Staffordshire and Stoke-on-Trent
Integrated Care System

Joint Forward Plan
2023 - 2028

Published 30 June 2023

Contents

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 continue to 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). Although it is a five-year plan, it will be refreshed annually. The publication of the plan on 30 June 2023 is just the start of our journey, as our plan will continuously develop and evolve.

Our areas of 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 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 must continue working in partnership using a system-wide approach to prevention, alongside action to improve the wider determinants of health in our communities. We must also maintain our 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 some 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 managing 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 has 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 experiencing longer waiting times for services than we would like. It is essential that we treat people who are waiting as quickly as possible, prioritising those with the greatest clinical need, but also that we focus on transforming planned treatment services so that they are resilient and sustainable for the future.

Provision of services across our urgent care pathways has 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 and to 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 be 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. 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 Integrated Care System and with the Integrated Care Partnership now and in the future.

David Pearson
Chair - Staffordshire and Stoke-on-Trent Integrated Care Board

& Joint Chair of the Staffordshire and Stoke-on-Trent Integrated Care Partnership

Peter Axon
Interim Chief Executive Officer - Staffordshire and Stoke-on-Trent Integrated Care Board

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 five 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 (ICSs) 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 this partnership. The ICP is made up of partners, including local authorities, the police, the voluntary, community and social enterprise (VCSE) sector, and representatives from the ICB. There are partners who have a dual role across the ICB and the ICP, such as Healthwatch, primary care partners, NHS providers and local authorities, indicated by the red-edged circles in the diagram below. The diagram sets out key partners in the ICP and relationships to broader local and national stakeholders.
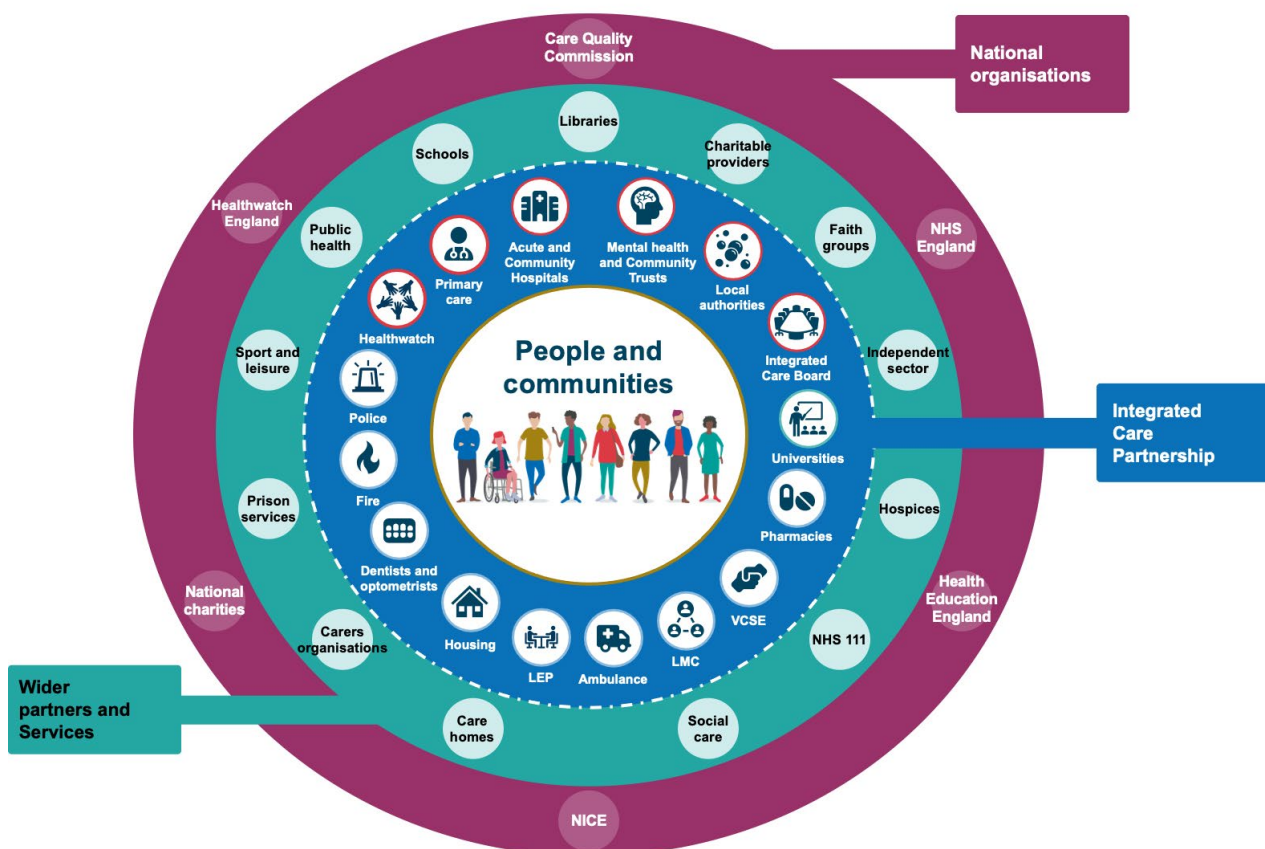
We have split our JFP into three distinct parts.

From reading Part 1 of this plan, you will get an overview of:

- why we need a JFP and some background to the current challenges we are facing
- our priorities and ambitions
- 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) partners.

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

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

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

Introduction

The scope of this document

The Integrated Care Partnership (ICP) strategy outlines how the Staffordshire and Stoke-on-Trent (SSOT) 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 one 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

Population of
1.13 million
according to the 2021 Census

258,000 people
live in Stoke-on-Trent

876,000 people
live in Staffordshire

Stoke-on-Trent's average population is younger

75%
of Staffordshire residents live in areas that are classed as urban

7.4%
of Staffordshire's population live in the 20% most deprived areas in England

Map labels: Leek, Newcastle-under-Lyme, Stoke-on-Trent, Cheadle, Stone, Uttoxeter, Stafford, Burton upon Trent, Rugeley, Penkridge, Cannock, Lichfield, Tamworth, Codsall

99.7% of
Stoke-on-Trent residents live in areas that are classed as urban

The overall population is estimated to increase from 1.13 million in 2018 **to 1.2 million by 2035 (increase of 6%)**

53% of Stoke-on-Trent's
population live in the most deprived 20% of communities in England

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.

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
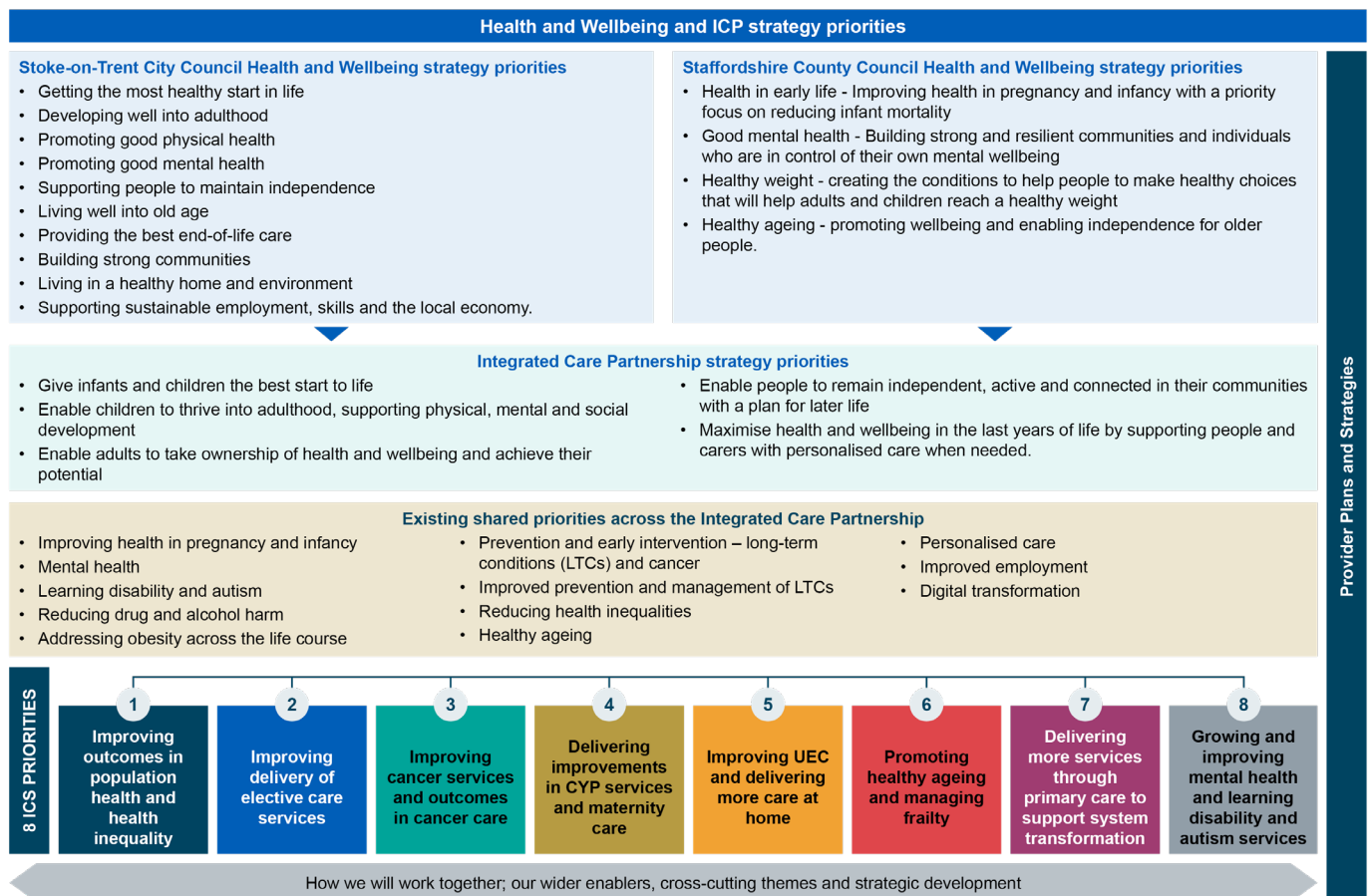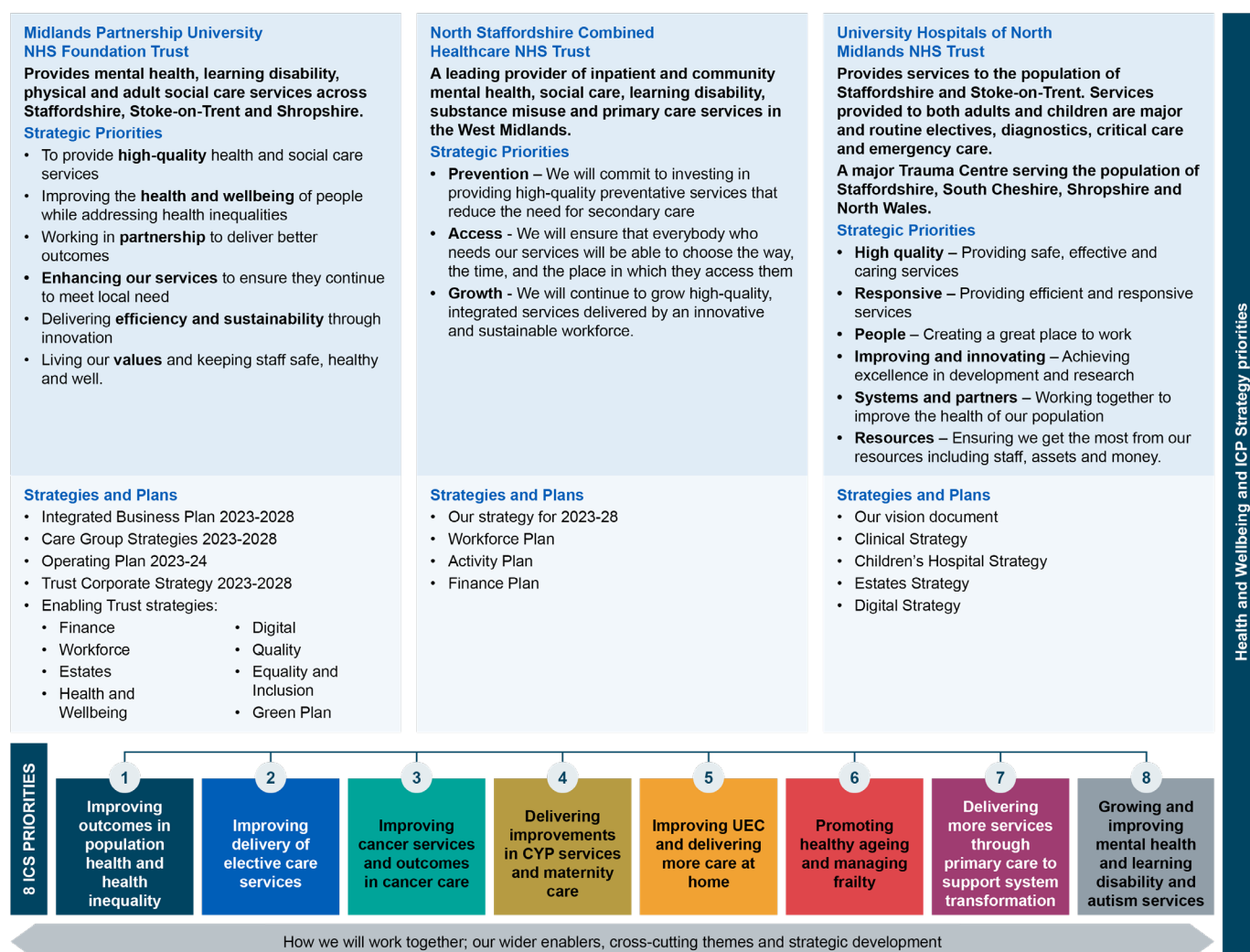- Building strong communities
- Living in a healthy home and environment
- Supporting sustainable employment, skills and the local economy.

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	2	3	4	5	6	7	8
Improving outcomes in population health and health inequality	Improving delivery of elective care services	Improving cancer services and outcomes in cancer care	Delivering improvements in CYP services and maternity care	Improving UEC and delivering more care at home	Promoting healthy ageing and managing frailty	Delivering more services through primary care to support system transformation	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

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 main ICS acute, mental health and community NHS providers, it purposely seeks not to replicate those. The high-level priorities and ambitions of our main providers are outlined in the diagram below.

Midlands Partnership University NHS Foundation Trust

Provides mental health, learning disability, physical and adult social care services across Staffordshire, Stoke-on-Trent and Shropshire.

Strategic Priorities
- To provide **high-quality** health and social care services
- Improving the **health and wellbeing** of people while addressing health inequalities
- Working in **partnership** to deliver better outcomes
- **Enhancing our services** to ensure they continue to meet local need
- Delivering **efficiency and sustainability** through innovation
- Living our **values** and keeping staff safe, healthy and well.

Strategies and Plans
- Integrated Business Plan 2023-2028
- Care Group Strategies 2023-2028
- Operating Plan 2023-24
- Trust Corporate Strategy 2023-2028
- Enabling Trust strategies:
  - Finance
  - Workforce
  - Estates
  - Health and Wellbeing
  - Digital
  - Quality
  - Equality and Inclusion
  - Green Plan

North Staffordshire Combined Healthcare NHS Trust

A leading provider of inpatient and community mental health, social care, learning disability, substance misuse and primary care services in the West Midlands.

Strategic Priorities
- **Prevention** – We will commit to investing in providing high-quality preventative services that reduce the need for secondary care
- **Access** - We will ensure that everybody who needs our services will be able to choose the way, the time, and the place in which they access them
- **Growth** - We will continue to grow high-quality, integrated services delivered by an innovative and sustainable workforce.

Strategies and Plans
- Our strategy for 2023-28
- Workforce Plan
- Activity Plan
- Finance Plan

University Hospitals of North Midlands NHS Trust

Provides services to the population of Staffordshire and Stoke-on-Trent. Services provided to both adults and children are major and routine electives, diagnostics, critical care and emergency care.

A major Trauma Centre serving the population of Staffordshire, South Cheshire, Shropshire and North Wales.

Strategic Priorities
- **High quality** – Providing safe, effective and caring services
- **Responsive** – Providing efficient and responsive services
- **People** – Creating a great place to work
- **Improving and innovating** – Achieving excellence in development and research
- **Systems and partners** – Working together to improve the health of our population
- **Resources** – Ensuring we get the most from our resources including staff, assets and money.

Strategies and Plans
- Our vision document
- Clinical Strategy
- Children's Hospital Strategy
- Estates Strategy
- Digital Strategy

Health and Wellbeing and ICP Strategy priorities

8 ICS PRIORITIES

1	2	3	4	5	6	7	8
Improving outcomes in population health and health inequality	Improving delivery of elective care services	Improving cancer services and outcomes in cancer care	Delivering improvements in CYP services and maternity care	Improving UEC and delivering more care at home	Promoting healthy ageing and managing frailty	Delivering more services through primary care to support system transformation	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

- 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** document is available here

Some of our population, in particular South Staffordshire residents, 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, such as Birmingham Hospitals. Their strategic priorities and plans will be reflected in the JFPs for their respective ICSs. However, in developing our JFP we have fully engaged with them and ensured our priorities are aligned.
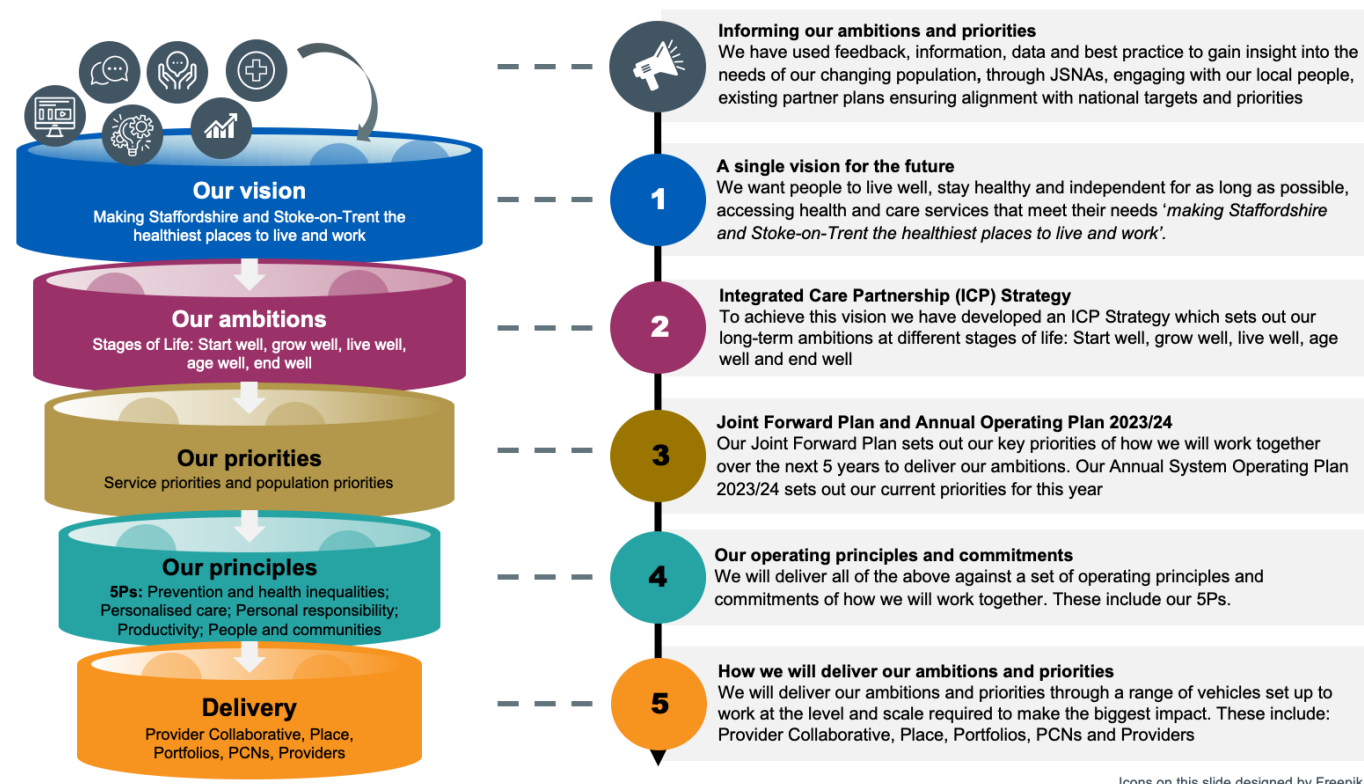
Our ambitions

To achieve our vision, we have taken insight from our population health work to develop the **Integrated Care Partnership Strategy**. 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.

Bringing our ambitions to life

This model explains how our vision, ambitions, priorities, principles and brought together and how as a system we will deliver these.

Our vision
Making Staffordshire and Stoke-on-Trent the healthiest places to live and work

Our ambitions
Stages of Life: Start well, grow well, live well, age well, end well

Our priorities
Service priorities and population priorities

Our principles
5Ps: Prevention and health inequalities; Personalised care; Personal responsibility; Productivity; People and communities

Delivery
Provider Collaborative, Place, Portfolios, PCNs, Providers

Informing our ambitions and priorities
We have used feedback, information, data and best practice to gain insight into the needs of our changing population, through JSNAs, engaging with our local people, existing partner plans ensuring alignment with national targets and priorities

1 A single vision for the future
We want people to live well, stay healthy and independent for as long as possible, accessing health and care services that meet their needs 'making Staffordshire and Stoke-on-Trent the healthiest places to live and work'.

2 Integrated Care Partnership (ICP) Strategy
To achieve this vision we have developed an ICP Strategy which sets out our long-term ambitions at different stages of life: Start well, grow well, live well, age well and end well

3 Joint Forward Plan and Annual Operating Plan 2023/24
Our Joint Forward Plan sets out our key priorities of how we will work together over the next 5 years to deliver our ambitions. Our Annual System Operating Plan 2023/24 sets out our current priorities for this year

4 Our operating principles and commitments
We will deliver all of the above against a set of operating principles and commitments of how we will work together. These include our 5Ps.

5 How we will deliver our ambitions and priorities
We will deliver our ambitions and priorities through a range of vehicles set up to work at the level and scale required to make the biggest impact. These include: Provider Collaborative, Place, Portfolios, PCNs and Providers

Icons on this slide designed by Freepik

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. **Tackling 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.

Across the system there a range of meetings and in place to assist it with managing delivery of the Joint Forward Plan. As system partners we will undertake a continuous appraisal of the position, performance, and delivery of the key priorities and goals set out in the JFP. This will include collectively reviewing performance metrics and delivery of programme priorities. Where necessary these will be reported by exception through to the Board or if appropriate via the Board Assurance Framework (BAF).

Assurance on delivery

As partners, we will undertake a continuous appraisal of the position, performance, and delivery of the key priorities. Our plans are made up of a range of quantitative and qualitative objectives and actions which will need to be delivered either through a provider/partner specific activity or a system-led transformation programme. Each national and local objective is aligned to one of the portfolios or enabling workstreams which make up the delivery architecture for the system. We have identified which deliverables are specific to individual providers and which deliverables require a system approach. We will use existing assurance mechanisms to understand compliance with progress reported to the ICB's Finance and Performance Committee.

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.

The JFP was presented at the Staffordshire HWB on 8th June 2023 in order for the Chair of the board to subsequently provide the below statement of support.

As a consequence to changes in the Stoke-on-Trent City Council leadership, following the local elections, the HWB did not meet as planned in June 2023. However, the Interim Director of Public Health has received and reviewed the JFP in order to provide the statement of support below on behalf of Stoke-on-Trent City Council.

I have received a copy of the Staffordshire and Stoke-on-Trent Joint ICS Forward Plan (JFP).

On behalf of Stoke-on-Trent City Council, I can confirm that the JFP takes into account our Joint Health and Wellbeing Strategy 2021-2025 and the joint priorities outlined in the Staffordshire and Stoke-on-Trent Integrated Care Partnership strategy.

Signed:

Andrea Fallon FFPH

Interim Director Public Health

Stoke-on-Trent City Council

The Staffordshire Health and Wellbeing Board can confirm that the draft Joint Forward Plan (JFP) has been presented at the Board on the 8th June 2023. The JFP takes into account the Staffordshire Health and Wellbeing Strategy 2022-2027 and the joint priorities outlined in the Staffordshire and Stoke-on-Trent Integrated Care Partnership Strategy.

Signed:

Councillor Mark Sutton

Chairman of the Staffordshire Health and Wellbeing Board

Staffordshire County Council

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
- our priorities and ambitions
- how we will work together to make an impactful change
- our enablers to success including quality, digital, people and estates.

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 healthcare 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.

2020			2030
76,072	**14,387 more people with cardiovascular disease** (**9%** increase by **2025**, **19%** increase by **2030**)		90,459
72,545	**12,234 more people who are obese** (**7%** increase by **2025**, **17%** increase by **2030**)		84,779
29,813	**5,149 more people with diabetes** (**7%** increase by **2025**, **17%** increase by **2030**)		34,962
16,178	**4,249 more people with dementia** (**12%** increase by **2025**, **26%** increase by **2030**)		20,427
20,489	**3,607 more people with depression** (**12%** increase by **2025**, **18%** increase by **2030**)		24,096
7,428	**2,167 more hospital admissions** (**13%** increase by **2025**, **29%** increase by **2030**)		9,595
4,050	**725 more people with bronchitis or emphysema** (**8%** increase by **2025**, **18%** increase by **2030**)		4,775

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 impacts on 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 and operational challenges, 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. As part of our engagement on the JFP, a public survey is published alongside it, which builds up 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.
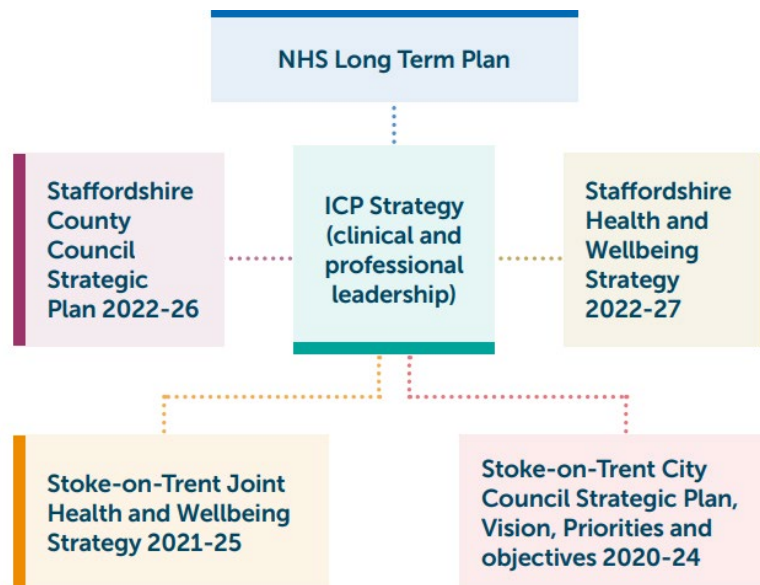
The portfolio plans and enabling function plans outlined in this document demonstrate how we will contribute to delivery of the ambitions outlined in the ICP strategy and how we will address our shared priorities.

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, Digital and Workforce) and broader leadership and support, such as quality, clinical and professional leadership.

ICS Vision: To make Staffordshire and Stoke-on-Trent the healthiest places to live and work

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

Local Priorities

DELIVERY PORTFOLIOS	Population Health, Prevention and Health Inequalities	Planned Care (Inc. Elective, Cancer, Diagnostics)		Children and Young People and Maternity	Urgent and Emergency Care	Frailty and Long-term conditions	Primary Care	Mental Health / LD&A
					COVID-19 New Treatments	COVID-19 Rehabilitation	COVID-19 Vaccination Programme	

Quality Assurance / Improvement and Safety

ENABLING PROGRAMMES	People and Workforce	Digital	Estates	Finance and Sustainability

ICB and Collaborative System Working

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 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:

Develop robust governance

Ensure service delivers value for money

Deliver and improve quality

Optimise workforce

Develop collaborative working across system, enabling integration

| Q1 | Q2 | Q3 | Q4 | | | | |
| JULY 2023 | OCT 2023 | JAN 2024 | APR 2024 | APR 2025 | APR 2026 | APR 2027 |

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:
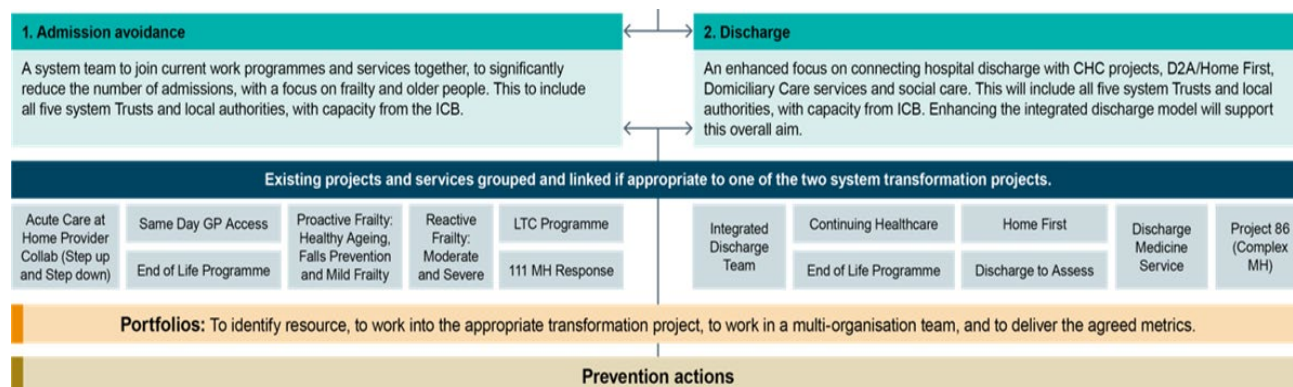
Some areas of transformation may be specific to a group of patients, for example, people with diabetes living in a particular area. In these cases, some very specific work will take place to design local solutions. Others will be broader service transformations and large-scale changes – for example, 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, shown below.

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**.

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 Governance framework is outlined in Appendix Governance Framework

Our ICS priorities and portfolios

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

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 frailty	**7** Delivering more services through primary care to support system transformation	**8** Growing and improving mental health and learning disability and autism services

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 Five Year Plans where a high-level overview of the key priorities and delivery timelines has been provided.

Improving population health

Our commitment – Dr 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 future |
|---|---|---|
| - 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:

People and communities
working with people and communities to empower them to build healthy, supportive and thriving neighbourhoods

Personalised care
holistic, integrated care designed around personal needs and preferences

Personal responsibility
working with individuals to empower them to make healthy choices and manage their health and wellbeing as an active partner

Prevention and health inequalities
promoting healthy decision making, optimising health and wellbeing and ensure fair and equal access for all

Productivity
making best use of resources and targeting those in greatest need, or with greatest ability to benefit

Underpinned by Population Health Management (PHM)
improve population health outcomes through intelligent decision making.

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 on the following table:

National Priority Area	Actions
• **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).
• **Mitigate against digital exclusion** • **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.
• **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.

National Priority Area	Actions
	• 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 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.
• **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.

National Priority Area	Actions
	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)

Group	Detail
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)

Group	Detail
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 ten 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

Safe in our Communities

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.

Safe At Home

Across the system we aim to respond sympathetically, effectively and confidentially to any member of staff who discloses that they are suffering from domestic abuse and are committed to supporting our staff. Examples of the approach taken within the ICB include ICB staff members who are identified as Domestic Abuse Ambassadors or Mental Health First Aiders.

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:
- Recover our core services and productivity, so that we deliver timely access to diagnostics and treatments for our population
- Over the life of this five-year plan, eliminate long waits
- Have sustainable, resilient services that will be designed to be more efficient and productive by the end of the five-year plan
- 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.
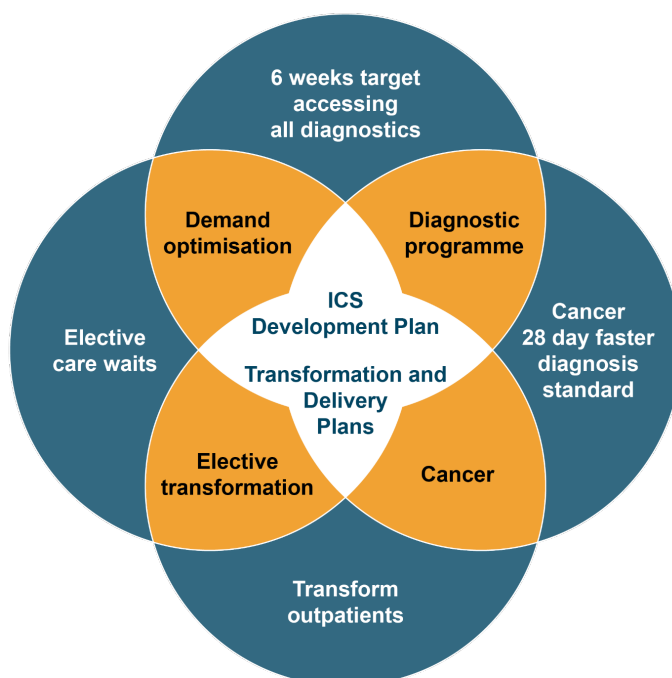
Elective recovery and transformation

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
  - 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:

- Demand management
- Productivity and efficiency improvements
- 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

- By March 2024 no one will wait more than 65 weeks for treatment
- By March 2025 no one will wait more than 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 six 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

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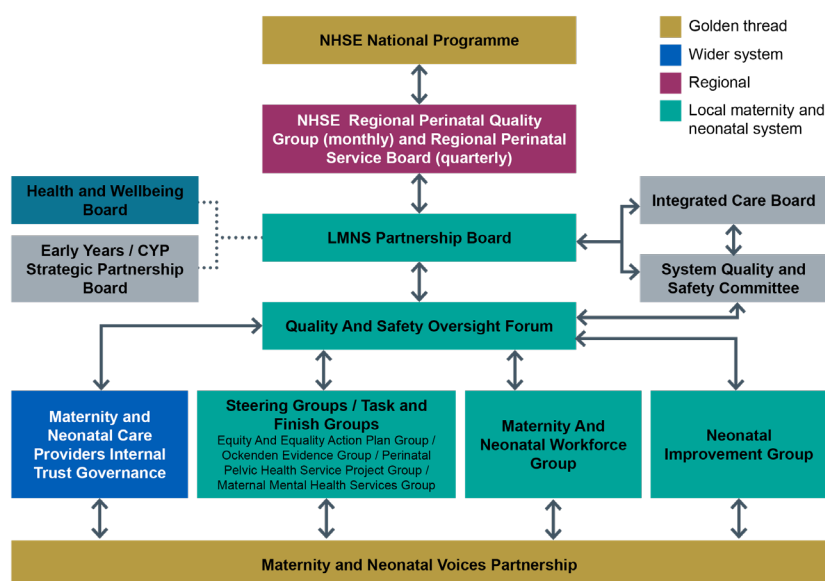
All activities in the maternity and neonatal programme will support achievement of the four themes of the Delivery Plan.

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.
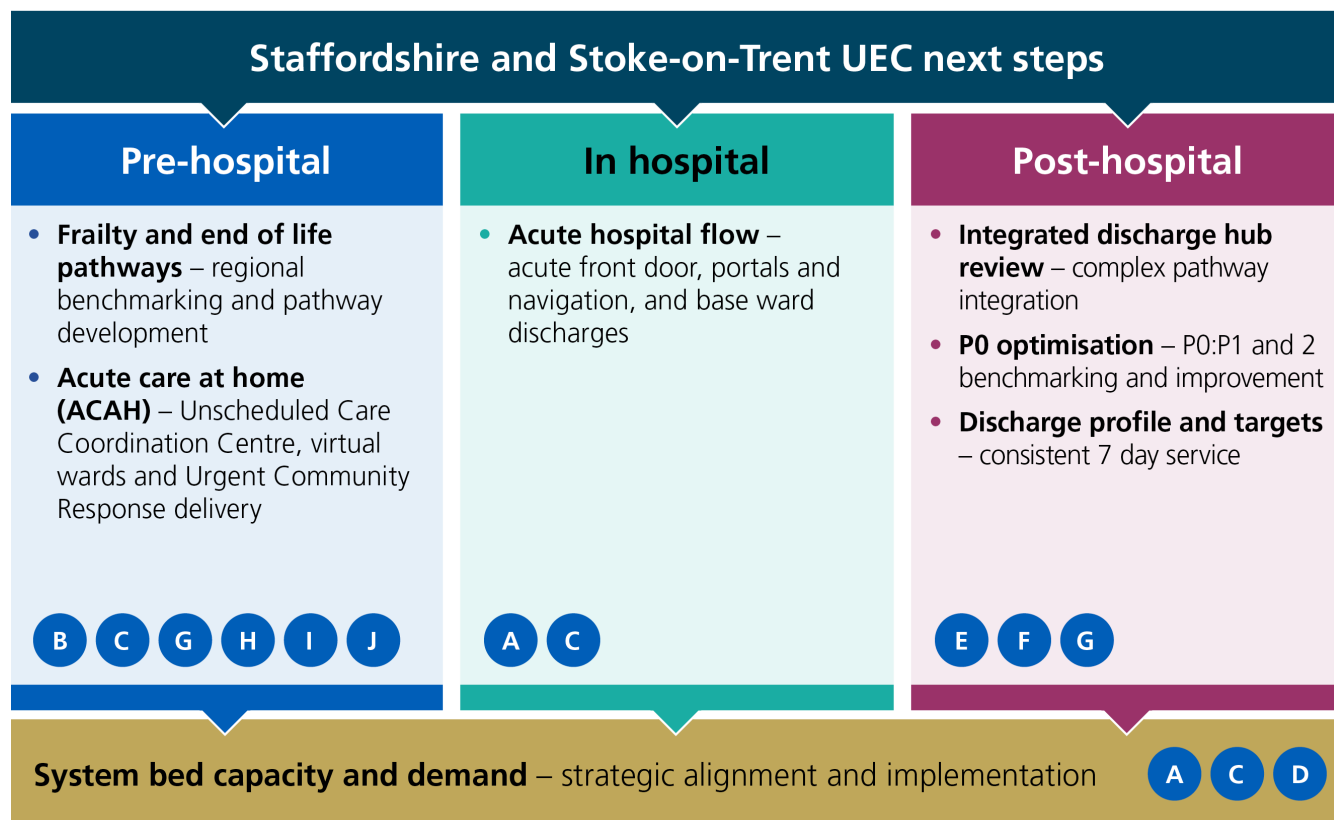
UEC recovery and delivery

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.

Staffordshire and Stoke-on-Trent UEC next steps

Pre-hospital

- **Frailty and end of life pathways** – regional benchmarking and pathway development
- **Acute care at home (ACAH)** – Unscheduled Care Coordination Centre, virtual wards and Urgent Community Response delivery

B **C** **G** **H** **I** **J**

In hospital

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

A **C**

Post-hospital

- **Integrated discharge hub review** – complex pathway integration
- **P0 optimisation** – P0:P1 and 2 benchmarking and improvement
- **Discharge profile and targets** – consistent 7 day service

E **F** **G**

System bed capacity and demand – strategic alignment and implementation   **A** **C** **D**

	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 health 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 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 of 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 trialling 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
- Full review of the Access programme with a view to enhancing provider collaborative offer to include the Clinical Assessment Service

- 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.
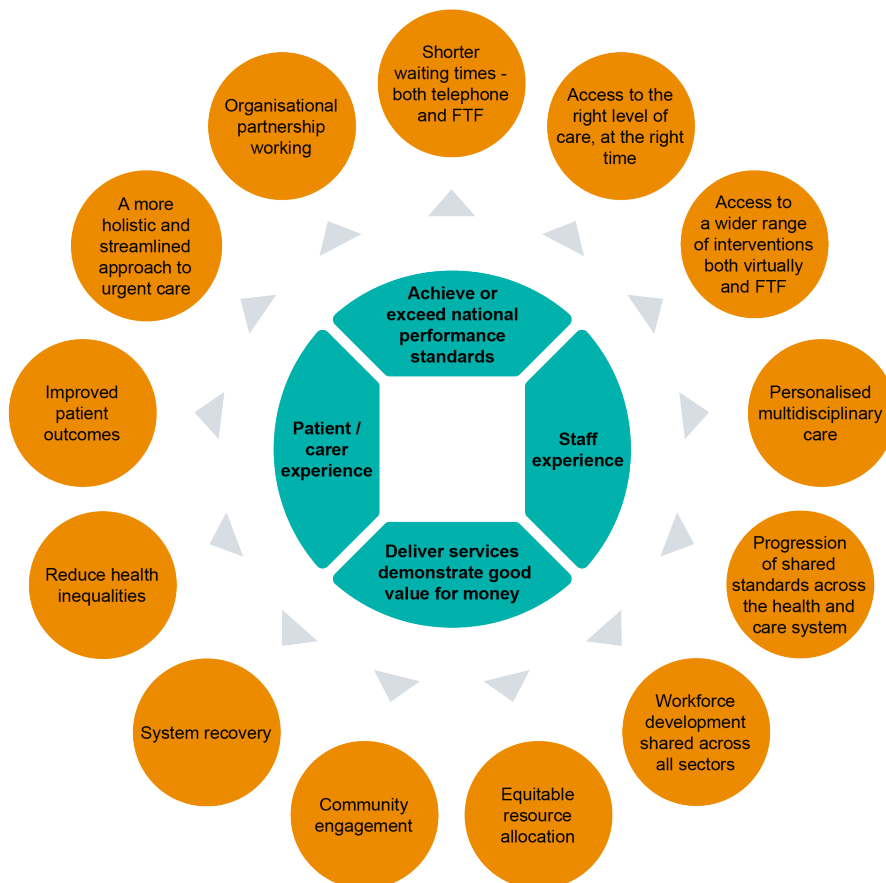
While our plans and strategy are in progress, we also need to maintain a tight operational grip on the daily UEC pressures. The ICB has developed its operational resilience to ensure that we can react to urgent care pressures and respond accordingly. This will largely be achieved through System Control 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.

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. These are the wider determinants of health, our health behaviours and lifestyles, an integrated health and care system and the places and communities we live in and with.

Improving Health and Wellbeing Framework

The wider determinants of health

Our health behaviours and lifestyles

An integrated health and care system

The places and communities we live in and with
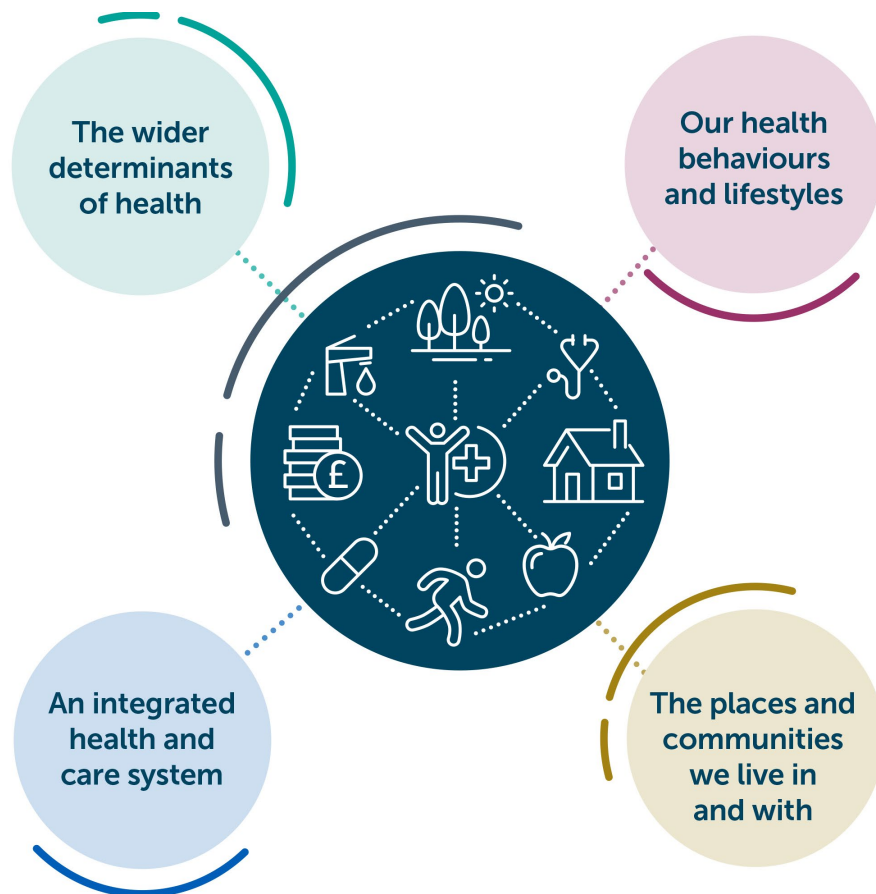
The ICP strategy and local authority health and wellbeing strategies are based around this model, which is embedded as the strategic approach across the system. We will ensure that our strategies and plans consider each of the four elements and where they interact, so we can effectively address the things 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 across to support recovery and transformation through collaboration across the ICS	Ensure improvement and effectiveness measures are built into new services
Establish 'task and finish' working groups, as appropriate, to take forward elements of the work programme	Review national, regional 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 define 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.

ONS population estimates for Staffordshire and Stoke-on-Trent CCGs
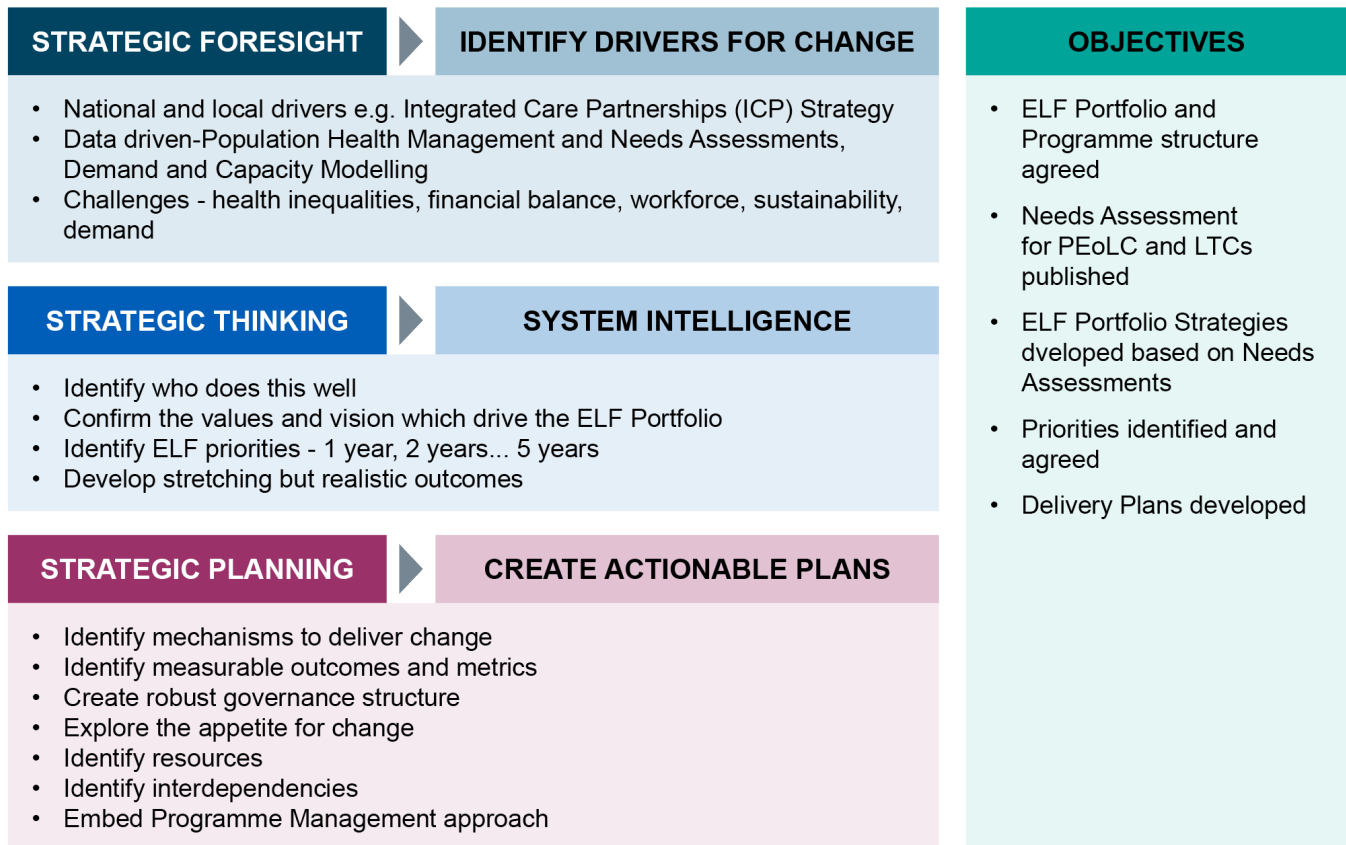

Legend: Under 75, 75+, % 75+
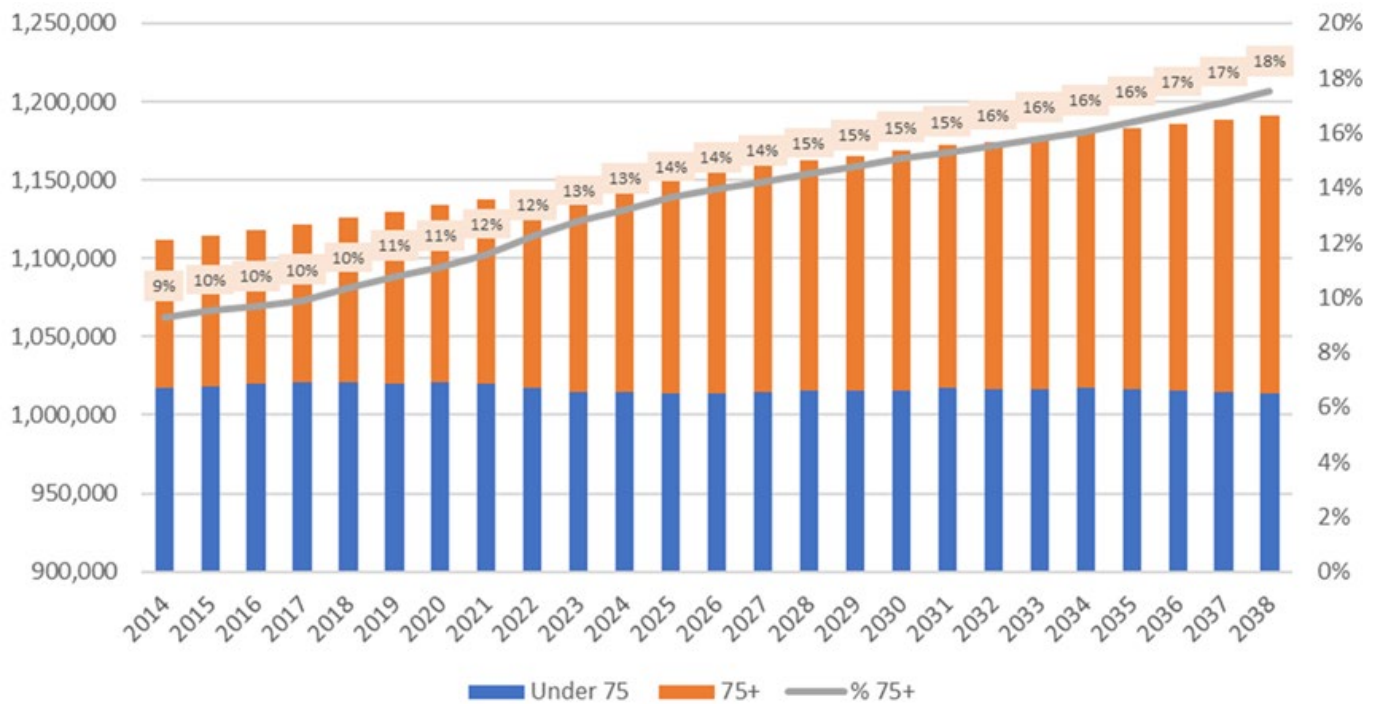
How do we plan to make a difference?

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. Currently, this consists of the identified workstreams: Palliative and End of Life Care (PEoLC), Long-Term Conditions and Frailty.

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:
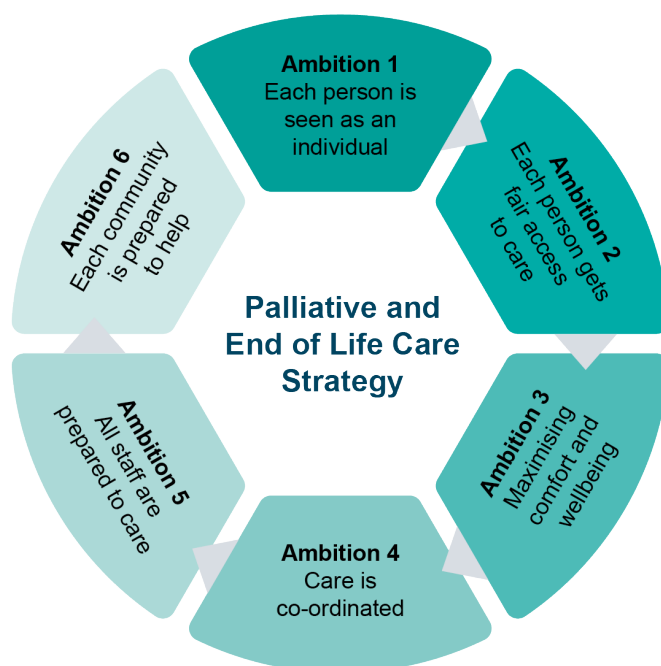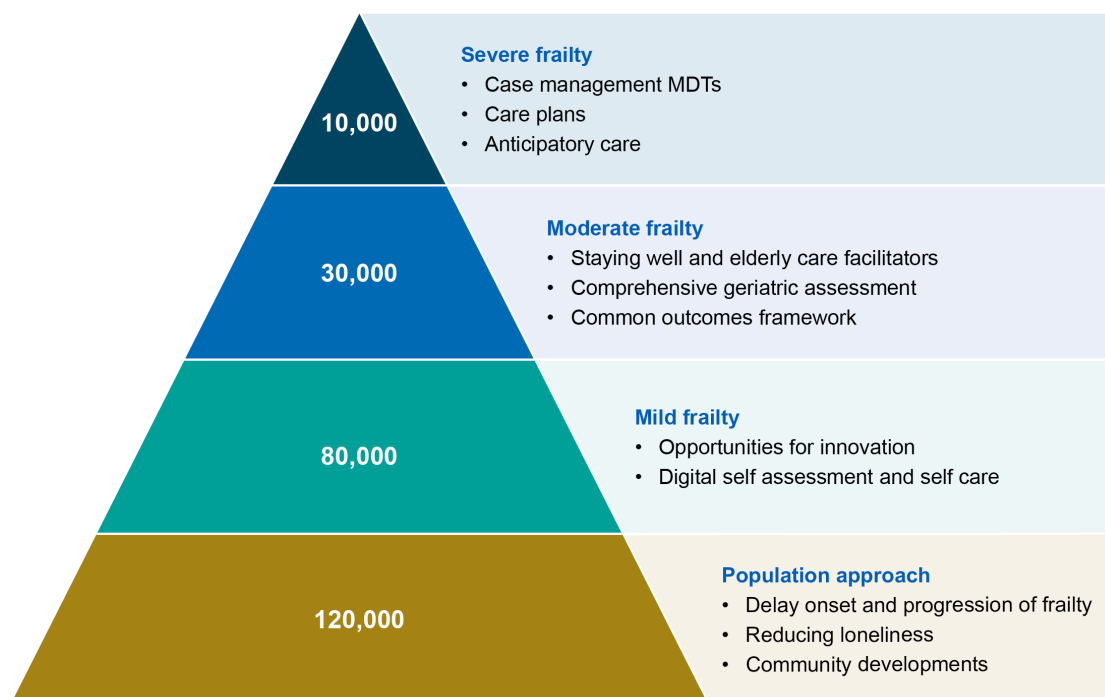

We will achieve this by:

- 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

Severe frailty
- Case management MDTs
- Care plans
- Anticipatory care

10,000

Moderate frailty
- Staying well and elderly care facilitators
- Comprehensive geriatric assessment
- Common outcomes framework

30,000

Mild frailty
- Opportunities for innovation
- Digital self assessment and self care

80,000

Population approach
- Delay onset and progression of frailty
- Reducing loneliness
- Community developments

120,000

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.
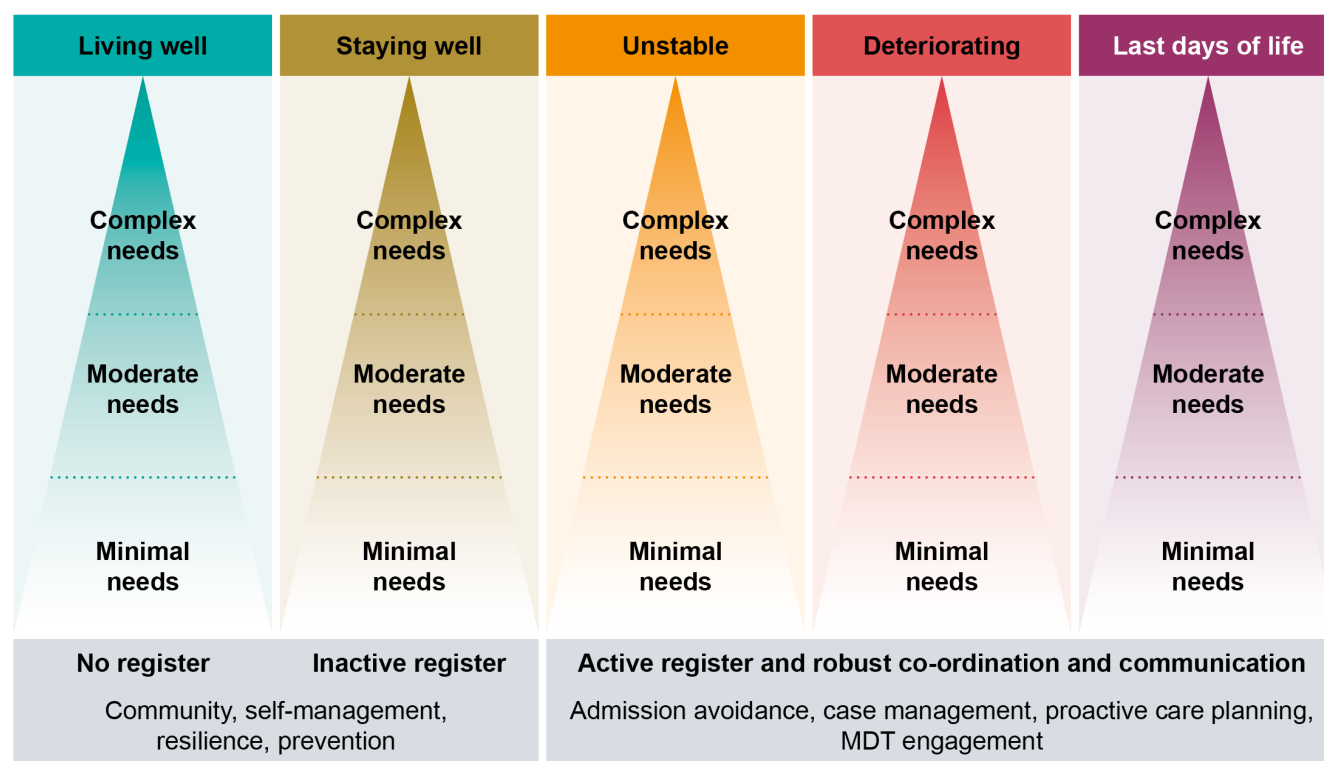
Long-term conditions (LTCs)

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.

The Living Well Model

Identifying holistic care needs and complexity for people in Staffordshire and Stoke-on-Trent:

Living well	Staying well	Unstable	Deteriorating	Last days of life
Complex needs	Complex needs	Complex needs	Complex needs	Complex needs
Moderate needs	Moderate needs	Moderate needs	Moderate needs	Moderate needs
Minimal needs	Minimal needs	Minimal needs	Minimal needs	Minimal needs
No register	Inactive register	Active register and robust co-ordination and communication		
Community, self-management, resilience, prevention		Admission avoidance, case management, proactive care planning, MDT engagement		

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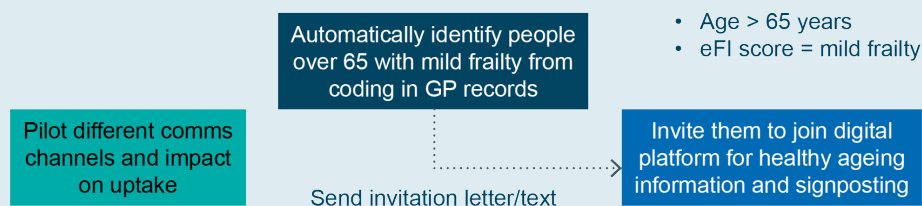
The online platform will also host information about healthy ageing (frailty risk factors) and signpost to local support.

✓ 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.

A Model for our Primary Care Ambitions

This model describes the interlinking elements that will enable primary care to achieve its vision of providing our population with equal access to high-quality services and more choice over where, when and how they access a consultation with a range of professionals.

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.
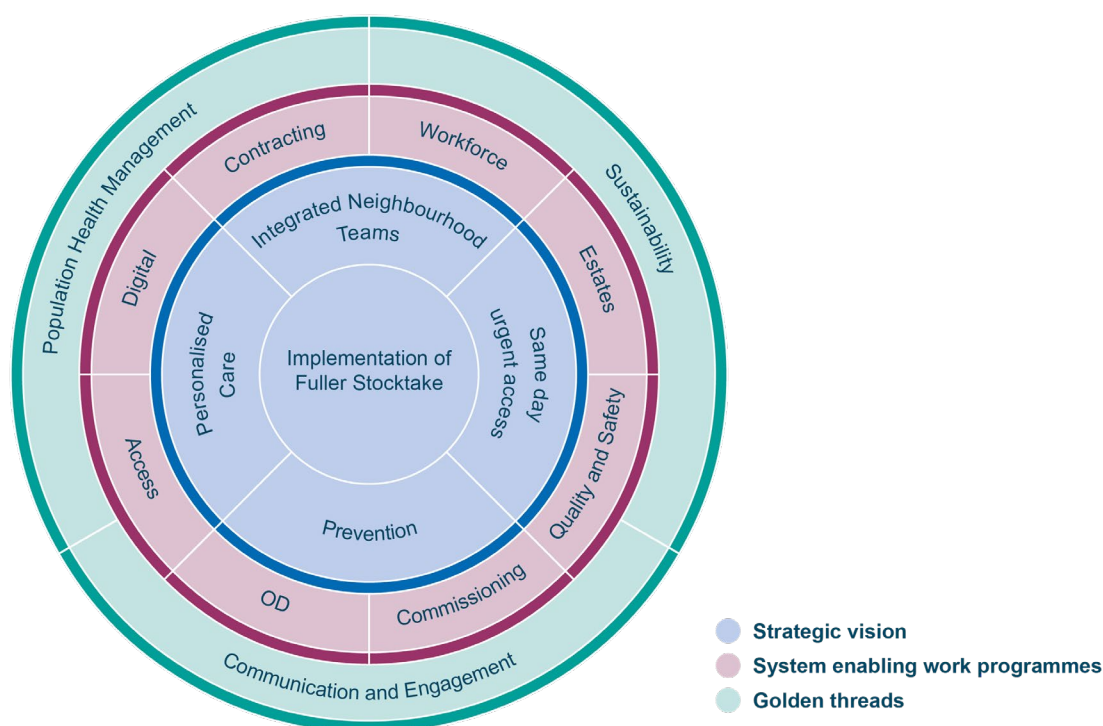
The General Practice Five-Year Forward Strategy forms the building blocks for our plans and sets out the approach and principles of how we can develop general practice over the next five years – for the benefits of our population and communities, for a diverse multi-disciplinary workforce, and for our 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. This will in turn drive improved access through increased appointments within primary care. 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 1,165 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.

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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

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 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 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. 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.

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.

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 three 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
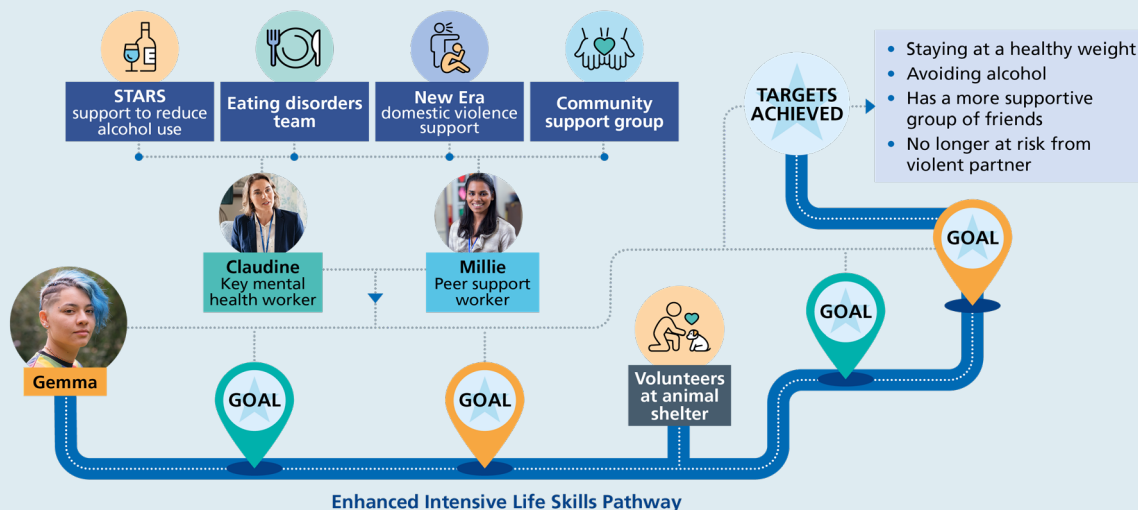
✓ Gemma is 24. She has a diagnosis of depression and anorexia. She experiences overwhelming emotions and mood swings. She sometimes self-harms and does unsafe things like binge drinking. Gemma suffered childhood sexual abuse and she has some physical health problems. She has a poor appetite and poor 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). We have produced an animation called LeDeR in Stoke and Staffordshire which outlines areas of learning, opportunities to improve and examples of excellent practice developed locally such as the introduction of the health passport.

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.

1. **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
2. **Place** – working alongside place partners and the VCSE in local communities to ensure housing, education, employment and life opportunities are more accessible and inclusive
3. **Universal services** – dentists, opticians and wider preventative services are accessible to all with reasonable adjustments
4. **Dedicated care and support** – to develop a joint independent sector market with health and social care that is fit for purpose
5. **Community services** – secondary mental health services for people with LDA
6. **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

We want to ensure all children, adults, families, and communities across our population are safe and free from all forms of abuse and harm. Safeguarding refers to the processes and policies of keeping people safe from abuse and promoting their wellbeing, where a child or adult is unable to protect themselves from abuse. Safeguarding is a whole system multi-agency approach that crosses all ages, places where people live and work, communities, and systems.

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 MPFT 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.

87 1:1s in **Phase 1** ICS Retention Programme **Phase 2** commenced

361 People Hub Staff and **8,810** shifts

Levy Transfer 15 Apprentices, **£315,000** in **2022**

53 Health and Social Care Apprentices on system rotational placements **Regional Apprenticeship Award Winner**

ICS People Web Pages launched, **826,083** clicks to date

205 face to face interventions by our Outreach Advisor with refugees and seldom heard communities

5 Virtual Work Experience Programmes delivered to **1,100+** Shortlisted for **2 HSJ Digital Awards**

HPMA Award for Innovation for the NHS and Social Care Reserve Model

Journey to Work concept launched including **Schools project** with **100** professionals signed up to visit schools

Integrated System Wide Workforce Planning (inc. workforce development funding)

Won **Highly Commended** at the **HSJ Partnership Awards for Primary Care Project of the year** - 'Growing our own together'

Robust and intuitive **People Metrics and reporting**

Over **800** referrals to the **Staff Psychological Wellbeing Hub**

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

135 people attended **New Futures Race** based leadership development

ICS Wellbeing Week held with nearly **12,000** staff taking part

3 ICS Staff Networks

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:
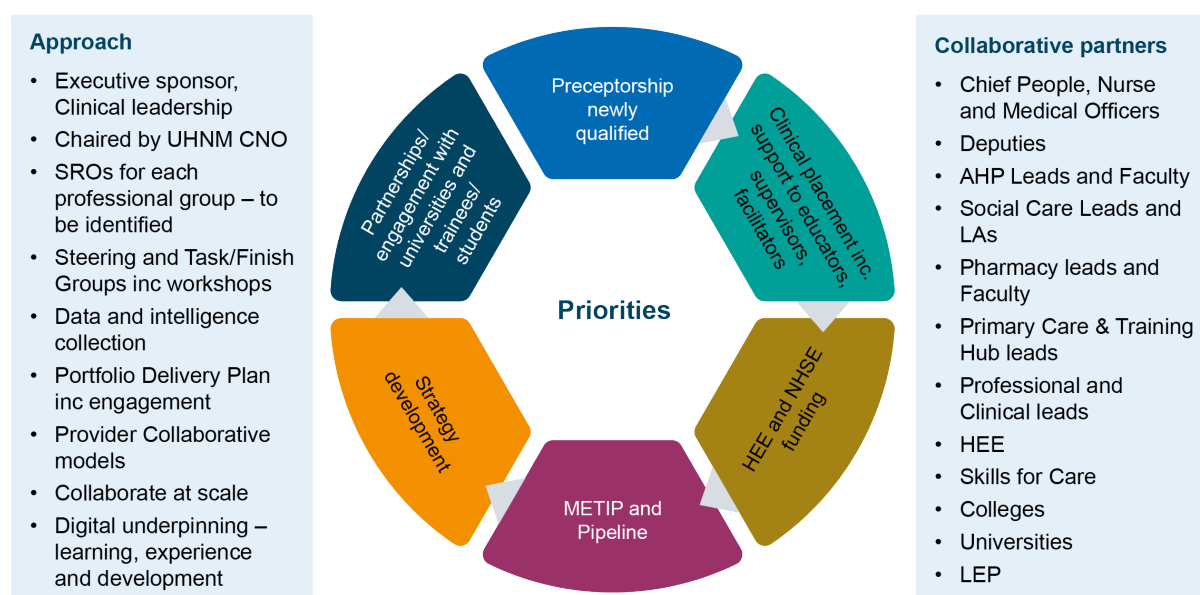
- Robust governance and oversight through the ICS People, Culture and Inclusion Committee
- Embedding our 'One Workforce' approach, driven and owned by our workforce
- Creating the right cultural environment for people to thrive, focusing on civility and safe working ethos
- Embedding inclusive cultures, 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 Multi-professional Education and Training Investment Plan (METIP) Journey to work – including schools engagement and outreach Education, training and development – 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.

Approach

- Executive sponsor, Clinical leadership
- Chaired by UHNM CNO
- SROs for each professional group – to be identified
- Steering and Task/Finish Groups inc workshops
- Data and intelligence collection
- Portfolio Delivery Plan inc engagement
- Provider Collaborative models
- Collaborate at scale
- Digital underpinning – learning, experience and development

Priorities

- Preceptorship newly qualified
- Clinical placement inc. support to educators, supervisors, facilitators
- HEE and NHSE funding
- METIP and Pipeline
- Strategy development
- Partnerships/ engagement with universities and trainees/ students

Collaborative partners

- Chief People, Nurse and Medical Officers
- Deputies
- AHP Leads and Faculty
- Social Care Leads and LAs
- Pharmacy leads and Faculty
- Primary Care & Training Hub leads
- Professional and Clinical leads
- HEE
- Skills for Care
- Colleges
- Universities
- LEP

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. This includes Assistive Technologies, Artificial Intelligence and connectivity of data, as well as online digital access. 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.		

1. Digitise

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

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

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

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

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

2. Connect

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

Development of data access and business intelligence
Comprehensive, system-level information asset management to drive evidence-based decision making and service improvement

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

3. Transform

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

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

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

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

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

No organisation will seek to make a profit through estates from another partner

This will include primary care and third sector health and care related partners

Space utilisation will be maximised and non-productive space minimised

Including making the best use of shared space and digital alternatives - regularly challenging how services are provided

We will seek to act as an estate system putting patients at the heart of our decisions

Acquisitions and disposals will support the system healthcare and a balanced budget

Our estate is a system asset

All estate should be seen as an asset by all system partners

Where a solution saves money we will proceed

The CFOs will ensure that all organisations are the same or better off as a result. No estates decision to save money can be at the cost of system efficiency

Enhancing the experience of the communities we serve

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 ten 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.

Carbon footprint (Emissions - tCO₂e)

Anaesthetic gases	Business Travel and NHS Fleet	
	Business Travel	NHS Fleet
3,550	18,760	5,060

Building energy

Coal	Electricity	
0	14,220	3,020
	SCOPE 2	SCOPE 3
Gas		Heat and steam
23,250	2,820	0
SCOPE 1	SCOPE 3	
Oil		
140	20	
SCOPE 1	SCOPE 3	

Water		Metered Dose Inhalers
2,860	730	16,820
SCOPE 3	SCOPE 3	

TOTAL 91,260

Carbon footprint plus (Emissions - tCO₂e)

Medicines, medical equipment and other supply chain

Business services	Food and catering	Medicines and chemicals
56,470	30,470	84,030
Medical equipment	Construction and freight	Non-medical equipment
41,140	33,770	44,840

Personal travel

Patient travel	Visitor travel	Staff commuting
23,220	6,780	15,430

Commissioned health services outside NHS	18,680

TOTAL 446,080

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.

1. **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

2. **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

3. **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

4. **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

5. **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) partners.

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 and Partner Member of ICB Board

"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 and Partner Member of ICB Board

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.

Achieves financial sustainability within five years and achieves in year financial targets	Targets money to improve performance, waiting lists and care	Enables delivery of system operational targets	Supports system transformation	Addresses inequalities and helps eliminate unwarranted variation
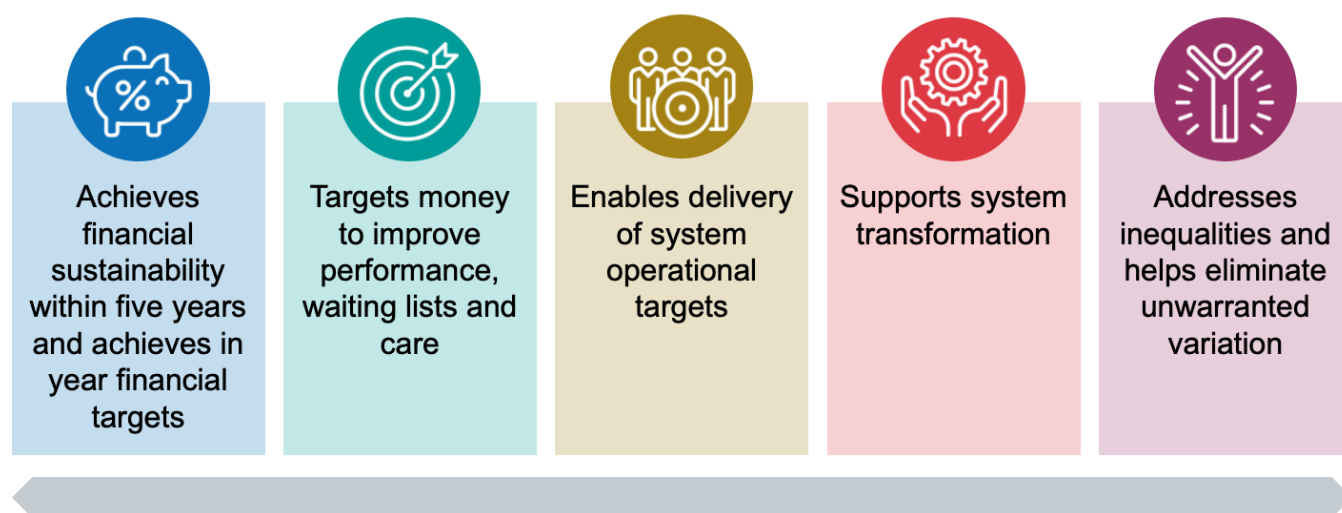
The six-step plan recognises that in the five-year period of this JFP, there will be little or no allocation growth, reflecting the national formula that assesses we are currently receiving more than our fair share of national resources. In this context we need to plan on the basis of no growth in staffing or capacity, and so we will need to address the demands for additional services through raised levels of productivity.

A six-step plan

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

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

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

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

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

3. Productivity
More activity through the existing capacity

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
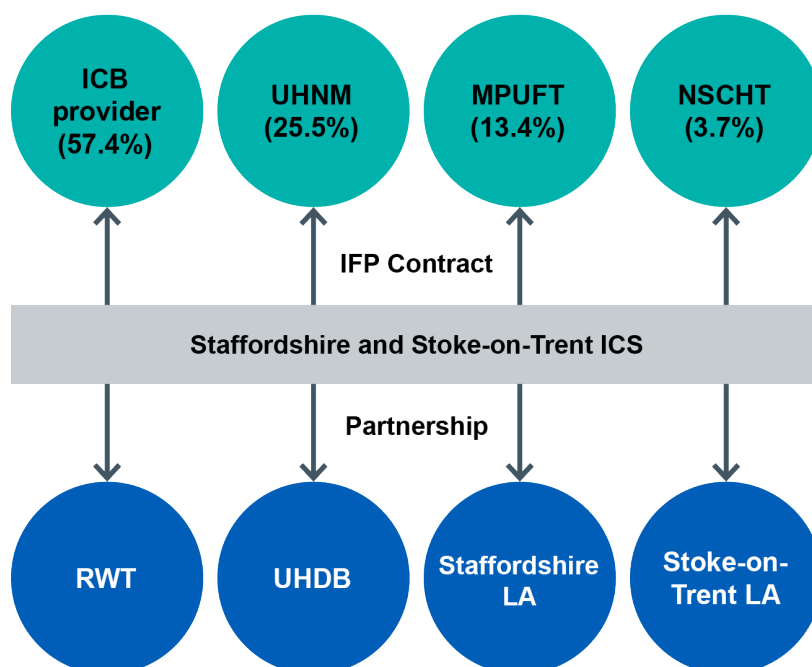
assumptions that allows all partners back to financial balance at the same time given a similar effort. The IFP brings a true partnership to the management of resources within the system.

Intelligent Fixed Payment (IFP) Model

The system has introduced an IFP contract which binds the NHS organisations around using our collective resources as efficiently and effectively as possible. This model describes the providers involved and the working mechanics behind the IFP Model.

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 CFOs collectively agree to revisit i.e. guidance change

- Earmarked funds will be excluded i.e. MHIS / COVID-19 / SDF / ERF

- In-year changes to IFP contract value are to be agreed via Finance and Performance Committee

- All changes to IFP should exclude overheads unless an additional marginal cost is incurred.

ICB provider (57.4%) UHNM (25.5%) MPUFT (13.4%) NSCHT (3.7%)

IFP Contract

Staffordshire and Stoke-on-Trent ICS

Partnership

RWT UHDB Staffordshire LA Stoke-on-Trent LA

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 two 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

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: 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

- Prevention and social prescribing
- Volunteering
- Procurement
- 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 (MPFT, 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 MPFT 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 MPFT'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 are delivered through a network of community lounges. These bring together support from statutory partners and wider agencies in 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 by the housing, social work 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 at the community lounge

- ✓ After four months of support through the community lounge, where all the wraparound 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. They are now regularly attending health appointments 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:

- Developing collaborative integrated research addressing the health and care priorities of our region, expanding the range and diversity of research undertaken in our region
- Fostering a culture of collaborative research and innovation with strong leadership championing the strategy
- Developing the capacity and capability for evidence-based health and care
- 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
- Developing a collaborative infrastructure for research and innovation in our region to reduce duplication, supporting and growing an increased research portfolio
- 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	People, places and communities	Impact	Innovation
Championing a research culture where everyone is valued and able to contribute to, and benefit from, research	Creating opportunities for inclusive research across diverse communities	Creating an eco-system where research outputs can be rapidly adopted into practice/policy	Working with business and commercial partners, facilitating deeper partnerships and securing co-investment
Developing innovative career pathways, embedding research into health and care professional roles	Enhancing the opportunity for people to shape research, reducing health inequalities across our diverse urban and rural geography	Developing co-production strategies that support the mobilisation of knowledge	Connecting research and innovation
Sharing knowledge and expertise, developing research professional roles across the partnership	Enhancing the opportunities to engage in research – championing the people and teams that support this	Transforming health and care through high quality research	Accelerating translation, commercialisation and knowledge exchange
	Developing infrastructure that supports wider engagement in research	Supporting sustainability through new approaches to health and care research delivery	
		Supporting economic development through income generation	

Our strategic objectives provide the framework for how we will achieve our vision and realise our principles through:

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 (MPFT/Keele), evidence-based practice groups for GP nurses and physiotherapists). As a Trust securing university hospital status, MPFT continues to develop these opportunities for social workers and nurses. MPFT 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 ten 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.

PROVIDER COLLABORATIVE BOARD

Prevention Portfolio	UEC Portfolio	MH / LD&A Portfolio	Planned Care Portfolio	Primary Care Portfolio	End of Life, LTCS & Frailty Portfolio	CYP / Maternity Portfolio	Enabling Workstreams
	Adult Critical Care (UHNM/SATH)	Adult Eating Disorders	Tier 3 And 4 Weight Management	Shared Care Complex Medicines	High Intensity Users	Children's Asthma	Recruitment Efficiencies
		Camhs					All Age Safeguarding
	Acute Care at Home	Adult Secure	MSK				Sustainability
		Reach Out (LD&A) Perinatal					Estates Voids and Disposals
							Occupational Health

Key

■ These are collaboratives which sit across more than 1 ICS (including the Regional Collaboratives)

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 one 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 were 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 the high-level deliverables of each of our Portfolios
- provide 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 and 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 section.
Duty as to climate change	See Sustainability section, Delivering a Net Zero NHS section, Procurement section

Statutory Duty	Reference to relevant section
Duty to involve the public	See Working in partnership with people and 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

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.	✓	✓	✓	✓	✓

Portfolio	Delivered by:				
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.	✓	✓	✓	✓	✓
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.	✓	✓	✓	✓	✓

Portfolio	Delivered by:				
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.	✓	✓			

Portfolio	Delivered by:				
Urgent and Emergency Care – High-Level Deliverable (continued)	Y1	Y2	Y3	Y4	Y5
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 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

Portfolio	Delivered by:				
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			
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).	✓	✓	✓	✓	✓

Portfolio	Delivered by:				
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 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.	✓	✓	✓	✓	✓

Portfolio	Delivered by:				
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.	✓	✓	✓	✓	✓
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**.**	✓	✓	✓	✓	✓

Portfolio	Delivered by:				
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 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.		✓	✓	✓	✓

Portfolio	Delivered by:				
Learning Disabilities and Autism – High-Level Deliverable (continued)	**Y1**	**Y2**	**Y3**	**Y4**	**Y5**
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.		✓	✓	✓	✓

Governance framework

The ICB brings together partners responsible for planning and delivering health and care to ensure shared leadership and joint action to improve the health and wellbeing of the people who live locally. The arrangements described in the [ICB Constitution](#) (the Constitution) describe how we organise ourselves together to provide the best health and care, ensuring that decisions are always taken in the interest of the populations we serve. The Constitution is underpinned by the duty that requires NHS bodies to consider the effects of their decisions on the health and wellbeing of the people of England, the quality of services and the sustainable and efficient use of resources.

Our Board

The ICB meets as a unitary board and is collectively accountable for the performance of the ICB's functions to NHSE & I. Meetings of the Integrated Care Board (ICB) are usually held in public on a bi-monthly basis. The prime function of these meetings is to conduct the business of the Integrated Care Board. Members of the public are invited to ask questions of clarification relating directly to the agenda at the meeting.

Our board members are passionate about patient care and shaping the future of the NHS. They are all experts in their respective fields and have a wealth of experience in healthcare and other, related industries including the prevention, diagnosis or treatment of illness and the protection or improvement of public health. The ICB Board membership is outlined on the [ICB website](#)

Between recruitment and selection of staff dedicated to discharging operational business processes; and appointment to our Board of "Partner Members" (from ICS Partners) and selection of ICS Partners to act as core members of ICB Board Assurance Committees, we ensure that we have the right balance of expert opinion and external advice to help guide and inform the safe discharge of all of the statutory functions and duties of the ICB.

When designing our Board composition (membership), as currently set out in the ICB Constitution, we have followed NHS England advice on appointing clinical positions to comply with these areas. The extended clinical and professional leadership structure also ensures that clinical leaders advise all tiers and governance arrangements of the ICB, and all aligned clinical forums like GP engagement groups and the ICS Health & Care Senate.

The ICB Board remains accountable for all the ICB's functions, including those that it may have delegated, or has had delegated to it (e.g., by NHSE) and therefore appropriate reporting and assurance mechanisms are in place as part of agreeing terms of a delegation.

Governance and Decision Making

The [ICB Governance Handbook](#) is a virtual document which provides further details on how governance arrangements in the ICB will operate by bringing together a number of governance documents, so it is easy for interested people to navigate. This governance exists to ensure that decision-making is lawful, statutory duties and wider legal, regulatory duties are met, and that decision-making is enhanced from a quality and scrutiny perspective.

This is supported by the ICB Functions and Decision Map which sets out the governance for the new integrated NHS landscape. The Functions and Decisions Map sets out the governance arrangements that support accountability for whole-system delivery and performance. The purpose of the Functions and Decisions Map is to facilitate transparent decision-making and foster the culture and behaviours that enable system working. The Functions and Decisions Map is a high-level structural chart that details the health commissioning duties of the ICB. It also sets out which key decisions are delegated and taken by which part or parts.

The ICB has agreed a Scheme of Reservation and Delegation (SoRD) which is published in full in the ICB Governance Handbook. The SoRD sets out those functions that are reserved to the board and those functions that have been delegated to an individual or to committees and sub-committees.

The ICB Board has established a number of committees to assist it with the discharge of its functions. These committees are outlined in the ICB Functions & Decisions Map.

Through ensuring core governance requirements are in place and using the available assurance mechanism provided by ICB bodies like the Audit Committee (and Internal / External Audits of ICB arrangements), we can reassure ourselves and all key stakeholders that the ICB is designed to fulfil its wider role and purpose.

Pharmacy and medicines optimisation: how we will support wider ICS ambitions

Specific plans described below for Pharmacy and medicines optimisation 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 for the service to begin.

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 their blood pressure checked in the last six months.

Contraception services

We will support community pharmacies with training and putting arrangements in place to provide ongoing treatment initiated by a 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. 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 a 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 (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 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 Healthcare Financial Management Association (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 in 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 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.
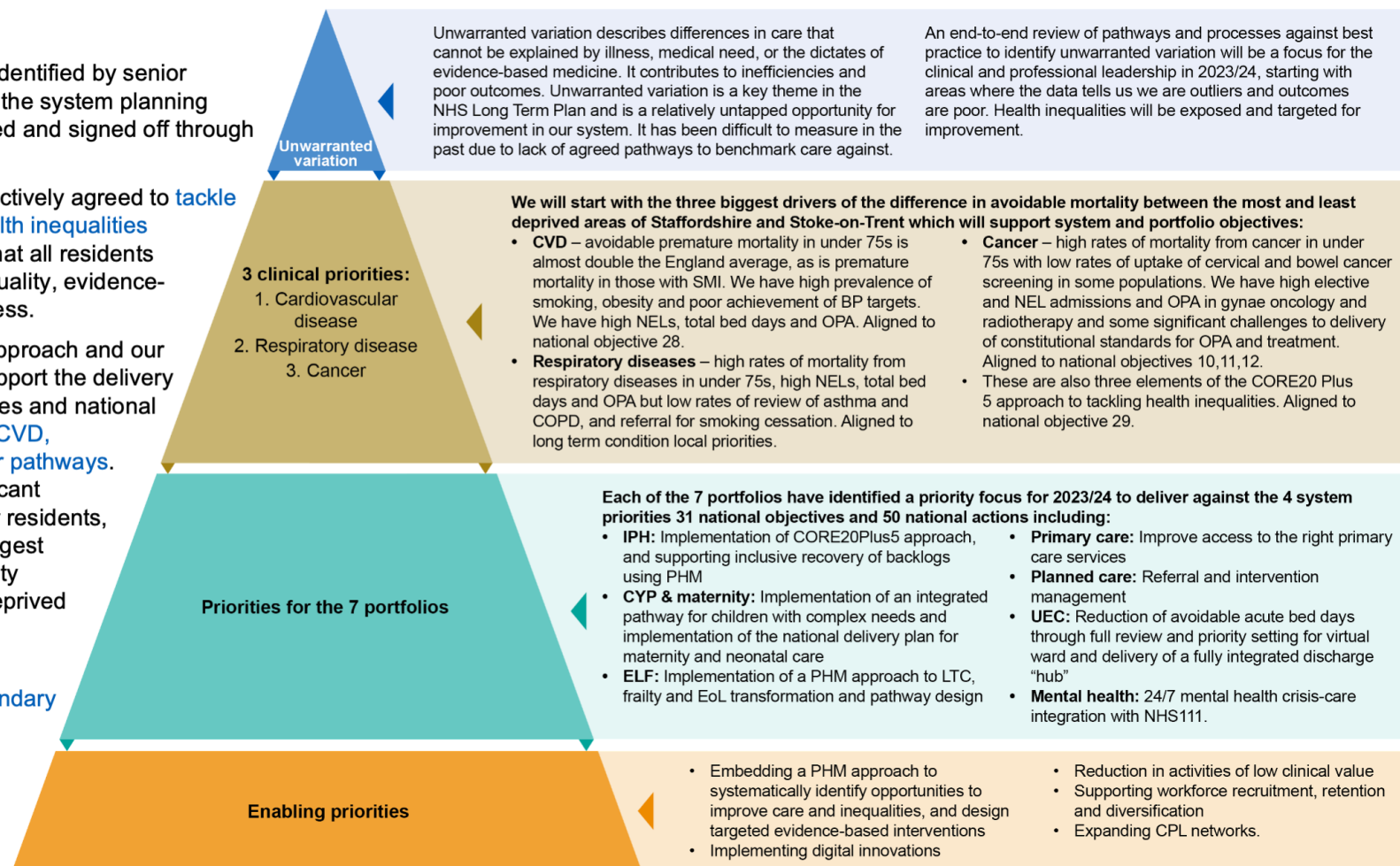
Clinical and professional leads (CPL) focus for 2023/24

- The focus areas were initially identified by senior clinicians and professionals at the system planning summit 2023/24, and developed and signed off through the Health and Care Senate.

- As a CPL community, we collectively agreed to tackle unwarranted variation and health inequalities because we strongly believe that all residents have the right to expect high quality, evidence-based care with equitable access.

- As CPL leads, our collective approach and our three clinical level priorities support the delivery of the high level system priorities and national objectives through a focus on CVD, respiratory disease and cancer pathways. These conditions cause significant premature mortality across our residents, and are responsible for the biggest difference in premature mortality between our most and least deprived communities.

- We will also focus on the opportunities for primary, secondary and tertiary prevention and Identifying and tackling health inequalities.

Unwarranted variation

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

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

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

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

Priorities for the 7 portfolios

Each of the 7 portfolios have identified a priority focus for 2023/24 to deliver against the 4 system priorities 31 national objectives and 50 national actions including:
- **IPH:** Implementation of CORE20Plus5 approach, and supporting inclusive recovery of backlogs using PHM
- **CYP & maternity:** Implementation of an integrated pathway for children with complex needs and implementation of the national delivery plan for maternity and neonatal care
- **ELF:** Implementation of a PHM approach to LTC, frailty and EoL transformation and pathway design
- **Primary care:** Improve access to the right primary care services
- **Planned care:** Referral and intervention management
- **UEC:** Reduction of avoidable acute bed days through full review and priority setting for virtual ward and delivery of a fully integrated discharge "hub"
- **Mental health:** 24/7 mental health crisis-care integration with NHS111.

Enabling priorities

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

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.

Term	Definition
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.
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. It 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.

Term	Definition
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.

Term	Definition
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

Abbreviation / Acronym	Description	Abbreviation / Acronym	Description
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
IPH	Improving Population Health	JFP	Joint Forward Plan

Abbreviation / Acronym	Description	Abbreviation / Acronym	Description
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
MPFT	Midlands Partnership University NHS Foundation Trust	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	NSCHC	North Staffordshire Combined Healthcare
OPA	Outpatient Attendance	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

Abbreviation / Acronym	Description	Abbreviation / Acronym	Description
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

Abbreviation / Acronym	Description	Abbreviation / Acronym	Description
TB	Tuberculosis	TIF	Targeted Investment Fund
TLHCs	Targeted Lung Health Checks	UCCC	Unscheduled Care Coordination Centre
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		