South and West Herts Health and Care Partnership

South and West Hertfordshire Health and Care Partnership Delivery plan, 2026/27

1. Introduction

The HCP's vision is to be a 'single team' responsible for planning, improving and delivering population-based health and care services for the people of South West Hertfordshire ('SWH'), delivered by via a neighbourhood working model. The HCP has made significant progress towards achieving this vision; however it is still in the early stages of formation and continues to evolve and embed working practices that will enable effective transformation of services that respond to our population's health and care needs.

The progress the HCP has made in both delivering transformational change that improves health and care outcomes for our population and embedding the structures and processes transact these changes has been enabled through strong relationships which have empowered individuals working beyond their 'day jobs'. Furthermore the HCP has taken an approach of 'form follows function'. It has evolved and tested working practices and then designed organisational structures that ensure the governance is fit-for-purpose and enables safe and effective decision-making. For instance the HCP's Finance & Commissioning and Quality & Performance Committees operated in shadow form for several months prior to enacting the Host Provider model and phase 1 delegation.

The HCP will be continuing to evolve and over the next 12 months we anticipate that the HCP will:

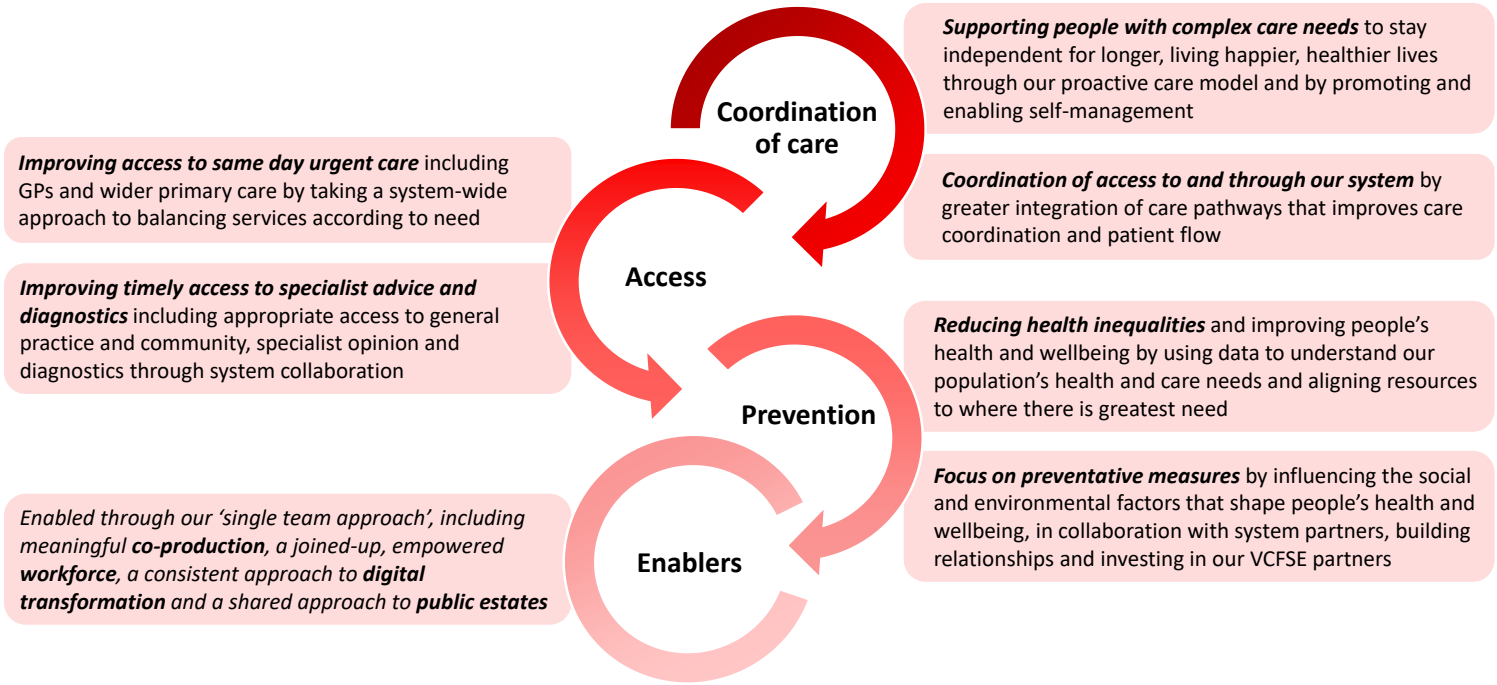
- **Deliver our clinical and care transformation priorities** of coordination of care, access and prevention which will further improve care for local residents, demonstrating the impact of partnership-working
- **Maturing our neighbourhoods** to move from formation to delivery, ensuring they have the requisite skills, capacity and cultures to lead and deliver change
- **Embedding the necessary structural and process enablers and tools** to deliver these changes
- **Continue to evolve the delegation model** by extending the scope of delegation and continually reviewing the governance processes to ensure that they remain fit for purpose, enabling appropriate financial flows, effective decision-making and reflect the HCP and ICB's risk appetite.

2. Clinical and Care Transformation Priorities

The HCP's vision sets out a core purpose of planning, improving and delivering population-based health and care services for the population that we serve. In doing this we deliver the following objectives:

- Our people experience **joined-up, person-centred care** that meets their needs and preferences.
- We **reduce health inequalities** in access, experience, and outcomes
- We use our **resources collectively and efficiently** to maximise health and wellbeing outcomes for our population
- **Staff and partners feel connected, valued, and empowered** to deliver integrated, high-quality care
- The framework for delivering these objectives is set out on the following page:

Figure 1: The Framework for delivering the HCP's objectives



The HCP has developed the following programme to deliver these priorities:

Workstream	Description	Anticipated outcomes
Coordination of care		
Frailty	Ongoing development of our proactive care model and continued development of the HCP's frailty transformation programme	• Improved delivery of proactive care leading to reduction in use of NEL acute services • Increase adherence to people's wishes regarding their care • Proactive medication reviews supporting a reduction in inappropriate prescribing • A greater proportion of people have the right support to reduce their risk of falls • Enhanced use of advanced care planning
Transition	Closing the gap in service provision for CYP services to adult services	• Increase in annual health checks • coordination of care for speciality pathways • Reduced admissions
Care Coordination Hub	Deliver a care coordination hub at Watford that brings together care coordination functions	• Supporting more of our population to receive urgent care in the right place, the first time, including as close to their usual place of residence as possible
Transfer of Care	Improve the transfer of care for patients who are exiting the acute hospital and those exiting rehab and DTA services	• Supporting population return to usual place of residence after acute care • Access to timely therapy support upon discharge to usual place of residence
Access		
Same day urgent care	Develop a neighbourhood-based model for same day urgent care	• Improved visibility of same day urgent care performance
Elective care	End-to-end pathways for a sub-set of clinical pathways that ensure timely access to appropriate care	• Improved use of local capacity • Improved direct access for patients
Prevention		

Anchor programme	Fully mobilise the HCP's anchor programme	• VCFSE organisations engaged as equal system partners • Services designed around lived experience, particularly underserved groups • Stronger, more sustainable community infrastructure
Screening programme	Enhancing screening provision and uptake across a range of conditions	• Increased uptake of screening • Increased rate of vaccinations • Increased proportion of conditions diagnosed at an early stage
Healthy lifestyles	Support individuals by promoting healthy lifestyles and enhancing wellbeing	• Improved prevention uptake in groups with historically low engagement • Reduction in avoidable deterioration and emergency admissions

3. Maturing our neighbourhoods

The HCP has developed a neighbourhood maturity matrix to assess our neighbourhoods' current maturity. neighbourhood has used the maturity matrix to undertake a maturity assessment. This assessment provided a baseline for each neighbourhood, enabling them to set their ambition for 2026/27.

Each neighbourhood has used the outputs of their maturity assessment to develop a neighbourhood development plan which sets out how each neighbourhood will achieve their ambition of neighbourhood maturity in 2026/27. Common themes from across all four neighbourhoods include:

- **Governance and leadership**: Defining roles and responsibilities through developing Terms of Reference templates, aligning neighbourhood governance to HCP processes, with clearly defined reporting mechanisms and tools and continuing to develop the neighbourhood clinical lead roles and the neighbourhood integration lead roles to establish mature and complementary ways of working
- **Neighbourhood team composition**: Defining a consistent integrated neighbourhood team model with dedicated resources from primary care, community, mental health, social care and VCFSE partners; clarifying team functioning within the neighbourhood and its relationships with teams working across the HCP, in line with the emerging HCP neighbourhood operating model
- **Culture development**: Developing team charters and delivering culture shaping workshops and events to embed collaborative working, shared values, communication and language
- **Estates mapping and strategy**: Whist this work features in each neighbourhood's individual development plan, the work will be undertaken collectively across the four neighbourhood. The Neighbourhood Integration Leads will ensure that work is shared to avoid duplication or variation in approach.

4. Enablers

The HCP has identified several enabling workstreams that will enable the HCP to establish the structures and processes that embed neighbourhood working as our delivery approach and also enable the effective delivery of our transformation programme and neighbourhood delivery plans.

Neighbourhood operating model: Pivotal to developing neighbourhood working is the development of our neighbourhood operating model which enables the HCP to orientate our services around communities within our neighbourhoods in order to deliver coordinated services to patients that make best use of our resources.

Estates utilisation: The HCP recognises that there are opportunities to use existing estate to enable better coordination of care through co-location. Furthermore the HCP will also need to develop neighbourhood health centres, as described in the 10 Year Plan.

Data and digital transformation: This is a key enabler of system integration, improving patient outcomes and operational efficiency. Access to data and information enables us to understand the populations we serve and how we provide care to them and much of our transformation programme is predicated on digital transformation.

Workforce: The HCP will be unable to deliver the proposed changes without the leadership and transformational capacity and capability to affect change and embed within day-to-day working to ensure sustainable delivery.

Governance and oversight: As the HCP develops and evolves it is necessary to ensure that the governance and oversight within the HCP remains fit-for-purpose.

Anchor Programme: The Anchor programme, which is described within our transformational workstreams is a key enabler to building relationships with, and stimulating the VCFSE sector to become mature and well-resourced delivery partners.

5. Delegation

The HCP's long term vision, and end point of delegation will be for WHTH to move to full capitation as part of an Integrated Health Organisation model which would see WHTH holding formal accountability for all services provided to the population of SWH. In progressing towards this long-term vision, the HCP will continue to take a phased approach.

The next phase of delegation will include:

1. Establishing nominal risk share arrangements for delegated services, including agreeing and implementing a shared risk corridor between WHTH and the ICB
2. WHTH assuming delegated commissioning responsibility for remaining adult and children community services and UEC contracts
3. Establishing a management agreement which sets out the roles and responsibilities for WHTH, as host provider, and the HCP in relation to primary care and prescribing
4. Clarifying WHTH, as host provider's, responsibility in relation to joint commissioning (e.g. for the BCF)

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