

2023/24 Operational Plan

Summary



Introduction

Our role as an Integrated Care Board (ICB) is to help bring partners together to integrate our approach to improving health and care services for our local population.

We have made positive strides towards that goal this year, but there is much more to do.

The development and publication of our Operational Plan for 2023/24 marks another step towards that aspiration of an integrated working environment where the focus of us all is on the best health and social care for our residents.

The full document sets out our key priorities as a system for 2023/24 and how we will measure our success.

This summary has been developed to highlight the key actions from across the system, delivered through the Portfolio structure we have created. The plan does not duplicate issues that are covered within the business plans of NHS providers, local authorities or other partners: instead, it aims to distil the key system level actions that are planned for this year.

Working with all our partners across the system, we want to improve the lives of people living across Staffordshire and Stoke-on-Trent now and in the future. We want to do this while restoring inclusively our services to pre-COVID levels, eliminating long waits to access services, and reducing unwarranted variation in our services. Alongside this, we will work to embed service changes which have proved beneficial to our people and communities – including our populations at neighbourhood level. We have a strong foundation to build on, but we know we need to continually look for new ways to strengthen our networks and adapt our communications, engagement, and operational delivery – to enhance our understanding of the needs of our diverse population.

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

Peter Axon
ICB Chief Executive Officer

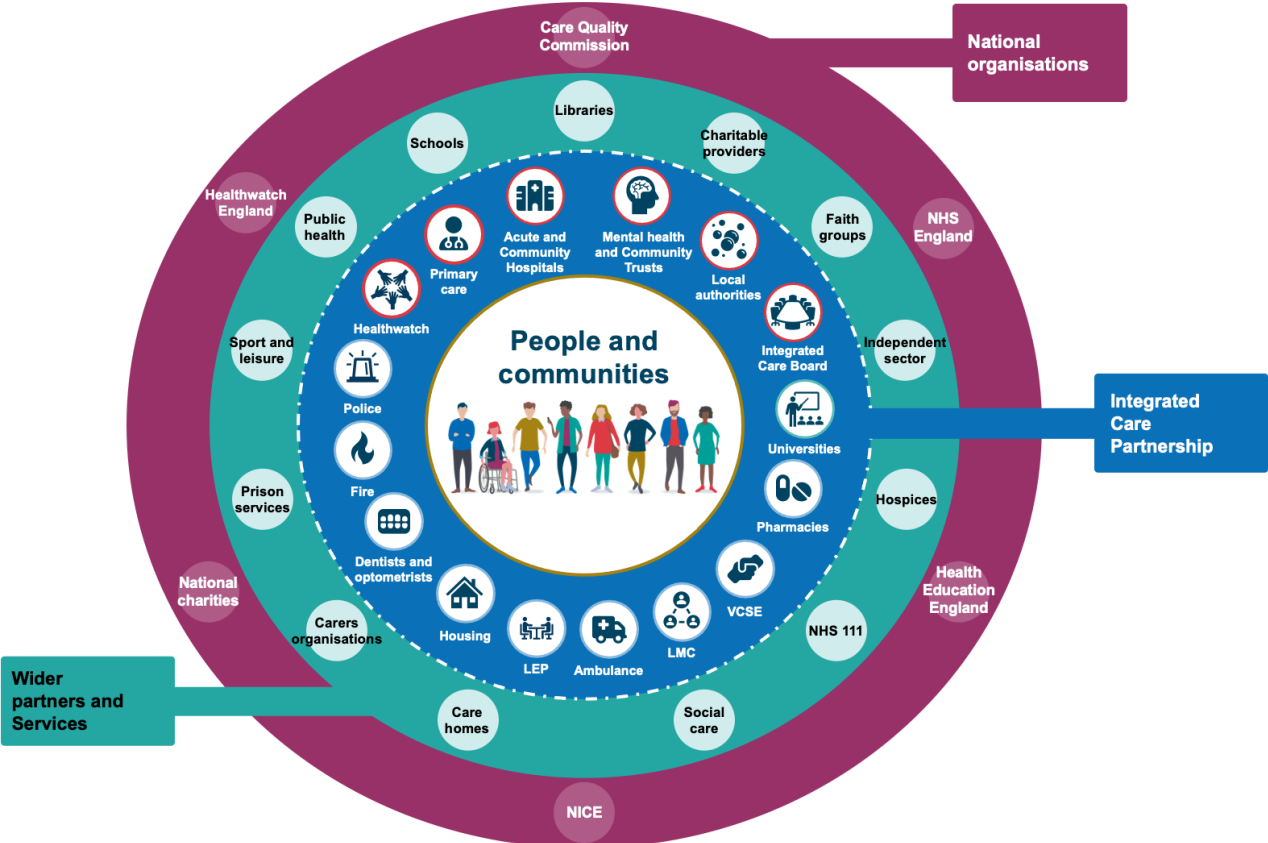


Our system explained

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.

Our system is made up of:

Term	Meaning
Integrated Care Partnership (ICP)	<p>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.</p> <p>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.</p>
Integrated Care Board (ICB)	<p>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.</p>



The purpose of the Operational Plan 2023/24

The purpose of the operational plan is to summarise national and system priorities, and how we will deliver them.

The full plan 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](#) and [ICS Joint Forward Plan \(JFP\)](#) to achieve our vision:



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

It is a working document that we will use throughout the year, using detailed actions and metrics, to measure delivery through our System Finance and Performance Committee.

The operational plan is year one of the ICS JFP.

Our full operational plan is split in to three main parts and a set of Appendices.

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

- Our System Plan on a page
- What we will deliver and how
- Our approach to developing our priorities.

In **Part 2** you will read about Our Portfolios focus for 2023/24 covering:

- Urgent and Emergency Care; Planned care including cancer and diagnostics; End of Life, Long-Term Conditions and Frailty; Primary Care; Mental Health, Learning Disabilities and Autism; Children and Young People and Maternity; Improving Population Health.

In **Part 3** you will read about:

- The implications for our resources in relation to workforce and finance.

The **Appendices** outline a series of enablers to delivery which include:

- Clinical and Professional Leadership
- Population health
- Continuing healthcare, personalised care, quality, digital, provider collaborative projects and working with people and communities.
- More detail on the 31 national objectives we need to deliver.

System priorities

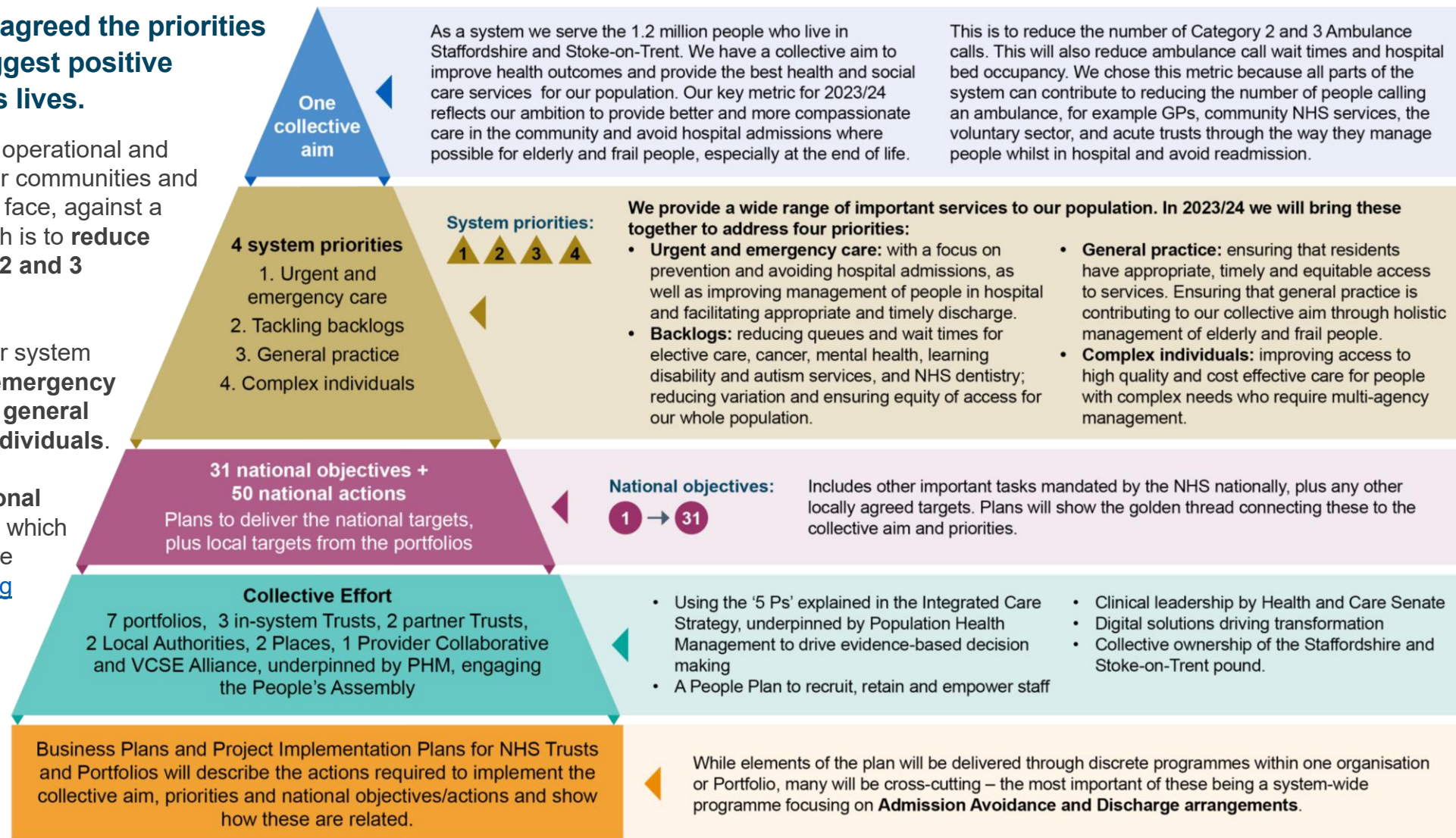
We have collectively agreed the priorities that will make the biggest positive difference to people's lives.

The plan contains current operational and population priorities for our communities and the current challenges we face, against a single collective aim, which is to **reduce the number of category 2 and 3 ambulance calls**.

This is focused around our system priorities for **urgent and emergency care, tackling backlogs, general practice and complex individuals**.

There are a set of **31 national objectives** and 50 actions which we must deliver. These are based on [national planning guidance](#).

Each national and local objective is aligned to one of the portfolios or enabling workstreams to support our **collective effort to deliver** the actions for 2023/24.

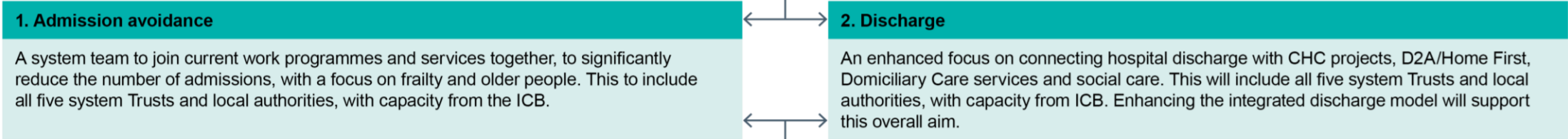


Our system-wide approach for pathway redesign

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

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

Our approach: One of the biggest challenges facing all systems is supporting the care of our frail elderly and those with long-term conditions. Our Continuing Healthcare (CHC) costs have increased by £50m, which is a cash-cost to the system. Our local authority partners are facing similar pressures in terms of funded social care placements. The demand for care currently outstrips the supply, resulting in lack of choice for our most vulnerable population and unsustainable pressure on our workforce in the care home sector. We know that some of these CHC and social care costs may be avoidable if patients are not admitted in the first place or, when they are, they are discharged with alternative home support packages. We know from evidence that patients degenerate if their discharge process is inadequate, and a large number of these people end up with a lifetime of dependency. Working together on admissions and discharges as two joined-up projects, we can positively impact on the quality of lives of our population. This will also have a positive impact on managing the demand for beds in the already constrained care home and positively impact on the finances. **So we propose two transformational projects for pathway redesign this in 2023/24:**



Existing projects and services grouped and linked if appropriate to one of the two system transformation projects.									
Acute Care at Home Provider Collab (Step up and Step down)	Same Day GP Access	Proactive Frailty: Healthy Ageing, Falls Prevention and Mild Frailty	Reactive Frailty: Moderate and Severe	LTC Programme	111 MH Response	Integrated Discharge Team	Continuing Healthcare	Home First	Discharge Medicine Service
	End of Life Programme						End of Life Programme	Discharge to Assess	Project 86 (Complex MH)

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

Prevention actions

Summary of what our Portfolios will focus on

- We have developed a structure of seven portfolios to help us deliver our system priorities.
- The diagram below demonstrates, at high level the key things that our portfolios have identified they need to deliver in 2023/24. The underpinning detail is contained in the [Operational Plan](#) and the [full list of national objectives are included in an appendix one](#) at the end of this summary.

PORTFOLIO	Children and Young People / Maternity	Planned Care, Diagnostics & Cancer	Improving Population Health	Urgent & Emergency Care	Mental Health, Learning Disability and Autism	Primary Care	End of Life, LTCS and Frailty (ELF)
	<ul style="list-style-type: none"> Deliver the key NHS Long Term Plan ambitions for a strong start in life for children and young people Implementation of the national delivery plan for maternity and neonatal care 	<ul style="list-style-type: none"> Deliver the goals for elective recovery in planned, cancer and diagnostics 	<ul style="list-style-type: none"> Embed measures to improve health and reduce inequalities 	<ul style="list-style-type: none"> Recovery of Urgent and Emergency Care Services 	<ul style="list-style-type: none"> Deliver the key NHS Long Term Plan ambitions 	<ul style="list-style-type: none"> Deliver the vision outlined in the Fuller Stocktake and make it easier for people to contact a GP practice 	<ul style="list-style-type: none"> Deliver the Ambitions for Palliative and End of Life Care national framework Deliver the key NHS Long Term Plan ambitions supporting people to age well Deliver the NHS Long Term Plan prevention priorities
NATIONAL OBJECTIVES	13 14	6 7 8 9 10 11 12	27 28 29	1 2 3 4	19 20 21 22 23 24 25 26	5 15 16 17 18	
SYSTEM PRIORITIES	1 3 4	1 2	1 2 3 4	1 2	1 2 3	1 2 3	1 2
KEY METRICS / DELIVERABLES	<ul style="list-style-type: none"> Design and Implement Long Term Conditions Programme (Diabetes, Epilepsy and Asthma) Implement Children with Complex Needs Project Implementation of the national delivery plan for maternity and neonatal care 	<ul style="list-style-type: none"> Ongoing implementation of Patient Initiative Follow Up (PIFU) Trajectory for eliminating 65 week waits delivered Meeting 85% day case /theatre utilisation Introduce Community Diagnostic HUBs Optimal use of lower GI 2ww 	<ul style="list-style-type: none"> Systematic implementation of the Core20 approach Implement NHS Long Term Plan prevention programmes Utilise population health management techniques 	<ul style="list-style-type: none"> Capital Investment Case 76% of patients seen within 4 hours in A&E Bed occupancy 92% or below Full review and priority setting for virtual wards. Enhance provider collaborative offer to include the Clinical Assessment Service. Deliver a fully integrated discharge "hub" 	<ul style="list-style-type: none"> Improve the crisis pathways including 111 and ambulance response Undertake a PICU Options Appraisal Minimise waiting times for autism diagnosis Increased number of people accessing IAPT Increased number of people with SMI having annual physical health check 	<ul style="list-style-type: none"> Deliver ARRS recruitment Implement digital solutions to provide enhanced remote care to people. Deliver recovery of dental activity Implement POD Delegation 	<ul style="list-style-type: none"> The creation of a PEOLC strategy Identification of Patients in the last 12 months of life recorded on Palliative Care Registers in Primary Care LTC strategy Transformation programme around CVD, Respiratory and Diabetes Delivery of the frailty strategy
	PEOPLE & COMMUNITIES	PERSONALISED CARE	PERSONAL RESPONSIBILITIES	PREVENTION & INEQUALITIES	PRODUCTIVITY		

Summary and next steps

- Over the last few pages, you have had the opportunity to see a summary of our 2023/24 Operational Plan for Staffordshire and Stoke-on-Trent.
- This plan forms the first year of our five-year Joint Forward Plan and describes how we will deliver our Integrated Care Partnership Strategy and priorities over the next five years.

Next steps

- As we continue with our plans, we have outlined the next steps in our progress. We will:
 - engage with local residents and partners to help shape our future priorities and plans
 - be asking how we could work better together to make Staffordshire and Stoke-on-Trent the healthiest place to live and work and we are keen to hear your views
 - listen to the feedback to help inform the refresh of the Operational Plan and Joint Forward Plan in 2023/24.

For further information about our plan, and our work, you can read the following documents:

- [Staffordshire and Stoke-on-Trent Integrated Care Partnership Strategy](#)
- [2023/24 Operational Plan](#)
- [Joint Forward Plan](#)
- [Staffordshire and Stoke-on-Trent Integrated Care Board website](#)



Appendix one

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