Staffordshire and Stoke-on-Trent
Integrated Care Partnership

ICP Strategy

Foreword

We want to make sure that everyone in Staffordshire and Stoke-on-Trent has a fair opportunity to live a good life. Looking at some of the inequalities that we know still exist is simply not good enough and many of these can only be addressed by partners working together.

Improved health and wellbeing will be achieved through better support and high-quality services, but also through preventing people from becoming unwell and supporting them to live well in their communities. We recognise that we need to look beyond health and care services to understand the barriers and opportunities to living a healthier life and are committed to working with people and communities to address them

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

Dr Paul Edmondson-Jones

Chief Medical Officer
NHS Staffordshire and Stoke-on-Trent
Integrated Care Board

Introduction

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

We are setting out how each organisation in the Staffordshire and Stoke-on-Trent Integrated Care System (ICS) can integrate their existing strategies to enhance what they are already doing. A first step towards that is creating a shared target for our ICS, identifying what we want to change and how we will improve the health and wellbeing of our population.

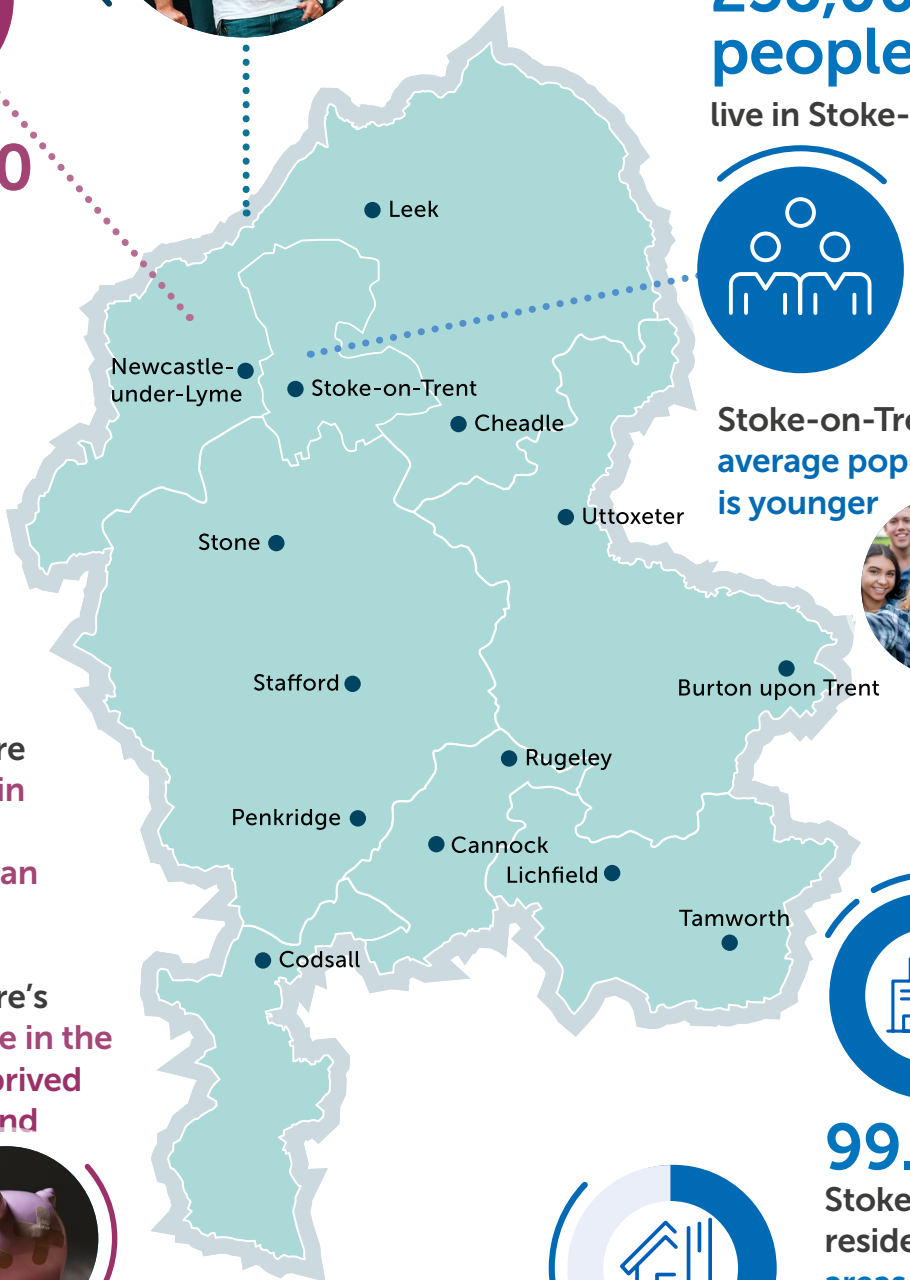
This is about far more than health and care services. We will address the key things that influence people's health, including social, economic and environmental factors that we know make a difference.

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

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

Staffordshire and Stoke-on-Trent Integrated Care System

The Health and Care Act 2022 outlines how health and care organisations must deliver joined-up care via Integrated Care Boards (ICBs), bringing together a wide range of partners, not just the NHS.

With the broad and inclusive membership of the partnership, we can address wider factors that influence health, care and social needs (see Appendix 1 for membership details).

We will deliver this by using smaller, integrated 'place' working that will follow our shared approach but have the flexibility to meet the specific needs of different populations. These will be:

- **Staffordshire**
- **Stoke-on-Trent.**

Close partnerships across the NHS, local authorities, the voluntary community social enterprise sector (VCSE), Healthwatch, hospices, universities and wider public sector organisations are crucial to our approach. This will enable greater influence and action to achieve significant impacts on health and wellbeing.

We come together in partnership to improve the health and wellbeing of our local population, making Staffordshire and Stoke-on-Trent the healthiest places to live and work.

The Staffordshire and Stoke-on-Trent Integrated Care System includes:

- **7** Integrated Care System portfolios
- **2** upper tier local authorities
- **8** district and borough councils
- **25** primary care networks
- **143** GP practices
- **2** acute hospital trusts
- **2** mental health trusts
- **1** community health trust

Context

Our services are generally safe and well-led, thanks to our incredible staff. However, we are not complacent and there are many challenges and opportunities that will affect our ability to continue to deliver high-quality care in future.

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. People in our most deprived areas live with poor health for 12 years more than those living in less deprived communities.

Demand for our health and care services has increased across primary care, community health services, social care and within the voluntary sector. This has been made worse by the **COVID-19 pandemic**.

Services are still recovering from disruption caused by the pandemic, with huge efforts ongoing to reduce people waiting for treatment and care. Despite the best efforts of our hospital teams, there remains a backlog for diagnostic, elective care and cancer services, while community, mental health, social and primary care services are also managing longer waiting lists. The impact on people's health has not been equal, with some people experiencing long COVID-19 and other harm to their physical and mental health. The full impact of COVID-19 remains to be seen.

People across Staffordshire and Stoke-on-Trent experience **fragmented care** because of avoidable and unfair differences in the types of services that are available in different areas.

Some communities also experience **social exclusion** – 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.

There is a health and social care **workforce crisis** which is heavily impacting the wellbeing of staff and the sustainability of services. This needs to be addressed to ensure high-quality care can continue to be delivered at all levels.

Finances are a challenge, with health and care organisations being asked to do more with no additional funding. NHS finances are improving, but there is a significant financial deficit that must be balanced in future years without impacting the quality of our services.

Strong partnership across our system is the best way to address the issues we face.

Staffordshire and Stoke-on-Trent Integrated Care Strategy

The strategy focuses on long-term priorities to prevent ill health, reduce inequalities, and deliver better health and care services for our population. We need to reflect the needs of our population identified in existing Joint Strategic Needs Assessments and our goals must be aligned with partners' existing strategies.

In developing this document, we have collaborated with a cross-organisation Strategy Executive Group and Writing Group, developing a strategy that can be owned by all members.

There will be a single ICP strategy, but the engine room for delivery will be at a local level.

Developing our strategy

A phased approach to strategy development:

Phase 1 to Dec 2022

- **What is the evidence telling us about our population needs**
- **What does good look like: existing good practice, research evidence, innovation, engagement, PHM programme**
- **What could this look like for Staffordshire & Stoke-on-Trent: our vision, approach and ambition**
- **Publish 'Initial' Strategy.**

Phase 2 to Mar 2023

- **Involvement and engagement from system wider stakeholders: webinars, meetings, discussion groups, surveys**
- **Writing the Strategy: co-production approach**
- **Agreement of and commitment to the ICP Strategy**
- **Publish Final Strategy.**

31 March

Addressing our population's health and care needs

We have **existing** joint strategic needs assessments that identify our population's health and wellbeing needs at Place:

Staffordshire Joint Strategic Needs Assessment

Stoke-on-Trent Joint Strategic Needs Assessment

These tell us where our population health and care outcomes can be improved to bring them into alignment with national average across the ICS population. This intelligence was used along with existing strategies and the NHS Long Term Plan to identify priorities.

Going forward the strategy will be underpinned by population health management, community engagement and the best research evidence to ensure **decision making is informed** by the health and care needs of our population.

What we are hearing from people and communities

Current high level strategic issues/priorities we hear in the press and in discussion with residents and stakeholders:

- **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**
- **Difficulty accessing primary care and/or seeing your GP**
- **Difficult to arrange social care and/or community services.**

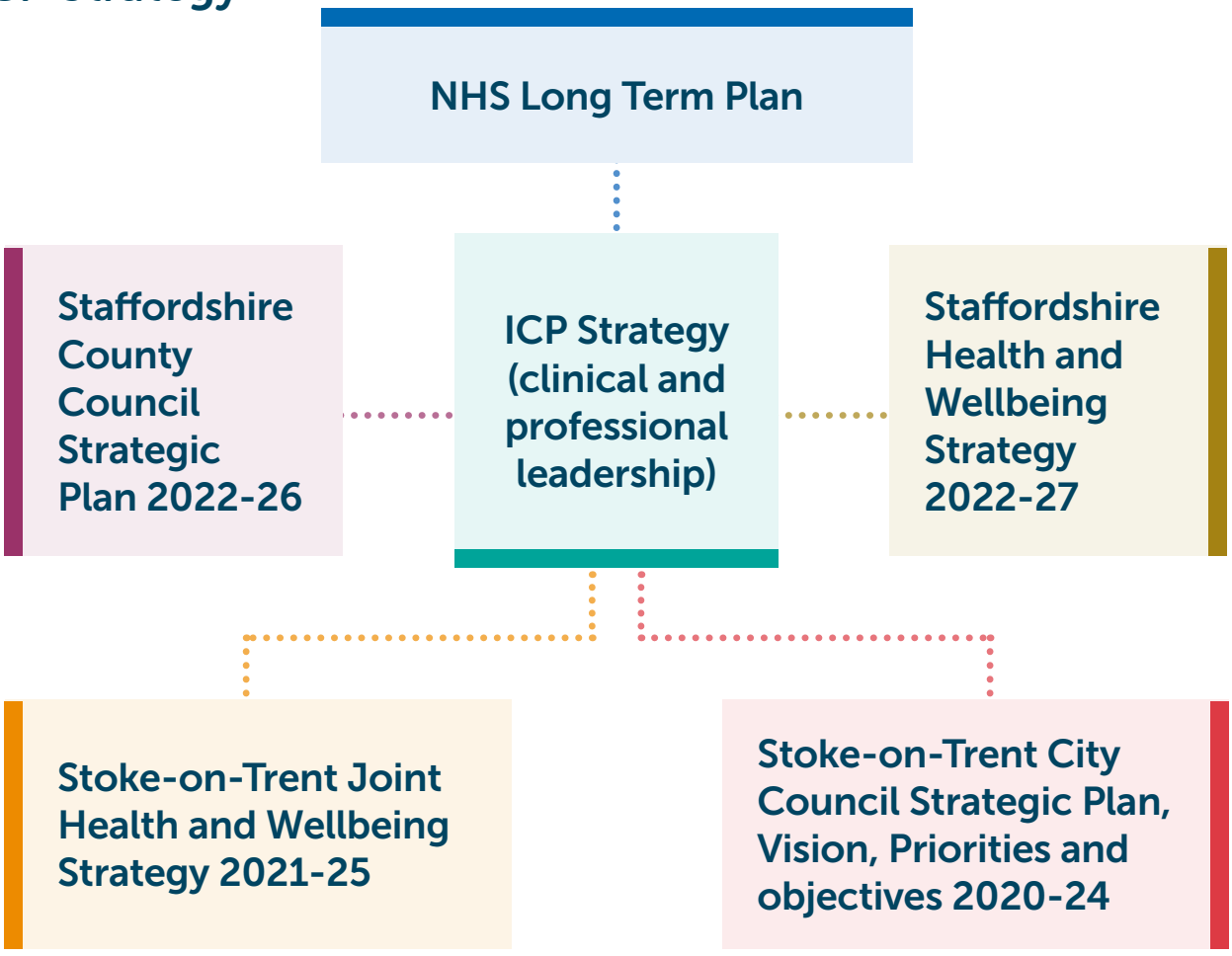
Existing shared priorities

We want to integrate existing programmes of work in a way that enhances our collective action and expands on existing good practice.

We have engaged with local people and communities to identify where there are existing shared priorities across our ICS:

- Improving health in pregnancy and infancy (priority focus on reducing infant mortality)
- 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.

ICP Strategy



Strategy vision

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

We have an agreed vision for the future of health and care to improve population health and wellbeing in Staffordshire and Stoke-on-Trent. All partners will work together to achieving this. We want people to live well, stay healthy and independent for as long as possible, accessing health and care services that meet people's needs when they experience physical, mental health, or social problems.

Strategy ambitions

Improve population health and wellbeing outcomes

We want to enable people to live well and stay healthy and independent for as long as possible.

To achieve this, we will work in partnership to prevent ill health throughout people's lives, using a system-wide approach to prevention, alongside action to improve the determinants of health in our communities and a focus on reducing health inequalities.

By taking this holistic approach we aim to give people the best start to life and support their health and wellbeing as they grow older. Addressing health inequalities will help give people more equal opportunity to benefit from health and care, addressing known disadvantages relating to where they live, personal circumstances, age, gender or ethnicity.

Address inequalities in access, experience and outcomes from health and social care services

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.

We will address health inequalities to give our population equal opportunity to use and benefit from the health and care services available.

Achieve a sustainable and resilient ICS

We recognise that, while we want to look to the future, 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.

Immediate system pressures include:

- Increasing demand for urgent and emergency care
- Elective or planned care recovery
- Managing the impact of winter
- Improving access to gps and dental services
- Improving access to mental health services
- Resolving the multiple challenges social care services face.

As an ICS, we can better plan and respond to threats, incidents and emergencies that could affect health and care, building a resilient and sustainable system.

Working in partnership with communities to achieve social, economic, and environmental community development

Working in partnership with people and communities is central to our approach. Listening to their views has been crucial in informing the strategy, so that it speaks for the population as well as the health and care workforce.

Going forward, we will actively involve people in deciding how we deliver services, to ensure we effectively address what they need to live healthy lives.

While the health and care an individual receives is important, we know that up to 80% of a person's long-term health is related to wider factors, including employment, housing and education. We will look objectively at how we, as organisations embedded in our communities, can promote health and wellbeing, provide more equal employment opportunities and enable people to access everything they need to realise their potential.

Working with communities and VCSE sector partners will be essential to achieving this, co-producing community-based solutions that reflect what local people need to maintain or improve their health and wellbeing.

Our strategy approach

Understanding the needs of our population

The King's Fund population health model can be used to explore and understand the health and care needs of the population and the factors that influence our population's health and wellbeing.

Future integration of health and care will be informed by our collective understanding of our population's health and care needs. It will need to take into account how we work in partnership to address the four elements to improve health and wellbeing.

The SSOT ICS health and wellbeing strategies are also based around this model, which is embedded as our strategic approach across the system. We are committed to ensuring that shared strategies and plans across our ICS 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.

Improving health and wellbeing

People and communities

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

Personalised care

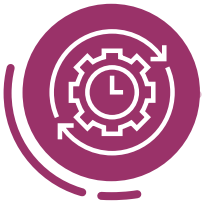
holistic, integrated care designed around personal needs and preferences

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.

Five Ps approach

People and communities

The voices of local people in Staffordshire and Stoke-on-Trent add real value to how we plan and deliver health and care services. Involving people ensures we meet our legal duties, but more importantly it helps us better understand people's needs, experiences, ideas and aspirations. Subsequent engagement then reveals if change is working.

There are opportunities to build relationships based on trust, especially with marginalised groups and those affected by health inequalities. Developing ways of involving people that are clear and accessible for all is vital.

District and Borough Councils, Healthwatch and other VCSE partners will play a key role in how we develop or expand engagement that empowers people and communities.

We will expand use of strengths-based approaches, learning from what works well and building on existing networks and relationships to make Staffordshire and Stoke-on-Trent the healthiest places to live and work. Strengths-based (or asset-based) approaches focus on individuals' strengths (including personal strengths and social and community networks) and not on their deficits.

By working more closely with local people in future we will:

- Adopt a strengths-based approach, recognising the value communities can bring to our services
- Invest in developing community networks and resources offering health and wellbeing, social, education and welfare support
- Recognise the value partnership can bring in improving wider determinants of health, employing people and procuring services from local communities as integrated care partnerships grounded in the local community.

Personalised care

We are working towards offering 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.

Personalised care focuses on giving people more choice and control over how their care is planned and delivered. It should be based on what is important to them and will enable a good quality of life. Sharing patient records and information between partners will help improve our understanding of people's needs and preferences.

To achieve our aims, we need to build 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.

As we deliver personalised care across the life course we will:

- Work with people as equal partners
- Allow people to self-manage their care in the community.

Personal responsibility

Individual choice is something we must strongly protect. However, we want people to be able to take personal responsibility for their health and wellbeing by making appropriate choices about nutrition, sufficient physical activity, and the avoidance of risks such as smoking and drug or alcohol misuse.

People can also take responsibility for how they access and use the care that they receive, knowing when to use self-care management, medication and attend appointments with health and care professionals.

For people to take responsibility for their own health, they need to be motived and feel empowered to do so.

To enable people to take greater responsibility for their health and care we will:

- Work with people and communities to promote healthy lives and choices
- Use personalised care and shared decision making to empower them to actively take ownership and responsibility for managing their health and wellbeing in an appropriate way. Shared decision-making ensures that individuals are supported to make decisions that are right for them. It is a collaborative process through which a clinician supports a patient to reach a decision about their treatment.

Prevention and health inequalities

We will enable people to remain as healthy and independent 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.

Our integrated approach will focus on preventing illness through improved access to preventative services such as screening, immunisations and smoking cessation. We will also work with people and communities to achieve environments that promote health and wellbeing. We know that adverse life experiences, abuse or growing up in a family with mental health or substance use problems can have a negative impact. We must work together to understand and address the factors that put people at risk.

Prevention remains important for people living with long-term illness and we will focus on delivering personalised care, empowering people to take personal ownership and self-manage such conditions in the community. This will enable people to live well, independently from care, for as long as possible.

Prioritising prevention reflects the growing evidence supporting resources being shifted 'upstream' for people as well as health and care services. There is broad support for this approach in both our communities and workforce.

Unprecedented demand means that preventing disability, physical and mental health problems and loss of independence has never been more integral to the future sustainability of our services.

The intelligence on our population's health and our engagement clearly demonstrate that some people experience health inequalities. Future improvements in health outcomes are required to achieve a fairer, more productive and equitable society.

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

- Offering equal opportunity to 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 ICS partners
- Using population health management (PHM), engagement and research to better understand the needs of inclusion health groups.

Productivity

Our 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 do this by embedding continuous quality improvement and evidence-based practice across health and care. This ensures our decisions and services are responsive to what our population needs, improving population health outcomes and using available resources effectively.

There is good evidence that improving co-ordination between services that were previously working separately can significantly improve productivity. This will also allow us to design services that can intervene earlier to improve health and wellbeing, for example by providing self-management support for long-term conditions.

As we integrate health and care, we will also bring together digital systems. Giving health and care professionals more information and enabling faster communication between services will improve diagnosis, treatment and patient experience.

Our workforce is also key to productivity. This doesn't mean people working even harder, it means working differently to achieve the right skill mix of health and care staff, will help to tackle workforce pressures.

To realise improved productivity in future, placing our system on a more sustainable footing, we will:

- Adopt an intelligence-led continuous quality improvement approach
- Use the best guidance, research evidence and innovation in how we use digital technology, our workforce, and models of care
- Deliver an increased focus on prevention to reduce demand
- Use integration to improve access to health and care services for all people and ensure improved co-ordination of care.

Population health management

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

This approach will be central to all we do, ensuring we focus efforts on the best ways to support our communities, and ensuring there is as little variation as possible in services across Staffordshire and Stoke-on-Trent.

We deliver this approach in partnership across the NHS and other public services including councils, the public, schools, fire service, voluntary sector, housing associations, social services and the police.

Our workforce will feel the benefit of knowing their hard work is targeted at those at greatest risk of illness or death, enabling them to provide personalised and proactive care. Improving the care available before emergency health crises develop will help to prevent some illnesses, adverse events and complications.

Embedding population health management will:

- Deliver integrated health and care that is underpinned by intelligent decision-making using data on our population's health and care needs
- Use data to understand risk and protective factors, enabling us to target resources to those at increased risk of poor health outcomes or with greatest potential to benefit from care
- Identify inequalities in access, experience, and outcomes of care to inform improvements to care pathways so that we offer high quality inclusive care
- Proactively target preventative interventions and services to those identified as being at higher risk of illness or adverse events, for example infant mortality or emergency hospital admission.

Improving population health across the life course

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

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

We will integrate health and care to achieve a greater impact for our population at different stages of life.

The key life course stages

Start well
(0-5 years)

Our priority: we will give infants and children the best start to life

Together we can ensure all infants and children experience the best start to life, setting them on a course of improved life-long health and wellbeing. In doing this we will progress on:

- **Reducing infant mortality**
- **Ensuring children achieve good development during early life and are ready for school.**

Why?

The period from conception to age five is a critical time for a child's growth and development, impacting on their health and wellbeing all the way through to adulthood.

Optimal early development is vital to ensure children achieve good physical, cognitive and emotional development and are ready to learn as they transition to school age.

Infant mortality, the number of children who die before their first birthday, is an indicator of the general health of an entire population, reflecting the ability of society to protect the lives of children under one year old.

Most children across Staffordshire and Stoke-on-Trent have a good start to life in their first five years. However, some unfortunately do not and we see high rates of infant mortality and many children not achieving key development milestones and being prepared for school.

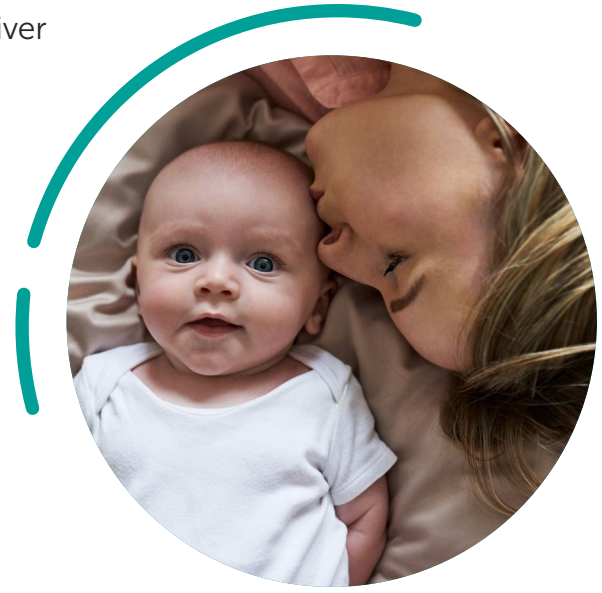
Children born into and growing up in our most deprived communities are at the greatest risk. This can be because of poor early childhood development due to several factors, for example, low breastfeeding rates, smoking during pregnancy and low birth weight.

Adverse childhood experiences and delayed development milestones have a lasting effect on health and wellbeing through childhood and later in life. For some, these difficulties start before they are born and strong maternal support during pregnancy is important for safe delivery, good birth weight and good outcomes after birth.

Supportive relationships during pregnancy and early years development are essential for fostering good emotional wellbeing and mental health in both mothers and children. While many families and carers can provide this, sometimes additional support is required to enable mothers to give their child the best start to life.

To ensure all infants and young children are provided with the best start to life we will:

- Use population health management to inform a targeted approach to preventing infant mortality and poor early childhood development, identifying families, mothers and children who require additional support and address health concerns before they become more serious
- Ensure all children under five years old have equal opportunity to access and benefit from early years services, development checks and childhood vaccination programmes
- Work in partnership with communities to prevent wider determinants affecting early years development and tackle health inequalities that place infants and children at greater risk of adverse childhood experience
- Deliver a child and family centred approach, recognising unique needs, circumstances, and preferences to provide the best start to life
- Deliver personalised holistic support, including co-ordinated multi-disciplinary care informed by shared care records and improved data sharing across maternity and children's services
- Invest in evidence-based early childhood education and development programmes to deliver improved outcomes for children and families
- Recognise the contribution of community-based programmes that support parents and caregivers, such as access to affordable childcare and paid parental leave
- Deliver programmes of education and support for parents and caregivers, promoting positive parenting practices, healthy behaviours and encourage early intervention and care for children when needed.
- Partner with people and communities to deliver community-based approaches and social networks that support the health and development of young children.



Grow well (6-18 years)

Our priority: we will enable children to thrive into adulthood, supporting physical, mental and social development

Together we can enable all children and young people (CYP) to fully realise their potential, ensuring those who need support to achieve good physical, mental and social development can access it so they can thrive and are supported as they prepare for or transition to adulthood. In doing this we will progress on:

- **Improving mental health and wellbeing in CYP and families**
- **Improving educational attainment and aspiration, through integrated support for those who need it across all ages.**

Why?

Childhood and adolescence are stages during which the right environment, opportunities, behaviours, and support can have a lifelong positive impact on health and wellbeing.

Sadly, some children and young people are exposed to adverse childhood experiences during early life and experience challenges with their physical, mental, and social development. This can have a negative impact on their school life and their aspirations for the future.

Through childhood health inequalities start to appear and some are more likely to be admitted to hospital for a range of health problems or high-risk behaviours and are more likely to experience mental health and emotional wellbeing problems. We also see increasing numbers of children who are overweight or obese.

This has an impact on child and adolescent development, and we see some young people not fulfilling their educational potential or at increased risk of becoming involved in the youth justice system.

To support all CYP to achieve good physical, mental and social development, fulfilling their potential and achieving key development milestones, we will:

- Focus on early identification and support for CYP who have had an adverse childhood experience or have trouble in their physical, mental, and social development, delivering integrated and personalised care to enable them to thrive and realise their potential

- Use population health management to reduce risk of adverse childhood experiences
- Use population health management to identify, understand and target risk factors that contribute to poor mental health and impaired physical, mental, and social development in CYP
- Develop a child-centred approach to integration of care pathways for CYP who need support or care, offering care and support that is inclusive and focused on their needs
- Use population health management to identify and prioritise local action to address unnecessary variation in CYP's services
- Ensure integrated pathways are in place across services to support the transition to adulthood and prevent unnecessary or ineffective transfer between services
- Co-produce community, digital and education-based approaches to building resilience in CYP, enabling them to make informed choices and better access support when required to prevent adoption of risky behaviours that harm health and wellbeing
- Ensure CYP have a voice in the planning, design and delivery of health and care services so that we better meet their needs.

Live well (19-64 years)

Our priority: we will enable adults to take ownership of health and wellbeing and achieve their potential

As people progress through adulthood, we can empower them to have ownership of their health and wellbeing. We want to help them achieve their potential at work and be involved in society. In doing this we will:

- **Improve access to good employment and housing for vulnerable people in our communities**
- **Increase prevention of premature mortality from cardiovascular disease, respiratory disease, alcohol harm and suicide.**

Why?

There is extensive evidence that good work and good housing improves health and wellbeing and quality of life.

There are several milestones in people's lives such as starting work and becoming a parent or carer where it is important that they have ownership of their health and wellbeing, reinforcing healthy behaviours, intervening early when ill health occurs and providing opportunities to access employment and housing.

Sometimes people's lives can be 'interrupted' or less positive if they experience risk factors for poor health such as poverty, violence and complex trauma, severe mental illness or social exclusion. The impact of these, if not addressed, can grow and result in poor health and wellbeing.

We also know that for some, these risk factors can result in homelessness, drug and alcohol dependency, unemployment or coming into contact with the criminal justice system. This can then lead to longer-term issues such as having greater difficulty in accessing good employment, good housing and experiencing poorer access to health and care services.

Throughout this life stage, health and care professionals and other partners can ensure they make every contact count and use personalised care to support and empower people to make positive changes to their physical and mental health, wellbeing, and social circumstances.

Where we identify individuals or groups experiencing difficulty accessing services, we can proactively deliver integrated approaches to prevent social disadvantage and the impact this has on individual and population health.

To enable all adults to take ownership of health and wellbeing and achieve their potential we will:

- Use population health management to identify individuals and groups experiencing social exclusion and health inequality, developing targeted approaches so we offer equal opportunity to benefit from good housing, employment, inclusive access to health and care and prevent adverse experiences
- Proactively offer targeted preventative health and care to people at increased risk of premature mortality from cardiovascular disease, respiratory disease, alcohol harm and suicide, developing integrated pathways and improved prevention against adverse health outcomes and mortality
- Use targeted personalised care to deliver an inclusive approach to health and care services that meets the physical, mental, and social needs of those at risk of adverse experiences and health inequalities, empowering them to have greater ownership of their lives, health and wellbeing
- For those with long-term physical or mental health problems, we will use personalised care and digital technology to empower working age people to have the skills and knowledge to better self-manage independently in the community
- Innovate how we use digital tools and our workforce to develop a prevention approach to personalised care across our ICS, encouraging people to take greater ownership of their health and wellbeing

- Use population health management and quality improvement to identify and prioritise local action to address unnecessary variation in quality of care, informing the development of integrated services that offer the right care at the right time, reducing spend and improving health and care outcomes.
- Work in partnership with people and communities to identify and co-produce approaches that enable partner organisations to improve access to employment, housing and health and care services for individuals who experience or are at increased risk of social exclusion
- Work in partnership with people and communities to identify, develop and make best use of community assets that enable people to better meet their physical, mental and social needs in the community, especially for those at risk of social exclusion
- Recognise the value of lived experience of people and communities and involve them in the planning and delivery of integrated health and care services.

Age well (65- years)

Our priority: we will enable people to remain independent, active and connected in their communities with a plan for later life

How people age is influenced by their choices in early life and how they approach getting older. Together we can empower over-65s to remain physically, mentally, and socially active, prolonging the period of life spent living in good health and independently in the community. In doing this we will progress on:

- **Increasing the number of over-65s living active, connected, and independent lives in the community**
- **Reducing harm from falls and preventable emergency admissions to hospital for over-65s.**

Why?

The World Health Organisation has referred to 2020-2030 as the 'healthy ageing decade', where we need to focus on creating a more sustainable health and care system, providing proactive, preventative, and predictive health and care to help our population to age well.

There is good evidence that increasing physical, mental and social activity in those over-65s provides a broad range of benefits and contributes to 'successful healthy ageing'. Staying active in later life can prevent loss of physical ability to do normal daily tasks, prevent social isolation, improve personal resilience and prevent or delay the onset and progression of dementia, disability and frailty. We can increase the years spent in good health and improve quality of life for over-65s, enabling people to maintain their independence for longer.

More needs to be done to delay the onset and progression of frailty to prevent falls and hospital admission – which further increase the risk of illness and death due to loss of physical function and other harms during hospital stays. We can also protect them from avoidable harm and reduce the number of people needing emergency hospital admission or needing to live in a care home due to the loss of their independence.

Life expectancies have risen for decades and will continue to do so, but locally people can expect to spend between 16 and 25 years at the end of life living with poor health. National evidence shows that there are increasing numbers of over-65s living with multiple long-term conditions, meaning that the health and care that they need is increasingly complex.

To enable over-65s to remain independent, active and connected in their communities with a plan for later life we will:

- Develop community-based approaches that enable over-65s to age well, focusing on tackling social isolation, improving physical activity and empowering people to improve their health and wellbeing at home or in their community
- Use population health management to understand the current and future health and care needs of over-65s, the contribution of different social factors to healthy ageing and inequalities, to inform the development of integrated health and care pathways focused on enabling healthy ageing and prevention frailty
- Develop prevention programmes using population health management to proactively identify those at risk of developing frailty or with mild frailty to offer community-based and digital services promoting education, awareness, and independence
- Develop models of personalised care for over-65s living with complex health and care needs and/or severe frailty, focused on preventing harm and loss of independence through avoidable falls and emergency hospital admissions
- Innovate how we use digital tools and recruit, train and deploy workforce in delivering personalised care to over-65s to prevent the progression of frailty and avoidable crises that increase emergency care activity
- Use population health management and quality improvement to identify and prioritise local action to address unnecessary variation in quality of care, informing the development of integrated models of health and care services that offer the right care at the right time and in a way that is personalised to individual needs, reducing spend and improving health and care outcomes
- Work with people and communities to achieve a positive shift in attitudes towards ageing and frailty, recognising the strengths this population group has and can contribute to society and encouraging open discussion on plans for later life
- Value the views and voices of over-65s in how we deliver health and care services, involving organisations and representatives of this population group in the planning and delivering of care.

End well

(all people needing palliative or end of life care)

Our priority: 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 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 and carers**
- **Reduce preventable emergency hospital admissions at the end of life.**

Why?

There is good evidence that delivering effective personalised care at the end of life can improve wellbeing and improve management of symptoms in people with life-limiting or terminal illness. Advanced care planning allows health and care professionals to discuss people's own values, wishes and what matters most to them in life and in dying, so care is reflective of people's choices.

Increasingly hospices and teams delivering end-of-life or palliative care in the community play a vital role for people, their families and carers. Over the past decade we have seen increases in the number of people dying at their home, care home or religious establishment, with fewer people dying in hospital (below 50%), and increases in the number of health and care professional contacts with people receiving end-of-life care.

Over the past decade we have unfortunately seen increases in the number people experiencing three or more emergency hospital admissions at the end of life which can be disruptive and has a negative impact on a person's quality of life.

National survey data suggests that most people would prefer to die at home, with few wishing to die in hospital. This highlights a need for an effective integrated care approach centred on personalised care that reduces avoidable emergency admissions and ensure more people can die in their place of choice, experiencing good quality of life at the end of life.

To maximise health and wellbeing in the last years of life by supporting people and carers we will:

- Use population health management to identify and address avoidable differences in access, experience and outcomes from palliative and end-of-life care, working towards equal opportunity to benefit from personalised support
- Develop tools to support identification of people approaching or in their last year of life to proactively offer personalised care based on advance care plans reflecting people's values, wishes and preferences
- Use advance care planning and shared care records to create multi-disciplinary palliative and end-of-life care that is reflective of people's values, wishes and preferences
- Recruit, develop and deploy our palliative and end-of-life care workforce to deliver effective multi-disciplinary personalised care
- Involve partners and people with lived experience in the development of local palliative and end-of-life care planning and delivery so we provide care that is reflect of people's needs at the end of life
- We will utilise the support available from assets and social networks in our communities supporting people at the end of life and during bereavement.

Inclusion Health Groups for our ICS

Strong focus on health inequalities in the Strategy

Inclusion Health Groups can be socially excluded and experience multiple overlapping risk factors in our population resulting in health inequalities.

- Learning disability and autism
- Women from ethnic minority communities and/or experiencing poverty
- Individuals, households and communities at risk of serious violence

Engagement to understand challenges

Identified in Health and Wellbeing Strategies, national strategies and having a legal duty to ensure equitable opportunity to benefit from health and care services.

- Informal carers
- Military Veterans
- Asylum Seekers and Vulnerable Migrants
- Our older population (prioritising those vulnerable or socially isolated)

Design targeted health and care interventions

Using a population health management approach and community engagement to understand the health and wellbeing needs of these groups to inform the development of integrated approaches to improving health and wellbeing.

- The population experiencing homelessness
- Others as identified by PHM at Place and Community.

How we will monitor and evaluate our strategy approach

As we implement this strategy in our ICS over the next five years it is important to monitor and evaluate its progress in achieving the aim and ambitions we have outlined.

To inform this 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.

Appendix 1

Proud to be working with:

City of Stoke-on-Trent

Staffordshire County Council

NHS England

healthwatch Stoke on Trent

healthwatch Staffordshire

NHS West Midlands Ambulance Service University NHS Foundation Trust

NHS Midlands Partnership NHS Foundation Trust *A Keele University Teaching Trust*

NHS University Hospitals of Derby and Burton NHS Foundation Trust

NHS University Hospitals of North Midlands NHS Trust

SUPPORT STAFFORDSHIRE Countywide Support for the Voluntary, Community and Social Enterprise (VCSE) sector

vast INVESTING IN COMMUNITIES

NHS North Staffordshire Combined Healthcare NHS Trust

Keele UNIVERSITY