Staffordshire and Stoke-on-Trent Integrated Care System

Joint Forward Plan

Draft Version V4.0

26th May 2023

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Foreword from ICB and ICP Chairs

Foreword is being develop for ICP Chairs and ICB Chair.

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Executive Summary

In line with the Health and Care Act 2022, Integrated Care Boards (ICBs) and their partner NHS Trusts and NHS Foundation Trusts must develop a **Joint Forward Plan (JFP) which sets out the vision for the next 5 years**. We have worked in partnership across the Staffordshire and Stoke-on-Trent Integrated Care System (ICS) to co-produce this plan. The plan will be updated on an annual basis in collaboration with local Health and Wellbeing Boards (HWBs).

This JFP sets out how we will transform services and pathways to support delivery of the vision and ambitions outlined in the Integrated Care Partnership (ICP) Strategy whilst also addressing the operational challenges we face today.

The diagram below outlines the key priorities of the Staffordshire County Council Health and Wellbeing Strategy 2022 - 2027; the Stoke-on-Trent City Council Joint Health and Wellbeing Strategy 2021- 2025, and the Staffordshire and Stoke-on-Trent Integrated Care Partnership Strategy. It reflects already existing shared priorities which are included in the portfolio section of this document.

{DRAFTING NOTE: Concentric circles diagram to be inserted to show partners across the system as discussed at ICB Board Development session. To be discussed with NEDs and Chair 6th June

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The Scope of this Document

The ICP strategy outlines how the Staffordshire and Stoke-on-Trent (SSOT) Integrated Care Partnership (ICP) will work over the next five years to improve services for our people and communities. By working closely together we can identify new opportunities and have a greater impact than any partner can achieve on their own.

This Joint Forward Plan outlines how the Integrated Care System (ICS) will support the delivery of the ambitions articulated in the ICP Strategy describing our collective priorities over the period 2023 to 2028. The JFP describes how the ICB and its partner trusts intend to arrange and/or provide NHS services to meet population's physical and mental health needs of the population.

These are aligned to the core national, regional and local strategic drivers of the NHS including the NHS Long Term Plan (LTP), the Health and Care Act and the Core20PLUS5 approach. This document is the first Joint Forward Plan (JFP) for NHS partners since the inception of the statutory ICS in Staffordshire and Stoke-on-Trent. The production of this plan has followed guidance issued by NHS England (NHSE) and the detailed operational planning and financial framework issued to NHS organisations for 2023/24.

In preparing this JFP, we have had regard for the regulatory and statutory requirements, particularly the 2023/34 planning guidance, and the **four key aims established for Integrated Care Systems**. We have also had regard for the **'Triple Aim'** established for NHS bodies that plan and commission services, requiring them to consider the effects of decisions on:

- The health and wellbeing of the people of England (including inequalities in that health and wellbeing).
- The quality of services provided or arranged by both themselves and other relevant bodies (including inequalities in benefits from those services).
- The sustainable and efficient use of resources by both themselves and other relevant bodies

The **JFP takes account of Health and Wellbeing Strategies of both our local authorities 2022 to 2026** and the joint priorities outlined in the **ICP strategy**.

The plan sets out how the **ICB is exercising its key functions and discharging its statutory duties** in an effective and timely way, and how this makes a meaningful contribution to the achievement of the ICS's four core purposes.

The NHS operational planning guidance for 2023/24 NHS operational planning guidance has set out clear expectations for delivery and our collective submissions to NHS England aggregate our shared ambitions and commitments for 2023/24 – this is year 1 of the Joint Forward Plan. Detailed operational, activity, finance and workforce plans of all the relevant organisations will be set out within their annual operating plans and are therefore not duplicated here.

The plan is a live document that is delivery-focused, including specific objectives and underpinned by milestones and more detailed outline of deliverables across each quarter/and year and where appropriate supporting metrics which are available in more detail as required.

Who We Are

The **Staffordshire and Stoke-on-Trent Integrated Care System (ICS) brings together a range of partners who are responsible for planning and delivering health and care and to improve the lives of people who live and work in our area**. The ICS is simply the geographical area in which health and care organisations work together.

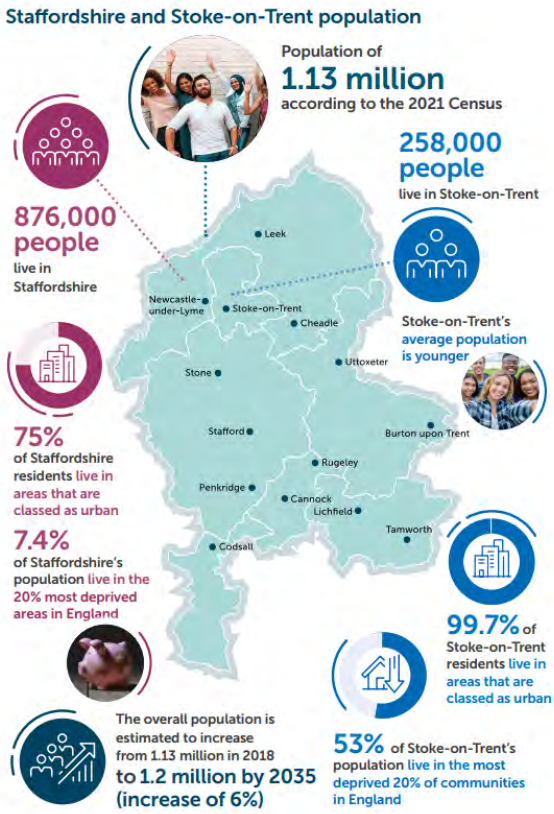
The purpose of ICSs is to bring partner organisations together to:

1. improve outcomes in population health and healthcare
2. tackle inequalities in outcomes, experience and access
3. enhance productivity and value for money
4. help the NHS support broader social and economic development

The Health and Care Act 2022 created a statutory basis for ICS' by creating a statutory Integrated Care Partnership (ICP) and an NHS Integrated Care Board (ICB) for each ICS.

Our ICS is made up of:

Term	Meaning
Integrated Care Partnership (ICP)	The ICP is made up of partners from across the local area, including voluntary, community and social enterprise (VCSE) organisations and independent healthcare providers, as well as representatives from the ICB. One of the key roles of the ICP is to assess the health, public health and social care needs of the area it serves, and to produce a strategy to address them. This, in turn, will direct the ICB planning of health services.
Integrated Care Board (ICB)	The statutory NHS organisation that replaced our 6 Clinical Commissioning Groups (CCGs), taking on their previous responsibilities to plan healthcare across Staffordshire and Stoke-on-Trent. The ICB holds responsibility for planning NHS services, including those previously planned by CCGs, managing the NHS budget and arranging for the provision of health services.



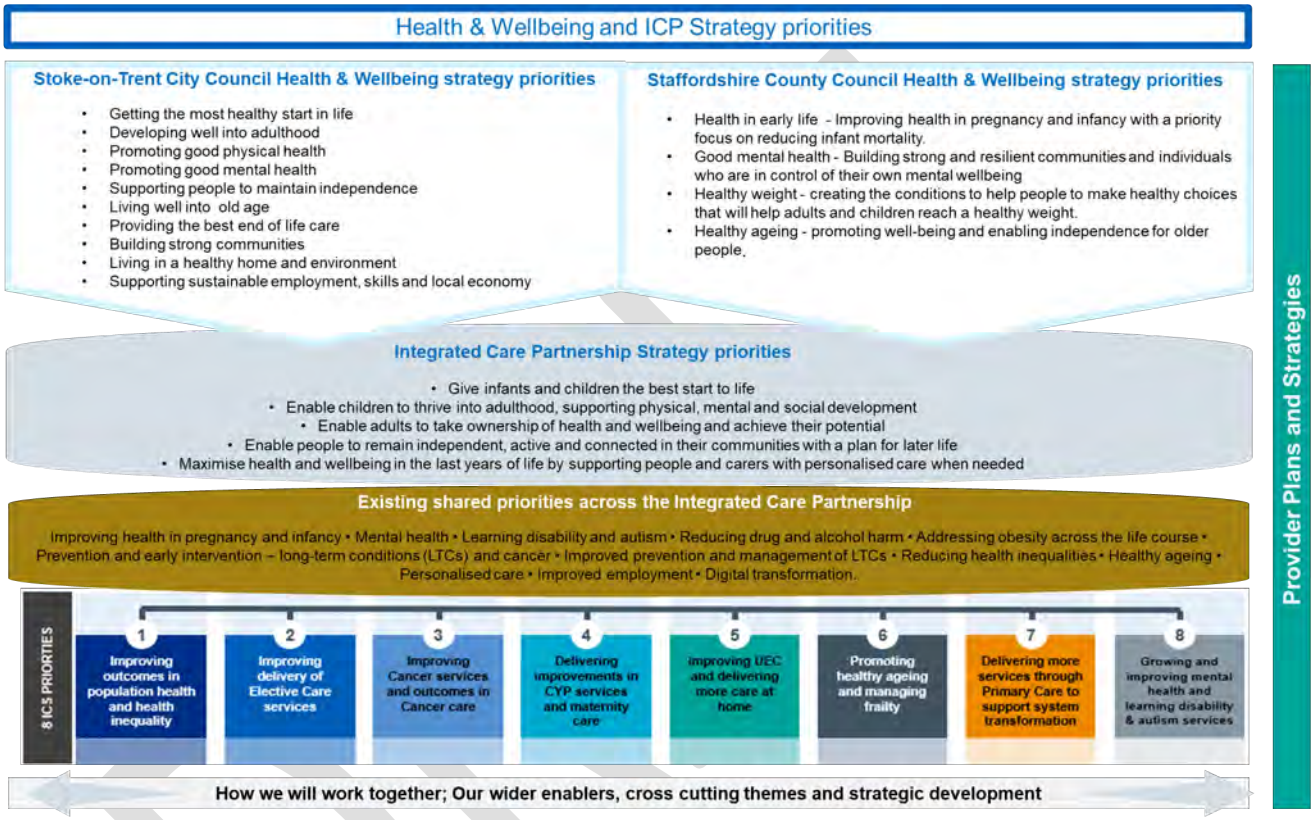
ICS Vision

Working with you to make Staffordshire and Stoke-on-Trent the healthiest places to live and work.

Our approach to developing our priorities

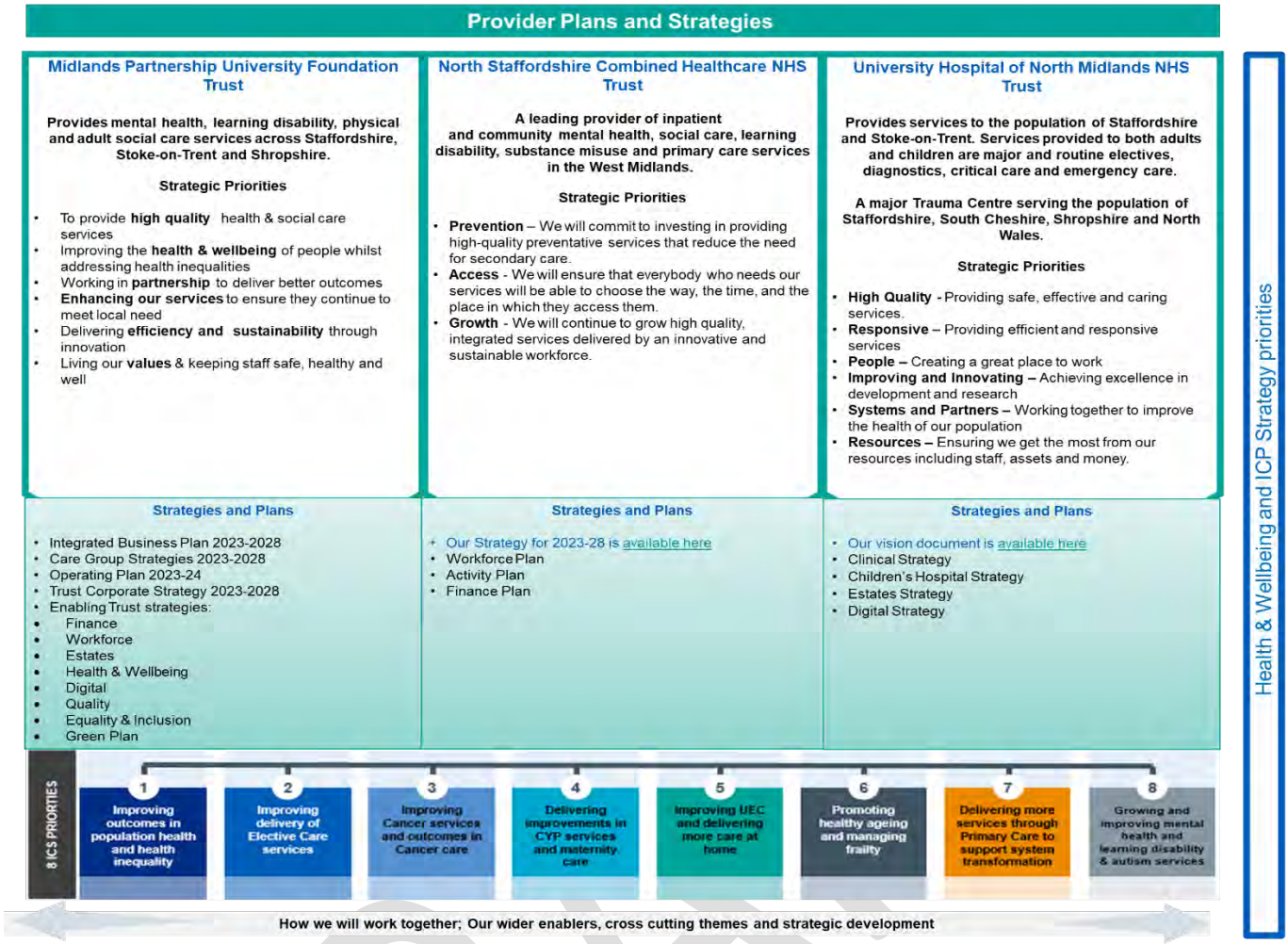
How we have informed our ambitions and priorities

Our ambitions and priorities have been informed by **understanding the needs of our population** identified in existing Joint Strategic Needs Assessments and engaging with our local people and communities to identify where there are existing shared priorities. We have ensured that our shared priorities through existing plans and strategies from all partners are aligned with national targets and priorities such as the NHS Long Term Plan and related policies and guidance; Local Authority priorities outlined in the Staffordshire Health and Wellbeing Strategy 2022-27; Stoke-on-Trent Joint Health and Wellbeing Strategy 2021-25.



All of our providers and delivery partners have a key role in the provision of safe, caring, responsive and effective services to our population. By joining together, we believe we can challenge ourselves to use our resources more effectively for our communities. **Working together allows us to remove duplication and remove barriers that often get in the way of seamless care**.

Whilst our JFP reflects the plans and five-year strategic directions for each of our ICS acute, mental health and community NHS providers it purposely seeks not to replicate those. Much of our population receive acute services provided University Hospitals of Derby & Burton NHS Trust and the Royal Wolverhampton NHS Trust as well as other acute and community providers which sit outside our footprint. Their strategic priorities and plans will be reflected in the JFPs for their respective ICSs however in drafting our JFP we have fully engaged with them and ensured our priorities are aligned.



Our ambitions

To achieve our vision, we have taken insight from our population health work to develop the **Integrated Care Partnership Strategy** based on an assessment of our health, public health and social care needs which sets out our **long-term ambitions** to prevent ill health, reduce inequalities, and deliver better health and care services for our population at different stages of life.

The strategy sets out our four strategic ambitions for the population. All of our collective work will align to and deliver change within these areas.

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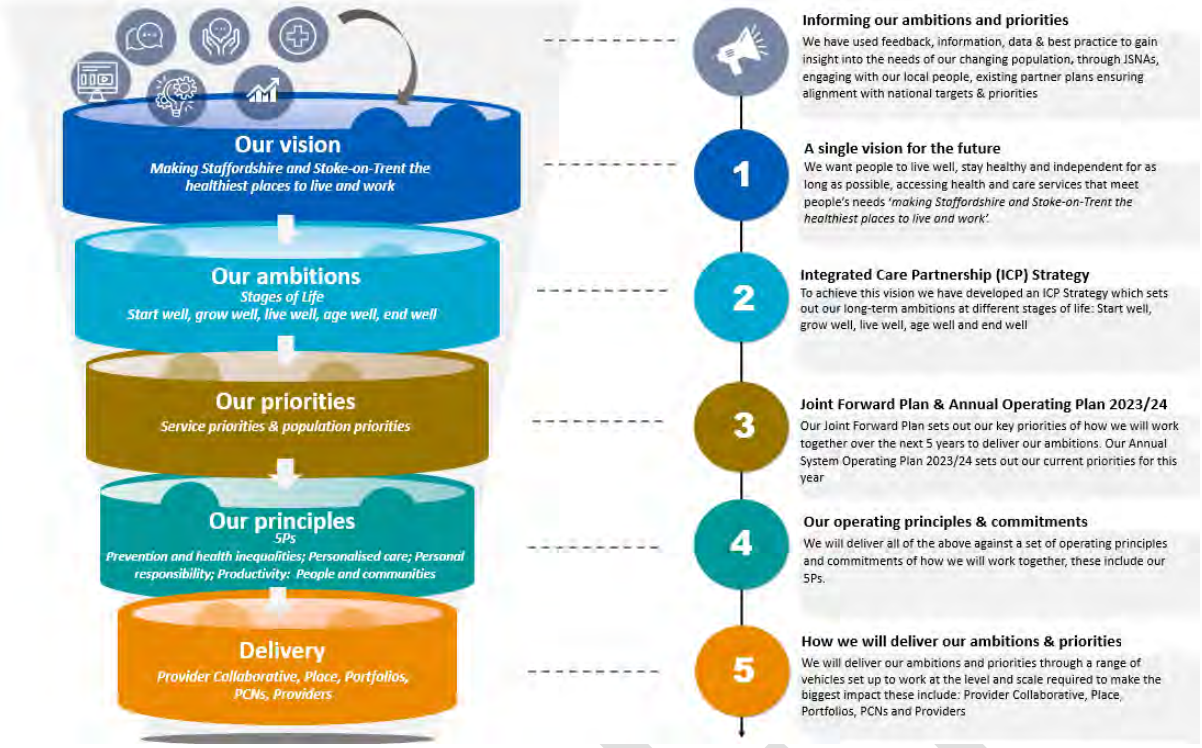

The four strategic ambitions outlined in the ICP strategy are to:

1. Improve population health and wellbeing outcomes.
2. Address inequalities in access, experience and outcomes from health and social care services.
3. Achieve a sustainable and resilient ICS.
4. Work in partnership with communities to achieve social, economic, and environmental community development.

Our priorities

We have used Population Health Management (PHM) methodologies to understand the **needs of our local population and the changes they face over the next five years**. This insight has helped us to develop a set of clinically owned local priorities that sit alongside our service priorities. Some of the changes we need to make may take longer in terms of transformation, but the planning will be started to enable this to be delivered as part of our JFP and the ambitions set out in our ICP strategy.

We have identified the 3 biggest drivers of the difference in avoidable mortality between most and least deprived areas of Staffordshire and Stoke-on-Trent, these are **cardiovascular disease, respiratory disease** and **cancer**.

Service Priorities

We also produce more detailed **Annual System Operating Plans**, starting with 2023/24. These plans will contain our current operational and population priorities for our communities and reflects our national targets and actions and the current challenges against a single collective aim which is to reduce the number of Category 2 and 3 ambulance calls. They are focused on four lenses:

- **Urgent and Emergency Care:** with a focus on prevention and avoiding hospital admissions
- **Backlogs:** Reducing queues and wait times inclusively, for elective care, cancer mental health, learning disability & autism services and NHS dentistry
- **General practice:** ensuring that residents have appropriate timely and equitable access to services
- **Complex individuals:** Improving access to high quality and cost-effective care for people with complex needs

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Our operating principles and commitments

We will deliver all of the above against a set of **operating principles and commitments** of how we will work together, these include:

Our '5Ps'

- **Prevention and health inequalities:** We will offer equal opportunity to access and benefit from preventative services
- **Personalised care:** We will work with people as equal partners to deliver co-ordinated care centred on individual's physical, mental and social needs
- **Personal responsibility:** We will work with people and communities to enable them to meet their health and wellbeing needs independently in the community
- **Productivity:** We will adopt an intelligence led continuous quality improvement approach across the work of our ICS. Innovation in use of digital technology, our workforce and models of care will be crucial to how we make best use of the resources we have
- **People and communities:** We will adopt a strengths-based approach in how we work with people and communities to develop community networks and resources offering health and wellbeing, social, education and welfare support, recognising the value that the partnership can bring in improving the wider determinants of health.

Our governance for success

- **Quality framework:** Providing outstanding quality services for all underpinned by our quality framework - includes both quality assurance and continuous quality improvement
- **ICB Constitution:** Organising ourselves together to provide the best health and care, ensuring that decisions are always taken in the interest of the population we serve
- **Clinical and professional leadership:** Integrating clinical and care professionals in decision making at every level and providing dedicated leadership development
- **Decision-making:** Ensuring that decision-making is lawful, statutory duties and wider legal, regulatory duties are met
- **Shared learning:** Creating a culture of shared learning, collaboration and innovation, working alongside our population and local communities

Health and Wellbeing Boards

We have involved both our Health and Wellbeing Boards (HWBs), covering Staffordshire and Stoke-on-Trent, in preparing our first JFP. This has included sharing a draft with each HWB, and their opinion on whether the JFP takes proper account of their health and wellbeing strategy.

{DRAFTING NOTE: Include the date we attended the HWB or any alternative arrangements we made}

{DRAFTING NOTE: Insert statements here}

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Our changing population and the impact on demand for health and social care

We have an **ageing population**. We have seen life expectancies increase, but people are not always living longer in good health.

On average, people spend between 16 and 25 years living with one or more long term conditions before they pass away, while **more people are living with complex health and care needs**.

National evidence shows that there are **increasing numbers of over-65s living with multiple long-term conditions**, meaning that the health and care that they need is increasingly complex. In Staffordshire and Stoke-on-Trent Cardiovascular Disease (CVD) avoidable premature mortality in under 75s is almost double the England average, as is premature mortality in those with a serious mental illness (SMI). We have high prevalence of smoking, obesity and poor achievement of blood pressure targets.

However, aging is not our only challenge. Some communities also experience **social exclusion** – this is where people struggle to access support with things like housing, secure employment, or health and care services. These problems are usually linked to other difficulties such as poverty, violence or complex trauma, and need special care.

In addition, Staffordshire and Stoke on Trent contains some of the **most deprived communities in England** and people in our most deprived areas live with poor health for 12 years more than those living in less deprived communities. Infant mortality is an indicator of the general health of an entire population. Stoke-on-Trent has had one of the highest birth rates in England and Wales in recent years; many of whom are likely to be born with a low or very low birthweight. The **infant mortality** rate is the highest in the country and almost twice as high as the average for England.

Generally, the adult population pre-pandemic experienced good wellbeing. Since the COVID-19 pandemic started all areas have been a decrease in life satisfaction, feeling worthwhile and happiness, and an increase in anxiety. **Nationally around 19% of adults aged 18-64 are estimated to have a mental health condition**. In Staffordshire and Stoke-on-Trent that equates to 125,500 adults. Based on 2017/18 Quality Outcomes Framework (QOF) registers, around one in ten (11%) adults are on a depression register and 0.8% are recorded as having a severe mental illness. Deprived communities have poorer health and wellbeing and higher levels of mental illness.

Poor **respiratory health** plays a key role in driving health inequalities. Lung disease remains the third biggest killer in the UK and outcomes for people with lung conditions have seen little improvement over the last ten years. We have high rates of mortality from respiratory diseases in under 75s, but low rates of review of asthma and chronic obstructive pulmonary disease (COPD). National projections suggest that by 2035; there will be higher proportions of people aged 65 years and over with multiple chronic conditions. The proportion of people aged 65 and over with 2+ conditions is projected to go from 54% in 2015 to 68% in 2035, and those with 4+ conditions from 10% in 2015 to 17% in 2035.

As an example, the diagram below shows the long term condition projections for 2030, in people age 65+ if we do nothing.

POPPI v15.0 17 November 2020. www.poppi.org.uk data sources: Institute of Public Care (IPC) and ONS . Crown copyright 2020.

As a result of all of these factors, **demand for our health and care services is increasing** across primary care, community health services, social care and within the voluntary sector. This has been made worse by the COVID-19 pandemic.

Challenges in our services

Across the country the performance of health and care organisations is set against a challenging backdrop of **increasing demand for services**. There are underlying demand pressures on the NHS and social care, driven by demographic growth and morbidity changes, with the pandemic increasing demand and negatively impacting on staff absence. This has caused an increase in elective waiting lists, in particular.

There is **a world-wide health and social care workforce crisis** which is heavily impacting the wellbeing of our staff and the sustainability of services. This needs to be addressed to ensure high-quality care can continue to be delivered at all levels. Workforce supply challenges due to turnover / burnout / age / lack of flexible working opportunities as well as financial challenges against a requirement to deliver increased activity via workforce productivity rather than increase in headcount.

Care and treatment in the usual place of residence is preferable – if safe to do so with an appropriate care model in place. We know that admitting elderly people via busy emergency departments can shorten their lives, and is often a poor experience. There are still people who are at the **end of their life being admitted into hospital**. We need to reduce unnecessary hospital admissions for our frail elderly population through effective proactive interventions as well as providing **rapid support at home** when they become sub-acutely unwell. This requires the provision of effective out-of-hospital services including virtual wards, remote care systems and other community teams. **Avoiding unnecessary admissions** will play an important part in improving our capacity to discharge people effectively. Our focus should be on keeping people within their own homes – reducing the often negative impact of hospital admission. People almost universally prefer to avoid hospitals where possible – and we need to be able to offer them that choice

Provision of urgent care services has been extremely challenging particularly during and following COVID-19. This means that our population have often **experienced significant delays in accessing urgent and emergency care**, with our hospitals unable to meet the required Emergency Department (ED) standards. Across the country, ambulance handover delays have reached critical levels leading to considerable delays for people waiting in the community and challenges surrounding patient flow of patients from the Emergency Department into hospital.

There has been **pressure in discharging people from hospital** and whilst we have made some progress in recent months, there is still further to go. Many are not discharged on a timely basis, and as a system we discharge more people into bed-based care rather than getting them home. We also have rising numbers requiring expensive CHC packages / social care compared to peers, with many remaining dependent on the health and care system for the rest of their lives. We should be striving to restore independence for our population. This cohort of people are cared for across acute, community and social care elements our system, and this is where there is evidence of duplication of effort and a risk of gaps

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between services. We know we have implemented step-down services like virtual wards which are not being used to their full potential.

Services are still recovering from disruption caused by the COVID-19 pandemic, with huge efforts ongoing to reduce **the number of people and the time waiting for treatment and care**. Despite the best efforts of our hospital teams, there remains a backlog for diagnostic, elective care and cancer services, while community, mental health, social and primary care services are also managing longer waiting lists. There were improvements in 2021 and 2022 compared to the first year of the pandemic but the number of elective procedures and outpatient attendances currently being carried out is still below pre-pandemic levels. There is considerable work to be done for services to return to the levels that our patients both expect and deserve. Many improvements have already been made including the use of tele-dermatology to speed up skin cancer diagnosis and the introduction of Faecal Immunochemical Test (FIT) testing as a means of eliminating bowel cancer for the majority of patients that test negative, however we recognise that there is much more to do.

The impact of COVID-19 on the demand for health care

The impact of the pandemic on people's health has not been equal, with some people experiencing long COVID-19 and other harm to their physical and mental health. The full impact of COVID-19 remains to be seen. People across Staffordshire and Stoke-on-Trent experience fragmented care because of avoidable and unfair differences in the types of services that are available in different areas.

Some communities also experience social exclusion – this is where people struggle to access support with things like housing, secure employment, or health and care services. These problems are usually linked to other difficulties such as poverty, violence or complex trauma, and need special care.

COVID-19 reinforced the importance of understanding and tackling health inequalities and of working directly with communities to understand their needs, reliably identify potential barriers, and design solutions. In responding to the pandemic, we have identified seldom-heard groups who need a more targeted approach to communication and engagement. We have collaborated more with staff, local people and the VCSE sector, and broadened our thinking, particularly towards digital engagement.

A set of assumptions were utilised to model future mental health needs of the general population in Staffordshire and Stoke-on-Trent by using evidence from previous epidemics and emerging information from the COVID-19 pandemic. These assumptions point to a significant rise in the number of adults with anxiety and depression, as well as significant potential for relapses for known psychosis patients. These assumptions suggest that nearly 200,000 adults in Staffordshire and Stoke-on-Trent are currently experiencing some anxiety, an increase of nearly 33,000 from before the pandemic. A further impact of the COVID-19 pandemic is the increase in the number of adults who will develop prolonged grief disorder.

Challenges for Managing our Resources

The ICS's ability to maintain and improve people's health and wellbeing is essential. This means making sure that **our health and care services are working in the most efficient ways possible and making the best use of funding and other resources like staff and buildings, to sustainably manage pressures** created by COVID-19 and the long-term growth in demand

We have **workforce challenges** similar to those faced at a national level. Workforce growth has not always kept pace with demand and nationally there is a workforce supply-demand gap. There are particularly gaps in demand for care workers, midwives, occupational therapists, physiotherapists and diagnostics staff. We need to work together to develop and support the current workforce and seek new opportunities to grow the workforce for the future

Finances are a challenge, with health and care organisations being asked to do more with no additional funding. There is a significant financial deficit that must be balanced in future years without impacting the quality of our services. Local authorities are also experiencing significant financial pressure and growing demands for services, not least social care services for adults and children. •We know that

the COVID-19 pandemic has had a significant impact on the delivery of continuing healthcare (CHC) in our ICS, – both in terms of performance and finance. This was due to the temporary suspension of the CHC Framework for six months between March and August 2020.

The COVID-19 pandemic has demonstrated that we can use the estate differently and more efficiently particularly with reference to non-patient facing roles and noting that virtual consultation and digital access has shown an alternative, and in many cases more accessible model of patient care and accessibility. Our estate ambitions, linking to the clinical imperatives or clinical strategies, are key for the successful delivery of the Integrated Care System (ICS) strategic objectives.

We saw an acceleration towards **digital technology** during the COVID-19 pandemic. Changing the way we do things – with access to services, information and support. Whilst this has been positive it also has meant those without digital access are at even greater risk of digital exclusion which we must continue to factor into our plans.

Despite the difficulties of the COVID-19 pandemic, as an ICS we are fully conscious that we must not ignore the even bigger challenge of climate change. The environmental change taking place now, and in the future will be the biggest global health threat of the twenty-first century. We are committed to meeting the **Net Zero Carbon** targets set out which means reaching Net Zero Carbon for our direct emissions (NHS Carbon Footprint) by 2040 and our indirect emissions (NHS Carbon Footprint Plus) by 2045 at the latest.

We know that to meet these challenges we will need to work together differently, ensuring that we make the best use of our resources, do more together to keep people healthy and prevent ill health, support people to self-care and tackle the health inequalities that exist.

What people have told us

We recognise that, while we want to look to the future, there are some immediate challenges we need to address as a priority. Failing to do so will result in an ongoing cycle of immediate pressures and an inability to focus on important longer-term actions.

Listening to what people and communities tell us is important to them has been central to the development of the Integrated Care Partnership (ICP) Strategy and the detailed provider strategies and plans. In developing our the ICP Strategy a desktop review was undertaken across all partner organisations to learn which themes and priorities had already been identified in engagement carried out over the previous two years. A summary of the information was used to shape a framework for the Strategy, which was subsequently taken out for further engagement with partners and the public.

Through our engagement activities we have heard from our population and stakeholders about:

- Long waits for ambulances, delayed handovers and corridor care
- Crowded Emergency Departments with long waits
- Long waits for elective care, planned operations and cancer care
- Frustrations around fragmented services
- Difficulty accessing primary care and/or seeing your GP
- Difficult to arrange social care and/or community services

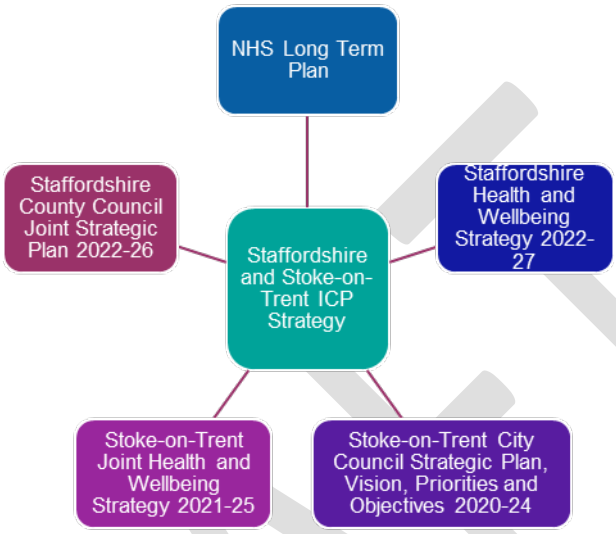
The JFP is informed by a range of engagement that have taken place including the work undertaken to develop the ICP Strategy during 2022/23, audits or other sources of intelligence. We have engaged on the draft JFP which involved a public survey asking for feedback in relation to the portfolio based key priorities building upon previous public and patient involvement work. The outputs from the survey will be utilised to support delivery of the JFP and future refreshes.

Looking at the insight we already have across the ICS, we will continue to prioritise our engagement activity using a thematic approach to reflect the settings of care in this JFP. We will develop a rolling plan of engagement for the coming months and years to help us listen to the views and experiences of local

people and communities and make sure this impacts the way we deliver our services and ambitions outlined in this plan.

Shared priorities across the ICS to improve population health and care outcomes

We have existing joint strategic needs assessments that identify our population's health and wellbeing needs at Place: Staffordshire Joint Strategic Needs Assessment, Stoke-on-Trent Joint Strategic Needs Assessment. These tell us where our population health and care outcomes can be improved to bring them into alignment with national average across the ICS population.



Through our ICP strategy we want to integrate existing programmes of work in a way that enhances our collective action and expands on existing good practice.

The portfolio plans and enabling function plans outlined in this document demonstrate how we will contribute to delivery of the ambitions outlined in the ICP strategy and how we will address our shared priorities.

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How we will work together to achieve our priorities

Our Focus

The Hewitt review published in 2023 proposes greater autonomy to enable Integrated Care System (ICSs) to better prevent ill health and improve NHS productivity and care, matched by renewed accountability. The way we work, and our operating model aims to address some of the key findings of the review.

Improving population health and tackling health inequalities is a complex task but is key to the operational and financial sustainability of health and social care. We recognise that one of the main challenges that our ICS must continue to address requires focus on prevention and proactively supporting people to stay well at home and arranging services in a way so that people receive care from the right people in the most appropriate setting. We know that only 10-20% of health outcomes are directly influenced by the NHS, which is why close collaboration with our wider partners outside the NHS is so important to us.

We will need to continue working in partnership to prevent ill health throughout people's lives, using a system-wide approach to prevention, alongside action to improve the determinants of health in our communities and a focus on reducing health inequalities. Our Clinical and Professional Leadership teams will be working collectively work to tackle unwarranted variation and health inequalities.

We need to ensure that we are looking ahead and planning services, based on an understanding of current population and future demand for services. Population Health Management is a way of working to help frontline teams understand current health and care needs and predict what local people will need in the future. A Population Health Management approach will enable us to reduce demand for reactive care services and use those resources to provide better proactive care for more people. We will take an evidence-based approach to service transformation and work across our established research partnership Staffordshire and Shropshire Health and Care Research Partnership (SSHERPa) to seek the evidence where we have the expertise to lead research working through our portfolios to bring knowledge to clinical and operational partners involved in service transformation work.

The Way We Work (Our Operating Model)

The way we work (our Operating Model) is an important development that enables us to realise our ambitions and for working collaboratively with all our system partners. Our structures must enable us to deliver our vision and aims. We are organised as a set of 7 Portfolios supported through our 2 Places and Provider collaboratives, Primary Care Networks and Neighbourhoods. This also includes a range of enabling functions and with broader leadership and support such as quality and clinical and professional leadership.

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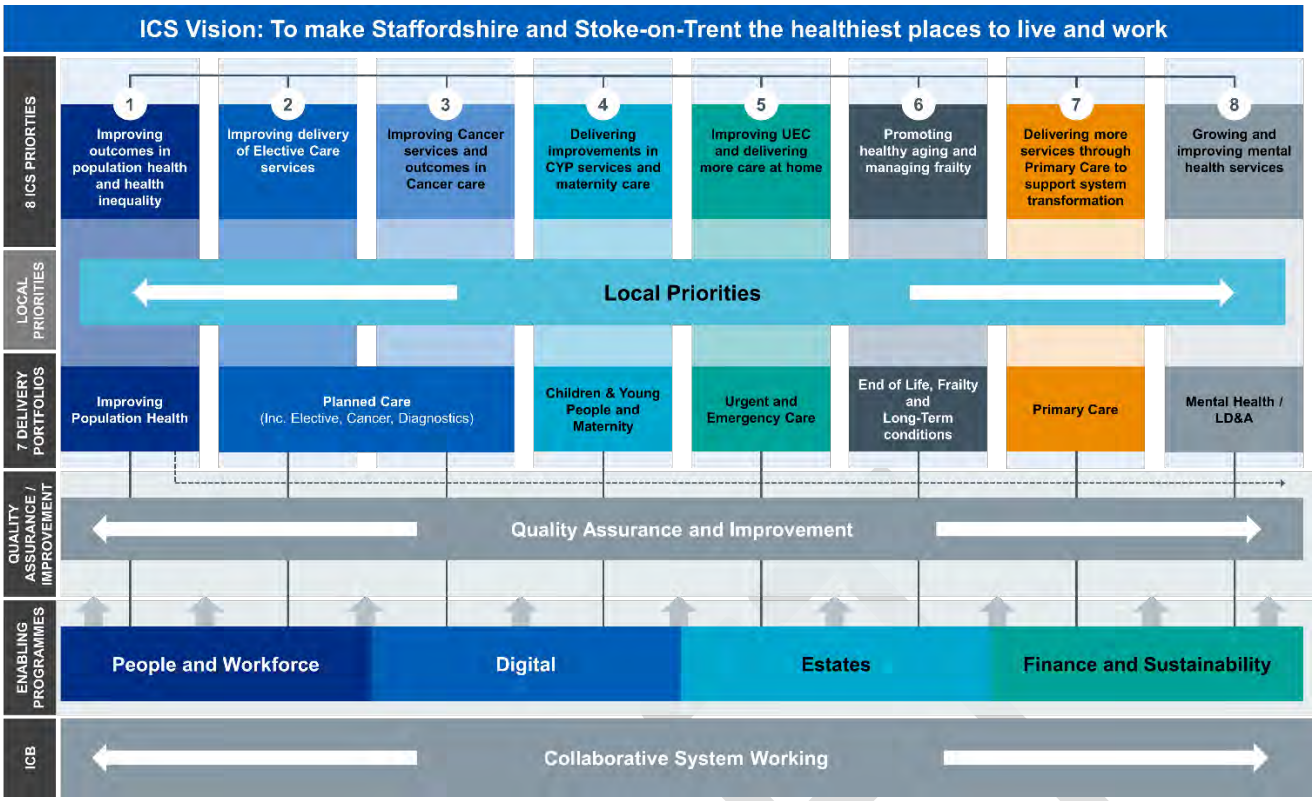

Portfolios

Our 7 *portfolios* are aligned against 8 key local priorities (Children and Young People and Maternity and Neonates are in one portfolio). The primary aim is to balance the implementation of change initiatives and the maintenance of business as usual. The portfolios are the system's way of bringing delivery and local transformation together. Each of our portfolios has an agreed set of senior leadership roles including an Executive Sponsor, a Senior Responsible Officer (SRO), a Portfolio Director and a Clinical Director. This enables the formation of teams from across the system, with a range of expertise to respond to priorities and deliver the work programmes set out within our plans. Each of these portfolios cannot be successful working in isolation and many priorities require involvement from more than one portfolio. Each portfolio will have an agreed dashboard of metrics and where identified outcome measures to support them to understand delivery.

Provider Collaboratives

Provider Collaboratives bring providers together to achieve the benefits of working at scale to improve quality, efficiency and outcomes and address unwarranted variation and inequalities in access and experience across different providers. Our collaboratives are part of a united approach to developing our Operating Model and share a significant interdependency with Place and Portfolio development. Provider Collaboratives are developing across the majority of our system portfolios and enabling workstreams as the delivery vehicle for transformation at scale involving two or more in system providers. Each has a Programme Board with Executive representatives from acute providers both within and outside of our system, community providers, Place, ICB, Local Authority and General Practice.

Place

We have a two Place model aligned with our upper-tier local authorities (Staffordshire County Council and Stoke-on-Trent City Council) which has been agreed by all system partners. Each Place will have an initial focus on developing integrated commissioning in the first instance.

Programme governance arrangements have been established and a small number of areas of focus agreed across all system partners, these are:

- Care Homes
- Learning Disabilities and Autism
- Transition and Preparation for Adulthood
- Dementia
- Section 117 placements

There is a full review of the schemes supported through the Better Care Fund to support further areas of integration with the aim of establishing transparency for system partners to underpin discussions on enhancing opportunities for integration.

Neighbourhood

Neighbourhoods provide a focus for smaller, identifiable populations based on particular characteristics or needs. Without the need to meet the requirements of a fixed size or model, different areas can find different solutions for different problems. As the wider ICP develops so too will our approach. As part of our wider strategic system development, we will work in partnership with people and communities at neighbourhood level.

Primary Care Networks (PCNs)

There are 142 practices across 25 PCNs in Staffordshire and Stoke-on-Trent. PCNs build on existing primary care services and enable greater provision of proactive, personalised, coordinated and more integrated health and social care for people close to home. A PCN is a group of GP practices working together to focus local care and are in the best position to understand the population health and care needs at a grassroots level. All PCNs have been established with Clinical Directors identified. PCNs are crucial to the implementation of the JFP, both through more resilient delivery of primary care in local neighbourhoods, and the integration of health and care services to better respond to the characteristics and needs of the local population.

Our system-wide approach for pathway design

We need to design models of care which help our patients and residents follow seamless care pathways and which remove unnecessary delays and duplication. In turn, these pathways need to help maximise the time our workforce spend in delivering care. Being successful in both of these aims will help us address the need for financial savings.

Our Approach

One of the biggest challenges facing all systems is supporting the care of our frail elderly and those with long term conditions. As an example, we have experienced sustained growth in the cost of Continuing Healthcare (CHC) which increased by £50m during 2022/23 relative to the previous financial year. This is a cash-cost to the system and one we know we do not experience in isolation. Our Local Authority partners are facing similar pressures in terms of funded social care placements. The demand for care currently outstrips the supply, resulting in lack of choice for our most vulnerable population and unsustainable pressure on our workforce in the care home sector.

We know that some of these CHC and social care costs may be avoidable if our population are not admitted to hospital in the first place or, when they are, they are discharged with alternative home support packages. We know from evidence that patients experience a decompensation in their outcomes if their discharge process is sub-optimal, and a large number of these people can end up with a lifetime of dependency.

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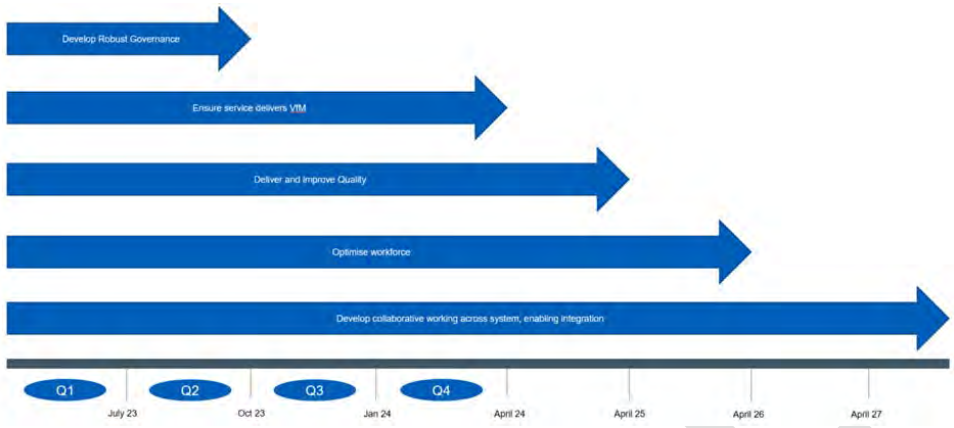
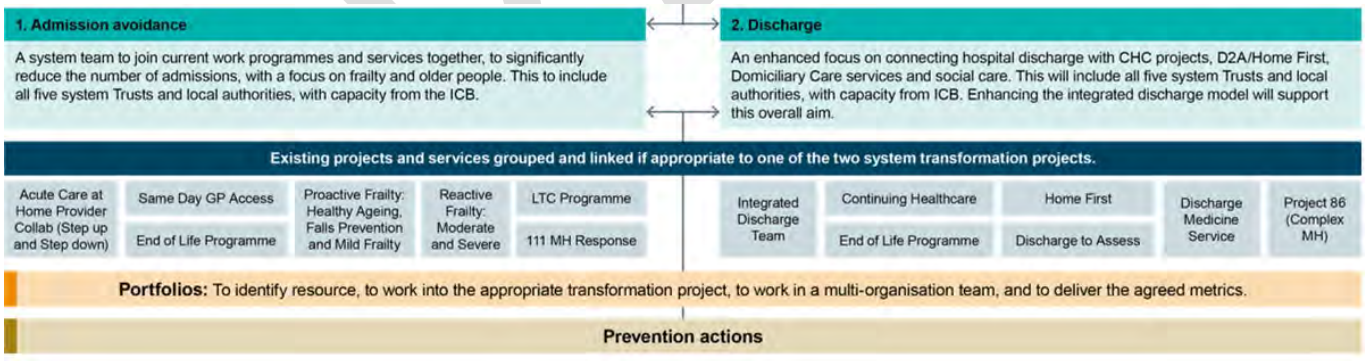
There are many different factors impacting the cost of CHC placements; increases in the numbers of patients assessed as eligible, the acuity of patient need, a misalignment of demand and supply together with under-developed provider markets and increases in providers own cost base through inflation, cost of living and workforce challenges.

This means we need a wide-reaching plan to return to a clinically and financially sustainable model for CHC. This plan also needs to strive to enhance the experience and outcomes of our patients through timely and accurate assessments and the securing of onward care packages. The diagram below provides an overview of the themes within the CHC Plan and the timeline over which they will be delivered:



We also know that the pressures we experience in CHC are not limited to that area of service alone and are an indicator of pathways that are not as connected as they could be. Working together on admissions and discharges as two joined-up projects, we can positively impact on the quality of lives of our population. This will also have a positive impact on managing the demand for beds in our already constrained care homes and positively impact on the finances.

We have proposed two transformational projects for pathway redesign starting in 2023/24:



Some transformation may be specific to a group of service users e.g., diabetics in a certain geographic patch and therefore some very specific work will take place to design local solutions. Others will be broader service transformations and large-scale changes probably e.g., the development of a model for Urgent Treatment Centres which will serve the whole population. What this means is we don't have a one size fits all approach to service transformation. The current programme of transformational work is explored more within each of the portfolio sections of this document.

Supporting Collective Accountability through Our Leadership Compact

No single partner alone, can achieve what we need to for our population. We will work together to make sure that we promote the long-term wellbeing of our population by each of us taking responsibility for what happens not just in services that our organisations individually provide, but across health and care services. This is called "Collective Accountability". Our focus is shifted to jointly figuring out how things can be done differently in the future and working together to get the right things done.

To support our commitment to collective accountability, we have developed a leadership compact in partnership across the system which supports how we will work together. We have co-created a common understanding of the behaviours expected of our leaders, supported by a compact to ensure mutual accountability between individuals and organisations. The leaders of the organisations within the ICS have agreed to adopt the System Leadership Compact.

The Functions and Decisions Map sets out our governance arrangements that support accountability. It is designed to support decision-making and cultivate cultures and behaviours that enable system working and collective accountability.

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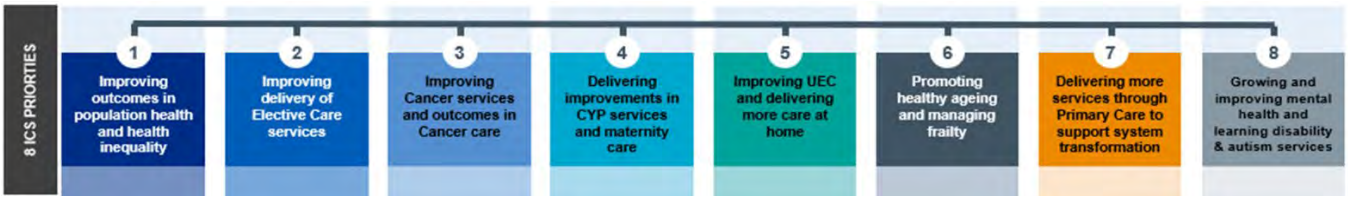
Our ICS Priorities and Portfolios	This section of our Joint Forward Plan sets out the key ambitions and focus of each of our portfolios for the population.



Approach

Each portfolio is introduced by a commitment statement written by the Executive lead or Senior Responsible Officer. Each portfolio has set out their ambitions (priorities) over the next five years and considered their plans against 4 key questions.

1. Why is this important for our population? Reflecting on the current picture and challenges.
2. What do we know about people's local experiences? Considering any existing engagement activity, intelligence or data
3. How do we plan to make a difference? Overview of the key deliverables' portfolios plan to implement over the next five years. The underpinning detail including timelines and actions will be captured in local plans.
4. How will we know we are making a difference? Portfolios have considered how their plans will be measured or what that the outcomes will be for our population. Each portfolio has an underpinning dashboard of performance metrics or broader outcomes from the operating plan, the NHS oversight framework, the NHS long term plan and our local priorities. Performance metrics are monitored against their planned trajectories or targets where relevant.

Improving Population Health

Our Commitment - Dr Paul Edmondson-Jones, Chief Medical Officer

We want to make sure that everyone in Staffordshire and Stoke-on-Trent (SSOT) has a fair opportunity to live a good life. Looking at some of the inequalities that we know still exist is simply not good enough and many of these can only be addressed by partners working together. Improved health and wellbeing will be achieved through better support and high-quality services, but also through preventing people from becoming unwell and supporting them to live well in their communities. We recognise that we need to look beyond health and care services to understand the barriers and opportunities to living a healthier life and are committed to working with people and communities to address them'. 'Working together is the fundamental principal behind the Staffordshire and Stoke-on-Trent Integrated Care Partnership (ICP), building on our collective resources and making better use of shared learning and experience. Our residents need to be an equal part of that partnership and we look forward to working with them to achieve our ambition of making Staffordshire and Stoke-on-Trent the healthiest place to live and work.

Ambitions

We will take a systematic approach to prevention and health inequalities across the life course by:

- offering equal opportunity to preventative services
- using personalised care to better manage illness, long term conditions and disease progression
- using personalised care to ensure services are inclusive and centred on people's physical, mental health and social needs
- making tackling health inequalities a core business in the work of all partners
- using population health management, engagement and research to better understand the needs of inclusion health groups.

Why is this important for our Population?

Population Health Management

Making intelligent decisions for the future

- Scale, Spread, Sustain (Infrastructure, Intelligence, Interventions, Incentives)
- Cultural Change
- Drive ICP Strategy
- Integrated Intelligence Collaboative

Population health management helps us understand the health and care needs of our population both now and in the future. We do this by using linked data from across our health and care partners to help us better understand our residents needs and how they vary across their life course. By understanding more about our residents, we can identify groups of the population with similar needs and design targeted services to meet these needs, moving away from a one size fits all model, to evidence-based interventions which are effective in the particular group we are looking to support. This approach will be central to all we do, ensuring we focus efforts on the best ways to support our communities, and make certain that our population can expect the same high-quality services wherever they reside.

Health Inequalities

Building fairer futures

- Core20PLUS5
- CYP Core20PLUS5
- Broader inequalities (protected characteristics)
- Tackling inequalities with specific interventions/innovations

Health inequalities are avoidable and unjust differences between people or groups due to social, geographical, biological or other factors. These differences have a huge impact, because they result in people who are worse off experiencing poorer health and shorter lives. We know that some people, groups and communities do not have equal opportunity to access health and care services and when using services have worse experiences and outcomes from care. Addressing health inequalities will help give people more equal opportunity to benefit from health and care, addressing known disadvantages relating to where they live, personal circumstances, age, gender or ethnicity. The desire to reduce health inequalities is embedded throughout this document

Prevention

Changing the future

- Primary (risk factors for disease)
- Secondary (early detection and diagnosis)
- Tertiary (preventing progression of disease)

Prevention is a key part of improving the health of our populations, but not simply primary prevention where we seek to help people make healthy lifestyle choices, but secondary prevention of illness through screening, early detection and diagnosis, and tertiary prevention for people living with long-term illness to optimise their health and prevent deterioration. We will focus on delivering personalised care, empowering people to take personal ownership and self-manage such conditions in the community. This will enable people to live well, independently from care, in their community for as long as possible. At the same time, we recognise that when people need to use health or care services, it is important to provide high-quality and effective treatment or care at all ages. We will also work with people and communities to achieve environments that promote health and wellbeing.

Five Ps approach

Our ICP strategy outlines the five things we need to change if we are going to make a difference. This may need us to undertake transformation in our services, to make that happen.

We firmly believe that communities are the best medicine. Our themes have been developed to take account of that. Looking at prevention, for example, we can promote healthy decision making for our local population. And when it comes to our neighbourhoods we will work with local people and our communities, so they become healthy, supportive and thriving

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How do we plan to make a difference?

We will take a systematic approach to **prevention and health inequalities** across the life course by:

- Offering equal opportunity to preventative services
- Using personalised care to better manage illness, long-term conditions and disease progression
- Using personalised care to ensure services are inclusive and centred on people's physical, mental health and social needs
- Making tackling health inequalities a core business in the work of all ICS partners
- Using population health management (PHM), engagement and research to better understand the needs of inclusion health groups

We will work alongside Quality Assurance and Improvement leads to ensure the fundamental standards of quality are delivered – including managing quality risks, including safety risks, and in particular, addressing inequalities and variation; but also, to continually improve the quality of services, in a way that makes a real difference to the people using them.

Health Inequalities

We will focus on:

- Developing a **health inequalities strategy** by 31st December 2023 which will articulate our system-wide approach to tackling health inequalities and particularly access, experience and outcomes in line with our new legal duties.
- Delivering the **Five Priority Areas for Improvement of Healthcare Inequalities** through the IPH and wider portfolios. We have aligned our local improvement of healthcare inequalities as outlined below:

National Priority Area	Actions
1. Restore NHS services inclusively	Supporting elective recovery and restoring services inclusively to ensure inequalities are addressed – focusing on waiting lists. Identifying health inequalities associated with diagnostics, elective and cancer care and put measures in place to reduce their impact. (See Planned Care Section)
2. Mitigate against digital exclusion 3. Ensure datasets are complete and timely	One Health & Care: Shared Care Record (ShCR) - will ensure that by 2024 ICS constituent organisations are connected to an integrated life-long health and care record, sharing data across NHS and local government organisations, and supporting collaboration at a system, inter-regional and regional level including West Mids ShCR and Secure Data Environment West Mids partnership. PHM: Implement Intelligence infrastructure to enable PHM to understand the population.
4. Accelerate preventative programmes	Alcohol • Develop improvement of optimal Alcohol Care Teams in hospitals with the highest rates of alcohol dependence-related admissions. • Develop an Alcohol Harm Reduction Strategy by 31 December 2023 to underpin the ICP Strategy. Tobacco • Embed and continually improve the development of tobacco dependence treatment services in all inpatient and maternity settings through the Tobacco Steering Group. • Evidenced based (PH48/NG92/PH26) smoking cessation offer available for at risk populations, inpatients, pregnant women and for those with SMI.

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National Priority Area	Actions
	• Smoke free pregnancy pathways to support the Saving Babies Lives care bundle and a significant driver in delivering the ambition to reduce the number of stillbirths reduction of (Maternity Section). Obesity and Weight Management • Improve uptake of lifestyle services through cross-portfolio working, for example, Diabetes Prevention Programme and Low-Calorie Diets (ELF section). Implementation of the new Digital Weight Management Programme and digitally supported self-management services. The delivery of our identified provider collaborative projects around Tier 3 and 4 weight management (Planned Care Section). Antimicrobial Resistance (AMR) • Antimicrobial resistance continues to be a priority for the ICS. The focus of work will continue to support the appropriate management of antibiotics to ensure effective prescribing through local formularies in line with national guidance and local microbiological intelligence. (Pharmacy and Medicines Optimisation Section) Vaccination and immunisation • Vaccination is one of the most effective public health interventions to prevent the spread of infectious disease and its complications. • Work is ongoing with NHS England to review future Vaccination Strategy which aligned to the expected delegation of vaccinations services, will allow systems to develop vaccination services locally. • Support will be provided to local providers to deliver responsive, effective vaccination services which ensures access for all. Recent experience from the COVID-19 programme on improving vaccine uptake in under-served communities will be drawn on to improve uptake in all vaccination programmes. Integrated programmes offering vaccinations to similar groups at similar times is a key focus to improve uptake and efficiency moving forward. Our focus is on 1. Improving uptake and coverage and reduce variation 2. Identification of programmes for additional focus such as MMR due to reductions in uptake over recent years and disruption to school-age immunisation programmes during the pandemic. 3. Addressing vaccine inequalities 4. Improving co-administration and co-promoting of other immunisation/wider health and wellbeing programmes Resettled Migrants and Asylum Seekers • We are working to address the healthcare needs of asylum seekers and resettled migrants who are resident locally to provide initial health assessments and screening prior to registration with GP services. • We will continue to provide ongoing support to these residents to ensure all health requirements are met including screening and immunisation. • We will continue to provide support the Afghan Resettlement Scheme and the Homes for Ukraine schemes to ensure all healthcare needs are met.

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National Priority Area	Actions
	Tuberculosis (TB) • We will work with public health and TB specialist services to ensure that adequate provision is in place for effective TB screening and treatment pathways. • Links are established with the NHSE Regional TB board and local UK Health Security Agency (UKHSA) representatives to share best practices across systems. We are working to ensure that TB screening is appropriately undertaken for migrants and asylum seeker who are resident within SSOT. Pause Stoke-on-Trent – Led by Stoke-on-Trent City Council • The service will work intensively with women who have lost a child / children to care and / or adoption. During this 'pause' in repeat pregnancies, bespoke work with women allows them to resolve their own trauma and lifestyle needs and, in the event, they become pregnant again, the programme is designed to give them the skills and changes which mean they can go on to care for future children, safely.
5. Strengthen leadership and accountability	The Improving Population Health portfolio incorporates PHM, Health Inequalities and Prevention 1. Chief Executive sponsorship from 2 x Local Authorities has been secured. 2. Dedicated Senior Responsible Officer (SRO) 3. Dedicated Clinical Lead 4. Dedicated resources agreed to support Improving Population Health within Chief Medical Officer structure 5. Aligned Finance Business Partner 6. Core20 Ambassadors 7. All Primary Care Networks (PCNs) have health inequality leads 8. All system Partners have health inequality leads

Inclusion Health Groups (IHGs)

Inclusion Health is a term used to describe people who are socially excluded and experience multiple overlapping risk factors in our population resulting in health inequalities. Identified in Health and Wellbeing Strategies, national strategies and having a legal duty to ensure equitable opportunity to benefit from health and care services.

Using a PHM approach and community engagement we will understand the health and wellbeing needs of IHGs to inform the development of integrated approaches to improving health and wellbeing. Health Inclusion Groups include Learning disability and autism; Women from ethnic minority communities and/or experiencing poverty; Individuals, households and communities at risk of serious violence; Informal carers; Military Veterans; Asylum Seekers and Vulnerable Migrants; Our older population (prioritising those vulnerable or socially isolated); The population experiencing homelessness; Others as identified by PHM at place and Community.

CORE20PLUS5

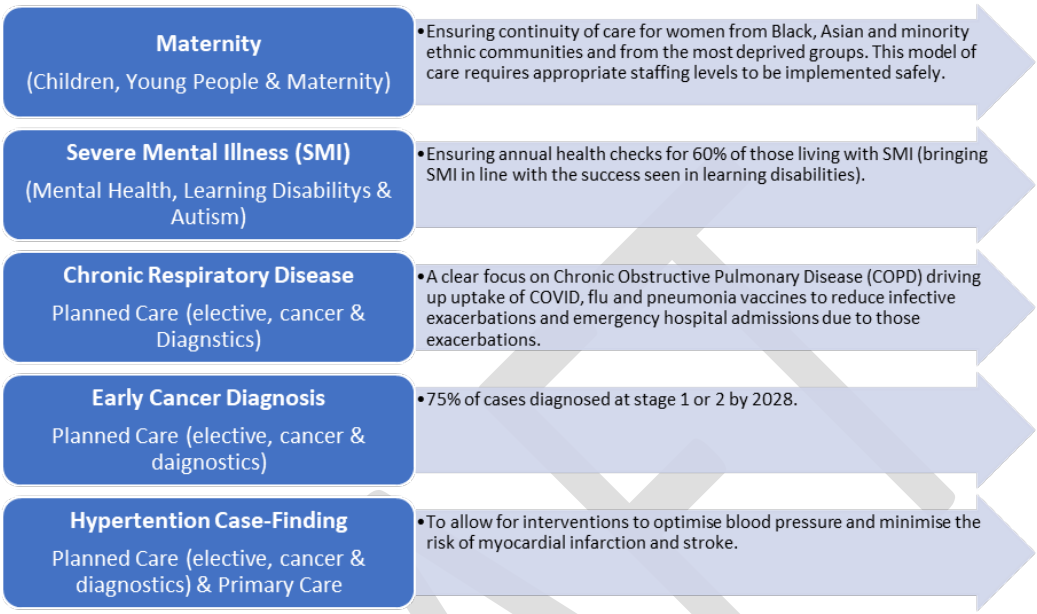
Core20PLUS5 is a national approach to support the reduction of health inequalities. The approach defines a target population cohort – the 'Core20PLUS' – and identifies '5' clinical areas in which rapid improvements should be made for the target population. PLUS, groups are population groups, defined by the ICS, which experience poorer than average health access, experience and / or outcomes across their communities. This includes inclusion health groups.

Our focus on Core20 implementation will incorporate:

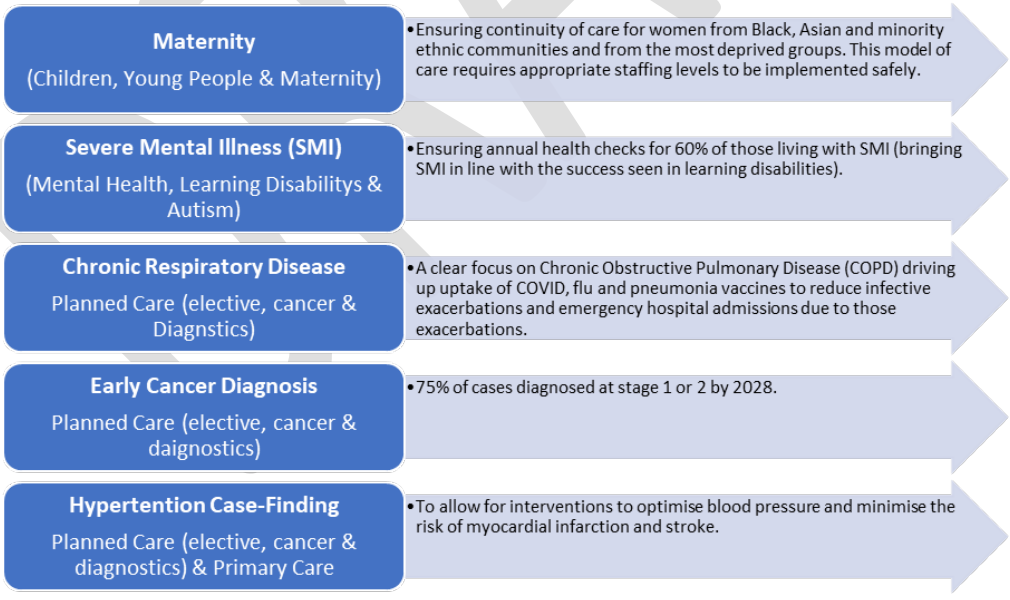
- Core20PLUS Connectors – empowering local community leaders in tackling barriers to healthcare
- Core20PLUS Ambassadors – pioneer clinicians and professionals addressing healthcare inequalities

The initial PLUS5 groups identified for Adults and Children and Young People and where transformation and delivery will occur are:

Core20PLUS5 (Adults)



CORE20PLUS5 (Children and Young People)



Population Health Management (PHM) programme

PHM focuses on the wider determinants of health – which have a significant impact as only 20% of a person's health outcomes are attributed to the ability to access good quality health care – and the crucial role of communities and local people. Local health and care systems have started to use data to design new models of proactive care and deliver improvements in health and wellbeing which make best use of their collective resources.

PHM is a partnership approach across the NHS and other public services including councils, the public, schools, fire service, voluntary sector, housing associations, social services, and police. All have a role to play in addressing the interdependent issues that affect people's health and wellbeing.

For example, adults and children who live in cold, damp housing may be more likely to develop respiratory problems over future years because their lungs are affected by mould spores in their home. Working with partners on factors such as poor housing will allow us to reduce the impact on the health and wellbeing of our population, reducing or preventing the need for healthcare and tackling health inequalities.

Our vision for the PHM programme is to enable, implement and embed the approach, to help us understand current, and predict future health and care needs, so that together we can improve outcomes, reduce inequalities, improve use of resources and engage our community appropriately.

Embedding PHM will:

1. Deliver integrated health and care that is underpinned by intelligent decision-making using data on our population's health and care needs.
2. Use data to understand risk and protective factors, enabling us to target resources to those at increased risk of poor health outcomes or with greatest potential to benefit from care.
3. Identify inequalities in access, experience, and outcomes of care to inform improvements to care pathways so that we offer high quality inclusive care.
4. Proactively target preventative interventions and services to those identified as being at higher risk of illness or adverse events, for example infant mortality or emergency hospital admission.

The life course approach of the ICP Strategy recognises that at different stages of life, people have different physical, mental health and social needs. This evidence-based PHM approach allows us to look at what each organisation can contribute to improve the health and wellbeing of the population at different stages of life.

Set out against the PHM Maturity Matrix and with the support of a Partner following a recent procurement process, our roadmap to scale, spread and sustain a PHM approach which will continue to be rolled out against the 4 main components: Infrastructure, Intelligence, Interventions and Incentives.

How will we know we are making a difference?

As we implement the ICP Strategy over the next five years it is important to monitor and evaluate its progress in achieving the aim and ambitions we have outlined. To inform this we have developed a framework of health outcomes against each life course stage that we will use to evaluate the progress of the strategy. From this initial set of outcomes, we will establish a framework of measures that will inform what we need to do to improve these outcomes.

One of our ICS strategic objectives is 'reducing health inequalities'; in monitoring and measuring progress, outcomes and success against this strategic objective we will be looking to:

- Reduce the difference in life expectancy and healthy life expectancy between the most and least deprived communities ICS over the next 10 years.
- Co-develop a Health Inequalities Strategy and outcomes framework to underpin the ICP Strategy by 31 December 2023
- Establish an ICS Health Inequalities Steering Group to co-ordinate, scale and sustain action on heath inequalities, responsive to population needs by JSNA and PHM, by the ICB and ICS partners by July 2024
- Establish PHM for health inequalities and prevention, enabling prioritisation of action at system, Place and PCN on Core20PLUS5 population health inequalities and local priorities identified by JSNA by March 2024.
- Establish governance and process mechanisms so that health inequalities and opportunities for prevention are identified, considered and addressed in planning and decisions across all programmes in the ICB Delivery Plan by 31 March 2024.

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- Identify the 'Core20' population and work with all ICB portfolios to reduce inequalities in health outcomes compared to the Staffordshire and Stoke-on-Trent population at agreed intervals.
- Identify the 'PLUS5' population groups and work with aligned portfolios to reduce inequalities in health outcomes compared to the Staffordshire and Stoke-on-Trent ICS population at agreed intervals.

Serious Violence

The Government introduced the Serious Violence (SV) Duty on 31st January 2023, as part of the Police, Crime, Sentencing and Courts Bill. The Duty is a key part of the Government's wider programme of work to prevent and reduce serious violence; taking a whole-system approach to understand the causes and consequences of serious violence, focussed on prevention and early intervention.

At a local level, the ICS and partners have developed and published a multi-agency Serious Violence Strategy for Staffordshire and Stoke-on-Trent (2020-23), built on a public health approach. The aim of the Serious Violence Strategy is to *"work together to strengthen the visibility, early identification and partnership response to prevent serious violence and its associated harms".* It has five priority areas:

1. Primary prevention – seeking to prevent the onset of serious violence or to change behaviour so that serious violence is prevented from happening.
2. Secondary prevention – halting the progressing of serious violence once it is established. This is achieved by earl identification flowed by prompt, effective support.
3. Tertiary prevention – rehabilitating people with established serious violent behaviour or supporting victims.
4. Enforcement and criminal justice – developing innovation criminal justice practices that reduce offending behaviour and recidivism.
5. Attitudinal change – changing attitudes and behaviour towards all types of serious violence at a societal, community and personal level.

How will we know we are making a difference?

- The numbers of children, young people and adults presenting to A&E or accessing ambulance services due to assault and injuries will reduce.
- Children and young people will be better equipped to identify risk and vulnerability in themselves and others.
- Children, young people and adults will receive the appropriate mental health, wellbeing, therapeutic support in a timely way following an incident of serious violence.
- Families will receive improved levels of support following an incident of serious violence.

Planned care (elective, cancer, diagnostics)

Our Commitment - **Helen Ashley, Senior Responsible Officer**

We continue to focus on the delivery of two overarching objectives - the recovery of capacity to levels that meet or exceed pre-COVID levels, in order to eliminate long waiting times as well as the transformation of pathways in order to promote the use of alternatives to traditional outpatient and surgical interventions.

Continued focus on access and reporting of diagnostic services will ensure the delivery of cancer pathways and the ability of primary care clinicians to deliver care in the most appropriate settings.

Ambitions

The Planned Care, Cancer and Diagnostics portfolio ambitions are to:

1. Recover our core services and productivity, so that we deliver timely access to diagnostics and treatments for our population
2. Over the life of this 5-year plan eliminate long waits
3. Have sustainable, resilient services that will be designed to be more efficient and productive by the end of the 5-year plan
4. Undertake longer term transformation of services, so that they are resilient and sustainable for the future.

Why is this important for our Population?

People expect timely access to services, and to be seen, diagnosed and treated within timescales agreed nationally to support them to live well. For time sensitive conditions, such as cancer symptoms our population expect to be prioritised for early diagnosis and treatment to improve their long-term outcomes.

We know that the more cancers we are able to diagnose early, the more people will survive to live with and beyond cancer. Earlier, and faster diagnosis with high-quality personalised treatment and care for people with cancer is essential for people to stay well. Targeted Lung Health Checks for lung cancers are being delivered in our ICS. A significant percentage of cancers found are being found at stage 1 or 2, above what would be found nationally without interventions like this. These checks can help identify problems earlier.

We know that musculoskeletal (MSK) conditions, such as osteoarthritis hip and knee, back pain and neck pain have a huge negative impact on the health of the population. Our ICS has one of the highest rates of back pain in the West Midlands, with 153,930 (18.1%) people reporting back pain in 2012. In 2019, MSK conditions have remained the third most important cause of loss of health and wellbeing for our population. Low back pain is the still the second most important condition.

Accurate and timely diagnosis is important in making sure people with respiratory conditions can access the care they need as soon as possible. A key part of diagnosis for lung conditions such as COPD is spirometry. Although this was paused throughout the COVID-19 pandemic, we will need to restart spirometry services to support our population to live well.

What do we know about people's local experiences?

Through involvement work undertaken to date through the development of the ICP Strategy our local communities have told us that they experience:

- Long waits for elective care, planned operations and cancer care

The portfolio will continue with specific engagement and involvement with our population to talk to our communities about their experiences.

In many cases our patients will be offered treatment in another service, such as a private hospital or a community service where it is deemed safe and appropriate to do so. We know that many patients are nervous or reluctant to accept an offer of treatment elsewhere and we are keen to understand the reasons for this.

How do we plan to make a difference?

The diagram below depicts the overarching focus of the Planned Care, Cancer & Diagnostic Board.

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Elective Recovery and Transformation

We will focus our recovery actions around:

- Utilising the collective capacity across our hospitals and independent sector providers where it is safe and appropriate to do so.
- Restoring NHS services inclusively and supporting elective recovery to ensure inequalities are addressed – focusing on waiting lists.
- Implementation of Get It Right First Time (GIRFT) recommendations and improve and maintain theatre productivity and other efficiency measures.
- Ensuring the NHS "Choice" agenda is fully utilised to ensure patients can receive timely treatment. Choice is also highlighted as a key enabler of elective care recovery and is part of ICB duties to enable choice of provider and services.
- Ensure our operating theatres are fully utilised as far as possible by starting on time, fitting in the optimal number of procedures and minimising delays between patients.
- Offering virtual appointment options and developing opportunities for patients to only initiate their follow up if they require it.

The Planned Care Programme Board is focussed on transformational changes which will deliver improved productivity. Our transformation work will support future planning and help manage the number of patients coming onto the waiting lists. Using elective care and cancer data we have been able to identify where the focus of the portfolio needs to be, in terms of offering the largest scope for transformation and improvement.

We will focus on:

- The transformation of pressured services, by ensuring effective pathways are in place to ensure that each patient receives treatment in the lowest appropriate tier of care that meets their needs.
- High volume services/specialties which we will focus on include:
  - Trauma & Orthopaedics including MSK
  - Gynaecology & Urology
  - Ophthalmology
  - Gastroenterology & Colorectal
  - ENT

The above five specialities cover 60% of the total Referral to Treatment (RTT) waiting list. For each of these areas a system wide Transformation Group has been or is in the process of being developed. The governance, performance and outcomes of these clinical areas will be overseen by the Planned Care, Cancer and Diagnostic Board. The diagram below depicts the overarching focus of the Planned Care, Cancer and Diagnostic Board. Each Transformation group will be utilising the 'Elective Recovery Improvement Plans' (ERIP) which identified areas to aid recovery:

1. Demand management
2. Productivity and efficiency improvements
3. Capacity increase

Across all of the clinical areas there will be matrix framework supporting transformational changes:

- Recovery – elective care waits
- Advice and Guidance
- Diagnostic waits and diagnosis times
- Outpatient transformation
- GIRFT, pathway redesign, and ensure equity across the county Getting It Right First Time - GIRFT

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- Digital
- Workforce
- Health Inequalities

More broadly we aim to:

- Identify health inequalities associated with diagnostics, elective and cancer care and put measures in place to reduce their impact. We will do this by making minor adjustments to services to improve accessibility for people experiencing inequality.
- Recognise the variation resulting from the legacy Clinical Commissioning Group (CCG) commissioning arrangements. We will ensure as far as is practicable to remove unwarranted variation in patient outcomes and access.
- Have better defined referral criteria to ensure patients are referred to the most appropriate in the first instance.
- Maximise the value of advice and guidance provided by consultants to primary and community care clinicians so that patients with routine conditions are managed in primary care with clinical support from hospital specialists and that appropriate patients are referred to hospital services.
- Utilise elective hubs to separate elective and emergency care to protect elective care services from the impacts of surges in demand for urgent care.
- Reduce inefficiency and waste by ensuring that referrals to service are of sufficient level of detail to ensure that patients are seen by the most appropriate clinician first-time.
- Delivery of our identified provider collaborative projects around Tier 3 and 4 weight management and MSK.
- Review what is offered to people with back pain in our communities through our research partnerships with Keele University, including
    - Over the next 12 months we will work to develop a dashboard that we will use to hold ourselves to account.
    - Beyond 2023/24 we will be looking at values and interventions for the back pain segment of the population followed by the knee pain segment in over 45s.
    - We are currently testing an app for people with back pain to support self-management.
    - Future projects will in include a trial of shared decision-making tools in primary and community care and supporting providing an exercise class to people on waiting lists for hip and knee surgery.

Cancer services recovery and transformation

The NHS Long Term Plan highlights that despite the progress made in cancer survival over the last two decades, we can do more to diagnose cancer earlier. We also know that deprivation and other societal factors affects the changes of a person having their cancer diagnosed early, and we need to do more to eliminate these differences. We know that screening saves lives and understanding more about the people who are less likely to have screening aligns with both the cancer ambition of early diagnosis and the core20PLUS5 framework.

We will focus on:

- Reduce inequality utilising the Midlands Cancer Screening Dashboard to inform targeted interventions that improve screening uptake and address late-stage diagnosis.
- Faster cancer diagnosis being achieved, and patients will commence their first definitive treatment within 62 days through an increase in diagnostic capacity and therefore shorter waiting times for diagnostic results
- Awareness raising campaigns to encourage patients with symptoms to seek support sooner and to access screening, resulting in more cancers diagnosed at an earlier stage supporting the ICP strategy ambitions to improve population health and wellbeing outcomes
- Optimising the use of new services and diagnostics such as Breast Pain clinics, virtual nasal endoscopy, FIT negative pathways and tele-dermatology, releasing specialist capacity on the for patients most at risk of cancer.

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- Targeted Lung Health Checks (TLHCs) programme expansion.
- Review our patient-initiated follow-up pathways

Diagnostic recovery and transformation

Most people will have a diagnostic test in their lives – whether that is a blood test in primary care to find out cholesterol or sugar levels; an x-ray to check for a fracture, or something more invasive like endoscopy or a biopsy to help diagnose a cancer. It is vital that patients get the rights tests at the right time so that the right clinical care is provided.

We will focus on:

- Increasing capacity in our diagnostic services to meet current and forecasted demand.
- Additional capacity sourced and utilised to ensure that we can deliver the 6-week diagnostic standard by March 2025.
- Delivery and utilisation of three community diagnostic centres (CDCs) during the life of this plan which will provide timely and local access to key diagnostic tests. The centres in Tamworth (UHDB) and Cannock (The Royal Wolverhampton NHS Trust (RWT)) will be operational during 2023/24. A business case is being produced for a further centre in Stoke-on-Trent, the benefits of which are likely to be seen in early 2024/25.
- Recommissioning of diagnostic spirometry services as these have not been available since the pandemic.
- Updated diagnostic referral guidance to ensure that patients are referred for the most appropriate diagnostic test in accordance with “best practice” guidance to improve coordination, communication and to enhance patient experience.

How will we know we are making a difference?

We have established trajectories and milestones on our improvement journey, and these will be reviewed and monitored through the Planned Care Portfolio Board and action taken to address any deviation from plan. We will utilise our portfolio dashboard to review progress against targets and trajectories.

Long Waits (to be revised in light of NHSE guidance)

- By March 2024 no one will be waiting more than 65 weeks for treatment
- By March 2025 no one will be waiting beyond 52 weeks for treatment
- By March 2026 no one will be waiting more than 36 weeks for treatment
- By March 2027 no one will be waiting more than 26 weeks for treatment
- By March 2028 no one will not wait more than 18 weeks for treatment.

Diagnostics

- By June 2023 no one will not wait more than 13 weeks for a diagnostic test
- By March 2025 no one will not wait beyond 6 weeks for a diagnostic test.

Cancer

- By March 2024 the Cancer “faster diagnosis standard” of 75% will be achieved.
- By March 2024 the number of patients receiving their first definitive cancer treatment will have increased in accordance with national expectations.

Case Study

✓ Simon is 53 years old and is a hospital porter. He has had several incidents of back pain over the years but recently has begun to worry about his back pain and his future.

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- ✓ Simon went to see his FCP (First Contact Practitioner) and was given a through clinical assessment. The FCP used the STarT Back tool with Simon and reassured that there was no serious underlying spinal condition, but recognised the pain was troublesome. He felt alone and the pain was making work difficult and stopping him from doing the things that he enjoyed.
- ✓ Simon was given access to a SelfBack phone app which allowed him to gain access to exercises and information to help himself manage on a daily and weekly basis. It also enabled him to record how his condition was progressing. The recorded data was then shared with Simon's FCP to enable them to better support Simon.
- ✓ Simon found the app easy to use and it helped him to describe and manage his back pain. His FCP was able to look at Simon's progress. Simon described the app as like having a friend in his pocket'. He was able to get back to his hobbies and minimise any time off work.

Children and Young People (CYP) and Maternity

Children and Young People

Our Commitment - **Jon Rouse, Chief Executive Officer Sponsor for CYP**

We are putting the health and wellbeing of our children and young people at the heart of the work of our Integrated Care System (ICS). We are determined that our children get the best start in life, including high quality maternity services. By engaging with children and young people, we will develop programmes that meet their priorities. We have already identified early priorities such as reducing infant mortality, improving mental health and reducing obesity. We want to provide superb care close to home for children with relatively common conditions such as asthma, diabetes and epilepsy, so they don't need to go into hospital as often. And we will also ensure that we support children with complex needs to the best of our ability, joining up their care and helping them to thrive within their communities.

Ambition

The Vision for Children and Young People is that Children in Staffordshire and Stoke-on-Trent will grow up healthy, happy and with their families and friends, are able to look after their own wellbeing, while knowing they will get exceptional care and treatment when they need it.

- The voice and needs of our children and young people will be at the forefront of our decision-making.
- We will take a holistic approach that considers children's physical, mental and emotional wellbeing, and the relationship between them.
- We adopt a personalised approach in the way that we care for children and young people.
- Our approach to child health starts even before conception, helping future parents to make good health choices and decisions, including through pregnancy.
- We will plan transition to adult services with young people and their families early and in a way that reflects personal circumstances.
- We will seek to ensure that young people and families don't have to keep repeating their story but will instead feel the wrap-round care of trusted professionals.

We work with CYP voices, NHS, local authority and voluntary, community and social enterprise (VCSE) organisations. Our vision reflects the aims of the Integrated Care Partnership (ICP) Strategy 'Start Well' agenda to give all our children the best start in life and to 'Grow Well' enabling children to thrive into adulthood. The plan is not designed to replace other more detailed plans that may exist operationally. It is a high-level overarching plan to outline system priorities for CYP.

There is a clear shared ambition to work with local people, communities, and staff to improve the health and wellbeing of our children and young people, using our collective resources much more effectively. We will take a holistic integrated approach to how we deliver services and empower people to make healthy choices to optimise health and wellbeing in our children and young people.

Why is this important for our Population?

The health of children and young people is crucial to the future wellbeing and prosperity across Staffordshire and Stoke-on-Trent. This needs to start at the earliest opportunity – firstly from pregnancy and early years, but also through childhood and as children transition into adulthood. We are committed to delivering better health outcomes for children and young people in our community through the vision set out. We want to see children, young people and families who are supported to start, grow and live well.

Particular groups of children are more likely to experience poor outcomes linked, for example, to gender, socioeconomic status, ethnicity, disability, sexual orientation, being a young carer, a looked after child or being in the youth justice system. Reducing inequalities will have a far-reaching impact on improving outcomes for children and young people. Both of the local authority Health and Wellbeing Boards have existing strategies aimed at improving the outcomes of children and young people.

Staffordshire and Stoke-on-Trent is home to 246,800 children and young people under the age of 19 and future projections indicate that this number is increasing. Whilst most children are happy, safe and have loving homes, some families face challenges that means they cannot thrive in the way they want to. Some health outcomes for our children are poor. Most children and young people with complex needs are secondary school age, attend mainstream schools and are white British, a slightly higher proportion are male (53%). There is a wide range of types, combinations and severity of needs experienced by this cohort; the most common needs include mental health, Special Educational Needs and Disability (SEND), persistent absence and substance misuse. We are aware that there are several longer-term national pressures that have contributed to an increasing number and severity of complex needs amongst children, young people and young adults across Staffordshire and Stoke-on-Trent; for example, a system already under strain following cuts to services, cost-of-living pressures, improved identification of need and growth in young person population. However there remains a significant gap between the outcomes achieved by those with and without complex needs across multiple domains.

Stoke-on-Trent has had one of the highest birth rates in England and Wales in recent years; many of whom are likely to be born with a low or very low birthweight. The infant mortality rate is the highest in the country and almost twice as high as the average for England. The first 1,000 days of life is a critical phase, what happens in these early days has life-long effects on many aspects of health and wellbeing and life chances including educational achievement, progress at work and physical and mental health.

There have been several sudden infant deaths within the local area where unsafe sleep practices and other risk factors may have contributed to the death. This has resulted in a focussed increase in awareness from a variety of angles including a new multi-agency training package of face-to-face sessions which enabled staff to be updated about the evidence base around safer sleeping practices and to also to analyse the issues seen in practice and begin to problem solve using a collaborative approach.

Across Staffordshire and Stoke-on-Trent children are more likely to be admitted to hospital for a range of health problems, including controllable long-term conditions such as epilepsy, diabetes and asthma. Additionally increasing numbers of our children are overweight or obese, particularly at reception age, increasing the risk of developing serious health conditions in later life.

The prevalence of obesity for our population is worse than the England average for children particularly at reception age. We recognise a need to make improvements in nutrition and access to physical activity working closely with schools, sports clubs, cultural groups, and VCSE partners.

What do we know about people's local experiences?

The 2021 'Health of the Midlands Children and Young People – Asthma' report explores the asthma-related health needs of the population. Staffordshire and Stoke-on-Trent were specifically identified due to higher prevalence rates and improvements required in relation to adequate management and annual reviews.

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Data via Public Health Fingertips for 2021/22 indicates that nationally 65.6 per 100,000 population of CYPs under 19yrs are admitted for epilepsy. Although the ICS has similar prevalence (17.82%) compared to 17.9% nationally for our Learning Disability patients with epilepsy, there are pockets where this is much higher at 22.79%.

The Staffordshire Council of Voluntary Youth Services (SCVYS) has been commissioned to facilitate the creation of a Co-production Charter and accompanying Toolkit to support professionals when engaging with children and young people. The toolkit is expected to include a wide range of information on co-production, models of participation so that professionals can use checklists to understand which tool fits best and quality assurance tools to enable evaluation and improvement. These tools, which will be publicly launched on the 12th September 2023, will be utilised to support ongoing engagement with children and young people that will inform future plans and priorities.

How do we plan to make a difference?

The CYP programme has developed a plan across the system to set the direction for children and young people and co-ordinate activity that sits under each of the priority areas. The plan is in its final stage of development and will be published later this year following approval at ICP Board. Our initial areas of focus are outlined below and will be reviewed on an on-going basis to ensure they remain relevant.

- Best start in life: improve the survival of babies and young children to reduce infant mortality.
- Increase the number of children and young people to achieve and sustain a healthy weight.
- Support children and young people to achieve their potential by enjoying good emotional wellbeing and positive mental health.
- Support children with complex needs with the help they need so that they can fulfil their potential.
- Effectively manage long term conditions to reduce avoidable admissions in relation to asthma, epilepsy, and diabetes.

How will we know we are making a difference?

- We will improve the survival rates of babies and young children through:
  - Reducing the number of mums who smoke during their pregnancy.
  - Increasing the rates of infant feeding initiation and continuation.
  - Reducing the number of pre-term births and babies with a low birth weight.
- We will increase the number of children who achieve and maintain a healthy weight.
- We will improve children and young people's access to mental health support when and where they need it.
- We will reduce the number of children and young people in care.
- We will see maintained or reduced activity for our hospital admissions in relation to asthma, epilepsy and diabetes

Maternity

Our Commitment - **Heather Johnstone, SRO Maternity Transformation Programme**

We work in partnership with organisations across the ICS to deliver joined up health and care services. The Local Maternity and Neonatal System (LMNS) remains committed to bringing together all partners, including users of these services, to work to ensure high quality, safe care for mothers and their babies. We are equally committed to ensuring that we take every opportunity to learn from high profile maternity investigations such as the Ockenden and Kirkup reports, to avoid reoccurrence in local services. We will listen to our families to support the implementation of the Three-Year Delivery Plan for Maternity and Neonatal services (2023) ensuring voices are heard relevant to local need and in relation to local arrangements.

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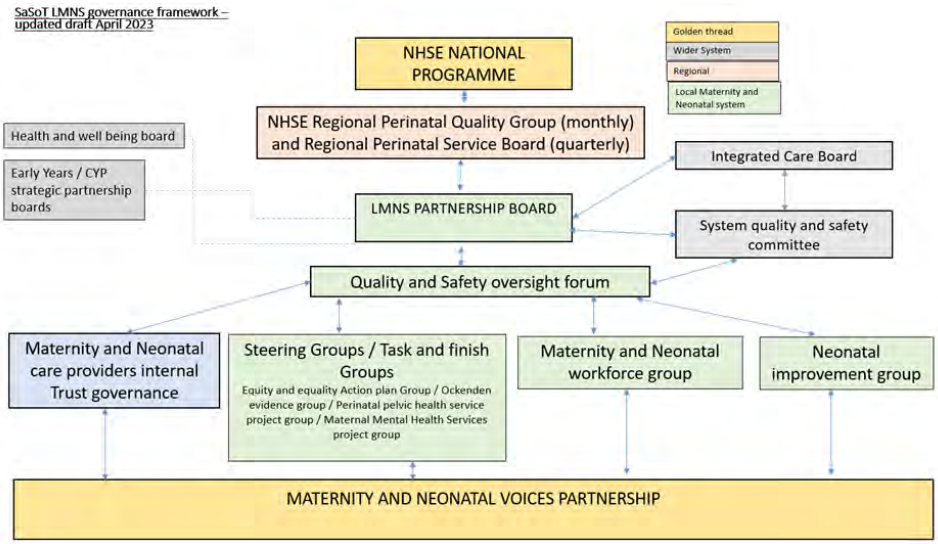
Ambition

The Staffordshire and Stoke-on-Trent Local Maternity and Neonatal System's (LMNS') ambition is to make maternity and neonatal care safer, more personalised, and equitable for all and will achieve this through the governance process as set out below. On 30th March 2023, NHS England published a 3-year Delivery Plan for Maternity and Neonatal Care. This together with the local Equity and Equality Action Plan sets out how the system will work together to address the challenges identified to date and improve outcomes for those accessing our local services.



All activities within the Maternity and Neonatal programme will support achievement of the 4 themes within the Delivery Plan.

1. Listening to, and working with, women and families with compassion.
2. Growing, retaining, and supporting our workforce with the resources and teams they need to excel.
3. Developing and sustaining a culture of safety, learning and support.
4. Standards and structures that underpin, safer, more personalised, and more equitable care.

The ICB Maternity team will work with system partners to measure achievement against the identified success factors and report progress through to LMNS Partnership Board as set out above.

Why is this important for our Population?

Listening and responding to all women and their families is an essential part of safe and high-quality care. It improves the safety and experience of those using maternity and neonatal services within our system and helps address health inequalities. Our Maternity and Neonatal Voices Partnership (MNVP) provides the voice of local women and their families, to ensure that their needs and requirements are at the heart of the local offer and equitable for all.

Our Equity and Equality Action Plan aims are to improve equity for mothers and babies from Black, Asian, and mixed ethnic groups, and those living in the most deprived areas, and promote race equality within staff groups. The MNVP will seek out and listen to these voices and to ensure services are representative of the whole local population.

Reducing stillbirths continues to be a priority locally and a nationally mandated objective. Saving Babies Lives (version two) promotes a care bundle designed to tackle stillbirth and early neonatal deaths and is a significant driver in delivering the ambition to reduce the number of stillbirths. The initiative brings together five elements of care:

1. Reducing smoking in pregnancy
2. Risk assessment and surveillance for fatal growth restriction
3. Raising awareness of reduced fetal movements

4. Effective fetal monitoring during labour
5. Reducing preterm

The LMNS is working with trusts to effectively implement and embed all elements of the care bundle, with a cohesive process of reporting and monitoring. Reducing smoking is pregnancy is one example of working collaboratively with our public health colleagues and address the prevention agenda through a Tobacco dependency working group. Just one example of how partners are working together across the ICS.

What do we know about people's local experiences?

Sadly, there are times when care within maternity and neonatal services are not as good as they should be. Recent independent reports by Donna Ockenden on Maternity services in Shrewsbury and Telford NHS trust, and Bill Kirkup on Maternity and Neonatal services in East Kent and previously Morecambe Bay, have set out many examples of poor care. The reports reveal that families from some groups, especially ethnic diverse groups (EDG), have had particularly poor experiences and poorer outcomes than those not from EDGs.

Listening and responding to all women and families is an essential part of safe and high-quality care. Women and their families are at the heart of everything we do. Working with our local population is critical, if we are to offer personalised, safer more equitable care, which is tailored to individual need. The Ockenden Report recognised the need for an independent voice to support families, particularly where there has been ad adverse outcome. As a result, a Maternity Independent Senior Advocate role has been created and in place from June 2023.

We know through our work with local providers of maternity and neonatal care, that there are workforce challenges, recruitment and retention, consistent with the national picture. We also need to listen to the local experiences of staff in order to foster career and working environments where staff are happy and enjoy working.

How do we plan to make a difference?

The national Three-Year Delivery Plan for Maternity and Neonatal services pulls together a number of maternity and neonate initiatives; the Ockenden and Kirkup Reviews, Saving Babies Lives and the Equity and Equality Action Plan, as well as the requirements for Better Births, the NHS 5-year plan, and the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme. These and emerging initiatives will continue to be delivered and influence service delivery under 4 identified themes, each with 3 objectives. These are:

1. Listening to, and working with, women and families with compassion
    - Objective 1 – Care that is personalised
    - Objective 2 – Improve equity for mothers and babies
    - Objective 3 – Work with service users to improve care

2. Growing, retaining, and supporting our workforce with the resources and teams they need to excel
    - Objective 4 – Grow our workforce
    - Objective 5 – Value and retain our workforce
    - Objective 6 – Invest in skills

3. Developing and sustaining a culture of safety, learning, and support
    - Objective 7 – Develop a positive safety culture
    - Objective 8 – Learning and improving
    - Objective 9 – Support and oversight

4. Standards and structures that underpin safer, more personalised, and more equitable care
    - Objective 10 – Standards to ensure best practice
    - Objective 11 – Data to inform learning

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- Objective 12 – Make better use of digital technology in maternity and neonatal services

We will focus on

- The work identified from our initial benchmarking exercise to identify our position against the 4 themes. It is intended that an initial plan, including the proposed prioritisation of actions, will be produced with recommendations for approval at the LMNS (Local Maternity and Neonatal System) Partnership Board.
- Utilising learning from previous reports, we will establish task and finish groups with clear governance and address recommendations within the Single Delivery Plan, informed by our local benchmarking exercise and the views of local women and their families.
- A public survey is under development, based on portfolio priorities. The findings of which will shape plans to address the needs of our local population. There are many avenues for collecting and collating feedback which will contribute to an overall communication and engagement plan.
- Our Maternity and Neonatal Voices Partnership (MNVP) who will assist us to deliver this ambition, by being committed to listening to the voices of local service users and using those voices to drive forward change and improvement in local maternity and neonatal services. The MNVP works closely with service providers to represent and highlight the voice of local women and their families in all areas, championing the local provider offer and ensuring it remains relevant to local need. The MNVP works proactively to seek ways of engaging with local, seldom heard communities, including those from ethnic minorities, and those living in areas of high deprivation.

We will listen to women and their families, whilst also paying due attention to our maternity and neonatal workforce actions and voices. By working together, we believe we can make a real difference. Interdependencies within and beyond our system are key part to getting this right and making a difference.

How will we know we are making a difference?

The Three-Year Delivery Plan helpfully includes information stating what success will look like for each of the 4 themes listed above, as well as the evidence needed to demonstrate that success. These are:

Theme 1 – Listening to, and working with, women and families with compassion outcome measures

- Our outcome measure for this theme will be indicators of women's experience of care from the Care Quality Commission (CQC) maternity survey. This will be analysed by ethnicity and deprivation and evidenced through feedback on personalised care and evidence of working with women and families to improve services, including co-production.
- Progress measures will include implementation of local Perinatal Pelvic Health and Mental Health Services, the number of women accessing those services and the proportion of maternity and neonatal services with UNICEF Baby Friendly Initiative (BFI) accreditation.

Theme 2 – Growing, retaining, and supporting our workforce with the resources and teams they need to excel

- We will determine overall success by listening to staff and use the NHS Staff Survey, the National Education and Training Survey, and the General Medical Council (GMC) national training survey as outcome measures.
- Progress will be measured through review of provider workforce returns showing establishment figures and vacancy rates for obstetricians, midwives, maternity support workers, neonatologists, and neonatal nurses. In line with the 2023/24 workforce planning guidance, there will be an annual census of maternity and neonatal staffing groups to facilitate the gathering of baseline data for those stated above, and include obstetric anaesthetists, sonographers, allied health professionals, and psychologists.
- Staff turnover, sickness absence and retention rates will continue to be monitored alongside NHS Staff Survey questions on staff experience and morale and provide evidence of success.

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Theme 3 – Developing and sustaining a culture of safety, learning and support

- Achieving meaningful changes in culture will take time and progress measures are difficult to identify and can have unintended consequences. We will primarily determine overall success by listening to the people who use and work in our frontline services.
- Outcome measures for this theme are through midwives' and obstetrics and gynaecology specialists' experience results from the NHS Staff Survey, the National Education and Training Survey and the GMC National Training Survey. We will explore how to better understand the experiences of other staff groups.
- Evidence of progress with be through Trust Boards; assurance they are using an appreciative enquiry approach to support progress with plans to improve culture, and regularly sharing and acting on learning, and staff feedback on how incidents and issues of concern are managed.

Theme 4 – Standards and structures that underpin safer, more personalised, and more equitable care

- Focusing on clinical outcomes and outcome measures: maternal mortality, stillbirths, neonatal mortality, brain injury during or soon after birth, and preterm births. These will be monitored by ethnicity and deprivation.
- Local implementation of version 3 of the Saving Babies' Lives Care Bundle using a national tool and a periodic digital maturity assessment of maternity services. For women who give birth at less than 27 weeks, the proportion who give birth in a Trust with on-site neonatal intensive care and the proportion of full-term babies admitted to a neonatal unit, measured through the avoiding term admissions into neonatal units (ATAIN) programme.
- Provision of a standardised tool to support clinical audits demonstrating implementation of shared standards for version 3 of the Saving Babies' Lives Care Bundle.
- Through our dashboard we will be able to support benchmarking and improvement against the national maternity dashboard which contains LMNS metrics.

The table below sets out the progress measures as identified in the Three-Year Delivery Plan, and which will be utilised to report progress via the Governance Process set out above.

Summary of progress measures

Theme 1 • Implementation of perinatal pelvic health services and perinatal mental health services in place • NHS Mental Health Dashboard - no. of women accessing specialist perinatal mental health services • Proportion of maternity and neonatal services with UNICEF BFI accreditation
Theme 2 • Establishment, in-post and vacancy rates for obstetric anaesthetists, sonographers, allied health professionals and psychologists • Annual census of maternity and neonatal staffing groups • Assess retention through monitoring staff turnover, sickness rates and NHS Staff Survey results on experience and morale
Theme 3 • Results from the NHS Staff Survey, National Education and Training Survey, GMC National Training Survey
Theme 4 • Local implementation of Saving Babies' Lives Care Bundle v3 using a national tool • Proportion of births at less than 27 weeks, at trusts with on-site neonatal intensive care • Avoiding Term Admissions into Neonatal Units (ATAIN) programme measurement of the proportion of full-term babies admitted to a neonatal ward • Overview of the progress of maternity services via a periodic digital maturity assessment of trusts

Strategic Transformation and Service Change

In March 2022, the Freestanding Midwife-led Birthing units (FMBUs) at County Hospital, Stafford and Samuel Johnson, Lichfield (births only) were suspended following the pandemic in line with national guidance to ensure safe staffing within the consultant units at Royal Stoke Hospital and Queens Hospital in Burton. Whilst the initial closures were related to Covid-19, significant staffing challenges in the maternity workforce have prevented both Trusts from being able to safely reopen these units. Throughout this period,

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the Home Birth services for both Trusts have had both fixed term and intermittent (in line with escalation) periods of suspension and are also currently closed. As staffing has increased, attempts have been made to reinstate the Home Birth services. Unfortunately, this has not been sustainable.

The ongoing closure under the temporary service change arrangements cannot continue therefore during 2023/24 the ICB will be working with system partners to explore all possible options for future service provision and will undertake the appropriate stages required within the NHSE service change process.

Urgent and Emergency Care

Our Commitment - Matthew Lewis, Senior Responsible Officer

We recognise that people in our catchment areas deserve the best quality urgent and emergency care, as close to home as possible, and as swiftly as possible. Our work through the Urgent and Emergency Care (UEC) Board aims to offer people rapid access to assessments and treatments, whether they are being looked after in their home, in primary care, by paramedics or in the hospital. We intend to make use of the full range of technology to manage the needs of people, ranging from traditional one-to-one appointments to virtual consultations and wearable devices to monitor vital signs without leaving their home. Equally, anyone that requires admission should have access to the right level of expertise, diagnostics and treatment with minimal delay.

Ambitions

1. Our offer will be simple, consistent and timely.
2. If you need advice, signposting or care, we will deliver this in the most appropriate setting dependent upon your condition.
3. We will ensure people receive care in the place that best meets their needs and outcomes, for physical and mental health.
4. Your care will be designed around the principle of “what matters to me rather than what is the matter with me”.

Why is this important for our Population?

All of our population have a need for urgent or unscheduled care from time to time, whether this is a life-threatening emergency situation or a requirement for less acute care. Sometimes, this might be as a “one off” type intervention – for example, following an accident – or be part of a longer treatment pathway requiring two or more interventions across health and care.

Urgent and emergency care is complex. We have in place a range of services which can be accessed on an unscheduled basis, ranging from community pharmacy, Minor Injuries Units through to major trauma centres, both within Staffordshire and Stoke-on-Trent but also over the border in Walsall, Wolverhampton and Good Hope. We are also increasing the range of services which can be scheduled as part of an urgent care intervention, including those which are as a result of clinical triaging through NHS 111 or 999 calls. We need to support our population so that they know which services to access when.

When our hospital beds are full, this affects the whole urgent and emergency care pathway for example people might have to wait a long time in an emergency department or ambulances being delayed at hospital. We know that most people want to leave hospital and, where possible, return to possible living in their own homes. Many of these people are in the last 1,000 days of life, so we need to be able to get them home as swiftly as possible. Improving discharge pathways will improve people’s lives and support their carers.

What do we know about people's local experiences?

Through involvement work undertaken on the ICP Strategy our local communities have told us that they experience:

- Long waits for ambulances, delayed handovers and corridor care
- Crowded EDs with long waits
- Inconsistencies with discharge pathways

Provision of urgent care services has been extremely challenging particularly during and following COVID-19. This means that our population have often experienced significant delays in accessing urgent and emergency care, with our hospitals unable to meet the required Emergency Department (ED) standards. Across the country, ambulance handover delays have reached critical levels leading to considerable delays for people waiting in the community.

The portfolio will continue with specific engagement and involvement talking to our communities about their understanding and experiences of urgent and emergency.

How do we plan to make a difference?

Urgent and Emergency Care (UEC) Strategy

We have this year refreshed our UEC Strategy which makes clear what services will be available to our population should they need emergency or urgent care that cannot be met in a planned/scheduled care environment.

Our strategy is being finalised for approval through the UEC board in June 2023. The strategy will:

- Describe the vision, approach and ambition for Urgent and Emergency Care.
- Address how we will work towards increased integration of health, social care and health related services.
- Ensure we develop services that support all our patients to have equal opportunity to benefit.
- Develop plans that utilise data to drive to action.

Our delivery vision is to:

1. Have a local integrated offer that supports patients calling 111 or 999 that maximises out of hospital pathways where possible.
2. Maximise opportunities for self-care where appropriate.
3. A hospital bed is not always the best place for you, therefore we shall support you to remain in your community and home where possible.
4. If you are admitted to hospital urgently, we will work from the point of admission to support your discharge, ensuring timely interventions that aim to get you back to your home, maximise your independence and your longer-term goals.
5. We shall support people who are at the end of their life to be cared for in their preferred place, to have their choices respected and their dignity protected.

UEC Recovery and Delivery

Our immediate priority is to focus on local UEC recovery and delivering the ambitions in the 2-year national UEC plan (see figure below). We will maximise resource and capacity in our acute hospitals so that we can reduce avoidable delays in our ED, both for ambulance handovers and also those patients who self-present.

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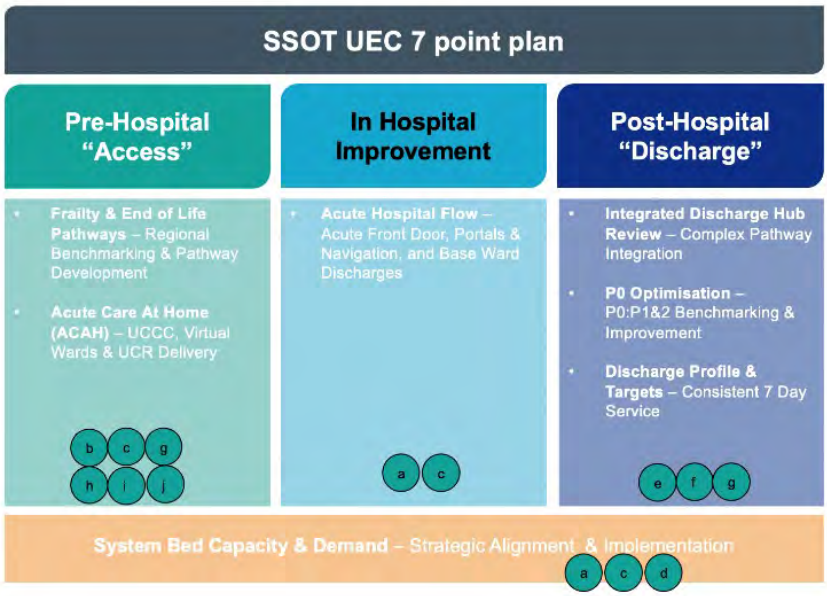
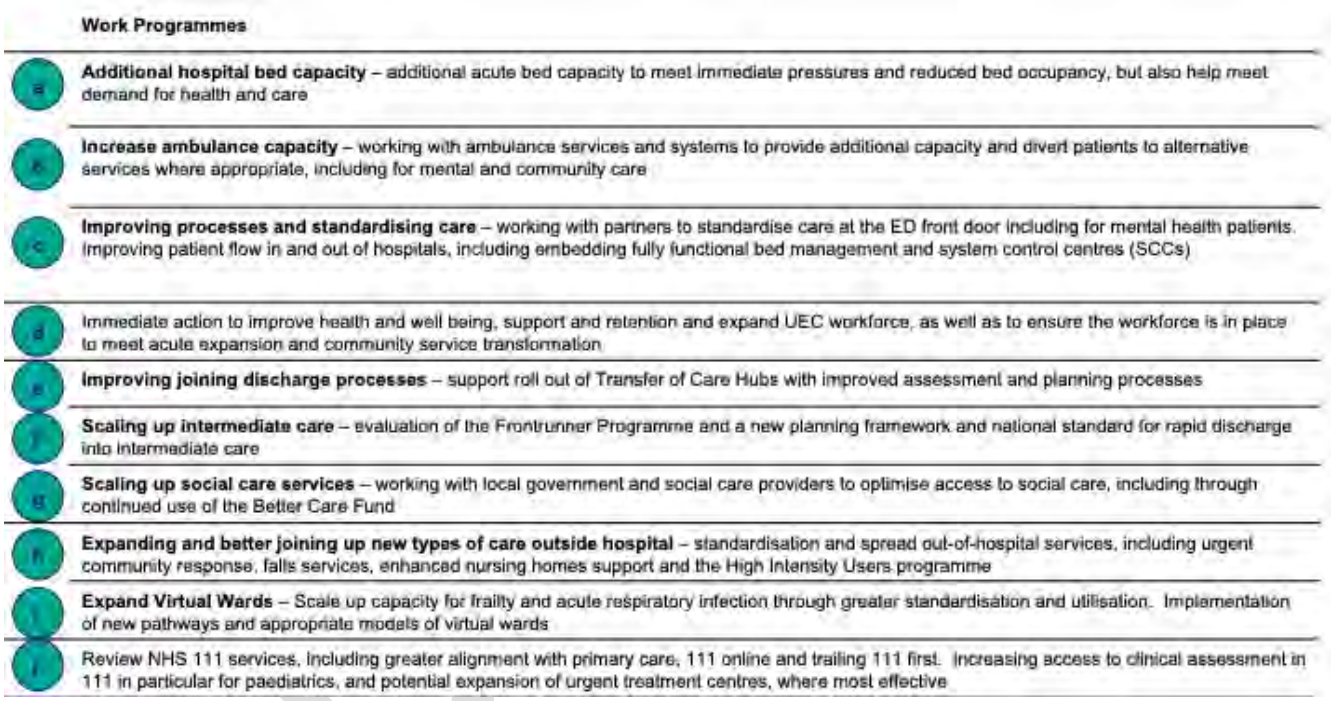
We have worked together to develop and agree local plans to develop the capacity required to deliver UEC Recovery, which is aligned to the national recovery plan. Our local plans are focussed on 7 key priority areas, split over pre-hospital, in hospital and post hospital programmes of work.

Recovery planning and delivery is undertaken through a system team and through the System UEC Delivery Group, which reports to the UEC Board.

The immediate focus priority areas align to the National UEC Recovery Plan and are outlined in the diagrams to the right and below.





We will focus on recovery over the next 2 years through:

- Progressing the business case to provide 50 additional beds at Royal Stoke University Hospital.
- A full review the use of Virtual Ward beds for both admission avoidance and early supported discharge to allow patients to get the care they need at home safely and conveniently, rather than being in hospital.
- Promotion of Acute Care at Home as an alternative to hospital admission.
- A full review of our pre-hospital "Access" programme with a particular focus on NHS111 provision
- Work with our acute hospital providers on the UEC improvement programme to improve acute hospital flow, deliver the 76% ED waiting times standard, the 92% bed occupancy target and improve ambulance handover delays.
- Assessment of the options and proposals for fully accredited Urgent Treatment Centres (UTCs) aiming to move to full accreditation in 2024. This will be supported by our Strategic Transformation function and will include an options appraisal process to identify which of the current urgent care portals meet the principles and standards for UTCs. Further data analysis and impact assessments will be undertaken to inform and shape the proposals and options for delivery of UTCs.

- Delivering a fully integrated discharge “hub” with physical co-location at The University Hospitals of North Midlands NHS Trust (UHNM).
- Improving our number of discharges and achieve a consistent 7-day service for both UHNM and The University Hospitals of Derby and Burton NHS Foundation Trust (UHDB).
- Utilising the Better Care Fund monies over 2023/24 and 2024/25 to prioritise schemes that are most effective in supporting discharges over a 7-day period.

The recovery plan will be underpinned by the ICS People Plan and our commitment to improving the health, wellbeing and experience of our workforce; retaining our workforce; education, training and development offers; attracting the right people with the right values; leading with compassion and creating an inclusive culture.

In addition, during 2024/25 we will focus on:

- Full accreditation of our Urgent Treatment Centres (UTCs)
- The re-procurement of our Clinical Assessment Service
- Increasing utilisation of our 111 service.

Collaboration with Partners

Working as a portfolio it provides us with an opportunity to join things up and look across existing pathways and organisational boundaries to do something different. The 2022/23 Winter Planning process embedded a culture of ensuring all planning within the portfolio is agreed at system level with mutual ownership across our partnership which will be embedded as part of our ways of working.

In order to effectively deliver our plans we are working in partnership with our provider organisations across including University Hospitals of North Midlands (UHNM), University Hospital of Derby and Burton (UHDB), Midlands Partnership University Foundation Trust, Staffordshire County Council, Stoke-on-Trent City Council, West Midlands Ambulance Service, East Midlands Ambulance Service, Midlands and Lancashire Commissioning Support Unit, North Staffordshire Combined Healthcare NHS Trust and other key providers including primary care, voluntary, community and social enterprise (VCSE) and others.

Our revised governance structure ensures we have full oversight and accountability of our delivery programme across the system.

Whilst our plans and strategy are in progress, we also need to maintain tight operational grip on the daily UEC pressures. The ICB has developed its operational resilience to ensure that we can react to urgent care pressures and respond accordingly. This will largely be achieved through System Control Centre (SCC) working in collaboration with our partners. The SCC, operational from 08:00 – 20:00 seven days a week, has been fully operational since the 1st December 2022 in line with winter planning and has visibility of operational pressures across the system to ensure the safest and highest quality of care possible for the population.

How will we know we are making a difference?

We will have:

- Improved ED waiting times so that no less than 76% of people are seen within four hours by March 2024 with further improvement in 2024/25 and reduced 12-hour ED waits to 0.
- Supported partners to improve category 2 (a serious condition, such as stroke or chest pain, which may require rapid assessment) ambulance response times to an average of 30 minutes or less on average over 2023/24, with further improvement in 2024/25 towards pre-pandemic levels.
- Improved ambulance handover times in ED.
- Reduced how many adult general and acute (G&A) beds are occupied to 92% or below.
- Reduced emergency admissions with more people will be supported by Urgent Community Response (UCR) services and integrated urgent care services, meeting or exceeding the 70% 2-hour UCR standard to avoid hospital admissions and enable people to live independently.
- 80% utilisation of virtual wards by September 2023.

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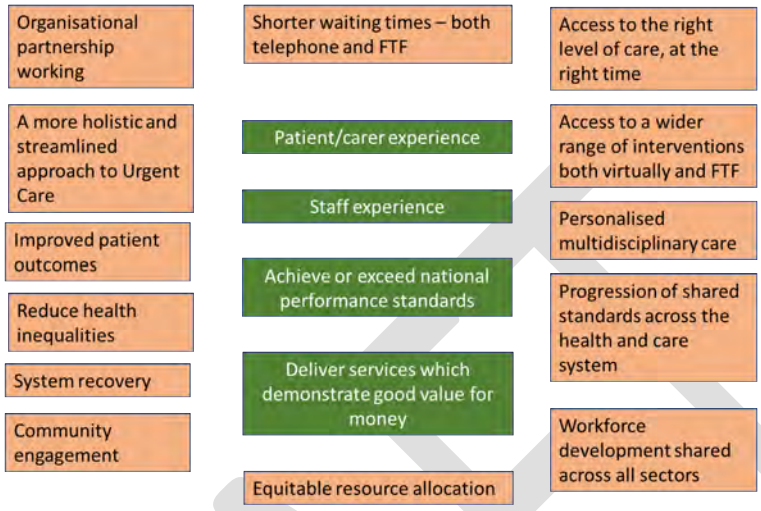
- Improved the number of discharges on Pathway 0 (a simple discharge) to 80%.
- Improve our number of discharges and have a consistent 7-day service.
- Expanded mental health crisis care provision for all ages including improving the operation of all age 24/7 crisis lines and Mental Health liaison services in acute hospitals.
- Urgent mental health support will be universally accessible by using NHS 111 and selecting 'option 2' by April 2024.
- All partners will be working together to improve hospital flow.
- Services delivered closer to home



Case Study

- ✓ At 99 years of age, Dot is fiercely independent and determined to look after herself in her own home. Recently workers in the shop next door realised she was struggling. They spoke to the local police community support officer who became a regular visitor and was able to build up a good relationship with Dot and finally convince her to let him contact social services about putting in place some support.
- ✓ The adult social care team got our discharge service, 'Home First' involved and Dot accepted two care calls initially, and as her trust in the team grew, agreed to four calls.
- ✓ Alerted by the Home First staff, social care colleagues visited Dot who was plainly unwell and put in place arrangements for two-night sits – but this was going too far for Dot who refused the overnight care. Unfortunately, because she was unwell Dot fell on two consecutive nights and was in a bad way. Her Home First worker spent a lot of time with Dot, explaining how the night sits could help her stay at home safely and she finally agreed. The team also put in place other support including assistive technology, a falls bracelet and delivery of a hot meal each day. After a couple of nights Dot started to feel better and the night sits were stepped down.
- ✓ Dot is continuing to be supported at home by Home First and is looking forward to her 100th birthday later this year.

End of Life, Frailty and Long-Term Conditions (ELF)

Our Commitment - Steve Grange, Senior Responsible Officer

Our portfolio is committed to high-quality, person-centred care pathways and culture. Utilising outstanding leadership, clinical governance and culture which will be used to drive and improve the delivery of high-quality person-centred care for our End of Life, Long Term Condition and Frailty (ELF) pathways. We aim to drive the prevention agenda forward using a coproduced, multiagency approach backed with sound data and future modelling which will enable us to predict demand and meet the needs and aspirations of our population. We will ensure this is supported with high standards of transformation methodologies and

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planning oversight which will be delivered and assured through a full portfolio governance approach. Ensuring the right partners at the right times are at the helm of everything we do, and that people are at the heart of the portfolio.

Ambitions

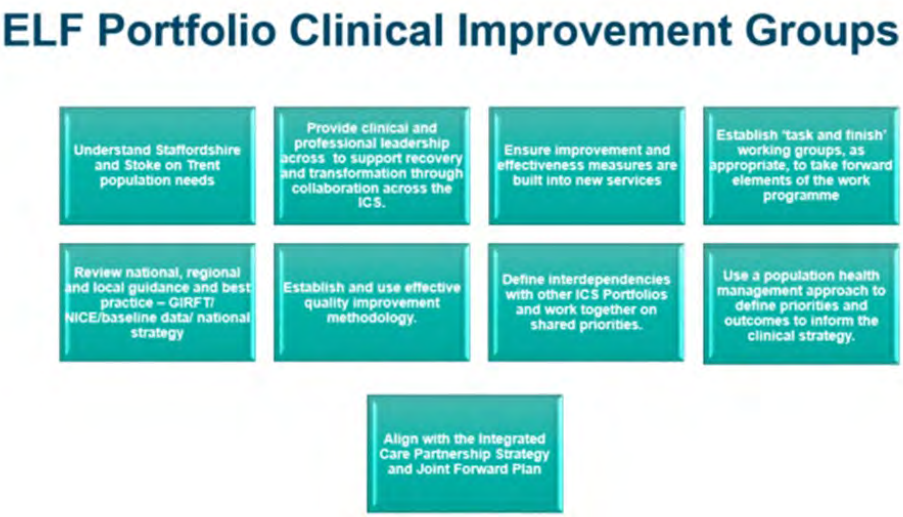
Population Insight and PHM

The ELF portfolio approach to integration of health and care will be informed by our collective understanding of our population's health and care needs. We will consider how we work in partnership to address the four elements described in the diagram below to improve health and wellbeing.

The ICP strategy and local authority health and wellbeing strategies are based around this model, which is embedded as the strategic approach across the system. We will ensure that our strategies and plans consider each of the four elements and where they interact so we can effectively address the things that affect the health and wellbeing of local people.

Clinical Insight

At the heart of our ambition is ensuring that we harness the right expertise including ensuring that everything we do is driven through Clinical Improvement Groups which will bring the appropriate clinical and professional insight to review and develop clinical pathways.



Digital

The use of digital solutions including risk stratification will also be a key element of our programme of work.

Palliative and End of Life (PEoL) care

Our ambition is to work together to enable everybody to have the care and support to allow them to live to the end in the best way that they can. The ICP Strategy has a focus on the 5 stages of life including 'Ending Well'' and includes the following as a priority for our system “we will maximise health and wellbeing in the last years of life by supporting people and carers with personalised care when needed”.

Our priority: we will maximise health and wellbeing in the last years of life by supporting people and carers with personalised care when needed.
High-quality palliative and end-of-life care is important to ensure people, their family and carers all have access to appropriate support.

Together we will focus on enabling:

- people to live as well as possible at the end of their life,
- ensuring they can die with dignity and that care plans are
- reflective of their wishes and preferences.

To achieve this, we will progress on:

- Offering personalised, high-quality end-of-life care for people and carers
- Reduce preventable emergency hospital admissions at the end of life

Frailty

Our ambition is to delay the onset of frailty and slow down its progression. Care of older people will be more streamlined to make our pathways more collaborative, integrated and patient-centred reflecting 5 key areas of our Frailty Strategy – Prevention and Healthy Ageing, Mild, Moderate and Severe Frailty and Proactive Falls Prevention.

Long Term Conditions (LTCs)

Our ambition is to enhance person-centred approaches to long term conditions including, supported self-management, proactive care, and support for families and carers. These approaches are fundamental and essential components for people living with LTCs that would result in significant benefits for people, their families, and communities.

The NHS Long Term Plan published in 2019 identifies cardiovascular disease, stroke and respiratory disease as a clinical priority. Our plans for cardiovascular disease (CVD), Diabetes and Respiratory include the development of Clinical Improvement Groups and develop a strategy to improve the health outcomes and quality of life for all those living with or at risk of CVD, Diabetes and Respiratory conditions. CVD and respiratory conditions are also explicitly referenced in the ICP Strategy focused around on how we increase prevention of premature mortality from CVD and respiratory disease.

Interdependencies with other portfolios

We recognise that not all of the end-to-end pathways for the ELF programme areas sit in one portfolio of work. We know that we have many interdependencies such as:

- Falls – Urgent and Emergency Care (UEC) and Care Homes
- Virtual wards – UEC
- Palliative care conversations – Primary Care and Care Homes
- ReSPECT Documentation – Primary Care and UEC
- Long Term Conditions – Planned Care, Primary Care and Improving Population Health

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We will aim, where appropriate to work in conjunction with other portfolios, continuing the joint working approach.

Why is this important for our Population?

It is recognised through ongoing patient and public involvement that our population needs access to health and care at the right time, right place and right pathway to ensure their needs and wants are achieved. Our portfolio aims to achieve this through robust pathways and transformation to meet their needs.

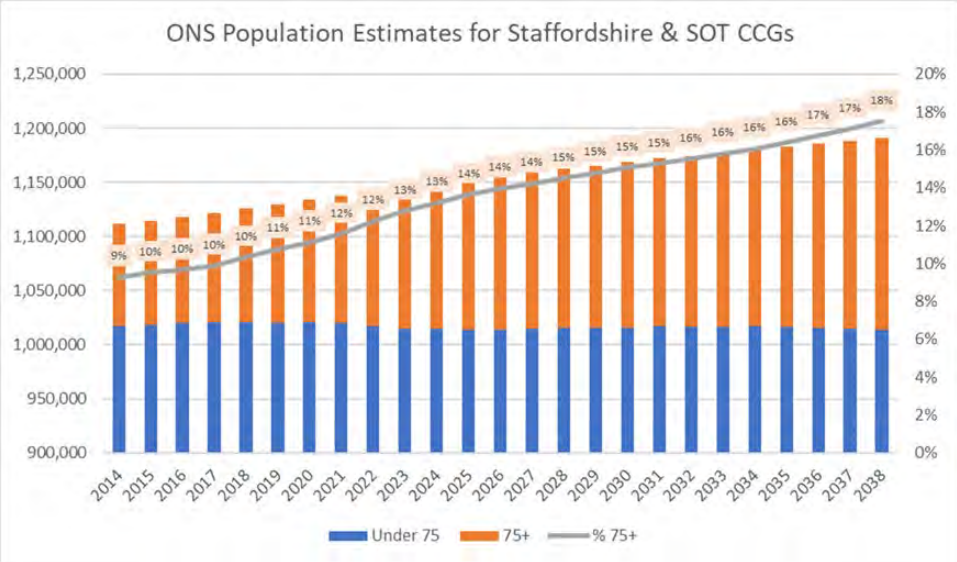
Many parts of the health and care system fail to sufficiently improve the quality of life of older people and those with a long-term condition. We know that people at the end of their life and their carers may not always have access to the consistent and personalised care that they require and that there are unacceptable variations in health inequalities amongst our population. We want our services to be more streamlined to make it more collaborative, integrated and patient centred. It is hoped that such an approach will benefit the population; and improve the efficiencies and outcomes within the NHS. The newer developments in treatments, service reconfigurations and technology should enable such a strategic change.

What do we know about people's local experiences?

A strategic needs assessment has been undertaken to understand current and future health and wellbeing need and demand in older people and to shape our approach to promoting healthy ageing and managing frailty.

We will replicate this needs assessment approach across palliative and End of Life services and LTCs including how we engage with and learn from our communities' experience. We know there is a huge demand on our services and access to these services can be a challenge. We want to engage with our patients and develop pathways that provide the best outcomes.

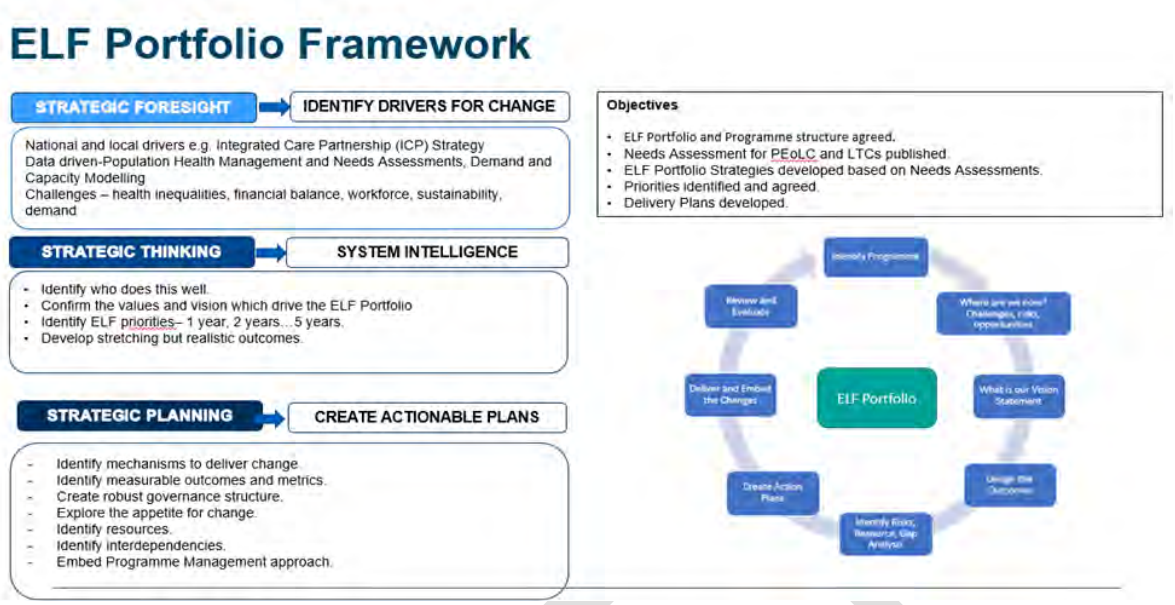
The graph below shows the scale of the frailty demand rising year on year. We aim to reduce the rate in which this growth occurs but ensuring we have robust service pathways in place.



How do we plan to make a difference?

To manage this increasing level of demand within available budgets will be challenging and we want to engage with our partners in supporting preventative approaches e.g., Core20Plus and utilise people's experience to understand how we shape services to maximise their impact.

The ELF Portfolio Framework aims to ensure a consistent and comprehensive approach to foresight, thinking and planning in order to develop the right strategy and plans for delivery.



We will utilise the above framework to implement a portfolio of work to address the challenges we are facing. At the current time this consists of identified work streams below – however the strategy and plans for the portfolio continue to evolve.

Palliative and End of Life Care (PEoLC) Programme

Our aim is to deliver outcomes for Staffordshire and Stoke-on-Trent patients and carers which are described in the National Ambitions for Palliative and End of life Care:

We will achieve this by:

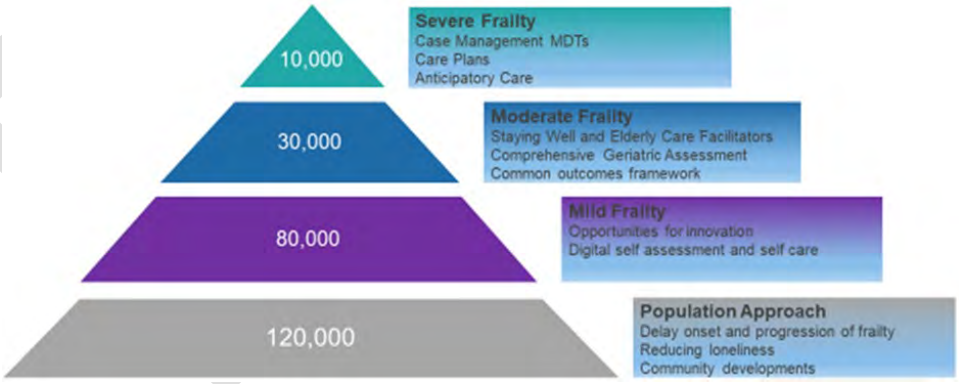
- Facilitating strategic and operational collaboration between providers of health and care services.
- Developing a comprehensive needs assessment which will identify key demographics, predictive modelling, current performance against 'what good looks like', identify baseline and highlight inequalities.
- Develop a comprehensive strategy for Palliative and End of Life Care.
- Identifying and establishing projects for delivery against the ambitions and reflecting national guidance

- Our work will include focusing on:
    - 24/7 access including Co-ordination and Advice Line
    - Access and availability of Palliative Care Medication – Reviewing what medication is available at what times and mapping the risks and opportunities.
    - Improving identification of people in the last year of life acknowledging that timely identification of people approaching the end of life allows for conversation, planning and prioritisation.
    - The number and quality of the Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) plans completed to support holistic personalised care planning and offering an opportunity for people to share what matters to them most and have their care delivered to enable these preferences.
    - Workforce and Training looking at workforce capacity, skill mix, training and professional development including identifying if there is access to appropriate training for community assets.
    - The Compassionate Communities approach and learning from implementation in Cannock area of Staffordshire to be considered under PEoLC Programme Ambition 6 'Each community is prepared to help'.
    - Having the right stakeholders at the helm of our programmes of work at the right time, such as the hospices and community End of Life services running our clinical improvement groups.

We will meet the new duty within the Health and Care Act 2022 for ICBs to commission Palliative Care services within ICSs to meet their population needs.

Frailty Programme

The ageing population brings with it enormous opportunities and challenges to our health and care system. The World Health Organisation (WHO) has referred to 2020-2030 as the healthy ageing decade, where we will focus on creating a more sustainable healthcare system, providing proactive, preventative and predictive medicine. In order to do this, we must consider primary, secondary and tertiary prevention, as well as looking at population and individual based approaches.



We will progress on or aims to delay the onset of frailty and slow down its progression. We will:

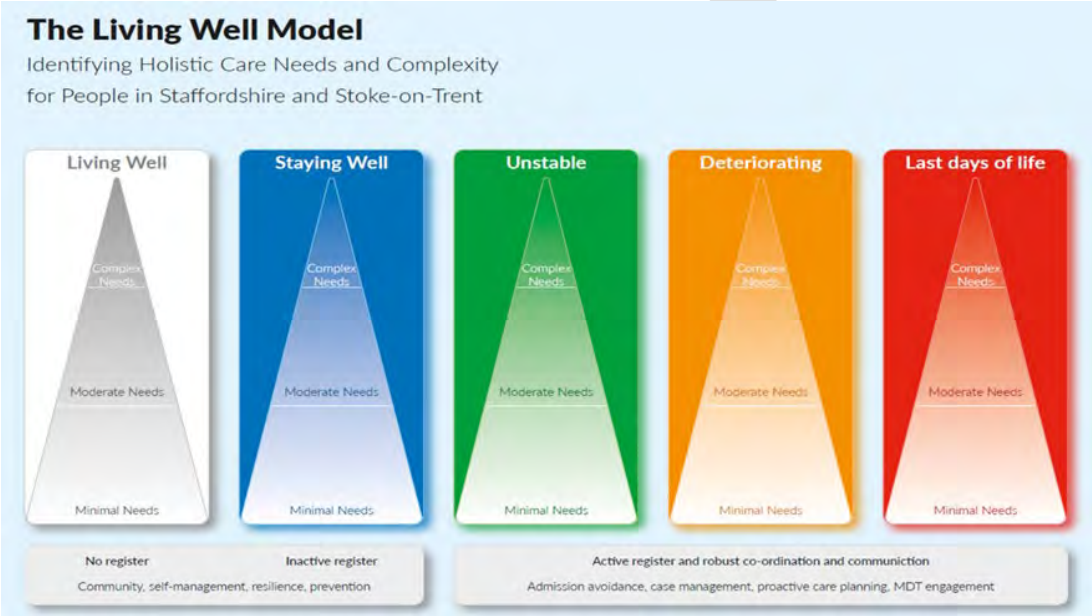
- Deliver the Frailty Strategy through detailed plans including development of a healthy ageing and prevent / delay frailty plan.
- Implement the Loneliness Reduction Plan to create more connected and 'age-friendly' communities of people and professionals
- Agree and roll out of system-wide Quality Outcomes Framework to improve the quality of life/timely access to integrated support for people living with frailty
- Develop quantifiable goals to reduce health inequalities and improve healthy life expectancy.
- Utilise PHM approaches and predictive modelling to assess impact of delivery options on resources and health outcomes.
- Provide needs assessments for the strategy at different levels e.g., Local Communities, Practice, PCN and Local Authority levels.

- Consider how the enabling functions of workforce, digital and estates, can support better integration with other transformation programmes.

Long Term Conditions (LTCs)

Long term conditions are key focus and caring for these needs requires a partnership with people over the longer term. This is particularly important in supporting the increasing numbers of people with more than one long term condition. Anticipatory care of long-term conditions is a priority in the Long-Term Plan as the care of patients with long term conditions is one of our greatest challenges. Current services are fragmented and there is variation in terms of patient outcomes.

The work on long term condition pathways will encompass prevention to end of life, utilising the Living Well Model to support the development of disease pathways to incorporate national drivers and enable new ways of integrated working.



During 2023/24 a refresh of the current programme structure and approach will take place. To support this, we will:

- Facilitate strategic and operational collaboration between providers of health and care services.
- Developing a comprehensive needs assessment which will identify key demographics, predictive modelling, current performance against 'what good looks like', identify baseline and highlight inequalities.
- Develop a comprehensive LTCs Strategy, reflecting the ambitions within the Long-Term Plan and ICP strategy, using a PHM approach to improve health outcomes, reduce health inequalities and reduce disease progression in cardiovascular disease, diabetes and respiratory. This will be scoped against national guidance including the Long-Term Plan and in conjunction with other portfolios to ensure that all interdependencies are identified and considered as part of the strategy development.
- Identifying and establishing projects for delivery against the LTC Strategy reflecting national guidance

Across the duration of this plan, we will focus on:

- Ensuring as many people living with diabetes as possible receive their 8 (9) Care Processes (diabetic annual health checks) and improve the proportion of diabetic patients achieving the three treatment targets in relation to blood pressure, HBa1c and lipids.
- Improve the foot ulcers and reducing amputation rates caused by Diabetes and reducing clinical risk.
- Improving care through the National Diabetes Prevention Programme and increasing uptake for people living with diabetes particularly through structured education classes recognising that both type 1 and type 2 conditions require differing information, advice and support.

- Case finding and accurate diagnosis of Chronic Obstructive Pulmonary Disease (COPD) to achieve early intervention and support the patient through their journey.
- Improving access to pulmonary rehabilitation making services more accessible, sustainable and meet quality assured national standards.
- Work in conjunction with other portfolios to identify and consider their interdependencies and the impact on people at risk of developing or living with LTCs such as:
    - supporting the uptake of health checks of people with SMI to support improvements to their physical health.
    - support the delivery of a joined-up weight management approach to implement both preventive and treatment strategies for people at risk of or are overweight or obese and their impact on people living with or at risk of LTCs.

How will we know we are making a difference?

The ELF Portfolio is committed to developing robust metrics and monitoring processes to ensure delivery of our programme and its objectives.

Our programme will be built from local data and a full baseline process will take place. This has allowed us to track any changes locally and for us to understand what impact we are making.

We need to 'measure what matters' and not make assumptions regarding what the data is telling us. We will ensure clinical and other expertise frames the key metrics which are identified to support our portfolio in measuring performance.

End of Life

- Increase in identification of people in the last 12 months of life recorded on Palliative Care registers in Primary Care from 0.5% (Baseline 0.5% 21/22 and mid Mar 23).
- Have identified and understand our key demographics, inequalities, baseline, current performance and predictive modelling.
- Fewer people dying in hospital.
- Reduced avoidable emergency admissions.
- More people dying in their place of choice.

Frailty

- 10% increase in uptake of all preventative services offering to people who are deemed preventable or mild on the frailty scale by 2028.
- 10% increase in the number of people with severe frailty who have a completed ReSPECT document and an Anticipated Care Plan.
- HN service offer to identify 2000 people at risk of hospital admission with a 10% reduction in the cohort.

Long Term Conditions

- Ensure 70% of people enrolled for pulmonary rehabilitation go on to complete the programme and have a discharge assessment.
- Increased number of our population achieving the 8 care processes for diabetes care
- Patients who are identified of having a 20% or greater increased chance of developing CVD (cardiovascular disease) are treated with Statins.
- AF – 10% increase in screening/identification (Pulse Check).

Case Study

Piloting a Digital Tool to Support Self-Management of Mild Frailty

✓ Frailty is associated with reduced mental and physical wellbeing, quality of life and independence. It is also associated with increased health and care needs, risk of admission and risk of death.

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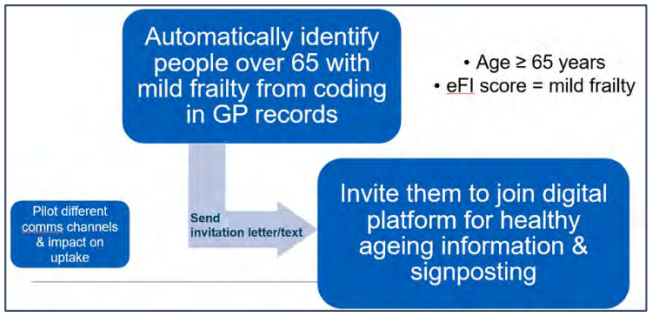
- ✓ There is an opportunity to slow progression of mild frailty. Digitally guided self-management is considered to be a cost-effective way to reach a large cohort which encourages self-efficacy and a proactive approach to healthy ageing. It is associated with delay in progression of frailty and associated quality of life reductions. It is also associated with a delay in need for health and care services.
- ✓ In 2023 we will pilot a digital health education tool for people with mild frailty utilising the following process:



The online platform will also host information about healthy ageing (frailty risk factors) and signpost to local support.

- ✓ The pilot evaluation will seek to ascertain the following quantitative and qualitative measures:
    1. Take-up rate Differential take-up – inequalities, impact of comms channels
    2. Content engagement metrics
    3. Focus groups with samples who do and do not take up offer
    4. Reasons for engaging/not engaging
    5. Views on comms, platform and content

- ✓ The pilot is anticipated to achieve a modest take-up and modest effect size, but once refined can be offered to larger numbers at modest cost with potential for roll out to other cohorts and geographies in future. The evaluation will also seek to understand digital inequality within the older cohort, preferred communications across the different neighbourhoods and to utilise this information to tailor future strategies to reach a wider audience.

Timelines

2023: Pilot with mild frailty sample

- ✓ Make offer to 5,000
- ✓ Qualitative and quantitative evaluation of overall approach
- ✓ Recommendations for next stages of development and evaluation

2024: Begin roll-out to mild frailty cohort

- ✓ 80,000 cohort across SSOT
- ✓ Use pilot results to guide strategies to improve reach/reduce inequalities

2025 and beyond

- ✓ Consider cluster Randomised Control Trial (RCT) to measure triple bottom line health outcomes, service use, carbon footprint
- ✓ Consider extending offer to healthy over 65-year-olds

Primary Care

Our Commitment - **Chris Bird, Chief Transformation Officer**

This is an exciting time for Primary Care. We will soon publish a General Practice (GP) Strategy developed in partnership with General Practitioners (GPs) and sets a shared ambition to improve access, experience and outcomes for our population. This will sit alongside the ICB taking on delegated responsibility for other elements of primary care including dentistry, pharmacy and optometry. This means for the first time the service planning and delivery of all aspects of primary care will be together in one place and offers huge opportunities for us to better reflect the needs of our local populations. At the same time, we have ambitious plans for building on the great work of our Medicines Optimisation Team to increase their profile across the ICS and offer a tangible demonstration of the value they have to offer in improving services to our communities.

Ambition

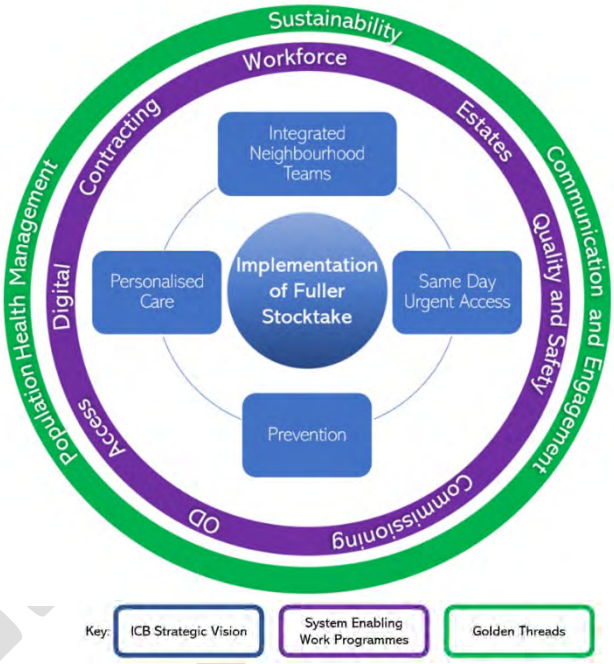
Our General Practice 5-year Forward Strategy is based on the vision of our population receiving a universal offer of general practice provision, with equitable access to high quality services. Our population will have more choice over where, when and how they access a consultation with a range of professionals to meet their needs. We want to enable those in our population with the most complex needs to have more time with their GP, supporting their continuity of care. We also want to empower our population and support self-care leading to happier more independent lives, with care delivered closer to home based on general practice being at the core of a revitalised approach to the delivery of integrated working.

Our vision is dependent on integrating actions from the 4 building blocks in the Fuller Stocktake NHS England » Next steps for integrating primary care: Fuller stocktake report same day urgent access, integrated neighbourhood teams, prevention and personalised care, into our existing 8 key enabler programmes as well as 3 golden threads: sustainability, PHM, communication and engagement that will underpin the work we do with general practice.

The General Practice 5-year Forward Strategy forms the building blocks for our plans and sets out the approach and principles of how we can develop general practice over the next five years – for the benefits of our population and communities, for a diverse multi-disciplinary workforce, and for our local health and care system.

The strategy will be supported by metrics and monitoring through a Primary Care portfolio dashboard and a 3-year benchmark report of practice, Primary Care Network (PCN), ICS and national average level data. A practice and PCN maturity matrix highlighting variation across key indicators is also in development to enable us to target approaches and support.

The NHS England new primary care access recovery plan will also be used to form the delivery of our access programme.



Why is this important for our Population?

Primary Care remains the first point of contact for many people seeking health services in their local community and play an important "gatekeeper" role, ensuring as many people as possible receive the care they need close to home. Primary Care often acts as both an advocate, as well as co-ordinating their care. GPs and their teams make up the vast majority of NHS contacts that take place and in doing so, alleviate pressure across the health service, including in Emergency Departments.

Demand for health and social care services is rising – a quarter of the population experience long-term conditions, which may be related to age, or circumstances associated with - or exacerbated by - stress, diet, activity levels, alcohol, smoking, air quality, poverty, isolation, or poor housing. People with long-term conditions such as diabetes, Chronic Obstructive Pulmonary Disease (COPD), arthritis and hypertension account for around 50% of all GP appointments. Whilst workloads for our health and care professionals are high and increasing; workforce recruitment and retention challenges have been deepening across primary care.

Our General Practitioner numbers continue to decline. The challenge in recruiting and retaining GPs is well documented and multifactorial, due to an ageing workforce and work pressures in primary care. Also, not enough medics are attracted to the profession or once trained are choosing to work in other areas, including abroad. Mitigations such as skill mixing, workload initiatives and redirecting workflow, plus national and local schemes to support recruitment and retention are in place. By working with Registrars, GPs, Practices, Primary Care Networks and Clinical Leads, we aim to retain GPs wherever possible whilst also creating a robust pipeline of newly qualified GPs. There are also risks around practice nurse numbers due to retirements over the next 5-10 years which will particularly be seen in some of our local areas. There are initiatives and plans in place to support how we improve this picture to attract and retain to ensure we have the valuable skills and expertise needed.

We have however made good progress against the recruitment of alternative roles and skill mix as part of the Additional Roles Reimbursement Scheme (ARRS) with an additional 475 (headcount) recruited to date since 2019. This is across a range of roles such as Clinical Pharmacists, Physicians' Associates, Social Prescriber Link Workers, Care co-ordinators and Paramedics. This creates a multidisciplinary approach to the delivery of general practice care and develops collaborative work across the health and care system. This will support with the implementation of the Fuller Stocktake particularly in relation to same day urgent access allowing GPs to focus on continuity of care for those with more complex needs.

Despite this challenging workforce backdrop, numbers of appointments have continued to increase. Nearly 5.8 million appointments were delivered between November 2021 – October 2022, this is an increase of 16% since pre-COVID and of which over 75% appointments delivered face to face.

It is vital that our population understands how the model of general practice is changing reflecting on new workforce models to help build confidence in this approach as well as maximising the potential around digital solutions whilst taking into account digital inclusion so that no patients (or staff) get left behind in relation to technological advances.

What do we know about people's local experiences?

Access to general practice remains one of the highest priorities for our communities.

The National GP Patient Survey in 2022 told us that:

- 71% of patients report their overall practice experience as "good" compared to a national average of 72%.
- 49% of patients find it easy to get through to their GP practice by phone compared to a national average of 53%.
- 55% of patients report their overall experience of making an appointment as "good" compared to a national average of 56%.
- 93% of patients report having trust and confidence in their last appointment with a healthcare professional which is line with the national average.

The Friends and Family test is another important feedback tool for patients to report about their recent experience of their general practice services and whilst this was paused during COVID-19, we expect to be able to use future feedback to capture more real time local patient experience data.

A large proportion of General Practices have input from Patient Participation Groups (PPGs). These groups consist of patients who wished to be involved in taking an active role in helping to shape ideas to help improve their local general practice services and enhancing the patients' experience. We will continue to use our PPGs to provide valuable insight and support practices in gathering more local real time feedback which they can use to shape improvements. Locally we are also seeing Primary Care Networks (PCNs) having combined PPGs across groups of practices to shape local services provided through that network approach.

How do we plan to make a difference?

Our population will experience:

- More integrated, personalised and flexible care through the implementation of the 4 building blocks of the Fuller Stocktake and outputs from our 8 key enabler programmes.
- Good access to general practice by improving location, times, ease of arranging appointments through digital and technology support, and speed of access with a range of workforce to meet their needs.
- An equitable approach to general practice provision including a consistent offer of local enhanced services for our population working across portfolios on pathway redesign.
- Reduced variation in care, services, and outcomes.

Our practices will:

- Work in partnership on the existing work programmes to tackle the challenges around recruitment and retention of the workforce (including maximising the opportunities of the Additional Roles Reimbursement Scheme) and addressing workload pressures through implementation of initiatives such as care navigation and utilisation of the Community Pharmacy Consultation Scheme (CPCS).
- Receive consistent training and development, as well as health and wellbeing initiatives, to support its workforce.
- Be supported to have a strong voice within the system.

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- Engage in PCN estates planning and Cloud Based Telephony review to inform system estates planning and access programme.
- Be able to engage with research and innovation groups and studies which supports maintaining primary care clinical staff in the region.
- Have access to high-quality digital tools such as online consultation, messaging and booking tools.

How will we know we are making a difference?

- Our population will report having good access to a consistent general practice service offer
- We will see a measurable improved patient experience through for example higher scores each year in the annual National GP Patient Survey and other local survey feedback.
- Deliver more appointments in general practice evidenced through the quarterly trajectory in place for 2023/24 and outcomes from PCN Capacity and Access Plans.
- Increased usage of online consultations.
- Increased use of various digital solutions to provide enhanced remote care to our population
- There will be an annual increase in workforce numbers, with more GPs and general practice nurses recruited and retained and a further increase of additional roles to compliment the general practice skill mix. We will be working towards our contribution of the national targets for increasing GPs and expanding additional roles.
- Increased connection of people to activities and community-based services through development of Social Prescriber Link worker roles.
- There will be reduced variability and better outcomes for our population across general practice services which we will measure through annual results via the Quality Outcomes Framework (QOF) and our local annual practice incentive scheme (Quality Improvement Framework).
- General practice will be fully participating in conversations about the designing of services at both a system and place level.
- General practice staff will feel supported, valued, and developed and we will explore how we will measure this in the next 3-6 months.
- Recover dental activity by improving units of dental activity (UDAs) towards pre-covid levels and improving access to primary care dentistry for the vulnerable population.
- Support the transformation of ophthalmology pathways, including the requirement to expand direct access and self-referral where GP involvement is not clinically necessary by September 2023.

Case Study

Our access programme

- ✓ Working with system partners, we are identifying and developing solutions to allow patients to access care using a variety of methods, professionals, and new technology. This includes how we maximise the opportunities of the general practice skill mix as part of the Additional Roles Reimbursement Scheme (ARRS) and communicating an understanding of these roles to our population.
- ✓ All 25 PCNs have implemented enhanced access which is part of a standardised and better understood access offer for patients as part of routine services. The offer is providing appointments between the hours of 6:30pm to 8pm Monday to Friday and between 9am and 5pm on Saturdays. For our local population, this equates to an additional 1165 hours of access to general practice every week.
- ✓ 43% of practices have already participated in an NHS England Accelerate Access Programme (cohorts 1-5, awaiting details for cohort 6) aiming to support practices to smoothing patient flow, understanding patient and staff experience data, involving the Patient Participation Group (PPG) and providing digital support including website design as well as extracting and understanding demand and capacity data to develop improvements.
- ✓ As part of our Access Programme, we are embarking on piece of work focused on capacity and demand. We will be working with a leading behavioural change expert to develop a unique capability in supporting organisations influence patterns of demand through changing or 'Nudging' behaviours. This work uses a range of techniques that have foundations in psychology, economics

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and service improvement without forcing people in any way or removing choice. We expect this approach to deliver tangible results and will support us during 2023/24 to help us trial methods of influencing the demand on Primary Care, improving access and reducing inequalities.

Research

- ✓ There is an active primary care centre at Keele University with a particular focus on musculoskeletal and mental health. These centres undertake support maintaining and attracting primary care clinical academics to the region to support the active research culture.
- ✓ There is also an established partnership between the National Institute for Health and Care Research (NIHR) Clinical Research Network: West Midland and many of our local GP practices allowing clinical staffs to engage and deliver research studies. Active engagement in research and innovation is supporting to maintain primary care clinical staff in the region.
- ✓ The General Practice Nurse (GPN) Evidence Based Practice group identifies areas of clinical uncertainty and clinical variation in day-to-day practice that impacts on patient care and to develop the research awareness and skills of the GPN workforce.
- ✓ The group consists of GPNs and Advanced Nurse Practitioners who are supported by clinical academics at Keele University to appraise and use best available evidence to influence practice at the point of care through the exploration of critically appraised topics (CATs). CATs provide a summary of the best available evidence to answer a clinical question and are co-designed by Clinical academics and GPNs with results shared for adoption and implementation into day-to-day practice. The outcome is that evidence-based research translates into evidence-based practice.

Pharmacy and Medicines Optimisation

Our Commitment

Locally the Pharmacy Leadership Group brings together professionals across Primary, Secondary and Community care who are united in delivering better pharmaceutical care for the population. National strategies have led to a significant increase in clinical pharmacy teams working in General Practice and the expansion of the role of the Community Pharmacist which brings opportunities to innovate and deliver medicines related outcomes at scale. The Pharmacy Leaders across the different professional sectors are aligned in their commitment to realise the benefits from the opportunities presented by these national changes.

Ambition

As pharmacy teams our motto is “ensuring that the right patients get the right choice of medicine, at the right time”[1] and in this respect our vision is that this overarching principle is embedded in healthcare services from design and planning stage through to delivery of a service at individual patient level. So, we will work with all major System portfolios with design and delivery of services on this basis, but additionally we have some specific aims:

After staffing, medicines are the second largest area of expenditure for any system and as custodians of medicines supply and spend, we will ensure that the ICS gets best value from this investment.

Why is this important for our Population?

Using medicines is the most common healthcare intervention but we have national and international evidence that the way medicines are used is suboptimal. Our ambitions around antimicrobial prescribing,

[1] Medicines Optimisation: Helping patients to make the most of medicine

medicines safety and the impact of use of medicines on the environment are based on this type of evidence.[2] [3] [4]

Nationally there have been major initiatives around broadening of the role of pharmacy teams in the community and in General Practice.[5] We need to make the most of these opportunities to improve access to primary healthcare services especially through Community Pharmacy Services.

Integrated Community Pharmacy Services

Over the last 4 years several national initiatives such as the NHS Long Term Plan, Pharmacy Integration Fund and the 5 Year Forward View have paved the way for Community Pharmacy to deliver services that would align with the needs of our Population. The introduction of ICSs provides flexibility for local commissioning of community pharmacy services that can meet the specific needs of our population.

Antimicrobial Stewardship (AMS)

AMS entails measuring and improving how antibiotics are prescribed by clinicians and used by patients. Improving antibiotic prescribing and use is critical to effectively treat infections, protect patients from harm caused by unnecessary antibiotic use and combatting antibiotic resistance. This is not a new priority but with the challenges of the COVID-19 pandemic and the aftermath where suddenly there was a hike in other viral infections the use of antibiotics has increased. We need a renewed emphasis on driving the right use of antimicrobials across the system.

Medicines safety

Overprescribing refers to a situation where patients are given medicines that they do not need or want, or which may do them harm. A recent review on the subject[6] has found that overprescribing is a serious problem in health systems. As well as the physical and mental impact on patients, overprescribing can lead to more hospital visits and preventable admissions, even premature deaths. There is also the cost in wasted medicines.

Overprescribing may disproportionately affect Black, Asian and Minority Ethnic communities and those who are more vulnerable, such as the elderly and those with disabilities. Recent initiatives by the NHS have helped stem the growth rate of overprescribing but it still is at unacceptable levels. Evidence is limited, but the review estimates that it is possible that at least 10% of the total number of prescription items in primary care need not have been issued.

We know what will reduce overprescribing: shared decision-making with patients; better guidance and support for clinicians; more alternatives to medicines, such as physical and social activities and talking therapies; and more Structured Medication Reviews (SMR) for those with long-term health conditions. Clinical pharmacy teams in general practice are well placed to deliver some of these interventions.

Discharge from hospital is associated with an increased risk of avoidable medicines-related harm. Better communication between hospitals and community pharmacies about changes to a patient's medication when they leave the hospital will enable community pharmacies to support patients more appropriately. Such discharge schemes have shown to improve health outcomes, prevent harm and reduce admissions.

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[2] Tackling antimicrobial resistance 2019 to 2024 (publishing.service.gov.uk)

[3] Good for you, good for us, good for everybody: a plan to reduce overprescribing to make patient care better and safer, support the NHS, and reduce carbon emissions (publishing.service.gov.uk)

[4] NHS England » The National Patient Safety Improvement Programmes

[5] The National Patient Safety Improvement Programmes

[6] Good for you, good for us, good for everybody: a plan to reduce overprescribing to make patient care better and safer, support the NHS, and reduce carbon emissions (publishing.service.gov.uk)

Shared care medicines

Due to their potential side effects, shared care medicines usually require significant regular monitoring and/or regular review by a specialist but the prescribing is undertaken by the patient's GP. Full collaborative working across primary and secondary care, together with the patient being fully involved in the decision-making process is the key marker of success in this pathway of care. Locally there is significant variation in this arrangement across different geographical areas and also in the level of service provision. There are digital barriers to effective and prompt communication between specialists and GPs. The service requires multiagency co-operation to address safety issues, to optimise treatment and to improve patient experience.

Carbon impact

The NHS is committed to being a 'net-zero' public organisation.[7] Of all the medicines pressurised metered dose inhalers contribute the most pollution in terms of greenhouse gases. All systems are planning to reduce the carbon impact of inhalers not just by switching to low carbon alternatives but by considering a range of interventions.

For further information see Appendix: Pharmacy and Medicines Optimisation: Low carbon and cost effective inhaler guide Final

Drugs budget

Effective management of drugs budgets is crucial to sustaining NHS services and it is routine practice. However, in the past separate local healthcare organisations have managed drugs budgets separately which has at times resulted in shift of cost pressures from one organisation to another or has required perverse incentives to drive cost improvement plans.

Pharmacy workforce

The pharmacy workforce is the third largest single staff group in the NHS and the focus has been on integrating this workforce into multidisciplinary teams to supply direct patient care. Like all other systems we need to plan for use of the pharmacy workforce at scale to meet demands on healthcare and at the same time not destabilise the traditional infrastructure for medicines procurement and supply and for specialist services such as compounding of aseptic products, quality assurance and medicines information. Alongside this development the NHS needs to support new training arrangements for Pharmacy graduates which requires placements across different sectors of pharmacy to equip pharmacists of tomorrow to take on new roles.

For further information see Appendix: Pharmacy and Medicines Optimisation: How We Will Support Wider ICS Ambitions.

What do we know about people's local experiences?

We will continue to engage with our population to understand their experiences about access to treatments. However, we have known already through prescribing related PHM data that shows where we need to make improvements:

- Prescribing level of medicines for minor conditions through General Practice is one of the highest in the country. Providing access for treatments for minor conditions via Community Pharmacy would release valuable capacity in General Practice to deal with more serious conditions.
- Potent lipid lowering drugs that have been approved recently by the National Institute of Clinical Excellence (NICE) are not routinely available in Primary Care which means that patients are having to wait longer to get right treatment via specialists in secondary care.

[7] NHS England. The NHS Long Term Plan.

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- We know hypertension in our area is under-diagnosed and yet we are not making sufficient use of hypertension case finding service in Community Pharmacy.
- Prescribing level of antibiotics across the ICS is one of the highest in the country. Last year we carried out audits in General Practice – 118 practices participated, and 1,992 patient records were audited which showed low threshold for prescribing of antibiotics and a significant level of non-adherence to national recommendations for choice and dosage of antibiotics.
- Our audits on prescribing of certain high-risk drugs showed that systems are lacking across both primary and secondary care to ensure that patients are advised appropriately about the risks associated with taking their medicines and that there is prompt follow up and review.
- Polypharmacy is a term that is used for patients taking multiple drugs. Various prescribing measures show that we have high levels of polypharmacy in our area. Overprescribing itself can have a negative effect on mental and physical health.

A survey we have conducted showed that patients are experiencing various barriers in prompt access to shared care medicines and sometimes there are complications in follow up. The survey also highlighted that where good systems are in place shared care medicines arrangements can meet patient expectations.

How do we plan to make a difference?

- Integrating community pharmacy services into the wider Staffordshire and Stoke-on-Trent health and care services to support our population to access primary care services
- Developing and showing the role of pharmacy teams in General Practice to deliver optimal medicines-related outcomes for patients
- Tackling the risk of antimicrobial resistance so that we maintain the effectiveness of antibiotics for treating serious and life-threatening infections
- Reducing harm from drugs including collaborative working across different sectors of pharmacy to reduce risk of medication errors during transfers of care
- Transforming shared care medicines arrangements between primary and secondary care to ensure that patients get can complex medicines from their surgery even though their care requires regular monitoring by a hospital consultant or specialist clinician
- Reducing the carbon impact of medicines to support delivery of the ICS Green Plan
- Joint working to get best value for expenditure on drugs across the system, including implementation of prescribing costs in primary care, joint working on development of cost improvement plans, early adoption of newly released cost-effective medicines and horizon-scanning and planning for impending cost pressures.
- Working with the ICS People Function we will develop a system wide pharmacy workforce resilience plan that incorporates optimising skill mix, extending capability of pharmacy professions and supporting wider training and development opportunities which will make Stoke-on-Trent and Staffordshire an attractive place for pharmacists and pharmacy staff to work and stay.
- Roll out of the smoking cessation service through accredited pharmacies to provide a smoking cessation service for including referrals from expectant mothers and their household members.
- Digital solutions in place across all our Trusts so that discharge medicine service referrals to community pharmacies from hospitals become routine practice, supporting the post-hospital UEC pathway
- Delivery of a Hypertension case finding service between practices and pharmacies at neighbourhood level to improve diagnosis rates for hypertension.
- Medicines use is a golden thread that runs though many of our portfolios of work especially End of Life, Long Term Conditions and Frailty (ELF) and Mental Health. The Pharmacy Leadership Group will actively support the portfolios to ensure that our public has access to the best treatments that are evidence based and supplied in the safest manner possible.

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How will we know we are making a difference?

We will have a set of measures aligned to our ambitions and plans that will show the progress that we are making both in terms of medicines optimisation activity and outcomes for our population.

Mental Health, Learning Disabilities and Autism

Our Commitment - Ben Richards, Senior Responsible Officer for Mental Health, Learning Disabilities and Autism

We are well on our journey to make mental health, learning disabilities and autism everyone's business.

Over the coming year we will operationalise our investment in perinatal mental health, mental health ambulance provision and children's autism services, while still progressing our community mental health transformation and Transforming Care (for patients with a learning disability) programmes to deliver effective care for patients.

The impact (and challenge) that comes with the wider implementation of the Oliver McGowan training programme is not to be underestimated, both in terms of the operational challenges it will create but also in raising understanding across the whole health and care system.

Mental Health

Ambition

We will work in an integrated and collaborative way to ensure mental health is given equal priority to their physical health needs and that people receive the help and support they need closer to home and family.

By bringing together leaders from all local partners, we will continue to raise the profile of mental health in our system and enable new models of support to be developed, delivered by a wide range of partners.

The Vision for Mental Health, Learning Disabilities and Autism is to ensure older people, adults, young people and children feel supported whether they find themselves in need of help in crisis or to maintain their day-to-day mental health and wellbeing.

Why is this important for our Population?

The Five Year Forward View for Mental Health, published in 2016, represented a major step, securing an additional £1 billion in funding for mental health, so that an additional 1 million people nationally could access high quality services by 2020/21. Since then, we have all lived through a pandemic which has led to increase in demand for mental health support alongside increased severity of cases. We have made significant progress against delivering these improvements, but more must now be done as we look to implement commitments for Mental Health and support recovery of services.

Like physical health, people can experience both temporary and long-term mental ill-health. Mental ill-health conditions affect around one in four people in any given year. People can experience mental ill health at any age and the implications are wide-ranging. For children and young people, educational outcomes may be negatively affected, which can result in more limited job opportunities. For people of working age, they may be less productive at work and more likely to be unemployed. Among elderly people, they are more likely to be isolated and less active in their community. For people of all ages with mental ill health, it can be challenging to carry out everyday tasks. Mental ill-health problems are more common in areas of higher deprivation and poor mental health is consistently associated with unemployment, less education and low income.

Our work around models of future mental health needs suggests that nearly 200,000 adults in Staffordshire and Stoke-on-Trent are currently experiencing some anxiety, an increase of nearly 33,000 from before the

pandemic. And an increase of 113,000 adults is estimated to be experiencing some level of depression, although it is unknown how many of those experiencing anxiety and/or depression will present themselves to their local mental health services and it could take several years before the full impact is known. It is estimated that 10% of known psychosis patients will relapse in the first 6 months, increasing to 20% between 6 and 12 months. This equates to just over 900 patients in the first six months increasing to over 1,800 by 12 months. A further impact of the COVID-19 pandemic is the increase in the number of adults who will develop prolonged grief disorder, estimated to be 535 adults.

What do we know about people's local experiences?

There are some stark differences in outcomes between those with a mental illness and the general population which runs across all areas of life such as education, employment, housing and health and wellbeing outcomes. For people who experience with poor mental health or who have a mental health diagnosis, stigma and discrimination present significant barriers to full participation in health care, education and citizenship.

Mental Health of Children and Young People in England 2022 - wave 3 follow up to the 2017 survey Key findings:

- In 2022, 18.0% of children aged 7 to 16 years and 22.0% of young people aged 17 to 24 years had a probable mental disorder.
- In children aged 7 to 16 years, rates rose from 1 in 9 (12.1%) in 2017 to 1 in 6 (16.7%) in 2020.
- In young people aged 17 to 19 years, rates of a probable mental disorder rose from 1 in 10 (10.1%) in 2017 to 1 in 6 (17.7%) in 2020.

Across Staffordshire and Stoke-on-Trent:

- The rate of hospital admissions for mental health conditions in the under 18's (2021/22) is higher in Staffordshire than in the West Midlands region. At 112.4 per 100,000, Staffordshire is 3rd highest in the region. Whilst Stoke-on-Trent has the lowest rate in the region.
- The rate of hospital admissions as a result of self-harm in 10–24-year-olds (2021/22) is higher in Staffordshire than in the West Midlands region. At 473.0 per 100,000, Staffordshire is 3rd highest in the region. Whilst Stoke-on-Trent on the other hand has the second lowest.
- The proportion of looked after children under 17 whose emotional wellbeing is a cause of concern (2021/22) was higher in Staffordshire and Stoke on Trent than in the West Midlands region. At 38%, Staffordshire had the 4th highest proportion in the region, whilst at 37%, Stoke on Trent had the 5th highest.
- The proportion of school age children with social, emotional and mental health needs (2021/22) was higher in Stoke on Trent than in the West Midlands region. At 3.0%, Stoke on Trent had the 7th highest proportion in the region. Whilst Staffordshire on the other hand, at 2.3% was the second lowest.

How do we plan to make a difference?

The national commitment, which will support local delivery of improved mental health services, is strong. Funding is being ring-fenced, the deliverables for improved services set out up to 2023/24 are clear and in many cases mandated. Systems such as our own are measured against the progress they make, and NHS organisations are regulated in accordance with this. The ICS is therefore committed to delivering in line with the Mental Health Implementation Plan (2019). We have developed our local response, the Staffordshire and Stoke-on-Trent Mental Health Implementation Plan, jointly with commissioners, the two NHS Mental Health Trusts and most importantly our service users and carer advocates.

We will focus on:

- Improving access to Talking Therapies, for people with anxiety and or depression, including for women accessing perinatal Mental Health services, and those with Serious Mental Illness (SMI).
- Extending the period of care for women accessing perinatal Mental Health services.
- Deliver support that is personalised and within a person's locality.
- Utilising assets within communities with an emphasis on self-management and recovery.

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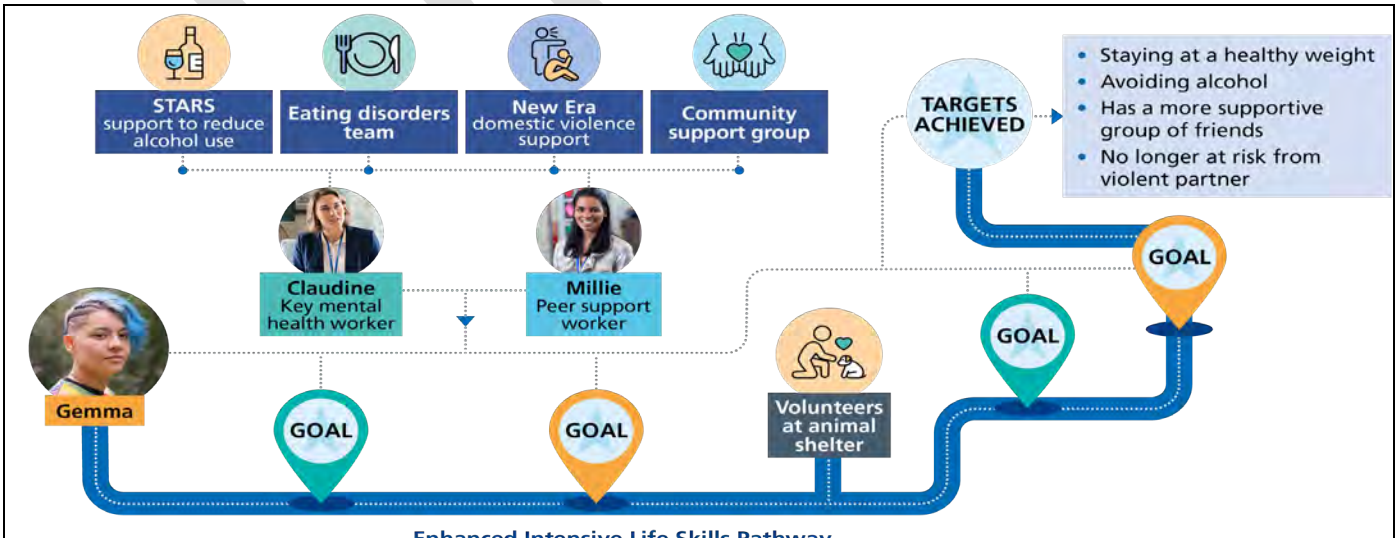
- Increasing the number of people receiving SMI physical health checks.
- Increasing the number of adults who have access to Individual Placement and Support.
- Integrating models of support configured around the Primary Care Networks (PCNs).
- Implementing systematic best practice reviews to ensure quality of services.
- Implementing a whole systems pathway supported by Structured Clinical Management for people with a 'personality disorder'.
- Ensuring more children access evidence-based treatment.
- Implementation of crisis and home treatment provision across the life course.
- Ensuring eating disorder provision meets commissioning guidance across the age span.
- Eliminating inappropriate out of area placements and an improved therapeutic offer in inpatient settings.
- Reducing the number of suicides and increasing bereavement support available.
- Improve the dementia diagnosis rate.
- Working with patients and staff to redesign our local inpatient mental health services. This includes the inpatient mental health services that were provided at the George Bryan Centre in south east Staffordshire. We made some temporary changes to services when the George Bryan Centre had to close in 2019 and are now proposing to make these temporary changes permanent. The consultation for this has now closed. The findings from the consultation will be considered and developed into a decision-making business case (DMBC) for consideration by the ICB Board.

How will we know we are making a difference?

- Increasing in 2023/24 the proportion of people with severe mental illness receiving a full annual health check and follow-up interventions from 2022/23 reported levels.
- Increasing in 2023/24 the number of people with severe mental illness accessing Individual Placement Support and gaining and retaining paid employment.
- Working towards eliminating inappropriate adult acute out of area placements by March 2024.
- Improved access to talking therapies for all age groups.
- Increasing access to specialist perinatal mental health care in 2023/24 against reported 2022/23 levels.
- Meeting the NHSE Mental Health Investment Standard (MHIS) providing parity across mental health and physical health services.

Case Study



Enhanced Intensive Life Skills Pathway

✓ Gemma is 24. She has a diagnosis of depression and anorexia. She experiences overwhelming emotions and mood swings. She sometimes self-harms and does unsafe things like binge drinking. Gemma suffered childhood sexual abuse and she has some physical health problems. She

has a poor appetite and poor sleep. She goes to a community group which she finds helpful. She is also experiencing domestic violence and has been assaulted by her partner.

- ✓ In the past, there was a risk that someone in Gemma's situation might be seen by mental health services on an ongoing basis, with lots of re-referrals, but without much improvement and with no end in sight.
- ✓ To make progress, Gemma needs a clear treatment pathway with goals and an end point. She also needs the right specialist help.
- ✓ Gemma contacts the ACCESS team who complete an assessment. They feel Gemma would be helped by the Enhanced Intensive Life Skills pathway. This will help her learn skills and strategies to manage her symptoms and meet the goals she sets. For example, she will learn ways to understand healthy relationships, helping her to build a more supportive social circle.
- ✓ Gemma has a mental health worker from the team, who will coordinate her care.
- ✓ She has a peer support worker, who has had similar mental health difficulties and uses her experiences and empathy to support others.
- ✓ Gemma and the teamwork out the goals she would like to meet to manage her symptoms. They explore which specialist services could help her meet her goals.
- ✓ Gemma agrees to see all the services suggested by the team.
- ✓ With support from Staffordshire Treatment and Recovery Service (STARS), Gemma begins to drink less alcohol. She uses her new skills to control her urges to drink and do other risky things.
- ✓ Gemma gets support from New Era, a service that helps anyone affected by domestic abuse in Staffordshire and Stoke-on-Trent. Gemma begins to recognise her self-worth and takes steps to leave her violent partner.
- ✓ Input from the Eating Disorder service helps Gemma stay at a healthy weight. She now has skills to help her keep eating well.
- ✓ She is supported to stay in her community support group. She also starts volunteering at a local animal shelter, which she really enjoys.
- ✓ Although Gemma is getting help from several services, she is not being moved from one to another, which could cause delays and gaps in her care. Instead, they support her at the same time and in a coordinated way. Gemma and her named workers from each service regularly meet to update her care plan and review her goals. She is always involved in the planning.

Learning Disabilities and Autism (LDA)

Ambition

To make Learning Disabilities and Autism everyone's business to ensure equal access and reasonable adjustments are considered across all services.

Why is this important for our Population?

People with learning disabilities, autism or both, their families and carers should be able to expect high quality care across all services provided by the NHS. They should receive treatment, care and support that is safe and personalised; and have the same access to services and outcomes as their non-disabled/neuro divergent peers. But we know some people with learning disabilities, autism or both encounter difficulties when accessing NHS services and can have much poorer experiences than the general population. As a result of these failings, people with learning disabilities, autism or both are at risk of preventable, premature death and a grossly impoverished quality of life.

We know that many people with learning disabilities, autism or both have positive life experiences and outcomes. However, some do not experience the same opportunities that other people take for granted. Our population with a learning disability and / or autism is diverse in its needs and inequality can take many forms which impacts on health and wellbeing, to which organisations from across the system need to respond.

The Joint Strategic Needs Assessment (JSNA) – all age and all system (LDA) identified that the average age at death for people with a learning disability is 22 years younger for men, and 26 years for women compared to the wider population (Learning from Lives and Deaths (LeDeR) 2022).

What do we know about people's local experiences?

People with a learning disability (LD), autistic people and their families have told us they struggle educationally and can have difficulty accessing, housing, employment, leisure, retail sport, cultural and religious opportunities in their local area. They also feel lonelier and more unsafe and can be more vulnerable to crime and abuse. Ten key themes have emerged locally.

Key themes

- There are lower reported levels of autism reporting in Stoke-on-Trent with potentially 600 children reported with autism compared to statistical neighbours.
- There is LD cohort growth in Staffordshire with 17.7% growth in children with Special Educational Needs (SEN) in 5 years with the LD cohort size around 40% higher than national proportion.
- There is variation in completion of annual health checks in Stoke-on-Trent 80.6% completion rate v Southeast Staffordshire 61.7%.
- Weight Management - a younger problem with peak obesity in LD males 25-34 years compared to non-LD 55-64 years.
- There is strong growth in epilepsy demand. LD prevalence in East Staffordshire 22.8% compared to 17.9% nationally. Children and Young People (CYP) register growth of 10% in one year.
- There is higher cancer prevalence at 2% for our population compared to 1.5% nationally.
- Acute activity demand is increasing sharply. Four-year growth rate for autism CYP over 50%.
- Housing strategies lacking focus - strategy documents for housing do not obviously recognise the current and future needs of autism and learning disabilities.
- Police crime incidents are increasing for autism with 23% more incidents involving autistic people in 2021 compared to 2020.
- We have data issues to resolve with a system wide need for more specific autism recording and better data sharing.

How do we plan to make a difference?

Much work has been undertaken to transform the local offer for people with learning disabilities, autistic people, and their families. We do however recognise there is much more to do which will continue through the delivery of our plans in 2023/24 and beyond.

We aim to:

- Reduce health inequalities by improving the uptake of annual health checks, reducing over-medication through the Stopping the Over-Medication of children and young People with a learning disability, autism or both (STOMP) and Supporting Treatment and Appropriate Medication in Paediatrics (STAMP) programmes and taking action to prevent avoidable deaths through learning from deaths reviews (LeDeR)
- Improve community-based support so that people with a learning disability and autistic people can lead lives of their choosing, in their own homes not hospitals: reduce reliance on specialist hospital hospitals and strengthen our focus on children and young people.
- Develop a clearer and more widespread focus on the needs of autistic people and their families, starting with autistic children and young people with the most complex needs.
- Make sure that all NHS commissioned services are providing good quality health, care and treatment to people with a learning disability, autistic people and their families. Reasonable adjustments are made to make sure people with a learning disability and autistic people get equal access to the support that they need.
- Build on the insights and strength of people with lived experience and their families in all our work.
- Become a model employer of people with a learning disability and autistic people.

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- Make sure that NHS commissioned services has an awareness of the needs of people with a learning disability and autistic people, working together to improve the way it cares, supports, listens to, works with and improves the health and wellbeing of them and their families.
- Improve understanding of the needs of people with learning disabilities and autism and work together to improve their health and wellbeing through the roll out of the Oliver McGowan Mandatory Training over the next 3 years.

Our work is arranged around six workstreams for LDA.

1. Identification – Primary Care actions to establish baselines at PCN, Place and ICS level and undertake Health and Wellbeing Roadshows. This will support us to increase the number of Annual Health Checks and quality of their impact.
2. Place – working alongside place partners and the VCSE in local communities to ensure housing, education, employment and life opportunities are more accessible and inclusive.
3. Universal Services – Dentist, Opticians and wider preventative services are accessible to all with reasonable adjustments.
4. Dedicated Care and Support – To develop a joint independent sector market with health and social Care that is fit for purpose.
5. Community Services – Secondary mental health services for people with a Learning Disability and Autistic people.
6. Inpatient Settings – Appropriateness, with the right care locally supporting timely discharge, reducing reliance on inpatient care where appropriate. Physical conditions and Mental wellbeing are both part of this workstream.

How will we know we are making a difference?

- 75% of People with LD (aged 14+) will have an Annual Health Check
- For people who have been referred to an autism diagnosis service, people will be waiting no longer than 18 weeks from referral to first appointment by 2024/25
- There will be reduced reliance on inpatient care for people with a learning disability and/or autism who are in inpatient care for a mental health disorder
- 100% of LeDeR reviews will be undertaken within 6 months of notification of death
- Expected high levels of compliance with Oliver McGowan Mandatory Training

Case Study

My Name is Tom (not my real name) I am 46 years old, and I have spent 36 years in hospital.

Why?

- ✓ I have a learning disability and I can't communicate in a way that makes sense to you.
- ✓ When I am anxious, upset or angry, you worry about the things I may do to you and myself.
- ✓ I have a family who I love, I haven't been able to see as much of them as I would like as I have lived a long way away for a lot of the 36 years.
- ✓ I have met some lovely people over the years who have really helped and cared for me. I have also met some not very nice people who have been cruel and have not cared for me in the way they should!

But a break-through

- ✓ A lovely nurse has helped everyone see that hospital does not need to be my home and I can have a home of my own with people chosen to help me to live my life in a way that makes sense to me.
- ✓ I moved into my own home in spring 2022.
- ✓ I have my own things that I don't have to share with people I don't know or like.
- ✓ I go out into my local community and do the things I like when I like.
- ✓ Most importantly, I can see my family as they are close by, and they can finally see me living a life that they never thought was possible.

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Cost profile illustration for Tom

- ✓ Current actual annual cost £750,000, profiled with a 6.5% annual increase over the 36 years as an inpatient.
- ✓ Tom recently moved to a community setting with an annual cost of £330,000.
- ✓ In this illustrative example the total cost difference is £6.1 million pounds over the 36 years.

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Our Enablers to Success	The previous sections of our Joint Forward Plan set out the key objectives and priority actions of our portfolios. Successful delivery is also reliant on some key enablers and their overarching programmes of work which will support delivery of the Joint Forward Plan. They are set out in this section covering Quality Assurance & Improvement; Our People Plan; Digital; Estates; Sustainability and Delivery of a Net Zero NHS.

Quality Assurance & Improvement

Our Commitment - Heather Johnstone, Chief Nursing and Therapy Officer

We Our system is collectively committed to delivering our statutory duty for quality through a programme of quality assurance and improvement activity with a greater emphasis on population health and health inequalities. This commitment includes recognition that we are jointly accountable for quality.

Our emerging Quality Strategy describes the systems and processes that exist to ensure that we not only continue to monitor the quality and safety of health and care but that we also strengthen our links to the quadruple aims for Integrated Care Boards (ICBs) whilst responding to emerging best practice. Our commitments are intended to ensure our population can access high quality, safe care and that if things go wrong, they can be assured we will listen, learn and change practice.

Why is this important for our population?

Quality is a golden thread between vision, analysis, systems and people and is a part of all developing strategies within the ICS, by ensuring a shared understanding of how the vision, goals and values of all organisations need to meet our quality commitments.

How we plan to make a difference?

The ICS recognises the essential role all partners have in providing oversight of the quality of care provided, and in creating and sustaining a culture of openness, learning and continuous improvement. The ICB's Chief Nursing and Therapies Officer is the designated executive clinical lead for quality and safety.

Our emerging ICS Quality Strategy has been developed through partnership across the ICS and has evolved over a series of workshops. We have agreed a Quality Ambition and are focused on developing a vision, approach and measurable outcomes for the next three to five years. Our intention is to create a cohesion between all partners' quality strategies.

We exercise our shared commitment to quality through a systematic quality assurance structure to ensure that performance concerns and risks on quality and are escalated appropriately and openly. The governance structure includes individual providers' Clinical Quality Review Meetings (CQRM), the System Quality Group (SQG) and Quality and Safety Committee (QSC) which includes representatives from across the ICS as well as the Care Quality Commission, Healthwatch organisations, Health Education England and NHS England. Both SQG and QSC maintain strong links with the Health and Care Clinical Senate to ensure a strong clinical and care focus continues.

The emphasis has shifted from provider-based reporting to system level and agreement on common risks and areas of concern are a core part of the quality approach and are underpinned by the explicit expectation that all members of the QSC share accountability for the quality of services and for driving required improvements.

Across the ICS we work collaboratively to identify early warning signs of emerging issues or impacts. Where routine quality and safety monitoring, soft intelligence and other forms of feedback and review highlight areas of concern the ICB's Nursing & Quality team, alongside other system professionals, undertake additional quality assurance activities including (but not limited to) announced and unannounced visits (including evenings and weekends), deep dives into data and focussed reviews. If these highlight further areas of concern or a lack of plan to address identified concerns, the escalation process outlined within the National Quality Board guidance is followed.

To enable the system to provide outstanding quality services for all, our shared vision and underpinning quality framework include both quality assurance and continuous quality improvement (CQI). In line with the guidance set out by National Quality Board our approach to CQI is focused on developing capacity and capability to practice quality improvement (QI), support the embedding of QI in all levels of change, nurturing a learning culture and sharing best practice. Within our ICS partners have worked collaboratively developed a framework and a set of mutually agreed principles. The delivery mechanisms for CQI at a system level include a CQI Sub-Group that focuses on the strategic development and deployment across the ICS, a QI Network which is a joint ICS endeavour with Shropshire, Telford and Wrekin ICS that brings people together from across both systems to connect, learn, share and improve and the support of a number of identified System CQI projects. As the system matures and the CQI continues to grow, there are a number of areas that we will be looking to strengthen these will include the development of an ICS CQI Training offer and the further embedding of CQI within Place, Provider Collaborative and ICB delivery portfolios.

A core principle at the heart of CQI is putting the people we serve at the centre of change and the ambition is that through the growth and embedding CQI further across the system that we can also move towards co-production being our default approach to involvement within CQI and the ICS.

Quality is an enabling function to our operating model. Nominated quality leads are embedded into multi-disciplinary teams supporting portfolios and place to ensure that quality is a golden thread throughout all discussions and that quality outcomes are used to evidence ongoing and sustainable improvement. The quality leads provide subject matter expertise, advice, and insight to champion quality as a central principle. The quality lead will ensure that quality risks are recorded and escalated through our quality governance processes, quality impacts & learning are managed and shared, identify opportunities for and promote the use of quality improvement ideology and methodologies.

Our system quality dashboard, alongside portfolio dashboards, focuses on more traditional measures of quality e.g., serious incidents, infection prevention and control as well as quality indicators within the NHS Outcomes Framework. Our ambition is that as we implement the Patient Safety Incident Response Framework (PSIRF) and work alongside portfolios to deliver the ICS priorities. The dashboard will evolve and reflect current system intelligence focusing on system-based approaches to learning, outcomes and health inequalities which complement our Quality Strategy and cover the breadth of the system's portfolios.

Safeguarding

The Health and Care Act transfers all relevant statutory duties from Clinical Commissioning Groups to the Integrated Care Boards (ICBs). These include statutory duties on safeguarding children, children with SEND and Looked After Children, as set out in the Children Act (2004). This also includes children in the justice system, as set out in the Crime and Disorder Act (1998). The ICB has a statutory duty to safeguard children under the 'Children Act 1989 / 2004'; this is set out in the statutory guidance 'Working Together to Safeguard Children 2018' and to safeguard vulnerable adults under the Care Act 2014. As a statutory responsibility, robust safeguarding processes must be embedded and strictly adhered to.

Each individual within the ICB accountability structure will work with their counterparts in the police and the local authorities that form the safeguarding partnerships, including the Local Safeguarding Children Boards, that exist within the ICB geographical footprint. As set out in Working Together to Safeguard Children (2018), safeguarding responsibilities are shared equally between health, police and local authorities.

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Our ambition is for children, young people and adults to feel safe across Staffordshire and Stoke-On-Trent. The ICB Safeguarding Team are working in partnership with the two Local Safeguarding Children and Adult Safeguarding Boards and providers across the health, Social Care, Education, Police and VCSE to ensure the safety and wellbeing of children and adults are at the heart of everything it does.

How will we know we are making a difference?

- Care Quality Commission (CQC) ratings will reflect that our services are safe and of a high quality. We will be able to demonstrate strong leadership, clear oversight of any CQC improvement plans and measurable improvements to any areas identified within the NHS System Oversight Framework.
- Partners, including people and communities, work together to deliver shared quality improvement priorities based on a sound understanding of quality issues within the context of the local population's needs, variation and inequalities.
- We will have nurtured a learning culture across the system, driven by compassionate and inclusive leaders. We will be able to demonstrate ongoing work to review progress and impact, and share and celebrate learning, improvement and best practice from within and external to our system.

People Plan

Our Commitment - Alex Brett, ICB Chief People Officer and MPUFT Chief People Officer

Our workforce is our greatest asset in providing high quality care for our populations, however we also recognise the significant workforce challenges we face across health and care. Our people have worked tirelessly and passionately to deliver services to our local population despite the challenges they face with workforce supply, sickness absence and the ongoing impacts that working in health and Care has on their health and wellbeing. Whilst these system pressures have impacted significantly on workforce availability and resilience, our people and leaders have continued to work together, forging strong relationships to develop innovative approaches to support our people and deliver services to our population.

As we continue on the exciting journey of developing our ICS and Integrated Care Partnerships, we know that we need to harness the collective effort of our workforce to meet the demands we face, having greater impact on what we can achieve together, reducing duplication and working across boundaries. We are therefore committed to work as "One Workforce" where "operating as a whole is greater than the sum of the parts" under an anchor employer model.

Introduction

Our system has been working collaboratively from a workforce perspective since 2017. Relationships have formed during this time between NHS, Local Authority, ICB, Primary Care, Social Care and voluntary, community and social enterprise (VCSE) partners to tackle the workforce pressures at a system level. Following the establishment of the Integrated Care Board (ICB), we have continued to build on our collaborative approach towards delivering the National guidance for ICB People Functions (ICS People Function (england.nhs.uk), August 2021) to support a sustainable "One Workforce" within Health and Care.

Utilising the National People Plan, our Local People Plan sets out how we will work together to deliver the practical actions to close the workforce gap and work differently in a compassionate and inclusive culture. We await the launch of the National People Strategy which will subsequently require local plans to be updated and delivered in line with the national vision and our changing local landscape.

The Hewitt Review helpfully supports our approach to breaking down organisation boundaries in the way we have already mobilised staff and deployed contingent workforce, created and promoted system career pathways and recruited to entry level roles. The system welcomes the recommendation of a Social Care workforce strategy which sets the strategic direction for a more integrated workforce. The ICS People

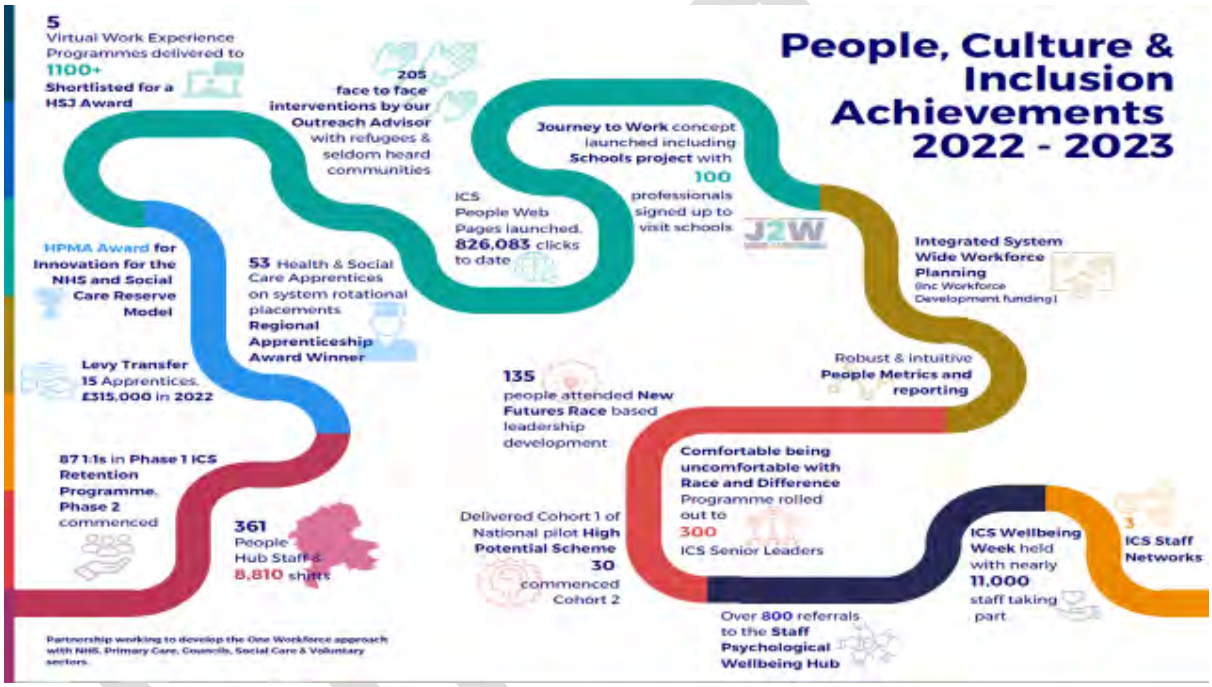
Function will facilitate the development and implementation of this at system level, ensuring it supports the local workforce actions.

Alignment to portfolios and People Operating Model

The ICS People Function plays a pivotal role in the implementation of the ambitions and priorities of the ICS. Support is aligned to each of the 7 portfolios. Our aim is to work with all of our system partners to inform, transform and improve our immediate and future workforce supply, and the way we look after our people and retain our people. We will act as enablers to help make our local area a better place to live, work and be a patient, and build a workforce which is representative of our local communities.

Achievements and current position

There continues to be significant momentum in addressing the workforce challenges The figure below outlines the achievements made across the ICS.



Our future intentions and Operating Model

The ICS faces a number of well-known **workforce challenges** with the three main challenges being:

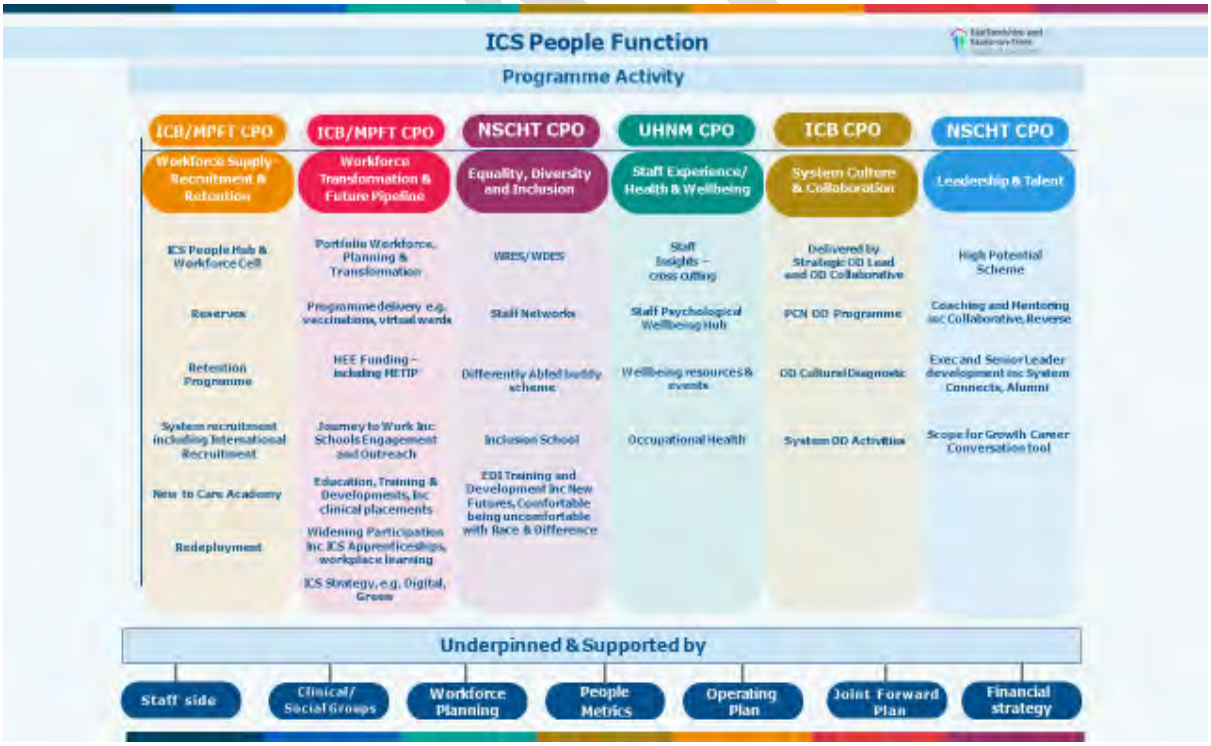
- workforce supply due to turnover / burnout / age / lack of flexible working opportunities
- cultural / behavioural change required between all partners to move to a system way of working, to remove organisational boundaries and reduce duplication
- financial challenge; requirement to deliver increased activity (due to population demand and elective recovery) via workforce productivity rather than increase in headcount.

Our **ICS People Collaborative** approach, developed over time with health and social care partners, is mature and effective in collectively tackling these workforce challenges. We will continue to work together to transform the way we recruit, retain and develop our workforce through:

- Robust governance and oversight through the ICS **People Culture and Inclusion Committee**
- Embedding our **'One Workforce'** approach, driven and owned by our workforce,
- Creating the **right cultural environment** for people to thrive, focussing on civility and safe working ethos
- Embedding **inclusive cultures**, understanding our workforce and building on our achievements in regionally recognised **equality and diversity** activities
- Building on the **leadership and talent offer**

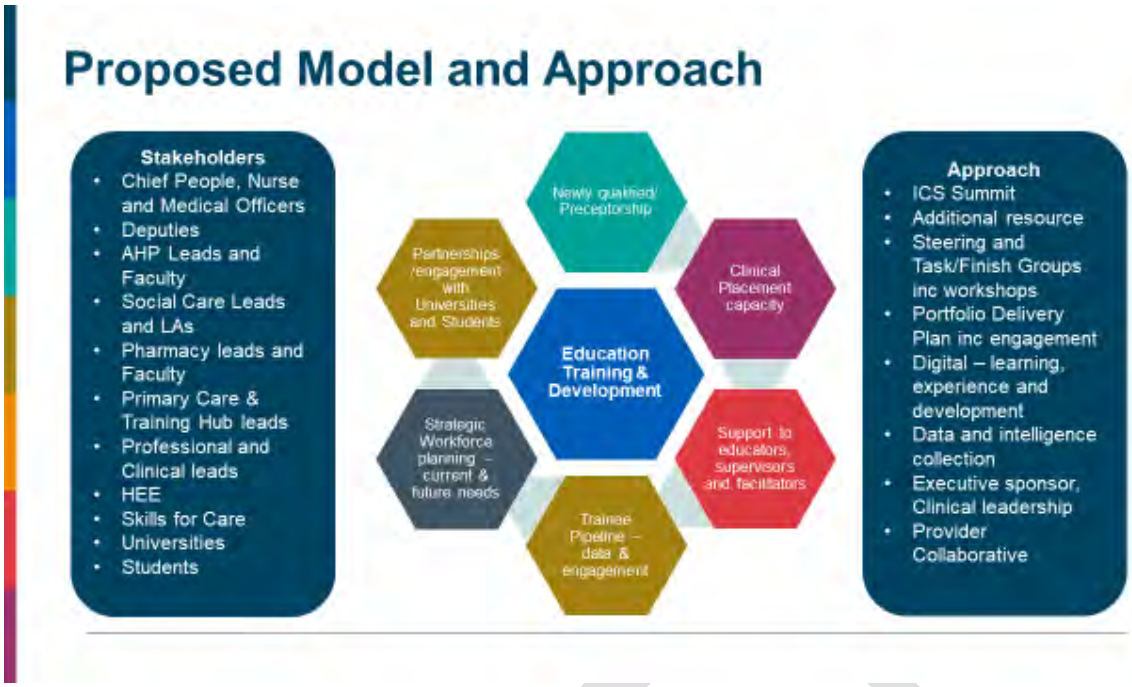
- Integrated **workforce planning and transformation**, including designing new staffing models and roles to deliver treatment and care differently.
- Partnership working to improve **workforce supply**
- Further development and utilisation of the National Healthcare People Management Association (HPMA) award winning **ICS People Hub and Reserves** to provide a contingent, flexible workforce at system level.
- Development of an **ICS New to Care Academy**
- **ICS Retention programme** aligning to national programme objectives whilst creating local solutions to retain our workforce
- Implementing and embedding the **Journey to Work** concept with our partners, communities, schools and colleges to build our pipeline, create opportunities for everyone and ensure our workforce represents our local population.
- Strengthening our **outreach** work with refugee, seldom heard and deprived communities to support and develop people into careers in health and care
- Supporting **Health and Wellbeing** through system resources and events, the ICS Staff Psychological Wellbeing Hub and system Occupational Health contract.
- Expanding **Widening Participation** activities across all our partners including education engagement, T-Levels, Apprenticeships, workplace learning schemes
- Enable **digital workforce transformation** and equip our population with digital skills for self-care and prevention.
- Developing our **ICS Education, Training and Development strategy**

To tackle the workforce challenges is a vast undertaking. The ICS People Function is the linchpin for the system working together to make an impact and ensure focus remains on the key areas required to make transformational changes. Our delivery approach is summarised in the following infographic.



Education and Training

The infographic below describes the collaborative approach the system is taking in relation to our duty to promote Education, Training and Development. With the recent appointment of an Executive Clinical Sponsor for this workstream, work has commenced to drive forward specific projects including planning an ICS Summit, strengthening our work with Universities, clinical placement capacity and career pathways.



Members of the collaborative will help us understand the supply pipeline, future plan and ensure placement capacity matches current and future requirements. The workstream activity will be driven and monitored through a steering group and will report formally into the People Culture and Inclusion Committee and ICB Board, considering key challenges and risks from a clinical, social and education pathway and future supply perspective.

The various workstreams and projects under the collaborative will be brought together within a system-wide strategy, developed by partners. The workstream will undertake long term planning at system level, incorporating provider level plans and activities, identifying opportunities to scale and spread programmes and consider productivity and efficiencies. We will build on successes in design and implementation of new roles to meet future service needs and to attract a diverse, skilled workforce e.g. Physician Associates, Advanced Nurse Practitioners. In line with the Hewitt review recommendations, we will operate across organisational boundaries to develop career pathways which support delivery of high quality services to our population. We will also consider the training and development implications of blended roles and tasks to support continuity of care and improve patient experience.

Integrated workforce planning against service pathways across our portfolios will identify workforce supply needs, inform planning for overall placement capacity and clinical education offers, and consider how our students and trainees play a crucial role in the delivery of our services. This integrated planning process will highlight the workforce demands against the activity and finances available and identify our short- and long-term education, training and development requirements. Integral to the planning process will be the understanding and utilisation of education and student/trainee pipeline information available (including the Health Education England (HEE) e-tool).

We will educate and train our workforce to support population health, prevention and tackle health inequalities, embedding into practice and partnership working.

Close partnership working with our Health Education England partners will support us in utilising and allocating funding available across the system, aligned to national and ICS priorities and portfolio planning. The workstream will support the Multi-Professional Education and Training Investment Plan (METIP) process, whilst also including social care and wider workforce educational and training needs. Additionally, the workstream will coordinate partners and enable discussion around education tariffs.

Strengthening relationships with our local Education providers will be fundamental and at the core of the workstream and approach. By working in partnership with education, we will ensure high quality provision,

expand our capacity and improve our future pipeline. We will collaborate on development of curriculum and courses which meet the needs of our system, whilst also considering student requirements.

We will focus on how we develop our placement capacity through a specific programme of work, building on the HEE Clinical Placement Expansion programme. We will bring together clinical, professional and education teams to develop a collective approach, share learning to improve and develop the clinical educational offer and experiences for our students. The programme will include scoping current clinical placement landscape across the whole system - in both NHS and Private, VCSE and Independent sectors; undertake placement profiling for undergraduate registered and non-registered placements; consider innovative models of support for learners across a variety of providers to enhance learning and create multi-organisational and diverse placement pathways.

Clinical, professional and workforce teams will consider how we strengthen relationships with our students and create a healthy pipeline of new registrants into our providers. Working together, we can maximise the opportunities for our new entrants and offer careers in services which best meet their needs. We will be flexible and adaptable to the changing needs of our future workforce - exploring rotational opportunities across the system will form part of future offers to our workforce.

We will develop and test innovative and forward thinking approaches to delivery of education, training and development, with digital being a key enabler to this workstream to create efficiencies and improve quality of education and training. We will also develop system-wide approaches to digital upskilling of our existing & future workforce.

To support development of our entry routes into education, training and jobs across the system, we are currently implementing and embedding the **SSOT Journey to Work** concept with our partners, communities, and education providers. This model will capture our approach to Widening Participation, Schools Engagement, Apprenticeships, Community Outreach, New to Health and Care Academy models, and Retention.

The duties and workstream activities also link with the **ICS Retention programme** including post registration / new starter support, preceptorship offers, Continuing Professional Development (CPD), career progression and development, experience, return to practice initiatives.

The **SSOT Reservist programme,** which attracts non-registered and registered professionals to support the system ad-hoc during surge and emergency periods, provides an opportunity to maintain clinical and care competencies and supports CPD. This programme includes: people returning to practice, those wanting to trial health and care before they take up a permanent position and a specific project supporting ICB registered staff to work within our providers to maintain their registration whilst also supporting the quality and service improvement agenda.

The ICS recognise the huge value volunteers add in supporting and caring for our patients and population; during times of increased operational pressures and emergencies; and in helping people get back into the workplace and create opportunities for paid work. We will continue to work with our voluntary sector partners to build our voluntary sector relationships, scope and develop volunteering offers available to our communities, explore new ways for volunteers to support the workforce and expand existing schemes e.g. NHS cadets, T-Levels and companion reserves.

Digital

Digital Transformation is a key enabler in addressing system pressures and improving the way we deliver care, ensuring our highly skilled and trained professionals are able to focus on providing the best care possible and improving their productivity. Nationally, the NHS is focused on meeting the challenges of the future and is investing £2billion to support Digital Transformation. There are national frameworks to support us in our prioritisation of investment such ‘What Good Looks Like’ and ‘A Plan for Digital Health and Social Care’ policy paper which both explain the need for change and the expected results from any ICS digital transformation.

Our Digital Roadmap

Digital enablement is transforming health and social care services.

- Our roadmap will enable every member of staff to deliver and provide excellence in service.
- Every service user to receive the care expected of a world leading health and social care service We will work with our system portfolio, provider collaboratives and Place to realise the benefits of full digital enablement.

Approach

The Digital Roadmap has been developed collectively by system stakeholders and confirmed by our Digital Collaboration Forum.

- The strategy sets out how and where we prioritise our digital investment across the Integrated Care System.
- Seeks to create a culture whereby benefits are realised across the system from digital investments already made.
- Aims to provide a system approach for future digital investments, to realise improvements and deliver most benefit for care recipients and providers.
- Ensure health and care information is available to health and care professionals as and when they need it, regardless of their location and organisation.
- Defines the role of organisations and portfolios in this task and seeks to empower clinical leaders to find the best clinical models.
- Sets a timeframe and process for this work, recognising that the financial outlook is currently very uncertain.

Aim

The Digital Roadmap aims to empower our care providers and population to make the most of the benefits full digital enablement can deliver.

Outcomes

Our digital roadmap will help us to achieve outcomes that will improve the experience of our staff and population.

Our digital initiatives are aligned with national aims, local need, our collective ICS goals and ambitions.

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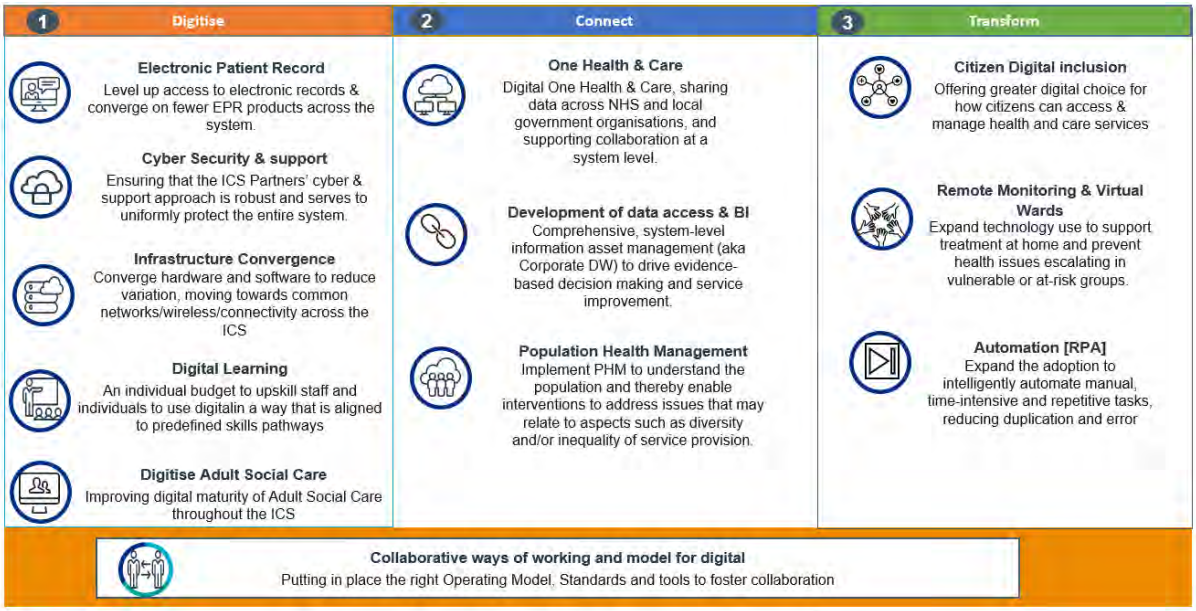

Estates

We are adopting an integrated approach to estate development, use and planning, working closely with workforce, finance, sustainability, Net Carbon Zero and digital to ensure our estate plans and solutions meet the needs of the growing local population and their healthcare needs including the needs of accessibility to services. Adopting this approach allows us to think differently, be innovative, and creates a unified and collaboratively produced approach for the development of our Estates Programme.

Our Estates Mission is to:

'Work together across provider boundaries to view our individual estate as part of a collective estate that is held and jointly reviewed for the benefit of patients and staff'

With an overarching vision to:

'Create a better utilised public estate which will drive efficiencies and in turn enhance the experience for the communities we serve.'

Our Charter

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Our Estates Strategy

The development of a system-wide Estates Strategy fully engages and secures commitment from across all system partners towards a common goal of One Public NHS Estate.

The Strategy will be built around four main pillars:

1. Leadership - With strong, stable leadership at all levels: in providers, in systems and amongst national partners that is centrally guided, yet locally defined and delivered.
2. Investment – Identifying clear and consistent capital priorities to enable the right investment in the right place.
3. Data, evidence, and information – Using data evidence driven approach to decision making and management of our assets to enable strategic decision making, effective use of resources and building the case for ongoing investment in the NHS estate. Underpinned by effective digital infrastructure to analyse timely, accurate estates data and having a deep understanding of estate user needs will provide clear evidence that will demonstrate the impact of investment on these needs.
4. People, skills, and capability - Ensuring the estates workforce is structured corrected and that they have the right skills, tools, and capability to operate effectively, as well as attracting people into our workforce with the knowledge and skills the NHS need and retaining. these skills within our workforce.

Our Estates Strategy has four main elements

1. Compliance is the test that our estate is safe and well managed and appropriate to our healthcare requirements and we give assurance that standards are met and adhered to.
2. Culture is key that we have the right approach to system working, the way we do things and the right values embedded in our people to deliver excellence in healthcare across our system, the understanding of our cultural paradigms and how we effect change.
3. Patient Experience is where we listen, engage and learn from the people and communities who use our services that we are doing what matters to them.
4. Economics is the management and processes and measures in place that our limited capital and revenue budgets for estate are appropriately targeted for best value inclusive of social benefit.

The strategy will deliver a focus on efficient use of estate while consistently demanding that estate decisions are collective decisions with clinicians so patient benefit and healthcare outcomes have both scrutiny and assurance of quality outcome and value for money.

Our ambitions

Each organisation in the system has a detailed estates plan. At a system level, we are seeking to consolidate on work done to date to release outdated and surplus assets, and to prepare to support and to enable the transformation of services. A pre-requisite of this is clarity of priority from clinical strategies. The local system faces on-going pressures to manage space utilisation, to meet both clinical and non-clinical requirements.

The ICS Estates Programme has developed a plan to support recovery, management and operation of an efficient, value for money, safe estate that supports clinical services and strategy; opportunities to achieve efficiency savings and reduced running costs and promote system resilience. The plan has three distinct areas of activity:

System savings through the release of voids and disposals

- To deliver cashable savings from identifiable surplus property assets and void space.
- Use of developer contributions (Section 106 and Community Infrastructure Levy)
- Manage and minimise voids recognising fixed and unavoidable costs such as Private Finance Initiative (PFI) and Community Health Partnerships (CHPs).
- To consider and deliver relocations to achieve more efficient use of space.

- Reduce duplication and obsolete estate whilst promoting flexibility and resilience; and promote better use of space through One Public Estate.

ICS System Transformation

- Develop a system-wide view of existing assets and financial flows, as a baseline
- Integration of services to drive efficiency and better patient care and experience and reduce estate footprint.
- Use of digital in estate utilisation and removal of poor estate.
- Focus on clinical priorities and healthcare outcomes that require estate development and focus on key strategic business case planning for central funding.
- System modelling of estate assets leading to removal of any surplus
- Accessible estate for all partners to support Carbon Net Zero inclusive of travel carbon footprint (linking with digital).

Primary Care Estate Management

- We are developing Clinical Plans and Strategic Estate Plans for each of the 25 PCNs.
- Secure funds through Section 106 submissions to support the development of new Primary Care infrastructure.
- Work with 9 Local Planning Authorities with regards to the Local Plans and new housing development.
- Work with public sector partners to make the best use of the public estate through the One Public Estate (OPE). We have collaborated with Councils to jointly deliver Primary Care infrastructure projects.

Sustainability

The wider determinants of health are a diverse range of social, economic and environmental factors which influence people's mental and physical health. As such, we view sustainability actions as part of our preventative health and wellbeing actions. Building on the wealth of good practice at the local organisational level and aligning with local plans and strategies, we work with all our partners to collaborate as an '**anchor system'** to use our assets for social, economic and environmental benefit. Operating as an anchor system, we will continue to develop but have an initial focus around:

- Environmental protection, tackling climate change and restoring nature are intrinsically linked to the health of our communities. Sustainability therefore not only supports the delivery of the JFP, but it also underpins its overarching needs. For instance, if the UK hits its climate change targets, we could save up to 144,000 lives per year through more active lifestyles, less vehicle pollution and healthier carbon friendly diets, thereby improving outcomes in population health and healthcare. These outcomes alone tackle an array of health issues we face including obesity, diabetes, CVD, respiratory disease, cancer and mental health and wellbeing.
- Placing a significant focus on the roles of education and training in the supply and retention of the workforce alongside the valuable role education provide as anchor organisations. Implementing and embedding the Journey to Work concept with our partners, communities, schools and colleges to build a robust offer of support to increase our pipeline, create opportunities for everyone and ensure our workforce represents our local population.
- Estates decisions which should benefit patient experience or outcomes, staff working conditions and be efficient for the healthcare and public sector system. Utilising all public estate in a functional and useful way is a necessity so the One Public Estate agenda is recognised and incorporated in our planning and thinking in how we maximise healthcare outcomes and return on public sector investment. Decisions will demonstrate the commitment to net carbon zero, social awareness and value for money.

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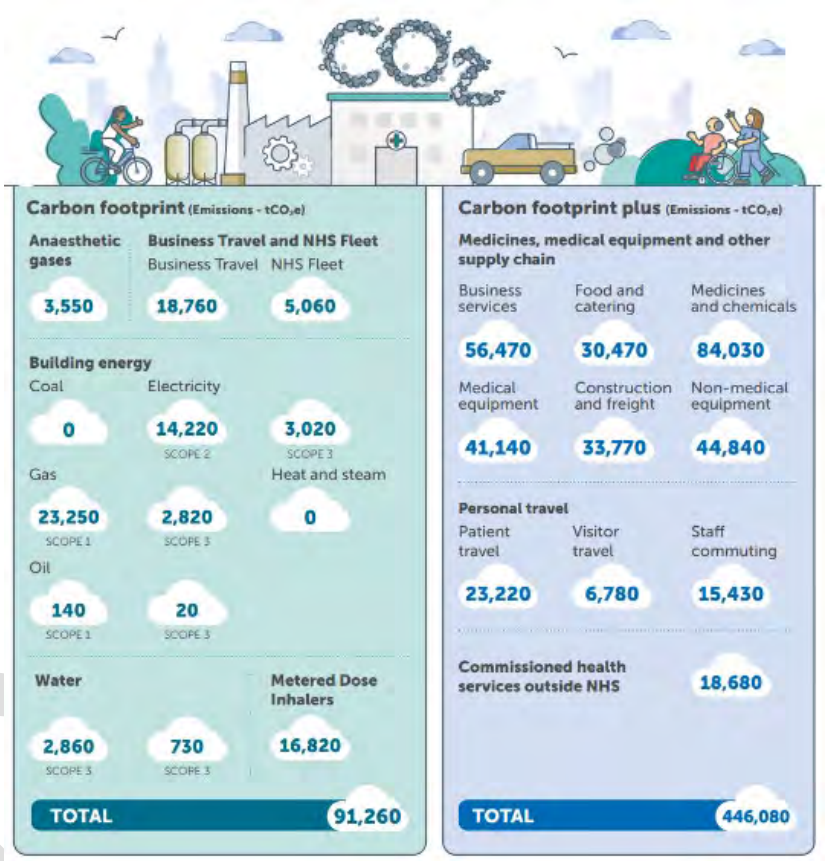
Delivering a Net Zero NHS

In October 2020, a new strategy, 'delivering a net zero National Health Service', was published by the greener NHS national programme. It outlines that "The climate emergency is a health emergency. Climate change threatens the foundations of good health, with direct and immediate consequences for our patients, the public and the NHS'. It explains that 'the situation is getting worse, with nine out of the 10 hottest years on record occurring in the last decade and almost 900 people killed by heatwaves in England in 2019. Without accelerated action there will be increases in the intensity of heatwaves, more frequent storms and flooding, and increased spread of infectious diseases …'

We believe that our green journey is important to all aspects of our plan including delivering benefits to our citizens and patients, our workforce and also our finances. The figure below outlines the ICS carbon footprint for 2019/20.



We have already started our green journey and are proud to have achieved a range of initiatives which have not only reduced our carbon footprint but also prompted behaviour changes which are important in moving forward in our delivery of a net zero health service.

Our green vision is to achieve net zero healthcare within Staffordshire and Stoke-on-Trent ICS, in line with the Greener NHS programme. We want to develop greener health and social care systems which strive to deliver high-quality services and improve the health and wellbeing of the population.

Our Green Plan for 2023-25 was agreed in Summer 2022 and details our sustainability goals. We have a Greener NHS Programme Group in place working with and supported by the NHSE Green Team. The Green Plan supports the four core purposes of the ICS re-iterating its importance to supporting the overall JFP. The actions outlined in the the Green Plan are aligned to the set of agreed delivery themes outlined below, the underpinning delivery plan outlines leads and timescales against each theme.

1. Leadership and System Governance - The key focus for this theme is to have a senior system approach that enables the Green Plan to be delivered. Senior leadership buy-in is imperative for the actions determined in this plan to be delivered. Sustainability needs to permeate through all decisions that are made to understand the long-term impacts of them on both the environment and local

communities. This theme would need to be delivered through a system-wide approach. For example, ICB job descriptions could include sustainability responsibilities in them. This could then be cascaded out to other organisations so it becomes a system requirement for all employees to consider sustainability within their role.

2. Energy Management - The key outcomes for this theme are to ensure there is a clear understanding of the system use of energy and how and where savings and efficiencies can be made. This theme would need to be delivered by individual organisations, due to specific contracts and abilities to make changes.
3. Workforce Development - The key outcomes for this theme is to ensure there is a workforce in place that is based on the right culture, behaviours and opportunities to adapt and change. This requires training opportunities so professionals can understand the implications of achieving net zero in their role and whether they need to make any changes in how they deliver their day-to-day work. This theme would need to be delivered through a system-wide approach. A framework for expected behaviours, across the ICS, should be produced, providing an expected way of working for all organisations across the ICS.
4. Community Impact - All decisions taken and services delivered by the ICB/ICS are done so for the benefit of the local communities which we serve. A decision on reducing travel will have a positive impact on the local community as the air pollution levels will decrease. It is vital that local communities are involved in these decision-making processes and this theme will ensure this takes place. The social value delivered through our services, and through our suppliers, is also paramount and must be considered as a part of the focus on reducing health inequalities. This is a theme that would need to be delivered as a system, although each organisation would need to ensure they included community focused activities in their processes.
5. Data analytics and baselining - This theme will give the ICS more visibility and a deeper understanding of the current picture. This theme will provide the data required to enable the next steps to take place by shifting the paradigm beyond data to move it to action, with a focus on local communities, employees and the impacts of decisions made. This theme will need to be led by individual organisations in the first instance. Individual data can then be collected and a system baseline can be developed over time.

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Our Finance Strategy

Our Commitment - Paul Brown, ICB Chief Finance Officer

Our system is collectively committed to delivering our financial duty of living within the financial resource made available to us and this commitment is set out within our Financial Strategy.

Our Financial Strategy is centred on our view that the optimum financial solutions come from the best clinical models. We enter the 5-year planning period with a high level of financial challenge, but with an explicit commitment by all partners to deliver a path to financial sustainability.

Our Financial Strategy describes a clear six-step plan, which has clinical and operational buy in, and we can already demonstrate successes in key areas. We recognise the need to make tough decisions and bare down on unwarranted variation and improve productivity.

Challenges and Opportunities

All partners across our system and nationally are facing financial pressures at the same time as we face further activity, workforce and financial challenges.

"All the organisations that make up the ICS face significant financial challenges at the present time. However, there is a marked commitment to address those challenges together, owning each other's positions and seeking the best possible shared outcomes. In particular, it has been great to see our finance teams working collaboratively on shared plans, including our approach to place-based working and integrated services."
Jon Rouse, Stoke-on-Trent City Director

"The joint efforts of the Stoke-on-Trent and Staffordshire ICB - local authorities and NHS commissioners and providers - address the significant financial challenges that we all face. I am particularly encouraged by the level of joint working by our commissioners and finance staffs to ensure excellent levels of care at best value for money".
John Henderson CB, Staffordshire County Council Chief Executive

As a system we need absolute focus on system transformation and efficiency. We will work together on system level responses to our financial challenges where needed, and not just within individual organisations. Much of the work done in how financial resources have been managed to date has been achieved through developing trusting relationships, understanding risks and opportunities and ensuring that actions were taken at organisational, place and system level as appropriate.

For further information see Appendix: Our Finance Strategy: Finance Governance and Controls

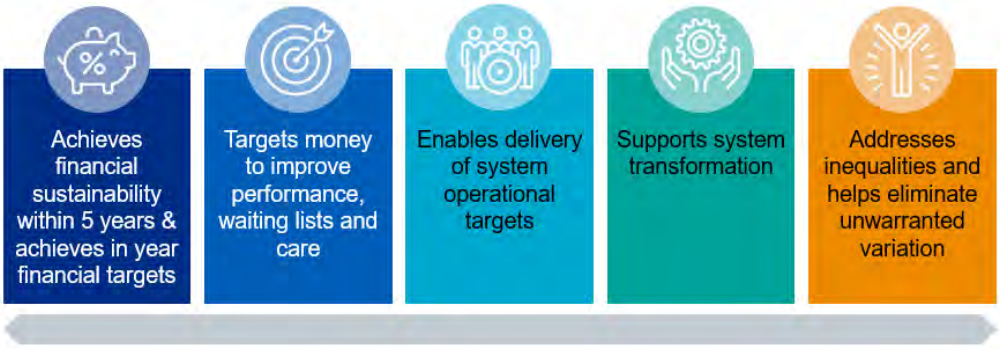
Our Finance Strategy

We have worked to a set of guiding values and behaviours which have ensured that decisions around our duty to break-even, how we allocate monies and manage financial risk have been made collectively together. We will continue to do this over the lifetime of this plan to ensure that we can use our resources to deliver the core purposes of an ICS in particular to 'enhance productivity and value for money'.

Our strategy

- sets out the approach to how we will use our resources.
- outlines a six-step plan to the delivery of financial sustainability.
- has been developed collectively by the Chief Finance Officers (CFOs) of the system.
- socialised widely with colleagues with clinical, operational, workforce, digital and strategic planning responsibilities.

The Finance Strategy looks to balance longer and shorter-term objectives. We need to keep the system in financial balance. We need to address the inequalities our population experience and we need to address the priorities for health. The strategy is centred on five principles and sets out a six-step plan to developing the mitigations to our underlying deficit of circa £160m.



The six-step plan recognises that in the 5-year period of this JFP, there will be little or no allocation growth, reflecting the national formula that assesses we are currently receiving more than our fair share of national resources. In this context we need to plan on the basis of no growth in staffing or capacity, and so we will need to address the demands for additional services through raises levels of productivity:

Productivity

The Financial Strategy recognised that 2023/24 would be extremely challenging and set a goal to continue to hold costs at current levels except for inflation, to collectively find alternatives to acute admission for urgent care and to improve productivity. As a system, the productivity challenge is sitting at the heart of our work to address not only the financial but also our workforce challenges and also reflecting impacts on our population. It is also one of the ambitions set out in the ICP Strategy to making best use of resources and targeting those in greatest need, or with greatest ability to benefit. "Doing less of the unnecessary" is a concept which is flowing through our work programmes and will support the delivery of our efficiency agenda but also feature in the delivery of our waiting times and activity throughputs.

A document "System Productivity Challenge" was shared at a number of our system-wide forums including our System Performance Group and used as part of the development of the strategy. Each operational portfolio has been tasked with focusing on the development of productivity opportunities as a key part of the operational plans. Productivity Improvement Plans will be developed which set out the projects and metrics against which we will monitor success.

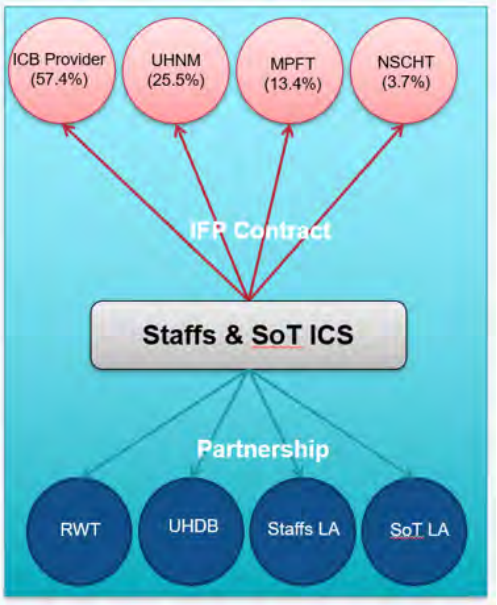
We submitted a balanced one-year financial plan in May 2023 for the 2023/24 financial year. We are now beginning the work to refresh the Financial Strategy, in line with the aims and objectives set out within this plan. It envisaged that this will be completed by the late Autumn and will set out the financial outlook for the next five years and how the system plans to address the financial challenge through a focus on cost control, maximising the resources allocated to the front line and maximising the productivity opportunity.

The Intelligent Fixed Payment (IFP) and how it works

There have been a number of demonstrable successes in how system resources have been managed. These have only been possible because of the partnership and collaborative ethos that has driven decision-making over this time. The System has introduced an IFP contract which binds together the NHS organisations around using our collective resources as efficiently and effectively as possible. The intention of the IFP model is to allocate the ICB revenue resource limit amongst NHS partners on a fair shares basis, which is complex set of assumptions that allows all partners back to financial balance at the same time given a similar effort. The IFP brings a true partnership to the management of resources within the system.

The Working Mechanics:

- Performance indicators will be monitored, as defined, however penalties will not be issued
- IFP 'base shares' (%) are derived from the 2021/22 exit 'net' underlying position.
- The baseline will be updated 'Tri-annually' unless CFO's collectively agree to revisit i.e. guidance change
- Earmarked funds will be excluded i.e. MHIS / Covid19 / SDF / ERF
- In year changes to IFP contract value are to be agreed via Finance & Performance Committee
- All changes to IFP should exclude overheads unless an additional marginal cost is incurred



We are proud to have been recognised by the Healthcare Financial Management Association (HFMA) as finance team of the year. This was the first time that the award went to a system rather than an individual provider. It demonstrates that the finance community is working collectively to ensure the best system solutions are chosen, rather than the organisationally focussed decision making of the past.

Capital Investment Plans

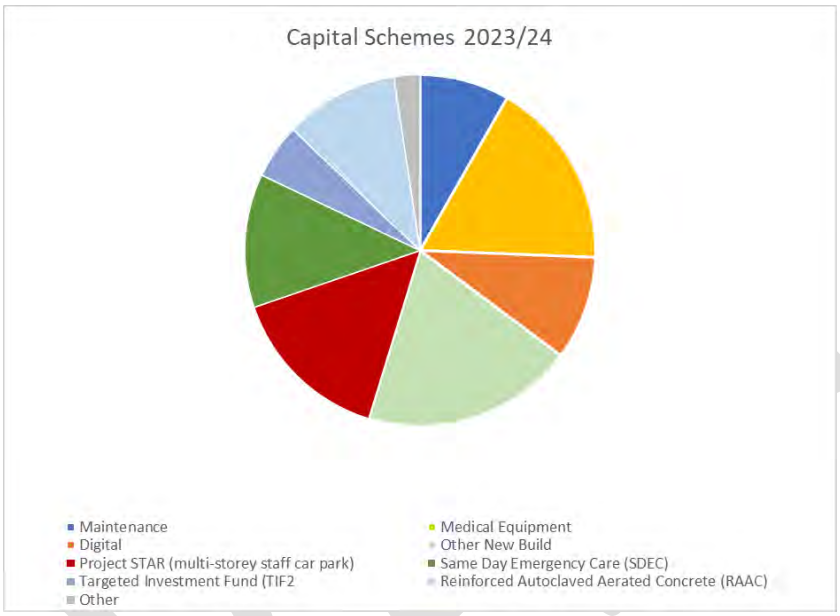
Under the Health and Care Act 2022 (the 2006 Act) Integrated Care Boards (ICBs) and partner NHS trusts and NHS Foundation Trusts are required to prepare joint capital resource use plans. The capital budget is for the construction of new buildings and the replacement of medical and other equipment. The plans are intended to ensure there is transparency for local residents, patients, NHS health workers and other NHS stakeholders on how the capital funding provided to ICBs is being prioritised and spent to achieve the ICB's strategic aims. This aligns with ICBs' financial duty to ensure that their allocated capital is not overspent and their obligation to report annually on their use of resources.

2023/24 is year 2 of the current 3-year capital plan. The plan has been developed to refresh the existing capital plans taking into account any slippage in timetables, the impact of inflation and any new anticipated public dividend capital. The capital schemes submitted within our system financial plan for 2023/24, including both internally funded and public dividend capital (PDC) funded schemes, total £95.6m. As per

previous years, maintenance medical equipment and digital schemes continue to be a driver behind our capital spend outside of new builds and large value individual schemes.

Nationally prioritised areas make up a large proportion of spend through multi-year schemes in reinforced autoclaved aerated concrete (RAAC) programme to replace potential collapsed ceilings and mental health wards to improve quality of dormitories, both schemes have national allocations through PDC that fall short of the total requirement but supplemented with internally funded resource. The largest internally funded program is project star, a multi-storey car park for staff use at Royal Stoke Hospital.

There are further system level priorities which are not reflected within the current capital plans and for which the system is seeking further capital resource, main schemes are community hubs in the north and Stoke-on-Trent community diagnostic centre.



Category	Value £m	%
Maintenance	7.9	8.26%
Medical Equipment	16.6	17.36%
Digital	9.2	9.57%
Other New Build	18.7	19.56%
Multi-storey staff car park (Project STAR)	14.4	15.01%
Same Day Emergency Care (SDEC)	11.8	12.29%
Targeted Investment Fund (TIF2)	4.8	5.02%
Reinforced Autoclaved Aerated Concrete (RAAC)	10.1	10.52%
Other	2.3	2.41%
Total	**95.6**	

Procurement

The ICB is responsible for shaping and designing most of the health and care services that local people need, then selecting the best organisations to run them. The process of specifying a service and identifying the appropriate organisation or organisations to deliver the service is called 'procurement'. The ICB follows strict processes to obtain best value for money and get the most out of taxpayers' investment in the NHS whilst ensuring transparency, fairness, non-discrimination, public good, integrity, open and fair competition.

The ICB procurement policy sets out our approach to all common procurement activities including the governance structure, standing financial instructions, and how we will fulfil our statutory obligations

including Public Contracts Regulations and support NHS-wide policies such as Greener NHS. In particular our policy drives broader social and economic development by ensuring all NHS procurements include a minimum 10% net zero & social value weighting and adhere to future requirements set out in the NHS Net Zero Supplier Roadmap. During the period of this JFP there will be annual procurement forward plans which will be aligned to each of our portfolios.

For further information see Appendix: Our Finance Strategy: Procurement.

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Personalised care

Personalised care means people have choice and control over the way their care is planned and delivered, based on 'what matters' to them and their individual strengths, needs and preferences. The NHS Long Term Plan places a commitment for ICBs and wider ICS partners to roll out personalised care to its population to enable individuals to have more choice and control over the way their care is planned and delivered. Choice plays a big factor in everyday life, and that should be no different when it comes to decisions about the care received for physical or mental health. To support the ICB Duty to promote involvement of each patient our aim is to offer personalised care to everyone throughout their lives. We want to support people to manage their health and wellbeing, rather than only diagnosing or treating illness or existing conditions that become more severe.

We will focus on

- development of a Personalised Care Strategy to embed the approach of the Comprehensive Model for Personalised care in existing portfolio areas, Provider Collaboratives and Place.
- the ongoing development of strengthened relationships between individuals and professionals across the health and care system.
- Promoting and offering personal health budgets.
- Increasing the number of personalised care support plans (PCSPs) for identified cohorts in line with the PCSP model.
- Delivery of increased referrals to social prescribing link workers (or other equivalent PCI trained professionals).
- Building the capacity and capability of our workforce to offer personalised care. We want our staff to involve people in decisions about their care, so that the decisions are right for the individual and people are better placed to manage their own health and wellbeing.
- Utilising a population health management approach to achieve better experience and outcomes for individuals that is based on what matters to people, individual circumstance, challenges and assets to enable everyone to have the opportunity to lead a healthy life.

As we deliver personalised care across the life course we will:

- work with people as equal partners
- empower people to self-manage in the community.

Better Care Fund and Integration Ambitions

To support the strategic planning and development of joint commissioning intentions across health and social care aligned to the delivery of the Better Care Fund (BCF) plans, the ICB jointly with both Staffordshire County Council and Stoke-on-Trent City Council, have developed Joint Commissioning Boards (JCB) that act as a sub-committee of the respective Staffordshire and Stoke-on-Trent Health and Wellbeing Boards. The aim of the JCBs is to continually promote collaborative, integrated and best practice working across the BCF and wider joint commissioning proposals and pathways.

The national Better Care Fund (BCF) programme supports local systems to successfully deliver the integration of health and social care in a way that supports person-centred care, sustainability and better outcomes for people and carers. The Better Care Fund (BCF) Policy Framework sets out the Government's priorities for 2023-25 and will support us with delivering against some of the challenges we have identified including improving discharge, reducing the pressure on Urgent and Emergency Care and social care, supporting intermediate care and unpaid carers.

We recognise the importance of ensuring our plan is right and that alongside other plans it delivers care, which is person-centred, coordinated and tailored to the needs of the individual, their carers and family. Partners are committed to working together to collectively address pressures in the system, to improve services and provide better joined up, holistic care and support.

The ICS operates in collaboration alongside local and neighbouring NHS organisations, local authorities, and voluntary, community and VCSE sector. The partners have a clear shared ambition to work with local people, communities, and staff to improve the health and wellbeing of individuals and to use their collective resources more effectively. Our ICP strategy also sets out as one of the 5ps the ambition to use integration to improve access to health and care services for all people and ensure improved co-ordination of care.

The focus for integration remains to identify and progress areas and pathways where both the ICB and Councils, as well as other partners, believe that there are clear opportunities to develop and implement specific, concrete proposals to improve outcomes and/or cost effectiveness. The ICS has already developed a set of actions for delivery, which are featured in some of our portfolio plans as detailed below. These form part of our BCF plans and how we intend to discharge our duties in relation to promoting integration.

- Improving outcomes in population health and health inequalities.
- Improving Urgent and Emergency Care and delivering more care at home.
- Timeliness and effectiveness of Discharge to Assess pathways, admission avoidance and improved patient experience and communications.
- Promoting healthy aging and managing frailty.
- Delivering more services through primary care to support system transformation.
- Growing and improving mental health services.
- Quality improvement in care homes, including improving the effectiveness of Enhanced Health in Care Homes, Identification of and support to deteriorating patients, technology and equipment in care homes and revised pathways to prevent unnecessary admissions to hospitals from care homes.
- Increased investment via the BCF in initiatives and services like Pathway 1 Rehabilitation, Reablement and Recovery, to support people to live safely and independently within their own homes for as long as possible and, where residents do require a spell in hospital, that this is as brief as is possible, supported to return to their own home or usual place of residence in a safe and timely manner with appropriate support as required to live as independently as possible.
- Enhanced support to the Adult Social Care market with investment of further monies to support the home care market in terms of recruitment and retention among other supports to build capacity in the market in light of continual demand for home care. This will be supported by enhancing the local authority enablement offer to support the market, providing short term support to individuals where required due to market capacity issues, to ensure that they are able to remain to live independently within their own home and minimise the need to admission into acute health services.
- Continued use of Disabled Facilities Grants (DFG) funding through schemes such as the Safe and Warm Homes, utilising capital funding to support residents and families on low incomes to access improvements to their home to keep them safe and warm. This will also help to ease fuel poverty in the city. Alongside of this is the continued development of the new Energy Advice Service to provide and maintain a free-to-access independent energy advice service to residents and agencies working in the city to assist households to keep warm, reduce fuel bills and maximise their income, with the aim of supporting people to remain within their own homes and reducing the need to access health and social care services during a period of spiralling cost of fuel and cost of living.

Clinical and Professional Leadership

The NHS Long Term Plan highlights the importance of visible senior clinical leadership in enabling and assuring the delivery of high-quality care both within organisations and within the new system architecture. We recognise the importance of clinical leadership being at the heart of how we will work differently. They bring a different perspective to team conversations and strategic decisions, the outcomes of which are then jointly owned. We are committed to ensuring that we have visible senior clinical leadership across the system and embedded in our portfolios.

We know that there are many Clinical and Professional leads doing great work. They have worked hard to offer care and provide services in difficult times. However, there are opportunities to modernise, improve services and transform the way in which we work which requires us to ensure that Clinical and professional leadership is central to our work. The national guidance 'building strong integrated care systems

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everywhere: ICS implementation guidance on effective clinical and professional leadership' identifies two expectations and five core principles for effective clinical and professional leadership.

We have used this opportunity to continue to develop a local clinical and professional framework and an underpinning culture that meets local needs and national requirements. We aim to put our talented and committed clinical and care professionals at the heart of our health and care services which allows them to influence our approach and be involved in decision making, whilst bringing their colleagues along with them.

Our CPL community will collectively work to **tackle unwarranted variation and health inequalities**. As CPL leads, there will be a particular focus around the delivery of the high-level system priorities and national objectives through a **focus on CVD, respiratory disease and cancer pathways.** For further information see Appendix: Cross Cutting Themes: Clinical and Professional Leads (CPL) Focus

In addition, our Health and Care Senate provides leadership and expertise into programmes of work, each of our portfolios has an aligned Clinical Director. The senate at the system level and the health and care assemblies at place level were established in 2021/22 to support work across the ICS.

Working in Partnership with People and Communities

As we have moved to a new way of working as an ICS this has given us a unique opportunity to reset our relationship with people and communities, to one where people are treated as active partners in their own health and wellbeing rather than passive recipients of services.

Working together we are in a stronger position to achieve the four key aims of aims of an ICS by engaging with our population to understand barriers and opportunities and using that insight to collaboratively build social assets and services that will help to tackle inequalities, improve outcomes in population health and enhance productivity and value for money.

Understanding the views of local people will help us to explore ideas such as the smarter use of technology, providing care in different settings closer to home, and looking for new ways to reduce health inequalities. We have a strong foundation to build on, but we know we need to continually look for new ways to strengthen our networks and adapt our communications, engagement, and operational delivery – to enhance our understanding of the needs of our diverse population.

Our Working with People and Communities Strategy recognises and values the benefits of a community-focussed approach and builds on established relationships and best practice already being delivered by partners and communities. It is shaped by a co-produced set of principles that reflects how people have told us they would like to be engaged to empower them to become active participants in their own health and wellbeing. Our strategy supports the duty to involve people and communities in our decisions and any service changes.

Our People and Communities Assembly helps to shape and assure the ICB and its partners on our approach to working with people and communities and continually monitor diversity and inclusivity to ensure greater input by people who experience the greatest inequalities. Involvement activity will use a range of techniques, both online and in person, but more importantly will be tailored to meet the different needs of our population.

The Assembly will advise the ICB on how best to meet its legal duties to involve, acting as a critical friend, but also holding the ICB to account. It will also help to review and update our working with people and communities' strategy.

Assurance around working with people and communities is provided to the ICB Board via the Quality and Safety Committee and our Non-Executive Chair is responsible for championing the public voice as well as promoting our work on health inequalities, public engagement, and insight. A system-wide Communications and Engagement group, with representation from partners, supports a strategic

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approach to joint activity wherever possible as well as identifying opportunities to optimise resources and develop our collective effectiveness around community engagement.

Our Strategic Transformation and Service Change Programmes

There is no formal definition of 'substantial' service change, but this usually involves a change to the range of services available and/or the geographical location from which services are delivered. Service reconfiguration and service decommissioning are types of service change. Reconfiguration can be small-scale (for example, changing the location of a routine diagnostic test) or large-scale (for example, merging two hospitals across a city at two sites, to one larger city centre hospital). In addition to our operational transformation, we have a number of strategic transformation programmes where there may be a number of potential options available to provide healthcare in a different way. Our approach supports the duty to involve people and communities in our decisions and any service changes. about the planning, development and operation of services commissioned and provided.

Our 7 portfolios are supported by our Strategic Transformation function to support the options appraisal process and to ensure that business cases stand up to the rigour of the NHSE assurance process.

The table below summarises the key areas of focus.

Programme and portfolio
Inpatient mental health services (IMHS) *Mental Health, Learning Disabilities and Autism portfolio*
Urgent and emergency care (urgent treatment centre designation) *Urgent and Emergency Care (UEC) portfolio*
Cannock transformation programme *Primary Care, UEC, Planned Care portfolios*
Maternity *Children and Young People and Maternity portfolio*
Community Diagnostic Centres (CDCs) *Planned Care portfolio*
Assisted Conception *Planned Care portfolio*

Voluntary Community and Social Enterprises (VCSE)

We recognise the invaluable role that the VCSE organisations can play to support us in proactively reaching out and involving seldom-heard groups such as deprived communities, children and young people, ethnic minority communities, as well as those with disabilities, sensory impairments, the homeless and travelling communities.

The VCSE Healthy Communities Alliance brings together VCSE organisations to engage with statutory health and care organisations so that they can:

- Have a strong collective voice for the role of the VCSE sector.
- Inform, engage, consult, and empower one another in relevant health & care structures, relationships, policy and practice.
- Bring VCSE sector knowledge, skills, and expertise to address health inequalities.
- Increase the role and influence of the VCSE sector in ICS strategic thinking and decision making.
- Network with one another, develop contacts, share information and best practice.
- Develop working relationships between organisations and across sectors.

The Alliance aims to increase health equity of our communities through community-based approaches, and to support the health and care agenda in its broadest sense.

The Memorandum of Understanding MoU) between the Alliance and the ICB has been signed off and outlines a set of shared values and associated behaviours which underpin the partnership and reflects four agreed priorities. There are four key areas on which the ICB and the Alliance agree to focus their initial collaborative work. Each will be progressed through an agreed ICS portfolio or enabling programme

1. Prevention and Social prescribing
2. Volunteering
3. Procurement
4. Communications and Engagement

During the pandemic, we established a Communities2gether forum to focus on the needs of seldom-heard groups. Representatives from equality and health inclusion groups come together to shape and develop resources that can be shared via their own communication channels to spread the key messages. Although initially the focus was on communications around COVID-19, and the vaccine in particular, the group is now being used to advise on a range of topics of community interest. The group continues to support our equality work around the COVID-19 vaccination, with community leaders being uniquely placed to work with some of our target groups.

Case Study from Support Staffordshire: The Diabetes Picture Staffordshire

Background

- ✓ The East Staffordshire & Surrounds Diabetes UK Patient Network (ESSDUKPN) was originally focused geographically in Burton-on-Trent, Staffordshire. Local groups fundraised for Diabetes UK nationally and for local awareness raising. Over time, many groups in Staffordshire stopped functioning, particularly due to pandemic.
- ✓ ESSDUKPN are experts by experience, advocates for patients and critical friends of partners and are forthright in their criticism and commentary on local services. With no active groups in Lichfield District or Tamworth, ESSDUKPN expanded and began to support more people over a wider area. They had strong links with district patient groups and now with the ICB, sitting also on the North Staffs Diabetes Clinical group.
- ✓ Representatives of ESSDUKPN joined the Southeast Staffordshire VCSE Alliance. Alliance partners (MPUFT, PCNs, Staffordshire County Council) have a keen interest in improving the support for people living with Diabetes, which was a priority for the partnership which was successful in securing National Lottery Community Funding for a 3-year Healthy Communities project across the Southeast of Staffordshire.

Support Staffordshire Intervention

- ✓ This funding increased the capacity of Support Staffordshire Community and Development Officer and grant support for ESSDUKPN to increase their sustainability, scope, reach and impact. Through a round of funding from CCG underspend and continuation funding via the National Lottery Community Fund, the group have over 2 years of income to support their activities. While there is huge demand for support for people in communities the growth of the group needs to be sustainable.
- ✓ In Burton, one of the aims of ESSDUKPN is to reach into the various multi-cultural communities who have traditionally been seldom heard or participated in previous groups. Where this has been challenging, Support Staffordshire are supporting different approaches and ways of working to achieve this aim.
- ✓ They continue to run a popular online support group (attended by people outside of and elsewhere in Staffordshire) and with this extra capacity and resources, Support Staffordshire have worked with them to roll out new, in person support group meetings in Uttoxeter, Burton, Lichfield, Burntwood and Tamworth.
- ✓ “We would not be in this situation without Support Staffordshire. It has been invaluable to attend Locality meetings and access their other networks. They help getting our name out and about and we are now receiving referrals and contacts with people directly, to join the new groups and access our support”. John Bridges, Chair ESSDUKPN

Difference being made

- ✓ ESSDUKPN can now work comfortably in partnership with larger VCSE organisations to make the most of their reach, including Burton Albion Community Trust, Community Together and MHA Communities across the Southeast of Staffordshire. This includes partnering with MPUFT and some of those organisations on new community based Ambulatory Care Foot Clinics in Burntwood and Tamworth. They work with Staffordshire County Council Public Health on pre-Diabetes information and awareness.

Case Study from VAST: Stoke-on-Trent Community Health Champions

- ✓ The Community Health Champions project in Stoke-on-Trent has a network of over 200 Volunteer Champions representing the diverse communities in the city. Champions are trained and supported to share clear information on health-related matters with family, friends, colleagues and their local community with an overarching aim of improving health and wellbeing across the city.
- ✓ The network includes representatives from over 75 local VCSE sector organisations and partners across the city and this reach means the project can identify concerns within local communities and provide advice and information through trusted local people, enabling better engagement with health messaging.
- ✓ A recent example of the way the project supports ICS colleagues to reach diverse communities includes supporting UHNM's Health Improvement Practitioners from the Breast Care & Screening Team to reach out to women who were not engaging with their service. They recognised women were experiencing language and other cultural barriers preventing them from accessing advice and support so, through the Community Healthy Champions (CHC) network, VAST facilitated a meeting with ladies from the Sudanese Community.
- ✓ Working with the Sudanese Community organisation the CHC team identified that the information session would need to take place in familiar surroundings and provided practical support including a projector to enable this. The CHC team worked with them to identify members within the group who could provide translation and facilitate the learning and the session was a great success with 18 ladies informed and empowered to share their learning with others in their community.
- ✓ The Community Health Champions project works effectively across the ICS bringing statutory partners together to support local communities. A recent Community Health Champions event enabled partners from Stoke-on-Trent City Council's Public Health team, along with colleagues from MPUFT's 0-19 Hub Team, to share information on their support for children and families with Champions with a reach to approximately 485 families each week.

Intelligence

The purpose of an intelligence function is to ensure that the decisions we make are routinely informed by a range of data, evidence and knowledge. It should support all aspects of our work – from a really great understanding of the needs of our population and how they access our services, through to identifying where we have unwarranted variation in our service offers and health inequalities.

The COVID-19 pandemic has demonstrated the importance of the ability to draw upon the right intelligence at the right time. This encompassed a multi-disciplinary approach with analytical teams working seamlessly with digital and information technology, information governance, finance, people/workforce, service redesign, quality improvement, clinical, and public health and other local authority teams. This would not have been possible without intelligence and analytical collaboration between the NHS, local authorities and wider system partners.

We now want to build on the developments made over the last three years and harness the knowledge and insight of our broadest range of partners to deliver a virtual intelligence network which maximises the information and insight available to our operational teams.

Our Vision is 'To create an analytical resource to support improvements in the health and wellbeing of people in Staffordshire and Stoke on Trent by providing usable intelligence to help partners make better decisions, improving service pathways and system efficiency and helping deliver better patient outcomes.'

We will co-develop an intelligence function with partners which will and enable us to maximise the utility and value of our data and ensure that intelligence from data informs decisions on prioritisation, change, and operational planning. This will empower and enable the ICS to realise the true value of data and analytics at all levels of the system.

As a system we are committed to developing a system-wide intelligence strategy by Summer 2023 and will engage broadest range of partners to do this. Key to this strategy will be:

- Effective collaborative networking across our teams, sharing skills and expertise to deliver for the system
- Doing it once and well [to relieve reporting pressures]
- Breaking down unnecessary barriers to data sharing and supporting cross system information governance processes to enable the Intelligence Function to operate effectively and lawfully.
- A system-wide development programme for our analysts
- Exploration of new ways of accessing and sharing data, exploiting opportunities to work across boundaries to join up data and expand our insights on the drivers of health.
- Supporting delivery of the digital roadmap "to connect" and development of data access and Business Intelligence (BI)

Our commitment to system working to realise the potential of data and intelligence has the potential to transform the way in which we operate to better serve our communities' health and social care needs. Our approach will support our portfolios with their strategic thinking.

Research and Innovation

Our ambition is to build a culture of research and innovation across our ICS that is responsive to those in most need in the communities that it serves. We are ambitious in our plans to support collaborative research, to attract and retain high calibre, motivated and innovative staff to support best care in our regions.

To deliver our ambition we will continue to build on our considerable strengths in research and innovation in our region. We are part of the Staffordshire and Shropshire Health and Care Research Partnership (SSHERPa) whose ambition is to enhance the opportunities for collaborative research working with our neighbouring ICS (Shropshire, Telford and Wrekin). The SSHERPa partnership brings together our local Higher Education Institutions (Keele and Staffordshire Universities), NHS providers, Local Authorities, Voluntary and Community Sector Networks, National Institute for Health and Care Research (NIHR) Clinical Research Network West Midlands and West Midlands Academic Health Science Network. Building and strengthening these partnerships gives opportunities to identify and develop ideas, and apply for funding to support research and innovation, at a system wide level.

Individual partners within the ICS have a strong track record of delivering and collaborating on research and innovation. We have a multi-disciplinary collaborative research partnership, which will develop and deliver high quality research that improves the health and well-being of our communities, ensuring that health and care commissioning and service provision is evidenced based and underpinned by research and innovation. It is widely recognized that organisations with a reputation for providing excellence in research attract and retain high quality staff and achieve better patient outcomes. Through the SSHERPa partnership approach we will reduce competition in research, reduce duplication, maximize our research opportunities, and expand the opportunities for our local population and health and care staff to become engaged and involved in research. We will take an evidence-based approach to service transformation working through our portfolios to bring knowledge to clinical and operational partners involved in service transformation work.

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We are currently drafting our Research and Innovation Strategy which outlines in further detail our vision and objectives. Our vision is to support evidence-based health and care transformation, driving best health and care for our communities through excellence in research. We will achieve this vision by delivering against the following core objectives:

1. Developing collaborative integrated research addressing the health and care priorities of our region, expanding the range and diversity of research undertaken in our region.
2. Fostering a culture of collaborative research and innovation with strong leadership championing the strategy.
3. Developing the capacity and capability for evidence-based health and care.
4. Increasing the opportunity for our region's population to engage in research and for our communities to identify and shape health and care research needs.
5. Developing a collaborative infrastructure for research and innovation in our region to reduce duplication; support and grow an increased research portfolio.
6. Supporting the implementation of best evidence into practice – commissioning and provision of services.

Our strategic objectives provide the framework for how we will achieve our vision and realise our principles through:			
Workforce Development Championing a research culture where everyone is valued able to contribute to, and benefit from, research. Developing innovative career pathways, embedding research into health and care professional roles. Sharing knowledge and expertise, developing research professional roles across the partnership.	**People, Places & Communities** Creating opportunities for inclusive research across diverse communities. Enhancing the opportunity for people to shape research, reducing health inequalities across our diverse urban & rural geography. Enhancing the opportunities to engage in research – championing the people and teams that support this. Developing infrastructure that supports wider engagement in research.	**Impact** Creating an eco-system where research outputs can be rapidly adopted into practice/policy. Developing co-production strategies that support the mobilisation of knowledge. Transforming health and care through high quality research Supporting sustainability through new approaches to health and care research delivery Supporting economic development through income generation	**Innovation** Working with business and commercial partners, facilitating deeper partnerships and securing co-investment. Connecting research and innovation. Accelerating translation, commercialisation and knowledge exchange.
Examples to bring the above to life: Our region has supported innovative career pathways for healthcare practitioners. For primary care we have developed clinical academic career routes for General Practitioners (Keele University/Primary Care), and partners continue to develop integrated career opportunities that embed evidence into clinical decision making (e.g., clinical academic physiotherapists (MPUFT/Keele), evidence based practice groups for GP nurses, physiotherapists). As a Trust securing University Hospital status, MPUFT continue to develop these opportunities for social workers, nurses. MPUFT have also developed the regional training programme for research and innovation	**Examples to bring the above to life** SSHERPa secured NHS England Research Engagement Network Development funding to proactively build the research and innovations networks within under-served communities. Working with our VCSE network partners, we have developed research champions in these communities and established a research engagement network lead for the VCS communities. We also delivered the NHS England Touchpoints project - testing ways in which the NIHR 'Be Part of Research' research volunteer registry can be promoted to the general public.	**Examples to bring the above to life** Supporting economic development through income generation - over the last 10 years of partnership working our localities have drawn in over £50million of research income, driving best care and health for our regions. Since our inception in 2022, SSHERPa has brought in over £250k to support the development of our research and innovation networks. Working with partners we ensure research outputs are proactively adopted into practice (example of Keele's Impact Accelerator Unit working with the ICS MSK Transformation group).	**Examples to bring the above to life** Working with our partners, particularly Keele and Staffordshire Universities and West Midlands AHSN, we have supported the development and delivery of initiatives to support subject matter experts to bring innovation to the health care market (e.g., Business Bridge - Keele University). Working with WM AHSN we seek to develop proposals to schemes such as UKRI and SBRI to support the development, translation and commercialisation of innovations that address our local health needs (example of 2023 Drug Death Challenge - SBRI - MPFT: NHS X proposal developing Self Back App). North

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open to all partners (STARS - Supporting the Advancement of Research Skills). UHNM have developed the Centre for NMAHP Research & Education Excellence) to proactively support research across their workforce.			Staffordshire Combined Healthcare NHS Trust's Innovation Nation annually celebrates local innovations developed by staff that address ICS priorities.
Supported by high quality research, empowering all to engage, improving outcomes through partnership and leadership			

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System Development Overview

We will continue to work with local partners to strengthen integration, how we work together, and decision-making. The establishment of our system portfolios leadership model has started the ball rolling. The ongoing organisational development of the portfolios will be a key factor during 2023 to ensure that they are established and recognised ways of working at system and place level.

During 2022 the ICS commenced on the Place and design process through the Staffordshire Executive Group and Stoke-on-Trent Executive Group respectively, work will progress through 2023/24 on the governance arrangements, place leadership and identification of functions to delegate to Place.

In January 2023 the ICB signed Memorandum of Understanding (MOU) with the Voluntary, Community and Social Enterprise (VCSE) Alliance; through this MOU there is recognition the collaboration benefits of all partners and beneficiaries. The Integrated Care Board is committed to working with our VCSE partners to support the development of the Alliance and to effectively embed the Alliance in the ICS architecture.

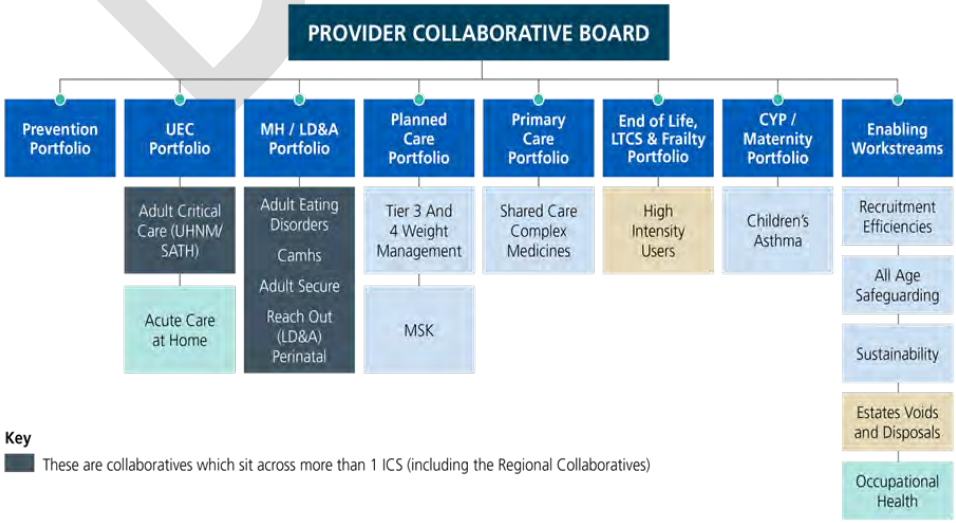
We will create a culture and system to ensure effective cross sector collaboration, a shared understanding of each sector activity, drivers and perspectives to build successful and strong relationships and remove barriers.

As the wider ICP develops so too will our system approach to people and communities. We will continue to review our approach and how we work in partnership with people and communities.

Provider Collaboratives

The Health and Care Act 2022 established a duty for collaborative delivery. The key pillars of system, places, and provider collaboratives offer opportunities to improve mental and physical health care and reduce fragmentation and gaps in existing pathways.

Collaboration between providers in and outside of our system has always taken place and we have a good track record of effectively working in partnership. As part of the ongoing development of the provider collaborative approach we will continue to focus on working at scale to properly address unwarranted variation and inequality in access, experience and outcomes across wider populations. We have collaborations that sit across the ICS and outside, working with Regional Collaboratives particularly in relation to Adult Critical Care and Mental Health and Learning Disabilities and Autism (LDA) programmes.



This work will help us to improve resilience in our services and ensure that specialisation and consolidation occur where this will provide better outcomes and value. We will work alongside our system portfolios, Place and enabling workstreams to identify further opportunities to collaborate whilst mobilising our collaboratives in development.

Place Development

Both local authorities shared their visioning papers based on the Integration White Paper. The ICB is developing a bridging document identifying areas of alignment and difference, and the ICB proposals bringing the paper together for one overarching view, to be presented to Chief Executive Officers (CEOs) for discussion and agreement in mid-September. Programme governance for the development of Place has been agreed by all partners.

Future developments for the Place model include:

- A full review of the Better Care Funds will be carried out to support further areas of integration with the aim of transparency across aligned services in year one to support discussions re full integration.
- Continuing to work with Staffordshire County Council to determine and define the roles of the Districts and Borough Councils in the Place arrangements.
- Developing formal agreements for working across Place where needed – e.g., standardising discharge processes to ensure consistent model
- Development of governance to continue to provide system oversight to Place
- An emerging difference in approach to Place between the local authorities continues to be discussed and developed to ensure that the Place offer is consistent for our population recognising local need wherever possible.

Neighbourhood

Neighbourhoods are the vehicle to drive forward meaningful, holistic discussions with our communities relating directly to proactive and preventative services and indirectly to system level service developments. Place-based approaches in our local neighbourhoods have a key role in fostering links with people and communities to empower them to build healthy supportive and thriving neighbourhoods. We will develop our approach with our partners about how we work in partnership with people and communities. The approach will cover a range of assets such as:

- District and borough councils as local housing and planning leads
- Health, Public Health and Social Care
- Local enterprise partnerships and economic development forums
- Schools and educational/early years establishments
- VCSE including faith groups
- Primary Care Networks
- Universities

Led by the community, supported by all of the organisations in our Integrated Care Partnership and built together, we will jointly need to define “what” we want to achieve at neighbourhood level with the “how” developed together.

Delegation of direct commissioning functions in 2023 and Specialised Commissioning

Historically responsibility for commissioning different elements of patient pathways can sit with different organisations both nationally and locally. By integrating the commissioning of services with ICBs wider commissioning responsibilities where appropriate, ICBs will be the commissioner for the primary, community, secondary and tertiary elements of pathways for their population, enabling them to design

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care that joins up around population needs, and invest resources where they can have best effect on outcomes.

The Health & Care Act 2022 set out the transition on the commissioning of Primary Care services and some specialised services from NHSE to the ICBs. The aims of the transition are to break down barriers and join up fragmented pathways to deliver better health and care so that our population can receive high quality services that are planned and resourced where people need it.

The primary care services that will be delegated to ICBs from 1st April 2023 are on track for transition and cover:

- Primary Pharmacy
- Optometry
- Dental Services

The services that will be delegated will be woven into the work of the Primary Care portfolio.

NHS England (NHSE) will delegate responsibility to all ICBs/multi-ICBs for specialised services that have been identified as suitable and ready for further integration subject to system readiness.

We will deliver on our plans for formal delegation of functions from NHSE and from 2023/24 onwards the ICB will continue collaboratively working with West Midlands ICBs on specialised commissioning arrangements. A Delegated Commissioning Group has been established to coordinate all activity relating to the delegations and this will continue to meet throughout 2023/24 to help address any post-delegation issues.

Specialised services support people with a range of rare and complex conditions. They often involve treatments provided to patients with rare cancers, genetic disorders or complex medical or surgical conditions. They deliver cutting- edge care and are a catalyst for innovation, supporting pioneering clinical practice in the NHS. Although ICBs have assumed responsibility for commissioning most NHS services, responsibility for some, often low-volume, high-cost, services and drugs currently remains with NHSE. NHSE has stated that specialised commissioning functions and budgets for some specialised services will be delegated from NHSE to ICBs.

Commissioning and financial responsibility for their respective populations have been delegated individually to each ICB to determine how best to manage these services. The readiness of ICBs to take on delegated responsibility for specialised commissioning functions is being assessed through responses to a series of questions within a Pre-Delegation Assessment Framework (PDAF). ICBs have submitted a completed assessment proforma to NHSE.

Pan system working

The 6 ICBs in the West Midlands are collaborating to establish an Office of the West Midlands. We have jointly agreed that Birmingham and Solihull (BSOL) ICB will be the host for staff performing these functions for West Midlands with responsibility from 01 April 2023 and staff transferring from July 2023. From April 2024 BSOL will also be the host for the Midlands team supporting all 11 ICBs for the delegated specialised commissioning portfolio.

The Vision for the Office of the West Midlands (WM) is:

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

The Core purpose is:

- To commission a set of agreed functions at a West Midlands level on behalf of 6 ICBs through shared leadership and joint decision making

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

The areas that ICBs have jointly identified for collaborative working in year one are:

- To manage the mobilisation and commissioning of delegated functions from NHS England (NHSE) with regard to Direct commissioning e.g., Pharmacy, Optometry & Dentistry (from 2023) and a subset of specialised services (from 2024).
- To agree a West Midlands work programme for the ICBs were working together would add value and benefit for the population and the systems (next slide)
- To jointly consider other functions and services that NHSE may be reviewing for either delegation or transfer of hosting responsibility as part of their future design.

The Office of the West Midlands will be a servant of the 6 ICBs working to a distributed leadership model with each ICB taking a lead on defined annual programme of joint work.

The agreed joint programmes of work are as follows:

Project/Programme	Distributed leadership
[Delegated functions] Pharmacy, Ophthalmology, Dentistry, General Medical Advice and Support Team (GMaST), Complaints	Simon Trickett, Hereford and Worcester ICB
Operating Model Development. Collaboratives	Phil Johns, Coventry and Warwickshire ICB
Integrated Staff Hub OWM hosting Specialised Commissioning	David Melbourne, Birmingham and Solihull ICB
Commissioning Support Unit review	Simon Whitehouse, Shropshire, Telford and Wrekin ICB
111/999 (BC ICB lead Commissioner) Closer working with WM Combined Authority	Mark Axcell, Black Country ICB
Immunisations and Vaccinations	Peter Axon, Staffordshire and Stoke on Trent ICB

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