Hertfordshire and West Essex Integrated Care Board

Meeting Book 2 - HWE Board - Appendices for Information

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

Appendices - Exception/Additional Reports - FOR INFORMATION

- Quality Escalation Report
- Performance Escalation Report
- Finance Escalation Report
- Full HCP Integrated Delivery Plans
  - East and North Herts Full Integrated Delivery Plan
  - South West Herts Full Integrated Delivery Plan
  - West Essex Full Integrated Delivery Plan
  - Mental Health, Learning Disability and Neurodiversity Full Integrated Delivery Plan

Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

Hertfordshire and West Essex Integrated Care Board (HWE ICB) Quality Escalation Report

June 2025

Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

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Executive Summary

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

Position since Previous Report: **NEW.**

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

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

Position since Previous Report: **NEW.**

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

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

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

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

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

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

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

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

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

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

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

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

- Improvements being seen in performance and quality of service.

Hertfordshire and West Essex Integrated Care System

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Sharing Best Practice / Learning from Excellence

Sharing Best Practice / Learning from Excellence

Hertfordshire Community NHS Trust (HCT) Special Recognition Honour award.

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

Princess Alexandra Hospital Trust (PAHT) - impact of Trauma Committee training initiatives.

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

ENHT NHS staff survey 2024 results.

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

ENHT awarded Teaching Trust status.

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

West Hertfordshire Teaching Hospitals NHS Trust (WHTHT) Accident and Emergency (A&E).

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

Key Priority Areas

Please note subsequent slides include RAG ratings. RAG key is detailed below:

	Ongoing/In progress		On track		Complete/To be closed

Patient Experience and Safety - ICB

ICB Area February / March 2025	Compliments	Complaints	PALS	Member of Parliament	General Practitioner (GP) queries	Whistle-blowing	PSII recorded on STEIS	Never Events (included in PSII numbers)
East and North Hertfordshire	1	44	73	15	75	1	1	**0
South and West Hertfordshire	1	30	77	13	28	0	2	**0
West Essex	0	17	40	7	35	0	2	2
All ICB localities	0	3	20	0	* 0	0	* 0	* 0
Other	0	17	55	0	0	0	0	0
Total	2	111	265	35	138	1	5	2

* Not applicable as Patient Safety and GP queries are recorded as location specific.
** New Never Events referenced in Executive Summary will be captured in the next report as declared in April/ May.

ICB area	Key themes and Risks	Improvement Actions and Mitigations
All localities.	40% of all the queries received by the Patient Experience Team relate to access to services. The top 2 types of service the queries involve are: GP practices - 30% Dental practices - 13%	The queries about access are wide ranging – further analysis of the data from the last 12 months will be undertaken to identify themes, learning and whether additional supportive actions need to be taken.
Primary Care.	**Example of learning from a Primary Care complaint.** A patient presented in the surgery with symptoms requiring review by a doctor. A doctor was not on the premises when the patient arrived, so the patient returned home. The process to ensure the review took place on the same day failed and led to a 24-hour delay to the patients review.	As a direct result of this complaint the practice have changed their processes to: • Enhance communication between staff members when a second opinion is indicated. • Ask the patient to remain in the surgery until they have been seen.

National Patient Safety Strategy Implementation (1/2)

Priority Area	Current Position	Status for HWEICB
Safety Culture.	• Work is ongoing work across the system, which underpins all patient safety workstreams.	In progress.
Medical Examiner (ME) System for Community Deaths.	• The Patient Safety Team has now met with all 3 Medical Examiner Offices in Hertfordshire and West Essex and has gathered feedback that will be shared through communication to GP practices in the coming weeks. • Meetings focused on themes and learning have been arranged on a quarterly basis, and the monthly meetings stood down. These themes and learning will feed into the ICB's Learning from Deaths forum, and all the MEs have been invited to future meetings. • Intelligence from ME Offices continues to feed into the ICB quality oversight work. • The workstream to implement the process has been completed successfully, so updates will be provided going forward, by exception.	Complete.
Ongoing Implementation of the Patient Safety Incident Response Framework (PSIRF).	• The ICB continues to focus on PSIRF transition for our smaller and independent sector providers, and review and the sign-off of updated provider plans. • Work is ongoing with the ICB's patient safety network to review and align system priorities and system-wide learning.	On track.
System-wide Learning from Deaths Forum.	• The forum focused on End-of-Life care at its latest meeting in early May. Invites were extended to the MEs, Care Home Teams and hospice providers to bring valuable themes and learning for discussion. • Providers were asked to share a case study at the meeting to identify themes and quality improvement priorities going forward.	On track.
National Patient Safety Alerts.	• The ICB continues to focus on our internal process for managing safety alerts. • Robust processes although in place within providers, are varied, and discussions are underway with the patient safety network to understand how these might be aligned in the future.	In progress.

National Patient Safety Strategy Implementation (2/2)

Priority Area	Current Position	Status for HWEICB
Improving Patient Safety in Primary Care.	• Work continues on the implementation plan through internal working group. Discussion with both Hertfordshire and Essex Local Medical Committees has been arranged. • One practice has adopted the PSIRF principles as part of a pilot, and the ICB is supporting their journey. • The patient safety team regularly adds shared learning case studies for primary care on the patient safety resource page of the GP training hub, and practices are encouraged to review these with their teams. • Learning relating to an 'out of hours' dental incident involving recognition of the signs of sepsis has been shared with all dental and orthodontic practices in HWE.	In progress.
Supporting organisations to transition to and embed the Learning from Patient Safety Events (LFPSE).	• Issues with the functionality of the system remain for ICB oversight, and so incidents meeting Patient Safety Incident Investigations (PSII) or Never Event criteria continue to be logged on the historical system for ICB awareness. • The rollout for primary care will be incorporated into the wider strategy workstreams; however, some practices and pharmacies are now using the system.	On track.
Patient Safety Education and Training.	• ICB staff compliance with patient safety training remains high. The training is a mandatory requirement. As the initial requirement has been satisfied, further updates will not be provided.	Complete.
Patient Safety Improvement.	• All programmes led by local Patient Safety Collaboratives, local providers and the ICB where appropriate, are engaged in the main programs of work. Updates will only be provided if there are any changes going forward. A joint acute provider discussion on Martha's Rule took place on 10 April 2025, hosted by the ICB.	Complete.
Ongoing implementation of the framework for involving Patients in Patient Safety.	• A system-wide forum for Patient Safety Partners (PSPs) was recently held. PSPs across the system have agreed to work collaboratively going forward to ensure learning is shared.	On track.
Patient Safety Specialists Priorities.	• The latest version of priorities was recently discussed in the Patient Safety Network meeting. It was recognised there is further work required in some areas of the system, which the Network will support.	In progress.

Quality Improvement (QI)

Priority Area	Current Position	Status
Creating shared purpose and system priorities.	• Work linked to the successful Health Foundation bid has now been completed. • The bid supported implementation of the HWE System Quality Improvement (QI) Network, including two face-to-face improvement events, regular network meetings with patient engagement, development of a dedicated internet page, tracking and monitoring outputs and improvements. The evaluation has now been completed following the successful face-to-face event that took place earlier in the year.	Completed.
NHS Impact update and HWE ICB QI delivery plan in place.	• Baseline NHS Impact assessments have been completed for Trusts and a report for our readiness to change as an ICB is now completed. Feedback from the ICB NHS Impact report has been used to inform the 3-year QI delivery plan and the HWE ICB QI approach and has now been signed off by the Executive Team.	Completed.
ICB QI delivery plan.	• HWE ICB QI delivery plan, developed following the ICB's NHS Impact self-assessment has been approved. The delivery plan is aligned to our Quality Strategy, PSIRF, the NHS Impact 5 key priorities, medium term plan and our ICB operating model.	Completed.
Developing QI communications plan: **- To build the 'will' to create a movement for QI.** **- Promoting Herts and West Essex QI Network System update as an enabler for change.**	• NHS Futures Platform dedicated page and 'Weekly Wednesdays' update is in place on all local, national and evidence-based resources for QI. Positive feedback from Network members has been received. Continue engagement with staff, patients and partners to build the will for QI and to ensure sustainability of the Network. The Network membership is steadily increasing and currently at 129 members. • Aim is to deliver 6 network 'Learn and Celebrate' events in 2025/26. Currently on track and delivered 3/6 webinars hosted by our providers. A 2025/26 timetable and network event planner is in place. Positive feedback continues to be received which is used to shape future Network events, masterclasses to accelerate adoption and learning of QI in the system.	On track.
ICB QI capability and capacity building plan.	• Scoping work has been completed. HWE QI offers for building capability and capacity within the ICB and across system for our staff, smaller providers and primary care are in place. • 'HWE QI approach': Introduction to QI training offer commenced in December 2024 as a test pilot. We have delivered the 2 test waves of training to the Nursing and Quality directorate and a monthly QI training planner was launched fully from January 2025. Currently a total of 35 staff have been trained across HWE ICS, with 28 trained staff from HWE ICB and we are on target to achieve our 10% ICB goal for year 1 (2025/26) on QI delivery plan.	In progress.

Safeguarding All Age

Theme	Issue and Impact	Mitigating Action	Status
Disproportionate suicides amongst Care Leavers in Hertfordshire. The ICB has a Corporate Parental responsibility in regard to the Children and Social Work Act, 2017.	• Looked After Children are disproportionately diagnosed with enduring mental health concerns. • ICB analysis findings suggests greater preventative health interventions can help reduce the experience of mental impact and possible suicides.	• The suicide prevention team will be included in all statutory reviews. Multiagency actions agreed and will be shared with the next escalation report. • The HWE ICB safeguarding team are asking the Board to endorse the Corporate Parenting Board's proposal for Care Leaver to become a Protected Characteristic.	In progress.
Ongoing increased reporting of Domestic Abuse and Domestic Abuse Related Deaths including Domestic Homicides.	• More than 85% of all child protection cases are linked to domestic abuse. • Inextricable links to preventable deaths and health inequalities and adverse childhood experiences. • There are gaps in primary care response to domestic abuse.	• Multiagency strategy is in place to support the identification of cases and referrals. Work is ongoing to strengthen gaps between preventable deaths strategic plan and Violence Against Women and Girls implementation requirements. • Strategic focus on strengthening arrangements to tackle domestic abuse via the newly created children and young people Domestic Abuse Board.	In progress.
National Child Mortality Database reports - 28% increase in unexpected Child Deaths across HWE ICB.	Links have been made to indices of deprivation, ethnicity, domestic abuse and smoking.	The Child Death Review process supporting ongoing public health campaigns, safer sleeping, bed poverty, parental smoking and maternal obesity.	In progress.

Infection Prevention and Control (IPC)

Area	Issue	Mitigating Action	Timescale
C.diffIcile (C. diff).	Nationally, C. diff cases are above pre-pandemic levels and rising. In 2024, the United Kingdom reported the highest number of cases for 13 years. This has now been declared as a national incident. At the end of February 2025, HWE ICB, WHTHT and PAHT reported cases above their NHSE ceilings for this point in the year with ENHT reporting to be under their ceiling. However, all three place bases and WHTHT have infection rates below that of the East of England. ENHT and PAHT reporting to be above that of the region.	• Next healthcare associated infection (HCAI) oversight group meeting will be attended by all 3 place. Agenda focus on C.diff and revisit system wide action plan. • Plan for ENHT case reviews to include primary care. • Case reviews for community C. diff infections collated and analysed. However, ICB IPC team has limited access to community patient data. • In conjunction with the ICB Antimicrobial Stewardship Lead, a focused discussion took place at May's Committee, reviewing data analysis and case studies involving C.diff and antimicrobial prescribing.	Ongoing.
IPC and Winter Pressures.	The infectious diseases annual report shows that infectious diseases were the primary reason for over 20% of hospital bed usage. As of 4th April, national data indicates that the rate of hospital admissions with confirmed SARS-CoV-2 remains stable and below baseline. Influenza A activity continues to slowly decrease and is at baseline levels and Influenza B activity remains stable and is above baseline. Cases of norovirus have also decreased but remain elevated. This reflects a similar picture that is being reported locally with no respiratory or gastrointestinal outbreaks being reported within the acute hospitals, at the time of writing the report. This has eased the system pressure issues on bed closures for IPC reasons.	• Increased IPC collaboration with HWE System Co-ordination Centre (SCC). Training session for HWE on call managers covering High Consequence Infectious Diseases (HCID), Infectious Diseases (ID) and Outbreak Procedure Cards. • HCID and ID and Outbreak Procedure cards to be updated following the derogation of clade 1 mpox (no longer meets the criteria of a HCID). • IPC weekly outbreak spreadsheet sent to SCC and system partners to act as an early warning system. • SHREWD (cloud-based application) access for IPC team to support Trust IPC teams with IPC bed closures daily. • Gap analysis undertaken on new NHSE Commissioning guidance for ICBs on the clinical response to local incidents and outbreaks of infectious disease. • Trust assurances provided regarding IPC compliance. • IPC support to care homes with outbreaks and to support and facilitate hospital discharges.	To be closed.

Mental Health - Children's

Area	Issue and Impact	Mitigating Actions	Timescale
HPFT. **Eating Disorder and Children's and Adolescent Mental Health Services (CAMHS), Community.**	• Increasing wait times to both urgent and routine eating disorder and CAMHS community pathways, in line with national picture. • HPFT waiting times have been driven by increasing complexity and acuity (eating disorder) and staff shortages (ED and CAMHS).	• Oversight and support in place with commissioners. • Mitigating actions in place with improvements being made in line with needed trajectories. • ED improvement trajectory is to reach close to 100% by the end of Q2 2025/26. • CAMHS community recovery trajectory by December 2025 for all areas.	Ongoing. Q2 2025/26. December 2025.

Learning from Lives and Deaths - People with a Learning Disability and Autistic People (LeDeR)

Area	Issues and Mitigating Actions	Mitigating Action	Timescale
HWE.	• Learning Disability Annual Health Checks (AHC) are not always taken up by the most vulnerable. Quality of LD AHCs is variable and heath action plans (HAP) are not always evidenced. In Hertfordshire not all practices take up targeted offers of support.	• West Essex Learning Disability AHC Forum looking into uptake of AHCs of 14–17-year-old and improving quality of AHCs and HAPs moving forwards. • Hertfordshire AHC data shows increased delivery in 2024-25, indicating positive impact on engaging those not attending for AHC, through the work of the Health Equality Nurses. End-of-year data will be reviewed and identify gaps and practice engagement. • Increase in 14-17-year-old uptake in Hertfordshire. Targeted actions to boost uptake and improve AHC and HAP quality continue.	March 2026. May/June 2025. March 2026.
HWE.	• LeDeR reviews have highlighted that lack of flexibility of access to services can impact on risk of poor health outcomes. E.g., a lack of reasonable adjustments.	• New Information Standard notice requiring action by all system partners to implement reasonable adjustment digital flag. • Task and finish group established with Integrated Care System leads for assurance of digital flag checklist to achieve compliance across organisations. Opportunity to support services to be better informed. There is an opportunity to undertake national training.	December 2025.
HWE.	• We Deserve Better Report released in summer 2023 highlight people from diverse backgrounds are dying earlier.	• 'Improving health outcomes for people who have a learning disability and/or autism from Global Majority Communities' group is led by Hertfordshire County Council. There are 4 workstreams. Hertfordshire and SET LeDeR Programme are supporting a workstream each demonstrating a joint learning commitment.	June 2025.

Maternity and Children's

Area	Issues and Overview	Mitigating Action	Timescales
HWE Special Educational Needs and Disability (SEND) Sufficiency.	• Emerging and increasing issue linked to the number of special school places being increased in parts of Hertfordshire and West Essex (WE). • Additionally satellite special schools are in the planning and progress on inclusion. • These in turn place pressure on the nursing, therapy and paediatric input for these children. • At present, requirements for expansion (much of which comes into effect in September 2025) cannot be fully supported by our current capacity.	• HWE ICB commissioners are working with Local Authorities and providers to understand the impact and mitigating actions.	Ongoing.
Essex Neuro-diversity.	• Strategic approach for Essex was raised at the Essex SEND Joint Commissioning Group and was met with a request for further work-up. • Interest from Essex Councillors regarding Attention Deficit Hyperactivity Disorder (ADHD) medication and changes to GP prescribing which is being managed by ICB WE commissioner.	• West Essex continues to operate with a demand capacity gap although are managing longest waiters well. • Health Care Resourcing Group (HCRG) and commissioners are looking into the potential of applying the Portsmouth tool for identifying neurodiversity. • Mid and South Essex ICB and Suffolk and North - East Essex ICB include ADHD medicines management information on their websites. HWE have requested to share this information on HWE ICB website so that Councillors can be signposted.	Ongoing.

Local Maternity Neonatal System – LMNS

Area	Issues and Overview	Mitigating Action	Timescale
Maternity Care - Antenatal, Intrapartum and Postnatal Out of Area.	• Within HWE Integrated Care System, no ability to share patient records due to lack of electronic patient record systems inoperability. • No access to patient information from out-of-area. • Identified as a theme from National Patient Safety Incident Investigations – a contributory factor resulting in neonatal mortality.	• Partnership work is underway to mitigate digital risks. • LMNS now linked in with Shared Care record Team, this will mitigate some issues but not all. • LMNS are modelling new ways of delivering care across border. • Safety actions have been set and are being tracked and progressed through the LMNS Quality and Safety Forum.	Ongoing.
PAHT.	• PAHT has successfully moved towards exiting from the National Maternity Services Support Programme, the National Board will review in June formally the position. PAH maternity services remain challenged with Digital development and data linked to new patient record system, IPC, and Quality Improvement issues.	• LMNS to provide enhanced oversight in the form of more regular touchpoints, including meetings and site visits. • LMNS Digital Midwife to support data challenges. LMNS to ease pressure by supporting QI and limiting assurance asks to essential/nationally mandated asks only for Quarter 1. • LMNS linking with IPC for oversight of issues and offer support.	Ongoing.
Digital.	• New electronic patient record system implementation at PAHT has caused challenges in reporting clinical quality data. • Reduced oversight of quality metrics on LMNS dashboard. • ENHT have experienced similar challenges with improvements being made.	• LMNS and regional digital leads supporting PAHT to resolve issues. • Added to PAHT risk register and will escalate any current areas of concern directly to LMNS Quality and Safety Lead. • Resolution at ENHT cannot be shared to support PAHT as digital electronic patient record systems are in place. • Providers have shared verbal updates on quality metrics and key performance indicators. • Aiming for resolution by May 2025.	May 2025.

Assurance and Oversight - Acute and Urgent Care

Area	Risk	Mitigating Action	Timescale
Never Events - ENHT.	February 2025. Misplace nasogastric (NG) tube.	• Duty of Candour completed with family. • A rapid review of the care has been carried out with clinical teams from relevant wards. • After Action Focus planned with all specialities involved in the care. • Use of NG Care bundle - incident shared with ward team to ensure NG care bundle is completed. • Incident to be managed in line with PSIRF.	Ongoing.
WHTHT.	May 2025. Oral rather than intravenous medication administered.	• Patient nursed post-incident with no further complications. • Duty of Candour completed with family. • Incident to be managed in line with PSIRF.	
ENHT Paediatric Audiology.	Ongoing risks due to a range of factors including estates, workforce competency, capacity, with limitations around mutual aid.	• ENHT continue to progress workstreams in a range of areas, supported by both NHSE Region and HWE ICB. Progress remains challenging as referrals continue and waiting lists continue to rise with limited specialist workforce. • Regular review of pathway development status to support opening of further pathways. Hearing Aid pathway opened March 2025 and Auditory Brainstem Response pathway opened in May 2025. • System mutual aid and levelling up discussions being held in addition to wider mutual aid discussions regionally and nationally. Limited mutual aid available. • Current timeline for ENHT under 3s is Spring 2026 due to required estates work.	Ongoing. May 2025. Autumn 2025.
EEAST Section 29a notice, and regulation breaches (17 and 12) issued by Care Quality Commission (CQC).	If EEAST do not meet needed CQC standards there is a risk of poor patient outcomes and experience with impacts on staff.	• Regional commissioner SNEE ICB continues to work with EEAST under enhanced quality assurance review process and improvement position. HWE ICB continues to participate in Rapid Quality Review Meetings led by SNEE ICB, alongside EEAST's Director of Quality and key partners including CQC and NHS England. • Progress evidenced in mandatory training, call waiting times, and medicines management. • Longer-term actions around Emergency Operations Centre staffing, cultural improvements, and incorporating staff feedback to remain under review through Rapid Quality Review and routine quality assurance processes.	Ongoing. Complete. Ongoing.

Assurance and Oversight – Adult Mental Health

Area	Issue and Impact	Mitigating Action	Timescale
Compliance with Serious Mental Illness (SMI) Physical Health Checks (Inpatients) completion. **Impact on effective care delivery.**	**EPUT.** 88% physical health check compliance in February 2025, a decrease from 97% in January 2025 (95% target) . **HPFT.** 98.99% physical health check compliance in February 2025. Consistently meeting target of 95% since September 2024**.**	**EPUT.** • Consultants are focusing time in completing gaps in the small number of partially completed (breached) physical health checks. • The drop in compliance with SMI physical health checks will be discussed at the Pan Essex internal assurance meeting.	Ongoing.
Rate of service users with a completed up to date risk assessment.	**HPFT.** 88.74% for February 2025. There has been a month on month decrease since April 2024 where 91.68% was achieved. **EPUT.** 100% for February 2025. Consistently achieved 100% for the last 12 months.	**HPFT.** • Continuous Quality Improvement workshop planned to evaluate progress. • Clinical discussion to take place on the need for risk assessment of people on ADHD and Autistic Spectrum Disorder (ASD) waiting lists.	Ongoing.

Assurance and Oversight - Community

Area	Issue and Impact	Mitigating Action	Timescale
AJM Healthcare – Wheelchair Services.	Delays in equipment provision. Adult and children's health, education and wellbeing, outcomes and end-of-life experiences are being negatively impacted. Some improvement seen over recent months linked to quality and safety.	• Improvement trajectory of June 2025 for 95% of patient caseload to be seen within the 18-week pathway has been agreed, with good compliance to-date. • The ICB multidisciplinary team continue to work closely with AJM for support. • Partnership Quality Visit took place February 2025 focussed on patient safety and clinical effectiveness. AJM and ICB will work collaboratively in achieving evidenced improvements. • March 2025 System Quality Meeting agreed to step down from enhanced to routine quality assurance and improvement, in line with National Quality Board Guidance. • An AJM-led system-wide forum with system partners will be established.	June 2025. September 2025. Complete. June 2025.
Whistleblowing concerns received into the ICB (January to April 2025).	Whistleblowing concerns have been received across provider types, including community and primary care.	• ICB actions taken forward in line with ICB whistleblowing policy. • Appropriate assurances sought from providers, and intelligence triangulated across relevant commissioners and CQC.	Ongoing.

Assurance and Oversight - Primary Medical Care

Primary Medical Care	ICB Place	Inadequate	Requires Improvement	Good	Outstanding	Awaiting publication	Total
	East North Hertfordshire (ENH)	0	4	42	0	1	47
	South and West Hertfordshire (SWH)	0	1	46	1	1	49
	West Essex (WE)	1 (awaiting new rating)	2	24	1	1 (plus 1)	29

Area	Issue	Mitigating Action	Timescale
West Essex (WE) Practice.	Currently rated Inadequate (March 2024). Re-assessed November 2024. Full outcome awaited.	• ICB support provided to address CQC issues raised. • Next steps to be agreed when outcome known.	Ongoing.
South and West Hertfordshire (SWH) Practice.	Warning notice (January 2025) received following CQC assessment in December 2024. Full outcome awaited.	• Practice received draft report and sent back factual accuracy comments. • ICB support provided to address CQC issues raised.	Ongoing.
West Essex (WE) Practice.	Re-assessed by CQC in June 2024. Warning notice issued for Regulation 17 Rated Requires improvement overall with Inadequate for Safe (Report published March 2025).	• Support being provided by ICB teams with addressing CQC issues raised.	Ongoing.
All Practices in Hertfordshire and West Essex.	There is a risk that practices are yet to be identified as not meeting the required quality standards.	• Resilience Index Tool used in risk and information sharing meetings, with targeted support offers to reduce risks. • Pilot ICB Contract Quality review or visit rolling programme commenced April 2025. All Practices will receive a desk top review with decision to visit tailored to risk and need. • Pilot CQC assessment preparation support pilot commenced April 2025.	Ongoing.

Assurance and Oversight - Care Homes

System Care Home Overview *further detail provided in the Quality Dashboard*					
CQC	3 Inadequate	52 Requires Improvement	207 Good	10 Outstanding	26 Not Yet Rated
PAMMS	14 Poor	56 Requires Improvement	142 Good	16 Excellent	28 Not Yet Rated

Area	Issue	Mitigating Action	Timescale
East and North Hertfordshire.	2 care homes are in a Safety Improvement Process (SIP). Quality concerns relate to: • Consistency in management oversight, audits and governance. • Feeding and nutrition. • Leadership, consistency in management. • Medication management. • Impact - service provision, resident experience, safety.	• Regular visits in place from across the ICB multidisciplinary teams to support improvement requirements and oversight. • Hertfordshire Care Providers Association (HCPA) are supporting with training. • Improvement progress is being made against action plan in key areas, to support de-escalation planning. • Admission embargos have been partially lifted for both homes.	Ongoing.
South and West Hertfordshire.	1 care home is in a Safety Improvement Process. Quality concerns relate to: • Not embedding safety processes competently. • Poor attitude to Duty of Candour. • Poor leadership. • Not responsive to improvement actions.	• Regular visits in place from across the ICB Multidisciplinary teams to support improvement actions and oversight. • Admission embargo is in place.	Ongoing.
West Essex.	1 care home is in a formal safeguarding process. Quality concerns relate to: • Severity of falls injuries • Poor quality investigation and audit processes • Slow action progression	• Home placed into suspension of admissions. • Regular visits in place from across the ICB. Multidisciplinary teams to support improvement actions and oversight.	Ongoing.
South and West Hertfordshire.	2 supported living providers are in a SIP, 1 is in Quality Assurance Meeting. • Consistency in management oversight, audits and governance. Impact - service provision, resident experience and safety.	• ICB Care Home team supporting County Council led System Wide Intervention Meeting (SWIM) for oversight and assurance. • Providers working with HCPA for training support.	Ongoing.

Acronyms

A&E	Accident and Emergency
ADHD	Attention Deficit Hyperactivity Disorder
AHC	Annual Health Checks
ASD	Autism Spectrum Disorder
ATLS	Advanced Trauma Life Support
CAMHS	Children and Adolescent Mental Health Service
CQC	Care Quality Commission
EEAST	East of England Ambulance Service NHS Trust
ED	Emergency Department
ECF	Enhanced Commissioning Framework
ENH	East and North Hertfordshire
ENHT	East and North Hertfordshire NHS Trust
EPUT	Essex Partnership University NHS Foundation Trust
GP	General Practitioner
HAP	Health Action Plan
HCPA	Hertfordshire Care Providers Association
HCRG	Health Care Resourcing Group
HCID	High Consequence Infectious Disease
HCT	Hertfordshire Community NHS Trust
HES	Hertfordshire Equipment Service
HPFT	Hertfordshire Partnership University NHS Foundation Trust
HSCP	Health and Social Care Partnership
HWE	Hertfordshire and West Essex
ICB	Integrated Care Board
ICS	Integrated Care System
ID	Infection Disease
IPC	Infection Prevention and Control
LD	Learning Disability
LFPSE	Learning from Patient Safety Events
LMNS	Local Maternity and Neonatal System
MCA	Mental Capacity Act
ME	Medical Examiner
MHST	Mental Health Support Team
Mpox	Clade I Mpox Virus
NE	Never Event
NG	Nasogastric
NHS	National Health Service
NHSE	NHS England
NELFT	North East London NHS Foundation Trust
OOA	Out of Area
PAHT	Princess Alexandra Hospital NHS Trust
PALS	Patient Advice and Liaison Service
PSII	Patient Safety Incident Investigation
PSIRF	Patient Safety Incident Response Framework
PSP	Patient Safety Partners
QI	Quality Improvement
SARC	Sexual Abuse and Rape Crisis
SCC	System Coordination Centre
SEIPS	System Engineering Initiative for Patient Safety
SEND	Special Education Needs and Disabilities
SET	Suffolk, Essex and Thurrock
SIP	Safety Improvement Process
SOP	Standard Operating Procedure
SMI	Serious Mental Illness
SNEE	Suffolk and North East Essex
STEIS	Strategic Executive Information System
STQI	System Transformation and Quality Improvement
SWH	South and West Hertfordshire
SWIM	System Wide Intervention Meeting
WE	West Essex
WHTHT	West Hertfordshire Teaching Hospitals NHS Trust

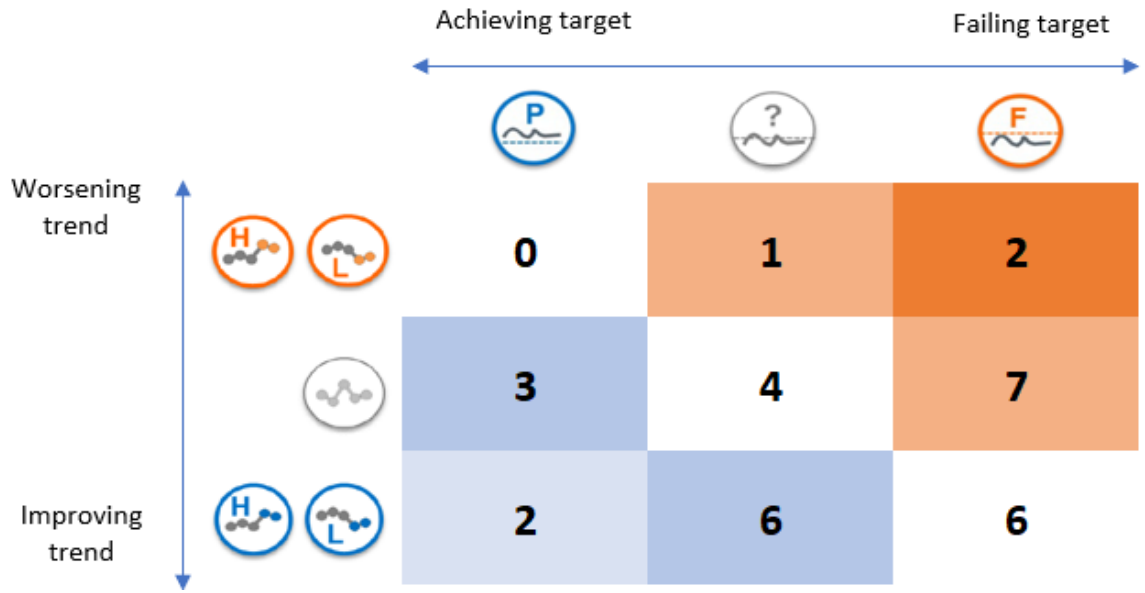
Hertfordshire and West Essex Integrated Care System

HWE ICS Performance Report

May 2025

Working together
for a healthier future

Executive Summary: KPI Risk Summary



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

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

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

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

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

High Risk	Programme
Ambulance Handovers	UEC
18 Week RTT	Elective
6 Week Waits	Diagnostics
Ambulance Response Times	UEC
Out of Area Placements	Mental Health
CAMHS 28 Day Standard	Mental Health
Community MH - CYP Waits for 1st Appt	Mental Health
ADHD	Community

Moved to lower risk category | Moved to higher risk category | No change to risk category

Executive Summary

URGENT CARE	**4 Hour Performance**	**Region: HWE better than average**	**National: HWE better than average**

- NHS 111 abandoned call performance continues on an improved trend with performance meeting standard;
- Cat 2 ambulance response times continue to reduce and reached 34 minutes in March; although the best performance since June 21, times remain outside the national 30-min std and are longer than regional average;
- Hours lost to handover has improved significantly since January; performance is on a variable trend, close to the fair shares handover target and has moved from highest to high risk category;
- 4 hour ED performance continues on a variable trend and improved to 77% in March; this is the best since June 21 and better than national and regional average, moving from variable to low risk. Improvements have been made across all 3 places with the biggest improvement seen in West Essex.

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

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

DIAGNOSTICS	**6 Week Waits**	**Region: HWE worse than average**	**National: HWE worse than average**

- The overall PTL continues to increase and is far higher than the historic mean. Excluding paediatric audiology, diagnostic performance continues on an improved trajectory although has declined since Dec. There remains significant challenges to paediatric audiology with variation by Trust; a return to reporting of the challenged service at ENHT in June 24 saw a step change decline in performance. Overall diagnostic performance has improved however moving from a declining to variable trend and from highest to high risk.

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

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

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

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

CHILDREN	**Various**	**Community 18 Week %: HWE worse than national**	**Community MH 1st Appts: HWE better than national**

- The number of children on community waiting lists remains very high with children's community waits continuing as an area of highest risk. Waits over 52 weeks increased in Feb to 4,396.
- 18 week % for children's community waits remains largely the same at c37% which is below the national average of c50%. The main pressures continue to be Community Paeds, Therapies and Audiology;
- Autism Spectrum Disorder (ASD) waiting lists and times continue to grow as funding/investment remains unresolved continuing as an area of highest risk. ADHD services are also high risk due to rising demand & waits;
- The 28-day CAMHS access standard in Hertfordshire has not been achieved since 2021. Performance has seen some recovery to 61% in March 2025 moving to a variable trend. Vacancy rates continue to impact;
- Children's waits for a Community MH 1st appointment decreased to 125 days in Feb and continue to better the national average (253 days); there remains variation across the system.

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

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

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

- There has been sustained improvement in the % of gp appts seen on same day, remaining at low risk. The % seen within 14 days continues along the mean and is marginally below this year's plan of 89%;
- CHC assessments <28 days have continued to see significant improvements and met the 80% standard for the first time in Feb. Moving from variable to low risk, performance is better than regional & national average.

Executive Summary: Performance Benchmarking by Provider / Place

February 2025

Hertfordshire and West Essex ICB (PROVIDERS)

Area	Activity	Data Published	East and North Herts Trust	Trend Against Last Month	Position Against National	Position Against Region	Provider Ranking	West Herts Teaching Hospital Trust	Trend Against Last Month	Position Against National	Position Against Region	Provider Ranking	The Princess Alexandra Hospital Trust	Trend Against Last Month	Position Against National	Position Against Region	Provider Ranking
A&E	% Seen Within 4 Hours (with additional mapped activity)	March 25	76.28%	✓ 5.23%			50	81.88%	✓ 2.505%			18	72.04%	✓ 9.163%			80
	% >12hr Waits in ED From Arrival	March 25	11.76%	✓ -39.15%			74	8.51%	✓ -10.92%			49	7.61%	✓ -21.42%			45
Cancer	28 Days Faster Diagnosis	February 25	79.16%	✓ 8.796%			89	87.10%	✓ 9.94%			18	75.18%	✓ 11.63%			123
	31 Days Standard	February 25	96.99%	✗ 0.47%			46	97.44%	✓ 0.01%			41	90.63%	✓ 3.74%			111
	62 Days Standard	February 25	79.62%	✗ -7.87%			30	79.88%	✓ 2.35%			29	54.11%	✓ 7.60%			131
RTT	Incomplete Pathways <18 weeks	February 25	62.38%	✓ 1.98%			57	61.07%	✓ 0.46%			65	44.49%	✓ 0.40%			151
	52+ Weeks as % of Total PTL	February 25	1.63%	✓ -8.63%			81	2.03%	✗ 0.20%			82	4.70%	✗ 11.52%			137
	65+ Weeks as % of Total PTL	February 25	0.05%	✓ -20.57%			78	0.00%	– 0.00%			27	0.09%	✓ -89.57%			91
	78+ Weeks as % of Total PTL	February 25	0.00%	– 0.00%			54	0.00%	– 0.00%			27	0.00%	– 0.00%			62
Diagnostics	% Waiting 6+ Weeks	February 25	47.58%	✓ -15.13%			149	8.22%	✓ -48.61%			58	32.58%	✓ -14.47%			136
	Activity	**Data Published**	**East and North Herts (06K)**	**Trend Against Last Month**	**Position Against National**	**Position Against Region**	**Provider Ranking**	**South and West Herts (06N)**	**Trend Against Last Month**	**Position Against National**	**Position Against Region**	**Provider Ranking**	**West Essex (07H)**	**Trend Against Last Month**	**Position Against National**	**Position Against Region**	**Provider Ranking**
Mental Health	Dementia Diagnosis Rate	February 25	62.5%	– 0.00%			78	62.8%	✗ -0.16%			75	73.8%	✗ -0.41%			14
	Out of Area Placements	February 25	26	✗ 23.08%	n/a	n/a	n/a	26	✗ 23.08%	n/a	n/a	n/a	11	✓ -36.36%	n/a	n/a	n/a
CHC*	% of Eligibility Decisions Made Within 28 Days	February 25	78.6%	✓ 12.12%	72.47%	72.47%	76	90.6%	✓ 22.24%	84.48%	84.48%	51	75.0%	✓ 4.76%	69.51%	69.51%	80
	% of Assessments Carried Out in Acute Settings	February 25	0.0%	– 0.00%	0.00%	0.00%	61	0.0%	– 0.00%	0.70%	0.70%	94	0.0%	– 0.00%	0.00%	0.00%	64

LEGEND

Performance against National/Regional
- Better
- Worse

Performance against previous month
- ✓ Improvement
- ✗ Deterioration
- – No change

Provider Ranking
- First quartile
- Middle quartile
- Lowest quartile

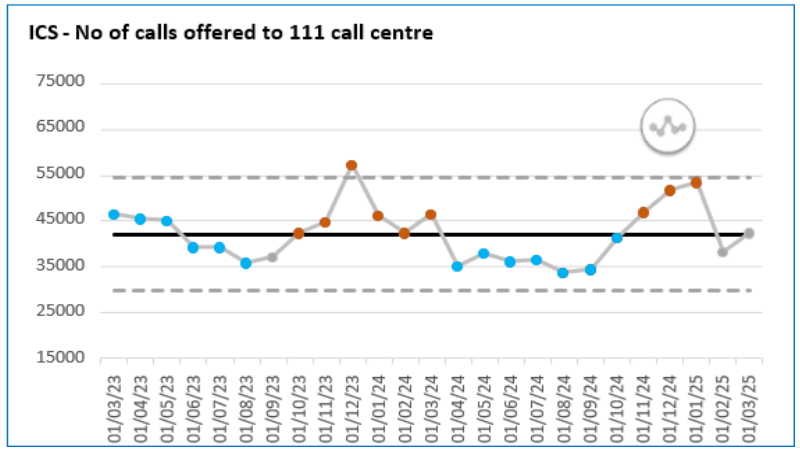
Note: this summary will be updated in the next report to reflect the priorities in the 25/26 planning guidance. Review of primary care and community data also underway to include in future reports.

Performance by Work Programme

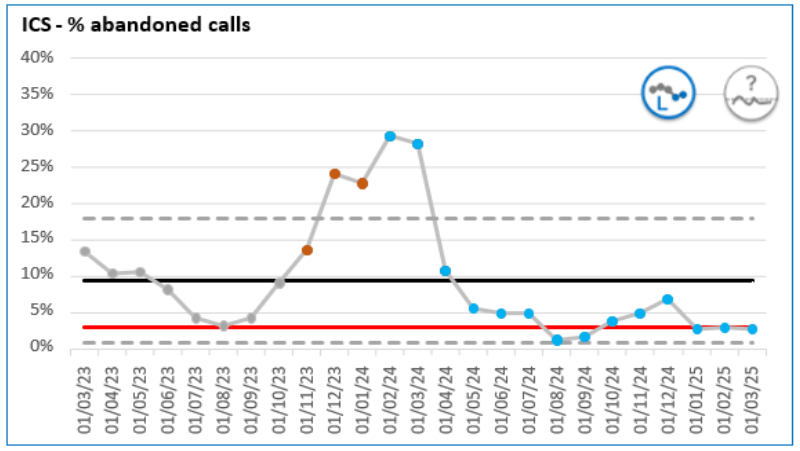
Click link to relevant slides:

Slide 6: NHS 111
Slide 7: Urgent 2 Hour Community Response
Slide 8: Ambulance Response & Handover
Slide 9: Emergency Department
Slide 10: UEC Discharge & Flow
Slide 11: Planned Care
Slide 13: Diagnostics
Slide 15: Cancer
Slide 17: Mental Health
Slide 26: Autism Spectrum Disorder (ASD)
Slide 29: Attention Deficit Hyperactivity Disorder (ADHD)
Slide 31: Community Wait Times
Slide 35: Community Beds
Slide 37: Integrated Care Teams
Slide 39: Continuing Health Care
Slide 40: Primary Care
Slide 42: Appendix A, Performance Benchmarking (ICB)
Slide 43: Appendix B, Statistical Process Control (SPC) Interpretation
Slide 44: Appendix C, Glossary of Acronyms

NHS 111



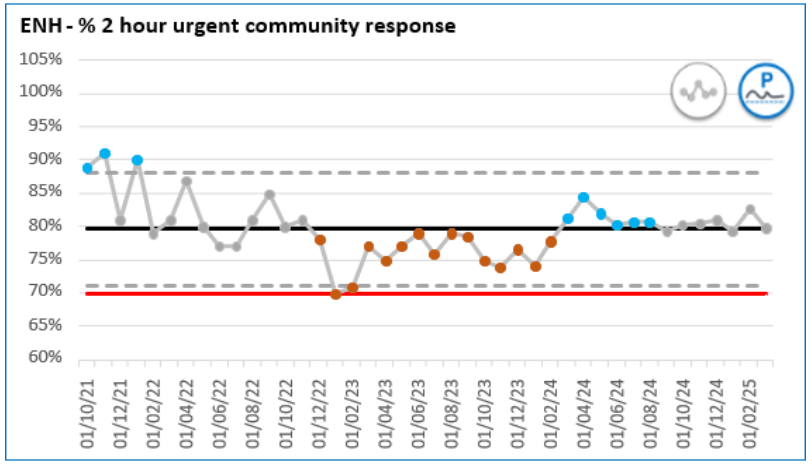
	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Hertfordshire	38,664	36,171	37,120	37,559	31,770	28,488	34,210	35,506	55,508	33,429	32,688	37244	36,476	36,129	31,480	31,479	28,904	29,880	33,785	35,612	45,507	36,827	34,131	37,204	28,074	30,234	28,840	29,230	27,032	27,624	32,962	35,222	41,099	33,636	30,149	33,899
West Essex	0	0	0	0	0	0	0	0	0	0	461	9152	9,161	8,991	7,783	7,647	6,885	7,210	8,453	9,158	11,641	9,210	8,361	9,394	6,986	7,574	7,136	7,334	6,600	6,752	8,233	8,822	10,770	8,673	7,981	8,632
ICS	38,664	36,171	37,120	37,559	31,770	28,488	34,210	35,506	55,508	33,429	33,149	46,396	45,637	45,120	39,263	39,126	35,789	37,090	42,238	44,770	57,148	46,037	42,492	46,598	35,060	37,808	35,976	36,564	33,632	34,376	41,195	46,767	51,869	42,309	38,130	42,531

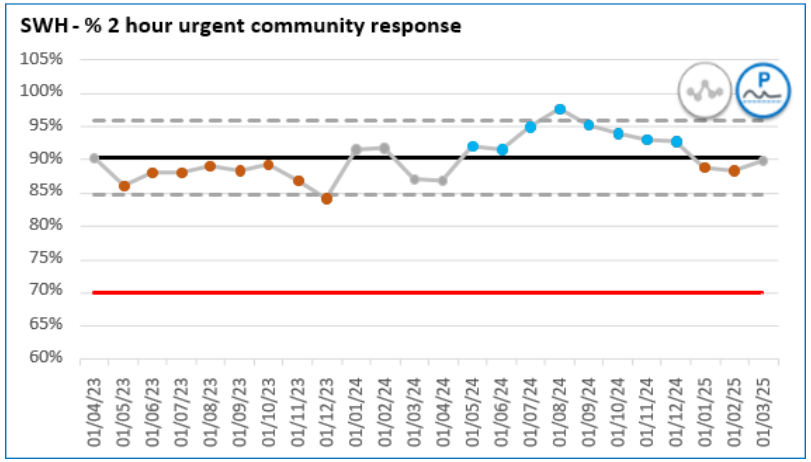


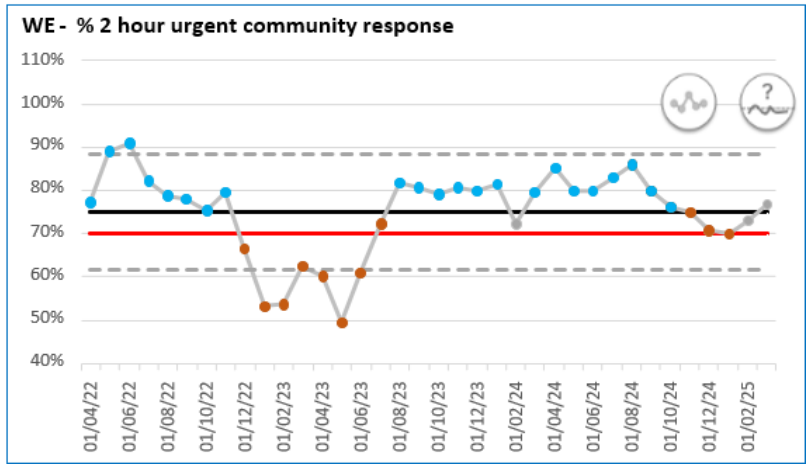
	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Hertfordshire	7.8%	7.4%	10.3%	15.0%	35.4%	5.6%	10.5%	8.1%	42.7%	13.8%	12.7%	13.0%	10.2%	10.3%	8.2%	4.3%	3.2%	4.2%	9.3%	13.7%	24.4%	23.3%	29.8%	28.1%	10.8%	5.6%	5.0%	4.9%	1.3%	1.6%	3.8%	5.2%	6.9%	2.8%	2.9%	2.8%
West Essex	8.5%	9.4%	11.8%	18.5%	38.5%	6.2%	11.8%	9.6%	46.2%	16.2%	13.9%	14.7%	10.9%	12.1%	8.7%	4.7%	3.3%	4.8%	8.6%	13.6%	23.5%	21.2%	28.2%	29.2%	11.5%	5.3%	4.7%	5.0%	1.3%	1.6%	3.9%	4.7%	7.2%	2.5%	2.6%	2.5%
ICS	7.8%	7.4%	10.3%	15.0%	35.4%	5.6%	10.5%	8.1%	42.7%	13.8%	12.7%	13.4%	10.3%	10.6%	8.3%	4.3%	3.2%	4.3%	9.2%	13.7%	24.2%	22.9%	29.5%	28.3%	10.9%	5.6%	5.0%	4.9%	1.3%	1.6%	3.8%	5.1%	6.9%	2.8%	2.9%	2.7%

ICB Area	What the charts tell us	Issues	Actions
HUC	• Call volumes have reduced from the peaks seen in winter and are within expected common cause variation limits • Abandoned call rates are consistently achieving the <3% standard	• Occasional intermittent telephony issues delaying staff availability to accept calls during February – business continuity and national contingency measures enacted • Average handing time impacted, with longer average hold times for clinical advice	• New Operational Delivery Manager (ODM) role proactively managing all elements of the 111 service, challenging AHT and productivity in real time • Non-Clinical Floor Walkers (NCFWs) continue to be directly accessible for all pathways queries before clinical input • Workshops for all Health Advisors to support improvement of individual performance, which overall improves KPI performance • HUC-wide rota patterns under review due to address continued issues with weekend rota fill. Project plan in place with senior management and workforce planning teams to agree next steps

Urgent 2 Hour Community Response (UCR)





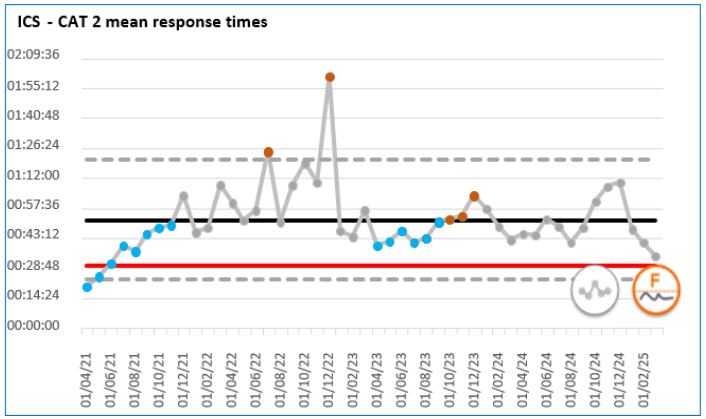


Referrals	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
West Essex	412	397	416	391	461	386	454	511	483	558	724	629	636
East & North Herts	707	736	691	621	659	676	657	678	717	688	763	583	671
South & West Herts	400	417	423	442	363	352	319	370	414	340	376	506	508

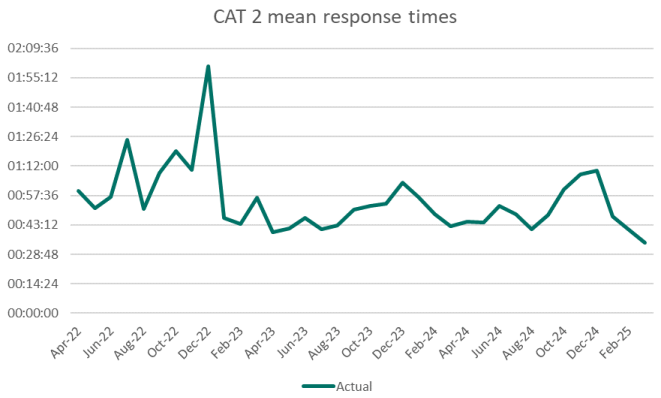
ICB Issues, escalation and next steps

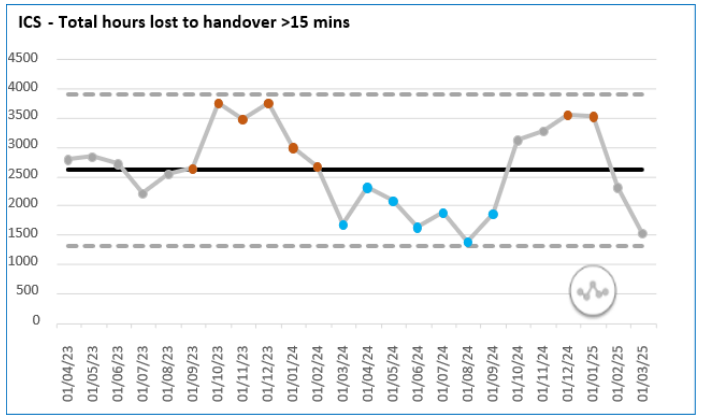
- The ICS and all three places achieved the 70% national standard
- West Essex performance has returned to compliance with improvement seen in each of the last two months
- Notable increase in SWH activity following inclusion of the HAARC vehicle numbers

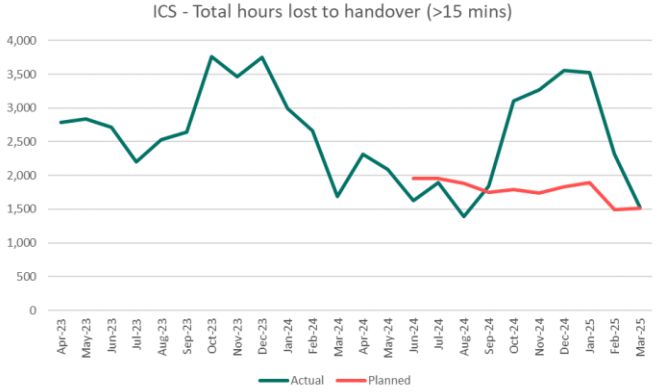
Urgent & Emergency Care (UEC) - Ambulance Response and Handover



Recovery Trajectories







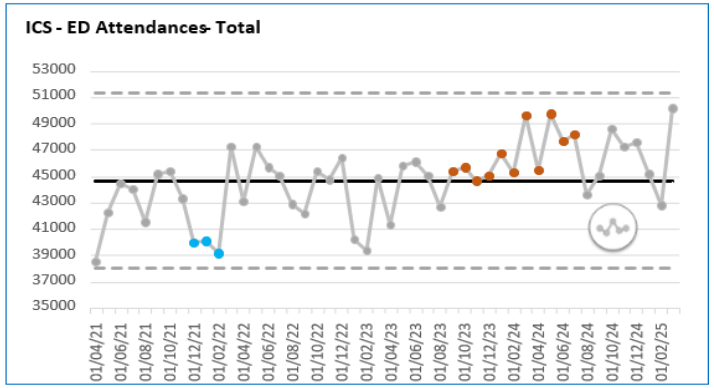
What the charts tell us

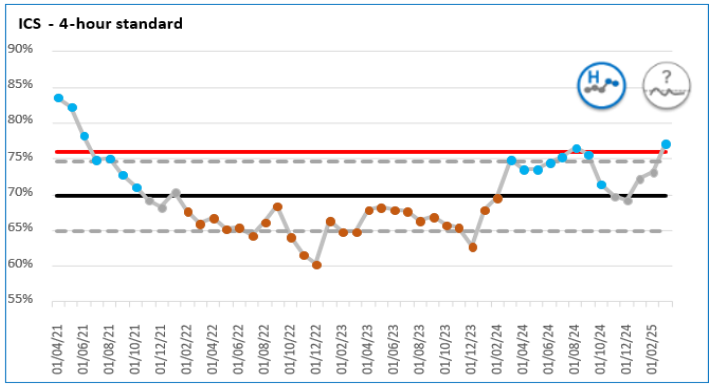
- The mean Category 2 ambulance response time has been reducing over the last four months and reached 34 minutes in March. This remains above the 30 minute target, but is the best performance since Jun-21
- However, mean C2 response times in HWE remain longer than the regional average (Mar-25 = 32 mins)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

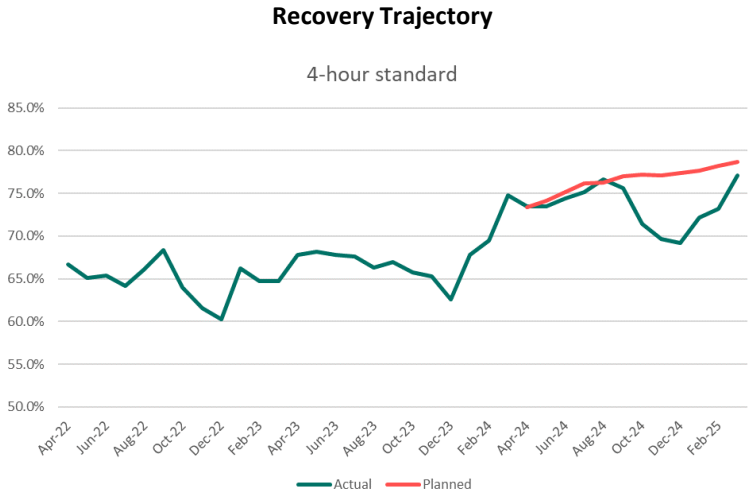
ICB Issues and actions

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

UEC – Emergency Department





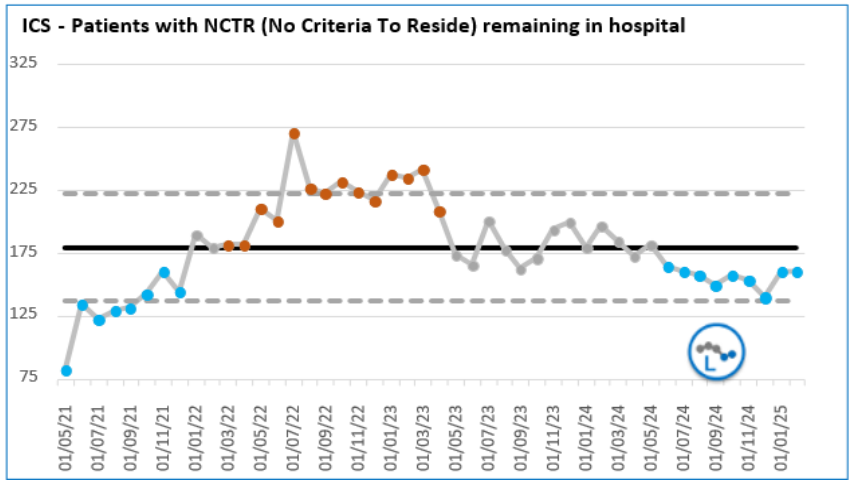


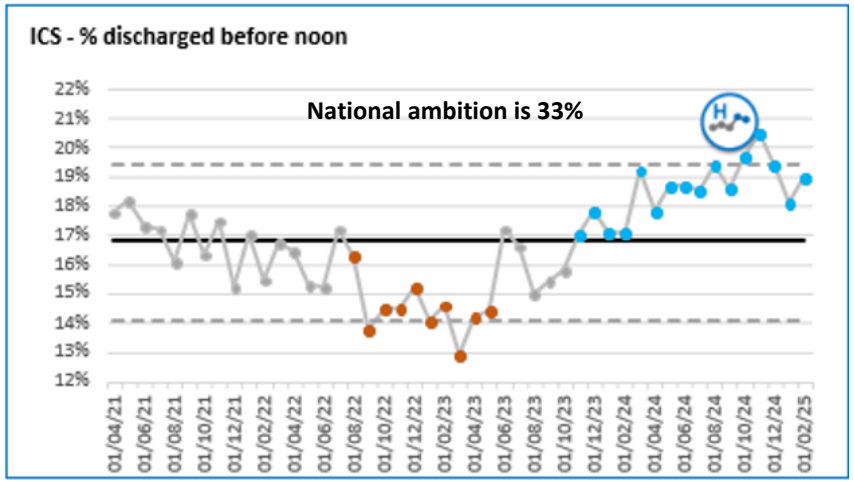
	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
East And North Hertfordshire Place (ENHT and HUC)	17,01	19,00	18,00	18,23	17,11	16,63	17,83	17,42	17,78	15,77	15,35	17,58	15,95	18,22	18,13	17,59	16,63	17,70	17,93	17,65	17,76	17,93	17,92	19,73	18,14	19,71	18,70	19,09	17,26	18,12	19,29	19,13	18,78	17,94	16,81	20,40
West Hertfordshire Hospitals NHS Trust	14,73	15,63	15,63	15,14	14,83	14,13	15,54	15,55	16,66	14,11	13,70	15,73	14,75	16,02	16,07	15,89	14,86	15,96	15,77	15,93	16,15	16,59	15,64	17,28	16,31	17,39	17,14	16,95	15,67	16,34	17,10	16,81	16,88	15,72	14,99	17,18
West Essex Place (PAH and HCT)	11,39	12,57	12,00	11,68	10,89	11,37	11,96	11,80	12,01	10,33	10,31	11,58	10,58	11,52	11,88	11,54	11,20	11,68	12,00	11,08	11,12	12,16	11,67	12,60	10,96	12,58	11,78	12,16	10,95	11,58	12,15	11,29	11,93	11,54	10,93	12,56
ICS	43,13	47,21	45,64	45,06	42,84	42,14	45,33	44,78	46,46	40,22	39,37	44,90	41,29	45,77	46,09	45,03	42,70	45,34	45,70	44,66	45,04	46,69	45,24	49,63	45,42	49,69	47,63	48,20	43,88	46,05	48,55	47,24	47,60	45,21	42,73	50,15

	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
East And North Hertfordshire Place (ENHT and HUC)	70,5%	70,9%	70,1%	67,5%	71,9%	70,7%	68,4%	64,8%	64,9%	69,3%	67,2%	67,6%	70,5%	69,5%	69,2%	70,0%	69,2%	70,8%	68,8%	66,7%	64,6%	70,2%	72,7%	76,2%	72,4%	72,0%	73,1%	72,9%	76,4%	76,2%	71,8%	70,6%	69,7%	72,7%	72,3%	76,3%
West Hertfordshire Hospitals NHS Trust	62,1%	58,2%	60,5%	63,2%	65,0%	70,2%	64,6%	60,2%	60,0%	68,4%	69,0%	68,1%	71,4%	74,1%	73,1%	71,3%	69,1%	69,9%	71,8%	71,4%	67,1%	69,5%	70,8%	78,2%	78,8%	79,8%	82,6%	83,5%	84,2%	81,7%	77,7%	75,9%	76,4%	80,3%	79,8%	81,9%
West Essex Place (PAH and HCT)	66,8%	64,9%	64,6%	60,2%	58,6%	62,7%	56,6%	58,6%	54,0%	58,6%	55,6%	55,9%	58,5%	57,6%	58,6%	59,1%	58,5%	57,1%	53,3%	54,2%	52,7%	61,8%	63,0%	67,9%	67,4%	67,0%	64,6%	65,8%	66,1%	66,2%	61,9%	58,8%	58,4%	60,7%	65,4%	72,0%
ICS	66,6%	65,1%	65,4%	64,1%	66,1%	68,4%	64,0%	61,5%	60,3%	66,2%	64,8%	64,8%	67,8%	68,2%	67,8%	67,7%	66,4%	67,0%	65,8%	65,3%	62,6%	67,8%	69,5%	74,8%	73,5%	73,5%	74,4%	75,2%	76,6%	75,6%	71,4%	69,7%	69,2%	72,2%	73,2%	77,1%

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

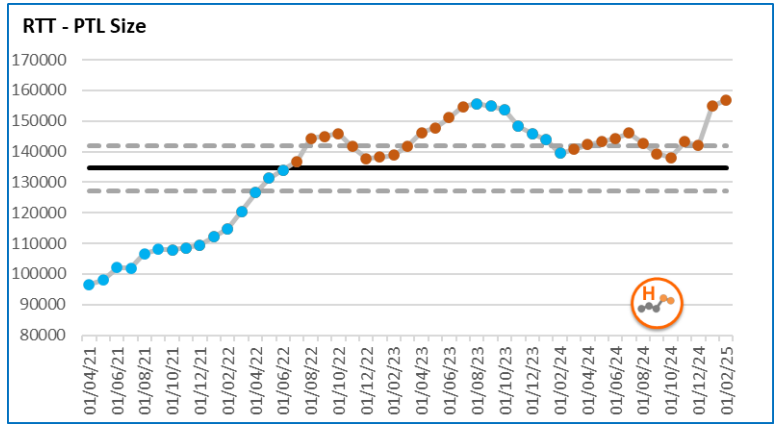
UEC – Discharge & Flow





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

Planned Care – PTL Size and Long Waits



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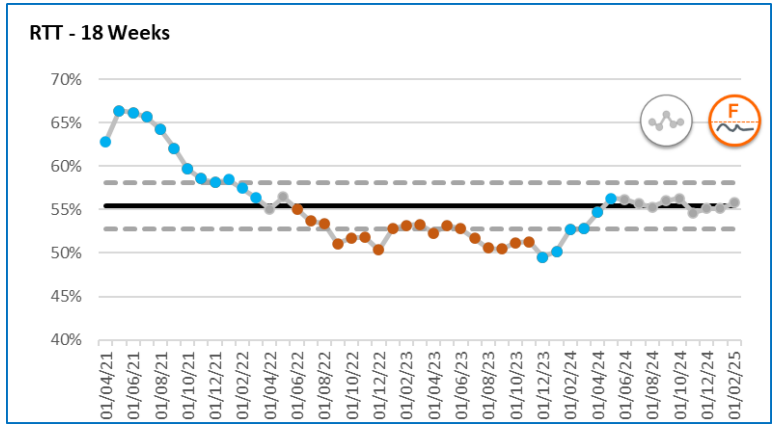
EAST AND NORTH HERTFORDSHIRE NHS TRUST	51259	52241	53993	55737	59979	58006	59917	60713	60999	60488	61406	61782	62296	62295	63245	63592	62958	63472	63258	61909	61208	59807	55116	56022	57103	58098	59050	57780	56594	56322	57704	56276	54355	54726	56552
WEST HERTFORDSHIRE HOSPITALS NHS TRUST	49522	53146	54626	55530	57611	60326	59727	53831	49537	50343	50169	52995	56574	57933	60626	62689	64384	62966	63054	60236	58731	58220	58693	58599	57474	55671	53409	51478	49894	47797	46168	45752	45616	45692	46048
THE PRINCESS ALEXANDRA HOSPITAL NHS TRUST	25780	25862	25287	25573	26759	26623	26237	27093	27172	27408	27247	27012	27372	27523	27137	28442	28312	28341	27426	26056	25991	25767	25715	26067	27687	29389	31928	36850	36248	35131	34188	41199	42062	54423	54245
ICS	126561	131249	133906	136840	144349	144955	145881	141637	137708	138239	138822	141789	146242	147751	151008	154723	155654	154779	153738	148201	145930	143794	139524	140688	142641	143581	144387	146108	142736	139250	138060	143227	142033	154841	156845



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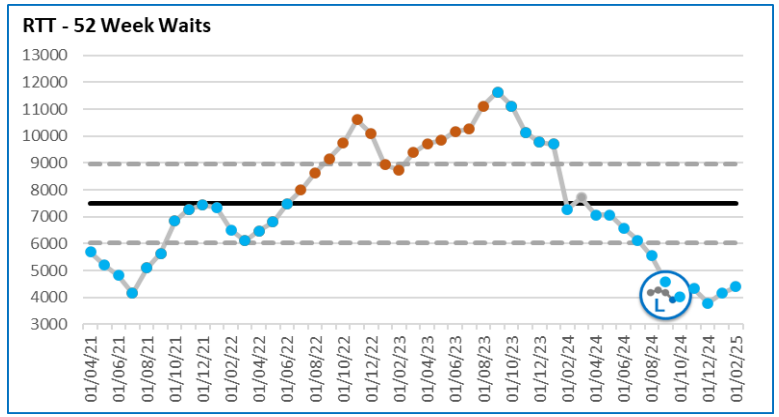
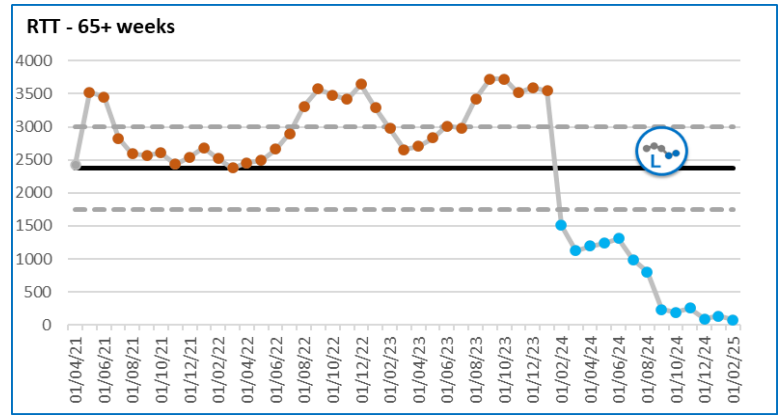
EAST AND NORTH HERTFORDSHIRE NHS TRUST	55.2%	56.9%	55.4%	55.8%	56.6%	53.8%	54.4%	53.9%	50.5%	50.9%	50.9%	49.8%	48.5%	49.9%	49.8%	49.5%	48.8%	49.8%	51.6%	52.2%	50.3%	49.9%	54.2%	55.0%	58.2%	61.0%	60.2%	58.7%	57.3%	58.3%	58.9%	59.2%	59.9%	61.1%	62.4%
WEST HERTFORDSHIRE HOSPITALS NHS TRUST	57.5%	57.9%	56.4%	52.8%	51.0%	48.6%	49.4%	50.1%	51.2%	56.4%	57.4%	58.2%	56.6%	57.0%	55.5%	52.6%	50.8%	49.9%	50.2%	49.9%	48.4%	50.0%	51.4%	51.4%	52.8%	54.6%	55.1%	56.0%	57.4%	58.3%	59.7%	60.5%	61.6%	60.8%	61.1%
THE PRINCESS ALEXANDRA HOSPITAL NHS TRUST	50.4%	52.5%	51.4%	51.1%	51.5%	50.9%	50.9%	50.5%	48.4%	50.3%	50.7%	51.4%	51.9%	52.8%	53.5%	54.5%	54.2%	53.2%	52.6%	52.6%	50.2%	51.1%	52.7%	51.2%	51.2%	50.1%	50.6%	50.8%	49.4%	49.2%	47.2%	41.8%	41.8%	44.3%	44.5%
ICS	55.1%	56.5%	55.1%	53.7%	53.4%	51.1%	51.7%	51.8%	50.3%	52.8%	53.2%	53.3%	52.3%	53.2%	52.8%	51.7%	50.6%	50.5%	51.2%	51.3%	49.5%	50.2%	52.7%	52.8%	54.7%	56.3%	56.2%	55.7%	55.3%	56.0%	56.3%	54.6%	55.1%	55.1%	55.8%



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11
	202223												202324												202425											
THE PRINCESS ALEXANDRA HOSPITAL NHS TRUST	1818	1674	1785	1911	1909	1898	1804	1721	1773	1850	1814	1870	1973	2098	2280	2376	2516	2557	2171	1965	1919	1941	1959	1987	2033	2290	2148	2364	2098	1726	1659	2377	2043	2261	2547
WEST HERTFORDSHIRE HOSPITALS NHS TRUST	1193	1431	1660	1783	2078	2587	3413	4272	3544	2681	2315	2729	2694	2439	2504	2440	2769	2982	3039	2488	2246	2407	2420	2657	2334	2283	2156	1724	1473	1086	822	693	710	924	933
EAST AND NORTH HERTFORDSHIRE NHS TRUST	3473	3699	4027	4294	4628	4688	4527	4618	4778	4404	4618	4797	5064	5308	5400	5450	5831	6097	5912	5684	5612	5350	2909	3078	2696	2502	2283	2048	1978	1759	1554	1254	1045	967	922



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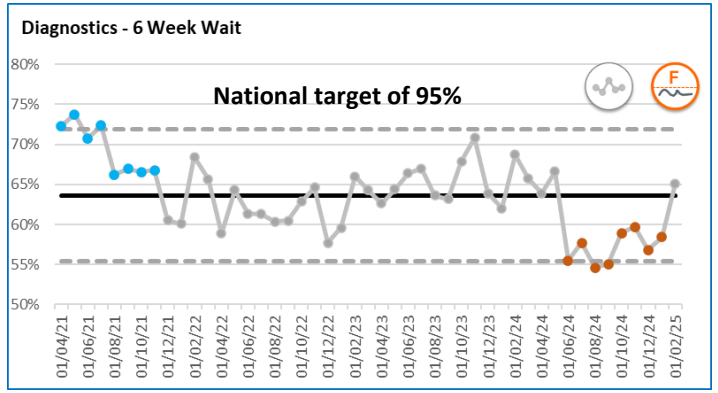
ICS	2453	2493	2666	2901	3314	3575	3479	3420	3645	3293	2977	2659	2709	2832	3013	2983	3425	3722	3727	3515	3596	3545	1508	1127	1198	1239	1307	991	801	235	194	259	95	133	81
THE PRINCESS ALEXANDRA HOSPITAL NHS TRUST	701	679	739	768	765	745	636	572	636	658	592	549	604	707	816	878	955	1018	840	756	830	718	655	519	583	571	596	455	399	162	137	234	61	97	51
WEST HERTFORDSHIRE HOSPITALS NHS TRUST	459	480	499	480	566	680	719	767	831	819	607	548	495	504	524	455	569	636	621	466	434	402	353	245	242	289	343	296	180	3	12	0	0	1	0
EAST AND NORTH HERTFORDSHIRE NHS TRUST	1293	1334	1428	1653	1983	2150	2124	2081	2178	1816	1778	1562	1610	1621	1673	1650	1901	2068	2266	2293	2332	2425	500	363	373	379	368	240	222	70	45	25	34	35	30

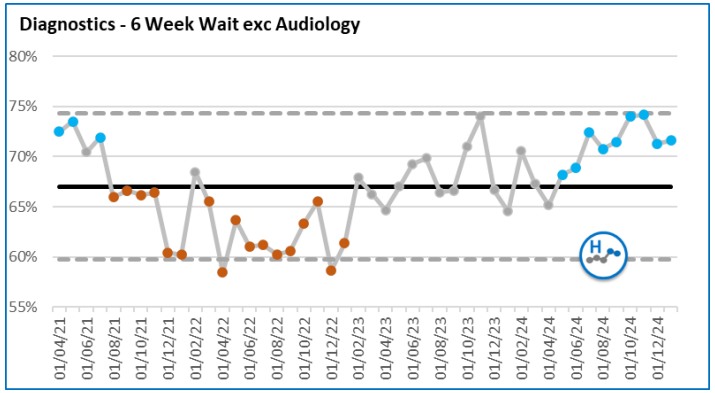
Community Paediatrics patients have been excluded from RTT reporting from February 2024 in line with national guidance
Waiting lists therefore show significant reductions

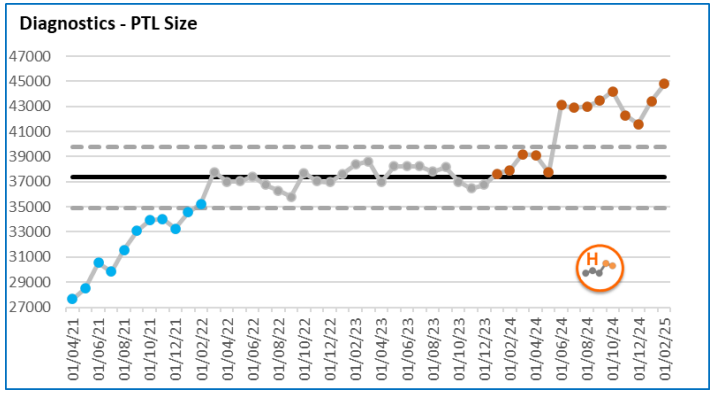
Planned Care – PTL Size and Long Waits

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

Planned Care – Diagnostics







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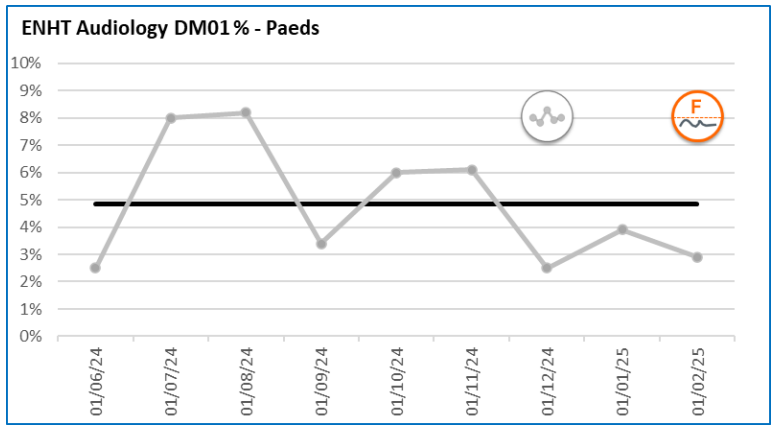
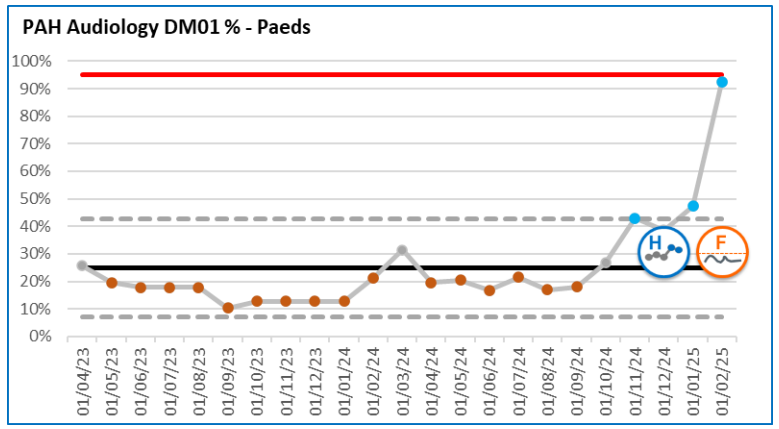
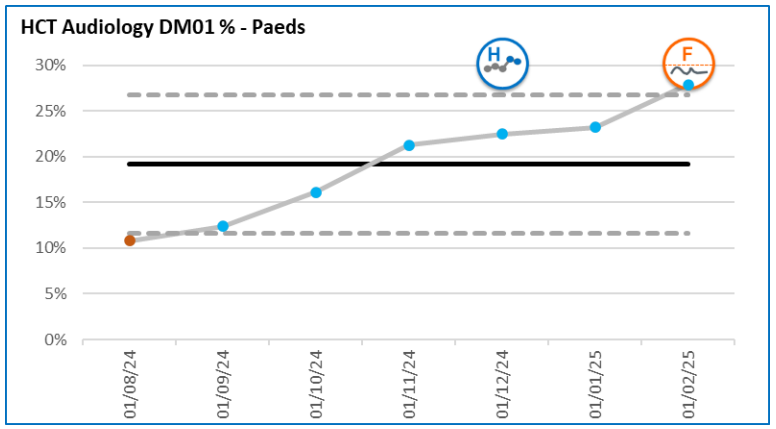
EAST AND NORTH HERTFORDSHIRE NHS TRUST	45.9%	53.0%	52.2%	50.3%	50.6%	50.0%	53.5%	56.9%	49.3%	54.5%	61.8%	58.1%	54.7%	58.2%	60.3%	60.4%	56.5%	57.2%	59.4%	62.5%	53.3%	49.2%	55.3%	51.7%	50.5%	53.6%	39.2%	42.3%	41.3%	40.9%	44.8%	46.5%	44.7%	45.2%	52.4%
WEST HERTFORDSHIRE HOSPITALS NHS TRUST	66.6%	67.6%	65.4%	67.8%	68.3%	70.7%	71.1%	69.9%	65.0%	62.0%	64.7%	63.1%	63.8%	65.8%	67.3%	69.5%	68.5%	70.8%	78.3%	83.3%	84.1%	85.2%	90.9%	88.3%	86.0%	89.3%	91.6%	91.7%	92.1%	92.0%	93.4%	94.7%	90.3%	87.8%	91.8%
THE PRINCESS ALEXANDRA HOSPITAL NHS TRUST	81.3%	86.9%	76.7%	78.8%	74.0%	71.4%	72.6%	74.2%	64.5%	65.7%	74.6%	76.4%	74.9%	73.5%	76.0%	75.9%	70.3%	65.8%	72.6%	73.1%	64.9%	65.3%	75.2%	71.8%	70.7%	71.0%	69.6%	74.7%	69.2%	68.3%	70.2%	65.1%	57.8%	62.7%	67.4%
HERTFORDSHIRE COMMUNITY NHS TRUST																													10.8%	12.4%	16.1%	21.3%	22.5%	23.2%	27.9%
ICS	58.9%	64.3%	61.4%	61.3%	60.3%	60.5%	62.9%	64.6%	57.7%	59.6%	66.0%	64.3%	62.6%	64.4%	66.4%	67.0%	63.6%	63.2%	67.9%	70.8%	63.9%	62.0%	68.7%	65.7%	63.9%	66.6%	55.5%	57.7%	54.6%	55.1%	58.9%	59.7%	56.8%	58.4%	65.1%

What the charts tell us	Issues	Actions
• Performance significantly improved at each of the four providers during February. There is significant variation in Trust performance: ENHT – 52.4%, WHTH – 91.8%, PAH – 67.4% and HCT 27.9% (Note: HCT only provides Paediatric Audiology Diagnostics – see next slide) • 6-week wait performance across the ICS improved to 65.1% • Decline since May 2024 driven by the inclusion of ENHT Audiology • Excluding audiology, performance continues on an improving trajectory although has declined since December • Step change increase to PTL in June 24 due to return to reporting of Paediatric Audiology at ENHT with HCT also commencing reporting in August 24. Excluding Paediatric Audiology, the diagnostic PTL has remained fairly steady since March 22	**ENHT** • The most significant long waiters remain in Audiology. The 0-3 years and complex paediatric pathways remain paused • There remain significant challenges in the MRI service with demand currently greater than capacity **PAH** • Continued issues in accurately report DM01 backlog for multiple modalities, primarily Endoscopy, following Alex Health launch • Non-Obstetric Ultrasound (NOUS), Echocardiography and Audiology are the key challenges at PAH **WHTH** • In February modalities not reaching the 95% target were MRI, colonoscopy, flexi-sig, gastro and audiology	**ENHT** • Paediatric Audiology: hearing aid pathway went live in Mar-25 and the ABR pathway due to open on 28th April. Estates work ongoing to enable re-opening of 0-3 years and complex pathways. Discussions in relation to further mutual aid ongoing. • Adult audiology: Lister estates work commenced; ongoing discussions regarding outsourcing as currently there is insufficient capacity to clear backlog and meet recurrent demand; business case completed for system growth funding • MRI outsourcing and mobile van have improved waiting times **PAH** • Reporting issues being progressed as part of Alex Health data quality improvement programme. Projected to be resolved in June data reported in July • NOUS: Ongoing recruitment to increase capacity • Echos: Additional NHSP staffing and capacity in place – notable backlog improvement in latest local data • Audiology: Paediatric backlog nearing clearance and focus has switched to adults. Need to recruit 3 x WTE between June and September **WHTH** • There has been a loss of capacity associated with the Surgical Centre works which has impacted cystoscopy in particular and the pause in activity at SACH has further impacted delivery. SACH reopened at the end of February • Recovery actions are in place with insourcing of endoscopy activity, an increase in additional sessions, business case approved for Cardiac MRI expansion, process reviews and re-establishment of lost capacity where possible.

Planned Care - Paediatric Audiology Diagnostics

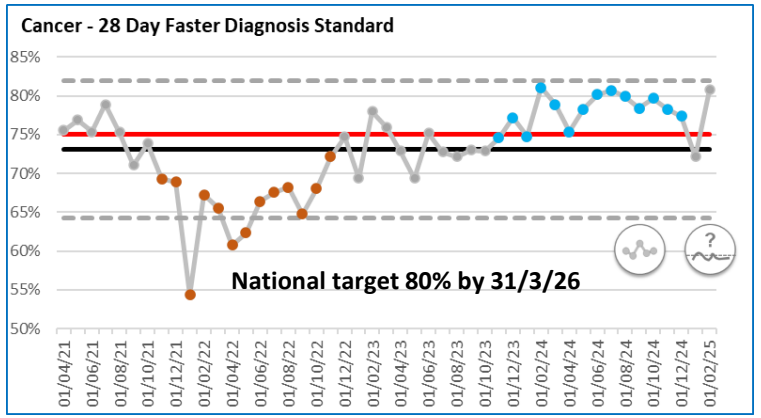






What the charts tell us	Issues	Action
• All providers are below the performance target of 95% with significant variance by provider • PAH are on an improved trend having seen a significant improvement in 2025 to achieve just under the 95% standard in February • ENHT continues on a variable trend, with significantly lower performance levels averaging c.5% • HCT are on an improving trend, with performance increasing in each of the last 6 months to reach 28% in February	• Ongoing support for mutual aid, particularly for 0-3 cohort and hearing aids. Mutual aid request has been submitted by ENHT for specific cohorts of children, system discussions taking place to understand any support available within the ICS. Discussions also taking place with NHSE regional and national teams. • Support requested to obtain SME support from the national register, following submission of request. National MOU for SMEs not yet signed for HWE system, query from providers sent to national team 12th March, awaiting response. • Largest area of risk remains estates for 0–3-year-olds and VRA. Capital bid has been submitted with request for NHSE to expedite review based on current risk within HWE system.	• System wide paediatric audiology oversight group in place and ICB escalation team • Mutual aid discussions in place with all providers to agree levelling up process; comms agreed and sent by NHSE regarding identification of workforce to support extra clinics. Letter also sent to HWE provider Medical Directors requesting support with levelling up across the system. • Data task and finish group progressing consistent local reporting of PTL and DM01 data, demand and capacity modelling and mapping of clinics to support mutual aid. New report has been produced which enables a view of waiting times / referral trends split by provider / age cohort / patient pathway. • Clear timelines for estates work across providers; current work being undertaken is on track including Peace Children's Centre and Lister Hospital. Awaiting outcome of capital bid submitted for required estates work at Hertford County Hospital. • Workforce mapping completed to seek assurance regarding competencies as well as understand available workforce to support mutual aid. Next steps link to system level scientific leadership, awaiting guidance from NHSE.

Cancer



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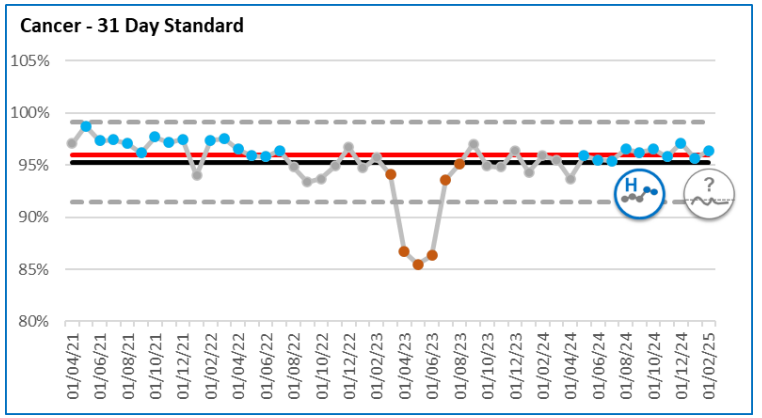
EAST AND NORTH HERTFORDSHIRE NHS TRUST	68.1%	64.2%	70.8%	71.8%	72.7%	69.7%	71.4%	71.7%	77.4%	65.8%	76.1%	72.9%	69.8%	69.3%	76.4%	75.9%	73.0%	74.1%	77.8%	78.2%	80.5%	76.1%	83.4%	81.0%	77.5%	80.1%	78.7%	80.6%	77.0%	75.9%	76.8%	77.1%	76.6%	72.2%	79.2%
WEST HERTFORDSHIRE HOSPITALS NHS TRUST	52.2%	58.3%	55.3%	60.6%	60.1%	57.8%	63.3%	71.6%	72.8%	70.1%	80.1%	78.7%	76.0%	68.0%	74.8%	68.6%	68.5%	69.8%	66.2%	68.7%	74.6%	74.1%	79.8%	78.1%	77.7%	80.5%	82.2%	81.3%	84.1%	80.7%	82.9%	82.7%	82.3%	78.4%	87.1%
THE PRINCESS ALEXANDRA HOSPITAL NHS TRUST	64.1%	65.9%	74.4%	72.2%	72.8%	68.4%	70.4%	73.6%	74.5%	72.1%	77.4%	76.6%	72.4%	71.2%	74.7%	74.5%	75.3%	75.7%	75.5%	77.9%	77.0%	74.5%	80.3%	77.9%	70.7%	74.4%	79.5%	80.3%	78.4%	78.3%	79.0%	71.0%	72.2%	66.4%	75.2%
ICS	60.9%	62.5%	66.3%	67.6%	68.2%	64.7%	68.0%	72.2%	74.8%	69.4%	78.1%	76.1%	72.9%	69.4%	75.2%	72.8%	72.2%	73.0%	72.9%	74.6%	77.2%	74.8%	81.1%	78.9%	75.4%	78.3%	80.2%	80.7%	79.9%	78.4%	79.7%	78.3%	77.4%	72.2%	80.8%



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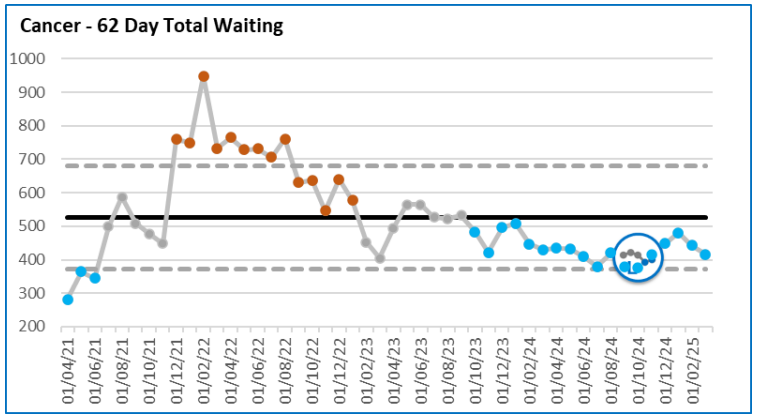
EAST AND NORTH HERTFORDSHIRE NHS TRUST	98.4%	97.6%	97.5%	97.1%	95.8%	93.2%	92.9%	95.5%	97.8%	95.8%	96.1%	93.0%	83.7%	80.5%	83.2%	93.8%	96.6%	97.0%	96.3%	95.9%	96.7%	96.8%	96.1%	96.0%	94.6%	96.4%	96.7%	96.6%	97.0%	96.8%	96.1%	96.1%	97.0%	96.5%	97.0%
WEST HERTFORDSHIRE HOSPITALS NHS TRUST	96.4%	96.4%	95.3%	95.9%	94.3%	95.3%	95.8%	94.8%	96.1%	92.6%	96.7%	99.5%	96.3%	99.0%	97.7%	94.1%	96.4%	99.0%	96.2%	94.4%	97.7%	88.1%	97.6%	96.1%	94.4%	94.3%	91.3%	93.3%	97.5%	96.1%	98.7%	99.0%	98.6%	97.4%	97.4%
THE PRINCESS ALEXANDRA HOSPITAL NHS TRUST	81.9%	82.9%	83.3%	92.9%	89.6%	90.4%	95.6%	90.7%	90.6%	91.0%	92.1%	92.9%	92.5%	95.3%	88.8%	91.3%	84.7%	91.3%	85.3%	88.8%	91.8%	87.4%	92.3%	92.3%	87.3%	94.9%	94.4%	91.8%	91.2%	91.1%	95.3%	87.6%	95.4%	87.2%	90.6%
ICS	96.5%	95.9%	95.8%	96.4%	94.8%	93.4%	93.7%	94.9%	96.7%	94.7%	95.7%	94.1%	86.7%	85.5%	86.3%	93.6%	95.1%	97.0%	94.9%	94.8%	96.4%	94.3%	95.9%	95.5%	93.7%	95.9%	95.5%	95.4%	96.5%	96.2%	96.5%	95.8%	97.1%	95.6%	96.4%



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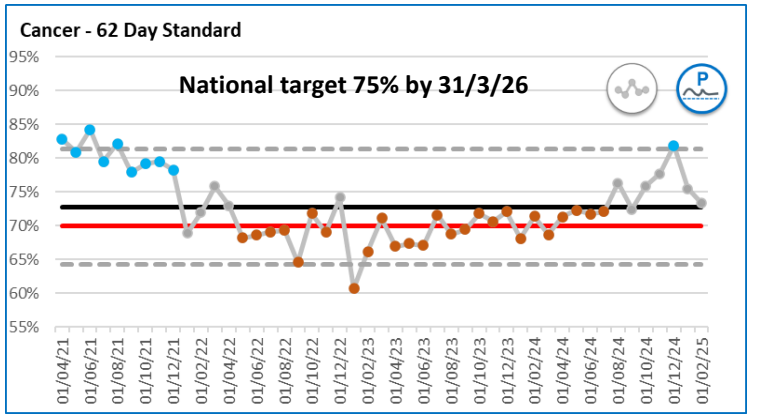
WEST HERTFORDSHIRE HOSPITALS NHS TRUST	83	109	88	132	179	130	128	129	331	347	374	307	261	297	297	277	270	257	233	195	191	184	129	125	127	158	149	135	139	100	118	121	148	142	118	86	97	84	71	63	67	74	58	82	72	88	76	74
THE PRINCESS ALEXANDRA HOSPITAL NHS TRUST	107	141	161	212	224	201	190	127	175	176	303	194	182	156	128	125	162	152	163	149	193	182	153	120	148	213	203	166	148	167	149	110	141	165	135	118	141	157	167	162	134	108	110	149	178	185	163	152
EAST AND NORTH HERTFORDSHIRE NHS TRUST	92	114	96	155	184	178	160	193	253	226	272	232	322	275	306	304	329	221	242	203	256	211	170	160	199	224	203	212	239	226	234	194	234	195	170	194	196	192	171	155	220	197	209	184	199	208	204	190



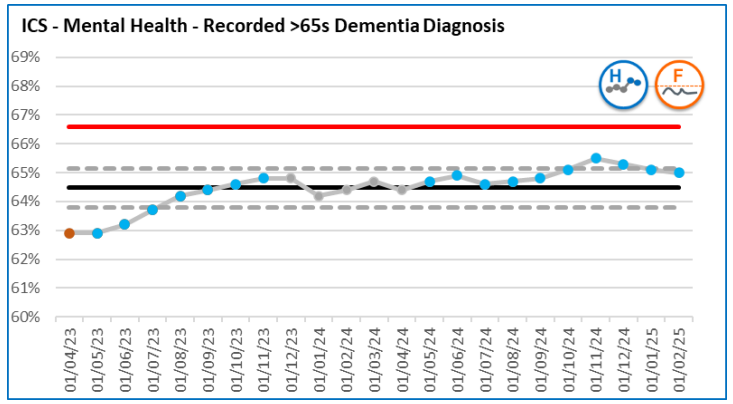
	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25
EAST AND NORTH HERTFORDSHIRE NHS TRUST	86.3%	79.1%	79.9%	85.4%	82.7%	79.3%	78.0%	78.8%	87.2%	77.5%	78.7%	85.7%	84.3%	82.1%	81.5%	82.7%	82.1%	78.6%	86.6%	86.3%	82.2%	86.1%	83.6%	82.5%	85.9%	83.6%	82.8%	86.9%	87.5%	84.4%	86.9%	85.6%	87.0%	85.9%	79.6%
WEST HERTFORDSHIRE HOSPITALS NHS TRUST	61.0%	64.6%	60.2%	61.8%	61.6%	59.9%	67.3%	63.7%	68.3%	54.6%	59.2%	61.1%	66.5%	60.2%	64.4%	69.7%	68.8%	75.3%	75.6%	75.5%	70.9%	62.6%	72.7%	71.6%	70.4%	69.5%	74.1%	68.9%	74.9%	78.3%	76.0%	78.4%	87.2%	78.0%	79.9%
THE PRINCESS ALEXANDRA HOSPITAL NHS TRUST	64.9%	51.8%	61.6%	52.3%	59.4%	44.8%	66.1%	58.0%	63.5%	46.9%	56.2%	57.7%	43.0%	48.8%	49.4%	56.4%	49.6%	48.3%	47.1%	40.9%	55.7%	44.2%	48.8%	46.4%	46.6%	54.1%	52.3%	56.0%	59.0%	51.1%	54.4%	60.0%	60.9%	50.0%	54.1%
ICS	73.0%	68.2%	68.6%	69.1%	69.3%	64.6%	71.8%	69.0%	74.2%	60.7%	66.2%	71.1%	66.9%	67.4%	67.1%	71.6%	68.8%	69.5%	71.8%	70.6%	72.1%	68.1%	71.4%	68.7%	71.3%	72.3%	71.7%	72.1%	76.3%	72.4%	75.9%	77.7%	81.9%	75.5%	73.4%

Hertfordshire and West Essex Integrated Care System

Cancer

What the charts tell us	Issues	Actions
• 28-day Faster Diagnosis Standard (FDS) performance improved sharply in February reaching 80.8% which is slightly above target. However, both PAH and ENHT are under target although both showed large improvements. • The 31-day target was chieved, reaching 96.4% in February • Performance against the 62-day standard declined over the last two months and although remaining below the national target, it is surpassing the 70% standard expected in the 24/25 National Planning Guidance • There has been variable performance at each Trust with significant 62-day variation currently: ○ ENHT 79.6% ○ WHTH 79.9% ○ PAH 54.1% ○ ICB overall 73.4% • The 62-day backlog is variable and has decreased over the last two months	**ENHT** • The 28-day FDS and 31-day treatment were both met in February. However, the 85% target for the 62-day treatment standard was not met. • Urology remains the most challenged of the high-volume pathways. For Urology, the Trust is dealing with increased demand: in M1-11 of 24/25, demand for Urology diagnosis was 6.7% higher than M1-11 23/24 • There has been a reduction in the >62 day backlog over the past few months and there were 164 patients on the >62 backlog as of 13th April **WHTH** • 28-day FDS challenges remain in Haematology, Head and Neck and Urology. • 31-day performance standard has been met across all specialities, except Head and Neck and Urology • 62-day, Haematology, Head and Neck, Upper GI and Urology pathways continue to have challenges. Pathway complexity, patient choice and surgical and out-patient capacity issues sited as main reasons for delays. **PAH** • Lower GI (40.0%) and Urology (43.9%) were the biggest FDS challenges in February. Overall March performance is expected to fall, but the Trust is confident of achieving their 77% plan for April • Overall, 62-day performance fell to 54.1% in February, but this is reflective of the continued push to reduce >62-day backlogs • Urology, Skin and Head & Neck are the key challenges in terms of the greater than 62-day waits, collectively accounting for 69% of the overall patient backlog	**ENHT** • ENHT has been putting in place pathway changes / additional capacity in Urology. These include; MRI van at the Lister; one-stop flexi-cystoscopy pathway and additional TP biopsy capacity. However, the impact of these interventions has been limited so far on performance. Partly due to the increase in demand outlined opposite • Head & Neck - agreed with Oral Surgery/MaxFax consultant to review all reports at MDT and introduced 2 negative templates one for PIFU and one for FU • Haematology – to introduce bloods clinic at Lister McMillan Cancer Centre to start in September **WHTH** • Cancer Improvement Programme Board continues to oversee service level plans and service developments. Weekly long wait meetings continue and 2/3 times weekly breach validation reviews in place. • Gynae Clinical Fellow now supporting with results clinics and MDTs • One-stop diagnostic pathway for Prostate (Urology), started in February 2025, following the successful appointment of a CNS and New Registrar to support the pathway using Cancer Alliance funding. Cancer Alliance funded cystoscopy outsourcing in place to support the bladder pathway while a one-stop pathway is developed. • Breast Pain pathway to continue for another year as part of regular breast service delivery • Work underway to move haematology appointment booking to the Outpatients Booking Team, which is expected to reduce time to first appointments **PAH** • Princess Alexandra Hospital remains in Tier 2 of the national oversight and support infrastructure for Cancer recovery. Focussed bi-weekly escalation meetings and NHSE clinical support are in place • The >62-day backlog spiked following Alex Health launch (clinic build issues and OP capacity). Now steady week on week improvement - currently 151 (at 13/4/25) v. the Trust's fair shares target of 112 • LGI FDS performance has been impacted by Endoscopy staffing gaps. Recruitment has now been completed with improvement expected from June • Programme to improve the oversight of patients transferred to tertiary centres in progress – more frequent contact with the tertiary centres and additional reporting to monitor activity and improve 62-day performance

Mental Health – Dementia Diagnosis in Primary Care



	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25
ENHCCH	59.4	59.7	60.2	60.2	60.2	59.5	59.3	59.5	59.2	59.0	58.8	59.2	59.2	59.2	59.0	59.1	60.9	59.0	59.8	59.7	59.6	59.7	60.5	60.7	60.7	61.3	61.8	62.5	63.0	63.6	63.8	63.7	62.7	62.8	63.7	62.9	62.9	63.1	62.9	62.7	62.6	63.2	63.2	62.8	62.5	62.5
HVCCG	59.2	59.6	59.6	59.8	60.0	59.8	60.1	60.3	60.6	60.5	60.6	60.4	60.6	60.8	60.7	60.6	61.2	60.9	61.3	61.7	61.3	61.1	61.4	61.3	61.3	61.5	61.9	62.2	62.2	62.0	62.1	62.3	61.9	62.1	62.0	62.0	62.6	62.5	62.3	62.3	62.6	62.8	63.1	63.0	62.9	62.8
WECCG	67.6	68.0	67.7	67.7	67.6	67.3	67.1	67.0	66.7	66.4	66.5	66.6	66.6	66.5	66.9	67.6	67.7	67.6	68.5	68.3	67.6	68.3	69.9	69.9	70.0	69.8	70.4	70.9	70.9	71.5	71.5	71.5	71.2	71.2	71.5	71.3	71.7	72.7	72.1	72.9	72.8	73.0	74.1	74.3	74.1	73.8
ICS	61.0	61.4	61.5	61.6	61.7	61.3	61.3	61.4	61.4	61.2	61.1	61.2	61.3	61.3	61.4	61.5	62.5	61.6	62.2	62.3	61.9	62.1	62.9	62.9	62.9	63.2	63.7	64.2	64.4	64.6	64.8	64.8	64.2	64.4	64.7	64.4	64.7	64.9	64.6	64.7	64.8	65.1	65.5	65.3	65.1	65.0

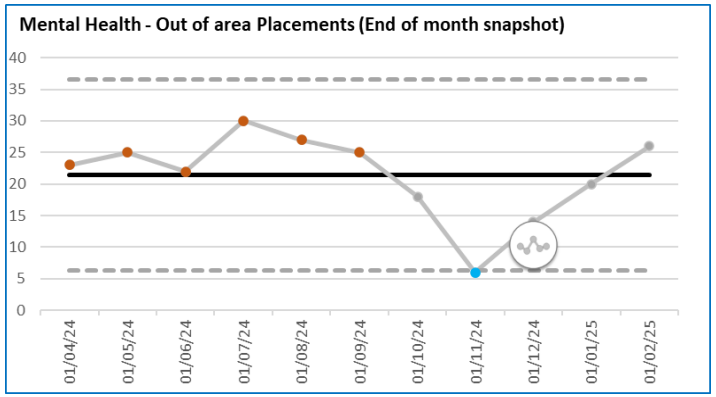
ICB Area	What the charts tell us	Issues	Actions
Dementia Diagnosis in Primary Care	• National data for Feb 2025 shows the ICS dementia diagnosis rate decreasing slightly against the national target (66.7%) at 65.0% for the ICB with continued variance at Place: • South and West Herts: 62.8%. • East and North Herts: 62.5%. • West Essex: 73.8%	• Hertfordshire – Demand for memory assessment via HPFT EMDASS remains high. • Hertfordshire - Actions required in primary care including a coding exercise but currently not prioritised due to GP capacity, not mandated as part of ECF, and key targets dropped from new GP contract.	**Herts** • Commissioners will continue to monitor and disseminate Dementia Diagnosis Rates data despite target being dropped from national planning guidance. • Monthly performance report continues to monitor HPFT EMDASS progress in Hertfordshire. • A new and improved EMDASS referral form has been coproduced with partners, is now live on GP systems and has been positively received by system. • Hertfordshire memory service is currently reducing waiting lists through increased capacity with waiting time for diagnosis currently within the 80% target and waited time at 74% in March 2025.

Mental Health – Out of Area Placements (OAPs)

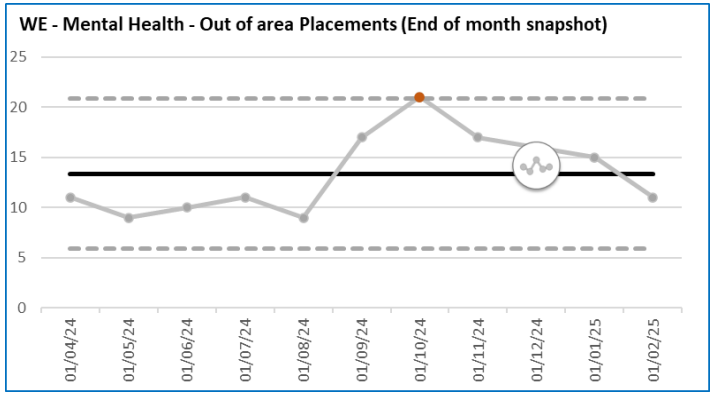
- The basis for measurement of OAPs has changed for 24/25
- Previous reporting was based on the number of out of area bed days in the month
- From April 24, reporting is based on the number of active OAPs at month end

HWE February total out of area placements:
37 vs. 6 plan

Hertfordshire



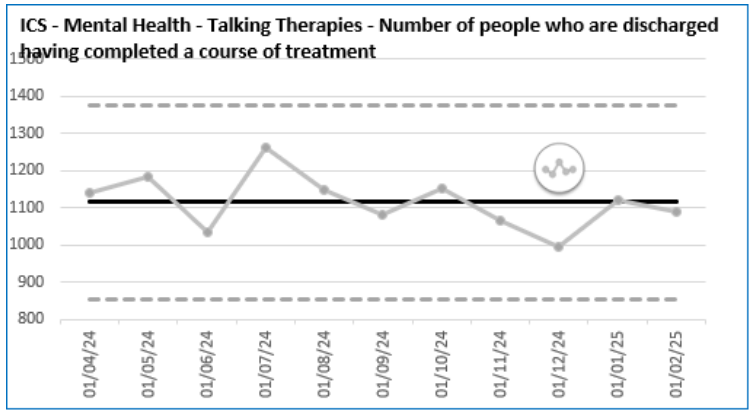
West Essex



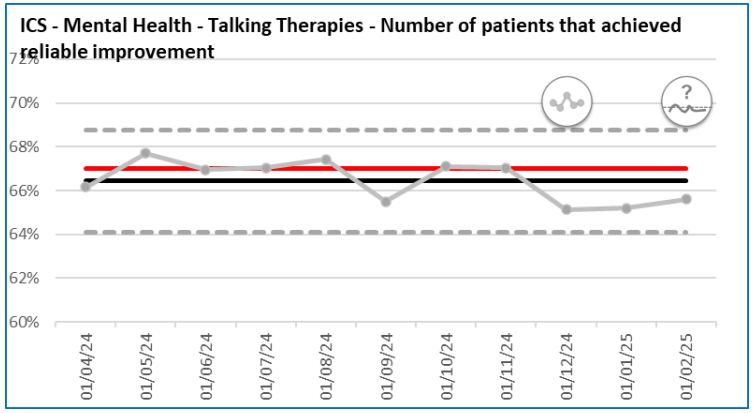
ICB Area	What the charts tell us	Issues	Actions
West Essex	• End of March: 7 people reported out of area (-9 compared to Dec) for west Essex with a total number of 193 bed days (-159 compared to Dec).	• National shortage of MH beds continues • Length of stay OOA and repatriation to place – Longest stay 193 days, although within the 6-month guidance it remains crucial that people are repatriated as soon as they are able • Reduction of local beds due to an increased numbers of SNEE patients placed in EPUT beds • London COMPACT agreement is seeing local beds taken up by London residents, this has an effect on number of local beds available being reduced pushing WE and Herts patients OOA	• Essex wide review of all inpatient beds as well as at place (West Essex) continues. Planning and guidance released in February 2025 identifies capital funding to be ringfenced to reduced out of area placements. This will support this programme • NHSE reported in April that capital funding to be released for MSE and West Essex • Review and remodel of weekly system DTOC calls with stronger governance and responsibilities – follow up MADE calls with provider following December event, including NHSE representatives • Discussions with Trusts to come together with NHSE to review the London COMPACT
Herts	• Winter pressures resulted in an increase in out of area bed placements to 26 (as measured on the last day of the month).	• Reduced capacity last year due to closure of Aston Ward until 7/10/24 and the position improved in Nov but has since increased due to winter pressures. • Hertfordshire has a low number of beds per population and there is ongoing support by provision of additional block beds • National shortage of MH beds, high occupancy rates and use of OOA beds has continued, particularly over the winter period • Placement challenges for service users with complex needs who are ready for discharge • Inpatient recruitment - 13% vacancy on adult acute and urgent care services, which will impact flow.	• Alternatives to admission continue to be developed, including a crisis house, and MHUCC • Wider Executive led work at system level to support placement of longer term DTOCs. • Bed management system continues to be developed and implementing plan to include OAPs. • Enhanced Discharge team fully recruited (addition of Senior Social Worker, Occupational Therapist & Discharge Co-Ordinator) - ways of working developed including input to service users in OOA beds. • Holding ongoing daily Bed Management meetings (3 x a day) to explore all alternatives to admission. • Senior, clinically led team attending providers ward rounds in person to unblock and support discharge • Twice weekly clinical review meetings, led by Medical Lead, involving crisis teams and community services, focusing on barriers to discharge, facilitating early discharges with crisis support. • Collaborative working with HCC reviewed to support service users requiring HCC involvement for discharge. • Plan in place to reduce number of OAPs to 0 by end of June 2025. • Perfect week in April: to prioritise service user and carer experience through effective flow.

Talking Therapies

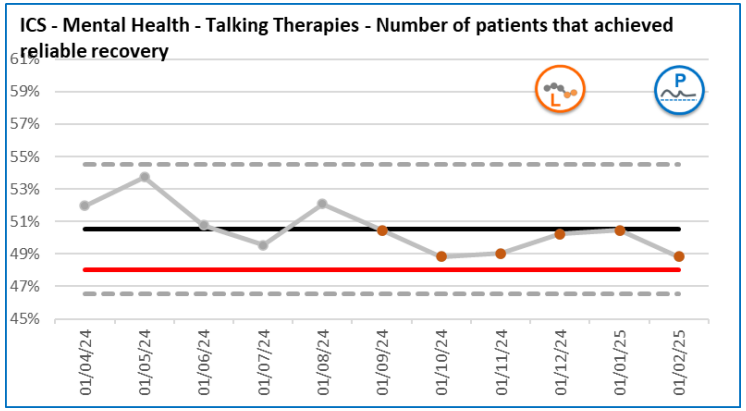
Number of people who are discharged having completed a course of treatment
Percentage of patients that achieved reliable recovery
Percentage of patients that achieved reliable improvement



Adults receiving treatment	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25
Hertfordshire	930	875	925	956	837	1039	947	909	970	879	802	926	909
WECCG	170	184	214	225	198	222	200	173	184	186	193	193	179
ICS	1100	1059	1,139	1181	1035	1261	1147	1082	1154	1065	995	1119	1088



Reliable improvement rate	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25
Hertfordshire - Actual	65.30%	63.70%	64.80%	66.80%	65.47%	66.06%	66.25%	64.53%	65.77%	66.89%	64.46%	63.50%	65.24%
West Essex - Actual	68.82%	71.20%	72.90%	70.50%	73.23%	71.62%	73.00%	70.52%	73.37%	67.74%	68.91%	73.58%	67.60%
ICS - Actual	65.82%	64.97%	66.29%	67.50%	66.96%	67.04%	67.42%	65.49%	66.98%	67.04%	65.33%	65.24%	65.63%

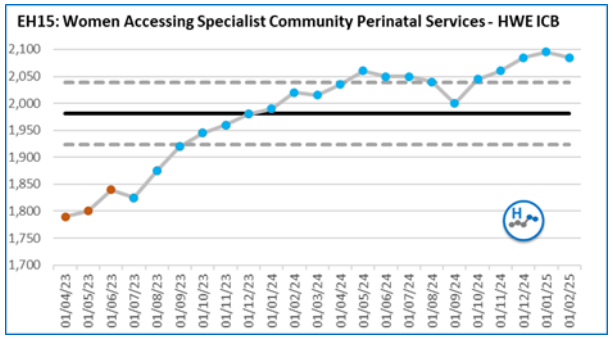


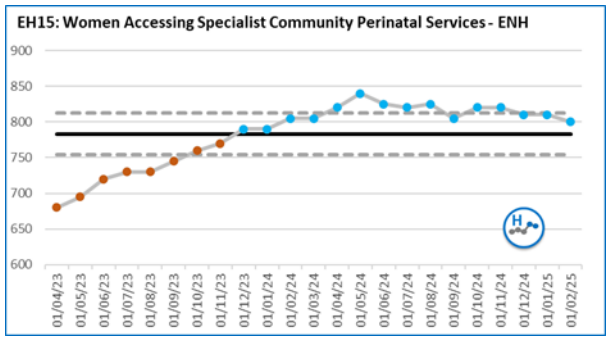
Reliable recovery rate	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25
Hertfordshire - Actual	53.90%	54.00%	50.80%	52.60%	50.41%	48.66%	51.23%	49.13%	47.90%	48.48%	51.58%	49.81%	47.77%
West Essex - Actual	56.00%	57.10%	57.00%	57.50%	52.06%	53.24%	55.61%	56.55%	52.81%	51.37%	46.07%	53.13%	53.76%
ICS Actual	54.00%	54.10%	52.10%	53.60%	50.76%	49.55%	52.08%	50.41%	48.75%	49.02%	50.39%	50.45%	48.83%

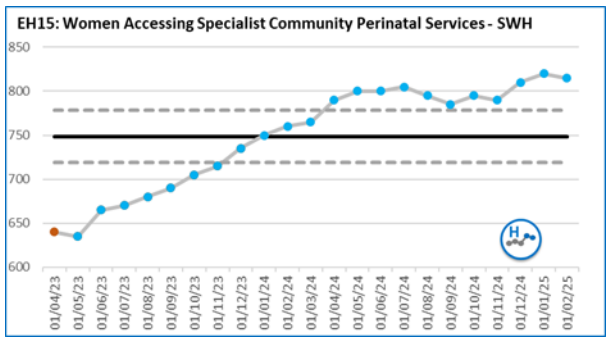
ICB Area	What the charts tell us	Issues	Actions
Hertfordshire & West Essex	**West Essex Year End** *(Note: narrative includes March 25 data)* • Referrals; data for Q4 shows 1,996 referrals which is increase from previous quarters • Recovery; 55% on average and 72% for Reliable Improvement **Hertfordshire** • Similar levels of completed treatments in Jan and February 2025 which have increased since December. • 65% reliable improvement rate in Feb 2025. • 47% reliable recovery rate in Feb 2025.	• Measurement now relates to completion of a course, with at least two appointments. Previously access / first appointments • Consistency of data collection and quality across the system continues to be monitored due to changes in the MHSDS. • Continuing focus on addressing attrition and drop-out rates following the change in counting for 24/25 • West Essex overall DNA rate is 10% & patient cancellation rate approx. 14%. Drop out rate, approx. 30% for referral to assessment & 50% for assess to treatment. • Potential risk in Hertfordshire if procurement process is not successful for building capacity to support 'counselling for depression'. • In Hertfordshire the pressure remains at Step 3; more assessments required and a greater need for step 3 treatment.	• NHSE advise that positive practice guide being drafted to support services reducing dropouts. • NHS England system wide planning calls scheduled to support ICBs throughout 25/26 • NHS England representation embedded within West Essex contract meetings • Increased access to funded training posts via NHSE • NHSE Autumn trainee funding support for 100% paid salary until 2028 *opportunity* that will support HPFT step 3 waits/ reasonable growth ambition , HWE meeting in place with NHSE to discuss 28th April. • Procurement of counselling providers in Hertfordshire by May 2025, leading to an improvement of pathways and ensuring right modality in place for service users. Announcement of tender process outcome following standstill period 24th April 2025. HPFT Actions: • Choose & Book has been rolled out to all Herts team to increase flow of patients from referral to initial appointment; to be reviewed for efficiency and improvements • The Time to Change group-based initiative is being rolled out across Herts to improve the engagement in treatment at Step 3. • All teams are required to offer clients further resources and support whilst waiting, such as the webinars and online self-help information. • Workforce, productivity and adjusted caseloads are under regular review.

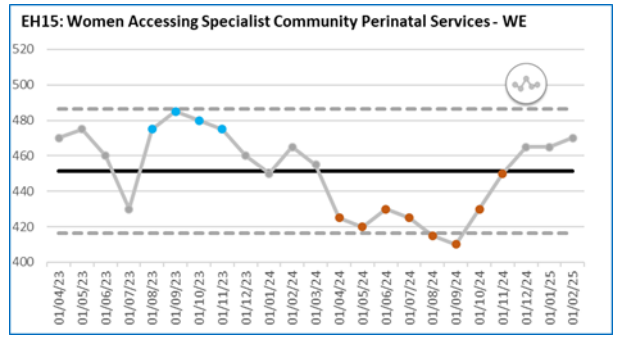
Community Perinatal Mental Health

Number of women accessing (1+ contact) specialist community PMH and MMHS services in the previous 12 months









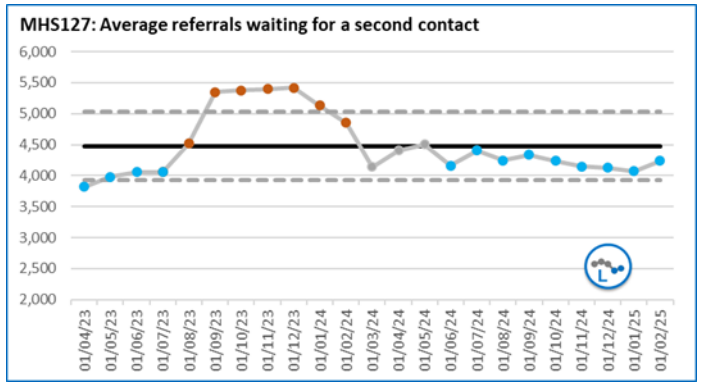
HWE 24/25 year-end plan: 2,089

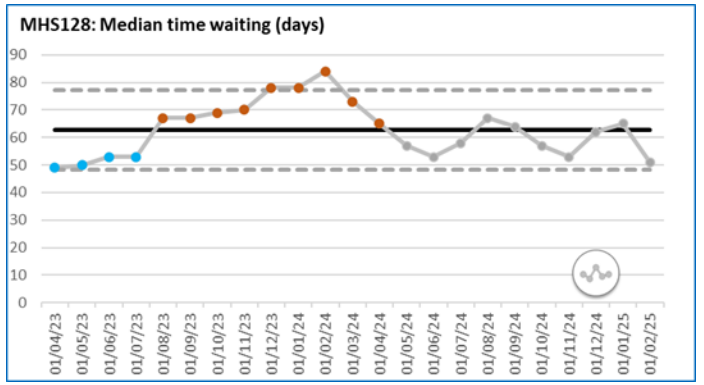
ICB Area	What the charts tell us	Issues	Actions
Hertfordshire & West Essex	**West Essex** • To achieve the cumulative 10% national target West Essex services are required to see 444 births Rolling 12 months). Local data is currently showing that at the end of Feb that a cumulative % of 9.92 and a rolling 12 month of 10.76% **Hertfordshire** • Consistently exceeding national target.	**West Essex** • There are 2 reporting methods being used; local data relates to specific time in the contract year whereas national data monitors on a 12-month rolling access report. **Hertfordshire** • Contractual reporting has been changed to reflect national 12 month rolling measure.	**West Essex** • Continually monitor local services on the 12-month access target to ensure services remain on track • Review of contract reporting schedules and DQIP meetings with EPUT **Hertfordshire** • Continued monitoring to ensure that we remain on track

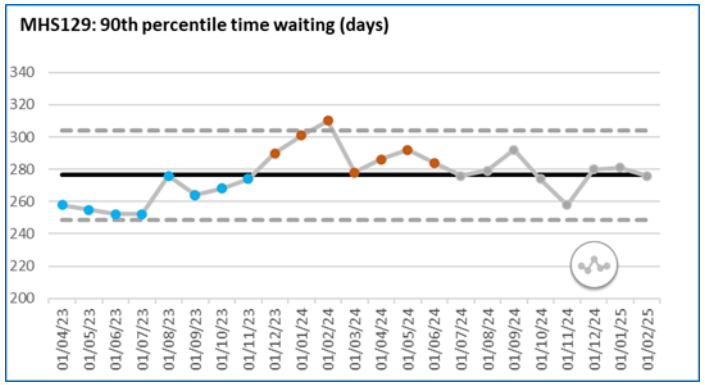
Mental Health – Community Waits

Adults and Older Adults – time still waiting for second contact*

* Please note NHS community MH dashboard waiting times front page states experimental waiting times and this section is being reported to support data quality improvement. Therefore, the data should not be used at this point to assess local activity and performance.



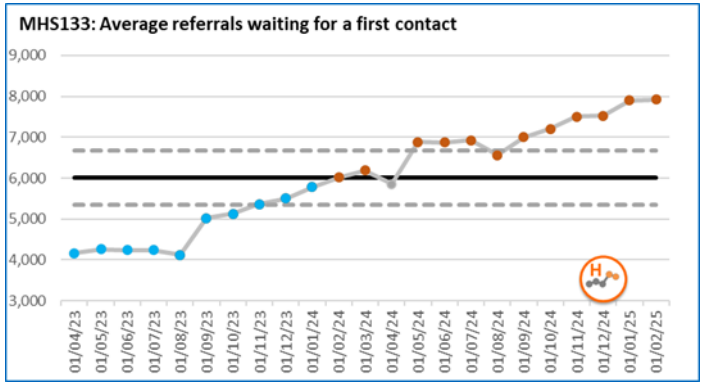


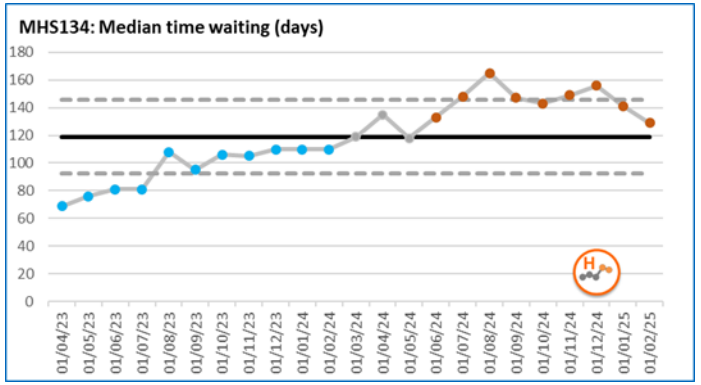


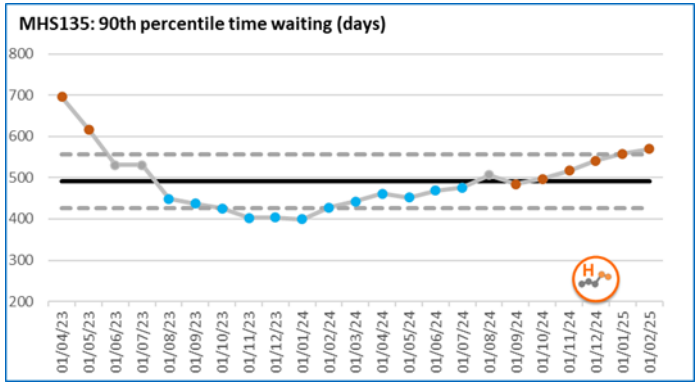
ICB Area	What the charts tell us	Issues	Actions
Hertfordshire & West Essex	**West Essex** • As of Jan 2025, 105 referrals of which 35 (9.1%) are still waiting for a second contact in 4 weeks. • 7.2% (25) have been waiting two to four weeks for second contact. 20 of those have been waiting less than one week. **Hertfordshire** • As of January, there were 43.3% of referrals with 2 plus contacts in 4 weeks compared to the national average of 30.6%. • Referrals with 2 plus contacts and a baseline outcome measure were at 88.9% compared to the national position of 49.1% (latest data June 2024).	• There remains gaps in the datasets with sporadic data month on month on the NHS England platform. Unclear if missing data is included as a rolling month or if accumulative data is included. • Although EPUT open referrals remain consistent month by month, the last 6 months the case loads have increased by 10% • In Hertfordshire, the data flow from Primary Care and VCSFE providers to MHSDS or the GP equivalent has not been worked through. This relates to the transformed PCN areas that have ARRS workers and Enhanced Primary Care. The data collection from these new services is recorded locally on System one or EMIS but this is not a shared system with the MH Trust (West Essex VSCE data flow is via a shared system with MH trust)	• Essex wide meetings scheduled to discuss the community mental health transformation, with a focus on the medium term plan, safety and improved access and better integration of services • ICBs and providers continue to engage with NHSE regarding data platforms • In Hertfordshire, a Trust-wide waiting times steering group is in place to ensure the care and safety of all people waiting for services. • HPFT Service lines are incorporating the new waiting times into their transformation work. SNOMED codes have been re-mapped on the HPFT EPR, PARIS, and continue to be reviewed as changes are made at National level. Internal reporting has been developed and key areas for action are being determined. • Hertfordshire is also working with NHSE and Voluntary Community, Faith and Social Enterprise (VCFSE) providers to look at the data flow from them to MHSDS, to include as part of the second contact information • All ICBs and providers of services continue to engage with NHSE with regional discussions being held regarding the MH data platform and progress is being made to capture accurate data for all pathways

Mental Health – Community Waits

Children – time still waiting for a first contact* *Please note NHS community MH dashboard waiting times front page states experimental waiting times and this section is being reported to support data quality improvement. Therefore, the data should not be used at this point to assess local activity and performance.

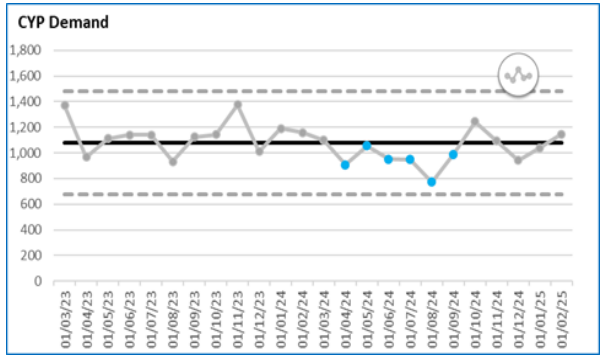


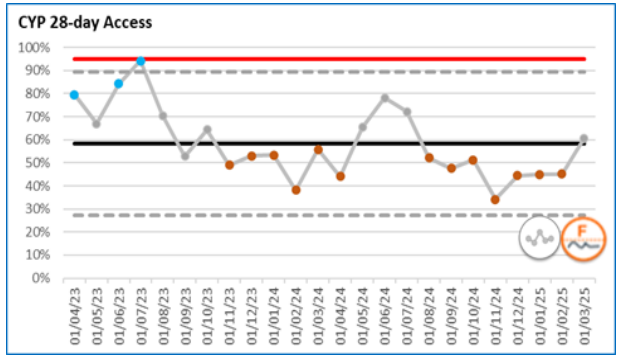


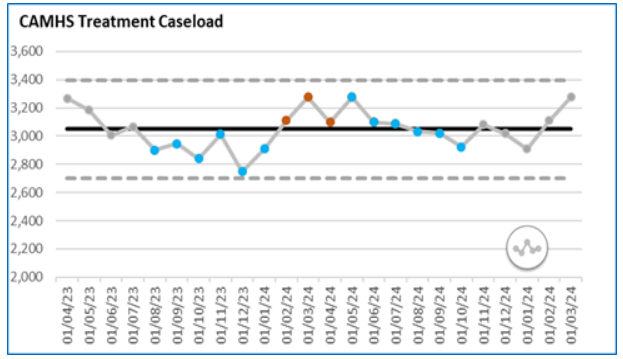


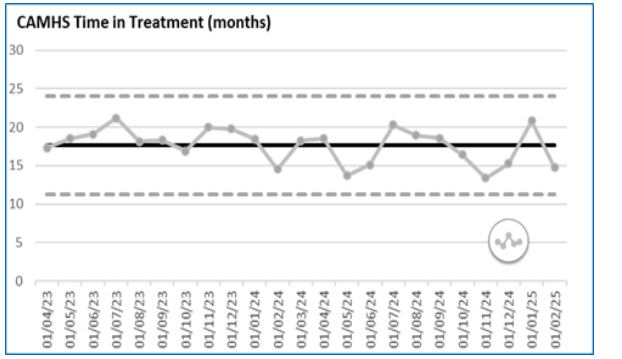
ICB Area	What the charts tell us	Issues	Actions
Hertfordshire & West Essex	• Median waiting times continue to drop to 125 days, which benchmarks well against the national average of 253 days • Within the system there is variation : • East & North Herts - 35 days in February (down from 77 in December 24) • South & West Herts - 143 days (down from 182 in December 2024) (this is due to ASD/ADHD diagnostic pathways data flowing into MHSDS) • West Essex - 38 days at end of February 2025 down from 72 days in December 2024 • 90th percentile waiting times for the quarter to February were tracking above 541 days, but continues to benchmark well against the national average of 821 days (as at Feb 25) • Within the system there is variation: • East & North Herts – 284 days (down from 330 days in December 2024) • South & West Herts – 459 day (down from 564 days in December 2024) same as above; this is due toASD/ADHD pathway data flowing via MHSDS. For E&N Herts it flows via CSDS which is not used for these metrics) • West Essex – 266 days at end February 2025, down from 309 days in December 2024	• The biggest impact on the Hertfordshire waiting list and long waiters is Autism & ADHD backlogs / waiting lists for diagnostic pathways • South & West Hertfordshire data is reflective of the historically longer waiting times in the patch, due to ASD / ADHD backlogs (for East & North these services are delivered by ENHT not HPFT/HCT)	• CYP services in Herts are incorporating the new waiting times in their transformation work and service design. SNOMED coding has been re-mapped on the HPFT EPR, PARIS and internal reporting is under development with first draft produced in March 2025. • An HPFT Trust-wide waiting times steering group is in place to ensure the care and safety of all people waiting for services • Local provider dashboards are in place for assessment & treatment activity, caseloads and waiting times. Average waits not always reflective of challenges experienced by service, but recovery action plans in place where applicable and closely monitored by commissioning leads • Commissioners, HPFT and now an HCT representative are linked into EOE waiting times standards group. Long waiters in HPFT all relate to ADHD backlog • Across NELFT Team Managers review their waiting list monthly, and >18-week waiters on a weekly basis. All waiters >18 weeks have a clinical harm review in place and the team will be working towards seeing all longest waiters as soon as possible.

Mental Health – CAMHS Services









What the charts tell us

West Essex

- West Essex does not have a formal KPI for 28 days; the cohort of YP seen <4 weeks is monitored at monthly provider meetings
- There has been a rise in demand during Q4
- Numbers on caseload remain consistent with those as @ end of Q3
- Time in treatment has increased but reflects acuity and complexity of caseload

Herts – HPFT only

- Demand into the service is, as expected, tracking around the historic mean
- 28-day performance has been falling since May-24 reaching a low of 34% in November 24 but seeing some recovery to 61% in March 2025
- Caseloads have reduced by 12% over the last 12 months.
- Time in treatment is variable and close to the historic mean

Issues

West Essex

- The SPA continues to see a steady increase in demand for referrals and work is ongoing to continue to stream line the referral process
- The rise of acuity / complexity of referrals continues, this is monitored via RAG systems for triage
- Team manager CAMHS hub team on long term sickness
- Clinical lead role will become vacant due to promotion internally.

Herts – HPFT only

- Clinicians have reported increased acuity / complexity of referrals
- Active issue regarding recruitment to vacancies impacting on capacity and performance, cover provided by agency staff to mitigate
- Acquiring highly skilled CYP clinicians remains difficult. Non-health support roles being used to bolster teams
- All underperforming quadrants now have trajectories for recovery in place.
- Transfers of care for >18 years from CYP are impacting on flow

Actions

West Essex

- Strong team in West Essex with additional support provided by the clinical lead and Head of Service across Essex. Clinical lead role out for recruitment.

Herts – HPFT only

- CYP Community waiting times remain at Level 3 business continuity with the Divisional Director leading & monitoring recovery
- SLT professional leads overseeing performance in their quadrant teams
- Recovery trajectories have been updated to reflect vacancies and recruitment to show impact on waiting lists.
- Number of assessments undertaken has increased over the last quarter and backlog is now decreasing.
- Recruitment gaps are being addressed through active recruitment and bank and agency cover.
- Clear patient safety focused plan in situ and held at weekly Quadrant Safety Group
- Care of Waiters protocol is in place with longest waiters regularly reviewed.
- Caseload management tool developed and in active use across the quadrants. Improvements in recording are underway to facilitate reporting of treatment waits.
- CYP programme of work to improve transition experience and outcomes

Mental Health – Learning Disability (LD) Health Checks

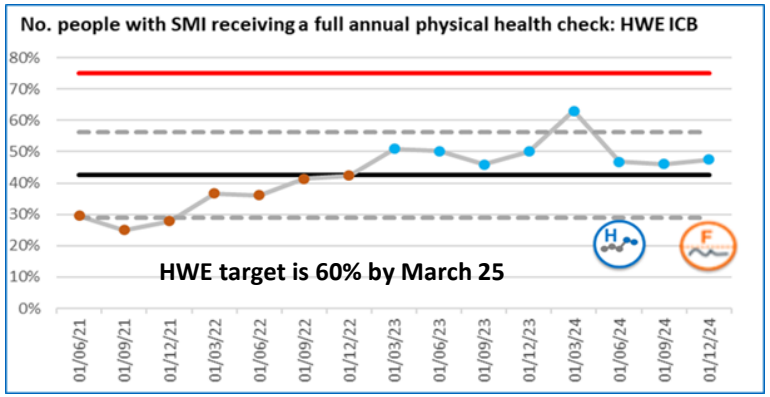
LD Health Checks January 2025	Total LD Register (age 14+)	Completed health checks	Health Checks Declined	Patients NOT had a health check	% Completed health checks *	Comparison to January 2024
NHS Hertfordshire and West Essex ICB	**7,774**	**4,836**	**138**	**2,800**	**62.2%**	**55.6%**
East & North Hertfordshire	3,220	1,951	69	1,200	**60.6%**	**55.6%**
South & West Hertfordshire	3,394	2,191	38	1,165	**64.6%**	**58.6%**
West Essex	1,160	694	31	435	**59.8%**	**43.3%**

*** 75% Year End Target**

ICB Area	What the charts tell us	Issues	Actions
Hertfordshire & West Essex	• All three places achieved the 75% standard in 23/24 • January 25 data shows the ICB and each place notably ahead of the equivalent 23/24 position at this point in the year	• It is challenging to forecast end of year performance against the 75% LD Health Checks standard, as a large proportion of health checks are carried out towards the end of the year, and particularly in Quarter 4	• Ongoing work between HWE Team and NHSE to cross check local data against national systems

Severe Mental Illness (SMI) Health Checks

Number of people with severe mental illness (SMI) receiving a full annual physical health check – percentage achievement in the 12 months to the end of the period

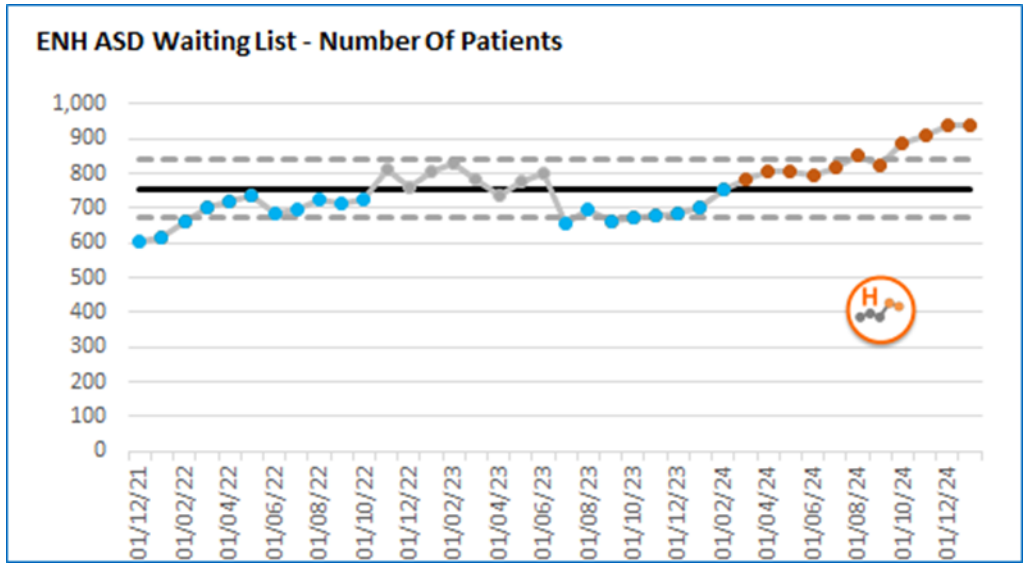


	2021/22				2022/23				2023/24				2024/25		
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3
East and North Herts Place	19.6%	11.9%	15.1%	25.8%	24.0%	36.3%	40.4%	45.9%	49.7%	47.7%	49.4%	60.5%	52.3%	52.7%	53.6%
South West Herts Place	39.4%	38.2%	39.5%	47.5%	44.6%	46.4%	43.6%	55.9%	51.0%	44.8%	52.2%	66.9%	38.9%	36.8%	38.1%
West Essex Place	28.9%	24.5%	30.6%	36.5%	38.5%	38.9%	44.0%	50.4%	49.4%	44.8%	46.4%	59.2%	52.1%	52.4%	55.3%
NHS Herts & West Essex ICB	**29.6%**	**25.1%**	**27.9%**	**36.7%**	**36.1%**	**41.3%**	**42.4%**	**51.0%**	**50.2%**	**45.9%**	**50.0%**	**63.0%**	**46.8%**	**46.1%**	**47.5%**

- The systems for submitting and reporting of SMI Health Checks data has changed for 24/25
- Health Checks undertaken in Secondary Mental Health Services may not currently be fully captured, and therefore a direct comparison to last year's data is not possible at present. This is a known national issue

What the charts tell us	Issues	Actions
• Current data is not capturing all health checks undertaken in secondary care MH services • Despite the data quality position, South & West Hertfordshire is notably performing lower at 38.1% than East & North at 53.6% • ICB data pulled from Ardens however shows the following performance for quarter 3 - East and north Herts at 54% - Southwest Herts at 59%* - West Essex at 54% **National data for SWH only showing 4125 people on SMI register with only 1570 PHC completed , however local data at 5045 people with 2967 PHC completed*	• Data quality issues as per NHSE disclaimer. The data presented here are considered experimental owing to the fact that they are known to be incomplete both in terms of the number of Practices who have not supplied information, and that some of those that have supplied information have supplied partial data. The experimental label of these statistics will be reviewed and removed once data completeness improves sufficiently.	• The data is being extracted from General Practice Extraction Service (GPES), an alternative system this year in Primary Care. There is a piece of work that needs to take place in order that the GPs are recording the data for health checks undertaken in primary care, as well as those carried out when a person is under the care of the MH Trust. This is a known national issue • Data by practice in place showing those practices current performance against target to be shared with practices : ongoing • Work with ICB BI leads and Provider leads to understand reporting requirements of secondary mental health services and primary care QOF data to ensure clear guidance and responsibilities, in line with the NHSE reporting procedures • Standardise record checking process agreed as an action for the Data Subgroup of the contract meeting • HCP place meetings in SW and ENH attended to present current support offer to GPs and identify further actions to support programme of work • Support the improvement of interoperability and provider electronic care records and information systems to enable monitoring of performance against equity of access to care • Working with Regional MH Team to look at shared care protocols to detail who is responsible for the physical health check, and how support for people who only engage with secondary care and not primary care will be captured, awaiting response • Review and development of a potential business case an ICB wide primary care outreach support on hold due to current financial position

Autism Spectrum Disorder (ASD) – East & North Hertfordshire



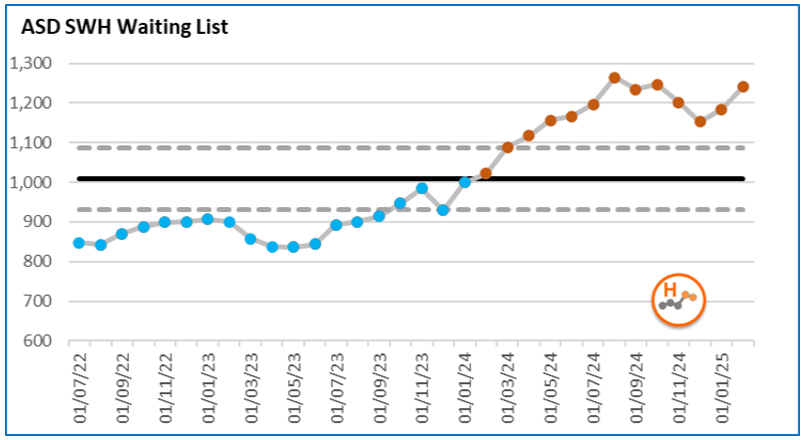
- In ENH, patients have a first appointment with Community Paediatrics. If the clinician, then considers that the patient requires an ASD assessment then they are added to the ASD waiting list
- Data is available on the waiting times for the first community paediatrics appointments and also for ASD assessments once a patient has been added to the ASD assessment waiting list. However, data is not available for both pathways combined
- The chart opposite shows the trend in the number of patients waiting for an ASD assessment once they have been referred by a community paediatrician
- The table below summarises how long patients on the ASD waiting list have been waiting (as of Jun-24):

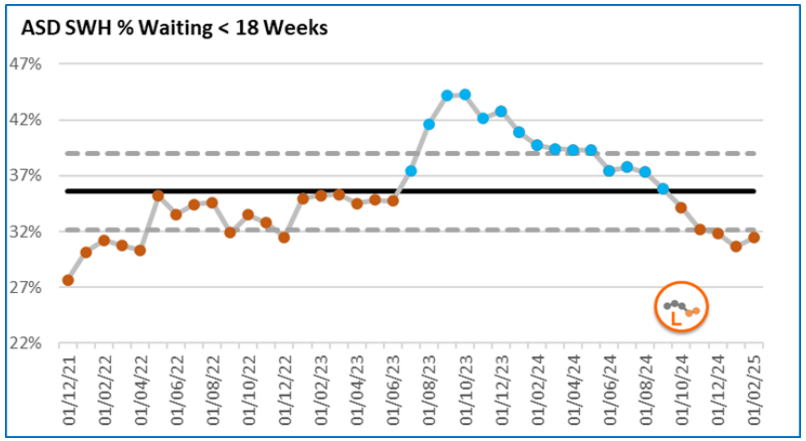
Waiting list bucket	Number of patients (Dec-24)	Number of patients (Jan-25)
<18 weeks	91	71
18 – 65 weeks	508	505
66 – 78 weeks	100	106
>78 weeks	242	257

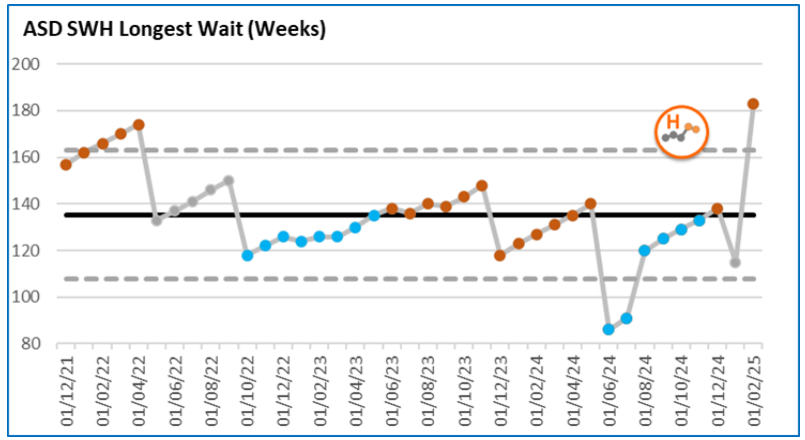
ICB Area	What the charts tell us	Issues	Actions
East & North Herts	• The ASD waiting backlog waiting list continues to increase and reached 939 patients in Jan-25 which is the highest recorded level • The number of patients waiting >78 weeks for an ASD assessment has risen from 86 in Dec-23 to 257 in Jan-25 • The waiting list shown above does not include patients waiting for their first Community Paediatrics appointment, even if they have been referred by their GP as query ASD. It only shows patients who have been assessed by a community paediatrician and referred for a detailed ASD assessment	• Data not currently reportable on the same basis as the other two ICB Places • Backlog funding ended December 2023 and waiting lists are increasing. In addition to this, further increases in demand predicted • Awaiting confirmation of investment into the service	• Procurement process to outsource assessments for autism completed – currently in stand-still period. New provider in place from 11th September • Learning Disabilities, Mental Health and Autism HCP continuing to develop support offer for parents, carers, families and CYP with behaviours and / or needs associated with Autism and / or ADHD • Funding approved for Neurodiversity Support Centre for the next 3 years • Understanding My Autism funding ends July 2025, not currently extended. • The MHLDA HCP and providers continue to scope implementation of new pathway • Hertfordshire wide single point of referral logging for all ASD and ADHD referrals is progressing with providers working together to plan implementation in autumn 2025

Autism Spectrum Disorder (ASD) – South & West Hertfordshire

			Patients Waiting			% waiting < 18 weeks			Longest wait (weeks)			
Place	Provider	Age	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Latest data
SWH	HCT	Children	1184	1241	↑	30.64%	31.46%	↑	115	183	↑	February



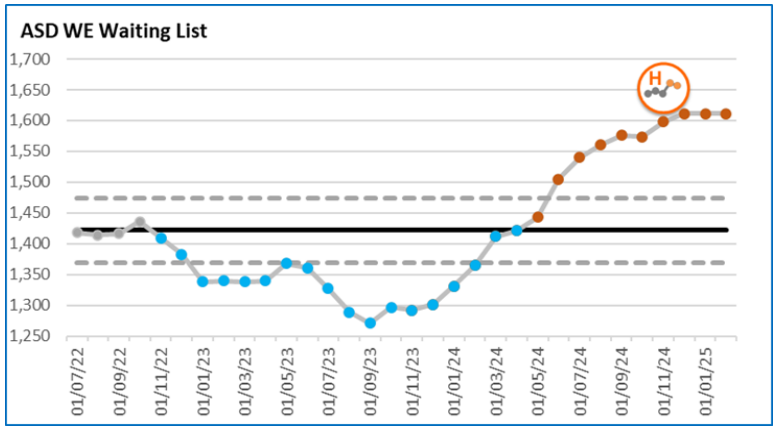


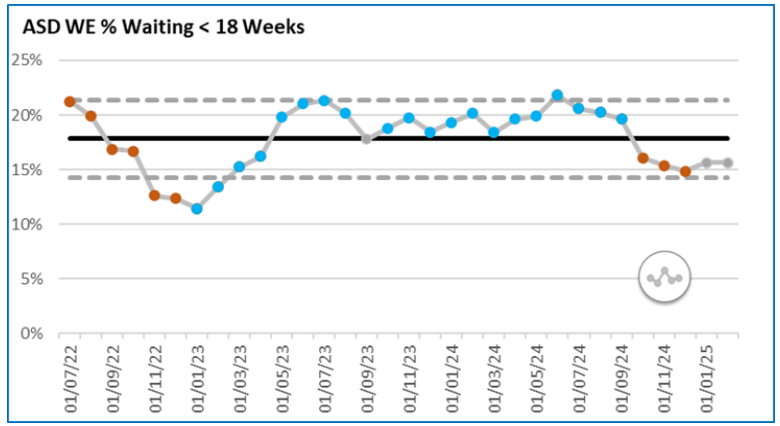


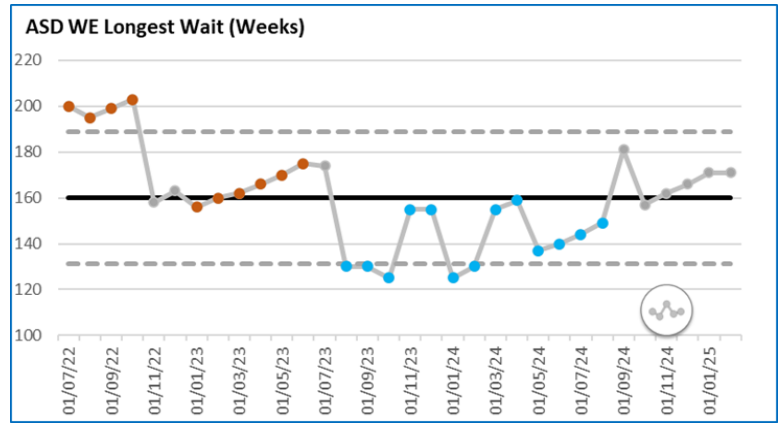
ICB Area	What the charts tell us	Issues	Actions
South & West Herts	• The ASD waiting list has increased for the last two months and remains consistently above the historic average • The % of ASD waiters <18 weeks remains low but increased slightly in February • The increase in longest wait is likely a single patient and will quickly recover	• Capacity in existing services does not meet demand • Further increases in demand predicted • Awaiting confirmation of investment into the service for 2025/26	• As a result of a focus on the long waits in Comm Paeds. (first wait), the waiting list in ASD (second wait) is increasing as expected • Procurement process to outsource assessments for autism completed – currently in stand-still period. New provider in place from 11th September • Learning Disabilities, Mental Health and Autism HCP continuing to develop support offer for parents, carers, families and CYP with behaviours and / or needs associated with Autism and / or ADHD • Funding approved for Neurodiversity Support Centre for the next 3 years • Understanding My Autism funding ends July 2025, not currently extended • The MHLDA HCP and providers continue to scope implementation of new pathway • Hertfordshire wide single point of referral logging for all ASD and ADHD referrals is progressing with providers working together to plan implementation in autumn 2025

Autism Spectrum Disorder (ASD) – West Essex

			Patients Waiting			% waiting < 18 weeks			Longest wait (weeks)			
Place	Provider	Age	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Latest data
WE	HCRG	Children	1611	1611	→	15.64%	15.64%	→	171	171	→	February



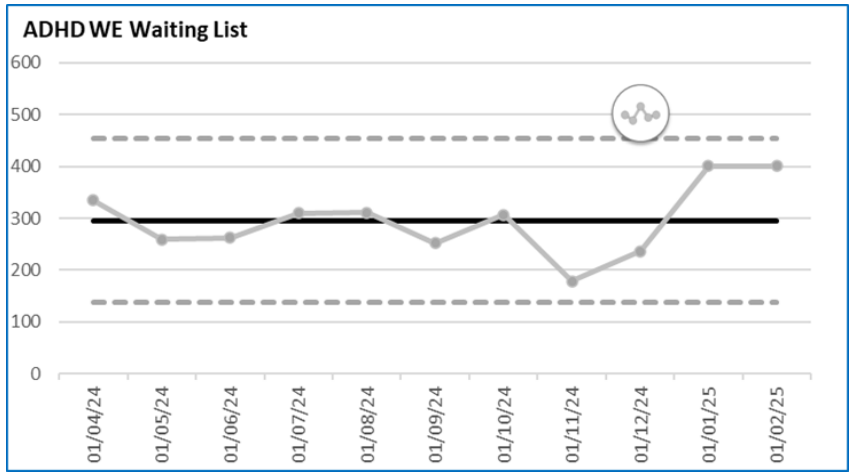


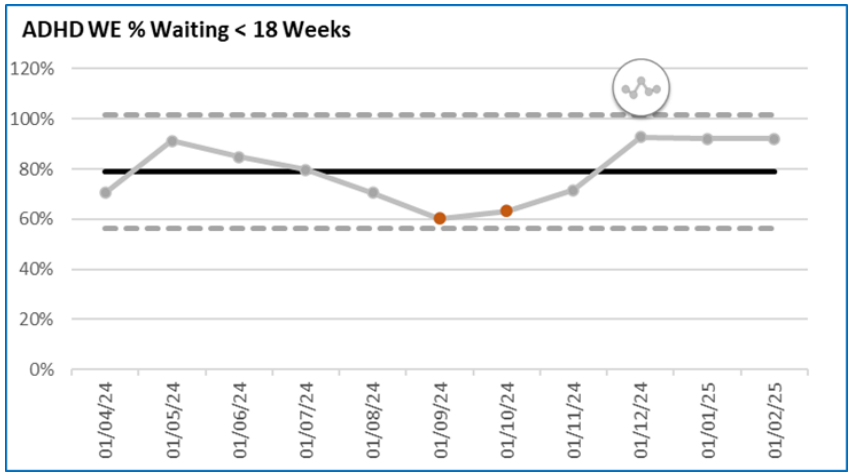


ICB Area	What the charts tell us	Issues	Actions
West Essex	• To note data has been copied over from January in the absence of February data being available • The ASD waiting list remains very high • The % of waiters <18 weeks remains low and fell in each of the six months leading up to January • The longest wait has been steadily increasing but remains within common cause variation limits	• No February data received from HCRG following cyber incident All issues are ongoing in the absence of additional resource: • Average monthly referral rate continues to be >70% greater than commissioned capacity • Demand and capacity analysis forecasts continued waiting list growth • Imminent CQC / Ofsted SEND Inspection for Essex. ASD waiting times and progress with improvement since last inspections in 2019 and 2022 expected to be highlighted	• Once access to data platforms have been reopened, HCRG will provide back-dated performance data which will be reflected on this report • Business case submitted to increase core capacity for sustainable delivery – remains outstanding. Potential to be considered as part of recommissioning of the contract • Seven additional team members undergoing ADOS training. Two paediatricians being trained in A3DI to support JADES team during absences • 'Waiting well' workstream continues with local partners at Place, led by trainee psychologist at HCRG • Continuing to explore use of the ND Profiling Tool

Attention Deficit Hyperactivity Disorder (ADHD)
West Essex & East & North Hertfordshire

			Patients Waiting			% waiting < 18 weeks			Longest wait (weeks)			
Place	Provider	Age	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Latest data
WE	HCRG	Children	401	401	→	92.02%	92.02%	→	40	40	→	February

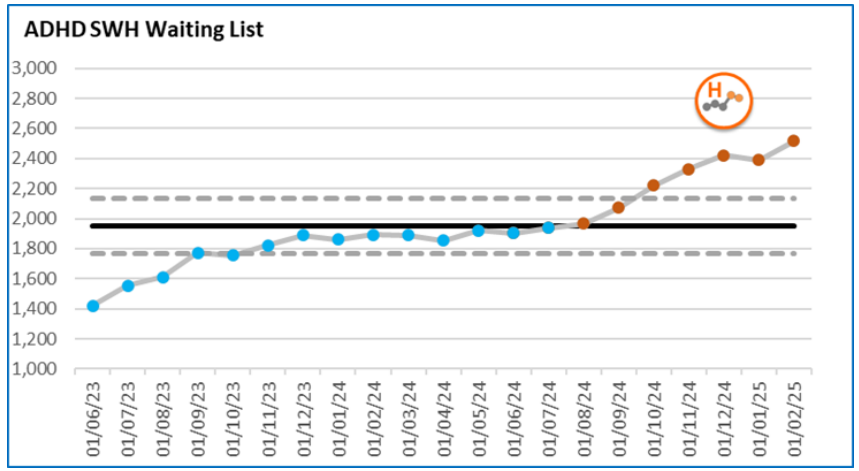


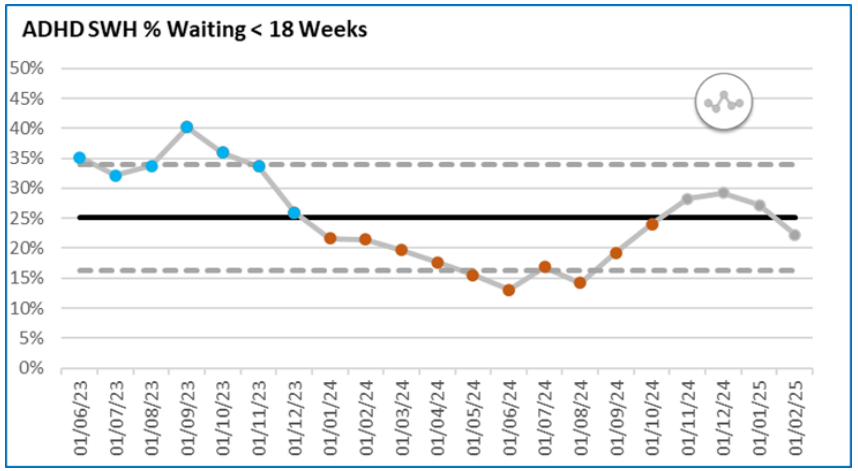


ICB Area	What the charts tell us	Issues	Actions
West Essex	• West Essex data has been copied over from January in the absence of February data being available • West Essex waiting lists continue to fluctuate at historic average levels • The % of children waiting <18 weeks are also within common cause variation limits	• ENHT is not currently able to report on waiting times / waiting list sizes for patients waiting for an ADHD assessment • No February data received from HCRG for West Essex following cyber incident • Referral rates for WE have increased by 250% by the end of Q3 • WE Adult services are limiting the number of young people transitioning to adult care, resulting in Paediatrics holding an increasing caseload of >18yrs • Referral rates continues to rise, resulting in risk to maintaining waiting list performance	• Once access to data platforms have been reopened, HCRG will provide back-dated performance data which will be reflected on this report • WE pathway redesign complete, incorporating ASD and ADHD into a single referral pathway route • WE Adult transition issues have been raised, however the number of referrals accepted is limited under contract activity plans. There is no resource in the system to increase capacity for adult transition

Attention Deficit Hyperactivity Disorder (ADHD) – South & West Hertfordshire

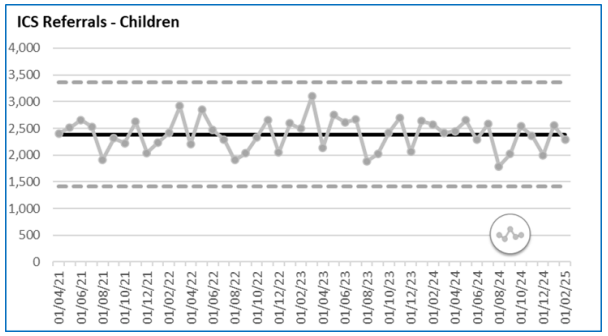
			Patients Waiting			% waiting < 18 weeks			Longest wait (weeks)			
Place	Provider	Age	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Latest data
SWH	HPFT	Children	2391	2518	↑	27.19%	22.28%	↓	186	191	↑	February

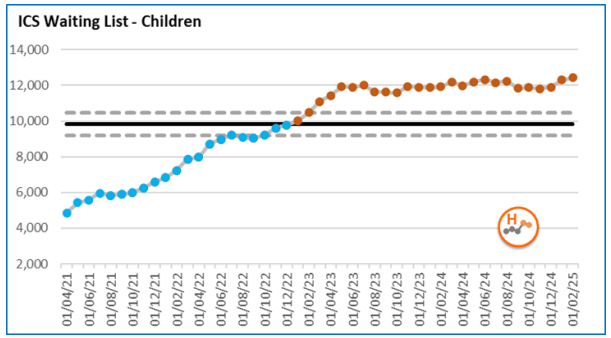


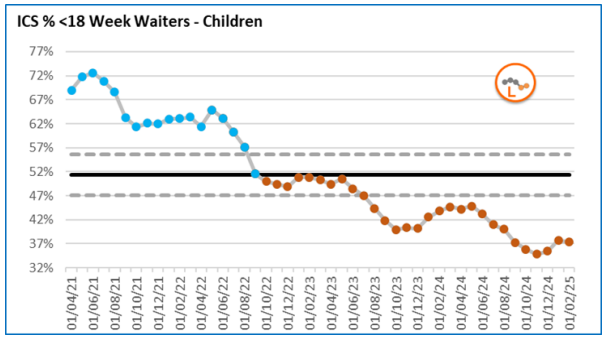


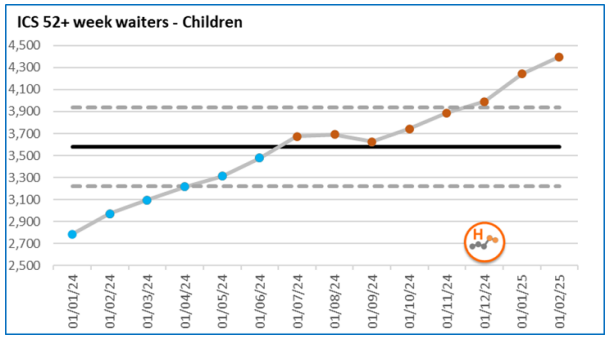
ICB Area	What the charts tell us	Issues	Actions
West Essex	• Overall waiting list was relatively stable but has notably increased over the last six months • The % of ADHD patients waiting <18 weeks has declined in recent months but remains within common cause variation limits	• Awaiting confirmation of investment into the service for 2025/26	• Learning Disabilities, Mental Health and Autism HCP continuing to develop support offer for parents, carers, families and CYP with behaviours and / or needs associated with Autism and / or ADHD • Funding approved for Neurodiversity Support Centre for the next 3 years • The MHLDA HCP and providers continue to scope implementation of new pathway • Hertfordshire wide single point of referral logging for all ASD and ADHD referrals is progressing with providers working together to plan implementation in autumn 2025

Community Waiting Times (Children)









		Referrals			Patients Waiting			% Waiting <18 weeks			Patients Waiting >52 Weeks			
Place	Age	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Latest data
ICS	Children	2551	2292	↓	12309	12422	↑	37.75%	37.35%	↓	4241	4396	↑	February

Place	Provider	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Latest data
ENH	HCT	356	328	↓	565	548	↓	87.43%	83.94%	↓	0	0	→	February
ENH	AJM (W/Chairs)	34	14	↓	137	132	↓	62.04%	61.36%	↓	0	0	→	February
ENH	ENHT Community Paeds.	254	191	↓	6608	6735	↑	13.77%	13.76%	↓	4085	4208	↑	February
ENH	**All**	**644**	**533**	↓	**7310**	**7415**	↑	**20.37%**	**19.80%**	↓	**4085**	**4208**	↑	**February**

Place	Provider	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Latest data
SWH	HCT	1337	1199	↓	3649	3663	↑	55.39%	55.36%	↓	153	188	↑	February
SWH	AJM (W/Chairs)	31	23	↓	132	126	↓	62.12%	70.63%	↑	3	0	↓	February
SWH	Communitas (ENT)	NO DATA	NO DATA	-	NO DATA	NO DATA	-	NO DATA	NO DATA	-	NO DATA	NO DATA	-	February
SWH	**All**	**1368**	**1222**	↓	**3781**	**3789**	↑	**55.62%**	**55.87%**	↑	**156**	**188**	↑	**February**

Place	Provider	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Latest data
WE	EPUT (W/Chairs)	20	18	↓	38	38	→	94.74%	92.11%	↓	0	0	→	February
WE	HCRG	519	519	→	1180	1180	→	86.36%	86.36%	→	0	0	→	February
WE	**All**	**539**	**537**	↓	**1218**	**1218**	→	**86.62%**	**86.54%**	↓	**0**	**0**	→	**February**

NOTE: **Work underway with all Community Providers currently not providing accurate community waiting list data**
No HCRG February 25 data received. January numbers carried forward ti ensure consistency of overall system reporting

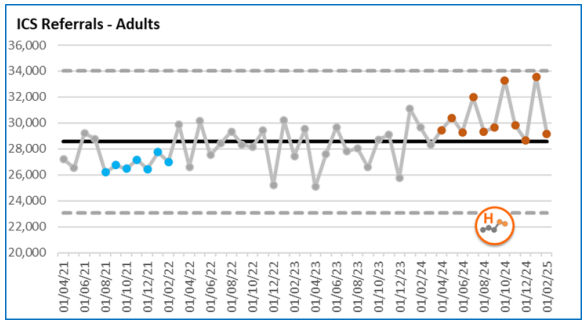
Hertfordshire and West Essex Integrated Care System

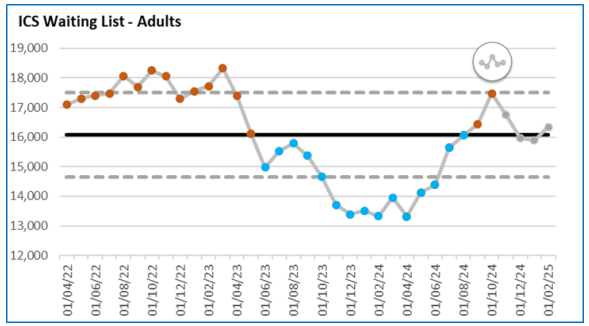
Community Waiting Times (Children)

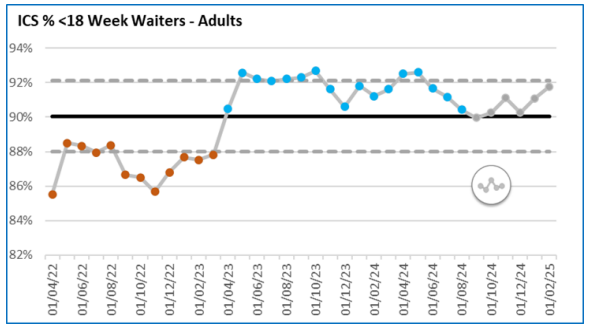
The NHS 18-week Referral to Treatment (RTT) standard only applies to consultant led services. For Children's community services this include Community Paediatrics (ICS wide) and Children's Audiology (SWH). Other services have locally agreed waiting times standards which may be 18 weeks or less. All services are shown compared to an 18-week target for an overall view of waiting time performance.

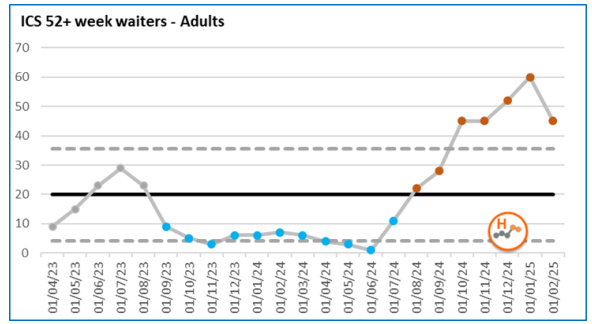
ICB Area	What the charts tell us	Issues	Actions
ICB	• The total number of children on waiting lists remains very high, but has plateaued at c.12,000 • The % of children waiting less than 18 weeks is broadly unchanged at c.37%, compared to the national average of c.50% • The longest waits are within the ENHT Community Paediatrics Service where there are now 4,208 x 52 week waits • There are additionally 188 x 52 week waits within HCT services in South & West Hertfordshire – a notable increase over the last 2 months • Consultant led 18-week RTT performance: SWH Community Paediatrics – 38.0% SWH Children's Audiology – 40.4% ENH Community Paediatrics – 13.8% WE Community Paediatrics – NO DATA	**Hertfordshire** • Most HCT children's specialist services are seeing a marked increase in demand • Waiting times in the SWH HCT Community Paediatrics service are stable but there is an increase in long waits • There are continued waiting time pressures in Paediatric Audiology in SWH, but there has been improvement with a 59% decrease in total waiters since a high point in June 2023. The service has supported ENHT newborn hearing pathways • Improvement in waiting times across Hertfordshire for children's therapies (OT, Speech & Language and Physiotherapy) although they remain under pressure, EHCP performance and workforce position is improving **West Essex (WE)** • No February data received from HCRG following cyber incident	**Hertfordshire** • Waiting list initiatives in place to limit the risk of 65+ week waiters • Community Paediatrics in SWH is continuing to receive non-recurrent extra investment to increase workforce capacity and introduce new specialist nursing posts. Service working at full establishment • Paediatric Audiology in SWH is focusing on higher priority appointments, especially follow ups, and signposting to interim advice whilst awaiting assessment. Implementing patient self-booking to reduce NBIs. Demand and capacity analysis completed and identified required staffing model to reduce the waiting list • Focus on reducing DNA / NBI rates for children living in relatively more deprived neighbourhoods • Children's Therapies – increasing capacity through successful recruitment, waiting list initiatives and outsourcing. Pilot for self-booking in one locality has reduced NBI, now being rolled out to other localities • EHCP dashboard developed to improve waiting list management **West Essex (WE)** • Increases in places at Harlow Fields special school will increase demand a pressure on therapies, community paediatric and special school nursing provisions. Currently looking at mitigations in the absence of additional resource being available to increase capacity inline • New Designated Clinical Officer for SEND in post and proactively working with both Essex and Herts DCOs • Care Closer to Home workstream restarted with PAHT • Dietician vacancy filled • Still awaiting release of identified CYP funding to close the gap between demand and capacity • Preparation for recommissioning of HCRG contract ongoing

Community Waiting Times (Adults)









		Referrals			Patients Waiting			% Waiting <18 weeks			Patients Waiting >52 Weeks			
Place	Age	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Latest data
ICS	Adults	33567	29179	↓	15881	16347	↑	91.10%	91.77%	↑	60	45	↓	February

Place	Provider	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Latest data
ENH	HCT	10176	7742	↓	9695	9835	↑	90.14%	90.34%	↑	46	33	↓	February
ENH	AJM (W/Chairs)	130	105	↓	515	481	↓	60.00%	64.24%	↑	6	3	↓	February
ENH	**All**	**10306**	**7847**	↓	**10210**	**10316**	↑	**88.62%**	**89.12%**	↑	**52**	**36**	↓	**February**

Place	Provider	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Latest data
SWH	CLCH	7942	7931	↓	1439	1597	↑	99.72%	99.62%	↓	0	0	→	February
SWH	CHEC (Ophthalmology)	NO DATA	NO DATA	-	NO DATA	NO DATA	-	NO DATA	NO DATA	-	NO DATA	NO DATA	-	February
SWH	Circle Health (MSK)	NO DATA	NO DATA	-	NO DATA	NO DATA	-	NO DATA	NO DATA	-	NO DATA	NO DATA	-	February
SWH	Communitas (ENT)	NO DATA	NO DATA	-	NO DATA	NO DATA	-	NO DATA	NO DATA	-	NO DATA	NO DATA	-	February
SWH	The Gynaecology P/Ship	NO DATA	NO DATA	-	NO DATA	NO DATA	-	NO DATA	NO DATA	-	NO DATA	NO DATA	-	February
SWH	HCT	903	969	↑	937	997	↑	96.58%	97.99%	↑	0	0	→	February
SWH	AJM (W/Chairs)	125	100	↓	579	562	↓	63.21%	67.79%	↑	8	9	↑	February
SWH	**All**	**8970**	**9000**	↑	**2955**	**3156**	↑	**91.57%**	**93.44%**	↑	**8**	**9**	↑	**February**

Place	Provider	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Latest data
WE	EPUT	14178	12251	↓	2609	2759	↑	100.00%	99.42%	↓	0	0	→	February
WE	EPUT (W/Chairs)	113	81	↓	107	116	↑	97.20%	100.00%	↑	0	0	→	February
WE	Mayflower	NO DATA	NO DATA	-	NO DATA	NO DATA	-	NO DATA	NO DATA		NO DATA	NO DATA	-	February
WE	**All**	**14291**	**12332**	↓	**2716**	**2875**	↑	**99.89%**	**99.44%**	↓	**0**	**0**	→	**February**

NOTE: **Work underway with all Community Providers currently not providing accurate community waiting list data**

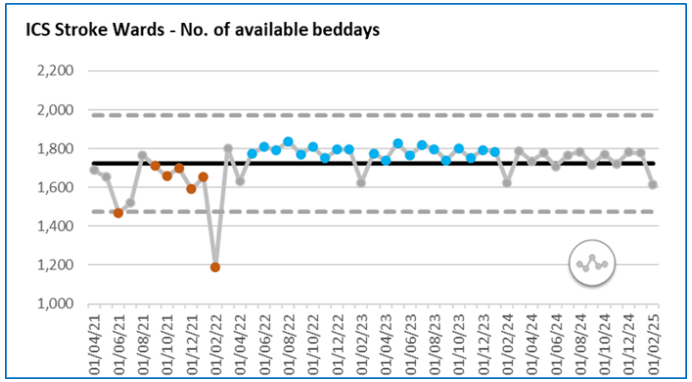
Hertfordshire and West Essex Integrated Care System

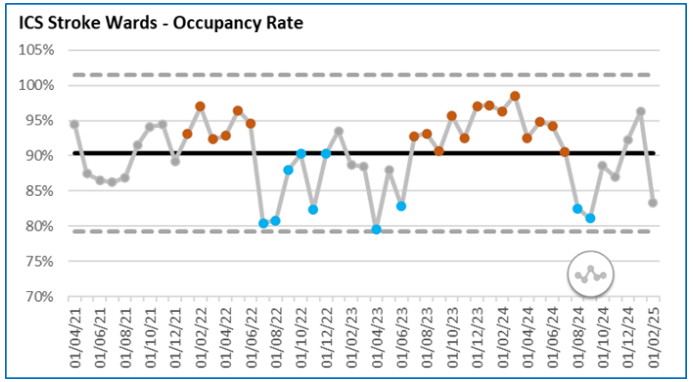
Community Waiting Times (Adults)

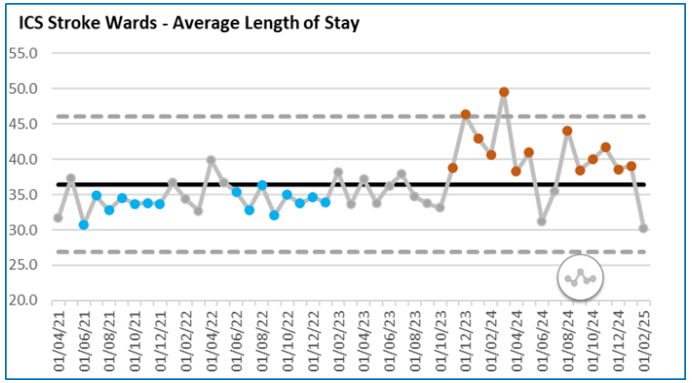
The NHS 18-week Referral to Treatment (RTT) standard only applies to consultant led services. For Adult community services this include Skin Health (ENH), Respiratory (S&W), and Podiatric Surgery (WE). Other services have locally agreed waiting times standards which may be 18 weeks or less. All services are shown compared to an 18-week target for an overall view of waiting time performance.

ICB Area	What the charts tell us	Issues	Actions
ICB	• **Data for five community providers is currently excluded from the overall HWE system position as noted on the previous slide. Work is ongoing to resolve reporting from April 25** • The % of patients waiting less than 18 weeks remains comparatively strong at 91.8%, compared to the national average of c.85% • Overall waiting lists remain close to the historic 16k average • 52 week waits reduced at both HCT and AJM wheelchairs – down from 60 to 45 in month • Consultant led 18-week RTT performance: ENH Skin Health – 92.7% SWH Respiratory – 100% WE Podiatric Surgery – 70.7%	**East & North Hertfordshire (ENH)** • Increase in referrals compared to 2023/24 • Slight reduction in the 'waiting within target' performance in recent months when compared to the pre-pandemic baseline and last year **South & West Hertfordshire (SWH)** • MSK services previously delivered by Connect have been reprocured with Circle. Work continues to resolve data quality issues before incorporation into this report • Four other Providers currently with reporting issues • CLCH – Slight decrease in number of referrals received in month and increase in total number of patients waiting on caseload. However, no patients waiting more than 52 weeks **AJM (Wheelchairs)** • 12 x 52 week waits reported in the February position, which is an improvement from 16 in the December position. Commissioners continue to work with AJM to oversee improvement plans and it should be noted that quoted waiting times are from referral to chair handover, and patients will have had multiple appointments in the interim with plans in place **West Essex (WE)** • SLT, Podiatry and Bio-Mechanics breaches of waiting times due to vacancies / capacity / long-term sickness. Maximum wait of 10 weeks v. 8-week target • MSK breaches and increased PTL following transfer of iMSK patients from Stellar Healthcare on contract termination. Also impacted by long-term sickness	**East & North Hertfordshire (ENH)** • All waits, especially longer waits, are closely monitored and subject to robust internal governance • Service productivity initiatives continue • Comprehensive health inequalities metrics in place and analysis has allowed the Trust to compare waiting times and DNA rates for those living in relative deprivation versus those that do not. Targets have been set to address discrepancies • Extensive focus on digital initiatives to support and improve patient access • Forecasting suggests a generally stable trend over the next 12 months **South & West Hertfordshire (SWH)** • Working with Circle and ICB contract leads to resolve reporting issues following re-tender of SWH MSK contract from 1st April • Contract teams also working with the other four providers not currently reporting to resolve for 25/26 • Daily and weekly monitoring remain in place. Additional external support sourced for services where there are waiting times concerns. These include Neuro, Bladder and Bowel, Planned Care Therapy, and Respiratory services **West Essex (WE)** • SLT breaches continue to improve month on month – recovery expected from March • Podiatry / Bio-Mechanics – band 6 post out to advert. Locum support from 14th April • iMSK recovery plan agreed and continued month on month improvement

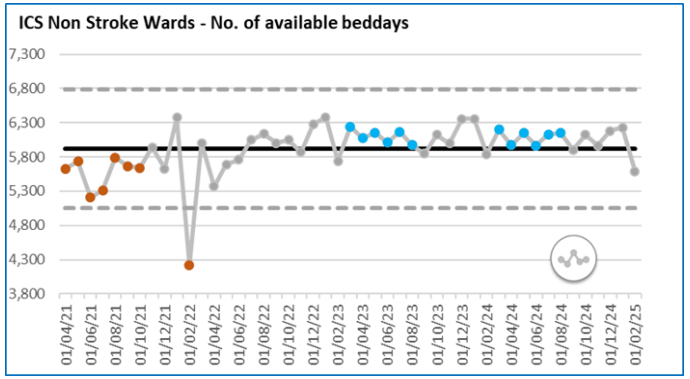
Community Beds (Stroke & Non-Stroke)

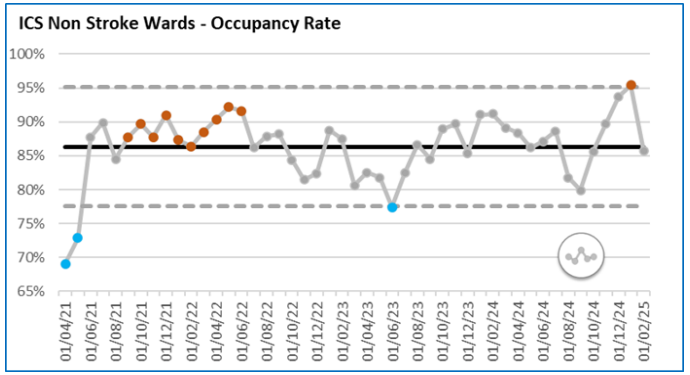


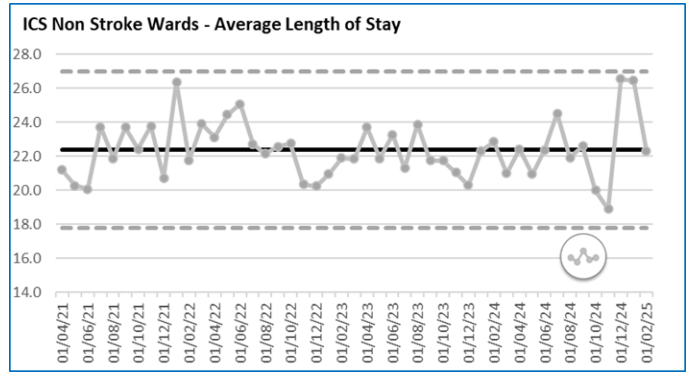




Stroke Wards		Number of available beddays			Occupancy Rate			Average length of stay (days)			
Place	Provider	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Latest data
ENH	HCT	744	672	↓	95.30%	88.10%	↓	37.8	26.5	↓	February
SWH	CLCH	600	550	↓	99.83%	92.73%	↓	39.8	29.6	↓	February
WE	EPUT	434	392	↓	92.86%	61.99%	↓	40.0	41.0	↑	February
ICS	**All**	**1778**	**1614**	↓	**96.23%**	**83.33%**	↓	**39.0**	**30.3**	↓	**February**





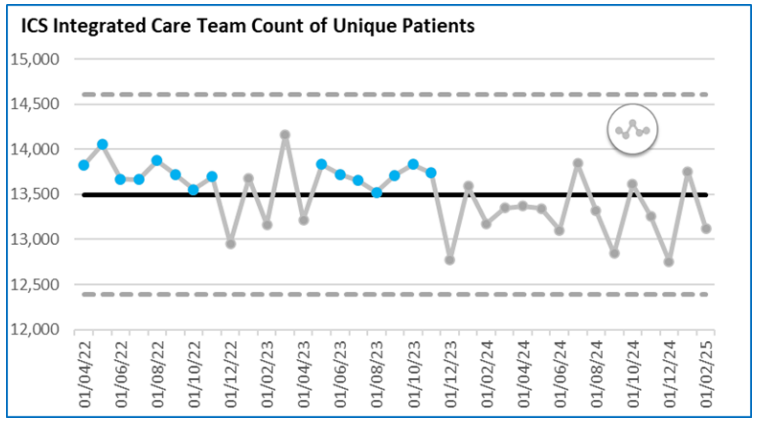


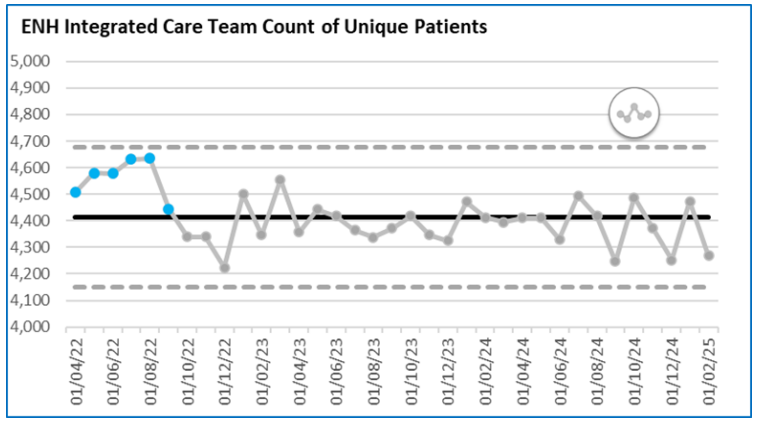
Non-Stroke Wards		Number of available beddays			Occupancy Rate			Average length of stay (days)			
Place	Provider	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Latest data
ENH	HCT	1739	1484	↓	91.78%	84.23%	↓	23.7	20.2	↓	February
SWH	CLCH	2232	2060	↓	98.84%	95.68%	↓	25.8	23.9	↓	February
WE	EPUT	2263	2044	↓	94.92%	76.81%	↓	29.1	22.0	↓	February
ICS	**All**	**6234**	**5588**	↓	**95.44%**	**85.74%**	↓	**26.4**	**22.3**	↓	**February**

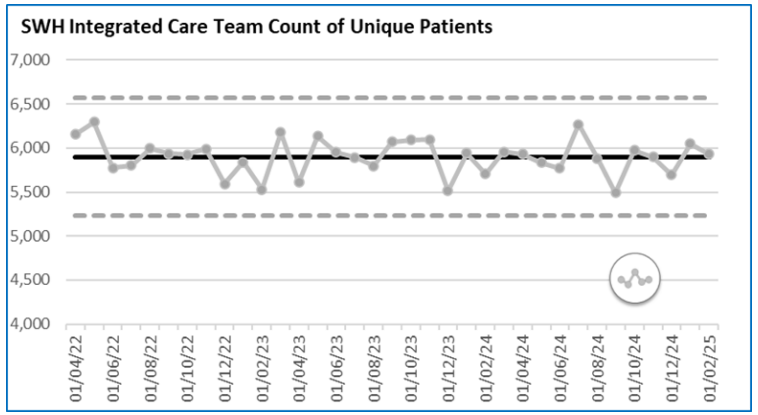
Community Beds (Stroke & Non-Stroke)

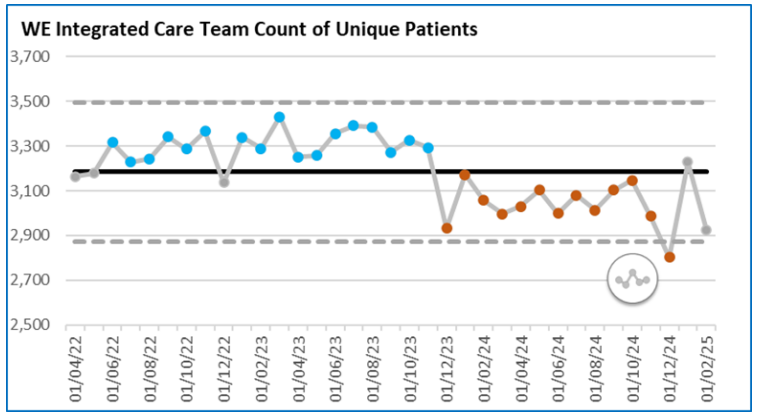
ICB Area	What the charts tell us	Issues	Actions
ICB	**Stroke Beds** • Available stroke bed days remain stable • Overall stroke bed occupancy rates dropped to 83.3%, driven primarily by a reduction at EPUT to 62.0% • CLCH occupancy remains high at 92.7% • Overall length of stay is within common cause variation limits, but is highest within EPUT at 41 days **Non-Stroke Beds** • Available non-stroke bed days reduced due to lower number of days in February • Overall non-stroke bed occupancy rates reduced at all providers, returning to the historic average of c.85% • Overall length of stay reduced at all providers, returning to the average of c.22 days	**East & North Hertfordshire (ENH)** • Bed occupancy remains the highest at Danesbury with an average of 90% over the past 12 months. Herts & Essex and QVM both have a 12-month average occupancy of 82 • Average length of stay over the past 12 months for Herts & Essex averaged 24 days, and 27 days at QVM. At Danesbury, there is now normal variation with an average of 37 days. Admissions into community hospitals show no significant change in trend at Herts and Essex and QVM • Danesbury has the least admissions with an average of 17 a month, with QVM averaging 18, and Herts & Essex averaging 32 **South & West Hertfordshire (SWH)** • Although reduction in occupancy rates from previous month, this remains high • Reduction in average length of stay **West Essex (WE)** • Length of stay on stroke ward increased by 1 day, but has reduced from 49 days in November, as the longest stay patients have been discharged • Non-stroke bed occupancy and length of stay have seen positive improvements and both decreasing. This is reflective of the D2A ward opening, and despite increased acuity of patients. Continuous improvement work ongoing	**East & North Hertfordshire (ENH)** • New process regarding criteria to reside in place to support discharge • Step up as well as step down in place **South & West Hertfordshire (SWH)** • Daily assurance calls remain in place with HCC, with clear escalation process • TOCH has now gone live • Deep Dive into all units currently underway. Focus is on referral numbers, admissions & discharges and average length of stay **West Essex (WE)** • Daily escalation calls in place to support all delayed discharges • Discharge to Assess (D2A) – 22 dedicated beds now in place to support system

Integrated Care Teams (ICT)









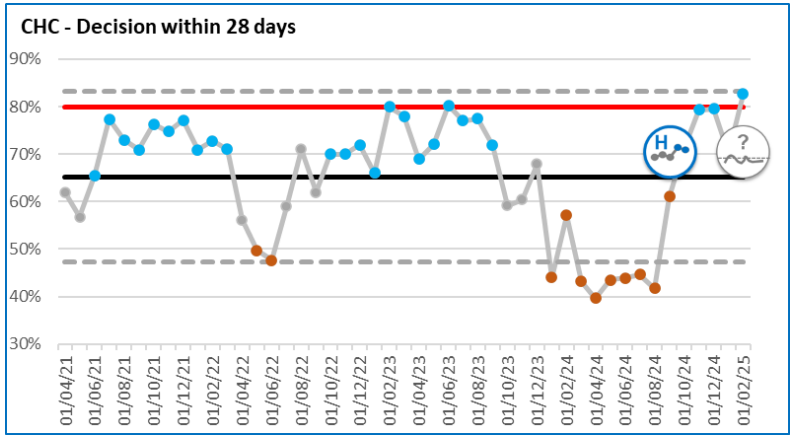
			Contacts (unique patients)			Contacts (unique patients) per 1000 population			
Place	Provider	Age	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Latest data
ENH	HCT	All	4473	4269	↓	7.1	6.8	↓	February
SWH	CLCH	All	6051	5932	↓	8.7	8.6	↓	February
WE	EPUT	All	3228	2923	↓	9.6	8.7	↓	February
ICS	**All**	**All**	**13752**	**13124**	↓	**8.3**	**7.9**	↓	**February**

Hertfordshire and West Essex Integrated Care System

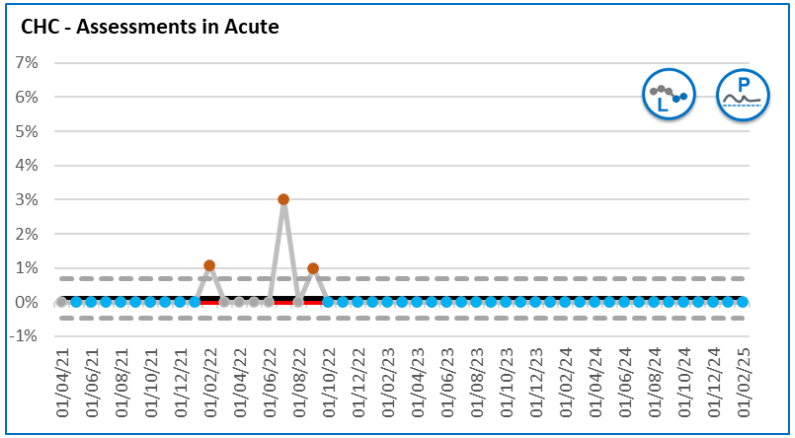
Integrated Care Teams (ICT)

ICB Area	What the charts tell us	Issues	Actions
ICB	• Unique contacts across the ICS and within each place are within common cause variation limits • However, other than in one-month, contacts in West Essex have trended below the historic average during 24/25	**East & North Hertfordshire (ENH)** • The number of individuals rereferred to the ICT is similar to pre-pandemic • There is an increase in the first-to-follow-up appointment ratio linked to increased acuity • The overall caseload is much higher than in 2019/20 across all localities • Patient complexity is increasing, with more intensive treatments required. e.g. numbers of intravenous antibiotics (IV) and End of Life (EOL) patients **South & West Hertfordshire (SWH)** • Slight reduction in contacts. This is due to planned and unexpected leave **West Essex (WE)** • Since April 2021 ICTs have seen a reduction in referrals. Contacts per patient however have increased, suggesting an increase in acuity of patients receiving care in the community • Contacts reduced in month, but are still up compared to the 2803 for December position	• Care Closer to Home programme underway across HWE to reduce variation and shift to reporting outcomes and impact, to compliment the activity driven data that exists **East & North Hertfordshire (ENH)** • A comprehensive transformation programme in place focused on workforce, wound care and diabetes management with the ICT • Model being developed to improve capacity, agility and consistency across ICTs • Comprehensive SystmOne optimisation project continues roll out - aiming to streamline use of clinical systems with a prospective productivity gain • The Hospital at Home services appear to be effectively supporting reduced Acute demand **West Essex (WE)** • Work progressing to support development of Integrated Neighbourhood Teams of which the ICTs are integral, alongside socialisation of the new HWE Care Closer to Home model of care • Proactive care model for segments 4 & 5 to support a 25% reduction in NELs • Proposal to accelerate support in Harlow with an additional matron submitted to BCF

Continuing Health Care (CHC)



	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25
East & North Hertfordshire	70.8%	74.2%	84.9%	86%	100%	83%	100%	70%	88%	83%	91%	87%	82.5%	86.5%	82.1%	75.6%	87.5%	82.9%	75.7%	77.1%	80.0%	50.0%	80.4%	67.5%	65.0%	71.9%	48.8%	71.7%	64.3%	63.6%	64.9%	82.1%	71.2%	69.0%	78.6%
South & West Herfordshire	47.2%	35.2%	23.4%	36%	41%	33%	50%	63%	58%	63%	72%	67%	50.0%	61.7%	73.6%	71.8%	69.7%	56.5%	86.4%	45.8%	47.5%	34.9%	35.4%	23.5%	22.4%	23.2%	28.0%	28.6%	24.4%	57.1%	80.4%	81.0%	81.4%	70.4%	80.6%
West Essex	88.9%	89.5%	85.0%	75%	100%	85%	89%	81%	78%	64%	87%	89%	91.7%	91.3%	87.9%	92.9%	83.9%	87.5%	92.6%	70.8%	92.9%	76.5%	84.6%	76.2%	71.4%	56.8%	71.8%	52.1%	66.7%	73.1%	65.5%	66.7%	75.0%	71.4%	75.0%
ICS	56.2%	49.7%	47.6%	59%	71%	62%	70%	70%	72%	66%	80%	78%	68.9%	72.1%	80.3%	77.1%	77.5%	71.9%	89.2%	60.4%	67.9%	44.0%	57.1%	43.2%	39.6%	43.5%	43.9%	44.6%	41.7%	61.1%	72.1%	79.3%	79.5%	70.1%	82.7%

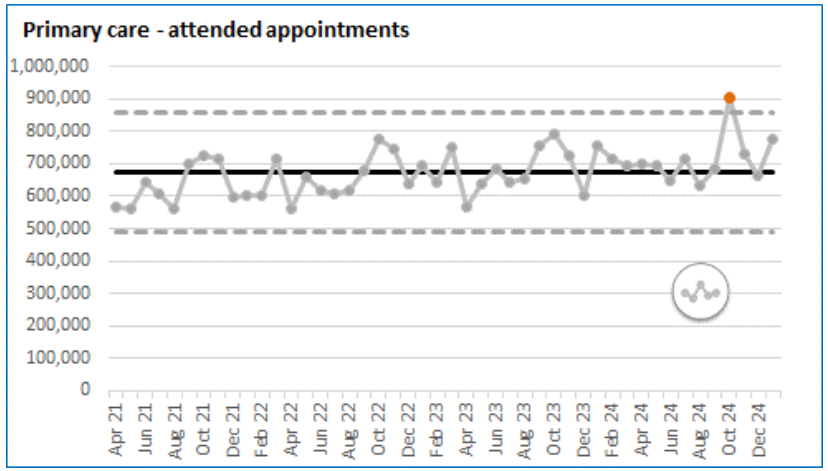


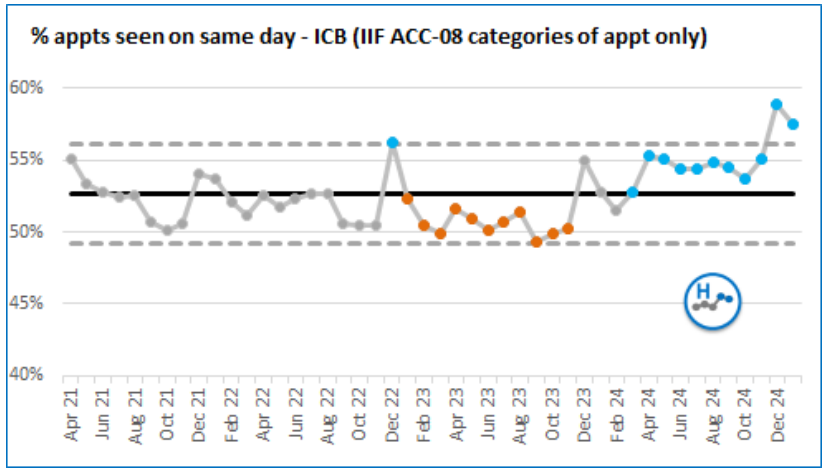
	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25
East & North Hertfordshire	0%	0%	0%	5%	0%	6%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
South & West Herfordshire	0%	0%	0%	3%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
West Essex	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
ICS	0%	0%	0%	3%	0%	1%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%

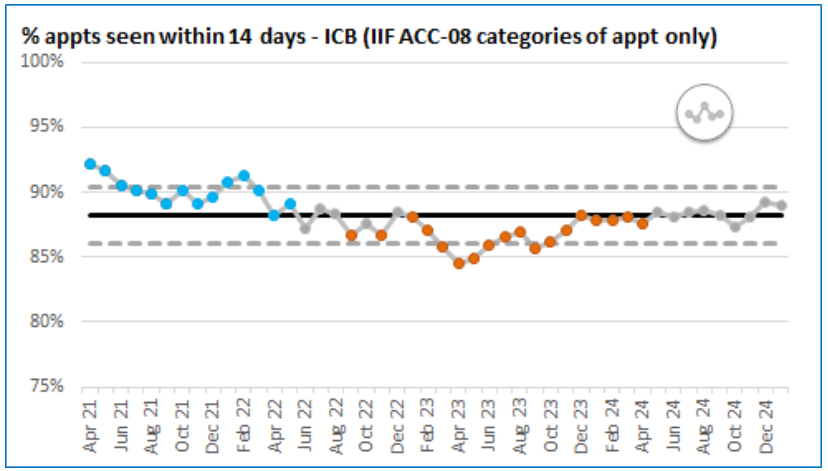
	What the charts tell us	Issues	Actions
HWEICB	• The 28-day standard has notably improved over the last two months, most significantly in South & West Hertfordshire • February overall performance significantly improved and the ICB has achieved the national target (>=80%) for the first time since its formation: ○ Overall ICB – 82.7% ○ West Essex – 75% ○ ENH – 78.6% ○ SWH – 90.6% • The recovery of the 28-day standard was forecast to be achieved by Q4 24/25 and is on track • The assessments in an acute setting <15% standard continues to be routinely achieved	• The newly recruited starters do not have previous CHC experience and therefore require robust training and development, this is an ongoing concern. • Continued concerns around Social Worker availability across all areas is predicted to have a negative impact on the 28-day KPI. • Both East & North Herts and West Essex remain short of the target due to a lack of nursing capacity within the team, this continues to be addressed where possible given current system limitations.	• Weekly meetings are in place across all areas to monitor performance. Additional assurance meetings are being held with NHSE • A further comprehensive layer of management control and support is being implemented across the East & North Herts and West Essex service to significantly improve work allocation, daily analysis of completed work, case status and risk identification. This approach is similar to that which has improved the service in South & West Herts • More robust induction and training packs are being developed for new starters to ensure they can become as productive as possible with day-to-day operations as quickly as possible

Hertfordshire and West Essex Integrated Care System

Primary Care







NOTE: %s in the above charts are based on appointments made, not requests received

What the charts tell us

- Although the number of primary care attended appointments continues to show standard normal variation, there is a continued slight upward trend in the number of attended appointments. For example, the number of appointments attended in M1-10 of FY2425 have been 5% higher than M1-10 of FY2324.
- The % of appointments seen on the same day of booking has been above the long-term mean for the last eleven months, suggesting that there has been a sustained improvement in this metric. The chart above now shows the % of same day appointments for a subset of appointment types where the patient would typically want the first available appointment, rather than reviews / check-ups (IIF ACC-08 categories of appointment)
- The % of appointments which were seen within 14 days of booking has returned towards the mean over the last nine months, and performance is only marginally below this year's plan of 89%. The chart above now shows the % of same day attendances for a subset of appointment types where the patient would typically want the first available appointment, rather than reviews / check-ups (IIF ACC-08 categories of appointment)

Primary Care

Issues	Actions
• National contract for 24/25 imposed without agreement and Collective Action in Primary Care added to the risk register – new contract for 25/26 agreed however while formal collective action stood down the principle of not undertaking unfunded work remains • General Practice continues to see increases in demand against a backdrop of working through the backlog, workforce pressures and negative media portrayal • 24/25 focus on cutting bureaucracy, helping practices with cash flow and increase financial flexibilities and continue to improve patient experience of access • 25/26 greater emphasis on performance management with launch of new Primary Care General practice dashboard and supporting elective recovery through Advice and Guidance Local Enhanced Service, reducing bureaucracy continues with reduction in QOF indicators, and new contract requirement for access to online consultations • 25/26 contract changes for Dental and Community Pharmacy	**Engagement with the National Access Recovery Plan** • Logging local intelligence on practices taking part in collective action and ongoing work with HETCG and liaison with LMC to identify and mitigate any issues arising • Annual GP Patient Survey (GPPS) was published in July (data collected Jan –Mar 24). Overall slight improvement and PCCC and Primary Care Board oversight of results. Action plan developed through the Access MDT Group Triangulation with other data held does not show any strong correlation e.g. number of appointments, digital telephony etc. • GPPS 2024 Dental Access results shows HWE as best performing in East of England • National Monthly Health Insights survey Wave 7 (published March 25) shows 12.7 point improvement in % of patients rating their overall experience of general practice as good. • Many practices transitioning to Modern General Practice (MGP) through demand / capacity analysis, use of cloud-based telephony, roll out NHS app, online GP registration, development of GP and PCN websites and testing triage models. Audit undertaken of the latest position for all practices for 24/25 year-end update. • Local CAIP - 29 of 35 PCNs have submitted their self-declaration based on the PCN's progress in implementing the Modern General Practice Access (MGPA) model and specifically in delivering against three priority domains. Specifically, these are Better Digital Telephony – 29 PCNs; Simpler Online Requests – 24 PCNs; Faster Care Navigation, Assessment and Response – 26 PCNs. PCNs can submit their self-declaration up to 31 March 25 • Transition Cover – All practices supported with further funding to implement modern general practice • All practices now have Cloud Based Telephony of some level. Looking at options for improving services at the circa 25 practices who are on the lowest level of CBT • National GP Improvement Programme - 43 practices & 4 PCNs participated in this nationally supported facilitated programme • Support Level Framework (SLF): Self-assessment tool to support practice teams in understanding what they do well, what they might wish to do better, and where they might benefit from development support. Roll-out of SLF facilitated sessions for practices at increased pace in 24/25 • The majority of practices have progressed towards full enablement of prospective records access; over 725k patients across HWE have access to their records; 60% of practices have 90%+ of patients with online access + records access enabled; over 80% of practices with 80%+ • Partnership working to increase self-referrals in high volume services: Physio, IAPT, Podiatry etc. • Communications to support ICB and practice websites, media statements and patient comms re the Delivery Plan • Inclusion of newly qualified GPs in the ARR scheme from Oct 24, with 21 of 35 PCNs claimed by end of Jan-25. Workforce Leads engaging with PCNs to support further recruitment • Review of newly launched national CATS GP Performance Dashboard, noting negative variation identified in Access and Patient Experience for 21 practices, Workforce 4 practices have negative variation, Clinical Outcomes and Quality negative variation in 4 practices and for Vaccs and Imms there are 17 practices identified. Further analysis planned through conversation with BI, monthly Access MDT and Risk and information sharing groups. The CATs tool will feed in to local contract monitoring noting limitations of using bottom decile and take as a starting point for discussion with practices to understand if variation is unwarranted. • Planning for June submission of GP practice plans focussed on access and unwarranted variation and identify practices suitable for GPIP and PLS • Work in progress on implementation of the Advice and Guidance LES **Other** • Active engagement with LMCs to refine Enhanced Commissioning Framework (ECF) for 25/26, including specific activity-based payment for Wound Care activity. • Trend analysis to identify practices with poor access via complaints and patient contacts • Initiatives for Primary Care Workforce to support recruitment and retention, supported by the HSE ICB Training Hub • Daily review of OPEL reporting by practices and follow up by place Primary Care Teams with individual practices • Pharmacy First now live, work with Community Pharmacy leads and practices to promote service • Approval of extension of Urgent Dental Access pilot to support Operating Plan submission to ensure delivery of our required additional dental appointments • Child Focused Dental pilot agreed

Appendix A: Performance Benchmarking (ICB)

February 2025 — Hertfordshire and West Essex ICB

Area	Activity	Latest Published Data	Data Published	Trend Aagainst Last Month	NATIONAL Position National vs (ICB)	REGIONAL Position EoE Region vs (ICB)	ICB Ranking
111	Proportion of Calls Answered < 60 secs	80.9%	March 25	✗ -0.33%	82.07% (Worse)	84.93% (Worse)	20
	Proportion of Calls Abandoned	2.7%	March 25	✓ -5.63%	3.16% (Better)	2.37% (Worse)	18
A&E	% Seen Within 4 Hours (with additional mapped activity)	78.4%	March 25	✓ 4.634%	74.98% (Better)	74.80% (Better)	11
	% >12hr Waits in ED From Arrival	9.2%	March 25	✓ -25.68%	9.71% (Better)	9.17% (Worse)	16
Cancer	28 Days Faster Diagnosis	80.3%	February 25	✓ 10.21%	80.21% (Better)	77.65% (Better)	21
	31 Days Standard	94.6%	February 25	✓ 4.27%	91.75% (Better)	89.80% (Better)	12
	62 Days Standard	70.0%	February 25	✗ -1.54%	66.96% (Better)	61.99% (Better)	13
RTT	Incomplete Pathways <18 weeks	57.0%	February 25	✓ 0.73%	59.2% (Worse)	54.9% (Better)	15
	52+ Weeks as % of Total PTL	2.66%	February 25	✗ 3.69%	2.61% (Worse)	3.71% (Better)	28
	65+ Weeks as % of Total PTL	0.08%	February 25	✓ -30.14%	0.18% (Better)	0.27% (Better)	11
	78+ Weeks as % of Total PTL	0.00%	February 25	✓ -31.17%	0.02% (Better)	0.03% (Better)	10
Diagnostics	% Waiting 6+ Weeks	28.8%	February 25	✓ -21.58%	17.46% (Worse)	24.69% (Worse)	40
Mental Health	Dementia Diagnosis Rate	65.0%	February 25	✗ -0.15%	65.40% (Worse)	64.00% (Better)	21
	Out of Area Placements	37	February 25	✗ 5.41%	n/a	n/a	n/a
CHC *	% of Eligibility Decisions Made Within 28 Days	82.7%	February 25	✓ 15.18%	75.53% (Better, at 76.73%)	76.17% (Better, at 76.73%)	26
	% of Assessments Carried Out in Acute Settings	0.0%	February 25	▬ 0.00%	0.40% (Better, at 0.31%)	0.13% (Worse, at 0.31%)	27

LEGEND

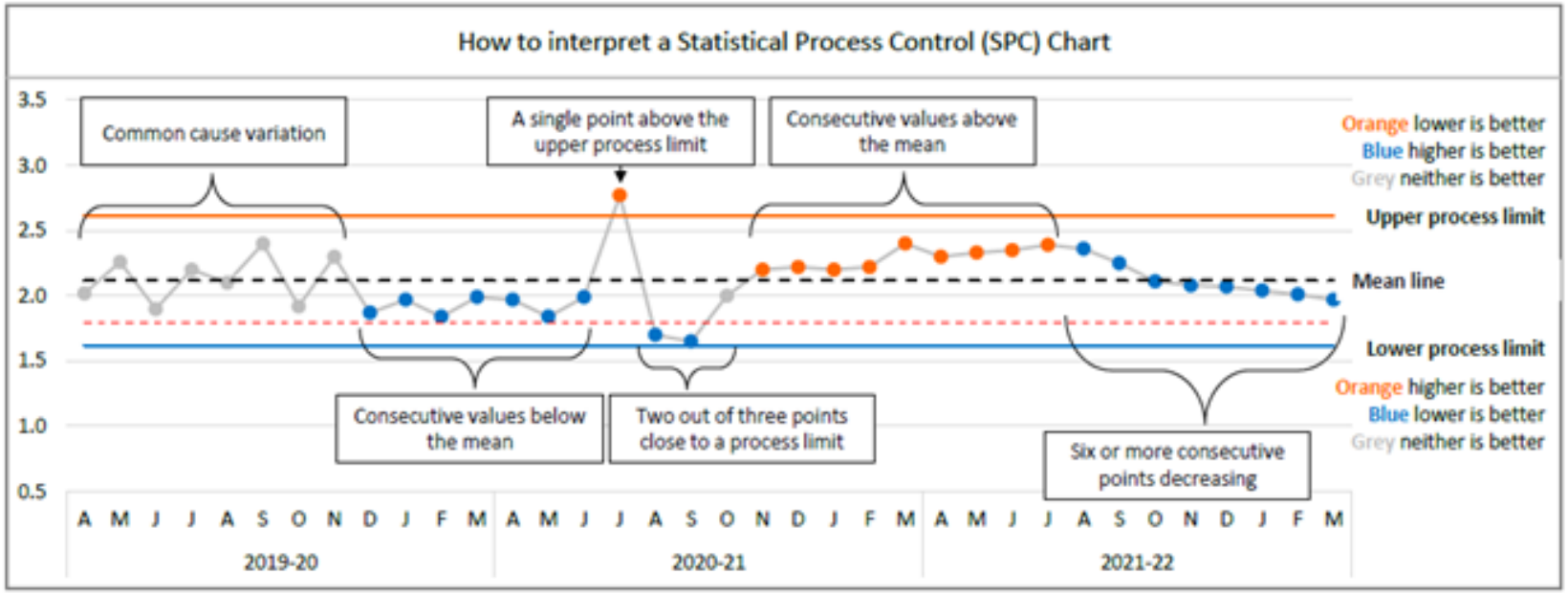
Performance against National/Regional
- Better
- Worse

Performance against previous month
- ✓ Improvement
- ✗ Deterioration
- ▬ No change

Provider Ranking
- First quartile
- Middle quartile
- Lowest quartile

* **CHC benchmarking and ranking** is based on quarterly data only.
The latest data is Q3 for 2024/25 (covering Oct - Dec 2024).

Appendix B: Statistical Process Control (SPC) Interpretation



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

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

Appendix C: Glossary of acronyms (1 of 2)

A&E	Accident & Emergency
AAU	Ambulatory Assessment Unit
ADHD	Attention Deficit Hyperactivity Disorder
AHC	Annual Health Check
ASD	Autism Spectrum Disorder
BAME	Black Asian & Minority Ethnic
BAU	Business As Usual
CAMHS	Children & Adolescent Mental Health Service
CCATT	Children Crisis Assessment & Treatment Team
CCC	Care Coordination Centre
CDC	Community Diagnostic Centre
CDU	Clinical Decision Unit
CHAWS	Child Health and Women's Service
CHC	Continuing Healthcare
CISS	Community Intensive Support Service
CLCH	Central London Community Healthcare NHS Trust
CPCS	Community Pharmacy Consultation Service
CQI	Continuous Quality Improvement
CQC	Care Quality Commission
CT	Computerised Tomography (scan)
CYP	Children & Young People
D2A	Discharge to Assess
DEXA	Dual Energy X-ray Absorptiometry (bone density scan)
DMAS	Digital Mutual Aid System
DQ	Data Quality
DST	Decision Support Tool
DTA	Decision To Admit
DTOC	Delayed Transfer of Care
DWP	Department for Work & Pensions
EAU	Emergency Assessment Unit
ECAT	Emergency Clinical Advice and Triage

ECHO	Echocardiogram
ED	Emergency Department
EEAST	East of England Ambulance Service NHS Trust
EIP	Early Intervention in Psychosis
EMDASS	Early Memory Diagnosis and Support Service
EMIS	Supplier of GP Practice systems and software
ENHT	East & North Herts NHS Trust
EPR	Electronic Patient Record
EPUT	Essex Partnership University NHS Foundation Trust
F2F	Face-to-Face
FDS	Cancer 28 day Faster Diagnosis Standard
FHAU	Forest House Adelescent Unit
FNC	Funded Nursing Care
GIRFT	Getting It Right First Time
GP	General Practice
GPPS	GP Patient Survey
HALO	Hospital Ambulance Liaison Officer
HCA	HealthCare Assistant
HCT	Hertfordshire Community Trust
HEG	Hospital Efficiency Group
HPFT	Hertfordshire Partnership NHS Foundation Trust
HCRG	Health Care Resourcing Group
HUC	Hertfordshire Urgent Care
ICB	Integrated Care Board
ICP	Integrated Care Partnership
ICS	Integrated Care System
IPC	Infection prevention and control
IS	Independent Sector
IUC	Integrated Urgent Care
IUATC	Integrated Urgent Assessment and Treatment Centre

Glossary of acronyms (2 of 2)

LA	Local Authority
LD	Learning Disability
LDAHC	Learning Disability Annual Health Checks
LMNS	Local Maternity Neonatal System
LMS	Local Maternity System
LoS	Length of Stay
MADE	Multi Agency Discharge Event
MDT	Multi Disciplinary Teams
MH	Mental Health
MHSOP	Mental Health Service for Older People
MOU	Memorandum Of Understanding
MRI	Magnetic Resonance Imaging
MSK	Musculoskeletal
NHSE	NHS England
NICE	The National Institute for Health & Care Excellence
NMCTR	Not Meeings Criteria To Reside
NOK	Next Of Kin
NOUS	Non-Obstrtric Ultrasound
OOAP	Out of Area Placements
OPEL	Operational Pressures Escalation Levels
OT	Occupational Therapy
PAH / PAHT	The Princess Alexandra Hospital NHS Trust
PCN	Primary Care Network
PEoLC	Palliative & End of Life Care
PIFU	Patient Initiated Follow-Up
PMO	Project Management Office

PRISM	Primary Integrated Service for Mental Health
PTL	Patient Tracking List
RCA	Root Cause Analysis
REAP	Resource Escalation Action Plan
RESUS	Resuscitation
RTT	Referral to Treatment (18-week elective target)
SACH	St Albans City Hospital
SAFER	Tool to reduce patient flow delays on inpatient wards
SDEC	Same Day Emergency Care
SLT	Speech & Language Therapist
SMART	Surge Management and Resilience Toolset
SMI	Severe Mental Illness
SRG/LDB	System Resilience Group / Local Delivery Board
SSNAP	Sentinel Stroke National Audit Programme
SVCC	Single Virtual Call Centre
T&O	Trauma and Orthopaedic
TOCH	Transfer of Care Hub
TTA	Take Home Medication (To Take Away)
UEC	Urgent Emergency Care
US	Ultrasound Scan
UTC	Urgent Treatment Centre
VCSFE	Voluntary, Community, Faith and Social Enterprise
WAF	Winter Access Fund
WGH	Watford General Hospital
WHHT	West Herts Hospital Trust
WW	Week Waits

Hertfordshire and West Essex Integrated Care System

HWE ICB Finance Report Month 1 2025/26

Working together
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HWE ICS Revenue Financial Position Month 1 2025/26

This is the reported financial position for Month 1 (April). The ICS reported a Year-To-Date overspent position of £13.566m. The ICS planned to be £13.688m overspent at Month 1, so the YTD variance is favourable to plan by £0.122m.

MONTH 1 2025/26	YTD PLAN	YTD ACTUALS	YTD VARIANCE
ORGANISATION	£'000	£'000	£'000
ENHT	(4,684)	(4,682)	2
HCT	(30)	(30)	0
HPFT	(1,593)	(1,587)	6
PAH	(1,897)	(1,864)	33
WHTH	(2,422)	(2,341)	81
TOTAL HWE ICS PROVIDERS	**(10,626)**	**(10,504)**	122
HWE ICB	(3,062)	(3,062)	0
TOTAL HWE ICS ORGANISATIONS	**(13,688)**	**(13,566)**	122

MONTH 1 2025/26 Payroll Costs	YTD PLAN		YTD ACTUALS		YTD VARIANCE	
ORGANISATION	WTE	£'000	WTE	£'000	WTE	£'000
ENHT	6,932	37,086	6,568	36,673	**364**	**413**
HCT	2,525	11,177	2,334	10,572	**191**	**605**
HPFT	4,673	22,709	4,669	22,432	**4**	**277**
PAH	4,284	23,787	4,191	23,505	**93**	**282**
WHTH	5,450	31,063	5,455	31,832	**(5)**	**(769)**
TOTAL HWE ICS PROVIDERS	**23,864**	**125,822**	**23,217**	**125,014**	**647**	**808**

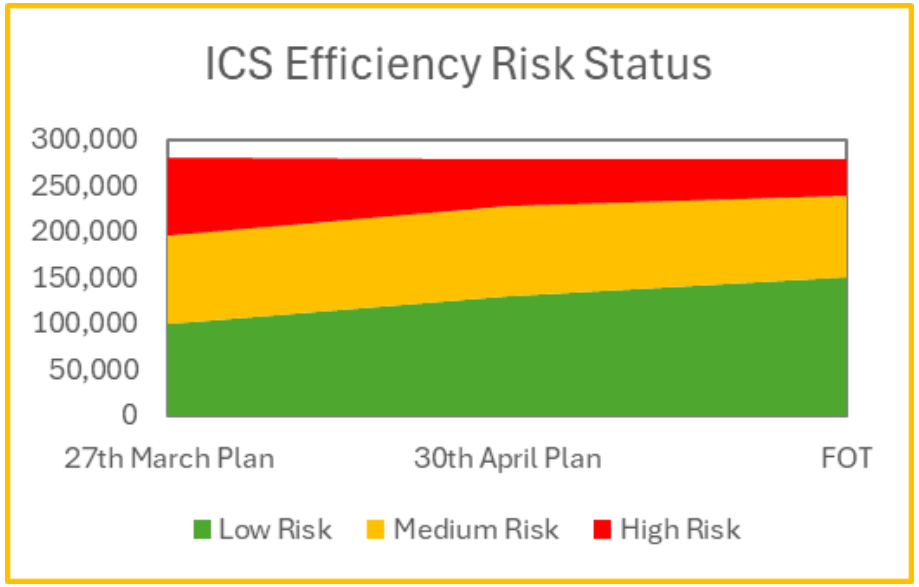
The Year-To-Date reported spend on Payroll for Month 1 (April) for the ICS Trusts was reported to be favourable. The number of staff employed (WTE) were 647 WTE ahead of plan and the spend was £0.808m ahead of plan.

HWE ICS Efficiencies
Month 1 2025/26

At Month 1 (April), 56% of the ICS efficiency schemes were Fully Developed, with 5% remaining Unidentified. The ICS has categorised 53% to be of Low risk, and 15% as High risk, with the level of risk varying between the Providers.

MONTH 1 2025/26 Efficiencies	TOTAL	Development Stage				Risk Level		
		Fully Developed	In Progress	Opportunity	Unidentified	Low	Medium	High
ORGANISATION	£'000	%	%	%	%	%	%	%
ENHT	35,760	38%	19%	26%	17%	38%	19%	43%
HCT	8,626	27%	24%	26%	23%	23%	45%	32%
HPFT	27,468	64%	19%	17%	0%	43%	37%	20%
PAH	26,150	37%	26%	12%	25%	37%	29%	34%
WHTH	33,408	75%	24%	0%	0%	50%	25%	25%
HWE ICB	144,785	60%	40%	0%	0%	65%	35%	0%
TOTAL HWE ICS ORGANISATIONS	**276,197**	**56%**	**32%**	**7%**	**5%**	**53%**	**32%**	**15%**

The Efficiency Programme has been de-risked since the original Planning Submission



Level of Risk	27th March Plan	30th April Plan	FOT	%
Low Risk	98,826	129,127	149,666	54%
Medium Risk	97,530	98,699	88,730	32%
High Risk	83,659	51,370	40,801	15%
Total Efficiencies	280,016	279,196	279,197	100%

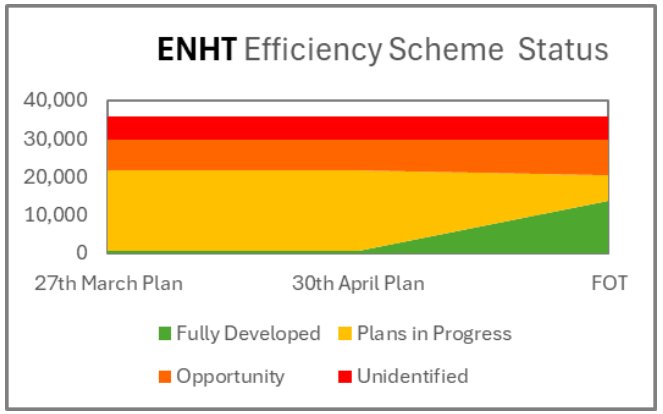
The system has reassessed the risk level of the efficiency programme since its initial submission. It has shown improvement in classifying 54% of efficiency targets as low risk at the end of Month 1.

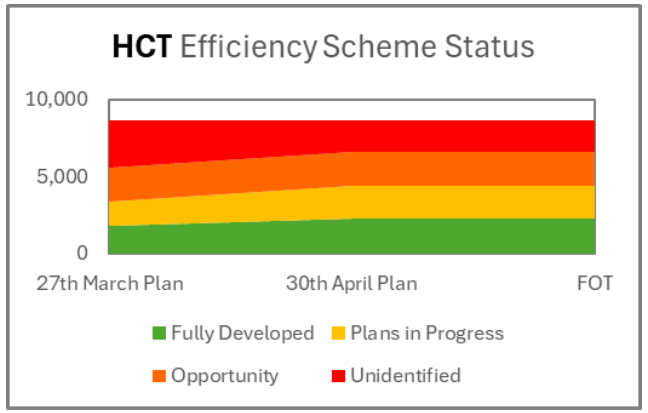
The risk levels of the efficiency programme vary between individual providers. The next two slides will explore the level of improvement achieved by each organisation in developing efficiency schemes and de-risking the efficiency programme since the original plan.

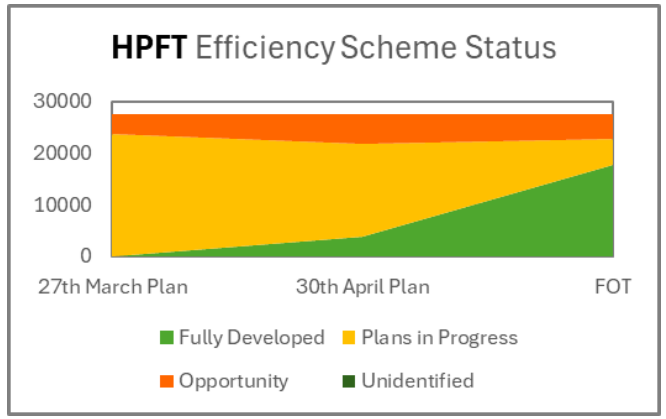
The two sets of graphs for each organisation may provide insight into the frequency of review of risk rating at each change of development stage of efficiency schemes, as well as each organisation's risk appetite.

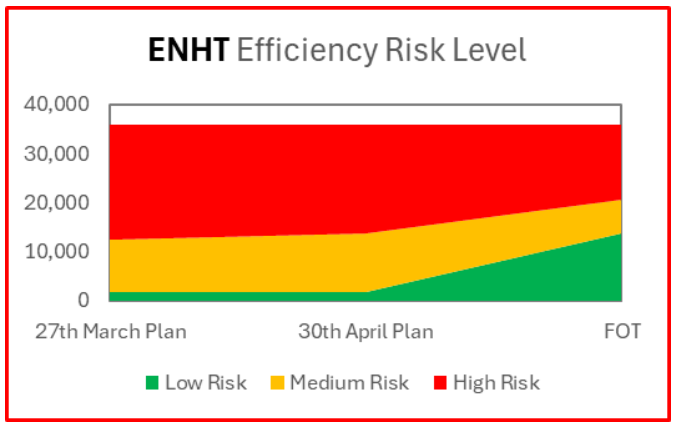
Despite differing levels of risk, all organisations are forecasting to achieve 100% delivery of the efficiency programme by the year-end.

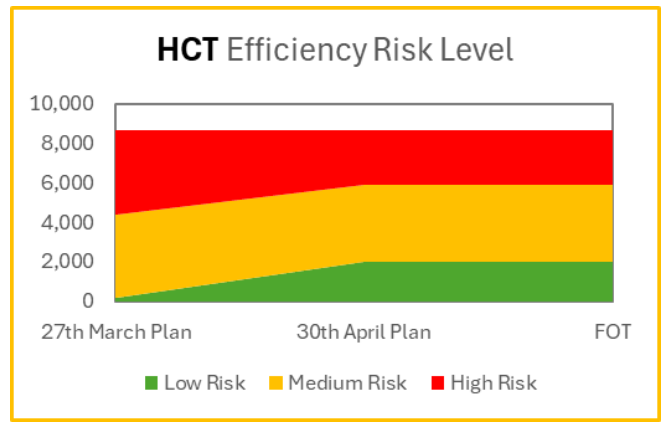
Efficiency Scheme Development & Risk Level by Individual Organisation (Slide 1 of 2)

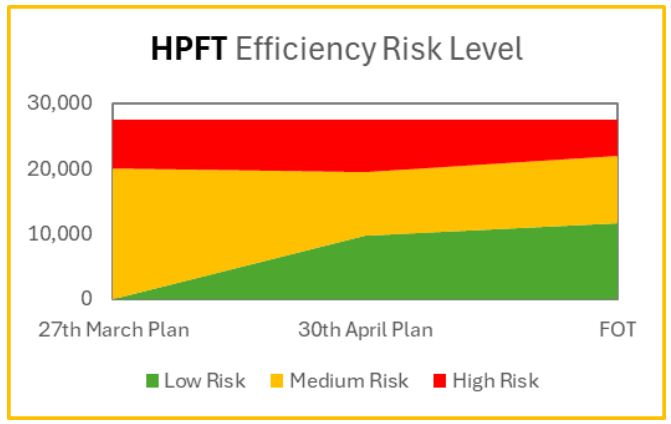










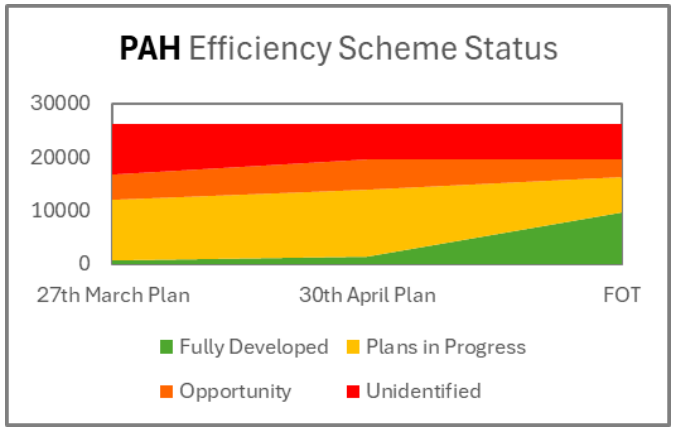


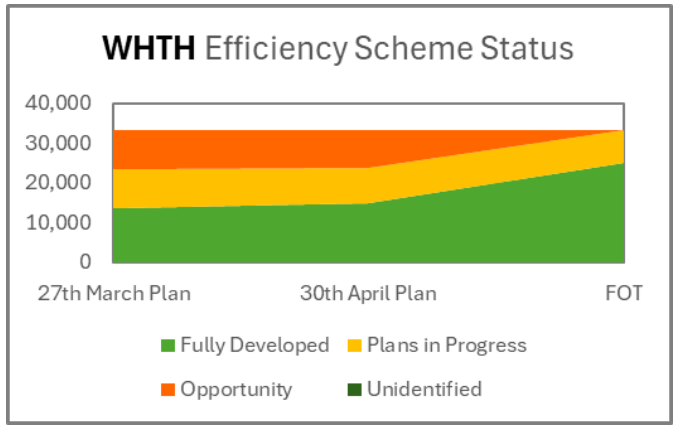
Level of Risk	27th March Plan	30th April Plan	FOT	%
Low Risk	1,764	1,764	13,600	38%
Medium Risk	10,711	11,908	6,908	19%
High Risk	23,285	22,088	15,252	43%
Total Efficiencies	35,760	35,760	35,760	100%

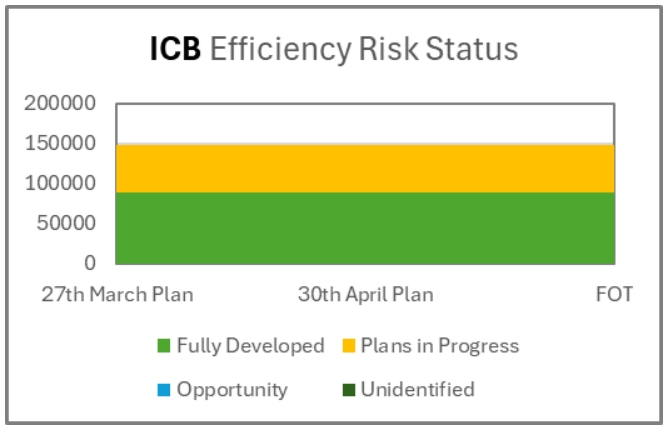
Level of Risk	27th March Plan	30th April Plan	FOT	%
Low Risk	186	1,993	1,993	23%
Medium Risk	4,169	3,870	3,870	45%
High Risk	4,271	2,763	2,763	32%
Total Efficiencies	8,626	8,626	8,626	100%

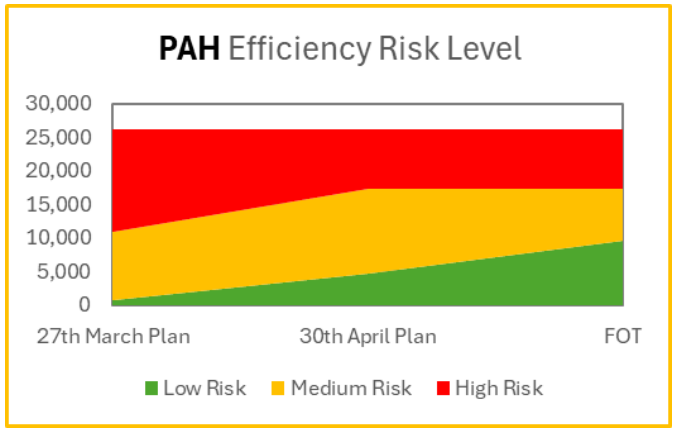
Level of Risk	27th March Plan	30th April Plan	FOT	%
Low Risk	0	9,698	11,587	42%
Medium Risk	20,098	9,747	10,269	37%
High Risk	7,370	8,023	5,612	20%
Total Efficiencies	27,468	27,468	27,468	100%

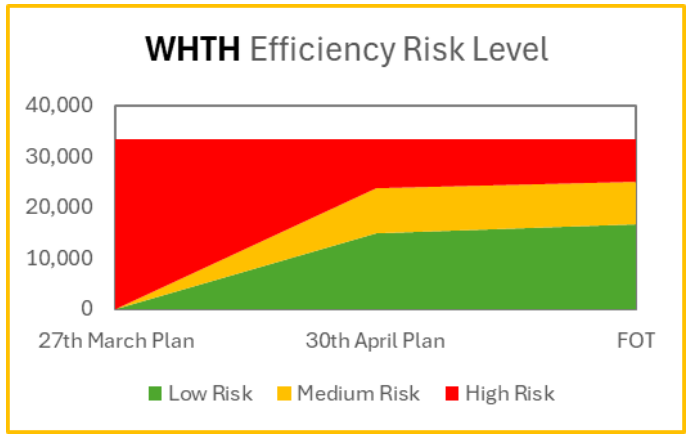
Efficiency Scheme Development & Risk Level by Individual Organisation (Slide 2 of 2)

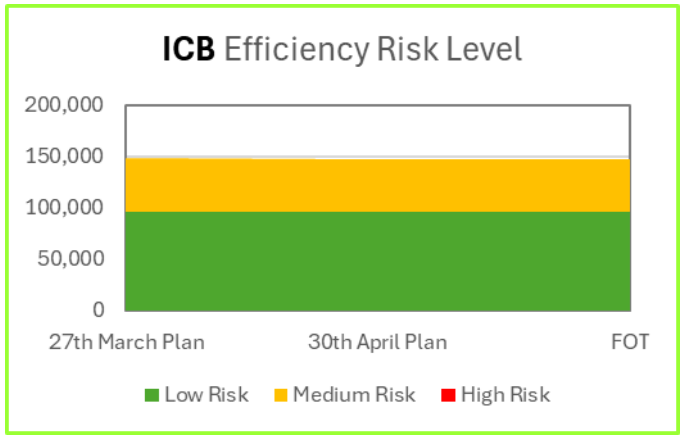












Level of Risk	27th March Plan	30th April Plan	FOT	%
Low Risk	708	4,743	9,614	37%
Medium Risk	10,116	12,585	7,714	29%
High Risk	15,326	8,822	8,822	34%
Total Efficiencies	26,150	26,150	26,150	

Level of Risk	27th March Plan	30th April Plan	FOT	%
Low Risk	708	4,743	9,614	37%
Medium Risk	10,116	12,585	7,714	29%
High Risk	15,326	8,822	8,822	34%
Total Efficiencies	26,150	26,150	26,150	100%

Level of Risk	27th March Plan	30th April Plan	FOT	%
Low Risk	96,168	96,168	96,168	65%
Medium Risk	52,437	51,617	51,617	35%
High Risk	0	0	0	0%
Total Efficiencies	148,605	147,785	147,785	100%

HWE ICS Response to NHS England's Efficiency Assurance Questions for Month 1 Reporting

Efficiency Assurance Questions	ENHT	HCT	HPFT	PAH	WHTH	ICB
Do your efficiency and financial plans reconcile across revenue, capital, and cash positions?	Yes	Yes	Yes	Yes	Yes	Yes
Is the impact of cash-releasing efficiency savings on workforce fully triangulated, owned, and appropriately profiled in budgets?	Yes	Yes	No	Yes	No	No
What percentage of all your efficiency initiatives have comprehensive project documentation, including clear connections between workforce reductions and budgets?	21% - 50%	21% - 50%	51% - 75%	51% - 75%	76% - 100%	51% - 75%
Describe actions being taken to identify opportunities for 'unidentified' efficiencies.	1*	2*		3*		
In the ICB efficiency plan, are there any system wide efficiency schemes (including unidentified) that do not have organisation level ownership within the system? If yes, provide the total value of those schemes.						Yes - £35,921
Has an executive Senior Responsible Owner (SRO) been appointed for the overall efficiency program? Please provide the name and job title in the free text box.	Yes	Yes	Yes	Yes	Yes	Yes
What percentage of efficiency schemes have an executive Senior Responsible Owner (SRO) appointed for each individual scheme?	51% - 75%	76% - 100%	76% - 100%	76% - 100%	76% - 100%	76% - 100%

1* - ENHT	Review internal productivity, model hospital, NHSE opportunity matrix, procurement benchmarking
2* - HCT	The Trust has strengthened CIP processes for 25/26 and there are regular meetings between PMO and managers across the Trust
3* - PAH	Model Health and benchmarking as appropriate is undertaken regularly. Reviews of areas of overspend also regularly reviewed. Temp staffing deep dives under way within all Divisions. Improvement programmes established for all identified key areas to ensure benefits captured as part of these programmes of work. Electronic health benefits identified in business case. Local knowledge and divisonal input into local/divisonal/team specific savings. Host/lead provider arrangements may yield additional opportunities as yet unquantified. Utilising system meetings to share efficiency schemes.

East and North Herts Health and Care Partnership

ENH Health and Care Partnership

Integrated Delivery Plan

June 2025

Working together
for a healthier future

Introduction

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

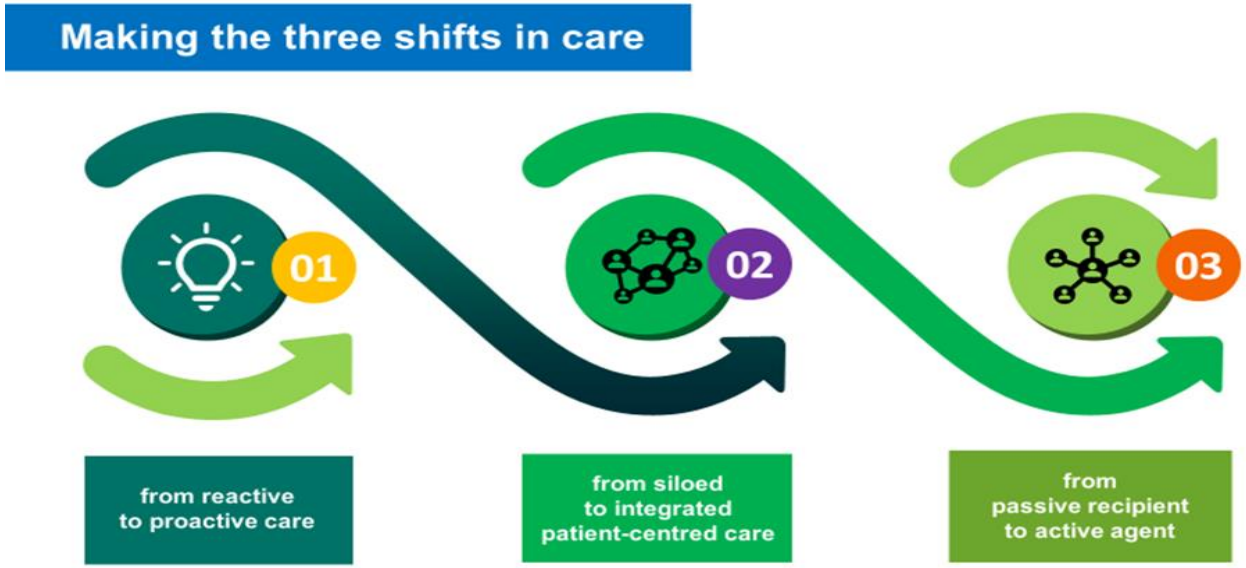
- The IDP provides a detailed update on the operational planning process for 2025/26, designed to ensure the system remains aligned around delivering key priorities while achieving financial breakeven.

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

3 Year Integrated Delivery Plan – a reminder

HWE Medium Term Plan

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



Immediate priorities 2024/25

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

East and North Herts Health and Care Partnership

Our approach

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

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

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

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

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

Our approach

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

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

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

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

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

ENH HCP Strategic Alignment with MHLDA HCP & Partners 2024-26

*Example of aligned priorities. Not indicative of all partner priorities

2025-26 HCP transformation priorities	HCP Clinical Priorities	MHLDA HCP 6 Strategic Priorities	Hertfordshire County Council	Healthwatch	VCFSE	Hertfordshire District & Borough Councils
ENH HCP Opportunities		• Mental health support • Integrated pathways • Improve the health and wellbeing	• Integrated Health and Care pathways • Improvement to access • Improve the health and wellbeing	Enhancing patient experience and opportunities for co-production	• Improve the health and wellbeing • Connecting with our community	• Exploration of co-location of services • Care coordination • Enhancing public health
1. Community Paeds – ASD assessments 2. Audiology	Priority conditions for Children & Young People	• Children and young people receive emotional and mental wellbeing support in a range of settings • Hertfordshire develops a **strategic all-age approach** to supporting people with neurodiversity including **Autism and ADHD**	• Every child has the best start in life • Good emotional and mental wellbeing throughout life • Healthy and sustainable places and communities	• Influence at a strategic level • Focus on evidence and outcomes • Reach more seldom heard groups	• To bring together charities & community groups so we can best support our region in collaboration & partnership • Viewing a carer holistically and adopting a 'Whole Family' approach will ensure that assessments identify appropriate support mechanisms that will compliment a carer's aspirations and wellbeing needs	• Planning & development • Housing • Leisure Services development
3. Care Closer to Home	Priority LTC conditions for adults	• The **physical health** of people with serious mental illness, learning disabilities and autism is prioritised and the **stark differences in life expectancy** is addressed	• Good nutrition, healthy weight and physical activity • Good emotional and mental wellbeing throughout life • Reduction in smoking and substance misuse • Healthy and sustainable places and communities			
	Priority UEC pathways inc. 7 High Impact Interventions	• **People in crisis** receive **appropriate and timely support** from all organisations • People with **dementia** are **diagnosed earlier** and supported by **integrated services** and in dementia friendly communities				

East and North Herts Health and Care Partnership

Our Population – what the data tells us

- Population Health Management PHM data shows us that ENH has a similar profile to the ICB average, with general levels of good health. There are areas of deprivation in Stevenage, Broxbourne and Hatfield that are associated with poorer outcomes. People in these areas are more likely to live with long term conditions, require emergency care and die before the age of 75

- Cardiovascular disease (CVD) and cancer are the leading causes of inequalities in premature deaths (deaths that are considered preventable), between the most and least deprived

- Spend on emergency care is in line with the ICB average and there has been a 5.8% increase in spend compared to the year before. There is growth in rates of emergency admissions across CYP (particularly aged < 5) and older adults, as well as for chronic ambulatory care sensitive conditions (ACSC) (although the rate of admission for ACSC is the lowest across the ICB)

- ENH has the highest rate of contacts with mental health secondary care services within the ICS and has seen a levelling off in the rate of emergency admission for self-harm after seeing improvements between 2021/22 and 2023/24

- Among older adults, the rate of emergency admission is increasing, there has been a significant increase in the proportion of people who have three or more admissions in the last 90 days of life, however, the rate of admission for falls is stable

Clinical priorities

- The clinical priorities have been identified from triangulation of available data, performance and quality issues, with HCP, ICB and national priorities. Generally, the population in ENH experience good levels of health, however, there are inequalities and variation.

- The leading causes of preventable deaths in people under 75 years is cancer and cardiovascular disease (CVD). There is an aging population in ENH, with a 120% projected increase in the number of people aged 65 years or over from 2018 to 2029, this will impact on the presenting health conditions and needs.

- Priority areas:
  - Children and young people
    - Audiology
    - ASD and ADHD
    - Community nursing
    - Emergency attendances and admissions
  - Care Closer to Home (CCTH)
    - Frailty – The 7 interventions
    - Integrated services (heart failure, diabetes, lipids, stroke (ICCS), respiratory diseases)
  - Planned care
    - Cancer
    - Ophthalmology
    - Elective recovery
    - Diagnostics (audiology and MRI)
  - Prevention
    - Obesity
    - Vaccination

Performance priorities

- The table below shows the priority areas of performance and the relative delivery risk associated with each area *(March 2025)*

Performance metric summary

Highest Risk	Programme
ASD / ADHD	Community
Community Waits (Children)	Community
Diagnostic 6 week waits	Elective

High Risk	Programme
CHC decisions within 28 days	CHC
Theatre Utilisation	Elective
% of on the day GP Appointments	Primary Care
Ambulance Handovers	UEC
Ambulance Response Times	UEC
ED 4 Hour Standard	UEC

Variable Risk	Programme
Community Waits (Adults)	Community
Diagnostics PTL size	Elective
RTT 65 Week Waits	Elective
% of <14 day GP Appointments	Primary Care
Access-to-stack patients completed per day	UEC
ED attendances	UEC

Lowest Risk	Programme
28 Day Faster Diagnosis	Cancer
31 Day Standard	Cancer
62 Day Standard	Cancer
CHC assessments in acute setting	CHC
RTT 78 Week Waits	Elective
Virtual ward occupancy	UEC

Virtual ward is in the lowest risk bucket but the occupancy is probably too high

Low Risk	Programme
Day case rates	Elective
RTT PTL size	Elective
2 Hour UCR	UEC
NHS 111 Calls Abandoned	UEC
Non-Elective Length of Stay	UEC

Moved to higher risk category

Moved to lower risk category

Hertfordshire and West Essex Integrated Care System

East and North Herts Health and Care Partnership

Medium Term Plan Dashboard

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

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

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

East and North Herts Health and Care Partnership

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

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

Urgent and Emergency Care

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

Impact
"What does it mean for me?"

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

Performance measures
"What will we measure?"

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

Anticipatory care

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

Same day emergency care and UEC

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

Frailty 25% saved admissions ambition by 27/28

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

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

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

East and North Herts Health and Care Partnership

HCP Priorities (Year 1, 2 and 3)

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

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

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

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

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

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

Financial Summary – Investment Sought

- The additional investment which we sought for our priority areas in 2025/26 is set out below. As this investment funding is not available, as an HCP we will continue to work collaboratively on the following areas to seek efficiencies, reduce costs and transform services to benefit our population:
  - **Care Closer to Home - £1.5m total in year investment sought (£2.0m FYE)**
    - **Proactive care:** £1.0m in year (£1.4m FYE) investment sought to target 2,400 patients (in four tranches of 600 patients over a year) who are most at risk of admission (4,009 patients in total identified in ENH) for up to 12 weeks of remote monitoring. This includes the cost for the software to monitor the patient and increasing frailty clinic to 5 sessions per week. This is currently being piloted in two localities, Lower Lea Valley and Stevenage
    - **Minus-9:** £0.5m in year (£0.6m FYE) investment sought to enhance Urgent Community Response to capture patients who may otherwise be in hospital in 9 days' time and provide them with wrap-around care to prevent admission
  - **Community paediatrics (ASD assessments)**
    - £1.5m investment sought for 2025/26 and subsequent years to reduce the current neurodiversity assessment waiting list through the outsourcing of autism assessments
  - **Paediatric Audiology**
    - External investment of £887k sought in 2025/26 and subsequent years to access appropriate capacity to reduce the existing backlog of audiology patients, which combined with internal trust realignment of budgets (to allow the correct workforce to manage ongoing demand), will enable the delivery of a safe and well led service in line with recommended current practice

*(*further detail on each priority, including aims and ambitions, risks and mitigations is included in the appendix)*

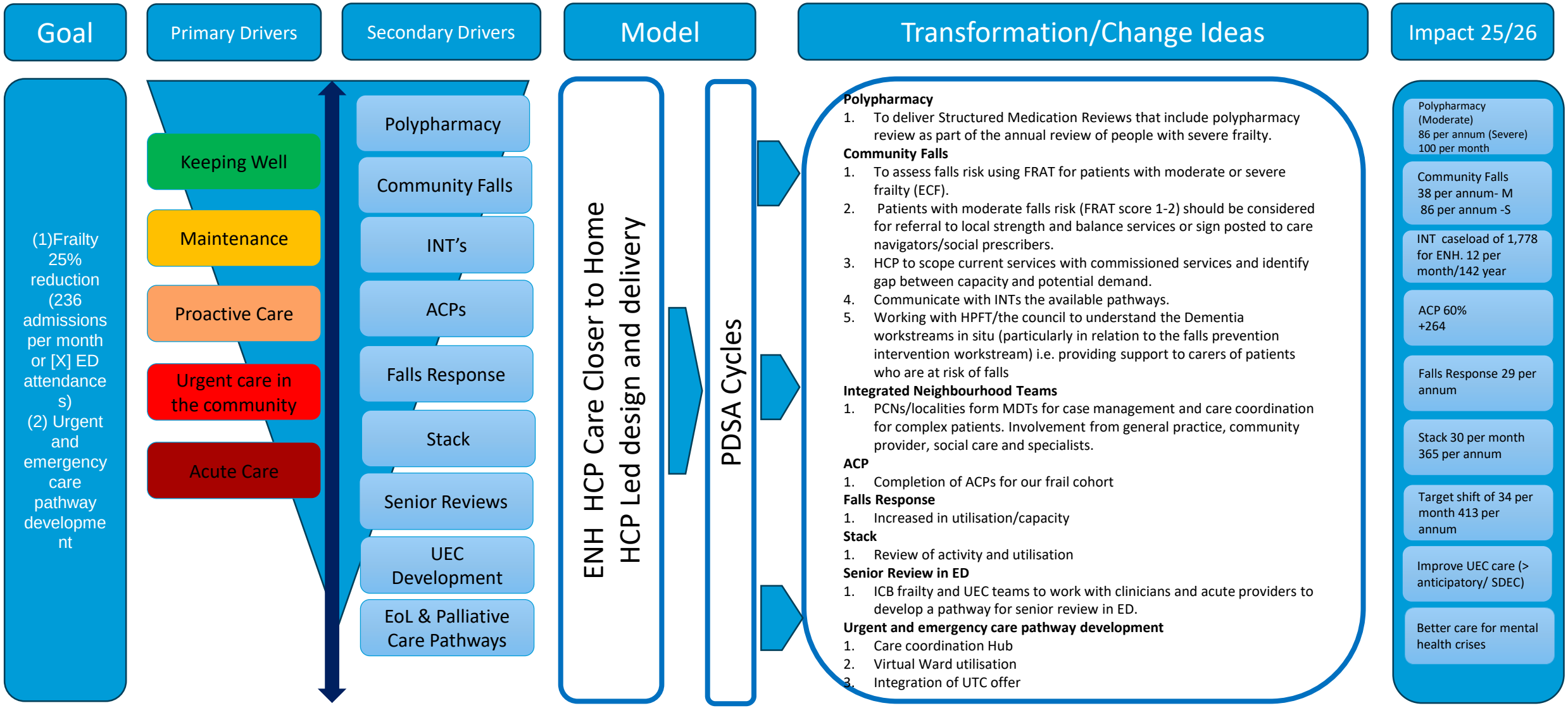
The Plan

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

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

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

ENH HCP Focus on Frailty- Strategic transformation driver diagram



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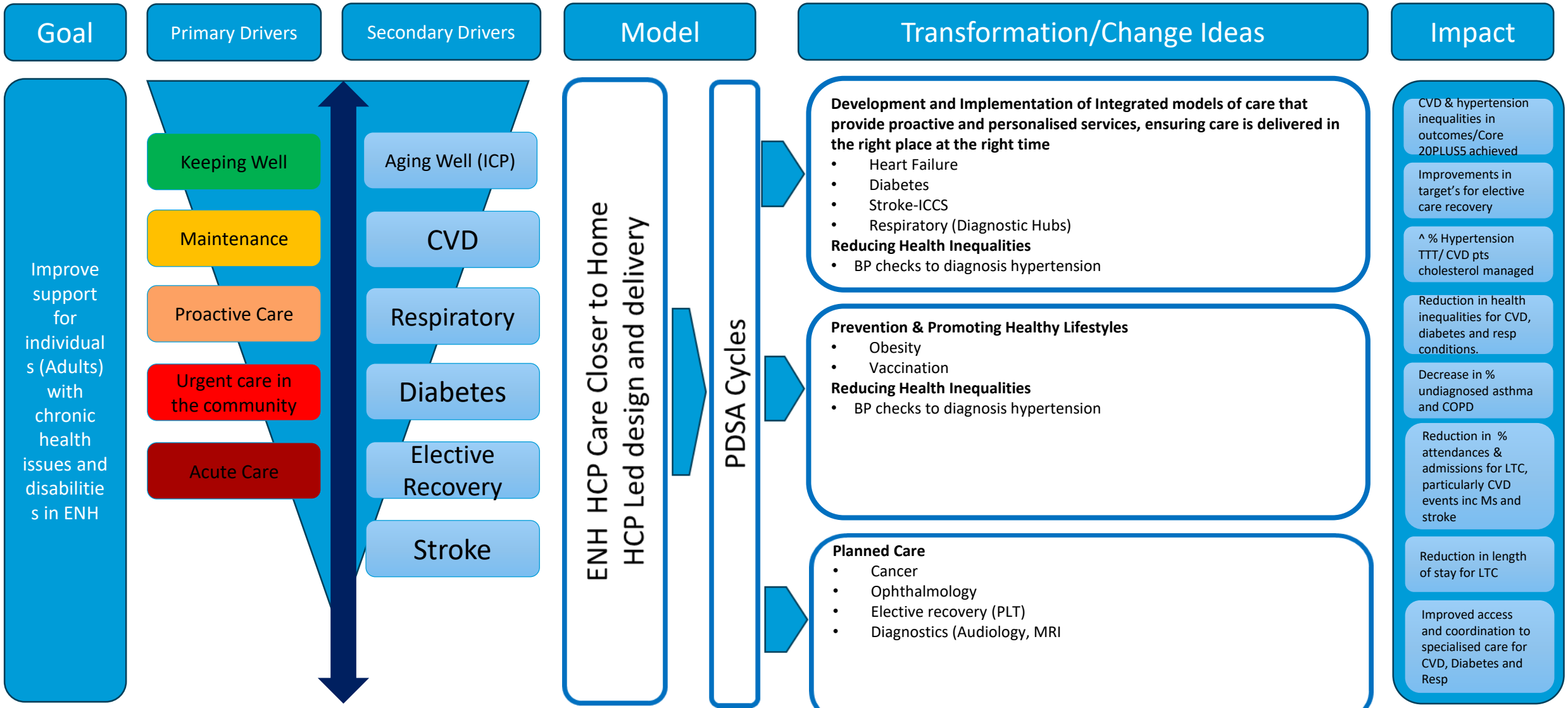
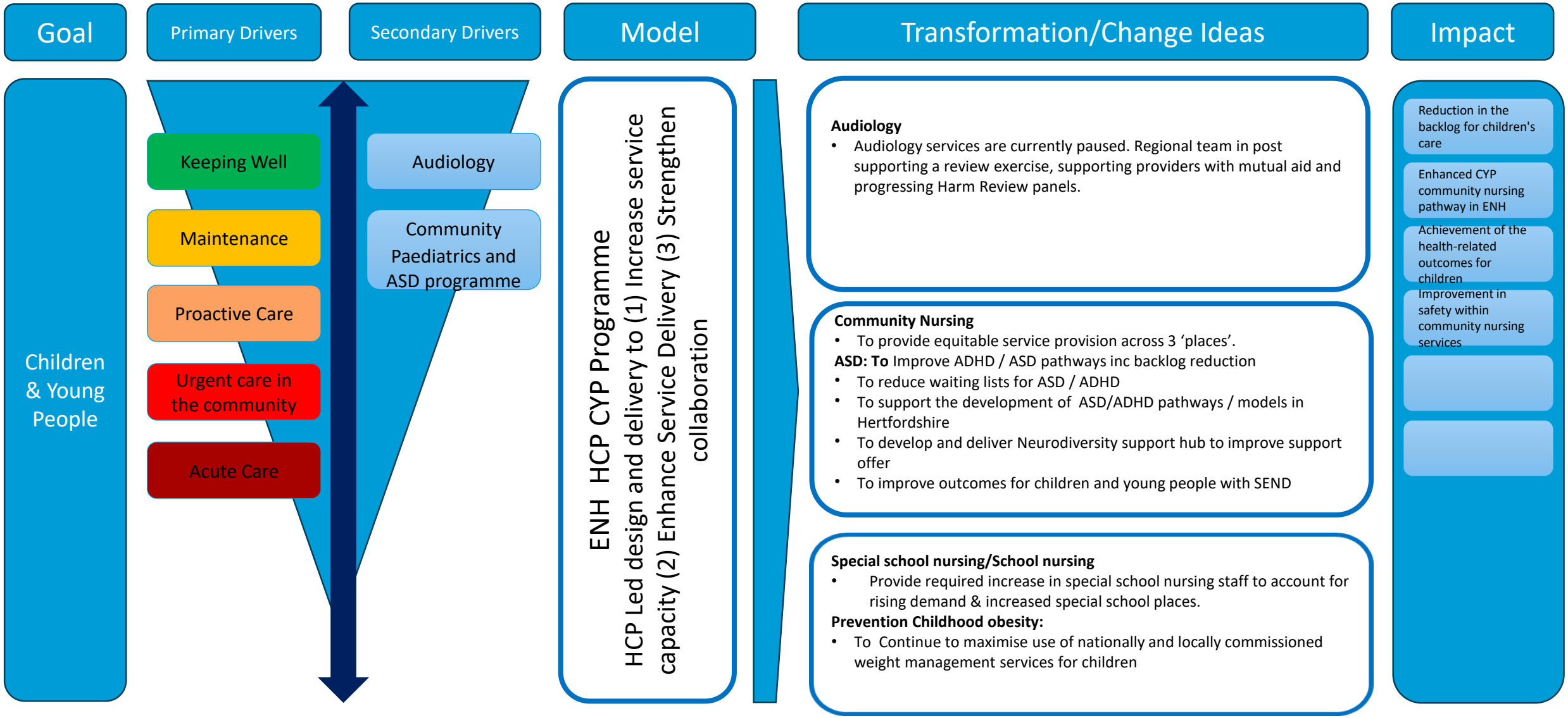
ENH HCP Focus on Adults- Strategic transformation driver diagram



East and North Herts Health and Care Partnership

ENH HCP Focus on CYP- Strategic transformation driver diagram



East and North Herts Health and Care Partnership

Strategic objectives and priorities for ENH

Strategic objective 1
Improve the health and wellbeing of our population

Priority 1 Tackle health inequalities in access, experience, and outcomes.

Priority 2 Improve outcomes for adults and children and young people.

Strategic objective 2
Transform health, care and wellbeing services to meet local needs and promote independence

Priority 1 More personalised, preventative, and proactive care.

Priority 2 Embed use of population health management

Priority 3 Improved join-up of care for people with physical and mental health needs and learning disabilities

Strategic objective 3
Establish an efficient, effective and sustainable partnership

Priority 1 Ensure effective collaboration.

Priority 2 Address wider determinants of help through strong relationships with non-health partners

Priority 3 Develop an accountable, efficient, effective and inclusive partnership with the right capabilities.

HCT - Productivity/Efficiencies and CIP Plans

HCT Improvements - efficiency/productivity/ planned care/ transformation

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

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

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

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

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

HCT - Productivity/Efficiencies and CIP Plans

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

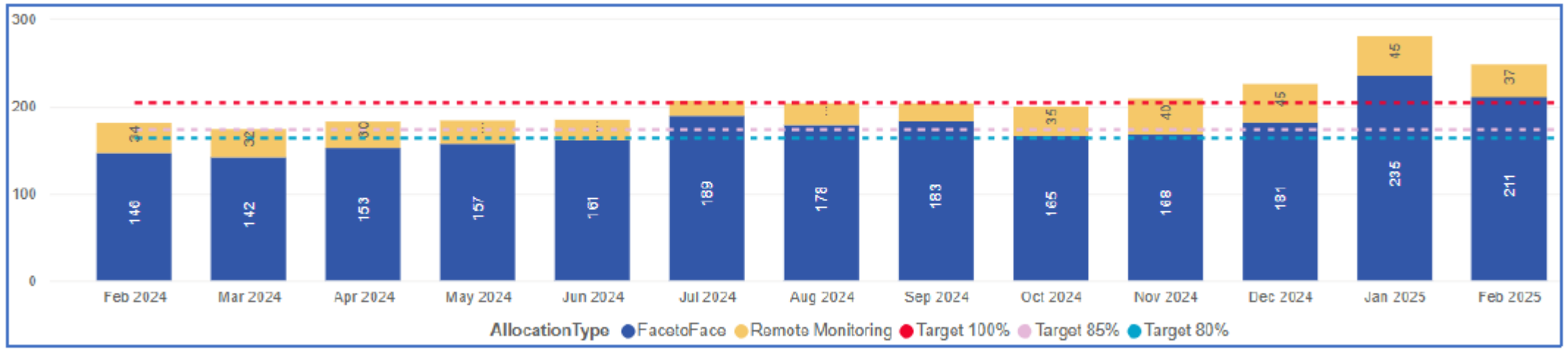


Fig.5 Hospital at Home average daily occupancy. Link

Primary Care - Productivity/Efficiencies and improvement initiatives

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

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

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

ENHT productivity

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

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

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

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

ENHT productivity continued…

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

ENHT Operational Performance Plan Overview

2

Elective Performance

Compliant with national targets

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

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

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

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

UEC Performance

Compliant with national targets

Ambitious trajectory for adult ED

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

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

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

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

Cancer Performance

Compliant with national targets

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

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

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

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

Diagnostics Performance

Audiology, ultrasound & MRI will not reach DM01 compliance

Local trajectories achievable, but risk regarding MRI transformation delivery

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

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

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

ENHT Improvement – planned care

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

ENHT Improvement – planned care

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

Overview - UEC and reduction in NEL admissions 7 interventions

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

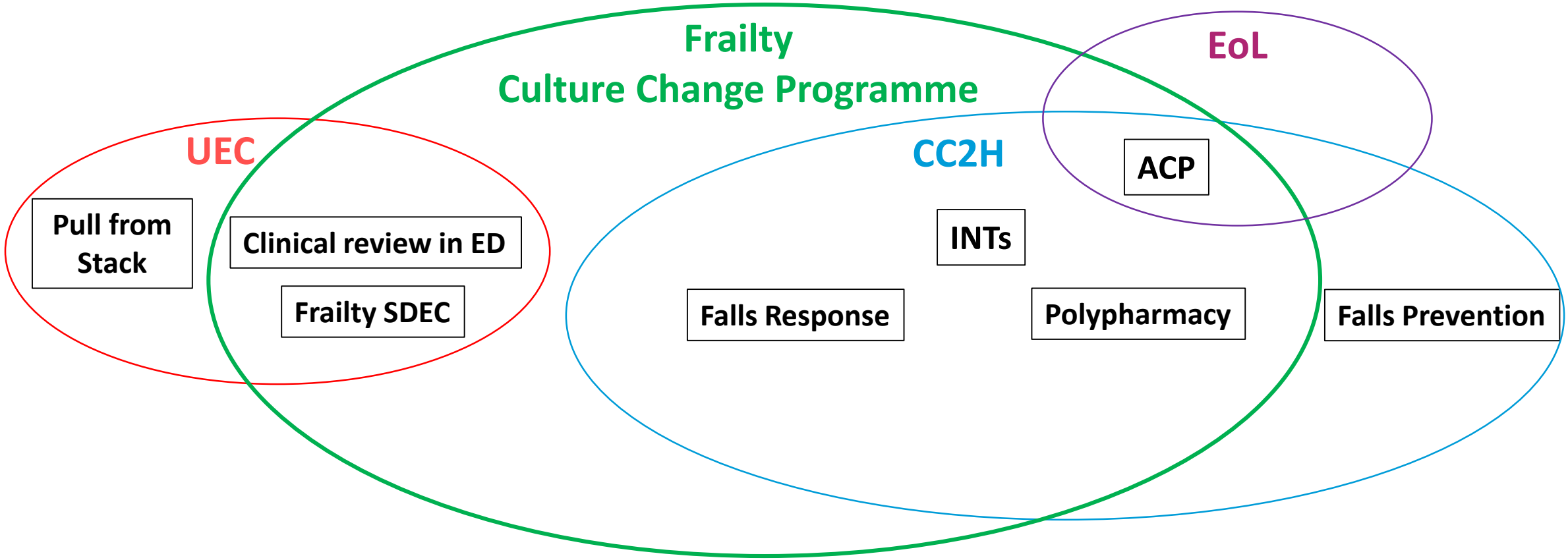
- ENH Place December 2024 SUS data shows a 3% reduction in frailty admissions growth YTD for aged 65 + (from 9% to 6%)

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

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

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

NEL Frailty Admissions Reduction Programme



8 Interventions (including Frailty SDEC) and Cultural Change Programme

East and North Herts Health and Care Partnership

Work to establish Targets in ENH

PHM Modelling has established:

- On average in 2023/24 , there were 1,884 admissions per month across East & North Herts in people aged 65 years and older. It is estimated that half of the admissions in people aged 65 years and over are living with frailty. Therefore, there are c. 942 admission per month across East & North Herts in people aged 65 years and over living with frailty
- If a 25% reduction in monthly admissions were achieved across East & North Herts, we would see 236 fewer admissions per month (and 2,826 fewer per year) in people aged 65 years and over living with frailty
- The median overnight length of stay of each admission was 4 days. A 25% reduction in monthly admissions could therefore release ~31 bed days per day

- 7 high impact interventions have been identified to support this reduction and individual aspirations have been assigned to each of these
- A 25% data dashboard has been developed and includes a variety of measures to help support progress towards achieving this ambition
- Workstreams underway and workstream leads have established a target for each intervention and are monitoring progress against this
- ENH has committed to the following overall ambition for reduced frail admissions:
    - 25/26 10%
    - 26/27 15%
    - 27/28 25%

UEC - ENHT Improvement

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

UEC - ENHT Improvement

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

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

Workforce

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

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

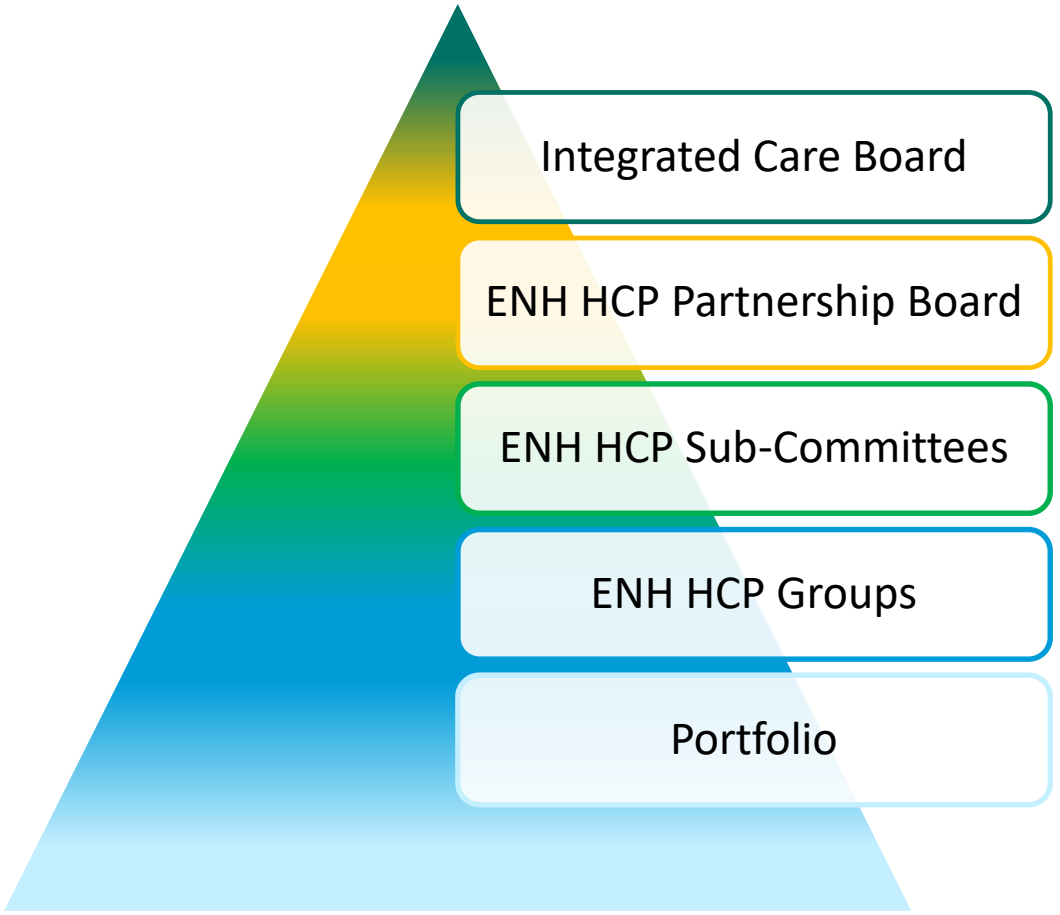
- **Workforce assumptions made in modelling - HCT**
  - No proposed growth in the ENH workforce
  - The 5% CIP equates to c125 WTE. The Trust plans to achieve this through maintaining a 7% Vacancy Rate (7.4 % average for 2024/25) which equates to c175 WTE
  - The plan includes a 40% reduction in agency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

Our Model

- Considering the agreed principle that each HCP can operate in the way that best works for it, HCPs were given a range of options in terms of their governance arrangements:

1. Remain as an ICB sub-committee (i.e. current model)
2. Joint venture (via contracting route)
3. Joint venture ("special purpose vehicle")
4. Lead / host provider (via one provider or via an integrator)
5. Committee(s) in common
6. New single organisation

- **ENH HCP is in the process of moving towards a host provider model which will align it with the approach taken in South West Hertfordshire HCP and West Essex HCP**



Reporting and Governance

How will we know we are achieving our aims and ambitions?

- We will develop measurable outcomes goals and an outcomes dashboard to track them
- We will set clear trajectories which are regularly reported against at sub-committees and Partnership Board
- We will continuously review & improve through our sub-committees and our HCP Partnership Board

Acute Provider Collaborative

Acute Provider Collaborative

- ENHT is establishing an Acute Provider Collaborative with Bedfordshire Hospitals, The Princess Alexandra Hospital and West Herts Hospitals, through which the trusts will work together to improve patient care and outcome and improve efficiency

- The Collaborative will initially focus on elective care and developing sustainable clinical services. ‘Quick win’ projects have been identified for 2025/26 in Interventional Radiology, supporting the vascular hub services at Luton and Lister Hospitals and in Emergency Ophthalmology, addressing gaps in out-of-hours cover for East and North Herts and West Essex

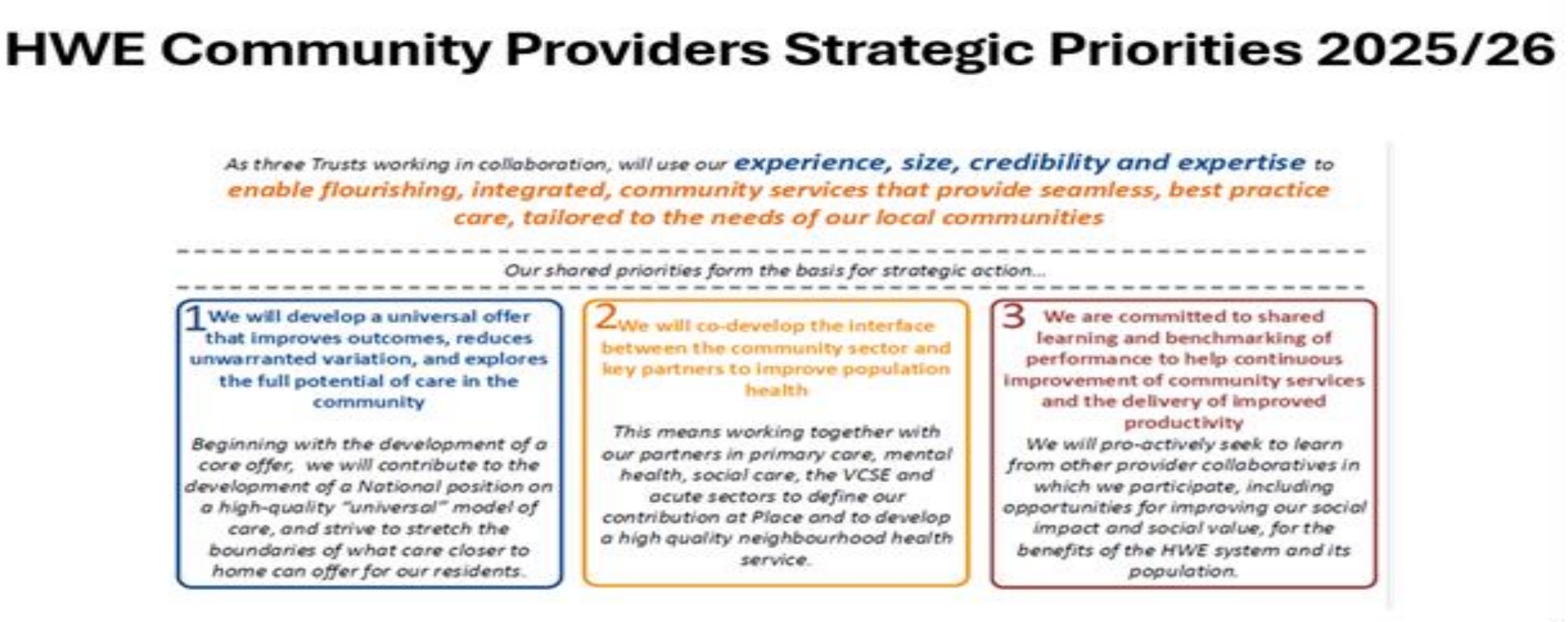
- The four acute trusts are currently undertaking a service review and prioritisation process to assess the relative strength or fragility of a range of elective care specialties, identify opportunities for collaboration and agree priorities for the next three years

Community Provider Collaborative

Community provider collaborative (CPC)

- The HWE community provider collaborative (HWECPC) was formed in 2024 between HCT, CLCH and EPUT
- It has worked with the ICB to develop and drive the ICB Community Services Review (and associated recommendations) and the subsequent Care Closer to Home Strategy which is now being implemented
- It has sought to bring together and articulate a unified/single voice for NHS community providers to help challenge and support place and system thinking about the opportunities offered by community services working as a proactive system partner
- Key areas of work have included benchmarking services e.g. Hospital@Home, sharing CIPS to support mutual improvement and working with the ICB to develop new core community services specifications to reduce variation across places
- The CPC has agreed 3 key strategic priorities and is currently developing a work plan for delivery in 2025/26 to explore how it can most effectively interface with the ICB, HCPs and the acute provider collaborative to raise strategic aspiration, reduce duplication of community representation and support reduction in unwarranted variation in community services and pathways

Community Provider Collaborative



Digital priorities

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

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

ENH HCP Risks and issues log

Theme	Risk Description	Link to Transformation Risk	Likelihood	Impact	RAG Score	Mitigation
Transformation capacity	Limited organisational transformation capacity among colleagues increases the risk of failing to deliver key programmes, potentially undermining impactful change for ENH partnership.	• Frailty (7 High Impact Interventions) • INT development programme	3	4	12	• ENH HCP will formalise agreements for shared transformation resources across partners. • The Virtual Transformation Team will support priority programmes and explore opportunities for collaboration..
Workforce/resource allocation	There is a risk that partners may fail to establish effective mechanisms for jointly allocating resources to priority areas, resulting in fragmented decision-making, poorer patient outcomes, and sustained system pressures. Additionally, the limited capacity of a small group of senior leaders with key responsibilities could slow progress, hindering the development of the ICP.	• INT development programme	4	4	16	• Establish Joint Resource Allocation Framework to support prioritisation of transformation programmes • Strengthen Governance and Accountability • Enhance Leadership Capacity • Promote Collaborative Working and Shared Learning
Difference in philosophy.	There is a risk that existing organisational transformation priorities do not align with ENH Place, leading to a lack of local ownership and the development of a model that fails to meet ENH needs.	• INT programme	3	3	9	• Establish ENH-specific programmes, re-scope current programme(s), and/or appoint a new SRO/Leadership.
Lack of investment in agreed models	There is a risk that partners develop new models of care without securing investment, resulting in disengagement and reduced motivation for future innovation.	• Community Nursing • Asthma Nurse • Frailty & INT programme	3	3	9	• Work with partners to develop a shared approach to risk • Align New Models with Funding Opportunities • Pilot and demonstration of impact to support business planning
Lack of data to develop new models of care	There is a risk that partners are unable to effectively share relevant data, hindering the development of informed new models and resulting in suboptimal transformation decisions.	• Care closer to Home • Frailty	3	4	12	• Establish Clear Data-Sharing Protocols • Implement Secure Data Integration Platforms • Promote a Data-Sharing Culture
Duplication of effort	There is a risk of duplication in programme efforts, which could result in inefficiencies, misalignment of resources, and lack of coordinated impact.	• INT programme	3	3	9	• (Re)scope the programmes with a broad range of colleagues to ensure an inclusive approach.

Appendices

1. ENH HCP priorities 2024-25

2. Audiology detail

3. Community paediatrics detail

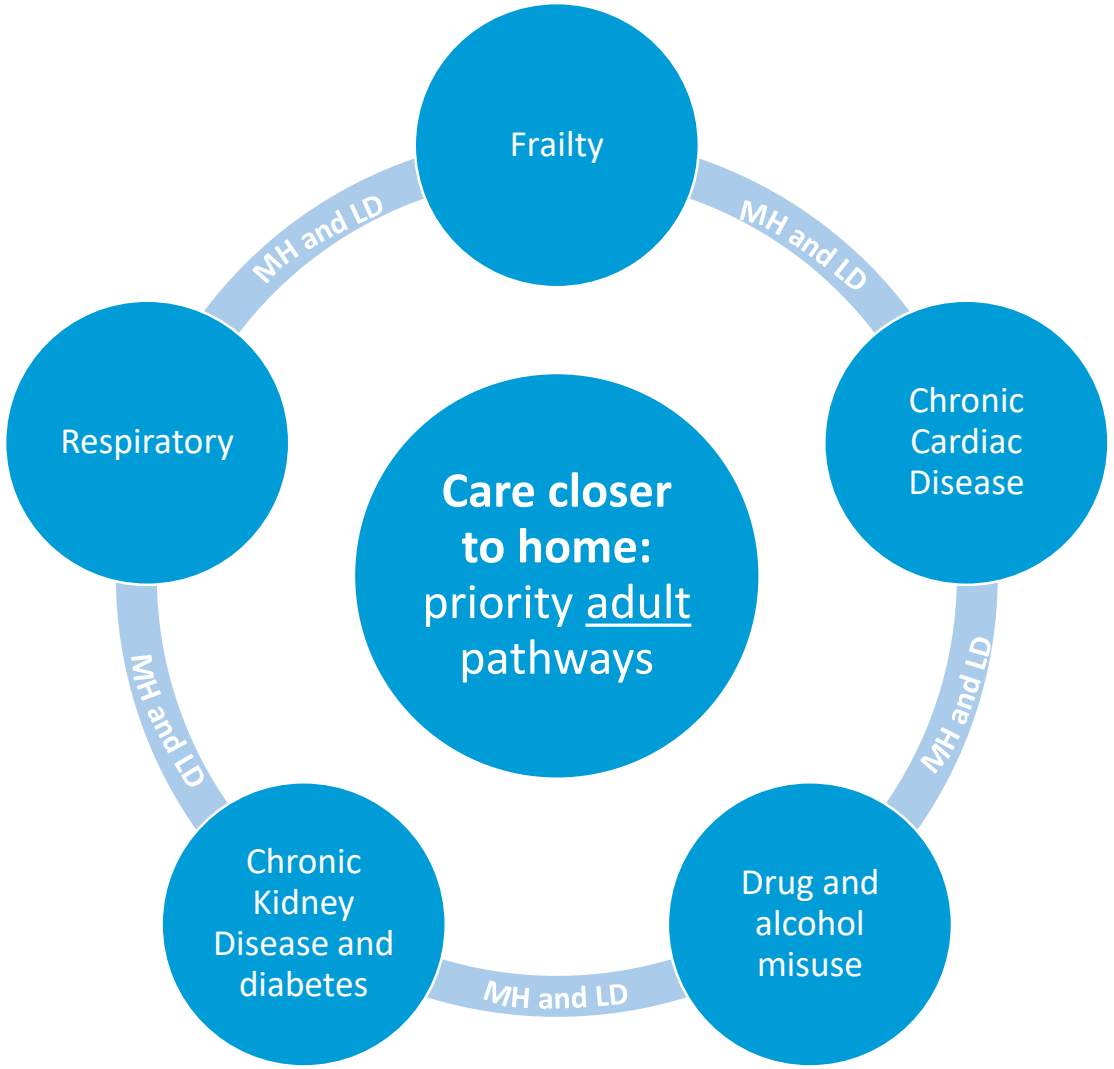
4. Care Closer to Home detail
   - Overview
   - Proactive and Minus-9
   - INTs
   - 7 interventions
   - UEC

5. BCF priorities for 2025-26

6. Good examples of Place based working

East and North Herts Health and Care Partnership

ENH HCP Adult Priorities 2024-2025



ENH HCP Priorities	ICB Priority	ENH Delivery Plan (Areas of focus)
CVD	Reduce inequality with a focus on outcomes for CVD and hypertension	• Development of a Cardiac Rehabilitation proposal for the population of ENH
		• Evaluation of the new integrated heart failure service to identify future development opportunities
		• GIRFT (Get it right first time) Implementation of recommendations from GIRFT plan
Diabetes	Elective Care recovery	• Development and mobilisation of an ENH Diabetes and Endocrine Recovery Plan that delivers efficiencies and productivity
Respiratory	Elective Care recovery	• Development of a proactive approach to management of respiratory conditions in ENH • To enhance local respiratory service, offer including Tier 3 Asthma service • To enhance and improve and development resp pathways in ENH • To reduce prescription of cortical steroids in ENH • To ensure the new IHFS is aligned and linked to the ICRS respiratory service
Frailty	Improve UEC through more anticipatory/SDEC care	• Development of workplans to support delivery of 25% NEL activity in ENH.
		• To support the delivery of frailty programmes in ENH including Falls, End of Life and Advanced Care Plans
		• Development and Implementation of Integrated Neighbourhood Teams in ENH

East and North Herts Health and Care Partnership

ENH HCP Children's and Young Peoples Priorities 2024-2025

ENH HCP Priorities	ICB Priorities	ENH Delivery Plan (Areas of focus)
Community Nursing	Focus on improved access in community services and neurodiversity services	• Development of an Integrated Tongue Tie Pathway for ENH
		• Development of an integrated proposal for community nursing offer in ENH • Development of Hospital at Home: Neonatal Jaundice as part of the community nursing provision
		• Childhood Obesity
Respiratory/Asthma		• To improve outcomes for children and young people with Long Term conditions
Care Coordination		• Development of Care Coordination proposal for CYP in ENH to provide practical and emotional support to families, coordinating with other professionals and agencies.
Diabetes		• ENHT working with the ICB to roll out the hybrid closed loop programme
Emerging Priorities		• Neurodiversity
		• Development of a workforce model to increase capacity in ENH
		• Audiology

East and North Herts Health and Care Partnership

Audiology

Current position

- ENHT provide the service. Patients are facing long waits due to an extensive waiting list backlog and following the pause of paediatric audiology services at ENHT since summer 2023 following estates and workforce safety issues raised by UKHSA
- Currently 7,000 adults and 4,500 paediatric patients waiting on an audiology waiting list in ENH
- More than 95% of the waiting list have been waiting >6 weeks, with a significant proportion waiting >13 weeks. As of January 2025, the average wait for adult audiology patients was 47 weeks, and for paediatric patients 49 weeks
- There is a clinical risk to patients as hearing impacts on daily living, particularly for children
- Doing nothing for both adults and paediatrics will: continue to impact the DM01 position with the position/performance declining; significantly impact patient experience and elevate the potential harm to them

Aims and ambitions

We will	Which will achieve	We will measure this through
Support the identification and resourcing of additional audiology capacity across a range of mutual aid, outsourcing and substantive staffing options	Capacity to reduce the backlog of audiology patients over the next c. 2 years Ensure equal access for patients to services to tackle health inequalities	DM01 compliance Total PTL size
Work as a partnership to identify opportunities to reduce waiting lists and deliver efficiencies.	Shorter waiting times Earlier identification of issues	DM01 compliance Monitoring waiting lists
Work with community services (e.g. Herts Hearing Advisory – hearing aid repairs – retubing and batteries)	Care closer to home	

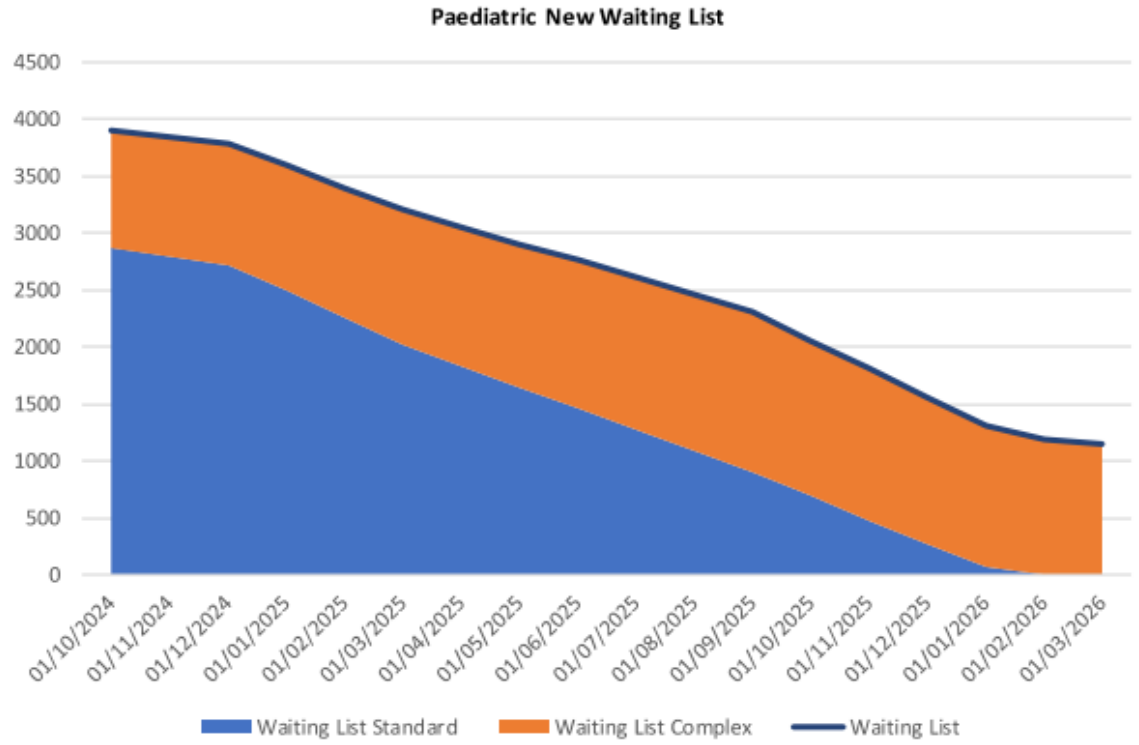
Audiology

Investment Required

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

Investment Impact

The investment would enable the delivery of a safe and well led service in line with recommended current practice. This investment will allow a range of mutual aid and outsourcing options to be brought online to allow those individuals currently waiting to be seen.



Note: Complex waiting list impact is dependent on estates works, which is subject to a separate improvement plan.

Audiology

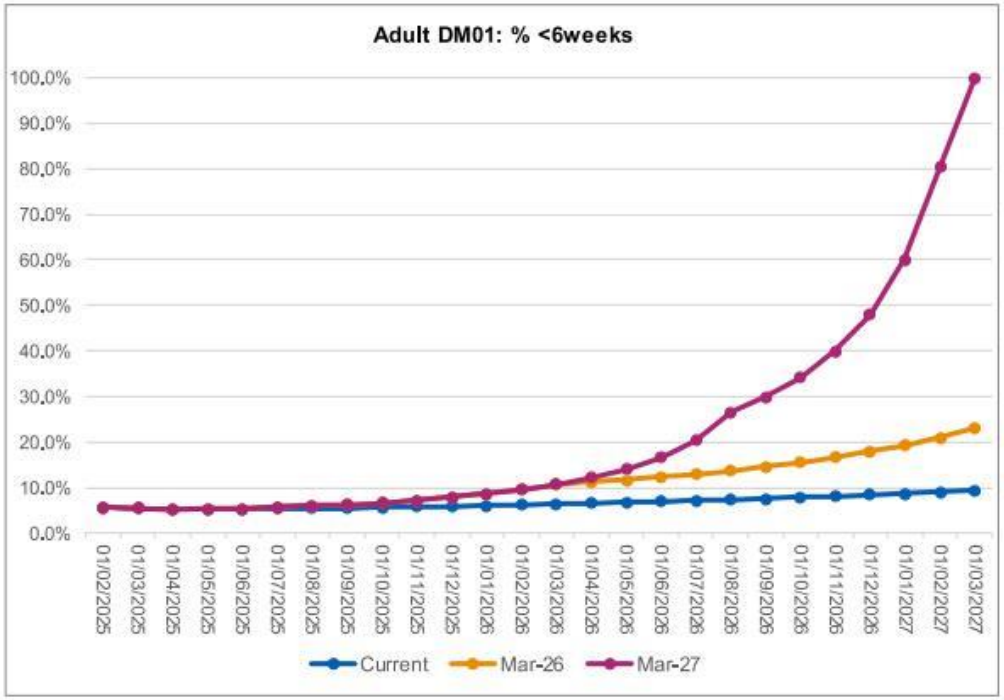
Risks

- Audiology, specifically paediatric audiology, is challenged nationally, which has significantly minimised effective mutual aid and additional capacity solutions available within the NHS. These challenges are likely to continue, especially in relation to staffing availability.

- Complex waiting list impact is dependent on estates works, which is subject to a separate improvement. March 2026 line is indicative of impact if investment only available for one year, March 2027 line is indicative of impact from multi-year investment.

What we will do to deliver change if no funding available

- With no investment available, the HCP will review to what extent possible it can best work together to mitigate the ongoing risk to individuals requiring audiology support through existing pathways. In addition, it will continue to engage across our wider system and other HCPs to identify steps and locations to improve access for those needed access to the service.



Note: March 2026 line is indicative of impact if investment only available for one year, March 2027 line is indicative of impact if multi-year investment agreed.

Community Paediatrics

Current position

- ENH Community Paediatric Service (provided by ENHT and HCT) has seen an increase in both referral volumes and numbers added to the Communication Disorder Assessment Clinic (CDAC) list for a specialist Autism assessment.
- Capacity has not grown at the same rate as the demand increase, and with the current capacity, an individual referred to the service today, will wait approximately 4.5 years for a first appointment.
- As of February 2025, there are over 6,500 individuals awaiting a Community Paediatric first appointment; 1,500 have been waiting over 104 weeks; the longest wait is 145 weeks. There are over 900 individuals on the CDAC list awaiting a full autism assessment, with an average wait of 13 months.
- There is considerable collaborative effort to implement a Single Point of Access for paediatric neurodiversity and to undertake a system-wide redesign of services, however, these will take time to finalise and implement and will only have benefit for new referrals. The business case is currently with the ICB for review. Parallel capacity is required to reduce the current backlog of assessments and move closer to the ICB's ambition of no-one waiting over 65 weeks for community paediatrics.

Aims and ambitions

We will	Which will achieve	We will measure this through
Reduce waiting times for Neurodiversity Assessment to enable children and young people to unlock access to support and maximise the opportunity for them to reach their potential, through a focus on: Joint implementation of the Single Point of Access for referrals Finalisation of the Nine Box Model for paediatric neurodiversity services across HCT, ENHT and HPFT	A sustainable service model that utilises system-wide expertise	Reduced waiting times Reduced PTL size
Review the skill mix to optimise staff able to undertake ADHD medication reviews and monitoring	Released consultant capacity for 1st appointments and specialist assessments	
Stabilise the current waiting time for specialist autism assessment through utilising outsourcing opportunities	Capacity to reduce the backlog of autism assessments	Reduced waiting times Reduced PTL size

Community Paediatrics

Investment required

- A minimum £1.5m investment was sought for 2025/26 and subsequent years to reduce the current neurodiversity assessment waiting list through the outsourcing of autism assessments. This would allow internal resources to be reconfigured to increase capacity for ADHD and/or complex assessments, ensuring that individuals waiting for something other than an autism assessment are not disadvantaged.

Impact of Single Point of Access and Nine Box Model

- Whilst the investments being proposed would be demonstrated in reduced waiting times, it will provide wider societal and educational benefits by helping our young population and their families earlier. Timely diagnosis can help our young population, and their families understand factors that underpin their responses to certain situations better, reducing stress and reduce the misinterpretation of neurodiversity as a behavioural issue.

Risks

- Although neurodiversity waits do not pose a physical risk to children a late autism spectrum disorder (ASD) diagnosis can significantly impact a child's development, often leading to increased social and emotional difficulties, lower self-esteem, missed opportunities for early intervention, potential academic struggles, and a higher risk of developing mental health issues due to a lack of understanding and support for their unique needs; essentially, the longer a child goes without appropriate interventions, the more challenging it can be to manage their autism.

What we will do to deliver change if no funding available

- With investment not available, the HCP will consider how it can work together to mitigate the ongoing risk to an ever-increasing neurodiversity waiting list and how it works with other HCPs to ensure that there is equity in access across the system.

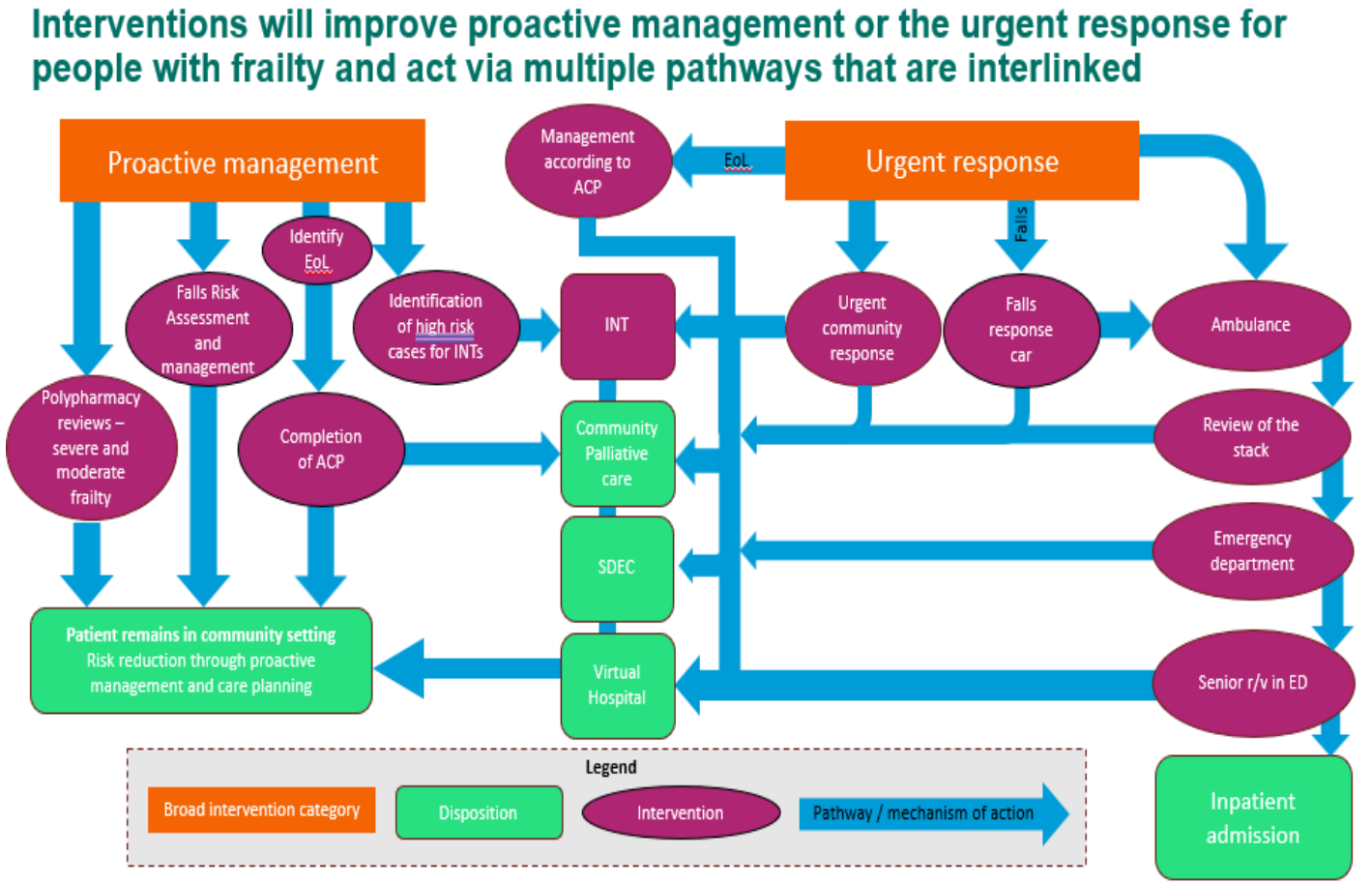
Care Closer to Home (overview)

- The partnership has worked together and developed the 'care closer to home' strategy which provides the direction for *how* our integrated pathways and services are delivered in East and North Hertfordshire. Under our care closer to home strategy we have three portfolios of work: (1) priority conditions and/or cohorts; (2) priority delivery models and (3) priority UEC programmes

Care Closer to Home Strategy **Purpose**: "*To enable people to live as happily, healthily, and independently as possible*" **Vision**: "*Partners organise their resource around people to provide the right care, at the right time, and in the right place*" **Mission**: *"To develop a co-ordinated, high-quality, and joined-up range of services that meet the needs of people, reduce pressure on the health and care system, and improve working conditions for staff"*		
Priority condition and/or cohorts: Cardiovascular disease Diabetes Frailty Drug and alcohol misuse Respiratory Children and young people.	**Priority delivery models:** Integrated Neighbourhood Teams Hospital at Home Community Diagnostic Centres Integrated services.	**Priority Urgent and Emergency Care programmes**: Same day access admission avoidance system control centre improved flow and discharge

Care Closer to Home (overview)

- The following graphic shows how proactive management through the Priority Delivery Models and Priority Urgent and Emergency Care programmes come together with multiple organisations working together with individual patient needs at its centre.



East and North Herts Health and Care Partnership

Care Closer to Home (Proactive and Minus-9)

Care Closer to Home Priority Delivery Model (Proactive care and minus –9 proactive care)

- To provide a system wide proactive healthcare model that will enable early detection, prevent deteriorating health, and provide a robust home healthcare program, avoiding preventable hospital admissions by utilising data and remote monitoring for people with long-term / complex conditions, allowing for better health outcomes and improved quality of life for the patient.
- Identifying Proactive Care patients through a Public Health Management Risk Stratification Tool and offering a comprehensive home healthcare programme utilising system partners & remote monitoring capabilities for case management for long-term conditions and complex needs.

Objectives

- To Prevent Hospital Admission
  - Avoiding deconditioning
  - Avoiding infections synonymous with hospital admissions
- To Reduce Falls
  - Reduce ACB Scores
  - Reduce FRAX & FRAT Scores
- Address Health Inequalities
- Reduce GP Contacts
- Reduce Ambulance Call Outs
- Reduce Hospital at Home use
- Monitor and evaluate patient/Clinical outcomes supported by dedicated wrap around care

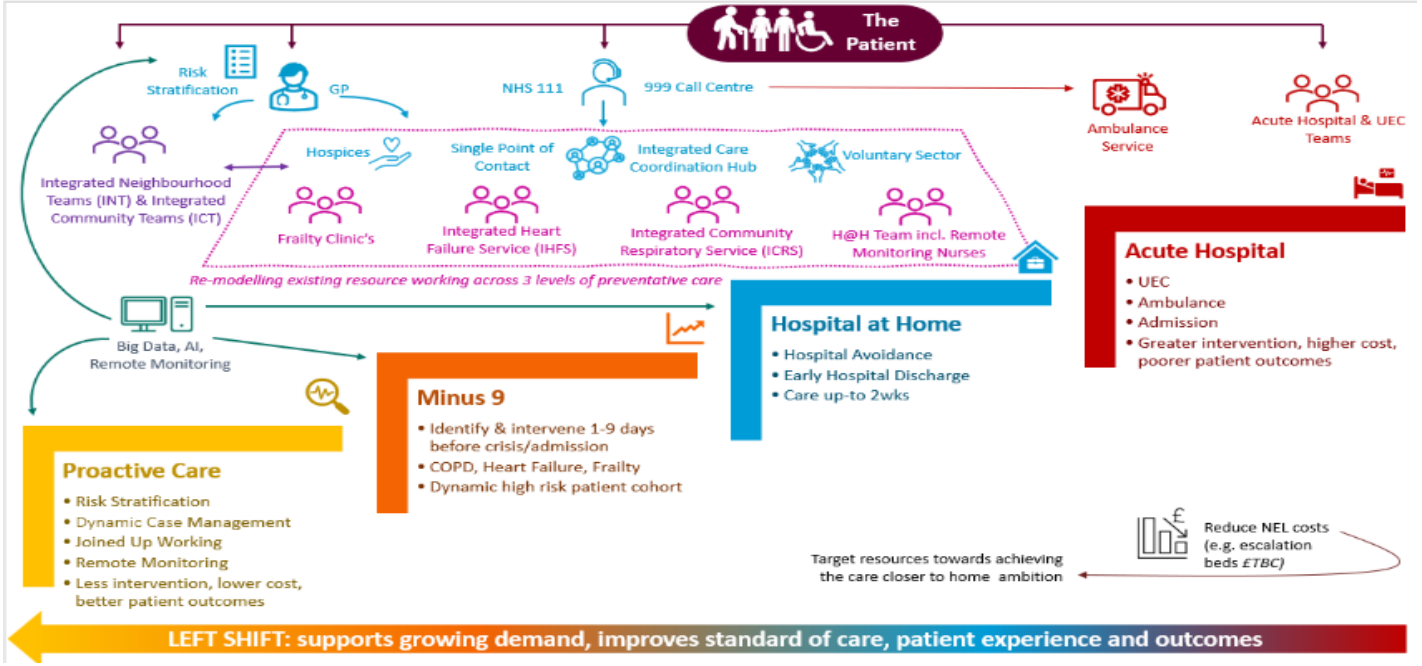
Care Closer to Home (Proactive and Minus-9)

Investment required – Proactive Care

- Proactive care - £1.0m in year (£1.4m FYE) investment sought to target 2,400 patients (in four tranches of 600 patients over a year) who are most at risk of admission (4,009 patients in total identified in ENH) for up to 12 weeks of remote monitoring. This includes the cost for the software to monitor the patient. This is currently being piloted in two localities, Lower Lea Valley and Stevenage

Investment required – Minus-9

- £0.5m in year (£0.6m FYE) investment sought to enhance Urgent Community Response to capture patients who may otherwise be in hospital in 9 days' time without intervention and provide them with wrap-around care to prevent admission



East and North Herts Health and Care Partnership

Care Closer to Home (INTs)

Care Closer to Home Priority Delivery Model (Integrated Neighbourhood Teams)

Integrated Neighbourhood Teams (INT) are a key component of local and national strategies, with multi-disciplinary working with individual patients care at its heart

Each INT is expected to utilise the collective resource of all partner members, including Primary Care multidisciplinary teams with staff delivering proactive care, ARRS funded roles, clinical resources; Community services teams delivering care for the identified group (e.g. community falls team) and Secondary care providers using clinical capacity released as a result of associated reduction in emergency admissions, to support the INT.

The INTs will provide a range of different functions to support the health of their local population. A key function is the proactive management of complex high-risk cases. This will support the local ambition to improve outcomes and experience for people living with frailty and in their last year of life through coordinated care and case management.

- Delivering integrated care at 'Neighbourhood' level is a key component of NHS delivery plans and strategy, from the NHS Long Term Plan (2019), to the Fuller Stocktake, Darzi review and recently published NAPC report on Creating Integrated Neighbourhood Teams.
- Locally, INTs form a core part of the future delivery model in Hertfordshire and West Essex (HWE) ICS, as outlined in the HWE primary Care Strategic Delivery Plan and 'Care Closer to Home' strategy.
- One of the ways that neighbourhood teams can support people locally is through delivering coordinated care for complex patients. This multi-agency, case management care meets the needs of the individual, making best use of local assets and services. This care is intensive, community support and so needs to be targeted to people at highest risk of poor outcomes.
- Getting proactive care for complex cases right will support the ICS ambition to reduce avoidable emergency care for people living with frailty or in their last year of life.

High Level Summary of Priorities – Care Closer to Home (7 interventions)

Care Closer to Home Priority Delivery Model (7 interventions)

- Our place, like the wider HWE ICS has an ageing population and increasing levels of multi morbidity. This group has the highest risk of needing emergency care and represents the greatest level of service use (both from emergency care and planned or proactive care).

- We recognise that hospital care does not always provide the best outcomes and value for our frail and end of life population. Reducing demand has been identified as one of the ICS five key priorities in the next two years. Analysis by the ICS has identified 7 interventions that will support this, through delivering the appropriate care in settings closer to home, some, including INTs and the Urgent and Emergency Care Stack are already in progress.

- In ENH place we have implemented a governance structure that aims to connect the work and support the implementation of these high impact interventions, and drive delivery in a proactive and integrated way.

- Population health and performance data will inform opportunities to increase utilisation of capacity across all health and care services, including virtual ward beds, same day access and specialist services that will deliver falls and frailty pathways. This approach will focus on Improvements across the 7 high impact workstreams will be measured through an iterative approach, encouraging the sharing of best practice, fostering cultural change across partners in ENH.

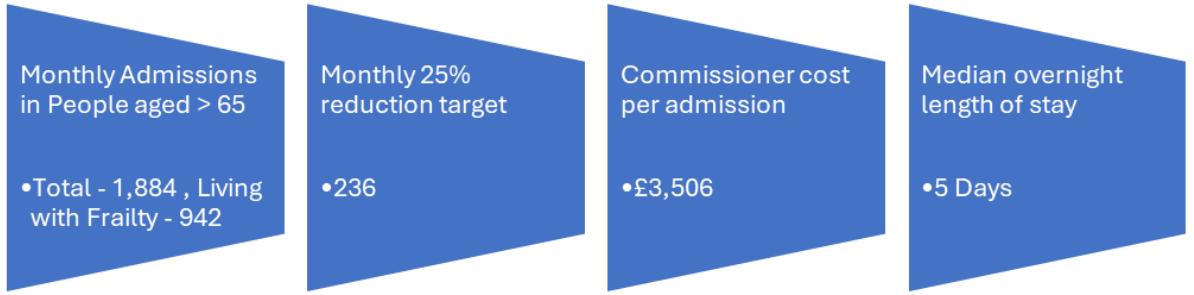


Figure: Place based assumptions Targets, Admissions costs, and lengths of stay East and North Herts Residents

East and North Herts Health and Care Partnership

Care Closer to Home (7 interventions)

Risks

- Workstreams within the 7 interventions share delivery resources, which can impact time available on a particular element, but the shared understanding of wider programme supports drive to delivery for care closer to home for the patients.

What we will do to deliver change if no additional funding available

- We will continue to review progress against the 7 interventions to identify pathway efficiencies through application of lean and QI methodologies.
- We will maintain ongoing engagement with all our stakeholders to share best practices across teams, fostering the spread and adoption of new working methods. Our focus will be on making small improvements that will significantly reduce NEL admissions for our frail population.
- Through our Care Closer to Home approach in ENH, we are cultivating a culture of change, exploring training opportunities to upskill our workforce, ensuring strong leadership throughout our programs and operational teams, and continuously enhancing open lines of communication.
- Paper Advanced Care Plans will continue to be used in the area, as a digital solution will not be available in year

Polypharmacy for Moderate and Severe Frail patients

- As part of the ECF, practices are funded to complete a polypharmacy review for all patients with moderate frailty who have 8 or more repeat medications. National funding is provided to practices to undertake a polypharmacy
- ECF target of 60% of moderate frailty and 80% of people with severe frailty having a polypharmacy review. Actions are taken to deprescribe and manage medications

Community Falls (Moderate and High Risk)

- Patients with a moderate or sever frailty who have a low falls risk to be offered strength and balance classes. Those this high risk of falls are referred to a community falls/frailty clinic for a multifactorial assessment and management of risks
- ECF target of 60% of moderate and severe frailty cohort having a FRAT assessment and onward referral to falls prevention services (S&B or community frailty service)

Integrated Neighbourhood Teams delivering Case Management

- People with moderate or severe frailty, or with advanced disease or multi-morbidity are assessed for management by INTs. INTs to case manage patients in Multi Disciplinary setting, optimising care and developing agreed care plans
- Success Factor - 3 per 1000 population managed through INTs over 12 month period

Advanced Care Plan (Digital)

- Creating a digital ACP that is accessible for all clinical teams is not in scope for year 1. Instead work will continue in the roll out of hard copy ACPs. Clinical teams access, review and act on ACPs, utilising community services to manage patients in their preferred place of care
- Success Factor - 1500

Falls Response

- Whilst all people who fall and are unable to get up must have appropriate clinical assessment, a proportion of falls can be responded to by community based services. In addition, alternative pathways for patients experiencing a long lie, head injury or fall in a care home are potentially amenable to an alternative management pathway
- Success Factor - 1796 falls attended by EIV(increase from 1497)

Stack

- Access to the ambulance stack by the virtual hospital can enable the VH team to identify patients amenable to management on VH, thus avoiding a conveyance to hospital and associated admission
- Success Factor - 6.1 per day

Senior Review in ED

- Patients who are frail or in their last year of life are assessed to determine in they are suitable for management in the Virtual Hospital. A senior clinician, with knowledge of the capabilities of the VH determines the appropriateness

Care Closer to Home (Priority UEC Programme)

Six core UEC strategic priorities

1	Understand and predict our population needs in order to support those at greatest risk and deliver tailored population -based approaches
2	Partners within the system work together to ensure joined up and coordinated care, including improved flow and early supported and safe step-down from services.
3	Prevention and proactive, personalised care is embedded across the system to empower people to live and age well avoiding the need for services wherever possible.
4	When people need same day or urgent care they can easily and rapidly access the right care.
5	Effective and efficient emergency care pathways that are appropriate, safe, and closer to home.
6	Focus on children and young people, mental health crisis response, and frailty and end-of-life care.

Hertfordshire and West Essex Integrated Care System

- UEC is designed and delivered at both place and at ICB/ICS level to provide a consistent approach to demand management. This approach is derived from multiple strategies outlined at National, Regional, ICB and Place HCP levels.
- The ICB UEC strategy outlines 6 core priorities for delivery over the coming years

East and North Herts Health and Care Partnership

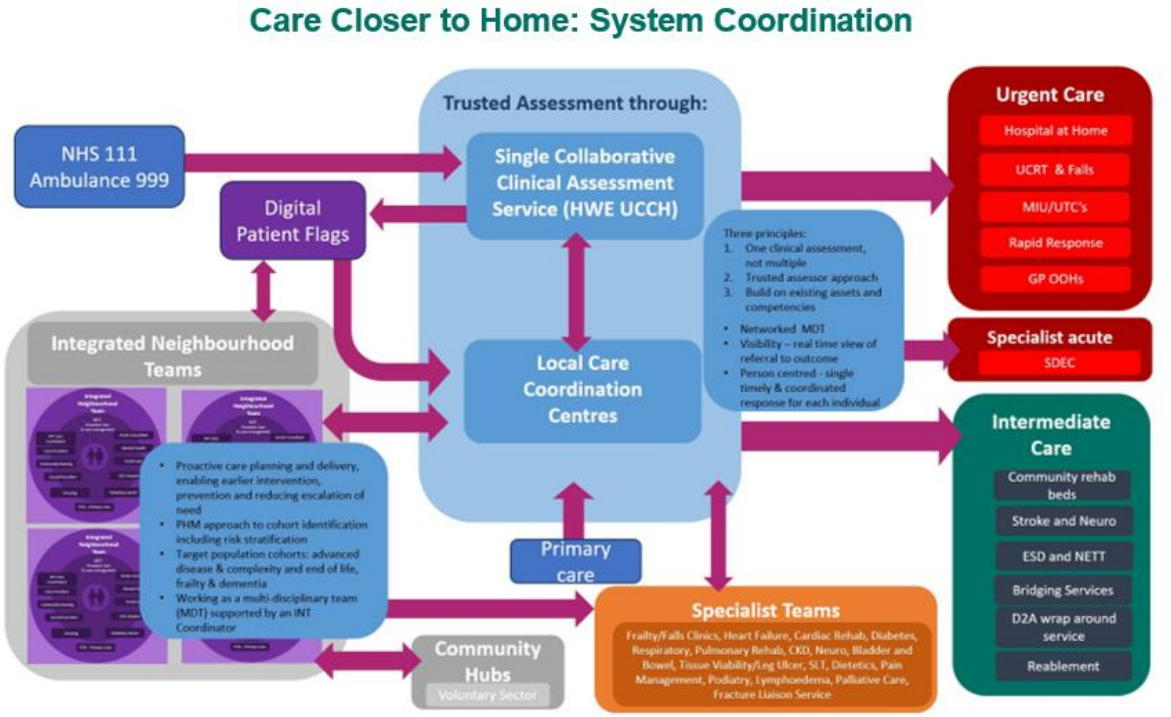
Care Closer to Home (Priority UEC Programme)

The focus for UEC at East and North Hertfordshire Place is outlined in the figure below (highlighted green) which will support the implementation of both the HWE ICB priorities and its Medium-Term Plan.

Care Closer to Home (Priority UEC Programme)

- The diagram below outlines the links with urgent care to support the delivery of the CCTH programme and 10% frailty admission reduction and vice versa

- A main component of this is UEC demand management and the UCCH (unscheduled care coordination hub). To support this work at Place there are 3 key provider led initiatives – System Coordination, Unscheduled Care Coordination Hub and Integrated Single Front Door



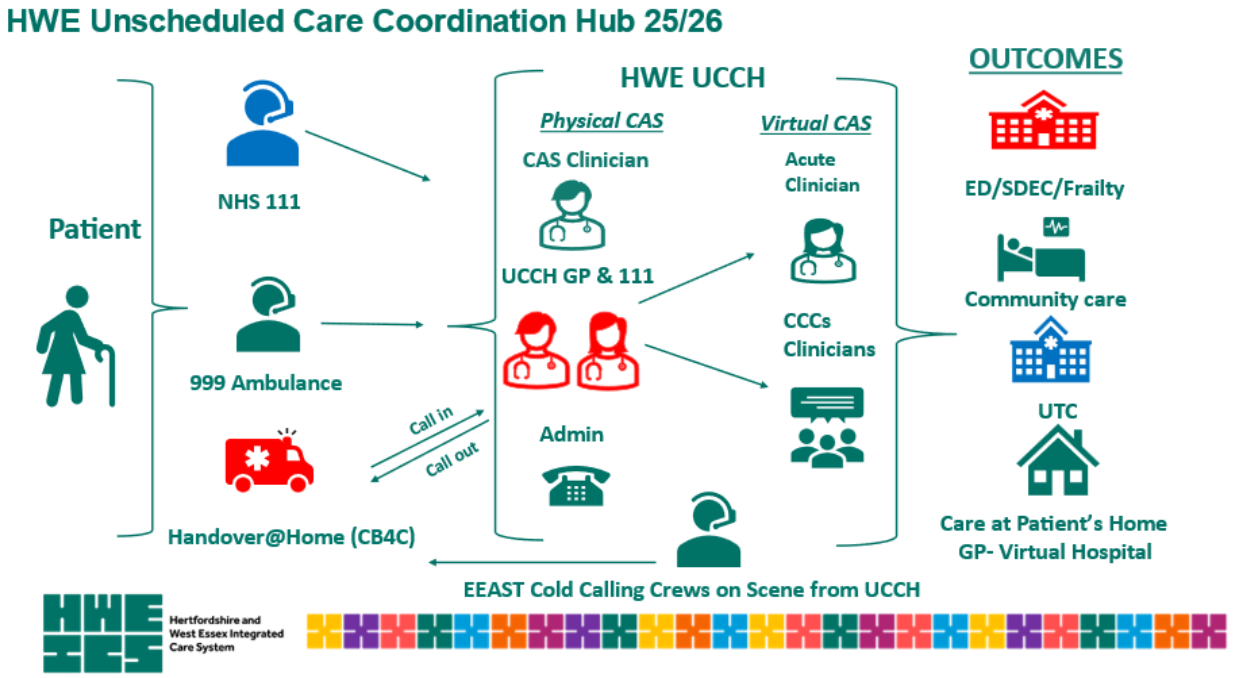
Key UEC developments to progress in 2025/26

- ❑ Implement UTC/MIU review recommendations (to be shared April 2025) in relation to CYP, enable all UTCs to see and treat all ages, review of on-day primary care capacity and efficacy of IUC
- ❑ Robust plans to maximise uptake, and reduce inequality in uptake of vaccinations, in particular childhood and flu vaccinations
- ❑ Support parents of young children in areas with high attendances rates and communities experiencing health inequalities, through links to social prescribers and VCFSE sector support
- ❑ Ensure a consistent model for paediatric SDEC based on population need
- ❑ Scale up INTs so there is consistency in approach, and they are guided by the implementation toolkit
- ❑ Implementation of CCTH model including developing closer working between IMC services and Hospital at Home/Virtual Ward
- ❑ SCC to take next steps to achieve maximum maturity against NHSE expectations and consider colocation with UCCH and LOC
- ❑ Further develop and scale up the Unscheduled Care Co-ordination Hub (UCCH)
- ❑ Embed robust advance care plans using consistent documentation and sharing across the UEC system
- ❑ Continue to embed population-level frailty identification and assessment at key points in the UEC pathway
- ❑ Improve care coordination and optimise referral pathways between primary care and care coordination centres, and pathways in both directions between SDEC and community providers
- ❑ Proactively use remote monitoring and health technology to target community services and prevent deterioration
- ❑ Engage and learn from our communities, especially those facing health inequalities.

Care Closer to Home (Unscheduled Care Coordination Hub (UCCH)

The premise of the UCCH is to provide a single point of contact for clinical support to frontline clinicians and support use of alternative pathways such as UCR or Virtual Ward

ENHT are developing a UEC plan for 2025/26 which promotes the use of a single access front door to acute services to ensure that patients receive the right care for their needs e.g. an emergency patient has access to the emergency department



UEC Mission and Vision

NHS East and North Hertfordshire NHS Trust

Mission

" Our mission is to provide outstanding, safe, compassionate, high quality and timely integrated urgent and emergency care se rvices to the community we serve."

"Guided by Innovation, Inclusivity and Respect we will improve health outcomes and experience for those who use our services"

Vision

We will ensure right care, in the right place at the right time through;

- Removing waste and improving existing processes
- Developing the environment and infrastructure to follow clinical pathways through UEC departments
- Our clinical operating will transform, moving to a single front door model for walk in attendances that triages and streams users to the right department before entering the emergency department
- Reducing footprint and footfall within the Emergency Department by enhancing UTC and same day emergency care (SDEC) capacity and provision

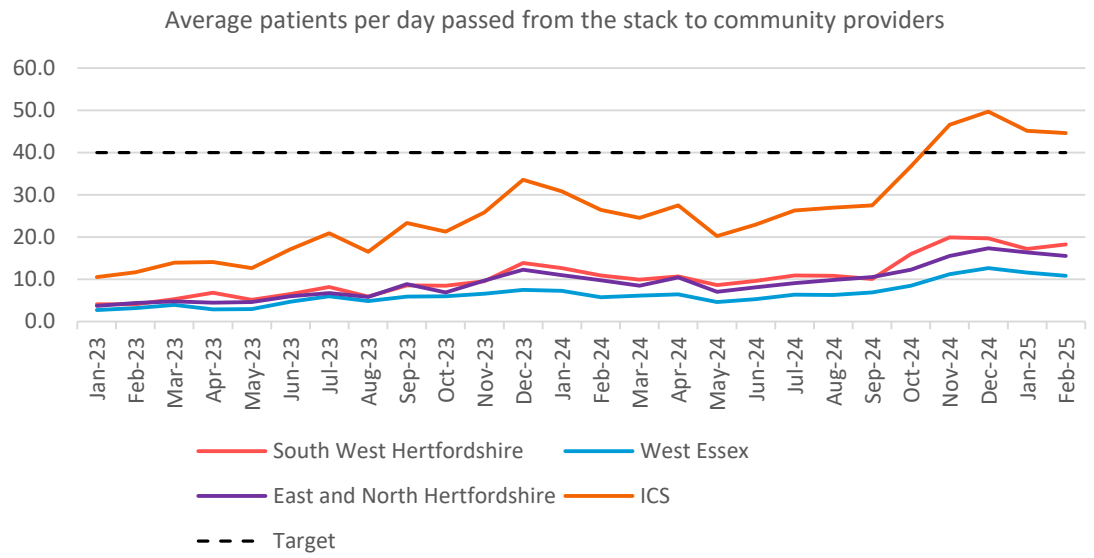
East and North Herts Health and Care Partnership

Care Closer to Home (Unscheduled Care Coordination Hub (UCCH)

Patients passed per day via access-to-stack (Feb-25)

	Actual	Target*	Variance to target
ICS	44.6	40	4.6
East and North Hertfordshire	15.5	15.7	-0.2
South West Hertfordshire	18.3	14.9	3.4
West Essex	10.8	9.4	1.4

*Target apportioned to each place on the basis of the number of day-time C3-C5 incidents in month. No target for each age group, so select all in cell B15 if you want a target



% patients accepted by community providers

	Actual	Target	Variance to target
ICS	79%	95%	-16%
East and North Hertfordshire	82%	95%	-13%
South West Hertfordshire	77%	95%	-18%
West Essex	80%	95%	-15%

% patients completed by community providers

	Actual	Target	Variance to target
ICS	38%	55%	-17%
East and North Hertfordshire	37%	55%	-18%
South West Hertfordshire	36%	55%	-19%
West Essex	44%	55%	-11%

East and North Herts Health and Care Partnership

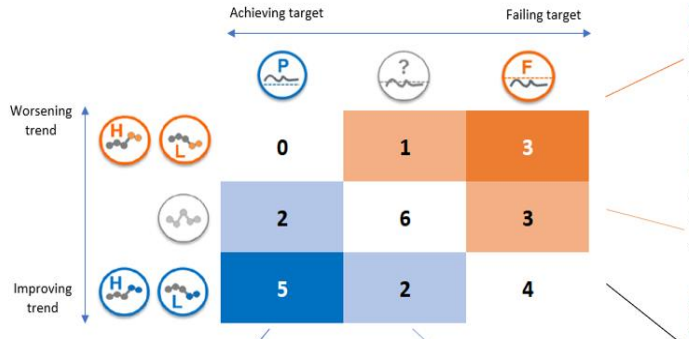
Care Closer to Home (UEC performance priorities)

		Validated data							Unvalidated data	
Place	Indicator	Previous Month	Current Month	Latest Month	Month Change	Current month trajectory	Variance to target	12 month trend	Latest weekly performance	
ENH	% abandoned calls	2.8%	2.9%	Feb-25	↑	3.0%	-0.1%		1.5%	↓
ENH	CAT 2 mean response times	00:50:10	00:42:39	Feb-25	↓	na	na		na	
ENH	Access to stack - average patients completed per day	6.0	5.8	Feb-25	↓	na	na		3.6	↓
ENH	% 2 hour urgent community response	79.2%	82.8%	Feb-25	↑	70.0%	12.8%		na	
ENH	Total hours lost to handover (>15 mins)	1561	1169	Feb-25	↓	489	680		151	↓
ENH Place	4-hour standard	72.7%	72.3%	Feb-25	↓	77.0%	-4.7%		77.8%	↑
ENH	% of type 1 patients spending more than 12 hours in ED	17.2%	16.4%	Feb-25	↓	10.0%	6.4%		na	
ENH	National GEMI score rank (low = good, out of 169 sites)*	151	145	Jan-25	↓	na	na		na	
ENH	Bed occupancy (G&A)	91.3%	91.8%	Feb-25	↑	91.2%	0.6%		90.0%	↓
ENH	Patients with NCTR (No Criteria To Reside) remaining in hospital	61	54	Feb-25	↓	79	-25		59	↑
ENH	% discharged before noon	16.1%	16.9%	Feb-25	↑	33.0%	-16.1%		na	
ENH	Virtual ward occupancy	138.2%	121.6%	Feb-25	↓	84.8%	36.8%		na	

◄ This table *(left)* looks at current performance (March 2025) for UEC across the ENH Place. Although there are some areas not meeting the required standard there is overall improvement across all areas

We are also starting to see C2 performance improvement by reducing demand to the 999 service and enabling them to respond appropriately

Performance metric summary



Highest Risk	Programme
ASD / ADHD	Community
Community Waits (Children)	Community
Diagnostic 6 week waits	Elective

High Risk	Programme
RTT PTL size	Elective
Ambulance Handovers	UEC
Ambulance Response Times	UEC
ED 4 Hour Standard	UEC

Variable Risk	Programme
28 Day Faster Diagnosis	Cancer
CHC decisions within 28 days	CHC
Community Waits (Adults)	Community
Diagnostics PTL size	Elective
RTT 65 Week Waits	Elective
Theatre Utilisation	Elective
% of <14 day GP Appointments	Primary Care
% of on the day GP Appointments	Primary Care
Access-to-stack patients completed per day	UEC
ED attendances	UEC

Lowest Risk	Programme
31 Day Standard	Cancer
62 Day Standard	Cancer
CHC assessments in acute setting	CHC
RTT 78 Week Waits	Elective
Virtual ward occupancy	UEC

Low Risk	Programme
Day case rates	Elective
2 Hour UCR	UEC
NHS 111 Calls Abandoned	UEC
Non-Elective Length of Stay	UEC

Virtual ward is in the lowest risk bucket but the occupancy is probably too high

Moved to higher risk category

Moved to lower risk category

What does our performance tell us?
UEC performance priorities:

1. 4-hour A&E performance
2. Ambulance C2 Performance
3. Ambulance Handover Performance

East and North Herts Health and Care Partnership

BCF priorities for 2025-26

- Continuing to embed a ‘HomeFirst’ approach, shifting focus from bedded support to enabling, person-centred support delivered at home
- Implementation of the local Intermediate Care (IMC) Strategy, and working with services for a consistent, therapy-led approach to IMC services
- Continuing to deliver the Integrated Approach to Complex Care Programme
- Working alongside the Care Closer to Home Programme to deliver ‘neighbourhood health’ objectives and linked programmes, including the Discharge to Assess programme
- Continuing to support prevention using services such as the Early Intervention Vehicle and working closely with community and voluntary sector partners
- Harnessing digital technology to improve care delivery across all services
- Jointly monitoring and improving capacity and demand planning and metric performance against the national standards

Good Examples of Place Based Working (1)

Evaluation on Carer's cafes in North Herts

- The carers café in North Hertfordshire has been operating for one year, receiving positive feedback from 73 participants with a satisfaction score of 4.82 out of 5. The café has contributed to improved mental health and wellbeing, stronger social connections and better access to advice and support for carers leading to a reduced demand on clinical and GP services. The carers café has also been recognised with an HWE ICB award and was a finalist for a national GP award.

Cheshunt Memory Hub

- The Cheshunt Memory Hub enables partners to collectively share and utilise resources in one place, providing a one-stop shop to better support patients with dementia. The model is being built on by putting in clinicians who can do assessments and ultimately the aim is to diagnose straight forward dementia cases in the Hub. The aim is to create a dementia friendly community within Lower Lea Valley, proactively case managing high risk patients with dementia so they are less at risk of hospital admission and empower them to live well with dementia. Carers will be offered carer health checks and local support by Carers in Herts, including providing them with the right information on what support they can get.

New family space opened at Lister's Children Assessment Unit

- A new designated space at Lister Hospital for families with children and young people with a palliative or end-of-life condition has opened in the summer of 2024, made possible by funding from Hertfordshire and West Essex ICB received as part of NHSE long term funding for children's palliative and end of life care. Located in the Children's Assessment Unit (CAU), the new space (which has been named the Phoenix Room) will give families a comfortable and quieter area when at Lister. The room can also be used by families with children or young people who have special educational needs and disabilities. A range of new equipment for the CAU has been purchased, including hand-held oxygen saturation monitors for the community children's nursing team, blankets and teddies for bereaved families, more reclining parent chairs in the CAU and a communication aid.

Good Examples of Place Based Working (2)

Enhanced Health in Care Homes (EHCH) service reflecting new guidelines

- The service is designed to improve the clinical outcomes of adults residing in all CQC-registered nursing and residential homes including Learning Disability (LD) & Discharge to Assess (D2A) residents (excluding short stay respite services, neurological services, and flexi care schemes) in ENH.
- Service delivery will involve new residents to have completed RESPECT plans, Advanced Care Plans (ACPs), and Therapeutic Escalation Plans (TEPs) (including preferred place of care and death) and care and support plan reviews (including medication reviews) following discharge from secondary care, this will support a reduction in the number of conveyances, A&E attendances, and admissions taking place within the ENH care home resident population, and therefore aligns with this ICB/HCP target of reducing admissions.
- This enhanced service is also viewed across the HCP as an important opportunity to accelerate development of integrated neighbourhoods at place.

Proactive Prevention for Carers project

- HCC is using Accelerating Reform Fund monies for carers to work on ways to better identify carers at an earlier stage, using data and artificial intelligence to identify and then offer a proactive contact. This is a partnership with Carers in Hertfordshire and ICB is engaged. Initial trial reaching out to a smaller number of carers in the Broxbourne area starting this month.

Tackling high blood pressure

- ENH HCP health inequalities group has been successful in an ICB bid for the provision of blood pressure machines for use in non-health community settings. This project aims to tackle health inequalities by supporting individuals from more diverse ethnic populations to take their blood pressure, to improve the detection and prevention of high blood pressure, which can have very serious health consequences. We are engaging with local faith leaders to identify faith centres to distribute machines to.

Good Examples of Place Based Working (3)

Stevenage Same Day Access hub and proposal for integration with Urgent Treatment Centre (UTC)

- The two same day access Stevenage hubs have been operational and running on a PCN footprint since July 2023 with differing operational formats. The Stevenage locality was identified as one of the three priority areas within the ICB Primary Care Strategy requiring more same day access appointments within primary care due to high levels of increasing demand and associated impact on secondary care.
- Following an evaluation paper of the hubs and more recently of the ENHT UTC provision; the PCN's have worked together to prepare a proposal paper for a one locality model for financial year 25/26.
- Although no funding can be committed at the current time, the ICB's review of Urgent Treatment Centre (UTC) provision across the whole system has progressed and there is system wide agreement that the ICB cannot continue with the current model of multiple access points into type 3 services, UTC fronting emergency departments, standalone UTCs, Minor Injury Units, same day access provision in primary care and standalone out of hours provision.

Asylum seeker healthcare provision

- Continued provision of healthcare for a vulnerable patient co-hort who are placed in Initial Accommodation Contingency hotels, most have complex needs, language barriers, experienced recent/past trauma plus a lack of knowledge of their previous healthcare history.
- Collaborative system wide working and support with partners across Hertfordshire including public health and County Council colleagues.
- GP practices and Primary Care Network's support this patient co-hort through a Locally Enhanced Service which is commissioned to enable delivery of primary medical care via in-reach clinics.

Good Examples of Place Based Working (4)

Hospital at Home

- Thousands of patients across East and North Hertfordshire have benefited from the Hospital at Home service since it started in January 2022. HCP partners have worked collectively on this. Hosted by Hertfordshire Community NHS Trust, the Hospital at Home service provides face-to face nursing care and therapy, as well as remote monitoring services for patients with a range of conditions that would've previously required a hospital admission. The service currently supports c220 patients a day. At a cost of £6.6m this is approximately £82 per patient, per day.
- The service is delivered via a capability model that utilises the clinical expertise of the multidisciplinary team that includes doctors, advanced clinical practitioners, pharmacists, social workers, and support staff. This model enables the delivery of patient centred care, tailored to meet the individual needs of patient's, across a range of clinical pathways.
- The service has also worked closely with the East of England Ambulance Service to enable people who have called 999 to receive care safely in their home and avoid a transfer to hospital, if not required.

Good Examples of Place Based Working (5)

Tackling Inequalities locally

Community Cookalongs – from 27 February 2025, 6 online free sessions with aim to get families cooking dinner together, building confidence in the kitchen and shaking up the family menu. The recipes have been designed to appeal to families with primary-aged children – including fussy eaters GP surgeries in Stevenage and north Hertfordshire have also had a hand in developing Community Cookalongs alongside local councils and Letchworth Garden City Heritage Foundation. They reflect work by the NHS and local services to give every child the best start in life and to support general lifestyle improvements for local people: showing families that healthy eating can be affordable, quick and easy and supporting families to spend quality time together.

Volunteer fairs highlighting value of communities working together. The fairs have been an ideal opportunity for charities, community groups and health services to showcase their work to residents, and network and build relationships with one another, in addition to adding more volunteers to their cause. Visitors also had the chance to take part in health checks, such as having their blood pressure checked. The first fair organised by the partnership was so successful in helping people understand the support and services available in the community, two more took place in 2024. A fourth is planned for Volunteers Week in 2025.

South and West Herts Health and Care Partnership

HCP Implementation Plan

2025/26

Working together
for a healthier future

Our HCP Implementation Plan
Overview of plan

Our HCP Implementation plan sets out our programme of work for 2025/26. It includes:

Section	Description	Overview of content
Introduction and context	How the HCP has identified its priorities and developed the workplan	This section includes an overview of progress to date, the national and local priorities that the HCP will be held to account to and how we have aligned our workplan to these priorities
HCP operating model	How the HCP will be organised in order to effectively plan, commission and deliver health and care services on behalf of the population we serve	This section describes our host provider model, our governance structure and key roles and responsibilities within the HCP
Neighbourhood Operating Model	How we will develop out neighbourhoods to become the engines for operational delivery within the HCP	This section describes our four neighbourhoods, how we expect they will work and the composition of our neighbourhood leadership teams
HCP workplan	Our transformation programme delivered at place level in 2025/26	This section is broken down to our 5 HCP programmes, as well as our productivity and enablers and describes how this work supports us to deliver national and local priorities
Delegation next steps	How we will work with the ICB to implement our Delegation Framework and plan for future delegation.	This section includes success measures for delegation in 2025/26 and next steps for accountability, governance, oversight, contracting, financial control and workforce

1. Introduction and context

HCP progress to date

During 2024/25 the HCP has made significant progress both in establishing and embedding new ways of working and in transforming our models of care to deliver tangible improvements for our local population. Key successes include:

Transforming our ways of working

- **Governance**: Reviewing the HCP's governance structure and establishing new sub-committees (Finance & Commissioning committee and Quality & Performance committee) to ensure the HCP has the correct infrastructure in readiness for delegation 2025/26
- **Leadership**: The HCP has established an executive team with clinical and managerial leadership from key partners within the HCP including WHTH, CLCH and the ICB to drive the strategic agenda and ensuring the delivery plan is implemented. Our executive team includes our 4 neighbourhood clinical leads
- **Collaboration**: The HCP has made significant progress in developing strong relationships that have enabled effective collaborative working and joint decision-making. This has included regular touch points with key stakeholders including district councils and the VCFSE sector
- **Delegation**: The HCP has developed a framework for delegation which has been approved by both the ICB and the HCP's host provider (WHTH). This is ground-breaking thought leadership which will help shape national approaches to delegation

Transforming our models of care

- **Urgent and emergency care:** SWH has achieved sustained improvements through collaborative working via the System Resilience Group which sets clear, strategic deliverables as system partners. Successes include our A&E 4 hour target (performance in January was 80.3% and WHTH was 8th nationally), increasing our Access to Stack by 100% and reducing our nMCTR numbers from over 100 to c60-70 and DTA overstayers by 50% in one month. An exemplar of our partnership working in UEC is embedding a secondary care consultant within the Urgent Community Response service
- **Elective, cancer and diagnostics:** SWH's improvements in elective, cancer and diagnostics performance have been achieved through collaborative working and joint decision-making, including top-performing in the region on 65 week waits and strong performance on diagnostics and cancer standards, with 98.6% of cancer patients starting treatment within 31 days of agreeing a treatment plan in December. We are working as a place partnership to plan and deliver new CDCs at St Albans and Hemel Hempstead and a community ultrasound clinic in Hertsmere
- **Primary care:** SWH has appointed a Care Closer to Home Clinical Lead and 4 Neighbourhood Clinical Leads who will provide leadership to our neighbourhoods, including ensuring the continuing progress and delivery of our Integrated Neighbourhood Team Initiatives which take localised approaches to targeted, preventative care to our frail, elderly population
- **Virtual hospital:** SWH has established a high performing virtual hospital which has supported over 3,000 patients. The VH has reduced hospital length of stay, non-elective admissions, and is continuing to expand and evolve (launching a new general medical pathways in October and reaching over 100 beds in step-down pathways by December)
- **Proactive and preventative care:** SWH has approved a pilot for proactive model of care which will offer a holistic, multi-disciplinary team approach to keep our most vulnerable older patients at home where possible, reducing risk of further deterioration. This model is funded using a Social Funding model which minimises risk to the HCP and enables multi-year investment in transformation
- **Joint integrated respiratory service:** SWH co-designed and agreed a new service model for integrated respiratory care which is fully integrated, bringing together teams from CLCH and WHTH to provide seamless pathways across primary, community, and secondary care services, removing duplication of diagnostic tests and outpatient appointment

National priorities

NHSE has set the following national priorities for 2025/26 which will improve patient outcomes, and ensure that health and care systems are enabled to deliver these improvement:

Improving patient outcomes

Elective Care	• Reduce the time people wait for elective care, improving the % of patients waiting no longer than 18 weeks for elective treatment to 65% by March 2026, with every trust expected to deliver at least 5% improvement • Continue to improve performance against the cancer 62-day and 28 day Faster Diagnosis Standard to 75% and 80% respectively by March 2026
Urgent and Emergency Care	• Improve A&E waiting times and ambulance response times compared to 2024/25, with a minimum of 78% of patients seen within 4 hours in March 2026 • Category 2 ambulance response times should average no more than 30 minutes across 2025/26
Primary Care	• Improve patients' access to general practice, improving patient experience • Improve access to urgent dental care, providing 700,000 additional urgent dental appointments
Mental Health	• Improve patient flow through mental health crisis and acute pathways, reducing average length of stay in adult acute beds • Improve access to CYP mental health services, to achieve the national ambition for 345,000 additional CYP aged 0-25 compared to 2019

Delivering improved patient outcomes

Reform	• Drive reform that will support delivery of our immediate priorities and ensure the NHS is fit for the future • Focus on reducing demand through developing neighbourhood health service models and making use of digital tools
Resources	• Live within the budget allocated, reducing waste and improving productivity • Deliver a balanced net system financial position in collaboration with system partners
Quality and safety	• Maintain our collective focus on the overall quality and safety of our services • Continue to address variation in access, experience and outcomes

System priorities

The ICB have identified 5 priorities in their Medium Term Plan, and these have a direct alignment to the national priorities for 2025/26:

1. Reduction in the backlog for **children's care**

   aligned to the elective care national priority

2. Reduce inequality with a focus on outcomes for **cardiovascular disease** and **hypertension**

   aligned to the primary care national priority

3. **Elective** care recovery

   aligned to the elective care national priority

4. Improve **urgent and emergency care** through more anticipatory and more same day emergency care

   aligned to the urgent and emergency care national priority

5. Better care for **mental health crises**

   aligned to the mental health national priority

Within these priorities the ICB has identified 7 high impact interventions which are aimed at reducing non elective admissions in our frail elderly

Polypharmacy reviews

Reducing the number of people on multiple medication and reducing anticholinergic burden through medication reviews for people with frailty and living in care homes

Community falls

Reducing the number of falls through the community falls services and social prescribing

INTs

Proactively managing people at risk identified through INT searches

Advanced Care Plans

Increasing the number of people on the end of life register and/ or with moderate and severe frailty who have completed care plans

Falls response

Reducing the number of people conveyed to hospital following a fall in the community or in care homes

Access to the Stack

Increasing the number of people passed from the stack to community providers

Senior reviews in ED

Increasing the number of people over 65 who have a completed clinical frailty score and reducing the number of admissions for people with frailty

HCP priorities

The HCP's vision and objectives is aligned to the ICS's Medium Term Plan and includes the enablers identified within the national priorities for 2025/26 to ensure that we are able to deliver the anticipated improvement in patient outcomes described in our vision and objectives

Our vision is to be a **'single team'** responsible for planning, improving and delivering population-based health and care services for the people of South-West Herts, delivered by via a **neighbourhood working model**

Our strategic priorities:

- Improve the general **health and well-being** of our residents and improve **health and care services**
- Tackle the **inequalities** which affect people's physical and mental health including the **wider determinants**
- Deliver **empowerment and preventative care**, modelled on proactive outreach into communities
- Support citizens **to manage their own health conditions effectively** to address social determinants to include housing, planning and employment
- Develop our staff to evolve into **fully integrated teams** that are empowered to co-design and deliver transformed services

Deliver on the **five ICS priorities**
(including the 7 high impact interventions)

How we will achieve this:

- Use **population data** and **local insights** to understand the health needs of our citizens
- Develop and co-design a **shared clinical strategy**
- Develop a **workforce plan** focused on our shared ambition of integration, centred on building staff skills and capability and working as a single team
- Commit to achieve a **balanced financial position** annually
- Develop and agree an **operating model** delivered by our neighbourhoods

Developing the HCP's workplan

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

Slide 9 **sets out a series of "I statements"** which are the outcomes that the HCP wants to deliver for its local population, as citizens, patients and tax payers. We have aligned the national and system priorities to these statements to ensure that the HCP delivers these priorities

Slide 10 **sets out the programmes of work** which will enable the HCP to successfully deliver the priorities aligned to these "I statements". This includes the level at which these programmes of work will be planned and delivered

Slide 11 **describes the success measures for these** which will enable the HCP to demonstrate when these programmes have successfully delivered these outcomes. These success measures are explicitly aligned to the quantifiable measures as set out in national and system (MTP) priorities

Slide 12 **describes the enabling programme** together with the success measures that will ensure we have successfully delivered the enabling workstreams

Aligning national and regional priorities

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

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

South and West Herts Health and Care Partnership

Aligning the HCP's workplan to local and national priorities

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

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

HCP oversight

HCP-led design and delivery

Neighbourhood-le

What success looks like
Service delivery outcomes

By April 2026, we are aiming to measure improvement with the following metrics…

HCP Programme	Success measure	National priority	System priority	How we know we will have achieved this
Addressing inequalities/ Long Term Conditions	**Increasing detection of hypertension**	Primary Care	Reducing inequalities	• Hypertension QOF measures - 2% increase from baseline • Increase age standardised prevalence of hypertension
	Improving treatment for people with hypertension	Primary Care	Reducing inequalities	• Increase the percentage of patients with hypertension whose last blood pressure was in target • Increasing the percentage of patients with hypertension treated according to NICE guidelines
Elective care planning	**Reducing elective waiting times**	Elective care	Elective care recovery	• Reduce the number of patients waiting 18 weeks or longer for elective treatment to 65% • Having 0 people waiting 52 weeks or longer for treatment • Meeting the FDS cancer targets • Increase the number of patients waiting less than 6 weeks for diagnostics to 95% • Improve theatre productivity to 85%
	Reducing elective length of stay	Elective care	Elective care recovery	• Increase the percentage of surgery consistently undertaken as day case surgery to 85%
Children & Young People	**Reducing community waiting times for CYP**	Elective care	Children's care	• No community paediatric waits greater than 65 weeks • Secondary wait for ADHD & Autism assessment following community paediatric 18 weeks
	Reducing emergency admissions for CYP	UEC	Children's care	• Reduce emergency admission rates for children and young people by 5%
	Reducing A&E attendances for CYP	UEC	Children's care	• Reduce A&E attendances for children and young people by 5%
Urgent and emergency care	**Improving transfer of care back home**	UEC	UEC	• No more than 50 patients nMCTR per day • 95% of patients discharged back to their usual place of residence
	Reducing ED waiting times	UEC	UEC	• Minimum of 78% of patient seen within 4 hours • Improving category 2 ambulance response times • A higher proportion of patients admitted, discharged and transferred from ED within 12 hours across 2025/26 compared to 2024/25 • Proportion of mental health attendances spending over 12hrs in the department (reduction target to be set after assessment framework finalised)
Urgent and emergency care/ Frailty and end of life	**Reducing emergency admissions for people living with frailty/ older people**	UEC	UEC	• Decrease rate of emergency admissions for falls in the community of people aged 65+ by 5% • Reduce non elective admissions for people living with frailty (by 25%)
				• Reducing percentage of deaths with 3+ emergency admissions in the last 90 days of life b

What success looks like
How we work

By April 2026, we will have…

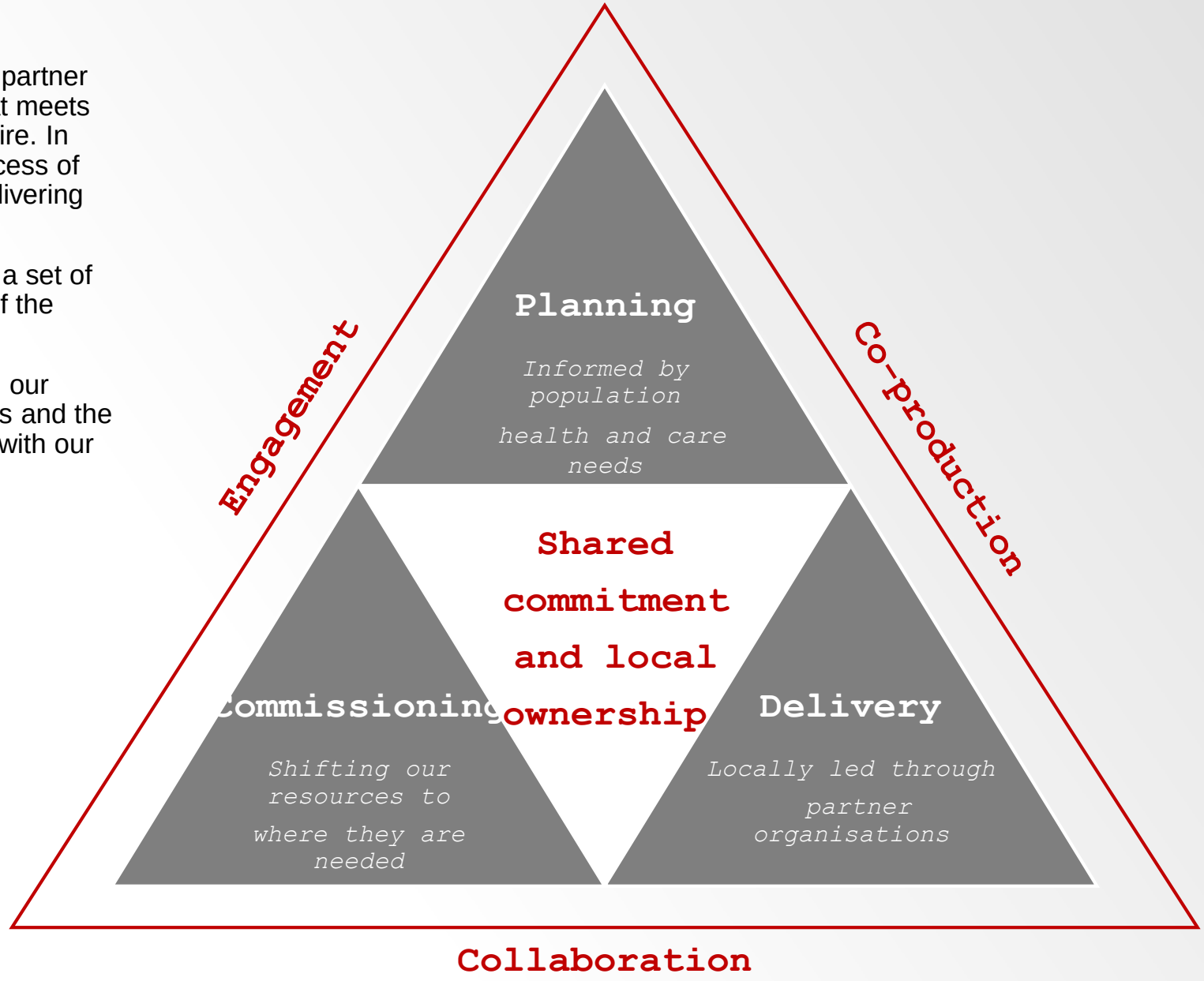
National priority	Success measure	Enabling workstream	How we know we will have achieved this
Reform	• Maturing neighbourhood health service models • Neighbourhood transformation initiatives explicitly aligned to population need	**Neighbourhood development**	• Fully resourced neighbourhood teams (as per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

How the HCP works

The HCP is a collaboration of NHS, local authority and other partner organisations that designs and delivers services in a way that meets the needs for people living within South and West Hertfordshire. In order to deliver meaningful change the HCP is starting a process of devolving responsibilities of planning, commissioning and delivering services to our HCP, through a host provider model

Our success is derived from a shared commitment to deliver a set of joint objectives that have been locally defined, on the basis of the population's health and care needs

Membership of our HCP Board, committees of the board and our neighbourhoods is representative of our partner organisations and the communities that we serve. Co-production and engagement with our partners and communities is central to our ways of working



2. HCP Operating Model

Overview of host provider model

Overview of host provider model

In order to enable SWH HCP to plan, commission and manage healthcare services on behalf of their local population, the ICB will devolve responsibility for planning, commissioning and delivering services to the HCP. A host provider model is necessary because the ICB can only delegate to another legal entity. As such WHTH will become the 'host provider' on behalf of SWH HCP and the HCP will be constituted as a committee of the Trust Board. *This model is described more fully on the following page*

Rationale for host provider model

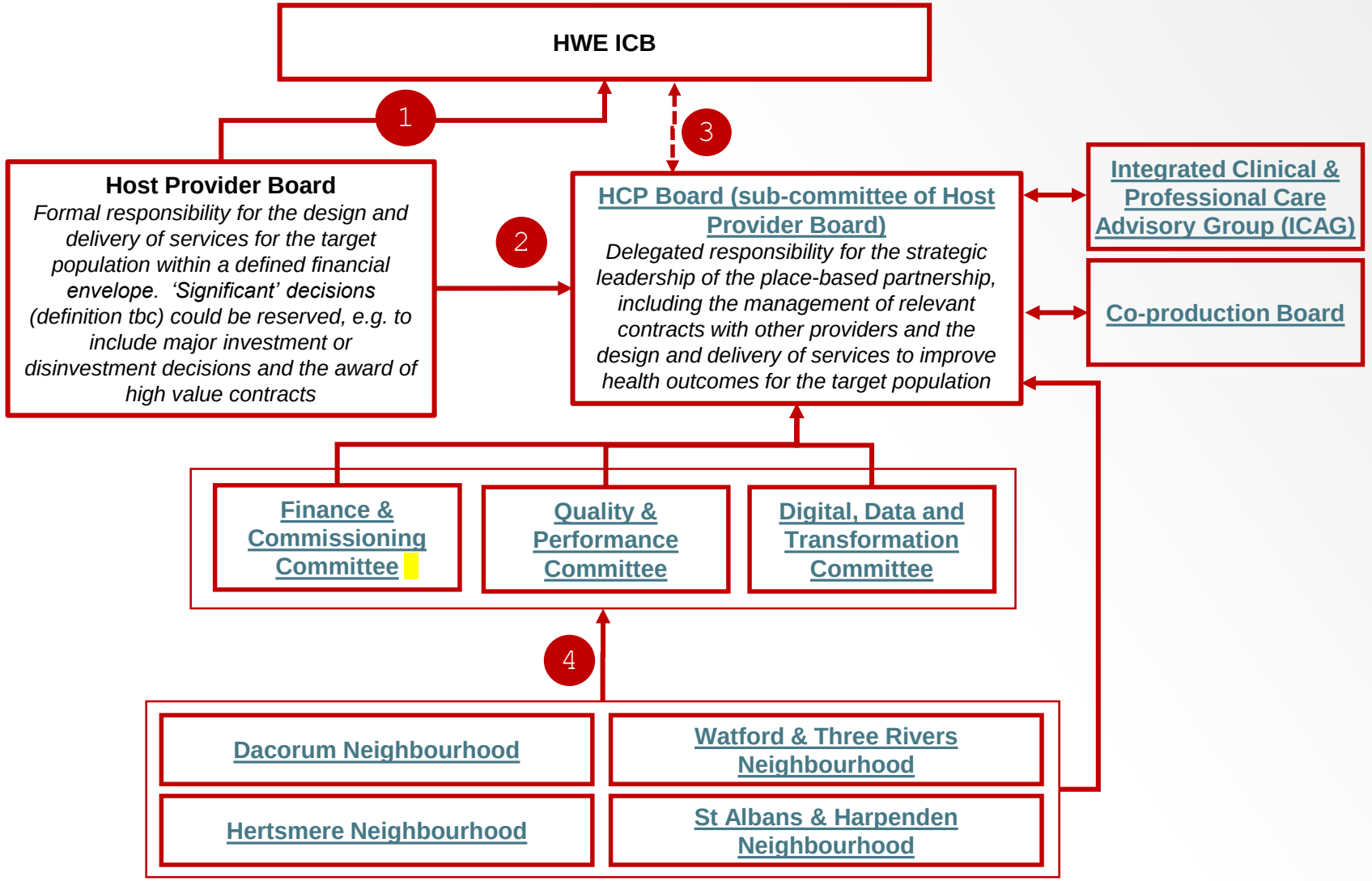
The host provider model provides a framework for governance, accountability and collaboration that empowers the HCP to exercise greater autonomy in commissioning decisions whilst fostering innovation and closer alignment with the needs of the community. It does this by enabling functional integration so that HCP partners can:

- Work together effectively as a **single team**
- Take **responsibility for planning and delivering** high quality services
- Be **responsive to local population health need**
- Prioritise the **prevention** of ill health and the predominance of **care closer to home**

Collaborative approach

The HCP will continue to embed its collaborative, partnership model by promoting shared accountability and collective decision-making. WHTH, as host provider, will delegate responsibility for transacting the HCP's core business and strategic development to the HCP. The HCP Board will retain its broad membership and representation from across the HCP, including ICB board non-executive membership.

HCP operating model



1. Responsibility for designing and delivering health and care services for the population served by the HCP delegated to the Host Provider Board within a specified delegated budget . Host Provider Board remains accountable to HWE ICB for the specified delegated budget

2. Discharges function through HCP Board, re-constituted as host provider sub-committee with co-opted members from across local system

3. ICB Board membership of HCP Board ensures strategic 'join-up' and protects against Host Provider 'marking own homework'

4. Neighbourhoods to become the delivery arm of the HCP and will embed the HCP's clinical and care operating model at a local level whilst driving productivity and efficiency through transformational change that improves health and care provision for their local population, aligned to locally-determined priorities

The role and function of the HCP's Board and Committees is described in full in Appendix 1

The role of the HCP Executive is to support the HCP board by driving the strategic agenda and ensuring the delivery plan is implemented. They will achieve this by:

Standing items

1. Providing oversight and assurance to **transformational delivery** within the HCP across all partners, identifying opportunities for collaborative working

2. Providing **escalation to HCP Board** including:
   - Decisions for approval
   - Items for discussion

3. Ensuring alignment with the **ICB's development agenda** by:
   - Influencing the ICB's development
   - Sharing intelligence and peer support to other HCPs
   - Supporting the ICB to deliver its work plan in relation to HCP development

4. Provide oversight and quality assurance of the HCP's sub-committees of the board, taking action as required

Key deliverables

5. Providing **oversight and leading on design and delivery** of year 1 of our Integrated Delivery Plan

6. **Defining clear milestones and measurable outcomes** for year 2 of our Integrated Delivery Plan

7. Providing leadership in embedding the **HCP's Clinical and Care Operating Model** including:
   - Ensuring alignment with national and system-led work, including Care Closer to Home workstream
   - Ensuring HCP-wide and neighbourhood-level service transformation and development is consistent with the emerging operating model

8. Supporting **neighbourhood development** through:
   - Providing strategic direction and advice to neighbourhoods
   - Enabling shared learning between neighbourhoods
   - Providing oversight of neighbourhood-level operational delivery

HCP Executive
Role descriptions

Role	Job summary
HCP Exec Lead (WHTH, host provider)	• **Day-to-day executive lead** for the HCP, reporting to the HCP SRO on behalf of the HCP Exec • Working with the HCP exec to develop the team, shape the HCP's operating model and formulate our approach to delegation with the ICB • Accountability for operational delivery of HCP plans and agreed priority metrics • Ensuring acute provider alignment with the HCP's strategy and priorities
Place Director (ICB)	• **Leading on place-based commissioning** on behalf of the HCP executive team, ensuring alignment with the ICS priorities and strategic direction of the ICB • Representing the HCP within the ICB • Line management and development of ICB staff aligned to the HCP • Working with the HCP exec to shape the HCP's operating model and approach to delegation
Community Services Director (CLCH)	• **Leading on operational delivery** of HCP priorities on behalf of the HCP executive team • Informing the HCP's strategic direction from a community perspective • Ensuring community provider alignment with the HCP's strategy and priorities • Informing and guiding the care closer to home agenda • Informing the HCP's operating model and approach to delegation
Care Closer to Home Lead	• **Clinical strategic leadership for the HCP,** including as chair of the quality and performance HCP committee • Providing connection with the ICB, focusing on care closer to home • Managing the neighbourhood clinical leads

Role	Job summary
Neighbourhood Clinical Leads (x4)	• **Neighbourhood clinical leadership-** setting objectives and strategic direction • Working with the place and community services director to drive operational delivery of agreed HCP priorities within neighbourhood teams • Representing their neighbourhood within the HCP executive • Ensuring the HCP's strategy, priorities and workplan is informed by neighbourhood health and care needs • Reflecting HCP priorities within neighbourhood workplans • Clinical scrutiny of HCP strategic planning and decision-making
Acute Clinical Lead (WHTH)	• **Lead acute clinician for the Health & Care Partnership** • Working with CCTH lead and ICB AMD to provide clinical direction for the HCP • Management of 'neighbourhood consultants', acting as a point of escalation where necessary • Identifying opportunities for clinical transformation from an acute provider perspective • Clinical scrutiny of HCP strategic planning and decision-making
Deputy Chief Finance Officer (ICB)	• **Financial leadership within the HCP,** supporting ongoing development of the finance & commissioning committee • Identifying opportunities for productivity and efficiency improvements across the HCP • Ensuring consistency of financial information and promoting open book accounting • Informing the HCP's operating model and approach to delegation
Associate Medical Director (ICB)	• **Leading on developing our insights function** for the S&WH HCP, drawing on ICB-wide PHM teams and provider functions as required. • Providing connection with the ICB's medical directorate-sharing intelligence and offering advice from an ICB-wide perspective

There are several key functions required to successfully plan, commission and manage services delegated from the ICB to WHTH, as host provider, on behalf of the HCP

Establishing the HCP teams

The skills, capacity and capability to deliver these functions currently exists within the HCP and is distributed across the ICB and partner organisations. In order to effectively deliver these functions, the HCP will need to build teams around shared resources that can provide targeted support to both the HCP and the neighbourhoods. These teams will be built from the existing capacity and capability, drawing together expertise from across the HCP, aligned to our HCP vision of working as a *"'single team', responsible for planning, improving and delivering population-based health and care services for the people of SWH".*

Developing the HCP functions

Establishing the new HCP functions will require new ways of working, including bringing diverse teams together. In order to establish effective working it will be necessary to undertake a comprehensive organisational development programme which will develop a single team ethos, with a shared identity and common purpose. This organisational development programme will need to:

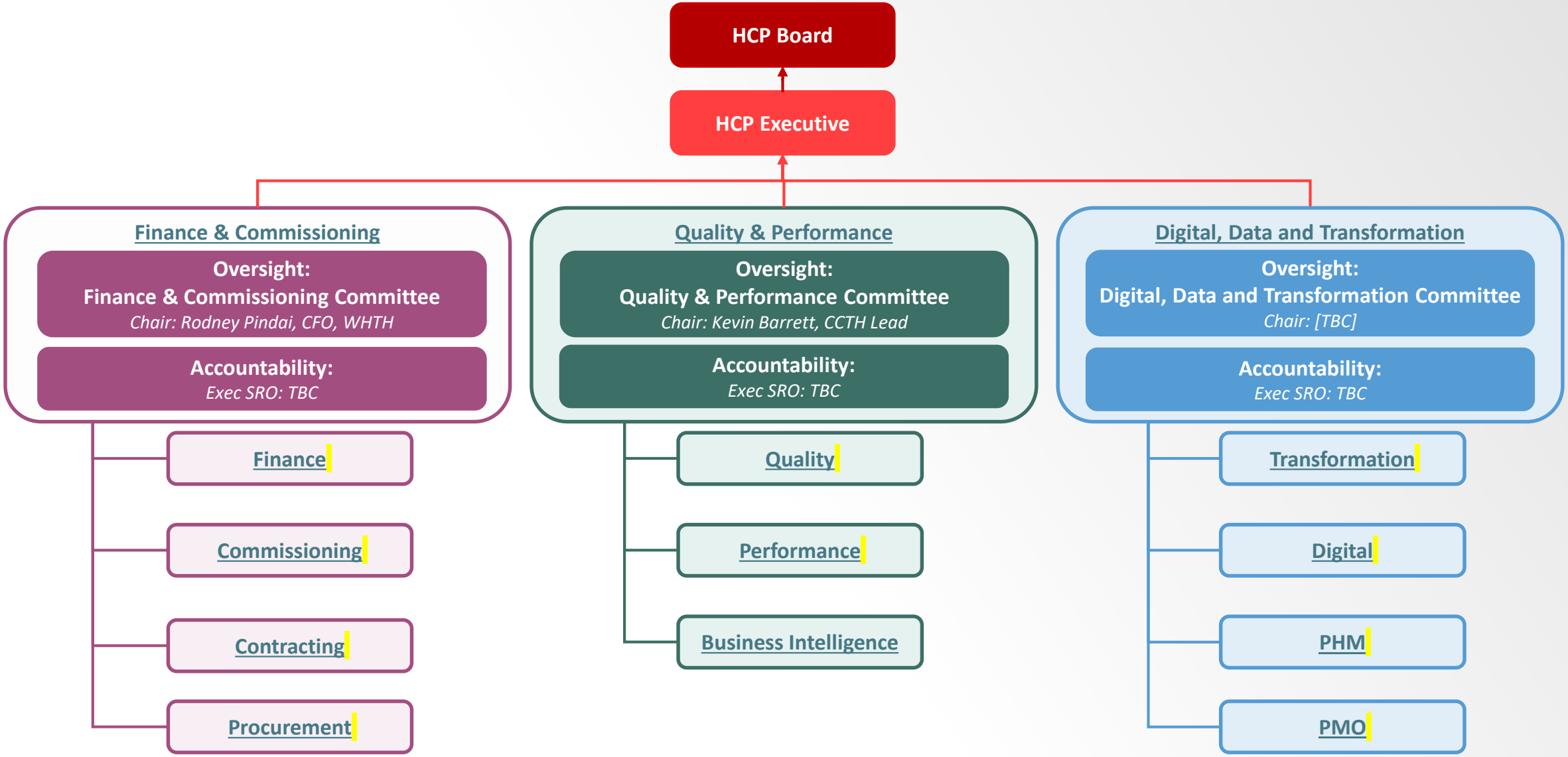
- Establish a common language
- Clearly define team structure and roles including leadership and reporting
- Promote shared learning and cross-functional working
- Establish effective communications and information sharing across the HCP
- Recognise and build on existing team strengths and individual capabilities

Leading the HCP functions

The HCP functions will be grouped to enable explicit alignment to the HCP's sub-committees which can provide clear accountability through the HCP exec to the HCP Board. Each group of services will be led by an SRO from the HCP exec who will provide leadership and strategic direction whilst, ensuring joined up working across the functions. Line management and pastoral care will be through the Place Director.

These HCP functions are set out on the following page

HCP Functions Overview



These HCP functions, including an example of key tasks and the required skills and capabilities are described in full in appendix 2

3. Neighbourhood operating model

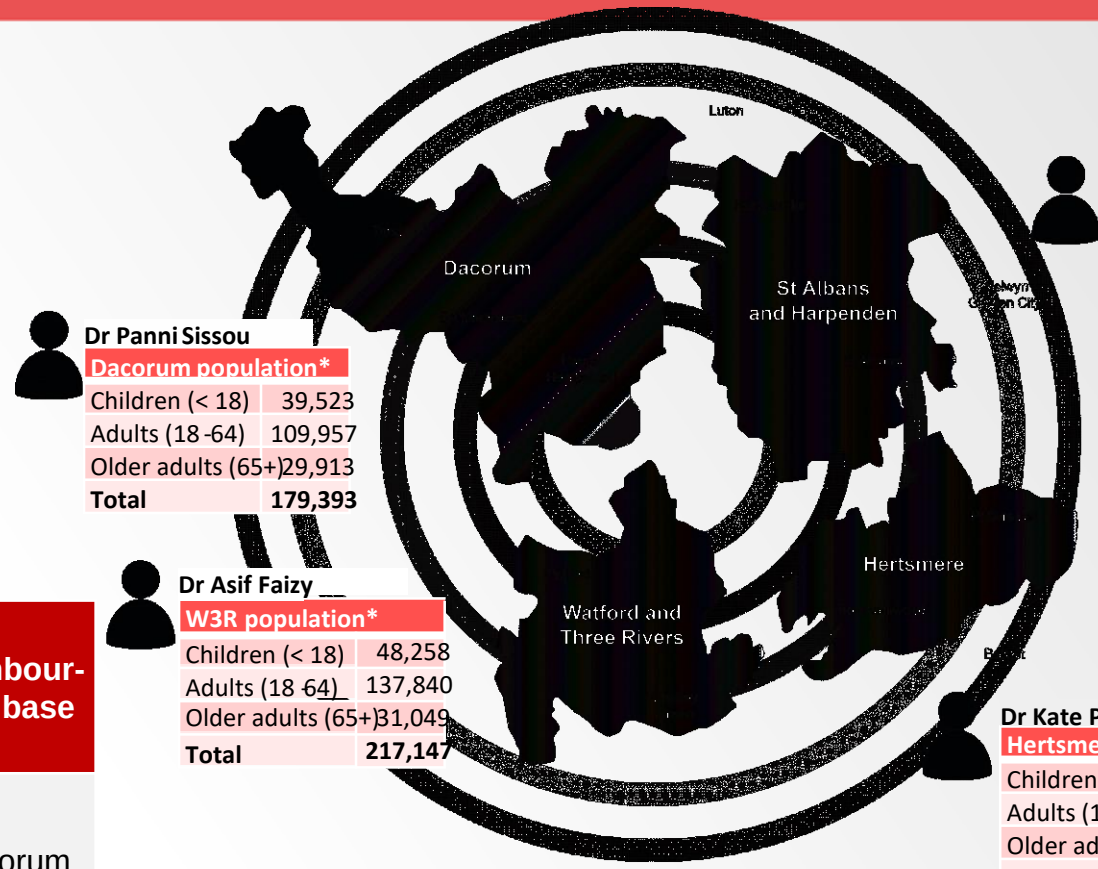
Our Neighbourhoods

SWH HCP has four neighbourhoods representing the **patients registered in the GP practices** residing in each neighbourhood

A list of GP practices in each neighbourhood is provided in appendix 3

Each locality is led by a clinical lead, supported by a leadership and management team.

Each locality will have a dedicated base where the core teams will be expected to co-locate



Dr Panni Sissou

Dacorum population*	
Children (< 18)	39,523
Adults (18 -64)	109,957
Older adults (65+)	29,913
Total	**179,393**

Dr Asif Faizy

W3R population*	
Children (< 18)	48,258
Adults (18 -64)	137,840
Older adults (65+)	31,049
Total	**217,147**

Dr Bethan Rees

St&H population*	
Children (< 18)	35,941
Adults (18 -64)	91,802
Older adults (65+)	23,582
Total	**151,325**

Dr Kate Page

Hertsmere population*	
Children (< 18)	20,169
Adults (18 - 64)	55,895
Older adults (65+)	16,386
Total	**92,450**

Neighbour-hood	Neighbourhood Clinical Lead	Integration Lead	Secondary Care Consultant	Community Service Director/ Manager	Neighbour-hood base
Dacorum	Dr Pani Sissou	Debbie Foster	Sarah Klinger	Leanne Fishwick Frankie Pepper	The Forum
St Albans & Harpenden	Dr Bethan Rees	Freya Powell	Mike Koa-Wing	John Harle Una McCann	Harpenden Memorial Hospital
Watford & Three Rivers	Dr Asif Faizy	Amanda Burfot	Deepan Vyas	Kevin Barrett Gill Jacobs	BRE
Hertsmere	Dr Kate Page Dr Liam Chapman *(deputy clinical*	Aimee Vanner	Chanpreet Arbi	Louise Ayres Chris MacKay	Hertsmere Borough

Ways of working

The 4 neighbourhoods in SWH are the engines for **operational delivery**. They will:

- **Embed the clinical and care operating model** at a local level, informed by the HCP-wide operating model
- Drive **productivity and efficiency** through transformational change that improves health and care provision for their local population, aligned to **locally-determined priorities**

Objectives

In delivering these core aims, neighbourhoods will enable partner organisations to work collaboratively and effectively to:

- Develop a **joint understanding** of local health and care needs and inequalities, as well as local services and capacity for delivery
- **Align delivery models** with locally identified health and care needs
- Understand **opportunities for improving** health and care provision that will reduce inequalities and drive productivity and efficiency
- Develop and delivering a **joint work plan** to respond to these
- Promote **active engagement** with staff and stakeholders
- Establish **multi-disciplinary team working** that crosses organisational boundaries
- **Embed and monitor delivery of models** of care determined by the clinical and care operating model

Approach

Neighbourhoods will develop a comprehensive workplan, which partners from across the neighbourhood will be jointly responsible for delivering. This workplan will describe a transformational journey to develop a service delivery model that is aligned to the HCP operating model and reflects local population health and care need including inequalities. In developing and implementing the roadmap the neighbourhood will:

- Review data provided by the ICB, councils and other partners that provide **insight to population health and care needs** and service delivery models
- **Define how the neighbourhood will deliver models of care** consistent with the HCP-wide clinical and care operating model
- Engender a **culture of collaboration and trust** by identifying opportunities for joint working and sharing of information
- Ensure these **models of care are adhered to**
- Identify opportunities for **productivity and efficiency improvements and transformation**, aligned to need and the ICB and HCP's strategic priorities
- **Establish working groups** to scope, plan and deliver INT initiatives
- Provide **oversight and assurance** on the delivery of INT initiatives

Leadership

The neighbourhood will be chaired by a Neighbourhood Clinical Lead

- The chair will be responsible for ensuring a multi-disciplinary approach that enables all partners to actively contribute
- The chair will be supported by a neighbourhood leadership team which will provide capacity and capability to design and structure the neighbourhood's work plan

Delivery of this work plan will require active engagement from partner organisations to deliver transformational change as required

Driving productivity and efficiency

The 4 neighbourhoods in SWH are the engines for **operational delivery**. They will:

- **Embed the clinical and care operating model** at a local level, informed by the HCP-wide operating model
- Drive **productivity and efficiency** through transformational change that improves health and care provision for their local populations, aligned to **locally-determined priorities**

INT and other transformation initiatives should demonstrate alignment to locally-determined priorities. They should also drive productivity and efficiency. In scoping and designing initiatives neighbourhoods should:

Scoping and designing

- Understand their local population and agree priorities, aligned to these population health and care needs
- Ensure a multi-disciplinary approach in scoping opportunities to enable all partners across the neighbourhood to actively contribute
- Agree critical success measures to track progress
- Develop a comprehensive programme plan to track progress in delivery
- Identify resource required to deliver change and seek commitment from partner organisations to commit resource as requires

All transformation initiatives should employ robust programme management to support delivery and progress reporting including:

Delivery

- Project documentation including a clear delivery plan with timelines for delivery, milestones, clearly defined accountabilities, anticipated outcomes and success measures
- Working groups that will focus on delivery, troubleshooting and escalating of issues
- Regular reporting on both delivery and outcomes, using an agreed highlight report with the HCP's governance structure as follows:

Oversight & assurance

- Seeking advice on scoping and delivery of initiatives from the HCP's ICAG and Co-production board, as applicable
- Providing regular updates on progress and delivery of the Neighbourhood Transformation Plan to the HCP's Quality and Performance Committee and HCP Board
- Approval from the Finance and Commissioning Committee on Initiatives that have a funding or resourcing implication

The neighbourhoods will measure progress through critical success measures and locally-agreed outcomes for initiatives, reported through highlight reports.

Data & insights

Examples of data and insights available to support neighbourhoods include:

- PHM data packs, broken down to PCN-level
- JSNAs
- Herts Insights for insights into local communities, population, wellbeing & health, economy, work & education, housing & transport and environment & sustainability at district council level

Neighbourhood Leadership Team

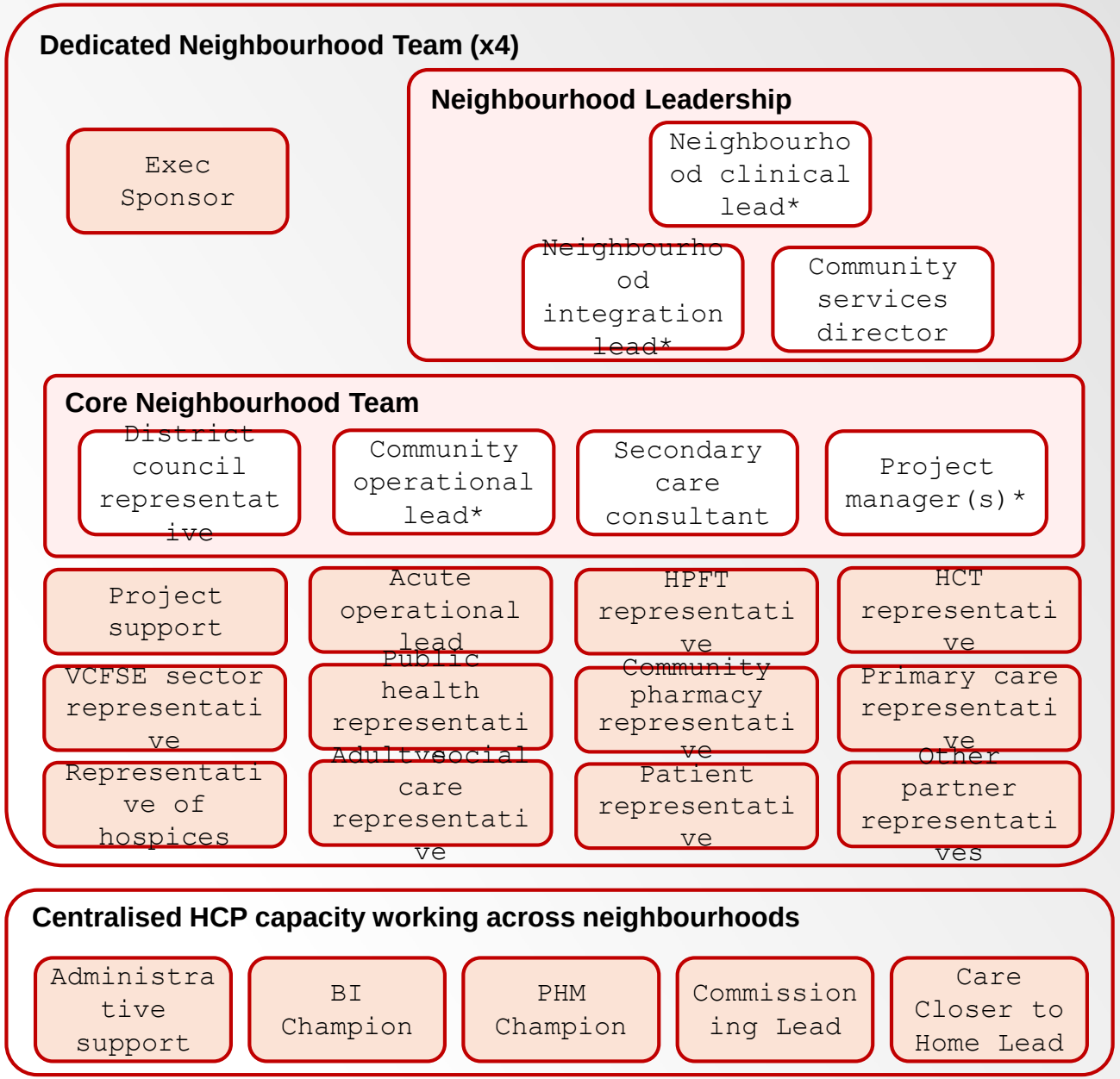
A successful neighbourhood will require a fully established leadership team that can:

- Provide **leadership** including a sense of common purpose, joint ownership and accountability for neighbourhood partners
- Drive **operational delivery** within the neighbourhood
- Set a **strategic direction** for the neighbourhood
- Enable to the neighbourhood to **understand its population**, including their health and wellbeing needs and how we currently serve our population, including through the provision of relevant information and analytical capability
- Support the neighbourhood in identifying **opportunities for productivity and efficiency improvements**
- Provide **structure and rigour** that can enable the neighbourhood to develop a coherent workplan that can be successfully delivered
- Enable appropriate **oversight and assurance** that gives confidence that the neighbourhood is delivering its workplan
- Ensure **alignment** with the HCP agenda and the ICB's priorities

The skills and capacity to deliver this cannot reside within a single person and therefore the neighbourhood chair will be supported by a core neighbourhood team, with additional, centralised resource.

The key roles within the neighbourhood team are described in appendix 4

**co-located as a neighbourhood leadership team at least 1 day per week*



4. HCP Workplan

Developing the HCP workplan

Theory of change

The HCP recognises that change takes place both through:

1. **Continuous improvement-** step-wise or gradual quality improvement focused on system-wide priorities with clearly aligned metrics and incentives, led at neighbourhood level
2. **Directed transformation-** significant change involving multiple system partners in targeted areas where significant opportunities for improvement have been identified. This transformation will require dedicated resource and will be led at place level

Developing the HCP's workplan

The HCP workplan describes the key areas of directed transformation which will be delivered at place level in 2025/26

- It is aligned to our system-wide priorities which are informed both by national planning guidance and the ICB's Medium Term Plan
- The HCP has finite capacity for transformation and therefore the workplan focuses on areas of high impact that require partnership working for planning and delivery
- It has been informed by the following priorities:
    - Data and insights-led
    - Centrally planned and implemented at neighbourhood where appropriate
    - Aligned to system-wide priorities and hardwired into partner organisations' priorities
    - Continual learning and improvement
    - Owned and led by the HCP executive, delivered through partners

Prioritisation process

Workstreams included within our HCP workplan have been prioritised based on the following criteria:

- **Impact/ Feasibility assessment**: Schemes will be included in the workplan only if they are high impact/ high feasibility
- **Alignment to national and local priorities**: Schemes selected must directly deliver national/ local success measures
- **Resource availability**: All schemes must have identified programme and delivery resource
- **Partnership working**: Schemes must require collaborative working across 2 or more partner organisations in both planning and delivery. The HCP will maintain a line of sight on schemes that are planned and delivered within a single organisation, without leading on delivery

Programmes of work

The HCP's workplan is grouped into programmes that explicitly align with to local and national priorities

An overview of the worsktreams aligned to each of the programmes, together with success measures for 2025/26 are set out on the following pages

HCP Programme	ICS Priority	Overview
Long Term Conditions	Addressing **inequalities/ Long Term Conditions**	Ensuring that the ICB-led long term conditions pathways are embedded at HCP level, including locally designing and implementing the integrated heart failure pathway and engaging with the ICB's plans for hypertension
Elective and planned care	**Elective care** recovery	Reducing inappropriate and avoidable referrals through addressing variation in advice and guidance, referral volumes and application of the ICB's pathways to support primary care decision making
Children and young people	Reduction in the backlog for **children's care**	Ensuring children are ready to transition to the next stage of their life with a focus on identifying and closing gaps in transition services (from children and young people to adult services) and reducing avoidable admissions by developing a nurse-led prevention of admissions pathway
Urgent and emergency care	Improve **urgent and emergency care** through more anticipatory and more same day emergency care	Improving access and flow through enhanced care coordination for same day care and establishing a transfer of care hub, expanding the virtual hospital
Frailty and end of life		Reducing avoidable ED attendances and NEL admissions through implementation of the ICB's 7 high impact interventions including a programme of advanced support for nursing and residential homes
Productivity and enablers		Ensuring the foundations are in place to embed our clinical and care operating model, including embedding our neighbourhood model, data, digital and workforce development and ensuring our oversight and governance remains fit-for-purpose as we take on delegated responsibility for commissioning

Better care for mental health crises will be lead and delivered by the MHLDN HCP and the HCP will support and ensure alignment with SWH programmes

Aligning the HCP programme of work with the MHLDN HCP

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

Examples of aligned work delivered through the MHLDN HCP include:

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

Long term conditions

The long term conditions programme will be led by Sam Williamson (SRO) and Shan Haydar and Debbie Foster (senior manager)

Our long term conditions programme will support the HCP to achieve the MTP success measures of:

- Increasing hypertension QOF measures by 2% against the baseline
- Increasing age standardised prevalence of hypertension
- Increasing the percentage of patients with GP recorded hypertension whose last blood pressure was in target

Workstream	Description	Success measures
Integrated heart failure	• Implementation of an integrated heart failure service model of that will integrate specialist management of heart failure across providers and by disease stage, to improve clinical outcomes and quality of life for people with heart failure. • The initial areas of review include triage, diagnosis of heart failure, MDT working, cardiac rehab and reviewing opportunities for reducing duplication across acute and community caseloads	• Reduction in waiting times for patients referred to HF service • Reduce number of non-elective admissions for people with HF • Reduce number of bed days utilised by patients with a primary diagnosis of HF • Reduce rate of emergency admission for heart failure
Hypertension	• Continued engagement with the ICB-wide hypertension plans, including: • Increased diagnosis in primary care settings, including general practice, community pharmacy and dental and optometry pilot sites • Identifying hypertension champions across acute and community providers • Delivery of hypertension initiatives in acute and community providers to 'Make Every Contact Count' • Enable information sharing from acute and community providers with general practice	• Increase the hypertension prevalence in SWH

Elective and planned care programme

The elective and planned care programme will be led by Tom Galliford (SRO) and Fran Gertler (senior manager)

Our elective and planned care programme will support the HCP to achieve the MTP success measures of:

- No patients waiting more than 52 weeks for treatment
- Increasing the number of patients waiting less than 6 weeks for diagnostics to 95%

Workstream	Description	Success measures
GP Knowledge and Skills	• Review anonymised advice and guidance queries to identify common learning themes or recurring issues in 3 high volume specialties • Identify actionable education opportunities, which can be shared via GP bulletins and webinars	*TBC*
Effective use of data and feedback	• Prepare data-driven advice and guidance utilisation reports, to include sharing dashboards for each practice showing data such as: • Number of A&G requests sent • Response times • Outcomes (e.g., avoided referrals, subsequent outpatient referrals) (maybe) • Common specialities accessed • Identify an advice and guidance champion and a lead GP for each PCB to review data, share feedback and champion best practice in advice and guidance	*TBC*
Standardised referral process	• Develop a referral proforma for high volume specialities to help guide referrals and to signpost to FAQs (to be tested initially in urology) • Reduce variation in consultant responses to advice and guidance requests, e.g. using GIRFT advice and guidance specialities	*TBC*

Children and young people programme

The children and young people's programme will be led by Ros Nerio (SRO) and Naomi Mason (senior manager)

Our children and young people's programme will support the HCP to achieve the MTP success measures of:

- No community paediatric waits greater than 65 weeks
- Reduce emergency admission rates for children and young people by 5%
- Reduce A&E attendances for children and young people by 5%

Workstream	Description	Success measures
Children's Virtual Hospital: Prevention of admissions	• Phase one of children's virtual hospital will commence with a prevention of admissions pathway: • Fully scope a prevention of admission pathway, which will provide a nurse-led prevention of admissions pathway to divert children at the ED/ UTC front door • Service to be led by ACPs and will link into children's community nursing teams, aligning to the early support discharge pathway • The pathway will explore care coordination for SEND and will be aligned to the care coordination workstream within the UEC programme	*Recognised as an HCP priority; however on hold due to resource constraints*
Readiness for next stage in life	• Undertake comprehensive audit of current pathways for transitioning from children's to adult services to identify gaps in service provision/ areas of good practice • Scope opportunity for closing gaps in service provision and develop proposal for commissioning new services	*Recognised as an HCP priority; however on hold due to resource constraints*

Urgent and emergency care programme

The urgent and emergency care programme will be led Leanne Fishwick (SRO) and Ed Davis (senior manager)

Our urgent and emergency care programme will support the HCP to achieve the MTP success measures of:

- Decreasing rate of emergency admissions for falls in the community of people aged 65+ by 5%
- Reducing non elective admissions for people living with frailty by 25%
- Reducing percentage of deaths with 3+ emergency admissions in the last 90 days of life by 5%

It is split into the following workstreams:

Workstream	Description	Success measures
Care coordination	• Creation of a single point of care coordination for clinicians where patients require timely and seamless access to urgent same day supported decision making • Work during 2025/26 will include: • Mapping the current service • Review of best practice • Establishing a clinical design and operational design group • Designing the future model • Model testing and mobilisation • Implementation	• Reduction of ED attendances • Improved clinician experience
Transfer of care hub	• Development of a transfer of care hub for SWH to facilitate efficient discharge from WHTH	• Reduce NMCTR from 74 to 50 per day (1500 per month based on a 30 day month) • 95% of all discharges to home (either P0 or P1)
UCR resource mapping	• Focus on additional UCR resource required to deliver the contribution to the 25% reduction in non-elective activity	• Clear understanding of the maximum capacity of UCR and additional resource required to support increased access to stack
Virtual hospital	• Expansion of Frailty H@H	*Recognised as an HCP priority; however on hold due to resource constraints*
Improving same day urgent care	• To include output form system wide UTC review. A review of all urgent on day activity and modelling how this can be delivered across neighbourhoods	• Clear strategy for delivering urgent same day care for 2026/27

Frailty and end of life programme

The frailty and end of life programme will be led by Kevin Barrett (SRO) and Pamela Shepherd (senior manager)

Our frailty and end of life programme will support the HCP to achieve the MTP success measures of:

- Decreasing rate of emergency admissions for falls in the community of people aged 65+ by 5%
- Reducing non elective admissions for people living with frailty by 25%
- Reducing percentage of deaths with 3+ emergency admissions in the last 90 days of life by 5%

It is split into the following workstreams:

Workstream	Description	Success measures
Falls prevention	• Implementation of falls risk assessment across general practice (ECF) • Implementation of falls prevention pathways, including: ○ Referral of high risk falls to falls clinic ○ Reviewing management of IV fluids in the community for falls patients ○ System-wide education of pathways	• Increase in proportion of people with moderate/ severe frailty who have had a FRAT score completed • Reduction in non-elective admissions for a fall
Falls response	• Review and development of SWH falls pathway, including gap analysis and joining up care to closer to home • Review falls response scheme (EIV and HAARC cars)	• Count of community 2 hour responses for a fall • Reduction in number of people with a community fall receiving a 2 hour response that are conveyed to hospital • Reduction in % of community 2 hour responses conveyed to hospital • Reduction in non-elective admissions for a fall
Advance Care Plans	• Roll out of ReSPECT and implementation plan for digital ACPs • Review of format for GSF meeting • Active engagement with the ICB's Culture Change Programme to embed new ways of working • Education and training programme	• Increase in the proportion of people who have an ACP completed or reviewed last 12 months: ○ On the EoL register ○ With moderate/ severe frailty
Access to stack	• Ensuring that patients pulled from the stack have access to frailty-specific interventions • Ensuring alignment with the HCP's UEC programme	• Increase the average number of people pulled from the stack each day • Increase the average number of people accepted by UCR • Increase the average number of people completed by UCR

Frailty and end of life programme *(continued)*

Workstream	Description	Success measures
Senior review in ED	• Improvement including a range of initiatives such as: ○ Implementation of senior review at the front door ○ Accuracy of CFS scoring ○ Workforce development of junior doctors, ACPs and nurses, consultant recruitment, educational programme	• Increase in proportion of people who have had a CFS completed during an ED attendance • Increase in proportion of people aged 65+ with a CGS score of 4+ who are admitted as an emergency
Polypharmacy / medicines optimisation	• Including polypharmacy reviews, safe prescribing and reducing the anticholinergic burden • Developing and implementing SWH's Medicines Optimisation Plan and reviewing progress through the Medicines Optimisation Transformation Group • Training and education to support appropriate deprescribing	• Increase in proportion of people who have had a medication review completed: ○ On 8+ medications ○ Living in a care/ residential home ○ With severe frailty • Reduction in proportion of patients with moderate/ severe frailty who are prescribed 10+ repeat medications
INT	• Neighbourhood-led transformation initiatives to proactively manage high risk, frail patients through MDTs • This will include a holistic assessment of patient needs (including falls risk assessment) • Proactive care model (piloted first in Dacorum) will test an alternative funding model as a proof of concept for a proactive, data driven, person-centred care model for "high risk" older people with frailty	• Count of people identified through GP IT searches • Count of people added to the INT proactive care caseload • Reduction in proportion of people with moderate/ severe frailty: ○ Admitted to hospital (NEL) ○ Attending ED
Nursing and residential home advanced support offer	• An oversight group that will make tactical and operational plans to support care home residents to be treated in their normal place of residence and therefore avoid an ED attendance/admission • Support includes targeted application of all of the "7 high impact interventions" and additional support such as lifting devices and a virtual hospital training package	• Reduction in ED attendances for people living in nursing and residential home by: ○ 10% in months 1-6 (equivalent of 1 per day) ○ 20 % in months 7-12 (equivalent of 2 per day)

We will consider further success measures to determine whether each workstream is having the intended impact such as increasing the proportion of ACPs that are shared and used

Productivity and enablers programme

The enablers programme will be led by Toby Hyde (SRO) and Ros Nerio (senior manager)

Our enablers programme is split into the following workstreams

Workstream	Description	Success measures
Neighbourhood development	• Developing and embedding a fully resourced neighbourhood operating model, as described in section 3 • Develop and apply consistent approaches to using data and insights to understand population health and care needs at a neighbourhood level • Support neighbourhoods to identify, prioritise and deliver transformation priorities, aligned to their population's health and care needs • Neighbourhoods to develop a comprehensive neighbourhood plan • Map services delivered at neighbourhood level and develop consistent approaches to reviewing local neighbourhood delivery models	• Maturing neighbourhood health service models • Neighbourhood transformation initiatives explicitly aligned to population health and care need
Transformation methodology	• Articulate an HCP 'Theory of Change', which will set out the HCP's approaches to decision-making, prioritisation, measuring impact and evaluation of change • Agree a consistent QI methodology to be used across HCP transformation initiatives • Map optimal level for planning and implementing change (ICB, HCP, neighbourhood) and ensure all transformation work is planned and designed at the optimal level • Review transformation and programme management capacity and capability across the HCP and align to existing and planned transformation initiatives • Undertake HCP-wide training to embed theory of changes and QI methodology	• Established approach to change and transformation that addresses our immediate priorities and ensures sustainability
Data and digital transformation	• Establish a digital transformation group within the HCP board • Support GP sign up to the data sharing agreement • Agree key metrics for measuring progress, including common definitions and baselines for measuring progress • Establish regular reporting at neighbourhood and HCP level which reflects the above metrics and progress towards delivery	• Data platforms and performance reporting enable effective information sharing, transparency of performance and data-driven decision making

Productivity and enablers programme *(continued)*

Our enablers programme is split into the following workstreams

Workstream	Description	Success measures
Workforce development	• Establish partnership wide professional forums for different staffing groups (e.g. nurses, AHPs) to share learning and experience and build relationships • Identify opportunities for shared training and development, and where applicable offer training on an HCP-wide basis • Develop an HCP-wide organisational development which builds a shared common purpose and develops consistent behaviours and ways of working • Identify opportunities for rotational posts, commencing with virtual hospital and care coordination	• Empowered workforce enabled to frictionlessly work across the HCP partnership
Maturing commissioning function	• Agree HCP staffing model (staff required to undertake delegated functions) • Transfer of staff to HCP for delivering HCP's commissioning responsibilities • Develop proposals for delegation in 2026/27 and refine delegation framework • Develop proposals for outcome-based contracting	• Effective management of delegated budgets • Joint ownership of system-wide financial performance
Establishing effective governance and oversight	• Review current governance arrangements to ensure fitness-for-purpose (role of finance & commissioning committee and quality & performance committee and ability to effectively discharge this role) • Align performance reporting to national and local priorities • Document the HCP's approach to quality and risk assurance and ensure alignment of resource to deliver function	• Reduction in variation in access, experience and outcomes • System-wide visibility of performance • Strong focus on quality and safety, led through the HCP's quality and performance committee

5. Delegation next steps

Success measures for delegation in 2025/26

The ICB and WHTH, as host provider on behalf of SWH HCP, have approved a Delegation Framework which sets out the principles of delegation.

The ICB has agreed with SWH HCP to delegate 7 contracts for adult community services in 2025/26. The following success measures have been identified for enacting these principles, as set out in the Delegation Framework in 2025/26

Accountability	• The HCP board is formally reconstituted as committee of WHTH's board (without impacting on partnership ethos and membership) • HCP board to take on formal responsibility for managing the budgets for adult community contracts included in phase one of delegation from 1st April
Governance and oversight	• Governance and oversight for commissioned services delegated from WHTH as host provider to the HCP and enacted through the HCP's F&C and Q&P committees
Financial control and risk sharing	• Robust contract management process to manage place-based contracts embedded within the HCP- this will include appropriate risk-sharing between the ICB and WHTH as the host provider
Contracting	• Affected sub-contractors notified that the contracting responsibility will shift to the host provider
Workforce	• Clear understanding of skills and capacity required to deliver delegated functions, and workforce accordingly aligned

As the HCP prepares for further delegation in 2026/27 it will need to review its current delegation arrangements and enact further changes to ensure that delegation arrangements are fit-for-purpose

Next steps for implementing delegation
Accountability, governance and oversight

- Whilst responsibility will be delegated to WHTH, as host provider, this will be enacted through the HCP's Board in order to maintain the current models of partnership working and collaborative decision. To achieve this the HCP Board will:
  - Be reconstituted as a committee of WHTH's Board
  - Retain ICB, local government and VCFSE representation
  - Include NED representation, from both the ICB and WHTH
- The ICB will provide independent oversight, holding responsibility for monitoring performance of WHTH and partners across the HCP

- As part of the review and refresh of current governance arrangements during 2025/26 consideration will be given to:

1. **Reporting:**
   - Aligning performance reporting to local and national priorities
   - Streamlining and consolidating reporting
   - Enabling real-time reporting performance reporting on an HCP-wide basis
   - Agree reporting requirements from the HCP to the ICB, and the HCP to WHTH board

2. **Oversight:**
   - Review current quality oversight and risk management processes to ensure proportionality and sufficient grip and oversight of delegated services
   - In anticipation of delegation of acute services develop processes for the HCP, in conjunction with the ICB to hold WHTH to account as a provider of acute services

Next steps for implementing delegation
Contracting, financial control and risk sharing

- Whilst WHTH will be formally responsible for managing the budgets for adult community contracts included in phase one of delegation, day-to-management will be delegated to the HCP
- The HCP will also be responsible for ensuring that robust contract management process are in place
- The ICB and host provider will also need to determine appropriate risk-sharing arrangements, which will determine how under/overperformance for delegated contracts is managed

- In establishing appropriate arrangements for financial control and risk sharing the HCP will:

1. **Contracting and contract management:**
    - Review existing contract management processes, which are currently undertaken by the ICB, to ensure they are proportionate and provide appropriate assurance. This will include identifying opportunities for streamlining meetings and avoiding duplication
    - Develop an HCP-model for commissioning for the future including:
        - Reviewing options for alternate contracting models that would enable outcomes-based commissioning
        - Developing proposals for performance incentives aligned to HCP-wide outcomes
        - Reviewing payment mechanisms and approaches to risk-sharing

2. **Budgetary responsibility:**
    - Clearly define financial accountability structures through an HCP position statement and a review of the delegated limits and the F&C Committee's terms of reference
    - Develop robust financial forecasts
    - Agree principles for managing overspend and taking corrective action across the HCP

3. **Risk sharing agreements:**
    - Jointly agree with the ICB any retained risks
    - Specify thresholds whereby the ICB may take action for financial performance

Next steps for implementing delegation
Workforce development

- The benefits of the host provider model will be most effectively realised with clearly defined teams built around shared resources that can provide targeted support in response to HCP and neighbourhood needs
- Skills and capability for both the commissioning and delivery functions include: business intelligence, population health management, contracting and procurement, finance and quality improvement
- These skills currently exist across the HCP, and much of the commissioning capacity and capability resides within the ICB's place-based team; however in order to fully realise the potential of a host provider model these skills will need to be embedded within the host provider so it is expected that in time (but not necessarily in 2025/26) these staff will be transitioned into WHTH, as host provider
- In order to ensure that the HCP has access to the necessary skills and capabilities in order to deliver it delegated functions the following steps will be required:

1. **Capacity and capability audit:**
    - Determine skills and capabilities required to deliver delegated functions
    - Identify all roles within the scope of delegated functions
    - Undertake capacity and capability gap analysis

2. **Organisational development:**
    - Identify any gaps in capabilities or technical skills
    - Develop a comprehensive OD programme that reflects technical skills development, culture, leadership development change management
    - Identify opportunities for shared learning, mentoring and shadowing to promote system-wide learning and understanding
    - Deliver OD to all affected staff

3. **Staff transfer:**
    - Undertake options appraisal for preferred staffing models for delivering delegated functions
    - Consult with affected staff

Appendices

Appendix 1: HCP Board

The HCP Board is constituted as a sub-committee of the WHTH, as the host provider. It is responsible for transacting the HCP's core business and leading strategic thinking on behalf of the HCP. In doing this the HCP Board will:

- Take responsibility for **commissioning and oversight** of delegated services
- Provide guidance to the HCP to **enable the transformation** of health and care delivery
- Promote **understanding and alignment** of individual organisation strategies and plans.
- Drive whole-system **planning and prioritisation**
- Lead the **resolution** of strategic challenges, issues and risks between partners
- Provide appropriate **escalation** to WHTH's Board

HCP Core Business

In providing assurance of the HCP's core business; the Board will:

- Take accountability for the development and delivery of the HCP's **financial plan**, within its delegated budgets
- Scrutinise and approve rec**ommendations proposed by the HCP's sub-committees** and transformation workstreams
- Assure and drive the **performance and delivery of neighbourhood models**

In doing this the Board will receive and discuss the following business items:

Standing core business items

- Place Director's report (bi-monthly)
- Neighbourhood updates (bi-monthly)
- Finance and Commissioning Committee updates (monthly)
- Quality and Performance Committee updates (monthly)
- Data, Digital and Transformation Committee updates (monthly)

Ad hoc core business items

- Investment and spending decisions
- HCP delivery plan
- Recommendations and actions arising from the HCP's sub-committees

HCP Strategy

In providing strategic leadership, the Board will:

- Participate in **development of strategy** across the ICS
- Take joint accountability for development and implementation of plans to **transform the delivery of health and care** in SWH
- Drive **whole-system planning and prioritisation**
- Lead the **resolution of strategic challenges**, issues and risks between partners

The Board will achieve this by:

- Providing **constructive challenge** to the HCP's operational delivery and transformation agenda
- Ensuring that the HCP **considers the broader context** of national and ICB priorities and best practice
- **Bring together activity, finance, operations and quality intelligence** from NHS providers
- **Maintaining oversight, understanding and alignment** of individual organisation strategies and plans

South and West Herts Health and Care Partnership

Appendix 1: Sub-committees of the board

The HCP has established a Finance & Commissioning Committee and a Quality & Performance Committee. It will also establish a Digital, Data and Transformation Committee in 2025/26. These committees are sub-committees of the HCP Board and their role is to:

- Provide **oversight** of services delivered on behalf of the population of SWH
- Provide appropriate levels of **scrutiny on key issues** and areas of concern by undertaking deep dives
- Make **recommendations** to the HCP Board, including recommendations relating to service developments, transformation and commissioning decisions for delegated services

Finance and Commissioning Committee

The committee has been established to provide **financial oversight**, **strategic guidance**, and **facilitate decision-making** related to investment and spending within the delegated budgets of the Place-Based Partnership.

The committee is authorised by the HCP board to:

- Oversee **procurement and contracting processes** within the HCP's delegated limits
- Consider **commissioning and investment proposals**
- Oversee and approve the **HCP's financial strategies, plans and budgets**
- Ensure **delegated budgets are utilised efficiently** and effectively to support the HCP in delivering its strategic objectives and priorities
- Identify opportunities for **operational efficiencies** and **transformational improvements**
- Inform the HCP's **prioritisation of transformation initiatives** based on value for money
- Provide a **forum for discussion and decision-making** on matters of financial allocations, investments and expenditures within the delegated budgets
- Provide **assurance and oversight** to the ICB Strategic Finance and Commissioning Committee and the HCP Board
- **Monitor financial performance** against approved budgets

Quality and Performance Committee

The committee has been established to provide **effective oversight** of quality and performance, **drive continuous improvement** and foster a **culture of accountability and collaboration** such that the HCP delivers safe, high quality health and care services on behalf of the population it serves.

The committee is authorised by the HCP board to:

- **Understand quality and performance** issues at HCP level. This includes setting objectives and priorities needed to improve the quality of care for local people, devolved down to providers as appropriate.
- **Gain timely insight into quality and performance** concerns/issues that need to be addressed, responded to and escalated.
- **Provide positive assurance** that risks and issues have been effectively addressed.
- **Give the HCP Board confidence** about maintaining and continually improving both the equity, delivery and quality of their services whilst reducing health inequalities.

Digital, Data and Transformation Committee

The committee will be established to provide **oversight** of transformation, including embedding **digital transformation** within the HCP's core business and transformation agenda and ensuring that **population health management** informs HCP strategy, planning and delivery.

The committee is authorised by the HCP board to:

- Ensuring a **coherent transformation plan** that is aligned to the HCP's strategy and system-wide priorities
- **Monitor progress** in delivering transformation programme and achieving measurable improvements
- Developing a **population health management framework** which sets out how the HCP will use PHM to understand its population, identify health and care priorities, target interventions to reduce inequalities and measure impact
- Set a **digital roadmap** that ensures interoperability and data sharing
- Oversee the **development of digital tools** within the HCP
- Ensure robust **data governance** within the HCP

Appendix 1: Advisory committees of the board

The HCP has established an Integrated Clinical and Care Advisory Committee (ICAG) and a Co-production Board. These are the committee's advisory committees which are established to:

- Provide clinical and care **advice and insights** to all relevant committees and will lead on transformation
- Ensures that co-production is at the heart of how the HCP works and **embeds the community, patient and public voice** within the HCP

ICAG

The committee has been established to provide **clinical and care practitioner leadership** to the HCP, **driving the strategy** and ensuring that resources are utilised to best effect to achieve **improved outcomes** for the South and West Herts population.

The committee is authorised by the HCP board to:

- Provide **clinical and care professional leadership** to the HCP
- Drive and monitor **improvements in health outcomes**
- Provide clinical and care **oversight and endorsement** of the transformation of key pathways, and to ensure agreed pathways are safely implemented
- Recommend **appropriate integrated clinical governance** structures to ensure the effective operation of integrated services and the wider HCP
- Feedback and galvanise **support from clinicians and care professionals** across all partner organisations for the implementation of agreed pathways
- Highlight and **propose mitigations** for any clinical and care risks of implementing agreed pathways
- Advise **solutions to barriers and obstacles** to implementation that have been escalated to ICAG
- Ensure **coherence and consistency** across transformation programmes
- Ensure national and ICS priorities are considered in clinical models and pathways
- Make the **appropriate links** with other local and regional clinical groups.

Co-production board

The HCP has made a commitment to adopting co-production as its default approach and the committee has been established to **oversee** and **provide guidance** on how best to use co-production as well as other forms of involvement and engagement.

The committee is authorised by the HCP board to:

- Oversee the **HCP's approach to engagement** work
- Provide **advice and support** to partners within the HCP in undertaking engagement activity and coproduction, including signposting and advice on appropriate routes for engagement
- Ensure that the **patient and public voice is built into** the HCP's work
- Ensure that transformation initiatives undertaken on behalf of the HCP, or its partner organisations, develop **sound approaches to public engagement** and seek appropriate coproduction support
- **Make recommendations** about what work of the SWHHCP could be coproduced and how
- **Provide assurance** to the HCP Board that the coproduction or engagement activity matches the agreed principles and good practice

Appendix 2: HCP Functions
Finance and Commissioning

Function	Description	Examples of tasks	Skills and capabilities
Finance	• Managing the financial resources allocated to the HCP to ensure the effective and efficient use of funding • Overseeing financial planning and budgeting • Monitoring expenditure across health and care services • Ensuring financial sustainability and compliance with regulatory requirements • Supporting decision-making on funding, considering efficiency and equity	• Setting and managing budgets • Financial reporting and assurance • Undertaking financial risk management and mitigation planning • Identify and managing efficiency savings	• Financial planning and management • NHS finance and accounting knowledge • Data analysis and reporting • Financial modelling and risk assessment • Stakeholder engagement and negotiation
Commissioning	• Planning and designing health and care services based on population health and care needs • Ensuring service provision aligns with national and local priorities, quality standards, and patient outcomes • Working with partners across the HCP to co-design service models	• Undertaking needs assessments and population health analysis • Care model design and pathway development • Developing service specifications • Performance monitoring and assuring commissioned services	• Strategic planning and needs assessment • Stakeholder engagement and co-production • Performance monitoring and contract management • Policy and regulatory understanding • Impact assessment
Contracting	• Negotiating, managing and overseeing contracts • Ensuring that contracts deliver value for money, meet service quality requirements and align with local priorities • Monitoring contract performance, including addressing underperformance	• Developing and negotiating contracts and agreements • Undertaking performance reviews and compliance checks • Contract negotiation and dispute resolution	• Contract law and procurement knowledge • Negotiation and conflict resolution • Relationship management and partnership working • Performance monitoring and risk mitigation

Appendix 2: HCP Functions
Quality and Performance

Function	Description	Examples of tasks	Skills and capabilities
Quality	• Ensuring that all commissioned services meet clinical, patient safety and care quality standards • Working with provider partners to maintain and improve service quality • Embedding a culture of continuous improvement and patient safety • Responding to quality concerns, serious incidents and patient feedback	• Quality reporting and assurance • Managing serious incidents and investigations • Implementing national and local quality improvement initiatives • Embedding a quality improvement methodology	• Clinical governance and quality assurance • Incident investigation • Risk management • Quality improvement • Data interpretation
Performance	• Monitoring and reporting on statutory performance metrics and locally agreed KPIs • Identifying areas of underperformance • Undertaking root cause analysis to understand the drivers and working with provider partners to support improvement • Supporting transformation and efficiency with through evidence-based decision-making	• Performance reporting • Benchmarking against national performance indicators and local priorities • Escalation and intervention in areas of poor performance	• NHS performance management and reporting • Data analysis and benchmarking • Change management and service improvement • Collaborative problem solving
Business Intelligence	• Providing analytical insights to support system-wide decision making • Developing and maintaining data dashboards, reporting and developing forecasting models • Liaising with system partners to identify data sources and supporting integration across multiple health and care datasets • Ensuring data quality	• Data collection, validation and integration • Predictive analytics and demand forecasting • Reporting on outcomes and service performance, including inequalities • Reporting and insights on transformation initiatives	• Data analysis and interpretation • Business intelligence tools • Statistical modelling and forecasting • Health informatics • Data governance

Appendix 2: HCP Functions
Data, Digital and Transformation

Function	Description	Examples of tasks	Skills and capabilities
Transformation	• Identifying opportunities for driving productivity and efficiency and improving clinical and patient outcomes • Designing and implementing service transformations and pathway improvements • Developing integrated service models across system partners • Embedding best practice, quality improvement and evidence-based care	• Redesigning care pathways/ models of care • Implementing national transformation initiatives • Embedding system-wide transformation initiatives within the HCP (e.g. CCTH)	• Service redesign and change management • Programme planning, delivery and evaluation • Clinical engagement • Stakeholder management and coproduction • Population health and expertise in health inequalities
Digital	• Leading digital transformation and technology-enabled care • Driving innovation in digital health solutions • Promoting interoperability and data sharing • Ensuring compliance and NHS digital standards and data governance requirements	• Developing a digital roadmap to comprehensive interoperability and data integration • Integrating digital solutions into transformation opportunities`	• Digital strategy and transformation • Health informatics and systems development • Data governance and cybersecurity • Project management and user adoption strategies
PHM	• Identifying health inequalities and using data to target transformation opportunities and resource planning • Supporting prevention and early intervention strategies • Identifying the wider determinants of health and opportunities to address these • Embedding PHM within commissioning, transformation and broader service planning • Addressing inequalities through data-	• PHM analytics and population segmentation • Targeting interventions for high risk populations • Supporting the development of integrated care models	• Public health analysis • Health inequalities and social determinants of health • Data driven decision making • Partnership working and community engagement

Appendix 3: List of GP practices per neighbourhood

Neighbourhood	PCN	GP Practice
Dacorum	Alliance	• Hatfield Road Surgery • Grove Hill Medical Centre • Woodhall Farm Medical Centre • Verulam Medical Group (Colney) • Consulting Rooms
	Alpha	• Rothschild House Surgery • The Manor Street Surgery • Gossoms End Surgery
	Beta	• Fernville Surgery • Parkwood Surgery • Everest House Surgery
	Delta	• Lincoln House Surgery • Haverfield Surgery • Kings Langley Surgery • Bennetts End Surgery • Archway Surgery
Hertsmere	Potters Bar	• Parkfield Medical Centre • Highview Medical Centre • Annandale House
	Herts Five	• Fairbrook Medical centre • Schopwick Surgery • The Red House • The Grove Medical Centre • Little Bushey Surgery
St Albans and Harpenden	Alban Healthcare	• Midway Surgery • Grange Street Surgery • Parkbury House Surgery
	Harpenden Health	• Village Surgery • Elms Medical Practice • Davenport House Surgery
	HaLo	• Lodge Surgery • Harvey Group Practice
Watford and Three Rivers	Attenborough	• Attenborough Surgery
	Central Watford	• Suthergrey House Medical Centre • Watford Health Centre • The Elms Surgery
	MVPS	• Manor View Practice • South Oxhey Surgery
	North Watford	• Vine House Health Centre • Sheepcot Medical Centre • Abbotswood Medical Centre
	Rickmansworth and Chorleywood	• Chorleywood Health Centre • Gade Surgery • The Colne Practice
	The Grand Union	• Garston Medical Centre • New Road Surgery
	Bridgewater	• Bridgewater House Surgery

Appendix 4: Neighbourhood Leadership Team Roles

Neighbourhood leadership team

Role	Function	Job summary
Neighbourhood Clinical Lead	• Chair • Setting the strategic direction and forward plan for the neighbourhood • Providing oversight and assurance on operational delivery • Leading productivity and efficiency improvement work	• Agreeing neighbourhood meeting agendas and ensuring matters discussed meet the neighbourhood's objectives • Setting objectives and strategic priorities for the neighbourhood • Representing the neighbourhood at HCP board, including presenting neighbourhood updates • Promoting effective working across the neighbourhood and ensuring all partner organisations have the opportunity to actively contribute to strategy development and delivery within the neighbourhood • Providing effective oversight of operational performance and agreeing action where applicable • Providing leadership to INT initiatives and strategic transformation
Neighbourhood Integration Lead	• Supporting neighbourhood development and maturation • Steering the strategic direction and aligning with HCP strategy • Developing the neighbourhood's workplan • Promoting alignment with the HCP and providing connection into the ICB • Brokering relationships between partner organisations and promoting collaboration • Coordinating multi-disciplinary working	• Supporting the neighbourhood to determine its priorities and identifying opportunities for productivity and efficiency improvement • Aligning multiple data sources including PHM data, JSNAs, Herts Insights to inform neighbourhood priorities and identify opportunities for improvement • Developing the neighbourhood workplan • Preparing neighbourhood updates for the HCP Board • Designing a prioritisation process for neighbourhood priorities and transformation initiatives • Identifying opportunities for shared learning and collaboration with other neighbourhoods • Developing partnership-wide leadership models (OD plan and leadership team) • Signposting and connecting teams
Community Director (CLCH)	• Steering the strategic direction for the neighbourhood • Ensuring alignment with community service provision • Providing senior leadership of community services within the	• Ensuring operational alignment of activity with neighbourhood workplans • Ensuring operational alignment of community services with neighbourhood teams • Troubleshooting and unblocking key issues within community services • Setting objectives and strategic priorities for the neighbourhood

Appendix 4: Neighbourhood Leadership Team Roles
Neighbourhood core team

Role	Function	Job summary
District Council representative	• Supports the chair in setting the strategic direction and forward plan for the neighbourhood • Representative of district councils	• Ensuring a broad, person-centric focus for neighbourhood objectives and strategic priorities for the neighbourhood • Promoting effective working across the neighbourhood and ensuring all partner organisations actively contribute to strategy development and delivery within the neighbourhood • Representing their district council in a consistent manner with representatives of other partner organisations
Secondary care consultant (WHTH)	• Representing acute clinical professionals • Offering advice and expertise to shape neighbourhood-level working	• Offering scrutiny on clinical decision making and proposing opportunities for improvement • Providing clinical insight to neighbourhood prioritisation and objective setting • Providing clinical scrutiny of transformation initiatives and coordinating input from specialist acute colleagues were applicable • Ensuring alignment with acute clinical priorities
Community service operational lead	• Providing operational oversight of the integrator role • Promoting operational alignment with partner organisations	• Coordinating multi-disciplinary working across INTs and other transformation initiatives • Identifying staff to be involved in specific task groups and associated projects where applicable • Providing operational insight to neighbourhood prioritization and objective setting • Offering scrutiny on decision making and proposing opportunities for improvement
Project	• Secretariat support • Supporting the development of the neighbourhood workplan • Providing oversight to neighbourhood	• Secretariat for neighbourhood meetings • Developing components of the neighbourhood workplan • Tracking delivery and providing oversight of neighbourhood workplan delivery

Appendix 4: Neighbourhood Leadership Team Roles
Additional roles within the neighbourhood

Role	Function	Job summary
Project manager(s)	• Supporting the development of the neighbourhood workplan • Project planning, tracking and reporting • Risk assessment • Communication	• Development of INT programme plans including: o Scoping initiatives, in collaboration with neighbourhood partners o Providing the necessary evidence base to support the initiative o Identifying and mitigating risks and interdependencies o Developing a delivery plan with clear milestones and owners • Tracking delivery, including holding delivery partners to account for their milestones as applicable • Providing ownership and accountability of individual workstreams within the neighbourhood workplan
Acute service operational leads	• Providing operational oversight of the integrator role • Promoting operational alignment with partner organisations	• Coordinating multi-disciplinary working across INTs and other transformation initiatives • Identifying staff to be involved in specific task groups and associated projects where applicable • Providing operational insight to neighbourhood prioritisation and objective setting • Offering scrutiny on decision making and proposing opportunities for improvement
Stakeholder representatives (HPFT, HCT, HCC (public health), community pharmacy, VCFSE sector)	• Representing their organisation/ professional group • Taking responsibility on behalf of their organisation/ professional group to support the neighbourhood	• Decision-making and responsibility to support neighbourhood delivery • Ensuring reciprocal and timely communication on applicable issues identified through neighbourhood working • Seeking ratification for changes in ways of delivering services within their organisation, where applicable • Identifying staff to be involved in specific task groups and associated projects where applicable

Appendix 4: Neighbourhood Leadership Team Roles
Centralised HCP capacity working across the neighbourhood

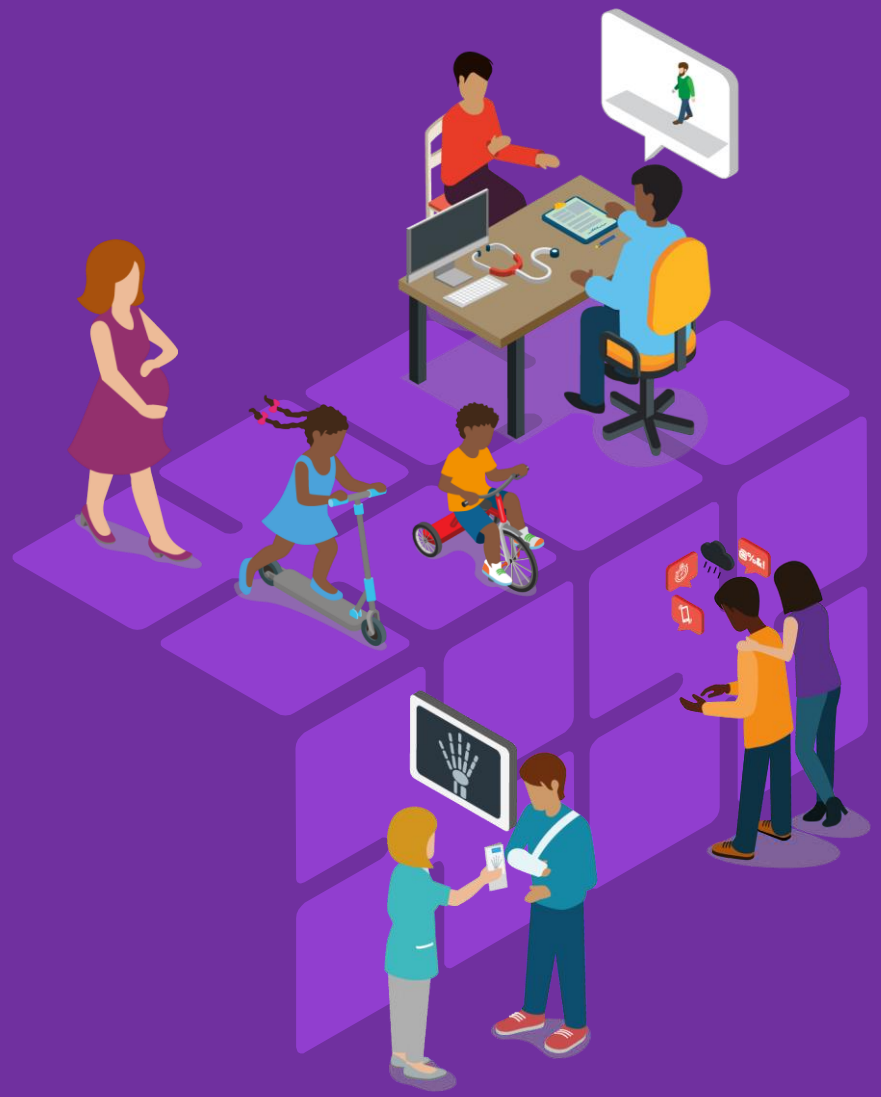
Role	Function	Job summary
Administrative Support	• Meeting administration • Secretariat functions	• Coordinating neighbourhood meetings including: o Diary management o Sharing agendas and meeting papers o Producing minutes • Supporting programme management including: o Scheduling relevant meetings o Completing highlight reports • Holding the neighbourhood risk register and action log
BI Champion	• Access to data and informatics	• Providing data on neighbourhood-level operational delivery • Responding to ad hoc data requests as part of INT initiative development • Monitoring INT and other productivity and efficiency improvement initiative delivery through agreed performance metrics
PHM Champion	• Access to PHM data and tools	• Provision of PHM analysis and critical appraisal • Support in using a range of PHM tools including risk stratification and segmentation with guidance at neighbourhood level • Identifying and understanding inequalities
Commissioning Lead	• Enhancing services currently delivered at neighbourhood-level • Identifying opportunities for developing new services	• Reviewing existing pathways within existing contracts • Identifying opportunities for improvement within pathways • Prioritising service development opportunities at neighbourhood level • Tracking contract expiry dates • Performance management of contracts including neighbourhood-level insight where applicable
Care Closer to Home	• Providing connection with the ICB/ HCP • Acting as a point of continuity across all	• Promoting shared learning and consistency (where appropriate) across all neighbourhoods • Offering scrutiny for operational delivery and proposing opportunities for improvement

West Essex Health and Care Partnership

Integrated Delivery Plan- 2025 -2028

Summary

Final draft, v5



April 2025

Working together
for a healthier future

The West Essex Health and Care Partnership

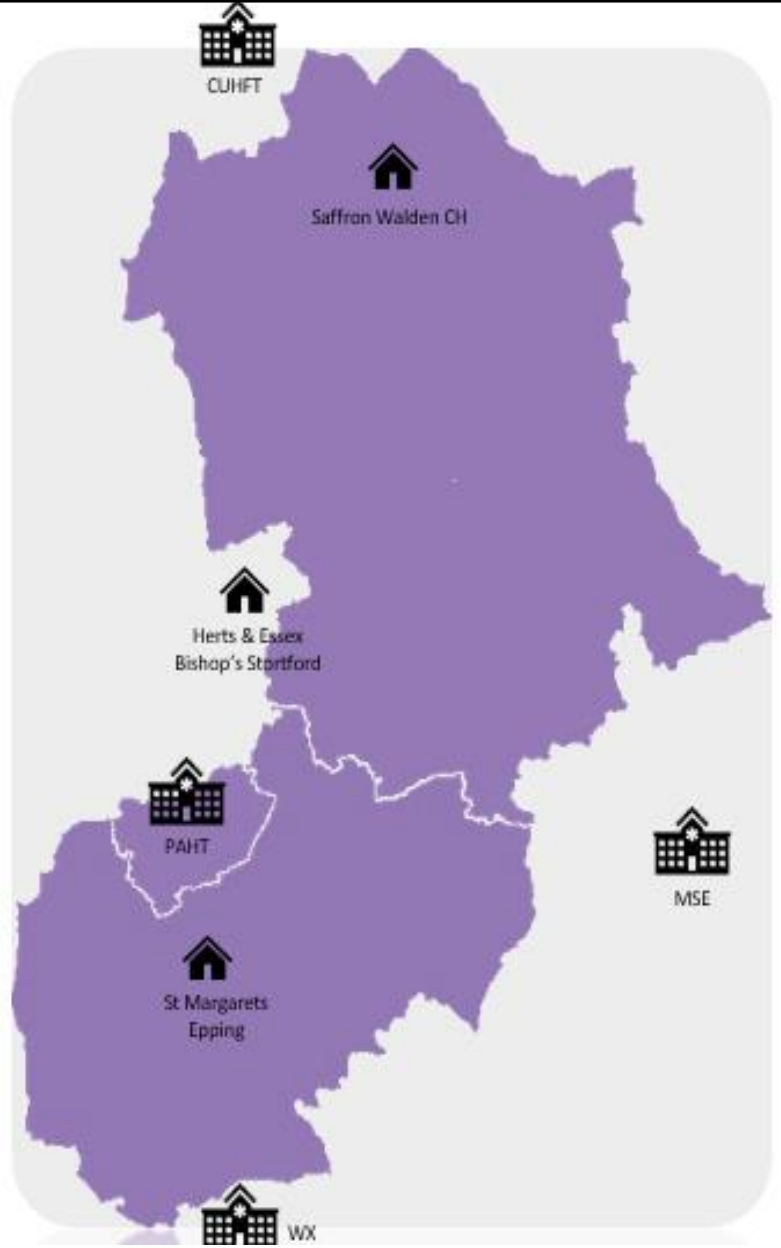
From April 2025 Princess Alexandra Hospital (PAHT) will take on the responsibility as host provider, with delegated responsibility for the commissioning and management of NHS services from the Hertfordshire and West Essex Integrated Care Board (ICB), operating through the West Essex (WE) Health and Care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

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

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

Our priorities for the next three years are

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



West Essex Health and Care Partnership

Our Population

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

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

Epping Forest

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

Population snapshot

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

Harlow

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

Population snapshot

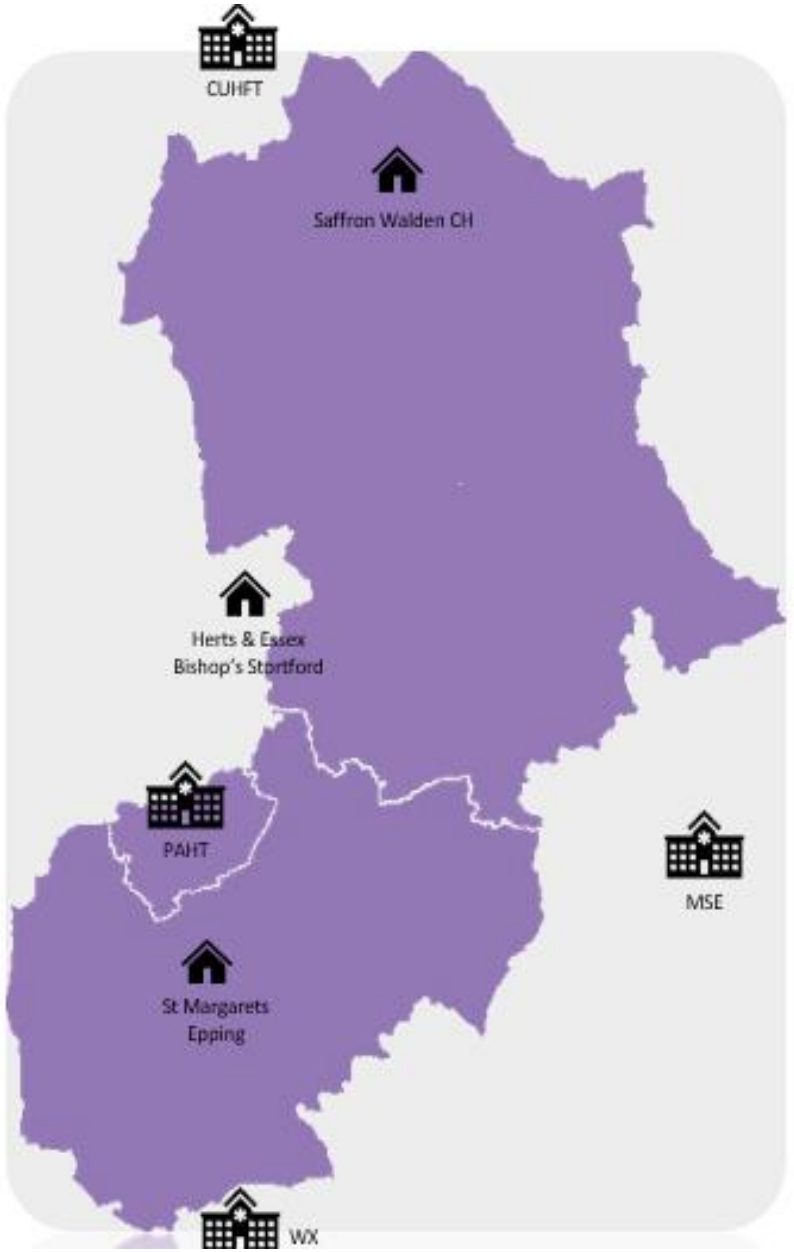
Harlow south and north have a younger population profile than England average.
Higher rates of childhood obesity.
Wider determinants data shows Harlow south is the most deprived PCN within the ICB, Harlow north one of the most deprived.
The average number of chronic conditions for people is higher than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

Uttlesford

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

Population snapshot

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



West Essex Health and Care Partnership

Principles underpinning our priorities and plans

Principles

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

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

West Essex Health and Care Partnership

Our 3 Year Priorities

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

What success looks like
Patient outcomes

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

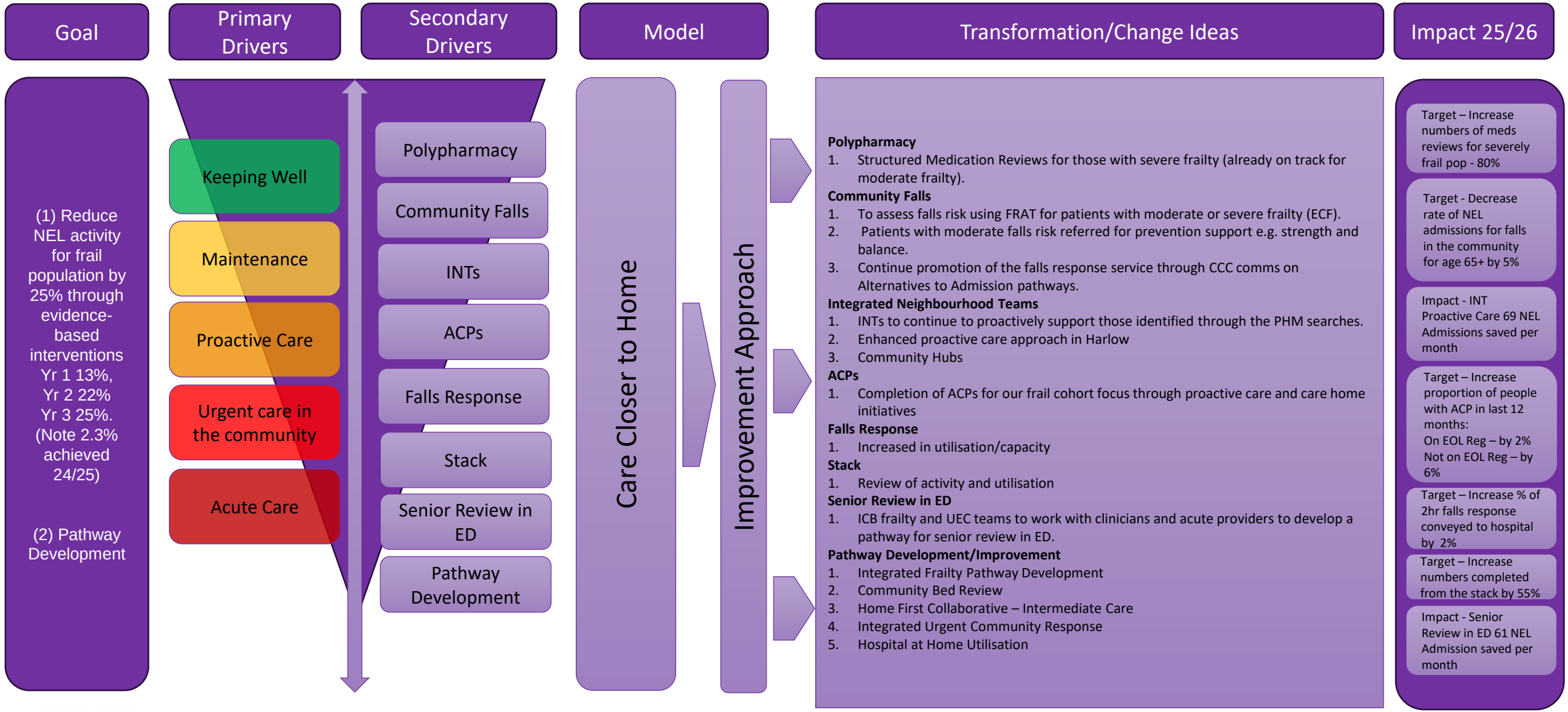
Our 3 Year Priorities

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

What success looks like
Patient outcomes

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

Example : Addressing dependency on acute hospitals for our frail population



West Essex Health and Care Partnership

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

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

Funding stream for schemes 2526:

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

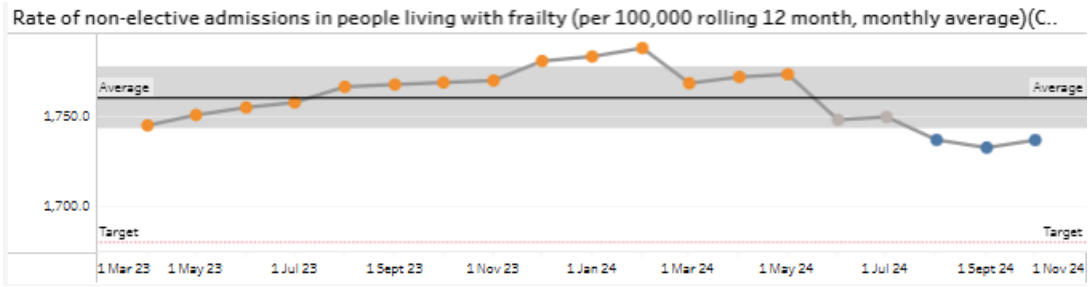
Senior review in ED – PAH contract

UCRT expansion – EPUT contract re-alignment

Billie- blankets – TBC

Transformation savings 2526:

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



West Essex Health and Care Partnership

Delivering through our localities and neighbourhoods

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

Epping Forest

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

Harlow

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

Uttlesford

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

Stort Valley and Hoddesdon

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

Epping Forest

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

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

Harlow Locality

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

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

Uttlesford

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

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

Stort Valley and Villages

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

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

West Essex Health and Care Partnership

Contributions to financial sustainability- Productivity and Efficiency

The partnership is committed to the best use of resources to deliver health & care for the residents of West Essex.

PAHT has a detailed PQP programme shown in the appendices, with £1.5mill for theatre efficiency and £2.6mill from AlexHealth benefits with £6.7mill relating to staffing improvements. 69% is expected to be recurrent savings. There is currently £9mill un-identified. Reduction in bed days delivered through transformation will form part of the un- identified PQP.

EPUT have detailed CIP plans and income generation ideas including reducing non pay spend to 23/24 out-turn, review of service line reporting data and staffing reviews. CIPS are included in EPUT contract value.

The Finance & Commissioning Committee has set a challenge to save £1mill within the WE HCP contracts and a further £1mill across the estates use, with particular focus on St Margaret's Hospital site, Saffron Walden & one public estate opportunities.

The recent rescinding of the Elective Recovery Fund cap will provide opportunities to deliver more elective care than planned, supported by the bed occupancy reduction transformation & the estate efficiencies.

A Medicines Optimisation group is being set up to explore ways that the partnership could share pharmacy procurement & operational opportunities.

Planning assumptions

Outlined below are the key planning assumptions made in developing the IDP for WEHCP.

- Contributions to financial plans within this IDP do not form part of the ICS recovery plans i.e. estates, transformation relating to UEC activity
- IDP has been developed assuming there is no additional investment and transformation will need to be delivered through the repurposing of existing contracts including disinvestment, reductions in duplication and improvements in productivity and efficiencies
- Governance for BCF and pooled budgets will continue through existing West Essex BCF Board with ECC.
- The IDP was developed prior to the announcement of running cost reductions. The IDP plans may need to be reprioritised to deliver within reduced workforce.
- A budget for WEHCP will be provided from the ICB from April 2025
- HCP transformation programmes including Frailty and UEC are not included in the operational plan activity or workforce submissions however they are included within the financial plan as part of the 5.8% provider PQP target for PAHT.
- IDP priorities for E&NH HCP are aligned with the ambitions to reduce admissions at PAHT to deliver targets in Appendix xx
- Activity baselines for modelling impact of transformation programmes are either 23/24 or actual to December 2024, as stated in the detailed modelling. No population growth has been included in the transformation impact modelling.
- MTP targets are based on 23/24 baseline (22/23 Hypertension QOF measures)
- For acute patient flows external to West Essex (WX, MSE and CUHFT) it is assumed they comply with operational planning requirements which will be monitored through our localities to ensure equity of access for our population and activity delivered within plans
- Final activity, delivery of performance standards, workforce and financial plans are to be triangulated by the ICB

- **PAHT**
- PAHT performance standards comply with operational planning requirements and have been triangulated.
- The workforce plan is aligned to the key national directives on reductions in bank and agency workforce (15% reduction in bank and 30% reduction in agency).
- PAHT financial plan was submitted as breakeven with a PQP target of 5.8% aligned to the national average. This is driving an efficiency program of £26.15m. To achieve a breakeven submission there is £24.7m of system support funding to match that received in 2024/25 along with a further temporary £15.8m system support funding.

- **EPUT**
- Delivery of the Care Co-ordination Centre, Care Closer to Home model of care, INTs and Community urgent care standards to be delivered within the contract uplift of 1.65% and efficiency savings.

Enablers and interdependencies

- Overlap of current service delivery with transformational delivery and funding both in the same financial year
- WE financial envelope and the commissioning limitations of sharing resources
- Development of the Host Provider model for the WE HCP and the lead provider model for PAH/EPUT
- Opening of the elective hub at St Albans
- Community Diagnostic Centre opening at St Margaret's Hospital & the bid for financial support to develop the diagnostic pathways
- Whilst the IDP feeds the detailed NHS plan, the work of the District & County Councils are essential partners to delivering the Care Closer to Home model, in the development of neighbourhood services, Integrated Neighbourhood Teams, prevention & wellbeing in addition to collaborative working on estates. The planning process has included local district plans and the Better Care Fund & Market Shaping Local Delivery (Care provision) plans.
- Digital – The ongoing development of AlexHealth at PAH including the patient portal and 6 clinical pathways, the implementation of Nova in EPUT, the implementation of a system-wide cancer monitoring software and focus on using technology to support patients at home will all enable collaborative working and delivery of the partnership priorities.
- Estates – The partnership aims to develop capacity & services at Saffron Walden, St Margaret's and across shared public estate to ensure that we deliver the priorities of the partnership within the localities.
- Workforce – The partnership are developing joint working groups to deliver the Integrated Delivery plan, clinical, operational & transformation teams. The recent national announcement of rationalisation of NHSE, ICBs and provider corporate resources may affect the delivery of the Integrated Delivery Plan.

Aligning our plans with our partners

The IDP has been developed with all the HCP partners and has been built to deliver the ICBs Medium Term Plan priorities, combining the partner priorities and the needs of the locality populations.

WEHCP Priorities 2024/25

Prevention focus obesity and mental wellbeing
Proactive approach focussing on our frail population through INTs
Urgent and emergency care in the community

H&WE ICB MTP

Children have the best start in life
Increase healthy life expectancy and reduce inequalities
Improve access to services
Improve wellbeing
Ensure financial sustainability

25/26 PAH Priorities

Children
Frailty
Urgent and Emergency Care

EPUT West Essex Op Plan

Safe high quality integrated services-Care Closer to Home
Enable each other to be the best
Work with partners
Support communities to thrive

Essex County Council

ECC's vision for social care *aims:*

- Reduce reliance on residential care
- Increase provision for complex care
- Increase and evolve community-based services
- Develop a wider range of accommodation options
- Increase choice and control using Personal Assistants, Micro-enterprises, Individual Service Funds and Direct Payments
- Improve our short term and early help service offer

Harlow District Council

Reduce health inequalities
Increase physical activity & healthy weight
Mental health & wellbeing
Addiction issues
Long term independence

Epping Forest District Council

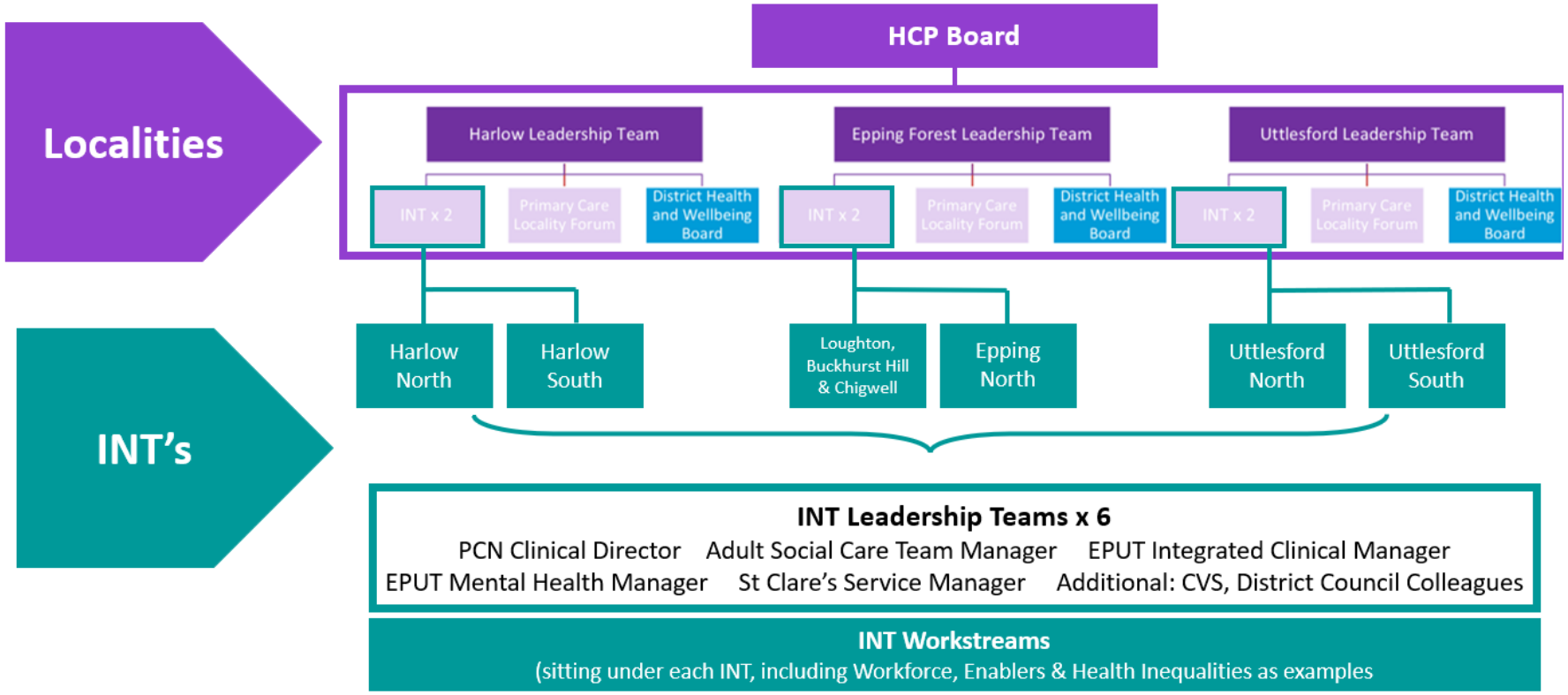
Reduce loneliness & isolation
Increase physical activity
Mental health & wellbeing
Alcohol & substance misuse
Support for rising costs of living

Uttlesford District Council

Healthy resilient communities
Healthy active lifestyles & healthy weight
Mental wellbeing
Improve access to services
Alleviate increased living costs

West Essex Health and Care Partnership

How we will deliver & monitor progress



- A refreshed reporting and governance structure will be developed to support the monitoring of the IDP through the existing committees, ensuring that progress against the activity, workforce, finance, digital & transformation plans are delivered.
- Metrics will be based on the Medium Term Plan objective metrics, national operating standards and the transformation ambitions set at WE and locality level. Partners will monitor, support & challenge progress against this mutual plan.

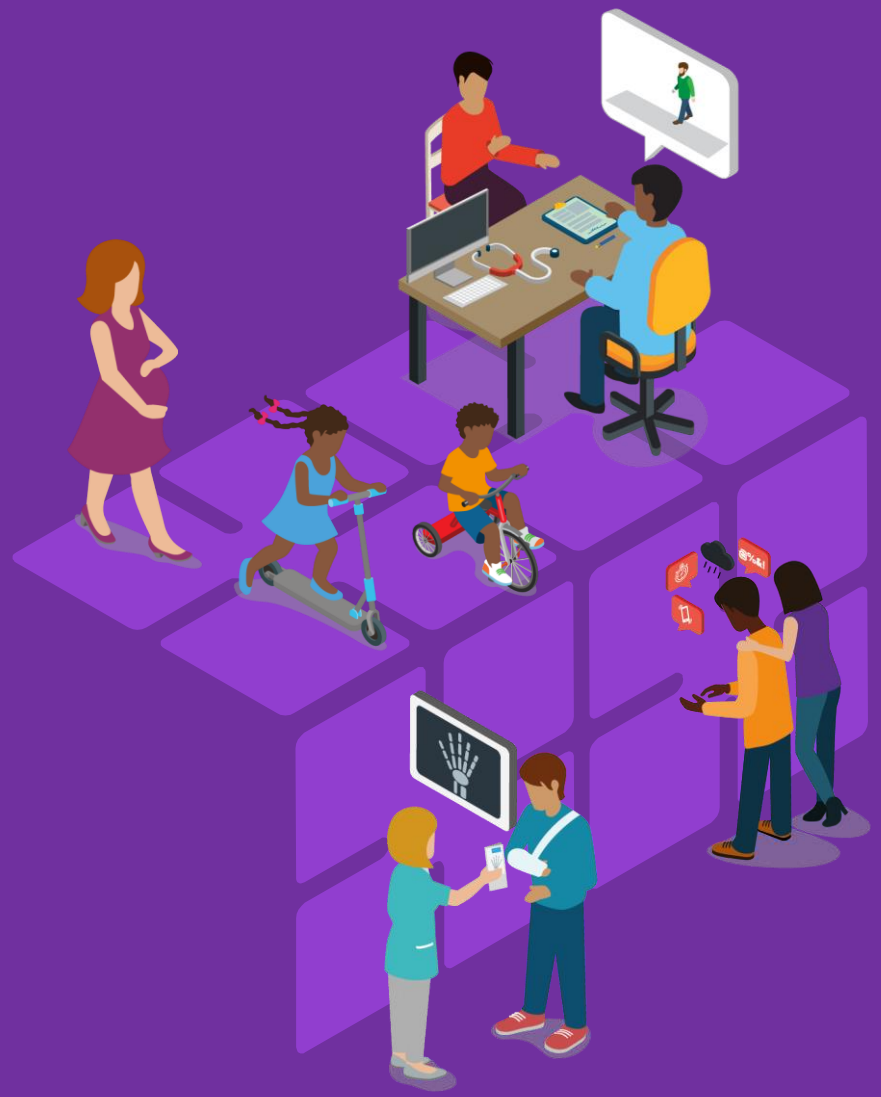
- ICS/B reporting will also be revised to simplify the additional reporting required to communicate key achievements such as progress on the Medium Term Plan, Care Closer to Home, UEC & Frailty.
- Combined reporting through host provider of transformation and PQP through the PM3 project management system and through HCP dashboards will further support efficient monitoring ensuring easy access to tailored local reporting.

West Essex Health and Care Partnership

Risks

- West Essex HCP financial budget is not yet finalised. Reporting against the budget is complex and requires multi-partner involvement
- The recent national announcement of rationalisation of NHSE, ICBs and provider corporate resources may affect the delivery of the Integrated Delivery Plan.
- New extended commissioning framework (ECF) in primary care not yet signed up to it – impacts INT & frailty, Medicines Optimisation, ACPs, wound dressings & GP treatments
- Ability/appetite to fund the transformation by transferring resources
- Complexity of elective recovery plans – combination of efficiency, change in working practice & operational capacity.
- Confidence in PAHT activity data quality to illustrate achievements of the transformation programmes
- Confidence in delivery of transformation
- Cultural change to support the integration aims requires longer timeframe than the delivery of the IDP allows
- Local authority re-organisation reducing capacity & focus for partnership transformation & delivery

West Essex Health and Care Partnership



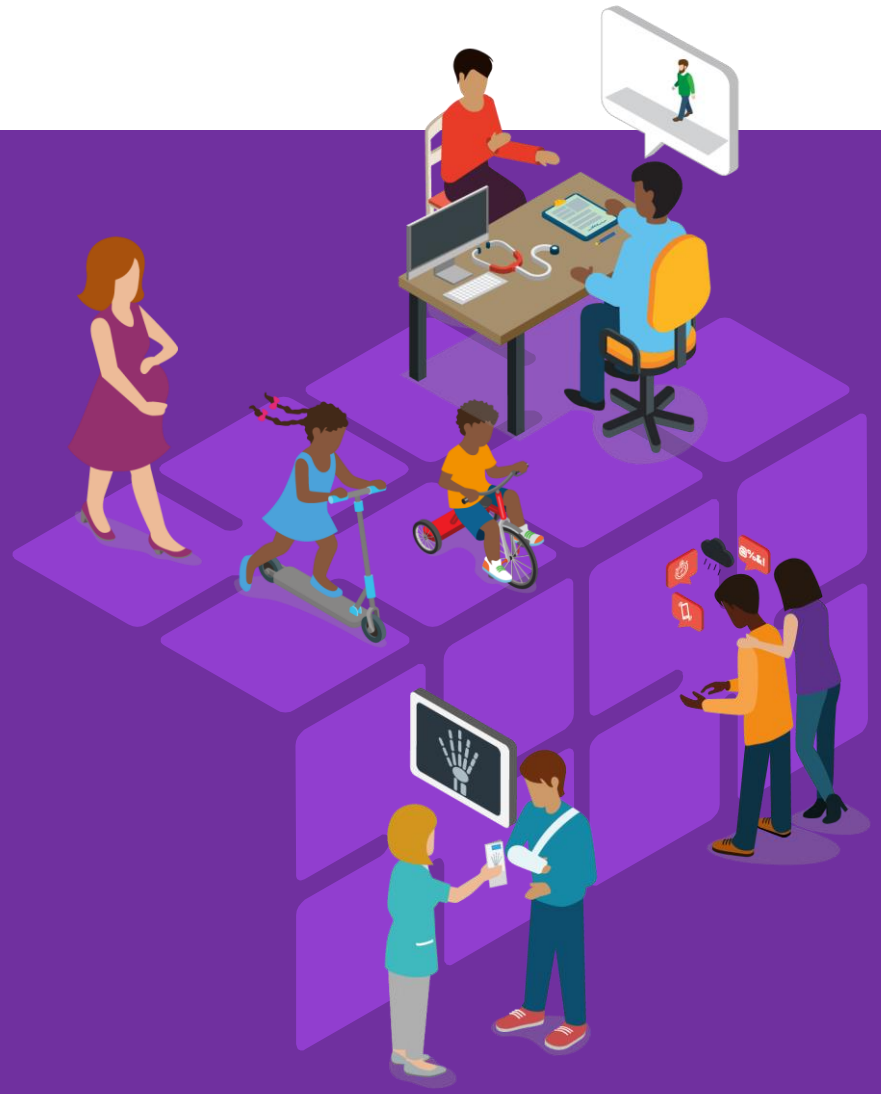
Appendices

April 2025

Working together
for a healthier future

West Essex Health and Care Partnership

NHS



Appendix 1 - Detailed Plans

Transformation Programmes

Medium Term Plan summary metrics

Working together
for a healthier future

West Essex HCP – Transformation Programmes – Addressing Inequalities

Transformation Aim	Projects	What will be different in 25/26? Activity Impact	Cost/saving £'000	Quality Impact
Bump to 5 focussing on reducing childhood obesity:	Maternal & healthy lifestyle coaching Padlet – Bump to 5 information School Readiness Kitchen Visions & Five Dinners Oral Health Projects	2 year programme in Harlow & Waltham Abbey	ECC	Reduced obesity & associated health issues. Improved oral health
Cardio-vascular disease	To increase detection of CVD by 2% from baseline of 14.9% by 31/3/26	Harlow 16.21% Epping Forest 17.90% Uttlesford 16.86%	ICB	Reduced CVD, reduced associated health conditions
Winter Vaccination – every contact counts in every partner setting	All partner approach to winter vaccination levels improvement	Improve vaccination rates: Covid – 44.8% WE 24/25, EofE 48.1% RSV – 51.5% WE 24/25, EofE 60.8% Flu 74.7% WE 24/25 (All eligible 65+)	To be confirmed – all partner support	Reduced winter illness, attendances at primary & urgent care services and reduced admissions & IPC outbreaks.
Adults Mental Wellbeing	2nd Workshop 25/3/25	Focussing on addressing: • Social isolation • Access to services	To be confirmed, likely to be partner support	Improve mental health, reduce deterioration of physical conditions
Healthier together, CYP	O/S CYP team		ICB	

West Essex Health and Care Partnership

West Essex HCP – Transformation Programmes –
Addressing dependency on acute hospital for our frail population

Transformation Aim	Projects	What will be different in 25/26? Activity Impact	Cost/saving £'000	Quality Impact
Integrated pathways	Frailty Pathway	Scoping year 1, Planning year2, Delivery year 3 – care closer to home, reduced appointments, greater financial sustainability	N/A 25/26	Better patient experience, reduced waiting times, earlier intervention, contribution to 25% reduction in frailty admissions
Frailty 25% ambition – Better Winter = 92% bed occupancy 30/9/25 & 89% bed occupancy 31/3/26 (Overlaps with Urgent care)	Integrated Neighbourhood Teams - 7 interventions including: • Senior review in ED • Medicines optimisation • FRAT assessment • Advanced Care plans • Community matron review of Harlow cohorts	Year 1 - 832 saved attendances & admissions (WE population) Year 2 - 1456 Year 3 - 1716 (cumulative) PAHT bed occupancy 89% by 31/3/26 Virtual ward occupancy increased	Cost of Senior review in ED/Acute MDT at front door o/s £2mill CIP saving in PAHT in saved agency & bank staff for outlying and surge ward capacity	Prevention of ill health & condition deterioration, reduced admissions to both community & acute care, Better patient experience in community & acute ED & wards, Improved communication & delivery of patient wishes.

West Essex Health and Care Partnership

West Essex HCP – Transformation Programmes – Improving access to Urgent and Emergency Care service for adults & children

Transformation Aim	Projects	What will be different in 25/26? Activity Impact	Cost/saving £'000	Quality Impact
Reducing ED waiting times **More of adult's urgent care needs met in the community**	PAH UEC Improvement project, including senior review in ED/MDT at front door Call before convey & access to stack Urgent Community Response improvement IUATC primary care led front door Discharge Improvement Programme Virtual Ward utilisation Intermediate Care Community bed utilisation	Reduced ED attendances, PAH 2% year 1, 2% year 2, 3% year 3. 78% 4 hour standard & 30 minute ambulance handover. Increased patients transferred from ambulance stack to community services Increased capacity utilised in Community Urgent Response service 1278 additional saved attendances & admissions to acute Increased utilisation of IUATC Reduced numbers of no criteria to reside patients, higher numbers discharged by midday Improved VW utilisation Improved community beds utilisation	Reduced agency & bank staff costs in acute OPAL/AAU used as Assessment areas – reduced staffing costs from bedded capacity Dependant whether within existing contracted capacity	Prevention of ill health & condition deterioration, reduced admissions to both community & acute care, Better patient experience in community & acute ED & wards, Improved communication of patient wishes

West Essex HCP – Transformation Programmes – Delivering Elective Care

Transformation Aim	Projects	What will be different in 25/26? Activity Impact	Cost/saving £'000	Quality Impact
Reducing elective waiting time **Reducing elective length of stay** **Maintaining equity of access across population**	PAHT: Elective recovery programme Cancer programme Urology, Lower GI & tele-dermatology Outpatient and theatre utilisation programmes HCP wide: faster diagnosis pathways including Community Diagnostic Centre Strategic: Options for elective Hub STM site (Yr 2)	1% of W/L 52 week waits by 31/3/26, 76% 18 week performance Cancer performance, 62, 31 & 28 day 85% theatre efficiency, improved OP utilisation, delivery of elective recovery Year 1 – draw up plans, year 2 & 3 funding & development	Within PAH contract Cancer Alliance funded through PAH PAH PQP savings Funding request to CDC national programme for delivery To be confirmed	Improved diagnosis & treatment times for patients, better patient experience
	Heart Failure Integrated Pathway	Year 1 – scoping of the implementation of the clinical pathway, year 2 delivery of the pathway	Within the PAHT/EPUT contracts	Better patient experience, reduced waiting times, earlier intervention 25% reduction in frailty admissions

West Essex Health and Care Partnership

West Essex HCP – Transformation Programmes – Improving outcomes for our children and young people through integrated pathways

Transformation Aim	Projects	What will be different in 25/26? Activity Impact	Cost/saving £'000	Quality Impact
Children & Young People	Family Hub – additional emergency appointments for children PAHT: Paediatric Front door HCP wide: Paediatric INTs Yr 2	ED/IUATC/GP improved utilisation & reduced acute admissions Year 1 draw up the project plan and prepare for year 2 implementation	To be confirmed	Improved access to urgent care, reduced deterioration, better patient experience
	Jaundice admissions – Billie blankets	130 attendances & admissions per year	To be confirmed	Reduced deterioration in condition, care at home
	Procurement of new Essex Child & Family Wellbeing Service Contract with ECC	Year 1 – draw up integrated service specifications Year 2 – 3 new contract	To be confirmed	Reducing community waiting times for CYP
Children & Young People 52 week waits	ENT & Other specialities – requires surgical paediatric nursing team, identified theatre resources, specific plan for delivery of sufficient activity.	ENT 0 52 week waits by 31/3/26 Other specialities - 0 52 week waits by 30/9/25	Within PAH contract	Reduce the impact of long waits on children's development & school readiness, reduced GP, UTC & ED attendances

West Essex Health and Care Partnership

Where we are starting from – Medium Term Plan current performance

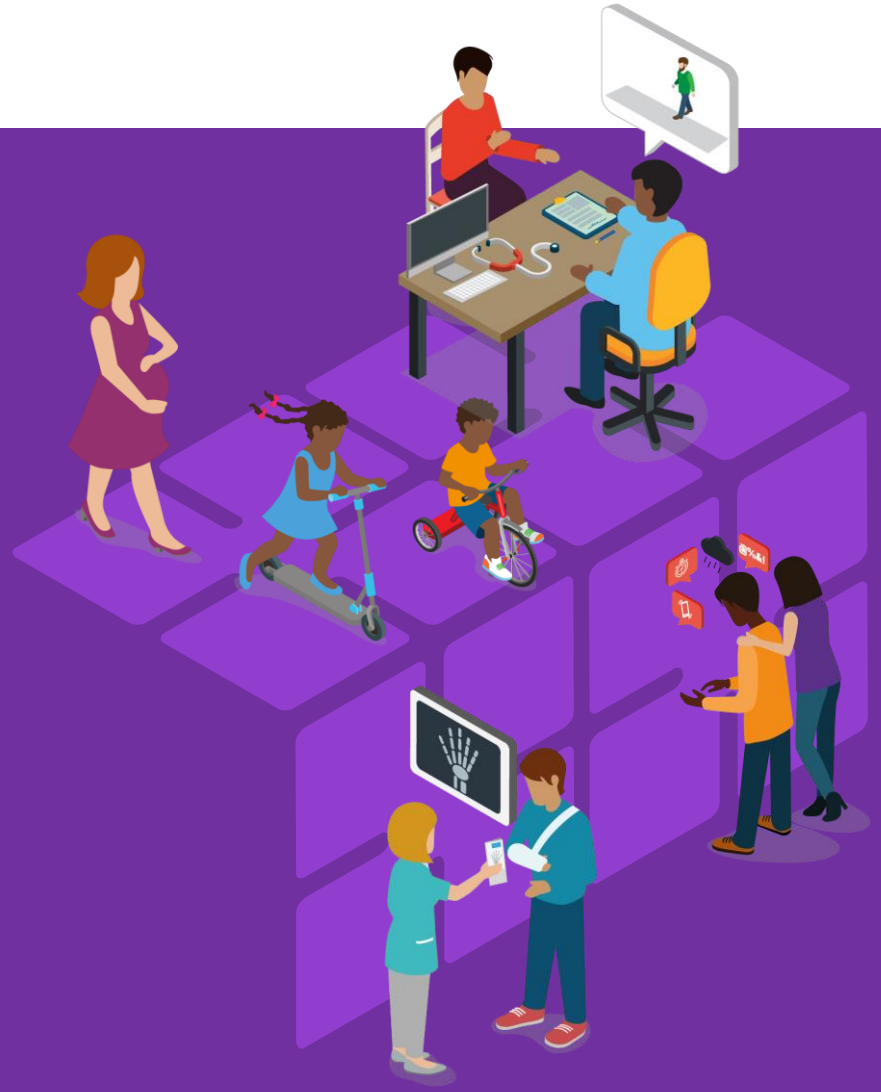
Using Population health management and performance intelligence, the HCP has been focussed on priorities which address the challenges across a range of areas. These directly align to the ICB MTP priorities and indicators have been used across all 3 Place Areas. We will use the MTP metrics in addition to local metrics to measure the outcomes of the IDP, at both Place and Locality level.

Medium Term Plan Dashboard - West Essex HCP	Target	Recent Month	Previous Month	West Essex ambition 31/3/26
Measure		Positive trend/Negative trend		
Hypertension prevalence as per QOF	16.5%	15%	14.90%	16.90%
% of people on Hypertension QOF register with their most recent Blood Pressure in target as defined by QOF measures HYP008 & HYP009	80%	78.20%	78.70%	80.00%
Rate of emergency admissions for falls within the community for people aged 65+(per 100,000 Rolling 12 month, monthly average)	133.1	134.4	136.5	133.1
Rate of non-elective admissions in people living with frailty (per 100,000 rolling 12 month, monthly average)	1679.8	1736.5	1732.3	1644
Percent of all deaths where the person has had an emergency admission in the last 90 days of life (Rolling 12 months)	5%	5.2%	5.3%	5.00%
Patients waiting greater than 65 weeks between referral and treatment	0	97.00	61.00	Patients waiting greater than 52 weeks - <1% of the waiting list
Percent of Outpatient and Day Cases where Surgery is consistently undertake. Percent calculations are based on a rolling 3 month period.	85%	79.30%	83.80%	85.00%
Patients should wait less than six weeks for a diagnostic test	95%	68.70%	63.70%	95.00%
Capped elective theatre utilisation helps understand the effectiveness of the operation scheduling processes within planned valid elective sessions in comparison to other organisations.	85%	79.20%	71.20%	85.00%
Patient Tracking List (PTL) for elective care, which is a list of patients awaiting treatment	-	54,423	42,062	49,953 PAH W/L
Rate of emergency admissions for people aged under 18 (per 100,000 rolling 12 month, monthly average)	308.7	314.8	316.9	308.7
Rate of A&E Attendances for children and young people (per 100,000 rolling 12 month, monthly average)	-	3315.9	3264.2	
HWE Percent of callers who required urgent response, who were assessed within 24hrs of the referral being made (Not currently available at place level)	67%	59.40%	46.50%	67%
HWE Number of people with mental health needs admitted to a unit outside of their local network of services (Not currently available at place level)	4	35	30	4
HWE Percent of people under adult mental illness specialties who were followed up within 72 hours of discharge from psychiatric in-patient care	75%	89.50%	93.40%	75%

West Essex Health and Care Partnership

West Essex Health and Care Partnership

NHS



Appendix 2 - Operational Plan extracts

Working together
for a healthier future

NHS Planning Guidance

NHSE has set the following national priorities for 2025/26 which will improve patient outcomes, and ensure that health and care systems are enabled to deliver these improvement:

Improving patient outcomes

Elective Care	• Reduce the time people wait for elective care, improving the % of patients waiting no longer than 18 weeks for elective treatment to 65% by March 2026, with every trust expected to deliver at least 5% improvement • Continue to improve performance against the cancer 62-day and 28 day Faster Diagnosis Standard to 75% and 80% respectively by March 2026
Urgent and Emergency Care	• Improve A&E waiting times and ambulance response times compared to 2024/25, with a minimum of 78% of patients seen within 4 hours in March 2026 • Category 2 ambulance response times should average no more than 30 minutes across 2025/26
Primary Care	• Improve patients' access to general practice, improving patient experience • Improve access to urgent dental care, providing 700,000 additional urgent dental appointments
Mental Health	• Improve patient flow through mental health crisis and acute pathways, reducing average length of stay in adult acute beds • Improve access to CYP mental health services, to achieve the national ambition for 345,000 additional CYP aged 0-25 compared to 2019

Delivering improved patient outcomes

Reform	• Drive reform that will support delivery of our immediate priorities and ensure the NHS is fit for the future • Focus on reducing demand through developing neighbourhood health service models and making use of digital tools
Resources	• Live within the budget allocated, reducing waste and improving productivity • Deliver a balanced net system financial position in collaboration with system partners
Quality and safety	• Maintain our collective focus on the overall quality and safety of our services • Continue to address variation in access, experience and outcomes

Operational Performance

The Princess Alexandra Hospital NHS Trust

25/26 Operational Performance	Baseline Dec-24	Planning Assumption Mar-26
General and Acute overnight bed occupancy		
Number of overnight G&A beds occupied - available and occupied	98.6%	97.4%
NEL Average length of stay - acute trusts		
NEL Average length of stay - acute trusts	7.60	7.60
Cancer 28 day waits (faster diagnosis standard)		
Percentage of patients receiving a communication of diagnosis for cancer or a ruling out of cancer, or a decision to treat if made before a communication of diagnosis within 28 days following	72.2%	80.0%
Cancer 62-day pathways. Total patients seen, and of which those seen within 62 days		
Percentage of patients seen within 62 days	60.9%	75.0%
Cancer 31 day performance		
Percentage of people treated beginning first or subsequent treatment of cancer within 31 days of receiving a decision to treat/earliest clinically appropriate date	95.4%	96.6%
PIFU	Apr 2024 - Dec 2024	Mar-26
PIFU as percentage of total outpatient attendances	1.7%	3.0%
A&E	Apr 2024 - Jan 2025	Mar-26
Percentage of attendances at Type 1, 2, 3 A&E departments, departing in less than 4 hours	60.4%	78.0%
Percentage of attendances at Type 1 A&E departments, departing in less than 4 hours.	47.9%	71.0%
Percentage of attendances at Type 2 and 3 A&E departments, departing in less than 4 hours	100.0%	100.0%
Percentage of attendances at type 1 A&E departments where the patient spent more than 12 hours	0.0%	6.5%
Outpatients	Jan-25	Mar-26
Percentage of patients waiting for first attendance who have been waiting less than 18 weeks	42.0%	56.3%
RTT	Nov-24	Mar-26
Percentage of patients waiting no longer than 18 weeks for treatment	45.5%	60.0%

The Operational Plan will deliver all performance targets aligned to the national requirement by March 2026.

The table highlights key metrics from the operational plan submission showing the baseline data and the planning assumption included to be achieved by March 2026.

This is an aspirational planning submission which will require transformational change to deliver it.

There are a number of risks to delivery including the condition of the estate, availability of workforce and the impacts on both activity delivery and reporting following the implementation of Alex Health.

Financial Plan 25/26

The Princess Alexandra Hospital NHS Trust

PAH - Bridge from FOT	£000
2024/25 Forecast Outturn	**(1,097)**
Non-recurrent efficiencies utilised in 24/25	(3,702)
Non-recurrrent Pay PQP in 24/25	(10,045)
Pathology Service Change	(1,881)
CDC - 24/25 underspend not planned for in 25/26	(373)
Elective Recovery Funding Increase net of costs	971
Elective Recovery Funding - change in methodology for core payment	(4,177)
Alex Health FYE	(2,767)
Alex Health Benefits/PQP to offset FYE costs	2,553
Alex Health Sustainment	(1,246)
Additional Cost Pressures:	
Utilities	(871)
Resident Doctors Review - costs above forecast outturn	(636)
Vascular contract adjustment	(437)
HEE non-recurrent funding	(843)
Other movements including non-recurrent benefits in 24/25	(1,911)
Depreciation and financing costs/income movements net of funding	(1,885)
Inflation including incremental drift - net of inflation funding	(11,121)
25/26 PQP Target excl Alex Health benefits shown above	23,597
2025/26 - Final Plan Submission before System Efficiency Support	**(15,871)**
System Efficiency Support - to be identified by ICS	15,871
2025/26 - Final PAH Plan	**0**

The financial plan for 25/26 is based on the following key assumptions:

- The overall position is break-even but includes two significant system support funding elements:
  - £24.7m of system support equal to that provided in 25/26.
  - £15.87m of additional system support to bring PAH to break-even whilst the ICS work through transformation and efficiency schemes to close the system gap.
- PAH have a PQP target of 5.8% which is £26.15m to include £2.55m of Alex Health benefits.
- The Elective Recovery Funding is capped at 128% but with a change in the calculation methodology of the core/fixed element of the elective recovery income it has provided an additional pressure for PAH of £4.2m.
- There are a number of cost pressures that remain within the 25/26 position and will continue to be reviewed. In particular the cost pressure currently arising from Pathology service transformation is being reviewed across the ICS.

Final Workforce Submission 21.03.25

The Princess Alexandra Hospital NHS Trust

Total Establishment (WTE)			Mar-25 Plan Workforce (WTE)				Mar-26 Plan Workforce				Mar-25 vs Mar-26 Growth %			
Plan Establishment as at Mar-25	Plan Establishment as at Mar-26	Total Increase/ (Decrease)	Total Workforce	Total Substantive	Plan Bank	Plan Agency	Total Workforce	Total Substantive	Plan Bank	Plan Agency	Total Workforce	Total Substantive	Plan Bank	Plan Agency
4,097.77	4,097.77	0.00	4,235.14	3797.62	386.79	50.73	4,203.92	3,841.05	328.05	34.82	-1%	1%	-15%	-31%

High level Assumptions :

- Total establishment excludes pathology
- Total substantive staff in post excludes pathology, staff on career break and staff out to external secondment
- EHR benefit realisation in plan will phase out some post commencing Nov-25 (28.15 WTE substantive & 20.07 WTE bank & agency)
- EHR sustainment business case **option 2** included from Nov-25 (53.30 WTE)
- Increase to the establishment include approved business cases for CDC, surgical centre and vanguard (56.73 total WTE)
- Increase to substantive staff in post through, increase recruitment, staff retention and reducing temporary staffing
- To reduce spend on temporary staffing, plan bank and agency usage worked up using NHSE operational guidance of 30% reduction in agency and 10% reduction in bank usage. (average bank & agency run rate 495.33 wte)
- Streamline the recruitment process to move bank to substantive, any long lines of work over 10 weeks will be offered if covering a vacancy

PQP

The Princess Alexandra Hospital NHS Trust

PQP Themes	£000
Temporary Staffing - Bank & Agency	5,610
Procurement	518
Alex Health Benefits	2,629
Pathology Testing Reduction	541
Corporate Services	986
Additional Sessions linked to Productivity	1,492
International Nurse Recruitment	500
Estates Schemes	441
Central non-recurrent schemes	2,000
Nursing paid at shift rather than grade	570
Non Pay (excl procurement schemes)	800
Drugs cost reduction	187
Contract changes / Income Review	653
Private Patient Income	13
Legal & Professional Fees	150
Other	102
Unidentified PQP	8,958
Total PQP Target 25/26	**26,150**
% of PQP unidentified	**34%**

The Operational Plan assumes the following with regards to efficiency for 25/26:

- Total target is £26.15m which is equivalent to 5.8% of total expenditure. This is in line with the national average.
- Currently work is underway to identify the opportunities and to allocate the PQP target across Divisions and Corporate Services based on opportunity rather than a blanket 5.8% reduction.
- The expectation is that **£16.6m** will be achieved recurrently. This is 63% of the total target.
- Divisions and corporate teams are working to ensure schemes are included on PM3 and

EPUT West Essex Care Unit

Strategic priorities

2023-2028

We will deliver safe, high quality, integrated care services

- Consolidation of the functionality of the CCC – right care, right place, right time
- Use INT's as the vehicle to deliver the proactive population health management approach & personalisation of care + support to increase care delivered in the community and reduce demand on secondary care – 25% reduction in NELS's
- We will improve end-of-life pathways supporting more people to die in their preferred place
- Progress Community MH Transformation in line with priorities of the LTP

We will enable each other to be the best we can be

- Continue to lead the WE HCP workforce development group supported by HRBP to support R&R, development of new roles & staffing models
- Continue system partnership working to deliver the WEHCP priorities
- Improve use of the apprenticeship levy to support staff development

We will work together with our partners to make our services better

- Collaboration across HWE CHS + MH to optimise best practice & parity
- Implement the replacement for CPA - Sec 75 review completed WE shift of social workers to primary care to support prevention
- Collaboratively review of MH shared care protocols with primary care
- Expansion of rotational roles with PAH + jointly funded roles across WEHCP
- Continue support to care homes & independent care providers
- Progression of collaboration initiatives across CHS and MH with the Voluntary sector and District council partners including suicide prevention

We will support our communities to thrive

- Support of community 'hubs' across WE
- Support to the "Harlow Levelling Up" programme with ECC & Partners including Epping Forest – Core 20 + 5 approach
- Support career opportunities across health and social care from local communities, schools , 6th form colleges and FE career fairs and offer student placement opportunities
- Continue to support inclusive recruitment events for people with neuro diversity

Primary Care – ICB narrative

Key area to focus on delivery	25/26 improvement opportunity planned
Action plans to improve general practice contract oversight, commissioning and transformation and tackle unwarranted variation in 25/26.	Continue to progress current plans to meet this objective
Support delivery of modern general practice and target support to practices to deliver access and a good overall experience for patients,	Complete a qualitative review of practice Modern General Practice (MGP) implementation to identify best practice & potential outliers. To inform targeted approach on Practice Level Support (PLS) delivery To improve access via Pharmacy First, HWEICB will support seamless digital referrals from GP practices to community pharmacies, ensure training and resources for relevant stakeholders The ICB will review relevant ONS Health Insight Survey questions to understand improvement of patient experience of access to general practice.
Identify those practices (no.) requiring targeted support to improve access and move to modern general practice; secure/ provide high quality evidence based support	Contract & quality visit programme – covering all HWE practices over 3 years, selected on a random basis Practice level support programme
Commission additional urgent dental appointments	HWEICB plan to continue to offer an urgent access scheme in 25/26 and have received the national guidance on the specification and minimum standards and will now work to determine what that

HWE ICB activity submission – primary & community

Key area to focus on delivery	25/26 planned activity
Appointments in general practice	9,068,187
Virtual Ward capacity & occupancy	474 patient capacity, 85.65% occupancy. 5% decrease in capacity from Dec 2024
Community Care contacts	2,200,881
Community Services waiting lists over 52 weeks	3,812 (April ’25) to 3,936 (March ’26), all but 10 are children
Urgent Community Response Referrals	28,355
Number of unique patients seen by an NHS dentist - adult	602,639 = 46.11% of resident population. (Quarter 2 24/25 = 39.06%)
Number of unique patients seen by an NHS dentist - child	350,148 = 99.45 % of resident population. (Quarter 2 24/25 = 61.64%)
Pharmacy First Consultations	170,963
Non elective length of stay community beds	12.3 days across the year (Quarter 3 24/25 = 14)

HWE ICB activity submission – mental health

Key area to focus on delivery	25/26 planned activity
Active inappropriate adult MH out of area placements	HPUFT April 15, May 5, June – March 26 = 0. (Sept 2024 = 20) HCT = 0 ICB = April = 23 reducing to 5 by March 2026
Average length of stay for adult acute beds	52.3 days (ICB). (Nov 24 = 50)
Access to talking therapies for anxiety & depression – reliable recovery	48% (Sept 2024 = 46%) 15,542 patients having 2 or more appointments.
Access to talking therapies for anxiety & depression – reliable improvement	67% (Sept 2024 = 62% 16,460 patients having 2 or more appointments
People accessing community perinatal & maternity mental health services	2088 per month, 2024/25 = 2000 pm
Access to children & young people mental health services	21,330 per month, 24/25 = 20,425
Individual placement support access	Average of 1,811 per month

The year ahead

East of England Ambulance Service NHS Trust

NHS England planning guidance: in 2025/26, ambulance services must:

- Achieve a Category 2 response time of 30mins as a mean across 25/26
- Clinically navigate an increased proportion of C2 and all C3&C4 calls
- Maintain deployed staff hours on the road
- Improve 'See and Treat' rates
- Improve 'Hear and Treat' rates
- Reduce avoidable conveyances
- Develop realistic, stretched operational plans for 2025/26

How we are going to make the changes

East of England Ambulance Service NHS Trust

- Operational Productivity dashboard will track week by week KPIs.
- Where we see unwarranted variation, this can be compared to other sectors.
- Weekly Performance and productivity meetings are in place.
- Maximalise the UCCH offer (X2 Triaging GPs 08:00 22:00) by the end of April 2025. (Place area Targets four CB4C) Workshop for the UCCH in May 2025.
- Increase the staff trained to work in the UCCH from EEAST for resilience.
- Greater emphasis on Forecasting and Planning.
- Some of these KPIs will be cultural challenges as well and will take time to embed.
- Working with staff to review their own individual portal metrics

Local Authority Plans

Essex County Council - Better Care Fund Plan

	iBCF	ECC Discharge Funds	Health Discharge Funds		Health Inequalities
	ECC/ICB	ECC	ICB	Total	IBCF
2025/26 Funding:	**£ 895,000**	**£ 500,000**	**£ 2,528,000**	**£ 3,923,000**	**£ 705,000**
Allocated:					
Bridging/Home to Assess	£ -	£ 500,000	£ 500,000	£ 1,000,000	
Discharge to Assess	£ -	£ -	£ 386,400	£ 386,400	
Complex Bedded Care	£ -	£ -	£ 729,600	£ 729,600	
Prevention - LBC Care Home hub	£ -	£ -	£ 96,000	£ 96,000	
Pathway 0/1 Support Home	£ -	£ -	£ 260,000	£ 260,000	
Care Co-ordination Centre/ToCH	£ 139,000	£ -	£ 517,000	£ 656,000	
Alliance delivery leads	£ 60,000	£ -	£ -	£ 60,000	
Contingency/Home to assess/winter	£ 696,000	£ -	£ -	£ 696,000	
Stepping Stones					£ 70,000
Harlow enhanced pro-active care					£ 76,011
Remaining:	**£ -**	**£ -**	**£ 39,000**	**£ 39,000**	**£ 558,989**

Uttlesford District Council –

January 2025 - relaunched grant application plans

Joint commissioning with rural transport,

Obesity focus.

Active Essex,

Leisure centres,

Dentists - affordable & NHS

Harlow District Council –

Proposed priorities for Health & Wellbeing Board are based on the H&W Strategy.

24/25 projects include:

Free counselling for 18-25 yr olds

Oral health & hygiene for children

Assisted gardening

Release project – recovering from addiction

Smile & Thrive – oral health & healthy eating

Natural Health service – river cruises

Shared Stores

Mental Health Toolkit

Harmony in Motion, Tai Chi & Qigong

Five Dinners

Museum & open road gardening

Winter warmers – hot meals, meter top-up & food vouchers

Sam's Place, families with SEND children

Local Authority Plans

Epping Forest District Council –

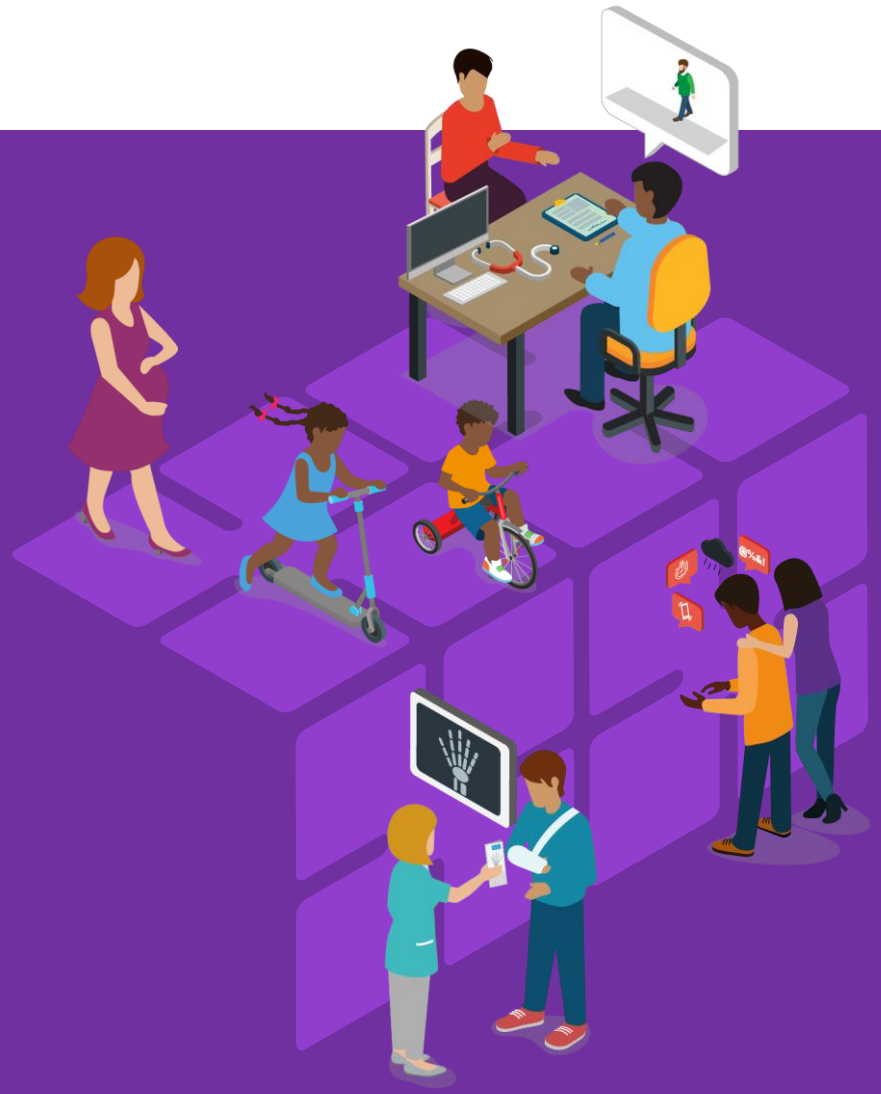
- Sustain and support the development of multi-agency hubs in the areas of Limes Farm (Chigwell), Oakwood Hill, Ninefields and rural areas
- Deliver a range of community health and wellbeing activities and events across the district in line with emerging health and wellbeing priories.
- Health Impact Assesments (HIA) Quality Assurance - HIA assess the impact of developments on local populations and set out mitigating factors to address negative outcomes.
- West Essex Short Breaks Programme - Develop a range of social and physical activity programme for children and young people aged 0-14.In partnership with Accuro (Uttlesford), Harlow Council.
- West Essex Adult Inclusion Project – support neurodiverse adults into community based social activity, volunteering and employment.
- Deliver a range of community activities and events specifically aimed at reducing loneliness and social isolation
- Youth Vaping – raise awareness of issues of vaping – delivered by youth council

- Supporting NHS recruitment – invest UKSPF funding to support NHS recruitment

West Essex Health and Care Partnership

NHS

Appendix 3 - Our population



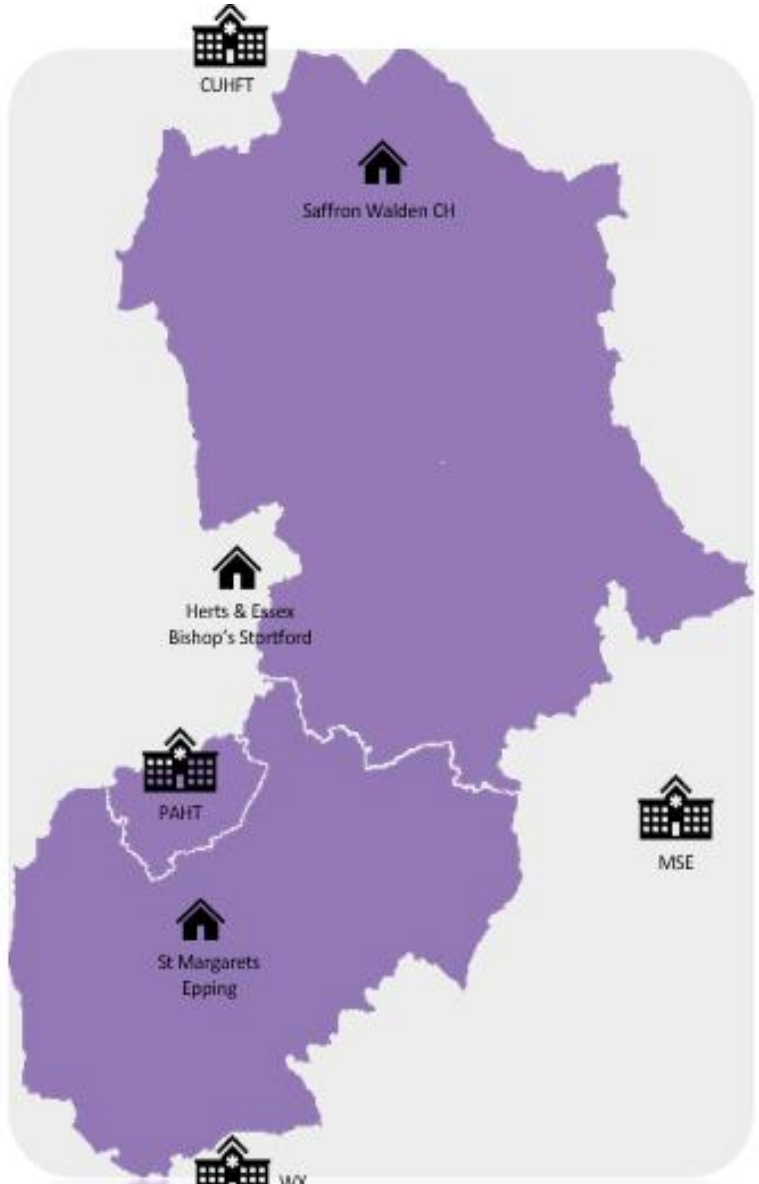
Working together
for a healthier future

Our Population

Our population

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

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



West Essex Health and Care Partnership

Who are our communities

Epping Forest

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

Population snapshot

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

Harlow

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

Population snapshot

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

Uttlesford

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

Population snapshot

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

Who are our wider communities

East & North Herts PCNs on the West Essex Border also contribute to activity flowing through PAHT, using adult community services from HCT. Uttlesford patients access services from Cambridge University Hospitals & Mid & South Essex and Epping Forest patients access Whipps Cross.

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

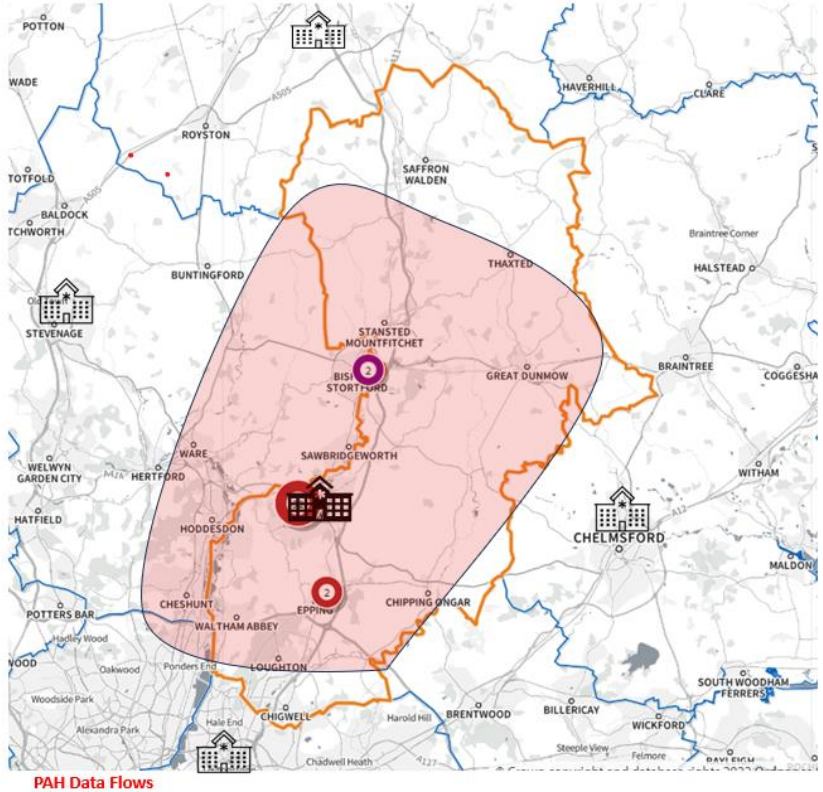
Stort Valley and Villages PCN
Clinical Lead: Dr Sian Stanley
Frailty admissions rate: **1664**
4.7% reduction
INT: **Mature**

Hoddesdon and Broxb PCN
Clinical Lead: Dr Rob Mayson
Frailty admissions rate: **1679.1**
6.9% increase

E&N Herts Frailty Admission Trajectory

INT- Proactive case management		Registered population 65+	Proposed INT capacity	Total admissions avoided per annum	Year 1 case load capacity	Year 2 caseload capacity
Broxbourne Alliance	0.079147	8181	136	27	95	136
Hatfield*	0.038302	3959	160	32	46	92
Hertford and Rurals	0.134786	13932	156	31	120	156
Hitchin and Whitwell	0.086432	8934	143	29	104	143
Hoddesdon & Broxbourne	0.086403	8931	126	25	104	126
Icknield	0.117788	12175	176	35	120	176
Lea Valley Health	0.051604	5334	102	20	62	102
Stevenage North	0.072549	7499	136	27	87	136
Stevenage South	0.10375	10724	148	30	120	148
Stort Valley & Villages	0.09957	10292	207	41	119	207
Ware and Rurals	0.071456	7386	107	21	86	107
Welwyn Garden City A*	0.058212	6017	179	36	70	140
ENH Total	1	103364	1778	356	1132	1669
Admisisons avoided per annum					226	334
Percentage of PHM modellled aspiration					63%	94%

5 cases needed to avoid 1 admission



West Essex Health and Care Partnership

To help everyone in our area live long and healthy lives by supporting independence and providing seamless care

Our Population – what the data tells us

The recently published Overview of Health in Hertfordshire & West Essex ICB report highlighted specific areas of focus to be considered in the development of the Integrated Delivery Plan

- Population growth in HWE is higher than the ONS projection at 6% since 2018 and with significant house building plans in West Essex this will continue to rise. Population growth is fastest in the 65+ age group at 10%
- Over-arching indicators show higher rates of premature mortality for Harlow & neighbouring Broxbourne
- Less than half the children receiving free school meals achieve a good level of school readiness at the end of reception year. For children the data shows higher levels of obesity with a long term rising trend in obesity.
- Fewer people aged 45+ have had a blood pressure check in HWE compared to national & regional averages, there is an increasing trend in hypertension prevalence in WE which suggests improved diagnosis and follows the medium term plan focus on HT diagnosis actions
- Diabetes prevalence continues to increase in line with national projections. Emergency care for diabetic ketoacidosis, hypoglycaemia, diabetic foot disease and angioplasty are statistically worse than national average and acute care length of stay is longer for these patients than those without diabetes.
- Prevalence of depression & serious mental illness are lower in HWE compared to the national average & declining.The rate of suicide in HWE is statistically lower than the national & regional averages, reducing over the period 2018-20. The suicide rate in males is 3.4times higher than in females.
- The rate of emergency admissions for people with dementia is highest in WE although likely due to the high diagnosis rate. The directly standardised mortality rate from dementia is higher in Harlow & Epping and lower than the national in Uttlesford.

West Essex HCP – Integrated Delivery Plan – Population Health

- Over-arching indicators show higher rates of premature mortality for Harlow & neighbouring Broxbourne:

Indicator Name	Time period	England	East of England	HWE ICB	WE HCP	Epping Forest	Harlow	Uttlesford	Hertfordshire	Essex
Emergency readmissions within 30 days of discharge from hospital (Persons All ages) %	2023/24	14.8	13.8	13.2		13.4	13.3	11.8	#	#
Under 75 mortality rate from all causes (Persons <75 yrs)	2022*/ 2023	341.6 →	*312.4	*280.6		288.2 →	390.1 →	231.9 →	292.5 →	318.9 →
Under 75 mortality rate from causes considered preventable (Persons <75 yrs)	2022*/ 2023	153.0 →	*134.9	*119.8		114.3 →	189.9 →	106.0 →	124.2 →	135.5 →
Mortality rate from a range of specified communicable diseases, including influenza (Persons All ages)	2021 - 23/ 2022*/ 2023^	^16.4 ↑	*11.1	*11.2		8.5	12.8	10.7	12.9	10.8

Less than half the children receiving free school meals achieve a good level of school readiness at the end of reception year.

For children the data shows higher levels of obesity with a long term rising trend in obesity.

Indicator Name	Time period	England	East of England	HWE ICB	WE HCP	Epping Forest	Harlow	Uttlesford	Hertfordshire	Essex
Reception prevalence of overweight (Persons 4-5 yrs)	2023/24	12.4 ↓	12.0	11.7 →	12.8 →	11.9 →	13.4 →	13.3 →	11.4 →	12.5 →
Reception prevalence of overweight (including obesity) (Persons 4-5 yrs)	2023/24	22.1 ↓	20.5	19.8 →	21.7 →	20.2 →	24.4 →	20.5 →	19.2 →	21.0 ↓
Year 6 prevalence of overweight (Persons 10-11 yrs)	2023/24	13.8 ↓	13.4	12.6 →	13.4 →	13.8 →	15.5 →	10.6 →	12.4 →	13.4 →
Year 6 prevalence of severe obesity (Persons 10-11 yrs)	2023/24	5.5 →	4.7	4.0 ↑	4.3 →	3.8 →	5.7 →	3.0 ↑	3.9 ↑	4.6 ↑

West Essex Health and Care Partnership

West Essex HCP – Integrated Delivery Plan – Population Health

- Children & young people in West Essex have a higher emergency admission rates in areas of higher deprivation

Indicator Name	Time period	England	East of England	HWE ICB	WE HCP	Epping Forest	Harlow	Uttlesford	Hertfordshire	Essex
Admissions of babies under 14 days (Persons <14 days) per 1,000	2020/21*/ 2022/23	84.8 ↑				*57.1	*35.6	*60.8	104.5 →	75.5 ↑
A&E attendances (under 1 year) (Persons <1 yr) per 1,000	2022/23	1132.3				1213.8	1687.9	966.8	1239.8	1112.1
A&E attendances (0 to 4 years) (Persons 0-4 yrs) per 1,000	2022/23	797.3				780.0	1148.0	602.9	820.7	805.8
Emergency admissions (0 to 4 years) - registered population (Persons 0-4 yrs) per 1,000	2020/21 - 22/23	137.2	123.7	109.2	68.6					
Child mortality rate (1-17 years) (Persons 1-17 yrs)	2018 - 20*/ 2020 - 22	10.4			*8.1				8.0	10.0

Cardiovascular Disease:

Fewer people aged 45+ have had a blood pressure check in HWE compared to national & regional averages, , there is an increasing trend in hypertension prevalence which suggests improved diagnosis and follows the medium term plan focus on HT diagnosis actions.

Diabetes prevalence continues to increase in line with national projections. Emergency care for diabetic ketoacidosis, hypoglycaemia, diabetic foot disease and angioplasty are statistically worse than national average and acute care length of stay is longer for these patients than those without diabetes.

West Essex HCP – Integrated Delivery Plan – Population Health

Mental Health

Prevalence of depression & serious mental illness are lower in HWE compared to the national average & declining.

The rate of suicide in HWE is statistically lower than the national & regional averages, reducing over the period 2018-20. The suicide rate in males is 3.4times higher than in females.

Indicator Name	Time period	England	East of England	HWE ICB	WE HCP	Epping Forest	Harlow	Uttlesford	Hertfordshire	Essex
Depression: QOF prevalence - retired after 2022/23 (Persons 18+ yrs)	2022/23	13,2	12,1	11,9	11,8	9,9	13,3	13,1	11,9	12,1
Depression: QOF incidence - new diagnosis (Persons 18+ yrs)	2023/24	1,5	1,1	1,2	1,0	0,9	1,0	1,2	1,2	1,1
Mental Health: QOF prevalence (Persons All ages)	2023/24	1,0	0,9	0,8	0,8	0,9	0,8	0,7	0,9	0,8
Learning disability: QOF prevalence (Persons All ages)	2023/24	0,6	0,6	0,5	0,4	0,3	0,5	0,3	0,6	0,5
Emergency Hospital Admissions for Intentional Self-Harm (Persons All ages)	2022/23	126,3	107,0	78,4		43,5	72,5	59,3	84,2	98,0
Attended contacts with community and outpatient mental health services, per 100,000 (Persons All ages)	2019/20	30674		28298	22455				29644	22968
Inpatient stays in secondary mental health services, per 100,000 (Persons All ages)	2019/20	241		195	205				191	234
Suicide rate (Persons 10+ yrs)	2018 - 20*/ 2020 - 22^/ 2021 - 23	10,7	^9,1	^7,3	*10,9	11,2	7,0	8,6	8,1	8,8

The dementia diagnosis rate in HWE is 65.2% (12,701 people recorded as having dementia compared to estimate 19,490), compared to the national target of 2/3rd of people with dementia receiving a diagnosis.

The rate of emergency admissions for people with dementia is highest in WE although likely due to the high diagnosis rate.

The directly standardised mortality rate from dementia is higher in Harlow & Epping and lower than the national in Uttlesford.

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

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

Integrated Delivery Plan

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1. Foreword from the MHLDN HCP's Co-Chairs

As co-chairs of the Hertfordshire Mental Health, Learning Disability and Neurodiversity Health and Care Partnership (MHLDN HCP), we are pleased to introduce our first Integrated Delivery Plan.

Over the last three years, the MHLDN HCP has developed into a mature partnership of statutory and non-statutory partners. By bringing together the insight and expertise of different sectors, local organisations and our communities, we make tangible improvements to the lives of people with mental illness, people with learning disabilities and neurodivergent people.

The pace of change is accelerating, with significant reforms taking place across both Local Government and the NHS. In this context, the MHLDN HCP is how we will maintain a collective focus, as a whole system, on what our residents, patients, service users and carers tell us is most important – accessible, high-quality, compassionate and enabling care and support for them and for their loved ones.

This Integrated Plan sets out how the MHLDN HCP will prioritise activity and delivery for the next three years. It establishes how we will meet nationally set targets as well as how we will deliver our own local strategies and priorities. Bringing this together into one single plan allows the MHLDN HCP to lead, monitor and challenge delivery.

All the activity we have identified requires collaboration and joint working across different organisations. We can foster the innovation that comes from bringing together different professions, practitioners and people with lived experience.

In partnership, we will tackle the variation and inequalities that stop people with mental illness, people with learning disabilities and neurodivergent people from living long, healthy and happy lives.

Karen Taylor, Chair

Chris Badger, Chair

2. Introduction to the Hertfordshire Mental Health, Learning Disability and Neurodiversity Health and Care Partnership

The Hertfordshire Mental Health and Learning Disability Collaborative (as the HCP was originally titled) was established in November 2019, based on the following principles:

- The mental health and learning disability needs for the whole population of Hertfordshire needed to be met in any model of system delivery – covering the range of needs, from low-level and episodic support to the interventions provided for people with severe mental illness and learning disabilities
- Any model must also support people living with mental illness and learning disabilities with their holistic needs including their physical health
- To do this effectively required the alignment and integration of mental health services and social care services and so any model should align with the County Councils' boundaries
- Existing arrangements in support of this integration, specifically the pooled budget for mental health and learning disabilities in Hertfordshire and the formal joint commissioning arrangements should be recognised and provide the foundation for further development
- Effectively supporting this population requires strong collaborative working with the place-based partnerships.

Drawing on these principles, the HCP was established and brought together partners from across the health and social care system, including statutory and VCFSE sectors.

Together, these partners developed a vision for Hertfordshire:

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

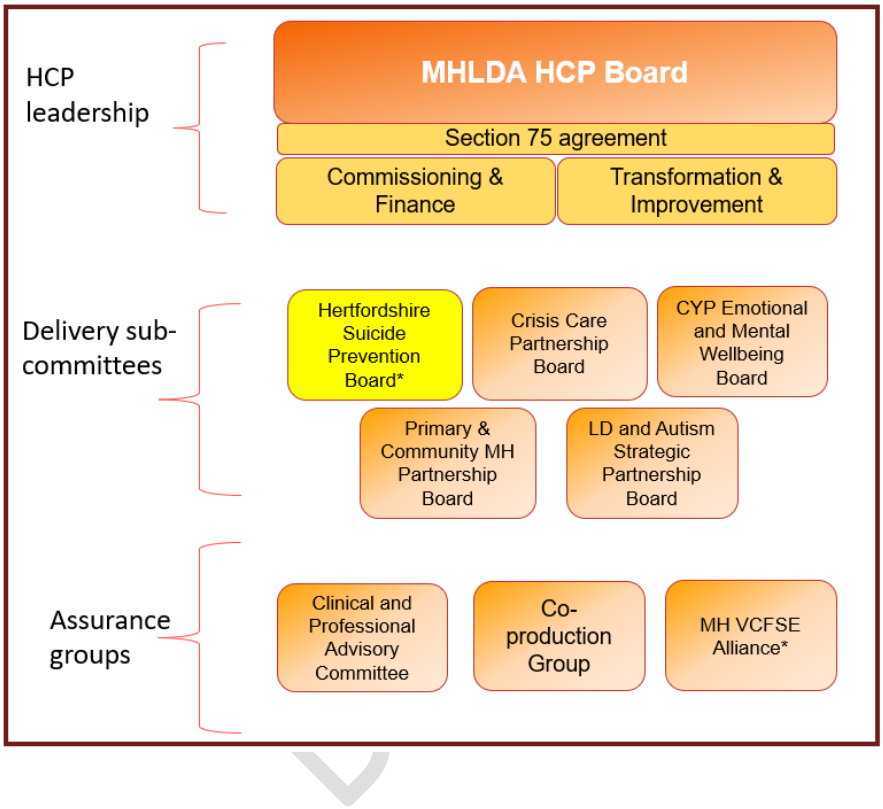
This vision was supported by four guiding principles, which outlined the HCP's ambition for what partnership working could achieve.

- **Providing a strong mental health, learning disability and neurodiversity voice across the system**
- **Ensuring safe, high-quality mental health, learning disabilities and neurodiversity support and services**
- **Focussing on preventing people from becoming unwell and promoting positive health and wellbeing**
- **Integrating mental and physical health and care support**

Since its first meeting, the MHLDN HCP has matured into a true multi-agency partnership. It provides strategic leadership and oversight of activity taking place across different agencies and focuses on those areas where collaboration and integration can result in tangible improvements for local people.

The MHLDN HCP is co-chaired by the Chief Executive of HPFT and HCC's Executive Director of Adult Care Services, reflecting the longstanding integrated arrangements that already exist around mental health and learning disability services.

The MHLDN HCP also comprises a set of delivery sub-committees, which, in turn, mobilise the appropriate local organisations and people with lived experience to progress key programmes of work.



The HCP works closely with the other Health and Care Partnerships in the system, aligning its transformation activity with their programmes and mobilising the relevant clinical and operational expertise so that the needs of people with severe mental illness, people with learning disabilities and neurodivergent people feature in all local service developments.

The HCP also interfaces with the East of England Mental Health and Learning Disability Provider Collaborative – made up of the six NHS mental health trusts providing services across the East of England – with responsibility for the commissioning at a regional level inpatient mental health beds for children and young people, low and medium secure inpatient beds for adults with a learning disability or a mental health issues, specialist inpatient services for adults with eating disorders and mother and baby services for women with a serious mental illness.

3. National Context

Mental Health

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

Nationally there has been a significant growth in demand for mental health support. In April 2024 there were around one million people nationwide waiting for mental health services.

In England and Wales, suicide was the leading cause of death in people aged 5-34 years in 2018. In males aged 20-34 years, almost 26% of deaths were by suicide.

The Darzi review, published in 2024, found that:

- The prevalence of depression has increased from 5.8 per cent in 2012 to 13.2 per cent a decade later in 20228.
- The rise in need for mental health services is not evenly distributed in the population.
- For adults, mental health referrals have been increasing at a rate of 3.3 per cent a year. But for children and young people, the rate of referrals has increased by 11.7 per cent a year from around 40,000 a month in 2016 to almost 120,000 a month in 2024.
- People with a mental health flag tend to experience wait times that are approximately 25 per cent longer than those without.
- In 2023-24, more than 80,000 people with mental health crises waited more than 12 hours and more than 26,000 waited for more than 24 hours in A&E departments. Analysis from the RCEM showed that patients in 2022 with a primary diagnosis of mental illness were twice as likely to wait for 12 hours or more than the rest of the population.

Mental health accounts for more than 20 percent of the disease burden but less than 10 percent of NHS expenditure.

There are a number of national programmes and initiatives in place to address these issues, following on from the Five Year Forward View for Mental Health and the NHS Long Term Plan. These programmes concentrate on:

- Community Mental Health Transformation
- Inappropriate use of out of area mental health beds
- People with significant mental health concerns in the community who do not engage with services – following learning from the recent Nottingham review
- Increasing access to support for children and young people, including through the expansion of the Mental Health Support Teams in schools programme

- Increasing employment rates for people with mild to moderate mental health issues through the Talking Therapies and Individual Placement Support programmes
- Mental Health, Learning Disability and Autism Inpatient Quality Transformation programme, and Quality of Care programme.
- Supporting people in a Mental Health crisis
- Several specific service developments relating to service areas:
    - Perinatal mental health
    - Early Intervention in Psychosis
- Eating Disorder services.
- The national Suicide Prevention Strategy, addressing the number of people who die by suicide.

The Mental Health Bill, currently making its way through Parliament, aims to strengthen the voice of people subject to the Mental Health Act, to add statutory weight to people's rights to be involved in planning for their care and to inform choices regarding their treatment, care and support.

Learning Disabilities

A learning disability is a lifelong condition that affects how a person learns new things. It can be caused by various factors, such as brain development problems, illness or injury in early childhood, or genetic conditions.

A learning disability is different for everyone. Lots of people who have a learning disability can work, have relationships, live alone and get qualifications. Other people might need more support throughout their life.

A profound and multiple learning disability (PMLD) is when a person has a severe learning disability and other disabilities that significantly affect their ability to communicate and be independent. Someone with a profound and multiple learning disability might have difficulties seeing, hearing, speaking and moving. They may have complicated health and social care needs due to these or other conditions.

There is no comprehensive dataset that records the prevalence of learning disabilities in England. However, it was estimated that there were approximately 1.3 million people with learning disabilities living in England in 2020 – equivalent to 2.2% of adults and 2.5% of children.

The Department of Education publishes annual reports on the number of children with special educational needs (SEN) and the support they receive at school. SEN is not equivalent to a diagnosis of learning disabilities; however, three categories of SEN are associated with learning disabilities: moderate learning difficulty, severe learning difficulty and profound and multiple learning difficulties. Taken together, these terms are approximately equivalent to the adult term 'learning disabilities.' In 2018, there were 34 per 1,000 children with learning disabilities known to schools (where their primary need was either moderate, severe or profound and multiple learning difficulties).

There are a number of national programmes and initiatives in place to address these issues including:

- Building the Right Support, a programme to improve the lives of people with a learning disability, reducing the number of people in mental health inpatient beds and reducing health inequalities.
- The Learning from lives and deaths – People with a learning disability and autistic people (LeDeR) programme and our local implementation of our reviews, annual report and learning into action works.
- The national Core20PLUS5 programme to reduce health inequalities. The approach defines a target population – the 'Core20' - the most deprived 20% of the national population, plus locally defined underserved populations, such as people with drug and alcohol dependence, people with a learning disability and autistic people. It then identifies five clinical areas requiring accelerated improvement, including serious mental illness, early cancer diagnosis, chronic respiratory disease and hypertension case finding., which includes people with mental health as a priority group
- The expected Mental Health Act reforms and resulting local implementation.

Neurodiversity

'Neurodiversity' refers to the natural diversity in human brains. Neurodivergence is the term for when someone's brain processes, learns, and/or behaves differently from what is considered "typical". Some neurodivergent conditions include:

- Dyslexia
- Dyspraxia (also called Developmental Coordination Disorder, or DCD)
- Dyscalculia
- Attention Deficit Hyperactivity Disorder (ADHD)
- Autism Spectrum Condition (ASC).

The two most common neurodivergent presentations in health and social care services are Autism and ADHD.

Autism is a lifelong developmental disability that affects how a person communicates with, and relates to, other people and the world around them. It is estimated that around 700,000 people in the UK have a diagnosis of autism. The estimated prevalence of autism in adults in England is 1.1%.

Autistic people often have co-existing physical health conditions or mental health problems that, if unrecognised and untreated, may further impair their psychosocial functioning. The most common comorbidities in autistic people include mental health disorders (including anxiety and depression, OCD, and ADHD), sensory problems, gastrointestinal problems and epilepsy.

Autism is considered neither a learning disability nor a mental health problem, although both can be more common among autistic people. It is estimated that 80% of autistic young

people and adults experience mental health issues during their life, with anxiety and depression particularly common. Furthermore, it is estimated that one in three adults with a learning disability also have autism.

In July 2021, the Department of Health and Social Care and the Department for Education published a national strategy for autistic children, young people and adults. The Strategy outlined specific ambitions related to six key areas: helping people to understand autism; helping autistic children and young people at school; helping autistic people to find jobs; making health and care services equal for autistic people; making sure autistic people get help in their communities and; help for autistic people in the justice system.

ADHD is defined by the World Health Organization as a persistent pattern of inattention or hyperactivity-impulsivity that has a direct negative impact on academic, occupational, or social functioning. Around 1 in 20 children are estimated to be impacted by ADHD globally.

The number of referrals for ADHD assessments and treatment, as well as the number of prescriptions provided, has increased significantly. There are challenges with current service modals nationally and their ability to keep pace with demand as well as ongoing discussion as to the balance to be struck between the use of medication and therapeutic treatment options. There is also variation in experience and outcomes for different populations.

In March NHS England launched an ADHD Taskforce in March 2024 to work alongside government, the NHS, voluntary sector and experts by experience to identify ways to improve care for people living with ADHD. The Taskforce is expected to publish an interim report for feedback ahead of a final report later in the year.

4. Understanding our population health needs

As a system we have a detailed understanding of the prevalence of local needs and the level of demand for services.

Joint Strategic Needs Assessment

As an HCP, our work activity is underpinned by the comprehensive analyses provided through Joint Strategic Needs Assessments. The full range of evidence and analysis available includes:

Adult Mental Health

- JSNA of Adult Mental Health and Wellbeing (2025) (Mental Health JSNA Adults)

Children's Mental Health

- JSNA of Children's Mental Health and Wellbeing (2025) (Mental Health Children and Young People JSNA)
- JSNA of Perinatal Mental Health and Wellbeing (2025) (Perinatal Mental Health JSNA)

Impact of mental health on other services

- Demand of mental ill health on services in Hertfordshire (2023) - Demand of mental ill health on services)

Learning Disabilities and Neurodiversity

- JSNA of Learning Disabilities (2024) (learning-disabilities-jsna.pdf)
- JSNA Autism (2023) (Autism Spectrum Disorder JSNA)
- JSNA Lite Bite (2025) reviewing the available evidence on possible links between autism spectrum disorder, substance use and poor mental health (lite-bite-autism-co-occurring-mh-substance-use.pdf)
- JSNA Lite Bite (2022) exploring the risk of suicide and suicide prevention strategies in children and young people with Attention Deficit Hyperactivity Disorder (ADHD) and Autism Spectrum Disorder (ASD) (lite-bite-cyp-adhd-asd-suicide-risk.pdf)

Older People

- JSNA of Dementia (2022) - hertfordshire.gov.uk/microsites/jsna/jsna-documents/dementia-jsna.pdf
- JSNA of Ageing Well – (Ageing Well JSNA (2023)

Growth in demand

Analysis conducted in 2021, noted that the pre-Covid pattern of around 75,000 referrals per year in relation to mental health and estimated that Hertfordshire might expect to see up to as many as 89,000 new referrals per year. As noted in Section 3, the increase in demand has been seen nationally and has been experienced across local services.

Addressing inequalities

People with learning disabilities and people with serious mental illness are dying at a much younger age than the general population. They are dying of preventable physical health conditions. Some are dying without receiving care and treatment that is freely available on the NHS.

The improvements in healthy life years and life expectancy of the general population, through investment in public health, have not been realised to the same extent amongst people with autism, learning disabilities and people with serious mental illness. These health inequalities were compounded by the Covid-19 pandemic.

The Learning Disability Mortality Review Programme (LeDeR) was established in 2017 to improve health care, reduce health inequalities and prevent premature deaths amongst people with a learning disability and autistic people. The 2025 LeDeR research shows that the median age at death of people with a learning disability in Hertfordshire was 64, compared to a general population median of 81 years. There is a similar disparity for people with severe mental illness

While Hertfordshire is overall less deprived than the national average, there are concentrated pockets of significant deprivation, particularly in parts of Hertsmere, Stevenage, Broxbourne, Borehamwood, Waltham Cross and central Watford—which rank among the most deprived 10% nationally. Currently, 10% of the county's population fall within the Core20 most deprived cohort.

Analysis by the Jospeh Rowntree Foundation and The King's Fund described the impact of deprivation on mental health: in the poorest communities, the depression rate was twice as high, double the number of people were in contact with mental health services, and nearly four times as many were sectioned under the mental health act as in the least deprived areas.

Our own local analysis highlights some key areas of variation and disparity, where people from with different protected characteristics can experience differences in access, experience and outcome from services and support. Specific examples include:

- People from Black/Black British groups are three times more likely to be detained under the Mental Health Act
- People from Black/Black British groups are less likely to be offered least restrictive interventions
- Community Treatment Order are used over four times more often for the Black/Black British group
- People from Asian/Asian British group are underrepresented in mental health and learning disability services.
- Referral rates for children and young people from the most deprived 20% of the local population are significantly higher at 2174 per 100,000 in comparison to those from the least deprived areas (1340 per 100,000)

- Access rates for children and young people from BAME communities were significantly lower (1449.9 per 100,000) than those from non-BAME communities (2488.9 per 100,000).

5. Our current performance and delivery

The MHLDN HCP coordinates activity across a wide range of partner organisations. While each organisation takes responsibility for its own services and performance, the MHLDN HCP is developing its capabilities to provide system-wide monitoring and review of the key outcomes measures and activities for people with mental illness, people with learning disabilities and neurodivergent people.

As a system we have some real areas of strength, where we are delivering over and above targets and expectations, For example:

- More people with learning disabilities are receiving annual health checks, exceeding the national target
- The number of people with severe mental illness receiving annual health checks is increasing, although there is more to do before we hit the national target
- We have reduced the number of people with learning disabilities in inpatient beds – both children and adults
- We have maintained our performance in supporting young people to access mental health services

However, we know that there are key areas and services where performance needs to be improved. For example:

- Too many people are waiting too long for an Autism and/or ADHD assessment
- We are still not meeting the Dementia Diagnosis target in Hertfordshire
- Children and Young People with eating disorders are facing delays in accessing services and support
- Too many people are placed in out-of-area settings, which can be less conducive to their support and recovery

Key actions to address these areas of poor performance are contained in the delivery plans in Section 8. The MHLDN HCP Quality, Transformation & Performance Committee has developed a performance overview report and will be responsible to identifying and addressing poor performance across the MHLDN HCP.

Public Health Outcomes Framework

The Public Health Outcomes Framework provides national and county level data and includes data on outcomes for people with mental illness and learning disabilities. A copy of the relevant indicators and existing performance is incorporated as Appendix B.

Hertfordshire performs better than the England average in relation to:

- Premature mortality in adults with severe mental illness
- Adults in contact with secondary mental health services who live in stable and appropriate accommodation
- Adults with a learning disability who live in stable and appropriate accommodation

- The percentage of the population who are in receipt of long-term support for a learning disability that are in paid employment
- Gap in employment rate for people (aged 18-69) who are in contact with secondary mental health services and on the Care Plan approach and the overall employment rate
- The percentage of the population who are in contact with secondary mental health services and on the Care Plan approach that are in paid employment
- Suicide rate

Hertfordshire performs below the England average in relation to:

- Gap in the employment rate between those who are in receipt of long-term support for a learning disability and the overall employment rate

Performance against NHS Operational Planning and Long Term Plan indicators (2024/25)

The NHS Long Term Plan and Operating Plan establish performance metrics to support the monitoring and delivery of NHS priorities. Our performance against these metrics is included as Appendix C.

Hertfordshire and West Essex has met or exceeded targets in relation to:

- The number of Children and Young People accessing mental health services
- The number of women accessing specialist community perinatal mental health services
- The number of adults who have had two or more contacts with community mental health services
- The number of people completing a course of treatment with Talking Therapies services

Hertfordshire and West Essex has improved performance but not yet met the target in relation to:

- Reliable recovery rates for people accessing Talking Therapies
- The percentage of people registered with SMI receiving a full health check

Hertfordshire and West Essex has not met the target in relation to:

- Dementia diagnosis rate
- Reliable improvement scores for people accessing Talking Therapies
- The number of inappropriate out of area placements for adults

6. Our local strategic context

Our plans and priorities have been developed within the wider system and partnership system in which we operate. This section summarises these strategies and the key elements relevant to the activity of the MHLDN HCP.

Health and Wellbeing strategies

a) Hertfordshire Health and Wellbeing Strategy

Hertfordshire's Health and Wellbeing Strategy sets out the vision and strategic priorities for improving health and wellbeing and reducing health inequalities in the County.

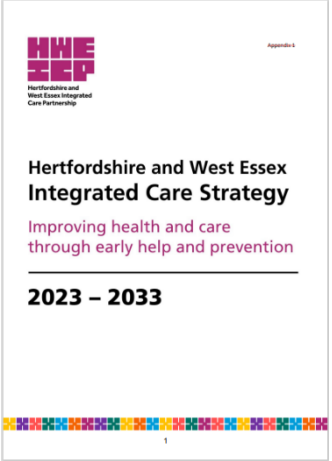
The Strategy established six priorities including one focussed on **Good emotional and mental wellbeing throughout life.** The Strategy sets out the following commitments to deliver this strategy:

- We address the stigma around mental health and champion initiatives such as the Just Talk campaign
- We develop a wider understanding of mental health, learning disabilities and autism across organisations and communities
- Children, adults and older people are supported to be socially connected in their communities to overcome isolation, build resilience and increase social connections
- Children and young people receive emotional and mental wellbeing support in a range of settings, including the further development of the Mental Health Support Teams in schools Initiative
- We provide a wellbeing offer that supports early identification of mental health problems and improve early identification both through healthcare pathways and in our work with the community
- People in crisis receive appropriate and timely support from all organisations
- The physical health of people with serious mental illness, learning disabilities and autism is prioritised and the stark differences in life expectancy for people with serious mental illness and/or learning disabilities is addressed
- Hertfordshire develops a strategic all-age approach to supporting people with neurodiversity including Autism and ADHD
- People with dementia are diagnosed earlier and supported by integrated services and in dementia friendly communities

- We provide tailored support for people who are homeless or sleeping rough, considering issues such as ability to commit to treatment, chaotic lifestyles and dual diagnosis
- That, in line with Hertfordshire's Suicide Prevention Strategy, we work together so that no one gets to the point where they feel that suicide is their only option

Hertfordshire and West Essex strategies

a) Hertfordshire and West Essex - Integrated Care Plan



The Hertfordshire and West Essex Integrated Care Strategy sets out how system partners will work together over the next 10 years to create healthy and safe communities where everyone's contributions are valued, and we all have the opportunities and support we need to thrive.

The Strategy identifies six strategic priorities including a priority to **Improve our residents' mental health and outcomes for those with learning disabilities and autism**. Within this strategic priority, the Strategy identifies the following actions:

1. Reduce the gap in life expectancy between people with a learning disability and SMI compared to the general population and improve integrated pathways to access housing, education, employment, and skills
2. Ensure there are clear pathways and timely access to psychological therapies for children, young people and adults who require this support
3. Work more effectively as a system to ensure that reasonable adjustments are integrated in all pathways through implementing the NHS Accessible Standards.
4. Develop and deliver an integrated neurodiversity service for children and young people
5. Reduce suicide through a focus on system support of suicide prevention
6. Work with local employers and partners to ensure they develop suitable opportunities and roles for people with LD and SMI to access and maintain employment and to develop new skills.

b) Hertfordshire and West Essex Integrated Care Board – Medium Term Plan

Hertfordshire and West Essex Integrated Care Board's (HWE ICB) Medium Term Plan sets out its vision for Hertfordshire and West Essex and the key priorities and shifts in care models that will be needed to achieve it. The Medium Term Plan set out the areas where HWE ICB will focus its efforts and investment in coming years.

The Medium Term Plan sets out the five key transformation objectives that will support the delivery of its vision

- Give every child the best start in life
- Increasing healthy life expectancy and reducing inequality
- Improving access to health and care services
- Increasing the number of residents taking steps to improve their wellbeing
- Ensuring financial sustainability

Underneath these five transformation objectives are key ambitions related to improving outcomes for people with mental illness, learning disability and autism. See section x

c) Hertfordshire and West Essex Integrated Care Board – Joint Forward Plan

The Joint Forward Plan outlines the specific activity that Hertfordshire and West Essex Integrated Care Board (HWE ICB) will take forward to support the delivery of its health and care strategic ambitions including its Medium Term Plan and priorities for the next two years.

The Joint Forward Plan identifies five system priorities – the five most important things that HWE ICB and its partners must deliver over the next two years.

- A reduction in the backlog for children's care
- Reduce inequality with a focus on outcomes for cardiovascular disease and hypertension
- Elective Care Recovery
- Improve urgent and emergency care through more anticipatory and more same day emergency care
- Better care for Mental Health crises

While all five priorities will impact on individuals with mental illness, learning disabilities and neurodivergent people, the priority related to mental health crisis and the elements of the children's priority related to neurodivergent young people are clearly within the remit and responsibility of the MHLDA HCP.

In relation to mental crisis, the Joint Forward Plan aims for an 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.

The Plan establishes an ambition to improve our crisis support to provide better care and outcomes for our residents by reducing long waits and Section 136 demand, and reducing out of area placements, preventable admissions and suicides.

In relation to Children and Young People, the Joint Forward Plan aims to develop improved and integrated services, including services for children with special educational needs and disabilities (SEND).

Success would improve equity in access to services, enable the waiting times for community paediatric services and Attention Deficit Hyperactivity Disorder (ADHD) assessment to be reduced and improve outcomes for children to support giving them the best start in life.

d) Hertfordshire and West Essex Health Creation Strategy

The Hertfordshire and West Essex Health Creation Strategy is a direction of travel document, to help all parts and levels of the Hertfordshire and West Essex Integrated Care System (HWE ICS) to build on the excellent partnership working prior to, but especially during, the Covid pandemic and to ensure that the importance of the work the VCFSE sector does is factored in and acknowledged across the system.

It seeks to openly address the challenges of effective joint working with the VCFSE sector, often due to fragmented and complex local delivery models within the sector, differing service provision, resourcing challenges, fragmented funding and uncertain funding streams.

It also starts to lay the foundations needed to ensure the VCFSE sector are treated as equal partners in HWE ICS.

The strategy sets out four key ambitions:

- We will build on community assets
- We will make every contact count
- We will find out who is missing out
- We will ensue there is always someone who can help

e) Hertfordshire and West Essex supporting strategies

The activity of the MHLDN HCP is also informed by the following HWE ICS strategies:

- HWE ICS Quality Strategy
- HWE ICS People Strategy 2023-2025
- HWE ICS Digital Strategy 2022-2032
- HWE ICS Estates Infrastructure Strategy
- HWE ICS Urgent and emergency care strategy 2024-2029

Local strategies

There are number of local strategies which have been developed or supported by the MHLDN HCP and which define our activity and delivery against key national and local priorities. Each of these strategies is accompanied by an action plan.

The **Hertfordshire Dementia Strategy 2023 -2028** establishes a vison of a county where people affected by dementia have access to timely, skilled, and well-coordinated support from diagnosis to end of life, which helps achieve the outcomes that matter to them.

The Strategy identifies seven key themes, identified through work with people affected by dementia, our voluntary sector partners, health and care professionals and providers. These seven themes are the structure and priorities around which local delivery is coordinated.

1. Promoting Health and Wellbeing
2. Enabling Equitable and Timely Access to Diagnosis.
3. Ensuring People with Dementia have Equitable Access to Appropriate Health and Care Services.
4. Supporting People Affected by Young Onset Dementia.
5. Supporting Carers of People with Dementia.
6. Preventing and Responding to Crisis.
7. Developing Dementia-Friendly Communities

The **Big Plan for adults with Learning Disabilities in Hertfordshire** is a joint-commissioning strategy developed by Hertfordshire County Council and NHS partners and based on what people with learning disabilities in Hertfordshire have said matters to them.

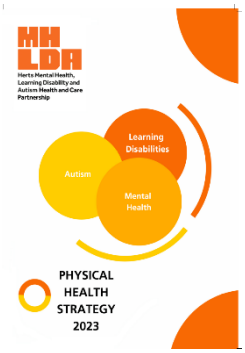
The Big Plan is focused on supporting people with learning disabilities to live well in Hertfordshire by helping people and their families to do more themselves and by supporting local communities to help people more. It identifies specific activity to take forward across three areas:

1. Good lives happen when we are healthy
2. Good lives happen when people live locally
3. Good lives happen when people are involved in their local communities

Hertfordshire Suicide Prevention Strategy's vision is to make Hertfordshire a county where no one ever gets to a point where they feel suicide is their only option. In practice, this means the ambition is for zero suicides.

The six key priorities for Hertfordshire are:

1. Support for men
2. Support for those bereaved by suicide
3. Addressing training needs
4. Support for children and young people
5. Reducing access to means of suicide
6. Support research, data collection and monitoring



The **Physical Health Strategy's** vision is to do everything possible to prevent the premature deaths of people with learning disabilities, people with mental illness and autistic people throughout the life span.

Its strategic ambition is to significantly improve the physical health of people with learning disabilities, people with mental illness and autistic people in a generation aiming to be at least as good as the wider population in Hertfordshire and West Essex by 2030.

To achieve this, the Strategy sets out actions to significantly improve the life expectancy of people with learning disabilities, people with mental illness and autistic people in a generation, by tackling the top causes of death, scaling up and standardising improvement programmes for the early recognition of physical health conditions and early intervention, aligned with the NHS Long Term Plan & Learning Disability Mortality Review Programme.

The Hertfordshire **All Age Autism Strategy** sets out the broad priorities for local health and care services for autistic people based on national legislation and guidance, as well as feedback from autistic people and their families. The all age autism strategy's priorities are as follows:

1. Autistic people have access to a timely diagnosis, and support while waiting for a diagnosis, plus post-diagnosis support.
2. Autistic people have equal access to reasonably adjusted mental health services when they need them.

3. Autistic people and their families have access to a range of support in their local communities.
4. Autistic people can fulfil their potential in education, employment, or training.
5. Autistic people have equal access to reasonably adjusted physical healthcare services when they need them and working to improve health outcomes for autistic people.
6. Autistic people who have ongoing care and support needs have access to appropriate services and support to lead a fulfilling life.

The **Carers Strategy for Hertfordshire** is a single Strategy for Adult Carers and Young Carers and is focused on delivering the specific objectives that carers have identified as most important to them. These objectives include:

1. Being informed and having access to the right information
2. Being able to sustain and develop a life outside of caring
3. Maintaining carers health and wellbeing
4. Receiving consistent and joined up services.

The **Hertfordshire Drug and Alcohol Strategy** sets out national and local evidence and an understanding of local need, to outline the priorities to address drug and alcohol harm for the next 5 years.

The Strategy sets out three key aims:

1. To tackle drug supply using robust enforcement measures, proactive policing, and effective information and intelligence sharing
2. To improve access for both people accessing drug and alcohol treatment services and carers, providing clear pathways into treatment, recovery, and support for both adults and young people
3. To prevent young people from becoming involved in substance use and support those that do

Within the second aim is a specific objective to improve support pathways and outcomes for individuals who have both substance use and mental health issues.

The **SEND Strategy** establishes a vision that in Hertfordshire we want all Children and Young People with special educational needs and disabilities (SEND) to be included and valued, so that they can live happy and fulfilling lives.

The Strategy is made up of five ambitions that underpin how services and support will be delivered across education, health and social care over the next 3 years:

1. Tailoring - Plan and deliver services that are flexible, respect individual wishes and meet individual needs.
2. Enabling - Continue to develop a skilled, learning workforce that strives for excellence and staff are proud of their own achievements and celebrate those of others.
3. Supporting - Provide sufficient and appropriate provision in Hertfordshire and within their community to meet children and young people's wishes and needs.
4. Collaborating - Work in partnership with other organisations to deliver the right services at the right time to prevent problems escalating.
5. Succeeding - Support all children and young people with SEND to achieve success in all areas of life, understand the impact of the pandemic and work to ensure our young people achieve their potential.

In addition to the strategies highlighted above, the activity of the MHLDN HCP is informed by the following system strategies.

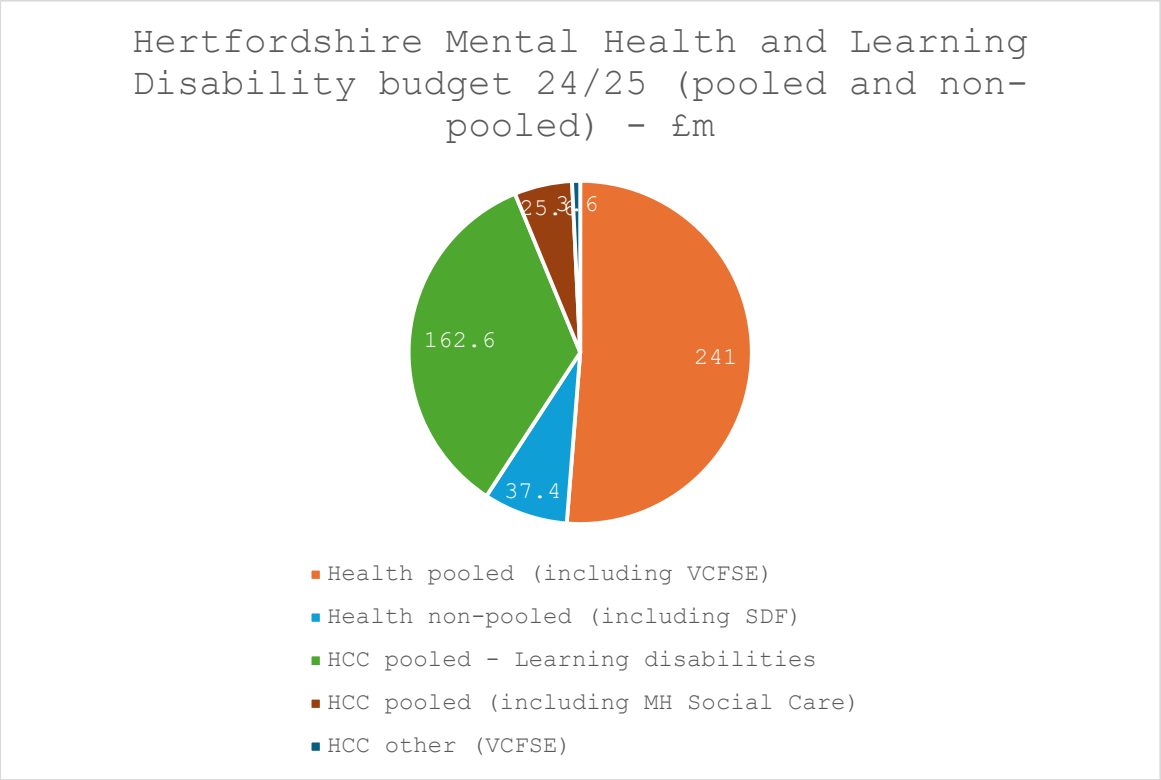
- Hertfordshire Gambling Harms Strategy
- Hertfordshire Public Health Strategy
- Hertfordshire Adult Care Services Plan 2021-2025
- Accessibility Strategy 2023 - 2026

7. Finance and productivity

The MHLDN HCP has a key role to play in delivering financial sustainability across the system. The current financial pressures being experienced across Local Government, the NHS and the VCFSE will require us to make difficult decisions in relation to what can be resourced. By working together, we can reduce the risk of duplication and consider how the collective resources of partner organisations can be aligned and directed to best effect.

The partners in the HCP hold responsibility for a pooled budget covering mental health and learning disability services across Hertfordshire County Council and Hertfordshire and West Essex ICB. The pool is overseen by the Integrated Health and Care Commissioning Team on behalf of the partners.

The total funding within the pooled budget was £454m in 2023/24, with contributions as detailed in the chart below



There are other elements of spend, overseen by the Integrated Health and Care Commissioning Team that are not sat within the pool. The MHLDN HCP's activity currently extends beyond just those services commissioned through the MH/LD pooled fund and includes activity in relation to dementia, suicide prevention and increasingly both adult and children's neurodiversity.

With the support of HWE ICB and HCC we will consider what other elements of system activity and funding are best determined once, at a county-level, through the MHLDN HCP including non-pooled funds. We will also need to consider how primary care allocations are made, recognising that delivery will often be at a neighbourhoods/PCN level but led and coordinated by the HCP.

Delivering value and efficiency savings

The national and local financial position across both the NHS and local government is challenging.

In 2025/26 efficiency savings described as Delivering Value are required to ensure that NHS budgets are balanced. The HPFT share of these savings is approximately £28million. Part of the solution to delivering these savings is to improve productivity. Nationally the areas highlighted where productivity can be improved in mental health include:

- Talking Therapy services
- Increasing the number of people seen by each clinician in community services for adults, children and young people
- Reducing length of stay in inpatient services
- Lowering temporary staffing costs
- Ensuring corporate costs are kept to an absolute minimum
- Exploring commercial opportunities

Hertfordshire County Council has a savings target of £42m in 2025/26, (on top of an extremely challenging savings target of £46m in 2024/25). This is set against an overall increase in budgets of £128m to ensure that services are maintained and improved for residents. Key transformation and savings programmes for the Authority are:

- Connect & Prevent Programme in Adult Care Services, which is the single largest efficiency programme within the Authority, delivering £25m of savings by 2028/29. This is through investment in a transformation prevention programme improving outcomes for people we support, enabling them to remain more independent for longer, preventing, reducing or delaying their need for long term care.

- Children's social care savings, delivering transformation in both supporting children to be at home with their families where appropriate, but also reducing the cost of their care where required

- Organisational Resourcing

The Local Authority continues to face significant risks in dealing with the impact of inflationary pressures, meeting increased service demand, (particularly in Adults with Disabilities and Children Looked After), and the impact of SEND and schools High Needs Block.

Further information can be found in HCC's Integrated Plan (budget).

8. Our Integrated Delivery Plan Priorities

Our priorities for the next 3 years have been designed to address the strategic and financial context as outlined in earlier sections in this report. They incorporate national priorities and operating plan expectations and deliver against the system key system priorities outlined in HWE ICB's MTP and JFP.

Our priority work is focussed on 10 key areas:

- Delivering better care for people experiencing mental health crisis
- Improving the availability of local beds to provide better, more effective care for inpatients and finding alternatives to admission
- Delivering integrated services and support for people with learning disabilities, neurodivergent people and their families and carers
- Delivering improvements in the emotional and mental wellbeing of children and young people and support for parent/carers
- Delivering a neighbourhood health model to increase access to mental support
- Delivering the Hertfordshire Suicide Prevention Strategy - making Hertfordshire a place where no one ever gets to a point where they feel suicide is their only option
- Developing better support and services for people with complex needs, in particular people with co-occurring mental health and substance use issues
- Delivering more joined-up support for older people's mental health including more integrated action around Dementia, memory support and support for carers
- Addressing the life expectancy gap for people with severe mental illness, people with learning disabilities and neurodivergent people by tackling the wider determinants of health and wellbeing
- Leading improvements in the mental wellbeing of people in Hertfordshire by championing public health, workplace and educational activity throughout the county

Delivering better care for people experiencing mental health crisis	
MHLDN HCP Senior Responsible Officer(s):	Sharn Tomlinson, CEO, Mind in Mid-Herts Katy Healy, COO, HPFT
Key partners involved:	Hertfordshire Constabulary, West Hertfordshire Hospitals Trust, East and North Herts Trust, CGL, East of England Ambulance Service, Herts MIND Network, Mind in Mid-Herts, Viewpoint, Hertfordshire County Council, Carers in Herts
MHLDN HCP Delivery Board	
The **Crisis Care Partnership Board (CCPB)** convenes partners across Hertfordshire to lead on the delivery of the National Crisis Care Concordat and Hertfordshire's Declaration on improving outcomes for people experiencing mental health crisis.	
Strategic alignment	
National	• Reduce 12 hour waits in A&E through: maximising the use of crisis alternatives, including 111 mental health option, crisis resolution and home treatment teams, and community mental health services to keep people well at home; ensuring robust system oversight and implementation of the mental health OPEL framework
HWE ICB MTP	• Improve access to health and care services
HWE ICB JFP	• Better Care for Mental Health crises • Improve urgent and emergency care
Local strategies	• Mental Health Crisis Support is a key element HWE ICB's Urgent and Emergency Care Strategy • Right Care, Right Person model of police resourcing has a key element focused on section 136 handovers
Delivery priorities for 2025/26	
• Respond to the increase in demand for Section 136 capacity through new capital investment • Lead joint work between mental health providers and police colleagues to maximise Section 136 productivity and reduce police handover time • Complete the system-wide review of Children and Young People Mental Health crisis support and implement its recommendations to measurably improve the experience and outcomes for children and young people	

- Address inequalities in access, experience and outcomes by implementing the Patient and Carer Race Equality Framework across Crisis Care Partner
- Develop a crisis team for people with Complex Needs (ASCENT) with go-live planned for Quarter 4 2025/26.
- Evaluate the effectiveness and impact of the Mental Health Response Vehicle
- Develop a new seven bed Crisis House
- Review the case for a Crisis Text service and how it can add value to existing crisis pathways

How will we know we are having an impact

- Proportion of admissions with no previous contact
- The proportion of adult MH A&E attendances waiting over 12hrs
- Increase response to Community Crisis Services urgent referrals
- 75% of inpatient discharges to have 72-hour post discharge follow up by March 2026

Medium term ambitions

- Review and refresh of the crisis model for older people
- Embed the new system-wide MH escalation procedure coordinated by the ICB System Coordination Centre.
- Improve pathways between community, crisis and specialist mental health support to keep people in the community and well at home. This will include working with NHS England through the "Community Mental Health Project" to review and enhance community Mental Health transformation.
- Improve consistency of practice and training to better integrate support for people in crisis by undertaking a full training needs analysis and implementing its recommendations
- Undertake a full system appraisal of capacity and demand for crisis and crisis alternatives to inform the development and appropriate resourcing of a single multi-agency crisis pathway

Risks and constraints

- Funding for the Mental Health Urgent Care Centre has not been confirmed for 2026/27.
- Bid for capital to support section 136 suite capacity has been submitted but we will not know the outcome until June 2025.
- Funding for Mental Health Response Vehicle for 2026/27 subject to findings and recommendations from an evaluation
- Uncertainty over budgets for 2025/26 and future years

Key co-dependencies with other programmes and decisions required from outside the Board

- Key co-dependency with the activity of the Hertfordshire Suicide Prevention Board including the evidence and intelligence from the Real Time Suicide Surveillance

activity and the Suicide Prevention pathway activity within HPFT and the acute hospital trusts • Key co-dependency with the Children and Young People's Emotional and Mental Wellbeing Board related to the review and redevelopment of the Children and Young People's Crisis offer.
What will feel different from the perspective of people accessing services/support and their carers
• More people who find themselves in crisis will receive support in an appropriate setting. Support will be provided by a variety of agencies and support will be more integrated to address each individual's specific needs.

Improving the availability of local beds to provide better, more effective care for inpatients and finding alternatives to admission	
MHLDN HCP Senior Responsible Officer(s):	Katy Healy, COO, HPFT Robin Goold, Head of Integrated Health and Care Commissioning Team, HWE ICB/HCC
Key partners involved:	Hertfordshire County Council, Independent Sector Providers, Herts Mind Network, Mind in Mid-Herts
MHLDN HCP Delivery Board	
HPFT's Transformation Board oversees and drives delivery of transformation and improvement activity within the Trust. The Board ensures that appropriate plans are in place to deliver measurable impact for service users, carers and families.	
Strategic alignment	
National	• Deliver the 10 High Impact Actions for mental health discharges and ensure that system discharge plans include mental health acute pathways, reducing average lengths of stay in the adult acute mental health pathway, improving local bed availability and reducing the need for inappropriate out of area placements
HWE ICB MTP	• Improve access to health and care services
HWE ICB JFP	• Better Care for Mental Health crises • Improve urgent and emergency care
Local strategies	• HWE ICB Urgent and Emergency Care Strategy
Delivery priorities for 2025/26	
• Implement the Culture of Care and National Inpatient Quality programme • Develop and deliver new clinical pathways for autism and psychosis (including schizophrenia and bi-polar disorder) • Deliver a new service for people with Emotionally Unstable Personality Disorder • Introduce an intensive enablement service – a new mental health and social care pathway for people with complex needs • Establish a new complex case panel to assist with discharge planning and opportunity to improve joint-work with Hertfordshire County Council and other providers • Create 15 adult acute beds on HPFT estate through the repurposing of Dove Ward • Implement a 14-bed Intensive Enablement Service for people with functional mental illness and complex needs • Scope the need for an Assessment and Treatment Unit for functional frailty • Implement a new integrated digital solution for flow management • Support and embed regional Mental Health discharge peer review findings	
How will we know we are having an impact (relevant performance indicators and targets)	
• A reduction in the average length of stay from 54.8 days to 51.8 days	

• A reduction to zero inappropriate out of area placements, subject to agreement on local block contracts • A reduction in readmission rates • Delivery of key Culture of Care outcomes
Medium term ambitions - activity planned for 2026/27 and 2027/28
•
Risks and constraints (including areas where funding not yet confirmed)
• Funding still to be confirmed for the ASCENT model • Confirmation of capital monies may be delayed leading to knock-on impact in service developments
Key co-dependencies with other programmes and decisions required from outside the Board
• Key co-dependency with the activity of the Crisis Care Partnership Board and the Learning Disability and Autism Strategic Partnership Board
What will feel different from the perspective of people accessing services/support and their carers
• All services users will be supported in the most appropriate, least restrictive way possible. • If admissions are required, people never stay longer than required for their effective treatment.

Delivering integrated services and support for people with learning disabilities, neurodivergent people and their families and carers	
MHLDN HCP Senior Responsible Officer(s):	Beverley Flowers, Deputy Chief Executive & Director of Strategy, HWE ICB Tracey Gurney, Operations Director, Adult Disability & Mental Health Services, HCC
Key partners involved:	HWE ICS, HCC (ACS), HCC Children Services, 0-25 service IHCCT, Children, Young People and Maternity Commissioning, Primary Care GP, HCP, Carers in Herts, Representative from Co-production Boards, HPFT, Public Health Commissioning and Operations, NHSE
MHLDN HCP Delivery Board	
The **Learning Disabilities and Autism Strategic Partnership Board** provides the strategic direction and oversight for the Learning Disabilities and Autism agenda in Hertfordshire. It drives the delivery of learning disabilities and autism programmes forward and ensures these programmes deliver the identified outcomes, minimise inpatient admissions and support children and adults to live in their local community.	
Strategic alignment	
National	• Work with local system colleagues to ensure that there is high quality and accessible community infrastructure in place for people with a learning disability and autistic people
HWE ICB MTP	• Increase healthy life expectancy and reducing inequality • Improve access to health and care services • Increase the number of residents taking steps to improve their wellbeing
HWE ICB JFP	• Reduce inequality with a focus on outcomes for cardiovascular disease and hypertension
Local Strategies	• Hertfordshire Health and Wellbeing Strategy • The Big Plan for Adults with Learning Disabilities • All-Age Autism Strategy • SEND Strategy
Delivery priorities for 2025/26	
• Reduce health inequalities through the effective delivery of STOMP/STAMP • Deliver the recommendations of the LeDeR Annual review with a focus on the actions to address the higher death rates in global majority groups	

- Sustain and increase the number of people with learning disabilities receiving an Annual Health Check
- Deliver the All-Age Autism Strategy and improve community-based services and support for autistic people
- Implement the recommendations from the National Discharge guidance and benchmarking review
- Implement the Mental Health Act reform recommendations related to Pre-DSR and workforce, Positive Behaviour Support and Risk Assessment & Management
- Undertake remaining Mental Health Act activity in relation to prevention, including intensive day opportunities and effective alternatives to admissions including crash pads/emergency respite provision
- Bring forward proposals for clinical and therapeutic input for autistic adults
- Develop a new Learning Disability strategy and a delivery plan following significant consultation and co-production

How will we know we are having an impact (relevant performance indicators and targets)

- By March 2026, deliver a 20% reduction in the number of adults with learning disabilities and adults with autism in inpatient care (compared to March 2024)
- By March 2026 reduce the number of young people with learning disabilities and young people with autism in inpatient care to four
- Increase the number of people with learning disabilities receiving an annual health check and health action plan
- Admission and length of stay of adults with a learning disability / autistic adults is in line with Transforming Care principles
- Evidence of improved access to clinical pathways and support
- All Age Autism Strategy Implementation progressing and on track

Medium term ambitions - activity planned for 2026/27 and 2027/28

- Continued implementation of All Age Autism Strategy Delivery Plan to allocated timescales.
- Implementation of Learning Disability Strategy and its delivery plan within agreed timescales.

Risks and constraints (including areas where funding not yet confirmed)

- Continued financial constraints including removal of the ringfence from the Learning Disability and Autism Service Development Funding
- Changes to HWE ICB operating model and staffing

Key co-dependencies with other programmes and decisions required from outside the Board

- There is a co-dependency with the activity of the Children and Young People's Neurodiversity Transformation Steering Group in relation to the delivery of the All-Age Autism Strategy
- Both the All-Age Autism Strategy and the Learning Disability Strategy will require multi-agency commitment and activity from across the MHLDN HCP's sub-committees.

What will feel different from the perspective of people accessing services/support and their carers

- People will continue to receive high quality, personalised services that are efficient, cost effective and support meaningful activity with opportunities for choice, encouragement of greater independence
- Good evidence of engagement and co-production in partnership with individuals, family and carers
- Less disparity in experience of equitable access to services for autistic people
- A reduction in health inequalities experienced by LDA population including improved outcomes for people from global majority communities from and adults and CYP perspective
- People supported to live well in the community
- An increase in life expectancy/ quality of health for LDA population

Delivering improvements in the emotional and mental wellbeing of children and young people and support for parent/carers	
MHLDN HCP Senior Responsible Officer	David Evans, Chief Strategy and Partnerships Officer, HPFT Miranda Gittos, Director of Specialist Services and Commissioning, HCC Children's Services
Key partners involved	HWE ICB HPFT, HCT, HCC, Primary Care, Education and schools, VCFSE, NHS England
MHLDN HCP Delivery Board	
The **Children's Emotional and Mental Wellbeing Board** provides leadership, oversight, and strategy to improve the outcomes and effectiveness across the continuum of Children and Young Peoples Mental Health Services (CYPMHS) in Hertfordshire. Its functions include: • System Assurance in ambitions, demand, and capacity. • Consider and allocates transformation funding investment appropriately in accordance with need. • Agrees CYPMHS priorities and sets strategic direction The board achieves this through an integrated, multi-agency approach, driving shared responsibility and decision making for the CYPMHS System.	
Key strategies and plans	
National	• Improve productivity by reducing unwarranted variation in the numbers of CYP accessing services and the number of contacts per whole time equivalent hours worked • Reduce local inequalities in access to CYP mental health services, between disadvantaged groups and the wider CYP population. • Expand Mental Health Support Teams
HWE ICB MTP	• Every child has the best start in life • Improve access to health and care services • Increase the number of residents taking steps to improve their wellbeing
HWE ICB JFP	• A reduction in the backlog for Children's Care
Local strategies	• SEND Strategy
Delivery priorities for 2025/26	
• Improve access to CYP Mental Health services, ensure consistent practice and reducing variation between CYP mental health services providers across the continuum of need.	

- Increase productivity by ensuring that clinical hours are focused on clinical delivery for example by reducing clinical time spent on administration.
- Improve recruitment and retention, reducing agency use.
- Realise improvements through the CYPMHS HertsHub to increase efficiency and reduce clinical time on referrals by enabling staff involved with the child to see interventions across organisations.
- Clarify national expectations around the expansion of the Mental Health Support Teams in schools offer
- Work with schools and early years settings to improve transitions and transitions between children and adult services
- Develop more accessible support to address the gap in access between disadvantaged groups and wider children and young people populations.
- Implement the new Autism/ADHD pathway for children and young people
- Review and develop pre and post diagnosis support for children with Autism and/or ADHD as part of the All-Age Autism Strategy
- Develop PCN-based provision of emotional and mental wellbeing support for Children and Young People

How will we know we are having an impact (relevant performance indicators and targets)

- Reduce the wait for community paediatrics services to 65 weeks by April 2026. This will include ASD, ADHD and language assessments
- Reduction in waiting times for an Autism and ADHD diagnosis
- Increased number of families and professionals accessing the neurodiversity support hub in Hertfordshire
- Increase the number of CYP accessing mental health services to achieve the national ambition for 345,000 additional CYP aged 0–25 compared to 2019.
- Improve productivity by reducing unwarranted variation in the numbers of CYP accessing services and the number of contacts per whole time equivalent hours worked

Medium term ambitions - activity planned for 2026/27 and 2027/28

- Continued delivery against the five priority pillars: access; equality, equity, diversity, and inclusion; productivity and efficiency; crisis services; and transition.

Risks and constraints (including areas where funding not yet confirmed)

- As a system we are committed to further expansion of MHSTs as funding allows. Without increasing funding, physically increasing coverage will be challenging to deliver on this objective without diluting the current offer. An unintended consequence could be a reduction in access numbers due to a reduction in delivery to achieve wider spread (e.g. less group work). The CYPEMWB holds a risk register, which sets out mitigation and current position for awareness and ownership.

Key co-dependencies with other programmes and decisions required from outside the Board
The CYPEMWB aligns with multiple boards across the system. This includes: • SEND Priority Executive and Partnership and Assurance Boards • HWE MHLDA Programme Board • Hertfordshire Health and Wellbeing board • CYP ND transformation programme, with progress on this being reported on a regular basis to CYPEMWB.
What will feel different from the perspective of people accessing services/support and their carers
• Improved CYP journey and experience • More CYP thriving / improved outcomes • Improved, quicker access for CYP • Normalisation of emotional and mental wellbeing • Significant reduction in 'bounce' and 'rejected' referrals • Better demand and capacity across the whole CYPMHS system • More professional confidence in system • More effective, efficient system for professional

Delivering a neighbourhood health model to increase access to mental health support closer to people's homes	
MHLDN HCP Senior Responsible Officer(s):	Ed Knowles, Development Director MHLDN HCP
Key partners involved:	HCC, HPFT, S&WHCP, ENHCP, Herts Mind Network, Mind in Mid Herts, Viewpoint, Carers in Hertfordshire

MHLDN HCP Delivery Board

The Primary and Community Mental Health Partnership Board leads the move towards new models of community mental health, centred around primary care and focused on increasing access to and availability of mental health support across the county. The Partnership Board leads multi-agency activity to ensure that interventions and models of care are integrated, personalised and coordinated at a neighbourhood level.

Key strategies and plans

National	• Deliver effective courses of treatment within NHS Talking Therapies and reduce ill-health related inactivity, through access to Individual Placement Support (IPS)
HWE ICB MTP	• Increase healthy life expectancy and reducing inequality • Improve access to health and care services • Increase the number of residents taking steps to improve their wellbeing
HWE ICB JFP	• Reduce inequality with a focus on outcomes for cardiovascular disease and hypertension
Local strategies	• HWE ICS Health Creation Strategy

Delivery priorities for 2025/26

- Delivery of MHLDA Physical Health strategy
- Expansion of the Individual Placement Support scheme
- Delivery of a system-wide approach to Intensive and Assertive Outreach.
- Mobilisation of mental health, learning disabilities and neurodiversity elements of Care Closer to Home.
- Develop PCN-based provision of emotional and mental wellbeing support for Children and Young People
- Expansion of the Depression pathway across all providers
- Review workforce, activity and performance of Talking Therapies to meet the 2025/26 NHS target

- Support the regional and local review of new model of care via the Community Mental health Project and consider effectiveness of integrated working including impact of ARRS workers and Enhanced Primary Care Mental Health

How will we know we are having an impact (relevant performance indicators and targets)

- Access to NHS Talking Therapies for Anxiety and Depression - reliable recovery – 67% target
- Access to NHS Talking Therapies for Anxiety and Depression - reliable improvement – 48% target
- Women Accessing Specialist Perinatal Mental Health Services - at least as many people will access support as did in 2024/25
- Individual Placement Support access (12 month rolling) - at least as many people will access support as did in 2024/25
- Number of people with severe mental illness receiving Annual Health Checks

Medium term ambitions - activity planned for 2026/27 and 2027/28

- Implement the recommendations from the LGA peer review of Community Mental Health
- Review Information, advice and guidance accessibility and develop HCP approach
- Understand patient and staff experience of Personalised Care Framework to support implementation and move away from CPA.

Risks and constraints (including areas where funding not yet confirmed)

Continued funding of services, or allocation of funds to service areas to meet required performance objectives, or part of the integration agenda

Key co-dependencies with other programmes and decisions required from outside the Board

The development of the neighbourhood model will require the coordination of a large number of relevant programmes and services including:

- Co-occurring Mental Health and Substance Use Programme
- Dementia Programme
- Making Every Adult Matter (MEAM)
- IHCCT MH VCFSE services Review
- HCC Complex Needs VCFSE services review

The development of PCN-based provision of emotional and mental wellbeing support for Children and Young People will be a priority led by the Children and Young People's Emotional and Mental Wellbeing Board

What will feel different from the perspective of people accessing services/support and their carers

The right care and support will be more accessible, responsive and joined up relating to the individual and carers presenting needs and continued recovery journey

Delivering the Hertfordshire Suicide Prevention Strategy - making Hertfordshire a place where no one ever gets to a point where they feel suicide is their only option	
MHLDN HCP Senior Responsible Officer(s)	Aideen Dunne, Public Health Consultant, HCC Emma Wadey, Director of Nursing, HPFT
Key partners involved:	The Ollie Foundation, Hectors House, HPFT, HCC, Hertfordshire Constabulary, HWE ICB, Mind in Mid-Herts, Herts Mind Network, Carers in Herts

Delivery Group:

Hertfordshire's **Suicide Prevention Board** aims to provide strategic leadership and oversight of the suicide prevention programme being delivered across Hertfordshire. Responsibility for oversight and delivery of the Suicide Prevention Strategy for Hertfordshire sits with this Board.

Strategic alignment	
National	• Reduce the suicide rate over the next 5 years – with initial reductions observed within half this time or sooner • Improve support for people who have self-harmed • Improve support for people bereaved by suicide
HWE ICB MTP	• Increase healthy life expectancy and reducing inequality
HWE ICB JFP	• Better Care for Mental Health crises
Local strategies	• Hertfordshire Health and Wellbeing Strategy • Hertfordshire Suicide Prevention Strategy

Delivery priorities for 2025/26

- Refresh and publish JSNA profiles for child and adult emotional and mental health wellbeing (completed in May 2025)
- Finalise and publish the refresh of the Suicide Prevention Strategy for 2026 -2030 (due to be published Oct 2025)
- Complete the Suicide Audit for 2025 and ensure the findings and learning are embedded by local partners.
- Ensure RTSS data is more visible to system partners and is being used strategically to inform population level action on suicide prevention.
- Continue to undertake cluster reviews as required, ensuring the learning from the process is embedded in the local system by relevant partners.
- Refresh of the Suicide Prevention Board focus and membership (June 2025)
- Re-contract the Suicide Bereavement Support Service

How will we know we are having an impact (relevant performance indicators and targets)

- Evidence of the findings of local cluster reviews and annual suicide audit being implemented by partners.
- Identified an action plan to improve the strategic use of RTSS by MHLDA partners
- Published Suicide Prevention Strategy with an action plan for implementation, with leads identified

- Refreshed Suicide Prevention Board that is meeting quarterly, and the impact of the group is more visible to MHLDA partners, and wider system partners.

Medium term ambitions - activity planned for 2026/27 and 2027/28

- Delivery of the Suicide Prevention Strategy, with ownership sitting with the Suicide Prevention Board
- Building the profile and use of RTSS in a more strategic way to inform population level priorities and action

Risks and constraints (including areas where funding not yet confirmed)

- Challenging funding positions across both health and local authority partners
- Staff turnover within Public Health and key delivery partners and the impact this may have on delivery momentum

Key co-dependencies with other programmes and decisions required from outside the Board

- Delivering better care for people experiencing mental health crisis
- Delivering integrated services and support for people with learning disabilities, neurodivergent people and their families and carers.
- Delivering improvements in the emotional and mental wellbeing of children and young people
- Co-occurring mental health and substance use issues programme.
- Public Health all ages mental health and suicide prevention programme
- HPFT suicide prevention pathway
- Key Suicide Prevention, bereavement and carers support services/ commissioning

What will feel different from the perspective of people accessing services/support and their carers

- Continued support for people bereaved by suicide – families, friends, carers and professionals including first responders.
- The Suicide Prevention strategy identifies key at risk population groups and important risk factors for poor mental health, this will ensure that services are configured around the most at risk populations.
- RTSS and locally produced JSNA will identify where public mental health and prevention can have the greatest impact, supporting more people to remain in good mental health.
- Greater collaboration and alignment of commissioning of services focused on suicide prevention and bereavement support, reducing fragmentation and improving service user experience.

Developing better support and services for people with complex needs, in particular people with co-occurring mental health and substance use issues	
MHLDA HCP Senior Responsible Officer(s)	Sarah Perman, Director of Public Health, HCC Ed Knowles, Development Director, MHLDA HCP)
Key partners involved:	HPFT, CGL, CGL, Herts Mind Network, Mind in Mid-Herts, Viewpoint, Carers in Herts, Hertfordshire County Council, Hertfordshire Constabulary, East of England Probation, Healthwatch, West Hertfordshire Hospitals Trust, East and North Herts Trust, District and Borough Councils

MHLDN HCP Delivery Board

The **Mental Health and Substance Use Steering Group** brings together multi-agency partners to ensure that people experiencing co-occurring mental health and substance use will be able to access joined up integrated care in primary care, urgent care, mental health services, and drug and alcohol services.

- To improve access pathways into and between mental health and substance use services.
- To ensure we are using best practice and evidence-led models of care, and that we understand how these models of care interact with one another.
- To make the best use of resources & ensure that existing services are delivering effectively including post-intervention/support recovery.

Key strategies and plans

National	• Better care for people with co-occurring mental health and alcohol/drug use conditions
HWE ICB MTP	• Increase health life expectancy and reduce inequality • Improve access to health and care services • Increase the number of residents taking steps to improve their wellbeing
HWE ICB JFP	• Better Care for Mental Health crises
Local strategies	• Hertfordshire Health and Wellbeing Strategy • Hertfordshire Drug and Alcohol Strategy

Delivery priorities for 2025/26

- Complete MHSU service mapping to understand the full provision of MHSU services across Hertfordshire.

- Develop & implement a communications plan to raise awareness of MHSU services (aligned to the D&A stigma campaign).
- Engage with service users and carers to understand their challenges in accessing MHSU services for their co-occurring MHSU needs.
- Commence 18-month pilot of 4xD&A Workers in HPFT Adult Community teams, working alongside CGL & evaluate the impact.
- Review and update the joint working protocol between HPFT and CGL to ensure its relevance and accuracy.
- Carry out a 'deep dive' into the deaths of individuals with co-occurring MHSU to understand areas of good practice and areas for improvement.
- Improve system oversight and learning from deaths of people with co-occurring MHSU.
- Explore trauma training requirements & opportunities for existing services that provide prevention, early intervention and ongoing post-intervention recovery support for individuals with co-occurring MHSU needs.

How will we know we are having an impact (relevant performance indicators and targets)

- Specific indicators are being developed as part of the co-occurring MHSU programme during 25/26 to capture information and reflect the joint work across agencies.

Medium term ambitions - activity planned for 2026/27 and 2027/28

- To ensure sustainability of improvements and ongoing activities to improve co-occurring MHSU pathways beyond the fixed-term 25/26 programme management.

Risks and constraints (including areas where funding not yet confirmed)

- Sustainability of Drug & Alcohol Grant funding through Office for Health Inequalities and Disparities (OHID) post 25/26.
- Sustainability & expansion of 4xD&A workers in HPFT beyond 18-month pilot pending evaluation.
- Sustaining the focus on co-occurring MHSU post dedicated programme management in 25/26

Key co-dependencies with other programmes and decisions required from outside the Board

- Primary and Community Mental Health Partnership Board
- Making Every Adult Matter (MEAM)
- Drug & Alcohol Strategic Board
- Drug & Alcohol Treatment & Recovery Implementation Grant (DATRIG) Oversight Group
- Drug & Alcohol Management Group
- Alcohol & Drug Related Deaths

What will feel different from the perspective of people accessing services/support and their carers
• The right care and support will be more accessible, responsive and joined up. Individuals will not feel like they are falling between a gap in services.

Delivering more joined-up support for older people's mental health including more integrated action around Dementia, memory support and support for carers	
MHLDN HCP Senior Responsible Officer(s)	Helen Maneuf, Director of Older People Services, HCC
Key partners involved	HCC, Carers in Herts; AgeUK Herts; University of Hertfordshire; HPFT; Herts Care Providers Association; District and Borough Councils, Herts Sports and Physical Activity Partnership

MHLDN HCP Delivery Board

The **Dementia Strategy Steering Group** oversees delivery of the Hertfordshire Dementia Strategy and provides strategic oversight and alignment of the delivery programme to HWE ICP, ICB and HCC Strategies and priorities.

The Steering Group directs activity within working groups and workstreams, including proposing deep-dives, events, research and initiatives to improve service delivery to people with dementia and their carers living in Hertfordshire.

Key strategies and plans

National	• Enabling Equitable and Timely Access to Diagnosis • Ensuring People with Dementia have Equitable Access to Appropriate Health and Care Services • Supporting People Affected by Young Onset Dementia. • Supporting Carers of People with Dementia
HWE ICB MTP	• Increase healthy life expectancy and reducing inequality • Improve access to health and care services • Increase the number of residents taking steps to improve their wellbeing
HWE ICB JFP	• Better Care for Mental Health crises
Local strategies	• Hertfordshire Dementia Strategy 2023 – 2028 • Hertfordshire Health and Wellbeing Strategy • Hertfordshire and West Essex Integrated Care Strategy • Hertfordshire Carers Strategy • HWE ICB Primary Care Strategy

Delivery priorities for 2025/26

- Support improvements in residential and nursing care, transitions between home, hospital and hospice care, and reducing re-admission to hospital.
- Ensure that Hertfordshire is ready for the introduction of new drug therapies when they are approved for NHS use.

- Review and co-evaluate the Mild Cognitive Impairment (MCI) pathway and cognitive stimulation therapies offers (CST) and recommend and implement improvements where required.
- Rolling out the new Dementia Friendly Hertfordshire Accreditation Scheme across the County with links to the new support and training offers from Memory Support Hertfordshire.
- Improve access to and take-up of Carers health checks and emotional support services and increasing respite breaks for Carers.
- Promote and enable activity that reduces people's risk of dementia in later life, such as healthy activity, stopping smoking and reducing alcohol intake, and managing other health conditions in line with the Lancet research.

How will we know we are having an impact (relevant performance indicators and targets)

- Improved dementia diagnosis rates across Hertfordshire
- Memory Support Hertfordshire performance metrics including numbers of contacts from members of the public / professionals, type of information requested, courses / activities accessed
- Number and spread of organisations registering for and being accredited as dementia aware or dementia friendly
- Number of dementia related activities that are age-appropriate for people with YOD or other rare forms of dementia
- Improved health outcomes for people caring for someone with dementia – numbers of people accessing health checks, reduction in carers crisis interventions, qualitative data from carers on their own wellbeing as a carer
- Improved pathways for people in hospital, in transition spaces, or moving from one care setting to another (including discharge from hospital back to home or residential care) – quantitative and qualitative data from professionals, clinicians and people using services to be agreed

Medium term ambitions - activity planned for 2026/27 and 2027/28

- Improve data collection for people from groups and with protected characteristics who are under-represented in dementia diagnosis and service take-up
- Improve access to high quality respite or day care for people with dementia to improve wellbeing outcomes for carers
- Development (or plans for) a specialised dementia residential care / respite unit for young onset and rare forms of dementia
- Improve diagnosis pathways for people with Young onset dementia and improve data collection for this cohort
- Improve accreditation rates for dementia aware and dementia friendly organisations in Hertfordshire

Risks and constraints (including areas where funding not yet confirmed)

- Funding for capital projects in residential to make them more dementia friendly, or to enable specialist provision
- Care providers not being sufficiently skilled or available to deliver safe care to people with dementia
- Increasing population growth and age profile currently predicts higher levels of people with dementia, who will require more expensive care and health resource over time.

Key co-dependencies with other programmes and decisions required from outside the Board

- Public Health Ageing Well Programme
- HPFT EMDASS Recovery Programme
- ICB / SW HCP / EN HCP – Frailty, Care Closer to Home and End of Life Programmes
- University of Hertfordshire DEMCOM and MEDAL studies
- Memory Support Hertfordshire Implementation Plan

What will feel different from the perspective of people accessing services/support and their carers

- Improved and more accessible services - more personalised to people's unique needs and that enables them to have more control over their day to day lives and social connectedness
- Improved pathways and associated support/information at significant transition points such as moving between hospital, home and residential / hospice care
- Improved emotional and physical wellbeing of carers and family networks
- Improved awareness and acceptance of dementia in the community, and safe places for people to go where they are treated with dignity and respect
- Improved awareness of and access to services for marginalised groups

Addressing the life expectancy gap for people with severe mental illness, people with learning disabilities and neurodivergent people by tackling the wider determinants of health and wellbeing	
MHLDN HCP Senior Responsible Officer(s)	Asif Zia, Chief Medical Officer, HPFT Lucy Rush, Director of Quality and Practice and Principal Social Worker
Key partners involved	HPFT, HCC, HWE ICB, Hertfordshire Mind Network, Mind in Mid-Herts, Viewpoint, Carers in Herts, SWH HCP, ENH HCP,
MHLDN HCP Delivery Board	
The **Clinical and Practice Advisory Committee** comprises senior clinical and professional leadership from across the local NHS, social care and voluntary sector. Its membership ensures that all professional voices are included – social workers, Allied Health Practitioners, Public Health and medical/clinical input. The Committee makes formal recommendation to the MHLDN HCP Board on clinical, practice and professional priorities and any associated ethical issues. It also ensures co-ordination and alignment with the clinical leadership of the Integrated Care System and with the clinical leadership of the geographical/place Health and Care Partnerships.	
Strategic alignment	
National	• CORE20PLUS5
HWE ICB MTP	• Increase healthy life expectancy and reducing inequality
HWE ICB JFP	• Better Care for Mental Health crises
Local strategies	• Hertfordshire Health and Wellbeing Strategy • MHLDN HCP Physical Health Strategy • Carers Strategy
Delivery priorities for 2025/26	
• Deliver the recommendations and activity proposed in the MHLDN HCP's Physical Health Strategy • Deliver the recommendations of the LeDeR Annual review with a focus on the actions to address the higher death rates in global majority groups • Bring together multi-agency data and insight to populate the Patient and Carer Race Equality Framework • Increase the number of people with learning disabilities receiving an Annual Health Check • Develop more accessible support to address the gap in access between disadvantaged groups and wider children and young people populations.	

- Implement the recommendations from the Dementia Strategy's Equality Impact Assessment including improved data collection for people from groups who are under-represented in dementia diagnosis and service take-up
- Implement the MHLDN HCP's Public Sector Supported Employment pledge
- Deliver the practice changes to implement the provisions of the new Mental Health Act

How will we know we are having an impact (relevant performance indicators and targets)

- Sustained strong performance in the number of people with learning disabilities receiving an annual health check and health action plan
- An increase in the number of people with severe mental illness receiving and annual health check and health action plan to meet the national target
- Adoption of the MHLDN HCP Public Sector Employment Pledge leading to demonstrable improvement in the number of people offered appropriate employment

Medium term ambitions - activity planned for 2026/27 and 2027/28

- Improve access, experience and outcomes for people with protected characteristics by employing Patient and Carer Race Equality Framework insights across wider MHLDN HCP partners
- Develop a MHLDN HCP Housing Strategy for Hertfordshire
- Better connect and align local supported employment activity
- Develop a programme to support carers' mental health and wellbeing
- Improve our understanding and recording of sensory needs to improve our ability to tailor services and support

Risks and constraints (including areas where funding not yet confirmed)

- Recent changes to the GP contract mean that while numbers of people with severe mental illness and learning disabilities are recorded there is no longer a requirement to hold separate registers. We will see what impact this might have and look to mitigate any risks.

Key co-dependencies with other programmes and decisions required from outside the Board

- The delivery of the MHLDN HCP's Physical Health Strategy will require substantial joint-working with SWH HCP and ENH HCP to ensure that the development physical health services in each area fully considers the specific needs of people with mental illness, people with learning disabilities and neurodivergent people.
- The delivery of this priority overlaps significantly with the delivery of transformational change against all the other priorities. The role of the CPAC and the MHLDN HCP Board will be to ensure that we maintain a focus on these key elements of delivery.

What will feel different from the perspective of people accessing services/support and their carers
• People with protected characteristics who currently have differential access, experience and outcomes from services and support will see improvements in all these areas and will feel comfortable and able to access personalised care and support.

Leading improvements in the mental wellbeing of people in Hertfordshire by championing public health, workplace and educational activity throughout the county

As the role of the MHLDN HCP develops we now have the opportunity to consider our role in relation to wider population wellbeing. Specific deliverables and the appropriate governance to ensure delivery will be developed over the course of 2025/26.

9. How we will deliver our priorities

Engagement, experience and coproduction

The MHLDN HCP is committed to holding the insight and experience of patients, service users and carers at the heart of what we do.

We have a systematic approach to understanding and responding to lived experience and working in partnership with service users and carers to coproduce improvement. This is evidence-led, ensuring that we are utilising what we already know – this could be existing experience feedback, research, JSNA etc.

There is a range of co-production, co-design and engagement activity that takes place across our partnership, including the well-established Mental Health, Dementia and Learning Disability Co-Production Boards administered by the County Council, HPFT's Service User and Carer Councils and the work undertaken through advocacy and user-voice organisations, including Carers in Herts, Viewpoint and Healthwatch Hertfordshire.

The MHLDN HCP is considering how best to ensure that the insight and learning from all of this activity informs the work of the wider partnership. This will reduce the risk of duplicative activity, but also allow for a clearer and more detailed insight into the experiences and ideas of local people, service users and carers. Over the course of this Integrated Delivery Plan, the MHLDN HCP will develop the necessary structures and processes to help make this happen.

Workforce

As part of the HWE ICB's 2025/26 submission for the NHS Operating Plan, the Mental Health and Learning Disabilities workforce across the County was captured, including staff working with people with Dementia.

	Staff in post end 31 March 2025 (WTE)	Establishment end 31 March 2025	Establishment planned 31 March 2026
Mental Health Trust	3,654.09	3,946.57	3,946.57
Non Mental Health Trust	79.39	99.66	103.16
Primary Care	TBC	TBC	TBC
Non-NHS	430.88	436.48	470.68
Total	4,164.36	4,482.71	4,520.41

Over the course of 2025/26 we will need to understand the triangulation between workforce, funding, and activity levels, particularly considering financial pressures across different partners organisations,

NHS England's operating plan triangulation tool did not include mental health this year so will need to consider what local tools are available to conduct this analysis.

In Adult Mental Health there has been a growth in workforce in the last year related to:

- The introduction of the Mental Health Response Vehicle service and the mobilisation of the Mental Health Urgent Care Centre
- The development of peer support workers in VCFSE services
- Funding placements and trainees working in Talking Therapies

Digital

The MHLDN HCP will consider how it can support the coordination of digital and data developments across partner organisation to support its delivery priorities. Key areas of work include:

- Coproducing and using digital care plans together with our service users, carers and partners
- Enhancing our digital care assistants to provide intuitive, personalised support to navigate, advise and guide service users and carers
- Enabling real-time shared care with digital systems across partners
- Creating digital pathways to guide and support professionals and to share with service users to help them manage their recovery
- Using evidence based digital interventions to improve outcomes for our service users and carers
- Working across the MHLDN HCP to strengthen our population health approach

Governance

Host Provider and Lead Provider arrangements

On 09 April 2025, HWE ICB wrote to HPFT setting out its view on the next steps for implementing its operating model and the implications for the MHLDN HCP.

The letter identified the host provider model as the best route through which to deliver clearer governance and strengthened accountability for HCPs. Assuming that there is national support for the overall direction of travel, HWE ICB noted that the next step in implementing its agreed operating model would be for HPFT to become the host provider for the MHLDN HCP from 01 July 2025 and to take a greater leadership role in relation to MHLDA-related health services across Hertfordshire.

Both the MHLDN HCP Board and HPFT's Board and Hertfordshire County Council fully support these developments and the necessary arrangements for HPFT to become the host

provider from 01 July 2025 and to develop Lead Provider arrangements for 2026/27. For over 15 years, people in Hertfordshire have benefitted from integrated working arrangements in relation to mental health and learning disability. Given all the national and local changes, including the changes to local government structures and footprints, it is important that this integration is maintained and deepened.

Work will take place over 2025/26 to take forward the necessary work between HCC, HPFT and the ICB to establish the legal, financial and governance arrangements that will support these developments. This will include the necessary work to ensure arrangements to formalise the role of the Partnership within the County Council's decision-making structures.

Sub-committees and delegated functions

The MHLDN HCP has established a sub-committee structure to allow it to take on and arrange increasing responsibility delegated from HWE ICB.

The **Finance & Commissioning Committee** provides oversight of the strategic financial management of NHS and HCC monies associated with Mental Health, Learning Disabilities and Autism. This will primarily apply to the pooled fund for Mental Health and Learning Disabilities between HCC and HWE ICB but will also apply to non-pooled budgets, for example wider system spend on Dementia, neurodiversity and suicide prevention.

The Committee will also provide oversight of joint-commissioning activity which will include making recommendations to the HCP Board around the commissioning and decommissioning of services, significant variations to existing activity and the identification of opportunities to better respond to local need.

The **Quality, Transformation & Performance Committee** will provide strategic oversight to drive improvement in the quality and performance of the services and interventions that support people with mental ill-health, learning disabilities and neurodivergent people. The Committee will implement a framework and reporting mechanisms that will provide effective and joined-up oversight of quality and performance across health, social care services and local VCFSE services.

The **Clinical and Practice Advisory Committee** comprises senior clinical and professional leadership from across the local NHS, social care and voluntary sector. Its membership ensures that all professional voices are included – social workers, Allied Health Practitioners, Public Health and medical/clinical input.

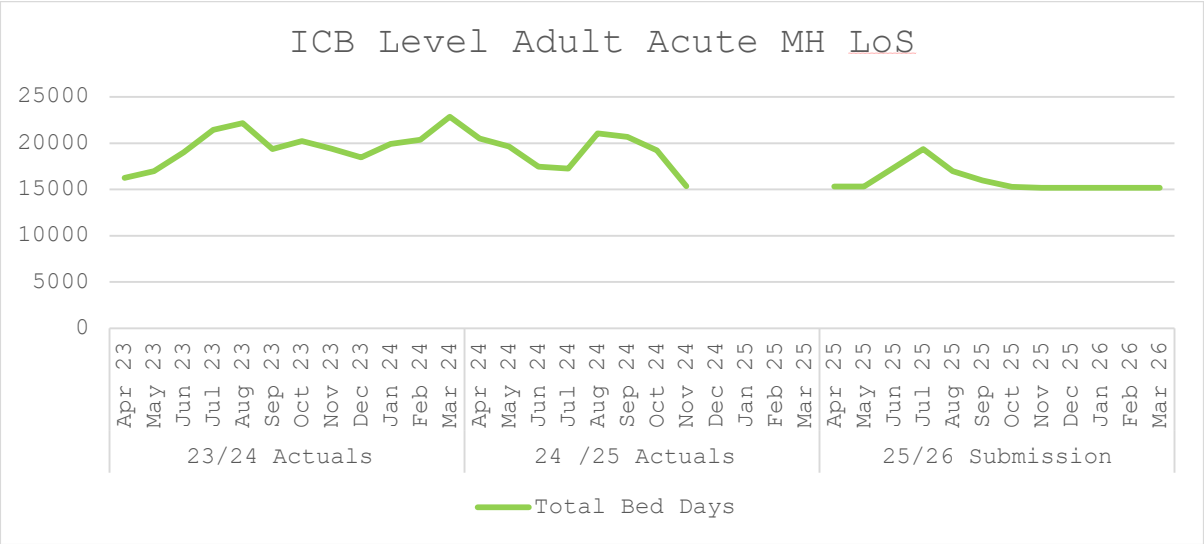
The Committee makes formal recommendation to the MHLDN HCP Board on clinical, practice and professional priorities and any associated ethical issues.

It also ensures co-ordination and alignment with the clinical leadership of the Integrated Care System and with the clinical leadership of the geographical/place Health and Care Partnerships.

Appendix A – Operational Planning – current performance and proposed trajectories

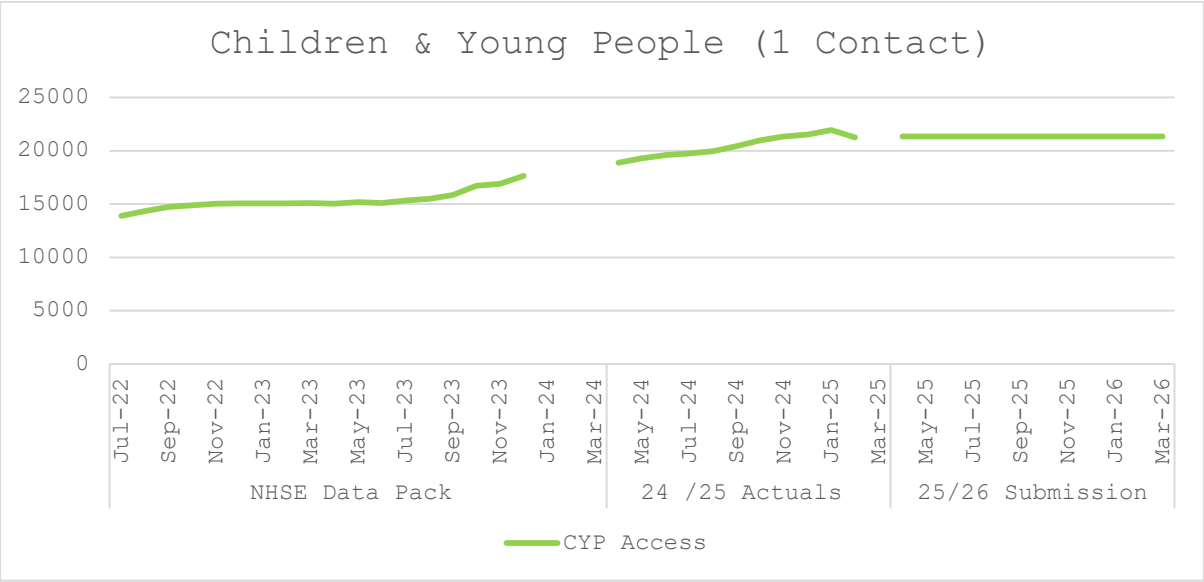
The following charts present the historical and current performance against the key NHS operational planning metrics. They also set out the proposed trajectories for future activity as submitted to NHS England as part of HWE ICB's overall planning submission.

E.H.37 - Average Length of Stay in Adult Acute MH Beds



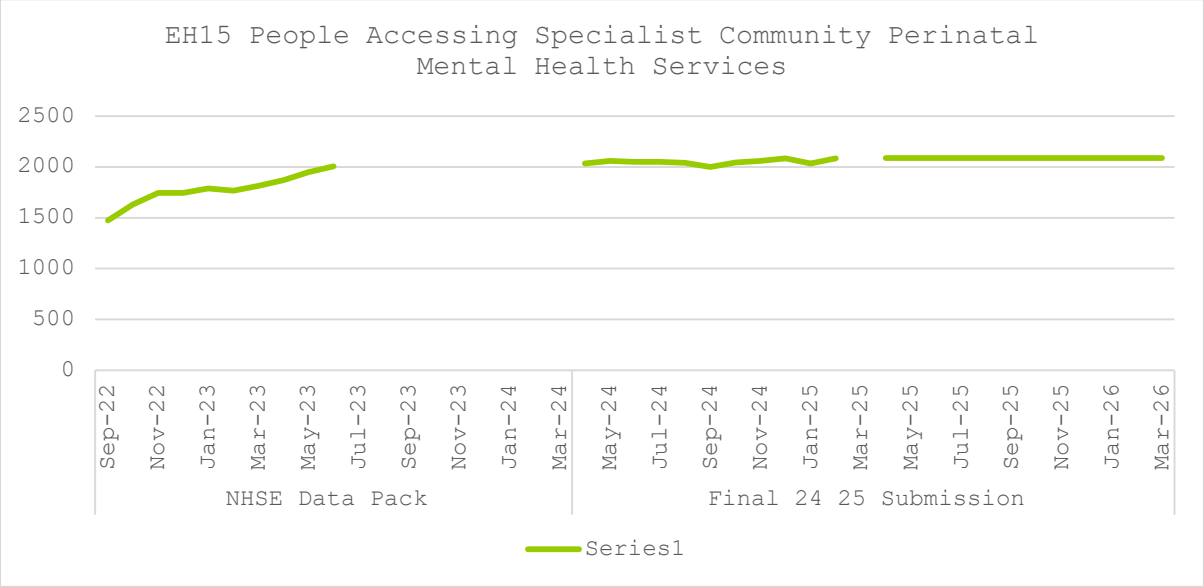
This is a new Metric for 2025/26. The data presented in the table is at HWE ICB level incorporating HPFT, EPUT and Independent Sector Provider performance. There has been no nationally set target yet.

E.H.9 – Access to Children and Young People Mental Health Services



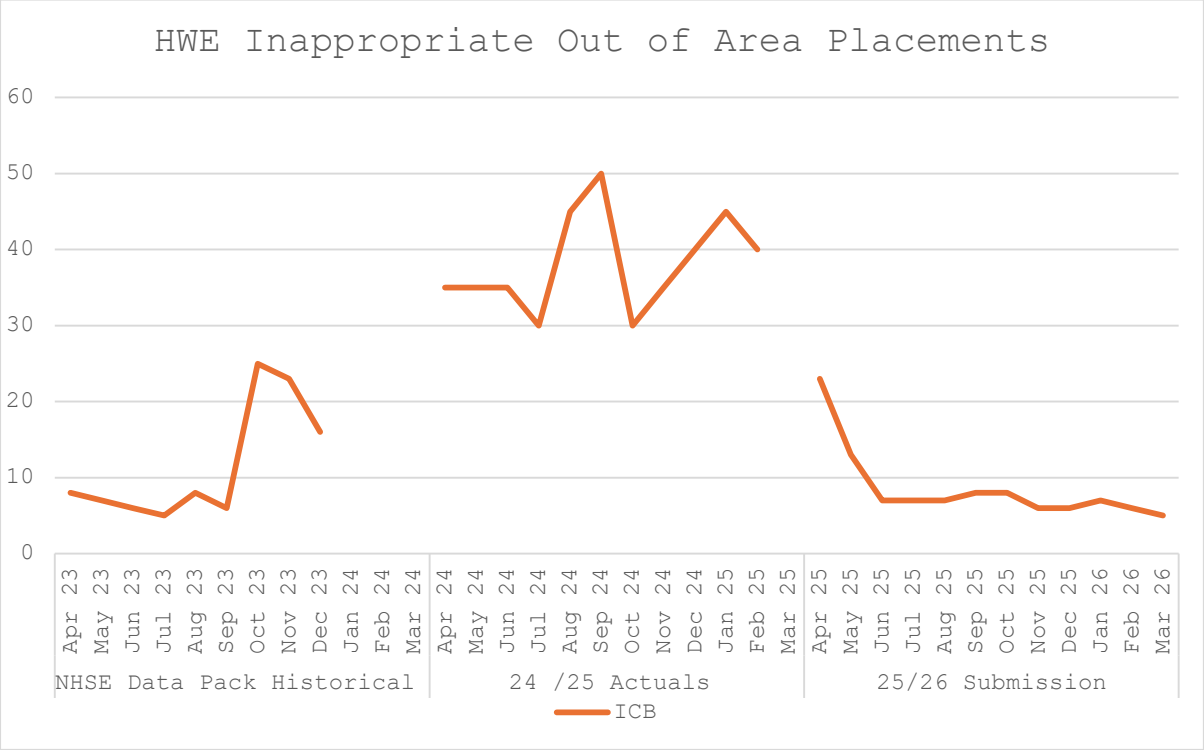
Areas that were already meeting the NHS Long Term Plan ambition were advised to maintain performance, so a flat trajectory has been submitted. This does not factor in any increase that would arise from the expansion of the Mental Health Support Teams in schools.

E.H.15 - Number of people accessing specialist community PMH and MMHS services in the reporting period



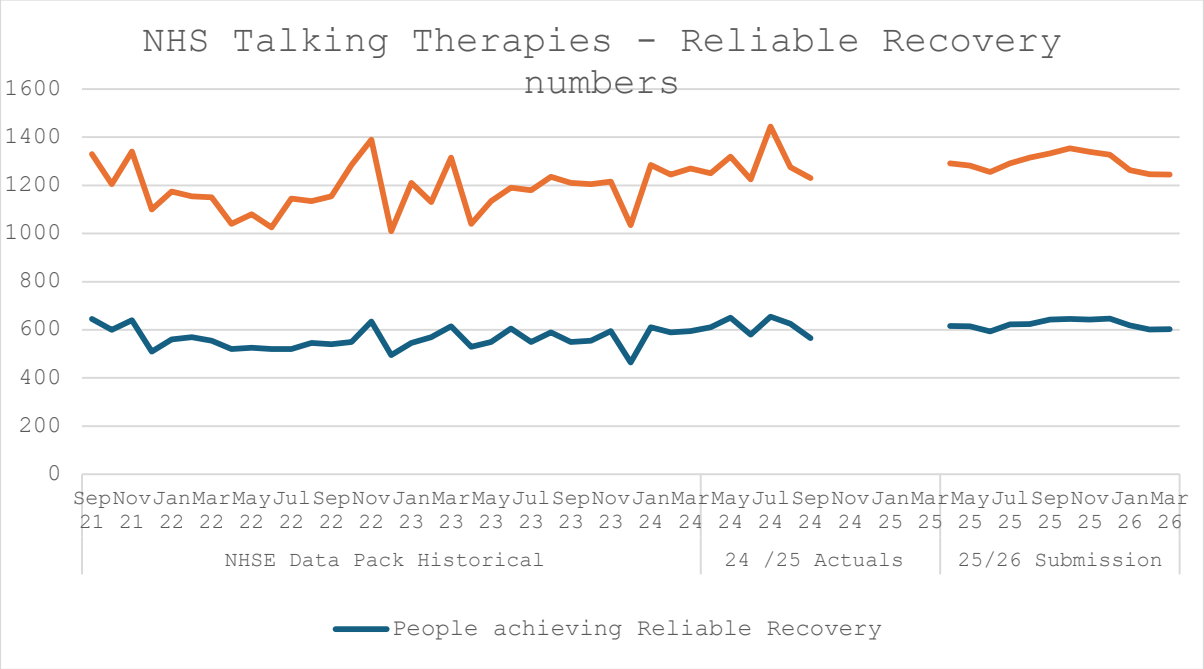
Areas that were already meeting the NHS Long Term Plan ambition were advised to maintain performance, so a flat trajectory has been submitted.

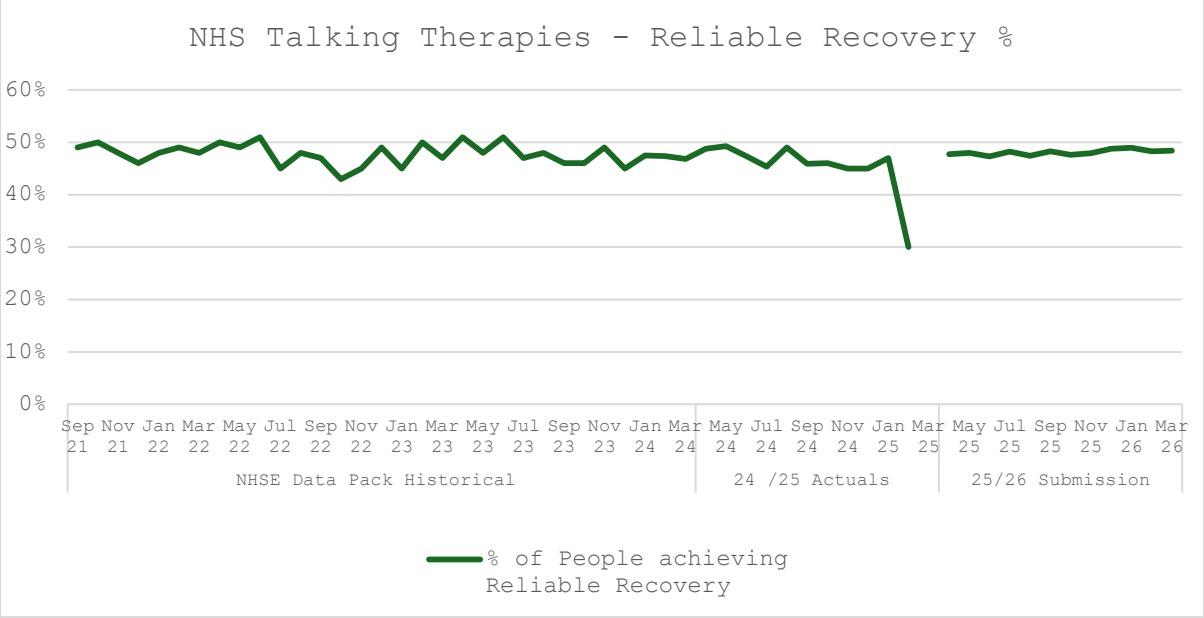
E.A.5 - Active inappropriate adult acute mental health out of areas placements (OAPs)



Data in the chart above is HEW ICB level. Target is to eliminate inappropriate out of area placements by March 2027.

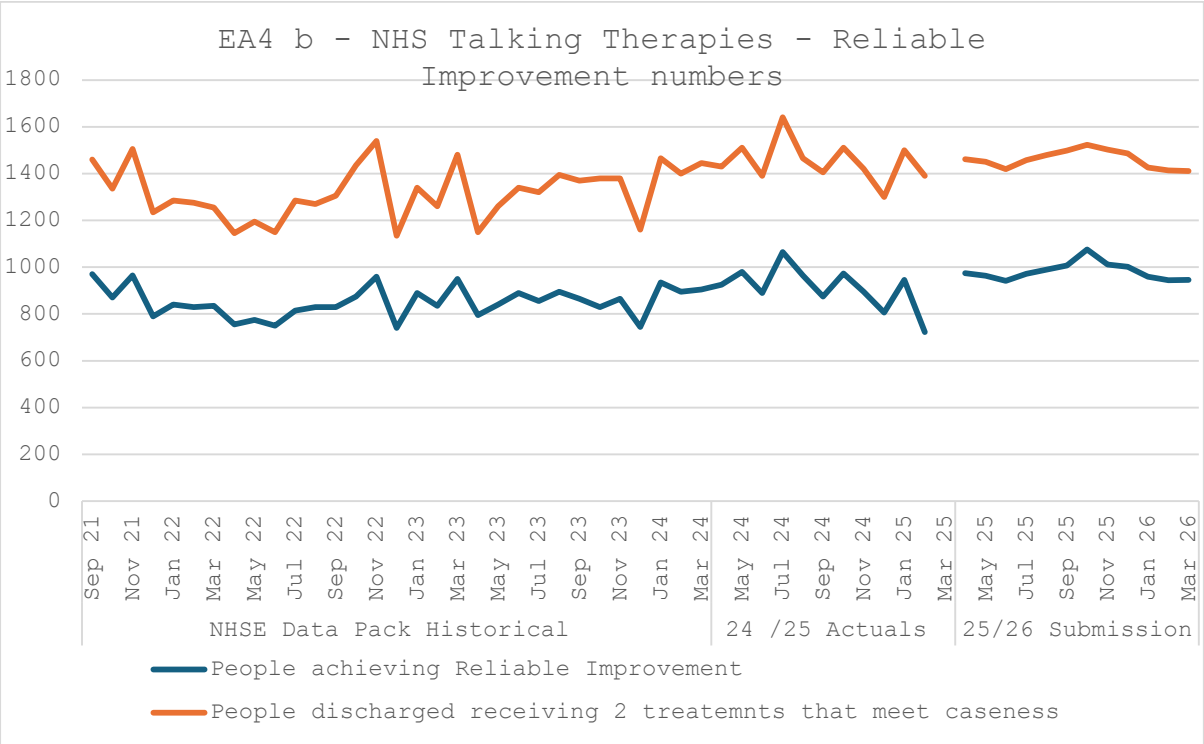
Access to NHS talking therapies for anxiety and depression - <u>reliable recovery</u>

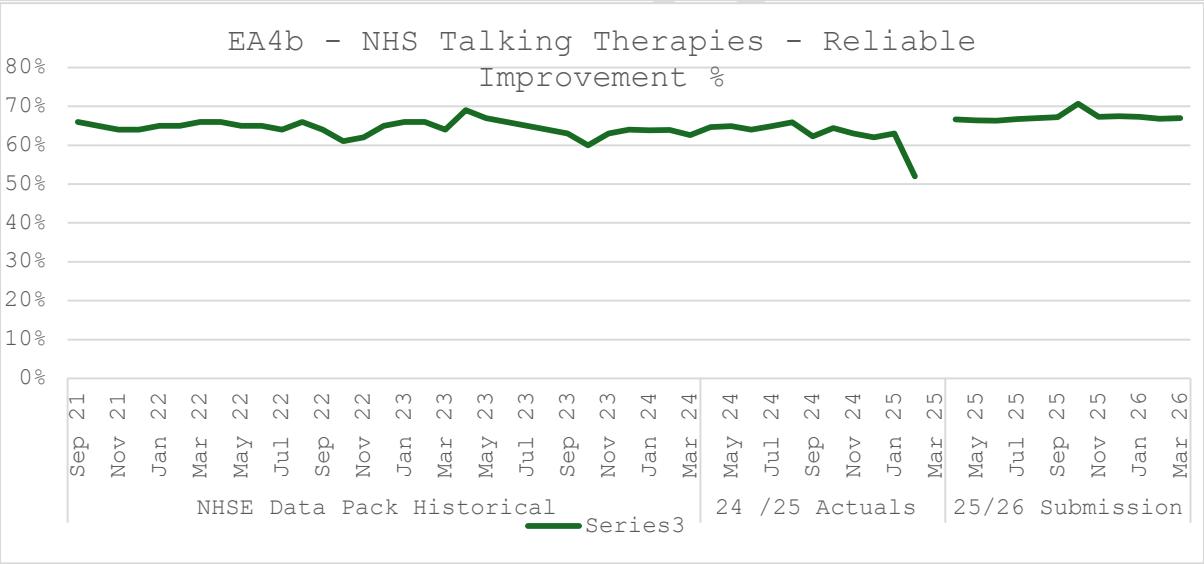




Performance over 2024/25 averaged at 47% so did not meet target. The Reliable recovery is expected to be 48%, however an indicative target of 50% has been proposed. Some data issues currently under investigation.

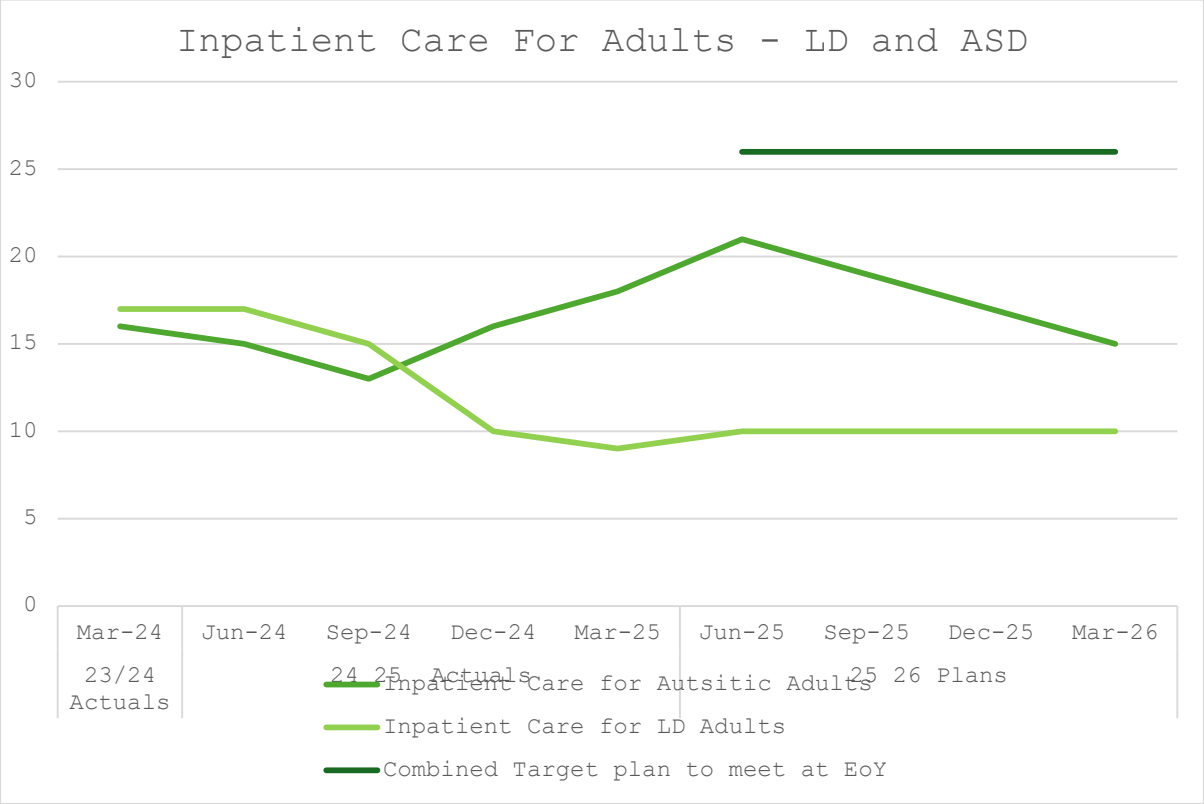
E.A.4b - Access to NHS talking therapies for anxiety and depression - <u>reliable improvement</u>

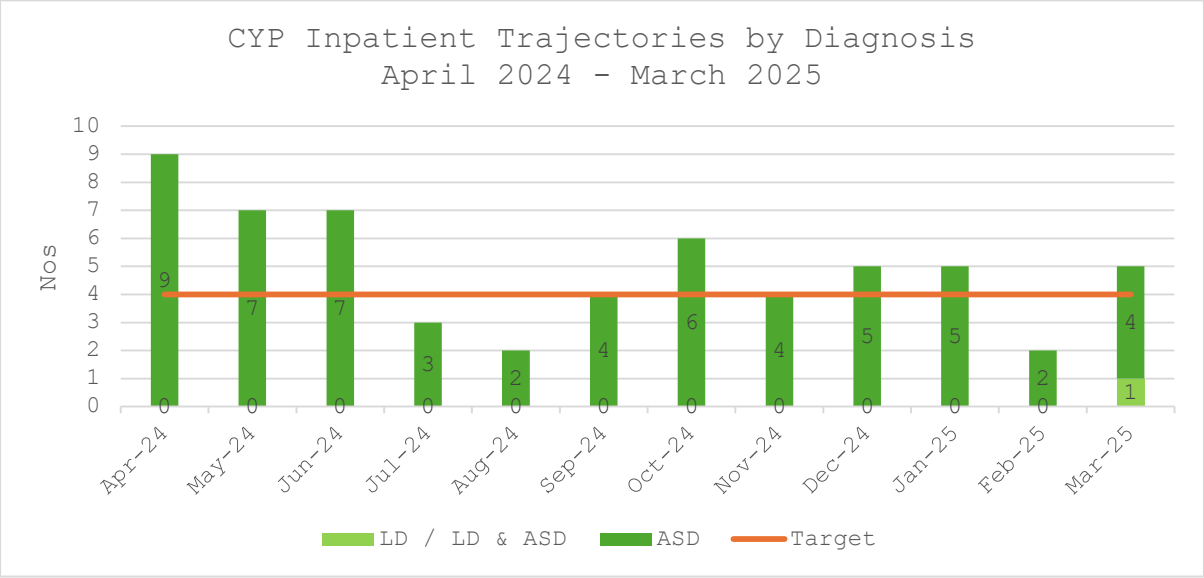




Performance over 2024/25 averaged at 64% so did not meet target of 67%. Reliable improvement Target 67%. A flat trajectory has been submitted at the target level. Some data issues currently under investigation.

E.H.32 / EH33 /EH 1c – Reliance on Inpatient Care for LD & A

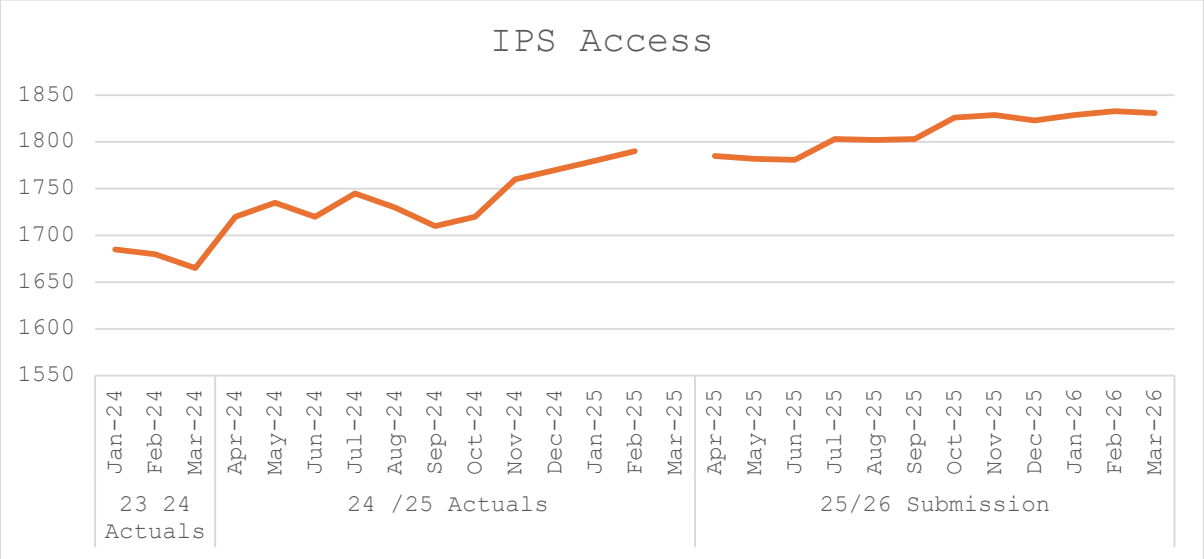




This represents a change in how these figures are reported with Adult Learning Disabilities and Adults with Autism split out.

The target is to make 20% reduction on March 2024 numbers by March 2026. The CYP trajectory remains number per 1m population which equates to four children/young people.

E.A.35 – Access to Individual Placement Support (IPS)



No targets for have been set nationally for the expansion of the IPS programme for 2025/26 with systems expected to advise what growth they feel is achievable. Systems will then be required to evidence how that growth will be achieved. The trajectory that has been proposed is the average of activity in 24/25 plus additional growth from Autumn Statement funded posts. Some potential data quality issues are under investigation.

Appendix B - Public Health Outcomes Framework – Mental Health and Learning Disabilities indicators

Indicator	Period	Herts			England			
		Recent Trend	Count	Value	Value	Worst	Range	Best
Gap in the employment rate between those who are in receipt of long term support for a learning disability (aged 18 to 64) and the overall employment rate (Persons, 18-64 yrs)	2022/23	–	-	72.3	70.9	100.0		
Gap in the employment rate for those who are in contact with secondary mental health services (aged 18 to 69) and on the Care Plan Approach, and the overall employment rate (Persons, 18-69 yrs)	2020/21	–	-	64.7	66.1	76.0		
The percentage of the population who are in receipt of long term support for a learning disability that are in paid employment (aged 18 to 64) (Persons, 18-64 yrs)	2022/23	→	189	6.3%	4.8%	0.0%		
Adults with a learning disability who live in stable and appropriate accommodation (Persons, 18-64 yrs)	2023/24	↑	2,496	83.0%	81.6%	48.8%		.4%
Adults in contact with secondary mental health services who live in stable and appropriate accommodation (Persons, 18-69 yrs)	2020/21	–	-	80.0%	58.0%	5.0%		0%
Excess under 75 mortality rate in adults with severe mental illness (SMI) (Persons, 18-74 yrs)	2021 - 23	–	-	375.8%	383.7%	644.7%		
Premature mortality in adults with severe mental illness (SMI) (Persons, 18-74 yrs)	2021 - 23	–	1,940	81.8	110.8	232.5		55.2
The percentage of the population who are in contact with secondary mental health services and on the Care Plan Approach, that are in paid employment (aged 18 to 69) (Persons, 18-69 yrs)	2020/21	–	352	15.0%	9.0%	1.0%		
The percentage of the population with a physical or mental long term health condition in employment (aged 16 to 64) (Persons, 16-64 yrs)	2022/23	–	-	69.0%	65.3%	43.4%		
Gap in the employment rate between those with a physical or mental long term health condition (aged 16 to 64) and the overall employment rate (Persons, 16-64 yrs)	2022/23	–	-	9.6	10.4	20.1		
Suicide rate (Persons, 10+ yrs)	2021 - 23	–	-	8.1	10.7	19.6		

Appendix C – Performance against NHS Operational Planning and Long Term Plan indicators

Line	Description	Std	Basis	Period	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	YTD
01	CYP 1 Contact <18s	-	R12M	Mar-25	19,080	19,545	19,995	19,990	20,110	20,425	20,975	21,330	21,515	21,940	21,925	21,970	21,970
02	CYP 1 Contact <18s Plan	-	R12M	Mar-25	18,277	18,481	18,685	18,876	19,057	19,345	19,661	19,977	20,181	20,502	20,823	21,153	21,153
03	Variance to Plan	0.0%	R12M	Mar-25	4.4%	5.8%	7.0%	5.9%	5.5%	5.6%	6.7%	6.8%	6.6%	7.0%	5.3%	3.9%	3.9%
04	Perinatal MH	-	R12M	Mar-25	2,040	2,060	2,045	2,040	2,035	2,000	2,045	2,060	2,085	2,095	2,085	2,125	2,125
05	Perinatal MH Plan	-	R12M	Mar-25	2,089	2,089	2,089	2,089	2,089	2,089	2,089	2,089	2,089	2,089	2,089	2,089	2,089
06	Variance to Plan	0.0%	R12M	Mar-25	-2.3%	-1.4%	-2.1%	-2.3%	-2.6%	-4.3%	-2.1%	-1.4%	-0.2%	0.3%	-0.2%	1.7%	1.7%
07	Talking Therapies Completed Courses of Treatment	-	MTH	Mar-25	1,430	1,510	1,390	1,640	1,465	1,405	1,510	1,420	1,300	1,500	1,390	1,525	17,485
08	Talking Therapies Completed Courses of Treatment Plan	-	MTH	Mar-25	1,318	1,318	1,318	1,318	1,318	1,318	1,318	1,318	1,318	1,318	1,318	1,318	15,816
09	Variance to Plan	0.0%	MTH	Mar-25	8.5%	14.6%	5.5%	24.4%	11.2%	6.6%	14.6%	7.7%	-1.4%	13.8%	5.5%	15.7%	10.6%
10	Talking Therapies Reliable Improvement	67%	MTH	Mar-25	65.0%	65.0%	64.0%	65.0%	66.0%	62.0%	64.0%	63.0%	62.0%	63.0%	52.0%	60.0%	60.0%
11	Talking Therapies Reliable Improvement Plan	67%	MTH	Mar-25	67.1%	67.1%	67.1%	67.1%	67.1%	67.1%	67.1%	67.1%	67%	67%	67%	67%	67.1%
12	Variance to Plan	0.0%	MTH	Mar-25	-2.1%	-2.1%	-3.1%	-2.1%	-1.1%	-5.1%	-3.1%	-4.1%	-5.1%	-4.1%	-15.1%	-7.1%	-7.1%
13	Talking Therapies Reliable Recovery	48%	MTH	Mar-25	49.0%	49.0%	47.0%	45.0%	49.0%	46.0%	46.0%	45.0%	45.0%	47.0%	30.0%	46.0%	46.0%
14	Talking Therapies Reliable Recovery Plan	48%	MTH	Mar-25	48.5%	48.5%	48.5%	48.5%	48.5%	48.5%	48.5%	48.5%	49%	49%	49%	49%	48.5%
15	Variance to Plan	0.0%	MTH	Mar-25	0.5%	0.5%	-1.5%	-3.5%	0.5%	-2.5%	-2.5%	-3.5%	-3.5%	-1.5%	-18.5%	-2.5%	-2.5%
16	Inappropriate OAPs active at the end of the period	-	MTH	Mar-25	35	35	35	30	45	50	30	35	40	45	40	50	50
17	Inappropriate OAPs active at the end of the period Plan	-	MTH	Mar-25	13	12	11	9	8	7	6	6	6	6	6	4	4
18	Variance to Plan	0.0%	R3M	Mar-25	169%	192%	218%	233%	463%	614%	400%	483%	567%	650%	567%	1150%	1150%
19	CMH 2+ Contacts (Transformed)	-	R12M	Mar-25	15,735	15,745	15,750	15,810	15,980	16,185	16,270	16,345	16,475	16,530	16,565	16,735	16,735
20	CMH 2+ Contacts (Transformed) Plan	-	R12M	Mar-25	11,595	11,595	11,595	11,595	11,595	11,595	11,595	11,595	11,595	11,595	11,595	11,595	11,595
21	Variance to Plan	0.0%	R12M	Mar-25	35.7%	35.8%	35.8%	36.4%	37.8%	39.6%	40.3%	41.0%	42.1%	42.6%	42.9%	44.3%	44.3%
22	Dementia Prevalence	66.7%	MTH	Apr-25	64.4%	64.7%	64.9%	64.6%	64.7%	64.8%	65.1%	65.5%	65.3%	65.1%	65.0%	65.2%	65.1%
23	Dementia Prevalence Plan	66.7%	MTH	Apr-25	64.2%	64.5%	64.7%	64.9%	65.1%	65.4%	65.6%	65.8%	66.0%	66.3%	66.5%	67%	66.7%
24	Variance to Plan	0.0%	MTH	Apr-25	0.1%	0.2%	0.2%	-0.3%	-0.4%	-0.6%	-0.5%	-0.3%	-0.7%	-1.1%	-1.5%	-1.5%	-1.6%
25	SMI Health Checks	60.0%	R12M	Mar-25		47.0%			46.0%			48.0%			55.0%		55.0%
26	SMI Health Checks Plan	60.0%	R12M	Mar-25		48.7%			52.4%			56.2%			0.0%		0.0%
27	Variance to Plan	0.0%	R12M	Mar-25		-1.7%			-6.4%			-8.2%			55.0%		55.0%

Line	Description	Std	Basis	Period	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	YTD
01	CYP1 Contact <18s	-	R12M	Mar-25	16,005	16,250	16,580	16,835	16,810	16,830	17,185	17,560	17,625	18,025	18,410	18,635	19,080	19,545	19,995	19,990	20,110	20,425	20,975	21,330	21,515	21,940	21,925	21,970	21,970
02	CYP1 Contact <18s LTP Target	-	R12M	Mar-25	16,084	16,371	16,657	16,944	19,230	19,517	19,803	20,090	20,376	20,662	20,949	21,236	21,235	21,235	21,235	21,235	21,235	21,235	21,235	21,235	21,235	21,235	21,235	21,235	21,235
03	Variance to LTP Target	0.0%	R12M	Mar-25	-11.5%	-11.5%	-11.1%	-12.2%	-13.6%	-13.5%	-13.2%	-12.5%	-13.5%	-12.2%	-12.1%	-12.2%	-10.1%	-8.0%	-6.6%	-5.8%	-5.3%	-3.8%	-4.2%	0.4%	1.9%	3.3%	3.2%	3.5%	3.5%
04	CYPED Urgent <1 Wk	95%	R3M	Mar-25	75.0%	77.0%	67.0%	90.0%	90.0%	92.0%	92.0%	79.0%	78.0%	76.0%	75.0%	73.0%	78.0%	88.0%		100%	80.0%	88.0%	78.0%	74.0%	53.0%				67.4%
05	CYPED Routine <4 Wks	95%	R3M	Mar-25	95.0%	95.0%	97.0%	92.0%	93.0%	93.0%	93.0%	90.0%	83.0%	81.0%	75.0%	81.0%	78.0%	87.0%	84.0%	91.0%	87.0%	89.0%	90.0%	91.0%	87.0%	70.0%	55.0%		85.4%
06	CYP Paired Scores		MTH	Mar-25	27.0%	31.0%	34.0%	36.0%	32.0%	33.0%	33.0%	39.0%	36.0%	33.0%	42.0%	40.0%	36.0%	40.0%	41.0%	41.0%	35.0%	33.0%	40.0%	36.0%	45.0%	40.0%	38.0%	36.0%	36.9%
07	CYP Self-Rated Measurable Improvement		MTH	Mar-25	45.0%	50.0%	47.0%	50.0%	43.0%	40.0%	46.0%	52.0%	51.0%	42.0%	42.0%	49.0%	48.0%	49.0%	52.0%	54.0%	45.0%	55.0%	48.0%	61.0%	53.0%	56.0%	56.0%	55.0%	50.6%
08	CYP referral-spells w aiting more than 104 w eeks for a 1st contact	0	MTH	Mar-25													105	110	130	155	160	175	195	215	245	250	280	290	290
09	Perinatal MH	-	R12M	Mar-25	1,800	1,810	1,850	1,870	1,890	1,935	1,960	1,970	1,960	1,990	2,010	1,995	2,040	2,060	2,045	2,040	2,035	2,000	2,045	2,060	2,085	2,095	2,085	2,125	2,125
10	Perinatal MH LTP Target	-	R12M	Mar-25	1,810	1,810	1,810	1,810	1,810	1,810	1,810	1,810	1,810	1,810	1,810	1,810	1,810	1,810	1,810	1,810	1,810	1,810	1,810	1,810	1,810	1,810	1,810	1,810	1,810
11	Variance to LTP Target	0.0%	R12M	Mar-25	-0.8%	0.0%	2.2%	3.3%	4.4%	6.9%	8.3%	8.8%	9.4%	9.4%	11.0%	10.2%	12.7%	13.8%	13.0%	12.7%	12.4%	10.5%	13.0%	13.8%	15.2%	15.7%	15.2%	17.4%	17.4%
12	Talking Therapies Completed Courses of Treatment	-	MTH	Mar-25													1,430	1,510	1,390	1,640	1,465	1,405	1,510	1,420	1,300	1,500	1,390	1,525	17,485
13	Talking Therapies Completed Courses of Treatment LTP Target	-	MTH	Mar-25													1,273	1,315	1,273	1,315	1,315	1,273	1,315	1,273	1,315	1,315	1,188	1,315	15,485
14	Variance to LTP Target	0.0%	MTH	Mar-25													12.3%	14.8%	9.2%	24.7%	11.4%	10.4%	14.8%	11.5%	-1.1%	14.1%	17.0%	18.0%	12.9%
15	Talking Therapies Reliable Improvement	67%	MTH	Mar-25													65.0%	65.0%	64.0%	65.0%	66.0%	62.0%	64.0%	63.0%	62.0%	63.0%	52.0%	60.0%	62.7%
16	Talking Therapies Reliable Recovery	48%	MTH	Mar-25	51.0%	48.0%	51.0%	47.0%	48.0%	46.0%	47.0%	49.0%	45.0%	47.0%	47.0%	47.0%	49.0%	49.0%	47.0%	45.0%	48.0%	46.0%	48.0%	45.0%	45.0%	47.0%	30.0%	46.0%	46.4%
17	Non-White British	48%	R3M	Mar-25		49.0%			45.0%			45.0%			45.0%			44.0%			46.0%			47.0%			41.0%		44.5%
18	White British	48%	R3M	Mar-25		51.0%			48.0%			48.0%			48.0%			50.0%			47.0%			46.0%			44.0%		46.7%
19	Talking Therapies Recovery	52%	MTH	Mar-25	53.0%	51.0%	54.0%	50.0%	50.0%	48.0%	51.0%	52.0%	49.0%	51.0%	51.0%	51.0%	52.0%	53.0%	50.0%	48.0%	53.0%	49.0%	50.0%	48.0%	49.0%	51.0%	32.0%	49.0%	48.7%
20	Talking Therapies Waiting <6 Wks	75%	MTH	Mar-25	78.0%	80.0%	78.0%	78.0%	76.0%	75.0%	74.0%	75.0%	77.0%	78.0%	77.0%	73.0%	78.0%	76.0%	74.0%	73.0%	74.0%	74.0%	74.0%	71.0%	74.0%	69.0%	73.0%	68.0%	73.0%
21	Talking Therapies Waiting <18 Wks	95%	MTH	Mar-25	93.0%	93.0%	93.0%	93.0%	92.0%	93.0%	93.0%	94.0%	94.0%	95.0%	96.0%	96.0%	96.0%	97.0%	96.0%	96.0%	97.0%	97.0%	97.0%	96.0%	95.0%	95.0%	93.0%	89.0%	96.6%
22	Talking Therapies >90 Day Waits	10%	MTH	Mar-25	17.0%	15.0%	16.0%	19.0%	14.0%	17.0%	15.0%	15.0%	18.0%	20.0%	18.0%	17.0%	19.0%	19.0%	20.0%	23.0%	20.0%	25.0%	22.0%	21.0%	16.0%	19.0%	18.0%	16.0%	19.9%
23	EIP Treated <2 Weeks	60%	R3M	Mar-25	67.0%	64.0%	69.0%	75.0%	77.0%	73.0%	76.0%	76.0%	80.0%	80.0%	86.0%	86.0%	81.0%	78.0%	79.0%	84.0%	90.0%	87.0%	85.0%	82.0%	80.0%	75.0%	73.0%	74.0%	74.0%
24	Follow Up <72hrs Discharge	80%	R3M	Mar-25	68.0%	68.0%	69.0%	62.0%	61.0%	60.0%	66.0%	60.0%	67.0%	57.0%	63.0%	58.0%	57.0%	52.0%	51.0%	48.0%	49.0%	39.0%	53.0%	61.0%	46.0%	59.0%	46.0%	47.0%	47.0%
25	Admitted No Prior Contact	-	R3M	Mar-25	14.0%	13.0%	13.0%	11.0%	11.0%	12.0%	16.0%	15.0%	13.0%	11.0%	12.0%	21.0%	18.0%	16.0%	15.0%	11.0%	11.0%	10.0%	11.0%	12.0%	10.0%	11.0%	13.0%	12.0%	12.0%
26	Non-White British	-	R3M	Mar-25	23.0%	25.0%	24.0%	15.0%	14.0%	14.0%	20.0%	19.0%	15.0%	13.0%	19.0%	25.0%	20.0%	16.0%	12.0%	0.0%	13.0%	21.0%	19.0%	16.0%	14.0%	13.0%	18.0%	19.0%	19.0%
27	White British	-	R3M	Mar-25	13.0%	11.0%	13.0%	16.0%	11.0%	7.0%	10.0%	12.0%	12.0%	12.0%	14.0%	14.0%	13.0%	12.0%	13.0%	8.0%	0.0%	6.0%	0.0%	0.0%	7.0%	8.0%	8.0%	6.0%	6.0%
28	Adult LOS >60 Days	8.0	R3M	Mar-25	5.0	5.0	5.0	5.0	6.0	6.0	7.0	6.0	5.0	5.0	6.0	7.0	8.0	7.0	7.0	6.0	8.0	7.0	7.0	6.0	8.0	8.0	8.0	9.0	9.0
29	Older Adults LOS >90 Days	8.0	R3M	Mar-25	8.0	9.0	7.0	9.0	9.0	10.0	11.0	12.0	11.0	10.0	11.0	11.0	10.0	7.0	5.0	4.0	4.0	5.0	5.0	5.0	3.0	5.0	6.0	6.0	6.0
30	Mean LoS for Adult Acute, Older Adult Acute and RCUdischarges (days)		R3M	Mar-25																							44.0	45.0	47.0	47.0
31	Inappropriate OAPs active at the end of the period	0	MTH	Mar-25													35	35	35	30	45	50	30	35	40	45	40	50	50
32	OAP Bed Days (inappropriate)		R3M	Mar-25	795	695	1,070	1,070	1,225	1,270	1,250	965	1,105	1,225	900	785	2,050	2,570	2,775	1,815	3,020	3,480	2,315	3,470	4,175	3,855	3,175	3,495	3,495
33	SMI Health Checks	-	R12M	Mar-25														47%			46%			48%			55%		46%
34	SMI Health Checks LTP Target	-	R12M	Mar-25														60%			60%			60%			60%		60%
35	Variance to LTP Target	-	R12M	Mar-25														-13%			-14%			-12%			-8%		-14.0%
36	IPS	-	R12M	Mar-25	1,605	1,560	1,570	1,590	1,625	1,640	1,640	1,645	1,655	1,685	1,680	1,665	1,720	1,735	1,720	1,745	1,730	1,710	1,720	1,760	1,770	1,780	1,790	1,790	1,790
37	IPS LTP Target	-	R12M	Mar-25													834	849	865	880	896	911	927	942	958	973	989	1,004	1,004
38	Variance to LTP Target	0.0%	R12M	Mar-25													106.2%	104.4%	99.8%	98.3%	93.1%	87.7%	85.5%	85.8%	84.8%	82.9%	81.0%	78.3%	78.3%
39	CMH 2+ Contacts (Transformed)	-	R12M	Mar-25	12,465	12,565	13,325	13,620	13,875	14,070	14,320	14,575	14,675	14,900	15,095	15,060	15,735	15,745	15,750	15,810	15,980	16,185	16,270	16,345	16,475	16,530	16,565	16,735	16,735
40	CMH 2+ Contacts (Transformed) LTP Target	-	R12M	Mar-25	6,638	6,869	7,099	7,330	7,561	7,791	8,022	8,253	8,483	8,714	8,945	9,175	9,237	9,299	9,361	9,423	9,485	9,547	9,609	9,671	9,733	9,795	9,857	9,919	9,919
41	Variance to LTP Target	0.0%	R12M	Mar-25	87.8%	88.7%	87.7%	85.8%	83.5%	80.6%	78.5%	76.8%	73.0%	71.0%	68.8%	64.1%	70.3%	69.3%	66.3%	67.8%	68.5%	66.9%	69.3%	69.0%	69.3%	68.8%	68.1%	68.7%	68.7%
42	CMH referral-spells w aiting more than 104 w eeks for a 2nd contact	0	MTH	Mar-25													545	70	65	425	55	345	300	265	235	200	190	170	170
43	Dementia Prevalence	66.7%	MTH	Apr-25	62.9%	62.9%	63.2%	63.7%	64.2%	64.4%	64.6%	64.6%	64.8%	64.2%	64.4%	64.7%	64.4%	64.7%	64.9%	64.6%	64.7%	64.8%	65.1%	65.5%	65.3%	65.1%	65.0%	65.2%	65.1%
44	CCS Very Urgent Referrals seen w/in 4hrs		MTH	Mar-25		32.0%	27.0%	37.0%	40.0%	53.0%	43.0%	51.0%	42.0%	48.0%	58.0%	45.0%	43.0%	45.0%	30.0%	41.0%	52.0%	40.0%	42.0%	35.0%	30.0%	43.0%	57.0%	23.0%	42.3%
45	CCS Urgent Referrals seen w /in 24hrs		MTH	Mar-25	52.0%	55.0%	59.0%	55.0%	54.0%	65.0%	66.0%	59.0%	63.0%	64.0%	60.0%	64.0%	64.0%	65.0%	59.0%	59.0%	55.0%	61.0%	61.0%	56.0%	61.0%	62.0%	59.0%	58.0%	60.1%
46	LPS Referrals from A&E seen w /in 1hr		MTH	Mar-25	66.0%	62.0%	64.0%	64.0%	62.0%	59.0%	53.0%	62.0%	66.0%	62.0%	62.0%	62.0%	67.0%	68.0%	70.0%	63.0%	58.0%	61.0%	63.0%	59.0%	59.0%	62.0%	60.0%	56.0%	62.3%
47	ECDS 12hr breaches - CYP (%)		MTH	Mar-25	7.0%	11.0%	13.0%	9.0%	14.0%	9.0%	14.0%	12.0%	10.0%	6.0%	6.0%	8.0%	16.0%	10.0%	3.0%	4.0%	5.0%	6.0%	7.0%	11.0%	9.0%	18.0%	11.0%	8.0%	9.2%
48	ECDS 12hr breaches - Adult (%)		MTH	Mar-25	22.0%	20.0%	24.0%	23.0%	25.0%	27.0%	28.0%	27.0%	32.0%	29.0%	25.0%	23.0%	20.0%	25.0%	21.0%	21.0%	20.0%	24.0%	25.0%	28.0%	23.0%	25.0%	21.0%	23.0%	24.2%