2023/24 Operational Plan

Foreword

Our role as an Integrated Care Board (ICB) is to help bring partners together to integrate our approach to improving health and care services for our local population. We have made positive strides towards that goal this year, but there is much more to do. This Operational Plan for 2023/24 marks another step towards that aspiration of an integrated working environment where the focus of us all is on the best health and social care for our residents.

The document sets out our key priorities as a system for 2023/24 and how we will measure our success. The document aims to draw out key actions from across the system, delivered through the Portfolio structure we have created. The plan does not duplicate issues that are covered within the business plans of NHS providers, local authorities or other partners: instead it aims to distil the key system level actions that are planned for this year.

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 Integrated Care System (ICS) have agreed to adopt the System Leadership Compact which is outlined further in this document. These behaviours have supported the development of this plan, and I am grateful to my CEO colleagues and their teams for the way that they have engaged in the development of this first system plan.

Working with all our partners across the system, we want to improve the lives of people living across Staffordshire and Stoke-on-Trent now and in the future. We want to do this while restoring inclusively our services to pre-COVID levels, eliminating long waits to access services, and reducing unwarranted variation in our services. Alongside this, we will work to embed service changes which have proved beneficial to our people and communities – including our populations at neighbourhood level. 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.

The context for this plan is a very challenging financial and operating environment. The plan sets out a collective goal and priorities agreed in February by the executive teams of all statutory organisations. It describes the need to come together behind two significant system initiatives over the year, which will help us address the significant underlying financial challenge.

Collectively we need to come together to meet this challenge, and keep the system in a sustainable financial position which will enable our work to enhance the quality and sustainability of our services.

Peter Axon
ICB Chief Executive Officer

System Leadership Compact

Trust

- We will be **dependable**: we will do what we say we will do and when we can't, we will explain to others why not
- We will act with **integrity** and **consistency**, working in the interests of the population that we serve
- We will be willing to take a **leap of faith** because we trust that partners will support us when we are in a more exposed position.

Courage

- We will be **ambitious** and willing to **do something different** to improve health and care for the local population
- We will be willing to make **difficult decisions** and take proportionate risks for the benefit of the population
- We will be open to **changing course** if required
- We will **speak out** about inappropriate behaviour that goes against our compact.

Openness and Honesty

- We will be **open** and **honest** about what we can and cannot do
- We will create a **psychologically safe environment** where people feel that they can raise thoughts and concerns without fear of negative consequences
- Where there is disagreement, we will be prepared to **concede** a little to reach a consensus.

Leading by Example

- We will **lead with conviction** and be ambassadors of our shared ICS vision
- We will be committed to **playing our part** in delivering the ICS vision
- We will live our **shared values** and agreed leadership behaviours
- We will positively promote **collaborative working** across our organisations.

Respect

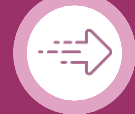
- We will be **inclusive** and encourage all partners to contribute and express their opinions
- We will **listen actively** to others, without jumping to conclusions based on assumptions
- We will take the time to **understand** others' points of view and **empathise** with their position
- We will respect and uphold **collective decisions** made.

Kindness and Compassion

- We will show **kindness**, **empathy** and **understanding** towards others
- We will **speak kindly** of each other
- We will support each other and seek to solve problems **collectively**
- We will challenge each other **constructively** and with **compassion.**

System First

- We will put **organisational loyalty and imperatives** to one side for the benefit of the population we serve
- We will spend the Staffordshire and Stoke-on-Trent pound **together** and **once**
- We will develop, agree and uphold a **collective** and **consistent** narrative
- We will present a **united front** to regulators.



Looking Forward

- We will focus on **what is possible** going forwards, and not allow the past to dictate the future
- We will be **open-minded** and willing to consider new ideas and suggestions
- We will show a willingness to **change the status quo** and demonstrate a positive 'can do' attitude
- We will be open to **conflict resolution.**

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The purpose of the one-year Operational Plan 2023/24

- The purpose of this plan is to summarise national and system priorities, and how we will deliver them across ICB delivery and enabling portfolios, providers and partners
- We have worked in partnership across the system to co-produce this one-year operational plan for 2023/24
- This one-year operational Plan reflects national and system priorities and builds on the Integrated Care Partnership (ICP) Strategy, the Health and Wellbeing Strategies, wider partner strategies and plans that focus on our local population
- It forms the first year of the Joint Forward Plan and acts as a delivery mechanism for the ICP Strategy
- The actions outlined in this document have been developed at a point in time, and are based on a range of current assumptions
- This is a working document that we will use throughout the year. It will allow us to track progress and to hold one another to account
- This plan and the how, is underpinned by a more detailed outline of deliverables across each quarter. The underlying high level detail for each portfolio is available from each lead.
- The document and the underlying detail categorises deliverables so that it is clear where the responsibility for delivery sits – at System, Provider, Place, Primary Care Network (PCN) or Portfolio. This enables appropriate governance for decision making and to monitor delivery. Specific actions and metrics are part of the plan and the System Performance Group will allow executives to stay on top of the detail and System Finance and Performance Committee will scrutinise progress.

Key achievements in 2022/23

Over 2022/23, we built on our system-first approach to the leadership of our system. There have been many successes where we were able to make much more progress working collectively – that would have been impossible working in single organisations. These include:

- System Chief Operating Officers (COOs) led the system through a very challenging winter period and maintained services despite disruption due to industrial action. We ended the year in a much stronger place within our urgent and emergency care (UEC) pathways and ambulance waits, although clearly we still have a long way to go.
- System Chief Finance Officers (CFOs) led the system to delivering the third consecutive year of financial balance with all organisations achieving financial balance. CFOs worked as a team to collectively manage risk and to develop a medium-term Financial Strategy focussed on addressing the underlying deficit.
- System Directors of Strategy (DoS) were integral in the partnership approach to developing our plans during 2022/23. They have ensured that plans are devolved into their respective organisations, both leading and contributing to the design and approach of system planning.
- Our ICS People Collaborative approach has continued to develop over time with health and social care partners. It is mature and effective in collectively tackling our workforce challenges and has been a key enabler to delivery during 2022/23.
- Chief Nursing Officers and quality leads have worked collaboratively to develop a framework and a set of mutually agreed quality principles. Our teams work collaboratively to identify early warning signs of emerging issues or impacts.
- Our System Clinical and Professional Community have delivered, along with organisational operational teams, a range of work.

This includes:

- the System Winter Plan to deliver enhancements to a number of schemes, including expansion of the Community Rapid Intervention Service (CRIS) to include a two-hour Urgent Community Response service, Community Falls Response services and expansion of our virtual wards offer
- making progress in recovering our elective waiting time performance during 2022/23, against an ongoing high level of COVID-19 infection, patient acuity, capacity constraints in social care, and workforce availability
- making good progress in reducing the backlogs of patients waiting 62 days or more for cancer treatment
- improvements across primary care, specifically face-to-face GP appointments, where Staffordshire and Stoke-on-Trent is the second-highest performing ICB in the region
- achieving transformation across mental health and learning disabilities the ICS has operated a comprehensive Mental Health Programme which has delivered a large number of improvements.

In developing the 2023/24 Operational Plan, we have reflected on the lessons learned in addressing the challenges over the last 12 months in both setting our local priorities and also in how we use our portfolios, places, provider collaboratives and our broader partners to set ourselves up for the delivery of those priorities in the next 12 months.

The system plan on a page for 2023/24

- CEOs and system leaders from across the ICS came together to set the strategic direction for the 2023/24 planning round and agree organisational and individual contributions to that.
- As a system, we have collectively agreed the priorities that will make the biggest positive difference to people's lives that can be best achieved by working across the whole of Staffordshire and Stoke-on-Trent.
- We have one collective aim and each priority, objective and action is aligned to a portfolio, provider or partner. How we will measure delivery of is outlined further on in this plan.
- The key aim is to reduce the number of Category 2 and 3 ambulance calls.
- The system plan on a page has been agreed and signed off with our partners, Integrated Care Partnership and Integrated Care Board.

One collective aim

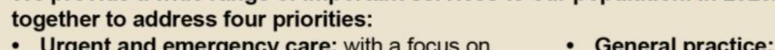
As a system we serve the 1.2 million people who live in Staffordshire and Stoke-on-Trent. We have a collective aim to improve health outcomes and provide the best health and social care services for our population. Our key metric for 2023/24 reflects our ambition to provide better and more compassionate care in the community and avoid hospital admissions where possible for elderly and frail people, especially at the end of life.

This is to reduce the number of Category 2 and 3 Ambulance calls. This will also reduce ambulance call wait times and hospital bed occupancy. We chose this metric because all parts of the system can contribute to reducing the number of people calling an ambulance, for example GPs, community NHS services, the voluntary sector, and acute trusts through the way they manage people whilst in hospital and avoid readmission.

4 system priorities

1. Urgent and emergency care
2. Tackling backlogs
3. General practice
4. Complex individuals

System priorities:



We provide a wide range of important services to our population. In 2023/24 we will bring these together to address four priorities:

- **Urgent and emergency care:** with a focus on prevention and avoiding hospital admissions, as well as improving management of people in hospital and facilitating appropriate and timely discharge.
- **Backlogs:** reducing queues and wait times for elective care, cancer, mental health, learning disability and autism services, and NHS dentistry; reducing variation and ensuring equity of access for our whole population.
- **General practice:** ensuring that residents have appropriate, timely and equitable access to services. Ensuring that general practice is contributing to our collective aim through holistic management of elderly and frail people.
- **Complex individuals:** improving access to high quality and cost effective care for people with complex needs who require multi-agency management.

31 national objectives + 50 national actions

Plans to deliver the national targets, plus local targets from the portfolios

National objectives:

Includes other important tasks mandated by the NHS nationally, plus any other locally agreed targets. Plans will show the golden thread connecting these to the collective aim and priorities.

Collective Effort

7 portfolios, 3 in-system Trusts, 2 partner Trusts, 2 Local Authorities, 2 Places, 1 Provider Collaborative and VCSE Alliance, underpinned by PHM, engaging the People's Assembly

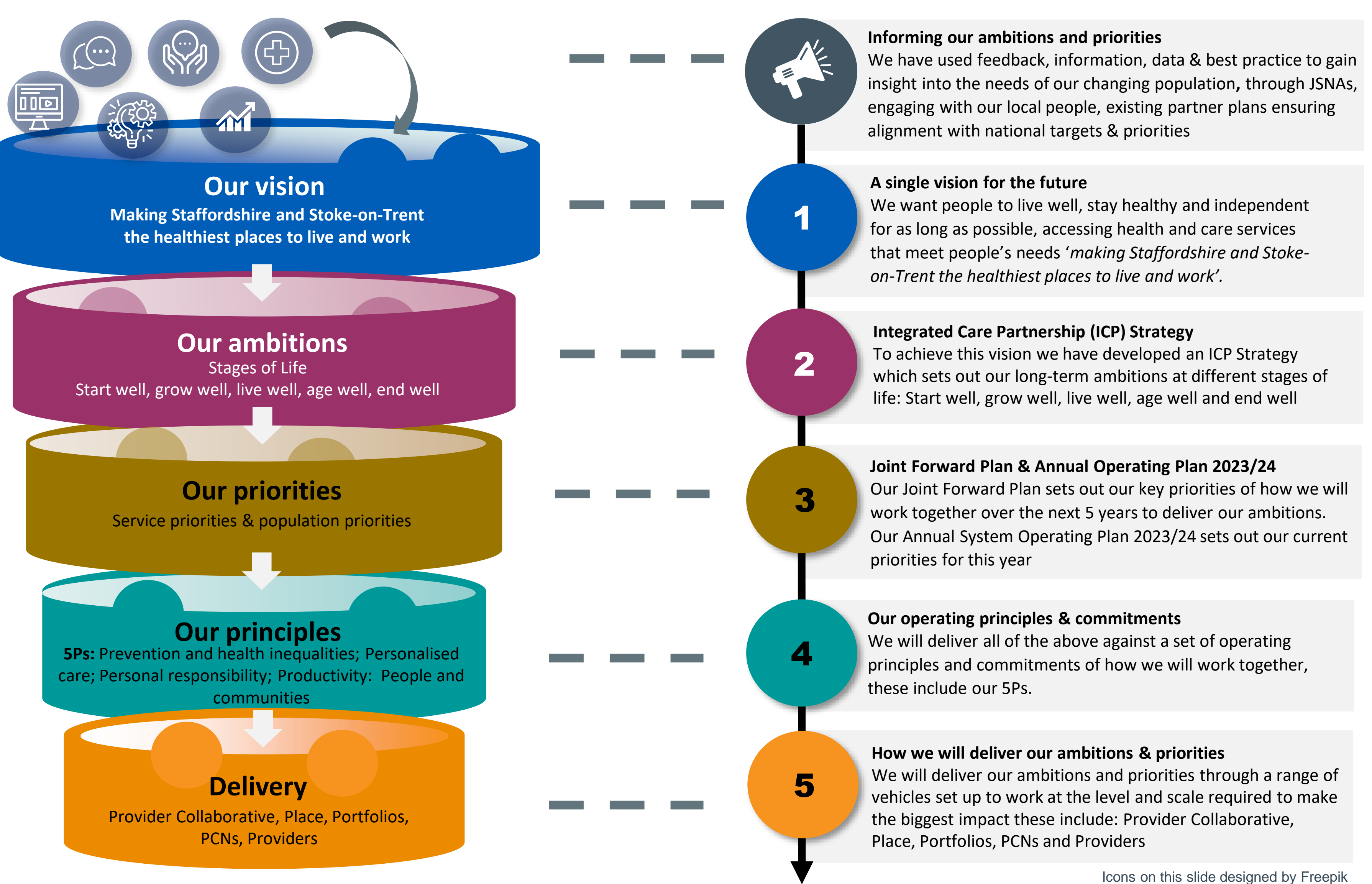
- Using the '5 Ps' explained in the Integrated Care Strategy, underpinned by Population Health Management to drive evidence-based decision making
- A People Plan to recruit, retain and empower staff
- Clinical leadership by Health and Care Senate
- Digital solutions driving transformation
- Collective ownership of the Staffordshire and Stoke-on-Trent pound.

Business Plans and Project Implementation Plans for NHS Trusts and Portfolios will describe the actions required to implement the collective aim, priorities and national objectives/actions and show how these are related.

While elements of the plan will be delivered through discrete programmes within one organisation or Portfolio, many will be cross-cutting – the most important of these being a system-wide programme focusing on **Admission Avoidance and Discharge arrangements**.

Our approach to developing our priorities

- This one-year plan reflects national and system priorities and builds on the ICP Strategy, the Health and Wellbeing Strategies, wider partner strategies and operating plans that focus on our local population
- The principles of our approach are illustrated in the diagram (our 'Hopper Model') which shows how the converging parts of our vision, ambitions and priorities will be delivered by working together to improve health outcomes and provide the best health and social care services for our population
- We used this hopper to create this plan that clearly defines the system objectives for the year ahead and apply those tasks to the appropriate part of the system – Trust, Provider Collaborative, Portfolio.

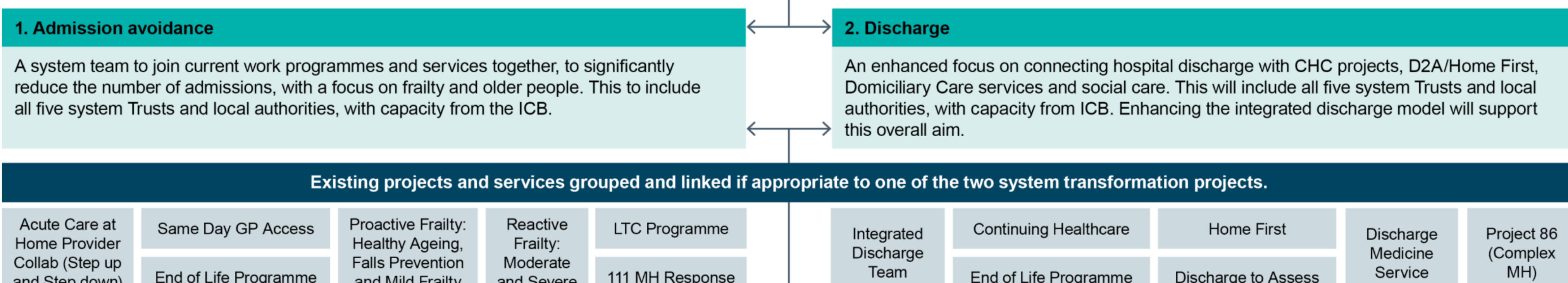


Icons on this slide designed by Freepik

Our system-wide approach for pathway redesign

Our goal: 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. Our Continuing Healthcare (CHC) costs have increased by £50m, which is a cash-cost to the system. 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 patients are not admitted in the first place or, when they are, they are discharged with alternative home support packages. We know from evidence that patients degenerate if their discharge process is inadequate, and a large number of these people end up with a lifetime of dependency. 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 the already constrained care home and positively impact on the finances. **So we propose two transformational projects for pathway redesign this in 2023/24:**



Portfolios: To identify resource, to work into the appropriate transformation project, to work in a multi-organisation team, and to deliver the agreed metrics.

Prevention actions

The case for a system-wide focus

1. Admission avoidance

- 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. 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
- 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 escalated into hospital who have clearly indicated they want their care at home, and an enhanced community offer will help ensure their wishes are met
- Avoiding unnecessary admissions will play an important part in improving our capacity to discharge people effectively.

Benefits

- One system-wide operationally led project would reduce avoidable emergency admissions, improve the quality of life for people with long-term and acute conditions and their families, and would reduce pressures on cross-system resources. A key focus will be on older frail people for whom alternative services are a better route to maintaining their independence and quality of life, as well as being a much lower cost
- The focus will be to help clinicians access the existing services that we already have in place
- This will be established as a six-month task that will aim to reduce the number of people receiving their urgent care in the hospital setting.

The case for a system-wide focus

2. Discharge

- We know all parts of the system either rely on or contribute to effective discharge arrangements and we spend monies in every organisation on aspects of facilitating discharge. 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

- As a system, we need something big to get behind where there is a realistic opportunity to improve outcomes and simultaneously take out unnecessary costs. We know that too many people are being admitted to a hospital bed and then become deconditioned. Many are not discharged on a timely basis, and as a system we appear to 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 between services

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

  We need to understand why this is the case and how those services need to be changed to maximise their impact/productivity. We need to engage with clinicians across the system to make the most of the opportunity that virtual wards and telehealth offer our population.

Benefits

- The system aim should be for one system-wide, operationally-led project that would improve the lives of people (largely the elderly or those with complex needs), who are ending their lives in a state of dependency with the opportunity to reduce inefficiencies, remove duplicated effort and ultimately take costs out of the CHC and social care
- To critically review all aspects of discharge processes and support through a structured approach to redesign a seamless pathway. This needs to maximise the impact of services commissioned through the Better Care Fund as well as by local authorities and the NHS, and should address unwarranted variation within the system in terms of access to service offers
- We will set this up as a six-month task, that will deliver cash out from CHC and social care later in 2023/24, but more importantly lead us to a better 2024/25 and beyond.

How we will deliver the plan

- All portfolios have identified the actions that they need to address in 2023/24. These actions come from a mixture of:
  - 31 national objectives and 50 national actions
  - Ongoing national Long Term Plan 2019 commitments
  - National guidance and frameworks not published as part of the 2023/24 planning guidance
  - Other locally determined actions to address system priorities of providers, local authorities and our broader system partners
  - Where actions are the responsibility of one of the statutory organisations, the governance arrangements of that organisation will apply and the ICB will take assurance from those governance mechanisms
  - Where actions require several organisations to be involved, the ICB governance mechanism applies and decisions and monitoring occurs at the system level
  - Each slide indicates which national objectives the portfolio will deliver or which local priority they will contribute to using a circle or a triangle. Example:

System priorities:

National objectives:

  - A list of the national objectives is provided on slide 54.
  - The plan is underpinned by a more detailed outline of objectives/ deliverables across each quarter. The link to the detail of each Portfolio plan is available from each lead.

- We are keen to build on the successes of 2022/23 by being a lot more rigorous in our assessment of delivery. The system Programme Management Office (PMO) and the Transformation Delivery Unit (TDU) will coordinate the monitoring of all tasks and metrics. Exceptions will be discussed and corrective action agreed at System Performance Group, then scrutinised at System Finance and Performance Committee
- We will deliver our ambitions and priorities through a range of vehicles that have been set up to work at the level and scale required to make the biggest impact on improving population health and wellbeing in Staffordshire and Stoke-on-Trent. These include:
  - **Provider Collaborative:** Enabling workstreams as the delivery vehicle for transformation at scale to improve quality, efficiency and outcomes and address unwarranted variation and inequalities in access and experience across different providers
  - **Place:** Aligning with our local authorities where at scale is required with multiple partners
  - **Portfolios:** Bringing delivery and local transformation together
  - **Primary Care Networks (PCNs):** PCNs build on existing primary care services and enable more resilient delivery of primary care in local neighbourhoods, and the integration of health and care services
  - **Providers and Partners:** Provider organisations will focus on local service change when this is required to drive change and efficiency and includes a range of providers in an advisory capacity.

Summary of what we will deliver

- The place mat demonstrates at a high level, objectives, metrics and deliverables of the System Plan
- This is underpinned by Business Plans and Project Implementation Plans for NHS trusts. Through Portfolios, we have described the actions required to implement the collective aim, priorities and national objectives/actions and show how these are related.

PORTFOLIO	Children and Young People / Maternity	Planned Care, Diagnostics & Cancer	Improving Population Health	Urgent & Emergency Care	Mental Health, Learning Disability and Autism	Primary Care	End of Life, LTCS and Frailty (ELF)
	• Deliver the key NHS Long Term Plan ambitions for a strong start in life for children and young people • Implementation of the national delivery plan for maternity and neonatal care	• Deliver the goals for elective recovery in planned, cancer and diagnostics	• Embed measures to improve health and reduce inequalities	• Recovery of Urgent and Emergency Care Services	• Deliver the key NHS Long Term Plan ambitions	• Deliver the vision outlined in the Fuller Stocktake and make it easier for people to contact a GP practice	• Deliver the Ambitions for Palliative and End of Life Care national framework • Deliver the key NHS Long Term Plan ambitions supporting people to age well • Deliver the NHS Long Term Plan prevention priorities
NATIONAL OBJECTIVES							
SYSTEM PRIORITIES							
KEY METRICS / DELIVERABLES	• Design and Implement Long Term Conditions Programme (Diabetes, Epilepsy and Asthma) • Implement Children with Complex Needs Project • Implementation of the national delivery plan for maternity and neonatal care	• Ongoing implementation of Patient Initiative Follow Up (PIFU) • Trajectory for eliminating 65 week waits delivered • Meeting 85% day case /theatre utilisation • Introduce Community Diagnostic HUBs • Optimal use of lower GI 2ww	• Systematic implementation of the Core20 approach • Implement NHS Long Term Plan prevention programmes • Utilise population health management techniques	• Capital Investment Case • 76% of patients seen within 4 hours in A&E • Bed occupancy 92% or below • Full review and priority setting for virtual wards. • Enhance provider collaborative offer to include the Clinical Assessment Service. • Deliver a fully integrated discharge "hub"	• Improve the crisis pathways including 111 and ambulance response • Undertake a PICU Options Appraisal • Minimise waiting times for autism diagnosis • Increased number of people accessing IAPT • Increased number of people with SMI having annual physical health check	• Deliver ARRS recruitment • Implement digital solutions to provide enhanced remote care to people. • Deliver recovery of dental activity • Implement POD Delegation	• The creation of a PEoLC strategy • Identification of Patients in the last 12 months of life recorded on Palliative Care Registers in Primary Care • LTC strategy • Transformation programme around CVD, Respiratory and Diabetes • Delivery of the frailty strategy

PEOPLE & COMMUNITIES | PERSONALISED CARE | PERSONAL RESPONSIBILITIES | PREVENTION & INEQUALITIES | PRODUCTIVITY

Part 2

Our Portfolios focus for 2023/24

Bringing delivery and local transformation together

- Our Portfolios are aligned to eight key focus areas: Urgent and Emergency Care; Planned care including cancer and diagnostics; End of Life, Long-Term Conditions and Frailty; Primary Care; Mental Health, Learning Disabilities and Autism; Children and Young People and Maternity; Improving Population Health
- Each Portfolio has an agreed set of senior leadership roles including an Executive Sponsor, a Senior Responsible Officer (SRO), a Portfolio Director and a Clinical Director.

Urgent and emergency care

- We are working in partnership with our provider organisations across including University Hospitals of North Midlands NHS Trust, University Hospitals of Derby and Burton NHS Foundation Trust, Midlands Partnership University NHS 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 and the third sector. Our revised governance structure fully reflects this
- Provision of services has been extremely challenging. Our population have experienced significant delays in accessing urgent and emergency care, with our hospitals unable to meet the required A&E waiting time standards. Across the country, ambulance handover delays have reached critical levels – leading to considerable delays for people waiting in the community – especially for our Category 2 and 3 patients
- As a system, we have worked together to co-produce and agree local plans to develop the capacity required to deliver UEC recovery. These plans feed into our more detailed local UEC plans. In developing our short, medium and longer term strategy for UEC, we have focussed on seven priority areas for 2023/24 which are fully aligned to the 2023/24 national UEC Recovery Plan. The focus is to ensure consistent simplified delivery and our plans are be focused on provider collaboration where appropriate.

Our commitment

“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 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.”

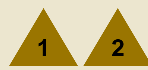
Matthew Lewis, SRO

Our high level key measures for urgent and emergency care

			Year 1 (2023/24)			
	Objective	**Baseline**	Q1	Q2	Q3	Q4
Recovery	Improve A&E waiting times so that no less than 76% of patients are seen within four hours by March 2024 with further improvement in 2024/25.	76.2%	72.0%	79.7%	77.5%	75.6%
Recovery	Reduce adult general and acute (G&A) bed occupancy to 92% or below*.	91.7%	90.6%	90.6%	90.6%	90.6%
Pre-hospital	Consistently meet or exceed the 70% two-hour urgent community response (UCR) standard.	84.4%	85%	85%	85%	85%
Pre-hospital	Reach 80% utilisation of virtual wards at a minimum by the end of September 2023.	35%	63.9%	70.9%	75.5%	86.2%
Post-hospital	Improve number of discharges on Pathway 0 to 80%.	72%	76.4%	77.6%	78.8%	80%

* Subject to successful capital investment for additional beds

Urgent and emergency care 2023/24 deliverables



- Deliver the wide ranging actions set out in National UEC Recovery Plan

- Deliver the system UEC Delivery seven-point plan pre-hospital, in hospital and post-hospital

- Progress capital investment business case for 45 additional beds at Royal Stoke University Hospital – essential to close the peak capacity gap in winter 2023/24
- Full review and priority setting for virtual wards
- Work with interdependent strategies and programmes e.g. primary care, mental health, end of life, long-term conditions and frailty
- Full review of the access programme with a view to enhancing provider collaborative offer to include the Clinical Assessment Service
- Work with UHNM on the UEC improvement programme to improve acute hospital flow, and deliver the 76% emergency department standard, the 92% occupancy target and improve ambulance handover delays
- Deliver a fully integrated discharge "hub" with a single operational tasking structure and physical co-location
- Improve the discharge profile and targets and achieve a consistent seven-day service.

Staffordshire and Stoke-on-Trent UEC next steps

Pre-hospital

- **Frailty and end of life pathways** – regional benchmarking and pathway development – Steve Grange/ Lynn Millar
- **Acute care at home (ACAH)** – Unscheduled Care Coordination Centre, virtual wards and Urgent Community Response delivery – Paul Bytheway / Jennie Collier

B C G H I J

In hospital

- **Acute hospital flow** – acute front door, portals and navigation, and base ward discharges – Paul Bytheway

A C

Post-hospital

- **Integrated discharge hub review** – complex pathway integration – Paul Bytheway / Sam Merridale
- **P0 optimisation** – P0:P1 and 2 benchmarking and improvement
- **Discharge profile and targets** – consistent 7 day service – Paul Bytheway / Jennie Collier

System bed capacity and demand – strategic alignment and implementation – Paul Bytheway / Jennie Collier / Ashleigh Shatford

Planned care including cancer and diagnostics

- Despite improvements in 2021 and 2022 compared to the first year of the pandemic, the number of electives and outpatient attendances currently being carried out is still well below pre-pandemic levels
- All providers of planned care continue to work towards recovery of elective and day case activity; people continue to be triaged for potential referral to the Independent Sector and other NHS trusts
- Building on both the operational planning guidance and also the NHS Triple Aim, the Planned Care, Cancer and Diagnostics Portfolio has two main aims: recovery and transformation for 2023/24 and beyond
- The ICB shows a similar profile to the national one, with a large increase in the numbers of people on the referral to treatment (RTT) waiting lists and a corresponding decrease in performance against the 18-week target
- Additionally, the number of people waiting over 52 weeks for treatment and over six weeks for diagnostics has increased. We will continue to build on the progress made in reducing the number of people waiting over 104 and 78 weeks for their surgery.

Our commitment

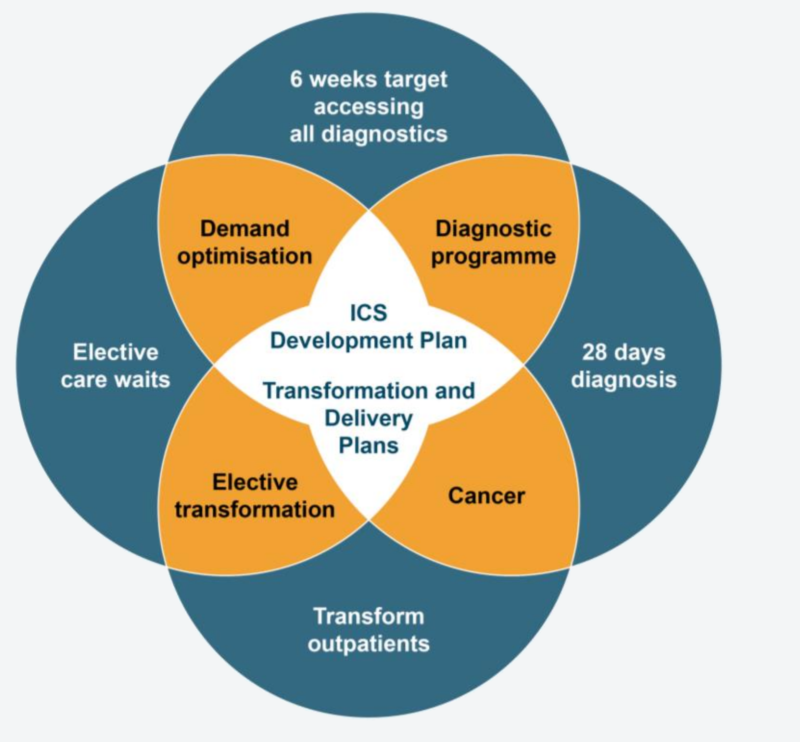
“From a planned care perspective, the ICS continues to focus on the delivery of two overarching objectives – the recovery of capacity to levels that meet or exceed that in existed pre-COVID in order to eliminate long waiting times, as well as the transformation of patient pathways in order to promote 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.”

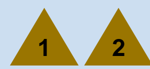
Helen Ashley, SRO

At ICB level as at 2 April 2023:

- **8,966** people were waiting more than 52 weeks, compared to 8,213 people in the same week in 2022 (w/e 03/04)
- **588** people were waiting more than 78 weeks, compared to 2,001 people in the same week in 2022 (w/e 03/04)
- **44** people were waiting more than 104 weeks, compared to 613 people in the same week in 2022 (w/e 03/04).



Planned care 2023/24 deliverables



- Eliminate waits of over 65 weeks 6
- Aim to reduce outpatient follow-ups
- Deliver the system-specific elective activity target (103%)

- Increase productivity and meet the 85% day case and 85% theatre utilisation expectations
- Referral and intervention management
- Outpatient transformation

- We will support the reduction of 65-week waits through ongoing validation and review of long waiters. ICS partners will collaborate to ensure all available capacity is used to clear backlog of patients waiting for treatment. This will include the use of mutual aid from providers external to the system and the ICS will work with people to take up the offer of treatment. The ICS will make full use of the NHS 'Choice' agenda to ensure people can receive timely treatment
- We will aim to deliver an appropriate reduction in outpatient follow-ups through continuing to provide improved access to primary care services, increasing the diversion rate of outpatient attendances and exploring opportunities through reinvigoration of the system Demand Management Group
- We will deliver the system-specific elective activity target and create additional outpatient activity through driving the implementation of the Patient Initiative Follow Up (PIFU) work to support a personalised care model
- The ICS will implement GIRFT recommendations and improve and maintain theatre productivity and other efficiency measures.

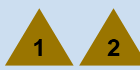
Our high level key measures for planned care

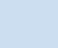
	Year 1 (2023/24)				
Objective	**Baseline**	Q1	Q2	Q3	Q4
Eliminate waits of over 65 weeks for elective care by March 2024.*	2,267 (Dec 2022)	2,925 *1,680*	2,140 *1,272*	1,199 *750*	0 *0*
Aim to deliver a reduction in OPFU in line with the national ambition to reduce OPFU activity by 25% against the 2019/20 baseline by March 2024.	520,688 (2019/20)	132,081	136,761	135,834	136,344
Deliver the system-specific elective activity target 103%.	103%	103.9%	103.2%	103.0%	103.0%
Increase productivity and meet the 85% day case and 85% theatre utilisation expectations.**	System submission compliant	UHNM internal trajectory	UHNM internal trajectory	UHNM internal trajectory	UHNM internal trajectory

*ICB level trajectories are shown for 65-week waits first, with UHNM trajectories shown underneath in italics

**System submission is compliant. Current UHNM performance achieves 85% overall.

Cancer and diagnostics 2023/24 deliverables



- Increase the percentage of people that receive a diagnostic test within six weeks  8
- Deliver increased diagnostic activity and capacity 9
- Meet national standards to reduce the number of people waiting over 62 days 10
- Meet the faster diagnosis standard 11
- Increase the percentage of cancers diagnosed at stages 1 and 2 12

- Continue to improve diagnostic test wait times and activity levels through improved used of existing capacity. In 2023/24, we have planned to deliver 20% more diagnostic test activity than 2019/20 – maximising the pace of roll-out of Community Diagnostic Centres (CDCs)
- We will build on the progress made to improve performance against cancer standards through:
  - Supporting capacity expansion – especially diagnostic capacity at pathway pinch-points
  - Ensuring as many two-week wait skin referrals as possible are accompanied by high quality images to enable remote triage and maximise discharge / Straight to excision without outpatient appointment
  - Ensuring optimal use of lower GI two-week wait referrals by diverting FIT negative patients to alternative pathways where clinically appropriate
  - Promote more consistent primary care initiated "straight to test".
- Promote and maximise use of non-site specific referral pathways
- Support an increase in the percentage of cancers diagnosed at an early stage through:
- Targeting communities with poorer outcomes to increase awareness of cancer symptoms and importance of cancer screening programmes
  - Expand the Targeted Lung Health Check Programme into south Staffordshire.
- Use the Midlands Cancer Screening Dashboard to inform targeted interventions that improve screening uptake, address late-stage diagnosis and health inequalities.

Our high level key measures for cancer and diagnostics

			Year 1 (2023/24)			
	Objective	**Baseline**	Q1	Q2	Q3	Q4
Diagnostic recovery	Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95%.	65.60% (Oct 2022)	69.13%	75.64%	76.58%	78.56%
	Deliver increased diagnostic activity levels.	470,585 (2019/20)	133,856	143,026	143,225	143,170
Cancer recovery	Reduce the number of patients waiting over 62 days (UHNM).**	740 (Dec 2022)	170	148	124	102
	Meet the 75% cancer faster diagnosis standard by March 2024 (UHNM).	57.62% (Dec 2022)	67.49%	70.77%	75.46%	79.98%
	Meet the 28 day waits faster diagnosis standard 75% (ICB).	62.67% (Nov 2022)	68.53%	71.36%	75.16%	78.76%
	Increase the number of patients with suspected cancer seen on a non-specific pathway following GP referral or referral from another service (ICB).	24 (Oct 2022)	83	109	123	140
	Increase the percentage of lower GI suspected cancer referrals with an accompanying FIT result (ICB).	62% (Oct 2022)	71.97%	90.91%	84.77%	94%

** At the point of publication of this plan, regional and national discussions are ongoing in relation for an improved trajectory of 62 day waits – so these numbers may change. In addition, the diagnostic recovery target is set for March 2025, the figures above show the trajectory for the first year only 2023/24.

End of life, long-term conditions and frailty

Palliative and end of life care

We aim to help meet peoples' wishes, including their preferred place of care and death which requires consistent effective identification, care planning and for rapid processes for discharge to be in place. This requires close working between inpatient team and the community-based services including local authorities, voluntary and community sector, pharmacy, the ambulance service and our local hospices.

Long-term conditions

Existing plans include developing Clinical Improvement Groups to provide strategic overview of the system, and developing a strategy to improve the health outcomes and quality of life for all those living with or at risk of cardiovascular disease (CVD), diabetes and respiratory conditions. CVD and respiratory conditions are also explicitly referenced in the ICP Strategy – focused on how we reduce premature deaths from them.

Frailty

We aim 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 five key areas of our Frailty Strategy: Prevention and Healthy Ageing, Mild, Moderate and Severe Frailty, and Proactive Falls Prevention.

Our commitment

"Our Portfolio is committed to high-quality, person-centred care pathways and culture. Using 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 conditions and frailty 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 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. "

Steve Grange, SRO

Our high level key measures of success for end of life, frailty and long-term conditions

	Objective	Baseline
PEoLC	Identification of patients in the last 12 months of life recorded on Palliative Care Registers in primary care increased from 0.5%.	0.5% 2021/22 and mid-Mar 2023
Long-term conditions	Enrol 85% of those referred for pulmonary rehabilitation (PR) with stable COPD within 90 days.	N/A
	Ensure 70% of patients enrolled for PR go on to complete the programme and have a discharge assessment.	N/A
	Eight care processes – increased offer rollout to diabetes patients.	Only 37.7% reach, based on 2021/22 data
	Patients with >20% increased chance of CVD treated with statins.	Only 57.4% reach, based on 2021/22 data
	AF – 10% increase screening/identification (Pulse Check).	Baseline 32% mid-March 2023
Frailty	10% increase in the number of people with severe frailty who have a completed ReSPECT document and an Anticipatory Care Plan.	Based on performance end of 2022/23, the baseline is 5,714 using: • Unique views on SCC adult social care webpages: 3,723 • Unique views of Staffordshire Connects adult homepage: 1,641 • CHPs: 348 • Mild frailty digital self-management of risk: baseline 0 (new offer) • MECC digital self-completion: baseline 0 (new offer)
	90% completion rate of the Clinical Frailty Scale (Rockwood) for each moderately frail patient assessed as part of Staying Well Service and Facilitated Admission Avoidance Scheme.	N/A
	10% increase in the number of people accessing self-help and support under prevention service offer, Staffordshire County Council service adult social care webpages, Staffordshire Connects and community health partnerships.	5,714, based on performance end of 2022/23
	HN service offer to identify 2,000 patients at risk of hospital admission with a 5% reduction in the cohort	Pilot showed a 26% reduction in the cohort, but that has many caveats

End of life, long-term conditions and frailty 2023/24 deliverables

- Drive improvement in Palliative and End of Life Care (PEoLC) framed by the National Ambitions, including the new legal duty (Health and Care Act 2022)
- Deliver the outcomes for patients and carers which are described in the National Ambitions for PEoLC
- Develop a comprehensive Long-Term Conditions Strategy
- Agree a healthy ageing and prevent/delay Frailty Plan.

Palliative and End of Life Care (PEoLC)

In response to the six National Ambitions and the statutory duty on ICBs to commission PEoLC, the programme of work for 2023/24 will include:

1. Developing comprehensive PEoLC Needs Assessment identifying key demographics, inequalities, baseline, current performance and predictive modelling
2. Developing a strategy for Palliative and End of Life Care. This is expected to include:
   - 24/7 access including a Co-ordination and Advice Line
   - Access and availability of palliative care medication
   - Improving identification of people in the last year of life, the number and quality of Respect Plans completed
   - Workforce and training.

Long-term conditions

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

- Develop a comprehensive Long-Term Conditions Strategy, reflecting the ambitions of the NHS Long Term Plan. We will use a population health management (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 NHS Long Term Plan and in conjunction with other Portfolios to ensure that all interdependencies are identified and considered as part of the strategy development.

Concurrently the Portfolio will continue to focus on actions within the following projects:

- Improving uptake of the eight care processes
- Improving care of foot ulcers and reducing amputation rates caused by diabetes
- National Diabetes Prevention Programme
- Case finding and accurate diagnosis of chronic obstructive pulmonary disease (COPD)
- Improving access to pulmonary rehabilitation.

Frailty

During 2023/24, we will:

- Develop a healthy ageing and prevent/delay Frailty Plan
- Implement the Loneliness Reduction Plan
- Agree and roll out the system-wide Outcomes Framework.

Primary care

We have set out a strategy for the next five years to deliver the vision for General Practice. During 2023/24, we implement year one of our strategy.

Our population will experience:

- More integrated, personalised and flexible care
- An equitable offer of general practice provision
- Reduced variation in care, services and outcomes
- Empowerment to self-care.

The ICB will:

- Work in partnership on the existing programmes to tackle the challenges around recruitment and retention of the workforce and addressing workload pressures
- Provide consistent training and development, as well as health and wellbeing initiatives, to support our workforce
- Support general practice to have a strong and consensus voice locally and within the system
- Integrate actions from the four building blocks in the Fuller Stocktake into our existing eight enabler programmes.

Our commitment

"This is an exciting time for primary care. The ICB will soon publish a General Practice Strategy developed in partnership with 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."

Chris Bird, Chief Transformation Officer

Our high level key measures for primary care

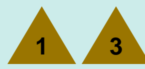
	Year 1 (2023/24)					
	Objective	Baseline	Q1	Q2	Q3	Q4
Access	Deliver more appointments in general practice by the end of March 2024.	5,917,885 (FOT)	1,369,269	1,444,707	1,613,923	1,359,691
Workforce	Deliver Additional Roles Reimbursement Scheme (ARRS) recruitment against 26K additional roles by March 2024.	388.70 (FOT)	451.73	503.67	555.60	608.17
	GP WTE (working towards national 6K target) by March 2024.	680.9 (Feb 23)	682.57	677.43	672.28	667.87
Dental activity recovery	Recover dental activity towards pre-pandemic levels.	1,908,485 (Year to end Jan)	469,462	469,462	469,462	469,462

Primary care 2023/24 deliverables

- Improve access to the right primary care services 5
- Deliver more appointments in line with the national trajectory 15 16
- Continue workforce and recruitment to Additional Roles Reimbursement Scheme (ARRS) and WTE GP roles 17
- Implementation of the Fuller Stocktake
- Support recovery of backlogs across the system (including dental) 18

- We will build on the programme of work already started to improve access and deliver more appointments in general practice by end of March 2024 evidenced through the quarterly trajectory in place for 2023/24. Practices will be supported with digital solutions including advanced telephony solutions, online consultations, video consultation, messaging and booking solutions, GP Connect (allowing NHS111 to book into GP appointment books) to provide enhanced remote care to people
- We will continue to focus on increasing 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 implement the vision of the Fuller Stocktake report focusing on a population health management approach through the building of integrated neighbourhood teams, same day urgent access, prevention and personalised care
- We will review and implement the recommendations from the national general practice access recovery plan when this is published focusing initial recovery actions on:
  - The POD Joint Commissioning Groups (West Midlands) which have set contracts with all dental providers (units per quarter) to recover backlogs in dental activity
  - Recovery of mental health performance around supporting dementia diagnosis and SMI annual physical health checks.

Medicines optimisation 2023/24 deliverables



- Enhance service provision through community pharmacy to improve access to healthcare in primary care 5
- Reduce overprescribing in general practice 30
- Reduce the carbon impact of medicines
- Reduce the risk of microbial resistance to antibiotics used in primary care
- Reduce the risk of harm to people from medicines

- The Community Pharmacist Consultation service will improve access to primary care by referring people requiring advice and treatment for certain minor illness conditions from a GP practice to a community pharmacist, ensuring that people have access to the same levels of care, close to home and with an emphasis on self-care. This will be evidenced through the quarterly trajectory in place for 2023/24
- Population health management data relating to prescribing trends in primary care shows that the ICB has high level of polypharmacy. Clinical pharmacists employed in general practice will support teams to conduct structured medication reviews in people aged 65 and over with eight or more prescription items including care home residents who also tend to be on multiple drugs
- Of all the medicines, inhalers used in asthma and COPD contribute the most to carbon emissions in the environment. The ICB Medicines Optimisation team has produced guidance on choice of inhalers. Practices will be supported to implement this guidance in 2023/24
- Last year, 83% of practices completed audits on antibiotic prescribing and identified areas for improvement with regard to managing volume of prescribing and meeting NICE recommendations on choice and appropriate dosing of antibiotics. During 2023/24, practices will be supported to implement interventions targeted at areas requiring improvement.

Our high level key measures for medicines optimisation

			Year 1 (2023/24)			
	Objective	**Baseline**	Q1	Q2	Q3	Q4
Access	Referrals to Community Pharmacist Consultation service from all relevant sources (general practice and NHS 111).	24,210 (general practice Apr 2022-Mar 2020) 7,351 (NHS 111 Jan 2021-Oct 2022)	7,427	7,569	10,749	8,513
Overprescribing	% of structured medication reviews conducted in general practice.	Based on % delivery of 20,429 SMRs	15%	40%	70%	100%
Carbon impact	Inhalers with low carbon impact as a percentage of all inhalers (based on prescriptions dispensed).	44.94% (per quarter)	44.94 %	45.44 %	45.94 %	46.44 %
Clinical Audit	Number of patient case notes reviewed as part of clinical audit programme on prescribing.	Target 80% of maximum of 9,045	0	2,412	4,824	7,236
Antibiotics (AMR)	Number of antibiotic prescriptions per weighted patient (known as STAR-PU) per year.	Current 12-month rolling average is 1.123	= or < 1.161	= or < 1.161	= or < 1.161	= or < 1.161
Cost	% of CIP delivered.	80% target	20%	40%	60%	80%

Mental health, learning disabilities and autism

- We know that the pandemic has had a significant impact on mental health, and this is now compounded by the cost-of-living crisis. Mental health demand and acuity is high as a direct consequence of the COVID-19 pandemic – with national predictions for mental health needs to remain at elevated levels for some time to come
- Much work has been undertaken over recent years to transform services and this will continue through the delivery of our plans in 2023/24.

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.

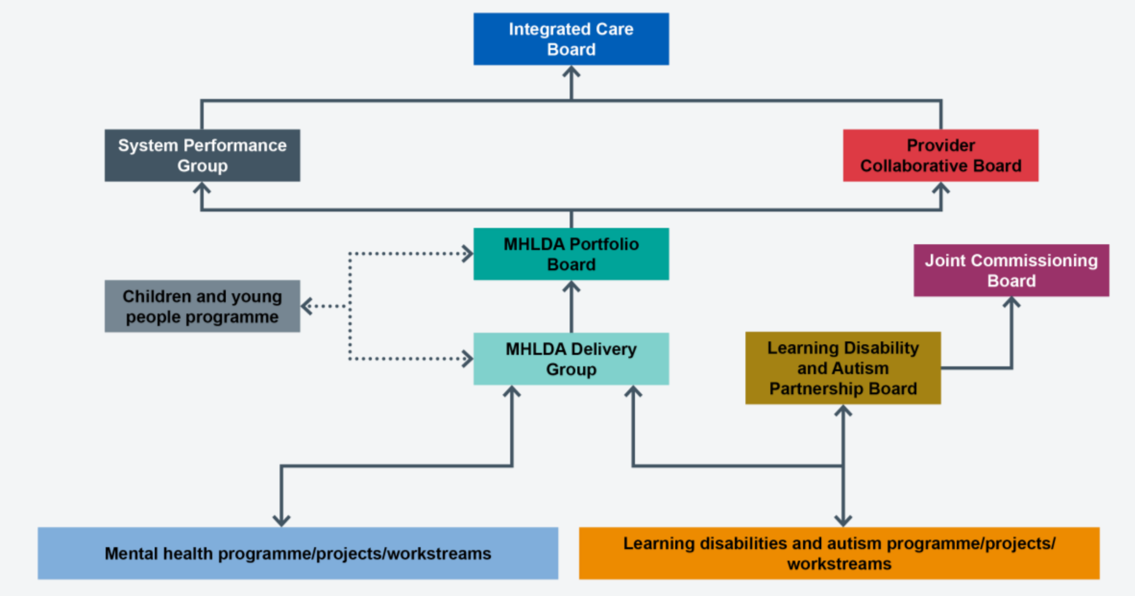
- We work in an integrated and collaborative way to ensure mental health is given equal priority to physical health needs and people receive the help and support they need closer to home and family
- By bringing together leaders from all local partners, we will continue to raise the profile of mental health in our system and enable new models of support to be developed, delivered by a wide range of partners
- The Mental Health, Learning Disability and Autism Portfolio brings together local commissioners, providers, regulators, the voluntary sector and other local stakeholders to identify, test, agree and implement the optimal solution of mental healthcare services for the local health and care economy
- We recognise that our plans need to be linked with the work of a range of other Portfolios (e.g. children and young people and urgent and emergency care), and that there are interdependencies across the ICB.

Our commitment

"As a system, we are well on our journey to make mental health, learning and disability 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 people with a learning disability) programmes to deliver effective care for our population. 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 social care system."

Ben Richards, SRO

Mental health, learning disabilities and autism Portfolio



Mental health 2023/24 deliverables

- Improve access to mental health support for children and young people 19
- Increase the number of people accessing IAPT treatment, perinatal mental health services and supported by community mental health services

- Work towards eliminating inappropriate adult acute out of area placements 22
- Improve the crisis pathways including 111 and ambulance response

- We will continue to seek to increase the number of people accessing Talking Therapies (IAPT) treatment to populations that will benefit from interventions, including those who are currently under-represented, increasing opportunities for liaison with physical health pathways, and combining psychological treatment with employment support
- In collaboration with our maternity providers and maternity Portfolio, we will increase access to perinatal mental health services recruiting in line with indicative 2023/24 workforce profile and contribute to the delivery of the Local Maternity and Neonatal System (LMNS) Equity and Equality Action Plan by understanding and improving equalities of access
- We will continue to work towards eliminating inappropriate adult acute out of area placements during 2023/24 by completing demand and capacity work and appraising and implementing our options for PICU
- We will co-create the long-term vision and service model to localise and realign inpatient services and improve therapeutic inpatient care and repatriating service users with complex rehab needs
- Working collaboratively with the UEC Portfolio, we will improve the crisis pathways for all ages, including 111 and ambulance response through agreed processes with our 111 provider, outlining the call flow process of people in crisis calling NHS 111 and the national procurement of mental health response vehicles (MHRVs).

Our high level key measures for mental health

			Year 1 (2023/24)			
	Objective	**Baseline**	**Q1**	**Q2**	**Q3**	**Q4**
Out of area placements	Work towards eliminating inappropriate adult acute mental health out of area placement (OAP) bed days.	160	0	0	0	0
IAPT access	Increase the number of adults and older adults accessing IAPT treatment.	7,579.5	7,367	7,509	7,650	7,792 (30,318 Year-end)
Adult mental health	Achieve a 5% year-on-year increase in the number of adults and older adults supported by community mental health services.	11,241 (2022/23 Q1)	10,934	11,513	12,093	12,678
Perinatal access	Improve access to perinatal mental health services.	760	304	608	912	1,216
CYP access	Improve access to mental health support for children and young people through increasing the number of under-18s supported through NHS-funded MH services.	16,300.5	15,154	15,800	16,600	17,648
SMI physical health checks	Number of people with SMI having annual physical health check.	3,695 (2021/22)	3,967	4,587	5,282	6,268
Dementia	Recover the dementia diagnosis rate to 66.7%.	69.4% (Feb 2023)	74.99 %	75.67 %	76.57 %	75.74 %

Learning disabilities and autism 2023/24 deliverables

- Make learning disabilities and autism everyone's business to ensure equal access and reasonable adjustments are considered across all services
- Increase the rates of annual health checks

- Improve and minimise waiting times for autism diagnosis
- Reduce reliance on inpatient care for both adults and children

- Implement the actions coming out of Learning Disability Mortality Reviews (LeDeRs)

Our plans are arranged around six workstreams to deliver against the priorities for learning disability and autism:

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 – housing provision and home in the local community. Making education, employment and life more accessible and inclusive
3. Universal services – dentists, 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 autism
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.

- Across the ICS, we will also 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.

Our high level key measures for learning disability and autism

		Year 1 (2023/24)				
	Objective	**Baseline**	**Q1**	**Q2**	**Q3**	**Q4**
Learning disability registers and annual health check	75% of people with learning disability (aged 14+) have a completed annual health check.	80.7% (FOT)	13%	32%	53%	75%
Autism Assessments to begin within 13 weeks (average)	Minimise waiting times for autism assessment (MPFT CYP).	13 weeks	13	13	13	13
	Minimise waiting times for autism assessment (Black County adults).	60 weeks	60	60	50	45
	Minimise waiting times for autism assessment (NSCHT CYP).	50 weeks	50	40	20	13
	Minimise waiting times for autism assessment (NSCHT adults).	50 weeks	50	50	40	35
Reliance on inpatient care for people with a learning disability and/or autism	The number of adults who are in inpatient care for a mental health disorder.	15 ICB 15 NHSE	12 14	12 14	12 14	12 14
	The number of under-18s who are in inpatient care for a mental health disorder.	3	3	3	3	3
Learning Disability and/or Autism Mortality Review	100% of LeDeR reviews are undertaken within six months of notification of death.	100%	100%	100%	100%	100%

Children and young people and maternity

- We are committed to delivering better health outcomes for children and young people (CYP) in our community through the vision set out. This is also explicitly referenced in the ICP Strategy – focused around giving children the best start to life and setting them on a course of improved life-long health and wellbeing
- As an ICB, we work with NHS, local authority and voluntary and community organisations. The plan is not designed to replace other more detailed plans that may exist operationally. It is a high-level over-arching plan to outline system priorities for CYP.

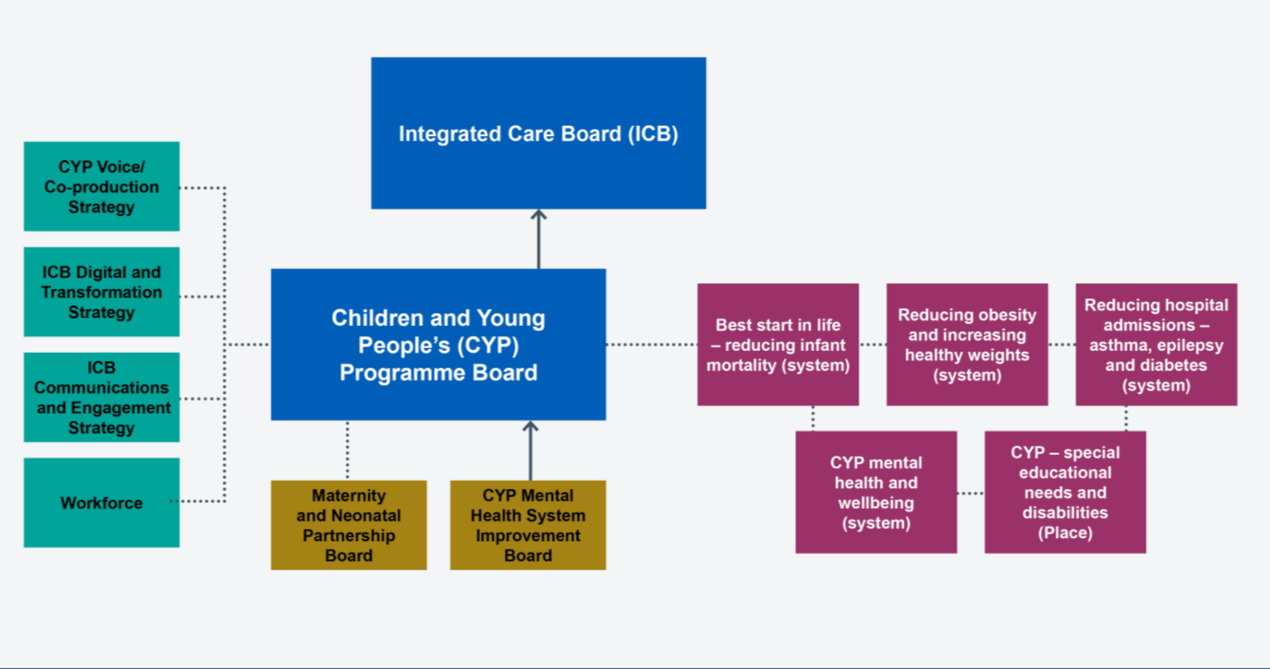
The vision for children and young people is to ensure that children are healthy and happy. They will be motivated, and we will support them to make informed choices about healthy and safer lifestyles.

- 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 want to see children, young people and families who are supported to start, grow and live well
- We will utilise **Core20PLUS5** to review system level inequalities for CYP
- 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 CYP programme board will provide the governance for the Children's ICS Delivery Plan. This is a relatively newly established group, with members from a wide range of organisations
- We recognise that our plans need to be linked with the work of a range of other Portfolios (e.g. Mental Health and UEC), and that there are interdependencies across the ICB.

Our commitment

"We are putting the health and wellbeing of our children and young people at the heart of the work of our ICS. We are determined that our kids 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."

Jon Rouse, CEO Sponsor for CYP



Children and young people 2023/24 deliverables

- Improve the survival rates of babies and young children to reduce infant mortality
- Increase the number of children able to achieve and sustain a healthy weight
- Reduce avoidable hospital admissions in relation to asthma, epilepsy and diabetes
- Improve pathways and support for children and young people (including those with complex needs) by enjoying good emotional wellbeing and positive mental health and so that they can fulfil their potential.

- We will work with our partners to develop and implement a systematic approach to infant mortality surveillance and governance and raise awareness of the key risk factors associated with infant mortality
- Opportunities will be identified within existing commissioned services (health visitor, school nursing, family weight management) to promote healthy lifestyle and opportunities to utilise the National Child Measurement Programme (and its data) more effectively
- We want CYP and families to be more confident in managing their asthma. We will support this through the implementation of the national asthma bundle. The Asthma Friendly Schools (AFS) programme will be piloted and a community-based clinic for emergency department discharges in relation to asthma commenced
- Children's asthma is one of the Portfolio Provider Collaborative projects
- The roll out of the national epilepsy and diabetes bundle will continue and a gap analysis undertaken against the bundle of care
- A dedicated space for children and young people will be developed on the ICS website
- During 2023/24, we will support children with complex needs with the help they need so that they can fulfil their potential by exploring an improved and integrated, multi-disciplinary response. We will identify local stakeholders and scope existing provision with an aim to identify gaps in service provision and designing solutions to meet any gaps.

Our high level key measures for children and young people

Objective	Year 1 (2023/24)				
	Baseline	Q1	Q2	Q3	Q4
Reduce hospital admissions for diabetes (flat activity).	52.9	52.9	52.9	52.9	52.9
Reduce hospital admission for epilepsy (flat activity).	83.6	83.6	83.6	83.6	83.6
Reduce hospital admission for asthma (flat activity).	197.1	197.1	197.1	197.1	197.1
Reduce numbers of CYP in residential care outside the ICS geography.	Data flows being established through discussion with CEO sponsor.				

- Baseline measure is 2019/20 admission rate per 100,000.
- In relation to reducing hospital admissions and for the purposes of reporting, 2019/20 data has been used as a baseline measurement.
- National sources of data indicate that there are specific areas of focus where, compared to nationally benchmarked figures, we are below average. Through the programmes of work, we will be looking to make improvement to align with benchmarked figures during 2023/24.These include:
  - Infant mortality rates – Staffordshire and Stoke-on-Trent
  - Obesity rates – Staffordshire and Stoke-on-Trent at Reception age, and Stoke-on-Trent at Year 6.

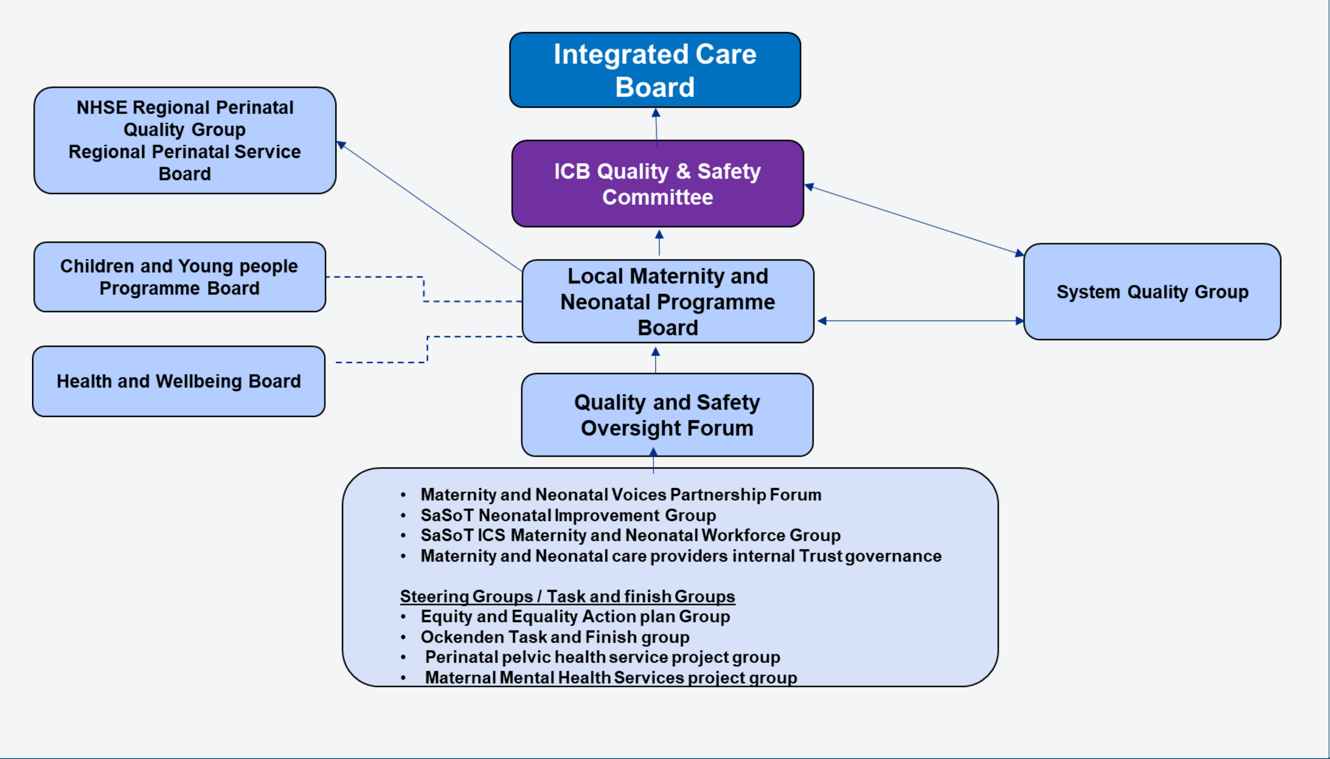
Maternity and neonate

- Despite the challenges created by the pandemic, the Local Maternity and Neonatal System (LMNS) have continued to develop a system approach to maternity and neonate care, identifying where we can make a positive change to our services and improve care for our women/birthing people, babies and their families
- We continue to work towards delivering a range of transformation objectives to make maternity and neonatal care safer, more personalised and more equitable
- On 30 March 2023, NHSE published a three-year Single Delivery Plan for maternity and neonatal services that:
  - sets clear priorities to continue to deliver our maternity and neonatal safety ambitions and provide more personalised care
  - brings together actions from the final Ockenden Report, the report into East Kent, the NHS Long Term Plan and Maternity Transformation Programme deliverables
  - has input from services users, frontline colleagues, system leaders and national stakeholders, including a new working group led by the Royal Colleges.
- The plan will help shape our action plans going forward
- We recognise that our plans need to be linked with the work of a range of other Portfolios. This diagram recognises how we work across partners and Portfolios.

Our commitment

"The local maternity and neonatal system remain committed to bringing together all partners, including users of these services, to work to ensure high quality, safe services 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 Ockenden to avoid reoccurrence in local services. We will listen to our families to support the implementation of the single delivery plan at a local level ensuring local arrangements remain relevant to local need."

Heather Johnstone, SRO Maternity Transformation Programme



Maternity and neonate 2023/24 deliverables

- Implementation of the national single delivery plan for maternity and neonatal care
- Listening to, and working with, women and families with compassion
- Growing, retaining, and supporting our workforce with the resources and teams they need to excel 14
- Developing and sustaining a culture of safety, learning, and support 13
- Standards and structures that underpin safer, more personalised, and more equitable care
- Benchmarking and development of a single delivery plan.

The three year Single Delivery Plan for maternity and neonate care will form the basis of our work programme during 2023/24. We will work together as maternity and neonate services with wider partners as appropriate to embed and deliver the required actions. The ICB will support and monitor the delivery of these requirements through the 12 identified objectives aligned to the four themes within the plan:

Theme 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

Theme 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

Theme 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

Theme 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; Objective 12 – Make better use of digital technology in maternity and neonatal services.

Theme	Progress measures	Year 1 (2023/24)				
		Baseline	Q1	Q2	Q3	Q4
1	• Implementation of perinatal pelvic health services and perinatal mental health services in place • NHS Mental Health Dashboard – number of women accessing specialist perinatal mental health services • Proportion of maternity and neonatal services with UNICEF BFI accreditation.	The national single delivery plan outlines how success against each theme will be determined. The high level key measures for Maternity and Neonates are in development to support and reflect system delivery against the four themes.				
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.					
3	• Results from the NHS Staff Survey, National Education and Training Survey, GMC National Training Survey.					
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.					

Improving Population Health

Improving population health across the life course

The life course approach recognises that at different stages of life, people have different physical, mental health and social needs. This evidence-based 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.

Offering high quality services from conception to death, targeted to those who need it most or have the greatest potential to benefit, will make a significant difference to people and communities in Staffordshire and Stoke-on-Trent.

Population Health Management (PHM)

PHM will help us to understand the health and care needs of our population both now and in the future. We will do this by looking at lots of different health and care data, using intelligence and evidence to make decisions on the different services we need to provide and where to act and react to local needs.

Health Inequalities

This approach will be central to all we do, ensuring we focus efforts on the best ways to support our communities, and ensuring there is as little variation (inequity) as possible in services. Our objectives for health inequalities are set out overleaf.

Prevention

An integrated approach will focus on preventing illness through improved access to preventative services. We will work with people and communities to achieve environments that promote health and wellbeing. We will work together to understand and address the factors that put people at risk.

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, for as long as possible.

Our commitment

"We want to make sure that everyone in Staffordshire and Stoke-on-Trent 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".

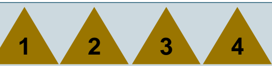
"Working together is the fundamental principal behind the Staffordshire and Stoke-on-Trent Integrated Care Partnership, building on our collective resources and making better use of shared learning and experience. Our residents need to be an equal part of that partnership and we look forward to working with them to achieve our ambition of making Staffordshire and Stoke-on-Trent the healthiest place to live and work."

Dr Paul Edmondson-Jones, Chief Medical Officer

Integrated Care Partnership Strategy

Population Health Management *Making intelligent decisions for the future*	Health Inequalities *Building fairer futures*	Prevention *Changing the future*
• Scale, Spread, Sustain (Infrastructure, Intelligence, Interventions, Incentives) • Cultural Change • Drive ICP Strategy • Integrated Intelligence Collaboative	• Core20PLUS5 • CYP Core20PLUS5 • Broader inequalities (protected characteristics) • Tackling inequalities with specific interventions/innovations	• Primary (risk factors for disease) • Secondary (early detection and diagnosis) • Tertiary (preventing progression of disease)

Research & Innovation

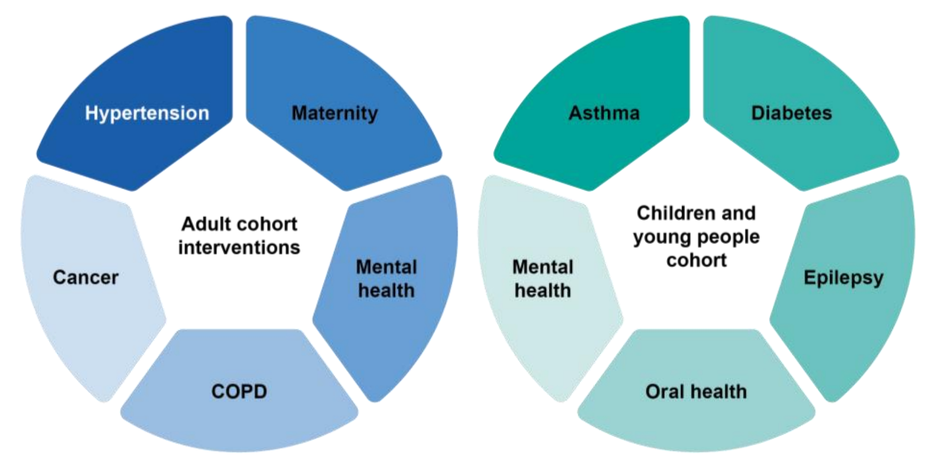


Health inequalities 2023/24 deliverables

- Restore NHS services inclusively
- Mitigate against digital exclusion
- Ensure data sets are complete and timely
- Strengthen leadership and accountability
- Systematic implementation of the Core20 approach.

- Our plans and deliverables reflect the NHS England operational planning guidance national inequalities priorities to: Restore NHS services inclusively, Mitigate against digital exclusion, Ensure data sets are complete and timely, and Strengthen leadership and accountability.
- The systematic implementation of the Core20 approach will start with PLUS5 Groups identified for both adults and children. We will utilise the Core20Plus5 Tailored Support Offering covering connectors, collaborative, ambassadors and trajectories to develop and mobilise our work to take forward the national inequalities priorities and Core20plus5.

Core20PLUS5 – adults, children and young people



Restore NHS services inclusively	• Delivery of ICS Elective Recovery Plan with specific objectives enabling inclusive recovery • Undertake health impact assessment against Elective Recovery Plans • Establish Board-level reporting on health inequalities in elective care patient treatment lists • Use population health management approach to prioritise elective and cancer care waiting lists • Identify and agree high impact action plan from Midlands Decision Support Unit paper on evidence-based intervention.
Mitigate against digital exclusion	• Deliver the ICB Digital Transformation Strategy • Strengthen links with existing programmes in the ICS on digital inclusion with local authorities • Use research and innovation programme to understand barriers to digital inclusion and innovate on new approaches to digital tools for health and care.
Ensure data sets are complete and timely	• Improve data quality towards creating a 'single version of the truth' through the One Health and Care Record, ICS population health management programme and existing programmes of work in ICP partner organisations • Undertake engagement with frontline clinical and administrative staff to understand barriers to capturing accurate data on protected characteristics within services • Embed reporting on inequalities data completeness within ICS governance arrangements • Develop and use the integrated intelligence collaborative to facilitate data sharing between organisations to underpin a strong population health management approach with high quality linked data sets.
Strengthen leadership and accountability	• Establish a network of 'Inequalities Senior Responsible Officer' roles in ICP partner organisations • Develop a programme of reporting on health inequalities to ICS governance arrangements • Maintain a system-wide Health Inequalities Group • Establish a Health Inequalities and Prevention Network and training offer within the ICS • Undertake ICS development programme to strengthen the ICP commitment to health inequalities agenda and support development of a strong ICS programme • Use the Healthcare Inequalities Improvement Planning Matrix across Portfolios and programmes to inform inclusive planning of delivery.

Prevention plans 2023/24 objectives

- Implement NHS Long Term Plan prevention programmes
- Embed prevention across all portfolios
- Utilise population health management techniques to target prevention programmes
- Empower people to take personal ownership
- Self-management of conditions.

- Prevention remains important for people living with long-term illness and 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, for as long as possible.
- Prioritising prevention reflects the growing evidence supporting resources being shifted 'upstream' for people as well as health and care services. There is broad support for this approach in both our communities and workforce.
- We will utilise population health management techniques to target prevention programmes to those with greatest capacity to benefit and address health inequalities.
- We will use the ICP Strategy and Joint Forward Plan to embed prevention across all of our portfolios towards improving future population health and care outcomes.

We will implement NHS Long Term Plan prevention programmes across the ICS, including a focus on:

- Development of tobacco dependence treatment services in all inpatient and maternity settings
- Evidence-based (PH48/NG92/PH26) smoking cessation offer available for at-risk populations, inpatients, pregnant women and for those with severe mental illness (SMI)
- Improve uptake of lifestyle services, Diabetes Prevention Programme, low calorie diets, the new Digital Weight Management Programme and digitally supported self-management services
- Restore diagnosis, monitoring/management of hypertension, atrial fibrillation, high cholesterol, diabetes, asthma and COPD registers and spirometry checks for adults and children, to pre-pandemic levels in 2022/23
- Develop improvement of optimal Alcohol Care Teams in hospitals with the highest rates of alcohol dependence-related admissions
- Weight management – implementation of T3 and T4 services
- Continue to adopt culturally competent approaches to increasing vaccination uptake.

Part 3

The implications for our resources

Workforce

- Approach to planning: Shared vision based on the NHS People Plan and NHS People Promise, developed and informed by collaboration and historical delivery.
- Transformation: Implementation and introduction of new roles. In the long-term, drive approaches to develop supply opportunities through career pathways.
- Key recruitment activities: Continue to understand 'hard to recruit' and hotspot areas and subsequent interventions to address, be an 'employer of choice'.
- Retention: Significant focus on retention challenges and mitigations to support retention initiatives, including improvement on-boarding, flexibility and career development.
- Health and wellbeing: Continue to strengthen existing support available to staff to help them be well at work.
- Temporary staffing: Oversight of temporary staffing usage and plans to continue to support identification of improvement opportunities to decrease reliance where possible.
- Key risks and issues: Challenges remain in relation to supply and retention and specific shortages in specific areas of the workforce.

The above is underpinned by support and implementation at scale to ensure opportunities for duplicity are maximised across the system.

Our commitment

"We continue to build on our collaborative approach towards delivering the National guidance for ICB People Functions to support a sustainable 'One Workforce', linked to our People Promises, focusing on priorities to:

- Inform and insight: Informing and actively shaping workforce supply (partnership with Health Education England)
- Transform and collaborate: Ensuring the transformation activity is understood and incorporated, where new roles or development to existing workforce is required, at scale
- Maintain and improve: Ensuring we maintain and improve wellbeing and mitigate the retention risks within our ICS
- Equity: Ensuring the impact of the above addresses the areas of highest need from a population health/reducing health inequalities perspective."

Alex Brett, Chief People Officer

People Plan priorities:

Supporting the health and wellbeing of all staff

Growing the workforce for the future and enabling adequate workforce supply

Supporting inclusion and belonging for all, creating a great experience for staff

Valuing and supporting leadership at all levels, and lifelong learning

Leading workforce transformation and new ways of working

Educating, training and developing people and managing talent

Driving and supporting broader social and economic development

Transforming People services and supporting the People profession

Leading coordinated workforce planning and intelligence

Supporting system design and development

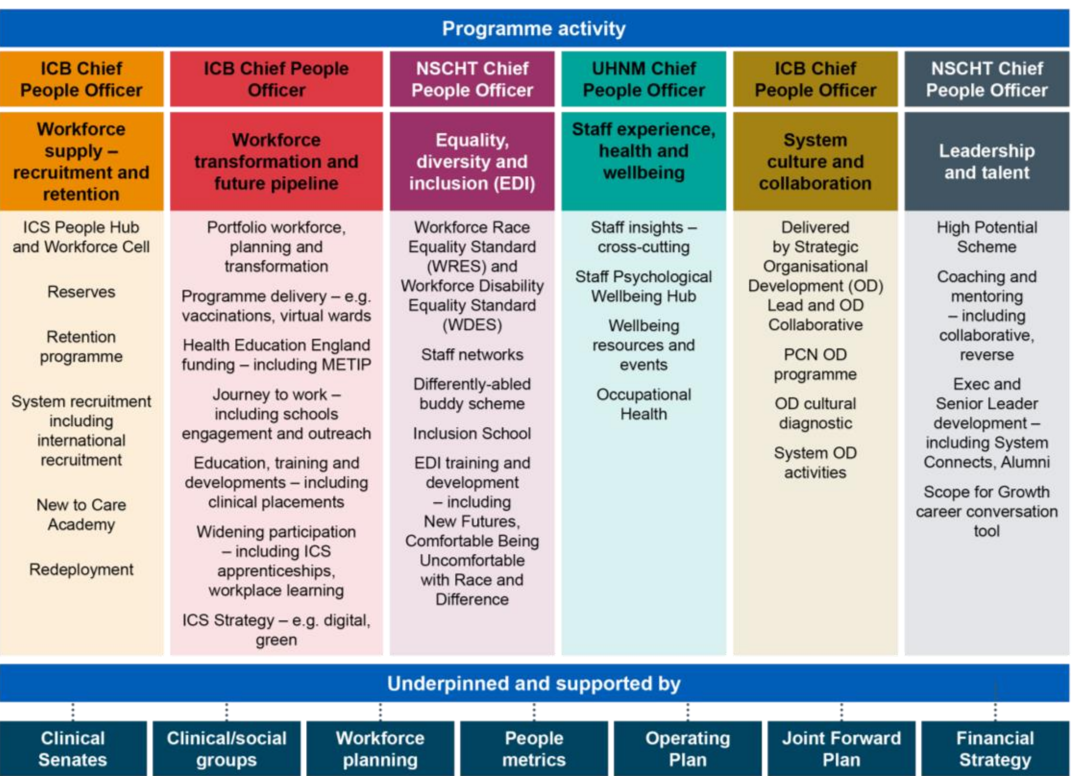
Looking forward

To tackle the workforce challenges and close the gaps is a vast undertaking. The ICS People Function is key for the system working together to strengthen the offer to our existing workforce, attract and support more people from our local communities into careers in health and care, and create a robust pipeline of trained and skilled people to deliver quality treatment and care to our population.

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

- Embedding ‘One Workforce’ approach, driven and owned across organisational boundaries
- Creating the right cultural environment for people to thrive, focusing on civility and safe working ethos, embedding inclusive cultures underpinned by equality and diversity
- Integrated workforce planning and transformation, aligned to national and system priorities and portfolios, including design of new staffing models and roles to deliver care differently
- Further development of the national 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 – attracting, training and supporting our local population into entry level roles and career pathways across health and care
- Implementing and embedding the Journey to Work concept with partners, communities, education to build a robust offer of support to increase our pipeline, create opportunities for everyone and ensure our workforce is representative of 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
- Expanding Widening Participation activities across all our partners including Cornerstone, T-Levels, traineeships, apprenticeships, workplace learning
- Developing our ICS Education, Training and Development Strategy with our education providers, addressing our collective challenges including clinical placement capacity, future pipeline and transforming course offers
- Provide the workforce with the tools and skills to enable digital transformation and to support our population in building their digital skills for self-care and prevention.

ICS People Function



Finance

"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 2023/24 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 bear down on unwarranted variation and improve productivity."

Paul Brown, Chief Finance Officer

Context	• System achieved breakeven in 2022/23 • System plan is a **breakeven** for 2023/24 • Significant risk in getting breakeven – unmitigated value £83m and further risks where mitigations are currently being assessed.
Goal	• National expectation is that systems will achieve break-even and break-even remains our goal, notwithstanding the risks identified above • Tackle the underlying deficit during the year so that we enter the 2024/25 planning period in better shape • Reward for getting there, since this would be the second consecutive year of system breakeven since COVID, is that the system legacy debt of £300m would be written off.
Actions	• Whole system to undertake a line-by-line review and agree costs that can be removed, to support in-year balance and contribute towards the elimination of the underlying deficit • Agreement to a 'Double Lock' mechanism so that no part of the system takes decisions that would mean missing 2023/24 financial target or worsening the underlying position • 2023/24 target achieved and underlying deficit eliminated through four actions: organisational grip (delivery of organisational positions), system oversight on system stretch, the line-by-line and a transformational focus on discharge and CHC.

Delivering the Financial Plan

- The system has agreed the following key actions to continue our focus on the financial position.

- Revisit all workforce plans to maximise the opportunities to reduce reliance on temporary staff and cut premium costs and ensure that growth in workforce delivers improved productivity or addresses key delivery targets
- Deliver a CHC Recovery Plan which arrests the escalation and seeks to reverse the growth in care costs. This will include the development of ambitious plans, jointly with our local authority colleagues to stimulate and manage the care market
- Ensure we maximise all possible efficiencies in both primary and secondary care in terms of prescribing and drugs costs, such as the urgent implementation of biosimilar switches
- Collectively work with our community trust and local authority partners to ensure that investment in the Better Care Fund and discharge funding, is directed at services which make a tangible contribution to delivery, especially in terms of admission avoidance for the frail elderly and timely discharge arrangements from acute settings
- Develop the efficiency plans, increasing the proportion that are delivered through recurrent schemes.

1. Capacity
Other than specific targeted additional funding (e.g. TIF) capacity will be static

2. Workforce
Broadly, workforce establishment will be the same – but more staff in post and fewer agency

3. Productivity
More activity through the existing capacity

4. Savings
2% cash out to cover cost pressures and the convergence factor

5. Manage activity
Integrated care models so that more pathways take place outside of the acute sector

6. Repatriate
Replace use of Independent Sector for electives, mental health placements with in-house capacity

Annex A - Our enablers to success

There are a series of enablers to delivery, outlined in the following slides, which include:

- Clinical and Professional Leadership in each portfolio. Our clinical leads through the clinical senate have set our their priorities
- Understanding current, and predict future health and care needs (population health)
- Broader enabling functions and programmes
- Our provider collaborative programme

Clinical and professional leads (CPL) focus for 2023/24

- The focus areas were initially identified by senior clinicians and professionals at the system planning summit 2023/24, and developed and signed off through the Health and Care Senate.
- As a CPL community, we collectively agreed to tackle unwarranted variation and health inequalities because we strongly believe that all residents have the right to expect high quality, evidence-based care with equitable access.
- As CPL leads, our collective approach and our three clinical level priorities support the delivery of the high level system priorities and national objectives through a focus on CVD, respiratory disease and cancer pathways. These conditions cause significant premature mortality across our residents, and are responsible for the biggest difference in premature mortality between our most and least deprived communities.
- We will also focus on the opportunities for primary, secondary and tertiary prevention and Identifying and tackling health inequalities.

Unwarranted variation

Unwarranted variation describes differences in care that cannot be explained by illness, medical need, or the dictates of evidence-based medicine. It contributes to inefficiencies and poor outcomes. Unwarranted variation is a key theme in the NHS Long Term Plan and is a relatively untapped opportunity for improvement in our system. It has been difficult to measure in the past due to lack of agreed pathways to benchmark care against.

An end-to-end review of pathways and processes against best practice to identify unwarranted variation will be a focus for the clinical and professional leadership in 2023/24, starting with areas where the data tells us we are outliers and outcomes are poor. Health inequalities will be exposed and targeted for improvement.

3 clinical priorities:
1. Cardiovascular disease
2. Respiratory disease
3. Cancer

We will start with the three biggest drivers of the difference in avoidable mortality between the most and least deprived areas of Staffordshire and Stoke-on-Trent which will support system and portfolio objectives:

- **CVD** – avoidable premature mortality in under 75s is almost double the England average, as is premature mortality in those with SMI. We have high prevalence of smoking, obesity and poor achievement of BP targets. We have high NELs, total bed days and OPA. Aligned to national objective 28.
- **Respiratory diseases** – high rates of mortality from respiratory diseases in under 75s, high NELs, total bed days and OPA but low rates of review of asthma and COPD, and referral for smoking cessation. Aligned to long term condition local priorities.
- **Cancer** – high rates of mortality from cancer in under 75s with low rates of uptake of cervical and bowel cancer screening in some populations. We have high elective and NEL admissions and OPA in gynae oncology and radiotherapy and some significant challenges to delivery of constitutional standards for OPA and treatment. Aligned to national objectives 10,11,12.
- These are also three elements of the CORE20 Plus 5 approach to tackling health inequalities. Aligned to national objective 29.

Priorities for the 7 portfolios

Each of the 7 portfolios have identified a priority focus for 2023/24 to deliver against the 4 system priorities 31 national objectives and 50 national actions including:

- **IPH:** Implementation of CORE20Plus5 approach, and supporting inclusive recovery of backlogs using PHM
- **CYP & maternity:** Implementation of an integrated pathway for children with complex needs and implementation of the national delivery plan for maternity and neonatal care
- **ELF:** Implementation of a PHM approach to LTC, frailty and EoL transformation and pathway design
- **Primary care:** Improve access to the right primary care services
- **Planned care:** Referral and intervention management
- **UEC:** Reduction of avoidable acute bed days through full review and priority setting for virtual ward and delivery of a fully integrated discharge "hub"
- **Mental health:** 24/7 mental health crisis-care integration with NHS111.

Enabling priorities

- Embedding a PHM approach to systematically identify opportunities to improve care and inequalities, and design targeted evidence-based interventions
- Implementing digital innovations
- Reduction in activities of low clinical value
- Supporting workforce recruitment, retention and diversification
- Expanding CPL networks.

Population health management (PHM)

The vision for the programme is to enable, implement and embed a population health management 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 population health management will:

- deliver integrated health and care that is underpinned by intelligent decision-making using data on our population's health and care needs
- 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
- identify inequalities in access, experience, and outcomes of care to inform improvements to care pathways so that we offer high quality inclusive care
- 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.

Population health management programme key areas

Infrastructure

- Organisation and human factors
- Digital infrastructure and maturity
- Information governance process
- Vision

Intelligence

- Advanced analytical tools
- Analyses and actionable insight
- Alignment of multi-disciplinary analytical and improvement teams
- Development of a cross-system ICS intelligence function

Interventions

- Care model design and delivery
- Monitoring and evaluation of patient outcomes and impact of intervention to feed into continuous improvement cycle
- Person-centred care
- Community wellbeing voluntary and third sector

Incentives

- Population health based contracting and payment models
- Workforce development and modelling
- Enabling governance

Continuing healthcare 2023/24 deliverables

- We know that the pandemic has had a significant impact on the delivery of continuing healthcare (CHC) – 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
- Although the system achieved the closure of the deferred backlog of assessments for individuals with care while the suspension was in place via COVID monies, the impact and aftermath to return to business as usual has and continues to be a significant challenge
- The service has consistently underachieved the NHS England Quality Premium Standard of >80% of Decision Support Tools completed within 28 days throughout 2022/23
- During Q3 of 2022/23, we were the third highest ICB nationally in terms of CHC eligibility rates which stand at 30% against an average of 23%, and there has been a visible and sharp increase from October 2022 onwards. The ICB was also the 12th highest across the country in terms of Fast Track eligibility
- A CHC Action Plan has been developed and approved by the ICB Finance and Performance Committee. The Action Plan will be subject to detailed monitoring throughout 2023/24.

"Our CHC position offers significant challenge and will be a real area of focus for us throughout 2023/24 as we work to deliver a return to a clinically and financially sustainable service model. This will involve a wholescale review of the CHC service, including interdependencies with other pathways and models of care. Our ability to work in partnership as a system will be the key to success in ensuring we are able to secure improvements in quality, efficiency and effectiveness."

Chris Bird, Chief Transformation Officer

Our high level key measures for continuing healthcare

	Year 1 (2023/24)				
Objective	**Baseline**	Q1	Q2	Q3	Q4
Reduction in the number of patients in D2A requiring a full DST to be completed.	The baselines are in development to then build quarterly targets from.				
Reduction of the overdue CHC backlog to 10% of the caseload.					
Reduction in costs for CHC packages and placements					

During 2023/24, we will focus on:

1. Engaging with the market to develop a financial sustainable commissioning process for both the market and the system that maintains good quality and safe care to our population.
2. Working with system partners to review current CHC discharge processes to ensure delegated decision making is in line with the Framework and Regulations, whilst maintaining flow within the urgent care system by supporting discharge within the set parameters and principles agreed for CHC.
3. Developing a robust and transparent CHC Policy that articulates the ICB's intentions to provide CHC-funded services to those eligible.

Quality

Our commitment

"Our system is collectively committed to delivering our statutory duty for quality through a programme of quality assurance and improvement activity. 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 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."

Heather Johnstone, Chief Nursing and Therapy Officer

- Our partners play a vital role in providing oversight of the quality of care provided, and in creating and sustaining a culture of openness, learning and continuous improvement
- The emphasis has shifted from provider-based reporting to system-level. 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 Quality and Safety Committee share accountability for the quality of services and for driving required improvements
- System partners 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 and 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. In the event that 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
- Partners have worked collaboratively to develop a framework and a set of mutually agreed principles. 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. 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.

Digital

Our commitment

"From a resident's perspective, it is critical that each of us can engage digitally when accessing health and social care services, providing a seamless care journey, underpinned by accurate and up to date information. We shouldn't have to repeat the same information every time we see a new health and care professional. From a health and care provider perspective, information needs to be accessible at the point of care so that safer and better decisions can be made about people's care."

Chris Ibell, Chief Digital Officer

Our Digital Roadmap

The ICB Digital Roadmap aims to empower our care providers and recipients of care to make the most of the benefits full digital enablement can deliver. The Digital Roadmap has been developed collectively by system stakeholders.

The aim of the system is to provide the best health and social care for our 1.1m residents	The goal of integrated care means that we focus on the patient pathway, and not the organisation	This means that our digital solutions are a system resource and needs to be targeted to where it can have the biggest impact	This Digital Roadmap is an enabler of this goal	The underpinning principle is that we enable the best use of digital technology to improve efficiency and care coordination	And from that, the best digital enablement models will appear

Our digital initiatives for 2023/24 are aligned with national aims, local need, and our collective ICS goals and ambitions to digitise, connect and transform.

1 Digitise

Electronic Patient Record (EPR)
Level up access to electronic records and converge on fewer EPR products across the system

Cyber security and support
Ensuring that the ICS partners' cyber and support approach is robust and serves to uniformly protect the entire system

Infrastructure convergence
Converge hardware and software to reduce variation, moving towards common networks/ wireless/connectivity across the ICS

Digital learning
An individual budget to upskill staff and individuals to use digital in a way that is aligned to predefined skills pathways

Digitise adult social care
Improving digital maturity of adult social care throughout the ICS

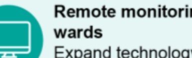
2. Connect

One Health and Care
Digital One Health and Care, sharing data across NHS and local government organisations, and supporting collaboration at a system level

Development of data access and business intelligence
Comprehensive, system-level information asset management (AKA Corporate DW) to drive evidence-based decision making and service improvement [I think DW is data warehousing?]

Population Health Management (PHM)
Implement PHM to understand the population and thereby enable interventions to address issues such as diversity and/or inequality of service provision

3. Transform



Citizen digital inclusion
Offering greater digital choice for how citizens can access and manage health and care services

Remote monitoring and virtual wards
Expand technology use to support treatment at home and prevent health issues escalating in vulnerable or at-risk groups

Automation (RPA)
Expand the adoption to intelligently automate manual, time-sensitive and repetitive tasks, reducing duplication and error

Collaborative ways of working and model for digital
Putting in place the right operating model, standards and tools to foster collaboration

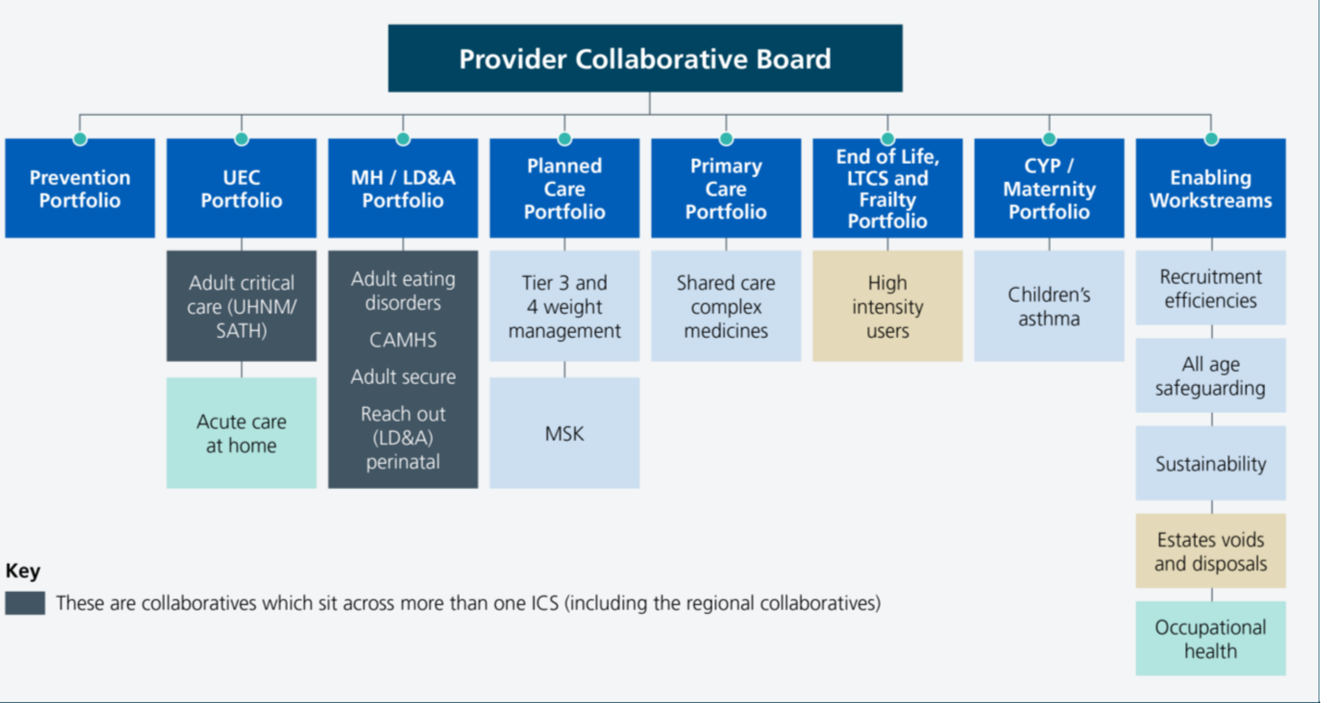
Provider collaborative projects

- The Provider Collaborative approach has an Executive Sponsor and is developing well across the majority of our system portfolios and enabling workstreams as the delivery vehicle for transformation at scale
- A Programme Board meets monthly with Executive representatives from acute providers, community providers, Place, ICB, local authority and general practice. A Board Work Programme has been agreed to enable the delivery of the ICS Advanced Design features and will be revised when the Provider Collaborative Maturity Matrix is finalised
- Our approach has been developed against a set of design principles
- A Development Framework to support emerging provider collaborations has been tested and is in place, reflecting the design principles, system priorities and the ICS Advanced Design features
- The Provider Collaborative Board both oversees the developing collaboratives and those collaboratives which we are apart of outside of our system including Lead Provider Collaboratives, e.g. mental health and Provider Partnerships
- During 2023/24, we will focus on a range of projects across our portfolios. The TDU will work with the Provider Collaborative Programme Director to ensure consistency of approach for all provider collaborative projects through the project lifecycle road map.

Our commitment

"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. Over the next 12 months we will continue to focus on working at scale to properly address unwarranted variation and inequality in access, experience and outcomes across wider populations. This will also 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."

Tracy Bullock, Executive Lead



Place

Our commitment

"We are committed to working in partnership with our system colleagues in establishing the two Place-based Partnerships – Stoke-on-Trent and Staffordshire. Through these partnerships, we will create an engine room of collaboration between organisations so that we can better Through these arrangements we will better plan and deliver health and care services focussed on improving health and wellbeing."

Chris Bird, Chief Transformation Officer

- We have a two Place model aligned with our upper-tier local authorities (Stoke-on-Trent City Council and Staffordshire County Council) which has been agreed by all system partners developing the governance to continue to provide system oversight to Place
- System agreed Place model will focus on integrated commissioning, with both local authorities having integrated health and social care teams. Both local authorities shared their visioning papers based on the Integration White Paper. The ICB is pulling together a bridging document identifying areas of alignment and difference, and the ICB proposes bringing the paper together for one overarching view, to be presented to CEOs for discussion and agreement in mid-September
- Programme governance for the development of Place was agreed by all system partners, and the operational and steering groups first met in September 2022. Initial Place Executive meetings were held in early October. This structure will be in place on an individual basis
- Priorities for Place were identified and agreed as care homes, learning disabilities and autism, transitions/preparation for adulthood, dementia and S117. Work programmes have commenced to develop the approach to these areas feeding into the Place Executive Groups. These programmes contribute to the delivery of system and national priorities and objectives
- Full review of the Better Care Funds to support further areas of integration with the aim of transparency across aligned services in the first year to support discussions regarding full integration. Alignment meetings between Place and Provider Collaborative leads commenced to ensure that close working is achieved and the developing models complement each other, and interdependencies are identified and acted upon
- 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
- An emerging difference in approach to Place between the local authorities which continues to be discussed and developed to ensure that the Place offer is consistent for our population recognising local need wherever possible
- Development of governance to continue to provide system oversight to Place
- The ICB is fully committed to delegation where it makes sense, recognising that full system buy-in is required and that a robust process needs to be followed.

Personalised care 2023/24 objectives

- The NHS Long Term Plan places a commitment for ICBs and wider ICS partners to roll out personalised care to its population
- Personalised care is also a key enabler to managing demand for urgent and unplanned care services through individuals, families and carers taking a more proactive, preventative approach to health and wellbeing through forward health and care planning and self-care management
- We will do this through the ongoing development of strengthened relationships between individuals and professionals across the health and care system
- We will take learning from the areas of system change and embedded personalised care approaches achieved through the Memorandum of Understanding (MOU) foundations
- Population health management will be a driver 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.

Our commitment

"We have a unique opportunity to transform the way health and social care services are designed and delivered in Staffordshire and Stoke-on-Trent. Working with partners, we want to rebuild new and improved services in a different way to ensure they address inequalities and better support individuals, families and communities now and in the future."

Chris Bird, Chief Transformation Officer

Our high level key measures for personalised care

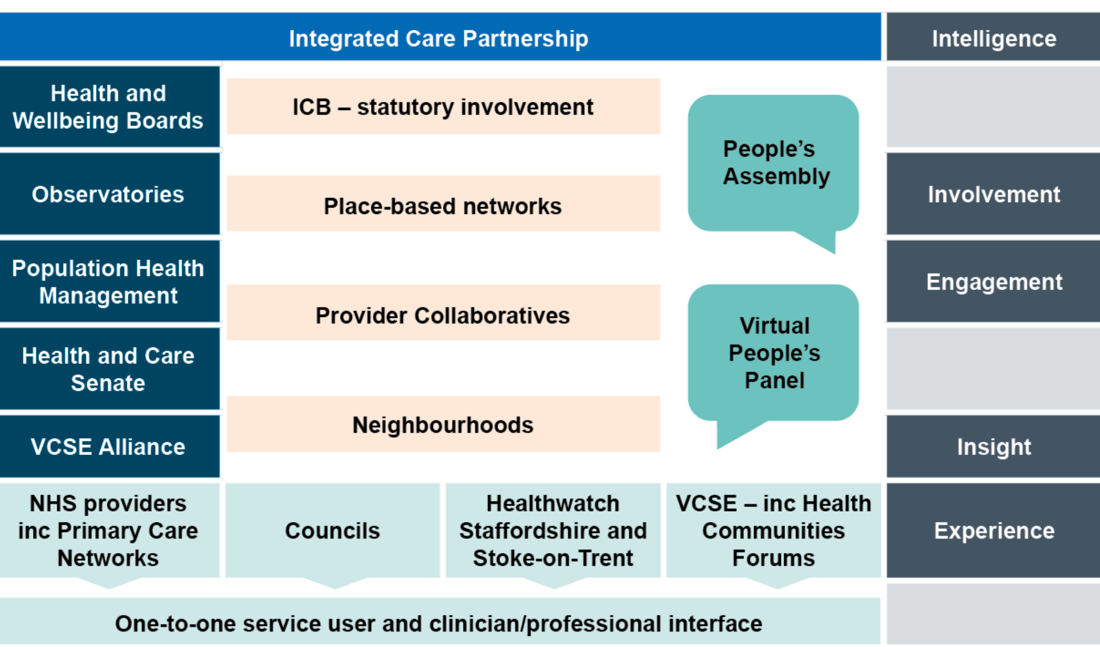
		Year 1 (2023/24)			
Objective	**Baseline**	Q1	Q2	Q3	Q4
Promote and offer personal health budgets for people with a legal right to have in priority local cohorts.	2,556	2,588	2,620	2,652	2,684
Increase the number of personalised care support plans (PCSPs) for identified cohorts in line with the PCSP model.	62,268	63,046	63,824	64,602	65,380
Delivery of increased referrals to social prescribing link workers (or other equivalent PCI trained professionals).	24,646	24,954	25,262	25,570	25,878

During 2023/24, we will continue to focus on:

- Further developing and embedding the areas of good practice delivered and achieve through the personalised care MOU, Partnership Agreement and Expansion Funds
- Develop an ICS Personalised Care Strategy to embed the approach of the comprehensive model for personalised care in existing Portfolio areas, Provider Collaboratives and Place.

Working with people and communities

- Transitioning to a new way of working as an integrated care system 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 the ICS by engaging with the public 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
- 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 across Staffordshire and Stoke-on-Trent
- Our People and Communities Assembly will help 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
- The Assembly advises 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 as the ICS matures and evolves, supporting the vision to make Staffordshire and Stoke-on-Trent the healthiest place to live and work.



Strategic transformation and service changes 2023/24

- Service change is any change to the provision of NHS services which involves a shift in the way front line health services are delivered, and/or the geographical location from which services are delivered
- In addition to our operational transformations, we have a small number of strategic transformation programmes where our focus for 2023/24 requires wider community engagement to manage the change
- The Portfolios are supported by our System Transformation function to manage those significant service changes. The table on the right summarises the key actions.

Programme and portfolio	Key actions for 2023/24
Inpatient mental health services (IMHS) *Mental Health, Learning Disabilities and Autism Portfolio*	• Technical Group to receive report of findings 9 June 2023 • Following receipt of the report of findings, to begin development of the Decision Making Business Case (DMBC) and reviewing impact assessments • Share report of findings with the Staffordshire Health Overview and Scrutiny Committee • Papers to be developed and submitted to take report of findings through ICB governance process (September 2023).
Urgent and emergency care (urgent treatment centre designation) *Urgent and Emergency Care (UEC) Portfolio*	• Further technical session to take place May 2023 • Briefing paper to be shared following the technical events • Stage 1 NHS England assurance check point meeting to take place • West Midlands Clinical Senate desktop review of proposals • Integrated impact assessments developed • Travel impact analysis • Governance process to be developed (multiple providers) and signed off • Business case to be developed and taken through approved governance routes.
Cannock transformation programme *Primary Care, UEC, Planned Care Portfolios*	• Planning application to be submitted early March 2023 – delayed until April 2023 • Agree lease arrangements for accommodation to house service offer • Completion of feasibility study to confirm location for Alliance Medical mobile MRI scanner • Completion of UEC specification, costs of service provision and potential procurement route.
Maternity *Children and Young People and Maternity Portfolio*	• Communications and involvement plan to be developed • Stakeholder mapping conducted • Bi-weekly maternity meeting to be established • Service change programme office to be established.
Community Diagnostic Centres (CDCs) *Planned Care Portfolio*	• Implementation plans for University Hospitals of Derby and Burton and Royal Wolverhampton NHS Trust CDCs to be assured via Planned Care Portfolio Board • (North CDC) Implementation Group to be established reporting into the Planned Care Portfolio Board and Strategic Transformation Group.
Assisted Conception *Planned Care Portfolio*	• Technical Group to receive report of findings May 2023 • Following receipt of the report of findings, revise the draft interim policy and reviewing impact assessments • Share report of findings with the Staffordshire Health Overview and Scrutiny Committee • Take report of findings and interim policy through ICB governance process.

Annex B
Assurance on delivery and 31 National Objectives

We will deliver our ambitions and priorities through a range of vehicles that have been set up to work at the level and scale required to make the biggest impact on improving population health and wellbeing in Staffordshire and Stoke-on-Trent.

Delivery

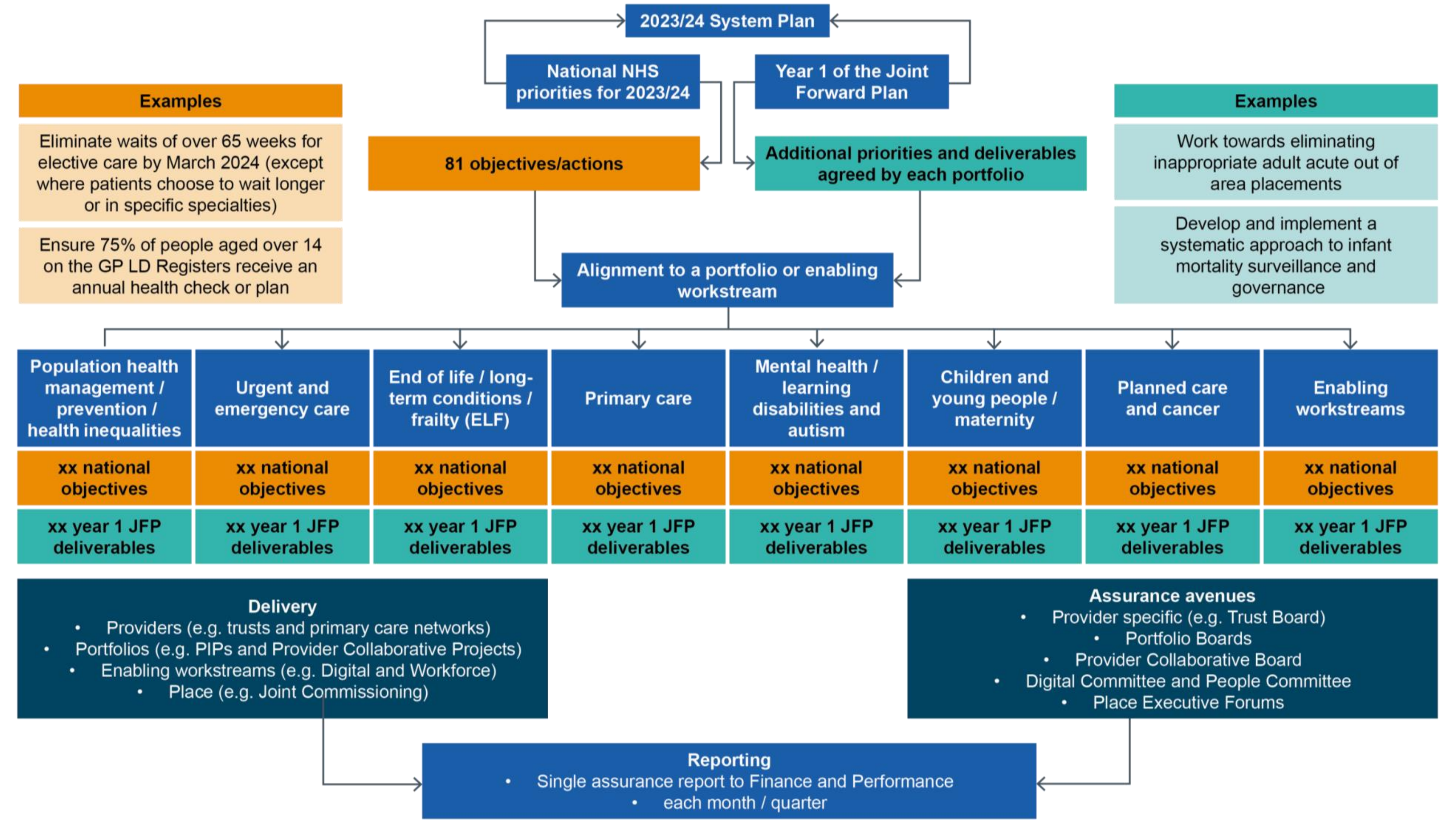
Assurance on delivery

- As partners, we will undertake a continuous appraisal of the position, performance, and delivery of the key priorities and goals set out in the 2023/24 plan
- All system leaders need to be collectively assured that there are mechanisms in place to demonstrate compliance against the 2023/24 System Operating Plan
- The System Operating Plan is made up of a range of quantitative and qualitative objectives and actions which will need to be delivered either through a provider specific activity or a system-led transformation programme. Often there is a clear interdependency between these two types of activity that needs to be managed for an objective to be delivered
- The challenge for the ICS/ICB is to bring these different approaches together into a single view of performance.

How will we make this happen?

- Each national and local objective is aligned to one of the portfolios or enabling workstreams which make up the delivery architecture for the system
- We have identified which deliverables are specific to individual providers and which deliverables require a system approach
- We will use existing assurance mechanisms to demonstrate compliance, e.g. Statutory Trust Boards and Portfolio Boards. Any gaps will be escalated to Executive Leads who attend the System Performance Group in the first instance
- Progress will be reported to the ICB's Finance and Performance Committee, who will take overall responsibility for the delivery of the 2023/24 System Operating Plan
- A flow chart of how this should work in practice is set out on the next page.

Assurance on delivery



	National objectives	Portfolio
1	Improve A&E waiting times so that no less than 76% of patients are seen within four hours by March 2024 with further improvement in 2024/25	UEC (Slide 16)
2	Improve Category 2 ambulance response times to an average of 30 minutes across 2023/24, with further improvement towards pre-pandemic levels in 2024/25	
3	Reduce adult general and acute (G&A) bed occupancy to 92% or below	
4	Consistently meet or exceed the 70% two-hour urgent community response (UCR) standard	
5	Reduce unnecessary GP appointments and improve patient experience by streamlining direct access (DA) and setting up local pathways for direct referrals	Primary Care (Slide 23)
6	Eliminate waits of over 65 weeks for elective care by March 2024 (except where patients choose to wait longer or in specific specialties)	Planned Care (Slide 18)
7	Deliver the system-specific activity target (agreed through the operational planning process)	
8	Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95%	Diagnostics (Slide 19)
9	Deliver diagnostic activity levels that support plans to address elective and cancer backlogs and the diagnostic waiting time ambition	
10	Continue to reduce the number of patients waiting over 62 days	Cancer (Slide 19)
11	Meet the cancer faster diagnosis standard by March 2024 so that 75% of patients who have been urgently referred by their GP for suspected cancer are diagnosed or have cancer ruled out within 28 days	
12	Increase the percentage of cancers diagnosed at stages 1 and 2 in line with the 75% early diagnosis ambition by 2028	
13	Make progress towards the national safety ambition to reduce stillbirth, neonatal mortality, maternal mortality and serious intrapartum brain injury	Maternity (Slide 31)
14	Increase fill rates against funded establishment for maternity staff	
15	Make it easier for people to contact a GP practice, including by supporting general practice to ensure that everyone who needs an appointment with their GP practice gets one within two weeks and those who contact their practice urgently are assessed the same or next day according to clinical need	Primary Care (Slide 23)
16	Continue on the trajectory to deliver 50 million more appointments in general practice by the end of March 2024	
17	Continue to recruit 26,000 Additional Roles Reimbursement Scheme (ARRS) roles by the end of March 2024	
18	Recover dental activity, improving units of dental activity (UDAs) towards pre-pandemic levels	
19	Improve access to mental health support for children and young people in line with the national ambition for 345,000 additional individuals aged 0-25 accessing NHS-funded services (compared to 2019)	Mental Health (Slide 26)
20	Increase the number of adults and older adults accessing IAPT treatment	
21	Achieve a 5% year-on-year increase in the number of adults and older adults supported by community mental health services	
22	Work towards eliminating inappropriate adult acute out of area placements	
23	Recover the dementia diagnosis rate to 66.7%	
24	Improve access to perinatal mental health services	
25	Ensure 75% of people aged over 14 on GP learning disability registers receive an annual health check and health action plan by March 2024	Learning Disabilities and Autism (Slide 27)
26	Reduce reliance on inpatient care, while improving the quality of inpatient care, so that by March 2024 no more than 30 adults with a learning disability and/or who are autistic per million adults, and no more than 12–15 under-18s with a learning disability and/or who are autistic per million under-18s are cared for in an inpatient unit	
27	Increase percentage of patients with hypertension treated to NICE guidance to 77% by March	IPH (Slide 33)
28	Increase the percentage of patients aged between 25 and 84 years with a cardiovascular disease risk score greater than 20% on lipid lowering therapies to 60%	
29	Continue to address health inequalities and deliver on the Core20PLUS5 approach	
30	Deliver a balanced net system financial position for 2023/24	Finance (Slide 38)
31	Improve retention and staff attendance through a systematic focus on all elements of the NHS People Promise	Workforce (Slide 36)