Shropshire, Telford and Wrekin

Joint Forward Plan

2024-29

Final

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Executive summary

The Shropshire, Telford and Wrekin (STW) Integrated Care System (ICS) has developed this Joint Forward Plan to outline how our health and care system will work together to deliver the priorities we have jointly agreed over the next five years.

This plan has been developed through a collaborative approach with all system partners and wider stakeholders in this diagram (right) and is based on engagement with our local communities. It is not set in stone, and we will continue to engage with our communities beyond the publication of the plan.

Since March 2020, when the COVID-19 pandemic was declared, our health and care system has been through some of the most challenging few years in its history. The pandemic changed the way we worked, lived and how our health and care was delivered. As a system, as partners and as individuals, we learned a lot about working together and the importance of community and wellbeing. However, the pandemic has also exacerbated our challenges and the demand for services.

For example, we are seeing unprecedented demand for mental health and wellbeing services, particularly for our children and young people (CYP). The backlog of planned operations and medical interventions has grown, and we have experienced challenges in delivering several constitutional standards. Our whole system also faces significant challenges in recruitment and workforce shortages, particularly in relation to restoring elective inpatient and cancer activity.

In July 2021, our system was formally placed in the national Recovery Support Programme (RSP) due to serious, complex, and critical quality and finance concerns that required intensive support.

Our system is currently spending more than its allocated finances and, therefore, our plan is set in the context of a financial recovery trajectory. Rather than spending more, we need to allocate resources based on creating health value – implementing innovative financial flows and payment mechanisms, and considering allocation of resources to provider collaboratives and 'Places'. We need to think and work differently to meet these challenges, including working more closely together.

One example of working together is the Office of the West Midlands – a partnership of West Midlands Integrated Care Boards (ICBs). The six ICBs in the West Midlands are working together to ensure at-scale collaboration and distributive leadership will add value and benefit from a shared set of common goals and priorities for citizens and patients throughout the West Midlands.

The three key elements of our plan are:

1. ***Taking a person-centred approach (including proactive prevention, self-help, and population health to tackle health inequalities and wider inequalities).***

We are committed to working with service users, carers, and partners to support our citizens to live healthy, happy, and fulfilled lives. This will mean supporting people to proactively look after their own health, putting a greater emphasis on preventing illness and staying well, but also providing the right care when and where they need it. Chapter 2 talks about person-centred care, what it is and how we will deliver it.

2. ***Improving place-based delivery, having integrated multi-professional teams providing a joined-up approach in neighbourhoods, supporting our citizens and providing care closer to home, where possible.***

The STW Local Care Transformation Programme (LCTP) brings together a collection of transformation initiatives that will deliver more joined-up and proactive care closer to home, supporting improved health and wellbeing for our population. This is encompassed by the local care vision of "adding years to life and life to years". Details of the LCTP are set out in Chapter 3 of this plan.

3. ***Providing additional and specialist hospital services through our Hospital Transformation Programme (HTP).***

The HTP is putting in place the core components of the acute service reconfiguration, agreed as part of the Future Fit consultation. It is helping us to address our most pressing clinical challenges and establish solid and sustainable foundations upon which to make further improvements. Details of the HTP are set out in Chapter 4 of this plan.

In conclusion, this plan highlights the work that we are undertaking across the ICS to improve the care we provide for the citizens of Shropshire, Telford and Wrekin. We understand that this is an ambitious plan which faces significant challenges. But while there is much work to be done, we believe that it is achievable. We must deliver our plan to improve the health and care services for our population through the strong commitment of our partner organisations and by talking to and working with our communities.

Progress of Joint Forward Plan in 2023/24

2023/24 was the first year of the Shropshire, Telford and Wrekin Joint Forward Plan and progress has been made across many areas.

One of the plan's key areas of focus was delivering a person-centred approach. The system has shown its commitment to this by implementing a Person-Centred Facilitation Team to ensure the approach is embedded in transformation programmes. An example of this is the Women's Health Hubs, which have person-centred care at the core of the service model.

A primary focus of the plan was on delivering place-based care to ensure we provide care closer to home to deliver services that meet the needs of the population. An example of this was the implementation of Community and Family Hubs which are one-stop centres where families can access information, guidance, support and services.

After the pandemic, the ICS has been working to recover and improve elective care services across the county. Some of the key improvements in 2023/24 include:

- Community Diagnostic Centre opened delivering improved access to tests and scans
- Phase one of the musculoskeletal health (MSK) transformation programme completed to streamline pathways and improve outcomes for patients.

There have been improvements in support to vulnerable children and young people with the update of the Children and Young People Transformation Plan. During the year, the ICB has supported Hope House Children's Hospice and Shropshire Community Health NHS Trust to work together to support the care for children and young people with life-limiting or life-threatening conditions.

Other areas of progress during 2023/24 include:

- The ICB presenting at the Regional Health Inequalities Conference to share learning and best practice with other systems
- Developing and submitting the HTP full business case
- New service model for talking therapies implemented to ensure consistency of care and improved outcomes
- Completing the autism passport project to improve understanding of autism.

The ICB is committed to building on this work and continuing to improve services for our local population.

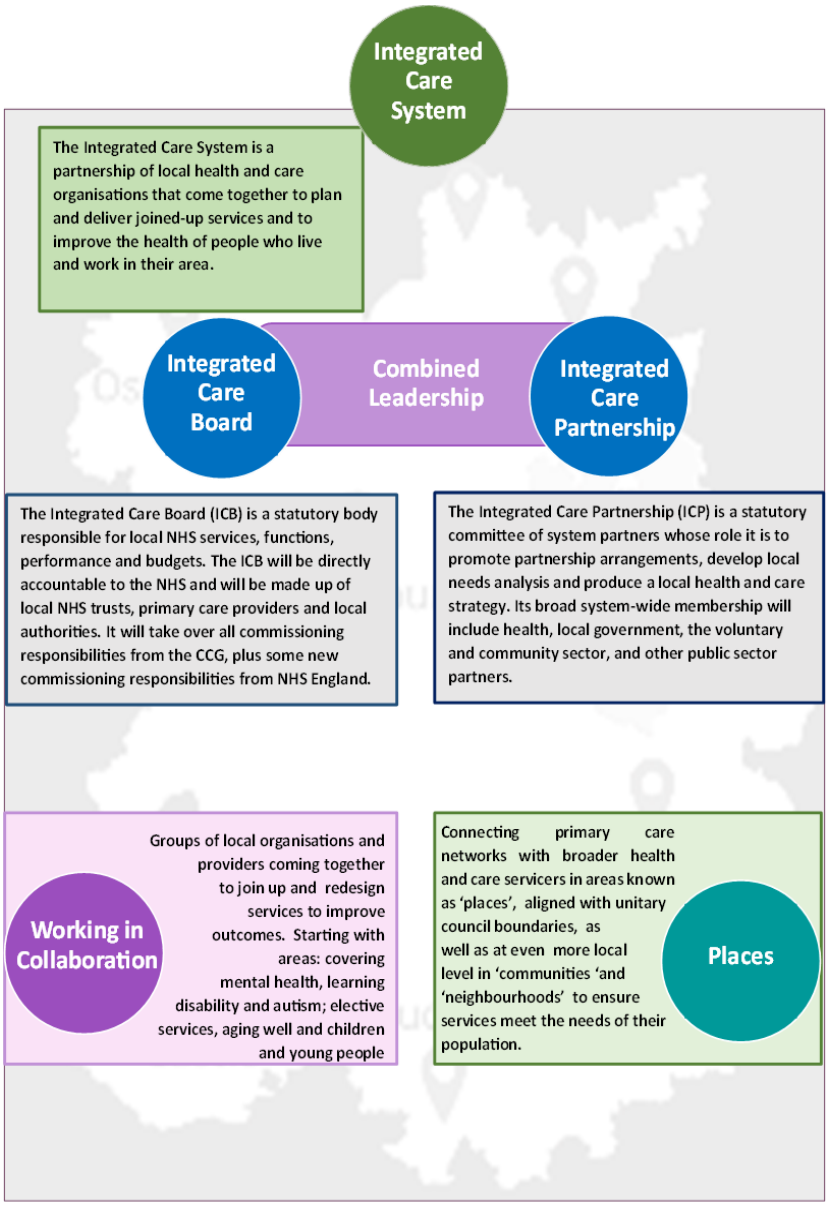
Chapter 1: our Integrated Care System (ICS)

1.1 Background

Our Joint Forward Plan has been developed through a collaborative approach with all system partners and wider stakeholders, including our Health and Wellbeing Boards. We will be held to account for its delivery by our population, patients and their carers or representatives and, in particular, through the Integrated Care Partnership (ICP), Healthwatch and the local authorities' Joint Health Overview and Scrutiny Committees.

As an ICS we understand the importance of developing our health and care services based on the views of our local population, alongside the evidence on population health. We have been working with our two Healthwatch organisations to hear what our residents are telling us.

Residents have asked for "a person-centred approach to our care". People must be at the heart of everything we do and by delivering joined-up services in both acute and community settings, we can give everyone the best start in life, create healthier communities and help people age well.



1.2 Our population

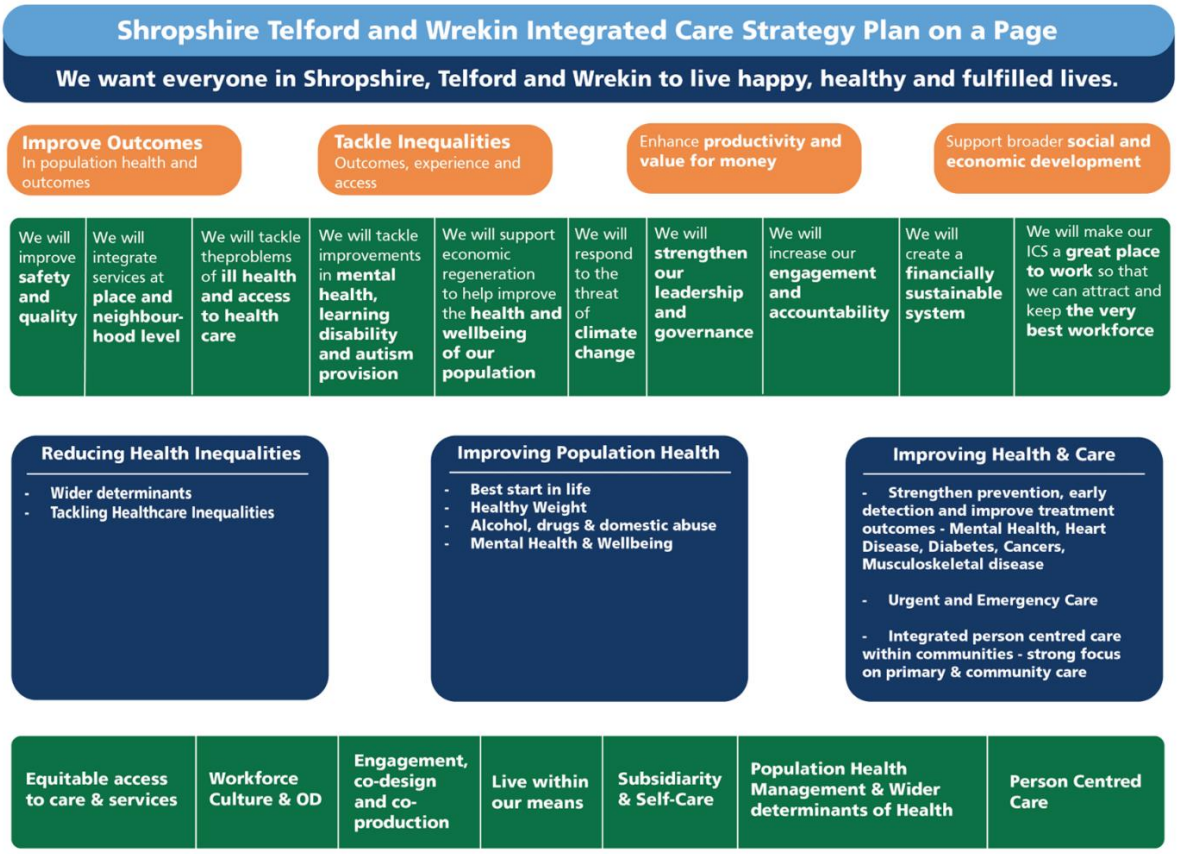
Our approach to population health and business intelligence, and our understanding of our population and their needs, will ensure that as a system, we are working on the right priorities. Furthermore, it will then provide the in-depth analysis to support commissioners in facilitating work with providers, community assets and our population to find solutions to our 'wicked[1]' issues.

[1] Wicked issues – A problem that is difficult or impossible to solve because of its complex nature

Our councils provide the Joint Strategic Needs Analysis for our populations and communities. These inform the Health and Wellbeing Strategies for each of our Places and, subsequently, our interim Integrated Care Strategy, which was approved on 20 March 2023 by the Integrated Care Partnership.

1.3 What we want to achieve

Within the context described above, our ICS vision, pledges and strategic priorities are summarised in the diagram below:

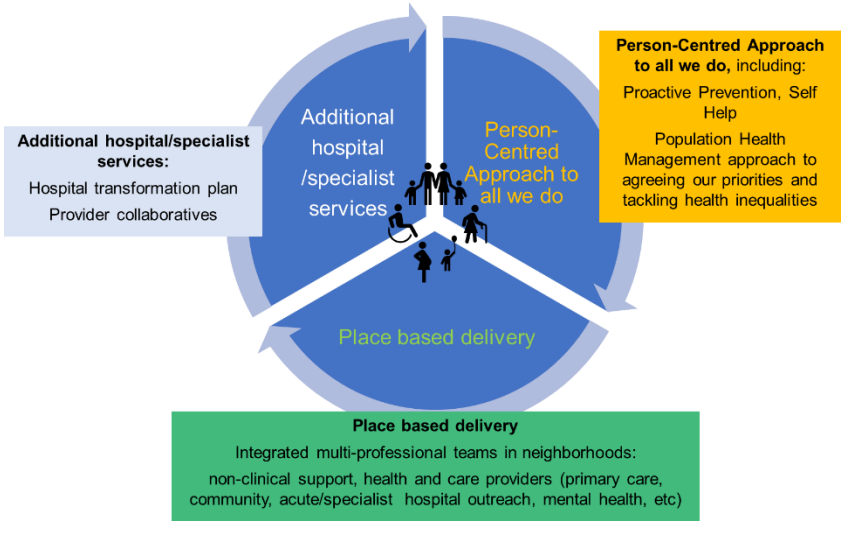


1.4 How we will deliver these priorities

There are three key components of our plan which will help us achieve our priorities and our model of care. These are shown in the diagram on the right.

Our two Places will play a major role in delivery of our priorities. The table below shows how the ICS priorities align with our Place priorities.

A detailed overview of the population health priorities, inequalities priorities and health and care priorities across Shropshire, Telford and Wrekin and the ICS can be found in Appendix A.



Case study: Healthy Lifestyles Service, part of the Teldoc Diabetes Pathway

Teldoc patients are now able to book an appointment to see a Healthy Lifestyles advisor at the Oakengates Medical Practice, Telford. Clinics are scheduled three days a week for patients requiring support with pre-diabetes or those who are newly diagnosed with diabetes. Being part of the Teldoc diabetes pathway allows patients to meet with an advisor without using the standard referral route (online form completion or telephoning the service) making it more accessible to the patient. Co-location of the Healthy Lifestyles Service with a primary care provider demonstrates the joint working between these two organisations and makes the two services work seamlessly together. Patients can access follow-up support with their advisor in a community clinic close to their home, removing the need to visit the GP surgery for this type of intervention.

1.5 Our operating model

Although we are a challenged system, we are an ambitious one. Our operating model outlines how we plan to deliver our statutory duties and our ambitious plans. The operating model has our purpose at its foundation:

NHS Shropshire, Telford & Wrekin Integrated Care Board			
Our goal as an organisation is to lead and support delivery of the four Integrated Care System (ICS) aims across Shropshire, Telford & Wrekin:			
Improving outcomes in population health and healthcare	Tackling inequalities in outcomes, experience and access	Enhancing productivity and value for money	Helping the NHS to support broader social and economic development
Our purpose reflects our roles through the lenses of Strategic Commissioner, System Convenor, System Oversight and as a System Partner:			
Strategic Commissioner – • commissioning of health and care services to reduce the health inequalities that exist. • leading engagement with local communities and all our staff to shape how services are developed.	**System Convenor –** • leading on the development of system-level strategies and plans to transform health and care services across our system. • focussing on effective joint working arrangements with all partners.	**System Assurance –** • providing the first line of oversight of health providers across our ICS. • adding value and focus on improving the experience of local people.	**System Partner -** • playing an influential role in the development of strategic solutions that are implemented with partners. • focussing on reducing duplication and improving collaboration. • playing an active role as a local employer to support the local economy

In combination with our purpose and goals – our values, behaviours and leadership approach shape the design principles for our ICB teams and functions, our relationships within and beyond our organisation and how we design our processes. This includes how we commission and how we support our providers of care to collaborate.

We undertake our unique role in the Shropshire, Telford and Wrekin health and care system with compassion, respect, drive and integrity. This means that we value diverse contributions, drawing on the expertise and experience of local people, staff and partners, alongside high-quality intelligence to make choices which best serve the people of Shropshire, Telford and Wrekin. You can expect to see and experience:

Integrated Care System
Shropshire, Telford and Wrekin

NHS
Shropshire, Telford and Wrekin

Our ambition to succeed. You will also see our people being supported and trusted to do the difficult things with integrity and creativity.

Our shared purpose. This will be supported by our empathetic, inclusive approach where the contributions of all are valued as we work together to reduce inequalities.

Our optimism. Where our drive for improvement will be shared with clarity, enthusiasm, and openness.

Our unwavering focus. Where we concentrate on improving health and wellbeing with the people of Shropshire, Telford and Wrekin.

Ambition

Measured by evidence of behaviours captured through the appraisal process, feedback from ICS partners and staff surveys, along with transparency in decision making and ethical issues in our records

Compassion

Measured by evidence of behaviours captured through the appraisal process, feedback from ICS partners and staff surveys, along with demonstration of the impact of lived experience in the development and tracking of plans

Optimism

Measured by evidence of behaviours captured through the appraisal process, feedback from ICS partners and staff surveys, along with feedback from our lived experience groups

Focus

Measured by evidence of behaviours captured through the appraisal process, feedback from ICS partners and staff surveys, along with evidence that our investment of resources is aligned to our priorities for improvement in health outcomes and reduction in health inequalities

These values form one of the pillars of our recruitment and retention processes and shape our behaviours.

We have worked with our staff to develop design principles which underpin how we design our functions to deliver our purpose:

Outcome focussed	Design for our four purposes and unique role in the ICS
Positive future mindset	Design for how we want to work in the future
Affordable	Align our resources to our priorities and live within our means
Clear	Clear roles and functions, aligned to the commissioning cycle to ensure clear relationships and contributions within and beyond the ICB
Collaborative	Do once what can be done once for all (ICB or ICS, or prepare for that in the future) Support colleagues to be intelligent consumers of specialism and design to serve our colleagues and partners
Challenge assumptions	Find new ways of working, support others to hold their responsibilities
Compliant	Fulfil our statutory obligations
Enabling	Design for: expertise and freedom to act; efficiency; the ability to flex and change; developing talent; and transition through pain points supported by governance which supports us and keeps us safe

These design principles, along with our values, behaviours and leadership models, form the principles of how we design our operating processes:

- Strategy will be grounded in population health management approaches, have measurable outcomes, clearly laid out contributions to its implementation, draw on experience and insight from across the ICS and align resources to clinical priorities
- Our relationships within the ICS will be grounded in mutual support and our shared success will make Shropshire, Telford and Wrekin a great place to work
- We will place our people in roles that they have the skills and experience for, create clear career pathways and ensure that every member of the team understands how they can make decisions and contribute to the delivery of our purpose
- We will set out clear accountability and ensure collective responses to any challenges we face
- Our record keeping will ensure transparency in our decision-making process and how we prioritise.

How we will work together to make decisions and deliver:

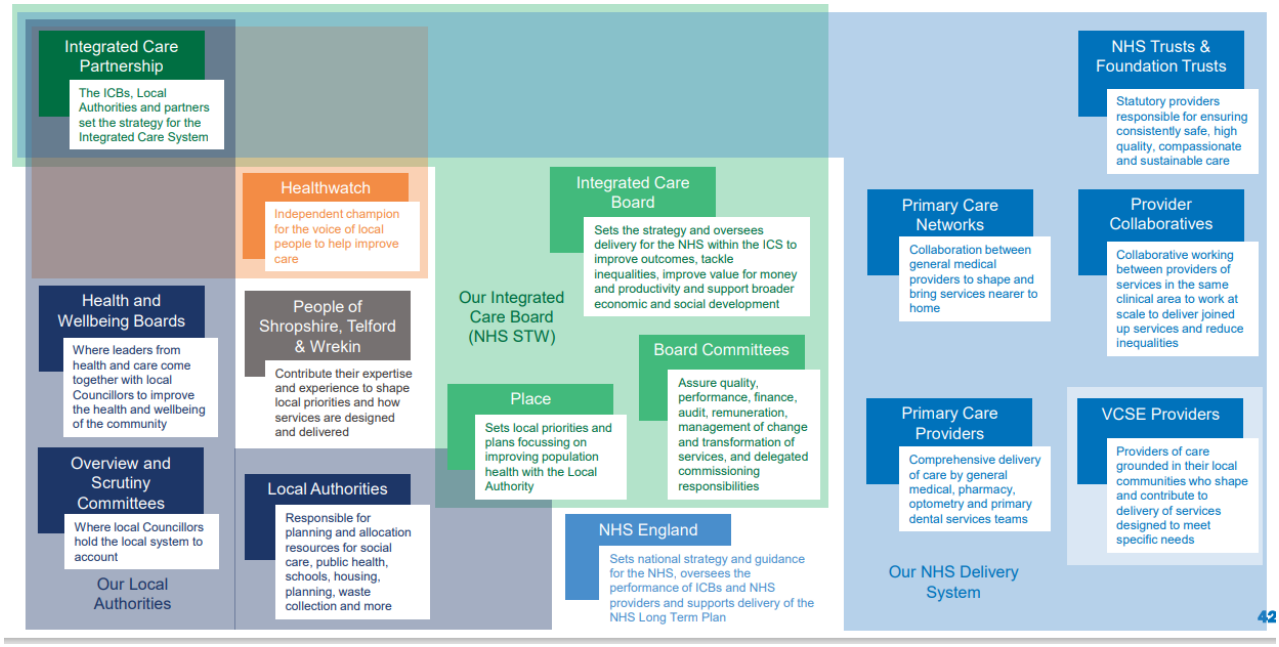


Figure 1: Our Integrated Care System

Working with the Good Governance Institute, the ICB has completed a 'Making Meetings Matter' review to develop a governance improvement programme. The aim of the programme was to develop a simplified corporate divisional structure for the ICB with fewer, more efficient meetings that strengthen assurance, management of processes and board oversight. The proposal has two phases:

- Stage one: meeting structure for immediate adoption (Figure 2)
- Stage two: meeting structure for adoption once Places and provider collaboratives are more mature.

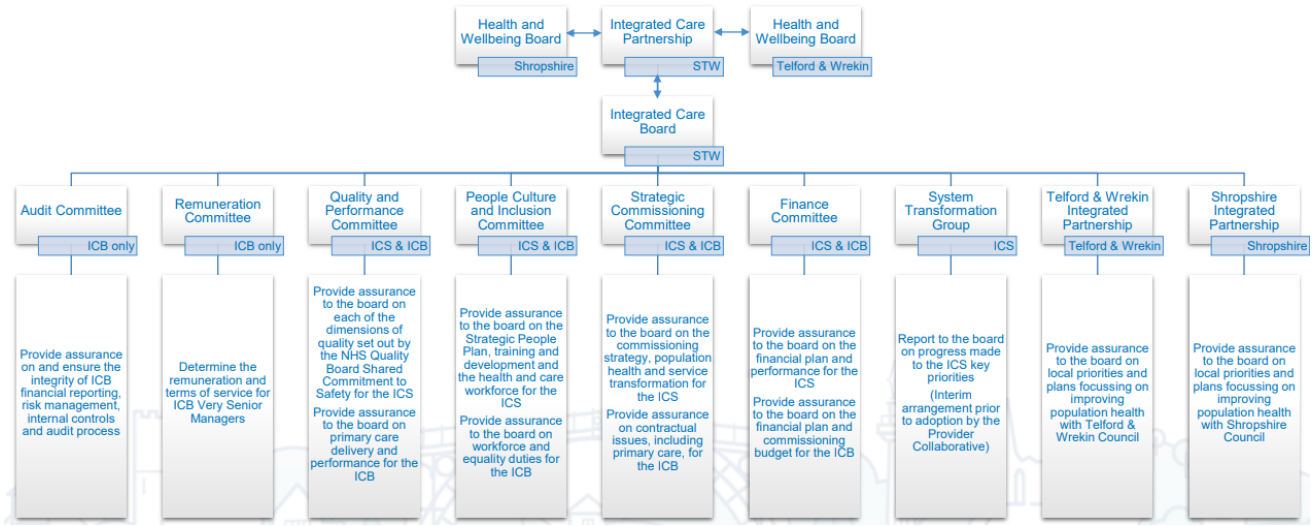


Figure 2: Stage one governance structure

Beneath the System Transformation Group, there are management groups (tier two groups) responsible for reviewing progress in the priority areas of: urgent and emergency care (UEC), elective care/cancer and diagnostics, mental health, learning disability and autism, children and young people, workforce (agency and recruitment), financial improvement, and our Local Care Transformation Programme (LCTP).

It is the responsibility of the system executive directors to decide on the management groups, including their purpose and membership, to drive the delivery of the system objectives. There are existing groups which could be used for this purpose. Each tier two group is chaired by an executive director, and this is likely to be an ICB executive director until the provider collaborative is in a position to take full responsibility for delivery.

Any tier three groups required will report into one of the tier two groups. Tier four groups may be required, and they will report into a tier three group.

A core principle of these proposals is to recognise the distinctive role of the board and management. In particular:

- The ICB board sets the strategy and receives assurance
- ICB committees provide and receive assurance on risks to the ICB strategy and support continuous improvement
- ICB executives develop and implement plans and actions.

ICB Board

The board of our ICB is a unitary board at the centre of the ICB governance framework. It is accountable for the performance and assurance of the NHS and the wider Integrated Care System (ICS) within Shropshire, Telford and Wrekin in both operational delivery and to ensure progress towards its four aims. To discharge this, the board also sets the strategy for the NHS within the ICS and supports the delivery of the Integrated Care Partnership (ICP) Strategy.

The board provides leadership for the transformation of the NHS in Shropshire, Telford and Wrekin, and oversees the activities carried out by the ICB, in Place and in the ICP, ensuring good corporate, financial, clinical and quality governance throughout the ICS. The board convenes committees within the ICB or across the ICS to assure these activities.

All members of the board are jointly and equally responsible for the decisions and actions of the board and, whilst drawing on their experience in undertaking their ICB role, do not represent the particular interest of any organisation, community or group.

Our non-executive directors provide leadership of the key assurance functions of the board including chairing the committees of the ICB. Our partner members lead ICS delivery portfolios.

Our Places

Telford and Wrekin Integrated Place Partnership (TWIPP) and Shropshire Integrated Place Partnership (ShIPP) are our system's two Place-based partnership boards. They are based on the well-established relationships with our local authority partners. Our Joint Forward Plan describes the actions and ambitions to deliver the Place-based strategies over the coming five years.

The members of our Place partnerships include Primary Care Network clinical directors, voluntary community and social enterprise (VCSE) sector providers, Healthwatch, NHS providers and local authority colleagues across public health, adult and children's social care.

Both Places have strategies that are based on delivery of their respective Health and Wellbeing Board strategies and the Integrated Care Strategy (a joint strategy published in March 2023 signed off by the ICP).

Governance arrangements for our Places are currently developing to reflect the increasing maturity of the partnerships and the system ambition to raise the profile and importance of Place-based delivery. The revised arrangement will address:

- ShIPP and TWIPP reporting directly to the board of the ICB for assurance, delivery, quality and finance
- Attendance at the STW ICB as the Place-based leaders
- Attendance at the STW ICP
- Attendance at the Health and Wellbeing Board (HWBB) in recognition of the connections between the HWBB, ICB and the ICP.

Our Place delivery model recognises that neighbourhoods are key to having thriving communities that support people to keep well, prevent ill health, and manage long-term conditions closer to their homes, schools, or primary care. Our neighbourhoods are delivering local care through Integrated Neighbourhood Teams which use a 'team of teams' approach to bring together different disciplines to ensure an integrated approach to meeting local needs. The partnerships are using performance dashboards supported by the ICB team to monitor delivery and performance of the local Health and Wellbeing Strategy and local plans (including Integrated Neighbourhood Teams).

Our provider collaborative

In STW, a Committees in Common (CiC) structure has been established to support our provider collaboratives using a provider leadership model. The collaborative is made up of:

- Shrewsbury and Telford Hospital NHS Trust
- Shropshire Community Health NHS Trust
- Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust
- Midlands Partnership University NHS Foundation Trust.

Each of the four providers has delegated authority to their own committee members who will meet and share oversight and decision making. This structure will enable the providers to work together to further join up services and drive improvement aligned to the Integrated Care Strategy and Joint Forward Plan priorities. Our providers have established collaboratives with others and are now developing around clinical priority areas or supporting integrated provision of services provided beyond the boundaries of Shropshire, Telford and Wrekin.

Delivering the commissioning cycle

The ICB works to deliver its four purposes through the three phases of the commissioning cycle:

- Strategic planning – co-assessment of ICS needs, planning of services, engagement with stakeholders
- Procuring services – service specification development, provider selection, engagement with stakeholders, contract development
- Monitoring and evaluation – contract compliance, oversight of delivery, feedback from stakeholders.

In combination, this enables our ICS to respond and transform delivery. The ICB will not undertake every part of each phase of the commissioning cycle, but it will hold the responsibility for ensuring that all activities happen. The fundamentals of commissioning (in its fullest sense) remain crucial in structuring health services. However, how we commission is being transformed. The introduction of the provider selection regime requires a new function within the ICB that can collaborate with partners in a different way. We will use the commissioning cycle to align the efforts and contributions of each function in the ICB to achieve our commissioning objectives.

Figure 3: How we will work together to deliver outcomes

1.6 Our approach to quality

As a system, we commit to using all available resources, including Right Care Opportunities, to deliver improved quality by removing unwarranted variation and improving outcomes at a population health level.

It is our ambition to create outstanding quality by:

- Committing to patient-centred, personalised care where patients have ownership of their own care, but also routinely inform development and delivery of future services based on the learning of their lived experiences
- Strengthening integrated multi-disciplinary working across our organisations to ensure our population receives care in the right place at the right time
- Streamlining care with robust pathways to ensure sufficient capacity for planned care, designed to improve patient experience and outcomes
- Making sure people can navigate a simplified urgent care system to meet both physical and mental health needs
- Supporting our health and care providers to achieve improved CQC ratings where appropriate.

Key organisations' CQC ratings – 1 June 2023

Organisation name	Inspection category	Publication date	Overall	Safe	Effective	Caring	Responsive	Well led
Midlands Partnership University NHS Foundation Trust	Mental health services (relevant to STW)	5 July 2019	Good	Good	Requires improvement	Good	Good	Good

Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust	Specialist NHS hospital	21 February 2019						
Severn Hospice (Apley site)	Hospice service	11 January 2022						
Severn Hospice (Bicton site)	Hospice service	12 January 2022						
Shrewsbury and Telford Hospital NHS Trust	Acute hospital NHS non-specialist	18 November 2021						
Shropshire Community Health NHS Trust	Community health NHS and independent	1 August 2019						

Key areas where we need to improve quality of services (June 2023):

- Children and young people's (CYP) services
  - We want to strengthen the multi-agency approach to the prevention of poor mental health and improve access when services are needed
  - We want to ensure children's acute services are safe and effective, and waiting lists are tackled in line with adult services
- Urgent and emergency care (UEC)
  - We want to improve timely access to urgent and emergency care
- Diabetes care
  - We want to focus on prevention of diabetes and ensuring healthy lives for people with diabetes
- Maternity care
  - We want to continuously improve our maternity services and sustain improvements made in response to the Ockenden reports.

As a system, we will fully prepare for the CQC framework to monitor the quality of services for integrated care systems.

Our plans to continuously improve the quality of our services are outlined in the table below:

How will we monitor quality?	How will we measure and sustain quality?	How will we improve quality?
• Listening to those with experience of care • System quality risk register • System risk escalation • System quality metrics at Place • System Quality Group with clear terms of reference and feed to Regional Quality Group • The Quality and Performance Committee seeking assurance against the risks	• Executive champions of quality health and social care coming together at System Quality Group to drive quality services forward across the ICS and beyond • Contracts and local quality requirements • Clearly defined system quality metrics • Themed quality visits • Partnering with Healthwatch and the voluntary sector	• Integration of quality improvement expertise into system priority programmes • Research and innovation • Rapid learning from incidents and themes across partners • Finding out what works through quality improvement projects with partners across the ICS • Focus on personalised palliative and end-of-life care

with the partnership of key agencies across the ICS, in line with national guidance • Learning from deaths, child death overview panel (CDOP), infant mortality and people with a learning disability and autistic people (LeDeR) • The co-ordinated introduction of a Patient Safety Incident Response Framework (PSIRF) and learning from incidents as a system and beyond, driven by patient safety specialists and patient safety partners • Receiving and discussing quality exception reports monthly at ICB Board.	• Co-production with those who experience care • Feedback from our residents • Quality accounts.	• Aging well though the support of care homes and domiciliary care to deliver the highest possible care they can • A focus on early years • Ensuring quality care is accessible to all though strategic integration of quality and Core20PLUS5.

1.7 Our approach to engagement with communities

In line with our values, we have built our Joint Forward Plan through a process of genuine engagement with our local communities, stakeholders, and our staff.

Comprehensive and meaningful engagement will ensure our services are more responsive to people's physical, emotional, social and cultural needs. We will take active steps to strengthen public, patient and carers' voices at Place and system levels. We have engaged with groups who are seldom heard and have the greatest health inequalities to ensure they are not excluded from the dialogue.

We have developed a set of principles for involvement which have been shaped with input from people across our health and care system and communities. They have been informed by the knowledge and experience of a diverse range of people, including those with lived experience of using our services and those for whom involvement is already embedded into their working practices.

Read our full Involving People and Communities Strategy.

To support staff to plan and undertake the appropriate level of involvement of people and communities, we have built an Equality and Involvement Committee into our governance arrangements. The role of the Committee is to provide assurance to the Board that our strategies, plans, service designs and developments have adequately and appropriately:

- considered and addressed the health and care needs and aspirations of residents in Shropshire, Telford and Wrekin who do, or may, experience inequalities in access to health services and health outcomes,
- involved people who do, or may, use the services under consideration.

Read more about the role of the Committee and its membership.

During 2023, we launched the Big Health and Wellbeing Conversation asking people who live, work or access health and care services in Shropshire, Telford and Wrekin how the care they receive could be improved. The Big Health and Wellbeing Conversation aimed to understand local views on what is affecting their health and wellbeing and what could make the biggest difference to improve experiences of local health and care services. The feedback gathered will help NHS Shropshire, Telford and Wrekin to develop future plans.

The key recommendations from the Big Conversation were:

- Improve communication with patients and between services
- Improve access to appointments including increasing virtual appointments
- Raise awareness of services to help people to live well
- Support patients to minimise digital exclusion
- Sharing learning from patient experience of poor-quality services.

1.8 Our approach to commissioning intentions

Commissioning intentions describe how the organisation intends to shape local services to meet the needs of the population. As the ICB moves to become a strategic commissioner, a new approach to

commissioning intentions has been developed. The commissioning intentions will provide a framework to facilitate the ICB to lead, develop and embed an outcome-based commissioning approach which is data driven and evidence based, reflecting the needs of the population and providing strategic direction without being prescriptive on how services are delivered.

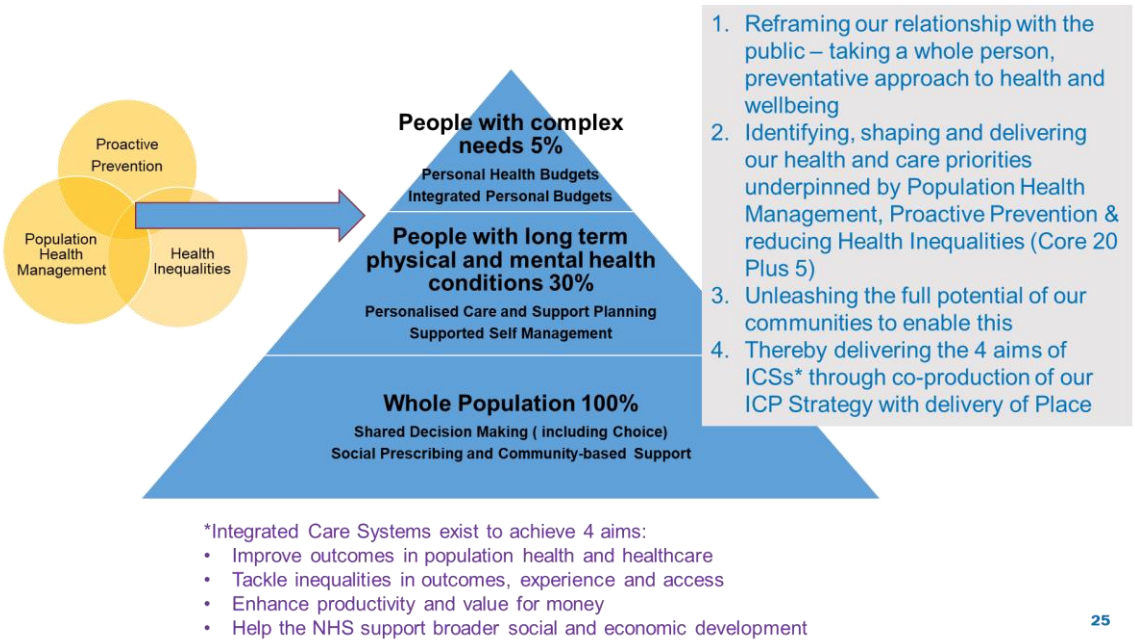
High-level commissioning intention	Relevant section of JFP
We will develop thriving places across STW with the appropriate governance arrangements in place to support the delegation of delivery and decision making to deliver the required outcomes.	Chapter 3
We will develop thriving provider collaboratives to support the delegation of pathway design based upon a set of outcomes and specified financial envelope to the Committee in Common and wider pathway-based collaboratives across STW.	2.3
We will jointly create a resilient, innovative, sustainable care market that delivers high-quality support to meet the needs and future demands of our population.	2.2
To meet the health needs of our eligible residents by commissioning local, best value, high-quality, safe, effective and outcome-driven care and support in the most appropriate setting.	Chapter 2
To transform adult mental health services including inpatient provision, dementia provision and crisis support, to enable adults with severe mental illness to have greater choice and control over their care and support.	4.6
We will redesign services through co-production to ensure that children and adults with learning disabilities and autism have the right support locally to thrive.	2.4
We will jointly transform services for CYP including integrated pathways across physical and mental health, reducing health inequalities, and ensuring that CYP get the right help at the right time to meet their potential, are able to self-manage and are resilient.	2.4
We will develop a provider collaborative to ensure that people nearing the end of their life receive high-quality and compassionate care and are supported to live well and to die with dignity in a place of their choosing, with people being identified earlier and care needs anticipated so that this can be planned for in advance.	4.4
We will transform outpatient provision to ensure patients are seen in the right place, at the right time, by the right healthcare professional, saving patients time and ensuring clinical time is used effectively.	4.2
We will transform ophthalmology services to provide timely, safe, effective and sustainable integrated eye care services at the right time, in the right location by the right person, with excellent patient experience.	4.2
We will transform cardiovascular services to provide high-quality cardiology services for our patients, carers, and their families at the right time and in the right location, delivering excellent patient experience.	4.6
We will commission and deliver a provider-led collaborative for musculoskeletal (MSK) services across STW to reduce duplication,	4.6

High-level commissioning intention	Relevant section of JFP
streamline processes, release efficiencies and improve patient pathways.	
To transform our UEC services into an improved, simplified and financially sustainable 24/7 UEC model; delivering the right care, in the right place, at the right time, for all our population.	4.6
We will commission a highly effective virtual ward service delivered via the provider collaborative.	3.4
We will commission a fully integrated falls pathway focussed on prevention through to specialist falls provision.	3.5
We will roll out the proactive care model across STW and ensure delivery to a defined cohort of people by multi-disciplinary Integrated Neighbourhood Teams.	3.5
We will ensure the delivery of an end-to-end diabetes pathway to empower people to manage their diabetes, or risk of diabetes, effectively by making them aware, educated and able to access high-quality and equitable care.	4.6
We will commission effective services to enable people to live healthier, longer lives through the prevention and management of cardiovascular disease (CVD).	4.6
Through the Primary Care Improvement Plan, we will ensure that everyone in STW has good access to general practice services and can access good quality care when they need it.	3.6
Through our approach to health inequalities, we will improve the health of our population through tackling inequalities in outcomes, experience and access.	2.6
Through our Medicines Optimisation team, we will ensure that all providers deliver high-quality, safe pharmaceutical care to help improve patient outcomes, reduce avoidable admissions and health inequalities, all while delivering the best value for money.	3.6
We will ensure that due process is followed to deliver the final maternity service delivery model across STW.	4.3
We will commission a sustainable community bed model that is cost effective, meets needs and focuses on rehabilitation and reablement to deliver optimum outcomes for the residents of STW.	3.4

Chapter 2: delivering person-centred care

2.1 How we will implement a person-centred care approach

The diagram below summarises how we will implement our person-centred approach.



What we mean by a ‘person-centred approach’.

Person-centred care moves away from professionals deciding what is best for patients or service users, and places the person at the centre, as an expert in their own experience and lives. The person, and their family where appropriate, become an equal partner in the planning of their care and support, ensuring it meets their needs, goals, and outcomes.

With an emphasis on ‘doing with’ rather than ‘doing to’, person-centred care runs through both individual and group settings, allowing users of services to be active not only in their own care but also in the design and delivery of services. This approach can improve both the experience and quality of care.

Person-centred care relies on several aspects, including:

- People’s values and putting people at the centre of their care, considering people’s preferences and chosen needs
- Ensuring people are physically comfortable and safe
- Emotional support involving family and friends
- Making sure people have access to appropriate care that they need, when and where they need it
- Ensuring people get all the information they need, in a way that is accessible for them, to make decisions for their care and support.

Person-centred care also recognises the strong and evidenced link between non-clinical, community support, and improvement in health and wellbeing.

We will facilitate a strengths-based approach in our communities to utilise non-clinical resources, recognising that the wider determinants of health affect 90% of our health and wellbeing, with health and care services impacting only 10%.

We will take the following actions:

Action	Owner	Timescale
Establish leadership, governance and resource for this programme of work.	Strategic Commissioning Lead	March 2025
Identify our priorities through a population health management approach, identifying health inequalities and taking a proactive prevention approach.	Clinical Lead for Personalised Care	March 2025
Embed our person-centred facilitation team to coordinate and enable this approach.	Clinical Lead for Personalised Care	March 2025
Involve the full range of people who can contribute from the outset. This includes, but is not limited to, people in our communities and those enabling their voice, such as Healthwatch, representatives from non-clinical provision including VCSE and social prescribing, multi-professional clinical and care leads, health and care managerial leads, and representation from person-centred facilitation teams.	Clinical Lead for Personalised Care	March 2025
Develop and mandate a structured person-centred approach to wrap around each ICS priority workstream, realising opportunities for using non-clinical community resources (including via social prescribing), choice, shared decision making, supported self-care, personalised care planning and personalised health and care budgets.	Clinical Lead for Personalised Care	March 2025
Inspire, equip and support our leadership and wider workforce in this approach.	Clinical Lead for Personalised Care	March 2025
Agree a five-year plan to shift resource towards person-centred, preventative services and action, including support for VCSA development as a provider collaborative.	Clinical Lead for Personalised Care	March 2025
Social prescribing expansion into A&E, midwifery, children, young people and families and local health and wellbeing centres.	Public Health	2024/25

2.2 Delivering integration and joint commissioning

Joint commissioning refers to arrangements in which public bodies look to undertake the planning and implementation of services collaboratively. This could be for a whole population or in relation to people with particular needs (such as those with a complex disability). We believe that commissioning collaboratively as a system enables benefits for everyone, including improved outcomes and experiences for people, reduced duplication, best use of resources and improved access to services.

We will use joint commissioning to deliver integrated services.

Integration focuses on the strengths of people and communities as a cornerstone of how we will work. As described in our model of care – people, communities and public services work together to support people to build the foundations for a healthy and fulfilling life.

The diagram on the right demonstrates this people and community-centred approach that is echoed throughout this plan and the ICS's work.

Specifically, we will work together to design and invest in pathways which are person-centred and hold organisations jointly accountable for the overall experience of individuals and families. We will also engage people with lived experience, communities, and professionals in setting the overall priorities for an area and designing pathways that reflect local needs and opportunities. We will develop performance management frameworks which consider not only quality of individual services, but also the extent to which people experience integrated, high-quality care. We will use the financial and workforce resources available across our organisations to support local populations in the most effective means possible. The Better Care Fund (BCF) enables this joint working and focuses on local priorities at place-based level.

Action	Owner	Timescale
Create a versatile, cost-effective and sustainable market at Place.	Director of Strategic Commissioning	April 2025
Invest in early help, prevention and community services.	Director of Place & Partnerships	April 2025
Improve and embed mental health and wellbeing across all services.	Director of Place & Partnerships	April 2025
Support and develop the health, family/carer support and social care workforce.	Director of Place & Partnerships	April 2025
Support urgent care with a focus on reablement and care at home.	Joint Commissioning Leads	April 2025

Case study: Integration and Transformation Programme

The Integration and Transformation Programme is working to prevent the escalation of need and reduce long-term impacts and effects that the pandemic has had on local people in Shropshire.

The approach aims to create a more positive and promising future for people of all ages and builds on the Strengthening Families approach to Early Help. The programme is based on evidence, data, insight and learning regarding local need and from successful integration programmes nationally, where a similar approach has been adopted. It is intended to reduce inequalities in our population and poverty in all its forms, providing early support and interventions that reduce risk and enable children, young people, adults, and families to achieve their full potential and enjoy life.

2.3 Provider collaboratives

Provider collaboratives are partnerships that bring together two or more NHS trusts (public providers of NHS services including hospitals and mental health services) to work together at scale to benefit their populations. While providers have worked together for many years, the move to formalise this way of working is part of a fundamental shift in the way our health and care system is organised, continuing to move from an emphasis on organisational autonomy and competition to collaboration and partnership working. The rationale for providers working together in this way comes down to improving efficiency, sustainability and quality of care. Collaborative arrangements see providers coming together to consolidate services for greater efficiency, increase sustainability by making better use of a limited workforce and improve quality of care by standardising clinical practice to tackle variations in care across different sites.

In STW, provider collaboratives are still developing and have been referred to in various sections of this plan. The main focus is how a provider collaborative will drive patient outcomes and quality while supporting the following areas:

- How we tackle unwanted variation
- How we improve resilience on delivery
- How we improve productivity
- Governance accountability
- Leadership development.

Whilst we have a number of established and formalised collaboratives already, for example, Shrewsbury and Telford Hospital NHS Trust and University Hospital of North Midlands NHS Trust collaborating in the provision of a range of speciality services, a number of collaboratives are still in stages of development towards formalisation.

STW is committed to the development of its collaborative arrangements and has commenced a programme of work to develop this approach further to ensure it forms a cornerstone of our delivery approach going forwards.

<u>Progress to date</u>

Each of STW's provider trusts (Shrewsbury and Telford Hospital NHS Trust, Shropshire Community Health NHS Trust, Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust and Midlands Partnership University NHS Foundation Trust) have agreed to form a series of Committees in Common, with delegated authority from their respective boards to develop the provider collaborative approach.

This will encompass both the development of a provider collaborative infrastructure to support the approach across STW, as well as the oversight of a number of collaborative programmes of work.

To support the development of the provider collaborative infrastructure, a series of externally facilitated development sessions have been held for trust executives and non-executives to support the implementation of the Committees in Common arrangements. The first shadow Committee in Common was held in November and they have been scheduled to take place monthly thereafter.

At the inaugural meeting in November, the Committees in Common agreed four priority programme areas for the STW Provider Collaborative:

1. Urgent and emergency care (UEC) with a key focus on Virtual Wards, Integrated Discharge Team and sub-acute wards
2. Children and young people (CYP): mental health, learning disability and autism
3. Musculoskeletal (MSK) pathways
4. Workforce.

The identified areas are those where there is potential for providers to deliver better outcomes for patients through more formalised collaborative approaches.

In addition to these priority programmes, mapping work has been undertaken to establish pipeline areas for collaboration, including, for example, a broader approach to mental health provision through collaborative delivery arrangements.

Future plans

We will continue the development of both our local provider collaborative infrastructure and collaborative programmes focusing on developing effective partnerships and working collaboratively to provide seamless, well integrated services whilst bringing the design and provision of care closer together for the benefit of our communities. The provider collaborative will focus on the delivery of outcomes in relation to specific programmes set by the ICB and act as the strategic commissioner for the STW population.

Over the five years covered by this plan, we will seek to ensure that the provider collaborative works across statutory and non-statutory organisations and use co-production with the wider communities involved with service delivery.

Local provider collaboratives (LPC) under integrated models would see delegation of functions to the provider collaborative from the ICB, pooled budgets for areas agreed by the collaborative as being within the scope of the provider collaborative and a focus on adding value, increasing efficiency, and improving quality of care.

Action	Owner	Timescale
Agree pipeline potential schemes to progress.	Director of Collaborative Programmes	April 2024
Devolve appropriate level of decision making and resource to provider collaborative to support delivery of	ICB Board	TBC

phase one priorities and to support future expansion of workstreams.		

2.4 Children and young people (CYP)

Our system is committed to focusing on the needs of children and young people in our population. We know that children need to live happy, healthy and fulfilled lives and the pandemic has impacted on them in many ways. Throughout this plan, we consider children and young people and their families and carers, including those children with complex needs and the support their families need. The offer starts before conception and through to adulthood. We are committed to engaging children and young people in the development, review and delivery of our service offer to them.

Some of the key priorities we have identified for children and young people are to:

- develop transformative care pathways for asthma, epilepsy, diabetes and obesity.
- work with partners in education, mental health, and safeguarding to ensure that, no matter how complex, our children's needs are met.
- hear the voices of children as we plan and deliver their care.
- use Core20PLUS5 children's model to drive improvement and reduce inequalities.

Action	Owner	Timescale
Implement the Children and Young People (CYP) Transformation Programme and develop joint action plans to ensure all standards/deliverables are met, robust care pathways are in place and transition guidelines are robust: asthma, epilepsy, diabetes, and obesity.	Head of Transformation	March 2025
Tackling health inequalities using the national CYP Core20PLUS5 framework, we will drive improvement action across CYP services: asthma, diabetes, epilepsy, oral health and mental health.	Head of Transformation	March 2025
CYP and Adolescent Mental Health Services (CAMHS) including neuro-developmental (ND): co-produce the long-term model for mental health and ND for CYP for the system.	Head of Transformation	March 2025
Using the national CYP Core20PLUS5 framework we will drive improvement action across CYP services: asthma, diabetes, epilepsy, oral health and mental health.	Head of Transformation	March 2025
Special Educational Needs and Disability (SEND) joint action plan, associated outcome framework and delivery of the change programme.	Designated Clinical Officer	March 2025
To ensure the voices of CYP are heard during the development, review and delivery of services, we will co-produce and embed the CYP voices model.	Head of Transformation	March 2025
Establish CYP Joint Commissioning plan. Working collaboratively with partners, we will develop a joint commissioning plan that meets the needs of CYP and supports them to achieve their full potential. This will include SEND,	Head of Commissioning	TBD

mental and physical health, safeguarding and CYP with complex needs.		
Children and Young Peoples Mental Health services: achieve a shared and coherent vision across our system, to drive forward our transformation programme, including a full review across a number of service elements, alignment of pathways, and expansion of services where needed.	TBD	TBD

CYP mental health is addressed in Chapter 4.

Case study: Telford and Wrekin Schools Health and Wellbeing Programme

The Schools Health and Wellbeing Programme supports local early years settings and primary schools to enhance their health and wellbeing offer. With a focus on reducing excess weight and obesity, a tiered approach is being used to target children and families across Telford where there are higher than average levels of obesity and deprivation. A health and wellbeing toolkit for schools has been launched to provide access to resources and training, as well as a support package to help achieve a Healthy Schools rating.

Wrockwardine Wood Junior School is one of the schools that took part in an enhanced package of support and has recently been awarded a Gold Healthy Schools rating. Staff continuing professional development (CPD) and parent engagement has been a key focus and the school has taken part in many activities to promote physical activity and healthy eating such as the Eat Well project - where children receive education sessions on sugar awareness and family cooking on a budget. The school has also incorporated active learning and getting children moving throughout the day, for example, times table recall is done in an active manner. Through this, the school have recognised an increase in confidence and enjoyment of physical activity and pupils have said: “We love it when we get up and move when we are learning. It helps us remember things better”.

2.5 Proactive prevention

Big Conversation:

You said: "I think there should be more focus on preventative healthcare and health lifestyles".

We did: Delivering prevention agenda through joint commissioning and improved proactive prevention.

Our system is unified in our vision to improve prevention for people living in Shropshire, Telford and Wrekin. By working together at Place, with primary care, the voluntary and community sector, community services, care and council services, businesses, and people themselves, we can take a proactive approach to identifying risk in the population and supporting people to reduce their risk.

Proactive prevention begins in childhood. We must recognise the cumulative effect of the impact of Adverse Childhood Experiences (ACEs) and trauma which are causally and proportionately linked to poor physical, emotional and mental health, and have a significant impact on social, educational and

health outcomes. Proactive prevention through the life course can be threaded through our Place-based programmes of work and developing resilient communities.

In this context, the system-wide proactive prevention approach builds on what is already in place across Shropshire, Telford and Wrekin.

It will provide:

- a common vision of proactive prevention that is centred around a person's strengths and community assets, self-care and early intervention and advice (preventing escalation of needs).
- common language and clear communication messages.
- a shared culture with a shared set of values, standards, and beliefs
- consistent ways of working and consistent decision making.
- multi-agency intelligence from a variety of sources to support and inform decision making.

The following actions will be taken:

Action	Owner	Timescale
Agree and implement an effective method to gather and use multi-agency intelligence across the system.	Director of Planning and Performance	April 2024 and ongoing
Ensure all information is accessible and meets the NHS standard.	Communications and Engagement Team	April 2024
Make best use of available technology to improve coordination of care, communication, understanding and monitoring of health.	Digital Programme lead	April 2024 and ongoing
Identify the opportunities for proactive prevention, reducing inequalities, and increasing self-management for each of the priority programmes.	Each programme director / SRO health inequalities	April 2024 and as and when new priority programmes are developed
Agree a set of values, standards, beliefs and ways of working.	Director of Partnerships and Place	July 2024
Engage / consult with internal and external stakeholders for each of the priority programmes	Director of Communications and Engagement	April 2025

2.6 Our approach to tackling inequalities and duty to reduce health inequalities

We know that there are differences in services across the county which we need to reduce. Healthcare inequalities are unjustifiable differences in the outcomes for people in relation to the services we offer. At the core of health inequalities is the access to care that people receive and the opportunities that they have to lead healthy lives. Whilst the ICB recognises its duty to address access to health services,

we also wish to recognise and work with partners to tackle the causes of the wider determinants of health inequalities, including preventable causes of ill health.

Research has demonstrated that certain sections of society, those living in the 20% most deprived areas and individuals that form marginalised communities, experience greater burdens of ill health when compared to wider society. To address this, NHS England (NHSE) has advocated the Core20PLUS5 focus on health inequalities reduction. This will run alongside the ICB's general duty to reduce inequalities in access.

The nationally mandated priorities, as a minimum, require the ICB to ensure we are addressing the following areas:

Nationally mandated priorities

Healthier choices (delivery of commitments and targets in the Long Term Plan)

- Weight management
- Physical exercise
- Health eating
- Tobacco dependency
- Alcohol dependency.

National key lines of enquiry for reducing health inequalities (operational planning requirements)

- HI KLOE 1: Restoring inclusive recovery
- HI KLOE 2: Complete/timely datasets
- HI KLOE 3: Mitigating digital exclusion
- HI KLOE 4: Accelerated programmes
- HI KLOE 5: Leadership/accountability.

Core20PLUS5 clinical areas of required acceleration for adults (operational plan and NHSE priority)

- Early cancer diagnosis
- Hypertension/lipids
- Vaccine uptake
- SMI health checks
- Continuity of care for ethnic minorities in maternity services
- Reduction in respiratory inequalities
- Increased detection of CVD.

Core20PLUS5 clinical areas of required acceleration for CYP (operational plan and NHSE priority)

- Continuous glucose monitoring in diabetes
- Asthma
- Access to mental health services
- Increased access to epilepsy nurses with a focus on learning disabilities and autism
- Oral extraction backlog for under 10s.

In January 2023, STW undertook an evaluation to provide an early and detailed assessment of how well the dispersed approach to the implementation of the priorities was working. Significant progress has been achieved during the first year of implementation and the process of evaluation has helped to focus on providing additional opportunities to improve knowledge, increase coordination, accountability and commitment.

The system is working up a rolling programme of data analytics that will be used to identify key health inequalities by programme area, for example, cancer, urgent and emergency care, mental health, and children and young people. This will then inform our ongoing programme of work to reduce inequalities across STW. This programme will align with the needs assessments being undertaken by our public heath colleagues to give a holistic view of our inequalities and their wider determinants and inform the actions required across the system to reduce inequalities over time. This programme will be agreed in line with the priorities identified within the Integrated Care Strategy. Working in

collaboration with our Places, we need to ensure that we are contributing to the reduction of wider inequalities that impact on health inequalities, such as housing, education and employment.

The following recommendations and actions were agreed and will be delivered over the next 12 months:

Recommendation	Actions	Owner	Timescale
Population health management	• Working with the Population Health Management Group develop our system-wide knowledge and intelligence and agree key performance metrics.	ICB lead for health inequalities	Q1
Anchor institution	• Assessment of our systems maturity as an anchor institution. • Develop a programme of work to increase our impact as an ICS.	ICB lead for health inequalities	Q2 2024/25 Q3/4 2024/25
Systematic approaches to prevention/lifestyle management	• Explore and embed innovative methods to integrating lifestyle support, advice and referrals to local support offers within clinical pathways. • Commence with waiting well initiatives to improve health and wellbeing, particularly relating to those waiting for MSK interventions.	ICB lead for health inequalities	Q4 2024/25
Strengthen the consistency of governance arrangements for reporting health inequalities (HI)	• Secure additional PMO resource to drive progress. • Co-ordinate system-wide Health Inequalities Implementation Plan. • Develop a consistent monitoring framework which links through local governance and feeds into the quarterly NHSE stocktake reports, highlighting any areas that require regional/national support (for example, shared learning). • Providers take forward the HI asks within the operational plan. To assist in our legal duty to promote reduction of health inequalities, this will form part the schedule 2N of NHSE Standard Contract. • Ensure all operational plans and Core20PLUS5 objectives are reported to the System Health Inequalities Board. • Ensure quarterly reporting to Board. • Develop and implement a peer-support programme that accelerates our ambition to normalise health inequalities into our everyday business.	SRO for health inequalities	2024/25
Promote understanding of the HI agenda and support staff to deliver	• Work with our People team to develop an HI training module/workshop and embed HI and health literacy training within staff competencies/inductions. • Share best practice locally, regionally and nationally.	SRO for health inequalities	2024/25

Case study: Outreach vaccination service – reducing inequalities

A collaboration was formed between both local authorities (Telford and Wrekin and Shropshire Council) to provide operational support for the NHS and deliver an outreach COVID-19 vaccination programme, focused on reducing inequalities. More than 10,000 people have been vaccinated on the mobile bus, referred to as 'Bob' or 'Betty', which was loaned by Shropshire Council, along with a driver, to make the service as accessible as possible.

Using a community-centred and intelligence led approach, our most deprived, rural and ethnically diverse communities have been able to access a vaccination on their doorstep, helping protect and prevent further ill health. Team Bob or Betty has played an important part in the COVID-19 Vaccination programme and has made Shropshire, Telford and Wrekin one of the top performing vaccination programmes for reducing inequalities nationally. The positive outcome of this approach will inform the way future programmes will be rolled out in the community.

Case study: Black and Asian community health and wellbeing project

After listening to community leaders and analysing data, several health concerns were identified for Black and Asian communities across Telford and Wrekin. It was clear that, to tackle health inequalities, we needed to work more closely to understand what solutions and community-led activities would improve their health and wellbeing and prevent ill health both now and in the future. Funding was utilised for an Asset Based Community Development project, involving seven community organisations representing a wide range of our target residents. This project has enabled these groups to work together for the first time, leading to new positive working relationships, the achievement of shared goals and a greater level of community cohesion, making a real difference to their health and happiness.

Local people have had the opportunity to attend training courses including Making Every Contact Count, walk leader training, healthy eating and cooking sessions, mental health first aid, suicide prevention and physical activity courses. Community workshops and health and wellbeing activities have engaged more than 3,500 participants and have included cricket, football, netball, community cooking sessions, fitness classes, martial arts and mental health sessions, craft and chatter groups, music and mindfulness, swimming, walking groups and seated exercise.

2.7 Duty to address the needs of survivors of abuse

We have a duty to address the needs of survivors of abuse in our area. People can be survivors of a range of different types of abuse, such as domestic abuse, sexual abuse, child sexual exploitation (CSE), criminal exploitation, neglect, financial or emotional abuse. The table below summarises our approach and actions to delivering this duty.

Preventing abuse	Supporting those who have suffered abuse	How will we know our approach is working?
• Effective multi-agency working though safeguarding partnerships • Delivering the requirements of the Serious Violence Duty • Commissioning services based on existing resources and robust population information	• Listening to victims and their needs • Implementing a trauma-informed approach to relevant commissioned services	• Robust multi-agency datasets to triangulate crime, social care and health data • Working with Healthwatch and those with lived experience • Working in safeguarding partnerships to gain intelligence on

• Linking with the voluntary sector • Linking local and NHSE commissioned services • Participation in the Criminal Justice Partnership • Engaging those with lived experience in our plans and actions, including co-production • Implementing the Liberty Protection Safeguards in line with national timescale • Engaging CYP and their carers in our plans and actions.	• Building pathways based on knowledge and information about the effectiveness of interventions • Focusing on the prevention of ill mental health • Working with schools and education establishments • Meeting the needs of looked-after children • Engaging CYP in our plans • Delivering the actions required in the Independent Inquiry into Child Sexual Exploitation in Telford (IITCSE).	changing themes in abuse and the prevention measures needed as a dynamic process • Benchmarking with other areas and engagement in regional and national improvements • Audit of services • Gaining feedback from service users to ensure the approaches are working.

We will take the following actions:

Action	Owner	Timescale
Build pathways for supporting survivors, based on knowledge and information with partners	ICB Chief Nursing Officer	March 2025
Engage with CYP in our plans	ICB Chief Nursing Officer	March 2025
Monitor training compliance for health staff	ICB Chief Nursing Officer	March 2025
Complete audits to ensure continued liaison between local authorities and GP practices to share risks and ensure appropriate flags are in place	ICB Chief Nursing Officer	March 2025
Ensure outcome of tender for trauma-informed services for CSE survivors meet the needs of survivors	ICB Chief Nursing Officer	March 2025
Scope the role of 0-19 service with home-educated children and the Childrens Safeguarding Practice Review and ensure learning embedded into practice	ICB Chief Nursing Officer	March 2025
Monitor the implementation of Serious Violence Duty Strategy	ICB Chief Nursing Officer	March 2025
Ensure a system pathway for survivors of CSE is sustained and assured	Designated nurse for children's safeguarding	March 2025
Embed education and training on CSE through contracts and their review	Designated nurse for children's safeguarding	March 2025
Ensure GP services in STW are identifying CYP at risk of CSE though consistent coding	Named GPs for safeguarding adults and children	March 2025

Review the health input into the Multi-agency Safeguarding Hubs (x2) in STW	Designated nurse for children's safeguarding	March 2025
Improve awareness and referral into early help services, as this will include potential victims/survivors of CSE and serious violence	Designated nurse for children's safeguarding	March 2025
Implementing the Serious Violence Duty Strategy in line with safeguarding partnerships and national requirements.	Designated nurse for children's / adults' safeguarding	March 2025

Chapter 3: Place-based delivery

3.1 Our Places

Role of Place

Place is defined by NHS England as being a geographic area that is defined locally. In Shropshire, Telford and Wrekin ICS, we define 'Place' as the areas coterminous with our two local authorities: Telford and Wrekin, and Shropshire. Both have strong Place-based integration boards – Telford and Wrekin Integrated Place Partnership (TWIPP) and Shropshire Integrated Place Partnership (ShIPP). Both ShIPP and TWIPP are accountable to their local Health and Wellbeing Boards (HWBBs) as well as the STW ICB.

The role of ShIPP and TWIPP is to implement proactive prevention, reduce health inequalities, and improve outcomes for the local population.

ShIPP and TWIPP reflect the identity of each of the Places and benefit from the assets and strengths of the communities within that Place. However, the Places ensure that standards of access and quality do not vary. They connect across STW to ensure that the evidence of the most effective prevention, population health and care models are applied in every neighbourhood.

Our integrated strategy is overseen by the Integrated Care Partnership and is informed by the HWBB Strategies of our two Places. This plan sets out how we deliver the strategy across the system, ensuring that organisational strategies understand how they will contribute and impact on this delivery. The HWBB strategies for both Places will be reviewed in 2027/28 and will inform the integrated strategy and delivery, and set out the further ambition of the system in 2029.

Action	Owner	Timescale
Develop appropriate governance to enable effective Place and neighbourhood delivery (recognising Shropshire and Telford and Wrekin as individual Places)	Director of Place & Partnerships	April 2024
Devolve appropriate level of decision making to Place, in accordance with the Health and Care Act subsidiarity principles	ICB Board	TBD
All system priority areas engage and involve Place in transformation planning and delivery	Transformation Leads	April 2024

Delivery of TWIPP and ShIPP strategic plans	Director of Place & Partnerships	Annually

Supporting social and economic development

Telford and Wrekin's Health and Wellbeing Strategy refresh proposals have been developed based on Joint Strategic Needs Assessment (JSNA) intelligence and informed by engagement with residents as part of the development of the 'Vision 2023 – Building an Inclusive Borough'.

Shropshire's Health and Wellbeing Strategy is being developed at a community level by engaging with the residents and local town councils using the data from the JSNA.

The ICP brought together the available intelligence from the HWBB strategies to inform the priorities for the Integrated Care Strategy and Joint Forward Plan. The refresh of the Joint Forward Plan continues to use the HWBB strategies and Integrated Care Strategy as its anchor points and reflects wider determinants and health inequalities.

The JSNAs, population health intelligence and the interim Integrated Care Strategy informs system partners about areas of health and social need and inequalities gaps within our communities. In Shropshire, the Social Task Force meets bimonthly to address wider socio-economic development and the wider determinants that impact health, care and wellbeing and reports into the HWBB. In Telford and Wrekin, the HWBB covers health and care including socio-economic factors and priority areas are reported back through the board. Areas of delivery for the partnership are reported through the Place partnerships to deliver and give assurance on. This process is evolving.

Health inequalities are widening, so our partnerships focus on the root causes of health inequalities, the wider determinants, and address inequity of access to services for those most in need. We need to understand the multiple barriers people can face in accessing our services more fully, and we are taking a person-centred approach to do this. We are using this approach to deliver our Women's Health Hubs across STW.

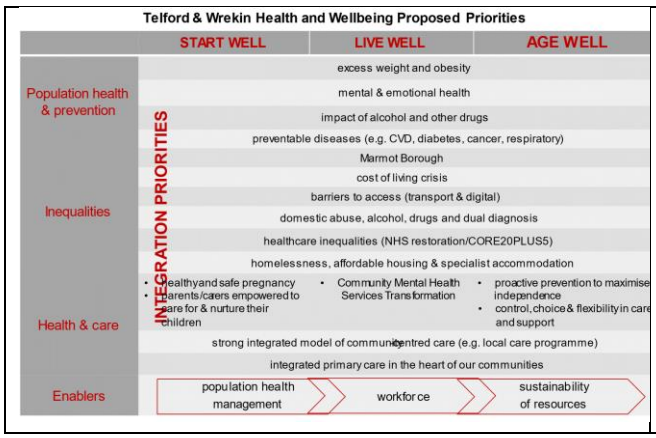
We are tackling the wider determinants of health, such as homelessness, healthy homes, poverty and the cost of living, through positive work and employment of the social task force and HWBB. This includes warm spaces, access to leisure, road and transport reports, and warm housing being made available through VCSE organisations. We also aim to give every child the best start in life which will influence a range of outcomes throughout people's lives.

We are improving equity of access to healthcare for those living in our most deprived areas, including rurally excluded locations, as well as other forms of exclusion. This includes Core20PLUS5 and a focus on preventable health conditions. For adults, this includes hypertension, early cancer diagnosis, health checks for severe mental illness (SMI) and LDA, vaccinations, continuity of carer in maternity. For children, this includes epilepsy, diabetes and asthma.

As the partnership develops our five-year plan, we are considering broader system working. Programmes of work need to demonstrate how they will deliver against the Integrated Care Strategy. This includes:

- Local planning and regeneration including transport
- Housing and employment
- Education
- Climate and green planning

- VCSE and community partners, police and fire service
- HTP
- Local Care Integration Programme including Integrated Neighbourhood teams.



Shropshire Joint Health and Wellbeing Strategy priorities 2022-2027

Strategic Priorities Long-term aims and how we will achieve them	Key areas of focus Identified areas of health and wellbeing need in Shropshire
Joined up working	Workforce
Working with and building strong and vibrant communities	Healthy Weight and Physical Activity
Improving Population Health	Children & Young People incl. Trauma and ACEs (All-age)
Reducing Inequalities	Mental Health

Other – These form part of the Key Priorities			
Social Prescribing	Drugs and Alcohol	Smoking in Pregnancy	Housing
Suicide Prevention	Food Poverty	Killed and Seriously Injured on Roads	Air Quality
Exploitation			

3.2 Telford and Wrekin

Telford and Wrekin Health and Wellbeing Strategy

Telford and Wrekin Health and Wellbeing Board refreshed its priorities, and the updated strategy was approved in June 2023. The priorities are based on engagement and insight with our Telford and Wrekin residents and intelligence from the Joint Strategic Needs Assessment (JSNA) on local health and wellbeing outcomes and inequalities gaps. Delivery of these health and wellbeing strategy priorities is steered and overseen by the TWIPP, the Best Start in Life Board and the Community Safety Partnership.

Telford and Wrekin Integrated Place Partnership

TWIPP comprises of senior officers from Telford and Wrekin Council, NHS Shropshire, Telford and Wrekin, primary care networks (PCNs), Midlands Partnership University NHS Foundation Trust, Shropshire Community Health NHS Trust, Shrewsbury and Telford Hospital NHS Trust, Healthwatch, Shropshire Partners in Care and the voluntary sector. TWIPP's strategic priorities are aligned to the Integrated Care Strategy as well as Telford and Wrekin's Health and Wellbeing Strategy. Currently, no delegation of budget or resources from the system is in place, but this is an ICS ambition and work will need to be developed in relation to quality and finance to further enable delivery at Place. For TWIPP and strategic priority alignment, see Appendix A.

Supporting the implementation of the Strategic Plan is a set of actions for the ICB and Telford and Wrekin Place, as indicated in the table below:

Action	Owner	Timescale
Delivery of 'live well' programmes aimed at encouraging healthy lifestyles and improving mental wellbeing	Service Delivery Manager: Health Improvement, Telford and Wrekin Council (TWC)	March 2025
Delivery of the Place-based elements of the system-wide strategy for cancer (including early cancer diagnosis)	NHS STW and Deputy Director: Public Health, TWC	March 2025

Delivery of programmes to improve awareness of, and reduce, inequity of access to vaccination, screening and health checks	Service Delivery Manager: Health Improvement, TWC and Deputy Director: Public Health, TWC	March 2025
Deliver Start for Life and Family Hub transformation programme	Deputy Director: Public Health, TWC and Group Specialist, Family Hubs, TWC	March 2025
Deliver improved social, emotional and mental health services for Telford and Wrekin's children and young people	TBC	March 2025
Delivery of Telford and Wrekin's Learning Disability Strategy objectives (for example, reducing the number of people with learning disabilities in in-patient care and increasing the number of people with learning disabilities who have had an annual health check)	Learning Disability Partnership Assistant Director, Adult Social Care, TWC	March 2025
Delivery of Telford and Wrekin's Autism Strategy objectives (for example, increasing the number of autistic people who have had an annual health check and reducing the number of people awaiting an autism assessment, and the time between referral, diagnosis and support)	Autism Partnership, Assistant Director: Adult Social Care, TWC	March 2025
Development of a Place-based Mental Health Strategy, co-producing it with people with lived experience (for example, supporting the Mental Health Alliance to continue to help shape multi-disciplinary mental health support)	Mental Health Alliance, Assistant Director: Adult Social Care, TWC	March 2025
Implementation of Local Care Transformation Programme (LCTP) workstreams at Place	LCTP Programme Director, NHS STW	March 2025
Support with developing integrated neighbourhood teams linked to the Local Care Transformation Programme's Proactive Care workstream	Integration Programme Manager, TWC and PCN Clinical Directors	March 2025
Deliver the Place-based elements of the national NHS objectives for 2024/25 for prevention and health inequalities	ICB Health Inequalities Lead and Director of Public Health, TWC	March 2025
Implementation of the Healthy Weight Strategy	Service Delivery Manager: Health Improvement, TWC	March 2028
Delivery of the Ageing Well Strategy.	Ageing Well Partnership, supported by Adult Social Care, TWC	March 2028

3.3 Shropshire

Shropshire Health and Wellbeing Strategy

The Shropshire Health and Wellbeing Board acts to ensure that key leaders from the health and care system work together to improve the health and wellbeing of Shropshire residents. Board members collaborate to understand their local community's needs, agree priorities and work together to plan how best to deliver services. Shropshire's Health and Wellbeing Board has produced its Joint Health and Wellbeing Strategy based on the needs of local people, setting out the long-term vision for Shropshire and identifying the immediate priority areas for action and how the Board intends to address these.

The priorities of the Joint Health and Wellbeing Strategy are developed in response to the Shropshire Joint Strategic Needs Assessment (JSNA). The JSNA fulfils a statutory duty to identify areas of health and wellbeing need through the examination of national and highly localised data. In Shropshire, the JSNA is considered a dynamic assessment that is regularly updated as new understanding and data come to light. In addition to thematic assessments, we are working towards the development of Locality Needs Assessments, which demonstrate the need in our very local communities (18 Place plan areas).

Shropshire Integrated Place Partnership (ShIPP)

ShIPP aims to work collaboratively to deliver the system priorities. It does this by working in partnership with shared collaborative leadership and responsibility. Clinical/care leadership is central to the partnership, to ensure that services provide the best quality evidence-based care and support for our people, improving outcomes and reducing health inequalities. It is expected that through the programmes of ShIPP, and routine involvement and co-production, local people and the workforce can feed ideas and information to inform and influence system strategy and priority development.

The table below shows the alignment of priorities across Shropshire Place:

Shropshire, Telford & Wrekin ICS Pledges	Shropshire Health & Wellbeing Board (H&WBB) Priorities	Shropshire Integrated Place Partnership (ShIPP) Priorities
Tackling the problems of ill Health	Improving population Health	
Tackling Health Inequalities and access to Health Care	Reduce Inequalities	Tackling health inequalities
Creating system sustainability	Joined up working	Integration & Better Care Fund (BCF)
Delivering Improvements in Mental Health/learning disability autism provision	Mental Health	Mental Health
Workforce	Workforce	Workforce
Integrating services at place and neighbourhood level	Working with and building strong and vibrant communities	Community capacity & building resilience within the VCSE
Climate change	Children & Young People incl. Trauma Informed Approach	Children's & young peoples' strategy
Enhanced engagement and accountability	Healthy Weight and physical activity	Prevention/healthy lifestyles/healthy weight
Improving safety & quality		Supporting Primary Care Networks
Leadership & Governance		Local Care and Personalisation (incl. involvement)

The table below indicates the actions that will be taken to deliver these priorities in Shropshire:

Action	Owner	Timescale
Deliver the all-age Local Care Transformation Programme across communities in Shropshire	All system partners	2024/25
Expand CYP integration test and learn sites to become all-age delivery in North Shrewsbury, Ludlow, Market Drayton, and develop a roll out plan for rest of county	Public Health	2024/25
Deliver more Health and Wellbeing Centres in Oswestry, Highley, Ludlow, Shrewsbury, that include multi-disciplinary team (MDT) approaches	Partners identified across voluntary and community sectors through public services	2024/25
Develop a neighbourhood model to connect with Health and Wellbeing Centres – this includes PCNs being supported by joint working and integrated approaches for proactive care, neighbourhood, integrated discharge and Social Care Hubs (including reablement), and rapid response.	Local Care Transformation Programme	2024/25

3.4 Local Care Transformation Programme (LCTP)

Local Care is a system wide commitment to a range of community-based transformation programmes and initiatives that aim to reduce the need for unplanned health care, keep people safe, well, and independent at home, and contribute to improved population health and wellbeing.

Local Care involves:

• Integrating health and care at place and neighbourhood levels to deliver more joined up, proactive, and personalised care in local communities and in people's homes
• Expanding the range of community-based services available to citizens
• Health and care professionals working together in a joined-up way across different settings focused on the person's goals, needs, and wishes and as part of wider teams with partners including the Voluntary Sector

The programme consists of initiatives that will deliver more care into the community achieving improved outcomes and experiences for patients, while also helping to relieve pressure on our acute hospital services so that those services are able to deliver quality services when people need them.

The programme was established in 2022 and to date has focused on three key critical initiatives:
• **Implementing alternatives to hospital admission**, providing 2-hour rapid response in the community
• **Setting up of a Virtual Ward** providing sub-acute care in the place people call home that would otherwise need to be provided in an acute hospital, thereby providing an improved experience for patients. Initially, there has been a focus on the frailty pathway including enabling referral to the Virtual Ward from care homes and rapid response teams.
• **Implementing an integrated discharge team (IDT)** to support timely and appropriate discharge from hospital with the necessary community support in place

Case study – Virtual Wards

Remote monitoring was successfully used with a patient in their 80s who had a suspected diagnosis of Chronic Obstructive Pulmonary Disease. They had received treatment including steroids, antibiotics, inhalers, and medication to help their condition improve. Their pulse, blood pressure, temperature and oxygen levels were near normal, but needed monitoring. A visit by a nurse to record their observations would not have been necessary and would have interrupted the patient's day while they waited for a visit. The patient was keen to use the equipment, and after a short training session was happy with recording their own observations. When their observations showed a change, they were contacted by telephone and advice was given about self-care, and the observations that evening were normal again. This meant that the patient's deterioration was picked up quickly without the patient needing to attempt to get in contact with team, and without

The next phase of Local Care is focused on the development of neighbourhood approaches including the roll out of health and care multi-disciplinary teams to support people in their local communities, which will be a multi-year programme of change. The system is committed to rolling out the proactive care model, as one type of MDT/neighbourhood approach.

The role that our community hospitals play is front and central to the delivery of Local Care, providing crucial facilities in which to develop vibrant health and care hubs serving the local population's needs in our rural communities. Whilst our ambition for the existing community hospital sites in clear, the system recognises that there will be difficulties in terms of the lack of available capital and staffing challenges across both bed and community-based services and close working will be required with all stakeholders in designing services that are co-produced and sustainable moving forwards.

The development of our local approach to care is critical in also supporting the system's commitment to reducing health and rural access inequalities and delivering care as close to home as possible. The ICB has already collated significant feedback from communities in terms of what they would like to see in the future and as a next step will undertake the process of aligning this with the Joint Strategic Needs Assessments for Shropshire, Telford and Wrekin. This will then form the basis of the next stage of engagement with all of our local stakeholders and neighbours within Powys with the intention of developing evidence-based options for care at a local level for each of the sites, working closely with our Places in Telford and Wrekin and Shropshire as our strategic delivery partners which we intend to commence in the summer 2023.

By delivering Local Care we will:

- Expand community-based services and provide suitable alternatives to hospital-based care.
- Support people with long-term conditions and those with a range of health and wellbeing needs to be empowered in the delivery of their care.
- Respond swiftly to those in crisis to avoid unplanned hospital admissions.
- Ensure a focus on proactive care and early intervention that promotes good health and wellbeing.
- Develop a deeper understanding of the needs of our population and make demonstrable progress in tackling health inequalities.
- Focus rehabilitation services to help people maximise their functional outcomes and independence, focusing on the personal goals that matter most to patients.

Enable our staff to work flexibly across organisational boundaries in more integrated and joined up ways that enables staff to deliver high quality care for their patients; thereby supporting staff wellbeing and job satisfaction.

Action	Owner	Timescale
Reviewing community-based services for sub-acute care and reablement to make best use of our available resources, including our staff and our physical assets including community care settings.	Director of Strategic Commissioning	September 24
Neighbourhood working (Integrated Neighbourhood Teams): Employing a proactive care approach focused on keeping people well and preventing avoidable health issues for those at high-risk of a non-elective hospital admission. Developing our approach to neighbourhoods to bring together multi-disciplinary teams of staff from across primary care, community care, social care and the voluntary and community sector to work together to deliver joined up, person-centred and proactive care	Director of Place & Partnerships	24/25
To review all of the bed based provision across STW providing P2 and P3 care to ensure capacity meets demand linked to the PWC reablement work and to deliver within the available financial envelope.	Director of Strategic Commissioning/ Director of Planning & Performance	April 25

3.5 Proactive care (previously anticipatory care)

Proactive care is a key workstream of the LCTP (linked to programme four). It is a model of care, delivered in the community, to a targeted cohort of patients with multiple long-term conditions who would benefit from integrated care to support management of their conditions. A successful model will result in reductions in the use of unplanned care, reductions in morbidity, addressing health inequalities, improved patient experience and supporting people to stay well for longer.

Working in partnership with system providers, the voluntary and community sector, the public and patients, the project aims to embed a system-wide model that is flexible enough to meet the needs of the population for delivery at a local level.

Work is taking place with two PCNs to develop existing MDT arrangements to align more closely with the key components of the proactive care model. Any learning from this work will be further developed as soon as possible.

Action	Owner	Timescale
Implement a collaboratively designed template for personalised care and support plans	Project Lead	From April 2024
Agree the geographical boundaries of the Integrated Neighbourhood Teams (INTs) including the GP practices within each and any alignment with existing local authority teams, community teams and community assets/meeting places	Director of Place & Partnerships	June 2024

Review support to people living with frailty to identify opportunities for integration	Director of Strategic Commissioning	March 2025
Redesign falls pathways to create a consistent approach	Director of Place & Partnerships	March 2025
Create framework to guide the further roll out and expansion of proactive care delivery across STW	Director of Place & Partnerships	March 2025
Deliver the six key elements of the proactive care model with the understanding that there will be flexibility at INT level around the roles required in each team to deliver them	Director of Place & Partnerships	2024/25
Implement medicines management: structured medication review and access to clinical pharmacist to be integrated within all falls services / pathways / MDTs.	ICB Chief Pharmacist	TBD

3.6 Primary care networks (PCNs) and general practice

Big Conversation:

You said: "Trying to get through to a GP is so difficult… you just have to keep trying each morning and hope to get an appointment".

We did: Focus on improving access in primary care to tackle the early morning rush, improve confidence in patients that their needs will be met and to widen the scope of services available in community pharmacy.

The current model of contracting for and providing general medical services has not changed in decades, despite changes to the way modern healthcare is accessed and delivered. Despite the huge amount of demand and work delivered in general practice, there have been increasing levels of dissatisfaction in primary care access and care for both patients and staff, and these challenges are now threatening the sustainability of our primary care services. General practice is suffering the same challenges in workforce and resources as the rest of our system. In particular, there are challenges related to the development of GP estates, and primary care estates need to be incorporated into the wider enabler of the system estates plan.

Primary care networks were set up to support groups of practices to deliver the Primary Care Network Direct Enhanced Service (PCN DES). Some PCNs are more mature than others and are using resources aligned to PCNs to develop and work with neighbourhood models of care and influence the local care programme as members of the place partnerships. Primary care will be at the heart of healthcare and must be appropriately resourced to support and enable true integration.

In May 2023, a delivery plan for recovering access to primary care was published by NHS England (NHSE). The aims of this plan are to tackle the 8am rush in general practice, to enable people to know

their needs will be met when they contact the practice and to widen the scope of services available from community pharmacy. There are four areas this plan focuses on:

- Empowering patients
- Implementing modern general practice access
- Building capacity
- Cutting bureaucracy.

There is a need for evolution in the way primary care is delivered, protecting its core strengths, such as continuity of care, and placing it at the heart of new health and social care systems. Primary care is the ideal deliverer of person-centred care with the need for patients to be invested in their health planning through the use of personal health plans. We propose to have an integrated primary care service, providing streamlined access to care and advice, that is straightforward to navigate, more proactive, provides personalised care and support from an MDT based around neighbourhoods, and helps people to stay well longer.

Primary care cannot achieve this alone. It will need system support to provide the conditions for locally led change and a supporting infrastructure to implement change. GPs must lead and support any changes proposed, ensuring we maintain stability in primary care.

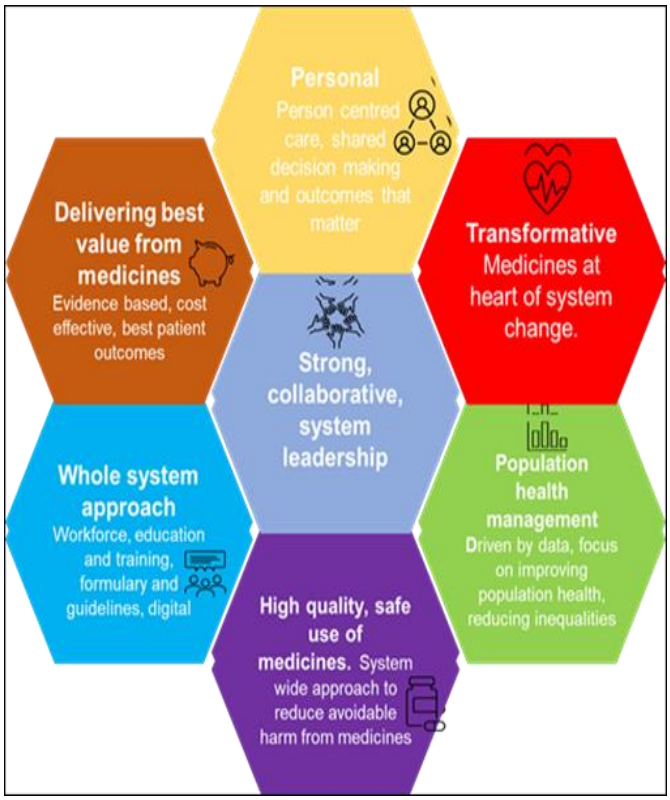
Key actions are below:

Actions	Owner	Timescale
Implement the action plan to recover access to primary care delivery	Associate Director of Primary Care	2024/25
Enable PCNs to develop integrated neighbourhood teams (INT)	Associate Director of Primary Care	2024/25
Develop and deliver with the GP Board the Fuller recommendations as a clear set of system actions	Associate Director of Primary Care	2024/25
Work with primary care networks to deliver the contract DES	Associate Director of Primary Care	2024/25
Review the Primary Care Strategy to incorporate the national Primary Care Access Recovery Plan (PCARP) guidance	Associate Director of Primary Care	2024/25
Co-design and put in place infrastructure and support for INTs	Associate Director of Primary Care	2024/25
Support a primary care forum and representation	Associate Director of Primary Care	2024/25
Embed primary care workforce planning in system workforce plans	Associate Director of Primary Care	2024/25
Develop a primary care estates plan	Associate Director of Primary Care	2024/25
Implement development plan to support the sustainability of primary care	Associate Director of Primary Care	2024/25
Implement the PCARP plans that incorporate the Fuller recommendations	Associate Director of Primary Care	2024/25
Primary care commissioning framework – deliver all practice-commissioned services outside of General Medical Services via a single contracted framework preventing opt-out of individual services	Associate Director of Primary Care and Director of Strategic Commissioning	2024/25

Align services across Shropshire and Telford	Associate Director of Primary Care	2024/25
Integration and optimal use of community pharmacy to support primary care recovery and capacity	ICB Chief Pharmacist	2024/25
Commission pathfinder sites to inform the development of future clinical services that incorporate prescribing from within community pharmacies	ICB Chief Pharmacist	2024/25
Growth in number of Additional Roles Reimbursement Scheme (ARRS) roles supporting the creation of MDTs and provision of additional support to ensure new roles are embedded	Associate Director of Primary Care	2024/25
GP practices – for those practices that are outliers, targets will be set to bring down A&E attendances and minor injury unit (MIU) attendances to ICB average	Associate Director of Primary Care / Director of Planning & Performance	2024/25
Deliver the local care programme integration with neighbourhood teams and primary care networks.	Associate Director of Primary Care and Director of Strategic Commissioning	In line with LTCP timescales

3.7 Our approach to medicines

Medicines play a crucial role in maintaining health, preventing illness, managing chronic conditions and curing disease. In an era of significant economic, demographic and technological challenge, it is crucial that patients get the best quality outcomes from the medicines that they are prescribed.



Our vision for medicines optimisation within STW ICS delivers a patient-focused approach to getting the best possible health benefits from the investment made in medicines. This requires a holistic approach, an enhanced level of person-centred care delivery, and partnership between clinical professionals and patients. Our aim is to ensure that the right patient gets the right medicine, at the right time. We will focus on wider health outcomes including improved clinical outcomes for patients, reducing avoidable hospital admissions related to medicines (HARMs), reducing health inequalities and utilising a population health management approach. A patient-centred approach will, in turn, ensure we get the best from our investment in medicines, and that patients live longer, healthier lives. It will also support the system to achieve its aims in transforming care by improving capacity through admission avoidance, earlier

discharge and supporting high-quality access to care in alternative settings.

Over the next five years, our strategy will focus on six key themes:

Theme	Focus
Person-centred care	• Holistic approach to shared decision making • High-quality prescribing to improve patient outcomes and reduce health inequalities. Currently, we have a focus on cardiovascular, diabetes and respiratory disease • Equity of access to medicines and a standardised approach with shared guidelines to best practice in all settings • Supporting patients to self-care where appropriate.
Delivering best value	Making best use of available resources by: • Shared system evidence-based and cost-effective formulary – 90% adherence in all settings • Best value biologics (high-cost drugs) – 90% use of best value biologics • Reduce prescribing of low-priority medicines • Reduce waste • Reduce environmental impact of medicines and inhalers (working towards NHS net zero in 2040)
Medicines Quality and Safety	• System approach to improving medicines safety across primary and secondary care. Aim to align incident report system across all providers, improving safety by reporting and learning from medication errors whilst encouraging an open culture • Reducing hospital admissions related to medicines (HARMS) – World Health Organisation challenge to reduce this by 50% • Improving performance against national and local targets – currently, our focus is anticoagulation, sodium valproate in pregnancy and prescribed dependence performing medicines (opioids) • Deprescribing to reduce inappropriate polypharmacy • System Antimicrobial Resistance Strategy by July 2023.

View the Medicines Strategy.

Action	Owner	Timescale
Focus on integration of community pharmacy to the wider ICB planning and improve delivery of commissioned services as part of primary care recovery programme	Community Pharmacy Clinical Lead	March 2025
Community pharmacy – independent prescribing pathfinder. Integration of new community pharmacy national services within primary care	ICB Chief Pharmacist	April 2025
Reduction of hospital admissions related to medicines / admission avoidance through optimal use of medicines Improvements in health outcomes and health inequalities through better use of medicines	ICB Chief Pharmacist	April 2025

Green agenda – all providers working to deliver the green agenda for medicines	ICB Chief Pharmacist	April 2025
Antimicrobial resistance – whole-system approach to improving antimicrobial use and prescribing	ICB Chief Pharmacist	April 2025
Integrate electronic prescription services (EPS) across NHS providers, integration of community pharmacy with primary care patient records	System Lead Pharmacist and Director of Strategy (SaTH)	2023-2026
Improve recruitment and retention of a resilient pharmacy workforce	System Pharmacy Lead	Ongoing
Meet national and regional targets for antimicrobial resistance, best value biologics and medicines value programmes	System Pharmacy Lead	Ongoing
Improve system-wide outcomes, for example, improvements in patient outcomes, health inequalities, HARMs, secondary care admissions, morbidity, and mortality through improved quality and safer prescribing	System Pharmacy Lead	
Manage financially available resources – getting the best out of every £1 we invest in medicines.	System Pharmacy Lead and Chief Pharmacists	Year on year

3.8 Community pharmacy, optometry and dental

In April 2023, the contractual services for pharmacy, optometry and dental (POD) services were delegated to ICBs. The management of the contracts will be undertaken in partnership with the Office of the West Midlands (OWM) through joint governance arrangements.

These primary care services are becoming increasingly important, never more so than through the COVID-19 pandemic.

Community pharmacy services will expand through the Recovering Access to Primary Care Delivery Plan published in May 2023. There are opportunities to deliver services to alleviate pressure in general practice but there are also challenges. Workforce in community pharmacy is under the same challenges as other healthcare services. There is a national lack of NHS dentists, and this is particularly an issue across STW. In Shropshire, many of our rural communities do not have access to a pharmacy and, therefore, some of the options to access the proposed services will be a challenge.

Action	Owner	Timescale
Work with Office of the West Midlands Office to ensure contractual changes, quality and challenges are addressed for STW POD services and contribute to the development of services and strategy for delivery	OWM and Director of Strategic Commissioning	2024/25
Implement the action plan for community pharmacy services set out in the Recovering Access to Primary Care Delivery Plan	Community Pharmacy ICB lead	2024/25
Review low availability of NHS dental services across STW and work with OWM to develop a plan for increasing access.	OWM and Dental leads	2024/25

3.9 Voluntary, community and Social Enterprise

Our system has a wealth of experience as well as knowledge, professional expertise and skills in our voluntary, community sector (VCSE). During the COVID-19 pandemic, the VCSE delivered an unprecedented level of services to our communities.

The VCSE across STW is committed to supporting the delivery of the priorities within our plan and to joint working that has, and will continue to, shape and improve services in STW from a grassroots perspective. As a system, we need to support the VCSE ambition to deliver well-resourced services to our places, neighbourhoods and communities. With the knowledge of the communities and populations they serve, sustainable community services will underpin the person-centred approach to delivery of prevention, self-care and keeping well throughout a person's health and care journey. Our strong VCSE sector underpins healthy communities, supports wellbeing and specialist services.

We recognise that, to reduce inequalities, we will need to draw on the knowledge of the local authorities, voluntary, community and social enterprises (VCSEs) and other partners with experience and expertise in this regard. The VCSE sector is an important partner in our system and plays a key role in improving health, wellbeing, and care outcomes due to their reach and connection with communities. Our partnership working has been formalised within two Memorandum of Understandings (MOUs) with the VCSE and Healthwatch. These MOUs set out why the ICS values the role of the VCSE and Healthwatch in improving health, social care and wellbeing in this area, and explains why and how we wish to work in partnership on shared ambitions.

Action	Owner	Timescale
Use long-term contracts (NHS standard) with the VCSE to create sustainability of services, to be flexible and have a proportionate approach to funding - including grants as well as long-term contracts	ICB Contracts team	From April 2024
Use the experience, expertise and skills of VCSE when developing our person-centred approach and training for health and care staff	Director of Partnerships and Place	March 2025
Use the VCSE experience, knowledge, skills and expertise to transform services within our communities, so that they deliver the model of care	Director of Partnerships and Place	March 2025
Include the VCSE at the earliest opportunity in the development of our health and care pathways in partnership	Director of Partnerships and Place	Ongoing
Work to support the VCSE Alliance.	Director of Partnerships and Place	Ongoing

Case study: OsNosh community interest company (CIC)

OsNosh is an initiative which brings the community together in all aspects of the food cycle, including building community gardens with the help of local growers, using creative cooking to educate and inspire, creating a space to learn, grow and belong, fighting food poverty, promoting food equality and preventing waste through surplus food recycling.

Starting with community meals, providing a 'pay as you can' offer to a handful of people, this initiative is now supporting more than 200 people and offers share tables, takeaway hot meals, community events and regular community meals with the help of a workforce of more than 180 volunteers.

This sustainable community project has had an overwhelmingly positive and heart-warming response from local charities and businesses. Every week, dishes are delivered to a wide range of people in the local community, including those in need, helping to save food wastage. It also provides the opportunity to share culinary knowledge with ways to cook up tasty and nutritious food for pennies.

Chapter 4: Hospital and clinical services

4.1 Hospital Transformation Programme (HTP)

Our Hospital Transformation Programme (HTP) is our second major system transformation programme and is a key part of the bigger picture for our patients and communities. We are trying to address the following critical issues:

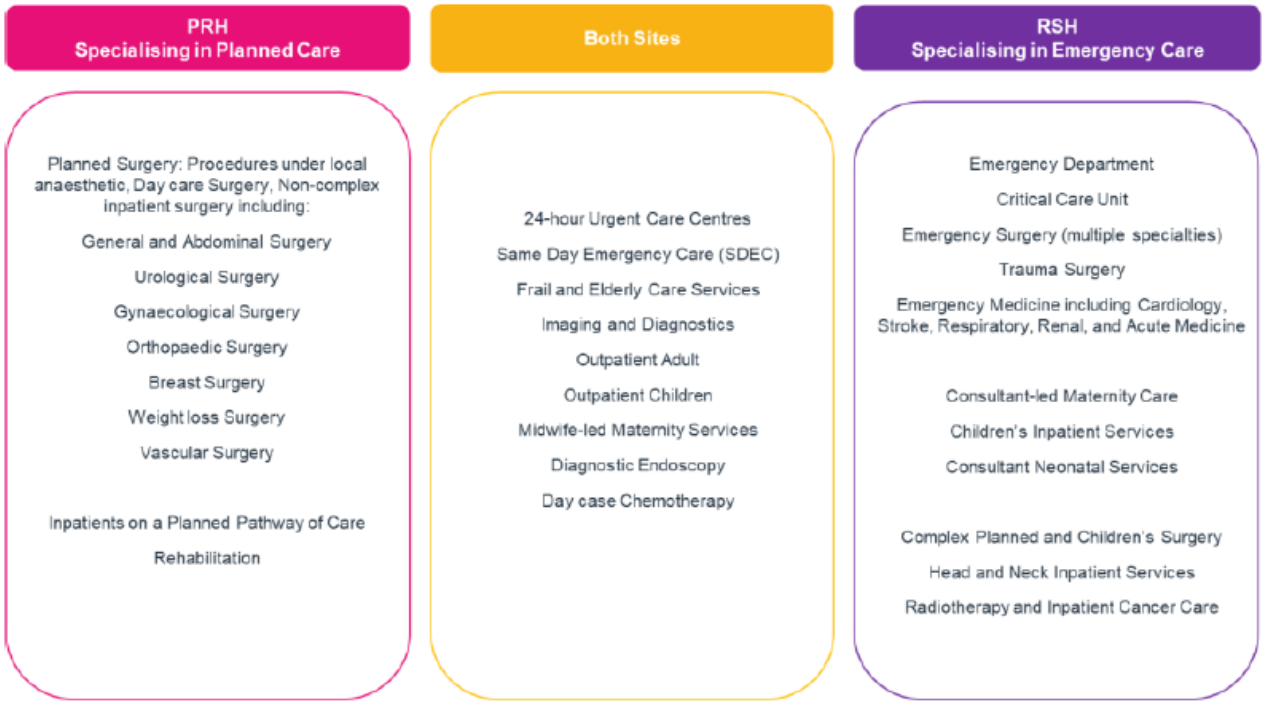
- Our workforce challenges:
    - We are overly reliant on agency and temporary staff because we are unable to recruit and retain the high calibre staff we need. This is mainly due to the current configuration of services which means that staff must work across sites and are unable to access multi-disciplinary support when they need it for our sickest patients. Our clinical environments also do not currently provide the capacity, space or layout needed to provide modern-day healthcare. All these factors impact negatively on our people, resulting in them leaving and impacts our ability to attract the number and skill mix of the substantive staff that we need.
- Our clinical model challenges:
    - The clinical model is not fit for purpose because of the outdated service configuration that prevents us from addressing quality and operational issues. This becomes more impactful as more and more hospital trusts across the UK reconfigure their services to better meet the needs of their citizens, patients, and staff.
    - Our greatest areas of risk are the sustainable provision of critical care and emergency medicine services, and consistently providing uninterrupted planned care capacity to ensure we can treat the many patients who are waiting for planned procedures, many of which are life changing.
- Our infrastructure challenges:
    - Our infrastructure does not support the delivery of modern-day healthcare, our digital aspiration, or the capacity we need to care for our patients in a safe and dignified way.
    - The configuration of our buildings does not lend itself to robust infection prevention processes as we need more single rooms and better ventilation.
- The needs of our population are changing – our systems, processes and estate need to be able to meet those changing needs.

To address these challenges, the HTP is transforming services across our acute hospital sites and putting in place the core components of the acute service reconfiguration agreed as part of the Future Fit consultation. Key benefits include:

- A dedicated emergency department with immediate access to medical and surgical specialities
- Ring-fenced planned care services supporting the needs of our population
- A much better environment for patients, families, and staff
- Improved integration of services for local people.

The diagram below demonstrates what we are moving towards:

Figure S-07: High level outline of services on each site



To deliver the programme our next steps are as follows:

All actions for the HTP are in draft subject to national approval of the Financial Business Case (FBC).

Action	Owner	Timescale
Financial Business Case (FBC) approval	HTP programme lead	Q1 2024/25
Main build construction to begin	HTP programme lead	Q1-Q2 2024/25
Further staff, patient and community engagement	HTP programme lead	2023-26
Implement new ways of working	HTP programme lead	Q4 2026

4.2 Elective care

At the beginning of the 2022/23 financial year, our providers developed a three-year plan in alignment with the NHS England Long Term Plan on how to rise to the challenges of addressing the elective backlogs that had grown during the pandemic. These plans include several large-scale transformation programmes on pathways and how services are provided. They form part of the system-wide elective

recovery deliverables, acting as a key enabler for being more efficient, and thereby releasing capacity that can be freed up to recover waiting lists.

Duty to offer patient choice

As standard ongoing practice, processes are in place to ensure NHS STW honours its statutory obligations in ensuring patient choice, as per the National Choice Framework set out by the Department of Health and Social Care (DHSC).

While GPs and referring clinicians can offer choice by utilising the e-Referral Service (eRS) at the point of referral, in STW we have a Referral Interface Service which processes all routine and urgent referrals. This means the majority of the choice conversation with patients, and ensuring the provision of patient choice, is provided by this team. It is an embedded standard working practice for this team to offer a minimum of five possible provider options to choose from when a patient has been referred into consultant-led care.

Mapping of referral pathways, whether in their current or future state, also forms a standard part of any review, redesign and transformation of services, service change or development. This would always include the need to ensure the provision of patient choice as part of that commissioned pathway.

Even with the recent move towards developing and implementing direct referral pathways as per the GP Access Recovery Plan, and areas of innovation like the implementation of electronic eyecare referrals from optometry to secondary care, we are still ensuring pathways are in place and that the referral goes via the Referral Interface Service to ensure patients are informed, involved and empowered in their own care, options and decision making.

Although patient rights and the National Choice Framework are already well established, further work is happening currently in STW to enhance public and staff communications and awareness. The aim of this work is to raise the profile of these statutory rights, and what patients should expect, through various communications tools. These include the development of a public-facing Choice Policy Statement that will be published on the ICB and ICS website, use of posters, leaflets, and social media channels to promote the messaging, as well as providing links to the national ‘easy read’ leaflets around these patient rights.

An Integrated Impact Assessment was completed on our patient choice work and supported by the Equalities and Involvement Committee, the outputs from which informed a bolstered range of public FAQs for publishing.

There is a local communications plan in place, aligned with the national communications toolkit on patient choice which was made available in December 2023. This plan was developed to inform and raise awareness and understanding among key stakeholders including staff from provider trusts, primary care and the ICB, along with the public, Healthwatch, MPs and councillors.

Strategically over the coming year, we will be working with primary care and provider colleagues as part of all transformation and service programmes, to start working towards encouraging patients to be more actively involved and manage their own appointment choices through things like My eRS and the NHS App.

Work is underway on the development of a robust accreditation framework and process for the listing of other providers, which will broaden the range of provider options that can be made available to patients to choose from. This work will be completed in the coming months.

Finally, as per the request issued by central Government in May 2023, the ICB actively participates in the national rollout of Patient Initiated Digital Mutual Aid. Through this, and aligned with the national phased rollout programme, long waiting patients are proactively identified and validated, before being offered the opportunity of changing to an alternative provider who has a shorter waiting time than where they are currently.

The national toolkit suggested that minimal communications were required as patients will be contacted directly where they have been identified as eligible to change provider, however we continue to ensure patients are aware of their right to choose.

Outpatients – service provision

New approaches and ways of providing outpatient services to help recover some of the post-COVID long waiting lists include:

- Addressing health inequalities as part of waiting list recovery
- Increased use of advice and guidance (and preventing some face-to-face appointments)
- Virtual consultations (and preventing some face-to-face appointments)
- Patient-initiated follow-ups (and preventing some routine follow-ups)
- Improved capturing and reporting of the above in system data
- Validation and review of waiting lists
- One-stop clinics
- Nurse-led telephone follow-ups
- Remote reviews
- Looking at ways of reducing missed appointments.

The development of Community Diagnostic Centres (CDCs) is a central pillar of the ICS strategy for integrated care and core to the restoration and recovery of the NHS across the county. The first CDC in the county will be in Telford (TF1):

- The facility was implemented during 2023/24.
- Additional MRI capacity was introduced as part of the CDC from October 2023.
- Additional CT capacity was introduced as part of the CDC from May 2023.
- The CDCs also contribute to providing certain services in communities rather than general hospital settings, as part of moving towards more locally available services where clinically appropriate.

Funding was also approved during 2022/23 for an Elective Hub at Shrewsbury and Telford Hospital NHS Trust (SaTH) to increase capacity and deliver activity to help reduce the surgery backlog. Within the Hub, there will be two theatres and an associated recovery area. This scheme will create a ring-fenced elective day-case facility bed base 52 weeks a year. This is planned to open June 24.

The creation of an additional theatre and associated recovery facilities at The Robert Jones and Agnes Hunt (RJAH) Orthopaedic Hospital NHS Foundation Trust was also approved, with plans including:

- Construction undertaken during 23/24

- The Theatre will be operational in the second half of 24/25. This capacity will enable RJAH to deliver an additional 1,200 elective cases recurringly
- This will deliver a 9% increase in elective activity for the delivery of additional spinal disorders and orthopaedic activity.

Linked to the NHS Long Term Plan, the broader programme of elective care transformation is to lead and oversee transformative change on areas of elective care that will ensure individuals needing planned care see the right person, in the right place, at the right time (first and every time), and get the best possible outcomes, delivered in the most efficient way, whilst also enabling elective recovery through being more innovative, effective and efficient.

Outpatients transformation

Big Conversation:

You said: “Waiting times are very long and communication is poor".

We did: Focus on the recovery of elective waiting lists to reduce long waits through improving pathways and maximizing our use of resources

This five-year programme of work, running until 2026, is to transform the provision of outpatient services in the county to be more effective and efficient, whilst generating efficiencies that help enable recovery of long elective waiting lists and waiting times through reutilisation of freed up capacity.

High-level benefits expected from this programme of work are as follows:

Patients and carers	• Safer and quicker care • Better experience • Seamless communication • Care that fits around you • Reduced travel/stress
Primary care and GPs	• Manageable demand • Ability to target available resources • Supported, sustainable teams • Seamless communication
Secondary and hospital colleagues	• Safe care • Manageable demand • Ability to target resources • Supported, sustainable teams • Seamless communication
Integrated Care System	• Improved health and wellbeing of the local population • Better outcomes • Increased value • Less waste • More resources

With alternative approaches and ways of providing outpatient services, people may no longer need to visit a hospital. This generates a number of environmental benefits that will contribute to the system green and net zero plans including:

- Reduced miles travelled by patients, and their family and carers
- Reduced CO_2 emissions
- Reduced hospital car park use
- Reduced time needed for appointments (for virtual or telephone consultations).

Action	Owner	Timescale
Develop and implement one whole-system MSST model and pathway with a lead provider identified	Chief Operating Officer RJAH	August 2024
Implementation of phase one of Elective Hubs (SaTH)	Chief Operating Officer SaTH	March 2025
Implementation of phase two of Elective Hubs (RJAH)	Chief Operating Officer RJAH	March 2025
Implementation of the enhanced recovery programme for total hip replacements and total knee replacements	Senior Responsible Officer (SRO) for MSK and clinical leads	March 2025
Build on digital solutions to support flexible clinic capacity to increase use of virtual outpatient	Chief Operating Officers for all providers	March 2025
Implement high-volume, low-cost and best practice pathways	Chief Medical Director (CMO) and Chief Nursing Officer (CNO)	March 2025
Implement the 'gold standard' for patient-initiated follow-ups	Director of Strategy, CMO	March 2025
Implement the first phase of the MSK transformation	SRO MSK	March 2025
Develop roadmap for health inequalities elective recovery principles	Director of Strategy	March 2025
Both acute trusts to develop SMART action plans for health inequalities elective recovery principles	Director of Strategy, Chief Operating Officer (COO)	March 2025
Complete intensive piece of work focussing on ensuring consideration of health inequalities in waiting list recovery	Director of Strategy	March 2025
Review and redesign of improved integrated end-to-end eye care pathways and processes that are more effective and efficient	Director of Elective and Director of Strategic Commissioning	March 2025
Review and redesign of integrated orthopaedic surgery provision with a lead provider identified	Director of Strategic Commissioning & Provider Collaborative	April 2025
Commissioning of a comprehensive pain management service (covering MSK and non-MSK pain) to include deprescribing and support to patients who have dependency on opioids or other medicines used to treat pain (added by medicines management)	Director of Strategic Commissioning & Provider Collaborative	April 2025
Redesign multispecialty pathways where eye care is a key factor, including giant cell arteritis, patients on Hydroxychloroquine.	Director of Elective and Director of Strategic Commissioning	March 2026

Improved integrated infrastructure for collectively managing multi-morbid patients	Director of Place & Partnerships	March 2027
Redesign pathways and services for contact lenses, dry eye, low vision, and move to cataract pre-op assessments and consent being done in optometry to enable direct-to-surgery listing	Director of Elective and Director of Strategic Commissioning	March 2027
Optimise use of one-stop clinics and remote reviews to minimise the number of appointments needed	Programme SRO, clinical lead and programme lead	2021-27
Redesign and improve pathways and processes to ensure they are efficient and effective (weaving in Getting it Right First Time)	Programme SRO, clinical lead and programme lead	2021-27
Improve patient experience – right appointment, in the right place, with the right person, at the right time, first time	Programme SRO, clinical lead and programme lead	2021-27
Reduce travel requirements and disruption for patients by providing some services closer to home or in their own home/environment	Programme SRO, clinical lead and programme lead	2021-27
Improve staff experience	Programme SRO, clinical lead and programme lead	2021-27
Reduce hospital car park occupancy	Programme SRO, clinical lead and programme lead	2021-27
Reduce CO_2 emissions through reduced travel to appointments	Programme SRO, clinical lead and programme lead	2021-27
Reduce waiting lists, waiting times and delays for elective services through more efficient ways of working	Programme SRO, clinical lead and programme lead	2021-27
Improve communication with patients, carers and guardians	Programme SRO, clinical lead and programme lead	2021-27
Maximise use of new technologies, approaches and innovation	Programme SRO, clinical lead and programme lead	2021-27
Optimise use of available resource and value for money, including staffing, time, and clinic space	Programme SRO, clinical lead and programme lead	2021-27

4.3 Maternity services

Maternity transformation was highlighted as a key area at the establishment of the ICB in our System Development Plan, based on the findings of the first Ockenden report. We have already made significant improvements in the quality and safety of maternity care since then.

In March 2023, NHS England (NHSE) produced a three-year delivery plan for local maternity and neonatal services. The plan encompasses four themes:

- Listening to and working with women and families with compassion
- Growing, retaining and supporting our workforce
- Developing and sustaining a culture of safety, learning and support
- Standards and structures that underpin safer, more personalised, and more equitable care.

Based on this vision, we will, together with local transformation and partners across the system such as providers, commissioners and system users, deliver a plan to transform our Local Maternity Neonatal System (LMNS). We will also work with 'Maternity Voices' to engage with parents and families about services to ensure co-production of services is at the heart of pathways.

Action	Owner	Timescale
Develop an LMNS maternity transformation plan for 2023-26 with system partners	LMNS programme	Three-year phased approach
Options appraisal and clinical senate process	Director of Strategic Commissioning	TBC
Stakeholder engagement: • Pre-consultation Integrated Impact Assessment, repeated after consultation if required. • Undertake pre-consultation if required • Undertake formal consultation following NHSE assurance if required.	Director of Strategic Commissioning	TBC

Evaluation and Decision-Making Business Case (DMBC) if required.	Director of Strategic Commissioning	TBC
Pre-Consultation Business Case (PCBC) development and NHS assurance if required	Director of Strategic Commissioning	TBC
Transparent, evidenced-based and assured process in place to fully inform Board decision making	Director of Strategic Commissioning	TBC

4.4 End-of-life care

It is the commitment of Shropshire, Telford and Wrekin (STW) ICS that people nearing the end of their life receive high-quality, compassionate care and are supported to live well and to die with dignity in a place of their choosing. Across STW, we know that this is provided for the majority of people. However, we also know that we can do more, particularly for those that do not access, or have difficulty accessing, services. We want to identify people in their last journey of life earlier and anticipate care needs that can be planned for in advance.

Actions we propose to take are as follows:

Action	Owner	Timescale
In 2023, people told us that they would like to understand more about advance care planning for people living with dementia, what dying looks like, and what to expect if you are caring for someone in the last weeks and days of life. We will work with people and the public to shape how we might deliver these subjects	STW commissioning and contracting lead system communications and engagement lead	June 2024
Improve access to same-day care and support for residents eligible for Continuing Healthcare (CHC) fast track and approaching end of life	Head of CHC	September 2024
Develop an integrated children and young people Palliative and End of Life Care (PEoLC) Strategy	Chair, Children and Young People PEoLC Working Group	March 2025
Create greater integration between generalist and specialist services by implementing the second year of the PEoLC Strategy	STW SRO, Clinical Lead and Commissioning and Contracting Lead and Provider Collaborative	March 2025
People in the last year of life to be systematically identified and offered an assessment and advance care plan		March 2025
Better support people to live as well as possible by identifying people earlier in their last journey of life and to anticipate care needs that can be planned for		April 2025
All people on an end-of-life care register will have an identified coordinator		April 2025

Everyone will have access to the care they need at any time of the day		April 2025
People, their families and loved ones will have access to 24/7 advice and guidance		April 2025
Build a workforce with the knowledge, skills, and confidence to deliver compassionate care		April 2025
Address inequalities to ensure that access to care is available to all		April 2025
Develop an enhanced service to provide an additional level of care for those with more complex needs		April 2025
Offer support for families and loved ones in the care of someone that is dying, and continue this after their death		April 2025
Localities to work together for people, their families and loved ones		March 2026
Palliative and end-of-life care is to be seen as everyone's responsibility		March 2026
Digital enhancement to support, electronic shared care records, centralised information to support care delivery and monitor progress.	ICB Deputy Medical Director	In line with digital strategy

Babies, children and young people with life-limiting or life-threatening conditions

The number of babies, children or young people (BCYP) with life-limiting or life-threatening conditions in our region is, thankfully, low – with an average of 11 expected to die each year. The specific and often very complex needs for BCYP who require palliative and end-of-life care means that an all-age strategy is not appropriate, and the Shropshire, Telford and Wrekin Integrated Babies, Children and Young People Palliative and End of Life Care Strategy will be developed.

In addition, over the next 12 months, Hope House Children's Hospice will be working with Shropshire Community Health Children's Nursing Team to establish joint working arrangements and the role of specialist nurses. It is anticipated that evaluation of this work will evidence a sustainable workforce model that will enable learning in practice for nurses that do not have a specialist qualification and a more sustainable model of 24/7 care for those BCYP who will die at home.

4.5 Duty to take specialist and clinical advice

To ensure that clinical and/or specialist advice is at the core of supporting our plans, advice given is embedded throughout the ICS governance structure. This is provided through a range of options from individual clinical leads working on pathways or specialities to our Health and Care Senate, a forum for clinicians to share learning, information, and challenges across our system.

There are also four specialist delivery groups that support the ICS. These are:

- Mental Health and Learning Disabilities and Autism Delivery Group
- Children and Young People, SEND and Families Delivery Group
- Urgent and Emergency Care Delivery Group
- Planned Care Delivery Group.

Specialist advice is supported by NHS England through the clinical and specialist networks.

4.6 Clinical strategy and Priorities

In response to the national and system context, the Shropshire, Telford and Wrekin Clinical Strategy 2023-25 sets out six priority health improvement pathways which are:

- Urgent and emergency care (UEC)
- Cancer
- Cardiac
- Diabetes
- Musculoskeletal (MSK)
- Mental health

In addition to the above, the ongoing programmes of work in relation to maternity and neonatal services will continue. Other priority areas such as respiratory, urology and gynaecology will be monitored and included in further phases of the clinical improvement programme.

Clinical Priority 1 – urgent and emergency care

Across NHS STW, our levels of emergency admissions are broadly flat, if not slightly reducing, compared to pre-pandemic levels, mostly within the GP direct admissions cohort. Our A&E attendances have grown since the levels in 2019/20 but have remained flat since 2021/22, however Type 3 (minors e.g. minor injury/minor illness) attendances have increased at a faster rate than our Type 1 (majors e.g. chest pain).

In line with national and local requirements, we plan to:

Action	Owner	Timescale
Reduce the proportion of patients with no criteria to reside who are not discharged (phased trajectory totalling a reduction in delayed discharges of 75 a day by April 2024). This will achieve a 15-20% improvement in the four-hour target, reduce 12-hour waits by 50 per day and reduce ambulance delays by 10 per day	Clinical Strategy Lead	April 2024
To develop a service specification and meaningful clinical outcome measures for the service model, the impact that Virtual Ward activity will have, supporting system flow, based on actual activity data and to implement within the Shropshire Community Health NHS Trust contract	Director of Strategic Commissioning and Clinical Lead	April 2024
Establish a clinically led reference group for Virtual Wards and integrated discharge team (IDT) – with membership across acute, primary, community and social care	Clinical Lead	April 2024
Expand community services and reduce unwarranted demand. This will be achieved through: • improvements in long-term conditions and frailty pathways • adult and young person's asthma (reduction of admission rate from 108 per 100k to 90 by April 2024 and 75 by April 2025)	Clinical Strategy Lead	April 2024 April 2025 April 2025

• increased use of virtual wards (reduction in admissions by 20% or 30-40 per day by April 2025)		
Review pre-hospital urgent care services to determine a future model that provides the most efficient delivery	Director of Urgent Care	March 2025
Enhance provision for high-intensity users	Director of Urgent Care	March 2025
Expand the IDT and simplify the Fact-Finding Assessment Process	Director of Urgent Care	March 2025
Reintroduce the discharge to assess process	Director of Urgent Care	March 2025
Develop antibiotic therapy in the community	Director of Urgent Care and AD Medicines	March 2025
Expand the urgent community response service	Director of Urgent Care	March 2025
Improve health inequalities by reducing the number of emergency admissions of patients with long-term conditions by 20% by April 2025 and undertake further assessment of inequalities in A&E due to deprivation and ethnicity	Clinical Strategy Lead, STW SRO Health Inequalities	March 2025
Through the Social Care Discharge Improvement Plan, we will deliver 20 additional discharges per day into social care, rising to 30	Clinical Strategy Lead	March 2025
Through the Acute Discharge Improvement Plan we will, ensure discharge planning is undertaken within two days of admission , optimise same-day emergency care, continue to embed the home first principles, and increase the Virtual Ward capacity – resulting in circa additional 40 discharges per day)	Clinical Strategy Lead	March 2025
Review all out of hospital service offers due to the volume of offers we currently have with the ambition of a full redesign	Director of Urgent Care	April 2025
Through the Local Care Transformation Programme, we will improve utilisation of community services including Virtual Wards (phased roll out)	Clinical Strategy Lead	2024/25
Appropriate access to care: To ensure our services provide consistent access to pre-hospital care or access to pathways that redirect non-emergency presentations away from our Emergency Department. Ensuring the right care, first time.	Director of Urgent Care	Two-year programme to be aligned to HTP

Clinical Priority 2 – Cancer

We plan to work collaboratively to implement changes to make significant improvements in the lives of people diagnosed with cancer and enable more people to live full lives beyond cancer.

As a system, we want to ensure that people understand when to go and seek advice from their GP, or other health professional, as we know how much early diagnosis can impact on the long-term prognosis for people living with cancer. However, we know that once a cancer has been diagnosed, there have to be high-quality services available to ensure that people get the best treatment at the right time. In some cases this will mean that people may have to travel further for surgery or other treatments to ensure that they get the high-quality care and treatment needed to improve their outcome. That is not to say people should not receive high-quality care and treatment as close to home as possible, but is a recognition that to maximise survival and outcomes, we may not be able to provide everything within Shropshire, Telford and Wrekin (STW). This is particularly relevant to some childhood and rare cancers where specialised care needs to be centralised in larger cancer units.

We have significant variation in both early diagnosis and outcomes for our population. We need to work in partnership to ensure that we provide the right information for our population to enable people to understand the risks they are taking with their health in the short, medium and long term. This includes advice on what alterations that they can make to their lifestyle that will enable them to live longer, happier and healthier lives, thereby reducing the rates of cancer and the impact on the individual.

In line with national and local requirements we plan to:

Action	Owner	Timescale
Meet the 'Faster Diagnosis' standard by April 2024 with the opening of a Community Diagnostic Centre and rapid diagnostic service to achieve the 75% faster diagnosis standard by April 2024	Clinical Strategy Lead	March 2025
Restore and transform acute services and increase cancer treatment capacity by 13% from the 2019/20 baseline. For colorectal, skin and prostate, we will implement best practice pathways and achieve a median of 28 days for each pathway by April 2025. We will increase elective cancer capacity with a focus on lower GI, gynaecology and urology, engage with specialised commissioning to increase treatment capacity by 13% based on the 2019/20 baseline for chemotherapy, radiotherapy and the specialised surgery population of STW	Clinical Strategy Lead	April 2025
Enhance personalised care for our population by delivering a 25% increase in September 2022 baseline by April 2025 and the roll out of patient stratified follow-ups which will be in place for 10 cancer pathways by April 2025.	Clinical Strategy Lead	April 2025
Increase the number of patient diagnoses at stage one and two. Improvement trajectory to be developed and agreed to achieve 75% of cancers diagnosed at stage one and two by March 2028	Cancer Transformation Team	Ongoing improvements until March 2028
Reduce health inequalities in bowel cancer and cervical screening coverage	Clinical Strategy Lead	Ongoing

Case Study: Core20PLUS5 Connectors (known locally as STW Cancer Champions)

STW, in partnership with both local authorities, were successful in their bid to be selected as one of 11 wave one pilot sites across the country taking part in the NHS England Health Inequalities Core20PLUS5 Connectors programme.

The aim of the programme is to develop and support community-based roles know as 'Connectors' who will impact on the goals of the Core20PLUS5, a national approach to tackling health inequalities. They will act as a voice for local communities by raising awareness of barriers, helping to reduce health inequalities for our under-served populations.

As STW is an outlier for early cancer diagnosis, our local pilot specifically aims to:

1. Raise awareness of cancer signs and symptoms and local screening services
2. Understand barriers to people accessing healthcare services
3. Positively contribute to STW's achievement of the goal of 75% of cases diagnosed at stages one or two by 2028.

The project is delivered in partnership between the NHS, local authorities and the community and voluntary sector, with Lingen Davies Cancer Fund and Qube Oswestry Community Action as our lead delivery partners.

A collaborative approach has been pivotal to ensure the project benefits from the engagement expertise of our Local Authority Outreach Teams and lead delivery partners, both in terms of raising awareness of the opportunity to become a Connector but also in engaging with and building trust with our under-served communities.

Clinical Priority 3 – Cardiac pathway

In line with national and local requirements we plan to:

Action	Owner	Timescale
Establish a cardiovascular disease (CVD) project group to drive work, increasing our 'treatment to target' outcomes for hypertension	Head of Health Inequalities	June 2024
Restore inpatient and outpatient care through transformation and increase capacity to meet the elective target of 130% or pre-COVID baseline by April 2025	Clinical Strategy Lead	April 2025
STW will continue to work with system partners to deliver the CVD Strategy, focussing on case-finding and management interventions across all areas (community outreach, primary care and secondary care) to improve prevention and accelerate Make Every Contact Count (MECC) interventions	Head of Health Inequalities/ Director of Place & Partnerships	2024/25
Continue embedding national programmes for smoking, alcohol and weight management, including the initiation of the NHS low calorie diet programme and working with local authorites to design connected community tobacco cessation pathways.	Director of Place & Partnerships	2024/25

To enhance the use of digital technologies in prevention inclusively.	Head of Digital	
Improve medicines management: lipid management, heart failure, rapid dose titration, anticoagulation management	ICB Chief Pharmacist	2024/25
Increase the rates of early detection and treatment to reduce the proportion of undiagnosed patients for three metrics: hypertension, coronary heart disease and heart failure	Clinical Strategy Lead	TBC
Improve discharge and ongoing patient management and support	Clinical Strategy Lead	TBC
Clinical initiatives established to support include: • Early detection and treatment • Acute restoration and transformation • Enhancement of discharge and ongoing management • Improved pharmacological treatment and management.	Clinical Strategy Lead	TBC
Reviewed and redesigned cardiology pathways and processes that are more effective and efficient with an initial focus on cardiac rehabilitation and heart failure	Director of Place & Partnerships	TBD
Improve integration of cardiology pathways across primary, community and secondary care to function collectively as one service with one common aim	Director of Place & Partnerships	TBD
Optimise the CVD prevention agenda (linked to primary care focus on earlier identification and management of arrythmia and hypertension)	Associate Director of Primary Care	TBD
Roll out year two of Innovation for Healthcare Inequalities Programme (InHIP) targeted work to identify and treat individuals with hypertension (subject to successful funding bids)	Head of Inequalities	TBD
Optimise pharmaceutical management of people with hypertension.	ICB Chief Pharmacist	TBD

Clinical Priority 4 – Diabetes

In line with national and local requirements, we plan to:

Action	Owner	Timescale
Increase the proportion of patients achieving all eight care processes initially focusing on two care processes: foot care (improve standard by 10% September 2023 and a further 15% by April 2024) and urinary albumin (5% by September 2023 and	Clinical Strategy Lead	April 2024

a further 5% by April 2024) as these are the biggest outliers for Type 2 diabetes		
Work with nine outlying practices to achieve the national average for all eight care processes by April 2024	Clinical Strategy Lead	April 2024
Reduce hospital spells for diabetic foot issues to 15 per 100k population by April 2024 and the relative number of diabetic lower limb amputations by 11 per 100k population by April 2024	Clinical Strategy Lead	April 2024
To develop an Integrated Diabetes Pathway approach (Place/Provider Collaborative) across CYP and adults including transitions between services	Director of Place & Partnerships	September 2024
Care Closer to Home – development of neighbourhood-based teams linked to LCTP	Director of Place & Partnerships	September 2024
Development of prevention based pathways via PLACE	Director of Place & Partnerships	April 2025
Optimise pharmaceutical management of diabetes	ICB Chief Pharmacist	April 2025
Improve access to specialist care delivered from acute	Head of Elective	Ongoing
Clinical initiatives established to support include: • Review of care and treatment across primary care and community care settings • Lower limb care management	Clinical Strategy Lead	TBC

Clinical Priority 5 – Musculoskeletal (MSK)

The population of STW continue to experience variation within the system and in comparison to other regions. For instance, a person from the most deprived quintile is 41% more likely to be readmitted as an emergency following surgery than a person from the most affluent quintile. We also know that there is an underrepresentation of specific population groups on our waiting lists and our rates for diabetic amputations are significantly higher than other regions. We have ambitions to improve safety and quality, integrate services, tackle health inequalities and access to care, and create a great place for staff to work. The ICS has an opportunity to demonstrate an efficient and sustainable way to fulfil these ambitions by taking a population-based approach to meet the needs of patients facing musculoskeletal (MSK) concerns.

Through our evidence-based understanding of the current challenges, we have identified the following actions:

Action	Owner	Timescale

Reduce referral rates per 10k population with the aim of moving into the third quartile for activity with a referral rate reduced from 11.9 to 8.2, or 167 referrals per week, by April 2024	Clinical Strategy Lead	April 2024
Restore inpatient activity levels and eradicate 52-week-waits, with a total activity requirement increasing to 228 per week from April 2025. Phased trajectory in place	Clinical Strategy Lead	April 2025
Reduce expenditure on MSK by £15m per year by April 2025	Clinical Strategy Lead	April 2025
Clinical initiatives established to support include: • Demand analysis and referral reduction • Outpatient transformation • Inpatient restoration and redesign.	Clinical Strategy Lead	TBC

Clinical Priority 6 – Mental Health

Our priorities include an ambition to prevent mental disorders in young people (and by default adults) through effective mental health promotion and prevention, as well as transforming current services to ensure they are accessible, integrated and reflect the best available evidence.

Action	Owner	Timescale
Adult Mental Health		
Complete Adult Services Transformation Programme	Programme Director and SRO MPFT	April 2024
Complete review of Talking Therapies Service (previously IAPT) model and implement new service model	Director of Mental Health, CYP and LD&A and System SRO Mental Health	April 2024
Develop our Talking Therapies Service model to link into the mental health elements of pathways for the clinical priorities and respiratory services, including cancer pathways	Clinical Strategy Lead	March 2025
Develop and implement a programme of work to enable local repatriation of individuals receiving community rehabilitation who are being supported away from their family and home area	Director of Mental Health, CYP and LD&A and System SRO Mental Health	April 2025
Deliver service improvements for Talking Service to achieve national access targets		March 2029
Finalise and implement three year plans to deliver the Mental Health LD&A Inpatient Quality Transformation Programme and development of a system bed base		July 24

strategy. Localise and realign inpatient care focusing on the key workstreams: • Population Health Analysis / Inequalities / Needs Analysis including bed modelling and baseline audits to identify current service gaps against standards. • Understand our current state to develop an ICB vision statement, self rating and develop a detailed action plan including required interventions for Adult Mental Health, Rehabilitation and MD&A. Undertake I & We statement requirements		
Develop and implement trauma-informed services across the breath of adult and CYP services	Clinical Strategy Lead	Ongoing
Crisis Support		
Undertake a demand and capacity review to determine our local needs	Director of MH CYP LD&A and System SRO Mental Health	2024/25
Develop the support to reduce suicide and a pathway for bereavement support		Ongoing
Increase support to individuals prior to reaching a crisis through early intervention		TBC
Develop pathways with VCSE support with a focus on the twilight 6pm-2am shift, including closer working with ambulance service and police		TBC
Develop non-hospital crisis beds with the third sector to reduce hospital admissions		
Develop services for the homeless community and review pathways into substance misuse and secondary mental health services		TBC
To continue to work with West Midlands Ambulance Service to develop mental health support within their offer	Clinical Lead and Commissioning and Contracting Lead	Ongoing
Children and Young People's (CYP) Mental Health		
Undertake a review of the existing CYP MH services (BEE U) and service redesign/ procurement based on CYP plan above	Director of MH CYP LD&A and Clinical Strategy Lead	2024/25
Develop the offer for prevention and early intervention to support CYP and their families as part of review above		2025
Develop and offer training to all staff across the system to understand the negative impact of adverse childhood experiences (ACEs) in later life	Clinical Strategy Lead and System SRO MH	TBC
Develop the mental health support offer for family, parent, and carer support for children with complex needs	LA Leads, Director of MH CYP LD&A and Clinical Strategy Lead	TBC

Ensure transitional planning is a part of all CYP to adult pathways.	Clinical Strategy Lead	Ongoing
Older People's Mental Health Services		
Achieve the dementia diagnosis rate of 66.7% for 2023/24 and continue to deliver the national target rates from 2024 onwards	Director of Mental Health, CYP and LD&A and System SRO Mental Health	March 2024
Undertake demand and capacity modelling for future service demand relating to dementia Fully implement the revised model of service delivery necessary across the system to achieve the principles of the Dementia Vision including VSCE and Primary Care		March 2025
Planning implementation of services needed for the implementation of new medicines for early onset dementia expected late 2024/25, wrap around clinical and support services, and access to PET scans	ICB Chief Pharmacist/ Director of Strategic Commissioning	TBD
Maximise opportunities to join up thinking and service delivery with SaTH to ensure high quality, timely discharges for older adults experiencing mental health problems	Director of Mental Health CYP and LD&A and Clinical Strategy Lead	Ongoing
Maximise opportunities to join up thinking and service delivery with primary care to ensure high quality, integrated care for older adults experiencing mental health problems	Director of Mental Health CYP and LD&A and Clinical Strategy Lead	Ongoing
Learning Disabilities and Autism		
Develop and implement a diagnostic learning disability pathway	Clinical Strategy Lead	March 2024
Reduce the reliance on inpatient care for people with learning disabilities and address unwarranted variation/gaps in autism care. Achieve the adult national trajectory of no more than 30 per million individuals who are inpatients. Achieve CYP national target of no more than 11 per million individuals who are inpatients	Director of Mental Health CYP and LD&A, Clinical Strategy Lead	March 2024
Develop services for individuals with ASD who don't meet current criteria for secondary mental health services		August 2025
Jointly commissioned community provision and support for children and adults locally and co-produce the offer within the community	Director of Strategic Commissioning	TBD
Development of an all-aged joint neurodiversity (ND) pathway across the system: Carry out a review of current offer, understanding national evidence, local good practice and challenges and develop a jointly commissioned pathway (Linked to action in section 2.4)	Director of Strategic Commissioning	TBD
LD&A transformation programme: Including areas such as key worker, STOMP/STAMP, learning disability diagnosis, programmes to reduce health inequalities, and trained workforce.	Director of Strategic Commissioning	TBD

Specialist Mental Health Services		
Perinatal Support		
Develop services to ensure the longest wait for tokophobia (a pathological fear of pregnancy), bereavement and loss does not exceed four weeks from referral to assess and treat	Director of Mental Health CYP and LD&A, Clinical Strategy Lead	March 2024
Maximise opportunities to work with West Mercia police and partners in local authority to consider what support can be offered to individuals and families affected by Operation Lincoln – the police investigation into maternity services at Shrewsbury & Telford Hospital NHS Trust.		Ongoing
Eating Disorder Services		
Develop and implement eating disorder services including specialist services for more complex longer-term individuals	Director of Mental Health, CYP and LD&A and Clinical Strategy Lead	April 2025
Neurodevelopment Disorders		
ADHD and ASD		
Mainstream services will be trained to ensure reasonable adjustments are made for those with ADHD/ASD	Clinical Strategy Lead	March 2025
Ensure there are clear shared care agreements in place and that there are processes for reviewing prescribing for ADHD	Clinical Strategy Lead	2023-25
Develop a robust assessment, diagnosis and treatment pathway and reduce the waiting list to 18 weeks for ADHD/ASD.	Director of Mental Health, CYP and LD&A and Clinical Strategy Lead	March 2027
Learning Disabilities		
Mainstream services will be trained to ensure reasonable adjustments are made for those with ADHD/ASD.	Clinical Strategy Lead	March 2025
Provider Collaborative		
Scope potential to implement a Mental Health Provider Collaborative across MH providers, local authorities and the ICB.	Programme Director Provider Collaborative Scoping Programme	March 2025

Chapter 5: Enablers

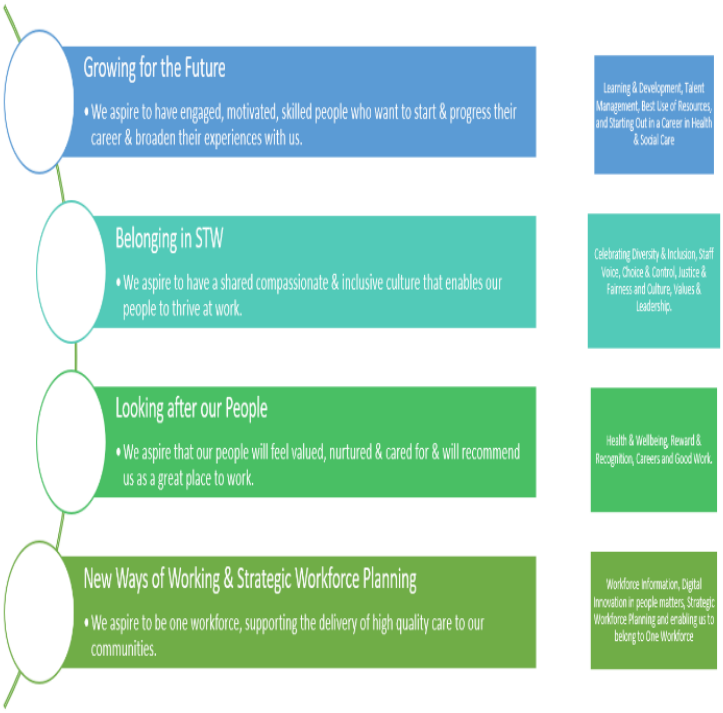
5.1 People

Our system workforce has been working collaboratively for many years, an approach underscored during the system's response to the COVID-19 pandemic. During this time, relationships have formed between NHS, local authority, ICB (formerly CCGs), primary care, social care and voluntary sector partners to tackle the workforce pressures at a system level.

Our ICS people committee draws its membership from a broad range of stakeholder organisations and continues to build on our collaborative approach towards delivering the national guidance for ICB people functions to support a sustainable 'One Workforce' within health and care – creating a compassionate and inclusive culture and working collaboratively as a system to address our workforce challenges.

People Strategy 2023-27

Our People Strategy sets out our ambition for the next five years for the circa 23,000 people who work with us across health and social care. It is structured around the four core pillars of the NHS People Plan, underpinned by the NHS People Promise and the ambitions set out in the Future of NHS Human Resources and Organisational Development. Our four ambitions are set our below and describe what we want to do, and that we can be flexible to accommodate changing demands.



We are now working across our system with our partners to jointly agree the delivery plan and priorities for the next five years.

We have retained most of our previous NHS STW Local People plan portfolios to enable strategic consistency, and to ensure we can continue to see the golden thread of strategic connection with national NHS People priorities.

Workforce

It is essential that we deliver on our operational plan and the modelling between the Workforce Plan and the Financial Plan is crucial.

Our key priority is to maximise available cross sector workforce across a wider group of providers with the aim to ensure this is an enabler to the delivery of our financial deliverables.

The STW people priorities have been developed through an integrated approach to workforce planning, and there are a range of efficiencies linked to our workforce plan in 2024/25 to reduce costs

and to ensure we stay within our percentage of total pay bill across the year. Our initiatives include the reduction of unavailability, replacing agency/temporary with substantive staff, joining national programmes such as the national bank, West Midlands cluster agency for medical workforce, and the NHS Emeritus programme for retired clinicians. Our strategic national NHS People priorities are aligned to the LTWP, 'Train, Retain, Reform', and our additional priorities to support a sustainable 'one workforce' across the NHS and health and care.

Training and education

Education and training are an essential lever to the delivery of our integrated workforce plan to support delivery of services across the system. Trained, educated staff supply, including trainees, are fundamental to this. In addition, there is geographical disparity being in a predominantly rural geographical footprint.

Through the Workforce Plan, we have identified critical areas for education and training that brings together partners including university and higher education with required skills, upskilling, reskilling, or new skills to deliver the activity.

We have identified the following areas for education and training focus in the short to medium term and our ongoing LTWP people plans will continue to strengthen this.

- Expansion of education and training for Operating Department Practitioners (ODPs)
- Theatre nurses, and theatre practitioners
- Pharmacists and pharmacy technicians including community pharmacy workforce
- Diagnostic radiographers
- Consultants in cardiology, urology, A&E and community paediatrics
- Health Care Assistants (HCAs), Health Care Support Workers (HCSWs) and nursing associate
- Dentists and dental nurses
- Nursing – adult, paediatrics, maternity, and community.

A live example of this has been the expansion of ODP Apprentices. Also, the HCSW academy has significantly expanded our HCSW roles during 2023/24 and the academy will expand to support pharmacy.
A new pharmacy technician apprenticeship programme will create sustainable entry level supply across all providers including community pharmacy.

Other examples of training and education available are SELR (Structured English Language Reference programme) for consultants, expansion of TNAs, developmental roles, university top-up scheme for children's nursing, apprenticeships, career pathways. Health Visitor cohorts and Dental Nursing training pathway to name a few in conjunction with our education providers.

5.2 System procurement

National priorities

Nationally the NHS launched the NHS Commercial Portfolio and the Strategic Framework for NHS Commercial during 2023. This outlines how the NHS and government functions will work together to transform public procurement. The NHS Commercial Portfolio has seven main service offerings:

- People and Community
- Technology and data

- Commercial strategies
- Governance, assurance, and processes
- Sourcing and management
- Commercial capability/best practice
- Sustainability and innovation.

The Strategic framework builds on several of the national commercial function service offers but goes further to provide a centrally driven blueprint for whole system commercial and supply chain transformation across four thematic areas.

- Our People
- Digital and Transparency
- How we work
- Influence and scale.

The introduction of the 2023 Procurement Act in October 2024 will necessitate significant changes to NHS procurement practices.

Local governance
The System Director of Procurement chairs a bi-monthly Procurement Working Group encompassing NHS and local authorities within STW which will enable future collaboration within procurement. A monthly System Product Evaluation Group has been introduced to look at standardisation of products and suppliers linked to patient pathways. Standardised use of products will assist with better knowledge and safer usage of products leading to a better patient experience. Other benefits include efficiencies, standardised training, and equity for patients.

Local function
The Shropshire Healthcare Procurement function has focussed on training to support the demands of the changing ICS landscape and has embedded several apprenticeship positions to grow our own procurement workforce.

The function has developed and matured over recent years and is well advanced in terms of partnership working as an ICS with proactive engagement to deliver as a system.

The procurement function has embedded the use of national benchmarking tools (Spend Comparison) and workplan pipeline (Artamis) to enable the system to understand system spend profiling, transparency of expenditure and to assist with identifying opportunities.

Local priorities

	1 Year	2-3 Years	4-5 Years
Local	• Procurement awareness and training – Divisions and key depts. • Efficiencies/cip • Review strategic supplier management options. • Contract management. • Identify Collaborative Trust project opportunities. • Increase procurement profile in trusts. • Clinical Nurse Procurement Specialists – System product standardisation. • Review and implement actions Sustainability plan. • Review and reduce use of waivers. • Review staff survey results & staff well-being. • Review e-procurement strategy and progress against P2P/GS1/PEPPOL/Catalogue management/ Scan4safety. • Update and implement new Procurement people plan. • Spend profile – trust and division level. • KPI's – dashboard monitoring inflation/savings/value added activities/capital/social value/operational performance. • Introduction IMS SaTH. • Income generation supplying GP's. • Review of items held in stores and cip opportunities. • System procurement key areas workforce/estates/digital.	• All procurement via one department, ICB/SaTH/SCT/RJAH. • All contracting via procurement – digital/estates/pharmacy/GP. • One supply chain and logistics service for all providers. • Manage key suppliers to drive reciprocal benefits and gain share. • Review partners and supply routes to ensure BVFM – patient pathway/service redesign. • Collaboration STW/LA's - BSOL/BCA/Worcs and others – shared workplan & joint contracts. • Reduce number of products and suppliers used within the Trust. • Totally electronic P2P system implemented, and staff/service managed by procurement. • Update e-procurement strategy in line with national guidance and ICS working. • Review IMS benefits. • Increase supply to GP's/voluntary organisations. • Roll out IMS at RJAH/SCT. • Doing business with SHPS – increased use of SME's.	• Drive efficiencies and saving via full contract management. • Collaboration across Shropshire and West Midlands/other STP where appropriate – benefits from joint workplan activity. • Demonstrate best value for money for ALL strategic products. Supported by benchmarking and model hospital metrics. • Review logistics provision – STP/GP's, off site location. • Hospital Transformation Programme review procurement & logistics implications. • Tender transport logistics provision. • Review e-procurement/GS1/scan4safety requirements and update action-plan. • Review procurement structure/skill mix and succession planning. • Review procurement strategy/1-5 year plan.
National	• SCS – national benchmarking tool (STW comparison/opportunities). • Atamis – national workplan and pipeline management (STW all projects managed through Atamis). • Model hospital metrics -improve performance. • Introduction new Procurement Act. • Framework consolidation programme – reduction. • CCIAF – certification review. • New PSR regulations for healthcare contracting. Procurement all non-NHS to NHS contracts. • Digital – single supplier registration portal. • Strategic framework for NHS Commercial key areas: - - Our people/Digital and transparency/How we work/Influence and scale	• Adopt GS1 & PEPPOL to drive efficiencies, including logistics. • CCIAF aim for Best. • Work with NHSSC on value-based procurement initiatives. • Review NHS core list and opportunities/pressures. • Digital – 1 single e-commercial platform. • Our people – NHS commercial strategy – commercial workforce plan – review.	• Continue to support national agenda, contributing to pilots and working groups. • Review current National landscape and requirements. • Integrate Scan4Safety work into Procurement and wider Trust. • Demonstrate BVFM – procurement service costs.
How	• Use benchmark tool to identify opportunities. • Review department skill set and recruit/train as appropriate. • Deep dive of Shropshire spend data. • Introduction of dashboard and suite of reports. • System PEG • Cultural review procurement/stores well being	• Greater emphasis on driving efficiencies and supplier relationship management. • Achievable targets based on market knowledge "where we sit". Benchmarking/Model hospital. • Train and keep staff (correct skill mix) • Introduction of System procurement structure and collaborative workplan. • Increased awareness of procurement and non-pay expenditure within Trusts. • Progress actions from cultural review/wellbeing.	• Dedicated contract management resource. • Review "as is" – fit for purpose/bvfm • Leading procurement and logistics function for Shropshire, Telford & Wrekin, including GP's/LA's/Care homes/veterinary establishments.

5.3 Digital as an enabler of change

In light of recent announcements from NHS England (March 2024) about potential funding for digital in 2025/26, further work is required to outline local plans.

As an ICS, we place our people at the heart of our digital journey and work together as a system to manage health and wellbeing services for our population. We promote a digital first, not digital only, approach to improving care. Shropshire, Telford and Wrekin ICS are currently moving through the process of digitally transforming, to 'level up' and align with both ICS and national objectives. This means putting in place the right infrastructure that our impacted users expect. It means providing digital access to medical and care records, and it means ensuring information can be shared easily between our different care settings.

The NHS England Frontline Digitisation programme (FDP) aims to support ICSs in reaching an accepted baseline of digital maturity and accelerate the overall adoption of core technology required for real digital transformation of services. We recognise that there is a long way to go in our ICS digital journey, but by taking the initial steps to digitally transform and improve our technological capabilities, we are solidifying our commitment to excellence, and are aligned to the national focus to provide high quality care to patients, improving accessibility and consistency of services through digital innovation.

Our current and future position

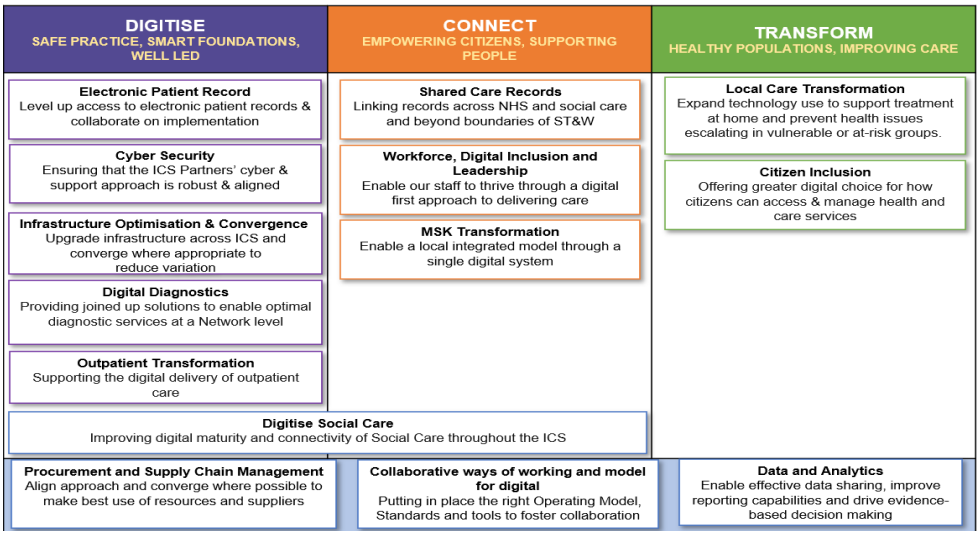
The table below shows our current position and the future desired state of our ICS:

Current	Future
• A 'digitally immature' system • Digital inclusion across communities is worse than the national average • Ageing estate across the system – community hospitals, primary care, SaTH, and local authorities	• Build upon collaboration to date and focus on how we can support our organisations to meet national expectations and deliver against local priorities • Put coordination and structure around the digital portfolio thus protecting the time of our staff by

• Silos based with digital services and digital management being delivered out of each organisation.	prioritising their workload and sharing the resources we have • Combine the needs of our citizens, staff and organisation with the expectations of national bodies and regional partners to prioritise focus for investment and effort in digital transformation • Ensure we work to a plan to support those who are 'digitally excluded'.

Our Digital Pledges

To deliver our ambitions and pledges, we will embed sustainable ways of working to ensure we are best set up to successfully deliver our digital portfolio.



We will also:

Action	Owner	Timescale
Embrace digital into our culture	Digital Transformation Lead	2024/25
Learn and converge as an ICS	Digital Transformation Lead	2024/25
Streamline procurement across the ICS	Digital Transformation Lead	2024/25
Upskill workforce and communities in data literacy	Digital Transformation Lead	2024/25
Work for patients collectively focusing on citizen inclusion in all digital decisions	Digital Transformation Lead	2024/25
Govern and manage our digital portfolio together	Digital Transformation Lead	2024/25
SATH EPR programme – detailed Trust-wide and departmental programme		
Implement Careflow PAS and Careflow ED	SATH EPR programme	2023/24 – 2024/25

2024/25 – Implement Careflow Connect, Electronic Prescribing and Medicines Management (EPMA) and Order Comms	SATH EPR programme	2024/25

5.4 Data and Information

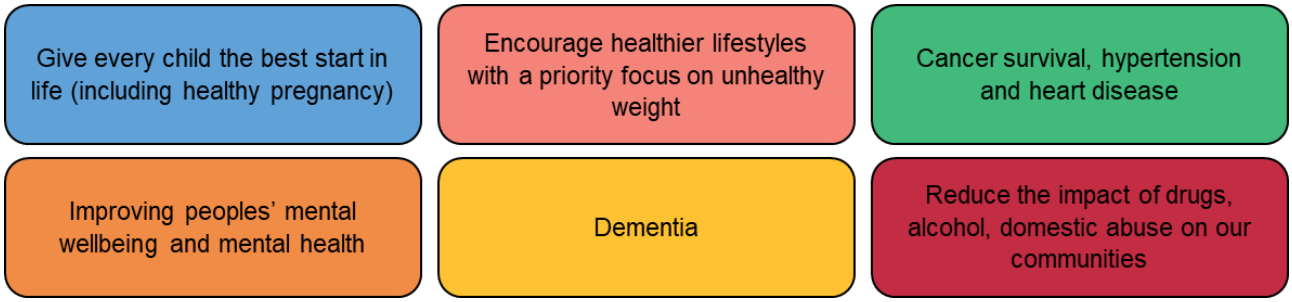
There is an ambition to develop a system-wide approach to the management and visibility of linked data in place to inform Strategic Commissioning and outcome-based approaches to pathway redesign.

Action	Owner	Timescale
Design and agree a data strategy across the ICS	Head of Business Intelligence & Analytics	2024/25
Procure service from CSU to provide infrastructure to process, load, and present linked data in a secure environment	Head of Business Intelligence & Analytics	2024/25
Design, create and implement a solution to publish reporting	Head of Business Intelligence & Analytics	2024/25
Agreed Data Quality Improvement Plan	Head of Business Intelligence & Analytics	2024/25

5.5 Population health management (PHM) as enabler of population health

Population health management (PHM) is a person-centred, data-driven approach that seeks to improve the physical and mental health of people over their lifetime. PHM allows our system to use all the digitally-collated data, intelligence and insight from our area to make collective decisions and prioritise key issues and specific populations of people, depending on need and equity. It requires clinicians, professionals, and frontline workers to expand their focus from treatment and/or assessment to considering the whole person and their health risk.

System leaders, in conjunction with local stakeholders and the public, have set our ambitions and priorities for PHM over the next five years. We expect our priorities to evolve and respond to conversations with the public over the next five years. Our six population health priorities are:



5.6 Estates – System Physical Infrastructure, Estates Strategy and Planned Delivery

In line with NHSE requirements, all ICSs need to draft their Estates and Physical Infrastructure Strategies. This process will need to be fully integrated into all system, clinical and non-clinical

workstreams. The development of the strategy will aid system thinking and alignment across the infrastructure components and core objectives, and must fully integrated with all elements of the forward plan. We aim to deliver an estate which is fit for purpose and provides high-quality care environments which enable the safe delivery of services for our communities. This means an estate which is compliant and functionally suitable, environmentally sustainable, accessible, flexible, and designed around changing service needs.

ICS Estates and Physical Infrastructure Strategies will be used to inform future NHS Treasury Funding.

The Estates and Physical Infrastructure Strategy will be comprised of the following components:

- Estates physical infrastructure
  - Primary care estate
  - Community estate
  - Acute
  - Mental health
- Other physical infrastructure
  - Energy
  - IT physical infrastructure
- Medical equipment
- Zero carbon roadmap.

The strategy will also support the system priorities of HTP, MSK Transformation and Outpatient Transformation as well as existing physical infrastructure workstreams and projects like Community Diagnostic Centres, Cavell Centres and non-clinical estates rationalisation.

Action	Owner	Timescale
Implement Estates and Physical Infrastructure Strategy	ICB, managed by Estates lead	Early 2024

5.7 Financial sustainability and productivity

The Shropshire, Telford and Wrekin system has a significant underlying financial deficit which is one of the reasons that we are part of the Recovery Support Programme (RSP). The system and ICB is therefore subject to significant scrutiny around finances and financial decisions, with a specific requirement to develop an approach to recovering and making sustainable our financial position.

A system financial framework was therefore developed in 2020/21 and agreed by all organisations and all system partners, working closely together to deliver a roadmap for financial recovery.

All organisations have:

- approved the approach of ‘one model, one consistent set of assumptions’ and recognise that the position of each organisation will evolve and change transparently
- agreed to mobilise and deliver the plan to enable the development and delivery of the financial strategy and Financial Improvement Framework as part of an Integrated System Strategy
- ensured that the transparent and agile approach to financial planning and management continues across the system
- recognised the initial financial control totals in the Financial Improvement Framework with a commitment to agree organisational control totals within that

- agreed to work together to use our resources flexibly and effectively, to deliver the system vision.

To ensure that all decision-making is open and changes are understood and approved by all, the system has been operating under the 'triple-lock' process and using a principle of 'moving parts.' This means that decisions are made at local, ICS and regional level (triple lock) and that new expenditure can only be committed if it is backed by new income or efficiency ('moving parts'). The principles are designed to ensure decisions are owned by each organisation and at system level, with oversight from NHSE. All investment decisions are made using a system-wide prioritisation framework/scoring mechanism to ensure that decisions take into account the triple aims of the system – health and wellbeing of the population, quality of service provision and sustainable and effective use of resources.

The Integrated System Improvement Plan provides the mechanism by which the ICB will come out of NHSE oversight level NOF 4. Delivery against monthly milestones within the plan is reported to ICB exec group and the Strategy Committee by the Planning and Performance team. Evidence of delivery is collated and submitted to NHSE, and then formal progress is presented at our Improvement Review Meetings which are likely to move from monthly to quarterly in 2023/24. Formal changes to the RAG status of our exit criteria are agreed at the regional NHSE Recovery Support Oversight group (RSOG). The formal sign off of exit criteria is through the national Quality and Performance Committee based on the recommendations from the regional RSOG.

In 2023/24, the impact of the first-year strategies have supported the delivery the 2023/24 £129m underlying exit deficit.

In 2024/25, the financial plan will deliver an improvement on the underlying recurrent deficit position through the following:

- Business as usual efficiency of 3.5%
- Stretch efficiency targets up to 4-5%
- Prioritisation of limited growth funding and investments, unless essential for generating income and meeting agreed waiting time targets
- Workforce monitoring and controls, reducing agency spend and escalation costs
- Controls on expenditure through the Triple Lock process for transactions of £10k across the system
- Reviewing cost pressure drivers to ensure effective controls and monitoring systems are in place
- A system-wide approach to efficiency, transformation, and productivity.

The medium to long term plans will be developed during 2024/25 setting out the recovery trajectory for the system showing a year-on-year improvement in the underlying position, including a detailed multi-year revenue and capital (strategic and operational), workforce, efficiency, and transformation plan.

A system-wide approach to efficiency and transformation is in place. We use a project management approach to ensure effective monitoring of achievement using business intelligence data and financial analysis. System-wide programmes will include Workforce and Digital, and drive efficiency through consolidation and collaboration, improving use of NHS estate, and focusing on system-wide priorities for transformation – for example, the Local Care Transformation Programme and MSK.

All ICB contracted services will be reviewed to ensure value for money is achieved. Where this is not the case, decommissioning and disinvestment will be considered. A clear prioritisation approach for the best use of available resources will be deployed.

A system productivity oversight group has been in place since June 2023 and meets monthly to coordinate and oversee delivery of the system level improvement in productivity and efficiency. It will

work with regional leads to ensure our systems and processes are aligned to regional and national priorities and allow all parts of the system to share ideas and best practice for improvement. Intelligence on the opportunities for productivity will be drawn from benchmarking sources NHS Futures, Model Hospital, GIRFT, NHS productivity reports and local benchmarking with other ICB's and providers. The productivity oversight group will be supported by system resources across finance, business intelligence, clinical and operational leadership and project management to ensure the delivery of productivity improvements. Providers will have their own individual plans, but the impact and learning will be shared at the oversight group to ensure our plans are delivering the required improvement. It reports to the System Financial Management Group, which in turn reports to the System Finance Committee.

The recent Hewitt review of ICSs outlined the need to focus on the creation of health value and implementation of innovative financial flows and payment mechanisms. As the system matures, opportunities to understand the cost of whole care pathways and intelligence through population health management approaches will allow consideration of resource allocation to provider collaboratives and places.

ICBs have been notified that baseline running cost allowances (allocations to fund the running costs of an ICB) will reduce by 30% in real terms by 2025/26, with at least 20% to be delivered by 2024/25. This provides us with an opportunity to review how we deliver the core business of the ICB alongside the development of our models for provider collaboratives and place.

Action	Owner	Timescale
As system matures and population health information is available, development of resource allocation methodology to provider collaboratives and 'Place'	System	Ongoing
Exit National Outcomes Framework level 4 (NOF4)	Director of Planning and Performance	March 2026

5.8 Our commitment to research and innovation

Duty in respect of research

Since developing and publishing our JFP in 2023, a research and innovation strategy has been produced and agreed through the Staffordshire and Stoke-on-Trent, Shropshire Telford and Wrekin Health and Care Research Partnership (SSHERPa) – signed off at the STW ICS Research and Innovation Committee in November 2023.

The key pillars of the research strategy are as follows:

1. Developing collaborative integrated research that addresses the health and care priorities of our region, expanding the range and diversity of research undertaken in our region
2. Fostering a culture of collaborative research and innovation with strong leadership championing the strategy
3. Developing the capacity and capability for evidence-based health and care
4. Increasing the opportunity for our region's population to engage in research
5. Developing a collaborative infrastructure for research and innovation in our region to support and grow an increased research portfolio
6. Supporting the implementation of best evidence into practice – commissioning and provision of services.

Our strategic objectives provide the framework for how we will achieve our vision and realise our principles through:			
Workforce Development • Championing a research culture where everyone is valued and able to contribute to, and benefit from, research • Developing innovative career pathways, embedding research into health and care professional roles • Sharing knowledge and expertise, developing research professional roles across the partnership.	**People, Places and Communities** • Creating opportunities for inclusive research across diverse communities • Enhancing the opportunity for people to shape research, reducing health inequalities across our diverse urban and rural geography • Enhancing the opportunities to engage in research – championing the people and teams that support this • Developing infrastructure that supports wider engagement in research.	**Impact** • Creating an eco-system where research outputs can be rapidly adopted into practice/policy • Developing co-production strategies that support the mobilisation of knowledge • Transforming health and care through high quality research • Supporting sustainability through new approaches to health and care research delivery • Supporting economic development through income generation.	**Innovation** • Working with business and commercial partners, facilitating deeper partnerships and securing co-investment • Connecting research and innovation • Accelerating translation, commercialisation and knowledge exchange.
Supported by high quality research, empowering all to engage, improving outcomes through partnership and leadership			

Executive leadership and hosting of SSHERPa is now in place along with a provider executive sponsor and programme management support. We have a dedicated ICB lead for research (Chief Medical Officer) who provides senior leadership between SSHERPa and the ICB.

Work has also continued to develop and enhance partnerships across the health, care and the VCSE sector to advance research and innovation to support the four core purposes of the ICS. Development of our research engagement activities to reach wider communities has been supported through the establishment of voluntary and community sector research coordinators and the development of a research connector's network across our region. These links provide routes by which we can engage with under-served communities by taking research to those who do not currently have the opportunity to engage in research.

As part of developing the local research infrastructure, members from the voluntary, community and social enterprise (VCSE) sector are now key partners of SSHERPa and a dedicated patient, public and community involvement and engagement work stream is in place. This draws together those working in public engagement across all settings and community engagement with VCSEs, to ensure

that new studies are in development, and established NIHR portfolio studies are shared across the widest population. Since February 2024, just under 5,000 people have been recruited to take part in a research study in NHS Shropshire Telford and Wrekin ICS, and through our community networks we are seeking ways in which we can extend these opportunities further.

Through working with communities, we have established voluntary and community sector research coordinators, hosted by the VCSE and funded through the NHSE REN programme, developed a research connectors network across our region and supported individual community research champions. We will continue to work with all health and care research partners to seek ways in which we can engage with under-served communities by taking research to those who do not currently have the opportunity to engage in research. Partners include NHS trusts, local authorities, VCSE organisations, universities, National Institute for Health and Care Research (NIHR), Clinical Research Network West Midlands (CRN WM) and the West Midlands Health Innovation Network.

Developing collaborative integrated research addressing the health and care priorities of our region: Examples of how we are supporting this agenda include the successful application to be part of a national programme around dementia biomarkers, developing applications to establish a NIHR Mental Health Research Group (led by Keele University but with VCSE as co-applicants) and the development of a dementia study across rural locations.

We were delighted to secure NHSE research engagement network funding and to have delivered the NHSE Touchpoints programme as part of SSHERPa, where more than 11,000 people were directed to the NIHR Be Part of Research website. We work closely with our university partners to support 'home grown' research, and work with our NIHR CRN WM to ensure portfolio studies come to our region. Our priority is to work with partners to better understand how participation in these programmes can influence evidence-based service transformation in our region.

On a regional level, SSHERPa partners form part of West Midlands Secure Data Environment (WM SDE) Network workstreams, and have strong links with local research infrastructure and stakeholders to ensure that we support staff, organisations and our local population to be involved in research to support health and care priorities. We are working closely with NIHR CRN WM as it transitions to the new NIHR Regional Research Delivery Network to understand implications for support for wider settings including primary care and community settings.

Across our ICS research partners, we are driving collaborative working, actively sharing best practice. We have an established research governance work stream whereby we are streamlining processes with the aim of establishing one 'SSHERPa' check for studies that operate across organisational boundaries. Through this, workstream organisations are sharing knowledge and expertise to support organisations without research and development infrastructure – for example, VCSE. SSHERPa partners work closely to share training and workforce opportunities (STARs and research practitioners), develop research engagement approaches targeting different health and care professionals (for example, evidence based practice groups such AHP/GPNs, CENREE, NMAHP, LENSE, criminal justice settings, SCREEN for social care, PRIDE for public health); and seek innovative ways to build the capacity and capability for research, through joint clinical academic appointments, shared training opportunities and innovative research and innovation roles.

We were delighted that our work in driving research and innovation through SSHERPa, and the progress we have made in embedding research within the ICS, was recognised at the NIHR CRN WM annual awards 2023, with SSHERPa winning the 'Shining Research Star' award.

Action	Owner	Timescale
Identify research needs and shape plans	Chief Medical Officer	April 2025
Ensure research support and delivery posts are sustainably funded where appropriate so everyone can play a role.	Chief Medical Officer	By 2026
Collaborate with local research infrastructure and stakeholders including industry where appropriate – National Institute for Health & Care Research Clinical Research Network (NIHR CRN), West Mids Academic Health Science Network (WMAHSN), Academic Research Council (ARC), Biomedical Research Centre (BRC), Impact Acceleration Account (IAA) capital bids etc.	Chief Medical Officer	Ongoing

Innovation

We want to be an innovative and learning healthcare system to help improve the lives of patients. On this basis, we will work with a range of partners, including primarily the local Academic Health Science Network (AHSN), which is the innovation arm of the NHS. The voluntary and community sector can be a particularly rich source of innovation and new ideas.

Action	Owner	Timescale
Undertake horizon scanning across the ICS to identify opportunities for innovation, then consider scaling cost effective or cost-saving innovation in order to drive economic development	Director of Strategic Commissioning	2023-2028
Engage with stakeholders for innovative idea generation.	Director of Comms and Engagement, plus all	2023-2028

Appendix A: Summary of priorities

Overview of the population health priorities, inequalities priorities and health and care priorities across Shropshire, Telford and Wrekin and the ICS

Telford and Wrekin Health and Wellbeing Board proposed Priorities	Telford and Wrekin Integrated Place Partnership (TWIPP) Priorities	Shropshire, Telford and Wrekin ICS Priorities	Shropshire Health and Wellbeing Board Priorities	Shropshire Integrated Place Partnership (ShIPP) Priorities
Population health priorities				
Best start in life: Start for Life Family Hubs	Best start in life	Best start in life	CYP including trauma informed approach	CYP's strategy
Healthy weight	Healthy weight	Healthy weight	Healthy weight and physical activity	Prevention/healthy lifestyles/healthy weight
Mental health and wellbeing	Mental health, learning disability and autism	Mental wellbeing and mental health	Mental health	Mental health
Prevent, protect and detect early	Reducing preventable diseases through early diagnosis, screening, immunisation, and improving reach of services	Preventable conditions – heart disease and cancer	-	-
Alcohol, drugs and domestic abuse	-	Reducing impact of drugs, alcohol and domestic abuse	-	-
Inequalities priorities				
Inclusive resilient communities, housing and homelessness and economic opportunity	-	Wider determinants: • Homelessness • Housing • Cost of living	Working with, and building, strong and vibrant communities	Community capacity and building resilience within the VCSE
Prevent, protect and detect early Closing the gap, starting well, living well and ageing well	Core20PLUS5 and reducing barriers to access	Inequity of access to preventative care	Reduce inequalities Improving population health	Tackling health inequalities
Closing the gap, deprivation, equity, equality and inclusion	-	Deprivation and rural exclusion	Reduce inequalities and improve population health	Tackling health inequalities
-	Reducing barriers to access	Digital exclusion	-	-
Health and care priorities				
-	Proactive prevention, local prevention and early intervention services	Proactive approach to support and independence	-	-
Integrated neighbourhood health and care, primary care and closing the gap	Local care transformation (includes neighbourhood working)	Person-centred care integrated within communities	Joined up working	Local care and personalisation (including involvement), integration and Better Care Fund (BCF)
-	Older adults and dementia	Best start to end of life (life course)	-	-

Best start in life: Start for Life Family Hubs, social, emotional and mental health, and SEND	Best start in life SEND and transition to adulthood	Children and young people's physical and mental health and focus on SEND	Children and young people including trauma informed approach	CYP strategy
-	-	Mental, physical and social needs supported holistically	-	-
-	Accessible information, advice and guidance	People empowered to live well in their communities	-	-
-	Primary care access and integration, and place-based development in line with the Fuller report	Primary care access (general practice, pharmacy, dentists and opticians)	-	Supporting PCNs
-	-	Urgent and emergency care access	-	-
-	-	Clinical priorities: e.g. MSK, respiratory, and diabetes	-	-

Appendix B: List of acronyms

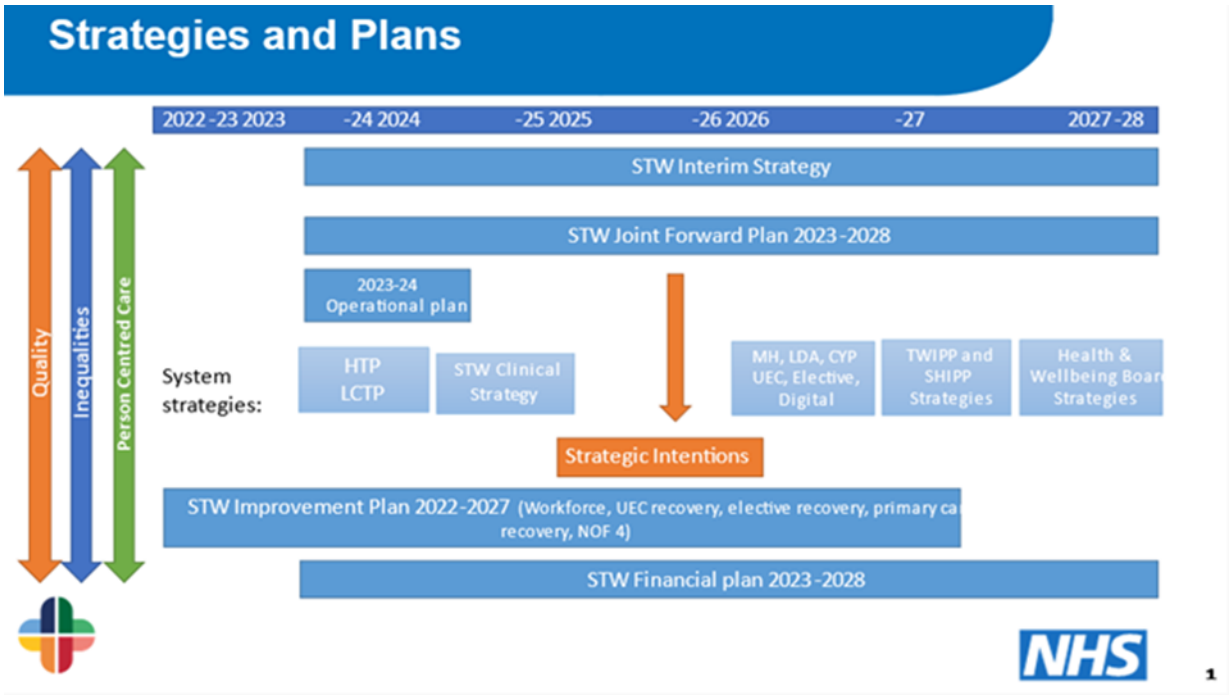
Acronym	Meaning	Acronym	Meaning
BAF	Board Assurance Framework	MH	Mental Health
ACE	Adverse Childhood Experience	MIU	Minor Injury Units
AHP	Allied Health Professional	MOU	Memorandum of Understanding
AHSN	Academic Health Science Network	MPFT	Midlands Partnership University NHS Foundation Trust
ARC	Academic Research Council	MSK	Musculoskeletal
BAME	Black, Asian and minority ethnic	MSST	Musculoskeletal Service Shropshire and Telford
BAU	Business as Usual	MTAC	Maternity Transformation Assurance Committee
BCYP	Babies, Children or Young People	NHSE	National Health Service England
BI	Business Intelligence	NIHR	National Institute for Health and Care Research
BCF	Better Care Fund	NHSI	National Health Service Improvement
BTI	Big Ticket Items	NQB	National Quality Board
CCG	Clinical Commissioning Group	OD	Organisational Development
CDC	Community Diagnostic Centre	ODG	Operational delivery Group
CDH	Community Diagnostics Hub	ORAC	Ockenden Report Assurance Committee
CDOP	Child Death Overview Panel	PCN	Primary Care Network
CEO	Chief Executive Officer	PHM	Population Health Management
CL	Clinical Lead	PL	Programme Lead
CQC	Care Quality Commission	PMO	Project Management Office
CRN	Clinical Research Network	POD	Primary, Optometry and Dental
CVS	Council for Voluntary Service	PSIRF	Patient Safety Incident Response Framework
CYP	Children and Younge People	QIP	Quality Improvement Plan
DHCS	Department of Health and Social Care	QSC	Quality and Safety Committee
DTOC	Delayed Transfers of Care	RJAH	The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust
ED&I	Equality, Diversity and Inclusion	ROS	Readiness to Operate Statement
FREED	First Episode Rapid Early Intervention for Eating Disorders	ROP	Recovery Oversight Programme
G2G	Getting to Good	RSP	Recovery Support Programme
HARMs	Hospital Admissions Related to Medicines	SaTH	Shrewsbury and Telford Hospital NHS Trust
HBPOS	Health Based Place of Safety	SDP	System Development Plan
HCSW	Health Care Support Worker	SEEDS	Support and Education on Eating Disorders

HI	Health Inequality	SFH	Sherwood Forest Hospitals NHS Foundation Trust
HTP	Hospital Transformation Programme	ShIPP	Shropshire Integrated Place Partnership
IAPT	Improving Access to Psychological Therapies	SCHT	Shropshire Community Health NHS Trust
ICB	Integrated Care Board	SMI	Severe Mental Illness
ICP	Integrated Care Partnership	SOAG	SaTH Safety Oversight and Assurance Group
ICS	Integrated Care System	SOF4	Segment 4 of the System Oversight Framework
IDC	Integrated Delivery Committee	SOP	Standard Operating Protocols
IG	Information Governance	SRO	Senior Responsible Officer
IITCSE	Independent Inquiry into Child Sexual Exploitation in Telford	SSHERPa	Staffordshire and Shropshire Health Economy Research Partnership
INT	Integrated Neighbourhood Teams	STW	Shropshire, Telford and Wrekin
JHWBB	Joint Health and Wellbeing Board	TWC	Telford and Wrekin Council
JSNA	Joint Strategic Needs Assessment	TWIPP	Telford and Wrekin Integrated Place Partnership
KLOE	Key Lines of Enquiry	UEC	Urgent and Emergency Care
LCTP	Local Care Transformation Programme	UHNM	University Hospitals of North Midlands NHS Trust
LDA	Learning Disability and Autism	UTC	Urgent Treatment Centres
LeDeR	Learning from Life and Death Reviews of people with a learning disability and autistic people	VCSE	Voluntary, Community and Social Enterprise
LMNS	Local Maternity and Neonatal System	VCSA	Voluntary and Community Assembly
LTP	NHS Long Term Plan	WMAHSN	West Midlands Academic Health Science Network
LTP	Local Transformation Plan	WMAS	West Midlands Ambulance Service
MDT	Multi-Disciplinary Team		

Appendix C: List of strategies and plans

The Joint Forward Plan was informed by, and based on, the following strategies and plans of the Shropshire, Telford and Wrekin Integrated Care System:

- Interim Integrated Care Strategy
- STW Clinical Strategy – status: signed off
- STW Improvement Strategy
- Operational Plan
- HTP Strategy
- LCTP Strategy
- Mental Health, Learning Disabilities and Autism
- Children and Young People
- Urgent and Emergency Care
- Digital Strategy
- TWIPP and SHIPP strategies
- Health and Wellbeing Board strategies
- Strategic Intentions
- STW Improvement Plan
- Financial Plan.



For further information or copies of these documents, please contact stw.generalenquiries@nhs.net.

Appendix D: How we engaged our different stakeholders

To inform our Joint Forward Plan, we launched the Shropshire, Telford and Wrekin Big Health and Wellbeing conversation programme of engagement with our communities, staff, and partners. It was essential that our engagement activity was accessible and as visible as possible, using all established methods of communication and engagement such as a range of printed materials, online and face-to-face contact through a variety of meetings and events, as well as embarking on new channels of digital engagement.

Partnerships were formed with VCSE organisations, Healthwatch and local media organisations to maximise reach and raise awareness about the activity. Activity was tailored to ensure it is appropriate for the local population and those with specific protected characteristics. New technology and social media were used to communicate and engage with citizens.

Our approach was to collaborate extensively with local people who use health and care services, their families and any carers, local political stakeholders as well as members of the public, including seldom heard groups to ensure that our residents help inform our decisions.

Listening Events

To launch the Big Health and Wellbeing conversation, we organised six listening events for the public and our stakeholders. Locations for the public events were selected based on the intelligence of our partners and stakeholders, based on current local issues and existing activity. Six locations in Shropshire, Telford and Wrekin were identified. These were:

- Telford – Sutton Hill
- Bishops Castle
- Telford Centre
- Ludlow
- Market Drayton
- Shrewsbury.

Those that attended the sessions were taken through a short presentation about the Shropshire, Telford and Wrekin ICS, the challenges that exist within the system, and how their feedback would feed into the development of the Joint Forward Plan.

Big conversation survey

An online survey was launched to support the ‘conversation,’ enabling us to capture qualitative and quantitative data. We encouraged people to complete the survey, as well as capturing important demographic data and data for future engagement and follow up.

STW citizen pledges

A large part of the ‘conversation’ emphasised the need for people to take more personal responsibility for their own health and wellbeing and promoting community resilience.

Citizens were given information about pressures that exist in the system and the small things they can do to improve things; for example, the impact of attending A&E for a non-emergency and the benefits of accessing their local pharmacy versus a GP.

We used this opportunity to promote the STW pledges. The public were asked to suggest some pledges, things they could do to improve their own wellbeing or changes to the way they currently use health and care services which could help address some of the challenges faced in the system.

Community outreach

A community engagement team conducted on-street, opportunistic engagement at prime locations within communities, such as supermarkets, GP practices and outpatient clinics. Street teams focussed on areas of high deprivation and targeted groups of people who would not normally contribute to engagement activity.

Stakeholder engagement

A series of stakeholder engagement sessions were held throughout the period, including with primary care, hospital clinicians, councillors, MPs, VCSE colleagues and Healthwatch to ensure they have an opportunity to be part of the 'conversation' and the design process. This also meant they had an early opportunity to view our priorities and proposals.

Stakeholders were provided with opportunities to:

- Input and share ideas about how they, or their organisations, could contribute to local delivery
- Describe what they would like to see in the health and care system over the next five years
- Identify ways we could transform, plan or commission services differently to increase access and reduce inequalities.

Establishing a people's network

We have been recruiting a system-wide citizen network of local residents to enable us to gather public views and opinions on a wide variety of topics, allowing members of the public to get involved in shaping the future of local health and care services. The panel will form a large, representative group of local residents who are able and willing to be engaged on a wide range of local issues and offer their opinions.

Engagement with community groups

We attended several existing community groups and meetings to engage with protected characteristics and equality groups. The format depended on the demographics and needs of the group. The aim of this engagement was to gain insight into the experiences of marginalised groups in order to improve access and reduce inequality.

Our community group outreach work approach has included:

- Ethnic minority groups
- Faith groups
- Families
- Veterans
- Ex-offenders
- Carers
- Patient groups
- Older people
- LGBT communities
- Substance misusers
- Looked-after children
- Children and young people
- Farmers' groups
- Parent groups
- Homeless/rough sleeping people
- People with long-term conditions
- Disability groups
- People experiencing domestic abuse

- People living in deprived areas
- People living in rural communities

PR and media engagement

We launched a proactive PR campaign to help us reach a large audience without the expensive cost of traditional advertising and marketing. This increased the viability of the ICS and the engagement exercise.

Digital activity

To ensure maximum reach, we needed our digital campaign to be varied and wide ranging. The digital campaign consisted of a mixture of interactive website content, social media sharing and interaction, consistent and frequent e-newsletters to staff in all partner organisations, and utilising existing channels. Photo and video content generated during the outreach activity was also shared on social media.

Appendix E: Actions by year

All actions for the Hospital Transformation Programme are draft subject to national approval of the Financial Business Case (FBC).

JFP Actions in date order.pdf