

Shropshire, Telford and Wrekin Integrated Care Strategy



Contents

Foreword.....	2
Chapter 1 - Overview of our Integrated Care System	3
Chapter 2 - Integrated Care Partnership (ICP) vision, purpose and priorities	5
Chapter 3 - Improve outcomes in population health and healthcare.....	8
Chapter 4 - Tackling inequalities in outcomes, experience and access.....	20
Chapter 5 - Support broader social and economic development	27
Chapter 6 - Enhance productivity and value for money	30
Chapter 7 - Performance monitoring and scrutiny	32



Foreword

We want to make sure that everyone in Shropshire, Telford and Wrekin has a fair opportunity to have a great start in life and live happy, healthy, and fulfilled lives. The existing inequalities are simply not good enough, and many of these can only be addressed by partners working together.

Improved health and wellbeing will be achieved through better support, high-quality services, and a focus on preventing illness while helping people live well in their communities. We recognise that achieving this requires looking beyond health and care services to identify the barriers and opportunities for healthier living. We are committed to working with people and communities to address these challenges.

Shropshire, Telford and Wrekin has a strong history of joint working across our local authorities, NHS partners, the Voluntary, Community and Social Enterprise Sector (VCSE) and wider partners. Most recently, our Health and Wellbeing Boards, Health Scrutiny, COVID-19 and Cost of Living responses demonstrate what can be achieved through collaboration. We continue to build the relationships needed to support our residents in enjoying the highest quality health and wellbeing for themselves, their families, and their communities.

This Integrated Care Strategy is built upon the priorities of each place's Health and Wellbeing Strategies and the findings of our Big Health and Wellbeing Conversation. Residents have raised concerns about challenges in getting appointments, long waiting times, and difficulties contacting services by phone, with some areas specifically highlighting issues with accessing GPs. Transport and digital exclusion have also been raised as concerns. Residents told us there was a lack of awareness of how and where to get the right support for their needs. Overall, residents told us we need to work better together.

Partners within the Shropshire, Telford and Wrekin Integrated Care Partnership have heard this feedback and are committed to thinking and working differently with each other and with our communities. Today, we have a unique opportunity to achieve this through joining up our services and taking a more preventative approach. That's what this Shropshire, Telford and Wrekin Integrated Care Strategy is all about.

We look forward to working with all our communities to make Shropshire, Telford and Wrekin a place where everyone has the chance to live a long and healthy life. We know that more needs to be done to give everyone the very best start and every chance to live a long and healthy life. This includes working with partners in the wider economy to create good jobs and increase everyone's prosperity with investment in skills, housing, culture, and infrastructure. To have the best chance of achieving this, we need to think and work differently with each other and with our communities.

A greater emphasis on prevention is crucial to improving the quality of people's lives and the time they spend in good health. We recognise that not everyone has an equal chance of a happy, healthy long life and therefore we need to do more to tackle inequalities, including health inequalities.

As a Partnership, we are involving our communities and community partners in our conversations, listening to what local people and our staff have to say, so that everyone in Shropshire, Telford and Wrekin is part of our shared purpose.

Chapter 1 - Overview of our Integrated Care System

The Integrated Care System (ICS) brings together health and care organisations across Shropshire, Telford and Wrekin to collaborate more closely. Our ICS, known as Shropshire, Telford and Wrekin ICS, is responsible for planning local health and care services. It consists of an Integrated Care Board (ICB) and an Integrated Care Partnership (ICP), which work together to address the needs of our community.

Shropshire, Telford and Wrekin ICS includes the following partners:

- NHS Shropshire, Telford and Wrekin Integrated Care Board (ICB)
- Shropshire Council (our Shropshire Place)
- Telford and Wrekin Council (our Telford and Wrekin Place)
- Shrewsbury and Telford Hospital NHS Trust
- Shropshire Community Health NHS Trust
- Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust
- Midlands Partnership University NHS Foundation Trust
- West Midlands Ambulance Service NHS Foundation Trust
- Primary Care Networks (PCNs): 9 PCNs (4 in Telford and Wrekin, 5 in Shropshire)
- General Practice, Pharmacy, Optometry and Dentistry
- Healthwatch Shropshire and Healthwatch Telford and Wrekin
- Voluntary, community and social enterprise organisations across the county

We are an ambitious ICS dedicated to making a real difference to the lives of local people.

We have previously engaged with our residents, patients, health and care staff, our local system partners, and the VCSE sector. Based on the feedback received, we have developed ten pledges that will guide our work moving forward.



Our pledges

Our ICS Pledges

- | | | | |
|---|--|--|--|
|  <p>1.</p> | <p>We will improve safety and quality.</p> |  <p>6.</p> | <p>We will respond to the threat of climate change.</p> |
|  <p>2.</p> | <p>We will integrate services at place and neighbourhood level.</p> |  <p>7.</p> | <p>We will strengthen our leadership and governance.</p> |
|  <p>3.</p> | <p>We will tackle the problems of ill health, health inequalities and access to health care.</p> |  <p>8.</p> | <p>We will increase our engagement and accountability.</p> |
|  <p>4.</p> | <p>We will deliver improvements in mental health, learning disability and autism provision.</p> |  <p>9.</p> | <p>We will create a financially sustainable system.</p> |
|  <p>5.</p> | <p>We will support economic regeneration to help improve the health and wellbeing of our population.</p> |  <p>10.</p> | <p>We will make our ICS a great place to work so that we can attract and keep the very best workforce.</p> |

The ICP operates as a statutory committee. It is made up of partners from across the local area, including VCSE and independent healthcare providers, as well as representatives from the ICB board. Our ICP is responsible for bringing together our system partners to develop a plan to address the broader public health, health and social care needs of our local populations, and tackle health inequalities.

Our ICP aims to make home and the community the hub of care, ensure that services are person-centred and seamless, empower patients, promote health, and prevent illness where possible.

The ICP provides a forum for NHS leaders and local authorities to come together, as equal partners, with key stakeholders from across the system and community. Together, the ICP has produced this Integrated Care Strategy to improve health and care outcomes and experiences for the population. This strategy is underpinned by a co-produced integrated 5-year plan called the Joint Forward Plan (JFP). The JFP informs our operating model, strategic commissioning intentions and operational annual plans.

Chapter 2 - Integrated Care Partnership (ICP) vision, purpose and priorities

(Our vision is currently draft and will be developed and committed to in 2025)

We want everyone in Shropshire, Telford and Wrekin to have a great start in life and to live healthy, happy and fulfilled lives.

We will work together with our communities and partners to improve health and wellbeing by tackling health inequalities, encouraging self-care, transforming services, and putting people at the heart of all we do.

Our ambition is to provide our communities across Shropshire, Telford and Wrekin with safe, high-quality services and the best possible experience from a health and care system that is joined up and accessible to all.

By transforming how and where we work, improving access to services, and making the best use of our resources for the benefit of our communities, we will better meet the needs of our population, now and in the future.

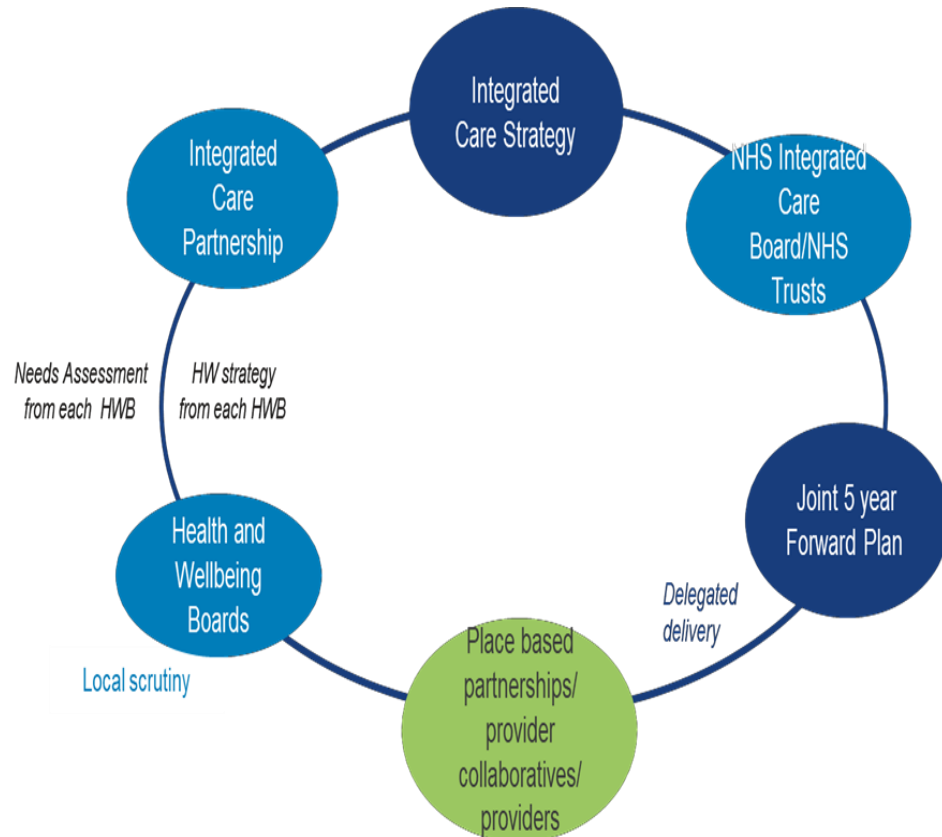
We will focus on our places and our communities to create truly integrated care, including working across our boundaries and borders.

Joining up health and care is not new; a lot of has already been done towards this and we will continue to build on this work. This includes building on the positive joint working we saw in the system throughout the COVID-19 pandemic.



Our purpose: four strategic objectives

Our cycle of development



This Integrated Care Strategy, developed through the ICP, is a key step in setting out the high-level needs assessment and long-term health and wellbeing priorities for Shropshire, Telford and Wrekin. A clear governance, planning and delivery cycle exists to support partnership working across the system. This development cycle will be complemented by a comprehensive consultation and engagement process to ensure co-design.

Our priorities

Integrated Care Strategy priorities

(from the Joint Strategic Needs Assessments to inform the Health and Wellbeing strategies and the Joint Forward Plan)

Population Health Priorities

- Best start in life
- Healthy weight
- Mental wellbeing and mental health
- Dementia
- Preventable conditions:
 - Hypertension
 - Heart disease
 - Cancer
- Reducing impact of drugs, alcohol and domestic abuse

Inequalities Priorities

- Wider determinants:
 - Homelessness
 - Housing
 - Cost of living
- Inequity of access to preventative healthcare:
 - Cancer and cancer screening
 - Heart disease and screening
 - Diabetes
 - Annual health checks for severe mental illness, learning disabilities and autism
 - Vaccinations and immunisation
 - Preventative maternity care
- Deprivation and rural exclusion
- Digital exclusion

Health and Care Priorities

- Proactive approach to support independence
- Person- centred integrated care within communities
- Best start to end of life (life course)
- Children and young people physical and mental health and a focus on SEND
- Mental, physical and social needs supported holistically
- People empowered to live well in their communities
- Primary care access (general practice, pharmacy, dentists and opticians)
- Urgent and emergency care access
- Clinical priorities e.g. MSK, respiratory and diabetes

Chapter 3 - Improve outcomes in population health and healthcare

Each Health and Wellbeing Board (HWBB) has a statutory duty to publish a Joint Strategic Needs Assessment (JSNA) to inform the development of the Health and Wellbeing Strategies.

The Telford and Wrekin Health and Wellbeing Strategy refreshed proposals have been developed based on JSNA intelligence. They have also been informed by engagement, including about 3,000 residents contributing through a telephone survey and focus groups in 2022, as well as a resident survey in 2020 completed by about 5,500 residents. Further engagement and community consultation on the proposed health and wellbeing refresh priorities were undertaken in 2023.

The Shropshire Health and Wellbeing Strategy has been developed at a community level by engaging with the residents and local Town Councils using the data from the JSNA.

The ICP has consolidated the available intelligence from the HWBB strategies the system to inform the priorities for the interim Integrated Care Strategy.

The JSNAs and population health intelligence, along with the interim Integrated Care Strategy, should guide system partners on areas of need, such as health and social needs, and the inequalities in our communities.

The Integrated Care Strategy has been developed with stakeholders through engagement into a five-year plan to support the commissioning and provision of services that meet the needs of the population.

The intelligence in this section shows the key themes and headlines from the JSNAs and the population health priorities for our places and our system.

Demographic and socio-economic headlines

Telford and Wrekin

Fastest population growth in the West Midlands (2011-2021 = 11.4% growth) and 2nd fastest growth nationally in 65+ years population (35.7%).

Population changing - becoming more diverse and ageing (median age now same as West Midlands at 39.6 years).

27% Telford and Wrekin residents live in 20% most deprived areas in England – circa 45,100 people (this is referred to as NHSE CORE20), significantly higher than the England average and just over a fifth (21%) of children and young people are living in poverty.

Life expectancy at birth and at age 65 for men and women is significantly worse than England average and there are significant inequalities gaps.

Shropshire

139,000 households - predicted to increase 28% by 2043.

23% of the population +65 years (18.5% in England).

26% increase in Looked After Children (LAC) between 2019/20 to 2020/21.

44,969 people live 30 minutes or more, by public transport, to their closest GP.

An estimated 3,740 people are currently living in care home settings in Shropshire, with this figure likely to increase in the future.

The relatively affluent county masks pockets of deprivation, growing food poverty, health inequalities and rural isolation, with the county overall having a low earning rate.

Shropshire, Telford and Wrekin (STW) area

Total Population in 2020 was 506,737 (Shropshire 325,415 Telford and Wrekin 181,322). Male 49.5 % female 50.5%. Across a total geographical area of 3,487 square kilometres.

Average annual births 4,600 and deaths 4,920.

Shropshire is predominately 66% rural (101 people/sq km) and Telford and Wrekin is predominantly urban (620 people/sq km).

By 2043 there will be an estimated 589,330 people in STW, 30% will be over 65 (currently 21%).

There are over 155 care homes in the area with more than 4,320 beds.

Across STW there are 88,000 people with a long-term limiting illness.

Population health priorities

Using evidence from our Joint Strategic Needs Assessments (JSNA) and our two Health and Wellbeing Strategies, the following shared priorities emerged:

- Give every child the best start in life (including healthy pregnancy).
- Encourage healthier lifestyles with a priority focus on unhealthy weight.
- Improve people's mental wellbeing and mental health.
- Reduce the impact of drugs, alcohol, and domestic abuse on our communities.

Key headlines from Shropshire, Telford and Wrekin's JSNAs

At a national level, the trend of ever-increasing life expectancy noted throughout the 20th century, aided by improvements in public health approaches as well as advances in treatment and medicine, gradually slowed, stalled and in some places declined over the course of the 21st century. While there were improvements seen in 2019, these were mostly undone by the COVID-19 pandemic, which caused life expectancy to fall sharply in 2020. This pattern is also evident across Shropshire, and Telford and Wrekin, with male life expectancy in both areas, and female life expectancy in Telford and Wrekin, appearing to peak in 2014. The latest three-year figures (2020-2022) indicate that both females (82.1 years) and males (78.0 years) in Telford and Wrekin can expect to live shorter lives than the national averages (females 82.8 years, males 78.9 years), and around two years shorter than their neighbours in Shropshire (females 83.9 years, male 79.8 years), who themselves can expect to live a similar length of life to the average person in England.

Healthy life expectancy provides insight into the burden of ill health within an area and shows the number of years a person can be expected to live in good health without disability or long-term illness. The latest figures (2018-2020), again highlight the inequalities between two areas and between the different genders, with females in Telford and Wrekin expected to live just 60.3 years in good health, almost seven years fewer than their Shropshire neighbours (67.1 years) and three years fewer than the national average (63.9 years). For males, again, it is Telford and Wrekin that finds itself an outlier, with men expected to live just 57.6 years in good health, five years fewer than men from Shropshire (62.8 years) and the national average (63.1 years).

- The gap in life expectancy is primarily driven by mortality from cardiovascular disease and cancer. Telford and Wrekin has significantly higher rates of premature (under 75) mortality from both cardiovascular diseases and preventable cancers compared to the national average.
- Excess weight is the most significant lifestyle risk factor in the population, with over two-thirds of adults living within both areas estimated to be overweight. Telford and Wrekin found to have significantly high levels of childhood excess weight and obesity.
- The level of alcohol related-hospital admissions in both areas is significantly above the national average.
- Adult smoking rates in routine and manual groups in both Shropshire and Telford and Wrekin are a key driver of inequalities.

- Smoking in pregnancy is a particular issue for Shropshire and Telford and Wrekin, with levels of maternal smoking at birth significantly worse than the England overall average. The highest levels are seen amongst younger mothers and those living in deprived communities.
- Mental health is a key cause of poor health amongst our communities, with levels of poor mental health in children and younger people increasing.
- The physical health of adults with serious mental illness is also a cause for concern, with both Shropshire and Telford and Wrekin having high rates of excess mortality in this group compared to the national average.

Wider determinants of health					
Public Health Outcomes Framework Indicator	Period	England	ICB/STW	Shropshire	Telford & Wrekin
Children in relative low income families (under 16s)	2022/23	19.8%	21.7%	18.9%	25.4%
School readiness: percentage of children achieving a good level of development at the end of Reception (age 5)	2022/23	67.2%	67.8%	67.6%	68.0%
School readiness: percentage of children achieving the expected level in the phonics screening check in Year 1 (age 6)	2022/23	78.9%	78.8%	77.5%	80.5%
First time entrants to the youth justice system - Persons aged 10 to 17)	2022	148.8	-	37.2	109.5
16 to 17 year olds not in education, employment or training (NEET) or whose activity is not known	2022/23	5.2	-	7.9	3.1
Adults with a learning disability who live in stable and appropriate accommodation (aged 18-64)	2022/23	80.5	-	88.1	77.3
Adults in contact with secondary mental health services who live in stable and appropriate accommodation (aged 18-69)	2020/21	58.0	-	71	59.0
Gap in the employment rate between those with a physical or mental long term health condition (aged 16 to 64) and the overall employment rate	2022/23	10.4	-	10.4	12.7
Gap in the employment rate between those who are in receipt of long term support for a learning disability (aged 18 to 64) and the overall employment rate	2022/23	70.9	-	70.1	73.4
Gap in the employment rate for those who are in contact with secondary mental health services and the overall employment rate (aged 18-69)	2021/22	69.4	-	70.2	69.6
The percentage of people in employment (aged 16 to 64)	2022/23	75.7%	76.9%	77.3%	76.0%
Sickness absence: the percentage of employees who had at least one day off in the previous week	2019-21	1.8%	-	2.2%	1.7%
Sickness absence: the percentage of working days lost due to sickness absence	2019-21	1.0%	-	1.0%	0.9%
Violent crime - hospital admissions for violence (including sexual violence)	2020/21 - 2020/23	34.3	-	18.3	19.9
Homelessness: households owed a duty under the Homelessness Reduction Act	2022/23	12.4	-	8.2	15.5
Social Isolation: percentage of adult social care users who have as much social contact as they would like (18+ yrs)	2022/23	44.4%	-	46.0%	41.1%
Social Isolation: percentage of adult carers who have as much social contact as they would like (18+ yrs)	2021/22	28.0%	25.3%	24.9%	26.4%

Wider determinants of health

Compared to England Better Similar Worse

Overarching Health Inequalities Outcomes

Public Health Outcomes Framework Indicator	Period	England	ICB/STW	Shropshire	Telford & Wrekin
Male life expectancy at birth (1-year range)	2022	79.3	79.1	79.7	77.8
Female life expectancy at birth (1-year range)	2022	83.2	83.2	83.6	82.2
Male life expectancy at birth (3-year range)	2020-22	78.9	-	79.8	78
Female life expectancy at birth (3-year range)	2020-22	82.8	-	83.9	82.1
Male healthy life expectancy at birth	2018-20	63.1	-	62.8	57.6
Female healthy life expectancy at birth	2018-20	63.9	-	67.1	60.3
Male life expectancy at 65 (1-year range)	2022	18.7	18.9	19.4	17.8
Female life expectancy at 65 (1-year range)	2022	21.2	21.4	21.8	20.6
Male life expectancy at 65 (3-year range)	2020-22	18.4	-	19.3	17.8
Female life expectancy at 65 (3-year range)	2020-22	20.9	-	21.6	20.2

Health inequalities : Key clinical areas: Maternity and early years

Long Term Plan NHS prevention priority: healthy weight

Public Health Outcomes Framework Indicator	Period	England	ICB/STW	Shropshire	Telford & Wrekin
Under 18 conception rate / 1,000	2021	13.1	-	12.5	19.5
Teenage mothers (under 18)	2020/21	0.60%	0.70%	-	-
Baby's first feed breastmilk	2020/21	71.7%	70.9%	74.8%	66.0%
Smoking at time of delivery	2022/23	8.8%	11.4%	-	-
Year 6 prevalence of overweight (including obesity) (aged 10 - 11) - 1-year range	2022/23	36.6%	34.6%	31.2%	38.9%
Year 6 prevalence of overweight (including obesity) (aged 10 - 11) - 3-year range	2020/21-2022/23	36.6%	-	31.7%	39.9%
Year 6 prevalence of obesity (including severe obesity) (aged 4-5) - 1-year range	2022/23	22.7%	21.1%	17.6%	25.3%
Year 6 prevalence of obesity (including severe obesity) (aged 4-5) - 3-year range	2020/21-2022/23	22.5%	-	17.8%	25.9%
Reception prevalence of obesity (including severe obesity) (aged 4-5) - 1-year range	2022/23	9.2%	9.8%	8.6%	11.2%
Reception prevalence of obesity (including severe obesity) (aged 4-5) - 3-year range	2020/21-2022/23	9.7%	-	9.1%	11.9%

Compared to England Better Similar Worse

Overarching Health Inequalities
Outcomes

HI 5 key clinical areas: maternity
Long Term Plan NHS prevention
priority: healthy weight

HI 5 key clinical areas: maternity
Long Term Plan NHS prevention
priority: healthy weight

Health inequalities : Key clinical areas: Hypertension case finding					
Long term plan accelerate diabetes and CVD Primary prevention programmes					
Long Term Plan NHS prevention priority: healthy weight					
Public Health Outcomes Framework Indicator	Period	England	ICB/STW	Shropshire	Telford & Wrekin
Estimated overweight (including obesity) prevalence in adults (18+)	2022/23	64.0%	-	66.1%	66.4%
Recorded adult obesity prevalence (18+)	2022/23	11.4%	11.7%	-	-
Estimated adult obesity prevalence (18+)	2022/23	26.2%	-	28.6%	28.4%
Recorded diabetes prevalence (17+)	2022/23	7.5%	7.7%	-	-
Under 75 mortality rate from circulatory diseases considered preventable - 1-year rate	2022	30.8	32.1	-	-
Under 75 mortality rate from cardiovascular diseases considered preventable - 3-year rate	2020-22	30.1	-	27.3	36.8
Health inequalities : Key clinical areas: Early cancer diagnosis					
Percentage of cancers diagnosed at stages 1 and 2; - 1-year rate	2021	54.5%	-	56.7%	51.7%
Percentage of cancers diagnosed at stages 1 and 2; - 3-year rate	2019-2021	54.3%	53.7%	-	-
Bowel cancer screening coverage (aged 60-74)	2022/23	72.0%	74.6%	76.0%	71.40%
Bowel cancer uptake coverage (aged 60-74)	2022/23	70.2%	73.5%	-	-
Breast screening coverage (aged 53 to 70)	2022/23	66.6%	71.1%	-	-
Breast screening uptake (aged 53 to 70)	2022/23	65.4%	70.2%	-	-
Cervical cancer screening coverage (aged 25 - 49)	2022/23	67.0%	72.2%	-	-
Cervical cancer screening coverage (aged 50 - 64)	2022/23	74.9%	76.5%	-	-
Under 75 mortality rate from cancers considered preventable - 1-year rate	2022	49.6	49.9	-	-
Under 75 mortality rate from cancers considered preventable - 3-year rate	2020-22	50.5	-	40.1	60
		Compared to England	Better	Similar	Worse

HI 5 key clinical areas: hypertension case finding

LTP accelerate diabetes and CVD prevention programmes

Long Term Plan NHS prevention priority: healthy weight

HI 5 key clinical areas: Early cancer diagnosis

Health inequalities : Key clinical areas: Chronic respiratory disease					
Under 75 mortality rate from respiratory diseases considered preventable - 1-year rate	2022	18.2	13.2	-	-
Under 75 mortality rate from respiratory diseases considered preventable - 3-year rate	2020-22	17.0	-	10.6	20.1
Population vaccination coverage : Flu (at risk persons)	2022/23	49.1%	53.3%	57.3%	47.8%
Health inequalities : Key clinical areas: Severe mental illness					
Excess under 75 mortality rate in adults with severe mental illness (SMI) (aged 18-74)	2018-20	389.9%	-	477.6%	475.4%
Premature mortality in adults with severe mental illness (aged 18-74)	2018-20	103.6	-	89.0	134.4
Emergency hospital admissions for intentional self-harm	2022/23	126.3	103.1	92.0	121.2
Long Term Plan NHS prevention priority: Alcohol Care Team					
Admission episodes for alcohol-related conditions (narrow definition)	2022/23	475	-	507	571
Under 75 mortality rate from liver disease considered preventable - 1-year rate	2022	19.1	18.9	-	-
Under 75 mortality rate from liver disease considered preventable - 3-year rate	2020-22	18.7	-	18.1	19.1
Long Term Plan NHS prevention priority: NHS Tobacco Dependency programme					
Smoking prevalence in adults (18+)	2022	12.7%	12.4%	10.0%	16.7%
Smoking prevalence in adults in routine and manual occupations (aged 18-65)	2022	22.5%	21.5%	17.6%	26.5%
Smoking attributable mortality	2017-19	202.2	-	173.7	246.1
Smoking attributable hospital admissions	2019/20	1398	-	1,475	1,944

 Compared to England Better Similar Worse

HI 5 key clinical areas: Chronic respiratory disease

HI 5 key clinical areas: Severe Mental Illness

Long Term Plan NHS prevention priority: Alcohol Care Team

Long Term Plan NHS prevention priority: NHS Tobacco Dependency programme

Deprivation, ethnicity and access to services

Deprivation - IMD 2019 Decile (IMD- Index of Multiple Deprivation)

Deprivation:

- Shropshire is a relatively affluent county which masks pockets of high deprivation, growing food poverty, and rural isolation.
- More than 1 in 4 people in Telford and Wrekin live in the 20% most deprived areas nationally with some communities ranking among the most deprived in the country.



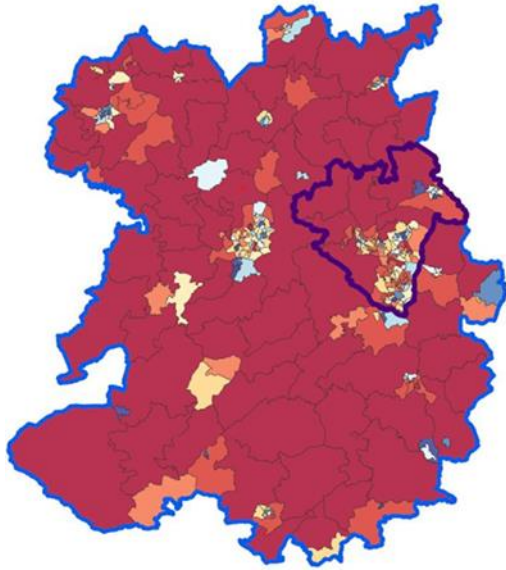
Ethnicity - % BAME 2011 Census (BAME - Black, Asian and Minority Ethnic)

Ethnicity:

- In Shropshire approximately 14,000 people (5.6%) from BAME and other minority ethnic groups were recorded in 2011. Data suggests that this number has increased, particularly within Eastern European populations.
- In Telford and Wrekin 10.5 % of the population from BAME and other minority ethnic groups, however more recent estimates, including the school census and midyear estimates suggest the percentage is closer to 17%.



Indices of Multiple Deprivation (IMD) 2019 Decile



Access:

- According to the 2019 IMD data, there are significant areas of Shropshire, Telford and Wrekin that have the lowest level of access to key services including GP services, post office and education.

Cost of Living:

- The Cost of Living Vulnerability Index is 1,203 for Shropshire and 1,348 for Telford and Wrekin – both in the highest quartile of local authorities nationally.

What our residents have told us

As an ICS we understand the importance of developing our health and care services based on the views of our local population, along with evidence on population health.

Our residents have said they wanted ‘a person-centred approach to our care’, and this is central to all the work we are doing.

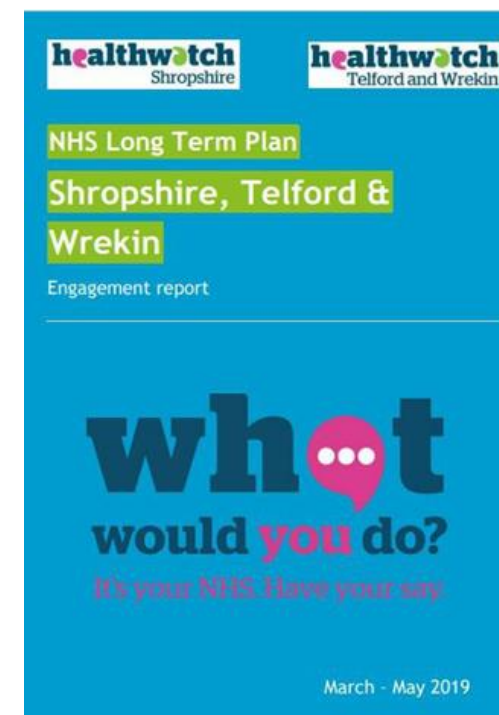
People are at the heart of everything we do, and by delivering joined-up services in both acute and community settings, we can give everyone the best start in life, create healthier communities and help people age well.

These are the top ten statements from all respondents to the Shropshire, Telford and Wrekin questionnaire, highlighting the measures that are most important to our residents:

1. “Professionals that listen to me when I speak to them about my concerns”
2. “Access to the help and treatment I need when I want it”
3. “I want to be able to stay in my own home for as long as it is safe to do so”
4. “I want my family and me to feel supported at the end of life”
5. “Choosing the right treatment is a joint decision between me and the relevant health and care professional”
6. “I want there to be convenient ways for me to travel to health and care services when I need to”
7. “Easy access to the information I need to help me make decisions about my health and care”
8. “Having the knowledge to help me to do what I can to prevent ill health”
9. “Communications are timely”
10. “I have to consider my options and make choices that are right for me”

Those who had long-term conditions told us to focus on:

- Getting help and communications
- Impact of having more than one conditions
- Waiting times
- Access to ongoing care and support
- Transport and travel



When asked how our residents would like to be supported in living a healthier life, and what services can do to provide better care and make it easier for them to take control of their health and wellbeing, they responded:

1. Access and timely intervention, e.g., local services that people know about, that are available when people need them (including 24 hour) and that they can get to easily, including services that can help people to live healthy lives such as affordable gyms and social groups.
2. Tackling isolation and loneliness, e.g., making sure socially isolated people know what support is available to them and how to access it, including homeless people and people who do not have a named GP or relationship with services.
3. Consistent and reliable information and education for all ages, e.g., reducing confusion by giving clear and consistent information that can be trusted, including information about services such as available appointments, and giving people a single point of contact to improve consistency, including appropriate signposting and offering information and advice (for example, advice about medication).
4. Services working together, including information sharing and a flexible approach to working, e.g., ensuring staff know what other services are out there and talking to each other, improved referral processes, social services and the NHS working together.
5. Building strong communities and investment in local people, e.g., supporting and promoting local groups to enable and encourage people to get together, for example, walking groups and dementia groups.

What our partners have told us

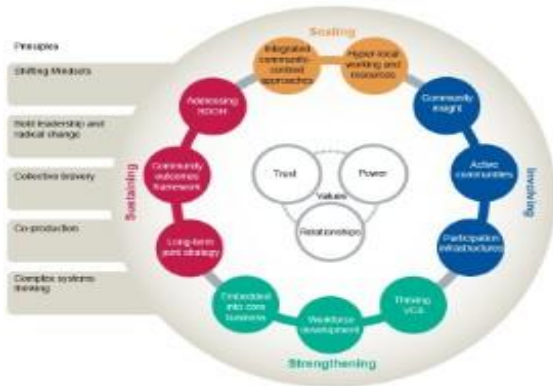
Together with the views of our partners, clinicians, staff and service users we can identify what is working well, what can be improved and what is important to them. This will enable us to plan, design and deliver health and social care services that are right for our local population of Shropshire, Telford and Wrekin.

Our clinical priorities identified through the HWBB consultations and engagement:

- Cancer
- Cardiac including hypertension
- Respiratory
- Urgent and emergency care
- Diabetes
- Orthopaedics
- Mental health

Chapter 4 - Tackling inequalities in outcomes, experience and access

Our approach



Intelligence-led population health management, including equity profiling for inclusion groups



Narrow the gap in service and support uptake and outcomes by proactively targeting people in inclusion based on equity profiling and engagement insight

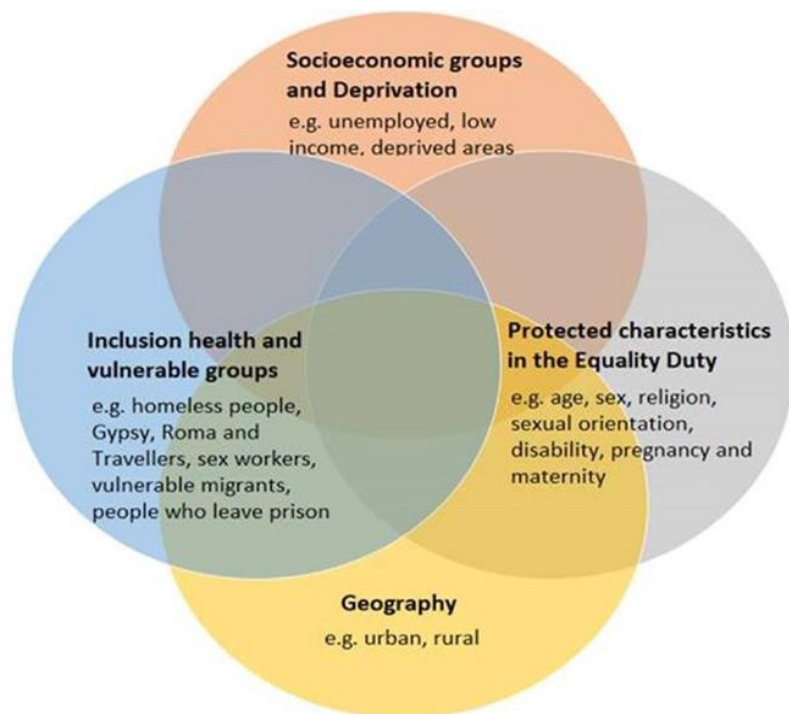


Inequalities and health inequalities

Inequalities in the wider determinants of health (such as housing, education, cost of living and access to green space) contribute to health inequalities.

Health inequalities are unfair, systematic, and avoidable. Therefore, reducing health inequalities requires action to improve outcomes across all the factors that influence our health.

Approximately 10% of our health is impacted by the healthcare we receive.



Inclusion groups

Clear focus where outcomes are poorest for people and families who are:

- from black and minority ethnic groups
- living in deprived communities, including rurally deprived
- affected by alcohol and drugs, including prescribed and OTC
- victims and survivors of domestic abuse
- experiencing poor emotional and mental health
- living with physical disabilities, learning disabilities and autism
- living with sensory impairment
- protected characteristic groups under the Equality Act
- at risk of exploitation
- LGBTQ+
- service personnel and veterans
- looked after children and care leavers
- asylum seekers and refugees

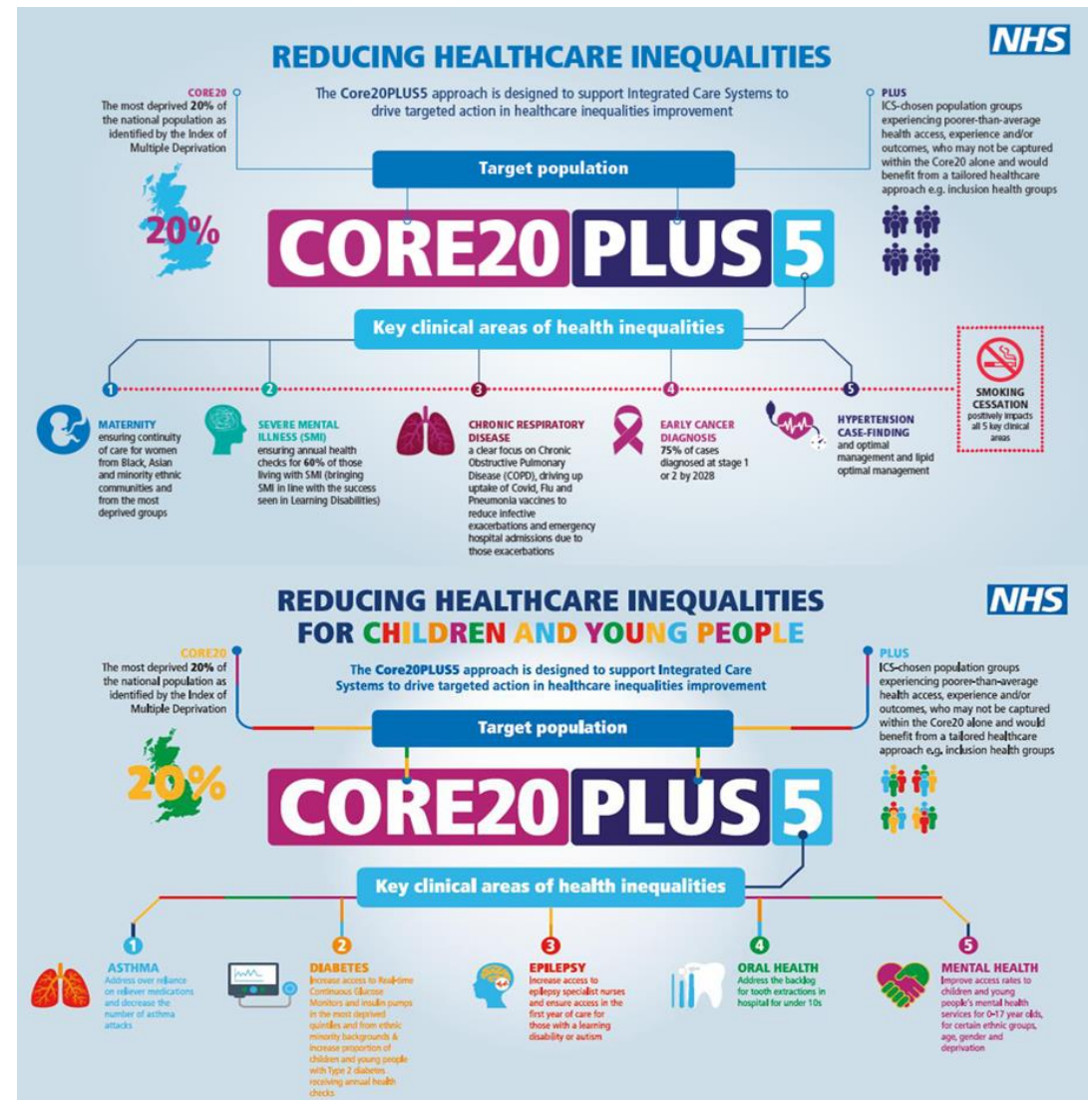
Overview of tackling in equalities

An overview of the key focus areas in tackling inequalities includes addressing the following:

- Wider determinants of health, cost-of-living crisis, heat and fuel poverty, housing, employment, education and rurality.
- Inclusive, connected, healthy and sustainable communities.
- Healthy behaviours and lifestyles, with a focus on strengthening prevention.
- A person-centred approach that addresses holistic needs.
- Best start in life for EVERY child.

Health inequalities are widening, and our partnership needs to focus on the root causes of health inequalities, the wider determinants, and address inequity of access to services for those most in need. We need to understand the multiple barriers people can face in accessing our services. We therefore commit to accelerating targeted collaborative local action to reduce health inequalities through the following priorities, which address the wider determinants of health:

- Homelessness, healthy homes, poverty and cost of living, as well as positive work and employment.
- Ensuring every child has the best start in life by influencing a range of outcomes throughout the child's life and into adulthood.
- Improving equity of access to healthcare for those living in our most deprived areas, including rural and other forms of exclusion (for example Core20 Plus 5 programme and a focus on healthcare preventable diseases). For adults, this includes hypertension, early cancer diagnosis, health checks for SMI and LDA, vaccinations and continuity of carer in maternity. For children, this includes epilepsy, asthma and diabetes.



Health and Wellbeing Board priorities

Telford and Wrekin

Our vision - happier. healthier. fulfilled lives

Telford & Wrekin
Health & Wellbeing Strategy
Priorities



Borough Vision 2023 ambition – inclusive, healthy, independent lives

Shropshire Joint Health and Wellbeing Strategy priorities 2022-2027

Strategic Priorities		Key areas of focus	
Long-term aims and how we will achieve them		Identified areas of health and wellbeing need in Shropshire	
Joined up working		Workforce	
Working with and building strong and vibrant communities		Healthy Weight and Physical Activity	
Improving Population Health		Children & Young People incl. Trauma and ACEs (All-age)	
Reducing Inequalities		Mental Health	
Other – These form part of the Key Priorities			
Social Prescribing	Drugs and Alcohol	Smoking in Pregnancy	Housing
Suicide Prevention	Food Poverty	Killed and Seriously Injured on Roads	Air Quality
Exploitation			

Inequality plan

Shropshire Inequality Plan

Wider Determinants	Healthy Lifestyles	Healthy Places	Integrated Health and Care
Marmot; (i) Create fair employment (ii) Ensure healthy living standard	Marmot; (iii) CYP and adults – maximise capability and control (iva) Strengthen ill-health prevention (lifestyles)	Marmot; (i)v Create healthy and sustainable places and communities	Marmot; (vi) Give every child the best start in life (ivb) Strengthen ill-health prevention (transformation/disease programmes)
Inequalities Work Programmes			
Embed health in all policies	Smoking/tobacco dependency	Air pollution	Restore NHS services inclusively
Housing – affordable/specialist/supported	Healthy weight	Planning	Rurality
Economy and skills	Physical activity	Culture and leisure	Mitigate digital exclusion
Workforce		Licensing	Datasets complete
Education incl. SEND		Food Insecurity	Strengthen leadership and accountability
Early years			Population health management
Post 16			Personalisation/personalised care
SEND			COVID and flu vaccination
LD&A/SMI			Annual health checks for people with:
Transports			Continuity of carer (maternity)
			Chronic respiratory disease
Social Inclusion Groups	Social Inclusion Groups (Continued)	PCN health inequality plans	Hypertension case-finding
Domestic abuse	Drug and alcohol misuse		Diabetes
Exploitation	Looked after children		Children and Young People
Homelessness	Ethnic minority groups		Trauma informed workforce
Learning disability	Prisoners and their families		Healthy Start
Autism			Oral health
Gypsy and traveller families			Best Start in Life
Asylum seekers/refugees			Children/families in need
Unpaid carers			Complex need
Physical disabilities			Mental Health (MH transformation plan)
LGBTQ+			Suicide prevention
Services personnel and (families and veterans)			Social prescribing
			Integrated Impact Assessment (IIA)

Person-centred approach

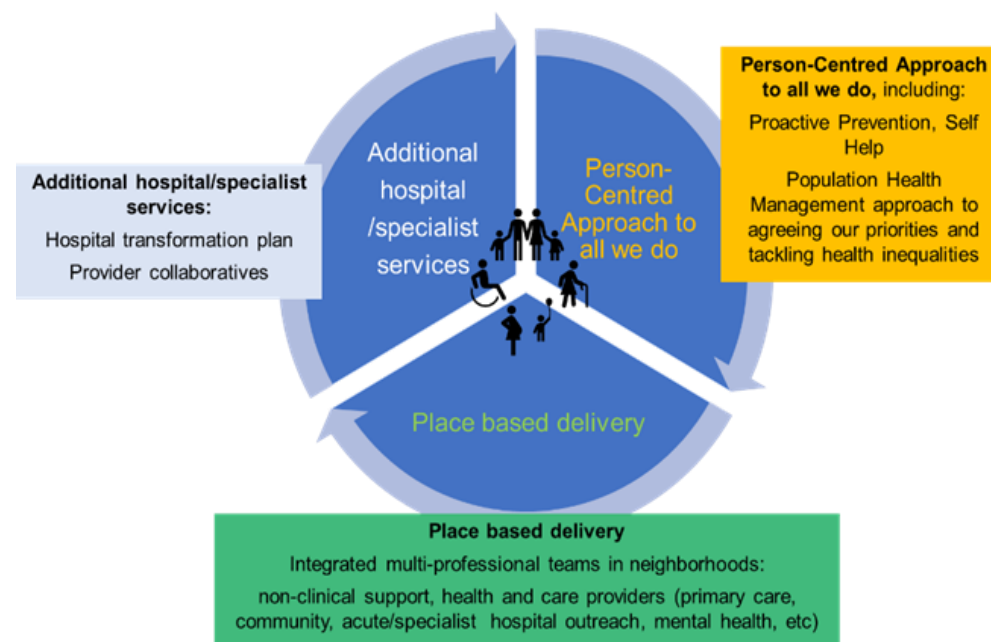
Person-centred care shifts away from professionals deciding what is best for a patient or service user, and places the person at the centre, as an expert of their own experience and life. The person, and their family where appropriate, becomes an equal partner in the planning of their care and support, 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.

Key aspects of person-centred care include:

- Valuing people’s preferences and placing them at the centre of their care, considering people’s preferences, and chosen needs.
- Ensuring people are physically comfortable and safe.
- Providing emotional support involving family and friends.
- Ensuring access to appropriate care as needed, when and where they need it.
- Providing accessible information to empower individuals to make informed decisions about their care and support.

Person-centred care also acknowledges the significant and proven link between non-clinical community support and improvement in health and wellbeing.



Chapter 5 - Support broader social and economic development

The Joint Forward Plan (JFP) promotes broader system collaboration. It outlines three key areas that system strategies must align with, demonstrating how they will support and underpin the priorities within the Integrated Care Strategy.

The evolution of the 'Places' and provider collaboratives will have an impact on how services are delivered in the future, with enabling strategies clearly demonstrating how they will facilitate the system priorities. The JFP also illustrates how the system's operating model will achieve the outcomes and impacts of the strategic commissioning intentions.

Key components of the JFP include:

- Local planning and regeneration
- Climate and green planning
- Hospital Transformation Programme
- Local Care Programme included integrated approach to neighbourhood teams

Enabling strategies encompass:

- **Workforce:**
 - Our local people plan outlines and supports our system response.
 - Initiatives to support and nurture our people.
 - Fostering a sense of belonging in STW.
 - Implementing new care delivery methods.
 - Futures workforce growth strategies, with a focus on nursing and Health Care Support Workers (HCSW).
- **Digital:**
 - Approval of a comprehensive digital strategy for the system.
 - Implementation of a Shared Care Record system.
 - Integration of advanced care delivery systems.
 - Remote monitoring capabilities.
 - Utilisation of artificial intelligence to enhance care delivery.

- **Communications and Engagement:**
 - Approval of a Communication and Engagement plan.
 - The STW JFP serves as the operational framework for delivering the ICP's Strategy and its priorities, defining partnership narrative, approaches, methodologies, and key questions.
 - The Equalities Involvement Committee will guide and advise on ongoing dialogue and development.
 - Engagement with citizens will be enhanced through collaboration with Healthwatch and NHS/LA enabling workstreams.
- **Population Health Management:**
 - Development of a Population Health Management (PHM) Strategy to ensure accurate data, insights, and evidence to support system decision.
 - Establishment of an analytical 'engine room' to drive insighted and capacity building.
 - Grow analytical skills and capacity.
 - Implementation of a system-wide work programme grounded in the continuous development of JSNAs as its foundation.

This structured approach ensures alignment across system-wide initiatives, fostering effective collaboration and strategic implementation of priorities to benefit our communities in Shropshire, Telford and Wrekin.

Provider Collaboratives

Provider Collaboratives will play an important role in enacting strategic priorities and delivering objectives commissioned for the healthcare system. These collaborations will build on a strong local commitment to partnership working and will develop to support specific areas of delivery where integration will produce better outcomes for the population. In particular, collaborative delivery mechanisms will support providers of care to add value to the ICS by:

- developing and delivering collaborative approaches to specific challenges that are within providers' ability to resolve
- developing partnership relationships, strengthening communication between providers, sharing approaches to challenges and opportunities
- addressing efficiency, productivity and sustainability through collaborative working, integration or the consolidation of service delivery or corporate functions
- reducing inequalities of access and unwarranted variation, where provider collaboration can best achieve this
- adopting some commissioning responsibilities within the ICS where this will align better with operational delivery and transformation, improve decision making and accelerate change

The Provider Collaborative will act as a key conduit for providers to work together as a single unit under which a range of collaborations will be developed to deliver outcomes commissioned by the ICB. These collaborations may form between internal STW ICS partners or across ICS borders where this brings benefits to our population.

Voluntary, Community and Social Enterprise involvement

Our system has made a commitment to our partners in the Voluntary and Community Sector that we will prioritise sustainable partnerships with a longer-term view to support the delivery of outcomes through place and provider collaboratives. The cost-of-living crisis has had a major impact on our voluntary sector and yet they continue to deliver a range of excellent services to our populations.

Supporting prevention, management and wider determinants of health has a huge impact on people's lives, delivers a person-centred approach and offers excellent value for money. But VCSE services, whilst voluntary are not 'free' and the system has agreed to facilitate, support and evaluate the work our VCSE does to ensure that we can continue to have vibrant communities in the years to come.

Chapter 6 - Enhance productivity and value for money

Our Integrated Care Partnership (ICP) will explore whether needs can be better met through arrangements such as the pooling of budgets, under Section 75 of the NHS Act 2006. Section 75 is a crucial for enabling integration and will play a central role in delivering our Integrated Care Strategy.

The term 'left shift' is used to describe a strategic direction that promotes delivering more care in lower-cost, out-of-hospital settings, ideally at home, while emphasising prevention. The underlying premise is that acute care tends to be more expensive and may become the default option when preventive services aren't optimal in either capacity, capability, or delivery.

According to a recent point prevalence audit, nearly 20% of patients in acute care on the audit day could have been treated appropriately in 'left shift' settings such as community hospitals, care homes, or in their own homes with additional primary care and social care support. However, this finding requires further analysis and integration into the Joint Forward Plan (JFP) to ensure that appropriate integrated primary and community services are being developed to support the 'left shift'.

'Left shift' also encompasses prevention and early support services that operate below primary, community and social care. However, transitioning to a 'left shift' approach will not occur automatically; it requires a conscious effort by the system to embrace change and recognise that the costs and benefits of this shift will not vary across different parts of the system.

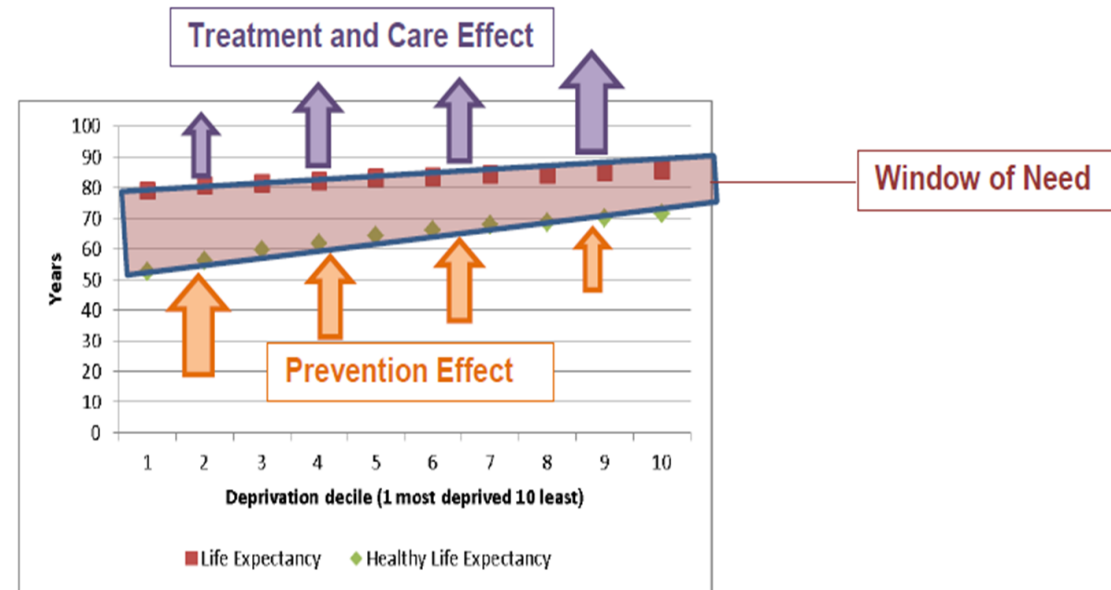
In summary, 'left shift' aims to:

- Close the Care and Quality Gap: by narrowing the gap between the highest and lowest standards of care and raising the overall quality standards for everyone.
- Close the Health Gap: despite longer life expectancy, most health issues and premature deaths in our community stem from preventable diseases such as dementia, diabetes, certain cancers, and respiratory illnesses.

This strategic shift towards 'left shift' is essential for improving healthcare efficiency, enhancing patient outcomes, and promoting healthier lives across our community.

Focusing on prevention/early intervention:

- Reduces/prevents demand
- Delays health and care service need
- Delivers better outcomes by extending healthy life expectancy
- Reduces inequalities



Chapter 7 - Performance monitoring and scrutiny

High-level outcomes for the system are broadly agreed upon, though they may evolve further through consultation and co-production, and will be integrated into our operational and Joint Forward Plan (JFP). The Integrated Care Strategy will continue to be developed collaboratively with residents, partners, and stakeholders on an ongoing basis. This iterative process will support and inform the strategic commissioning intentions and priorities.

The Joint Forward plan will be refreshed annually, with the first year guiding the operational planning process and its fifth year developed in collaboration with the Strategy and Development Directorate, Health and Wellbeing Boards, and the Integrated Care Partnership (ICP). Oversight of plan delivery will be the responsibility of the Integrated Care Board, supported by assurance from the Places and Provider Collaboratives as they evolve within the system operating model.

Additionally, scrutiny of the high-level strategy and the JFP will also be overseen by the Joint Health Overview and Scrutiny Committee to ensure alignment and effectiveness.

High level outcomes

Outcome Focus – potential high level outcomes

The health of our population will be improved through a focus on....	Our Outcomes
<p>The health of our RESIDENTS</p>	<ol style="list-style-type: none"> 1. We will increase healthy life expectancy across STW and narrow the gap between different population groups 2. We will reduce early deaths from preventable causes – cardiovascular and respiratory conditions, cancers and liver disease – focussing on those communities which currently have the poorest outcomes 3. We will improve life expectancy of those with Serious Mental Illness 4. We will increase the proportion of people in STW with a healthy weight 5. We will improve self-reported mental wellbeing 6. We will reduce the number of children & young people who self-harm 7. We will reduce alcohol related hospital admissions 8. We will reduce the proportion of pregnant women who smoke 9. We will lower the burden and minimise the impact of infectious disease in all population groups
<p>The health of our SERVICES</p>	<ol style="list-style-type: none"> 1. We will increase the proportion of our residents who report that they are able to find information about health and care services easily 2. We will increase the proportion of our residents who report that they are able to access the services they need, when they need them 3. We will increase the proportion of our residents who report that their health and care is delivered through joined up services as close to home as possible

Outcome Focus – potential high level outcomes

The health of our population will be improve through a focus on....

Our Outcomes

The health of our **STAFF**

1. We will improve our ability to attract, recruit and retain our staff
2. We will improve staff training and development opportunities across all our partners
3. We will improve self-reported health and wellbeing amongst our staff
4. We will increase Equality and Diversity workforce measures in all organisations

The health of our **COMMUNITIES**

1. We will reduce the impact of poverty on our communities
2. We will reduce levels of domestic violence and abuse
3. We will reduce the impact of alcohol on our communities
4. We will reduce the impact of Adverse Childhood Experiences (ACEs) on our communities
5. We will reduce the number of young people not in education, training or employment
6. We will increase the number of our residents describing their community as a healthy, safe and positive place to live

The health of our **ENVIRONMENT**

1. We will increase the proportion of energy used by the estates of our partner organisations from renewable sources
2. We will reduce the total carbon footprint generated through travel of patients using our services
3. We will increase the use of active travel, public transport and other sustainable transport by our staff, service users and communities