Herefordshire and Worcestershire Health and Care NHS Trust

Operational Delivery and Transformation Plans Summary 2026-2031

The Trust operates a disciplined performance and delivery framework aligned to organisational priorities, commissioning intentions, and NHS England standards, with a strong focus on reducing long waits, improving access and flow, supporting financial sustainability, and contributing to NHS 10-Year Plan transformation.

Key areas include:

Priority	**Trajectory/Delivery**
Elimination of 104-week waits in community services.	Trajectory currently being finalised by Trust and ICB colleagues.
Delivery of access and recovery standards within psychological therapies.	Work with system partners on the continued expansion of Talking Therapies for adults, with 10,052 completed treatments by 2028/29, a reliable recovery rate of 53% and a reliable improvement rate of 71%. IPS access to also be increased to meet national standards with 696 people accessing the service by the end of 2026/27, 768 by the end of 2027/28 and 807 by the end of 2028/29.
Achievement of 2-hour response time in urgent care.	Being delivered.
Adult Acute Mental Health Average Length of stay reductions.	58 days in April 2026, reducing to 55 days by March 2027, 51 days by March 2028 and 49 days by March 2029.
Older Adult Acute Mental Health Average Length of Stay Reductions	62 days in April 2026, reducing to 58 days by March 2027, 55 days by March 2028 and 53 days by March 2029.
Sustained reduction / elimination in inappropriate out-of-area placements.	0 inappropriate out of area placements to be maintained from April 2026.
Roll out of Mental Health Support Teams in Schools.	65% (2 new teams) by the end of 2026/27 80% (2.5 new teams) by the end of 2028/29 100% (1 new team) by the end of 2030/31.

Over the next 3-5 years, the Trust will focus on delivering safe, effective, and financially sustainable services through the transformation of core service models. Our overarching aim is to support people to live independently at home, with access to the right support—both digitally and in person—when they need it.

Ahead of April 2026, the Trust is establishing a transformation team with a forward-looking remit of three to five years. This team will assess future service requirements and determine how we can meet patient need safely within the financial envelope.

Working alongside operational teams, the transformation function will identify best practice, map current services and processes, and design new models of care that deliver improved outcomes, supported by appropriate digital tools and technologies.

We will develop three-year plans collaboratively with commissioners and partners, ensuring alignment with commissioning intentions, coordinated multi-year investment, and a shared focus on agreed outcomes. Patient and carer voice will be central to this work, particularly as we expand selfcare technologies and increase the use of patient initiated follow up. This approach will reduce unnecessary handovers and create a more seamless experience for people moving between services.

A number of programmes are already underway:

Community Hospital Transformation

Worcestershire's 213 community hospital beds currently provide bed-based rehabilitation, limited step-up care, some subacute capability, and long-term care planning. The transformation programme is reviewing whether this configuration represents the best use of resources. Early modelling suggests that relocating Pathway 3 and long-term care planning patients into alternative settings, such as care homes, could release up to 25% of bed capacity. New models under development include therapy led rapid rehabilitation and increased step-up provision for frail and subacute patients who might otherwise require acute admission. Clinical workshops are underway, with implementation planned for summer 2026 and anticipated benefits for winter 2026/27.

2026/27 Key Milestones/Targets

- Progress the Community Hospital Transformation programme with system colleagues, exploring options for:
    - developing delirium and dementia pathways with dedicated bed capacity
    - enhancing minor injury units to become urgent treatment centres
    - ringfencing beds and capacity to deliver Community Assessment and Treatment Units
    - frailty specific step-up pathways and community based same day emergency care.
- Pathways into community hospitals, criteria, alternative care settings and workforce to also be reviewed.
- Completion of pilots/initiatives linked to the above, with business cases and new service specifications developed, as required.
- Handover of Worcester City Inpatient Unit to Worcestershire County Council by 31st March 2027 (aligns with cost improvement and efficiency savings targets, as well as recent capacity and demand modelling).

Years 2-5

- Full implementation of the community hospital transformation programme priorities that supports acute hospital admission avoidance, improved system flow, delivers a left shift from hospital to community and supports treatment to prevention.

- Outcomes will include:
    - An increase in the percentage of patients in community hospital beds reported as being cared for in optimal settings as per annual Point Prevalence audits,
    - An increase in the number/percentage of patients admitted to community hospital bed with greater rehabilitation potential i.e., lower acuity and high rehabilitation need,
    - An increase in the proportion of patients discharged directly to home or community-based rehabilitation,
    - A reduction in the number of patients waiting to be admitted to a community hospital bed,
    - A reduction in the average length of stay for community hospital patients.
    - Improvements in the identification of patients who are frail and/or end-of-life,
    - A reduction in the number of patients being admitted to an acute hospital for ambulatory care sensitive conditions and/or are end-of-life,
    - A reduction in readmission rates for preventable conditions (i.e., frailty, falls, dementia and delirium).

Neighbourhood Health Developments

Neighbourhood Health (NH) is a key transformation priority and the Trust will work with system partners in 2026/27 and beyond to:

- support the drive forward of the NH agenda in both ‘places’ across the ICB.
- work with partners to understand opportunities regarding the emerging Single Neighbourhood Provider (SNP) and Multi Neighbourhood Provider (MNP) models.
- play a key role in the ongoing development of frailty, end-of-life, and long-term condition pathways, with a focus on continuity of care and proactive planning.
- Make use of digital technology to enhance services and improve productivity, including the use of a wound care app, continuous glucose monitoring (Dexcom) and a scheduling/allocation tool.

In Herefordshire, we will continue to contribute mental health expertise to the One Herefordshire model. In Worcestershire, the NH programme is progressing across three areas:

Joint Leadership and Governance: A governance structure is in place, bringing together leaders from provider Trusts, local authorities, public health, PCNs, and the VCFSE sector. PCN footprints are currently used as population boundaries, though these will be reviewed to ensure they remain optimal. Shared outcomes must be agreed, balancing national priorities—such as reducing admissions and improving access—with a locally preferred preventative, patient centred vision.

Embedding the Six Core Components: A baseline assessment is mapping Worcestershire's position against the six national components: population health management, modern general practice, standardised community services, neighbourhood MDTs, integrated intermediate care, and urgent neighbourhood services. This will identify strengths, gaps, and priority areas for development.

Focus on High Need Cohorts: Neighbourhood Teams (NTs) will prioritise cohorts where early impact is most achievable, informed by public health data. Likely groups include adults with frailty or dementia, children with complex needs (via extended neighbourhood health MDTs involving children's community nurses and therapists etc), high emergency department users, and people at end of life. Decisions will be required on whether all neighbourhoods adopt a shared focus or tailor priorities to local demographics.

2026/27 Key Milestones/Targets

- Development of provider collaboratives. New single neighbourhood and multi-neighbourhood provider contracts. Delivery to be centred on the ICS Frailty Strategy.
- Standardise community NH services and governance arrangements. This includes equitable allocation of resources (levelling), working with the ICB and system partners to address non-commissioned work, and progressing the digital initiatives described above.
- Development of a new NT service specification.
- Engagement workshops with clinical teams across the Trust to scope what could be delivered at Neighbourhood level versus what requires a countywide or multi-neighbourhood provider level approach.
- EPR migration depending on outcome of options appraisal.
- Work with Primary care to embed NH Delivery Framework focusing on Frailty and End of Life care.
- Define Neighbourhood footprints and address border issues.
- Integrate the Council's Roaming Nights service with the Evening and Nights Community Nursing service
- Roll out trauma wound closure across the county.

- Consider the development of 24/7 Neighbourhood Mental Health Centres, as further national guidance emerges.

Years 2-5

- Embed advances in technology such as remote monitoring, text messaging.
- Embed advances with community diagnostics.
- Further integration with voluntary sector to progress Public Health initiatives
- Embrace benefits of Shared Care Record, Patient Portal and NHS app. Online bookings.
- Scope integration of the LA's Reablement service with NTs to provide integrated Intermediate care offer including Reablement SPA into Care Coordination hubs.

UEC Interface

A major area of transformation will be the urgent and emergency care interface, bringing together the single point of access, urgent community response, and Hospital at Home. By integrating these functions and linking them with Neighbourhood Health teams, we intend to establish care co-ordination centres. These centres will use systemwide data to help keep people safely at home and support timely discharge. Scoping is underway, with a full proposition expected in spring 2026 and implementation later in the year to support winter 2026/27.

The following key milestones/targets are in addition to the community hospital and neighbourhood health transformation milestones/targets highlighted above.

2026/27 Key Milestones/Targets

- Embed changes to UCR model subject to investment providing cover to Nursing Homes and close alignment to Hospital at Home, holding a caseload for 48 hours where appropriate.
- Reach 30 bed offer for Hospital at Home, with 80% occupancy and progress expansion, in line with new investment.
- Roll out of the Washwood Heath model pending system agreement (care co-ordination hubs and integrated Neighbourhood teams).
- Progress integration opportunities with WAHT regarding Heart Failure and Respiratory virtual ward pathways.
- Increase Call before Convey numbers particularly for Care Homes through rolling out CAD to nights team, increasing Adastra referrals, and community team referrals into acute single point of access.
- Embed 24-hour palliative care response service (possibly through 3rd party provider).

Children and Young People's Services Transformation

The Trust recognises the unacceptable waits in Community Paediatrics and Neurodevelopmental services. Working with the ICB, two three-year plans are being developed for implementation from April 2026. These plans will set out efficiency gains, operating model changes, and investment requirements to reset capacity and meet demand.

Neurodevelopmental

- Reducing waiting lists
- Developing a new model of care for neurodiversity
- Designing improved pathways for children and young people with learning disabilities

2026/27 Key Milestones/Targets

- Improve our data, better understand our demand and capacity and reduce the number of children waiting, tackling access for our longest waiters using screening tools, including ambient voice, physical health clinics and PIFU.
- Develop a more effective system response, including a specialist GP triage hub, to ensure referrals are triaged quickly and efficiently and train our nurse prescribers, increasing sustainable clinical time for children and families.
- Build operational, digital and workforce foundations needed to reduce waits and create a more consistent, supportive experience for families. Creating opportunities for co-production with children and their families.

Years 2-5

- Design and deliver a 'one door' neurodevelopmental service for Herefordshire and Worcestershire for children and young people (Year 2).
- Embed redesigned pathways, with education and awareness with local partners, demonstrating results to families (Year 2).
- Use learning to refine pathways and secure a sustainable, trauma-informed, whole-system approach, supporting families without relying on diagnosis (Year 2).
- Embed and evaluate the new combined model (Year 3).
- Expand and evaluate our digital resources (Year 3).
- Strengthen professional networks across education, social care, primary care and VCSE, so families experience joined-up support, shared expertise and earlier help (Year 3).
- Eradicate all long waits and restore to constitutional standards for waiting times (Year 3).

Community Paediatrics

- Strengthening resilience and productivity across CYP services
- Integrating paediatric care within Neighbourhood Health models

2026/27 Key Milestones/Targets

- Improve our data, better understand our demand and capacity and reduce the number of children waiting within national targets.
- Build operational, digital and workforce foundations needed to reduce waits and create a more consistent, supportive experience for families. Creating opportunities for co-production with children and their families.
- To redesign the service from a medical model to a social integration model, aligning with the Neighbourhood approach. i.e using the universal, targeted, specialist model.
- Improved access and patient flow through streamlined processes and stepping stones.

Years 2-5

- Embed redesigned pathways, with education and awareness with local partners, demonstrating results to families (Year 2).
- Use learning to refine pathways and secure a sustainable whole system approach. (Year 2).
- Expand the neighbourhood model in line with the system and promote system/cross agency working. (Year 2 and 3)
- Expand and evaluate our digital resources (Year 3).
- Strengthen professional networks across education, social care, primary care and VCSE, so families experience joined up support, shared expertise and earlier help (Year 3).
- Eradicate all long waits and restore to constitutional standards for waiting times (Year 3).

Mental Health Redesign

The mental health redesign programme aims to modernise adult rehabilitation inpatient services (with the correct bed base) and improve acute inpatient pathways, thus reducing unwarranted variation and eliminating inappropriate out of area placements.

The rehabilitation redesign has progressed through extensive engagement, precomputation activity, and a structured evaluation process that reduced seven initial ideas to three viable options. Following new developments, the Programme Management Board agreed a temporary pause to allow further engagement with Level 1 and Level 2 rehabilitation providers and to refine financial modelling and appraisal methodology.

Key milestones going forward are set out below and alongside this work, the Trust will engage with its Acute partners in 2026/27 to discuss the national plans for mental health emergency departments to be co-located with or near at least half of Type 1 emergency departments by 2029.

2026/27 Key Milestones/Targets

- Clinical Senate review in August 2026 (following completion of partnership exploration and options appraisal in Q4 of 2025/26.
- NHS England Stage 2 meeting in November 2026.
- Public consultation beginning November 2026 and running for approximately three months.
- Sign-off redesign plans and commence implementation.

Years 2-5

- Embed community rehabilitation offers including forensic and assertive outreach models to create a seamless service providing level 1 and 2 support in the community reducing the need for inpatient rehabilitation.
- Work with the local authority to look at alternatives for admission avoidance, including crisis housing and respite options.
- Monitor and review the new rehabilitation and inpatient pathways to ensure patient experience is enhanced and efficiencies and targets are delivered