Staffordshire and Stoke-on-Trent Integrated Care System

Joint Forward Plan 2023–2028

Summary

Foreword

We are delighted to present this summary of our first Joint Forward Plan (JFP), as the Staffordshire and Stoke-on-Trent Integrated Care System (ICS). The JFP sets out how we will transform services and pathways to support delivery of the vision and ambitions of the Integrated Care Partnership (ICP) Strategy.

Improving population health and tackling health inequalities are complex tasks. Over the longer term, we will continue our focus on prevention and 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. We know that only 10 to 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 must continue using a system-wide approach to prevention, alongside action to improve the wider determinants of health in our communities. These are social, economic and environmental factors which influence people's mental and physical health.

Becoming an ICS has given us a unique opportunity to reset our relationship with people and communities. We want a relationship 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 better understand 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. While 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 ICS and with the ICP now and in the future.

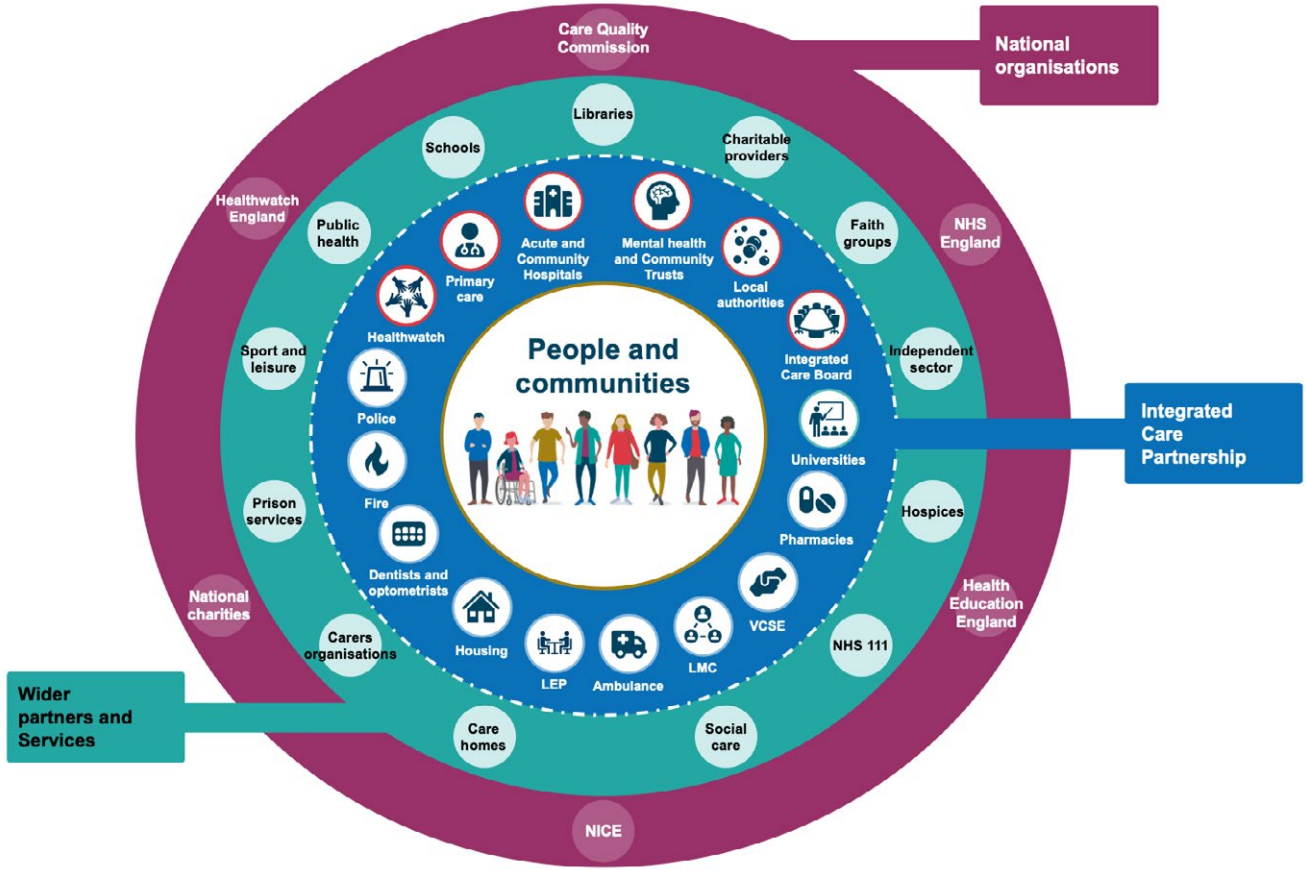
Peter Axon
ICB Chief Executive Officer

Our system explained

The Staffordshire and Stoke-on-Trent Integrated Care System (ICS) brings together 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 an ICS 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.



LEP –
Local Enterprise Partnership

LMC –
Local Medical Committee

NICE –
National Institute for Health and Care Excellence

VCSE –
Voluntary, Community and Social Enterprise sector

Our system is made up of two 'places' aligned to the upper tier local authorities, Provider Collaboratives, Primary Care Networks and neighbourhoods.

Provider collaboratives bring providers together to achieve the benefits of working at scale (in bigger groupings). This helps to improve quality, efficiency and outcomes and helps us stop people experiencing inequalities in their access to and experience of different providers. Provider collaboratives are developing in most of our system portfolios and are helping to transform services that are delivered by two or more providers. Each has a Programme Board with executive representatives from acute providers both within and outside our system, community providers, Place, ICB, local authority and general practice.

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 – where local commissioners work together to provide health and social care services.

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. In Staffordshire and Stoke-on-Trent, 142 practices are grouped into 25 PCNs. They will be crucial to the implementation of the Joint Forward Plan, through more resilient delivery of primary care in local neighbourhoods, and the integration of health and care services.

Neighbourhoods provide a focus for smaller, identifiable populations with 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.

The purpose of the Joint Forward Plan 2023–2028

The purpose of the Joint Forward Plan is to set out how we will deliver our ambitions in the Integrated Care Partnership Strategy over the next five years, with the Operational Plan 2023/24 being the first year of the Joint Forward Plan.

It describes our health and wellbeing priorities, how they align with the ICP Strategy and the shared Integrated Partnership priorities, and how these are delivered through the portfolios (such as primary care and mental health).

What is in our plan?

We have split our Joint Forward Plan into three parts:

1

In Part 1 of the plan, you will read about:

- why we need Joint Forward Plan
- our priorities and ambitions
- how we will work together
- what will help us succeed, including our Digital and People teams.

2

In Part 2 you will read about:

- our Finance Strategy
- our wider system development ambitions
- a range of themes which go across all our work, such as personalised care, integration, and working with our voluntary, community and social enterprise (VCSE) partners.

3

Part 3 of the plan is a series of appendices which:

- summarise how we will meet the statutory requirements placed on the Integrated Care Board
- give an overview of the actions and achievements the portfolios will deliver, and their target dates for doing these things
- provide copies of supporting documents referred to in the main body of the document.

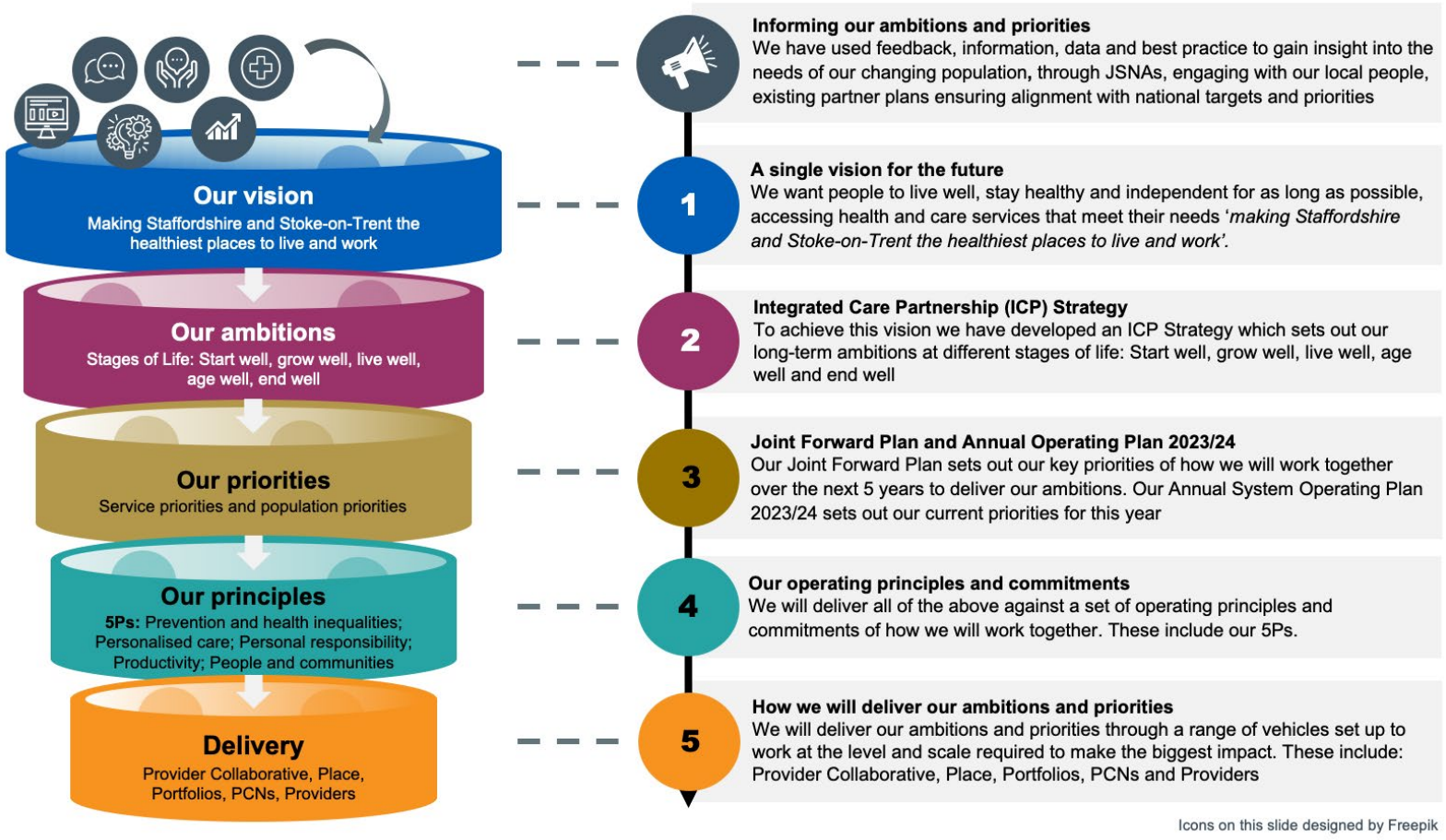
Our vision

To achieve our vision, we have developed an Integrated Care Partnership Strategy.

The Strategy is based on an assessment of our health, public health and social care needs. It 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.

This diagram shows how we will bring our vision, ambitions, priorities and principles to life.

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



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How we have brought our organisational priorities together as One Health and Care System

We have developed our ambitions and priorities based on our understanding of our population's needs.

We identified these through:

- Joint Strategic Needs Assessments
- Engaging with local communities.

We have made sure that all our shared priorities, including those from our partners' existing plans and strategies, are in line with national targets and priorities.

These include:

- The NHS Long Term Plan and related policies and guidance
- Staffordshire Health and Wellbeing Strategy 2022–27
- Stoke-on-Trent Joint Health and Wellbeing Strategy 2021–25.

Health and Wellbeing and ICP strategy priorities

Stoke-on-Trent City Council Health and Wellbeing strategy priorities

- Getting the most healthy start in life
- Developing well into adulthood
- Promoting good physical health
- Promoting good mental health
- Supporting people to maintain independence
- Living well into old age
- Providing the best end-of-life care
- Building strong communities
- Living in a healthy home and environment
- Supporting sustainable employment, skills and the local economy.

Staffordshire County Council Health and Wellbeing strategy priorities

- Health in early life - Improving health in pregnancy and infancy with a priority focus on reducing infant mortality
- Good mental health - Building strong and resilient communities and individuals who are in control of their own mental wellbeing
- Healthy weight - creating the conditions to help people to make healthy choices that will help adults and children reach a healthy weight
- Healthy ageing - promoting wellbeing and enabling independence for older people.

Integrated Care Partnership strategy priorities

- Give infants and children the best start to life
- Enable children to thrive into adulthood, supporting physical, mental and social development
- Enable adults to take ownership of health and wellbeing and achieve their potential
- Enable people to remain independent, active and connected in their communities with a plan for later life
- Maximise health and wellbeing in the last years of life by supporting people and carers with personalised care when needed.

Existing shared priorities across the Integrated Care Partnership

- Improving health in pregnancy and infancy
- Mental health
- Learning disability and autism
- Reducing drug and alcohol harm
- Addressing obesity across the life course
- Prevention and early intervention – long-term conditions (LTCs) and cancer
- Improved prevention and management of LTCs
- Reducing health inequalities
- Healthy ageing
- Personalised care
- Improved employment
- Digital transformation

8 ICS PRIORITIES

1. Improving outcomes in population health and health inequality
2. Improving delivery of elective care services
3. Improving cancer services and outcomes in cancer care
4. Delivering improvements in CYP services and maternity care
5. Improving UEC and delivering more care at home
6. Promoting healthy ageing and managing end of life, LTC and frailty
7. Delivering more services through primary care to support system transformation
8. Growing and improving mental health and learning disability and autism services

How we will work together; our wider enablers, cross-cutting themes and strategic development

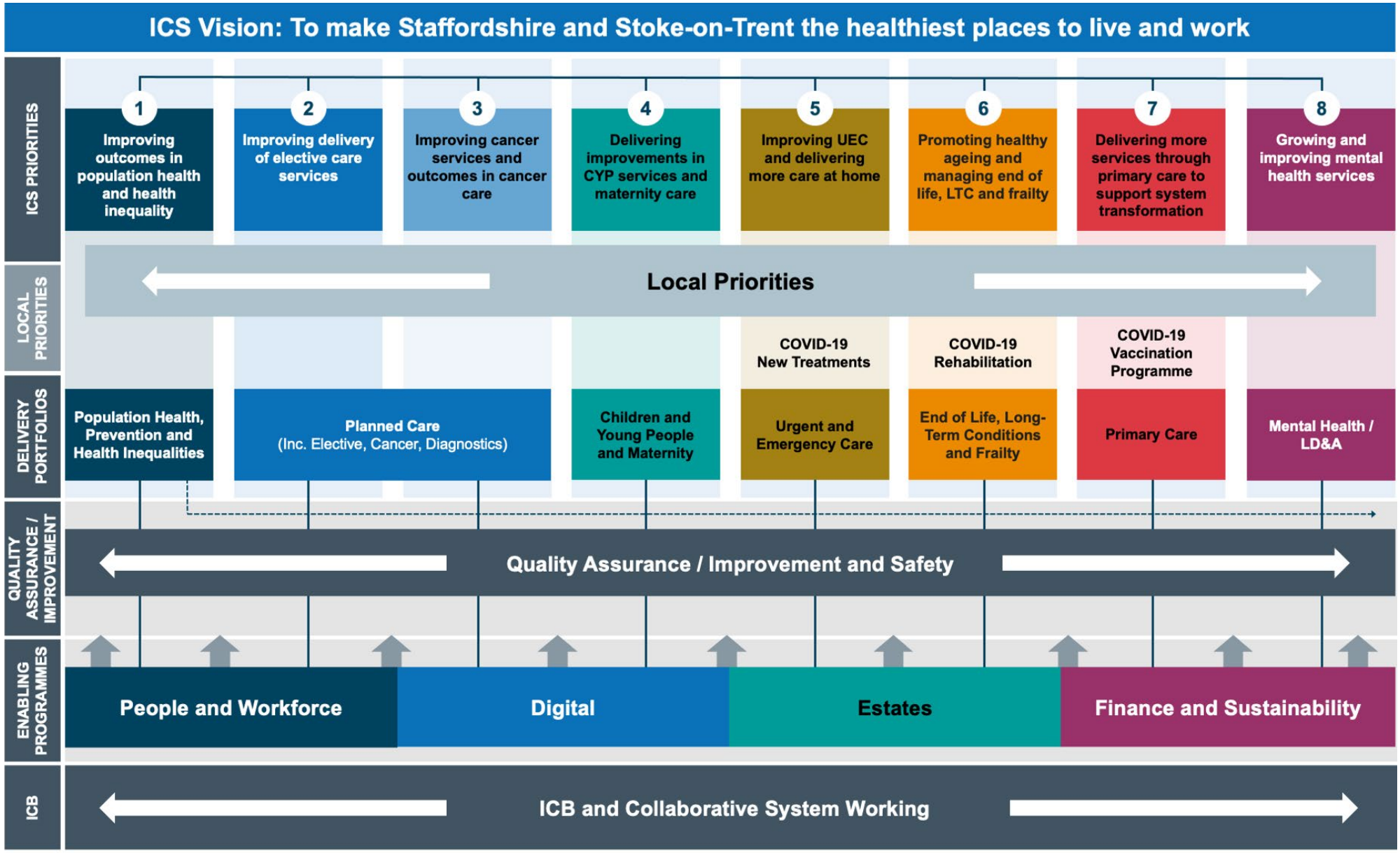
Provider Plans and Strategies

Operational model

Our seven **portfolios** are aligned with eight key local priorities (**Children and Young People** and **Maternity and Neonates** are in one portfolio). The portfolios are the system's way of bringing delivery and local service 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 allows us to form teams from across the system, which have the range of expertise to respond to priorities and deliver the work programmes set out in our plans.

- Population health, prevention and reducing inequalities
- Planned care and cancer
- Children and young people and maternity
- Urgent and emergency care
- End of Life, Long-Term Conditions and Frailty
- Primary care
- Mental health and learning disabilities and autism


ICS Vision: To make Staffordshire and Stoke-on-Trent the healthiest places to live and work
ICS PRIORITIES
1
Improving outcomes in population health and health inequality
2
Improving delivery of elective care services
3
Improving cancer services and outcomes in cancer care
4
Delivering improvements in CYP services and maternity care
5
Improving UEC and delivering more care at home
6
Promoting healthy ageing and managing end of life, LTC and frailty
7
Delivering more services through primary care to support system transformation
8
Growing and improving mental health services
LOCAL PRIORITIES
Local Priorities
COVID-19 New Treatments
COVID-19 Rehabilitation
COVID-19 Vaccination Programme
DELIVERY PORTFOLIOS
Population Health, Prevention and Health Inequalities
Planned Care (Inc. Elective, Cancer, Diagnostics)
Children and Young People and Maternity
Urgent and Emergency Care
End of Life, Long-Term Conditions and Frailty
Primary Care
Mental Health / LD&A
QUALITY ASSURANCE / IMPROVEMENT
Quality Assurance / Improvement and Safety
ENABLING PROGRAMMES
People and Workforce
Digital
Estates
Finance and Sustainability
ICB
ICB and Collaborative System Working

Portfolio five-year plans

Portfolio	Delivered by:				
Improving Population Health – High-Level Deliverables	**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.	✔	✔			

Portfolio	Delivered by:				
Planned Care – High-Level Deliverables	**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, maximising use of independent sector 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 'Get It Right First Time' (GIRFT), national directives such as reducing unnecessary outpatient follow-up appointments (OPFU) and local transformations such as the creation of dedicated elective care hubs, to 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 Deliverables	**Y1**	**Y2**	**Y3**	**Y4**	**Y5**
Eliminating long waits • Achieving standard (95% of patients receive diagnostic test within six weeks by 2025) • Embed the key strategies and GIRFT principles set out nationally, including increasing diagnostic capacity, and recovery of pre-pandemic productivity levels to ensure that we are able to deliver the target of 95% of patients receiving a diagnostic test within six 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.	✔	✔			

Portfolio	Delivered by:				
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. 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 who 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 and young people's access to mental health support when and where they need it.	✔	✔	✔	✔	✔

Portfolio	Delivered by:				
Children and Young People – High-Level Deliverable	**Y1**	**Y2**	**Y3**	**Y4**	**Y5**
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.	✔	✔	✔		
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.	✔	✔	✔	To be reviewed in line with national guidance	
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 Seven immediate and essential actions from the Ockenden report	✔				

Portfolio	Delivered by:				
Urgent and 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 trialling 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.	✔	✔			

Portfolio	Delivered by:				
Urgent and Emergency Care – High-Level Deliverable	**Y1**	**Y2**	**Y3**	**Y4**	**Y5**
One 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 NHS 111 provision.		✔	✔		
Acute Care at Home Provider Collaborative The Acute Care at Home Service providing collaborative working across primary, community and secondary care through three service areas: Unscheduled Care Coordination Centre (UCCC) which is a clinical triage telephone line, our two-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 one) • Deliver strategy to reduce health inequalities and reduce disease progression in cardiovascular disease, diabetes and respiratory LTCs (Year two 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 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			

Portfolio	Delivered by:				
Primary Care – High-Level Deliverable	**Y1**	**Y2**	**Y3**	**Y4**	**Y5**
Increase the number of GPs in practice to support the national target of an additional 6,000 GPs by 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 complement the general practice skill mix. We will be working towards our contribution to 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.	✔	✔	✔	✔	✔

Portfolio	Delivered by:				
Pharmacy and Medicines Optimisation – High-Level Deliverable	**Y1**	**Y2**	**Y3**	**Y4**	**Y5**
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 professionals 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's 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 mental health crisis care provision and alternatives to A&E, including NHS 111, ambulance response, crisis resolution home treatment teams and mental health 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.	✔	✔	✔	✔	✔

Portfolio	Delivered by:				
Mental Health – High-Level Deliverable	**Y1**	**Y2**	**Y3**	**Y4**	**Y5**
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.		✔	✔	✔	✔

Portfolio	Delivered by:				
Learning Disabilities and Autism – High-Level Deliverable	**Y1**	**Y2**	**Y3**	**Y4**	**Y5**
Dedicated care and 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.		✔	✔	✔	✔

Next steps

The way we have designed our portfolios has allowed us to bring together our structures in a different way to support delivery of services.

- We will continue to work with local partners to strengthen our working relationships and processes
- We will continue with the organisational development of the portfolios in 2023. This will be key to ensuring that portfolios are established and recognised as ways of working at system and Place level
- We will continue to involve and speak to our local population through the portfolios. This will support the annual refresh of our Joint Forward Plan.

Examples of our planned public and population involvement programme

Programme	Portfolio
Inpatient mental health services (IMHS)	• Mental health, learning disabilities and autism
Urgent and emergency care (urgent treatment centres)	• Urgent and emergency care (UEC)
Cannock transformation programme	• Primary care • UEC • Planned care
Maternity	• Children and young people • Maternity and neonates
Community diagnostic centres (CDCs)	• Planned care
Assisted conception	• Planned care