Shropshire, Telford & Wrekin

Joint Forward Plan

2023 – 2028

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Executive Summary

The Shropshire, Telford & 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: 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 come through the most challenging few years in its recent 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. The backlog of planned operations and medical interventions has grown. We have experienced challenges in delivering several constitutional standards. Our whole system 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 within our system that require intensive support.

Our system is currently spending in excess of 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 on the basis of creating health value, implementing innovative financial flows and payment mechanisms and considering allocation of resources to provider collaboratives and “places”. We need to think differently and work differently in order to meet these challenges. We are better able to address these challenges by working more closely together.

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

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 person-centred care.

2. ***Improving place-based delivery, having integrated multi-professional teams providing a joined 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 4 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.

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 but with significant challenges and there is much work to be done, but we believe that it is achievable, and we must deliver our plan to improve the health and care services for our population with the strong commitment of our partner organisations and by talking to and working with our communities.

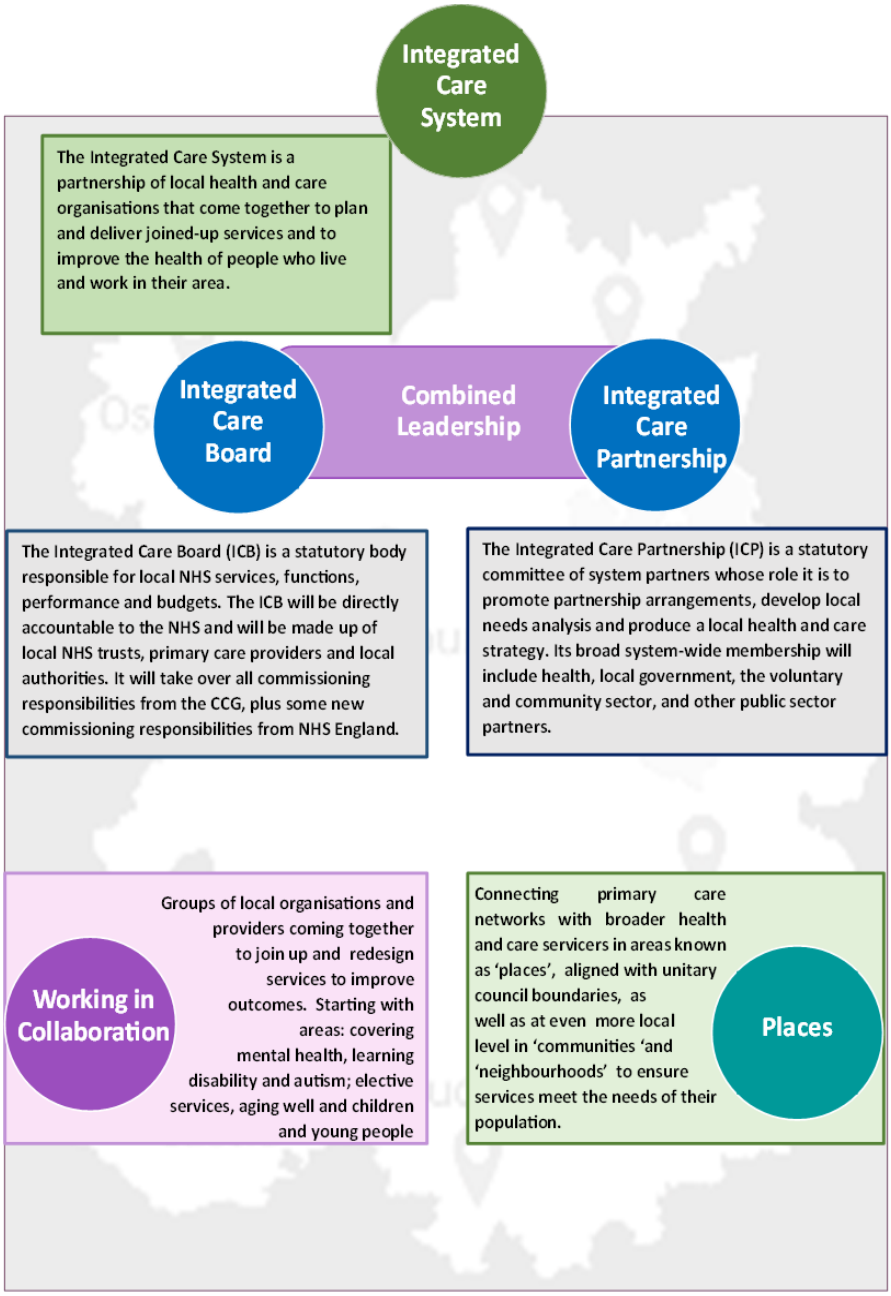
Chapter 1: Our Integrated Care System (ICS)

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 the acute and community settings we can give everyone the best start in life, creating healthier communities and helping people to 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 issues.

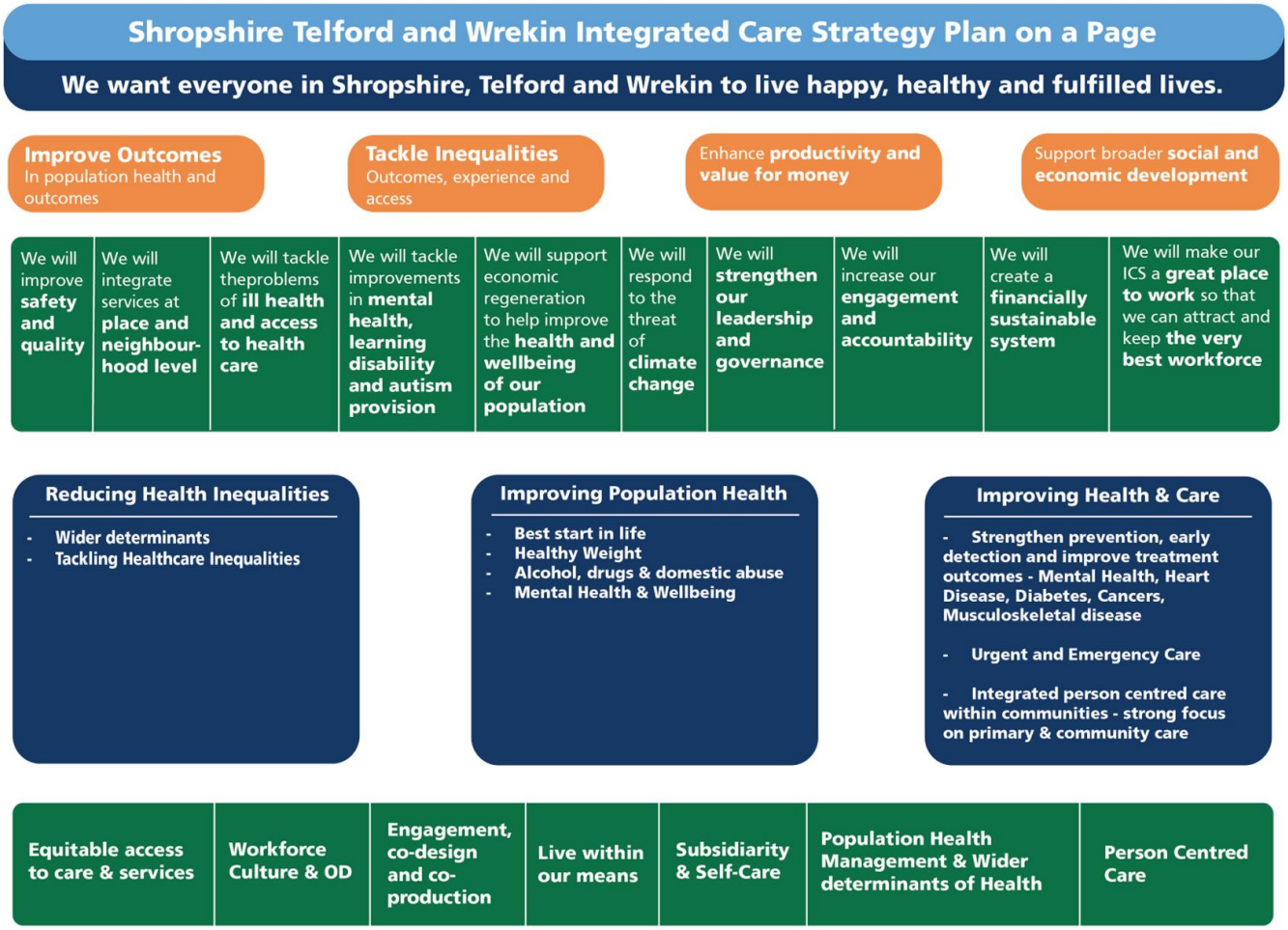
Our Councils provide the Joint Strategic Needs Analysis for the populations and communities of each of our places. These inform the Health and Wellbeing Strategies for each of our places and

subsequently our interim Integrated Care Strategy, which was approved 20th March 2023 by the Integrated Care Partnership. The Strategy can be found here:

https://www.shropshiretelfordandwrekin.nhs.uk/wp-content/uploads/NHS-STW-Interim-Integrated-Care-Strategy-V-9.0-2.pdf

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:

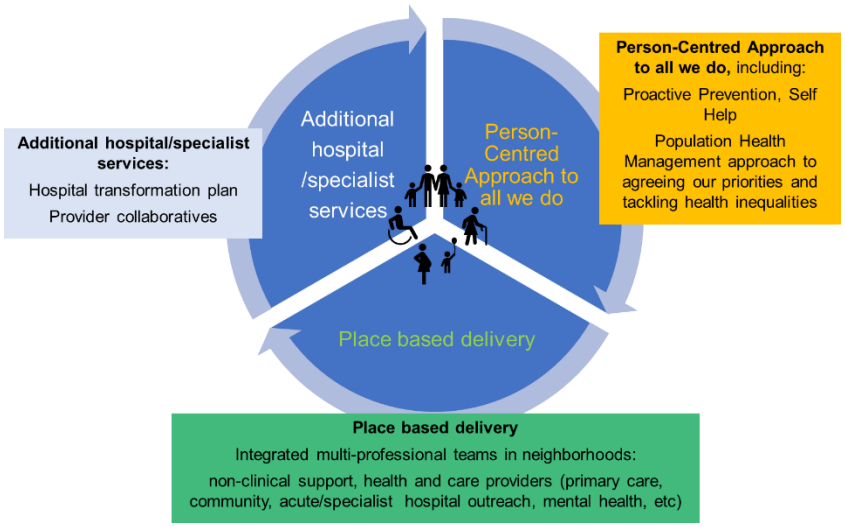


1.4 How we will deliver these priorities?

To achieve our priorities and our model of care there are three key components of our Plan, as shown 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 seen in Appendix One



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 on 3 days a week for patients requiring support with pre-diabetes or 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 2 organisations and makes the 2 services work seamlessly together. Patients can go on for 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 model of care

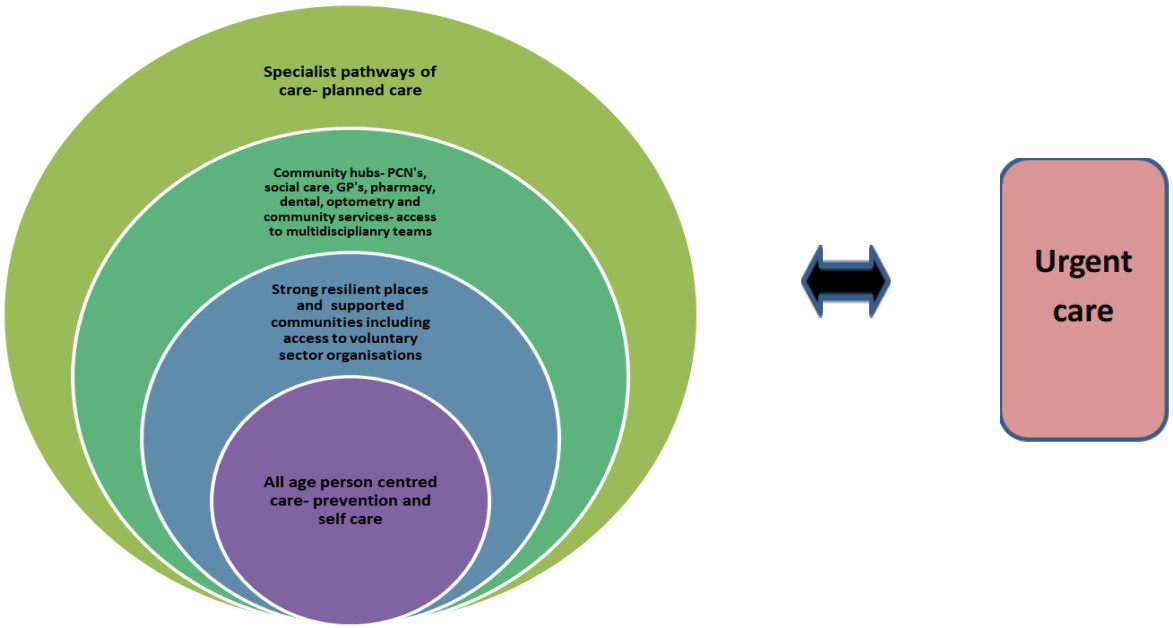
Although we are a challenged system, we are an ambitious one. Our public and stake holder engagement through 'The Big Conversation' have consistently told us they want more services closer to home or work, easy straight forward access and communication about onward services and referrals or support within their community for self-care.

Our model of care is designed to take the views of our communities into account and therefore starts with keeping well and healthy with prevention and self-care at the heart, supported by resilient, strong communities that offer services to keep people happy and well, supported by our community and voluntary sector and our 'Places'.

Access to health and care is through community based 'hubs' that deliver a range of health and care services including physical, mental and social care services and includes our primary care services, general practice, community pharmacy, optometrists and dentists. Our Local Care Transformation Programme will ensure that care is delivered through a multi-disciplinary integrated team supported by our community services.

Referral to planned health care or specialist services such as cancer services or orthopaedic services, for example, will be timely and well communicated. Our Hospital Transformation Programme and our providers of health and care working in 'Provider Collaboratives' will ensure that our clinical priorities are being met, but also support prevention and self-care.

We want our model of health and care to deliver truly integrated services that are built on person-centred needs and communication that is clear so that pathways from prevention to acute or planned and specialist services can be clearly understood and co-produced with individuals and our communities, developing a system of improvement by measuring impacts and outcomes, and using learning to expand and improve continuously.



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 receive care in the right place at the right time.
- Streamlining care with robust pathways to ensure with 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.
- Support our health and care providers to achieve improved CQC ratings where appropriate.

Key Organisations CQC ratings 1st 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)	5th July 2019						
Robert Jones and Agnes Hunt Orthopaedic NHS Foundation Trust	Specialist NHS Hospital	21st February 2019						
Severn Hospice (Apley site)	Hospice Service	11th January 2022						
Severn Hospice (Bicton site)	Hospice Service	12th January 2022						
Shrewsbury and Telford NHS Trust	Acute Hospital NHS Non -Specialist	18th November 2021						
Shropshire Community Health NHS Trust	Community Health NHS and Independent	1st August 2019						

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

- Childrens and young people's 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
  - We want to improve timely access to urgent and emergency care as well as providing it where the person needs it.
- Diabetes care
  - We want to focus on prevention of diabetes and 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 quality of services for Integrated Care systems.

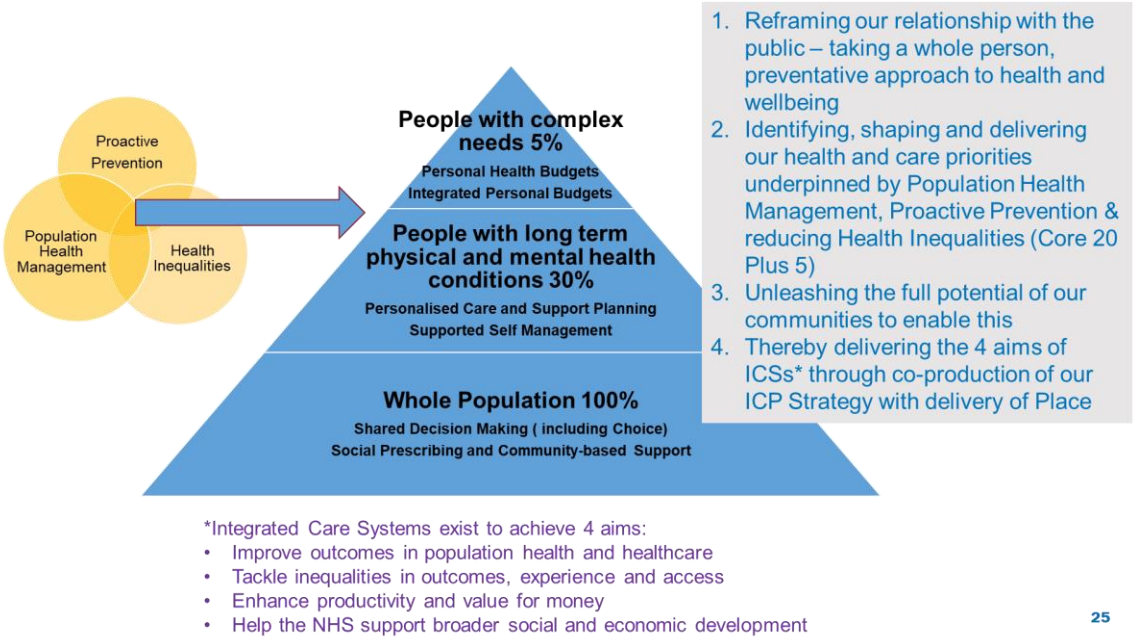
Our plans to continuously improve the quality of our services are outlined in the table below:

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 with the partnership of key agencies across the ICS in line with national guidance. • Learning from deaths, CDOP, infant mortality & LeDeR. • The co-ordinated introduction of 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.	• 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. • Co-production with those who experience care. • Feedback from our residents. • Quality accounts.	• 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. • Aging well though 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, no matter background, creed or location though strategic integration of quality and Core20PLUS5.

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 a patient or service users, and places the person at the centre, as an expert of their own experience and lives. The person, and their family where appropriate, becomes 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	2023
Identify our priorities through a population health management approach, identifying health inequalities and taking a proactive prevention approach	Clinical Lead for Personalised Care	2023/24
Establish our Person-Centred Facilitation Team to coordinate and enable this approach.	Clinical Lead for Personalised Care	2023/24
Involve the full range of people who can contribute from the outset – including but not limited to, people in our communities and those enabling their voice including 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 Team.	Clinical Lead for Personalised Care	2023/24
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	2023/24
Inspire, equip and support our leadership and wider workforce in this approach	Clinical Lead for Personalised Care	2023/24
Agree 5-year plan to shift resource towards person-centred, preventative services & action, including support for VCSA development as a provider collaborative	Clinical Lead for Personalised Care	2023/24

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 to be realised 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 and communities, with public services working together, 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 Integrated Care System's work.

Specifically, we will seek jointly 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 which 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 a focus on local priorities at place-based level.

Case Study: Integration and Transformation Programme

The Integration and Transformation Programme's is working to prevent escalation of need and to reduce the 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 corporate 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 and support the following areas:

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

We will continue the development of a local Provider Collaborative for Mental Health across Shropshire, Telford and Wrekin for all mental health transformation, 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. Increasingly over the 5 years covered by this plan we will seek to ensure that the provider collaborative works across statutory and non-statutory organisations alongside co-production with the wider communities involved with upon by service delivery.

Our system Provider collaboratives are:

- Shrewsbury and Telford Hospitals and Shropshire Community Trust
- Midlands Partnership University Hospital FT
- GP Practices (51 practices) working through a GP Board.

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.

2.4 Children and Young people

Our system needs to focus more on our children and young people. We are awaiting feedback from the engagement through the “Big Conversation” to understand the priorities of children and young people. We know that children also need to live happy, healthy and fulfilled lives and the pandemic has impacted on them in many ways. Throughout this plan we need to consider children and young people, 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. CYP mental health is addressed in chapter 4, however we will develop the children’s strategy which includes prevention, early help and physical health throughout 2023/24.

2.5 Proactive Prevention

Our system is unified in our vision to improve prevention for people living in Shropshire, Telford & Wrekin. By working together at Place, with Primary Care, the voluntary and community sector, community services, care and council services, business 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 (A.C.E.’s) 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 and Telford & 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 a set of values, standards, beliefs and ways of working	Director of Partnerships & Place	July 2024
Agree and implement an effective method to gather and use multi-agency intelligence across the system	Director of Planning & Performance	April 2024
Engagement/Consultation with internal and external stakeholders for each of the priority programmes	Director of Comms & Engagement	April 2025
Identify the opportunities for proactive prevention, reducing inequalities, and increasing self-management for each of the priority programmes	Each programme director / Senior Responsible Officer Health Inequalities	April 2024 and as and when new priority programmes are developed
Ensure all information is accessible and meets the NHS standard	Comms & Engagement Team	April 2024
Agree a communications strategy to ensure messaging is consistent and clear across the system	Director of Comms & Engagement	July 2023
Make best use of available technology to improve coordination of care, communication, understanding and monitoring of health.	Digital Programme lead	April 2024 and ongoing
Workforce development through education and training and development of new roles and new ways of working.	Director of People	December 2023 and ongoing

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 form marginalised communities experience greater burden of ill health when compared to wider society. To address this NHSE has advocated the Core20+ focus on health inequalities reduction. This will run alongside the ICBs general duty to reduce inequalities in access.

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

Nationally Mandated Priorities

Healthier Choices (Delivering of commitments and targets in the LTP)

- 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 Carer for BAME in maternity services
- Reduction in respiratory inequalities inc. VACC
- 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 MH Services
- Increased access to epilepsy nurses with a focus on LD& A
- Oral extraction backlog U10s

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 is 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 e.g., Cancer, Urgent and Emergency Care, Mental Health, Children

and Young People that will then inform our ongoing programme of work to reduce inequalities across STW. This work 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 by the end of July and will be 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
Strengthen the consistency of governance arrangements for reporting HI.	• Secure additional PMO resource to drive progress. • Co-ordinate system wide 2023/24 HI 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 (i.e., shared learning). Providers to 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 plan and Core20PLUS5 Objectives are reported to the System Health Inequalities Board • Ensure quarterly reporting to board from Q2 onwards	SRO Health Inequalities	2023/24
Promote understanding of the Health Inequalities agenda and support staff to deliver	• Collate HI, health literacy and population health training and resources. • Create a central 'resource directory' on local Intranet. • Work with our People Team to develop a HI training module/workshop and embed HI and health literacy training within staff competencies/inductions. • Share best practice locally, regionally and nationally.	SRO Health Inequalities	2023/24
Confirm baseline data, available intelligence and analytical requirements for each priority HI area.	• Explore data resources to identify a core set of metrics. • Develop a HI Dashboard which can support impact and outcomes monitoring at a granular level.	Director of Planning & Performance	2023/24

Case Study: Outreach vaccination service – reducing inequalities.

A collaboration was formed between both local authorities (Telford & Wrekin and Shropshire Council) providing operational support for the NHS to deliver an outreach COVID 19 Vaccination programme focussed on reducing inequalities. Over 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, protecting and preventing further ill health. Team Bob or Betty has played an important part in the COVID 19 vaccination programme, making Shropshire, Telford & 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: Core20PLUS Connectors (known locally as Shropshire, Telford & Wrekin (STW) Cancer Champions)

Shropshire, Telford & Wrekin, in partnership with both Local Authorities, were successful in their bid to be selected as one of 11 wave 1 pilot sites across the country taking part in the NHSE Health Inequalities Core20PLUS Core 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) – acting as a voice for local communities through raising awareness of barriers and therefore helping to reduce health inequalities for our under-served populations.

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

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

2.6 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; 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. • 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 timescales. • Engaging children and young people and their carers in our plans and actions.	• Listening to victims and their needs • Implementing a trauma-informed approach to relevant commissioned services. • Building pathways based on knowledge and information about the effectiveness of interventions. • Focussing on prevention of mental ill 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).	• Robust multi-agency data sets to triangulate crime, social care and health data. • Working with Healthwatch and those with lived experience. • Working in safeguarding partnerships to gain intelligence on 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
Complete IITSCE health actions	ICB Chief Nursing Officer	December 2023
Implementing the requirement of the Serious Violence Duty in line with Safeguarding Partnerships and national requirements	ICB Chief Nursing Officer	March 2024
Build pathways for supporting survivors, based on knowledge and information with partners.	ICB Chief Nursing Officer	March 2024
Working with schools and education establishments regarding abuse	ICB Chief Nursing Officer	December 2023
Engage with Children and Young people in our plans	ICB Chief Nursing Officer	March 2024

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 & Wrekin Integrated Care System we define ‘place’ as the areas coterminous with our two local authorities: Telford & Wrekin, and Shropshire. Both places have strong place-based integration boards – Shropshire Integrated Place Partnership (SHIPP) and Telford & Wrekin Integrated Place Partnership (TWIPP). Both SHIPP and TWIPP are accountable to their local Health and Wellbeing Boards as well

as the STW Integrated Care Board (ICB). See Appendix B: for Telford & Wrekin Integrated Place Partnership priorities

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 and connect across STW to ensure that the evidence of the most effective prevention, population health and care models are applied in every neighbourhood.

3.2 Telford & Wrekin

Telford & Wrekin Health and Wellbeing Strategy
Telford & Wrekin Health and Wellbeing Board is refreshing its priorities and the updated strategy will be approved in June 2023. The priorities are based on engagement and insight with our Telford and Wrekin residents and intelligence from the 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 Health and Wellbeing Strategy

Telford & Wrekin Integrated Place Partnership
The Telford & Wrekin Integrated Place Partnership (TWIPP) comprises of senior officers from Telford & Wrekin Council, NHS Shropshire, Telford & Wrekin, Primary Care Networks, Midlands Partnership Foundation Trust, Shropshire Community Health Trust, Shrewsbury and Telford Hospital Trust, Healthwatch, Shropshire Partners in Care and the Voluntary Sector. TWIPP's strategic priorities are aligned to the Integrated Care Strategy as well as the Telford & 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, TWC	April 2024
Development of a Healthy Weight Strategy		April 2024
Delivery of the place-based elements of the system wide strategy for cancer (including early cancer diagnosis)	NHS STW & Deputy Director: Public Health, TWC	April 2024
Delivery of programmes to improve awareness of and reduce inequity of access to vaccination, screening and health checks	Service Delivery Manager: Health Improvement, TWC & Deputy Director: Public Health, TWC	April 2024
Deliver Start for Life and Family Hub transformation programme	Deputy Director: Public Health, TWC	April 2024

	& Group Specialist, Family Hubs, TWC	
Deliver improved social, emotional and mental health services for TW children and young people	TBC	April 2024
Consult on the draft co-produced SEND and Alternative Provision Strategy for 2023-2028 and implement final strategy	Director: Education and Skills, TWC	April 2024
Delivery of TW Learning Disability Strategy objectives (including 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	Aprils 2024
Delivery of TW Autism Strategy objectives (including 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	April 2024
Development of a place-based Mental Health Strategy, co-producing it with people with lived experience (including 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	April 2024
Development of a place-based Ageing Well Strategy, co-producing it with people with lived experience (including for example developing a new integrated dementia model of care)	Service Delivery Manager: Community Specialist Teams, Adult Social Care, TWC	April 2024
Implementation of Local Care Transformation Programme workstreams at place	LCTP Programme Director, NHS STW	April 2024
Support with developing integrated neighbourhood teams linked to the Local Care Transformation Programme's Proactive Care Workstream	Integration Programme Manager, TWC & PCN CDs	April 2024
Support Primary Care to meet their 2023-24 access requirements	PCN CDs & Associate Director of Primary Care, NHS STW	April 2024
Support Primary Care to meet their target to recruit to additional roles by March 2024.		April 2024

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 (JHWBB) 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 JHWBB can be found at the following link: The JHWBB strategy 2022-27.

The priorities of Joint Health and Wellbeing Strategy are developed in response to the Shropshire Joint Strategic Needs Assessment (JSNA). The Needs Assessment 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 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 coproduction, local people and 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)

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 has taken part in an enhanced package of support and has recently been awarded a Gold Healthy Schools Rating. Staff 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. This is 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".

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 Programme across communities in Shropshire	All system partners	2023 and ongoing
Expand CYP integration test and learn sites to become all age delivery in North Shrewsbury, Ludlow, Market Drayton, and develop roll out plan for rest of county.	Public Health	31st March 2024 and ongoing
Deliver more Health and Wellbeing Centres; Oswestry, Highley, Ludlow, Shrewsbury, that include MDT approaches.	Partners identified across Voluntary and Community through Public Services	2023 and ongoing
Develop a Neighbourhood Model – to connect with Health and Wellbeing Centres – that 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 Programme	31st March 2024 and ongoing delivery
Social Prescribing expansion into A&E, midwifery, children, young people and families and local health and wellbeing centres.	Public Health	31st March 2024 and ongoing

3.4 Local Care Transformation Programme (LCTP)

The Local Care Transformation Programme (LCTP) is one of our system's two major transformation programmes. The LCTP brings together a collection of transformation initiatives that will deliver more joined up, integrated and proactive care in peoples' homes and local communities, 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".

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

In 23/24 and beyond, the programme will focus on the following:

- **Virtual ward phase 2** - Expanding the Virtual Ward to further pathways including respiratory and cardiology in 23/24 and supporting more people to return home from an acute hospital sooner
- **IDT phase 2** - Implementing a Discharge to Assess model to support patients to safely return home where any ongoing care needs can be assessed (this is distinct from sub-acute medical care and may involve discharging home to identify rehabilitation and reablement needs or ongoing care needs).
- **Sub-acute care and rehabilitation** – reviewing and where appropriate redesigning some of our models of sub-acute care (above and beyond the Virtual Ward) and rehabilitative care models to complement the Hospital Transformation Programme. This will involve looking at how we make best use of our community assets including our community bed base capacity.
- **Neighbourhood multi-disciplinary team working** – working with our two places and aligning with a person-centred approach.

The implementation of neighbourhood based multi-disciplinary teams will be a multi-year programme of change.

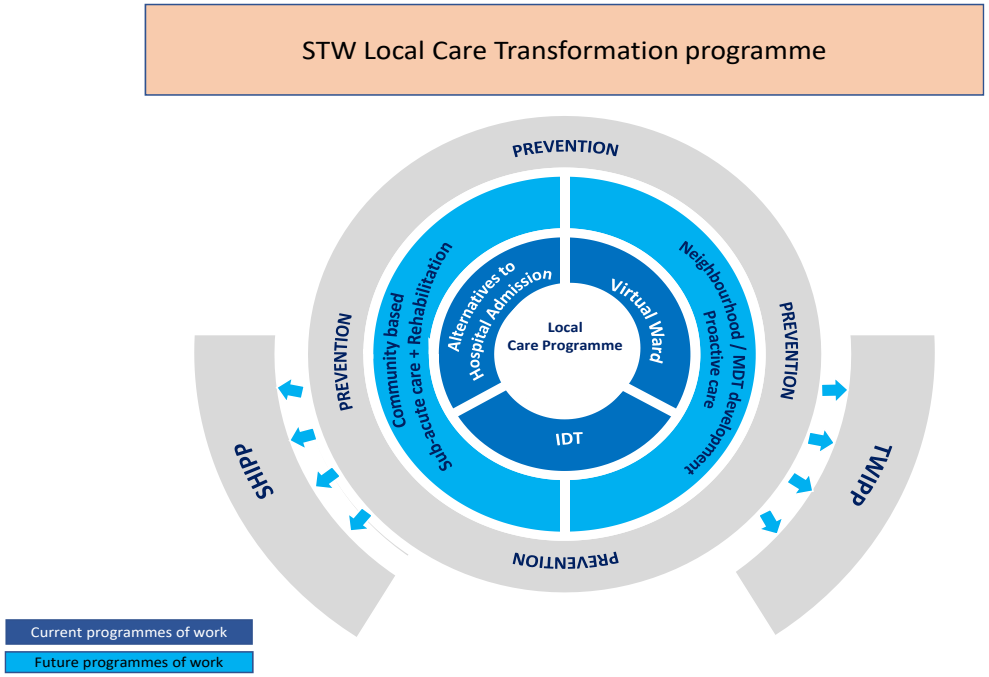
The role that our community hospitals play is front and central to the delivery of Local Care, providing crucial facilities in which to develop vibrant health and care hubs serving the local population's needs in our rural communities. Whilst our ambition for the existing community hospital sites in 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.

The scope of the programme is summarised in the diagram below. The transformation initiatives within Local Care are inextricably linked with our intentions for a more proactive approach to prevention (see section 2.2).

The Programme will focus on creating the necessary levers and enablers, unblocking barriers to change, and promoting lasting change. The system is actively working with NHSE to help provide the necessary infrastructure to enable the programme to achieve this strategic role.



By delivering the six critical programmes of work below 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
Local Care programme refresh – reviewing the scope of future programmes of work to ensure clear priorities and assigned responsibilities across system partners	Interim STW LCTP Programme Director	Q3
Programme 1: Avoiding hospital admissions through provision of wider services including rapid response	Complete	Transfer to BAU
Programme 2: Implementing a 'discharge to assess' model to support patients to safely return home where any ongoing care needs can be assessed	SRO for community transformation	Ongoing D2A implementation complete by Q4
Programme 3: Opening 250 'Virtual Ward' beds to enable more patients to return to the place they call home to receive medical care that would otherwise be delivered in an acute hospital.	SRO for community transformation	Ongoing Expansion complete by end of Q3 - 250 beds
Programme 4: 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.	Director of Strategic Commissioning ICB	Ongoing
Programme 5: 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.	Place based delivery Development framework to be in place by end of Q4	Ongoing
Programme 6: 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 ICB	ongoing

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 waiting around for a visit.

Based on this success the LCP is planning to open 250 'Virtual Ward' beds to enable more patients to return to the place they call home to receive medical care that would otherwise be delivered in an acute hospital.

3.5 Proactive Care (Previously Anticipatory Care)

Proactive Care is a key workstream of the Local Care Transformation Programme (linked to programme 4). 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 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, 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 developed further as soon as possible.

Action	Owner	Timescale
Review support to people living with frailty to identify opportunities for integration	Director of Strategic Commissioning (DoSC)	March 24
Redesign falls pathways to create a consistent approach	DoSC	March 24
Framework to guide the further roll out and expansion of proactive care delivery across STW	DoSC	Q2 and 3 2023/24

3.6 Primary Care Networks and General Practice

The current model of contracting for and providing General Medical Services has not changed in decades, yet the way modern healthcare is accessed and delivered has changed. 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 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 PCN's are more mature than others and are using resources aligned to PCN's 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. 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 focusses 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, personalised care and support from a multidisciplinary team based around neighbourhoods; and help people to stay well longer.

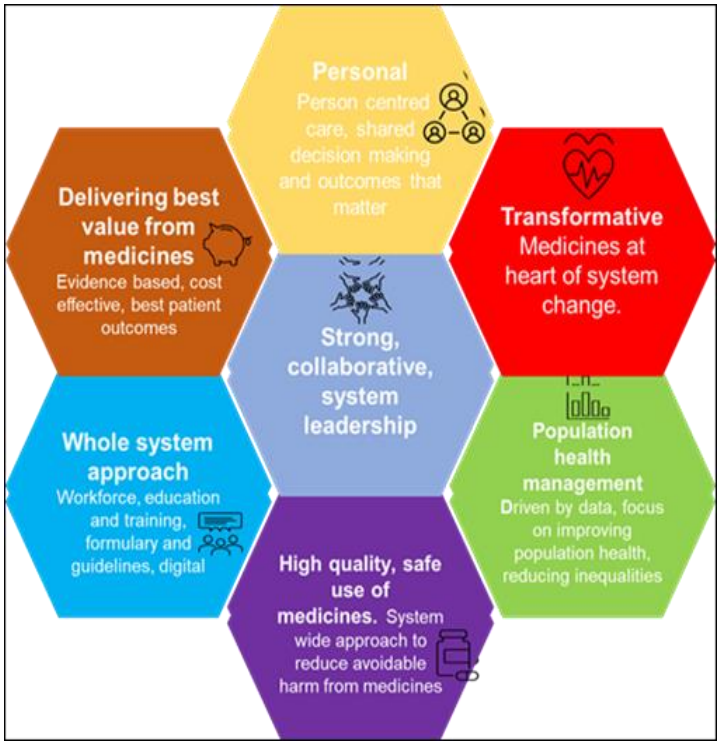
Primary care cannot achieve this alone - it will need system support to provide the conditions for locally led change, and a supporting infrastructure to implement change. GPs must lead and support any changes proposed, ensuring we maintain stability in primary care.

Key actions are below:

Actions	Owner	Timescale
Develop an action plan to deliver the recovering access to primary care delivery	Associate Director of Primary Care	Summer 2023
Enabling PCNs to develop integrated neighbourhood teams (INT)	Associate Director of Primary Care	Summer 2023
Develop and deliver with the GP Board the 'Fuller recommendations' as a clear set of system actions	Associate Director of Primary Care	Summer 2023
Work with Primary Care networks to deliver the contract DES	Associate Director of Primary Care	Ongoing
Deliver the Local care programme integration with neighbourhood teams and primary care networks	Associate Director of Primary Care Director of Strategic Commissioning	In line with LTCP timescales
Deliver the actions from the Primary Care Strategy (under development)	Associate Director of Primary Care	Action plan by Autumn 2023

Co-design and put in place infrastructure and support for integrated neighbourhood teams	Associate Director of Primary Care	Action plan by Autumn 2023
Supporting a primary care forum and representation	Associate Director of Primary Care	Action plan by Autumn 2023
Primary care workforce planning embedded in system workforce plans	Associate Director of Primary Care	Action plan by Autumn 2023
Developing a system-wide estates plan for primary care	Associate Director of Primary Care	Action plan by Autumn 2023
A development plan to support the sustainability of primary care	Associate Director of Primary Care	Action plan by Autumn 2023
Consider how to take the Fuller recommendations forward	Associate Director of Primary Care	Action plan by Autumn 2023

3.6.1 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-focussed 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 & utilising a population health management approach. A patient centred approach will in turn ensure we get the best from our investment in medicines, 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) – WHO 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

Action	Owner	Timescale
Integrate prescribing electronic systems (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 & regional targets for Antimicrobial Resistance, Best Value Biologics and Medicines Value programmes	System Pharmacy Lead	Ongoing
Improve system–wide outcomes e.g. improvements in patient outcomes, health inequalities, HARMs secondary care admissions, morbidity and mortality through improved quality & safer prescribing	System Pharmacy Lead	
Manage financial available resources – getting the best out of every £1 we invest in medicines	System Pharmacy Lead and Chief Pharmacists	Year on year

3.7 Community Pharmacy, Optometry and Dental

In April 2023 the contractual services for Pharmacy, Optometry and Dental services were delegated to ICB's. The management of the contracts will be undertaken in partnership with the West Midlands Office 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 published in May 2023. There are opportunities to deliver services to alleviate pressure in general practice but there are challenges. Workforce in community pharmacy is under the same challenges as other health care services. There is a national lack of NHS dentists, this is particularly an issue for 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 the West Midlands Office to ensure contractual changes, quality and challenges are addressed for STW POD services	Office of the West Midlands and AD Primary Care	Ongoing
Develop and deliver an action plan for Community Pharmacy services set out in the Recovering Access to Primary Care Delivery Plan	Community Pharmacy ICB lead	Summer 2023
Review low availability of NHS dental services across STW and work with OWM to develop a plan for increasing access	Office of the West Midlands and Dental leads	April 2024

3.8 Voluntary and Community Sector (VCS)

Our system has a wealth of experience as well as knowledge, (professional) expertise and skills in our Community and Voluntary Sector. During the Covid-19 pandemic the VCS delivered an unprecedented level of services to our communities.

The Voluntary and Community Sector across STW will support and is committed to supporting the delivery of the priorities within our plan and to joint working that has and will continue to contribute to shape and improve services in STW from a grassroots perspective. As a system we need to support the VCS 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 well-being and specialist services.

We recognise that to reduce inequalities we will need to draw on the knowledge of the local authorities, VCSE 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 sets out why the ICS values the role of the VCS 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
Include the VCS at the earliest opportunity of development of our health and care pathways in partnership	Director of Partnerships and Place	Ongoing
Use long term contracts (NHS standard) with the VCS 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 VCS when developing our person-centred approach and training to health and care staff	Director of Partnerships and Place	April 2024
Use the VCS experience, knowledge, skills and expertise to transform services within our communities, so they deliver the model of care	Director of Partnerships and Place	April 2025
Work to support the VCS Alliance	Director of Partnerships and Place	Ongoing

Case Study: OsNosh CIC

OsNosh is an initiative which brings the community together in all aspects of the food cycle, for example; 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 over 200 people, offering share tables, takeaway hot meals and community events and regular community meals with the help of a workforce of over 180 volunteers.

This sustainable community project has had an overwhelmingly positive and heart-warming response from local charities and businesses. Every week they deliver dishes to a wide range of people in the local community, including those in need, saving food going to waste, and sharing their 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 is our second system major transformation programme and 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

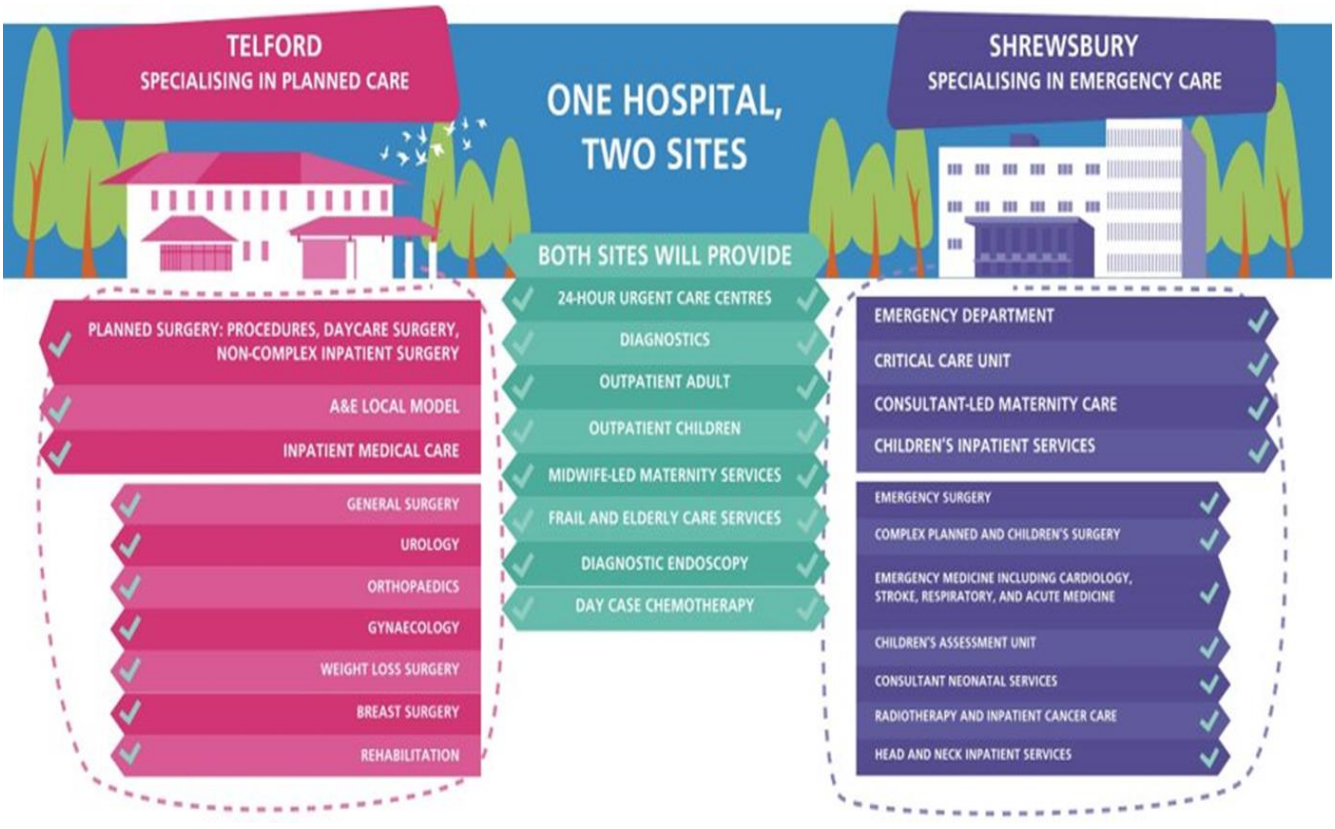
of services which means that staff must work across sites; are unable to access multi-disciplinary support when they need it for our sickest patients; our clinical environments do not provide the capacity, space or layout needed to provide modern day healthcare. All these factors impact negatively on our people, resulting in them leaving and impacts our ability to attract the number and skill mix of 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 are able to treat the many our 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 – 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 Hospital Transformation Programme 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:



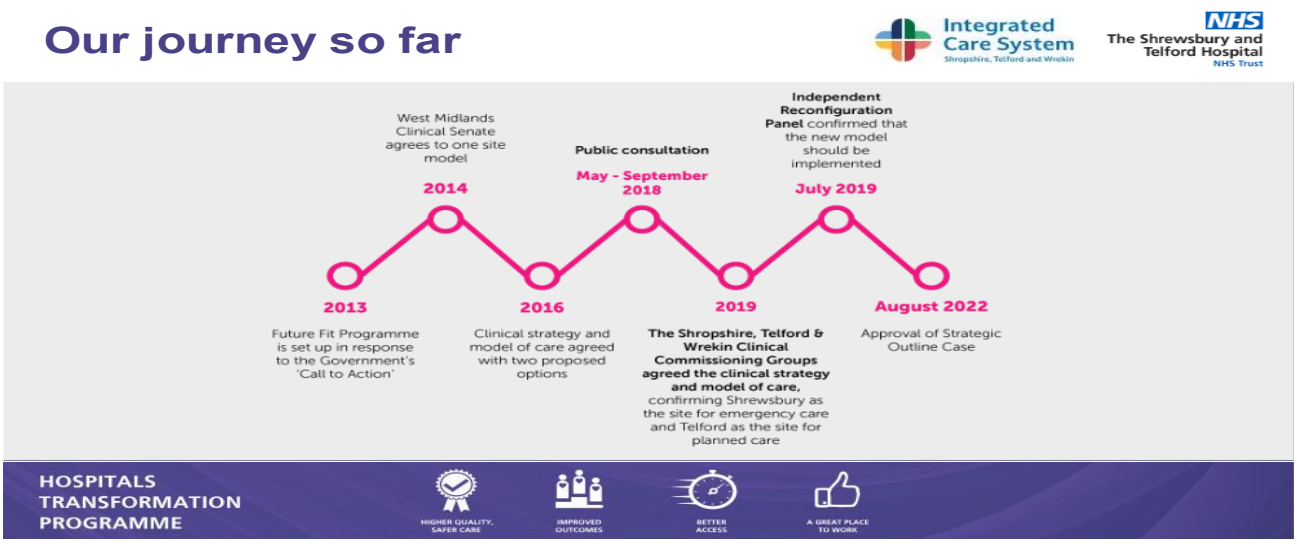
To deliver the programme our next steps are as follows:

Action	Owner	Timescale
Outline Business case with pathway design and architect designs to be submitted to NHS England	HTP programme lead	Summer 2023
Develop full business case an submit for regional and national approval	HTP programme lead	Autum 2023
Start Implementation	HTP programme lead	2023/24
Further staff, patient and community engagement	HTP programme lead	2023 - 2026
Implement new ways of working	HTP programme lead	Q4 2026

4.2 Elective Care

At the beginning of 22/23 financial year our providers developed a 3-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, including a number of large-scale transformation programmes of work on pathways and how services are provided, form part of the system-wide elective recovery deliverables as a key enabler for being more efficient and thereby releasing capacity that can be freed up to recover waiting lists.

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 used 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 (CDC's) is a central pillar of the ICS strategy for integrated care and core to restoration and recovery of the NHS across the county. The first CDC in the county will be in Telford (TF1)

- the facility is expected to be operational during 23/24
- additional MRI capacity will be introduced as part of the CDC from October 2023
- additional CT capacity will be introduced as part of the CDC from May 2023
- the CDC's 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 22/23 for an Elective Hub at 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.

In addition, the creation of an additional theatre and associated recovery and facilities at The Robert Jones and Agnes Hunt Orthopaedic Hospital was also approved, with plans including:

- Construction planned to be completed by October 2023.
- The Theatre will be operational by January 2024. This capacity will enable RJAH to deliver an additional approximately 282 elective cases in 2023/24 and 1,200 elective cases recurringly thereafter.
- This will deliver 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 & efficient.

Outpatients Transformation

This 5 year programme of work running until 2026 is to transform the provision of Outpatient services in the county to be more effective & 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 & Carers	Safer and quicker care Better experience Seamless communication Care that fits around you Reduced travel/stress
Primary Care & GP's	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 & wellbeing of the local population Better outcomes Increased value Less waste More resources

With alternative approaches and ways of providing Outpatient services that mean people may no longer need to visit a hospital, this generates a number of other more 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 CO2 emissions
- Reduced hospital car park use
- Reduced time needed for appointments (for virtual/telephone consultations)

Action	Owner	Timescale
Implementation of phase one of elective hubs (SaTH)	DoS	July 23
Implementation of phase two of elective hubs (RJAH)	DoS	January 24
Implementation of the enhanced recovery programme for total hip replacements and total knee replacements	SRO MSK and clinical leads	April 23
Build on digital solutions to support flexible clinic capacity to increase use of virtual outpatient	DoS	March 24
Implement High Volume Low Cost and Best Practice pathways	MD and CNO	March 24
Implement Bluespier Theatre Management software in SaTH	DoS	March 24
Implement the "Gold Standard" for patient initiated follow ups	DoS, MD	March 24
Implement the first phase of the MSK transformation	SRO MSK	March 24
Develop roadmap for health inequalities elective recovery principles	DoS	June 23

Both acute trusts to develop SMART action plans for health inequalities elective recovery principles	DoS, COO	September 23
Complete intensive focussed piece of work focussing on ensuring consideration of health inequalities in waiting list recovery	DoS	April 23
Implementation of the Community Diagnostic Centre	SRO CDC	December 23
Optimised use of Advice & Guidance as a new way of providing Outpatient services, preventing some unnecessary face to face hospital appointments	Programme SRO, Clinical Lead and Programme Lead	2021-2027
Optimised use of Virtual Consultations as a new way of providing Outpatient appointments, preventing a number of face to face hospital appointments and preventing travel for patients	Programme SRO, Clinical Lead and Programme Lead Programme SRO, Clinical Lead and Programme Lead	2021-2027
Optimised use of Patient Initiated Follow Up discharges, maximising patient involvement in their own care and preventing a number of routine follow up appointments	Programme SRO, Clinical Lead and Programme Lead	2021-2027
Optimised use of one stop clinics and remote reviews to minimise the number of appointments needed	Programme SRO, Clinical Lead and Programme Lead	2021-2027
Redesigned and improved pathways and processes to ensure they are efficient and effective	Programme SRO, Clinical Lead and Programme Lead	2021-2027T
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	2021-2027
Reduce travel requirements and disruption for patients by providing some services closer to home or in your own home/environment	Programme SRO, Clinical Lead and Programme Lead	2021-2027
Improve staff experience	Programme SRO, Clinical Lead and Programme Lead	2021-2027
Reduce hospital car park occupancy	Programme SRO, Clinical Lead and Programme Lead	2021-2027
Reduce CO2 emissions through reduced travel to appointments	Programme SRO, Clinical Lead and Programme Lead	2021-2027
Reduce waiting lists, waiting times and delays for elective services through more efficient ways of working	Programme SRO, Clinical Lead and Programme Lead	2021-2027

Improve communication with patients, carers and guardians	Programme SRO, Clinical Lead and Programme Lead	2021-2027
Maximised use of new technologies, approaches and innovation	Programme SRO, Clinical Lead and Programme Lead	2021-2027
Optimise use of available resource and value for money, including staffing, time, and clinic space	Programme SRO, Clinical Lead and Programme Lead	2021-2027
Contribute to system workforce transformation through improvements to recruitment & retention from new and different ways of working, and types of role	Programme SRO, Clinical Lead and Programme Lead	2021-2027

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 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 Local Maternity Neonatal System (LMNS). We 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 – 2026 with system partners	Local Maternity and Neonatal System (LMNS) Programme	3 year phased approach

4.4 End of Life Care

It is the commitment of Shropshire Telford & Wrekin Integrated Care System 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. In Shropshire Telford & Wrekin we know that for the majority of people we do this. 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
Create greater integration between generalist and specialist services by implementing the second year of the Palliative and End of Life Strategy	STW Senior Responsible Officer, Clinical Lead and Commissioning and Contracting Lead	March 24
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
People in the last year of life to be systematically identified and offered an assessment and advance care plan.		April 2024
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 2024
People their families and loved ones will have access to 24/7 advice and guidance.		April 2024
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
Localities to work together for people, their families and loved ones.		March 2026
Develop an enhanced service to provide an additional level of care for those with more complex needs.		April 2025
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
Palliative and end of life care is to be seen as everyone's responsibility	STW Senior Responsible	March 2026

Offer support for families and loved ones in the care of someone that is dying and after their death	Officer, Clinical Lead and Commissioning and Contracting Lead	April 2025
Babies, Children and Young People Palliative and End of Life Care Strategy will be developed in 2023.	Chair Childrens and Young Person's PEoLC Working Group	December 2023
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.		September 2023
For 2023 people have 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	April 2024

Babies Children and Young People with Life Limiting or Life-Threatening Conditions

The number of Babies, Children or Young People (BCYP) with life limiting / life threatening conditions in our region is, thankfully, low, with an average of 11 BCYP who might be 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 & Wrekin Integrated Babies, Children and Young People Palliative and End of Life Care Strategy will be developed in 2023.

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 advice and /or specialist advice is at the core of supporting our plans that advice is embedded throughout the ICS Governance structure. From individual clinical leads working on pathways or specialities. A Health and Care Senate, a forum for clinicians to share learning, information and challenges. There are also four specialist boards that support the ICS. They are:

- Mental Health and Learning Disabilities and Autism Programme Board
- Children and Young People, SEND and families Programme Board
- Urgent and Emergency Care Board
- Planned Care Board

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 2023-2025 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 19/20 but have remained flat since 21/122, however with Type 3 (Minors e.g. minor injury/minor illness) attendances increasing 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
Review pre-hospital urgent care services to determine a future model that provides the most efficient delivery	Director of Urgent Care	March 24
Enhance provision for high intensity users	Director of Urgent Care	March 24
Expand the Integrated Delivery Team and simplify the Fact Finding Assessment Process	Director of Urgent Care	March 24
Reintroduce the discharge to assess process	Director of Urgent Care	March 24
Develop antibiotic therapy in the community	Director of Urgent Care and AD Medicines	March 24
Expand the Urgent Community Response service	Director of Urgent Care	March 24

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, In addition this will achieve 15-20% improvement in 4 hr target, reduction of 12hr waits by 50 per day and a reduction in ambulance delays by 10 per day)	Clinical Strategy 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 persons asthma (reduction of admission rate from 108 per 100k to 90 by April 2024 and 75 by April 2025) and • increased use of virtual wards (reduction in admissions by 20% or 30 – 40 per day by April 2025)	Clinical Strategy Lead	Ongoing April 2024 April 2025 April 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	April 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	April 2023/24
Through the Acute Discharge Improvement Plan we will ensure discharge planning is within 2 days of admission and full utilisation of criteria led discharge, same day emergency care, continue to embed the home first principles, increase virtual ward capacity (predicted circa additional 40 discharges per day by April 2024)	Clinical Strategy Lead	April 2024
Through the Local Care Transformation Programme we will Improve utilisation of community services including virtual wards (phased roll out commencing 2023)	Clinical Strategy Lead	Commencing 2023

Clinical Strategy 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 & 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
Implement FIT triage for patients referred on a 2ww colorectal pathway to achieve the target of 80% in year	Director of Planned Care	April 23
Evaluate the Tele-dermatology pilot to determine local deliver model	Director of Planned Care	March 24
Redesign prostate pathways in line with Best Practice Timed Pathway	Director of Planned Care	March 24
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	April 2024
Increase the number of patient diagnoses at stage 1 and 2. Improvement trajectory to be developed and agreed to achieve 75% of cancers diagnosed at stage 1 or 2 by March 2028.		Ongoing improvements until Match 2028
Restore and transform acute services and increase cancer treatment capacity by 13% from 2019/20 baseline. For colorectal, skin and prostate implement best practice pathways and achieve a median day of 28 days for each pathway by April 2025. 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 19/20 baseline for chemotherapy, radiotherapy and the specialised surgery population of STW.	Clinical Strategy Lead	April 2025
Reduce health inequalities in bowel cancer and cervical screening coverage	Clinical Strategy Lead	ongoing
Enhance personalised care by a 25% increase in September 2022 baseline by April 2025 April 2024/25and the roll out of patient stratified follow ups which will be in place for 10 cancer pathways by April 2024 and April 2025.	Clinical Strategy Lead	April 2025

Clinical Strategy Priority 3 – Cardiac Pathway

In line with national and local requirements we plan to:

Action	Owner	Timescale
Establish a CVD project group to drive the work increasing our "treatment to target" outcomes for hypertension	DD Partnerships and Place	June 24
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
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
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

Clinical Strategy 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 focussing 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 a further 5% by April 2024) as these are the biggest outliers for type 2 diabetes.	Clinical Strategy Lead	September 2023 April 2024
Work with 9 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
Clinical initiatives established to support include: • Review of care and treatment across primary care and community car settings • Lower limb care management	Clinical Strategy Lead	TBC

Clinical Strategy 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 identify the following actions:

Action	Owner	Timescale
Reduce referral rates per 10k population with the aim of moving into the 3rd 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
Reduce outpatient activity levels to national average rates this equates to a 25% reduction by March 2024	Clinical Strategy Lead	March 2024
Restore inpatient activity levels and eradicate 52ww 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 Strategy 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 MPUFT	April 24
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	Complete by April 25

	System SRO Mental Health	
Complete review of Talking Service (previously IAPT) model and implement new service model. Deliver service improvements to achieve national access targets	Director of Mental Health, CYP and LD&A and System SRO Mental Health	April 24 March 24- March 29
Develop our Talking Service model to link into the mental health elements of pathways for the clinical priorities and respiratory services, including cancer pathways.	Clinical Strategy Lead	April 23 – March 25
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 Mental Health, CYP and LD&A and System SRO Mental Health	2023 TBC
Implement 111 Option 2 for all urgent calls being directed to our local 24/7 access professionals		September 2023
Develop the support to reduce suicide and a pathway for bereavement support.		Ongoing
Increase support to individual prior to reaching a crisis- early intervention		TBC
Develop pathways with VCSE support with a focus on Twight 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
Develop an all age HBPOS offer with staff skilled in both adult and Children's mental health.	Director of MH CYP LD&A and System SRO Mental Health	March 25
Children and Young People's (CYP) Mental Health		
Develop and engage on an up-dated Children and Young People's (CYP) Local Transformation Plan (LTP)Strategy.	Director of MH CYP LD&A and Clinical Strategy Lead	2023-24
Undertake a review of the existing BEE U services and service redesign/ procurement based on CYP plan above	Director of MH CYP LD&A and Clinical Strategy Lead	2024 -2025
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		
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	Director of Mental Health, CYP and LD&A and System SRO Mental Health	March 2025
Achieve the Dementia Diagnosis rate of 66.7 % for 23/24 Continue to deliver the national target rates 24 onwards	Director of Mental Health, CYP and LD&A and System SRO Mental Health	March 2024
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 an integrated offer around the reduction of inappropriate prescribing for adults and children (STOMP/STAMP) and bring organisations together.	Director of Mental Health CYP and LD&A, Clinical Strategy Lead	Dec 2023 March 24
Raise the awareness of autism and what issues people may have as well as continue to expand the use of the Autism passport.		Ongoing
Develop services for individuals with ASD who don't meet current criteria for secondary mental health services.		August 25
Achieve 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		March 24
Develop and implement a diagnostic Learning Disability Pathway	Clinical Strategy Lead	March 24

Specialist Mental Health Services		
Perinatal Support		
Develop services to enable the longest wait for Tokophobia and bereavement and loss does not exceed 4 weeks from referral to assess and treat.	Director of Mental Health CYP and LD&A, Clinical Strategy Lead	March 24
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.		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 25
Neurodevelopment Disorders		
ADHD and ASD		
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 27
Ensure there are clear shared care agreements in place and that there are processes for reviewing prescribing for ADHD	Clinical Strategy Lead	2023-2025
Mainstream services will be trained to ensure reasonable adjustments are made for those with ADHD /ASD	Clinical Strategy Lead	March 25
Learning Disabilities		
Mainstream services will be trained to ensure reasonable adjustments are made for those with ADHD /ASD	Clinical Strategy Lead	March 25
Provider Collaborative		
Scope Potential to implement a Mental Health Provider Collaborative across MH Providers and Local Authorities and ICB	Programme Director Provider Collaborative Scoping Programme	March 24

Chapter 5: Enablers

5.1 People

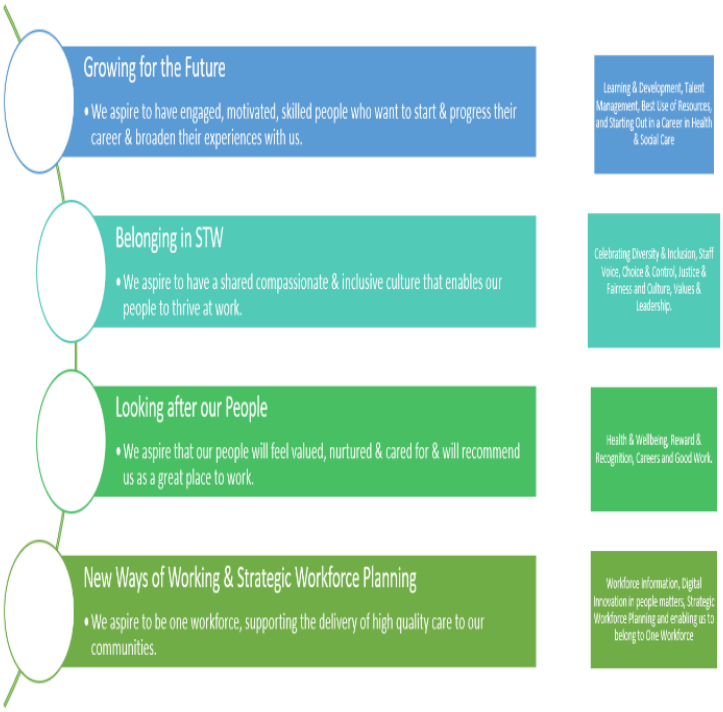
Our system workforce has been working collaboratively for many years, an approach underscored during the system's response to the Covid-19 pandemic. During this time relationships have formed between NHS, Local Authority, ICB (formerly CCGs), Primary Care, Social Care and Voluntary sector partners to tackle the workforce pressures at a system level.

Our ICS People Committee draws its membership from a broad range of stakeholder organizations 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 - 2027

Our People Strategy sets out our ambition for the next 5 years for the circa 23,000 people who work with us across health & social care and 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 & Organisational Development. Our four ambitions are set our below and describe what we want to do – and 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 5 years.

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

Action	Owner	Timescale
Align our People Strategy and STW workforce supply priorities with available capacity	Chief People Officer	September 2023
Enable implementation of People Strategy and STW workforce supply priorities	Chief People Officer	October 2023 – March 2024

5.2 Digital as an Enabler of Change

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

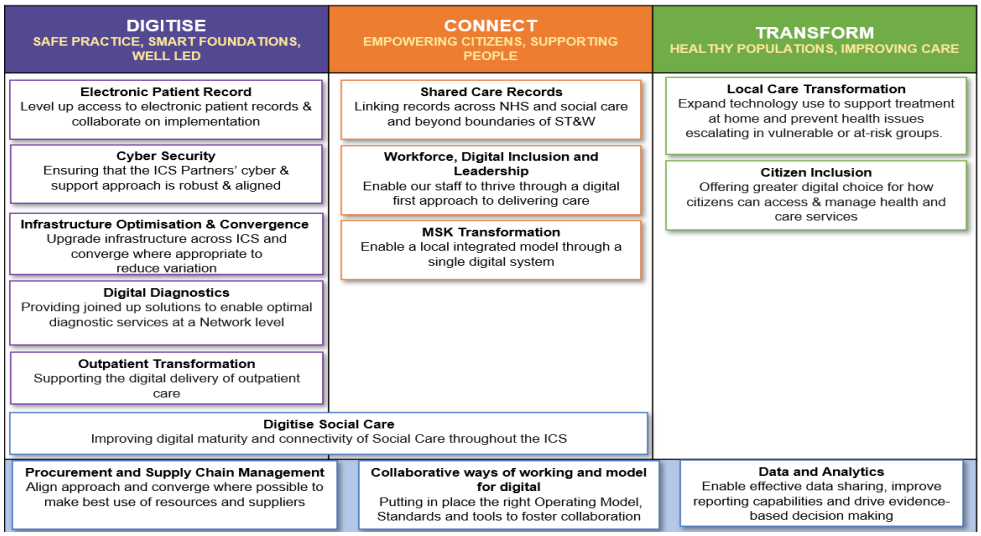
journey, but by taking the initial steps to digitally transform and improve our technological capabilities, we are solidifying our commitment to excellence, and are aligned to the national focus to provide high quality care to patients, improving accessibility and consistency of services through digital innovation.

5.2.4 Our current and future position

The table below shows our as-is 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, Local Authorities • Silos based with digital services and digital management being delivered out of each organisation	• 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 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'

5.2.5 Our Digital Pledges



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

Also, we will:

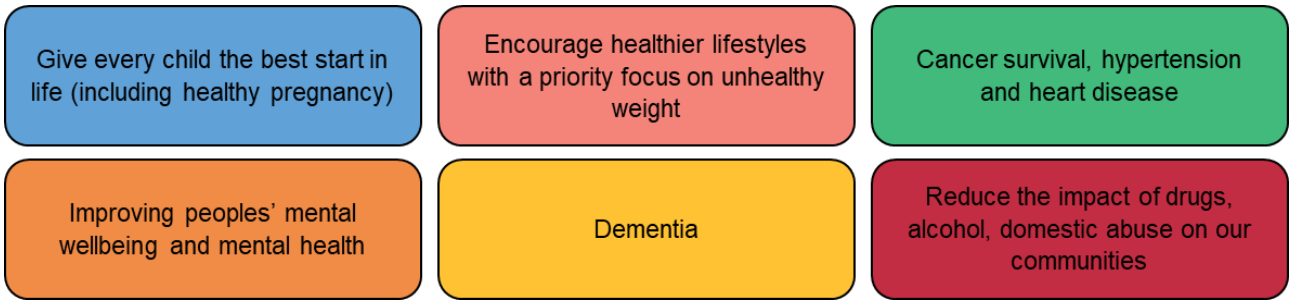
Action	Owner	Timescale
Embrace Digital into our culture	Digital Transformation Lead	2023/24
Learn and converge as an ICS	Digital Transformation Lead	2023/24
Streamline procurement across the ICS	Digital Transformation Lead	2023/24
Upskill workforce and communities in data literacy	Digital Transformation Lead	2023/24
Work for patients collectively focusing on citizen inclusion in all digital decisions	Digital Transformation Lead	2023/24

Govern and manage our digital portfolio together	Digital Transformation Lead	2023/24
SATH EPR programme – detailed Trusts wide and departmental programme		
Implement Careflow PAS and Careflow ED	SATH EPR programme	2023/24
24/25 – Implement Careflow Connect, Electronic Prescribing and Medicines Management (EPMA) and Order Comms	SATH EPR programme	2024/25

5.3 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, frontline workers to expand their focus from treatment / 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:



5.4 Estates - System Physical Infrastructure, Estates Strategy and Planned Delivery

In line with NHSE requirements all ICS need to draft their Estates and Physical Infrastructure Strategies by December 2023. 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 providing high quality care environments which enable the safe delivery of services for our communities. This means an estate which is in compliant and functionally suitable, is environmentally sustainable, is accessible to local people and which is 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
Agree Estates and Physical Infrastructure Strategy	Estates lead	December 2023
Implement Estates and Physical Infrastructure Strategy	ICB, managed by Estates lead	Early 2024

5.5 Financial Sustainability & 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 the financial position.

A system financial framework was therefore developed in 2020/21 and agreed by all organisations and all system partners work 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 (noting that this framework is now due a refresh in 2023/24 given the deterioration in the 2022/23 outturn compared to plan).
- 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 & Performance team. Evidence of delivery is collated and submitted to NHSE and then formal progress presented at our Improvement Review Meetings which are likely to move from monthly to quarterly in 23/24. 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 via the national Quality & Performance Committee based on the recommendations from the regional RSOG.

A system wide approach to efficiency, productivity and transformation is in place. This includes ensuring effective financial governance and controls, improving productivity through a system wide focus group, driving efficiency through consolidation and collaboration, improving use of NHS estate and focussing on system wide priorities for transformation e.g., the Local Care programme and MSK.

A system productivity oversight group will be in place from June 23 that will meet 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. 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 Integrated Care Systems 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
Development of system wide medium to long term financial plan with consistent assumptions and clear deliverable recovery trajectory	Director of Finance	September 23
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	April 24

5.6 Our Commitment to Communication & Engagement

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' voice at place and system levels. In particular, we engaged with groups who are seldom heard and have the greatest health inequalities to ensure they are not excluded from the dialogue.

1. Seek out, **listen**, and **respond** to the needs, experiences, and wishes of our communities to improve our health and care services	**2.** Ensure people are involved **in everything we do** as an ICS – from an individual's care, to service design and making decisions about health and care priorities
3. Relationships between our communities and health and care organisations are based on **equal partnerships**, **trust**, and **mutual respect**	**4.** Use existing and new **knowledge** about our communities to **understand** their needs, experiences and wishes for their health and care by developing methods for gaining **insights**
5. Involve people early and clearly explain the purpose of the involvement opportunities	**6. Reach out** to and involve groups and individuals who are often **seldom heard** by working with community partners
7. Make sure the communications and the ways people can get involved are **clear** and **accessible**	**8. Record** what people say and let them know what happened as a result
9. Ensure **staff** understand the importance of involving people in their work, and have the skills and resources they need to do it	**10. Learn** from when involvement is done well and when it could be improved.

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.

To read our full involving people and communities strategy click here https://www.shropshiretelfordandwrekin.nhs.uk/get-involved/our-approach/

To support staff to plan and undertake the appropriate level of involvement of people and communities, we have built into our governance arrangements an Equality and Involvement Committee. 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.
- Further information about the role of the Committee and its membership can be found here: https://www.shropshiretelfordandwrekin.nhs.uk/get-involved/our-approach/equality-and-involvement-committee-eic/

How we engaged our different stakeholders to inform our Joint Forward Plan

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. This has included listening events, a Big Conversation Survey, STW Citizen pledges, community outreach, stakeholder engagement, establishing a peoples network, engagement with a wide range of community groups, PR and media engagement and finally digital engagement.

See further details in Appendix F:

What people told us

"The plan should say how you will evidence that the priorities are being achieved and making a difference"

"Consider the need for local clinics/hubs (e.g., location that is easy for family to visit patients)"

"All-age mental health, but especially amongst young people, needs to be stronger and should be a higher priority"

"Care being closer to home should be about accessibility not how many miles away it is. Everyone should be able to access care easily. It should be clear what is meant by 'closer to home'"

"There is still inequality over access to technology, not all people have access to internet or technology, how can we ensure equitable access"

"More support needed for carer involvement in shared care and specifically how this could be improved upon"

"When you visit the hospital A&E the children's waiting area is often closed and it's not nice for us as young people to have to sit in the adult's area, it's noisy and there is nothing to play with"

To read our full involving people and communities strategy click here

https://www.shropshiretelfordandwrekin.nhs.uk/get-involved/our-approach/

Case Study: Black & 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, making it clear that to tackle health inequalities, we needed to work more closely to understand what solutions and community-led activities would improve their health, wellbeing and prevent ill health 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, to make 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 1st aid, suicide prevention and physical activity courses. Community workshops and health and wellbeing activities have engaged over 3500 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.

5.7 Our commitment to research and innovation

Research

It is our ambition to support all of our colleagues across the ICS to get involved in research. Staffordshire and Shropshire Health Economy Research Partnership (SSHERPa) brings together all partners across the ICS to develop collaborative approaches to enabling involvement in research across commercial/non-commercial – sharing resources/skills/knowledge; developing and expanding research capability.

Further, we are planning to promote engagement with the citizens of STW and encourage them to get involved and take part in research.

Action	Owner	Timescale
Identify research needs and shape plans	MD	April 24
Collaborate with local research infrastructure and stakeholders including industry where appropriate - NIHR CRN, WMAHSN, ARC, BRC, IAA capital bids etc.	MD	Ongoing
Ensure research support and delivery posts are sustainably funded where appropriate so everyone can play a role.	MD	By 2026

Innovation

We want to be an innovative and learning healthcare system, taking best applying it to services within Shropshire, Telford & Wrekin to 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

Appendices

Appendix A:

Overview of the Population Health Priorities, Inequalities Priorities and Health and Care Priorities across Shropshire, Telford and Wrekin and the ICS

Telford & Wrekin Health & Wellbeing Board proposed Priorities	Telford & Wrekin Integrated Place Partnership (TWIPP) Priorities	Shropshire, Telford & Wrekin ICS Priorities	Shropshire Health & 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	Children & Young People incl. Trauma Informed Approach	Children's & young peoples' 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 & 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 Economic opportunity	-	Wider determinants: • Homelessness • Housing • Cost of living	Working with and building strong and vibrant communities	Community capacity & building resilience within the VCSE
Prevent, protect and detect early Closing the gap Starting well - Living well – Ageing well	Core 20plus5 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 - inclusion	-	Deprivation and rural exclusion	• Reduce Inequalities • Improving 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 & independence	-	-
Integrated neighbourhood health and care • Primary care • Closing the gap	Local Care transformation (includes neighbourhood working)	Person-centred integrated within communities	Joined up working	Local Care and Personalisation (incl. involvement) Integration & 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 & mental health, SEND	Best Start in Life SEND & transition to adulthood	Children and young people's physical & mental health and focus on SEND	Children & Young People incl. Trauma Informed Approach	Children's & young peoples' 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, place-based development in line with the Fuller report	Primary care access (General Practice, Pharmacy, Dentists and Opticians)	-	Supporting Primary Care Networks
-	-	Urgent and emergency care access	-	-
-	-	Clinical priorities e.g. MSK, respiratory, diabetes	-	-

Appendix B: Telford & Wrekin Integrated Place Partnership priorities

Shropshire, Telford & Wrekin ICS Priorities	Telford & Wrekin Health & Wellbeing Board proposed Priorities	Telford & Wrekin Integrated Place Partnership (TWIPP) Priorities
Wider determinants: • Homelessness • Cost of living Deprivation and rural exclusion People empowered to live well in their communities	Inclusive resilient communities Housing and Homelessness Economic opportunity Green and sustainable borough Closing the gap – deprivation – equity – equality - inclusion Starting well - Living well – Ageing well	
Best Start in life Children and young people's physical & mental health and focus on SEND	Best Start in life • Start for Life Family Hubs • Healthy weight • Social emotional & mental health SEND	Best start in life SEND & transition to adulthood
Mental wellbeing and mental health	Mental health and wellbeing	Mental Health Learning Disability & Autism
Healthy weight	Healthy weight	
Reducing impact of drugs, alcohol and domestic abuse	Alcohol, drugs and domestic abuse	
Preventable conditions – heart disease and cancer Inequity of access to: • Cancer screening • Heart disease • Diabetes • Health checks SMI & LDA • Vaccinations • Preventative maternity care	Prevent, protect and detect early • Closing the gap	Reducing preventable diseases through early diagnosis, immunisations, screening and improving the reach of services Core 20plus5 and reducing barriers to access
Proactive approach to support & independence Primary Care Access Person-centred integrated within communities Urgent & Community Care access Clinical priorities e.g., MSK, diabetes, heart disease, cancer, mental health and UEC. Best start to end of life (life course)	Integrated neighbourhood health and care • Primary care • Closing the gap	Proactive prevention Accessible information, advice and guidance Local Prevention and early intervention services Older adults and dementia Local Care transformation (includes neighbourhood working) Primary Care access and integration, place-based development in line with the Fuller report

Appendix C: List of Acronyms

Acronym	Meaning	Acronym	Meaning
BAF	Board Assurance Framework	MDT	Multi-Disciplinary Team
A.C.E	Adverse Childhood Experience	MH	Mental Health
AHP	Allied Health Professional	MIU	Minor Injury Units
AHSN	Academic Health Science Network	MOU	Memorandum of Understanding
ARC	Academic Research Council	MPFT	Midlands Partnership Foundation Trust
BAME	Black, Asian and minority ethnic	MSK	Musculoskeletal
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 & Social Care	QSC	Quality & Safety Committee
DTOC	Delayed Transfers of Care	RJAH	The Robert Jones & 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 & 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 Trusts
HTP	Hospital Transformation Programme	ShIPP	Shropshire Integrated Place

			Partnership
IAPT	Improving Access to Psychological Therapies	ShropCom	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 Strategy	TWC	Telford and Wrekin Council
JSNA	Joint Strategic Needs Assessment	TWIPP	Telford & 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
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 & Social Enterprise
LMNS	Local Maternity and Neonatal System	WMAHSN	West Midlands Academic Health Science Network
LTP	Long Term Plan	WMAS	West Midlands Ambulance Service
LTP	Local Transformation Plan		

Integrated Care System
Shropshire, Telford and Wrekin

NHS
Shropshire, Telford and Wrekin

See embedded action plan for full details

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Appendix D: Summary of Actions

Shropshire, Telford & Wrekin

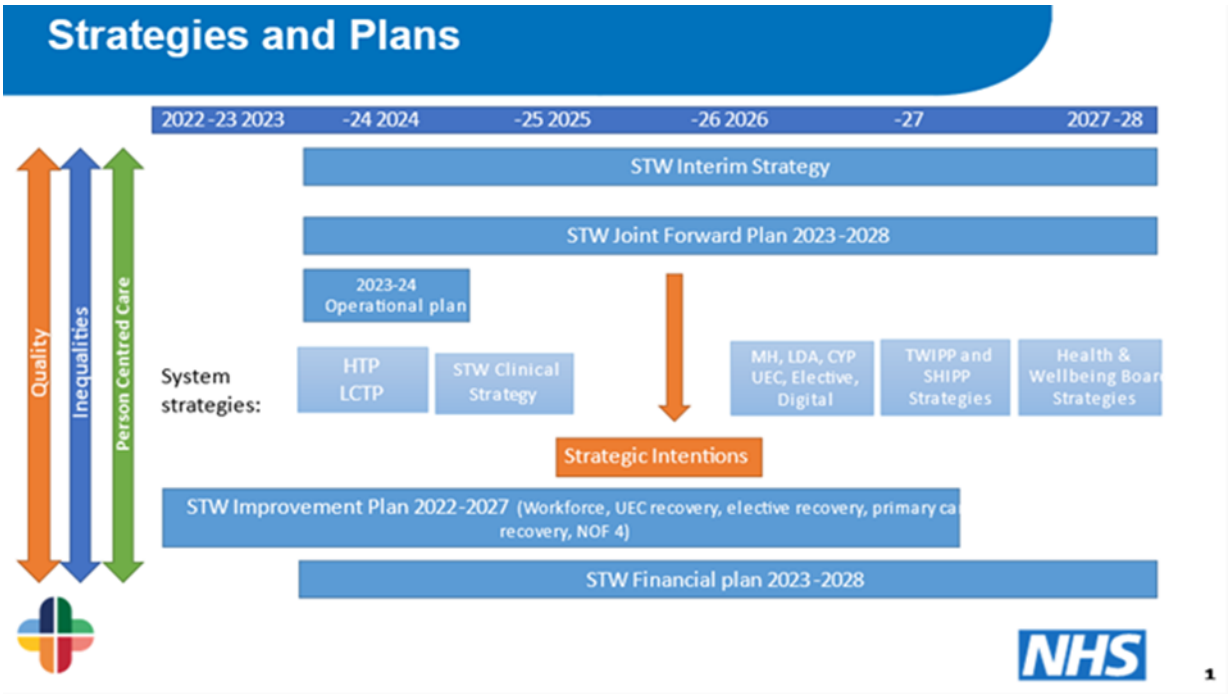
Joint Forward Plan
2023 – 2028

TASK	ASSIGNED TO	START	END	2023 - 2024				2024 - 2025				2025 - 2026				2026 - 2027				2027 - 2028			
				Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Person Centred Care																							
Identify our priorities through a population health management approach, identifying health inequalities and taking a proactive prevention approach	Clinical Lead for Personalised Care																						
Establish our Person-Centred Facilitation Team to coordinate and enable this approach.	Clinical Lead for Personalised Care																						
Involve the full range of people who can contribute.	Clinical Lead for Personalised Care																						
Develop and mandate a structured person-centred approach	Clinical Lead for Personalised Care																						
Wrap around each ICS priority workstream: planning and personalised health and care budgets.	Clinical Lead for Personalised Care																						
Inspire, equip and support our leadership and wider workforce in this approach	Clinical Lead for Personalised Care																						
Agree 5-year plan to shift resource towards person-centred, preventative services & action	Clinical Lead for Personalised Care																						
Pro active prevention																							
Agree a set of values, standards, beliefs and ways of working	TBC																						
Agree and implement an effective method to gather and use multi-agency intelligence across the system	TBC																						
Engagement/Consultation with internal and external stakeholders for each of the priority programmes	TBC																						
Identify the opportunities for proactive prevention, reducing inequalities, and increasing self-management for each of the priority programmes	TBC																						
Ensure all information is accessible	TBC																						
Agree a communications strategy to ensure messaging is consistent and clear across the system	TBC																						
Make best use of available technology to improve coordination of care, communication, understanding and monitoring of health.	TBC																						
Workforce development through education and training and development of new roles and new ways of working.	TBC																						
Strengthen the consistency of governance arrangements for reporting HI.	TBC																						
Assess how dedicated HI roles contribute to success.	TBC																						
Identify baseline staff competencies and capacity to rapidly increase knowledge and skills on HI.	TBC																						
Confirm baseline data, available intelligence and analytical requirements for each priority HI area.	TBC																						

Appendix E: List of strategies and plans

The JFP 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 boards strategies
- Strategic Intentions
- STW Improvement Plan
- Financial Plan



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

Appendix F: How we engaged our different stakeholders to inform our Joint Forward Plan

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 printed materials in a range of formats, 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 specific protected characteristics and audiences. 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 decided 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 a 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 e.g., the impact of attending A&E for a non-emergency, benefits of accessing their local pharmacy versus a GP.

We used this opportunity to socialise the STW pledges. The public were asked to suggest some pledges, things they can 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 in communities (e.g., Supermarkets, GP practices and outpatient clinics). Street teams will focus on areas of high deprivation and target groups of people who would not normally contribute to engagement activity.

Stakeholder engagement

A series of stakeholder engagement sessions throughout the period, including 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 and are sighted early on our priorities and proposals.

Stakeholders will be provided with opportunities to:

- Input and share ideas about how they / their organisations can contribute to local delivery
- Describe what they would like to see in the health and care system over the next five years – what will things look like in five years' time?
- Identify ways we can transform / plan / 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, which will 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 offer their opinion and be engaged on a wide range of local issues.

Engagement with community groups

We attended a number of 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 to support improving access and reducing inequality.

Our community group outreach work approach has included:

- Black, Asian and Minority Ethnic groups
- Faith groups
- Families
- Veterans
- Ex Offenders
- Carers
- Older People
- LGBT
- Substance Misusers
- Looked After Children
- Children and Young People
- Farmers groups
- Homeless People
- People with long term conditions
- Disability groups
- People living in deprived areas

PR and media engagement

A proactive PR campaign was launched, the PR campaign enabled us to reach a large audience without the expensive cost of traditional advertising and marketing and increased viability of the ICS and the engagement exercise.

Digital activity

To ensure maximum reach our digital campaign required it 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, using their existing channels. Photo and video content generated during the outreach activity was also shared on social media.