Figure 3: The Hertfordshire and West Essex Integrated Care Strategy*

# 5. The role of the ICB

In its Medium-Term Plan, the ICB sets out its priorities for 2024-2030, focusing on:

- Increasing healthy life expectancy and reducing inequality – through a focus on reducing cardiovascular disease (CVD) and high blood pressure (hypertension). We will also work to reduce dependency on alcohol, drugs and tobacco and deliver our suicide prevention strategy.

- Giving every child the best start in life – through reducing waiting times in targeted children's services (such as community paediatrics, paediatric audiology), making improvements to services for children with special educational needs and disabilities (SEND) and improving our emergency pathways for children. We will continue our system journey of improvement in maternity services, including implementing the 'Saving Babies Lives' care bundle'.

- Improving access to health and care services – by improving same day access for urgent and emergency care (UEC), expanding our mental health crisis support and child and adolescent mental health services (CAMHS). Also by continuing our work on reducing the waiting times for non-emergency care and treatment, delivering sustained improvement in cancer services (such as 'time to diagnosis' and 62-day referral to treatment standards) and developing our community diagnostic centres (CDC) and elective care and treatment hub, as well as providing improved care for people at the end of their lives. We also aim to increase the number of citizens taking steps to improve their wellbeing – through mental health work in schools and improved frailty support in residential care and nursing homes.

- Successfully delivering our financial plan each year – by utilising the resources available to us as best we can to deliver our priorities and to maximise the benefits for residents and staff. This will include maximising the opportunities from the New Hospital Programme, reviewing our community services and developing and utilising improved care models such as Integrated Neighbourhood Teams (INTs).

The ICB will work directly to deliver improvements in the areas within its remit, such as access to services, and in partnership to achieve those priorities that need a whole system partnership approach to be successfully delivered. The ICB's Medium Term Plan will include more detail on how it will deliver these priorities.

| | | | | | | |
|---|---|---|---|---|---|---|
| Our mission | Better, healthier and longer lives for all | | | | | |
| We will achieve this by: | Improving physical and mental health across our population | Tackling unequal access, experience and outcomes | Enhancing productivity and value for money | Ensuring the NHS supports broader social and economic development | | |
| In the first 3 - 5 years we will | Increase healthy life expectancy and reduce inequality | Give every child the best start in life | Improve access to health and care services | Increase the numbers of citizens taking steps to improve their wellbeing | Achieve a balanced financial position annually | |
| The ICB will deliver this by: | Setting direction for the NHS in Hertfordshire and West Essex | Allocating NHS resources fairly and effectively | Supporting, equipping and empowering our people | Working with and pooling resources with our partners | Enabling improvement and driving change, with a focus on quality | Using data and evidence to generate insight and assess imapct |

*Figure 4: HWE ICB Strategic Framework*

The ICB has agreed five key NHS objectives for the years 2024-26. They are aligned with our strategic principles and priorities and are as follows:

**1. Reduce inequality with a focus on reducing cardiovascular disease (CVD) and high blood pressure (hypertension):**
We are seeing a fall in life expectancy due to health conditions including heart disease and widening health inequalities. Through better detection and treatment, this should reduce avoidable life expectancy limiting conditions through reducing heart attacks, strokes and reducing hospital admissions.

**2. Improve the availability of urgent and emergency care (UEC) by providing more anticipatory and same day emergency care services:**
By enhancing our urgent and emergency care services, we should improve outcomes for our frail residents, by reducing deconditioning and providing better support closer to home. This will also improve ambulance handover times, reduce hospital attendances and admissions, and decrease our spending on surge and escalation beds. It will also support our growing older population to stay healthy for longer.

**3. Better care for people in mental health crises:**
Improving our crisis support should provide better care and outcomes for our residents by reducing long waits and Section 136 demand, and reducing out of area placements, preventable admissions and suicides.

**4. Reducing waiting lists for non-emergency care:**
We aim to reduce waiting times and the number of people waiting for treatment, as well as reduce unwarranted variation across clinical networks. This focus will improve our achievement of the national cancer standards, provide improved patient outcomes and experience by waiting times, and improve the quality and safety of our services.

**5. A reduction in the backlog for children's care:**
This can be achieved by developing improved and integrated services for children and young people, including services for children with special educational needs and disabilities (SEND). Success would improve equity in access to services, enable the waiting times for community paediatric services and Attention Deficit Disorder (ADHD) assessment to be reduced and improve outcomes for children to support giving them the best start in life.

We expect to review these priorities following the publication of the new 10-year plan for the NHS.
**An overview of all of priorities is included in Appendix 2.**

# 6. Delivering our priorities

To support the delivery of this Joint Forward Plan, we have developed an updated delivery programme, outlining our key plans for the next five years in line with our Medium-Term Plan. Within this we link our plans to the health needs of our population, and the challenges faced by our communities, along with feedback we have received from residents.

To ensure that these deliverables are focused on the right areas, they are aligned to our Integrated Care Strategy, our ICB's strategic priorities and our ICB's Medium Term Plan. Our plans incorporate work with our ICS partners as well as a focus on the things we directly act on to support the delivery of the Integrated Care Partnership's wider system priorities.

They will also support us to achieve the outcomes that are outlined in figure 5 over the next five years, with the indicators being used to demonstrate progress. These are reported to the ICB executive team and Board via a monitoring dashboard.

Further details as to how we will deliver our ambitions are outlined in our Joint Forward Plan Delivery Plan (link to be inserted)

| ICB priority | Indicators | Expected outcome |
| --- | --- | --- |
| **Reduce inequality with a focus on outcomes for CVD and hypertension** | • To increase the hypertension QOF prevalence across HWE by 2% by March 2026.<br>• Increase in percentage of patients with GP recorded hypertension in whom the last blood pressure reading was within target range to 77%<br>• To increase the age standardised prevalence of hypertension in the most deprived 20% of the ICB population from 17.6% to 19% by March 2026. | Reduce under 75 mortality from long-term conditions |
| **Improve Urgent and Emergency Care (UEC) through more anticipatory and more Same Day Emergency Care** | • Decrease rate of emergency admissions for falls within the community for people aged 65+ by 5% by March 2027.<br>• 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. | Reduce the rate of unplanned hospitalisations for chronic ambulatory care sensitive conditions (Reduce unwarranted ED attendances & admissions) |
| **Better care for Mental Health crisis** | • Increasing our response to Urgent Referrals to Community Crisis Services (CCS) referrals in 2024/25 from 64% to 67%.<br>• Reduce the use of out of area inappropriate beds for adults requiring a mental health inpatient stay across the ICS from 16 people to 4 by March 2025.<br>• 72 hours post discharge follow up: 75% of the inpatient discharges to have 72 hour follow up by March 2025. | 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. |
| **Elective Care Recovery** | • Reduce number of patients waiting more than 65 weeks for treatment, to 0 by 30 September 2024.<br>• 85% of surgery across HWE is consistently undertaken as a day case by March 2026<br>• Reduce the number of patients waiting more than 6wks for diagnostic services year on year and by March 2025 ensure that 95% of patients have their diagnostic within 6weeks. | Reduction in the numbers waiting for elective activity and diagnostics (reduced PTL size). |
| **A reduction in the backlog for Children's Care** | • Reduction in wait for community paeds services to 65 wks. by April 2026.<br>• Reduction in ED attendance and admission rates for children and young people by 5% by 2028 | All children will have the best start and live a healthy life |

*Figure 5: ICB priorities, indicators and outcome measures*

# 7. Supporting change

The following areas and initiatives will support the delivery of our strategic priorities and improve health outcomes for our residents.

## Armed Forces Community

The Armed Forces Act (2021) requires public sector bodies to take account of the unique needs of the armed forces community, through legislation which came into effect in November 2022.

We have worked closely with our two upper-tier local authorities (Hertfordshire and Essex County councils) as well as the voluntary sector including Hertfordshire and Essex Healthwatch organisations, who provide specific Joint Strategic Needs Assessments for our armed forces community, which includes serving personnel and reservists, veterans and their families. We also work closely with both counties' Armed Forces Covenant Boards and chair a Health subgroup of the Hertfordshire Armed Forces Community Board.

**We are focused on three key areas:**

1. Social prescribing – we run a community Single Point of Contact (SPOC) advice and case management service called Op Community across the ICB which supports serving and reservist families as well as veterans and their families. The service is embedded within the systemwide Hospital & Community Navigation Services (HCNS) for governance and integration purposes.
2. General Practice - We will continue to encourage all practices to sign up for Veteran Friendly Practice accreditation and network across PCNs on training and awareness raising of dedicated services available for the Armed Forces Community
3. Improving the identification of veterans and members of the armed forces community in our communities, so that we can commission services that meet their needs.

Our five-year vision is to help deliver locally the national vision of England being the best place to be a veteran, with a fully integrated system wide approach to improve health and wellbeing outcomes for our armed forces community. We work closely with our local Ministry of Defence (MoD) serving and reserve units to include them in our planning and delivery of more integrated Armed Forces Community (AFC) focused services.

## Cancer

We continue to closely monitor and assess our performance at tumour site level to identify areas of underperformance and implement improvement plans to support faster and earlier diagnosis for our patients.

Cancer referrals in 2024 were higher than expected in HWE for several pathways. Each of our provider Trusts has robust mechanisms in place to manage and adjust as needed to ensure demand is effectively managed.

We continue to closely monitor our cervical screening uptake rates against the 80% national target for the 25-49 and 50-64 age

groups. This data enables us to target specific communication campaigns to particular areas and strive to improve our position.

We initiated Targeted Lung Health Checks in March 2024 and we continue to deliver services for the east and north Hertfordshire population. We are planning to roll out a Targeted Lung Health Check (TLHC) programme for a selection of practices within the south and west Hertfordshire area by mid-2025, and for the west Essex area by autumn 2025.

We continue to monitor the use of Faecal Immunochemical Testing (FIT) as a screening test for colon cancer, aiming to meet the standard of 80% of all Lower GI referrals being accompanied by a FIT result. The ICB is performing reasonably well against this standard and is aware of the challenged areas, targeting resources to ensure continuous improvement.

The ICB will continue to explore opportunities for the provision of tele-dermatology services and community spot clinics to support earlier and faster interventions.

As we refresh our JFP to address 10-year plan some of the wider strategic plans such as the future of the Mount Vernon Cancer Centre will be woven into our operational plans over the next five years.

## Climate Change and Sustainability

In line with pre-guidance from NHSE and the timeline within the trajectory towards the NHS net-zero targets, a new Green Plan 2025 – 2028 will be completed for the ICS and its partners. This will review the previous plan including, what has worked, what needs addressing and how this has shifted the needle for partners and the system overall. The sustainability agenda will continue to be embedded into the Estate Infrastructure Strategy and 10-year capital pipeline,

It will also address the newly released Biodiversity Net Gain requirements and the NHS Travel and Transport Strategy. These will both be delivered locally by January 2026 as part of the revised Green Plans. This will also emphasise the delivery and monitoring of progress across the ICS.

Each of these elements will also help to mitigate the health harms of climate change and environmental factors, for instance air pollution alone contributes to 1 in 20 deaths in the UK and increases the number of cases of cancer, heart disease and asthma. The ICB will be signed up to both the Hertfordshire and Essex air quality strategies in 2025.

We will continue to share and learn from our colleagues, such as the Cheshire 10-point plan, outlined in Figure 6, to support general practices to reduce their environmental impact in line with the NHS Net Zero ambitions, by adopting similar approaches in our estates planning and procurement.

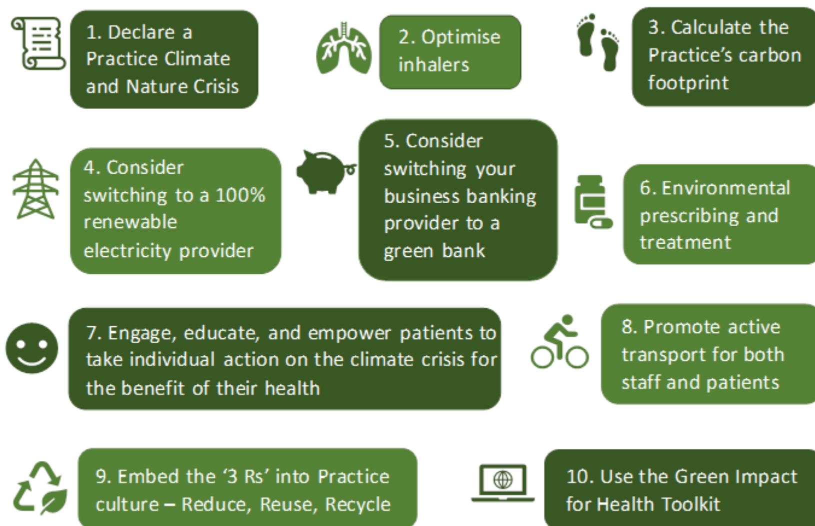



*Figure 6: Cheshire 10-point plan for General Practice*

In addition to our ICS-wide Green Plan, each Health and Care Partnership (HCP) is committed to creating stronger, greener and healthier communities and working to reduce their environmental impact through reducing resource consumption in support of delivering the national Net Zero NHS targets. Each of the provider organisations within our HCPs have published their sustainability commitments and Green Plans to deliver their individual goals. All business cases that are considered by each HCP must demonstrate a commitment to achieving our green goals as part of their governance process.

**Key deliverables of the ICS Green Plan: 2025-26**

- Implementation and delivery against action plans
- Review and communicate our progress against actions.
- Measurement and reporting of system carbon reductions – targets will be fully embedded across all partners with supporting policies and procedures.
- Create and embed a Sustainability Impact Assessment (SIA) for decision making related to capital projects, procurement and commissioning.
- Ongoing communications and engagement, including developing training and carbon literacy (mandatory training).
- Focus on hard to deliver and outstanding actions and where this can be addressed collectively.
- Reflect on what is working and what can be improved moving forward.

**Key Performance Indicators**

- Leads assigned to each workstream.
- Cooperative system wide projects identified and launched.
- System wide Working Group operating and reporting.

## Clinical Leadership

We are committed to local implementation of programmes aimed at clinical and care professional leadership, as identified in Chapter 4 of the NHS Long Term Plan.

In keeping with system objectives with a greater emphasis on partnership working across health, inside and outside the NHS, and the broader public sector, the following are three key components in our plan for clinical and professional leadership:

a. Broadening the clinical and professional backgrounds of those in clinical and professional leadership positions.
b. Promoting clinical and professional leadership at all levels of seniority, including but not limited to, leadership for quality improvement, development of future senior leaders and encouraging practice at the top of one's licence.
c. A multidisciplinary forum, similar to a Clinical Senate, which establishes broad-based clinical and professional oversight of the above activities and other appropriate multi-professional initiatives such as medicines management and research.

## Digital

We agreed our 10-year Digital Strategy in 2022 which focuses on digital improvements that will help us to improve patient care. We have identified five key themes as our digital strategy mission, covering new technology, strengthening our digital skills as a workforce, helping our residents access online services, and collaborating and sharing information to improve care. Our key plans for digital improvements include:

- A new cancer management system has been procured implementation will be completed early 25/26.
- New electronic patient records in East and North Hertfordshire NHS Trust in (2025/26)
- In 2025/26 we intend to expand on this success by connecting our mental health trusts to the NHS App and expend Acute specialties visible on the NHS App not Outpatients.
- We will deploy Acoustic monitoring technology to care homes across the ICS to help prevent fall. We estimate this will be made available to 1000 beds across our system at care homes with the highest falls rates.
- Enhancements to Shared Care Record capabilities – subject to funding.

We will continue to support the remaining practices in 2025-26 to move to Cloud Based Technology and optimise the usage of existing systems.

## Estates

We recognise the need to ensure our buildings are suitable to meet the health and care needs of our population, now and in the future recognising that the recent National Policy Planning Framework (NPPF) mandates each of the system's thirteen Local Planning Authorities to deliver unprecedented 5-year housing supply.

Modernising and transforming our buildings is critically important and will enable us to deliver improved access to services and make our health and care system more efficient. We will build on our estates plans to include additional and flexible capacity in primary care; development of integrated neighbourhood care hubs; and acute hospital estate improvements.

This will build on existing organisational and system estate plans, including our work on a major capital investment at Epping and Bishop's Stortford to improve the available of diagnostic tests and treatments in local communities. Since the last report, contracts and leases have been entered into for the first diagnostic centre at Epping where it will be patient ready by January 2026.

By the end of 2024/25, the hybrid vascular unit at Lister and refurbishments to operating theatres at St Albans City hospital were completed, improving patient access and experience.

There are exciting plans in development to improve hospital provision for the benefit of patients in our area through the New Hospitals Programme. Both Watford General and PAH are part of the nationally funded New Hospital Programme with new hospitals to be put in place by 2034, which will transform the services provided by these hospitals.

There have been many smaller General Practice schemes where paper records have been digitised or stored off site facilitating the former records rooms to be repurposed again improving patient access. A brand-new purpose built General Medical Centre also opened in Hertford during the summer of 2024.

HWE ICS Estates Infrastructure Strategy 2024 – 2034.

At the end of September 2024 and at the request of NHSE, HWE ICS submitted its 10-year Estates Infrastructure Strategy 2024 – 2034. It summarises the frameworks, strategies, policies, priorities, care models at national and local levels.

It also sets out the geographical area, population (current and forecasted) at system level and within each Health Care Partnership (HCP) based on projections provided by each of the thirteen Local Planning Authorities, the health providers serving the population and illustrates the distribution of healthcare assets highlighting the risks and challenges. The estate is categorised as 'core, flex, or tail' listing the assets identified for disposal. It also reflects on infrastructure projects completed since the last version produced in 2019. The estates and facility workforce is identified as risk and challenge recognising further need for a system working solution to mitigate the risk.

We also set out principles and priorities to be considered in investment decisions, clinical opportunities within each HCP and plans for the estate to meet the demand and this informed the capital pipeline with estimated costs all subject to the HWE ICS being funded in order to be able to deliver. Many of the major health infrastructure projects span areas sometimes wider than the boundary of an individual HCP and in the case of the cancer service currently provided at Mount Vernon, broader than the HWE ICS geography. The HWE ICS is refreshing its Green Plan which was written into the Estates Strategy as well as its plans and intention towards Net Carbon Zero, which is also reliant on securing funding. In recognition of limited funding opportunities, the focus of the HWE ICS will be estate rationalisation and optimisation whilst also having regard to the Government's National Planning Policy Framework (NPPF) which was published at the end of 2024 which sets the growth for Hertfordshire to increase the delivery of 10,096 new homes annually noting that in 2023/2024, 5,387 new homes were delivered. Our Strategy lists these major sites across HWE ICS.

Our current allocated funding for HWE ICS just covers the ongoing maintenance of the estate and is insufficient to deliver the projects set out in the pipeline and the 10-year costed programme. Our system recognises that it will need to work within allocated funds,

when these are known, and has introduced a capital prioritisation matrix which is being worked on so that all system partners can agree on a way forward. All projects are set out for discussion and each one is subject to relevant governance support and approval. Our strategy therefore does not set out a commitment to any particular course of action.

NHSE advised the ICB of our capital allocation for 2025/2026 at the beginning of February 2025.  The allocation is similar to previous years and will be allocated to system partners for their infrastructure maintenance and repair, with a difference this year in that IFRS-16 commitments must also be taken from the annual allocation.  Unlike previous years, for 2025/2026 there is additional allocation subject to NHSE approval and support for work supporting estates safety, primary care, reducing mental health out of area placements and physiological sciences diagnostics. Major capital schemes such as the two new hospitals at Harlow and Watford are due to be funded by central government and are therefore outside this allocation.

## Finance

Information about the ICB's financial duties is included in Appendix 3.

To ensure financial stability, the ICB along with its partners set a challenging Cost Improvement Programme. Longer term the system will need to be more transformative and increase investment on prevention services in order to improve the health of our population, improve the quality of our services, and improve value for money for taxpayers.

To support the delivery of financial balance, the ICB and partner trusts work together as a single system, but also in place-based collaboratives to explore clinical and service delivery models and opportunities for transformation of services.

Whilst each individual organisation agrees through its own governance processes an operational and financial plan for its organisation, this plan does reflect the spirit of the duty to collaborate.

Risk management remains a vital part of system planning and system plans take account of financial risks and how they will be managed. A key aspect of the system's approach to risk and performance management is the regular sharing of data in a transparent way. This helps to identify any increasing likelihood of risks crystallising and affecting underlying financial performance. This allows for peer review and discussions on the opportunities to mitigate emerging financial problems. To support this the Finance Directors across the system meet regularly to review performance and agree actions to be taken.

The ICB's Strategic Finance and Commissioning Committee. regularly sees financial performance information relating to the ICB and also for each of the partner trusts mapped to the ICS.

## Patient Choice and Personalised Care

Personalised care represents a shift in focus from traditional medical models to approaches that enable people to have greater choice and control over the way their care is planned and delivered, based on what matters to them and their individual strengths, needs and preferences.

We are working hard to improve opportunities for people to make choices about their care. We want to ensure that all patients can discuss with their GP or healthcare professional the different options available including pros and cons of treatments, and where appropriate, whether to have treatment. By enabling choice of provider and services that best meet people's needs, we will uphold people's legal rights in line with statutory requirements and guidance.

Social prescribing has been embedded in primary care in recent years and is improving outcomes for some of our most deprived residents as well as reducing demand on other services.
Patient choice has both constitutional and legal commitments which are embedded in key policy drivers within the NHS, including the NHS Long Term Plan and Universal Personalised Care. Choice is also highlighted as a key enabler of elective care recovery.

The ICB has a Choice policy statement available on our website and we will engage with healthcare providers and professionals to promote the choices available, to ensure patient awareness, and to ensure that information on patients' legal rights to choose is publicised and promoted.

## Population Health Management (PHM)

Within the next five years we expect the ICS to have built the capabilities to utilise Population Health Management information to drive a data-led focus on person-centred care. This should enable us, through our partnerships, to begin to see an impact of improved population health outcomes described within our outcomes framework and deliver our overarching system level outcomes. This is described in more detail in our recently developed PHM Strategy.

Our PHM strategy, which has been developed through collaborative working across Hertfordshire and west Essex, will enable our workforce to understand the needs of the population and the opportunities for improvement. This will therefore support improvements in population outcomes and health inequalities through the development of right services/high impact interventions for the right cohort of individuals at the right time. Adopting this approach will help ensure that proactive care models are considered across the system and our services are responsive and able to meet the needs of the population. The strategy summarises our key activities over the next five years to help us achieve our ambitions.

Implementation of the ICB PHM data platform, 'DELPPHI', supports the ICB and system partners to measure the health outcomes of our population and the impact interventions are having. This platform supports with the ICB approach to PHM that follows an improvement cycle methodology, where needs and opportunities

are identified; interventions to improve outcomes are developed using evidence based best practice; and the impact is evaluated.

Existing tools are being used to enable the identification of needs and opportunities, and as an extension those 'segments' of the population for whom outcomes can be improved. The ICB continues to work with the University of Hertfordshire to implement advanced analytics, including scenario modelling. The tools described are being implemented in 2025, and the ICS expects to develop key analytical capabilities to develop our workforce. This will support the ICS to develop its 'Intelligence Function' as described within Integrating Care: Next Steps to building strong and effective integrated care systems across England.

Our PHM resources can be accessed here: [Population health management – Hertfordshire and West Essex Integrated Care System (hertsandwestessexics.org.uk)]

## Procurement

The Provider Selection Regime (PSR) came into force on 1 January 2024 and replaced:

- Public Contracts Regulations 2015 when arranging health care services.
- National Health Service (Procurement, Patient Choice and Competition) Regulations 2013.

The ICBs procurement policy has been revised to take account of the new legislative requirements. Systems and processes have also been established to ensure that the ICB is compliant with the PSR statutory guidance and legislation, including provider accreditation request to provide patient choice services.

A business case planning process has also been implemented to review existing contracts, future commissioning proposals and make recommendations on procurement process.

In addition to the PSR, the ICB is in the process of updating its procurement policy to take account of and be complaint with the statutory guidance of the Procurement Act 2023 and the National Procurement Policy statement that was published in February 2025. The new Act has a significant focus of the Transforming Public Procurement Programme and will replace the following four sets of regulations:

- The Public Contracts Regulations 2015.
- The Utilities Contracts Regulations 2016.
- The Concessions Contracts Regulations 2016.
- The Defence & Security Public Contracts Regulations 2011.

## Quality

Our goal is to set out a single vision of quality in our system, based on the need to provide high quality personalised and equitable care for all now and into the future, ensuring that quality is central to planning and decision making within our health and care system. To meet our ambitions and support delivery, we will adopt the National Quality Board (NQB) 'Seven Steps' outlined below:

1. **Setting clear direction and priorities**
   To deliver a new service model, which delivers better services in response to local needs, invests in keeping people healthy and out of hospital, and is based on clear priorities, including a commitment to reducing health inequalities.

2. **Bringing clarity to quality**
   Setting clear standards for what high quality care and outcomes look like, based on what matters to people and communities.

3. **Measuring and publishing quality**
   Measuring what matters to people using our services, monitoring quality and safety consistently, sharing information in a timely and transparent way, using data effectively to inform improvement and decision-making.

4. **Recognising and rewarding quality and learning**
   Recognising, celebrating and sharing outstanding health and care, learning from others and helping others learn, recognising when things have not gone well.

5. **Maintaining and improving quality**
   Working together to maintain quality, reduce risk and drive improvement. This will be supported by implementing our 2025-2028 ICS Quality Improvement Delivery Plan.

6. **Building capability for improvement**
   Providing multi-professional leadership for quality; building learning and improvement cultures; supporting staff and people using services to engage in coproduction; supporting staff development and wellbeing.

7. **Staying ahead**
   By adopting innovation, embedding research and monitoring care and outcomes to provide progressive, high-quality heath and care policy

In 2023 the ICS Quality Strategy was developed with quality leads, a range of system partners and with valuable contributions from members of our communities. Five quality principles (as outlined in Figure 7) were agreed as areas of focus across the system for the next 3 years and a range of defined actions have been taken and aligned to evidence our progress and successes against each of those principles.

# The Quality Principles of the Hertfordshire and West Essex Integrated Care System

The development of the 5 local Quality Principles for the Hertfordshire and West Essex Integrated Care System occurred following a Quality Strategy event attended by each of the below organsiations, as well as members of our population. These build on the National Quality Board's Principles and are tailored to the needs of our system.

**Our local Quality Principles**

- Developing, providing and co-designing services which are person centred
- To effectively collaborate across organisations to continually improve care
- To create a healthy and positive environment for our population and workforce
- To use information and technology in the best possible way
- To ensure the services we provide are accessible and available to everyone

NHS West Hertfordshire Teaching Hospitals NHS Trust

NELFT NHS Foundation Trust

Essex County Council

NHS Hertfordshire and West Essex Integrated Care Board

NHS The Princess Alexandra Hospital NHS Trust

Hertfordshire

NHS 75 Central London Community Healthcare NHS Trust

NHS Hertfordshire Community NHS Trust

NHS Hertfordshire Partnership University NHS Foundation Trust

NHS Essex Partnership University NHS Foundation Trust

NHS East and North Hertfordshire NHS Trust

hcrg Care Group | Essex Child and Family Wellbeing Service

*Figure 7: Hertfordshire and West Essex's Five Quality Principles*

**This is a sample of the key actions taken or planned:**

- To have a fully developed system in place to gather feedback from our GP colleagues regarding feedback they, or their patients, want to give regarding NHS services. This is to understand where important quality improvement work can be focussed and is part of the Seven Step quality cycle
- To establish systems and processes to learn from deaths across the health and care system to improve patient safety.
- To engage with members of our communities to capture their experiences, including experiences of frailty services, to identify where improvements can be made.
- To explore how to effectively share key pieces of information to and for our communities, initially via GP practice websites, whilst being mindful of those who are digitally excluded.
- To increase the promotion of Freedom to Speak Up Guardians to ensure they are accessible and available to all staff.

Progress against all the actions that have been committed to be undertaken during 2023 and 2024 remain closely monitored whilst also considering potential further opportunities for improvement that can be aligned to the Quality Principles.

The Quality Strategy, as well as an easy-read version, has been published on the ICB's website. Following feedback from members of our community regarding simplicity, a Quality Strategy Plan on a Page has also been developed to condense all the essential information on one page. This will be shared with colleagues across the ICS.

## Reducing Health Inequalities

Our continued plans for reducing health inequalities over the next five years set out our ambition to improve health equity, in line with our Integrated Care Strategy, Medium Term plan and principles of the NHS LTP. This plan sets out the approach we will take in closing the gap in variances of outcomes for people that may be due to ethnic background, circumstances in which they live or other factors outside of their control. In the first year of the plan, we will continue work to clarify our performance in the Core20Plus5 framework for adults and children and young people.

We will continue work to tackle inequity of outcomes based on our developed population health needs assessment. This includes wider determinants of health for the population of the ICS, targeting specific groups such as ethnically diverse groups, unpaid carers, veterans and members of the Gypsy, Roma Traveller community, refugees and migrants, victims of domestic violence and those living with a serious mental health illness or a learning disability.

In collaboration with system partners, an outcomes framework is being developed with clear performance metrics that will support the ICB to evidence is performance in delivering on its delegated legal duties to tackle inequalities. This will identify areas where modifiable risk factors can be better prevented using asset-based community development, community connectors and social prescribing. In Hertfordshire and west Essex we have areas of significant deprivation and inequalities. Through partnership work with colleagues including the VCFSE sector we aim to narrow the gap in varied outcomes, building longevity into actions, ensuring they are sustainable and benefiting our communities.

To achieve this aim, we are collaborating with local voluntary sector partners and a newly formed Faith and Health Network, to connect on a local scale with local communities, hearing their issues, and supporting their solutions. This is sustained through connecting partners into Health and Care Partnership boards and Integrated Neighbourhood Team structures.

Working with our Population Health Management team and system partners, we will continue to develop our understanding of the local population needs and areas of inequity, supported by the continued development of these system partnerships.

During the coming year of the plan, we will continue to work to drive down inequalities in outcomes for members of communities most at risk, through enhanced neighbourhood working between 'Primary Care Networks' of GP practices and VCFSE partners, enhancing current partnership working with sustainable models for engagement, and communication and delivery. The PHM team will build reporting from the linked record data through a new data platform so that progress in achieving outcomes will be viewable by geography, age, population segment and other cohorts, supporting for example inequalities work such as Core20Plus5.

Our Health Inequalities Statement (link to be added) sets out further details about how we will reduce Health Inequalities across Hertfordshire and west Essex.

## Research and Innovation

Hertfordshire and west Essex has well established research capabilities embedded within our provider organisations. The Health and Care Act 2022 enables our ICS to develop an integrated approach to research and ensure this capability and capacity aligns with the delivery of our key priorities. The ICB has appointed a Head of Research and Innovation and is working with the University of Hertfordshire to mobilise a research and innovation hub to further strengthen our research and innovation capacity and capability across our ICS.

The ICS has developed a research strategy which incorporates the findings of a recent project to understand our system's research capacity and ensure representation in research for our whole population. Its guiding principles are:

1. Embed the benefits of research, innovation and evaluation to better meet the needs of the health and social care system and enable the delivery of this Joint Forward Plan.

2. Ensure that research, evidence, innovation and evaluation underpins the way we enhance, transform or devise services using a well governed approach to manage risk, ensuring patient safety and public confidence.

3. Ensure that the voices of our diverse residents inform all we do, promoting inclusion, and representing good value for our taxpayers.

4. Make the HWE ICS a national exemplar for the use of research, innovation and evaluation to meet the needs of our residents and workforce and deliver the integrated care strategy to improve population health outcomes.

5. Aim to achieve financial sustainability by 31 March 2026.

To support this work we are running workshops and refining business case templates to establish this early in the project and embed evaluation across the ICB

## Safeguarding Specific Research and Innovation

Over the next five years the safeguarding team will provide leadership through innovative practice and collaborative research.

1. The safeguarding team provided leadership to complete a multiagency evaluative research project. The research tested the effectiveness of Learning and Improvement in Practice in collaboration with Hertfordshire University, Hertfordshire Safeguarding Adults Board, HSAB /Hertfordshire Safeguarding Children's Partnership HSCP. The findings from this research identified areas of good practice and made recommendations for improvement. The action plan is monitored as part of the Learning and Development strategic objectives.
2. Improving the life chances for infants and children through collaborative research into the cause and prevention of suicide. Findings from the Child Death Overview Panel (Essex Safeguarding Children Board ESCB /Bedfordshire University/HSCP/ Public Health.
3. Collaborative working between Child Death Overview Panel (CDOP) Essex and Hertfordshire to reduce child death linked to unsafe sleeping.
4. Contributing to the 'Innovative Domestic Abuse Perpetrator' programme in collaboration with the University of Bedfordshire safeguarding children partnership and community safety partnerships.

5. To reduce non accidental death and traumatic injury in childhood through the introduction and innovative practice of the 'ICON' infant crying programme.
6. Leading on national development for the primary care 'Community of Practice', to strengthen learning and innovative practice.
7. Supporting the national drive for a domestic abuse 'Community of Practice' to develop research-led intersection of risk assessment.

## Safeguarding

Legislation, statutory guidance and multiagency policies and procedures support organisations and practitioners to drive the agenda of safeguarding children and adults. These include Working Together 2023, the Children Act 19896/2004; The Mental Capacity Act, 2005; The Care, Act 2014; The Children and Social Work Act, 2017; Domestic abuse Act, 2021; The Health and Care Act, 2022. The recent legislation on Domestic Abuse Act 2021 and the Serious Violence duty January 2023 is driving our system to embed practice to meet these legislative requirements.

In Essex we continue to work collaboratively with the Suffolk and North East Essex, (SNEE) and Mid and South Essex (MSE) systems to develop an evidence based Strategic Needs Assessment and operational plan. HWE is also committed to reducing inequalities identified within the national agenda to address the disproportionate amount of Violence Against Women and Girls. This goes beyond the scope of domestic abuse, with a specific focus on children as victims, recognising that they are impacted by serious violence. There is work ongoing to strengthen the application of research on the support for perpetrators.

The HWE ICB continues to work with partners to ensure that the application of the Mental Capacity Act (MCA) 2005 is consistently applied for people aged 16 and above. This pertains to patients who are, or who need to be deprived of their liberty in order to enable their care or treatment, but who lack the mental capacity to consent to care. Arrangements are supported in the most proportionate, least restrictive way ensuring legislative requirements are met. We are using findings from statutory reviews to work in partnership to ensure that the principles of the MCA and 'making safeguarding personal' is embedded in the planning and delivery of care for the local population, both children and adults.
Our safeguarding teams work in partnership with our local authorities' children's and adult services to promote the health and welfare of children and support Adults at Risk and promote a learning culture to act as a preventive measure towards improving the lives of all of our communities. This work is supported by several partner safeguarding plans and strategies including Hertfordshire 2022-2024 for adults, strategic priorities 2023-2025 for children and Essex Children Board plan 2022-

27, Southend Essex Thurrock Domestic Abuse Board strategy 2020-2025, Hertfordshire Domestic Abuse Strategy 2022-2025 and our HWE ICB Safeguarding Strategy for children. Work is ongoing to strengthen the contributions from voluntary agencies, including faith groups, to keep our communities safe.

The safeguarding teams will drive leadership to improve the safety of Looked After Children in residential settings in response to the national review phase one and two of the Hesley report 2022 and 2023, to ensure that safe, effective and appropriate provision for children with disabilities and complex needs are aligned with local inclusion plans when planning for care through regional care cooperatives. We will also work to strengthen and improve access for adults with complex physical, and mental health needs.

We monitor and share with partners safeguarding children and adult Key Performance Indicators (KPIs) on a quarterly basis to understand trends in referrals to children's and adult services, domestic abuse referrals by health, local authorities and police so we can respond to emerging trends and themes to promote and support safe care. We will use the findings of current evaluative research to strengthen the way we deliver learning from local, national and wider reviews.

The ICB as part of the Corporate Parenting Board has prioritised the lived experience of care leavers and children with care experience. This includes strengthening opportunities for employment and further education through the Deed of Covenant for Looked After Children (children looked after by the local authority). The aim is to improve equity, access to employment and further education and to reduce health inequalities for these children.

## Safeguarding priorities across the lifespan

Embedding and promoting the principles of 'Making Safeguarding personal' across the lifespan:

**Priority 1**

Work with statutory partners to promote models of early interventions for babies, children, young people and adults in west Essex and Hertfordshire.

**Priority 2**

Work collaboratively with ICPs and safeguarding partnerships to support the embedding of lessons learned to bring about change by capturing and sharing learning from national and local reviews.

**Priority 3**

Strengthen the transition to adulthood for young people to ensure that their welfare is protected and take steps to continue to address the impact of adverse childhood experiences and prepare them for adulthood.

**Priority 4**
Adopt the statutory partnership and safeguarding boards' priorities to reduce inequalities, challenge unconscious bias and address the impact of serious violence.

**Priority 5**
Promote the welfare of Adults at Risk and ensure that the principles of 'Making Safeguarding Personal' are embedded in all learning activities for adults and vulnerable children

## Supporting wider social and economic development

Part of our role as an 'anchor institution' is to support the NHS to develop broader social and economic development. We will use all the levers at our disposal, and partners' support as anchor institutions, to improve the economic wellbeing of residents as one of the key determinants of health and wellbeing. This includes improving employment outcomes for our residents and improved social value through our commissioning and procurement activities. We are developing our role to support this in several ways, which are outlined below:

- **Anchors Network** - 30 public sector organisations in Essex, including the West Essex Health & Care Partnership, have come together as the Essex Anchor Network (EAN) to drive greater prosperity and a better quality of life for their local population – through employment and workforce strategies, procurement and supply chain policies, investments and use of estates. This is with the aim of raising aspiration within communities, by engaging with schools and mentoring people.

  The Essex Anchors Group within this network is currently focusing on bringing employers and colleges closer together to specify skills needed for the future. The group is also looking to improve opportunities for work placements and apprenticeships.

  Building on the learning from Essex, the University of Hertfordshire has been working with partner organisations across the health, local authority and VCFSE sector to help identify early system priorities that would benefit from delivery in partnership. These areas are focused on positively impacting our workforce, research and innovation and our communities. Following on from the official programme launch attended by over 100 representatives of the wider Hertfordshire and west Essex system partners, this year we will focus on developing and articulating a strategic plan to capture both the early benefits of the agreed work and agree how ambitious the future plan for partnership working across health and care partners can be.
- **VCFSE sector and the VCFSE Alliance**
  The website 'Working Herts' has been launched to promote working in the VCFSE sector in Hertfordshire, to provide free promotion of jobs to encourage more people into the sector, and to provide an easy way for registered partners to

fill short term and part time roles by drawing on the capacity of those currently working in the sector who wish to build a portfolio.

The VCFSE sector also uses thousands of volunteers, with positive impacts for the volunteers' wellbeing and, where appropriate, their acquisition of new skills and employability. The VCFSE Health Creation strategy has a workstream on further developing volunteering roles to fit 21st Century lifestyles and to encourage Anchor Institutions to offer their staff opportunities to contribute to their communities too. This sector is also crucial in helping the most disadvantaged residents' access full benefit entitlements and other help. The Herts Cost of Living Group and the Better Life Chances partnership are forums where VCFSE and statutory sector work together to maximise the impact on those facing the greatest financial challenges.

We will continue to develop the new Volunteering for Health scheme (2024-2027) which will create an integrated volunteering 'system' with a volunteer passport and increase volunteer co-ordination capacity across the ICS.

- **Unpaid Carers** - A significant segment of the working population has caring responsibilities, including 30% of the national NHS workforce. The pressure on social care is making it harder for many carers to work and care. We have been awarded 'Accomplished' (level 2) status by Employers for Carers for our work to support carers who are juggling their unpaid carer role with being employed by the ICB. Work with local authority partners also focuses on helping carers to stay in or return to work where possible.

## Workforce

Our workforce continues to be recognised as a key enabler in delivering both the broader Integrated Care Strategy and Joint Forward Plan. Across our area we currently employ over 55,000 Full Time Equivalent (FTE) staff to provide health and care services. Our system-oriented workforce transformation programme continues to strengthen collaboration with system partners ensuring the most effective and efficient delivery of health and care services for our population.

The programme is supported by wider activities of the system's Primary Care Training Hub and as well as local authorities and respective Care Providers Association.

Going forwards we will seek to support both the ICB's strategic priorities, but also national requirements including supporting an increased focus on prevention and community support.

We have seen substantial progress in meeting our People Strategy priorities and we have seen the publication of the national NHS Long Term Workforce Plan and associated regional priorities. These actions fall into three priority areas:

- Train: increases to education, training apprenticeships and alternative routes into professional roles. Development of new roles designed to better meet the changing needs of patients and support the ongoing transformation of care.

- Retain: ensure we keep more staff by supporting people throughout their careers, improving flexible working options as well as the wider culture and leadership across organisations.

- Reform: improving productivity by working and training in different ways, building flexible skills, and ensuring staff have the right skills to take advantage of new technology.

We are making significant progress in improving our workforce data and analysis across the system, moving towards a position of triangulated analysis across workforce, activity and finance. Using this data we will be able to undertake more sophisticated workforce modelling and training plans, utilising artificial intelligence (AI) tools to design a workforce fit for the future health and care needs of our population.

Within the first year of delivery we have achieved the following areas of progress against our People Strategy aims and ambitions, which are monitored and governed by the systems' People Board and directed by respective sub- committees:
Our current People Strategy is coming to a close in 2025 and the system is currently reviewing progress and applying learning before beginning to engage with key stakeholders on a refreshed strategy. The refreshed strategy will still seek to support delivery of the aspirations of the Long-Term Workforce Plan (LTWP), acknowledging that we are anticipating a revised version of the LTWP in the summer of 2025. The following areas of activity continue to be system priorities

**We will produce a long-term workforce plan for the whole system, based on the needs of our population and accounts for the skills required to deliver those services.**

- QlikCloud system now in place across secondary care, aspiration is to now move towards incorporating primary and social care workforce data for a full-system view.
- Pilot projects linking AI tools between activity and workforce design are progressing, and we will seek to engage more effectively with the University of Hertfordshire and the research collaborative to further improve engagement.

**We will create communities empowered and enabled to provide the best possible care through innovation and integrated working.**

- The system has a range of digital focussed People projects now progressing and is in the process of establishing effective governance and networks to support delivery. We are also seeking to implement the national digital staff passport and Enabling Staff

Movement Toolkit to enable easier transfer of staff across organisations.

**We will develop sustainable workforce attraction strategies, particularly through domestic supply routes, to reduce system vacancies.**

- We have supported targeted recruitment key roles and continue to seek to reduce vacancy rates in those areas.

- We continue to provide long-term strategic support to the system through the use of the Health and Care Academy.

We are linking closely with local department for work and pensions contacts and stakeholders such as former Local Enterprise Partnerships in developing a range of supported employment programmes to support our local community into work.

# 8. 2024-2025 Progress

Our first Joint Forward Plan was published in June 2023, since its launch we have seen the following progress against our ICB MTP Priorities, which also support our ICS Integrated Care Strategy ambitions:

## 8.1 ICS 2024-2026 Priorities

The indicators that we have set, as outlined in Figure 5 (page 20) have been reviewed to reflect our progress in 2024-25. Unfortunately we haven't seen the progress that we would like in terms of trajectory as demonstrated by the data. However as outlined in this section we have undertaken lots of work to improve outcomes for our residents which we would hope would see demonstrable improvements in future years. Our efforts in relation to CVD and hypertension have resulted in an increase in the number of people coming forward for blood pressure checks.

Below is a summary of our performance against our indicators, including a comparison with our position last year.

| ICB Priority | Measure | Area | Target | 23/24 End of Year | 23/24 YTD | 24/25 YTD | RAG |
|---|---|---|---|---|---|---|---|
| **Reduce inequality with a focus on outcomes for CVD and hypertension** | Hypertensions QOF Prevalence | ICB | 15.60% | 13.9% | - | 14.3% | |
| | Patients with GP recorded hypertension whose last blood pressure was in target | ICB | 80% | 79.6% | - | 77.6% | |
| | age standardised prevalence of hypertension in the most deprived 20% of the population | ICB | 19% | 17.8% | - | 20% | |
| **Improve Urgent and Emergency Care (UEC) through more anticipatory and more Same Day Emergency Care** | Rate of emergency admissions for falls (per 100,000) within the community for people aged 65+ | ICB | 160.3 | 168.70 | 168.5 | 170.4 | |
| | Rate (per 100,000) of non-elective admissions in people living with frailty | ICB | 1,770.7 | 1,864 | 1,828.7 | 1,900 | |
| | % of Deaths with 3+ emergency admissions in last 90 days of life | ICB | 5% | 6.2% | 5.8% | 6.5% | |
| **Better care for Mental Health crisis** | Increase response to Community Crisis Services | ICB | 67% | NA | NA | 59.4% | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | urgent referrals in 24/25 from 64% | | | | | | |
| | Out of area inappropriate beds for adults requiring a MH inpatient stay | ICB | 4 | 23 | 10 | 35 | |
| | Inpatient discharges to have 72 hour follow up | ENH | 75% | 95.4% | 96.1% | 92.6% | |
| | | SWH | 75% | 94.9% | 95.5% | 86.7 | |
| **Elective Care Recovery** | No. of patients waiting more than 65 weeks for treatment | ICB | 0 | 3,515 | 3,722 | 133 | |
| | % of surgery consistently undertaken as a day case | ICB | 85% | 85.7% | 83.9% | 82.9% | |
| | % of pts waiting less than 6 weeks for diagnostic (excluding audiology) | ICB | 95% | 65.2% | 64.5% | 71.6% | |
| **A reduction in the backlog for Children's Care** | Emergency Admission Rate per 100,000 for CYP | ICB | 420.4 | 427.3 | 410 | 439.4 | |
| | A&E attendance Rate per 100,000 for CYP | ICB | -5% | 2,210 | 2,184 | 2,285 | |

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

- **CVD**: The trend in both diagnosis and control of hypertension in HWE is improving. We have increased the proportion of people with hypertension who have had a blood pressure check and whose last blood pressure reading is below the age specific threshold. The number of people submitting home blood pressure readings has also increased significantly.

  We have seen an increase in age standardised prevalence of hypertension from 15.24% to 20% from June 2023 to January 2025, which has exceeded our target of 19%.

  Through an ICB wide comms campaign we have significantly increased the number of people undertaking blood pressure checks at their local pharmacy from 3,129 in March 2024 to 6,089 in August 2024. We have also launched a pilot scheme through dental and optometry practices, which completed 243 checks in the same period, with an uptake of 73.4% of eligible patients at the pilot practices.

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

- **Same day emergency care (SDEC) for frailty:** We have successfully implemented a pathway to support patients to be directly referred for same day emergency care (SDEC) from ambulances to all three acute hospital

medical SDEC services as part of the unscheduled care coordination hub and an alternatives to admission pathway for primary care clinicians to support referral of patients direct to SDEC services. This allows access to the right specialist medical care for early senior clinical decision-making and rapid treatment to avoid long waits in A&E and hospital admission. We continue to make improvements in how we identify patients who are frail at the front door of our hospitals and are developing a pathway to ensure earlier senior clinical decision-making so patients who are most vulnerable avoid complications from hospital admission and are supported, where appropriate, to receive their urgent or emergency care needs in the community, closer to home, or on the same day through SDEC-by-default approach (including acute frailty services).

- **Frailty and End of Life:** Advance care planning is live in the west of Essex and east and north Hertfordshire areas, using PEACE and ReSPECT respectively to undertake person-centred discussions about preferences and priorities for future care. The rollout of ReSPECT has commenced in the south west of Hertfordshire and is expected to be complete by the end of 2024/25. Optimisation of our shared health care record (ShCR) is underway to support completion and use of advance care plans to reduce the number of inappropriate hospital admissions at the end of life, and support patients to die in their preferred place of death.

- **Falls Prevention and deprescribing**: Across HWE we have mapped our falls prevention and rehabilitation services, and the treatment pathways for people who have fallen and whose care and treatment could be provided in the community to avoid unnecessary conveyance to hospital. Through this we have identified opportunities to scope new, or maximise existing, commissioned services and clinical pathways to improve patient care.

  We have completed a system-wide review by our pharmacy and medicines optimisation team to identify individuals prescribed more than 10 medications. We then identified those older people at risk of the cumulative effect of taking medications with anticholinergic activity (the 'anticholinergic burden' (ACB) and supported clinicians in assessment and deprescribing as necessary to reduce the risk of falls.
- **'Care closer to home':** The approved model has been developed with engagement from a number of key stakeholders including clinical and professional leads. We are working to understand what capacity we will need as we shift more care from acute reactive services to more proactive and preventative care delivered by community or primary care. An implementation guide for proactive care in neighbourhood teams has been produced to support

integrated neighbourhood team working and delivery of proactive and anticipatory care for patients.

- **Integrated neighbourhood teams**: Integrated neighbourhood teams (INTs) have been established on all place footprints and priorities are being agreed and are already in place for some. The establishment of INTs provides a multidisciplinary approach to care provision for selected groups of patients, with the aim of improving the outcomes and experience of the local population.

- **Digital:** 84% of all Care Quality Commission (CQC) registered care home providers in our area now have digital care records.

## Better care for people in mental health crisis:

- **Children and young people (CYP):**
  We have exceeded the Mental Health Support Team (MHST) target of 23% by achieving 43% coverage across HWE schools. Additionally, 95% of all special schools have a Special Educational Needs MHST.

  We continue to progress our ambitions regarding the delivery of a Children and Young People's Mental Health Service (CYPMHS) HertsHub and two of its key components: the digital gateway and the central triage team (who will be able to triage referrals to all commissioned provision across Herts CYPMHS).

Progress on the website is developing well, with an indicative go live date of 2025. We will be working with our system partners on the content of the website, which will also be the access gateway once the digital referral portal is finalised. The CYPMHS has also commissioned a range of digital support providers for children and young people to access help and guidance for their mental and emotional wellbeing from online resources, including techniques to help with managing different emotions and improving young people's coping skills, to live chat, online cognitive behaviour therapy (iCBT), and one-to-one support via text, telephone, or video call depending on the needs and preferences of the young person. This resulted in an increase in the uptake of early help support, and a decrease in the number of referrals for specialist mental health services. This gives assurance that our CYP are seeking help at an earlier point, rather than letting their mental and emotional wellbeing needs go unmet for a longer period of time. It also reduces the likelihood of them requiring more intensive support at a later point in time.

We continue to see a reduction in the number of CYP who are admitted to wards following a crisis presentation at an Acute ED because of our embedded 24/7 CYP Integrated Hertfordshire Crisis offer.  We are currently evaluating the model to ensure that it remains responsive to the needs of CYP & considering a future model that seeks to consider how we work with the wider system to support crisis prevention, crisis support telephone/ text lines, community

offers and how we deliver our brief interventions and 7-day follow ups.

Within Hertfordshire, and across the ICB, we have seen an increase in access numbers for support for CYPMHS and we are expected to meet the long-term plan ambition.

Partners from across the Hertfordshire CYPMHS have come together through a series of facilitated health inequalities workshops to better understand the experiences and journey of CYP from vulnerable groups. The findings are being developed into a set of recommendations for CYPMHS. We have also developed a standardised Reasonable Adjustments framework across Herts CYPMHS to enable a uniformed and consistent approach to enabling providers to support all CYP with their mental health needs regardless of any other health needs.

The development of the Emotional Wellbeing in Education (EMWiE) Team has supported more empowered education settings (including Early Years and Further Education) with confidence and knowledge to support CYP with their emotional and mental wellbeing. This has included a new ‘Kite Mark’, embedding MH champions, training, and focussing on the emotional and mental wellbeing provision for children aged five and under. The team oversee the transitions work and have developed workshops, training specifically to support transition touch points (ages and stages, young people to young adult etc.) Overall we have seen a steady increase in accepted referrals year on year and accepted 19% more referrals in Q2 24/25 than in the same period of the previous year.

- **Mental Health Urgent Care Centre (UCC):** The final phase of the UCC building work has been complete and the centre is now fully open with 6 spaces for people experiencing mental health crisis. Since its launch in February 2024, the UCC has seen over 500 people transferred from emergency departments across the ICS, with most supported in the community post discharge without the need for an inpatient admission. Additional ways for people to access the centre have been opened, including walk-ins, (with more planned in the coming year), enabling professionals to refer directly to the UCC, avoiding emergency departments altogether and improving peoples experience of accessing crisis support.

We have established a system implementation group across Greater Essex including partners from across the three Essex facing ICBs and the county and unitary councils. The group has created a single development and work plan for Essex with leads identified for each area of the plan. This approach should prevent fragmentation and deliver better outcomes across Essex.

The ICB is working closely with the East of England Mental Health Provider Collaborative for specialist services to ensure our population has equity of access and reduces the

number of out of area placements so we provide care closer to home for people with complex mental health needs.

- **Reducing out of area placements:** HPFT have made significant strides to significantly reduce the number of patients they place outside of Hertfordshire, with more residential placements now being made in Hertfordshire. For west Essex, system partners continue to work with NHSE to review all placements and ensure timely discharges from inpatient beds.
- **Supported living:** We have successfully transitioned patients from longstanding specialist residential services into a supported living service in Hertfordshire. This means that patients who had spent significant years of their lives in specialist hospital are able to be cared for in the communities.

## Elective care recovery

- Clinical networks established for urology, gynaecology, theatres and perioperative care, musculoskeletal (MSK) and children and young people. Resources were secured for elective hub planning with mobilisation underway and building work now commenced.
- The New QEII Hospital Community Diagnostic Centre (CDC) is fully operational.
- Extended access for MRI and Audiology is live at Epping Community Diagnostic Centre (CDC), with ultrasound available at the Bishop's Stortford CDC.
- Operating theatre productivity rates have improved to the top quartile nationally (81.7%).

## A reduction in the backlog for children's care:

Unfortunately due to further unprecedented level of demand for community paediatrics and subsequent follow ups in relation to autism spectrum disorders (ASD) and attention deficit hyperactivity disorders (ADHD) during 2023-24 in Hertfordshire, we have seen our waiting list and times increase for access to children's care. For instance in Hertfordshire there has been an increase in demand for neurodiversity services (ASD and ADHD assessments) of around 24% a year and due to funding restraints, our workforce has not been able to grow at a similar rate to meet demand. We have though improved our data reporting and monitoring in relation to our waiting lists and therefore are able to fully understand our waiting times to support improvement. Also our support offer in Hertfordshire is considered strong with positive feedback from professionals, families, and children. In west Essex we have transformed our ASD assessment to the JADES pathway some time ago and recently aligned ADHD with this. A number of initiatives continue to be put in place to tighten referral processes and support those waiting.

Below is an overview of our current wait times:

| Area | Date | Number waiting for a community paediatric | Number waiting for ASD assessment follow up appointment (after community |
|---|---|---|---|

| | | 1st appointment | paediatrics 1st appointment in Herts, JADES pathway WE) |
|---|---|---|---|
| Hertfordshire | Mar 23 | 5797 | 1643 |
| | Mar 24 | 7046 | 1961 |
| | Oct24 | 8094 | 2134 |
| West Essex* | Mar23 | 296 | 1291 |
| | Mar 24 | 339 | 1961 |
| | Jan 25 | 524 | 1611 |

*There is no comm paed 1st appointment in WE, they go directly onto the ASD assessment pathway - the first appointment of which is the assessment itself.

- **Southend, Essex and Thurrock (SET) Children's Therapies**: 2024/25 marked the half-way point for the Southend, Essex and Thurrock (SET) Children's Therapies Transformation Programme. Following completion of a full analysis of need and resource, alongside aligning of health and education initiatives, implementation began with successful pilots for various aspects of the model being carried out across parts of Essex. Clinical facilitators have been working with local therapy teams to guide and support operational changes, and incorporating the voices of families continues to be supported by local Parent Carer Forums
- **SEND:** We have reviewed and made the necessary changes to our skill mix of our therapies teams and we have appointed new education leads.

  Additional clinics have been offered on Education, Health and Care Plans (EHCPs) to reduce waiting times for assessments; we have launched the new children and young people's integrated therapy services website.

  We have also completed a number of specifications focused on speech and language therapy and occupational therapy and physio and our new prioritisation framework is enabling resources to target children with the highest need.

- **Engagement:** A ICB Health Youth Council has been established, providing a structured and consistent framework to hear the voices of children and young people and undertake co-production. To complement this work and help patient groups understand what young people need from healthcare, a series of eight short videos have been produced and shared across multiple platforms.

## 8.2 Medium Term Plan Priorities

### Give every child the best start in life

**Maternity** The local maternity and neonatal system (LMNS) has been successful in delivering the year five Maternity Incentive Scheme (MIS), which supports the delivery of safer maternity care, designed to improve the delivery of best practice in maternity and neonatal services. The system is on track to deliver year six of the Maternity Incentive Scheme by March 2025.

Saving Babies Lives (SBL) version 3.0 has been successfully implemented across the system in line with year 6 of the Maternity Incentive Scheme. This implementation includes achieving at least 50% of all interventions across all six elements of the care bundle, with an overall compliance rate of 70%. The LMNS meets with providers quarterly to assess the quality and standard of the interventions undertaken, comparing these against nationally and locally set targets. All three providers have implemented SBL. While digital implementation initially impacts audit figures and poses a threat to attainment, it offers greater reliability and assurance than manually auditing small samples of paper records. The LMNS is working with providers to ensure any threats to implementation are mitigated and monitored through our governance and improvement processes.

- **Respiratory:** We have established an asthma board to oversee asthma improvements, including delivery of the National Children's Asthma Bundle of Care sharing learning across our system. Children and young people asthma clinical leads are in post. We have provisional funding to provide our Trusts with children and young people's diagnostic equipment and we have launched 'Asthma Friendly Schools' across our system. We have increased the proportion of children with an asthma care plan and there has been a decrease in the rate of children attending Emergency Departments with asthma
- **SEND:** Hertfordshire is on track in implementing many aspects of their improvement plan, demonstrating some examples of good practice. There has been evidence that the improvement plan is beginning to have a positive impact on the experiences of some children and young people. Communication with stakeholders has also improved with very good information in newsletters, briefings, meetings with stakeholders and the improvements to the local offer
- **Autism**: The autism spectrum disorder psychoeducational resource project continues to be delivered across Southend, Essex and Thurrock for parents, carers and young people, continuing to expand reach and access and had received positive feedback. The project will begin evaluation during 2025/26. Following the stakeholder engagement and marketing, the Southend, Essex and Thurrock (SET) Autism Alliance has been overseeing progress and delivery and development of the competency framework for the service with a specialised training plan, which includes Trauma Perceptive Practice (TPP). The core offer for adults went live in November 2024

  Since its inception in 2022, the Southend, Essex and Thurrock Keyworker Service has achieved the aims of delivering on the NHS Long Term Plan commitment of every child and young person (CYP) with learning disabilities and/or autism in the community with the greatest vulnerabilities and at risk of admission to Tier 4 Mental Health hospital having a designated Keyworker by 2024. The service has been successfully jointly recommissioned

to continue to provide services to vulnerable individuals for the next three to five years.

The Partnership for Inclusion of Neurodiversity in Schools (PINS) has been successfully delivered across 95 Essex mainstream primary schools, led by HWE ICB in partnership with HCRG Care Group and the Essex Family Forum. The project will ensure enhanced outcomes for neurodiverse students. In Hertfordshire the Neurodiversity Support Hub is jointly commissioned by the ICB and Hertfordshire County Council to provide support with or without diagnosis for ADHD, or autism. In addition, 'Understanding my autism/ADHD' sessions have been rolled out for children and young people. Also in Hertfordshire work has been undertaken to develop the Hertfordshire All Age Autism Strategy, which will formally be launched in 2025.

## Increasing healthy life expectancy and reducing inequality

- **Respiratory:** Respiratory hubs have been rolled out by PCNs across the ICB, which provide access to diagnostics for asthma closer to where people live.
- **Digital:** Links established with the wider NHS, universities, Academic Health Science Networks and others aligned to exploring and testing new technologies for care in line with the NHS Long Term Plan.
- **Armed Forces Community:** All our five local NHS Trusts are now accredited as 'veteran aware' with the Veteran Covenant Healthcare Alliance (VCHA), as well as achieving Employers' Recognition Scheme accreditation. We also have increased the number of our GP practices accredited with the Royal College of General Practitioners as 'veteran friendly' with at least one in each PCN and over 60% of all practices accredited. In addition we have added over 170 dedicated services for the armed forces community onto a national App called 'Forces Connect' which anyone can download and use to help improve access to local and specialist services.
- **Diabetes:** A diabetes educational session was delivered during protected learning time for primary care, which provided an update on current management and highlighted all the services available to patients.

**Reducing inequalities for people with a severe mental illness (SMI):**

- The ICB has continued to invest in outreach provision targeted at improving the uptake of physical health checks for people with a SMI and increase the number of physical health checks undertaken in primary care through the enhanced commissioning framework.
- The ICB also approved additional investment to increase the provision of individual placements and support (IPS) for people with a severe mental illness (SMI) and enhance access through primary care. Working with all system partners there has been a review of current

services and future services to achieve this.

**Learning disabilities:**

- NHSE learning disability Annual Health Check (AHC) data shows a significant increase in delivery. By September 2024, 531 more checks had been completed across Herts and west Essex. Work has progressed via a task and finish group to increase the number of young people on GP registers, boost AHC attendance, and educate families about these services and improving early identification of learning disabilities.
- In 2023-24, the STOMP team collaborated with 77 GP practices across Hertfordshire, conducted 558 initial assessments for psychotropic medication reviews, completed 155 at-home risk assessments for eligible individuals and provided intensive support for medication reduction to 91 people, where it was safe and appropriate. This work has led to significant, life-changing outcomes for individuals and their families.
- A task and finish group reviewed requirements for phase 1 of the reasonable adjustments digital flag and individual organisations taking steps to enable requirements to be in place. Further clarity is required from NHSE before we can progress with phase 2.
- Insights from the LeDeR Annual Report 23-24 have been disseminated across various forums, boards and services. Efforts are ongoing to progress improvements based on the 14 recommendations. Task and finish groups continue to address specific focus areas identified and planning is in progress for the third 'Big Health Get-together' engagement and co-production event in March 2025.

## Improving access to health and care services

**Primary care:** in 2024-25 there was a year-to-date increase of 3.5% in GP appointments compared to 23-24. This has been supported by an increased number of Full Time Equivalent (FTE) staff in a number of roles across primary care. This includes staff employed through the Additional Roles Reimbursement Scheme (ARRS), such as pharmacists, paramedics and physiotherapists, which has enabled patients access to the right care more quickly. An example of a service being supported by ARRS staff is minor illness clinics working at PCN level to support patients (in Stort Valley and Villages and Hertford and Rurals PCNs).

- Year to date data shows that in 24-25 88.25% of GP appointments were delivered within two weeks (our target is 89%). It also shows that we continue to increase year-on-year the number of completed online consultations with a 343% increase from 23-24.
- We have managed to increase the role of optometrists in the delivery of eye care ophthalmology pathway across primary care, community and hospital services. For instance, we have commissioned optometry-led post operative cataract pathways in west Essex and south and west Hertfordshire and are on track to have these also in

place in east and north Hertfordshire in 2025. This will free up our local hospitals to undertake more operations and bring this part of the pathway closer to the patient

- Regular networking and support forums for AHPs have been established by the ICB training hub
- Agreed action plans (where relevant) are in place for each PCN to support their development and to address local challenges and a new enhanced workforce dashboard has been produced.
- INT development is continuing with six INTs in east and north Herts, four in south and west Herts and six in west Essex. Patient cohorts are being confirmed across each INT, who are working with a variety of stakeholders from across the system to plan and deliver care. Current data available shows that there is still work to be done to ensure each PCN has a social prescribing link worker that can see children (currently in place in 8/35 PCNs in HWE).
- Additional 8,092 appointments booked in the enhanced dental urgent access pilot sites since December 2023. This pilot has been extended until March 25.
- 60% of GP practices now have cloud-based telephony.

**Same day urgent care**: A system-wide Urgent Treatment Centre (UTC) and Minor Injury Unit (MIU) review is in progress. As part of this we have reviewed the same day urgent care needs of our population and are reviewing our services against national UTC principles and standards so we reduce unwarranted variation and maximise the use and effectiveness of our UTCs to support our wider urgent and emergency care system and pressured emergency departments.

**Urgent and Emergency Care- managing demand:** In November 2024 we successfully implemented a new single point of contact model. The Unscheduled Care Coordination Hub (UCCH) brings together urgent care practitioners and clinicians (in both a physical and virtual UCCH setting) from the ambulance service, community services, and acute trusts to rapidly agree the best way to treat patients who are at high risk of urgent hospital attendance. This is to support patients to receive the right care, in the right place, first time with greater consideration and better use of urgent community pathways rather than conveying patients to A&E, and direct referral to medical same day emergency care (SDEC) when required. There has been an expansion of 999 calls to be proactively managed by the UCCH and lower acuity calls to 999 made by health care professionals are passed to the UCCH for review. Ambulance crews are also proactively reaching out to the hub whilst on scene to ascertain the most appropriate pathways are being utilised. We continue to monitor improvements in both the volume of 999 calls that are proactively managed by the UCCH and ambulance crew calls to the UCCH before conveying to hospital. We are also expanding the hub's efficiency by opening direct access routes for ambulance crews into surgical SDEC.

**Urgent and Emergency Care: system coordination:** The System Coordination Centre (SCC) has continued to evolve providing oversight of system pressures and supporting patient access to the safest high-quality care. A group has been set up to which monitors system risks and issues and reviews the SCC operational processes to ensure mitigation is in place. We are recruiting staff as part of a comprehensive workforce model for the System Coordination Centre. We have implemented the enhanced national Operating Pressure Escalation Level (OPEL) framework including consistent community and mental health parameters (and plan to implement acute trust and NHS 111 parameters by April 2025) including metrics on the ICS capacity dashboard (SHREWD) to ensure available system capacity is correctly utilised and supports patient flow.

**Cancer:**

The ICB has achieved an improved 28-day performance position in 2024/25 for all providers, consistently meeting and exceeding the 75% Faster Diagnosis standard for multiple months. This standard is the requirement that 75% of patients should not wait more than 28 days from referral to finding out whether they have cancer or not

Two of our three providers have shown sustained improvement in their 62-day performance. which sets out that there should be no more than 62 days wait between the date the hospital receives an urgent suspected cancer referral and the start of treatment However, one provider remains challenged in this area. Extensive improvement plans are in place to support this provider.

Although we have not yet reached the 80% target across the ICB, we are demonstrating good screening uptake for both age groups, with rates in the 70% range. This reflects a healthy position above the East of England and national averages.

We continue to monitor the use of faecal immunochemical testing (FIT) as a screening test for colon cancer, aiming to meet the standard of 80% of all lower GI (gastrointestinal) referrals being accompanied by a FIT result. The ICB is performing reasonably well against this standard and is aware of the challenged areas, targeting resources to ensure continuous improvement.

Capsule Sponge, a single-use device used to collect cells from the lining of the oesophagus, has been available in pilot format at all three providers in 2024. Plans are in development to secure substantive resources for this service.

Primary Care Networks (PCNs) in east and north Hertfordshire and West Essex are participating in a pilot focused on the early identification of individuals at risk of Barrett's oesophagus or oesophageal cancer. This pilot has received very positive feedback and will conclude in March 2025, after which we will await further guidance and evaluation to support future planning for this community-based service.

We have successfully established breast pain-only clinics in all three localities in 2024, and these are currently transitioning to substantive services.

We continue to provide a non-site-specific pathway service (NSSP) for all our GPs across the ICB, with these pilots currently transitioning to business-as-usual models.

The 2023 national cancer patient experience survey results showed an average response rate of 52% across our three providers. This survey identifies areas for review and consideration, supporting the development of detailed improvement plans. Some key findings are outlined below:

Below outlines the average rating of care for our Trusts on a scale of n a scale of 0 (very poor) -10 (very good):

| **Provider** | **2023** | **2022** | **RAG** |
|---|---|---|---|
| ENHT | 8.8 | 8.7 | |
| PAH | 9.2 | 9.1 | |
| WHTHT | 8.7 | 8.8 | |

- The percentage of patients who ‘said they were always treated with respect and dignity while in hospital’.

| ENHT | 80% | 82% | |
|---|---|---|---|
| PAHT | 96% | 81% | |
| WHTHT | 76% | 83% | |

- The percentage of patients who ‘said they were told sensitively that they had cancer’.

| ENHT | 71% | 67% | |
|---|---|---|---|
| PAHT | 88% | 75% | |
| WHTHT | 72% | 73% | |

**Dementia:** Implementation of the Hertfordshire Dementia Strategy has continued across health, care and voluntary and community partners. Diagnosis rates in Hertfordshire have continued to increase in 2024/25 but remain below the national target although the number of people waiting for assessment has reduced by 19% between April and November 2024. Increasing diagnosis rates and early diagnosis will be a key element of preparing for new disease modifying treatments and peoples longer term outcomes. As a result, work is underway to increase diagnosis activity by wider professionals to diagnose people earlier in their condition.

Focused work has started to make links with ICB frailty programmes to improve access to health care services for people with dementia and contributing to the 25% reduction targets for the acute trusts alongside work to understand our response for people with young onset and rare forms of dementia to provide interventions specific to people’s circumstances. Our 25% target is to reduce avoidable hospital admissions for our frail population by 25%.

Local service development has started at a Primary Care Network and Integrated Neighbourhood Teams level, where dementia support has been identified as a local priority, offering the opportunity of local learning that can be expanded across the ICS area.

The new 'Memory Support Hertfordshire' community support service went live in October 2024 providing targeted dementia specific support to people with dementia and their carers.  A Hertfordshire dementia-friendly accreditation scheme has been developed to maintain and develop dementia awareness since the ending of the national scheme.

West Essex place continue to work with secondary care (PAH) in the development and implementation of a dementia and delirium strategy with aims and outcomes that support secondary care in the transfer of those living with dementia either into or out of hospital or preventing inappropriate admission where possible. For older adult mental health, we continue to develop effective pathways with system partners to ensure access to mental health support at the right time, preventing inpatient admissions through appropriate assessment of needs and support from our community mental health teams including intensive support.

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

- **Obesity:** We have increased referrals into the national Digital Weight Management Programme, with Hertfordshire and west Essex now in the top 15 ICBs for the highest number of eligible referrals.  We have also mobilised a new Hertfordshire-wide, integrated tier 2 and tier 3 weight management service for adults.

- **Smoking Cessation:** We have implemented the national tobacco dependency programme pathways, in maternity, acute inpatient (in limited) but high impact specialities; community inpatient and mental health inpatient settings.

- **Digital:** We have increased uptake of the NHS App. In 2024/25 Hertfordshire and west Essex patients logged into the app 1.5 million times in October 2024, compared to 750,000 times in October 2023. 121,0000 repeat prescriptions were ordered in October 2024 through the app as opposed to the same month in the previous year.

- **Primary care:** Numerous campaigns over the year have been undertaken across primary care to help patients to self-manage (where appropriate), as well as promotion of the NHS app, information about how different healthcare professionals based in primary care can help, and the promotion of helpful websites such as https://www.hwehealthiertogether.nhs.uk/

### Ensure financial stability

Our system is contributing to recovering the current financial position in Hertfordshire and west Essex by supporting a financial recovery plan developed by all partners. Trusts are working together to reduce excess costs, identify opportunities

to collaborate on corporate and clinical services where this drives efficiencies improvements, cost reduction and avoidance, income generation and service productivity improvements. We are working with partners to improve the health and wellbeing of our population and reduce demand on acute care services.

- **Staffing:** Our aspiration remains to meet the recovery needs of the system through reductions in overall workforce and particularly a reduction in the use of temporary staffing as set out in our operational plans. We have made substantial progress in reducing the system's reliance on expensive agency staffing, reducing agency staff use by almost 40% compared to plan. During 2024/25:
    - We have instigated extensive vacancy control processes across the system, with vacancies being reviewed at organisational, system and regional levels prior to recruitment.
    - Productivity across the system has significantly improved, and we are looking to make further improvements through the introduction of innovation and digital solutions.
    - Agency staffing usage is a third less than projected use - this has resulted in some additional bank staff use.
- Productivity: An overview of our 2024-25 year to date performance is outlined in Figure 8 on Page 56

## ICS Workforce Plans

**Reduce overall staff turnover and leaver rates:** Over the course of this year, we have seen reductions in turnover from 15.4% to 10.9%, and leaver rates from 10.6% to 7.2%. Our aim is to continue to provide the best support and development offer to our workforce to ensure we retain skills and knowledge within our system.

| | 2024/25 Current Perf | | | | 2025/26 - Target | | | |
|---|---|---|---|---|---|---|---|---|
| | HWE | ENHT | PAH | WHTH | HWE | ENHT | PAH | WHTH |
| Improvement of 4% in Theatre utilisation | 79.1% | 81.7% | No data | 73.6% | 85.0% | 85.0% | 85.0% | 85.0% |
| Improvement of 4% Day case rate | 84.1% | 87.2% | 85.1% | 78.2% | 85.0% | 85.0% | 85.0% | 85.0% |
| Increase number of cases > Value weighted activity greater 107% of 2019/20 | 127.8% | 140.8% | 99.0% | 165.2% | 120.0% | 130.0% | 120.0% | 120.0% |
| Improve average cases per 4-hour session >2.8 | 2.3 | 2.3 | No data | 2.1 | 2.8 | 2.8 | 2.8 | 2.8 |
| Improve utilisation - capped >85% | 79.1 | 81.7 | No data | 73.6 | 85.0 | 85.0 | 85.0 | 85.0 |
| Improve average late starts (minutes) <15 | 26 | 24 | No data | 32 | 15.0 | 15.0 | 15.0 | 15.0 |
| Improve average inter case downtime (minutes) <15 | 14 | 13 | No data | 17 | 15.0 | 15.0 | 15.0 | 15.0 |
| Improve average early finish (minutes) <30 | 47 | 43 | No data | 55 | 30.0 | 30.0 | 30.0 | 30.0 |
| Improve average unplanned extensions (minutes) <30 | 22 | 16 | No data | 36 | 30.0 | 30.0 | 30.0 | 30.0 |
| Improve % of emergency surgery conducted within elective lists <1% | 1.0 | 0.9 | No data | 1.3 | 1.0 | 1.0 | 1.0 | 1.0 |
| Improve additional capacity (%) including 5% on the day cancellation rates <5 | No data | No data | No data | No data | 5.0 | 5.0 | 5.0 | 5.0 |
| Increase day case rates >85% | 84.1% | 87.2% | 85.1% | 78.2% | 85.0 | 85.0 | 85.0 | 85.0 |
| Reduce day case to in patient conversion rate <5% | 7.8 | 3.9 | 16.8 | 8.1 | 5.0 | 5.0 | 5.0 | 5.0 |
| Reduce Elective Length of Stay <2 days | 2.4 | 2.2 | 3.0 | 2.2 | 2.0 | 2.0 | 2.0 | 2.0 |
| Reduce Non-elective Length of Stay <5 days | 8.8 | 8.3 | 9.0 | 8.8 | 8.0 | 8.0 | 8.0 | 8.0 |
| Make first appointment count > 55% | 49.3 | 47.7 | 44.3 | 50.5 | - | - | - | - |
| Reduce cancellations /DNAs <5% | 6.7 | 6.4 | 9.2 | 7.0 | - | - | - | - |
| Increase virtual appointments >25% | 20.9 | 23.6 | 27.7 | 15.0 | - | - | - | - |
| Increase advice and guidance diversion rate >20% | 13.0 | 18.7 | 18.7 | 12.3 | - | - | - | - |
| Increase PIFU | 1.6 | 2.5 | 2.0 | 2.4 | - | - | - | - |
| Reduce follow-up appointments Ratio of new to follow up > 1.6 | 1.9 | 1.6 | 2.3 | 1.9 | - | - | - | - |

*Figure 8: 2024-25 Productivity performance data*

# 9. Case studies

This section builds on the previous section and includes case studies demonstrating the outcomes from some of our work.

## Cardiovascular disease and population health management

The population health management data pack provided by the ICB for a Welwyn Garden City-based group of GP practices identified that local residents were more likely than the ICB average to have undiagnosed hypertension (high blood pressure) which can cause significant and life-changing illness. The pack showed that people with the following protected characteristics are more likely to be at risk from hypertension:

- men more than women
- people aged 50+
- people who are black/black British or Asian/Asian British ethnicity.

To tackle this health inequality, patient-focused hypertension campaign materials, case study advice and resources aimed at reducing the health risks faced by people with these protected characteristics were included in the data packs for relevant areas. The ICB also launched an area-wide hypertension publicity campaign, featuring people from these at-risk groups, encouraging people to take up blood pressure checks at local pharmacies.

Early results show a significant increase in the numbers of people taking up blood pressure checks at pharmacies before and after the campaign launch, from 3,129 checks before the campaign was launched in March 2024, to an average of 5,376 checks per month from June 2024 onwards, a 72% increase in take-up.

## Stevenage: same day access Primary Care Network hubs:

**Setting:**

Stevenage was identified as one of three priority areas across the ICB requiring more same day access appointments in primary care due to high levels of increasing demand. This was evidenced by the number of 'in hours' emergency department attendance rates and associated impact and pressures. Early modelling work also showed that approximately 50% of patient contacts into the practices required a same day appointment. The in-hours call rate to the 111 service was also significantly higher than average across place. Over 50% of the Stevenage population live within the five most deprived deciles for deprivation.

Both PCNs have previous experience of operationalising same day access hubs and have previously set up dedicated acute respiratory hubs to help support. The hubs will match population need and have integrated pathways with other services (NHS 111, ED, SDEC, UTC, and virtual wards) to support referrals, diagnostics, treatment, and monitoring. For example there would be the flexibility to support seasonal demand, for acute respiratory illness.

**Activity:**

- The implementation of the total triage model has been transformative in terms of reduction in number of phone calls into the Stevenage North hub and practices.
- Reception and administrative staff are now better trained in care navigation which allows patients to be allocated appointments in terms of need not want and to support them with better signposting to alternative community provision, such as Pharmacy First.
- Across the two hubs on average there are an additional (circa) 1,200 appointments per week available; these are a mix of face to face, telephone & virtual.
- Staff morale has improved as they are able to offer patients something extra given the demand for on the day appointments is high.
- Dedicated number of 111 slots per week – directly bookable.
- Training and development for staff – staff empowerment
- Hubs use a multi skilled workforce including GPs, Emergency Nurse Practitioners, Paramedics, Advanced Nurse Practitioners, mental health workers and physiotherapists.

**Impact**

- 111 in-hours call reduction for Stevenage North PCN.
- More same day access to appointments in primary care.
- Patients seen by the right professional at the right time for their specific concern, closer to home.
- Excellent feedback from patient surveys and comments very supportive of hubs
- Low non-attendance rates at appointments.
- Able to offer more appointments to support patients with long term conditions

## Loughton, Buckhurst Hill and Chigwell care home hub pilot

**Situation/Setting:**

Provision of support to care homes in Loughton, Buckhurst Hill and Chigwell (LBC) is provided by Essex County Council's social care, Essex Partnership University Trust (EPUT), St Clare Hospice and general practice. The general practice element of care was provided by the individual practices that patients within the care homes were registered with, meaning that each care home was assigned 2-3 practices and many practices covered multiple homes. Both practices and care homes reported difficulties with this model.

The aim of the centralised care home hub is to provide an integrated neighbourhood team approach across LBC. This has meant putting in place a lead GP working across six care homes, totalling 218 beds, with a dedicated team supporting this including a pharmacist, paramedic and a care co-ordinator. These roles work alongside the existing community resource within social care and EPUT, enabling fewer hand-offs and more seamless care for patients. The set up and mobilisation of this service took huge time, effort and commitment from the INT who established a dedicated project team to support this workstream. This required working with all participating practices and the wider stakeholders who support residents' care in their care home.

**Action:**

- The INT had to work in a timely and structured way to mobilise the project. As well as weekly core project team meetings, monthly project groups were established with stakeholders to work through several areas to allow for successful mobilisation. These meetings covered: -
    - GP and additional roles reimbursement scheme recruitment
    - clinical governance and referral pathways
    - IT infrastructure
    - communication networks - including all system partners, care homes and community pharmacies
    - quality assurance and data analysis
- Participation from community matrons and care home managers was crucial to the success of these meetings, where operational processes were discussed and agreed, and any concerns talked through.
- Alongside this the team worked with the ICB in the run up to the go-live date to ensure key performance indicators were set out to allow for the evaluation of the service following the pilot period.

**Impact:**

- The project is still in its early phase. Three months' worth of KPI data has been reviewed with many being met. Next, we will focus on all End-of-Life KPI's with training being arranged by the community provider for the care home hub and PCN as a whole. We are working with end-of-life care commissioners, EPUT and St Clare Hospice to deliver this.
- The wider system target of reduction in readmissions requires more time in order to see the impact the service has throughout the year. However, the first three months' worth of data looks promising showing that the average number of admissions from these homes appears to have fallen since the establishment of the service when compared to last year. Targets continue to be monitored monthly and further outcome data will be shared in the six-month evaluation.
- Qualitative feedback to date has been extremely positive from care home managers, GPs, community staff and families. This feedback is being captured to inform the midway evaluation of the pilot. Key themes coming out of feedback so far highlight better response to urgent/on the day requests, better follow ups for patients recently discharged from hospital to home, reduced hospital admissions, prescriptions arriving in a timely way (care home not having to chase), reduced complaints from patients and relatives, patients and carers being pleased with the service because there is always someone there who will respond to care home requests.

# Appendix 1 – ICB Statutory Duties

As an ICB we have a number of statutory duties that we are required to fulfil by law. This Joint Forward Plan includes details as to how these duties will be delivered. We will exercise our statutory duties with the aim of:

- **Meeting our population's needs** through commissioning of healthcare services and working with our partners in health and social care to deliver services that meet the needs of our population. ***See sections 1 and 2 for further details.***

- **Promoting integration** within our system by working with our providers as well as our health and social care partners to build on existing integration and collaboration to better align and integrate our services to create efficiencies and benefits for our residents. ***See section 3 for further details.***

- **Having regard to the wider effects of healthcare decisions** through our governance and decision-making processes at system, place and neighbourhood levels. Ensuring that the NHS triple aim is considered in our decision making and evaluation processes. The triple aim being better health and wellbeing of the people of England (including by reducing inequalities with respect to health and wellbeing), better quality of NHS health care services (including by reducing inequalities with respect to the benefits obtained by individuals from those services), more sustainable and efficient use of resources by NHS bodies. ***See sections 2, 3, 4, 5 6 and 7 for further details.***

- **Achieving a balanced financial position**: To support delivery of financial balance the ICB and partner trusts work together as a single system, but also through our Health Care Partnerships to explore clinical and service delivery models and opportunities for transformation of services. So, whilst each individual organisation agrees through its own governance processes an operational and financial plan for its organisation, this plan reflects the spirit of the duty to collaborate. ***See section 7 and Appendix 1 for further details.***

- **Improving the quality of services** in line with our duty to continually improve the quality of care and outcomes and to deliver the ambition set out for us within the National Quality Board Guidance – 'A Shared Commitment to Quality' and the Long-Term Plan's ambition for quality in the NHS. Our goal is to provide high quality personalised and equitable care for all, now and into the future, ensuring that quality is central to planning and decision making within our health and care system.

Also that the care we provide is aligned with Public Health and Adult Social Care, the NHS Patient Safety Strategy and the People Plan. ***See section 7 for further details.***

- **Reducing health inequalities** across our population and across all services and settings, reducing avoidable and unfair differences in health between different groups in society. We will use local intelligence including population health management systems to enable health and care staff to identify people most at risk of ill health and identify areas where health inequalities are greatest to ensure that resources can be targeted at people with the greatest need. We will also work in an integrated way to reduce the factors that contribute towards health inequalities. ***See sections 2, 3, 5, 6 and 7 for further details.***

- **Promoting involvement and patient choice** of each person by expanding the choices and control that people have over their own care. Through social prescribing the range of support available to people will widen, diversify and become accessible across the area. Enhanced digital capabilities will ensure that people are empowered and will have the ability to access, manage and contribute to digital tools, information and services articulated throughout our JFP. ***See sections 2 and 7 for further details.***

- **Involving our residents** who use our services, their carers, and communities, along with our staff that deliver our services. We will engage with them at the earliest stages of service design, development, and evaluation. We recognise that those with 'lived experience' of a particular issue or condition, their families and carers, and the staff that support them are often best placed to advise on what support and services will make a positive difference to their lives. In HWE we are informed by the views gathered and shared by our Patient Engagement Forum and Youth Council to support our decision making. We are committed to working with our residents to improve services and will listen to what our residents tell us and respond to their needs. ***See sections 2 and 7 for further details.***

- **Addressing the needs of victims of abuse** by ensuring that the proper systems are in place to help. We will continue to develop best practice to safeguard children who are subject to abuse and neglect, including victims of criminal or sexual exploitation. Adults or older people with greater vulnerabilities or complex needs will have specialist integrated drugs and alcohol support. Specialist support recognises and tackles the complexity of vulnerable adults' needs, including victims of domestic abuse or sexual assault, sex workers, homeless people, veterans and older people.
  We will develop effective pathways to integrated services for

domestic abuse victims and perpetrators. Agencies will collaborate to help everyone in the family affected by domestic abuse. The Serious Violence Duty (January 2023) will drive the ICS to embed practice to meet legislative requirements. ***See section 7 for further details.***

- **Promoting innovation** by utilising and realising the benefits of innovation to enable positive change in the way that we deliver our services. We will look to use innovation to improve our interactions with the public, patients and their families and develop new improved models of care. We will also look to advancements in technology to improve the management and delivery of care and deliver new treatments. ***See section 7 for further details.***

- **Promoting education and training** through the delivery of our ICS People Strategy we will strengthen our health and care workforce and enable career development by embedding a culture of training and development across the system. This will be done by developing a system-oriented career and leadership pathway, ensuring staff from all backgrounds can access appropriate training and development opportunities and developing a system-led talent management process.

  We will also work with educational institutions to develop training and placement opportunities to address key skills gaps. ***See section 7 for further details.***

- **Obtaining appropriate advice** to enable us to successfully discharge our functions through our ICB governance arrangements that incorporate expert advice and also through broader engagement of the public (as outlined in section 2 and throughout this document). Also by strengthening relationships with national and regional clinical networks, academic health science networks and our local university to support with innovation and review pathways. ***See section 7 for further details.***

- **Supporting delivery of our local health and wellbeing strategies** through alignment with our plans and strategy detailed in our JFP and also with the Integrated Care Strategy***. See sections 2 and 4 for further details***.

- **Utilising, facilitating and promoting both local and national research** – we have well established research capabilities embedded within our provider organisations. Through research engagement network development (REND) funding will build on initial progress to develop an ICS research strategy. ***See section 7 for further details.***

- Delivering against our targets to **tackle climate change** by building on our initial progress and delivering our ICS Green Plan 2022-25 in collaboration with our partners. ***See***

***section 7* for further details.**

- **Providing children and young people with the best start in life** irrespective of where they were born and live. Our aim is to improve the health and care system to ensure that services are joined up and easy to access when and where they are needed and to ensure that the voice of the child is at the heart of all we do. Over the next five-years we want to see improvements in the health of children and young people as a result of the work we do across the ICS, and with our neighbouring partners across Essex. ***See section 4, 5 and 6 for further details.***

- **The Public Sector Equality Duty (section 149 of the Equality Act 2010) (PSED) -** requires that public bodies should place considerations of equality, where they arise, at the centre of formulation of policy, side by side with all other pressing circumstances of whatever magnitude. The general equality duty not only applies to the general formulation of policy, but also applies to decisions made in applying policy in individual cases.

The views of our residents, patients, staff and communities in west Essex and Hertfordshire have informed and shaped the development of this plan. This was done using an approach that includes a wide- ranging literature review, focus groups, stakeholder engagement events and surveys. What our residents have said is included in each of the priorities covered in this plan.

We acknowledge that our responsibilities under the Public Sector Equality Duty are ongoing, and any work undertaken to deliver on the priorities will ensure that the views and needs, of the nine protected equality groups will be included, where appropriate.

# Appendix 2 – Overview of Hertfordshire and west Essex priorities

| Owner and Timeframe | Priorities | | | | | Delivered by |
|---|---|---|---|---|---|---|
| ICP Integrated Care Strategy (2022 – 2032) | Give every child the best start in life | Support our communities and places to be healthy and sustainable | Support our residents to maintain healthy lifestyles | | | ICB, county, district and borough councils, VCFSE and health providers |
| | Enable our residents to age well and support people living with dementia | Improve support to people living with life-long conditions, long term health conditions, physical disabilities and their families | Improve our residents' mental health and outcomes for those with learning disabilities and Autism | | | |
| ICB Medium Term Plan (2024-2030) | Increasing healthy life expectancy and reduce inequality | Giving every child the best start in life | Improving access to health and care services | Increasing the numbers of citizens taking steps to improve their wellbeing | Successfully delivering our financial plan each year | ICB and health providers |
| ICB short term ambitions (2024-2026) | Reduce inequality with a focus on CVD and hypertension | Reducing waiting times in targeted children's services | Reducing UEC demand by delivering more anticipatory/same day care | Provide better care to people in mental health crises | Continue our elective care recovery | ICB and health providers |

# Appendix 3 – ICB financial duties

As set out in section 223M of the National Health Service Act 2006 (“the 2006 Act”) (as inserted by section 29 of the Health and Care Act 2022), each ICB and its partner trusts must exercise their functions with a view to ensuring that, in respect of each financial year:

- local capital resource use does not exceed the limit set by NHS England
- local revenue resource use does not exceed the limit set by NHS England.

Furthermore, under section 223L of the 2006 Act (as amended) NHS England may set financial objectives for ICBs and their partner trusts, and each ICB and its partner trusts have a duty to seek to achieve those objectives. NHS England has set the objective that each ICB, and the partner trusts whose resources are apportioned to it, should deliver a financially balanced system, which may be referred to as a ‘duty on breakeven’.

ICBs also have a duty to deliver financial balance individually (section 223GC of the 2006 Act). This is to promote careful financial management and to reflect legislation that requires NHS England and ICBs to manage within a fixed budget.

Where an ICB considers it necessary to deliver overall system financial balance but with a deficit in the ICB itself, NHS England should be notified at the earliest opportunity. Additionally, each ICB should ensure it does not exceed the running cost allocation limit, which will be published as part of ICB allocations.

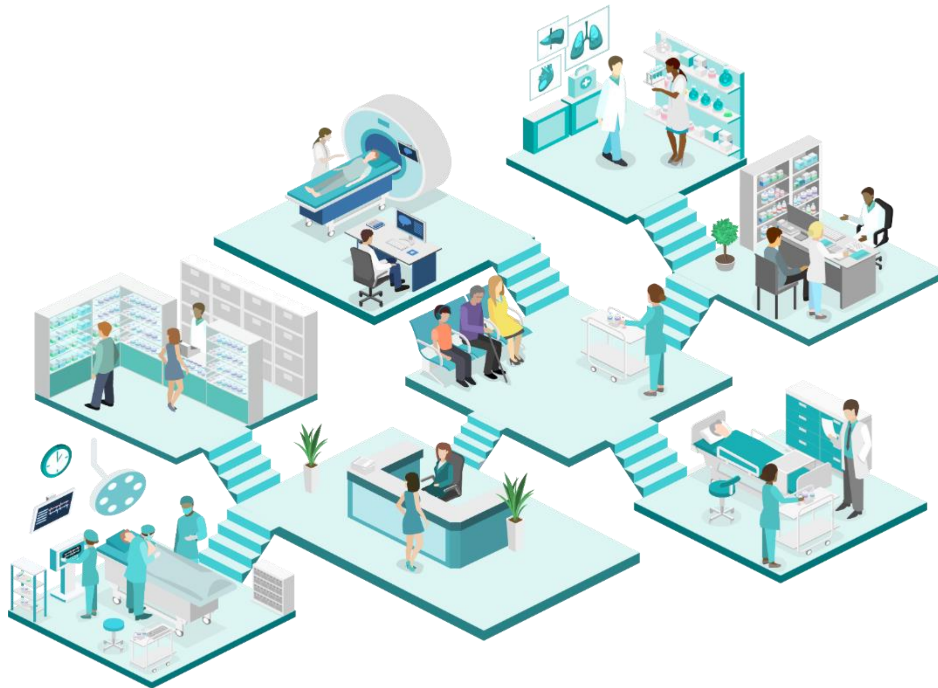
Under the legislation, the system financial duties rest on each ICB and its partner trusts. As each trust may be the partner of more than one ICB, the legislation provides for NHS England to apportion a trust’s resource use for these purposes to one or more ICBs. NHS England has apportioned the revenue and capital resources of all trusts exclusively to a single principal ICB. The objective of this approach is to ensure that the ICB and trusts’ mutual responsibilities are clear, e.g. to meet system financial balance, and to provide stability and continuity in planning relationships.

While the measure of system financial balance will be based on the mapping of a trust to a principal ‘host’ system, this does not change the requirement for all commissioners to work with the providers of their commissioned services to support financial sustainability and agree contractual terms that underpin this. Likewise, trusts that are formal partners of more than one ICB are required to confirm that their operational and financial plans are compatible with and align to all relevant system plans.

Given the requirement for systems and ICBs to seek to deliver a breakeven position each year, they should not plan for any in-year surplus or deficit.

Any system or ICB that is overspending is expected to take all necessary steps to correct its rate of expenditure to address the overspend. In the event a system does overspend against its allocation for the year, the amount of the overspend will be carried forward and maintained as a cumulative system position. Cumulative system overspends will need to be repaid.

Access to any historical surplus for non-recurrent expenditure will be aligned with performance through the NHS Oversight Framework, and subject to national affordability. Any approved drawdown must be used for non-recurrent investment.



# Glossary of terms

| Acronym | Full Term |
|---|---|
| ARRS | Additional Roles Reimbursement Scheme |
| AFC | Armed Forces Community |
| AHP | Allied Health Professionals |
| Anchor Institution | Typically refers to large, typically non-profit, public-sector organisations whose long-term sustainability is tied to the wellbeing of the populations they serve |
| CAMHS | Children and Adolescent Mental Health Service |
| CDC | Community Diagnostic Centre |
| CETRs | Care, Education and Treatment Reviews |
| CVD | Cardiovascular disease |
| CYP | Children and Young People |
| CPCS | Community Pharmacy Consultation Service |
| CQC | Care Quality Commission |
| DNA | Did not Attend |
| DSR | Dynamic Support Register |
| EAN | Essex Anchor Network |
| EEAST | East of England Ambulance Service Trust |
| ENH | East and North Hertfordshire |
| FH | Familial Hypercholesterolaemia |
| FIT | Faecal Immuno Testing |
| FDS | Faster Diagnosis Standard |
| FSM | Free School Meals |
| GIRFT | Getting it Right First Time |
| HCP | Health and Care Partnership |
| HEE | Health Education England |
| HIU | High Impact User |
| HMLDA | Hertfordshire Mental Health, Learning Disability and Autism |
| HWE | Hertfordshire and West Essex |
| HUC | HUC (formerly Herts Urgent Care) |
| ICB | Integrated Care Board |
| ICP | Integrated Care Partnership |
| ICS | Integrated Care System |
| INT | Integrated Neighbourhood Teams |

| | |
|---|---|
| JFP | Joint Forward Plan |
| JSNA | Joint Strategic Needs Assessment |
| LDCT | Low-Dose Computed Tomograph |
| LD | Learning Disabilities |
| LoS | Length of Stay |
| LTP | Long Term Plan |
| MDT | Multi-Disciplinary Team |
| MHST | Mental Health Support Teams |
| MOU | Memorandum of Understanding |
| MSE | Mid and South Essex ICB |
| MSK | Musculoskeletal |
| NHS LTP | NHS Long Term Plan |
| NDDP | NHS Diabetes Prevention Programme |
| NQB | National Quality Board |
| ND | Neuro Diversity |
| OPA | Outpatient |
| OPFA | Outpatient First Appointment |
| PCN | Primary Care Network |
| PHM | Population Health Management |
| PROMs | Patient Reported Outcome Measures |
| PTL | Priority Target List |
| RTT | Referral To Treatment |
| SDEC | Same Day Emergency Care |
| Section 136 | Legal powers of the police to take someone to a place of safety if they think they have a mental disorder and need care or control. |
| SEND | Special Educational Needs and Disabilities |
| SPOC | Single Point of Contact |
| SMI | Severe Mental Illness |
| SWH | South and West Hertfordshire |
| TLHC | Targeted Lung Health Check |
| UCR | Urgent Community Response |
| UCC | Urgent Care Centre |
| UEC | Urgent & Emergency Care |
| UDA | Units of Dental Activity |

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