TOGETHER WE'RE BETTER

Transforming health and care for Staffordshire & Stoke-on-Trent

Case for Change

Contents

V0.51

17 May 2019

Executive summary

Together We're Better brings together local organisations to improve the way health and care is provided across Staffordshire and Stoke-on-Trent. We are committed to changing the way we deliver health and care across Staffordshire and Stoke-on-Trent so that it better meets the needs of our local people and improves everyone's lives.

Together We're Better is one of the 44 Sustainability and Transformation Partnerships in England and includes our local authorities (Stoke-on-Trent City Council and Staffordshire County Council), local NHS clinical commissioning groups (North Staffordshire CCG, Stoke-on-Trent CCG, Stafford & Surrounds CCG, East Staffordshire CCG, Cannock Chase CCG and South East Staffordshire and Seisdon Peninsula CCG), local providers, GPs, voluntary and community groups, Healthwatch and the local population.

Our area has seen significant challenges in the past, and while many improvements have been made, we believe further challenges need to be addressed to improve health and care to meet the needs of our population. We have developed this Case for Change to describe our challenges and explain why change is necessary. This Case for Change builds on the previous 2016 publication, aiming to provide further detail to help inform the public and wider stakeholders. This Case for Change further sets out the needs of our population, the current provision of health and care and outlines our vision and aims for local health and care in the future.

The purpose of this Case for Change is threefold:

- To set out the challenges we face;
- To describe the potential model of care to support health and care services across our area;
- To outline the next steps in terms of the development of the Pre-Consultation Business Case (PCBC).

We are focussed on addressing the challenges facing our area. As set out later in this Case for Change, specific issues have been identified across our area with the provision of acute, community, mental health and social care services. These issues have been grouped across six key considerations, which are presented in Figure 1.

Figure 1: Key considerations in our Case for Change

In addition to this Case for Change, we have recently produced a Pre-Consultation Business Case which outlines proposals to address challenges within our community services in the North of our geography. The 14 week consultation process closed on 17th March 2019. The feedback from the consultation events will be independently evaluated.

As an STP, we will continue to develop plans across our wider services to address a broad range of issues and opportunities including: services such as prevention, children's services, the development of integrated care systems (ICS's), and use of digital technology. While these services are central to the delivery of our health and care services,

plans to address these issues and opportunities are described within our sustainability and transformation plans and are not the focus of this Case for Change.

The following challenges have been outlined within this Case for Change;

- There exist areas of high deprivation within our STP, which have implications for the long-term health and wellbeing of the local population.
- There is significant health inequalities across our area, significant improvements could be made to improve outcomes.
- Coupled with the above, the healthcare needs of the population are growing, with increasing levels of long-term conditions and multi-morbidities. We will need to focus on prevention and ensuring we have the right strategies for this changing demand.
- We could deliver a better start for children and young people.
- We need to better protect and support the mental health of the population.
- The quality of healthcare could be significantly improved in a number of critical areas to better manage demand and address the challenges we face.
- We need to review our community service offer to ensure patients are treated effectively in the most appropriate setting for their needs.
- We have fragmented data flows across our organisations, and patients are not yet benefitting from digital technology.
- Our workforce is under increasing strain with significant vacancies and increasing demand from more complex patients.
- The system has a significant financial deficit which will continue to grow if bold action is not taken.
- Significant action will be needed to deliver the ambitions of the NHS Long Term Plan, supporting our Case for Change.

We have developed a model of care to address these challenges and provide the benefits of holistic, integrated care to our population. Through our clinical model, our vision is to ensure that our population will have:

- Access to **urgent and emergency care services** that are appropriate and deliver that care within the right setting. This includes working with other parts of the system to ensure that people are not having to access urgent and emergency care for exacerbations of conditions that should be managed in other ways;
- **Care integrated around the individual**, delivered as close to home as possible;
- **Integrated and efficient complex care pathways** that are simple to navigate, with rapid access to specialists and diagnostics; and
- **Enhanced primary care and community services**, aiming for continuity of care pathways which will be improved by working alongside social care and the voluntary sector.
- **Supportive care that provides integrated mental and physical health services within the community.**

The scope of this ongoing work includes:

- Urgent and emergency care (inc. UTCs, emergency departments) all ages
- Planned care (18 years and over)
- Maternity services (inc. freestanding and alongside MLUs)
- Community mental health services
- Inpatient mental health services (East/South East Staffordshire)

It does not include:

- Services for people under 18 years of age
- Preventative services commissioned and delivered by Local Authority
- North community services including community beds
- Wider inpatient mental health services

- Learning disability services
- Social care services.

Our commitment

In light of the health needs of our local population and the changing demands on the NHS in Staffordshire and Stoke-on-Trent, we face a variety of complex challenges affecting our health and care services. This means we cannot continue to deliver these services the way we do now. We must take action to ensure our health and care provision is clinically and financially sustainable as well as fit for the future. We are committed to working as a system through the Together We're Better Programme to seek and make the necessary improvements for our population.

This document

The remainder of this Case for Change is structured in the following way:

- **Section 1** provides background to the Together We're Better Programme (who we are, our partners, and background to this Case for Change);

- **Section 2** outlines the issues our local health and care economy is facing across the six key considerations this Case for Change is focussed on (Poverty and Deprivation, Health and wellbeing, Care and Quality, Workforce, Finance and efficiency, and Estates);

- **Section 3** presents estimated demand and capacity across the sector;

- **Section 4** presents the opportunities that we are targeting as we move forward, including a summary of our proposed model of care;

- **Section 5** outlines the next steps we will look to undertake, including engagement with key stakeholders such as the public and our workforce;

- **Section 6** presents a conclusion; and

- **Appendix** with supporting data.

1. Background to Together We're Better

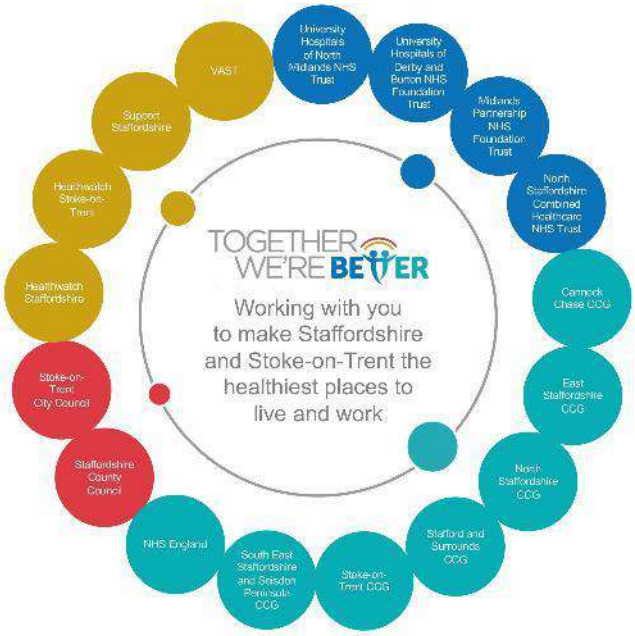
1.1 Who we are and our partners

Together We're Better is the partnership transforming health and care for the people of Staffordshire and Stoke-on-Trent. Together We're Better is one of 44 Sustainability and Transformation Partnerships (STPs) in England, which brings together local NHS organisations, Stoke-on-Trent City Council, Staffordshire County Council and the two Healthwatch organisations. Our partners are committed to changing the way we provide health and care across Staffordshire and Stoke-on-Trent so that it better meets the needs of our local people and improves everyone's lives.

We truly believe that all the organisations have the ability, knowledge and skills to deliver high quality, innovative services through a focus on community-based support, collaborative leadership and working together across our nine local areas. Ultimately this programme is seeking to improve care working with and for our local population.

Our partner organisations work together across two local authorities and six clinical commissioning groups (CCGs) as part of Together We're Better. These are presented in Figure 2 .

Figure 2: Together We're Better programme partner organisations



The **two local authorities** within the footprint are Staffordshire County Council and Stoke-on-Trent Council, which are both upper tier local authorities. Staffordshire County Council is split into eight districts: Cannock Chase; East Staffordshire; Lichfield; Newcastle-under-Lyme; South Staffordshire; Stafford; Staffordshire Moorlands; and Tamworth. Within this Case for Change, we have considered the challenges within our STP, and these nine local areas.

The Clinical Commissioning Groups include:

- North Staffordshire CCG;
- Stoke-on-Trent CCG;
- Stafford & Surrounds CCG;
- East Staffordshire CCG;
- Cannock Chase CCG; and
- South East Staffordshire and Seisdon Peninsula CCG.

As a partnership, we work with a range of partner organisations across the area to deliver care, including:

- **Acute Trusts**, including University Hospital North Midlands NHS Trust (UHNM), University Hospitals of Derby and Burton NHS Foundation Trust (UHDB), The Royal Wolverhampton NHS Trust (RWT), Virgin Care;
- **Mental Health Trusts**, including North Staffordshire Combined Healthcare NHS Trust (NSCHC) and Midlands Partnership NHS Foundation Trust (MPFT);
- **NHS Community Trusts**, including University Hospitals of Derby and Burton NHS Foundation Trust, Staffordshire & Stoke-on-Trent Partnership NHS Trust[1]), Virgin Care; and
- 187 general practices;
- Other health and care providers.

The local health and social care service landscape is complex and there are indications of under and over capacity. In terms of NHS capacity there are five other main Acute Hospitals on the borders of the STP footprint that deliver services to Staffordshire patients: New Cross (Wolverhampton), Good Hope (Birmingham), Walsall Manor (Walsall), Royal Derby (Derby), Leighton (Cheshire).

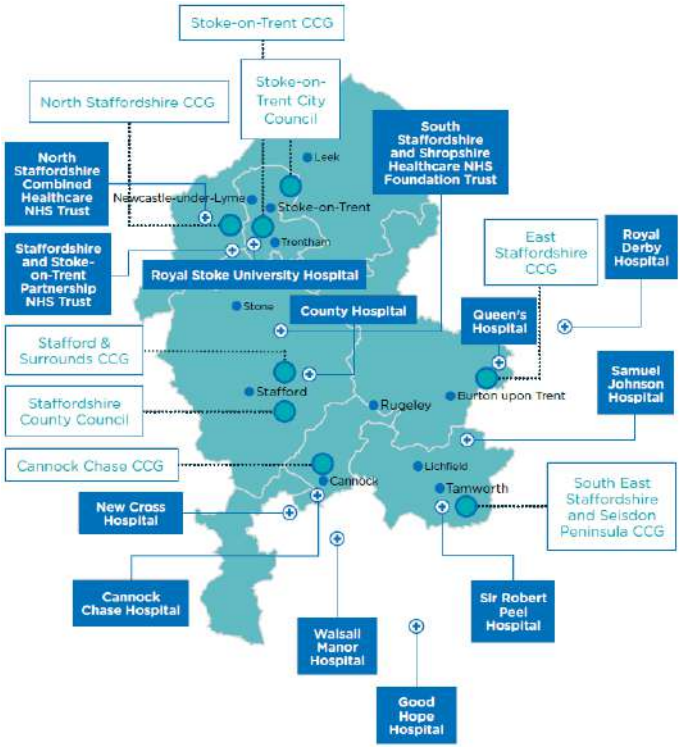
NHS elective services are also provided to the local population by the following non-NHS providers: Nuffield North Staffordshire, Nuffield Derby, Nuffield Wolverhampton, Rowley Hall, Malling, Ramsey, Spire Little Aston and Spire Regency.

The map shows the area covered by the Together We're Better programme and where our partner organisations are located. It sets out the Staffordshire and Stoke-on-Trent local authorities, Clinical Commissioning Groups and NHS trusts that buy and deliver different types of health and care for our local population. It includes trusts outside the county that offer specialist services or where people may choose to receive care if it is more convenient for them. Not included in this map are the wide range of voluntary sector and independent providers that offer services who have also been asked to join in the Together We're Better conversation about what health and care may look like in future.

Around 1.1 million people live in Staffordshire and Stoke-on-Trent, across a geographical area of 1,048 square miles.

[1] In June 2018 South Staffordshire and Shropshire Healthcare NHS Foundation Trust (SSSFT) and Staffordshire and Stoke-on-Trent Partnership NHS Trust (SSOTP) joined together to become Midlands Partnership NHS Foundation Trust (MPFT).

Figure 3: Area covered by the Together We're Better programme



We are making progress in promoting integrated care across all of our organisations, for example through the creation of Midlands Partnership NHS Foundation Trust (MPFT). The MPFT was formed following a merger between South Staffordshire and Shropshire Healthcare NHS Foundation Trust and Staffordshire and Stoke-on-Trent Partnership NHS Trust. In Staffordshire MPFT enables patients to have one care plan covering their physical and mental health and social care needs, reducing unnecessary duplication and enabling better care co-ordination. As a result, the creation of MPFT has helped to make our care system less confusing for patients when they are at their most vulnerable[2].

1.2 Our vision

Our vision is to work with you to make Staffordshire and Stoke-on-Trent the healthiest places to live and work. This means:

- Helping you live well, for longer, and supporting you to be as independent as possible so we can be there when you need us;
- Delivering care as close to home as possible, ensuring that your experience of health and care is the best it can be; and
- Treating people rather than conditions and giving mental health equal priority to physical health.

Our aims are to:

- Promote prevention strategies and empower people for self-care and shared decision making;
- Co-ordinate and integrate care, with early intervention and step down possible where appropriate and greater use of digital technologies; and

[2] MPFT, A New NHS Trust is Launched, 2018

- Reduce unwarranted clinical variation, through providing evidence based, effective care and using our workforce in the best way.

We believe that we can achieve these aims across Staffordshire and Stoke-on-Trent by addressing our challenges and providing an effective model of care across our population and geography.

1.3 Background to the Case for Change

1.3.1 The NHS and social care in England is facing complex challenges that are placing increasing pressure on the system

An ageing population and an increase in long-term conditions (LTCs) are resulting in major changes in our health needs. This is placing ever greater pressure on the NHS. Recent guidance and objectives from the NHS, including the *Five Year Forward View* and the *NHS Long Term Plan,* has focussed on improving and preventing ill health and supporting the growing number of people who are elderly, or suffer from long-term conditions.

The most essential resource in delivering high quality health and care services is our workforce, but it too is experiencing significant challenges as the increasing demand on the system is outstripping the supply of healthcare professionals. This is further exacerbated by issues such as an ageing workforce and more recently the impact of Brexit, which has seen a reduction in the supply of healthcare professionals from Europe. Recent reviews by eminent think tanks have re-emphasised these challenges[3].

All these challenges need to be met at a time of unprecedented financial pressure affecting the NHS. It is important that any plans for future services can support the NHS to be financially sustainable. Additional funding of £2.45 billion is available through the Provider Sustainability Fund to support systems, transform care delivery, and achieve financial balance across England. Despite this and further additional funding announced in the 2017 Autumn Budget of £6.3 billion, and a further 3.4% annual real terms funding increase for the next five years announced in July 2018, the challenge remains substantial as the National health sector's deficit was £960 million at the end of 2017/18. Recent statements by the Secretary of State have emphasised the importance of workforce, technology and prevention.

Similarly, there are challenges across social care. There is an increasing cost of caring for older and disabled people, placing the social care system under strain, exacerbated by a 9% fall in adult social care spending in the UK between 2009/10 and 2016/2017. Pressures on social care in the UK are projected to rise at an annual rate of 3.9%, which would lead to a UK funding gap of £18 billion opening up by 2030/31. In England, the financial thresholds to access social care are 12% lower in 2018/19 than they were in 2010/11, meaning fewer people can now access publicly funded social care[4].

Until recently, the number of children in care has remained relatively stable (excluding Unaccompanied Asylum-Seeking Children), against a national increase in numbers. However over the last 12 months we have experienced an increase in the number of Looked after Children. As the overall population continues to grow, the number of children needing statutory intervention and intensive specialist support from children's services will remain significant.

1.3.2 Significant action will be needed to deliver the ambitions of the NHS Long Term Plan

On 7 January, the NHS Long Term Plan was published setting out key ambitions for the service over the next 10 years[5]. The Long Term Plan builds on and reaffirms the policy platform outlined in previous documentation including the NHS Five Year Forward View. The Long Term Plan seeks action in a number of areas to address the challenges

[3] *The health care workforce in England, Make or Break?* The Health Foundation, The King's Fund and the Nuffield Trust, November 2018

[4] Institute for Fiscal Studies, The Health Foundation, The King's Fund and the Nuffield Trust, 2018, *What's the problem with social care, and why do we need to do better?*

[5] NHS Long Term Plan, NHS, January 2019

the NHS is facing, all of which will have implications for how we deliver care within the Staffordshire and Stoke-on-Trent. The Long Term Plan calls for us to:

Develop a new service model for the 21st century by boosting out-of-hospital care

This requires integrating community and primary care to provide fast and flexible support to people in their own homes as an alternative to hospitalisation. To address avoidable stays in hospital we will need to tackle the pressure on emergency hospital services, reduce patient delays in being discharged and increase the provision of 'same day emergency care'. We would also need to support the roll-out of digitally-enabled primary and outpatient care, which will give patents convenient access to services and health information with the new NHS App as a digital 'front door'.

Have a greater emphasis on prevention and health inequalities

The Long Term Plan sets out new practical commitments for action to improve prevention relating to a number of illnesses. This includes taking steps to help people stop smoking, overcome drinking problems and avoid Type 2 diabetes, with a particular focus on the communities and groups of people most affected by these problems. We also need to develop a plan detailing how we will reduce health inequalities and unwarranted variations in care by 2023/24 and 2028/29.

Further progress on Care Quality and Outcomes

Building on sustained progress in improving health services and health outcomes for children and young people, we are committed to further action in addressing a number of growing health issues facing children. This includes our management of illnesses in children such as asthma, epilepsy, diabetes, learning disabilities and mental health problems. The Long Term Plan sets out several ambitious targets in improving health outcomes in young people, such as 50% reductions in stillbirth, maternal mortality, neonatal mortality and serious brain injury by 2025. Over the next five years, the Long Term Plan requires paediatric critical care and surgical services to evolve to ensure that children and young people are able to access high quality services as close to home as possible.

Better care, for the adult population, will need to be delivered to address increasingly prevalent major health conditions such as cancer, stroke, mental illness and diabetes. This includes providing education and exercise programmes to thousands more patients with heart problems and improving the early diagnosis of cancer. We will need to develop new and integrated models of primary and community mental health care to support adults and older adults with severe mental illnesses, which would be enhanced through the delivery of a 24/7 community-based mental health crisis response for adults by 2020/21.

Back our workforce

The NHS workforce is to be enhanced by increasing efforts in training and recruiting more professionals. This includes expanding clinical placements for undergraduate nurses, providing more medical school places, and developing a variety of routes into the NHS such as apprenticeships. To better deal with the increasing prevalence of adults with multiple conditions the Long Term Plan wishes to accelerate the shift from a dominance of professionals in highly specialised roles to a balance of more generalist roles. To make our healthcare system a consistently great place to work, a modern employment culture will need to be adopted which promotes flexibility, wellbeing and career development.

Making better use of data and digital technology

The NHS plans to provide convenient access to services and health information for patients with the new NHS App as a digital 'front door'. We will need to change how we deliver our care to take advantage of digital tools which can help improve the planning and delivery of services, for example through the analysis of patient and population data.

The commitments made by the NHS in the Long Term Plan align to the drivers of our Case for Change and provide further impetus for our local health and care system to take action and deliver improvements in outcomes and quality for our local population.

1.3.3 Local views on services

Since the development of the original STP Case for Change in 2016, we have continued to listen to views on services, gained insights from people's personal experiences and invited suggestions on how we can do things better. We have held various engagement events to obtain feedback directly from our residents and staff and have also reviewed feedback via the Friends and Family Test, staff survey results and GP survey results.

Many of the specific challenges and issues that we know we need to address through transformational change have been identified by reviewing and taking into consideration the views of people of Staffordshire and Stoke-on-Trent, together with current evidence-based best practice principles, and NHS objectives and guidance. We are aiming to describe the challenges and opportunities within our local area with this Case for Change.

This Case for Change focusses on the more pressing priorities for health and care in Staffordshire and Stoke-on-Trent. It considers how we can improve the outcomes and experiences for our residents through addressing these issues and transforming how we deliver health and care services.

We will set out our approach of how we will continue to work together with our patients, local communities and staff. This includes how we will seek people's views and engage their help to inform the development and design of the changes needed to improve the quality and sustainability of our health and care system.

1.3.4 Clinical views on services

To help understand future health needs, we have been carrying out a whole system analysis of current activity.

This has been tested and refined through our Clinical Working Group (CWG), comprising clinicians from across the system. The CWG provides clinical expertise and challenge to develop and test our work on an ongoing basis and has refined our needs analysis through three focuses sessions. This has included:

- testing assumptions (clinical and wider assumptions); and
- testing the baseline demand and activity analysis.

As a result of this, the needs analysis supporting this Case for Change was refined.

In addition to the CWG, we have held a series of system-wide workshops to develop and test the Case for Change and clinical services, including:

- understanding the vision and aims for clinical services across Staffordshire and Stoke-on-Trent;
- understand the future service requirements, linked to our understanding of future need; and
- identifying the dependencies between different services.

As a result of this process, we have developed the aims for clinical services in the future and the end-point we need to reach. This will continue to evolve as we listen to the public and further explore the needs of our population.

We are now undertaking further work to define the future clinical model to ensure it will meet the needs of our population, achieve our aims for clinical services and address the challenges we have described in the rest of this document.

1.3.5 System Risks

At the time of writing this document the system faces the following risks;

- **Clinical sustainability:** alongside the need to deliver financial sustainability, the system needs to ensure that clinical sustainability is not compromised and that we plan for a service that is fit for the future, responsive to local needs and recognises the priorities and commitments in the NHS Long Term Plan.
- **Balance between organisational and system focus:** The ability to deliver the 2019/20 system control total will be affected by the balance between organisational and system focus against the backdrop of the legislative and regulatory context. To date, the ability of the system to progress towards financial sustainability has been limited by the pressures to deliver individual organisational financial positions.
- **Out of area spend**: A significant proportion of the CCGs' contract spend lies outside of the Staffordshire and Stoke-on-Trent STP. The ability to deliver clinical and financial sustainability for the Staffordshire and Stoke-on-Trent health and care economy, therefore, requires engagement with out of area providers, commissioners and STPs, and the ability to leverage change outside of the STP footprint.
- **Delivery of efficiencies and savings plans:** The delivery of the system control total of a £88m deficit requires a system saving plan of over 5.8% of current expenditure. These savings include traditional efficiencies, such as theatre productivity and reducing procurement costs, as well as more transformational efficiencies, as STPs move towards a more integrated model with a shift of services and resources away from the hospital and bed based traditional services towards a locality focussed model.

1.3.6 System Priorities and Deliverables

Our ultimate goal is to support individuals to live well for longer with the majority of care being delivered closer to home through integrated services that ensure all of our community assets are understood and utilised working with our local authority, voluntary and community sector partners. In line with the Long Term Plan deliverables and our agreed system priorities, Our STP will review and accelerate the delivery of our broader plans, building on the progress made against the Five Year Forward View, the GP Forward View and the Mental Health Forward View, all of which are reflected within our STP Programme scope.

Our ambitions and aligned deliverables are outlined below;

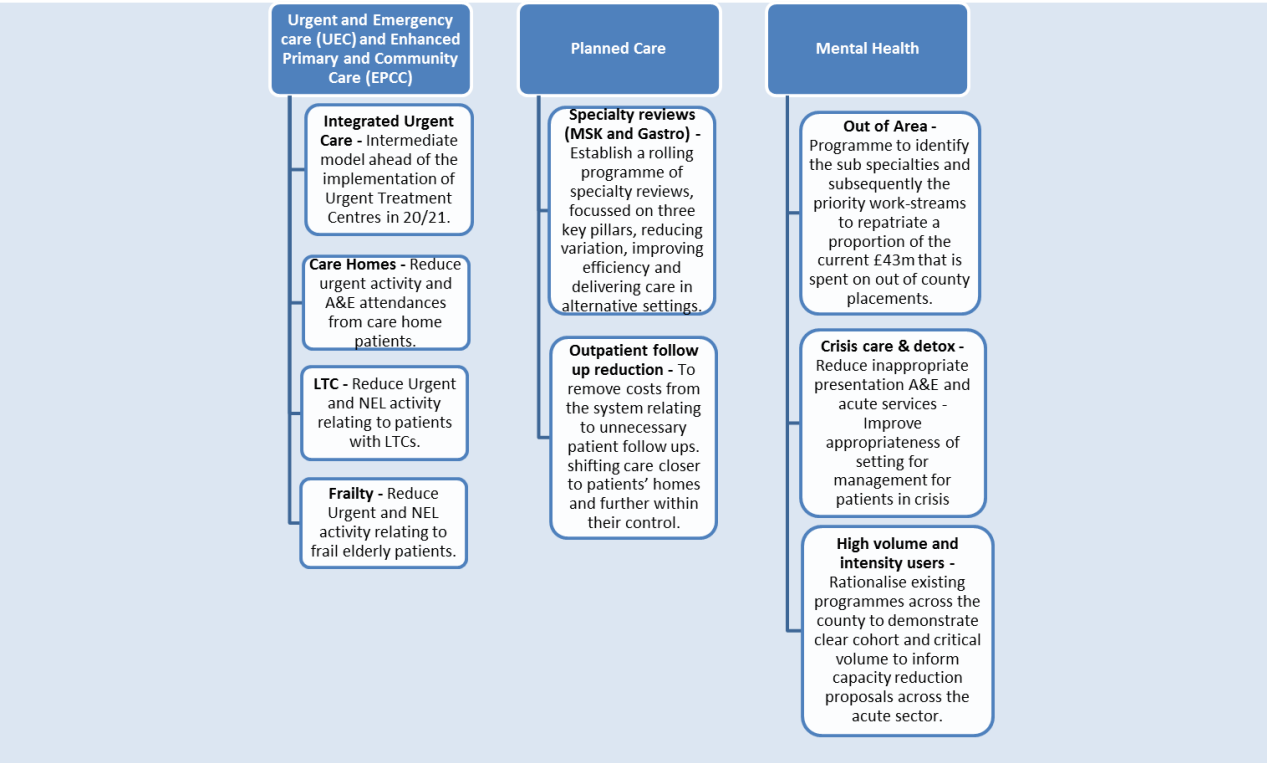
<table>
<tr><th>Service Transformation</th><th>Productivity</th><th rowspan="3">Prevention</th></tr>
<tr><td>• Enhanced Primary & Community Care Urgent and Emergency Care
• Planned Care
• Mental Health
• Children & Young People and Maternity
• Specialised Commissioning
• Cancer</td><td>• System-wide productivity and efficiencies
• Whole system cost reduction portfolio</td></tr>
<tr><th colspan="2">Enablers</th></tr>
<tr><td colspan="2">• Digital
• Estates

• Workforce
• OD & leadership
• Governance
• New Commissioning and delivery models</td></tr>
</table>

Our system priorities are reflective of a system wide STP plan that shows an accelerated and concerted effort that is cross-organisational to both understand and develop a set of meaningful transformational programmes (and associated schemes) that reflect our shared ambition to reduce variation, remove duplication, improve the quality and access to care and deliver a break even control total by 2023.

We have a number of transformation programmes that span our STP priorities and do not require major service changes. We are ensuring that this work and the development of the model of care are fully aligned.

In 2019/20 the delivery focus in our STP is around UEC and EPCC; Planned Care and Mental Health as outlined in the diagram below:



As a system we recognise that Individual transformation schemes will not be enough to deliver our ambitions alone. Significant transformation around the how, what, and where we deliver services as a system that will involve significant service redesign is also a significant priority for 2019/20. In line with the Long Term Plan, the heart of our model of care focusses on enabling people to remain in their communities and receive care close to or in their own homes as an alternative to hospitalisation and this will require significant adjustments to our infrastructure, capacity and activity profiling across commissioning and provision.

2. Why we need to change – The challenges we face

There is consensus across Staffordshire and Stoke-on-Trent system partners that if we do not redesign and transform services to improve quality, whilst using the available resources as efficiently as possible, our population will experience poorer health outcomes as a direct result.

In this section we describe the challenges we currently face, across the six key considerations for our Case for Change. These considerations, which the remainder of this section is structured around, are presented in Figure 4 .

Figure 4: Key considerations in our Case for Change

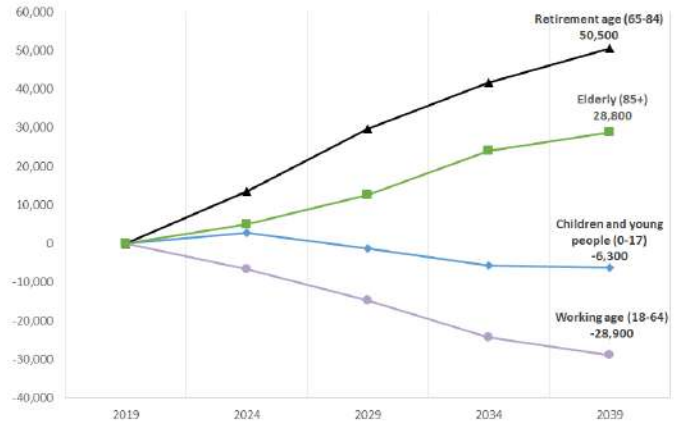
2.1 The scale of the challenge - Demographics and deprivation

Characteristics of the local population

As one of the 44 STPs in England, Together We're Better consists of two main local authorities, Stoke-on-Trent City Council and Staffordshire County Council. Our area of Staffordshire and Stoke-on-Trent has a combined population of 1.1m, with c. 871,000 people living in Staffordshire and 255,000 in Stoke-on-Trent.[6]

The population is expected to grow between 2019 and 2039 by approximately 4%, which will result in increasing pressure on our health and care services.[7] In addition to the population growing, it is also getting older. 20% of the population in Staffordshire and Stoke-in-Trent is aged 65 or over, which is above the national average of 18%. By 2039 the population aged 65 and over will grow by 34% or circa. 79,400 extra people. At the same time the ratio of working age people (aged 16-64) to older people (aged 65 and over) in Staffordshire and Stoke-on-Trent is projected to fall from 2.9 in 2019 to 2.1 in 2039 adding pressure to the local economy including the health and care workforce.

Figure 5: Population forecasts for Staffordshire and Stoke-on-Trent[7]



Our ageing population is already contributing to the health and social care challenges our STP faces, with patients aged 70 and over accounting for over 30% of acute attendances in 2017/18 but only making up 15% of the population. This share of activity for the over 70s is expected to increase to 35% by 2028[8], which has implications across the healthcare system from community care demand to increased prevalence of long-term conditions such as cardiovascular disease, cancer and dementia. It is therefore vital we develop a health and social care system which can address the growth in demand resulting from demographic trends.

Around 8.1% of Staffordshire and Stoke-on-Trent's population are from a minority ethnic background concentrated mainly within East Staffordshire (13.8%) and Stoke-on-Trent (13.6%) compared to 20% nationally.[9]. Research suggests that in most health care systems black and minority ethnic (BME) populations experience poorer health and greater barriers to access services[10].

Living in a rural area has a positive association with people's life satisfaction. However, it can also present difficulties in accessing services. In addition, the structural demographic change towards an older population is the single most significant factor in an increasing prevalence of rural isolation. Almost four-fifths (78%) of Staffordshire and Stoke-on-

[6] ONS, Population Estimates for UK, England and Wales, Scotland and Northern Ireland: Mid-2017

[7] ONS, 2016-based subnational population projections for local authorities and higher administrative areas in England

[8] TWB, Needs Analysis, 2019

[9] ONS 2011 census data

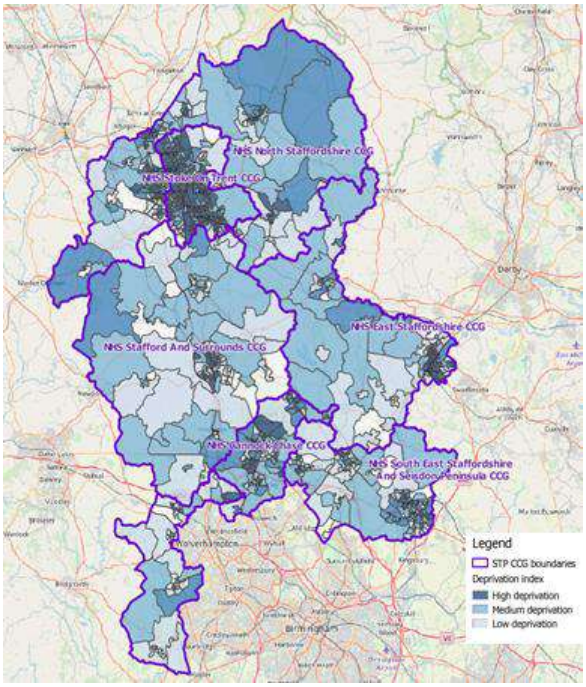
[10] PGMJ (2005) Access to health care for ethnic minority populations.

Trent area is considered rural with 19% of the population living in these areas which is higher than the national average of 17%.[11] South Staffordshire (40%), Stafford (32%), Staffordshire Moorlands (30%) and Lichfield (30%) are particularly rural whilst Stoke-on-Trent and Tamworth populations are classified as urban.

Deprivation

Levels of deprivation vary significantly across Staffordshire and Stoke-on-Trent, as presented in Figure 6 below. Based on the average weighted Index of Multiple Deprivation 2015 Score, Stoke-on-Trent is ranked as the 14th most deprived local authority area (out of 326) in England, whereas Staffordshire is relatively affluent with pockets of high deprivation in some urban areas[12]. Over 30% of the population of Stoke-on-Trent lives in the 10% most deprived areas in England, and only 16.5% live in areas classified as 'better than the English average'. Stoke-on-Trent is also ranked as the 14th most deprived area for health-related deprivation.[12]

Figure 6: Deprivation across the STP



At an STP footprint level the overall deprivation score is below the national average. However, at a more granular level deprivation scores vary significantly across the County and City as shown in Figure 6. In Stoke-on-Trent more than 30% of the population live in areas classed in the 10% most deprived in England and over 50% in the 20% most deprived; this compares to just 9% across Staffordshire County. However, some of the remote rural areas in Staffordshire do have issues with hidden deprivation and in particular around geographical access to services. As table 1 shows deprivation varies considerable across from over 50% in Stoke-on-Trent to under 2% in South Staffordshire.

Table 1: Deprivation in Staffordshire and Stoke-on-Trent[13]

	Number living in most deprived quintile	Percentage

[11] ONS Rural and Urban Area Classification 2011

[12] Ministry of Housing, Communities & Local Government, Index of Multiple Deprivation 2015, based on rankings of lower tier local authorities on average scores

[13] Ministry of Housing, Communities & Local Government, Index of Multiple Deprivation 2015

Cannock Chase	13,700	13.8%
East Staffordshire	21,400	18.2%
Lichfield	4,000	3.9%
Newcastle-under-Lyme	14,900	11.5%
South Staffordshire	1,500	1.4%
Stafford	7,200	5.3%
Staffordshire Moorlands	4,600	4.7%
Tamworth	13,400	17.5%
Staffordshire	**80,700**	**9.3%**
Stoke-on-Trent	**136,200**	**53.3%**
West Midlands	**1,745,400**	**29.8%**
England	**11,325,900**	**20.4%**

Poverty and deprivation are key determinants of poor health outcomes[14]. The British Medical Association recognises a negative cycle exists between poverty and health, in which unemployment and deprivation contribute to poor mental and physical health. Those in poverty may be unable to afford chargeable costs of care and adopt healthy behaviours, which in turn may lead to worse health outcomes, therefore affecting future economic opportunity[15]. For example, adults in poverty are more likely to smoke which increases the risk of long-term conditions later in life[16].This negative cycle can transfer across generations, even from at the point of birth where children born in poverty are more likely to have a low birthweight, which is a factor in infant mortality as well as later physical and mental health[17].

It is therefore unsurprising that areas of high deprivation are associated with lower health outcomes. The Marmot Review finds across England there is a strong relationship between neighbourhood income and life expectancy. For example, people living in the poorest neighbourhoods will on average die seven years earlier than people living in the richest. Furthermore, education status is strongly related with the incidence of cardiovascular disease, cancer and obesity[18].

This is consistent with trends observed locally within our STP, with those living in economically deprived areas also experiencing poorer health outcomes, for example in Staffordshire and Stoke-on-Trent there is a six to eight years gap in life expectancy for men and women living in the most deprived areas compared with those living in the least deprived areas.[19] 9.6 years for men and 6.4 years for women in Stoke-on-Trent.

Stoke-on-Trent is the most deprived area of the STP across five of the seven drivers of deprivation, and it has one of the highest rates of health deprivation in the country. In contrast, Stafford, Lichfield and South Staffordshire are some of the least deprived areas in our STP in terms of income, employment and education, and they also have some of the lowest level health and disability deprivation in the area[20]. These areas do however suffer from some deprivation related to geographical access to services.

[14] The Marmot Review, Fair Society, healthy lives, 2010.

[15] BMA, Health at a price: reducing the impact of poverty, 2017

[16] The University of Edinburgh, Impacts of poverty on children and young people, 2012; Allen et al., Social determinants of mental health, 2014

[17] The University of Edinburgh, Impacts of poverty on children and young people, 2012; Allen et al., Social determinants of mental health, 2014

[18] The Marmot Review, Fair society health lives, 2010

[19] Public Health England, Public Health Outcomes Framework, data accessed February 2019

[20] Gov, Index of multiple deprivation, 2015

Table 2: Deprivation across Staffordshire and Stoke-on-Trent local authority areas[21]

STP districts	Index of multiple deprivation	Index, drivers of deprivation						
		Income	Employment	Education, Skills and Training	Health Deprivation and Disability	Crime	Barriers to Housing and Services Decile	Living Environment
Stoke-on-Trent	3.5	3.9	3.2	3.0	2.5	3.9	6.9	4.8
Cannock Chase	5.2	5.0	4.6	3.8	4.4	5.9	7.6	7.3
Tamworth	5.6	5.3	5.4	4.1	5.2	5.9	5.6	7.6
Newcastle-under-Lyme	5.8	5.9	5.0	5.4	4.4	5.9	7.9	6.8
East Staffordshire	6.0	6.3	6.1	5.2	5.6	6.9	7.0	4.2
Staffordshire Moorlands	6.5	7.0	6.0	5.7	6.2	7.1	5.8	5.9
Lichfield	7.1	6.7	6.4	6.5	7.0	8.0	5.7	7.0
Stafford	7.2	7.4	6.9	6.7	6.4	7.6	6.2	6.5
South Staffordshire	7.3	6.7	6.6	6.0	7.5	7.1	6.6	7.2

Most deprivation Medium deprivation Least deprivation

Deprivation also affects our children: 24% of Stoke-on-Trent's children are born in low income families, whereas the rest of the local authority districts in the STP are below England's average of 17%[22]. However, some of the County's wards experience level of up to 30% with levels increasing significantly to over 40% in some wards after housing costs[23]. Deprivation is linked to poor child health outcomes starting in infancy, for example Stoke-on-Trent and East Staffordshire have infant mortality rates higher than the England average and are the highest and 7th highest rate in the country respectively[24].

A "healthy start to life" is the best way of ensuring that they can grow into healthy, happy, confident adults who are able to enjoy their life and make a positive contribution to society. Some children also experience poorer health outcomes depending on where they live and the opportunities they have around them to thrive. Therefore, reducing the number of children and young people living in poverty across the STP area will secure a better future for them and reduce unacceptable inequalities. National research also suggests that high quality childcare is associated with benefits for a child's development, with the strongest impacts evidenced amongst children from disadvantaged communities particularly in the first three years. The benefits include cognitive, language and social development.[25] The evidence suggests that low quality childcare produces either no benefit or negative effects.

Figure 7: Children in low income families[26]

[21] ONS index of multiple deprivation 2015. Heatmap compares numbers within table.

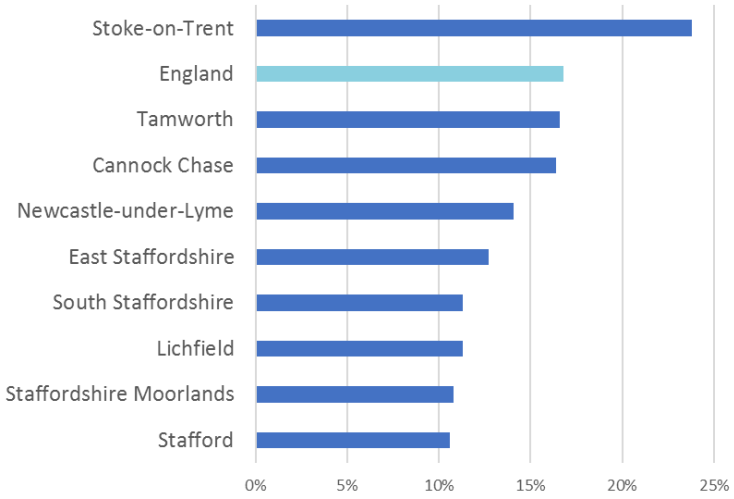
[22] PHE, Local authority health profiles, 2014-2016

[23] http://www.endchildpoverty.org.uk/poverty-in-your-area-2018/

[24] ONS, Child mortality statistics, 2015-2017

[25] Melhuish EC, Provision on young children, with emphasis given to children from disadvantaged backgrounds, Institute for the Study of Children, Families & Social Issues, Birkbeck, University of London, Prepared for the National Audit Office. 2004

[26] PHE, Local authority health profiles, 2014-2016



Wider determinants of health

Socioeconomic factors (education, employment and housing) are major drivers of population health, and preventable deaths. In our STP, the partnership recognises that the greatest gains in health and wellbeing are achieved through influencing the environmental, economic and social determinants of health rather than individual interventions. Some of the key factors are described below:

- **School readiness and educational achievement** - Children have reached a good level of development at the end of the Early Years Foundation Stage if they have achieved at least the expected level within key areas of learning (communication and language; physical development; personal, social and emotional development; literacy and mathematics). During 2018, 75% of children in Staffordshire achieved a good level of development which was higher than the England average of 72% and the West Midlands average of 70%. However, in Stoke-on-Trent only 62% of children achieved a good level of development. Furthermore, inequalities affect early year's development with lower proportion of children in some cohorts achieving a good level of development such as those eligible for free school meals, those with special educational needs and looked after children[27]. In 2018, 39% of pupils achieved a 9-5 pass in English and Maths in the West Midlands, compared to an England average of 43%. Levels across both the County and City are lower (33% in Stoke-on-Trent and 38% in Staffordshire)[28]. Similar to early years, children from some cohorts do less well putting them at risk of unemployment, poverty and poorer health outcomes in the future. Education attainment is influenced by both the quality of education children receive and family circumstances.
- **Unemployment -** rates in both Staffordshire and Stoke-on-Trent are both falling but disparities exist across our areas. Staffordshire has an unemployment rate below that of the UK; however in Stoke-on-Trent the unemployment rate is high at 5.5%, compared to the national average of 4.1% national average[29]. Whilst employment in the County is high the average salary is lower than England reflecting lower skilled and lower paid jobs.[30]

[27] Department for Education, Early years foundation stage profile results, 2017/18

[28] Department for Education, Key stage 4 and multi-academy trust performance 2018 (revised)

[29] ONS, Regional labour market: Local indicators for counties, local and unitary authorities, 2019

[30] Staffordshire JSNA; https://www.staffordshireobservatory.org.uk/documents/Health-and-Wellbeing/Staffordshire-Joint-Strategic-Needs-Assessment-Annual-Update-2019.pdf

Table 3: Unemployment rates in Staffordshire and Stoke-on-Trent by local authority area

District	Unemployment rate (2017/2018)
Stafford	2.7%
Lichfield	2.7%
Staffordshire Moorlands	2.8%
South Staffordshire	2.8%
East Staffordshire	3.0%
Newcastle-under-Lyme	3.4%
Cannock Chase	3.6%
Tamworth	3.8%
United Kingdom	4.1%
Stoke-on-Trent	5.5%

- **Housing -** In Stoke-on-Trent, 23% of households are socially renting, with an average of 19% across West Midlands and 20% across England[31]. The proportion of households that socially rent in Staffordshire is lower at 15%. The affordability of housing varies substantially across the STP, with house prices on average being 7.4 times greater than gross annual pay in Lichfield, but only 4.6 times greater in Stoke-on-Trent[32]. Although most areas are seeing a gradual reduction in affordability over time, Newcastle-under-Lyme has seen a slight improvement in affordability between 2011 and 2017[33]. Poor housing comes at significant costs to the NHS[34,35] with cold homes in particular increasing preventable mortality and ill health. Fuel poverty across the STP area is higher than the national average. As well as income and fuel prices, one of the key drivers of fuel poverty is the energy efficiency of our homes with households that are owner-occupied or privately rented being less energy efficient; homes in rural areas and older homes are also less energy efficient.[36] Children living in cold and damp houses are at increased risk of poorer health outcomes and reduced performance at school.[37] The STP area experiences higher rates of children being admitted to hospital for long-term conditions, in particular respiratory conditions and also performs poorly in terms of GCSE attainment.

Lifestyle factors

Lifestyle factors are another further major driver, this including smoking, alcohol and obesity, as well as what we eat and how active we are. Excess weight, lack of exercise, smoking and excess alcohol consumption account for 40% of ill health across England and is one of the largest pressures on health and care resources[38].

Our population is taking greater responsibility for their own health through their lifestyle choices. However, there are specific challenges where individuals are at risk of reduced life expectancy or are vulnerable.

- **Obesity and overweight is significantly worse than the England average in Staffordshire and Stoke-on-Trent for both children and adults.** The prevalence of Staffordshire children who were obese in Reception (aged four to five) in 2017/18 was 10% and is higher than the England average; it also doubles to

[31] ONS, Census data (2011)

[32] ONS, Housing affordability in England and Wales: 2017

[33] ONS, Housing affordability in England and Wales: 2017

[34] Nicol S, Roys M and Garrett H, Briefing paper: The cost of poor housing to the NHS, Building Research Establishment (BRE) Trust, BRE 2015

[35] Local Government Association, Healthy homes, healthy lives, Local Government Association, May 2014

[36] Housing and Health in Staffordshire 2019. https://www.staffordshireobservatory.org.uk/documents/Health-and-Wellbeing/Housing-and-Health-in-Staffordshire-2019.pdf

[37] The Health Impacts of Cold Homes and Fuel Poverty, Marmot Review Team, 2011

[38] Public Health England, Burden of Disease Study for England, 2013

20% by the time children are in Year 6 (aged 10-11). This trend is also seen across the City; Reception (9%) and Year 6 (24%). Newcastle also has a higher rate of children who are obese in both age groups. The level of obesity in Children is closely linked to deprivation. Around two thirds of adults in Staffordshire and Stoke-on-Trent are overweight or obese with excess weight being particularly high in Cannock Chase, Newcastle and Stoke-on-Trent. The proportion of adults who are morbidly obese in Staffordshire overall and in Cannock Chase is also worse than the England average[39]. Coupled with these are large numbers of children and adults who are inactive and eat unhealthily.

- Smoking prevalence in the County is lower than the national average whilst rates in the City are higher than England. **Smoking in pregnancy** rates across the STP area are higher than the England average. Across Staffordshire, overall smoking-attributable deaths and hospital admissions are lower or similar to the England average; however Stoke-on-Trent has **higher rates of mortality and people being admitted to hospital** due to smoking-related illnesses in the population aged 35 and over compared to the national average[40].
- **There is variation in the impact of alcohol-consumption across the area**. Alcohol-specific mortality for women in Staffordshire and both alcohol-specific and alcohol-related mortality in men and women in Stoke-on-Trent is higher than the England average. During 2017/18 there were higher rates of alcohol-related admissions across both Staffordshire and Stoke-on-Trent compared to the England average[41]. Rates of alcohol-related admissions are high in five of the eight districts in Staffordshire (Newcastle-under-Lyme, Cannock Chase, Stafford, East Staffordshire and Staffordshire Moorlands).

These lifestyle factors, along with other factors, have a direct influence on life expectancy and health and wellbeing outcomes of our population. There is a clear variation in drivers of population health across the area, and an increased focus on prevention is necessary to achieve improvements in ill health and reduce preventable deaths.

[39] Public Health England, Public Health Outcomes Framework, data accessed February 2019

[40] Public Health England, Local Tobacco Control Profiles, https://fingertips.phe.org.uk/profile/tobacco-control; data accessed February 2019

[41] PHE, Local alcohol profiles for England, https://fingertips.phe.org.uk/profile/local-alcohol-profiles (data accessed February 2019)

2.2 The scale of the challenge – Health and wellbeing

The previous section has summarised the diversity of the population across the geography of Staffordshire and Stoke-on-Trent, and the factors that are contributing to current and future population health challenges and needs. This section sets out how we are performing overall and across key disease areas such as cancer, diabetes and cardiovascular disease.

Life expectancy and healthy life expectancy

Overall life expectancy at birth in Staffordshire is almost 80 years for men and 83 years for women; both are similar to the national average; however both men and women in Stoke-on-Trent have lower life expectancy than the England average by about two to three years.[42] At a district level men and women in Cannock Chase have shorter life expectancy at birth by 10-11 months (Table 4). Women in East Staffordshire and Newcastle also have shorter life expectancy than the England average and can expect to live 11 and nine months less than the national average respectively. Conversely in some areas such as Stafford and Lichfield men can expect to live over a year longer than people across England as a whole.

Whilst people are living longer they are not necessarily living healthier. Men and women in Stoke-on-Trent have a lower healthy life expectancy which means they start to experience poorer quality of health earlier (at 60 years for men and 59 years old for women), compared to people in Staffordshire (63 years for men and 64 years for women) and across England (64 years old)[43]. This means that men in the County spend 16 years in ill-health whilst those in the City spend 17 years in ill-health. For women the time spent in ill-health is higher at 19 years and 22 years for the County and City respectively. At a district level men and women in Cannock Chase, Newcastle-under-Lyme and Tamworth also have shorter healthy life expectancies than the England average.[44]

[42] Life expectancy 2015-2017, Office for National Statistics, Crown copyright

[43] PHE, Local authority health profiles, 2015-2017

[44] Healthy life expectancy 2009-2013, Office for National Statistics, Crown copyright

Table 4: Life expectancy at birth, 2015-2017[45]

	Men		Women	
	Life expectancy at birth (years)	**Difference to England (years)**	**Life expectancy at birth (years)**	**Difference to England (years)**
Cannock Chase	**78.7**	-0.8	**82.2**	-0.9
East Staffordshire	79.1	-0.5	**82.2**	-0.9
Lichfield	**80.7**	1.2	83.1	0.0
Newcastle-under-Lyme	79.2	-0.3	**82.4**	-0.8
South Staffordshire	80.2	0.7	**83.8**	0.7
Stafford	**80.5**	1.0	83.6	0.5
Staffordshire Moorlands	79.8	0.3	83.0	-0.2
Tamworth	78.9	-0.6	83.0	-0.1
Staffordshire	**79.7**	**0.2**	**82.9**	**-0.3**
Stoke-on-Trent	**76.5**	**-3.1**	**80.8**	**-2.3**
West Midlands	**78.8**	**-0.8**	**82.7**	**-0.4**
England	**79.6**		**83.1**	

Key: Statistically better than England; statistically worse than England

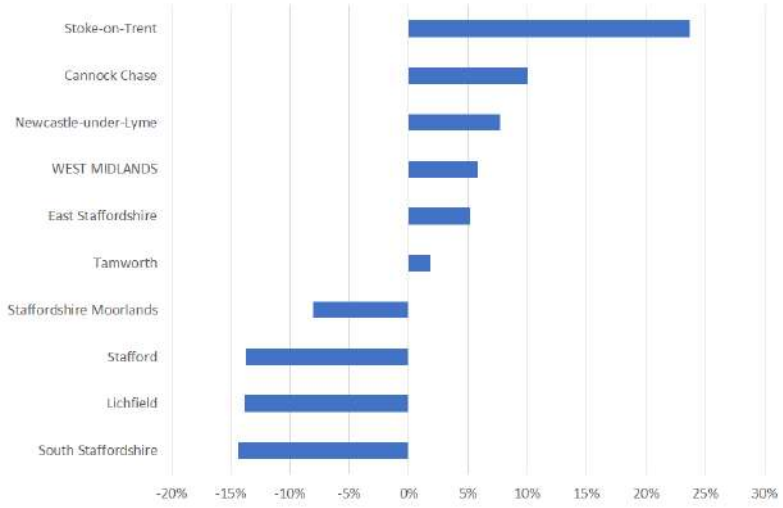
Mortality

High mortality rates at the then Mid Staffordshire Foundation Trust saw the launch of the Francis Inquiry, which resulted in the eventual dissolution of the Trust. The Keogh review then led to University Hospitals of Derby and Burton NHS Foundation Trust (DBFT) being placed in special measures. However, both organisations have acted upon the recommendations of these reports to improve outcomes.

Mortality varies significantly across the STP local authority districts. Four of the nine STP local authority areas have mortality rates below the England average whilst Stoke-on-Trent, Cannock Chase and Newcastle-under-Lyme have higher than average under 75s mortality rates. Furthermore, Stoke-on-Trent has one of the highest mortality rates in the country, placing them in the top 5% of England local authority districts.

Figure 8: Under 75 mortality relative to England average[46]

[45] Office for National Statistics, Crown copyright



Staffordshire STP also has areas with a high number of deaths that could have been potentially prevented through better lifestyle, socioeconomic and environmental factors. For example, Stoke-on-Trent has the highest rate of deaths from preventable causes in the West Midlands and is in the top 25 in the country from a total of 326 local authority districts[47]. Newcastle-under-Lyme, Cannock Chase and East Staffordshire also have preventable mortality rates that are higher than the England average. In comparison, Lichfield, Stafford and South Staffordshire have a lower rate of potentially preventable deaths compared to the England average.

This trend continues across key disease groups, as shown in Table 5, Stoke-on-Trent places in the top 25 in the country for preventable mortality caused by cardiovascular disease, cancer, liver disease and respiratory disease. Deaths from preventable liver disease are particularly high in Stoke-on-Trent where the mortality rate is almost double that of the England average; preventable liver disease mortality is also significantly higher than the England average in East Staffordshire, Newcastle-under-Lyme and Cannock Chase. This emphasises the inequality in health outcomes across our geography.[48]

Table 5: Position in England of rates of mortality from preventable causes[49]

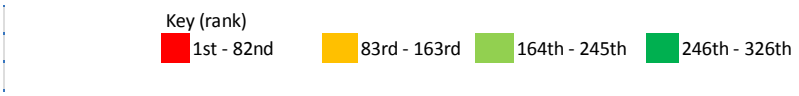
District	Cardiovascular diseases (preventable)	Cancer (preventable)	Liver disease (preventable)	Respiratory disease (preventable)	Injuries (preventable)	All causes
Stoke-on-Trent	31	18	6	25	31	15
Cannock Chase	73	73	44	112	227	79
Newcastle-under-Lyme	49	93	38	133	115	98
East Staffordshire	138	96	34	97	38	111
Tamworth	77	85	106	120	131	125
Staffordshire Moorlands	215	188	131	118	259	174
Stafford	235	165	129	264	228	204
Lichfield	249	220	275	249	210	205
South Staffordshire	186	199	177	297	154	207

[46] PHE, Local authority health profiles, 2015-2017

[47] Public Health England, Public Health Outcomes Framework, data accessed March 2019

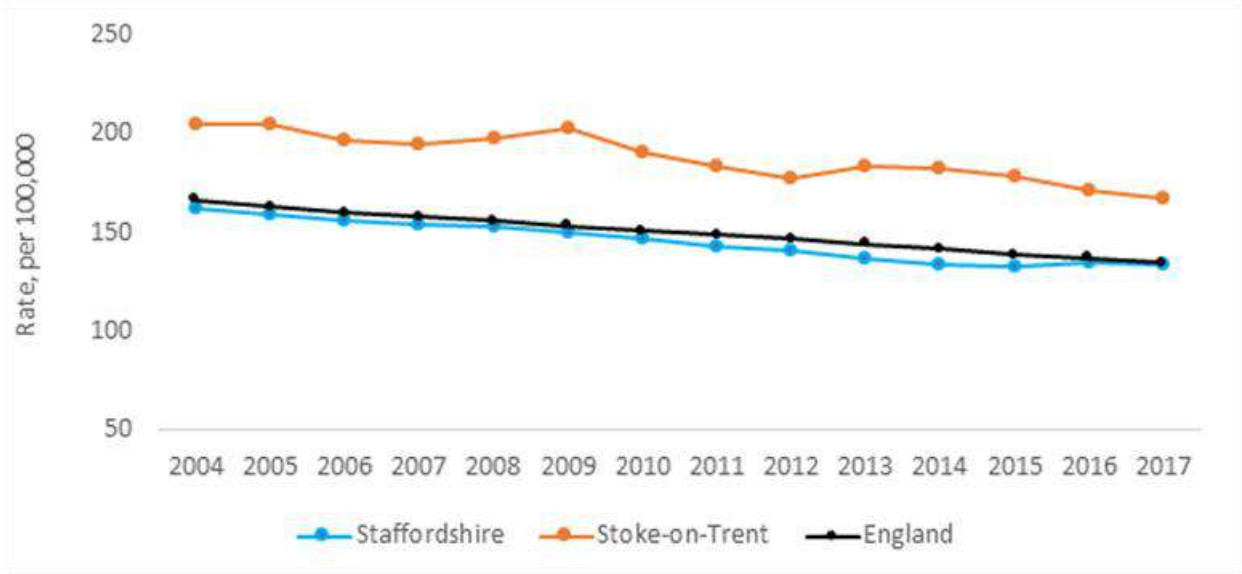
[48] PHE, Public health profiles, 2015 - 2017

[49] PHE, Public health profiles, 2015 - 2017



Since 2012 cancer mortality rates have been decreasing however, this has not been consistent, with rises in 2008 and 2013. As Figure 9 demonstrates below, deaths from cancer are 25% higher in Stoke-on-Trent than in Staffordshire and across England[50].

Figure 9: Under 75 mortality rate for cancer[51]



Less than half of all cancers in East Staffordshire were diagnosed at an early stage during 2016, this compares with South Staffordshire where 62% were detected early.[52] Five of the six CCGs across our system were in the bottom 30% against peers for cancer detection at stage 1 and 2[53]. Significant improvement will be required to meet the NHS commitment to increase the proportion of cancers diagnosed early[54]. Uptake of the NHS screening programmes for cancer across the STP are variable; for example, breast screening rates in the County have fallen and are now lower than the national average.[55] Cervical screening rates in the County have also fallen but remain higher than the England average whereas rates in the City for both cervical screening and bowel screening are below average.

Mortality from liver disease is also of concern as rates of people dying before 75 have increased by 50-60% across the County and City over the last 15 years.

Children and young people

The health inequalities across our STP are observed in children and young people starting in infancy. Infant mortality rates in Stoke-on-Trent (2015-2017) were the highest in the Country whilst rates in East Staffordshire were ranked 8th

[50] PHE, Public health profiles, 2015 - 2017

[51] Public Health England

[52] Public Health England, Public Health Outcomes Framework, data accessed March 2019

[53] Together We're Better STP, 2016

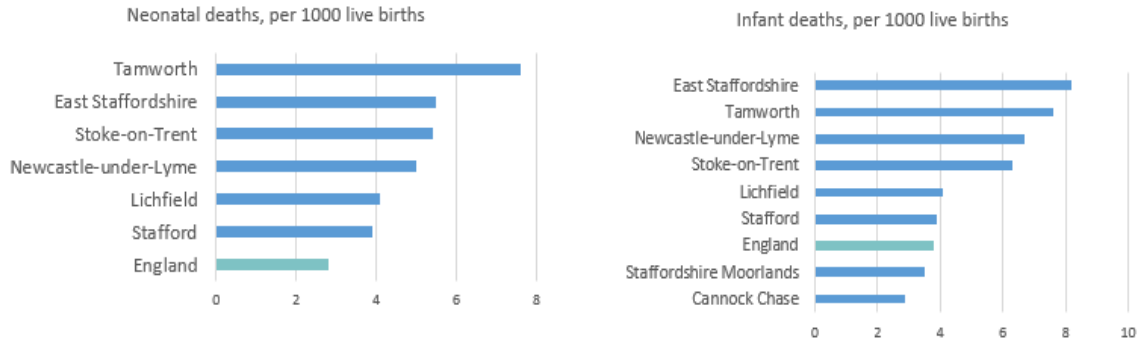
[54] NHS England, NHS Long Term Plan, 2019

[55] NHS England, NHS Long Term Plan, 2019

and also higher than the national average. Neonatal infant mortality rates during 2014-2016 were also higher than the national average across both Staffordshire and Stoke-on-Trent[56].

Associated risk factors for infant mortality perform worse than the average across the County and City, for example the STP area has higher than average smoking in pregnancy rates, lower than average breastfeeding initiation and prevalence rates, and maternal obesity is also prevalent across all localities, higher than average babies born with a low birthweight in some areas and lower than average uptake of some vaccinations for both mother and children in some areas, with many of these factors presenting together.[57,58]

Figure 10: Neonatal and infant deaths by local authority district



As part of the Healthy Child Programme, health visitors assess the needs of the family and provide early help as required. The health review aimed at 2-2.5 year olds uses the Ages and Stages Questionnaire 3 (ASQ-3) to assess child development outcomes which include: communication, skills, problem solving, social-emotional development and aspects of physical development. Delays in development identified at this stage are known to lead to poorer longer-term outcomes including mental health and wellbeing. Experimental data from October 2017 to March 2018 reported on the outcomes of the ASQ for around 4,800 Staffordshire STP children aged 2-2.5 years which found that 73% of children aged 2-2.5 years had met the expected level across all five levels of development which is lower than the national average of 82%.[59]

Research shows that children born to teenage mothers have higher rates of infant mortality, are more likely to smoke during pregnancy and are at increased risk of low birthweight which impacts on the child's long-term health. Teenage mothers are three times more likely to suffer from postnatal depression, experience poor mental health and are at increased risk of living in poverty.[60] Teenage pregnancy rates across the STP and in particular in Newcastle, Tamworth and Stoke-on-Trent are higher than the national average.[61] In recent years, Stoke-on-Trent has out-performed England in the fall in rates of teenage pregnancy.

Similar to the national picture the number of children in Staffordshire and Stoke-on-Trent with special educational needs or disability continues to fall: from 19% in 2009 to 14% in 2018. However, the proportion of children who have a statement or education, health and care (EHC) plan over this time has increased slightly to around 3.4% (around 5,500 children). The most common primary types of needs identified across the Staffordshire STP area were: moderate learning difficulty (31%); speech, language and communications needs (19%); social, emotional and mental health (13%); specific learning difficulty (11%) and autistic spectrum disorder (10%)

---

[56] ONS, Child mortality statistics, 2016

[57] Staffordshire and Stoke-on-Trent JSNA 2017: Children's Story, https://www.staffordshireobservatory.org.uk/documents/Health/JSNA/2017/Childrens-Joint-Strategic-Needs-Assessment-April-2017.pdf

[58] PHE, Local authority health profiles, 2015-2017

[59] PHE; Child development outcomes at 2 - 2½ years, 2017/18 (October 2018 release), Crown Copyright © 2018

[60] PHE and LGA; A framework for supporting teenage mothers and young fathers

[61] ONS Conception Statistics 2016

The latest survey on the prevalence of children's mental health found that around one in 18 (5.5%) children aged two to four and one in eight (12.8%) five to 19 year olds had at least one mental disorder equating to around 2,100 pre-school aged children and 24,200 school-aged children and young people (aged five to 19) in the Staffordshire STP area.[62] More information on emotional wellbeing and mental health is provided later on in this document.

A&E attendances across the STP area during 2017/18 were lower than the England average; however, some areas such as Cannock Chase, Lichfield and Tamworth had rates that were higher. Unplanned hospital admissions for children and young people across the County and City were higher than average and in particular for long-term conditions and respiratory conditions. Self-harm admissions for children and young people aged 10-24 in Stoke-on-Trent are also higher than average and rates across both the County and City have increased over the last seven years.

Parental issues such as domestic abuse, mental ill-health or substance misuse (alcohol or drug misuse) are key issues for our communities and frequently identified as the key factor which results in children needing extra care. These are often symptoms of wider socio-economic and environmental inequalities such as education, employment and income and housing. Parenting has also been found to be the single largest variable implicated in poor health outcomes such as ill-health and accidents, teenage pregnancy, substance misuse, truancy, school exclusion and under achievement, employability, juvenile crime and mental illness.[63]

Long term conditions

The two key factors for developing a long-term condition (LTC) are lifestyle and ageing. Long-term conditions are likely to grow as the population continues to age. National research indicates a rising demand for the prevention and management of people with multiple conditions rather than single conditions. By the time people reach 65 most will have developed at least one long-term condition and large proportions will also have developed two or three conditions.[64] The proportion of multiple conditions is also more prevalent in deprived communities.[65] People with LTCs are the most intensive users of the most expensive health care services[66]. People with multiple long-term conditions have an increased risk of hospital admission, length of stay and readmission, poorer quality of life, and risk of early death. [67]

Conditions such as atrial fibrillation, diabetes, hypertension (high blood pressure) and high cholesterol levels can increase risk of heart disease, including heart attacks and strokes, and many cases of dementia. Whilst treatment of these conditions is very effective at preventing cardiovascular events, late diagnosis and under treatment is common.

---

[62] Mental Health of Children and Young People in England 2017, NHS Digital, Copyright 2018

[63] BMA Growing up in UK 2013

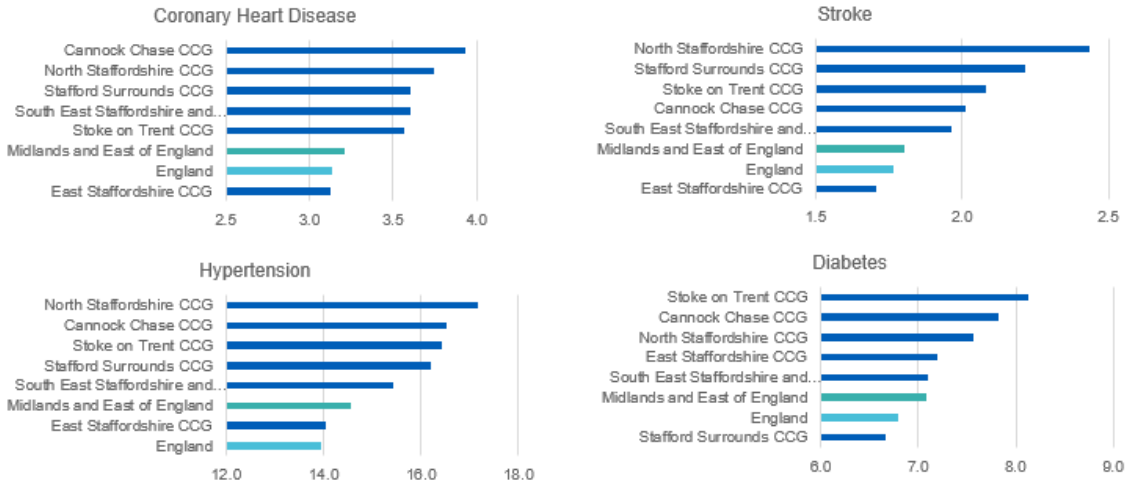
[64] Melzer D et al. The Age UK almanac of disease profiles in later life. A reference on the frequency of major diseases, conditions and syndromes affecting older people in England. © 2015 University of Exeter Medical School Ageing Research Group, University of Exeter. All rights reserved

[65] Barnett K, Mercer SW, Norbury M, Watt G, Wyke S and Guthrie B (2012). Research paper. Epidemiology of multi-morbidity and implications for health care, research and medical education: a cross-sectional study. The Lancet online

[66] LTC Compendium of Information, Department of Health

[67] https://www.kingsfund.org.uk/projects/time-think-differently/trends-disease-and-disability-long-term-conditions-multi-morbidity

Figure 11: Long-term condition prevalence in Staffordshire and Stoke-on-Trent by CCG[68]



As shown in Figure 11, there are significant differences in the prevalence of long-term conditions within the Staffordshire STP, which has implications on how we provide health and care services. In Staffordshire and Stoke-on-Trent, diabetes and coronary heart disease prevalence exceeded the England average in five of the six CCGs in 2017/18. The proportion of people with diabetes maintaining good blood sugar control was worse than the England average in half the system's CCG footprints. The risk of stroke in North Staffordshire is more than double that in East Staffordshire, while Stafford and Surrounds has a 35% greater occurrence of people with cancer than those in Stoke-on-Trent [69]. The rate of dementia in five of six of our CCG footprints is higher than England average, with it being 25% more common in North Staffordshire than East Staffordshire[70].

The scale of these differences is also present in localities within CCG footprints, as demonstrated in Table 22 (see Annex)[71]. For example, in North Staffordshire, the prevalence of Osteoporosis is double in Leek & Biddulph compared to Moorlands Rural. In addition, there is a 30% difference in the rate of dementia between the localities in Cannock Chase.

These health and wellbeing challenges mean we need to consider how we can best provide health and care services for our population. These services need to be preventative and support the management of comorbidity and the complexity of conditions.

Adult Social Care

One of the key drivers of adult social care needs within any given area is population change. As noted earlier the STP's population continues to grow in both size and average age with the older population predicted to grow faster than the general population: by 2029 the number of residents aged 75 and over, an age group which the likelihood of requiring care and support increases significantly, will rise more dramatically from 107,700 in 2019 to 142,700 in 2029, an increase of 33% or around 35,000 people.[72] This progressively older population for Staffordshire and Stoke-on-Trent will mean the numbers of people with increasingly complex and long-term conditions (such as hypertension, diabetes, chronic obstructive pulmonary disease, dementia) will continue to grow, which in turn will impact on the need

[68] QOF, prevalence data 2017/18

[69] QOF, prevalence data 2017/18

[70] QOF, prevalence data 2017/18

[71] 2017-18 QOF Prevalence for Staffordshire CCG localities

[72] 2016-based household projections, Office for National Statistics, Crown copyright

and provision for social care support. National research that asked about the care options people would choose if they needed care and support in looking after themselves (when older, if not already) suggests that most people would like to stay in their own home with informal or formal support.[73]

Around 56% people aged 65 and over in the Staffordshire STP area are thought to have a limiting long-term illness. Between 2019 and 2029, this is projected to increase to 58% equating to 28,900 additional people.[74] Almost a third of older people in Staffordshire and Stoke-on-Trent have difficulty undertaking at least one self-care activity such as bathing or showering, getting dressed without help, feeding, cutting their toenails or taking medicines whilst around four in ten are unable to manage at least one domestic task on their own (includes household shopping, washing and drying dishes, cleaning windows inside, using a vacuum cleaner to clean floors, opening screw tops, dealing with personal affairs and practical activities) with numbers projected to increase over the next decade.[75]

National research indicates that around seven in ten people aged 65 and over who are admitted to hospital due to a hip fracture require post support and care. Around 62,100 people aged 65 and over in the Staffordshire STP area are thought to have fallen at least once in the last 12 months which is predicted to increase by 22% to 75,500 people by 2029. In terms of hospital admissions from falls there is anticipated there will be a 27% growth to 6,200 in 2029.[76]

The number of people aged 65 and over with dementia in Staffordshire and Stoke-on-Trent is projected to rise from around 14,500 in 2019 to 18,900 in 2029; an increase of 30%. The latest research suggests that almost two in five people (38.7%) with late-onset dementia live in care homes with the remaining living in the community.[77] This is likely to put pressure on good quality care home availability for dementia in the future.

Some adults with learning disabilities, mental health or physical disabilities also require support and care often in their own home and, for a small number, anticipated to require support in a care home. Based on 2016-based population projections, the number of people across the STP aged 18 to 64 will fall by around 2% between 2019 and 2029. During this period in Staffordshire and Stoke-on-Trent:

- the number of people aged 18 and over with a moderate or severe learning disability (who are therefore likely to require care) is estimated to remain at around 4,400
- the number of people aged 18-64 with a mental health condition is estimated to fall slightly from 125,500 people in 2019 to 122,600 in 2029
- the number of people aged 18-64 estimated to have a moderate or serious physical disability is estimated to also fall from 70,500 people in 2019 to 69,600 in 2029[78]

Many older people are also reliant on family and friends to help with some day-to-day activities. Data from the 2011 Census found around 12% of Staffordshire and Stoke-on-Trent's population provide **informal (unpaid) care** to family and friends.

Evidence also suggests that **loneliness and social isolation** is harmful to health and wellbeing. Older people are particularly vulnerable to social isolation and loneliness which can be a result of loss of friends and family, mobility or income. As well as links to physical and emotional health, loneliness can lead to individuals visiting their GP more frequently and losing their independence earlier than average. Research shows that lacking social connections could be as damaging to our health as risk factors such as smoking (less than 15 cigarettes a day), obesity and physical activity.[79] In addition Marmot suggests that social connectivity not only helps reduce the risk of mortality and reduces

[73] Mori Survey 2005 for Commission for Social Care Inspection

[74] Projecting Older People Population Information (POPPI)

[75] Projecting Older People Population Information (POPPI)

[76] Projecting Older People Population Information (POPPI)

[77] Dementia UK: update, © Alzheimer's Society 2014. All rights reserved

[78] Projecting Adult Needs and Service Information (PANSI) and Adult Psychiatric Morbidity Survey 2014, NHS Digital, Copyright © 2016, Health and Social Care Information Centre

[79] Holt-Lunstad J, Smith TB, Layton JB (2010) Social Relationships and Mortality Risk: A Meta-Analytic Review. PLoS Med 7(7): e1000316

the development or delays the onset of certain diseases such as dementia but can also help individuals recover when they do fall ill.[80]

Mental Health and Wellbeing

Good mental health and wellbeing is important for our physical health, relationships, education, training, work and in achieving our potential. Research suggests that around half of adults with long-term mental health problems will have experienced their first symptoms before the age of 14, 75% of lifetime mental illness arises by the mid-20s. In additional around 40% of young people are thought to have experienced at least one mental disorder by the time they reach 16.[81]

Causes of mental illness are complex and include factors relating to the environment, personal and social circumstances and culture. Risk factors or triggers can be both the cause and consequence for poor mental health and include family breakdown, unemployment, debt or poverty, homelessness or poor housing, social isolation and loneliness, bereavement, poor physical health, long-term health conditions or disabilities, domestic abuse and drug or alcohol misuse.

Children and Young People

The latest survey on the prevalence of children's mental health found that the prevalence of mental disorders in pre-school aged children was 5.5% and in five to 19 year olds was 12.8% equating to 26,300 children aged two to 19 in Staffordshire and Stoke-on-Trent.[82] Older children (aged 17-19) were also more likely to have a mental health disorder compared with younger children (five to 10) – 16.9% and 9.5% respectively.

A child's relationship with their parents (or carers) has a major impact on the child's social and emotional development. Likewise parents' ability to provide a nurturing relationship depends on their own emotional and social wellbeing which can depend on a range of factors, for example, the family environment, their social networks and employment status. The prevalence of poor emotional wellbeing and mental health is higher in vulnerable groups such as those living with a parent with mental illness, those living in toxic family environments, looked after children, offenders and children with special education needs or learning disabilities. Many children will have more than one risk factor and are at increased risk of poor emotional wellbeing and mental health. Other emerging risks to children's emotional wellbeing include social media and cyber bullying.[83]

Adults

Generally, the population of Staffordshire and Stoke-on-Trent have good wellbeing; 81% of residents feel satisfied with their lives; 83% feel the things they do in their life are worthwhile; 74% of residents feel happy and 66% of people do not feel anxious.[84]

However, it is estimated that around 19% of adults aged 18-64 are estimated to have a mental health condition equating to 125,500 adults in Staffordshire and Stoke-on-Trent. Based on 2017/18 QOF registers, around one in ten (11%) Staffordshire STP 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.

---

[80] Marmot M (2010). Fair Society, Healthy Lives. London: The Marmot Review. Available at: www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review

[81] Joint Commissioning Panel for Mental Health, December 2015

[82] Mental Health of Children and Young People Survey, NHS Digital

[83] Staffordshire JSNA, Emotional wellbeing of children and young people in Staffordshire, July 2018 https://www.staffordshireobservatory.org.uk/documents/Health-and-Wellbeing/Emotional-wellbeing-JSNA-July-2018-FINAL.pdf

[84] ONS, Headline estimates of personal wellbeing from the Annual Population Survey (APS): by counties, local and unitary authorities, 2017/18

Figure 12: Depression and mental health[85]

There are some stark differences in outcomes between those with a mental illness and the general population in Staffordshire and Stoke-on-Trent which runs across all areas of life such as education, employment, housing and health and wellbeing outcomes. For example, people with a severe mental illness in Staffordshire and Stoke-on-Trent are over three times more likely to die early than the general population[86], they are more likely to have poorer lifestyles, such as smoking, and less likely to take up their offer of preventative and other health checks.[87] For people with mental health, stigma and discrimination are barriers to full participation in health care, education and citizenship.

During 2017/18 around 17% of admissions in Staffordshire and Stoke-on-Trent also had a recorded diagnosis of a mental health condition (13% electives, 24% emergency).[88]

Half the CCG footprints were above peer average for the number of people detained under the Mental Health Act 1983 per 100,000 population. Four out of six CCGs had a significant proportion of patients with common mental health conditions waiting for assessment longer than 90 days. Four of the CCGs performed poorly against their peers for unplanned readmissions to mental health service within 30 days of discharge. Of these four CCGs, East Staffordshire and Stafford and Surrounds were over 20% worse than peers.[89]

Four CCGs reported a significant proportion of patients with common mental health conditions waiting for improved access to psychological therapies (IAPT) assessment longer than 90 days. Furthermore, Stoke-on-Trent was the only CCG to report a rate of at least 50% of treatments commencing within 2 weeks of psychosis referrals[90], suggesting some national standards on waiting times have been challenged.

Suicide Prevention

Suicides rates across the County and City are similar to the England average. However, rates in Stafford are higher than England.[91] The number of admissions for people who self-harm in Staffordshire is similar to the England average, however rates in the City are higher than England; Newcastle-under-Lyme also has a higher than average rate of people admitted to hospital due to self-harm.[92] There are early signs that suicide rates are falling, however

[85] QOF, prevalence data 2017/18

[86] Public Health England, Public Health Outcomes Framework, data accessed March 2019

[87] Improving mental health and wellbeing outcomes in Staffordshire: an evidence base, 2016

[88] Hospital episode statistics (HES) via HES Data Interrogation System (HDIS), extracted 1 October 2018. Copyright © (2018), re-used with the permission of The Health & Social Care Information Centre. All rights reserved

[89] TWB STP

[90] TWB STP

[91] Public Health England, Public Health Outcomes Framework, data accessed March 2019

[92] Public Health England, Public Health Outcomes Framework, data accessed February 2019

more needs to be done to ensure this improvement is sustained in the longer term. Member organisations of the Staffordshire and Stoke-on-Trent STP have signed up to a zero suicide charter to commit all organisations to work together to implement a system wide suicide-reduction strategy and underpinning action plan.

Summary

The extent of the health issues and health inequalities within our STP presents a challenge for how healthcare is delivered, especially if we are to reduce health inequalities as outlined in the Long Term Plan[93]. The Long Term Plan calls for a new care model which is flexible to differences in local health needs and is committed to reducing the prevalence of health inequalities. This will require an enhanced and integrated health system across emergency, primary and community care, as well as a greater emphasis on prevention and self-care measures. By changing our care model we will be better positioned to implement the actions committed through the Long Term Plan in reducing unwarranted variations in health inequalities and unwarranted variations in care by 2023/24 and 2028/29.

[93] NHS England, NHS Long Term Plan, 2019

2.3 The scale of the challenge - Care and quality

Section 2.2 has outlined the scale of the challenge and there is a requirement to ensure that the health and care services need to reflect the changing needs of our population. Patient and public views outline that we should be managing care closer to home in ways which enable patients to manage their own condition and to live as independently in their own home for as long as possible. At the same time, when people have an urgent or serious condition, people want access to high quality services and a skilled and competent workforce to manage their need.

Health services across Staffordshire and Stoke-on-Trent provide a range of health and care services that are safe and well-led. However, there is variation across the area and a number of other challenges which impact on patient outcomes and experience.

2.3.1 Acute services

Urgent and emergency care

Urgent and emergency care across the STP is complex for patients to access and understand. There are many points of access for patients, including emergency departments, walk in centres, minor injury units and extended GP services, as summarised in Table 7. In the south of our geography, much of our population access care out of area, for example at the Royal Wolverhampton NHS Trust. This is leading to complex care pathways for patients, resulting in reduced patient experience

Ambulance and NHS111 performance

West Midlands Ambulance Trust (WMAS) is the provider of ambulance services across Staffordshire and Stoke-on-Trent, supported by Staffordshire Doctors Urgent Care (Vocare) which provides NHS111 services.

Calls to WMAS have remained relatively stable over the past 12 months, with peaks during winter. Despite increasing calls over these periods, its performance is one of the best in England, as shown in the table below[94].

Table 6: WMAS response times performance

Category	WMAS		England		Target	
(hr:min:sec)	Mean	90th percentile	Mean	90th percentile	Mean	90th percentile
1	6:51	11:48	7:13	12:33	7:00	15:00
2	12:04	0:21:55	21:18	0:43:29	18:00	40:00
3	0:32:55	1:12:42	1:00:28	2:21:52	N/A	2:00:00
4	0:51:48	2:03:55	1:23:41	3:11:57	N/A	3:00:00

The West Midlands Ambulance Service has effective response times across categories compared to other ambulance services and the England average. A high proportion of patients are seen and treated at 36%, with only 3% heard and treated (therefore not visited by a paramedic), compared with the England average of 29% and 5% respectively.

[94] NHS England, Ambulance performance indicators, October 2018

While performance is generally good across the area, an increasing proportion of NHS 111 referrals are being recommended to attend A&E, rather than to primary or community care, placing further strain across the system[95].

Figure 13: Percentage of calls recommended by NHS 111 to attend A&E

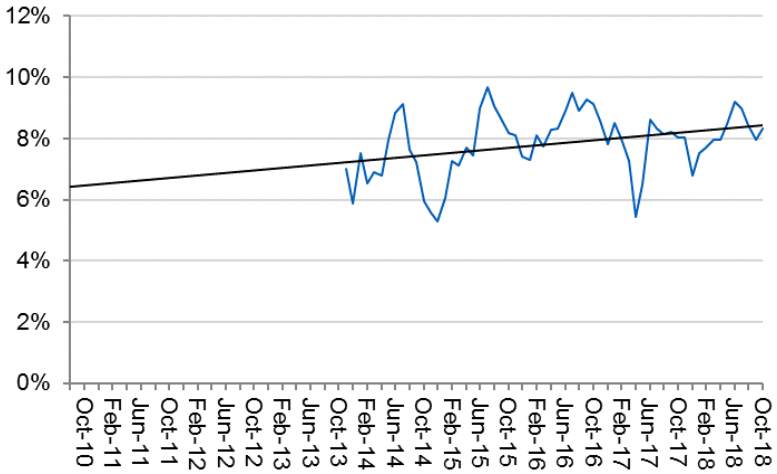
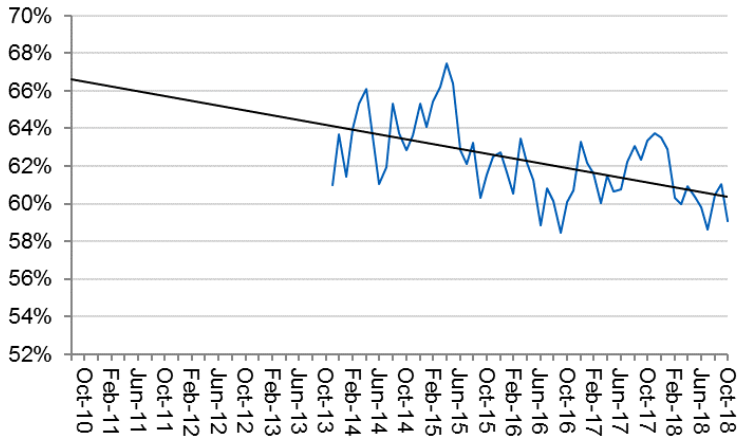


Figure 14: Percentage of calls recommended by NHS 111 to attend primary or community care



This pattern does mean fewer patients are being handled out of hospital, with more patients attending the A&E department. This is often not the most appropriate place to treat patients, and creates further pressures for the emergency department.

Under the Long Term Plan we will need to implement the 'Urgent Treatment Centre model' by autumn 2020 so that all localities have a consistent offer for out-of-hospital urgent care, with the option of appointments booked through a call to NHS 111. This will require our ambulance service to develop links with Urgent Treatment Centres and community based services to provide a locally accessible and convenient alternative to A&E for patients who do not need to attend hospital[96].

Table 7: Urgent and emergency care 'map'

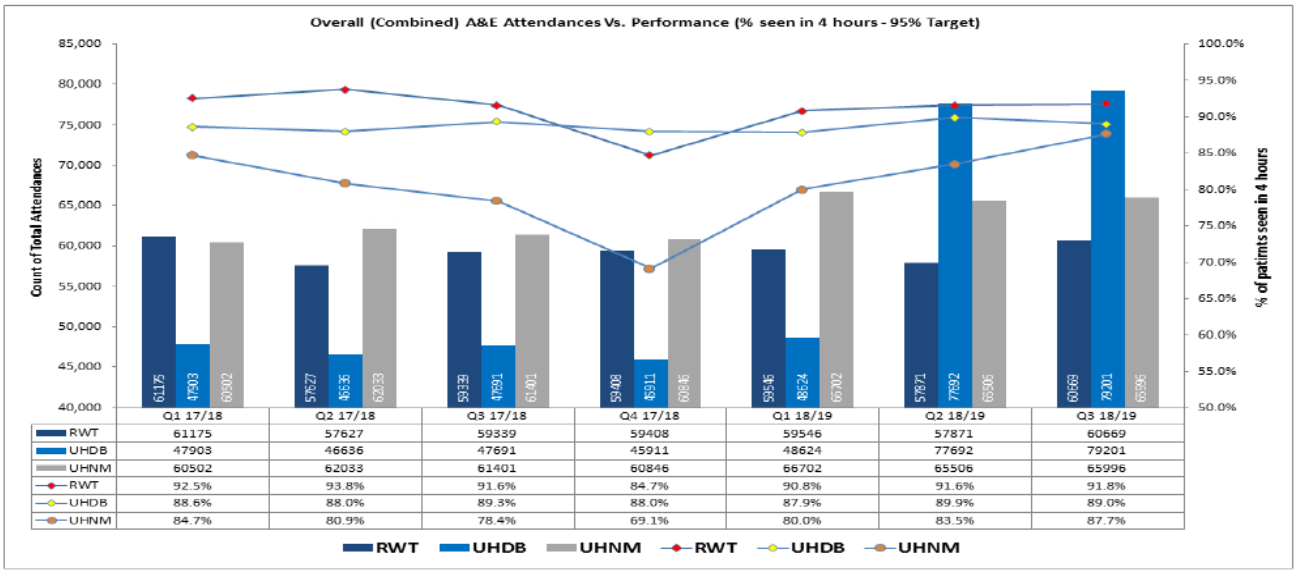
[95] NHS 111 minimum data set, 2018/19 (accessed November 2018)

[96] NHS England, NHS Long Term Plan, 2019

Type of urgent and emergency care	University Hospitals of North Midlands NHS Trust	University Hospitals of Derby and Burton NHS Foundation Trust	The Royal Wolverhampton NHS Trust	GP federations	Vocare	NH Solutions
Accident & Emergency	Royal Stoke University Hospital County Hospital (adult A&E)	Queen's Hospital				
Minor Injury Unit	Leek Moorlands Hospital County Hospital (children's)	Samuel Johnson Hospital Sir Robert Peel Hospital	Cannock Chase Hospital			
Walk-in Centre	Haywood Community Hospital			Hanley		Midway
Urgent Care Centre					Royal Stoke	

Across the NHS, some estimates suggest that between 1.5 and 3 million people who come to accident and emergency (A&E) each year could have their needs addressed in other parts of the urgent care system. Often patients turn to A&E because it seems like the best or only option, as it can be difficult for patients to understand which services to access and when[97]. This is reflected in the high number of attendances at our A&Es. Over the last four years there has been an 8% increase in attendances. However, the proportion of non-elective admissions and A&E attendances by 70+ group has remained at c.20%[98].

Figure 15: A&E attendances and percentage seen within 4 hours[99]



	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Q1 18/19	Q2 18/19	Q3 18/19
RWT	61175	57627	59339	59408	59546	57871	60669
UHDB	47903	46636	47691	45911	48624	77692	79201
UHNM	60502	62033	61401	60846	66702	65506	65996
RWT	92.5%	93.8%	91.6%	84.7%	90.8%	91.6%	91.8%
UHDB	88.6%	88.0%	89.3%	88.0%	87.9%	89.9%	89.0%
UHNM	84.7%	80.9%	78.4%	69.1%	80.0%	83.5%	87.7%

Attendances at A&E follow a seasonal pattern, increasing over winter. This seasonal trend continued last winter, and overall attendances were similar to the same period last year[100]. However, performance against the 4 hour A&E target remained poor as shown in Figure 16 below, with half of the Staffordshire STP providers missing their A&E target by over 10%[101]. The system has not achieved the target since November 2013 at University Hospitals North Midlands

[97] NHSE, NHS Five Year Forward View, 2017

[98] Needs analysis

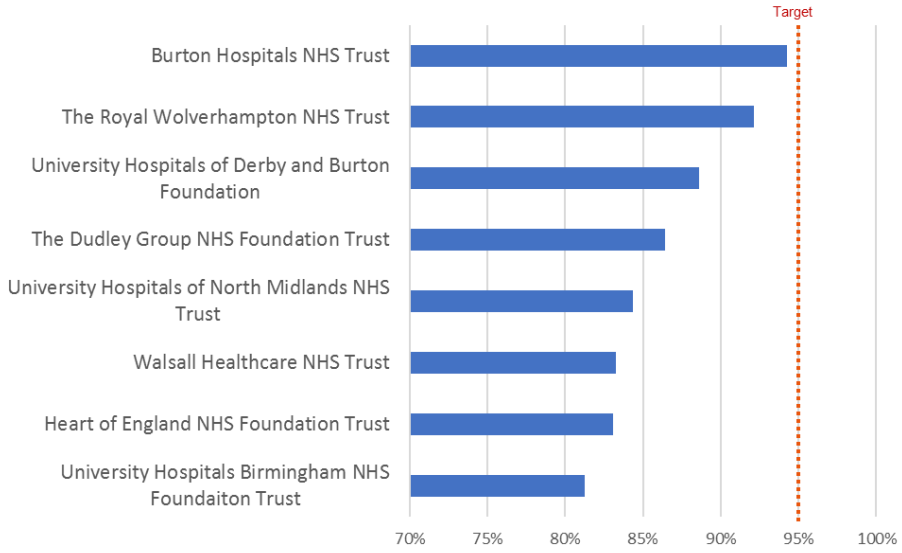
[99] NHS England, A&E Attendances and Emergency Admissions, 2017 - 2018

[100] West Staffordshire A&E Delivery Board footprint Urgent Care Performance Review, 2018

[101] CCG performance data, M7 2018

(UHNM), however, University Hospitals of Derby and Burton Foundation Trust (DBFT) recently met the target in May 2018[102]. Data from Q3 (2018/19) demonstrates an improvement in performance at UHNM compared to 2017/18.

Figure 16: A&E 4 hour performance by provider[103]



Non-elective admissions

Within our urgent and emergency care system, patients are admitted too often into acute hospital care. For example, non-elective admissions are 10% higher when compared to top-quartile performance across similar CCGs. East Staffordshire and Stoke-on-Trent, in particular, have a high number of non-elective admissions to hospital. This is pronounced in Stoke-on-Trent, where unplanned hospitalisations for chronic ambulatory care sensitive conditions are 45% above the national average (813 per 100,000 persons in England, compared with 1,182 per 100,000 persons in Stoke-on-Trent, for October 2016 to September 2017)[104].

The remaining CCGs are all either broadly in line with peer group top quartiles or performing notably better, with Staffordshire and Surrounds CCG and Cannock Chase CCG having lower admissions than peers, as summarised in the following table.

[102] NHS statistics, A&E Attendances and Emergency Admissions

[103] CCG performance data, M7 2018

[104] https://digital.nhs.uk/data-and-information/publications/clinical-indicators/ccg-outcomes-indicator-set/current/domain-2-enhancing-quality-of-life-for-people-with-long-term-conditions-ccg/2-6-unplanned-hospitalisation-for-chronic-ambulatory-care-sensitive-conditions

Table 8: Non-elective inpatient admissions benchmarking opportunity (2016/17)[105] to similar CCGs

NHS Clinical Commissioning Group	NEL admissions per 100k	% to upper quartile performance	% to upper decile performance
North Staffordshire CCG	11,432	3%	19%
Stoke-on-Trent CCG	14,325	23%	23%
Cannock Chase CCG	9,483	-3%	0.4%
East Staffordshire CCG	12,276	19%	19%
SE Staffordshire and Seisden Peninsula CCG	10,490	14%	16%
Staffordshire and Surrounds CCG	9,222	-3%	4%
Weighted Average	**11,477**	**10%**	**15%**

Once patients are admitted, they spend too much time in hospital beds. Hospital length of stay is around 7% higher than similar areas (based on RightCare peer group data), compared to top-quartile performance, as shown in the table below. Further, the number of stranded patients (those with a length of stay in hospital of over 7 days) and super-stranded patients (those with a length of stay in hospital of over 21 days) has been growing. Royal Stoke Hospital had 54 more stranded patients in December 2017 than in December 2016, and County Hospital, Stafford saw a similar increase.

Table 9: Length of stay benchmarking opportunity (2016/17)[106]

NHS Commissioning Group	Length of Stay (days)	% to upper quartile performance	% to upper decile performance
North Staffordshire	3.8	7%	10%
Stoke-on-Trent	3.8	9%	11%
South East Staffordshire and Seisden Peninsula	2.9	7%	12%
East Staffordshire	3.7	9%	9%
Stafford and Surrounds	3.8	5%	9%
Cannock Chase	4.3	7%	13%
Weighted Average	**3.7**	**7%**	**10%**

These findings have been echoed in the 2014 review by Dr Ian Sturgess who noted that the "North Midlands System appears to be too heavily reliant on 'bed based' solutions". He went on to note that "hospital bed[s] [are] not a 'place of safety' and although the risks of harm can be reduced … harm will always occur".

[105] 2016/17 hospital admitted patient care activity data, RightCare peer group (peers selected using 12 demographic variables)

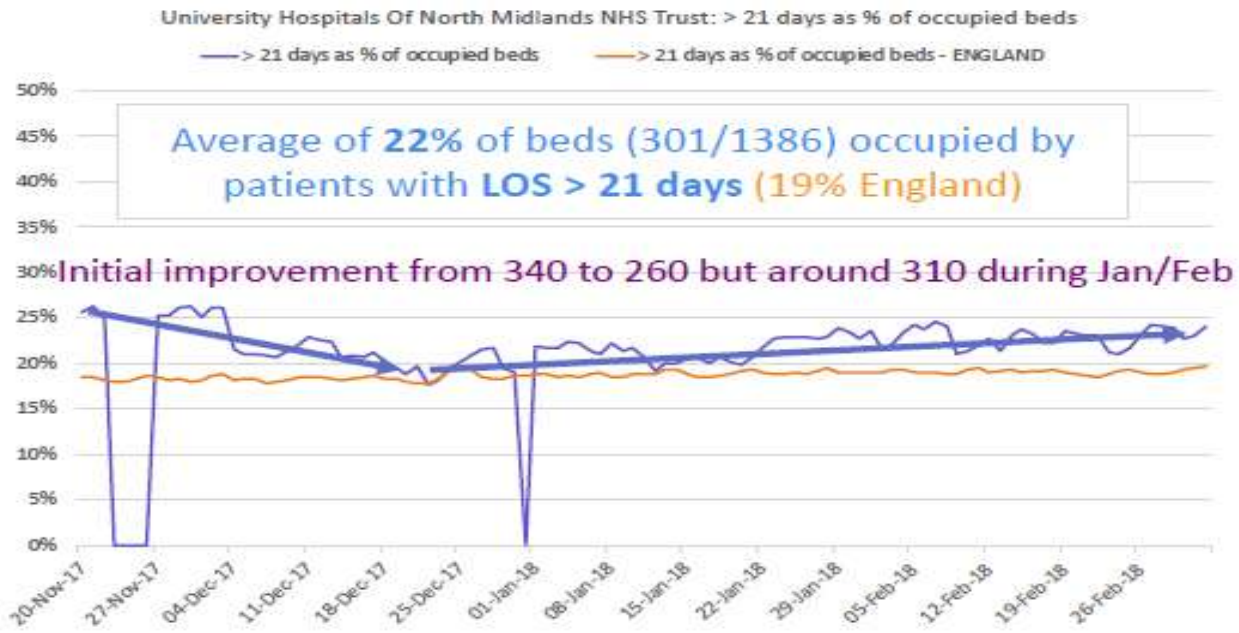
[106] 2016/17 hospital admitted patient care activity data, RightCare peer group (peers selected using 12 demographic variables)

High levels of demand in A&E and a high admission rate leads to strain on resources within the system, with a high bed occupancy impacting on planned operations due to the lack of available beds. The admission rate at UHNM, at 28%, is significantly higher than at RWT or DBFT, at 14% and 15% respectively[107]. There is also a higher length of stay at the Trust compared to peers. Reducing hospital length of stay can reduce the growing demand for beds and release capacity in the hospital system. However, this requires careful design of how patients flow through the system alongside the development of new care models.

During the 2017/18 winter, there were significant challenges.

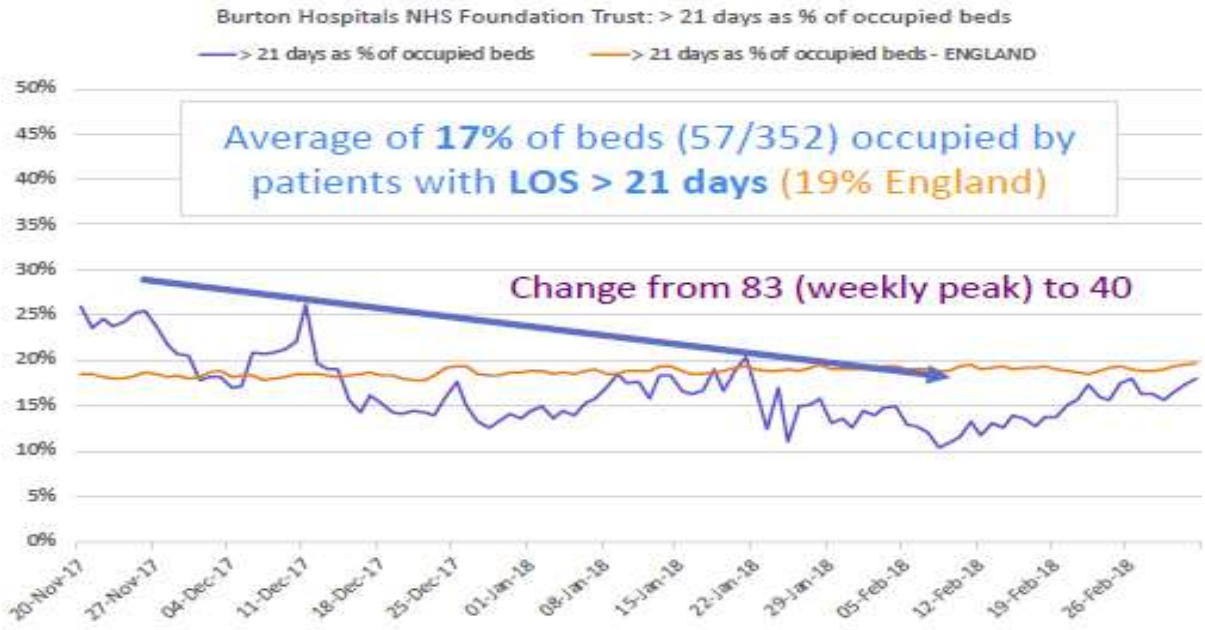
UHNM faced very high bed occupancy at 98%, versus 94% across England. This is despite having a higher percentage of escalation beds than the national average and 129 escalation beds being opened between January and the end of February 2018. The number of patients staying over 21 days at UHNM (22%) was higher than the national average (19%). The equivalent figure for DBFT was 17%. f

Figure 17: Percentage of patients staying over 21 days as a percentage of occupied beds[108]



[107] 2016/17 hospital admitted patient care activity data, RightCare peer group (peers selected based on 12 demographics)

[108] West Staffordshire A&E Delivery Board, *Fusion 48: Summary of Recommendations and Critical Success Factors*, June 2018



Throughout winter 2017-18, UHNM utilised the beds at Bradwell community hospital to care for patients who were medically stable but were not listed as medically fit or unmet demand. The beds within the community hospitals do not have access to diagnostics on site (with the exception of the Haywood) and the staffing model is not in line with that required to care for acutely ill patients.

Discussions have also been held between the Acute Trust and commissioners regarding the potential use of community estates for acute capacity but due to challenges and staffing, there is a preference that all acute beds remain on the UHNM site and through the wider STP, options around this will be explored and may be subject to formal consultation.

The extent of the challenges in our emergency care suggests we need to be ambitious in the changes we make to our health system. Implementing the Long Term Plan provides a case for change as it would require our existing system to evolve, for example if we are to roll-out 'same day emergency care' and achieve significant integration with other services[109].

Delayed transfers of care

In recent years Staffordshire and Stoke-on-Trent reported a higher than average number of delayed transfers of care from hospital, with the rate of delays attributed to social care in particular being significantly higher than the national average.

The launch of the Better Care Fund led to the setting of ambitious improvement targets by the Department of Health and Social Care. The most recent targets for Staffordshire and Stoke-on-Trent were based on a reduction of 30% for NHS delays and 40% for social care delays from the rate at the end of 2017, as part of a national target of no more than 4,000 people delayed at any time by September 2018.

After the publication of the 2018 targets, investigation of recorded delays revealed that some local Trusts had been under-counting, which meant that, once corrected, this would have a significant impact on Staffordshire and Stoke chances of achieving the targeted reduction in delayed days by September. Following negotiation with NHS England, the baseline was adjusted to be closer to the estimate of what the true position would have been had the recording been accurate at the time. However, NHS England were not able to accommodate the difference in full without

[109] NHS England, NHS Long Term Plan, 2019

compromising the national 4,000-day target, meaning that our local targets have been slightly more demanding than the original 30% and 40%.

Whilst the targets were not quite met by the end of September, Staffordshire (Table 10) has achieved some impressive reductions in delays since the peak delays in early 2018. For example:

- NHS delays have reduced by 30%.
- Social care delays have reduced by 46%.
- Delays overall have reduced by 36.5%.

Stoke-on-Trent (Table 11) also achieved significant reductions in 2018. For example:

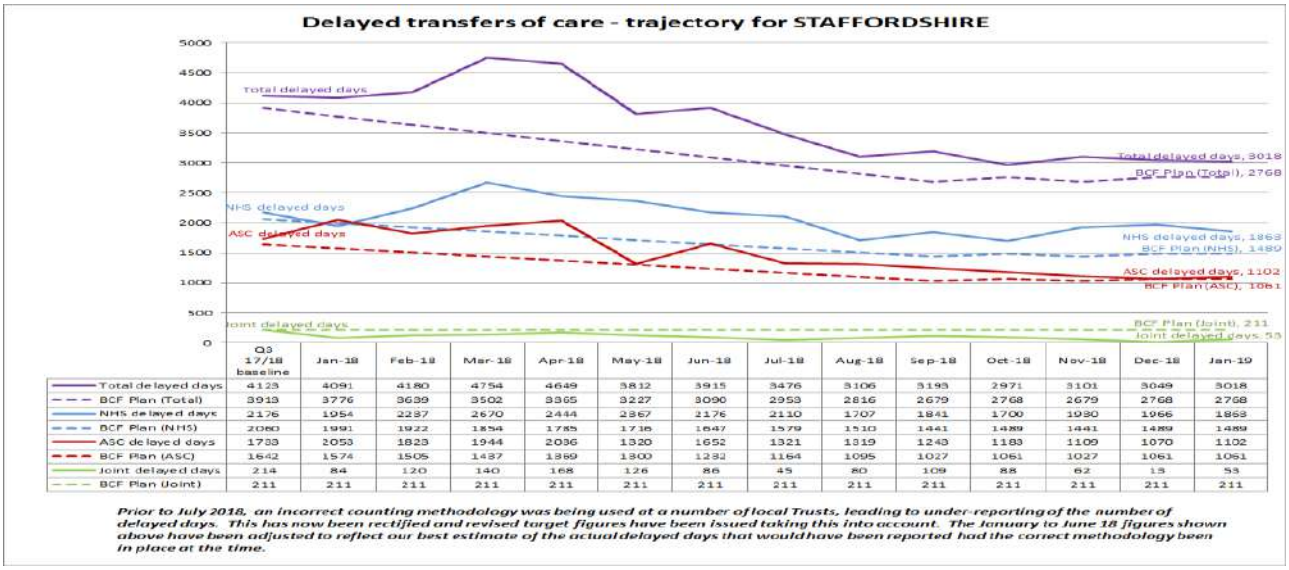
- NHS delays reduced by 25% during the calendar year. There was a sharp increase in January 2019 but this was temporary problem and operational performance has rebounded strongly in February to maintain the overall improvements in the system.
- Social care delays reduced from a peak of 488 days in June 2017 to average 25 days per month for the second half of 2018.
- Delays overall reduced by 34% during the calendar year.

These reductions are significantly better than the national averages of 2.5% (NHS delays) and 17% (social care and joint delays).

At this time, no new Better Care Fund targets have been set and as such we continue to measure our progress against the September target.

The charts (Table 10 and 11) illustrate the performance achieved to date and show how Staffordshire and Stoke-on-Trent compares against national benchmarks.

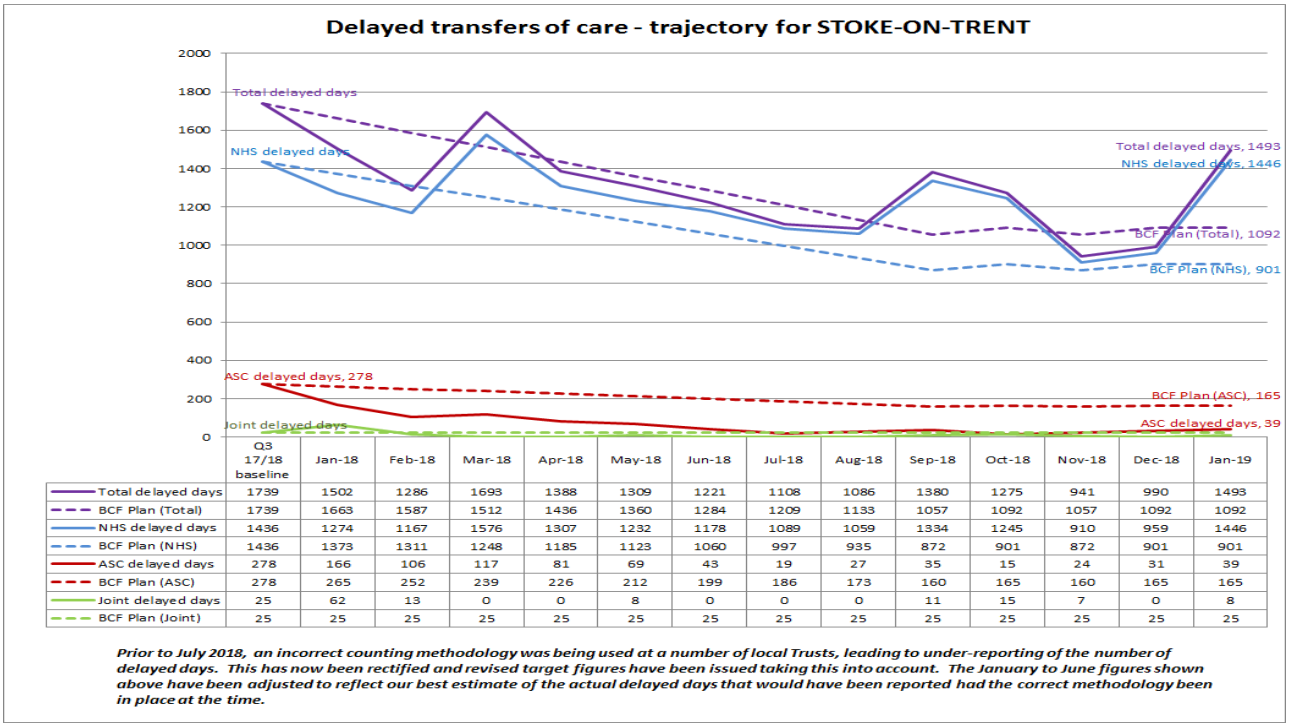
Table 10: Trajectory of Delayed Transfers of Care for Staffordshire CCG



	Q3 17/18 baseline	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19
Total delayed days	4123	4091	4180	4754	4649	3812	3915	3476	3106	3193	2971	3101	3049	3018
BCF Plan (Total)	3913	3776	3639	3502	3365	3227	3090	2953	2816	2679	2768	2679	2768	2768
NHS delayed days	2176	1954	2287	2670	2444	2367	2176	2110	1707	1841	1700	1980	1966	1863
BCF Plan (NHS)	2080	1991	1922	1854	1785	1716	1647	1579	1510	1441	1489	1441	1489	1489
ASC delayed days	1733	2053	1823	1944	2036	1320	1652	1321	1319	1243	1183	1109	1070	1102
BCF Plan (ASC)	1642	1574	1505	1437	1389	1300	1232	1164	1095	1027	1061	1027	1061	1061
Joint delayed days	214	84	120	140	168	126	86	45	80	109	88	62	15	53
BCF Plan (Joint)	211	211	211	211	211	211	211	211	211	211	211	211	211	211

Prior to July 2018, an incorrect counting methodology was being used at a number of local Trusts, leading to under-reporting of the number of delayed days. This has now been rectified and revised target figures have been issued taking this into account. The January to June 18 figures shown above have been adjusted to reflect our best estimate of the actual delayed days that would have been reported had the correct methodology been in place at the time.

Table 11: Trajectory of Delayed Transfers of Care for Stoke-on-Trent CCG



	Q3 17/18 baseline	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19
Total delayed days	1739	1502	1286	1693	1388	1309	1221	1108	1086	1380	1275	941	990	1493
BCF Plan (Total)	1739	1663	1587	1512	1436	1360	1284	1209	1133	1057	1092	1057	1092	1092
NHS delayed days	1436	1274	1167	1576	1307	1232	1178	1089	1059	1334	1245	910	959	1446
BCF Plan (NHS)	1436	1373	1311	1248	1185	1123	1060	997	935	872	901	872	901	901
ASC delayed days	278	166	106	117	81	69	43	19	27	35	15	24	31	39
BCF Plan (ASC)	278	265	252	239	226	212	199	186	173	160	165	160	165	165
Joint delayed days	25	62	13	0	0	8	0	0	0	11	15	7	0	8
BCF Plan (Joint)	25	25	25	25	25	25	25	25	25	25	25	25	25	25

Prior to July 2018, an incorrect counting methodology was being used at a number of local Trusts, leading to under-reporting of the number of delayed days. This has now been rectified and revised target figures have been issued taking this into account. The January to June figures shown above have been adjusted to reflect our best estimate of the actual delayed days that would have been reported had the correct methodology been in place at the time.

2.3.2 Planned care

From a National perspective there are key challenges that the NHS must deliver for its future sustainability:

- Achievement of the 92% 18-week Referral to Treatment constitutional target
- Reduce the amount of cancelled operations
- Redesign and reduce the number of outpatient follow ups
- Ensuring patients are treated as close to their place of residence wherever clinically appropriate
- Increase efficiency of District General Hospitals and spend on services (including 7-day services)
- Reducing demand into hospitals

To address these, the Planning Guidance 18/19 requires delivery of Referral to Treatment times and elective care:

- Deliver the NHS Constitution standard that more than 92% of patients on non-emergency pathways wait no more than 18 weeks from referral to treatment (RTT)
- Deliver patient choice of outpatient appointment, and achieve 100% of use of e-referrals by no later than April 2018 in line with the 2017/2018 CQUIN and payment changes from October 2018
- Streamline elective care pathways, including through outpatient redesign and avoiding unnecessary follow ups

Demand for elective care is increasing with significant growth over the last 6 years and is predicted to continue to grow at an increasing rate. In many specialties and providers, national standards are not being met. Benchmarking suggests there are longer than average patient waits, inappropriate and inconsistent referrals, inefficient pathways and longer than average length of stay. The provider landscape is complex, and delivery is from multiple sites; leading to duplication and inefficiencies and an unaffordable cost base, operating outside of the allocated cost envelope.

Other key challenges to be addressed by the Staffordshire system are:

- Capacity v demand mismatches, including social care

- A need to reduce the increasing demand on the system from all tiers of care (primary care initiatives alongside examples such as improved self-help, more pathology tests to reduce outpatient appointments, increase digital solutions such as Advice and Guidance, Skype consultations for follow ups, etc.)
- Elective care operations/treatments being cancelled due to Urgent and Emergency Care pressures.
- Consistency of elective services across days of the week and across providers

Benchmarking suggests there are longer than average patient waits and that patient pathways could be more efficient. Patients wait longer than peers in many areas for treatment, especially for cancer and mental health services[110].

Demand for elective care is increasing; the 14% growth over the last 4 years is expected to continue to grow at an increasing rate[111]. In many specialties and in most providers, national standards are not being met. Growing demand is impacting quality, with some 418,000 patients were waiting longer than the 18 week standard for hospital treatment in September 2017, a 20% increase on the previous year. As shown in the table below, most CCGs are breaching rates of patients seen within 18 weeks (national target of 92%)[112], with North Staffordshire CCG and Stoke-on-Trent CCG breaching most regularly.

Table 12: Referral to treatment (RTT), November 2018[113]

NHS Clinical Commissioning Group	% within 18 weeks	Average (median) waiting time (in weeks)	92nd percentile waiting time (in weeks)
Cannock Chase	91%	6.0	19.1
East Staffordshire	92%	5.9	18.0
North Staffordshire	85%	7.4	23.3
South East Staffordshire and Seisdon Peninsula	92%	5.6	18.3
Stafford and Surrounds	88%	6.5	21.1
Stoke-on-Trent	84%	7.6	23.3

Referral to Treatment (RTT) performance is particularly challenged at UHNM, where only 82.3% of patients are seen within 18 weeks, this compares to 90.8% at RWH and 91.3% at DBFT. The national measures for people who have been referred by their GP for suspected cancer to be seen within two weeks generally shows good performance within the geography. There are however specific challenges for Cannock Chase CCG, where only 89% of patients are seen within 14 days, missing the NHSE standard of 93% of patients being seen within two weeks.

Cancellations are higher than the national averages, with the number of last minute elective operations cancelled for non-clinical reasons at UNHM being four times higher than the average across all England providers. [114]

[113] NHSE, Consultant-led Referral to Treatment Waiting Times, November 2018

[113] NHSE, Consultant-led Referral to Treatment Waiting Times, November 2018

[113] NHSE, Consultant-led Referral to Treatment Waiting Times, November 2018

[113] NHSE, Consultant-led Referral to Treatment Waiting Times, November 2018

[114] NHS England - QMCO data collection

There was on average 17 operations cancelled each day by the Staffordshire providers in the second and third quarter of 2018[115]. This could be related to the challenges around urgent and emergency care and delayed transfers of care impacting on planned care. Professional guidance, including from the Royal College of Surgeons, recommends separating planned surgery from emergency surgery, either through locating them separately or having dedicated facilities and staff. Separating these patients results in more definitive treatment and investigation, and reduces infection rates and length of stay[116].

Table 13: Number of cancelled operations by provider

Provider	18/19 Q2	18/19 Q3	Period total	Per day average
University Hospitals Birmingham NHS Foundation Trust	743	723	1,466	**8.00**
University Hospitals of North Midlands NHS Trust	511	461	972	**5.30**
The Dudley Group NHS Foundation Trust	130	153	283	**1.50**
University Hospitals of Derby and Burton Foundation	122	131	253	**1.40**
The Royal Wolverhampton NHS Trust	60	69	129	**0.70**
Walsall Healthcare NHS Trust	13	29	42	**0.20**
Total	**1,579**	**1,566**	**3,145**	**17.20**

A number of studies have shown that separating planned care from emergency care can be beneficial. Providing planned care separately has been shown to improve outcomes for patients with complex conditions, due to a higher focus with smaller volumes. Where patients are less complex and volumes are higher, focusing on a smaller range of routine planned care can improve mortality rates[117]. Separation may also benefit emergency care, as spill over from planned care within a specialty or from other specialties impacting negatively on emergency care[118].

As the table below shows, the STP CCGs largely improved in their planning of referrals between April and October 2018, although East Staffordshire CCG observed the greatest number of months where referrals was higher than planned[119].

[115] CCG performance data, M7 2018

[116] The Royal College of Surgeons of England, Separating emergency and elective surgical care: Recommendations for practice (2007)

[117] Separate & Concentrate: Accounting for Patient Complexity in General Hospitals – Kuntz, Scholtes, Sulz (2017)

[118] Economies of Scale and Scope in Hospitals: An Empirical Study of Volume Spillovers – Freeman, Savva and Scholtes (2018)

[119] CCG performance data, M7 2018

Table 14: Total referrals, activity vs. planned[120]

CCG	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18
North Staffordshire & Stoke-on-Trent combined	6.2%	3.9%	(1.6%)	(2.9%)	(8.1%)	(5.1%)	(2.6%)
Stoke-on-Trent	5.3%	2.8%	(2.7%)	(2.1%)	(6.8%)	(5.2%)	(2.1%)
North Staffordshire	7.3%	5.5%	(0.2%)	(3.9%)	(10.0%)	(5.0%)	(3.3%)
East Staffordshire	4.1%	11.7%	4.7%	3.1%	(3.2%)	1.1%	2.2%
Cannock Chase	2.5%	1.1%	(1.0%)	(3.2%)	(6.7%)	(5.4%)	(3.3%)
Stafford & Surrounds	(3.0%)	(0.1%)	(4.9%)	(5.4%)	(15.0%)	(13.5%)	(9.2%)
South East & Seisdon	6.6%	10.7%	6.1%	0.7%	(1.0%)	1.3%	6.7%

A key performance opportunity which has been identified nationally is Theatre Utilisation. The UHNM is currently performing at a combined utilisation of 83%, against a national aspirational target of 85%. Burton Hospital Foundation Trust is performing at 75%, with the main theatres delivering 80% and the Orthopaedic theatres at 86%. This highlights an opportunity related to booking, scheduling and improving the flow of patients through theatres on the day of surgery. There are small amounts of theatre usage on Saturday and Sunday linked to waiting list initiatives. There is duplication, inefficiency in theatre utilisation, inefficient pathways, do not operate fully 24/7 and there is evidence that efficiencies can be achieved at scale. Some providers are already working together in a network to deliver efficiencies.[121]

2.3.2 Primary care

General Practice is the foundation of health care delivery in the NHS. It is central to bringing care closer to home, preventing unnecessary hospital care and identifying which people need specialist services. However, general practice is under pressure; patient expectations are rising, there is a growing need to keep people out of hospital and provide a greater range of services in the community.

The objective of primary care is to provide better clinical outcomes despite rising patient expectation, increasing demand, a falling percentage of the NHS budget and workforce capacity issues. This is clearly a challenging situation and demands new and flexible thinking about how we will deliver services. One of the great strengths of primary care has always been its ability to adapt to meet the demands made upon it.

The Primary Care workforce is under pressure with fewer graduates entering into the profession, a large proportion of older GPs approaching retirement and a lack of training for alternative workers such as Nurse Practitioners or Physician's Assistants.

There is a need for a stronger role for primary care, at scale, which will require a new operating model serving larger populations and delivering a wider range of services.

[120] CCG performance data, M7 2018

[121] Together We're Better, Elective Care Transformation Plan, 2018

Central to the vision of better health outcomes for communities will be greater integration across organisational boundaries with GPs playing a pivotal role at the heart of the health and social care system. Integrated IT systems and data sharing between organisations will be central to this and will require organisations to share clinical information to improve patient outcomes and ensure better coordination and continuity of care.

The shortage of GPs and other primary care professionals is the biggest challenge facing general practice and a key risk to the sustainability of the partnership model that has delivered primary care services for over 70 years.

The GP Partnership Review was published on 15th January 2019 and identified a number of reasons which are driving the workforce shortage and particularly the number of GPs who are willing to take on a partnership role. These include:

- Declining investment into general practice from 11% of the total NHS budget to 7%.
- Early and mid-career GPs finding the partnership role unattractive.
- The lifetime and annual pension caps prompting earlier retirement.
- The increase in the number of hospital nurses and corresponding decrease in nurses in primary and community care.
- The increasing frailty and complexity of patients.
- Increasing demands of a growing population.
- Increasing workload pressures with a new generation of GPs looking for better work life balance.
- Increased personal liability and risk associated with premises

Across Staffordshire and Stoke-on-Trent the CCGs and partners have put in place to following to support the primary care workforce in Staffordshire. In summary, these include:

- Optimised practice footprint – 187 practices (6,400 av. list) to 156 practices (7,600 av. list)
- Delivery of the Ten high Impact Changes - Care Navigation, workflow optimisation,
- Primary Care at Scale - Extended Access, nursing homes, frailty hubs, MDTs, 9 Primary Care Home Sites, 2 Prime Ministers Challenge Fund sites, Four GP Federations
- Primary Care Workforce Strategy including new workforce models – Clinical pharmacists, PA preceptorship, Staffordshire and Stoke on Trent Partnership Trust (SSOTP) redeployment
- Digital – Patient online, patient WIFI, Docman10
- Estates – 4 Estates Technology Transformation Fund (ETTF) capital developments and One Public Estate development
- GP Retention programme – 10 CCG funded placements
- British Medical Journal marketing campaign
- Social prescribing pilots
- Training hub development

While many of these actions have certainly supported primary care locally, it is clear that further contractual reform is required to address some of the nationally driven challenges. On this basis, the GP partnership review concluded with seven key recommendations that were presented to Simon Stevens:

1. There are significant opportunities to reduce the personal risk and unlimited liability currently associated with GP partnerships.
2. The number of general practitioners who work in practices, and in roles that support the delivery of direct patient care, should be increased and funded.
3. The capacity and range of healthcare professionals available to support patients in the community should be increased, through services embedded in partnership with general practice.

4. Training should be refocused to increase the time spent in general practice, to develop a better understanding of the strengths and opportunities of primary care partnerships and how they fit into the wider health system.
5. Primary care networks should operate in a way that makes constituent practices more sustainable and enables partners to address workload and safe working capacity, while continuing to support continuity of high quality, personalised, holistic care.
6. General practice must have a strong, consistent and fully representative voice at system level.
7. There are opportunities to enable practices to use resources more efficiently by ensuring access to both essential IT equipment and innovative digital services.

Primary Care Networks

A Primary Care Network (PCN) contract will be introduced from 1 July 2019 as a Directed Enhanced Service (DES). It will ensure general practice plays a leading role in every PCN and mean much closer working between networks and their Integrated Care System. This will be supported by a PCN Development Programme which will be centrally funded and locally delivered.

There is a clear requirement under the new contract that each STP footprint will have 100% Primary Care Network population coverage to go live by July 2019. There is an expectation that PCNs will largely align to the current locality footprint, however, it is likely that there will be some changes to as PCNs form around the smaller nationally determined populations of 30,000 - 50,000.

Practices have been working together under locality arrangements in Staffordshire and Stoke-on-Trent and it is recognised that PCNs are at different stages of development. Some are well established, others will require ongoing support.

2.3.3 Community services

In North Staffordshire, the Clinical Commissioning Groups (North Staffordshire and Stoke-on-Trent) have outlined how we might deliver community care differently across the area, with the aim of improving patient outcomes and access to clinically appropriate care whilst preventing, where clinically safe, acute hospital admissions or prolonged inpatient stays.

The detail of this is outlined within the Pre-Consultation Business Case (PCBC) regarding the Future of Local Health Services in Northern Staffordshire.[122] The options, focussed on delivering high quality care and improving outcomes, are currently have been consulted on by key stakeholders (public and wider stakeholders). Following the recent deadline for the consultation (19th March 2019) a full response to the consultation will be created for the CCG Governing Bodies and all responses will be considered. This will be used to refine and initiate a further assessment of the impact of the suggested proposals. The analysis undertaken post consultation will inform a Decision Making Business Case (DMBC) which will be submitted to Governing Bodies to enable final decisions on community services and bed based in North Staffordshire and Stoke-on-Trent.

Core to the North Community hospitals PCBC sits integrating community services and providing an enhanced offer across the localities. A similar approach in South Staffordshire needs to be considered to ensure there is parity of access and outcomes for patients compared to the North, and meet the increasing demand within the system. For those patients who receive elective care outside of the Staffordshire footprint there is the requirement to ensure the pathway into community services is efficient and effective to reduce the number of re-admissions to acute care.

The demand on our acute services is having a significant impact on our community hospitals and the services they provide. This demand will grow if we are to provide fast support to people in their own homes as an alternative to hospitalisation and increase support for people living in care homes, as per the Long Term Plan. This therefore

[122] https://www.healthservicesnorthstaffs.nhs.uk/health-services-north-staffs/1461-pre-consultation-business-case-main-body-final/file

creates a challenge in transforming our community care offer while ensuring we are delivering community care to our patients in the most appropriate setting for their needs[123].

In 2015, the CQC inspected SSOTP (excludes Longton Cottage Hospital due to temporary closure of beds in 2015) and indicated that overall the core community service 'requires improvement'. Since that CQC inspection, SSOTP has made changes to address these challenges in the quality of community services. It is currently waiting for the overall results of the CQC's 2018 inspection but has already received "Good" ratings for several of its locality "Home First" services. Furthermore, SSOTP has merged with South Staffordshire and Shropshire Healthcare Foundation Trust (SSSFT) to form Midlands Partnership NHS Foundation Trust which is a rated 'Good' as a provider across all domains.

The CCGs historically commissioned reablement via the Local Authorities and Intermediate care and Palliative Care via SSOTP. This had led to fragmentation of services and difficulties in ensuring patients were discharged into the right capacity. Lack of an integrated approach and confidence in the service offer also impacted upon the numbers of people deemed suitable for discharge into home based services. In addition, assessments for longer term social care were also being carried out on acute wards which led to delays in discharges, in turn leading to high levels of Medically Fit For Discharge (MFFD) and unmet demand.

When considering community services, historically too many people have ended up in bed-based care for long periods. This is supported by local and national evidence which the CCGs have developed. Based on discussions across the system, the historically higher bed base is likely to have been the result of:

- A bed dependency culture in the North of the County where there is a high number of community beds;
- Utilisation of the Community Hospitals in the South as acute overflow due to issues in discharging patients who are MFFD;
- Patients being assessed within the acute setting at an early stage of their admission when their physical or mental health is not at a point where an accurate assessment can be made;
- Too many frail patients being admitted, decompensating and becoming complex discharges requiring high levels of care;
- A lack of understanding of the community services available to discharge and the level of care that can be provided;
- Variation in commissioned services across Staffordshire and varying levels of investment to support discharge;
- A demand and capacity mismatch leading to patients being placed in services other than those they have been assessed for, which creates blockages within the system; and
- Risk adverse decisions that prevent people going straight home when they could do so.

These findings are consistent with Dr Ian Sturgess' 2014 review which found for the frailty pathway that "the urgent and emergency care pathway in the North Midlands system is currently not fit for purpose with a high dependency on bed based solutions… there are many systems nationwide that do not have community hospital beds and yet they do not suffer the level of 'stranded patients' seen in the North Midlands system".

In South Staffordshire, our community hospitals – the Sir Robert Peel Community Hospital in Tamworth and the Samuel Johnson Community Hospital in Lichfield (both owned and managed by DBFT) – deliver many outpatient services from each site. The table below provides an overview of the services at both hospitals[124].

[123] NHS England, NHS Long Term Plan, 2019

[124] NHS Choices: Sir Robert Peel Community Hospital; Samuel Johnson Community Hospital

Table 15: Summary of services on offer at the community hospitals in South Staffordshire

Sir Robert Peel Community Hospital	Samuel Johnson Community Hospital
Minor Injury Unit	Minor Injury Unit
X-ray and ultrasound department	X-ray and ultrasound department
Day case theatre	Renal Dialysis Unit
Surgical ward	Midwife-led Birth Unit
Inpatient wards	Ante Natal Clinics
Outpatients (consultant-led)	Inpatient wards
	Outpatients (consultant-led)

In 2015, the CQC inspected the Community Hospitals and indicated that overall both sites were 'good' across all domains with the Minor Injury Unit at Samuel Johnson Hospital being classed as requires improvement.

The community hospital beds within the two sites have historically been used by acute trusts as overflow for patients who are medically fit for discharge and waiting support upon discharge. This has led to a significant proportion of patients being discharged from an acute setting into community hospital beds to effectively wait for another service. As a result of the capacity available, community bed capacity has been somewhat relied upon to support urgent care discharge flow rather than as assessment and rehabilitation capacity.[125]

Discharge to Assess has not been implemented in full across South Staffordshire with similar issues to the North identified in relation to the follow and management of patients with further challenges relating to repatriation of Staffordshire patients who require assessment or rehabilitation post-acute stay in an Out of County Hospital. Work has been ongoing to model the required capacity against demand to support the delivery of D2A across both home and bed based services. This work has been undertaken alongside Staffordshire County Council to deliver an integrated approach to hospital discharge blurring the boundaries between health and social care to provide seamless transfers of care and requires both investment and also service redesign to deliver the new model of care aligned with best practice.

Community Services across South Staffordshire and delivered by MPFT and for East Staffordshire by Virgin Care. MPFT were inspected by CQC in 2016 under the previous guise of SSSFT and were classed as good across all domains. Virgin Care were inspected in 2017 and were also classed as good across four of the domains with the well led domain achieving outstanding status.

Early evaluations of the new care models show that strengthening services in the community may moderate, and in some cases reduce, demand for hospital care. The care models are examples of a future in which primary care teams, integrated community teams, and others work together to meet the needs of patients and service users[126]. These models are outlined within the NHS 10 Year Plan and form the basis of the future model of care across Staffordshire and Stoke-on-Trent. This may include the consideration of further investment where services are not commissioned in significant volume which will form part of the Pre-Consultation Business Case.

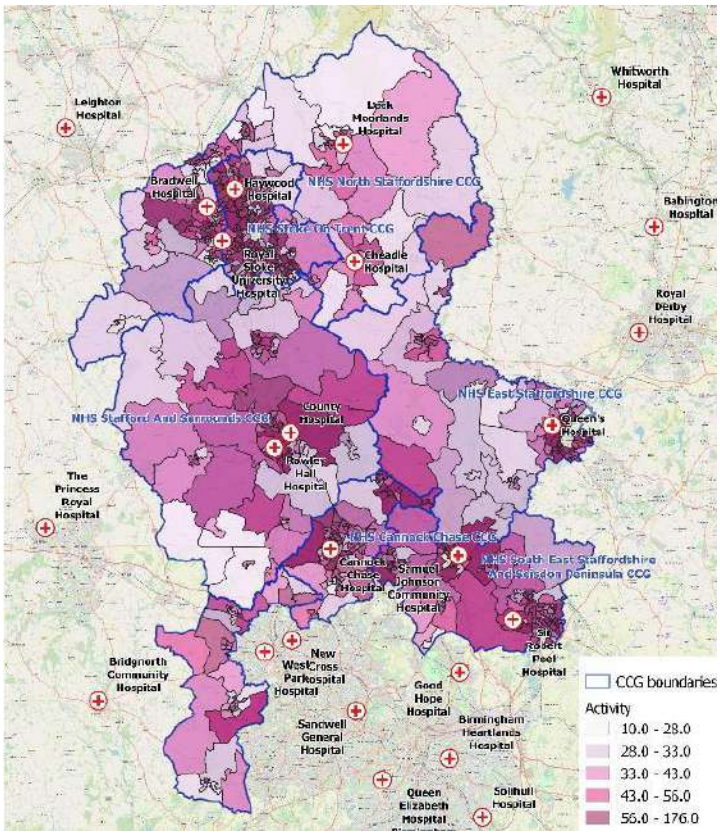
[125] North Staffordshire & Stoke-on-Trent Clinical Commissioning Groups, The Future of Local Health Services in Northern Staffordshire, 2018

[126] Kings Fund, Reimagining community services, 2018

2.3.4 Maternity care

In 2017, there were 11,784 births across Staffordshire and Stoke-on-Trent; 8,491 in Staffordshire and 3,293 in Stoke-on-Trent[127]. The Office for National Statistics population estimates indicate that there may be a small decrease in the number of births between 2016 and 2022, with 11,800 births predicted in 2022; 8,400 in Staffordshire and 3,400 in Stoke-on-Trent[128]. As the diagram below shows there is a significant concentration of births in urban areas, particularly in Stoke-on-Trent, Cannock and Tamworth[129]

Figure 18: Live births, 2015-2017



Women in Staffordshire and Stoke-on-Trent currently have a choice of place of birth recommended by Birthplace, Better Births and the National Institute of Clinical Excellence (NICE)[130]. These services are offered by UHNM and DBFT; they include:

- A consultant-led obstetric unit, Royal Stoke University Hospital (UHNM);
- A alongside Midwife Birth Unit, Royal Stoke University Hospital (UHNM);
- A midwife-led unit at the Freestanding Midwife Birth Unit, County Hospital (UHNM);
- A midwife-led unit, Samuel Johnson Community Hospital (DBFT);

[127] Office for National Statistics, Birth Summary Tables - England and Wales, 2018

[128] Office for National Statistics: Population projections incorporating births, deaths and migration for regions and local authorities: Table 5 (24 May 2018)

[129] Nomis, births, 2017

[130] Nice, Intrapartum care for healthy women and babies, 2017

- A Delivery Suite, Queen's Hospital (DBFT); and
- At home anywhere in Staffordshire.

While the Royal College of Obstetricians and Gynaecologists (RCOG) and the Royal College of Midwives (RCM) support stand-alone midwife-led birthing units, RCOG only recommends this route for low-risk women who have previously had children. The RCM recognises that stand-alone units have fewer interventions and other benefits[131].

The table below sets out the total number of births in 2016/17 for Staffordshire and Stoke-on-Trent and provides a breakdown of midwifery-led births for each labour and birth care setting.

2,337 births across the area were midwifery-led. Over half of the midwifery-led deliveries (53%), took place at the Alongside Midwife Birth Unit at Royal Stoke University Hospital. In comparison, 6% took place in the Freestanding Midwife Birth Unit at County Hospital and home births made up 3.4% of the midwifery-led deliveries, as shown below.

Table 16: Number of births in 2016/17 by care setting for labour and birth

Care setting for labour and birth	2016/17
Alongside Midwife Birth Unit, Royal Stoke University Hospital	1,227
Freestanding Midwife Birth Unit, County Hospital	141
Midwife-led unit, Samuel Johnson Community Hospital	264
Midwifery-led births, Queen's Hospital	625
Home (UHNM)	37
Home (DBFT)	43
Total births in midwifery-led setting	**2,337**
Total births	12,126
Percentage in midwifery-led setting	**19.3%**

The Freestanding Midwife Birth Unit at County Hospital sees only a small number of births at c.140 per annum. This is significantly below the 350 births indicated by the Trust Special Administrator for a clinically and financially sustainable service[132]. This is in line with evidence suggesting that stand-alone midwife-led birthing units can be challenging in terms of financial sustainability and staffing[133].

As foetal and neonatal care has developed, pre-term birth is more common and the survival rate of sick newborn babies is continuing to improve[134]. Neonatal critical care capacity needs to keep pace with these advances to improve short and long-term outcomes for these children. Through the Long Term Plan, we will need to accelerate action to

[131] https://www.kingsfund.org.uk/publications/reconfiguration-clinical-services/maternity-services

[132] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/366881/TSA-Final-report-Volume-One-FINAL.pdf

[133] https://www.kingsfund.org.uk/publications/reconfiguration-clinical-services/maternity-services

[134] NHS, NHS Long Term Plan, 2019

achieve the targeted 50% reductions in stillbirth, maternal mortality, neonatal mortality and serious brain injury by 2025.[135]

2.3.4 Mental health services

Mental health services are provided across our geography by Midlands Partnership NHS Foundation Trust (MPFT) and North Staffordshire Combined Healthcare NHS Trust (NSCHT). MPFT was formed on 1 June 2018 following a merger between South Staffordshire and Shropshire Healthcare NHS Foundation Trust and Staffordshire and Stoke on Trent Partnership NHS Trust and provides mental health services across the south of the geography. North Staffordshire Healthcare NHS Trust provides mental health services across Stoke-on-Trent and North Staffordshire.

The demands on the two mental health providers across the area have increased over recent years. This is associated with increasing knowledge and awareness of mental health issues coupled with services becoming more accessible for the population.

Acute Care & Crisis

Four of the CCGs also performed poorly against their peers for unplanned readmissions to mental health service within 30 days of discharge. Of these four CCGs, East Staffordshire and Stafford and Surrounds were over 20% worse than peers. Additionally, there are higher levels of emergency hospital admissions of those people who self-harm in Staffordshire and Stoke-on-Trent[136] than of peer areas. Stoke-on-Trent was the only CCG to report a rate of at least 50% of treatments commencing within 2 weeks for psychosis referrals[137]. Follow-up on patients discharged from psychiatric inpatient care is broadly strong across the STP, with all CCG's placing in the top 50% of CCGs for the greatest proportion of patient follow-ups relative to those discharged[138].

Table 17: Follow up of Patients discharged from psychiatric inpatient care (QA)[139]

CCG	Percentage of patients on CPA who were followed up within 7 days after discharge from psychiatric inpatient care (QA)	
	Value	Rank among England CCGs (out of 482)
East Staffordshire CCG	100%	1
South East Staffs and Seisdon and Peninsular CCG	98%	51
Stoke on Trent CCG	96%	108
Stafford and Surrounds CCG	96%	117
Cannock Chase CCG	95%	137
North Staffordshire CCG	93%	164

Progress has been made in relation to crisis care, with an all age 24 hour mental health liaison service in place at the Royal Stoke Hospital, however similar services are not available in other acute hospital sites in the geography.

Additionally, whilst progress has been made in significantly reducing adult out of area placements and provide care for inpatient admissions to mental health facilities locally, there are inconsistencies in relation to the provision of home treatment services for adults across the STP.

The NHS has committed to further action to support mental health in adults and older people, which will require reform of our mental health care offer and how it interacts with other services. For example, it is proposed in the Long Term

[135] NHS, NHS Long Term Plan, 2019

[136] TWB STP, 2016

[137] TWB STP, 2016

[138] NHSE, Mental Health Community Teams Activity, 2018.

[139] NHSE, Mental Health Community Teams Activity, 2018.

Plan that there should be new and integrated models of primary and community mental health care, which will support adults and older adults with severe mental illnesses. We will also need to ensure that a 24/7 community-based mental health crisis response for adults and older adults is available by 2020/21.[140]

Children and Young People

Access to mental health services for children and young people has improved over recent years, but there continue to be inconsistencies in access times for community services, many of which are too long. In addition, more needs to be done to avoid placing children and young people who require admission outside the Staffordshire and Stoke-on-Trent area, which can be extremely disruptive and distressing for young people and their families.

The National Service Framework for Children and Young People (NSF, 2004) recommends that Specialist CAMH's Services meet the needs of young people and their families in a variety of ways through intensive outpatient services, assertive outreach and inpatient provision with these services being delivered flexibly in a variety of settings. These services are not consistently provided across the STP geography and in particular, intensive outreach services which help to avoid admission to inpatient units and shorten length of stay, need to be expanded and consistently provided.

The STP has been successful in securing participation in national 'trailblazer' pilot, to provide mental health support directly to schools, but this is currently at the pilot stage and in Stoke-on-Trent and North Staffordshire only. Expansion of this initiative to support more educational institutions across a wider geography is required.

Integrating Physical & Mental Health

People with a Severe Mental Illness (SMI) face stark health inequalities and are less likely to have their physical health needs met, both in terms of identification of physical health concerns and delivery of the appropriate, timely screening and treatment. Compared to the general population, individuals with SMI (such as schizophrenia or bipolar disorder) face a shorter life expectancy by an average of 15–20 years, are three times more likely to smoke and are at double the risk of obesity and diabetes, three times the risk of hypertension and metabolic syndrome, and five times the risk of dyslipidaemia (imbalance of lipids in the bloodstream). Clearly, more needs to be done to address this healthcare provision in primary and secondary care, address gaps in training for primary care and secondary mental health clinicians and improve the integration between mental and physical healthcare. In addition, there is a strong commitment to support most mental health conditions within community settings.

Learning Disability Services

The current Learning Disability (LD) and Autism system is fragmented and reactive in nature resulting in often poor user experience, duplicated activity and high cost. The delivery of a properly co-ordinated system can make a huge difference to people's lives and also gives people the best possible chance of staying out of hospital, residential or nursing care altogether. For people who do need to be admitted to hospital, integrated care would give them the best possible chance of being discharged sooner to a bespoke placement.

The Learning Disability adult population of Staffordshire and Stoke-on-Trent known to statutory services is approximately 3,200. Currently there is not a single commissioning approach to services and user experience is varied. The lack of consistent pathways to support service users leads to a greater reliance on inpatient beds, leading to long stays and higher costs of services.

Transitions between Children's and Young People and Adult Services also vary in quality and very often young people fall through the gaps and transition can be poor resulting in crisis. A main concern is that the lack of a system-wide approach means that we do not fully understand the issues, isolated decision making and ultimately could achieve better quality outcomes than we currently achieve.

[140] NHS, NHS Long Term Plan, 2019

2.3.5 Social care

The health and care system is inextricably linked: the sustainability of the NHS is critically dependent on public health and adult social care. Social care is seeing increased demand and the need to work more closely with health to develop new care models to accommodate these pressures and budget constraints.

Staffordshire County Council and Stoke-on-Trent City Council, who are responsible for these functions, are under unprecedented financial pressure in the face of falling government funding, rising demand from an ageing population, and rising costs. Significant challenges include:

- Meeting the Care Act 2014 requirement to provide or arrange services that help prevent people developing needs for care and support or delay people deteriorating such that they would need ongoing care and support while meeting the needs of the increasing numbers of people with complex needs, frailty and health needs who require such support.
- The risks to the care market (domiciliary care and care homes, including:
    - the challenges of recruiting and retaining sufficient numbers of good quality managers, care workers and nurses
    - competition for potential care workers from other employment sectors, such as retail and distribution
    - increasing costs in the provision of care, particularly in relation to ensuring that the National Living Wage is complied with
    - the pressures on available funding for commissioners, and the challenges in planning for the longer term given the relative lack of certainty nationally regarding the funding of adult social care
- The rising numbers and complexity of safeguarding concerns raised in relation to people with care and support needs.

The recently published Staffordshire and Stoke-on-Trent Adult Safeguarding Partnership Board had three strategic priorities in 2017/18 - engagement, transition (preparing for adulthood) and leadership in the independent care sector. The recently published Annual Report 2017/18 reported on Section 42 enquiries. The Care Act 2014 (Section 42) requires that each local authority must make enquiries, or cause others to do so, if it believes an adult is experiencing, or is at risk of, abuse or neglect.

    - During the course of the year in Staffordshire there have been 4908 occasions when concerns had been reported that adults with care and support needs may be at risk of or are experiencing abuse or neglect. Following initial assessment it was determined that the duty of enquiry requirement was met on 3198 of those occasions which is 65% of the total reported. This proportion is higher than the 61% in the previous year.
    - Of those people the subject of Section 42 enquiries, the most prevalent location for harm/abuse for Staffordshire residents was the person's own home at nearly 50%. The next most common locations in Staffordshire were residential homes (21%) and nursing homes (16%).
    - In Stoke-on-Trent there were 2242 reported safeguarding concerns in relation to adults with care and support needs. This was an increase of 289 from 1953 in the previous year an increase of 14.8%. This is the second annual rise in the past 2 years. Following initial assessment it was determined that the duty of enquiry requirement was met on 621 of those occasions which is 28% of the total reported. This proportion is higher than the 19% in the previous year.
    - Of those people the subject of Section 42 enquiry in Stoke-on-Trent, the most prevalent location for harm/abuse was nursing home (24%), own home (21%) and residential home (21%).
- The way in which the system develops its approach to using the voluntary sector as part of its core approach to delivering solutions to challenges in the market.

Our cross-cutting Health and Care Collaboration is considering use of funding across the system and how it might be rebalanced in order to protect support adult social care. We will move from articulating the financial challenge facing adult social care to setting out how this might be addressed through a more sustainable configuration of funding[141].

Current care home provision

Currently in Staffordshire and Stoke-on-Trent there are 342 care homes, of which 98 (29%) are with nursing. In total there are 10,160 beds, of which 5425 (53%) are with nursing. Some care homes have dual registration, meaning that the same bed can be registered for use as either nursing or residential depending upon demand[142].

The care home bed base equates to approximately 1 bed for every 110 residents in the Staffordshire and Stoke-on-Trent CCGs (ONS-population; 2016). Nationally there are approximately 460,000 care home beds (based on CQC 2017 state of adult social services report), which equates to approximately 1 bed for every 120 residents. Staffordshire and Stoke-on-Trent has care home provision about 8% higher than England as a whole[143].

Staffordshire County Council care home bed provision in 2018 estimates a small surplus in terms of its care home bed provision when compared with estimated demand. This is approximately 130 residential beds and 560 nursing beds. Though there is variance by area, with some having a shortfall in supply of care home beds, including:

- South Staffordshire shortfall of 50 care home beds.
- Staffordshire Moorlands shortfall of 50 care home beds.
- Staffordshire and Stoke-on-Trent overall shortfall of [100] EMI / Dementia care home beds.

Though a large number of Care Homes have a CQC rating of 'Good' or better, a number still require improvement (as highlighted in the table below). The CCGs are working with both Staffordshire and Stoke-on-Trent local authorities to implement a Care Home Turnaround team to support homes with training and quality standards across the board and to improve overarching standards of care. The Provider Improvement and Responsive Team (PIRT) will be able to provide flexible and effective support to care homes with identified quality short falls. This will ensure care homes benefit from rapid assessment of problem areas and intense support designed to enable the home to improve in a sustainable way in future.

Table 18: CQC Ratings of Care Homes with Staffordshire and Stoke-on-Trent

	Outstanding	Good	Requires improvement	Inadequate	Not rated
Staffordshire	1	150	74	7	22
Stoke-on-Trent	1	58	22	0	7
Local health economy	2	208	96	7	29

Emergency Hospital Admissions from Care Homes

[141] TWB STP

[142] Care Home Strategy, November 2018

[143] Care Home Strategy, November 2018

In 2017/18 over 12 months, there were approximately 6,400 emergency admissions from people aged 65 and over resident in care homes across the six CCGs. This equates to c.0.6 admissions per year per care home bed. This is a higher rate of emergency admissions per bed than was reported by the British Geriatrics Society (BGS) in 2015, where it was found that non-elective admissions across England equated to 0.59 admissions per year per bed for residential care home beds and 0.45 admissions per year per bed for nursing home beds. On that basis the admission rate from Staffordshire care home beds as whole was found to be c.17% higher than expected from national data[144].

Though historically speaking, since 2015/16 there has been no significant increase in the overall number of admissions of people aged 65 and over from care homes. This suggests that actions undertaken to reduce avoidable admissions have been sufficient to offset activity growth over time (due to an ageing population), though reductions beyond this have not been delivered.

To continue improving our support to people living in care homes, the Long Term Plan proposes the roll-out of NHS England's Enhanced Health in Care Homes which aims to improve services and outcomes for people living in care homes and those who require support to live independently in the community. This will require our system to develop stronger links between primary care networks and local care homes, and ensure there is a consistent team of healthcare professionals to support all care homes.[145]

2.3.6 Embedding digitally-enabled care

Our technology systems are currently fragmented which makes it difficult for organisations to communicate with each other, therefore increasing the risk of duplication and error. Patients have yet to fully benefit from the advances in technology, for example in supporting care homes, utilising technology in care packages and delivery and through improved prevention and diagnosis of illnesses.

Innovation and technology present a significant opportunity in improving the quality of care and outcomes, from prevention right through to hospital aftercare. To support the NHS commitment in embedding digitally-enabled care throughout the system, we need to seek new ways of working, upgrade our existing technology infrastructure and digitally-enable our staff. For example, the NHS App will create a standard online way for people to access the NHS, but we will need the right infrastructure in place so the app works seamlessly with other services at national and local levels.[146]

The introduction of care-improving technologies will require a health and social care system which is able to adapt to the changes brought about by these very technologies, which is therefore a challenge to our existing care model.

2.3.7 Cultural challenges to improving quality

Strong leadership of organisations facing the challenges described above is essential. Studies have shown that successful leaders are passionate about improving quality and safety, are in touch with issues at the front line and are hands-on. With the development of sustainability and transformation partnerships, increasingly the importance of system leadership is being emphasised, where setting system-level aims, developing and executing strategy, aligning leadership efforts and creating the capacity for change can create an effective system that is attractive to staff[147].

However, there are barriers within the Staffordshire and Stoke-on-Trent STP to achieving this. The current health and care system is fragmented, with organisations sometimes working in silos rather than integrating care across organisational boundaries, as the Care Quality Commission found in it's review of local health and social care

[144] Care Home Strategy, November 2018

[145] NHS, NHS Long Term Plan, 2019

[146] NHS, NHS Long Term Plan, 2019

[147] https://www.kingsfund.org.uk/sites/default/files/Roles-of-leaders-high-performing-health-care-systems-G-Ross-Baker-Kings-Fund-May-2011.pdf

systems[148]. Greater integration is needed across the system to deliver the ambitions of the NHS Long Term Plan, which particularly seeks greater integration between emergency care, primary care and community care to address growing demand on the NHS[149].

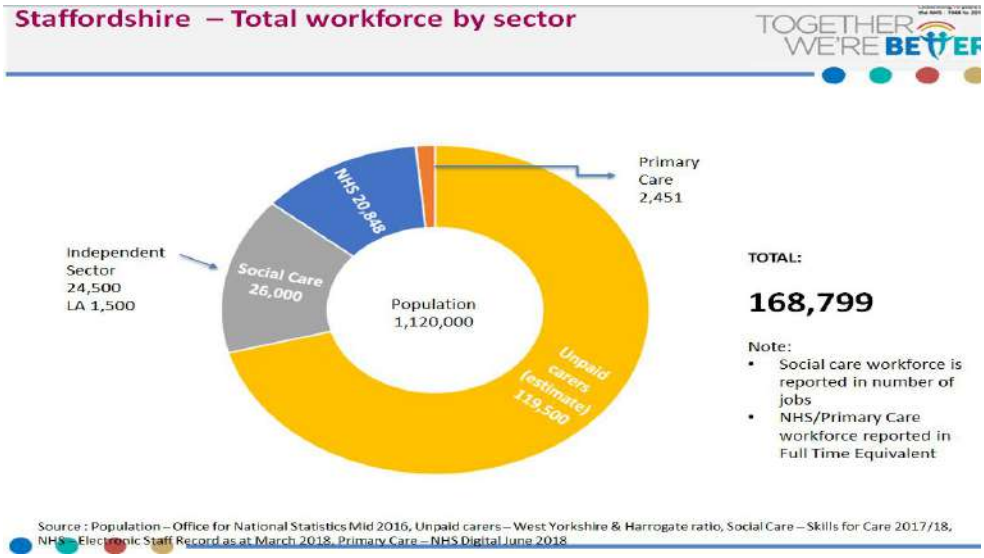
There are further practical barriers to integrating care, such as fragmented IT systems – meaning patient records cannot be shared – and competition between providers which prevents the formation of a collaborative culture. There are inconsistent arrangements for local accountability, and variation in how data is reported on quality outcomes. Patients are often moved across the health and care system from organisation to organisation, with no single point of accountability.

These cultural and leadership challenges mean that it is difficult to form a comprehensive strategy for quality improvement. There are many initiatives across Staffordshire and Stoke-on-Trent now looking to integrate care and dissolve organisation boundaries, however more work is required before a tangible improvement in quality, safety and patient experience will be seen.

[148] CQC, Staffordshire Local system review report, 2018

[149] NHS England, Long Term Plan, 2019

2.4 The scale of the challenge - Workforce



The health and social care services are facing significant workforce challenges, which apply equally to Staffordshire and Stoke-on-Trent. This is across all levels of staff, including medical, nursing, therapies and non- registered staff. Recruitment challenges on the front line can result in significant challenges to clinical sustainability, as well as financial stability due to an increased reliance on temporary workforce.

Our workforce is experiencing significant challenges, as demand growth outstrips the availability of health care professionals. Across the STP, there is a 10.9% NHS workforce vacancy rate, compared with 8.9% across the Midlands and East. There is a particular challenge in the medical consultant workforce, with a consultant vacancy rate of 16.1% in Staffordshire compared to 9.3% average in Midlands and East. Further to this, there has been a reduction in the nursing workforce of 264 FTE (-4.7%) since March 2013. There are currently shortages in children's social worker and educational psychologists (the numbers will be quantified via other work programmes).

The workforce challenges at a national level

The NHS nationally faces many workforce challenges, including:

- **Demand outstripping the growth in the workforce.** There are currently 45,000 clinical vacancies across the NHS [150].
- **Nurse training.** Health Education England commissioned 3,100 fewer adult nurse training places in 2014/15 compared to 2004/5, a reduction of 19%.
- **The impact of Brexit.** There has been a reduction in the supply of nurses from Europe and this could continue post Brexit[151].
- **Ageing workforce.** The nursing workforce is ageing, with 30% of nurses likely to leave in the next 10 years [152]. This is also well-documented within primary care, as outlined in Section 3.2[153].

[150] See https://www.hee.nhs.uk/our-work/workforce-strategy

[151] "Beyond Brexit: Assessing key risks to the nursing workforce in England", See https://www.rcn.org.uk/-/media/royal-college-of-nursing/documents/publications/2017/december/pdf-006625.pdf

[152] Institute for Employment Studies, 'One in three nurses to reach retirement age within ten years', 7 July 2016, www.employmentstudies.co.uk/news/one-three-nurses-reachretirement-age-within-ten-years

[153] 'The future of primary care', https://hee.nhs.uk/sites/default/files/documents/The%20Future%20of%20Primary%20Care%20report.pdf

The STP workforce team have carried out research across the sector into the reasons for high turnover and challenges to recruiting to our roles, and the feedback is summarised as:

2.4.1 Primary care

There are approximately 358 primary care nurses currently working in Staffordshire and Stoke-on-Trent. These staff members are supported by a number of other roles across a skill mix comprising of Health Care Assistants, Advanced Nurse Practitioners, Urgent Care Practitioners, Physiotherapists and Mental Health Therapists. There is a significant challenge in the recruitment and retention of these nurses due to the nature of the role (lone working with high responsibility) and the ageing workforce. The Primary Care nursing workforce will also be impacted by the overall reduction in nursing graduates and compounded by the fact that an additional qualification (Primary Care Nursing Fundamentals Course) is often required prior to obtaining a post in general practice. As at September 2018 – there were 12 full-time equivalent (FTE) primary care nurse vacancies and 4 (FTE) practice nurses due to retire.

The local NHS England Primary Care team have provided the following potential reasons for challenges in the Primary Care Nurse workforce:

- The inequity of funding aligned to GPN compared to the funding allocated to the GP workforce.
- Extra money or resources not available to back fill for training or development.
- A national shortage of nurses, removal of the student nurse bursary, plus changes to the NHS landscape are making it harder to recruit and retain GPNs
- The need to raise and promote the profile of Practice Nursing within General Practice as a first destination career.
- General Practice Nursing terms and conditions are not standardised to Agenda for Change, therefore, individual practices set their own Terms & Conditions including pay scales causing difficulty in retention.

The medical workforce in Primary Care has steadily declined which is partly driven by a high turnover rate, with medical leavers averaging approximately 11% of the workforce per annum between 2009 and 2017[154]. Retirement is commonly reported as the primary reason for staff leaving, which represents a broader challenge the NHS is facing with an ageing workforce. For example it is reported 30% of NHS nurses are likely to leave in the next 10 years [155], which is likely to affect primary care[156].

[154] Data provided by Staffordshire STP

[155] Institute for Employment Studies, 'One in three nurses to reach retirement age within ten years', 7 July 2016, www.employmentstudies.co.uk/news/one-three-nurses-reachretirement-age-within-ten-years

[156] 'The future of primary care', https://hee.nhs.uk/sites/default/files/documents/The%20Future%20of%20Primary%20Care%20report.pdf

There are a total of 577 full time GPs in the STP, with Stoke-on-Trent CCG accounting for the biggest share. At the time of reporting there were 85 vacant GP posts within Staffordshire and Stoke-on-Trent, which presents a significant risk in achieving the targeted additional 120 FTE is required by September 2020. Furthermore these issues are likely to be compounded with large numbers of GPs predicted to leave the profession in coming years for retirement, coupled with a previously limited number of GP trainees coming through.

Table 19: GP workforce in Staffordshire 2018

CCG	GP FTE
NHS Cannock Chase CCG	67
NHS East Staffordshire CCG	80
NHS North Staffordshire CCG	117
NHS South East Staffordshire and Seisdon Peninsula CCG	106
NHS Stafford and Surrounds CCG	69
NHS Stoke-on-Trent CCG	138
Total	**577**

The supply challenge will be compounded by any new models of care which depend on the GP workforce. A greater GP workforce is needed to deliver the NHS Long Term Plan of using primary care as a means to help avoid up to a third of outpatient appointments[157]. To establish a sustainable workforce, the STP needs to consider how to deliver the skill mix and roles required to ensure primary care can be sustained.

Urgent and emergency care

Nationally there is a shortage of emergency doctors (particularly consultants) and steps have been taken locally to address this problem by skill mixing with various training and non-career grade colleagues.

Within the emergency department there are challenges recruiting to both the medical and nursing workforce as shown by the workforce profiles outlined below

UHNM A+E Workforce Data January 2019

[157] NHS England, NHS Long Term Plan, 2019

A&E Staff Group	M10 2018/19 Budgeted WTE	M10 2018/19 Staff in Post	M10 2018/19 Vacancy WTE
Medical	94.77	82.83	11.94
Nhs Infrastructure Support	49.06	40.07	8.99
Qualified Nursing	200.55	170.62	29.93
Scientific Therap & Tech	4	2.8	1.2
Support To Clinical	108.85	97.59	11.26
Grand Total	**457.23**	**393.91**	**63.32**

Burton Hospitals A+E and Emergency Workforce Data as at January 2019:

The information below is a summary of the emergency department information at Queens, Samuel Johnson and Sir Robert Peel Hospitals.

Row Labels	Sum of Budgeted	Sum of Contracted	Sum of Vacancy
BURTON	**3,049.44**	**2,775.15**	**274.30**
Admin & Clerical	**905.19**	**848.47**	**56.72**
Allied Health Professionals	**220.84**	**214.57**	**6.27**
HCAs & Support Staff	**466.03**	**409.06**	**56.97**
Medical & Dental	**335.81**	**290.59**	**45.22**
Nursing & Midwifery	**982.73**	**881.20**	**101.54**
Other Non Clinical	**41.65**	**34.97**	**6.68**
Scientific Technical & Therapeutic	**97.19**	**96.29**	**0.90**

The high vacancy rates in medical and nursing for Burton hospitals are having a significant impact on agency spend which is high in both areas. To adapt to the high vacancy rate, new roles are being tested across the STP. The minor injuries units at Leek Hospital, Samuel Johnson and Sir Robert Peel Community Hospital sites and a walk-in centre at the Haywood Hospital are staffed with Advanced Nurse Practitioners, Nurse Practitioners and registered nurses and support workers. At Samuel Johnson and Sir Robert Peel, their work is overseen by GPs via partnership working with a local practice. GPs are also utilised to see appropriate patients and support the A&E out of hours. There are significant challenges in the overall supply of GPs locally as described previously.

Community care

The majority of the workforce in Staffordshire and Stoke-on-Trent that support the health and care of its residents work in the community. Although a significant proportion of these are employed by the NHS and Local Authority; the majority are employed by the voluntary sector.

The NHS workforce are grouped into integrated local care teams. The innovative Integrated Care Team model was piloted across Staffordshire and Stoke-on-Trent from July 2018 and has now been developed into the "Living Well Model." This will combine the working of community teams across organisational boundaries and will result in significant economies of scale for workforce. The NHS community provider has challenges in recruiting and retaining its nursing, therapies and non-registered workforce in a trend that is reflective of the whole STP. The biggest challenge for all providers of health and care in the community is the supply of registered nurses at band 5 and domiciliary care workers. There is an ageing workforce; the majority of the NHS providers' the non-registered workforce is over 50; 80% of nurses in social care are over 50 and the majority of nurses in the NHS are over 50. Furthermore turnover is high with Staffordshire and Stoke-on-Trent having a higher than average number of nurses leaving the area for find jobs elsewhere.

The Home First model of care, which aims to support people to leave hospital earlier and support people so they don't need to go to hospital, has helped reduce the challenges of providing sufficient capacity and capability in the community-based workforce because the skill-mix required to deliver this model of care is more sustainable. We need to maintain the progress made and ensure that our workforce has the right size and skills to meet future demands.

Social Care

The social care workforce in Staffordshire is made up of staff who work for a variety of providers, such as for the NHS, Local Authority, Primary Care and Third Sector (voluntary and independent). There are also a significant number of carers who support their friends and family in Staffordshire.

The social care workforce faces a number of challenges. As Figure 19 below shows, the ratio of social care workforce per 1,000 population is less than the Midlands & East average, which could suggest the STP may struggle to provide the quality of social care which is comparable to its peers. The ability to build staffing numbers could be inhibited by a large number of vacancies, with 5.1% of social care positions vacant, although this is slightly better than the Midlands & East average of 6.7%.

Figure 19: Social care workforce per population[158]

Type	Staffordshire STP	Midlands & East average
Per 1,000 population	23%	25%
Per 1,000 population aged 70+	165%	189%

There are numerous independent/voluntary organisations which provide staff to care for the people of Staffordshire. This is primarily in the form of domiciliary care workers and personal assistants. Skills for Care* estimate that in Stoke-on-Trent 3.5% (300 vacancies) and Staffordshire 5.8% (1200 vacancies) of the roles in adult social care were vacant. The workforce in independent domiciliary care organisations is very transient and Skills for Care report that the turnover rate is up to 29.7%* in some areas. Not all of the turnover results in workers leaving the sector, of the new starters in this area over three quarters (78%) were recruited from within the adult social care sector, i.e. a significant number of carers do move from one agency or provider to another.

[158] Sources: Skills for Care (SfC), Social Care Data –August 2017 Report

Both recruitment and retention are challenges, mitigated but not fully resolved by a range of co-ordinated recruitment, training and support offers. While the level of challenge in recruitment and retention does vary across the different geographical locations in the STP area, common themes include competition for this workforce from other employment sectors, pay rates, the requirement to work unsocial hours and, for some, lone working. Furthermore the rate of sickness is higher than average in Stoke-on-Trent with the average number of sickness days taken being 7.6 annually (5.4 nationally and 4.7 regionally).

2.5 The scale of the challenge - Finance and Efficiency

The new funding settlement announced by the Prime Minister in June 2018 promised NHS England's revenue funding would grow by an average of 3.4% in real terms a year over the next five years delivering a real terms increase of £20.5 billion by 2023/24. This represents a step change on recent years, which have averaged 2.2%, and moves closer to returning to the NHS long-term average funding trend of 3.7% per year since 1948. Despite these funding rises, the challenge remains significant, with a sector deficit of £960m at the end of the 2017/18 financial year[159].

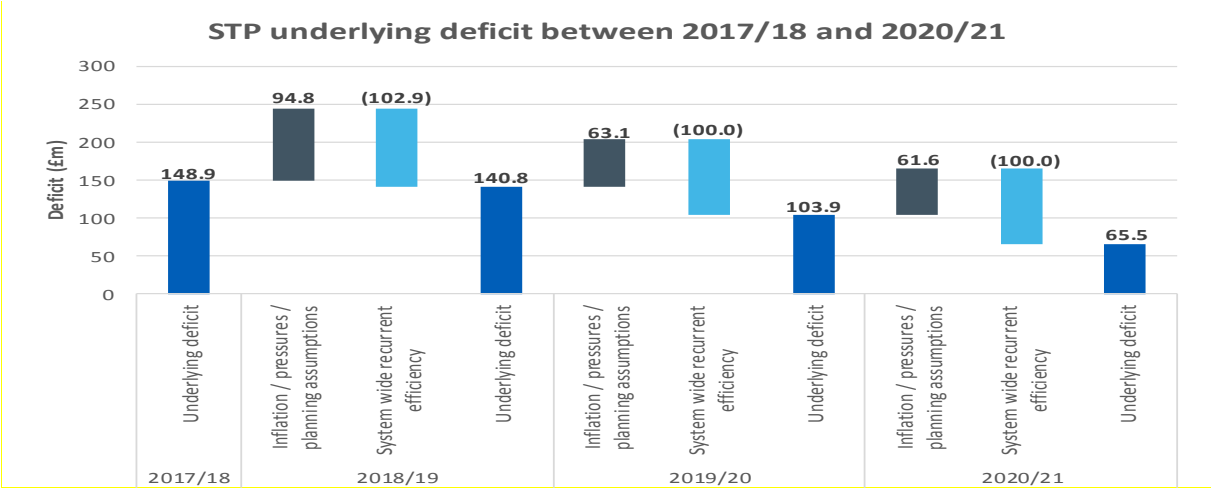
As a system, and in common with many parts of the NHS, we are currently spending more money than we are receiving. In 2017/18, Staffordshire & Stoke-on-Trent STP had a deficit of £112.6m. When considering the efficiencies we are planning over the next few years, we expect there will be a recurrent deficit of £65.5m by 2020/21. This deficit is driven by high levels of avoidable admissions, high cost of urgent and emergency care, multiple access points, duplication of services, and too much estate.

Challenges outlined in our quality and workforce have resultant impacts on our finances. For example, North Staffordshire Combined Healthcare has a workforce of 1255, with MPFT combining staff from South Staffordshire and Shropshire of 3298 and SSTOP of 3571 with the Trust having a staff absence rate of between 4% and 5%. The STP has agreed that the workforce sustainability strategy will initially focus on primary care. It will then proceed to ensure mental health, social care and community workforce planning aids efficient development of emergency and urgent care pathways[160].

Our financial challenge is likely to grow as inflation and demand growth continue to outstrip increases to funding. This is unsustainable and we need to make changes to address this.

The following graph shows the annual impact of the cost pressures and efficiency assumptions to the underlying deficit between 2017/18 and 2020/21.

Figure 20: STP financial analysis



As a system, we must recognise that our current operating model is not sustainable. Significant work is to be undertaken to deliver the planned mitigations, as well as seeking further mitigations to bridge the residual gap.

Health financial year 2019/20 planning

[159] NHS Improvement. Performance of the NHS provider sector for the year ended 31 March 2018. https://improvement.nhs.uk/documents/2852/Quarter_4_2017-18_performance_report.pdf

[160] TWB STP

As the STP plans for the immediate financial years, the underlying system deficit at the end of 2018/19 is estimated at a deficit of circa £200m. Work undertaken by system leads currently estimates baseline budgets in 2019/20 increasing by over 8%. Staffordshire and Stoke-on-Trent CCG allocations for 2019/20 are increasing by an average of 5.6%. As a result, given the underlying 18/19 STP deficit of circa £200m, the shortfall between projected expenditure growth (as a result of demand and inflation) and income growth, means that there is an estimated gross 2019/20 deficit of circa £245m.

NHSE and NHSI have set control totals for all STP organisations for 2019/20. On an aggregated basis, the STP has an £88.1m deficit control total. To deliver this system control total means a saving requirement of over £157m on the estimated 2019/20 baseline deficit. This is equivalent to a saving of over 6.0% to deliver the 2019/20 deficit system control total, and over 9.0% to deliver an overall breakeven position.

Work is underway to identify saving opportunities. Currently, a significant proportion of the savings required to deliver an £88.1m 2019/20 deficit control total is unidentified.

The planning for the next financial year further outlines the current status quo as not being sustainable, and the need for a system wide change to mitigate the gap.

Local authority financial year 2019/20 planning

Staffordshire County Council

Staffordshire County Council is spending a record amount on social care for a growing ageing population and children in care as national funding is reducing: 10 years ago SCC spent around £200m [net] on adults' and children social care services; for 2019/20 this figure exceeds £315m. Government funding on the other hand is reducing: the revenue support grant allocated to Staffordshire County Council has reduced from £150m in 2009/10 to £10m in 2019/20 and zero after that.

In 2017/18 and 2018/19 Staffordshire County Council levied the maximum level of Council Tax increase, without requiring a referendum, including the maximum 3% adult social care precept, in order to replace funding lost from the Revenue Support Grant. Our planning assumptions continue to assume that the increases levied each year will be up to the referendum principles which are announced annually, making planning difficult.

Local authorities have a legal obligation to set a balanced budget. Work began in March 2018 to identify savings in order to balance the budget and close a £35m p.a. financial gap. The 5 year Medium Term Financial Strategy approved by the Council in February 2019 includes savings proposals which rise to £62mp.a., but also includes use of general balances. These are currently lower than the risk assessment requires and exposes the Council to huge risk. An amount of one-off resources totalling £28m is required to balance the budgets in both 2019/20 and 2020/21 and to fund the redundancy costs that will be incurred as a result of the savings options.

Specifically, for adults and children's social care savings of some £38m p.a. are required to be delivered by 2023/24. On top of this are significant risks around rising costs of social care and management of the provider market.

For 2019/20 Staffordshire County Council have set a balanced budget which includes savings proposals of £40m. Specifically, for adults and children's social care savings of some £19m are required to be delivered in 2019/20. Consultation is required with staff and the public and there is an expectation that service standards will reduce.

Stoke-on-Trent City Council

In line with local authorities across the country the financial challenge facing Stoke-on-Trent City Council over recent years has been very significant, with the council experiencing a 28% cut in spending power in cash terms between 2010/11 and 2017/18. The council has delivered savings of £194m between 2011/12 to 2018/19. The challenge

remains substantial with an initial savings requirement of £18m in 2019/20 against a net general fund budget of £218m.

The City Council is continuing to grow the economy and invest in the area to attract jobs, businesses, residents and visitors. More money is being generated through more new people paying council tax and business rates and the additional income it has generated is being reinvested to support the provision of essential services valued by residents. After taking account of additional income projections in relation to council tax and business rates and the full year impact of savings implemented in 2017/18 and 2018/19, savings totalling £12.8m are required in 2019/20.

The demands and challenges facing social care continue to increase in line with national trends. The numbers requiring support, the complexity of need and the associated costs continue to rise. In balancing these challenges significant investment continues to be made in social care services with £138.2m being allocated to support the vulnerable in 2019/20.

Funding beyond 2019/20 remains uncertain which makes longer term planning challenging however the government intend to implement the Fair Funding Review for the 2020/21 financial year via the local government finance settlement process. Indicative allocations to individual authorities are expected to be available autumn 2019. The funding forecasts for 2020/21 and beyond will be updated and refreshed as further details emerge.

STP System wide contracting approach

Work has progressed via the STP on an Intelligent Fixed Payment System (IFPS) which is a different contractual approach to 2019/20 that shares risk across the system and seeks to minimise investment expectations against the growth allocation. It is based on collaboration not competition with the NHS National Tariff arrangements being set aside between the intra STP partners in 2019-20 enabling the system to concentrate on the cost of providing healthcare within the County, and in bringing the whole health system back to clinical, operational and financial balance.

A transformation programme is in development supported to identify opportunities to reduce capacity and demand and the resultant cost to the system. This is backed up by work on major programmes including frailty, end of life care, population health management and alignment of incentives and removal of financial barriers to integrated care.
This approach is not without risk but the IFPS by nature of fixing payments to STP based providers attracts a lower degree of financial risk by facing challenges together on a collaborative basis whilst supporting delivery in a safe and operationally balanced environment built on jointly owned Transformational schemes with STP partners.

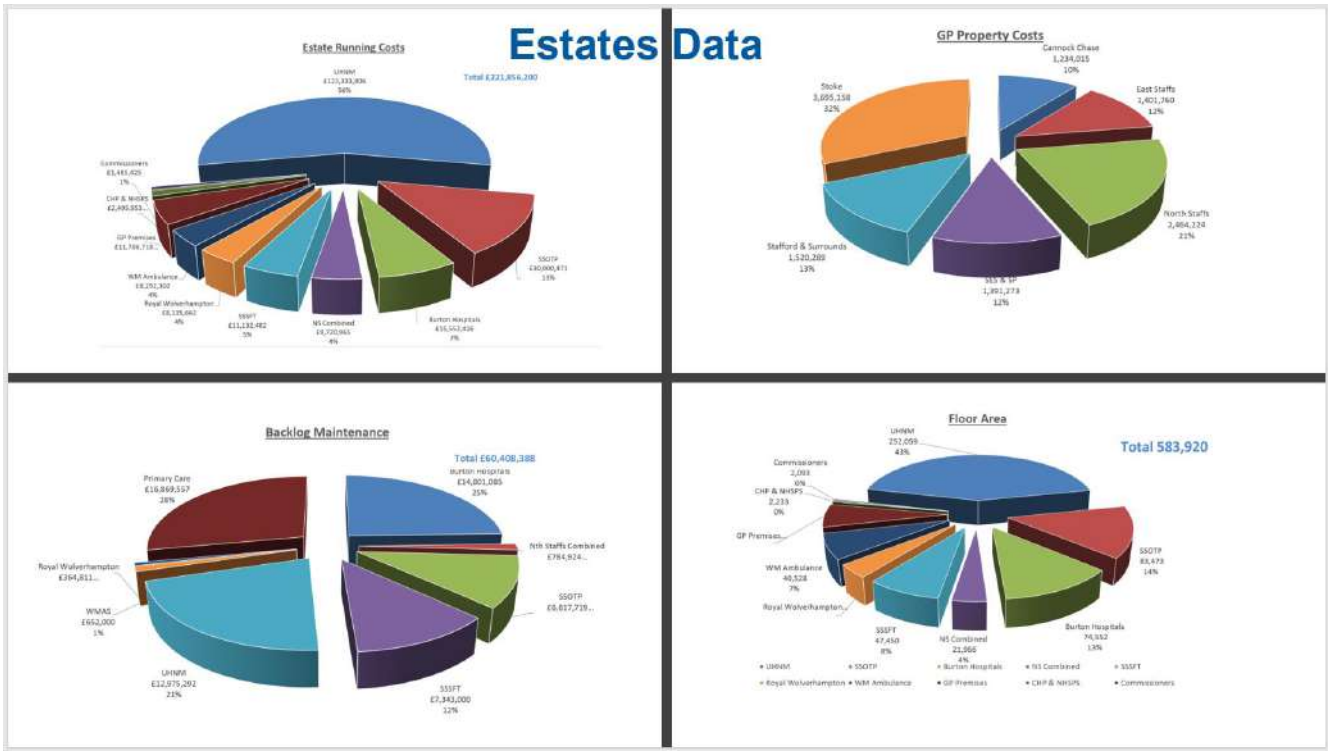
The work on the fixed payment system only provides a way for collectively managing the financial risk. The 2019/20 systems programmes will underpin the short term improvement in our financial sustainability, however, the medium long term financial sustainability requires us to ensure we are using resource most effectively to improve health outcomes for our population. These major services changes in the model of care are part of our objective to deliver the most appropriate care to our populations in a way that supports financial sustainability.

Although financial sustainability is not the primary reason for developing these new models of care, demonstrating that the outcomes of the model of care will increase the financial sustainability of the system will an important outcome.

2.6 The scale of the challenge - Estates

Ensuring that we have an estate that is fit for purpose going forward is a major challenge. Currently, there are significant levels of backlog maintenance whilst going forward the current estate is not fit for purpose to deliver the five year forward view and develop the new models of care set out by the STP.

The headline figures are shown in the charts below.



Significant parts of the estate are in need of complete renewal and require high levels of investment.. As a key component of the estates strategy are the development of integrated community hubs and care villages that support integrated solutions across NHS services and partner organisations. The redevelopment of the estate will allow this to be realised. However, this will require access the necessary levels of capital funding to achieve the ultimate goals.

A summary of the key drivers and challenges facing the estate is contained within the next table.

Drivers for Change	Estates Impact
Population growth	• Additional GP practices incorporated within community health facilities wherever possible. • Integration of GP and community care at scale, provided through multi-specialty centres.
The financial challenge across the health economy: must be addressed, but the quality of service must also be maintained	• Estate savings and efficiencies needed to assist reduction in spend on infrastructure. • Modern, purpose-built premises with bookable spaces for use by many providers will ensure quality of provision.
Need to drive efficiencies via closer work with provider organisations	• Integrated, multi-specialty healthcare centres provide potential solution, including greater efficiencies in administrative services.
Pockets of multiple deprivation, with high levels of high-risk behaviours and multiple conditions	• Use of the estate for preventative measures can be achieved through reconfiguration. • Multi-speciality centres needed for frail elderly and those with Long Term Conditions/complex needs.

A system approach is required to achieve the maximum outcomes. Reconfiguration of the estates will respond to the following:

- Enhancing the patient journey with an improved quality estate, greater access to primary care and integrated community based services
- Integration with local authority services is increasingly important
- The NHS needs to identify significant revenue savings that cannot be found through efficiencies alone, but through whole system and service redesign with a specific focus on integrated health and social care, greater levels of care within communities and new commissioning models
- A sustainable funding solution for estate improvements is required
- Significant revenue cost and capital may be tied up in underutilised and inefficient estate which is often not in the right location to deliver the necessary services to the local population
- Implementation of improved methods of clinical delivery through changing care models incorporating technology to provide patient care to a widely dispersed population and reduce costs
- Key consideration of the One Public Estate and introducing drivers for change through collaborative working with other organisations

Issues facing the primary care estate

General practice in England is under pressure. The traditional GP partnership model, which currently serves an average of around 6,650 patients per practice, is widely acknowledged to be too small to respond to the financial and demographic challenges facing the NHS.

Small practices have limited infrastructure to improve access and address variations in quality. They are vulnerable to marginal reductions in income and have insufficient staff to respond to new clinical, administrative and regulatory demands. Policies to avoid hospital admissions and discharge people earlier from hospital have resulted in more acutely ill people needing care in the community. But small practices may struggle to provide high-quality care for

these patients because they lack formal links with other services and organisations. The resulting pressure on GPs, and frustration for patients and carers as they move between poorly coordinated teams of professionals, has been well documented.

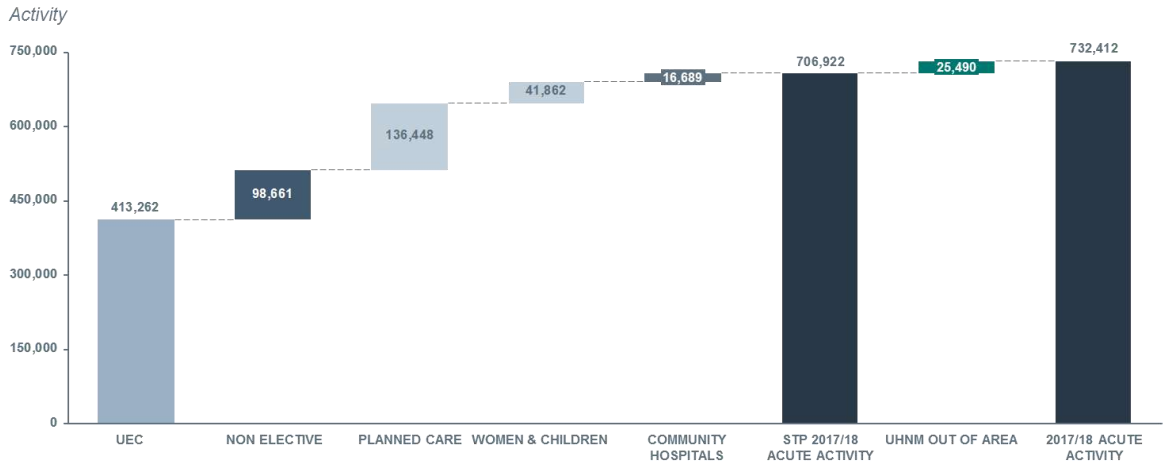
3. Capacity and demand forecasting

These increasing challenges for the system mean that pressures across the NHS (acute, primary and community) are likely to increase. An analysis of current and future activity has established how these pressures may increase, as shown in the figures below.

3.1.1 Acute services

The overall acute urgent and emergency care attendance and non-elective and planned inpatient and day case activity in the footprint is estimated to be 706,875, with UHNM out of area activity is estimated to be 25,490. This is included in the analysis due to the associated capacity required for this activity. Outpatients account for a further c.1.65m attendances however this isn't included in the below figure

Figure 21: Together We're Better acute services activity 2017/18



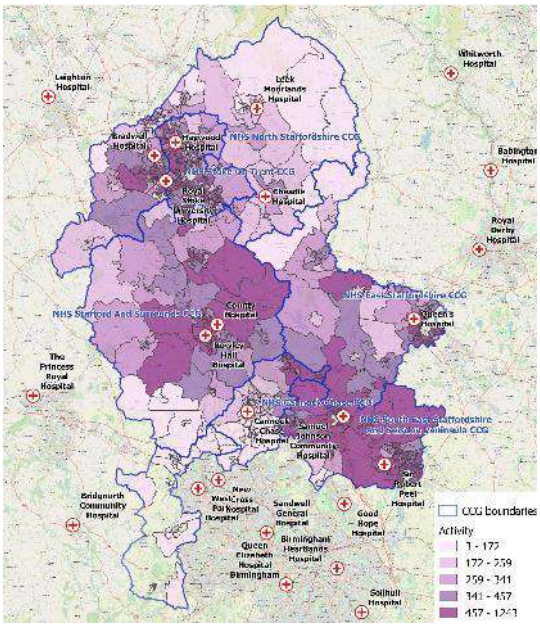
For acute services, the figure above shows that despite increased efforts in out of hospital care provision, if nothing is done, there is likely to be a growth in acute activity due to demographic and non-demographic growth. An increase in activity with rising admissions and increasing numbers of delayed transfers of care can result in high bed-occupancy rates.

Figure 22 below presents A&E UEC admissions across the STP in 2017/18. the first map shows the flows of activity by STP footprint residents to sites within the footprint. The adjacent figure, presents the flows of STP footprint residents to sites outside the footprint.

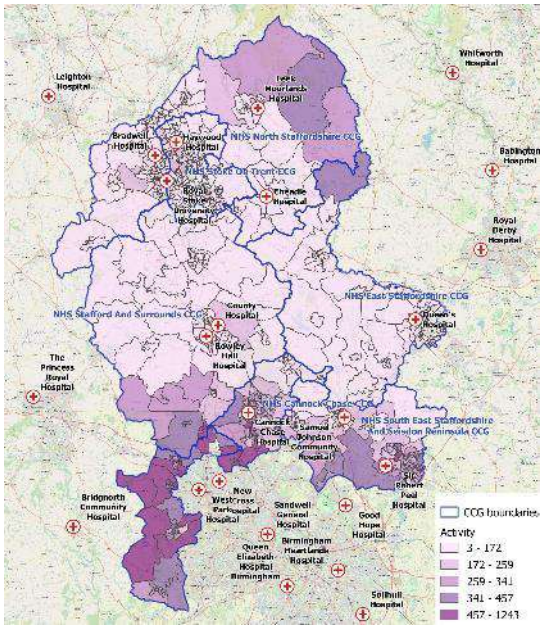
The maps show there is a concentration of elective, non-elective and emergency activity going to providers within the STP from densely populated areas such as Cannock, Stafford, Stoke-on-Trent and Tamworth. There are also many patients located within the southern areas STP going to providers outside the footprint, possibly because of their close proximity to neighbouring sites such as New Cross Hospital and West Park Hospital. Similar patterns are seen for non-elective, elective and women & children admissions (located in the annex)

Figure 22: A&E UEC admissions 2017

Activity going to providers within footprint



Activity going to providers outside footprint



There has been a national increase in emergency admissions due to a rise in the number of attendances and due to an increased proportion of admission to hospital with an increased from 19% in 2003/4 to 27% in 2015/16[161]. This highlights the importance of finding alternative ways to manage demand and treat patients quickly and efficiently once they are admitted. Without changes, hospitals across the system will increasingly be under pressure particularly given further pressures due to population growth. This will result in significant pressures across Staffordshire and Stoke-on-Trent. The overall impact of doing nothing is shown in the following graphs.

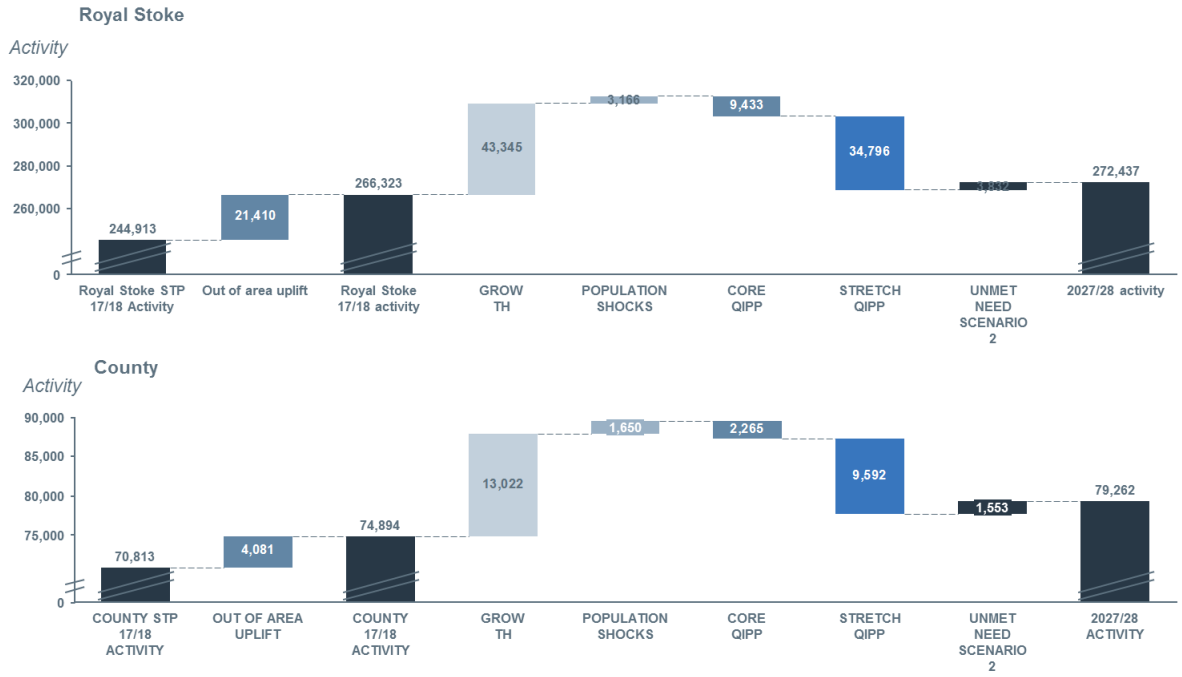
The overall impact of acute provision within the STP is shown in the following figures. Acute providers in other STP footprints have undertaken a similar analysis of the demand across those STP footprints which highlight similar issues regarding growth across the acute sector.

Figure 23: Together We're Better acute services do nothing activity 2027/28

[161] https://www.kingsfund.org.uk/publications/hospital-activity-funding-changes

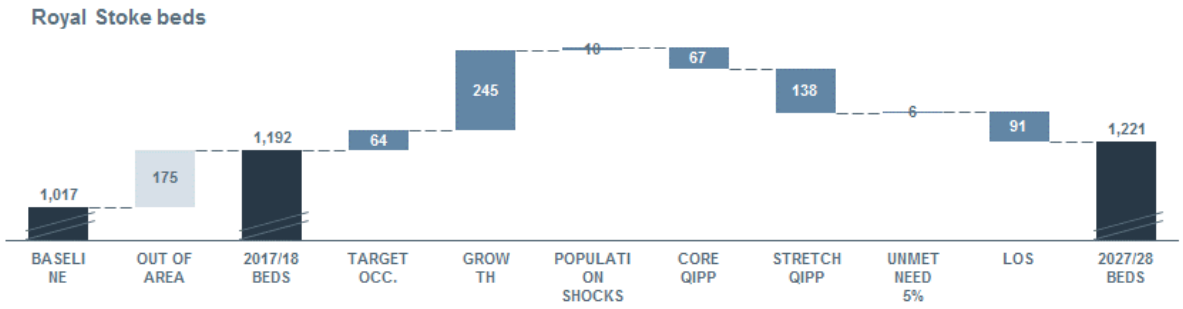
This also applies to UHNM, where a similar growth profile can be seen for both Royal Stoke and County hospitals.

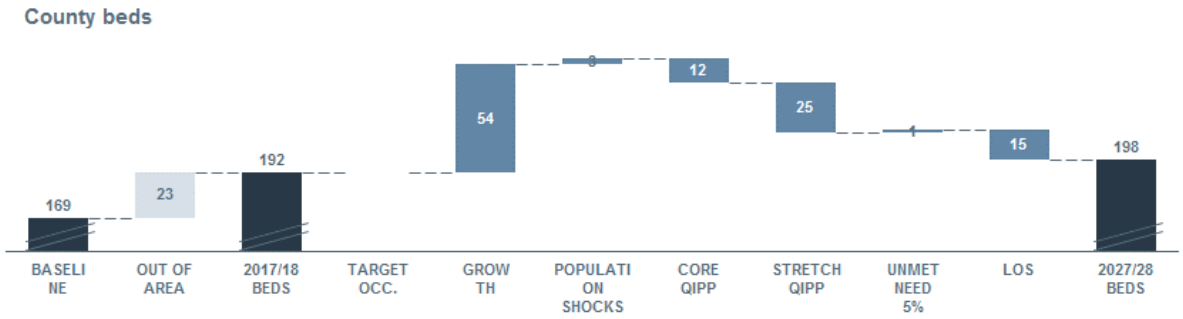
Figure 24: UHNM sites acute do-nothing activity 2027/28



This increase in activity will place further strain on resources in the acute, and has an impact on the bed numbers required at UHNM acute sites, as shown in the figure below

Figure 25: UHNM do nothing bed requirements





Some of the change in demand could be attributed to demographic changes due to an increasing population, the rise in people living with multiple long-term conditions and patients' rising expectations. There is growth in acute activity across all boroughs, however, some boroughs show a higher rate of increase than others, in part due to population shocks (such as new housing developments).

Table 20: Acute activity for do nothing across boroughs

Local authority	Baseline	Growth	Population shocks	Core QIPP	Stretch QIPP	Unmet need	2027/28
Tamworth	46,737	5,678	-1,168	-902	-2,724	214	47,835
Staffordshire Moorlands	30,095	5,600	1,631	-1,045	-3,132	434	33,583
Stafford	60,701	11,114	2,511	-2,079	-6,554	837	66,529
South Staffordshire	46,095	8,300	-806	-1,403	-4,495	438	48,130
Newcastle-under-Lyme	85,810	14,475	-660	-1,719	-5,270	544	93,181
Lichfield	54,937	8,800	704	-1,109	-3,328	376	60,381
East Staffordshire	52,806	9,241	4,396	-1,958	-6,139	468	58,815
Cannock Chase	48,528	7,080	405	-1,159	-3,785	413	51,483
Stoke-on-Trent	117,805	19,022	1,601	-3,991	-12,293	1,027	123,171

Local authority	Baseline	Growth	Population shocks	Core QIPP	Stretch QIPP	Unmet need	2027/28
Unknown local authority*	163,361	28,228	0	-4,893	-9,413	5,616	182,899

3.1.2 Community services

Moving care into the community is a challenge; despite the increased emphasis on providing care out of hospital and closer to people's homes, the system has maintained a focus on the acute sector.

Furthermore, demand and activity have risen across all the services, not just the acute sector, and this increase has been sustained. This further emphasises the need to find ways to moderate rising demand across the system.

Figure 26 below show community admissions across the STP in 2017.

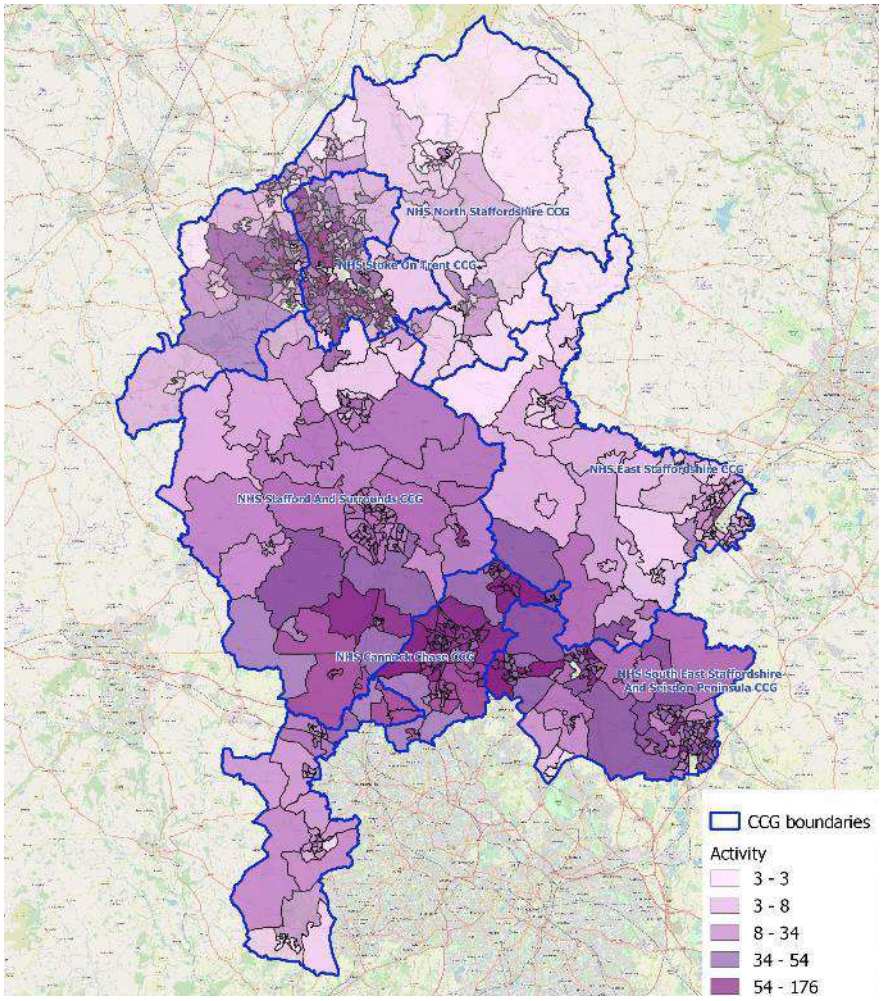


Figure 26: Community admissions 2017[162]

The analysis below shows current community activity, focusing particularly on outpatient contacts and Home First contact hours.

'Home First' approach brings together Discharge to Assess and the Track and Triage interventions, along with short-term intensive rehabilitation input. The service provides clinically-led interventions such as community nursing or physiotherapy in the community to optimise independence, prevent unplanned admissions and support timely

[162] Based on HES admissions data. Note, any counts for a given LSAO by provider less than 5 is supressed.

discharge, including providing any appropriate equipment. The service covers patients regardless of their normal place of residence, and so includes care home residents.

The figure below shows outpatient care contacts at MPFT. Community outpatient activity at MPFT accounts for c.1.3m care contacts and a further 163,005 Home First contact hours (over six months where reliable data is available). There are additional discharge to assess beds commissioned in care homes. This pool of beds is flexible with beds opened and closed as needed.

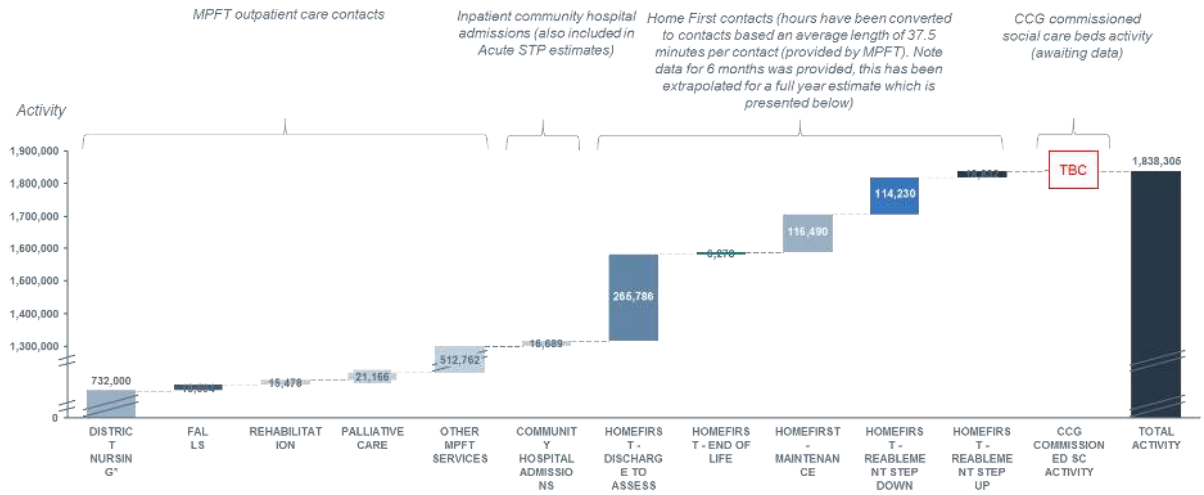


Figure 27: Community baseline activity

While community services are more sustainable, an increased local, regional and national emphasis on out of hospital care means that further activity is likely to move into this sector. It is essential to ensure that there is sufficient capacity to meet this demand.

3.1.3 Care home resilience

There are also pressures on care homes which form a critical part of the care system and are increasingly integrated with the delivering of community services.

Staffordshire

Social care providers in Staffordshire, typically small or medium sized independent businesses, are struggling in the face of costs which are rising faster than local authorities' ability to increase funding as well as difficulties in recruitment. This is most evident in general nursing and residential care for people with dementia. There are particular 'hotspots' where analysis shows that there is a shortfall in capacity either currently or likely to emerge over the next 5 to 10 years.

Stoke-on-Trent

There is a diverse Care Home market in Stoke-on-Trent catering for younger adults and older people. It is generally recognised that recruiting appropriate numbers of staff and retaining them is proving a challenge across all care services, and care homes is no exception. There is a challenge to maintain staff, and ensure that there are continually growing levels of expertise in the sector. There have been some concerns raised about financial viability of some care homes. Increased vacancy numbers, due to decline in residential referrals or, sometimes, following suspensions of new referrals to a home due to concerns raised, can add to these financial uncertainties, and much is

being done by Stoke-on-Trent City Council to consider its contractual terms and financial offer to mitigate this for the future. In the main, the market has good and supportive links with the City Council and there is a record of effective improvements being rendered following issues being identified and remedial action, directed by the Local Authority, being completed. There is currently one care homes under Large Scale Enquiry (LSE) and there is an ongoing target to increase the number of homes that are Good and Outstanding and further work with the market is planned to realise this.

Table 21: Current Care Home Provision with Staffordshire and Stoke-on-Trent [163]

	Nursing home		Residential home		Total	
	Total homes	**Total beds**	**Total homes**	**Total beds**	**Total homes**	**Total beds**
Staffordshire	79	4,256	175	3,458	254	7,714
Stoke-on-Trent	19	1,169	69	1,277	88	2,446
Local health economy	98	5,425	244	4,735	342	10,160

Local authorities' aim to only place residents in care homes where other options to help people retain independence within either their own home (through use of family networks, community support, voluntary sector services or commissioned domiciliary care) or another suitable setting (e.g. group supported living or extra care provision) has been exhausted. This section reads as if care homes are the only options for residents.

An unstable care home market can result in system-wide challenges, for example when a care home provider fails. This can impact the number of delayed transfers of care from acute and community service, further increasing occupancy rates and preventing patients flowing to a place more appropriate for their needs. A sustainable care home market is therefore critical to effective acute and community services.

[163] Care Home Strategy, November 2018

4. Proposed model of care

Together We're Better's vision is to make Staffordshire and Stoke-on-Trent the happiest and healthiest place to live and work. We know this is a bold ambition, one that can only be achieved by working in partnership with our communities.

Since the development of our original Case for Change in March 2016, we have begun to see a transformation in the way health and care services are being delivered in Staffordshire and Stoke-on-Trent. Our partners are spearheading a new approach towards integrated working that brings together a range of primary, community and mental health services, alongside social care professionals and the voluntary and independent sector – enabling a coordinated, local approach to improving the health of the community they serve.

By working in this way, we can help more people to lead healthy and active lives, to remain independent for longer, and to predict personal needs and plan care to prevent problems from arising. This in turn will reduce the need to attend or stay in hospital and cut the length of time a patient spends there. We know that long, unnecessary stays in hospital not only lead to poorer outcomes for patients, but also prevent hospitals from focusing on the important role they play in managing critical and life-threatening conditions.

We have described the health and care challenges we are currently facing in Staffordshire and Stoke-on-Trent, both from a clinical and financial perspective. In this section, we highlight further opportunities to address some of the issues outlined previously, which we want to explore as part of the next phase of transformation through Together We're Better with the intention of developing potential solutions alongside our patients, local communities and staff.

The NHS Long Term Plan (LTP) was published at the beginning of 2019, and set out key ambitions for the service over the next 10 years.[164] We are committed to delivering the aims of the LTP, all of which will have implications for how we deliver care within the Staffordshire and Stoke-on-Trent. The commitments made by the NHS in the LTP align to the drivers of our Case for Change and our vision for the model of care, providing further impetus for our local health and care system to take action and deliver improvements in outcomes and quality for our local population.

To meet the changing demographic demands for care and make sure people's outcomes continue to improve, we must transform the way in which care is provided to ensure people are cared for in the right place. We have developed this model of care to address these challenges and provide the benefits of holistic, integrated care to our population. Through our clinical model, our vision is to ensure that our population will have:

- Access to **urgent and emergency care services** that are appropriate and deliver that care within the right setting. This includes working with other parts of the system to ensure that people are not having to access urgent and emergency care for exacerbations of conditions that should be managed in other ways;
- **Care integrated around the individual**, delivered as close to home as possible;
- **Integrated and efficient complex care pathways** that are simple to navigate, with rapid access to specialists and diagnostics; and
- **Enhanced primary care and community services**, aiming for continuity of care pathways which will be improved by working alongside social care and the voluntary sector.
- **We are supporting care that provides integrated mental and physical health services within the community.**

Our model of care aims to achieve improvements across primary and community care, urgent and emergency care, planned care, maternity and mental health.

What will be different for patients?

[164] NHS Long Term Plan

We expect that implementing this proposed model of care will generate benefits to patients, professionals, and the wider healthcare system. Overall, our proposed model of care seeks to improve patients' outcomes and access to clinically sustainable and appropriate care as an alternative to acute hospital admission or prolonged inpatient stays.

The model of care has been designed from the perspective of patient needs across an integrated pathway rather than through individual service offerings. The model of care will also address specific, often system-wide, issues that have traditionally prevented collaborative and patient-focused ways of working. It will:

- Help people recover quickly so their independence can be restored as quickly and safely as possible;
- Focus on reducing the number of patients presenting at A&E/Emergency portals with exacerbations in their condition(s), and reducing the number of avoidable non-elective admissions to hospital through proactive case management at a locality level;
- Reduce unnecessary admissions and expedite discharges, decreasing the time spent in acute hospital;
- Help people more effectively live with and manage one or more long term health condition
- Give people real choice to die in their preferred place of residence without unnecessary admissions to hospital;
- Address the fragmented care pathways across our area;
- Allow resources to flow to parts of the system best able to react to current and projected demand.
- Allow more efficient and appropriate diagnosis and treatment, improving transfer times
- Enable integrated care to operate seamlessly across primary, community and mental health care as an integrated model of care and case management; and
- Integrate seamlessly with social care provision to wrap services around individual patients.

This model of care will therefore address the challenges set out in our Case for Change and provide the benefits of holistic, integrated care to our population.

We are making no assumptions at this point in time in regard to specific site or location of services outlined within our models of care. The implications for sites will be outlined through the process of developing the long-list and refined short-list of potential options.

Design principles

For each of the following programmes we have applied the following design principles:

- Accessibility – Service users will receive the right care, in the right place, at the right time.
- Quality – Services will meet the needs of the individual, are consistently high quality and cost effective.
- Equality – Services will offer equitable care to our population.
- Consistent service delivery – Services will developed to reduce variation in service provision and provide continuity of care
- Choice – Service users will be offered a person centred approach with more choice and control.
- Parity of esteem – Services will be developed that value mental health equally with physical health
- Financial sustainability.

The logic models for the programmes can be found in the appendices.

4.1 Developing a new vision for health and care in Staffordshire and Stoke-on-Trent

Integrated care teams and community hubs

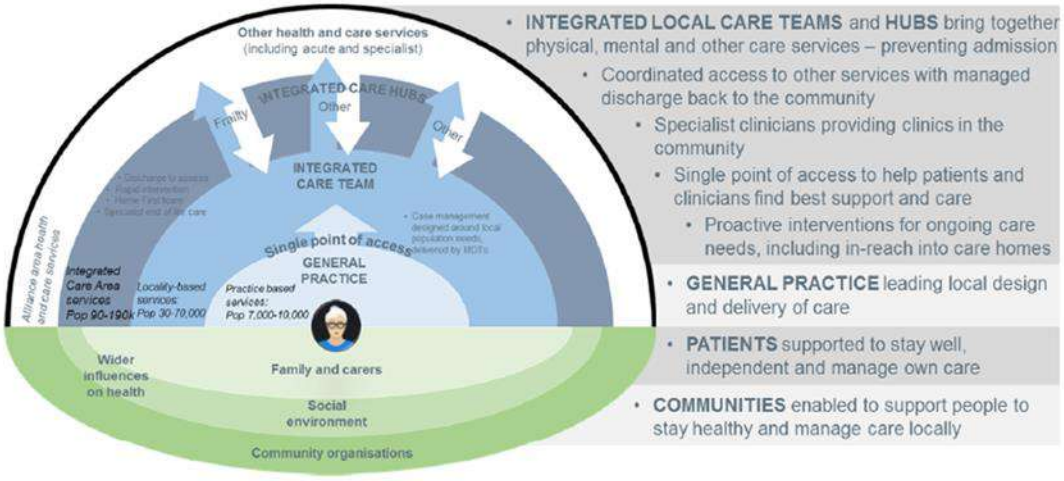
We want to start our vision from where they are, at home and in their communities. This recognises that community and primary care services will be key to support people to remain at home and able to get on with their lives in their communities.

We need to review our community service offer to ensure patients are treated effectively in the most appropriate setting for their needs. A large number of patients are ending up and spending too long in our acute hospitals and are ending up in community hospital beds, waiting for other appropriate services.

In line with the Long term plan, we will develop a new service model to integrate primary and community care. Integrated care is central to our vision for the whole of Staffordshire and Stoke-on-Trent. Integrated Care Teams (ICTs) will operate seamlessly across primary and community care, the voluntary sector and social care to wrap services around individual patients. Larger integrated care areas across our geography will contain multiple ICTs and provide enhanced access to general practice and integrated care hubs.

Integrated care hubs will form the base for ICTs, provide diagnostics and specialist elements of care and focus on in-reach to care homes. Based on the nationally recommended model, our Home First approach brings together discharge to assess and the Track and Triage interventions, along with short-term intensive rehabilitation input. In this way, integrated care teams and community hubs will allow more patients to be treated at home and be discharged from hospital earlier, reducing admission rates and decreasing length of stay. There will be the focus for the improved management of dementia and frailty, including in-reach into and support for care homes and provision of memory clinics.

This model is summarised in the figure below:



Integrated care provides the following benefits

- Improved access to physical and mental health, learning disabilities and social care services
- A single joined-up service around the service user and their family – creating less confusion when individuals are at their most vulnerable
- Reducing confusion, duplication and enabling better care co-ordination
- Improved information sharing between professionals
- A more effective and efficient service to manage increasing demand
- A move towards an integrated physical and mental health offer for our population

ICTs may be deployed in different ways to reflect local needs and take varied forms. For example the frailty hub in Lichfield forms part of the model for an integrated care team. There are four early implementers across Staffordshire and Stoke-on-Trent; Meir, Leek, Stafford and Lichfield.

Reviewing our community hospitals services offer

We have explained how the current demand on our urgent and emergency care services is directly affecting our community hospital services in South Staffordshire. As a result of delays in patients receiving the care they need when they need it and in the most appropriate clinical setting, community beds have become waiting rooms with unacceptably long waiting times for the right service.

However, in North Staffordshire, we are successfully delivering the Discharge to Assess service as part of our 'Home First' approach. The service is providing short-term care to bridge the gap between hospital and home, which includes clinically-led interventions such as community nursing or physiotherapy in the community to help optimise independence, prevent unplanned admissions and support timely discharge for patients.

We therefore want to review our community care provision across South Staffordshire to understand what patients, the local community and our staff think about current services and how we might deliver them differently in order to provide the right community care in the right place at the right time for patients.

Feedback we have received to date on community services in Staffordshire and Stoke-on-Trent has covered themes such as[165]:

- Flexibility of services;
- Getting the right service at the right place;
- Being able to get services on your doorstep; and
- Holistic care from a physical health, mental health and social care perspective.

We are keen to explore these further as well as other themes that may arise through the review of our community hospitals services offer in South Staffordshire.

Planned Care

Where people have health conditions which need specialist care e.g. shared care between primary and specialist team for long-term conditions (both medical and surgical), we want to ensure that we have the right pathways across our primary, community and acute sector.

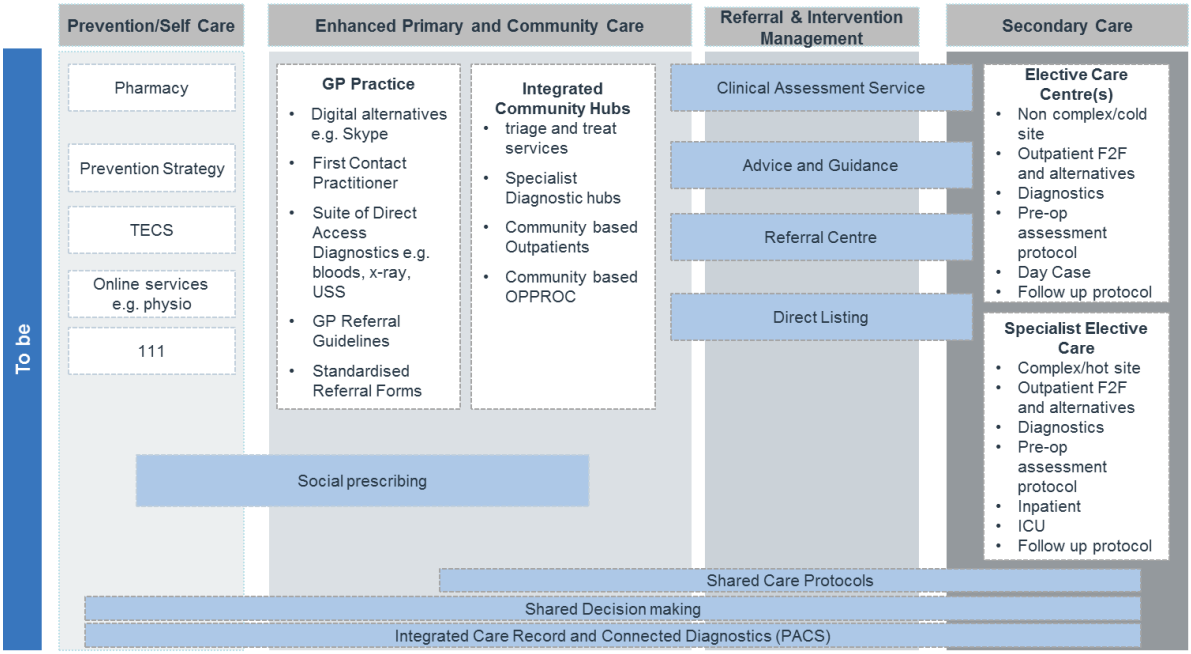
Demand for elective care is increasing with significant growth over the last six years and is predicted to continue to grow. In many specialties and providers, national standards are not being met, with increasing waiting times, inappropriate referrals and inefficient pathways.

The continuity of care across primary, community and urgent care settings will enable a shift in how we deliver planned care. Pathway redesign will allow outpatient appointments to be delivered closer to home. There are about 307 million patient consultations at GP surgeries each year. Some GPs are now offering their patients the choice of quick telephone or online consultations, saving time waiting and travelling, with c. 50–70% of the public willing to use video consultations for minor ailments. The use of digital solutions to provide advice and guidance will mean that fewer face-to-face consultations will need to take place.

Additional capacity through enhanced primary and community care and alternative methods of providing outpatient consultation services (for example, Skype, telehealth, remote consultations) will free up capacity and improve the delivery of day case elective surgery and inpatient surgery. Meanwhile, increasing standardisation of planned care will create opportunities to enhance the efficiency and effectiveness of planned care procedures. We also expect the trend

[165] Healthwatch Staffordshire Conversation Events Report (02/08/2017) and Healthwatch Stoke-on-Trent Conversations Events Report (December 2016)

towards fewer surgical interventions and increased day case activity will increase the complexity of remaining in inpatient settings and we will explore appropriate ways to deliver this.



The diagram above outlines the planned care model of care which builds upon the integrated primary and community care model. Additional capacity and demand modelling and speciality reviews will support further refinement of the model by specialty.

Mental Health

The mental health model of care across Staffordshire and Stoke-on-Trent is interwoven with the development and delivery of the integrated primary and community care model. The model will enable more people to access high quality mental health services with mental health needs being addressed alongside mental health conditions. The improved mental health services will enable people to stay in their communities close to family and friends.

We need to address the high incidence of depression and suicides across our STP and develop an integrated mental health care which delivers on the ambitions of the LTP, this will be delivered by the integrated care teams and community hubs. By 2020/21 the STP will provide Crisis Resolution and Home Treatment Teams, (CRHT), resourced to operate in line with best practice – delivering a 24/7 all-age community-based crisis response and intensive home treatment as an alternative to acute inpatient admissions.

By 2020/21 all acute hospitals will have all-age mental health liaison teams in place and at least 50% of these will meet the CORE 24 service standard as a minimum. As part of Home First, the CCGs have commissioned a robust older people's mental health stay at home pathway which wraps services around the patient for the first 72 hours with a gradual reduction in the package of care as patients become more settled at home and able to undertake tasks unassisted.

In addition we need to consider the model of care for patients who require in-patient provision in the East/South East of Staffordshire.

Maternity services

We have clinical and financial sustainability issues within our geography relating to our maternity services, and there are a number of services operating at a small scale. This is likely to be further affected by the estimated fall in the

number of births over the next five years as well as the increasing trend in the number of more complex maternity cases.

Aligned to the most recent national guidance – Better births: improving outcomes of maternity services in England – we will ensure we provide a high-quality service across all options for women, including a single point of access, continuity of carer and ante- and postnatal care delivered closer to home.

We will continue to provide a real choice of maternity care settings for women that meet their needs now and in the future. As such, we will maintain safe, appropriate and high-quality options to provide this choice. Our ongoing work will therefore consider the best and most viable ways to provide these options.

Simplifying our urgent and emergency care

The NHS 5 Year Forward View described the need for a redesign of urgent and emergency care services for people of all ages with physical and mental health problems. Delivery will be through the implementation of immediate improvements and service redesign as well as longer term planned transformation and implementing new models of care. For Staffordshire this will mean a significant change in the way that our urgent and emergency care services are provided to our local population; with more care being delivered closer to home and a reduced number of hospital attendances and admissions.

The National Urgent and Emergency Care Delivery Plan accompanies the "Next Steps on the NHS Five Year Forward View (5YFV)" publication, articulating in more detail the offer, specification, delivery plan, expected costs and benefits of seven UEC priorities, which will deliver transformation of Urgent & Emergency Care.

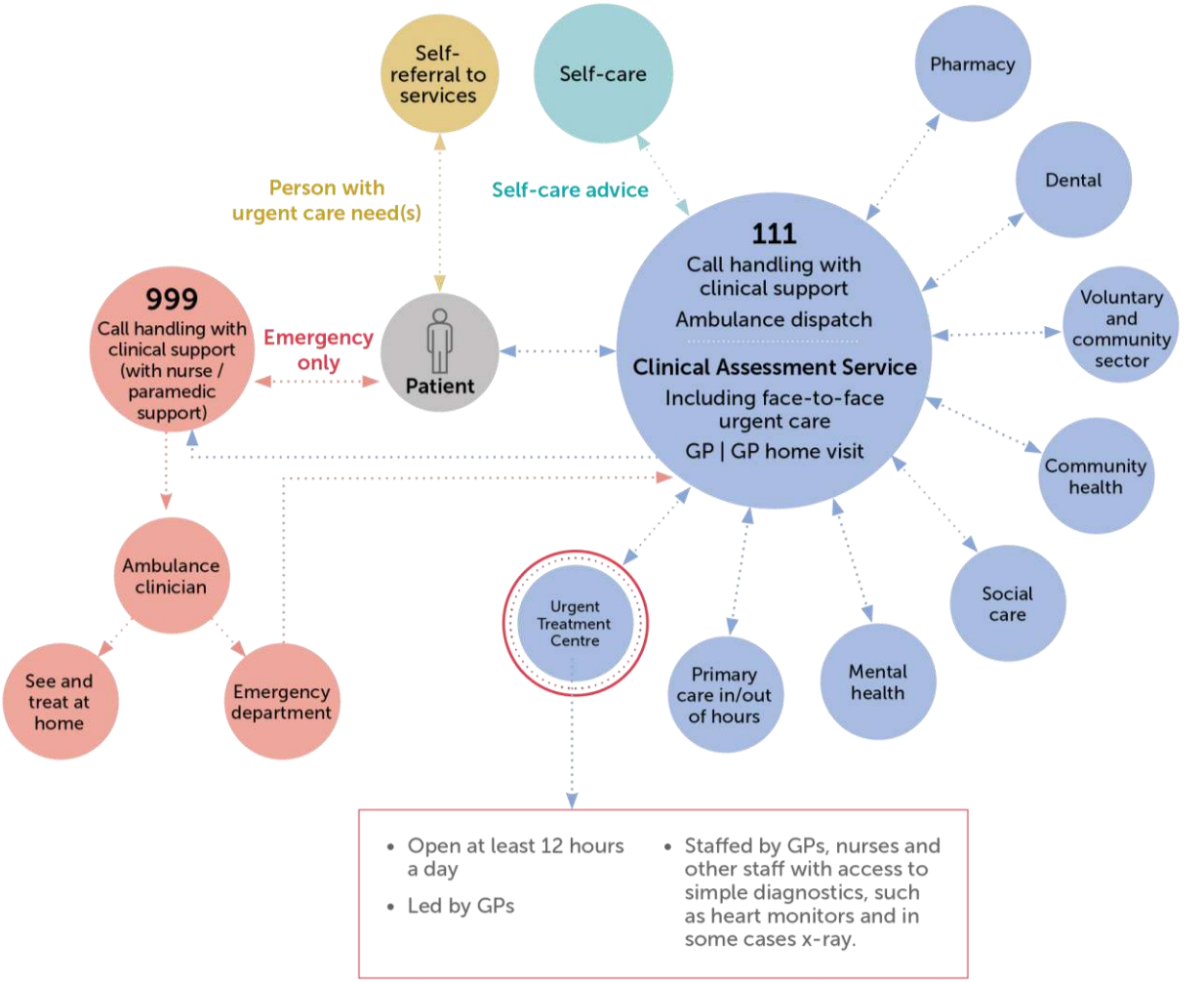
We will commission an integrated urgent and emergency care service, aligning emergency departments, NHS 111, urgent treatment centres, GP out-of-hours and routine and urgent GP appointments.

Interdependencies between these services mean we have an opportunity to simplify access and improve navigation. There is a national mandate to move from walk-in-centres, minor injury units and other similar facilities to urgent treatments centres (UTCs). Aligning our urgent services to national requirements for UTCs will enable us to provide the appropriate level of care to our population; our work on our care model will ensure we have an appropriate number of UTCs for our population.

We will use our urgent and emergency care workforce appropriately to provide complex care to patients. We will ensure that staffing meets relevant clinical standards of care and that relevant co-dependencies between services are maintained. Patients with the highest acuity will be treated in our emergency departments, enabled by integrated care hubs and development of UTCs.

The diagram outlines the urgent and emergency care model of care:

Urgent and emergency care – model of care

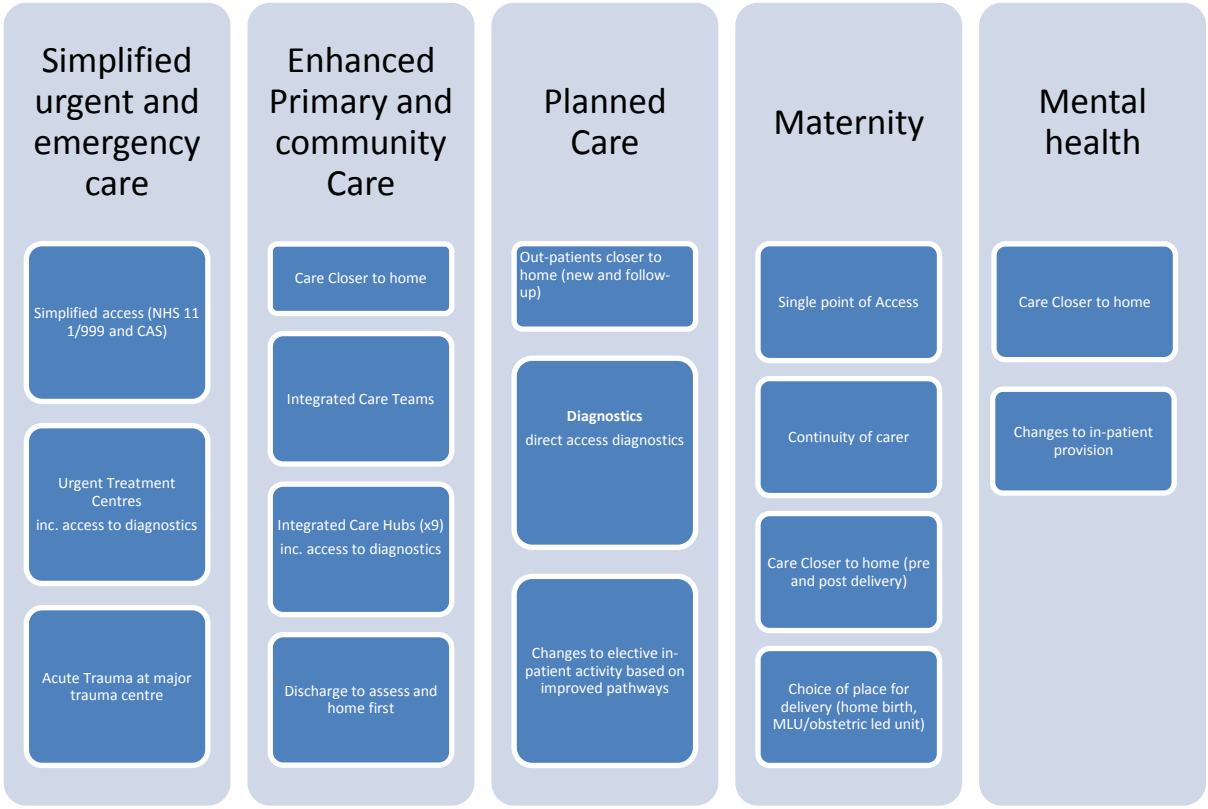


By simplifying access to urgent and emergency care we will ensure that patients are directed and treated in the most appropriate care setting for their urgent care needs. This model shall support all ages, and shall look to prioritise the development of pathways for patient groups that use emergency services where alternative services may provide a better outcome and experience.

4.2 The scope of the model of care

The scope of this ongoing work includes:

- Enhanced primary and community care (18 years and over)
- Urgent and emergency care (inc. UTCs, emergency departments) all ages
- Planned care (18 years and over)
- Maternity services (inc. freestanding and alongside MLUs)
- Community mental health services
- Inpatient mental health services (East/South East Staffordshire)



It does not include:

- Services for people under 18 years of age
- Preventative services commissioned and delivered by Local Authority
- North community services including community beds
- Wider inpatient mental health services
- Learning disability services
- Social care services.

Our next steps are to understand the specific options in all these areas and any specific fixed points. The process for undertaking this is outlined within section 5.

5. What happens next

The case for making these urgent changes is compelling if we want to be able to maintain and improve the quality and sustainability of our health and care system in Staffordshire and Stoke-on-Trent. In order to meet the challenges described in this Case for Change, we believe we need to review our services and change the way they are currently provided across acute, primary and community care settings. However, it is of paramount importance that we work together to ensure these improvements happen, collectively with our communities, patients, staff and partner organisations.

Reviewing our services, in line with the proposed model of care outlined in Section 4, is the next phase towards developing potential solutions to address our health and care challenges. Feedback from local communities, patients and staff has been invaluable in helping us identify these opportunities and getting us to this point. We now want to continue working with these groups to seek their views on emerging ideas and their help in shaping possible options.

In this section, we set out how we will engage patients, the public and our workforce as we work to make change happen quickly and explain the process we will follow.

Consultation process

This Case for Change is part of a suite of documents that will be published to support the STP's consultation with the public on the future of services and is in line with NHS England service change guidance. If there is a requirement to change services that requires public consultation, much of the content will be used as part of the Case for Change within the Pre-Consultation Business Case, in line with NHS England service change guidance. Subject to public consultation and any decision to change services or invest in capital schemes, capital business cases in the context of an overall Strategic Outline Case or Programme Business Case would be needed, in line with NHS England and NHS Improvement guidance and HM Treasury Green Book guidelines.

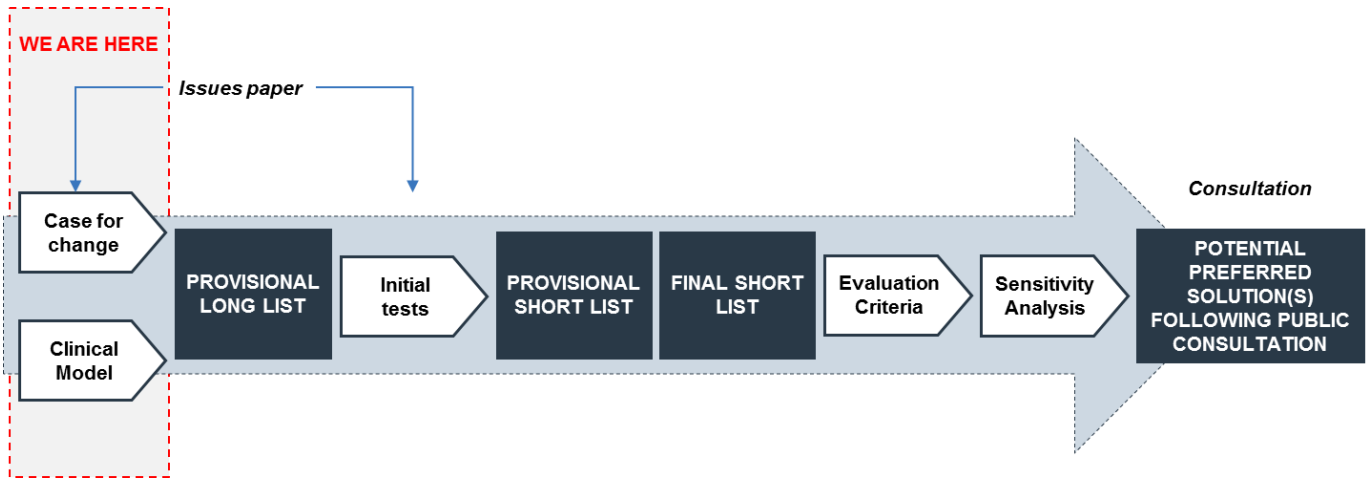


Figure 28: Pre-consultation process

Engaging patients and the public

We are committed to actively involving patients, carers and local communities across Staffordshire and Stoke-on-Trent in helping us to develop our plans for change. The Together We're Better programme has considered all the feedback from patient and public engagement to date and has plans in place to continue public dialogue.

This engagement has supported us to identify further opportunities to improve the way we provide health and care services across the area as part of this next phase of the Together We're Better programme. We will keep actively

engaging with people about all these opportunities and the detail of the individual projects that will deliver the changes.

Engagement will take into account different health inequalities and geographies. We will also involve seldom heard groups and a range of people with a particular interest in health and care, such as formal patient and carer support groups. We have completed a 'gap analyses' of the information to identify groups of people we haven't yet heard from. From this we have developed an approach to help us engage with these harder to reach groups. This will help make sure that they are included in future engagement about transformation and when we consult on any proposed service changes. We will make sure that we involve specific sets of people covered by the Equality Act 2010, and find ways for them to make their views known, especially if they need extra support to do so.`

A steering group has been formed to manage and inform the communications and patient and public involvement enabler work stream. Members of this group include Healthwatch Staffordshire and Healthwatch Stoke-on-Trent, Staffordshire County Council and Stoke-on-Trent City Council, VAST (representing voluntary and community groups, charities and social enterprises) and the Communications Executive (on behalf of communications and engagement leads from all public-sector organisations in Staffordshire and Stoke-on-Trent). It is Chaired by the Lay Member for Patient and Public Involvement for the CCG to ensure that statutory duties are being met.

We will be running a series of public events at different locations across Staffordshire and Stoke-on-Trent where we can hear directly from patients and local communities. We acknowledge that the events across the area will not engage inclusively with all groups of people. We will therefore work with our partners to identify alternative routes to reach these groups and hear their views.

These events will allow us to gather people's views on the transformation opportunities set out in this Case for Change and on the emerging ideas to help develop potential solutions to the issues we've described previously. They will also enable us to continue to seek feedback in general on what's important to those who use our services.

The events will include a process where individuals can help us to develop the options for change alongside our teams of doctors, nurses, other clinicians, managers and staff.

Engaging the workforce

As described in Section 3, the health and care system faces some difficulties in developing, keeping and using the right workforce, which mean we have to take a fresh look at the way we provide services. We need to be realistic about the number and type of staff we require, both now and in the future, and come together across Staffordshire and Stoke-on-Trent to plan how to do this. We are already doing pioneering work through our Physician Associate programme which shows how we can introduce new workforce models to address these challenges, but there is more we can do by focussing on the further transformation opportunities outlined previously.

People who took part in previous engagement events have told us that staff working in health and care must be kept properly informed about our plans for transformation so they can be involved in any changes and we will be running a series of engagement events with our clinical, operations and finance colleagues to review emerging ideas and commence development of potential solutions. Feedback from the events will inform these discussions and shape the design of possible options. We acknowledge that not everyone will be able to participate in the events so we will also open up other communication channels, so we can keep engaging with our workforce and getting their feedback on changes.

How we will manage the change together?

We know the kind of fundamental change we are talking about is not easy and takes time. There are some things we have got on with though which are starting to have an impact on the immediate pressures and are creating a different offer for local people. We will continue to develop the work of the Together We're Better programme with our staff across different organisations, with strong clinical leadership working with our patients and local communities.

As mentioned, we will be running a series of engagement events with our patients, local communities and staff to present the issues discussed in this Case for Change and to seek their help in developing solutions. We will then share the solutions developed with smaller groups of people to turn them into options and will run a scoring process with these groups to create a shortlist of options.

Some of the options may require formal public consultation depending on the level of service change involved. We will involve as many people as possible in this process and it will be supported by a programme of communications to ensure there is wide understanding of the formative stages of the process and when there will be opportunities available for people to participate in the process.

This Case for Change is part of a suite of documents that will be published to support the STP's consultation with the public on the future of services and is in line with NHS England service change guidance. If there is a requirement to change services that requires public consultation, much of the content will be used as part of the Case for Change within the Pre-Consultation Business Case, in line with NHS England service change guidance. Subject to public consultation and any decision to change services or invest in capital schemes, capital business cases in the context of an overall Strategic Outline Case or Programme Business Case would be needed in line with NHS England and NHS Improvement guidance and HM Treasury Green Book guidelines.

6. Conclusion

Together We're Better is committed to changing the way we provide health and care across Staffordshire and Stoke-on-Trent so that it better meets the needs of our local people and improves everyone's lives. We have developed this Case for Change to describe our challenges and explain why change is necessary and are focussed on addressing the challenges facing our area.

We aim to address these key challenges:

- **We need to address the high level of health inequality across our geography:** mortality and the prevalence of long term conditions such as obesity, stroke and cardiovascular disease vary significantly across Stoke-on-Trent and Staffordshire. This presents challenge in developing a healthcare model which is flexible to local need. We will need to improve the uptake and availability of screening and preventative treatments.
- **We need to emphasise prevention and improved health self-management of our population:** the health needs of our population is growing, with an increasing prevalence long term conditions and multiple morbidities. We will need to focus on prevention and health self-management of our population to reduce the risk of future illness and hospital visits.
- **We could deliver a better start for children and young people:** Infant mortality is particularly high in some areas and more can be done to improve the care given to children and young people. This is an area we will focus on improving as part of the STP Strategic Plan.
- **We need to better protect and support the mental health of the population:** We need to address the high incidence of depression and suicides across our STP and develop an integrated mental health care which delivers on the ambitions of the Long Term Plan.
- **The quality of healthcare could be significantly improved in a number of critical areas to better manage demand and address the challenges we face.** Patients are admitted too often into acute hospital care with a high rate of non-elective emergency admissions and high length of stay compared to peers. There is significant variation across the area in urgent and emergency care provision and performance which is impacting on patient outcomes and experience. We need to simplify access to urgent and emergency care, improve demand management, and ensure patients can be discharged from hospital to a place that better meets their needs. This needs to involve much greater integration of care across the NHS and with social care partners.
- **We need to review our community services offer to ensure patients are treated effectively in the most appropriate setting for their needs:** In the past, a large proportion of patients have been discharged from an acute setting into community hospital beds to effectively wait for another service. We need to provide support to people in their own homes as an alternative to hospitalisation and increase support for people living in care homes.
- **We want to review the service offer to Staffordshire and Stoke-on-Trent:** to meet future population need for health and care services through a greater emphasis on prevention, integrating care and providing a greater proportion of care in the community rather than acute trusts, and making use of new technologies where possible as an adjunct and alternative to services.
- **We will need to embed digitally-enabled care throughout our system to take advantage of the opportunities bought about by new technology:** To support the NHS commitment in embedding digitally-enabled care throughout the system, we will need to seek new ways of working, upgrade our existing technology infrastructure and digitally-enable our staff.
- **We need to address our issues of clinical and financial sustainability**: Our STP is experiencing high clinical workforce vacancy rates across primary, community and acute care. This is impacting on our financial challenge which is likely to grow further as inflation and demand growth continue to outstrip increases to funding. This is unsustainable and we need to make changes to address this.
- **Our workforce is under increasing strain with significant vacancies and increasing demand from more complex patients.** There is an increasing proportion of roles vacant, which is likely to get worse when many

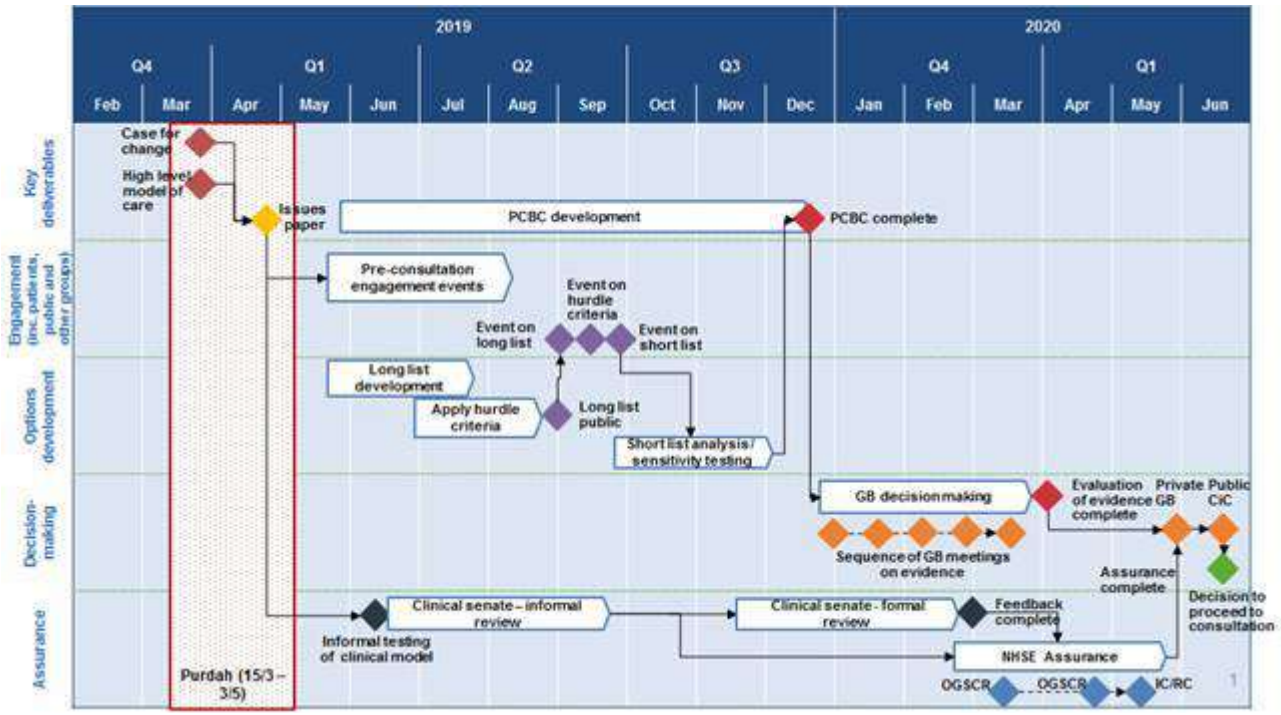
of our staff members enter retirement. We will need to develop a flexible and skilled workforce to deliver the modernised service envisaged by the Long Term Plan.

We are already carrying out work to address our challenges, through enhanced primary care, new approaches to reducing hospital admissions and increased funding for wider health and care services. However more needs to be done to ensure our health and care provision is clinically and financially sustainable, as well as being fit for the future according to the NHS Long Term Plan.

Reviewing our services is therefore the next phase towards developing potential solutions to address our health and care challenges. We will ensure that we continue to work together to make these improvements, collectively with our communities, patients, staff and partner organisations.

Feedback from local communities, patients and staff has been invaluable in helping us identify these opportunities and getting us to this point. We now want to continue working with these groups to seek their views on emerging ideas and their help in shaping possible options.

7. Appendix 1 – STP PCBC timeline



Engagement with the West Midlands Clinical Senate

In 2017, the CCGs approached the West Midlands Clinical Senate to request independent clinical advice on the Community Hospitals and Discharge to Assess (D2A) model of care. The CCGs met again with the Independent Clinical Review Panel in early 2018 and the Senate's report was published on 30 July 2018.

In June 2018, the CCGs sought Independent Clinical Review Panel advice on the Clinical Assurance of North Staffordshire Freestanding Midwife Birth Unit (FMBU).

Following feedback from NHS England, the CCGs will engage with the West Midlands Clinic Senate to seek assurance of the draft case for change prior to submitting the final version to the strategic sense check panel (indicative date: mid-May).

8. Appendix 2 – Logic models

Urgent and emergency care – logic model

Benefit	Input	Output	Outcome
Consistency of service delivery and minimise variation in access to Urgent and Emergency Care	• Standardisation of an integrated urgent care model and subsequently implementing UTCs	• Access to consistent urgent and emergency care services	• Reduction in A&E attendances • Delivery of 4 hour A&E target • Reduced healthcare acquired functional decline
Improving efficiency	• Simplified access to appropriate UEC for patients' needs	• UEC needs are met and do not impact on A&E delivery. A&E is available for those most in need.	• Reduction in A&E attendances • Delivery of 4 hour A&E target • Reduced healthcare acquired functional decline
Improved patient experience	• Clinical Assessment Service • Urgent Treatment Centres • Directory of services	• Access to multi-professionals through the CAS • Access to urgent diagnostics through alternatives to A&E	• Reduced A&E wait times • Delivery of 4 hour target
Enhanced professional support	• Clinical Assessment Service • Directory of Services • Integrated Urgent Care services	• One single point of access for urgent care needs • Direct support for healthcare professionals	

Planned care - logic model

Benefit	Input	Output	Outcome
Population Health	• Prevention and self care - targeted public health campaigns	• Lifestyle educated, engaged population empowered to actively manage healthcare needs	• Reduced requirement for care resulting in improved cost base and improved population health
Improving Efficiency	• Development of elective care centre(s) • Separation of elective and non elective services	• Reduced cancelled Ops, reduced variation and improved clinical outcomes	• Improved performance position, improved financial position
Demand Management and standardisation	• Enhanced Primary and community care integrated service solution developed from general practice focussing on prevention at scale, self care and transformation of out of hospital care.	• Increased and faster access to care closer to home improving outcomes • Effective referral management ensuring appropriate direction of referral to appropriate professional.	• Less pressure on acute services and value for money
Improving outcomes and eliminating unnecessary activity	• Optimisation of outpatient and diagnostic pathways	• Streamlined pathways and reduced duplication • Faster cancer diagnosis	• Reduced mortality

Mental Heath – logic model

Benefit	Input	Output	Outcome
More people accessing treatment for their mental health condition	• Increased access to psychological therapies as part of integrated care teams • Early Intervention in Psychosis services	• Mental Health Practitioners as part of Integrated Care Teams • Waiting time of 2 weeks and delivery of NICE concordat care	• Improved mental health and people supported to stay in their communities
Mental Health needs are met alongside physical health needs	• Integrated psychological therapies • All age Psychiatric Liaison services in acute hospitals 24/7 • Annual physical health checks for people with severe and enduring mental health	• Mental health treated able to manage long term care better • Better engagement with primary and community services • Reduced admissions • Reduced length of stay	• Improved quality of life for people with Long Term Conditions • Early access to mental health care • Reduction in mortality for people with SMI
Accessibility of services that respond to emotional distress and urgent mental health needs	• Expansion of Crisis Response and Home Treatment Teams (all age) • All age Psychiatric Liaison services in acute hospitals 24/7 • Provision of Crisis cafes	• Reduced impact on Police and Ambulance • Ability to de-escalate mental distress in appropriate environment	• Fewer admissions to in-patient beds • Reduced suicide rates
Specialist services working together and supporting whole population	• Eating Disorder services in place for both CYP and adults • Bed management across both Trusts • Perinatal mental health services in place • Integrated pathways in place linked to new models of care with specialised commissioning	• Eating disorder treatment in place	• Eating disorder treatment in place • Fewer admissions to specialised services • People treated in their communities maintaining links to their friends and families

Maternity – logic model

Benefit	Input	Output	Outcome
Improved experiences for women and their families	• System wide review of care delivery	• Increased access to maternity care	• Reduced stillbirths and neonatal deaths.
Improving patient access	• Development of maternity hubs	• Access to specialists roles throughout maternity.	• Improved continuity of care and carer, delivered closer to home.
Decreasing unwarranted variation in quality, safety and outcomes	• Meeting clinical standards in line with national standards set out in BB and SBLCB	• Provision of equitable choice	• Reduced stillbirths and neonatal deaths.
Solving workforce challenges	• Implementation of Birth Rate plus recommendations	• Appropriate workforce for current and future models of care	• Model of care will be in line with the national standards.
Improving efficiency	• Partnership working between CYP, public health and the NHS	• Integrated care	• Improved experience for women and their families.

9. Appendix 2 – Supporting data

Table 22: Locality health profiles[168]

[168] 2017-18 QOF Prevalence for Staffordshire CCG localities

Cannock Chase CCG

Long term condition prevelance, 2017/18	Cannock	Great Wyrley	Rugeley
Asthma	6.0	5.9	5.6
Atrial fibrillation	2.0	2.2	2.4
Cancer	3.3	3.2	3.3
Cardiovascular disease – primary prevention	1.1	0.8	1.3
Chronic kidney disease	4.5	4.7	3.3
Chronic obstructive pulmonary disease	2.5	2.3	2.7
Dementia	0.7	0.9	1.0
Depression	13.3	10.9	9.8
Diabetes mellitus	7.7	8.1	7.7
Epilepsy	1.1	1.0	0.9
Heart Failure due to LVD	1.0	0.9	1.0
Hypertension	15.5	17.2	17.9
Learning Disability	0.7	0.5	0.5
Mental health	0.8	0.6	0.7
Obesity	11.5	10.2	13.6
Osteoporosis: secondary prevention of fragility fractures	0.6	0.5	0.2
Palliative care	0.3	0.2	0.3
Peripheral arterial disease	0.7	0.6	0.8
Rheumatoid arthritis	1.1	1.1	1.3
Secondary prevention of coronary heart disease	3.9	3.8	4.2
Stroke and transient ischaemic attack	1.9	2.1	2.1

East Staffordshire CCG

Long term condition prevelance, 2017/18	Burton	Uttoxeter
Asthma	6.0	6.7
Atrial fibrillation	2.0	2.4
Cancer	2.8	3.5
Cardiovascular disease – primary prevention	1.1	0.7
Chronic kidney disease	4.3	4.2
Chronic obstructive pulmonary disease	1.9	1.8
Dementia	0.7	1.0
Depression	8.8	7.5
Diabetes mellitus	7.2	7.2
Epilepsy	0.8	1.0
Heart Failure due to LVD	1.0	1.3
Hypertension	13.7	15.3
Learning Disability	0.4	0.7
Mental health	0.6	0.7
Obesity	10.0	11.5
Osteoporosis: secondary prevention of fragility fractures	0.4	0.5
Palliative care	0.2	0.6
Peripheral arterial disease	0.5	0.6
Rheumatoid arthritis	0.7	0.9
Secondary prevention of coronary heart disease	3.1	3.3
Stroke and transient ischaemic attack	1.6	2.0

Long term condition prevelance, 2017/18	Leek & Biddulph	Moorlands Rural	Newcastle Central	Newcastle North	Newcastle South
Asthma	6.9	6.5	6.2	6.1	6.2
Atrial fibrillation	2.7	2.8	2.2	2.4	2.4
Cancer	3.2	3.9	2.7	3.4	3.0
Cardiovascular disease – primary prevention	1.3	1.3	1.8	1.3	1.2
Chronic kidney disease	4.2	4.5	3.3	4.5	4.5
Chronic obstructive pulmonary disease	2.5	1.9	2.1	3.1	2.2
Dementia	1.0	0.9	1.2	1.1	0.8
Depression	11.0	10.5	12.1	12.6	12.2
Diabetes mellitus	7.7	7.8	7.5	8.3	6.6
Epilepsy	0.9	0.9	1.1	1.1	0.8
Heart Failure due to LVD	0.8	1.1	0.9	1.0	0.7
Hypertension	18.3	19.2	15.8	17.6	15.0
Learning Disability	0.5	0.5	0.5	0.4	0.4
Mental health	0.9	0.7	0.9	0.8	0.8
Obesity	13.5	11.8	11.2	13.3	10.4
Osteoporosis: secondary prevention of fragility fractures	0.8	0.3	0.4	0.5	0.6
Palliative care	1.5	0.4	0.3	0.2	0.4
Peripheral arterial disease	0.7	0.6	0.8	0.7	0.6
Rheumatoid arthritis	0.9	0.9	0.8	1.0	0.7
Secondary prevention of coronary heart disease	4.1	3.8	3.6	3.7	3.4
Stroke and transient ischaemic attack	2.6	2.6	2.2	2.5	2.3

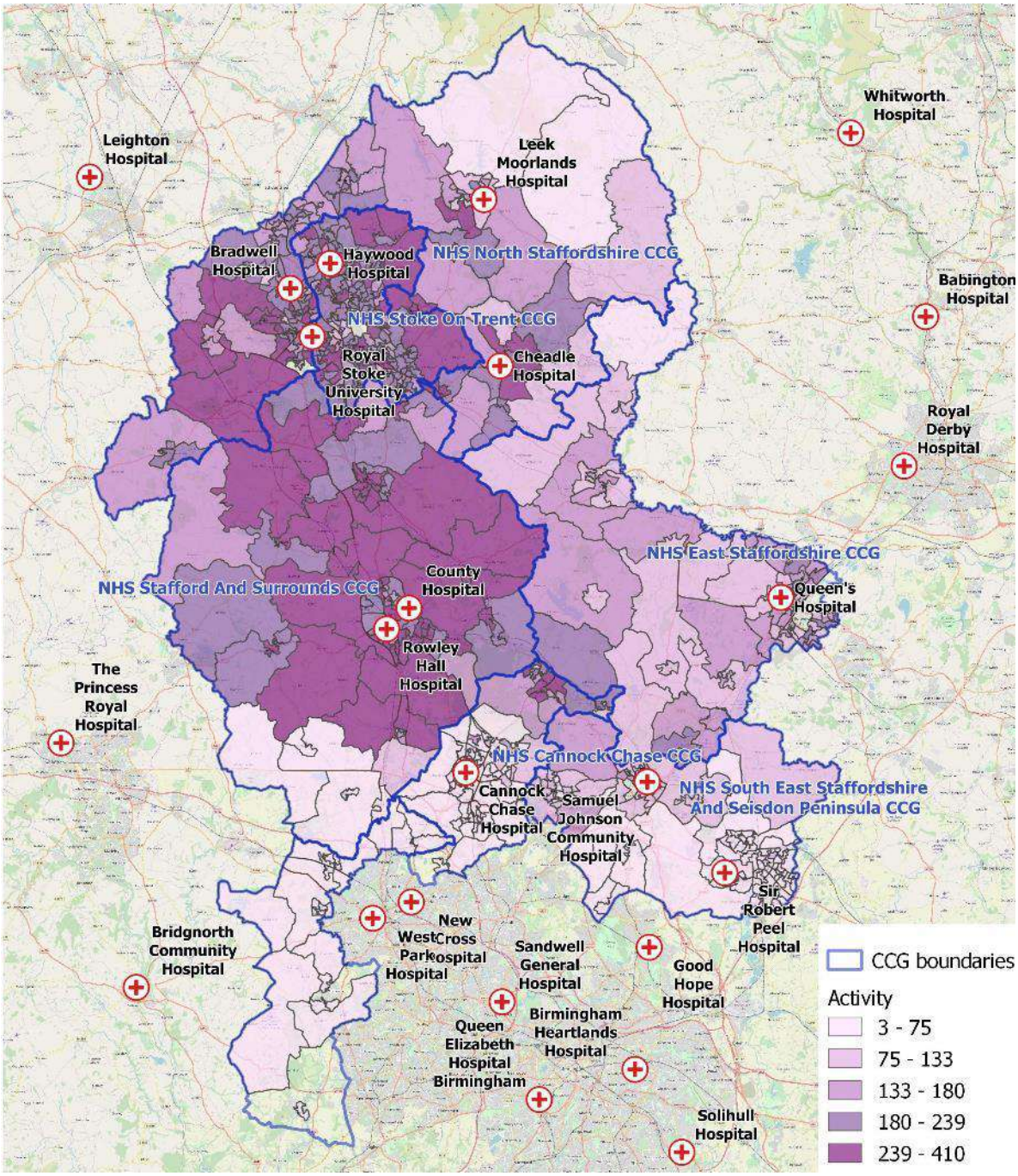
Long term condition prevelance, 2017/18	South Stafford general pracice network	Stafford primary health care alliance	Stone and Eccleshall
Asthma	6.0	6.1	6.2
Atrial fibrillation	2.4	2.6	2.6
Cancer	3.5	3.3	3.8
Cardiovascular disease – primary prevention	1.4	1.1	1.4
Chronic kidney disease	3.4	4.0	3.5
Chronic obstructive pulmonary disease	1.6	2.0	1.4
Dementia	0.8	0.9	0.8
Depression	7.6	11.4	10.9
Diabetes mellitus	6.5	7.0	6.5
Epilepsy	0.9	1.2	0.8
Heart Failure due to LVD	0.8	0.8	0.9
Hypertension	16.1	15.8	16.9
Learning Disability	0.2	0.5	0.4
Mental health	0.6	0.9	0.6
Obesity	9.6	10.0	8.7
Osteoporosis: secondary prevention of fragility fractures	0.4	0.5	0.2
Palliative care	0.2	0.4	0.3
Peripheral arterial disease	0.6	0.8	0.6
Rheumatoid arthritis	1.0	1.0	0.8
Secondary prevention of coronary heart disease	3.4	3.6	3.9
Stroke and transient ischaemic attack	2.1	2.2	2.5

Long term condition prevelance, 2017/18	Lichfield	Seisdon	Tamworth
Asthma	6.3	6.1	6.3
Atrial fibrillation	2.4	2.9	2.0
Cancer	3.3	3.7	3.0
Cardiovascular disease – primary prevention	1.2	1.1	1.0
Chronic kidney disease	4.8	5.3	4.5
Chronic obstructive pulmonary disease	1.8	1.7	2.0
Dementia	0.9	1.1	0.7
Depression	9.1	7.5	11.9
Diabetes mellitus	7.1	6.9	7.2
Epilepsy	0.8	0.9	0.9
Heart Failure due to LVD	0.9	0.9	0.9
Hypertension	15.6	17.2	14.3
Learning Disability	0.4	0.4	0.6
Mental health	0.7	0.6	0.8
Obesity	8.7	7.8	12.0
Osteoporosis: secondary prevention of fragility fractures	0.8	0.4	0.6
Palliative care	0.2	0.2	0.3
Peripheral arterial disease	0.6	0.5	0.6
Rheumatoid arthritis	0.9	0.9	0.9
Secondary prevention of coronary heart disease	3.7	3.7	3.5
Stroke and transient ischaemic attack	2.0	2.2	1.8

Long term condition prevelance, 2017/18	ANEW	Longton	Meir	NEB
Asthma	6.0	6.4	6.6	6.1
Atrial fibrillation	1.6	2.0	2.0	2.3
Cancer	2.2	2.8	2.6	2.9
Cardiovascular disease – primary prevention	1.4	1.8	1.4	1.6
Chronic kidney disease	3.6	4.2	4.0	4.4
Chronic obstructive pulmonary disease	2.6	2.8	2.6	2.5
Dementia	0.9	0.7	0.8	1.1
Depression	13.9	13.8	14.7	14.8
Diabetes mellitus	8.3	8.8	8.5	7.9
Epilepsy	1.1	1.2	1.3	1.2
Heart Failure due to LVD	0.8	0.9	0.9	0.9
Hypertension	14.9	18.0	16.9	16.9
Learning Disability	0.7	0.7	0.8	0.6
Mental health	1.1	0.9	1.0	0.9
Obesity	13.7	15.0	16.4	15.7
Osteoporosis: secondary prevention of fragility fractures	0.4	0.5	0.3	0.9
Palliative care	0.3	0.3	0.4	0.4
Peripheral arterial disease	0.7	0.8	1.1	0.9
Rheumatoid arthritis	0.8	0.9	1.0	0.8
Secondary prevention of coronary heart disease	3.2	3.9	3.7	3.8
Stroke and transient ischaemic attack	1.8	2.0	2.1	2.3

Figure 29: Elective admissions 2017/18 activity map

Activity going to providers within footprint



Activity going to providers outside footprint

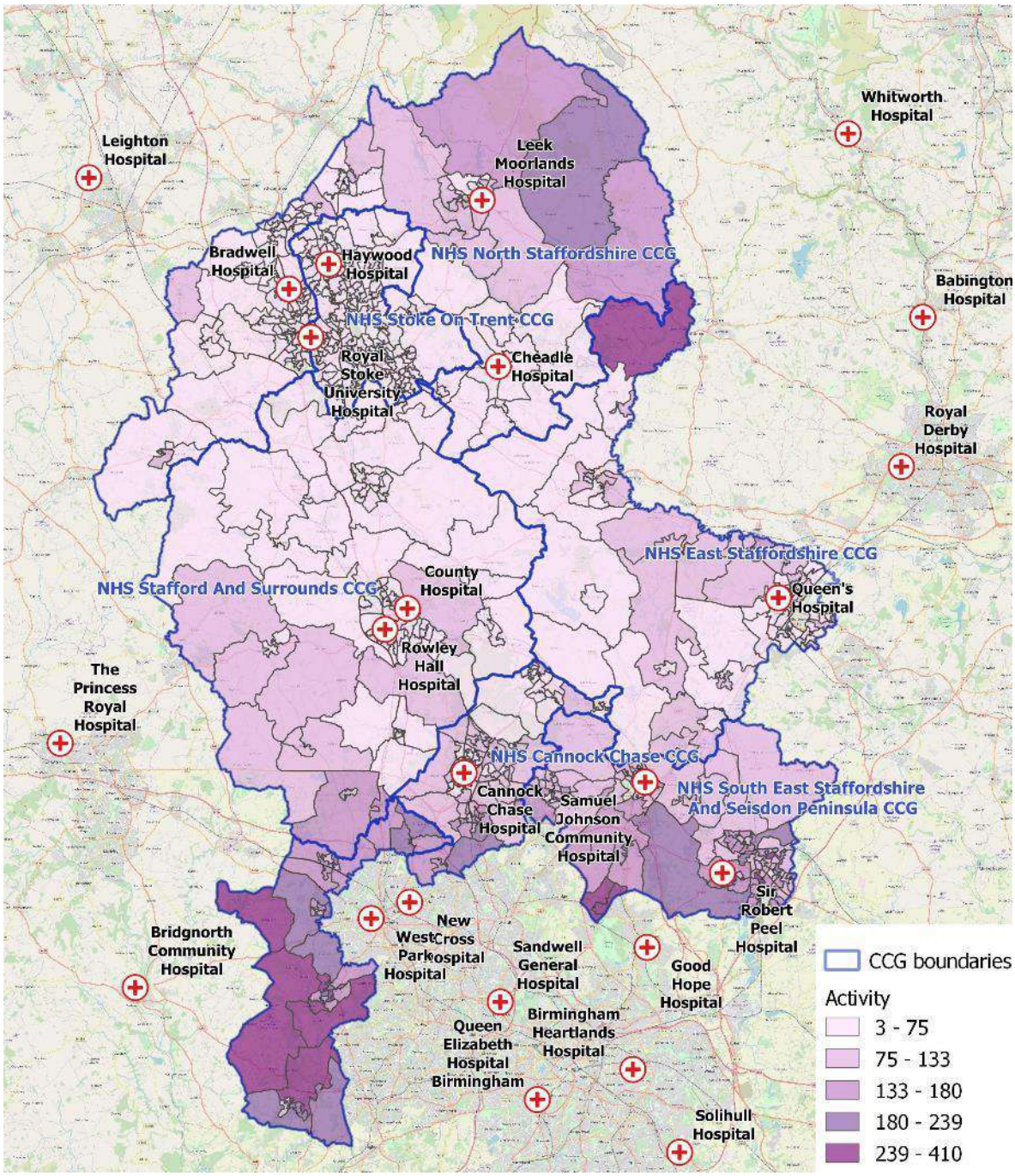
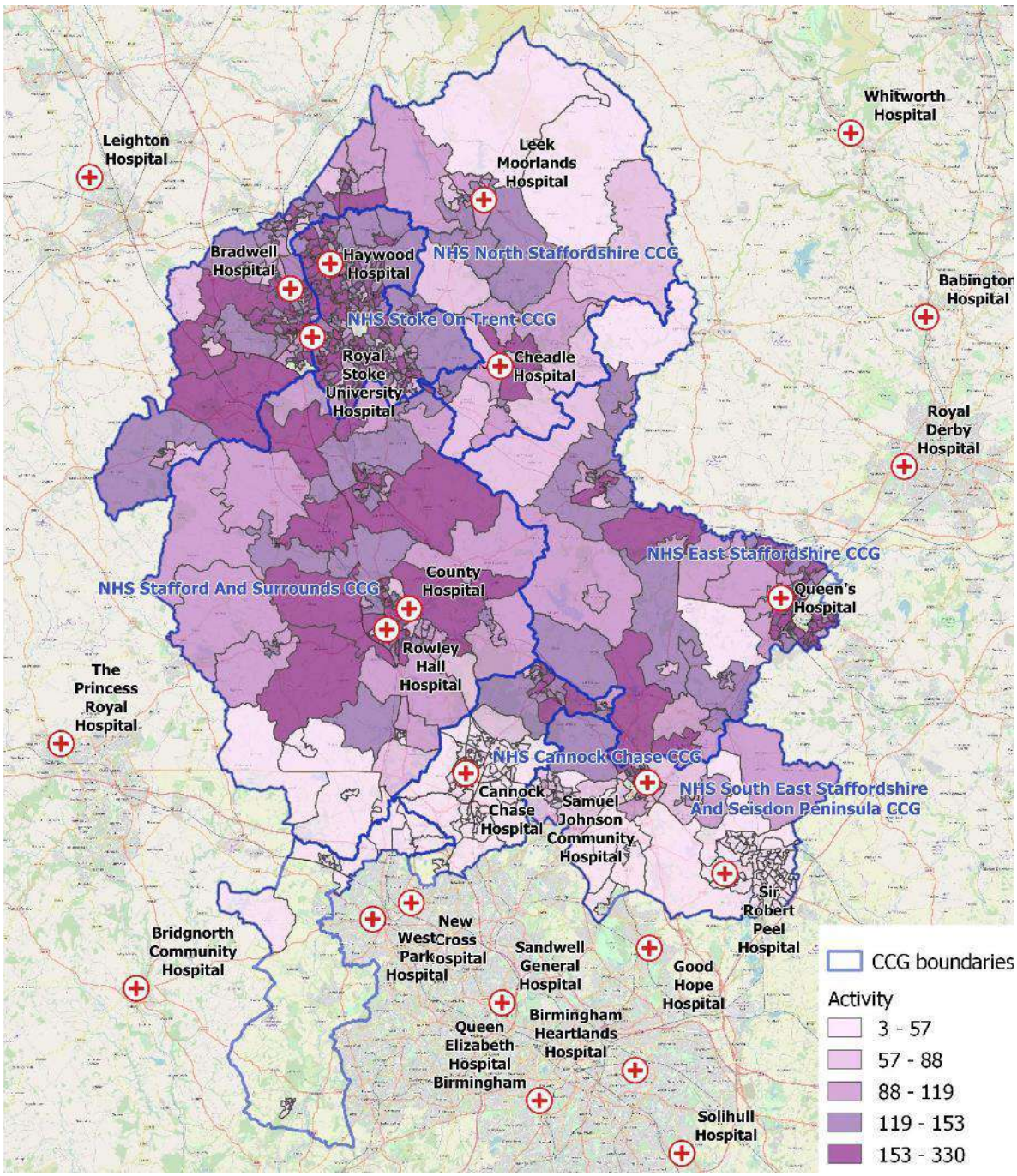


Figure 30: Non-elective admissions 2017/18 activity map

Activity going to providers within footprint



Activity going to providers outside footprint

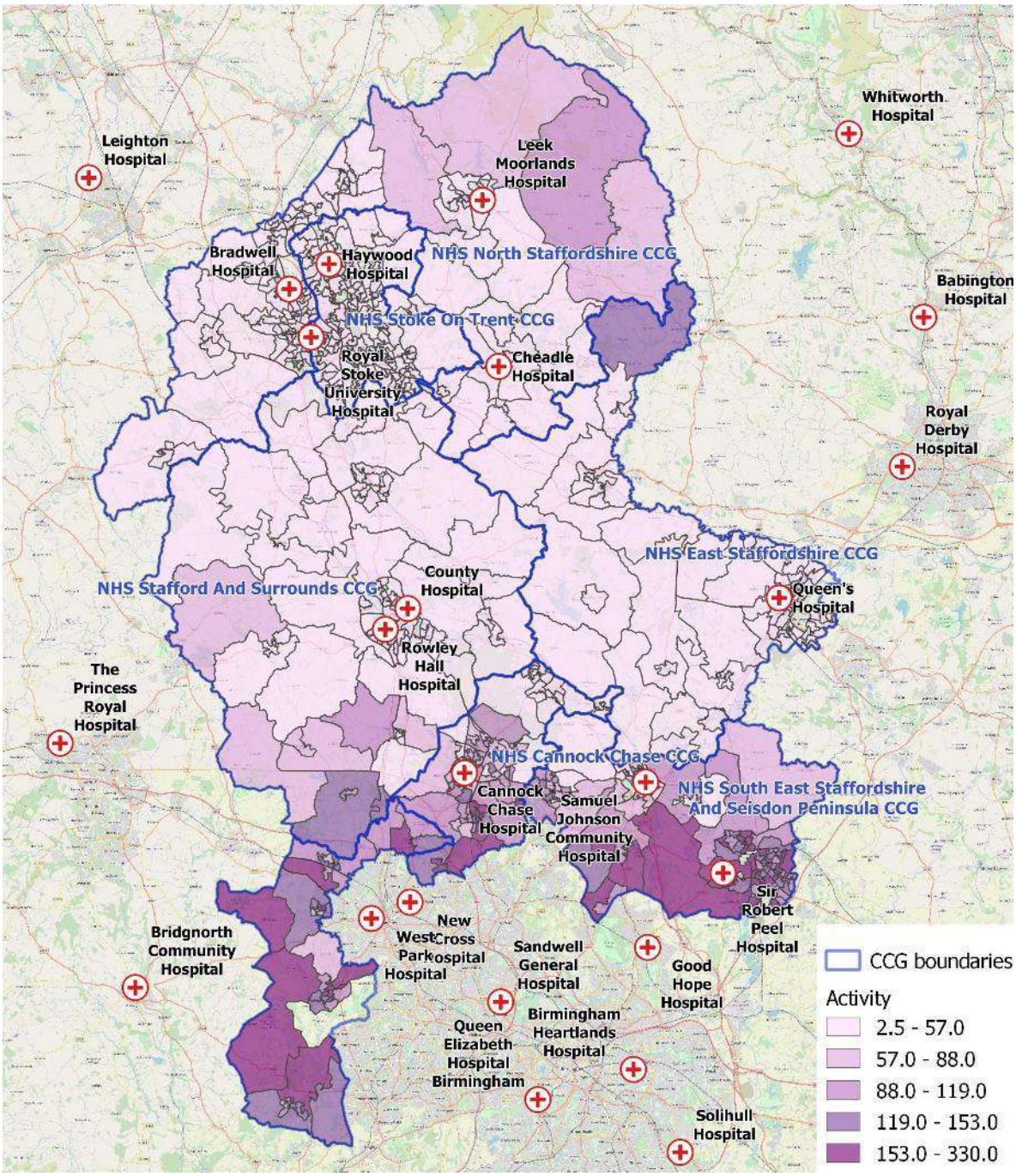
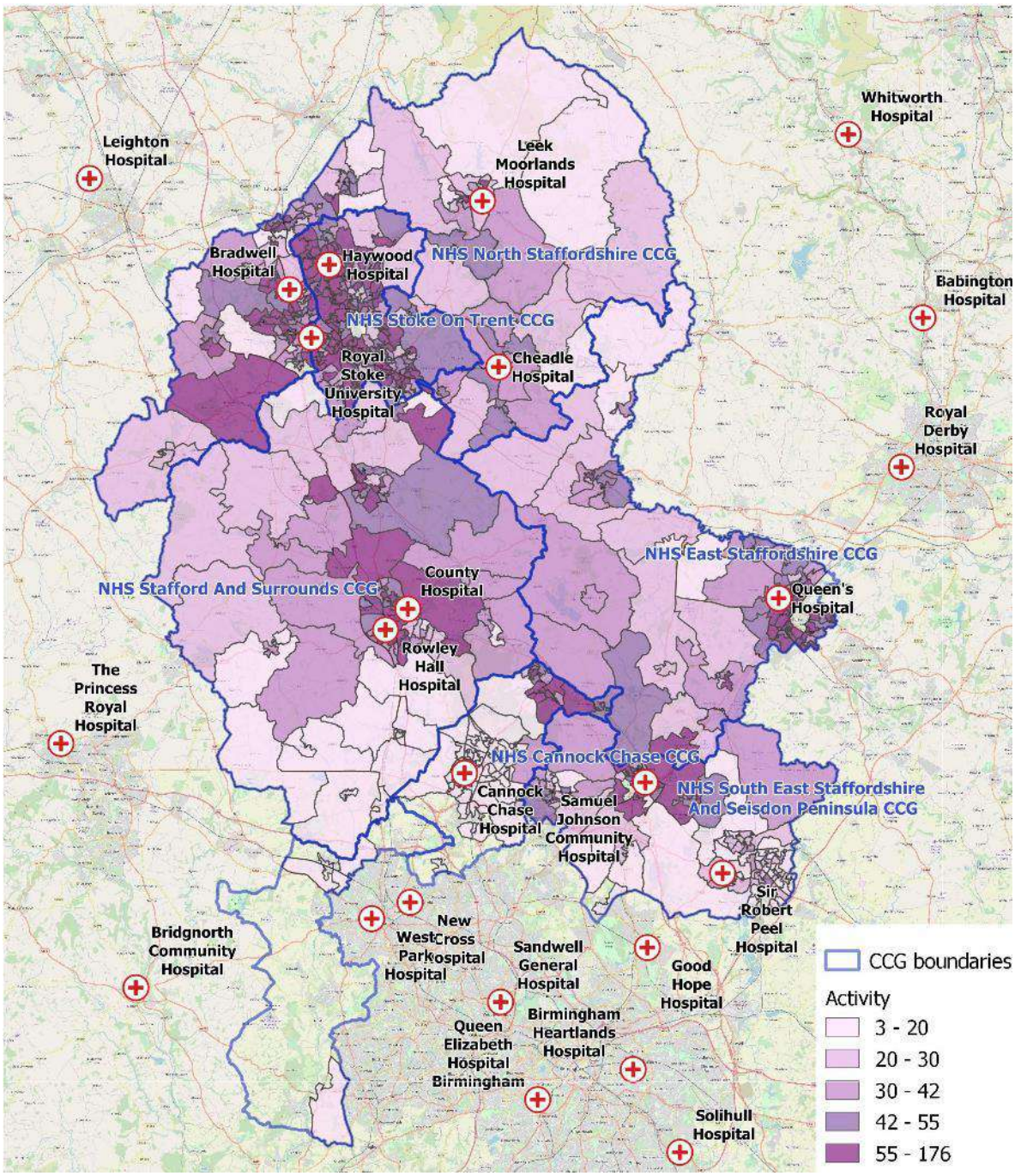


Figure 31: Women and children admissions 2017/18 activity map

Activity going to providers within footprint



Activity going to providers outside footprint