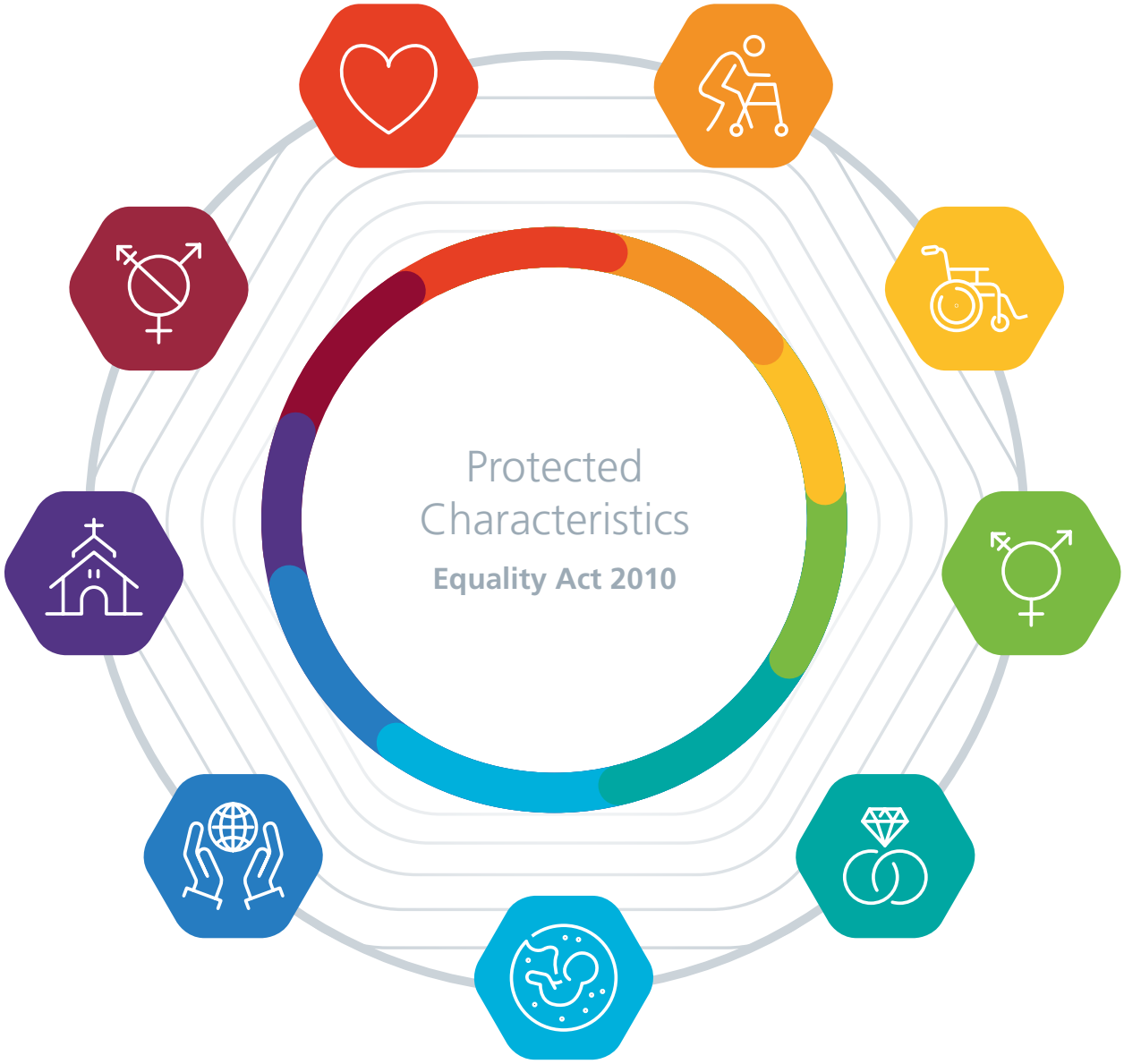
Cannock Chase Clinical Commissioning Group
East Staffordshire Clinical Commissioning Group
North Staffordshire Clinical Commissioning Group

South East Staffordshire and Seisdon Peninsula Clinical Commissioning Group
Stafford and Surrounds Clinical Commissioning Group
Stoke-on-Trent Clinical Commissioning Group

NHS

# Equality and Inclusion Strategy

## 2019 - 2021



# Contents

# Accessibility Statement

The six Staffordshire and Stoke-on-Trent CCGs want patients, service users, carers, public, staff and partner organisations to be able to understand our information in the format that is most accessible to their individual needs.

This includes identifying and reasonably removing 'barriers' for people accessing our information, services, premises, any employment or engagement opportunities and considering requests for reasonable adjustments as appropriate.

This information can be made available in alternative formats, such as easy read or large print, and may be available in alternative languages, upon request.

**If you need this or another document in an alternative format**, please contact us at **staffordccg.feedback@northstaffs.nhs.uk**

or telephone **01785 854482**.

## Document Status

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# 1 Executive Summary

**The six Staffordshire and Stoke-on-Trent CCGs are membership organisations consisting of 152 GP practices in Staffordshire and Stoke-on-Trent. Our role is to commission (buy) healthcare services for local people and we are committed to improving the health of our communities.**



Cannock Chase Clinical Commissioning Group, East Staffordshire Clinical Commissioning Group, North Staffordshire Clinical Commissioning Group, South East Staffordshire and Seisdon Peninsula Clinical Commissioning Group, Stafford and Surrounds Clinical Commissioning Group, Stoke-on-Trent Clinical Commissioning Group

This is Staffordshire and Stoke-on-Trent CCGs' first combined approach to our Equality and Inclusion Strategy and describes how we will support achieving this main aim while addressing the national legal and mandated requirements for public sector organisations (and their provider partners).

The overall aim of Staffordshire & Stoke on Trent CCGs is to ensure that all sections of our communities have the best possible healthcare outcomes by commissioning high quality, equitable and integrated services.

Our Equality and Inclusion (E&I) Strategy sets out our commitment to taking equality into account in everything we do. We recognise the importance of embedding equality principles and practices within the six CCGs planning and decision making to support us as Clinical Commissioning Groups to commission high quality, equitable and integrated services for our local population. The overarching purposes of this strategy are to:

- Explain our approach over the next three years (2019 to 2021).
- Set out our shared equality objectives.
- Fulfill our legal duty.

This strategy will be a flexible framework for our equality and inclusion activity which is an integral part of the way we do business. The strategy aims to harness how we achieve better health outcomes, improve patient access and experience, have a representative and supported workforce and inclusive leadership at all levels.

Sally Young

**Director of Corporate Services**,
Governance and Communications

# 2 Introduction

**The NHS Long Term Plan identifies promoting equality and inclusion is at the heart of the NHS values. This strategy sets out how the six Clinical Commissioning Groups (CCGs) in Staffordshire and Stoke-on-Trent will demonstrate this in all that we do - working in partnership with the wider NHS and our local partner organisations and communities, to ensure that advancing equality and inclusion is central to how we conduct our business.**

Staffordshire and Stoke-on-Trent CGGs are committed to ensuring that:

- Commissioning decisions, business cases and any other significant plans and strategies are evaluated for their impact on equality.
- To carry out robust equality impact and risk assessments and consult / engage those who are involved as part of the decision-making process.

# 3 Local population


With approximately

**850,000**

people living in Staffordshire

and around

**250,000**

people in Stoke-on-Trent.

The **population** is expected to **grow by approximately** **6%** over the next 25 years.

With our **complex** and **frail elderly population** growing faster than the national average

This will mean **a greater incidence of chronic ill health in our older population**, even though our older population is, overall growing less than the national average*

*16% **growth rate in the 65+ population by 2021**
additional residents aged 85 and over by 2027 in Staffordshire and 740 for Stoke-on-Trent.

This greater burden of ill health is linked to higher levels of obesity, poor smoking cessation rates, increasing alcohol related admissions and high levels of deprivation in some parts of Staffordshire and Stoke-on-Trent.

Stoke-on-Trent is characterised by high levels of deprivation and is currently ranked as the **14th most deprived local authority** (out of 326) in England.

**Nearly** **133,000** **people**
(over half the population) live in areas classified as being among the **top 20%** most deprived in England.


The health of people in Stoke-on-Trent is generally worse than the England average.

Staffordshire as a whole is far less deprived than Stoke-on-Trent, although pockets of high levels of deprivation exist across the most of the main towns in the county with **9% of its population living in the fifth most deprived areas nationally**. In addition, some of the remote rural areas in Staffordshire have issues with hidden deprivation, particularly around access to services.

**See Appendix 1** for Population health issues & health drivers.

# 4 CCGs and STP priority objectives to 2021

**The CCGs belong to 'Together We're Better' which is the Staffordshire and Stoke-on-Trent Sustainability and Transformation Partnership (STP) which brings together local health and care organisations to improve the way health and care is provided across Staffordshire and Stoke-on-Trent and includes commissioners, clinicians, health service providers, local authorities and voluntary sector organisations. They continue to develop proposals for transformational change which seek to address how local health and care services could be delivered differently to meet local needs against the backdrop of significant challenges faced by the local health economy.**

As a system, our fundamental challenge is the ability to achieve clinical and financial sustainability against a backdrop of a growing demographic need, increasing demand and responding to innovations, while also maintaining quality and performance. Our focus is one of delivering the right care in the right place within the funding envelope that we have been given.

During 2019/20 we will continue to streamline our governance and working arrangements, whether it is through merger or working together more closely.

There are real demographic and health delivery challenges locally. Recognising these challenges to deliver health care that meets the needs of an ageing population with significant presence of multiple long-term conditions necessitates a left shift towards care at home or within the community.

**See Appendix 3** for CCGs and STP priority objectives.

# 5 Our Equality Legal Duties

## The Equality Act 2010 requires general and specific duties of all public bodies.

### The General Equality Duty

The general equality duty applies to 'public bodies', including CCGs.

In summary, those subject to the general equality duty must, in the exercise of their functions, have due regard to the need to:

- Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act.
- Advance equality of opportunity between people who share a protected characteristic and those who do not.
- Foster good relations between people who share a protected characteristic and those who do not.

These are often referred to as **the three aims** of the general equality duty.

The Equality Act explains that the second aim (advancing equality of opportunity) involves, in particular, having due regard to the need to:

- Remove or minimise disadvantages suffered by people due to their protected characteristics.
- Take steps to meet the needs of people with certain protected characteristics where these are different from the needs of other people.
- Encourage people with certain protected characteristics to participate in public life or in other activities where their participation is disproportionately low.

The Act states that meeting different needs includes (among other things) taking steps to take account of disabled people's disabilities. It describes fostering good relations as tackling prejudice and promoting understanding between people from different groups.

To comply with the general equality duty, a public authority needs to have due regard to all three of its aims.

### The Specific Public Sector Equality Duty

As well as complying with the general duty, we must also comply with the following specific duties:

- Publish information to demonstrate compliance with the Public Sector Equality Duty at least annually.
- Prepare and publish equality objectives at least every four years.

## The Bracking Principles

The Bracking Principles have been taken from the Equality and Human Rights Commission's paper on Making Fair Financial Decisions (Equality and Human Rights Commission 2012).

Case law sets out broad principles about what public bodies need to do to have 'due regard' to the aims set out in the general equality duties. These are sometimes referred to as the 'Brown principles' and set out how courts interpret the duties. They are not additional legal requirements but form part of the Public Sector Equality Duty (PSED) as contained in section 149 of the Equality Act 2010.

- Decision-makers must be made aware of their duty to have 'due regard' and to the aims of the duty.
- Due regard is fulfilled before and at the time a particular policy that will or might affect people with protected characteristics is under consideration, as well as at the time a decision is taken.
- Due regard involves a conscious approach and state of mind. A body subject to the duty cannot satisfy the duty by justifying a decision after it has been taken. Attempts to justify a decision as being consistent with the exercise of the duty, when it was not considered before the decision, are not enough to discharge the duty. General regard to the issue of equality is not enough to comply with the duty.
- The duty must be exercised in substance, with rigour and with an open mind in such a way that it influences the final decision.
- The duty has to be integrated within the discharge of the public functions of the body subject to the duty. It is not a question of 'ticking boxes'.
- The duty cannot be delegated and will always remain on the body subject to it.
- It is good practice for those exercising public functions to keep an accurate record showing that they had actually considered the general equality duty and pondered relevant questions. If records are not kept, it may make it more difficult, evidentially, for a public authority to persuade a court that it has fulfilled the duty imposed by the equality duties.

In Bracking v Secretary of State for Work and Pensions [2013], the Court of Appeal approved the 'Bracking principles', as well as setting out some additional principles that are relevant for a public body in fulfilling its duty to have 'due regard' to the aims set out in the general equality duty. These principles are that:

- The equality duty is an integral and important part of the mechanisms for ensuring the fulfilment of the aims of anti-discrimination legislation.
- The duty is upon the decision maker personally. What matters are what he or she took into account and what he or she knew.
- A body must assess the risk and extent of any adverse impact and the ways in which such risk may be eliminated before the adoption of a proposed policy.

CCGs are committed to the governance approved Equality Impact and Risk Assessment (EIRA) scrutiny process, which includes application of the above principles. CCGs are keen to do the right and ethical thing first time, as well as meeting both their legal responsibilities and NHS England mandated equality standards.

## The Human Rights Act 1998

The Human Rights Act 1998 (HRA) came into force in 2000. Everyone in the UK is protected under the Act. The Staffordshire and Stoke-on-Trent CCGs, as public authorities, are obliged by law to respect the basic human rights of all citizens. As public bodies we must, at all times, act in a manner compatible with rights protected in this Act and safeguard these for patients and staff in our care and employment.

Human Rights are underpinned by a set of common values and have been adopted by the NHS under the acronym **FREDA**.

The FREDA principles represent:

- Fairness (e.g. fair and transparent grievance and complaints procedures).
- Respect (e.g. respect for same sex couples, teenage parents, homeless).
- Equality (e.g. not being denied treatment due to age, sex, race etc.).
- Dignity (e.g. sufficient staff to change soiled sheets, help patient to eat/drink).
- Autonomy (e.g. involving people in decisions about their treatment and care). Consideration of Human Rights is also given in our Equality Impact and Risk Assessment process, to ensure that our policies and strategies are compatible with the rights afforded by this Act

## The Health and Social Care Act 2012 and NHS Constitution

The Act builds on the core principles and values of the NHS – a comprehensive service that is available to all, based on need and free at the point of use.

The CCG is committed to upholding the NHS Constitution which outlines a number of commitments and pledges to uphold patient dignity and human rights.

## NHS England Equality Standards

### Equality Delivery System (EDS)

The EDS is a national framework which has been mandated by NHS England to all NHS organisations since April 2015. It is used to support the CCGs to deliver better equality outcomes for patients and communities and better working environments for staff, which are personal, fair and diverse.

The EDS provides a robust framework against which we can assess and grade performance against a range of nationally determined indicators grouped under the four EDS goals.

### The four goals are:

- Better health outcomes.
- Improved patient access and experience.
- A representative and supported workforce.
- Inclusive leadership.

CCGs have developed four new equality objectives which align to the EDS performance framework.

## Workforce Race Equality Standard

NHS Workforce Race Equality Standard (WRES) is a useful tool to identify, monitor and reduce any disparities in experience and outcomes for NHS employees and job applicants of different ethnicities. The Standard tracks progress to identify and help eliminate discrimination in the treatment of Black Asian Minority Ethnic (BAME) employees.

## Accessible Information Standard

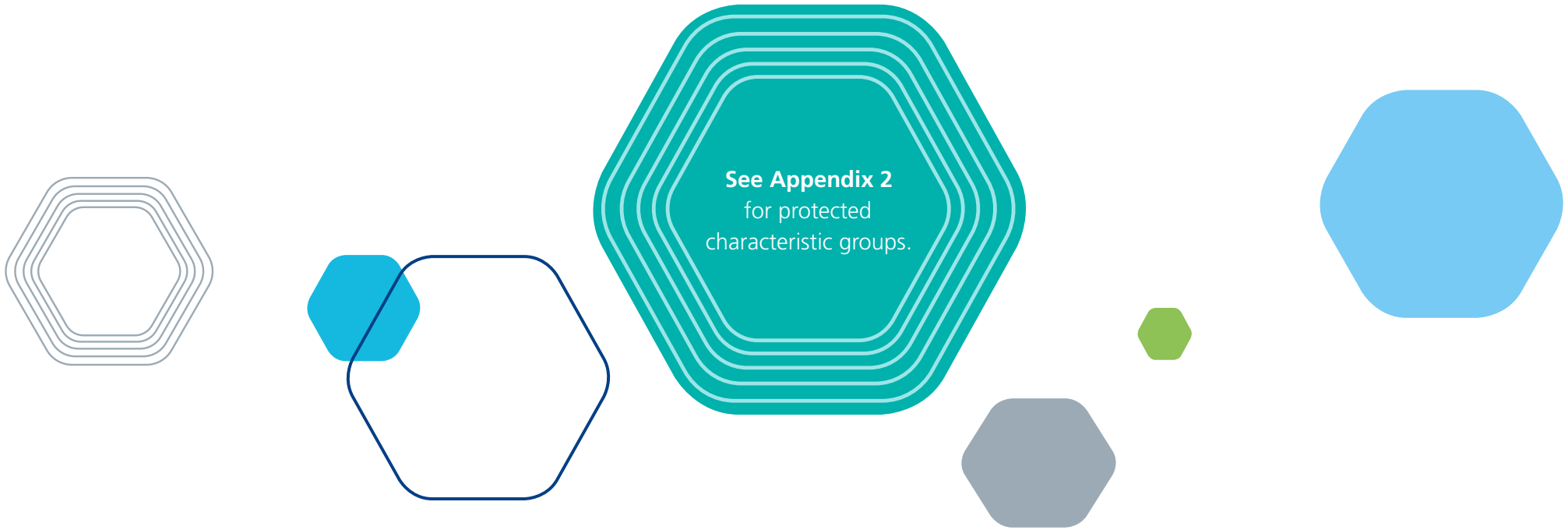
The aim of the Accessible Information Standard (AIS) is to make sure that people who have a disability, impairment or sensory loss receive information that they can access and understand and any communication support that they need.

The AIS informs organisations how they should make sure that patients, service users, their carers and parents, can access and understand the information they are given. This includes making sure that people get information in different formats if they need it, for example in large print, braille, easy read or via email.

The AIS also informs organisations how they should make sure that people get any support with communication that they need, for example support from a British Sign Language (BSL) interpreter, deaf-blind manual interpreter or an advocate.

Commissioners must ensure that their commissioning and procurement processes, including contracts, frameworks and performance management arrangements, with providers of health and/or social care reflect, enable and support implementation and compliance with this standard.

Commissioners must seek assurance from provider organisations of their compliance with embedding this standard, including evidence of identifying, recording, flagging, sharing and meeting of needs.



# 6 The aims of the strategy

1

**Ensure transparent delivery** and **good governance** for our legal equality and human rights responsibilities as CCGs working closely together.

2

**Ensure that all commissioned and contracted services deliver better outcomes** for our population as a whole between 2019 and October 2021 and those with protected characteristics in particular, and by including robust contract management and setting demanding targets and actions for provider partner organisations in line with these principles.

3

**Involve our patients, service users, carers, protected groups, staff and wider public** in improving fair access to services and patient experience, ensuring that seldom heard groups have specific, fair opportunities to engage and work with CCGs to shape more inclusive services.

4

**Scrutinise all strategies, policies, service designs and re-designs, decommissioning of services, programmes and projects** using Equality Impact and Risk Assessment (EIRA) scrutiny process for any consequences / adverse impacts arising for people likely to be impacted by healthcare changes under early stage consideration. Consider any reshaping of services; incorporating findings into contracts with providers.

5

**Ensure opportunities are proactively supported to improve the health and wellbeing of our workforce through good staff engagement.**

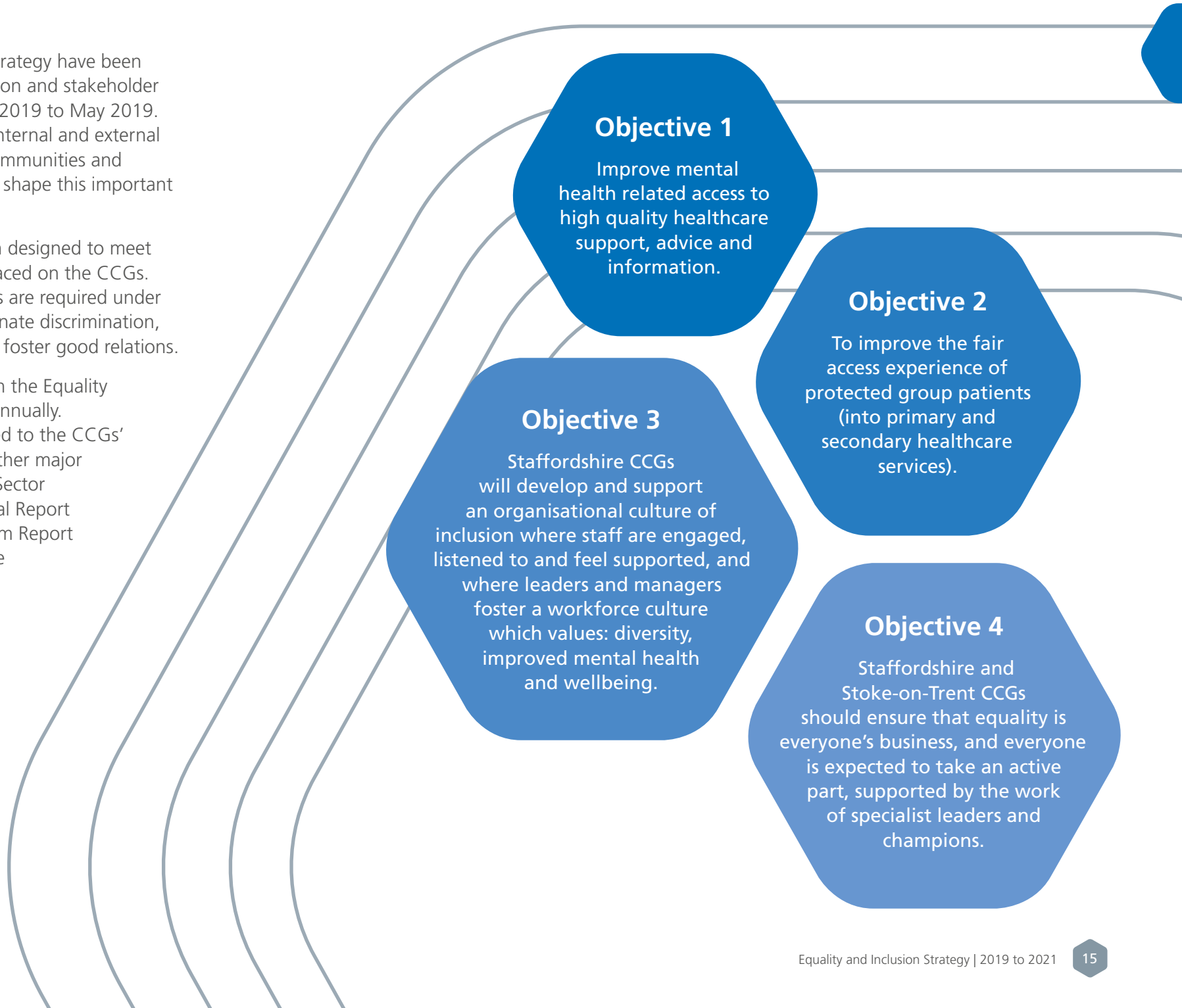
# 7 Four Equality Objectives 2019 to 2021

**Staffordshire and Stoke-on-Trent CCGs have four new shared equality objectives for delivery between 2019 and October 2021. CCGs are required to review their objectives annually as part of this three year strategy for equality. The strategy will focus on how CCGs deliver these objectives as well as meeting our legal responsibilities as a commissioner of healthcare services.**

These objectives and the strategy have been subject to online consultation and stakeholder feedback from September 2019 to May 2019. We have welcomed both internal and external feedback from our local communities and stakeholders to help CCGs shape this important document.

These objectives have been designed to meet a range of public duties placed on the CCGs. As public bodies, the CCGs are required under equality legislation to eliminate discrimination, advance opportunities and foster good relations.

These objectives along with the Equality Strategy will be reviewed annually. Information will be provided to the CCGs' governing bodies and/or other major committees via the Public Sector Equality Duty (PSED) Annual Report and Equality Delivery System Report to ensure the objectives are being progressed.



# How we deliver

# 8 Governance

## CCGs demonstrate robust governance for Equality and Inclusion through the following arrangements:

The Governing Bodies provide strategic leadership and are responsible for agreement of the Equality & Inclusion Strategy.

The Communications, Engagement, Equalities & Employment Committee delivery and monitor the Equality & Inclusion Strategy and related work programmes and receive the following reports;

Public Sector Equality Duty Annual Report – specific duty requirement

Equality Delivery System grading report - four goals with 18 required outcomes over a four-year cycle

Annual Workforce Race Equality Standard report

Annual provider compliance assurance report

Equality Objectives progress report quarterly

The Equality and Inclusion Strategy and four equality objectives will be reviewed annually to ensure they are 'fit for purpose' as CCGs, Sustainable Transformation Programmes (STPs), and Integrated Care Partnerships (ICPs) continue to develop.

# 9 LEAF

**The CCGs have a Communications and Engagement Strategy which was co-produced with patient representatives and complements the Equality and Inclusion Strategy. Listening to and responding to our seldom heard patients is a high priority as we know that it leads to better commissioning decisions and more accessible services for patients. There are a range of opportunities for patient and carer representatives to feedback their views on impacts arising from changes in services which are under early stage consideration. These range from our formal Local Equality Advisory Forum (LEAF) which is a group of critical friends who represent diverse and seldom heard communities to making sure that we consider protected groups when we undertake stakeholder analysis to engage and consult with people to understand barriers to proposed service change and unintended consequences of change on protected groups.**

# 10 Procurement

**Invitation to Tenders (ITTs) include a set of bespoke equality questions for potential providers, which are scored by CCGs' subject matter experts. This is according to content and evidence of how they are embedding equality and inclusion into the way providers do business through both workforce and service delivery issues.**

**The CCGs want to make the procurement process accessible to a range of skilled providers.**

# 11 Equality Impact and Risk Assessment

**Equality Impact and Risk Assessment (EIRA) is the CCGs agreed scrutiny process to provide an audit trail of evidence for taking 'due regard' or prompting of deliberate thought and consideration of seldom heard / vulnerable groups, in all our planning and decision making. Targeted engagement seeking feedback on unintended consequences or impacts arising for those likely to be affected by changes, supports vulnerable groups working with CCGs to help to shape more inclusive services. The EIRA aims to identify improved outcomes for vulnerable patient groups, through early stage consideration of patient and carer feedback received.**

## 12 Training

**All staff complete an online equality e-learning module once every three years from the date of joining. In addition, targeted equality and inclusion training is delivered to all Governing Body members annually. This training focuses on 'what do senior decision makers need to know?' Targeted EIRA annual workshop training is delivered to all staff who complete equality impact and risk assessment scrutiny, as part of their job role, using the UASSURE electronic platform.**

## 13 Reporting

**Progress on the strategy's equality objectives will be provided through the Communications, Engagement, Equality and Employment (CEEE) Committee and to the CCGs' Governing Body in Common through the Public Sector Equality Duty (PSED) Annual Report.**

# 14 Staff Engagement Group

**The Staff Engagement Group (SEG) was established in 2018 bringing together representatives from all directorates and divisions across the six CCGs. The group meets monthly, chaired by a Lay Member. The main remit of the group is to provide and represent the views of the workforce, to work with management to improve the working lives of staff and provide liaison between the workforce and management. The SEG receive reports on equality matters relevant to the workforce and make recommendations which are incorporated into action plans and comment on workforce policies.**

# 15 Provider Monitoring

**Equality and inclusion compliance checks are carried out through monitoring and reporting arrangements for provider partner contracts and close working with Procurement Contract Managers. Provider partners are subject to the same legal responsibilities as CCGs, in a way that is reasonable and proportionate to the size of their resources.**

# Appendix 1:
# Population health issues & health drivers

| Population Health Issues | Population Health Drivers* |
|---|---|
| **Obesity** – Obesity and excess weight was significantly worse than the England average in six of the nine District/Unitary Authorities across the region. | **Cancer Mortality**<br>**Waiting times** – Both acute Trusts (BHFT & UHNM) were the worst performing Trusts relative to peers in terms of cancer waiting standard from urgent GP referral to being seen in 2015/16 (79% and 75% of patients being seen within 62 days). |
| **Complex frail older people** – Half the CCGs across the system exceeded their peer averages for injuries due to falls (ages 65+). Stoke-on-Trent was 30% above the national average. | **Diagnosis** – Five of the six CCGs across our system were in the bottom 30% against peers for cancer detection at stage 1 and 2 (based on latest Public Health England (PHE) data). |
| **Smoking** – Stoke-on-Trent, Newcastle and Cannock have high rates of deaths due to smoking related illnesses in the 35+ population compared to the national average. | **Mental Health**<br>**Assessment** – Four CCGs reported a significant proportion of patients with common mental health conditions waiting for assessment longer than 90 days. |
| **Preventable Mortality** – Cancer was the primary reason for premature deaths for both Staffordshire and Stoke-on-Trent local authorities between 2012-2014, approximately twice as high as the next largest contributors to premature deaths: heart disease and stroke. | **Psychosis referrals** – Stoke-on-Trent was the only CCG to report a rate of at least 50% of treatments commencing within two weeks. |
| **Long-Term Conditions** – Diabetes and coronary heart disease prevalence exceeded the England average in five of the six CCGs for 2014/15. | **Long-Term Conditions**<br>**Diabetes (secondary prevention)** – The proportion of people with diabetes with good blood sugar control was worse than the England average in half the system's CCGs.<br>**Obesity** – Obesity and excess weight was significantly worse than the England average in six of the nine District/Unitary Authorities across the region. |

| Population Health Issues | Population Health Drivers* |
|---|---|
| **Alcohol** – Hospital stays for alcohol related harm were significantly higher than the England average for five of the six CCGs. This was highest in Stoke-on-Trent CCG – 52% higher than England average. | **Complex Frail Elderly**<br>Reablement – The number of people who are offered reablement to allow discharge from hospital as a proportion of all discharges from hospital aged 65+ was 1.2% compared to the England average of 2.9%, almost 59% less than the national average. This is likely to have a significant impact on the number of non-elective admissions. This may also be a contributing factor towards the high number of injuries due to falls for those aged 65 and over. |
| **Mental Health** – The number of detentions under the Mental Health Act (per 100,000 population) were above per average for three of our CCGs in 2013/14. Additionally we have higher levels of emergency hospital admissions of those people who intentionally self-harm in Staffordshire and Stoke-on-Trent. | |

*Whilst we have shown both issues and drivers we are not suggesting specific cause and effect.

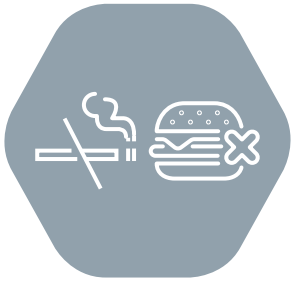
# Appendix 2:
# The Protected Characteristic Groups

| Name | Definition |
|---|---|
| **Age** | Age is defined by being of a particular age (for example being 35 years old) or by being in a range of ages (for example being between 60 and 75 years old). |
| **Disability** | A person is classed as having a disability if they have a physical or mental health condition and this condition has a 'substantial and long-term adverse effect on his or her ability to carry out normal day to day activities.' These words have the following meanings:<br>• Substantial means more than minor or trivial.<br>• Long term means that this condition has lasted or is likely to last for more than twelve months. There are progressive conditions that are considered to be a disability.<br>These include:<br>• People who have had a disability in the past that meets this disability.<br>• There are additional provisions relating to people with progressive conditions.<br>• People with HIV, cancer, multiple sclerosis are covered by the Act from diagnosis.<br>• People with some visual or hearing conditions are automatically deemed to have a disability. |
| **Gender Reassignment** | Gender reassignment protects people who have changed their gender from what they were identified as at birth. The Equality Act covers people at any stage of this process. |

| Name | Definition |
|---|---|
| **Sexual Orientation** | Sexual orientation means a person's sexual preference towards people of the same sex, opposite sex or both. |
| **Sex** | Sex is included to protect the individual man or woman from being discriminated against (as defined within the Equality Act 2010). |
| **Race** | Race refers to a group of people defined by their race, colour and nationality (including citizenship) ethnic or national origins. |
| **Religion or Belief** | Religion has the meaning usually given to it but belief includes religious convictions and beliefs including philosophical belief and lack of belief. Generally, a belief should affect your life choices or the way you live, for it to be included in the definition. |
| **Pregnancy and Maternity** | Pregnancy is the condition of being pregnant or expecting a baby.<br><br>Maternity refers to the period after the birth, and is linked to maternity leave in the employment context. Protection against maternity discrimination is for 26 weeks after giving birth. |
| **Marriage and Civil Partnership** | The definition of marriage varies according to different cultures, but it is principally an institution in which interpersonal relationships are acknowledged and can be between different sex and same sex partners. Same-sex couples can have their relationships legally recognised as 'civil partnerships'. In England and Wales marriage is no longer restricted to a union between a man and a woman but now includes a marriage between a same sex couple. |

# Appendix 3:
# CCGs and STP Priority Objectives

**These are supported by system-wide programmes for mental health and health and social care collaboration. The strategic objectives, which will deliver the Five Year Forward View, deliver constitutional targets and improve quality, care and outcomes. They are summarised below and specific Staffordshire and Stoke-on-Trent challenges addressed by work-streams, are grouped under these objectives. Cumulatively these refined priorities will have a direct impact upon the way in which acute services are organised and from where.**



### Focused Prevention

Address the economic, social and environmental determinants of health. Focus current spend and prevention services on promoting healthy ageing and tackling health inequalities in Staffordshire and Stoke-on-Trent. Identify the top three industrial prevention actions (e.g. secondary prevention of diabetes, reducing the harm caused by smoking in pregnancy, obesity prevention in high risk individuals). Identify where upstream investment in prevention and early intervention services will have a positive impact on both the health of the population of Staffordshire and Stoke-on-Trent in the short, medium and long term and will have an upstream positive impact on the population of Staffordshire and Stoke-on-Trent and reduce high cost care.

### Enhanced Primary & Community Care

Enhance primary and community care at pace to enable the frail elderly and those with long term conditions to live independent lives and avoid unnecessary, costly and upsetting emergency episodes. Best practice pathways for the frail elderly and those with long term conditions will be introduced. Address the fragility within the domiciliary and home care sectors. Improve reablement and intermediate care collaboration with the local authorities. Across health and care, we will integrate community, mental health, primary, social care and the voluntary sector.

## Effective & Efficient Planned Care

Develop options to re-configure services for planned care to deliver 'state of the art' highly efficient 7 day elective centres; keeping day case and outpatients local. Aims are to reduce duplication, deliver improved care at lower cost, and to include the release of estate. In parallel deliver productivity and efficiencies by specialty to reduce patient waiting time, improve referral processes, improve the quality of care and reduce costs. Improvements in productivity will further inform the re-configuration options as it will lead to a reduction in the required capacity to meet the Staffordshire and Stoke-on-Trent demand. This will lead to the potential for elective care being delivered across a reduced number of sites in Staffordshire and Stoke-on-Trent.

## Simplify Urgent & Emergency Care System

Simplification of the urgent and emergency care pathway to ensure that people receive the right care, in the right place, at the right time, and with the right level of clinical expertise. Minimise the access points of emergency care – Urgent Care: Consolidate minor injuries, walk-in, GP urgent appointments, NHS 111, and other urgent and response services with access to diagnostics in community facing urgent care units. Implement alternative rapid response community facing services which support the ability of the system to avoid unnecessary hospital attendances and admissions, and where admission does occur, reduce length of stay and increase the number of people returning to their usual place of residence post discharge. A&E standards to be achieved consistently and maintained through alignment and engagement between the STP and A&E delivery boards. Consider a change of purpose on one site from A&E to Urgent Care Centre.

## Reduce Cost of Services

Manage and deliver Cost Improvement Plans (CIP) and Quality, Innovation, Productivity and Prevention (QIPP) with a coordinated effort, ensuring that all providers and CCGs are in a strong position to deliver their in-year efficiencies through robust and forensic assessment of deliverability and the undertaking of significant mitigation actions where identified. Generating a long list of tactical savings outside of traditional QIPP/CIP. Develop a system-wide approach to the management and appointment of temporary staff, and sharing clinical capacity and expertise across the system irrespective of employer in order to reduce dependency upon agency workforce to lower cost. Rationalise estate and management costs to reduce fixed costs.

**The NHS Long Term Plan is clear on the importance of integrated working and the development of Integrated Care Systems. Along with equivalent provision mechanisms it essentially suggests a shift for local areas from focusing redesign initiatives on predominantly curative and episodic care interventions, to looking at a prevention focused pathway and whole system transformation in line with a population health management and outcomes approach to care delivery.**

We aim to commission accessible, preventative, inclusive services for all sections of our local communities that improve the health outcomes of our patients and carers. We know that different groups experience and take up services differently.

*"In some areas, a partnership will evolve to form an integrated care system, a new type of even closer collaboration. In an integrated care system, NHS organisations, in partnership with local councils and others, take collective responsibility for managing resources, delivering NHS standards, and improving the health of the population they serve.*

Local services can provide better and more joined-up care for patients when different organisations work together in this way. For staff, improved collaboration can help to make it easier to work with colleagues from other organisations. In addition, systems can better understand data about local people's health, allowing them to provide care that is tailored to individual needs."

**Source:** STP Strategic Plan Oct 2018 – Transforming Care for Staffordshire and Stoke-on-Trent

**Source:** https://www.england.nhs.uk/integratedcare/integrated-care-systems/

# Notes


Protected
Characteristics
Equality Act 2010