Contents

Joint Forward Plan 2025-30: Delivery Plan

Introduction

This document outlines our specific plans in Hertfordshire and west Essex to support the delivery of our health and care systems strategic ambitions including our Medium-Term Plan and priorities for 2024-26. Further details of these can be viewed in the overview of our Joint Forward Plan Hertfordshire_and_West_Essex_Joint_Forward_Plan_2024_2029.pdf (ics.nhs.uk) – Link to be updated/added

Please note: Our Joint Forward Plan Delivery Plan was created prior to the government announcements concerning the future of NHS England and ICBs and we may update our plan during the coming year to reflect the impact of these changes.

A guide to this document:

Section 1: Delivering our priorities for 2025-2030

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

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

Section 2: Delivering our ambitions for 2025-2030

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

Under each ambition in this section there is a summary of the relevant strategic challenges relating to it, as well as patient and resident engagement findings that have informed and continue to inform our plans. Below this are our specific plans for delivering this ambition over the 2025-30 period along with the progress indicators for each plan, through which we will internally track our progress. Similarly to section 1,

each ambition has a set of key indicators (‘How will we know that we have made a difference’) that show how we will demonstrate overall progress of this work, measure the impact for our population and evidence that we are making a positive difference.

Section 3: Our workforce plan

Our health and social care workforce are an integral part of everything that we do and our workforce plans, detailed in this section, will help us to deliver our ambitions and priorities. Where appropriate our workforce plans are woven into our plans for each priority and ambition. This section provides an overview of our system workforce plans, which support the delivery of the system’s 2023-2025 People Plan and work towards the requirements of the NHS Long-Term Workforce Plan. An updated workforce plan is to be developed in 2025-26 and subsequent iterations of our JFP will be updated to reflect this.

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

Section 4: Key milestones

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

Section 5: Index

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

1. Delivering our priorities for 2025-2026

1.1 A reduction in the backlog for children's care

What will we do to make a difference:

2025-26	2026-30	Progress Indicators
Attention Deficit Hyperactivity Disorder (ADHD) / Autistic Spectrum Disorder (ASD): Implement our new clinical pathways, including revised staffing model to reduce diagnostic waits and ensure the right people are offered assessments through improved multi-agency support built around the child and family. These changes will initially focus on Hertfordshire, as in west Essex they have made significant service improvements and developments but there are plans for west Essex to be incorporated into the second phase of developments. Increase neurodiversity support offer for professionals, children, young people and families Refine the ADHD pathway in west Essex to allow direct access and improved experience for families, similar to the 'Journey of Autism' diagnosis and early support pathway.		Reduction in waiting times for a diagnosis Increased number of families and professionals accessing the neurodiversity support hub (in Hertfordshire) Increased take up in Hertfordshire by children and young people taking up the 'understanding my autism' sessions available.

The digital patient interface for referrals into west Essex community healthcare is being developed and we are working across the Essex Southend and Thurrock Transforming Care Partnership to progress and deliver a pilot around accelerated autism assessments for children and young people at risk of admission Undertake an evaluation of Autism Spectrum Disorder Psychoeducational Resource pilot across Essex, Southend and Thurrock and monitor and review pathways and support offered in line with changing needs and demand Roll out the Hertfordshire-wide clinical pathway for neurodiversity services. Starting with the single point of access for all referrals. Support local providers in addressing waiting list backlogs and reduce the time children, young people and families have to wait for assessment.		
Family Services: Complete phase 1 of the Family Hub Service model, delivering universal and targeted support for children, young people and families, including support with: parenting, helping parents and carers to manage their child's behaviour and respite	Complete phase 2 of the Family Hub Service model expanding the hub further to encompass support for 0–25-year-olds and increase	An increase in the proportion of children receiving early help support. An increase in the number of children receiving mental health support.

support. It will also support adults with challenges that impact on children, including support with parental substance misuse, mental health, physical disabilities or domestic abuse. We will commission the Public Health Nursing (PHN) contract as part of the Family Centre Service and mobilise this new service with strong partner and community links within the Voluntary, Community, Faith and Social Enterprise (VCFSE) sector, schools, Hertfordshire County Council and districts/borough councils. We will work with these partners to drive a preventative approach with holistic whole family support, making every contact count and reduce duplication between our services.	collaboration with partners and other services. Carrying out the ECFWS procurement. To consider the impact of the social care reforms on the expectations for family hubs to align with Family Help.	A reduction in the proportion of 0–4-year-olds attending Emergency Departments (ED). An increase in the proportion of children under 5 years old who have had the required immunisations.

How will we know that we have made a difference:

We will have:

- Reduced the wait for community paediatrics services to 65 weeks. by April 2026. This will include ASD, ADHD and speech and language assessments
- Reduced the rate of ED attendance and admissions for children and young people by 5% by 2028.
- Demonstrated improved outcomes for children, young people and families through our approaches to partnership working.

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

What will we do to make a difference:

2025-26	2026-30	Progress Indicators
Cardiovascular Disease (CVD): Continue to improve detection and control of hypertension (high blood pressure) through awareness raising (communications campaign) and community engagement events, increased access to blood pressure measurements in general practice, community pharmacy, outpatients and other community settings, as well as adopting a 'Making Every Contact Count' campaign across NHS providers and working with wider non-NHS organisations to use every opportunity to achieve health and wellbeing. Work collaboratively with regional team to deliver the Regional CVD New Care Model. Continue to improve the performance of local stroke services to pre-pandemic Sentinel Stroke National Audit Programme (SSNAP) standards and continue implementation of the Integrated Community Stroke Service specification (ICSS). Development and implementation of an integrated lipid service and improving the delivery of core care for people with raised cholesterol in primary care.	Continue to monitor and improve hypertension detection, monitoring and treatment, with a specific focus on tackling inequalities. Continued implementation of an integrated lipid clinic. Working towards full implementation of an integrated community stroke service (ICSS). Continued implementation of a completely integrated care model for people with heart failure.	Increased identification of hypertension. Increased proportion of people with hypertension who are treated to age specific thresholds. Increase in the identification of hypertension among people living in the most deprived 20% of our communities. Reduce the waiting time for an Echocardiogram (ECHO).

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

Medicines Optimisation: Reducing the harm from medicines prescribed by implementing a system wide plan to reduce overprescribing and medicines waste. Sharing best practice across the system – we will develop effective communication methods at place and within integrated neighbourhood teams. Empower patients to know about the medicines they take, the expected outcome, potential side effects and the criteria for discontinuation	Embed a culture of shared decision making.	

How will we know that we made a difference:

We will

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

1.3 Elective care recovery

What will we do to make a difference:

2025-26	2026-30	Progress Indicators
To complete the building work and mobilise the Community Diagnostic Centre (CDC) spoke site at St. Albans City Hospital (SACH) offering additional capacity for MRI and CT scans. Complete work on the Elective Hub at SACH, offering additional capacity for elective surgery for orthopaedic and ENT surgery. Outpatients: embed the shared decision making campaign and reduce the number of people who do not attend appointments without prior notice (DNAs). Continue to increase the number of people on a patient initiated follow up pathway and work towards supporting people through the functionality of the new patient portals. Increase the use of triage, specialist advice and guidance, implement 'Get it Right First Time (GIRFT), through: • standardisation and streamlined clinical pathways • increasing our capacity to undertake elective care, support the reduction in variations in access time	Diagnostics: To complete the building work and mobilise the endoscopy unit at St Albans City Hospital and complete and mobilise Clinical Diagnostic Centre (CDC) hub at St Margarets Hospital in Epping, offering a range of diagnostic tests. Continue to improve constitutional standards for elective care, cancer diagnosis and treatment and diagnostics. Increase the uptake of PIFU. Reduce the missed appointment rate (DNA).	**Waiting list:** Reduce the size of the elective waiting list and the time patients spend waiting: 2026 –134,140 open pathways 2029 – 92,300 open pathways **RTT performance:** March 2029 • 92% of patients wait less than 18 weeks **Productivity:** September 2025 - Theatre utilisation greater than 85%. March 2025 - Day case/outpatient treatments rates greater than 85%. **Diagnostics:** March 2026: 95% of patients needing diagnostic tests seen within six weeks. **Outpatients:** March 2026: DNA rate across all providers and specialities less than 6%. **Cancer:** March 2026 – faster diagnosis standard 80%, 62 day 75%.

• improved clinical outcomes and overall waiting times in accordance with the national standards by March 2025. Increase specialist advice activity and scope potential opportunities for one stop clinics, to support the backlog of people waiting for their first outpatient appointment. Optimise the use of remote consultations and reduce variation in pathways and processes. Increase Multi-Disciplinary Team (MDT) working (utilising the different workforce skill mix accordingly), to enable a single outpatient appointment with multiple healthcare professionals, to reduce pressure on estates and increase capacity. Increase Patient Initiated Follow Ups (PIFU). Complete the development with the University of Hertfordshire of the Decision Support Tool (DST), to allow improved analysis of patient pathways, demand and capacity to support future planning.	Adopt the one outpatient principle using one stop clinics and diagnostics first. Reduce the variation in remote consultation across the system. Increase the number of clinical pathways where appropriate. DST: Roll out to all specialities in the system	55% of outpatient appointments are a first appointment or a follow up with treatment. Single outpatient appointment for those patients with multiple conditions. PIFU March 2029 - 5% Functioning DST tool Cardiology May 2025 Roll out to other specialities 2025/26.

Increase the use of digital technology to give patients more choice and control.	Increase the use of patient engagement portal to keep patients informed of their pathway progress, to make/change appointments and allow access to their records/results.	

How will we know that we have made a difference:

We will have:

- Reduced the number of patients waiting more than 65 weeks for treatment, to 0 by March 2025. Delivery of 65% patients waiting less than 18 weeks, with a maximum of 1% of patients waiting over 52 weeks by March 2026.
- Ensured that 85% of surgery across HWE is consistently undertaken as a day case or as an outpatient by March 2026.
- Maximised the productivity of our operating theatres and outpatients services. Increase the number of outpatient 1st and follow up with procedures to 55% March 2026, and theatre efficiency to 85%, minimum 2.5 cases per list by September 2025.
- PIFU rates at 5% March 2029.
- Waiting lists size March 2026, 134,140 open pathways, March 2029 – 92,300 open pathways.

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

What will we do to make a difference:

2025-26	2026-30	Progress Indicators
Same day emergency care (SDEC) for frailty: Continue to improve on our identification and acknowledgement of people's frailty at the front door of ED so that they can be swiftly referred to alternative services closer to home, if most appropriate, to meet their urgent care needs. If they require emergency care, we will endeavour to provide this on the same day, either through same day emergency care (SDEC) or acute frailty services with swift comprehensive geriatric assessment and frailty expertise to turn patients' diagnosis and treatment around promptly and avoid unwanted or unnecessary admission to hospital. To support the ambition to provide greater same day emergency care, efficient direct referral pathways between our ambulance service and acute trust SDEC services will be further developed with a focus on increasing the proportion of frail patients seen and treated on the same day through direct access to acute frailty services and surgical SDEC via the unscheduled care coordination hub (UCCH).	We will continue to make frailty everybody's business and embed digitally enabled (direct booking) referral pathways to ensure SDEC is accessible across all parts of the healthcare system (primary care, community care and hospital at home, 111 and 999), including from a single point of access. We will continue to develop the remote clinical support available from senior clinical decision-makers in our acute trust to support 'call before convey' and direct access to SDEC.	Increase percentage of patients at risk of frailty (aged 85+ or over 65+ with conditions) who have a clinical frailty score (CFS) recorded and accessing support. Increase proportion of frail patients who receive same day emergency care.
Frailty and End-of-Life: We have utilised data to identify seven key interventions to reduce admissions for those frail	Continue to embed sustainable and robust advance care plans across the health and care	Increase proportion of people who are routinely identified as likely to be in the last 12 months

and end of life. These are: • Community falls • Advance Care Plans • Falls Response • Integrated Neighbourhood teams • Polypharmacy • Pre-admission clinical review • Utilisation of the stack We will continue systematic identification of patients who are likely to be approaching the end of their life and support clinicians to undertake person-centred discussions about preferences and priorities for future care to develop advance care plans. We have developed a dashboard to monitor the impact of our interventions. We will utilise this to determine low rates of proactive identification within cohorts.	system, use continuous quality improvement methodologies. Continue to strengthen our care coordination for those at end-of-life to facilitate care closer to home, learning from discharge facilitator pilots, and embedding end of life skills in our hospital at home workforce with clear pathways to specialist palliative support so that those at the end of their life who experience acute illness or exacerbation of long-term conditions can be supported and cared for closer to home.	of life and who have an advance care that has been reviewed in the last 12 months. Reduce rate of emergency admissions for people on the end-of-life register Increase proportion of palliative and end of life care (PEoLC) patients who die in their place of choice.
Falls prevention and deprescribing (including reduction in anticholinergic medicines) Across HWE, we have mapped our falls prevention and rehabilitation services. Teams have identified opportunities to maximise existing, commissioned services and clinical pathways to improve patient care. A system-wide review by the pharmacy and medicines optimisation team to identify individuals prescribed more than 10 medications, identify those older people at risk of the cumulative effect of taking	Continue to develop our proactive approach to preventing falls, using continuous quality improvement methodology and learning from pilots, such as use of sensor devices in peoples' own homes to predict falls or early decline in functioning. Increase identification of those at risk of falls and promote self-referral into falls prevention services. Ensure patients at various falls risk receive best practice care and interventions, continue to develop strong links between	Reduction in prescribing for individuals on 10 or more medications. Reduce rate of emergency admissions for falls within the community for people aged 65+ Increase the proportion of people aged 75+ accessing falls services within the community.

medications with anticholinergic activity (the 'anticholinergic burden' (ACB), and support clinicians in assessment and deprescribing as necessary to reduce the risk of falls.	community falls prevention services and the voluntary sector. Development of a fracture liaison service to identify those at risk of osteoporosis and proactively manage them to avoid falls-related injuries.	Reduce hip fracture rate in people aged 65 and over.
Care Closer to Home (CCH) strategic model of care, to refocus the system towards preventative and proactive primary and community-based care, shifting away from reactive hospital-based care. CCH will deliver a consistent model of care for our adult population that is fit for the future. The model will ensure equity of access experience and outcomes for our residents and support a move to a more sustainable financial system. The model will underpin our community provider contract specifications to support a greater proportion of frail, older population to receive care in the community. CCH will enable a proactive approach to managing chronic disease and complex care through integrated neighbourhood team (INT) working which will be embedded at scale. Using population health management data INTs identify and prioritise specific cohorts, those prioritising complex and frail cohorts at risk, or rising risk, of deterioration and future unplanned care will be supported to design	Continued scaling up of the CCH strategic model reflected in community provider contracts and our Health Care Partnership's 3-year Integrated Delivery Plans (IDP's). Continuous improvement and evaluation of the impact of our INT proactive care. Further scaling of anticipatory care using remote monitoring and health technology data to identify patients at high risk of acute deterioration, predict future hospitalisation, and target earlier community care, enhanced monitoring and oversight, to prevent deterioration and avoid unplanned hospital admission. Scope expansion of our hospital at home to include other conditions and capabilities, driven by data in relation to population need in planned care and for children and young people.	INTs delivering a collaborative service and continue to refine and develop new models of care with system partners. Reduce rate of unplanned hospitalisation for chronic ambulatory care sensitive conditions Reduce emergency readmissions within 30 days of discharge from hospital. Reduce readmission rates from reablement. Increase the proportion of older people (65+) who were still at home 91 days after discharge

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

A clear understanding of the demand for intermediate care and alignment to 'discharge to assess' to ensure appropriate capacity and maximise timely access to support in the most suitable community setting for patient needs. CCH will act as an anchor for our Health Care Partnerships to deliver their 3-year Integrated Delivery Plans from April 2025.		

How will we know that we have made a difference:

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

1.5 Better care for mental health crisis

What will we do to make a difference:

2025-26	2026-30	Progress Indicators
Crisis services: We will undertake collaborative partnership working to continue to mobilise mental health ambulance response vehicles. We will continue to monitor the impact of the system wide Mental Health Urgent Care Centre (18+) at Lister Hospital, open up the additional ways for people to access the centre and explore options for increasing the offer to other acute trusts across the ICS. Explore integration of mental health expertise in unscheduled care hubs and review support to those people with co-occurring substance misuse and mental health. Continue to map coverage of mental health crisis care to understand the gaps, including emergent neurodiversity needs within the community and inpatient services. We will continue to develop our community service offer to improve the prevention of mental health crisis	To provide a comprehensive, accessible integrated urgent care response across the system to support people experiencing mental health crisis, including those suffering co-occurring substance misuse. To build on the improvements of 2025-26 and continue to develop our community services to support the prevention of mental health crisis and reduce inpatient admission	Increase the number of crisis beds available. Increase 'see and treat' for patients in mental health crisis. Reduced ambulance conveyances for mental health crisis. Improved patient experience. Reduce emergency department (ED) presentations for those with a mental health condition. Improved pathways for those with a mental health condition presenting at ED.
Right crisis care, in the right place, with the right person: Continue to monitor (as appropriate) the mobilisation of capital developments and evaluate the benefits of them to enhance accessibility to adult crisis services, improving the quality of the built environment as well as people's experiences.	Scope and explore potential capital developments to support admission avoidance and reduce out of area placements across the ICB, delivering value for money and better outcomes for people with mental health, learning disability and autism needs.	Reduction in out of area bed placements and length of inpatient stays. Reduction in length of inpatient stays.

Continue to work with all partners to embed the Right Care, Right Person Programme (RCRP) partnership approach to ensure that the people in mental health crisis are seen by the right professional. **Reducing out of area bed placements** Ongoing work with partners to reduce the number of out of area bed placements through review of all placements, enhanced admission avoidance via community-based alternatives and by ensuring timely proactive discharges. Where people do need to spend time as an inpatient, the care that they experience is safe, personalised and enables people and the staff caring for them to flourish. Build on the foundations of the first year (2024-2025) of improvements to enhance the quality and safety of people experiencing poor mental health, learning disability and autism in inpatient settings by continuing to embed the new care model(s) and focus on shift in culture for staff and organisations.		Reduction in police handover time for S136 detentions.
Long-term plan ambitions for children and young people's (CYP) mental health services: Continue to increase mental health support teams working with schools to embed effective whole school approach to the emotional wellbeing of students. Hertfordshire focus: Continue to develop our Equity Equality Diversity and Inclusion (EEDI) practice and policy, to tackle health inequality enabling open and accessible services regardless of additional	Increase access for children and young people (CYP) and improve outcomes, listening to their feedback, addressing waiting times and tackling health inequalities. Continue to increase access to Herts CYP mental health services in line with NHSE targets, improved navigation, and awareness. Ensuring offers are informed by data, effective, and can support preventative actions.	

vulnerabilities (Core24Plus5). Increase access through improved system awareness and navigation, with clear accessible clinical pathways. Evaluate service delivery and activity to ensure it remains outcome focused, seek to develop a systematic approach with stakeholders to grow, retain and align the workforce to meet the needs of children and young people in Hertfordshire. Develop crisis support, ensuring continuation of 24-hour access for 6 days a week and develop approaches to prevent crisis triggers using evidence informed data. Develop, grow, and embed co-production with children, young people, and families to ensure they are involved in shared decision making and feel empowered to have an active role in their own mental health and wellbeing. West Essex: Continue to ensure that children and young people (CYP) aged 0-25 have access to mental health services via adult mental health pathways and school/college based mental health support teams. Maintain 24/7 access to community crisis response and intensive home treatment as an alternative to acute inpatient admissions; sustain the target of 95% of CYP with eating disorders accessing treatment within 1 week for urgent cases and 4 weeks for routine cases. Ensure CYP mental health plans align with those for CYP with learning disability, autism, (Transforming Care cohort) special educational needs and disability (SEND), CYPs services, health, and justice.	Understand Herts user experience and professional confidence in services to support any system improvement. Monitor and understand demand and capacity of CYP mental health services. In west Essex, alongside expanding access, the focus will be on developing and improving core services, particularly in the areas of early intervention, prevention, community health, reducing inequalities, improving quality. With more of an emphasis on improving outcomes and experience of service for our CYP, families, and carers. Work towards 100% of children and young people who need it achieving access to specialist mental health care. Build on THRIVE methodology and principles, ensure Hertfordshire users and their families are involved in shared decision making and feel empowered to have an active role around their own mental health and wellbeing.	

Increasing and improving access to digital interventions: Continue to maintain early help and support by providing innovative digital therapies as well as an efficient digital platform gateway for all mental health services; with focus on empowerment/self-care for Herts CYP/families/Carers, providing guidance, information, self-help and tailored support. In west Essex, continue to develop digital support offer for CYP's mental health, balancing the digital offer with face-to-face provision, responding to feedback from CYP. Ensure there are digital leads across all North East London Foundation Trust (NELFT) Southend Essex Thurrock (SET) Child and Adolescent Mental Health Services (CAMHS). Development of comprehensive offer (web, social media, treatment options).		Improve service user experience of CYP mental health services digital support.
Digital: Continue to review and monitor the 'all age digital intervention offers' including impact, outcomes data and experience feedback. To support those who are digitally engaged and motivated to use online mental health self-help tools and artificial intelligence (AI) based therapeutic interventions to gain quicker access to support. Develop and embed the CYP mental health 'front door' triage team and the digital gateway portal and support improved navigation, increasing access, automated referrals, brief and single session interventions, advice and guidance to improve both the experience and journey of CYP.	Increase deployment of the online library of self-care apps that can support community mental health models. Enable electronic access to appointments, letters and care plans to help primary care networks and community working. Use automation for common tasks to increase capacity and provide more time to care. Implement systems to make it easier to book, track and manage rooms, equipment and resources to support new models of care in community and primary care networks. Herts CYP mental health services 'front door' triage team functioning; with outcomes and benefits	Increased mental health data on Shared Cared record use. Reduce missed appointments. Increase access to electronic services i.e. appointments, letters. Improve patient satisfaction.

Enhance mental health data available on the Shared Care Record to provide greater information sharing across the system to enable improved visibility of patient needs at other care settings i.e. Emergency Department/Primary care.	realisation expected in the summer of 2025. Undertake a review of the Herts CYP mental health triage team to understand the impact and consider growth.	
Essex Child and Adolescent Mental Health Services (CAMHS): In west Essex the focus will be on prevention and early intervention, acute and crisis, supporting recovery. Key priorities will include the expansion of the CYP mental health primary care roles to increase access. Expand Mental Health Support Teams in educational settings; expand access to First Episode Rapid Early Intervention for Eating Disorders (FREED) and Avoidant/ Restrictive Food Intake Disorder (ARFID), CYP eating disorder (CYPEDs) pathways. Maintenance of CYP's eating disorder community intensive support services; improving access to infant mental health service and increasing access to health and justice mental health provision. Ensure continuity of early intervention and prevention (non-clinical services) designed to complement the core CAMH service offer. Extend the Mental Health Liaison Nurse roles in acute settings to assist paediatric teams to respond to mental health needs of CYP. Roll out of self-harm management toolkit in education settings, expanding the community mental	Consider the implementation of new combined clinical model for ASD/ADHD across NHS providers in Hertfordshire.	70% Service users reporting satisfaction with services received. 92% Referral to Treatment (RTT), incomplete pathways, CYP waiting to start treatment <18 weeks. 95% RTT (completed pathways) – CYP seen <18 weeks. Reduce the number of missed appointments to the target rate of 10%.

health and children and young people learning disability neurodevelopment team. Mobilising at risk mental health teams; maintain pathways to support the Young Adults transition (18-25) and embed the principles of THRIVE to ensure services are needs led. In Hertfordshire, evaluating the paediatric mental health liaison model for children and young people with mental health needs who present in acute paediatric settings as part of the wider crisis model. Design a new clinical model and pathways for ASD/ADHD services and explore potential shared learning from west Essex regarding ASD support hub pilots. Continue to reduce out of area placements and explore alternative options to maximise our local bed base. Continue with the quality transformation programme for mental health, learning disability and autism inpatient services under the Commissioning Framework for mental health inpatient services.		

How will we know that we have made a difference:

We will have:

- Increased our 24-hour response to urgent referrals to community crisis services in 2025-26 from 60% to 67%.
- Reduced the number of active inappropriate adult acute mental health out of area placements across the ICS to zero (0) by March 2027
- Reduction in the average length of stay for adults and older adults in acute mental health inpatient services
- 75% of inpatient discharges to have 72-hour post discharge follow up by March 2026.

2. Delivering our ambitions for 2025-2030

2.1 Give every child the best start in life

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

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

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

Our Plans:

2025-26	2026-2030	Progress Indicators
SEND: Continuing the children's therapies transformation programme across Southend, Essex and Thurrock, ongoing local implementation of the delivery framework, staff engagement, resource modelling around local schools and density of need. Formalising our commissioning strategy at place to facilitate further integration of therapy services, alignment of guidance and information resources for parents, carers and young people and continued engagement to identify new opportunities. In Hertfordshire we will deliver against the SEND priority action and improvement plan. The Hertfordshire SEND Local Area Partnership's priority action plan was approved by Ofsted and the Care Quality Commission (CQC) in January 2024. The plan addresses two priority actions and five improvement areas. https://www.hertfordshire.gov.uk/microsites/local-offer/media-library/documents/hertfordshire-priority-action-and-improvement-plan-pdf-995kb.pdf	Full integration of Special Educational Needs and Disabilities (SEND) and core therapy services in west Essex	Achievement of The Balanced System® framework Reduction in therapy waiting times for early support and specialist intervention Delivering the Hertfordshire SEND Local Area Partnership's priority action plan targets. The Department of education and NHSE scheduled monitoring visits.
Obesity: Working in partnership to tackle and reduce the number of children aged four to five and ten to	To implement ICP pledges around childhood obesity once agreed.	Delivery of ICP pledges for reducing childhood obesity.

eleven years old who are overweight. Improving awareness and access to emotional wellbeing and mental health support services (school years 1-3) to reduce the number needing specialist mental health hospital provision. We will utilise the Primary Care Networks and Integrated Neighbourhood Teams to deliver health inequalities projects to support levelling up and achieve health equity. HWEICP to agree pledges and plans around childhood obesity.		Reduction in the number of CYP requiring specialist Mental Health Hospital Provision in relation to obesity.
Epilepsy: Work with partners to deliver the national bundle of care for children and young people, and the national 'Epilepsy12' programme to improve outcomes for children and families living with epilepsy. We will monitor and evaluate the regional pilot to increase access to epilepsy nurses.	Following the regional pilot evaluation, we'll work with our regional colleagues to support a system wide approach for sustainable children's epilepsy services. We will review and continue to identify deliverables in the epilepsy bundles. share good practice and continue to make improvements where gaps are identified.	Reduction in Accident and Emergency attendances and admissions for children and young people with epilepsy
Engagement: To continue the current success of the youth council, and recruit more young people while increasing the youth council's diversity and inclusivity across our system. To provide more opportunities for children and young people to contribute to, and co-produce services, policies and campaigns.	To make connections in the community which allow us to capture the voices and lived experiences of young adults aged between 19-25 years old, resulting in a fully established participation and co-production function in the children and young people teams.	A diverse and robust youth council membership which reflects the make-up of our area. An increase in the number of services, policies and campaigns which have

To broaden the range of methods we employ to communicate with children and young people. To work through the community of practice to explore closer working with the children and young people's groups run by partner organisations.		demonstrably been influenced, guided or co-produced by children and young people.
Maternity: Working closely with regional workforce colleagues to monitor improvements in growing, retaining and supporting our workforce through recruitment and retention leads. We will continue to implement the 'Saving Babies Lives Care Bundle version 3' which provides evidence-based practice for providers and commissioners of maternity care across England to reduce perinatal mortality; including interventions to reduce stillbirths, neonatal brain injury, neonatal death and preterm births. Begin to deliver the national maternity early warning score tool developed by the Royal College of Physicians which improves the detection and response to clinical deterioration in adult patients and is a key element of patient safety and improving patient outcomes	We will ensure that we have the right numbers of the right staff available to provide the best care for women and babies, by regular local workforce planning to meet recommended staffing levels and reducing the number of vacancies for midwifery posts by 2027/28. Ensure full delivery of the three-year delivery plan for maternity and neonatal services	Delivery of our 5-year equity and equality action plan LMNS implementation of the perinatal strategy.
Undertake a system wide approach to improve access for children and young people (CYP) to ensure 'No Wrong Door' approach and ensure smooth transfer	Continue to improve access, waiting times and outcomes for children and young people and reduce health inequalities	Increase in baseline data for access to groups facing health inequalities across Herts CYP

between services with a focus on health inequalities through CYP mental health services triage team. Understand service gaps and identify hard to reach groups work with providers to deliver solutions.	through people's lived experience to understand if health inequalities are reducing and access is improving. Continue to improve access to services and promote good mental health for all, with an additional focus on children and young people who are more vulnerable to poor mental health.	mental health services. Improvement in service user surveys for Herts CYP mental health services.

How will we know that we have made a difference:

We will have:

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

2.2 Increasing healthy life expectancy and reducing inequality

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

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

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

Our plans:

2025-26	2026-30	Progress Indicators
West Essex: Pilot interventions adapted according to need; to include learning from Core20Plus5 Connectors wave 2, Levelling Up in Harlow, proactive social prescribing, Community Agents in Essex and other models. Further develop and implement the 'Neighbourhood Network' developing tool designed to help primary care networks to build on community assets and address health inequalities (years 1 and 2). Share draft Social Prescribing (SP) strategy and a new vision for social prescribing for children and young people with Health Creation Strategy Group and Primary Care Networks as the basis for further development as part of the 'No Wrong Door' strand of the Health Creation Strategy (years 1 and 2).	Understand the full impact of social prescribing on individuals, community development, capacity and commissioning of the voluntary, community, faith and social enterprise sector (VCFSE). Work with the VCFSE to digitally embed and integrate activities and outcomes in improving analysis to address wider determinants of health. Identify some of the five Core20Plus5 clinical areas of focus and take a targeted approach concentrating on the most deprived district/ borough councils to address health inequalities (Stevenage, Harlow, Broxbourne, Watford and Welwyn Hatfield (Years 1-3)).	Social value created in communities and preventing crisis/ill health. Proportion of residents reporting satisfaction for local area as place to live and work, access to and use of green space, housing quality.
Specialist Commissioning To integrate the med tech funding mandate and specialised services devices programme into our contract management and research teams. We will continue to develop our targeted lung health check programme focussing on areas of deprivation and high smoking prevalence, as well as armed forces veterans who are known to be smokers. We will develop an integrated approach to our personalised care programme for patients with complex co- morbidity receiving specialised services, to develop personalised Shared Care Records and	We will implement transformation plans through specialist clinical network and provider collaboratives as agreed through the East of England Joint Commissioning Committee We will ensure local clinical networks and provider collaborative arrangements are integrated into the planning and delivery of our Medium-Term Plan, repatriating appropriate clinically safe services from	

integrated personalised care plans. Priority areas include patients with sickle cell disease and patients, carers, veterans, children and young people with specialist needs. Maintain robust and safe cancer services at Mount Vernon Cancer Centre, seeking capital to deliver the strategic re-provision plan. Identify services which can be delivered closer to home in outpatients and diagnostics. Continuing to work closely with East of England Joint Commissioning Committee for Specialist Services to manage and report on the 70 delegated services. We will collaborate and co-commission with cross boundary specialist services. Working collaboratively with our colleagues in the five East of England Integrated Care Boards to develop a 5-year strategic plan for specialist services. Ensuring priority focus on planning the future re-location of Mount Vernon Cancer Centre (MVCC). We will ensure our cardiac network links to specialist services for CVD, so patients continue to get access to the wide range of specialist cardiac care available in Cardiothoracic Centres in the East of England and London.	London providers so patients receive specialist services closer to home – such as chemotherapy at home and red blood cell exchange closer to home. We will continue working closely with UCLH as the preferred tertiary provider of the Mount Vernon Cancer Centre (MVCC) to ensure safety and responsiveness of cancer care to our population during this transition phase to relocate MVCC to the Watford Hospital site by 2032.	

The ICS UEC programme will develop joint planning and commissioning links with specialist services such as adult and paediatric critical care services as well as neonatal critical care networks as part of the East of England Joint Commissioning Consortium for specialist services delegated from NHSE. We will link in with the use of the Elective Recovery Fund (ERF) for specialist services to ensure we reduce long waits and comply with expected national standards of care by April 2026 for our elective specialist services. 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. The top clinical priorities for the East of England Specialist Services Joint Commissioning Consortium for 2025-26 are: • CVD/Cardiac services • Cancer Services and MVCC • Renal Services		
Digital: Implementation of a shared data platform including population health management (PHM), to	In west Essex digital inclusion activity will be progressed with county and district council	

level-up data access, intelligence and analytics. Complete and increase utilisation of resident access platforms and report on primary care digital response to health inequalities. During 2026/29 we will increase the use of the NHS App based prescribing.	involvement, by implementing a personalised approach require reasonable adjustments and targeted resources to ensure those experiencing digital exclusion are not further disadvantaged	
Embed all age suicide prevention and postvention into business as usual: Working with the voluntary sector agree a 5-year strategic plan focussed on suicide prevention, including the development of agreed metrics for system wide prevention monitoring. Implement suicide prevention training for the Armed Forces Community (AFC) working closely with our two county suicide prevention boards. Reduce suicide, suicide attempts and self-harm rates working in partnership with health partners. The ICB will recommission (in line with funding availability) the system wide suicide bereavement (postvention) service (operational since October 2022). This service offers specialist bereavement counselling and bespoke support to those affected by suicide including family, friends, carers, emergency service responders and other professional touched by the death and links to the two county councils' real time suicide surveillance pathways.	Utilise the population health data; national, regional and local suicide prevention strategy and needs analysis including the three-year coroners' audit of suicides to identify high risk groups, trends and clusters of our population. In west Essex we will continue to support the west Essex Suicide Prevention Strategy linking plans with priorities which result in better outcomes for those experiencing poor mental health and are at risk of self-harm or suicide. This will include a range of partners including the voluntary sector.	Report on the suicide numbers per Hertfordshire and west Essex population Agree 5-year plan as part of the system wide Better Care Fund including the voluntary sector.

Voluntary, Community, Faith and Social Enterprise (VCFSE): Improve the identification of carers in acute and community NHSE services building on new HCP toolkit on carers. Review of VCFSE Alliance will report March 2025 with plans for enhanced ways of working. The Health Creation Strategy is yielding significant developments including new 'Volunteering for Health' project funded by NHSE et al, three years' funding with programme lead just appointed and with further roll out during 2025-26. Partnership of alliance with university on online social impact tool (now in testing phase). Working to agree a 5-year strategic plan for social prescribing services; focus on health inequalities, data, impact and asset-based community development through the prevention lens. Ongoing work (year three) of partnership with the Assura Foundation process to support grass root charities to address health inequalities in partnership with primary care networks.		Increased identification of friend and family carers. Monitor acute provider delivery of section 91 of Health and Care Act
Diabetes: Improvement in the delivery of core care for people with diabetes.	Continue to implement a fully integrated model of care for diabetes.	Improve of diabetic eight care processes and three treatment targets. Increase in the number of people receiving a urine

ICS-wide roll out of the pathway to remission, including training, webinars for GPs. Continue to increase referrals to prevention programmes, such as pathway to remission and national diabetes prevention programme. Development and initial implementation of the integrated model of care for diabetes, to improve equitable access to holistic care for people with diabetes. Primary care will continue to be funded to deliver core care processes and manage the health needs of people with non-diabetic hyperglycaemia and diabetes proactively.		albumin to creatinine (ACR) care process. Increase the take up rates of diabetic structured education classes.
Respiratory: The ICS will continue our implementation of the asthma diagnosis hubs and to improve the delivery of core care for people with chronic obstructive pulmonary disease (COPD) in primary care. Work with PCNs to increase the number of respiratory hubs across the system. Further join up of diagnostic hubs with secondary care. Primary care will continue to be funded to deliver core care processes and manage the health needs of people with COPD proactively.	Continue to improve access to respiratory diagnostics, at PCN and Place level (e.g. sleep studies). Continued development of existing integrated respiratory services.	Improve accredited members of staff to deliver spirometry. Increase the number of pulmonary rehabilitation classes delivered face to face. Increase the proportion of people with a long-term respiratory condition who have a diagnosis confirmed by appropriate tests.

		Reduce prescription of high dose corticocortical steroid inhalers in east and north Hertfordshire.
Learning disability and autism health inequalities: Continue to deliver and improve the quality of learning disability annual health checks (target 75%), including health action plans. Ongoing monitoring of LeDeR 3-year action plan taking into account our population health needs and identification of future priorities and planning. Sharing learning from the LeDeR reviews across the system to improve quality. Continue to develop access to preventative and proactive support as an identified theme from LeDeR and safety incidents for autistic adults and adults who have a learning disability. Building on Phase 1 reasonable adjustments digital flag work further work with NHS England to ensure technical operating system can sync with each other to ensure smooth information sharing in line with phase two requirement to flag and share reasonable adjustments using the reasonable adjustment flag on the NHS Spine. Build on the enhanced commissioning framework 2024-25 expectation that general practices will hold an	Contract review with all commissioned services to ensure integrated models of care, continue to embed learning from the national LeDeR programme across health and care partners locally. Review learning from the national autism annual health check pilot and continue to explore how this can be implemented locally. Continue to improve access to services, exploring further training on reasonable adjustments. Develop system roadmaps to meet learning disability and autism population needs at local level, to ensure sustainable services in line with the expansion of communities.	**learning disability and autism health inequalities:** Continue to deliver and improve the quality of learning disability annual health checks (target 75%), including health action plans. Ongoing monitoring of LeDeR 3-year action plan taking into account our population health needs and identification of future priorities and planning. Reducing overprescribing in people with learning disabilities.

autism diagnosis register and make the necessary reasonable adjustments for autistic people to access health services. Continue to reduce waiting times for autism assessments and explore the different models of autism diagnosis pathways, ensuring compliance with NICE guidelines. We will continue to work with partners on the delivery of the Essex All Age Autism Strategy 2020 to 2025 and the Hertfordshire All Age Autism Strategy which. This work aligns with this Joint Forward Plan priority to "improve mental health and outcomes for learning disabilities and autistic population and to 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": Ongoing development work and approval of a new combined clinical pathway for assessment of young people with autism and/or ADHD. Implementation of new pathway commenced in Q4 2024/25 with full service expected to go-live in Autumn 2025/26. Hertfordshire Neurodiversity Support Hub has received funding for the next three years and continues to play a vital role in supporting parent/carers and families who require support for neurodivergent young people.		

Addressing Health Inequalities- Mental Health: We will continue to invest in employment support for people with a Severe Mental Illness aligned to individual placement and support (IPS). Work to improve the uptake of physical health Checks for people with an SMI. We will work to improve access to clinical pathways and support for people with autism and learning disabilities to support their health needs. Health system alignment, including pathways commissioned services such as reducing smoking rates among people with severe mental illness.		Increase the number of people accessing employment support. Increase the % of people with an SMI receiving an annual physical health check.

How will we know that we have made a difference:

- An increase in life expectancy across our system.
- A lower rate of mortality from all cardiovascular disease.
- A fall in the rate of suicide across Hertfordshire and west Essex.
- A reduction in high dose inhaled corticosteroid inhaler prescribing.
- A reduction in high carbon inhaler use.
- A reduction in overprescribing in people with learning disabilities.

2.3 Improving access to health and care services

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

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

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

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

Our plans to improve access to health and care services:

2025-26	2026-2030	Progress Indicators
Same day urgent care: A system-wide review of urgent treatment centres (UTCs) and minor injuries units (MIUs) made several recommendations to ensure we are providing the right level of access for our population's same day urgent care needs. It is proposed that the initial focus will be to make urgent treatment centres the 'front door' of our acute hospitals. We will also review the opportunity to shift some of the lower acuity main A&E activity to be appropriately managed in our urgent treatment centres, Further work will be undertaken to review the reasons behind a large increase in attendances seen at our urgent treatment centres and minor injury units, including understanding our on-day primary care capacity and activity and efficacy of NHS 111 as well as patient choice.	We will share learning across the system in relation to different models of UTCs and same day access hubs and spread best practice across HWE to ensure we have equitable access and outcomes. Enable virtual networking of our emergency departments, same day emergency care (SDEC) services and urgent treatment centres to ensure patients have appropriate and timely access to diagnostics regardless of where they access the system.	Reduce low acuity presentations at type 1 emergency departments. Reduce emergency admissions for acute conditions that should not usually require hospital admission.
Urgent and emergency care – managing demand: We will build on the successes of the 2024/25 model of the unscheduled care coordination hub, following the evaluation exercise. We will work collaboratively with the Herts and West Essex ICS to understand and agree priorities for winter 2025/26 by arranging a workshop, including acute, community, urgent care and mental health providers. Through the collaboration of the demand management oversight group, we will explore the potential of putting in place more UEC access points, such as new SDEC pathways for direct referrals from NHS111 and 999.	Expand the category of ambulance calls that can be automatically redirected and proactively managed by the unscheduled care hub, so that people dialling 999 with non-time critical presentations can be supported to directly access alternative pathways. Continue development of the model to become a single point of access across the	Reduce number of clinical assessments, referrals, and wait times for patients (reduce % abandoned calls, mean 999 call answering times) Reduce ambulance conveyances.

We will also scope new opportunities behind primary care direct referral access to SDEC. We will build onto an existing unscheduled care coordination hub model, taking into account quantitative and qualitative evaluation of the model which was implemented in November 2024. We will continue to maximise opportunities for ambulance crew to 'call before convey' to increase direct referrals to alternative sources. We will also explore benefits of co-location of the ICB System Coordination Centre with the unscheduled care coordination hub and evaluate its impact on the wider system collaboration and quicker system response.	system with no boundary restrictions. Enable access to multidisciplinary teams, to include acute consultants, with specialty clinical advice lines for guidance to support 'call before convey', and both mental health and drug and alcohol expertise. Continue to embed a trusted assessor approach across our urgent care pathways and digital interoperability to share records to ensure patients do not have to repeat their medical information.	Reduced category 2 mean response times
Urgent and emergency care: system coordination Evolving and developing the System Coordination Centre (SCC) ensuring oversight of system pressures and supporting patient access to the safest and highest quality of care possible. The SCC will continue to develop true system coordination, with real-time clinical input into decisions made by the system to keep patients safe. Continued implementation of the operating pressure escalation level (OPEL) framework with specified agreed incremental actions to support interventions across the ICS on key issues influencing patient flow. Ongoing development of a dashboard (SHREWD) to support whole system near-live monitoring of demand and system impacts and interdependencies.	Continued development of the System Coordination Centre to enable true system coordination. Ongoing development and evolution of the SCC working groups. Continue to meet NHSE SCC mandated requirements, sustaining 100% compliance against the NHSE required operational standards for SCCs.	Reduced category 2 mean response times Improved ED all-type 4-hour performance

Primary Care – access recovery plan/implementation of modern general practice: Continue to support increase in digital access including effective triage and signposting to more efficiently utilise available appointments and improve access, especially improving same/next day assessment and appointments with 2 weeks. We will monitor the impact of this and respond to any unintended consequences that may arise. Integrated neighbourhood team and PCN collaborative models, especially on same day hubs, to handle demand more effectively NHS App and wider digital access implementation to empower patients and reduce need to contact practices directly We have identified priority areas for the role of optometrists in the delivery of eye care ophthalmology pathway across primary care, community and hospital services and are working closely with local and regional partners on commissioning and implementation with a plan for greater access to optometry diagnostic tests and investigations by April 2025. In addition to these, we are exploring expansion to improve same day access to optometrists for a range of minor eye conditions which is a service currently commissioned across west Essex and Stort Valley in east and north Hertfordshire. Strengthen professional development and career pathways for Allied Health Professionals (AHPs) working in primary care and continue to embed new models into business as usual - expand and optimise scope of practice. Work with PCNs to understand and support challenges faced, garner further information (helping to triangulate skill mix with		To continue to deliver an increase in for 25-26. To deliver c89% of appointments within 2 weeks (for those appts where patient would request the first available). - 24/25 to Sept 88.25% Increasing year-on-year numbers of completed online consultations from April 2024 to March 2028. 24/25 to Sept 162k online/video consultations; 343% up on 23/24 Continued engagement and support to take place with PCNs to understand current workforce position and future requirements and aspirations

capacity and patient experience), improve recruitment and retention and identify (and share) those workforce models which are proving through clinical and operational experience to be the most effective and resource efficient. Referral optimisation – develop a referral management service/process improving patients access to planned care. Phase 2 of the project new enhanced workforce dashboard which includes data from primary care and social care is due to begin in April 2025, however this will be dependent on the business case and finances being approved.		Full utilisation of ARRS budget by each PCN Production of a new enhanced workforce dashboard.
Integrated Neighbourhood Teams (INT): Continue to support the development of Integrated Neighbourhood Teams (INTs) with clarity of purpose and clear governance arrangements. Following recruitment of all GP locality leads across the ICB, there is now ongoing work to embed this locality leadership through integrated neighbourhood care boards and the implementation of documents to support the establishment of INTs, such as: terms of reference, memoranda of understanding, risk sharing agreements. Ongoing evaluation to understand impact and using quality improvement methodologies to continually show improvement. Exploring what further support and resources can be provided to INTs in 25/26 to help them further evolve in form and function and contribute to a 25% reduction in non-elective admissions for those with frailty.		**I**NTs will proactively manage specific cohorts of patients, as agreed by each INT, within the community to reduce unplanned healthcare needs. INT's delivering improved health and wellbeing outcomes in line with their plans.

Population Health Management data will continue to be shared with INTs and each INT through a collaborative approach will identify the interventions including delivery, with the Health and Care Partnership The Primary Care continuous professional development programme is regularly reviewed and refreshed to ensure that the training provided is aligned to the ICS' strategic priorities. As part of this review the intention is to increase the number of funded leadership courses for primary care managers. In addition to the universal training offer, there is some scope in the programme to address support individual development needs of individual staff, practices, PCNs or INTs; all INTs will have identified a population group that would benefit from a joined-up approach. Population Health Management data will continue to be shared with INTs and each INT through a collaborative approach will identify the interventions, including delivery, with the Health and Care Partnership.		
Dental: Implementation of our dental workforce, recruitment and retention plan. A review of secondary care dental pathways will be undertaken to identify opportunities for treatment to be delivered in the community improving equity of access. Development of one single specification for a Special Care Dental Service.	Review the current special care dental contracts (SCDC) across Herts and west Essex to build a case for change for a new contract start date 1 April 2027. Mobilise Orthodontic Services – April 2027 Commission Special Care Dental Service - April 2027	Successful mobilisation of services following completion of procurements

Implementation of child focussed dental practice pilots to support children accessing mainstream dentistry without the need for general anaesthetic intervention. Long-term commissioning of orthodontic services to commence procurement. Review enhanced access pilot and commission substantive service to address health inequalities in deprived areas, and meet the national ambition outlined in the NHSE 2025/26 priorities and operational planning guidance to increase the number of urgent dental appointments.		
Pharmacy integration: Embed pharmacy delivery in primary care services with noticeable improved patient experience and outcomes, continuing to support independent prescribers To continue embedding community pharmacy leads in system leadership, strategic planning and pathway design, optimise 'Pharmacy First' into primary care service delivery, integrating community pharmacy as part of the Integrated Neighbourhood Teams (INTs). To increase number of independent prescribers via greater availability of designated prescribing practitioners (DPPs) and multi-sector placements; including embedding the NHSE-funded 'Teach and Treat' project, utilisation of training hub DPP funding, and promotion of ARRs funding opportunities. Map current		Increase utilisation of pharmacy workforce (e.g. accredited checking technicians/ pharmacist roles) Increase number of independent prescribers Increase number of trainee placement providers in general practice Increase referrals from GP practices to community pharmacies for the NHS Pharmacy

community pharmacy provision incorporating this into wider system resilience and capacity planning. To extend independent prescribing community pharmacy pathfinder programme and develop integrated service delivery model with Pharmacy First service. To review demand against current provision to identify and address problems with accessing pharmacy services. Increase the number of referrals from GP practices, acute trusts, Urgent Treatment Centres (UTCs) and NHS 111 to community pharmacists through the Pharmacy First service and expand the number of pathways that offer patient self-referral and conditions that can be seen.		First service during 2025-26.
Primary Care: Our ambition is for each primary care network to have a children and young people's social prescriber / personalised care practitioner in place by March 2025. Continue to aim for each Primary Care Network (PCN) across HWE to have a young people's social prescriber / personalised care practitioner in place by March 2025. Continue to work with GP practices supporting them in becoming Royal College of GPs (RCGP) accredited as 'Veteran Friendly'.		Increased recruitment of Allied Health Professionals and non-registered workers. increase the number of children and young people's social prescriber/personalised care practitioner in GP practices (currently in place in 8/35 PCNs in HWE).

		Increase the number of veteran friendly GP practices across HWE
2024-2025: Improved cancer operational performance: Continue to assess performance at tumour site level to highlight areas of underperformance, and where improvement plans will deliver a faster and earlier diagnosis. **Improved cancer screening uptake, widening offering to other screening initiatives as they develop:** Continue delivery for the east and north Hertfordshire population. Commence roll out of a lung cancer screening programme for a selection of practices within the south and west Herts area by mid-2025, and for the west Essex locality by autumn 2025. **Improved extended use and implementation of cancer screening innovation tools and techniques**: Continue to monitor the use of Faecal Immunochemical Testing (FIT) used as a screening test for colon cancer. Within east and north Hertfordshire a 'smart' referral form is being used within GP practices, allowing GPs to provide advice and signposting at the time of referral. Extend the provision of tele-dermatology services and community spot clinics supporting earlier and faster interventions. Evaluate current tele-dermatology pilots and implement services for patients referred for a suspected skin cancer.	Improved stage 1 and 2 diagnosis (75% by 2028) measured against 2023/24 baseline: Ongoing awareness sessions and activities to support cancer information, awareness and understanding. Assess position of stage at diagnosis to see where a shift from stage 3 and 4 to stage 1 and 2 is not demonstrated. Identify areas where further work and improvement will be required.	Improved screening uptake targeted lung health checks 80% of bowel cancer referrals are accompanied by a FiT result. 100% population coverage of non-specific symptoms pathway (NSSP)

Breast pain Clinics: Transition the East and North Hertfordshire Trust community-based breast pain clinic pathway into business-as-usual pathways. Develop a community-based breast pain clinic pathway and commence transition to a community-based model for The Princess Alexandra Hospital and West Hertfordshire Teaching Hospital. Transition the non-site-specific pathway service (NSSP) pilots to business-as-usual models (subject to funding), exploring the potential of a system wide pathway/model.		
West Essex/Essex mental health: Implement system mapping of inpatient beds in collaboration with partners across Essex. Move from Care Programme Approach to personalised tailored care with new ways of working/care co-ordination across Essex and the Integrated Care Board (ICB)	Consolidate and review community mental health transformation (in line with the national roadmap and mental health strategy direction of travel). Review of Right Care, Right Person with system partners in line with police strategies.	Reduction in out of area placements
National mental health and learning disabilities strategy: The (ICB) will respond to the expected national strategy and continue to embed and consolidate work with partners to support our population, such as employment, physical health checks, understanding the housing needs of the population and working though community mental health transformation across primary care networks.	Ensure our local strategies and workstreams are refreshed to implement the national strategy.	
Mental health, learning disability and autism inpatient quality programme: To deliver the HWE ICB Mental health, Learning Disabilities and /or Autism inpatient quality transformation programme (3-year plan) including the key elements of the inpatient pathway and the three key stages – purposeful admission, therapeutic care and	Implement stage three of the HWE ICB Mental health, Learning Disabilities and /or Autism inpatient quality transformation programme.	Strategy implementation milestones met.

proactive discharge. MH Trusts will continue to engage with NHS England to deliver the “culture of care” programme - a ward to board initiative - to embed lived experience into organisations to drive quality improvements and shape service re-design. This is one element of a programme of work which is supporting the reduction of using out of area placements across Hertfordshire and West Essex.		
Older adult mental health transformation: Continue implementing the Hertfordshire Dementia Strategy 2023-2028, which sets out the broad priorities for health and care services in Hertfordshire, based on what people affected by dementia and their support networks say is most important to them. In west Essex we will build on close working relationships with Princess Alexandra Hospital (PAH) to implement the co-developed dementia and delirium strategy which supports the transfer of those living with dementia in or out of hospital or preventing admission where possible. We will continue to work to improve access to mental health support at the right time preventing inpatient admissions through appropriate assessment and support from community mental health teams, including intensive support. Alzheimer’s UK will continue to work within PAH to prevent unnecessary admissions and support timely discharges for those living with dementia in west Essex. Dementia diagnosis rates overall continue to hover around the national target with some significance variation across the ICB area and further improvement work to do, as early intervention	Maintain a fully integrated older adult mental health and community health teams; in west Essex provide intensive support at place (including care homes) and explore development of services in west Essex that meets the needs of people with mild-cognitive impairment to ensure they have access to the correct health support.	Increase dementia diagnostic rate across Herts and west Essex

and diagnosis will be key element of preparing for new disease modifying treatments and peoples longer term outcomes. The ICB will continue to engage in regional and national forums about these new treatments and has established local working groups.		
Improving the pathways for young adult mental health services: Focus on improvement of transitions between CYP mental health services and adult services with support from system-wide "transition" navigator and care leaver navigation roles. Ensure those CYP who need support can access adult mental health support effectively, efficiently and are involved in shared decision making, feeling empowered to have an active role around their own mental health and wellbeing.	Embed Herts Young Adult transition workers across CYP and adult mental health services and undertake an evaluation to understand the impact and effectiveness of transition workers. Key indicators: to be confirmed.	Continual review and patient feedback.
Learning disabilities and autism transforming care: Continue to reduce the number of people in long stay placements, implement and embed the requirements of the new dynamic support register and care education and treatment reviews for autistic people, embedding our oversight processes with key partners to provide preventative support, prevent admission to a mental health hospital, and support discharge with appropriate support. Undertake a contract review of all services to ensure they support integrated models of care. Continue to reduce waiting times for autism assessments and raise awareness of annual health checks for those with a diagnosis of autism. Improve access to preventative and practical support for autistic adults and adults with a learning disability.	Undertake a full review of contracts and services to ensure future services are sustainable and meet the needs of our local population. Implementation of the Hertfordshire All Age Autism Strategy by 2029.	Reduce the number of patients in long stay placements. Reduce the number of people waiting for an adult autism Assessment. Strategy implementation milestone.
Digital: Pathology Business Unit - Migrate to the transformation state for the new outsourced pathology contract to HSL standardising the service across the ICS.	Continue to progress ICS Digital Strategy. Continue to invest in shared care records	

Electronic patient record (EPR) - ENHT expected to go live in mid-summer 2025 with OrbisU. Cancer management system - Somerset cancer registry awarded contract for a new cancer system for our three acute trusts. To be deployed in 2025. Shared care records - Invest further in ShCR and consider national record location service to share more information for new models of care/MTP. Federated data platform– to be progressed in ENHT and PAH following the implementation of their EPR systems.		

How will we know that we have made a difference:

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

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

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

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

2025-26	2026-30	Progress Indicators
Tobacco Dependency: Expand the national Tobacco Dependency Programme acute inpatient pathway to all specialties and all inpatients and increase the number of patients offered support through this programme across all pathways i.e. maternity, community inpatients and mental health inpatients.	Continue the progress to increase the number of patients offered support through the NHS Tobacco Dependency Programme across all pathways. Implement the national Tobacco Dependency Programme outpatient pathway and continue to work with providers across our system to achieve the national ambition of a Smoke Free England by 2030.	Achieve 100% coverage of inpatient pathway by year 1 in maternity: acute and mental health inpatients. Achieve 40% coverage of this pathway by year 1 in community outpatient services
Sustainability – Green Plan Focus on implementing and delivering against agreed action plans, launching system wide campaigns to co-ordinate communications on progress. System carbon reduction targets will be fully embedded across all partners with supporting policies and procedures. Review of the Green Plan to reflect on changes and new guidance, such as strategic estates, travel and transport strategy and bio-diversity net gain, creating a new 5-year plan with our partners. Supported by ongoing communications and engagement, which will include training and carbon literacy as part of mandatory training programme.	Focus on those hard to deliver actions; and reflect on what is working and identify areas that need further improvement.	Leads assigned to each work-stream. System wide campaign launched. Reduction in harmful emissions across the HWE NHS footprint

Primary Care: Commission enhanced oral (dental) support; scope our plans with education and public health. Scope and commission outreach to care homes and undertake targeted interventions through the development of Integrated Neighbourhood teams (INT) using population health data to inform future plans. Continue to embed and increase utilisation of Pharmacy First to enable integration of primary care services. Ongoing development of the action plan for the Oral Health Alliance Group across both health and social care partners; targeting CYP as the first priority and then wider vulnerable/hard to reach groups. Continue training and development of the three personalised care roles (social prescribing link worker, health and wellbeing coach and care coordinators). Strengthen the relationships and alignment between our integrated neighbourhood teams (INTs) and the voluntary, community, faith and social enterprise (VCFSE) sector and, supporting prevention and reducing inequalities, including digital; provide additional funding (within the available resource envelope) for initiatives aimed at reducing avoidable variation in the health status across different groups within our local population. Offer training in 'healthy conversations' through our public health teams to enable both clinical and non-	**Medicines Optimisation:** Reduce medicines waste and maximise use of inhalers with a lower carbon footprint.	Identify and deliver interventions through INTs

clinical staff to develop their skills in behaviour change to support the wider prevention agenda. Support patients to self-manage a wider range of health concerns (where appropriate) by providing clear and prominent information, correct signposting to sources of help through either the NHS App, healthcare professionals and useful websites. Increased uptake of Pharmacy First to further support integration of primary care services. Medicines Optimisation: reduce medicines waste and maximise use of inhalers with a lower carbon footprint. Overprescribing**:** to address overprescribing by improving repeat prescribing processes in primary care and considering non- pharmacological options for disease management where appropriate.		
Vaccinations: Work with regional and community colleagues to improve the uptake of vaccinations by supporting the roll out of the regional call and recall service for patients who have not received a dose of MMR. MMR is viewed as a good marker for uptake of a number of immunisations and vaccinations so the service will attempt to tackle low uptake for other vaccinations at the same time.		Improved uptake in MMR compared to April 2024 Maintain current uptake of COVID vaccines (52% as of 3 June 2024)/

Continue to provide practice level data to enable GPs to target vaccination offers to cohorts with low uptake and improve health inequalities. Continue to work with public health and community colleagues to improve vaccinations in those people who are currently seeking asylum by targeting deployment of vaccination teams to asylum seeker hotels. Support roll out of annual flu programme across primary care in late 2025 and implement autumn booster programme for COVID as defined by Joint Committee on Vaccination and Immunisation (JCVI). Continue roll out and catch-up programme for new RSV vaccination during 2025 to over 75s and infants as defined by JCVI in conjunction with Regional, CSAIS and primary care colleagues. Work with practices to promote uptake of pneumococcal vaccine for eligible LD patients.		Continue to work towards meeting the national flu vaccination targets across eligible cohorts. Complete autumn covid booster programme by end of January 2026 including all care home residents and eligible housebound patients.

How will we know that we have made a difference:

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

2.5 Ensuring financial sustainability

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

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

Our plans to support our changing demographics and financial challenges:

Financial Recovery: A range of high-impact schemes have been identified to help address our financial challenges in 2025-6, these broadly fall into five workstream areas:

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

These are currently being developed into **detailed projects with phasing of savings, including potential impact in 24/25 being quantified.**	
Workstream	**Ambition for 2025- 26**
Workstream 1 - Improving Productivity *Our system aims are to adopt good practices and use a data driven approach to improve the productivity of elective care pathways, focussing on our five high impact changes based on a 'Best in HWE Benchmark'. These tools will be used to drive up productivity, reduce variation and create room for maximisation of elective recovery fund (ERF) income. By delivering more services at a reduced cost e.g. by maximising use of available theatre time and by delivering Outpatient first appointments using a one-stop model. The specific areas of focus for this work are listed in the adjoining column:*	**Outpatients Optimisation:** • Make first appointment count percentage of 1st OP appts (ERF scope) >52% • Reduce cancellations /DNAs <5% • Increase virtual appointments >25% • Increase advice and guidance diversion rate >20% • Increase PIFU TBC (24-25 had a 2.3% increase) • Reduce follow up appointments TBC (24-25 had a 1.8% decrease) • Increase number of cases >23/24 activity plan 122.5% • Improve average cases per 4-hour session >2.8 • Improve utilisation - capped >85% • Improve average late starts (minutes) <15 • Improve average inter case downtime (minutes) <15 • Improve average early finish (minutes) <30 • Improve average unplanned extensions (minutes) <30 • Improve % of emergency surgery conducted within elective lists <1% • Improve number of additional cases there is capacity to treat <200 • Improve additional capacity (%) including 5% on the day cancellation rates <5% **Day Cases:** • Increase day case rates >85% • Reduce day case to patient <5% **Reduced Length of Stay (LoS):** • Reduce Elective Length of Stay <2 days • Reduce Non-elective Length of Stay <8 days (24-25 8.8 days) **Outpatients Optimisation:**

	• Make first appointment count • Reduce cancellations /DNAs <5% • Increase virtual appointments >25% • Increase advice and guidance diversion rate >20% • Increase PIFU • Reduce follow-up appointments **Hospital at home Optimisation:** • Maximise utilisation of current capacity • Increase capacity in successful and new specialties • Share and implement best practice success across HWE
Workstream 2 - Manage workforce growth and reduce agency spend *Our aim is to improve the productivity of our workforce; employ fewer people more cost effectively through the development of the primary and community workforce; through digital innovations and performance processes provide assurance around the operational use of workforce data.*	Using system workforce data and analysis of growth in workforce to at least deliver our 25-26 plan requirements: We will achieve this by: • Initiating changes in workforce skills mix. • Reducing workforce to safer staffing ratios. • Improving job planning. • Reviewing roles added during COVID for value add. • Driving harder on reducing agency staffing levels. • Initiating more robust vacancy control processes. • Managing turnover better and make use of lower cost apprenticeships where appropriate. • Implementing consistent job planning practices across the system utilising shared resources and any required approached to procurement. • Working with service commissioners and the University of Hertfordshire to apply mathematical modelling to key areas of service commissioning and design to ensure the most efficient, effective and safe service delivery.
Workstream 3 - Transformative approach to managing frailty and elderly care	**See pages 13-15 and 44-45**.

Workstream 4 - Transformative approach to managing growth and costs in mental health and learning disability and autism services The increased growth for these services needs a focused coordinated approach from across multiple service providers to support mental health integration, ensuring a coordinated support for physical health, mental health and wider social needs.	We will adopt an integrated approach to carry out a review of pathways and capacity required. The challenge of developing services to meet the growth in demand hasn't allowed time for review of both capacity and pathways; through an integrated approach we need to tackle the demand and capacity issues that are highlighted within our system. *Initial areas of focus for this work are:* • Implement a range of initiatives to manage growth in services and address historical cost pressures. • Address issue of historical bed base and use of premium contracted beds ensuring we have the correct number and mix of beds to meet the population need into the future. • Agree a system approach to investing in backlog clearance and agreeing waiting times for neuro diversity services. • Realising the financial and non-financial benefits of the new mental health Urgent Care Centre. • Use the national utilisation tool to review staffing growth and link to safe staffing levels. • Explore opportunities for more efficient group consultation models. • Review bed flow and target issues that delay discharges, Linked to the above we plan to undertake the following: • Agree proposals for 2025-26 to manage immediate demand. • Develop proposals for 2025-2035 which will describe how bed configuration, demand and flow will be managed differently going forward. These proposals will include capital and staffing proposals and costs, needed to create the planned change.
Workstream 5 - Secure better value from contracts and increase efficiency	**Commissioning and contract optimisation** • continue our ongoing review of all commissioned contracts • review of the decision-making process around high-cost complex cases • review of clinical thresholds to improve outcomes i.e. fitness and readiness for surgery optimisation • review of all contracted and non-contract activity that the ICB has with the private sector and outside the ICS area, to look for opportunities to appropriately repatriate. **Back-office benchmarking**

	• Use regional benchmarking data to review the opportunities for sharing back-office functions e.g. across acute trusts or between trust and local authorities within a Place • Consider previously untested services **Estates optimisation** • Use current Estates Strategy refresh to identify best use of estate • Identify excess estate for disposal

How will we know that we have made a difference:

We will have:

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

3. Our workforce plan

The system is coming to the end of its 2023-2025 People Plan and is in the process of reviewing the outcomes, achievements and areas that require further progress and support. The system is working closely with regional and national colleagues and engaging with health and care providers to deliver the ambitions set out in the 10-year plan and refreshed Long Term Workforce Plan when received.

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

		support those activities through the *Retain* area of the system workforce transformation plan as part of this programme going forwards.

2024-2026 priority: TRAIN

What will we do to make a difference:

2025-26	2026-30	Progress Indicators
Clinical Education: • Prioritise development of a local pipeline of registered staff and key clinical professionals, working closely with education sector and related stakeholders. • Working with Herts Futures and other related stakeholders to support skills development across our system in developing a workforce ready to meet the future needs of our population. • Continue to develop service-based workforce modelling to understand long-term workforce needs. • We will support the development of advanced clinical practice pathways and review skill mixes required for the best possible care.	• We will work towards the ambitious targets set by the Long-Term Workforce Plan for clinical education within Hertfordshire and West Essex. • We will support the development of the University of Hertfordshire Medical School.	• UCAS Applications to University of Hertfordshire • Clinical Placement monitoring • Retention of students into locally based employment
Supply: • We will apply the overhauling recruitment toolkit	• We will have developed a system approach to staff recruitment	• Provider workforce returns reviewed at People and

across the system. • We will introduce a talent pool ensuring talent is retained within the sector. • We will promote key areas of workforce vacancy through innovative campaigns, specifically for care worker and learning disability roles. • We will limit our use of temporary staffing, reducing our agency spend and improving our agency cap compliance rates. • Having completed the procurement of our collaborative bank, we will seek to introduce further efficiencies and activity to understand and where possible reduce our spend on temporary staffing. • We will work with system and regional partners to support the delivery of supported employment programmes such as WorkWell and Connect to Work.	enhancing recruitment services across health and care and ensuring that applications are representative of our whole population and talent is effectively supported into the sector. • We will continue to reduce agency usage across the system and encourage an appropriate substantive and temporary staffing mix.	Performance Committees • System and organisational vacancy rates. • Temporary staff usage and % of pay bill
Apprenticeships and T-levels • Support the delivery of the new apprenticeships with the University of Hertfordshire, addressing key workforce shortages. • Continue to monitor system-wide data collection of apprenticeship and levy use with regular monitoring through the national database. • We will continue to promote diversification of the apprenticeship offer as well as the gifting of levy	• Development and delivery of system integrated apprenticeship programmes that support delivery of care across the sector. • Work towards full utilisation of the apprenticeship levy within Hertfordshire and West Essex. • Introduce placement opportunities across the sector for T-level	• Apprenticeship take up across providers. • Apprenticeship levy spend across the system. • T-level placement utilisation

to key stakeholder partners within the system.	learning and development.	
Health and Care Academy • We will seek a sustainable model for the Health and Care Academy across the system. • The Health and Care Academy will engage with all schools and colleges within Hertfordshire and West Essex, promoting health and care careers to our community. • The Academy will continue to seek to provide innovative means of promoting career opportunities within the sector. • We will further expand and develop our work experience programme and increase the number of active career outreach ambassadors.	• Have work experience programmes in all key providers as well as wider areas of the sector. • Developed effective pathways between schools, further education, higher education institutions and employment.	• Engagement contacts with school/colleges • Entry level position vacancies
Volunteering • We will support the VCFSE in delivering the 'volunteer for health' programme and associated projects going forwards.		

How will we know that we have made a difference:

We will have:

- Turned around the decline in applications for clinical education to local and regional higher education institutions.
- Developed effective domestic and local community pipelines across school, further education, higher education into health and care employment and be able to monitor progress of employment from local communities.
- Be able to monitor apprenticeship levy spend and improve levels of spending through apprenticeship route development.

2024-2026 priority: REFORM

What will we do to make a difference:

2025-26	2026-30	Progress Indicators
Productivity: • We will further improve our understanding of workforce productivity across the system. • Following regional recommendations we will focus on consistent application of medical job planning across the system. • We will support the system in meeting the operational planning targets of returning to 2019 levels of WTE/activity and returning corporate support services to 2022 cost levels. • We will continue to engage with the national team to review and refine the productivity diagnostic tool and expand its purpose to community and mental health providers.	• We will support service developments and innovation in identifying and developing the appropriate workforce and encourage movement to preventative measures and community care.	• Improvements to productivity and efficiency data reported to performance committee.

Skills capacity and modelling: • Working alongside the system's research collaborative and the University of Hertfordshire we will continue to develop our understanding of workforce modelling – with a focus on delivery of the decision-making tool for cardiology services going forwards. Once the pilot is completed, we will seek to apply this to other areas. • We will seek assurance from providers around the safe workforce guards being in place and effectively monitored. • We will seek to apply the learning from AHP staff modelling tool developed at Princess Alexandra Hospital to other areas of the system. • Support the primary care training hub with role development, training requirements and data modelling.	• We will continue to explore new role opportunities. • Support development and skills experience of MDT teams working across the system	• Skill mix and staff establishment review processes increasingly undertaken on system and integrated basis.
Digital and technological innovation • We will support the Artificial Intelligence and activity/workforce modelling programmes of work with the University of Hertfordshire, encouraging data sharing and exploratory thinking and working in this area. • We will continue to work with regional and system partners to review shared efficiencies including the introduction of virtual HR assistant across the system.	• Understand and review opportunities for shared procurement for digital solutions on a system basis. • Maximise and be delivering appropriate shared functions on a system basis. • Support full system	• Improvements to productivity and efficiency data reported to performance committee.

• Prepare for initial implementation of digital staff passport. • with the University of Hertfordshire, encouraging exploratory thinking and working in this area. • We will continue to explore back-office efficiencies with digital and technological innovations with partners and key stakeholders. • Prepare for initial implementation of digital staff passport.	implementation of the NHS Digital Staff Passport	
Medical transformation and education • We will continue to support the University of Hertfordshire in their application to become a medical school • Review wider requirements for medical training development and expansion, particularly within primary care and dental services. • Support development of the clinical educator strategy, providing practical support to organisations for expansion of placement support. • Continued delivery of the Oliver McGowan training across the system to meet regional targets set out. Continued expansion of the Oliver McGowan training across the system.	• Successful recruitment and delivery of the University of Hertfordshire medical school. • Full system uptake of Oliver McGowan Training.	• Reduced reliance on agency spend in key areas of medical workforce. • Reduced vacancies in key shortage areas of medical staffing. • Improved turnover and leaver rates of medical workforce. • Sustained improvements to system productivity and efficiency.

How will we know that we have made a difference:

We will have:

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

2024-2026 priority: RETAIN

What will we do to make a difference:

2025-26	2026-30	Progress Indicators
Talent and Leadership • Continued system-wide delivery of Mary Seacole programme. • Review system management and leadership programmes for potential to combine/ share removing duplication and increasing system working. • Improve digital capability across the system. • Exploit the capability of Talent Time banking platform to offer opportunities for one-to-one coaching sessions to support job search/application/ interview as well as networking and shadowing opportunities. • Leverage the work of HPFT on career pathways and look at opportunities to build and share	• Host a consistent approach to leadership pathways and review.	• System turnover rate. • System leaver rate and destination. • Staff survey data and pulse surveys. • Student retention and application rates.

across the system. • Promote the coaching hub and encourage qualified coaches across the system to sign up - explore options for system functionality.		
Culture, equality, diversity and inclusion: • Improve diversity in those who are applying, interviewed and successfully appointed, so that we have more global majority staff in senior positions. • Create a sub-committee from the EDI committee that will focus on combating bullying and harassment. • Ensure equality of access to development, to support diversity of senior leadership. Collaborate with the Talent and Leadership Committee to create a process for staff to access stretch opportunities across the system. • Support delivery of the recommendations of the Healthwatch international recruitment review across the system.	• Continued development and delivery of the anti-racism strategy across the system. • Delivery of system culture proposals highlighted above, with improved links to VCFSE and students within the system. • Undertake a review of system culture and develop proposals for key areas of progress	• System Turnover rate. • System leaver rate and destination. • Staff Survey data and pulse surveys. • WRES and WDES data returns.
Health and wellbeing • The system is reviewing the most significant causes of sickness/absence and seeking to address the most prevalent reasons across our system. • We will seek consistent application of the sexual	• Development of detailed wellbeing plan to support reductions in sickness/absence across the system and reduce absence.	• Staff sickness/absence rates. • System turnover rate, • System leaver rate and destination. • Staff survey data and pulse surveys.

safety charter across the system. • Continue to roll-out the menopause awareness and signpost support services across the system to all staff. • Map out what organisations currently do and produce an approach to wellbeing conversations that encompasses career development, flexible working and other wellbeing metrics.	• E-rostering and team management available across the system.	

How will we know that we have made a difference:

We will have:

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

4. Key milestones:

Area	Activity	Date for completion
Armed Forces Community: Veterans & Families	Continue to work closely with the Hertfordshire Armed Forces Covenant Board, leading their Health Subgroup and assisting the Herts Suicide Prevention Board to update suicide data to include Armed Forces Community in the Hertfordshire Suicide Prevention Strategy. Continue with Op Community social prescribing service with HCNS. To increase focus on prevention and training for the armed forces community, with training to be rolled out to GP practices and NHS Trusts in 2025/26 via membership of the Armed Forces Network (AFN), run by NHS South East Region and the new Veterans Covenant Healthcare Alliance (VCHA) Regional training leads	Sept 2025 April 2025 -26 March 2026
Autism Spectrum Disorder (ASD) & Attention Deficit Disorder (ADHD)	Develop a new model for children and young people's autism and ADHD assessment, including redeveloping the clinical pathways to form a single-entry pathway across Hertfordshire with alignment and oversight across the ICS.	Clinical pathway implementation by 31 Jan 2025
Cancer	Achievement of the Faster Diagnosis Standard (FDS) and 62-day standard Targeted lung health checks: • East and north Hertfordshire - partial coverage achieved • South and west Hertfordshire and west Essex mobilisation commenced Faecal Immunochemical Testing (FIT) – delivery of 80% of all LGI urgent suspected cancer referrals being made informed by a FiT result. Delivery of 75% of improved stage 1 and 2 cancer diagnosis.	April 2025 April 2025 April 2025 April 2025 March 2028

Cardiovascular disease	**Hypertension** • Evaluation of dental and optometry hypertension case finding pilot • Completion of primary care data cleansing project, to ensure correct coding and management of people with hypertension. **Heart failure** • Implementation of ICS model of heart failure care and adoption of clinical pathways **Lipid management** • Implementation of lipid management service	December 2025 September 2025 June 2027 March 2027
Care closer to home	Commence delivery of 2025-26 HCP integrated delivery plans (IDP's) Implement resource shift Implement step change for winter Commence delivery of 2026-27 HCP IDP's	April 2025 September 2025 October 2025 April 2026
Dental	The following areas of dental transformation will be undertaken to address health inequalities and gaps in provision: • Improved domiciliary care – housebound and residential nursing homes services – pilot expanded across further care homes and evaluation to be done • Level 1 endodontic and periodontal services and the East of England trauma pathway • Level 2 oral surgery – planned review of services to ensure current provision is meeting the needs of the population • Improved dental access for asylum seekers/ migrants	 March 2026 March 2026 March 2026 April 2026

	• Completion of 12-month alternative therapies pilot with Guys and St Thomas' NHS Hospital Trust to reduce the need for sedation or referrals into secondary care • Completion of a dental training needs analysis • Review of the current special care dental contracts (SCDC) across Herts and west Essex for new contract start date 1 April 2026 Further key dental priorities include: • Review enhanced access pilot and commission substantive service to address health inequalities in deprived areas • Scope and commission integrated out of hours dental service within the wider out of hours pathway	October 2025 December 2025 April 2027 April 2025 April 2026
Diabetes	Development of ICS wide integrated model of care for diabetes Implementation of the integrated model of care for diabetes at each Place. Continued improvement in completion of eight care process	April 2025 March 2028 April 2026
Digital	Advanced care plans added to additional pathways. Shared care records for all pathways Single cancer patient tracking list (PTL) Shared care records across all our health and care providers Data and analytical maturity	March 2026 March 2026 March 2026 March 2027 March 2029
Frailty and end of life	To have consistent and up to date falls pathways across HWE, including identification and management of osteoporosis. To increase our identification of those at risk of falls. To increase utilisation of falls services. To have osteoporosis services across HWE	April 2026 April 2026 April 2026 March 2029

Green Plan	Creation and ratification of refreshed ICS Green Plan. Delivery of ICS travel and transport strategy. Strategic Estates Plan – sustainability section complete.	July 2025 January 2026 March 2026
HMHLDA HCP	Continue to implement milestones as per Hertfordshire Dementia Strategy 2023-2028 Hertfordshire Dementia Strategy 2023-2028	December 2028
Integrated Neighbourhood Teams (INT)	Implementation of documents to support establishment of INTs. INTs will proactively manage specific cohorts of patients, as agreed by each INT, within the community to reduce unplanned healthcare needs. INT's will deliver improved health and wellbeing outcomes in line with their plans. Review of primary care continuous professional development programme to ensure availability of relevant and appropriate leadership training	September 2025 December 2025 April 2026 and beyond March 2026
Maternity	Improve our governance structures to enable clarity on reporting of progress with the single delivery plan. Agree key deliverables with clear progress measures and timescales.	March 2026
Mental health	Mental Health Urgent Care Centre (UCC) additional pathways open, facilitating access to the service. Implementation of year 2 priorities of the Southend, Essex and Thurrock mental health strategy for 2023-2028. Re-procurement of ICB wide suicide bereavement service Ongoing development work and approval of a new combined clinical pathway for assessment of young people with Autism and/or ADHD. Implementation of new pathway commenced in Q4 2024/25 with full service expected to go-live in Autumn 2025/26.	Spring 2025 March 2026 September 2025 Autumn 2025

	Implement Year 2 of the HWE ICB Mental health, Learning Disabilities and /or Autism inpatient quality transformation programme (3-year plan 2024-2027) Commence initial evaluation (using data available) of impact of the ICB wide mental health ambulance response vehicles ahead to inform service 2026/27	March 2026 January 2026
Obesity	Early prevention support embedded into relevant clinical pathways including: • non-alcoholic fatty liver disease • sleep apnoea • diabetes • elective surgery • cardiology • fertility.	March 2026
Pharmacy Integration	Ensure actions to reduce inappropriate polypharmacy and reduce medicines wastage are included in integrated neighbourhood teams and place-based teams plans. Increase referrals from GP practices and NHS 111 to community pharmacists through the Pharmacy First service Ensure that all foundation pharmacist trainees allocated within HWE for 2025/26 have access to a Designated Prescribing Practitioner (DPP)	March 2026 April 2026 July 2025
Planned Care	Elective Hub building in St Albans to be completed and treating patients. To build and mobilise remaining CDC sites: • St Albans Hospital CDC • St Albans Hospital Endoscopy • Epping CDC	September 2025 2025-26 2026-30 2026-30
Primary Care Access Recovery Plan/Implementation	Implement Modern General Practice access, including implementation of better digital telephony; highly usable and accessible online journeys for patients; faster care navigation, assessment, and response.	March 2026

of modern General Practice	Put in place action plans by June 2025 to improve contract oversight, commissioning and transformation for general practice, and tackle unwarranted variation. Further progress (from April 24 baseline) on implementation of the four recommendations on primary care/secondary care interface from the Academy of Medical Royal Colleges. – Improve implementation at six and twelve-month points.	June 2025 and March 2026 September 2025 and March 2026
Sustainability	Creation and ratification of refreshed ICS green plan	March 2026
Therapies	**West Essex** • Implement workforce integration (in shadow form, remodelled workforce allocation based on need and greater school-based delivery. • Commissioning integrated workforce for CYP therapies. **Hertfordshire** Workforce strategy to be implemented in full. To include apprenticeships, rotational posts, progressive posts, training leads and international recruitments. Families to be kept updated and support materials to be made available, whilst waiting. 'Waiting Well' strategy to be developed and implemented.	September 2025 April 2027 Recruitment ongoing, first wave to be completed by 2026. 30 April 2025
Tobacco Dependency	Expansion of national tobacco dependency programme acute inpatient pathways to cover all specialities. Implementation of national tobacco dependency programme outpatient pathway	April 2025 April 2027
Urgent and emergency care	Unscheduled care coordination development: - Continue to pass low acuity health care professional heralded calls via access to the stack (A2S) - to clinically validate certain NHS 111 calls that would normally receive a Category 2 level response from the ambulance service where clinically appropriate and provide an alternative pathway of care - expand 999 calls that can be proactively managed by the unscheduled care hub and community providers	March 2026 March 2026 March 2026

	- simplifying opportunities for ambulance crews to call before convey/handover at home	March 2026
	- allow further direct access for SDEC referrals for NHS 111 and 999 crews	March 2026
	- innovative demand management model to manage NHS 111 and 999 calls	March 2026
	- development of a single point of access with access to multidisciplinary teams (including acute consultants, mental health, drug and alcohol specialists) via Trusted Assessor approach	March 2026
	- coordination of the Unscheduled Care Coordination Hub with the HWE ICB System Coordination Centre	March 2026
	System Coordination Centre (SCC)	
	- implementation of enhanced national OPEL Framework (including consistent primary care, community, Mental Health and NHS 111 parameters)	March 2025
	- development of a single ICS wide system resilience framework	May 2025
	- development of an ICS capacity dashboard to ensure all available system capacity is correctly utilised	October 2025
	- development of a system wide SCC SharePoint page	Ongoing
	- continue to evolve and implement the below SCC working groups including 'SCC Safety, Oversight and Operational Group', 'HWE ICS Operational Planning Group for Seasonal Pressures', and 'SCC Operational Working Group'	Ongoing
	- Continue to meet NHSE SCC mandated requirements, sustaining 100% compliance against NHSE Required Operational Standards for SCCs	March 2026
	Implementation of UTC/MIU recommendations	
	- Place-based teams supported at system level to make co-located urgent treatment centres the 'front door' to the acute hospital.	March 2026
	- Review opportunity to shift some of lower acuity main A&E attendances to be appropriately managed in our UTCs.	June 2026
	- Review the reasons behind a large increase in type 3 ED activity	October 2026

	- Implementation of wider UTC/MIU review recommendations Maximise use of Same Day Emergency Care (SDEC) with direct referral pathways from ambulance service, primary care and NHS 111. Develop SDEC for frailty and pathways between acute frailty services and links with frailty care in the community. Explore further potential behind allowing direct access to NHSE 111 and 999 to other types of SDEC, such as Surgical SDEC across ENHT, WHHT and PAH.	March 2026 March 2026
Vaccinations	Complete spring COVID booster programme by end of June 2025 including all care home residents and eligible housebound patients. Support roll out of annual flu programme across primary care in late 2025 and implement autumn booster programme for COVID as defined by the Joint Committee on Vaccination and Immunisation (JCVI).	July 2025 Autumn 2025
Workforce	Completion and implementation of associated actions of the 'overhauling recruitment' toolkit. Completion of 'people promise' exemplar site at Hertfordshire Partnership Foundation Trust. System participation in digital staff passport. University of Hertfordshire medical school accepting up to 70 students in its first year of operation. Concerted system approach to volunteering and integration to wider VCFSE	April 2025 April 2025 April 2026 September 2026 June 2026

5. Index

To be added once document is complete.