Appendix A

Herefordshire and Worcestershire Integrated Care System

Herefordshire General Practice

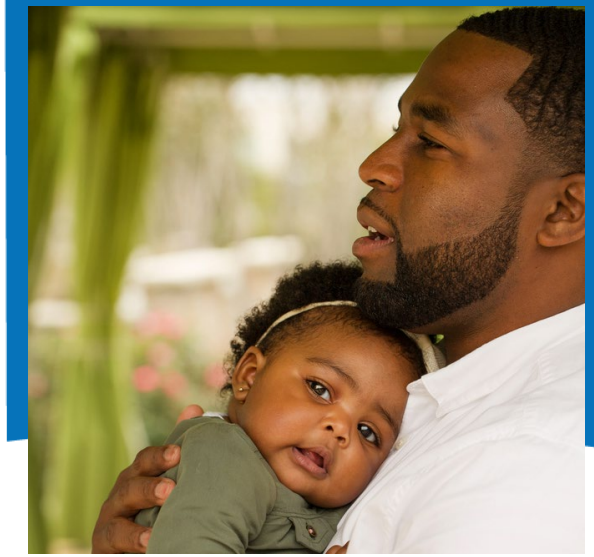
General Practice Worcestershire

NHS Wye Valley NHS Trust

NHS Herefordshire and Worcestershire Health and Care NHS Trust

NHS Worcestershire Acute Hospitals NHS Trust

NHS Herefordshire and Worcestershire




Driving the shift upstream to more prevention and best value care in the right setting

NHS Five Year Joint Forward Plan 2025/26 – 2029/30

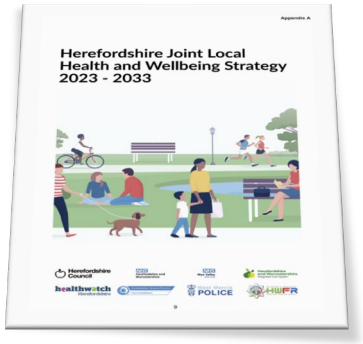
Version: 2025 Refresh, May 2025

The strategic intent of the Joint Forward Plan…

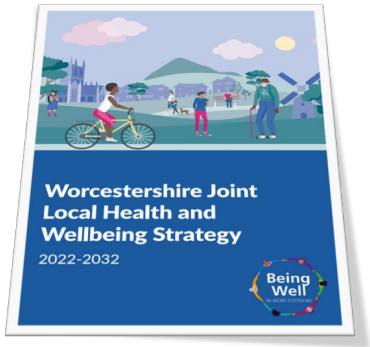
Driving the shift upstream to more prevention and best value care in the right setting

More focus on:

- **Self-care and independence**, enabling all people to look after their own health
- Promoting healthy behaviours which **reduce, delay and prevent** ill health
- **Co-production, personalised care and support**, meeting the needs of individuals
- **Population health management** and better use of data to target efforts
- **Sustainability of services,** and delivery of the right care models



Outlining the NHS contribution to the two Joint Local Health and Wellbeing Strategies.



Enabling reduction in:

- **Healthcare inequalities** – unequal access, outcomes and experience
- Days people spend in the **wrong care setting**
- The time spent **waiting** to access healthcare
- **Inefficient use of resources** and financial deficits
- **Avoidable pressures** on services
- People experiencing **digital exclusion**

Contents and navigating the Joint Forward Plan

Appendix 1 Core service areas and pathways	This section of the plan provides information on the development, transformation and improvement plans for specific service areas identified below:		
	• Maternity and neonatal care • Early years, children and becoming an adult • Elective, Diagnostics and Cancer Care • Frailty • Palliative and End-of-life	• Learning disability and autism care • Mental health and wellbeing • Long-term Conditions • Stroke care and cardiovascular disease	• Urgent and emergency care • Primary Care • General Practice • Pharmacy, Ophthalmic and Dentistry
Appendix 2 Key enablers and strategic system development	This section of the plan provides information on the key strategic enabler programmes and strategic developments that will support the core service areas and pathways:		
	• Quality, Patient safety and experience • Clinical and professional Leadership • Medicines and pharmacy • Health inequalities • Prevention	• Personalised care • Working with communities • Commitment to carers • Support to veteran health	• Addressing need of victims of abuse • Digital data and technology • Research and Innovation • Greener NHS
	• NHS Trust Provider Collaboratives • Mental health collaborative	• One Herefordshire Partnership • Worcestershire Place Partnership	• Office for the West Midlands ICBs
Appendix 3 The statutory requirements	The section outlines how the ICB meets its statutory duties as set out in the national guidance.		
	• Cross reference to show how the JFP addresses the specific requirements of the two health and wellbeing strategies. • Nominated lead officer for each duty and a cross reference for demonstrating which section of the JFP addresses the requirement.		

Introduction to the Joint Forward Plan

This, the third Joint Forward Plan for Herefordshire and Worcestershire has been produced by NHS Partners across Herefordshire and Worcestershire. This version contains minor updates, and a fuller refresh will be considered later in 2025/26 after the publication of the NHS 10 year plan. It describes the shared priorities that partners will collectively work on over the next five years. in response to the Integrated Care Strategy and Joint Local Health and Wellbeing Strategies. The strategic intent is to collectively drive the shift upstream to more prevention and achieve best value care in the right setting.

We would like to thank the two Health and wellbeing boards for their ongoing support for the plan and recognising its contribution to delivering the two Joint Local Health and Wellbeing strategies. We will continue to work together to enable good health and wellbeing for the people of Herefordshire and Worcestershire.

As representatives of NHS partners in Herefordshire and Worcestershire we endorse the plan on behalf of our organisations, recognising our role in delivering the priorities within it.

Russell Hardy - Chair
Foundation group partner organisations

Crishni Waring - Chair
NHS H&W ICB

Mark Yates - Chair
H & W Health and Care NHS Trust

Dr Roy Williams - On behalf of Worcestershire General Practice

Dr Nigel Fraser - On behalf of Herefordshire General Practice

Opinion of Herefordshire Health and Wellbeing Board

The Herefordshire Health and Wellbeing Board are committed to improving the health of our local commu[illegible]es and tackling health inequalities. We recognise the val[illegible]rking with all our partners, and that our communiti[illegible]t the heart of how we work differently to em[illegible]s and reduce demand across health and so[illegible]

The NHS Five Year J[illegible] provides a key delivery mechanism for [illegible]mbitions as set out in the Integrated C[illegible]d the Joint Local Health and Wellbeing [illegible]gnising the importance of prevention and the wid[illegible]s that affect the health and wellbeing of our residents.

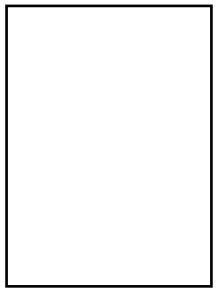
This opinion will be updated following the Herefordshire Health and Wellbeing Board – 9th June 2025

Councillor Carole Gandy
Chair of Herefordshire Health and Wellbeing Board

Opinion of Worcestershire Health and Wellbeing Board

Following the Worcestershire County council elections in May 2025 there will be a new Health and Wellbeing Board Chair, following which an opinion will be confirmed and included here.

This opinion will be updated following confirmation by the Worcestershire Health and Wellbeing Board Chair



To be confirmed,
Chair of Worcestershire Health and Wellbeing Board

Introduction to the Joint Forward Plan

The mandatory requirements for the JFP

- The Health & Care Act 2022 requires each Integrated Care Board (ICB) in England, and their partner NHS trusts and foundation trusts, to produce and publish a Joint Forward Plan (JFP).
- As well as setting out how the ICB intends to meet the health needs of the population within its area, the JFP is expected to be a delivery plan for the Integrated Care Strategy of the local Integrated Care Partnership (ICP) and relevant joint local health and wellbeing strategies (JLHWSs), whilst addressing universal NHS commitments.
- As such, the JFP provides a bridge between the ambitions described in the Integrated Care Strategy developed by the ICP and the detailed operational and financial requirements contained in NHS planning submissions.
- Systems have the flexibility to determine the scope of their JFP, as well as how it is developed and structured. Systems are encouraged to use the JFP to develop a delivery plan for the Integrated Care Strategy that is owned by the whole system, including Local Authorities and Voluntary Community and Social Enterprise partners.
- As a minimum though, it should describe how the ICB, its partner NHS trusts intend to meet the physical and mental health needs of their population through arranging and/or providing NHS services.
- This should include delivery of universal NHS commitments and address the four core purposes of ICS.
- The guidance that systems are required to follow sets out 3 principles for Joint Forward Plans:

Principle 1	Principle 2	Principle 3
Fully aligned with the wider system partnership's ambitions.	Supporting subsidiarity by building on existing local strategies and plans as well as reflecting the universal NHS commitments.	Delivery focused, including specific objectives, trajectories and milestones as appropriate.

The planning framework within which the JFP is set

The Health and Care Act 2022 put **Integrated Care Systems (ICS)** on a statutory footing and has provided the opportunity for local partners across the NHS, Local Government and the Voluntary Community and Social Enterprise to work in a more integrated way in the pursuit of better outcomes for local people.

The act established **Integrated Care Boards (ICB)** and required ICBs to come together with Local Authorities that provide public health and social care functions to form an **Integrated Care Partnership (ICP)**. The core purpose of the ICP is to provide a platform for local partners to come together to agree and **Integrated Care Strategy** for the whole ICS area, addressing the 4 core purposes of ICSs:

- Improve outcomes in population health and healthcare
- Tackle inequalities in outcomes, experience and access
- Enhance productivity and value for money
- Support broader social and economic development

The **Integrated Care Strategy** aligns to the two **Joint Local Health and Wellbeing Strategies (JLHWS)** in the ICS area, and identifies three shared priority areas, which address issues identified in the respective **Joint Strategic Needs Assessments**:

Integrated Care Strategy Shared Priorities across Herefordshire and Worcestershire		
Providing the best start in life	Living, ageing and dying well	Preventing ill health and premature death from avoidable causes

This **Joint Forward Plan (JPF)** sets out how NHS Partners will contribute to the delivery of:

- The shared priorities set out in the Integrated Care Strategy
- The priorities identified in the two Joint Local Health and Wellbeing Strategies
- National priorities for the NHS set out in the NHS Long Term Plan and mandatory national planning requirements.

The JFP will not set out new priorities; instead it will describe actions, timelines, targets and performance measures that will demonstrate the core areas of focus that NHS partners will focus on over the coming 5 years.

The JFP is the NHS contribution to ….. The Integrated Care Strategy ……

The Integrated Care Partnership approved the system Integrated Care Strategy in April 2023. The strategy sets out the shared ambition of system partners for achieving ***Good Health and Wellbeing for Everyone*****.**

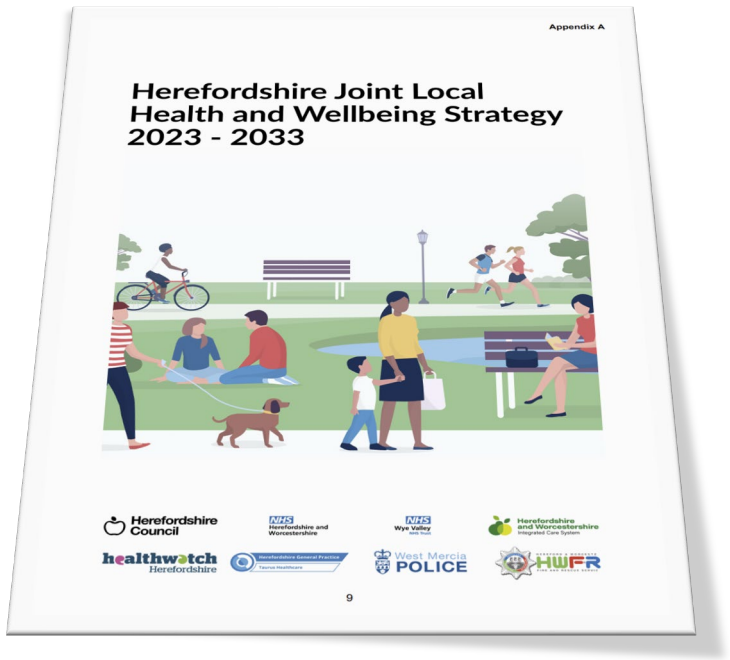
The ambition outlined in the strategy is for ***working together with people and communities to enable everybody to enjoy good physical and mental health and live independently for longer***.

Underpinning the strategy are 8 commitments that partners across the ICS have agreed as being fundamental to delivering integrated care.

The three shared priority themes and underpinning performance measures have been developed directly in response to the Joint Strategic Needs Assessments for each county and the priorities that are reflected in **Joint Local Health and Wellbeing Strategies**.

The strategic enablers bring partners together to work collectively in those areas that provide the essential platform for collaboration and working in a different way.

The JFP is the NHS contribution to ….. The two Health and Wellbeing Strategies



Herefordshire's Joint Local Health and Wellbeing Strategy (JLHWS) was approved in April 2023 and covers a 10-year period.

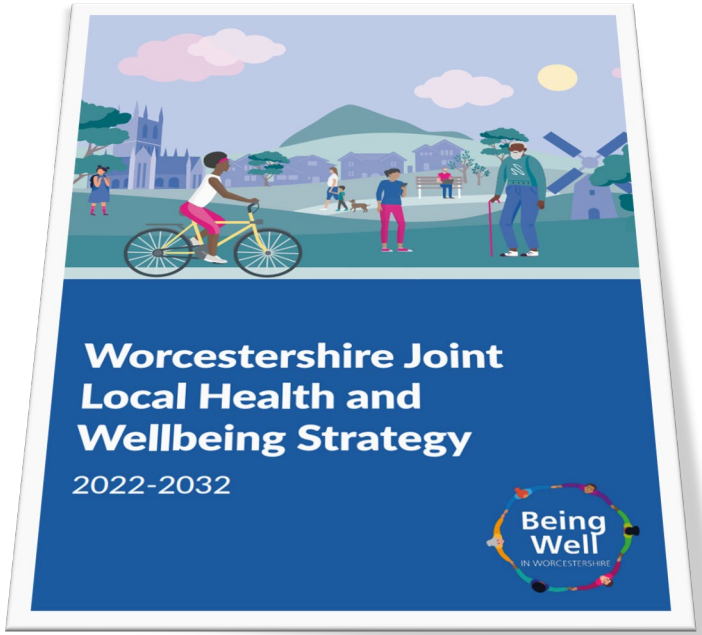
It was developed collectively by partners working together to agree a common ambition and set of priorities that were clearly identified through an extensive engagement exercise.

There is very strong alignment between the JLHWS and the Integrated Care Strategy, with both documents sharing a common vision and complementing priority areas of focus.

Worcestershire's Joint Local Health and Wellbeing Strategy (JLHWS) was approved in November 2022 and also covers a 10-year period.

Development of the strategy occurred in parallel with early work on developing the Integrated Care Strategy, which enabled strong alignment in some key areas.

Mental health runs through all three of the Integrated Care Strategy themes, mental health for children as part of the best start in life priority; good mental health through living ageing and dying well particularly focused on therapies and dementia care and reducing suicides as part of the third priority.



Herefordshire JLHWS Core Priorities	Integrated Care Strategy Priorities		
	Best start in life	Living, Ageing and Dying Well	Prevent ill health and premature death from avoidable causes
Best start in life for children	●	●	
Good mental wellbeing throughout life	●	●	●

Worcestershire JLHWS Core Priorities	Integrated Care Strategy Priorities		
	Best start in life	Living, Ageing and Dying Well	Prevent ill health and premature death from avoidable causes
Good mental health and wellbeing	●	●	●

● Directly aligned priorities where work led and undertaken at county level will directly deliver the Integrated Care Strategy priorities at System level

The key steps to deliver our JFP in 2025/26…

Building on what we have delivered together in the first two years of our JFP there are some specific pieces of work that will drive forward the delivery of our strategic intent during 2025/26:

Driving the shift upstream to more prevention and best value care in the right setting

The **'Building a Sustainable Future'** programme, a medium to long term transformation programme has been developed following a workshop with Senior Leaders in 2024/25 where a range of challenges from clinical sustainability, quality and safety, financial and strategic changes programmes were discussed. The Building a Sustainable Future programme forms the backbone of the system responses to the medium-term challenges of developing services able to meet the predicted increase in demand.

The overarching aim of the programme is to enable:

'Resilient services that have the capacity to meet the predicted demand, quality and performance standards, and which are delivered within our collective financial envelope'.

Key to the success in the development of the Building a Sustainable Future programme has been building a strong base of **strong Clinical Engagement** to provide input and support the programme and the longer-term vision.

A successful Clinical Engagement event in Feb 2025 generated positive feedback and enthusiasm to drive the Building a Sustainable Future programme forward.

To support the delivery of the **Medium-term Financial Framework** a **benefits realisation framework** has been developed to ensure that each intervention or initiatives impact can be quantified from an activity and performance, financial and workforce perspective. Understanding these impacts is a critical piece of work to ensure that we have the right services for patients and to support improving the financial position and delivery of our performance ambitions underpinned by the right workforce.

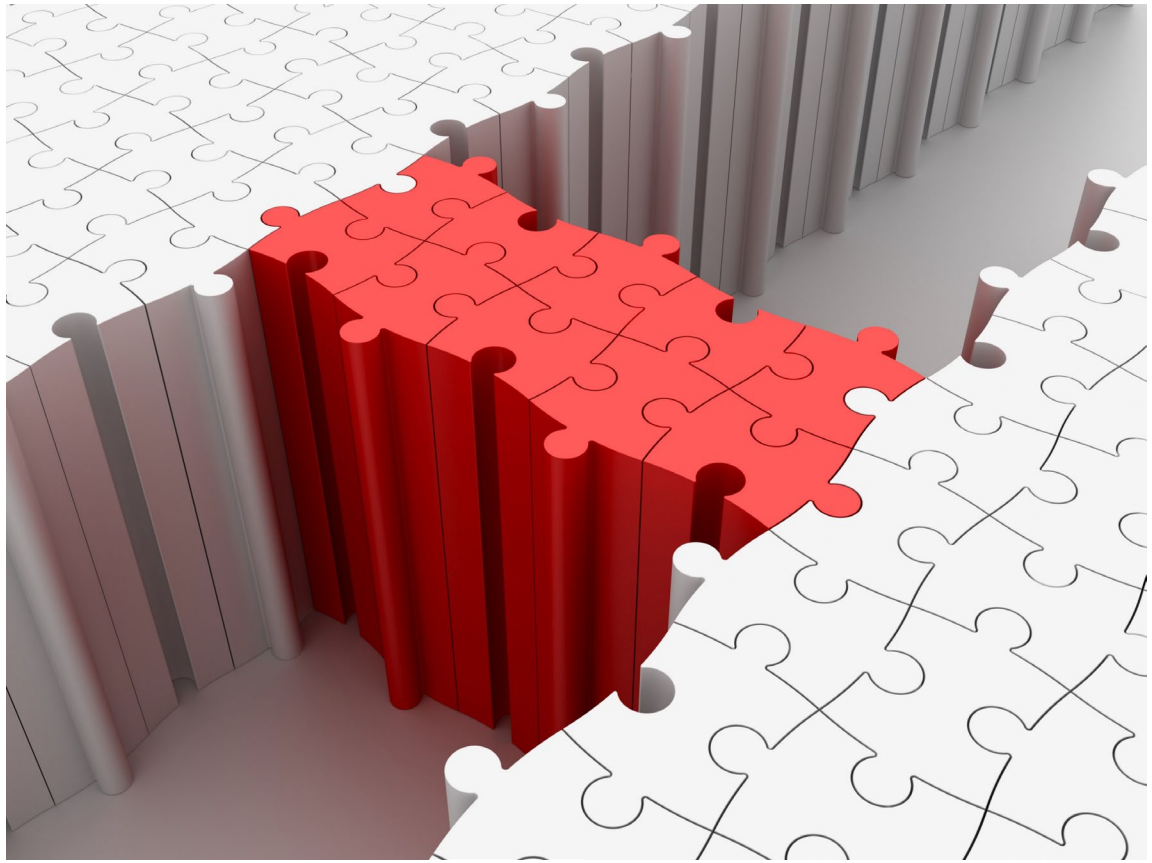
Delivering **Neighbourhood Health Activities** to Improve access to general practice and primary care. Prevent avoidable admissions to hospital, residential and nursing homes. Ensure unavoidable admissions are short and cost effective. Using population health management tools and techniques to standardise community services , develop multi disciplinary teams, intermediate care and home first, urgent neighbourhood services and modern general practice. This will support the **shift from acute to community**.

Develop and implement a **Work and Health Strategy** to articulate the NHS role in supporting **improved social and economic impact**. This will take the same type of strengths-based approach as we have done in targeting recruitment into health and social care from communities where access to employment opportunities are limited by existing barriers.

Herefordshire and Worcestershire are one of 15 systems across England to have been successful in bidding for a **grant of £2.4 million to deliver Workwell over 2 years.** The workwell programme is live and will continue to grow, using a coaching model to support people with health issues to stay in or return to work. This personifies our commitment to help address the wider determinants of health and to support vulnerable people in our communities by using existing partnerships across the NHS and Local Authorities. We will deliver a refreshed NHS Green Plan to contribute to wider sustainability.

Reducing health and healthcare inequalities remains a strong focus, with the local **Health Inequalities Ambassadors programme** now embedded through programmes. A key enabler will be the development of a **Population Health Management – Strategic Implementation Plan,** which will define a clear vision to engage our leadership and build a community of practice to enable us to provide access to the right data and insights and put it into the hands of those that can make a difference. A core facet of PHM is **engaging patients, service users and citizens** to understand their needs and look at how we can design services to effectively meet these needs within the resources available, improving access, outcomes, experience and reducing health inequalities. This will support the **shift from treatment to prevention.**

The Strategic Context for the Joint Forward Plan



Strategic Context - What is working well – The second year of our joint forward plan, 2024/25

Some of the best access to GP service in England

- The most recent ONS Health Insights Patient Survey at the beginning of 2025 ranked the ICB as the best in the country where 86% of patients reported a 'good' overall experience of access to general practice.
- GP Practices are providing patients with access to around 466,000 appointments a month. This is almost 80,000 appointments per month more than pre-pandemic.
- Excellent progress has been made in Self-referral pathways: adult audiology went live in 2024 and now Physiotherapy/Musculo-skeletal and weight management pathways have been developed. About 4,000 self-referrals are made each month.

Reduced waits for patients awaiting cancer diagnosis

- Achieved 78.6% for the 28-day Faster Diagnosis Standard performance in March 2025 which is above the 2025/26 Operational Planning target of 75%.
- Achieved 69.5% of patients received first definitive treatment within 62-days of referral, narrowly missing the 70% target.
- We are the 8th highest performing area for cervical screening coverage in England.
- Lower gastrointestinal (GI) Urgent Suspected Cancer referrals accompanied with a FIT (faecal immunochemical test) remains consistently above the 80% target and 2nd highest in the Midlands.

Better adult learning disability care in the community

- 77.9% of people with learning disabilities received an Annual Health Checks.
- LeDeR reviews performance metrics continue to exceed national and regional performance, demonstrating that people with learning disabilities and Autism are supported in the community rather than inpatient care.

Positive impact on reducing health inequalities

- 5,000+ reached with essential prevention services in the most underserved communities (vaccinations, health checks, screening and early cancer referrals).
- HWICB exceeded the 90% eligible referral target into the NHS Digital Weight Management Programme with 2,384 eligible referrals (95%).

Recovering diagnostic and elective services

- As of March 2025, there are 1464 people waiting longer than 52-week, this is less than the system Operational Planning target. We will continue to work on eradicating these long waits in 2025/26.
- HWICS continue to be one of the highest performing ICB for Value Weighted Activity in elective care at over 135%.
- Waiting times longer than 13-weeks in Audiology achieved a 58.9% reduction in the number of people waiting. Pathway mapping and improved triage processes have led to this improvement.
- The percentage of people seen for diagnostics within 6-weeks reached 81.1% in March 2025, better than the average national average of 81.9%.

Better access to urgent and emergency care

- Both WVT and WAHT have improved emergency access standard (EAS) as of March 2025, with a system level of 65.4%.
- Ambulance Category 2 mean response time achieved less than 30 minutes as at February 2025. The performance throughout 2024/25 was better than 2023/24.
- Launched less than 45-minute ambulance handover protocol in March 2025 to improve on the timeliness of the handovers from ambulances to Emergency Departments.

Strategic Context - The biggest strategic challenges that NHS partners need to address

Tackling increasing demand for health and care services

The national challenges for health and social care providers are well documented. Delayed and reduced services during the Covid-19 pandemic increased the backlog for people waiting for urgent and elective services. Overall, there has been an increase in demand and complexity of need and services are struggling to provide a positive experience with good outcomes for individuals.

At the same time the population is ageing, with over 44,000 more over 65 years olds living in Herefordshire and Worcestershire by 2031, over a quarter of the increase being over 85 years old. By 2033 there will have been a 50% increase in the number of people who are over the age of 80. Alongside this demographic growth, there will be an increase in frailty, with projections indicating that people living with the highest levels of frailty will increase by around 28% over the next 10 years.

Securing sustainable workforce and clinical models for all services

There are around 39,000 people working in health and care services across the system. Around 18,500 work in Primary and Secondary Care and 20,000 in Social Care. Turnover is slowly reducing in the sector from an all-time high post COVID. In recent years, turnover has been at 10% for staff in the NHS and 26% of staff in social care. Vacancy rates range between 7% -10%. Recruitment activity to bring more people into Healthcare and care worker roles has had a positive effect but there remain critical areas of workforce shortages in nursing, some medical specialities and social workers There are around 300 nurse vacancies across the system (200 in the NHS and 75 in Social Care) and a reliance upon international recruitment. There is also a lack of pharmacy professionals across the system, with increased numbers moving to community pharmacies.

Sickness rates fluctuate at around 5.5% across the NHS organisations with mental health being cited as the main cause. That said, Staff engagement has improved over the last year and is in the top third of NHS organisations across the Midlands.

Workforce shortages in some specialties have resulted in increased levels of service fragility, particularly in cancer and stroke pathways. In the most extreme examples, such as haematology, emergency service changes have been needed whilst sustainable options were identified. In other instances, to fill gaps in substantive rotas and minimise risks to patients, health and care services have relied heavily on bank and agency staff.

However, with spend on agency staff in 2024/25 being over £50m and accounting for 6.2% of the total workforce budget, this is not a financially sustainable solution. As well as the financial pressure it creates, it can also lead to inconsistency in care provision and poorer experiences. Partners across NHS services are working together to reduce the reliance on agency staff to reduce these risks going forward.

Demand and workforce challenges can impact the effectiveness of services to see and treat patients in a timely and clinically safe manner, negatively impacting on healthcare outcomes. Addressing the signs of vulnerability requires early identification and solution-planning with the engagement of clinicians. Subsequently proactive work to pre-emptively identify vulnerabilities has led to the system developing a fragile services framework.

Financial sustainability and optimising use of services

As a deficit financial system, there is a requirement imposed on all system partners to implement stringent productivity, efficiency and savings programmes. This requires partners to introduce rigorous cost control measures and explore options for reducing service levels to bring spending into line with financial allocations. This includes freezing any new income and halting any service developments or business cases that do not identify lower cost delivery models or have clearly identified funding streams. This downward pressure needs to be understood in the context of the system being overfunded using the national formula.

In September 2024, partners replicated the study undertaken a year earlier to audit whether people were being cared for in the most appropriate care setting for their needs at the time. The study showed that just over 70% of the 1,679 people reviewed were being cared for in the right care setting – if an optimal balance between capacity, demand and flow efficiency was achieved. Showing there is a significant opportunity to improve processes and re-balance capacity across care settings, to deliver optimal outcomes.

Alongside this, the strategic demand and capacity model work suggest that without change, the system will require between an additional 365 acute beds by 2033. The upper end of this range is comparable to building new wards that are equivalent in scale to about 2/3rds the size of Hereford County Hospital. Even if the finances were available to fund such expansion, the workforce would not exist to staff it. Therefore, finding mitigating actions and alternative solutions is critical to the delivery of improved health outcomes and reduced health inequalities.

A focus on ensuring care is accessed in the right setting which means moving activity, treatment and resources towards more preventative rather than reactive treatments, as part of the solution. As will ensuring that the wider social determinants of health are addressed through effective alignment of vision, plans and effort with local authority and VCSE partners. For example, the development of the “Community Paradigm” concept and relevant application to local circumstances will be one of the key platforms for making local services both sustainable and effective in supporting improved outcomes for the population.

The ‘Building a Sustainable Future’ programme, a medium to long term transformation programme has been developed following a workshop with Senior Leaders in 2024/25 where a range of challenges from clinical sustainability, quality and safety, financial and strategic changes programmes were discussed.

Strategic Context - Operational performance - Priorities for year 3, 2025/26

Reducing backlogs and long waits for elective care

- Improve the percentage of patients waiting no longer than 18 weeks for treatment to 65% nationally by March 2026, with every trust expected to deliver a minimum 5%-point improvement
- Improve the percentage of patients waiting no longer than 18 weeks for a first appointment to 72% nationally by March 2026, with every trust expected to deliver a minimum 5%-point improvement
- Reduce the proportion of people waiting over 52 weeks for treatment to less than 1% of the total waiting list by March 2026

Reducing long waits for cancer care

- Improve performance against the headline 62-day cancer standard to 75% by March 2026
- Improve performance against the 28-day cancer Faster Diagnosis Standard to 80% by March 2026

Improving access to primary care services

- Improve patient experience of access to general practice as measured by the ONS Health Insights Survey
- Increase the number of urgent dental appointments in line with the national ambition to provide 700,000 more

Reducing waste and improving productivity

- Deliver a balanced net system financial position for 2025/26
- Reduce agency expenditure as far as possible, with a minimum 30% reduction on current spending across all systems
- Close the activity/ WTE gap against pre-Covid levels

Improving safety and reducing health inequalities

- Improve safety in maternity and neonatal services, delivering the key actions of the of the 'Three-year delivery plan'
- Reduce inequalities in line with the Core20PLUS5 approach for adults and children and young people
- Increase the % of patients with hypertension treated according to NICE guidance, and the % of patients with GP recorded CVD, who have their cholesterol levels managed to NICE guidance

Improving mental health and learning disability care

- Reduce average length of stay in adult acute mental health beds
- Increase the number of CYP accessing services to achieve the national ambition for 345,000 additional CYP aged 0–25 compared to 2019
- Reduce reliance on mental health inpatient care for people with a learning disability and autistic people, delivering a minimum 10% reduction

Reducing long waits for urgent care

- Improve A&E waiting times, with a minimum of 78% of patients admitted, discharged and transferred from ED within 4 hours in March 2026 and a higher proportion of patients admitted, discharged and transferred from ED within 12 hours across 2025/26 compared to 2024/25
- Improve Category 2 ambulance response times to an average of 30 minutes across 2025/26

Strategic Context – Workforce - Creating a sustainable inclusive workforce

Building on the improvements of 2023/24, we have delivered a range of outcomes in attraction, retention, leadership and potential, the ICS Academy and culture and inclusion. We have also refocussed our efforts so that we can use these key 'workforce enablers' to help to alleviate some of the system challenges as well as to support the transformation work.

Another successful year of recruitment has reduced the number of vacancies across our NHS Providers. Each organisation has their own recruitment programme and there has been a system-wide attraction programme. Most of the NHS Trusts have recruited key posts in Nursing and Midwifery and are now managing turnover. We have commenced work on the NHS Universal Family Care Leaver Covenant Programme which will enable us to attract and recruit into our entry level vacancies. This is to tackle health inequalities, especially within under-represented groups, support workforce pipelines into both NHS and Social Care entry level roles/careers and to support the delivery of our Diversity and Inclusion objectives.

Turnover has been reduced through a range of mental health and wellbeing programmes delivered across the system. A combination of retention programmes, more flexibility, greater development and a focus on inclusivity has led to a greater number of people choosing to stay within the NHS. This is borne out in some strong engagement survey results for 2024.

In line with the NHS Long Term Workforce Plan, we have developed a shared workforce vision focused on providing opportunity for both existing and newly hired staff. To address our workforce challenges we have adopted a Grow Our Own approach to encourage local people into the system and are supporting them to stay through career and leadership development programmes. We have developed a shared approach to growing future nurses to mitigate against potential high levels of retirement over the next five years. This has been accomplished by working together to maximise the potential of our education providers and the new Three Counties Medical School. This work has allowed us to retain our staff through organisational support and crucially, prepared us to review and reform how services are delivered when workforce is not available.

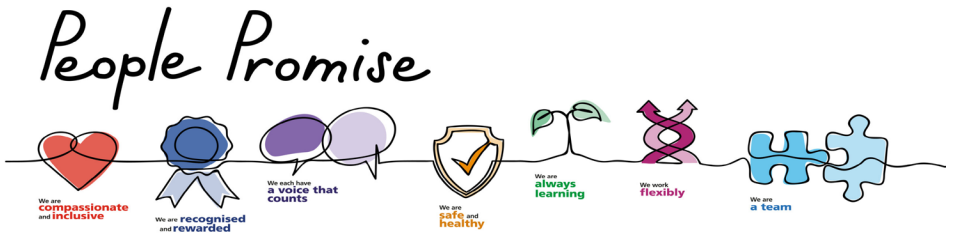
The collaborative and innovate work of the ICS Academy continues through the work of the faculty groups who meet as professional groups to share their workforce challenges and best practice. In 2024/25 the Healthcare Science faculty has improved connection between Herefordshire and Worcestershire teams and are now working together on career pathways and targeted recruitment activities in their field. The AHP faculty has worked to produce a fair share model for student placements. This will help to ensure that AHP students have a good placement experience. The Pharmacy faculty produced a workforce strategy and associated delivery plan. The VCSE faculty resumes in April 2025 with a new focus on workforce training and development. In 2025 a new Psychological Services Faculty will also be created and the Medical Faculty will expand to include Dental.

Training and development courses and resources offered through the ICS Academy Exchange continue to grow, supporting the ICS workforce to pursue their careers. Resources include career conversations supporting documents, career pathways in multiple fields, project and change management and the new ICS Leadership behaviours. A range of ICS wide course offers have also been advertised or booked through the ICS Academy Exchange including Mary Seacole Leadership Programme, QSIR, Reasonable Adjustment Digital Flag and Oliver McGowan which are easily accessible and popular.

During 24/25 we have co-designed and agreed our ICS Leadership Behaviours describing how we will all engage with each other when we are working across the system – these are Open, Inclusive, Courageous, Compassionate and Innovative. We launched the System Leader Connect programme, to engage and develop our senior leaders in effective system working with a key focus on building relationships. We have also expanded development support and capacity available to support the system and its leaders - including a cohort of new 360 feedback facilitators, a group of wider team and change facilitators and development opportunities to support our qualified coaches.

All NHS organisations have worked hard on to deliver an improved experience by delivering their people promise plans. The 2024 survey showed a positive shift in compared to 2023 demonstrating the impact of these efforts. All four NHS organisations have put a real focus on creating happy, safe and engaging places of work and the ICS has moved from the bottom half in the Midlands region to the top third on most of the indicators. A happy and engaged workforce will typically perform better and offer discretionary effort where it is needed so intrinsically linked to improvements in performance, and so, by extension an improved experience for the people who use their services.

In September 2024, we held our inaugural 'Big Inclusion Conversation' conference, where colleagues from across the system came together to celebrate our successes and plan our future work. At the event we launched 'Making Inclusion a Reality', our 5-year Culture and Inclusion strategy for the system and our new Active Bystander programme. We have now trained 18 facilitators who will deliver the Active Bystander programme across the ICS in 25/26.



Strategic Context – Workforce – Addressing our challenges

Workforce availability in some specialisms remains a key challenge for the system. Some of these are being covered by medical locums which can impact service delivery to patients. There is limited international recruitment and so we will work with the faculties and through direct engagement to understand the attraction and retention challenges for the different areas.

Our strategy is to grow-our–own skills wherever possible, particularly in entry level roles and Nursing and Allied Health Professional roles, encouraging local people to stay within the system and develop their career here.

Providing a good placement experience is vital to 'grow our own' particularly for Nursing, Midwifery and AHP students. An exercise to map the clinical student placement provision from NHS Trust and PCN providers and the allocation of students from different universities is currently being undertaken to find where more placements could be offered.

Targeted attraction of Health Care Assistants, Health Care Support Workers and Care Workers through marketing and promotional material provides a pool of entry level staff in short supply and where we compete with other local employers such as retail. We are also developing pipelines to ensure a sustainable route in for hard-to-reach groups and hard-to-fill vacancies.

Wellbeing, resilience and change management are an important focus for retention, enabling our people to navigate what appears to be a challenging period of change and transformation.

We will also work closely with our Transformation Programme – Building a sustainable future – as a key enabler we will work with leads to establish the workforce requirements of the different workstreams to enable change to support key priorities, including the three shifts (Hospital to community, treatment to prevention, analogue to digital).

System leader connect will have an eye to the future – ensuring that we have a succession plan for our senior leadership drawn from our aspiring, talented, local leaders.

Medical Staff

- Medical 'faculty' working together with TCMS to increase the number of trainees across the system.
- Working with Worcester University to ensure student placements do not limit student numbers.
- Devising new approaches to attraction, including bespoke packages, new advertising campaigns and a focus on clinical leadership support
- Target challenging vacancies through apprenticeships and grow our own initiatives
- Promote and use career pathways to case studies and opportunities

Clinical Support and Social Care

- Growing numbers of Health Care Assistants and Health Care Support Workers through targeted outreach.
- Improved promotional material to attract those New to Care including online presence.
- Develop pipelines for employment through the universal family scheme and similar programmes.
- Explore cadet/T-level and BTEC routes into this workforce
- Leadership and management resources to aid retention
- Establish a process to share apprenticeship levy to allow more social care providers to benefit from it.

Pharmacy

- An innovative approach to attraction based on engagement with colleges in 2024
- Increased use of pharmacy apprenticeships
- Development and promotion of career pathways, talent and succession plans.
- Maintain and support the work of the pharmacy faculty.

Mental health nursing

- Engagement with the sector to understand attraction and retention challenges
- Target areas of high vacancy for apprenticeships.
- Outreach events targeted to Sixth Form and local colleges that offer relevant courses, and targeting regional universities with proximity to Worcestershire that have students qualifying in Mental Health Nursing in March 2026
- Agreed talent development offer for mental health nurses.

Strategic Context – Workforce – Attracting and Retaining People

Healthcare is a rewarding career but it can be stressful. In 24/25, NHS Trust providers have been asked to plan to deliver services with a significant reduction in bank and agency use and whilst reducing the number of non-clinical substantive roles. Retention, reduction in sickness absence and targeted attraction into vacancies that attract locum spend will be vital.

Continuing to maintain nurse capacity through 'grow our own' initiatives such as apprenticeships and other education programmes that ensure supply of critical clinical resources in the system will remain important to mitigate the risk posed by an aging workforce.

This includes our apprenticeship hub, which brings together system apprenticeship leads enables us to practically understand how we are prioritising our organisational levies and target these at the system risk areas. A case in point is the system approach to developing more nurses through the trainee nurse associate and registered nurse apprenticeship route.

Exit interview data and HR theory is clear that people want to feel that their wellbeing is supported, they have career opportunities to progress, they have good relationships with their line managers and that they feel a sense of belonging. Pay and reward are of course important factors but where the above is in place, they become slightly less pivotal.

Retention activities are therefore built around ensuring that these things are in place. Reducing sickness through providing quick access to Wellbeing support for staff, supported by capable managers, provides the basic cornerstone of retention. Offering development opportunities to move around in one's career and working with leaders and line managers to improve their capability means that people feel valued and empowered by their managers.

Delivering our Inclusion and EDI strategy means that everyone, regardless of their background will feel that they form an important part of the organisations in which they work. Through the work of the faculties and understanding key operational risks, these interventions will be targeted where they are likely to make the biggest difference.

The ICS Academy is now an established central point for collaborative working on innovative projects to ensure the retention of the ICS workforce. This yea this has included engagement outreach with local colleges where students participated in focus groups to understand how we can attract their age group into health and social care roles.

In addition, the new research and innovation strategy and the research consortium will be reporting into othe ICS Academy Steering group to showcase the work that is being undertaken and to highlight research as a career development opportunity that will keep high potential staff in our ICS workforce.

We will maintain our ambition to be a great place to work – our cross-system group will continue to meet to share best practice, learning and resources because we are better together – especially as we face into an uncertain period of change.

Activities to deliver this include:

- Development of pipelines for employment into entry level roles
- Development of bespoke attraction products to bring in medics to sure up fragile services
- Greater joint planning off the back of the staff surveys (end calendar year)
- Developing career pathways to enhance career ambitions for entry level jobs
- Wellbeing offer enhanced through leadership capability programme
- Improved placement capacity to support clinical education, including T-levels, apprenticeships and grow our own initiatives across the system including in the VCSE and Social Care Sectors.

Strategic Context – Workforce – Growing our Own and Reforming Services

Growing and developing our people, teams and organisations

While we will continue to attract people into our system to ensure we can deliver key services, we also want to retain key talent.

We therefore will focus on growing our own skills, offering job opportunities and long term careers for those that want to work within our system. The coming together of the organisations across the system offers a far wider range of options for people and an eco-system that they can move around in, while knowing that the experience that they gain will continue to benefit the sector locally.

Through offering a greater range of development opportunities for our various professions, developing educational links with further and higher education providers, creating more placements for the new Three Counties Medical School in Worcester University and making it easier for people to move around our organisations. We are also developing a suite of resources to support team development to not only enhance productivity and wellbeing but to improve attraction and retention.

We continue to deliver our 'Making Inclusion a Reality' strategy, through improving access to reasonable adjustments through a new Health and Wellbeing Passport for colleagues. We are also working to improve the experience of our neurodiverse colleagues with a 'Neurodiversity Toolkit'. Through the delivery of the Active Bystander programme, we will support colleagues to feel confident to take an early intervention approach to prevent negative behaviours from escalating. This will contribute to improving the health and wellbeing our staff and patients and people who draw on our support to grow a culture of civility and respect.

We link in with regional and national colleagues to develop system wide approaches to succession planning and talent management.

Activities to deliver this include:

- Development of innovative new roles, drawing upon clinical knowledge
- A joint talent and leadership development offer, available to all providers at ICS Academy, linked to career conversations and pathways
- Delivering our ICS Inclusion Strategy which brings together staff networks, ensuring everyone feels that they have representation
- Roll out and embedding of our leadership behaviours – developed with focus groups from across the system in 2024
- Delivery of our system leader connect programme

Reforming Services

While we can act quickly to bring in some of the skills we need, there are others that are so scarce nationally or take so long to grow that we must instead think differently about how we deliver our services. Making greater use of digital tools must also drive reform of services for the patient or user.

Providing organisational design and development expertise to clinicians and operational colleagues to think differently about the delivery of services is our approach to reimagining how services might be provided. This is supported with ongoing workforce planner business partnering to each service pathway so that when workforce is identified as a risk, they are able to help the service to consider how else it might continue to deliver.

Workforce is a key enabler for the 'Building a sustainable future programme. This work will focus our activities to those areas of transformation that have been prioritised to address critical need to reform the way services are delivered in Hereford and Worcester within its financial limits.

Activities to deliver this include:

- Developing workforce planning capability across the NHS through a transformation programme focussed on reviewing public health data for service pathways.
- The development of the faculties in workforce planning and consideration of public health data for their function.
- Deeper understanding of the operational workforce risks by service line using the STAR framework approach and how to mitigate those in the short and long term.
- The development of more integrated, cross-organsiational / systemwide roles where appropriate.
- Focussed work on converting high agency spend into longer term sustainable workforce through the use of apprenticeships, new roles and digital solutions.
- Aligning digital and data with people and workforce to increase the digital capability of staff, enabling them to be more open to future digitalisation of services.

Strategic Context – Finance - The financial history and financial plan for 2025/26

Actual Spending v Formula Allocated to Herefordshire and Worcestershire

Prior to the pandemic the system was under-funded against target using the national funding formula. The closing distance from target in 2019/20 for the 4 CCGs in the ICS area was -3.52%, equivalent to £35m. Any overspends against this allocation were funded using non-recurrent funding sources.

During the pandemic, costs were fully funded, and system baselines were reset at actual spend levels. In essence, this process resulted in historic overspends being incorporated into financial baselines generating a significant change to the base funding level for H&W ICS.

Going into 2025/26 this the system is now overfunded against fair share target, using the national funding formula by 3.9%. This is consistent with the previous financial year.

Change in spending pattern in recent years

Growth in spend over this period was seen in all areas, with the exception of running costs. The expenditure for the system includes Pharmacy, Ophthalmic and Dental (POD), as well as specialized commissioning (spec comm). Expenditure continues to grow in acute services, including the nationally allocated deficit support allocations and in continuing care. Growth has been seen in community services and primary care, these are lower than our forward-looking ambitions around a shift upstream to more prevention and out of hospital care, through neighborhood health care. The ambition over the life of the Joint Forward Plan is to change this position.

Spend Area	19/20	25/26 Plan	Change	
Acute	£559.2m	£1,032.6m	£473.4m	85%
Mental health	£110.5m	£176.0m	£65.5m	59%
Community Services	£130.0m	£215.6m	£85.6m	66%
Continuing Care	£68.0m	£119.4m	£51.3m	75%
Primary Care	£147.1m	£213.1m	£66.0m	45%
Primary Care Prescribing	£125.6m	£163.5m	£37.9m	30%
POD (Delegated)	£0.0m	£76.8m	£76.8m	100%
Spec Comm (Delegated)	£0.0m	£167.8m	£167.8m	100%
Other Programme	£22.3m	£24.3m	£2.1m	9%
Running costs	£16.3m	£11.1m	(£5.2m)	(32%)

The 2024/25 financial outturn

The original financial plan for 2024/25 was for a £79.9m deficit, before the inclusion of national deficit support to get the system to a balanced financial plan. Whilst the plan was not without financial risk in a number of areas, these were mitigated in-year across the system. Subject to external audit at the time of updating this document, the system has reported a balanced position for the year as shown in the table below. Efficiency delivery was slightly lowered than planned and whilst agency expenditure reduced from previous levels it was still above the plan agreed. Both areas were mitigated through non-recurrent financial opportunities.

The Plan for 2025/26

The system financial plan for 2025/26 has been agreed with NHS England at breakeven, in line with NHS England planning requirements. The position includes £73.2m of national deficit support monies. The plan includes a challenging efficiency requirement of £133.1m (6.1%), and a further reduction in agency expenditure to a maximum of £36.2m. Financial risks within the submitted plan have a level of identified mitigations but, the largest areas unmitigated relate to efficiency savings required. Management plans for both efficiency and financial risks are continually being developed. The table below sets out the plans for each organisation.

Surplus / (Deficit)	Integrated Care Board	Worcs Acute	Health and Care Trust	Wye Valley	ICS Total
24/25 plan (deficit)	+£8.8m	(£57.3m)	+£0.0m	(£31.4m)	(£79.9m)
24/25 out-turn (deficit)	+£11.3m	(£5.7m)	+£0.0m	(£5.6m)	£0.0m
25/26 plan (deficit)	+£0.0m	£0.0m	£0.0m	£0.0m	£0.0m
Delivery Plan Requirements for 25/26					
Efficiency savings	£42.1m	£53.0m	£13.5m	£25.0m	£133.6m
% efficiency saving	1.9%	6.6%	4.4%	6.0%	6.1%
Trust Agency expenditure	-	£22.0m	£6.1m	£8.1m	£36.2m
% of Staffing Cost	-	4.7%	2.6%	3.3%	3.8%

Strategic Context – Finance – Building a Sustainable Future and benefits realisation

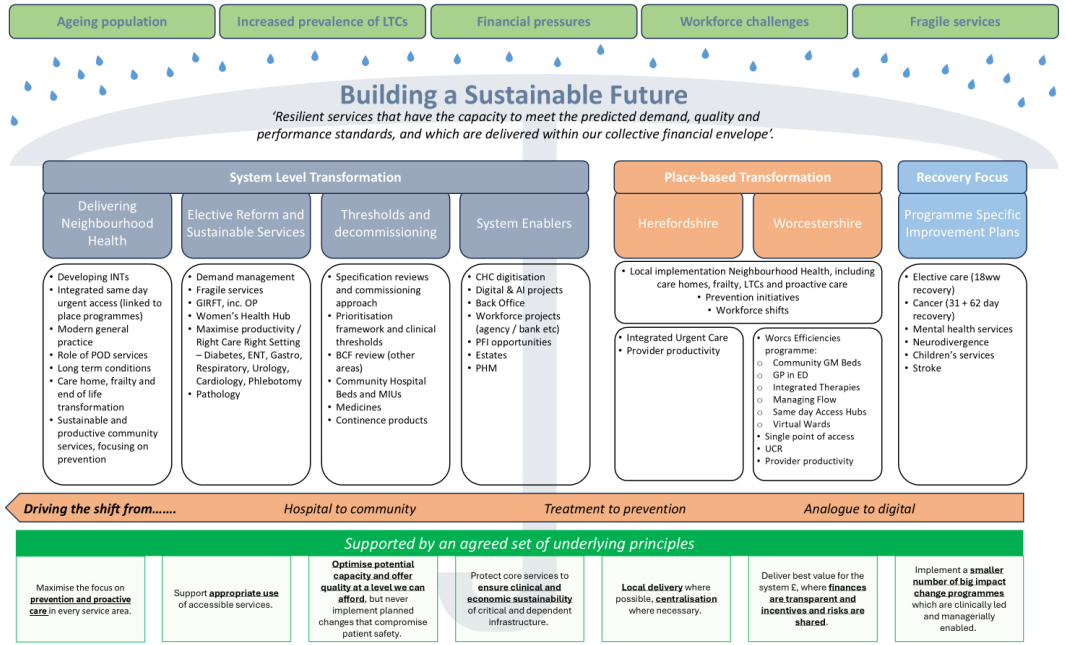
Building a Sustainable Future

Herefordshire and Worcestershire health and care partner organisations work together each year to develop a local operational plan that meets strategic and financial objectives as well as delivering the right services for our population. In recognition of the financial challenges facing the system in 2025/26 and beyond senior leaders, including Clinicians have worked together to develop a programme of work called "Building a Sustainable Future".

The overarching aim of the programme is to enable the delivery of:

'Resilient services that have the capacity to meet the predicted demand, quality and performance standards, and which are delivered within our collective financial envelope'.

The 'Building a Sustainable Future' programme, a medium to long term transformation programme has been developed following a workshop with Senior Leaders in 2024/25 where a range of challenges from clinical sustainability, quality and safety, financial and strategic changes programmes were discussed.



The Building a Sustainable Future programme forms the backbone of the system responses to meet the medium-term financial challenges, to deliver the predicted increase in demand, delivered within allocated budget. This supports all aspects of annual and medium-term planning, with a particular focus on the contribution to the Medium-Term Financial Framework.

Key areas of focus for 2025/26 have been agreed through the Building a Sustainable Future Board, chaired by the ICB Chief Executive Officer, and are summarised below:

1. Frailty
2. Elective Reform
3. Releasing time to care
4. Prioritisation of services
5. Population Health Management
6. Public awareness and education

The financial contribution to sustainability of the system is a key part of the detailed transformation plans which underpin the priority areas for 2025/26.

Benefits realisation

A benefits realisation framework has been developed to ensure that each intervention or initiatives impact can be quantified from an activity and performance, financial and workforce perspective. Understanding these impacts is a critical piece of work to ensure that we have the right services for patients and to support improving the financial position and delivery of our performance ambitions underpinned by the right workforce.

Investment Standards

Delivery of the Investment Standards that were developed for 2024/25, and continue into 2025/26, to support the Building a Sustainable Future programme have progressed, following the identification of potential savings. The focus has been on:

- Best Value Care in the Right Setting or "Left shift"
- Prevention and addressing Health Inequalities
- Virtual Wards
- Growing our own nursing workforce

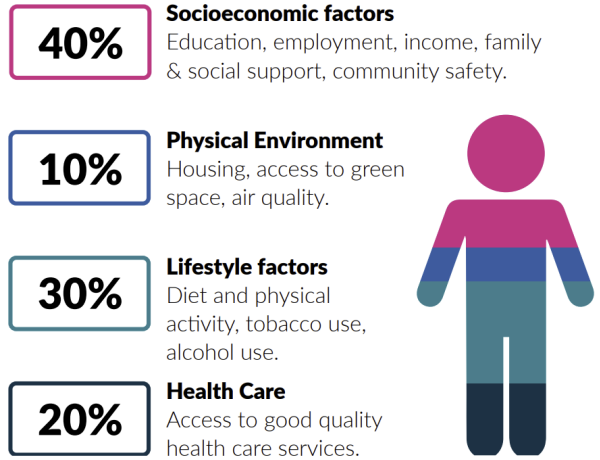
The core focus

Driving the shift upstream to more prevention and best value care in the right setting

What do we mean by driving the shift upstream to more prevention and best value care in the right setting?

A greater focus on prevention

The major focus of the JFP is on driving a shift to a model of healthcare that places greater emphasis on the **importance of preventing ill-health** rather than a focus on treating the symptoms of it. The NHS cannot achieve this by working in isolation only through effective partnership working and good engagement with communities. This is the emphasis of the Health and Wellbeing Strategies and the Integrated Care Strategy. The core focus of NHS partners in this JFP is on the "20%" of factors that contribute to people's health and wellbeing outcomes (as per the diagram right).



Adapted from an illustration of the impact of healthcare and non-healthcare factors on a person's health. Source: Institute for Clinical Systems Improvement Going Beyond Clinical Walls. Solving Complex Problems (October 2014).

Whilst it is not the core business of the NHS to focus on the wider determinants of health, such as education, employment, housing and environment, as a major employer of around 2.5% of the local population (circa 20,000 employees), many of whom live in the ICS area, NHS bodies clearly have an important role to play and contribution to make.

The focus of this plan though is on the core business of the NHS, which is the provision of services. Through implementation of this plan, there will be a drive through planning and resource allocation approaches over time that increasingly rebalance the prevention v treatment equation:

During the early phases of implementation, the service areas outlined in appendix one, through their respective programme boards, will be charged with the task of identifying what specific actions can be implemented to contribute towards this overall ambition.

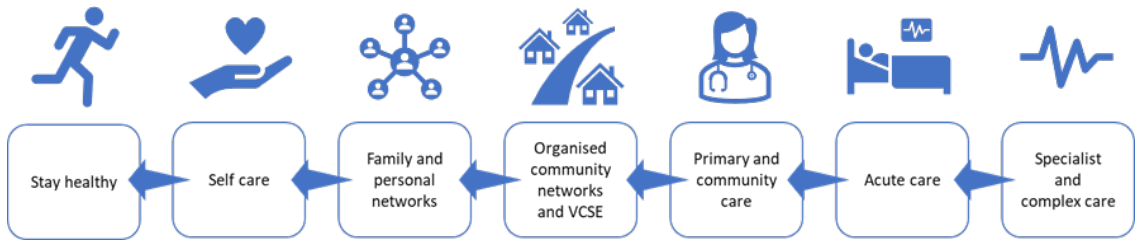
This ambition will also be incorporated in the medium-term financial strategy, 'Building a Sustainable Future'.

Providing best value care in the right setting

The role of the NHS is to provide care and treatment for people when they need it. The second element of shift in focus is on ensuring that the care is provided in the most optimal setting for the person's needs at any given point in time. Optimal represents the balance between quality, safety, appropriateness of setting and best cost care. Optimal is not just about cost reduction and financial savings, although savings are a clear beneficial by-product of getting optimal care.

Achieving optimal care settings will typically result in faster recovery from illness and a greater chance of return to independence. For example, a co-produced document called *"Supporting patients' choices to avoid long hospital stays"* highlighted that people's physical & mental ability and independence can decline if they are spending time in a hospital bed unnecessarily. As well as being at risk of acquiring hospital acquired infections, for people aged 80 years and over, 10 days spent in a hospital bed equates to 10 years of muscle wasting. Thus, there is a significant quality and service improvement benefit to be achieved by getting this right.

Providing care in the optimal setting requires NHS partners to work together to deliver more care towards the left-hand side of the spectrum below.



The Point Prevalence Audit undertaken in 2022, 2023 and 2024 identified that around 25% of people could be cared for further along towards the left-hand side of the diagram above. The financial opportunity associated with this cohort, if scaled up annually, was in the region of £12 to £15m, even taking account of the need for the additional capacity required to accommodate them in the other setting. Alongside the quality improvements, the opportunity to achieve this shift in focus is therefore very compelling.

Understanding the issues and opportunities around “optimal care settings” – The Point Prevalence Audit

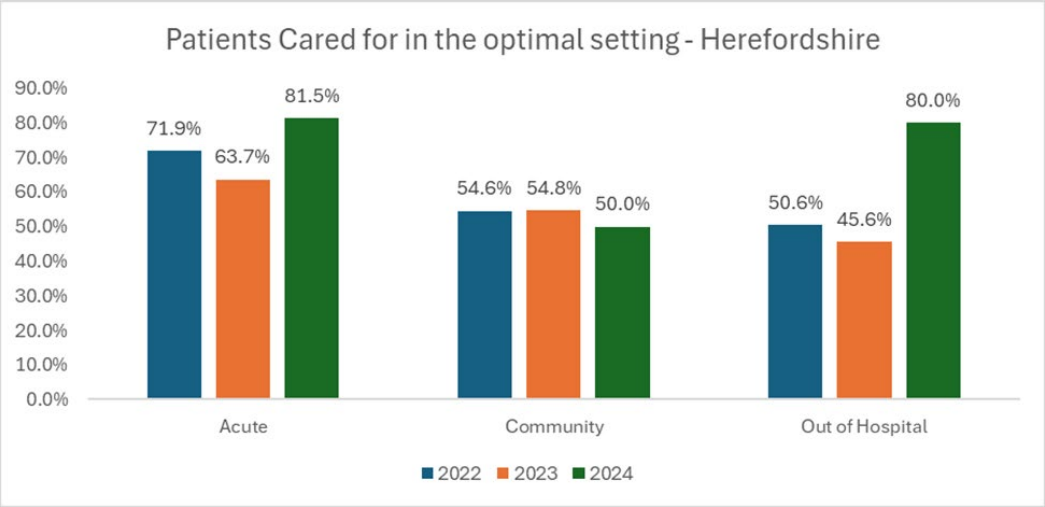
The Point Prevalence Audit

In September 2024 the system wide **Point Prevalence Audit** was conducted to assess the extent to which people in the health and care system are cared for in the most optimal care setting for their needs at the time. The audit, which replicated the method from 2022 and 2023 looked at 1,679 people across 103 care settings – including acute beds, community beds, discharge pathways and other home-based care such as community teams and virtual wards. The study showed that around 70% of patients audited were in the right care setting.

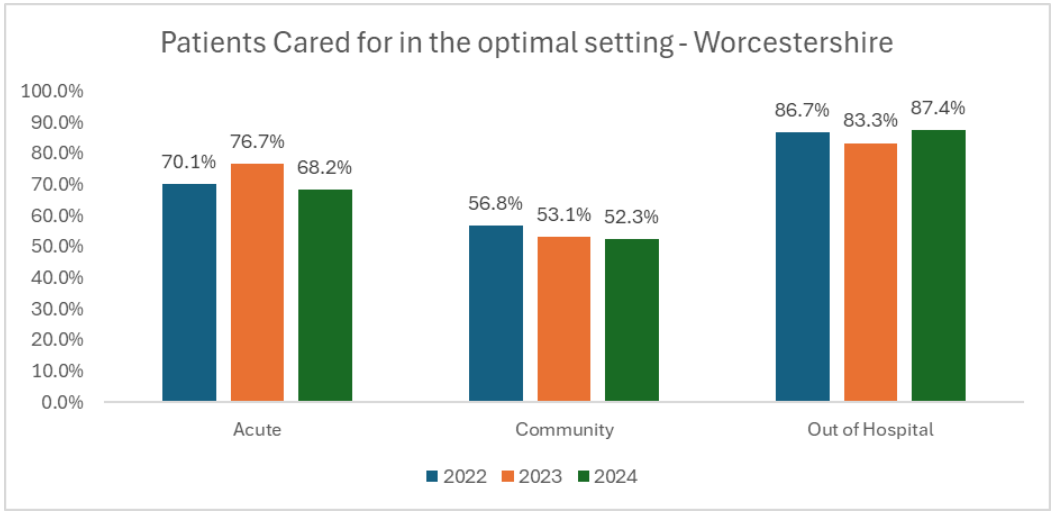
The charts below provide an overview of the shift in % of patients being cared for in the most optimal setting across the last three years.

Percentage of patients in the optimal care setting for their needs at the time

There were some notable changes to the results in PPA 3 compared to previous years, in particular in relation to Herefordshire’s results. There were a far higher proportion of patients assessed as being in the right care setting in both acute beds and out of hospital care. However, there was very little change in the position for community hospitals.



In Worcestershire the position was similar for community hospitals and there was some slight improvement from an already high baseline for out of hospital care. However, there was a fall in the proportion of patients deemed to be in the right care setting in acute beds.



Opportunities to optimise care settings – the balance between hospital and community

The opportunity to realise the government policy ambition to see a shift from Hospital to Community can be seen most clearly in the use of community hospital beds. Across both counties, in all three years, no audit has shown that more than 60% of patients are in the optimal care setting for their needs at the time.

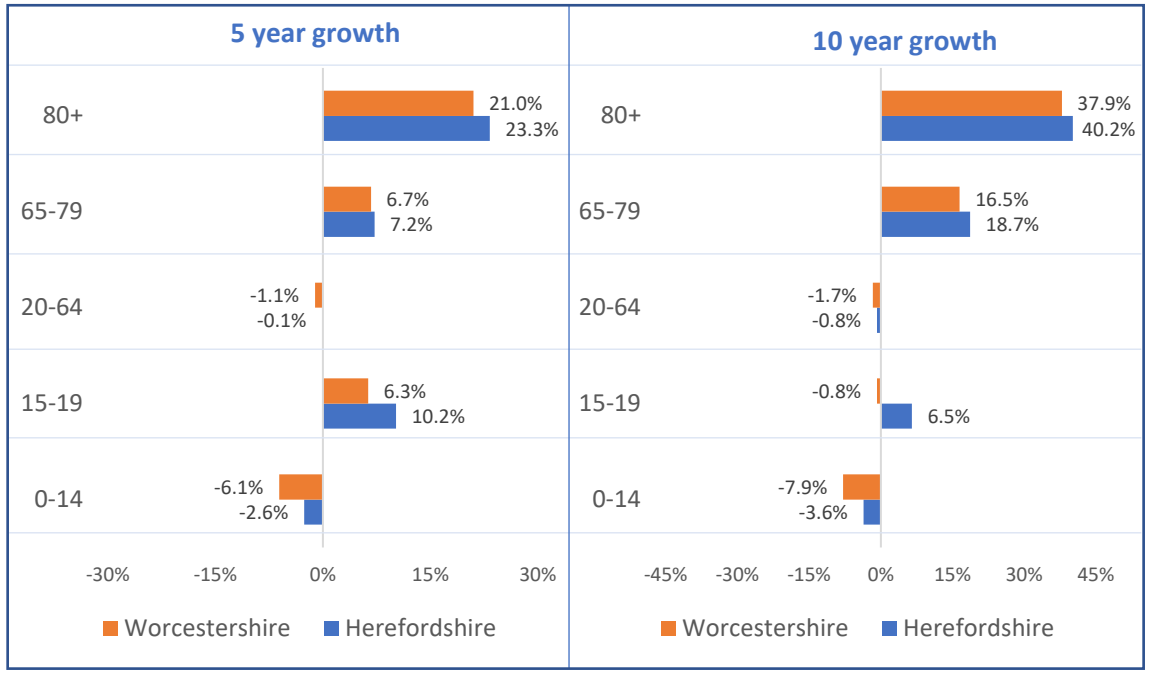
Creating additional capacity in home-based discharge pathways, accessing more capacity in domiciliary care and in residential / nursing homes would enable the system to operate more efficiently and effectively with fewer community hospital beds than are currently in use. The system will seek to address these opportunities through the Building a Sustainable Future Programme. This can be seen in the strategic demand and capacity modelling, described on the next two pages of this document.

If you would like to access further detail, you can do so here: Best Value Care in the Right Setting Update 2025

Developing a better understanding of future demand and capacity requirements

The final element in the strategic planning work to support the development of the JFP has been the development of a system wide **strategic demand and capacity model**. The point prevalence audit results indicated that there is a mismatch between demand and capacity; which ultimately leads to people being treated in care settings that are not optimal for their needs, frequently at higher cost to the system. The first phase of the demand and capacity model work has been to quantify the future impact over 5 years of not optimizing the provision of care. The second phase of the work, to be conducted during the first 3-6 months of JFP implementation will be to model the potential solutions to mitigate that growth in demand.

Population growth: Population numbers are forecast to grow most in the older age groups in the population – more than 20% over 5 years and nearly 40% over 10 years for people aged 80 years or more.



Likely Impact on Frailty Demand: Whilst age alone is not an indicator of future health demand, it does provide a basis for calculating likely levels of frailty that services are likely to be responding to. Initial model projections suggest the following impact:

Frailty Risk Category	10 Yr impact – Herefordshire	10 Yr impact – Worcestershire
No frailty score	+21%	+21%
Low score	+19%	+17%
Moderately low score	+28%	+27%
Moderately high score	+33%	+32%
Highest score	+36%	+38%

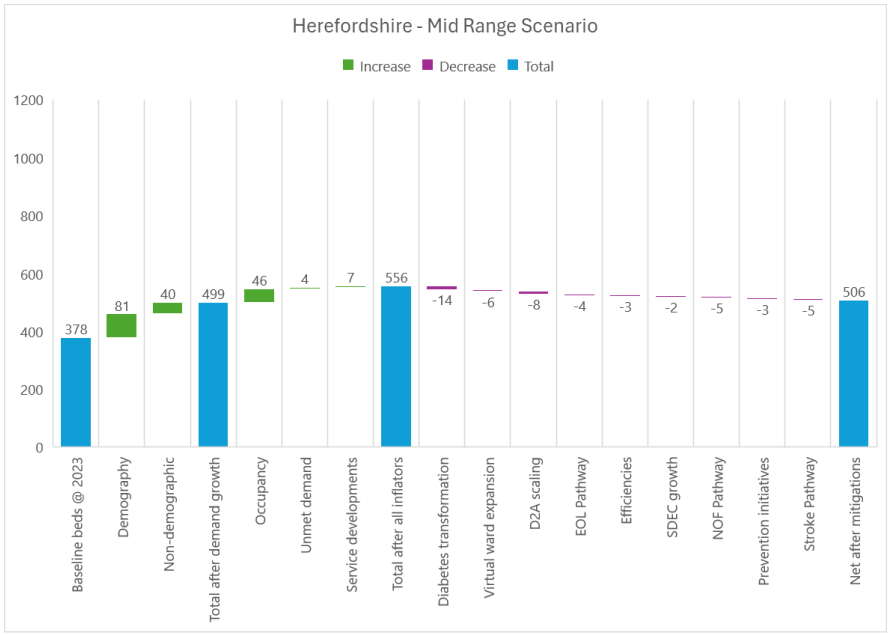
Unmet demand: The model calculates the impact of unmet demand (such as people waiting in ambulances or on trollies in A&E that would be admitted if beds were available). However, they are often cared for in unconventional settings for their whole hospital stay.

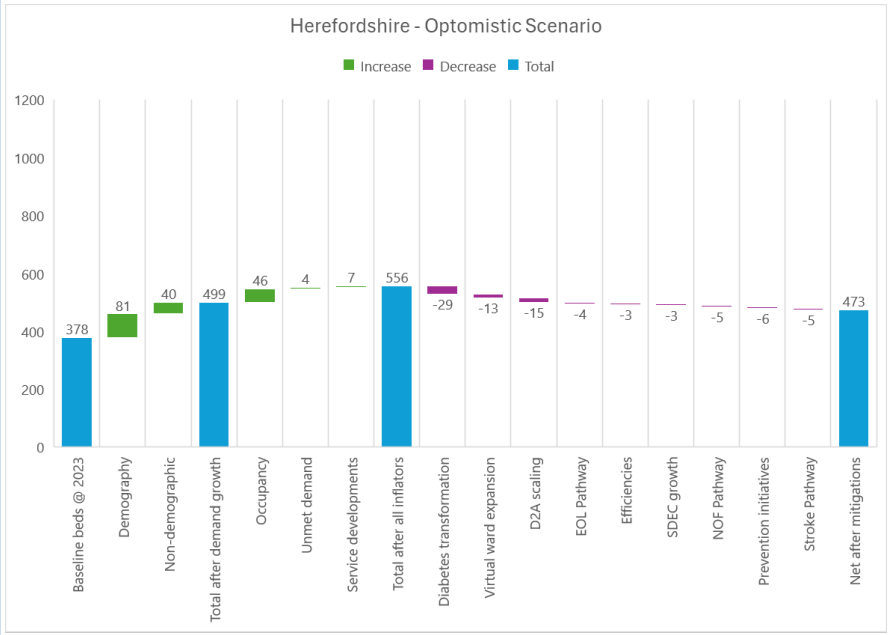
Sub-optimal flow: The model also calculates the impact sub-optimal flow on projected future bed numbers. There are two main mitigations to this, one of which is increasing the size of the bed pool to enable better flow, the other is to optimize practice to ensure that patients are only admitted when necessary and don't have any delays to their discharge.

Initial aggregate demand impact: Bringing together all aspects of growth, the draft model indicates future demand growth that will need to be mitigated by actions to be delivered under the JFP is an additional 274 beds.

Aggregate acute bed requirement in 10 years under the do nothing scenario	Acute Bed Impact	
Baseline beds	1,229	
Demographic growth	+236	
Non-demographic growth	+129	
Measure of un-met demand	+8	+311
Impact of sub optimal flow	+83	
New service developments	+28	
Mitigations, efficiencies and transformation programmes	-123	
Net ten year bed requirement for acute care	1,540	

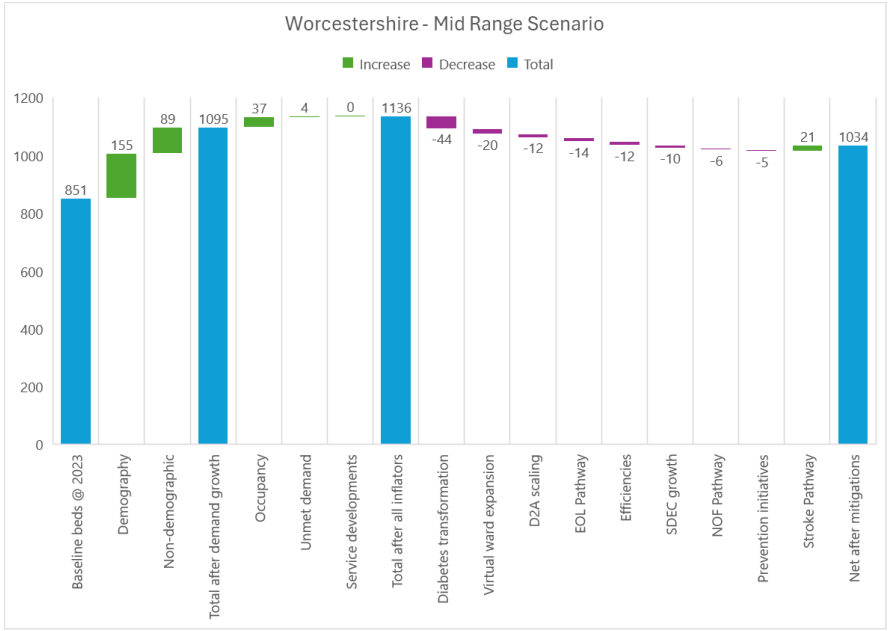
Developing a better understanding of future demand and capacity requirements – modelling the mitigations

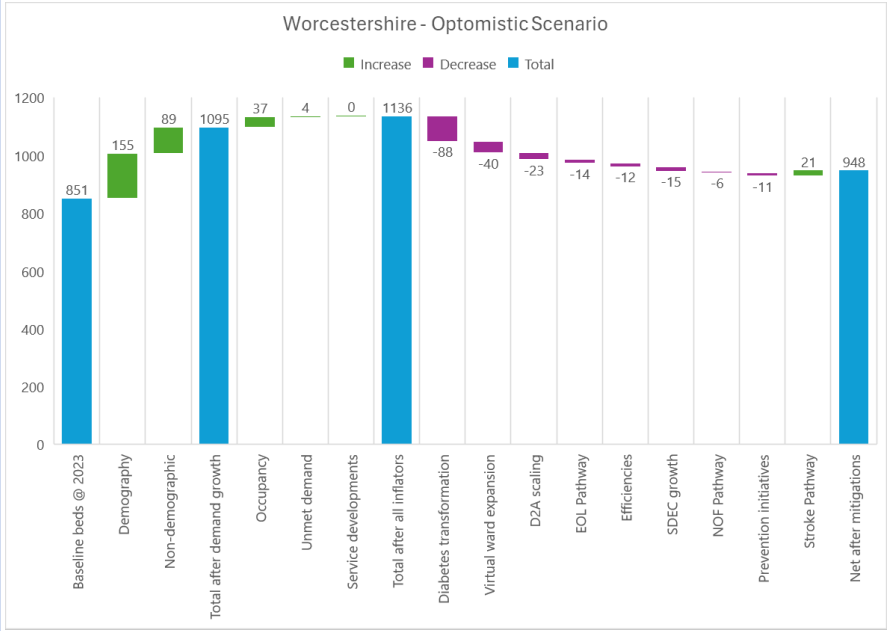




Herefordshire

- **Mid-range scenario** bed requirement by 2033 grows from 378 beds to 506 beds (+128).
- **Optimistic scenario** bed requirement by 2033 grows from 378 beds to 473 beds (+95).
- **Occupancy improvement** calculation is equivalent to 46 beds.
- **Unmet demand** metric is equivalent to 4 beds.
- **Mitigations**: The biggest mitigation opportunities are diabetes transformation and D2A pathways.





Worcestershire

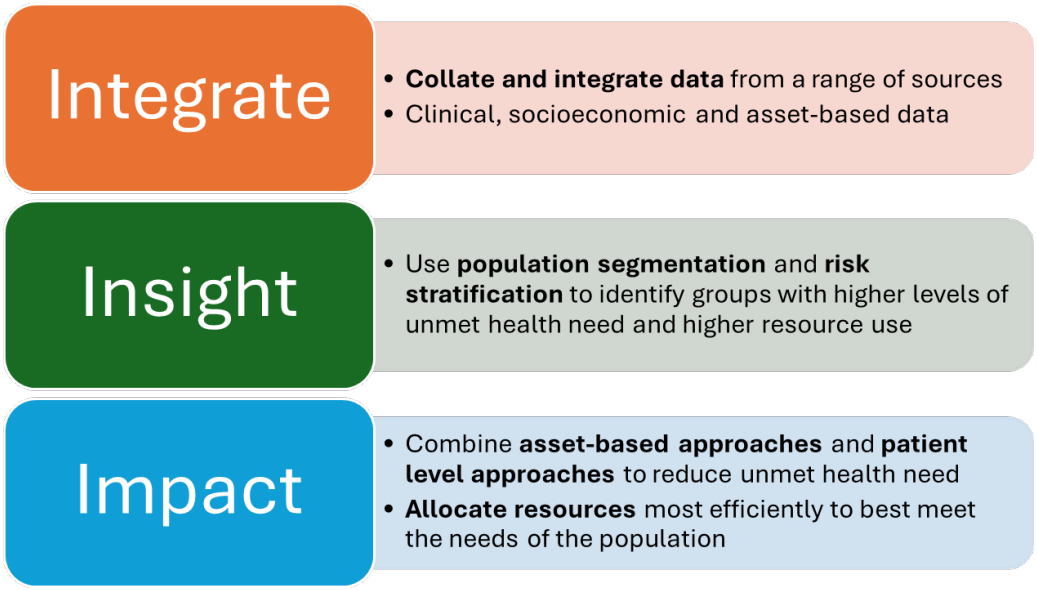
- **Mid-range scenario** bed requirement by 2033 grows from 851 beds to 1034 beds (+183).
- **Optimistic scenario** bed requirement by 2033 grows from 851 beds to 948 beds (+97).
- **Occupancy improvement** calculation is equivalent to 37 beds.
- **Unmet demand** metric is equivalent to 4 beds.
- **Mitigations:** The biggest mitigation opportunities are diabetes transformation and virtual ward scaling.

Population Health Management - Supporting the shift upstream to more prevention and best care in the right setting

Introduction

Population Health Management or PHM is for everyone working in integrated care. All ICS Partners working together to improve population health by data driven planning and delivery of proactive care to achieve maximum impact with the resources available, alongside the demand and capacity modelling described above.

PHM is a key strategic enabler delivery of the core areas of focus (Appendix 1) and the cross cutting themes (Appendix 2). PHM is not a new concept and is something that system partners already do. However. it is only at its most effective when both aspects come together and are tackled as part of a single coherent plan. In essence, PHM has three major components to it:



Population Health Management is a key enabler and sits within the **Building a Sustainable Future programme** as a key enabler. This includes both short and long-term activities. During 2024/25 the neighbourhood health accelerator sights tested the concept of integrated neighbourhood teams. Learning from this is being fed into the development of Neighbourhood Health activities. Increasing deployment of PHM is key to the successful delivery of this programme.

What next?

The ICB will facilitate the development and deployment of a of a system wide Population Health Management **Strategic Implementation Plan** during 2025/26, this will include:

- Taking astrength based approach, building on good practice where PHM tools and techniques are already being deployed.
- Identifying a clear leadership and programme delivery structure, brining together information, clinical and strategy capabilities.
- Endorsing a clear vision of PHM as an iterative evolution towards a new operating model to guide the change over a 5 years period.
- Calculating the return-on-investment time to support the shift upstream to prevention and enable Developing a community driving adoption, spread and sustainability via use cases choices, and building a movement.
- Developing a PHM infrastructure and analytics capability – including a clear road map linked to the wider analytics development plan.
- Developing an approach to linked data sets – including the required information governance agreements within a clear road map linked to the refreshed digital strategy.
- Building on the governance platform established through the Analytics Board and Health Inequalities, Prevention and Personalisation (HIPP) Programme Board.

How will we deliver?

Developing a robust Strategic Implementation Plan for Population Health Management is a central tenant of the shift upstream to prevention and will therefore become a key corporate project in 2025/26. Learning will be drawn from the national PHM Academy with opportunities to learn from other systems as well as from within Herefordshire and Worcestershire, focusing on the development of infrastructure to integrate data, draw insights and develop impactful changes to deliver improved outcomes for the comr

A system based PHM Steering group is being established to oversee the Development and delivery of the PHM Strategic Implementation Plan. This group will drive delivery, support shared learning and seek to mitigate Any risks to delivery of the plan.

Engagement Approach

Developing the Joint Forward Plan – Engagement approach

As a health and care system we are committed to close working with individuals, communities, partners and wider stakeholders. In developing the **structure and content** of our second Joint Forward plan, we have built on existing insights from recent engagement, these include:

- **The HW Integrated care strategy : 3 phases of engagement** - A thematic review of relevant existing patient and public engagement undertaken over the last two years. Extensive stakeholder engagement and broader feedback following the publication of the draft integrated care strategy.
- **Joint forward plan insights** – Complimenting the Integrated Care Strategy engagement, narrowing the scope to focus in on health services in line with the NHS Long term plan.
- **Specific engagement** – With NHS partners, including the 3 NHS Trusts, General Practice representatives and the Integrated Care Board.

The engagement strategy for the JFP recognises the benefit of aggregating together information from various sources and using this as a basis for filling in gaps in knowledge. The table below describes some of the engagement that has been undertaken by the ICB in partnership with providers:

Engagement activity – 2024/25 included...	
• Quarterly voices report produced and published, including engagement Accessible information • Autism (Adults) • Cancer – Macmillan Cancer Inequalities Project, Cancer – Patient Experience Survey • Diabetes • Frailty • Complaints, Concerns and Compliments • Mental Health • Menopause	• NHS 10 Year Plan • Palliative and End of Life Care Strategy • Public Perceptions of Health and Social Care • Stroke • Urgent and Emergency Care • General Practice • Long Term Plan • Maternity • Engagement on communications for ICB communications & engagement framework

In addition, these specific engagement activities there are various ongoing programmes of engagement with patient representatives engaging in meetings and specific activities.

Engaging individuals and communities

You can find more detail in **Appendix 2: Key enablers**, about our commitment to early engagement and ongoing dialogue with people and communities. You can also find out more about our wider system approach to engagement in our **ICS Engagement Strategy**.

Involvement opportunities are made available here:

https://www.hwics.org.uk/get-involved/involvement-opportunities

The Joint Forward Plan is owned equally by the ICB, the three NHS Trusts and the two General Practice Organisations that operate across the system. This joint ownership means that we can work together to support effective engagement and evaluation of delivery throughout the life of the plan.

Engagement insights will be used to develop programmes and also to evaluate their effectiveness. With the publication of the Joint Forward plan being an opportunity to share the core areas of focus for the system over the next few years. This should make it easier for local people to understand where change and improvements are being made and to get involved.

Next steps

- Opportunity to feedback and get involved in more in-depth engagement for specific clinical services pathways
- Embedding engagement insights into the delivery of the core strategic intent: ***"Driving the shift upstream to more prevention and best care in the right setting"***

Implementing the Joint Forward Plan

The implementation approach for the Joint Forward plan is now embedded in the infrastructure outlined at the beginning of appendix 1. This also reflects the landscape in terms of strategies and plan:

- **NHS System operational plan for 2025/26** - This outlines the key operational delivery priorities for healthcare during the third year of the Joint Forward Plan.
- **The Integrated Care Strategy for 2023-2033 –** This brings together a broad range of partners across the Integrated Care System, around a shared vision for improving health and well-being for everyone and three key priority areas.
- **Worcestershire Joint Local Health and Wellbeing Strategy** – This identifies a key priority focus on Good Mental Health and Well Being, supported by healthy living at all ages; safe thriving and healthy homes, communities and places; quality local jobs and opportunities.
- **Herefordshire Joint Local Health and Wellbeing Strategy** – This identifies two key priorities of Providing the Best Start in Life for Children's" and "Mental Health and Wellbeing", supported by six enablers: access, living and ageing well, good work for everyone, supporting those with complex vulnerabilities, housing/homelessness, reducing carbon footprint.

The Joint Local Health and Wellbeing Strategies and the Integrated Care Strategy provide the long-term frame, with the Joint Forward Plan translating this into NHS focused medium-term delivery priorities; and the Operational Plan focusing in turn establishing the annual priorities.

Year 3 implementation focus

During the second year of implementation there are two main streams for the Joint Forward Plan:

- **Stream 1:** Developing and implementing the opportunities for **driving the shift upstream to more prevention and best value care in the right setting** maximising on the three shifts, expected within the NHS 10 year plan. Delivered through Population health management, evidence based decision making increasing the provision of pro-active care.
- **Stream 2:** Continued delivery of the year 3 priorities for the **core areas of focus and cross cutting themes** building on what we have delivered in year 1.

There is a significant role for existing programme boards with the system governance structure to develop, align content and instil ownership of delivery of the plan from the outset.

Stream 1: Developing and implementing the opportunities for **driving the shift upstream to more prevention and best value care in the right setting** maximising on the approach to Population health management, evidence-based decision making increasing the provision of pro-active care.

Stream 1: Driving the shift upstream to more prevention and best care in the right setting.	Phasing
Development of Building a sustainable future programme on Neighbourhood Health	2025/26
Drive the shift from Treatment to Prevention through delivery of key prevention programmes, including implementation of the Population Health Management Framework	2025/26
Drive the shift in Acute to Community through implementation of actions outlined in response to the Best Value Care in the Right Setting and Poist prevalence reports	2025/26
Deliver the Building a sustainable Future priority programmes – System enablers. Including Digital Strategy and Transformation	2025/26

Stream 2: Continued delivery of the year 3 priorities for the **core areas of focus and cross cutting themes** building on what we have delivered in year 1 and 2.

Stream 2: Delivery of year 3 priorities for core areas of focus and cross cutting themes	Phasing
Delivery of the year 3 priorities for the core areas of focus: See appendix 1.	2025/26
Delivery of the year 3 priorities for the cross-cutting themes: See appendix 2.	2025/26
Ongoing focus on system development, ensuring that mechanisms for collaboration are strong and effective in enabling delivery of the priorities within the JFP.	2025/26

Joint forward plan – 25/26

Appendix 1:
Core areas of focus

This section sets out how the Joint Forward Plan addresses national requirements set out in **the NHS Long Term Plan** and **local priorities** to ensure the NHS makes a positive contribution to improved health outcomes for the population through delivery of high-quality patient centered pathways that are overseen by programme boards across the ICS. This includes a summary of what we have delivered in 2024/25 and what our focus is for 2025/26 and beyond.

Version: 2025 Refresh, May 2025

Delivering High quality, patient centred integrated pathways: INTRODUCTION

There are a broad range of work programmes across Herefordshire and Worcestershire, within place and neighbourhoods. These are established to develop and deliver programmes of work focused on local and national priorities including those set out in the https://www.longtermplan.nhs.uk/.

In this section you will find a high-level summary of year 2 delivery, and the priorities that are developed and overseen at a system level through Herefordshire and Worcestershire ICS Programme Boards.

Core areas of focus can be found in this document, which include:

1. Maternity and neonatal care
2. Early years, children and becoming an adult
3. Elective, Diagnostics and Cancer Care
4. Frailty
5. Palliative and End-of-life
6. Learning disability and autism care
7. Mental health and wellbeing
8. Long-term Conditions
9. Stroke care
10. Urgent and emergency care
11. Primary Care
12. General Practice
13. Pharmacy, Ophthalmic and Dentistry
14. Specialised Services

Cross cutting themes can be found in Appendix 2 and include:

1. Quality, Patient safety and experience
2. Clinical and care professional Leadership
3. Medicines and pharmacy
4. Health inequalities
5. Prevention
6. Personalised care
7. Working with communities
8. Commitment to carers
9. Support veteran health
10. Addressing the needs of victims of abuse
11. Digital data and technology
12. Research and innovation
13. Greener NHS

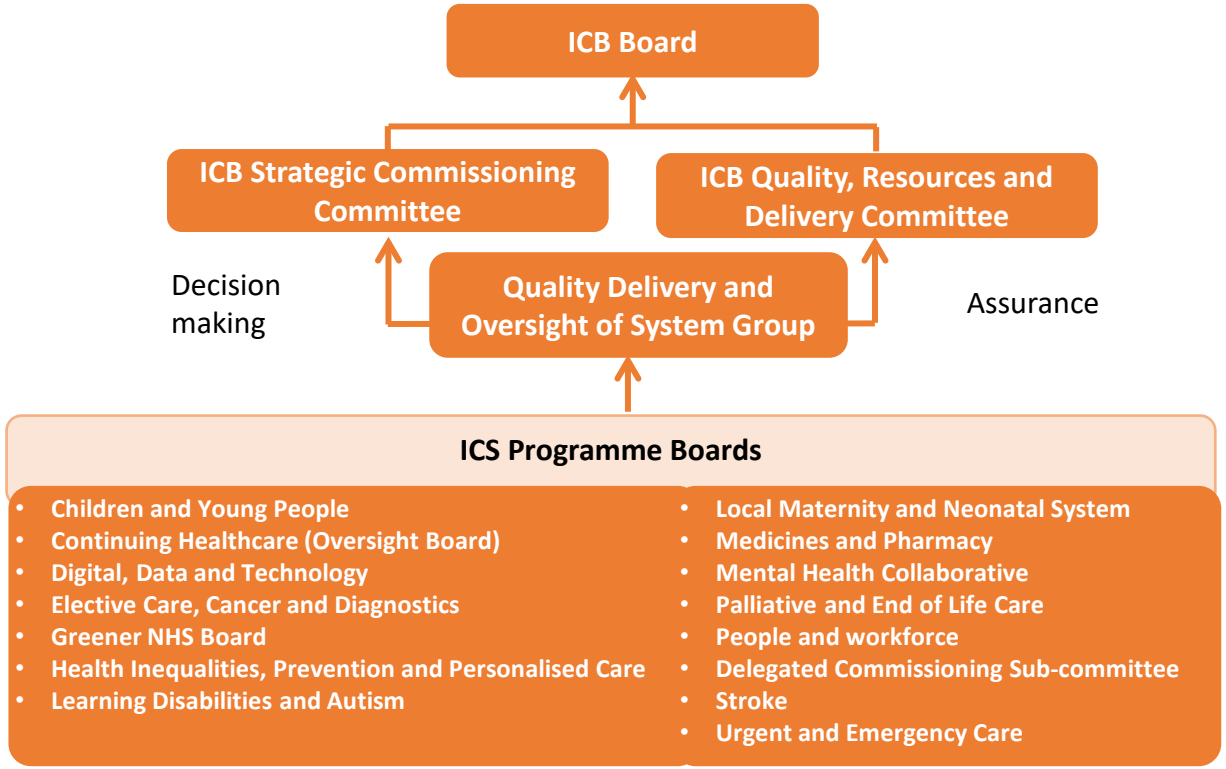
The role of an ICS Programme Board

The ICS Programme Boards are responsible for overseeing delivery of programmes across Herefordshire and Worcestershire, including the Joint Forward Plan, which will include regular reporting on progress against plan delivery and mitigating / escalating risks to delivery through to the ICB Quality, Resources and Delivery Committee.

The ICS Programme Boards bring together organisations to coordinate and oversee delivery of improvement and transformation activities across Herefordshire and Worcestershire. They are responsible for setting the strategic direction and ensuring that comprehensive delivery plans and monitoring frameworks are in place. Whilst the Programme Boards are not decision-making forums, the governance framework allows timely decision making through the ICB Strategic Commissioning Committee.

Joint ownership

The membership of each ICS Programme Board represents the key stakeholders engaged in a particular programme area, including NHS and Local authority partners, Healthwatch, networks and alliances and representatives of the patient voice, in addition to operational and clinical staff. The chart below summarises the governance structure.



Core areas of focus

In this section we answer the following questions for each core area of focus. The programmes of work included will be reviewed and refreshed in the Joint Forward Plan annually.

1. Why this is important?
2. What we are doing
3. What will we deliver and when?
4. Where you can find more detail

High quality, patients centred services: MATERNITY AND NEONATAL CARE

Theme 1

1. Why is this important?

The Local Maternity and Neonatal System (LMNS) vision is to work together to deliver consistent, high quality, safe personalised care that is delivered equitably according to local need.

High quality maternity and neonatal care is essential in ensuring every child across Herefordshire and Worcestershire has the best start in life.

During 2024 we saw an increase in deliveries to 6,315.

- Our smoking in pregnancy rates remain higher than the national ambition of 6%.
- Whilst our initiation of breastfeeding rates were higher than the national average, we know that there are groups within our population where breastfeeding is much lower, and further work is needed to support this.
- Over a quarter of women who booked for maternity care had BMI>30, similar to 2023.

All of these factors contribute to health inequalities and poor outcomes for babies and families. Our LMNS continues to work in partnership to reduce health inequalities and providing safe, personalised, equitable care.

The LMNS consists of Herefordshire & Worcestershire Maternity and Neonatal Voices Partnerships, Wye Valley NHS Trust, Worcestershire Acute Hospitals NHS Trust, Herefordshire and Worcestershire Integrated Care Board, Herefordshire and Worcestershire Health and Care NHS Trust, Herefordshire Council and Worcestershire County Council.

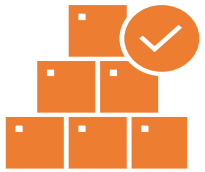
2. What have we delivered in our first two years, 2023 - 2025?

- The LMNS completed a 3-year pilot of Perinatal Pelvic Health Services and the service is now commissioned across Herefordshire and Worcestershire. The team have been recognised nationally as an area of good practice.
- The Maternity and Neonatal Voices Partnership (MNVP) has continued to develop, with Neonatal Champion role to ensure the voices of local Families who experience neonatal care are heard. An MNVP strategic role has commenced to enable further capacity for engagement across the system.
- A system led approach has been taken to ensuring our Trusts are compliant with the expectations of the Saving Babies' Lives Care Bundle Version 3. This will have an impact on reducing neonatal and maternal mortality, still births and intrapartum brain injury. The compliance rate for Saving Babies Lives has improved in Worcestershire from 49% in 23/24 to 94% 24/25 and in Herefordshire from 59% in 23/24 to 87% in 24/25.
- The LMNS continues to implement the Perinatal Quality Surveillance model, ensuring that there is trust board and ICB oversight of key factors that impact on perinatal quality and safety, such as staffing, culture and learning from incidents.
- The LMNS has worked with stakeholders to co-produce a strategy that outlines our deliverables and local plans for implementation to align with the NHS England Three Year Delivery Plan. The Digital and Reducing Health Inequalities strategies are being refreshed to ensure a continuous focus on digital innovation and reducing health inequalities, specifically reducing prematurity, access and prevention. The Infant Feeding Strategy was produced in 2024 and monitored through the Perinatal Health and Wellbeing Group.
- The LMNS continues to conduct Perinatal Mortality reviews to ensure shared learning to improve care. This has increased the opportunities for shared learning and external peer review.
- The LMNS programme team has conducted a series of insight visits, supported by NHS England Regional Perinatal team to review quality, safety and culture within our system.
- The LMNS has supported the Trusts to implement the BRAIN pneumonic to aid shared decision making and has funded birth rights and inclusive language training based on feedback from the MNVP.
- The locally delivered Movements Matter campaign highlighted the importance of acting on reduced fetal movements and not using home dopplers. It had a wide reach and social media activity showed a high click rate particularly from men.
- Partnership working within the system has improved through the LMNS Board Development programme facilitated by the Kings Fund, and through collaborative working with our buddy LMNS Coventry and Warwickshire.
- A preconception campaign (in collaboration with Tommy's & C&W LMNS) aimed at reaching more vulnerable groups is launching in March 25, linked to the Womens Health Hubs.

3. What are the priorities going forward?

In addition to national priorities, our local shared priorities of the LMNS are:

- Intelligence to identify and act on issues as early as possible
- Prevention and reducing health inequalities.
- High quality, safe maternity and neonatal care
- Listening to local women and birthing people and our staff



High quality, patients centred services: MATERNITY AND NEONATAL CARE

Theme 1

4. What will we deliver and by when?

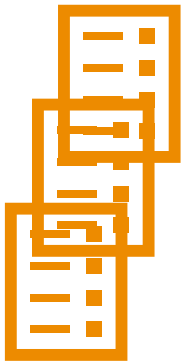
Priorities	Deliverables	Year of delivery
Listening to women and families with compassion	• Enable women to have personalised care through personalised care and support planning. • Provide Perinatal Pelvic Health services that meet the needs of patients. • Enable and empower our Maternity and Neonatal Voices Partnerships to gather intelligence and represent our local families, coproducing maternity and neonatal services.	2025/26
Growing and developing our workforce	• Develop and implement local evidence-based retention action plans • Deliver supervision, training and support as needed by staff. • Listen to, and act on, staff and student feedback • Continue to facilitate a workforce and culture that supports learning and delivers safe, equitable care.	2025/26
Developing and sustaining a culture of safety	• Share learning from incidents across the Local Maternity and Neonatal System and learning from incidents at a national and regional level. • Promote positive culture through supportive leadership. • Identify any concerns, raising them early and addressing them. • Improve quality through delivery of the SCORE action plan.	2025/26
Meeting and improving standards and structures	• Implement national evidence-based guidance such as the Saving Babies Lives' Care Bundle V3 and monitoring local progress against outcomes. • Use evidence-based tools such as MEWS and NEWTT-2 to better detect concerns and act sooner on safety issues. • Make better use of digital technology in maternity and neonatal services through implementing the Local Maternity and Neonatal System digital strategies. • Regular oversight and open scrutiny of intelligence to identify issues, inform learning and improve quality.	2025/26
Prevention and tackling health inequalities	• Deliver equitable care through the implementation of the LMNS reducing health inequalities strategy. • Improve outcomes through a focus on healthy lifestyles and mental health, from pre-conception through the perinatal period, and understanding and removing barriers to access • Support women and families with multiple complexities during pregnancy/perinatal period • Develop a dashboard to assist understanding of health inequalities, enabling focussed work to reduce Health inequalities.	2025/26

5. Where you can find more detail?

There are two active Maternity and Neonatal Voices Partnerships (MNVP) in Herefordshire and Worcestershire, this is an opportunity for members of the public to have a say in how maternity services are run in both counties.

If you would like to get involved please contact:-

hwicb.herefordshiremvp@nhs.net – Herefordshire MNVP
hwicb.worcsmvp@nhs.net- Worcestershire MNVP



High quality, patients centred services: EARLY YEARS, CHILDREN AND BECOMING AN ADULT

Theme 2

1. Why is this important?

- Across Herefordshire & Worcestershire Children and Young People (CYP) represent approx. 19% of our population, with approximately 140,000 0-19 years old (Public Health Profiles 2021).
- Overall, this is a good place to live. There are relatively low levels of poverty and deprivation, and many children and young people are happy.
- For children and young people living in areas of high deprivation or experiencing poverty, there are barriers to accessing services.
- Some children and young people are at the biggest risk of poor outcomes. Including those with additional needs; exposed to family and behavioural risks; or with experience of the care system.
- 14.1% of children in Worcestershire and 12.2% in Herefordshire are living in low-income Families.
- 65% of children achieve a good level of development at the end of reception in Worcestershire and 71.8% in Herefordshire.
- Emotional wellbeing is a cause for concern in 39% of looked after children in Worcestershire and 42% in Herefordshire.
- The prevalence of overweight (including obesity) of children in Reception is 20% in Worcestershire and 25% in Herefordshire.
- Hospital admissions for children aged 0-14 is a rate of 71.9 per 10,000 for Worcestershire and 100.1 per 10,000 for Herefordshire.
- In Worcestershire 3.9 % of pupils have an Education Health and Care Plan and 2.6% in Herefordshire.

2. What have we delivered in our first 2 years 2023-2025?

- Development of CYP Health Inequalities pack to support interventions to improve health outcomes.
- Commissioned Lumi Nova, a digital based app suitable for 7-12 year olds to support low level anxiety related mental health issues.
- Undertaken a procurement exercise for emotional wellbeing and mental health services for 0-25 year olds. The service will commence in April 2025.
- Rolled out the national Asthma Care Bundle, delivered a pilot programme of community-based nurse led intervention and support to children at risk of poor asthma control and worked with housing colleagues on environmental factors and schools to support awareness raising and improve pupil attendance.
- Established a 2-year pilot programme of youth workers employed to support young people with long term conditions to transition from children to adults' health services.
- Piloted a psychological therapy programme to assist those children & young people with epilepsy.
- Jointly held transition clinics with adult services for children and young people with diabetes.
- Employed a Designated Clinical Officer for Special Education Needs & Disabilities (SEND) in Herefordshire.
- Agreed additional recurrent funding to support Paediatric therapist recruitment in Herefordshire and in Worcestershire.
- Initiated an evidence-based review of children's therapy delivery across the ICS – transformation in progress.
- Funding provided to Parent Carer Forum, and recruitment of Co-Production officers in Worcestershire to support SEND improvements through engagement and coproduction.
- Engaged with parents, carers and other stakeholders to design a future neurodivergence provision, including assessment and support.
- Engaged in two Local Area SEND Partnership inspections and started to address the improvements identified.

3. What are the priorities going forward?

- Development of locality based care pathways, redesigning community services.
- Review the CAMHS service ensuring clinical pathways are evidence based with a defined service specification.
- Continue to deliver the NHSE National Children and Young People's Transformation Programme to meet the commitments in the NHS Long Term Plan, as identified in the delivery plan.
- Enhance preparation for adulthood, recognising the needs of young people with long-term conditions and/ or complex needs.
- Continued engagement in Public Health-led Best Start in Life, particularly in early language and communication skills, as well as early identification and appropriate support of child development (at universal level).
- Continue to improve Special Educational Needs and Disabilities provision, including future model of community health services to address the needs of children and young people and reduction in waiting times particularly for neurodivergence assessments.
- Procure Neurodivergence support service.
- Review of Phlebotomy pathways across the system.

High quality, patients centred services: EARLY YEARS, CHILDREN AND BECOMING AN ADULT

Theme 2

4. What will we deliver and when?

Priorities	Deliverables	Year of delivery
Asthma - to support CYP with asthma, including diagnosis, care planning, and reducing emergency admissions.	• Co-production and launch of school asthma guidance to support best practice • Develop accreditation of asthma friendly schools in Herefordshire as part of the Healthy Schools programme • Pilot within Worcestershire with the Housing Association to review housing stock where Children and Young People with asthma are identified. • Roll out of resources to support families living with damp and mold, reducing the risk of an asthma attack.	By 2025/26
	• Embed the Asthma Care Bundle, risk stratification in Primary Care, understand & support clinical and CYP training needs • Toolkit for schools including development of training packages including videos for education settings to complement the schools asthma policies. • Develop local pathways of care for early diagnosis of asthma, ensuring appropriate referrals through to secondary care	By 2027/28
Epilepsy - Standardised approach to management of childhood Epilepsy.	• Continued improvement to the capacity of epilepsy nurse specialist support across ICS. • Evaluation of PAVES and Youth Worker projects to support development of options appraisal for provision of psychology and mental health support for Children and Young People with epilepsy.	By 2025/26
	• Identify and embed transition to adult services for children and young people with epilepsy. • Embed pilot projects as business-as-usual	By 2027/28
Obesity – to support a reduction in overweight and obese children across ICS.	• Obesity / Health Weight Summit as part of the Integrated Care Partnership Assembly to develop system wide strategy • Incorporate and embed CYP into the system wide Obesity strategy. • Pilot Social Prescribing/Coaching roles to take a Whole Family Approach	By 2025/26
	• Hard-to-reach CYP & Family's at risk of obesity & in areas of deprivation, are supported to access & shape support to address barriers to lifestyle changes.	By 2027/28
Diabetes - Reducing inequality and variation in outcomes.	• Evaluation of youth worker pilot • Further investigation and implementation of technology with individuals affected by health inequalities. .	By 2025/26
	• Prevention and education aligning with Obesity workstream and improving care and outcomes for CYP living with type 2 diabetes.	By 2027/28

High quality, patients centred services: EARLY YEARS, CHILDREN AND BECOMING AN ADULT

Theme 2

Priorities	Deliverables	Year of delivery
Infant Mortality – to reduce the infant mortality rate across Herefordshire and Worcestershire	• Continue to audit Saving Babies Lives V3 compliance • Work as a system within the Perinatal Health and Wellbeing Group to coordinate prevention and transformation work streams feeding into place based Best Start in Life programmes.	By 2025/26
	• Improve systems to identify and support families whose children are at risk of infant mortality due to modifiable risk factors	By 2026/27
Urgent & emergency care	• Develop and embed a robust seasonal illness plan • Further development of the Handi App, adding additional conditions to support self management • Continue to develop common conditions pathway document across both Herefordshire and Worcestershire	By 2025/26
	• CYP are engaged in transition services and effective management of long-term conditions to avoid crisis presentations. • Consistent pathways across the ICS to provide CYP appropriate care in the most appropriate setting.	By 2027/28
Neurodivergence	• Embed CYP components of All-Age Autism Strategy. • Improve timely and appropriate access to services providing support, advice, information, training and interventions across the system.	By 2025/26
	• Improve waiting times for children's Autism and ADHD diagnostic assessments • Raise awareness and understanding of Neurodivergence in CYP workforce. • Implementation of redesigned Neurodiverse pathways • Increase take-up of annual health checks for 14-25 yrs	By 2027/28
Special Educational Needs and Disability (SEND)	• Continued increase in the number of children who are school-ready with appropriate plans in place. • Continued transformation of Paediatric Therapies model of delivery to enhance timely support	By 2025/6
	• Further develop joint commissioning of support & intervention services in both counties. • Improve transition into adulthood • Deliver the SEND improvement plans in both counties (and priority action plan in Worcestershire)	By 2027/28
Address healthcare inequalities to improve outcomes for Children and young people	• Continue to follow the national framework for the Core 20 plus 5 model, developing interventions to address inequalities.	By 2025/6

High quality, patients centred services: EARLY YEARS, CHILDREN AND BECOMING AN ADULT

Theme 2

Priorities	Deliverables	Year of delivery
Mental Health and Emotional Wellbeing Transformation Plan.	• Improve timely information, advice, and support • Improve mental health support for 0-25yrs and their families • Enhance pathways to avoid crisis & enhanced community-based solutions • Improved CYP mental health access rates by offering a range of services	By 2025/6
	• Improve mental health services within schools – aligned with the national guidance of MHST's in all schools by 2030	By 2027/28
Health and Wellbeing of Children Looked After (CLA)	• Review of Looked After Children's Services model in Worcestershire to ensure statutory health assessments for CLA are completed within timeframes and health needs are identified and addressed. • Pilot and evaluation of Initial Health Assessments contracting arrangements • Improve the process & timeliness of Adoption Medicals in Worcestershire. • Increase uptake of vaccinations within LAC across Worcestershire – review of children on the caseload with reduced vaccination status, complete RHA and raise awareness of vaccination • Herefordshire to raise awareness of vaccinations within schools and young people - co-produce promotional materials, raise awareness with engagement. Review of communications sent to parents. Increase HPV vaccine uptake amongst boys	By 2025/6
CYP Community Health Services	• Review and update service specifications for CYP community health services • Review Community Paediatric provision - Capacity and Demand modelling to commence April 2025 • Complete review of Children Community Nursing services with particular focus on EoL care in Herefordshire • Implementation of redesign of provision in Therapy Services incorporating 'The Balanced Approach' - universal, targeted and specialist provision. • Provider led review of Worcestershire Child Development Service • Continued development of a universal strand of provision in Occupational Therapy and Physiotherapy with a prevention / early intervention focus.	By 2025/26
	• Embed system adoption of universal, targeted and specialist approach within children community health services linked with development of the Best Start in Life programme with a focus on prevention and Family Hubs • Explore shared workforce opportunities across the system.	By 2027/28
Children's Cancer and planned Care	• Work with NHS across Region to ensure specialist care continues to meet children's needs. • Support & enhance Paediatric oncology shared care unit (POSU) at Worcester Acute Hospital to deliver injection-based outpatient chemotherapy • Develop level 2 Paediatric Critical Care capability at Worcestershire Acute Hospital.	By 2026/27

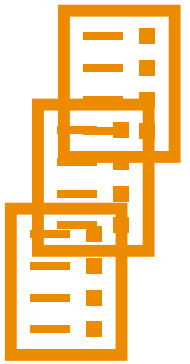
4. Where you can find more detail?

Engagement opportunities are circulated through parent carer forums and the ICS communications system.

We listen to the voice and experience of children, young people and Family's facilitated by Action for Children and specific feedback via existing youth forums, compliments and complaints.

The identified priorities reflect the Place based Children & Young Peoples Plan where regular updates are provided

Requests for information can be made to the CYP team at hwicb.cypteam@nhs.net



High quality, patients centred services: ELECTIVE, CANCER AND DIAGNOSTIC CARE

Theme 3

1. Why is this important?

To improve patient safety, outcomes and experience we must eradicate all long elective, cancer and diagnostic waits for assessment and treatment.

Waiting times remain in a challenged position post-COVID with waiting times being higher than we would like.

Despite having the 2nd lowest referral rate per 1,000 population, demand has increased circa 14% year on year.

The pandemic had a significant impact on planned care services, with access to many elective services paused, limited access to diagnostic tests and a significant reduction in patients being referred with suspected cancer. Demand has now returned to above pre-Covid levels, resulting in many services struggling to manage the levels of demand alongside addressing the backlog of patients that accumulated during the pandemic. This has resulted in patients are waiting longer for the diagnostic investigations, clinical assessment and treatment of cancer and non-cancer conditions.

In addition to recovering services, incidence of many health conditions such as cancer is expected to increase, with Cancer Alliances nationally predicting a 10% year on year increase in urgent suspected cancer referrals.

2. What have we delivered in our second year, 2024/25?

- Elimination of elective waits over 104 weeks, and over 78 weeks in most specialties with significant progress towards elimination of 65-week waits .
- Continued good performance against diagnostics targets, although a small number of challenged modalities remain.
- Patient Initiated Follow Up (PIFU) and Personalised Care Follow Ups (PCFU) continuing to be rolled out across a number of specialties enabling more people to self-manage their follow-up pathways.
- Fragile services framework in place with agreed ways of working to increase service resilience and sustainability.
- Utilisation of the Independent Sector Provider accreditation framework to support patient choice and ensure quality of the services delivered.
- Routinely providing access to FIT testing in primary care in +80% of urgent suspected colorectal cancer referrals to enable higher risk referrals to be effectively identified and managed accordingly.
- Robust Getting It Right First Time (GIRFT) programme of work in place across a range of specialties to ensure effective use of resources.
- Consistently performing above stretch target for Specialist Advice.
- Development of common conditions documents to support management in primary care.
- Elective Surgical Hubs live in both Worcestershire and Herefordshire.
- Ongoing development of CDC2 in Hereford City with expected go live summer 2025.

3. What are the priorities going forward?

- Continuing recovery of elective, cancer and diagnostic services in line with 2025/26 Operational Planning priorities. This includes achievement of cancer standards, restoring waiting times in diagnostics and reduction in elective waiting times with 65% (or minimum improvement of 5% on 2024/25 performance) waiting less than 18-weeks by March 2026.
- Delivering the priorities identified within the Elective Care Reform guidance including transforming and transitioning services to maximise productivity and improve quality across the elective, cancer and diagnostics pathways, ensuring services are safe, sustainable and accessible to patients, embracing the digital agenda to enable services to modernise through better use of technological developments such as AI.
- Development of guiding principles in Planned Care services on what represents good quality services, working with Healthwatch in Herefordshire and Worcestershire to obtain patient and public feedback.
- Ensuring patient choice is available and offered to patients, whilst also ensuring equity of access to NHS services.
- Ensuring effective integration across services and providers of planned care by adopting a pathway approach to service change and improvements to support earlier intervention and therefore diagnosis.

High quality, patients centred services: ELECTIVE, CANCER AND DIAGNOSTIC CARE

Theme 3

3. What will we deliver and when?

Priorities	Deliverables	Year of delivery
Restore waiting times for elective, diagnostics and cancer	• Work collaboratively with all providers locally, regionally and nationally to increase capacity to support elimination of long waiting times across planned care services. • Optimisation of system elective surgical hubs - Alexandra Redditch (WAHT) and Hereford (WVT) • Launch of Community diagnostic centre in Hereford – increase volume of diagnostic capacity Summer 2025 • Delivery of 65% (or minimum 5% improvement on current performance) patients waiting no longer than 18 weeks for elective treatment • Delivery of 95% diagnostic tests within 6-weeks.	By 2025/26
Outpatient transformation • Referral Optimisation • Maximise Productivity • Reduction of follow ups • Reduce elective waits	• Delivery of Out-Patient Transformation programme across the ICS to include embedding patient initiated follow up (PIFU), helping put patients in control of their follow up appointments and achieving national requirement (5% discharged/moved to PIFU pathway) • Deliver an appropriate reduction in outpatient follow up activity including use of remote consultations. • Explore opportunity to embed one stop clinics, aligned to diagnostic development of Community Diagnostic Centres (Phase 2/CDC 3). • Ensure optimum use of Specialist Advice to support effective referral management. • Delivery of robust GIRFT and Further Faster programme to maximise productivity and support ongoing reductions in waiting times. • Embed digital support/solutions to support delivery of patient pathways and improved patient experience.	By 2025/26
Improving screening uptake	• Reducing variation in screening uptake in the registered and non-registered populations, and addressing poor uptake in harder to reach cohorts or cohorts with poorer outcomes; • Optimisation of the PCN DES Supporting Earlier Diagnosis – targeting non-responders and hard to reach groups;	By 2025/26
Supporting earlier diagnosis	• Implementation of Lung Cancer Screening Programme (Q4 2025/26) and continuing focus on utilisation of FIT testing in primary care; • Targeting populations at higher risk of developing cancer such as people with learning disabilities and autism; • Implementation of Non-Specific Symptoms pathway; • Offering improved access to liver surveillance in patients with fatty liver disease/ cirrhosis to support earlier identification of liver cancer.	By 2025/26
Implementing Best Practice Timed Cancer Pathways (BPTP)	• Ensuring 5 BPTP are in place across the ICS with a focus on achieving above the 80% 28-FDS standard and delivery of over 75% patients starting their cancer treatment within 62-days; • Undertaking audits in line with national requirements to confirm compliance with BPTP and areas for improvement; • Reducing treatment variation across cancer pathways in line with best practice recommendations outlined in clinical and GIRFT audits; • Transformation and innovation in pathology services	By 2025/26
Empowering patients through personalisation of care	• Optimisation and expansion of Personalised Care Follow-up pathways; • Use of digital technology to support a better patient experience, including use of a Patient Portal to support self-management, electronic End of Treatment Summaries to improve transition of care between secondary and primary care, and improved communication. • Improving support services for patients living with cancer such as delivery of HOPE courses, better access to psychosocial care;	By 2025/26

High quality, patients centred services: ELECTIVE, CANCER AND DIAGNOSTIC CARE

Theme 3

3. What will we deliver and when?

Priorities	Deliverables	Year of delivery
Understand and address health inequalities in planned care	• Ongoing understanding of inequalities in access, experience and outcomes of care for Core 20, BME populations and Inclusion Health Groups across Planned Care. • Working closely with stakeholders such as Healthwatch to reduce the impact of health inequalities on outcomes in planned care.	By 2025/26
Longer term vision for planned care	• Development of a system wide strategy for planned care based on the 10 Year Plan (and Cancer Plan) due to be published early in 2025.	By 2025/26

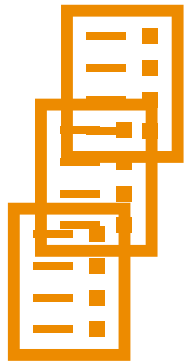
4. Where you can find more detail?

Regional and national strategies for Planned Care can be found at:

- Getting It Right First Time
- Home - West Midlands Cancer Alliance (wmcanceralliance.nhs.uk)
- NHS England » Publication of the plan to reform elective care for patients
- NHS England » 2025/26 priorities and operational planning guidance

Link to the National Cancer Patient Experience Survey:

- Tell us about your experience of cancer care - National Cancer Patient Experience Survey



High quality, patients centred services: FRAILTY

Theme 4

1. Why is this important?

Herefordshire and Worcestershire has an older population than the rest of England, with the number of people over 65 years increasing and younger populations decreasing.

By 2030 (compared to 2021), it is predicted that the number of people aged 80-84 years will increase by 48% in Herefordshire and by 51% in Worcestershire. The increase in the over 85 age group is forecast to be 36% in Herefordshire and 35% in Worcestershire.

The projected increase in ageing population means that a greater number of people living in Herefordshire and Worcestershire will be at risk of developing or living with Frailty.

Frailty is a long-term condition in which multiple body systems gradually lose their reserves and functions, resulting in an increased vulnerability and risk of unpredictable deterioration from minor events. The development of Frailty is strongly linked with increasing age but can affect anyone at any age. This growing number of people at risk of living with poor health will lead to more people needing greater support and care from social and health services.

The prevalence of Frailty within Herefordshire and Worcestershire is significant. In 2024, it was known that over 7,000 people registered with a GP are living with severe frailty, and 8% of Herefordshire's and Worcestershire's population that are aged 65 years or above are living with moderate Frailty.

2. What we have delivered in our second year, 2024/25?

- Delivery of an Integrated Care System (ICS) Frailty Strategy,
- Worcestershire Acute Hospital Trust (WAHT) have initiated their own internal Frailty Transformation Programme that aligns to ICS' Frailty strategy, and endorse the ethos of 'Making Frailty everyone's business',
- Frailty Same Day Emergency Care areas have been established in two of WAHT hospital sites, that are supported 7by Geriatric Emergency Medicine services (GEMs),
- Single Point of Access (SPoA) service has expanded to integrate both community and acute workforce which support Ambulance service to appropriately direct frail patients to the best place to meet their care needs and wishes,
- Enhancements proactive assessment and care planning for people with Frailty through more Comprehensive Geriatric Assessments being undertaken within General Practices, and progress being made with standardising across all Herefordshire and Worcestershire NHS healthcare providers.
- Progress with piloting Frailty focussed Integrated Neighbourhood Teams, which aims to improve the care coordination and delivery of care for patients living with Frailty,
- Wholistic review of the Falls care pathways and assessments, with improving access and outcomes of preventative and reablement services, alongside public resource to raise self-awareness about risk of falls and self-management.

3. What are the priorities going forward?

It remains that our integrated care vision that **"People living in Herefordshire and Worcestershire who are at risk of, or living with frailty will, live well in a supportive community with accessible, personalised and coordinated high-quality care delivered in the most appropriate setting whenever they need it."**

This vision will be realised through a wholistic and place-based approach whereby to health and social care organisations across Herefordshire and Worcestershire will work together to collaborate, develop and enhance integrated care services for people at risk of or living with Frailty, to improve their health outcomes and quality of life.

The ICS Frailty strategy states the nine key desired outcomes of which all transformation plans undertaken must strive to deliver:

1. Increased community interventions measures to prevent the onset and progression of frailty
2. Increased early identification of people living with or at risk of frailty
3. High quality proactive comprehensive assessment of people living with or at risk of frailty.
4. High quality accessible and coordinated personalised care for people living with frailty, their Family's and carers in every care setting
5. Frailty attuned acute care which facilitates timely discharge and smooth transitions between care settings
6. High quality reablement and rehabilitation after a period of illness and at times of transition from hospital
7. High quality end-of-life care for people with frailty, their Family's and carers.
8. Compassionate, timely and effective advanced care planning in all health and care settings.
9. A workforce with the appropriate skills to provide specialist care to patients in all health and care settings.

High quality, patients centred services: FRAILTY

Theme 4

3. What will we deliver and when?

Priorities	Deliverables	Year of delivery
Frailty onset prevention	• Map and raise awareness of the community resource available to residents to support them with reducing their risk and/or delay on the onset of Frailty.	By 2025/26
Early identification and proactive care for those living with Frailty	• Develop a standardised approach to proactively identify those living with Frailty in Primary, Community and Secondary Care services, supported by the development of risk stratify tools and consistent implementation of nationally recommended clinical frailty scoring *i.e.,* Rockwood Frailty Score. • Continue to develop and implement the proactive care and management in primary care of those living with Frailty through the Clinical Excellence and Investment Framework (CEIF) and requiring utilisation of a standarised multidimensional holistic assessments (*i.e.,* Comprehensive Geriatric Assessment) to inform care and treatment plans. • Self-assessment against national Proactive Care Framework, to seek and identify further opportunities for improving of proactive Frailty care across the ICS, and establish improvement plans for those opportunities deemed high priority and attainable.	By 2025/26 & beyond.
Reactive Care	• Establish the current urgent and emergency care processes and provision variation and fragmentation for those living with Frailty at place, and neighborhood levels by undertaking reactive pathway mapping. • Following mapping the 'as is' reactive pathway, co-produce the 'future' reactive pathway that addresses the inequities and inequalities with accompanying transformation plans. • Continue the development and expansion of Frailty Same Day Emergency Care Services as per the national FRAIL Strategy, • Reinforcement and develop Frailty specific Advice and Guidance services whereby primary care clinicians can access to specialist clinical advice, enabling a patient's care to be managed in the most appropriate setting, strengthening shared decision making.	By 2025/26.
Reablement, rehabilitation and recovery	• Undertake a system wide self-assessment against the National Intermediate Care Framework to establish current alignment to nationally recommended good practice and guidance for step-down intermediate care for adults who need support after discharge from acute inpatient settings and virtual wards to help them rehabilitate, re-able and recover. • Utilise the learning from the self-assessment to scope, prioritise and devise improvement plans for the gaps and opportunities identified.	By 2025/26

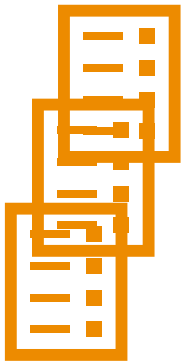
4. Where you can find more detail?

NHS England » Proactive care: providing care and support for people living at home with moderate or severe frailty

NHS England » FRAIL strategy

NHS England » Advice and Guidance

Intermediate care framework for rehabilitation, reablement and recovery following hospital discharge



High quality, patients centred services: FRAILTY

Theme 4

3. What will we deliver and when?

Priorities	Deliverables	Year of delivery
Data & digital enablement	• Scope the development and maintenance of frailty integrated registers across primary, community and secondary services, and were possible social care and public sector services. • Move toward a Population Health Management approach and function to help drive a data led focus on person-centered care for those at risk of or living with Frailty. • Establish the system need and digital capabilities for community remote monitoring for those who are housebound and living with Frailty.	By 2025/26 & beyond.
Workforce	• Understand system partners Frailty workforce infrastructure and capabilities, alongside roles and responsibilities of providing care for those living with Frailty to establish required competencies and identify any upskilling needs. • Collaborate and co-produce standardised training and education support and resources for clinician and care providers across Herefordshire and Worcestershire. • Establish model for an 'Integrated Core Frailty' team that across all health and social care sectors and aligns to national Neighbourhood health Guidelines.	By 2025/26 & beyond.
Care Homes Transformationa nd Quality Improvement Programme	• Establish a system Programme which aims to improve health outcome and care practices for those who reside in Care Homes through a strategic and integrated Quality Improvement and Transformation programme approach and is sensitive place-based needs within Herefordshire and Worcestershire. • Review and recommission Enhanced Health Care Homes framework delivery, addressing the known variation in service provision, accessibility and outcomes. • Evaluate and continue to develop remote monitoring within Care Homes across Herefordshire and Worcestershire. • Establish the need and capabilities for Care Homes to have direct access to SPoA to appropriately direct frail patients who reside in a Care Home to the best place to meet their urgent care needs and wishes.	By 2025/26 & beyond.
Communication and Engagement	• Devise communications and engagement plans with system partners to advocate and champion Frailty across public and professional communities. • Set as standard the requirement across all Frailty and Care Home improvement work for planned and purposeful engagement with our communities, experts by experience and staff groups to encourage collaborative working on the redesign of services and pathways were appropriate.	By 2025/26 & beyond.

4. Where you can find more detail?

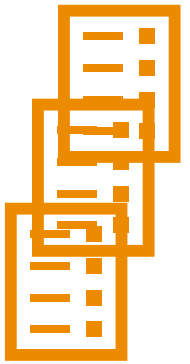
NHS England » Population Health Management

NHS England » Neighbourhood health guidelines 2025/26

NHS England » Providing proactive care for people living in care homes – Enhanced health in care homes framework

NHSE (online) Ageing well and supporting people living with frailty. Available from: NHS England » Ageing well and supporting people living with frailty

British Geriatric Society. (2023) *Joining the dots: A blueprint for preventing and managing frailty in older people.* Available from: Joining the dots: A blueprint for preventing and managing frailty in older people | British Geriatrics Society (bgs.org.uk)



High quality, patients centred services: PALLIATIVE AND END OF LIFE

Theme 5

1. Why is this important?

Ageing population

Herefordshire and Worcestershire's population is due to increase by approximately 5.4%. H&W have older population structures than the rest of England, with over 65+ increasing and younger populations decreasing.

Increased multimorbidity

The ageing population increase will reflect a significant increase of people living with dementia, frailty and other long-term conditions.

Increased number of deaths

Nationally, deaths are predicted to increase by 22% 2030-2040

Increased number of people dying at home

- The majority of bereaved Family's included in the national VOICES survey believed the deceased had wanted to die at home (81%), with a selected sample showing 22% had home as place of death documented on death certificates.
- Community services will need to be available to support people to die well at home, if it is their wish and where it is possible.

2. What have we delivered in our second year, 2024/25?

- We continue to work towards improving the sharing of information with the use of the Shared Care Record. This has an End-of-Life tab which shares data coded in EMIS in line with the End- of-Life Professional Record Standards Body data set for appropriate health provides across the system to view.
- Our digital ReSPECT plan is in development with phase 1 planning to go live during early 2025
- A standard advance statement document called My Wishes has been created for use across the system. A paper version has been launched and this will go live on the patient portal app across the ICS early 2025
- Successful Fast Track Home pilot in Worcestershire which has been rolled out and is now business as usual
- Standardised EMIS protocol agreed for the safe prescribing of anticipatory medications across the ICS
- Development of a PEoLC dashboard collating data across the system
- Development of Bereavement Toolkit on ICS Academy Exchange
- Development of Transitions Toolkit for CYP

3. What are the priorities going forward?

The Palliative and End-of-Life Programme Board is implementing the Herefordshire and Worcestershire Personalised End-of-Life Care Strategy 2020-2025, working in partnership with representatives across the ICS.

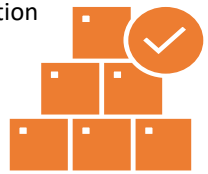
The vision is that "adults and children living in Herefordshire and Worcestershire, regardless of their diagnosis, will be supported to live well until the end of their life". It is imperative that care at the end-of-life is compassionate, tailored to the dying person and people important to them, and includes effective communication and assessments.

The six strategic outcomes are:

1. Increased and early identification of people who would benefit from end-of-life support and personalised care planning
2. High quality care for people at the end of life, their Family's and carers in every setting
3. Accessible, coordinated and digitally enabled palliative and end-of-life services for all patient groups
4. A workforce with the appropriate skills to provide people at the end of their life with high quality care and support
5. High quality bereavement care, support and information available to all
6. An embedded ReSPECT process which supports compassionate, effective and timely Advance Care Planning in all care settings

The key areas of delivery are:

- 24/7 Single point of access for palliative and end-of-life care advice and support for patients
- Making the best use of digital opportunities to improve communication and sharing of information, e.g. digitalisation of ReSPECT and Advance Statement; digitalisation of the palliative care register; and developing the Shared Care Record (ShCR)
- Review of Bereavement services
- Review of Anticipatory medications
- Development of Palliative and end-of-life care Virtual Ward



High quality, patients centred services: PALLIATIVE AND END OF LIFE

Theme 5

4. What will we deliver and when?

Priorities	Deliverables	Year of Delivery
24/7 Single point of access to timely support and advice	Scope service need and options	By 2025/26
Coordinated education and training across the ICS focusing on communication and clinical skills to improve timely recognition of dying, promoting personalised care and advance care planning discussions	Early identification, ambitions mapping, ICS academy, End of Life Care Hub (ECHO) opportunities for sharing learning	By 2025/26
	Continued ambitions self-assessment, developments required based on those assessments. Continued development and work with ECHO hubs and the ICS academy	By 2027/28
Shared access to electronic patient information	Complete capability to share information: - Shared Care Record interoperability with EMIS. - Worcestershire out of hours access to the Shared Care Record	By 2025/26
	Develop access for Care Homes to Shared Care Record	By 2027/28
Embed digital ReSPECT process	Launch and promote digital ReSPECT Launch and promote digital Advance Statement	By 2025/26
	Review data collection, patient and carer feedback to inform promotion and take-up of ReSPECT	By 2027/28
Increased early identification of people who will benefit from end of life support and personalised care planning	Develop education for Primary Care and other practitioners.	By 2025/26
	Review of the new primary care template Develop ICS wide palliative care register-possibly with using clinithink	By 2027/28

High quality, patients centred services: PALLIATIVE AND END OF LIFE

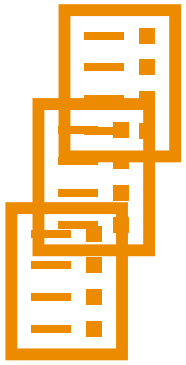
4. What will we deliver and when continued ?

Priorities	Deliverables	Year of Delivery
High quality care for people at the end of life, their Family's and carers in every setting	Data dashboard to include core 20+5 data. Identify inequalities, geographical inequalities, engaging with hard-to-reach communities. Continue anticipatory medication work. CHC FT review and re procurement.	By 2025/26
	Review services and address inequalities ICS PEoLC virtual ward Review impact of changes from the anticipatory medications work CHC FT impact of new service	By 2027/28
Data dashboard and strategic needs analysis (SNA)	Work with data analytics team to create new data dashboard and collect new data to inform population needs. Meet with stakeholders to explore results of the SNA as part of new strategy	By 2025/26
	Continue to monitor and update data dashboard Develop any proposals to reflect findings of the SNA	By 2027/28
High quality bereavement care, support and information available to all	Bereavement group, mapping of services and update leaflets	Completed 2024/25
	Continue to monitor and review bereavement services	By 2027/28

5. Where you can find more detail?

Palliative and End of Life Care Programme:

- Herefordshire and Worcestershire Personalised End of Life Care Strategy 2020-2025 file (herefordshireandworcestershireccg.nhs.uk)
- Ambitions for Palliative and End of Life Care: A national framework for local actions 2021-2026 ambitions-for-palliative-and-end-of-life-care-2nd-edition.pdf (england.nhs.uk)
- NHSE NHS England » Resources and support
- Please email jadebrooks@nhs.net for more information, or to become a patient representative or person with lived experience on any of the palliative and end of life care groups.



High quality, patients centred services: LEARNING DISABILITY AND AUTISM CARE

Theme 6

1. Why is this important?

National LeDeR report findings from 2021:

- 49% of deaths avoidable/ amenable to good health and social care (and at least 2 times higher than general population)
- Life expectancy 20 years less than general population

In addition, for autism, life expectancy is at least 10 years less than average for population, and over 80% of autistic adults experience mental health difficulties in their life.

One of the main factors is that people with a Learning Disability and autistic people (LDA) are underserved groups and do not have consistent access to health services in a timely way due to lack of reasonable adjustments and diagnostic overshadowing. This means health care is sometimes accessed or provided at a late stage of presentation, when the health condition is at an advanced stage or the person is in a crisis (leading to Mental Health Act assessment and hospital/ restricted environment admissions, Emergency Department attendance) and core universal services such as routine vaccinations and or cancer screening are delayed or missed.

2. What have we delivered in 2024/25?

- Continued to maintain Annua Health checks take up above national target.
- On track to complete sensory friendly assessments of 66% of all GP Practices.
- Continued local rollout of RADF, asking local organisations to audit their compliance as per national checklist.
- Fully recruited to key worker service and halved number of CYP in T4 beds
- LeDeR performance consistently above regional and national averages.
- Review of neurodivergence pathway for CYP ongoing.
- Invested £225k to reduce waiting times for young people aged 16-18 in Worcestershire.
- Primary Care CPD Day Held on September 2024 to improve awareness of LD Annual Health Checks.
- New templates in place for Annual Health Checks and Health Action Plans.
- New proposed pathway for LD Bowel Screening presented to the ICB Elective, Cancer and Diagnostic board for approval.
- 'Keeping well and looking after your lungs' video on respiratory health co-produced with Speak Easy Now and disseminated

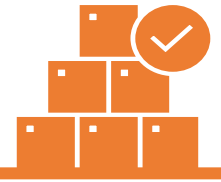
3. What are the priorities going forward?

The Learning Disability and Autism Programme Board have oversight of the plans to improve outcomes for people with disabilities and people with Autism.

Our vision is that all people with a learning disability and/or autism can live healthy and positive lives, and we will do this by promoting reasonable adjustments and tackling health inequalities across the system.

In line with the NHS Long term plan commitments, we will:

- Taking action to tackle the causes of morbidity and preventable deaths in people with a learning disability and for autistic people.
- The whole NHS family will improve its understanding of the needs of people with a learning disability and autism, working together to improve their health and wellbeing. Including training for the workforce, reasonable adjustments and a digital flag in patient records
- Reducing the waiting times for children and young people with suspected autism
- Increased investment in personalised care and community support.
- Continue to focus on improving the quality of inpatient care and timely discharge where appropriate.



High quality, patients centred services: LEARNING DISABILITY AND AUTISM CARE

Theme 6

4. What will we deliver and when?

Priorities	Deliverables	Year of delivery
Rollout sensory-friendly and accessible environments for autistic people into other NHS settings	At least 5 NHS settings will be assessed and have an improvement plan	By 2025/26
Good quality Learning Disability Annual Health checks routinely given to all people with a Learning Disability	Sustain up take of AHCs at 85%, Health Action Plans over 90%, including 14-24 year olds, supported by quality improvement programme focusing on Health Action Plans	By 2025/26
Vaccination and screening rate for people with a learning disability and autism comparable to general population	Awareness raising and targeted work, built around AHCs	By 2025/26
Reduction in avoidable deaths - Learning from the Deaths of People with a Learning Disability Review programme (LeDeR)	Programmes of work following on from LeDeR Learning into Action workstream. Current focus is healthy lifestyles; suicide reduction for autistic people	By 2025/26
Reduction in waiting times for autism diagnosis	Comprehensive review of neurodivergence pathway for CYP to ensure consistency across ICS and more timely diagnosis	By 2025/26
Support to autistic people post-diagnosis	Continued investment in adult support service and explore option for a service for CYP and families	By 2025/26
Raise awareness and inclusion of autistic people in mainstream services	Continued roll-out of Oliver McGowan Mandatory Training programme	By 2025/26
Keep number of young people in Tier 4 beds and adult inpatient numbers within national targets	Sustain low number of young people in T4 beds and reduce numbers of adults in locked rehab beds.	By 2025/26
Increase community Occupational Therapist, Physical Therapist, Speech and Language Therapist and epilepsy support capacity	Deliver service enhancements following agreed investment in community health service	By 2025/26
Tackle heath inequalities Ensure that people with complex needs are supported to live in the community and admission to in-patient units is avoided	• Over 85% of eligible people with a learning disability have an annual health check and over 90% of those have a health action plan • Vaccination and screening uptake is at least on a par with the rest of the population • In-patient rates are in line with or better than the national targets • Waiting lists for community support is less than 18 weeks • Oliver McGowan Mandatory Training has been rolled out across the system	By 2027/28

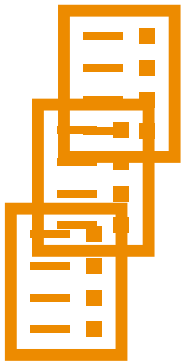
5. Where you can find more detail?

https://www.hwics.org.uk/our-services/learning-disabilities-and-autism

Co-production underpins our approach and we work closely with the Learning Disability Partnership Boards and the Autism Partnership Boards in Herefordshire and in Worcestershire. Experts with lived experience are actively involved, with support, in all strategic developments, and co-chair the Partnership Boards. Family carer voices are also strongly represented.

People with a learning disability can contact SpeakEasy NOW if they wish to become involved https://speakeasynow.org.uk/contact-us/

Our partnership arrangements also include the Acute and Community Provider Trusts, both Councils and the voluntary and independent sector.



High quality, patients centred services: MENTAL HEALTH AND WELLBEING

Theme 7

1. Why is this important?

We know that people are waiting longer than they should to access diagnosis and treatment.

After a decade of improving population wellbeing the COVID-19 pandemic is widely considered to have negatively impacted population mental health and wellbeing. Measures of population wellbeing worsened, particularly during the two main waves of the pandemic and have not fully recovered to pre-pandemic levels.

The proportion of adults aged 18 and over reporting a clinically significant level of psychological distress increased from 20.8% in 2019 to 29.5% in April 2020, then falling back to 21.3% by September 2020. There was a subsequent increase to 27.1% in January 2021, followed by a further decrease to 24.5% in late March 2021.

While there has been considerable economic recovery from the initial shocks of the COVID-19 pandemic, new challenges have emerged, with high levels of inflation and a rise in the cost of living.
Concerns have been raised about the impact this may have on population mental health, and nationally providers continue to report greater acuity of need across mental health services.

Furthermore, these challenges have highlighted and widened some of the existing inequalities in mental health and wellbeing in the population.

2. What have we delivered in 2024/25?

- Access to mental health services for children and young people has expanded significantly and will continue to expand into 2025/26, including broader treatment options through new commissioned services (e.g. Lumi Nova).
- A 3-year Mental Health Acute Inpatient Strategy has been developed to support improved quality of services, closer to home.
- Rapid expansion of NHS Talking Therapies staffing through trainee recruitment, to bring H&W Talking Therapies services in line with national workforce expectations and expand access to services.
- Re-procurement of Children and Young People's Emotional Wellbeing and Mental Health Services, including additional investment and expansion, across both counties.

3. What are the priorities going forward?

A key strategic development as part of the creation of the Integrated Care System has been the establishment of a **Mental Health Collaborative,** which brings together commissioning and provider functions, primary and secondary provision and broader connections to local stakeholders.

The overarching reason for creating the mental health collaborative has been to put the responsibility for organising services and pathways as close as possible to the front-line services that provide patient care. This marks a significant change from the traditional commissioning model of developing detailed services specifications that providers respond to; much more towards a model of agreeing outcomes that providers design service delivery models to address.

In 2024-25 a review was undertaken of the existing Mental Health Collaborative arrangements, with a series of recommendations to ensure clarity of governance processes and improve outcomes for patients. One of the key recommendations is to develop a mental health strategy.

Priority areas for 2025-26 include:

1. Reduction of inpatient average Length of Stay to prevent unnecessary delays, and Out of Area Placements
2. Redesigning Inpatient and Rehabilitation Pathways across the ICS
3. Increasing access to Individual Placement Support (IPS) services
4. Maintain and continue to increase access to CYP mental health services
5. Continue to expand NHS Talking Therapies workforce capacity while maintaining quality standards
6. Improve waits in UEC pathways for patients with mental health illness in line with national standards

The role of the Herefordshire and Worcestershire Mental Health Collaborative is described in more detail in Appendix 2, theme 15.

High quality, patients centred services: MENTAL HEALTH AND WELLBEING

Theme 7

4. What will we deliver and when?

Priorities	Deliverables	Year of delivery
Children and young people	Continue to increase access to CYP mental health services (please see slide 8 on CYP mental health transformation)	By 2025/26
NHS Talking therapies	Delivery of all completed treatments and expansion targets while maintaining quality and waiting standards	By 2026/27
Early intervention in Psychosis	Continue to deliver required standards	By 2025/26
Dementia	Improve post-diagnostic support and timeliness of diagnosis	By 2025/26
Perinatal Mental Health	Maintain access standard for perinatal mental health services	By 2025/26
Out of areas placements (OAP) and inpatient LoS	Reduction of average Length of Stay and eliminaton of inappropriate OAPs in line with national standards	By 2025/26
Physical Health for people with a serious mental illness (SMI)	Maintain delivery of SMI health checks	By 2025/26
Adult community mental health	Take forward local review recommendations following Independent Mental Health Homicide Review	By 2025/26
Urgent mental health care	Delivery of 10 High Impact Actions for urgent mental health services	By 2025/26
Mental Health Strategy	• Mental Health JSNA to be completed • New Mental Health Strategy to be developed by the Mental Health Collaborative • Delivery of new national priorities • Reduction in health inequalities for people experiencing mental health illness	By 2025/26

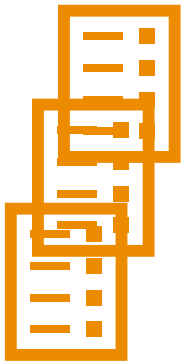
5. Where you can find more detail?

The Worcestershire Health and Wellbeing Strategy 2022-2032 contains a strong mental health focus and is available here:
Health and Wellbeing Strategy 2022 to 2032 | Worcestershire County Council

The Herefordshire Health and Wellbeing Strategy 2023-2033 also contains a strong mental health focus and is available here:
Herefordshire Joint Local Health and Wellbeing Strategy 2023 - 2033

The Herefordshire and Worcestershire Mental Health Strategy is due to be reviewed during 2025, in line with new national NHS strategy.

Public engagement opportunities are advertised through the ICB and local authority websites, as well as on the Herefordshire and Worcestershire Health and Care NHS Trust website.



High quality, patients centred services: LONG TERM CONDITIONS

Theme 8

1. Why is this important?

The prevalence of LTCs in H&W is projected to increase substantially over the next 10 years. Approximately 20, 000 more people will be living with Chronic Obstructive Pulmonary Disease (COPD), Heart Failure, Stroke or Diabetes in 2033 compared to 2023. This increased prevalence is estimated to cost the system £11 million more per year in urgent care utilisation alone.

These projections are in part driven by the increase in are over 65-years old population, which we anticipate to increase by 36, 000 by 2030. However, we are also seeing an increasing prevalence of type 2 diabetes in the 15-19 and 40-49 age ranges in our two counties, demonstrating a need for increased education and prevention to improve quality of life for younger people with LTCs and to prevent LTCs developing so early in life.

We are increasingly aware of growing excess mortality resulting from cardiovascular disease and this trend is greatest in our most deprived communities. People in our most deprived communities are developing multiple LTCs at a younger age than those in our least deprived communities. It is essential that we tackle this inequality difference to ensure all people can live as well as possible.

2. What have we delivered in our second year, 2024/25?

- Long Term Conditions Strategy 2024 – 2029 approved and published.
- Cardiovascular disease forum embedded (ICB & PCN Leads), focussing on sharing best practice and achievement of
- CVD Clinical Excellence and Improvement Framework (CEIF) developed to reduce unwarranted variation across areas which are resulting in high cost and poor health outcomes.
- Continued roll out of a video library for patients, enabling education and supported self-management across long-term conditions.
- Continuous Glucose Monitoring is being delivered as business as usual, with above average uptake regionally.
- Hybrid Closed Loop is being rolled out, with progress exceeding regional average.
- All Primary Care Networks delivering Spirometry testing, with continued increase in activity.
- Fractional exhaled Nitric Oxide (FeNO) testing is increasing by 23% average month on month.
- Continuation of the National Diabetes Prevention Programme demonstrating high retention rate.
- Following roll out of NHS Type 2 Diabetes Path to Remission Programme, there are positive results relating to course completion and weight loss.
- Reduction in both major and minor amputation rates resulting from Diabetes Foot Care service improvements.

3. What are the priorities going forward?

The work on long-term conditions is overseen and delivered through multiple programme boards, aligning to the strategy, which has the following priorities:

Prevention

- People will be actively signposted to appropriate education and organisations that can increase their knowledge, skills and confidence to live as well as possible, reducing their risk of developing long-term conditions.
- People will have improved access to evidence-based high impact interventions that prevent deterioration of long-term conditions.

Early and Accurate Diagnosis

- People who are at increased risk of developing a long-term condition will be proactively identified and supported.
- More people will have their LTC(s) identified sooner and closer to home.

Personalised Management

- People will be provided with education, support and resources to enable them to take a more active role in decisions about their care.
- People with multiple LTCs will receive proactive, holistic assessments, including medication and mental health reviews

Right care in the right setting

- Increase collaboration by services to enable care to be delivered as close to home as the complexity allows.
- Increase adoption of digital technologies that enable more effective self-management outside of a hospital setting.

High quality, patients centred services: LONG TERM CONDITIONS

Theme 8

4. What will we deliver and when?

Priorities	Deliverables	Year of delivery
Strategy	Long Term Conditions Strategy - Continued delivery in three priority areas of Diabetes, Respiratory and Cardiovascular Disease (including Heart Failure), with monitoring of delivery plans through maturity matrices.	Ongoing to 2029
Cardiovascular Disease (CVD)	Continued and enhanced delivery of high impact interventions for secondary prevention: • Community pharmacy hypertension case finding • Cholesterol search and risk stratification • NHS health checks • Case finding and direct-acting oral anticoagulation to prevent atrial fibrillation related strokes • Cardiac rehabilitation for patients post-ACS and diagnosis of heart failure • Optimisation of hypertension treatment • Optimisation of heart failure treatment through annual reviews • Optimising management post ACS, including lipid management.	By 2025/26, but ongoing throughout delivery of JFP
Diabetes National: Local:	• Develop an all ages Diabetes Service Specification that spans multiple providers and services. This will clarify the pathway, drive collaboration and support system wide accountability for outcomes. • Further improve the delivery of 9 diabetes care processes, including enhancements, e.g. the roll out of the Type 2 Diabetes in the Young programme. • Improve identification of individuals at high risk of Type II Diabetes and signpost to NHS Diabetes Prevention Programme or structured education as appropriate. • Improve NDPP uptake and engagement with people who have a Learning Disability or Autism, reducing inequalities. • Delivery of NICE Technology Appraisal for Hybrid Closed Loop by 2029 and improve access to Continuous Glucose Monitoring. • To begin / continue delivery of the following high impact interventions for secondary prevention. • Improve equity of access, and the quality of Diabetes structured education across the two counties.	Ongoing throughout delivery of JFP
	• Improve the Digital offer for enabling supported self-management in Type 1, including in Children and Young People. • Improve pre-diabetes screening and symptom awareness, with particular focus on addressing inequalities • Improve peri operative care of people with diabetes to reduce length of stay and outcomes. • Further development of a Diabetes Support Team in Primary Care Networks to deliver care closer to home (DiAST model of care) • Improve clinical leadership for MDFT	By 2027/28
Respiratory	• Reduce inequalities in access, experience and outcomes in pulmonary rehabilitation. • Establish Getting it Right First Time programme of work. • Ensure that Spirometry and FeNO provision is reflective of NICE guidance, is accessible, and of good quality. • Achieve accreditation for the Pulmonary Rehabilitation service. • Deliver Pulmonary Rehabilitation 5-year plan • Establish and embed a coordinated asthma transition pathway.	By 2025/26 By 2027/28
Neurology	• Develop an ICS plan to support service improvement across Neurology services.	By 2025/26

5. Where you can find more detail?

- Multiple_LTCs_Survey_-_Engagement_Report_-_Final.pdf (hwics.org.uk)
- https://www.england.nhs.uk/ourwork/prevention/secondary-prevention/
- National Asthma and COPD Audit Programme (nacap.org.uk)
- pulmonary-rehabilitation-service-guidance.pdf (england.nhs.uk)
- spirometry-commissioning-guidance.pdf (england.nhs.uk)
- CVDPREVENT

High quality, patients centred services: STROKE CARE

Theme 9

1. Why is this important?

1. Lack of 7-day service provision in Hyper Acute/Acute stroke services, and unlikely to deliver in current format;
2. Current medical workforce challenges mean moving the service from 5 – 7 days (in and out of hours) is unlikely to be achievable;
3. Services at both Wye Valley NHS Trust (WVT) and Worcestershire Acute Hospitals NHS Trust (WAT) are classed as fragile due to longstanding medical establishment staffing gaps;
4. Increasing demand for stroke services over the next ten years increase this challenge further with expected demand to increase by 20% over the next 15 years across the ICS.
5. Achievement of **key clinical and performance standards** will continue to be a challenge and unlikely to be achievable unless changes are made to the existing service models;
6. National Clinical Guideline 2023 recommendations presents challenges in compliance;
7. Acute Stroke services have a current risk score of 16 on H&W ICB Risk Register.
8. System and regional level support for Service change to deliver a sustainable stroke service within the ICS for the future.

2. What have we delivered in our second year, 2024/25?

- Sustainable delivery of 7-day acute stroke care model
  - Proposed single site acute stroke model at Worcestershire Royal Hospital endorsed by NHS Clinical Senate;
  - Clinical Senate recommendations agreed by Stroke Programme Board and local action plan developed;
  - Pre-Consultation Business Case and Outline Business Case have been drafted to include demand modelling, workforce requirements and impact assessments.
- Service Improvement programme
  - Roll out of 'CT Perfusion' (advanced imaging) at both acute hospital sites to enable physicians to make faster, more accurate triage or transfer decisions;
  - Wye Valley NHS Trust are part of a national programme to improve Thrombolysis rates, with shared learning into Worcestershire;
  - SQuIRE quality improvement programme concluded with 4 improvement projects implemented across the ICS.

3. What are the priorities going forward?

ICS Stroke Programme Board (SPB) involves stakeholders across the stroke pathway (Herefordshire, Worcestershire and Powys Teaching Health Board) Healthwatch, West Midlands Ambulance Service, Stroke Association and Patient engagement. The Programme Board focusses on the entire Stroke Pathway, from Hyper-acute to Rehabilitation and Life After Stroke.

Priority 1: The Stroke Programme Board is committed to delivering a new, **sustainable 7-day acute stroke services model**. This will modernise how services assess and treat patients; ensuring optimal clinical model of care and the best use of resources across the entire pathway, including staffing and use of technology. To achieve this vision, the SPB has commenced a pre-consultation process, and a preferred clinical model has been agreed. SPB are now looking at the post-acute pathway, including life after stroke and are working towards an options appraisal process to agree a pathway that will align with the proposed endorsed acute pathway. It is recognised that this pathway model will require capital investment and is the longer-term strategy required to deliver sustainable stroke services for the future.

Priority 2: The **Stroke Services Improvement programme** focusses on:

- Workforce development;
- Digital enablers (for example, pre-hospital video triage);
- Performance Standards;
- Development of patient pathways, in line with national standards;
- Focus on health inequalities with a targeted CVD prevention programme to reduce the incidence of Stroke.

The Stroke Programme is aligned to and supported by the Integrated Service Delivery Network (ISDN) and The National Stroke Quality Improvement in Rehabilitation (SQuIRe) programme.

High quality, patients centred services: STROKE CARE

Theme 9

4. What will we deliver and when?

Priorities	Deliverables	Year of delivery
Service Improvement Programme	• Workforce developments resulting in robust medical and nursing workforce with joint working/posts across Hereford County Hospital and Worcester Royal Hospital to ensure resilience. • Advances in digital technology embedded, with virtual consultations part of everyday practice where appropriate. • Development of a service specification for an integrated community stroke service. • Development of Clinical Guidelines for Stroke. • Improvement in performance standards.	By 2025/26
Sustainable delivery of 7-day acute stroke care model	• Agreement of post-acute pathway including Life After Stroke.	By 2025/26
	• Completion and presentation of Pre-Consultation Business Case and Outline Business Case. • Commencement of the Pre-Consultation process.	By 2025/26
	• Stroke services transformed with agreed pathways embedded and services delivered in line with national guidelines and performance standards.	By 2027/28

5. Where you can find more detail?

In January 2022 we considered all the previous patient and public feedback we had received about stroke services. This was summarised in a paper, which is available here.

A further Stroke Services issues paper was written in September 2022 and further engagement undertaken :-

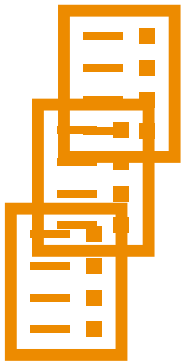
Stroke Services :: Herefordshire and Worcestershire Integrated Care System (hwics.org.uk)

Integrated Community Service Specification - Feb 2022

National Clinical Guideline for Stroke 2023

Stroke - Getting It Right First Time - GIRFT

Integrated Life After Stroke Support



High quality, patients centred services: URGENT AND EMERGENCY CARE SERVICES

Theme 10

1. Why is this important?

The Urgent and Emergency Care (UEC) system in Herefordshire & Worcestershire is in a challenged position. However, ICB and system partners remain committed to making sustainable improvements across the entire health system to support timely care and efficient patient flow.

The National delivery plan for recovering UEC services sets out core indicators to Increase urgent and emergency care capacity by March 2024 including:

1. No less than 78% of patients (in Emergency Departments) are seen within 4 hours
2. Ambulance category 2 mean response time is less than 29 minutes
3. Achieve an average adult G&A bed occupancy of 96% or below

The system forecast outturn for 2025-26 against these targets which demonstrate the challenged situation are:

1. 78%
2. 29
3. 96%

2. What have we delivered in our second years, 2024/25?

- Launched of Single point of access covering Community and Acute Trusts, improving the coordination of people to the most appropriate service (in both counties)
- Continue to grow virtual ward beds in line with the UEC strategy of a model hospital
- Improvement in ambulance category 2 response times
- Implementation of national call-before-convey requirement, building upon the success of the urgent community response service.
- System Coordination Centre fully compliant with national standards and oversight of the day-to-day urgent and emergency care pressures.
- Improved and enhanced same day urgent care pathways
- Further development of same day emergency care with Frailty SDEC established at one of the sites

3. What are the priorities going forward?

- The Urgent and Emergency Care Programme Board is driving forward improvements for a responsive and affordable urgent and emergency system that meets the population's needs. This includes preventative or activities to manage ill-health before it becomes an emergency, and timely and efficient patient flow, resulting in less ambulance handover delays and minimising waits within Emergency Departments.
- Delivery of 78% EAS by March 2026.
- Delivery of less than 30-minute category 2 response times throughout 25/26
- Significant reductions to numbers of patients waiting over 12 hours in our Emergency Departments

The six priorities are:

1. Population management - To apply population health management approach to identifying those most at risk
2. Care at Home - To maximise the coordination of services to proactively intervene early and prevent the deterioration of frailty and ill-health
3. Future model of urgent care - To establish a model of integrated urgent care that supports people to access advice and interventions. This will include a procurement of out-of-hour GP provision, outbreaks management and enhancements to single point of access.
4. Emergency care - To consistently demonstrate an effective and efficient emergency care provision.
5. Discharge and recovery - To have a 'zero delay' approach to discharge planning with coordinated support for people to optimise their recovery.
6. Operational resilience - To demonstrate effective resource allocation to de-escalate or prevent pressure.

4. What will we deliver and when?

Priorities	Deliverables	Year of delivery
Population Health Management	• Implement data gathering on health inequalities • Undertake population health assessments • Tailor approaches to people most-at-risk of requiring urgent & emergency care	By 2025/26 By 2025/26 By 2025/26
Care at Home	• Care at Home delivered by Integrated Neighbourhood Teams • Development of virtual hospital • Frailty competent workforce	By 2025/26 By 2025/26 By 2026/27
Future model of urgent care	• Procurement of Integrated Urgent Care including out-of-hours GP service, outbreak management and enhanced single point of access. • Delivery of a single point of access and enhance care navigation	By 2025/26 By 2025/26
Emergency care	• Consistently achieve under 29 minutes category two ambulance response times. • Achieve high performing Emergency Departments (emergency access standard) • Implement 'front door' streaming to right care setting • Maximise same day emergency care, including access to diagnostics 7-days	By 2025/26 By 2026/27 By 2025/26 By 2026/27
Discharge and Recovery	• Commit to returning home sooner #Homeforlunch • Enhance Frailty Rehabilitation & Discharge pathways • Improve Discharge-to-Assess pathways across the system	By 2025/26 By 2025/26 By 2025/26
Operational resilience	• Conduct annual winter and surge planning • Run public awareness campaigns to support people to use the right service • Develop shared training, common approaches and local knowledge across the workforce • Operate 7-day working across urgent & emergency care	Ongoing By 2025/26 By 2026/27 By 2026/27

5. Where you can find more detail?

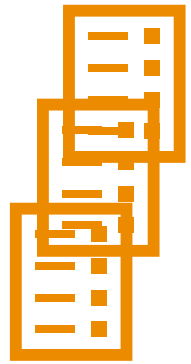
The ICB and ICS system partners are refreshing the UEC Strategy, a link will be shared when this is available.

More information and context for the ICBs priorities can be found within the national recovery plan:

- B2034-delivery-plan-for-recovering-urgent-and-emergency-care-services.pdf (england.nhs.uk)

Findings from Healthwatch talking to our patients will inform the focus of other workstreams to ensure care in the right place, at the right time, as close to home as possible, further engagement will be planned with Herefordshire:

What patients told us about why they "walk in" to A&E Departments in Worcestershire | Healthwatch Worcestershire



High quality, patients centred services: PRIMARY CARE SERVICES (GENERAL PRACTICE)

Theme 11

1. Why is this important?

Every day, more than a million people benefit from the advice and support of primary care professionals – acting as a first point of contact for most people accessing the NHS & providing an ongoing relationship to those who need it. This enduring connection to people is what makes primary care so valued by the communities it serves.

The most recent ONS Health Insights Patient Survey at the beginning of 2025 ranked the ICB as the best in the country where 86% of patients reported a 'good' overall experience of access to general practice.

Workforce challenges for General Practice include the attraction and retention of GPs and Practice Nurses. 28% of the GP workforce and 30% of the nursing workforce are over 50 years. In 2024-25 Partner numbers continue to decrease (-4%), but the numbers of salaried GPs is increasing (+16%). Overall the GP workforce has increased by 3.6 FTE.

2. What have we delivered in our second year, 2024/25

Implementation of the local Herefordshire and Worcestershire Primary Care Access Recovery Plan – Year 2

- Delivered **5.5 million appointments** in General Practice (2024). This is 20% more appointments than before the COVID-19 pandemic, and an increase on 2023. GP Practices are providing patients with access to around 466,000 appointments a month. This is almost 80,000 appointments per month more than pre-pandemic.
- By the end of March 2025, all practices will have implemented the Modern General Practice Access (MGPA) model to tackle the 8am rush, provide rapid assessment and response and avoid asking patients to ring back to book an appointment.
- For cloud-based telephony, online access to patient records, digital communication tools and Online Consultation solutions, we have 100% of our Practices offering these services.
- Online consultations are currently averaging around **70,000 admin or clinical contacts per month**.
- Excellent progress has been made in Self-referral pathways: adult audiology went live in 2024 and now Physiotherapy/Musculo-skeletal and weight management pathways have been developed. **About 4,000 self-referrals are made each month**.
- Primary-Secondary Care Interface is working in line with their 'working better together principles'. Consultant to Consultant referrals policy allows direct inter-hospital referrals when clinically needed, rather than going back through the GP.
- Bureaucracy has been reduced as part of the 'red tape challenge' event in December 2024. A Primary Care Liaison Officer is in post to work across the system on any barriers to facilitate change and improve capacity and patient care. NHS Trusts have established clear call and recall systems for patients for follow up tests or appointments.
- The Herefordshire & Worcestershire ICB's published Primary Care Access Plan was approved by the H&W ICB Board on 20 November 2024, which can be accessed via the website at agenda item 8: https://herefordshireandworcestershire.icb.nhs.uk/meetings/past-board-papers and was commended by NHS England.
- The ONS Health Insights Survey ranks Herefordshire & Worcestershire ICB top across the whole of England for patients reporting a 'good' overall experience of access to general practice.

Workforce

- Recruitment to the Additional Roles Reimbursement Scheme (ARRS) continued during 2024. On 1st August 2024, the government announced additional funding to support GP recruitment from Oct-March 24-25. By Jan 25, 6 PCNs had appointed 5.7 WTE ARRs funded GP.
- 25-26 funding has been expanded to included practice nurses as well as continued funding for GPs & GP joiners and leavers data has improved since March 2024.
- 371 direct patient care staff recruited up to Jan 25.
- General Practice Staff Survey – year 2 participation. Results demonstrate H&W equal to national survey average.
- General Practice workforce retention and attraction schemes implemented for 24-25.
- Support Level Framework (SLF) visits with Practices identified priorities and support offered through ICB General Practice Improvement Programme (GPIP) /Service Development Funding (SDF).

Estates

- Revision of General Practice estates plans as part of the draft ICS Infrastructure Plan 24/25, submitted 31st July 2024.
- Funding bid submitted in March 2025 to support General Practice to increase premises and appointment capacity as part of NHS England's Estates Modernisation and Utilisation Fund.

Governance

- Established the Delegated Commissioning Sub-Committee in July 2024, to provide a governance mechanism for the assurance and oversight of the delivery of nationally mandated Primary Care services that are delegated to the ICB (Primary Medical Services, Pharmacy, Ophthalmic, Dental Services)

High quality, patients centred services: PRIMARY CARE SERVICES (GENERAL PRACTICE)

Theme 11

3. What are the priorities going forward?

Enabling General Practice Strategy priorities

Planning and oversight is currently governed via the GP Sustainability and Transformation Forum, with overall accountability with the Strategic Commissioning Committee. Delivery via Herefordshire General Practice and General Practice Worcestershire Boards.

Integrated Neighbourhoods Teams – developing and supporting services delivered at a neighbourhood level – are central to transformation priorities of the Herefordshire & Worcestershire Integrated Care System

Enhancing services in primary care by prioritising workforce, estates and technology investment at a neighbourhood level will enable our citizens to have better local access to a wider range of services they need when they need it

Creating the conditions to better manage patient demand for primary care will enable GP practices to provide continuity of care to those who want and need it and give increased focus to prevention – support the ICS aspiration to reduce inequality and enhance outcomes.

All designed to ensure that the people who need and want to access primary care can get it, and that GPs have more time to provide continuity of care and deliver more preventative care going forward

5. Where you can find more detail?

- **Long Term Plan**
https://www.longtermplan.nhs.uk/publication/nhs-long-term-plan/

- **Hewitt Review**
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment data/file/1148568/the-hewitt-review.pdf

- **Fuller Stocktake**
https://www.england.nhs.uk/wp- content/uploads/2022/05/next-steps-for- integrating-primary-care-fuller-stocktake- report.pdf

4. What will we deliver and when?

Priorities	Deliverables	Year of delivery
Implementation of Fuller Report	• Lead & co-ordinate ICS response to Fuller & the moving towards a new model of care at Neighbourhood level. Starting in 2024\25 we want the System to orientate itself around 15 Neighbourhoods to reflect the needs of our Communities.	By 2024/25
General Practice	• Lead the co-production of a "Enabling General Practice" 3 year strategy with short, medium and long-term priorities. Set in the context current pressures, whilst raising ambition. • Drive a standardised and consistent offer to all residents of the highest standard • Focus and target unwarranted variation across all practices and see an improvement across accessing and ease of contact with practices as well as a broad range of long term conditions • Co-produce with General Practice a transformation programme which supports all practices in reaching their potential and builds capacity within practices to manage change and drive improvement	By 2024/25
Primary Care Estates	• Support General Practice to access funding and implement schemes to increase estates and access capacity via the Estates Utilisation and Modernisation Fund	By end of 2025/26
Primary Care Access Recovery Plan	• Engage on at scale solutions which sit within our PCARP and use this as a springboard to resilience, sustainability and transformation, utilising digital technology as additional forms of access. • Utilising additional workforce from the ARRS funding, and community pharmaices offering extra capacity for primary care. • Lead and coordinate the response to Year 2 of the National Access Recovery Plan – supporting practices and PCNs deliver their Access Improvement Plans, navigating the national Improvement Programmes to maximise implementation of transformation support tools locally to enact the necessary change. • Work across the system to enhance left shift activities delivering clear closer to patients while preventing unnecessary workload for GPs that should be undertaken in acute settings.	By end of 2025/26
GP Retention Review and refresh around	• Implement a GP Retention Plan and expect a drop in numbers leaving in early stage of their careers and a rise in well being • Review years 1 and 2 of – Enabling general practice and Dental Access strategy • Redefine priorities based on progress made and updated PCN/General Practice Contract from April 2024	By 2027/28 By 2024/25

General Practice Worcestershire's vision is to offer patient-centred healthcare which is high quality, cost-effective and fully integrated with our local partners to ensure a sustainable health service for our communities across Worcestershire. Our vision will be delivered by ensuring we have a happy, valued, supported multi-disciplinary workforce across General Practice.

What we delivered in 2024/25…

Access-

✓ Continued work to meet the three domains of Modern General Practice Access;

- Better digital telephony: telephony systems include call back functionality and reporting mechanisms to support capacity planning and access improvements
- Simpler online requests: online clinical and administrative requests can be submitted during core hours with appropriate responses and signposting enabled
- Faster care navigation, assessment and response.

✓ Introduction of PCN Hubs. The Same Say Urgent Access Hubs were introduced in Worcestershire in Autumn 2024 to support increasing demand for patients needing on the day care in General Practice and to reduce the impact of this on the wider system including Accident and Emergency. The hubs have been successful with high levels of uptake. Each of the 10 PCN's are providing a hub to support patients from their constituent practices, providing flexibility of access when demands across the network differ, whilst still providing care closer to home and maintaining some degree of continuity. When individual PCNs are under pressure, the hubs can be repurposed for cross county support.

Workforce-

✓ We have maintained recruitment within the ARRS workforce to meet national targets and flexed according to the ARRS changing criteria

✓ Introduction of Work & Health Coaches in collaboration with system partners as part of the Workwell initiative.

Sustainability

✓ **T**hrough General Practice Worcestershire Board, working to become a proven platform for future investment in general practice, supporting sustainable general practice and investment in care closer to the patient.

✓ Metered dose inhaler changes as part of CEIF

Delivery of Integrated Neighbourhood Teams

✓ Continued work on the programme and timeline for implementation of the Fuller stocktake with phased delivery, via the Place-plan. Building on the learning from the 3 Accelerator sites to rapidly scale up efficiency and integration across community teams, general practice and social care.

✓ Continued District Collaborative working, with a focus on Prevention and Tackling Health Inequalities. Particular focus on CVD with targeted initiatives for this patient cohort. Increase in community involvement in local services such as menopause, smoking cessation, ageing well, diabetes prevention events.

✓ Working with our Community and Acute partners on Frailty, Virtual Ward, Primary/Secondary interface.

Work with the ICB on the "Enabling General Practice" 3 year strategy

✓ General Practice Worcestershire Board established and includes elected practice manager, ICB, LMC. The Board has continued to operate throughout 24/25 as central point of contact and has supported system wide meetings with GP representation.

What will we deliver over the next five years?

- **Access-**delivery of the national access priorities including integrated urgent care, direct access, improving prevention and tackling health inequalities, and supporting improved patient outcomes in the community through proactive primary care. Focus on patients who would benefit most from continuity of care and the creation of a patient charter detailing what patients can expect from their GPs and practices. A recent national survey highlights significant improvement in patient experience of GP access, with the latest results for Hereford and Worcestershire showing the highest patient satisfaction of GP access of any across the country.

- **Workforce-** continue to flex recruitment to the ARRS workforce, stabilise General Practice workforce including the partnership model and retaining the workforce including clinical roles in training. Development of a local general practice workforce strategy for Worcestershire to support Recruitment, Retention & Reform, working closely with Partners.

- **Sustainability**-Become a proven platform for future investment in general practice, supporting sustainable general practice and investment in care closer to the patient. Continue to deliver high quality, value for money services, harnessing the use of digital innovation in primary care where this supports patient need.

- **Delivery of Integrated Neighbourhood Teams -** Extend the Population Health Management approach beyond GP data and use the intelligence to maximise the impact of integration and reduce duplication as part of the implementation of the Fuller stocktake programme. Hosted visit from Claire Fuller to Stourport Medical Centre to highlight innovation in both counties

- **Deliver the general practice actions outlined in the "Enabling General Practice" 3 year strategy – progressing** beyond the ending of the PCN DES in 24/25, focusing on sustainable and resilience general practice.

High quality, patients centred services: GENERAL PRACTICE HEREFORDSHIRE

Herefordshire General Practice

Theme 12

In 2023/24, we established Herefordshire General Practice Collaborative. This model has successfully united representatives from all 19 Herefordshire practices, the Local Medical Committee (LMC), Primary Care Networks (PCNs) and Federation (Taurus Healthcare) to strengthen our working partnerships. The aim of the changes is to improve the delivery of 24/7 General Practice, create greater resilience for practices, provide variety and development for our workforce and to amplify the voice of General Practice in our local health and wellbeing system and is focussed on delivering this over the next five years.

Neighbourhood health

- HGP is committed to supporting and helping lead this next stage of development into neighbourhood health, and to build on use of the population health data.
- Ensuring we are an effective system partner, working with communities, health, care and voluntary partners to improve the experience of our services through integrated neighbourhood working and securing resources to deliver effective and appropriate out of hospital care
- Building on current success in expansion of MDT teams to further develop into future neighbourhood health integrated models

24/7 Integrated Urgent Care

- Developing the IUC agenda bringing together the pressures in the community alongside those of the acute, with integrated data sets that reflect capacity and demand in all sectors.
- Explore and develop a localised element of 111 that dovetails with existing IUC in a more seamless way, ensuring patients are supported to find the right care at the right time
- Retaining the OOH contract for local control that supports continuity of care and increasing integration of services.
- Build on the effective remote hub HRH, to support the IUC across the system, testing out the impact of face to face overflow.

Accessible, Sustainable general practice

- Continuing to deliver the modern general practice program to improve access
- Underpin the fair share of resources to ensure practices and primary care at scale remain financially viable, through both the national contracts, and the development of local contracts eg LES, CEIF
- Support the movement of work from the acute to the community, but with an appropriate shift of resources.
- Shape development & support delivery of ICS estates & digital plans, facilitating access and the delivery of integrated health & social care anchored around our neighbourhoods.

Develop New Services

- Deliver a new ADHD service that can provide a quality service that dovetails with general practice and mental health services, creating a more financially resilient service for the future.
- Explore the movement of services into the community that can support the system backlog and allows care closer to home, through subcontracting opportunities.

Primary secondary care interface

- Build on the supportive relationships to ensure that primary and secondary care reduce unnecessary shift of workload, reducing unnecessary appointments, whilst supporting workload shift into the community that is appropriately resourced.

Prevention

- Continue to develop the prevention agenda in the community, with talk wellbeing working alongside PCNs and practices to promote activities that support wellbeing and tackle inequalities
- Continue the workwell project to support people getting back to work

Thriving General Practice workforce

- Develop & implement a local General Practice workforce strategy to support recruitment, retention and role redesign, and that identifies the needs of our teams and attracts, values and supports our workforce
- Continue to implement ambitious plans to not only recruit but support and develop additional roles in General Practice, maximising our collective skills and expertise and our productivity
- Work together to embed new models of care, such as Herefordshire Remote Health, that not only supports patient access but offers increased flexibility for clinicians.

High quality, patients centred services: PRIMARY CARE SERVICES - PHARMACY, OPTOMETRY AND DENTAL (POD)

Theme 13

1. Why is this important?

NHS England delegated the commissioning of

the Pharmacy, Optometry and Dental (POD) services to H&W ICB in April 2023. The Office of the West Midlands (OWM) was established to support the six ICBs to deliver their commissioning responsibilities.

The Office of the West Midlands (OWM) is hosted by BSoL ICB who provide, oversight, leadership, and support for the workforce who were transferred from NHSE. This arrangement is supported by a formal hosting agreement between the West Midlands ICBs. All decisions are made through the 3 tier Joint Commissioning arrangement and their sub-groups which each ICB is a member of.

Herefordshire & Worcestershire has the Strategic Lead Role for POD services. What this means is – Simon Trickett, via the West Mids CEO Group is the Chief Exec lead for specific programmes such as developing a needs-based allocation formula to support Dental Services for example and escalating any issues to NHSE that may require dispute/resolution.

Specialised Services was also devolved in April 2024, and additional services such as Vaccinations & Immunisations and Screening programmes will be delegated in 2026.

Over the last 10 years there has been a decline in the number of Dental Practitioners providing NHS dental services to patients, this is particularly prevalent in Herefordshire and improving access to Dental services is a key priority in 2024/5.

2. What have we delivered in our second year, 2024/25

- Established the Delegated Commissioning Sub-Committee in July 2024, to provide a governance mechanism for the assurance and oversight of the delivery of nationally mandated Primary Care services that are delegated to the ICB (Primary Medical Services, Pharmacy, Ophthalmic, Dental Services)
- Development of a local Dental Recovery Plan, which aims to improve access and support the dental workforce.
- Development of a Dental Services Equity Audit by the Consultant in Dental Public Health, which has helped to inform commissioning intentions.
- Dental access is slowly improving. Between March 2022 to December 2024, dental access increased from 46% to 56% for children and 33% to 36% for adults, with the benchmark being 55%, which was the level of access pre-pandemic.
- Mobilisation of a new dental practice in Hereford City in June 2024, with a 2nd site due to open in May 2025. Combined, these two new services will provide much needed additional dental access for around 7,000 residents.
- Implementation of a proof-of-concept Dental Training Centre, which aims to recruit more dentists from overseas, and support them through the mentoring process.
- Continued to build on relationships with Local representative Committees such as the Local Dental Committee (LDC), Local Optometric Committee (LOC) and Local Pharmaceutical Committee (LPC) to understand the challenges and opportunities for providers to inform future strategic commissioning intentions.
- Worked closely with Community Pharmacies to implement the community pharmacy element of the national Primary Care Access Recovery Plan. In the two-year programme:
  - *Pharmacy first commenced for seven common health conditions at the end of January - Sinusitis, sore throat, earache, infected insect bite, impetigo, shingles, and uncomplicated urinary tract infections in women without the need to visit a GP practice in addition to 40+ conditions pharmacies routinely manage. To date **13,906 consultations** have been referred by GP practices FY 24 25 (4,557 through clinical pathways and 9,348 as minor illness referrals).*
  - *Oral contraception service has been expanded. Between April 2024 and December 2024, **3,124 consultations** completed for initiations and ongoing supply of oral contraception.*
  - *Blood pressure check service has been expanded, encouraging utilising technology, to improve efficiency of referrals to community pharmacies. 89 pharmacies signed up and the service is delivering over target at **139.3%** (Nov 2024)*
  - *Discharge medicine service - Working closely with secondary care pharmacy teams to increase referrals into this service. All 3 NHS Trusts have commenced the service helping to reduce 30-day readmissions*
  - *Approved for 3 H&W sites to host independent prescribing pharmacist clinics – acute conditions; contraception; hypertension and CORE20PLUS5 initiatives. Herefordshire and Worcestershire ICB are the only ICB to fulfil all sites.*
  - *Pharmacy Engagement PCN Lead role, working with PCNs to increase patient, public awareness and referrals.*
  - *Ensure safe use of medicines and the position of community pharmacy is routinely built into our commissioning arrangements including a major provider of Flu and COVID-19 vaccine delivery across HWICS*

3. What are the priorities going forward?

- Accelerate Pharmacy First National Services so that there is an equitable offer for patients to self-refer or be referred increasingly into pharmacy-based services. GP connect update and access record is required to be switched on in GP practices by October 2025 to enable more streamlined messages on clinical services provided by pharmacies.
- Continue to implement the local Dental Recovery Plan priorities.
- Continue to build relationships with Community Optometrists, and the development of integrated pathways
- Increase clinical pathway referrals from practices.

4. What will we deliver and by when?

Priorities	Deliverables	Year of delivery
Primary Dental services	Implement the local Dental Recovery Plan actions, in addition to the government manifesto for additional urgent dental appointments.	During 2025/26
Delegated responsibilities	Continue the governance and oversight of Pharmacy, Ophthalmic and Dental delegated responsibilities (in addition to General Medical Services) via the Delegated Commissioning Sub-Committee, established July 2024. .	During 2025/26
Increase Dental Access	Mobilisation of the 2nd dental service in Hereford City to increase access for patients Commence commissioning plans for additional dental activity, in accordance with the local Dental Recovery Plan	May 2025 By June 2025
Optometry	Continue to build relationships with Community Opticians and develop integrated pathways where clinically appropriate	During 2025/26
Community Pharmacy	Accelerate referrals into Pharmacy First services for minor conditions and clinical pathways plus BP checks and contraception services through integrated pathways. Full digital integration into discharge medicine pathways confirms patient understanding of changes made to medicines whilst in hospital after they are discharged. Continue to input into national learnings of independent prescribing by community pharmacists as part of the national pathfinder programme – essential to workforce plans	During 2025/26

5. Where you can find more detail?

Dental patients to benefit from 700,000 extra urgent appointments - GOV.UK

Pharmacy First: what you need to know - Department of Health and Social Care Media Centre (blog.gov.uk)

High quality, patients centred services: SPECIALISED SERVICES

Theme 14

1. Why is this important?

Specialised Services are a diverse portfolio of NHS pathways accessed by a small group of people living with rare or complex conditions, including cancer, neurological, genetic and complex mental health needs.

ICBs were established to work with all partners to create a system where decisions are taken as locally as possible.

In 2024/25 the ICB became responsible for 59 acute specialised services delegated from NHSE, following the delegation of pharmacy, optometry and dental services in 2023/24. In 2025/26 a further delegation of other acute and mental health specialised services, as well as vaccination, screening and child health information services, is to be delegated.

What does this mean for the population of Herefordshire & Worcestershire? It means that the ICB will be able to influence the development of an integrated care pathway (for example, a cancer pathway) thereby ensuring that it reflects the local needs of our population within the larger over-arching commissioning policy across the West Midlands.

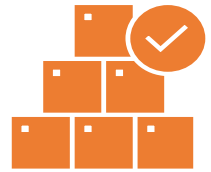
2. What have we delivered in 2024/25?

2024/25 saw the continuation of the joint work between NHSE and ICBs to facilitate the safe transition of the delegated services across the 11 Midlands ICBs. It is proposed that in 2025/26 - subject to consultation – NHSE staff in the West Midlands supporting all these services will transfer to NHS Birmingham and Solihull Integrated Care Board.

3. What are the priorities going forward?

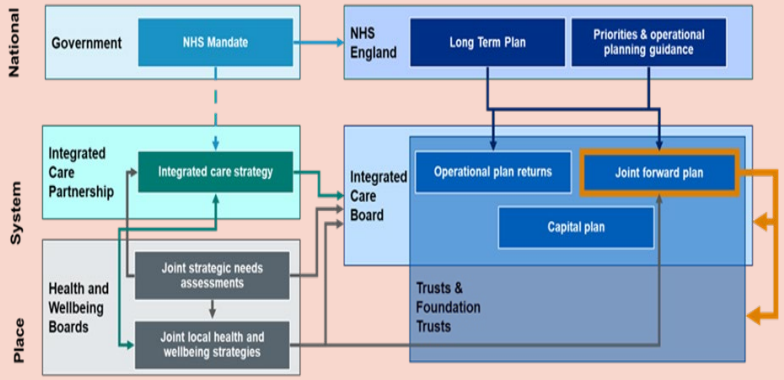
The over-arching national priorities for Specialised Services in 2025/26 are:

- Continue to reduce elective care waiting times – with 65% of patients waiting less than 18 weeks.
- Improve ambulance response and A&E waiting times – with a minimum of 78% of patients seen within 4 hours
- Improve patients access to general practice and urgent care dental care access, including 700,000 additional urgent dental appointments
- Accelerate patient flow in mental health crisis and outpatient care pathways



High quality, patients centred services: SPECIALISED SERVICES

Theme 14

Priorities	Deliverables	Year of delivery
To demonstrate NHSE priorities align with wider system partnership (ICB) ambitions, support subsidiarity and be delivery focused.	Production of an Integrated Commissioning Plan for 24/25 building on existing local strategies and plans, emphasising collaboration with local entities, and reflecting universal commitments. Whilst maintaining a delivery focused approach, incorporating specific objectives, trajectories, and milestones to ensure actionable plans and measurable outcomes 	**2024/25**
	Delivery of the integrated commissioning plan	**2025/26 and beyond**

5. Where can you find more detail?

[NHSE Midlands]

Joint forward plan – 25/26

Appendix 2: Strategic Enablers – Cross cutting themes

The section also identifies **how key enabling strategies** will be delivered to support the improved outcomes described in the core areas of focus section.

The section also describes the **strategic system developments** that will ensure that the system has the right structures, capacity and capabilities to deliver the plan.

Version: 2025 Refresh, May 2025

Strategic Enablers - cross cutting themes and strategic development areas

Cross Cutting Themes

Underpinning and supporting delivery of the core areas of focus outlined in Appendix 1 are a set of strategic enabling functions. These "cross-cut" all service areas and are fundamental components of delivering high quality, patient centred integrate services:

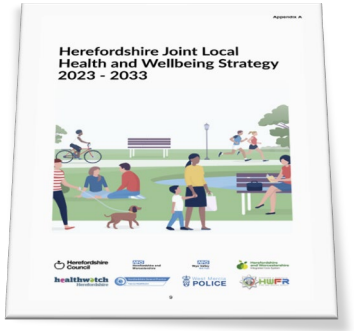
1. **Quality safety and patient experience**
2. **Clinical and care professional leadership**
3. **Medicines and pharmacy**
4. **Health inequalities**
5. **Prevention**
6. **Personalised care**
7. **Working with communities**
8. **Commitment to carers**
9. **Support veteran health**
10. **Addressing needs of victims of abuse**
11. **Digital, data and technology**
12. **Research and innovation**
13. **Greener NHS**

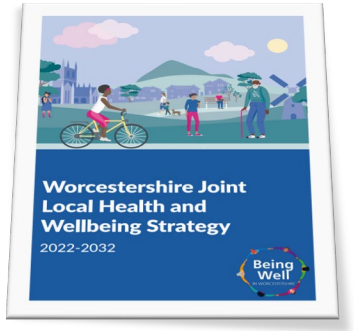
Strategic System Developments

In addition, there are a suite of strategic system developments that will support improved ways of working to maximise the opportunity for integration, enable greater focus on upstream prevention and delivery of best value health care in the right settings:

14. **Mental health collaborative**
15. **NHS Trust collaboratives**
16. **One Herefordshire Partnership**
17. **Worcestershire Place Partnership**
18. **Office for the West Midlands ICBs**

Together these supporting enablers provide the platform from which local NHS and Primary Care Partners can work together to deliver the priorities set out in the Integrated Care Strategy, the two Joint Local Health and Wellbeing Strategies and the NHS Long Term Plan





1. Quality, Safety and Patient Experience

Theme 1

Why is this important?

- What matters to people matters to us, listening to patients, their families and carers experience is essential to continuous improvement of services
- We have collective and individual responsibility to act in a manner that seeks ensure safe, effective and high quality care delivery and safeguard those in need of health and social care
- ICB has a Duty to ensure continuous quality improvement and as an ICS we are committed to this
- Learning and improvement cultures enable collaboration that leads to assurance of sustainable improvements in safety, clinical effectiveness and personalised experience

What have we delivered in 2024/25?

- Implementation and embedding of Patient Safety Incident Response Framework with continued growth of a system Patient safety specialist network and ICS Patient Safety Community of Practice to provide system opportunities for improvement and shared learning.
- This pilot project to safely develop, test and deliver an innovative approach of implementing AI into a patient management system to lead to better process flow and outcomes in CHC that is now being scaled up
- Improvement work related to Learning Disability and Autism including exemplary work around sensory friendly GP practices and children and adult admission avoidance. Surveillance status downgraded to 'by exception' which is the lowest level of surveillance the system can achieve.
- Establishment of ICS Collaborative for C-Diff Quality Improvement
- Oversight and governance processes established across the ICB to ensure patient safety quality and patient experience are central to ICB oversight

What are the priorities going forward?

- Improving indicators and experience of emergency care
- Improving system position for C-diff trajectories through quality improvement.
- Focus on implementation of Primary Care Patient Safety Strategy
- Further strengthen patient safety oversight with the development of patient safety dashboard
- Establish an ICS Deterioration Network and develop ICS strategy for PIER framework and Martha's Rule
- Delivering the national ambition to reduce still births, maternal and neonatal deaths and intrapartum brain injury Check planning guidance

ICS System Quality Group

The ICS System Quality Group met bi-monthly during 2024/25. The key aim of the group is to generate a shared commitment to improving quality and enable progress to be made on key system wide priorities.

The Group consists of key senior leaders from across the ICS and partner organisations who have a commitment to continuous quality improvement. Through discussion on key agenda items members have started to establish agreement about key cross cutting system priorities for improvement that are not otherwise managed through ICS Programme Boards.

During 2024/25 members have shared learning themes generated from organisation, 'place', system or Regional level processes, for the purpose of enabling system wide improvement.

What are we measuring?

During 2025/26 population health level dashboards will provide refreshed opportunities to understand what matters to people and track progress against priorities

- Rates of infection and antimicrobial prescribing
- Trends in mortality from specific causes and excess mortality
- Key metrics aligned to Saving Babies Lives Care Bundle
- Metrics agreed within each Trust and the ICS Patient Safety Incidents Response Plan
- Agreed quality, safety and experience Patient Safety Dashboard

Who is accountable?
ICS Forum for Healthcare acquired infection, Local Maternity and Neonatal System Board, ICS Mental Health Collaborative, ICS System Quality Group, Quality, Resources and Delivery Committee

Where can we see more detail?
System wide strategies on ICS webpage

Next steps
Continue working with partners across the system and regulators to agree, through the ICS System Quality Group, key system quality priorities that add value over and above the quality focus of each of the ICS Programme Boards.

2. Clinical and Care Professional Leadership

Theme 2

Why is this important?

As a system we are committed to embedding clinical and professional leadership throughout Primary Care Networks, neighborhood's, place and system structures and in our multidisciplinary forums across Herefordshire and Worcestershire. We have very string Clinical and professional Leadership forums in our two places, which are key but also are developing a culture of grass roots clinical engagement in service redesign and the "Building a Sustainable future" Programme, the system is held acocuntable to this through the Clinical Advisory Subcommittee which oversees Clinical transformation and policy.

Clinical and professional leaders

- Are trusted voices – connected with patients, communities and people working in health and care services
- Have the knowledge and expertise to make difficult decisions about how to use our limited resources most effectively, taking account of these int eh decisions they make
- Can use their diverse professional voices to create innovative solutions to problems
- Work effectively together across system and place, avoiding duplication, adding value, making a difference
- Are committed to collaboration and will seek to understand each others' professions and the unique contribution they make to improving health and care outcomes for local people – Including those who haven't been as involved in the past.
- Will make time for networking and building relationships across sectors
- Build on good practice and what works well, understanding that the transition to statutory ICS is an opportunity
- Embody leadership values and behaviours reflecting and connecting place and system

What will we deliver and when?

Clinical and Care leadership through delivering priorities: There is a strong clinical presence in the existing governance structures in H&W that support clinically led decision making

- Clinical leadership in the delivery of the **Getting it Right First Time (GiRFT) priority clinical areas**, focused on clinical productivity as a key enabler for reset and recovery and supporting the best use of resources programme.
- Clinical engagement and leadership of the **Building a sustainable future programme.**
- ICB Medical director, chair the **Quality, Delivery and Oversight** group and **Clinical advisory sub-committee,** providing support and challenge around solution focused decisions.

Who is accountable?

Clinical leader are in post to increase the capacity and capability in the ICB, driving improvement and transformation, Reporting to the CMO:

- Deputy Chief Medical Officers
- Interim Chief Clinical information officer
- Primary care, Veteran, military health and Vaccinations
- Clinical lead for social change
- End of life
- Ageing well and frailty

Where can you see more detail and get involved?

- The Clinical and Care Professional Leadership Framework describes the approach.

3. Medicines and Pharmacy

Theme 3

Why is this important?

- Medicines are the most common medical intervention in the NHS[1] and are an important part of preventing disease or slowing disease progression.
- In England in September 2024, 1,054,989 people received 10 or more medicines with 429,259 of them being aged 75 or over (8% of the population) and 143,982 aged 85 or over (8.9% of the population).[2]
- In December 2024[3], 7.2% of over 75s in H&W were prescribed 10 or more regular medicines in primary care which is a slight increase on December 2023 but lower than the national average.
- A person taking 10 or more medicines is 3 times more likely to suffer harm and 16.5% of unplanned hospital admissions are due to adverse drug reactions and polypharmacy. Over a 7-year period there was a 53% increase in the number of admissions caused by adverse drug reactions.[2]
- However, medicines are not always taken correctly, and it has been estimated that between 30% and 50% of medicines prescribed for long-term conditions are not taken as intended.[1]
- The NHS in 22-23 spent £18.5 billion on prescribed medicines in primary care in England.[4] H&W annual spend on medicines is in excess of £230 million, with approximately £152 million in primary care.
- Antimicrobial resistance (AMR) which is the loss of antimicrobial effectiveness is increasing. The UK Government recognizes this and supports effective and careful use of antimicrobials (antimicrobial stewardship AMS) in the NHS. [5]
- Community pharmacy is an essential part of primary care, offering easy access to health services with 80% of people in England living within a 20-minute walk of a pharmacy.[6] Community pharmacy is delivering an increasing number of clinical services, supporting the primary care access recovery plan.
- The expertise of pharmacists and the role of pharmacy technicians has evolved and expanded significantly to deliver clinically focussed person-centred care integrated into multidisciplinary care teams and local systems across primary care, in general practice, in community care and in hospital pharmacy. This has led to pressures within the existing workforce which combined with the reforms to Foundation Year (FY) training for pharmacists makes workforce a key priority.[7]

Who is accountable?

- Medicines and Pharmacy Board, involving representatives from all sectors of the pharmacy profession across the ICS, with oversight of the Medicines and Pharmacy Strategy.

What will we deliver and when?

- Our vision is to ensure the population of Herefordshire and Worcestershire receive safe and effective access to medicines and technologies at the right time and in the right place. Working collaboratively, we will strive to improve and transform services, reduce health inequalities and deliver new ways of working, always keeping the population and patients at the heart of activity.

References

1. NICE Medicines Optimisation Quality standard Introduction | Medicines optimisation | Quality standards | NICE
2. Health Innovation Network: The mechanics of tackling overprescribing and problematic polypharmacy, February 2025
3. Data from Epact polypharmacy dashboard
4. NHSBSA: Prescribing Costs in Hospitals and the Community
5. NICE. Antimicrobial Stewardship
6. Delivery plan for recovering access to primary care. May 2023
7. NHSE. Initial education and training of pharmacists (IETP) reform. February 2024

3. Medicines and Pharmacy

Theme 3

	Our key priorities are:	What we have delivered in 2024/25	What we plan to deliver in 2025/26
Improve Health Outcomes	• Defined clinical use of medicines and technologies across the ICS through up to date and approved clinical policy, guidance and position statements.	• Horizon scanning and planning for new interventions anticipated during 2025/26. • Introduction of anticipated new medicines for endometriosis, kidney disease, migraine, and weight management. • Year 1 of a 5 year plan for hybrid closed loop systems for managing blood glucose in type 1 diabetes for those with greatest clinical need. • Extension of the eligibility for COVID-19 treatments • Ongoing work in relation to the National Patient Safety Alert on valproate	• Prioritising the introduction of new medicines for respiratory and kidney disease, skin problems, migraine, endometriosis, diabetes weight management and the menopause. • Year 2 implementation of hybrid closed loop • Further extension of eligibility for COVID-19 treatments.
Reduce Avoidable Harm	• Working across all sectors to co-ordinate work designed to improve medication safety focusing on high-risk medicines. • Focus on safety as patients move between organisations eg. discharge from hospital with changes to medicines supported by the Discharge Medicines Service (DMS) across the ICS. • Increase system awareness and undertaking in medicines audits. • Support and implement local antimicrobial stewardship (AMS) plans.	• Increasing the use of the Discharge Medicines Service • Introduction of an ICS Medicines Safety Group • Production of a primary care AMS dashboard to focus on total antimicrobial prescribing, course length and choice of antimicrobial agent.	• Re-launch of Community Pharmacy Intervention Scheme • Reduction in total antimicrobial prescribing • Production of structured medication review data to support the national drive to tackle over prescribing • Participate in national project work to address inappropriate antidepressant prescribing • Use the ICS Medicines Safety Group as forum to oversee implementation of National Patient Safety alerts and share learning.
Productivity & Achieving Best Value	• Working with clinicians to ensure cost effective medicines choice and reducing use of medicines or technologies considered ineffective or low priority.	• Improved use of technology e.g Electronic Prescribing and Medicines Administration system (ePMA) • Introduction of biosimilar medicines in ophthalmology, dermatology, diabetes and gastroenterology. • Updated pathways for use of medical retinal treatments. • Improved use of blood glucose testing strips with the lowest acquisition costs.	• Introduction of more biosimilar medicines in ophthalmology, dermatology, diabetes and gastroenterology. • Review use of first line biologic medicines used for chronic diseases • Improved use of Hybrid Closed Loop devices with the lowest acquisition cost • Normalising use of generic consenting principles to ensure early adoption of cost-effective agents
Service Delivery & Sustainability	• Develop a pharmacy workforce plan to help build a sustainable workforce across all sectors of pharmacy • Using community pharmacy professional expertise for common conditions management; safe medicines use following hospital discharge; blood pressure checks; contraception services; vaccination services and new clinical services as they are introduced. Ensure referral pathways are robust for complete episodes of care.	• Production of Pharmacy Faculty workforce newsletters, attendance at careers/recruitment events and supporting providers with the Foundation Year training reforms. • Introduction of Pharmacy First service; Blood Pressure Checks and Contraception services through community pharmacy. • Community Pharmacy Independent Prescriber Pathfinder Programme.is live in all HW approved sites • Working together locally and across the Region to understand and plan for future service needs to support the aseptic (sterile) preparation of medicines. • Community Pharmacy PCN Engagement Role employed to increase collaborative working between GP practices and pharmacies – focusing on and integrating work into the neighbourhood accelerator work • Delivered a Pharmacy Connect IP Teach and Treat programme to build independent prescribing in the community pharmacy setting	• Evaluation of Community Pharmacy Independent Prescriber Pathfinder Programme. • Development of strategies for workforce and community pharmacy to complement the overall Medicines and Pharmacy Strategy. • Explore options for improving the number of pharmacist FY placements in Herefordshire and Worcestershire e.g. by creating a database of Designated Prescribing Practitioners (DPP) and supporting existing pharmacist Independent prescribers to become DPPs • EPMA roll out should increase DMS referrals – work closely with Acute Trusts • Further increase vaccination programme delivery via community pharmacies
Greener NHS	• Promote the use of environmentally friendly medicines and packaging	• Ensuring sustainability considerations for all new medicine applications. • Promoting switches away from unit dose eye drops to alternative preservative free eye drop bottles. • Eliminating the use of desflurane by using lower carbon anaesthetic gases	• Improve use of inhalers with a lower carbon footprint • Consideration of available medicine/device recycling schemes. • Identifying solutions to reduce use and waste of nitrous oxide

4. Health Inequalities

Theme 4

Why is this important?

- ICB's and Local Authorities have legal duties to have regard to reduce health inequalities.
- The NHS Long Term Plan requires every local area to develop plans and take action to reduce health inequalities.
- The range in life expectancy across the social gradient of the region is 7.9 years for men and 5.6 years for women in Worcestershire; (Fingertips Public Health Outcomes Framework) and 5.4 years for men and 4 years for women in Herefordshire (Herefordshire JSNA Summary 2024).
- Marmot Review estimated that health inequalities cost society £31bn in lost production per annum, in 2010 prices. Whilst this is a national figure, its in local jobs and economies where this impacts.
- The additional treatment costs of health inequalities are estimated to be in the region of £5.5bn per year to the NHS. These will be replicated locally – equivalent to around £77m on a flat population share basis.

What have we delivered in 2024/25?

- Established the Health Inequalities Ambassador (HIA) Network comprising of 25 named individuals representing every ICS programme Board and enabler group, to apply a health inequalities to everything the system delivers. An innovative approach that has been recognised as best practice nationally.
- The ICS HIPP Board has received 12 health inequality focused discussions by HIAs across a range board and work areas.
- ICB allocated £4.4m to work programmes that have tackling health inequalities as their core purpose. With most funding allocated out to Primary Care Networks (PCNs) - over £3.9m to support the development and delivery of local health inequality plans and CVD targeted improvements as part of the Clinical Excellence and Investment Framework (CEIF).
- Development of a Core20PLUS5 dashboard by PH Herefordshire, using EMIS data for to support PCNs with the identification and development of projects to address health inequalities, as funded through CEIF.
- PH Worcs LSOA analysis of statistically high ED admissions to help inform targeting of preventative programmes of work to address unmet need.
- This includes the ICB and partner commissioned outreach prevention services in Herefordshire and Worcestershire, targeting our most underserved communities offering a range of services to meet individual needs. The Herefordshire service was shortlisted for a national award and the Worcestershire service has won an award.
- A mid-point evaluation has been completed independently by Worcester University which has provided a Plan, Study, Act, Do cycle ensuring the services continually improve and flex the local needs and insight.
- A pilot of the high intensity user programme with the British Red Cross in Worcester has been evaluated and will be rolled out across Herefordshire and Worcestershire in 2025/26. This will complement the upstream work of the LSOA ED analysis, to intervene earlier.
- The ICB was successful in a bid for Community Connectors across H&W. Employed and managed by the VCSE, the Connectors are engaging with GRT communities and Pakistani and Bangladeshi women to uncover the insights on barriers to healthcare. The valuable insights are being shared across the system services and programmes to make changes that improve access, experience and outcomes.
- This includes read across to the partnership cancer health inequality programme with Macmillan – which focuses on the same cohorts.

What are the priorities going forward?

- The aim of the ICS Herefordshire & Worcestershire strategic intent remains to make addressing health inequalities everyone's business,, through the continuation of a range tangible actions:
- A review of the HI Ambassador Network will provide a series of recommendations to enhance and strengthen the network.
- Maximising on our outreach prevention services by removing barriers to access to secondary prevention services, by targeting areas using data, engagement and evidenced based interventions.
- Delivery of the DWP Workwell programme through PCNs, supporting people who at risk of leaving employment due to ill health, to remain or return to work.
- Continuing to build awareness and skills within the workforce of the practical and relevant actions that can be taken to reduce health inequalities, to make it everyone's business.
- Evaluation of the outreach prevention services and a view on long-term sustainability.

What are we measuring?

- Development of a Health Inequalities, Prevention and Personalised Care dashboard, by bringing together HIPP related metrics from across all ICS Boards into a single view to track progress.

Who is accountable?

- Health Inequalities SROs have been identified within ICB and across all provider Trusts.
- Responsibility and delivery of reducing health inequalities sits at system, Place, PCN and neighbourhood level – as such it should cut across all work.
- An ICS Health Inequalities, Prevention and Personalised Care Board brings together representation across all the system programme and enabler Boards, with each having a dedicated named individual as the Health Inequality Ambassador. Representation cuts across VCSE, Healthwatch, Primary Care, Providers and includes Directors of Public Health.

Where can you see more detail and get involved?

CORE20PLUS5 (england.nhs.uk)
CORE20PLU5 Children and Young People(england.nhs.uk)

5. Prevention

Theme 5

Why is this important?

Integrated Care Boards have a duty under Section 14Z34 of the Health and Care Act 2022:

"Each integrated care board must exercise its functions with a view to securing continuous improvement in the quality of services provided to individuals for or in connection with the prevention, diagnosis or treatment of illness".

What have we delivered in 24/25?

- Tobacco Dependency services fully implemented across all acute inpatient, mental health inpatient and maternity services in H&W as of June 2024. This achieves the Long Term Plan (LTP) deliverable of all people admitted to hospital who smoke will be offered NHS-funded tobacco treatment services.
- There have been 2,012 eligible referrals into the Digital Weight Management Programme (DWMP) between April 24 and January 25, achieving 80% of the target so far. H&W have consistently been in the top 10 referring ICBs nationally for the DWMP for this financial year so far as of January 2025 data, as well as having the highest number of practices referring into the programme (91%).
- There have been 4,198 referrals into the NHS Diabetes Prevention Programme (NDPP) between April 24 and February 25.
- There have been 225 accepted referrals into the Type 2 Diabetes Path to Remission Programme between April 24 and January 25. There is an 80% acceptance rate for referrals into the programme. 127 service users have reached 6 months and have an average weight loss of 12.5kg. 38 service users have reached 12 months and have an average weight loss of 9.6kg.
- Continuation of the prevention outreach response services in both Herefordshire and Worcestershire, providing opportunistic testing of AF, blood pressure and lipid optimisation to our most underserved communities.
- CVD strategy has been drafted. An ICB Workshop was held in November 2024 to discuss opportunities to raise profile of national CVD high impact interventions.
- The development of a local dashboard and intelligence to map the patient journey. This work will complement the CVD Prevent Dashboard and information on this has been shared to promote engagement.

What are the priorities going forward?

- A broader review of the weight management pathway e.g. needs assessment, ICS system engagement.
- Exploration of targeted work with the National Diabetes Prevention Programme local provider, and GP practices to encourage referrals from PLUS groups (GP unregistered and rural communities) and exploring opportunities for LD/A groups.
- Delivery of prevention outreach service – targeting of GP unregistered citizens and the most underserved populations.
- Continuing to support Public Health colleagues and partners with the Loneliness and Isolation work within Worcestershire e.g. community grants.
- Monitoring of the delivery and implementation of the Joy Social Prescribing App across Worcestershire PCNs.

What are we measuring?

- A key element to the NHS LTP is tackling tobacco dependence, as tobacco smoking is the largest modifiable risk factor for health. The NHS will contribute to reducing the number of people smoking tobacco by delivering on the commitments outlined in Chapter 2 of the document: Prevention and Health Inequalities.
- To help tackle obesity, the LTP states that the NHS will provide a targeted support offer and access to weight management services in primary care for people with a diagnosis of type 2 diabetes or hypertension with a BMI of 30+ *(also outlined in the above link to Chapter 2 of the LTP).*
- These metrics will be encompassed as part of the development of a Health Inequalities, Prevention and Personalised Care dashboard bringing together the agreed deliverables into a single view to track progress against trajectories (Q2 2025)

Who is accountable?

- Prevention SROs in place across the system provider organisations.
- An ICS Health Inequalities, Prevention and Personalised Care Board brings together representation across all the system programme and enabler Boards, with each having a dedicated named individual as the Health Inequality Ambassador. Representation cuts across VCSE, Healthwatch, Primary Care, Providers and includes Directors of Public Health. This Board's function is to ensure the strategic intent of making health inequalities everyone's responsibility is realised through the application of health inequalities lens to all the work that we deliver to realise a close in the gap in healthcare inequalities through targeted prevention work.

Where can you see more detail and get involved?

- Information relating to the Long Term Plan priorities can be found here.
- Data is collated on the Regional Dashboards which can be accessed through the FutureNHS Collaboration Platform.
- Details around Your Health and Talk Wellbeing can be found on the ICS website. Information around what the service entails and upcoming events are included:
- Your Health – Worcestershire
- Talk Wellbeing – Herefordshire

6. Personalised Care

Theme 6

Why is this important?

Personalisation means health and care services delivering what matters most to each individual in a way that meets them where they are at. Engagement with our local population has told us that this relies on people having clear expectations of what is expected of them and what they can expect of their health and care professionals and services. Services are then able to offer support that is appropriate to the individual's level of need, making the best use of resources and getting the individual to the right support at the right time.

The Comprehensive model of Personalised Care outlines a three-tier approach to implementation: Universal (whole population) interventions; interventions targeted at those with Long-Term Conditions (LTCs) (30% of the population) and specialist interventions (5% of people with complex needs) (NHS, 2019). The NHS Long Term Plan outlines six interlinked components which underpin delivery: Shared Decision Making (SDM); Enabling Choice; Social Prescribing; Supported Self-Management (SSM); Personalised Care and Support Plans (PCSPs) and Personal Health Budgets (PHBs).

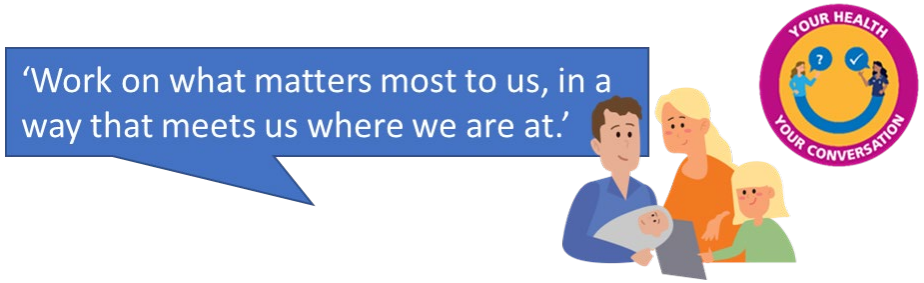
Supporting people with LTCs to self-manage is critical to addressing the rapidly growing demand this population represents . Our approach to supporting people to live well with their LTCs is to to raise awareness of how an individual's knowledge, skills and confidence, also termed activation, impacts on their ability to self-manage.

What have we delivered in 24/25?

- Developed and enhanced our training offer through the ICS Exchange platform. This now includes a Health Literacy training package and more modular and practical training.
- A health literacy network has been established, which is developing system wide health literacy commitments and a self-assessment tools to assess organisational maturity.
- A Personalised Care Toolkit has been developed to support system wide colleagues to implement personalisation approaches.
- There have been multiple examples of patient information improvements across the system, e.g. a Pulmonary Rehabilitation Guide, Endometriosis and Frailty videos.
- We continue to promote and develop our Long Term Condition video library, which provides health literate information on a range of topics.
- We piloted a Family Coaching service for children who are overweight, demonstrating positive outcomes from a whole family approach, the learning from this pilot has informed the children's hubs in Worcestershire and the service has been embedded in Herefordshire.
- We have piloted a service for high intensity users of urgent and emergency care services, SupportingYou. This is demonstrating a reduction in A&E attendances.

What are the priorities going forward?

- Continuation of the Supporting You Service in Worcestershire.
- Continuation of the Health Literacy programme.
- Continued development and delivery of the Health and Wellbeing and LTC video library.
- Promotion of the Peer Support Worker offer.
- Embedding use of Patient Reported Experience and Outcome measures across priority LTC services.



What are we measuring?

The dashboard that is in development is anticipated to measure: numbers of PHBs, number of personalised care and support plans (PCSPs), numbers of ARRS role team members and referrals to their services, the number of people accessing personalised care training and the number of registered carers. There are also specific outcome measures in place for the services that are being piloted and for the video library.

Who is accountable?

The Health Inequalities, Prevention and Personalisation Board is responsible for delivery of Personalised Care. This is a system wide meeting, with membership across health, the local authority and the Voluntary, Community Social Enterprise. The SRO is the ICB Chief Nursing officer.

Where can you see more detail and get involved?

Health Literacy - https://teamnet.clarity.co.uk/Topics/ViewItem/5813997c-1f90-477c-9de9-b10e00e42f56

Personalisation Toolkit - https://teamnet.clarity.co.uk/Topics/ViewItem/1680689e-80fe-4368-898e-b086007d97da

Any queries, please email: hw.personalisedcare@nhs.net

7. Working with Communities

Theme 7

Why is this important?
Our ambition is to place greater emphasis on early engagement and ongoing dialogue and partnerships with people and communities. From these early, open and genuine conversations we can work together with local communities, who are often better placed to create solutions to the health challenges we face.

What have we delivered in 24/25?
During 204/25 we have worked with all of our partners across the system to listen consistently to, and collectively act on, the experience and aspirations of local people and communities. This has included supporting people to sustain and improve their health and wellbeing, as well as working with people and communities to develop our plans and priorities, address health inequalities, and co-design services that equitably address the health challenges that our population faces.

Our key deliverables are detailed within the People and Communities Annual Reports and the Insights Reports:

1. People and Communities Annual Report – These reports are published annually and detail how the ICB has worked with ICS partners to engage with people and communities at a system, place and local level.
2. People and Communities Voices Report – Published quarterly, these reports collate soft intelligence and highlight key themes from the feedback garnered from people, communities and ICS partners, from across Herefordshire and Worcestershire. These insights are fed back to the key ICS and ICB decision makers for their consideration and to highlight any cross-cutting themes between services and areas of focus.

Some examples of our work include:

- NHS 10 Year Plan – Facilitated and ran two engagement events on the NHS 10 Year Plan. Representatives from Patient Participation Groups (PPGs) and health services from across Herefordshire and Worcestershire, joined us for two sessions. The interactive and informative sessions focused on national and local health priorities. Attendees had the opportunity to network, have their say on the NHS 10 Year Plan , engage on local plans, share best practices, and learn from each other's experiences. There was a lot of in-depth discussions and feedback generated from the two gatherings. The ICB has fed all the comments generated into the national NHS Change consultation, as well as internally using feedback to improve local health services and work on Integrated Neighbourhoods.
- Palliative and End of Life Care – This engagement exercise sought the views, stories and experiences of people who live, work or receive care in Herefordshire and Worcestershire, specifically targeting people who were receiving palliative or end of life care, those in the last year of life, and including carers. The feedback received was fed back to the programme board and will be used to shape the new Palliative and End of Life Care Strategy.

Priorities going forward
We intend to:

- Listen more and broadcast less, and where engagement is an ongoing and iterative process focused on what matters to people, not something 'done once'
- Hold ongoing conversations with communities about healthcare, built around community groups, forums, networks, social media, and any other place where people come together as a community
- Provide clear and timely feedback to local people about the impact of their involvement
- Develop plans and strategies that are fully informed by engagement with the public and patients
- Use insights and data to improve access to services and support reduction of health inequalities
- Focus on early prevention and supports communities to develop their own solutions to improving their health and wellbeing

Specific programme areas of focus are the NHS Ten Year Plan, Building a Sustainable Future (BSF) Programme and stroke services reconfiguration.

What we're measuring
- The ICB's compliance with undertaking our legal duties to involve the public in decision-making about NHS services.
- The feedback, sentiment and key themes that we have gathered from undertaking engagement with people and communities in Herefordshire and Worcestershire.
- The demographic details of the people and the communities we engage with. This is to ensure that we are listening to a wide and diverse range of people, and to highlight where more engagement needs to be undertaken with specific people, groups and communities.

Who is accountable?
- NHS Herefordshire and Worcestershire Integrated Care Board is responsible for ensuring that the statutory duty to involve are met across the system.
- The ICB is responsible for arranging effective health and care services for the Herefordshire and Worcestershire population; demonstrating that decision-making is clearly informed by insight
- Herefordshire and Worcestershire Integrated Care Partnership Assembly is responsible for ensuring that strategies for health and wellbeing are based on the needs and aspirations of local communities, and open to scrutiny and challenge
- The One Herefordshire Partnership and Worcestershire Executive Committee are responsible for delivering health and care services shaped by local need

Where can you see more detail and get involved?
Please see our strategy 'Working with people and communities in Herefordshire and Worcestershire' or for more information or contact the ICB Engagement Team.

8. Commitment to Carers

Theme 8

Why is this important?

Carers are a diverse group, and every caring situation is unique. Carers are people who care for a family member, a friend, or another person in need of assistance or support with daily living. They include those caring for children who have a disability or additional needs, older people, people living with long-term medical conditions, people with a mental illness, people with a disability, people with addiction, people experiencing substance misuse and those receiving palliative care.

The degree to which a carers own life is impacted by their caring role will vary. Parent carers are most likely to be caring the longest and experience the greatest financial impact. Some carers may find themselves caring for more than one person. The physical demands of caring may be greatest for those whose cared for is disabled or is frail. The emotional demands on carers may be greatest for those caring for someone at end of life or caring for someone with poor mental health.

According to the last Census (2021), there were 16,501 and 52,547 carers in Herefordshire and Worcestershire respectively, of which 7,701 (47%) and 25,171 (48%) care for more than 20 hours a week. This represents a rise in proportion of carers providing higher levels of care than in the previous census (around a third). Carer support organisations are in touch with 5,500 carers in Herefordshire, and 14,547 in Worcestershire. Worcestershire Association for Carers receives around 600 referrals per month, 85% of which result in 1 to 1 support. Local intelligence tells us that the complexity of caring roles is increasing. This includes carers maintaining responsibility for increasingly complex clinical needs against increasingly stretched finances. The number of carers is expected to rise by at least 60% by 2030 (Carers Trust).

By supporting carers, we enable people to remain living well within their communities, reducing the demand on health and social care and improving the health and wellbeing of both the carer and the cared for.

What have we delivered in our second year 2024/25?

1. Continued to support system partners to progress against Commitment to Carers statements.
2. Facilitated regular ICS Carer Reference Group (CRG). Key areas progressed include:
    - Empowering Carers at Discharge – working with pilot inpatient wards as part of the Accelerating Reform Fund project to identify and support carers, capturing learning to share systemwide
    - Improved recording of carer status across system partners.
    - Herefordshire carers strategy refresh and introduction of the Herefordshire Carers Partnership forum
3. Enabled opportunities, through the CRG and place-based forums, for carers to share their views and lived experience, and contribute to co-production of improvements in carer support.
4. Incentivised the following areas in primary care through the 2023/24 CEIF contract:

- Identification of GP practice carers lead.
- Delivery of carer awareness training.
- Drive to increase the number of carers identified and recorded in EMIS.
- Signposting to local carers support.
- Proactive offer of other support to carers, e.g., social prescribing.

What are the priorities going forward?

1. Continue the drive to recognise and support more carers across the system.
2. Capture and share Accelerating Reform Fund learning to enable improvement in carers support across Herefordshire and Worcestershire.
3. Continue to support carers forums across the two counties, strengthening the carer voice in planning and provision of services.
4. Work with system partners to develop carer awareness training package for staff.
5. Work with system partners to ensure carers voices are heard and the profile of work in support of carers is raised.

What are we measuring?

1. The number of carers identified across the system.
2. Qualitative progress towards the system Commitment to Carers by each provider organisation.
3. Feedback on patient and carer experience of services via periodic Healthwatch surveys.

Who is accountable?

The Carers programme is a component of the Personalised Care programme and accountability sits with the Health Inequalities, Prevention and Personalisation Board. The Carers Reference Group was established to develop and enable delivery against our system commitment to carers. These commitments are integral to place-based Carer Strategies held by our County Councils, which are supported by carer partnerships in both Herefordshire and Worcestershire.

Where can you see more detail and get involved?

Visit the ICB carers resource hub: [Resource Hub for Family, Carers and Loved Ones :: Herefordshire and Worcestershire Integrated Care System (hwics.org.uk)]

9. Supporting the Armed Forces Community

Theme 9

Why is this important?

The Armed Forces community is made up of serving personnel, veterans and their Family's and carers. There are an estimated 2.4 million veterans living in the UK. Within Herefordshire and Worcestershire there are currently approximately 30,000 military veterans. Herefordshire and Worcestershire ICB has a high density of veterans making up about 4.7% of the patient base. The Armed Forces Act 2021 makes it a legal duty on specified public organisations to have due regard to the principles of the Armed Forces Covenant when exercising their functions. These duties apply to ICBs. As an ICB we are working with system partners to give due regard to the health and social care needs of the Armed Forces Community in the planning and commission of services. We are working on building our engagement with this community to build our understanding for how we can support their health and wellbeing.

What have we delivered in our second year 2024/25?

Within the first two years alongside signing the armed forces covenant, the ICB has been an integral part in supporting this cohorts through both primary and secondary care. Leads from the system were invited to an Armed Forces Health Symposium where there were valuable conversations to take away to help deliver the promises to the Armed Forces Community.
With the introduction of the Talk Wellbeing Service in Herefordshire, they have reported a large number of veterans engaging with their services and through the training which has been undertaken by the team has supported clinicians in engaging with this group.
More practices in Worcestershire are signing up to the veteran friendly practice scheme too with compared to the first year we are nearly 10% higher in sign up rates.

What are the priorities going forward?

Within the next year it is key to ensure that we can continue to keep signposting the Armed Forces community to healthcare available within the system and to continue the identification of them within the healthcare system.
We will continue to encourage practices to sign up to the veteran friendly practice scheme.

What are we measuring?

There are two key measurables which we are working towards.

1. Increasing the number of veteran friendly practices across Worcestershire (as Herefordshire are already 100%). This is being collated by the Royal College of General Practioners
2. Increase the number of coded veterans on clinical system, initially in Primary Care. This is being supported by local BI teams to assist in sourcing the data.

Who is accountable?

The Clinical Lead on the project is Dr Jonathan Leach OBE, with project management in place to support. This will be delivered through following the key commitments from the Armed Forces Forward View that ICBs use indicators to measure progress. We will work with partner and provider organisations to develop and deliver objectives and actions to reduce any health inequalities and improve healthcare for this population. We will work closely with the service users to understand their needs and requests within the services.

Where can you see more detail and get involved?

If you have any questions or for more information on how to get involved or how this community could benefit your work, please email: hwicb.partnerships@nhs.net

10. Addressing the specific needs of victims of abuse

Theme 10

Why is this important?

The ICB has a duty to address the particular needs of victims of abuse, including an assessment of need. Working with health, social care and statutory partners to support victims, tackle perpetrators and prevent abuse. This includes reducing the health inequalities faced by victims of abuse.

There are a range of initiatives and services in place that will be built upon over the lifetime of the joint forward plan, these include:

- The Serious Violence Duty (SVD) is based on a public health approach which requires co-operation and collaboration including data across a range of partners. This approach to tackling violence means looking at violence not as isolated incidents or a sole police enforcement problem. It is about taking a multi-agency approach to understanding the causes and consequences of serious violence and focusing on prevention and intervention.
- Training plan to support upskilling of talk wellbeing and your health outreach services to spot those vulnerable to domestic abuse / serious violence etc
- Collaboration between Policing partners and roving vaccination teams in areas of deprivation and inequality.
- Pan West Mercia data group in place – With leadership from Herefordshire Council.
- District collaboratives – working between district councils, primary care networks, community support officers, voluntary sector to identify needs in the local community
- Funding secured by Herefordshire PCN's to collaborate with 3rd sector organisations supporting victims of domestic abuse, exploitation and youth crime.

What have we delivered in our second year 2024/25?

Services have been developed and commissioned responding to identified cohorts or individuals to support prevention and reduction in serious violence, these are listed below:

- Serious violence duty actions including strategic needs assessment to support action.
- SVD - Develop system wide data group in partnership with Police, Local Authority, West Midlands Ambulance Service, CSPs and other relevant organisations.
- Worked with partners in preparation for implementation of the Victims and Prisoners Act (2024).
- Delivered trauma informed care training, supported by the Integrated Care Partnership Assembly.
- Commitment to integrate the Workwell programme, supporting people to get back to and stay in work, with the IRIS programme in 2025/26.
- Supported the White Ribbon Campaign across system partners, seeking to end male violence against women and girls.

West Mercia Rape & Sexual Abuse Support Centre

WEST MERCIA WOMEN'S AID

What are the priorities going forward?

There are a number of services and programmes in place to ensure that we are addressing the needs of victims of abuse, these include:

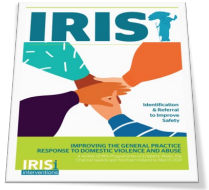
- **Domestic Abuse and Sexual Violence:** Working with the Police and Crime Commissioner as interim convener of the Victims and Prisoners Act 2024, implementing required actions.
- **IRIS:** A specialist domestic violence and abuse training support and referral Programme for General Practices that has been positively evaluated in a randomized controlled trial. Iris is a collaboration between primary care and third sector organisations specialising in domestic abuse. This service will continue in 2025/26 in Herefordshire, supported by Herefordshire Council and NHS Herefordshire and Worcestershire.
- **Climb:** A service which delivers early intervention and prevention for those at risk of criminal exploitation.
- **Purple Leaf and West Mercia Rape and Sexual Abuse Support:** A charity providing specialist front line support independent advocacy counselling and those affected by any form of sexual violence
- **Drive perpetrator programme:** A project which aims to reduce the number of child and adult victims of Domestic Abuse by deterring the perpetrator (in Place).
- **Steer Clear:** Prevention Programme working with young people who have been or could be involved in knife crime, continuing in 2025/26.

What are we measuring?

The overall approach is to ensure that all partners are sharing data and intelligence to build up a comprehensive picture of individuals and communities at risk of serious violence, domestic abuse or sexual violence. Those key hotspots across the system are being looked at and appropriate interventions will be put in place. This will be developed during 2025/26, working with West Merica Police and broader partners through Community Safety Partnerships.

Who is accountable?

The integrated care board (NHS Herefordshire and Worcestershire) has a specific duty to address the particular needs of victims of abuse. This will be delivered at place through the Herefordshire community safety partnership, Worcestershire community safety partnership and the crime reduction board.



11. Digital, Data, Analytics and Technology

Theme 11

Why is this important?

We cannot improve health outcomes and reduce health inequalities without data and technology, which is key to making health and care services more accessible to parts of our communities. This can be via remote and virtual care, better planning of services and enhanced sharing of patient information. Technology and data can play a core role to reduce elective backlogs, mitigating urgent care pressures, continuing to deliver responsive and timely community and primary care. Digital products can enable personalised preventative care by giving people more control over their lives by providing self-assessment, education, motivation and monitoring to help them manage their own health. We must ensure digital services are inclusive and provide for everyone's needs by listening to and designing with communities with seldom heard voices more closely.

What have we delivered in 2024/25?

- Written and published the system's Digital and Cyber Strategies to outline our ambitions and direction of travel.
- Continued the work on optimisation and increasing adoption of the Shared Care Record. This included a comprehensive evaluation of the service to date and taking action on the findings.
- Developed and enhanced our patient facing digital offer and Patient Portal to provide a front door to patients under our care.
- Worked closely with our system partners in work towards levelling up digital maturity.
- Embedded the enhanced BI and analytics service, delivering more aligned and standard performance and BI reporting and tools. Continuing to progress with the capabilities needed for effective population health management.
- Continued to work on refreshed technology to support staff capacity, efficiency and organisational productivity specifically unified communications, telephony and networks.
- Commenced work on Artificial intelligence pilots and initiatives to support productivity.

What are the priorities going forward?

Pillar 1: Getting the right infrastructure in place

- Sourcing and developing the essential operating systems, technology and software to enable us to deliver the best outcomes
- Levelling up the digital maturity and architecture of organisations

Including: Shared Care Record, Electronic Patient Records, Frontline Digitisation.

Pillar 2: Enabling integration of our data sources

- Ensuring systems and applications can talk seamlessly to each other – maximising interoperability
- Improving information to support decision-making

Including: Data Sharing Agreements, Agreed Standards, Data Security/Protection, Groundwork for Population Health Management and Federated Data Platform.

Pillar 3: Creating an environment to enable people to self-serve

- Providing our people with easy-to-use apps and systems, where they can access their information and help manage their own care and needs, closer to home where possible

Including: Patient Portal/NHS App, Patient access to their records, Improved and accessible information

Pillar 4: Supporting the transformation of services 'around the user'

- Ensuring all NHS staff have access to and are trained in the use of the right tools and systems to deliver the best care to and outcomes for our people

Including: AI and Automation Principles, Continuing Health Care, Piloting newer technologies

What are we measuring?

Each project measures outcomes and success. This will include improvements in productivity, efficiency, usability and usage. For example the number of people across our system using the Shared Care Record.

Who is accountable?

One of the ICS Programme Boards focuses on Digital, Data, Analytics and Technology and brings in the ICS Digital Clinical Leads, these two groups will be responsible for setting the digital agenda and collective vision. Their work will be informed by the ICS Analytics Board, Technical Design Authority and Clinical Safety Officer Group on digital transformation and improvement.

There are a number of Groups and Boards focusing on the technicalities of the deliverables including Shared Care Record, Cyber and Data Security and Primary Care. Based on the structures already in place in the NHS Trusts and primary care system in Herefordshire and Worcestershire, the ICB Digital Leaders will work closely with the organisation Boards and Steering Groups. There are strong links to the other five ICS Forums where digital plays a central role and vice versa delivery teams are accountable for the outcomes they are set up to deliver.

Where can you see more detail and get involved?

There is a digital section on the ICB website

Digital innovation :: Herefordshire and Worcestershire Integrated Care System (hwics.org.uk)

12. Research and innovation

Theme 12

Why is this important?
As a system we recognise the importance of promoting research an innovation in the provision of healthcare. The ICB Medical Director holds the responsibility for promoting this, ensuring it is clinically led and underpins the delivery of the Joint Forward plan.

What will we deliver and when?
- **Assets:** ICS Academy, Knowledge and research school, The Herefordshire and Worcestershire research consortium. Worcester University - Allied health professional school. I&I Bid – Engaging underrepresented communities. (Personalised care.) Innovation – Pods. Research network.
- **Resources:** Increase access to funding, ,E.g. NHIR and working in partnership with the academic health science network.
- **2024/25 priorities:** Delivering the new **5 year research and innovation strategy** developed and published last year. This will be led by the Herefordshire and Worcestershire research consortium, reporting into the ICS academy steering group.

Innovation - What are we building on?
To help promote innovation across the system, the ICB has created an Innovation Hub called: The CO-LAB www.icscolab.org.uk We believe this is the first example of an ICB-led Innovation Hub. It exists both virtually and physically, located deliberately in a rural community hospitals (Kidderminster Treatment Centre), where we know innovation traditionally receives less focus, but has real chance of improving health services. Approaching it's first year operating, it has had a number of successful initiatives and adoptions of innovation, including:

New Ways of Working and developing new knowledge:
- In partnership with Warwick University's "West Midlands Health and Wellbeing Innovation Network WMHWIN", The CO-LAB ran a 5-day Agile approach for one of our Trusts to help them co-design a new Heart Failure @ Home pathway with a "User focus". The co-design event included staff, commercial innovators and patients. Outputs included a framework for staff to use if interested in this type of approach, supplemented by education webinars.
- It is regularly used as a space anyone in the ICS can use for free to re-imagine pathways and processes. For example, it's used monthly by one of the trust's Transformation guiding board as part of it's Virginia Mason Programme.

Trial and Adoption of Innovation:
- The CO-LAB hosted certified VR anti-anxiety headsets and approached teams to trial. Following a successful trial on our Pediatric Oncology wards, where they reduced anxiety in children needing cannulas, improving patient experience and reducing clinic time, a number of headsets have been purchased for long-term use on those wards and are being trialed across multiple other wards within two Trusts (one within our ICS and one in a neighboring ICS)
- As the host for the first teleconsultation pod from a French-based innovator, The CO-LAB has worked extensively with the company on feasibility, demoing and real-world testing. The pods are now being used in the South East of England and is being deployed in system as part of an NIHR bid for the ICS.

Partnerships:
- The CO-LAB has partnered with innovative organisations to understand opportunities and art-of-the-possible to highlight to workstream leads, these include:
    - ICS Partnership with Amazon Web services, where the ICB participates in their Global Healthcare Incubator.
    - Satellite Catapult, currently arranging a trial of drone technology
    - IASME, working with a local innovator to train unemployed Neurodiverse young people for employment in cybersecurity
    - Partnership with multiple Universities, including a successful partnership with the University of Manchester on a systematic review of literature on the implementation of AI in health and care

Staff and wellbeing:
Early on in the hub's life it became apparent there was a significant ask for finding and spreading innovation practice for wellbeing of staff. Initiatives have included:
- Partnering with a Hypnotherapy provider, we setup an agreement to offer the hub's use whilst closed in return for free provision of sessions to front-line staff to address anxiety, sleep deprivation and relaxation. Sessions typically have 20 attendees, with great feedback
- The Hub is provided free of charge to ICS groups who want to host staff celebration or wellbeing events. For example, it is used as part of the International staff process, providing an area for them to come together, and celebrate pre-exam.
- NHSE provided sessions for Wellbeing in Leadership Roles, is being hosted at hub for several trusts in and out of the ICS.

Herefordshire and Worcestershire Research consortium
- Is the system wide group overseeing research in the system, we are looking to widen its brief to look at innovation too as part of the strategy refresh.
- It monitors performance / recruitment across the system, but also looks to broaden the scope of our research beyond organisational boundaries, looking at how we work with the local university as it develops
- Will hold oversight of delivery of the new strategy.
- Now reports into the ICS academy steering group, where previously it was not part of any formal governance.

13. Greener NHS

Theme 13

Why is this important?

The climate emergency is also a health emergency.

Poor environmental health contributes to major diseases including cardiac problems, asthma and cancer. Unaddressed, it will disrupt care and affect patients and people at all stages of their lives. Climate change impacts every single person and as such we all have a duty and responsibility to do something about it.

Herefordshire and Worcestershire ICS are committed to embedding environmental and sustainable practices into all areas of our work, as an enabler for better health. We see the work of the green agenda aligned to our principles of delivering high quality care; reducing health inequalities and improving the health and wellbeing for the communities we serve.

Reducing emissions will mean fewer cases of asthma, cancer and heart disease. Many of the drivers of climate change are also the drivers of ill health and health inequalities. In the UK, air pollution is attributable for 1 in 20 deaths, making it the greatest environmental threat to health. We can all play our part in tackling climate change through reducing harmful carbon emissions, which will improve health and save lives.

Environmental health impacts are often unfairly weighted in areas of deprivation and minority ethnic groups. For example, Black, Asian and minority ethnic groups are disproportionately affected by high pollution levels, and children or women exposed to air pollution experience elevated risk of developing health conditions.

What have we done in our second year, 24/25?

- Deepened relationships with public sector partners to support strategic developments and build awareness to our populations
- Continued to embed the system-wide ICS wide Sustainability Impact Assessment (SIA) into decision making.
- Increased the number of virtual appointments and virtual wards available to our patients thereby reducing carbon emissions through travel.
- Continued to reduce the amount of nitrous oxide used through identifying leaks within our system and changes to manifolds.

What are the priorities going forward?

- To refresh the HWICS Green Plan for 2025-8.
- To continue to increase the use of low carbon inhalers.
- To continue to strengthen our networks and connections to create greater impact.
- To strengthen our focus on Clinical Transformation pathway opportunities.
- To support our efficiency and productivity agenda by reducing waste across the system.
- To support delivery of social value

Who is accountable?

- Greener NHS SROs have been identified within ICB and across all provider Trusts
- Responsibility and delivery of Trust Green Plans sit at Trust provider level.
- Collectively agreed ICS Greener NHS actions sit at ICB level, working collaboratively with Providers to deliver through their existing governance groups.
- Engagement is undertaken directly with SROs, and operational working and engagement through a system Sustainability Leads group.

Where can you see more detail and get involved?

- ICS Green plan
- ICB Green Board papers

14. Mental Health Collaborative

Theme 14

Where we are now? – What we have achieved together

The Mental Health Collaborative met the national targets for:

- perinatal mental health
- access to mental health services for children and young people
- access to community mental health services
- recovery and improvement rates for people who have received talking therapies
- health checks for people with severe mental illness

The Collaborative recognised the challenge of Dementia diagnosis in our system, establishing a separate programme board with exclusive focus on Dementia care. A plan to improve dementia diagnosis is now in place that is tackling raising awareness and improving support for people living with Dementia.

A revised model of children and young people's emotional wellbeing and mental health service was procured, resulting in Melo being launched in April 2025.

The Collaborative conducted a governance review in 2024/25 to ensure there was greater focus on programme delivery, clearer accountability to the ICB and stronger collaborative strategic leadership.

Where next? – Areas of focus

The Collaborative will focus on five key delivery areas for 2025/26:

- Improving children and young people's mental health so there is multi-faceted and stratified support offer to children and families. This will include embedding the new Melo service, further expansion of MH in Schools and roll-out of Primary Partnership in Neurodivergence in Schools initiative. Additionally, the Collaborative will commission a support service for neurodivergent children and their families. The Collaborative wants children to be supported in a more timely manner and will focus on bringing down CAMHS waiting times.
- Inpatient care in acute psychiatric units. The Collaborative has put in place financial risk/share arrangements to remove the use of inappropriate out of area beds, so that people are cared for closer to their local communities and their families. Alongside this, length of stay will be reduced so that patients have a better opportunity for timely recovery. This will allow resources to be re-purposed for community mental health.
- The redesign of adult mental health acute and rehabilitation clinical pathways (using the GiRFT approach). This will deliver more modern, sustainable and appropriate recovery pathways, and the design will be undertaken with extensive consultation with patients, staff and wider community.
- Review of Adult Community Mental Health Services. This comprehensive review will ensure services provide the right support at the right time, and where necessary assertively, so that there is no risk of the homicides in Nottinghamshire occurring locally.
- Post-diagnostic dementia support. The offer will be recommissioned and will take account of feedback from Healthwatch consultation.

Strategic Focus:

For 2025/26, the Collaborative's strategic focus will be to:

- Ensure it is ready for the implementation of the Mental Health Bill
- Develop and agree a Mental Health Strategy for the local system. This will take account of the new 10 year NHS strategy and ensure that mental health remains a system priority.
- Review arrangements to ensure they are fit for purpose for the changing operational model for ICBs

15. NHS Trust Collaborations

Theme 15

Where we are now?

- Wye Valley NHS Trust (WVT) has been a full member of The Foundation Trust Group since 2016.
- Worcestershire Acute Trust (WAHT) became a full member of The Foundation Trust Group from July 2023 resulting in a joint Chief Executive and Chair across the four Foundation Group Hospitals.
- From April 2025, both trusts have a joint Acting Chief Executive Officer.
- WAHT and WVT has completed a service sustainability analysis, which influences areas of collaboration between the two trusts. There is continued mutual aid for vulnerable services with WVT being lead provider for dermatology and WAHT for MaxFax. Other areas identified as priority services for collaboration include ophthalmology, haematology and Interventional Radiology.
- WAHT and Herefordshire and Worcestershire Health and Care Trust – A Memorandum of Understanding is in place and a work programme agreed. Current work areas include international nurse recruitment, workforce wellbeing and vaccination, the systemwide stroke pathway and urgent care pathway (including frailty and virtual wards). Practical coordination of services between the two trusts is helped by colocation of the acute trust Single Point of Access team in HWHCT premises alongside their Care Navigation Team.
- WAHT and University Hospitals Birmingham – a range of tertiary services provided for Worcestershire residents including some cancer services, renal services, cardiothoracic and trauma services.
- WAHT and University Hospitals Coventry and Warwickshire – MDT working on clinical services in head & neck cancer, Improvement partner for Virginian Mason methodology.
- WAHT and Birmingham Women's and Children's Hospital- collaborative work around paediatric services and work ongoing to collectively support further delivery of paediatric surgery in-county and the expansion of paediatric High Dependency Care at Worcestershire Royal Hospital.
- South Midlands Pathology Network – board approvals received for LIMs outline business case and SM Pathology network collaborative.
- Continued member West Midlands Cancer Alliance.
- Foundation Group collaboration includes work to consolidate pharmacy aseptic medicines preparation facilities across the Group.
- At Place level in Worcestershire, provider collaborative work also includes services within primary care, with close collaboration managed through the Interface group.
- The West Midlands Mental Health and Learning Disability and Autism Provider Collaborative was informally formed in 2021 bringing together 7 Trusts in the West Midlands, including Herefordshire and Worcestershire Health and Care NHS Trust. The specialist inpatient pathways of forensic, LDA< CAMHS, adult eating disorders and mother and baby services are under this Collaborative arrangement and the collective leadership has also developed a governance structure to work on the greatest challenges in the H and LDA and opportunities to address these through working at scale. This has included supporting local systems (ICSs) to improve population health outcomes, building on best practice and developing a regional approach developing innovative clinical and workforce solutions, horizon scanning to maximise WM PC influence and implementation of changes.

Where next? – Areas of focus

- Shared Executive leadership between Acute Trusts will help to continue to strengthen collaborations during 2025
- Within Worcestershire, it is recognised that there is potential to improve patient pathways through increased collaborative working between the acute and community trust.
- The ICB-led Building a Sustainable Future program has identified key services for collaborative working across the ICS.
- Provider review of areas of opportunity around corporate support functions at Foundation Group, system or Place as appropriate
- Taking forward the review of options for Stroke services across H&W
- Continuing the development of a Pathology Network across the South Midlands

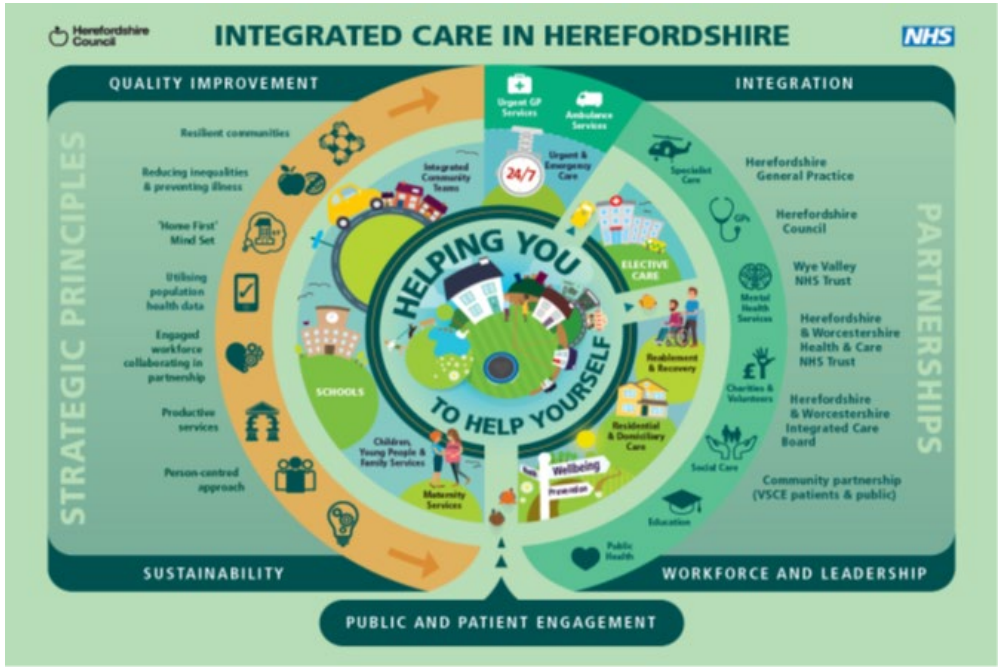
How we will get there? – Development steps

- Stratify provider collaborative arrangements based on service and population needs.
- Progress collaborative working through the Building a Sustainable Future program
- ICB-led methodology for vulnerable services is twofold:
    - At operational level to manage existing or at risk vulnerable clinical services with identified models to support in the short term.
    - Strategically a provider led self-assessment of all clinical services to theme by sustainability / resilience and / or growth domains as part of potential collaborative service model.

16. One Herefordshire Partnership

Theme 16

The One Herefordshire Partnership (1HP) drives the co-ordinated planning and delivery of the Herefordshire health and care system in order to deliver improvements in health and care outcomes through integrated working. 1HP partners share strategic objectives and reviews business cases, provides a forum for discussion on care pathway changes, oversees the Better Care Fund (BCF)and approves the objectives set by the Primary Care networks (PCNs).



Where we are now? What have we delivered in 2024/25

- Making a variety of improvements across the Best Start in Life programme
- Improving the primary/secondary care referral interface with direct access and internal referrals
- Providing improved value for money through the BCF with 22% more D2A purchases in 2024 than in 2023
- Improved collaboration with the Talk Community Healthy Lifestyle Service and delivering Talk Wellbeing Health Checks
- Developed a co-located Community Referral Hub with a SPA and virtual ward, delivering a material increase in WMAS referrals taken from the CAD

Where next? – Areas of focus

1HP 2025/26 priorities will remain as in the previous year.

- **Best Start in Life (HWBB Priority)**
- **Good Mental Wellbeing (HWBB Priority)**
- **Primary/Second Care Interface**
- **Integrated Urgent and Emergency Care**
- **Integrated Neighbourhood Development**
- **Driving Value Through the BCF**
- **Herefordshire Together (supporting VCSE schemes that deliver against 1HP priorities)**

In terms of improvements to outcomes, the partners are finalising a framework based around:

- Prevention and Population Health (HWBB Priorities) including child health, talking therapies and social isolation
- Management of complex community based care, including emergency admission reduction, discharge delay reduction and residential and care home admission reduction
- Improving access to services and early identification, including reduction of elective waiting times and increasing cancer identification

How we will get there? – Development steps

- Develop and agree the outcomes framework that sets out the improvements we will expect to see against the priorities
- Continue to refine the BCF and seek opportunities to improve value for money
- Consider how we might incentivise the urgent and emergency care pathway for general practice in order to prevent acute admissions
- Consider the structure of the partnership in light of the major changes to both the wider NHS structure and local authority boundaries and responsibilities

17. Worcestershire Place Partnership

Theme 17

The Worcestershire system spans many partner organisations and sectors. Whilst many have been working together for years, this is now being extended to deliver even greater collaboration as we strive to fully integrate health, public health and social care.

We recognise the required shift to achieve greater integration and have been working to establish a framework for the culture within which we will work, between key partners, by agreeing and centring on our **shared vision and values** and putting people in our communities at the heart of everything we do. We understand that an **equal partnership** between NHS and health, local government and our VCSE sector is vital, and we have been developing shared health and wellbeing principles as follows:

Together we will:-

- Place equal value and emphasis on the **physical health and mental health** and wellbeing
- **Protect health** and focus on supporting the **conditions for good health**
- **Focus on prevention**; to prevent, reduce or delay need for care and support
- **Improve health disparities** particularly for those who are vulnerable, disadvantaged or living with a disability
- **Listen** to people who use our services and strive to improve, ensuring a **quality experience**
- Deliver **proactive and better coordinated** care to help people to stay healthy and independent**,** based on each person's needs
- Work together in an **evidence-based way** to take to **system wide approaches** to improve health across the life course
- Maximise **shared funding opportunities** to achieve **best value** (including social value)
- Develop and support our **workforce**

District Collaboratives: District Collaboratives bring together statutory health and care services, District Councils, the Voluntary, Community and Social Enterprise (VCSE) and wider partners to deliver against shared priorities with their communities. This is a new way of working and represents a shift in how communities and health and care providers work together. This should see greater local autonomy and resources directed into communities to enable greater control over addressing the underlying causes of ill health through interventions people design for themselves. There is a focus upon building strong, resilient communities, understanding and being able to optimise local assets, whilst articulating gaps and opportunities available to further improve the local offer. We are increasingly seeing that local partnerships are most effective in improving population health and tackling health inequalities.

Where next? – Areas of focus

- Priorities identified by the Worcestershire Health and Wellbeing Board: Good mental health and wellbeing, supported by (1) Healthy living at all ages (2) Safe, thriving and healthy homes, communities and place (3) Quality local jobs and opportunities
- Place based integrated performance report to drive assurance and prioritisation of activities.
- Strong integrated GP leadership across whole county and ensure full support to mature and develop
- Identification and building on local place-based assets to provide foundation for further 'left shift'
- Shared delivery plan across local NHSE Provider Alliance; shared delivery demonstrates maturity of relationship
- Support development and sustainability of VCSE Alliance as an equal partner
- Deliver agreed model of integrated urgent care and frailty action plan, further reducing pressure on ED front door and thereby supporting flow.
- Increasingly looking at shared resources, building on the work of place-based intelligence, engagement and communication cells.
- Support improvements to Stroke pathway to ensure sustainability and high-quality outcomes
- Consider wider integration with other statutory partners eg police, fire

How we will get there? – Development steps

- Developing relationships of trust through working together to deliver place priorities, as listed above.
- Develop systems thinking to enable shared understanding of challenges and solutions across providers.
- Consider implications of adopting Community Paradigm approach and how we can harness local assets to support District Collaborative objectives
- Maximise impact of the reinvigorated Place Leadership, collaboration between HWB and other place-based governance infrastructure to deliver sustainable improvements.

Worcestershire Place Partnership – Progress

The following 3 priorities have been identified and agreed by Worcestershire Place Partnership:

- **Frailty:** move to a systemwide model of care where people identified as living with frailty are proactively and reactively cared for at home, in their local neighbourhoods, and in hospital, by members of the integrated Worcestershire place-based teams.
- **Long Term Conditions:** priority areas of work - heart failure, diabetes and COPD (respiratory).
- **Integrated Neighbourhood Teams/Neighbourhood Health:** prototyping work is progressing in 3 Integrated Neighbourhood Teams Accelerator Sites across Worcestershire. The three sites have identified their priority areas which are to progress proactive care for frail patients in the community (2 sites) and focus on improving the proactive management of diabetes in the community (1 site).

18. Pan system collaboration – The Office of the West Midlands Integrated Care Boards

Theme 18

The six ICBs in the West Midlands are collaborating to form an Office of the West Midlands. NHS Birmingham and Solihull ICB will host the staff performing these functions from 01 April 2023 and staff will transfer to the BSOL ICB in July 2023.

From April 2024 BSOL will also host for the Midlands team supporting all 11 ICBs for the delegated specialised commissioning portfolio.

Herefordshire and Worcestershire ICB will be leading a project on development and delivery of the dental access recovery plan.

The VISION:

Through at scale collaboration and distributive leadership, the Office of WM will add value and benefit to a shared set of common goals and priorities for West Midlands citizens and patients.

Purpose:

The core purpose is to :

- To commission a set of agreed functions at a West Midlands level on behalf of 6 ICBs through shared leadership and joint decision making
- To identify shared priorities and goals and clear projects and work programmes to deliver them
- To bring together in a single host ICB the shared teams and staff supporting the Office of the West Midlands and their ICBs.
- To develop distributive leadership and expertise across an agreed range of functions/teams for the benefit of all ICBs
- To provide a single coherent voice for the West Midlands ICBs where appropriate /a single point of contact/shared voice for change
- To share learning and support improvement across the ICBs
- To achieve best value and efficiency by working at scale where appropriate

Work Programme	Host ICB	Lead CEO
POD / GMaST / Complaints / Secondary Dental – Dental access recovery plan	Herefordshire and Worcestershire	Simon Trickett
Operating Model Development	Coventry and Warwickshire	Phil Johns
Collaboratives		
Integrated Staff Hub and OWN hosting	Birmingham and Solihulll	David Melbourne
Specialised commissioning		
Commissioning Support Service Review	Shropshire, Telford and Wrekin	Simon Whitehouse
NHS 111/999 Services	Black Country	Mark Axcell
West Midlands Combined Authority		
Immunisations and Vaccinations	Staffordshire and Stoke	Peter Axon

NHS
Office of the West Midlands
Partnership of Integrated Care Boards

Herefordshire and Worcestershire
Integrated Care System

Joint forward plan – 25/26

Appendix 3: Statutory Requirements checklist

This section includes a **cross reference to the two Health and Wellbeing strategies** for Herefordshire and Worcestershire, to identify the extent to which the JFP addresses the priorities set out therein.

The section also identifies which section of the JPF (or other documents) **show how the ICB will meet its statutory duties** as laid out in Appendix 2 of the mandatory guidance.

Version: 2025 Refresh, May 2025

Mapping to the Herefordshire Health and Wellbeing Strategy

Herefordshire Health and Wellbeing Priorities		Where and How the Joint Forward Plan Addresses this
Core Priority Areas	**Best Start in Life For Children**	• **Appendix 1, Theme 1** (Maternity and Neo-natal Care), **Appendix 1, Theme 2** (Early years, children and becoming an adult): The core focus of these two areas is directly aligned to the Health and Wellbeing priority or providing the Best Start in Life for Children.
	Good Mental Wellbeing throughout life	• **Appendix 1, Theme 6** (Learning Disability and Autism Care), **Appendix 1, Theme 7** (Mental Health and Wellbeing), **Appendix 2, Theme 15** (Mental Health Collaborative): The core focus of these three areas is directly aligned to the Health and Wellbeing priority of supporting Good Mental Wellbeing throughout life.
Supporting Priorities	**Improving access to local services**	• **Appendix 1, All Themes** – Improving access to core NHS services is a priority running through the work programmes of all core themes, including through the development of virtual wards and an overall ambition to invest more in preventative activities and to provide best value healthcare in the right setting. • **Appendix 1, Themes 11, 12 and 13** (Primary Care Themes): Improving access for primary care services will be a specific focus through implementation of the National Access Recovery Plan. Furthermore, the ICB is responsible for commissioning Dental Services from April '23 and is prioritising work to improve access, particularly for those with greatest need. • **Appendix 2, Theme 11** (Digital data and technology): A key theme of our digital strategy is to enable greater access to service through digital platforms and to support the development of virtual wards.
	Support people to live and age well	• **Main Document, overall theme:** The focus on upstream investment in prevention and providing best value care in the right setting emphasises the central focus of this plan on supporting people to live and age well. • **Appendix 1, All Themes** – Improved physical and mental wellbeing is fundamental to all themes in appendix 1, recognising the intent of the overall strategy in the long term to reduce demand on services by investing more time, money and focus on preventative activities • **Appendix 2, Theme 5 (Prevention):** This sets out how NHS services will work to support local prevention strategies through specific interventions.
	Good work for everyone	• **Main Document, Workforce Section (page 14)** – As a direct employer of more than 20,000 people across the ICS area, the NHS has a direct role in providing good work for everyone. The plan sets out our approach to filling our workforce gaps by attracting more people to work in the NHS, particularly in roles that are perfect for local people such as care assistants who can go onto develop a professional career locally.
	Support those with complex vulnerabilities	• **Appendix 1, Theme 2** (Early years, children and becoming an adult), **Appendix 1, Theme 6** (Learning Disability and Autism Care), These sections outline out work to support people with complex needs. Other services, particularly Primary Care also tailor their approaches to support complex needs. • **Appendix 2, Theme 4** (Health Inequalities), **Appendix 2 Theme 6** (Personalised Care), **Appendix 2 Theme 8** (Commitment to carers), **Appendix 2, Theme 9** (Support to veteran health), **Appendix 2, Theme 10** (Addressing the needs of victims of abuse): These sections outline specific local actions that will ensure that NHS partners support those people with complex vulnerabilities.
	Improve housing, reduce homelessness	• **Main Document, Population Health Management section (page 25),** NHS Partners recognise the inextricable link between poor housing / homelessness and poor health outcomes. A core focus of our population health management work will be to identify specific individuals whose health outcomes are impacted in this way and to implement targeted interventions to improve their outcomes.
	Reduce Carbon Footprint	• **Appendix 2, Theme 13** (Greener NHS), provides an overview of how local NHS partners will contribute to improving the environment and reducing the NHS carbon footprint.

Mapping to the Worcestershire Health and Wellbeing Strategy

Worcestershire Health and Wellbeing Priorities		Where and How the Joint Forward Plan Addresses this	
Core Priority: Good Mental Health and Wellbeing	**Whole Population Approach**	• **Appendix 2, Theme 17** (Worcestershire Place Partnership): This section outlines how partners will work together at county and district collaborative level to put integration at the heart of our service delivery.	The core focus of these areas is directly aligned to the Health and Wellbeing priority of supporting Good Mental Wellbeing throughout life: • **Appendix 1, Theme 6** (Learning Disability and Autism Care) • **Appendix 1, Theme 7** (Mental Health and Wellbeing) • **Appendix 2, Theme 14** (Mental Health Collaborative)
	Align and Support Local Strategies	• **Main Document, Population Health Management section (page 25),** NHS Partners recognise the inextricable link between poor housing / homelessness and poor health outcomes. A core focus of our population health management work will be to identify specific individuals whose health outcomes are impacted in this way and to implement targeted interventions to improve their outcomes. • **Appendix 2, Theme 11** (Digital, Data and Technology):	
	Commitment to reducing health inequalities	• **Appendix 2, Theme 4** (Health Inequalities), • **Main Document, Population Health Management section (p27)**	
	Engage local communities over the lifetime of the strategy	• **Appendix 2, Theme 7** (Working with Communities) • **Appendix 2, Theme 8** (Commitment to Carers)	
Supporting Priorities	**Healthy Living at All Ages**	• **Main Document, overall theme:** The focus on upstream investment in prevention and providing best value care in the right setting emphasises the central focus of this plan on supporting people to live and age well. • **Appendix 1, Theme 2** (Early years, children and becoming an adult), **Appendix 1, Theme 4** (Frailty), **Appendix 1, Theme 8** (Long term conditions): Improved physical and mental wellbeing is fundamental to all themes in appendix 1, recognising the intent of the overall strategy in the long term to reduce demand on services by investing more time, money and focus on preventative activities. • **Appendix 2, Theme 5** (Prevention)**:** This sets out how NHS services will work to support local prevention strategies through specific interventions.	
	Quality local jobs and opportunities	• **Main Document, Workforce Section (page 14)** – As a direct employer of more than 20,000 people across the ICS area, the NHS has a direct role in providing good work for everyone. The plan sets out our approach to filling our workforce gaps by attracting more people to work in the NHS, particularly in roles that are perfect for local people such as care assistants who can go onto develop a professional career locally.	
	Safe, thriving and healthy communities and places	• **Appendix 2, Theme 7** (Working with Communities): This section outlines how we will listen to our communities and use this intelligence to make sure we focus on doing the right things. • **Main Document, Population Health Management section (page 25),** NHS Partners recognise the inextricable link between poor housing / homelessness and poor health outcomes. A core focus of our population health management work will be to identify specific individuals whose health outcomes are impacted in this way and to implement targeted interventions to improve their outcomes. • **Appendix 2, Theme 13** (Greener NHS), provides an overview of how local NHS partners will contribute to improving the environment and reducing the NHS carbon footprint.	

Mapping of ICB duties to the Joint Forward Plan

The JFP must set out:	Executive Lead	Description of approach, governance arrangements and links to other evidence and references to demonstrate the ICB duty.
Describing the health services for which the ICB proposes to make arrangements.	**Chief Executive**	**Appendix 1, Core Areas of Service** provides an overview of the range of services that the ICB is making arrangements for. The ICB Operating Model and System Development Plan provides more detail on specific areas to demonstrate how services are organised and developed.
Duty to promote integration	**Executive Director of Strategy, Health Inequalities and Integration**	The duty to promote integration is inherent to the **design of the whole local system, as demonstrated in**: Integrated Care Strategy, JPF Main Document, JFP **Appendix 1 (Core areas of focus) and Appendix 2 (Enablers)** provide an overview of the approach and links to other documents that demonstrate how the ICB and system partners meet their statutory requirements in these areas. Additionally, there are a myriad of other documents that outline this, including: ICB Operating Model and Organisational Structure, Better Care Fund, ICB Contribution to the Health and Wellbeing Strategies, Place Partnerships and HIPP Board, Fragile Services Framework, Clinical and Care Professional Leadership Networks
Duty to have regard to the wider effect of decisions	**Executive Director of Strategy, Health Inequalities and Integration** **Director of Corporate Services**	**The Four Pillars of Integrated Care Systems**, built up from the Triple Aim were the **basis of the strategic planning framework** that was used to develop the ICS Strategy, the Joint Forward Plan and the linkages they have to the Health and Wellbeing Strategies. The ICB Governance Design, as set out in the ICB Constitution and Governance Handbooks outlines how the Governance Structure of the ICB is designed to ensure that the ICB meets its duty to have regard to the wider effect of its decisions. The main committee for ensuring this happens is the ICB Quality, Resources and Delivery (QRD) Committee, which is supported by the ICB Quality Delivery and Oversight of System Group (QDOS), which pulls together the activities of all the ICS Programme Boards and Forums.
Financial duties	**Chief Finance Officer**	**Main Document, pages 18 - 19** outline the 25/26 Financial Plan. It also outlines arrangements for developing a Medium-Term Financial Strategy, which will be used to set out the plan for returning the system to financial balance. The ICS Finance Forum (chaired by Wye Valley NHS Trust Chairman) is the strategic group that bring finance professionals together to build consensus around the financial plan.
Implementing any Joint Local Health and Wellbeing Strategy	**Executive Director of Strategy, Health Inequalities and Integration**	**The JFP has been developed to specifically demonstrate how NHS partners will contribute to the delivery** of the Integrated Care Strategy and the two Joint Local Health and Wellbeing Strategies. The overall approach to the development of the Integrated Care Strategy and the Operating Model for the system (build around place) has been created to ensure alignment between all strategic plans.
Duty to Improve quality of services	**Executive Chief Nurse**	**Appendix 2, Theme 1 (Quality, Safety and Patient Experience)**, provides an overview of the approach and links to other documents that demonstrate how the ICB and system partners meet their statutory requirements in these areas.
Duty to reduce inequalities	**Executive Director of Strategy, Health Inequalities and Integration**	**Appendix 2, Theme 4 (Health Inequalities) and Theme 5 (Prevention)** provide an overview of the approach and links to other documents that demonstrate how the ICB and system partners meet their statutory requirements in these areas.
Duty to promote the involvement of each patient **Duty to involve the public**	**Director of Operations – System Programmes** **Director of Communications & Engagements**	**Appendix 2, Theme 6 (Personalised Care)** provide an overview of the approach and links to other documents that demonstrate how the ICB and system partners meet their statutory requirements in these areas. **Appendix 2, Theme 7 (Working with Communities)** provide an overview of the approach and links to other documents that demonstrate how the ICB and system partners meet their statutory requirements in these areas. **Main Document, Population Health Management (page 25),** provides an overview of the approach and links to other documents that demonstrate how the ICB and system partners meet their statutory requirements in these areas.
Duty as to patient choice	**Managing Director**	**Patient choice is a key focus for the ICB.** There is a plan for an accreditation process for new providers in development that will be ready in late 2023. Addition, there will be revised patient information to promote choice and support patients decisions. Progress against Patient Choice will be reported through the Elective, Diagnostic and Cancer Programme Board through the SRO for patient choice.
Duty to obtain appropriate advice	**Chief Executive, through individual Executive Leads**	**There are a myriad of different arrangements** in place for ensuring that the ICB obtains relevant advice when making decisions. This includes arrangements with a legal firm to provide legal advice, and MOU with public health to provide support for undertaking needs assessments, arrangements with the CSU for provide procurement advice etc.

Mapping of ICB duties to the Joint Forward Plan

The JFP must set out:	Executive Lead	Description of approach, governance arrangements and links to other evidence and references to demonstrate the ICB duty.
Duty to promote innovation	**Chief Medical Officer & Director of Workforce and Digital**	The Chief Medical Officer is responsible for coordinating work across the ICB for promoting Innovation and the ICB employs and Officer within the Digital Team to support this work. **Appendix 2, Theme 11 (Digital Data and Technology)**, provides an overview of the approach and links to other documents that demonstrate how the ICB and system partners meet their statutory requirements in these areas.
Duty in respect of research	**Chief Medical Officer / LTC and Personalised Care Lead**	
Duty to promote education and training	**Chief People Officer**	**Main Document Pages 14 to 17** set out the key facets of the ICS System People Plan, which includes details and references to further information on the ICS Academy.
Duty as to climate change	**Executive Director of Strategy, Health Inequalities and Integration**	**Appendix 2, Theme 13 (Greener NHS)**, provides an overview of the approach and links to other documents that demonstrate how the ICB and system partners meet their statutory requirements in these areas.
Addressing the particular needs of children and young people	**Director of Operations – System Programmes**	**Appendix 1, Theme 2 (Early Years, children and becoming an adult)**, provides an overview of the approach and links to other documents that demonstrate how the ICB and system partners meet their statutory requirements in these areas.
Addressing the particular needs of victims of abuse	**The Chief Nursing Officer**	**Appendix 2, Theme 10 (Addressing the specific needs of victims of abuse)** The Director of Partnerships and Health Inequalities and Chief Nursing Officer is coordinating work to link in with external partners to ensure that the ICB fulfils across these areas, in addition to the services in place across Herefordshire and Worcestershire.

Other Recommended Content	Description of approach, governance arrangements and links to other evidence and references to demonstrate the ICB duty.
Workforce	**Main Document Pages 14 to 17** set out the key facets of the ICS System People Plan, which includes details and references to further information on the ICS Academy.
Performance	**Main Document Page 13** sets out the specific short term performance trajectories that are being aimed for. Longer term trajectories will be developed as part of the new approach to Strategic and Operational Planning and will be incorporated in the first refresh of the JFP.
Digital / Data	**Appendix 2, Theme 11 (Digital Data and Technology)**, provides an overview of the approach and links to other documents that demonstrate how the ICB and system partners meet their statutory requirements in these areas.
Estates	**The System Development Plan and ICS Operating Model documents** outline more detail on how the ICB and System Partners meet their statutory requirements in these areas.
Procurement / Supply Chain	
Population Health Management	**Main Document, Population Health Management (page 25),** provides an overview of the approach and links to other documents that demonstrate how the ICB and system partners meet their statutory requirements in these areas.
System Development	**Appendix 2, Theme 14 to 18** provide an overview of the approach and links to other documents that demonstrate how the ICB and system partners meet their statutory requirements in these areas.
Supporting Wider Social & Economic Development	The ICB fulfils its statutory duties through **membership of the Health and Wellbeing Boards** and engagement and contribution to the two Joint Local Health and Wellbeing Strategies, which both have a focus on tackling the wider determinants to health.
Veteran's Health	**Appendix 2, Theme 9** for detail on our approach to supporting veteran's health