STAFFORDSHIRE
HEALTH AND WELLBEING BOARD

Contact Officer: Jon Topham (01785 278422)
Email: StaffsHWBB@staffordshire.gov.uk

Staffordshire Health and Wellbeing Board

Thursday 4 March 2021
3.00 pm - 5.00 pm
Microsoft Teams Meeting

Our Vision for Staffordshire

"Staffordshire will be a place where improved health and wellbeing is experienced by all - it will be a good place. People will be healthy, safe and prosperous and will have the opportunity to grow up, raise a family and grow old, as part of a strong, safe and supportive community".

We will achieve this vision through

"Strategic leadership, influence, leverage, pooling of our collective resources and joint working where it matters most, we will lead together to make a real difference in outcomes for the people of Staffordshire".

Agenda

Chair: **Cllr Johnny McMahon, Cabinet Member for Health, Care and Wellbeing**
Dr Alison Bradley, Clinical Chair of North Staffordshire CCG

No	Time	Item	Presenter(s)	Page(s)
1.	3.00 pm	**Welcome and Routine Items** a) Apologies b) Declarations of Interest c) Minutes of Previous Meeting d) Questions from the Public	Chair	1 - 10
2.	3.05 pm	**Living with COVID**	Richard Harling	11 - 26
3.	3.15 pm	**Public Health Strategy / Plan**	Tony Bullock	To Be Tabled
4.	3.25 pm	**Obesity Strategy** a) Together Active - Physical Activity Participation b) Implementing a Whole System Approach to Obesity	Karen Coker Jude Taylor Tony Bullock	27 - 34 35 - 48

5.	4.10 pm	**Integrated Care System Plan**	Marcus Warnes Tracey Shewan	49 - 124
6.	4.25 pm	**Safeguarding Adults with Learning Disabilities**	John Wood	125 - 128
7.	4.45 pm	**Stoke-on-Trent and Staffordshire Safeguarding Children Board (SSSCB) Annual Report 2019/20**	Helen Riley	129 - 146
8.		**SEND Strategy**		147 - 166
9.	4.55 pm	**Forward Plan**	Chair	167 - 172
10.		**Any Other Business** a) Pharmaceutical Needs Assessment Staffordshire Observatory - Your health in Staffordshire		

Date of Next Meeting

Thursday 3rd June 2021 at 3:00pm via Microsoft Teams

Membership	
Johnny McMahon (Co-Chair)	Staffordshire County Council
Dr Alison Bradley (Co-Chair)	North Staffs CCG
Mark Sutton	Staffordshire County Council (Cabinet Member for Children and Young People)
Dr Rachel Gallyot	East Staffs CCG
Dr Gary Free	Cannock Chase CCG
Dr Paddy Hannigan	Stafford and Surrounds CCG
Dr Shammy Noor	South East Staffordshire and Seisdon Peninsula CCG
Dr John James	STP Chair of Clinical Leaders Group
Dr Richard Harling	Director of Heath & Care (SCC)
Helen Riley	Director for Families & Communities (SCC)
Craig Porter	CCG Accountable Officer Representative
Simon Whitehouse	Staffordshire Sustainability and Transformation Programme
Phil Pusey	Staffordshire Council of Voluntary Youth Services
Garry Jones	Support Staffordshire
Jeremy Pert	District & Borough Council Representative (North)
Roger Lees	District Borough Council Representative (South)

Tim Clegg	District & Borough Council CEO Representative
Howard Watts	Staffordshire Fire & Rescue Service
Jennifer Mattinson	Staffordshire Police
Jonathan Price	Staffordshire County Council

Note for Members of the Press and Public

Filming of Meetings

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Recording (including by the use of social media) by the Press and Public is permitted from the public seating area provided it does not, in the opinion of the chairman, disrupt the meeting.

Minutes of the Staffordshire Health and Wellbeing Board Meeting held on 10 December 2020

Attendance:

Johnny McMahon	Staffordshire County Council
Dr Alison Bradley	North Staffs CCG
Mark Sutton	Staffordshire County Council (Cabinet Member for Children and Young People)
Dr Shammy Noor	South East Staffordshire and Seisdon Peninsula CCG
Dr Richard Harling	Director of Heath & Care (SCC)
Helen Riley	Director for Families & Communities (SCC)
Craig Porter	CCG Accountable Officer Representative
Simon Whitehouse	Staffordshire Sustainability and Transformation Programme
Phil Pusey	Staffordshire Council of Voluntary Youth Services
Jeremy Pert	District & Borough Council Representative (North)
Roger Lees	District Borough Council Representative (South)
Tim Clegg	District & Borough Council CEO Representative
Jennifer Mattinson	Staffordshire Police
Simmy Akhtar	Healthwatch
Rita Heseltine	South Staffordshire District Council

Also in attendance:

Apologies: Dr Rachel Gallyot (East Staffs CCG), Garry Jones (Support Staffordshire) and Jonathan Price (Cabinet Member for Education (and SEND)) (Staffordshire County Council)

35. Declarations of Interest

District and Borough representative Cllr Jeremy Pert (Stafford Borough Council) declared an interest as the Chairman of Staffordshire County Council's Health Staffordshire Select Committee

a) Minutes of Previous Meeting

RESOLVED That the minutes of the meeting held on 3 September 2020 be confirmed and signed by the Co-Chair.

b) Questions from the Public

There were no questions at this meeting

36. COVID-19 Update

Dr Richard Harling updated the Board. Numbers of cases of Covid in Staffordshire had reduced following the second lockdown but was not falling as quickly now under the tier 3 arrangements. NHS locally were not under the same amount of pressure as they had been but the number of case rates in Staffordshire was still above the national average and there was still some way to go. However there was cause for optimism in the medium to long term as vaccinations begin to roll out and testing capacity locally increases. Vaccinations had started at Royal Stoke in this week but it would be a while before it was at full capacity. The vaccine was difficult to manage logistically and to administer outside a hospital setting. Nevertheless, in the following week, 6 vaccination centres would open.

Testing of asymptomatic cases was being rolled out. This would be available at schools, key public sector organisations and known hot spot areas. Dr Harling said that now was not the time to relax our guard despite the Christmas respite period, notwithstanding Government has to take a holistic view in balancing the impact of covid against economic recovery and mental health and well being.

A Member asked whether in the pending tier review, the allocated tier was likely to be county wide or based more locally on Districts. Application would likely be on upper tier authorities so Staffordshire would receive a countywide tier allocation. In fact rates in the county were now more convergent than had previously been the case.

Dr Harling had visited Keele university to see the pilot testing for students. This had been very well organised and students had now returned home for Christmas.

37. Strategy Questionnaire - Summary of Findings

The September meeting of the Board had considered the impact of Covid on the HWBB Strategy. The November workshop to explore the impact had been cancelled due to the second lockdown and a questionnaire circulated to members instead.

Overall there had been 10 responses to the questionnaire showing strong support for a focus on both Mental Health, for greater efforts to tackle the wider Determinants of Health and that the focus for delivery should be in strengthening partnerships and the JSNA.

Generally, respondents agreed it was not necessary to re-write the Strategy but there needed to be a focus on key delivery priorities. Mental health and health inequalities were issues that needed to be prioritised. Seven respondents believed there were gaps in the Strategy – specifically around Children and Young People, Mental health and Wider Determinants.

In terms of the Joint Strategic Needs Assessments (JSNA), respondents saw Wider Determinants of Health and Mental Health as key priorities. In terms of delivery mechanisms, the most popular was Partnership working and there was clear support for a stronger focus on the JSNA to drive decision making, particularly in the light of Covid.

The Board saw obvious links with determinants of ill health and obesity – people should be encouraged to take a more active lifestyle and the building environment around them should be conducive to that. They agreed that Covid had exacerbated inequalities in terms of health and this should be addressed.

A Member felt that much time was spent in considering responding to covid but more weight should be placed on the prevention agenda – a more proactive than reactive approach – where the Board could make a difference and make life easier for the NHS. He believed there was much potential in the prevention agenda and there should be a focus on key areas.

In terms of resources, keeping people independent even 6 months longer than they might otherwise be, represents significant savings.

Mark Sutton suggested the Board should be focussed and targeted in their approach to be most effective and not try and do everything. He believed a focus on public health of children and young people could have influence and shape early years.

The Board agreed the importance of partnership delivery – it was how well the Board linked and worked with the Integrated Care System that would make the difference. The place of the Board in the system was crucial and notably, Staffordshire Board would cover 3 ICS.

Representing Staffordshire Police, Jennifer Mattison suggested there was duplication between Boards and organisations in terms of safeguarding and health. The HWBB was a strategic board so its identified priorities should be multi agency. The Deputy Chief Executive and Director for Families and Communities, Helen Riley acknowledged the confusing partnership landscape and referred to a pending review to get clarity over lines of responsibility; identify duplication and identify where there are gaps. A Member had experience of a similar mapping exercise which had been very useful.

The Chairman suggested there was value in a focus on children and young people as a demographic and incorporate physical and mental health and obesity.

The Director agreed that the greatest difference could be made in focussing on children and young people but they must avoid duplication with the Families Strategic Partnership Board. Both Boards shared similar priorities and she agreed to explore with Senior Commissioning Manager how to consolidate and avoid overlap. The HWBB role was to champion projects, the FSPB was to do them.

The Director for Health and Care however, thought it too narrow to focus on a specific demographic – while influencing children had the potential to make a difference, some priorities identified could not be limited – for example influencing infrastructure and the built environment – while there could be a greater focus on children in some areas, there needed to be a whole population approach.

The Board were agreed on a focus on obesity but did not want to lose sight of inequalities and agreed the two were interrelated. The Chairman said the Board must be able to demonstrate a tangible difference from its actions and the more focussed the intent, the more likely that can be achieved.

RESOLVED That (a) the Board note the findings of the survey: Strategy Questionnaire

(b) agree that the priority areas of Obesity and Mental Health be brought for discussion at the March meeting of the HWBB (from cradle to grave and multi agency approach), and,

(c) The Deputy Chief Executive and Director for Families and Communities and the Senior Commissioning Manager undertake a review of partnerships to achieve clarity over lines of responsibility; identify areas of duplication and identify where there are gaps.

38. Commissioning Intentions

a) Staffordshire and Stoke-on-Trent Clinical Commissioning Groups Strategic Update

Dr Jane Moore, Director of Strategy, Planning and Performance reported that since March 2020 the system had been operating and planning in a very different environment and had responded to national guidance outlined in four letters to date. On 30 January 2020, NHS England and NHS Improvement had declared a Level 4 National Incident, triggering the first phase of the NHS pandemic response. In March 2020, a Covid control centre had been established to provide control and command, co-ordination and decision making across the STP.

National planning, commissioning and finance frameworks had not been published for 2021-22 yet, and formal commissioning intentions had not been produced. However,

partners across the system had continued to work closely together focusing and linking the priorities to be delivered through the Phase 3 plan and those outlined in the long term plan. The STP strategic five year delivery plan (FYDP) outlined the ambitions and priorities to increase the scale and pace of progress of reducing health inequalities. The phase 3 planning letter outlined the focus required on protecting the most vulnerable from Covid-19 with a clear commitment to tackling inequalities and services transformed around a place based model.

In April 2020, work around the pre-consultation business case had been suspended and a number of service changes made in line with national guidance and local need. The system was keen to retain the benefits seen during Covid-19 particularly those that have accelerated the delivery of the LTP/FYDP ambitions.

A number of service changes had now been reinstated or reintroduced harnessing digital technology to support virtual appointments and clinics. Covid-19 had accelerated some schemes such as the Community Rapid Intervention Service (CRIS) health navigator and digital consultation methodologies. An involvement strategy would be developed alongside this process to ensure transparency.

Dr Moore reported that UHNM were performing top in terms of their progress in recovery services.

b) SCC Commissioning Intentions

Dr Harling outlined the Health and Care Intentions. He identified key objectives around public health and prevention; care commissioning; adult social care and safeguarding; and, in-house learning disability care services.

The Board recognised its key partnership role and that there was merit in looking at prevention in various systems. Although in responding to the pandemic, commissioning was reactive rather than proactive, learning from it suggests more collaborative partnership working arrangements are effective and must be retained into 2021.

The Board agreed that there was cause for optimism regarding the vaccine, the system had coped well under the circumstances and learning from it will shape future commissioning decisions.

RESOLVED That the updates on Commissioning Arrangements for the Staffordshire and Stoke on Trent Clinical Commissioning Groups and the County Council be noted.

39. Population Health Management

Dr Jane Moore provided a summary of progress in the establishment of a population health management function in Staffordshire.

Population Health was an approach aimed at improving the health of an entire population. Led by CCGs, the Staffordshire health and care system had been working with NHS England, to develop population health management capacity and capability across the system and links with wider system partners including the Public Health team in the local authority, PCN clinical directors and ICP leads to deliver on the vision to apply PHM approach at a system, locality and neighbourhood level.

Following recommendations from the Task Group, the shadow ICS board endorsed a number of programmes of work, which included scoping on the establishing an intelligence hub and working to secure additional development support resource.

There is increasing recognition that from the joint intelligence approach used during the Covid-19 spike, the PHM approach should be progressed and formally develop the required infrastructure and intelligence capacity. Development of an Integrated System Intelligence Hub with representation from all system partners will oversee delivery of the PHM approach. Strong links will need to be established between existing work streams and the PHM programme of work and strong engagement with key stakeholders. It was intended that the Intelligence Hub would be the delivery vehicle supporting a Clinical Design Group, a Technical Design Group and the PHM Programme Board.

Dr Moore said that PHM introduced outcome focussed, clinically lead, evidenced based, data driven change. The emphasis was on collaborative partnership working to drive culture change and focus on inequalities.

Jeremy Pert appreciated the data driven approach of PHM and said that robust data was crucial. He asked how PHM was integrating with partner organisations data management systems - for example the County Councils observatory – and how it was engaged with the voluntary sector. The Board agreed a need to link with wider data sources to ensure a holistic view.

RESOLVED That progress in the establishment of a population health management function in Staffordshire be noted.

40. Staffordshire and Stoke-on-Trent Adult Safeguarding Partnership Board (SSASPB) Annual Report 2019-2020

RESOLVED That the Staffordshire and Stoke-on-Trent Adult Safeguarding Partnership Board Annual Report for 2019-20 be received for information and be considered in detail alongside the Children's Safeguarding Board Annual report at the Board meeting in March 2021.

41. Hospices

Dr Emma Hodges and David Webster Chief Executive Officers at St Giles hospice and Douglas Macmillan respectively, delivered a presentation on behalf of those hospices.

Covid-19 had significantly impacted voluntary income to the hospices and the two charities were working together to ensure a sustainable future for hospice care in Staffordshire. Sales this year to both hospices' shops were lower than last year by more than £1m each. This raised significant concerns around future funding for hospice care. Ms Hodges acknowledged excellent support from their local communities but there remained a significant shortfall in very uncertain times. If the situation did not improve there was a concern that they would not be able to continue to deliver the current breadth of services.

The CEOs asked for some assurance of funding support. They had shown resilience during the pandemic and had continued to deliver palliative care but the position was not sustainable. Craig Porter, representing the CCGs acknowledged the significant challenge and confirmed that the CCGs would work proactively with the hospices. Collectively the Board recognised the value of hospices but it would require all system partners to be willing to reduce their cost base to move funds to hospices for palliative care. It would be incumbent on all 6 hospices in the county to work together. Dr Hodges maintained that they had closed some shops for efficiency but this saving could only be achieved once. It was important for providers to understand the hospice business model and she asked for a 'seat at the table' in consideration of providing and funding palliative care.

RESOLVED That the Board recognise the high quality end of life care offered by Staffordshire hospices and the significant challenge facing them in ensuring a sustainable future.

42. Family Strategic Partnership Board - Future of Wider Governance Arrangements

Deputy Chief Executive and Director for Families and Communities referred to the current governance arrangements for the wider children's partnership agenda which were complex whilst potentially creating gaps and duplication. All partners were experiencing challenges around resources and making best use of capacity. She said it had been agreed for the various multi agency partnerships to conduct a round table discussion to attempt to streamline and simplify the current arrangements. The Board agreed there needed to be some rationalisation.

RESOLVED That the Board note the discussion to take place between the various Family Strategic Partnership Boards multi agency partnerships to attempt to streamline and simplify governance arrangements.

43. Staffordshire Better Care Fund 2020/21

Dr Richard Harling said that in June 2019 the Board had noted that the Staffordshire Better Care Fund (BCF) Policy Framework had been published and noted the financial risk presented by the delay in the publication of BCF Planning Requirements. In July,

the 2019-20 BCF Planning Requirements were published allowing the drafting of the BCF Plan to commence and removing the financial risk.

In January 2020, the HWBB noted the sign-off by the Co-chairs of the 2019-20 BCF Plan and the timescales for its approval. The Board also noted the request for re-base lining of the overall NHS contribution to adult social care in order to correct some historic issues with BCF funding.

In August the Board had noted that due to the ongoing pandemic, NHSE were not yet asking for BCF Plans and advised systems to assume BCF expenditure would be rolled over on existing services as in 2019-20 in order to maintain capacity in community health and social care.

In terms of 2020-21 planning, the BCF Policy Framework had still not been published however the NHS draft planning guidance had been shared which stated that planning requirements would be minimised and narratives reduced. NHSE had advised organisations to assume that expenditure of BCF funds should continue on existing services as in 2019-20. Timescales for completion of 2020-21 plans had not been confirmed.

The Board noted that Staffordshire BCF performance was good and there was reason to assume this would continue.

A new BCF steering group would meet quarterly from November 2020. The Council and the CCGs would begin planning for the 2020-21 BCF submission in line with the draft guidance.

RESOLVED That the Board (a) note the 2020-21 BCF Policy Framework had still not been published although the NHS draft planning guidance had been shared stating that planning requirements would be minimised,

(b) note the extension of existing schemes for 2020-21,

(c) confirm the delegation of authority to enter into the section 75 agreements for 2019-20 and 2020-21 to the Director of Health and Care, and,

(d) confirm the delegation of approval of 2020-21 plans to the Health and Wellbeing Board Chairs.

44. Staffordshire Joint Mental Health Strategy (2021-2025)

Richard Deacon, Commissioning Manager and Josephine Bullock, Strategic Commissioning Manager (CCG) explained that the current mental health strategy had been implemented in 2014 and was joint between the County Council, Staffordshire and Stoke on Trent CCGs and Stoke City Council. It had a wide remit which included interdependences with both protective and risk factors such as education, housing, employment, public health and law enforcement. Since then, other factors such as the

impact of Covid-19 on mental health and wellbeing and the introduction of the NHS Long Term Plan/NHS Mental health Implementation Plan 2019-20-2023-24, it seemed opportune to develop a new mental health strategy.

Mr Deacon and Ms Bullock outlined a joint approach to developing the Staffordshire Joint Mental Health Strategy 2021-25. It was envisaged that the new strategy would maintain a similar wide remit and it is proposed that the County Council and the CCGs work in partnership to coordinate and contribute to its development including key contributions from a range of other partners.

The new strategy would look to improve outcomes and wellbeing for people living with mental health problems and its development would involve a period of engagement and partnership with people with lived experience (of mental health) as well as a range of organisations across the public and private sectors and the voluntary and community sector.

The Board regretted that Stoke on Trent City Council had indicated that they would not be involved in the new Strategy but hoped that they may reconsider before the go-live date – anticipated to be August 2021. Simon Whitehouse asked what links had been established with the Mental Health Programme Board. Mr Deacon acknowledged that a link to that board had not yet properly been established but he undertook to facilitate it.

The Board accepted that current covid restrictions made it more difficult to engage with the more vulnerable groups and the Board which had agreed a focus on mental health and wellbeing, would endeavour to facilitate engagement. Ms Bullock maintained that it was important to structure the questions in such a way as to make them accessible and to gain most from the responses.

The Board noted that Healthwatch could help facilitate engagement.

RESOLVED That the Board (a) approve a joint approach by the County Council and Staffordshire CCGs to the coordination, contribution to and development of a new Staffordshire Joint Mental Health Strategy,

(b) contribute to the development of the new Strategy including formal sign off for any draft version as part of governance process, and,

(c) endorse the proposed scope of the new Strategy.

45. Troubled Individuals Proposals

The County Council's Lead Commissioner for Public Health, Anthony Bullock and Assistant Director for Commissioning, Natasha Moody, outlined proposals for dealing with 'Troubled Individuals'. Covid -19 had impacted on those families identified as having chaotic lives and the proposals were an approach to addressing their needs in a holistic way.

It had been identified that most rough sleepers faced numerous co-existing issues – drugs, mental health, offending and debt for example and that this group received services separately for each issue from different agencies.

The proposed approach would focus on the person as a whole and not address issues in isolation and it would be multi agency. The approach would follow the successful model adopted for Troubled Families (BRFC) but adapted for adults with complex needs.

The Troubled Individuals initiative would adapt existing BRFC infrastructure and delivery would be through an extension of the Place Based Approach. A task and finish group were working through the proposals.

Following a question from a Member, Mr Bullock confirmed that Districts would be encouraged to take responsibility for their own troubled individuals rather than displace the problem onto other districts.

District Housing Associations welcomed this approach.

RESOLVED That the Board (a) endorse the principles being developed to adapt the BRFC programme to include the Troubled Individual approach, and,

(b) commit to supporting the translation of these principles into practice (being prepared to change working practices where necessary and appropriate)

46. Forward Plan

RESOLVED That the Board's Forward Plan for 2020-2021 be noted.

Chairman

Living with Covid: 2021 and beyond

Version 6; 15 February 2021

Introduction

1. This paper considers the long term management of Sars-cov-2. The end of 2020 saw a resurgence of the virus in the UK, despite extensive restrictions, associated in part due to the emergence of new variants. At 15 February 2021 England remains in a third national lockdown with as yet no clear plan for whether and how this will be lifted.

2. Sars-cov-2 is now endemic and we are going to be living with it for many years. It also appears to be a versatile pathogen with the potential to evolve in ways that might confound control measures.

3. The paper considers the implications over a timescale from the latter half of 2021 until 2030. The intention is to stimulate discussion and perhaps develop a consensus. It focuses on three main themes;

    a) The ongoing Covid defences required.

    b) Potential scenarios depending on the evolution of the virus and the success of control measures.

    c) Management of impacts arising from the pandemic and response, on the Council and on wider society.

Covid defences

4. These are the ongoing control measures required to minimise spread of the virus and the frequency of complications.

5. The aims of Covid defences are:

    a) Avoid importing new variants of the virus.

    b) Identify and isolate a high proportion of cases and contacts – and do so quickly.

    c) Prevent and detect clusters and outbreaks and intervene to stop further spread of the virus.

    d) Increase population immunity through roll-out of vaccination.

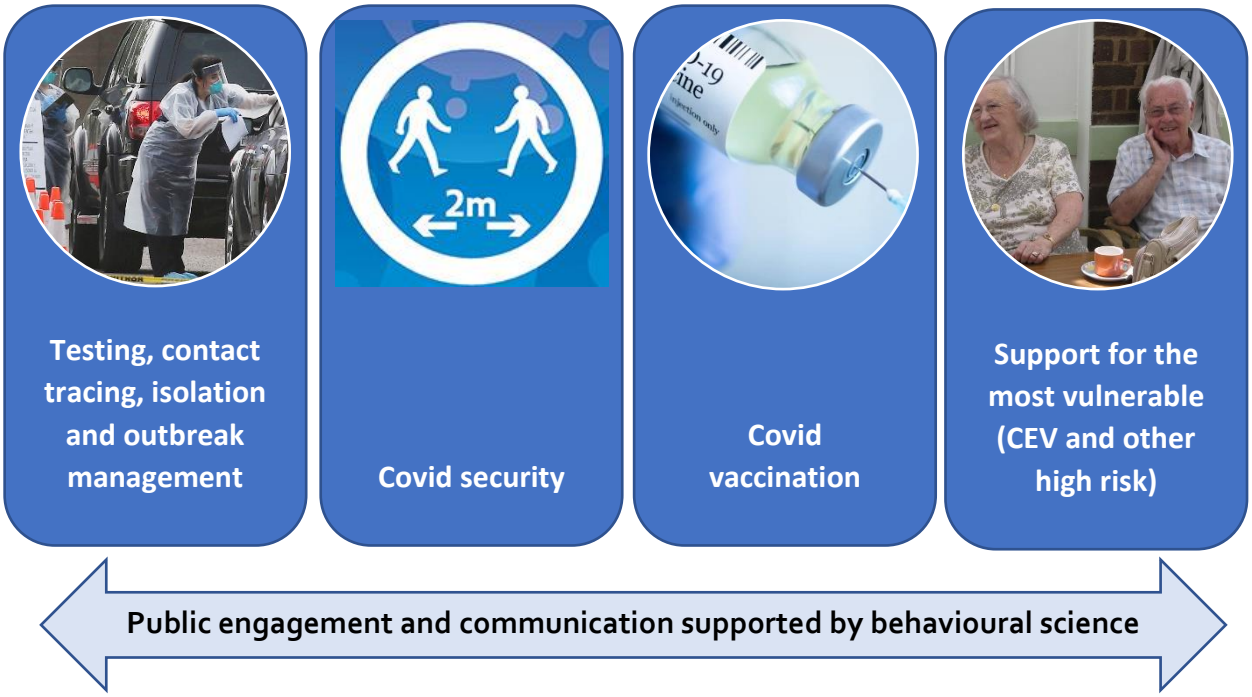
    e) Protect the most vulnerable.

    f) Enable social and economic activity.

    g) Build and maintain public trust and confidence.

6. The UK will need **border controls** to avoid the import of new variants. In addition it will need several layers of Covid defences at local level as summarised in Figure 1. Individually these are all imperfect but if implemented together there is the possibility that we might be able to manage the virus down to background levels.

Figure 1: local Covid defences



Testing, contact tracing, isolation and outbreak management

7. We will need facilities for testing both symptomatic and asymptomatic people long term. We will likely want to keep these separate from other health services.

8. For symptomatic testing we will want to ensure good access, which is likely to require a larger number of smaller sites, rather than a reliance on a smaller number of large sites.

9. For asymptomatic testing, we will want to target those settings and populations with the highest risk and/or prevalence of Covid. New technologies may offer an opportunity to make asymptomatic testing increasingly convenient.

10. We will need to maintain surge capacity to test large numbers of people in response to identification of new variants of concern.

11. We will need to maintain contact tracing and increase the proportion of contacts identified and the speed at which they are isolated.

12. We will need to consider incentives for testing and isolation. There is currently a national support payment for people on low incomes and it is not clear whether this will be sustained. We will need to consider how to make regular testing attractive and to ensure that people can isolate without facing hardship.

13. We will also need to consider monitoring and enforcement, with regular telephone follow up of cases and contacts, linked to support where necessary as well as visits where there is reason to doubt isolation. Over time we would want to transfer this enforcement from Police to local authorities to free up Police resources and make it a civil rather than a criminal enforcement activity.

14. We will need to maintain the capability to manage outbreaks across a range of settings, working with the new National Institute for Health Protection after 01 April 2021 to develop standard operating procedures that draw on their specialist knowledge as required.

15. Testing, contact tracing, isolation and outbreak management should be locally led and managed to ensure that:

    a) Local knowledge can be brought to bear.

    b) Information about cases and contacts links directly to action in response.

    c) It is accountable to the residents that it serves.

    d) The staff involved are properly invested in the efforts.

Covid security

16. Covid security will be especially important in health and social care settings used by people who are at high risk of complications. We will need a high standard of infection prevention and control, working with the NHS to support care providers, and with the CQC to monitor compliance and enforce standards where necessary.

17. For businesses, requirements to maintain hygiene and social distancing are likely to become routine alongside other health and safety measures. Our approach must be primarily supportive: helping businesses to adapt and implement sustainable control measures, especially following an outbreak.

18. We will need to sustain the capacity to monitor compliance, respond to concerns, and if necessary use enforcement powers against those businesses who seriously or persistently break the law. Those powers under the Health Protection Regulations will need to be sustained and if possible enhanced to enable local authorities to intervene quickly and decisively to limit the activities of businesses if necessary.

19. In public spaces at a minimum we will need to ensure good standards of hygiene. Depending on the degree of societal restrictions are in place we may need to continue to engage, explain and encourage the public to comply with social distancing and face coverings.

Vaccination

20. Following an initial rollout in 2021 it is likely that the population will need to be revaccinated regularly, probably at least annually in order to maintain immunity to emerging variants.

21. This is a significant endeavour: the population for Covid vaccination is likely to be double that for flu vaccination and the uptake will need to be greater in order to afford adequate protection.

22. We will need robust supply chains, reliable call-recall and uptake monitoring systems, and high-quality promotion campaigns, and may need dedicated facilities and staff.

Support for the most vulnerable

23. We will need to continue to ensure support for people who are Clinically Extremely Vulnerable, others who are at high risk of complications, and people on low incomes who are required to isolate (unless a national support payment remains in place as above). We can do this fairly straightforwardly through existing online and telephony arrangements, linked to social care functions where necessary.

Public engagement and communication

24. Public engagement and communication will be crucial including:

    a) General awareness

    b) The need to be vigilant to symptoms, get tested and isolate if necessary

    c) The importance of Covid security

    d) Any support available

Scenarios post April 2021

25. The future is unpredictable and there is a wide range of plausible scenarios. We should consider and prepare for all of these on the basis of 'hope for the best; plan for the worst'.

26. We may get a sense of which scenario is unfolding in later spring / early summer 2021. We should have vaccine uptake figures by March / April and if these are looking positive and case rates are low and falling then the government might start to ease restrictions.

27. If after a few months of looser restrictions case and complication rates remain low that would give some confidence that a more optimistic scenario is unfolding; if they climb straight back up again then we might have to be more pessimistic in our prognosis.

Best case

28. The best case scenario is that over the next six months we reach population immunity through rapid rollout of vaccination with good uptake and effectiveness similar to that seen in clinical trials.

29. Ongoing evolution of the virus does not significantly compromise natural or vaccine induced immunity, or if it does the vaccine can be reformulated and administered quickly enough to keep the population protected.

30. In this scenario local Covid defences would be sufficient to manage the virus down to background levels. This means that we would be seeing sporadic cases and the occasional outbreak, similar to other communicable diseases.

31. This would allow societal restrictions to be gradually lifted during the spring and summer 2021 without a resurgence of the virus, and allow life to return similar to 'normal' – as pre-covid - from the autumn with no need for ongoing restrictions.

Optimistic

32. An optimistic scenario is that over the next six months we reach partial population immunity. Rollout of vaccination is a little delayed, and uptake and effectiveness a little lower than the best case scenario.

33. Ongoing evolution of the virus partially compromises natural and vaccine induced immunity, and whilst the vaccine can be reformulated in response to new variants, uptake and effectiveness are suboptimal.

34. In this scenario Covid defences would be insufficient to keep the virus at background levels. We could expect resurgences at various times, possibly seasonally, with a requirement for temporary periods of some societal restrictions to avoid unmanageable pressures on the NHS.

35. This would allow societal restrictions to be partially lifted during spring and summer 2021. However with the risk of resurgence of the virus during the autumn and winter it might be necessary to maintain some restrictions throughout 2021 and into 2022 – perhaps similar to 'tier 1 or 2' - if the NHS were to be protected. These restrictions might then be reimposed at intervals - perhaps for a few months each winter.

36. This would allow life to return close to 'normal' for much of the year. However even if societal restrictions were relatively unintrusive and temporary they could still have a significant impact on residents and businesses. The prospect of enduring restrictions might have an ongoing impact on people's mental well-being, and some sectors might find it difficult to survive if their ability to operate were constrained for periods of the year.

Pessimistic

37. A more pessimistic scenario is that we reach limited population immunity over the next six months. Rollout of vaccination is delayed, uptake is poor, and effectiveness lower than expected from clinical trials.

38. Ongoing evolution of the virus significantly compromises natural and vaccine induced immunity, and the vaccine cannot be reformulated and administered quickly enough to keep up with the emergence of new variants.

39. In this scenario Covid defences would be insufficient to control the virus. We would expect ongoing circulation at significant levels.

40. This would require ongoing societal restrictions throughout 2021 and beyond in order to avoid unmanageable pressures on the NHS – perhaps moving between 'tier 3' and 'national lockdown' over the course of the year.

41. Any scenario towards the pessimistic end of the spectrum would pose a very significant challenge. The health and economic costs of societal restrictions are mounting. Whilst compliance by the public has been generally good so far, this has been on the understanding that they are transient: the public appetite for permanent restrictions is much less clear. We would likely need a full analysis and a much fuller debate about the balance between protecting the NHS versus the sacrifices that would necessitate to freedoms and livelihoods.

42. In particular we would need a proper consideration of the impact of ongoing societal restrictions on children and young people: whilst the benefit of restrictions accrues mainly to older people, the detriment falls disproportionately on the young. There is a risk that we compromise the future of an entire generation if we get the balance wrong. Even for older adults there would be an important conversation about their preference for a lower risk from Covid versus the reductions in quality of life that might entail.

Management of impacts

43. A summary of impacts is included below. This includes some challenges to address as well as opportunities to build on.

Impact on the Council

44. Whilst these are presented from the perspective of Staffordshire County Council many might apply to any large public sector organisation, and indeed some businesses.

Our People

45. **Our people.** The pandemic has produced an incredible response from our staff, with people going above and beyond to support critical functions, including volunteering to be redeployed into a whole range of new and different roles. We will need to consider how to maintain this spirit of endeavour with policies that encourage and reward staff for working flexibly.

46. On the downside, staff are tired, having worked long hours without a break for almost a year, and with no let-up in sight. Leaders need to remain positive to keep morale up and we will need to consider how to protect staff well-being in the short term. We will also need to ensure that there is sufficient capacity in the longer term to manage the many and varied challenges we will face. Some of the temporary Covid related roles will need to become permanent.

Our Operating Model

47. **Our operating model**. Whilst we will see some return to face to face interactions and office working under the more optimistic scenarios this is unlikely to return to the way things were pre-covid. We are likely to see an ongoing shift to online interactions with public services and between our staff. Some of this will be welcome as it will reduce travel time and costs and allow rationalisation of estates. However, we will need to consider about how we maintain access to services for those for whom online is difficult, and avoid isolation for staff from prolonged periods of working from home.

48. Another impact from the pandemic has been a surge in multi-disciplinary and cross team working: staff across the organisation are communicating and collaborating like never before. Also decision making has become quicker: staff have realised they have more freedom and authority than they perhaps realised and many of the perceived constraints of governance have fallen away. Both of these are benefits we should preserve.

Digital

49. **Digital.** The pandemic has produced a step change in use of technology including access to services, and communication between staff, as well as use of data to inform the response. We have an opportunity to build on this whilst considering how to ensure that neither residents or staff are left behind as we embrace new ways of working.

50. This will require further investment in IT systems and equipment as well as training where necessary. The Council has the opportunity to be a leader in embracing new technology and set an example that other businesses can emulate. We will need changes in legislation to facilitate ongoing digital working that has been successful during the pandemic: supervision of children's foster carers; children's Statutory Visits; Deprivation of Liberty Safeguards Best Interest Assessments; registration of deaths; school admissions appeals, and Elected Member meetings.

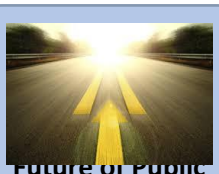
Demand

51. **Demand**. Demand for a range of public services, for example social care, is unpredictable and may increase as a result of complications from Covid and/or the impact of prolonged restrictions and an economic downturn. The NHS is likely to face an excess of acute hospital admissions for Covid for several more months, which may mean a backlog of over a year's worth of planned care by spring/summer. This may require either additional capacity or prioritisation.

52. In this context prevention will become more important than ever. We need to preserve and if possible increase investment 'upstream' to prevent, reduce and delay demand for more expensive services. We also need a renewed conversation about people's responsibility for themselves, their families and their neighbours and how we can help them to retain their impendence rather than becoming reliant on the state.

Funding

53. **Funding.** The Council will require ongoing funding for local Covid defences to sustain the capacity and capabilities required; funding to meet any increases in demand for our statutory duties; funding to support care providers; funding to pass on to local businesses to support recovery from and adjustment to Covid; and funding to mitigate the reductions in income that will likely result from a reductions in Council tax and business rate income arising from an economic downturn.



Future of Public Sector

54. **Future of Public Sector**. The pandemic has produced some excellent inter-agency working, including between the two tiers of local government in Staffordshire, and between the wider family of Local Resilience Forum organisations. This is a great foundation on which to build local partnerships and to make the case for further devolution of powers and funding from HM Government.

Impact on wider society

Economy

55. **Economy**. Ongoing societal restrictions followed by residual 'covid anxiety' as well as requirements for Covid security are likely to mean that any business that relies heavily on face to face interactions will see its profit margins eroded - by a combination of reduced footfall and higher running costs. Customer facing retail is likely to increasingly shift online. The hospitality sector will be especially challenged. All of this likely will produce an economic downturn, more severe and prolonged in more pessimistic scenarios.

56. The Council has a role in supporting businesses to recover and adjust, including to embed Covid security. We may need to completely 'reimagine' public spaces such as high streets: as retail and entertainment shifts online - what are these for? With the right vision there is the opportunity to attract new businesses to the county.

57. We will also need to consider how we support residents. Even under an optimistic scenario by the time lockdown is lifted some people will not have worked for the best part of a year, having been on furlough for much of the time, and unemployment is likely to increase. Some families will face financial hardship that we will need to consider how we mitigate to avoid long term problems with health and well-being and social cohesion.

Education & Learning

58. **Education and learning.** Education has been affected by the pandemic, despite herculean efforts by schools and universities to maintain onsite and online learning. Disruption to learning will be ongoing for the remainder of the spring term and into the summer.

59. Schools will face a challenge to recover 'lost learning' next academic year to mitigate the risk that some children's life chances have been compromised. Under the more pessimistic scenarios we might need to start thinking about a more permanent 'mixed model' of leaning that relies less heavily on a physical presence in classrooms – and ensure that all pupils have access. Universities may face a challenge if students may start to question the value of higher education if it is only able to offer largely online learning with little of the 'life experience' that has traditionally been an attraction.

Health and Wellbeing

60. **Health and well-being**. The pandemic has had a profound impact on quality of life, which could be ongoing, with an accompanied rise in mental health problems. The Council will need to consider how these could be mitigated. Under more pessimistic scenarios this might include helping residents adjust to a 'new normal', emphasising the positives of a new way of living.

61. The pandemic has already produced a substantial rise in social and lifestyle determinants of poor health – and these could also be ongoing. Unemployment, reduced educational achievement, as well as increased alcohol consumption, poor diet and inactivity may have a very significant impact on health outcomes over the next few decade. The Council will need to consider how these could be mitigated and which economic development and health improvement programmes are likely to have the greatest benefits for well-being in the long term.

Climate Change

62. Climate change. The reduction in road traffic as a result of the shift to digital will help to reduce greenhouse gas emissions. On the down side, public transport is relatively high risk for spread of the virus and footfall is well down. We will need to consider how we can make bus and rail networks Covid secure and whether they have a sustainable funding model. Some flagship projects such as HS2 must come into question. With more people working from home emissions from domestic heating may potentially increase.

Communities

63. **Communities**. The pandemic produced a surge in volunteering, particularly early on, much of it very local and informal. There is an opportunity to consider how we nurture and harness this longer term. Part of this will include an understanding of the model of community action: is this about organised efforts or is it 'simple acts of kindness' – or a bit of both? Is it about volunteers providing 'service' or is it peer to peer support?

Social Cohesion

64. **Social cohesion.** The public is hoping for things to 'get back to normal' and may be disappointed and disheartened if this takes longer than they had anticipated or is not possible. Any scenario towards the more pessimistic end of the spectrum may be accompanied by a loss of trust in establishment, particularly among younger people who have the most to lose from ongoing societal restrictions.

65. It is possible that 2021 could see a growing tension about the trade-offs between protecting the NHS and returning our freedoms and livelihoods. The Council has a clear leadership role in this climate, perhaps as an 'honest arbiter' in the debate, encouraging people to connect across generations, and focus on what people still can do rather than what has been taken away.

Staffordshire County Council

Living with Covid

4 March 2021

Summary

- We are going to be living with Covid for many years
- We will need to maintain a series of Covid defences: these are best led and delivered locally as part of a national system
- There is a wide range of plausible scenarios depending on the evolution of the virus and the success of control measures
- Principle is ‘Hope for the best; plan for the worst’
- We will need to manage impacts arising from the pandemic and the response, on the Council and on wider society
- We want to generate debate about the challenges and opportunities and build consensus
- We have discussed the issues at Cabinet, and our Covid-19 Member Led Local Outbreak Control Board and intend a discussion across the wider public sector at a dedicated event
- We will use the outputs to inform our strategic planning

Local Covid defences

Testing, contact tracing, isolation and outbreak management

Covid security

Covid vaccination

Support for the most vulnerable (CEV and other high risk)

Public engagement and communication supported by behavioural science

Scenarios

Best case

- Population immunity achieved and sustained
- Vaccine can be reformulated in response to emergence of new strains
- Covid defences reduce circulation of virus to background levels with occasional outbreak
- Societal restrictions can be lifted without pressure on NHS

Optimistic

- Partial population immunity achieved but uptake and effectiveness of vaccine suboptimal
- New strains partially compromise immunity
- Covid defences insufficient to keep virus at background levels – likely resurgences during winter
- Low level societal restrictions imposed seasonally
- Ongoing impact on well-being and economy

Pessimistic

- Limited population immunity achieved with uptake and/or effectiveness of vaccine poor
- New strains significantly compromise immunity
- Covid defences insufficient to control the virus with ongoing circulation
- Ongoing societal restrictions imposed
- Significant health and economic impact

Management of impacts

Our People

Our Operating Model

Digital

Impacts on the Council

- **Our people:** opportunity to encourage and reward staff for continuing to work flexibly; need to protect staff well-being
- **Operating model:** likely to see an ongoing shift online and a reduction in estates
- **Digital:** opportunities to facilitate access to services and communication between staff
- **Demand:** for public services is highly unpredictable and may increase
- **Funding:** required for Covid defences, increases in demand, to support care providers and businesses, and to mitigate reductions in income
- **Future of Public Sector:** pandemic has accelerated partnership working and demonstrated case for devolution

Demand

Funding

Future of Public Sector

Management of impacts

Economy

Education & Learning

Health and Wellbeing

Impacts on wider society

Economy: 'face to face' businesses will continue to see bottom line affected by reduced demand and Covid security

Education and learning: lost learning to recover and potential challenges for universities

Health and well-being: pandemic has damaged quality of life; mental health problems are rising; social and lifestyle determinants of health deteriorating

Climate change: benefit from reduced road traffic and emissions; questions about sustainability of public transport

Communities: we have seen a surge in volunteering and there is an opportunity to harness this longer term

Social cohesion: more pessimistic scenarios may see a tension between protecting the NHS and returning freedoms and livelihoods

Climate Change

Communities

Social Cohesion

Staffordshire County Council

Living with Covid

4 March 2021

Staffordshire Health and Wellbeing Board – 04 March 2021

Together Active – Physical Activity participation

Recommendations

The Board is asked to:

a. Note the change in governance arrangements to the Staffordshire and Stoke-on-Trent Active Partnership;

b. Consider the findings of the most recent Active Lives survey and the subsequent implications to the health and wellbeing of our residents; and

c. Endorse the recommended priority areas for action.

Background

Change in Governance

1. Together Active, is part of an England wide network of 46 Active Partnerships funded by Sport England. Active Partnerships deliver services and programmes that contribute to achieving both local and national priorities for physical activity and sport.

2. In September 2019, the organisation undertook a change in governance, moving from a hosted body to a Charitable Incorporated Body. This change will allow the organisation to be more agile and access a wider range of income streams, however whilst the name has been changed (formally known as Sport Across Staffordshire and Stoke-on-Trent) our organisational mission of “working together to create active places and healthy lives through Sport and Physical Activity” remains.

Adult participation in Sport and physical activity

3. Covering the period from mid-May 2019 to mid-May 2020, this report provides an update on the sporting and physical activity behaviours of adults in both England and Staffordshire. The period covered includes the seven-weeks from the 23 March to mid-May when England was in full lockdown in response to the coronavirus (Covid-19) pandemic. This caused unprecedented disruption to our lives and had a significant impact on our engagement in sport and physical activity.

4. In this report, we reveal that despite continued growth in the first part of the year nationally, activity levels in England were increasing until measures to counter the coronavirus pandemic were introduced in mid-March. Lockdown led to unprecedented decreases in activity levels between mid-March and mid-May. The disruption in the final two months wiped out those gains and resulted in a flat set of results for the year overall. Compared to the same two-month period 12 months earlier, we saw:

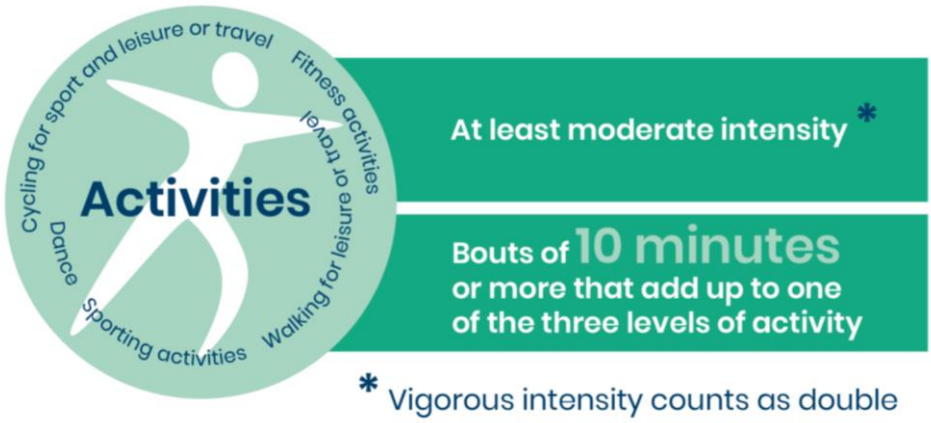
a. 3.0m (-7.1%) fewer active adults
b. 3.4m (+7.4%) more inactive adults.

5. As a result, over the full 12 months, the proportion of adults who were active in England was unchanged compared to last year. There was a small increase in the proportion who were inactive. This data regarding participation trends over the year is not available at a county level.

What do we mean by physically active?

6. Sport England categories physical activity into three groups:

a. Active (at least 150 minutes a week)
b. Fairly active (an average of 30-149 minutes a week)
c. Inactive (less than 30 minutes a week).



Staffordshire Adults Active Lives result

7. There was no significant change in adult activity levels in Staffordshire since 2019. Our most inactive districts are currently East Staffordshire (28.6%) Cannock Chase (27.8%) and Newcastle-Under-Lyme (27.6%) (See appendix 1).

	England	**Staffordshire**
Inactive	25.5%	25.6%
Fairly Active	11.7%	12.1%
Active	62.8%	62.3%

8. These figures put Staffordshire in the top 20% of the most inactive 'active partnerships' areas in England (9/45). Over the last five years Staffordshire has had consistently high levels of inactivity, with some of our Districts and Boroughs having the highest levels of inactivity nationally. In Staffordshire **260,200 residents aged 16+ are inactive**, potentially having a profound impact on their health and wellbeing.

Summary of demographic differences due to Covid-19 restrictions

9. It has been come clear that certain parts of the population are being disproportionately affected by the pandemic, significantly impacting their ability to be physically active and further widening already significant levels of health inequalities. Figures show;

    a. Whilst activity levels fell for all groups, falls were larger amongst lower social groups (NS-SEC 6-8) -6.4% than higher social groups (NS-SEC 1-2) -5.4%. As such, the gap between lower and higher social groups widened during this period.
    b. With disabled adults and those with a long-term health condition asked to shield, their activity levels decreased. This is likely to have driven the increase in the number of those with complex needs (three or more impairments) being inactive across the period, up 11.2% compared to 12 months earlier.
    c. The pandemic has widened the inequalities we observe between ethnic groups. Drops in activity levels were larger amongst those from Asian (excluding Chinese), Black and Other ethnic backgrounds these drops are larger for men from both Asian (excluding Chinese) (-20.8%) and Black backgrounds (-19.5%).

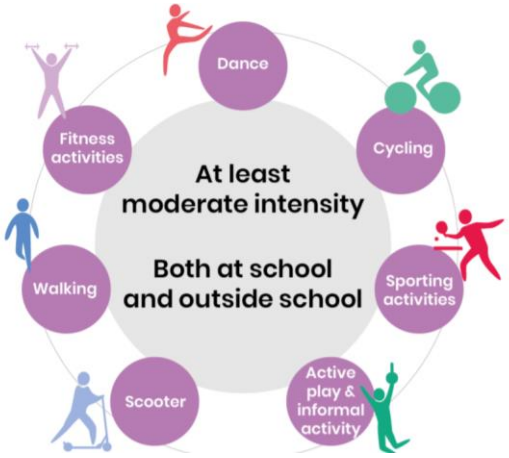
Active Lives Children and Young People survey (covering the academic year 2019 – 2020)

10. This is the third Active Lives Children and Young People Survey report, summarising the activity levels of 5- to 16-year-olds in England from September 2019 to July 2020. The period covered includes the disruptive storms last February, which resulted in school closures and the cancellation of many outdoor activities, and the unprecedented disruption caused by the coronavirus (Covid-19) pandemic, which primarily impacted the summer term. The disruption also impacted our collection of data. We were unable to collect any data during the last two weeks of the spring term (late March) when schools were closed, while we also had to switch from school to at home completion for the summer term. As a result, we don't have data covering the first full lockdown.

How do we define activity levels for young people?

11. Sport England defines activity levels for young people into three categories

    a. Active (an average of at least 60 minutes a day)
    b. Fairly active (an average of 30-59 minutes a day)
    c. Less active (less than an average of 30 minutes a day)



12. Children's lives have been disrupted by the pandemic and their usual play and activity habits continue to be inhibited. Again, inequalities were exacerbated, children with access to a garden and out of home space were more than twice as likely to participate, than those with neither.

13. Participation in active play fell in the year 3-6 and year 7-11 age groups, with the falls for boys and girls being of similar size. Participation held up for year 1-2 pupils. Children were much more likely to have taken part in Active Play if they were attending school every day (78.3%) instead of not attending (54.5%).

14. Not surprisingly, sporting activities (which include team sports, athletics/running and swimming) were collectively hardest hit, down 16% or just over a million fewer children and young people taking part, whilst the biggest gains were found in walking, cycling and fitness. Although overall reductions have been minimised, the disruption has had an unprecedented impact upon physical literacy, with changes to perceived competence, confidence and enjoyment of concern going forward.

Summary of England levels of activity for Children and Young People.

a. 3.2 million (44.9%) children and young people are active, taking part in sport and physical activity for an average of 60+ minutes a day and therefore meeting the new Chief Medical Officer guidelines.
b. The proportion of children and young people reporting they were active has decreased by 1.9% over the past 12 months.
c. 1.7 million (23.8%) are fairly active taking part in average of 30-59 minutes a day.
d. 2.3 million children and young people (31.3%) are less active (do less than an average of 30 minutes of sport and physical activity a day), an increase of 2.4% in the proportion reporting they are less active compared with 12 months ago
e. **Doubling** of the numbers of children **doing nothing** in the last 7 days – up by over quarter of a million Children and young people.
f. The average minutes spent doing activity per week fell by roughly an hour

Summary of Staffordshire levels of activity for Children and Young People

15. Sport England did not publish local authority data due to the lower response numbers as a result of school closures and restrictions making sample sizes less reliable. We have received a breakdown for Staffordshire, but this data should be treated with some caution.

    a. 40.1% of children and young people are active in Staffordshire but this is lower than the England average.
    b. 24.4% of children and young people are fairly active.
    c. 35.5% of children and young people are less active this is higher than in England and a significant increase on last year

16. The districts which have the highest 'less active' levels and higher than England are Staffordshire Moorlands (40.2%) and Cannock Chase (37.9%) (See Appendix 2).

Impact of Covid-19 on delivery of PE in schools

17. To build a picture of the current landscape, The Youth Sport Trust conducted an online survey, to understand the provision of both timetabled and extracurricular PE and any barriers to delivery, particularly in the light of ongoing Government guidelines and restrictions (e.g. maintaining class bubbles, cleaning and changing rules etc.) The survey reported that in secondary schools over a fifth of schools were offering less timetabled PE than before Covid. Around half of all schools will be delivering less extracurricular Sport in the Autumn term and, additional, around four in 10 will offer none.

18. PE teachers and senior leaders told the YST how life for children in schools is more sedentary, with restriction on their movement and some children not even moving between lessons. This resulted in almost three quarters of teachers reporting children returning to school with low levels of physical fitness.

Other key findings revealed:

a. 17% of key stage 2 delivered less or no curriculum PE, 22% at key stage 3 and 26% at Key stage 4
b. 73% of teachers reported children returning with low levels of physical fitness
c. 49% have noticed mental wellbeing issues in pupils including anxiety and fear
d. 50% of all teacher surveyed reported a cautiousness about interpreting the guidelines correctly.
e. 65% of all teachers surveyed said that being able to follow delivery guidance due to logistical issues including cleaning equipment, social distancing, having to stay in class bubble or staggered break time was an issue or barrier in delivering PA.

Conclusion

19. The on-going trend of inactivity in Staffordshire continues to be a concern, particularly for our young people. The impact of the pandemic has been profound

on both our behaviours but also on public and community sport and leisure provision. Supporting communities to change sedentary behaviours must now be a priority. Together Active has identified four key priorities areas for action:

a. Supporting schools, particularly primaries, to prioritise PE and activity play.

b. Sustaining and enhancing community sport and physical activity provision, (specifically those organisations working with priority audiences)

c. Delivering targeted campaigns regarding the importance of physical activity.

d. Supporting social prescribers and medical practitioners to incorporate physical activity into routine clinical and community care.

e. Advocating for physical activity to be a key strategy in fighting the pandemic and protecting and promoting the health and wellbeing of our communities.

List of Background Documents/Appendices:

Appendix 1-2 – Active Lives Data

Contact Details

Report Author: Jude Taylor
Telephone No: 07720262324
Email Address: Judetaylor@togetheractive.org

Appendix 1

Table 1 Sport and Physical Activity Levels (Adults aged 16+) Years November 2015-2016, May 2018- May 2019, May 2019 – May 2020

Sport and Physical Activity Levels (Adults aged 16+)	November 2015 - November 2016			May 2018 - May 2019			May 2019 - May 2020		
	Active (150+ minutes a week)	Fairly Active (30-149 minutes a week)	Inactive (<30 minutes a week)	Active (150+ minutes a week)	Fairly Active (30-149 minutes a week)	Inactive (<30 minutes a week)	Active (150+ minutes a week)	Fairly Active (30-149 minutes a week)	Inactive (<30 minutes a week)
England	62.1%	12.4%	25.6%	63.2%	12.0%	24.8%	62.8%	11.7%	25.5%
West Midlands	58.7%	12.9%	28.4%	59.0%	12.6%	28.4%	58.7%	12.7%	28.6%
Staffordshire	57.5%	13.0%	29.4%	60.0%	13.6%	26.4%	62.3%	12.1%	25.6%
Stoke-on-Trent	53.1%	14.3%	32.6%	53.0%	13.2%	33.8%	54.4%	12.8%	32.8%
Cannock Chase	55.1%	14.6%	30.3%	58.6%	14.9%	26.6%	57.4%	14.8%	27.8%
East Staffordshire	59.9%	11.5%	28.6%	60.1%	12.6%	27.3%	58.1%	13.3%	28.6%
Lichfield	58.2%	12.2%	29.6%	60.7%	13.6%	25.7%	65.9%	8.9%	25.3%
Newcastle-under-Lyme	56.7%	15.0%	28.4%	60.1%	15.3%	24.6%	63.9%	8.5%	27.6%
South Staffordshire	57.5%	15.2%	27.3%	60.4%	13.2%	26.4%	62.6%	12.1%	25.4%
Stafford	63.4%	8.8%	27.8%	60.3%	14.0%	25.7%	64.3%	14.2%	21.5%
Staffordshire Moorlands	52.5%	12.7%	34.8%	60.2%	12.2%	27.5%	64.8%	10.0%	25.2%
Tamworth	53.9%	15.9%	30.2%	58.9%	12.1%	29.0%	60.3%	16.2%	23.5%

Appendix 2

Table 2 Sport and Physical Activity Levels (Children and Young People in school years 1 – 11)

Sport and Physical Activity Levels (Children and Young People in school years 1-11)	Academic Year 2019-20			Change compared to Academic Year 2018-19					
	Active (an average of 60 minutes or more a day)	Fairly active (an average of 30-59 minutes a day)	Less active (less than an average of 30 minutes a day)	Active (an average of 60 minutes or more a day) [1]		Fairly active (an average of 30-59 minutes a day) [1]		Less active (less than an average of 30 minutes a day) [1]	
England, Academic Years 2018-19, 2019-20	Rate (%)	Rate (%)	Rate (%)	Absolute	Significance	Absolute	Significance	Absolute	Significance
England	44.9%	23.8%	31.3%	-1.9%	Significant decrease	-0.4%	No change	2.4%	Significant increase
West Midlands	44.4%	22.9%	32.7%	-1.1%	No change	-0.8%	No change	1.9%	No change
Staffordshire	40.1%	24.4%	35.5%	-4.8%	Significant decrease	-0.3%	No change	5.1%	Significant increase
Stoke-on-Trent	40.5%	18.9%	40.6%	-0.7%	No change	-6.7%	No change	7.4%	No change
Cannock Chase	40.0%	22.1%	37.9%	^	^	^	^	^	^
East Staffordshire	42.2%	23.7%	34.1%	-3.8%	No change	-0.3%	No change	4.1%	No change
Lichfield	41.8%	25.3%	32.8%	-9.4%	Significant decrease	3.7%	No change	5.7%	No change
Newcastle-under-Lyme	48.0%	19.6%	32.5%	11.6%	Significant increase	-7.9%	Significant decrease	-3.8%	No change
South Staffordshire	37.5%	28.8%	33.7%	-7.6%	No change	7.4%	No change	0.2%	No change
Stafford	45.3%	24.1%	30.6%	-8.1%	No change	2.0%	No change	6.0%	No change
Staffordshire Moorlands	29.4%	30.4%	40.2%	-24.0%	Significant decrease	2.1%	No change	21.9%	Significant increase
Tamworth	^	^	^	^	^	^	^	^	^

Caveats for LA Data

Some data is flagged orange within the ‘Change compared to year 17-18’ or ‘Change to year 18-19’ columns. This is because there are missing school phases or missing Terms within the data, again affecting the reliability / validity of assessing change to previous years. Activity levels differ by term, and so where you are not comparing like for like the result will be different due to the profile, not solely through a genuine change – if there is a genuine change this will be hard to unpick. In the case of large changes, you might assume the scale is exaggerated but the direction is likely, with smaller changes we would recommend not relying on these.

Staffordshire Health and Wellbeing Board – 04 March 2021

Implementing a Whole System Approach to Obesity

Recommendations

The Board is asked to:

a. Endorse and actively support a whole system approach to obesity across Staffordshire; and

b. Agree to become the system-wide governance for the whole system approach to obesity.

Background

The Issue

1. Obesity amongst children and adults continues to increase and is a national public health concern. In England nearly 25% of adults and approximately 10% of children are obese[i].

2. It is estimated that 40% of Britons could be obese by 2025 and that Britain could be a mainly obese society by 2050.

3. To summarise the extent of the issue within Staffordshire the key headlines are outlined below:

Date:	Indicator:	National Average:	Staffordshire:
2019	% of RECEPTION AGE CHILDREN that were overweight or obese	22.6%	ALL **8 districts** were **ABOVE** the national average. **NEWCASTLE-UNDER-LYME District = 27.9%**
2019	% of YEAR 6 CHILDREN who were overweight or obese	34.3%	**5 districts** were **ABOVE** the national average. **CANNOCK district = 37%**
2019	% of ADULTS who were overweight or obese	62.3%	**6 districts** were **ABOVE** the national average. **CANNOCK district = 70%**
2019	% of physically inactive ADULTS aged 19 and over	21.4%	**5 districts** were **ABOVE** the national average. **EAST STAFFORDSHIRE district = 25.1%**

Table 1

4. Additional relevant data at district, county and national level are outlined within **Appendix 1.**

5. Obesity is a complex problem with many drivers which include our behaviour, environment, genetics and culture. **Appendix 2** contains an example system map of obesity.

6. Some of the consequences of obesity amongst children & young people are demonstrated in Figure 1 below.

Figure 1: Guidance Childhood Obesity: applying All Our Health 24 October 2019

7. Obese adults are seven times more likely to become a type 2 diabetic than adults of a healthy weight.

8. Not only are obese adults more likely to get physical health conditions like heart disease, certain types of cancer, and respiratory problems they are also more likely to be living with conditions like depression.

9. Babies born to obese women face several health risks, for example a higher risk of foetal death, stillbirth, and congenital abnormality[ii].

10. At least 2.6 million people each year die as a result of being overweight or obese[iii].

11. The financial burden of obesity is also significant. **In 2014/15**, the **cost of obesity and related ill health to the NHS in England was estimated at £6.1 billion per annum.** Obesity also impacts **local authorities' social care budgets: direct costs attributed to obesity are estimated at around £352 million per annum**. Conditions linked to obesity, such as type 2 diabetes, although not yet

systematically quantified, are likely to impose a significant additional social care burden.[iv]

12. Regarding the COVID-19 pandemic, several studies report an increased risk of adverse outcomes in obese or morbidly obese people[v].

Policy context

13. On the 27th July 2020 the Government unveiled a new **Obesity Strategy (Tacking obesity: empowering adults & children to live healthier lives)** to get the nation fit and healthy, protect themselves against COVID-19 and protect the NHS. At the same time PHE have launched a **'Better Health' campaign** which will call on people to embrace a healthier lifestyle and to lose weight if they need to, supported by a range of evidence-based tools and apps providing advice on how to reduce the waistline.

14. A range of additional national strategies / plans to tackle obesity include:

    a. the Department for Education's aim to improve PE and sport in primary schools through the PE and sport premium,

    b. the Department of Digital, Culture Media, & Sport's aim to improve participation in Sport across all ages, and

    c. the Department of Transport's commitment to increasing the number of walking and cycling trips undertaken to school (increasing the % of children aged 5 – 10 that usually walk to school from 49% in 2014 to 55% in 2025).

    d. The NHS Long Term Plan (2019). Chapter 2 focuses on more NHS action required regarding prevention & health inequalities with obesity identified as a priority.

    e. New statutory Health Education curriculum for schools from September 2020.

15. There is no one single solution. We can only tackle obesity if it becomes everybody's business and is prioritised and embedded in everything we do[vi].

16. Within Staffordshire obesity is a priority and is linked to the following local strategies and plans:

Strategy / Plan:	**Outcomes / Priorities:**
Staffordshire Health & Wellbeing Board	**Outcome/s:** To help people stay as well as they can to reduce the growing pressure on services. • More people living beyond age 64 in good health. **Priorities:** • Living well

Strategy / Plan:	Outcomes / Priorities:
	○ Making good lifestyle choices: ▪ Lifestyle and mental wellbeing
Staffordshire Families Strategic Partnership	**Outcome/s:** • Happy and healthy ○ All children and young people are resilient, happy and healthy, making choices that support wellbeing. • Live Well ○ Children, young people and adults are supported to make good lifestyle choices. **Priorities:** • Happy and Healthy ○ Improve children and families' mental health and emotional wellbeing. ○ Encourage communities to be more active and live healthier lifestyles. ○ Reduce avoidable hospital admissions. ○ Improve community networks that promote independence and local resilience.
Staffordshire & Stoke-on-Trent Health & Care Transformation Board (STP) STP Prevention Workstream	**Outcome/s:** • Support people to maintain good health or improve wellbeing, and reduce number of people who need health or social care support • Reduce the level of diabetes, obesity and heart disease in Staffordshire and Stoke-on-Trent by working to support people to avoid or reduce the risks of developing these conditions. **Priorities:** • Simplify and connect services to ensure a local health and care system that promotes independence and wellbeing. • Create a 'think family and community first' culture so that families are able to live independently and manage their own care needs. • Ensure access to information that supports wellbeing and healthier lifestyles. • Seeking to reduce the risks to wellbeing by improving where and how people live.
Staffordshire & Stoke-on-Trent Maternity Transformation Programme Board (MTPB)	**Outcome/s:** • Increase breastfeeding rates (initiation and 6-8 weeks) • Ensure a healthy weight for mothers and babies **Priorities:**

Strategy / Plan:	Outcomes / Priorities:
(responsible for the maternity element of the STP).	• Working in partnership with Public Health to undertake a range of developments to improve the health and wellbeing of women and babies
Staffordshire Early Years Advisory Board (EYAB) (sub-group of the MTPB)	**Outcome/s:** • To reduce the % of overweight / obese children (reception and Year 6) • To increase the breastfeeding rate **Priorities:** • To improve outcomes for young children and their families and reduce inequalities between families in greatest need and their peers in: ○ Child and family health and life chances.
District Family Improvement Boards (report to the EYAB)	As outlined above.
Building Resilient Families and Communities (BRFC)	**BRFC Criteria:** Living well, improving physical and mental health and wellbeing: Parents and children with a range of health problems **Indicators:** Families experiencing challenges with physical / mental health and wellbeing Child / adult experiencing health problems **Outcome:** Families are positively managing health issues

Table 2

17. Although there has been, and continues to be, a wide range of activities taking place which link to preventing or reducing obesity amongst children and adults, the % of overweight / obese children and adults continues to rise. Therefore, **we need to work differently in order to 'turn the curve'.**

Whole system approach (WSA)

18. Public Health England (PHE) definition - "A local whole systems approach responds to complexity through an ongoing, dynamic and flexible way of working. It enables local stakeholders, including communities, to come together, share an understanding of the reality of the challenge, consider how the local system is operating and where there are the greatest opportunities for change. Stakeholders

agree actions and decide as a network how to work together in an integrated way to bring about sustainable, long-term systems change".

19. The benefits to implementing a WSA include:

    a. Identifying, implementing and aligning actions that have wider impact across the local system

    b. Enabling reach into local communities, working with and through an extensive range of stakeholders including communities

    c. Recognising the range and complexity of the causes of obesity, supporting a system-wide approach to understand and address health inequalities

    d. Recognising and identifying local assets which can help build on the particular strengths of the community

    e. Involving local communities, in particular disadvantaged groups, can better reflect the local realities, help improve health and wellbeing and reduce inequalities

    f. Developing transferable workforce skills and capacity – applicable to other complex issues.

20. A WSA does **not** rely on additional financial resources; it is about making the best possible use of the resources already available to improve a shared outcome.

21. PHE have developed a comprehensive guide to implementing a WSA to obesity. The production of this guide involved 4 pilot local authorities (LAs). An additional 9 LAs were involved in 'testing' the guide; including Dudley Metropolitan Borough Council and Solihull Metropolitan Borough Council. Table 3 below outlines the main phases involved in implementing a WSA.

Phase:	Aim:	Key steps:
1: Set-up	Secures senior-level support and establishes the necessary governance and resource structure to implement the approach.	1. Engage with senior leaders to obtain their support. 2. Set-up a core working team to undertake the day-to-day operations and coordinate the approach. 3. Establish resources to support the process. 4. Secure the accountability, advice and support of a group pf senior stakeholders offering a broad range of expertise to ensure the approach has

Phase:	Aim:	Key steps:
		sufficient challenge, governance and resource.
2: Building the local picture	Builds a compelling narrative explaining why obesity matters locally and creates a shared understanding of how obesity is addressed at a local level.	1. Collate key information about obesity locally 2. Start to understand the local assets including community capacity and interest 3. Establish a comprehensive overview of current actions 4. Identify the departments, local organisations and individuals currently engaged in supporting work around obesity.
3. Mapping the local system	Brings stakeholders together to create a comprehensive map of the local system that is understood to cause obesity. Agreeing a shared vision.	1. Prepare for workshop 1: • Identify and engage wider stakeholders • Prepare presentation slides and add local information • Prepare facilitators to undertake system mapping 2. Deliver workshop 1: system mapping 3. Begin to develop a shared vision
4: Action	Stakeholders come together to prioritise areas to intervene in the local system and propose collaborative and aligned actions.	1. Prepare for workshop 2: • Create a comprehensive local system map • Prepare presentation slides and add local information • Prepare facilitators to support action mapping • Refine a draft shared vision 2. Deliver workshop 2: action planning 3. Develop a draft whole systems action plan 4. Refine the shared vision
5: Managing the system network	Maintains momentum by developing the stakeholder	1. Develop the structure of the system network

Phase:	Aim:	Key steps:
	network and an agreed action plan.	2. Undertake the first system network meeting 3. Present the finalised shared vision 4. Agree the action plan
6: Reflect & refresh	Stakeholders critically reflect on the process of undertaking a whole systems approach and consider opportunities for strengthening the process	1. Monitor and evaluate actions 2. Maintain momentum through regular meetings 3. Reflect and identify areas for strengthening 4. Monitor progress of the whole systems approach and adapt to reflect how the system changes over time

Table 3

Progress to date

22. Staffordshire County Council's (SCC) Cabinet Members and Senior Leadership Team endorsed the implementation of a WSA to obesity on the 23rd September 2020.

23. SLT & Cabinet Member champions / sponsors agreed as follows:

    a. Cabinet Member for Health, Care & Wellbeing: Cllr Johnny McMahon
    b. Chief Executive: John Henderson

24. A Core Working Team has been established and is meeting regularly.

25. An action plan has started to be developed for the first 3 (of 6) phases of the WSA.

26. Additional Commissioning Officers have been recruited to support the WSA.

27. Resource / support has obtained from SCC's Insight Team regarding collating key information / data about obesity (initially in the 3 pathfinder districts).

28. Expressions of interest have been obtained from district councils regarding the pathfinder / pilot areas. All 8 districts expressed an interest in the WSA; 6 of which expressed an interest to become a pathfinder / pilot area. The 3 districts identified as pathfinder areas are as follows:

    a. Staffordshire Moorlands
    b. East Staffordshire
    c. Cannock

29. A Stakeholder Engagement Plan is in development.

30. Stakeholder workshops to map the local system will be arranged; 1 in each of the 3 pathfinder districts from April 2021.

List of Background Documents/Appendices:

Appendix 1	District, County and National Obesity / Obesity Related Data
Appendix 2	Example System Map

Contact Details

Board Sponsor: Cllr Johnny McMahon, Cabinet Member for Health, Care & Wellbeing

Report Author: Karen Coker, Senior Commissioning Manager (Children's Public Health)
Tony Bullock, Lead Commissioner (Adults Public Health)

Telephone No: 07581 025413 / 07807 378957
Email Address: karen.coker@staffordshire.gov.uk / anthony.bullock@staffordshire.gov.uk

[i] Tackling Obesities: Future Choices – Project Report 2nd Edition (Government Office for Science)

[ii] Obesity in pregnancy: a study of the impact of maternal obesity on NHS maternity services (Heslehurst N et al, January 2007)

[iii] Global Strategy on Diet, Physical Activity and Health (World Health Organisation)

[iv] Making obesity everybody's business: A whole systems approach to obesity (Local Government Association November 2017).

[v] Disparities in the risk and outcomes of COVID-19 (Public Health England June 2020)

[vi] Whole Systems Approach to Obesity: a guide to support local approaches to promoting a healthy weight (Public Health England July 2019)

APPENDIX 1: District, County and National Obesity / Obesity Related Data

Table 1: % of RECEPTION AGE CHILDREN who are overweight or obese (2019)

Cannock	East Staffs	Lichfield	NUL	South Staffs	Stafford	Staffs Moorlands	Tamworth	STAFFS	NAT AVE
24.7%	24%	25%	**27.9%**	27.6%	22.4%	23.5%	23.4%	**24.8%**	**22.6%**

Table 2: % of YEAR 6 CHILDREN who are overweight or obese (2019)

Cannock	East Staffs	Lichfield	NUL	South Staffs	Stafford	Staffs Moorlands	Tamworth	STAFFS	NAT AVE
37%	34.4%	32.4%	36.1%	33.3%	33.2%	35%	36%	**34.6%**	**34.3%**

Table 3: % of ADULTS who are overweight or obese (2019)

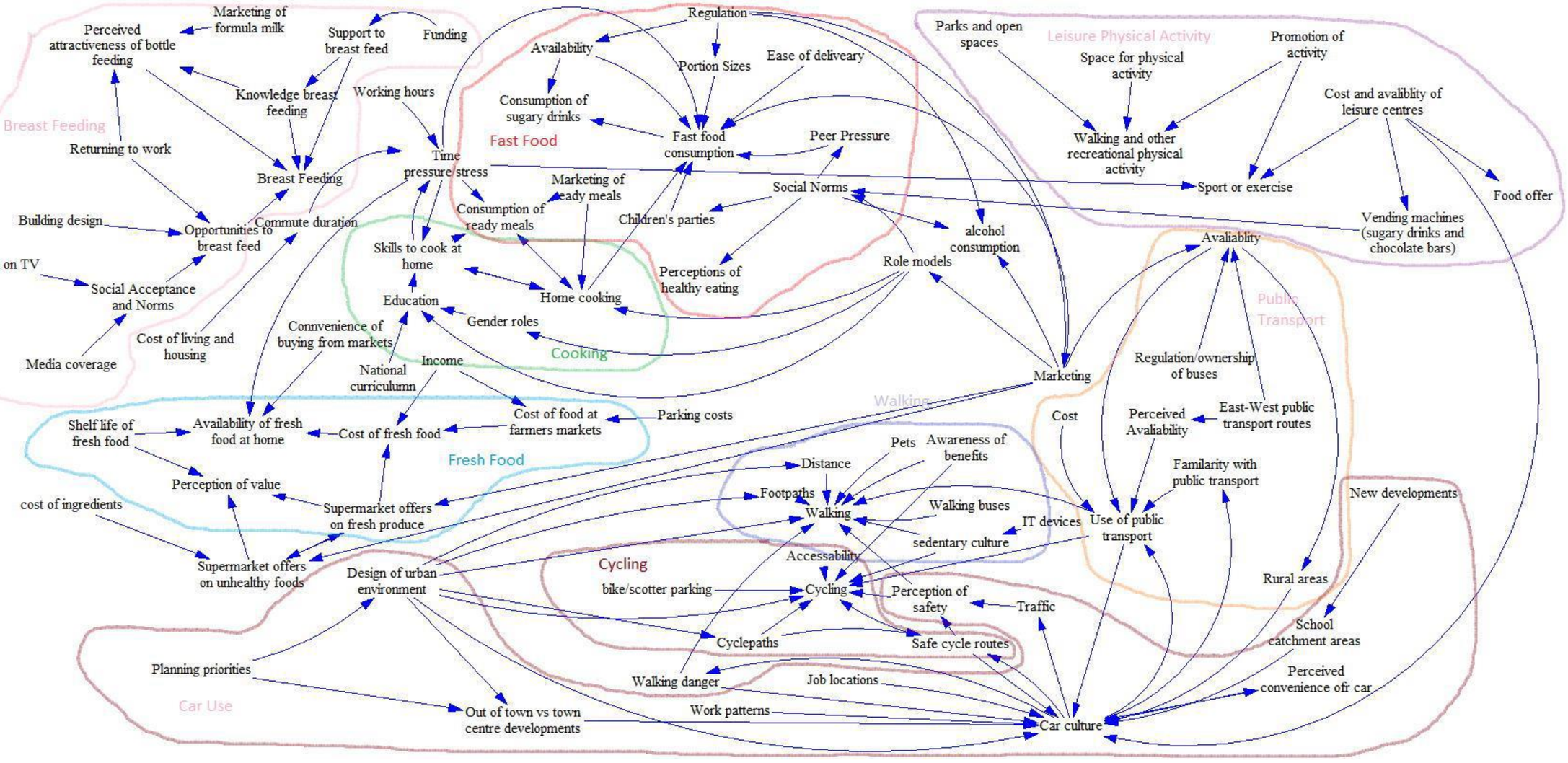
Cannock	East Staffs	Lichfield	NUL	South Staffs	Stafford	Staffs Moorlands	Tamworth	STAFFS	NAT AVE
70%	63.5%	68.6%	60.5%	62.7%	60.0%	63.1%	69.5%	**64.2%**	**62.3%**

Table 4: % of physically inactive ADULTS aged 19 and over (2019)

Cannock	East Staffs	Lichfield	NUL	South Staffs	Stafford	Staffs Moorlands	Tamworth	STAFFS	NAT AVE
21.9%	**25.1%**	22.7%	22.3%	19.9%	18.7%	19.7%	21.8%	**21.4%**	**21.4%**

Data source: Public Health England

APPENDIX 2: Example System Map



Staffordshire Health and Wellbeing Board – 04 March 2021

Integrated Care System Plan

Recommendations

The Board is asked to:

a. Consider the information provided and comment on the progress and priorities being made by health and care partners on the journey to an Integrated Care System (ICS).

b. Consider the information provided comment on the developments of a Strategic Commissioner function.

c. Consider the information provided comment on the developments of Integrated Care Partnerships (ICP).

d. Endorse the direction of travel and the proposal to becoming an Integrated Care System.

Background

1. Together We're Better is the local partnership, working together to transform health and care for the people of Staffordshire and Stoke-on-Trent.

2. It is one of 44 Sustainability Transformation Partnerships (STPs) in England. It brings together local NHS organisations, with Staffordshire and Stoke-on-Trent local authorities, the voluntary sector and the two Healthwatch organisations.

3. The Together We're Better Partnership has an agreed vision: Working with you to make Staffordshire and Stoke-on-Trent the healthiest places to live and work:

    a. Support you to stay well and independent by focusing on preventing ill-health and to self-care
    b. Treat you as a person, not as a set of health conditions or social care needs
    c. Make sure we are there when you need us, at the right time and in the right place
    d. Make health and care support available closer to your home
    e. Give mental health equal priority to physical health and wellbeing
    f. Make sure your experience of health and care is the best it can be.

4. NHS England published the **Long Term Plan** (LTP) in January 2019, which set out a phased development of improvements that all health and care systems are expected to deliver over the following five years.

5. Together We're Better responded to the priorities outlined by developing a **Five Year Delivery Plan,** with commitments and priorities for our population.

6. The majority of these priorities remain as first written, however the COVID 19 pandemic has highlighted the urgency in delivering on these actions, focussing on the system to make rapid changes and improvements.

7. This ICS Development Plan is linked to the **Five Year Delivery Plan** and includes the following structural commitments:

    a. Becoming an **Integrated Care System** by April 2021 that is clinically and professionally led, focused on system-wide sustainable improvement.
    b. Working together across health and social care to streamline the commissioning approach and to develop a system-wide **Strategic Commissioner**, which will align, and for some services, will be integrated with social care commissioning.
    c. Providers and commissioners will work together across primary, community and mental health services, including health and care professionals, along with voluntary and independent sector, to promote behavioural change and deliver service transformation co-ordinated by **Integrated Care Partnerships**.
    d. Strengthening primary and community services through developing sustainable **Primary Care Networks and the** implementation of integrated care teams.

8. In February 2021, the Secretary of State for Health and Social Care presented a 'white paper': *Integration and Innovation: working together to improve health and social care for all.*

9. At the heart of the legislative proposals, is the goal of joined up care for everyone in England. Instead of working independently every part of the NHS, public health and social care system should continue to seek out ways to connect, communicate and collaborate so that the health and care needs of people are met. Healthy, fulfilled, independent and longer lives for the people of England will require health and care services, local government, NHS bodies, and others to work ever more closely together. Different professions, organisations, services and sectors will work with common purpose and in partnership. This will be especially important when we seek to focus on the people and communities that are most in need of support.

10. The proposals seek to establish a statutory ICS in each ICS area. These will be made up of an ICS NHS Body and a separate ICS Health and Care Partnership, bringing together the NHS, local government and partners. The ICS NHS body will be responsible for the day to day running of the ICS, while the ICS Health and Care Partnership will bring together systems to support integration and develop a plan to address the systems' health, public health, and social care needs. Both bodies will need to draw on the experience and expertise of front-line staff across health and social care. ICSs will be accountable for outcomes of the health of the population.

11. The creation of a merged CCG is a necessary step on the journey towards the creation of an ICS from Staffordshire and Stoke-on-Trent. In February 2021, the GP membership of the six Staffordshire and Stoke-on-Trent CCGs voted in agreement for the proposal to merge.

STAFFORDSHIRE
HEALTH AND WELLBEING BOARD

List of Background Documents/Appendices:

NHS Long Term Plan (January 2019)

Government White Paper: Integration and Innovation: working together to improve health and social care for all (February 2021).

Appendix 1 - Staffordshire and Stoke-on-Trent Integrated Care Partnership Development Plan

Contact Details

Report Author: Tracey Shewan
Telephone No: 07548 212307
Email Address: tracey.shewan@staffsstokeccgs.nhs.uk

TOGETHER WE'RE BETTER

Transforming health and care for Staffordshire & Stoke-on-Trent

Staffordshire and Stoke-on-Trent
ICS Designation Development Plan

December 2020

Final Version

Foreword

The system response to Covid-19 has demonstrated the personal and collective commitment, we have as a system, to work together in the interests of our workforce and population. Equally there has been considerable learning from how system partners responded to the initial impact of Covid-19 and the subsequent ongoing response.

We will continue to capture and build on this learning to find ways to embed the improved ways of working and collaboration. System partners also recognise that there are perhaps 4 things that define external opinions of us as a system-

1. System relationships. Partners have worked hard to tackle some of the previous long-standing relationship issues that existed in the system. Good progress has been made on this front. However, there is an acceptance that we need to continue to focus on this area to ensure that we can bring constructive challenge and honest disagreement to the table without impacting on the relationship. The development of our OD approach will help with this at a senior level and maturity of relationships will also develop.
2. The financial position of the system. Significant progress has been made in this regard with the system expected to deliver on its breakeven position for 20/21. Whilst we recognise that this is an unusual year, we continue to take great strides in terms of setting a different financial strategy and an aligned approach that will support the 3 spatial levels that will exist with an ICS. The bold steps taken to move to the Intelligent Fixed Payment Approach have set the necessary foundations to progress the place-based delegation discussions
3. Urgent Care. The systems response to Covid-19 has demonstrated an ability to work collectively and in an integrated manner to best support each other and to focus on the best outcome for the resident / patient. There is more to do though, and we are committed to build on the Covid-19 response in a way that tackles some of our continued challenging performance across the urgent care agenda.
4. Forming a single strategic commissioning organisation (SCO). System partners recognise the importance of ensuring that the GP membership vote to support the merger of the 6 CCGs. This is recognised as a system responsibility and a priority that we will deliver on. Positive progress has been made in recent discussions with the LMC and with lead GPs across the system.

- System partners are clear that ICS designation is not an end, but rather, is a process that continues to evolve as the system tackles the challenges that it is facing. For our population, greater integration would allow them to tell their story once, navigate confidently between organisations and experience greater continuity of care. By working together as organisations, we can take big decisions around how and where care is delivered to make the most impact. This will include reorganisation of care to deliver support closer to home and helping people to live independently in their own home for as long as possible.

- We recognise that across our system there are very real health inequality challenges, many of which have worsened as a result of the Covid-19 pandemic. This is not an acceptable position and not one that sits comfortably with any of us. We have to do more to tackle these inequalities, but we know that one organisation working in isolation will not be able to solve these issues. We have to work differently at every level, and we have to make the local communities the focus of our approach to care.

- Our staff are undoubtedly our greatest asset and it is essential that we create the environment and conditions where they can deliver outstanding care in a coordinated and joined up manner. Too many times in the past we have allowed artificial barriers or boundaries to impede this. Our commitment is to find solutions to these blocks and to enable more integrated care to be the ever-increasing norm rather than the case study or the exception. The staff in our organisations are already at the forefront of integrated working and there are many examples of the innovative work that they have been able to achieve in current organisational structures. It is important to us that staff feel valued and are able to work in the way that enables them to provide high quality, compassionate and safe care.

- This development plan sets out how we will embrace the opportunities that integration provides for us and use it to tackle the health inequality challenge that exists. This is an exciting period and one that we embrace fully as we look to ensure that the residents of Staffordshire and Stoke-on-Trent get the very best health and care that they deserve.

Prem Singh
Independent Chair
Together We're Better

Who we are and who are our partners

- Around 1.1 million people live in Staffordshire and Stoke-on-Trent, across a geographical area of 1,048 square miles.
- Together We're Better is the partnership working together to transform health and care for the people of Staffordshire and Stoke-on-Trent.
- Together We're Better is one of 44 Sustainability and Transformation Partnerships (STPs) in England, which brings together local NHS organisations, Stoke-on-Trent City Council, Staffordshire County Council, voluntary, and the two Healthwatch organisations. Our partners are committed to changing the way we provide health and care, so that it better meets the needs of our local people and improves everyone's lives. (Diagram 1)
- Our partner organisations work together across two local authorities and six clinical commissioning groups (CCGs) as part of Together We're Better.

Diagram 1: Partners

Who we are and who are our partners

- The two local authorities within the footprint are Staffordshire County Council and Stoke-on-Trent City Council, which are both upper tier local authorities.
- Staffordshire County Council is split into eight districts and boroughs: Cannock Chase, East Staffordshire, Lichfield, Newcastle-under-Lyme, South Staffordshire, Stafford, Staffordshire Moorlands, and Tamworth.
- The clinical commissioning groups are:
    - North Staffordshire CCG
    - Stoke-on-Trent CCG
    - Stafford and Surrounds CCG
    - East Staffordshire CCG
    - Cannock Chase CCG
    - South East Staffordshire and Seisdon Peninsula CCG
- As a partnership, we work with a range of other organisations across the area to deliver care, including:
    - Acute trusts including University Hospitals of North Midlands NHS Trust (UHNM), University Hospitals of Derby and Burton NHS Foundation Trust (UHDB) and The Royal Wolverhampton NHS Trust (RWT)
    - Mental health trusts including North Staffordshire Combined Healthcare NHS Trust (NSCHT) and Midlands Partnership NHS Foundation Trust (MPFT)
    - NHS community trusts, including University Hospitals of Derby and Burton NHS Foundation Trust and Midlands Partnership NHS Foundation Trust (MPFT)
    - 151 General Practices, Vocare (urgent care services) and West Midlands Ambulance Service
- The local health and social care service landscape is complex. In terms of NHS capacity, there are five other main acute hospitals on the borders of the STP footprint that deliver services to Staffordshire and Stoke-on-Trent population:
    - New Cross (The Royal Wolverhampton NHS Trust)
    - Good Hope (University Hospitals Birmingham NHS Foundation Trust)
    - Walsall Manor (Walsall Healthcare NHS Trust)
    - Royal Derby (University Hospitals of Derby and Burton NHS Foundation Trust)
    - Leighton (Mid Cheshire Hospitals NHS Foundation Trust)
- NHS elective services are also provided to the local population by the following non-NHS providers: Nuffield North Staffordshire, Nuffield Derby, Nuffield Wolverhampton, Rowley Hall, Malling, Ramsey, Spire Little Aston, and Spire Regency.
- The voluntary, community and social enterprise (VCSE) sector plays an important role in providing services in the community and we recognise their ability to access those who may be considered ‘seldom heard’ but may in fact be the daily contact for the sector.

Introduction

- NHS England published the NHS Long Term Plan (LTP) in January 2019 that sets out a phased programme of improvements that all systems are expected to deliver on over the next five years.

- The STP responded to the national priorities set out in the LTP with a Five-Year Delivery Plan (FYDP). The plan set out our priorities and commitments to the population of Staffordshire and Stoke-on-Trent.

- The majority of the objectives of the LTP and our FYDP remain as valid now as when first written, but Covid-19 has highlighted the urgency with which we should take action, and the need to focus on working as a system to make rapid change to improve services.

- The impact of Covid-19 has meant that all our plans and ways of working have needed to be reviewed and updated to ensure they remain relevant and appropriate for the challenges that we face.

- The response to the Covid-19 pandemic demonstrated our personal and collective commitment, as a system, to work together in the interests of our workforce and population: we provided (and relied upon) mutual aid, we coordinated PPE, we enabled flexible staffing, increased frequency of communication messages and ensured we shared vital clinical and operational intelligence.

- Our Phase 3 submission set out how we would look to tackle some of the resulting issues from the initial Covid-19 response and restore services to meet the needs of the population that we serve. This submission helps to ensure a line of sight through from the LTP to the systems FYDP submission and through into the ICS designation process

- Staffordshire and Stoke-on-Trent have a diverse healthcare system, comprising both rural and urban areas, as well as extremes of affluence and deprivation, as well significant health inequalities. In order to address these inequalities, a place-based system of care is crucial so that clinicians and professionals, from areas with very different healthcare needs, are empowered to deliver different models of care.

- We have an established Health & Care Senate (H&CS) which has had increased focused in response to Covid 19; demonstrating the strength in working together across Staffordshire & Stoke on Trent as health, care and clinical leaders.

- This document sets out our development plan around how the system will continue to collaborate and deepen its approach to partnership working to tackle the challenges set out in the FYDP, whilst continuing to respond to the Covid-19 pandemic.

- It is essential that this development plan be read in conjunction with the system wide Five-Year Delivery Plan and the Phase 3 Recovery Plan. Each of these documents sets out some of the population and health inequality challenges. Read together they provide a compelling evidence base to support the need for integration of services that are focussed on the resident being at the heart of everything that we do.

- For residents, greater integration would allow people to tell their story once, navigate confidently between organisations and experience greater continuity of care. By working together as organisations we can take big decisions around how and where care is delivered to make the most impact. This could include reorganisation of care to deliver support closer to home and helping people to live independently in their own home for as long as possible.

- Staff in our organisations are already at the forefront of integrated working and there are many examples of the innovative work that they have been able to achieve in current organisational structures. We want to remove more barriers to let people work in the way that they already know makes the most sense for local people. It is important to us that staff feel valued and are able to work in the way that enables them to provide high quality, compassionate and safe care.

Our Vision and Aims – Long Term Plan submission

Diagram 2

Our vision is to ***make Staffordshire and Stoke-on-Trent the healthiest places to live and work.***

This means:

1. Helping our population live well, for longer, and supporting you to be as independent as possible so we can be there when you need us.

2. Delivering care as close to home as possible, ensuring that experience of health and care is the best it can be.

3. Treating people rather than conditions and giving mental health equal priority to physical health.

Our aims are to:

1. Promote prevention strategies and empower people for self-care and shared decision making.

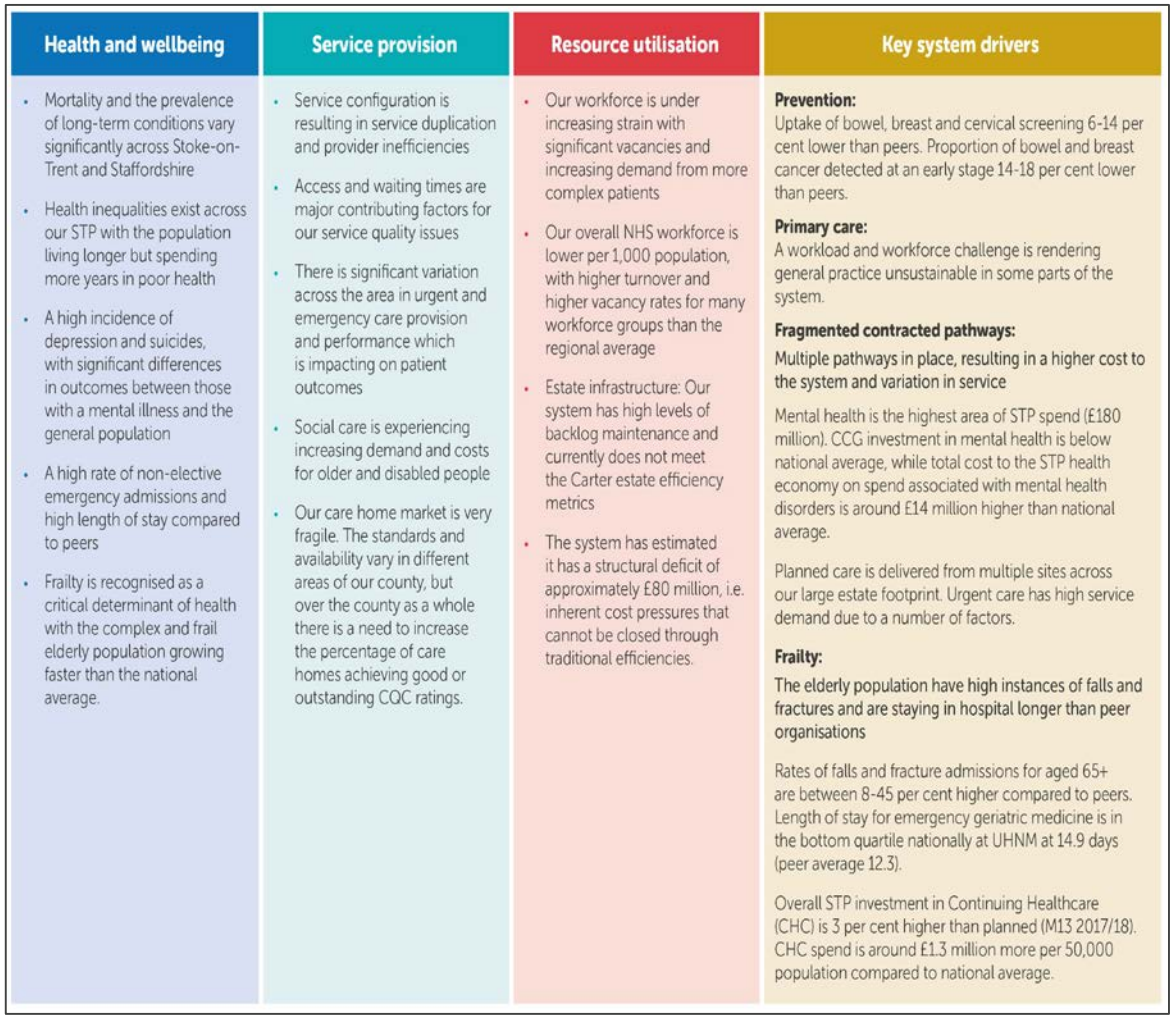
2. Co-ordinate and integrate care, with early intervention and step-down possible where appropriate and greater use of digital technologies.

3. Reduce unwarranted clinical variation, through providing evidence-based, effective care and using our workforce in the best way.

System Challenges and Opportunities

- We have been fortunate to be supported by regulators in the development of a range of strategic system diagnostics and thematic reviews. There are a range of population health and wellbeing drivers along with some key system drivers that were identified as part of the system diagnostic work.
- The drivers and issues identified are outlined in diagram 3 and have been tested and validated with partners. These areas will continue to inform our decision-making and focus our transformation agenda.
- A fundamental aspect of the system wide ICS Development Plan is how we use and evolve the initial work (that delivered an agreed and ambitious system FYDP) in order for us to meet the challenges of Restoration and Recovery from Covid-19.
- There is significant learning from the Covid-19 response that will support the ICS delivery programme and we will ensure that these do not sit in isolation of each other.
- Partners from across the system are aware that the frameworks developed to support delivery of the FYDP will need to be reviewed and updated to ensure that they remain fit for purpose given the impact of Covid-19.
- The frameworks that exist, such as the anchor institution approach, should enable the NHS to use its scale and size to develop better opportunities for local people. We need to maximise on these frameworks and approaches in manner that supports the development of our future workforce but also creates local momentum to improve the ambitions of local people.

Diagram 3: Drivers and Issues



Health and wellbeing	Service provision	Resource utilisation	Key system drivers
• Mortality and the prevalence of long-term conditions vary significantly across Stoke-on-Trent and Staffordshire • Health inequalities exist across our STP with the population living longer but spending more years in poor health • A high incidence of depression and suicides, with significant differences in outcomes between those with a mental illness and the general population • A high rate of non-elective emergency admissions and high length of stay compared to peers • Frailty is recognised as a critical determinant of health with the complex and frail elderly population growing faster than the national average.	• Service configuration is resulting in service duplication and provider inefficiencies • Access and waiting times are major contributing factors for our service quality issues • There is significant variation across the area in urgent and emergency care provision and performance which is impacting on patient outcomes • Social care is experiencing increasing demand and costs for older and disabled people • Our care home market is very fragile. The standards and availability vary in different areas of our county, but over the county as a whole there is a need to increase the percentage of care homes achieving good or outstanding CQC ratings.	• Our workforce is under increasing strain with significant vacancies and increasing demand from more complex patients • Our overall NHS workforce is lower per 1,000 population, with higher turnover and higher vacancy rates for many workforce groups than the regional average • Estate infrastructure: Our system has high levels of backlog maintenance and currently does not meet the Carter estate efficiency metrics • The system has estimated it has a structural deficit of approximately £80 million, i.e. inherent cost pressures that cannot be closed through traditional efficiencies.	**Prevention:** Uptake of bowel, breast and cervical screening 6-14 per cent lower than peers. Proportion of bowel and breast cancer detected at an early stage 14-18 per cent lower than peers. **Primary care:** A workload and workforce challenge is rendering general practice unsustainable in some parts of the system. **Fragmented contracted pathways:** Multiple pathways in place, resulting in a higher cost to the system and variation in service Mental health is the highest area of STP spend (£180 million). CCG investment in mental health is below national average, while total cost to the STP health economy on spend associated with mental health disorders is around £14 million higher than national average. Planned care is delivered from multiple sites across our large estate footprint. Urgent care has high service demand due to a number of factors. **Frailty:** The elderly population have high instances of falls and fractures and are staying in hospital longer than peer organisations Rates of falls and fracture admissions for aged 65+ are between 8-45 per cent higher compared to peers. Length of stay for emergency geriatric medicine is in the bottom quartile nationally at UHNM at 14.9 days (peer average 12.3). Overall STP investment in Continuing Healthcare (CHC) is 3 per cent higher than planned (M13 2017/18). CHC spend is around £1.3 million more per 50,000 population compared to national average.

Strategic Framework

- In response to our challenges and to deliver the Long-Term Plan, we have developed a strategic framework (diagram 4) that captures our vision, aims, objectives, and delivery priorities in a way that is accessible to our staff and our partners.

- We have used a series of strategic tests to model our thinking and provide a framework as we develop our maturity into an integrated care system:

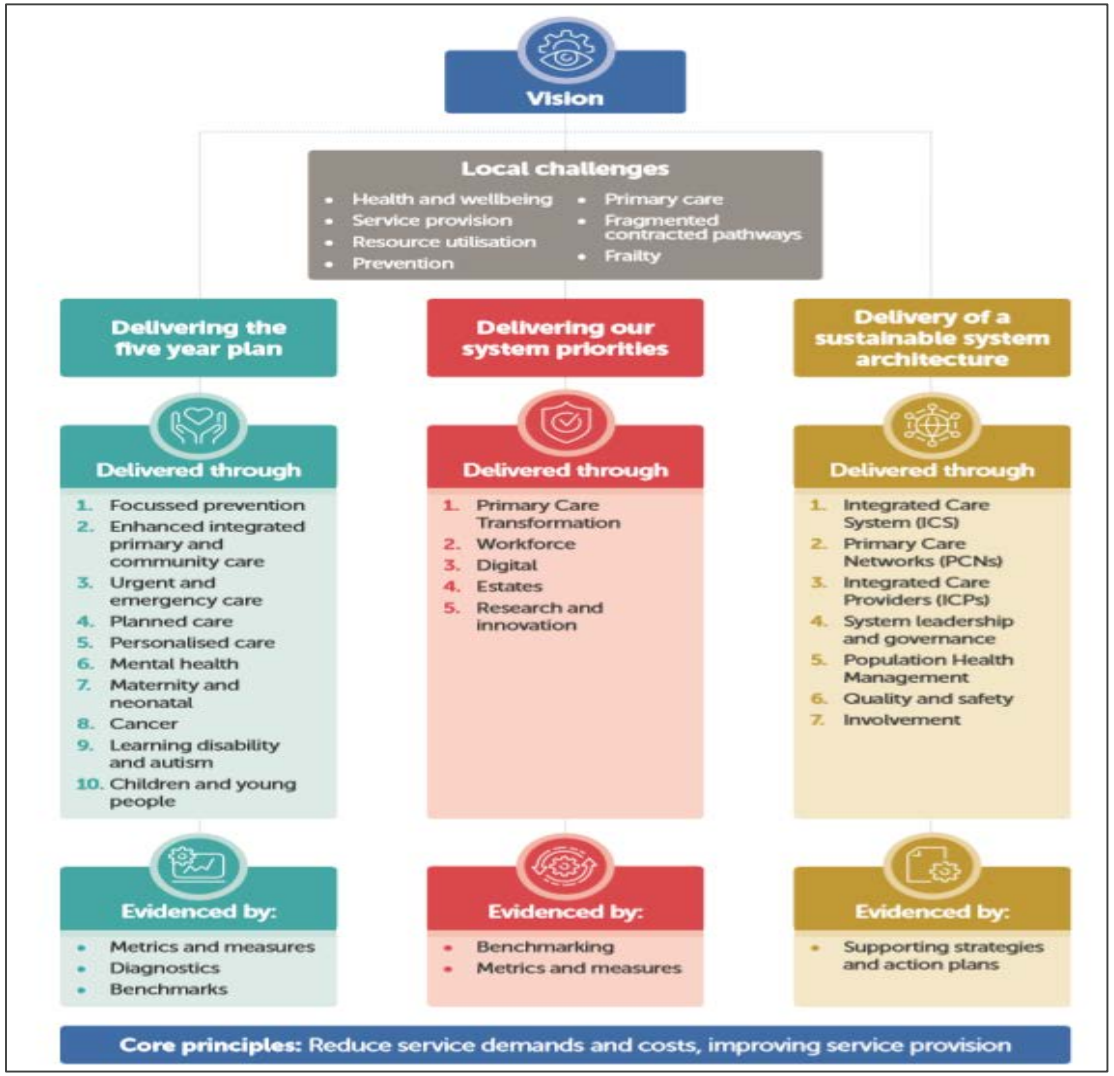
    - Do we have the right level of care for our population?
    - Are we doing this at / in the right place and at the right time?
    - Are we as efficient as we should / could be?
    - Do we have the right outcomes for people, communities and our population?

- We will use this framework to inform and align our organisational operational plans and as the baseline against which we will agree projects and schemes to deliver improvements.

We recognise that this will need to be refreshed and revisited as the system continues to develop. However, it is essential to recognise that we are not starting from a blank sheet of paper and that the local challenges are not new.

- Our approach to integration, based around the strategic framework, enables us to genuinely tackle these issues and develop solutions in the best interests of the population that we serve.

Diagram 4: Strategic Framework



Delivering the Five-Year Delivery Plan and Phase 3 Recovery Plan

The ICS Development Plan is aligned to our Five-Year Delivery Plan to ensure that we continue to pursue our ambition to make Staffordshire and Stoke-on-Trent the healthiest places to live and work by:

- Treating people rather than conditions and giving mental health equal priority to physical health
- Becoming an Integrated Care System by April 2021 that is clinically and professionally led and focussed on system-wide, sustainable improvement
- Working in partnership to streamline the commissioning approach and to develop a system-wide strategic commissioner across health and care, which will align, and, for some services, be integrated with social care commissioners
- Providers and commissioners working collaboratively across primary, community and mental health services, including health and care professionals and the voluntary and independent sector to promote behavioural change and deliver service transformation – co-ordinated by Integrated Care Partnerships
- Strengthening primary and community services through developing sustainable primary care networks and the implementation of integrated care teams to cover the entirety of the population – adopting a population health management approach and driving the local place-based integration agenda
- Setting clear aims and outcomes for our clinical models of care, aligning with a strength-based social care model, which will continue to evolve as we listen to our public
- Transform our urgent and emergency care offer that reduces fragmentation and is focussed on meeting the needs of those in urgent need of health and care services
- Delivering effective elective services that are pathway-based and ensure activity is evidence-based and improves outcomes
- Tackling the prevention agenda at every level for our main long-term conditions of CVD, respiratory and diabetes
- Delivering increased value in everything that we do with a focus on the sustainability of our health and care system

Our aspirations for the success of this journey will result in the delivery of our key objectives as determined within the FYDP, deliver the local priorities that are unique to Staffordshire and Stoke-on-Trent, and create a sustainable and integrated system for health and care.

Learning from Covid-19 and Impact of National Legislative Proposals

Learning from Covid-19

Covid-19 has undoubtedly been one of the greatest challenges the system has faced. Against that back drop there is a constant theme of collective pride in the responsive action which was mobilised and in the many specific improvements and innovations across health and care. We acknowledge the lives lost or damage experienced across our population and amongst public servants and that further strengthens our resolve to make our local health system the very best it can be for the population that we serve. Together we have a collective determination to learn from the experience so that improvements can be made in the future management of Covid-19 or learning embedded into mainstream practice.

As part of the regional work undertaken on learning from Covid-19 we have looked to focus our efforts on a number of main themes:

- The clear and common purpose which was understood by all health and care partners and their workforce was hugely empowering. This was supported by a strong sense of freedom to act.
- The robust governance arrangements that were implemented were felt to be supportive, enabling rapid decision making and implementation.
- The removal of the existing financial arrangements facilitated cross organisational working. Investment decisions were fast tracked, often in care delivery models which crossed organisational boundaries.
- Consistent and prolonged high levels of energy from staff with the emergence of new leaders from a range of organisations and professions, many with clinical backgrounds. This assisted the adoption and spread of new approaches.
- A reflection on our focus on place. This was where services and multi-organisational responses came together and there is an even stronger desire to really now strengthen and support local people in their own communities. We will make this a central feature of our continued transformation and improvement plans.
- The availability of co-ordinated data around population health and health inequalities has been shown even more starkly. We have to prioritise this over the coming months and use intelligence to direct our efforts

Legislative Proposals

The publication of 'Integrating care: Next steps to building strong and effective integrated care systems across England' sets out a clear direction of travel regarding the future of integrated care for the NHS. We broadly welcome the proposals that are detailed in the paper. However, there is recognition that any proposed change such as this can be unsettling for staff that are directly affected by it. It is our collective responsibility to ensure that we work as a system to maximise on the skills and attributes that currently support our health and care system.

We have reviewed the proposals, the ICS consistent operating arrangements and maturity matrix to establish a select number of key priorities that will help us to make significant progress. These are as follows:

- building on the success and learning from Covid-19
  - embedding the shift to agile leadership and decision making,
  - refresh and strengthen the common purpose that sets us apart as a system,
  - digital and innovative approaches to delivering care
- stepping up efforts to build on place through our approach to clinical and professional leadership and provider collaboratives;
- rapidly progressing transformation work – we are part of the first 6 systems in the Midlands to work on the GIRFT/ Model Health System work that is being led out by the region and we are keen to roll the approach t across a number of pathways;
- stepping up our efforts to work collaboratively to tackle the wider determinants of health and well-being,
  - focussing the NHS contribution towards social and economic development using frameworks for collective effort such as anchor institutions
  - building a different relationship with our voluntary and community sector partners that links us into communities and closer to the challenges
  - fully supporting the children and young people agenda across health and local government to give local children the very best start in life
- developing as a learning system, further OD/system effectiveness work such as PCN development and board effectiveness;
- an immediate demonstration of openness and transparency - board meetings in public (alternate months from February 2021) with papers published and in the public domain.

Strategic Risks

Risk	Mitigations
Insufficient system resource and capacity identified to assure and deliver the ICS Development plan.	• A transparent work programme that constituent organisations lead. • ICS / STP budget and resource to be reviewed and agreed in line with the delivery of the consistent operating requirements. • Agree 2021/22 budget with system partners based on review of functions required. • Agree budget hosting arrangements until primary legislation in place. • Review of core team resource required as part of the functional review and agree any new posts required to support transition to ICS.

Impact of a 'negative' vote from the CCG membership, to forming a single strategic commissioning organisation (SCO).	• Campaign Steering Group (CSG) discussions and process; supported by
	  • NHSE approved Communications & Engagement Plan for Merger;
	  • Additional CCG Clinical Chair and Executive discussions with key opinion formers / clinical leaders - e.g. Local Medical Committees, Primary Care Network Clinical Directors and GP Federations
	  • Member-facing narratives developed for financial strategy and devolved functions / staff / budgets to support ICP development during transition;
	• "Protected Primary Care" pledges included.
	• STP/ICS Chair and Executive Lead working collaboratively with the CCG Accountable Officer and CCG Clinical Chairs to promote the merger as part of the direction of travel to becoming an ICS.

Retention of valued workforce due to the national ICS proposals and an anticipated further period of organisational change.	• A detailed plan to support delivery of the Strategic Commissioner Development with an Executive Lead. • A communications plan and HR plan to support the workforce regarding alignment of posts to Strategic Commissioning or ICP based upon the functions.
PCN and place based engagement with delivery of Population Health Management (PHM) during Covid-19, acknowledging clinical time now until February is at a premium	• Progress is being made with the PHM Strategy readiness phase and foundations of PHM are in place. • PHM approach agreed and signed off through the Health and Care Senate.
Integration of Health and Social Care due to the spend assessments Local Authorities are currently subject to.	• Joint working on key service changes impacting health and social care looking at pathways in their entirety within existing budgets and identifying joint efficiencies. • Identification of lead commissioner arrangements and pooled budgets. • Moving towards joint posts working across health and social care.

Summary of Alignment of Development Plan Actions and Delivery Priorities

ICS Establishment Priorities	ICS Delivery Priorities	Development Plan Alignment (minimum operating requirements)	Impact
Development and implementation of our future model of care Underpinned by: 1. strong place based approach to care through our ICPs; 2. strategic commissioning arrangements that support a focus on outcomes and are underpinned through population health management; 3. simplified and understood governance; 4. integrated reporting that adds value and enables partners to focus their collective efforts in the right areas; 5. Clinical and professional leadership that is core to everything that we do and supports decision making as close to the resident as possible.	**Integrated delivery of UEC priorities to enable safe navigation of winter and future Covid-19 waves** • Digital first approach where this adds value and improves outcomes. • Agreed priority projects refreshed. **Restoring Elective and diagnostic capacity** • Clinical prioritisation of waiting lists. • Improve and maintain cancer pathways and support diagnostic developments. **Integration of Primary Care and Community Services** • Support development of Primary Care Networks (PCN) • Alignment of community physical and mental health services around a PCN to meet population needs. • Increased collaboration with local authority (LA) and Voluntary Community and Social Enterprise (VCSE) partners. **Health Inequalities** • Detailed review and refresh of current approach. **Children and Young People** • Alignment to refreshed LA strategies and targeted approach to joint commissioning. **Mental Health** • Strong crisis response integrated into community based offer. • Community transformation programme with all partners.	**System Planning/System Functions** • Develop and embed System Outcomes Framework. • Maximise system learning from Covid-19. • Develop our approach and implement population health management (PHM). • Finalise and embed system-wide approach to managing Finance, Quality and Performance. • Update Five-Year Delivery plan through reprioritisation exercise for 2020/21. • Finalise Operating Model confirming work at System, Place and Neighbourhood levels. • Estates Programme to oversee system-wide programme, future prioritisation and capital funding bids. • A system capital prioritisation and risk criteria developed. • Support financial stability and joint decision-making on investments, while holding the system to account for effective delivery. • Take a proactive stance on self-assurance, earning autonomy from our regulators to self-regulate on most issues.	• Undertaking the development Plan actions will put in place the key enablers to drive the development of integrated models of care in areas detailed in our delivery priorities. • Build on the approach of the Intelligent Fixed Payment (IFP) model to further strengthen the collaborative approach to developing solutions and reducing avoidable transactional costs. • Create a willingness for partners to invest outside of existing organisational boundaries to support transformation and develop essential social infrastructure. • Set clear outcome improvement targets at both system and place level to enable demonstration of delivery. • Use PHM to prioritise effort and to show outcomes in tackling the health inequality challenges. • Enable us to use our collective workforce resources more wisely, and support our staff to work in different ways with a “system” ethos.

Summary of Alignment of Development Plan Actions and Delivery Priorities

ICS Establishment Priorities	ICS Delivery Priorities	Development Plan Alignment (minimum operating requirements)	Impact
Transition of STP Governance to ICS Governance refreshed for system decision making and accountability for system strategy, performance and planning.	• Put our residents first, delivering person-centred care, close to home, and give them confidence that the changes we are making work well for them. • Support communities to thrive, through improved education, employment and economic growth, attracting investment to our area. • Integrated reporting underpinned by the principle of subsidiarity. • Alignment of priorities with the two Health and Well Being Boards and use necessary governance to support improved outcomes – challenge duplication and bureaucracy.	**System Leadership and Governance** • Appointment of ICS Lead Director. • Potential further additions to ICS Core Team as per the nationally indicated direction of travel with NHSE/I Board paper on options for primary legislation. • ICS Board to meet in public and for papers to be available to the public. • Focussed organisational development approach to support ICS Board membership development – support to have challenging conversations and build on previous OD work. • Distributive leadership approach.	• Clear and owned transition to ICS status with clarity on partners roles and responsibilities. • Governance approach that is light touch and proportionate to support agile decision making. • Clinical and professional leadership empowered to make decisions and then supported to implement at pace.
Developing and ensuring system accountability within, Safety, Quality, Performance and Finance.	• Delivery of Phase 3 submission with refreshed trajectories. • Integrated approach to reporting that reduces burden on individual organisations but improves timeliness of decision making.	**System Leadership and Governance** • Refresh of STP / ICS governance. • ICS / STP budget and resource to be reviewed and agreed in line with the delivery of the consistent operating requirements. • Strengthening of core STP team to support transition to ICS. • Refresh and update of current programme boards and transformation plans to ensure that there is clarity and alignment with system wide priorities. • Dedicated development time for committees and executive.	• Established ICS that meets the core operating requirements.

Executive Summary: Progress Against Consistent Operating Requirements

	Theme	Strengths	Development plan
System Functions	System Capabilities	• An established System Strategy, Finance and Performance (SFP) Committee • A System Performance and Assurance Working Group (SPAWG) • Confirmation of successful Wave 3 PHM Development Programme application • An established Health and Care Senate (H&CS) at ICS level with health inequalities as a priority • Investment in a central communications and engagement resource • System workforce planning has taken an 'open book approach' • Providers, Local Authorities, WMAS and GP practices are partners in the Integrated Care Record (ICR) • Commissioned the National Development Team for Inclusion (NDTI) to support in the development and delivery of a Community Led Support (CLS) programme.	• Finalise and embed system-wide approach to managing Finance, Quality and Performance • Agreed way of working to deliver PHM at scale to inform service and system change and integration • Communications and engagement team supporting the health inequalities programme, with a focus on reaching seldom heard groups • Consistent system HR, OD and recruitment processes, policies and programmes to support a system workforce • Continued development of the ICR
	Streamlined Commissioning	• A confirmed and finalised CCG merger timeline and roadmap • A detailed plan to support delivery of the Strategic Commissioner Development • A shared care record • During Covid-19 worked increasingly more as partners rather than commissioners and providers	• Achieve single CCG covering the STP footprint by April 2022 • Implement the plan to deliver a Strategic Commissioner function • Deployment of personal health records application • Develop work to plan and deliver specialised services as locally as possible
System Planning	System Plans	• System approach to developing Phase 3 recovery plans • An agreed Five-Year Delivery plan (FYDP) in response to the long term plan • Submission of a system Phase 3 Recovery plan agreed by relevant organisational boards • ICP plans outlining priorities identified in the summer of 2020 • A system ICS development plan • Part of the first 6 systems in the Midlands to work on the GIRFT/ Model Health System	• Stocktake of system plans to be completed • UEC plan and priority areas to be reviewed and refreshed • Covid-19 lessons learnt review to be progressed • Develop the system level strategic framework and system operating plan • Development of Digital Financial planning
	Capital and Estates Plans	• A system estates plan and strategy, rated "Good" • A System Capital Prioritisation Group to support a system by default approach. • System Local Estates Forum	• A system capital prioritisation and risk criteria • A system Estates Strategy (covering capital and estates), to include disposals • An agreed broader system section 106 policy
System Leadership and Governance	Leadership Model	• ICS Independent Chair appointed and in place • Clinical and professional input provided by the H&CS • A health inequality executive at board level within each organisation and a system inequalities lead • ICPs have been developed with PCNs at their heart • Provider collaboration across a number of levels	• Appoint to ICS Lead Director • Ongoing leadership development of health and care professionals • Develop clear and shared vision for ICPs aligned to transition towards strategic commissioning • Development of provider collaboration – vertical and across neighbouring STPs where this makes sense and is in the best interest of our residents
	System-Wide Governance	• Agreed terms of reference and membership of the ICS Partnership Board (ICS PB) • System Strategy Finance and Performance Committee • Good relationships with the Overview and Scrutiny Committees • H&CS, Healthwatch and voluntary sector partners on the ICSPB • Robust foundations locally for capturing the patient voice to inform and support transparency of the work at ICS and ICP level. • A culture of transparency, openness and collective ownership in relation to finance	• Progress the ICS PB to meet in public and to publish its papers • Integrated quality, finance and performance dashboard reported into the ICSPB • Delegation of financial responsibility to ICPs • A financial strategy that articulates how the system and the organisations within it will deliver the financial objectives and targets

Self-assessment and areas of development:
Consistent operating requirements

Self Assessment: System Capabilities

Theme	Strengths	Development Plan
System capabilities in place to perform the dual roles of an ICS, to co-ordinate transformation activity and collectively manage system performance, clearly defined at system, place and neighbourhood. These will include areas such as population health management, service redesign, provider development, partnership building and communications, workforce transformation, and digitisation. The system should also agree a sustainable model for resourcing these collective functions or activities. NHSEI will contribute part-funding for system infrastructure in 2020/21. Confidence in the system leadership to resolve current performance challenges	*Co-ordination of Transformation - System, Place and neighbourhood* • Agreed terms of reference and membership of the ICS Partnership Board (ICS PB) • An agreed FYDP. • An ICP Programme Board to coordinate ICP development activity. • A detailed ICP plan developed to support achievement of the critical path of ICP development. • Each ICP has aligned Director of Strategy capacity to provide the connection back to individual organisation and system wide transformation activity. • We have adopted an 'asset based' approach which means each ICP can make visible and value the skills, knowledge and connections that already exist in our communities and build on locality-focussed identities and groups. • We have commissioned the National Development Team for Inclusion (NDTI) to support us in the development and delivery of a Community Led Support (CLS) programme. *Collective Management of System Performance* • An established System Strategy, Finance and Performance (SFP) Committee. • A System Performance and Assurance Working Group (SPAWG). • Strong system delivery of mental health standards. • Recognition of areas e.g. urgent care where we have struggled to meet emergency care standards. • Significant progress in delivery of cancer standards. Acute Trusts working through cancer hub to ensure opportunities for mutual aid are exploited. *Resolving performance challenges* • Consistent approach to performance reporting and agreed data sets • Honesty of challenge and debate with agreed actions set out • Collaborative approach to problem solving • Build on system response to Covid-19 and UEC pressures *Population Health Management (PHM)* • An Executive Director providing senior leadership and expertise, acting as SRO for this programme of work. • A CCG Public Health Consultant in post leading delivery of PHM. • Active involvement with the NHSE PHM programme, and use of external experts Milliman, which supports the development of PHM capacity and capability across the system. • Confirmation of successful Wave 3 PHM Development Programme application with funding of £50k. • An established Health and Care Senate (H&CS) which has health inequalities as one of it's core priorities ensuring that inequalities are a key issue for wider clinical and professional leadership groups. • An inequalities strategic oversight group involving clinical and public health expertise to bring together the inequalities and prevention work streams.	*Co-ordination of Transformation - System, Place and neighbourhood* • Identify key transformation / change programmes that are likely to be locally and system driven. • OD plan to support system and place clinical leadership. • Identification and development of ICP leadership *Collective Management of System Performance* • Finalise and embed system-wide approach to managing Finance, Quality and Performance. • Continue to develop our performance reports to become an Integrated quality, finance and performance dashboard which provides appropriate and accurate information that is effectively processed, challenged and acted upon. • Clear and effective processes for managing risks, issues and performance. • Develop a proactive stance on self-assurance, earning autonomy from our regulators to self-regulate on most issues. *Resolving Performance Challenges* • Ensure that the system SFP has the correct membership and intelligence to support decision making and challenge • Clear route of escalation through to the CEO forum • Agree priority areas of focus and simplify list to an agreed and appropriate level *Population Health Management (PHM)* • Agreed way of working to deliver PHM at scale to inform service and system change and integration. • Continue to develop data sharing particularly in primary care. • An OD programme for the H&CS including PHM and inequalities. • Co-production of outcome measures, both qualitative and quantitative, with ICS and ICP representation. • Refreshed approach to PHM and full engagement with the PHM national programme. • PHM approach to be widened from public health colleagues and repurposed to support ICP development. • Approach to be set out for the January ICS Board and workplan to be agreed with confirmed timelines. • PHM priorities to be agreed by the January meeting of the ICS Board. • Clarity on resource available and LA partner engagement to be part of that key discussion.

Self Assessment: System Capabilities

Theme	Strengths	Development Plan
System capabilities in place to perform the dual roles of an ICS, to co-ordinate transformation activity and collectively manage system performance, clearly defined at system, place and neighbourhood. These will include areas such as population health management, service redesign, provider development, partnership building and communications, workforce transformation, and digitisation. The system should also agree a sustainable model for resourcing these collective functions or activities. NHSEI will contribute part-funding for system infrastructure in 2020/21.	*Communications, Involvement and Engagement* • Investment in communications and engagement (C&E) resource providing focused support across key development areas. • Integrated approach to C&E with a shared Director of Communications across the CCGs and ICS footprint, with a seat at the ICSPB. • Strong partnership working across C&E recognised regionally. *Workforce* • System expertise in place around workforce planning and workforce information/data. • Long-term workforce planning at system level as taken an 'open book approach', with all providers engaged in the process and sharing their workforce projections across the system. • A strong ICS workforce team in place to improve workforce supply and solutions are created in partnership as "System by Default." • Our system wide leadership programmes all have equality, health/wellbeing, fairness and reduction of bullying/harassment and violence at work as a golden thread running through them. *Digitisation* • A well established Digital Board comprising senior Digital, Clinical and Service leaders from all of main partners within the ICS footprint, chaired by a current CCG Clinical Chair. • A digital strategy that focuses around six strategic goals which collectively describes how digital technology will help transform health and care for citizens, health and care professionals and the wider system. • A Digital Clinical Advisory Group and Digital Design Authority. • Technology enabled care implemented prior to Covid-19 and rapidly expanded during the Covid-19 pandemic. *Resourcing* • Current resource supporting STP identified and based on partner contributions (NHS) • Small core team at present and reliant upon resource in kind from system partners • Core finance and workforce teams good examples of collaboration • Partner commitment to shared resource to support ICS Development • Integrated approach to communication and engagement with a shared Director of Communications across the CCGs and ICSPB footprints, with a seat at the ICSPB	*Communications, Involvement and Engagement* • Primary care, partner and public engagement on the development of the Strategic Commissioner function (2020-21). • Supporting the equality programme, with a focus on reaching seldom heard groups. • System wide approach to transformation, including key areas of urgent care, maternity, community care, mental health and planned care (2021-23). *Workforce* • Further develop the People Hub locally to make it the route into health and care careers in Staffordshire and Stoke-on-Trent. • Consider and develop consistent system HR, OD and recruitment processes, policies and programmes to support a system workforce. • Focus on inclusivity and diversity in our workforce utilising targeted approaches. *Digitisation* • Digital Board development to aid the progression from a voluntary collaborative group into being a key part of the governance structure of the ICS. • Development of the Digital Financial planning (sub-group of the Digital Board) to agree financial planning and management activities and prioritise and manage capital investments. *Resourcing* • Review national direction of travel and agree core STP / ICS transition team • Agree 21/22 budget with system partners based on review of functions required • Confirm partner commitment to supporting the ICS core functions • Agree budget hosting arrangements until primary legislation in place • A clear funding model for the collective functions that sets out how core capabilities will be funded across the system and agreement that resources will be shared and flexible.

Self Assessment: Streamlined Commissioning

Theme	Strengths	Development Plan
Streamlined commissioning arrangements, including one CCG per system with clearly defined commissioning functions at system, place and neighbourhood.	• A confirmed and finalised CCG merger timeline and roadmap. • Strategic Commissioning identified as a priority programme by the CEO Forum and the ICSPB. • A detailed plan to support delivery of the Strategic Commissioner development . • The Strategic Commissioner blueprint has been reviewed and detail added behind the identified functions. • During our response to Covid-19 we have worked increasingly more as partners rather than commissioners and providers, instead operating as a single team with clear lines of accountability.	• Formal merger application to be submitted by July 2021 (at the latest). • Delivery of programme of work to deliver the strategic commissioning function. • Identify hand over points from strategic commissioning into ICPs for delivery at a place based level. • LA and CCG integrated commissioning development - to develop an approach towards integrated health and social care services that improves outcomes for service users and efficiencies within resource allocated at the most appropriate level. • Develop an approach for planning and delivery of specialised services as locally as possible, joining up care pathways from primary care through to specialised services with the ultimate aim of improving patient outcomes and experience.

Self Assessment: Implementing a full shared care record

Theme	Strengths	Development Plan
Plans for developing and implementing **a full shared care record,** allowing the safe flow of patient data between care settings, and the aggregation of data for population health.	• The system has a live Integrated Care Record Solution, which is already well populated with data from partner organisations and provides the foundation upon which to build integrated care tools and enhanced data to improve health and care for the local population. • Active members of the Local Health and Care Records (LHCR) Group across the West Midlands and accordingly are committed to sharing the data in the Integrated Care Record with partners across the region through the LHCR programme. • Close collaboration with Shropshire, Telford and Wrekin STP will see the Staffordshire and Stoke-on-Trent ICR shared to create a single integrated care record covering both regions, which will prove especially useful for MPFT who provide services in both areas.	• During 2021, continued development of the ICR through our Shared Care Record (One Health & Care) delivery plans. • Deployment of personal Health records app, by February 2021, to the local population to empower the self-management agenda. • Core reviews planned of foundation IT services and planned maturity assessments utilising the HIMMS continuity of care model. • Digital and PHM work streams to continue to collectively work on data sharing protocols.

2 Self Assessment: System Plans

Theme	Strengths	Development Plan
System plans that reflect the key local recovery, performance and delivery challenges and that incorporate a development plan for the system. This should explicitly reference delivery across the system architecture, i.e. place and provider collaborative(s). **Confidence in reprioritised LTP delivery and recovery plans**	• The system development plan is contained within this document and is based on a detailed review of the ICS must dos, consistent operating arrangements and the ICS maturity matrix. • An agreed FYDP that was determined ready to publish pre Covid-19. • For 2021/22 started to develop system level strategic framework design and delivery groups for the system operating plan. • System partners developed a Phase 3 delivery plan which set out how the STP would recover health and care services, whilst managing the additional demand of winter pressures, and living alongside Covid-19. • Organisational phase 3 plans were used to support the development of recovery plans at the system and ICP level. • ICP priorities identified in the summer of 2020 and the ICP self-assessment alignment to the FYDP. • A Transformation Delivery Unit in place that supports the transformation agenda with recognition that this will need to be refreshed in order to fulfil the system wide PMO function. • Strong engagement with PCN CD to ensure alignment with the place agenda.	• Covid Wave 1 lessons learned, FYDP and phase 3 stock take to inform ICS planning by *March 2021.* • UEC plan and priority areas to be reviewed and refreshed. • Develop the system level strategic framework and system operating plan. • Focus on delivery on of the trajectories in the Phase 3 recovery plan. • Use Phase 3 recovery plans as a platform from which to deliver the constitutional standards. • Directors of Strategy take the leadership on development of the system operating plan. • Delivery of the ICP priority areas with a refreshed focus on place • Confirmation of place leadership to help drive local delivery and implementation

2 Self Assessment: Capital and Estates Plans

Theme	Strengths	Development Plan
Capital and estates plans agreed at a system level, as the system becomes the main basis for capital planning, including technology.	• A system estates plan and strategy, rated “Good”. • A System Capital Prioritisation Group, to review and prioritise capital plans across the system. • A system approach to developing plans (Phase 3, FYDP, system savings plans etc.) that involve strategy, finance and operational directors.	• A system capital prioritisation and risk criteria. • A system Estates Strategy (covering capital and estates), to include disposals. • An agreed broader system section 106 policy.

3 Self Assessment: Leadership Model

Theme	Strengths	Development Plan
A leadership model for the system, that explicitly includes the following: **1. ICS core leadership** team including: a. an STP/ICS leader with sufficient capacity and a non-executive chair appointed in line with NHSEI guidance and with delegated authority from system partners to act on their behalf and for the good of the local population. b. Sufficient leadership and delivery capacity to carry out the functions above **2. Place leadership** arrangements for each place within the system, ensuring that primary care (as a provider) is reflected in these arrangements. **3. Provider collaborative**(s) lead arrangements for "hospital systems", ambulance services and "acute mental health systems"	*ICS Core Leadership* • The role of the ICS Independent Chair appointed to and in place. • Clinical and professional input provided by the Health and Care Senate (H&CS) and its associated sub-groups. The structures support clinical and professional input from the front line of care. This professional leadership is readily accessible to the ICS Board. • A health inequality executive at board level within each organisation and a system inequalities lead. *Place Leadership* • Each of our ICPs are developing arrangements that reflect their unique identities and partners in the local system. • There is an established commitment to the three ICPs, each with leadership and governance in place which has been and will continue to be developed on an inclusive basis, including key partners and stakeholders. • The H&CS is supported by Health and Care Assemblies. • ICPs have been developed with PCNs at their heart and PCN representatives are fully involved in each of the three ICPS. *Provider Collaboratives* • Provider CEO's have taken lead roles on the 5 system workstreams. • Each of our provider organisations play an active and strong leadership role through the governance structures of the ICS. • UHNM is part of the N8 pathology network. • MPFT and NSCHT are actively involved in the development of the Regional mental health provider collaborative. • NSCHT is an active part of the Stoke-on-Trent Collaborative Network (CN). • Long-term workforce planning across the system has taken an 'open book approach'. • Acute provider and Community Teams already work closely to ensure that for patients with Long Term conditions (LTCs) every opportunity is taken to ensure care can be provided close to home.	*ICS Core Leadership* • Our focus will now concentrate on the appointment of the ICS Leader. The Regional Director will be part of the final appointment panel and decision-making process in line with NHSE/I guidance. • Ongoing leadership development of health and care professionals. • Review of core team resource as part of the functional review and agree any new posts required to support transition to ICS *Place Leadership* • Develop shared and collectively agreed view of placed-based leadership. • Develop clear and shared vision for ICPs aligned to transition towards strategic commissioning. • Develop 'Values /Behaviour Charter' to support collaborative working approach via Accelerated Design Events. • OD support programme aligned to System-Wide OD Programme. • Agree joint OD programme to support transition to locality commissioning arrangements. • Confirm ICP leadership and ensure there is clear PCN visibility and involvement *Provider Collaboratives* • Review all current collaborations – internal and external. • Establish simplified review process to identify specific risk areas re provider collaboration. • Facilitate vertical provider collaborations to support the integration agenda into ICPs. • Develop diagnostic collaborative with UHNM and other acute partners from neighbouring STPs.

3 Self Assessment: System Wide Governance

Theme	Strengths	Development Plan
System-wide governance arrangements to set out clear roles of each organisation and enable a collective model of responsibility, and nimble decision-making between system partners. These arrangements will include a system partnership board that sits in public and should be complemented by a public engagement approach that ensures full transparency of decision-making. The system-wide governance arrangements should be underpinned by agreed decision-making arrangements across the system architecture (i.e. place and neighbourhoods/PCNs) and agreements with respect to financial transparency.	*System-wide governance* • An interim governance structure based on 'function' has been established. The sub committees that have been formed enable the dual role of an ICS to be fulfilled and ensure that there is full partner engagement in all of this work. • The Terms of Reference and Membership of the ICSPB have been agreed and has continued to evolve as the role and task of the system wide Board becomes clearer. • Membership of the ICSPB includes all Statutory Organisations (Chair and CEO), both Local Authorities (elected members and officers), HealthWatch, Voluntary Sector and representatives of the PCN Clinical Directors. • The ICS Shadow Board is chaired by the Independent Chair of the STP. *Decision making* • Covid-19 response has demonstrated that system partners can be agile in decision making and make rapid progress when unified around a single compelling objective • Care home support response with both LA's, MPFT and the CCGs • Workforce deployment cell to trigger mutual aid across partners through a single approach • Tackling MFFD through rapid deployment of joint teams across both NHS and LA partners to free up hospital beds and to get people home safely and quickly *Public Engagement* • Robust foundations locally for capturing the patient voice to inform and support transparency of the work at ICS and ICP level. • Over 12 weeks during the summer of 2019, we worked with health and care professionals, partners and the public to understand their priorities for local health and care services. Their feedback helped inform our FYDP and priorities. • During summer/autumn 2020 we undertook further engagement with local community groups, to understand people's experiences during Covid-19, including future priorities. Working with our Healthwatch partners a wider public survey was carried out. This feedback will be considered by the restoration and recovery programmes and the ICSPB to inform future priorities and the approach to wave two. Financial Transparency (Place and neighbourhood) • A culture of transparency, openness and collective ownership and accountability in relation to finance.	*System-wide governance* • The governance structure will be reviewed as part of the ICS designation process and is part of our system development plan. • Progress the ICS Shadow Board to meet in public and to publish its papers by February 2021. • Develop the decision making arrangements. • An integrated quality, finance and performance dashboard reported into the ICSPB. Decision making • Review of current decision making forums and light touch governance review to enable clear base line to be set out • System wide review of lessons learnt report and gap analysis presented back to the ICS Board *Public Engagement During 2020/21* • Delivery of the Winter C&E plan and response to Covid-19 *(2020-21).* • Primary care, partner and public engagement on the development of the Strategic Commissioner function *(2020-21).* • System wide approach to transformation, including key areas of urgent care, maternity, community care, mental health and planned care *(2021-23).* • Significant mental health transformation programme over three years *(2020-23)* • Supporting the equality programme, with a focus on reaching seldom heard groups *(2020-21).* Financial Transparency (Place and neighbourhood) • A financial strategy that articulates how the system and the organisations within it will deliver the financial objectives and targets. • Delegation of financial responsibility to ICPs. • Refinement of the IFP approach to make sure that delegation of budgets is meaningful and supports integration • System approach to capital prioritisation that is built on place based priority areas

System by Default

Priority area	What are we trying to achieve?	What will this look like in practice?	What potential support will we need from NHSE/I?
Information Governance/ PHM	Maximisation of the use of data to improve health and care for the local population. by establishing clear data sharing models.	• Data sharing agreements in place across the system. • Population health management tools that can be used at system and place level. • A defined and agreed IG structure across the system.	• National directive for data sharing resolved. • Population health management support re 'best in class' tools and shared learning
Performance	A system based approach for collectively managing performance across Staffordshire and Stoke-on-Trent. Delivering assurance that is based on partnerships for improvement.	• System Strategy, Finance and Performance Committee. • A system-wide outcomes framework across health and care. • Integrated quality, finance and performance dashboard reported into the partnership board. • Single point of contact agreed for any system performance queries.	• NHSE/I are fully integrated into our Partnership Board as a key partner to support a fully integrated model of assurance, commissioning and delivery. • Agreed alignment of resource and staff into the ICS to support the continued devolution of specialised commissioning and independent contractor commissioning
Quality	A system-wide approach to quality and safety to achieve the best health outcomes for our population. Our shared vision and underpinning framework will not only focus on quality assurance but also quality improvement.	• A shared QI approach and methodology to support system wide change projects in line with system priorities. • A system Quality and Safety Group to steer the delivery of system wide quality assurance and improvement. • A system wide Quality Impact Assessment process. • A system wide approach to harm and mortality reviews	• Support for understanding how regulatory frameworks will apply to a system by default model and delivery of the frameworks.
Workforce	Delivery of the Staffordshire and Stoke-on-Trent People Plan which sets outs our plans for leadership & culture, education, CPD, new roles and recruitment in order to create a sustainable model of care for our population and its projected future needs.	• An STP/ICS People, Culture and Inclusion Board with agreed governance model for decision making, prioritisation and ensuring delivery and accountability. • A System Workforce Group with an STP/ICS Workforce lead and team to deliver our Local People Plan. • A Staffordshire People Hub which will hold system wide contingent workforce to support the recruitment, retention and deployment of workforce both in line with urgent pressures (but also as a career development mechanism in the medium term. • Leadership development programmes: High Potential Scheme pilot, Stepping Up, Stepping up Alumni, Reverse Mentoring, Pilot ICP Programmes, Winter Inclusion school, Cultural Racial Inclusion development programmes. • An STP Black, Asian and Minority Ethnic (BAME) network, networking with individual organisation BAME networks. • A System Health and Wellbeing Group developing the collective Health and Wellbeing offer. • Sharing practice (as regional leads) on People Hub, BBS and Reservists with other STPs.	• Clarity on the expected functionality of the ICS People function and devolved funding to resource this. • Support to develop IT resources to improve the functionality of the people hub and the database of contingent workforce. • Clarity of funding allocations for learning/development and leadership between HEE/NHSI/E and transparency of destination for these. • Ongoing support from regional HEE and NHSEI leads. • Clarity on the governance of the Primary Care Training Hub within the ICS and funding commitment confirmed for 3 years minimum rather than annually.

System by Default

Priority area	What are we trying to achieve?	What will this look like in practice?	What potential support will we need from NHSE/I?
Digital Transformation	A digitally enabled health and care system underpinned by a strategy that focuses around six strategic goals which collectively describe how digital technology will help transform health and care for citizens, health and care professionals and the wider system.	• A Digital Board with a single governance model for overseeing decision making, assurance and accountability. • A Digital Clinical Advisory Group and Digital Design Authority before being turned into defined work packages for delivery. • Quality assurance approach for signing off new digital systems and process. • Use of pioneer new technologies where appropriate and acting as a fast follower in others, learning from and sharing our learning and best practice with other systems. • Digital technology and processes wrapped around the needs of our citizens rather than directed by organisational boundaries. • Use of system wide digital maturity models to establish a common baseline and drive for common standards. • A commitment to the use of common tools, technologies and services within the ICS where applicable to simplify access for staff, achieve common data and information standards, deliver a seamless patient experience and gain best value for money.	• Strong engagement with our system to shape national digital policy and strategy and make the most exploit national opportunities and available funds. • Devolved allocation of Staffordshire and Stoke-on-Trent transformation funding will be used against our digital strategy priorities. • Fast follower funding where applicable. • Support to develop IT resources to improve the functionality of the people hub and the database of contingent workforce.
Clinical priorities for our ICS model	An agreed approach by the Health and Care Senate (H&CS) to identify system clinical priorities against which we will test our ICS model of care against in terms of both devolved commissioning and provision of care.	• Clinical and professional input provided by the H&CS, its associated sub-groups & the Health and Care Assemblies. • An established H&CS which has health inequalities as one of it's core priorities. • ICP place based priorities aligned to the FYDP and Phase 3 Recovery Plan.	• OD plan to support system and place clinical leadership.
STP Boundaries	Partners recognise the importance of coterminous boundaries and being able to be clear in regards to a defined population. Recognition that the system has flows across boundaries and into other areas.	• Three ICPs established with defined geographical footprints and formal place leadership confirmed. • Agreement to work with neighbouring STPs on boundary flows. • Work with Staffordshire County Council and Stoke-on-Trent City Council to ensure full engagement and added value for the work of the ICS. • Defining place in a way that works for residents and takes care as close to their normal place of residence as possible.	• National clarity / guidance on the role of the Health and Well Being Board in any future legislative change.

System by Default

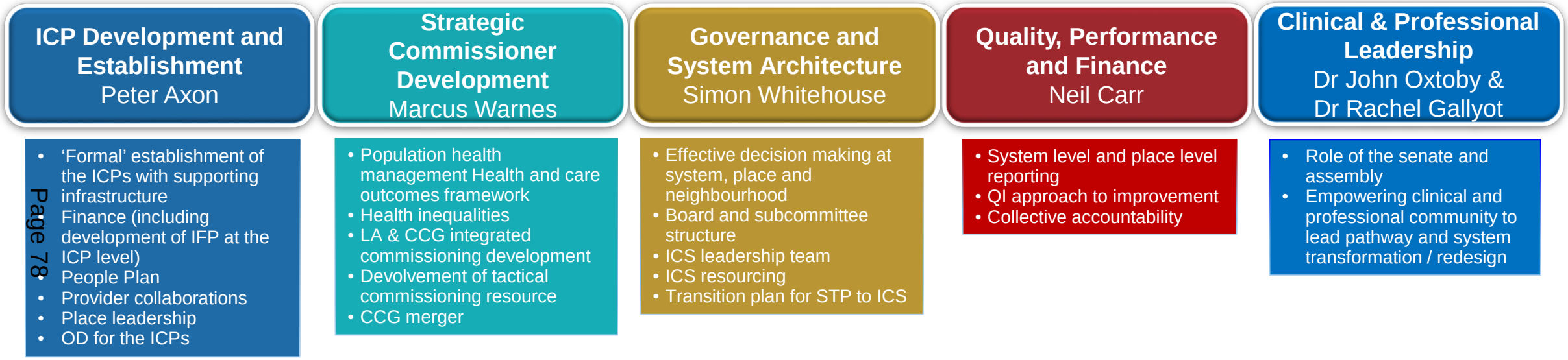
Priority area	What are we trying to achieve?	What will this look like in practice?	What potential support will we need from NHSE/I?
Finance	Allocation of resources to incentivise the best outcomes for our population. There will be a focus on collaboration and on system resources, rather than organisational, with an “open book” approach.	• A System Strategy, Finance and Performance Committee, supported by a System Finance Sub-Committee. • An agreed system financial strategy that articulates how the system and the organisations within it will work together to deliver its financial objectives & targets, and the roles and responsibilities of ICPs within this. • System allocation and agreement on distribution of resources, including a financial framework for ICPs. • Evolution of the current “Intelligent Fixed Payment” arrangements in place locally, including risk sharing arrangements. • Agreed system financial reporting and modelling, at system and place based level. • A culture of transparency, openness and collective ownership and accountability. • An agreed funding model for collective functions, recognising the required core capabilities.	• Clarity on broader longer term financial framework and expectations, coupled with the local flexibility around implementation models. • Confirmation of multi-year settlements, including capital, will support the development of a system by default arrangement to finance. • Clarity and transparency of specialised commissioning budgets, pressures, risks, and opportunities to help the system consider phasing of any future devolved direct commissioning as our system financial framework evolves.
Estates	An STP estates strategy to maximise the value from our public estate, outside of NHS boundaries and to embrace integrated service opportunities more widely with other partners beyond health and social care.	• An agreed system estates strategy and plan including estates pipeline and disposal plans; alignment to overarching capital planning. • A combined STP/OPE Estates Programme Board with a single governance model for overseeing decision making, assurance and accountability. • An agreed broader system section 106 policy across all planning authorities, with broader consideration of health infrastructure needs and increased engagement with health. • A System Capital Prioritisation Group, with multi functional representation to review and prioritise capital plans across the system.	• Ongoing access to capital funding to deliver our overarching strategy e.g. community hospitals. • Sharing of best practice around development of funding models.

Development Plan

Introduction

- The following sections describes the 5 system priorities agreed by the CEO Forum and the ICSPB, as key areas for development.
- These areas form the foundation of the ICS development plan, each with an identified Executive lead, as outlined in diagram 5 below.

Diagram 5: Agreed System Development Priorities



High Level Timeline

	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
Overarching Timeline	Develop plan post September submission	Draft ICS submission to Regional Team	· Present readiness assessment to QSRM · Final submission of system application for Feb review point	· Formal regional decision point · Documentation is submitted to national team for review.	RD presents submission to national team for discussion & ratification	Transition to ICS									
ICP Development and Establishment	Establish ICP Programme Board	· Develop place leadership, shared vision & values charter	Agree shadow governance arrangements and links to statutory organisational and system governance	· Shared view of ICP population health · Health outcome monitoring and reporting system · Planning for Change and Signs for Change workshops		· Co-design of financial framework · Strengthened involvement of patient and voluntary groups.	Co-design of future contracting models		· Embed a process to develop joint priority setting at place-based level						
Strategic Commissioner Development	Establish programme structure	· Set out output of functions mapping work	· Agree IG structure · Identify clinical leadership · Develop vision · Develop outcome frameworks linked to the Phase 3 recovery plans and FYDP (PHM)	Present PHM work plan to the ICSPB setting out the approach	Agreed way of working to deliver PHM at scale	· Co-production of inequalities outcome measures · Implement OD framework supporting new ways of working · IFR and the Covid-19 funding arrangements utilised to reconsider the future role of commissioning.	Identify hand over points from Strategic Commissioning into ICPs for delivery at a place based level		· Embed a process to develop joint priority setting · Membership Vote	· Formal Merger Application		· LA & CCG integrated commissioning development			
Governance and System Architecture	System Partners reviewed ICS development plan and signed off interim governance structure	Appoint ICS independent Chair		Engagement with major out of area acute providers and neighbouring STPs to ensure inclusion in system and ICP development work	· ICS Board Public Meeting · Establishment of ICP	· Appointment of ICS Director (TBC) · Covid Wave 1 lessons learned, FYDP and phase 3 stock take to inform ICS planning	· ICS Board Membership reviewed · Light touch review of ToR & supporting committee membership	Self-assessment against the ICS maturity matrix	Quarterly review of board acheivements	Transition to ICS					
Quality, Performance & Finance	Approval of pathway to a financial strategy.		Engagement with out of STP providers for system assurance report	Establish clear links with clinical senate to enable alignment of priorities	· An integrated quality, finance and performance dashboard reported into the ICSPB. · System Quality and Safety Committee established. · Agreement of 2021/22 IFP arrangements.	· Increased provider level data in the system assurance report · Mobilisation of ICPs and PCNs, agree delegated scope & accountability framework · Agreed 2021/22 system finance plan and strategy	A system wide approach to harm reviews in place	A shared QI approach and methodology to support system wide change projects	An integrated quality strategy that is aligned to organisational plans as well as the system, place and neighbourhood need	Development of a system wide customer care culture					
Clinical & Professional Leadership	Identified dedicated resources for the Senate to support its business	· OD support programme aligned to System-Wide OD Programme	Vision, Role and Terms of Reference in place for the Staffordshire & Stoke-on-Trent Health & Care Senate	· Role and ToR are in place for the Health and Care Assemblies · Conduct a Needs Assessment for the development of cross health economy pathways	· Develop and introduce an OD Leadership Programme that will help the Senate to deliver an ICS · Deployment of personal Health records app, by February 2021	· Process, tools and method to develop evidenced based health, care and clinically led strategy established	· Health & Care Senate and Assemblies launched · Achieve state of readiness to receive Population Health Management intelligence		· Empower the health, care and clinical community to develop clinically led system strategy and to lead the delivery of local transformation / redesign						

Integrated Care Partnership (ICP): Development and Establishment

ICP development and establishment

- A detailed ICP development plan has been produced to support achievement of the critical path of ICP development and establishment, built around three core themes of-
  - culture
  - governance and
  - operations

- The plan has been co-produced in collaboration with the Strategic Commissioner workstream to ensure that relevant interdependencies have been identified and a consistent approach agreed. It has been used to inform the ICS Roadmap and as a companion piece to the Phase 3 Recovery plan.

- The ICP Programme Board coordinates the ICP development activity whilst continuing to provide space for locally tailored responses to local issues.

- Oversight of the plan is coordinated through the ICP Programme Board, led by Peter Axon (CEO, NSCHT), which includes representatives from all three ICPs and the CCGs. This ensures that there is a strong local context to development, General Practice is represented as a provider in each ICP and that the link to neighbourhoods is strong.

- There is an established commitment to the three ICPs, each with leadership and governance in place which has been and will continue to be developed on an inclusive basis, including key partners and stakeholders.

- The ICPs have developed organically and at a pace that reflects local factors. ICS and ICP boundaries reflect local authority boundaries with good engagement at all levels of the ICS and ICPs, including opportunities for District and Borough Councils to engage at ICP level.

- There will be three core products that will support development:

  1. ICP Visioning Document – This articulates agreement between the ICS and ICP on key aspects of ICP development
  2. ICP Partnership Agreement - ICP level publication that sets out membership and governance of the individual ICPs
  3. ICP Delivery Plan - ICP level publication that sets out plans for improving health and care outcomes for local people within the ICP footprint

What is different about an ICP? Developing an Asset Based Approach

- The transition to an ICP provides a fundamental opportunity to place a new emphasis on the strengths and assets of our communities and open up new ways of thinking about improving health.

- We have adopted an 'asset based' approach which means each ICP can make visible and value the skills, knowledge and connections that already exist in our communities and build on locality-focussed identities and groups.

- We have commissioned the National Development Team for Inclusion (NDTI) to support us in the development and delivery of a Community Led Support (CLS) programme. This approach and the work that we have commenced is outlined in the **Appendices** of this development plan.

ICP (Place) Agreed Priority Areas for Transformation

The matrix below shows the individual ICP priorities identified in the summer of 2020 and the ICP self-assessment alignment to the FYDP. The self-assessment has been developed further to reflect consistent alignment for each ICP to the FYDP priorities. These priority areas form the work plans for the place agenda across our 3 geographical place footprints. These have been shared with Shadow ICS Board and each ICP has been working to deliver these through their agreed governance arrangements

ICP Priorities ↓	FYDP Priorities →	Focused Prevention	EPCC	UEC	Planned Care	Personalised Care	Mental Health	Maternity & Neonatal	Cancer	Learning Disability & Autism	CYP
South East ICP											
Long Term Conditions		*	*	*	*	*					
Enhanced Health in Care Homes			*			*					
Covid Rehab											
Cancer and Diagnostics									*		
Elective Pathway Priorities			*		*						
CRIS Roll out			*								
Mental Health		*	*			*	*			*	*
North ICP											
Sustained focus on restoration and Recovery		*	*	*	*	*	*			*	*
Improved access to integrated Mental Health Services		*	*			*	*			*	*
Children and Young People			*			*	*	*		*	*
Long Term Conditions (incl Tier 3)		*	*	*	*	*					
Frail Elderly			*	*	*	*	*				
Asset based demand management		*	*		*	*	*			*	*
South West ICP											
Admission Avoidance Pathways			*								
Mental Health Pathways - Post Covid Mental Health &Wellbeing		*	*			*	*			*	*
Enhanced support to care homes			*			*					
Effective Referral Pathways for Planned Care (Triage and Treat)			*		*	*			*		
Long Term Condition Pathways		*	*	*	*	*					
Staying Well Pathway (Frailty)			*			*					

Provider Collaboratives

Provider Collaboratives

- Each of our provider organisations play an active and strong leadership role through the governance structures of the ICS including the ICS (Shadow) Board and the System Strategy, Finance and Performance Committee.

- Provider CEO's have taken lead roles on the 5 system workstreams, agreed by the CEO Forum, as key areas for our development (slide 26).

- Long-term workforce planning across the system has taken an 'open book approach' through development of the FYDP and Phase 3 recovery plan. Arrangements for mutual aid have been have been utilised and effective during Covid-19.

- In order to build a compassionate and engaged workforce we have designed numerous initiatives which underpin the delivery of our system wide Local People Plan. We have developed programmes to support multidisciplinary leadership and talent, coordinating approaches to recruiting, retaining and developing an agile workforce.

- Whilst there is recognition that more can be done, provider collaborations within the STP are not new. Collaboration has been ongoing and our commitment to this will continue.

- Collaborations within the STP are structured as follows:
  - Horizontal Collaborations
    - Collaborations between acute providers on clinical services and / or clinical support & corporate functions. The majority of which are with partners external to the STP,
  - Vertical Integration
    - Collaborations between STP providers such as Social Care, Primary Care, Community Services and Mental Health,
  - Specialised Collaborations
    - These are in the early stages of development and are generally outside the STP and in support of developing safe and sustainable highly specialised tertiary services.

- University Hospital of North Midlands (UHNM) has on-going partnerships with a range of acute providers on a different footprint to our ICS boundaries but also within the ICS particularly with the 2 local mental health providers.
  - Clinical networks and specialist partnership arrangements are in place to support the delivery of the best possible outcomes for the population.
  - There are numerous opportunities for collaborative working and partnership/network arrangements available to explore in light of GIRFT network recommendations. UHNM is fully engaged with Specialised Commissioners to review these collaborative arrangements across wider geographies.
  - The Trust is part of the N8 pathology network that also includes Mid and East Cheshire and Shrewsbury and Telford Hospitals. From the 1st of December 2020 the Trust became the host of the North Midlands and Cheshire Pathology Service, providing services to the populations of Mid and East Cheshire, Staffordshire and Stoke-on-Trent.
  - Acute provider and Community Teams already work closely to ensure that for patients with Long Term conditions (LTCs) every opportunity is taken to ensure care can be provided close to home. All ICPs have identified LTCs as a priority which will strengthen that integration further.
  - Providers across Staffordshire are looking to work together in order to create Community Diagnostic hubs for the population of Staffordshire and Stoke-on-Trent. By reviewing both current provision and demand, data will be used to determine geographically where Diagnostic Hubs will have the most impact on patient pathways and access to healthcare.

Provider Collaboratives

Provider Collaboratives

- Midlands Partnership NHS Foundation Trust (MPFT) and North Staffordshire Combined Healthcare NHS Trust (NSCHT) are part of or lead on work within the Mental Health provider collaboratives.
    - Eating Disorders New Care Model - led by Midlands Partnership Foundation Trust
    - Child and Adolescent Mental Health services (CAMHS) New Care Model - led by Birmingham Women's and Children's Hospital.
    - Adult Low and Medium Secure Services - led by Birmingham & Solihull Mental Health NHS Foundation Trust (also work with St Andrew's Healthcare as part of the Reach Out).

- MPFT are leading on the deployment of long Covid clinics supporting rehabilitation of people that have had Covid-19. As a system we will use these clinics to profile the demand and data in order to shape a strategy that aligns to increases in acuity within general practice, primary care and community services. We plan to establish these clinics as part of our system resilience to support patients providing alternatives to hospital admission.

- MPFT and NSCHT are supporting the development of mental health surge plans. This has become one of four national models that form a community of practice and will influence surge planning into the new year. This data is being used locally within ICPs to understand the changes currently and build plans to support vulnerable people as the pandemic continues.

- At a PCN level, MPFT has signed contracts to deliver the DES including physical care and mental health. MPFT have worked collaboratively with general practice, to place workforce within practices, including occupational therapists, nurse prescribers for mental health to support the joint management of Serious Mental Illness (SMI), physiotherapists and extended hours which are all part of the DES and ultimately all part of hospital avoidance.

- The system continues to place a strong focus on admission avoidance and the work, which started twelve months ago, on the Community Rapid Intervention Service (CRIS) for North Staffordshire. The service is a joint partnership providing an integrated model across community, acute and social care services to provide sub-acute care in the community. Further detail on the work undertaken is explained in more detail in the Appendices of this development plan.

- Case studies in the Appendices also outline collaborative work on the NHS Continuing Healthcare Fast Track Pathway and The Staying Well Service (SWS) which was co-designed with partner organisations.

- NSCHT is an active part of the Stoke-on-Trent Collaborative Network (CN). The CN is a collective of around 20 plus voluntary organisations coming together with public bodies, chaired by the Chief Executive of the YMCA. The agenda is focussed on cross-cutting themes such as loneliness and economic prosperity to understand the linkages across all providers and better coordinate our resources.

- NSCHT has a small number of key voluntary sector bodies that are part of the supply chain of provision for services such as Community Drug & Alcohol Services and IAPT.

- Each ICP has been established with an inclusive governance model that sets a core membership of statutory partners but also allows sufficient local flexibility for ICPs to work with those voluntary/third sector partners which might be relevant in their local geographies.

- The North Staffordshire ICP model has active representation from both VAST and Support Staffordshire to represent the voluntary sector (VS) more generally but there is specific representation from larger VS partners in the Northern geography as well.

- ICP priorities developed in the summer were approved by ICP Stakeholder Group including VS representation. Subsequent working groups all have VS representation on them to ensure we make connections across the whole pathway of care

- Work will continue on our provider collaborative arrangements alongside any changes in legislation and as part of our development plan.

Strategic Commissioner Development

- Effective commissioning at the right level across the ICS is vital to create an environment in which our system is focussed on outcomes, our places and neighbourhoods are able to flourish and the benefits of integrated care can be realised.
- The vision is
    - A strategy agreed once for the whole system
    - Clinicians working in ICPs to agree the care pathways that work in that local context
    - Delivery in the neighbourhoods where primary care are empowered to work on the implementation of pathways
- The Strategic Commissioner Development work and ICP (Place) Development work are very closely connected. The leads from each area are working closely together to ensure that the interdependences are mapped across and to ensure that key milestones and decisions complement the other work stream.

anning and Delivery

- A detailed plan has been developed to support achievement of the critical path of Strategic Commissioner Function, built around the core milestones of-
    - Population health management
    - Health and care outcomes framework
    - Health inequalities
    - LA & CCG integrated commissioning development
    - Devolvement of tactical commissioning resource into ICPs
    - CCG merger
- The Executive lead accountable for this development priority is Marcus Warnes (CCG Accountable Officer).

Specialised Commissioning Planning and Delivery

- We will build on the opportunities provided by our transition to an ICS by ensuring specialised services are planned and delivered as locally as possible, joining up care pathways from primary care through to specialised services with the ultimate aim of improving patient outcomes and experience.
- We will work with Specialised Commissioning to plan specialised services alongside locally commissioned services, providing the opportunity to transform and improve clinical engagement across integrated whole system pathways and positively influence health outcomes.
- The end-to-end integration of pathways will deliver benefits to patient outcomes and experience, reduce unwarranted variation and improve value for money. Where required and appropriate, services will be redesigned at a system or broader level to maximise clinical efficiency and financial resources.

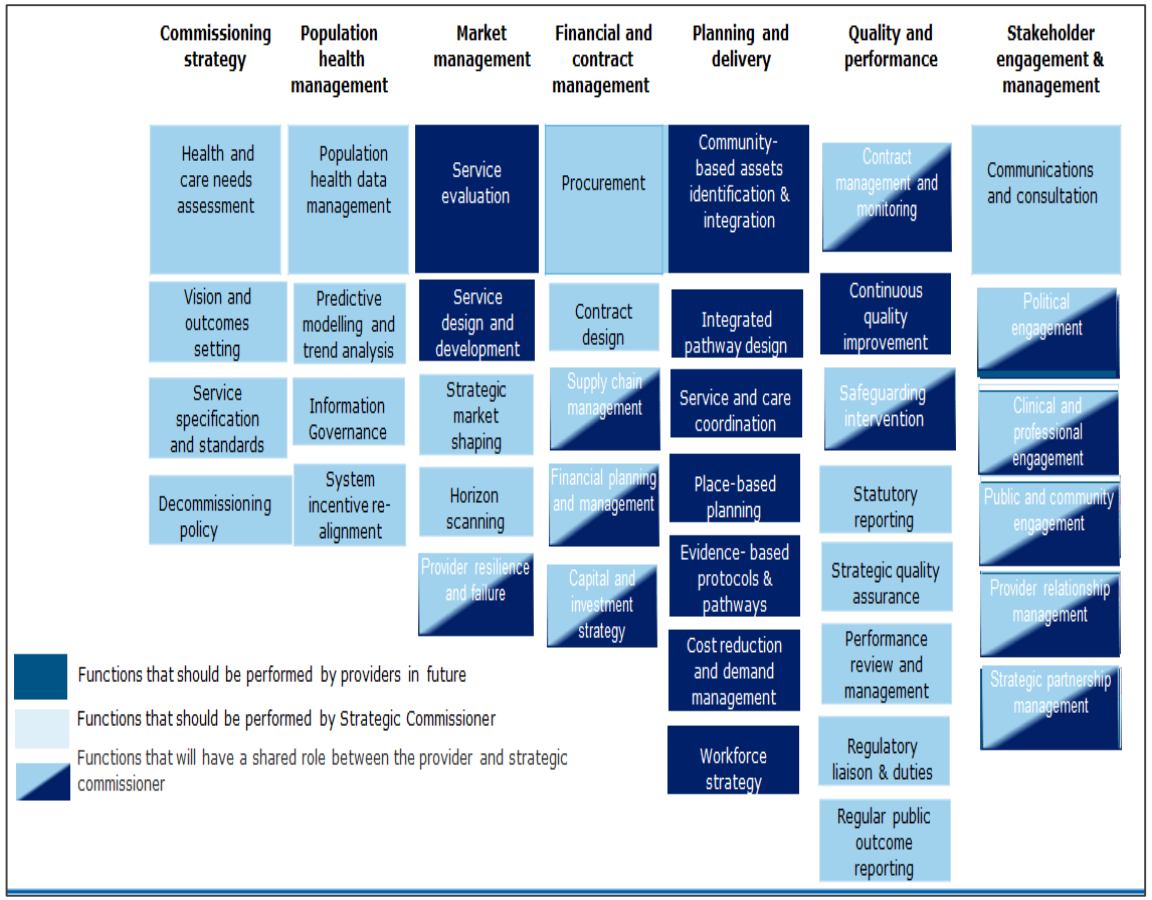
Engagement and Partnership Working

- The CCGs participate in the two Health and Wellbeing Boards (HWBBs), part of their role in this board is to ensure that the ICS Development Plan is aligned with the two Health and Well-being Strategies.
- We will work together with the two local authorities to align the ICS Plan with their respective corporate plans and provide regular updates to the HWBBs on progress of implementation.
- The CCG Clinical Chairs and Accountable Officer have been in detailed dialogue with NHSE/I regarding the CCG merger roadmap and timelines. This programme of work is underpinned by a more detailed plan which should be read as an accompanying piece to the ICS development plan.

Strategic Commissioner Blueprint

Strategic Commissioner Development

- The diagram below sets out the blueprint for the overarching functions that need to be delivered through the strategic commissioning work plan.



The Strategic Commissioner will:

- Ensure an in depth understanding of the health needs of the population in the System with a data driven population health management and a risk stratified approach;
- Identify and agree with all interested parties the priorities, which emerge from the above. This will involve aligning priorities, outcomes and resources with the two Local Authorities including the joint commissioning of services wherever possible;
- Develop and put in place outcome-based approaches for the delivery of priorities by all providers including ICPs;
- Take responsibility for allocating resources to ICPs and other providers to encourage local commissioning and delivery ownership;
- Ensure ongoing dialogue with patients and citizens so their views can contribute to the development of priorities and outcomes; and,
- Responsibility for public consultation over major service changes (including the PCBC)

Progress to Date

- We have taken the blueprint and added detail behind the functions in line with the vision for a Strategic Commissioner and place based care through the ICPs. These are split into determining the 'what' and delivering the 'how' and are outlined on the next slides.
- A communications plan underpins the work to ensure that the approach is supportive, managed internally with CCG staff and socialised with system partners.
- A HR plan underpins the function mapping in order to support the workforce through the transition of alignment of posts to Strategic Commissioning or ICPs.
- We have worked across the ICS work streams to co ordinate the approach linking to the ICP development and financial framework in particular;
- Clinical chairs, directors and lay members have been involved in the work to sense check functions.
- There are a number of functions that will need to sit centrally as part of an ICS and for the purpose of the splits, they have been aligned to Strategic Commissioning. If legislation changes in the future, there is a potential that a number of areas could move into the ICPs for delivery.
- The 6 CCG Governing Bodies in Common have previously agreed to the establishment of 3 Locality Commissioning Boards (LCBs) as a sub Committee of the Governing Bodies covering each of the Integrated Care Partnership (ICP) footprints. The Terms of Reference of the LCBs have been developed and agreed by the Governing Bodies in Common.

Functions Mapped

Strategic Commissioner Development

Strategic Commissioning		ICP	
Vision and outcomes setting	Strategic market shaping	Service evaluation	Service design and development
Health and Social Care Integration - Strategic planning	Whole system procurement	Health and Social Care Integration - local delivery	Local procurement
Consultation and engagement - whole service change	Contract design	Provider resilience and failure	Community - based assets identification & integration
System incentive re- alignment	Financial planning & management	Integrated pathway design	Service and care coordination
Capital and investment strategy	Contract management and monitoring - ICP and services commissioned across more than one ICP	Place-based planning	Evidence - based protocols & pathways
Provider relationship management	Strategic Partnership Management	Contract management and monitoring - local sub contracting	Financial monitoring - delegated budgets
Population health data management	Horizon scanning	Cost reduction and demand management	Engagement – Political / Clinical / Professional / Public / Community
Predictive modelling and trend analysis	EPRR	Outcome based service specifications	Management of delegated budgets
CPAG/IFR	Primary Care Strategy and Contracting	Local quality monitoring and delivery	Primary Care development and commissioning
Safeguarding and statutory quality functions	Strategic Urgent Care - 111/WMAS/OOH	Management of Urgent care performance and remedial actions	Medicines Optimisation
Corporate services - complaints, exec administration, FOIs, MP letters	Continuing Healthcare	Administration aligned to the ICPs	

Examples of Functions Mapped and Next Steps

Strategic Commissioning	ICP
Consultation and engagement -whole service change • CCGs will remain the statutory body and therefore responsible for consulting on material service changes (subject to change following the national engagement proposals around ICS's being placed on a statutory footing). • ICPs will feed the areas of consultation and engagement will be taken at a local level via the ICPs feeding into the formal process which will sit within strategic commissioning (to be determined as part of the new Health and Care Bill.).	**Engagement –Political / Clinical / Professional / Public / Community** • Engagement across multiple stakeholders to be undertaken through the ICPs in determining service and pathway changes. This will be both informal and formal. • ICPs will determine the methods and types of engagement working with the communications team in Strategic Commissioning to ensure legal requirements are met. • Relationships with MPs and Councillors including attendance at OSCs • Other public sector provision -fire and police etc.
Vision and outcomes setting • Taking the PHM data and information and develop strategies and outcome frameworks to define the 'what'. • Set the strategic priorities for delivery through the ICPs. • Work in partnership with ICP leads to define the outcomes.	**Service design and development and Integrated Pathway Redesign** • ICPs to take the required outcomes co-produced with strategic commissioning to design integrated services to meet the needs of the local population -'the how'. • Clinically led process aligned with the available financial envelope. • Lead provider arrangements to be identified and financial movements co ordinated. • QIPP/CIP/system savings to be considered in all redesign. • Care co-ordination and integration. • Consideration given to cross border commissioning by ICPs where appropriate and decided at ICP level. • Providers and commissioners across health, social care and the voluntary sector to take the co- produced required outcomes and develop integrated pathways. • Agreement of any financial realignment between providers. • Agree appropriate use of facilities and technology identifying efficiencies. • Development of CIP/QIPP programmes/system savings. • Identification of lead provider and mechanisms to hold to account through the ICP.

- The table shows an example of the detail of the "what" and "how" that sits within each function mapped.

Next Steps

- There is further work to be undertaken in breaking down the CSU functions into Strategic Commissioning or ICPs. Once the CSU work has been completed, this will then allow a breakdown of the ICP resource across the three ICPs and a gap analysis to be undertaken in terms of capacity and/or capability gaps to deliver against the functions.
- In quarter 4 discussions will commence with staff regarding alignment of posts to Strategic Commissioning or ICPs based upon the functions mapping.
- The functions mapping is a starting point and the way in which we work will evolve and change as we move forwards and the relationships and arrangements mature.
- The final version of the functions work (recognising that this is an iterative process), and structures will continue to be socialised with system partners as part of the ICS and ICP development work. This will enable provider partners to wrap staff around the functions to ensure that there is capacity and capability in place to deliver the requirements.

Health Inequalities and Prevention

Strategic Commissioner Development

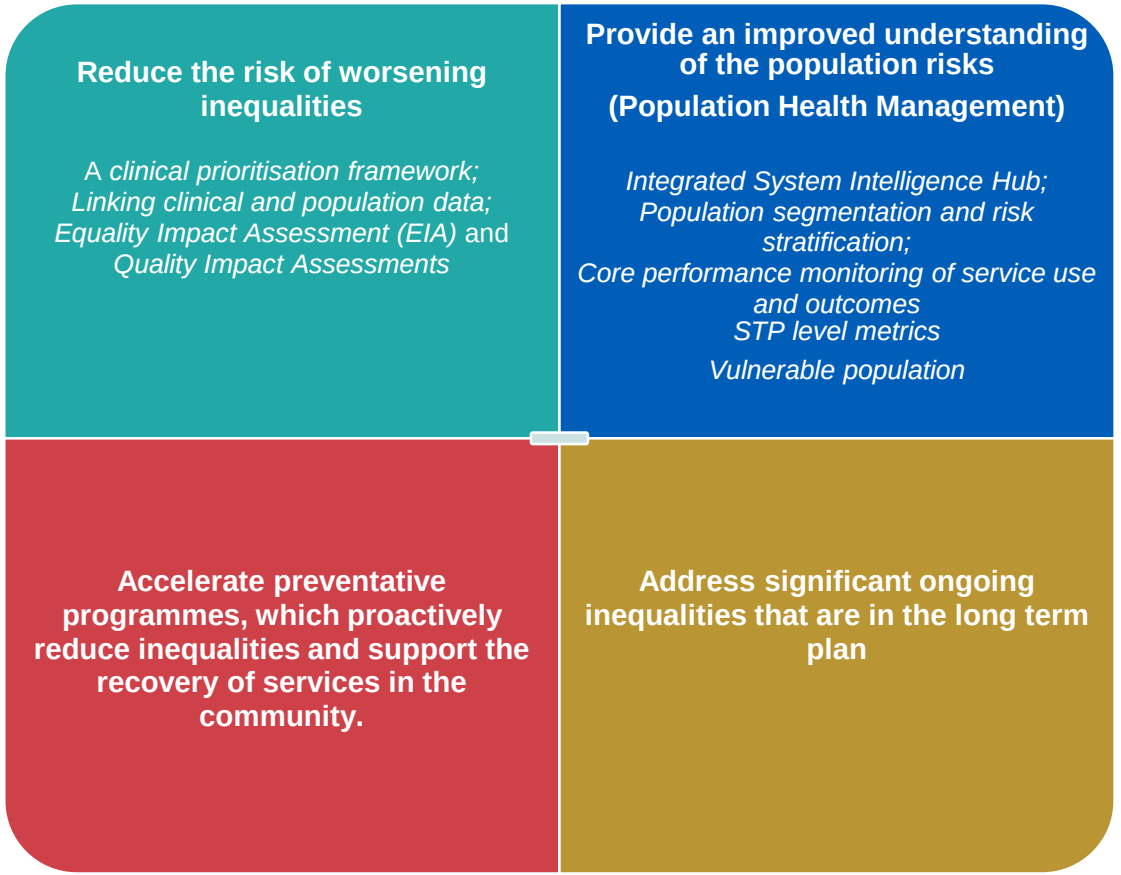
- The FYDP outlined the ambitions and priorities to work collaboratively to increase the scale and pace of progress of reducing health inequalities. This now includes protecting the most vulnerable from Covid-19, with our system Phase 3 recovery plan setting out a clear commitment to tackling inequalities. The work programme identified and PHM approach will support ensuring that inequalities are mainstream activity, core to, and not peripheral to, our work across the system.

Leadership and Governance Progress to Date

- An inequalities strategic oversight group has been established, involving clinical and public health expertise, aiming to bring together the inequalities and prevention work streams. This now needs to set out clearly its plans and ambitions and for these to be agreed by the ICS Board
- An Executive Director is in place providing senior leadership and acting as SRO for this programme of work.
- A Public Health Consultant in the CCGs is leading delivery of the development and of population health management across the system.
- An integrated intelligence group in place undertaking population modelling around Covid-19.
- Progress on both health inequalities and the population health management approaches that support it will be reported via the ICS partnership board.
- A Health inequality champion at board level within each organisation and a system inequalities lead will be identified as a priority
- We are working collaboratively and engaging with local communities through existing assets such as community groups, peer support groups and work undertaken by the voluntary sector to aid place based approaches.
- The Health and Care Senate which will be used to ensure that inequalities are a key issue for clinical and professional leadership groups and are represented in clinical prioritisation decisions.
- Work will continue with LA public health leads to ensure that the Phase 3 recovery plan health inequalities priorities are linked to the wider health inequalities and prevention agenda, via the Health and Wellbeing Boards as they begin to meet again.

Planned work programme -

- The system inequalities and prevention programme is based on a practical and pragmatic view of what can be achieved and where the most impact can be gained.
- The Strategic Oversight Group will present its work plan to the ICSPB in January 2021 and will set out its approach to PHM
- Key areas of work around health inequalities will cover four main programmes outlined in the diagram below.



Population Health Management: Providing an improved understanding of the population

- While every person will have their own unique requirements and circumstances, when working at scale across a whole population, groups with similar needs and characteristics can be identified. By understanding these groups, we can plan and deliver services in the most appropriate way and in the most convenient locations for their population.
- Population Health Management (PHM) is one of the key ways that we are working to develop effective and efficient system integration.
- The city and county both have areas of high deprivation and the PHM approach will help us to focus on reducing inequalities and to work together across health and care to improve wellbeing for everyone.
- PHM requires partners across the system to come together in new ways and we are proud of what we have achieved together so far.

Progress to Date

Pre-Covid-19

- A PHM task group was set up and endorsed by the shadow ICS board
- Establishment of the Intelligence cell
- Increased recognition and drive in the system for collaborative, cross-organisational system wide PHM approach

During Covid-19 response

- The Intelligence and Modelling cell have consolidated the analytical and intelligence skill set across the system.
- We have seen successful collaborative and system working with sharing of data, intelligence and resources.

Developing Clinically Led Strategies

- PHM will be a key tool utilised by the Health and Care Senate (H&CS) to generate evidence based strategy and prioritisation.
- The H&CS will deploy cross system population health analysis, in order to establish areas of need and priorities for targeting resource. The Health & Care Assemblies will have health, care and clinical representation at the local and PCN level. These smaller populations are well positioned to reflect local areas of needs at a granular level.

System:
How can we use population health analysis to decide how to allocate resources across providers?

Place:
How can we support people on multiple waiting lists in deprived areas?

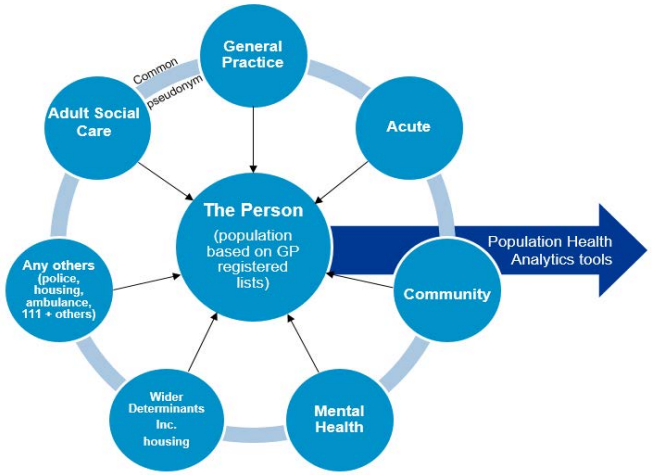
Neighbourhood:
Which at-risk patients should our MDT proactively engage in preventive efforts?

Person:
How can we leverage our neighbourhood assets to support this person who is at risk?

Resources = money, time, people, skill level, etc.

PHM Infrastructure

- Our Population Health Management (PHM) approach supports integrated teams at every level of a system with the 'person-based' analytics they need to drive better outcomes.



- The approach will support local teams to answer some of the questions they are faced with.
- By bringing together a linked data set that represents the total need of this population (Infrastructure), and providing advanced analytics that help professionals understand and prioritise risk, complexity and need (Intelligence), PHM supports these teams with the insights that can drive new proactive care models at scale (Interventions) at system, place and neighbourhood level.

Current action to support linked data sets

- Improving the recording of population data (ethnicity etc.) in clinical data
- Working with Upper Tier Local Authorities (UTLAs) to link clinical data to population testing data to support the management of outbreaks and understand and reduce the spread of infection in the community
- Working with UTLAs to link NHS data with LA data on vulnerable people to understand the impact of Covid-19 on health inequalities

Next steps include:

- Continuing to progress the infrastructure required for linked data sets
- Information Governance- SIRO, IG leads, data sharing agreements with system partners.

PHM Development Programme

- The system will benefit from the Wave 3 PHM development programme having been successful in the application to join.
- The programme aims to build capacity and capability by working with all tiers of the system to transform service delivery around key population groups.
- The intensive 22-week programme is designed to accelerate Integrated Care System (ICS) development through action learning sets, additional training and development

SYSTEM WORKSTREAM:

- 5 SME facilitated Action Learning Sets that **bring together all system stakeholders to develop a common understanding** and learn from international good practice
- Focus on **sharing learning across workstreams** and **collectively unblocking barriers** to scale PHM

PLACE & ICP WORKSTREAM:

- 3 Action Learning Sets with providers, Local Government and wider partners to **develop a scalable plan to restore services inclusively and address inequalities** by linking elective data with person level analysis

** 1 place funded through programme*

PCN WORKSTREAM:

- 5 Action Learning Sets with primary and secondary care partners, social care and third sector teams to **identify at risk groups and develop & deliver new holistic model of care**
- **Regular coaching** throughout the to key members of PCN MDTs

** 3-4 PCNs funded through programme depending on system footprint*

ANALYTICAL WORKSTREAM:

- 7 Action Learning Sets that bring together system analysts for **hands-on learning of PHM analytical techniques** and a facilitation to **create a sense of shared purpose** for system intelligence teams
- Local analyst community learns to directly **support MDTs designing intelligence-based care models** within the programme

FINANCE & CONTRACTING WORKSTREAM:

- 7 Action Learning Sets that bring together **finance and contracting leaders from commissioners and providers**
- Trained use of actuarial and predictive modelling to develop whole system demand models and drill down into a **new blended payment model based around a population cohort**

Population Health Management: Providing an improved understanding of the population

PHM Intelligence

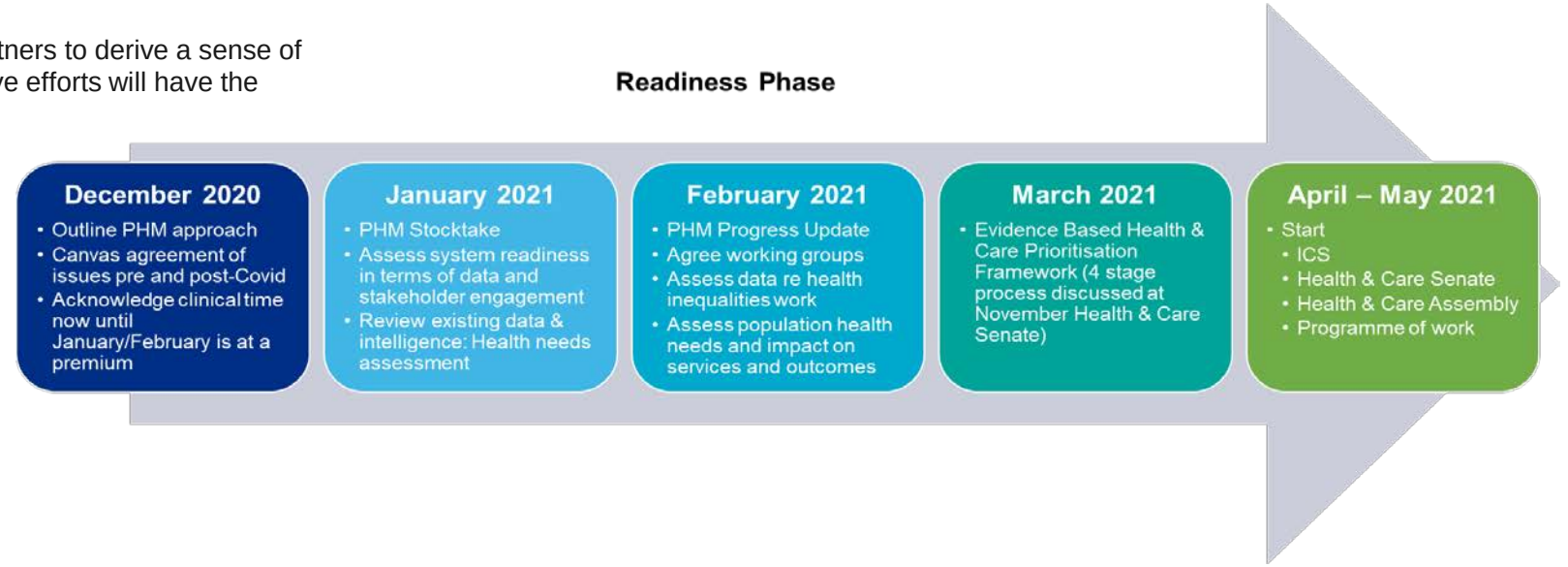
- Over the last nine months we have focussed on improving collaboration and sharing of data across the system and developing shared intelligence that is agreed collectively by all the organisations across the system.
- The H&CS is in a phase of readiness to use PHM intelligence to develop clinically led prioritisation and strategic development.

Next steps include working through the readiness phase to

- Undertake a pilot project using linked data sets to assess population health needs, prioritisation and using PHM analytics for developing appropriate interventions
- Work on Insights on how the use of linked datasets with integrated teams can support prioritisation and deliver change. e.g. interventions to reduce inequalities

Broader development and engagement in the system PHM approach will continue through delivery of:

- Development of core capabilities
- Stakeholder engagement by working with system partners to derive a sense of common purpose, priorities and agree where collective efforts will have the biggest impact



Governance and System Architecture

Model of Care

- Our overarching model of care and support is designed from the perspective of individual needs across an integrated pathway recognising that people will move both up and down the continuum of care in terms of the support and the intervention needed at specific points in their lives.
- Our approach to specific models of care is based on the application of a set of agreed design principles outlined below

1. Inpatient settings

- Reduced reliance on inpatient services
- Short-term support delivered as part of individual service designs including personalised risk and escalation plans

2. Entry intervention (de-escalation and management of crises)

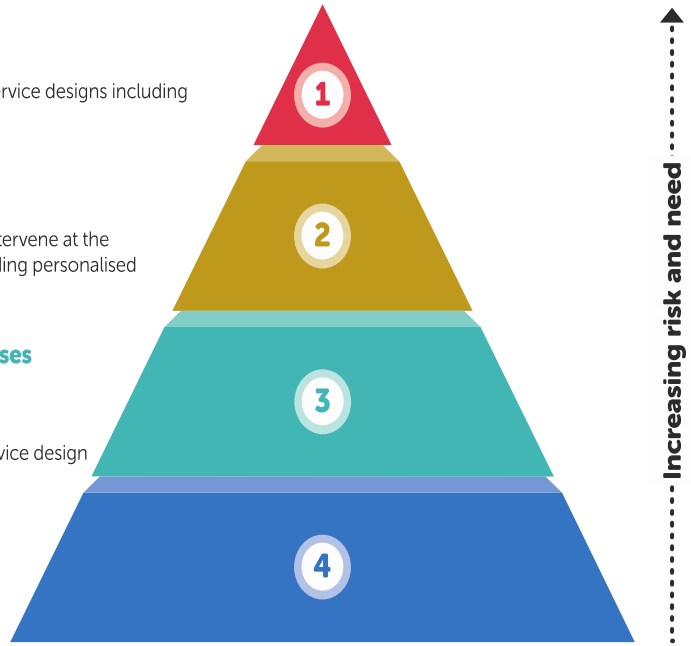
- Collaborative arrangements between partners to intervene at the right time based on individual service designs including personalised risk and escalation plans

3. Case management and prevention of crises

- Collaborative approach to care and support
- Early triggers and use of risk registers
- Flexibility of commissioning based on individual service design

4. Mainstream provision

- Public health prevention
- Primary care
- All services adapted to support



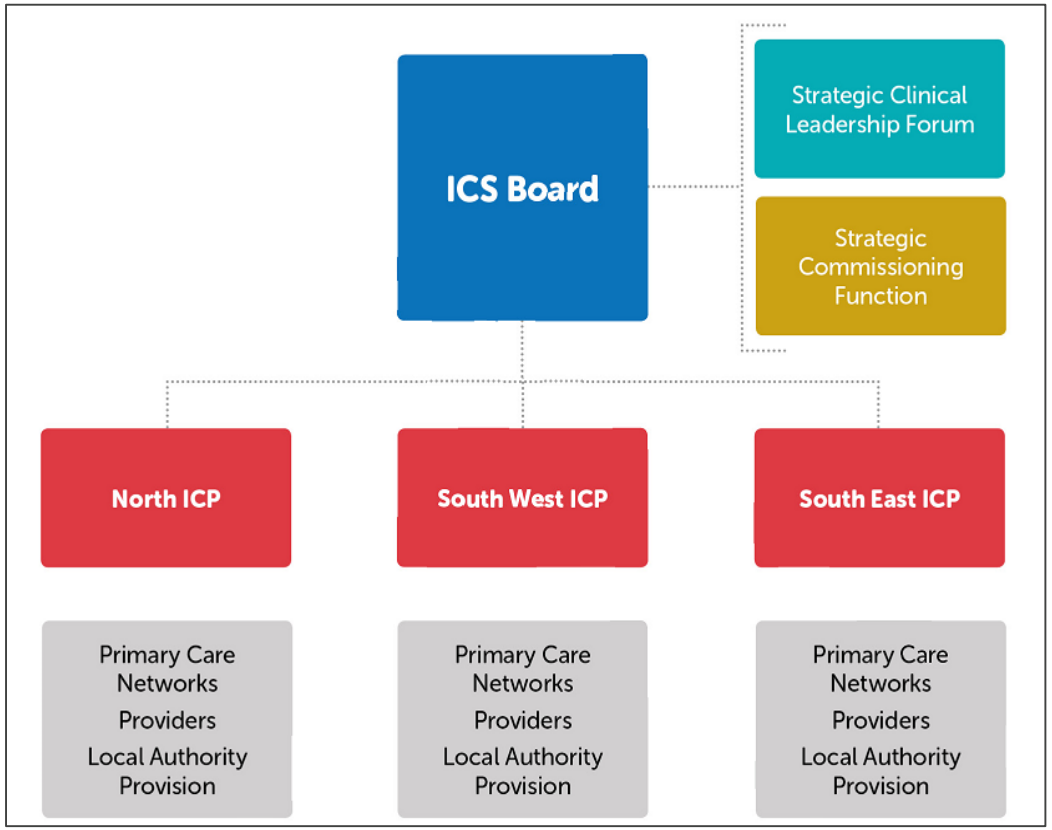
Delivered through

1. Integrated Care System (ICS)
2. Primary Care Networks (PCNs)
3. Integrated Care Providers (ICPs)
4. System leadership and governance
5. Population Health Management
6. Quality and safety
7. Involvement

System, Place and Neighbourhood Functions

Governance and System Architecture

- The FYDP set out a commitment to establishing a new system architecture by April 2021.
- ICPs will adopt an inclusive approach to promote engagement from all health & care partners including NHS, LA, Primary Care, Third Sector and other partners (e.g. Universities) who can influence the delivery &/or transformation of services.
- At ICP level, the focus is likely to be centred around three key elements:
    - Operational liaison and local coordination
    - Delivery of transformation aligned to STP/ICS priorities
    - A clear focus on how we tackle health inequalities through PHM
- The simplified governance set out opposite shows the ambition that the system has in order to move to fully functioning ICS, that is built on the ICP (Place) based model of care.

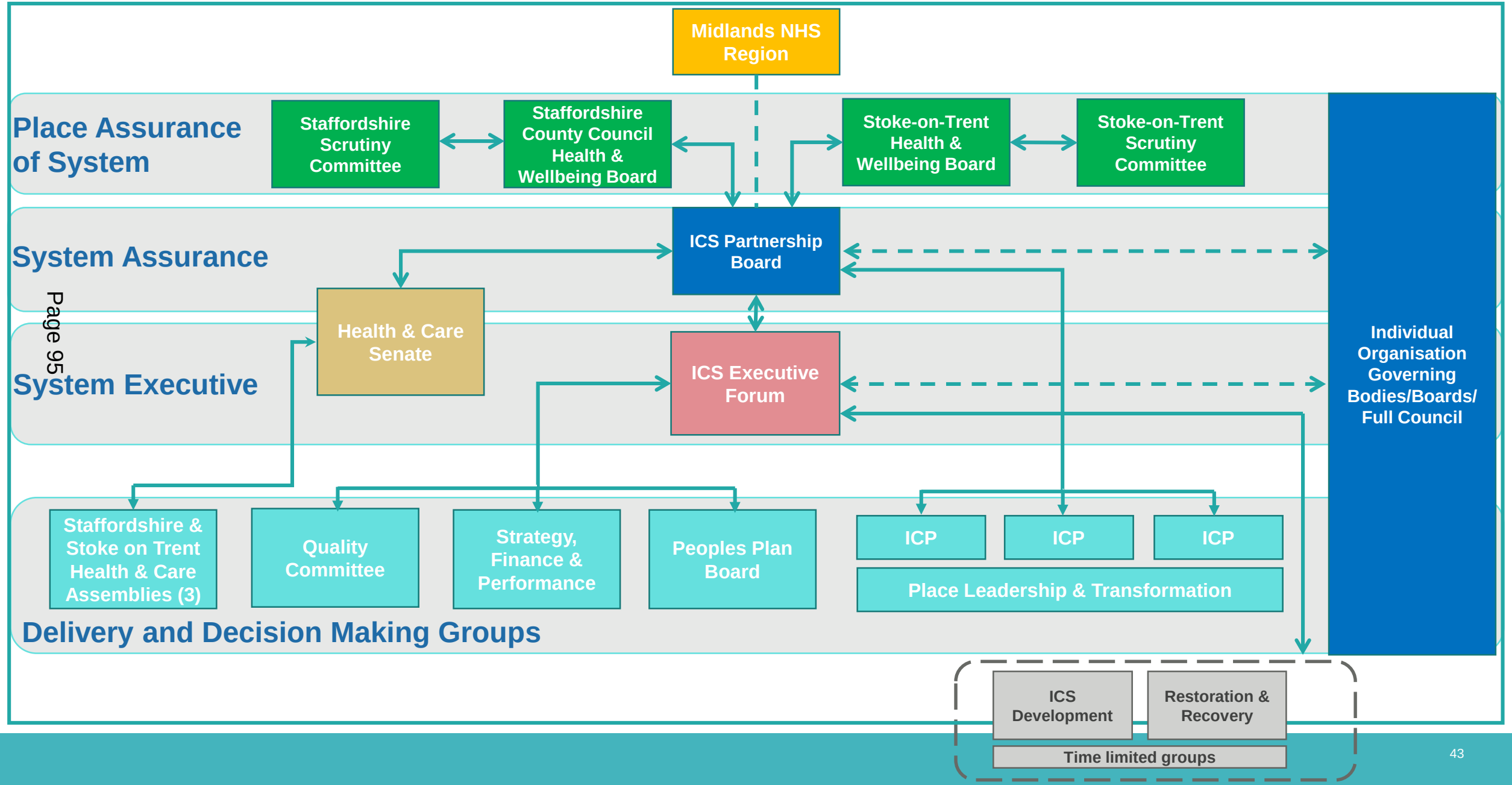


Draft (Interim) Governance Structure

Governance and System Architecture

- To support the ongoing partnership working an interim governance structure based on 'function' has been established and is shown in on the next page.
- The sub committees that have been formed enable the dual role of an ICS to be fulfilled and ensure that there is full partner engagement in all of this work.
- Central to the effectiveness of this structure is the tripartite relationship between the ICSPB, the Executive forum and the H&CS. These functions are are already established and will act as the vehicle to help facilitate ICS maturity development.
- This approach will continue to evolve but is focussed on-
    - Clarity of roles and responsibilities
    - Effective and simplified decision making
    - Recognising statutory organisations and their respective responsibilities and accountabilities
    - ICS & ICP development
    - Enabling the 'System by Default' Operating Model
- Progress continues to be made in regards to supporting decision making at the appropriate level – the principle of subsidiarity is applied in everything that we do
- The next stage of this work is to work through the functional requirements of an ICS and look to set them out at each level. This will require partner input and ownership and is an essential step to support the place (ICP) agenda.
- The functional analysis work will subsequently support the review of decision making. This will require legal support and input to ensure that any schemes of delegation are lawful and well understood. Partners are clear of the importance of getting this right but have not underestimated the scale of this task.
- The ICSPB will receive regular updates from the main standing committees to detail progress against the agreed objectives. These will be system based reports and will build from individual partner performance. The Board will rely on the Executive Forum to execute delivery and monitor implementation.
- We have a robust and well-functioning Mental Health (MH), Learning Disability and Autism Programme Board (MHPB) which will continue to operate within the ICS governance structure. There is appropriate representation from NHS partners within the STP and oversees deliverables in the FYDP. The MHPB will continue to oversee a transparent investment process of the Mental Health Investment Standard (MHIS) into priority programmes. More recently the MHPB have overseen the response and sign off of the submission in relation to the additional 2020/21 winter funding for post-discharge support for mental health patients.

Draft (Interim) Governance Structure



Place Assurance of System

- It is clear that there is still work to do to evolve and develop the governance to support effective system working. The recent publication from NHSE/I on the next steps for integration and the statutory establishment of ICS's provides an outline framework for us to work to but we anticipate that as further detail is provided that we will need to reflect this in our local approach.

Scrutiny Committees

- There are already strong relationships with both scrutiny committees and regular engagement enables a constructive and transparent process of scrutiny to function.
- We are clear that we expect this to continue as we move forward. However, there will be a need to consider how and who will have the statutory responsibility for any formal consultation that the system wishes to undertake. This will be dependent on the national legislation.
- Equally the role of the scrutiny committee in relation to the local place agenda will be an area that will need to be developed. It is likely that there will be a significant amount of local flexibility around the governance that is put in place and there is a strong local commitment

Better Care Fund

- The proposal for 2021/22 is to roll forward the Better Care Fund agreement as currently agreed. This is aligned to the national directive but the system will review this if that guidance changes as part for the Operational Planning Guidance for 2020/21. In future years it is likely that there will need to be a review of this budget as part of the budget setting process for the place based agenda. The future process for sign off will be revisited if the statutory responsibilities change as part of the ICS establishment.

Health and Well-Being Boards

- The 2012 Health and Social Care Act established Health & Well-being Board's (HWBBs) as committees of the Council. They were given statutory responsibility for producing the JSNA and for building a collective momentum in tackling the health inequalities in the local area. Each upper tier local authority is required to have a H&WBB.
- Locally there are two HWBB's (one for each LA) and system partners are represented on both. They have an important role to play given their responsibility for the JSNA. AS our ICPs develop and become more mature, there will be a need for much closer working.
- It remains unclear as to whether the proposed legislative changes will consider the purpose or need for HWBBs.

Involvement

- We have a strong track record in involving staff, service users and the voluntary sector in developing our priorities and plans. Understanding the views of our population helps to explore ideas such as the smarter use of technology, providing care in different settings closer to home and supporting the STP to seek ways to reduce health inequalities.

Existing feedback

- Over 12 weeks during the summer of 2019, we worked with health and care professionals, partners and the public to understand their priorities for local health and care services. Their feedback helped inform our FYDP and priorities.
- During summer/autumn 2020 we did further engagement with local community groups, to understand people's experiences during Covid-19, including future priorities. Working with our Healthwatch partners a wider public survey was carried out. This feedback will be considered by the restoration and recovery programmes and the ICSPB to inform future priorities and the approach to wave two.

Future communications and involvement activity at a system level, will include:

- Delivery of the Winter C&E plan and response to Covid-19 (2020-21)
- Primary care, partner and public engagement on the development of the Strategic Commissioner function (2020-21)
- Publication of Long Term Plan and support for the local People Plan
- Systemwide approach to transformation, including key areas of urgent care, maternity, community care, mental health and planned care (2021-23)
- Significant mental health transformation programme over three years (2020-23)
- Supporting the equality programme, with a focus on reaching seldom heard groups

Approach to Communications and Involvement

- We have robust foundations locally for capturing the patient voice to inform and support transparency of the work at ICS and ICP level.
- Healthwatch and voluntary sector partners are involved at a board level
- Integrated approach to C&E with a shared Director of Communications across the CCGs and ICSPB footprints, with a seat at the ICSPB
- Investment in a central STP C&E resource, led by the Director, that supports system transformation and co-ordination
- C&E leaders across providers/CCGs lead on specific priorities, using their individual expertise and report to the system group
- A C&E system group, with members from all partners, including local authorities, Healthwatch and the voluntary sector meets monthly chaired by the Vice Chair of the ICSPB
- The LRF C&E group meets weekly (during Covid-19) to co-ordinate the C&E response
- Aligned patient networks to support systemwide conversations, including the digital People's Panel and the face to face local representatives group. These are then supported with face to face groups at an ICP level.
- At an ICP level we are working to strengthen local networks with the voluntary and community sector, to inform future engagement activity
- Plans to strengthen our Local Equality Advisory Forum, working at a system level to listen to seldom heard groups
- Regular reporting on engagement activity into the PPI lay member committee within the CCGs (future Strategic Commissioner function) and the ICSPB to inform priorities
- Good relationships with the Overview and Scrutiny Committees to inform approach to involvement.

Quality, Performance and Finance

Quality

- Our underpinning philosophy is that quality should permeate everything we do, from the way we jointly plan and commission and deliver care, to the way we work collaboratively to drive improvement and innovation.
- To enable us to provide outstanding quality services for all our shared vision and underpinning quality framework will not only focus on quality assurance but also quality improvement.
- Fundamental elements of the quality framework are Quality Improvement and Quality Assurance.

Quality Improvement Elements

- Deploy a shared QI approach and methodology to support system wide change projects in line with system priorities, in particular and with initial focus on those priorities identified in the Phase 3 recovery plan response which broadly include:
  - Acceleration or preventative programmes which proactively engage those at greatest risk of poor health outcomes
  - Programmes to support those who suffer mental ill health
  - Action to address health inequalities
  - Restoration of services
- Establishment of a system QI steering group to prioritise and coordinate QI programmes
- Ensure all improvement programmes put the service user and carers right at the centre, and staff in the driving seat of change
- Establish a cohort or trained QI leaders able to work in partnership across boundaries
- Deploy a shared system and approach for report out of QI work programmes at key milestones
- Ensuring that we recognise and reward achievement

Quality Assurance Elements

- A system Quality and Safety Group to steer the delivery of system wide quality assurance and improvement
- Setting standards for what outstanding quality care looks like.
- Improving patient and carer experience through the development of ICS wide customer service culture
- Take findings from CQC Provider Collaboration Review and work together across the system to embed the learning both from examples of best practice and areas for improvement
- Embed a system wide Quality Impact Assessment process that ensures that system wide service development and changes do not put at risk the safety of our service users and their carers
- Establish a system wide mortality review process to better understand, measure and review patient mortality with the longer-term aim of reducing health inequalities
- Establish a system wide approach to harm reviews in line with the serious incident framework and national guidance on learning from deaths.

- The response to Covid-19 has seen dramatic changes in how health and care services are delivered and used. In the **Appendices** of this delivery plan we have outlined case examples of how the system has already worked together to overcome challenges in respect of the quality and safety agenda.

Performance, Improvement and Assurance

Quality, Performance and Finance

- One of the key roles of the ICS is to manage our own system performance and improvement process, taking on some of NHS England and Improvement's regulatory role, to ensure the best achievement of constitutional standards and of the commitments in the Long Term Plan.
- In the past this process has at times been characterised by a lengthy process that covers all areas of interest to regional, national and local leads that can absorb considerable resource and not always achieve a clear performance improvement.
- Our aim is that this becomes a more focused and supportive process taking a proactive stance on self-assurance, earning autonomy from our regulators to self-regulate on most issues. We want to use the same principles that have worked through Covid-19 to underpin our work on future performance challenges. Assurance will be a dialogue of equals focused on improvement for the population, system and organisation.
- The focus will be on improvement, supporting the spread and adoption of innovation and best practice between partners. The ICS are committed to delivering assurance that is based on partnerships for improvement.
- There is a well established system Strategy, Finance and Performance Committee (SFP) which responsible for agreeing the messages on performance. It will define the issues and actions that need to be taken to deliver the plan and will break these actions down into individuals / organisations and ensure that the action plan is coordinated across organisations.
- The SFP has the correct membership and intelligence to support discussion of the main issues, decision making and challenge on system performance.
- Where consensus on the actions or decisions can not be reached in the meeting there is a clear route of escalation through to the CEO forum.
- A System Performance and Assurance Working Group (SPAWG) was formed in July 2020 to support the remit of the SFP.
- The purpose of the SPAWG is to support an approach to gain shared understanding of system performance and intelligence in advance of the SFP and regulator system review meetings. The aim is that system partners collectively own and are sighted on the key issues and actions to improve performance. Partners are all involved in developing a jointly owned System Performance and Assurance report.
- The outputs of the group feed in to the SFP Committee.

Progress To Date

- The SPAWG meets on a monthly basis prior to the SFP.
- The monthly meetings and report produced by the SPAWG are evolving and will continue to develop as required. Currently the initial provider data contained within the report has come from those organisations that sit within STP. Progress is being made with University Hospitals of Derby and Burton and the Royal Wolverhampton NHS Trust to expand the report to include their data and to develop data flows from non-acute settings including primary care, community and mental health.

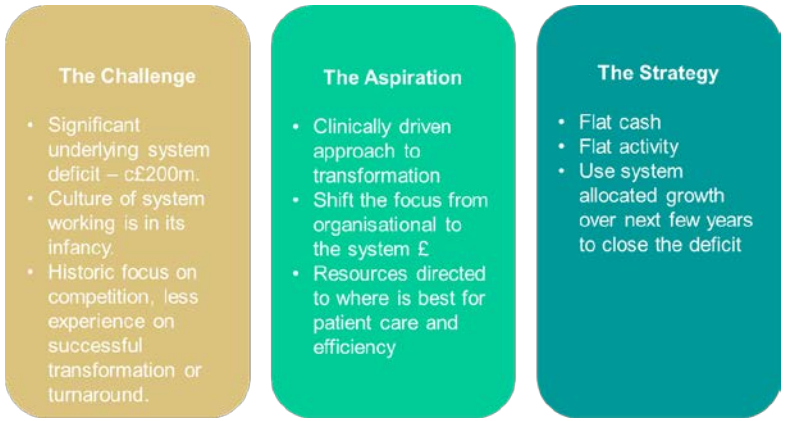
Finance

Quality, Performance and Finance

Financial Strategy

- The ICS will facilitate the development of a financial strategy that articulates how the system and the organisations within it will deliver the financial targets. It will define how the system will ensure that it is delivering the best healthcare for our population within the overall financial envelope.
- The strategy will define how the ICPs will deliver these outcomes. It will use evidence and data to define what can be done. It will define the expectations for the major drivers of the system financial position including provider productivity (system savings), investment in new services, funding, and managing activity growth, funding the delivery of system operational targets and managing financial risk.
- The pathway to a financial strategy was approved in October.
- Work on agreeing the principles of the financial strategy across the system has gone well, and all system partners understand the need for the strategy.

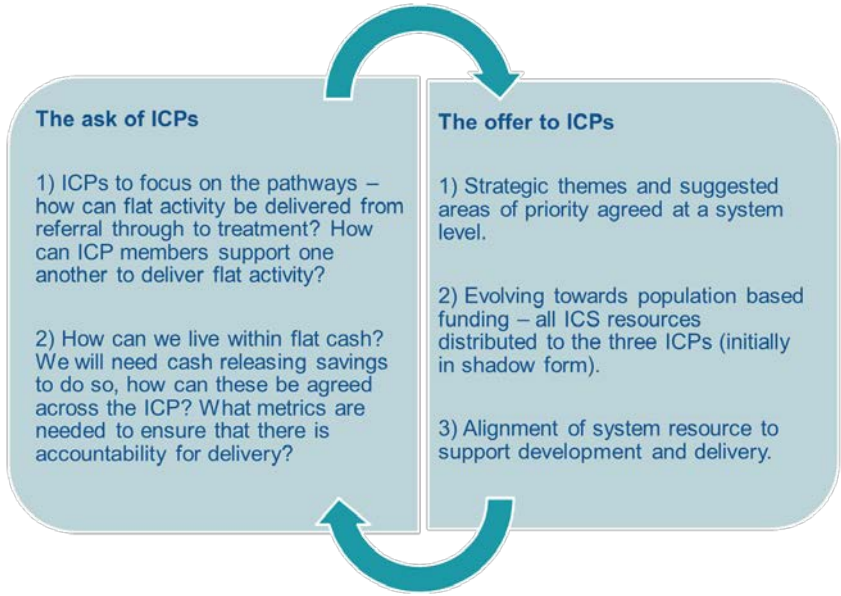
Financial Strategy on a Page



- The financial strategy principles recognise that, while there is a significant amount of uncertainty with respect to future ways of working and the financial regime, there are some key underlying assumptions and challenges that we can be confident of and start to shape our approach and response to.
- The strategy aims to strike a balance between what we do know and what we're waiting on confirmation of.

ICPs

- The approach proposed utilises the ICPs as the place where the work can be done across the system - to agree how flat cash and flat activity can be achieved.



- Once the more detailed arrangements for ICS and ICP is developed nationally we will continue to work flexibly to ensure that the analysis undertaken can accommodate all these views of the system's financial position

Finance

Opportunity Analysis

- The development of system opportunities was progressing throughout the late Winter and early Spring of 2020, however with the onset of the Covid pandemic this work was curtailed.
- Focus over the summer period has been the development of the restoration and recovery plan as well as the preparations for winter surge planning and the upturn in Covid. The next steps which sits alongside the development of the financial strategy roadmap is the preparation for the Phase 4 “Reset” plan. One of the key aspects of this will be the “refresh” of the FYDP priorities and opportunities as well as the consideration of the service developments implemented to respond to Covid-19.

The Intelligent Fixed Payment Approach

- The system is committed to evolving the Intelligent Fixed Payment (IFP) model to support the development of the ICS and ICPs. This will include the allocation of resources and the financial framework for ICPs, alongside supporting risk and gain share arrangements.
- The IFP represented a key step change in how we work together as a system to manage our financial positions. As we undertook 2020/21 planning, it was agreed that the IFP continue with similar arrangements before the Covid-19 central finance regime was put into place.
- The Finance Directors of the 4 statutory organisations oversee the management and development of the IFP and have agreed to establish a “shadow” IFP for ICP system in 2021/22 with a view to implanting it in full in 2021/22. This will allow partners to better understand the changes that are being proposed and not to destabilise individual organisation positions.
- Very early modelling of the 2021-22 baseline positions has been undertaken
- In the first instance, it is anticipated that the ICS holds the overall resource envelope for the system and is the level of aggregation that NHS England and NHS Improvement will hold the system to account for.
- Below this the 3 Integrated Care Providers would be delegated the CCG budgets which are relevant at a “Place” level – prescribing, continuing health care, and potentially delegated Primary Care.
- Providers would form “provider collaboratives” in both acute and community/mental health services to work with ICPs and each other in the best delivery of healthcare.
- In the first instance allocations would be made directly to the 5 NHS providers and 3 ICPs by the ICS. Risk and gain share arrangements would be agreed between each ICP and the 2 provider collaboratives to best manage care at a “place” level to improve patient pathways. Alternative risk and gain share agreements would be made between providers to manage risk and reduce competition.
- Whilst there is a significant amount of work to be done to establish this model, early modelling is now commencing. The financial allocations, and risk and gain share agreements, will need to be able to look at:
    - The organisational view;
    - The collaboration view; and
    - The place view.

Clinical and Professional Leadership

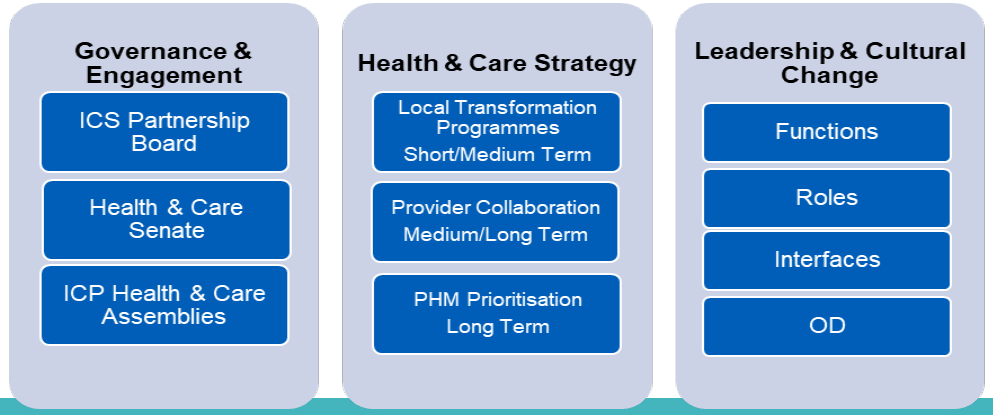
- Clinical and professional input for the ICS is provided by the Staffordshire and Stoke-on-Trent Health and Care Senate (H&CS) and its associated sub-groups, the Health and Care Assemblies. This will ensure strong clinical leadership at the centre of ICS decision-making.

- By working collaboratively with other system partners, strategic, evidence based, intelligence driven, health, care, clinical advice and leadership is at the heart of commissioning and service delivery. This will lead to improved provision of quality, safe and equitable health and social care resulting in improved outcomes for the population.

- The H&CS was established in 2019, by a group of health and care professionals who recognised the need for a concise system wide professional body, with representation from across the health and care sector. The structures support clinical and professional input from the front line of care, across Staffordshire and Stoke-on-Trent. This professional leadership is readily accessible to the ICS Board, establishing early and ongoing clinical input into system strategy and delivery.

- The Executive leads for this area of development are Dr John Oxtoby and Dr Rachel Tallyot.

- A detailed plan has been developed to support the provision of strong clinical leadership at the centre of ICS decision-making. The plan is built around 3 core areas of work:



Engagement

- The H&CS is multi-disciplinary and inclusive of representation from across health and social care, comprising representatives from Social, Primary and Secondary care clinicians as well as representatives of Local Authorities and senior doctors and nurses. The H&CS meets monthly with the frequency of meetings having been increased in response to Covid-19; demonstrating the strength in working together across the system as health, care and clinical leaders

- The H&CS is supported by three affiliated, place based Health & Care Assemblies. Initially the vision was of a single sub-group Assembly for the system. With the development of the three ICPs, the reality is that each ICP will form a local Health & Care Assembly affiliated to the H&CS.

- Clear strategic direction and prioritisation by the H&CS will enable the local Assemblies to lead, support and deliver clinical decision making at ICP level. The Assemblies are inclusive of a wide-range of health, care and clinical professionals who can assure the local delivery against the system strategy a prioritisation that they are affiliated to.

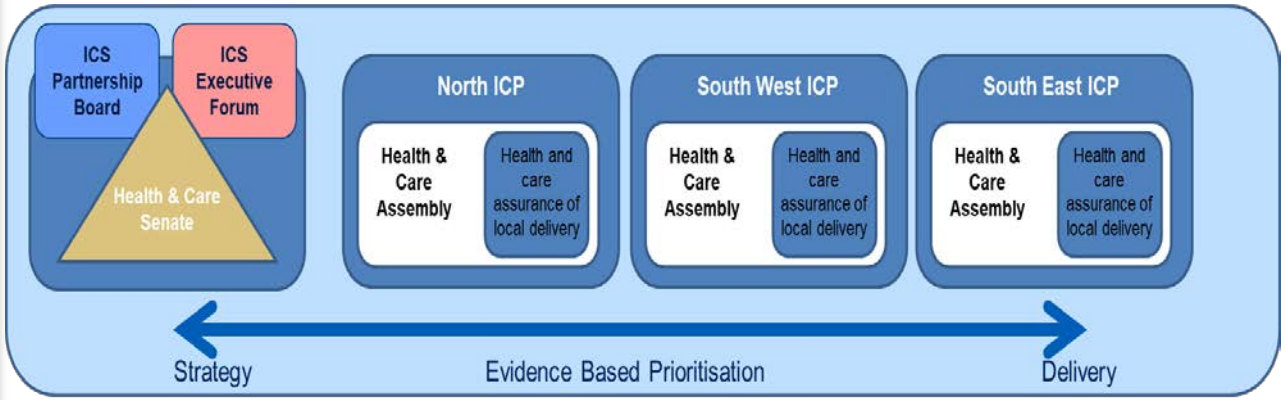
- Primary, Secondary and Community Care, Mental Health and C&YP Networks are integral to the H&CS and Assembly structures. the H&CS will co-opt members of these assemblies to provide specific expertise to assist with its work.

- The H&CS and Assemblies are powerful forums for harnessing the energy and expertise of health, care and clinical professionals across the system.

The Role of the Health and Care Senate in the ICS Partnership Board

Clinical and Professional Leadership

- The relationship between the H&CS and the ICSPB is crucial and symbiotic. The H&CS is represented directly on the ICSPB by its Chair and Vice-Chair, with a defined system function in clinically supporting the Board.
- The H&CS will provide clinical scrutiny of proposed developments from the ICS and, in addition, a conduit, ensuring that the views of professionals from across the system are communicated and well represented.
- The Chair or Vice-Chair of the H&CS will provide clinical representation at the Executive forum.
- The H&CS provides a clear link to the ICPs, through each Health and Care Assembly.
- Engagement with the ICSPB, and the level of clinical influence and visible effect on strategy decisions, will sustain the full support and involvement of senior professionals. This input is vital to the ICS, in order to ensure that the right decisions are made early, and to satisfy the important requirement for health, care and clinical engagement.



- In order to ensure that this relationship is strong, the following points are key:-
  1. The Chair and Vice-Chair of the H&CS are co-opted onto the Executive Forum and ICSPB
  2. Any major area of strategic work undertaken will have health, care and clinical involvement with representation agreed via the H&CS and Assemblies with additional input as required. All final documents and/or developments before they are agreed by the ICS Partnership Board will go through the H&CS as a mandatory gateway process
  3. The H&CS has the delegation to refer clinical matters, which it deems significant, to the Executive Forum and ICSPB;
  4. The H&CS is used to provide reviews of services across the system, utilising expertise from within the Assemblies;
  5. The H&CS works with Executive Leaders across the system and is integral in the development of clinical strategy.
- The developing structures described are well defined, guaranteeing strong clinical and professional input. This provides a broad range of expertise and ensures strong linkage between health, care and clinical professionals and the ICSPB.

Clinical and Professional Leadership

Tackling Variation across the System through Clinically Led Strategy and Prioritisation

- The H&CS is responsible for the development of clinically led strategic developments that will inform the ICS strategic direction considering:
  - Standing Items: The H&CS discusses the current health, care and clinical positions of Primary, Secondary and Community Care, Mental Health, Children & Young People and other health and care professions, offering independent strategic and objective health and care advice that is based on evidence, best practice, data intelligence and robust understanding of population health needs
  - Emerging & Time Critical Issues: The H&CS is an essential forum to get quick health, care and clinical representation. This has proven invaluable during the Covid-19 pandemic in matters such as:
    - Discussion and agreement around the legality of End of Life care
    - Local trust clinical assessment of referrals and how these are prioritised
    - Urgent pathway reviews, i.e. paediatrics
  - Proactive Development of the System Agenda: The H&CS will lead on the most urgent and top clinical priorities across the health and social care system that are informed by population health management.

Leadership and Cultural Change

- The model of health, care and clinical professional leadership has the key enablers to provide broad and robust delivery for the system. The H&CS is already operational and will evolve with the development of the ICS.
- The structure provides strong and clear linkage between the health, care and clinical providers and the ICSPB. This provides real influence to a wide group of health and care professionals, which is a key requisite to ensuring their continued engagement. The governance structure is multidisciplinary, with engagement from all spheres of health and care as well as social care and clinical professionals
- There is ongoing leadership development of the health, care and professionals, to ensure these individuals are equipped with the skills to drive and lead the health, care and clinical strategy across the system.

Progress To Date

Governance & Engagement

- Resource to support the H&CS functions and work programme is confirmed and providing input. The levels of resource and skills required will continue to be reviewed to ensure that there is sufficient capacity in place.
- The H&CS Terms of Reference have been approved and the meeting format and a proposed annual business cycle developed.

Health & Care Strategy

- During Covid-19 the H&CS has already begun to provide an essential function to get quick health, care and clinical representation on emerging time critical issues.
- The evidence based prioritisation framework has been developed and agreed
- The readiness phase to receive PHM as a tool to develop strategy has commenced.
- The PHM readiness phase has been presented at the H&CS.

- The system approach to PHM is outlined further in the strategic commissioner development section.

Becoming a Mature H&CS

- The H&CS has utilised the format of the ICS maturity matrix to critically assess its current position. This has been used to plot and develop its path to becoming a mature H&CS for Staffordshire and Stoke-on-Trent.
- A self-assessment of the leadership state of maturity will be undertaken on a quarterly basis.

Integrated Care Record (One Health & Care) Summary

- Staffordshire and Stoke-on-Trent have a live Integrated Care Record Solution, which is already well populated with data from partner organisations and provides the foundation upon which to build integrated care tools and enhanced data to improve health and care for the local population.

- We are active members of the Local Health and Care Records Group across the West Midlands and accordingly are committed to sharing the data in the Integrated Care Record with partners across the region through the LHCR programme. Our close collaboration with Shropshire, Telford and Wrekin STP will see the Staffordshire and Stoke-on-Trent ICR shared to create a single integrated care record covering both regions, which will prove especially useful for MPFT who provide services in both areas.

- The requirement for an ICR was identified in our original Digital Roadmap submission in the autumn of 2016. The procurement process used the HSS framework and a contract award was made to Graphnet / System C in July 2019. An implementation project began in September 2019 and the ICR achieved full Go Live status in August 2020.

- All of the ICS provider Trusts, both Local Authorities, WMAS and all 150 GP practices are partners in the ICR resulting in a comprehensive health and care record.

- An outline roadmap has been developed which will see further datasets added, additional users from within the Health and Care Economy connected and a range of new and exciting features being made available.

- The diagram summarises the organisations and data that are presently live, the future datasets that are currently in development and further features to be implemented over the coming months. The roadmap is presently being prioritised by the Digital Clinical Advisory Group and the Digital Design Authority before being turned into defined work packages for delivery.

Shared Care Record (One Health & Care) Delivery Plans

- University Hospitals Derby and Burton have commenced their data-sharing project following delays due to resource issues around the response to Covid-19. These delays continue although data is expected to be integrated into the solution from January 2021.

- Social Care data for Children will commence in early 2021 as there are dependencies on Staffordshire County Council system upgrades

- Community Data: MPFT are dependent on system upgrades to enable data flows for Community data, which will follow in 2021 once the two community systems in MPFT have been merged.

- User access: All main partners (with the exception of UHDB) are enabled to access the Shared Care Record. Further developments access will be deployed in further care settings such as hospices, care homes and NHS111 provider.

- Personal Health Record: The project has agreed the scope for the Personal Health Record, which is a mobile app, and website, which will empower patients/service users to manage their conditions and support wellbeing. Features include viewing appointments, medication and correspondence. Individuals will be able to record information such as weight and mood; there is the ability to link smart devices to include heart rate etc. An initial version of the app is expected to go live in February 2021 accompanied by a roadmap detailing when additional functionality will be available.

- Care Planning and end of life: The project team are working with the RESPECT collaborative group to explore how the solution can support the national standard. Currently the information is paper based with various local processes, which uploads copies to partner organisation local system. The requirement is to make the most up to date information available to all those involved in the individuals Health and Care provision. Once the latest version of the RESPECT document is finalised by the Resuscitation Council this will be loaded into the solution and deployed.

- Business Intelligence Tool: The project team are working with UHNM Lung Screening Team to identify the initial cohort of patients who meet the criteria to be part of the screening programme to pilot the BI tools. The Project Team are exploring the wider use of the solution with Information Governance Colleague to ensure all aspects of secondary use of data is understood before a wider role out is planned.

- Regional Expansion: Staffordshire are working really closely with our neighbours to breakdown the digital boundaries of the Shared Care Record. Most advanced is in Shropshire, Telford and Wrekin where the current Shared Care Record will be expanded to include Health and Social Care partners from within this area. Black Country discussions are underway to establish the most appropriate way to share data into the record.

- Information Governance: The current IG articles will be expanded both the include a wider range of organisations into the agreement but include further uses of the data specifically the secondary use of data to support health analytics.

Detailed maturity self-assessment and development plan against the five domains

Introduction: Maturity Matrix Self-Assessment

- The system took part in an ICS development programme in July 2019. At that point the system completed the self-assessment against the ICS Maturity Matrix.
- An initial gap analysis was undertaken to map the current system position against the maturity matrix and the July 2019 assessment. This forms the basis of the development needs that have been identified by the system to ensure that there is progress made towards the 'Thriving ICS' ambition.
- A stock take of our current position demonstrates that good progress is being made against most elements of the maturity matrix.
- The system has demonstrated an improved ability to work collaboratively as part of the Covid-19 response. Being part of the region wide review on lessons learnt has facilitated the system undertaking its own review to help support the process.
- Further work is being undertaken to map these development needs against the 5 workstream areas to ensure that there is comprehensive coverage.
- The following section provides a description of the progress made in accordance with the maturity matrix along with development points, owner / resources and timelines.
- In contrast to the previous assessment all domains we have assessed our progress against against the "thriving" characteristics, with actions identified to achieve this level of maturity.

Domain 1: System Leadership, Partnership & Change Capability

Themes	Progress	Development Points	Owner / Resources	Timeline
Strong collaborative and inclusive system leadership and governance	• ICS Independent Chair appointed and in place. • H&CS established at ICS level mirrored at ICP level by Health and Care Assemblies. • Clinical and professional leadership is readily accessible to the ICS Board, establishing early and ongoing clinical input into system strategy and delivery. • A health inequality executive at board level within each organisation and a system inequalities lead. • Focus on inclusivity and diversity at senior level in our workforce is a priority of the system workforce group. • Established commitment to the three ICPs , each with leadership and governance in place which has been developed on inclusive basis, including key partners and stakeholders • CEO leadership to ICP development supported by an Executive programme lead. • System wide ICP Programme Board in place to coordinate activity to support ICS roadmap.	• Independent Chair to work with ICS leadership team to put in place ICS governance in order to transition from the shadow ICS Shadow Board. • The H&CS is currently revisiting its terms of reference, identifying the role of clinical and professional leadership and the senate at a system level; and the role of leadership and assemblies at the ICP/Place level and developing work programme. • An OD plan to support system and place clinical and professional leadership. • ICP Visioning Documents, Partnership Agreements and Delivery Plans to be signed off.	STP Exec Forum	Feb 2021
Shared system vision and objectives	• Overall ICS vision as set out in the FYDP. • The H&CS has agreed an approach to identify the system clinical priorities. • Developing outcomes frameworks at both the system and programme level • The FYDP and ICS Roadmap 2020 sets out commitment to an ICS supported by an ICP model of delivery. • Each ICP identified 6 priorities during Summer 2020 which have been shared with the ICSPB. The ICPs have been working to deliver these through their current governance arrangements.	• Refresh and reframe the Vision and System Objectives, overarching strategy and strategic priorities in the FYDP post Covid-19. • The PHM team will continue to work with the H&CS focusing the areas outlined in the FYDP into a set of priorities based on population need. This will then be used to develop a system level strategic and outcome framework and form the basis of the strategic commissioning framework.	STP Exec Forum	April 2021
System transformation partnership and engagement	• The system has captured the learning and service changes resulting from Covid-19 and are using this to understand the opportunities for transformation as part of recovery. • Organisational phase 3 plans were used to support the development of recovery plans at the system and ICP level • The system has actively engaged with the population and used focus groups for specific patient groups to understand how the changes during Covid-19 have impacted on our population. • The ICPs have developed on the basis of inclusivity and are supported by governance and servicing arrangements • Each ICP has an aligned Director of Strategy to provide the connection back to individual organisation and system wide transformation activity.	• Developing outline proposals for major service change as a result of Covid-19 and feeding those in to our transformation work. • ICP Delivery Plans will include a communication and engagement plan to support delivery. • At ICP level strengthen the involvement of patient and voluntary groups.	ICS Leads ICP Leads	April 2021 March 2021

Domain 1: System Leadership, Partnership & Change Capability

Themes	Progress	Development Points	Owner / Resources	Timeline

Capacity and system transformation change capability	• System performance and assurance report developed based on system strategic and recovery priorities.
	• A Transformation Delivery Unit is in place that supports our transformation agenda.
	  ◦ Projects are aligned to the FYDP and Phase 3 recovery plan
	  ◦ Standardisation has been applied to our programmes and projects including reporting and oversight
	  ◦ Project management discipline has been deployed against system priorities reporting into our system SFP and providing oversight on programme delivery
	• System:
	  ◦ Commitment to ICP model of delivery with oversight through the ICS Roadmap and CEO leadership to the 5 priority areas identified
	  ◦ ICP development has been co-designed with the strategic commissioner programme of work to ensure alignment of future models
	• Place:
	  ◦ Three ICPs established with defined geographical footprints
	  ◦ Cross- organisation work between health and social care partners delivered on ICP priorities identified throughout Summer 2020
	• Neighbourhood:
	  ◦ 25 PCNs in place
	  ◦ PCNs and Local Authority locality approaches have been critical to the development of the ICPs to date
		• Achieve a single CCG covering the STP footprint by April 2022.
		• Implement the plan to deliver a Strategic Commissioner function
		• Working to increase the provider level data from out of area acute providers, community care and primary care to improve the impact of the system assurance report
		• PHM work stream and programme work streams are working on developing outcome frameworks linked to the Phase 3 recovery plans and FYDP.
		• Development of ICP delivery plans which set out priorities for action
		• Involvement of ICPs in development of system-wide financial strategy and schemes to support recovery to balanced financial position over the medium terms
		• TDU capacity to be reframed and enhanced to support local ICP delivery and place based transformation – system wide PMO capacity and capability
		• Transformation projects to be rebased following refresh and reframe of the Vision and System Objectives, overarching strategy and strategic priorities post Covid-19
			Strategic Commissioner
			
			ICP / ICS Leads
			
			ICP Programme Lead / CCG CFO
				April 2022
				
				March 2021
				
				December 2020
				
				April 2021

System culture and talent management	• Increasing diversity in senior positions is a priority for the system workforce group • Leadership development programmes: High Potential Scheme pilot leading the way nationally in pilot programme. Winter Inclusion school guest speaker and programme of sessions agreed, Cultural Racial Inclusion development programmes • A range of Stepping Up, Stepping up Alumni, Reverse Mentoring, Pilot ICP Programmes in place • A capability and capacity review of analytical/intelligence resource has been undertaken in the system to support development of PHM	• System workforce group co-ordinating across organisations to increase the diversity of workforce in senior posts • An integrated intelligence group to develop analytical and intelligence skills across the system	People Board	March 2021

Domain 2: System Architecture and Strong Financial Management and Planning

Themes	Progress	Development Points	Owner / Resources	Timeline
System architecture and oversight	• An interim governance structure based on 'function' has been established. • Sub-committees that have been formed enable the dual role of an ICS to be fulfilled and ensure that there is full partner engagement in all of this work. • System Performance and Assurance Working Group (SPAWG) set up to bring together an integrated provider and system view of performance and the key issues and actions for the system. • ICPs have been established and have been operational for several months working to deliver self-identified priority areas.	• Increase the provider level data from out of area acute providers, community care and primary care to improve the impact of the system assurance report. • System integrated Intelligence group and the SPAWG are working on the development of a system level dashboard and outcomes framework. • Digital Board development to aid the progression from a voluntary collaborative group into being a key part of the governance structure of the ICS.	CCG DoS ICP SRO	March 2021 March 2021

Streamlined commissioning arrangements	• A confirmed and finalised CCG merger timeline and roadmap.
	• A detailed plan to support delivery of the Strategic Commissioner Development particularly in relation to
	  • the functions delivered at system level by the strategic commissioner.
	  • a work programme on how current commissioning functions are part of ICP functions.
		• Developing a programme for further expansion of integrated commissioning with the Local Authority.
		• IFR and the funding arrangements utilised during Covid-19 are being used to reconsider the future role of commissioning.
		• Collaboration between ICP and strategic commissioning functions to determine nature and scale of locality commissioning support to enable ICP delivery.
		• Develop an approach for planning and delivery of specialised services as locally as possible, joining up care pathways from primary care through to specialised services with the ultimate aim of improving patient outcomes and experience.
			Strategic Commissioner	September 2021
				
				March 2021

System control totals, operating plans and financial risk sharing	• Implementation of Intelligent Fixed Payment (IFP) arrangements in 2019/20, and agreed these in shadow form in 2020/21 prior to the Covid-19 financial regime. • A System Capital Prioritisation Group, to review and prioritise capital plans across the system. • A system approach to developing plans (Phase 3, FYDP, system savings plans etc.) that involve strategy, finance and operational directors.	• A financial strategy that articulates how the system and the organisations within it will deliver the financial objectives and targets taking on board the learning from Covid-19. • Directors of Strategy to take the leadership on development of the system wide plans (eg Phase 3, operating plans) • Development of the system/provider capacity/demand models to prioritise system actions and resource allocation. • Involvement of ICPs in development of system-wide financial strategy and schemes to support recovery to balanced financial position over the medium terms.	ICP Programme Lead / CCG CFO / System DoS	March 2021
System wide financial governance and cross-cutting strategies	• A System Strategy, Finance and Performance group in place ensuring collective overview and ownership of current system position and plans. • A System Finance Director Group , with supporting infrastructure in place. • TDU established to support system efficiency opportunities.	• A financial strategy that articulates how the system and the organisations within it will deliver the financial objectives and targets taking on board the learning from Covid-19. • Development of system approaches to system savings. • Delivery programmes are in place but will need rebasing.	System DoFs	March 2021

Domain 3: Integrated Care Models

Themes	Progress	Development Points	Owner / Resources	Timeline

Population health management	• Developed an integrated intelligence function during Covid-19 that includes involvement from all organisations this has supported:
	  • Development of Covid-19 population models
	  • Capacity and demand modelling
	  • Population data on outbreaks and on the demographic distribution of Covid-19 admissions
	• An established system H&CS which has health inequalities and PHM as one of it's core priorities ensuring that inequalities are a key issue for wider clinical leadership groups.
	• A process for PHM based prioritisation at the system and place level
	• An initial work plan for the next six months.
	• Supporting the system understanding on health inequalities and the development of the inequalities work streams.
	• Active involvement with the NHS England regional team and PHM programme, and use of external experts Milliman, which supports the development of PHM capacity and capability across the system.
		• Population health management tools that can be used at system and place level.
		• Digital and PHM work streams continue to collectively work on data sharing protocols
		• Working with the H&CS and the system PHM group on developing a PHM Strategy and work programme for 2021/22.
		• Developing work on understanding the use and impact of CCGs inequalities funding on health inequalities.
		• Develop a plan to address the deficits identified as part of the Capability and Capacity review of functions.
		• Working with the integrated intelligence group on single population/clinical data sets for use at system and place level.
		• Work starting to develop primary care intelligence and PHM programme.
		• Development of system PHM infrastructure that can support ICP level needs analysis.
			ICP Programme Lead / CCG Director of Strategy	March 2021

Long term plan - care models and service changes	• Covid-19 has resulted in cross organisational system working on:
	  • Care homes
	  • Community care models
	  • Discharge and admission avoidance
	• All service changes as a result of Covid-19 have been captured, have QIAs and EIAs and are being used to inform the FYDP service change models/opportunities
	• There is an agreed overarching model of care and support outlined in the FYDP.
		• Consider which service changes made as a result of the response to Covid-19 need to be built into the FYDP service change models
		• For 2021/22 partners will be reinvigorating the System Objectives, overarching strategy and strategic priorities in the FYDP post Covid-19.
			Directors of Strategy	March 2021

Redesigning outpatient services and using new technologies and digital advances	• Rapid uptake of digital consultation in primary care – including video consultations. • Radical transformation to none face to face consultations across all sectors. • All system partners have deployed virtual technology during Covid-19.	• Embedding of change in practice and exploiting further opportunities for transformation e.g. patient initiated follow up.	Planned Care Cell Digital Board	March 2021

Domain 3: Integrated Care Models Continued

Themes	Progress	Development Points	Owner / Resources	Timeline
Development of Primary Care Networks	• ICPs have been developed with PCNs at their heart and PCN representatives are fully involved in each of the three ICPS. • An agreed Primary Care Strategy is in place. • 25 PCNS in place each with Clinical Directors.	• CCG Primary Care support to PCN Development to include link to ICP development to support PCN CDs to contribute at wider system level. • PCNs currently working on the Delivery of Enhanced services specification. • The CCG is refreshing the GP strategy post Covid-19, focusing on embedding the primary care operating model, continuing to support an expansion of the workforce, focussing in on cutting bureaucracy, refocusing QOF, and making more funding available. • Deliver development plan with PCNs: this is currently being refreshed and relates to the leadership and development of PCNs.	ICP Programme Lead / CCG Director of Primary Care	March 2021
The prevention agenda and addressing health inequalities	• Our system Phase 3 recovery plan set out a clear commitment to tackling inequalities including population analysis of Covid-19 admissions. • Development of a system prevention group and work programme. • An inequalities strategic oversight group has been established in the STP, involving clinical and public health expertise to bring together the inequalities and prevention work streams. • A health inequalities expert group. • Inequalities identified as a key priority and work programme by the H&CS • ICPs progressing delivery of 6 areas of priority, including a focus on reducing health inequalities and promoting the prevention agenda. • A bid is under consideration by the regional Health Equality Partnership Programme.	• A system inequalities and prevention programme of work focussing on actions that mitigate the impact of inequalities and help take pressure off services by supporting people and communities. • Work to be undertaken to improve healthcare recording of demographic and inequalities data • Work on understanding the use and impact of CCGs inequalities funding on health inequalities • Work with LAs and Voluntary sector on community approaches to prevention • Developing the social prescribing/interventions within PCNs. • Developing risk stratification approaches to identify pathways where health inequalities are important. • Development of inequalities metrics as part of the system outcomes framework • Continue work with LA public health leads to ensure that the Phase 3 and FYDP prevention agenda is linked to the wider health inequalities and prevention agenda via the Health and Wellbeing Boards. • Develop the system level strategic framework and system operating plan to include clear objectives around health inequalities. • Development of system wide PHM infrastructure that can support ICP level needs analysis.	ICP Programme Lead / CCG DoS	March 2021
Workforce models	• Long-term workforce planning across the system has taken an 'open book approach' through development of the FYDP and Phase 3 recovery plan, with all providers engaged in the process and sharing their workforce projections across the system. • Arrangements for mutual aid in place and effective during Covid-19	• Review of integrated workforce models post Covid-19, with opportunities for new roles and ways of working to be embedded.	People Board	March 2021
Personalised care models	• System partners are working with local authorities to deliver personalised care.	• Continued development of the long-term conditions pathways and specific operational areas such as wheelchairs, continuing healthcare. • Work with local authority to implement an integrated PHB offer.	Joint Commissioning Board	March 2021

Domain 4: Track Record of Delivery

Themes	Progress	Development Points	Owner / Resources	Timeline
Evidencing delivery of LTP priorities and service changes	• The system Phase 3 recovery plan was built on and around our FYDP priorities. • During summer/autumn 2020 further engagement was undertaken with local community groups, to understand their experiences during Covid-19, including discussion of future priorities. • All of the Covid-19 service changes have been reviewed against the FYDP ICP priorities have been cross referenced against the FYDP. • Delivery of priorities designed, developed and delivered through individual ICPs to support maturity and build tangible evidence base for added value enabled through ICPs.	• Use learning to inform transformation against an agreed methodology to consider whether in accord with the FYDP areas should be developed further as permanent service changes. • Continue the work with the H&CS to develop the clinical priorities supporting the FYDP. • Maintain focus on main priorities in the Phase 3 recovery plan. • Further development through ICP Delivery Plans which will include assessment of alignment to FYDP including evidence base of case for change.	ICS / ICP Leads	March 2021
Delivery of constitutional standards	• Strong system delivery of mental health standards. • A system assurance framework. • Recognition of areas e.g. urgent care where the system have struggled to meet emergency care standards. • Significant progress in delivery of cancer standards. Acute Trusts working through cancer hub to ensure opportunities for mutual aid are exploited. • Extensive data validation has reduced the number of patients waiting for elective care. • Good use of the independent sector with system wide plans for utilisation from January 2021.	• Focus on delivery on of the trajectories in the Phase 3 recovery plan. • Use Phase 3 recovery plans as a platform from which to deliver the constitutional standards.	ICS and ICP leads	March 2021
System operating plans	• An agreed FYDP that was determined ready to publish pre Covid-19. • For 2021/22 started to develop system level strategic framework design and delivery groups for the system operating plan.	• Directors of Strategy to support the development of the system operating plan in conjunction with ICP leads and the H&CS. • ICPs will become the 'engine rooms' of delivery for transformation and integration of health care pathways that harness expertise of Providers in translating plans into action	ICS and ICP Leads	March 2021
Challenging systemic issues	• Improved relationships through previous winters and in response to Covid-19 has given system partners the opportunity to work collaboratively to address systemic challenges • Significant evidence of co-production and co-delivery e.g. Care Homes • Covid-19 has focused the system to work collaboratively in providing joined up care. • As part of the our EPRR response a daily call is in place for leaders to address emerging issues in responding to Covid-19	• Confirm ICS role in developing provider relationships and alliances to system wide models of care (end to end pathways.) • Improved intelligence to support real-time demand and capacity modelling	ICP SRO	December 2020

Domain 5: Meaningful Geographical Footprint

Themes	Progress	Development Points	Owner / Resources	Timeline
Do you have a meaningful geographical footprint that respects patient flows and, where possible, is contiguous with local authority boundaries or have clear arrangements for working across local authority boundaries?	• Whilst geographical boundaries of the ICS do not respect patient flows the footprint of the ICP's create a closer alignment. • ICS and ICP boundaries reflect local authority boundaries with good engagement at all levels of the ICS and ICPs, including opportunities for District and Borough Councils to engage at ICP level. • ICPs cross local authority boundaries, though this is recognised, with clear arrangements in place for cross boundary working. • The upper tier Local Authority boundaries are coterminous with the boundary of the proposed ICS • The proposed single merged CCG boundary coterminous with the ICS boundary	• Engagement with major out of area acute providers and neighbouring STPs to ensure inclusion in system and ICP development work • Developing partnerships with Staffordshire County Council and Stoke-on-Trent City Council, and the VCSE sector.	ICS Lead	December 2020 Ongoing

Summary

- This plan sets out the work that has taken place in order to support the ICS development across Staffordshire and Stoke-on-Trent and progress against key operating requirements.
- The ICS development plan does not exist in isolation though. It is essential that this document is read in conjunction with-
    - The Five-Year Delivery Plan for Staffordshire and Stoke-on-Trent
    - The Phase 3 Recovery Plan
    - CCG Merger Project Plan
- As such, this plan helps to facilitate and support a change to the way that the system works to meet the changing needs of the population. Simply, it is not an end in itself.
- Equally there has been considerable learning from how partners responded to the initial impact of Covid-19 and the subsequent ongoing response. This plan looks to capture and build on this learning in order to find ways to embed the improved ways of working and collaboration.
- As system partners we demonstrated that during the Covid-19 we could respond by implementing and executing plans quickly and effectively. We need to carry this forward into our approach to delivering transformation.
- There is an exciting opportunity emerging around the approach towards truly integrated place-based care and the development of our ICPs. It remains early days with some of this work but there is a strong commitment from all partners to make this happen and for it to change how we deliver care to the population that we serve.
- In recognising the positive steps that have been made, there is a clear and coherent view on the next steps and the associated key risks. In producing this development plan, it has highlighted a number of areas where there is further work required if we are to deliver on the benefits of being an ICS.
- The ICS Partnership Board will have oversight of this process and the small steering group will progress the agreed actions. This will report through into the Exec Forum, but each CEO is expected to keep their own organisation fully informed of the progress being made and the associated risks.

Appendices

Case Studies and Patient Stories

Case Study: What is different about an ICP? Developing an Asset Based Approach

- The transition to an Integrated Care Partnership approach provides a fundamental opportunity to place a new emphasis on the strengths and assets of our communities and open up new ways of thinking about improving health.

- By adopting an 'asset based' approach, the ICP can make visible and value the skills, knowledge and connections that already exist in our communities and build on locality-focussed identities and groups. Working with patients and community groups, the ICP will empower people with the confidence to look after themselves and take control of their own health and care needs, thus help to prevent or delay ill-health in the longer term.

- We have commissioned the National Development Team for Inclusion (NDTI) to support us in the development and delivery of a Community Led Support (CLS) programme

- The CLS programme involves selected local authorities and health and social care partnerships implementing a new way of delivering community support. It brings innovation to how services are delivered; designed and driven by practitioners along with local partners and members of the community they are serving.

- There are a number of key principles that have been recognised as guiding this work;
  - Co-production brings people and organisations together around a shared vision
  - There is a focus on communities and each will be different
  - People can get support and advice when they need it so that crises are prevented
  - The culture becomes based on trust and empowerment
  - People are treated as equals, their strengths and gifts built on
  - Bureaucracy is the absolute minimum it has to be
  - The system is responsive, proportionate and delivers good outcomes

- The programme also provides access to a strong national network to enable sites to share experiences, learning, tools and ideas and address common challenges.

Community Led Support Programme Progress

- The programme is coordinated through the Assistant Director of Adult Social Care and offers a tangible commitment of the ICP to work in true collaboration across Local Authority and NHS boundaries.

- To date 20 community conversations with over 100 groups have been held to shift the emphasis away from 'what is the matter with you' to 'what matters to you'. A clear area of priority emerging through the conversations was a CLS approach to redesigning 'front doors' of service access including acute hospital, community and social care

- Learning from experience of introducing CLS change elsewhere, the focus will initially be on two 'innovation centres' within Stoke-on-Trent to mobilise CLS change at locality/neighbourhood level

- A focus on Community Wellbeing Teams and redesign of the Front Door utilising Social Care First Contact Teams and Social Care Community Teams based in community venues alongside partners to drive contact and communication with residents in the community. Establish a Community Front Door in order for residents to access help through the community as a method of supporting early and intervening with appropriate support.

- Good progress has been made in a short space of time and the next steps include:
  - Innovation Team to meet prior to Christmas break
  - Communication content to be agreed and distributed
  - Local Community Organisations contact to be made and a community meeting pulled together for the new year.
  - The geographical boundary is currently being developed and will be ready for the new year.
  - Planning for Change and Signs for Change workshops have been scheduled week commencing 11th January 2021.

Case Study: NHS Continuing Healthcare Fast Track Pathway - Integrated Working with Partners

- As of the 1st September 2020, the NHS Continuing Health Care (CHC) Framework restarted, including the reintroduction of NHS CHC Fast Track. To support this, the sourcing of Fast Track packages at home transferred to the CHC Team within the Midlands and Lancashire Commissioning Support Unit from 24th August 2020.
- Guidance mandates that the CCGs should consider the delivery of end of life care in the context of the *Hospital Discharge Service: Policy and Operating Model*. The guidance also defines the importance of the function of community referrals from a single point of access that retains responsibility for overseeing communication with the system.
- The guidance does not define the six week funding for any specific patient cohort or clinical need and therefore there was an opportunity to consider Fast Track/ End of Life Care Pathways, both in terms of admission avoidance and hospital discharge to ensure individual's needs are met safely, in a timely manner in their preferred place of care.
- There is recognition that to meet the national guidance current pathways require improvement.

Challenges

- Inconsistent wrap around provision across the Staffordshire and Stoke-on-Trent footprint for fast track patients to receive care and support to meet preferred place of care (home) in a timely manner.
- Delays/issues are experienced with timely identification of fast track patients leading to increased length of stay in hospital and deconditioning.
- The fast track process does not currently meet the requirements to support same day discharge as per the national discharge guidance.
- No current function in place to commence packages of care over a 7 day period.

Revised Pathway

- The overarching principle of this pathway is to support individuals who would ordinarily meet NHS Continuing Healthcare Fast Track criteria to receive care and support in a timely manner to prevent a hospital admission or facilitate hospital discharge. The pathway will provide
  - Rapid step down care for individuals who meet fast track criteria
  - The ability to support individuals who are in the community who require rapid intervention;
  - Standardisation & equity of care provision through a single point of access;
  - Building trust, up-skilling across organisations & strengthening of clinical expertise within the community;
  - Training and education;
  - Completion of care assessments at home and support patients to achieve their preferred place of care/ death.

Integrated Approach Across Partners

- Patients will be supported based on assessed need by Midlands Partnership NHS Foundation Trust (MPFT) community staff; this will include both personal and clinical care as required.
- Onward referral to other services such as Hospice at Home will be facilitated through the Palliative Care Co-ordination Centre and community services
- The Hospices (Douglas MacMillan, Compton and St Giles) have worked collaboratively with the CCGs and MPFT to enable them to provide an enhanced offer of provision and to support the implementation & mobilisation of this pathway.

Anticipated benefits

- Opportunity to work with Hospices to support future commissioning arrangements/ models of care.
- Quality and patient centred response.
- Reduced delays in discharge/prevention of unnecessary acute admission.
- Minimal hand off.
- Clear lines of responsibility and governance.
- 7 day working 9-8.
- Opportunity to undertake change management approach, learning as we go, developing the process as it is rolled out.

Case Study: Staying Well Service (SWS)

- Responding to Frailty is one of the key transformational elements which underpins delivery of the NHS long term plan. The ambition locally is to develop new services for older people to proactively manage frailty and associated system consequences.

- The Staying Well Service (SWS) was co-designed with partner organisations including CCGs, GP practices, mental health and community trust, acute trusts, voluntary sector and GP Federations. Extensive stakeholder engagement resulted in a 12 week pilot which was evaluated and learning was used to inform further roll out.

- The Staying Well pathway uses a proactive population health approach, utilising system partners to enable earlier detection and planned interventions to prevent or delay progression to severe frailty. It can help to identify undiagnosed disorders such as heart failure or potential impacts of Covid-19 (both physical and mental) as well as supporting social inclusion using local support networks, communities, and the voluntary sector.

- During the first phase of the pathway, the model involves primary care identification of patients with mild-moderate frailty, using a combination of risk stratification tools, in some areas the model also includes a multi-disciplinary team meeting between the GP Practice and a Staying Well Facilitator to discuss individuals identified by the practice.

- Patients identified are then referred to a single point of contact, within a community provider, who maps which services the patient is currently engaged with. A Staying Well Facilitator (SWF) follows this stage with a home visit or a booked telephone call to complete a holistic assessment of the patient's needs. The patient can then be:
    - Case managed by a SWF; and/or
    - Referred into a commissioned service as appropriate.

- The second phase of the pathway, includes referring the most vulnerable patients to a Staying Well Hub where a multi-disciplinary team, including a consultant, therapist (addressing occupational therapy and physical requirements), memory services, prescribing pharmacist and community connector (a voluntary sector role to address social isolation), decide which professionals needs to see/speak to the patient, contribute to the individuals assessment and co-produce an action plan.

- This will then be communicated to the patient, tracked after attendance to ensure delivery, and communicated back to primary care.

- The service is currently delivered in South East Staffordshire and Seisdon CCG, Stafford and Surrounds CCG and will be rolled out to Cannock Chase CCG

- The SWS enhances coordination of care for the population and working this way means:
    - More care in people's homes and in their local neighbourhoods
    - Person-centred care (holistic), organised in collaboration with the individual and their carers
    - Better experience of care for people and their carers
    - Coordinated care that is pro-active and preventative, rather than reactive and episodic
    - Better value care and support at home, with less reliance on care homes and hospital based care
    - Less duplication and 'hand-offs'
    - Stronger, more resilient communities

- Work with front line teams has ensured colleagues from partner organisations feel like one team despite being employed by different organisations. The model is continually improving and with a 6 monthly Plan Do Study Act cycle in place.

- The service aims to contribute to the following system benefits:
    - Shared skills, information knowledge, expertise, and resources
    - Building strong trusting relationships across sectors & organisational boundaries
    - Building local connected communities linking with 3rd sector
    - Improving Population Health with partners, moving towards ICS
    - Delivering system priorities, recovery and planned costs out
    - Improved patient pathways and better outcomes

- Findings and recommendations from the Service evaluation will enable focus on key success factors for working in collaboration in the future, ultimately contributing to building a sustainable dynamic health and social care system.

Staying Well Service (SWS): Patient Story

Background of Case

- Referral sent by GP practice to the Staying Well Service Single Point Of Contact.
- Patient contacted same day to arrange assessment.
- Holistic Assessment by Staying Well Facilitator

- Patient lives alone in sheltered accommodation has been there for 21 years. Previously had a very active social life and lots going on at accommodation when she moved in. Accommodation is now supported living no meetings or groups in the building, all friends have moved out and patient feels very isolated.
- Past Medical History: Hypertension, Cataracts, Anxiety,

Identified Issues

- Poor vision due to cataracts so struggles to go far alone. Does walk into hospital ground 3-4 times weekly to sit on bench and talk with people.
- Mobility is deteriorating and now uses own stick, this appeared too tall in height.
- Is struggling to use bathing facilities at home and is at risk of falling. No aids in situ. Is independent with other daily living activities.
- Patient reports that she is concerned that her memory is deteriorating and is worried about this. Is low in mood and very tearful about the fact that life has changed and isn't as it used to be. Does not attend any lunch clubs or befriending groups as feels too low in mood.
- Son in 70's and has commitments with Grandchildren so cannot visit patient very often, however does food shopping on weekly basis.

Actions:

- Referral to Emotional Wellbeing Clinic for anxiety.
- OT saw patient in clinic and agreed to do a follow up home visit to complete a bathing and mobility assessment in own home.
- Voluntary Agency to locate social groups.

What difference did it make to the patient, their independence and wellbeing?

6 Week Review:

- Patient reports feeling more positive has Emotional Wellbeing Clinic appointment in 1 week.
- OT assessment has been very positive now has bathing aids and grab rails so life much easier. Has new walking stick at correct height and feels more confident.
- Has made contact with an afternoon group for natter and tea and has attended 1 session to date.
- Patient states that she feels supported and listened to now and feels more positive about life.

Has intervention been preventative?

- Early intervention by Occupational Therapist reducing risk of falls/injury and admission to hospital.
- Emotional support and allowing patient time to talk may have given her the confidence to link in with afternoon group, reducing social isolation.
- All services have been provided within a rapid time scale from referral to Staying Well Facilitator Anxiety, clinic and follow up
- All services have been provided within the patient's own local community
- Joined up working by Community Provider, GP, Acute Hospital and voluntary services

Case Study: Community Rapid Intervention Service (CRIS)

The proposed service model set out 2 components of a future Attendance/Admission Avoidance service, to support residents of care homes, frail older people and people with multiple LTC's, through engagement with senior acute and community health and social care practitioners in the Staffordshire system:

- **Unscheduled Care Coordination Centre (UCCC):** A single point of access as a viable alternative to ED/hospital attendance. Offering real time access to a senior clinician who will take responsibility for patient care. Referrers are treated as trusted assessors with rapid transfer of care. One Stop Shop where coordinators liaise with planned care services and arrange care as required
- **Community Rapid Intervention Service (CRIS):** A service which provides a two hour rapid clinical response to patients within their own homes. Offering assessment, diagnostics, prescribe and administer treatment, and ongoing review as an alternative to ED. A medical consultant lead multi-disciplinary team that ensures individuals get the most appropriate care. Right care in the right place, every time.

Healthcare professionals worked together to identify **several principles** that would underpin a future model:

- Our aim is to have one integrated model across our entire system (Pan Staffordshire).
- The person must be at the centre of everything we do (with family and carer input also valued).
- Our aim is to improve patient outcomes and experience through the prevention of avoidable non-elective emergency admissions
- We need to make sure each person receives the right care, at the right time, in the right place, by the right professional, at the right cost.
- Personalised and timely care delivered within their usual place of residence
- Staff across organisations work together (co-locating where appropriate) to champion the 'home first' ethos.
- And the result of all these points - more people will remain and live more independently in their own homes.

Working this way means:

- Reduced pressure on the Emergency Department and hospital inpatient beds
- Reduced unnecessary admissions and decrease Healthcare Acquired Functional Decline (HAFD)
- Reduced level of deconditioning and increased dependency on Primary Care
- Improved patient outcomes and better experience
- No wrong door for someone that needs help.

The CRIS sought to measurably deliver the following outcomes:

- Reduction in non-elective emergency admissions to hospital by 4,173 per annum
- Equivalent to 22 admissions per day across the UHNM footprint
- Achieve £1.3m in efficiency savings
- Reduce ambulance conveyance by 20-25 a day

The service is **on track** to deliver the following outcomes by March 2021:

- Receive over 12,000 calls into the UCCC
- Accept on average 80 referrals a week from WMAS
- Complete over 6,500 CRIS patient visits
- Signpost/Refer approximately 1400 patients onto other Community Services
- Offer Clinical advice and support with clinical decision making for over 4000 patients
- UCCC will have prevented over 10,000 possible ED attendances
- CRIS will have prevented around 5,950 unnecessary hospital attendances/admissions following a patient contact

Community Rapid Intervention Service (CRIS) Patient Story

Background of Case

Frail 87 year old male with extensive co-morbidities presented as unconscious to District Nurses (DNs) on a routine visit.

Identified Issue

GCS was 3, with apnoeic episodes of 30-40 seconds. Likely massive stroke. NACPR in-situ but no ReSPECT form/ceilings of care in place, no palliative diagnosis and not expected to die imminently. Son was in London holding Lasting Power of Attorney for Health & Welfare. He was understandably distressed and requesting his father be conveyed to A&E.

Actions

West Midlands Ambulance Service paramedics attended, performed a full assessment, gathering the views of wife, son, care staff and DNs. They decided that although this gentleman was not in cardiac arrest he was clearly end-of-life and it was in his best interests to be made comfortable at home, with arrangements made for his family to be at his bedside.

A CRIS referral was made by the attending paramedics, and after discussions with the gentleman's son, he agreed his dad ought to be made comfortable at home.

An Advanced Clinical Practitioner visited, affirming the assessment made. A ReSPECT document and anticipatory medication to control any end-of-life symptoms, were put in place.

The gentleman's wife was able to attend to be with him and his son drove up from London.

In situations such as this, the easiest solution with the least resistance would be to convey the patient to A&E where he would have potentially passed away on a trolley, potentially after burdensome and invasive investigations/treatments.

It was a bold and brave decision to refer into CRIS and manage the gentleman at home, especially in light of his son's initial thoughts.

What difference did it make to the patient, their independence and wellbeing?

As a result of the referral the CRIS were able to put into place a clear plan for the gentleman to be managed comfortably in his preferred place of care, get the family including son on board and enable him to spend his final hours/days surrounded by his loved ones in a familiar setting.

Case Studies: Overcoming Challenges in Quality and Safety

Case Study 1 – Tissue Viability (Quality Assurance)

University Hospitals North Midlands (UHNM) observed an increase in pressure ulcer incidents reported during a three month period.

This increase was mainly related to Deep Tissue Injury. In particular there were six cases with potential infection transferred from the community.

In response to this Midlands Partnership NHS Foundation Trust (MPFT) and UHNM worked collaboratively to review the incidents and identify any key learning.

As a result of this joint review the two organisations have established a joint weekly review process that has enhanced communication and ongoing care for patients being transferred from one health provider to another.

Additionally MPFT have developed a patient information poster regarding risk factors associated with the development of pressure ulcers that has been shared with UHNM so that this can now be provided to patients on discharge.

Case Study 2 – Musculoskeletal and Community Physiotherapy Access Redesign North Staffordshire (Quality Improvement)

This work was facilitated by MPFT Quality Improvement Team and involved participants from MPFT, CCG, UHNM, Primary care, North Staffordshire Combined Healthcare and Keele University. Key elements of the work included:

- An away day training all attendees on QI, identifying opportunities to improve and looking at prioritising the major improvement work
- Progressing one of the priority areas around reviewing Access into the services.
- The development of a current state and vision the future state of how access might look, the aim is to reduce the wait times, standardise the access routes and to improve the operating consistency with the services to release capacity back into the services for clinical delivery.

Case Study 3 – Respiratory Pathway Redesign (Quality Improvement)

This work was facilitated by the CCG with support from MPFT Quality Improvement Team and involved participants from MPFT, UHNM, CCG, Primary Care, Staffordshire County Council and the voluntary sector.

The event was aimed at unifying and understanding where the cross cutting opportunities for improvement were.

QI principles were used to help frame the activities within the workshop which included a waste/values mapping exercise. This work is ongoing but currently paused due to Covid-19.

Staffordshire Health and Wellbeing Board – 04 March 2021

Safeguarding Adults with Learning Disabilities

Recommendations

The Board is asked to:

a. Note the evidence of health inequalities for adults with Learning Disabilities dying from COVID-19;

b. The HWB is asked to consider the findings with a view to initiating activity to understand the causes of the disproportionality and actions to tackle the determinants.

Background - Care Act 2014 considerations for Safeguarding Adult Board (SAB) and Health and Wellbeing Board (HWB)

1. Safeguarding Adult Boards (SABs) became statutory under the Care Act 2014 which states that the main objective of a SAB is to assure itself that local safeguarding arrangements and partners act to help and protect adults in its area who:

    a. Have needs for care and support
    b. Are experiencing or at risk of abuse and neglect; and
    c. As a result of those care and support needs are unable to protect themselves from either the risk of, or the experience of abuse and neglect.

2. Every SAB must send a copy of its annual report to the Chair of the HWB. It is expected that the HWB will fully consider the contents of the report and how they can improve their contributions to both safeguarding throughout their own work and to the joint work of the SAB.

3. The SAB is interested in a range of matters that contribute to the prevention of abuse and neglect of adults with care and support needs and should have an overview of how this is taking place in its area and how this work ties in with the HWB.

4. The HWB and the SAB have a mutual interest in ensuring that there is a clear prevention programme to improve health and wellbeing and reduce ill health, in line with the Health and Wellbeing strategy, as well as ensuring a commitment from all partners to the prevention programme and assuring its implementation.

Safeguarding of Adults with Learning Disabilities

5. This report draws together the growing evidence of the disproportionate impact of COVID-19 on adults with learning disabilities.

6. In June 2020 the Care Quality Commission published national data showing the number of deaths of adults with a learning disability receiving care during

coronavirus. The data shows that between 10 April and 15 May there were 134% more deaths than in the same period last year

7. From 10 April to 15 May, the Care Quality Commission received notifications of the deaths of 386 people with learning disabilities from providers delivering specialist services, 134% up on the 165 recorded in the previous year. Most of this difference is covered by the 206 deaths attributed to suspected or confirmed COVID-19.

8. The figures also showed that people with learning disabilities were dying from COVID-19 at a much younger age than the wider population. While 89% of people to have died from suspected COVID-19 up to May 22 this year were aged 65 or over, deaths from the disease were highest among people with learning disabilities aged 55-64, who accounted for a third of COVID deaths in the CQC figures. This reflects the 20-year life expectancy gap faced by people with learning disabilities in the UK.

9. In September 2020 a report by the Learning Disabilities Mortality Review Programme (LeDeR), which reviewed the circumstances leading to death for a sample of 206 adults with learning disabilities, 79% of whom died from COVID-19 from 2 March to 9 June 2020 found that people with learning disabilities have faced "discriminatory practices" through the pandemic, with data suggesting they died from COVID at six times the rate of the general population during the first wave.

10. Of those who died from COVID-19, 82% had a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decision. While reviewers felt that the majority of these (72%) were correctly completed and followed, several noted that frailty or learning disabilities were, inappropriately, given as a rationale for a DNACPR decision. Also, several reviewers noted that the decision-making process for DNACPR decisions had not adhered to the Mental Capacity Act (MCA), with no references to capacity assessments having been carried out in a number of cases.

11. In November 2020 a report from Public Health England, found that – based on cases referred to LeDeR and after adjusting for differences in age and sex, and likely underreporting – people with learning disabilities died from COVID at 6.3 times the rate of the general population, from 21 March to 5 June. Both the LeDeR and PHE reports showed that people with learning disabilities were dying from COVID at a much younger age than the general population, reflecting many previous reports showing premature mortality among the group. Those with learning disabilities aged 18-34 were 30 times more likely to die from the virus than the general population in that age bracket, while the age band with the largest number of deaths for people with learning disabilities was 55 to 64 years compared with over 75 for the general population.

12. The SAB has recently discussed the findings of the national research with a view to seeking clarification on the situation for adults with Learning Disabilities in Staffordshire. The local findings have some similarities with the published reports prompting a range of questions including - What should be done in relation to the findings? By whom?

13. The HWB is asked to consider the findings with a view to initiating activity to understand the causes of the disproportionality and actions to tackle the determinants.

14. It is likely that as a society we will be adapting life with COVID-19 for some years to come which adds to the importance of developing an effective response to health inequalities.

List of Background Documents/Appendices:

Appendix 1 - CQC Learning Disability deaths data published June 2020

Appendix 2 - Deaths of people with Learning Disabilities from COVID-19 published by University of Bristol September 2020

Appendix 3 - PHE Report – Deaths of people identified as having died with COVID-19 in England in Spring of 2020 published November 2020

Contact Details

Report Author: John Wood, Independent Chair of Staffordshire and Stoke-on-Trent Adult Safeguarding Board.
Email Address: john.wood1@staffordshire.gov.uk

Stoke-on-Trent and Staffordshire Safeguarding Children Board

Annual Report

Stoke-on-Trent and Staffordshire Safeguarding Children Board (SSSCB)

2019/2020

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Important Note: The body of this report was completed before the current coronavirus pandemic. Its impact on both the local community and local services had not been felt when this was written.

Introduction and Context

This is the first Annual Report of the Stoke-on-Trent and Staffordshire Safeguarding Children Board (SSSCB) since its formal merger in April 2019. The SSSCB was formed in response to the changes set out in Working Together 2018 and in particular the need to step down Local Safeguarding Children Boards and replace them with local partnership arrangements designed to safeguard children. Stoke-on-Trent and Staffordshire partners approached the reforms positively and were one of the 'early adopters' as identified by the Department for Education. The detail of which can be found here https://bit.ly/3pomZ8H

The key features[1] of the new arrangements are:

- that children are safeguarded, and their welfare promoted
- partner organisations and agencies collaborate, share and co-own the vision for how to achieve improved outcomes for vulnerable children
- organisations and agencies challenge appropriately and hold one another to account
- there is early identification and analysis of new safeguarding issues and emerging threats
- learning is promoted and embedded in a way that local services for children and families can become more reflective and implement changes to practice
- information is shared effectively to facilitate more accurate and timely decision making for children and families.

The SSSCB began formally meeting in April 2019 and it is fair to say that much of that time has been focused on embedding the new arrangements and understanding the role and contribution that partners can make. Board members acknowledge that these new arrangements are fairly radical but are necessary given the recommendations set out in the 2016 Wood review where Board arrangements were previously seen as 'not sufficiently effective'.

Early adopter status afforded the safeguarding partners (Local authority, Clinical Commissioning Group – CCG and the police) an opportunity to exercise their statutory functions in a more innovative and flexible way that could respond to the system more efficiently.

Change isn't easy and coupled with the Ofsted inspection that took place soon afterwards for Stoke-On-Trent local authority children and family service department in February 2019, this has meant a busy year for the Board.

Since the inspection the Stoke-on-Trent Children's Improvement Board, chaired by the DFE Commissioner Eleanor Brazil,

[1] Working Together 2018

has been in place to monitor and drive the improvement plan.

The local authority identified three key challenges which are outlined below:

- Reset and refocus on good practice and outcomes as a system, rapidly improve the quality of front line practice
- Focus on workforce capacity and leadership
- Focus on Children in Care – permanence and sufficiency

The Safeguarding Children's Board have continued to seek assurance from this group, and as such have acknowledged the progress the local authority continues to make.

Some examples of improvements to date include;

- the Children and Families Service have worked closely with their Partner in Practice, Leeds, and now have an agreed programme of Restorative Practice Training for all staff. Train the Trainers sessions will be rolled out in Autumn 2020
- A review of performance monitoring activity through the enhanced reporting system means that children who have missing episodes are now reviewed daily by the CSE coordinator. Links with the developing MACE panels results in closer synergy and early identification of any trend or patterns of behaviour in the area.
- As a result of all the audit activity there is no doubt that this programme of improvement on the basics of social work practice has had a major and broadly very positive impact. More work is to be done on the rate of progress.
- In 2019/20 court proceedings showed an average length being 38.7 weeks compared to a national average of 30 weeks. As such, all pre-proceedings and family proceedings guidance have been reviewed along with training provided to teams in expected standards. As a result, there is now a clear pathway in place to reduce drift.

In summary 2019/20 has been a very busy year for the Children and families Service in Stoke and has seen a number of improvements in practice and partnership working arrangements. The local authority has assured the Board that they are committed to good outcomes for children and young people in Stoke-on-Trent and will continue their improvement journey through 20/21.

Priority areas include the recruitment of a permanent and experienced workforce along with improving the quality of assessment and planning for young people. With the recruitment of a permanent senior management team the foundations are now in place for improvements to begin at pace which will be reported on in the next Stoke-on-Trent partners report for 2020/21.

Governance

A revised structure that sits underneath and reports into the Board provides members with the assurance that the wider safeguarding system is effective in meeting the needs of children and families. The Board agreed to delegate the function of performance and quality assurance to its newly formed Stoke-on-Trent and Staffordshire Safeguarding Children Partnership (SSSCP). This core statutory function as set out in Working Together 2018 is one that requires further development, but in the past 12 months the (SSSCP) have emerged with:

- a successful and smooth formal transition from 2 separate previous Board arrangements to one Board, whilst maintaining the Boards statutory responsibilities including the management and coordination of 2 on-going serious case reviews (outlined later in this report).
- an agreed term of reference that sets out their role and responsibilities for all relevant partners to collectively share performance information that will enable the Partnership to provide the assure the Board need, particularly against the Boards two priorities; Child Exploitation and Neglect
- A draft performance and quality assurance framework, along with a draft workplan, one of which includes a completed multi-agency audit of both local authority front door referral services and preparation for the previous JTAI around mental health
- A proposal for delivering and supporting the performance activity in relation to the previously mentioned framework in the form of a short-term commissioning arrangement.
- Completed 2 reviews. 1 is a serious case review that started prior to the new arrangements and the other is a Child Safeguarding Practice Review (CSPR). Both are yet to be published due to on-going criminal and legal proceedings.
- Via the Child Exploitation task and finish group the Board were successful in their bid to become one of the development sites for the Tackling Child Exploitation Programme[2] working with the University of Bedfordshire, Research in Practice and The Childrens Society

[2] Research in Practice https://tce.researchinpractice.org.uk/

- Oversight of the development of a new Board website and the learner management system for managing and booking multi-agency training

Subgroup activity

Although CSPR and training were initially outlined in the New Arrangement document as functions, the Board agreed to maintain these within a subgroup structure whilst trying to navigate the transition, which at the time involved a significant amount of activity. As such there are 4 subgroups that sit under and report into the SSSCP and the Board. These groups will be reviewed as part of the Boards new arrangements going forward in 2021/22.

These include the;

- **Child Death Overview Panel** (CDOP)
- **Child Safeguarding Practice Review group** (CSPR) – this replaced the previous 2 separate serious case review subgroups
- **Professional Development and Training subgroup** (PD&T) (2 separate subgroups)
- **Review of Restraint task group**. This group has a statutory footing in WT 2018 as a secure establishment exists within Staffordshire, HMYOI Werrington. The annual update from Werrington is shared with the SSSCP as part of their scrutiny and assurance role, some of which is included in this report.

Rapid Reviews and Learning from Child Deaths/ Significant Incidents

Since the introduction of the rapid review process in July 2018 (Chapter 4 of Working Together 2018), the Board have conducted 9 rapid reviews. These reviews take place following a serious incident notification (SIN).

The circumstances surrounding the SIN could be that a child has either died or been seriously harmed. The criteria can also include any child who is looked after by the local authority. Each local authority must notify the Child Safeguarding Practice Review Panel (commonly known as the National Panel) and Ofsted.

Of the 9 cases that were notified, Staffordshire notified 4 and Stoke-on-Trent notified 5. All resulted in a rapid review, which when scrutinised by the National Panel met their satisfaction. This acknowledgement by the Panel reassures the Board that the new process is not only clear and swift, but is also an open and transparent process, with strong evidence from agencies that enables others to see how well they work together to support children and families, as well identifying areas where this needs to improve.

Rapid reviews are a significant shift from what was a lengthy drawn out process to a new and richer more equitable learning space, and one that is showing a reduction in the unnecessary burden of process. The Board continue to work with their regional partners in Birmingham LSCP, also an early adopter, who continue to play a significant part in developing the rapid review paperwork and guidance.

Of the 9 children mentioned above, 7 will be included in a Thematic Review for the under 1's. This particular review aims to explore 4 themes, all of which are recurring and include;

1. professional challenge and escalation through the eyes of the practitioner
2. the child's voice and the impact of parental behaviours on children in terms of their optimum development
3. The quality and timeliness of Early Help Assessments (EHAs) including parental experience of the EHA process
4. domestic abuse with a focus on the impact of decision making through the eyes of the victim (mother)

Since the introduction of the rapid review process in July 2018), the Board have conducted 9 rapid reviews.

Of the 9 cases that were notified, Staffordshire notified 4 and Stoke-on-Trent notified 5.

To enhance the analysis achieved from the individual rapid reviews, each group will focus on specific learning conversations with front line staff, including those who had some degree of involvement with the families. Feedback from the families themselves, where achievable will be included in the review, the findings of which will be published in next year's annual report.

Serious case reviews (SCR) carried over/ Child Safeguarding Practice Reviews (CSPRs)

- The Board carried over 2 SCRs during its transition and although one is finalised, and the other is nearing completion, neither have been published because of ongoing parallel legal proceedings.
- The learning from those reviews has seen an overwhelming response from agencies, with a real desire to effect change. The importance of recognising low level neglect still exists and further work is needed by all partners to improve the front line response to identifying and then assessing neglect.
- It is the intention of the Board to begin by extending the priority into 20/21 and to commission the Graded Care Profile 2 (GCP2) tool later in the year as a way of improving our collective response. A steering group will be set up to oversee its implementation
- Further work by the SSSCP will aim to measure the effectiveness of the system by way of single and multi-agency audits and other performance measures, as well as an analysis of the support given in the very early days of signs emerging.
- Multi-agency training as well as single agency training all help to embed new tools and approaches such as restorative practice and include reference to revised policies and procedures and learning from reviews.
- More work is to take place with children and young people and the SSSCP are working through the performance and QA plan to agree local pieces of work that evidence the 'so what', and to determine how children's experiences compare to those findings from performance and QA activity.

Embedding learning

With the introduction of the new website, and the agreement by the Board to appoint a campaigns officer, work has started to improve the way in which the learning from reviews is shared.

- Speed is of the essence, as is quality therefore social media platforms such as Facebook and Twitter will be maximised to help facilitate key messages to the front line and wider public. Short video clips and child narrated animations are in the pipeline, as well as short Q&A topic based webinar sessions that will endeavour to help build confidence within the workforce, as well as introducing keynote speakers specialising in their field.

- Regular newsletters continue to raise awareness of Board priority areas, local child safety campaigns, changes to policies and procedures, consultations and much more.
- The richness from reviews is especially important and finding new and innovative ways to embed messages continues to be high on the Boards priority list.
- Closing the loop is just as, if not more important in terms of embedding learning so again through the work of the SSSCP to assure the Board that recurring themes from the rapid reviews are either reducing in number and/or complexity, or where they do continue to exist, the Board have a better understanding of why this is and the steps needed to try and resolve them.

Board priorities

Child Exploitation

The Child Exploitation Task Group was set up in 2019-20 to develop the Child Exploitation Priority.

The priorities set by the Safeguarding Board were:

- Development of a Child Exploitation Strategy
- Development of a multi-agency performance framework to monitor the impact of the strategy

To date the group has developed the strategy which will be launched in the next few months and is working with the Tackling Child Exploitation project team to develop the performance framework.

Neglect

Adopted following the learning from the most recent SCR, this priority area for the Board again raises concerns over our collective response to neglect, particularly for those families that resurface following a period of intervention whether that be early help or statutory support via a child in need plan/ child protection plan, only to be re referred once support is withdrawn.

Low level neglect is hard to recognise and respond to, and we must improve our understanding of the impact if we are to change the lived experience for these children. This begins with the Boards focus on neglect through its performance work, and with the support of the SSSCP an understanding of how agencies currently operate within the system.

Work is underway to explore the commissioning of the NSPCC Graded Care Profile 2, a tool to identify and assess neglect and a model for train the trainers to support its implementation. A multi-agency steering group will be responsible for the oversight of implementation, with reporting lines into the SSSCP. Neglect goes far beyond the responsibility of the Board therefore further work to align and strengthen the Boards relationship with other strategic Boards is key to its success.

Independent Scrutiny

As outlined in the New Arrangements document, independent scrutiny took on a new look and under the guidance in Working Together 2018 aimed to ensure the arrangements were:

- Objective
- Constructive and
- Promotes reflection to drive continuous improvement

To achieve this the Board

- Agreed to the review commissioned by DFE Commissioner Eleanor Brazil. The review aimed to consider whether the new arrangements would:
  1. Provide the necessary oversight of safeguarding activity in Stoke-on-Trent.
  2. Ensure that the strategic leadership across the system will drive the multi-agency improvements needed in services for children in need of help and protection in Stoke-on-Trent."
- Each met with individually with Mark Gurrey, a member of the National Panel and Independent Chair from the Wiltshire Safeguarding Partnership Panel at the request of Eleanor Brazil (also chair of the Children's Improvement Board in Stoke) and was intended to link to her overall review of children's services in Stoke-on-Trent.

- Mark said "A lot of good progress has been made in developing a response to the changes set out in 'Working Together 2018' to develop new multi-agency safeguarding arrangements. There is now a need to accelerate the pace of change of those developments and ensure that the partnership delivers on the aspirations it has set for itself and are required now by national guidance"
- In particular, a recommendation was for the partnership to review the governance arrangements and accelerate the arrangements for the delivery of independent scrutiny, the quality assurance work and set out how rapid reviews and individual case reviews are conducted so that together they can enable the safeguarding partners in Stoke and Staffordshire to have more detailed knowledge of and greater influence on the delivery of services to children and families in their areas.
- In response to the recommendations, the Board continued to work with its regional partner Birmingham LCSP, to streamline the rapid review process and further details can be found on page 8.
- Conducted a review mid-way through its new arrangements with support from the National Police Chiefs Council, an independent chair from outside the local area, who is also a member of the National Child Safeguarding Practice Review Panel as well as the DFE appointed commissioner supporting Stoke-on-Trent local authority. This review helped to focus the development plan for the Board and identify further areas for development
- Supported the local authority internal audit commissioned that provided the Board with the assurance that it was fulfilling its statutory functions, and again helped to improve and drive its development plan
- Representation from lead members adds an additional layer of scrutiny that provides a critical friend role
- Internal scrutiny processes enable further assurance of Board arrangements and activity

Relevant Partners

A key commitment within the new arrangements was to ensure that the relationships and coproduction around priorities was valued and owned by all partners across the wider partnership.

The SSSCP has utilised this past twelve months to review how the partnership can be most effective in translating the learning into practice improvements. Achievements so far

- All partners have reviewed the membership as well as the terms of refence offering assurance to the Board of their roles and responsibilities, including the work plan for the coming year
- Supported the design of the new website, the content and re design of new branding including the monthly SSSCB newsletter and supporting key messages through the development of a variety of platforms for disseminating key learning and updates from Board
- Maintaining the quality and content of Board policies and procedures

A further commitment of the Board was to ensure that there was a more direct relationship with the school designated safeguarding leads. This has begun with positive engagement and sharing of good practice through regular meetings and the dissemination of learning from rapid reviews. The impact is reflected in the quality of requests for children social care support and the confidence reported by those holding these roles.

In addition, the reporting that schools provide to the Board has collaboratively been redesigned and resulted in over 97% schools returning their analysis. This has provided assurance to the Board that the majority of schools are keeping children safe. For those that either self-identified or did not return there has been individual follow up conversations in support.

Workforce Development

Multi agency training continues to be a popular and a well-respected area of work for the Board, with increasing numbers accessing online training and core level 1 slides for those organisations that require a more flexible, autonomous and high-quality training offer. The range of courses offered by the Board covers 4 levels of learning from basic awareness courses, right through to more specialist training, including on-going 'top ups' through the introduction of awareness sessions such as safer sleeping and child exploitation events.

The evaluations suggest a high level of outcomes achieved through accessing the Boards training packages, with many indicating

- ✓ increased knowledge and understanding in a specific subject area
- ✓ increased confidence in spotting the signs of abuse
- ✓ Increased knowledge of the various pathways including referral routes
- ✓ A better understanding of the Board and what we do

Review of Restraint

HMYOI Werrington is a custodial setting which sits in the north of Staffordshire. As an establishment they can hold up to 118 boys aged between 15 & 18 yrs. At the time of writing, they have a population of 84.

Behaviour management remains a priority within Youth Custody as a whole. Werrington staff are trained twice yearly in both behaviour management and restraint minimisation. Restraint on children is only used as a last resort, when other de-escalation techniques have failed.

Any restraints used on children at Werrington are screened via the multi-agency Review of Restraint task group. The panel are able to view CCTV and all Use of Force paperwork. This review allows the Local Authority and the Head of Safeguarding at

Werrington to identify both good practice and learning outcomes

Annual updates are provided to the Board via the SSSCP Performance and Quality Assurance Framework, which offer assurances to the Board.

Outcomes so far include

- ✓ Improvements in the recording of restraints
- ✓ A reduction in the use of restraints and in particular those involving pain

Barnardo's is the UK's largest children's charity, and commissioned by the Ministry of Justice (MoJ) and contract managed by Youth Custody Service (YCS), to deliver the Independent Children's Rights and Advocacy Service (ICRAS) across the Children's & Young People's Secure Estate (U18 YOIs and STCs) in England and Wales, including Werrington YOI.

Believe in children Barnardo's

The service is publicised as 'Barnardo's: Your Rights, Your Voice' (BYRYV). This visiting and independent service has been delivered by Barnardo's since 2008 and was awarded renewed contract on the 1st January 2019. The ways in which Barnardo's empower children include in our current contract with the MOJ (2019-2023) a focus on:

- Developing children's awareness and understanding of their rights.
- Being required to independently refer allegations against staff to the LADO.
- Within 24 hrs of notification we offer support to children at their debrief, following their first time of being restrained in any establishment, and at future debriefs as requested by children.

As an independent service, Barnardo's would only be aware of safeguarding concerns as disclosed to them by children or others, or through observations made by their staff. As such, it is important to highlight the limited access to information, which is appropriate, but narrows the lens of the service's perspective. Barnardo's is not informed of any safeguarding referrals other than the ones it makes itself. Furthermore, it is worthy of note, that Barnardo's position is not to independently monitor the establishment. All concerns in relation to the use of restraint are viewed as safeguarding concerns by Barnardo's. Any safeguarding concern observed by Barnardo's staff, disclosed to them by children, families, or by other professionals, is reported through Barnardo's jointly agreed local protocols between Barnardo's and the individual establishments; and are contractually required. The safeguarding protocol outlines how Barnardo's staff raise

such concerns. In all establishments these protocols have been written by Barnardo's as part of our contract with the MOJ, then reviewed and signed by each establishment. Barnardo's staff delivering the service at Werrington YOI are expected to: '*… inform the Local Authority Designated Officer (LADO) where there is a concern or allegation that someone working or volunteering with children:*

- Has or may have harmed a child.
- May have committed a criminal offence related to a child.
- Has behaved towards a child or children in a way that indicates they may pose a risk of harm to children.'

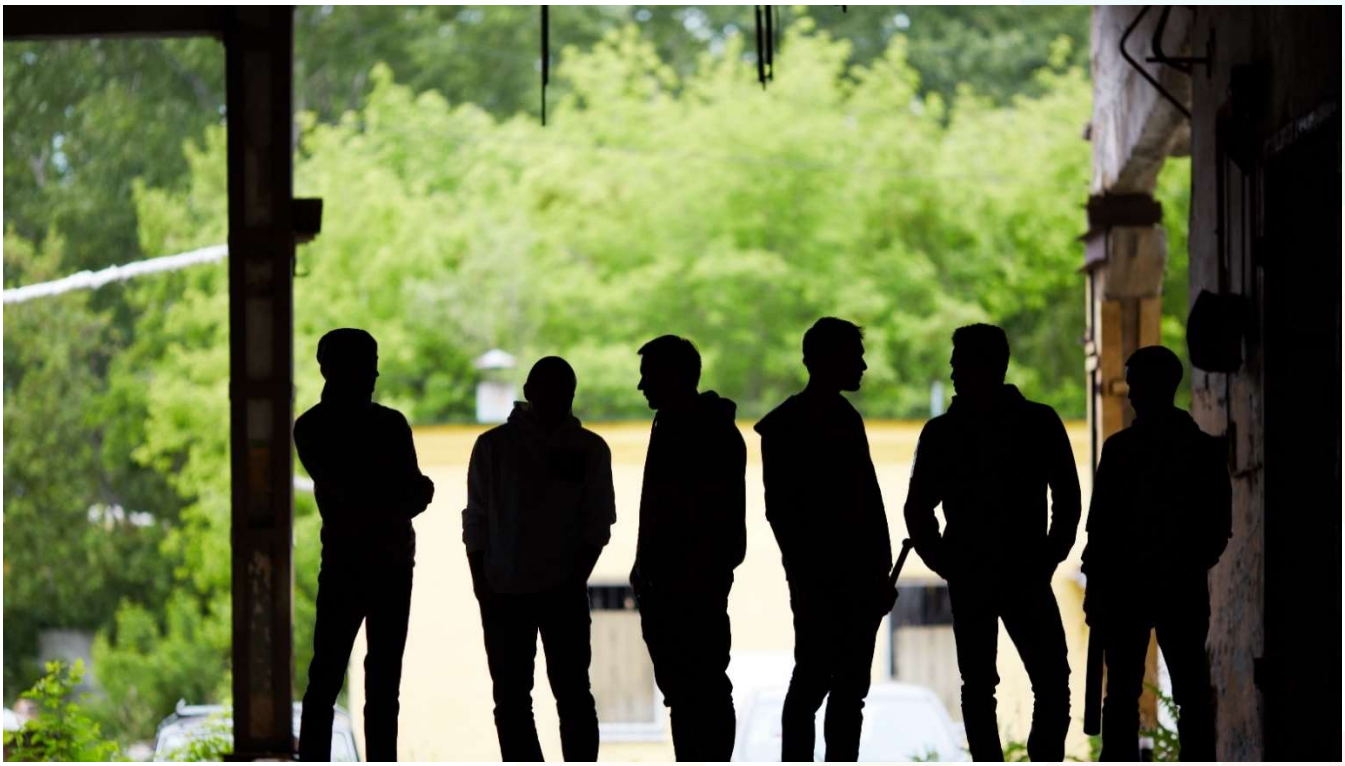
At the time of writing, Barnardo's are working with YCS to reach further clarity on YCS expectations of the service in the management and reporting of allegations against professionals, i.e. Barnardo's referral to the LADO.

Children at Werrington YOI have said about the Barnardo's service:

'Really understanding and open minded when I speak to them.'

'I believe Barnardo's is a great thing because some young people are scared to talk, and that's were Barnardo's help, they are brilliant company and the Barnardo's staff at Werrington are lovely, great.'

'The Barnardo's worker helps and assists me when I need.'



Looking ahead: changes and developments in the structure of SSSCB and Priorities for 2020-2021

Following the Ofsted inspection in Stoke-on-Trent there is a desire for the local authority to move to separate arrangements to enhance the focus on Stoke-on-Trent's challenges and separate arrangements would enable this.

For each new arrangement to agree it's priorities, budgets and staffing arrangements, whilst retaining joint priority areas and activity such as child exploitation and neglect and any ongoing reviews.

Staffordshire Health and Wellbeing Board – 04 March 2021

Special Educational Needs and Disability (SEND) Strategy 2021-26 Recommendations

The Board is asked to:

a. Note the update to the SEND Strategy in light of the responses received during the consultation period; and

b. Endorse the Staffordshire SEND Strategy as the core vision and key priority areas that the County Council, along with the Clinical Commissioning Groups (CCGs) and partners (including Education and Health Providers) will use to drive our ambition for improving provision for our children and young people.

Background

1. Staffordshire County Council and the Staffordshire and Stoke-on-Trent Clinical Commissioning Groups (CCGs) along with partners have been co-producing a new strategy to support the inclusion of all children and young people, particularly those with Special Educational Needs and Disabilities (SEND). This Strategy builds on the outcomes of the 2018 Ofsted/CQC Local Area SEND Inspection and the Written Statement of Action.

2. The SEND strategy for Staffordshire 2021-2026 has been co-produced with key stakeholders including health and education representatives, parents and carers. The draft strategy has been the subject of public consultation, which took place between November 2020 and January 2021, to seek feedback on the proposed vision, priorities and activities by which the Council, CCGs and partners will shape its work and decisions in relation to SEND over the next five years, and to inform the development of the new strategy.

3. The SEND strategy 2021-2026 (Appendix 1) sets out how the County Council and the CCGs with strategic partners will support the inclusion of all children and young people, with a focus on those with SEND.

4. The strategy has been developed over the last 8 months through a series of pre-consultation activities with partners including parents and carers. Throughout June and July 2020, over 370 people completed the SEND Survey. Our Facebook Live ‘SEND Strategy Discussion’ event that ran in August 2020 with the Staffordshire Voice Project had over 8,400 views and had 200 comments.

5. Through the consultation period, 5,063 parents and carers were emailed directly, the information was shared with education providers and the consultation was advertised on social media to reach a wide audience.

6. The ambition of the strategy is that all children and young people with SEND in Staffordshire are given the opportunity to reach their full potential, that they are able to engage with the right support at the right time from their family, the community

and the professionals who work with them to ensure that this happens. Parents and professionals have also shared experiences and comments from the children and young people they are supporting.

7. As part of our pre-consultation activities and formal consultation period, the strategy has been co-produced with parents and carers, as well as education providers and professionals from social care, health and education, to ensure it complements other County Council, CCGs and key stakeholder strategies.

8. Within the strategy, four priorities have been identified:

    a. Services communicate well with each other and families regularly and in a timely manner.
    b. Education settings, health and social care services work in partnership with families and other support providers to meet needs of children and young people
    c. The right support is made available for children and young people with SEND and their families at the right time
    d. Communities are inclusive: There is greater awareness in the community of SEND resulting in improved access to out of school activities for families with SEND.

9. The strategy is a high-level document with the implementation plan, linked to the activities set out within the local area written statement of action, now being finalised.

10. The responses received as part of the consultation identified that there is a high level of support for the vision and priorities, but this is tempered by a lack of belief that there will be the funding, resources and commitment for delivery, based on the current provision.

11. As stated within the Cabinet report on 18 November 2020, within the Children and Families System Transformation update, the aspiration for the SEND and Inclusion part of the children's system is to improve the outcomes for Staffordshire's children and their families. We aspire to an inclusive system underpinned by restorative practice and integrated into a District Footprint.

12. To achieve the best outcomes for children and make better use of the funding available, the aspirational model of the partnership will create an inclusive system where there are more children with SEND receiving SEND support in mainstream schools. Special schools will provide outreach support to mainstream schools that will allow mainstream schools to provide high quality support to children identified with SEND needs

13. The roll out of the SEND locality hub model is providing the mechanism to identify and support children experiencing difficulties early, reducing the need for EHCPs. These are supporting mainstream schools to provide a graduated response to additional needs.

14. As part of the strategy, a plan for specialist provision is being developed. This is because available places in our state funded specialist provision are limited due to numbers already on roll. The number of children with SEND educated in independent non maintained special schools continues to increase. The plan will consider the creation of additional enhanced provision in mainstream schools. Through doing this, it will be possible to educate more children locally and reduce the costs associated with educating children out of county in the independent non-maintained sector. There will also be a potential reduction in transport costs by placing children more locally.

15. The SEND strategy has been approved by Staffordshire County Council Cabinet at their meeting on Wednesday 17 February 2021. It will also be presented at the next Quality and Safety Committee of the Staffordshire and Stoke-on-Trent Clinical Commissioning Groups which is due to be held on Thursday 11th March 2021

List of Background Documents/Appendices:

Appendix 1 – SEND Strategy

Contact Details

Board Sponsors:	Helen Riley, Deputy Chief Executive and Director for Families and Communities
Report Authors:	Tim Moss, Assistant Director for Education Improvement and Strategy
Telephone No:	01785 277963
Email Address:	tim.moss@staffordshire.gov.uk
Report Authors:	Lynn Tolley, Deputy Director of Nursing, Quality and Safety
Telephone No:	01785 854094
Email Address:	Lynn.Tolley@staffsstokeccgs.nhs.uk

Staffordshire Special Educational Needs and Disabilities (SEND) Strategy 2021-2026

Staffordshire County Council

Cannock Chase Clinical Commissioning Group
East Staffordshire Clinical Commissioning Group
North Staffordshire Clinical Commissioning Group
South East Staffordshire and Seisdon Peninsula Clinical Commissioning Group
Stafford and Surrounds Clinical Commissioning Group
Stoke-on-Trent Clinical Commissioning Group

NHS

Introduction:

Our highest priority is to ensure that children with Special Educational Needs and Disabilities (SEND) receive the support they need to achieve the best possible outcomes in life.

We know that we need to strengthen, develop and deliver services to meet the needs of children and young people with SEND and their parents/carers. This strategy will set out our high-level vision and future strategic aims for Staffordshire that places children's outcomes at the forefront. These shared aims have been endorsed by all stakeholders.

The SEND and Inclusion Partnership Group are responsible for setting the vision and direction of services that support children and young people from 0-25 years with special educational needs and disabilities. The members of the Partnership are:

- Staffordshire County Council (SCC)
- Staffordshire and Stoke-on-Trent Clinical Commissioning Groups (CCGs)
- MPFT (Midlands Partnership NHS Foundation Trust)
- North Staffordshire Combined Healthcare NHS Trust
- Representatives from education (Primary, secondary, further education and special schools)
- Representatives from parent/carer groups

This strategy includes all children and young people aged 0-25 with SEND and their families. A child or young person has special educational needs if they have a learning difficulty or disability which calls for special educational provision to be made for them. Special educational provision is provision that is additional to or different from that which would normally be provided for children or young people of the same age in a mainstream education setting. In this document 'we' refers to all members of the partnership and as it is for children and young people from 0-25 years and their parents/carers 'education settings' refers to childcare providers, schools, further education and specialist provision; and 'support' refers to any extra help a child may need (including while in an education setting).

Developing the Strategy

We began by consulting with a range of professionals, young people and families to inform a self-evaluation of what is working well and what needs to improve. We also asked if you had a magic wand what would you change. The findings were reviewed by a group of parents/carers, SENDCos (Special Educational Needs and Disabilities Coordinators), and other professionals who then used them to collectively write the aims and priorities of the strategy. The strategy was developed during the Coronavirus pandemic in 2020, this made seeking the views of children challenging and we were reliant on hearing their views through the people who are supporting them and through recent consultations carried out for various purposes, for example as part of the development of the Autism Strategy. Further consultation took place on the first draft of the strategy and a number of changes were made as a result. Working together is an important part of the strategy and it was important to start as we mean to continue. As the action plan is developed to deliver the strategy we will continue to work with parents/carers and children and young people to ensure we are taking the right action to deliver our ambitions.

The voices of families were powerful and clear. They want Staffordshire to provide quick access to support at the right time, to have clear and regular communication and as a community to be welcoming and inclusive. This is captured in the 'Our Vision and Priorities' section of the strategy.

The success of this strategy depends on everyone working together. An action plan will be developed to support implementation; this will be co-produced and aligned with existing plans such as:

- the Written Statement of Action (which was developed in response to the last inspection from Ofsted and the Care Quality Commission)
- the Accessibility Strategy,
- the Preparing for Adulthood protocol,
- Joint Autism Strategy,
- Whole Life Disability Strategy and
- Education and Skills Strategy.

All plans will be regularly reviewed and adapted to respond to ongoing feedback with the implementation of the strategy overseen by the Partnership. You will be able to read the action plan and check on the progress of its implementation by reading the quarterly updates that will be provided to the Partnership Board (available on the Local Offer Website).

Context

In November 2018, Ofsted and the Care Quality Commission conducted a Local Area Review of SEND provision and found there to be a number of areas for development. In response, a Written Statement of Action was developed and as a Partnership we have improved our governance so that we can effectively lead and monitor SEND provision throughout Staffordshire.

Staffordshire is a large county with over 400 schools and academies providing education for around 120,000 pupils. About 13.5% of pupils in Staffordshire have special educational needs compared with a national average of 15.3%. The number of children and young people with an EHCP (Education Health and Care Plan) has been steadily rising each year from 3,500 in 2014 to 6,100 in 2021. There are far more children with SEND that are educated in a special school in Staffordshire than the national average (24% compared with 9%). More information about the picture in Staffordshire can be found on the next page.

Historical national underfunding has meant Staffordshire County Council has overspent on its SEND budget allocation each year. The gap has been financed through reserve funds which have now diminished. Although lobbying of the government has resulted in some additional funding it is anticipated that the amount of funding won't continue to rise and therefore a funding gap will again develop if nothing changes in the way we do things.

Everyone has a responsibility (particularly Education, Health and Social Care) to ensure that children and young people with SEND get the support they need when they need it. SEND and Inclusion District Hubs and Locality Management Groups have been set up in each district of Staffordshire to provide a mechanism to identify needs early and support children and young people experiencing difficulties; potentially reducing the need for EHCPs. Through Staffordshire County Council's Strategic Children's transformation programme, the delivery of the SEND support offer will be reshaped into district-based teams alongside social care services to ensure that all Staffordshire County Council services are aligned, to meet the child's needs.

What we know about Staffordshire

Staffordshire is a large county with over 400 schools and academies providing education for around 120,000 pupils

The percentage of pupils with SEND in Staffordshire in 2019/20 was 13.5% and in England 15.3%.

In 2019/20, 10.3% of pupils in Staffordshire required SEND support. This is lower than the national figure of 12.1%.

4% of the Early Years Population have high SEND needs. 20% go on to a special school, 15% mainstream school with an EHCP and 56% mainstream supported under school resources

There are 6,105 Children and young people with an EHCP

We have 12,758 pupils who have been identified with SEND that are being educated in mainstream settings

24% of SEND pupils in Staffordshire are placed in special academy schools compared to a national average of 9%.

Our % of pupils with an EHCP attaining age expected levels in key stage 2 in Staffordshire is lower than national average (6% compared with 9%).

2.1% of adults with learning disabilities were in paid employment in 2019/20 compared with an average of 5.4% for all English regions.

In 2019/20 70.7% of adults with learning disabilities lived in their own home or with their family.

The % of students with SEN Support gaining 9-5 at GCSE (including English and Maths) is 16.9% compared to 20.5% nationally

1% of those Electively Home Educated have an EHCP

2,500 pupils attend 23 special schools and 6 PRUs

In 2020 there were 1,127 requests for statutory EHC assessments and 489 were agreed (48%)

In January 2021, 33% of EHCP were issued within 20 weeks.

The number of mediation cases in Staffordshire appears to be low in relation to national averages

Unemployment and youth unemployment rates are lower than national averages

The number of personal budgets taken up for EHCP plans is significantly below national averages

Permanent exclusions for those at SEN support is higher than national averages

What you have told us

During the writing of this strategy we listened to some great examples of services being provided by mainstream schools and from services such as Early Help supporting parents/carers at home. However, there were also a number of negative experiences shared and suggestions for improvement and these are summarised below.

Our families have told us that:

- Experiences for families vary greatly between schools.
- Parents/carers and young people are not always equal partners in the process of developing a solution to meet their needs
- Professionals from different organisations do not always work well together with some professionals missing from important conversations such as involvement in the EHCP process.
- Communication could be improved so that everyone is clear what is happening.
- Documents received are not always easy to understand.
- Families need to repeat their story multiple times.
- It can be a ‘battle’ to get support unless in crisis.
- Waiting for support is a really difficult time for families. Children’s needs are not fully met and at the same time parents/carers are trying to understand new conditions and diagnoses.
- Things usually get better when an EHCP is in place
- Families get advice at the end of a process (when they are turned down for support) that could have been provided at the start.
- It feels like there is layer upon layer of decision making.
- Awareness in the community has dramatically improved over recent years, but there is still a way to go with some shops still inaccessible if you have impaired mobility, and community groups that are not able to open their doors to all.
- Within the home environment, families are generally happy with the support that their child receives but parents/carers would like to be able to have more breaks and time for themselves, for example, access to services which allow parents/carers to take an hour or two out for an evening meal, are very limited.

Professionals have told us that:

- Funding is focussed on high needs and sometimes we miss opportunities to prevent escalating needs.
- We do not always jointly commission, this means that services can be fragmented and results in some of the problems experienced by families.
- Physical issues can be overlooked where children and young people are either at, or just managing, to keep up with age related expectations.
- The root cause of issues is not always considered and addressed.
- SENDCOs do not always know where to go for support and signposting advice.
- When children with more complex needs in mainstream schools are awaiting an EHCP, the schools are needing to redirect educational resources away from all pupils or needs remain unmet. This is because the 'SEND notional budget' is based on an average funding formula and does not cover every child that needs extra help in the school.
- There can be a negative impact on the child/young person, their family, teachers and the other pupils in the class when children's needs are unmet.

Looking to the future:

- We need to be more aspirational for children and young people with SEND.
- Children and young people want to be able to go to groups and activities in their community just the same as everyone else (but they don't want their parents/carers to have to attend these groups/activities).
- Parents/carers want schools to ensure notional budgets are used appropriately and they are held to account for how the money is spent
- Parents/carers would like to see successful parent/carer support groups embedded across the county.

What we are hoping to achieve: the vision and priorities

A vision is a goal for the future. It is something to aspire to, not what is happening now. A shared vision helps the different partners involved in supporting children and young people with SEND and their families to understand the direction of travel and make sure we all work towards this. Our vision is that:

"All children and young people with SEND are given the opportunity to achieve everything that they can. They engage with the right support at the right time from their parents/carers, the community and the professionals that work with them to make this happen."

This will look different for every family as each child and young person is an individual with different abilities and needs who require different levels of support.

Importantly, we aim to support children and young people to have high but realistic aspirations for themselves and what they want to achieve.

We will strive for consistency throughout Staffordshire with education settings encouraged to be inclusive, needs met as early as possible, independence skills encouraged at every stage and children at the centre of every decision. We will work together because we are stronger as a team and it is everyone's responsibility to meet the needs of children and young people with SEND.

We have set 4 priorities to focus on to help achieve our vision.

These are:

1. We communicate well with each other
2. We work in partnership to meet the needs of children and young people
3. We ensure that the right support is available at the right time
4. We encourage communities to be inclusive

Making improvements in each of these priority areas will improve outcomes and experiences for children and young people with SEND and their families. Further details on each priority are set out below.

Priority 1

We communicate well with each other

a) There is good, regular communication between children and young people, parents/carers and all the professionals involved so that everyone is kept up to date.

b) Up to date information on how and where to access support is available and easy to access.

c) We work ‘with’ not ‘do to’. Children, young people and their families are equal partners when developing solutions to meet their needs.

d) All professionals understand Special Educational Need and Disability and can communicate effectively with children and young people with SEND.

e) When a professional is involved in supporting or assessing a child or young person, they will collaborate with other relevant professionals supporting the principle of ‘tell it once’ and ensuring that there are no gaps.

f) Regular opportunities are provided for children, young people their families/carers and professionals to provide feedback on, and influence the future delivery of services.

g) Partnership governance is effective and supports us to make effective decisions and share information.

h) There are good levels of satisfaction. If a family feels like they are being failed by the people who are supporting them, they will know how to raise this.

Priority 2

We work in partnership to meet needs of children and young people

a) Professionals from different organisations come together as a virtual ‘team’ to support a child. They all have high aspirations for children and young people and encourage them to do the same.

b) Everyone is clear about their expectations of each other. They work in a timely manner, respecting deadlines and making sure any transfers between services are planned and happen smoothly.

c) We all have honest conversations.

d) Appropriate professional advice is available. Where possible, we will work to the principle of ‘tell it once’ and ensure our advice is consistent.

e) Referrals, plans, and processes are easy to complete, and information easily understood. There is help available for those who need support to read, interpret and access documents.

f) The main focus is always what the child needs, which is more important than who will be funding support.

g) There will be awareness of what has already happened to avoid repeating actions that do not lead to improved outcomes.

h) Decisions are transparent and based on achieving the best outcomes for the child or young person. This will normally include the child being visited or spoken to by the people making decisions unless it is felt to not be in their best interests.

i) We have high aspirations for the services we commission and where we can we do it once and do it well.

j) Partners will jointly commission services for children and young people wherever it is possible to do so. We will provide clear pathways so that people understand how to find the appropriate support.

k) All transition points (for example, between classes, education settings, and from education into employment), are planned for, well in advance and as a result, go smoothly.

Priority 3

We ensure that the right support is made available at the right time

There are two elements to this priority:

1) That early help is in place to prevent needs escalating. We know that the graduated response process is often the best route for education settings to make sure that children and young people get the right support quickly.
2) When an EHCP is required that there is an effective process for completing one

Early help is in place to prevent needs escalating:

a) Children and young people with SEND are offered the support they need at an early stage, in a place they are comfortable and without the need for an EHCP (where this is possible).
b) Quality teaching is delivered to adapt learning for every child.
c) Identification at the earliest opportunity will help children longer term so everyone is encouraged to identify and provide support when a child is not developing in line with expectations and consider whether Early Help will support the child and family. Children and young people will not need to be in crisis to get support.
d) Parents/carers and education settings know who to approach for signposting advice.
e) Training is available so that everyone has the knowledge and skills to support early help for children with SEND.
f) It is recognised that no one is an expert in everything and there is a team of specialists available to advise when needed.
g) There will be rapid access to consistent advice and support (across Staffordshire) both at the beginning and also at times of crisis for those already receiving support.
h) The SEND and Inclusion District Model helps to meet the needs of children early within a partnership approach.
i) Funding is available to support early identification and support.
j) People supporting children and young people with SEND, including SENDCos, have adequate time dedicated to arranging and monitoring the support required for children in their setting. Induction advice and school-to-school support is available to help them succeed in their role.
k) Children and young people will be encouraged to have aspirations for their future, and professionals should be continually exploring further development.
l) Independence skills are encouraged from an early age and support is available to parents/carers to help them to also develop their child/young person's independence at home.

An effective EHCP process

a) There is awareness amongst education settings, parents/carers, and professionals that an EHCP is not appropriate for every child with additional needs and they will explore other options through the graduated response where suitable.
b) For those that do need an EHCP, the process is timely and easy to understand so that support can be put in place as quickly as possible and ensure there is a consistent experience for children and young people across Staffordshire. It is recognised that the national 20 week timescale is a significant proportion of the school year, however this timeframe does allow all of the people involved to properly contribute.
c) Evidence to support applications will be realistic and reflect the current needs of the child and sit alongside appropriate assessments to be used in the statutory process.
d) Professionals are knowledgeable and feel confident to meet the needs of those identified with SEND.
e) Training and advocacy are available to support families and education settings through the process.
f) Everyone has a voice that is shared and heard (child, family, carer, education, health, care).
g) The EHCP is reflective of the child's needs, designed to improve their outcomes, details specialist teaching provision required and as such is updated regularly (it will be a 'live' document for updating the elements that are not related to funding).
h) Any provision attached to the EHCP will be reviewed and adapted as necessary if the child/young person moves education setting (notice periods may apply). Parents/carers are offered a personal budget where this is suitable for their circumstances.
i) Children and young people are given the opportunity to be educated in their local mainstream education setting whenever it can meet their needs. These education settings will be well equipped to understand and meet the child's needs and know how to access specialist support when it is required.
j) Planning for the future is an important consideration in all EHCPs and annual reviews.
k) Education settings understand their role in preparing young people for independence and from the age of 14 preparing for adulthood will be a key feature in every EHCP and review (there are four key components to preparing for adulthood: living independently, gaining employment, having good health and participating in the community).

Priority 4

We encourage our communities to be inclusive

a) Places are friendly, welcoming and inclusive for children and young people with additional needs and their families (standards for schools can be found in the Accessibility Strategy).

b) Everybody is encouraged to be an advocate for SEND so that there is greater awareness of SEND in the community.

c) Training is made available to leaders of community groups.

d) Community facilities and organisers of activities and holiday clubs are encouraged to be accessible so that children and young people can participate in the activities that they want to do.

e) Education settings tailor learning opportunities and support children with SEND to fully participate in school life.

f) Wherever possible, children will access education placements that are close to home to help develop friendships in their local community and promote independence.

g) Good information, advice and guidance is available to support children. Children, young people, families and professionals should be able to find out what activities there are in the local area and how to access them.

h) Parents/carers have support mechanisms available to them locally

How our progress will be measured

A set of measures will be developed for each priority with clear timescales. These measures will then be monitored by the SEND Inclusion and Partnership Group. They will consider the voice and experience of children, young people, parents/carers and professionals to gain assurance that agreed actions are having the desired impact.

Below is a list of some of the things that the partnership will be looking for:

- Children and young people and their families will tell us that they feel:
    - Listened to and understood.
    - Part of their school community.
    - Well informed about their child's support.
    - Communication is clear and easily understood.
    - The support they receive is improving their outcomes.
    - More resilient because they are well supported.
    - Able to access more community activities (without their parents/carers needing to stay with them).
- More children and young people with SEND:
    - Are accessing the right support at the right time.
    - Improving their educational progress and attainment.
    - Engaged in further education and/or employment.
    - Are regularly attending school (either due to reduced exclusion or health reasons).
    - Are educated close to where they live.
    - Will receive the support that they need earlier and without the need for an EHCP.
- EHCPs are completed in a timely manner.
- Education settings are committed to inclusion.
- Provision maps and Local Offer show a breadth of support to meet need.
- There is true partnership working between different professionals and parents/carers with solutions developed together.
- Staffordshire compares well against other local authorities and nationally accepted frameworks.

How you can get involved

Further information about the strategy's progress alongside ways to provide feedback will be advertised on the SEND Local Offer website. There you will also find information on groups for young people, parents/carers and SENDCOs to help influence the delivery of SEND services. These groups are open to everyone; either a young person with a special educational need or disability or those that are supporting them. 'You said, we did' style documents will be produced to show that feedback is being listened to and acted on.

STAFFORDSHIRE
HEALTH AND WELLBEING BOARD

FORWARD PLAN 2021/2022

This document sets out the Forward Plan for the Staffordshire Health and Wellbeing Board.

Health and Wellbeing Boards were established through the Health and Social Care Act 2012. They were set up to bring together key partners across the NHS, public health, adult social care and children's services, including elected representatives and Local Healthwatch to lead the agenda for health and wellbeing within an area. The Board has a duty to assess the needs of the area through a Joint Strategic Needs Assessment and from that develop a clear strategy for addressing those needs – a Joint Health and Wellbeing Strategy. The Board met in shadow form before taking on its formal status from April 2013.

The Forward Plan is a working document and if an issue of importance is identified at any point throughout the year that should be discussed as a priority this item will be included.

Councillor Johnny McMahon and Dr Alison Bradley
Co-Chairs

If you would like to know more about our work programme, please get in touch on 07794 997 621

Unless otherwise stated, Public Board Meetings are held in Staffordshire Place 1, Trentham and Rudyard Rooms, at 3.00pm.

Public Board Meetings:
4 March 2021 – via Microsoft Teams
3 June 2021
2 September 2021
2 December 2021
3 March 2022

Date of Meeting	Item	Details	Outcome
4 March 2021 PUBLIC BOARD MEETING	**SEND Strategy** Report Author – Tim Moss Lead Board Member – Helen Riley	Agreed at the January 2020 meeting	
	Living with COVID Report Author – Richard Harling Lead Board Member – Richard Harling		
	Together Active Report Author – Jude Taylor		
	Obesity Strategy Report Author – Karen Coker		
	Adult Safeguarding Report Report Author – John Wood Lead Board Member – Richard Harling		
	Children's Safeguarding Annual Report Report Author – SSSCB Lead Board Member – Helen Riley		
	Integrated Care System Plan Report Author – Tracey Shewan		
	Public Health Strategy / Plan Report Author – Tony Bullock Lead Board Member – Richard Harling		
11 June 2021 PUBLIC BOARD MEETING	**Families Strategic Partnership Board Revised Strategy and Governance** Report Author – Kate Sharratt Lead Board Member – Helen Riley	Agreed at the January 2020 meeting	
Future Items for Consideration	**Broadband & Digital Infrastructure Strategy Update** Report Author – Lead Board Member – Richard Harling	Agreed at the January 2020 meeting as part of discussions around progress on recommendations from the Director of Public Health Annual Report.	
	Healthwatch Report Author – Lead Board Member -		

Date of Meeting	Item	Details	Outcome
	VCSE Report Author – Garry Jones / Phil Pusey Lead Board Member -		
	Director for Public Health Report Report Author – Lead Board Member –	Annual report	
	HWBB Delivery Plan Report Author – Jon Topham Lead Board Member – Richard Harling		
	Mental Health Strategy Report Author – Richard Deacon / Josephine Bullock Lead Board Member – Richard Harling		

HWBB Statutory Responsibility Documents		
Document	**Background**	**Timings**
Pharmaceutical Needs Assessment (PNA)	The PNA looks at current provision of pharmaceutical services across a defined area, makes an assessment of whether this meets the current and future population needs for Staffordshire residents and identifies any potential gaps in current services or improvements that could be made. The Health and Social Care Act 2012 transferred responsibility for developing and updating of PNAs to HWBs.	The current PNA was published in March 2018. The PNA is reviewed every three years (the next assessment is due in 2021)
Joint Strategic Needs Assessment (JSNA)	The H&WB arrange for: • an annual JSNA update report • 2 deep dive reports per year • Quarterly exception reporting	The Annual JSNA report comes to the March H&WB.
Joint Health and Wellbeing Strategy (JHWS)	The JHWS sets out how the needs identified in the JSNA will be prioritised and addressed.	JHWS was adopted by the H&WB at their June 2018. An action plan will be developed to set out how the Strategy will be delivered.
CCG and Social Care Commissioning Plans	The H&WB receive annually details of both CCG commissioning plans and Social Care to consider whether these have taken proper account of the JHWS.	Annually, normally at the March meeting.

Board Membership Role	Member	Substitute Member
Staffordshire County Council Cabinet Members	**CO CHAIR – Johnny McMahon** – Cabinet Member for Health, Care and Wellbeing Mark Sutton – Cabinet Member for Children and Young People Jonathan price – Cabinet Support Member for Education	Gill Burnett – Cabinet Support Member for Adult Safeguarding
Director for Families and Communities	Helen Riley – Deputy Chief Executive and Director for Families and Communities	
Director for Health and Care	Richard Harling – Director of Health and Care	
A representative of Healthwatch	Simmy Akhtar – Chief Officer, Healthwatch	Maggie Matthews – Healthwatch Advisory Board Chair
A representative of each relevant Clinical Commissioning Group	Gary Free – Chair of Cannock Chase CCG Paddy Hannigan– Chair of Stafford and Surrounds CCG Shammy Noor – Chair of South East Staffs and Seisdon Peninsula CCG Rachel Gallyot – Chair of East Staffs CCG **CO CHAIR - Alison Bradley** - Chair of North Staffs CCG	Marcus Warnes – Chief Operating Officer
Representative of the CCG Accountable Officer	Craig Porter – CCG Managing Director of South West Division	tbc

Staffordshire's Health and Wellbeing Board has agreed to the following **additional representatives** on the Board:

Role	Member	Substitute Member
District and Borough Elected Member representatives	Roger Lees – Deputy Leader South Staffordshire District Council Jeremy Pert – Cabinet Member (Community Portfolio) Stafford Borough Council	Brian Edwards
District and Borough Chief Executive	Tim Clegg – Chief Executive Stafford Borough Council	tbc
Staffordshire Police	ACC Jennie Sims	Chief Superintendent Jeff Moore
Staffordshire Fire and Rescue Service	Howard Watts – Director of Prevent and Protection	Jim Bywater
Together We're Better - Staffordshire Transformation Programme	Simon Whitehouse – Programme Director	tbc
Voluntary Sector	Phil Pusey – Chief Executive SCYVS Garry Jones – Chief Executive Support Staffordshire	tbc