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.

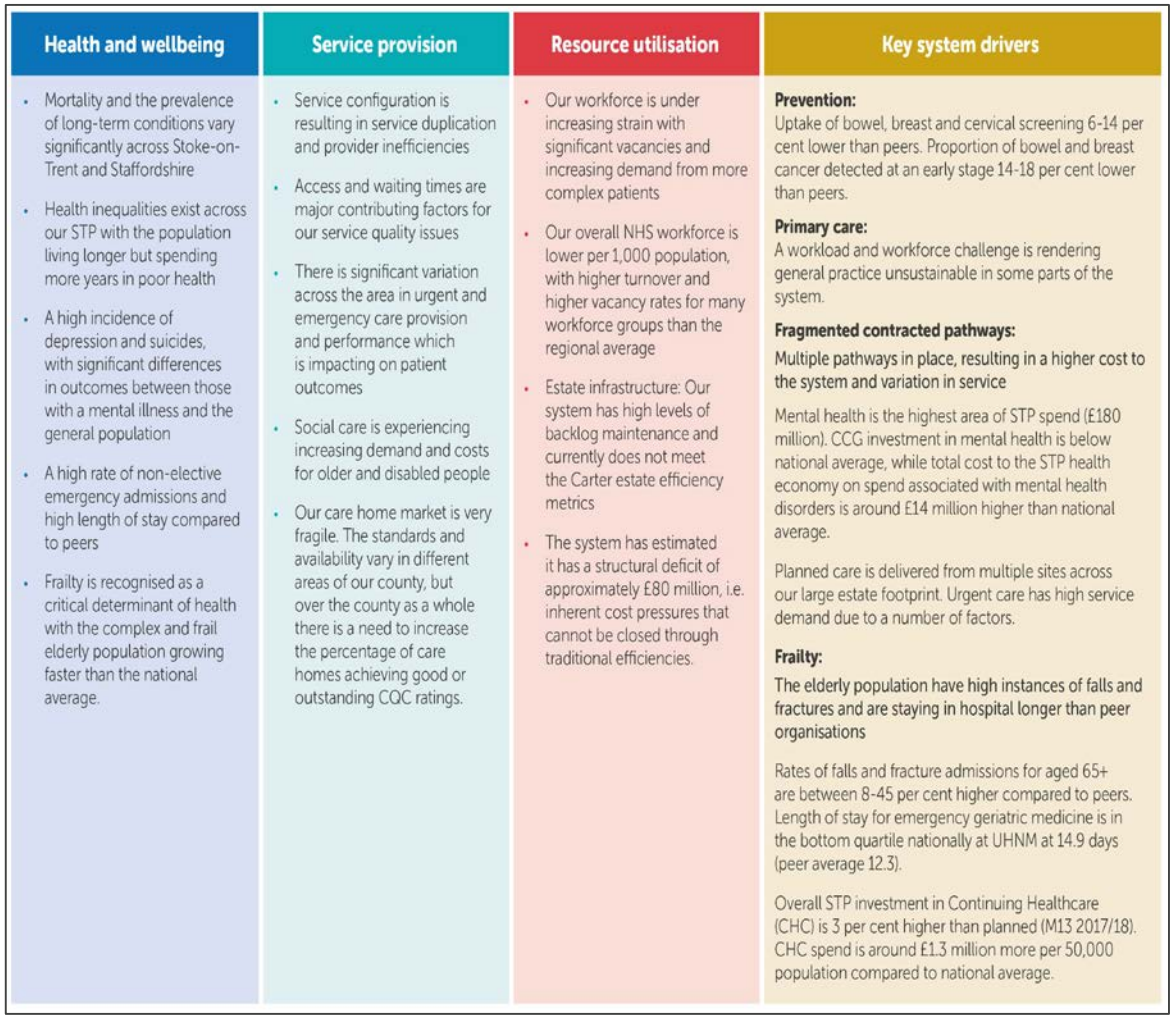
2. Co-ordinate and integrate care, with early intervention and step-down possible where appropriate and greater use of digital technologies.

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<br>• Health inequalities exist across our STP with the population living longer but spending more years in poor health<br>• A high incidence of depression and suicides, with significant differences in outcomes between those with a mental illness and the general population<br>• A high rate of non-elective emergency admissions and high length of stay compared to peers<br>• 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<br>• Access and waiting times are major contributing factors for our service quality issues<br>• There is significant variation across the area in urgent and emergency care provision and performance which is impacting on patient outcomes<br>• Social care is experiencing increasing demand and costs for older and disabled people<br>• 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<br>• 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<br>• Estate infrastructure: Our system has high levels of backlog maintenance and currently does not meet the Carter estate efficiency metrics<br>• 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:**<br>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.<br>**Primary care:**<br>A workload and workforce challenge is rendering general practice unsustainable in some parts of the system.<br>**Fragmented contracted pathways:**<br>Multiple pathways in place, resulting in a higher cost to the system and variation in service<br>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.<br>Planned care is delivered from multiple sites across our large estate footprint. Urgent care has high service demand due to a number of factors.<br>**Frailty:**<br>The elderly population have high instances of falls and fractures and are staying in hospital longer than peer organisations<br>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).<br>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:

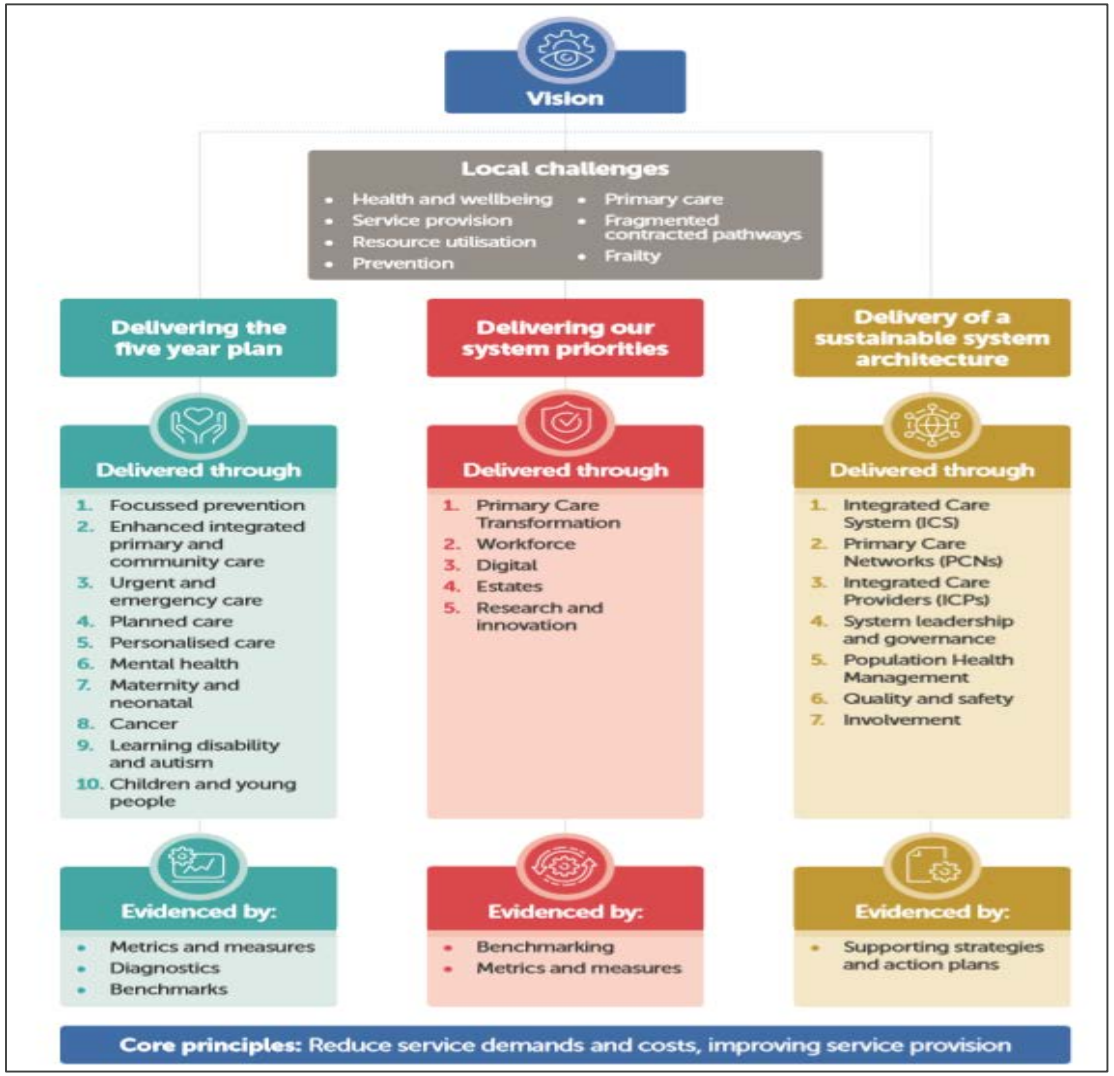
    - Do we have the right level of care for our population?
    - Are we doing this at / in the right place and at the right time?
    - Are we as efficient as we should / could be?
    - Do we have the right outcomes for people, communities and our population?

- 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.<br>• ICS / STP budget and resource to be reviewed and agreed in line with the delivery of the consistent operating requirements.<br>• Agree 2021/22 budget with system partners based on review of functions required.<br>• Agree budget hosting arrangements until primary legislation in place.<br>• 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<br>  • NHSE approved Communications & Engagement Plan for Merger;<br>  • 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<br>  • Member-facing narratives developed for financial strategy and devolved functions / staff / budgets to support ICP development during transition;<br>• "Protected Primary Care" pledges included.<br>• 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.<br>• 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.<br>• 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.<br>• Identification of lead commissioner arrangements and pooled budgets.<br>• 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**<br><br>Underpinned by:<br>1. strong place based approach to care through our ICPs;<br>2. strategic commissioning arrangements that support a focus on outcomes and are underpinned through population health management;<br>3. simplified and understood governance;<br>4. integrated reporting that adds value and enables partners to focus their collective efforts in the right areas;<br>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**<br>• Digital first approach where this adds value and improves outcomes.<br>• Agreed priority projects refreshed.<br><br>**Restoring Elective and diagnostic capacity**<br>• Clinical prioritisation of waiting lists.<br>• Improve and maintain cancer pathways and support diagnostic developments.<br><br>**Integration of Primary Care and Community Services**<br>• Support development of Primary Care Networks (PCN)<br>• Alignment of community physical and mental health services around a PCN to meet population needs.<br>• Increased collaboration with local authority (LA) and Voluntary Community and Social Enterprise (VCSE) partners.<br><br>**Health Inequalities**<br>• Detailed review and refresh of current approach.<br><br>**Children and Young People**<br>• Alignment to refreshed LA strategies and targeted approach to joint commissioning.<br><br>**Mental Health**<br>• Strong crisis response integrated into community based offer.<br>• Community transformation programme with all partners. | **System Planning/System Functions**<br><br>• Develop and embed System Outcomes Framework.<br><br>• Maximise system learning from Covid-19.<br><br>• Develop our approach and implement population health management (PHM).<br><br>• Finalise and embed system-wide approach to managing Finance, Quality and Performance.<br><br>• Update Five-Year Delivery plan through reprioritisation exercise for 2020/21.<br><br>• Finalise Operating Model confirming work at System, Place and Neighbourhood levels.<br><br>• Estates Programme to oversee system-wide programme, future prioritisation and capital funding bids.<br><br>• A system capital prioritisation and risk criteria developed.<br><br>• Support financial stability and joint decision-making on investments, while holding the system to account for effective delivery.<br><br>• 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.<br><br>• 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.<br><br>• Create a willingness for partners to invest outside of existing organisational boundaries to support transformation and develop essential social infrastructure.<br><br>• Set clear outcome improvement targets at both system and place level to enable demonstration of delivery.<br><br>• Use PHM to prioritise effort and to show outcomes in tackling the health inequality challenges.<br><br>• 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.<br>• Support communities to thrive, through improved education, employment and economic growth, attracting investment to our area.<br>• Integrated reporting underpinned by the principle of subsidiarity.<br>• 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**<br>• Appointment of ICS Lead Director.<br>• 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.<br>• ICS Board to meet in public and for papers to be available to the public.<br>• Focussed organisational development approach to support ICS Board membership development – support to have challenging conversations and build on previous OD work.<br>• Distributive leadership approach. | • Clear and owned transition to ICS status with clarity on partners roles and responsibilities.<br>• Governance approach that is light touch and proportionate to support agile decision making.<br>• 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.<br>• Integrated approach to reporting that reduces burden on individual organisations but improves timeliness of decision making. | **System Leadership and Governance**<br>• Refresh of STP / ICS governance.<br>• ICS / STP budget and resource to be reviewed and agreed in line with the delivery of the consistent operating requirements.<br>• Strengthening of core STP team to support transition to ICS.<br>• Refresh and update of current programme boards and transformation plans to ensure that there is clarity and alignment with system wide priorities.<br>• 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<br>• A System Performance and Assurance Working Group (SPAWG)<br>• Confirmation of successful Wave 3 PHM Development Programme application<br>• An established Health and Care Senate (H&CS) at ICS level with health inequalities as a priority<br>• Investment in a central communications and engagement resource<br>• System workforce planning has taken an 'open book approach'<br>• Providers, Local Authorities, WMAS and GP practices are partners in the Integrated Care Record (ICR)<br>• 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<br>• Agreed way of working to deliver PHM at scale to inform service and system change and integration<br>• Communications and engagement team supporting the health inequalities programme, with a focus on reaching seldom heard groups<br>• Consistent system HR, OD and recruitment processes, policies and programmes to support a system workforce<br>• Continued development of the ICR |
| | Streamlined Commissioning | • A confirmed and finalised CCG merger timeline and roadmap<br>• A detailed plan to support delivery of the Strategic Commissioner Development<br>• A shared care record<br>• During Covid-19 worked increasingly more as partners rather than commissioners and providers | • Achieve single CCG covering the STP footprint by April 2022<br>• Implement the plan to deliver a Strategic Commissioner function<br>• Deployment of personal health records application<br>• Develop work to plan and deliver specialised services as locally as possible |
| System Planning | System Plans | • System approach to developing Phase 3 recovery plans<br>• An agreed Five-Year Delivery plan (FYDP) in response to the long term plan<br>• Submission of a system Phase 3 Recovery plan agreed by relevant organisational boards<br>• ICP plans outlining priorities identified in the summer of 2020<br>• A system ICS development plan<br>• Part of the first 6 systems in the Midlands to work on the GIRFT/ Model Health System | • Stocktake of system plans to be completed<br>• UEC plan and priority areas to be reviewed and refreshed<br>• Covid-19 lessons learnt review to be progressed<br>• Develop the system level strategic framework and system operating plan<br>• Development of Digital Financial planning |
| | Capital and Estates Plans | • A system estates plan and strategy, rated "Good"<br>• A System Capital Prioritisation Group to support a system by default approach.<br>• System Local Estates Forum | • A system capital prioritisation and risk criteria<br>• A system Estates Strategy (covering capital and estates), to include disposals<br>• An agreed broader system section 106 policy |
| System Leadership and Governance | Leadership Model | • ICS Independent Chair appointed and in place<br>• Clinical and professional input provided by the H&CS<br>• A health inequality executive at board level within each organisation and a system inequalities lead<br>• ICPs have been developed with PCNs at their heart<br>• Provider collaboration across a number of levels | • Appoint to ICS Lead Director<br>• Ongoing leadership development of health and care professionals<br>• Develop clear and shared vision for ICPs aligned to transition towards strategic commissioning<br>• 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)<br>• System Strategy Finance and Performance Committee<br>• Good relationships with the Overview and Scrutiny Committees<br>• H&CS, Healthwatch and voluntary sector partners on the ICSPB<br>• Robust foundations locally for capturing the patient voice to inform and support transparency of the work at ICS and ICP level.<br>• 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<br>• Integrated quality, finance and performance dashboard reported into the ICSPB<br>• Delegation of financial responsibility to ICPs<br>• 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.<br><br>Confidence in the system leadership to resolve current performance challenges | *Co-ordination of Transformation - System, Place and neighbourhood*<br>• Agreed terms of reference and membership of the ICS Partnership Board (ICS PB)<br>• An agreed FYDP.<br>• An ICP Programme Board to coordinate ICP development activity.<br>• A detailed ICP plan developed to support achievement of the critical path of ICP development.<br>• Each ICP has aligned Director of Strategy capacity to provide the connection back to individual organisation and system wide transformation activity.<br>• 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.<br>• 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.<br><br>*Collective Management of System Performance*<br>• An established System Strategy, Finance and Performance (SFP) Committee.<br>• A System Performance and Assurance Working Group (SPAWG).<br>• Strong system delivery of mental health standards.<br>• Recognition of areas e.g. urgent care where we have struggled to meet emergency care standards.<br>• Significant progress in delivery of cancer standards. Acute Trusts working through cancer hub to ensure opportunities for mutual aid are exploited.<br><br>*Resolving performance challenges*<br>• Consistent approach to performance reporting and agreed data sets<br>• Honesty of challenge and debate with agreed actions set out<br>• Collaborative approach to problem solving<br>• Build on system response to Covid-19 and UEC pressures<br><br>*Population Health Management (PHM)*<br>• An Executive Director providing senior leadership and expertise, acting as SRO for this programme of work.<br>• A CCG Public Health Consultant in post leading delivery of PHM.<br>• 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.<br>• Confirmation of successful Wave 3 PHM Development Programme application with funding of £50k.<br>• 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.<br>• 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*<br>• Identify key transformation / change programmes that are likely to be locally and system driven.<br>• OD plan to support system and place clinical leadership.<br>• Identification and development of ICP leadership<br><br>*Collective Management of System Performance*<br>• Finalise and embed system-wide approach to managing Finance, Quality and Performance.<br>• 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.<br>• Clear and effective processes for managing risks, issues and performance.<br>• Develop a proactive stance on self-assurance, earning autonomy from our regulators to self-regulate on most issues.<br><br>*Resolving Performance Challenges*<br>• Ensure that the system SFP has the correct membership and intelligence to support decision making and challenge<br>• Clear route of escalation through to the CEO forum<br>• Agree priority areas of focus and simplify list to an agreed and appropriate level<br><br>*Population Health Management (PHM)*<br>• Agreed way of working to deliver PHM at scale to inform service and system change and integration.<br>• Continue to develop data sharing particularly in primary care.<br>• An OD programme for the H&CS including PHM and inequalities.<br>• Co-production of outcome measures, both qualitative and quantitative, with ICS and ICP representation.<br>• Refreshed approach to PHM and full engagement with the PHM national programme.<br>• PHM approach to be widened from public health colleagues and repurposed to support ICP development.<br>• Approach to be set out for the January ICS Board and workplan to be agreed with confirmed timelines.<br>• PHM priorities to be agreed by the January meeting of the ICS Board.<br>• 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*<br>• Investment in communications and engagement (C&E) resource providing focused support across key development areas.<br>• Integrated approach to C&E with a shared Director of Communications across the CCGs and ICS footprint, with a seat at the ICSPB.<br>• Strong partnership working across C&E recognised regionally.<br><br>*Workforce*<br>• System expertise in place around workforce planning and workforce information/data.<br>• 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.<br>• A strong ICS workforce team in place to improve workforce supply and solutions are created in partnership as "System by Default."<br>• 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.<br><br>*Digitisation*<br>• 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.<br>• 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.<br>• A Digital Clinical Advisory Group and Digital Design Authority.<br>• Technology enabled care implemented prior to Covid-19 and rapidly expanded during the Covid-19 pandemic.<br><br>*Resourcing*<br>• Current resource supporting STP identified and based on partner contributions (NHS)<br>• Small core team at present and reliant upon resource in kind from system partners<br>• Core finance and workforce teams good examples of collaboration<br>• Partner commitment to shared resource to support ICS Development<br>• 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*<br>• Primary care, partner and public engagement on the development of the Strategic Commissioner function (2020-21).<br>• Supporting the equality programme, with a focus on reaching seldom heard groups.<br>• System wide approach to transformation, including key areas of urgent care, maternity, community care, mental health and planned care (2021-23).<br><br>*Workforce*<br>• Further develop the People Hub locally to make it the route into health and care careers in Staffordshire and Stoke-on-Trent.<br>• Consider and develop consistent system HR, OD and recruitment processes, policies and programmes to support a system workforce.<br>• Focus on inclusivity and diversity in our workforce utilising targeted approaches.<br><br>*Digitisation*<br>• Digital Board development to aid the progression from a voluntary collaborative group into being a key part of the governance structure of the ICS.<br>• 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.<br><br>*Resourcing*<br>• Review national direction of travel and agree core STP / ICS transition team<br>• Agree 21/22 budget with system partners based on review of functions required<br>• Confirm partner commitment to supporting the ICS core functions<br>• Agree budget hosting arrangements until primary legislation in place<br>• 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.<br>• Strategic Commissioning identified as a priority programme by the CEO Forum and the ICSPB.<br>• A detailed plan to support delivery of the Strategic Commissioner development .<br>• The Strategic Commissioner blueprint has been reviewed and detail added behind the identified functions.<br>• 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).<br>• Delivery of programme of work to deliver the strategic commissioning function.<br>• Identify hand over points from strategic commissioning into ICPs for delivery at a place based level.<br>• 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.<br>• 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.<br>• 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.<br>• 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.<br>• Deployment of personal Health records app, by February 2021, to the local population to empower the self-management agenda.<br>• Core reviews planned of foundation IT services and planned maturity assessments utilising the HIMMS continuity of care model.<br>• 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).<br><br>**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.<br>• An agreed FYDP that was determined ready to publish pre Covid-19.<br>• For 2021/22 started to develop system level strategic framework design and delivery groups for the system operating plan.<br>• 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.<br>• Organisational phase 3 plans were used to support the development of recovery plans at the system and ICP level.<br>• ICP priorities identified in the summer of 2020 and the ICP self-assessment alignment to the FYDP.<br>• 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.<br>• 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.*<br>• UEC plan and priority areas to be reviewed and refreshed.<br>• Develop the system level strategic framework and system operating plan.<br>• Focus on delivery on of the trajectories in the Phase 3 recovery plan.<br>• Use Phase 3 recovery plans as a platform from which to deliver the constitutional standards.<br>• Directors of Strategy take the leadership on development of the system operating plan.<br>• Delivery of the ICP priority areas with a refreshed focus on place<br>• 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”.<br>• A System Capital Prioritisation Group, to review and prioritise capital plans across the system.<br>• 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.<br>• A system Estates Strategy (covering capital and estates), to include disposals.<br>• 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:<br>**1. ICS core leadership** team including:<br>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.<br>b. Sufficient leadership and delivery capacity to carry out the functions above<br>**2. Place leadership** arrangements for each place within the system, ensuring that primary care (as a provider) is reflected in these arrangements.<br>**3. Provider collaborative**(s) lead arrangements for "hospital systems", ambulance services and "acute mental health systems" | *ICS Core Leadership*<br>• The role of the ICS Independent Chair appointed to and in place.<br>• 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.<br>• A health inequality executive at board level within each organisation and a system inequalities lead.<br><br>*Place Leadership*<br>• Each of our ICPs are developing arrangements that reflect their unique identities and partners in the local system.<br>• 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.<br>• The H&CS is supported by Health and Care Assemblies.<br>• ICPs have been developed with PCNs at their heart and PCN representatives are fully involved in each of the three ICPS.<br><br>*Provider Collaboratives*<br>• Provider CEO's have taken lead roles on the 5 system workstreams.<br>• Each of our provider organisations play an active and strong leadership role through the governance structures of the ICS.<br>• UHNM is part of the N8 pathology network.<br>• MPFT and NSCHT are actively involved in the development of the Regional mental health provider collaborative.<br>• NSCHT is an active part of the Stoke-on-Trent Collaborative Network (CN).<br>• Long-term workforce planning across the system has taken an 'open book approach'.<br>• 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*<br>• 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.<br>• Ongoing leadership development of health and care professionals.<br>• Review of core team resource as part of the functional review and agree any new posts required to support transition to ICS<br><br>*Place Leadership*<br>• Develop shared and collectively agreed view of placed-based leadership.<br>• Develop clear and shared vision for ICPs aligned to transition towards strategic commissioning.<br>• Develop 'Values /Behaviour Charter' to support collaborative working approach via Accelerated Design Events.<br>• OD support programme aligned to System-Wide OD Programme.<br>• Agree joint OD programme to support transition to locality commissioning arrangements.<br>• Confirm ICP leadership and ensure there is clear PCN visibility and involvement<br><br>*Provider Collaboratives*<br>• Review all current collaborations – internal and external.<br>• Establish simplified review process to identify specific risk areas re provider collaboration.<br>• Facilitate vertical provider collaborations to support the integration agenda into ICPs.<br>• 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*<br>• 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.<br>• 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.<br>• 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.<br>• The ICS Shadow Board is chaired by the Independent Chair of the STP.<br><br>*Decision making*<br>• 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<br>• Care home support response with both LA's, MPFT and the CCGs<br>• Workforce deployment cell to trigger mutual aid across partners through a single approach<br>• 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<br><br>*Public Engagement*<br>• Robust foundations locally for capturing the patient voice to inform and support transparency of the work at ICS and ICP level.<br>• 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.<br>• 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.<br><br>Financial Transparency (Place and neighbourhood)<br>• A culture of transparency, openness and collective ownership and accountability in relation to finance. | *System-wide governance*<br>• The governance structure will be reviewed as part of the ICS designation process and is part of our system development plan.<br>• Progress the ICS Shadow Board to meet in public and to publish its papers by February 2021.<br>• Develop the decision making arrangements.<br>• An integrated quality, finance and performance dashboard reported into the ICSPB.<br><br>Decision making<br>• Review of current decision making forums and light touch governance review to enable clear base line to be set out<br>• System wide review of lessons learnt report and gap analysis presented back to the ICS Board<br><br>*Public Engagement During 2020/21*<br>• Delivery of the Winter C&E plan and response to Covid-19 *(2020-21).*<br>• Primary care, partner and public engagement on the development of the Strategic Commissioner function *(2020-21).*<br>• System wide approach to transformation, including key areas of urgent care, maternity, community care, mental health and planned care *(2021-23).*<br>• Significant mental health transformation programme over three years *(2020-23)*<br>• Supporting the equality programme, with a focus on reaching seldom heard groups *(2020-21).*<br><br>Financial Transparency (Place and neighbourhood)<br>• A financial strategy that articulates how the system and the organisations within it will deliver the financial objectives and targets.<br>• Delegation of financial responsibility to ICPs.<br>• Refinement of the IFP approach to make sure that delegation of budgets is meaningful and supports integration<br>• 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.<br>• Population health management tools that can be used at system and place level.<br>• A defined and agreed IG structure across the system. | • National directive for data sharing resolved.<br>• 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.<br>Delivering assurance that is based on partnerships for improvement. | • System Strategy, Finance and Performance Committee.<br>• A system-wide outcomes framework across health and care.<br>• Integrated quality, finance and performance dashboard reported into the partnership board.<br>• 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.<br>• 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.<br>• A system Quality and Safety Group to steer the delivery of system wide quality assurance and improvement.<br>• A system wide Quality Impact Assessment process.<br>• 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.<br>• A System Workforce Group with an STP/ICS Workforce lead and team to deliver our Local People Plan.<br>• 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.<br>• 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.<br>• An STP Black, Asian and Minority Ethnic (BAME) network, networking with individual organisation BAME networks.<br>• A System Health and Wellbeing Group developing the collective Health and Wellbeing offer.<br>• 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.<br>• Support to develop IT resources to improve the functionality of the people hub and the database of contingent workforce.<br>• Clarity of funding allocations for learning/development and leadership between HEE/NHSI/E and transparency of destination for these.<br>• Ongoing support from regional HEE and NHSEI leads.<br>• 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.<br>• A Digital Clinical Advisory Group and Digital Design Authority before being turned into defined work packages for delivery.<br>• Quality assurance approach for signing off new digital systems and process.<br>• 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.<br>• Digital technology and processes wrapped around the needs of our citizens rather than directed by organisational boundaries.<br>• Use of system wide digital maturity models to establish a common baseline and drive for common standards.<br>• 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.<br>• Devolved allocation of Staffordshire and Stoke-on-Trent transformation funding will be used against our digital strategy priorities.<br>• Fast follower funding where applicable.<br>• 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.<br>• An established H&CS which has health inequalities as one of it's core priorities.<br>• 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.<br>• Agreement to work with neighbouring STPs on boundary flows.<br>• Work with Staffordshire County Council and Stoke-on-Trent City Council to ensure full engagement and added value for the work of the ICS.<br>• 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

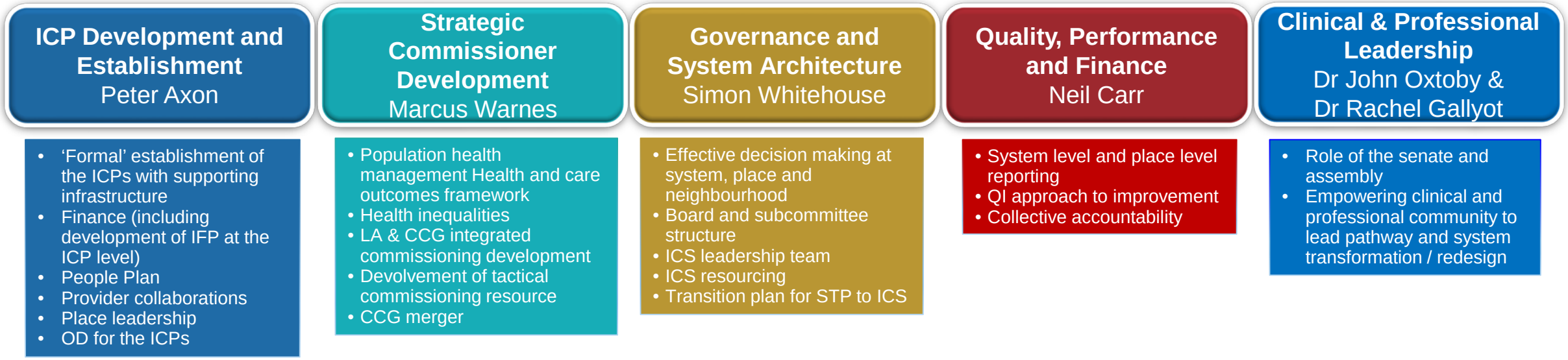
| Priority area | What are we trying to achieve? | What will this look like in practice? | What potential support will we need from NHSE/I? |
|---|---|---|---|
| **Finance** | Allocation of resources to incentivise the best outcomes for our population. There will be a focus on collaboration and on system resources, rather than organisational, with an “open book” approach. | • A System Strategy, Finance and Performance Committee, supported by a System Finance Sub-Committee.<br>• 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.<br>• System allocation and agreement on distribution of resources, including a financial framework for ICPs.<br>• Evolution of the current “Intelligent Fixed Payment” arrangements in place locally, including risk sharing arrangements.<br>• Agreed system financial reporting and modelling, at system and place based level.<br>• A culture of transparency, openness and collective ownership and accountability.<br>• 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.<br>• Confirmation of multi-year settlements, including capital, will support the development of a system by default arrangement to finance.<br>• 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.<br>• A combined STP/OPE Estates Programme Board with a single governance model for overseeing decision making, assurance and accountability.<br>• An agreed broader system section 106 policy across all planning authorities, with broader consideration of health infrastructure needs and increased engagement with health.<br>• 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.<br>• 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<br>· Final submission of system application for Feb review point | · Formal regional decision point<br>· 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<br>· Health outcome monitoring and reporting system<br>· Planning for Change and Signs for Change workshops | | · Co-design of financial framework<br>· 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<br>· Identify clinical leadership<br>· Develop vision<br>· 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<br>· Implement OD framework supporting new ways of working<br>· 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<br>· 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<br>· Establishment of ICP | · Appointment of ICS Director (TBC)<br>· Covid Wave 1 lessons learned, FYDP and phase 3 stock take to inform ICS planning | · ICS Board Membership reviewed<br>· 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.<br>· System Quality and Safety Committee established.<br>· Agreement of 2021/22 IFP arrangements. | · Increased provider level data in the system assurance report<br>· Mobilisation of ICPs and PCNs, agree delegated scope & accountability framework<br>· 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<br>· 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<br>· 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<br>· 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 Development and Establishment

# 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.

## Planning 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.

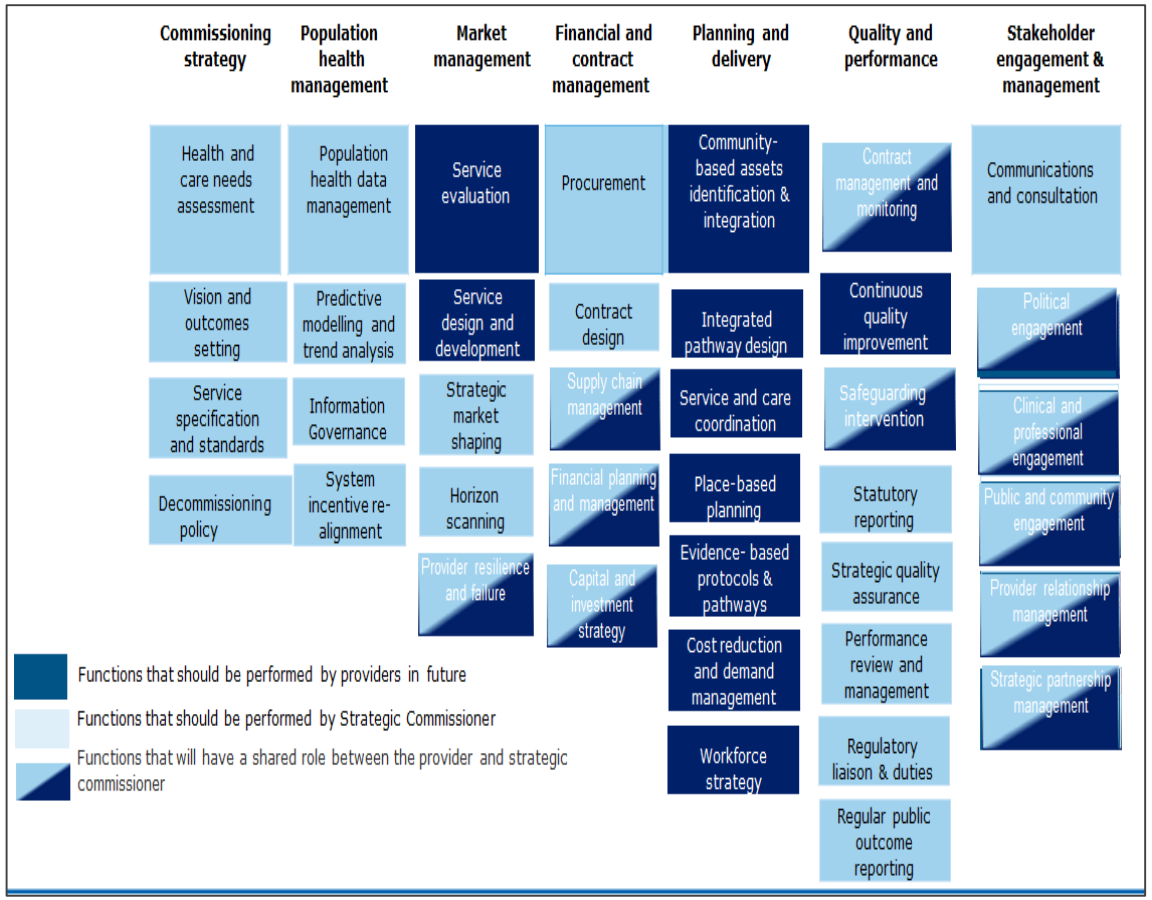
## Engagement and Partnership Working

- 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 Commissioner Development

| Strategic Commissioning | ICP |
|---|---|
| **Consultation and engagement -whole service change**<br><br>• 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).<br>• 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**<br><br>• Engagement across multiple stakeholders to be undertaken through the ICPs in determining service and pathway changes. This will be both informal and formal.<br>• ICPs will determine the methods and types of engagement working with the communications team in Strategic Commissioning to ensure legal requirements are met.<br>• Relationships with MPs and Councillors including attendance at OSCs<br>• Other public sector provision -fire and police etc. |
| **Vision and outcomes setting**<br><br>• Taking the PHM data and information and develop strategies and outcome frameworks to define the 'what'.<br>• Set the strategic priorities for delivery through the ICPs.<br>• Work in partnership with ICP leads to define the outcomes. | **Service design and development and Integrated Pathway Redesign**<br><br>• 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'.<br>• Clinically led process aligned with the available financial envelope.<br>• Lead provider arrangements to be identified and financial movements co ordinated.<br>• QIPP/CIP/system savings to be considered in all redesign.<br>• Care co-ordination and integration.<br>• Consideration given to cross border commissioning by ICPs where appropriate and decided at ICP level.<br>• Providers and commissioners across health, social care and the voluntary sector to take the co- produced required outcomes and develop integrated pathways.<br>• Agreement of any financial realignment between providers.<br>• Agree appropriate use of facilities and technology identifying efficiencies.<br>• Development of CIP/QIPP programmes/system savings.<br>• 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.

**Reduce the risk of worsening inequalities**

*A clinical prioritisation framework;*
*Linking clinical and population data;*
*Equality Impact Assessment (EIA)* and
*Quality Impact Assessments*

**Provide an improved understanding of the population risks**

**(Population Health Management)**

*Integrated System Intelligence Hub;*
*Population segmentation and risk stratification;*
*Core performance monitoring of service use and outcomes*
*STP level metrics*
*Vulnerable population*

**Accelerate preventative programmes, which proactively reduce inequalities and support the recovery of services in the community.**

**Address significant ongoing inequalities that are in the long term plan**

# 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?*

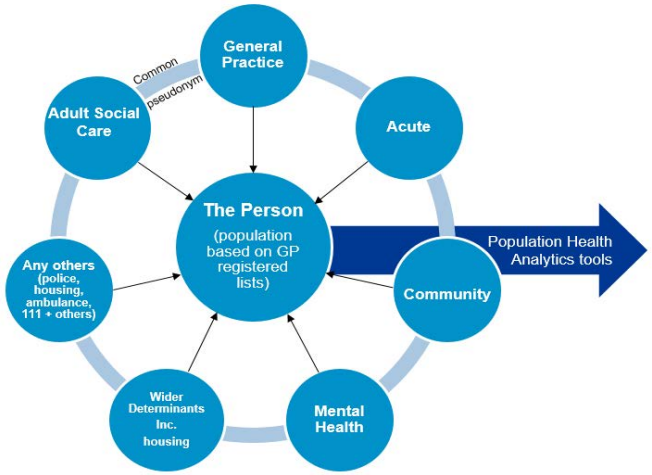
**Person:**
*How can we leverage our neighbourhood assets to support this person who is at risk?*

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

Strategic Commissioner Development

## 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**

Strategic Commissioner Development

# Population Health Management: Providing an improved understanding of the population

**PHM Intelligence**

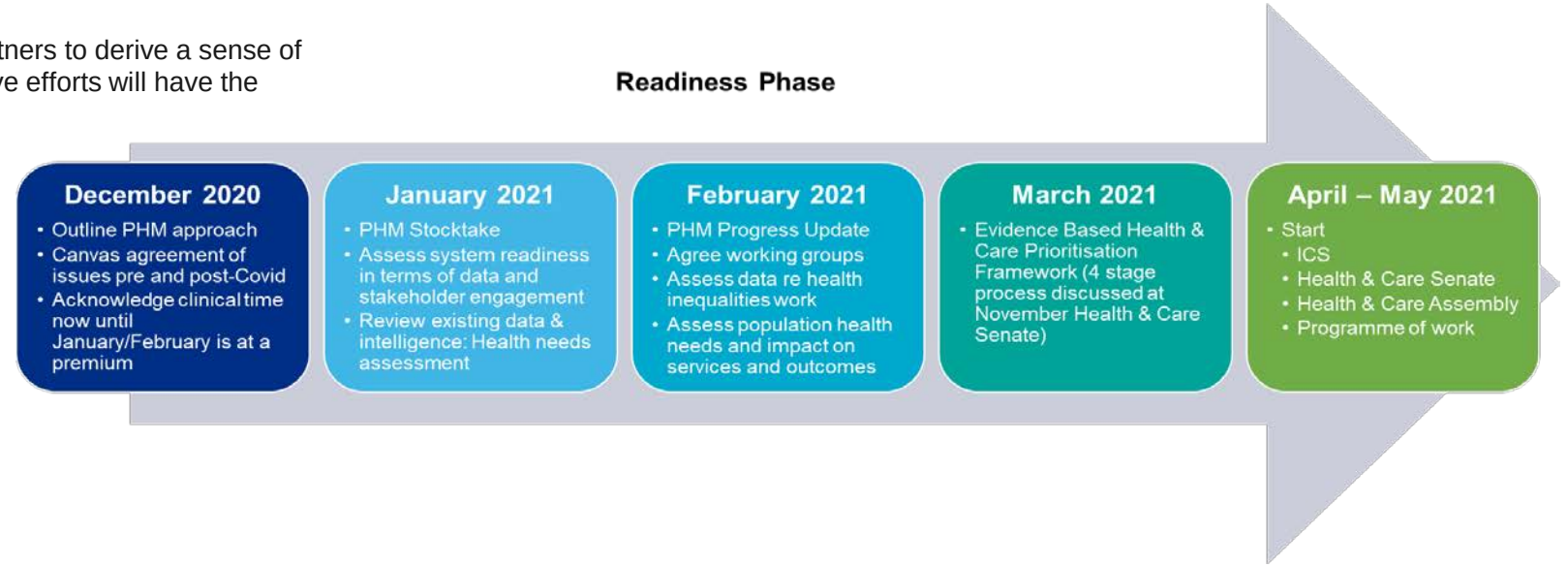
- Over the last nine months we have focussed on improving collaboration and sharing of data across the system and developing shared intelligence that is agreed collectively by all the organisations across the system.
- The H&CS is in a phase of readiness to use PHM intelligence to develop clinically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

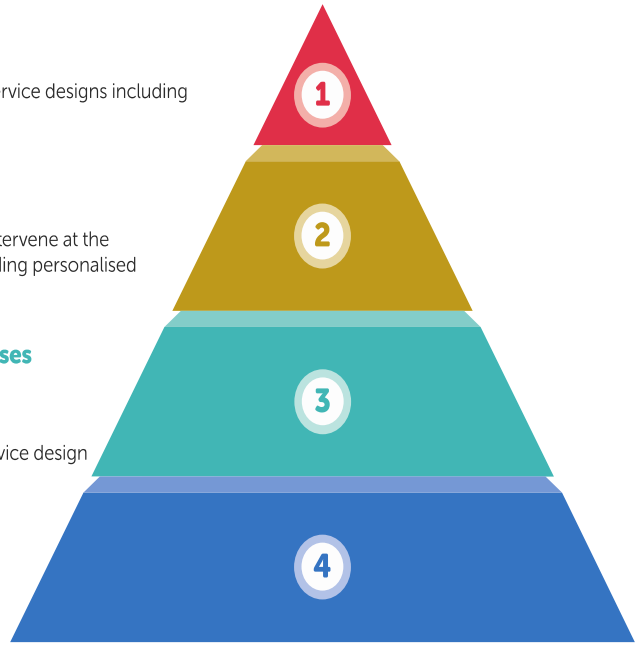
- Collaborative arrangements between partners to intervene at the right time based on individual service designs including personalised risk and escalation plans

**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

**Accessibility**
People will receive the right care, in the right place, at the right time.

**Quality**
Services will meet the needs of the individual, are consistently high quality and cost effective.

**Equality**
Services will offer equitable care to our population.

**Consistent service delivery**
Services will developed to reduce variation in service provision and provide continuity of care.

**Choice**
People will be offered a person centred approach with more choice and control.

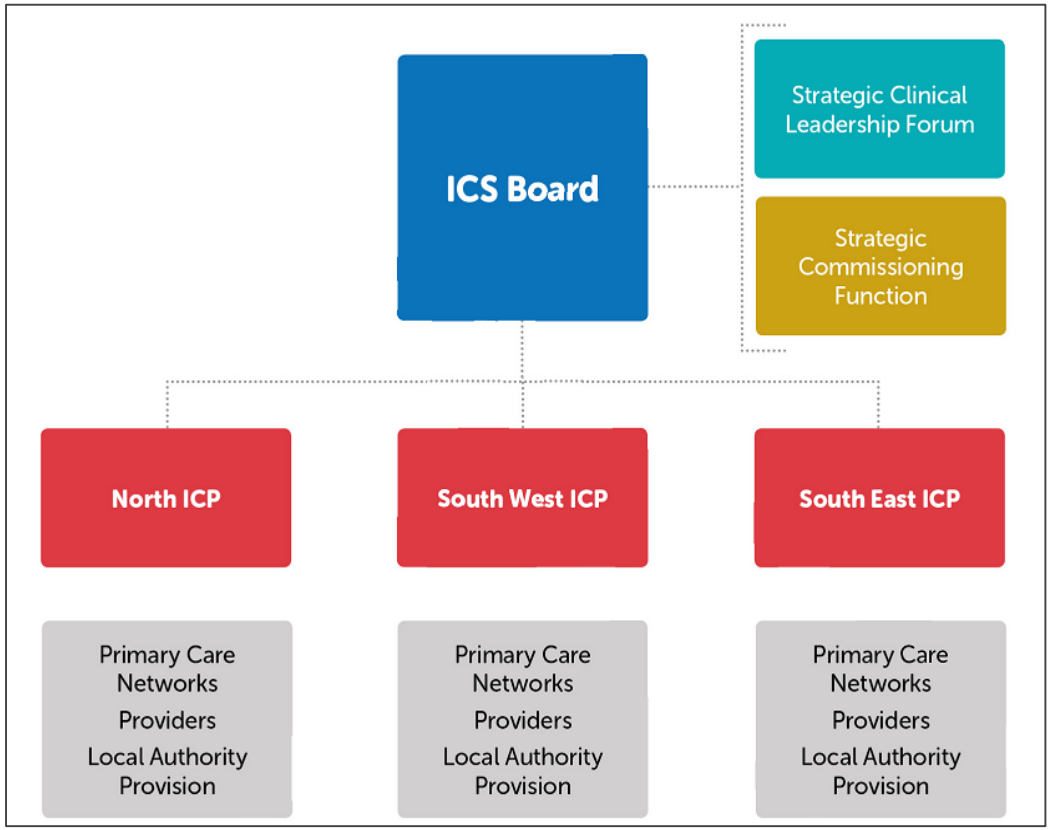
**Parity of esteem**
Services will be developed that value mental health equally with physical health.

**Financial sustainability**
System partners will spend resources wisely.

# 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.

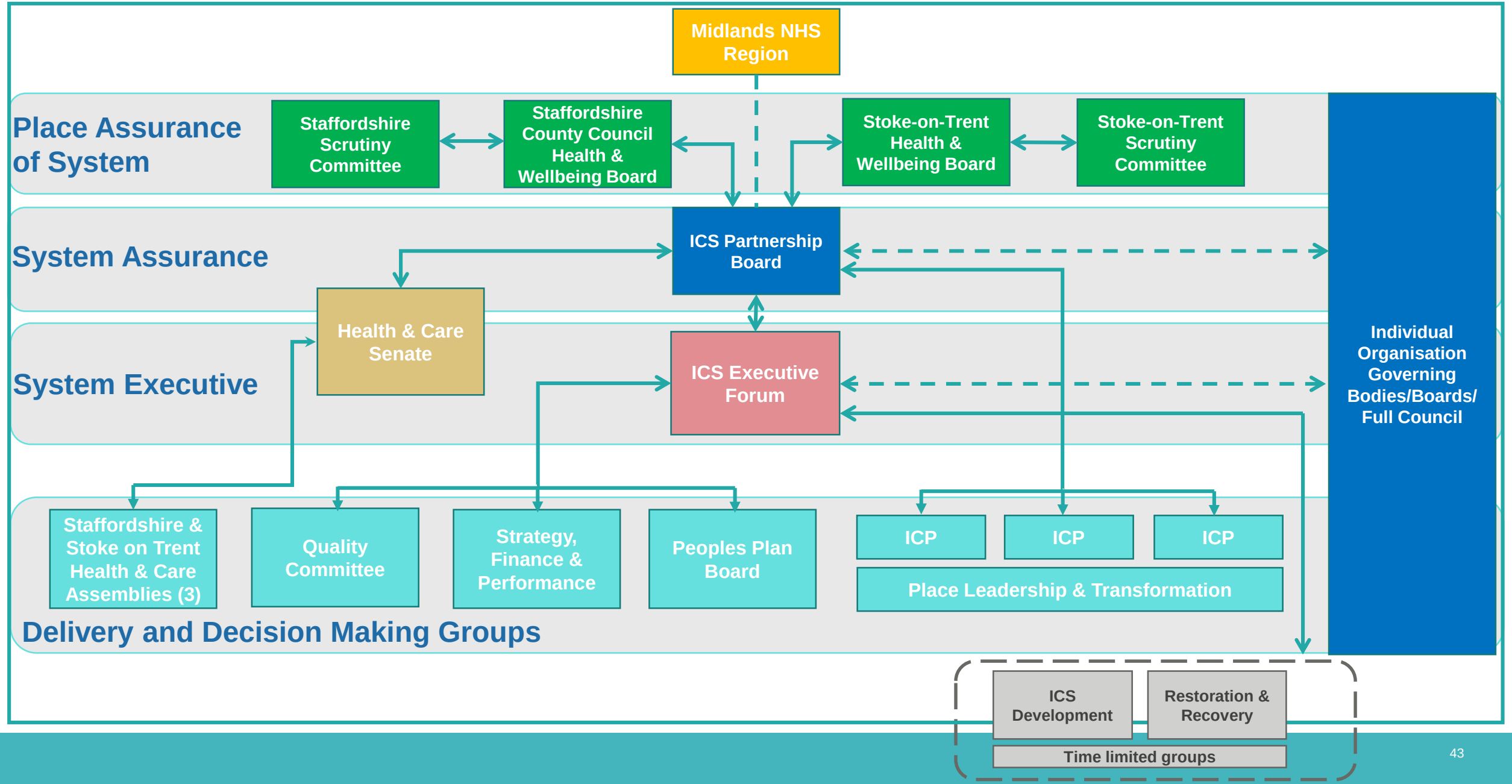


# Draft (Interim) Governance Structure

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

Governance and System Architecture

- 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

Governance and System Architecture

- 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.

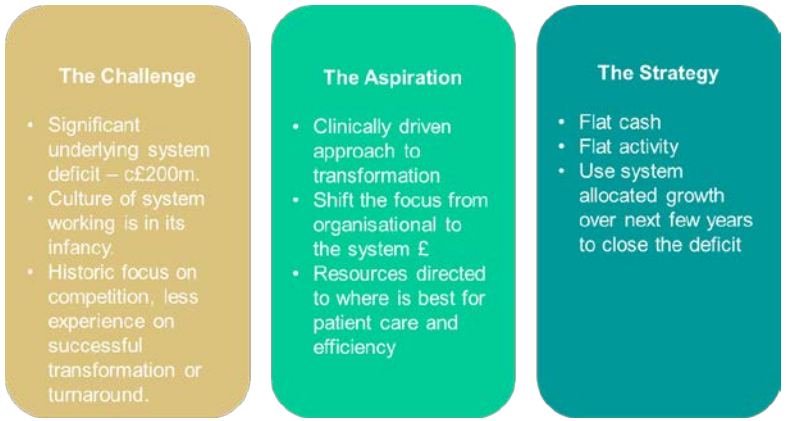
# Finance

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.

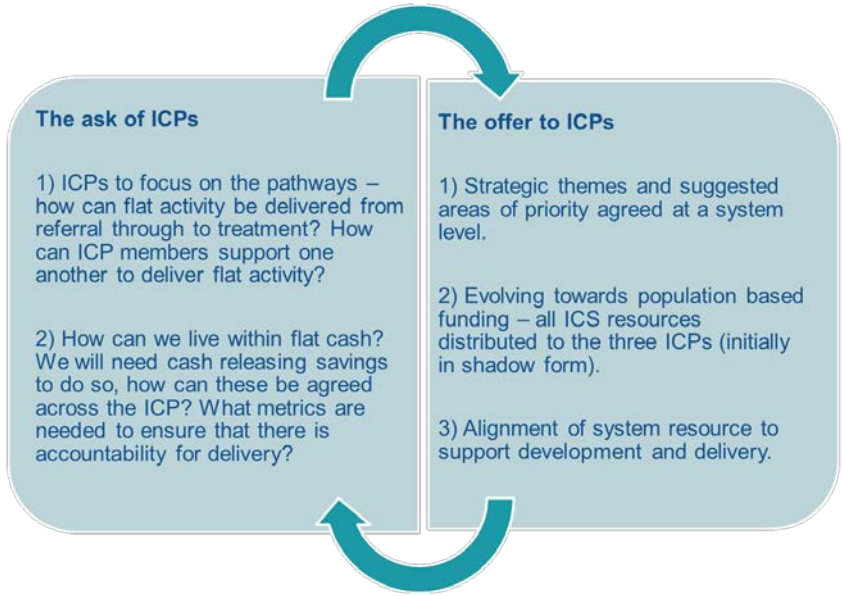
*Financial Strategy on a Page*




- 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

Quality, Performance and Finance

**Opportunity Analysis**

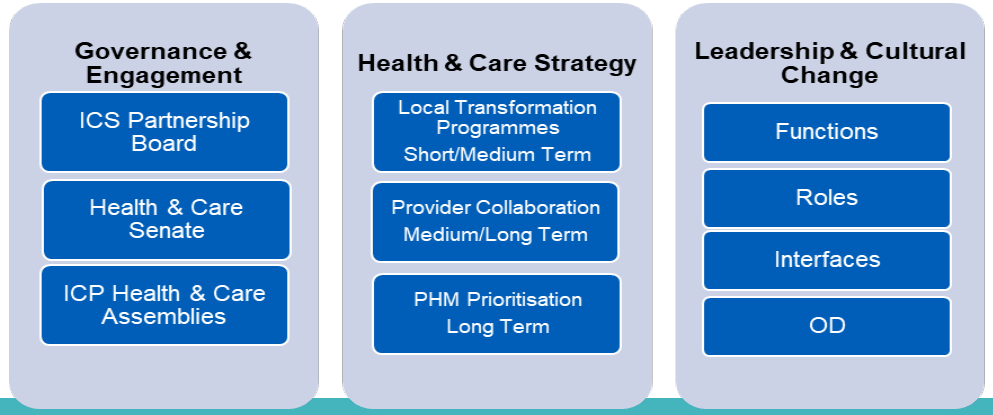
- The development of system opportunities was progressing throughout the late Winter and early Spring of 2020, however with the onset of the Covid pandemic this work was curtailed.
- Focus over the summer period has been the development of the restoration and recovery plan as well as the preparations 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 Gallyot.
- 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:



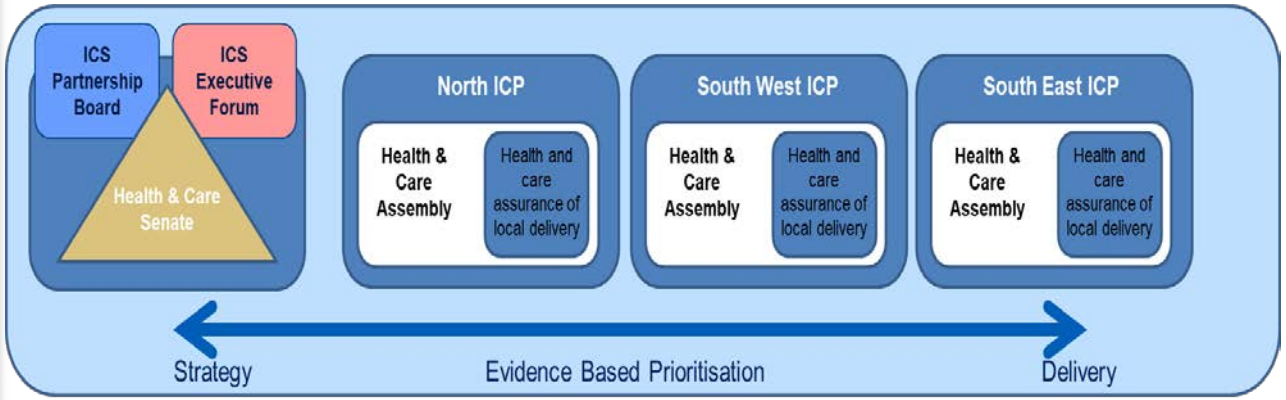

**Engagement**

- 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.<br>• H&CS established at ICS level mirrored at ICP level by Health and Care Assemblies.<br>• Clinical and professional leadership is readily accessible to the ICS Board, establishing early and ongoing clinical input into system strategy and delivery.<br>• A health inequality executive at board level within each organisation and a system inequalities lead.<br>• Focus on inclusivity and diversity at senior level in our workforce is a priority of the system workforce group.<br>• 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<br>• CEO leadership to ICP development supported by an Executive programme lead.<br>• 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.<br>• 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.<br>• An OD plan to support system and place clinical and professional leadership.<br>• 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.<br>• The H&CS has agreed an approach to identify the system clinical priorities.<br>• Developing outcomes frameworks at both the system and programme level<br>• The FYDP and ICS Roadmap 2020 sets out commitment to an ICS supported by an ICP model of delivery.<br>• 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.<br>• 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.<br>• Organisational phase 3 plans were used to support the development of recovery plans at the system and ICP level<br>• 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.<br>• The ICPs have developed on the basis of inclusivity and are supported by governance and servicing arrangements<br>• 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.<br>• ICP Delivery Plans will include a communication and engagement plan to support delivery.<br>• At ICP level strengthen the involvement of patient and voluntary groups. | ICS Leads<br><br>ICP Leads | April 2021<br><br>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.<br>• A Transformation Delivery Unit is in place that supports our transformation agenda.<br>  ◦ Projects are aligned to the FYDP and Phase 3 recovery plan<br>  ◦ Standardisation has been applied to our programmes and projects including reporting and oversight<br>  ◦ Project management discipline has been deployed against system priorities reporting into our system SFP and providing oversight on programme delivery<br>• System:<br>  ◦ Commitment to ICP model of delivery with oversight through the ICS Roadmap and CEO leadership to the 5 priority areas identified<br>  ◦ ICP development has been co-designed with the strategic commissioner programme of work to ensure alignment of future models<br>• Place:<br>  ◦ Three ICPs established with defined geographical footprints<br>  ◦ Cross- organisation work between health and social care partners delivered on ICP priorities identified throughout Summer 2020<br>• Neighbourhood:<br>  ◦ 25 PCNs in place<br>  ◦ 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.<br>• Implement the plan to deliver a Strategic Commissioner function<br>• 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<br>• PHM work stream and programme work streams are working on developing outcome frameworks linked to the Phase 3 recovery plans and FYDP.<br>• Development of ICP delivery plans which set out priorities for action<br>• Involvement of ICPs in development of system-wide financial strategy and schemes to support recovery to balanced financial position over the medium terms<br>• TDU capacity to be reframed and enhanced to support local ICP delivery and place based transformation – system wide PMO capacity and capability<br>• 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<br><br>ICP / ICS Leads<br><br>ICP Programme Lead / CCG CFO | April 2022<br><br>March 2021<br><br>December 2020<br><br>April 2021 |
| **System culture and talent management** | • Increasing diversity in senior positions is a priority for the system workforce group<br>• 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<br>• A range of Stepping Up, Stepping up Alumni, Reverse Mentoring, Pilot ICP Programmes in place<br>• 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<br>• 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.<br>• 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.<br>• 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.<br>• 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.<br>• System integrated Intelligence group and the SPAWG are working on the development of a system level dashboard and outcomes framework.<br>• 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<br><br>ICP SRO | March 2021<br><br>March 2021 |
| **Streamlined commissioning arrangements** | • A confirmed and finalised CCG merger timeline and roadmap.<br>• A detailed plan to support delivery of the Strategic Commissioner Development particularly in relation to<br>  • the functions delivered at system level by the strategic commissioner.<br>  • 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.<br>• IFR and the funding arrangements utilised during Covid-19 are being used to reconsider the future role of commissioning.<br>• Collaboration between ICP and strategic commissioning functions to determine nature and scale of locality commissioning support to enable ICP delivery.<br>• 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<br><br>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.<br>• A System Capital Prioritisation Group, to review and prioritise capital plans across the system.<br>• 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.<br>• Directors of Strategy to take the leadership on development of the system wide plans (eg Phase 3, operating plans)<br>• Development of the system/provider capacity/demand models to prioritise system actions and resource allocation.<br>• 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.<br>• A System Finance Director Group , with supporting infrastructure in place.<br>• 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.<br>• Development of system approaches to system savings.<br>• 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:<br>  • Development of Covid-19 population models<br>  • Capacity and demand modelling<br>  • Population data on outbreaks and on the demographic distribution of Covid-19 admissions<br>• 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.<br>• A process for PHM based prioritisation at the system and place level<br>• An initial work plan for the next six months.<br>• Supporting the system understanding on health inequalities and the development of the inequalities work streams.<br>• 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.<br>• Digital and PHM work streams continue to collectively work on data sharing protocols<br>• Working with the H&CS and the system PHM group on developing a PHM Strategy and work programme for 2021/22.<br>• Developing work on understanding the use and impact of CCGs inequalities funding on health inequalities.<br>• Develop a plan to address the deficits identified as part of the Capability and Capacity review of functions.<br>• Working with the integrated intelligence group on single population/clinical data sets for use at system and place level.<br>• Work starting to develop primary care intelligence and PHM programme.<br>• 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:<br>  • Care homes<br>  • Community care models<br>  • Discharge and admission avoidance<br>• 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<br>• 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<br>• 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.<br>• Radical transformation to none face to face consultations across all sectors.<br>• 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<br><br>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.<br>• An agreed Primary Care Strategy is in place.<br>• 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.<br>• PCNs currently working on the Delivery of Enhanced services specification.<br>• 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.<br>• 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.<br>• Development of a system prevention group and work programme.<br>• 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.<br>• A health inequalities expert group.<br>• Inequalities identified as a key priority and work programme by the H&CS<br>• ICPs progressing delivery of 6 areas of priority, including a focus on reducing health inequalities and promoting the prevention agenda.<br>• 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.<br>• Work to be undertaken to improve healthcare recording of demographic and inequalities data<br>• Work on understanding the use and impact of CCGs inequalities funding on health inequalities<br>• Work with LAs and Voluntary sector on community approaches to prevention<br>• Developing the social prescribing/interventions within PCNs.<br>• Developing risk stratification approaches to identify pathways where health inequalities are important.<br>• Development of inequalities metrics as part of the system outcomes framework<br>• 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.<br>• Develop the system level strategic framework and system operating plan to include clear objectives around health inequalities.<br>• 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.<br>• 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.<br>• 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.<br>• During summer/autumn 2020 further engagement was undertaken with local community groups, to understand their experiences during Covid-19, including discussion of future priorities.<br>• All of the Covid-19 service changes have been reviewed against the FYDP ICP priorities have been cross referenced against the FYDP.<br>• 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.<br>• Continue the work with the H&CS to develop the clinical priorities supporting the FYDP.<br>• Maintain focus on main priorities in the Phase 3 recovery plan.<br>• 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.<br>• A system assurance framework.<br>• Recognition of areas e.g. urgent care where the system have struggled to meet emergency care standards.<br>• Significant progress in delivery of cancer standards. Acute Trusts working through cancer hub to ensure opportunities for mutual aid are exploited.<br>• Extensive data validation has reduced the number of patients waiting for elective care.<br>• 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.<br>• 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.<br>• 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.<br>• 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<br>• Significant evidence of co-production and co-delivery e.g. Care Homes<br>• Covid-19 has focused the system to work collaboratively in providing joined up care.<br>• 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.)<br>• 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.<br>• 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.<br>• ICPs cross local authority boundaries, though this is recognised, with clear arrangements in place for cross boundary working.<br>• The upper tier Local Authority boundaries are coterminous with the boundary of the proposed ICS<br>• 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<br>• Developing partnerships with Staffordshire County Council and Stoke-on-Trent City Council, and the VCSE sector. | ICS Lead | December 2020<br>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.