NHS
Staffordshire and Stoke-on-Trent
Integrated Care Board

Staffordshire and Stoke-on-Trent Integrated Care Board Meeting HELD IN PUBLIC

Thursday 15 June 2023
1.00pm-3.00pm
Via MS Teams

[A = Approval / R = Ratification / S = Assurance / D = Discussion / I = Information]

	Agenda Item	Lead(s)	Enc.	A/R/S/ D/I	Time	Pages
1.	Welcome and Apologies • Leadership Compact	Chair	Enc. 01	S	1.00pm	1
2.	Quoracy		Verbal			2
3.	Conflicts of Interest		Enc. 02			3-4
4.	Minutes of the Meeting held on 20 April 2023 and Matters Arising	Chair	Enc. 03	A		5-12
5.	Action Log Progress Updates on Actions	Chair	Enc. 04	D		13
6.	Questions submitted by members of the public in advance of the meeting	Chair	Verbal	D	1.05pm	
	Strategic and System Development					
7.	ICB Chair and Chief Executive Update	DP/PA	Enc. 05	D/I	1.10pm	14-21
8.	Living My Best Life: A Joint Strategy for Disabled & Neurodivergent people in Staffordshire 2023-2028	CB	Enc. 06	A	1.25pm	22-33
	System Oversight and Governance					
9.	Quality and Safety Report	HJ	Enc. 07	S	1.50pm	34-43
10.	M1 Finance & Performance Report	HD/PSm	Enc. 08	D	2.00pm	44-57
11.	System Financial Plan 2023/24	HD	Enc. 09	D/I	2.10pm	58-77
12.	Joint Forward Plan 2023/24	CB	Enc. 10	A	2.20pm	78-219
13.	PCI Annual Report	AB	Enc. 11	D/I	2.30pm	220-255
	Committee Assurance Reports					
14.	Finance and Performance Committee	MN	Enc. 12	S	2.40pm	256-259
	Any other Business					
15.	**Items notified in advance to the Chair**	All		D		
16.	**Questions from the floor relating to the discussions at the meeting**	Chair			2.45pm	
17.	**Meeting Effectiveness**	Chair				
18.	**Close**	Chair			3.00pm	
19.	**Date and Time of Next Meeting** 20 July 2023 at 12.30pm in public – Stafford Hub					

ICS Partnership 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**.

NHS
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Stoke-on-Trent
Integrated Care Board

STAFFORDSHIRE AND STOKE-ON-TRENT INTEGRATED CARE BOARD
CONFLICTS OF INTEREST REGISTER 2023-2024
INTEGRATED CARE BOARD (ICB)
AS AT 8 JUNE 2023

Kev
Declaration completed for financial year 2023/2024
Declaration for financial year 2023/2024 to be submitted

Note: **Kev relates to date of declaration**

Date of Declaration	Title	Forename	Surname	Role	Organisation/Directorate	1. Financial Interest	2. Non-financial professional interests	3. Non-financial personal interests	4. Indirect interests	5. Actions taken *to mitigate identified conflicts of interest*
3rd April 2023	Dr	Buki	Adeyemo	Chief Executive	North Staffs Combined Healthcare Trust	Nothing to declare	1. Membership of WRES - Strategic Advisory Group (ongoing) 2. CQC Reviewer (ongoing)	1. Board of Governors University of Wolverhampton (ongoing)	Nothing to declare	(a) to (g) inclusive as required in any procurement decisions relating to third parties advice is offered to by company.
1st April 2023	Mr	Jack	Aw	ICB Partner Member with a primary care perspective	Staffordshire and Stoke-on-Trent Integrated Care Board	1. Principal Partner Loomer Medical Partnership Loomer Road Surgery, Haymarket Health Centre, Apsley House Surgery (2012 - present) 2. Clinical Director - About Better Care (ABC) Primary Care Network (2019 - ongoing) 3. Staffordshire and Stoke-on-Trent ICS Primary Care Partner Member (2019 - present) 4. Director Loomer Medical Ltd Medical Care Consultancy and Residential Care Home (2011 - ongoing) 5. Director North Staffordshire GP Federation (2019 - ongoing) 6. Director Austin Ben Ltd Domiciliary Care Services (2015 - ongoing) 7. CVD Prevention Clinical Lead NHS England, West Midlands (2022 - ongoing)	1. North Staffordshire GP VTS Trainer (2007 - ongoing) 2. North Staffordshire Local Medical Committee Member (2009 - ongoing)	1. Newcastle Rugby Union Club Juniors u11 Coach (ongoing)	1. Spouse is a GP at Loomer Road Surgery (ongoing) 2. Spouse is director of Loomer Medical Ltd (ongoing) 3. Brother is principal GP in Stoke-on-Trent ICS (ongoing)	(a) to (g) inclusive as required in any procurement decisions relating to third parties advice is offered to by company. (h) recorded on conflicts register.
1st April 2023	Mr	Peter	Axon	CEO ICB	Staffordshire and Stoke-on-Trent Integrated Care Board	Nothing to declare	Nothing to declare	Nothing to declare	Nothing to declare	No action required
6th April 2023	Mr	Chris	Bird	Chief Transformation Officer	Staffordshire and Stoke-on-Trent Integrated Care Board	1. Interim Chief Transformation Officer, NHS Staffordshire & Stoke-on-Trent ICB until 31.07.23. Substantive role - Director of Partnerships, Strategy & Digital , North Staffordshire Combined Healthcare NHS Trust (April 2023 - July 2023)	1. Chair of the Management Board of MERIT Pupil Referral Unit, Willeton Street, Bucknall, Stoke-on-Trent, ST2 9JA (April 2023 - March 2024)	Nothing to declare	Nothing to declare	(a) to (g) inclusive as required in any procurement decisions relating to third parties advice is offered to by company. (h) recorded on conflicts register.
3rd April 2023	Mr	Paul	Brown	Chief Finance Officer	Staffordshire and Stoke-on-Trent Integrated Care Board	Nothing to declare	1. Previously an equity partner and shareholder with RSM, the internal auditors to the ICB. I have no on-going financial interests in the company (January 2014-March 2017) 2. Previously a non-equity partner in health management consultancy Carnall Farrar. I have no on-going financial interests in the company (March 2017-November 2018)	Nothing to declare	Nothing to declare	No action required
1st April 2023	Ms	Tracy	Bullock	Acute Care Partner Member and Chief Executive	University Hospitals of North Midlands NHS Trust (UHNM)	Nothing to declare	1. Lay Member of Keele University Governing Council (November 2019 - November 2023) 2. Governor of Newcastle and Stafford Colleges Group (NSCG) (ongoing)	Nothing to declare	Nothing to declare	(h) recorded on conflicts register.
3rd April 2023	Ms	Alexandra (Alex)	Brett	Chief People Officer	Midlands Partnership NHS Foundation Trust Staffordshire & Stoke-on-Trent ICB	Nothing to declare	1. Chief People Officer- Midlands Partnership NHS Foundation Trust (June 2019 - ongoing) 2. Chief People Officer - Shropshire Telford and Wrekin ICB (April 2023 - ongoing)	Nothing to declare	Nothing to declare	(a) to (g) inclusive as required in any procurement decisions relating to third parties advice is offered to by company. (h) Recorded on Conflicts Register.
4th October 2022	Mr	Neil	Carr OBE	Community Services Partner Member and CEO of MPFT	Midlands Partnership NHS Foundation Trust	1. Member of ST&W ICB (ongoing)	1. Fellow of RCN (ongoing) 2. Doctor of University of Staffordshire (ongoing) 3. Doctor of Science Keele University (Honorary) (ongoing)	Nothing to declare	(a) to (g) inclusive as required in any procurement decisions relating to third parties advice is offered to by company. (h) recorded on conflicts register.	
3rd April 2023	Dr	Paul	Edmondson-Jones	Chief Medical Officer and Deputy Chief Executive	Staffordshire and Stoke-on-Trent Integrated Care Board	Nothing to declare	1. Charity Trustee of Royal British Legion Industries (RBLI) who are a UK wide charity supporting military veterans, the unemployed and people with disabilities	Nothing to declare	Nothing to declare	(h) recorded on conflicts register.
1st April 2023	Mrs	Gillian (Gill)	Hackett	Executive Assistant	Staffordshire and Stoke-on-Trent Integrated Care Board	Nothing to declare	Nothing to declare	Nothing to declare	Nothing to declare	No action required
1st April 2023	Dr	Paddy	Hannigan	Clinical Director for Primary Care	Staffordshire and Stoke-on-Trent Integrated Care Board	1. Salaried GP at Holmcroft Surgery integrated with North Staffordshire Combined Healthcare Trust and contract responsibilities taken over by NSCHT (1st January 2020 - ongoing)	Nothing to declare	Nothing to declare	Nothing to declare	(a) to (g) inclusive as required in any procurement decisions relating to third parties advice is offered to by company. (h) recorded on conflicts register.
4th April 2023	Mr	John	Henderson	Chief Executive	Staffordshire County Council	1. Salaried Employment as CE of Staffordshire County Council. (May 2015 - ongoing)	Nothing to declare	Nothing to declare	Nothing to declare	(a) to (g) inclusive as required in any procurement decisions relating to third parties advice is offered to by company. (h) recorded on conflicts register.
3rd April 2023	Mrs	Julie	Houlder	Non-Executive Director Char of Audit Committee	Staffordshire and Stoke-on-Trent Integrated Care Board	1. Owner of Elevate Coaching (October 2016 - ongoing)	1. Chair of Derbyshire Community Health Foundation Trust (January 2023 - ongoing) (Non-Executive since October 2018) 2. Non-Executive George Eliot NHS Trust (May 2016 - ongoing) 3. Director Windsor Academy Trust (January 2019 - ongoing) 4. Associate Charis Consultants Ltd (January 2019 - ongoing)	1. Owner Craftykin Limited (July 2022 - ongoing)	Nothing to declare	(a) to (g) inclusive as required in any procurement decisions relating to third parties advice is offered to by company. (h) recorded on ICB conflicts register
4th May 2023	Mr	Chris	Ibell	Chief Digital Officer	Staffordshire and Stoke-on-Trent Integrated Care Board	Nothing to declare	Nothing to declare	Nothing to declare	Nothing to declare	No action required
1st April 2023	Ms	Mish	Irvine	Associate Director of People	ICS/MPFT (hosted)	Nothing to declare	Nothing to declare	Nothing to declare	Nothing to declare	No action required

Date of Declaration	Title	Forename	Surname	Role	Organisation/Directorate	1. Financial Interest	2. Non-financial professional interests	3. Non-financial personal interests	4. Indirect interests	5. Actions taken *to mitigate identified conflicts of interest*
21st April 2023	Mrs	Heather	Johnstone	Chief Nursing and Therapies Officer	Staffordshire and Stoke-on-Trent Integrated Care Board	Nothing to declare	1. Visiting Fellow at Staffordshire University (March 2019 - March 2025)	Nothing to declare	1. Spouse is employed by UHB at Heartland's hospital (2015 - ongoing) 2. Daughter is Marketing Manager for Voyage Care LD and community service provider (August 2020 - ongoing) 3. Daughter in law volunteers as a Maternity Champion as part of the SSOT maternity transformation programme (2021 - ongoing) 4. Brother-in-law works for occupational health at UHNM (ongoing) 5. Step-sister employed by MPFT as Staff Nurse (ongoing)	(a) to (g) inclusive as required in any procurement decisions relating to third parties advice is offered to by company. (h) recorded on conflicts register.
3rd April 2023	Mr	Shokat	Lal	Non-Executive Director	Staffordshire and Stoke-on-Trent Integrated Care Board	1. Local government employee (West Midlands region) and there are no direct or indirect interests that impact on the commissioning arrangements of the ICB (ongoing)	Nothing to declare	Nothing to declare		(a) to (g) inclusive as required in any procurement decisions relating to third parties advice is offered to by company.
19th April 2023	Ms	Megan	Nurse	Non-Executive Director	Staffordshire and Stoke-on-Trent Integrated Care Board	1. Independent Hospital Manager for Mental Health Act reviews, MPFT (May 2016 - ongoing) 2. NED at Brighter Futures Housing Association, member of Audit Committee and Renumeration Committee	1. Chair Acton Academy Governing Body, part of North-West Academies Trust (September 2022 - ongoing)	Nothing to declare	Nothing to declare	(a) to (g) inclusive as required in any procurement decisions relating to third parties advice is offered to by company. (h) recorded on conflicts register
1st April 2023	Mr	David	Pearson	Chair	Staffordshire and Stoke-on-Trent Integrated Care Board	Nothing to declare	1. Non-Executive Chair Land based College linked with Chester University (2018 - ongoing) 2. Membership of the Royal College of Nursing (RCN) (1978 - ongoing) Membership cancelled with effect from 30/11/2022 (declaration to be removed from the register on 1st [illegible])	Nothing to declare	1. Spouse and daughter work for North Staffs Combined Health Care NHS Trust (2018 - ongoing: redeclared 21.11.21)	(a) to (g) inclusive as required in any procurement decisions relating to third parties advice is offered to by company. (h) recorded on conflicts register.
4th October 2022	Mr	Jon	Rouse	Local Authority Partner Member and CEO of Stoke City Council	Stoke-on-Trent City Council	1. Employee of Stoke-on-Trent City Council, local authority may be commissioned by the ICS (June 2021 - ongoing) 2. Director, Stoke-on-Trent Regeneration Ltd, could be a future estates interest (June 2021 - ongoing) 3. Member Strategic Programme Management Group, Staffordshire & Stoke-on-Trent LEP, may have future financial relationship with the ICS (June 2021 - ongoing)	Nothing to declare	Nothing to declare	Nothing to declare	(a) to (g) inclusive as required in any procurement decisions relating to third parties advice is offered to by company. (h) recorded on conflicts register.
4th April 2023	Mrs	Tracey	Shewan	Director of Communications and Corporate Services	Staffordshire and Stoke-on-Trent Integrated Care Board	Nothing to declare	1. Works shifts on Chebsey ward at MPFT (December 2022 - ongoing)	Nothing to declare	1. Husband in NHS Liaison for Shropshire, Staffordshire and Cheshire Blood Bikes (August 2019 - ongoing) 2. Sibling is a registered nurse with MPFT (August 2019 - ongoing) 3. Daughter works for West Midlands Ambulance Service (WMAS) (February 2021 - ongoing)	(a) to (g) inclusive as required in any procurement decisions relating to third parties advice is offered to by company. (h) recorded on conflicts register.
4th April 2023	Mr	Phil	Smith	Chief Delivery Officer	Staffordshire and Stoke-on-Trent Integrated Care Board	Nothing to declare	Nothing to declare	Nothing to declare	Nothing to declare	No action required
4th April 2023	Mrs	Josie	Spencer	Independent Non-Executive Director	Staffordshire and Stoke-on-Trent Integrated Care Board	Nothing to declare	1. Non-Executive Director Leicestershire Partnership Trust (May 2023 - ongoing)	1. Chief Executive Coventry and Rugby GP Alliance (May 2022 - ongoing)	Nothing to declare	(a) to (g) inclusive as required in any procurement decisions relating to third parties advice is offered to by company (h) interest recorded on the conflicts register
1st April 2023	Mr	Baz	Tameez	Manager	Healthwatch Staffordshire	Nothing to declare	Nothing to declare	Nothing to declare	Nothing to declare	No action required
3rd April 2023	Mrs	Sally	Young	Director of Corporate Governance	Staffordshire and Stoke-on-Trent Integrated Care Board	Nothing to declare	Nothing to declare	Nothing to declare	Nothing to declare	No action required

ANY CONFLICT DECLARED THAT HAS CEASED WILL REMAIN ON THE REGISTER FOR SIX MONTHS AFTER THE CONFLICT HAS EXPIRED

1. Financial Interest *(This is where individuals may directly benefit financially from the consequences of a commissioning decision, e.g. being a partner in a practice that is commissioned to provide primary care services)*
2. Non-financial professional interests *(This is where an individual may benefit professionally from the consequences of a commissioning decision e.g., having an unpaid advisory role in a provider organisation that has been commissioned to provide services by the ICB)*
3. Non-financial personal interests *(This is where an individual may benefit personally, but not professionally or financially, from a commissioning decision e.g. if they suffer from a particular condition that requires individually funded treatment)*
4. Indirect interests *(This is where there is a close association with an individual who has a financial interest, non-financial professional interest or a non-financial personal interest in a commissioning decision e.g. spouse, close relative (parent, grandparent, child etc) close friend or business partner*
5. Actions taken *to mitigate identified conflicts of interest*
(a) Change the ICB role with which the interest conflicts (e.g. membership of an ICB commissioning project, contract monitoring process or procurement would see either removal of voting rights and/or active participation in or direct influencing of any ICB decision)
(b) Not to appoint to an ICB role, or be removed from it if the appointment has already been made, where an interest is significant enough to make the individual unable to operate effectively or to make a full and proper contribution to meetings etc
(c) For individuals engaging in Secondary Employment or where they have material interests in a Service Provider, that all further engagement or involvement ceases where the ICB believes the conflict cannot be effectively managed
(d) All staff with an involvement in ICB business to complete mandatory online Conflicts of Interest training (provided by NHS England), supplemented as required by face-to-face training sessions for those staff engaged in key ICB decision-making roles
(e) Manage conflicts arising at meetings through the agreed Terms of Reference, recording any conflicts at the start / throughout and how these were managed by the Chair within the minutes
(f) Conflicted members to not attend meetings, or part(s) of meetings: e.g. to either temporarily leave the meeting room, or to participate in proceedings but not influence the group's decision, or to participate in proceedings / decisions with the agreement of all other members (but only for immaterial conflicts)
(g) Conflicted members not to receive a meeting's agenda item papers or enclosures where any conflict arises
(h) Recording of the interest on the ICB Conflicts of Interest/Gifts & Hospitality Register and in the minutes of meetings attended by the individual (where an interest relates to such)
(i) Other (to be specified)

NHS
Staffordshire and Stoke-on-Trent
Integrated Care Board

Staffordshire and Stoke-on-Trent Integrated Care Board Meeting HELD IN PUBLIC

Minutes of the Meeting held on Thursday 18 April 2023 12.30pm-2.30pm Newcastle Suite, Stafford Education and Enterprise Park, Weston Road, Stafford ST18 0BF

Members:	Quoracy	20/04/23	18/05/23	15/06/23	20/07/23	21/09/23	19/10/23	16/11/23	21/12/23	18/01/24	15/02/24	21/03/24
David Pearson (DP) Chair, Staffordshire & Stoke-on-Trent ICB	Over 50% of the quantum (nine out of seventeen members) with there being an equitable balance to represent that of a Unitary Board, split between proportions of Executive, Non-Executive and Partner Members, including: • the Chief Executive plus one other Executive Director (from CFO, CTO, CDO) • either the Medical Director (CMO) or the Director of Nursing & Therapies (CNTO) • three independent Members: i.e. Chair plus two Non-Executive Members • three Partner Members: with ideally at least one from each of the three cohorts	✓	✓									
Peter Axon (PA) Interim Chief Executive Officer, Staffordshire & Stoke-on-Trent ICB		✓	✓									
Paul Brown (PB) Chief Finance Officer, Staffordshire & Stoke-on-Trent ICB		✓	✓									
Phil Smith (PSm) Chief Delivery Officer, Staffordshire & Stoke-on-Trent ICB		✓	✓									
Sally Young (SY) Director of Corporate Services, Staffordshire & Stoke-on-Trent ICB		✓										
Tracey Shewan (TS) Director of Communications, Staffordshire & Stoke-on-Trent ICB		✓	✓									
Alex Brett (AB) Chief People Officer, Staffordshire & Stoke-on-Trent ICB		✓	✓									
Chris Ibell (CI) Chief Digital Officer, Staffordshire & Stoke-on-Trent ICB		✓	✓									
Heather Johnstone (HJ) Interim Chief Nursing and Therapies Officer, Staffordshire & Stoke-on-Trent ICB		✓	✓									
Dr Paul Edmondson-Jones (PE-J) Chief Medical Officer, Staffordshire & Stoke-on-Trent ICB		✓	✓									
Chris Bird (CB) Chief Transformation Officer, Staffordshire & Stoke-on-Trent ICB		✓	✓									
Julie Houlder (JHo) Non-Executive Director, Staffordshire & Stoke-on-Trent ICB		✓	✓									
Megan Nurse (MN) Non-Executive Director, Staffordshire & Stoke-on-Trent ICB		✓	✓									
Shokat Lal (SL) Non-Executive Director, Staffordshire & Stoke-on-Trent ICB		✓	✓									
Josephine Spencer (JS) Non-Executive Director, Staffordshire & Stoke-on-Trent ICB		✓	✓									
Jon Rouse (JR) City Director, City of Stoke-on-Trent Council		✓	✓									
John Henderson (JH) Chief Executive, Staffordshire County Council		✗	✗									
Dr Paddy Hannigan (PH) Primary Care Partner Member, Staffordshire & Stoke-on-Trent Integrated Care Board		✓	✓									
Dr Jack Aw (JA) Primary Care Partner Member, Staffordshire & Stoke-on-Trent Integrated Care Board		✓	✗									
Tracy Bullock (TB) Chief Executive, University Hospitals of North Midlands		✓	✗									
Neil Carr (NC) Chief Executive, Midlands Partnership NHS Foundation Trust		✓	✗									
Dr Buki Adeyemo (BA) Interim Chief Executive, North Staffordshire Combined Healthcare NHS Trust		✗	✓									
Simon Fogell (SF), Stoke-on-Trent Healthwatch		✓	✓									
Baz Tameez (BT), Staffordshire Healthwatch		✗	✓									
Present:												
Paul Winter (PW) Deputy Director of Corporate Governance, Compliance & Data Protection, Staffordshire & Stoke-on-Trent ICB		✗	✓									
Steve Grange (SG), Midlands Partnership NHS Foundation Trust		✓	✓									

Members:	Quoracy	20/04/23	18/05/23	15/06/23	20/07/23	21/09/23	19/10/23	16/11/23	21/12/23	18/01/24	15/02/24	21/03/24
Helen Ashley (HA), University Hospitals of North Midlands			✓									
Claire Cotton (CC), University Hospitals of North Midlands		✓	✓									
Gill Hackett (GH) Executive Assistant, Staffordshire & Stoke-on-Trent ICB		✓	✓									

		Action
1.	**Welcome and Introductions**	
	DP welcomed attendees to the ICB Board meeting. DP advised that this was a meeting being held in public to allow the business of the Board to be observed and members of the public could ask questions on the matters discussed at the end of the meeting. DP advised that the Leadership Compact document was included in the Board papers as a reminder that meetings should be conducted in accordance with the agreed principles. It was noted that the meeting was quorate.	
2.	**Apologies**	
	Apologies were received from John Henderson, Neil Carr (Steve Grange attending), Tracy Bullock (Helen Ashley attending), Jack Aw and Sally Young.	
3.	**Conflicts of Interest**	
	Members confirmed there were no conflicts of interest in relation to items on the agenda other than those listed on the register.	
4.	**Minutes of the Meeting held on 20 April 2023**	
	The minutes of the meeting held on 20 April 2023 were **AGREED** as an accurate record of the meeting and were therefore **APPROVED**.	
5.	**Action Log**	
	Actions were noted on the actions log.	
6.	**Questions submitted by members of the public in advance of the meeting**	
	No questions had been received in advance of the meeting.	
7.	**Community Story**	
	DP introduced Andrew Burr and stated that the presentation was about Andrew's community pharmacy and how he and his team go the extra mile to support their local community Andrew talked about an Integrated Medication Management system which was a central element of a good healthcare model. It directly impacted patient safety, outcomes and healthcare costs. Make Staffordshire leader in 18 months, DP thanked Andrew for his passionate and insightful presentation. He mentioned that the ICB were already looking at digital solutions on how things could be improved.	

	JHo asked what the role of pharmacies and the primary care portfolio was and how that would sit, in light of current discussions. CB responded that the primary care portfolio was focused on primary care, rather than general practice. The portfolio now included the new delegations through the POD to include pharmacies. CB introduced himself as the Executive Lead for Medicines Optimisation and stated that a lot of that resonated in Andrew's presentation. CB would therefore like to link in with Andrew to have further discussions with him. CI advised that he had been driving related initiatives through community pharmacies and what Andrew highlighted was areas of compliance and outcomes and he too welcomed the opportunity to discuss that with him. SL asked what the costs were. CB confirmed that the costs in 2022/23 were linked to national pressures. For 2023/24 there were efficiencies that they needed to identify and they had local schemes related to that. PB referred to the experience of covid, where people came together and stated that there was the scope and opportunity as a system to look at this collectively. SG agreed that this was setting the strategic bar for waste, patients not taking medications etc. and he was happy to take an action away to work with CB and colleagues to see where some of the things Andrew talked about could stimulate change in the portfolios. PH confirmed that the ICB spent £350m on medicines and the amount of attention did not mirror the medicines waste and patients not understanding the importance of medication and he felt there was a big opportunity here to do better. He stated that as an ICB, this was good time to have that conversation. DP thanked Andrew and confirmed that colleagues would contact him after the meeting to explore the issues raised in more detail.	
8.	**ICB Chair and Chief Executive Officer Report**	
	DP reported that it was a busy time of the year and thanked all staff across the entire County including the voluntary sectors, community etc. DP highlighted that the ICB's Learning Disability and Autism team had been shortlisted as finalists in the 'Together' category at BBC Radio Stoke's Make a Difference Awards 2023 and hoped for a successful outcome. PA advised that the system had delivered a small surplus for the financial year 2022/23 which was a slight improvement from the forecasted breakeven position. He reported that the 2023/24 Operating Plan had been submitted to NHSE on 4 May in which they had proposed a breakeven plan although it had significant risk PA reported that there was positive news on Electives to clear the 65 week wait cohort in which they are on track to deliver that ambition by March 2024. However there were still ongoing challenges with other waist times. PA stated that there had been some recent pressures in the system for Urgent and Emergency Care, although they had been managing the situation well. On a linked point he reported that the ICC team coordinated urgent and emergency care across the system.	

	JHo stated that there had been a lot of hard work in closing the financials for 2022/23 and acknowledged the work involved in planning for the 2023/24 financial plan. JHo asked if there was any link to the industrial action for junior doctors and doctors in general. PA acknowledged that there was often a natural spin out into primary care. PSm added there was a link with comms and the flows of patients. He confirmed that the main challenges in recent weeks has been industrial action which the national comms has had a big impact. AB advised that she had received notice for a statutory ballot for the RCN that did not agree the pay ward and that Consultants were also been balloted by the BMA. MN asked if they had received mutual aid from external providers. PSm responded that they had been on a journey of mutual aid and as part of tier 1 support had additional capacity. HA confirmed that they had support from the regional team and there was more they could do with the conversations with the patients. The Staffordshire and Stoke-on-Trent Integrated Care Board **NOTED** the contents of the report.	
9.	**Board Assurance Framework (BAF)**	
	CC reminded members that the Board had agreed the new format at the previous meeting where they would be mapping the strategic risks against the risks contained in the strategy. CC confirmed that the first Q1 would be presented in June to Committees and would then be presented to the Board in July. JHo added that all of the recommendations in the internal audit report had been progressed and the Audit Committee was intending to move to quarterly meetings and they would need to work on where the reporting would lie. The Staffordshire and Stoke-on-Trent Integrated Care Board were **ASSURED** that the process for the BAF risk management in on track to provide quarterly Committee / Board reporting.	
10.	**Quality and Safety Report**	
	HJ apologised and explained that the acronym PSIRF mentioned in the Quality & Safety report stook for Patient Safety Incident Response Framework. HR then highlighted some areas of the report for members to be aware of. She advised that NSCHT work closely with system partners to support children and young people requiring specialist mental health care. All agreed there was a need to consider how, as a system, they develop a stronger emphasis upon identifying and supporting young people, carers and families as early as possible to improve outcomes. It had been proposed that all stakeholders would link through the CYP portfolio to maximise learning from recent experiences, identify and close the gaps that exist within our current pathways. HJ reported that there was positive news for Staffordshire County Council for care services and the CQC rating for care homes continued to improve. With regard to Multi Agency Safeguarding Hubs (MASH), she had received formal notification that under this parliament these would not be progressed.	

	HJ asked members to read and understand the section on Quality Impact Assessments, as they were starting to roll out the training programme across the system. HJ advised that the NHSE Three-year delivery plan for maternity and neonatal services was now published and they were now developing an implementation plan. With regard to Industrial action, she confirmed that all system partners had offered support and the ICB would continue to work closely with partners. JS confirmed that she would seek more assurance around the management of risks throughout the year. HJ referred to the TORs that had been shared with the papers and asked the Board to ratify the decision made at the Quality & Safety Committee and the System Quality Group. MN asked about the progress on the on Freestanding Midwifery Birth Units which had been reported previously at Board. HJ confirmed that they were trying to get that up and running as soon as possible. The Staffordshire and Stoke-on-Trent Integrated Care Board • **RECEIVED** this report and seek clarification and further action as appropriate • **BE ASSURED** in relation to key quality assurance and patient safety activity undertaken in respect of matters relevant to all parts of the Integrated Care System. • **RATIFIED** the decisions in relation to: o Items approved at the Quality Safety Committee: ▪ Quality and Safety Committee Terms of Reference o Items approved at the System Quality Group: ▪ Soft Intelligence Process Standard Operating Procedure (SOP) ▪ Nursing Home Quality Assurance and Improvement Group (NHQAIG) - Terms of Reference.	
11.	**2022/23 Finance & Performance Report**	
	PB briefed the Board on the key points for **Finance** • The system had submitted a breakeven position for 2022/23 in line with the plan. However, the detailed accounts remained subject to audit. • As reported through the year, there were a number of areas of escalating spend and the achievement of break-even position was largely achieved through non-recurring mitigations, leaving the system with a substantial challenge for 2023/24. Details for the 2023/24 financial position were covered in the planning update. PSm briefed the Board on the key points on **Performance** • Pressures in **Urgent and Emergency Care** remained in line with February. He reported that there had been a reduction in ambulance handover delays. However, staffing shortfalls impacted significantly across all areas at the end of March. PSm added that the latest data confirmed that ambulances were attending to cat 2 calls in 10 minutes. He confirmed that UHNM had also achieved 70% on 4 hour waits in April. • The national target to eliminate **78+ week waits** by March 2023 has not been achieved. However, it was noted that waits of over 65, 78 and 104 weeks were decreasing. o As at w/e 16 April 3,032 65+ breaches are recorded. o As at w/e 16 April 653 78+ breaches are recorded. o As at w/e 16 April 54 104+ week waits are recorded.	

	• In **Cancer,** 92.0% of patients were seen within 2 weeks (93% being the national standard). • In **Diagnostics**, 104.5% of 19/20 activity was delivered in February, the first month exceeding 100%. • The number of **GP appointments** and **Learning Disability Annual Health Checks** are on track to achieve the year end targets. PSm added that they had kept on the stood-up capacity over the winter months and would now be de-escalation that over the next few weeks. He also reported that UHNM Planned Care had been put into tier 1 as they had a challenging start to the financial year. MN mentioned the ICB Greener delivery plan that had been presented to the Finance & Performance Committee and stated that there was significant opportunity across the system and assured members that they now had an SRO identified. JHo commented that they knew there was risk with the break-even plan and asked for clarity how the system was performing in relation to efficiencies and what was the process of monitoring. MN asked about the cat 2 compliance and where had they got to with the resubmission. PSm confirmed that the latest version WMAS have was 30 minutes across the system CB referred to the cover report which talked about GP appointments and he confirmed that they were on track with LD achieving 80%. JR referred to the women's access to community perinatal mental health and asked if they were concerned about the fall off on performance and asked what was being done about it. BA confirmed that they were expecting an improvement. CB added that within the plan they have included perinatal. HJ also added that it was also scrutinized within the Maternity board as well. DP thanked everyone involved in getting to the current position at the end of the recent financial year. The Staffordshire and Stoke-on-Trent Integrated Care Board **NOTED** the contents of the report.	
12.	**2023/24 Planning Update**	
	Operational Plan PB confirmed that the Operating Plan was discussed with all system partners at the May meeting of the Finance and Performance Committee and was approved by that Committee. It was now brought to the ICB Board for final approval. He advised that it was a system plan. He highlighted the hopper on page 83 within the plan which showed how they would bring things together and were focusing on ensuring the patients that required support, got it quickly. **Financial Plan** PB reported that a break-even system plan had been submitted to NHSE, following ratification by system CEOs and the Finance and Performance Committee. It was noted that there was very significant risk associated with the delivery of the break-even position, and that the National and Regional teams had been fully appraised of the level of risk. PB advised that the collective efficiency plan requirement has increased to 7.4%. The March submission indicated that there would be 800 patients waiting more than 65 weeks by the end of March 2024. Since that point the system had developed a plan to	

	reduce the 65-week waiters to zero by March 2024. He added that there had been no material workforce changes between submissions. DP thank all the CFOs involved in developing the plan. JHo commented that it showed a lot of integrated working together. However, she added that the board needed to have a clear indication of where they were. JS agreed that the Board needed early oversight of where anything may have slipped. PA gave his thanks to PB and the finance, planning and operational colleagues across the system. He added that at a national level there was focus on the targets and the next steps were to start a longer term planning piece. He advised that they would be bringing together system partners in July to start the process. JR commented that this was a triumph of integrated planning and they also needed integration on commissioning and integration on provision. JR stated that they had the first month's figures through and what they were seeing were two pressures, the impact of inflation and high level of demand in the system in the form of human need and complexity. PSm updated the response time that had been reported of 44 min against a 30 min target and confirmed that he had checked with WMAS and they were now reporting 34 min. The Staffordshire and Stoke-on-Trent Integrated Care Board • **APPROVED** the 2023/24 One Year Operational Plan • **NOTED** the submission of a breakeven financial plan for 2023/24 and the associated risks • **NOTED** the activity resubmission and the improved compliance with national targets • **AGREED** to regular escalations through to the board.	
13.	**ICB Purpose, Vision and Mission and Statements**	
	PA explained that the engagement page described the forums this had gone through. He added that all of the staff in the ICB have had opportunities to input into the statements and confirmed that it had been develop from the bottom up within the organisation. The Staffordshire and Stoke-on-Trent Integrated Care Board • **RATIFIED** the final versions of the ICB Purpose, Vision and Mission statements • Were **ASSURED** that the statements will be widely shared and communicated so that they can be owned by the workforce and recognised throughout the Staffordshire and Stoke-on-Trent ICS, alongside the Leadership Compact	
14.	**Assurance Reports from Committees of the Board**	
	<u>Quality and Safety Committee</u> Dealt with as part of the previous business. <u>Finance and Performance Committee</u> Dealt with as part of the previous business. <u>People, Culture & Inclusion Committee</u> SL reported that there had been a lot of good work done for the Annual Report which would be presented to the Board in June and he hoped it could become a deep dive item as well.	

	Audit Committee JHo confirmed that they had received a positive internal audit opinion for 2022/23. She reported that the board would receive a full update report in June on the progress in delivering the Action Plan to demonstrate compliance for the 2022/23 Emergency preparedness assessment. The Staffordshire and Stoke-on-Trent Integrated Care Board **NOTED** the Committee Assurance Reports.	
15.	**Any Other Business/Close**	
	No other business	
16.	**Questions from the floor relating to the discussions at the meeting**	
	No questions were received from the floor	
17.	**Meeting Effectiveness**	
	The Chair confirmed that the meeting followed the compact and closed the meeting at 2.30pm JHo reflected on the looking forward which she felt was very important. Simon Fogell stated that there were good front covers for each report but only one had completed for the QIA/EQIA section. AB agreed that this was an important point raised.	
18.	**Date and of Next Meeting**	
	15 June 2023 at 1.00pm via MS Teams	

DATE	ITEM	AGENDA ITEM	ACTION	ACTION OWNER	UPDATE	DUE DATE
18/05/2023			THERE WERE NO ACTIONS RAISED FROM THE MEETING ON 18 MAY 2023			

NHS
Staffordshire and Stoke-on-Trent
Integrated Care Board

REPORT TO:

Staffordshire and Stoke-on-Trent Integrated Care Board

Enclosure:	**05**

Title:	**Chair and Chief Executive Officer Report**

Meeting Date:	15 June 2023

Executive Lead(s):	**Exec Sign-Off Y/N**	**Author(s):**
David Pearson, ICB Chair and Peter Axon, ICB Interim Chief Executive Officer		Peter Axon, ICB Interim Chief Executive Officer

Clinical Reviewer:	**Clinical Sign-off Required Y/N**
Not required	N

	Action Required (select):										
Ratification-R		**Approval -A**		**Discussion - D**		**Assurance - S**		**Information-I**	**I**

Is the [Committee]/[Board] being asked to make a decision/approve this item? N			
Is the decision to be taken within [Committee]/[Board] delegated powers & financial limits?			
• N/A			
Within SOFD Y/N		**Decision's Value / SOFD Limit**	

History of the paper – where has this paper been presented		
N/A	Date	A/D/S/I

Purpose of the Paper (Key Points + Executive Summary):
This report provides a strategic overview and update on national and local matters, relevant to the Staffordshire and Stoke on-Trent system that are not reported elsewhere on the agenda. Specifically, the paper details a high-level summary of the following areas: **1. System & General Update** **2. Finance** **3. Planning and performance** **4. Quality and safety**

Is there a potential/actual Conflict of Interest?	N
Outline any potential Conflict of Interest and recommend how this might be mitigated	

Summary of risks relating to the proposal (inc. Ref. No. of risk it aligns to on Risk Register):
Any risks to ICB Strategic Objectives delivery implied by the subject matter are covered on our BAF.

Implications:	
Legal and/or Risk	Detailed in individual paper
CQC/Regulator	Detailed in individual papers
Patient Safety	Detailed in individual papers
Financial – if yes, they have been assured by the CFO	Detailed in individual papers
Sustainability	N/A
Workforce / Training	Detailed in individual papers

Key Requirements:			
1a.	How can the author best assure the Board that the decision put before it meets our statutory duty to reduce inequalities by ensuring equal access to services and the maximising of outcomes achieved by those services? **The Board will need to consider this statutory duty and how we reduce these.**		
1b.	How can the author best assure the Board that the decision put before it meets our new statutory duty to have regard to the wider effects of our decisions in relation to health & wellbeing, quality and efficiency? (If the paper is 'for information' / for awareness-raising, not for decision, please put n/a) **N/A**		
		Y/N	**Date**
2a.	Has a Quality Impact Assessment been presented to the System QIA Sub-group?	**N/A**	
2b.	What was the outcome from the System QIA Panel? (Approved / Approved with Conditions / Rejected)		
2c.	Were there any conditions? If yes, please state details and the actions in taken in response: • **Condition 1 & action taken.** • **Condition 2 & action taken.**		

3a.	Has an Equality Impact Assessment been completed? If yes please give date(s) • **Stage 1** • **Stage 2**	**N**	
3b.	If an Equality Impact & Risk Assessment has not been completed what is the rationale for non-completion?		
3c.	***Please provide detail as to these considerations:*** • Which if any of the nine Protected Groups were targeted for engagement and feedback to the ICB, and why those? • Summarise any disaggregated feedback from local Protected Group reps about any negative impacts arising / recommendations (e.g. service improvements) • What mitigation / re-shaping of services resulted for people from local Protected Groups (along the lines of 'You Said: We Listened, We Did'?) • Explain any 'objective justification' considerations, if applicable		
4.	Has Engagement activity taken place with Stakeholders / Practices / Communities / Public and Patients ***Please provide detail***	**N**	
5.	Has a Data Privacy Impact Assessment been completed? ***Please provide detail***	**N**	
Recommendations / Action Required:			
The Integrated Care Board is asked to: • **Note the updates in the report.**			

1.0 System and general update

1.1 ICB Purpose, Vision and Mission Statements

Through extensive engagement with ICB staff the following statements have been decided upon. To ensure that all staff become familiar with the narrative, these will be widely circulated and embedded through our Organisational Development programme.

Purpose: Leading collaboratively and strategically, we will achieve safe care, wellbeing and experiences for all of our residents and communities.

Vision: We will work together to ensure the best possible outcomes for our patients, residents and communities, within a culture of respect, trust and support.

Mission: Enabling effective delivery across organisational boundaries to improve outcomes and reduce inequalities, in population health and healthcare. Creating innovative, safe, and high-quality care for citizens, and our communities, that we are all proud of.

1.2 Population Health Management update

On 26 May, Dr Paul Edmondson-Jones, Senior Responsible Officer (SRO) for the Improving Population Health Integrated Care System (ICS) Portfolio, welcomed our recently contracted delivery partner, Optum, to Staffordshire and Stoke-on-Trent to meet the Population Health Management Programme core delivery team. The objectives for the day were to align our current state with the challenges we face and to begin to identify what success might look like from varying perspectives. The team also undertook some practical preparations for programme readiness.

1.3 ICP update

At the June meeting of the Integrated Care Partnership, Dr Paul Edmondson-Jones led a deep dive session into prevention with senior leaders from across the system committing to develop a single strategy to reduce alcohol harm across Staffordshire and Stoke on Trent. As part of the breakout sessions, partners discussed the interactions their organisations have with people who are at risk, and also what could be done in 2023/24 while we collectively develop the strategic approach to alcohol harm reduction.

1.4 System Long Term Planning

On 14 July, the system will begin a piece of work on long term planning. System leaders on will come together to discuss the approach to the granular three-to-five-year planning activity. It has been agreed that the process must be data and evidence driven with a focus on a small number of key ambitions over the longer term period, ensuring that prevention and proactive support for our population are front and centre of our activities.

2.0 Finance

The audit of the 2022/23 accounts is ongoing, with no material concerns arising so far. The national deadline for completion of the statutory audit is 30 June and the current expectation is that we will meet this deadline. Month 1 reporting for 2023/24 was very limited due to the lack of data available and no formal reporting process required by NHSE. Despite no new issues emerging in this financial year, there remains a huge amount of risk incorporated into our financial plan. Work is ongoing across all four system partners to try and deliver our challenging efficiency programme for the year. We are also beginning the process of forward planning to deliver the medium-term financial strategy.

3.0 Planning and performance

3.1 Elective care:

- Long- waiters continue to be a challenge for the system. At the end of May the number of patients breaching the 104-week position was 35 (up from 16); the forecast position for the end of June is currently 4 (previously zero). The number of patients breaching the 78 week-wait at the end of May was 410 (higher than previous forecast 389); the forecast for the end of June is 109. Nuffield accepted 42 patients from the 78 week wait cohort during May for treatment in June.
- Despite support from the National Get it Right First Time (GIRFT) team, the number of patients opting to receive treatment at the Royal Orthopaedic Hospital has been limited due to patient choice. However, key actions are being taken to re-organise treatment lists in order to prioritise long-waiters, which should remove approximately 10 additional long-waiters per week.
- Insourced providers SHS Partners and 18 weeks support have recommenced service delivery at University Hospitals of North Midlands NHS Trust and are treating 12 patients every weekend from the long-waiter cohort.
- The new modular hand surgery unit opens on 12 June and will undertake surgery on 15 additional patients/week.
- Cardiothoracic surgery suffered an increase in “on the day cancellations” in the last week of May due to consultant sickness and an unexpected increase in emergency cases.
- Work within the Trust to improve theatre throughput and productivity is showing early signs of improvement.

Cancer performance:

- University Hospitals of North Midlands NHS Trust (UHNM) continues to make good progress on cancer care delivery. However, a deterioration in 62-day standard performance has resulted in further scrutiny but there is still confidence that the Trust will achieve the “fair share” allocated target.
- UHNM compares well with others in relation to the 28-day faster diagnosis standard performing steadily at around 70%. There are plans are in place to achieve the target 75% by the end of March 2024.

3.2 Urgent Care

Operations:

- 111 have performed well this month; the Emergency Department and Ambulance validation has been in place at all times.
- We continue to make good progress with ambulance delays, although there have had some hot spots delays observed during May. The trend remains downwards with May being the 3rd best month for improved performance on 60+ handover delays in the last 17 months. Work is underway and ongoing to address pinch points.
- Infection Prevention Control (IPC) restricted beds remain at a minimum and there have been 0 COVID-19 patients in Intensive Therapy Units (ITU) recorded across all three acutes during May.
- May saw an increase in Emergency Department (ED) attendances up from 21,239 to 23,491, bed occupancy also rose from 89.9% to 91.8%. The impact of which is a slight

increase in patients waiting more than 12 hours in ED up from 7.1% in April to 7.6%. The number of patients waiting less than an hour is down to 86.25% from 93.42% for April.

- Acuity of patients admitted was higher during May. This is reflected in an increase in the Length of Stay (LoS) data with an average 7+ days up to 584 from 574, 14+ days up to 314 from 301 and 21+ days up from 177 to 192.
- Provider of Last Resort (PoLR) is consistently sitting at just one or two patients waiting.
- Daily complex discharges from UHNM are consistently running at above target. We have also seen significant increase in Complex weekend discharges.
- The system has continued to maintain performance during the extended Bank Holiday weekend periods through May. The system approach and collaborative working continues to support performance and delivery.

Delivery:

- The business case for the capital and revenue monies to create an additional 50 beds at University Hospitals of North Midlands NHS Trust (UHNM) has now been approved by NHS England and work has commenced to operationalise this.
- Following work with the Black Country Integrated Care Board, a revised trajectory to support Category 2 Ambulance Call-out (CAT2) performance has been submitted which now makes West Midlands Ambulance Service (WMAS) fully compliant in terms of CAT2 national targets. However, work is ongoing across the ICS to finalise a robust delivery plan to ensure that this can be achieved this year.
- The new governance arrangements around the Urgent and Emergency Care (UEC) Delivery Group have been approved by the UEC Board and will simplify the reporting and assurance mechanism from the three subgroups of the Delivery Group – 1) Access, 2) Acute Trust Internal UEC Improvement, 3) The Integrated Discharge Steering Group. These groups will provide a regular report to the Delivery Group which will then consolidate the information and provide a single, monthly, highlight report to the UEC Board.
- The draft Urgent and Emergency Care UEC Improvement Plan has been presented to the UEC Board and the final iteration will be signed off in the June Board meeting. The Urgent and Emergency Care (UEC) Strategy is also on track to be signed off by June UEC Board.
- The Integrated Discharge Hub has now been formally launched with a very successful engagement session taking place on 25 May. Further engagement sessions are being held throughout June to ensure all our stakeholder colleagues have an opportunity to ask questions and be part of the deployment of the hub throughout the summer months. The Integrated Discharge Director post is out for recruitment with closing date for applicants in mid-June.
- De-escalation of surge capacity remains a pressing priority. Providers have submitted initial plans for de-escalation, and these are being refined to ensure timeliness and appropriateness. Regular briefings to Finance colleagues and Chief Finance Officers (CFOs) are in place, with a report to System Performance Group (SPG) planned in June to reflect progress and financial implications.
- Work continues on the seven system high impact programme areas with good system engagement and initial progress observed.
- The Urgent and Emergency Care (UEC) Technical Event took place on 25 May. A briefing to executives with recommendations will be distributed shortly.

- Concerns remain around the regional 111 model going out for tender with regards to increased finance, workforce, and touch points for patients. The team continue to work through the proposal and have escalated to regional colleagues. Integrated Care Board (ICB) execs are sighted on challenges and risks.
- Relationship building with interdependent portfolios continues and requires further work to build an infrastructure of mutual support, accountability, and delivery.

3.3 Key figures for our population:

		Jan-23	Feb-23	Mar-23	Apr-23
*	**111 calls received**	30,580	29,179	32,784	33,789
	Percentage of 111 calls abandoned	8.3%	4.5%	14.1%	5.4%
	A&E and Walk in Centre attendances (UHNM)	18,739	17,923	20,545	19,268
	A&E and Walk in Centre attendances (other providers)	16,003	15,279	17,102	16,421
	Non elective admissions (UHNM)	6,954	6,536	7,525	7,414
	Non elective admissions (other providers)	5,480	5,033	5,686	5,222
	Elective and Day Case spells (UHNM)	6,811	6,491	7,312	6,417
	Elective and Day Case spells (other providers)	7,790	7,595	8,306	7,128
	Outpatient procedures (UHNM)	4,213	4,390	4,556	4,064
	Outpatient procedures (other providers)	7,762	7,017	7,955	6,857
	GP Appointments (all)	520,189	485,869	557,712	423,026
**	**Physical Health Community Contacts (attended)**	136,805	122,545	137,225	120,875
**	**Mental Health Community Contacts (attended)**	46,330	42,130	46,770	

**NHS 111 - latest month is provisional and subject to change*
***Physical and Mental health contacts - latest month is provisional and subject to change and both datasets are sometimes one month behind the other datasets*

Most datasets are subject to change following refresh - particularly the later months

Variation in Planned Care type activities (e.g. Elective/ Day Case admissions, OP/ GP appointments) is influenced by a variety of factors, including the number of working days in the month (activity in some months is affected by bank holidays). We will flag up if variation in these activities is abnormal.

4.0 Quality and safety

4.1 Patient Safety Incident Response Framework (PSIRF)

Training has now commenced for the first cohort of staff across the Integrated Care Board (ICB), University Hospitals of North Midlands NHS Trust (UHNM), Midlands Partnership University NHS Foundation Trust (MPFT) and North Staffordshire Combined Healthcare NHS Trust (NSCHT). This has been well received and provided much opportunity for discussion. It also allowed UHNM to showcase the significant work they have commenced regarding templates and processes within the new framework. This work was noted as being exemplary by the trainer. Briefings for senior ICB teams and execs regarding the framework and the changes it will bring are due to commence In July 2023.

4.2 System Quality Group

At the meeting on 3 June 2023, the Integrated Care Board were commended by NHS England on the way in which system partners worked together. It was commented that all ICBs are working across their respective systems, but it was clear from the conversations at the meeting, that partners were collaborating and reaching out to each other when they felt extra support was needed.

4.3 Chief Nurses selected to lead key piece of work

The Integrated Care Board (ICB) and University Hospitals of North Midlands NHS Trust (UHNM) Chief Nurses are joint Senior Responsible Officers (SROs) for the Midlands Distributed Leadership Model Research project, a new initiative focussing on supporting the implementation of a research development journey for Chief Nurses and Directors of Nursing in the Midlands.

4.5 CQC rating of Midlands Partnership University NHS Foundation Trust's (MPFT) Mental Health inpatient wards

Following a CQC assessment of Midlands Partnership University NHS Foundation Trust's (MPFT) Mental Health inpatient wards in both Staffordshire and Shropshire in November 2022, in May 2023 the regulator published their report rating the inpatient wards Inadequate. The overall CQC rating of the Trust remains Good. Discussions are ongoing within the system to receive assurance that actions stemming from the November visit are either in the final stages of completion or complete. These assurances are being sought through the usual channels within the system including CNO to CNO discussions and Quality assurance mechanisms such as the Quality and Safety Committee.

5.0 Summary of recommendations and actions from this report

ICB Board members are asked to note these updates.

David Pearson, ICB Chair

Peter Axon, Interim ICB Chief Executive Officer

NHS
Staffordshire and Stoke-on-Trent
Integrated Care Board

REPORT TO:

Staffordshire and Stoke-on-Trent Integrated Care Board

Enclosure:	**06**

Title:	**Living my Best Life - A Joint Strategy for Disabled and Neurodivergent people in Staffordshire 2023-2028**

Meeting Date:	15 June 2023

Executive Lead(s):	**Exec Sign-Off Y/N**	**Author(s):**
Chris Bird	Y	Karen Webb – Deputy SRO LDA

Clinical Reviewer:	**Clinical Sign-off Required Y/N**
Dr Waheed Abbasi	Y

	Action Required (select):								
Ratification-R		**Approval -A**	✓	**Discussion - D**		**Assurance - S**		**Information-I**	

Is the Committee being asked to make a decision/approve this item? Y			
Is the decision to be taken within Committee delegated powers & financial limits? Y			
• Author to check with Finance to determine if the decision is within Scheme of Financial Delegation (SOFD) approved limits			
Within SOFD Y/N	N/A	**Decision's Value / SOFD Limit**	N/A

History of the paper – where has this paper been presented		
	Date	A/D/S/I
Mental Health and Learning Disability Delivery Group	18 May 2023	D
Learning Disability and Autism Partnership Board	1 June 23	D
Quality and Safety Committee	14 June 23	A

Purpose of the Paper (Key Points + Executive Summary):

- Many people with disabilities and neurodivergences have positive life experiences and outcomes. However, some do not experience the same opportunities that other people take for granted. This Strategy aims to improve health and wellbeing, economic, educational, and social outcomes and help make Staffordshire a place where disabled people and people with neurodivergences can live their best lives.
- This is a joint Strategy between Staffordshire County Council (SCC) and Staffordshire and Stoke-on-Trent Integrated Care Board (ICB). It complements national and local strategies and good practice including SEND and Carers' strategies.
- It considers what people have told us. This includes our partners, the public, professionals, politicians, local organisations, and people living with disabilities and neurodivergences, and their families.
- In this Strategy, we are referring to the Equality Act (2010) definition of a disability, rather than, for example, using a narrow definition based around eligibility for services. This Equality Act definition is a 'physical or mental impairment with a significant and long-term adverse effect on an individual's ability to carry out normal day-to-day activities.' Neurodivergences are about brain function and behaviours that are not considered typical.

The Strategy supports a wide range of people, and not just those who receive services. It aims to raise community awareness and remove barriers so people can be recognised and treated as individuals and not for their disability or neurodivergence. Accountability will come through the Staffordshire county-wide joint Disability Partnership Board arrangements, so that meaningful change can happen at scale.

Is there a potential/actual Conflict of Interest?	**N**
Outline any potential Conflict of Interest and recommend how this might be mitigated	

Summary of risks relating to the proposal (inc. Ref. No. of risk it aligns to on Risk Register):
If the strategy is not approved for implementation the Local Authority and ICB will not be able to respond to the National Strategies and take forward key priorities.

Implications:	
Legal and/or Risk	N/a
CQC/Regulator	N/a
Patient Safety	N/a
Financial – if yes, they have been assured by the CFO	No financial implications identified as a direct result of the implementation of the strategy,
Sustainability	Strategy aims to improve outcomes
Workforce / Training	N/a

Key Requirements:	
1a.	How can the author best assure the Board that the decision put before it meets our statutory duty to reduce inequalities by ensuring equal access to services and the maximising of outcomes achieved by those services?

	The Strategy considers national policy changes and related local strategies. The strategy sets out the joint vision and intentions for improving life in Staffordshire over the next five years, from 2023 to 2028 for disabled, neurodiverse children, young people, and adults. The strategy takes a whole life course approach to improving outcomes; from childhood into adolescence, adulthood, and older age.		
1b.	How can the author best assure the Board that the decision put before it meets our new statutory duty to have regard to the wider effects of our decisions in relation to health & wellbeing, quality and efficiency? (If the paper is 'for information' / for awareness-raising, not for decision, please put n/a) Through the development of the strategy, it is recognised that inequalities span much wider that just health; this can involve differences in life expectancy, access to care, quality and experience of care, behavioural risks to health and the wider determinants of health. This Strategy is a joint strategy with Staffordshire County Council which looks to address all aspects to ensure that our statutory duties are met.		
		N	**Date**
2a.	Has a Quality Impact Assessment been presented to the System QIA Sub-group? The Strategy is a joint strategy led by Staffordshire County Council who have completed an Impact Assessment. This demonstrates that there is no disadvantage to any group. The assessment shows disabled and neurodivergent children, young people and adults and their families and carers will benefit from the strategy.	**N**	
2b.	What was the outcome from the System QIA Panel? (Approved / Approved with Conditions / Rejected)		
2c.	Were there any conditions? If yes, please state details and the actions in taken in response: • **Condition 1 & action taken.** • **Condition 2 & action taken.**		
3a.	Has an Equality Impact Assessment been completed? If yes please give date(s) • **Stage 1** • **Stage 2**		
3b.	If an Equality Impact & Risk Assessment has not been completed what is the rationale for non-completion? The Strategy is a joint strategy led by Staffordshire County Council who have completed an Impact Assessment. This demonstrates that there is no disadvantage to any group. The assessment shows disabled and neurodivergent children, young people and adults and their families and carers will benefit from the strategy.		
3c.	***Please provide detail as to these considerations:*** • Which if any of the nine Protected Groups were targeted for engagement and feedback to the ICB, and why those? • Summarise any disaggregated feedback from local Protected Group reps about any negative impacts arising / recommendations (e.g., service improvements) • What mitigation / re-shaping of services resulted for people from local Protected Groups (along the lines of 'You Said: We Listened; We Did'?)		

	• Explain any 'objective justification' considerations, if applicable		
4.	Has Engagement activity taken place with Stakeholders / Practices / Communities / Public and Patients 1. . The Strategy has been co-produced through a two-stage process: • Stage One. A survey exploring quality of life and factors considered most important by disabled and neurodivergent people for them to live their best lives. This was carried out during December 2022. • Stage Two. The draft vision and priorities for the Strategy have been discussed with disabled and neurodivergent people, politicians, carers and professionals face-to-face in each district/borough during January and February 2023 to seek their views.	**Y**	
5.	Has a Data Privacy Impact Assessment been completed? ***Please provide detail***	**N**	
Recommendations / Action Required:			
The ICB is asked to: Approve - **Living my Best Life -** A Joint Strategy for Disabled and Neurodivergent people in Staffordshire 2023-2028			

Staffordshire County Council

NHS
Staffordshire and Stoke-on-Trent
Integrated Care Board

Living my Best Life

A Joint Strategy for Disabled and Neurodivergent people in Staffordshire 2023-2028

Foreword

1. Many people with disabilities and neurodivergences have positive life experiences and outcomes. However, some do not experience the same opportunities that other people take for granted. This Strategy aims to improve health and wellbeing, economic, educational and social outcomes and help make Staffordshire a place where disabled people and people with neurodivergences can live their best lives.

2. This is a joint Strategy between Staffordshire County Council (SCC) and Staffordshire and Stoke-on-Trent Integrated Care Board (ICB). It complements national and local strategies and good practice (including our SEND and Carers' strategies, as detailed on our [ADD WEBPAGE ADDRESS] webpage here). It also considers what people have told us. This includes our partners, the public, professionals, politicians, local organisations and people living with disabilities and neurodivergences, and their carers.

3. In this Strategy, we are referring to the Equality Act (2010) definition of a disability, rather than, for example, using a narrow definition based around eligibility for particular services. This Equality Act definition is a 'physical or mental impairment with a significant and long-term adverse effect on an individual's ability to carry out normal day-to-day activities.' Neurodivergences are about brain function and behaviours that are not considered typical.

4. The Strategy supports a wide range of people, and not just those who receive particular services. It aims to raise community awareness and remove barriers so people can be recognised and treated as individuals and not for their disability or neurodivergence. Accountability will come through our new county-wide joint Disability Partnership Board arrangements, so that meaningful change can happen at scale.

5. We would like to thank everyone who has supported this Strategy so far. This marks the start of a journey. It will take years, not months for big changes to happen. We hope that through commitment from ourselves, our partners and the wider community, we can create the right conditions for this.

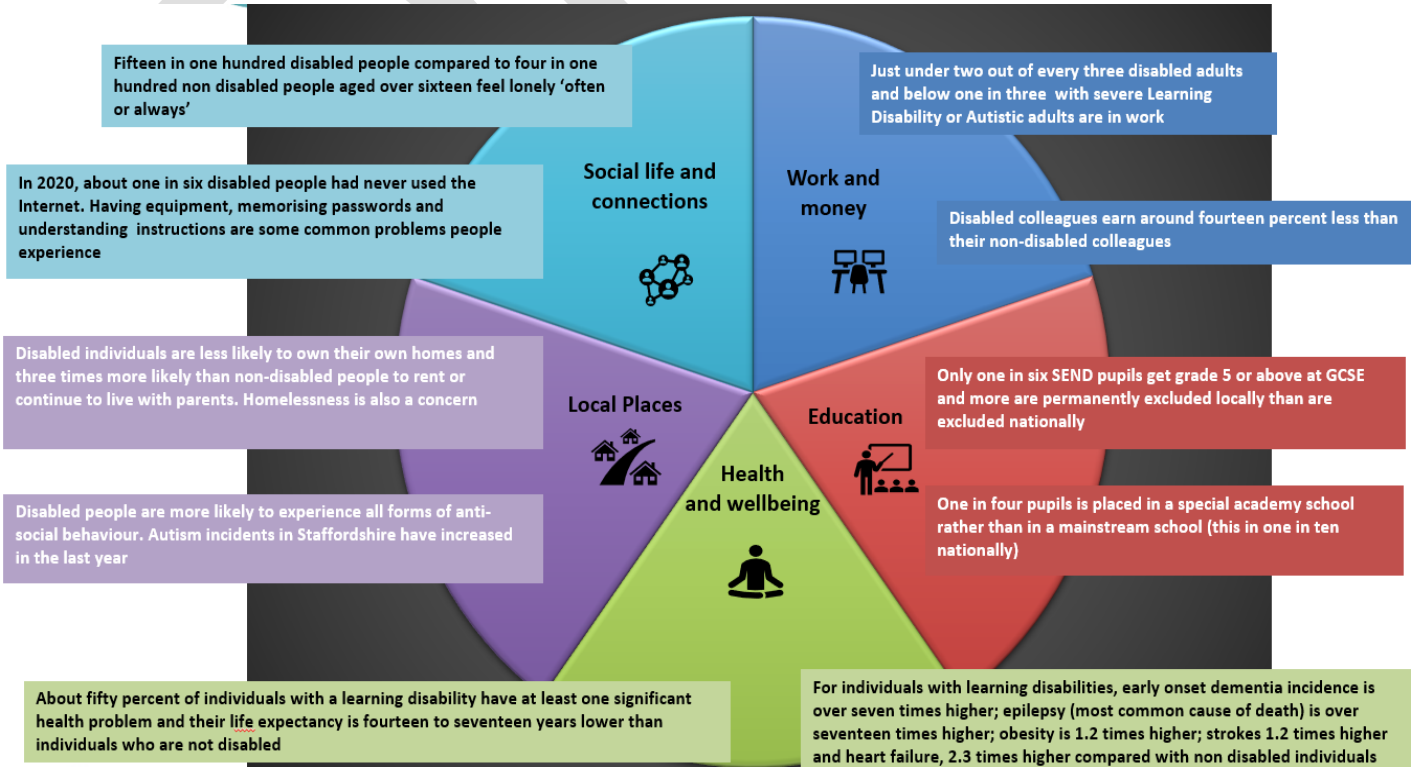
Cllr Julia Jessel - Cabinet Member for Health and Care, SCC
Cllr Mark Sutton – Cabinet Member for Children and Young People, SCC
Cllr Jonathan Price – Cabinet Member for Education (and SEND), SCC
Dr Richard Harling, MBE - Director of Health and Care, SCC
David Pearson, MBE - Non-Executive Chair, Staffordshire and Stoke-on-Trent ICB
Peter Axon – Interim Chief Executive Officer, Staffordshire and Stoke-on-Trent Integrated Care System / Board

Background: What We Know

Disability / Neurodivergence	Prevalence: Adults	Prevalence: Under 18's
Impaired mobility / Personal care activities	About 6 in 100 aged 18-65; 1 in 6 aged over 65	Less than 1 in 100
Registrable eye condition / Severe visual impairment	Approximately 2 in 100	Less than 1 in 1,000
Severe hearing loss	Around 3 in 100	Close to 0
Learning disability	About 1 in 40	Same as adults
Autism	About 1 in 100	1 in 50
Down syndrome	Less than 1 in 1,000	Same as adults
ADHD	Around 3-4 in 100	Same as adults
Fetal Alcohol Spectrum Disorder	Just over 3 in 100	Same as adults

6. Disabilities and neurodivergences can impact on people's experiences and their chances of achieving their potential. They may struggle educationally and at work. They may have difficulty accessing social, leisure, retail sport, cultural and religious opportunities in their local area. They may feel more lonely and unsafe and be more vulnerable to crime and abuse. They may also have problems accessing health services and using digital technologies. Certain disabilities and neurodivergences are associated with an increased risk of chronic ill health and can shorten an individual's life expectancy.

7. Some disabilities and neurodivergences are not diagnosed. Some are not visible. Not all people living with them want others to know. This makes reducing inequalities (ensuring everyone can experience things in an equal way) a more complex challenge.



What you have told us

Views on Quality of Life

8. Views on disabled and neurodivergent people's current quality of life suggest that disabled and neurodivergent people:
    i. Have good contact with friends and family.
    ii. Where they live feels like home and a place where they can do what they want.
    iii. People who support them are listening to their needs.

9. However, they:
    i. Do not have as many opportunities as they would like to learn and develop.
    ii. Do not know enough about activities and services in their communities.
    iii. Are not getting as much help as they would like when needed.
    iv. Are not having as much choice and control as they would like.
    v. Do not always feel respected and listened to (under 18's)

Views on what people need to live their best lives

10. The top five factors mentioned most often by disabled and neurodivergent people to live their best lives were:

For adults:

1. Family, friends and relationships
2. Access to health and social care, shops and other services
3. Appropriate and safe home
4. Social life, social skills, getting out and about
5. Learning and education.

For children:

1. Positive educational experience
2. Social life, social skills, getting out and about
3. Family, friends and relationships
4. Adjustments made to support me
5. Personal safety.

Our Shared Vision for the Strategy

We want Staffordshire to become a place where people living with disabilities and neurodivergences can do what matters to them; where they are valued and treated as equals in all aspects of society; and where they can live a healthier and better quality of life for longer.

The outcomes we aim to achieve

11. Based on suggestions from our engagement processes, we will aim to achieve the following outcomes through this Strategy:

⚖ A. Staffordshire is more open and inclusive.

i. Co-ordinating training and awareness raising for 'all.'

This includes general awareness raising in educational settings, in the wider community and in local businesses (including those that offer services to local communities and those that are employers).

It also includes specialist training and awareness raising for statutory service professionals (including education, emergency services, health and social care, housing, transport or police and criminal justice).

ii. Expanding 'Celebrating Differences' as a tool to record, share and grow good practice.

This means expanding Celebrating Differences from a campaign focussed on Learning Disability and Autism into a larger 'movement' representing all visible and invisible disabled and neurodivergent groups. We will consider introducing influential champions and positive role models, lived experience- mentoring and organisational equality self-assessments into this.

B. Stronger partnerships are built around and include disabled and neurodivergent people.

i. Continuing to establish the Disability Partnership Board and promoting inclusion and equality as a core theme for local partnerships.

The Disability Partnership Board (linking to the Family Strategic Partnership Board) will oversee the Strategy and involve individuals with lived experience and their carers. Inclusion and equality across all aspects of health and wellbeing will be considered (including for example housing, health and employment).

ii. The Council and Integrated Care Board (ICB) working closer together to improve outcomes.

The Council and the ICB will explore more opportunities for joint working and joint funding of services, where this improves outcomes.

iii. Creating more safe spaces in Staffordshire.

The Strategy will aim to help more businesses to offer designated safe spaces across local communities.

iv. Ensuring Supportive Communities and Family Hubs link with disabled and neurodivergent people and professionals.

These programmes of work helps individuals and local communities to help themselves. For example, Community help points and Family Hubs are central points of access to information and advice. Local community navigators help people navigate to opportunities and support available in the wider community. It is important to understand what is needed, maximise community capacity and link to wider support networks and improve accessibility of information for disabled and neurodivergent people, their carers and for professionals.

C. Disabled and neurodivergent people are communicating their needs and action is being taken.

i. Expanding opportunities to give more people a voice (self-advocacy), so they can communicate confidently, be heard and influence action.

This could include the following, among other actions:

a. Including a 'How can I help you' or similar campaign into Celebrating Differences to normalise reasonable adjustments.
b. Encouraging more peer support networks and providing a means for statutory and other organisations to communicate and share information with them.
c. Including people with lived experience and their carers in shaping strategies and services and feeding back on the impact this has.
d. Using or developing simple approaches so that people can identify their needs confidently and discretely.
e. Embedding health passports.
f. Applying lessons learnt from the LeDeR programme.

D. Disabled and neurodivergent people and their carers are better informed and in control.

i. Identifying people's preferences and making information, advice and guidance and signposting information more accessible to them.

This is about exploring the ways people with disabilities and neurodivergences prefer to access information and advice whilst also considering their different accessibility needs.

ii. Making sure that existing information, advice and guidance is comprehensive.

This is about supporting people to access digital technology. It is also about linking people to information and advice, including for example:

a) Helping them cope with day to day living (such as paying bills, completing online forms and locating disabled facilities).
b) Coping with key life changes (such as parenting and transition to adulthood).
c) Accessing specialist equipment and support.
d) Carer skills development to help carers cope with day-to-day challenges and changing needs of the individuals they support.

E. In carrying out their responsibilities for Care and support, the ICB and Council will consider the whole person's needs, aspirations and what they can do. It will not stop them doing what they want to do.

i. Reinforce a strengths-based approach across health and care.

This is about considering people's aspirations and potential in terms of service planning; market development; assessment and care planning; service commissioning; quality assurance; and monitoring of care and support provided. It is also about increasing people's choice and control in relation to the support they receive.

ii. Reduce health inequalities and improve access to NHS services.

This includes earlier identification and diagnostics, giving people tools and support to prevent their needs escalating and making adjustments so that people have equal access to and experience of services.

iii. Ensure quality and value for money of dedicated services.

This means offering a good standard of care and support as well as spending public money wisely and living within our means. It includes for example exploring more opportunities for joint working with the ICB.

Our Approach

Measuring our Success

The five strategy outcomes will form the basis of an action plan for this strategy. The County-wide Disability Partnership Board will meet every four months and oversee delivery of the action plan. It will provide an update on progress to the Staffordshire Health and Wellbeing Board every year.

NHS
Staffordshire and Stoke-on-Trent
Integrated Care Board

REPORT TO:

Staffordshire and Stoke-on-Trent Integrated Care Board

Enclosure:	**07**

Title:	**Quality and Safety Report**

Meeting Date:	15 June 2023

Executive Lead(s):	**Exec Sign-Off Y/N**	**Author(s):**
Heather Johnstone – Chief Nursing and Therapies Officer	Y	Cath Marsland - Associate Director of Quality and Patient Safety Lee George - Associate Director of Quality Assurance and Improvement Karen McGowan - Associate Director of Nursing and Quality Claire Underwood – Associate Director for Safeguarding and Director for Continuing Healthcare

Clinical Reviewer:	**Clinical Sign-off Required Y/N**
N/A	N

Action Required (select):									
Ratification-R		**Approval-A**		**Discussion-D**		**Assurance-S**	✓	**Information-I**	

Is the [Committee]/[Board] being asked to make a decision/approve this item? Y/N			
Is the decision to be taken within [Committee]/[Board] delegated powers & financial limits?			
N/A			
Within SOFD Y/N		**Decision's Value / SOFD Limit**	

History of the paper – where has this paper been presented		
This paper is a combination of those corresponding papers presented and discussed at the System Quality Group.		S

Purpose of the Paper (Key Points + Executive Summary):

This paper is intended to provide assurance to the ICB (Integrated Care Board) in relation to the key quality matters. These include:

Updates from the System Partners

Current ICB updates include:

- Pharmacy Update
- Nursing Home Quality Assurance and Improvement Group
- Infection Prevention and Control Board Assurance Framework (IPC BAF)

Updates on quality issues within the Portfolios

Other System Quality Matters by Exception:

- Education, Training and Development Group
- Industrial Action
- Patient Safety Specialists Network

Is there a potential/actual Conflict of Interest?	**Y/N**
Outline any potential Conflict of Interest and recommend how this might be mitigated	
No conflicts of interest were identified.	

Summary of risks relating to the proposal (inc. Ref. No. of risk it aligns to on Risk Register):
Risks aligned to these areas of work are submitted as a separate agenda item and discussed fully at the System Quality Group.

Implications:	
Legal and/or Risk	Risks identified and discussed within the agenda of QSC
CQC/Regulator	Discussed as appropriate and against the relevant organisation.
Patient Safety	All key areas in response to system assurance for patient safety have been identified within the report
Financial – if yes, they have been assured by the CFO	Potential financial implications on the quality of services across the system due to restoration and recovery
Sustainability	N/A
Workforce / Training	Many current quality issues relate to workforce matters including areas where gaps in workforce present ongoing challenges.

Key Requirements:		**Y/N**	**Date**
1a.	Has a Quality Impact Assessment been presented to the System QIA Sub-group?	N	
1b.	What was the outcome from the System QIA Panel? (Approved / Approved with Conditions / Rejected)		
1c	Were there any conditions? If yes, please state details and the actions in taken in response: • Condition 1 & action taken. • Condition 2 & action taken.		
2a.	Has an Equality Impact Assessment been completed? If yes, please give date(s) • Stage 1 • Stage 2	**N**	

2b.	If an Equality Impact & Risk Assessment has not been completed what is the rationale for non-completion?		
2c.	***Please provide detail as to these considerations:*** • Which if any of the nine Protected Groups were targeted for engagement and feedback to the ICB, and why those? • Summarise any disaggregated feedback from local Protected Group reps about any negative impacts arising / recommendations (e.g., service improvements) • What mitigation / re-shaping of services resulted for people from local Protected Groups (along the lines of 'You Said: We Listened, We Did'?) • Explain any 'objective justification' considerations, if applicable		
3.	Has Engagement activity taken place with Stakeholders / Practices / Communities / Public and Patients ***Please provide detail***	N	
4.	Has a Data Privacy Impact Assessment been completed? ***Please provide detail***	N	
Recommendations / Action Required:			
Members of the Integrated Care Board are asked to: • Receive this report and seek clarification and further action as appropriate • Be assured in relation to key quality assurance and patient safety activity undertaken in respect of matters relevant to all parts of the Integrated Care System.			

Quality and Safety Report to the Integrated Care Board – June 2023

1. Introduction

The purpose of this report is to provide assurance to the Integrated Care Board regarding quality matters whilst also providing a summary of the discussions and emerging issues raised at the key quality forums and System Quality Group throughout May 2023.

2. Quality Risks on the Register

No new quality risks have been reported this month.

3. Board Assurance Framework (BAF)

The strategic BAF risks for 2023/24 are being agreed prior to submission to the QSC.

5. Updates from System Partners (from SQG)

5.1 Staffordshire County Council (SCC)

Staffordshire continues to see improvements in regulatory ratings in the care homes. Further improvement is anticipated with the addition of increased nursing capacity.
Guidance and best practice via the MiDoS (Directory of Services) platform is being accessed by nearly 90% of care homes in Staffordshire and just under 21% of home care and supported living services.

The number of facilities rated as 'Requires Improvement' or 'Inadequate' within Staffordshire is above the West Midlands reported rate by 4.5% however it is 2.7% below the national figure.

It was noted that a number of placements in Staffordshire do not currently have a CQC rating, primarily because they are recently registered or have seen a change in provider.

5.1.1 Nursing Home Quality Assurance and Improvement Meeting

It was noted that only one Serious Incident (SI) was reported by local Care Homes between January and March 2023 which will be subject to a Root Cause Analysis (RCA) to identify any learning.

Soft Intelligence received during this same quarter has identified medication as a theme, predominantly missed medication. A Service Level Agreement (SLA) with practices, to carry out Structured Medication Reviews (SMRs) in Care Homes has been in operation during 2022/23 and is set to be repeated for 2023/24.

As the introduction of PSIRF (Patient Safety Incident Reporting Framework) moves forward it has been recognised nationally that Care Homes are not currently identified as a provider and therefore will not be inputting into the system when it launches in the Autumn. The national team are currently reviewing this position and will provide advice and recommendations as soon possible.

Prior to Covid-19, residents received dental care from dentists who attended the care homes. This has not resumed and is proving problematic. In addition, charges for dental care for residents attending dentists have increased. This is to be escalated to NHSE commissioning staff deployed to Birmingham and Solihull ICB as part of the Delegated Commissioning arrangements.

A workshop is to take place which will review all current care home activity, with a view to aligning priorities and developing a shared plan of work.

5.2 Stoke-on-Trent City Council

There was no one in attendance at the meeting, however representatives from SCC (Staffordshire County Council) were able to provide an update, stating there are currently no homes subject to an LSE (Large Scale Enquiry) in Stoke-on-Trent, no home closures and no business continuity concerns.

5.3 Midlands Partnership University NHS Foundation Trust (MPFT)

The Trust continues to make good progress against the action plan developed as a result of a Section 29A ruling following a CQC visit in November 2022 and subsequent warning notice in December 2022. The report has now been published.

The Trust reported a response rate of 90%+ for the Friends and Family Test, in line with the Quality Strategy objective.

Staff are being recognised during a number of events in May and June 2023. A Digital Leaders Impact Award was received for work to tackle digital poverty through the use of simple technology to communicate with service users and their families. The annual 'Celebrating Nurses Event 2023' recognised the input of nurses, the 'backbone' of service provision. And a 'Voice of frontline staff in continuous improvement' event is planned for 14th June 2023 to showcase and disseminate Quality Improvements.

5.4 University Hospital of North Midlands (UHNM)

The Trust provided updates on a number of quality initiatives. This included ongoing work to refresh the Clinical Excellence Framework (CEF) which has seen a drop in scores in clinical areas following a revised criteria to increase attainment scores. National and international evidence of harm is being utilised to address one of the areas; preventing deconditioning of older people.

The Trust are working in collaboration with John Hopkins Hospital in the USA to introduce a 'highest level of mobility' scale, a simple, standardised description of patient mobility across the multi-disciplinary team.

The ICB and UHNM Chief Nurses are joint SROs (Senior Responsible Officer) for the Midlands Distributed Leadership Model Research Project, a new initiative focussing on supporting the implementation of a research development journey for Chief Nurses and Directors of Nursing in the Midlands.

Following ICS (Integrated Care System) PSIRF (Patient Safety Incident Framework) training for system partners, UHNM were commended by the training provider on their bespoke template which is expected to be shared across other ICS' as good practice.

It was also confirmed that following a factual accuracy check, the Trust has returned the CQC draft report following a visit to Maternity Services in March 2023.

5.5 North Staffs Combined Healthcare NHS Trust (NSCHT)

There are continued reporting issues with results from the UHNM pathology laboratories following implementation of a new system at the start of the year. Work is ongoing to monitor the situation through weekly surveillance and a review of potential electronic requesting solutions.

The Trust are working with Keele to run a Health and Social Care Strategic Leadership event, have been shortlisted for an HSJ Digital Award and launched the 5-year Trust Strategy 'Prevention, Access and Growth'.

A new Health and Justice Service has been launched in collaboration with MPFT to enhance the support provided to individuals with mental health concerns, learning disabilities, substance misuse problems or other vulnerabilities. Support is to be provided at each point in the criminal justice process; from being suspected of a crime to those who have served prison sentences and released.

5.6 University Hospitals Derby & Burton NHS Foundation Trust

Whilst no report was submitted it was noted that a report was provided to the UHDB (University Hospitals of Derby and Burton) Trust Board meeting in May 2023 regarding the focused work undertaken across all sites to improve care received by patients who have a dementia diagnosis aligned to the organisation's visions and values that all patients receive care that is safe, inclusive, effective, and compassionate. A number of initiatives have been implemented that have seen an improvement in a standardised approach to the use of a dementia/delirium assessment tool, enhancing the knowledge and skills of the clinical workforce to provide personalised care and an MDT (Multi-Disciplinary Team) approach to support care which promotes safety, independence, well-being and comfort. A plan is in place to further improve and embed this change across all UHDB sites.

5.7 NHS England Workforce, Training and Education

Results from the GMC (General Medical Council) National Training Survey (NTS) for Postgraduate Doctors in Training, are awaited following closure of the survey on 16th May 2023. They are expected to be available in July 2023.

5.8 NHS England

NHSE Management of Change (MoC) to commence on 14th June 2023. Further updates to be provided as the MoC progresses.

ICS partners were commended by an NHSE representative for the collaboration that was witnessed within the SQG meetings and prompted a question about how prison health providers (non-NHS) could be represented at the meeting. It was agreed this would be considered and discussed further at subsequent meetings.

5.9 Healthwatch Staffordshire

Healthwatch continue to undertake 'Enter and View' visits, the reports of which are available on their website.

Concerns continue to be received regarding dentists and pharmacists as well as access to General Practice, particularly having to make many calls. It was acknowledged that people were generally satisfied with the standard of care received once they had seen a GP.

Findings from discussions with residents in care homes identify the importance of accessing outdoor space and the challenges of frailty and falls, where the homes they visited had many residents with dementia. Religious affiliation was also raised, and limited access to a minister, and again the decision not to admit patients after 4pm.

Healthwatch will be focussing on social care going forward and engaging with the fire service and the work they do to prevent and assist with falls.

5.10 Primary Care

Three practices continue to be supported following identification of quality concerns; 2 following 'Requires Improvement' ratings from the CQC and the third following a potential breach of Professional Standards.

A new Quality and Outcomes Framework (QOF) indicator has been introduced to support practices with staff wellbeing by reducing 'burnout' and increasing retention. The indicator outlines 5 steps for practices to follow. The first focuses on workforce planning and establishes a baseline of all work-related factors; flexible working, reasons for absence and support available to staff and new starters. A survey has been developed to support the ICB to gauge the position of each practice; support they may need but also good practice that could be shared with others.

Dashboards for monitoring north and south practices have now been combined into one dashboard across the ICS and will support the identification of broader themes and trends.

5.11 Pharmacy

An overview of Pharmacy services provided across the ICS was presented at SQG. The paper outlined the current challenges regarding the recruitment and retention of pharmacists and pharmacy technicians, and the current provision of only one dedicated aseptic unit across Staffordshire. It was noted that the Nationally English National Infusions Board aim to create a network of collaborative regional hub aseptic facilities in the long term which will support provider facilities across England and ensure safe, high quality and resilient supplies.

SQG were asked to support a range of recommendations including the development of an ICS Pharmacy Workforce Plan, the development of a Pharmacy Faculty and appointment of an ICS Chief Pharmacist to oversee the strategic approach to delivery of future pharmacy services. It was also agreed that the challenges for the Pharmacy Workforce, as set out in the paper, would be escalated to the Peoples Board and added to the ICB Risk Register.

6. ICB Updates

6.1 Infection Prevention and Control (IPC) BAF

The updated National Infection Prevention and Control Board Assurance Framework (BAF) was published by NHSE in April 2023. The framework is based on the 10 IPC criteria from the Health and Social Care Act 2008 and for use by all those involved in care provision in England. Across

Staffordshire and Stoke-on-Trent, providers have developed different mechanisms for providing their Boards with assurance of compliance against the 10 criteria.

Through close working with colleagues in provider organisations, the ICB Lead IPC Nurse is assured that Trust Boards are receiving this assurance.

7. Portfolio Quality Updates

Line by line review

To support timely and effective decision-making associated with the line-by-line review of the ICB's expenditure, additional Quality Impact Assessment (QIA) Panel meetings have provisionally been held in diaries at the end of May and beginning of June 2023. The importance of the QIA governance process to support the ICB to meeting its statutory duty (triple aim) has been emphasised by the ICB's Chief Nursing and Therapies Officer who presented an update at the ICB's Joint Executive and Leadership Team and Team Brief. 'Lunch and Learn' sessions have also taken place and feedback received from the training delivered has been very positive.

7.1 Planned Care, Cancer & Diagnostics

Work continues in partnership with UHNM to respond to the Tier 1 requirements. Work is underway, with system partners, to consider how to demonstrate and celebrate a system learning culture, continuous quality improvement and implementation of best practice through reporting.

7.2 Urgent and Emergency Care

Work continues within the UEC (Urgent and Emergency Care) workstreams to develop strategies and processes to manage surges throughout the year and prepare for winter pressures. Quality and prevention of harm continues to be a focus in all discussions.

7.3 Primary Care

A further meeting of senior nurses from all 11 Midland ICBs and chaired by Birmingham and Solihull (BSoL) ICB, took place on 23rd May 2023. This arrangement will continue for a further 3 months with a plan to split into east and west after that time.

A Standard Operating Framework (SOF) has been produced setting out the governance processes for all key functions; quality, performance, contracting, finance, and started to address the issues that were arising with regards to the flow and management of incidents and issues. A reporting template has been produced and is currently being trialled with ICBs in the East to ensure that information held by the host ICB (BSoL in the West) meets the needs of the ICBs they are working with.

The three pharmacy, optometry and dentistry (POD) areas are subject to different monitoring mechanisms, and primarily through questionnaires which support prioritisation of visits. ICBs were invited to share information and potential plans to visit premises in order to synchronise activity and maximise limited resources.

There was a discussion about incident management and identified that there are no outstanding practices under investigation in the West Midlands, all having been managed and back to routine surveillance. As Independent Providers, there is no access to StEIS (Strategic Executive Information System) and so any SIs would need to be reported via the ICBs.

NHSE staff supporting the PODs will continue to provide the functions they provided previously and so contact details have been shared with the ICBs to encourage sharing of intelligence.

7.4 End of Life, Frailty & Long-Term Conditions (E.L.F.)

Work continues to review the contracts associated with the E.L.F portfolio and prioritise reviews and associated work.

End of Life – following the report of an SI in one of the hospices, the respective Director has requested a meeting with the ICB Quality and Contracting Lead, with a view to seeking opportunities to improve quality and understand how SIs are managed. In addition, work is. progressing on reviewing the Lymphoedema service spec with contracting colleagues.

Long Term Conditions - whilst existing forums such as 'Falls' and 'The Deteriorating Patient' continue, specific work continues to review the contracts as set out above and invites to specific pieces of work as they arise.

7.5 Children, Young People & Maternity

The Children, Young People and Maternity portfolio were selected as the first Deep Dive to be presented to the ICB Confidential Board, which took place on 18th May 2023. The presentation was extremely well received and served as the template for future Deep Dives for each of the portfolios.

Following receipt of the Three-Year Delivery Plan for Maternity and Neonatal Services, work continues to review compliance using tools helpfully provided by NHSE and which will incorporate the existing maternity and neonatal work streams.

A strategic review of maternity services is being undertaken in collaboration with Derby and Derbyshire ICB, UHNM and UHDB following the temporary closure of the two Freestanding Maternity Birth Units (FMBUs) in March 2020.

7.6 Mental Health, Learning Disabilities and Autism (MHLDA)

Work has commenced within the portfolio on the National MHLDA Inpatient Quality Transformation Programme and further detail from NHSE is anticipated soon.

7.7 Population Health, Prevention and Reducing Inequalities

Work is currently underway with the team to identify potential opportunities to undertake Continuous Quality Improvement initiatives.

8. Other System Quality Matters by exception:

Education, Training and Development Group

NHS Staffordshire and Stoke-on-Trent Integrated Care Board

The first meeting of the ICS wide group took place on 17th May 2023, chaired by the UHNM Chief Nurse and in collaboration with the People Function. There was good representation from across the system. Feedback from the session is being collated and will be used to identify common themes and priority areas to collaborate on going forward.

Industrial Action (IA)

The next IA by Junior Doctors is planned for 14th to 17th June 2023 and expected to continue for 3 days per month, up until August 2023. In addition, WMAS are taking IA on 12th June 2023. System partners have collaboratively produced a plan which covers this period of time to ensure that patient safety is maintained. Both the BMA (British Medical Association) and RCN (Royal College of Nursing) are balloting their members, consultants and nurses, respectively, on their views regarding future IA.

Patient Safety Specialists Network

Following a review of attendance at recent meetings, it has been agreed to pause these meetings, to allow sufficient time for PSIRF (Patient Safety Incident Response Framework) to be embedded across the ICS and support a better understanding of how to maximise the roles and network.

NHS
Staffordshire and Stoke-on-Trent
Integrated Care Board

REPORT TO:

Staffordshire and Stoke-on-Trent Integrated Care Board

Enclosure:	**08**

Title:	**Finance & Performance Report**

Meeting Date:	15 June 2023

Executive Lead(s):	**Exec Sign-Off Y/N**	**Author(s):**
Paul Brown Chief Financial Officer	Yes	Finance, Planning and Intelligence Directorate

Clinical Reviewer:	**Clinical Sign-off Required Y/N**
N/A	N/A

Action Required (select):										
Ratification-R		**Approval-A**		**Discussion-D**		**Assurance-S**	ü	**Information-I**	ü

Is the [Committee]/[Board] being asked to make a decision/approve this item? Y/N			
Is the decision to be taken within [Committee]/[Board] delegated powers & financial limits?			
Within SOFD Y/N		**Decision's Value / SOFD Limit**	

History of the paper – where has this paper been presented		
	Date	**A/D/S/I**
Finance and performance committee	06/06/23	D/S/I

Purpose of the Paper (Key Points + Executive Summary):

The purpose of this report is to provide an update for the ICB Board on the key financial and operational performance issues.

Key points on **Finance**

- The audit of the 2022/23 accounts is ongoing at all of the organisations and as at the end of May no material concerns have been flagged. Audits are due to be concluded by the end of June.
- In line with previous years there has been no formal month 1 reporting process for the ICS financial position.
- Most of the financial risk sits within non-pay, including CHC and prescribing. A separate paper is provided on the progress in delivering the plan.

Key points on **Performance**

- Pressures in **Urgent and Emergency Care** during April remained in line with Q1. Some reduction in staffing shortfalls this month.
- **Ambulance handover delays** over 60 minutes at Royal Stoke reduced by 61% in April, due in part to collaboration across the system, and use of surplus capacity.
- **Referral To Treatment** - As at w/e 14 May:
  - 3,024 65+ week waits are recorded
  - 653 78+ week waits are recorded.
  - 43 104+ week waits are recorded.
- The ICB has agreed plans to get to zero patients waiting 78 weeks or more by June 2023, and zero 65 week waits by March 2024, although it is recognised that there are risks to achieving these plans.
- In **Cancer** during March**:** 90% of urgent referrals were seen within 2 weeks; 70.5% of patients were diagnosed within 28 days; and 60% of cancer patients were seen within 62 days.
- 99.8% of 19/20 **diagnostic** activity was delivered in March – 78.8% at year end.
- GP appointments and Learning Disability Annual Health Checks achieved the year-end targets.
- Zero inappropriate Out of Area Bed Days were recorded in February.

The ICB Board is asked to discuss and note the contents of this report.

Is there a potential/actual Conflict of Interest?	**Y/N**
Outline any potential Conflict of Interest and recommend how this might be mitigated	
None	

Summary of risks relating to the proposal (inc. Ref. No. of risk it aligns to on Risk Register):

- BAF Strategic Aim '(3C) (**Risk 961**) - Support the delivery of system financial balance by 2025/26'. (BAF submissions being reviewed by ICB Board and are subject to change)
- **Risk 123** - Underlying deficits from 2023/24: If the system saving schemes do not deliver the financial strategy, the system, its providers and consequently the ICB will be unable to deliver a financially sustainable position in line with the operating and planning framework.
- **Risk 121** - Delivery of the 2023/2024 Financial Plan: If the breakeven plan is not achieved the ICB will not achieve breakeven in the current period 2023/2024, resulting in losing the opportunity to write off historic deficits and reputational damage. The underlying deficit not being addressed adding to the financial challenge for 2024/2025.
- **Risk 111** – If continued delays to ambulance handovers are incurred and sustained, or levels increased there will be significant pressures placed onto ED, ambulance crews and the wider UEC system resulting in increased instances of patient harm, increased system capacity issues, 'lost' ambulance time and associative issues.
- **Risk 112** - If Industrial action continues there will be periods of additional pressure placed upon the system resulting in increased instances of patient harm, increased system capacity issues, compromised staffing ratios and the need for enhanced contingency measures.

Implications:	
Legal and/or Risk	Monitoring performance is a statutory duty of the ICB.
CQC/Regulator	Where non-delivery of activity indicates an adverse impact on patient safety this is investigated by the ICB Quality Team.
Patient Safety	Where non-delivery of activity indicates an adverse impact on patient safety this is investigated by the ICB Quality Team.
Financial – if yes, they have been assured by the CFO	The report provides a headline summary of the financial position Failure of the ICS to achieve its financial duty to remain within its resource limit
Sustainability	None specifically identified pertaining to this report
Workforce / Training	None specifically identified pertaining to this report

Key Requirements:		Y/N	Date
1a.	Has a Quality Impact Assessment been presented to the System QIA Sub-group?	**N**	
1b.	What was the outcome from the System QIA Panel? (Approved / Approved with Conditions / Rejected)		
1c	Were there any conditions? If yes, please state details and the actions in taken in response: • Condition 1 & action taken. • Condition 2 & action taken.		
2a.	Has an Equality Impact Assessment been completed? If yes please give date(s) • Stage 1 • Stage 2	**N**	
2b.	If an Equality Impact & Risk Assessment has not been completed what is the rationale for non-completion? Equality Impact Assessments and Quality Impact Assessments are completed as a matter of course for any service changes, programmes of work or new / updated policies, for example both assessments were undertaken previously, and will be undertaken once more this year, in development of the Winter Plan. In addition, specific Equality Impact Assessments covering the key risks relevant to the performance report will be undertaken Quarterly. Work has commenced upon this and updates will be provided accordingly.		
2c.	***Please provide detail as to these considerations:*** • Which if any of the nine Protected Groups were targeted for engagement and feedback to the ICB, and why those? • Summarise any disaggregated feedback from local Protected Group reps about any negative impacts arising / recommendations (e.g. service improvements) • What mitigation / re-shaping of services resulted for people from local Protected Groups (along the lines of 'You Said: We Listened, We Did'?) • Explain any 'objective justification' considerations, if applicable		
3.	Has Engagement activity taken place with Stakeholders / Practices / Communities / Public and Patients ***Please provide detail***	**N/A**	
4.	Has a Data Privacy Impact Assessment been completed? ***Please provide detail***	**N/A**	

Recommendations / Action Required:

The Integrated Care Board is asked to:

- Discuss and note the contents of the Finance and Performance report

NHS
Staffordshire and Stoke-on-Trent
Integrated Care Board

Report to the ICB Board on Finance and Performance

ICB Board Meeting – 15 June 2023

Executive Summary

The purpose of this report is to summarise the **key financial and operational performance issues for the ICB Board**.

Headlines

Finance

- The audit of the 2022/23 accounts is ongoing at all of the organisations and as at the end of May no material concerns have been flagged. Audits are due to be concluded by the end of June.
- In line with previous years there has been no formal month 1 reporting process for the ICS financial position. Slide 4 shows the current position on pay, which is broadly on plan.
- Most of the financial risk sits within non-pay, including CHC and prescribing. A separate paper is provided on the progress in delivering the plan.

Operational Performance by Exception

- ***This summary contains updated RTT positions for May using the latest available operational information.***
- During April levels of demand in **Urgent and Emergency Care** were similar to levels reported though March. Ongoing focus at UHNM has resulted in improved performance against the 4-hour ED target. Covid-19 admissions reduced through April although requirements for IPC restricted areas still had an impact on capacity. Staffing shortfalls and Covid-related absences were fewer during April.
- **Ambulance handover delays** over 60 minutes at Royal Stoke achieved the lowest levels reported for the last 16 months. This was due to a combination of system management of pressures, support, escalation and collaborative working across all partners, development and focus on the Improvement Plan, and the retention of surplus capacity [open] above the predicted model.
- **65+ week waits**: The ICS has submitted a revised plan to reduce patients waiting over 65 weeks to zero by March 2024.
    - The most recent ICB level data (w/e 14 May) shows 3,024 patients waiting over 65 weeks compared to 2,805 in March.
- **78+ week waits:** The ICB has agreed a route to 0 by the end of June, however there is significant risk to achieving this.
    - As at 14 May 653 ICB patients were waiting more than 78 weeks.
- **104+ week waits:** Numbers are decreasing; 43 patients were waiting over 104 weeks as at 14 May compared to 57 at the end of March.
- **Diagnostics:** At year end 78.8% of planned activity was delivered, although 99.8% of planned activity was delivered in March.
- **Cancer waiting times**: 90.3% of patients were seen within 2 weeks (national standard 93%), however a large number of patents were seen this month - the highest number of patients seen within 2 weeks for this year.
- Performance against the **Cancer 28 Day Faster Diagnosis Standard** declined in March – 70.5% of patients were told within 28 days.
- **Primary care:** The number of GP appointments and Learning Disability Annual Health Checks have achieved year end targets. Social prescribing referrals have not met the Q4 target.
- **Mental Health**: During February (latest available data) there were 0 inappropriate out of area bed days across the ICB.

Supplementary information

Month 1 finance update

Due to the lack of available information and the ongoing 2023/24 planning process, there has been no formal month 1 reporting process for the ICS financial position. This will resume in month 2 as the only information we have available to report on for month 1 is pay data. The position for pay is broadly on plan and no new issues or concerns have been raised at this stage. Most of the risk sits within non-pay, including CHC and as yet we do not have any reporting on those. As we submitted a revised breakeven financial plan in May for 2023/24 work has been ongoing during this month to update our finance storyboard in relation the revised plan.

System	Plan	Actual	Variance
Substantive staff including on-costs	88,915	85,364	-3,551
Bank staff including on-costs	5,346	7,130	1,784
Agency / contract	3,165	3,854	689
Other	160	162	2
Total gross staff costs	**97,586**	**96,510**	**-1,076**

NSCHT	Plan	Actual	Variance
Substantive staff including on-costs	6,827	6,587	-240
Bank staff including on-costs	292	424	132
Agency / contract	388	430	42
Other	26	28	2
Total gross staff costs	**7,533**	**7,469**	**-64**

UHNM	Plan	Actual	Variance
Substantive staff including on-costs	46,943	45,757	-1,186
Bank staff including on-costs	3,526	4,791	1,265
Agency / contract	1,660	2,178	518
Other			0
Total gross staff costs	**52,129**	**52,726**	**597**

MPFT	Plan	Actual	Variance
Substantive staff including on-costs	33,356	31,630	-1,726
Bank staff including on-costs	1,528	1,915	387
Agency / contract	1,117	1,246	129
Other	134	134	-0
Total gross staff costs	**36,135**	**34,925**	**-1,210**

ICB	Plan	Actual	Variance
Substantive staff including on-costs	1,789	1,390	-399

Urgent Care – Ambulance delays

	Indicator	Target	Period / Description	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	Change on previous period	Period trend
Ambulance	Ambulance handovers @ UHNM (all Patients at UHNM)		Handover delays of over 60 minutes	1,400	874	1,495	1,561	1,022	1,376	1,717	1,567	1,606	1,003	595	843	342	▼	
			Variance to 19/20	1,390	857	1,442	1,472	992	1,342	1,656	1,506	1,301	923	542	764	332		
			Handover delays of over 30 minutes	2,398	1,969	2,439	2,496	2,101	2,273	2,566	2,374	2,368	1,935	1,385	1,858	1,859	▲	
			Variance to 19/20	2,080	1,540	1,828	1,348	1,445	1,586	1,689	1,471	802	775	551	997	1,541		
			Handover delays of over 15 minutes	3,558	3,824	3,778	3,653	3,659	3,518	3,636	3,629	3,507	3,629	3,281	3,673	3,674	▲	
			Variance to 19/20	1,360	1,299	1,057	367	861	607	386	277	-428	85	46	877	1,476		
	Response Standards (WMAS - all responses) Times in hh:mm:ss	00:07:00	Category 1 mean	00:09:25	00:08:32	00:08:58	00:09:08	00:08:54	00:08:59	00:09:29	00:09:39	00:10:17	00:08:53	00:08:57	00:08:46	00:08:31	▼	
			Time variance to 19/20	00:02:17	00:01:22	00:01:46	00:01:51	00:01:43	00:01:26	00:01:53	00:02:14	00:02:32	00:01:27	00:01:30	00:01:12	00:01:23		
		22/23 - 00:18:00 23/24 - 00:30:00	Category 2 mean	01:28:01	00:40:26	01:01:39	01:11:06	00:43:06	00:59:25	01:35:21	01:05:13	02:25:40	00:34:06	00:28:45	00:30:08	00:25:37	▼	
			Time variance to 19/20	01:14:55	00:27:47	00:47:48	00:56:58	00:29:32	00:45:44	01:20:54	00:49:39	02:08:47	00:21:03	00:14:48	00:14:38	00:12:30		
	Time Lost		Hours lost in total (Handover)	3,800	2,264	3,572	4,116	2,728	3,178	4,532	3,921	4,839	2,498	1256	1817	581	▼	

Ambulance Activity

The data on this slide is for the West Midlands Ambulance Service (WMAS) and, in terms of response performance, reflects the service's responses across their area of operation (Staffordshire and Stoke-on-Trent). The 'Time Lost' line is the total time WMAS lost to Handovers at the University Hospitals of North Midlands (UHNM) and Burton Hospital.

- During April WMAS received 20,427 calls from the Staffordshire and SoT area (680 per day in average) which resulted in 14,571 assigned incidents. 13.3% were dealt with on the call, 31.2% were treated at scene, 55.6% were conveyed.
- The category 1 [mean] response time improved slightly in April but remains in breach of the 7 minute target, despite a reduction in the count of Category 1 incidents, from 1,780 in March to 1,608 in April, again for the Staffordshire and SoT area.
- The category 2 [mean] response time improved in April and is below the [23/24] 30-minute target (the new UEC Recovery Plan target is 30 minutes for 23/24). The category 2 incident volume decreased from 8,043 in March to 7,758 in April.
- April saw a notable improvement in 60 minute+ handover delays to [a period low of] 342. At site level there was a significant improvement in April (from March) at Royal Stoke (of 504 or 60.5%), whilst County Hospital reported an increase of 3 (30%).
- At Queens Hospital Burton the proportion of ambulance conveyances arriving through EMAS increased in April from 23.3% in March to 25.7%, with the average arrivals per day for the month decreasing slightly from 47 to 44.

Date Source: Performance data published by NHSE.
Time Period: Note the data is subject to a 2 month 'lag' for Provider re-submission, data published by NHSE. This is normal process.

Urgent Care - Performance against NHS Constitutional Standards

	Provider	Target	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	YTD	Change on previous period	Trend
A&E 4 Hour Performance (% seen in <4 hours)	University Hospitals North Midlands	95%	62.9%	62.8%	62.3%	63.4%	64.9%	66.0%	64.0%	62.9%	55.2%	63.1%	66.6%	67.1%	63.3%	▲	
	University Hospitals Derby & Burton	95%	62.0%	64.2%	61.7%	62.4%	63.0%	62.5%	61.0%	61.3%	55.9%	61.9%	59.9%	60.7%	61.3%	▲	
	The Royal Wolverhampton	95%	76.8%	79.5%	78.9%	80.4%	80.5%	79.3%	79.1%	73.5%	70.1%	76.8%	76.4%	75.4%	77.1%	▼	
	University Hospitals Birmingham	95%	54.7%	54.6%	53.2%	49.8%	52.7%	52.1%	52.1%	51.1%	49.9%	54.7%	47.6%	51.0%	52.0%	▲	
	The Dudley Group	95%	80.3%	74.7%	74.0%	75.6%	75.9%	75.0%	74.8%	72.5%	68.4%	75.1%	73.9%	68.9%	74.0%	▼	
	Walsall Healthcare	95%	73.9%	72.3%	72.5%	72.4%	73.9%	74.5%	70.6%	72.8%	69.7%	74.4%	77.7%	73.5%	73.0%	▼	

	Provider	Target	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	YTD	Change on previous period	Trend
A&E 12 Hour Trolley Breaches	University Hospitals North Midlands	0	878	390	555	665	346	695	1028	947	1289	1039	690	906	9428	▲	
	University Hospitals Derby & Burton	0	432	388	256	333	348	394	785	323	872	648	867	641	6287	▼	
	The Royal Wolverhampton	0	30	20	30	194	130	100	208	84	487	101	89	113	1586	▲	
	University Hospitals Birmingham	0	271	211	552	749	525	775	1384	1233	1830	1493	1279	1356	11658	▲	
	The Dudley Group	0	31	79	49	67	90	95	129	20	67	56	26	30	739	▲	
	Walsall Healthcare	0	6	10	1	35	13	14	63	91	259	148	125	265	1030	▲	

- Constitutional targets around 4 hour performance and 12 hour trolley breaches continue to be a challenge.
- Performance against the 4 hour target in March was similar to February at our main 3 providers.
- The number of 12 hour trolley breaches increased in March at 5 out of 6 providers.

Date Source: Performance data published by NHSE.
Time Period: Note the data is subject to a 2 month 'lag' for Provider re-submission, data published by NHSE. This is normal process.

Planned care activity – Month 12

Indicator	YTD 1920 v YTD 2223		
	19/20	22/23	% Var
Elective Ordinary Spells	19,137	16,777	-12%
Day cases	152,523	148,394	-3%
Outpatient procedures (Cons Led)	164,216	138,731	-16%
Outpatient first attendances without a procedure (Cons Led)	317,277	339,695	7%
Outpatient follow-up attendances without a procedure (Cons Led)	535,884	538,152	0.4%
Diagnostic Tests (Specific 7 Tests)	458,445	402,220	-12%

Elective Activity – Year end 2022/23

- Overall, 94.6% of 2019/20 activity was delivered, a shortfall of 9.4% on the plan to deliver 104% of 2019/20 activity.
- Elective Ordinary Spells were 12% below 2019/20.
- Day cases were 3% below 2019/20 .
- Outpatient procedures were 16% below 2019/20.
- Outpatient first attendances – 7% more attendances were delivered in 2022/23 compared to 2019/20, achieving our plan
- Outpatient follow-up attendances without a procedure (Cons Led) were 0.4% more than in 19/20, which was an adverse position as the target was to reduce the number of follow-ups.

Diagnostics – Year end 2022/23

- Diagnostic activity was 12% below 2019/20.
- It is to be noted that in March 2023 99.8% of planned activity was delivered.

*Note: The current Year End FOT is set to be **below** the 19/20 FOT for the above indicators (with the exception of outpatient follow-up attendances). This indicates that activity must increase for Elective Ordinary Spells, Day Cases, Outpatient and Diagnostics if the 2019/20 volume [target] is to be met.*

Planned care and Cancer – Month 12

Indicator	YTD 1920 v YTD 2223		
	19/20	22/23	% Var
RTT - admitted, completed	66,046	60,065	-9%
RTT non-admitted, completed	268,666	266,118	-1%
Incomplete Pathway - Total Waiting List	88,982	150,159	69%
Incomplete Pathway - 52+ Weeks	11	8,648	
Incomplete Pathway - 78+ Weeks	0	618	
Incomplete Pathway - 104+ Weeks	0	57	
GP and other (non-GP) referrals first consultant-led outpatients	406,751	446,350	10%
Cancer 28 days FDS - Total Patients Diagnosed	33,199	61,923	87%
Cancer 31 day Treatments	6,672	7,031	5%

Referral to Treatment - Year end 2022/23

- Completed admitted pathways were 9% fewer than in 2019/20
- Completed non-admitted pathways were 1% fewer than in 2019/20
- The RTT Waiting list is 69% larger than in 19/20.
- Referrals for a first outpatient appointment with a consultant were 10% fewer than in 2019/20.

Cancer - Year end 2022/23

- 28 days FDS - 87% more patients received a diagnosis or had cancer ruled out within 28 days compared to 2019/20.
- 5% more patients received cancer treatment within 31 days compared to 2019/20.

Updated RTT position as at week ending 14 May (*Please note this data is weekly and is not a final position and therefore is subject to change.*)

- 52+ week waits: 9,366 across all providers, of which 4,632 are at UHNM and 363 at the Independent Sector providers. The ICB and UHNM totals have decreased since 16 April. Fluctuations are driven by the 65+ and 78+ wait bands.
- 65+ week waits: 3,024 across all providers, of which 1,735 are at UHNM and 37 at the Independent Sector providers. The ICB and UHNM totals have reduced since 16 April, although they remain on a shallow upward trend overall.
- 78+ week waits: 653 across all providers, of which 535 are at UHNM. Of these, 8 waits are on the 2 week wait pathway, 499 routine and 28 urgent.
  - The **forecast** at UHNM (trust-wide) is for 463 patients to be waiting >78 weeks at the end of May.
  - 1 patient is currently forecast to breach 78 weeks at the Independent Sector providers.
- 104+ week waits: 48 across all providers, (41 at UHNM, 1 at UHB and 1 at another NHS provider). The ICB total remains on a downward trend.
  - UHNM **forecasts** 16 patients to be waiting >104 weeks by the end of May.

Date Source: SUS and Performance data published by NHSE. Time Period: Note the data is subject to a 2 month 'lag' for Provider re-submission, data published by NHSE. This is normal process.
Y/E Actual/FOT: When year end actual position is yet available, estimated FOT is used: RTT waiting list FOTs are calculated using linear regression; Other metrics are derived by applying the current YTD monthly average to the entire financial year.

Primary Care Summary

Appointments in General Practice

Indicator	Currency	Q1			Q2			Q3			Q4			YTD	Change on previous period	Trend
		Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23			
Appointments in General Practice	Count	423,294	484,394	448,258	455,173	470,805	501,940	571,228	556,735	469,981	520,189	485,869	557,712	5,945,578	▲	
	% to Plan	99.4%	114.6%	93.5%	98.8%	108.5%	93.3%	100.3%	99.6%	103.1%	106.1%	111.8%	131.7%	104.4%	▲	
	% to 19/20	99.6%	111.1%	108.8%	97.5%	116.4%	105.1%	104.9%	116.3%	112.7%	109.4%	114.5%	134.9%	110.6%	▲	

Year end – 2022/23

- Appointment activity in March was 31.7% above the plan – equating to 134,261 more appointments than planned.
- The ICB delivered 104.4% of the plan this year – equating to 252,440 more appointments.
- Total activity of 22/23 was 10.6% above that delivered in 19/20.

Metrics by Exception – <u>Performance against Target</u>

Indicator	Targets / Variance	Q1			Q2			Q3			Q4			YTD	Change on previous period	Trend
		Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23			
Total number of social prescribing referrals (cumulative)	*Cumulative target Q1: 3365, Q2: 6730, Q3: 11,780, Q4 16830*	3,103			6,692			9,991			16,786			16,786		
Learning Disabilities annual health checks (quarterly targets, cumulative data)	*Targets: Q1 12.29%, Q2 31.0%, Q3: 49.8%, Q4: 75%*	12.0%			29.4%			50.0%			80.7%			80.7%		
Antimicrobial resistance: total prescribing of antibiotics in primary care	0.871	0.989	1.003	1.008	1.013	1.019	1.013	1.013	1.024	1.073	1.103	1.121		1.121	▲	
	Variance to 19/20 (rate)	-0.063	-0.046	-0.037	-0.033	-0.027	-0.034	-0.032	-0.019	0.023	0.057	0.079		0.079	▲	

- Referrals to **Social Prescribing:** year end position fell short of the target by just 44 referrals with the total cumulative number of referrals at 16,786.
- **LD Annual Health Checks:** At year end 80.7% of eligible patients received a health check, exceeding the target of 75%.
- The **Antimicrobial Resistance** rate declined in February and remains in breach of the target set for our ICB.

Data Source: *Appointment in General Practice – Appointments in General Practice data collection (NHS Digital). Y/E Actual/FOT calculated using the 3 year cumulative average*
NHS Digital *- "Appointments in General Practice (experimental statistics). This is an experimental dataset and the full supporting information should be taken into consideration when interpreting activity in General Practice. Appointments are also affected by widespread variations in working methods (e.g. patient choice, preference, demographics), appointment recording, seasonality and number of working days services are available"*

Mental Health Summary

Indicator	Currency	Q1			Q2			Q3			Q4			YTD	Change on previous period	Trend
		Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23			
Inappropriate adult acute mental health Out of Area Placement (OAP) bed days - ICB level	Count	15			160			120			10	0		305	▼	
	% to Plan	8.3%			133.3%			200.0%						101.7%	▲	
	% to 19/20 (count)	12.0%			66.7%			88.9%			14.3%	0.0%		53.5%	▼	
	Provider wide actual - NSCHT*	0			115			20			0	0		135	⇨	
	Provider wide actual - MPUFT*	565			885			675			135	110		2,370	▼	
Access to NHS Talking Therapies (formerly IAPT)	Count	6,025			5,935			6,630			2,060	1,920		22,570	▼	
	% to Plan	75.5%			70.9%			76.6%						73.1%	▲	
	% to 19/20 (count)	116.4%			110.4%			120.1%			69.9%	65.1%		113.3%	▼	
Estimated diagnosis rate for people with dementia	Count	10,157			10,476			10,586			10,820			10,820	▲	
	% to Plan (numerator)	102.8%			105.2%			105.8%			107.3%			107.3%	▲	
The proportion of CYP with ED (**routine** cases) that wait 4 weeks or less from referral to start of NICE-approved treatment (rolling 12 months)	Percentage <4 weeks	78.3%			77.8%			80.0%			78.8%			78.8%	▼	
	Variation to plan (rate)	-0.5%			0.5%			-6.2%			-16.1%			-16.1%	▼	
	Variation to 19/20 (rate)	-13.9%			-13.7%			-14.4%			-17.8%			-17.8%	▼	
	Variance to National Target (95%)	-16.7%			-17.2%			-15.0%			-16.2%			-16.2%	▲	
The proportion of CYP with ED (**urgent** cases) that wait one week or less from referral to start of NICE-approved treatment (rolling 12 months)	Percentage <1 week	91.7%			98.1%			97.9%			100.0%			100.0%	▲	
	Variation to plan (rate)	8.3%			13.9%			7.9%			0.0%			0.0%	▼	
	Variation to 19/20 (rate)	-0.6%			-1.9%			-2.1%			0.0%			0.0%	▲	
	Variance to National Target (95%)	-3.3%			3.1%			2.9%			5.0%			5.0%	▲	

- **Out of Area bed days** (at ICB level) are down to zero in February (most recent data) from 10 in January.
  - **note that Provider data includes all patients not just S&SoT and is rounded by NHSE to the nearest 5 and must be used as an indicative guide only.*
  - *Zeroes are shown unsuppressed.*
- NHSE policy mandates the elimination of "inappropriate" out of area placements (IOAPs). All NHS Trusts are facing increased pressure on adult (including older adult) inpatient services with high demand and increasing acuity. This can result in people being placed in a unit, often operated by Independent Sector Providers (ISPs) out of area which can result in price differentials and competition for beds as well as complex quality assurance arrangements. This is especially an issue for acute and PICU provision.
- There is a co-ordinated approach across the West Midlands through the development of a Bed Strategy for non-specialised mental health & LDA provision that is an intention to addresses capacity and unmet need with the potential to improve quality, outcomes and value for money. This will build on, and help steer, local developments for Staffordshire and Stoke-On-Trent ICS. There are number of key actions underway beginning with Stage 1 Analysis: April- June 23 reviewing information on bed demand & capacity including, Inpatient Bed Strategies; and understand system challenges. Building to proposals for implementation from November 2023.
- Access to **Talking Therapies** is below 19/20 for January and February (most recent available) and year to date is below plan.
- **CYP eating disorder** service for **routine** cases: Q4 / YTD is below plan (by 16.1%), below 19/20 (by 17.8%) and below target (by 16.2%).
- The **CYP eating disorder** service for **urgent** cases: Q4 / YTD at 100% for <1 week waits. The plan and the variation to 19/20 are equal. At 100%, the target (95%) is exceeded.

Data Source: Performance data published by NHSE. Time Period: Note that Mental Health data is updated in different intervals to performance and activity data. This data is presented from the most recent [data] available.
Note re. CYP eating disorders (ED) data; the source is the initial cut of the data direct from NHSE/D and remains consistent (as a source) across the financial year. This may not match the published data as that is often subject to change and has a time lag.

Mental Health Summary

Indicator	Currency	Q1			Q2			Q3			Q4			YTD	Change on previous period	Trend
		Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23			
People with severe mental illness receiving a full annual physical health check and follow up interventions	Count	3,697			3,801			3,976			5,058			5,058	▲	
	% to Plan	112.4%			102.5%			87.5%			91.0%			91.0%	▲	
	% to 19/20 (count)	141.1%			149.1%			149.6%			188.2%			188.2%	▲	
Women Accessing Specialist Community Perinatal Mental Health Services	Count	310			455			530			620			620	▲	
	% to Plan	86.8%			84.6%			72.5%			69.1%			69.1%	▼	
	% to 21/22 (count)	96.9%			98.9%			91.4%			87.9%			87.9%	▼	
Access to Individual Placement and Support Services	Count	345			460			550			660			660	▲	
	% to Plan	156.6%			104.4%			83.2%			74.9%			74.9%	▼	
	% to 19/20 (count)	328.6%			270.6%			224.5%			203.1%			203.1%	▼	
Overall Access to Core Community Mental Health Services for Adults and Older Adults with Severe Mental Illnesses	Count	10,560			11,040			10,995			10,355			10,355	▼	
	% to Plan	93.9%			97.7%			96.9%			90.0%			90.0%	▼	
	% to 21/22 (count)	102.5%			111.6%			107.7%			101.6%			101.6%	▼	
Access to Children and Young People's Mental Health Services	Count	14,885			14,945			14,845			14,690			14,690	▼	
	% to Plan	75.2%			74.8%			73.2%			72.6%			72.6%	▼	
	% to 21/22 (count)	121.9%			114.4%			108.4%			101.4%			101.4%	▼	

- **Severe Mental Illness (SMI)** annual health checks: At Q4, 91% of the plan delivered, 88.2% above the 19/20 count.
- **Perinatal Access** – Q4 details a surge in the number of contacts, however the volume is only 87.9% of that in 2021/22.
- Access to **Individual Placement and Support Services** - Q4 to data reports a surge in the number of contacts to 660 but only 74.9% of the plan delivered.
- Overall Access to **Core Community Mental Health Services** (for Adults with SMI) reports a slight drop in Q4 with 90% of the plan delivered. The 21/22 count was exceeded.
- Access to **Children and Young People's MH Services** reports a slight drop in Q4 with 72.6% of the plan delivered. The 21/22 count exceeded.

Notes:

- *(*) Where metrics do not have a FOT they either do not have a plan or they are a combination of monthly data and quarterly plans therefore it is not possible to generate a linear forecast*
- *Overall Access to Core Community Mental Health Services for Adults and Older adults with Severe Mental Illnesses and Access to Children and Young People's Mental Health Services continue to be impacted by the move to ICBs. NHS Digital are working on getting the data for August and September into next month's publication of the MHSDS.*
- *Published First Episode Psychosis treatment data is currently withheld because the data has yet to be released by NHS Digital in a usable format (being only available at Sub-ICB level and rounded to the nearest 5/ suppressed where values fall below 5).*

Data Source: Performance data published by NHSE. Time Period: Note that Mental Health data is updated in different intervals to performance and activity data. This data is presented from the most recent [data] available.

NHS
Staffordshire and Stoke-on-Trent
Integrated Care Board

REPORT TO:

Staffordshire and Stoke-on-Trent Integrated Care Board

Enclosure:	**09**

Title:	**Delivering the Breakeven Plan 2023/24**

Meeting Date:	15 June 2023

Executive Lead(s):	**Exec Sign-Off Y/N**	**Author(s):**
Paul Brown, Chief Finance Officer	Y	Paul Brown, Chief Finance Officer Helen Dempsey, Director of Planning

Clinical Reviewer:	**Clinical Sign-off Required Y/N**
Proposals discussed with Clinical Leadership Team and Health and Care Senate.	N

	Action Required (select):										
Ratification-R		**Approval -A**		**Discussion - D**		**Assurance - S**		**Information-I**	**I**		

Is the Committee being asked to make a decision/approve this item? N			
Is the decision to be taken within Committee delegated powers & financial limits?			
Within SOFD Y/N	N/A	**Decision's Value / SOFD Limit**	N/A

History of the paper – where has this paper been presented		
	Date	A/D/S/I
Chief Finance Officers' meeting	24.05.23	A/S/I
Senior Leadership Team meeting	25.05.23	A/I
System Performance Group	31.05.23	I
Finance and Performance Committee	06.06.23	A

Purpose of the Paper (Key Points + Executive Summary):

The System submitted a balanced plan as part of the planning re-submission on 4 May.

Collectively the System needs to deliver £181m savings to achieve the breakeven position, before the emergence of any additional risk.

The paper sets out the structure around reporting and assurance of the delivery of plans, the benefits of approaching aspects of the plan as a System and an outline work programme to develop the medium term financial strategy and the 2024/25 Operating Plan.

The paper details the actions required to deliver the system breakeven plan for 2023/24 and to begin to address the c£150m recurrent deficit. These have been agreed by CFOs and CEOs and approved by the Finance and Performance Committee at the meeting on 6 June.

Is there a potential/actual Conflict of Interest?	Y/N
Outline any potential Conflict of Interest and recommend how this might be mitigated	
N/A	

Summary of risks relating to the proposal (inc. Ref. No. of risk it aligns to on Risk Register):
BAF 6: Sustainable Finances BAF 7: Improving Productivity Risk 121: Delivery of the 2023/2024 Financial Plan Risk 123: Underlying deficits from 2023/24

Implications:	
• Legal and/or Risk	Failure of the ICS to achieve its financial duty to remain within its resource limit
• CQC/Regulator	None specifically identified pertaining to this report
• Patient Safety	None specifically identified pertaining to this report
• Financial – if yes, they have been assured by the CFO	The financial plan submitted for 2023/24 has been agreed and signed off by the CFO
• Sustainability	Delivery of the financial plan and effective implementation of the IFPS are key to supporting the longer-term plan for financial sustainability
• Workforce / Training	None specifically identified pertaining to this report

Key Requirements:			
1a.	How can the author best assure the Board that the decision put before it meets our statutory duty to reduce inequalities by ensuring equal access to services and the maximising of outcomes achieved by those services? **N/A**		
1b.	How can the author best assure the Board that the decision put before it meets our new statutory duty to have regard to the wider effects of our decisions in relation to health & wellbeing, quality and efficiency? (If the paper is 'for information' / for awareness-raising, not for decision, please put n/a) **N/A**		
		Y/N	**Date**
2a.	Has a Quality Impact Assessment been presented to the System QIA Sub-group?	**N**	
2b.	What was the outcome from the System QIA Panel? (Approved / Approved with Conditions / Rejected)		
2c.	Were there any conditions? If yes, please state details and the actions in taken in response:		

3a.	Has an Equality Impact Assessment been completed? If yes please give date(s)	**N**	
3b.	If an Equality Impact & Risk Assessment has not been completed what is the rationale for non-completion?		
3c.	***Please provide detail as to these considerations:*** • Which if any of the nine Protected Groups were targeted for engagement and feedback to the ICB, and why those? • Summarise any disaggregated feedback from local Protected Group reps about any negative impacts arising / recommendations (e.g. service improvements) • What mitigation / re-shaping of services resulted for people from local Protected Groups (along the lines of 'You Said: We Listened, We Did'?) • Explain any 'objective justification' considerations, if applicable		
4.	Has Engagement activity taken place with Stakeholders / Practices / Communities / Public and Patients ***Please provide detail***	**N**	
5.	Has a Data Privacy Impact Assessment been completed? ***Please provide detail***	**N**	

Recommendations / Action Required:

The Integrated Care Board is asked to:

- Note the actions and proposals agreed by the CFOs and CEOs and proposed to the system Finance & Performance Committee to support the delivery of the plan and address the long-term financial challenge.

NHS
Staffordshire and Stoke-on-Trent
Integrated Care Board

System 2023/24 Financial Plan

Delivering the Break-Even position

Context and Introduction

- This paper follows discussion at System Performance Group, Senior Leadership Team and System Finance & Performance Committee where these actions to deliver the system break-even plan were approved.
- We agreed to the break even plan in the knowledge that this plan contains a huge amount of risk (quantified as £121m). Under the current arrangements, the ICB is required to be a single point for system reporting to NHSE, including the assurance of overall delivery and associated risks. We aspire to a collective system approach whereby the ICB can discharge this responsibility in as lean a method as possible without creating additional work for partners.
- This paper sets out some ideas about how we will **build some structure around the reporting and assurance** of the delivery of the plans. It also sets out ways we think **approaching aspects of the plan as a system will provide greater likelihood of achieving the target**. Finally, it sets out some proposals for the work required to build the **next iteration of the financial strategy**, aligned to the beginning of the 2024/25 planning period and in anticipation of the 3 year financial allocations due sometime in the Autumn, along with the refresh of the NHS Long Term plan.
- The 'stretch' of £40m was agreed relatively late in the day, and then the move to break-even was later still - the final plan includes efficiency of £181m. Consequently we need to ensure there is clarity about the management of the position and on where responsibilities for management action lie.
- We are left with an underlying deficit of c£150m. This is not going to get fixed through this work to balance 2023/24, so the paper also discusses the **medium term actions to start addressing this underlying challenge**.
- It is important that we address these actions as a system. This cannot be a purely NHS response, as we have significant pressure in social care as well, and so the actions are ones that we need to take jointly.
- The actions fall into two time periods; those that will help us address the break-even requirement for 2023/24; and those that are longer term but are important to address the underlying deficit.

Scale of the challenge and how we will report

Within the breakeven plan there is £181m efficiency ask equating to 7.5% of the RRL. This will be delivered through a combination of more traditional CIPs and cost control measures as well as larger scale transformations and system-wide approaches.

We will be under a great deal of scrutiny to report on delivery and to do this we have agreed that we need to be reporting at a manageable level.

Currently plans include 61% recurrent efficiencies and there remains 6% is unidentified.

We have agreed that we will:

- Build system level reporting from existing reporting, to ensure no additional workload requirements for partners to complete
- Partners will be responsible for managing schemes within their own control, the role of the ICB will simply be to coordination and playing back if there is duplication / additional opportunity from working collectively
- Focus for SPG will be on schemes that require system-wide actions or which have the possibility of greater impact through system level working

Area	Theme £k	UHNM	MPFT	NSCHT	ICB	ICS Total
Pay Efficiencies	Establishment reviews (including agency, erostering, corp)	6,827	1,860	1,877	-	10,564
	Service re-design - pay	-	7,946	911	-	8,857
	Other	-	416	300	-	716
	Total Pay	**6,827**	**10,222**	**3,088**	**-**	**20,137**
Non-pay Efficiencies	Procurement (excl drugs) - both clinical and non clinical	12,300	1,956	45	5,280	19,581
	Service re-design - non-pay	10,200	4,808	2,141	-	17,149
	Medicines optimisation	800	504	-	14,076	15,380
	Other (Estates, Corporate, Digital)	1,600	2,352	327	1,768	6,047
	Total Non-Pay	**24,900**	**9,620**	**2,513**	**21,124**	**58,157**
Income Efficiencies	Income Non-Patient Care	16,900	2,576	-	-	19,476
	Total Income	**16,900**	**2,576**	**-**	**-**	**19,476**
ICB Efficiencies*	Demand Management (referrals)	-	-	-	40,836	40,836
	CHC	-	-	-	25,152	25,152
	Primary care + POD	-	-	-	6,512	6,512
	Total ICB Efficiencies	**-**	**-**	**-**	**72,500**	**72,500**
Unidentified		6,373	3,055	927	-	**10,355**
Total Efficiencies		**55,000**	**25,473**	**6,528**	**93,624**	**180,625**

* ICB Efficiencies for procurement and medicines are included in non-pay

Delivery approach

There are two component parts for the delivery of the 2023/24 financial plan; supporting mechanisms; and specific actions that are required. These are summarised below:

Supporting Mechanisms

1. Double Lock and Cost Control
2. Line by Line review
3. System Efficiency & Productivity Reporting
4. Management Consultancy and Agency Staff control
5. Income Top Slice
6. Working across health and social care

Specific Actions

1. Delivery of CIP / efficiency
2. Management Costs / Enabling Functions
3. Medicines
4. Annual Leave Accrual
5. The two areas of focus - Avoiding Admissions / Improving Discharge
6. Maximise ERF

Double Lock and Cost Control

Supporting Mechanisms

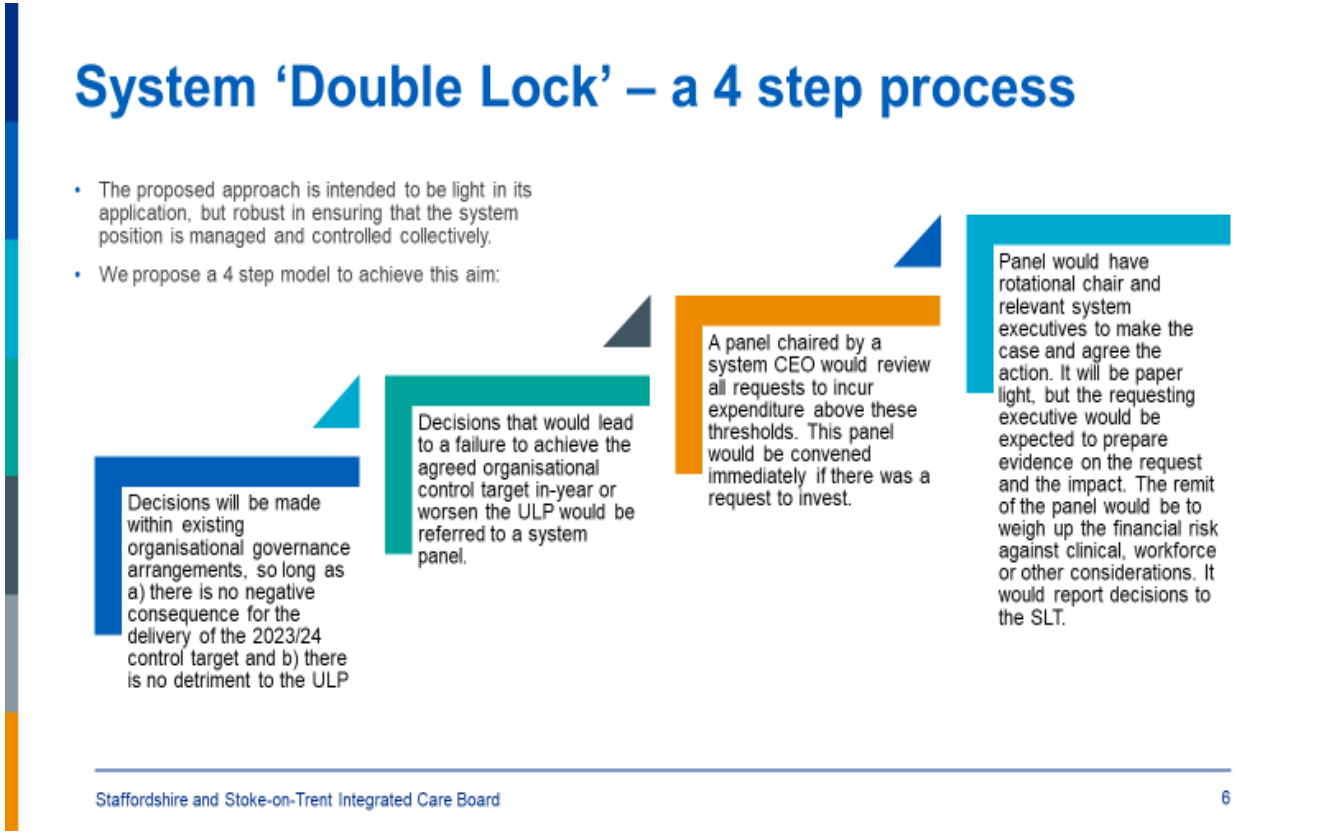
1. Double Lock and Cost Control
2. Line by Line review
3. System Efficiency & Productivity Reporting
4. Management Consultancy and Agency Staff control
5. Income Top Slice
6. Working across health and social care

Context

- Systems with a deficit plan are under a triple lock
- Cost control mechanisms designed by the National Team are very draconian and limiting
- We need to follow those principles of solid cost control, but retain local accountability.
- CFOs are currently reviewing the nationally prescribed "triple lock" controls to ensure we are not missing any value adding controls either at an organisation or system level

Approach

- Cost control will be exercised in the statutory organisations - no one has authority to increase workforce above establishment or procure non pay above budget.
- Double lock will kick in if we are moving to **reporting a forecast deficit** plan or if any organisation wants to make **recurrent investments** which are not income backed
- Full QIA and EQIA to be undertaken where needed



Line By Line Review

- All organisations have agreed to participate in a line-by-line review. This will be scrutinised by each F&P / Board and then consolidated at a system level and discussed at system F&P.
- The ICB has the largest amount of opportunity and the work has already started, with over £400m in scope as shown opposite. The process requires budget holders to assess each line of expenditure to assess if/how the expenditure relates to an ICB statutory duty or directly supports a national or local system plan priority. This work is to be completed by end July
- Any contracts that are not deemed essential may be subject to cessation of reduction of the quantum. Where so, QIA and EQIA assessments will be undertaken
- If a contract needs to continue, we seek an opportunity for joint procurement to deliver either cost savings or additional outputs for the same cost
- This could include LA partners, where so the VAT issues will need to be considered to ensure there is no hidden cost of a joint procurement
- Providers have agreed to undertake similar processes in a similar timeframe wherever possible
- Then the ICB team will collate and coordinate line-by-line exercise across the system and feedback on any further actions or opportunities that exist

Supporting Mechanisms

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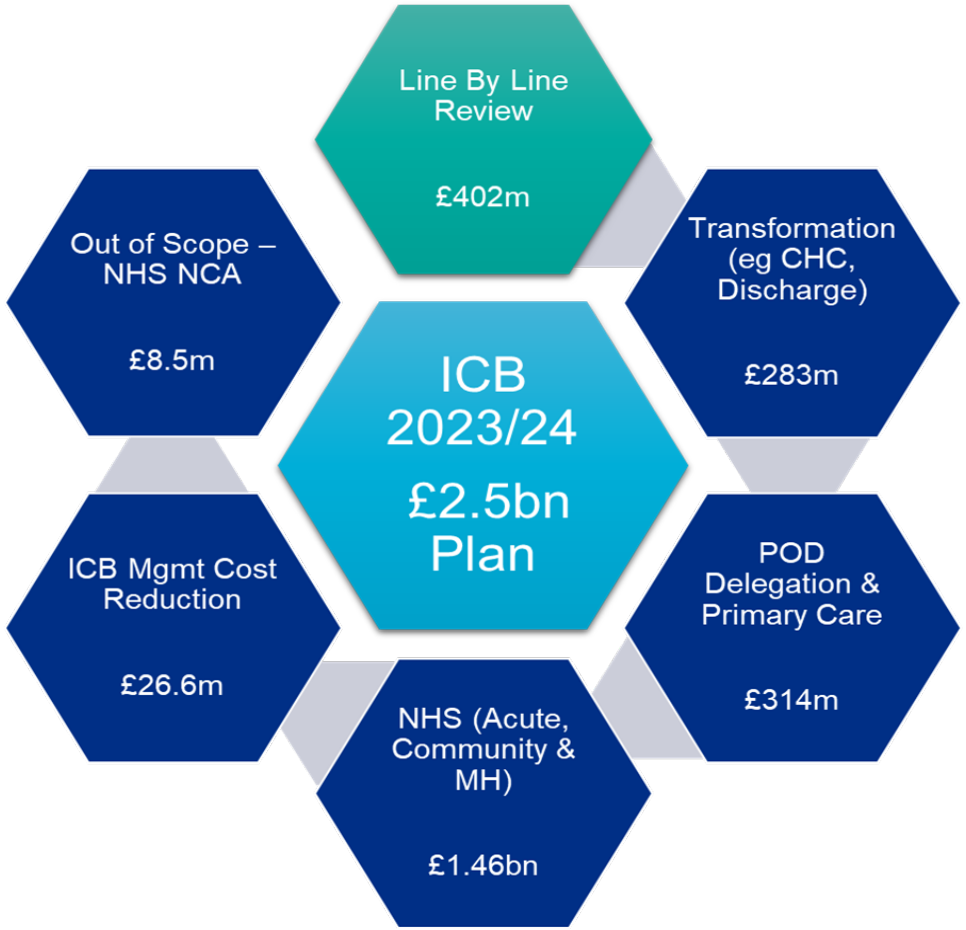

System Efficiency & Productivity Reporting

Context

- ICB will provide aggregated reporting of efficiency plans as described on page 3.
- Providers will manage productivity programmes and will report progress to SPG
- CFOs will agree a shared approach to risk rating and collectively agree when to factor non delivery into forecast out turn
- Reporting will analyse savings in three segments:
  - Cost growth avoided - part of this is the proxy savings delivered by Flat Activity.
  - Cash out / cost reduction
  - Productivity /efficiency - part of this will be the delivery of elective recovery at marginal costs

Approach

- As our system PMO, the TDU will consolidate reporting across the system with two key aims:
  - ➢ To eliminate the risk of double counts
  - ➢ To highlight issues for escalation

Supporting Mechanisms

1. Double Lock and Cost Control
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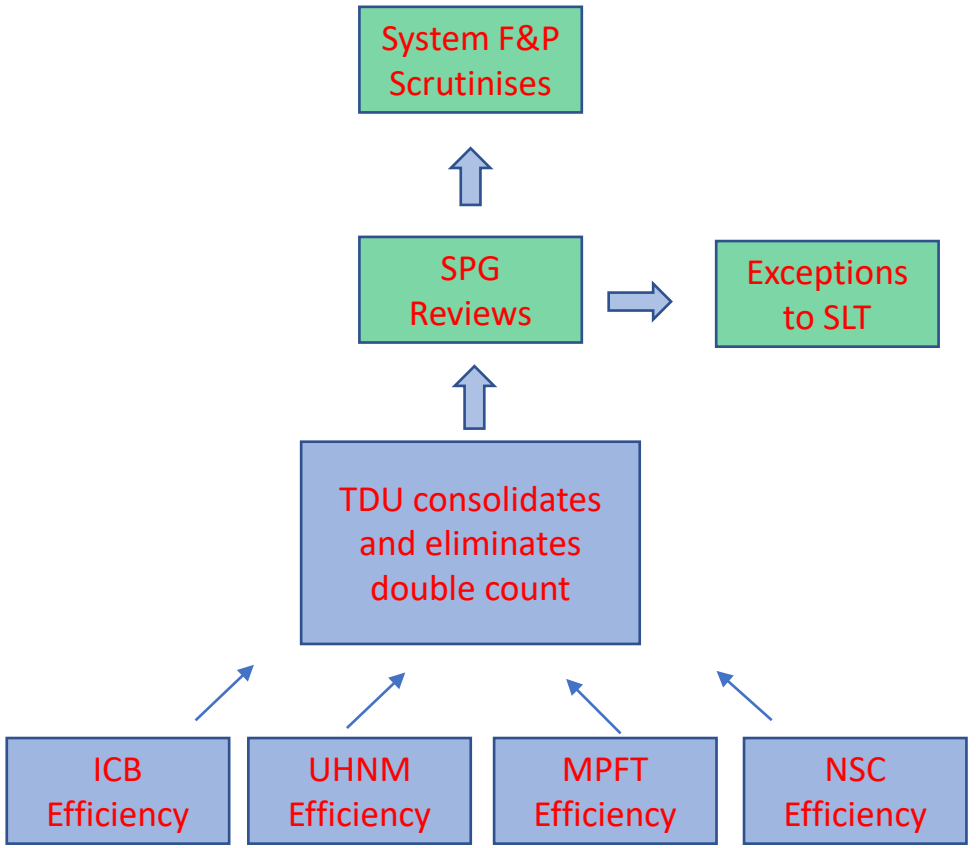

Management Consultancy and Agency Staff Control

Supporting Mechanisms

1. Double Lock and Cost Control
2. Line by Line review
3. System Efficiency & Productivity Reporting
4. Management Consultancy and Agency Staff control
5. Income Top Slice
6. Working across health and social care

Context

- The ICB has been assigned the task of overseeing the approval of the appointment of management consultancy or agency staff – see requirements opposite
- In the context of the challenged financial situation, it is not envisaged that there will be much, if any, use of either

Approach

- If any system partner wishes to employ a management consultant or appoint agency management staff on Band 7 or above, email SSOTICSnhsebusinesscase@staffsstoke.icb.nhs.uk .
- Request will discussed with workforce and with the ICB CFO. Depending on the issue, the matter will be discussed with system CFOs and if required, referred to SPG for discussion and agreement.

Non-clinical agency/off payroll worker approval process		**Consultancy services contracts with a financial value of £50k or more, and Interim VSM renumeration approvals.**
Trusts	**ICBs**	**Trusts and ICBs**
1. Trust cases will be approved by ICBs except where one or more of the following criteria applies, in which case a second level approval by NHSE is required and ICBs should complete the ICB review section of this form and forward the business case to NHSE for a final decision. a) Agenda for Change Band 7 or higher b) Have a rate of over £400 per day. c) Engagement longer than 25 working days d) Off framework and or above agency price cap	Approval by NHSE only	1. All Trust Interim VSM remuneration approval requests (with a day rate above £750), and business cases for consultancy Services with a financial value of £50k or more should be submitted to ICBs for a 1st level review and ICBs should forward the case to NHSE with a recommendation. 2. All ICB Interim VSM remuneration approval requests (with a day rate above £750), and business cases for consultancy Services with a financial value of £50k or more should be submitted to NHSE for approval.

Income Top-Slice

Context

- The system receives allocations as a result of fair shares of national funds (e.g. SDF) or through bidding for specific pots of non recurrent funding. There is a pre-supposition that these include coverage for overheads
- The ICB included £4.2m in its plans to come from additional allocations, not yet received - this was based on the 10% topslice agreed by CFOs at the planning stage against an assumed NR allocation of £42m.
- Given through the IFP arrangements, our system financial plan currently recovers all overheads, once £4.2m has been delivered, further allocations should provide for additional upside

Proposal

- As a minimum, 10% of any additional allocations (for all revenue bids at >£1m) will be retained to support the bottom line. This reflects the contribution historically included to cover management overheads
- If feasible we will need to go further and cover the service / support that the allocation is earmarked for, through existing resources, so that a larger slice can be retained to cover the shortfall in the funding
- Individuals bidding for funds need to ensure that their bids include coverage for overheads but recognise these will be released to support the system bottom line
- We will implement an approach whereby there is sign off for any material bids (£100k or above) to ensure that these are a) in line with the strategic objectives and b) if successful do not have unforeseen consequences which would be detrimental to any of the system partners

Working across health and social care

Supporting Mechanisms

1. Double Lock and Cost Control
2. Line by Line review
3. System Efficiency & Productivity Reporting
4. Management Consultancy and Agency Staff control
5. Income Top Slice
6. Working across health and social care

Context and initial agreement

- Both Councils and the NHS face significant underlying financial challenges.
- We need to do more together to collectively address those challenges / manage the market
- Councils face new membership arrangements so the timing may be difficult. However, given the scale of the challenges we face, it's proposed that we get on now with the work in the background, to agree the areas of focus.

Areas to focus on

- The proposal is to develop a list of specific tasks to work on across both upper tier Councils and the NHS
- Proposed that we agree a blend of projects of shorter and medium term impact, and agree specific tasks and timescales (note some are already under way to an extent in parts of the system)
- Long list ideas include:
  - In-housing nursing / care home provision or system block-booking capacity and collectively agreeing use of that capacity
  - In-house provision of children placement capacity
  - Joint workforce development / agency arrangements
  - Collective investment opportunities in technology

Delivery Phase

- Decision making would need to be carefully managed to ensure members and all stakeholders are supportive
- Once we have agreed on a smaller list of projects, we'll need to agree resourcing capacity and timescales

Delivery of CIP / Efficiency

Specific Actions

1. Delivery of CIP / efficiency
2. Management Costs / Enabling Functions
3. Medicines
4. Annual Leave Accrual
5. The two areas of focus - Avoiding Admissions / Improving Discharge
6. Maximise ERF

Approach

- Each organisation to deliver efficiency through internal processes
- System PMO to collate (as slide 7)
- Performance to be monitored through SPG and System Finance & Performance Committee
- Key elements are shown opposite

Pay £24m

- Focus on establishment reviews
- Agency compliance
- Service re-designs
- Schemes across corporate areas including digital and estates

Procurement and non pay £37m

- Inflationary controls
- Non recurrent benefit from fixed price utility contracts
- Line by line review
- Provider savings group with Staffs and Black country

CHC £25m

- Working with Liaison to review dependency requirements
- Reviewing pricing through tiered system and below inflation price increase
- Meeting care provider to explore collaborative working opportunities

Prescribing £14m

- Repeat prescriptions Hub to minimise waste
- Medicines optimisation service level agreement with GPs
- Minor ailments /OTC
- Optimise Rx

Management Costs / Enabling Functions

Specific Actions

1. Delivery of CIP / efficiency
2. Management Costs / Enabling Functions
3. Medicines
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5. The two areas of focus - Avoiding Admissions / Improving Discharge
6. Maximise ERF

Context

- As a system we spend c£250m on enabling functions. The big spending areas are Digital and Estates
- On digital we have duplicate set ups across the system and the advent of cloud technologies is an opportunity
- On the estate we have multiple building stock, some of which is in poor condition. There are opportunities to rationalise and sell of surplus estate
- Each organisation also has corporate and support functions which fulfil similar roles and, in many cases share the same or very similar systems and processes

Approach

- In the short term we need to save £4m more than in original plans. Furthermore, 2024/25 the ICB is expected to have a target to save £7m so we should aim to bring this savings target forward
- The longer term needs more thought, and some work on scoping before we agree

Immediate Action

- We need to work at pace on the scope for enabling functions to deliver savings. In the next few weeks we will come back to CEOs and the system with some suggestions, that when agreed, will be worked into transformational projects, as indicated to the right.
- In the short term, the ICB faces significant challenges to meet its Running Cost Target, with reductions of c30% envisaged. It is proposed that all management vacancies at Band 7 or above that become vacant across the system are considered by the People Hub.
- The People Hub will explore options to utilise existing system capacity rather than fill externally.

Transformation

- **System estates group** to look at options to rationalise estate - requires system to enforce that all facilities are system assets, not 'owned' by local teams. This will include joint work with LA partners. Kick off meeting in late June
- **System digital team** to be asked to look at options for significant harmonisation of digital capacity and infrastructure
- Consideration of opportunities from RPA and other opportunities for productivity improvement within corporate and support functions
- CSU to be asked to work with the system to review opportunities and options by end of August

Medicines

Context

- Medicines/prescribing are included within all organisation's efficiency plans and task number 1 is to ensure these deliver.
- In addition, there are examples where the system has not achieved rebates or reached decisions that would reduce the net system cost on drugs (e.g. Edoxaban, adalimumab).
- Whilst recognising individual organisations have programmes to deliver for medicines management, the focus here is to investigate where collectively savings could go further.
- Also to look at options to reduce expenditure outside of the NHS.

Approach

- Enhance the role of the Systems Medicines Group to monitor opportunities and agree targets / programmes of work
- Clinical engagement through the Integrated Medicines Optimisation Group and Health & Care Senate

Specific Actions

1. Delivery of CIP / efficiency
2. Management Costs / Enabling Functions
3. Medicines
4. Annual Leave Accrual
5. The two areas of focus - Avoiding Admissions / Improving Discharge
6. Maximise ERF

Terms of Reference of System Medicines Group

- Membership of pharmaceutical leads from all Trusts and primary care. Leadership capacity provided by the ICB – Mark Seaton to support on 2 / 3 days a week
- Responsible for developing medicines opportunities – those in addition to the projects underway in the individual organisations
- The group will:
  - Share organisational Medicines Management CIPs
  - Understand system position against benchmark
  - Develop a long list of ideas where system working can deliver more than teams working in isolation
  - Develop three year programme focused on cost reduction opportunities
- Reporting through the Health and Care Senate to seek approval to implement savings ideas

Annual Leave Accrual

Specific Actions

1. Delivery of CIP / efficiency
2. Management Costs / Enabling Functions
3. Medicines
4. Annual Leave Accrual
5. The two areas of focus - Avoiding Admissions / Improving Discharge
6. Maximise ERF

Background

- During Covid, staff across the system were authorised to carry forward additional days of leave that they had not used in the year
- This value is accrued on the balance sheets across the system – amounting to £16m
- As part of the financial plan to break even, we agreed to release all balance sheet flexibility to help us achieve the financial target

Proposed Approach

- All system partners agree that staff will be asked to use all leave in the current period, except in extreme situations
- Each organisation will need to consider how to enact this decision and potentially make changes to organisation policies
- This would allow the removal of the annual leave provision in the 2023/24 accounts
- It means that organisations will need to manage without those staff without bringing in additional agency or bank staff

Admissions Avoidance and Discharge

Background

- These two areas are identified within the 2023/24 Operating plan as high priority in terms of operational delivery, delivering more streamlined care for patients and improving productivity.
- Many programmes of work are already in place which address these two priorities across the portfolios. The aim of pulling them together as key priorities is to maximise the gain by the work programmes being well co-ordinated, and to seek all opportunities to stretch the financial savings

Proposed Approach

- Rather than create new meetings, to ask portfolios to work together and to use the existing SPG to discuss alignment

Specific Actions

1. Delivery of CIP / efficiency
2. Management Costs / Enabling Functions
3. Medicines
4. Annual Leave Accrual
5. The two areas of focus - Avoiding Admissions / Improving Discharge
6. Maximise ERF

Admissions Avoidance initiatives include:

- Maximising the value from the investment in CRIS/Virtual wards and other interventions such as respiratory hubs, proactive frailty services and medicines review
- Reduced unnecessary ambulance journeys
- Better access to primary care
- Services such as Health Navigator which address high frequency users

Discharge initiatives include:

- Line by line review of BCF to fully assess the impact of BCF funded services and divert spend to the most impactful area
- Internal discharge arrangement reviews within providers, focussed on lessons learnt from failed discharges
- CHC action plan
- Maximising the value from the investment in CRIS/Virtual wards and other interventions such as respiratory hubs, reactive frailty services and medicines reviews

Elective Recovery Fund

Background

- The system receives £48m for elective recovery through the ERF, so long as we deliver a Cost Weighted Activity (CWA) value of at least 103% of the equivalent value from before Covid (2019/20)
- This breaks down as roughly 50/50 between UHNM and other out of system providers
- There are 2 components for the ERF plan. Firstly, is to maximise the gain from delivering elective activity with marginal cost which is part of UHNM efficiency plans. Secondly, the ICBs exposure to out of system providers hitting higher elective levels

Proposed Approach

- A system team to monitor the activity and financial consequences of the decision being taken to manage elective activity
- The scope to be primarily about the 103% CWA target, however to also review the long waiter implication

Specific Actions

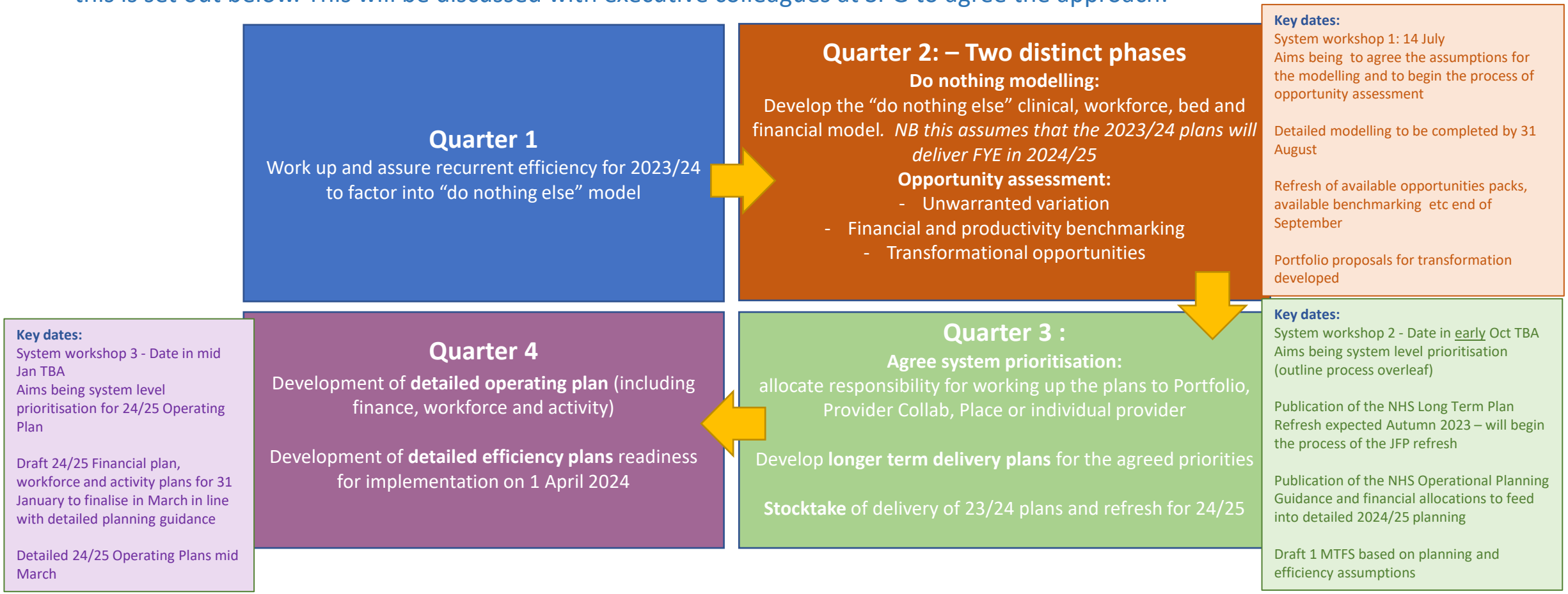
1. Delivery of CIP / efficiency
2. Management Costs / Enabling Functions
3. Medicines
4. Annual Leave Accrual
5. The two areas of focus - Avoiding Admissions / Improving Discharge
6. Maximise ERF

ERF oversight team TOR

- Membership of ICB to include Chief Delivery Officer and CFO, UHNM finance and operational input and Business Intelligence
- To assess the collective impact of ERF across UHNM and out of system providers
- To flag financial and operational risks to SPG

Addressing medium term financial sustainability

- The previous sections of this paper describe what we need to do to achieve financial targets in 2023/24. But it's clear that we face more deeply rooted challenges for the longer term. We now have an underlying deficit of c£150-£160m and simply relying on flat activity and flat cash supported by non-recurrent fixes will not lead to the sustainable future we need.
- We therefore need to commence the development of a longer term strategy for financial sustainability and the high level plan for this is set out below. This will be discussed with executive colleagues at SPG to agree the approach:



NHS
Staffordshire and Stoke-on-Trent
Integrated Care Board

REPORT TO:

Staffordshire and Stoke-on-Trent Integrated Care Board

Enclosure:	**10**

Title:	**Joint Forward Plan**

Meeting Date:	15 June 2023

Executive Lead(s):	**Exec Sign-Off Y/N**	**Author(s):**
Chris Bird Chief Transformation Officer	Yes	ICB Planning Team

Clinical Reviewer:	**Clinical Sign-off Required Y/N**
N/A	No

Action Required (select):									
Ratification-R		**Approval-A**	✓	**Discussion-D**	✓	**Assurance-**		**Information-I**	

Is the [Committee]/[Board] being asked to make a decision/approve this item? Y			
Is the decision to be taken within [Committee]/[Board] delegated powers & financial limits?			
Yes			
Within SOFD Y/N	Y	**Decision's Value / SOFD Limit**	No financial value attached to the decision.

History of the paper – where has this paper been presented		
	Date	**A/D/S/I**
• System Performance Group	31/05/23	A/D/I
• Integrated Care Partnership Meeting	05/06/23	A/D/I
• Finance & Performance Committee	06/06/23	I
• Staffordshire Health & Wellbeing Board	08/06/23	D/I
• Staffordshire and Stoke-on-Trent Health and Care Senate	08/06/23	I

Purpose of the Paper (Key Points + Executive Summary):

This report and copy of the Joint Forward Plan (JFP) provides the Board with the final draft of our JFP for discussion and approval.

The JFP is a five year plan, set within a statutory framework. The Staffordshire and Stoke-on-Trent JFP outlines how we will support the delivery of the ambitions articulated in the integrated care partnership (ICP) strategy (developed by the ICP) and the local health and wellbeing strategies of our upper tier local authority partners. It describes our collective priorities over the period 2023 to 2028.

The plan sets out how the ICB is exercising its key functions and discharging its statutory duties in an effective and timely way. It also addresses the four core purposes of the Integrated Care System and outlines how we shall meet our various legal obligations.

Specifically, the paper details a high-level summary of the following areas:

- The purpose of the Joint Forward Plan
- Health and Wellbeing Boards Involvement
- Stakeholder Involvement
- Our approach to developing the JFP

Is there a potential/actual Conflict of Interest?	**Y/N**
Outline any potential Conflict of Interest and recommend how this might be mitigated	
None	

Summary of risks relating to the proposal (inc. Ref. No. of risk it aligns to on Risk Register):
None specifically identified pertaining to this report.

Implications:	
Legal and/or Risk	None specifically identified pertaining to this report
CQC/Regulator	None specifically identified pertaining to this report
Patient Safety	None specifically identified pertaining to this report
Financial – if yes, they have been assured by the CFO	Where any financial impacts arise from the Joint Forward Plan, once agreed, these will be considered via the appropriate routes.
Sustainability	None specifically identified pertaining to this report
Workforce / Training	Where any workforce impacts arise from the Joint Forward Plan, once agreed, these will be considered via the appropriate routes.

Key Requirements:		**Y/N**	**Date**
1a.	Has a Quality Impact Assessment been presented to the System QIA Sub-group? • Where any service changes arise from the Joint Forward Plan, once agreed, relevant impact assessments will be completed.	**N**	
1b.	What was the outcome from the System QIA Panel? (Approved / Approved with Conditions / Rejected)		
1c	Were there any conditions? If yes, please state details and the actions in taken in response: • Condition 1 & action taken. • Condition 2 & action taken.		
2a.	Has an Equality Impact Assessment been completed? If yes, please give date(s)	**N**	
2b.	If an Equality Impact & Risk Assessment has not been completed what is the rationale for non-completion? • Where any service changes arise from the Joint Forward Plan, once agreed, relevant impact assessments will be completed.		
2c.	***Please provide detail as to these considerations:***		

	• Which if any of the nine Protected Groups were targeted for engagement and feedback to the ICB, and why those? • Summarise any disaggregated feedback from local Protected Group reps about any negative impacts arising / recommendations (e.g., service improvements) • What mitigation / re-shaping of services resulted for people from local Protected Groups (along the lines of 'You Said: We Listened; We Did'?) • Explain any 'objective justification' considerations, if applicable		
3.	Has Engagement activity taken place with Stakeholders / Practices / Communities / Public and Patients The JFP Plan builds on the ICP strategy, on which there was significant engagement with partners and key stakeholders. The JFP has been co-produced with system partners and stakeholders, including NHS providers, local authorities, voluntary, community and social enterprise (VCSE) partners and local Health and Wellbeing Boards (HWBs).	**Y**	
4.	Has a Data Privacy Impact Assessment been completed? Where any changes arise from the Joint Forward Plan, once agreed, relevant impact assessments will be completed.	**N/A**	

Recommendations / Action Required:

The Integrated Care Board is asked to:

- Approve this final draft of the Joint Forward Plan, with the caveat that a fully designed document will be developed for the 30th June publication date.
- Agree delegated approval to the ICB Chairman, David Pearson and interim ICB Chief Executive Officer, Peter Axon for sign-off by 30th June allowing for any final feedback from the HWBs.

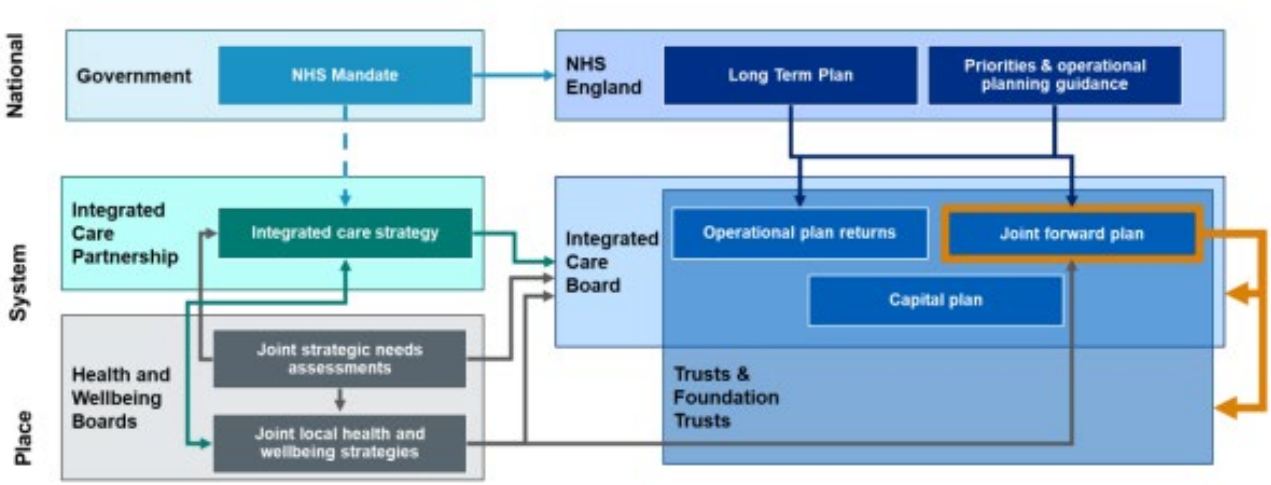
Introduction

Following the formation of Integrated Care Boards (ICBs) as statutory bodies, NHS England (NHSE) issued guidance on the new duty for ICBs, and their NHS partner trusts to develop a plan over 5 years – known as the Joint Forward Plan (JFP). Guidance gave systems significant autonomy to determine the scope of the JFP as well as how it is developed and structured.

This paper asks the ICB to approve the JFP.

The Joint Forward Plan

The JFP is a five-year plan, set within a statutory framework.



The Staffordshire and Stoke-on-Trent JFP outlines how we will support the delivery of the ambitions set out in the Integrated Care Partnership (ICP) strategy (developed by the ICP) and the local health and wellbeing strategies of our upper tier local authority partners. It describes our collective priorities over the period 2023 to 2028.

The plan sets out how the ICB is exercising its key functions and discharging its statutory duties in an effective and timely way. It also addresses the four core purposes of the Integrated Care System and outlines how we shall meet our various legal obligations.

Ordinarily, the JFP would need to be completed by the start of the financial year – 1 April - in line with the NHS operational planning cycle. However, for this first year, and in recognition of the ongoing development of guidance for integrated care systems, NHS England (NHSE) specified that the date for publishing and sharing the final plan is 30 June 2023.

Guidance states that ICBs and their partner trusts must consult with 'those for whom the ICB has core responsibility and anyone else they consider appropriate.' The development of our ICP strategy involved wide-ranging engagement with partners and the public, and the development of the JFP has used and built upon the insight gained during that engagement process.

The plan is a live document that is delivery-focused, including specific objectives, underpinned by milestones and more detailed outline of deliverables across each quarter/and year and where appropriate, supporting metrics which are available in more detail as required. We will use existing assurance mechanisms to understand our position against delivery of the priorities and ambitions outlined in the plan, e.g., ICB Board, Statutory Trust Boards, System Performance Group, Finance and Performance Committee and Portfolio Boards.

Health and Wellbeing Boards (HWBs) Involvement

The JFP guidance states that ICBs and their partner trusts 'must involve relevant HWBs in preparing or revising the JFP.'

Our local HWBs have received updates on the approach and development of the JFP. We are also required to seek the opinion of each HWB on the JFP, specifically as to the extent to which the plan considers the health and wellbeing strategies. The JFP will be presented to the Staffordshire HWB on the 8 June 2023. As a result of the change in administration at Stoke-on-Trent City Council, the Stoke-on-Trent HWB scheduled for 7th June 2023 was stood down. Work is underway to provide an alternative solution to seeking their opinion, through a senior officer.

Stakeholder Involvement

The JFP has been inclusive of and shared with wider partners and their teams including Staffordshire County Council, Stoke-on-Trent City Council and the VCSE alliance. Relevant portfolios, committees, leads and stakeholders have authored and assured their relevant sections. North Staffordshire Combined Healthcare NHS Trust, Midlands Partnership University Foundation Trust and University Hospitals of North Midlands will take the JFP through their boards for assurance/information

As it has developed drafts of the JFP have been shared with NHSE and positive feedback has been received.

The JFP builds on the ICP strategy, on which there was significant engagement with partners and key stakeholders. Looking at the insight we already have across the ICS, we will continue to prioritise our engagement activity using a thematic approach to reflect the settings of care in this JFP. Our expectation is that engagement with our communities and co-production is mainstreamed into our work. We will develop a rolling plan of engagement for the coming months and years to help us listen to the views and experiences of local people and communities and make sure this impacts the way we deliver our services and ambitions outlined in this plan. This will commence with an online survey starting at the end of June and will be used to support delivery of the JFP and annual refresh of the plan.

The JFP will be reviewed and updated on an annual basis, in line with annual operational planning guidance.

Our approach to developing the JFP

The ICB Board has received updates on the development of the JFP and discussed the approach to development. An ICB board development session to discuss the JFP was held in May 2023.

The local principles of how we would develop and structure the plan was lead and supported by NHS provider Directors of Strategy and Heads of Planning. The plan has been co-produced by system partners and subject matter experts, including NHS providers, primary care, local authorities, voluntary, community and social enterprise (VCSE) partners.

The commitments included in the JFP for 2023/24 are to be delivered within the constraints of the 2023/24 financial envelope. The 2023/24 JFP and one-year operational plan ambitions have been developed together to maximise alignment.

We have split the JFP into three distinct parts:

Part 1 provides an overview of

- why we need a JFP and some background to the current challenges we are facing
- what our priorities and ambitions are
- how we will work together to make an impactful change
- our enabling priorities

Part 2 of the plan describes

- our finance strategy
- our wider strategic system development ambitions
- a range of cross cutting themes such as personalised care, integration and working with our VCSE.

Part 3 of the plan is a series of appendices which

- summarise how we will meet the statutory requirements placed upon the ICB
- an overview of portfolio plan high level timelines
- provides copies of supporting documents referred to in the main body of the document.

Recommendation(s)

The ICB Board is asked to

- Approve this final draft of the Joint Forward Plan, with the caveat that a fully designed document will be developed for the 30th June publication date.
- Agree delegated approval to the ICB Chairman, David Pearson and interim ICB Chief Executive Officer, Peter Axon for sign-off by 30th June allowing for any final feedback from the HWBs.

Appendices

Appendix 1 – final draft Joint Forward Plan

Staffordshire and Stoke-on-Trent Integrated Care System

Joint Forward Plan

Final Draft Version V5.0

8 June 2023

Contents

Foreword 4
Executive Summary 6
Introduction 8
The scope of this document 8
Who we are 8
ICS vision 11
Our approach to developing our priorities 11
Part 1 15
Why do we need a Joint Forward Plan? 16
Our changing population and the impact on demand for health and social care 16
Challenges in our services 17
The impact of COVID-19 on the demand for healthcare 18
Challenges for managing our resources 19
What people have told us 20
Shared priorities across the ICS to improve population health and care outcomes 21
How we will work together to achieve our priorities 22
Our Focus 22
The way we work (our operating model) 22
Our system-wide approach for pathway design 24
Supporting collective accountability through our leadership compact 26
Our ICS priorities and portfolios 27
Improving population health 27
Serious violence 34
Planned care (elective, cancer, diagnostics) 35
Children and young people (CYP) and maternity and neonates 40
Children and Young People 40
Maternity and Neonates 43
Urgent and emergency care 48
End of life, long-term conditions and frailty (ELF) 54
Primary care 64
Pharmacy and Medicines Optimisation 69
Mental health, learning disabilities and autism 72
Mental health 73
Learning disabilities and autism (LDA) 77
Our enablers to success 80

Quality assurance and improvement 80
People Plan 82
Digital 87
Estates 89
Sustainability 91
Delivering a Net Zero NHS 92
Part 2 95
Our Finance Strategy 96
Challenges and opportunities 96
Productivity 98
The Intelligent Fixed Payment (IFP) and how it works 98
Capital Investment Plans 99
Procurement 100
Cross-cutting themes 101
Personalised care 101
Better Care Fund (BCF) and integration ambitions 101
Clinical and professional leadership (CPL) 102
Working in partnership with people and communities 103
Our Strategic Transformation and Service Change programmes 104
Voluntary, community and social enterprises (VCSE) 104
Intelligence 109
Research and innovation 109
Wider strategic system development 113
System development overview 113
Provider collaboratives 113
Place and neighbourhood development 114
Delegation of direct commissioning functions in 2023 and specialised commissioning 115
Pan system working 115
Part 3 117
Appendices 118
Matrix of statutory duties 118
Portfolio Five Year Plans 119
Pharmacy and Medicines Optimisation how we will support wider ICS ambitions 127
Financial Governance and Controls 129
Procurement 130
Glossary 132
Abbreviations and Acronyms 134

Foreword

We are delighted to present this, our first Joint Forward Plan, as the Staffordshire and Stoke-on-Trent Integrated Care System (ICS). This plan outlines the joint ambitions of partners, which both respond to and support the joint health and wellbeing strategies of our two upper tier local authority partners (Staffordshire County Council and Stoke-on-Trent City Council), and the integrated care partnership strategy. We are clear that achieving the ambitions in this plan will need us all to work together differently, as we shift our focus from treatment to prevention, support people to make healthy choices, improve our services and the way we provide care.

We have worked in partnership across the system to co-produce this Joint Forward Plan (JFP). Whilst this is a Five-Year plan, this will be refreshed annually. The publication of the plan on the 30th June 2023 is just the start of our journey, our plan will continuously develop and evolve.

Our Key Focus

Improving population health and tackling health inequalities is a complex task. Over the longer term we will continue our focus on **prevention and proactively supporting people to stay well** at home and arranging services in a way so that people receive care from the right people in the most appropriate setting. We know that only 10-20% of health outcomes are directly influenced by the NHS, which is why close collaboration with our wider partners is so important to us. We will need to continue working in partnership using a system-wide approach to prevention, alongside action to improve the wider determinants of health in our communities and a focus on **reducing health inequalities**. Reducing these inequalities is a central ambition of our partnerships as set out in the Integrated Care Partnership Strategy.

We recognise that the demand for **health and social care services** continues to increase, and the scale of challenge has deepened in a number of areas due to the impact of the COVID-19 pandemic. This includes the widening of inequalities, increasing levels of complexity in people accessing health and care services, and more people struggling with their mental health.

Non-essential clinical work was suspended to release capacity for COVID-19, infection prevention and urgent and cancer care. This meant patients awaiting routine planned treatment (known as elective care) have waited much longer than normal and a substantial backlog built up. Access to primary care/seeing a GP and dental services was also impacted. Although progress has been made to reduce long waits, our population are still continuing to experience longer waiting times for services than we would like. It is essential that we **treat people that are waiting** as quickly as possible, prioritising those with the greatest clinical need, but to also focus on **transforming planned treatment services** so that they are resilient and sustainable for the future.

Provision of services across our urgent care pathways have been extremely challenging, and our population have experienced significant delays in accessing urgent and emergency care, with our hospitals unable to meet the required Emergency Department (ED) standards. We will continue to use the strength we have as partners to ensure our population can **access timely urgent and emergency care**, when and where they need it.

We need to have the **right number and type of staff to deliver** transformed health and care services. To tackle the workforce challenges and close the gap is a vast undertaking. The ICS People Function is the linchpin 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, to deliver quality treatment and care to our population.

The NHS budget grew significantly in response to the COVID-19 pandemic. As we have moved back to the normal funding levels seen pre-pandemic the financial outlook will continue to look incredibly challenging not only for the NHS but for our local authorities. Much of the work we have done on how our financial resources have been managed to date has been achieved through developing trusting relationships, understanding risks and opportunities and ensuring that actions were taken at organisational, place and system level as appropriate. Over the years this plan covers we will need to continue to take this approach to **balance longer and shorter-term financial objectives**.

Transitioning to a new way of working as an ICS 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. Understanding the views of local people will help us to explore ideas such as the **smarter use of technology**, providing care in different settings closer to home, and looking for new ways to reduce health inequalities. We have a solid 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 last few years have shown us that when we come together, we can make real and tangible improvements for our local population. Whilst some of our challenges are significant, we believe that collaboration at all levels is the best way of tackling them. We will keep working flexibly across the Integrated Care System (ICS) and with the Integrated Care Partnership (ICP) now and in the future.

{DRAFTING NOTE: Insert titles and names}

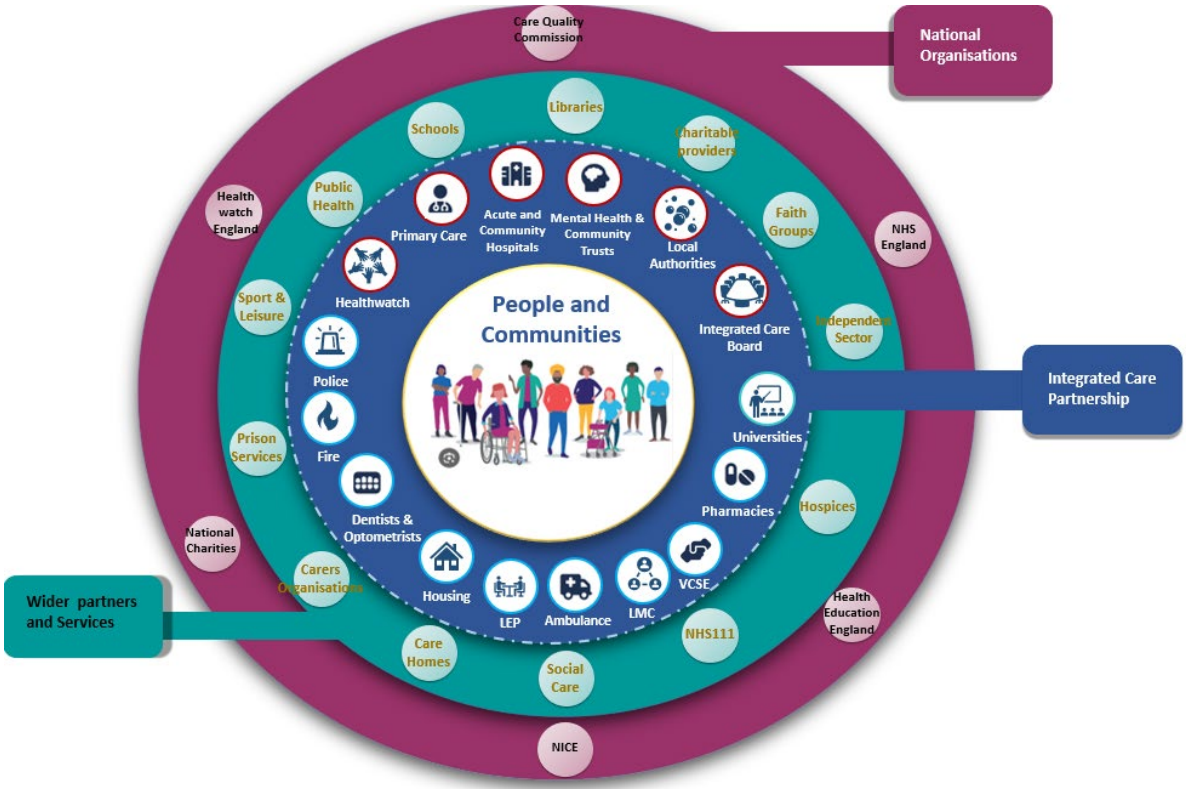
Executive Summary

In line with the Health and Care Act 2022, Integrated Care Boards (ICBs) and their partner NHS Trusts and NHS Foundation Trusts must develop a Joint Forward Plan (JFP) for the next 5 years. This is our first JFP since the Staffordshire and Stoke-on-Trent (SSoT) ICB was formally established on 1 July 2022. The JFP sets out how we will transform services and pathways to support delivery of the vision and ambitions outlined in the Integrated Care Partnership (ICP) Strategy to

"make Staffordshire and Stoke-on-Trent the healthiest places to live and work"

When Integrated Care Systems (ICS) were created, their aim was to join up working. The **SSoT ICS brings together a range of partners who are responsible for planning and delivering health and care and to improve the lives of people who live and work in our area**. The ICS is the geographical area in which health and care organisations work together. As part of the Health and Care Act 2022 an Integrated Care Partnership (ICP) was formed and an NHS Integrated Care Board (ICB) for each ICS. This partnership provides a united voice for Staffordshire and Stoke-on-Trent.

Working together is the basic principle behind the ICP, building on our collective resources and making better use of shared learning and experience. Our people and communities need to be an equal part of that partnership. The ICP is made up of partners, including Local Authorities, Police, the VCSE and representatives from the Integrated Care Board. There are partners who also have a dual role in sitting across the ICB and the ICP such as Healthwatch, Primary Care partners, NHS providers and local authorities, indicated by the red edged circles. The diagram below sets out key partners in the ICP and relationships to broader local and national stakeholders.



We have split our JFP into three distinct parts

From reading Part 1 you will get an overview of

- why we need a JFP and some background to the current challenges we are facing
- what our priorities and ambitions are
- how we will work together to make an impactful change
- our enablers to success including digital and people

In Part 2 you will read about

- our finance strategy
- our wider strategic system development ambitions
- a range of cross cutting themes which are golden threads through all our work such as personalised care, integration and working with our Voluntary Community and Social Enterprise (VCSE).

Part 3 of the plan is a series of appendices which

- summarise how we will meet the statutory requirements placed upon the ICB
- an overview of portfolio plan high level timelines
- provides copies of supporting documents referred to in the main body of the document.

Links to wider published documents are provided throughout the document. You are able to navigate through the document by clicking on the relevant link in the contents page.

Introduction

The scope of this document

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

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

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

In preparing this JFP, we have had regard for the regulatory and statutory requirements, particularly the 2023/24 planning guidance, and the **four key aims established for Integrated Care Systems**. We have also had regard for the **'Triple Aim'** established for NHS bodies that plan and commission services, requiring them to consider the effects of decisions on:

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

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

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

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

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

Who we are

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

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

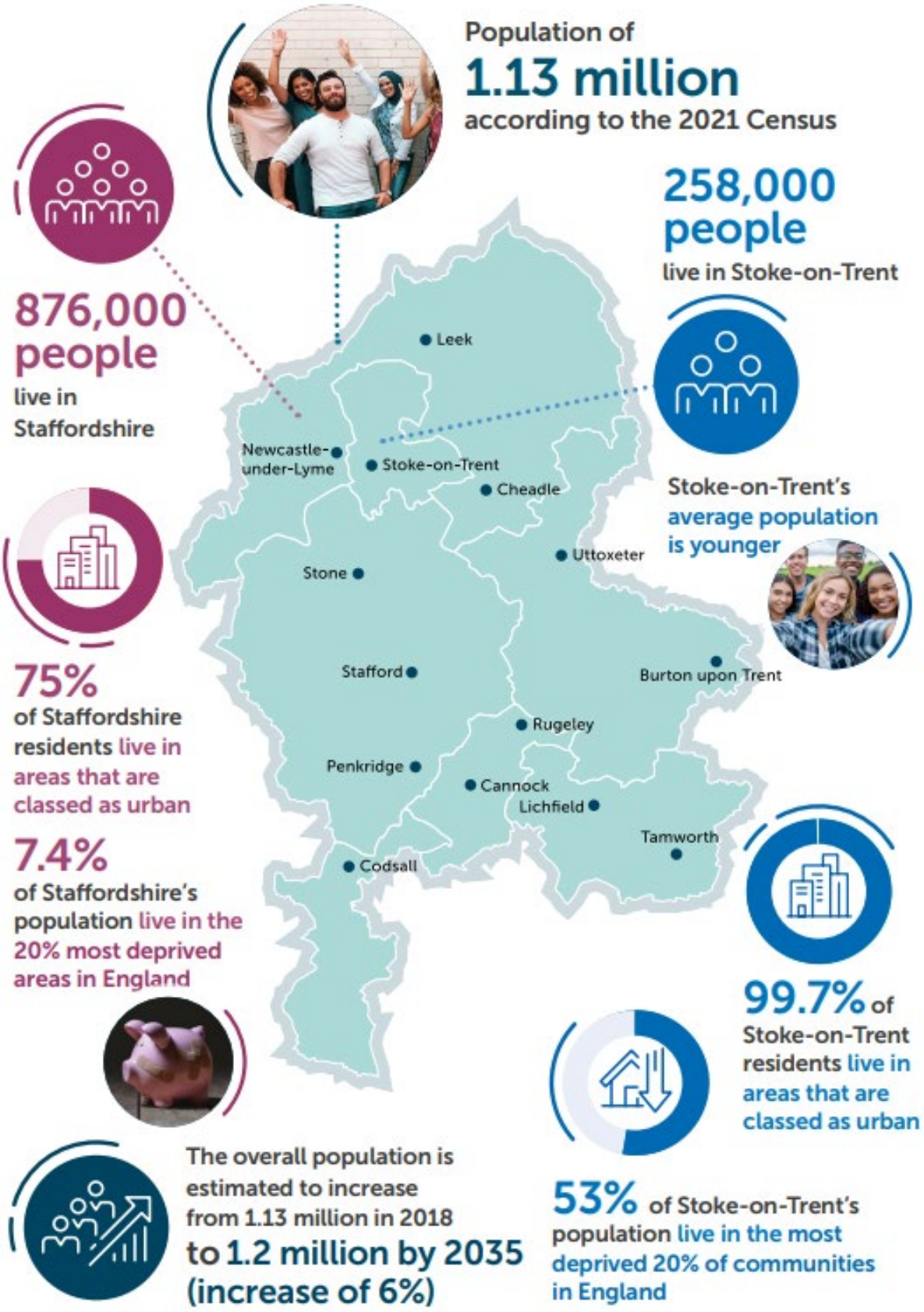
- improve outcomes in population health and healthcare
- tackle inequalities in outcomes, experience and access
- enhance productivity and value for money
- help the NHS support broader social and economic development

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

Our ICS is made up of:

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

Staffordshire and Stoke-on-Trent Population



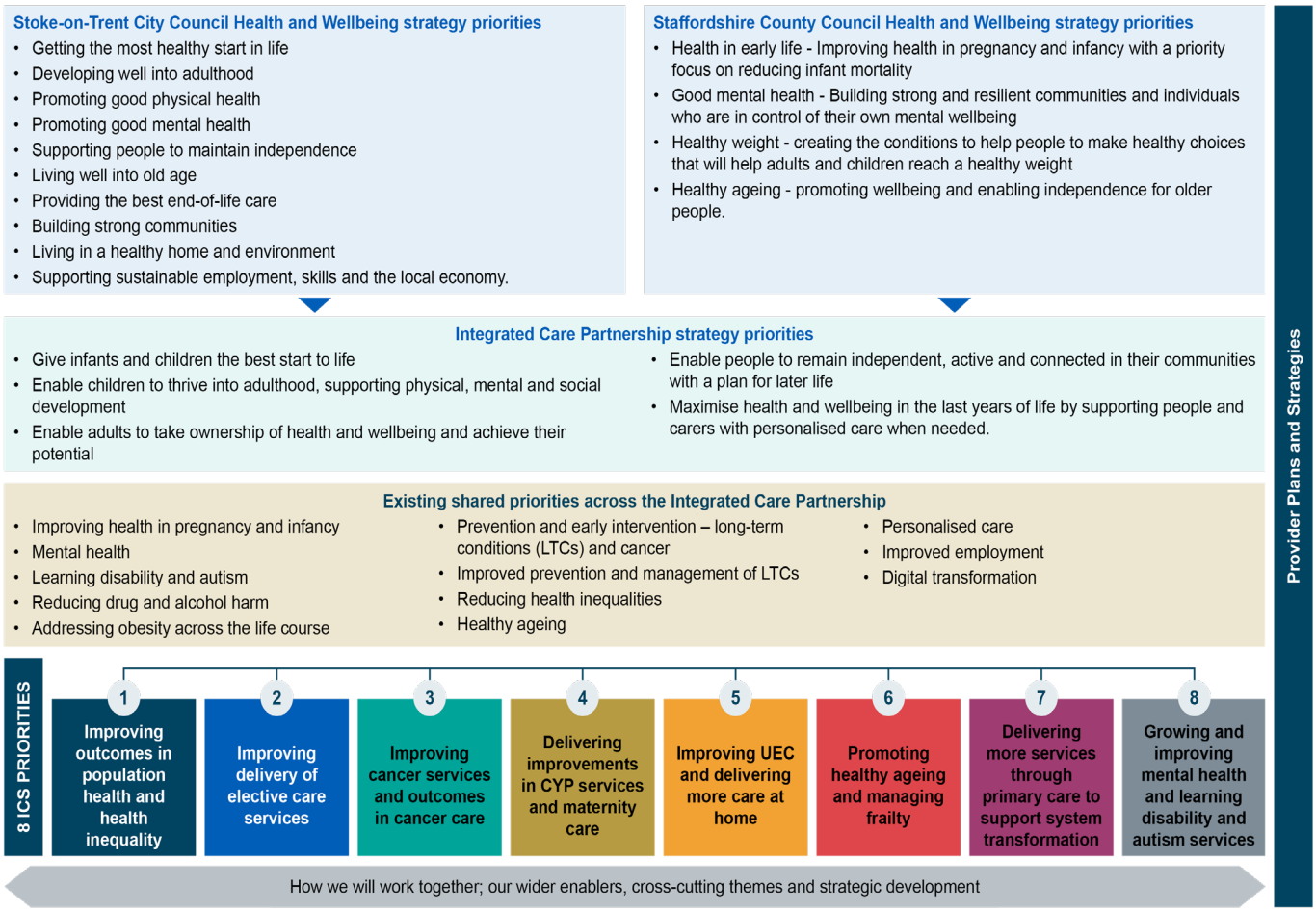
ICS vision

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

Our approach to developing our priorities

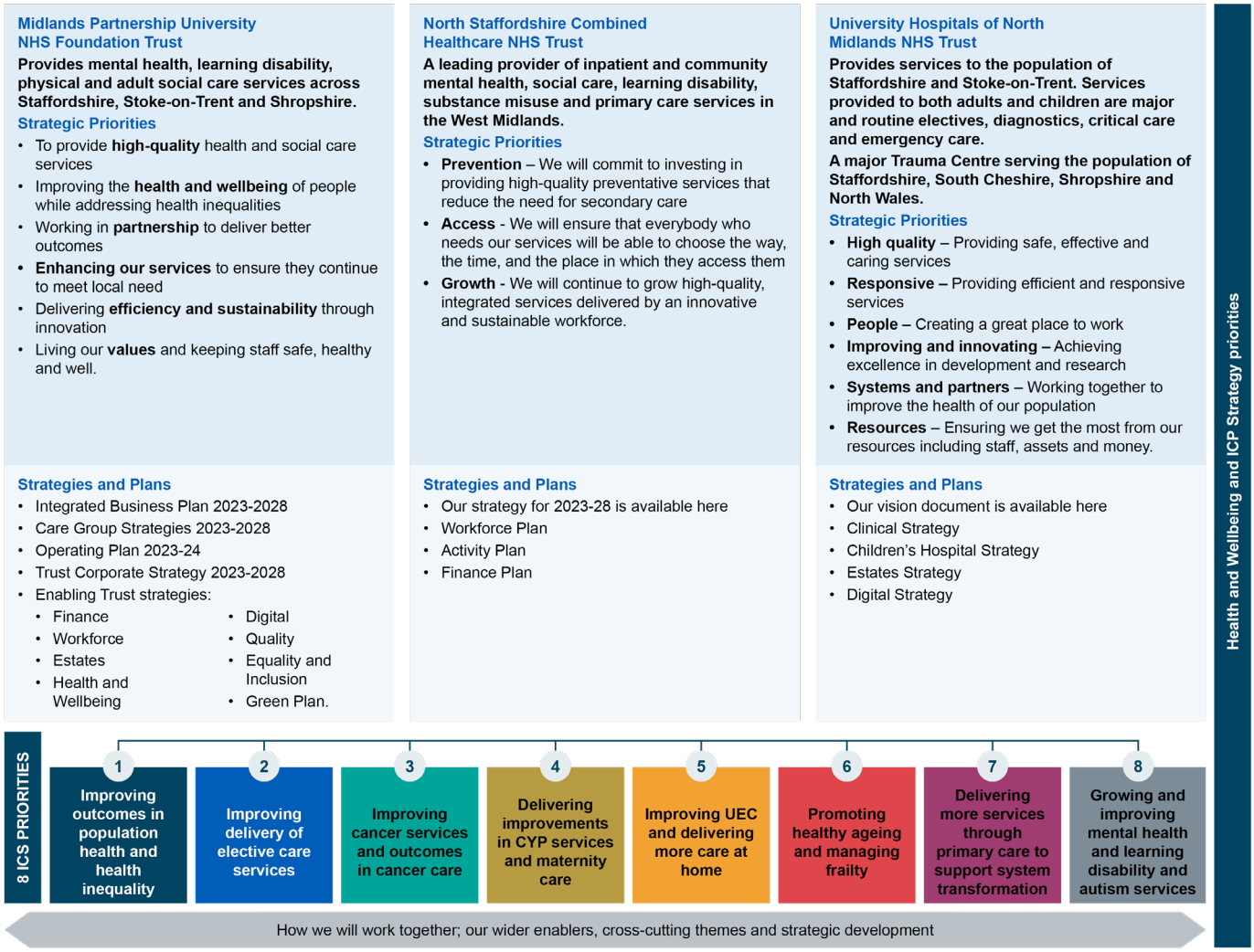
How we have informed our ambitions and priorities

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



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

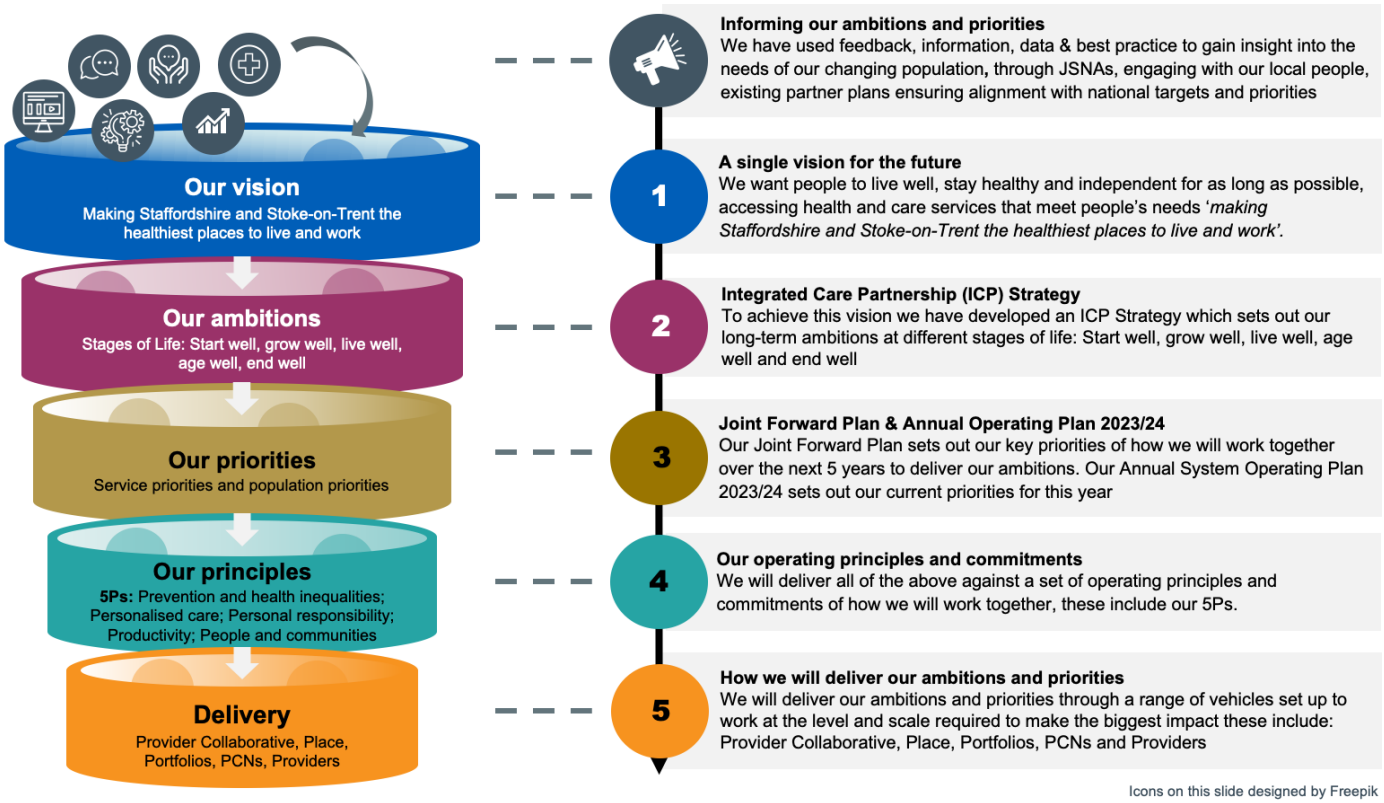
While our JFP reflects the plans and five-year strategic directions for each of our ICS acute, mental health and community NHS providers, it purposely seeks not to replicate those. Some of our population receive acute services provided by University Hospitals of Derby and Burton NHS Trust and the Royal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



Midlands Partnership University NHS Foundation Trust **Behaviours Values Mission** is available here
North Staffordshire Combined Healthcare NHS Trust **strategy for 2023-28** is available here
University Hospitals of North Midlands NHS Trust **our vision** is available here

Our ambitions

To achieve our vision, we have taken insight from our population health work to develop the *Integrated Care Partnership Strategy*. This is based on an assessment of our health, public health and social care needs which sets out our **long-term ambitions** to prevent ill health, reduce inequalities, and deliver better health and care services for our population at different stages of life.
The strategy sets out our four strategic ambitions for the population. All our collective work will align to and deliver change within these areas.



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

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

Our priorities

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

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

Service priorities

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

1. **Urgent and emergency care:** with a focus on prevention and avoiding hospital admissions
2. **Backlogs:** reducing queues and wait times inclusively, for elective care, cancer, mental health, learning disability and autism services, and NHS dentistry
3. **General practice:** ensuring that residents have appropriate, timely and equitable access to services
4. **Complex individuals:** improving access to high-quality and cost-effective care for people with complex needs.

Our operating principles and commitments

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

Our '5Ps'

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

Our governance for success

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

Health and Wellbeing Boards

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

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

Part 1

This section will give you an overview of

- why we need a JFP and some background to the current challenges we are facing
- what our priorities and ambitions are
- how we will work together to make an impactful change
- our enablers to success including digital and people

Why do we need a Joint Forward Plan?

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

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

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

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

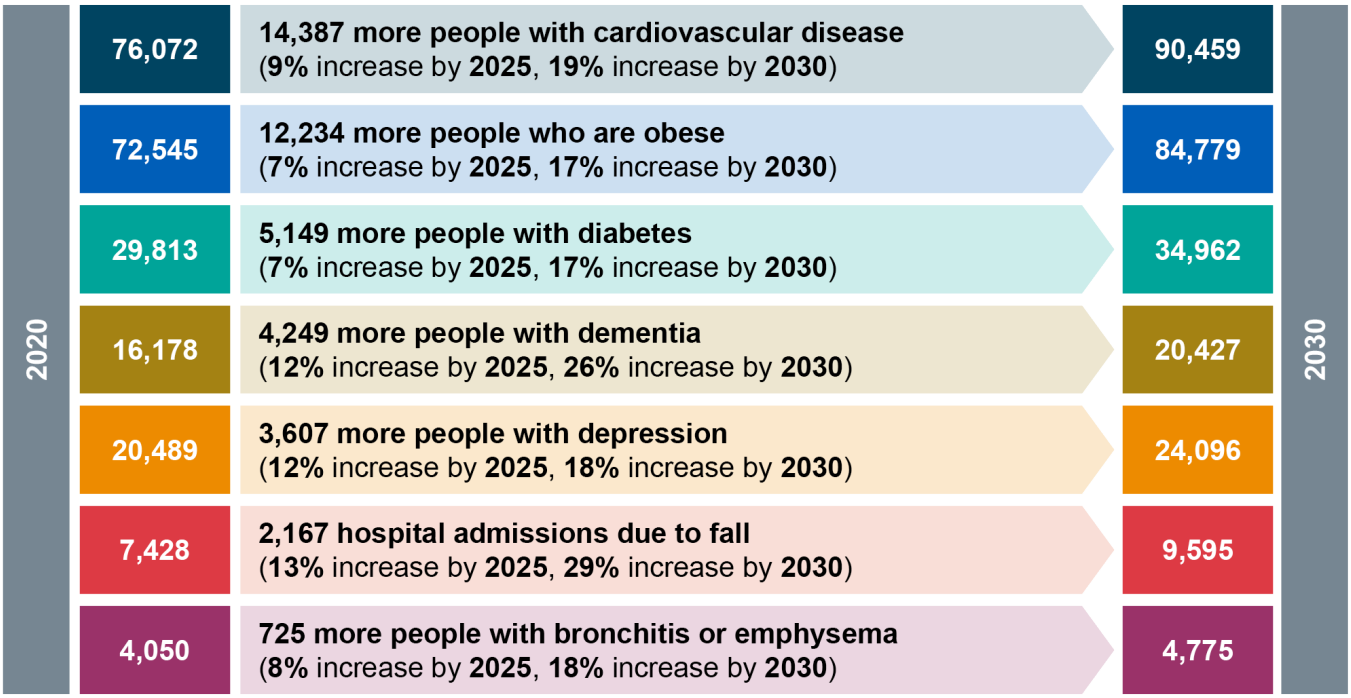
However, ageing is not our only challenge. Some communities also experience **social exclusion** – this is where people struggle to access support with things like housing, secure employment, or health and care services. These problems are usually linked to other difficulties such as poverty, violence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

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

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

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

As an example, the diagram below shows the long-term condition projections for 2030, in people aged 65 and over if we do nothing.



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

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

Challenges in our services

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

There is **a worldwide health and social care workforce crisis** which is heavily impacting the wellbeing of our staff and the sustainability of services. This needs to be addressed to ensure that high-quality care can continue to be delivered at all levels. We face workforce supply challenges due to turnover, burnout, retirement and lack of flexible working opportunities, along with financial challenges, and there is a requirement to do more by increasing workforce productivity rather than increasing the workforce itself.

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

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

There has been **pressure in discharging people from hospital** and although we have made some progress in recent months, there is still further to go. Many are not discharged on a timely basis, and as a system we discharge more people into bed-based care rather than getting them home. We also have rising numbers of people who need expensive continuing healthcare (CHC) packages or social care compared to our 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. Although we have implemented step-down services like virtual wards, they are not being used to their full potential.

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

The impact of COVID-19 on the demand for healthcare

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

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

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

Challenges for managing our resources

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

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

Finances are a challenge, with health and care organisations being asked to do more with no additional funding. There is a significant financial deficit that must be balanced in future years without impacting the quality of our services. Local authorities are also experiencing significant financial pressure and growing demands for services, not least social care services for adults and children. We know that the COVID-19 pandemic has had a significant impact on the delivery of continuing healthcare (CHC) in our ICS – both in terms of performance and finance. This was due to the temporary suspension of the CHC Framework for six months between March and August 2020.

The COVID-19 pandemic has demonstrated that we can use the estate differently and more efficiently, particularly in the case of non-patient facing roles. Virtual consultation and digital access have shown an alternative, and in many cases a more accessible, model of patient care. Our estate ambitions, linked to our clinical needs and strategies, are key for the successful delivery of the ICS's strategic objectives.

We saw an acceleration towards **digital technology** during the COVID-19 pandemic. This changed how we do things – in relation to access to services, information and support. Although this has been positive, it has meant that people without digital access are at even greater risk of exclusion. We must continue to factor this risk into our plans.

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

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

What people have told us

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

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

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

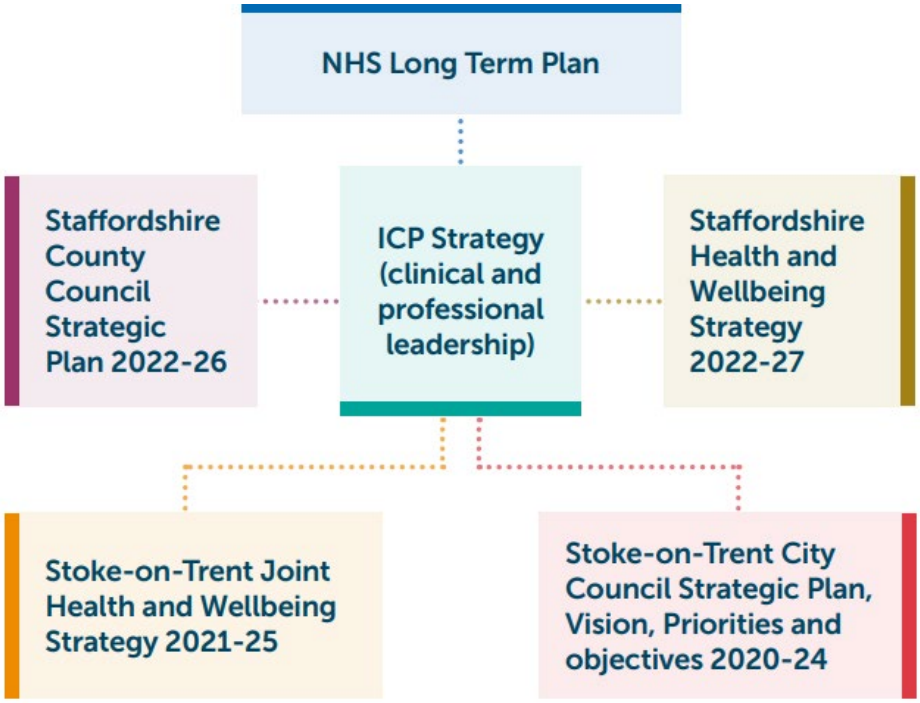
- Long waits for ambulances, delayed handovers and corridor care
- Crowded emergency departments with long waits
- Long waits for elective care, planned operations and cancer care
- Frustrations around fragmented services
- Difficulty accessing primary care and/or seeing your GP
- Difficulty of arranging social care and/or community services

The JFP is informed by a range of engagement activities, including the work undertaken to develop the ICP Strategy during 2022/23, audits and other sources of intelligence. Our engagement on the draft JFP involved a public survey, which asked for feedback on the portfolio-based key priorities, which built on previous public and patient involvement work. The findings from the survey will be used to support delivery and future updates of the JFP.

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

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

We have existing joint strategic needs assessments that identify our population's health and wellbeing needs: Staffordshire Joint Strategic Needs Assessment, Stoke-on-Trent Joint Strategic Needs Assessment. These tell us where our population's health and care outcomes can be improved to bring them up to the national average. The diagram below outlines the main documents utilised to develop our ICP strategy and shared priorities. Through our ICP strategy we want to integrate existing programmes of work in a way that enhances our collective action and expands on existing good practice.



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

How we will work together to achieve our priorities

Our Focus

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

We know that only 10–20% of health outcomes are directly influenced by the NHS, which is why close collaboration with our wider partners outside the NHS is so important to us.

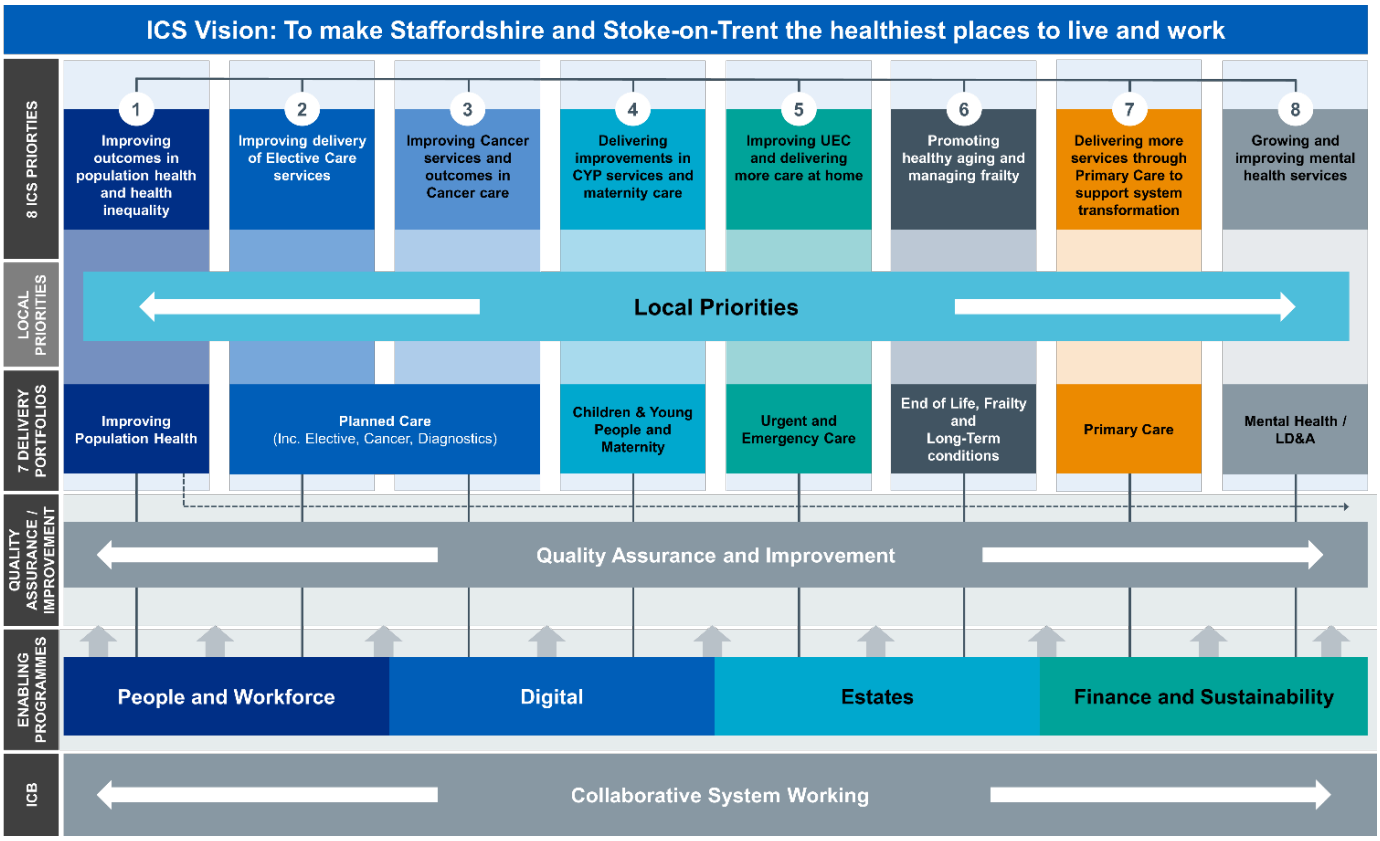
Improving population health and tackling health inequalities is a complex task but is key to the operational and financial sustainability of health and social care. Our main goals must include a focus on prevention, proactively supporting people to stay well at home, and arranging services so that people receive care from the right people in the most appropriate setting.

Our Clinical and Professional Leadership teams will be working collectively to tackle unwarranted variation and health inequalities.

Population health management (PHM) is a way of working to help frontline teams understand current health and care needs and predict what local people will need in the future. A PHM approach will enable us to reduce demand for reactive care services and use those resources to provide better proactive care for more people. We will take an evidence-based approach to service transformation. This will include working with our established research partnership, Staffordshire and Shropshire Health and Care Research Partnership (SSHERPa). This will give us the information we need to make decisions about changes to our services.

The way we work (our operating model)

The way we work (our operating model) is central to achieving our ambitions and working successfully with all our system partners. Our structures must enable us to deliver our vision and aims. We are organised as a set of seven Portfolios supported through our two Places and our Provider Collaboratives, Primary Care Networks and Neighbourhoods. This also includes a range of enabling functions (for example, Finance and IT) and broader leadership and support, such as quality, clinical and professional leadership.



Portfolios

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

Provider Collaboratives

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

Place

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

Programme governance arrangements have been established and some areas of focus have been agreed by all system partners:

- Care homes
- Learning disabilities and autism
- Transition and preparation for adulthood
- Dementia
- Section 117 placements

A full review of the schemes, supported through the Better Care Fund (BCF), will support further areas of integration. The BCF / place-based model is expected to underpin discussions about opportunities for integration across system partners.

Neighbourhood

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

Primary Care Networks (PCNs)

A Primary Care Network (PCN) is a group of GP practices working together. PCNs are in the best position to understand local people's health and care needs at a grassroots level. There are 142 practices across 25 PCNs in Staffordshire and Stoke-on-Trent. PCNs are crucial to the implementation of the JFP, through more resilient delivery of primary care in local neighbourhoods, and the integration of health and care services to better respond to the characteristics and needs of the local population.

Our system-wide approach for pathway design

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

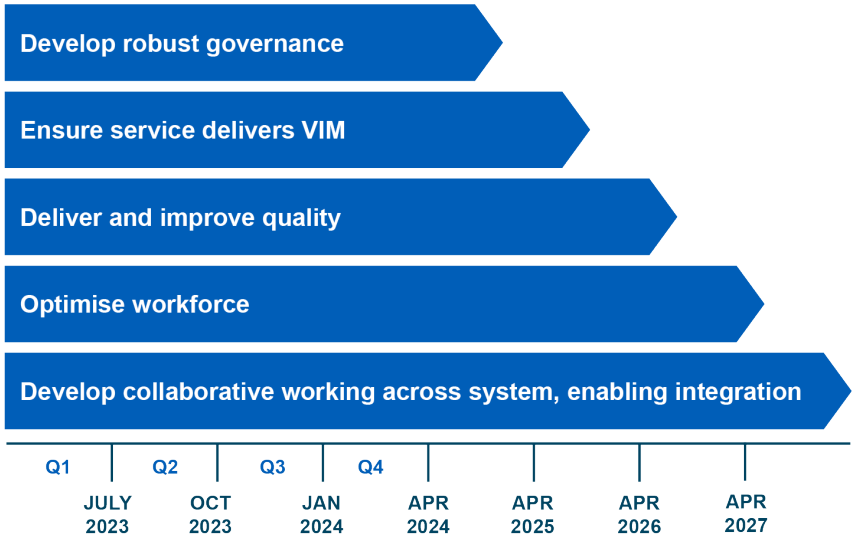
Our approach

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

We know that some of these CHC and social care costs might be avoidable if people are not admitted to hospital in the first place or, if they are admitted, they are discharged with alternative home support packages. We know from evidence that patients experience poorer outcomes if their discharge process is less good than it should be, and a large number of these people can end up with a lifetime of dependency.

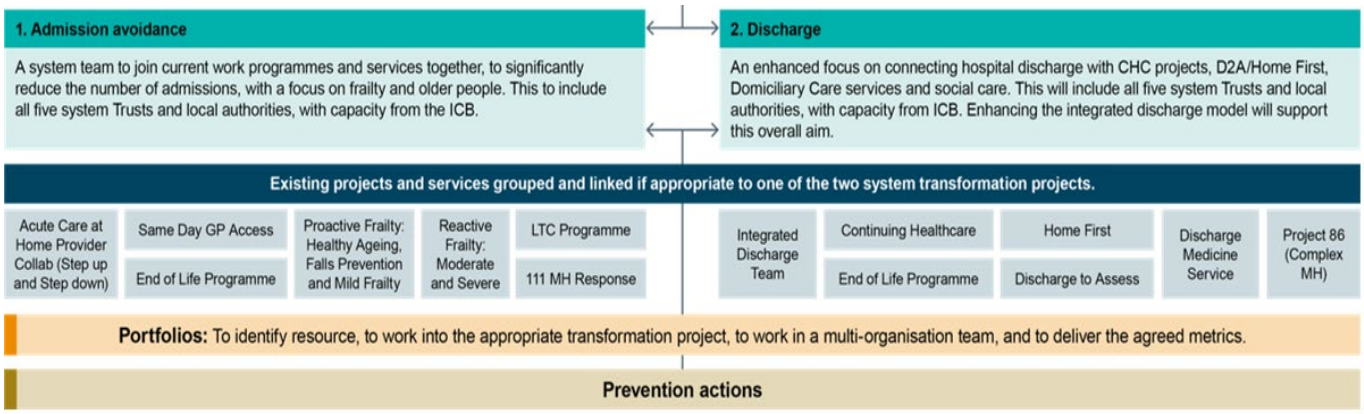
Many different factors impact the cost of CHC placements: increases in the numbers of patients assessed as eligible, the acuity of patients' needs, and demand exceeding supply, together with under-developed provider markets and increases in providers' own costs through inflation, cost of living and workforce challenges.

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



We know that the pressures we experience in CHC are not limited to that area of service, and are an indicator of pathways that are not as connected as they could be. By working together on admissions and discharges as two joined-up projects, we can have a positive impact on people's quality of life. This will also help manage the demand for beds in our already constrained care homes and have financial advantages.

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

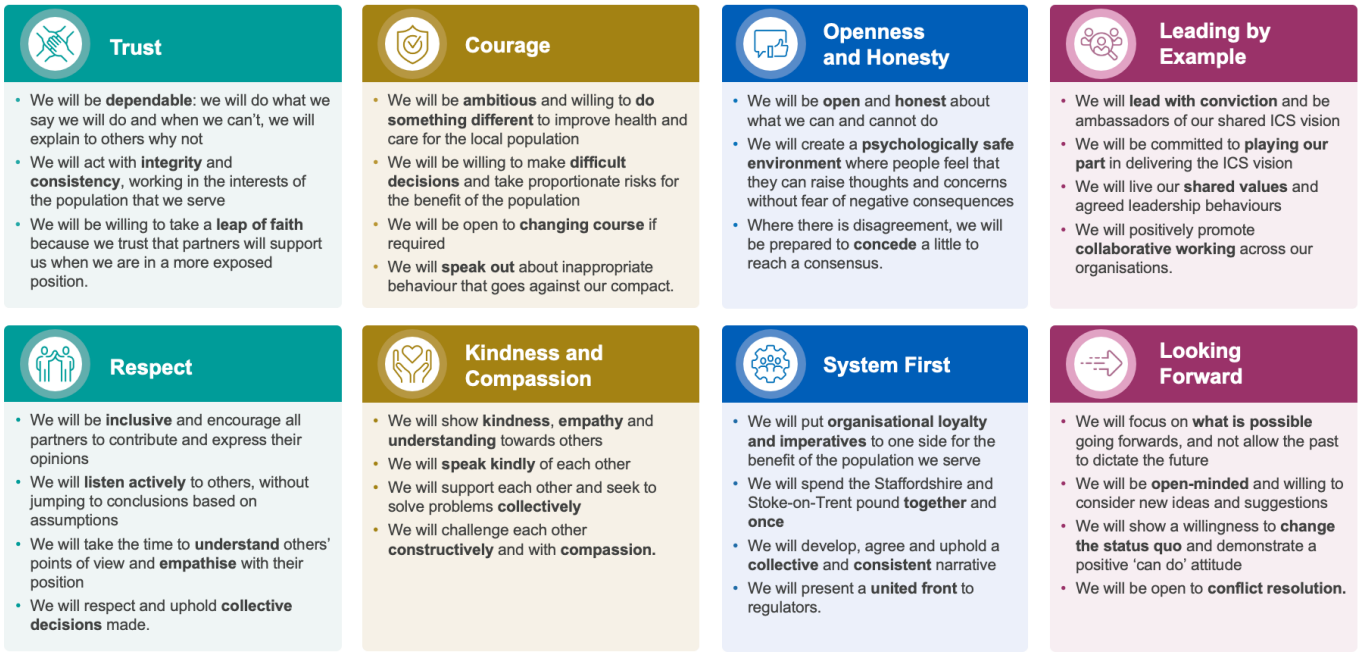


Some areas of transformation may be specific to a group of patients, for example, people with diabetes living in a particular area. In these cases, some very specific work will take place to design local solutions. Others will be broader service transformations and large-scale changes – for example, developing the model for Urgent Treatment Centres which will serve the whole population. This means we don't have a one-size-fits-all approach to service transformation. The current programme of transformational work is explored further in each of the portfolio sections of this document.

Supporting collective accountability through our leadership compact

No single partner alone can achieve what we need for our population. We will work together to make sure that we promote the long-term wellbeing of our population, and we will share 'Collective Accountability'. This means we each take responsibility for what happens in the services that our own organisations provide – but we will also share responsibility across all our health and care services. We will jointly figure out how things can be done differently in the future and work together to get the right things done.

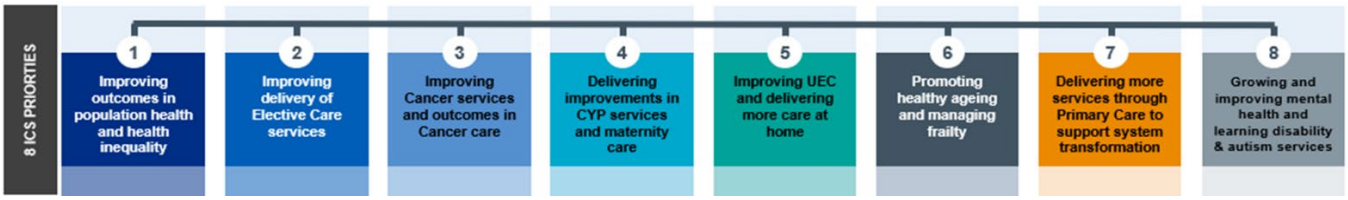
To support our commitment to collective accountability, we have developed a leadership compact in partnership across the system. We have co-created a common understanding of the behaviours expected of our leaders, supported by a compact to ensure mutual accountability between individuals and organisations.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



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

Our ICS priorities and portfolios

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



Approach

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

1. **Why is this important for our population?** Reflecting on the current picture and challenges
2. **What do we know about people's local experiences?** Considering any existing engagement activity, intelligence or data
3. **How do we plan to make a difference?** Overview of the key deliverables that portfolios plan to implement over the next five years. The underpinning detail including timelines and actions will be captured in local plans
4. **How will we know we are making a difference?** Portfolios have considered how their plans will be measured or what the outcomes will be for our population. Each portfolio has an underpinning dashboard of performance metrics or broader outcomes from the operating plan, the NHS oversight framework, the NHS Long Term Plan and our local priorities. Performance metrics are monitored against their planned trajectories or targets where relevant. See appendix: Portfolio 5 Year Plans where a high level overview of the key priorities and delivery timelines has been provided.

Improving population health

Our commitment – Paul Edmondson-Jones, ICB Chief Medical Officer

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

Ambitions

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

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

Why is this important for our population?

Population health management *Making intelligent decisions for the future*	**Health inequalities** *Building fairer futures*	**Prevention** *Changing the futures*
• Scale, Spread, Sustain (Infrastructure, Intelligence, Interventions, and Incentives) • Cultural Change • Drive ICP Strategy • Integrated Intelligence Collaborative	• 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
Population health management helps us understand the health and care needs of our population both now and in the future. We do this by using linked data from across our health and care partners to help us better understand our residents' needs and how they vary across their life course. By understanding more about our residents, we can identify groups of the population with similar needs and design targeted services to meet these needs, moving away from a one-size-fits-all model, to evidence-based interventions which are effective in the particular group we are looking to support. This approach will be central to all we do, ensuring we focus efforts on the best ways to support our communities, and make certain that our population can expect the same high-quality services wherever they live.	**Health inequalities** are avoidable and unjust differences between people or groups due to social, geographical, biological or other factors. These differences have a huge impact, because they result in people who are worse off experiencing poorer health and shorter lives. We know that some people, groups and communities do not have equal opportunity to access health and care services and when using services have worse experiences and outcomes from care. Addressing health inequalities will help give people more equal opportunity to benefit from health and care services, addressing known disadvantages relating to where they live, personal circumstances, age, gender or ethnicity. The desire to reduce health inequalities is embedded throughout this document.	**Prevention** is a key part of improving the health of our populations – not simply primary prevention, where we seek to help people make healthy lifestyle choices, but secondary prevention of illness through screening, early detection and diagnosis, and tertiary prevention for people living with long-term illness to optimise their health and prevent deterioration. We will focus on delivering personalised care, empowering people to take personal ownership and self-manage such conditions in the community. This will enable people to live well, independently from care, in their community for as long as possible. At the same time, we recognise that when people need to use health or care services, it is important to provide high-quality and effective treatment or care at all ages. We will also work with people and communities to achieve environments that promote health and wellbeing.

How do we plan to make a difference?

Our ICP strategy outlines the five things we need to change if we are going to make a difference. We may need to undertake transformation in our services, to make sure this happens. The diagram below illustrates our 'Five Ps' approach:

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

Health inequalities

We will focus on:

- Developing a **health inequalities strategy** by 31 December 2023. This will articulate our system-wide approach to tackling health inequalities, particularly in access, experience and outcomes, in line with our new legal duties.
- We will work alongside **quality assurance and improvement** leads to ensure the fundamental standards of quality are delivered – including managing quality risks (including safety risks) and, in particular, addressing inequalities and variation. We also have a goal to continually improve the quality of services, in a way that makes a real difference to the people using them.

Delivering the **five priority areas for improvement of healthcare inequalities** through the Improving population health portfolio and other portfolios. We have aligned our local improvement of healthcare inequalities as outlined below:

National Priority Area	Actions
1. Restore NHS services inclusively	Supporting elective recovery and restoring services inclusively to ensure inequalities are addressed – focusing on waiting lists. Identifying health inequalities associated with diagnostics, elective and cancer care and put measures in place to reduce their impact (see Planned Care Section).
2. Mitigate against digital exclusion 3. Ensure datasets are complete and timely	One Health and Care: Shared Care Record (ShCR) – will ensure that by 2024 ICS constituent organisations are connected to an integrated life-long health and care record, sharing data across NHS and local government organisations, and supporting collaboration at system, inter-regional and regional levels, including West Midlands ShCR and Secure Data Environment West Midlands partnership. PHM: Implement intelligence infrastructure to enable PHM to understand the population.
4. Accelerate preventative programmes	**Alcohol** • Develop improvement of optimal Alcohol Care Teams in hospitals with the highest rates of alcohol dependence-related admissions. • Develop an Alcohol Harm Reduction Strategy by 31 December 2023 to underpin the ICP strategy. **Tobacco** • Embed and continually improve the development of tobacco dependence treatment services in all inpatient and maternity settings through the Tobacco Steering Group. • Evidenced-based (PH48/NG92/PH26) smoking cessation offer available for at-risk populations, inpatients, pregnant women and for those with SMI. • Smoke-free pregnancy pathways to support the Saving Babies' Lives care bundle and a significant driver in delivering the ambition to reduce the number of stillbirths (Maternity section). **Obesity and weight management** • Improve uptake of lifestyle services through cross-portfolio working, for example, Diabetes Prevention Programme and Low-Calorie Diets (ELF section). Implementation of the new Digital Weight Management Programme and digitally supported self-management services. The delivery of our identified Provider Collaborative projects around Tier 3 and 4 weight management (Planned care section). **Antimicrobial resistance (AMR)** • Antimicrobial resistance continues to be a priority for the ICS. The focus of work will continue to support the appropriate management of antibiotics to ensure effective prescribing through local formularies in line with national guidance and local microbiological intelligence. (Pharmacy and medicines optimisation section). **Vaccination and immunisation** • Vaccination is one of the most effective public health interventions to prevent the spread of infectious disease and its complications. • Work is ongoing with NHS England to review the future Vaccination Strategy which, aligned to the expected delegation of vaccinations services, will allow systems to develop vaccination services locally. • Support will be provided to local providers to deliver responsive, effective vaccination services which ensure access for all. Recent experience from the

National Priority Area	Actions
	COVID-19 programme on improving vaccine uptake in under-served communities will be drawn on to improve uptake in all vaccination programmes. Integrated programmes offering vaccinations to similar groups at similar times is a key focus to improve uptake and efficiency moving forward. Our focus is on: 1. Improving uptake and coverage and reducing variation 2. Identification of programmes for additional focus, such as MMR, due to reductions in uptake over recent years and disruption to school-age immunisation programmes during the pandemic 3. Addressing vaccine inequalities 4. Improving co-administration and co-promoting of other immunisation/wider health and wellbeing programmes. **Resettled migrants and asylum seekers** • We are working to address the healthcare needs of asylum seekers and resettled migrants who are living locally to provide initial health assessments and screening prior to registration with GP services. • We will continue to provide ongoing support to these residents to ensure all health requirements are met including screening and immunisation. • We will continue to support the Afghan Resettlement Scheme and the Homes for Ukraine schemes to ensure all healthcare needs are met. **Tuberculosis (TB)** • We will work with public health and TB specialist services to ensure that adequate provision is in place for effective TB screening and treatment pathways. • Links are established with the NHSE Regional TB board and local UK Health Security Agency (UKHSA) representatives to share best practices across systems. We are working to ensure that TB screening is appropriately undertaken for migrants and asylum seeker living within Staffordshire and Stoke-on-Trent. **Pause Stoke-on-Trent – Led by Stoke-on-Trent City Council** The service will work intensively with women who have lost a child or children to care and/or adoption. During this 'pause' in repeat pregnancies, bespoke work with women allows them to resolve their own trauma and lifestyle needs. If they become pregnant again, the programme is designed to give them the skills to care for their children safely.
5. Strengthen leadership and accountability	The Improving Population Health portfolio incorporates PHM, Health Inequalities and Prevention. 1. Chief Executive sponsorship from two local authorities has been secured 2. Dedicated Senior Responsible Officer (SRO) 3. Dedicated Clinical Lead 4. Dedicated resources agreed to support Improving Population Health within Chief Medical Officer structure 5. Aligned Finance Business Partner 6. Core20 Ambassadors 7. All Primary Care Networks (PCNs) have health inequality leads 8. All system partners have health inequality leads.

Inclusion health groups (IHGs)

Inclusion health groups (IHGs) is a term used to describe people who are socially excluded and experience multiple overlapping risk factors resulting in health inequalities. IHGs are identified in Health

and Wellbeing strategies and national strategies. The ICB has a legal duty to ensure that there is equitable opportunity for all to benefit from health and care services.

Using a PHM approach and community engagement, we will understand the health and wellbeing needs of IHGs, which will help us develop integrated approaches to improving health and wellbeing. IHGs include: Learning disability and autism; Women from ethnic minority communities and/or experiencing poverty; Individuals, households and communities at risk of serious violence; Informal carers; Military veterans; Asylum seekers and vulnerable migrants; Our older population (prioritising those vulnerable or socially isolated); The population experiencing homelessness; Others as identified by PHM at Place and Community levels.

CORE20PLUS5

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

Our focus on Core20 implementation will incorporate:

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

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

Core20PLUS5 (Adults)

Maternity (Children, young people and maternity)	Ensuring continuity of care for women from black, Asian and minority ethnic communities and from the most deprived groups. This model of care requires appropriate staffing levels to be implemented safely
Severe mental illness (SMI) (Mental health, learning disabilities and autism)	Ensuring annual health checks for 69% of those living with SMI (bringing SMI in line with the success seen in learning disabilities)
Chronic respiratory disease Planned care (elective, cancer and diagnostics)	A clear focus on chronic obstructive pulmonary disease (COPD) driving up uptake of COVID, flu and pneumonia vaccines to reduce infective exacerbations and emergency hospital admissions due to those exacerbations
Early cancer diagnosis Planned care (elective, cancer and diagnostics)	75% of cases diagnosed at stage 1 or 2 by 2028
Hypertension case-finding Planned care (elective, cancer and diagnostics) and primary care	To allow for interventions to optimise blood pressure and minimise the risk of myocardial infarction and stroke

CORE20PLUS5 (Children and Young People)

Asthma (Children, young people and maternity)	• Address over-reliance on reliever medications • Decrease the number of asthma attacks
Diabetes (Children, young people and maternity)	• Increase access to real-time continuous glucose monitors and insulin pumps across the most deprived quintiles and from ethnic minority backgrounds • Increase proportion of those with Type 2 diabetes receiving recommended NICE care processes
Epilepsy (Children, young people and maternity)	Increase access to epilepsy specialist nurses and ensure access in the first year of care for those with a learning disability or autism
Oral health (Children, young people and maternity)	Tooth extractions due to decay for children admitted as inpatients in hospital, aged 10 years and under
Mental health (Children, young people and maternity / Mental health, learning disabilities and autism)	Improve access rates to children and young people's mental health services for 0-17 year olds, for certain ethnic groups, age, gender and deprivation

Population Health Management (PHM) programme

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

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

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

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

Embedding PHM will:

1. Deliver integrated health and care that is underpinned by intelligent decision-making using data on our population's health and care needs
2. Use data to understand risk and protective factors, enabling us to target resources to those at increased risk of poor health outcomes or with greatest potential to benefit from care

3. Identify inequalities in access, experience, and outcomes of care to inform improvements to care pathways so that we offer high-quality inclusive care
4. Proactively target preventative interventions and services to those identified as being at higher risk of illness or adverse events, for example infant mortality or emergency hospital admission.

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

Set out against the PHM maturity matrix (a self-assessment tool for understanding how far something has developed), we have a roadmap for our PHM approach. There are four main components: infrastructure, intelligence, interventions and incentives.

How will we know we are making a difference?

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

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

- Reduce the difference in life expectancy and healthy life expectancy between the most and least deprived communities in the ICS over the next 10 years
- Co-develop a Health Inequalities Strategy and outcomes framework to underpin the ICP Strategy by 31 December 2023
- Establish an ICS Health Inequalities Steering Group to co-ordinate, scale and sustain action on heath inequalities, responding to population needs as outlined by the Joint Strategic Needs Assessment (JSNA) and PHM, by July 2024
- Establish PHM for health inequalities and prevention, enabling prioritisation of action on Core20PLUS5 population health inequalities and local priorities identified by JSNA, by March 2024
- Establish governance and process mechanisms so that health inequalities and opportunities for prevention are identified, considered and addressed in planning and decisions across all programmes in the ICB Delivery Plan by 31 March 2024
- Identify the 'Core20' population and work with all ICB portfolios to reduce inequalities in health outcomes compared to the Staffordshire and Stoke-on-Trent population at agreed intervals
- Identify the 'PLUS5' population groups and work with aligned portfolios to reduce inequalities in health outcomes compared to the Staffordshire and Stoke-on-Trent ICS population at agreed intervals.

Serious violence

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

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

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

How will we know we are making a difference?

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

Planned care (elective, cancer, diagnostics)

Our commitment – Helen Ashley, Senior Responsible Officer

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

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

Ambitions

The planned care, cancer and diagnostics portfolio ambitions are to:

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

Why is this important for our population?

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

We know that the more cancers we are able to diagnose early, the more people will survive to live with and beyond cancer. Earlier and faster diagnosis with high-quality personalised treatment and care for people with cancer is essential for people to stay well. Targeted lung health checks for lung cancers are

being delivered in our ICS. Interventions like this mean that a significant percentage of cancers found are being found at stage 1 or 2, above what would be found nationally. These checks can help identify problems earlier.

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

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

What do we know about people's local experiences?

Through involvement work undertaken to date in the development of the ICP Strategy, our local communities have told us that they experience long waits for elective care, planned operations and cancer care.

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

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

How do we plan to make a difference?

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

Elective recovery and transformation

We will focus our recovery actions around:

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

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

We will focus on:

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

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

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

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

- Recovery – elective care waits
- Advice and guidance
- Diagnostic waits and diagnosis times
- Outpatient transformation
- GIRFT, pathway redesign, and ensuring equity across the county Getting It Right First Time - GIRFT
- Digital
- Workforce
- Health inequalities.

More broadly we aim to:

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

Cancer services recovery and transformation

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

We will focus on:

- Reducing inequality using the Midlands Cancer Screening Dashboard to inform targeted interventions that improve screening uptake and address late-stage diagnosis
- Faster cancer diagnosis being achieved, and patients starting their first definitive treatment within 62 days through an increase in diagnostic capacity and therefore shorter waiting times for diagnostic results
- Awareness-raising campaigns to encourage patients with symptoms to seek support sooner and to take up screening offers, so that more cancers are diagnosed at an earlier stage
- Optimising the use of new services and diagnostics such as breast pain clinics, virtual nasal endoscopy, FIT negative pathways and tele-dermatology, releasing specialist capacity for patients most at risk of cancer
- Targeted lung health checks (TLHCs) programme expansion
- Reviewing our patient-initiated follow-up pathways.

Diagnostic recovery and transformation

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

We will focus on:

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

How will we know we are making a difference?

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

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

- By March 2024 no one will wait more than 65 weeks for treatment
- By March 2025 no one will wait beyond 52 weeks for treatment
- By March 2026 no one will wait more than 36 weeks for treatment
- By March 2027 no one will wait more than 26 weeks for treatment
- By March 2028 no one will wait more than 18 weeks for treatment.

Diagnostics

- By June 2023 no one will wait more than 13 weeks for a diagnostic test
- By March 2025 no one will wait beyond 6 weeks for a diagnostic test.

Cancer

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

CASE STUDY

- Simon is 53 years old and is a hospital porter. He has had several incidents of back pain over the years but recently has begun to worry about his back pain and his future.
- Simon went to see his FCP (First Contact Practitioner) and was given a thorough clinical assessment. The FCP used the STarT Back tool with Simon and reassured him that there was no serious underlying spinal condition, but recognised the pain was troublesome. Simon felt alone and the pain was making work difficult and stopping him from doing the things he enjoyed.
- Simon was given access to a SelfBack phone app which allowed him access to exercises and information to help himself manage on a daily and weekly basis. He could also use the app to record how his condition was progressing. The recorded data was shared with his FCP to enable them to better support Simon.
- Simon found the app easy to use and it helped him to describe and manage his back pain. His FCP was able to look at Simon's progress. Simon described the app as "like having a friend in his pocket". He was able to get back to his hobbies and minimise any time off work.

Children and young people (CYP) and maternity and neonates Children and Young People

Our commitment – Jon Rouse, Chief Executive Officer Sponsor for CYP

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

Ambition

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

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

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

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

Why is this important for our population?

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

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

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

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

There have been several sudden infant deaths within the local area where unsafe sleep practices and other risk factors may have contributed to the death. In response, a new multi-agency training package has been introduced. This includes face-to-face sessions updating staff about the evidence base around safer sleeping practices. The sessions also allow staff to analyse the issues they see in practice and begin to problem-solve using a collaborative approach.

In Staffordshire and Stoke-on-Trent, more children than the England average are admitted to hospital for a range of health problems, including controllable long-term conditions such as epilepsy, diabetes and

asthma. Growing numbers of our children are overweight or obese, increasing their risk of developing serious health conditions in later life.

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

What do we know about people's local experiences?

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

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

The Staffordshire Council of Voluntary Youth Services (SCVYS) has been commissioned to facilitate the creation of a co-production charter and accompanying toolkit that professionals can use when engaging with children and young people. The toolkit is expected to include a wide range of information on co-production and models of participation. Professionals will be able to use checklists to understand which tool fits best and quality assurance tools to enable evaluation and improvement.

These tools, which will be publicly launched on the 12 September 2023, will be used to support ongoing engagement with children and young people that will guide future plans and priorities.

How do we plan to make a difference?

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

- Best start in life: improve the survival of babies and young children to reduce infant mortality
- Make improvements in nutrition and access to physical activity
- Support children and young people to achieve their potential by enjoying good emotional wellbeing and positive mental health
- Support children with complex needs with the help they need to fulfil their potential
- Effectively manage long-term conditions to reduce avoidable admissions in relation to asthma, epilepsy and diabetes.

How will we know we are making a difference?

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

Maternity and Neonates

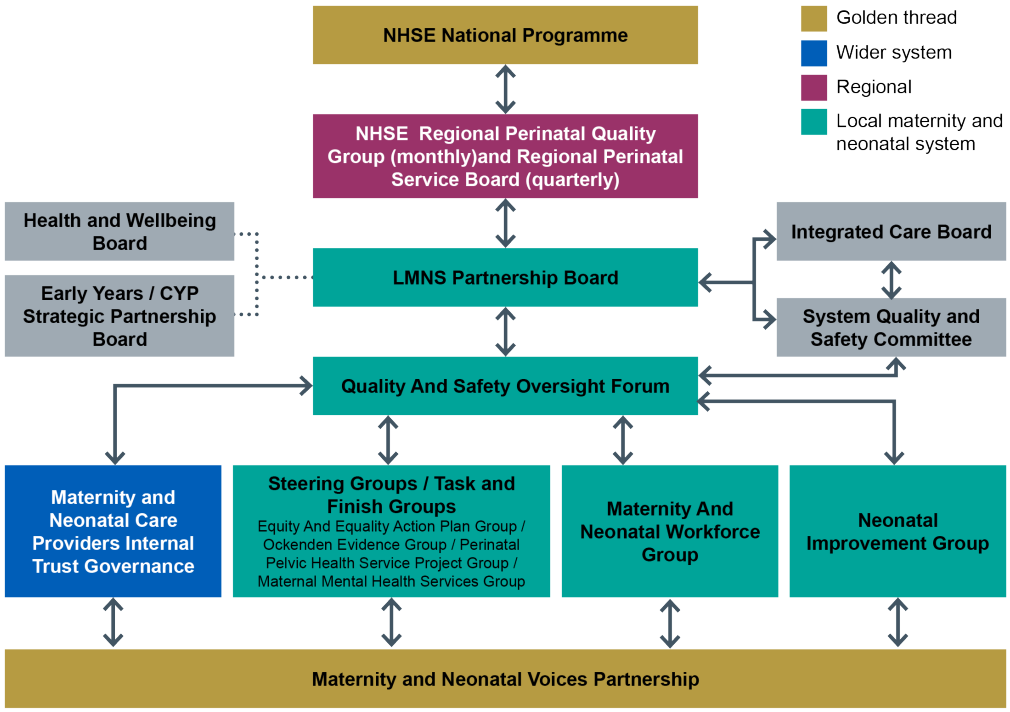
Our commitment – Heather Johnstone, SRO, Maternity Transformation Programme

We work in partnership with organisations across the ICS to deliver joined-up health and care services. The local Maternity and Neonatal System (LMNS) remains committed to bringing together all partners, including users of these services, to work to ensure high-quality, safe care for mothers and their babies.

We are equally committed to taking up every opportunity to learn from high-profile maternity investigations such as the Ockenden and Kirkup reports, to avoid reoccurrence of such events in local services. We will listen to our families to support the implementation of the Three-Year Delivery Plan for Maternity and Neonatal services (2023), ensuring voices are heard that are relevant to local need and arrangements.

Ambition

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



All activities within the maternity and neonatal programme will support achievement of the four themes of the Delivery Plan.

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

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

Why is this important for our population?

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

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

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

1. Reducing smoking in pregnancy
2. Risk assessment and surveillance for fetal growth restriction
3. Raising awareness of reduced fetal movements
4. Effective fetal monitoring during labour
5. Reducing preterm births.

The LMNS is working with trusts to effectively implement and embed all elements of the care bundle, with a cohesive process of reporting and monitoring. Having a tobacco dependency working group focusing on reducing smoking in pregnancy is one example of working collaboratively with our public health colleagues.

What do we know about people's local experiences?

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

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

We know that there are workforce challenges in recruitment and retention, consistent with the national picture. We also need to listen to the experiences of local staff, to foster working environments in which staff are happy and can enjoy working.

How do we plan to make a difference?

The national Three-Year Delivery Plan for Maternity and Neonatal services pulls together a number of maternity and neonate initiatives. These are the Ockenden and Kirkup reviews, Saving Babies' Lives and the Equity and Equality Action Plan, as well as the requirements for Better Births, the NHS Five

Year plan, and the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme. These and emerging initiatives will influence service delivery under four identified themes, each with three objectives. These are:

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

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

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

4. Standards and structures that underpin safer, more personalised and more equitable care
   - Objective 10 – Standards to ensure best practice
   - Objective 11 – Data to inform learning
   - Objective 12 – Make better use of digital technology in maternity and neonatal services.

We will focus on:

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

We will listen to women and their families, while also paying due attention to our maternity and neonatal workforce. By working together, we believe we can make a real difference.

How will we know we are making a difference?

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

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

- Our outcome measure for this theme will be indicators of women's experience of care from the Care Quality Commission (CQC) maternity survey. This will be analysed by ethnicity and deprivation and

evidenced through feedback on personalised care and evidence of working with women and families to improve services, including co-production.
- Progress measures will include implementation of local Perinatal Pelvic Health and Mental Health services, the number of women accessing those services and the proportion of maternity and neonatal services with UNICEF Baby Friendly Initiative (BFI) accreditation.

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

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

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

- Achieving meaningful changes in culture will take time. Progress measures are difficult to identify and can have unintended consequences. We will primarily determine success by listening to the people who use and work in our frontline services.
- Outcome measures for this theme are through midwives' and obstetrics and gynaecology specialists' experience results from the NHS Staff Survey, the National Education and Training Survey and the GMC National Training Survey. We will explore how to better understand the experiences of other staff groups.
- Evidence of progress will be through Trust Boards We will need assurance that all staff are using an appreciative enquiry approach (a strengths-based, positive approach) to support progress with plans to improve culture. Learning from staff feedback about incidents and issues of concern should be followed up and any necessary actions taken.

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

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

Summary of progress measures

Themes
Theme 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.
Theme 2 • Establishment, in-post and vacancy rates for obstetric anaesthetists, sonographers, allied health professionals and psychologists • Annual census of maternity and neonatal staffing groups • Assess retention through monitoring staff turnover, sickness rates and NHS Staff Survey results on experience and morale.
Theme 3 • Results from the NHS Staff Survey, National Education and Training Survey, GMC National Training Survey.
Theme 4 • Local implementation of Saving Babies' Lives care bundle v3 using a national tool • Proportion of births at less than 27 weeks, at trusts with on-site neonatal intensive care • Avoiding Term Admissions into Neonatal Units (ATAIN) programme measurement of the proportion of full-term babies admitted to a neonatal ward • Overview of the progress of maternity services via a periodic digital maturity assessment of trusts.

Strategic transformation and service change

In March 2022, services at the freestanding midwife-led birthing units (FMBUs) at County Hospital, Stafford, and Samuel Johnson Community Hospital, Lichfield (births only) were suspended as a result of the pandemic. This was in line with national guidance and was intended to ensure safe staffing at the consultant-led units at Royal Stoke Hospital and Queen's Hospital in Burton. Although the initial closures were related to COVID-19, significant staffing challenges in the maternity workforce have prevented the safe reopening of these units. Throughout this period, the homebirth services for both trusts (UHNM and UHDB) have had both fixed-term and intermittent periods of suspension and are currently closed. As staffing has increased, attempts have been made to reinstate the homebirth services. Unfortunately, this has not been sustainable.

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

Urgent and emergency care

Our commitment – Matthew Lewis, Senior Responsible Officer

We recognise that people in our catchment areas deserve the best quality urgent and emergency care, as close to home as possible, and as swiftly as possible. Our work through the Urgent and Emergency Care (UEC) Board aims to offer people rapid access to assessments and treatment, 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 that allow people to monitor vital signs without leaving their home. Equally, anyone that requires admission should have access to the right level of expertise, diagnostics and treatment with minimal delay.

Ambitions

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

Why is this important for our population?

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

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

When our hospital beds are full, this affects the whole urgent and emergency care pathway. For example, people might have to wait a long time in an emergency department (ED), or for an ambulance to arrive. We know that most people want to leave hospital and, where possible, go home as soon as they can. Many of these people are in the last 1,000 days of life, so we need to be able to get them home as swiftly as possible. Improving discharge pathways will improve people’s lives and support their carers.

What do we know about people’s local experiences?

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

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

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

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

How do we plan to make a difference?

Urgent and Emergency Care (UEC) strategy

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

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

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

Our delivery vision is to:

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

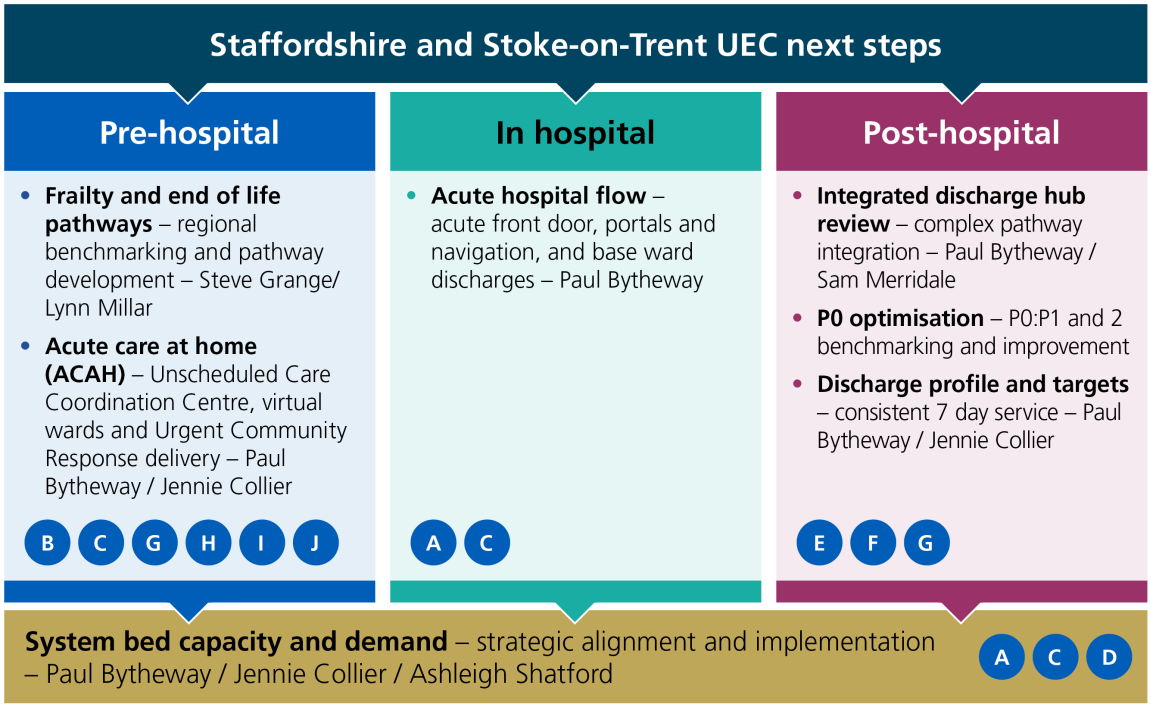
UEC recovery and delivery

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

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

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

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



	Work Programmes
A	**Additional hospital bed capacity** – additional acute bed capacity to meet immediate pressures and reduce bed occupancy, but also help meet demand for health and care
B	**Increase ambulance capacity** – working with ambulance services and systems to provide additional capacity and divert patients to alternative services where appropriate, including for mental and community care
C	**Improving processes and standardising care** – working with partners to standardise care at the ED front door including for mental health patients. Improving patient flow in and out of hospitals, including embedding fully functional bed management and system control centres (SCCs)
D	Immediate action to **improve health and wellbeing**, support and retention and expand UEC workforce, as well as to ensure the workforce is in place to meet acute expansion and community service transformation
E	**Improving joining discharge processes** – support roll out of Transfer of Care Hubs with improved assessment and planning processes
F	**Scaling up intermediate care** – evaluation of the Frontrunner Programme and a new planning framework and national standard for rapid discharge into intermediate care
G	**Scaling up social care services** – working with local government and social care providers to optimise access to social care, including through continued use of the Better Care Fund
H	**Expanding and better joining up new types of care outside hospital** – standardisation and spread out-of-hospital services, including urgent community response, falls services, enhanced nursing homes support and the High Intensity Users programme
I	**Expand Virtual Wards** – scale up capacity for frailty and acute respiratory infection through greater standardisation and utilisation. Implementation of new pathways and appropriate models of virtual wards
J	**Review NHS 111 services**, including greater alignment with primary care, 111 online and trailing 111 first. Increasing access to clinical assessment in 111 in particular for paediatrics, and potential expansion of urgent treatment centres, where most effective

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

- Progressing the business case to provide 50 additional beds at Royal Stoke University Hospital

- A full review of the use of virtual ward beds for both admission avoidance and early supported discharge, to allow patients to get the care they need at home safely and conveniently, rather than being in hospital
- Promotion of acute care at home as an alternative to hospital admission
- A full review of our pre-hospital Access programme with a particular focus on NHS111 provision
- Working with our acute hospital providers on the UEC improvement programme to improve acute hospital flow, deliver the 76% ED waiting times standard, the 92% bed occupancy target and reduce ambulance handover delays
- Assessment of the options and proposals for fully accredited Urgent Treatment Centres (UTCs) aiming to move to full accreditation in 2024. This will be supported by our Strategic Transformation function and will include an options appraisal process to identify which of the current urgent care portals meet the principles and standards for UTCs. Further data analysis and impact assessments will be undertaken to inform and shape the proposals and options for delivery of UTCs
- Delivering a fully integrated discharge 'hub' with physical co-location at the University Hospitals of North Midlands NHS Trust (UHNM)
- Improving our number of discharges and achieving a consistent 7-day service for both UHNM and the University Hospitals of Derby and Burton NHS Foundation Trust (UHDB)
- Utilising the Better Care Fund monies over 2023/24 and 2024/25 to prioritise schemes that are most effective in supporting discharges over a 7-day period.

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

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

- Full accreditation of our UTCs
- The re-procurement of our Clinical Assessment Service
- Increasing use of our 111 service.

Collaboration with partners

Working as a portfolio gives us an opportunity to join things up and look beyond existing pathways and organisational boundaries to do something different. In the 2022/23 Winter Planning process we ensured all planning within the portfolio was agreed at system level, with mutual ownership across our partnership. This approach will be embedded as part of our way of working in the future.

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

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

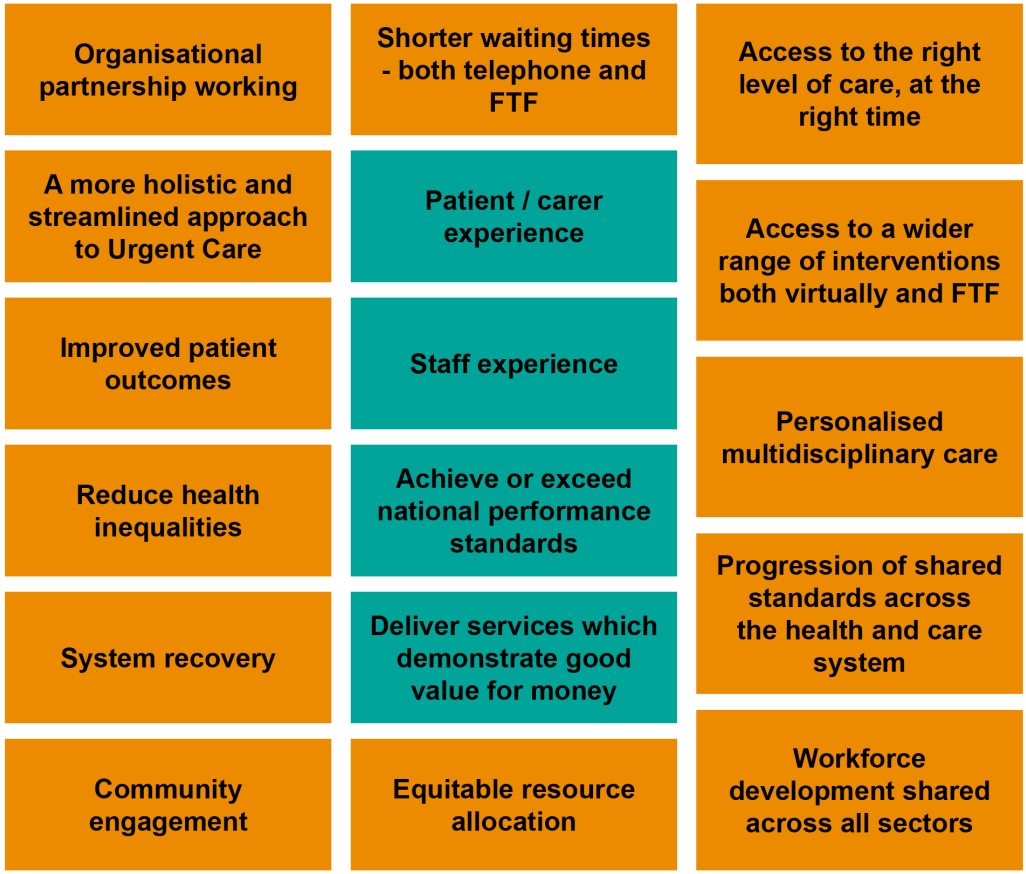
While our plans and strategy are in progress, we also need to maintain a tight operational grip on the daily UEC pressures. The ICB has developed its operational resilience to ensure that we can react to urgent care pressures and respond accordingly. This will largely be achieved through System Control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

How will we know we are making a difference?

We will have:

- Improved ED waiting times so that no less than 76% of people are seen within four hours by March 2024, with further improvement in 2024/25, and 12-hour ED waits have been reduced to 0
- Supported partners to improve category 2 (a serious condition, such as stroke or chest pain, which may require rapid assessment) ambulance response times to an average of 30 minutes or less on average over 2023/24, with further improvement in 2024/25 towards pre-pandemic levels
- Improved ambulance handover times in ED
- Reduced how many adult general and acute (G&A) beds are occupied to 92% or below
- Reduced emergency admissions, with more people supported by Urgent Community Response (UCR) services and integrated urgent care services, meeting or exceeding the 70% two-hour UCR standard to avoid hospital admissions and enable people to live independently
- Achieved 80% utilisation of virtual wards by September 2023
- Improved the number of discharges on Pathway 0 (a simple discharge) to 80%
- Improved our number of discharges and have a consistent 7-day service
- Expanded mental health crisis care provision for all ages, including improving the operation of all age 24/7 crisis lines and mental health liaison services in acute hospitals
- Made urgent mental health support universally accessible by using NHS 111 and selecting ‘option 2’ by April 2024
- Ensured that all partners are working together to improve hospital flow
- Increased the number of services delivered closer to home.

Below is a visual representation of the quality outcome measures for UEC. The teal boxes represent the core goals, and the orange boxes represent the specific outcomes which flow from the core goals.



CASE STUDY

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

End of life, long-term conditions and frailty (ELF)

Our commitment – Steve Grange, Senior Responsible Officer

Our portfolio is committed to high-quality, person-centred care pathways and culture. Our outstanding leadership and clinical governance will drive and improve the delivery of high-quality person-centred care for our end of life, long-term condition and frailty (ELF) pathways. We aim to drive the prevention agenda forward using a co-produced, multi-agency 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 that the right partners at the right times are at the helm of everything we do, and that people are at the heart of the portfolio.

Ambitions

Population insight and population health management (PHM)

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

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

Clinical insight

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

ELF Portfolio Clinical Improvement Groups

Understand Staffordshire and Stoke-on-Trent population needs	**Provide clinical and professional leadership to support recovery and transformation through collaboration across the ICS**	**Ensure improvement and effectiveness measures are bulit into new services**
Establish 'task and finish' working groups, as appropriate, to take forward elements of the work programme	**Review natioanl, regioanl and local guidance and best practice - GIRFT / NICE / baseline data / national strategy**	**Establish and use effective quality improvement methodology**
Define interdependencies with other ICS Portfolios and work together on shared priorities	**Use a population health management approach to defien priorities and outcomes to inform the clinical strategy**	**Align with the Integrated Care Partnership Strategy and Joint Forward Plan**

Digital

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

Palliative and End of Life (PEoL) care

Our ambition is to work together to enable everybody to have the care and support to allow them to live to the end in the best way that they can. The ICP Strategy has a focus on the five stages of life including 'Ending Well', and includes the following as a priority for our system:

We will maximise health and wellbeing in the last years of life by supporting people and carers with personalised care when needed.

High-quality palliative and end of life care is important to ensure that people, their family and carers all have access to appropriate support.

Together we will focus on enabling:

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

To achieve this, we will progress on:

- Offering personalised, high-quality end of life care for people
- Reducing preventable emergency hospital admissions at the end of life.

Long-term conditions (LTCs)

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

The NHS Long Term Plan published in 2019 identified cardiovascular disease (CVD), stroke and respiratory disease as clinical priorities. Our plans for CVD, diabetes and respiratory disease include the development of Clinical Improvement Groups and a strategy to improve the health outcomes and quality of life for all those living with or at risk of these conditions. CVD and respiratory conditions are also explicitly referenced in the ICP Strategy, with a focus on preventing premature mortality from CVD and respiratory disease.

Frailty

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

Interdependencies with other portfolios

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

- Falls – urgent and emergency care (UEC) and care homes
- Virtual wards – UEC
- Palliative care conversations – primary care and care homes
- ReSPECT Documentation – primary care and UEC
- Long-term conditions – planned care, primary care and Improving Population Health

We will aim, where appropriate, to work in conjunction with other portfolios.

Why is this important for our population?

Ongoing patient and public involvement has made clear that our population needs access to health and care at the right time, in the right place and through right pathway to ensure their needs and wants are achieved. Our portfolio aims to achieve this through robust pathways and transformation to meet their needs.

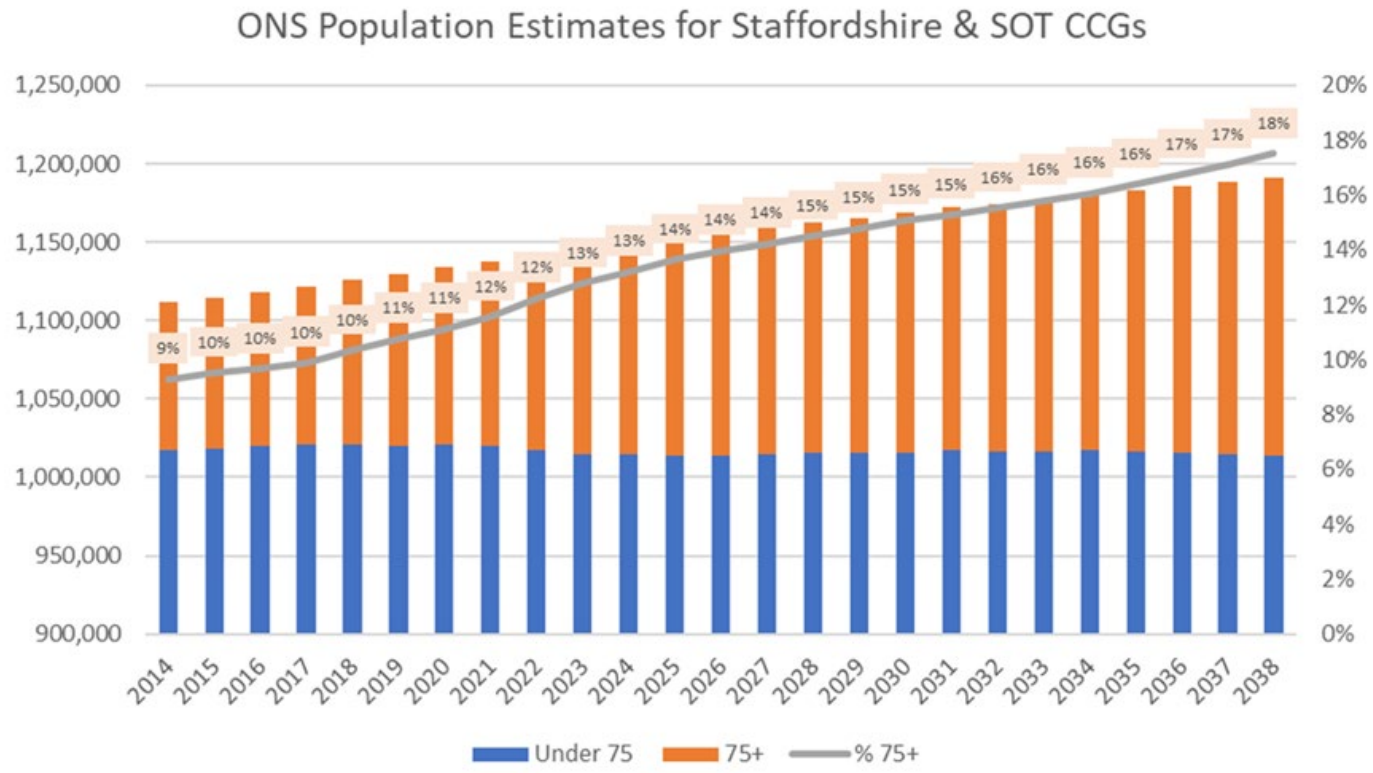
Many parts of the health and care system fail to sufficiently improve the quality of life of older people and those with a long-term condition. We know that people at the end of their life and their carers may not always have access to the consistent and personalised care that they require and that there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

What do we know about people's local experiences?

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

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

The graph below shows the scale of the frailty demand rising year on year. This data was collected prior to the formation of the ICB. We aim to reduce the rate at which this growth occurs and ensure we have robust service pathways in place.



How do we plan to make a difference?

To manage this increasing level of demand within available budgets will be challenging. We want to engage with our partners in supporting preventative approaches (for example, Core20Plus) and listen to people's experiences to understand how we shape services to maximise their impact.

The ELF portfolio framework (see diagram below) aims to ensure a consistent and comprehensive approach to foresight, thinking and planning, so that we develop the right strategy and plans for delivery.

ELF Portfolio Framework

STRATEGIC FORESIGHT ▶ **IDENTIFY DRIVERS FOR CHANGE**

- National and local drivers e.g. Integrated Care Partnerships (ICP) Strategy
- Data driven-Population Health Management and Needs Assessments, Demand and Capacity Modelling
- Challenges - health inequalities, financial balance, workforce, sustainability, demand

STRATEGIC THINKING ▶ **SYSTEM INTELLIGENCE**

- Identify who does this well
- Confirm the values and vision which drive the ELF Portfolio
- Identify ELF priorities - 1 year, 2 years... 5 years
- Develop stretching but realistic outcomes

STRATEGIC PLANNING ▶ **CREATE ACTIONABLE PLANS**

- Identify mechanisms to deliver change
- Identify measurable outcomes and metrics
- Create robust governance structure
- Explore the appetite for change
- Identify resources
- Identify interdependencies
- Embed Programme Management approach

OBJECTIVES

- ELF Portfolio and Programme structure agreed
- Needs Assessment for PEoLC and LTCs published
- ELF Portfolio Strategies dveloped based on Needs Assessments
- Priorities identified and agreed
- Delivery Plans developed

We will use this framework to implement a portfolio of work to address the challenges we are facing. At the moment this consists of the identified workstreams below – but our strategy and plans will evolve.

Palliative and End of Life Care (PEoLC) Programme

We aim to deliver outcomes for Staffordshire and Stoke-on-Trent patients and carers which match the national ambitions for palliative and end of life care:

We will achieve this by:

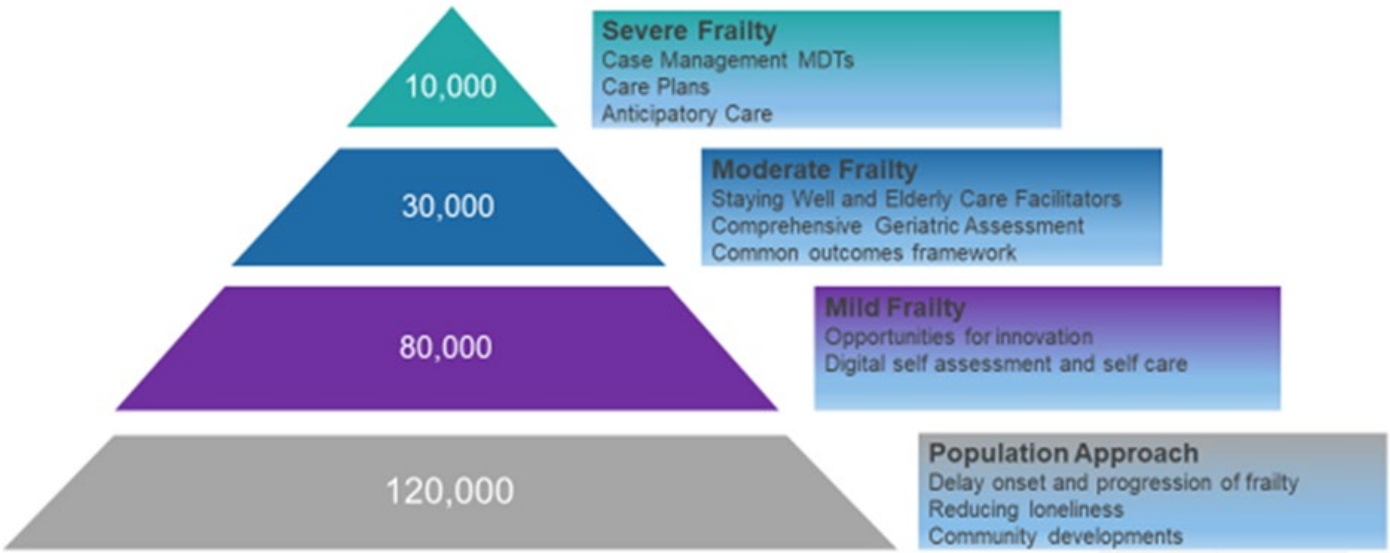
- Ensuring that providers of health and care services work in a collaborative way
- Developing a comprehensive needs assessment which will identify key demographics, use predictive modelling, compare current performance with 'what good looks like', and highlight inequalities
- Developing a comprehensive strategy for palliative and end of life care
- Identifying and establishing projects for delivery against the ambitions and reflecting national guidance.
- Our work will include focusing on:
- 24/7 access including Co-ordination and Advice Line
- Access and availability of palliative care medication – reviewing what medication is available at what times and mapping the risks and opportunities
- Improving identification of people in the last year of life, acknowledging that timely identification of people approaching the end of life allows for conversation, planning and prioritisation
- The number and quality of the Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) plans completed. The plans support holistic personalised care planning by giving people an opportunity to share what matters to them most
- Workforce and training, looking at workforce capacity, skill mix, training and professional development, including identifying if there is access to appropriate training for community assets
- The compassionate communities approach and learning from implementation in the Cannock area of Staffordshire to be considered under PEoLC Programme Ambition 6 – 'Each community is prepared to help'
- Having the right stakeholders at the helm of our programmes of work at the right time, such as the hospices and community end of life services running our clinical improvement groups.

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

Frailty Programme

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

Opportunity to slow progression of mild frailty



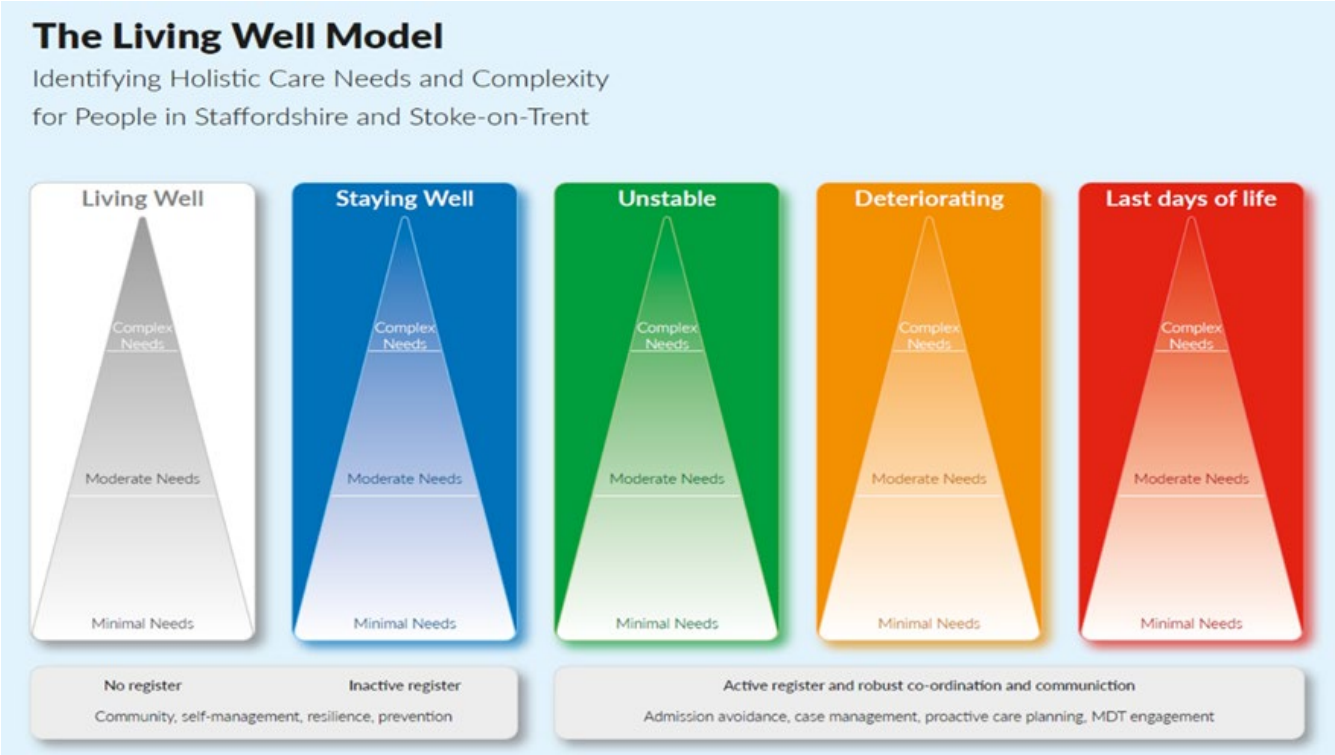
We will progress with our aims to delay the onset of frailty and slow down its progression. We will:

- Deliver the Frailty Strategy through detailed plans including development of a healthy ageing and prevent / delay frailty plan
- Implement the Loneliness Reduction Plan to create more connected and ‘age-friendly’ communities of people and professionals
- Agree and roll out a system-wide Quality Outcomes Framework to improve the quality of life/timely access to integrated support for people living with frailty
- Develop quantifiable goals to reduce health inequalities and improve healthy life expectancy
- Use PHM approaches and predictive modelling to assess impact of delivery options on resources and health outcomes
- Provide needs assessments for the strategy at different levels (local communities, primary care networks and local authorities)
- Consider how the enabling functions of workforce, digital and estates can support better integration of this programme with other transformation programmes.

Long-term conditions (LTCs)

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

The work on LTC pathways will encompass prevention to end of life. We will use the Living Well Model (shown in the diagram below) to support the development of disease pathways and enable new ways of integrated working.



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

- Ensure that providers of health and care services work in a collaborative way
- Develop a comprehensive needs assessment which will identify key demographics, use predictive modelling, compare current performance with 'what good looks like', and highlight inequalities
- Develop a comprehensive LTC strategy, reflecting the ambitions in the Long Term Plan and ICP strategy, using a PHM approach to improve health outcomes, reduce health inequalities and reduce disease progression in cardiovascular disease, diabetes and respiratory disease. This will be scoped against national guidance including the Long Term Plan. We will also work with other portfolios to ensure that all interdependencies are identified and considered as part of the strategy development
- Identify and establish projects for delivery against the LTC strategy, reflecting national guidance.

Across the duration of this plan, we will:

- Ensure as many people living with diabetes as possible receive their eight (nine) care processes (diabetic annual health checks) and improve the proportion of diabetic patients achieving the three treatment targets in relation to blood pressure, HBa1c and lipids
- Reduce the number of foot ulcers and amputations resulting from diabetes
- Improve care through the National Diabetes Prevention Programme and increase uptake for people living with diabetes, particularly through structured education classes, recognising that type 1 and type 2 conditions require different information, advice and support
- Improve rates of accurate diagnosis of chronic obstructive pulmonary disease (COPD) to achieve early intervention and support the patient through their journey
- Improve access to pulmonary rehabilitation, making services more accessible and sustainable, and meeting quality assured national standards
- Work with other portfolios to identify and consider their interdependencies and the impact on people at risk of developing or living with LTCs such as:
- supporting the uptake of health checks for people with SMI to support improvements to their physical health

- supporting the delivery of a joined-up weight management approach. This would put in place both preventive and treatment strategies for people who are overweight or obese, or at risk of becoming so, and who may be at risk of developing LTCs.

How will we know we are making a difference?

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

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

We need to 'measure what matters' and not make assumptions regarding what the data is telling us. We will ensure clinical and other expertise frames the key metrics we use to measure performance.

End of Life

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

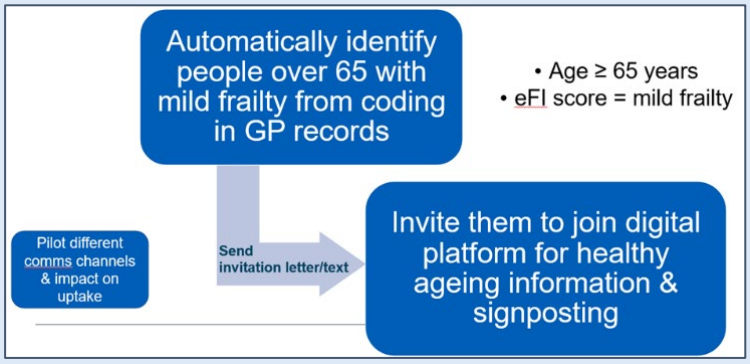
Frailty

- 10% increase in uptake of all preventative services offered to people who are deemed 'preventable' or 'mild' on the frailty scale by 2028
- 10% increase in the number of people with severe frailty who have a completed ReSPECT document and an anticipated care plan
- Health Navigator service offer to identify 2,000 people at risk of hospital admission with a 5% reduction in the cohort
- Ensure 70% of people enrolled for pulmonary rehabilitation go on to complete the programme and have a discharge assessment
- Increased number of our population achieving the eight care processes for diabetes care
- Patients who are identified as having a 20% or greater increased chance of developing cardiovascular disease are treated with statins
- Atrial fibrillation – 10% increase in screening/identification (pulse check).

CASE STUDY

Piloting a digital tool to support self-management of mild frailty

- Frailty is associated with reduced mental and physical wellbeing, quality of life and independence. It is also associated with increased health and care needs, risk of admission and risk of death
- There is an opportunity to slow progression of mild frailty. Digitally guided self-management is considered to be a cost-effective way to reach a large group of people and encourage a proactive approach to healthy ageing. It is associated with a delay in the progression of frailty and the reduced quality of life that it causes, and therefore a delay in need for health and care services
- In 2023 we will pilot a digital health education tool for people with mild frailty, using the following process:



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

✓ The pilot evaluation will seek to find out the following quantitative and qualitative measures:

1. Number of people accessing the online platform
2. Number of people accessing the online platform from different parts of the community and the impact of promotional methods
3. Focus groups with samples who do and do not take up offer
4. Reasons for engaging/not engaging
5. Views on communications, platform and content.

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

Timelines

2023: Pilot with mild frailty sample

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

2024: Begin roll out to mild frailty cohort

✓ Cohort of 80,000 across Staffordshire and Stoke-on-Trent
✓ Use pilot results to guide strategies to improve reach/reduce inequalities

2025 and beyond

✓ Consider cluster randomised control trial (RCT) to measure 'triple bottom line' (social, environmental, economic) health outcomes, service use, carbon footprint.
✓ Consider extending offer to healthy over-65-year-olds.

Primary care

Our commitment – Chris Bird, Chief Transformation Officer

This is an exciting time for primary care. We will soon publish a General Practice (GP) Strategy, developed in partnership with general practitioners (GPs), which sets out a shared ambition to improve access, experience and outcomes for our population. This comes as the ICB takes on delegated responsibility for other elements of primary care including dentistry, pharmacy and optometry. This means that, for the first time, the service planning and delivery of all aspects of primary care will be together in one place – offering us a huge opportunity 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. We want to increase their profile across the ICS and offer a tangible demonstration of how they can improve services to our communities.

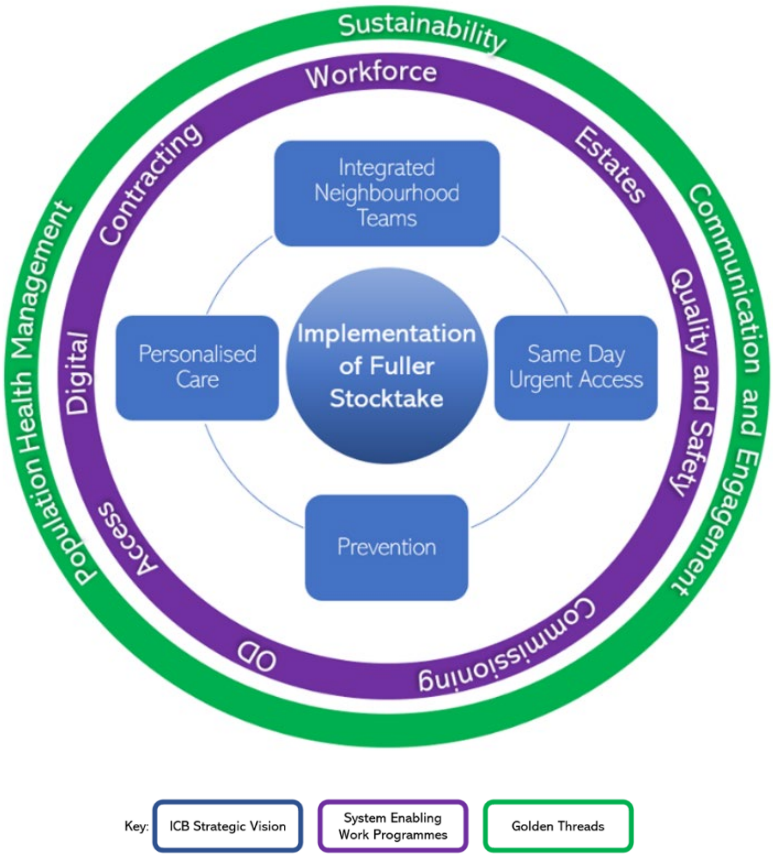
Ambition

Our General Practice Five-Year Forward Strategy is based on a vision of our population having equal access to high-quality services and more choice over where, when and how they access a consultation with a range of professionals. We want people with the most complex needs to have more time with their GP, supporting their continuity of care. We want to empower our population and support self-care, leading to happier, more independent lives. And we want care to be delivered closer to home, with general practice at the core of a revitalised approach to the delivery of integrated working.

Our vision is dependent on integrating actions from the four building blocks in the Fuller Stocktake (NHS England » Next steps for integrating primary care: Fuller stocktake report) into our existing eight key enabler programmes. The four building blocks are:

- same-day urgent access
- integrated neighbourhood teams
- prevention
- personalised care

There are also three ‘golden threads’ that will run through the work we do with general practice: sustainability, population health management and communication and engagement. All these elements are shown in the diagram below.



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

The strategy will be supported by metrics and monitoring through a primary care portfolio dashboard and a three-year benchmark report of practice, and through PCN, ICS and national average level data. We are also developing a practice and PCN maturity matrix (a self-assessment tool) highlighting variation across key indicators. This will help us to target approaches and support.

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

Why is this important for our population?

Primary care remains the first point of contact for many people seeking health services in their local community. It plays an important ‘gatekeeper’ role, ensuring as many people as possible receive the care they need close to home. Primary care can often act as an advocate for patients, as well as co-ordinating their care. GPs and their teams make up the vast majority of NHS contacts that take place. In doing so, they alleviate pressure in other parts of the health service, including emergency departments.

Demand for health and social care services is rising – a quarter of the population experience long-term conditions. These may be related to age, or circumstances associated with (or worsened by) stress, diet, activity levels, alcohol, smoking, air quality, poverty, isolation, or poor housing. People with long-term conditions such as diabetes, chronic obstructive pulmonary disease (COPD), arthritis and hypertension

account for around 50% of all GP appointments. While workloads for our health and care professionals are high and increasing, workforce recruitment and retention challenges have been deepening across primary care.

Our general practitioner numbers continue to decline. The challenge in recruiting and retaining GPs is well documented and has lots of causes, including an ageing workforce and work pressures in primary care. Not enough medics are attracted to the profession, and too many who do train are choosing to work in other areas, including abroad. Mitigations such as skill mixing, workload initiatives and redirecting workflow are in place, plus national and local schemes to support recruitment and retention. By working with registrars, GPs, practices, primary care networks and clinical leads, we aim to retain GPs wherever possible, while also creating a robust pipeline of newly qualified GPs.

There are also risks around the numbers of practice nurses, with many retirements likely to be seen over the next five to ten years. There are initiatives and plans in place to attract and retain staff and ensure we have the skills and expertise needed.

We have made good progress in recruiting for alternative roles as part of the Additional Roles Reimbursement Scheme (ARRS), with an additional 475 (headcount) recruited since 2019. The roles include clinical pharmacists, physicians' associates, social prescriber link workers, care co-ordinators and paramedics. The variety of roles creates a multidisciplinary approach to the delivery of general practice care and develops collaborative work across the health and care system. This will support with the implementation of the Fuller Stocktake, particularly in relation to same-day urgent access, allowing GPs to focus on continuity of care for those with more complex needs.

Despite the challenging workforce backdrop, numbers of appointments have continued to increase. Nearly 5.8 million appointments were delivered between November 2021 and October 2022. This is an increase of 16% since pre-COVID days. Over 75% of the appointments were delivered face to face.
It is vital that our population understands how the model of general practice is changing, and that people understand the new workforce models, so they can have confidence in this approach.
We also need to maximise the potential of digital solutions, while bearing in mind the need for digital inclusion, so that no patients (or staff) get left behind.

What do we know about people's local experiences?

Access to general practice remains one of the highest priorities for our communities.
The National GP Patient Survey in 2022 told us that:

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

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

A large proportion of general practices have input from Patient Participation Groups (PPGs). These are groups of patients who want to be involved in improving their local general practice services. We will continue to use our PPGs to gain valuable insight and support practices in gathering more local real-time feedback, which they can use to shape improvements. Locally we are also seeing primary care networks (PCNs) having combined PPGs across groups of practices.

How do we plan to make a difference?

Our population will experience:

- More integrated, personalised and flexible care through the implementation of the four building blocks of the Fuller Stocktake and outputs from our eight key enabler programmes
- Good access to general practice by improving location, times, ease of arranging appointments through digital support, and speed of access to a range of health professionals
- An equitable approach to general practice provision, including a consistent offer of local enhanced services for our population
- Reduced variation in care, services and outcomes.

Our practices will:

- Work in partnership on the existing work programmes to tackle the challenges around recruitment and retention of the workforce (including maximising the opportunities of the Additional Roles Reimbursement Scheme). They will address workload pressures through initiatives such as care navigation and use of the Community Pharmacy Consultation Scheme (CPCS).
- Receive consistent training and development, as well as health and wellbeing initiatives, to support their workforce
- Be supported to have a strong voice within the system
- Engage in PCN estates planning and Cloud Based Telephony review to inform the system estates planning and access programme
- Be able to engage with research and innovation groups and studies – which helps keep primary care clinical staff in the region
- Have access to high-quality digital tools such as online consultation, messaging and booking tools.

How will we know we are making a difference?

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

CASE STUDY – Our access programme

- ✓ Working with system partners, we are identifying and developing solutions to allow patients to access care using a variety of methods, professionals, and new technology. This includes how we maximise the opportunities of the general practice skill mix as part of the Additional Roles Reimbursement Scheme (ARRS) and communicating an understanding of these roles to our population.
- ✓ All 25 PCNs have implemented enhanced access, which is part of a standardised and better understood access offer for patients as part of routine services. The offer is providing appointments between the hours of 6:30pm to 8pm, Monday to Friday, and between 9am and 5pm on Saturdays. For our local population, this equates to an additional 1165 hours of access to general practice every week.
- ✓ 43% of practices have already participated in an NHS England Accelerate Access Programme (cohorts 1–5, awaiting details for cohort 6). This aims to support practices to smooth patient flow, understand patient and staff experience data, and involve the Patient Participation Group (PPG). The programme provides digital support including website design as well as extracting and understanding demand and capacity data to develop improvements.
- ✓ As part of our Access Programme, we are embarking on a piece of work focused on capacity and demand. We will be working with a leading behavioural change expert to develop a unique capability in supporting organisations to influence patterns of demand through changing or 'nudging' behaviours. This work uses a range of techniques, with foundations in psychology and economics, to influence people without forcing them or removing choice. It will support us during 2023/24 to trial methods of influencing the demand on primary care, improving access and reducing inequalities. We expect this approach to deliver tangible results.

CASE STUDY - Research

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

Pharmacy and Medicines Optimisation

Our commitment

Locally the Pharmacy Leadership Group brings together professionals from primary, secondary and community care who are united in delivering better pharmaceutical care for the population. National strategies have led to a significant increase in clinical pharmacy teams working in general practice and the expansion of the role of the community pharmacist. These national changes bring opportunities to innovate and deliver medicines-related outcomes at scale. The pharmacy leaders across the different professional sectors have a shared commitment to realise the benefits from these opportunities.

Ambition

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

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

Why is this important for our population?

Using medicines is the most common healthcare intervention but we have national and international evidence that the way medicines are used is suboptimal. Our ambitions around antimicrobial prescribing, medicines safety and the impact of use of medicines on the environment are based on this type of evidence.[2] [3] [4]

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

Integrated community pharmacy services

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

Antimicrobial stewardship (AMS)

AMS entails measuring and improving how antibiotics are prescribed by clinicians and used by patients. Improving antibiotic prescribing and use is critical if we are to effectively treat infections, protect patients

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

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

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

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

[5] The National Patient Safety Improvement Programmes

from harm caused by unnecessary antibiotic use, and combat antibiotic resistance. This is not a new priority, but with the challenges of the COVID-19 pandemic and the aftermath, which saw a hike in other viral infections, the use of antibiotics has increased. We need a renewed emphasis on driving the right use of antimicrobials across the system.

Medicines safety

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

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

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

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

Shared care medicines

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

Carbon impact

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

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

Drugs budget

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

Pharmacy workforce

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

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

What do we know about people's local experiences?

We will continue to engage with our population to understand their experiences of access to treatments. However, prescribing-related PHM data has already shown us where we need to make improvements:

- Prescribing level of medicines for minor conditions through general practice is one of the highest in the country. Providing access for treatments for minor conditions via community pharmacy would release valuable capacity in general practice to deal with more serious conditions
- Potent lipid lowering drugs that have been approved recently by the National Institute of Clinical Excellence (NICE) are not routinely available in primary care, which means that patients are having to wait longer to get the right treatment via specialists in secondary care
- We know hypertension in our area is under-diagnosed and yet we are not making sufficient use of hypertension case finding service in community pharmacy
- The prescribing level of antibiotics across the ICS is one of the highest in the country. Last year we carried out audits in general practice – 118 practices participated, and 1,992 patient records were audited, which showed a low threshold for prescribing of antibiotics and a significant level of non-adherence to national recommendations for choice and dosage of antibiotics
- Our audits on prescribing of certain high-risk drugs showed that systems are lacking across both primary and secondary care to ensure that patients are advised appropriately about the risks associated with taking their medicines and that there is prompt follow-up and review
- Polypharmacy is a term that is used for patients taking multiple drugs. Various prescribing measures show that we have high levels of polypharmacy in our area. Overprescribing itself can have a negative effect on mental and physical health.

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

How do we plan to make a difference?

- Integrating community pharmacy services into the wider Staffordshire and Stoke-on-Trent health and care services to support our population to access primary care services

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

How will we know we are making a difference?

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

Mental health, learning disabilities and autism

Our commitment – Ben Richards, Senior Responsible Officer for Mental health, learning disabilities and autism

We are well on our journey to make mental health, learning disabilities and autism everyone's business. Over the coming year we will put our investment in perinatal mental health, mental health ambulance provision and children's autism services into operation, while still progressing our community mental health transformation and Transforming Care (for patients with a learning disability) programmes to deliver effective care for patients.

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

Mental health

Ambition

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

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

The vision for mental health, learning disabilities and autism is to ensure older people, adults, young people and children feel supported, whether they find themselves in need of help in crisis or to maintain their day-to-day mental health and wellbeing.

Why is this important for our population?

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

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

Our work around models of future mental health needs suggests that nearly 200,000 adults in Staffordshire and Stoke-on-Trent are currently experiencing some anxiety, an increase of nearly 33,000 from before the pandemic. And an additional 113,000 adults are estimated to be experiencing some level of depression, although we do not know how many of those experiencing anxiety and/or depression will present themselves to their local mental health services. It could therefore take several years before the full impact is known. It is estimated that 10% of known psychosis patients will relapse in the first six months, increasing to 20% between six and 12 months. This equates to just over 900 patients in the first six months, increasing to over 1,800 by 12 months. A further impact of the COVID-19 pandemic is the increase in the number of adults who will develop prolonged grief disorder, estimated to be 535 adults.

What do we know about people's local experiences?

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

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

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

- In young people aged 17 to 19 years, rates of a probable mental disorder rose from 1 in 10 (10.1%) in 2017 to 1 in 6 (17.7%) in 2020.

Across Staffordshire and Stoke-on-Trent:

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

How do we plan to make a difference?

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

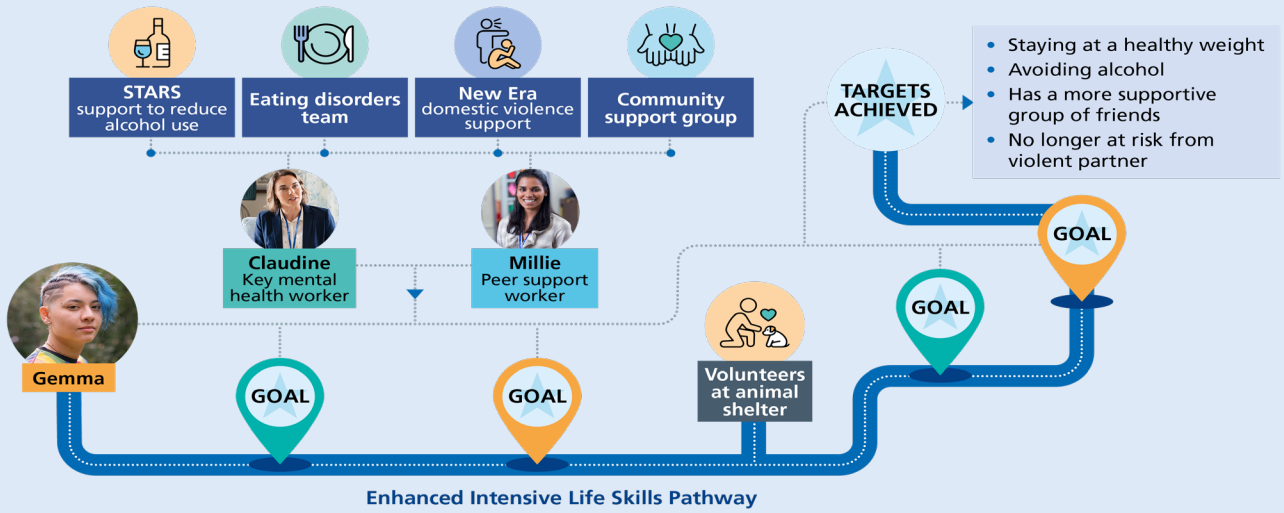
We will focus on:

- Improving access to talking therapies, for people with anxiety and or depression, including for women accessing perinatal mental health services, and those with serious mental illness (SMI)
- Extending the period of care for women accessing perinatal mental health services
- Deliver support that is personalised and within a person's local area
- Using assets within communities with an emphasis on self-management and recovery
- Increasing the number of people receiving SMI physical health checks
- Increasing the number of adults who have access to Individual Placement and Support
- Integrating models of support configured around the primary care networks (PCNs)
- Implementing systematic best practice reviews to ensure quality of services
- Implementing a whole systems pathway supported by structured clinical management for people with a 'personality disorder'
- Ensuring more children access evidence-based treatment
- Implementation of crisis and home treatment provision across the life course
- Ensuring eating disorder provision meets commissioning guidance across the age span
- Eliminating inappropriate out of area placements and an improved therapeutic offer in inpatient settings
- Reducing the number of suicides and increasing bereavement support available
- Improve the dementia diagnosis rate
- Working with patients and staff to redesign our local inpatient mental health services. This includes the inpatient mental health services that were provided at the George Bryan Centre in South East Staffordshire. We made some temporary changes to services when the George Bryan Centre had to close in 2019 and are now proposing to make these temporary changes permanent. The consultation for this has now closed. The findings from the consultation will be considered and developed into a decision-making business case (DMBC) for consideration by the ICB Board.

How will we know we are making a difference?

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

CASE STUDY



Enhanced Intensive Life Skills Pathway

- ✓ Gemma is 24. She has a diagnosis of depression and anorexia. She experiences overwhelming emotions and mood swings. She sometimes self-harms and does unsafe things like binge drinking. Gemma suffered childhood sexual abuse and she has some physical health problems. She has a poor appetite and poor sleep. She goes to a community group which she finds helpful. She is also experiencing domestic violence and has been assaulted by her partner.
- ✓ In the past, there was a risk that someone in Gemma's situation might be seen by mental health services on an ongoing basis, with lots of re-referrals, but without much improvement and with no end in sight.
- ✓ To make progress, Gemma needs a clear treatment pathway with goals and an end point. She also needs the right specialist help.
- ✓ Gemma contacts the ACCESS team who complete an assessment. They feel Gemma would be helped by the Enhanced Intensive Life Skills pathway. This will help her learn skills and strategies to manage her symptoms and meet the goals she sets. For example, she will learn ways to understand healthy relationships, helping her to build a more supportive social circle.
- ✓ Gemma has a mental health worker from the team, who will coordinate her care. She has a peer support worker, who has had similar mental health difficulties and uses her experiences and empathy to support others.
- ✓ Gemma and the teamwork out the goals she would like to meet to manage her symptoms. They explore which specialist services could help her meet her goals.
- ✓ Gemma agrees to see all the services suggested by the team. With support from Staffordshire Treatment and Recovery Service (STARS), Gemma begins to drink less alcohol. She uses her new skills to control her urges to drink and do other risky things.
- ✓ Gemma gets support from New Era, a service that helps anyone affected by domestic abuse in Staffordshire and Stoke-on-Trent. Gemma begins to recognise her self-worth and takes steps to leave her violent partner.
- ✓ Input from the Eating Disorder service helps Gemma stay at a healthy weight. She now has skills to help her keep eating well.
- ✓ She is supported to stay in her community support group. She also starts volunteering at a local animal shelter, which she really enjoys.
- ✓ Although Gemma is getting help from several services, she is not being moved from one to another, which could cause delays and gaps in her care. Instead, they support her at the same time and in a coordinated way. Gemma and her named workers from each service regularly meet to update her care plan and review her goals. She is always involved in the planning.

Learning disabilities and autism (LDA)

Ambition

To make learning disabilities and autism everyone's business, to ensure equal access and reasonable adjustments are considered across all services.

Why is this important for our population?

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

We know that many people with LDA have positive life experiences and outcomes. However, some do not experience the same opportunities that other people take for granted. Our population with LDA is diverse in its needs, and inequality in many forms impacts on health and wellbeing. This is something to which organisations from across the system need to respond.

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

What do we know about people's local experiences?

People with LDA and their families have told us they struggle educationally and can have difficulty in accessing housing, employment, leisure, retail, sport, cultural and religious opportunities in their local areas. They also feel lonelier and more unsafe and can be more vulnerable to crime and abuse. Ten key themes have emerged locally.

Key themes

- There are lower levels of autism reporting in Stoke-on-Trent with potentially 600 children reported with autism compared to statistical peers.
- The LD cohort is growing in Staffordshire with a 17.7% increase in the number of children with Special Educational Needs (SEN) in five years. The LD cohort size is around 40% higher than the national proportion.
- There is variation in completion of annual health checks. Stoke-on-Trent has an 80.6% completion rate compared to south east Staffordshire, where the rate is 61.7%.
- Weight management – this is a younger problem, with peak obesity in men with LD aged between 25 and 34 years whereas peak obesity in men without LD aged 55 to 64 years.
- There is a strong growth in epilepsy demand locally with epilepsy in LD prevalence showing at 22.8% compared to 17.9 % nationally
- There is higher cancer prevalence at 2% for our LDA population compared to 1.5% nationally.
- Acute activity demand is increasing sharply. The four-year growth rate for CYP with autism who need acute care is over 50%.
- Housing strategies lacking focus – strategy documents for housing do not clearly recognise the current and future needs of people with autism and learning disabilities.
- Police crime incidents are increasing for people with autism, with 23% more incidents involving autistic people in 2021 compared to 2020.

- We have data issues to resolve, with a system-wide need for more specific recording relating to people with autism, and better data sharing.

How do we plan to make a difference?

Much work has been undertaken to transform the local offer for people with LDA and their families. But we recognise there is much more to do, which will be achieved through the delivery of our plans in 2023/24 and beyond.

We aim to:

- Reduce health inequalities by:
- improving the uptake of annual health checks
- reducing over-medication through two programmes: Stopping the Over-Medication of Children and Young People with a Learning Disability, Autism or both (STOMP) and Supporting Treatment and Appropriate Medication in Paediatrics (STAMP)
- taking action to prevent avoidable deaths through Learning from Deaths reviews (LeDeR)
- Improve community-based support so that people with a learning disability and autistic people can lead lives of their choosing, in their own homes, not hospitals. We aim to reduce our reliance on specialist hospitals and strengthen our focus on children and young people
- Develop a clearer and more widespread focus on the needs of autistic people and their families, starting with autistic children and young people with the most complex needs
- Make sure that all NHS commissioned services are providing good quality healthcare and treatment to people with LDA and their families. We will make sure reasonable adjustments are made so that people with LDA get access to the support that they need
- Build on the insights and strengths of people with lived experience and their families in all our work
- Become a model employer of people with a learning disability and autistic people
- Make sure that NHS commissioned services have an awareness of the needs of people with LDA, working together to improve the way our services care, support, listen to, work with and improve their health and wellbeing
- Improve understanding of the needs of people with LDA and work together to improve their health and wellbeing through the roll out of the Oliver McGowan Mandatory Training over the next three years.

Our work is arranged around six workstreams for LDA.

- Identification – primary care actions to establish baselines in primary care networks and at place and ICS levels, and undertake health and wellbeing roadshows. This will help us increase the number of annual health checks and the quality of their impact
- Place – working alongside place partners and the VCSE in local communities to ensure housing, education, employment and life opportunities are more accessible and inclusive
- Universal services – dentists, opticians and wider preventative services are accessible to all with reasonable adjustments
- Dedicated care and support – to develop a joint independent sector market with health and social care that is fit for purpose
- Community services – secondary mental health services for people with LDA
- Inpatient settings – checking that inpatient care is appropriate, with the right care locally supporting timely discharge, and reducing reliance on inpatient care where appropriate. Physical conditions and mental wellbeing are part of this workstream.

How will we know we are making a difference?

- 75% of people with LD (aged 14+) will have an annual health check
- People who have been referred to an autism diagnosis service will be waiting no longer than 18 weeks from referral to first appointment by 2024/25

- There will be reduced reliance on inpatient care for people with LDA who are in inpatient care for a mental health disorder
- 100% of LeDeR reviews will be undertaken within six months of notification of death
- Expected high levels of compliance with Oliver McGowan Mandatory Training.

CASE STUDY

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

Why?

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

But a break-through came

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

Cost profile illustration for Tom

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

Our enablers to success

Successful delivery is also reliant on some key enablers and their overarching programmes of work which will support delivery of the Joint Forward Plan. They are set out in this section, which covers Quality Assurance and Improvement, Our People Plan, Digital, Estates, and Sustainability and Delivery of a Net Zero NHS.

Quality assurance and improvement

Our commitment – Heather Johnstone, Chief Nursing and Therapies Officer

Our system is collectively committed to delivering our statutory duty for quality through a programme of quality assurance and improvement activity, with an increasing emphasis on population health and health inequalities. This commitment includes recognition that we are jointly accountable for quality. Our emerging Quality Strategy describes the systems and processes that ensure we monitor the quality and safety of health and care and also strengthen our links to the quadruple aims for ICBs while responding to emerging best practice. Our commitments are intended to ensure our population can access high-quality, safe care and that if things go wrong, they can be assured we will listen, learn and change practice.

Why is this important for our population?

Quality is a golden thread that runs through all the strategies that the ICS develops. This helps ensure a shared understanding of how the vision, goals and values of all organisations need to meet our quality commitments.

How do we plan to make a difference?

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

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

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

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

Across the ICS we work collaboratively to identify early warning signs of emerging issues or impacts. Where routine quality and safety monitoring, soft intelligence and other forms of feedback and review

highlight areas of concern, the ICB's Nursing 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 focused reviews. If these highlight further areas of concern or a lack of plan to address identified concerns, the escalation process outlined in 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 the National Quality Board, our approach to CQI focuses 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. In our ICS, partners have worked to develop a framework and a set of mutually agreed principles. The delivery mechanisms for CQI at a system level include a CQI sub-group that focuses on strategic development and deployment across the ICS and a QI network, which is a joint ICS endeavour with Shropshire, Telford and Wrekin ICS. The QI network brings people together from both systems to learn, share and improve, and it supports some identified system CQI projects. As the system matures and our CQI continues to grow, we will develop an ICS CQI training offer and further embed 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 embedding CQI further across the system, we can also move towards a position where co-production is our default approach to involvement within CQI and the ICS.

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

Our system quality dashboard, alongside portfolio dashboards, focuses on more traditional measures of quality, such as serious incidents and infection prevention and control, as well as quality indicators within the NHS Outcomes Framework. Our ambition is that the dashboard will evolve and reflect current system intelligence, focusing on system-based approaches to learning, outcomes and health inequalities. This will complement our Quality Strategy and cover the breadth of the system's portfolios.

Safeguarding

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

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

Our ambition is for children, young people and adults to feel safe across Staffordshire and Stoke-on-Trent. The ICB Safeguarding Team are working in partnership with the two local Safeguarding Children

and Adult Safeguarding Boards and with providers across health, social care, education, police and the VCSE to ensure the safety and wellbeing of children and adults are at the heart of everything it does.

How will we know we are making a difference?

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

People Plan

Our commitment – Alex Brett, ICB Chief People Officer and MPUFT Chief People Officer

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

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

Introduction

Our system has been working collaboratively from a workforce perspective since 2017. Relationships have formed between NHS, local authority, ICB, primary care, social care and VCSE partners to tackle the workforce pressures at a system level. Following the establishment of the ICB, we have continued to build on our collaborative approach towards delivering the national guidance for ICB people functions (ICS People Function (england.nhs.uk), August 2021) to support a sustainable 'One Workforce' within health and care.

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

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

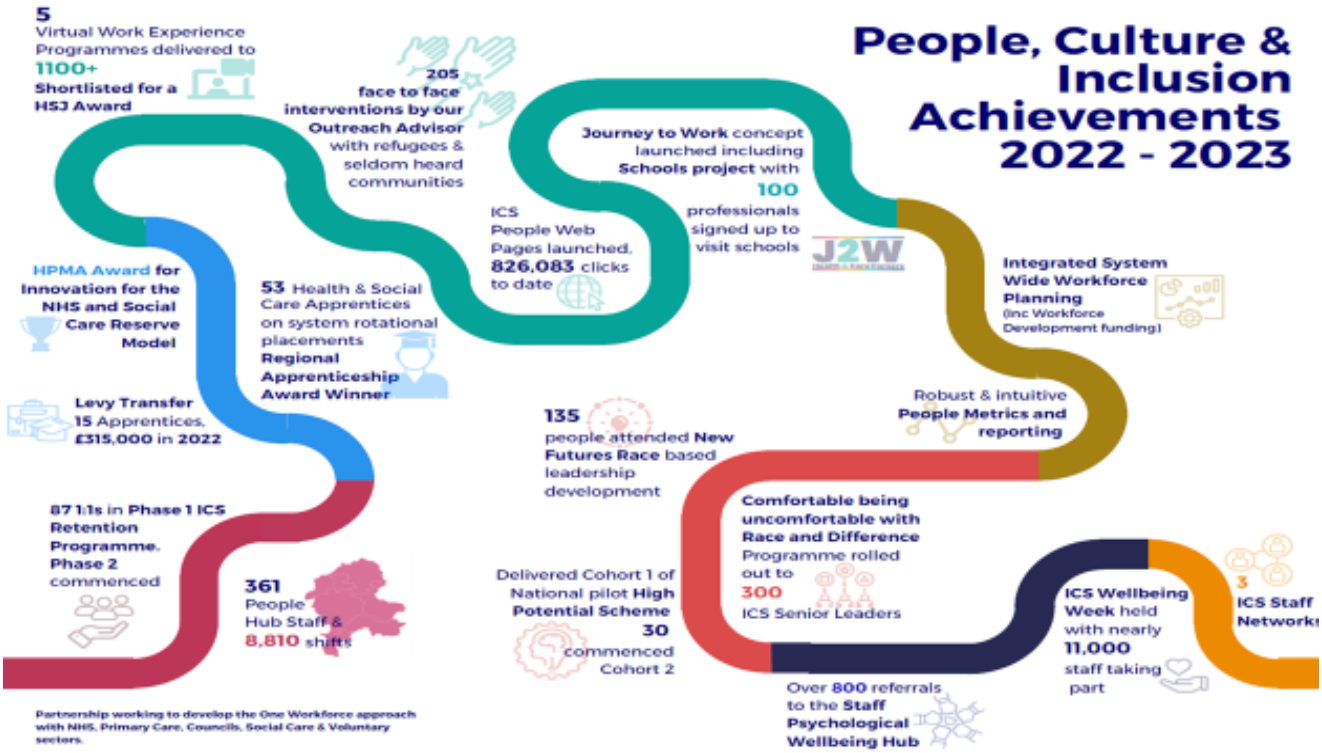
people function will facilitate the development and implementation of this at system level, ensuring it supports the local workforce actions.

Alignment to portfolios and People Operating Model

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

Achievements and current position

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



Our future intentions and operating model

The ICS faces several well-known workforce challenges with the three main challenges being:

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

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

- Robust governance and oversight through the ICS People, Culture and Inclusion Committee
- Embedding our ‘One Workforce’ approach, driven and owned by our workforce

- Creating the right cultural environment for people to thrive, focusing on civility and safe working ethos
- Embedding inclusive cultures, understanding our workforce and building on our achievements in regionally recognised equality and diversity activities
- Building on the leadership and talent offer
- Integrated workforce planning and transformation, including designing new staffing models and roles to deliver treatment and care differently
- Partnership working to improve workforce supply
- Further development and utilisation of the National Healthcare People Management Association (HPMA) award-winning ICS People Hub and Reserves to provide a contingent, flexible workforce at system level
- Development of an ICS New to Care Academy
- ICS Retention programme aligned to national programme objectives while creating local solutions to retain our workforce
- Implementing and embedding the Journey to Work concept with our partners, communities, schools and colleges to build our pipeline, create opportunities for everyone and ensure our workforce represents our local population
- Strengthening our outreach work with refugee, seldom-heard and deprived communities to support and develop people into careers in health and care
- Supporting health and wellbeing through system resources and events, the ICS Staff Psychological Wellbeing Hub and system occupational health contract
- Expanding widening participation activities across all our partners including education engagement, T-Levels, apprenticeships and workplace learning schemes
- Enabling digital workforce transformation and equipping our population with digital skills for self-care and prevention
- Developing our ICS Education, Training and Development strategy.

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

Programme activity					
ICB Chief People Officer	**ICB Chief People Officer**	**NSCHT Chief People Officer**	**UHNM Chief People Officer**	**ICB Chief People Officer**	**NSCHT Chief People Officer**
Workforce supply – recruitment and retention	**Workforce transformation and future pipeline**	**Equality, diversity and inclusion (EDI)**	**Staff experience, health and wellbeing**	**System culture and collaboration**	**Leadership and talent**
ICS People Hub and Workforce Cell Reserves Retention programme System recruitment including international recruitment New to Care Academy Redeployment	Portfolio workforce, planning and transformation Programme delivery – e.g. vaccinations, virtual wards Health Education England funding – including METIP Journey to work – including schools engagement and outreach Education, training and developments – including clinical placements Widening participation – including ICS apprenticeships, workplace learning ICS Strategy – e.g. digital, green	Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) Staff networks Differently-abled buddy scheme Inclusion School EDI training and development – including New Futures, Comfortable Being Uncomfortable with Race and Difference	Staff insights – cross-cutting Staff Psychological Wellbeing Hub Wellbeing resources and events Occupational Health	Delivered by Strategic Organisational Development (OD) Lead and OD Collaborative PCN OD programme OD cultural diagnostic System OD activities	High Potential Scheme Coaching and mentoring – including collaborative, reverse Exec and Senior Leader development – including System Connects, Alumni Scope for Growth career conversation tool

Underpinned and supported by						
Clinical Senates	**Clinical/social groups**	**Workforce planning**	**People metrics**	**Operating Plan**	**Joint Forward Plan**	**Financial Strategy**

Education and training

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

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

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

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

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

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

Strengthening relationships with our local education providers will be fundamental and at the core of the workstream and approach. By working in partnership with education, we will ensure high-quality provision, expand our capacity and improve our future pipeline. We will collaborate on the development of curriculum and courses which meet the needs of our system, while also considering student requirements.

We will focus on how we develop our placement capacity through a specific programme of work, building on the HEE Clinical Placement Expansion programme. We will bring together clinical, professional and education teams to develop a collective approach, share learning to improve and develop the clinical educational offer and experiences for our students. The programme will include:

- scoping the current clinical placement landscape across the whole system – in NHS and private, VCSE and independent sectors
- placement profiling for undergraduate registered and non-registered placements
- considering innovative models of support for learners across a variety of providers to enhance learning and create multi-organisational and diverse placement pathways.

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

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

To support development of our entry routes into education, training and jobs across the system, we are currently implementing and embedding the SSOT Journey to Work concept with our partners, communities, and education providers. This model will capture our approach to widening participation, schools engagement, apprenticeships, community outreach, New to Health and Care Academy models, and retention.

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

The SSOT Reservist programme, which attracts non-registered and registered professionals to support the system during surge and emergency periods, provides an opportunity to maintain clinical and care competencies and supports CPD. This programme includes:

- people returning to practice
- those wanting to try out working in health and care before they take up a permanent position
- a specific project supporting ICB registered staff to work within our providers to maintain their registration while also supporting the quality and service improvement agenda.

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

Digital

Our commitment – Chris Ibell, Chief Digital Officer

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.

Digital transformation

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

Our Digital Roadmap

Digital enablement is transforming health and social care services:

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

Approach

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

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

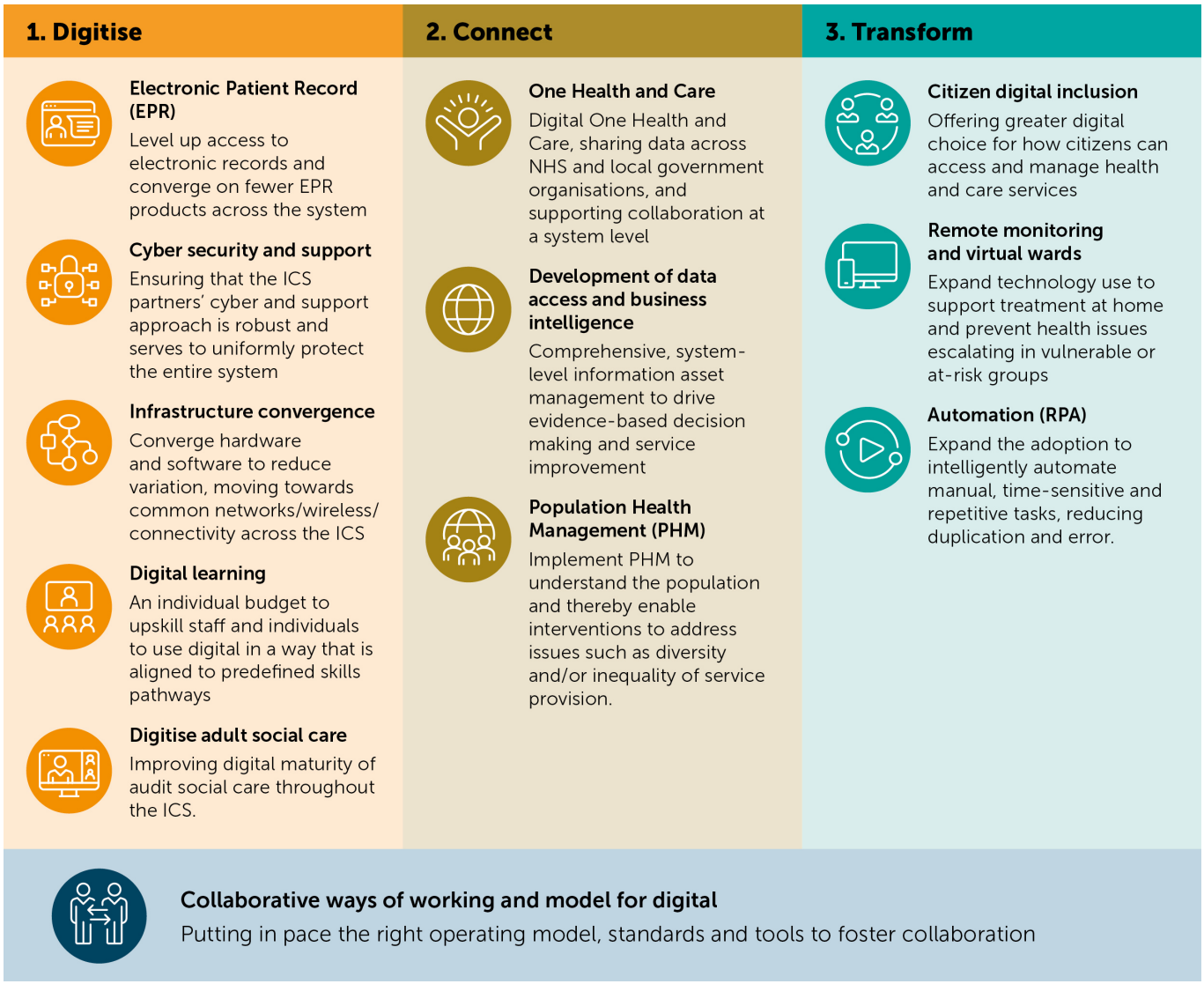
Aim

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

Outcomes

Our digital roadmap will help us to achieve outcomes that will improve the experience of our staff and population. Our digital initiatives are aligned with national aims, local need, our collective ICS goals and ambitions.

Digitise	**Connect**	**Transform**
✓ Meet the minimum level of digital maturity as set out in What Good Looks Like	✓ Connect our staff and organisations to one source of truth for citizen information	✓ Give patients better options to access health and social care services
✓ Increase our cyber security capabilities, resilience, clinical safety and accessibility	✓ Enable the public to access and contribute to their patient record	✓ Support patients to have care at home wherever possible
✓ Improve digital literacy among leaders and our workforce	✓ Drive better decision making about our population by providing improved quality of data	✓ Support patients to manage their own health and care
✓ Level up access and utility of digital health records across the system	✓ Support staff across the system to share knowledge and tools	✓ Put in place preventative technologies to reduce unnecessary hospital admissions
✓ Put in place digital standards to enable efficient and equal access to health and care	✓ Provide the optimum environment for staff to work in, with the connectivity to work digitally.	✓ Redesign how we work together so that our staff can benefit from a collaborative approach to delivering care.
✓ A robust, future proof and state-of-the-art information technology infrastructure.		



Estates

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

Our Estates mission is to work together across provider boundaries to view our individual estate as part of a collective estate that is held and jointly reviewed for the benefit of patients and staff.

With an overarching vision to create a better utilised public estate which will drive efficiencies and in turn enhance the experience for the communities we serve.

Our charter

Our Estates Strategy

The development of a system-wide Estates Strategy will secure a commitment from all system partners to a common goal of 'One Public NHS Estate'.

The strategy will be built around four main pillars:

1. **Leadership** – With strong, stable leadership at all levels: in providers, in systems and among national partners.
2. **Investment** – Identifying clear and consistent capital priorities to enable the right investment in the right place.
3. **Data, evidence, and information** – Using an evidence-driven approach to management of our assets to enable strategic decision making, effective use of resources, and building the case for ongoing investment in the NHS estate. This will be underpinned by effective digital infrastructure to analyse timely, accurate estates data. Having a deep understanding of the needs of the people using our estate will provide clear evidence that will demonstrate how investment can meet those needs.
4. **People, skills and capability** – Ensuring the estates workforce have the right skills, tools and capability to operate effectively, as well as attracting people into our workforce with the knowledge and skills the NHS needs.

Our Estates Strategy has four main elements:

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

The strategy will focus on efficient use of estate while consistently ensuring that decisions about estate are made collectively with clinicians, so that patient benefit and healthcare outcomes are considered alongside value for money.

Our ambitions

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

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

System savings through the release of voids and disposals

- To deliver cashable savings from identifiable surplus property assets and void space
- Use of developer contributions (Section 106 and Community Infrastructure Levy)
- Manage and minimise voids recognising fixed and unavoidable costs such as Private Finance Initiative (PFI) and Community Health Partnerships (CHPs)
- To consider and deliver relocations to achieve more efficient use of space
- Reduce duplication and obsolete estate while promoting flexibility and resilience, and promote better use of space through One Public Estate (OPE).

System transformation

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

Primary care estate management

- We are developing clinical plans and strategic estate plans for each of the 25 PCNs
- Secure funds through Section 106 submissions to support the development of new primary care infrastructure
- Work with nine local planning authorities with regard to the local plans and new housing development
- Work with public sector partners to make the best use of the public estate through OPE. We have collaborated with councils to jointly deliver primary care infrastructure projects.

Sustainability

The wider determinants of health are a diverse range of social, economic and environmental factors which influence people's mental and physical health. As such, we view sustainability actions as part of our preventative health and wellbeing actions. Building on the wealth of good practice at the local organisational level and aligning with local plans and strategies, we work with all our partners to

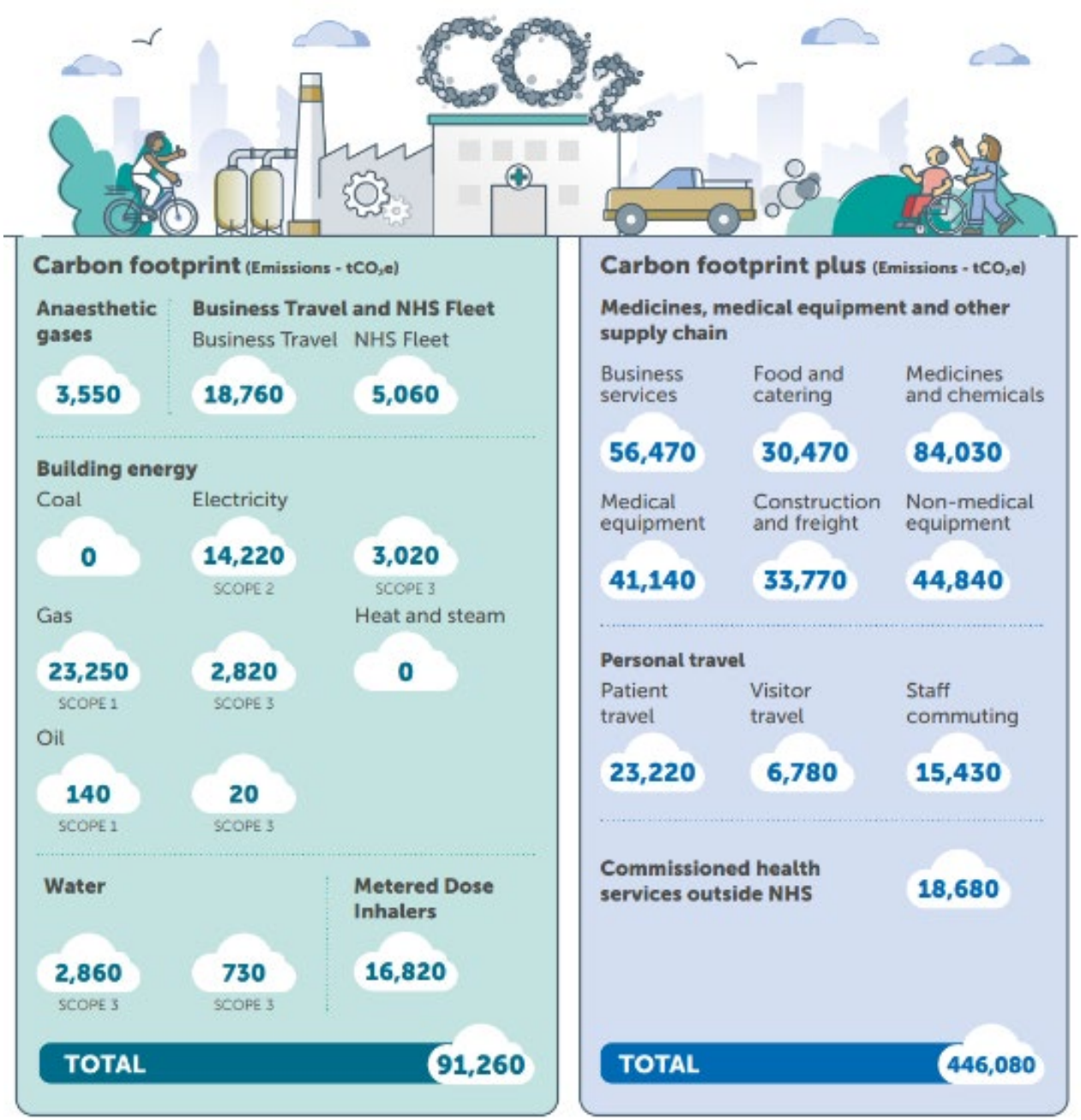
collaborate as an ‘anchor system’ to use our assets for social, economic and environmental benefit. Operating as an anchor system, we will continue to develop, but have an initial focus around the areas described below.

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

Delivering a Net Zero NHS

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

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



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

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

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

Leadership and system governance – the key focus is to have a senior system approach that enables the Green Plan to be delivered. Sustainability needs to permeate through all decisions, so that their long-term

impacts on the environment and local communities are understood and considered. This theme will need a system-wide approach. For example, ICB job descriptions could include sustainability responsibilities. This could be cascaded to other organisations so it becomes a system requirement for all employees to consider sustainability within their role.

Energy management – the key outcomes are to ensure there is a clear understanding of the system's use of energy and how and where savings and efficiencies can be made. This theme will need to be delivered by individual organisations, due to specific contracts and abilities to make changes.
Workforce development – the key outcome for this theme is to ensure our workforce has the right culture, behaviours and opportunities to adapt and change. Training will be needed so that professionals understand the implications of achieving net zero in their role and whether they need to make any changes in their day-to-day work. This theme will need a system-wide approach. A framework for expected behaviours across the ICS should be produced, providing an expected way of working for all organisations in the system.

Community impact – all decisions taken and services delivered by the ICB/ICS are for the benefit of the communities we serve. A decision on reducing travel will have a positive impact on the local community as air pollution levels will decrease. It is vital that local communities are involved in these decision-making processes and this theme will ensure this happens. The social value delivered through our services, and through our suppliers, is also paramount and must be considered as a part of our focus on reducing health inequalities. This theme will need a system-wide approach, although each organisation would need to ensure they included community-focused activities in their processes.

Data analytics and baselining – this theme will give the ICS more visibility and a deeper understanding of the current picture. It will provide the data required to enable the next steps to take place, shifting the paradigm from data to action, with a focus on local communities, employees and the impacts of decisions made. This theme will need to be led by individual organisations in the first instance. Individual data can then be collected and a system baseline can be developed over time.

Part 2

In this section you will read about

- our finance strategy
- our wider strategic system development ambitions
- a range of cross cutting themes which are golden threads through all our work such as personalised care, integration and working with our Voluntary Community and Social Enterprise (VCSE)

Our Finance Strategy

Our commitment – Paul Brown, ICB Chief Finance Officer

Our system is collectively committed to delivering our duty of living within the financial resource made available to us and this commitment is set out in 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 five-year planning period with a high level of financial challenge, but with an explicit commitment by all partners to deliver a path to financial sustainability. Our Financial Strategy describes a clear six-step plan, which has clinical and operational buy-in, and we can already demonstrate successes in key areas. We recognise the need to make tough decisions, bear down on unwarranted variation and improve productivity.

Challenges and opportunities

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

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

Jon Rouse, Stoke-on-Trent City Director

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

John Henderson CB, Staffordshire County Council Chief Executive

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

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

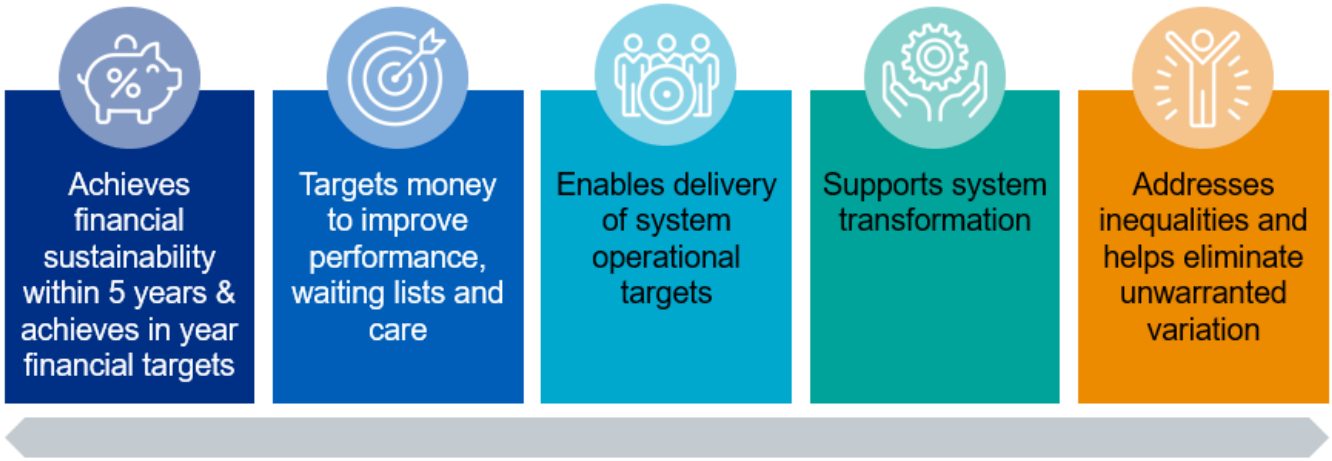
Our Finance Strategy

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

Our strategy

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

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



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

Productivity

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

A document titled 'System Productivity Challenge' was shared at several of our system-wide forums, including our System Performance Group, and was used in developing the strategy. Each operational portfolio has been asked to seek productivity opportunities as a key part of the operational plans. Productivity Improvement Plans will set out the projects and metrics against which we will measure success.

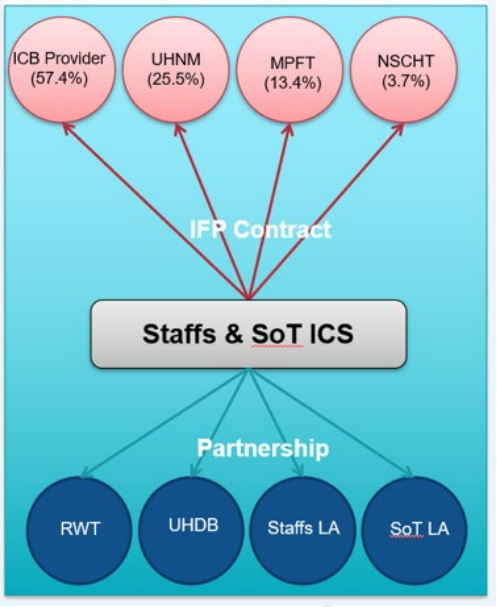
We submitted a balanced one-year financial plan in May 2023 for the 2023/24 financial year. We are now beginning the work to refresh the Financial Strategy, in line with the aims and objectives set out in this plan. This should be completed by late autumn and will set out the financial outlook for the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

The Intelligent Fixed Payment (IFP) and how it works

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

The Working Mechanics:

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



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

Capital Investment Plans

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

2023/24 is year 2 of the current three-year capital plan. The plan has been developed to refresh the existing capital plans, taking into account any slippage in timetables, the impact of inflation and any new anticipated public dividend capital. The capital schemes submitted in our system financial plan for 2023/24, including both internally funded and public dividend capital (PDC) funded schemes, total £95.6m. As per previous years, maintenance, medical equipment and digital schemes continue to be a driver behind our capital spend outside of new builds and large-value individual schemes.

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

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

Capital Schemes 2023/24

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

Procurement

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

The ICB procurement policy sets out our approach to all common procurement activities including the governance structure, standing financial instructions, and how we will fulfil our statutory obligations including Public Contracts Regulations. It also shows how we will support NHS-wide policies such as Greener NHS. Our policy drives broader social and economic development by ensuring all NHS procurements include a minimum 10% net zero and social value weighting and adhere to future requirements set out in the NHS Net Zero Supplier Roadmap. During the period of this JFP there will be annual procurement forward plans which will be aligned to each of our portfolios.

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

Cross-cutting themes

Personalised care

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

We will focus on:

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

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

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

Better Care Fund (BCF) and integration ambitions

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

The national BCF programme supports local systems to successfully deliver the integration of health and social care in a way that supports person-centred care, sustainability and better outcomes for people and carers. The BCF Policy Framework sets out the government's priorities for 2023–25 and will support us in delivering against some of the challenges we have identified. These include improving discharge, reducing the pressure on urgent and emergency care and social care, and supporting intermediate care and unpaid carers.

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

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

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

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

Clinical and professional leadership (CPL)

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

then jointly owned. We are committed to ensuring that we have visible senior clinical leadership across the system and embedded in our portfolios.

We know that there are many clinical and professional leads doing great work. They have worked hard to offer care and provide services in difficult times. However, there are opportunities to modernise, improve services and transform the way in which we work, which require us to ensure that clinical and professional leadership is central to our work. The national guidance 'Building strong integrated care systems everywhere: ICS implementation guidance on effective clinical and professional leadership' identifies two expectations and five core principles for effective clinical and professional leadership.

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

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

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

Working in partnership with people and communities

Moving to a new way of working as an ICS has given us a unique opportunity to reset our relationship with people and communities. The relationship we want is 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 an ICS by engaging with people to understand barriers and opportunities and using the insight gained to collaboratively build social assets and services that will help to tackle inequalities, improve outcomes in population health and enhance productivity and value for money.

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

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

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

The assembly will advise the ICB on how best to meet its legal duties to involve, acting as a critical friend, but also holding the ICB to account. It will also help to review and update our Working with People and Communities strategy.

Assurance around working with people and communities is provided to the ICB Board via the Quality and Safety Committee. Our Non-Executive Chair is responsible for championing the public voice as well as promoting our work on health inequalities, public engagement, and insight. A system-wide Communications and Engagement group, with representation from partners, supports a strategic approach to joint activity wherever possible as well as identifying opportunities to optimise resources and develop our collective effectiveness around community engagement.

Our Strategic Transformation and Service Change programmes

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

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

The table below summarises the key areas of focus:

Programme and portfolio
Inpatient mental health services (IMHS) Mental health, learning disabilities and autism portfolio
Urgent and emergency care (urgent treatment centre designation) Urgent and emergency care (UEC) portfolio
Cannock transformation programme Primary care, UEC, Planned care portfolios
Maternity Children and young people and maternity portfolio
Community diagnostic centres (CDCs) Planned care portfolio
Assisted conception Planned care portfolio

Voluntary, community and social enterprises (VCSE)

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

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

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

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

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

1. Prevention and social prescribing
2. Volunteering
3. Procurement
4. Communications and engagement.

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

CASE STUDY from Support Staffordshire: The Diabetes Picture Staffordshire

Background

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

Support Staffordshire Intervention

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

Difference being made

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

CASE STUDY from Voluntary Action Stoke-on-Trent (VAST): Community Health Champions

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

CASE STUDY Communities Together – Community-Led Support

- ✓ Communities Together has a vision for Stoke-on-Trent that all communities are vibrant and inclusive – where people are aspirational and feel a sense of belonging and pride in their places.
- ✓ The approach currently involves a network of over 30 organisations from the public, private and voluntary sector working in partnership with their communities to design and deliver different ways of working which maximise the strengths and community connections of people locally.
- ✓ Holistic advice and support is delivered through a network of community lounges. These bring together support from statutory partners and wider agencies within settings that are familiar and run by organisations rooted in the community.
- ✓ Carol attends the Community Cupboard project which aims to supply essential food items, cleaning and sanitary products at a low-cost price to anyone that needs a helping hand at Tommy Cheadles, Port Vale Foundation, a successful and well-established community lounge.
- ✓ Carol's son Michael (aged 32) was experiencing problems with his housing and was set to be evicted the following week. He felt let down by services from a young age so had little faith in professionals but was very worried about losing access to his children so agreed to accept support from agencies within the community lounge. He was supported through the housing, social worker and mental health teams as well as CDAS (Community Drug and Alcohol Service) to become drug free. As well practical support for Michael Carol was supported and reassured by the team within the community lounge.
- ✓ After four months of support through the community lounge where all the wrap around services were available all three children are regularly seeing Michael and Carol has a good relationship with her grandchildren who stay over at her house. Two of the grandchildren have additional needs and are regularly attending health appointments now and their school attendance has improved. Four months of a wraparound service in the community lounge has made a huge difference in their lives.

Intelligence

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

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

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

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

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

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

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

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

Research and innovation

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

To deliver our ambition we will continue to build on our considerable strengths in research and innovation in our region. We are part of the Staffordshire and Shropshire Health and Care Research

Partnership (SSHERPa), whose ambition is to enhance the opportunities for collaborative research working with our neighbouring ICS (Shropshire, Telford and Wrekin). The SSHERPa partnership brings together our local higher education institutions (Keele and Staffordshire Universities), NHS providers, local authorities, VCSE networks, National Institute for Health and Care Research (NIHR) Clinical Research Network West Midlands, and West Midlands Academic Health Science Network (AHSN). Building and strengthening these partnerships gives opportunities to identify and develop ideas, and apply for funding to support research and innovation, at a system-wide level.

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

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

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

Our strategic objectives provide the framework for how we will achieve our vision and realise our principles through:			
Workforce development Championing a research culture where everyone is valued, and able to contribute to, and benefit from, research Developing innovative career pathways, embedding research into health and care professional roles Sharing knowledge and expertise, developing research professional roles across the partnership	People, places and communities Creating opportunities for inclusive research across diverse communities Enhancing the opportunity for people to shape research, reducing health inequalities across our diverse urban and rural geography Enhancing the opportunities to engage in research – championing the people and teams that support this Developing infrastructure that supports wider engagement in research	Impact Creating an eco-system where research outputs can be rapidly adopted into practice/policy Developing co-production strategies that support the mobilisation of knowledge Transforming health and care through high quality research Supporting sustainability through new approaches to health and care research delivery Supporting economic development through income generation	Innovation Working with business and commercial partners, facilitating deeper partnerships and securing co-investment Connecting research and innovation Accelerating translation, commercialisation and knowledge exchange

Examples Our region has supported innovative career pathways for healthcare practitioners. For primary care we have developed clinical academic career routes for GPs (Keele University / primary care), and partners continue to develop integrated career opportunities that embed evidence into clinical decision making (e.g. clinical academic physiotherapists (MPUFT/Keele), evidence-based practice groups for GP nurses and physiotherapists). As a Trust securing university hospital status, MPUFT continues to develop these opportunities for social workers and nurses. MPUFT have also developed the regional training programme for research and innovation open to all partners (STARS – Supporting the Advancement of Research Skills). UHNM have developed the Centre for NMAHP Research and Education Excellence) to proactively support research across their workforce.	**Examples** SSHERPa secured NHS England Research Engagement Network Development funding to proactively build the research and innovations networks in under-served communities. Working with our VCSE network partners, we have developed research champions in these communities and established a research engagement network lead for the VCSE communities. We also delivered the NHS England Touchpoints project – testing ways in which the NIHR 'Be Part of Research' volunteer registry can be promoted to the general public.	**Examples** Supporting economic development through income generation – over the last 10 years of partnership working, our localities have drawn in over £50 million of research income, driving best health and care for our regions. Since our inception in 2022, SSHERPa has brought in over £250k to support the development of our research and innovation networks. Working with partners we ensure research outputs are proactively adopted into practice (example of Keele's Impact Accelerator Unit working with the ICS MSK Transformation group).	**Examples** Working with our partners, particularly Keele and Staffordshire Universities and West Midlands AHSN, we have supported initiatives to assist subject-matter experts to bring innovation to the healthcare market (e.g. Business Bridge – Keele University). Working with WM AHSN we seek to develop proposals to schemes such as UK Research and Innovation and Small Business Research Initiative to support the development, translation and commercialisation of innovations that address our local health needs (example of 2023 Drug Death Challenge – SBRI – MPFT: NHSX proposal developing Self Back App). North Staffordshire Combined Healthcare NHS Trust's Innovation Nation annually celebrates local innovations developed by staff that address ICS priorities.
Supported by high-quality research, empowering all to engage, improving outcomes through partnership and leadership			

Wider strategic system development

System development overview

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

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

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

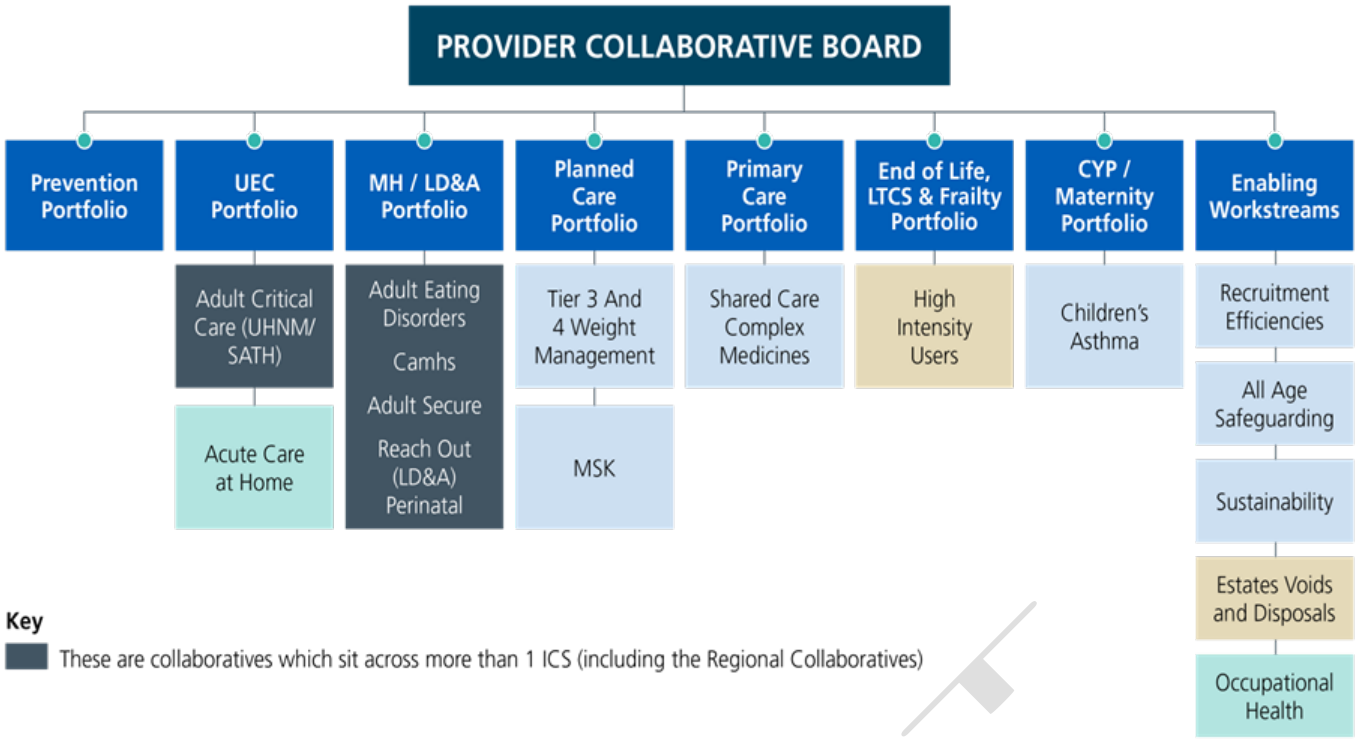
We will create a culture and system to ensure effective cross-sector collaboration, a shared understanding of each sector activity, drivers and perspectives to build successful and strong relationships and remove barriers.

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

Provider collaboratives

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

Collaboration between providers in and outside our system has always taken place and we have a good track record of effectively working in partnership. As part of the ongoing development of the provider collaborative approach we will continue to focus on working at scale to properly address unwarranted variation and inequality in access, experience and outcomes across wider populations. We have collaborations that sit across the ICS and outside, working with regional collaboratives particularly in relation to adult critical care and mental health and learning disabilities and autism (LDA) programmes.



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

Place and neighbourhood development

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

- District and borough councils as local housing and planning leads
- Health, public health and social care
- Local enterprise partnerships and economic development forums
- Schools and educational/early years establishments
- VCSE including faith groups
- Primary care networks
- Universities.

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

Delegation of direct commissioning functions in 2023 and specialised commissioning

Historically, responsibility for commissioning different elements of patient pathways can sit with different organisations both nationally and locally. By integrating the commissioning of services with ICBs' wider commissioning responsibilities where appropriate, ICBs will be the commissioner for the primary, community, secondary and tertiary elements of pathways for their population, enabling them to design care that joins up around population needs, and invest resources where they can have best effect on outcomes.

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

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

- Primary pharmacy
- Optometry
- Dental services

The services that will be delegated will be woven into the work of the primary care portfolio.

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

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

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

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

Pan system working

The six ICBs in the West Midlands are collaborating to establish an Office of the West Midlands (WM). We have jointly agreed that Birmingham and Solihull (BSOL) ICB will be the host for staff performing these functions for West Midlands with responsibility from 1 April 2023 and staff transferring from July 2023. From April 2024 BSOL will also be the host for the Midlands team supporting all regional 11 ICBs for the delegated specialised commissioning portfolio.

The vision for the Office of the West Midlands is “through at-scale collaboration and distributive leadership the Office of West Midlands will add value and benefit to a shared set of common goals and priorities for West Midlands citizens and patients.”

The core purpose is:

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

The areas that ICBs have jointly identified for collaborative working in year 1 are:

- To manage the mobilisation and commissioning of delegated functions from NHSE with regard to direct commissioning, for example pharmacy, optometry and dentistry (from 2023) and a subset of specialised services (from 2024)
- To agree a West Midlands work programme for the ICBs where working together would add value and benefit for the population and the systems
- To jointly consider other functions and services that NHSE may be reviewing for either delegation or transfer of hosting responsibility as part of their future design

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

The agreed joint programmes of work are as follows:

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

Part 3

In this section of the plan is a series of appendices which

- summarise how we will meet the statutory requirements placed upon the ICB
- an overview of portfolio plan high level timelines
- provides copies of supporting documents referred to in the main body of the document

Appendices

Matrix of statutory duties

Staffordshire and Stoke-on-Trent ICB will exercise its statutory duties through a range of approaches as outlined in the table below:

Statutory Duty	Reference to relevant section
Describing the health services for which the ICB proposes to make arrangements	Covered throughout document. Our Joint Forward Plan sets out how we will meet the needs of our population, across key pathway and population groups, driven by our understanding of population health need, patient/public feedback and service challenges and opportunities.
Duty to improve quality of services	See quality assurance and improvement section.
Duty to reduce inequalities	See Improving Population Health section.
Duty to promote involvement of each patient	See in Personalised Care section.
Duty as to patient choice	See Personalised Care section, Urgent and Emergency Care Portfolio section, Planned care (elective, cancer, diagnostics) section, End of Life, Frailty and Long-Term Conditions (ELF) section, Primary Care, Working in Partnership with People & Communities section.
Duty to obtain appropriate advice	See Governance Framework , functions and decision map section.
Duty to promote innovation	See Research and Innovation section.
Duty in respect of research	See Research and Innovation section.
Duty to promote education and training	See People Plan section.
Duty to promote integration	See Provider collaboratives section, Better Care Fund and Integration Ambitions section, Urgent and Emergency Care (UEC) Strategy section, System Development Overview section.
Duty to have regard to wider effect of decisions	See finance, estates, sustainability and green plans, Governance Framework , functions and decision map section.
Duty as to climate change	See Sustainability section, Delivering a Net Zero NHS section, Procurement section
Public involvement	See Working in Partnership with People & Communities section, Our Transformation Programme and Service Change section, Why do we need a forward plan section
Addressing the particular needs of children and young persons	See Children and Young People Portfolio section, Mental Health, Learning Disabilities and Autism Portfolio section, Learning Disabilities and Autism (LDA) section, Serious Violence and Safeguarding Section
Addressing the particular needs of victims of abuse	See Serious Violence and Safeguarding section.
Implementing any joint local health and wellbeing strategy	See Introduction, Our approach to developing our priorities section, Addressing our population's health and care needs section.
Financial duties	See Our Finance Strategy section.

Portfolio Five Year Plans

	Delivered by:				
Improving Population Health - High Level Deliverable	**Y1**	**Y2**	**Y3**	**Y4**	**Y5**
Tackling Health Inequalities Develop Health Inequalities Strategy	✓				
Tackling Health Inequalities • Restore NHS services inclusively, mitigate against digital exclusion, ensure datasets are complete and timely, accelerate preventative programmes, strengthen leadership and accountability • ICSs take a lead role in tackling health inequalities by building on Core20PLUS5 approach to support the reduction of health inequalities experienced by adults, children and young people, at both the national and system level	✓	✓	✓	✓	✓
Population Health Management (PHM) • ICS drive shift to population health, targeting interventions at those groups most at risk, supporting prevention as well as treatment • Systems in place that will act as the foundation for PHM • Implement technical capability required for PHM with longitudinal linked data available to enable population segmentation and risk stratification	✓	✓	✓	✓	✓
Prevention of Ill health System plans for prevention in line with national guidance and in conjunction with portfolios and enablers	✓	✓	✓	✓	✓
Prevention of Ill health • Develop a Prevention Strategy • Develop an Alcohol Harm Reduction Strategy	✓				
Prevention of Ill health • Support the implementation and roll out of tobacco dependency treatment services • Renew focus on reducing inequalities in access to/outcomes from NHS public health screening/immunisation services/vaccination programme	✓	✓			
Planned Care - High Level Deliverable	**Y1**	**Y2**	**Y3**	**Y4**	**Y5**
Delivering Elective Recovery/ Eliminating Long Waits Through delivery of the 103% activity target, continual review and validation of long waiters, maximise use of IS capacity and ensuring separation of elective and non-elective capacity we will recover pre-pandemic service performance.	✓	✓	✓	✓	✓

Improve Capacity and Productivity To implement plans such as alignment to GIRFT, national directives such as reducing unnecessary outpatient follow up appointments (OPFU) and local transformations such as the creation of dedicated elective care hubs we will optimise care pathways and improve productivity. Look at ways to implement digital opportunities to further support the objective.	✓	✓	✓		
Care Transformation We will explore and include national and local approaches and solutions to develop new models of care across our most challenged specialties, to ensure patients see the right professional, in the right place at the right time. Additionally, all transformation plans will work to reduce health inequalities where they are identified.	✓	✓	✓	✓	✓
Diagnostics - High Level Deliverable	**Y1**	**Y2**	**Y3**	**Y4**	**Y5**
Eliminating Long Waits/ Achieving Standard (95% of patients receive diagnostic within 6 weeks by 2025) Embed the key strategies and GIRFT principles set out nationally, including increasing diagnostic capacity, and recovery pre-pandemic productivity levels to ensure that we are able to deliver the target of 95% of patients receiving a diagnostic test within 6 weeks of referral by 2025.	✓	✓			
Optimise Diagnostic Pathways Identify future need for diagnostics in the system to understand what and where gaps are, to further ensure that patients get the right test at the right time in the right place. Within this the increased use of GP direct access, roll out of iRefer and other digital enablers will be considered, as will the opportunities presented by existing diagnostic networks.	✓	✓			
Cancer - High Level Deliverable	**Y1**	**Y2**	**Y3**	**Y4**	**Y5**
Reduce the number of patients waiting over 62 days • Continue and sustain additional capacity schemes such as in Skin and Endoscopy, which have contributed to the 62 day backlog recovery • Continue with the acute to community shift – putting care closer to home, and releasing specialist capacity	✓	✓			
Meet the cancer faster diagnosis standard of 75% by March 2024 Meet the cancer faster diagnosis standard by March 2024, so that 75% of patients urgently referred by their GP for suspected cancer are diagnosed or have cancer ruled out within 28 days.	✓	✓			
Screening and Early Detection Achieve an uptake in cancer screening via increased community awareness of warning signs which will help to increase the percentage of cancers diagnosed at an early stage (stage 1 and 2) with a particular focus on disadvantaged areas where rates of early diagnosis are lower.	✓	Will continue if funding available			
Personalised Care We will increase the proportion of patients whose follow up is through supported self management through access to remote monitoring on patient portals as early as clinically suitable and with patient choice and also increase access for patients to holistic needs assessments and recovery plans.	✓	✓	✓	✓	✓
Children and Young People - High Level Deliverable	**Y1**	**Y2**	**Y3**	**Y4**	**Y5**

Best start in life: improve the survival of babies and young children to reduce infant mortality We will improve the survival rates of babies and young children through: • Reducing the number of mums who smoke during their pregnancy • Increasing the rates of infant feeding initiation and continuation • Reducing the number of pre-term births and babies with a low birth weight		✓	✓	✓	✓
Recognise a need to make improvements in nutrition and access to physical activity Increase the number of children and young people to achieve and sustain a healthy weight			✓	✓	✓
Support children and young people to achieve their potential by enjoying good emotional wellbeing and positive mental health We will improve children & young people's access to mental health support when & where they need it	✓	✓	✓	✓	✓
Support children with complex needs with the help they need so that they can fulfil their potential Reduce the number of CYP in independent residential placements	✓	✓	✓	✓	✓
Effectively manage long term conditions to reduce avoidable admissions in relation to asthma, epilepsy, and diabetes We will see maintained or reduced activity for our hospital admissions in relation to asthma, epilepsy and diabetes	✓	✓	✓	✓	✓
Maternity and Neonates - High Level Deliverable	**Y1**	**Y2**	**Y3**	**Y4**	**Y5**
Single Delivery 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	✓	✓	✓	To be reviewed in line with national guidance.	
Single Delivery Plan 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	✓	✓	✓		
Single Delivery Plan 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	✓	✓	✓		
Single Delivery Plan 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	✓	✓	✓		
Ockenden	✓				

7 immediate and essential actions from the Ockenden report					
Urgent & Emergency Care - High Level Deliverable	**Y1**	**Y2**	**Y3**	**Y4**	**Y5**
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 2025 • Reduce adult general and acute (G&A) bed occupancy to 92% or below	✓	✓	✓	✓	✓
Pre-Hospital • Consistently meet or exceed the 70% two-hour urgent community response (UCR) standard • Reach 80% utilisation of virtual wards at a minimum by the end of September 2023	✓	✓	✓	✓	✓
Post-Hospital Improve number of discharges on Pathway 0 to 80%.	✓	✓	✓	✓	✓
Increase workforce size and flexibility Immediate action to improve health and wellbeing, support and retention and expand UEC workforce, as well as to ensure the workforce is in place to meet acute expansion and community service transformation	✓	✓	✓	✓	✓
Making it easier to access the right care Review NHS 111 services, including greater alignment with primary care, 111 online and trailing 111 first. Increasing access to clinical assessment in 111 in particular for paediatrics.	✓	✓	✓	✓	✓
UTC Designation Assessment of the options and proposals for fully accredited Urgent Treatment Centres (UTCs) aiming to move to full accreditation in 2024. This will be supported by our Strategic Transformation function and will include an options appraisal process to identify which of the current urgent care portals meet the principles and standards for UTCs. Further data analysis and impact assessments will be undertaken to inform and shape the proposals and options for delivery of UTCs.	✓	✓			
Discharge Provider Collaborative Work with our acute hospital providers on the Urgent and Emergency Care improvement programme to improve acute hospital flow to support the national targets of delivering the 76% Emergency Department waiting times standard and the 92% bed occupancy target and improve ambulance handover delays.	✓	✓			
One Single integrated single point of access behind 111 and 999 Carrying out a full review of our pre-hospital “Access” programme with a particular focus on NHS111 provision.		✓	✓		
Acute Care at Home Provider Collaborative The Acute Care at Home Service providing collaborative working across primary, community and secondary care through 3 service areas: Unscheduled Care Coordination Centre (UCCC) which is a clinical triage telephone line, our 2 hour urgent response (CRIS) and Virtual Wards.	✓	✓			
End of Life, Long Term Conditions and Frailty - High Level Deliverable	**Y1**	**Y2**	**Y3**	**Y4**	**Y5**

Palliative and End of Life Care Priorities To drive improvement in PEoLC in Staffordshire and Stoke-on-Trent framed by the National Ambitions for PEoLC	✓	✓	✓	✓	✓
Long Term Conditions Develop a system owned strategy to improve health outcomes (Year 1) Deliver strategy to reduce health inequalities and reduce disease progression in cardiovascular disease, diabetes, and respiratory LTCs (Year 2 onwards)	✓	✓	✓	✓	✓
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.	✓	✓	✓	✓	Review of strategy Yr 5
Primary Care - High Level Deliverable	**Y1**	**Y2**	**Y3**	**Y4**	**Y5**
Deliver more appointments in general practice by the end of March 2024 Good access to general practice by improving location, times, ease of arranging appointments through digital and technology support, and speed of access with a range of workforce to meet their needs.	✓	Review of national guidance			
Support the recruitment of additional staff into general practice to support the national target of an additional 26,000 roles by March 2024 Work in partnership on the existing work programmes to tackle the challenges around recruitment and retention of the workforce (including maximising the opportunities of the Additional Roles Reimbursement Scheme) and addressing workload pressures through implementation of initiatives such as care navigation and utilisation of the Community Pharmacy Consultation Scheme (CPCS).	✓	Review of national guidance			
Increase the number of GPs in practice to support the national target of an additional 6,000 GPs March 2024 There will be an annual increase in workforce numbers, with more GPs and general practice nurses recruited and retained and a further increase of additional roles to compliment the general practice skill mix. We will be working towards our contribution of the national targets for increasing GPs and expanding additional roles.	✓	Review of national guidance			
Recover dental activity towards pre-pandemic levels Recover dental activity by improving units of dental activity (UDAs) towards pre-covid levels and improving access to primary care dentistry for the vulnerable population.	✓	✓	✓	✓	✓
Fuller Stocktake Implementation of Primary Care elements of the four building blocks of the Fuller Stocktake (1. Integration, 2. Same Day Urgent Primary Care, 3. Personalised Care, 4. Prevention)	✓	✓	✓	✓	✓
Pharmacy and Medicines Optimisation - High Level Deliverable	**Y1**	**Y2**	**Y3**	**Y4**	**Y5**
Community Pharmacy Integration Integrating community pharmacy services into the wider Staffordshire and Stoke-on-Trent health and care services to support our population to access primary care services. The delivery metrics will be based on monitoring a number of new community services.	✓	✓	✓	✓	✓

Clinical Pharmacy in General Practice Supporting pharmacy teams in General Practice to deliver optimal medicines-related outcomes for patients through delivery of structured medication reviews and clinical audit.	✓	✓	✓	✓	✓
Antibiotics Tackling the risk of antimicrobial resistance so that we maintain the effectiveness of antibiotics for treating serious and life-threatening infections.	✓	✓	✓	✓	✓
Patient Safety Reducing harm from drugs including collaborative working across different sectors of pharmacy to reduce risk of medication errors during transfers of care. The work programme deliverables will be aligned to the National Medicines Safety Improvement Programme.	✓	✓	✓	✓	✓
Shared Care Medicines Transforming shared care medicines arrangements between primary and secondary care to ensure that patients get can complex medicines from their surgery even though their care requires regular monitoring by a hospital consultant or specialist clinician.	✓	✓	✓	✓	✓
Carbon Impact Reducing the carbon impact of medicine to support delivery of the ICS Green Plan.	✓	✓	✓	✓	✓
Best Value Medicines Joint working to get best value for expenditure on drugs across the system, including implementation of prescribing costs in primary care, joint working on development of cost improvement plans, early adoption of newly released cost-effective medicines and horizon-scanning and planning for impending cost pressures.	✓	✓	✓	✓	✓
Workforce Working with the ICS People Function we will develop a system wide pharmacy workforce resilience plan that incorporates optimising skill mix, extending capability of pharmacy professions and supporting wider training and development opportunities which will make Stoke-on-Trent and Staffordshire an attractive place for pharmacists and pharmacy staff to work and stay.	✓	✓	✓	✓	✓
Mental Health - High Level Deliverable	**Y1**	**Y2**	**Y3**	**Y4**	**Y5**
Children and Young People Mental Health Continually reviewing and refreshing the local transformation and implementation plan to ensure ICS alignment. Improving access to mental health support for children and young people, including those with Eating Disorders. Expanding service for 24/7 crisis provision, combining crisis assessment, brief response and intensive home treatment functions and training and mobilisation for the mental health support teams in schools.	✓	✓	✓	✓	✓
Urgent and Emergency Care Mental Health Services Develop and implement programme of work to expand/improve MH crisis care provision and alternatives to A&E, including NHS 111, ambulance response, crisis resolution home treatment teams and MH Liaison services in acute hospitals. Work towards eliminating inappropriate adult acute out of area placements and enhancing access to therapeutic interventions and activities within inpatient mental health services.	✓	✓	✓	✓	✓

Community Mental Health Services Implement transformed models of integrated primary and community care for people with SMI whilst increasing the number of adults with SMI receiving physical health checks. In partnership, develop and implement the Suicide Prevention Plan which delivers evidence based preventative interventions that target high risk locations and supports high risk groups. Implement local pathway for Adult ADHD assessment and diagnosis, treatment and intervention.	✓	✓	✓	✓	✓
Dementia Improve the lives of people with dementia, focusing on timely diagnosis, crisis prevention, personalised care and support for family/carers**.**	✓	✓	✓	✓	✓
Learning Disabilities and Autism - High Level Deliverable	**Y1**	**Y2**	**Y3**	**Y4**	**Y5**
Communication and Engagement Develop and implement a communication and engagement plan to support programme delivery and embed the message of Learning Disabilities and Autism being 'everyone's business'. Ensuring equal access and reasonable adjustments are considered across all services.	✓	✓	✓	✓	✓
Identification To ensure that people with a Learning Disability are correctly identified on GP Registers with appropriate digital flags in place to increase the uptake of annual health checks and the identification of needs for any reasonable adjustments to be made.		✓	✓	✓	✓
Place Collaborative working to ensure housing, education, employment and life opportunities are more accessible and inclusive.		✓	✓	✓	✓
Universal Services Ensure children with LD have their needs met by eyesight, hearing and dental services, and are included in reviews as part of general screening services and supported by easily accessible, ongoing care.		✓	✓	✓	✓
Dedicated Care & Support Work collaboratively across health and social care to develop a joint independent sector market that is fit for purpose, moving towards an integrated pooled budget arrangement.			✓	✓	✓
Community Services Implement plans to improve access to community services to reduce inappropriate admissions to inpatient services and support timely discharge.		✓	✓	✓	✓
Inpatients Implement plans to improve the quality and accessibility of locally available inpatient provision to ensure that, where an admission is appropriate, services are available locally and timely discharge is supported.		✓	✓	✓	✓
Inequalities Continuation of the LeDeR programme and implementation of actions identified through LeDeR reviews and learning.	✓	✓	✓	✓	✓

Workforce Training NHS and care staff will receive information and training on supporting people with a Learning Disability and/or autism through the roll out of Oliver McGowan Mandatory Training.	✓	✓	✓		
Autism waiting times Implement plans to minimise waiting times for autism assessment**.**		✓	✓	✓	✓

Pharmacy and Medicines Optimisation how we will support wider ICS ambitions

Pharmacy and medicines optimisation specific plans described below will also support deliverables of other portfolios for example improved access in primary care, reduced unplanned admissions to hospitals and better detection and management of long-term conditions.

Integrated community pharmacy services

Community Pharmacy Consultation Service (CPCS)

General Practice can refer patients to Community Pharmacy if they need a treatment for minor illness or require an urgent supply of medicines that they have run out of. Our area has the highest level of CPCS referrals from General Practice, but our ambition is to have CPCS referrals via NHS 111 and urgent treatment centres also. Note all the referrals will be via electronic means.
CPCS is not commissioned to provide medicines for minor illness free of charge. Locally we will enhance the service by making available a variety of treatments via community pharmacy so that patients do not have to see a practice-based clinician if the treatment can safely be provided by a community pharmacy. This will improve overall access to healthcare in primary care and it will also ensure that access is tailored to patient need.

Smoking cessation service

Both local health authorities commission smoking cessation services that members of the public can access directly. This capacity can now be expanded through national arrangements that are in place that allow accredited pharmacies to provide a smoking cessation service for patients who started the treatment as inpatients but have now been discharged. Additionally accredited community pharmacies can accept referrals from antenatal services to provide smoking cessation services to expectant mothers and their household members.
We plan to support the pharmacies with training and putting arrangements in place to commence the service.

Discharge Medicines Service (DMS)

We plan to have appropriate digital solutions in place across all our Trusts so that discharge medicines referrals to community pharmacies from hospitals become a routine practice in our area. We will also ensure that majority of these referrals are acted upon in community pharmacies.

Hypertension case finding service

We will support collaboration between practices and pharmacies at neighbourhood level to improve diagnosis rates for hypertension. Community pharmacies in Staffordshire and Stoke-on-Trent will opportunistically measure the blood pressure (BP) of consenting adults who come into the pharmacy by offering a blood pressure and ambulatory blood pressure check if appropriate. The service will only be provided for adults over the age of 40, not previously diagnosed with hypertension and who have not had BP checked in the last six months.

Contraception services

We will support community pharmacies with training and putting arrangements in place to provide either ongoing treatment initiated by sexual health clinic or General Practice or to initiate contraception for those who choose to have this service via a pharmacy. The service will be funded nationally.

Antimicrobial stewardship

We will run a clinical audit programme across both primary and secondary care to promote good practice such as prescribing antibiotics when it is strictly necessary.

Medicines safety

System partners are already collaborating on introducing measures to address risks associated with use of certain drugs that can cause significant harm.
In Primary Care we will be running clinical audits on prescribing of high-risk medicines and also, we will promote clinical pharmacist-led medication reviews to address overprescribing.

Shared care medicines collaborative project

Various providers from across the system and other staff who have specialist expertise will come together and agree a joint plan (including implementation) to transform the current arrangements for shared care medicines so that:

- The services are patient centred
- Variation in services across the local footprint is minimised
- The services meet the standards for monitoring and follow up

Carbon impact of medicines

Wider plans for delivering net zero NHS are described elsewhere in the document. This section focuses on plans for targeting inhaler therapy. We have already produced guidance which provides information on the carbon footprint of various inhalers and also compares inhalers on other aspects such as cost. The respiratory clinical network will lead on other initiatives:

- Promoting the use of the inhaler guide across primary and secondary care
- Structured medication reviews that improve asthma / COPD care
- Considering use of dose counters where these are not integral to the chosen inhaler
- Recycling schemes for returned inhalers

Drugs budget

System partners already have processes in place to manage drug formularies and assessment of new drugs. A cost improvement plan has been developed for prescribing costs incurred in primary care. It will now be implemented. The Pharmacy Leadership Group have agreed to form a working group that will look at cost saving opportunities in use of high-cost drugs and set up horizon scanning processes to manage impending cost pressures.

Pharmacy workforce

We plan to work collaboratively across different pharmacy sectors to pull together data that will help us understand our workforce profile (including ageing workforce).
Using data and working in collaboration with the People Team and the Training Hub we will develop a pharmacy workforce plan that is embedded in the overall system workforce plans, and which will:

- Maximise the workforce including recruitment to new roles for the benefit of our local communities
- Provide placement and job opportunities that will drive improved recruitment
- Enable supportive work environments to improve retention and reduce burnout

Financial Governance and Controls

The Integrated Care Board (or ICB) must ensure it can effectively discharge its full range of statutory functions and duties. This includes establishing committees of the ICB, to support the Board and exercise the delegated functions.

Our system has established a system-level Finance and Performance Committee which forms a key plan part of the formal governance of the ICB to monitor and identify and act on financial risks. The committee has oversight of the development and delivery of a viable and sustainable system financial plan and investments. The system has well established system level reporting and all NHS partners include the overall system position in their formal reporting to their own boards. In 2023/24 we will be looking at how we can further extend this with our Local Authority Partners.

NHSE guidance states that "the achievement of financial balance, while maintaining the quality of healthcare provision, is a legal requirement for all systems. The organisations within each system have a duty to co-operate in the delivery of system objectives. Further, when a system overspends against its allocation for the year, spending must be restricted elsewhere to make sure that overall the NHS remains within its spending limits". Given the high risk of delivering a balanced position in 2023/24, it is expected that NHSE will require the system to operate within a more stringent control environment. As such, rigorous financial governance will be a key component and focus of the system to address our material underlying deficit.

Supporting the establishment of the more stringent control environment a national audit exercise underpinned by the HFMA was undertaken by all NHS organisations and recommendations acted upon to ensure best practice in the following disciplines within finance:

- Business and financial planning
- Budget setting
- Budget reporting and monitoring
- Forecasting
- Cost improvement/ efficiency plans
- Board reporting
- Financial governance framework
- Culture, training and development

Key recommendations from the highlighted audit that are in the process of being implemented are:

- The development of detailed analysis of expenditure within budget reports which allow for month on month trends to be readily identified and separates recurrent and non-recurrent drivers to ensure an underlying position can be derived in real time.
- Incorporate Budget Management into the Performance / Objective setting of those individuals who have been assigned budgetary responsibilities.
- Establish a robust and clearly defined Business Case process ensuring that all Business Cases have been approved by the relevant departments prior to tabling at Finance and Performance Committee / ICB Board for approval

Key NHS partners within the system shared the outcome of their individual audits to highlight areas of Best Practice that had already been established in individual Trusts / ICBs to provide the opportunity for that learning to be disseminated in a consistent manner across the individual finance teams.

Procurement

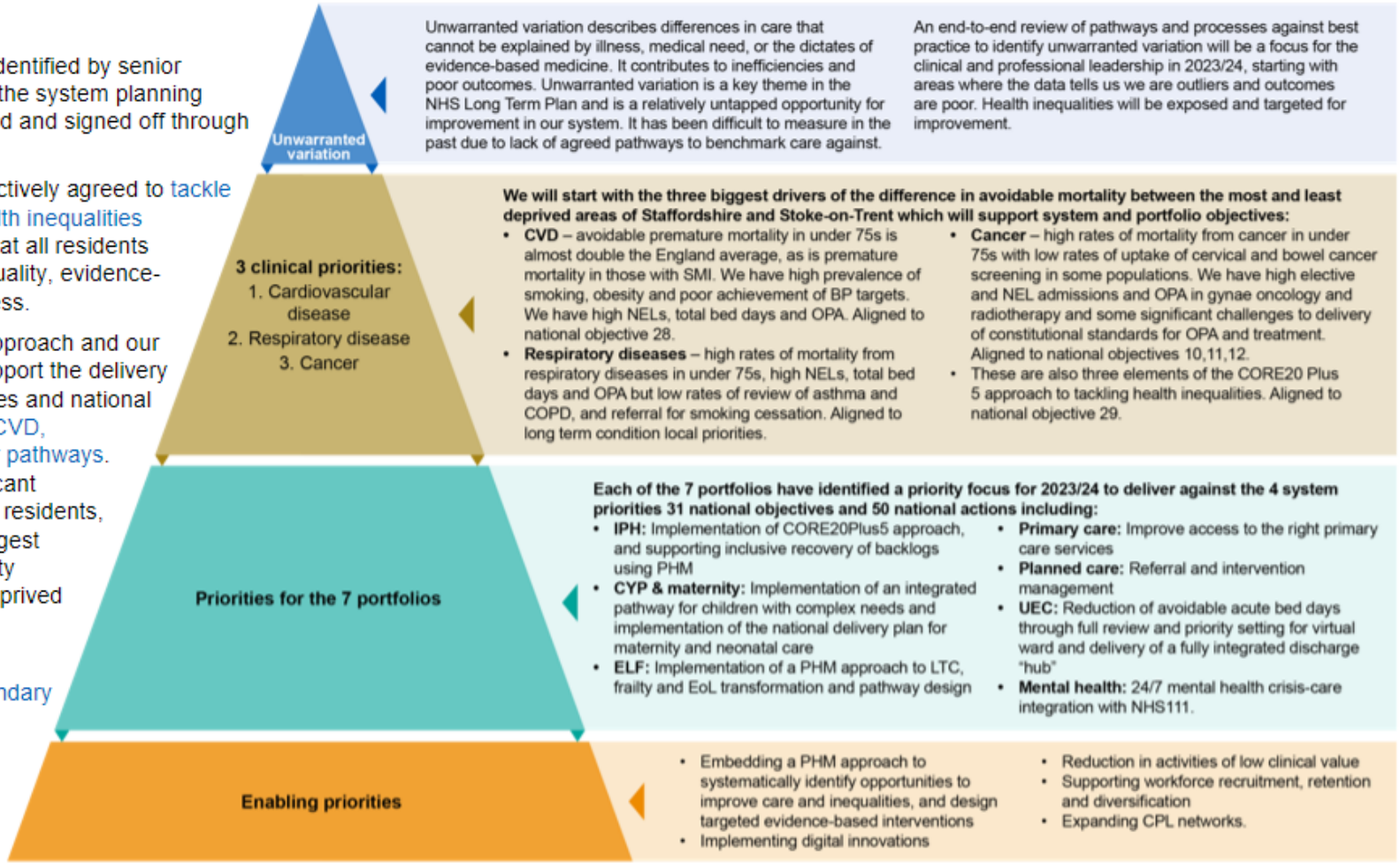
Health and care organisations have been working together in different ways for several years and while there have been steps taken towards collaboration already, previous laws have prevented services becoming properly joined-up. The 2022 Health and Care Act aims to change this and make it easier for NHS and social care organisations to work together.

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

The ICB procurement policy sets out our approach to all common procurement activities including the governance structure, standing financial instructions, and how we will fulfil our statutory obligations including Public Contracts Regulations and support NHS-wide policies such as Greener NHS. In particular our policy drives broader social and economic development by ensuring all NHS procurements include a minimum 10% net zero and social value weighting and adhere to future requirements set out in the NHS Net Zero Supplier Roadmap. During the period of this JFP there will be annual procurement forward plans which will be aligned to each of our portfolios.

Clinical and Professional Leads (CPL) Focus

- 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.



Glossary

Term	Definition
Clinical Commissioning Group (CCG)	Clinical commissioning groups were NHS organisations set up by the Health and Social Care Act 2012 to organise the delivery of NHS services in each of their local areas in England. On 1 July 2022 they were abolished and replaced by Integrated care systems as a result of the Health and Care Act 2022.
Emergency Department (ED)	The Emergency Department encompasses all emergency services provided in a hospital, including accident and emergency (A&E).
Health and Wellbeing Board (HWB)	A forum for local commissioners across the NHS, public health and social care, elected representatives, and representatives of Healthwatch to discuss how to work together to improve the health and wellbeing outcomes of local people.
Health and wellbeing strategies	Jointly-agreed and locally-determined set of priorities for local partners (between ICBs and local Authorities) to use as basis of commissioning plans.
Health inequalities	The gap in access to health services between different groups, social classes and ethnic groups and between populations in different geographical areas.
Independent sector	A range of non-public sector organisations involved in service provision, including private, voluntary and charitable organisations.
Integrated Care Board (ICB)	An integrated care board (or ICB) is a statutory NHS organisation which is responsible for developing a plan for meeting the health needs of the population, managing the NHS budget and arranging for the provision of health services in a geographical area.
Integrated Care Partnership (ICP)	An Integrated Care Partnership (ICP) is a statutory committee jointly convened by Local Authorities and the NHS, comprised of a broad alliance of organisations and other representatives as equal partners concerned with improving the health, public health and social care services provided to their population.
Integrated Care System (ICS)	Integrated care systems (ICSs) are partnerships of organisations that come together to plan and deliver joined up health and care services, and to improve the lives of people who live and work in their area.
Joint Strategic Needs Assessment (JSNA)	A document which analyses the health needs of a population to inform the commissioning of health, wellbeing and social care services. This document is updated annually.
National Institute for Health and Care Excellence (NICE)	NICE provides national guidance and advice to improve outcomes for people using the NHS and other public health and social care services. NICE produces advice and guidance; develops quality standards and provides a range of information services.
NHS England (NHSE)	NHS England leads the National Health Service in England. It has seven integrated regional teams that support the commissioning of healthcare services for different parts of the country.
NHS X	NHSX is responsible for setting national policy and developing best practice for NHS technology, digital and data, including data sharing and transparency.
Patient Participation Group (PPG)	A Patient Participation Group (PPG) is a group of patients, carers and GP surgery staff who meet to discuss practice issues and patient experience to improve the service. Since April 2015 the GP contract requires all surgeries to have a PPG.

Term	Definition
Place-based approach	A place-based approach brings together health and care organisations and teams, including the voluntary and community sector, with local people in a particular area to better join up services to meet their needs.
Planned care	Planned care is any treatment that is not an emergency and is where a patient is referred for treatment and planned appointments.
Primary care	Primary care is used to describe the services provided by GPs, NHS dentists, optometrists (opticians) and community pharmacists. This may also include other community health services
Primary Care Networks (PCNs)	Groups of GP practices in an area that work together, and with hospitals, social care, pharmacies and other services, to care for people with long-term conditions and prevent people becoming ill.
Provider	An organisation and legal entity, acting as a direct provider of health care services via an NHS contract. The following organisations may act as healthcare providers: • GP Practice • NHS Trust • NHS Foundation Trust • Registered non-NHS Provider (e.g. Independent Sector Healthcare provider) • Unregistered non-NHS Provider • Care Trust • Local Authorities with social care responsibilities • Other agencies
Referral to Treatment Time (RTT)	The time between a patient being referred into a healthcare service (usually by their GP) and the point at which they receive treatment.
Secondary care	More specialised care usually after referral from GP (primary care). This can be provided in a hospital or in the community
Social care	A range of non-medical services arranged by local authorities to help people
Transforming Care Partnership (TCP)	A national programme to make sure that people with learning disabilities or autism can live at home, or in their community close to their family home, rather than staying in hospital for a long time.
UK Health Security Agency (UKHSA)	The UK Health Security Agency is the government agency replacing Public Health England that is responsible for England-wide public health protection and infectious disease capability.
Urgent Care Centre (UCC) or Urgent Treatment Centre (UTC)	A centre which provides care and treatment for minor illnesses and injuries that require urgent attention.
Urgent community response (UCR)	Urgent community response teams provide urgent care to people in their homes which helps to avoid hospital admissions and enable people to live independently for longer.
Voluntary, community and social enterprises (VCSE)	Not-for-profit organisations set up to offer services to specific groups in society. VCSE organisations can include charities, public service mutuals, social enterprises, and many other not-for-profit organisations.

Abbreviations and Acronyms

Abbreviation / Acronym	Description	Abbreviation / Acronym	Description
ACPs	Advanced Care Plans	AFS	Asthma Friendly Schools
AMR	Antimicrobial Resistance	AMS	Antimicrobial Stewardship
ARRS	Additional Roles Reimbursement Scheme	ATAIN	avoiding term admissions into neonatal units
BAF	Board Assurance Framework	BCF	Better Care Fund
BI	Business Intelligence	BFI	Baby Friendly Initiative
BP	Blood Pressure	BSOL	Birmingham and Solihull
CAS	Clinical Assessment Service	CATs	Critically Appraised Topics
CCGs	Clinical Commissioning Groups	CDCs	Community Diagnostic Centres
CEOs	Chief Executive Officers	CFOs	Chief Finance Officers
CGA	Comprehensive Geriatric Assessment	CHC	Continuing Healthcare
CHPs	Community Health Partnerships	CNST	Clinical Negligence Scheme for Trusts
COPD	Chronic Obstructive Pulmonary Disease	CPCS	Community Pharmacy Consultation Scheme
CPD	Continuing Professional Development	CPL	Clinical and professional Leads
CQC	Care Quality Commission	CQI	Continuous Quality Improvement
CQRM	Clinical Quality Review Meeting	CSPs	Care Support Plans
CVD	Cardiovascular Disease	CYP	Children and Young People
DMS	Discharge Medicines Service	ED	Emergency Department
eFI	Electronic Frailty Index	EHIA	Equality and Health Inequalities Impact Assessments
ELF	End of Life Care, Long Term Conditions and Frailty	EoL	End of Life
ERIP	Elective Recovery Improvement Plans	ERS	Electronic Referral Services
ESSDUKPN	East Staffordshire & Surrounds Diabetes UK Patient Network	FIT	Faecal Immunochemical Test
G&A	General and Acute	GIRFT	Get It Right First Time
GMC	General Medical Council	GP	General Practice / General Practitioner
GPN	General Practice Nurse	HEE	Health Education England
HFMA	Healthcare Financial Management Association	HPMA	Healthcare People Management Association
HWBs	Health and Wellbeing Boards	IMHS	Inpatient Mental Health Services
ICB	Integrated Care Board	ICP	Integrated Care Partnership
ICS	Integrated Care System	IFP	Intelligent Fixed Payment

Abbreviation / Acronym	Description	Abbreviation / Acronym	Description
IPH	Improving Population Health	JFP	Joint Forward Plan
JSNA	Joint Strategic Needs Assessment	LDA	Learning Disabilities and Autism
LeDeR	Learning from Lives and Deaths	LMNS	Local Maternity and Neonatal System
LTCs	Long Term Conditions	LTP	Long Term Plan
MDT	Multidisciplinary Teams	MHA	Methodist Homes (care charity based in south Staffordshire)
MHIS	Mental Health Investment Standard	MMR	Measles, Mumps and Rubella
MNVP	Maternity and Neonatal Voices Partnership	MOU	Memorandum of Understanding
MSK	Musculoskeletal	NEL	Non-Elective
NHSE	NHS England	NICE	National Institute of Clinical Excellence
NIHR	National Institute for Health and Care Research	NMAHP	Nursing, Midwifery and Allied Health Professions
OPA	Outpatient Attend	OPE	One Public Estate
PCNs	Primary Care Networks	PCSPs	Personalised Care Support Plans
PDAF	Pre-Delegation Assessment Framework	PDC	Public Dividend Capital
PEoLC	Palliative and End of Life Care	PFI	Private Finance Initiative
PHM	Population Health Management	PPGs	Patient Participation Groups
PSIRF	Patient Safety Incident Response Framework	PTSD	Post-Traumatic Stress Disorder
QOF	Quality Outcomes Framework	QSC	Quality and Safety Committee
RAAC	reinforced autoclaved aerated concrete	ReSPECT	Recommended Summary Plan for Emergency Care and Treatment
RTT	Referral To Treatment	RWT	The Royal Wolverhampton NHS Trust
SBRI	Small Business Research Initiative	SCVYS	Staffordshire Council of Voluntary Youth Services
SDEC	Same Day Emergency Care	SEN	Special Educational Needs
SEND	Special Educational Needs and Disabilities	ShCR	Shared Care Record
SMI	Serious Mental Illness	SMR	Structured Medication Reviews
SQG	System Quality Group	SRO	Senior Responsible Officer
SSHERPa	Staffordshire and Shropshire Health and Care Research Partnership	STARS	Supporting the Advancement of Research Skills
STARS	Staffordshire Treatment and Recovery Service	STAMP	Supporting Treatment and Appropriate Medication in Paediatrics
STOMP	Stopping the Over-Medication of children and young People with a learning disability, autism or both	SV	Serious Violence
TB	Tuberculosis	TIF	Targeted Investment Fund
TLHCs	Targeted Lung Health Checks	UCCC	Unscheduled Care Coordination Centre

Abbreviation / Acronym	Description	Abbreviation / Acronym	Description
UCR	Urgent Community Response	UDAs	Units of Dental Activity
UEC	Urgent and Emergency Care	UHDB	University Hospitals of Derby and Burton NHS Foundation Trust
UHNM	University Hospitals of North Midlands	UKHSA	UK Health Security Agency
UTCs	Urgent Treatment Centres	VCSE	Voluntary, Community and Social Enterprise
WHO	World Health Organisation	WM	West Midlands
WM AHSN	West Midlands Academic Health Science Network	WMAS	West Midlands Ambulance Service
UKRI	UK Research and Innovation		

NHS
Staffordshire and Stoke-on-Trent
Integrated Care Board

REPORT TO:

Staffordshire and Stoke-on-Trent Integrated Care Board

Enclosure:	**11**

Title:	**Annual report: People Culture and Inclusion Programmes**

Meeting Date:	15 June 2023

Executive Lead(s):	**Exec Sign-Off Y/N**	**Author(s):**
Alex Brett	**N**	**Gemma Treanor**

Clinical Reviewer:	**Clinical Sign-off Required Y/N**
	N

Action Required (select):										
Ratification-R		**Approval-A**		**Discussion-D**	**D**	**Assurance-S**	**S**	**Information-I**	✓

Is the [Committee]/[Board] being asked to make a decision/approve this item? Y/N			
Is the decision to be taken within [Committee]/[Board] delegated powers & financial limits?			
• Author to check with Finance to determine if the decision is within Scheme of Financial Delegation (SOFD) approved limits			
Within SOFD Y/N		**Decision's Value / SOFD Limit**	

History of the paper – where has this paper been presented		
	Date	**A/D/S/I**
People Culture and Inclusion Committee	10.05.23	DSI

Purpose of the Paper (Key Points + Executive Summary):
The enclosed annual report explores the achievements, current work and future plans for our ICS People, Culture and Inclusion programmes. The report was developed in collaboration with our programme, clinical, workforce leads, alongside our partners from across the system. It reflects on key milestones and achievements in addressing some our greatest workforce challenges- against the backdrop of significant operational pressures, the formation of the Integrated Care Board (ICB), as well as working towards financial balance. Although these pressures have impacted workforce availability and resilience, the report captures how our people have worked together and developed innovative approaches to support our workforce and our local population.

- **NHS Staffordshire and Stoke-on-Trent Integrated Care Board**

Is there a potential/actual Conflict of Interest?	**N**
Outline any potential Conflict of Interest and recommend how this might be mitigated	

Summary of risks relating to the proposal (inc. Ref. No. of risk it aligns to on Risk Register):
Risks concerning the ability of partners and the system to participate in the programmes, release of staff to take part in schemes/training/engagement and financial envelope available to deliver. Additional risks associated with capacity of People Culture and Inclusion teams to support and deliver proactive work within pressured scenarios

Implications:	
Legal and/or Risk	Overall workforce risks outlined in the PCI Risk Register.
CQC/Regulator	NHSE and HEE reporting and assurance on workforce planning and metrics
Patient Safety	Direct correlation between workforce supply, planning, development and transformation with patient/service user safety.
Financial – if yes, they have been assured by the CFO	External funding supports delivery of schemes including NHSE (HEE), ICB, being monitored and reported. Specific challenges in relation to agency, operating plan and workforce growth delivery in line with financial envelope,
Sustainability	Across all programmes. Specific activity linked to Green/Sustainability plans
Workforce / Training	Across all programmes – detailed in report

Key Requirements:		**Y/N**	**Date**
1a.	Has a Quality Impact Assessment been presented to the System QIA Sub-group?	**N/A**	
1b.	What was the outcome from the System QIA Panel? (Approved / Approved with Conditions / Rejected)		
1c	Were there any conditions? If yes, please state details and the actions in taken in response: • Condition 1 & action taken. • Condition 2 & action taken.		
2a.	Has an Equality Impact Assessment been completed? If yes please give date(s) • Stage 1 • Stage 2	**N/A**	
2b.	If an Equality Impact & Risk Assessment has not been completed what is the rationale for non-completion?		
2c.	***Please provide detail as to these considerations:*** • Which if any of the nine Protected Groups were targeted for engagement and feedback to the ICB, and why those? • Summarise any disaggregated feedback from local Protected Group reps about any negative impacts arising / recommendations (e.g. service improvements)		

- **NHS Staffordshire and Stoke-on-Trent Integrated Care Board**

	• What mitigation / re-shaping of services resulted for people from local Protected Groups (along the lines of 'You Said: We Listened, We Did'?) • Explain any 'objective justification' considerations, if applicable		
3.	Has Engagement activity taken place with Stakeholders / Practices / Communities / Public and Patients ***Please provide detail***	**Y**	
4.	Has a Data Privacy Impact Assessment been completed? ***Please provide detail***	**N/A**	

Recommendations / Action Required:

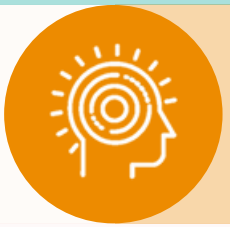
The Integrated Care Board is asked to:

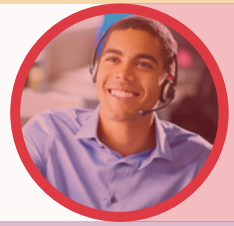
- Note the contents of the report and the progress made across the system in tackling our workforce challenges
- Be assured on the delivery of People, Culture and Inclusion programmes and the progress during 2022/23
- Provide ongoing support and engagement of partners in the delivery of People, Culture and Inclusion Programmes

Staffordshire and Stoke-on-Trent
Integrated Care System (ICS)

People, Culture and Inclusion Programmes

Annual Report 2022-2023





Contents

2 Introduction
3 Foreword
4 ICS People Plan Domains
5 People, Culture and Inclusion Achievements 22-23
6 Benefits Realisation
7 Looking After Our People
8 Spotlight on: Health & Wellbeing
9 Growing for the Future: Growing the Workforce
11 Spotlight on: Workforce Mobilisation
12 Spotlight on: SSOT People Hub Collaboration
13 Spotlight on: Schools Engagement
14 Belonging in the NHS: Supporting inclusion
15 Spotlight on: Race, Inclusion and Differently Abled
16 Spotlight on: Refugee Outreach Support Project
17 Belonging in the NHS: Valuing and supporting leadership
18 Spotlight on: High Potential Scheme
19 New Ways of Working
20 Growing for the Future: Educating & Training
21 Spotlight on: Allied Health Professionals (AHPs) Faculty
22 Spotlight on: Apprenticeships
23 Cross-cutting Theme: Driving & supporting broader social development
24 Spotlight on: Journey to Work
25 Cross-cutting Theme: Transforming People Services
26 Cross-cutting Theme: Leading coordinated workforce planning
27 New Ways of Working: Supporting system design & development
28 Allocation of Heath Education England Funding
30 Developing Plans for the Future Our Operating Model
31 Developing Plans for the Future Programme Activity
32 With huge thanks... To our Partners

Introduction

The Staffordshire and Stoke-on-Trent Integrated Care System (ICS) has continued to face significant pressures with day-to-day service delivery, restoring services to pre-COVID-19 levels, the ongoing impact of the pandemic, winter pressures and more recently industrial action.

Our people have worked tirelessly and passionately to deliver services despite challenges with workforce supply, sickness absence and the ongoing impact to their health and wellbeing.

We reflect on significant milestones from 2022-23, including the formation of the Integrated Care Board (ICB) and new governance structures, as well as working towards financial balance.

Although system pressures have impacted workforce availability and resilience, our people have worked together and developed innovative approaches to support our local population.

This annual report explores the achievements, current work and future plans for our People, Culture and Inclusion programmes.

Foreword

Wow, another amazing year of achievements across our People Culture and Inclusion Programmes. The collaboration between all our system partners truly shows in this Annual Report. We have worked together to tackle the workforce challenges to develop innovative solutions to growing our workforce, securing our future supply, retaining, looking after our people and developing an inclusive culture.

There are so many highlights for me! The achievements demonstrate the determination of our people and leaders to make Staffordshire and Stoke on Trent (SSOT) the best place to live and work. I am proud that Staffordshire and Stoke on Trent ICS continues to be recognised as an exemplar model for system People, Culture and Inclusion practice.

As we look to 2023-4, we will continue our journey towards creating 'One Workforce', develop more provider collaboratives and refresh our strategy in line with national direction. We will work with each ICS portfolio to define, transform and develop the workforce to deliver the best health and care for our population. **Thank you all for your contributions.**

Alex Brett, ICB Chief People Officer

Since my appointment as Non-Executive Director for the ICB People Culture and Inclusion Committee, I have seen the programmes and ICB People Function go from strength to strength. Partners from all sectors have shown their commitment to tackling the workforce challenges collectively, designing new and innovative ways of improving supply, retaining and looking after our most valuable asset.

For me, it is important that we reflect on the achievements and the impact the work of programmes has on the workforce and our population. I have been hugely impressed by the achievements and the impact made over the last year and **I look forward to seeing what more we can achieve together.**

Shokat Lal, Non-Executive
Chair of SSOT People, Culture and Inclusion Committee

Our programme achievements have been captured against the ICS People Plan domains

1. **Supporting the health & wellbeing of all staff.**
2. Growing the workforce for the future & enabling adequate workforce supply.
3. **Supporting inclusion & belonging for all, creating a great experience for staff.**
4. Valuing and supporting leadership at all levels, and lifelong learning.
5. **Leading workforce transformation and new ways of working.**
6. **Educating, training & developing people & managing talent.**
7. Driving & supporting broader social and economic development.
8. **Transforming people services & supporting the people profession.**
9. Leading coordinated workforce planning & intelligence.
10. **Supporting system design & development.**

People, Culture & Inclusion Achievements 2022 - 2023

5
Virtual Work Experience Programmes delivered to **1100+**

Shortlisted for a HSJ Award.

205 **face to face interventions by our Outreach Advisor** with refugees & seldom heard communities.

Journey to Work concept launched including **Schools project** with **100** professionals signed up to visit schools .

ICS People Web Pages launched, **826,083** clicks to date.

HPMA Award for Innovation for the NHS and Social Care Reserve Model.

53 Health & Social Care Apprentices on system rotational placements **Regional Apprenticeship Award Winner.**

Integrated System Wide Workforce Planning (Inc Workforce Development funding).

Levy Transfer **15** Apprentices, **£315,000** in **2022.**

135 people attended **New Futures Race** based leadership development.

Robust & intuitive **People Metrics and reporting** .

87 1:1s in **Phase 1 ICS Retention Programme. Phase 2** commenced.

361 People Hub Staff & **8,810** shifts.

Delivered Cohort 1 of National pilot **High Potential Scheme** **30** commenced Cohort 2.

Comfortable being uncomfortable with Race and Difference Programme rolled out to **300** ICS Senior Leaders.

ICS Wellbeing Week held with nearly **12,000** staff taking part.

3 **ICS Staff Networks.**

Over **800** referrals to the **Staff Psychological Wellbeing Hub.**

***All delivered through Partnership working to develop the One Workforce approach with NHS, Primary Care, Councils, Social Care & Voluntary sectors.**

Benefits Realisation

Our approach to measuring success and impact of People, Culture and Inclusion programmes

Understand & Scope

Use workforce plans, population data, education and pipeline information to identify areas for improvement.

Design

Collaborate, Research, Best Practice.

Engage

Involve health and care partners, wider partners, workforce, public and education.

Implement

Create clear project plans with milestones and outcomes.

Test

Trial, monitor progress & outputs of projects.

Listen & Adapt

Engage stakeholders, review & refine.

Assess the Impact

Use metrics and individual journeys to determine success.

Scale & Spread

Roll-out across programmes and boundaries.

*Underpinned and monitored via the **People Culture and Inclusion governance and Committee structure**

Looking after our people

Supporting the health & wellbeing of all staff and retention

Planned

- Development and approval for an ICS staff health and wellbeing strategy.
- Further promotion and outreach of staff health and wellbeing support available.
- System-wide health and wellbeing event.
- Support and training offered to non-clinical practice staff in wellbeing, as well as clinical to equip and empower.
- Development of an ICS wide Wellbeing Ambassador/Champions approach and community of practice.
- ICS workforce and Psychological support team work closely together to support development of new wellbeing initiatives linked to evidence.
- Broader psychological support offer across ICS, including social and primary care.
- Develop further wellbeing offers linked to population health data.
- Scope for Growth conversations supporting the health and wellbeing of our workforce.
- Promoting the NHS ‘Looking after Your Team, Looking after Your Career and Looking after You Too’ programmes in primary care.
- Implement learning from SSOT regional wellbeing project within SSOT.
- ICS retention programme delivery continues, evaluation undertaken, and recommendations considered for next stage of the programme.
- Develop offers to retain the workforce at system level, for example People Hub and reserves, career conversations, flexible working options and support.
- Retention Coordinators in place and scoping system needs.
- Commence work on local GP recruitment/retention plan through the appointment of Clinical Retention Champions.
- Research good practice in private sector to improve the employment cycle.
- Focus on retirement and options to return, with schemes to support those registered and unregistered to remain in the system.
- Test ‘try before you buy' schemes, including work experience, shadowing and job swaps.
- Deep dives into staff experience and reward and recognition offers as part of retention programme.
- Collaborate to introduce one occupational health contract for NHS trusts.
- System-wide NHS Staff Survey analysis and joint plan in place.

Delivered

- The ICS Staff Psychological & Wellbeing Hub ('The Hub') continues to deliver outreach and engagement across the system with a strong focus on Primary and Social care. From Jan 2022 - Feb2023, 124 Engagement sessions delivered reaching over 2500 staff.
- The Hub has offered support to all Health and Social care staff with over 800 referrals and developed a strong Hub social media presence with nearly 800 Twitter followers.
- The first online Health and Wellbeing Event held in March 2022. Keynote speakers: Sally Gunnell OBE, Michael West, Andrew Sharman, Andrew Whittaker and Colin McLachlan. Nearly 12,000 page views (analytics based on IP addresses, therefore the page views could be significantly higher).
- The Hub have delivered a Wellbeing Ambassador approach through the system including support to primary care and social care.
- Close liaison and learning via regional Be Well programme leads.
- Scope for Growth pilot has been completed for identified groups: HPS, New Futures, Stepping Up.
- Staffordshire Training Hub has regularly promoted the NHS Looking after You programmes to Primary Care via STH bulletin, social media and website.
- Completion of Phase 1 of System wide retention programme, working with partners in both NHS Trusts and Primary Care (GP Clinical Champions) to develop initiatives and collaborate on policy and messaging/resources.
- Launch in February ’23 of Phase 2 of System wide Retention Programme, Steering Group established and draft Joint Retention Strategy created through engagement with all partners. 4 Priority Areas identified for System and Working Groups established to support creation of action plans. Ensuring that the priorities align with strategies of partner organisations and work already underway.
- Retention Hub webpage created and development has begun to bring together useful retention resources into one place for all staff to access.
- NHS providers jointly awarded OH contract to TP Health Ltd with one contract managed at ICS level from April 2023. Supports collective ambition and vision of looking after our people, sharing best practice, identifying areas of pooling. expertise and provides an excellent foundation for further collaborations
- 2021 Staff Survey Analysis undertaken at system level, alongside Social Care workforce survey insights.

Be Well Midlands

SSOT ICS have had money assigned to support with the tackling of health inequalities: Existing health and wellbeing offers are to be re-marketed to support with attracting colleagues from under-represented staff groups.

The Staff Psychological Wellbeing Hub are taking a lead on this and have created a task and finish group, due to meet for the first time on 1st March 2023.

The aim is to create a number of coproduce staff support toolkits, tailored to specific under-represented staff groups, focusing initially on disability and neurodiversity, LGBTQ+, ethnic diversity.

Spotlight on: Health & Wellbeing

Staff Psychological Wellbeing Hub

Over **900** referrals from H&SC staff

From **Jan 2022-Feb 2023**, **1228 staff** accessed webinars with weekly themes delivered twice a week

Continuous outreach and engagement across the system with a strong focus on Primary and Social care. Also have a strong social media presence with nearly **800 Twitter followers**. From **Jan 2022-Feb 2023**, **124** Engagement sessions delivered reaching over **2500** staff

725 staff assessments carried out and **573** referred on to support services

Carer's Support Network launched with **30 staff** signed up. First monthly network with guest speaker took place in **Feb 2023**

Integration and collaboration between services, reducing duplication, streamlining and improving the experiences of staff

Growing for the Future 1

Growing the workforce for the future & enabling adequate workforce supply

Planned

- System wide recruitment planning in shared “high risk” areas; joint roles, flexible contingent workforce, continue International Recruitment.
- Joint approaches to campaigns, both externally for the public and internally at providers, including recruiting for 'hard to fill' staff groups.
- Streamlining recruitment processes across the ICS, utilising digital platforms
- Further recruitment to the ICS People Hub to support System wide (health and care) as required.
- Movement towards System by default approach to Contingent Workforce and ICS Collaborative Bank.
- More Health and Care Reserves working within SSOT.
- Increased Widening Participation activity in schools; wider than Cornerstone Schools – scope joint delivery potential between Health/Care.
- Targeted engagement work (at scale across System Partners) with wider community aligned to tackling health inequalities.
- Focus on increasing access to Health and Care roles from SSOT seldom heard communities.
- Launch of Virtual Work Experience programmes; Mental Health, Primary Care, Social Care.
- System wide Work Experience Portal; develop cross sector approach
- Cohort 4 of System Health and Care Apprenticeship.
- System Pharmacy Technician Apprenticeship in partnership with Primary Care/Staffordshire Training Hub.
- System wide approach to engagement with colleges; promoting all health and care careers.
- System wide workforce strategies developed for professional groups inc AHP, Pharmacy, Nursing, Practice Managers, Social Workers.
- Refresh of the Primary Care workforce strategy (ICB, Staffordshire Training Hub and ICS).
- Development of a ‘GPN school’ and further refine GPN Strategy
- GP and GPN Fellowship schemes.
- Recruitment of additional ARRS facilitators for Primary Care.

Delivered

- Targeted recruitment across the health and social care sector with system wide ‘New to Care’ recruitment events, attendance at jobs fairs, presentations at University Open Days, social media promotion and career conversations with existing staff.
- Campaigns to recruit include NHS Reserves, Reserve Registered Professionals, Social Care Reserves, Home Care Workers, Corporate Reserves and Companion Volunteers.
- SSOT People Hub supported UHNM and MPFT to recruit into brand new Virtual Wards roles.
- SSOT People Hub designed a Social Care Hub with Local Authority and care home providers - launching in Spring 2023.
- Scoping first steps towards collaborative bank, have developed model with UHNM Nurse Bank team to trial booking of People Hub Reserves into vacant shifts.
- Operated as system 'Workforce Cell' in times of escalation and surge. Reviewed and strengthened workforce mobilisation processes to provide a contingent workforce.
- SSOT Journey to work Concept developed and launched - encompasses all ICS widening participation, education provider engagement, community outreach, recruitment, retention and contingent workforce activities.
- Schools engagement pilot launched in September 2022, working with Primary, Middle and Secondary Schools from a range of demographic areas across Staffordshire & Stoke on Trent.
- Health and Care Force launched, which encourages employees from across the system to offer face to face and virtual visits to Schools as well as development of resources and lesson plans that can be accessed by all schools.
- Four live and one on demand virtual work experience programmes have been delivered including Mental Health, Primary Care, Hospital and Social Care. Hospital programme now available to students as an on-demand package.
- System wide work experience portal scoping commenced with HEE and neighbouring ICS.

Growing for the Future 2

Growing the workforce for the future & enabling adequate workforce supply

Planned

- Health and Care wide recruitment planning in shared “high risk” areas; joint roles, flexible contingent workforce, continue International Recruitment.
- Joint approaches to communication of campaigns with the population and relevant Providers both in Health and Care inc recruitment to ‘hard to fill’ staffing groups.
- Streamlining recruitment processes across the ICS, utilising digital platforms
- Further recruitment to the ICS People Hub to support System wide (health and care) as required.
- Movement towards System by default approach to Contingent Workforce and ICS Collaborative Bank.
- More Health and Care Reserves working within SSOT.
- Increased Widening Participation activity in schools; wider than Cornerstone Schools – scope joint delivery potential between Health/Care.
- Targeted engagement work (at scale across System Partners) with wider community aligned to tackling health inequalities.
- Launch of Virtual Work Experience programmes; Mental Health, Primary Care, Social Care.
- System wide Work Experience Portal; develop cross sector approach
- Focus on increasing access to Health and Care roles from SSOT seldom heard communities.
- Cohort 4 of System Health and Care Apprenticeship.
- System Pharmacy Technician Apprenticeship in partnership with Primary Care/Training Hub.
- System wide approach to engagement with colleges; promoting all health and care careers.
- System wide workforce strategies developed for professional groups inc AHP, Pharmacy, Nursing, Practice Managers, Social Workers.
- Refresh of the Primary Care workforce strategy (CCG, Training Hub and ICS)
- Development of a ‘GPN school’ and further refine GPN Strategy.
- Commence work on local GP recruitment/retention plan via appointment of Clinical Retention Champions.
- GP and GPN Fellowship schemes.
- Recruitment of more ARRS facilitators for Primary Care.

Delivered

- Outreach Advisor has completed targeted engagement work with various community groups including Amity Hub, YMCA and Sanctus to offer opportunities to gain employment and training opportunities in heath and care settings. Additional Outreach advisor recruited to support broadening scope and support to seldom heard communities.
- Traineeship programme adopted to offer health and care placement. opportunities for seldom heard communities, supported by the Outreach Team. Offers a pathway to apprenticeship programme following successful completion of the Traineeship.
- Cohort 4 of the Health Care Support Worker Apprenticeship were recruited in March 2023.
- Level 3 PT Pre-Registration Pharmacy Apprenticeship programme launched in November 2022 in partnership with NHS and Primary Care leads.
- Evaluation of ICS Apprenticeship scheme and implementation of learning
- Funding secured to support 5 Midwifery Apprenticeships. Recruitment commenced from existing workforce.
- Funding secured from HEE to up skill ODP workforce, will support various study days and 3 ODPs to undertake their degree top-up.
- Establishment of Primary Care Workforce Implementation Group with inaugural meeting held in March '23. Group priorities include identifying priorities, development of strategy.
- GPN Foundation School Programme Steering Group launched in January 2023
- Staffordshire Training Hub (STH) are encouraging development of the Professional Nurse Advocate role across Primary Care to support restorative clinical supervision, linking in regionally to promote growth.
- STH facilitated General Practice Fellowship Scheme and current cohort of second Fellows due to graduate in July 2023.
- Regional recognition of local work in developing new roles and improving supply e.g. Medical Physics, Audiology.
- Our partners have won awards from local universities and colleges for their work in developing and supporting apprenticeships.

Spotlight on:
Workforce Mobilisation

The People Hub have supported a wide range of services across the health and care system over the last twelve months...

From the **vaccination programme** (including support at mass vaccination sites, local vaccination sites via community pharmacies and PCNs, the Targeted Vaccination team, Children and Young People and School Aged Immunisation teams) to:

- The heart failure team
- vaccination programme
- allied health professionals' referral team
- national blood service
- discharge teams
- A&E
- frail and elderly assessment units
- walk-in clinics
- infection control teams
- antenatal vaccination teams
- nurses supporting asylum seekers
- mental health care and homecare services.

The People Hub workforce has been supporting a variety of communities and filling workforce gaps when the system was most under pressure. Workforce gaps and winter pressures meant additional beds in community hospitals were re-opened and People Hub staff stepped forward for additional training to work in these areas.

The People Hub has mobilised **registered and non-registered healthcare and admin staff** to provide support to the **NHS trusts in the area being affected by industrial action**. In addition, the People Hub team has forged strong relationships with workforce and operational colleagues, creating a robust workforce request and mobilisation process to take into account different circumstances.

Listen to **'Reserves set to deliver gold standard care this winter in Stoke-on-Trent'** Podcast **here**

This has included future planning for:

1. **Predicted hotspots** (e.g. bank holidays, school holidays)
2. **Shorter term request** (e.g. when industrial action dates have been agreed and published by trade unions) and;
3. **Immediate and urgent workforce demand** (whereby Mutual Aid assistance needs to be sought from neighbouring trusts)

The People Hub has increased and bolstered relationships and communication with key partner organisations and facilitates conversations to discuss, plan and resolve, where possible, the issues faced by a system under pressure.

Examples of support from the People Hub team:

Mutual Aid

Facilitated mobilisation for ACP & ENP from UHNM to MPFT to support Industrial Action

Surge

Mobilised 40 RN and HCA to UHNM to support winter pressures

Spotlight on:
SSOT People Hub Collaboration

Since working closely with **East Staffs PCN** during the **COVID-19 vaccination delivery programme** and supplying vaccinators and administrators, conversations led by the ICS People Hub Team to support an identified need in Primary Care initiated the development of an Admin Hub.

GP practices across Staffordshire and Stoke-on-Trent are using People Hub admin staff to help them deliver their patient focussed workloads, including data entry, appointment making, summarising, coding, answering phones etc.

Staff from the Admin Hub currently work with **practices across East Staffordshire, Burton, Lichfield and Tamworth** supporting nine practices, covering five roles, which equates to **over 1900 hours worked since June 2022**.

As success grows, the People Hub Team have now **reached out to Local Medical Council partners in North Staffs and SOT** to develop the Admin Hub further with at least **20 new GP practices keen to engage**.

As the Admin Hub becomes more established the ICS People Team will look to spread the offer wider across the rest of the county, with t**argeted recruitment campaigns and specialist training in GP practice systems**.

ICB Clinical Staff Upskilling Pilot

As part of **Reservist model**, the People Hub have worked with colleagues within the ICB, as well as partners within UHNM, MPFT and UHDB to pilot this exciting programme. **14 ICB clinicians** stepped forward in Cohort 1, were all matched with a clinical setting of their choice (**mental health, walk in centre, acute inpatient ward or A&E**) and are being released from their day jobs for one shift per month. The clinicians have been able to avail themselves of **bespoke refresher training provided by Staffordshire University**.

Plans are currently afoot to launch a 2nd Cohort, expanding the offer to corporate clinicians within NHS England Regional Team.

Tracey Shewan, Director of Communications and Corporate Services

"**I have found the pilot a wonderful step back in to front line Nursing...** the time and support I have had to do this has been amazing. I also can see from colleagues on the front line how impressed they are that we are doing this and showing our support and solidarity with them"

Kellie Johnson, Lead Nurse for Quality and Patient Safety

"The pilot has enabled experienced nurses who have moved into management/corporate roles to continue to offer direct patient care... ensuring that clinical leaders have an up-to-date knowledge of frontline care delivery with the privilege of ongoing learning through patient connections and stories."

1. **5 pilot schools – Primary, Middle and Secondary**
2. 12 month pilot - Formal launch Sept 23 for all schools
3. **Whole System Partnership working**
4. Consolidate the work of individual providers
5. **Physical and virtual interactions; materials and resources**
6. Register of Health and Care ambassadors
7. **Trialing resources with wider schools, drip feed from Year 1 to 12**
8. Toolkit accessible for all schools – linked to curriculum
9. **Links to other programmes – virtual work experience, apprenticeships**
10. Bringing Health and Care careers to life

Spotlight on: Schools Engagement

Engagement and promotion of health and care careers to increase awareness and knowledge, improving our **future recruitment supply...**

Primary School (Year 1 - 4)

- **Make Every Contact Count (MECC)** – Healthy Living, Wellbeing
- **Interactive, virtual materials:** Themed activity packs; Animated videos; real life videos; career pathway videos and visuals
- Aligned to the curriculum, lesson planning
- **Teacher resources and prop box**
- Health and Care employee parents visit schools to promote careers
- Information and guidance for parents
- **'Back to School'** scheme

Middle School (Year 5 - 8)

- **MECC** – Healthy Living, Wellbeing
- **Interactive, virtual activities:** Inspirational videos, 'someone like me' in varying roles; Career pathway videos; Career and inspirational talks; events
- Aligned to the curriculum, lesson planning
- Personality/values based quizzes and career questionnaires
- Linked to **SATs and careers information**
- Information and guidance for parents

Secondary School (Year 9 - 12)

- **MECC** - Health Living, Wellbeing and Sexual health
- **Interactive, virtual activities: Virtual Work Experience**; Social media; Career and inspirational talks; events
- Aligned to curriculum, lesson planning
- Personality/values based quizzes/ career questionnaires
- **Information about H&SC T levels, college, university**
- **Physical work experience/ Placements**

Belonging in the NHS

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

Planned

- Sustained focus on inclusion to influence leadership and development of the System
- ICS Workforce Dashboard to include WRES information.
- Triangulation of system WRES and WDES data with the current and development of EDI System Metrics.
- System Wide Reciprocal Mentoring - Preparing for launch early in 2022-23 using NHS Leadership Academy Reciprocal Mentoring Programme framework. Reciprocal Mentoring evaluation and learning lessons undertaken and acted upon across system
- Continue Inclusion School journey.
- Staffordshire and Stoke on Trent Stepping Up programme – Cohort 4 delivery.
- 'Comfortable being Uncomfortable' cultural education programme roll-out being extended to more leaders and teams.
- Cultural Education Programme wider System roll out.
- Stepping Up/New Futures alumni support, to include ongoing development opportunities and tracking of career progression.
- Development of the NHS Rainbow Badge programme on a system-basis, including extension of principles to non-NHS partners.
- New Futures Diverse Leadership Programme delivery.
- WDES Differently Abled Buddy Scheme (Provider pilot).
- Nominated Clinical Director EDI Champion (Staffordshire Training Hub).
- People, Culture and Inclusion programmes to further inform the development of an inclusive culture across the ICS.
- Widening participation from seldom heard groups - ICS Outreach Project in supporting Refugee community into roles with our sector.
- System wide inclusive recruitment in line with EDI High Impact Action plan.
- Scope 4 Growth Talent Management Career Conversations project commenced.
- HPS cohort 2 – increasing participation from those from ethically diverse communities
- Extend support to non-NHS system partners on developing inclusion.
- Diverse characteristics are proportionally represented across the ICS.

Delivered

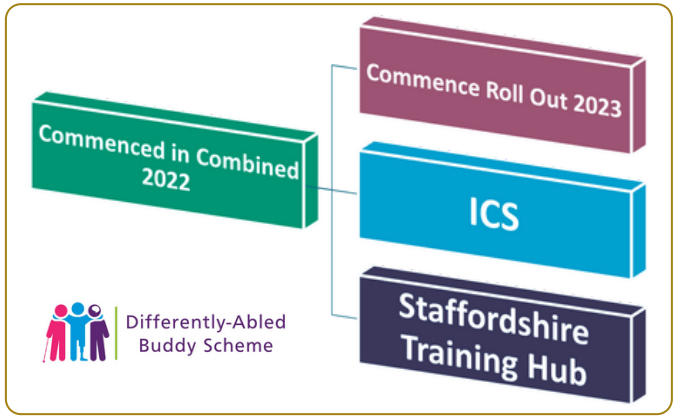
- Process established for collective NHS WRES and WDES metrics from 2023 this will include co-production of action plans and EDI system metrics from June 2023.
- Development of Midwifery WRES and associated action plan relaunched end 2022.
- ICS EDI reference group in review to reflect support Inclusion by design in our workforce, OD and education ICS approach throughout the year.
- Collaboration across the inclusion agenda, on workstreams such as EDS, WRES, WDES and re annual calendar of inclusion events (Black History Month, Pride etc).
- Three system Staff Networks meeting regularly and influencing change.
- Staff networks feed into development of ICS initiatives including reviewing an ICS health and reasonable adjustment passport based on good practice from Police and NHS; supporting widening participation initiatives; joint representation at community events e.g. PRIDE and "Let's Talk about…" webinar /interactive sessions for wider ICS partners and observances from an EDI and Belonging Lens.
- Reciprocal mentoring: NHS Leadership Academy programme suspended – revised timescale to commence Q1 2023.
- Inclusion School programme across system and beyond: Inclusion and Intersectionality the Big Questions with John Amaechi OBE – May 2022; RACE Forward: Your Role in Creating an Anti-Racist ICS with Karl George MBE and Yvonne Coghill CBE – February 2023.
- Local Stepping Up cohort 4 'New Futures' delivered to 33 participants in 2022. Cohort 5 commencing March 2023 (40 places offered). Alumni support continuing.
- Comfortable Being Uncomfortable with Race & Difference delivered to circa 300 system colleagues, including senior leadership.
- ICS will pioneer WRES Champions Programme from March 2023: supporting the WRES and wider inclusion and cultural transformation required to achieve anti racist and anti discriminatory culture across partner organisations and ICS.
- Race Code Assessments completed by NHS partners – this will form basis of EDI system governance and accountability. This includes workforce metrics.
- NHS Rainbow Badge Scheme assessments completed by NHS partners. Action plans to be triangulated and principles shared with wider partners with support to adopt.
- Differently Abled Buddy Scheme being implemented across the system, with funding from Feb 2023-end March 2024, including Primary Care via STH.
- Region's Chief Nursing Officer Developing Aspirant Leaders (DAL) programme uptake of 4 successful staff across the ICS.
- System participation in HEE BAME Aspirant Development Programme (one system candidate in 2021-22, 3 in 2022-23).
- Widening Participation and Out Reach Project have ICS EDI specialist support via working group, Outreach project launched in February 2022, supporting seldom heard communities to access training and job opportunities in health and social care.
- Inclusive Recruitment project progressing with sharing of resources and good practise, increasing use of ethnic diverse inclusive recruitment guardians across ICS
- Scope for Growth pilot delivered via New Futures and HPS 2022 cohorts.

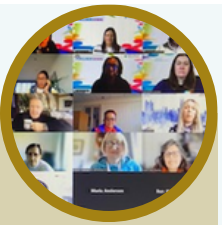
Spotlight on:
Race, Inclusion and Differently Abled

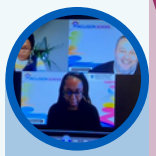
Creating System-wide Change on Race Inclusion

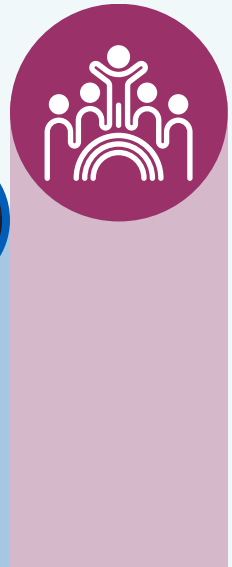
We know we still have much to do to create a wholly inclusive environment for everyone to thrive, progress and feel they belong in. However, we have truly laid the foundations for a **step-change in race inclusion across our system in 2022-2023**, embarking on a 'stepped up' and **multi-faceted programme** for change to propel us to our race inclusion future vision:

- **Our Inclusion School and Comfortable Being Uncomfortable programmes** have been a fundamental part of helping to change mind-set and culture on inclusion
- **We have worked to accelerate the advancement of our ethnic diverse talent,** whilst simultaneously developing the wider system environment to enable them to thrive
- **Our RACE Code shared journeys** will ensure that we continue to achieve and fix progress as we go, towards being an anti-racist system









Developing the Culture: Creating the right Climate

- System Reciprocal Mentoring
- developing Staff Network Executive Sponsors
- board development on race inclusion and health inequalities
- **Comfortable being Uncomfortable**
- Inclusion School
- developing NF Line Managers.

Changing Systems and Processes: Creating the right Environment

- Inclusive Recruitment programme
- RACE Code & associated action plans
- system WRES metrics
- **Model Employer/Race Disparity Ratio**
- engaging with our local communities on race inclusion and health inequalities.

Support & Development for Ethnic Diverse Work Force

- New Futures & Stepping Up Alumni
- developing Aspirant Leaders **(DAL) Programme**
- ENRICH network: system & OR
- developing Staff Network Leads.

Spotlight on:
Seldom Heard Community Outreach

Supporting people from seldom heard communities into healthcare roles by providing careers advice, work experience/volunteering opportunities and job application support. This is support is delivered from a variety of community venues, working alongside DWP, local authorities and housing associations.

Plans for 2023

- Increased support and presence in Job Centres county wide
- Visits to the Staffordshire Science centre University for Amity and YMCA customers
- Facilitated Virtual Work Experience sessions for community based customers
- Traineeship cohorts in January and February
- Additional Outreach Advisor
- Continued support via face to face and group sessions for seldom heard groups
- Potential flexible working pilot (administration)

205 face to face interventions with **Outreach Advisor** since **May 2022**

10 young people currently on placement as part of the **Traineeship programme** in partnership with **Stoke on Trent College** (5 individuals are progressing into Apprenticeship roles)

8 young people into various full time college courses, continuation of **HE courses and apprenticeships**

5 people into employment

Supporting 2 BTEC students with **volunteering placements at UHNM**

Information sessions in a variety of **Job Centres, Dentistry careers session at Amity Hub** and **Aspiration Summit**

Belonging in the NHS

Valuing and supporting leadership at all levels, and lifelong learning

Planned

- North Leadership Development Programme Systems Connects 120 people, 2 Trusts, system wide potential: Platinum and Gold. Masterclasses and cohort sessions underway.
- “Our System Connects” programme reaching circa 60 Band 7 (Gold) & 60 Band 8 (Platinum) leaders from across the System.
- Scope for Growth pilot to include a Train the Trainer model, Community of Practice, 3-5 year career plans for initial groups, target groups identified as High Potential Scheme 1 & 2, Stepping Up Programme/ Stepping Up Alumni.
- Potential & Development Conversation toolkit completed.
- High Potential Scheme Cohort 1 completed, cohort 2 commenced.
- Build a HPS support network: coaches, mentors, sponsors, assessors.
- West Midlands Coaching Collaborative to support ICS.
- Development of Diverse Coaches.
- New Futures diverse leadership programme delivered.
- Collaboration to commence with regional stakeholders including UHDB, MPFT, Derby & Burton Trusts on the system New Futures programme (equivalent Stepping Up) ready for launch March 2022.
- Talent pipeline/ leadership development activities within Social Care in partnership with Skills for Care.
- Expansion of our Leadership Programme for Band 6 (or equivalent) professionals following the success of the Gold & Platinum System to enable a passport approach to development ensuring an inclusive offer more widely.
- Development of System wide talent development tools.
- System wide careers events offering information about roles across the whole sector; NHS, social care and primary care.
- Introduce core offer to support PCN development in conjunction with the Midlands Leadership and Lifelong learning team . Additionally, OD Practitioners will work with PCNs on their progression through the maturity matrix.
- Staffordshire Training Hub roll-out of leadership courses and CPD across general practice, informed by practice-led Training Needs Analysis (TNA) e.g. Practice Management, Leadership Series.
- Inclusive Talent Leadership Programme to be utilised across system wide leadership talent pool.
- Alumni Leadership development to incorporate: New Futures, High Potential Scheme, System Connects.
- System coaches and mentors support all leadership programmes.

Delivered

- 'System Connects' platinum and gold programmes delivered…with more planned over 2023.
- Scope for Growth pilot completed objectives for participants of the identified groups. Train the Trainer module and Community of Practice in progress.
- High Potential Scheme Cohort 1 completed. Cohort 2 launched November 2022 as a Buddy Model with Shropshire using the early adopter model. 30 participants across SSOT and Shropshire, Telford & Wrekin (STW) ICS.
- HPS has a cohesive support network across the ICS including: Career coaches, sponsor, mentors and assessors.
- West Midlands Employers Coaching and Mentoring collaborative entered it’s second year. 3 year forward vision created by providers, collaborating on the system-wide development of coaching and coaching culture and across system support of leadership development programmes.
- Coaches from diverse backgrounds currently in training to support the WM Coaching Pool.
- All leadership and talent offers mapped across the system into a common framework of development pathways.
- Local Stepping Up cohort 4 ‘New Futures’ delivered to 33 participants in 2022.Cohort 5 commencing March 2023 (40 places offered). Alumni tracking and support continuing including masterclass sessions planned for 2023. New Futures programme is intended to Reset - Refocus - Re-energise our people with an ethnic diverse heritage and leadership ambition. Supporting progression and advancement into leadership roles.
- Alumni Leadership development have quarterly Masterclasses planned commencing in March 2023.
- ICS People team coordinating careers events at schools, colleges and universities, plus community events with a focus on reaching and supporting seldom heard groups. Sharing information about jobs, entry level requirements, training and qualifications, work place learning and experience programmes.
- PCN development well underway with the appointment of 3 OD practitioners working across all PCNs, in partnership with Staffordshire Training Hub and ICB Primary Care teams.
- Staffordshire Training Hub delivered a series of Next Steps in Leadership courses for aspiring leaders and those new to management courses - 98 x Primary Care staff attended.
- Launched Primary Care Coaching and Mentoring service open to GP Trainees, GP Locums, salaried and GP Partners to access up to 12 hours of coaching/mentoring.

Spotlight on:
High Potential Scheme

The **High Potential Scheme (HPS)** is an innovative, **24-month career development scheme** to help middle level leaders who have the ambition, aspiration and motivation to accelerate their careers to senior executive roles at a faster pace. The scheme is open to **clinical and non-clinical leaders** working in health and care.

Cohort 1

"It was fantastic to see our 14 Cohort 1 High Potential Participants Graduate in July 2022. Not only did over half of them gain promotion during their time on the scheme but since their graduation further career development opportunities have arisen for many of them to progress further."

Cohort 2

In November 2022 we were also delighted to Cohort 2, the Buddy Model launch, in partnership with Shropshire, Telford and Wrekin ICS, testing the pilot model for scale and spread. **Cohort 2 has 30 participants from a diverse of backgrounds, professions, including 3 participants from social care.**

New Ways of Working

Leading workforce transformation and new ways of working

Planned

- Increase People Hub resource/scope of practice through joint campaigns with wider system partners and continue to develop training packages and pastoral offer.
- Further develop ICS Reserve model inc. emergency 'Step Forward' workforce. Pilot model across sectors with engaged private providers.
- Continuing work with VAST/Support Staffordshire to collaborate further with the sector.
- Continue to build volunteer aspect of contingent workforce.
- Long term volunteer buddy schemes.
- Scope use of platforms to support system staff sharing e.g. Allocate/Patchwork, NHS Jobs3.
- Contribute towards and inform the ICS Digital assessment from a workforce perspective. Develop refreshed Digital People Strategy.
- Refresh of ICS People Programme website.
- Pilot Digital Staff Passport at system level with People Hub.
- Commence ICS People APP development (2-5yrs).
- Introduce Digital Champions Network.
- Development of a digital career pathway across the system, to consider rotations and innovative placements Inc. ICS apprenticeship.
- Establishing strong links with education providers to engage future workforce, promote NHS & Care digital and tech careers and to scope training and education.
- Development of a Digital Leadership programme including virtual classes and e-learning.
- Lead System-wide Workforce Planning to support clinical transformation pathways e.g. Cancer, Maternity, Urgent Care and wider Case for Change.
- Continue the development of a system workforce dashboard and metrics.
- Outreach work to ensure our opportunities are tailored to local workforce and deliver the needs of our population.
- Alignment of core training programmes and competencies across the system.
- Create and update key and clinical roles descriptions to better reflect the roles of the future.
- New joint roles and career pathways across the System.

Delivered

- Continued growth of the SSOT People Hub and reservist models, testing new and innovative ways to attract, recruit and retain people to a contingent workforce.
- Proactive planning with partners around the recruitment to high risk areas, such as domiciliary care, offering incentives such as intensive course of driving lessons to successful candidates.
- 37 new Reserves recruited to People Hub since launch of Winter Campaigns.
- Reserve model refined through partnership working with System colleagues in order to effectively support during times of surge and, more recently, industrial action.
- Currently scoping NHSE regional team Reservist pilot, supporting surge and return to practice.
- Continued partnership working with volunteer organisations and VAST/Support Staffordshire - with strong relationships built ahead of and during Winter 2023.
- Development of volunteer Companion role in partnership with UHNM.
- New SSOT People Hub Activity Dashboard created, tracking recruitment and deployment across the system.
- Contributed to development of ICS Digital Strategy and Roadmap.
- Digital Workforce Plan drafted following engagement with Chief Information Officers and Digital Collaborative - aligned to Digital Roadmap. Action plan and priorities to be agreed in April '23 including Digital Networks, digital skills and career pathways for digital and technology roles.
- ICS People Function Website refreshed and updated - 826,083 page views. Careers, jobs, training, retention and more all included on our ICS website.
- Scoping the use of digital systems to enable more effective offer to partners; deployment and payment of Hub staff. Introduced TRAC to support SSOT People Hub and system recruitment campaigns.
- Digital Leadership programme scoping commenced.
- System wide workforce planning support to all 7 ICS Portfolios.
- Continued development of ICS People Metrics, more recently focusing on including Social Care and Primary Care.
- ICS People Outreach team have worked with community groups and on a 1:1 basis with individuals to support opportunities within the local workforce.
- Exploring new rotational apprenticeship programmes, including a digital/social media apprentice, AHP focussed schemes.
- Working with local Colleges to help facilitate T Level placements in a number of areas including digital. T-Level placement planning at provider level.
- Schools engagement pilot commenced with a focus on primary schools as well as secondary.
- Secured funding to support 4 x Anaesthesia Associate trainees to support the developing theatre workforce and new way of working in theatres.

Growing for the Future

Educating, training, developing people & managing talent

Planned

- Refresh and launch of ICS System Wide Education, training and development Group. Partners Inc. NHS, LA, Social Care, Voluntary, Staffs Training Hub, CCG, Further & Higher Education providers.
- Scope system wide approach to Clinical Placements expansion and digital platforms to support understanding of placement capacity, develop plans with partners to improve capacity and experience.
- Working more closely with Education Providers.
- Gather higher and further education and destination data and intelligence.
- System approach to commissioning training places and overall engagement with Higher education Institutes (HEIs).
- Delivery of cohort 3 of System Wide Apprenticeship programme .
- System wide Pharmacy Technician Apprenticeship scheme development and launch in partnership with Staffordshire Training Hub.
- Commence planning for ICS Career Pathway progression e.g. Nurse Associates, Trainee Nurse Associates, Degree Apprenticeship, and pathway experience at System Level.
- Development of further ICS career pathways in line with system priorities, informed by workforce planning.
- Continued delivery of System wide Apprenticeship Levy Share.
- Develop new courses with Higher Education partners which respond to system need and workforce planning indications, informed by national and local drivers.
- Develop further Health and Care work experience and information sharing opportunities for all groups.
- Review system wide training delivery to find collaborative solution.
- Develop system Training Academy (2-5 years).
- Focus on developing an offer for Admin and clerical staff – training, career progression inc NHS, LA, Social Care, Primary Care.
- Proposals for developing senior leads as Career Coaches to support developmental & career conversations with high potentials and career development toolkit.
- GPS coaches in Primary Care.
- General Practice Pathway to progress and retain using apprenticeships.

Delivered

- ICS Education, Training & Development group re-launched with all system partners engaged. Workshops focusing on social care and nursing took place.
- Executive Senior Responsible Officer (SRO) identified to oversee the ICS Education and Training Collaborative - supported by a refreshed Steering Group approach, in partnership with HEE.
- Drafted Education & Training Strategy, underpinned by ICB Duty to promote education and training (Joint Forward Plan).
- Commenced discussions with HEE on METIP approach for 2023/24 and system oversight.
- Planning for a Workforce Summit being held in October 2023 has commenced to bring all system partners together to discuss challenges and joint solutions to the recruitment, training and retention issues across health and social care.
- Undertook scoping on Clinical Placements and explored system wide approach with partners, with Job Description and project brief developed with Clinical Leads. Unsuccessful recruitment to an ICS hosted post leading to discussions regarding provider collaborative approach.
- College and University Engagement plan in place to strengthen relationships.
- Working with HEE to collate Further education & Higher education destination data.
- Worked with system partners, HEE and NHSE to explore opportunities to transform, develop and train the workforce utilising HEE, NHSE and other funding.
- Cohort 3 system wide rotational Health Care Support Worker programme successfully took place in 2022, with cohort 4 recruited and starting in early 2023.
- PTPT Pre- Registration Pharmacy Technician cross sector apprenticeship programme launched
- Created new apprenticeship pathways including Midwifery, Student Nurse Associates in Social Care and Physician Associates in Primary Care and Mental Health.
- Work commenced to refresh and expand the ICS Health and Care Career Pathway ro include routes into registered professional occupations across our system - utilising the website to house the information and sharing to wider groups.
- Levy share system well established and continuing to offer to Staffordshire and Stoke on Trent Health and Care providers.
- Schools engagement group has helped to create a range of resources that can be used by individuals and education providers to share information about career opportunities in health and social care.
- 4 Virtual workforce experience programmes delivered plus 1 on demand programme
- Staffordshire Training Hub launched the Primary Care non-clinical Apprenticeship Programme to recruit new staff or upskill current workforce.
- System partners have explored innovative ways to deliver training and development opportunities including e-learning, simulation suites, online and videos.
- Secured a NHS Graduate Management Training Scheme (NHS GMTS) trainee who will undertake placements across the system.
- ICS New2Health & Care Academy scoping commenced with NHS and Social Care partners, building on New to Care recruitment successes in Social Care.
- STH undertaking a pilot for quality assurance of multi-professional clinical placements at PCN level to develop new ways of supporting education placements across Primary Care.
- STH leading a Trainee Nurse associate programme via ARRS funding - 7 trainees qualifying in September 2023. Second cohort recruitment underway for 13 TNAs plus Social Care scheme being supported by the model in conjunction with HEE.

Spotlight on:
Allied Health Professionals (AHPs) Faculty

The **SSOT AHP Faculty** facilitates system-wide working between health and care providers and Higher Education Institutions (**HEI**s) for all **AHP**s across our system, all activity aligning with the **Long Term Plan**, **People Plan** and I**CS goals**. Current membership includes 13-14 AHP disciplines, support workers and student AHPs. Monthly meetings held with representation from all providers Trusts, both HEIs and Private, Independent and Voluntary Organisations (PIVO) colleagues.

Strategically identifying and developing a strong sustainable AHP workforce, whilst promoting SSOT and sharing best practice across disciplines have been key focus. **Project leads have progressed workstreams and increased AHP efficiencies within and across provider Trusts, HEIs and PIVO in the ICS...**

Since 2022: SSOT AHP Faculty have attracted circa £271,000 funding, following 7 successful BIDs to fund leadership of key projects, alongside a successful joint £1,279,680 joint AHP and nursing BID

A twitter page and NHS future platform page has been created to further engage AHPs to support our communication channels

AHP Faculty Leadership Secondments, have also supported with development of future leaders

AHP Faculty have hosted 5 student AHP leadership placements, with more planned for academic year 2023/2024

The SSOT AHP Conference in November 2022 celebrated the success of ICS AHP staff and inspired best practice amongst colleagues. It was attended by 300 AHPs of all disciplines and included support worker colleagues

Overview of SSOT AHPs Across the System:

1,317.33 Known Full Time Equivalent AHPs and 455.48 Known AHP Support Workforce

Key Project Outputs for 2022 - 2023

AHP Preceptorship: ICS project to support to newly qualified staff, attract and enhance AHP retention. Implementation and impact now being evaluated. Work recognised locally, regionally and nationally, informing best practice and published

Developing AHP Support Workforce: Created an Aide Memoir to facilitate and empower support workers in Professional Development Reviews. Plus system resource area created. First AHP Support Worker celebration event scheduled for April 2023

Equality, Diversity and Inclusion: Golden thread through all work streams, but additional work undertaken to understand specific needs of the AHP workforce in SSOT. Focus groups planned and recommendations will be identified

Over 55's Project: Retaining expertise of senior colleagues: Surveyed senior AHPs considering retirement, captured reasons and factors that might enable their retention in workforce. Work ongoing

Workforce data and Intelligence: Created an ICS workforce data dashboard to support with future workforce planning for AHPs

PIVO AHP scoping project: Identifying where PIVO colleagues work to increase ICS engagement and collaboration. SSOT AHPs survey disseminated and database of all AHP PIVO providers being created

AHP student dashboard: Created to support AHP placement management & expansion system level

Apprenticeships: Two new AHP apprenticeship programmes negotiated with HEIs; Radiography BSc at Keele recruited 17 new apprentices (Jan 23); work ongoing to develop an Occupational Therapy apprenticeship also at Keele (anticipated start 2024)

Spotlight on: ICS Apprenticeships

Evaluation & developments...

Placement Feedback	Changes Made
Apprentices not aware of what is expected of them	Induction will be both college and employer based
Online review meetings can be daunting	Online review meetings changed to face to face, to be held at the college
Placements unsure of what the apprentices should/shouldn't be doing	New easy glance chart provided by the college of work the apprentice should be undertaking
Unsure of placement dates	Placements will run with a main base with 3, 1 month long SPOKE placements, all to be communicated with apprentice, college and placements
Uncertainty over salary commitment required	Clear throughout all promotional work the salary commitment, also clear within the updated memorandum of understanding (MOU)
ICS support and involvement throughout apprenticeships praised	

Mental Health First Aider
MHFA England

What's next...

- **Mental health first aid training**
- Monthly review meetings with the apprentices
- Quarterly review meetings with placements areas
- **Working with placement providers to open up in house training opportunities**
- Working with partners to support other apprenticeship opportunities
- **Numeracy Champions**
- Schools and Colleges Engagement Outreach activities

Cross-cutting Theme

Driving & supporting broader social and economic development

Planned

- ICS Widening Participation Strategy agreed and action plan implemented.
- System wide approaches to Widening Participation embedded and delivery of joint activities.
- System Career Pathways (including Apprenticeships) with various starting points to support participation (Traineeships).
- Continue support to workplace learning schemes e.g Step into work, Princes Trust Traineeships, T Levels, Staffordshire Cornerstone Employer.
- Further engagement with and opportunities for disadvantaged or seldom heard communities including Refugee/ Out Reach project.
- Robust work directly within communities to identify how to create job opportunities.
- Working with education institutions to develop the local future workforce across the health and care system.
- Appointment of Ambassadors to promote careers in health and care.
- More recruits from seldom heard communities in all NHS Trusts, Local Authorities and ICS People culture and Inclusion programmes.
- Further work with the Staffordshire and Stoke on Trent LEP to link into work being done in the private sector to support those from seldom heard communities find educational opportunities and work.
- Wellbeing Enabler project – linked to inequalities & mental health priorities.
- Understanding of workforce experience and inequalities at organisation and system level through WRES, staff survey/feedback (F2SU),H&W, psychological wellbeing hub, staff equality networks, gender pay and ethnicity pay gap reports.
- Through accountability and sustainability of Staff equality networks: understand and identify areas of inequality, enable workforce as representative of, and link with our local diverse communities.
- Understand service user experience and staff understanding of health inequalities and impact on population health and access to services/information.
- Digital enablers e.g. APP/Passport.
- Development of workforce specific actions to support ICS Green/Sustainability Strategy.

Delivered

- ICS Widening Participation Delivery plan agreed and being monitored by Widening Participation Group.
- Development of 'Journey to Work' Concept to promote and create entry points and further opportunities within health and social care for various groups including school leavers, job seekers and seldom heard communities.
- Continued promotion and delivery of workplace learning schemes such as Traineeships, Virtual and Physical work experience and T levels.
- ICS Cornerstone Employer Status maintained through working with schools and Careers Enterprise Company.
- Outreach Advisor worked with over 200 people from seldom heard communities to offer one to one support, careers guidance, Observerships and job opportunities across Staffordshire and Stoke on Trent.
- Outreach Advisor working closely with Equality and Diversity Lead, Local Authorities' and local community groups to understand areas of inequality.
- Provider level support to overseas colleagues in a range of forms inc Observerships,
- Scoping commenced with West Midlands Migration Service.
- College and University engagement in place to develop the local future workforce, with specific initiatives to support people from seldom heard communities e.g. ICS Apprenticeship Scheme.
- Development of Health and Care Force, aligned to existing Career Ambassador schemes inc iCare. register of professionals available to visit schools, colleges and events.
- Partnership working with Job Centres, Local Authorities and targeted recruitment campaigns to attract people New to Care.
- Training and shadowing packages in place, facilitated by ICS People Hub and in partnership with Health and Care Providers, to support with entry level requirements.
- Development of ICS People webpages providing accessible information on health and care careers.
- Member of Staffordshire and Stoke on Trent LEP and regular engagement with leads.
- Wellbeing Enabler project reviewed with focus on Mental Health First Aid Training funded by HEE and delivered by Changes to Social Care and Primary Care colleagues, with second cohort planned in 2023.
- Ongoing work with Population Health and Health Inequalities Portfolio team to understand the activities and alignment with the People programmes.
- Staff Networks successfully continue with engagement from staff across ICS
- Contributed to development of ICS Green/Sustainability Strategy.

Facilities & Estates

Spotlight on: Journey to Work

The health and care careers pathway 'Journey to Work' scheme brings opportunities together under one concept, making it easier for people looking to start, change or progress their careers.....

Hospital

Journey to Work will help to facilitate a career journey through a variety of routes across the **SSOT Health and Care system**. For those;

- **Leaving education**
- **Never worked in health/care**
- **Looking for a career change**
- **Wanting progression and development**

The aim is to **improve employment outcomes for local people** and **show there is an entry point and career for all in SSOT Health and Care Services**. We will support individuals through:

- Working with job centres and **job seekers**
- Reaching out to **seldom heard communities** with our outreach work and offer schemes such as **Traineeships**
- Offering **Apprenticeships** and opportunities
- Attracting and training people via our **ICS New to Care Academy**
- Working with **colleges and students**
- Creating a **Primary and Secondary school careers programme**

Social Care

Watch Edward's Story here

Mental Health

J2W Health & Care Careers

Cross-cutting Theme

Transforming people services & supporting the people profession

Planned

- Establishment of ICB People Function.
- Commencement in post of ICB NED lead for “One Workforce” People, Culture and Inclusion Committee.
- Appointment of Chief People Officer.
- Delivery of HR & OD efficiencies programmes focussing on multiple contracted service providers, provision of HR&OD functions and optimising the utilisation of Robotic Process Automation (RPA). Current projects focussed on:
  - Occupational Health - Move towards 1 OH Provider across the ICS
  - Recruitment - Standardise and streamline processes across ICS - explore options for delivering at scale, introduce RPA processes and maximise efficiencies
  - Workforce Planning/Information - ICS-wide planning and reporting functions scoped
- Consider Provider Collaboration and delivering at scale in wider People functions.
- Continue to provide OD and system development support and capability to organisations, provider collaboratives, clinical networks and other formal collaborative arrangements within the ICS.
- Work on Navigating Change Masterclasses, bitesize learning and supporting toolkit as part of the ICS People Transformation workstream has commenced as part of a system wide Health & Wellbeing offer.

Delivered

- ICB People Function team in place and development sessions taken place to support team development.
- All ICB Non-executive Directors NEDs appointed.
- Appointment of ICS NED chair for People Culture and Inclusion Committee.
- ICB Chief People Officer appointed.
- ICS People Collaborative Operating Model developed with NHS Trust Chief People Officer (CPO) and leads.
- Strong links established between ICS leads for Nursing, Therapies, Medical, Quality, Planning, Finance and People Leads.
- HR & OD efficiencies programmes progressed in the following areas:
  - System OH tender completed and new consortium provider from April 2023
  - Recruitment working group established and RPA scoping underway
  - Workforce planning, information systems and reporting scoped across ICS via a series of workshops. Workforce planning and intelligence peer network established. Additional resource appointed at ICS level, support and development plan in place with partners
- Provider Collaboration approach underway for Clinical Placement programme.
- Successful delivery of 8 bespoke sessions to support the ICS People Transformation, including: Navigating Change, Stress Management, Polishing Up your Resilience and Making Change Work For You. The sessions were delivered on line and included course materials and resources, to facilitate managers/leaders delivering onto their teams.

Cross-cutting Theme

Leading coordinated workforce planning & intelligence

Planned

- ICS People metrics and dashboard to include social care and primary care.
- ICs People metrics assurance and monitoring of agreed metrics.
- Developing overarching dashboards with both quantitative and qualitative data, incorporating information at a Trust/Provider and system level, which will allow us to track the benefits realisation of our collective endeavours, for example Staff Experience and Workforce Sustainability Dashboards.
- Utilise ICS level data for planning including workforce, population and health inequalities activities.
- Support social care managers to complete WF national minimum data set.
- Social care clear on projected future needs of RGNs and plan to achieve this.
- More workforce planning expertise at system level.
- Increased workforce planning capability and capacity across the system via training/mentoring/community of practice.
- Delivery of Strategic Workforce Planning in relation to operational plans.
- Workforce planning across clinical pathways - Case for Change, cancer, maternity and Urgent Emergency Care (UEC).
- Incrementally increasing system-wide working by influencing wider stakeholders via digital platforms, data and direct feedback from our workforce/ service users.
- Using workforce planning tools to plan at system and place level.
- Collaboration/streamline Agency/Bank rates at system level.
- Ensure project outcomes are recorded and impact evaluated to allow us to prioritise the work at system level, creating value for money.
- Utilise STH Primary Care TNA data and focus groups to assess workforce risks including retention and retirement.

Delivered

- Newly established ICS Workforce Planning and Information team in place, building relationships with key stakeholders.
- Developed and refined approach to workforce insight metrics and ensured transparency/knowledge of the position to increase awareness of workforce issues, subsequent mitigations and management of risk.
- Scoping commenced to develop workforce information capability across all portfolios, ensuring the approach is robust for future use and development.
- Supported programmes with workforce information and subsequent deep dive requirements to inform requirement/priorities and define/measure the impact of workforce interventions.
- Developed approaches to understanding the workforce planning position and opportunities, to ensure development and delivery is aligned to system and organisational priorities, via the Operational Plan.
- Enhanced and bolstered the system position by the working in partnership with NHS providers to develop plans and identify areas of opportunity for workforce planning improvement (capacity and capability).
- Developing approaches to contribute to effective operational workforce planning, including review of opportunities to enhance processes and approaches, e.g. budgeted establishment into ESR.
- Ensuring workforce planning is integral and considered both strategically and operationally to ensure the right people, with the right skills are in the right place at the right time, including enhancing of skills within HR professional community.
- Integrated planning and working between Strategic Workforce Planning and People Programme activities aligned to the intelligence and plans.
- Facilitated and delivered operational workforce planning national and regional requirements, in an unprecedented challenging planning round due to additional granularity and submission challenges.
- ICS People Culture and Inclusion programme assurance developed to track and measure impact of projects.
- Primary Care data and information being utilised to inform STH and Primary Care team focus, plus GP Recruitment and Retention Champions.

New Ways of Working

Supporting system design & development

Planned

- Appointment of mandated ICB Director(s) level posts.
- Appointment of Chief People Officer/Partner for the system.
- Supported transition of current CCG workforce into new ICS/ICB structures.
- HR processes to be undertaken with affected workforce as mandated posts are appointed to linking to support offers available.
- Health and wellbeing & leadership/OD support available for staff affected by change processes.
- Formalised ICS People Function as part of the new ICB structure.
- Creation and delivery of ICS OD programme – Lessons learned OD support, ICB board development, culture and behavioural change support across ICB, ICP and PCN's, including clinical leadership and place-based focus.

Delivered

- All ICB directorates, structures and functions established, in place and operating under new operating framework.
- Safe transfer (TUPE) of CCG staff into new ICB with roles and responsibilities established.
- ICB staff supported with health, wellbeing, leadership and OD offers.
- Transfer of System People functions to new ICB People function.
- ICB/ICS system wide OD strategy and programme developed to support evolvement and development of new ICB/ICS.
- Ongoing support to the emerging future functions ICS/ICP/ICB.
- ICB Board development programme ongoing.
- PCN OD programme progressing well with dedicated resource and plans in place.
- Supporting design, delivery and embedding of clinical leadership approach across the system.
- People Plan reviewed to directly align to the ICS strategic aims and population needs.
- Contributed to the development of the Joint Forward Plan and Integrated Care Partnership strategy .

Health Education England

Allocation of Heath Education England Funding 1

2022 - 2023

Planning for annual workforce development funding commenced early 2022 using well embedded governance processes.

Plans were in place to ensure that designated funding was swiftly allocated to agreed projects to address **local workforce priorities and the Health Education England (HEE) Mandate.** System partners have worked with HEE and NHSE colleagues to agree and secure further funding with a number of successful bids being approved.

HEE provided each ICS with **a workforce transformation allocation in 2022/23.** For Staffordshire and Stoke on Trent, this allocation was **£370,000 (see table).**

Project	Funding
Belonging	
Organisational Development	£50,000
Leadership programmes	£50,000
Lets work together programme	£20,000
Growing for the Future	
Trainee Nurse Associates - Social Care	£50,000
Clinical Placement expansion	£60,000
Community Outreach and Health Inequalities	£30,000
Education, Learning & Development 'reboot'	£5,000
Maternity Apprenticeships	£25,000
Looking after our People	
Retention in high pressure areas	£70,000
New Ways of Working	
Workforce Planning Capacity and Capability	£10,000
Total	**£370,000**

NHS
Health Education England

Allocation of Heath Education England Funding 2

2022 - 2023

Allocation of funding was based on the system workforce priorities identified by partners of the **People, Culture and Inclusion Committee**, with a focus on:

- **Belonging**
- **Future supply pipeline**
- **Widening Participation and outreach into communities**
- **Retention of current staff**
- **Hard to fill vacancies**
- **Development of existing employees**

The system received an **additional £750,000** in funding to further the work already started, and commence new transformational projects

This funding has helped deliver the outcomes detailed in this report.

2023/24 HEE funding allocations are yet to be confirmed, however once confirmed the process of allocation will mirror previous years.

Project	Funding
Belonging	
OD programme built on Messenger Review	£30,000
Leadership programme delivered at scale	£60,000
Equality, Diversity and Inclusion	£100,000
Growing for the Future	
Community Outreach - seldom heard and deprived community focus	£50,000
Workforce Planning capability and capacity	£70,000
Trainee Nurse Associates - Social Care	£30,000
Journey to work Concept including Schools engagement pilot	£150,000
Maternity apprenticeships	£25,000
Looking after our People	
Retention in high pressure areas	£150,000
New ways of working	
Virtual wards - Digital Upskilling/ OD	£25,000
Community upskilling eyecare / OPD	£60,000
Total	**£750,000**

Developing Plans for the Future

Our Operating Model

Looking forward, the system faces a number of well-known **workforce challenges**, reflected in the current position and experienced by partners. The three main challenges being:

- **Workforce supply** in registered workforce due to turnover/burnout/age/ lack of flexible working opportunities
- **Cultural/behavioural change** required between all Partners to move to a System way of working
- **Financial challenge**; requirement to deliver increased activity (due to population demand and elective recovery) via workforce productivity rather than increase in headcount.

To tackle the challenges and close the gap is a vast undertaking. The **ICS People Function** is the linchpin 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.

It is imperative that we continue to build on the partnerships forged over the years to enable delivery of the system priorities within the 7 portfolios. Our **ICS People Operating Framework** is captured in the following infographic:

Developing Plans for the Future

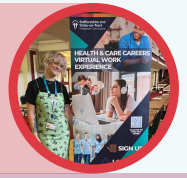
Programme Activity

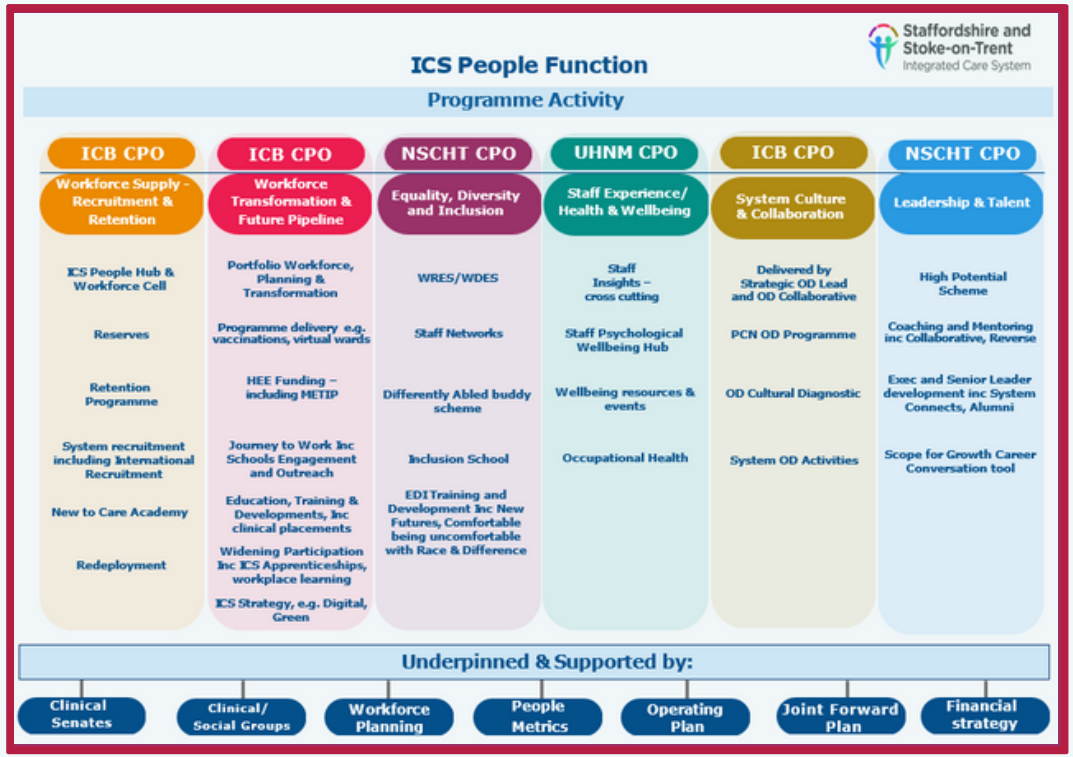
The **ICS People Function** ensures any interdependencies with national, regional and system strategies and portfolios are included in planning and delivery of the People Culture and Inclusion programmes, as follows:

- Delivery of national and regional functions e.g. ICS workforce planning and reporting, ICS People Plan
- Enabling function for 'One Workforce' operating model across ICB, NHS, Local Authority, Social Care, Primary Care, Voluntary Sector, private providers
- Delivery of Joint Forward Plan, ICP strategies, alignment to all 7 portfolios and partner strategies
- Direct link with ICB finance and planning functions including operational planning, agency, and people metrics.

We await the launch of the **National People Strategy** which will subsequently require local plans to be updated and delivered in line with the national vision and our changing local landscape. Additionally, the **Hewitt report** will outline recommendations regarding ICS oversight and governance, and the way we transparently share data and utilise it to improve our practices.

Meanwhile, our **ICS People Collaborative** approach, developed over time with health and social care partners, is mature and effective in collectively tackling our workforce challenges. Our **programme activity for 2023-24** is captured in the infographic:





With huge thanks…

To our Partners

NHS Staffordshire and Stoke-on-Trent Integrated Care Board

NHS Midlands Partnership NHS Foundation Trust
A Keele University Teaching Trust

NHS University Hospitals of North Midlands NHS Trust

NHS North Staffordshire Combined Healthcare NHS Trust

Staffordshire County Council

Primary Care Networks

SUPPORT STAFFORDSHIRE TOGETHER
Creating a Stronger Staffordshire

City of Stoke-on-Trent

Staffordshire Training Hub

NHS Health Education England

CARE

NHS England

vast INVESTING IN COMMUNITIES

Independent Care Providers

skillsforcare

Without the support and contributions of our partners and workforce, we would not have been able to achieve or make the difference we have.

We look forward to continuing our work with all partners with our People at the heart of everything we do.

NHS
Staffordshire and Stoke-on-Trent
Integrated Care Board

Board Committee Summary and Escalation Report

Report of:	Finance and Performance Committee
Chair:	Megan Nurse
Executive Lead:	Paul Brown
Date:	6 June 2023

Key Discussion Topics	Summary of Assurance	Action including referral to other committees and escalation to Board
PART A		
System Risk Register	There are 13 risks on the System Register of which 12 are high scoring (12 and above) and there is 1 medium risk. This is a decrease from May when there were 16 high scoring and 4 medium risks. The Committee approved the increase in score for risk 104: Winter Scheme De-escalation Plans from 12 to 20 and the decrease in score for risk 111: Ambulance Handover Delays from 20 to 12. 1 new risk: A&E Four Hours Performance – Urgent Treatment Centres (UTC) Designation has been added to the Finance and Performance Committee (FPC) Register. The Committee has good sight of the top risks for finance, performance and transformation.	Significant risk around de-escalation of winter schemes. Report to July committee if schemes are still operational.
Performance Report	The report provided detail on performance against key targets and levels of activity. Key points are outlined in the performance report presented to the Board so are not repeated here.	
Elective Care/Elective Recovery Plan	FPC will receive monthly reports on elective long waits to provide additional focus and assurance regarding System performance. FPC discussed the latest data on Staffordshire patients waiting over 78 weeks and the key areas of work	The ICB has submitted a compliant plan for zero 65 week waits by the end of March 2024. There is a risk that we will not achieve zero 104ww and 78ww by the end of June.

	being undertaken at UHNM to mitigate the position; these measures are subject to detailed scrutiny through the weekly Tier 1 escalation meetings with NHSE. There has been an improvement in the trajectory position but this does carry some degree of risk, in part due to further scheduled industrial action in June. The latest submission will be outlined at Board.	
ICS Finance Report	<u>Month 1 Report</u> There is no formal Month 1 reporting process for the ICS. The only information available is pay data and it was reported that this is broadly on plan with no new issues or concerns raised at this stage. However the more significant risks are in non-pay and so it was agreed that the Month 2 report will give a more complete position. <u>Delivering the breakeven Plan 2023/24</u> The paper set out the actions and proposals to deliver the System breakeven plan for 2023/24 and to begin to address the £150m recurrent deficit. The paper is being presented to this Board meeting for information so the key points are not repeated in this report.	The Committee approved the actions and proposals set out in the paper.
Monitoring System Delivery of the Operating Plan	The Committee discussed the proposed format and structure of a consolidated Performance Report. This will combine high-level performance focussing on the System priorities and the underpinning metrics, performance and working programmes at Portfolio level to achieve the 31 National Objectives and local ambitions.	
Joint Forward Planning Update	The report provided an update on progress to date in developing the Joint Forward plan (JFP). The paper is being presented to this Board meeting so the key points are not repeated in this report.	
Better Care Fund Plan 2023 - 2025	The report provided details on the BCF objectives, allocations, conditions and metrics. Following the publication of the 2023-2025 BCF Policy Framework, the ICB has been progressing discussions with the two Local Authorities. Final narrative plans and completed planning templates are due to be submitted by 28 June 2023.	The Committee delegated sign-off of the BCF to the FPC Chair Committee noting that the full BCF submission will be shared with the Committee at the July meeting.
System Transformation	The Committee received the	

and Service Change Update	Strategic Transformation and Service Change Programmes Update. In particular, the committee noted that further conversations have been held with UHDB and NHSE in relation to the strategic intent for the FMBUs at Stafford and Lichfield. A service change programme has been established and governance process put in place.	
ICS Capital Schemes Update	The quarterly report provided an update on the main capital schemes and the work of the System Capital Investment Group. The detailed reporting of in-year capital spend against plan is included in the monthly System Finance Report.	
ICS Oversight Framework Letter	Following the discussion at the May Committee meeting on the ICB approach to oversight and assurance, the outcome letters from the monthly meeting held with UHNM on 28 April, the quarterly meetings held with MPUFT on 2 May and NSCHT on 3 May were presented for information.	
PART B		
Risk Register	The Committee reviewed the 7 risks on the ICB risk register and approved the reduction in score from 15 to 9 for Risk 073: Transfer of Primary Care PODs to ICB.	New risk regarding implementation of PODs will be brought to the July committee.
2023/24 Financial Planning and Budget Sign-off	The paper updated the Committee on the final financial plan and budget for the ICB for 2023/24 as submitted to NHSE on 4 May 2023. As the System has now agreed a break-even financial plan, a revised ICB budget was presented to reflect this. The Committee noted the efficiency targets and the proposed reporting of their delivery as detailed in the paper.	FPC approved the final break-even ICB budget for 2023/24.
Budget Management – Line By Line Review	The paper provided an update on the ICB's line by line expenditure review that is part of the financial management actions to deliver the 2023/24 financial plan. To date, £2.6m savings have been identified and a further £2.76m assessed as future opportunities for savings.	
Continuing Healthcare Action Plan	The paper provided the Committee with an update on progress against the key actions and noted that the CHC Transformation Plan has now been aligned to four key workstreams with metrics identified.	

ICB Procurement Operations Group Highlight Report	This paper reported the key activities being co-ordinated by the Procurement Operations Group. It also included a proposal, supported by the Group, to expand the current community gynaecology service contracted for Stoke-on-Trent and North Staffordshire to residents of South Staffordshire. The proposed expansion will ensure equity of access, that patients are treated in the right setting, free acute capacity to tackle long waits and will be funded from the ERF. FPC was asked to approve the in-year expansion of service to the incumbent provider from June 2024 and full market test of the services to take effect	FPC approved the interim measure for community gynaecology in 2023/24 to expand contracted services to South Staffordshire via a contract variation to the existing Health Harmonie direct award and approved the procurement of a new community gynaecology contract to be undertaken in 2023/24 for a Staffordshire wide service to be procured through open market process to be in place for 1 June 2024. Approval was given following a detailed discussion and assurance around risk of challenge being assessed as low. This assessment is based on the commercial terms of current provision (less than tariff), limited providers in the market on the NHS Increasing Capacity Framework and commencement of open procurement process for 24/25.
Midlands and Lancashire Commissioning Support Unit – in-housing update	The paper provided an update on the developments of the ICB service review of the Midlands and Lancashire Support Unit (MLSCU) contract and the in-housing of a number of services by the ICB by 1 October 2023.	
Primary Care Forum Report	In order to have governance oversight, FPC received a summary report of the meeting that took place on 16 May. This reported on the discussions on General Practice and Pharmacy, Optometry & Dental (POD).	

Risk Review and Assurance Summary
The Board can take assurance regarding the reports provided and the discussions that took place at the Committee. Specific risks highlighted above, and in the FPC Risk Register.