Borough of Telford and Wrekin

Joint Health Overview & Scrutiny Committee

Wednesday 7 June 2023

2.00 pm

Council Chamber, Shirehall, Abbey Foregate, Shrewsbury, Shropshire, SY2 6ND

Democratic Services:	**Stacey Worthington**	**01952 382384**
Media Enquiries:	**Corporate Communications**	**01952 382406**

Committee Members: **Councillors D R W White, S Charmley (Co-Chair), N A Dugmore, O Vickers, K Halliday amd H Kidd.**
Co-optees H Knight, D Saunders, S Fogell, L Cawley (Shropshire Co-Optee), L Price (Shropshire Co-Optee) and D Sandbach (Shropshire Co-Optee).

	Agenda	Page
1.0	**Apologies for Absence**	
2.0	**Declarations of Interest**	
3.0	**Minutes of the Previous Meeting**	**3 - 6**
4.0	**Shropshire, Telford & Wrekin Joint Forward Plan**	**7 - 82**
	To receive an update from Claire Parker Director of Partnerships and Place, NHS Shropshire Telford and Wrekin.	
5.0	**Calling for an Ambulance in an Emergency - Report from Healthwatch Shropshire & Healthwatch Telford and Wrekin**	**83 - 142**
	To consider the report. Key points and summary are also available from this link Calling for an ambulance in an emergency | Healthwatch Shropshire.	

6.0	**Work Programme**	**Verbal Report**
7.0	**Co-Chair's Update**	**Verbal Report**

JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE

Minutes of a meeting of the Joint Health Overview & Scrutiny Committee held on Monday 23 January 2023 at 2.00 pm in The Telford Room, Addenbrooke House, Ironmasters Way, Telford, TF3 4NT

Present: Councillors D R W White (Co-Chair), S Charmley (Co-Chair) and S J Reynolds, K Halliday and H Kidd.
Co-optees: F Doran, H Knight, L Cawley, L Price and D Sandbach

In Attendance: R Boyode (Executive Director of People and Organisational Development, Shrewsbury and Telford Hospital Trust), T Dodds (Scrutiny Manager, Shropshire Council), C McInnes (Director of Operations for Women's & Children's Division, Shrewsbury and Telford Hospital Trust), S Vangenderen (Lead Consultant Psychologist, Shrewsbury and Telford Hospital Trust), K Williams (Deputy Director of Midwifery, Shrewsbury and Telford Hospital Trust), S Worthington (Senior Democracy Officer (Scrutiny), Telford & Wrekin Council) and S Yarnall (Democracy Officer (Scrutiny), Telford & Wrekin Council).

Apologies: Councillors N A Dugmore and Co-Optee D Saunders

JHOSC1 Declarations of Interest

Co-Optee, D Sandbach, declared that he received an NHS pension.

JHOSC2 Minutes of the Previous Meeting

RESOLVED – that the minutes of the meeting held on 19 December 2022 be confirmed and signed by the Chair.

JHOSC3 SaTH Maternity Services - Our Improvement Journey

The Executive Director of People and Organisational Development, the Director of Operations for Women's & Children's Division, the Lead Consultant Psychologist and Deputy Director of Midwifery, from the NHS Shrewsbury and Telford Hospital Trust (SaTH) provided an update on the improvement journey of the maternity services within the Trust. The presentation highlighted the changes from the publication of the first Ockenden report to date in relation to Maternity Services at SaTH. The update focused on how staff wellbeing had improved, opportunities for staff to provide feedback, the governance of maternity services at SaTH and improved culture of the organisation. The Trust had introduced the implementation of clinical psychologists to support nurses and midwifes with their mental health. Members were updated on how staff could provide feedback in different ways to highlight concerns and issues

that staff face; such as the 'Improvewell' app, an online platform for nurses and midwifes to anonymously provide feedback.

Following the presentation, Members asked the following questions:

Would the psychological support on offer to staff be accessible for patients and was it solely a support system for maternity services?

The services of psychological support were available for patients, parents, their families and friends. The Chief Psychologist at SaTH had helped to implement the support for staff and the service was expanding; there were plans for psychologists in the neonatal division and more clinical psychologists throughout the different divisions at SaTH.

How would feedback be received from patients who were less likely to provide feedback following an incident?

Matrons and ward managers would meet regularly and determine if there have been any incidents that have been raised; matrons and ward managers would then speak with the mothers or families to hear their feedback. Spot checks with patients could be utilised to help identify potential issues and to receive further feedback.

Had bank staff been used for vacancies and short-term shortage of staff?

Bank staff were rarely used and avoided when possible. It was explained that staffing levels were managed through weekly ward manager meetings to plan a 10 day forecast of staff to address any shortages. For long term shortages and vacancies it was said that vacancies for international recruitment would be used as well as advertising student places and apprenticeships.

The first Ockenden report highlighted concerns over levels of knowledge and experience amongst staffing levels; had this now been addressed?

There were now band 7 midwives on site that supported and provided knowledge and expertise that was otherwise missing.

Recently there was a letter from the Chief Nurse suggesting to abandon the Continuity of Carer; has this been done and when will any changes be implemented?

This had been completed and work was currently underway on alternate provisions.

When looking at the published staff survey results across the divisions at SaTH, maternity services appeared to be the worse division in the last year, why was this the case?

The results were reflective of the changing culture in the division, many changes had been made to the service since the survey had been completed.

It was explained that the current survey had recently been completed but the results were currently embargoed however, the trends showed a positive improvement.

SaTH is currently not included in a Local Neonatal Maternity Network (LNMS), when will the trust be a part of one?

Work was underway for the Trust to become part of an LNMS, and this was ongoing. The Committee would be notified should the Trust join any LNMS.

Was there currently an audit on the use of BadgerNet across maternity services and were mothers being trained on how to use it?

Midwifes showed patients how to use the system, however, an audit procedure had not yet been implemented.

When it came to the staff surveys were the changes implemented across the whole of SaTH?

The 'Improvewell' system that staff in maternity used to provide feedback was currently only used by the maternity division, with the 'making a difference' platform used by the remainder of the trust for staff to provide feedback. The difference between the two was explained; the 'Improvewell' feedback system was more clinical and specific to maternity

Members requested further examination of funding in maternity services at SaTH and requested that this be provided at a later date.

This was agreed.

Had staff withdrawn their feedback to the Ockenden Team or not provide it for fear of repercussions that they might face and what was in place to prevent this from occurring?

Members were assured that any surveys were anonymous and that the surveys are managed by external organisations to further anonymise any staff feedback.

Could patients self-refer themselves to psychological support or would a formal complaint be necessary to access this support?

Support was available to every patient, however, the level of urgency determined where the support was offered first due to the capacity of staff.

How did the system support mothers where English was an additional language, particularly when there had been issues with their care. Members raised particular concerns regarding mothers who had received outcome letters where they had not previously been aware of any concerns around their care.

Members were advised that significant investment had been made into the 'language line' and that they had implemented tablets to support mothers for whom English was not their first language. Members were assured that all patients were initially contacted by telephone, a letter would only be sent if they could not be reached on the phone.

When looking at the services provided during triage and across maternity, would mental health support be included?

It was confirmed that mental health support was available across the service for patients and staff.

How did the Trust provide support for staff that was burnt out and would this impact on their future role?

Staff were encouraged to seek help before they reached this stage and to normalise seeking help. Members were advised that support was discrete.

JHOSC4 Mid-Term Work Programme Review

The Scrutiny Manager, Shropshire Council, and the Senior Democracy Officer (Scrutiny), Telford & Wrekin Council, provided an update on the work programme to the committee. An overview of each item was discussed and discussion over future items were also considered to aid with the committees future work programme.

The Hospital Transformation Programme (HTP) would be an ongoing item for the Committee and it was suggested that the focus needed on a whole system approach with links to care in the community and adult social care.

Members discussed urgent and emergency care and felt that the focus should be on funding and investment into the area. Members also requested an update on virtual wards, with a particular focus on the costings and running of the wards.

Members requested to have a future item that focused on mental health support across the region.

JHOSC5 Co-Chair's Update

Members were advised that the next meeting of the committee would be the 9 March 2023 at Shirehall, Shrewsbury.

The meeting ended at 4.26 pm

Chairman: ----------

Date: Wednesday 7 June 2023

Shropshire Council and the Borough of Telford and Wrekin
Joint Health Overview & Scrutiny Committee (HOSC)

Agenda item no.	
Meeting date:	7 June 2023
Paper title	Shropshire, Telford and Wrekin five year Joint Forward Plan (JFP)
Paper presented by:	Claire Parker Director of Partnerships and Place NHS Shropshire, Telford and Wrekin
Paper approved by:	Claire Parker Director of Partnerships and Place NHS Shropshire, Telford and Wrekin
Paper prepared by:	Sarah Walker, Principal Improvement Consultant, MLCSU Irene Schwehla, Senior Improvement Consultant, MLCSU
Signature:	
Committee/Advisory Group paper previously presented:	

Action Required (please select):									
A=Approval	X	R=Ratification		S=Assurance	X	D=Discussion	X	I=Information	

Previous considerations:	**None identified.**

1. Purpose of the report

This paper will provide updates on progress to date regarding the development of the Joint Forward Plan (JFP) for the Shropshire, Telford and Wrekin Integrated Care Board which has been developed to implement the interim Integrated Care Strategy (IC Strategy) for Shropshire, Telford and Wrekin.

2. Background

a) As a statutory committee, jointly formed between NHS Shropshire, Telford and Wrekin and the two local authorities, Shropshire Council and Telford and Wrekin Council, the Integrated Care Partnership (ICP) was responsible for producing an integrated care strategy on how to meet the health and wellbeing needs of the local population.

The draft interim Care Strategy (IC Strategy) was presented to this committee in the meeting on 19 December 2022. Feedback received from the committee in this meeting was incorporated in the final version of the strategy.

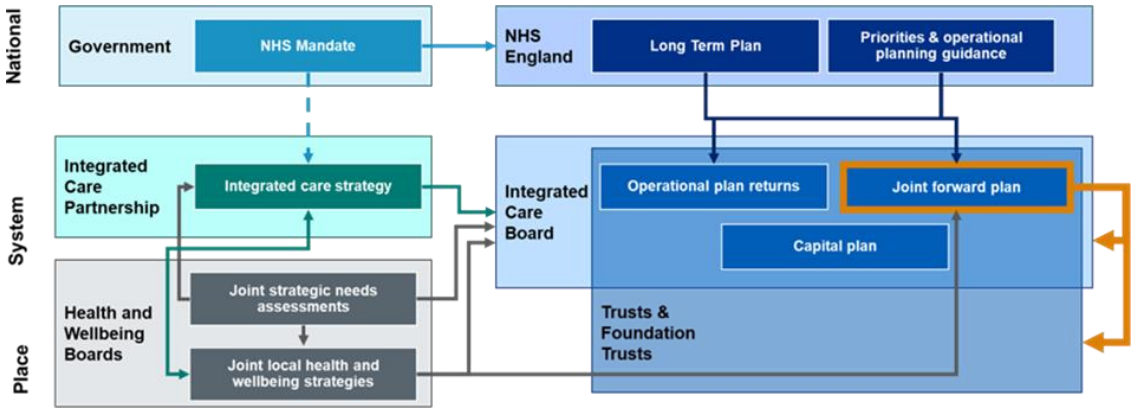
The IC Strategy has since been signed off by the Board of the Integrated Care Partnership (ICP) in its meeting of 20 March 2023 and published

https://www.shropshiretelfordandwrekin.ics.nhs.uk/integrated-care-strategy-and-joint-forward-plan/

b) The Health & Care Act 2022 requires each Integrated Care Board (ICB) in England to produce and publish a Joint Forward Plan (JFP). Guidance published by NHS England informed ICBs and their partner trusts that

- in the first interim year the date for publishing and sharing the final plan with NHS England, their integrated care partnerships (ICPs) and Health and Well-being Boards (HWBs), is 30 June 2023
- ICBs and their partner trusts must involve relevant Health and Wellbeing Boards in preparing or revising the JFP
- the final version must be published, and ICBs and their partner trusts should expect to be held to account for its delivery – including by their population, patients and their carers or representatives – and in particular through the ICP, Healthwatch and the local authorities' health overview and scrutiny committees

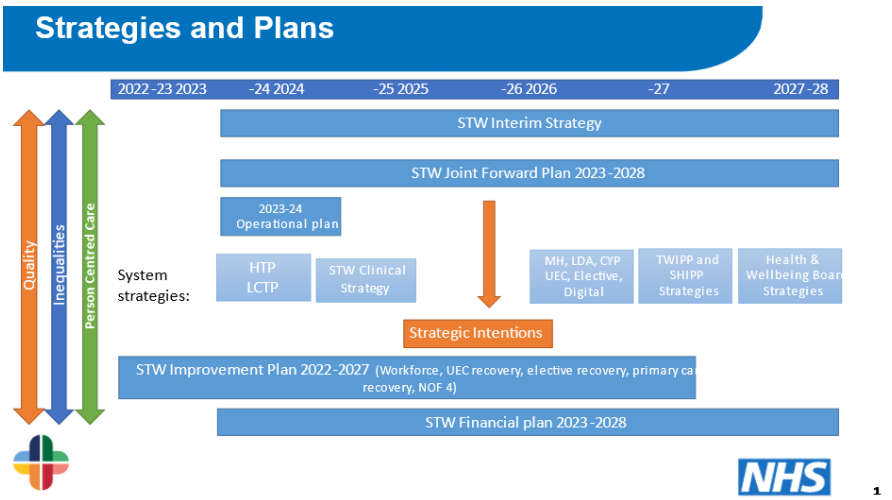
Statutory framework (not including interaction with wider system partners) relating to the JFP



3. Report

- In order to meet obligations set by the Health & Care Act 2022 to produce the required plan a Joint Forward Plan Working Group and a PMO were established. They have been coordinating the activities required to manage the JFP through its draft stages and approval process as well as ongoing engagement with key stake holders.

- The strategies and plans below were considered for and included in the development of the JFP



- NHS England guidance also stipulates that close engagement with partners will be essential to the development of JFPs and recommends close working with

- the ICP (ensuring this also provides the perspective of social care providers)
- primary care providers
- local authorities and each relevant HWB
- NHS collaboratives, networks and alliances
- the voluntary, community and social enterprise sector
- people and communities that will be affected by specific parts of the proposed plan, or who are likely to have a significant interest in any of its objectives

- In order to meet the requirements of the guidance feedback on iterations of the plan have been sought from

  - Telford and Wrekin HOSC
  - both Health and Wellbeing Boards
  - the ICB board
  - the ICB Strategy committee
  - the place based Bords SHIPP and TWIPP

  since the beginning of 2023.

- In addition a comprehensive programme of events and activities was undertaken to engage with key stake holders in the system and members of the public. Feedback from these events is being collated and analysed and will be reflected in the final iterations of the JFP.

- During June further feedback will be sought from the Joint Health and Oversight Scrutiny Committee (HOSC), the Shropshire, Telford & Wrekin Health and Wellbeing boards and the Integrated Care Partnership (ICP) board.

- The draft JFP was discussed in a meeting with the regional NHS England (NHSE) office in April 2023 and the project management methodology as well as the content of the plan received positive feedback. A virtually complete version was submitted for review and feedback from subject matter experts within NHS England on 22 May – see attached as Appendix A

- It is anticipated that a final version of the JFP will be signed off by the ICB board in its meeting on 28 June ready for publication by 30 June 2023.

4. Recommendation(s)

The Joint Health Overview & Scrutiny Committee is asked to:

- Note the updates on the Integrated Care Strategy (IC Strategy)
- Note the update on the development of the JFP

5.0 Alternative Options

No alternative options considered.

6.0 Key Risks

n/a

7.0 Council Priorities
n/a

8.0 Financial Implications
n/a

9.0 Legal and HR Implications
n/a

10.0 Ward Implications
n/a

11.0 Health, Social and Economic Implications
n/a

12.0 Equality and Diversity Implications
n/a

13.0 Climate Change and Environmental Implications

n/a

14.0 Background Papers
n/a

15.0 Appendices

A Version 9.0 of the JFP

16.0 Report Sign Off

Signed off by	Date sent	Date signed off	Initials
	30/05/2023		

Shropshire, Telford & Wrekin

Joint Forward Plan

2023 – 2028

(DRAFT MARCH 2023)

Please note this draft version for further engagement does not contain all the information collated from the 'Big Health and Wellbeing Conversation' during March 2023. However, this will be addressed as the document is developed during April to June prior to final publication.

The term 'placeholder' in the document denominates information which is currently under development and will be added in further iterations.

Foreword

Our Integrated Care Board (ICB) was established in July 2022 to support our system partners to deliver integrated care for the diverse populations across Shropshire, Telford & Wrekin (STW).

STW is a beautiful place to live and work, but we acknowledge that there is more to do to improve people's lives. We want everyone in STW to live healthy, happy and fulfilled lives, creating healthier communities and helping people to age well.

To do this, our system must work closer together to overcome disparities, reduce inequalities and ensure equity of outcomes for the communities of STW.

Our focus must be on people and place. We know that people who have jobs, and good housing in communities where they feel safe, remain healthier for longer. When people need care, services that are closer to home and are designed and delivered by neighbourhood teams, can lead to better health and wellbeing, and reduced inequalities. Therefore, we are adopting a collective responsibility approach across health and social care, the voluntary sector and other public bodies to support the people of STW to lead healthier lives.

In each of our places, our health and care services will work in partnership with people in our communities, to shape a person-centred, integrated and life course approach to preventing and living with ill health. Through this collective, holistic, asset-based approach to enabling health and wellbeing in our communities, we can minimise unnecessary pressure on NHS and social care services and achieve our ICS aims.

We hope this plan gives you a clear view of what our system is trying to achieve, and, more importantly, how it plans to do so, and the actions we will take over the next five years to ensure we deliver our goals.

Sir Neil McKay
Shropshire, Telford & Wrekin ICS Chair

The organisations who have developed this Plan are represented in the diagram below:

Executive Summary

The Shropshire and Telford & Wrekin (STW) Integrated Care System (ICS) has developed this Joint Forward Plan. The Plan outlines how our health and care system will work together to deliver the priorities we have jointly agreed over the next five years. It is not set in stone: we will continue to engage with our communities to co-produce solutions which meet their needs, while understanding the system's challenges too.

This plan has been developed through a collaborative approach with all system partners and wider stakeholders and is based on engagement with our local communities. It describes our system ambitions and demonstrates the alignment of our strategic priorities across the ICS, and more importantly, how we will deliver our priorities.

To develop a robust plan, we must acknowledge where we are currently. 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 affected. As a system, as partners and as individuals we learned a lot about working together and the importance of community and wellbeing. However, there have been consequences of the pandemic, and amplifications of previous trends.

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.

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, building on the good work that has already occurred in recent years.

One example of cooperation is the Office of the West Midlands – a partnership of West Midlands Integrated Care Boards. The six ICBs in the West Midlands are collaborating to establish an Office of the West Midlands which, through 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 to all Person-centred approach we do, including proactive prevention, self-help and a population health management to tackling health 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 where possible, putting a greater emphasis on preventing illness and staying well, but also providing the right care when and where they need it. We want to enable people to access an abundance of non-clinical approaches to health and wellbeing in their own communities (such as lifestyle interventions like exercise clubs and community activities).

Our place-based boards – the Shropshire Integrated Place Partnership (SHIPP) and the Telford & Wrekin Integrated Place Partnership (TWIPP) – will drive the delivery of this agenda with support from

their respective Health and Wellbeing Boards. SHIPP and TWIPP reflect the identity of each of the places and both have their own priorities and plans for delivering the person-centred approach in a way that benefits from the assets and strengths of their local communities and meets local needs. At the same time the Places ensure that standards of access and quality do not vary. They connect across STW to ensure that the evidence of the most effective prevention, population health and care models are applied in every neighbourhood.

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

The programme consists of initiatives that will shift more care into the community achieving better outcomes and experiences for patients, while also helping to relieve pressure on our acute hospitals so that those services are able to deliver quality services when people need them. The Local Care Transformation Programme (LCTP) will support our place based boards to establish a range of community-based services, closer to home (and in home), whilst also placing greater emphasis on prevention and self-care, helping our population to live healthy and independent lives in their normal place of residence for as long as possible.

The LCTP and the place based board's programmes will also focus on improving integration across our partner organisations including GPs, community services, community mental health services, adult and children's social care, care providers and voluntary organisations.

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 addition, our clinical priorities are:

- Urgent and Emergency Care
- Cancer
- Cardiac Pathway
- Diabetes
- Musculoskeletal (MSK)
- Mental Health

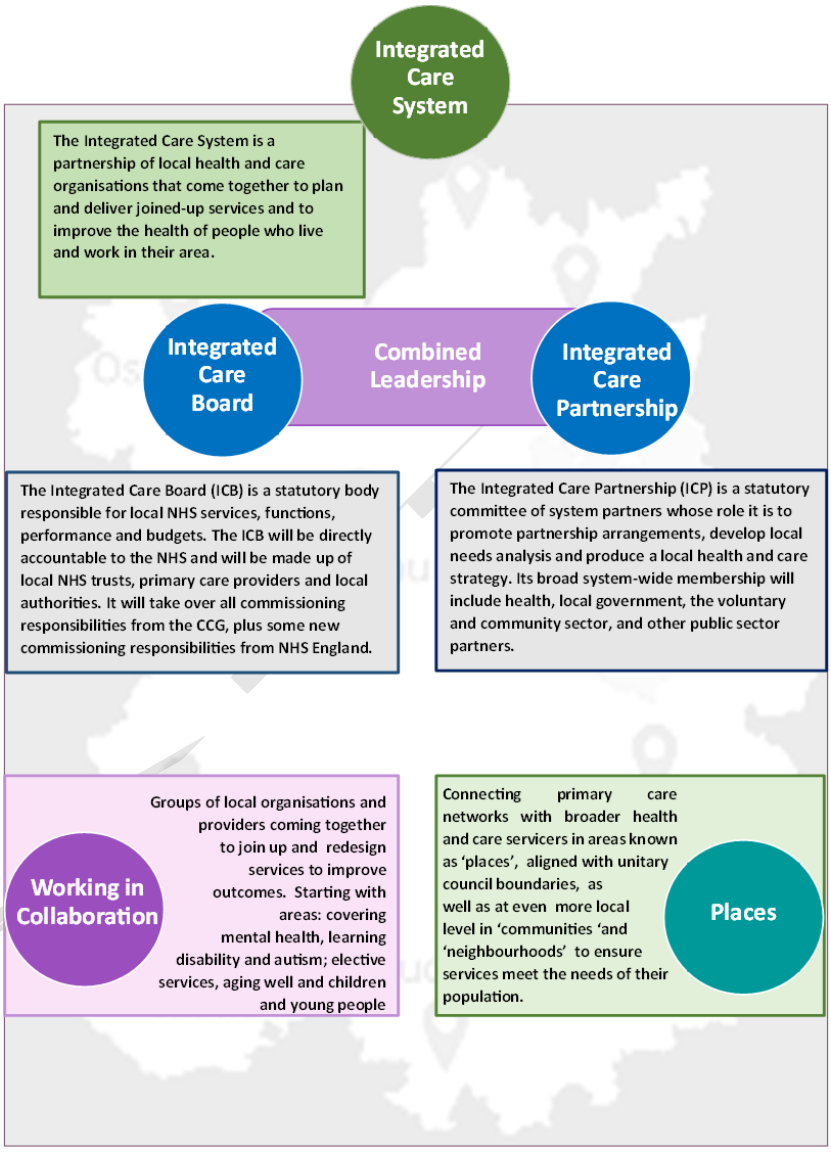
We must not forget that there are also key enabling factors that support the delivery of our plan, such as workforce, technology, research and innovation, the Green Agenda, and finance. This plan outlines the actions we will take in each of these areas.

In conclusion, this plan highlights the vast amount of work that we are undertaking across the ICS to improve the care we provide for the citizens of STW. We understand that this is an ambitious plan and that there is a lot of work for us to do, but we believe that it is achievable. All of our partner organisations are committed to pulling in the same direction in order to improve the lives of STW citizens.

Chapter 1: Our Integrated Care System (ICS)

1.1 Background

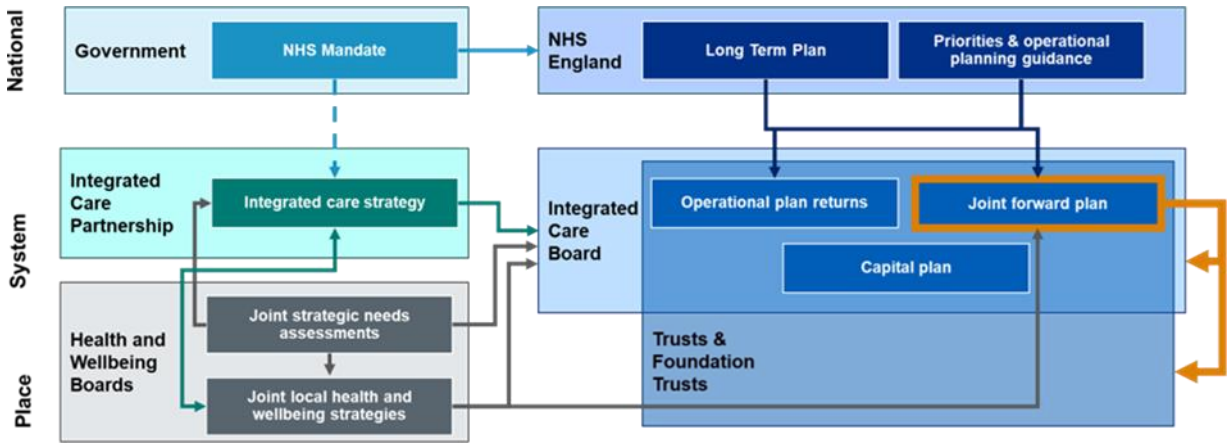
Our Integrated Care System has developed this Joint Forward Plan, which describes our system's ambitions, how our system will deliver these ambitions, and how we will facilitate joint action over the next five years. We have taken stock of the great work underway and aimed to provide a clear picture of our direction of travel and the alignment of plans across our partners and places. The different components and functions of the ICS are described in the diagram to the right.



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.

The diagram below indicates the framework within which the plan exists:

Statutory framework (not including interaction with wider system partners) relating to the JFP



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. As such, we have been working with organisations, in particular the two Healthwatches, to hear what our residents are telling us.

Residents have asked for 'A Person-centred approach to our care'. 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 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

The population we serve is diverse, with challenges set by our geography and demography. We have an ageing population. In the Shropshire Council area, 23% of the population is 65 years and over compared to the England average of 17.6%. Telford & Wrekin Council area has a greater than proportion than average of young people, but a rapidly growing older population, with the number of people aged 85 and over forecast to double in the next decade. One of the fastest growing local authority areas outside of London, the Telford & Wrekin population is both ageing and becoming more diverse. A largely rural Shropshire in contrast with a relatively urban, deprived Telford & Wrekin provides challenges to developing consistent, sustainable services with equity of access and long drive times to access acute services.

Shropshire, Telford & Wrekin can be described as a low wage economy; consequently, the wider determinants of health including education, access to employment and housing are important issues to consider when developing services that support good physical and mental health. Significant health inequalities are clearly apparent, particularly in Telford & Wrekin, and there are also health inequalities in specific neighbourhoods across the county.

The table below shows some of the key statistics:

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 & Wrekin live in the 20% most deprived areas nationally and some communities within the most deprived in the country.

Ethnicity

- In Shropshire, in 2011 there were approximately 14,000 people (5.6%) from BAME and other minority ethnic groups. Data suggests this has increased particularly in Eastern European populations.
- In Telford & 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%.

Access

- The access domain highlights significant areas of Shropshire, Telford & 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 & Wrekin – both in the highest quartile of local authorities nationally

The understanding of our population as indicated in the section above has informed the development of our plan.

1.3 Opportunities, Strengths, and Challenges

Being one of the smallest ICSs in the country presents us with challenges, but also with great opportunities. These are indicated in the diagram below:

Opportunities/Strengths

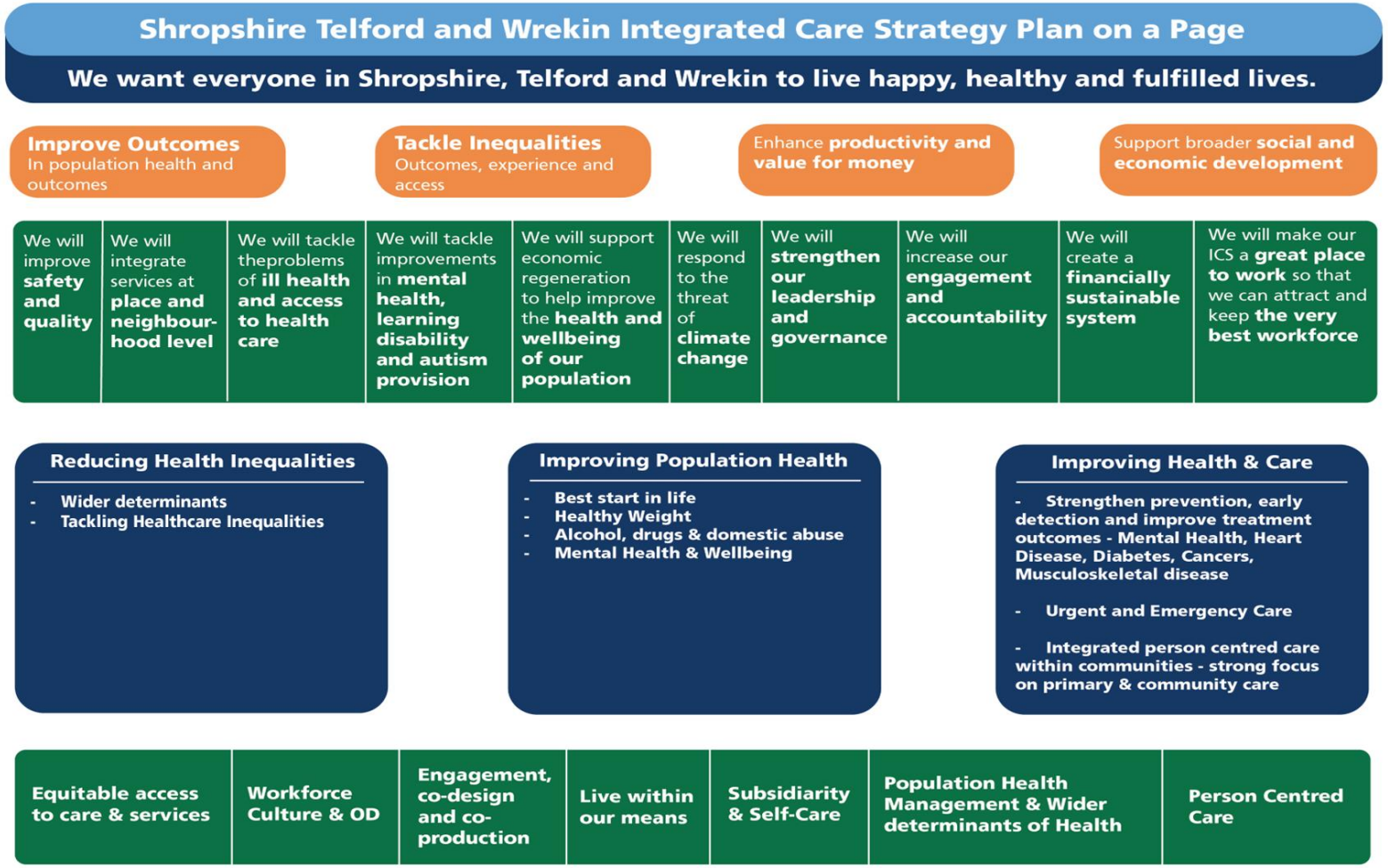
- **Our size:** We have significant opportunities to make large-scale changes, to shift our system culture and embed it in a manner that may not have been possible in a larger system.
- **Our leaders:** Leaders within the system have shown a significant willingness to rise to the challenge of being an ICS.
- **Our 'Places':** The diversity we see and understand across our two 'Places' means we are well positioned to maximise the impact on our populations.
- **Our dedication:** People both within our workforce and within our communities are actively facing up to the challenges we know we must tackle and are ready and willing to work together to do the right thing for our system.

Challenges

- **Quality:** Shrewsbury and Telford Hospital (SaTH) remains rated as 'inadequate' and is in 'special measures' for quality reasons.
- **Service Recovery:** Challenges remain in delivering several constitutional standards
- **Workforce:** Our whole system faces significant challenges in recruitment and workforce shortages creating further operating and service restoration challenges.
- **Sustainability:** On the 13th July 2021 our system was formally placed in the national Recovery Support Programme (RSP) because of being assessed at segment 4 of the NHS Oversight framework (NOF4). This is due to serious, complex, and critical quality and finance concerns within our system that require intensive support.

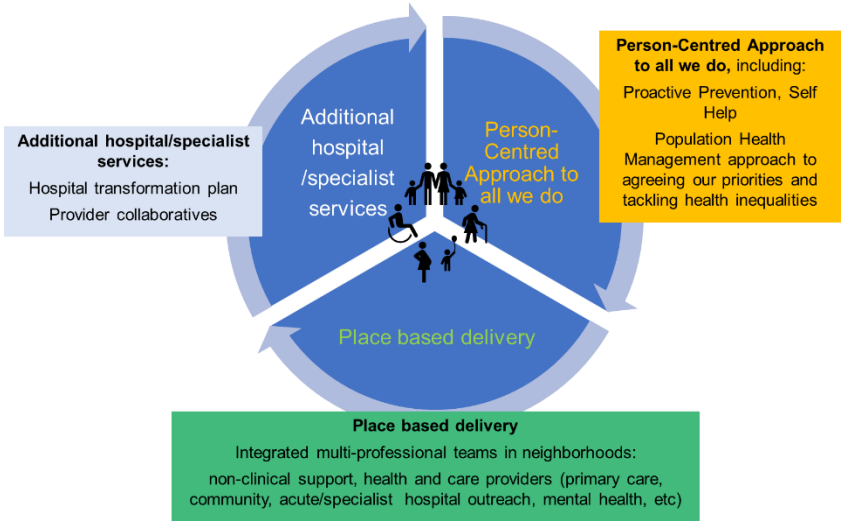
1.4 What do we want to achieve?

Within the context described above, our ICS Vision, Pledges and Strategic Priorities are summarised in the diagram below:



1.5 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 in the diagram below:



The remainder of this plan is structured around these three components, with a chapter on each. The plan then outlines the enablers that will be required for these three components to be delivered. We want to be clear on how these three components and the priorities will be delivered. In this regard, the table below shows how the ICS priorities align with our Place priorities. We intend for our two Places to play a major role in delivery of our priorities, and therefore you will see many of the priorities delivered at Place level:

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: • Cancer and cancer screening • Heart disease & screening • Diabetes • Annual health checks for severe mental illness, learning disabilities, Autism • Vaccinations and immunisation • Preventative maternity 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	-	-

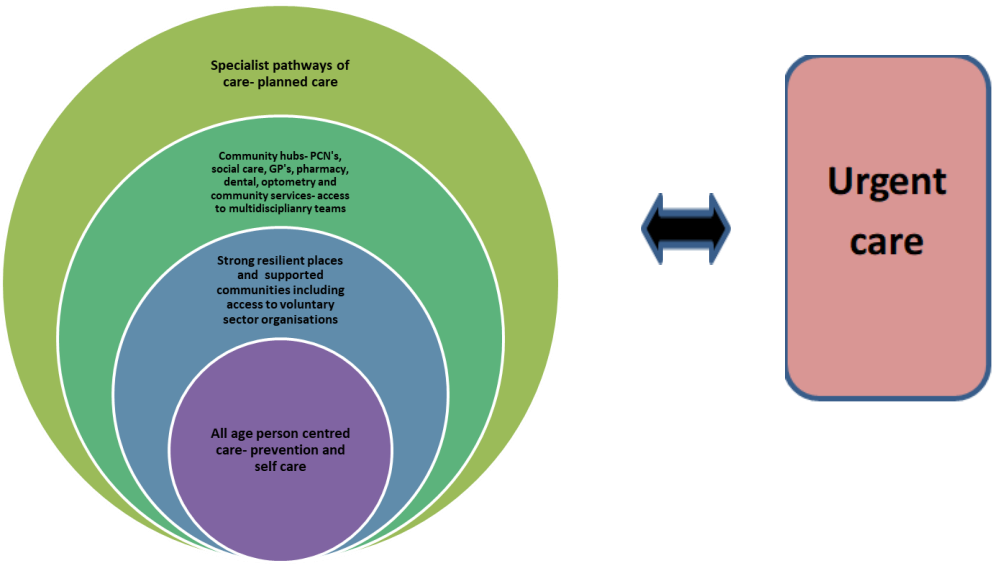
Case study – Healthy Lifestyles Service - part of the Teldoc Diabetes Pathway.

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.

1.6 Our proposed 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 proposed model of care is designed to take the views of our communities into account.



Our proposed model starts with keeping well and health, prevention and self care are at the heart of the model support 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 will be 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 approach and supported by our community services.

Finally, 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.

1.7 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 aspiration to create outstanding quality by:

- Committing to patient-centred, personalised care where patients have ownership of their own care, and routinely inform development and delivery of future services based on 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.
- The Health and Care Act 2022 gives the Care Quality Commission (CQC) the power to assess whether integrated care systems are meeting the needs of their local populations. Through specified ratings the CQC will be able to understand how integrated care systems are working to tackle health inequalities and improve outcomes for people and provide independent and meaningful assurance to the public of the quality of care in their area.
- We will be supporting our health and care providers to achieve best possible Care Quality Commission (CQC) ratings where possible.

There are some key areas where we need to improve the 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 also 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 and a simplified urgent care system, providing care 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.

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

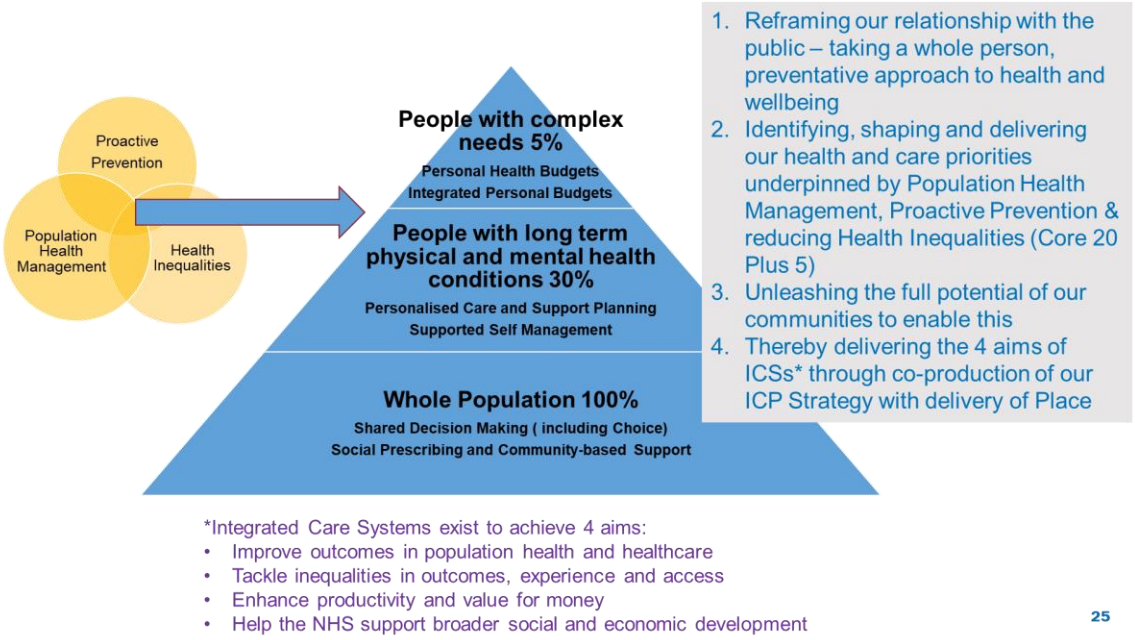
How will we monitor quality?	How will we measure and sustain quality?	How will we improve quality?
• Listening to those with experience of care. • System Quality Risk Register. • System risk escalation.	• Executive champions of quality health and social care coming together at System	• Integration of quality improvement expertise into system priority programmes. • Research and innovation.

• System Quality Group and Regional Quality Group. • The Quality and Performance Committee seeks assurance. • Learning from deaths, CDOP, infant mortality & LeDeR. • The co-ordinated introduction of PSIRF and learning from incidents, driven by Patient Safety Specialists and Patient Safety Partners. • ICB receives exception reports.	Quality Group to drive quality services. • System Quality Metrics. • Contracts and local quality requirements. • Themed quality visits. • Partnering with Healthwatch and the voluntary sector. • Co-production with those who experience care. • Feedback from our residents. • Quality accounts. • Rapid learning from incidents and themes across partners.	• Finding out what works through Quality Improvement Projects. • Focus on personalised palliative and end of life care. • Aging well though support of care homes and domiciliary care. • 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, which is the first component of our plan.



We will take the following actions to deliver this approach:

Action	Owner	Timescale
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 VCSA 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 Joint Commissioning and delivering integration

Joint commissioning refers to arrangements in which public bodies look to undertake the planning and implementation cycle 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.

In particular 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. The core of our model is people and communities, with public services working together to support people to build the foundations for a healthy and fulfilling life.

The model on the right demonstrates this people and community centred approach that is echoed throughout all 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.

2.3 Provider Collaboratives

Provider Collaboratives are under development 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

2.4 Proactive Prevention

The individual, social, and economic impacts of preventable ill health are extensive. 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.

Through this work we aim that communities will be connected and empowered, with services available closer to home, based on the health and care needs of the person. People will stay healthy for longer, and clinical and care outcomes will be optimised, and people will feel supported throughout their lives. Services will be responsive and innovative, engaging with local people, and making use of technology. The following actions will be taken:

Action	Owner	Timescale
Agree a set of values, standards, beliefs and ways of working	TBC	TBC
Agree and implement an effective method to gather and use multi-agency intelligence across the system	TBC	TBC
Engagement/Consultation with internal and external stakeholders for each of the priority programmes	TBC	TBC
Identify the opportunities for proactive prevention, reducing inequalities, and increasing self-management for each of the priority programmes	TBC	TBC
Ensure all information is accessible	TBC	TBC
Agree a communications strategy to ensure messaging is consistent and clear across the system	TBC	TBC
Make best use of available technology to improve coordination of care, communication, understanding and monitoring of health.	TBC	TBC
Workforce development through education and training and development of new roles and new ways of working.	TBC	TBC

2.5 Our approach to tackling Inequalities

Our Proactive Prevention approach defined above will help us to tackle inequalities. We know that there are differences in services across the county which we need to reduce. Together we want to tackle the causes of the problems such as loneliness, poverty and obesity, and work differently so that services are joined up, making the most of new digital technology and using buildings that are fit for the modern day.

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

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

Core20PLUS5 Clinical Areas of Required Acceleration for CYP (Operational plan and NHSE Priority)

- Continuous Glucose Monitoring
- Asthma
- Access to MH Services
- LDA access to Epilepsy Nurses
- 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 at this stage, from an NHS perspective. STW's evaluation has provided an opportunity to encourage cross-system learning to improve the current approach to health inequalities at both topic and system level. Significant progress has been achieved during the first year of implementation and the process of evaluation in itself, has helped to focus minds providing additional opportunities to improve knowledge, increase coordination, accountability and commitment.

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.	• Reaffirm system leadership which champions HI improvement. • Secure additional PMO resource to drive progress. • Develop a re-focused 2023/24 HI Implementation Plan which focuses on key areas of improvement and identifies strong impact outcomes.		

	• 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). • Explore how we can assist our Providers to take forward the HI asks within the Operational Plan. • Ensure CYP Core20PLUS5 Objectives are embedded through governance.		
Assess how dedicated HI roles contribute to success.			
Identify baseline staff competencies and capacity to rapidly increase knowledge and skills on HI.	• 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.		
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.		

Case Study: The Power of 10

This project forms part of an 'Early Intervention' Pilot aimed at developing more effective collaborative working between the statutory and community sector to improve outcomes for local people. Delivered from the vibrant community wellbeing centre in Oswestry, ten young people on the verge of exclusion are invited to join a ten week programme which, led by The New Saints FC Foundation in partnership with Marches Academy Trust and West Mercia Local Policing Team, is based on a central theme of sport/physical activity as the 'hooks' to engagement

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.

2.6 Duty to address the particular needs of victims of abuse

We have a duty to address the needs of victims of abuse in our area. People can be victims of a range of different types of abuse, such as Domestic Abuse; Sexual Abuse; Child Sexual Exploitation; Criminal Exploitation; 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.

We will take the following actions:

Action	Owner	Timescale
Complete IITSCE health actions	ICB Chief Nursing Officer	31.12.24
Implementing the Liberty Protection Safeguards	ICB Chief Nursing Officer	in line with national timescales
Implementing the requirement of the Serious Violence Duty in line with Safeguarding Partnerships	ICB Chief Nursing Officer	in line with national timescales
Build pathways for supporting victims, based on knowledge and information	TBC	TBC
Working with schools and education establishments regarding abuse	TBC	TBC
Engage with Children and Young people in our plans	TBC	TBC

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 the 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). Through the Health and Wellbeing Boards, SHIPP and TWIPP are accountable to, and rooted in, communities.

The role of SHIPP and TWIPP is to implement proactive prevention, reduce health inequalities, and improve outcomes for the local population: therefore being the delivery function of much of what is described in Chapter 2 above. They will also progress the delivery of integrated care through provider collaboration and developing new models of provision to meet the needs of the population in a sustainable way.

SHIPP and TWIPP reflect the identity of each of the places and benefit from the assets and strengths of the communities within place. At the same time, however, they ensure that standards of access and quality do not vary. They connect across STW, therefore, to ensure that the evidence of the most effective prevention, population health and care models are applied in every neighbourhood.

As our system matures the role of place will also further develop. Over the next three years the following development plan has been identified to ensure that place is able to achieve its role:

<table>
<tr><th></th><th>Year 1 (2023/24)</th><th>Year 2 (2024/25)</th><th>Year 3 (2025/26)</th></tr>
<tr><td rowspan="4">System/Place developments</td><td>Align the place boards as committees of the ICB</td><td colspan="2"></td></tr>
<tr><td>Confirmation of place-based structure to support place function</td><td colspan="2"></td></tr>
<tr><td>Development of place-based branding that all partners, and residents, can identify with and agree to use (e.g. Stronger Together,)</td><td>Place-based branding in place</td><td rowspan="2"></td></tr>
<tr><td colspan="2">Developing and agreeing a model of delegation from system to place</td></tr>
<tr><td colspan="2" rowspan="2"></td><td>Financial delegation model in place (Health and LA)</td></tr>
<tr><td>Resources are allocated to place to support the delivery of priorities</td></tr>
<tr><td rowspan="5">Changes residents will experience</td><td colspan="3">Strategies and plans are integrated at place</td></tr>
<tr><td colspan="3">Residents start to have one conversation about their health and care concerns</td></tr>
<tr><td colspan="3">Residents are more involved in developing their health and care system/services</td></tr>
<tr><td colspan="3">All partners working together to resolve system and place challenges</td></tr>
<tr><td></td><td colspan="2">Residents start to see more opportunities to prevent escalation of need</td></tr>
</table>

		Residents start to see more integrated services delivered at place, and sub-place depending on need.
		Residents start to see more health and care resources allocated to address specific health inequalities

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 as shown in the table below, are based on engagement and insight with our residents and intelligence from the JSNA on local health and wellbeing outcomes and inequalities gaps. As well as key local health and wellbeing challenges, the priorities recognise the wider determinants of health, including housing and homelessness, economic opportunity - poverty, employment and the cost of living, and the impact of living in our communities. Our life course approach provides the opportunity to identify key improvements needed to improve outcomes for residents at all stages in their lives. 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 & Wrekin Integrated Place Partnership

The Telford & Wrekin Integrated Place Partnership (TWIPP) has been in its current format since March 2019 and 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. It is worth noting that whilst the priorities, and associated deliverables, are looking to be delivered at place currently no delegation of budget or resources from the system is in place to enable this to happen. This is an identified risk to delivery. The below table demonstrates the alignment of 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	Best start in life SEND & transition to adulthood

	SEND	
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

Supporting the implementation of the Strategic Plan is a set of actions for the ICB and 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)	Deputy Director: Partnership and Place, 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	April 2024

	& Deputy Director: Public Health, TWC	
Deliver Start for Life and Family Hub transformation programme	Deputy Director: Public Health, TWC & Group Specialist, Family Hubs, TWC	April 2024
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	April 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

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 has been 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 received 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".

3.3 Shropshire

Shropshire Health and Wellbeing Strategy

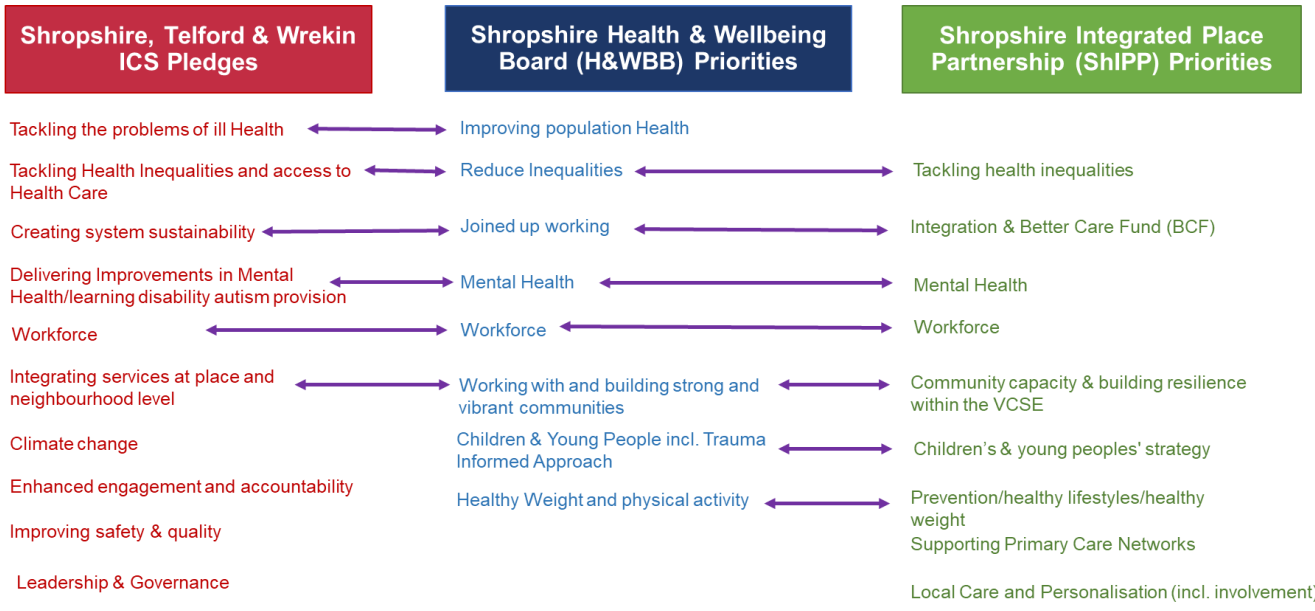
The Shropshire Health and Wellbeing Board acts to ensure that key leaders from the health and care system work together to improve the health and wellbeing of Shropshire residents. Board members collaborate to understand their local community's needs, agree priorities and work together to plan how best 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

As a subgroup of the Health and Wellbeing Board and the Integrated Care 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:



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

Action	Owner	Timescale
Deliver the all-age Local Care Programme across communities in Shropshire	TBC	TBC
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.	TBC	TBC
Develop more Health and Wellbeing Centres; Oswestry, Highley, Ludlow, Shrewsbury, that include MDT approaches.	TBC	TBC
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	TBC	TBC
Social Prescribing expansion into A&E, midwifery, children, young people and families and local health and wellbeing centres.	TBC	TBC

3.4 Local Care Transformation Programme (LCTP)

The Local Care Transformation Programme (LCTP) is one of the 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:

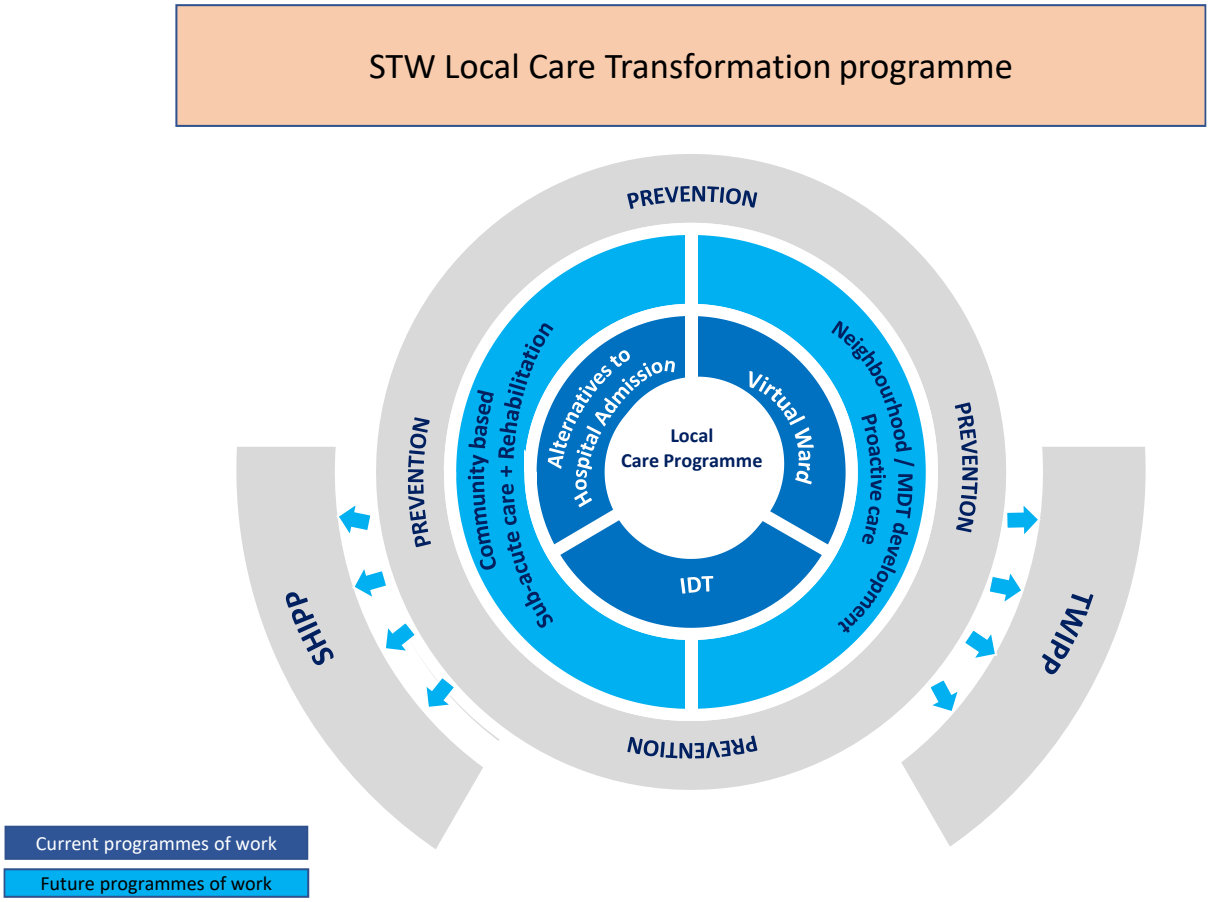
- **Implementing alternatives to hospital admission**, providing 2-hour rapid response in the community
- **Setting up of a Virtual Ward** providing sub-acute care in the place people call home that would otherwise need to be provided in an acute hospital, thereby providing an improved experience for 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 is anticipating to 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 to receive sub-acute medical care at home
- **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 strategic direction of 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, we will develop a strategy and framework for developing neighhourhood based multi-disciplinary teams providing joined up, proactive and preventative care to cohorts of people based on population health management approaches and data. This will enable STW to target support to individuals and families that will help to tackle inequalities and drive improvements in health and wellbeing. The implementation of neighbourhood based multi-disciplinary teams will be a multi-year programme of change. One example of MDT working include supporting people with frailty and multiple long term conditions to manage their conditions as best as possible, to maintain independence for as long as possible, to tackle loneliness, to support overall mental health and well-being, and to avoid preventable exacerbations that could otherwise lead to a hospital admission.

The scope of the programme is summarised in the diagram below, noting the importance of place based delivery for many of the Local Care initiatives, in particular for neighbourhood multi-disciplinary team working. The transformation initiatives within Local Care are inextricably linked with our intentions for a

more proactive approach to prevention (see section 2.2). Work is underway with system partners to refine our priorities and assign clear responsibilities for the delivery of future programmes of work. Our goal is for the Local Care Programme to provide strategic direction and support to a range of staff working hard across our system to implement more systemised, integrated and preventative models of care. 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 NHSEI to help provide the necessary infrastructure to enable the programme to achieve this strategic role.



The LCTP will deliver on its' ambition to deliver more joined up and proactive care closer to home through six critical programmes of work, as described within the table below:

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	TBC

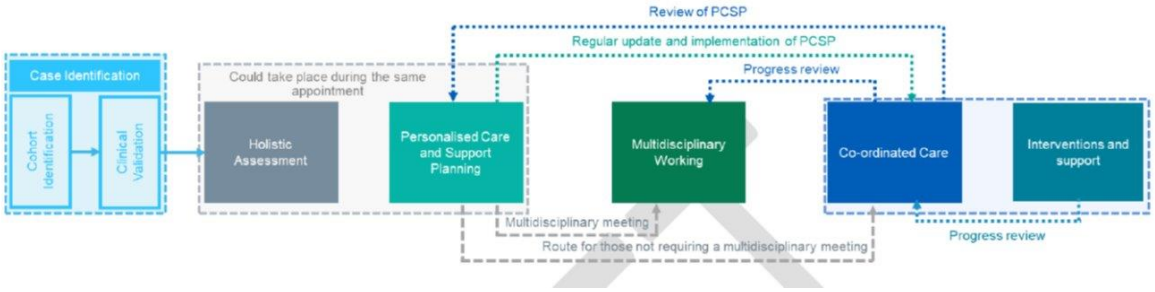
By delivering these six critical programmes of work we will:

- 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

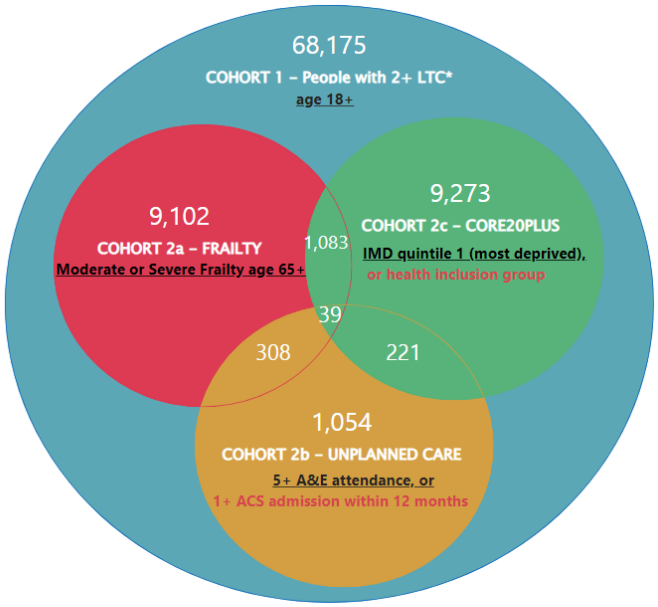
- Develop a deeper understanding of the needs of our population and make demonstrable progress in tackling health inequalities
- Focus rehabilitation services to help people maximise their functional outcomes and independence, focusing on the personal goals that matter most to patients
- Enable our staff 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

3.5 Proactive Care (Previously Anticipatory Care)

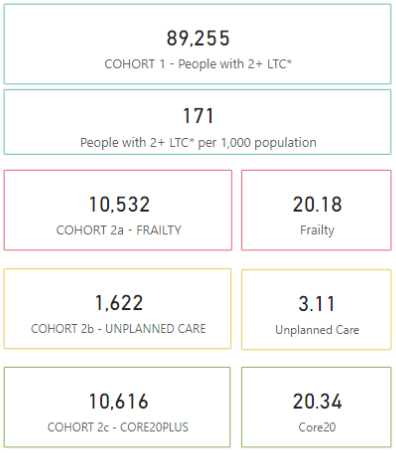
Proactive Care is a key workstream of the Local Care Transformation Programme (linked to programme 4). It is a model of care, delivered in the community, to a targeted cohort of patients with multiple long-term conditions who would benefit from integrated care to support management of their conditions. 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. The key components of the model are as follows:



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. The scale of the target cohort across Shropshire, Telford & Wrekin can be seen below in the diagram:



figures **included**/tbd



Data exclusions*	Data-driven exclusion applied
Individuals requiring specialist palliative care (these individuals should be identified through clinical validation so as not to exclude those receiving routine end of life care).	No
Individuals living in care homes	Yes
Individuals with mental health conditions but without physical health needs	Yes

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.

During Q2 and Q3 2023/24, colleagues across the system including PCN clinical directors, social care, voluntary sector and place colleagues will be coming together to develop a framework for the further roll out and implementation of the proactive care model, supported by a strategy for expanding the roll out of neighbourhood based multi-disciplinary teams. The development of strong neighbourhood based multi-disciplinary teams is critical to the delivery of proactive care for people with frailty and multiple long-term conditions.

Action	Owner	Timescale
Framework to guide the further roll out and expansion of proactive care delivery across STW	Director of Strategic Commissioning	Q3 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. 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.

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. We propose to have an integrated primary care service, providing streamlined access to care and advice; 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 laid out in the table 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 approaches 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 operates a patient-focussed approach to getting the best possible outcomes for patients from the investment made in medicines. This requires a holistic approach, an enhanced level of patient centred professionalism, 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 [link will need to be added to updated strategy – aim for this end Jun 2023] 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 Stregy by July 2023

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

3. Community and Voluntary Sector

Our system has a wealth of experience via the CVS. During the Covid-19 pandemic the CVS delivered an unprecedented level of services to our communities. However, as a system we need to support the CVS ambition to deliver well resourced services to our places, neighbourhoods and communities.

Action	Owner	Timescale
Include the CVS at the earliest opportunity of development of our health and care pathways- co-production	Director of Partnerships and Place	Ongoing
Agree longer term contracts with the CVS to enable sustainability, delivery and assessment of impacts and outcomes	ICB Contracts team	
Use the expertise of CVS when developing our person-centred approach and training to health and care staff	Director of Partnerships and Place	April 2024
Use the CVS knowledge and experience to transform services within our communities, so they deliver the model of care	Director of Partnerships and Place	April 2025
Work to support the CVS 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/Clinical services

4.1 Hospital Transformation Programme (HTP)

Our Hospital Transformation Programme is a key part of the bigger picture for our patients and communities. We are trying to address the following challenges:

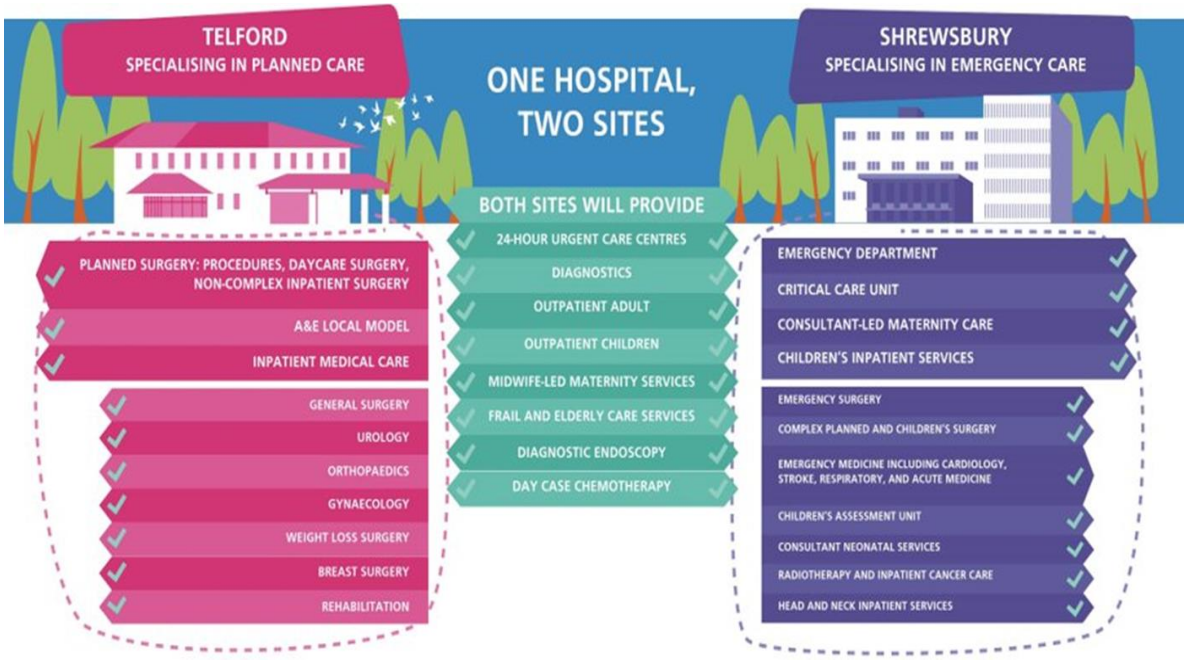
- We have two inadequately sized emergency departments, split site delivery of key clinical services (including critical care), insufficient physical capacity (particularly affecting planned services), mixing of planned and unplanned care pathways, and poor clinical adjacencies.
- The current clinical model is not fit for purpose for the current population due to an outdated service configuration
- Our workforce situation is not sustainable if we continue to duplicate services across both sites
- The needs of our population are changing

- Our buildings do not give us the capacity, space or layout we need for modern healthcare
- The local health system has one of the largest financial challenges in the NHS

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
X	TBC	TBC

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.

The ambition of the programme is to:

- review and redesign services with service users and providers around patients' needs
- provide high quality citizen-centred services
- ensure timely, safe, effective, and sustainable care
- provide a seamless care experience
- ensure 'right time, right location, right person'
- ensure integration across primary, community and secondary care
- reduce duplication and improve resource efficiency, ensuring value for money

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 you may no longer need to visit a hospital, this is also generating 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
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	2021-2027
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

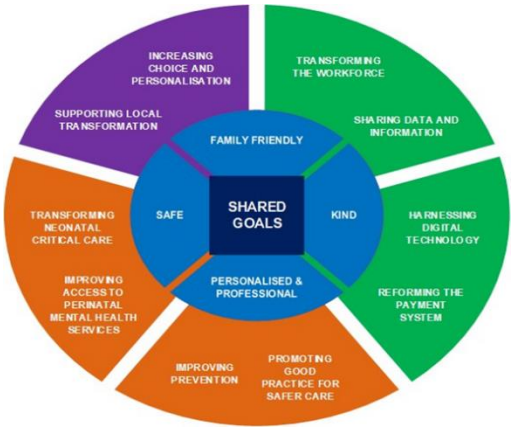
Maximised use of new technologies, approaches and innovation	Programme SRO, Clinical Lead and Programme Lead	2021-2027
Optimise use of available resource and value for money, including staffing, time, and clinic space	Programme SRO, Clinical Lead and Programme Lead	2021-2027
Contribute to system workforce 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).

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
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.	STW Senior Responsible Officer, Clinical Lead and Commissioning and Contracting Lead	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 Officer, Clinical Lead and Commissioning and Contracting Lead	March 2026
Offer support for families and loved ones in the care of someone that is dying and after their death		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	STW Commissioning and Contracting Lead System Communications and Engagement Lead	April 2024

the public to shape how we might deliver these subjects.		

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 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
Reduce the number of 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,	Clinical Strategy Lead	April 2024

reduction of 12hr waits by 50 per day and a reduction in ambulance delays by 10 per day)		
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	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
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	TBC
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	TBC

Clinical Strategy Priority 3 – Cardiac Pathway

In line with national and local requirements we plan to:

Action	Owner	Timescale
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
Reduce hospital spells for diabetic foot issues and the relative number of diabetic lower limb amputations by 15 per 100k population by April 2024 and the number of 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.

Adult Mental Health

Community mental health transformation programme:

- Over the next two years we will continue to develop and increase our support offer closer to general practice and to reduce gaps in service. Our ambition is to improve access times to 4 weeks from referral to assessment for all. We will develop robust pathways between primary care services and NHS Talking therapies and crisis teams.
- We will also focus on the physical health needs of those with severe mental illness ensuring that the GP registers are accurate and that all those individuals are invited for an annual health check. Our ambition is that equivalent of 70% of those on GP registers will have an effective annual health check with follow on activities to improve outcomes with a focus on health inequalities and access to services. We will increase near patient testing to provide a one stop shop approach and will work

with third sector to support those individuals who require it to attend for the checks. If some individuals are unable to attend, we will offer an outreach service.

- With communities facing a cost-of-living challenge, we will through the charitable sector, embed designated roles to support people living with SMI to easily access housing and debt advice.
- For those individuals who need to develop their skills to live in the community, our community rehabilitation team is developing and will support the repatriation of individuals who are at this time being supported away from their family and home area. We are working closely with LA colleagues to ensure we have robust care providers and accommodation to meet the needs of individuals.
- Adult eating disorders services have seen a huge increase in referrals since the pandemic and we will focus on providing support earlier for people. Our early intervention FREEDS model will be developed in 2023 and we will also develop SEEDs for more complex longer-term individuals.

Action	Owner	Timescale
Implement the Community mental health transformation programme	Clinical Strategy Lead	TBC
Increase the proportion of ED patients seen within the standard timescale. Initial focus to ensure national average of 85% urgent and 64% routine is achieved by April 2024. Further plans to be developed to increase the proportion to 95% by April 2025	Clinical Strategy Lead	April 2024 April 2025
Increase the number of patients accessing IAPT services by 11.6% April 2024 and a further 10% by April 2025 taking the total number of people accessing IAPT services to 2600 (increase of 560 patients)	Clinical Strategy Lead	April 2024 April 2025
Reduction in out of area placements by 30% by April 2024 and a further 20% by April 2025 whilst irradicating inappropriate out of area breaches by April 2024	Clinical Strategy Lead	April 2024
Increase dementia diagnosis rate to 66.7% by April 2024	Clinical Strategy Lead	April 2024
Clinical Initiatives to support include: • Detection and early intervention of dementia • IAPT development • CYP mental health transformation plan • Out of area review • Eating disorder service development Neurodevelopment service	Clinical Strategy Lead	TBC
Increasing our emphasis on recovery and on positive risk-taking supporting the work on suicide prevention, stepped care rehabilitation pathways, reducing out of area placements and strengthening the overall community services.	Clinical Strategy Lead	TBC

Crisis support

Over the next two years we will:

Action	Owner	Timescale
Undertake a demand and capacity review to determine our local needs		TBC
Implementing 111 Option 2 for all urgent calls being directed to our local 24/7 access professionals	TBC	TBC
A robust offer to reduce suicide and a robust pathway for bereavement support	TBC	TBC
Increase our offer to support individual prior to reaching a crisis.	TBC	TBC
Develop robust pathways into VCSE support with a focus on Twight 6pm-2am shift including closer working with urgent and emergency care (ambulance and police).	TBC	TBC
Develop nonhospital crisis beds with the third sector to reduce hospital admissions	TBC	TBC
Extend our offer to the homeless community and ensure robust pathways into substance misuse and secondary mental health services.	TBC	TBC
Develop an all age HBPOS offer with staff skilled in both adult and Children mental health.	TBC	TBC
Continue to work with West Midlands ambulance service to develop mental health support within their offer. Including mental health clinicians working in the control room, increased mental health training for all ambulance staff and a mental health response vehicle to support those who require crisis support their mental health.	TBC	TBC

Children and Young People's (CYP) Mental Health

During 23/24 we will be engaging on a Children and Young People's (CYP) Local Transformation Plan (LTP). The plan will capture the current levels of need, and the work undertaken in recent years to develop a 0-25 years emotional health and wellbeing service as well as the future improvements that still need to be undertaken. In common with CYP mental health services nationally we know there has been a step increase in the number of referrals received, in particular for core mental health services and autism assessments. Urgent demand and capacity modelling is underway to understand the new levels of service provision needed and the extra services needed to restore waiting lists back to target.

The process of jointly developing the CYP LTP will assist in improving our collective understanding of the strengths across our system, as well as the important and distinct roles of the various statutory and voluntary and community sector colleagues in delivering it. The overall shift has been to move to a greater understanding of the importance of prevention and early intervention. Key to this is improving our system understanding of the impact of adversity on the developing brains of our young people, and of the negative impact of adverse childhood experiences (ACEs) in later life.

Action	Owner	Timescale
Develop the Children and Young People's (CYP) Local Transformation Plan (LTP)	TBC	TBC
Demand and capacity modelling to understand the new levels of service provision needed and the extra services needed to restore waiting lists back to target.	TBC	TBC
Run a pilot service in Telford & Wrekin - aims to develop a small caseload with strong multi-disciplinary teams (MDTs) around the families to reduce the number of children entering care. The MDT will focus on substance misuse, adult mental health and CYP mental health and domestic violence.	TBC	TBC

Older People's Mental Health Services

We wish to see older people having access to the same services, or services of equivalent quality, to those for adults of working age. The principles set out above for community, crisis, and rehabilitation services should therefore all be read as also applying to older people, within an all-age service model. Effective care and treatment mean managing the process of increasing frailty over as long a period as possible, and whilst maintaining the highest possible quality of life – for the person with dementia, and for their carers and family. This process needs to begin with post-diagnostic support and continue through to end-of-life care. Effective support for families and carers is essential.

Actions	Owner	Timescale
Review our core offer to ensure that the full continuum of mental health conditions is reflected and understood. This will include a review of the numbers, function and location of beds as well as the crisis and community models, which help to keep people at home and avoid hospital admission.	TBC	TBC
Work more closely with the acute general hospital care system to ensure high quality, timely discharges for people experiencing mental health problems.	TBC	TBC
Continue to work up the actions from the existing dementia strategy to meet the rising demand for older people's mental health services which are inextricably linked to our aging population.	TBC	TBC

Learning Disabilities and Autism

Collectively as a system we have an ambition that children and young people with Special Educational Needs and Disabilities (SEND) should be supported and enabled to be healthy, happy and safe, and able to achieve their potential to lead a fulfilling life. Over the course of the next 2 years we aim to develop a system wide SEND outcomes framework, coproduced by all partners including CYP and their families STW has a strong history of parent / carer representation who have already commenced work around exploring what this could mean based on work developed previously. We will:

Actions	Owner	Timescale
Reduce unwarranted lengthy inpatient stays for those with LD&A by: – Delivering the inpatient target by robust management of these patients when they are in beds but also by using the Dynamic Support Registers to identify those at risk of admissions and then provide an integrated system response. – Focusing on accommodation which continues to be an issue for this LDA cohort, we will work with housing providers, landlords and care providers to ensure we have a robust local offer to meet people's needs; including for people with the most complex behavioural needs.	TBC	TBC
Reduce health Inequalities for those individuals on the LD&A General Practice registers: – We will review the accuracy and size of registers in General practice with a real focus on 14–25-year-olds many of whom have not been picked up since the changes in SEND policy. The system will map the present process of diagnosis for LD and develop a plan to close the gaps. We will review the quality and impact of the AHC and implementation of Health Action Plans.	TBC	TBC
Undertake a review impact of changes in MHA and the effect these have on the LDA cohort of individuals.	TBC	TBC
Develop integrated pathways with an integrated workforce and ensure a seamless high quality offer to the LDA community in STW.	TBC	TBC
Focus on health inequalities for this cohort of people not only reviewing their physical health needs but also support in the community and in employment.	TBC	TBC
Continue to run our key-workers project to support CYP and their families who are struggling and find navigating our complex system of support difficult.	TBC	TBC
Develop an integrated offer around the reduction of inappropriate prescribing for adults and children (STOMP/STAMP) and bring organisations together.	TBC	TBC
Develop robust pathways from referral to assessment within 18 weeks for adults with Autism Spectrum Disorder (ASD).	TBC	TBC
Raise the awareness of autism and what issues people may have as well as continue to expand the use of the Autism passport.	TBC	TBC
Develop services (which may include 3rd sector) for autistic people who don't meet current criteria for secondary mental health services.	TBC	TBC

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.

See Appendix …… for full case study

Specialist Mental Health Services

Perinatal Outcomes: As a system we will work towards achieving:

- 10% of all those giving birth having the opportunity to be supported by a specialist perinatal mental health team
- Support where required for those impacted by the Ockenden review

To achieve this, we will:

Action	Owner	Timescale
Continue to increase our offer with our very successful specialist perinatal services to ensure they continue to meet access targets and widen scope to ensure access to support for 2 years where required and interventions for partners.	TBC	TBC
We will review the demand and capacity of this service as access rates far exceed the national targets.	TBC	TBC
Ensure that the longest wait for Tokophobia and bereavement and loss are 4 weeks from referral to assess and treat.	TBC	TBC
We will work with West Mercia police to consider how we can support any individuals and families affected by Operation Lincoln.	TBC	TBC

IAPT Outcomes: As a system we will work towards achieving:

- As a minimum 12,948 individuals commencing treatment within the service during 23/24 with a commitment to continue to meet the national targets set on an annual basis

To achieve this, we will:

Action	Owner	Timescale
Rebrand our local service into NHS Talking therapies	TBC	TBC
Building pathways with Diabetes, respiratory and cancer teams, recognising the important connections between physical and mental ill health.	TBC	TBC

Dementia Outcomes: - As a system we will work towards achieving

- The diagnosis target of 66.7%
- Delivering the coproduced vision for dementia support across STW

To achieve this, we will:

Action	Owner	Timescale
meet diagnosis prevalence by providing assessment in primary and secondary care	TBC	TBC
deliver the dementia vision and strategy including some reconfiguration of workforce and introduction of some new roles across STW, for example Dementia Link Workers and Shropshire Admiral Nurses	TBC	TBC
Work with Primary Care (and then expand to all communities) to support them in becoming more Dementia aware	TBC	TBC
Provide a co –produced 'Living Plan' upon diagnosis	TBC	TBC
Develop peer support groups across the county which will be co-ordinated/facilitated by the dementia link workers	TBC	TBC
Undertake meaningful annual reviews where everyone involved in the persons care has the opportunity to contribute	TBC	TBC
Develop a respite offer for unpaid carers and increase awareness of dementia across the county.	TBC	TBC
Create virtual teams aligned to Primacy Care Networks so that people living with dementia and their unpaid carers feel well supported.	TBC	TBC

ADHD pathways Outcomes: - As a system we will work towards achieving

- An adult assessment service across STW with waiting times at 18 weeks form referral to treatment
- Robust Shared care arrangements with primary care
- Effective review and support for all those diagnosis with ADHD

To achieve this, we will:

Action	Owner	Timescale
Develop a robust assessment, diagnosis and treatment pathway and reduce the waiting list to 18 weeks for ADHD		2 years

Ensure there are clear shared care agreements in place and that there are processes for reviewing prescribing		
Mainstream services will be trained to ensure reasonable adjustments are made for those with ADHD		

We commit to adopting Trauma informed approaches

In STW there is a desire for services to be more trauma-informed and for the overall model of care to be a balanced bio-psycho-social approach with the need for a workforce that is much more psychologically minded, which supports individual recovery.

The main focus of all these developments is to encourage a profound culture change in services, towards an emphasis on what has happened to a person and not what is wrong with the person. Specifically, we will:

Action	Owner	Timescale
Support staff to help them focus on trauma.	TBC	TBC
Support the workforce with a culture change – shifting thinking from "what is wrong with you" to "what happened to you".	TBC	TBC
Integrate Trauma information into treatment plans and offer trauma-specific services.	TBC	TBC
Actively reduce or eradicate coercion and control, including medication as restraint, verbal coercion, threats of enforced detention etc.	TBC	TBC

Mental Health Provider Collaborative

We will explore 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.

Chapter 5: Enablers

5.1 People

Context

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

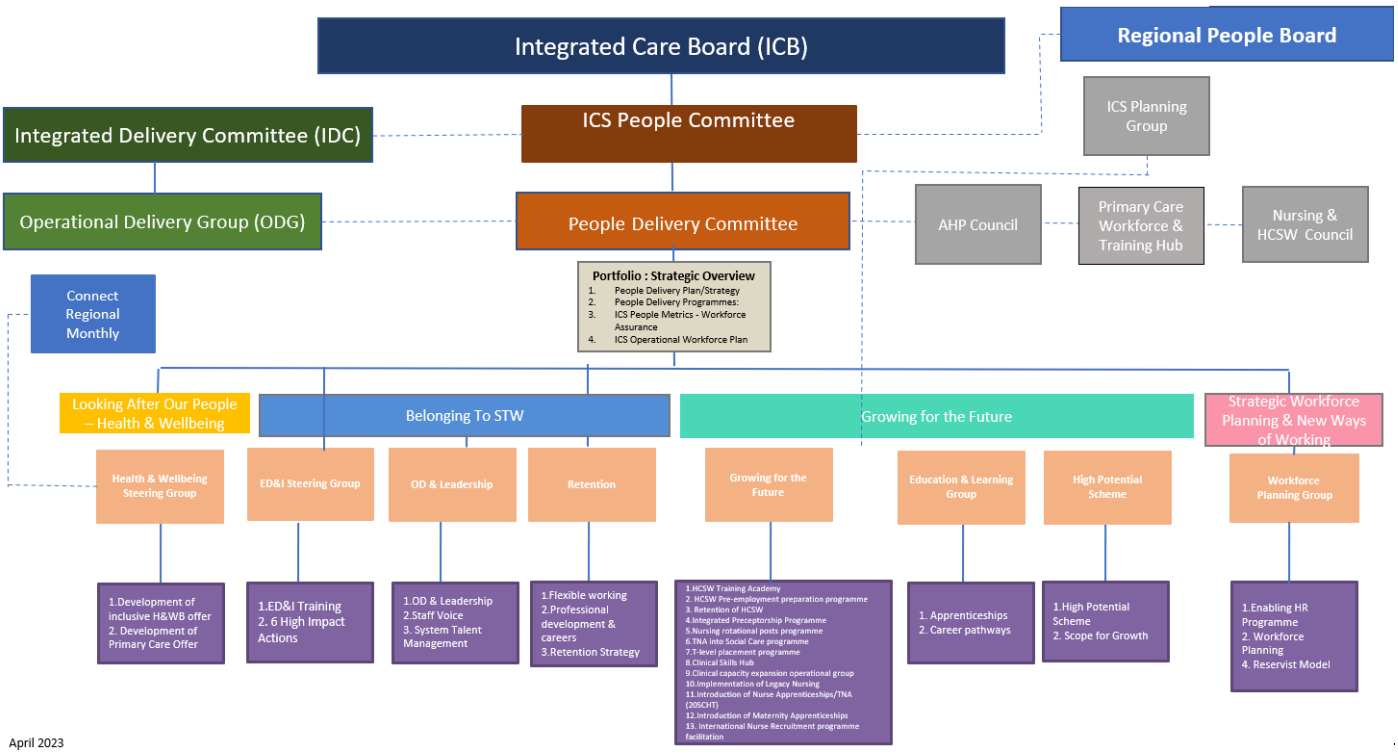
Recently our People Committee members and senior stakeholders have come together and co-created our People Strategy. This is a positive step towards working together with a shared strategic direction, underpinned by consistent and aligned organisational People delivery plans.

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.

Alignment to Portfolios and People Operating Model

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. Our current programmes, and the governance structure within which they sit, are set out in the diagram below:



Action	Owner	Timescale
Focusing on the recruitment, attraction and retention of staff from a range of diverse backgrounds to reduce agency spend and the workforce impact of high vacancy levels. This will be done through raising the profile and identity of working in Shropshire, Telford & Wrekin and promoting and offering transparent career pathways.	Chief People Officer	ongoing
Development and implementation of a Workforce Plan - addressing all areas of workforce including training and development and being focused in our pursuit of supporting, growing and seeking out talent and will explore opportunities across the system to share learning through talent management processes and the development of shared or rotational posts.	Chief People Officer	2023/24

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.

We have a portfolio of programmes, reflecting the key digital challenges identified across the ICS and solidifying our overarching vision. We are committed to enhancing our digital capabilities and maturity, through the effective management of data and the implementation and convergence of systems across all organisations affiliated with the ICS.

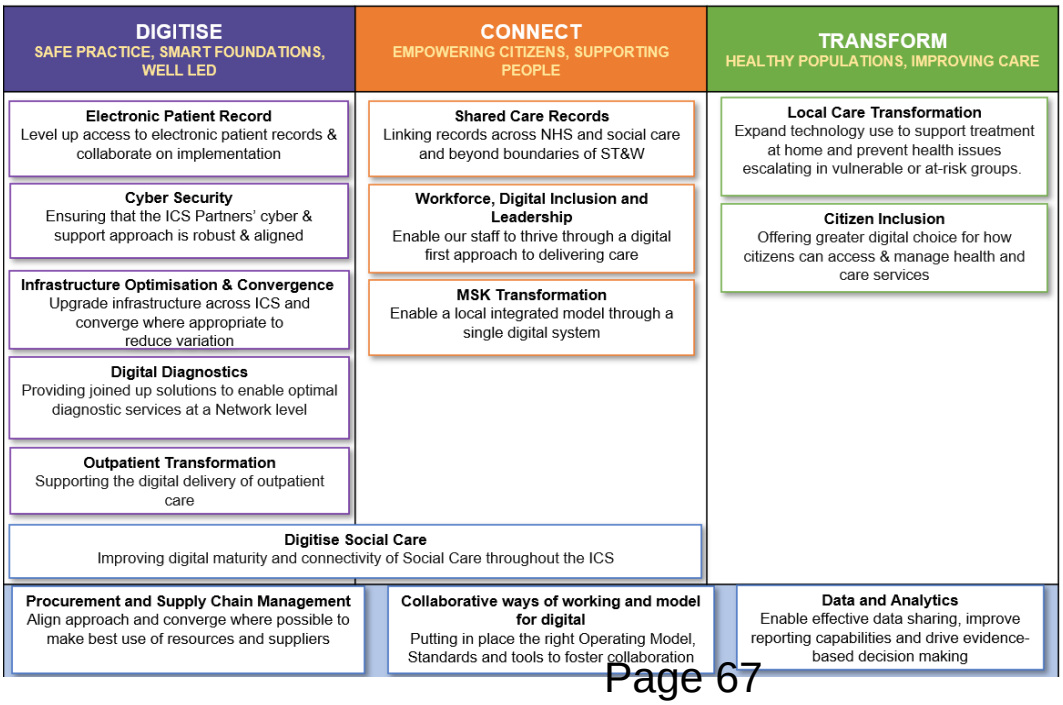
We recognise that there is a long way to go in our ICS digital journey, but by taking the initial steps to digitally transform and improve our technological capabilities, we are solidifying our commitment to excellence, and are aligned to the national focus to provide high quality care to patients, improving 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.

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:

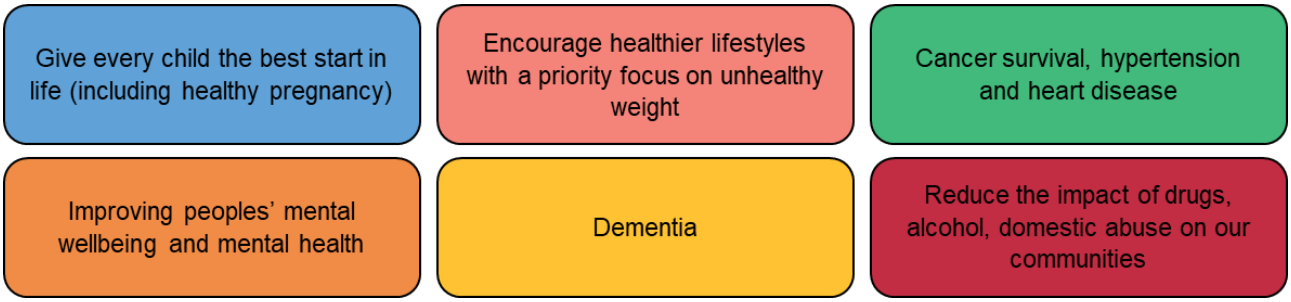
Action	Owner	Timescale
Embrace Digital into our culture	Digital Transformation Lead	2023/24
Learn and converge as an ICS	Digital Transformation Lead	2023/24
Streamline procurement across the ICS	Digital Transformation Lead	2023/24
Upskill workforce and communities in data literacy • Support the workforce through training modules to increase data literacy • work with the communities to increase digital health literacy • Provide a Digital resource to support and improve staff digital literacy skills	Digital Transformation Lead	2023/24
Work for patients collectively focusing on citizen inclusion in all digital decisions • Seek community feedback on existing digital functionality for managing own health, and input into digital developments • Include citizen engagement groups in the development of the ICS digital inclusion strategy • Identify the needs and preferences of the population across STW to inform and develop digital strategies	Digital Transformation Lead	2023/24
Govern and manage our digital portfolio together • Clinical input in digital transformation • Coordinated sharing of resources • Optimise digital services through engagement with strategic partners • Joined up approach across the system	Digital Transformation Lead	2023/24

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 the 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. It is a proactive approach that enables people who are healthy and well to remain healthy and well; as well as monitoring people who have increasing risk of ill health, and to support people to mitigate this 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:



These priorities will largely be delivered at Place level and more detail is provided on this in the next chapter.

5.4 Estates - System Estates Strategy and planned delivery

Update due Tuesday 26 May

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.

Priority areas of development identified for STW include:

- Re-provision of The Elms
- Redwoods C&YP S136 Suite
- Alternative estates for BEEU Services
- Some environmental changes to wards to improve safety, e.g. carriage of restricted items, fire safety

Action	Owner	Timescale
TBC	TBC	TBC
TBC	TBC	TBC

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.

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 eg the Local Care programme and MSK.

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

5.5 Our Commitment to Communication & Engagement

(update is being reviewed by Director of Comms and Engagement)

Communication and engagement are critical to the success of Shropshire, Telford & Wrekin joint forward plan. Only by working together as one with partners, key stakeholders, colleagues and the general public will we be able to achieve our ambitious plans. Good communications, engagement and involvement with stakeholders will mean:

- Increased awareness of STW as a system and our direction of travel.
- Involvement of all key stakeholders in shaping the services we plan, commission and deliver.
- Regular, clear communication about our plans that are easy to understand and access.
- Sharing system successes and opportunities across our workforce.

Our approach is 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. Will inform our stakeholders, engage with them in open discussions and co-design/ co-produce our services with them.

How we engage our different stakeholders:

Staff engagement - We work with communications and engagement leads in our different partner organisations to keep staff updated about ICS developments and to obtain their views. We use organisational communications channels including staff newsletters, intranets and face-to-face-staff briefings. We provide communications materials and templates to ensure that all staff across the ICS are receiving the same key messages. We encourage feedback and provide this to system leaders for them to take the views and suggestions of staff into account and inform their decision making.

Clinical engagement - (NW/AB to advise) We are committed to a clinically led system, by this we mean in its widest sense, including all health and care professionals across every discipline. We have a clinical prioritisation and design group as part of our system governance structure to ensure priorities are developed and delivered with those who best understand requirements.

Community and voluntary sector engagement - Working alongside local communities, voluntary and community organisations is essential if we are to fully understand and develop the services we offer. We work closely with the voluntary and community sector through the Shropshire Voluntary and Community Sector Assembly in Shropshire, the Chief Officers Group in Telford & Wrekin and groups who are the voice of people in local communities. We also continue to work alongside our two Healthwatch organisations to draw on their expertise, knowledge and insight into working closely with this sector.

Political involvement - Our local MPs and councillors have and do continue to have an interest in local health and care services. They are keen to be actively involved in order to share progress with their constituents and gather their views and also be informed for their conversations at a national level.

Co-production - Co-production is integral to the success of our system and our Joint Forward Plan. To continue to embed a culture of co-production across Shropshire, Telford & Wrekin co-production will need to be delivered at all levels (System, organisational, service delivery) and review the effectiveness of the co-production approach.

To read our system's communication and engagement strategy please see appendix X

How we have engaged to inform our Joint Forward Plan
Placeholder "Big Conversation Feedback- you said we did"

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.

5.6 Our commitment to research and innovation

Research

Each ICB must facilitate or otherwise promote (a) research on matters relevant to the health service and (b) the use in the health service of evidence obtained from research.

It is our ambition to support all of our colleagues across the ICS to get involved in research, working collaboratively with HEI/commercial/non-commercial. 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 through sharing of opportunities/knowledge; REND SCOPE, touchpoints study – working closely with NIHR CRN, who have a strong track record in research recruitment primary/community and strong delivery teams across patch.

Action	Owner	Timescale
Identify research needs and shape plans – REND developing VCS engagement and engaging with diverse communities	TBC	TBC
Consider skill mix at board level and across registered healthcare professionals		
Collaborate with local research infrastructure and stakeholders including industry where appropriate - NIHR CRN, WMAHSN, ARC, BRC, IAA capital bids etc.		
Ensure research support and delivery posts are sustainably funded where appropriate so everyone can play a role.		
Consider the role of RCF - joint appointments; strategy highlights workforce plans; shared posts across SSHERPA footprint.		

Innovation

We want to be an innovative and learning healthcare system, taking the best practice from around the world and 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. We will work with the AHSN on the adoption of new medicines, technologies (including digital delivery and the use of artificial intelligence), and diagnostic methods. The AHSN can provide access to proven innovation, but we will also looking for innovation from other sources – including our partners. 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.	TBC	TBC
Ensure that our people and our communities are involved in innovation. Engage with stakeholders for innovative idea generation.	TBC	TBC

5.7 Our commitment to Green Sustainability

(Update due Tuesday 23 May)

In October 2020, NHS England published 'Delivering a Net-Zero National Health Service', a report that details the scale of the environmental problems faced by the NHS and the country. This report sets ambitious targets requiring all NHS Organisations to become Net zero by 2040 for the NHS Carbon Footprint and by 2045 for the NHS Carbon Footprint Plus.

Both Telford & Wrekin, and Shropshire Councils have a target to be 100% net zero carbon by 2030. The journey to net zero has already started at system organisational levels. Examples of what we have achieved so far are:

An overall system reduction in reliance on fossil fuels of circa 1,066,000 kWh for PV arrays - achieved by the installation of renewable on site energy.

Around £2.98m saved from reduction in journeys - Achieved and quantified by MPFT, by moving outpatients clinics to telephone/video calls, delivering over 80,000 virtual consultations and by adapting agile (hybrid) working for our colleagues.

Adapted our sites to accommodate local wildlife – achieved by installing swift and bat boxes, sited beehives on some of our hospital sites, encouraged a diverse range of plants and fauna in our green spaces.

Completely eliminating desflurane from our clinical practices – achieved by adopting alternative methods such as less environmentally harmful anaesthetic gases and total intravenous anaesthetics (TIVA).

Diverting around 440 tonnes of waste from landfill each year - Achieved by RJAH in the period April 2020 – March 2021 where 100% of RJAH waste was diverted from landfill.

There is, however, much more work to be done. STW ICS has created a Green Plan which outlines the key actions to identify opportunities in the system where we can share learning, optimise efficiencies, and capitalise on collaborative working:

Action	Owner	Timescale
Establish our system baseline positions	TBC	TBC
Ensure that we have the right people delivering our net zero agenda	TBC	TBC
Consider how we can deliver care in a sustainable, balanced way	TBC	TBC
Harness digital technologies to approach a multifaceted challenge of delivering quality care outcomes, improving the	TBC	TBC

quality of our care and diagnostics, reducing waste, and optimising our building services		
Encourage our communities to avoid contributing to our carbon output	TBC	TBC
Focus on our supply chain's commitments to achieving net zero	TBC	TBC
Develop decarbonisation plans, continuing our transition to renewable energy, and in the interim making every kilowatt of fossil fuel energy count	TBC	TBC
Adopt practices to avoid creating waste that persists in nature, and recycling those we cannot.	TBC	TBC
Adapting our services to meet the challenges of climate change and extreme weather events	TBC	TBC
Encourage biodiversity	TBC	TBC

Appendix Item A: List of Acronyms

Acronym	Meaning	Acronym	Meaning
BAF	Board Assurance Framework	NHSE	National Health Service England
BAME	Black, Asian and minority ethnic	NHSI	National Health Service Improvement
BAU	Business as Usual	NQB	National Quality Board
BI	Business Intelligence	ORAC	Ockenden Report Assurance Committee
BTI	Big Ticket Items	PCN	Primary Care Network
CCG	Clinical Commissioning Group	PHM	Population Health Management
CDH	Community Diagnostics Hub	QIP	Quality Improvement Plan
CEO	Chief Executive Officer	QSC	Quality & Safety Committee
CQC	Care Quality Commission	RJAH	The Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust
CYP	Children and Younge People	ROS	Readiness to Operate Statement
DHCS	Department of Health & Social Care	ROP	Recovery Oversight Programme
DTOC	Delayed Transfers of Care	RSP	Recovery Support Programme
G2G	Getting to Good	SaTH	Shrewsbury & Telford Hospital NHS Trust
HTP	Hospital Transformation Programme	SDP	System Development Plan
ICB	Integrated Care Board	SFH	Sherwood Forest Hospitals NHS Trusts
ICP	Integrated Care Partnership	ShIPP	Shropshire Integrated Place Partnership
ICS	Integrated Care System	ShropCom	Shropshire Community Health NHS Trust
IG	Information Governance	SOAG	SaTH Safety Oversight and Assurance Group
JSNA	Joint Strategic Needs Assessment	SOF4	Segment 4 of the System Oversight Framework
LMNS	Local Maternity and Neonatal System	SOP	Standard Operating Protocols
LTP	Long Term Plan	SRO	Senior Responsible Officer
MDT	Multi-Disciplinary Team	TWIPP	Telford & Wrekin Integrated Place Partnership
MIU	Minor Injury Units	UEC	Urgent and Emergency Care
MOU	Memorandum of Understanding	UHNM	University Hospitals of North Midlands
MPFT	Midlands Partnership Foundation Trust	UTC	Urgent Treatment Centres
MSK	Musculoskeletal	VCSE	Voluntary, Community & Social Enterprise
MTAC	Maternity Transformation Assurance Committee	WMAS	West Midlands Ambulance Service

Appendix Item A: Action Plan

	Action	Owner	2023 - 2024	2024 - 2025	2025 - 2026	2026 - 2027	2027 - 2028
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 • 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	TBC				
	Agree and implement an effective method to gather and use multi-agency intelligence across the system	TBC	TBC				
	Engagement/Consultation with internal and external stakeholders for each of the priority programmes	TBC	TBC				
	Identify the opportunities for proactive prevention, reducing inequalities, and increasing self-management for each of the priority programmes	TBC	TBC				
	Ensure all information is accessible	TBC	TBC				
	Agree a communications strategy to ensure messaging is consistent and clear across the system	TBC	TBC				
	Make best use of available technology to improve coordination of care, communication, understanding and monitoring of health.	TBC	TBC				
	Workforce development through education and training and development of new roles and new ways of working.	TBC	TBC				

	Recommendation	Action					
Tackling Inequalities	Strengthen the consistency of governance arrangements for reporting HI.	• Reaffirm system leadership which champions HI improvement. • Secure additional PMO resource • Develop a re-focused 2023/24 HI Implementation Plan • Develop a consistent monitoring framework which links through local governance and feeds into the quarterly NHSE stocktake reports • Explore how we can assist our Providers to take forward the HI asks within the Operational Plan. Ensure CYP Core20PLUS5 Objectives are embedded through governance.					
	Assess how dedicated HI roles contribute to success.						
	Identify baseline staff competencies and capacity to rapidly increase knowledge and skills on HI.	• 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 Share best practice locally, regionally and nationally.					
	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.					
	Complete IITSCE health actions	ICB Chief Nursing Officer	31.12.24				
	Implementing the Liberty Protection Safeguards	ICB Chief Nursing Officer	in line with national timescales				
Victim Abuse	Implementing the requirement of the Serious Violence Duty in line with Safeguarding Partnerships	ICB Chief Nursing Officer	in line with national timescales				
	Build pathways for supporting victims, based on knowledge and information	TBC	TBC				
	Working with schools and education establishments regarding abuse	TBC	TBC				
	Engage with Children and Young people in our plans	TBC	TBC				

	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)	Deputy Director: Partnership and Place, 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 & Group Specialist, Family Hubs, TWC	April 2024				

Appendix Item C: References – to be completed and turned into formal reference formatting

- Integrated Care Strategy
- Clinical Strategy - status: signed off
- SATH Hospital Strategy
- CVD Stratey
- Operating Plan
- HTP strategy
- People Strategy
- Mental Health, Learning Disabilities and Autism
- Children and Young People
- Urgent and Emergency Care
- Strategic Intentions
- Elective Care
- STW Improvement Plan
- Financial Plan

healthwatch Shropshire

Calling for an ambulance in an emergency

A report into patient experiences

Engagement period June – September 2022
Report published 2 February 2023
(updated 6 February 2023)

Contents

About Healthwatch

Healthwatch Shropshire and Healthwatch Telford & Wrekin are your local health and social care champions.

If you use GPs and hospitals, dentists, pharmacies, care homes or other support services in your area, we want to hear about your experiences. We are independent and have the power to make sure NHS leaders and other decision makers listen to local feedback and improve standards of care. We can also help you to find reliable and trustworthy information and advice. Last year, the Healthwatch network helped nearly a million people like you to have your say and get the support you need

We work to make your voice count when it comes to shaping and improving services. We use a variety of methods to find out what people like about services, and what could be improved and we share these views with those with the power to make change happen. Our reports go to:

- the organisations who provide services
- the commissioners who pay for services (e.g. Shropshire, Telford & Wrekin Integrated Care Board, Shropshire Council)
- service regulators (the Care Quality Commission, NHS England)
- our national body Healthwatch England to let them know how local services are working in Shropshire, Telford & Wrekin

We are not experts in health and social care and surveys are just one of the methods we use to put a spotlight on services and ask people to share their views with us.

We are very grateful to all those who took the time to share their experiences with us. In this report we have published a selection of anonymised experiences or sections of experiences to illustrate wider findings. We will separately share all of the experiences we received, anonymised and in full, with the service providers to which they relate and with the Shropshire, Telford and Wrekin NHS.

Executive Summary

Background

Calling for an ambulance in an emergency was highlighted as a pressing issue for residents in Shropshire, Telford, and Wrekin in May 2022 when the Director of Public Health for Shropshire asked Healthwatch Shropshire to put out a call for people's experiences of calling 999. It was already understood that long waiting times were a significant issue, but the Director of Public Health wanted Healthwatch to help draw attention to people's individual voices and experiences, and the real-life impacts these waiting times were having.

The Director of Public Health in Telford & Wrekin also asked Healthwatch Telford & Wrekin to also ask their residents to share their experiences.

This report categorises these experiences, highlighting how people felt at the time, what happened and how things could be improved.

What We Did

To gather as many voices as possible we put out a call across the NHS, social care services, mainstream media, social media, and our community contacts for people's experiences of calling for an ambulance. Understanding the complexity of ambulance delays, we asked people to share their whole journey of using emergency services, from picking up the phone right through to discharge.

Who We Heard From

We received 168 responses (including 160 from Shropshire and 8 from Telford & Wrekin) which have been analysed to draw together key themes across our findings. We kept all the comments we received in the voice of the individual providing the information in order to retain the sentiment and emotion involved in these experiences.

We heard from a wide age range (15 to 80+) with 67 respondents being between 50-79 and 26 being between 25-49. 94 responses were regarding a family member or friend, but we also heard from 54 people reporting their own experience.

What We Heard About

Quality of Staff

Whilst we heard a lot of difficult experiences, we found that the people who described their interaction with staff found them to be excellent, with 43 out of 44 people telling us they had a positive experience.

- 'At all points the ambulance staff and rapid response team were kind, caring, thoughtful and professional, giving my father the time and reassurance, he needed every step of the way. They were cheerful, pleasant, and relaxed. To be honest, I don't know how they manage in such stressful times.'

Waiting Times

From the 114 individuals who reported a negative experience of calling for an ambulance, 107 (94%) attributed their concerns to long waiting times. 48 (55%) reported waiting over 6 hours for an ambulance to arrive.

A lot of people felt this had very serious consequences, particularly in causing indignity and long periods of discomfort, or in creating avoidable harm, and sometimes death.

- '…two grade two pressure sores developed where mum was lying in her own urine / faeces. The indignity and discomfort would have been extreme for her.'
- '…Had the ambulance arrived in the specific time for a non-breathing person who was being giving CPR from a few minutes into the call I am convinced the person would have survived.'

Call Categorisation

A few people felt that the ambulance delays were due to their calls being incorrectly categorised, and the urgency of their situation not being recognised.

- '…The decision not to send an ambulance immediately was because it was a fall - would it have made a difference if the word 'collapsed' had been used? I hope not!?'

However, some people reported being well supported by call handlers whilst waiting for the ambulance to arrive.

- '…I called for an ambulance and the ambulance call handler was wonderful and stayed with me on the phone the whole time…'

Alternative Travel Arrangements

Due to long waiting times, 17% of people were either advised to use their own transport, or they decided to do so themselves, reporting feeling like it was the last resort.

- '…I couldn't face a repeat of what happened 6 months previously when we already had to wait 5 hours and with extreme difficulty and some danger my husband was taken by car to the hospital.'

A further four people told us that they would have taken their own transport if they had been provided with a more accurate estimated arrival time for an ambulance. One individual suggested this was wider system problem.

- 'But because of the misleading information we stayed put. …. The fault here lies with the information given by the control room staff who are no doubt working to a script laid out by a higher authority, and no blame could be attributed to them.'

Falls

We heard from 38 individuals who called the Ambulance regarding a fall. Whilst many people explained nobody was seriously injured, 16 (42%) reported they had waited over 6 hours on the floor.

- '…Whilst my wife was never at risk of dying, spending 14 ½ hours on the floor is not a pleasant experience, being unable to move, to go to the loo or get remotely comfortable…'

We also heard from two social care agencies who felt that there needed to be more communication between themselves and the ambulance services, as agencies are limited in what help they can provide after someone falls.

- '…We have been directed by our OT that we should not be trying to get people to stand up and that our first port of call is to call for an ambulance to assess the person for injuries incurred and support to get up… we are not trained or qualified to assess for any serious injuries beyond regular First Aid Training.'

Emergency Department

Once arriving at the hospital, 75% of 74 people told us about a negative experience in (or waiting outside) the emergency unit with 58% attributing this to waiting a long time to be seen by a doctor. However, people reporting on care during this time praised the staff who were with them.

- '…Ambulance service was amazing, made sure that lady was comfortable and had enough food and drink.'

Discharge from Hospital

Delays in emergency services are often considered to be a knock-on effect of problems with discharging patients. From the 18 people who told us about the discharge process, 16 voiced negative experiences.

- 'The discharge process for me was a mess, confused, unnecessarily long, distressing…'

People described delayed discharges or being discharged from the hospital without the adequate support and facilities in place for their recovery period.

Healthwatch Shropshire and Healthwatch Telford & Wrekin are aware that the causes of ambulance delays are complex and so we invited the organisations involved from the point of someone calling from an ambulance to the person being discharged to let us know what steps they are taking to try to improve people's experiences and outcomes.

Response from the Integrated Care System

The Chief Medical Officer for Shropshire, Telford and Wrekin Integrated Care System[1], said:

NHS Shropshire, Telford and Wrekin would like to thank the residents of Shropshire, Telford and Wrekin who participated in this survey. The feedback that local residents gave, provides valuable insight and information into views around what might be needed to improve people's experience of calling for an ambulance in an emergency. Thanks also to Healthwatch colleagues for providing the team who undertook and managed the engagement process on behalf NHS Shropshire, Telford and Wrekin and the rest of the health and care system in the county.

Long ambulance waits and handover times are complex issues, and are a result of pressure on the whole health and care system. It's not just one part of the health and care system that is affected, all elements are under immense pressure – primary and community care, secondary care and social care. This impacts on everyone from our care workers delivering domiciliary care in people's homes, our GPs, community services through to our hospitals. To improve people's experience of calling for an ambulance in an emergency it is important we don't just look at one part of the health and care system, and rather that we take an holistic approach. In Shropshire, Telford and Wrekin this is exactly what we are doing with all partners working hard to address the whole-system issues that lie behind the long ambulance response times. Our focus remains on driving improvements with our health and care partners that will ensure patients are kept safe and can access the appropriate care when and where they need it.

A variety of steps have already been taken, including:

[1] https://www.shropshiretelfordandwrekin.ics.nhs.uk/

- Expansion of the number appointments across our Primary Care footprints
- The Acute Assessment Floor, which recently opened at Royal Shrewsbury Hospital (RSH) is an expanded medical assessment area, where we are now able to receive direct GP admissions. This means that these patients no longer have to go to A&E.
- A Winter Control Room, which uses multi-agency data to respond to pressures across the county as health and social care services.
- An Ambulance Decision Area at RSH and Telford's Princess Royal Hospital (PRH) which provides paramedics and Emergency Department (ED) staff to collaboratively care for patients within hospitals rather than on ambulances. This helps to free up ambulances to respond to new emergency calls.
- Increasing capacity at our ED departments and in our wards at the Royal Shrewsbury Hospital.
- Joint working of ambulance and community partners to provide the appropriate clinical care in the right setting via our Rapid Response teams, helping to prevent unnecessary hospital admissions.
- Diverting patients, as clinically appropriate, to our Same Day Emergency Centres (SDECs) and Urgent Treatment Centres.
- Provided booked slots for 111 patients to be seen and treated in SDECs and Urgent Treatment Centres to avoid times of peak demand.
- Joint work with ambulance services to understand and assess the clinical risk of all ambulance patients at the EDs and ensure that patients are offloaded in clinical priority order, followed by longest wait.
- Action taken internally to improve patient 'flow' through the RSH and PRH to enable earlier/more timely discharge of patients to create bed space for patients needing admission from our EDs and assessment areas.
- A virtual ward allowing patients to get the care they need at home safely and conveniently, rather than being in hospital.
- Significant investment in extending social care capacity in both care home and domiciliary care settings, allowing us to ensure patients get to their usual place of residence much more quickly, freeing space in wards and our EDs

- Nursing and therapy in-reach teams to care homes to facilitate additional discharge.
- 24/7 all age mental health helpline to support people who feel they have a mental health crisis.
- 24/7 crisis teams have been put in place to support people with mental health problems.
- Calm cafes in the community have been set up to support people when their mental health needs are escalating instead of going to A&E.
- Voluntary and community sector support for individuals at high risk of readmission to a mental health hospital.
- A Wellbeing Zone has been set up to support children and young people who have attended A&E frequently to reduce further attendances.
- In-reach staff to the acute hospitals to support children and young people who have a physical health and mental health problems (for example eating disorders) to ensure they have the most effective treatment and facilitate discharge.

In addition, a great deal of cross-system work is being done to improve the discharge of medically fit patients from the hospitals into the wider care system, to create much-needed capacity within the hospitals, which will positively impact handover delays.

Our focus is across the three pillars of our improvement work:

1. Community-based initiatives to better support people in their own homes
2. Changes to processes and systems that improve the patient journey through hospital
3. Discharge out of hospital and community/social care support

Addressing these three areas together will enable us to help more people stay well in their own homes for longer and ensure that those who do need acute care can access it in a timely fashion.

Responses from individual organisations can be found on page 47

Context

In May 2022, following concerns raised by local residents and reports of falling performance locally and nationally, the Director of Public Health for Shropshire, asked Healthwatch Shropshire to put out a call for comments about people's experiences of calling for an ambulance in an emergency in Shropshire. NHS Shropshire, Telford & Wrekin[2] had been having high level discussions with NHS England, members of the Shropshire, Telford & Wrekin Integrated Care System[3] (including Shropshire Council) and local MPs about the challenges people were facing when calling for an ambulance, including long waits caused by ambulances having to wait outside the Emergency Department at Shrewsbury and Telford Hospitals. Through Healthwatch's, independent role the Director of Public Health wanted us to help people working to address the problem to see beyond the data and hear the real impact in Shropshire, these delays are having on people's experiences of care and outcomes to inform planning.

In order to make sure people from across the county could share their views, the Director of Health and Wellbeing at Telford & Wrekin asked Healthwatch Telford & Wrekin to do the same piece of work. This report includes all experiences gathered across Shropshire, Telford & Wrekin.

We know that the causes of ambulance delays are complex. There are a number of things that affect how quickly an ambulance can get to a patient and all services across Shropshire, Telford and Wrekin have a role to play in improving waiting times. For example,

- The public can call for an ambulance only when they need to
- NHS 111 and 999 can make sure ambulances go to people who need them and other people are advised to get help from somewhere more appropriate, e.g. their GP or Pharmacist, or are told to go to a Minor Injuries Unit[4]
- Ambulance crews can 'see and treat' people who do not need to go into hospital and only take people to hospital if they need to

[2] https://www.shropshiretelfordandwrekin.nhs.uk/
[3] https://www.shropshiretelfordandwrekin.ics.nhs.uk/
[4] https://www.shropscommunityhealth.nhs.uk/miu

- The Emergency Department can work to improve how quickly they can accept patients who have arrived by ambulance so crews can go to their next call
- Wards in the hospital can work to discharge people who are well enough to leave so that people can go to the ward from the Emergency Department more quickly and make room for patients arriving by ambulance (this is called 'flow')
- Shropshire and Telford & Wrekin Councils can help the hospitals to discharge people by making sure there is care available to them at home or in the community (e.g. a Domiciliary Care package or a place in a care home).
- The health and social care system can work to improve the availability of a strong and resilient workforce and those on the ground are trained to respond, particularly in a large rural area
- Work can be done to make sure there are alternatives to emergency provision where appropriate, including supporting services in the community to keep people healthy and reduce the need for emergency admission

Due to this complexity we asked people to share their whole journey from making the call to ask for an ambulance, right through to going to the Emergency Department, onto the ward and then being discharged to see what was working well and where things could be improved.

We told the Executive Director of Nursing and Clinical Commissioning at West Midlands Ambulance Service (WMAS) about this piece of work and they thanked us for focusing on these issues and representing the public voice.

Note: Quotes used in this report are indexed with a number

What we did

We promoted our call to hear about experiences across the NHS and social care services and more widely through media, social media and community contacts, such as patient support groups, local councils and community centres.

This results of which included the Chief Officer of Healthwatch Shropshire being interviewed on BBC Radio Shropshire and several articles in The Shropshire Star.[5]

People were able to provide feedback through surveys on both Healthwatch Shropshire and Healthwatch Telford & Wrekin websites. Those without internet access could ring Healthwatch Shropshire to share their experience or send it by post.

The people we heard from

We heard from 168 people. 160 responses were received by Healthwatch Shropshire and 8 by Healthwatch Telford & Wrekin. The map in Appendix A gives an indication of where the respondents live.

In most cases, it was evident who was responding:

- 56 patients reported on their own experience
- 94 reported on the experience of a relative or friend

[5] https://www.shropshirestar.com/news/health/2022/08/05/health-group-asks-for-peoples-experience-of-ambulance-service/ https://www.shropshirestar.com/news/health/2022/08/22/mp-urges-people-to-share-experiences-of-ambulance-waits-with-healthwatch-shropshire/

- 4 reported on the experience of someone with whom they had no close relationship
- 5 health or social care professionals/workers reported

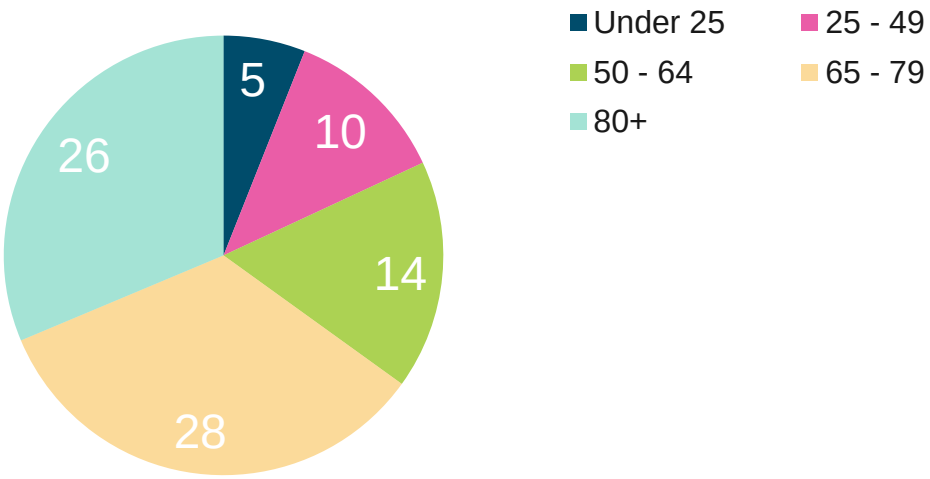
Gender of patients

(Not evident for all responses):

- 72 female, 71 male

Age of patients

(Not evident for all responses):



Date of the experiences

- Before October 2021 – 12

- Oct – Dec 2021 – 25
- Jan – Mar 2022 – 25
- Apr – Jun 2022 – 29
- Jul – Sep 2022 – 24
- Date not available - 53

A full demographic breakdown of respondents is available in Appendix A

Sentiment of experiences

People shared a range of experiences with us. Many people described their experiences of a number of services and so they included positive and negative aspects. The majority of positive comments described the kind and caring nature of staff from difference services:

"...The ambulance arrived in 10 minutes, two paramedics arrived and they were **kind** and **wonderful** and the ambulance took him straight to A&E. There was no waiting and he went straight in and he is still in Shrewsbury hospital now. "

"When the paramedics arrived, they were **amazing**, and **their care was exemplary**."

"He had **nothing but praise** for the care he received from everyone, from the point of speaking to the two call handlers [through to discharge from hospital]"

"The call handlers and the paramedics were **very helpful** and pleasant. "

"**Excellent**, **polite** and **professional** and very friendly and communicated very well with each other. **Really good teamwork**... **Very reassuring**."

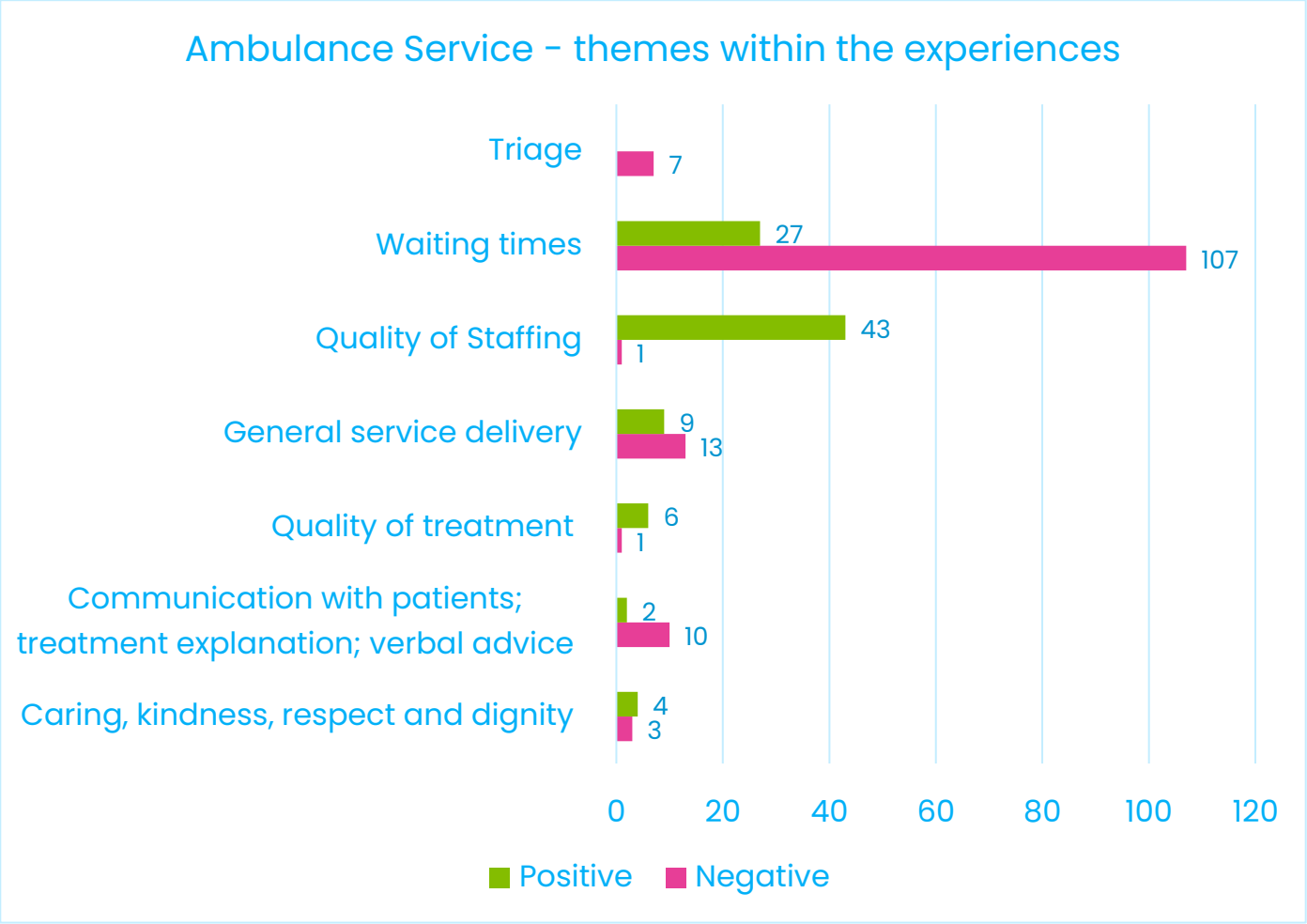
"At all points the ambulance staff and rapid response team were **kind, caring, thoughtful** and **professional**, giving my father the time and reassurance, he needed every step of the way. They were **cheerful, pleasant** and **relaxed**. To be honest, I don't know how they manage in such stressful times."

The services we heard about

Ambulance Services

163 people told us about their experience when needing an ambulance

- 46 people (28%) described a positive experience
- 23 people (14%) described a mixed experience, with both positive and negative aspects
- 91 people (56%) described a negative experience
- 3 people (2%) did not express any sentiment about their experience



Note. Each experience can include multiple negative or positive themes or a mixture of both.

Waiting times

Our focus within this piece of work was to hear the experiences of patients, it does not give a statistical accurate description of waiting times within Shropshire, Telford & Wrekin, however we thought it would be useful to give a summary of the wait times we heard about. A full statistical analysis can be found online[6] but it should be noted that the data covers the whole of the area served by West Midland Ambulance Service and not just Shropshire, Telford & Wrekin.

Of the 114 people who described a negative aspect to their experience 107 (94%) told us that the time it took for an ambulance to arrive was a concern.[7]

Table 1: Reported times of waiting for an ambulance

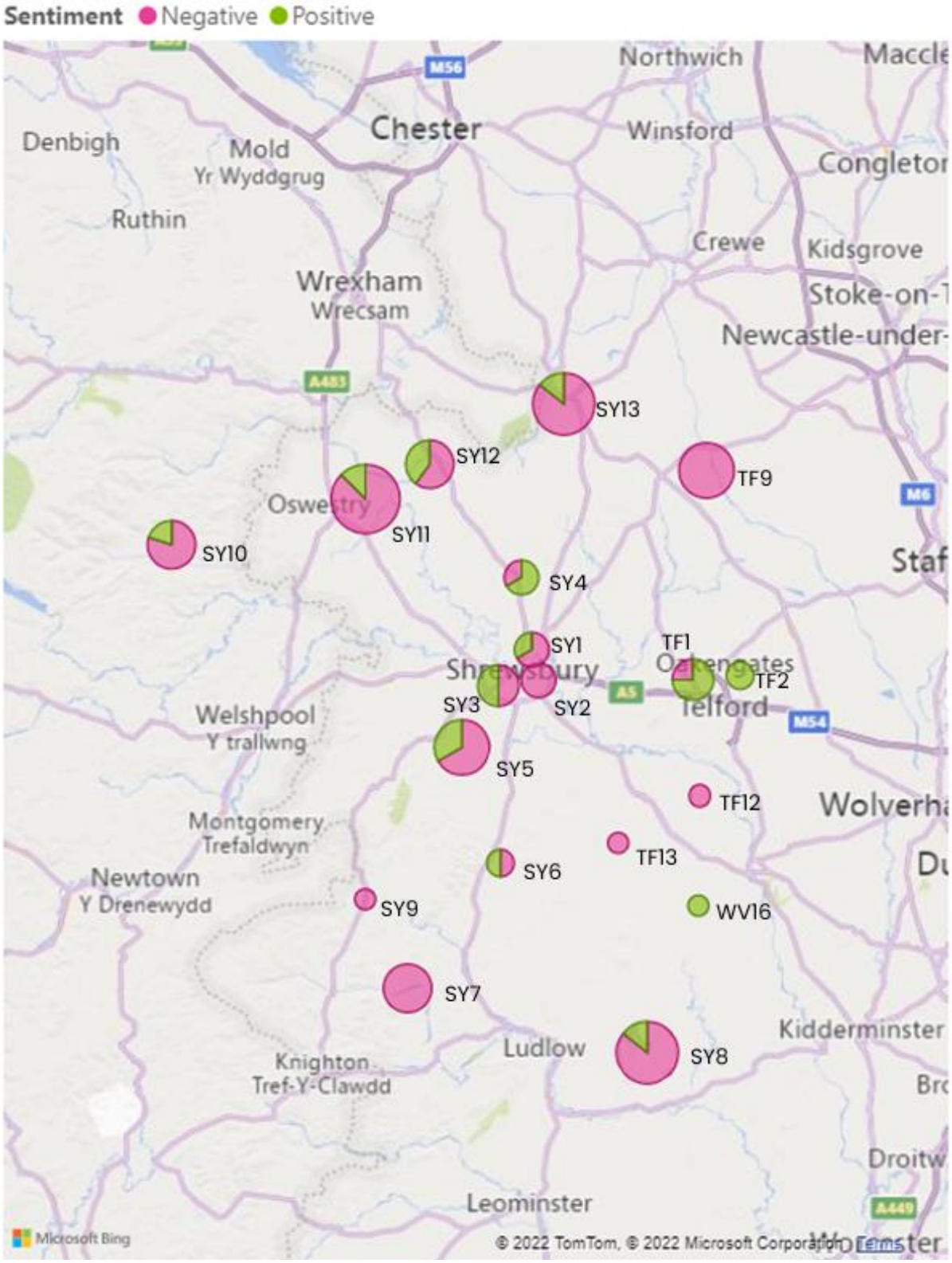
Health Issue	Length of wait [m=minutes; h = hours]							
	Less than 30m	31 – 60m	1 – 5 h	6 – 10 h	11 – 20 h	20+ h	Unstated	Total
Fall	1	1	8	12	10	1	5	38
Stroke	1	3	3	1	1	0	1	10
Heart / Chest pain	5	8	4	2	0	0	3	22
Other	19	8	10	6	11	4	15	73
Total	26	20	25	21	22	5	24	143

Table 1 only includes reports of those occasions when the ambulance arrived and was used to take patient to hospital. In addition, 33 people made alternative arrangements, either after waiting or having been advised of a long waiting time, see page 15.

[6] Statistics » Ambulance Quality Indicators Data 2022-23 (england.nhs.uk)

[7] An explanation of the ambulance response times and the categories of calls can be found here: NHS England » Ambulance Response Programme

Of the 134 experiences which included feedback about waiting times 74 included postcode information of where the ambulance was asked to attend. From this we can give an indication of the sentiment people felt about the waiting times. The largest bubble indicates 7 negative and 1 positive, the smallest bubble indicates 1 experience.



Postcode Area	Negative	Positive	Total	Postcode Area	Negative	Positive	Total
SY1	2	1	3	SY11	7	1	8
SY2	3		3	SY12	3	2	5
SY3	2	2	4	SY13	6	1	7
SY4	1	2	3	TF1	1	3	4
SY5	4	2	6	TF2		2	2
SY6	1	1	2	TF9	6		6
SY7	5		5	TF12	1		1
SY8	6	1	7	TF13	1		1
SY9	1		1	WV16		1	1
SY10	4	1	5	**Total**	**54**	**20**	**74**

Call categorisation

While most people who passed comment on the reason behind the ambulance waits acknowledged the pressures across the health and social care service there were a few who felt that there was a problem with the categorisation of the urgency of the call.

- 'In October 2021, having found my disabled dad (71) collapsed, but conscious in the bathroom, and having failed to be able to get him up an ambulance was called. I was told the wait would be a minimum of 5 hours - even though I explained that he was suspected covid positive and that he had his chest resting on a metal bar (toilet frame) which was holding his full weight. He soon lost consciousness so the service was called again - an ambulance was sent immediately but he was already in cardiac arrest and with a DNR in place passed away. Whilst accepting that the service is under immense pressure, identifying those in need of immediate help needs to be more thorough. Having said that he had 'fallen' meant that he was not seen as an urgent case. No account was taken of his history, the position he was lying in (head was trapped, lying forward, chest on a metal bar and back arched backwards) or the possible cause of the fall. The decision not to send an ambulance immediately was because it was a fall - would it have made a difference if the word 'collapsed' had been used? I hope not!?'
- 'My mum died in April this year. She was in a residential home with dementia unit. Mum was discovered by a care worker at approx. 5 am on

Saturday. She had a suspected broken hip; she was lying on the floor in her bedroom in a lot of pain when discovered. The first call to 999 was made at 5.18 am. There were 5 x 999 calls made in total that day and one clinician call-back at 10.23. One of the observations was although mum was in pain and at times shouting - the 999 handlers appear to put her vocal shouting down to her dementia. Mum waited 16 hours from the time an ambulance was called until the ambulance arrived.'

"July 2022 At around 2.30pm my son (17) had gone for a motorcycle ride with his father when unfortunately, he hit a branch in the road this threw him from his motorcycle about 20 feet, my son was in a lot of pain back hips and wrist. An ambulance was called, we were told one would be attending but couldn't give an ETA [estimated time of arrival]. A fireman attended the scene and assisted two ladies with traffic and keeping an eye on my son, sometime later an off-duty community nurse also assisted us at which point the ambulance was called again and ask to be quick due my sons' condition and that it had already been over an hour. Again we were assured one was on its way, after some time the community nurse rang a friend as she was concerned for my son, he attended the scene did observations and monitored my son for a while longer, rang the ambulance service again who again said 'there's one on the way' no ETA. Once my son's pupils became unevenly dilated, he was VERY concerned and was unable to get the ambulance service to respond any quicker he called an RTA doctor. Upon arrival he found my son to be tachycardic with an unreadable pulse suspected internal bleeding from his injuries. He had to call straight through to West Midlands Ambulance Service to escalate my son's case as he had been wrongly categorised. We nearly lost our son that day (his Birthday) this was almost definitely down to the wait time and lack of experience of the poor call handlers that are taught to adhere to a

script! … I feel that the call centre staff need more training/should be able to use their initiative. They need to listen!! 3x times they were called twice by medical professionals."

Support while waiting

Some people talked about the support they received from the call handlers while waiting for an ambulance.

Supportive experiences

- 'We found my father barely conscious and turning blue on the bedroom floor. We called 999 who sent an ambulance. Over time my father became increasingly unresponsive and we made another 999 call. My father became unresponsive and I think the ambulance call-out was re-prioritised/upgraded and I was supported in doing basic life support over the phone by the call handler…..'
- 'At 5am [in August] my wife called 999 to request an ambulance for me. I was suffering from a shortness of breath and nausea. The call was answered immediately and the operator talked my wife through various checks and recommended procedures while we awaited the ambulance. It arrived 12 minutes after making that call and the two paramedics wasted no time in stabilising me before I was able to get into the ambulance and head for Princess Royal Hospital, Telford.'
- 'I went to see my brother-in-law and found him slumped on the stairs, dehydrated and confused. I called for an ambulance and the ambulance call handler was wonderful and stayed with me on the phone the whole time. The ambulance arrived in 10 minutes, two paramedics arrived and they were kind and wonderful and the ambulance took him straight to A&E. There was no waiting and he went straight in and he is still in Shrewsbury hospital now.'

Unsupportive experiences

- 'I believe that if my husband had had the correct care from the two Paramedics/Ambulance Drivers … he would have had chance of survival. But from my initial call to 999 … that morning and up to the time he went into cardiac arrest, he was failed and did not stand a chance. The ambulance did not arrive until an hour later. I have since heard that the operator that answered the call should have stayed on the line in case my husband went into cardiac arrest whilst waiting for the ambulance to arrive. I told the lady on the phone; my husband was struggling to breath

and had crushing chest pains and was clammy. He had four stents 11 years ago due to Angina and I said he thought it was a heart attack, but she did not stay on the line whilst waiting for the ambulance to arrive.'

- 'Our GP phoned for an ambulance for my husband at noon and it did not arrive until 8.30am two days later. We called every hour and the call handlers were actually quite rude to us. If we had known that they would take such a long time then we would have transported him there. When he arrived at PRH we were told he had terminal cancer within an hour of being there and he died shortly afterwards. He was kept waiting in the ambulance on arrival even though he was in so much pain. It was a mess up and I feel I have been robbed of time with him.'

Consequences of long waits.

Many respondents told us about how the wait they experienced affected the patient.

Serious Consequences

Some felt that there were serious consequences:

- 'One morning at around 10:50 I needed to call an ambulance as I strongly believed my husband was having a heart attack. There was a 50-minute wait for an ambulance, which took him to Stoke where he underwent emergency surgery. Unfortunately, my 59-year-old fit, healthy, non-smoking and non-drinking husband suffered irreversible damage to his heart and is now in severe heart failure. We are of the belief that a quicker response would have quite probably prevented this. The fallout has been immense with my husband now having to retire. I had called within 5 mins of his symptoms occurring and administered aspirin but what he undoubtedly needed was to get into hospital quicker.'

- 'My Uncle had a fall while in care home. Waited for an ambulance for 16 hrs despite being obviously sick (had sustained head injury and was throwing up). He had to be transferred to RSH for a scan. The scan revealed bleed on the brain. The damage was lasting and he passed away. If ambulance had arrived earlier, he might still be alive.'

- 'My father fell ill on the weekend. He deteriorated the evening of Wednesday and was told twice by ambulance service that evening that they had no ambulances to send out and that he had to make his own way. He was unable to do this and went to bed for an early night. At 1am he shouted out alerting my mum who again rang for an ambulance who again told her they had no ambulances to send out and that he had to make his own way. Myself and my partner headed to my parents to help my dad get down the stairs so we could take him to hospital. He collapsed at the bottom of the stairs and stopped breathing. At this point we called 999 again and they finally prioritised his call. He was pronounced dead by

ambulance staff at 4.30am. There has since been an investigation and the ambulance service have admitted severe harm.'

- 'I work in a day centre for adult with disabilities… one of our service users struggling to swallow, I became quickly aware that we had a choking incident. I immediately phoned an ambulance, the person deteriorated very quickly and whilst on the phone to the ambulance service we started CPR and I sent a staff member for a defibrillator which was situated within a few minutes, the ambulance service knew we were administering CPR and that the person was not breathing… We waited over 30 minutes for an ambulance, I stopped checking the time after this, all the time we waited we performed CPR and used the defibrillator, the ambulance arrived and took over and the person was taken to Shrewsbury hospital where life support was put in place, sadly the person died three days later when they turned the life support off. Had the ambulance arrived in the specific time for a non-breathing person who was being giving CPR from a few minutes into the call I am convinced the person would have survived.'

- 'My father had a stroke at home. It took over an hour for an ambulance from Shrewsbury to arrive - this is well outside the 18-minute recommended time. He was then shuttled between hospitals (via ambulance) and passed away at the start of June when we agreed for support to be removed. If an ambulance or paramedic had arrived within the 18-minute target time the outcome may have been different.'

- 'Due to my husband [who had a heart attack] having to wait for 2 hours for the ambulance, he is suffering more complications and we were told that if he had treatment more quickly he would be in much better health.'

Discomfort and indignity

Others shared the discomfort and indignity that can result from a long wait:

- 'Whilst my wife was never at risk of dying, spending 14 1/2 hours on the floor is not a pleasant experience, being unable to move, to go to the loo or get remotely comfortable… there really should be a more responsive system to cope with falls such as these.'

- 'Earlier this year my aunty aged 82 fell backwards in her kitchen whilst holding a pan of potatoes. She hit the floor covered in water and found she could not move. This was at 12.15pm. She lay on the cold floor until the ambulance came at 11pm that night. Her dignity left her, she had to wee and poo on the floor.'

- 'I called an ambulance to my 69-year-old husband who lost all mobility with Covid positive result and I was unable to get him up from the floor. We waited 21 hours. The call was escalated twice by ShropDoc who suspected sepsis. He was incontinent of urine - could not get to toilet. He has epilepsy, diabetes, spinal deterioration, previous stroke.'

- 'In short, during those 16 hours waiting for the West Midlands ambulance service to respond two grade two pressure sores developed where mum was lying in her own urine / faeces. The indignity and discomfort would have been extreme for her.'

Alternative travel arrangements

Alternative arrangements included requesting help from the Police and attending a Minor Injuries Unity (MIU) but the most frequent we heard about were patients and families using their own transport to get to the Emergency Department, 28 people (17%) did this.

Using Own transport after waiting for an ambulance (11 people)

"About 4:00 PM my daughter fell, we didn't witness the fall but it was obviously when we found her that her left leg was broken. We rang 999 straight away and immediately they told us that the estimated waiting time was four hours or it could be longer. My daughter was in terrible pain and was outside and we couldn't move her. We were shocked by the time that we would have to wait and that we could not get any information updates. We needed some kind of medical assistance a friend went to Ludlow MIU but it was closed. We kept on ringing to get updates but all they would tell us that it would be 4 hours or more. In the end we drove her to Hereford hospital[8]. When we arrived at about 5:30 PM we were greeted with a line of parked ambulances. … During the time we were waiting for an ambulance we felt completely abandoned it was as though we were reaching out into a black hole. We were given no confidence that there was any kind of time limit to when an ambulance would be available. We were given no advice and there was no access to any kind of medical back up in the area from either the hospital or the GP. I still worry today about the decision we made to take her in the car but there seemed to be absolutely no other option.

[8] Depending on where people live within Shropshire, Telford & Wrekin the hospital they attend may be outside of the area.

We weren't sure whether there any other injuries whether she'd hit her head or whether we could do more damage by moving her but if they've been a private ambulance we would have paid whatever we needed to do to get to hospital in time. This experience has left us with the terrifying prospect that if any situations occur where we need urgent medical help that they may not arrive in time, in fact it has made us question about staying in the area."

- 'In the afternoon, we phoned for an ambulance, we were waiting and waiting. In the end we decided to drive the person who had had a seizure to the hospital ourselves (we phoned 999 to inform them of this as we would not want anyone else being delayed due to not informing 999). We had to beep other cars to move out of the way so that we could do the 40 min journey to the hospital as quickly (but safely) as possible - this is not acceptable … surely as we live a little distance from a hospital we should be given decent support in the time of a potentially life threatening / life altering situation, rather than us having no option but to transport an ill person ourselves - we do not have medical training, anything could have gone wrong but we felt we had no choice.'
- 'My 90+ year old father complained of dizziness, shortness of breath and high temperature. I called 111 to describe his symptoms and was quickly told that he needed a 999 emergency ambulance. This was at 9.30pm and he lives close to the town centre. By 11pm no ambulance had arrived so I called 999 and was told that they couldn't give me an ETA. I asked if it would be better for me to drive him to the hospital and they confirmed if probably would… He was told by one of the doctors at the RSH that if we hadn't have got him in when we did he would just have died.'
- 'My wife suffered a sudden severe abdominal pain. She had that very week undergone scans and consultations which showed several ovarian cysts - one of which was bleeding. The pain was so severe I had no option but to call for an ambulance. It was the first of four 999 calls requesting an immediate response over a period of an hour and 30 minutes. Despite the ambulance service placing the call as a high emergency priority, no ambulance arrived. It was clear the cyst had ruptured and internal bleeding was taking place. I had no choice but to take my wife to hospital myself.'
- 'My 91-year-old mother fell in the garden hitting her head on a concrete slab. She did not lose consciousness but could not get up, felt giddy and was vomiting, and she had a bleeding head wound with a prominent

swelling. My father was with her, my sister and I arrived shortly after his call. I tried to help her sit up but she could not move. I called 999 and after a long triage process was told there would be a 6 hour wait for an ambulance. She takes blood thinners and needed a CT scan to rule out an intracranial bleed. After about an hour we managed to get her into the house and a reclining chair. I received a call back from a paramedic who advised we should try and get her to hospital so we managed to get her into my car and I took her to Royal Shrewsbury Hospital where 10 ambulances were waiting outside A&E.'

- 'I was taken ill at work in a GP surgery, thankfully I was there and got the initial care that I needed. I had suspected Supraventricular tachycardia and the GP called for an emergency ambulance. I waited over four hours for an ambulance which never arrived, thankfully, there was a change in my condition which reduced my heart rate and the GP's allowed my husband to take me to A&E where I had to wait on my own for two hours before I was seen in triage and then received immediate treatment. I did receive a voicemail from the ambulance service to say that they were delayed and to call 999 if any change in my condition.'

- 'I was at the pool … collecting tadpoles with my grandson when … I fell back onto the bank. There was a very loud crack and I knew I had seriously broken my ankle. I crawled to a low broken wall and was able to sit, however I soon had to lie down as I was in shock. A young man helped us by calling the ambulance but they were unable to work out where we were even though we gave them the number of the life ring close by and instructions how to get to us. They were very busy so we waited and waited and my ankle was swelling in my wellington. I could manage the situation as long as I was perfectly still but it was raining and the ground was very cold. …. My son arrived to help us and after two and half hours my husband was able to find someone to open the gate at one end of the footpath and was able to get our car near to where I was. My son and the young man … carried me to the car as no time scale was given us for the ambulance to arrive. When I got to A&E I told them my ankle was broken.'

- 'I wouldn't call an ambulance again in the current crisis as the system is in crisis! An ambulance didn't come to my grandson with worsening breathing problems and the call handler eventually said it wasn't likely to any time soon! So we took him to Wrexham hospital.'

- 'My son [aged 9] woke unable to breathe properly 2am I rang ambulance. They said one was on its way 'blue lights.' 45 mins passed he was really struggling so neighbour brought round his oxygen tank, I rang 999 back and the call operator said the ambulance has had to divert to another emergency. and they couldn't come. My stepdad drove over and took my son straight to hospital, he had croup and his airway was closing. He needed steroid to open it back up. 6am the ambulance turned up. The paramedics could not believe it when I told them I rang 4 hours prior and that my son couldn't breathe and the call handler didn't think it was an emergency as he wasn't not breathing at all. He could barely breathe it

was horrific. The following night it happened again, so I didn't ring ambulance I rang my stepdad and he took him back he needed more steroids. It could have been such a different outcome seeing your baby not being able to breathe and him begging for help holding his neck. So scary to think you just can't get an ambulance anymore.'

- 'We called an ambulance at around 11pm. I was having a stroke. We waited over an hour and called again. Still no ambulance, we were spoken to rudely. We waited again for another 1/2 an hour and still no ambulance. A friend took me into A&E while my husband stayed with the children. He left at around 2am. It turns out I was triaged as a category 3 call. I was actually having a very severe stroke. I scored 16 on the NIHSS scale on presentation in hospital. There were two issues, being incorrectly categorised and being spoken to rudely and told to clear the line.'

- 'In April at 7:45am, my mum had a fall at home whilst I was at work. She was unable to move and was stuck on the floor in the kitchen. She luckily had her phone with her so called an ambulance and was told there would be a six hour wait. I rushed home from work and thankfully managed to get her onto a chair where we sat for many hours. We were called back at 11am by a paramedic to tell us the wait had gone up to twelve hours and that I was to give my mother paracetamol and ibuprofen. As my mum was in excruciating pain, by 4pm I was calling hourly to get an update on what was going on. My mum lost feeling all down her leg, her leg was cold and was going a blue/purple colour, although when telling this to the paramedics on the phone, they were unable to do anything. We called our local doctors who were extremely unhelpful and rather rude when speaking to my mum - claiming that I should have been able to move her and take her myself to hospital (she could not move, nor did I want to move her not knowing the extent to her injuries). We waited until 11pm when my mother began to get very restless and so I called my sister who lives in Lincolnshire for her to come home to help me. Her and her husband arrived at home and helped us move my mother into the car which was such a distressing experience seeing the pain she was in. We drove her to the PRH Telford….'

Advised to use own transport (10 people)

By Ambulance service (7 people)

"My father fell ill on the weekend. He deteriorated the evening of Wednesday and was told twice by ambulance service that evening that they had no ambulances to send out and that he had to make his own way. He was unable to do this and went to bed for an early night. At 1 am he shouted out alerting my mum who again rang for an ambulance who

again were told had no ambulances to send out and that he had to make his own way. Myself and my partner headed to my parents to help my dad get down the stairs so we could take him to hospital. He collapsed at the bottom of the stairs and stopped breathing. At this point we called 999 again and they finally prioritised his call. He was pronounced dead by ambulance staff at 4.30am. There has since been an investigation and the ambulance service have admitted severe harm."

- 'Mum had a stroke during the night. She called us for help, but it was a while before we realised that she had had a stroke. We called 999, but they said that there were no ambulances available, and we should take her to hospital. We took her to Hereford hospital (we live in Ludlow) at around 6pm, but it was 4am before she was seen.'
- 'Child, 11 years old had a horse-riding accident. Sustained head and facial injury. Parents rang the ambulance and were told blue light was on its way. After 1 hr, there was still no ambulance. Child was left bleeding on side of the road as parents were told not to move her. 999 would not say how long the wait would be. After another 30 min, still no ambulance. Parents were finally told to take the child to A&E. When they arrived in PRH 20 ambulances were queuing outside.'
- 'We rang 999 as it was apparent that Dad was having a stroke. He was outside in the garden at the time and could not walk to get into the house. He had lost all speech. We wrapped him in blankets and held him whilst we waited. After 1 hour, we rang again and was told an ambulance would be with us. We re-emphasised the importance of speed with a stroke and that due to him being taken off Warfarin recently, this was likely to be a clot and he may require thrombolysis. We waited another hour and rang A&E for advice on trying to get him there ourselves in my car. They advised that if we could, it would be the right thing to do. By now it was 7.30pm When we got to RSH, there were 5 ambulances outside.'
- 'Rang 999 at approx. 12.30am. My son (aged 10 months) had been poorly for a few days and was showing signs of respiratory distress. Paramedics arrived swiftly. Joint decision was made for me to take him to Telford A+E in the car rather than via ambulance as appeared stable (oxygen 92 awake). Drove to Telford and arrived at A+E. Was seen by nurses that observed oxygen was over 90 when awake but under 90 when asleep…I was happy

with decision for me to drive him there at the time but wonder if he'd have been put onto the high flow oxygen sooner if arrived via ambulance.'

- 'My husband was showing the signs of sepsis so we rang for an ambulance. This was late on a Thursday night in August. It arrived an hour later. They took his obs and said that it would be better if he drove himself to hospital if he could because if an ambulance took him, he would be waiting outside the hospital for much longer.'
- 'My Mother called for an ambulance to their residence in Oswestry 31st May as my father had fallen in the bathroom and she could not lift him. He lay on the floor without any clothing on for approximately 6 hours. He was 85 and when he eventually got to the Shrewsbury hospital he was diagnosed as having a bleed on the brain and transferred to Stoke. He had surgery and was recovering well and a week after being released home he suffered a seizure 16th June. We called 111 and then was advised to call 999. There were no ambulances available and no ETA and was advised t in order to expedite care we took him in the car 1.5 hours to Stoke. We arrived 1pm and he was made to wait until 8pm in a wheelchair and only after complaining was he moved to a bed and he then did not see a doctor until 10pm after another complaint was made. Over the following weeks he had two more operations in Stoke which were unsuccessful and sadly passed away 5th July.'

By Royal Shrewsbury Hospital (1 person)

- 'My mother needed an ambulance that the doctor had said we should call after she had problems after emergency surgery. We were told not to bother by the Surgical Assessment Unit (SAU) at Shrewsbury and to try to bring her in ourselves! Good job we had a vehicle, what if we hadn't?.'

By GP (2 people)

"A patient with known bony secondaries from cancer; had fall and painful leg at home; ambulance service flatly refused to attend despite his consultant telling his wife to call ambulance; she called our [GP] surgery and we intervened and only managed to get an ambulance many hours later. he had fractured femur but now also paraplegic from spinal secondaries. Afraid this is pretty typical. As a practice we are now taking the risk of

advising sick patients to organise their own transport to hospital." *A local GP Practice*

- 'I have recently received emergency lifesaving surgery at the Royal Shrewsbury Hospital. On 27th January 2022 my GP eventually gave me a 4pm walk in appointment. I was so ill she told me to lie down rather than sit on a chair. She called my husband in and asked him to take me to hospital knowing I needed urgent treatment and stated the ambulance at that time could incur a wait of 6-8 hours. She called the surgical department alerting them to my arrival, I then waited in the car, because I needed to lie down, for about 4 hours before being seen by anyone…'

Using own transport after being advised on wait time (6 people)

- 'A bit before 1 am on Sunday morning I rang 999 for an ambulance to take me to RSH. I had tripped in my lounge at home, fallen and bashed my cheek on the fireplace, blood was spurting everywhere, I was upset, shaken and the bleeding wouldn't stop. I live alone. I was told it would be a 6 hour wait at least. I could not drive myself there, I could barely see out of one eye. I was not given any advice at all about what to do. I rang my daughter who organised a taxi for me and stayed with me on the phone until it came.'

- 'Called an ambulance at approx. 10-50 pm for suspected heart attack. Told no ambulance available for hour and half. Phoned my daughter who came and took me to A&E at 11-15 pm I was seen straight away and given treatment and told I had a heart attack and needed to go to Stoke for an operation straight away by ambulance Again no ambulance available Staff were getting concerned after 1/2 hour wait and Stoke were phoning Shrewsbury to see how long I would be as a team was waiting for me to operate Shrewsbury then had to inform the ambulance service that it was now critical that I went so that they would come. At 1 am an ambulance eventually came to take me to Stoke Arrived at Stoke and immediately operated on by the waiting team who had been called out.'

- 'Following a relapse, my husband was again subject to a Mental Health Act (MHA) assessment in the afternoon and agreed to go into St George's Hospital, Stafford. At 6pm the ambulance service said no transport could be available for 6 hours i.e., midnight! I couldn't face a repeat of what happened 6 months previously when we already had to wait 5 hours and with extreme difficulty and some danger my husband was taken by car to the hospital.'

- 'A walker called asking to use our landline due to ineffective mobile reception in an attempt to call an ambulance to attend to his wife who had slipped, was in extreme discomfort and possibly broken her ankle in the ford close to our house. The call was made around 11.30am. Our son

made the call so the husband could return to his wife who had been left within the highway on the edge of the ford. The call control centre receiver seemed to have difficulty recording the facts as far as we had them but eventually concluded an ambulance would be sent. In answer to his question my son was told arrival would be within 6 hours! Along with the couple we decided that was unacceptable and with much difficulty moved the patient to a vehicle and transported her to A&E where the patient was very well treated…'

- 'My 85-year-old Mother-in-Law had a bad fall in April this year while she was shopping in Oswestry. Passers-by, including an off-duty nurse, assisted her and called an ambulance because she was bleeding from a head wound. They were told that the wait would be 6 hours or more, luckily there is a walk-in centre in Oswestry and my wife drove her there.'

- 'Last night my husband had a stroke. It was sudden onset. I called my daughter, called an ambulance. Even though it's the highest category the ambulance could not give any idea of how long. We knew he needed the clot busting drug asap. My daughter asked the neighbours and they put him in the car, he is 18 stone and couldn't stand. We rushed to hospital. With the help of security guards and nurses we got him to resuscitation when he had the clot busting drug. He is now fairly stable. Waiting for a bed. If we had waited he would most probably have irreversible damage. We took him to Wrexham. he is a patient there …they have been wonderful.'

Used own transport to get to preferred location (1 person)

- 'Contacted 111 that resulted in ambulance attending to do an assessment. Could not take me to my local hospitals, Wolverhampton being the nearest hospital available! Alternatively, my husband could drive me to Shrewsbury hospital himself. We arrived very, very early on the Sunday morning and were then subjected to the usual long, long wait. Staff working incredibly hard and doing their best. I think I was in A&E for many hours.'

Estimated Time of Arrival (ETA) Information

Four people reported that they would have made the decision to transport the patient if they had been given better information about the ETA of the ambulance and in one case the family feel that if they had the patient would not have died.

"In November 2021 my wife slipped on the decking and landed awkwardly injuring her back on the edge of the step. She was in extreme pain when she fell but thought she had only bruised herself and thought she would recover with rest. Two days later she was still in pain and it was getting worse

so I took her to the A&E at the Royal Shrewsbury Hospital. She was diagnosed with a "soft tissue injury" and sent home with pain killers. Five days after this my wife was I extreme pain and asked me to call for an ambulance, which I did at 0700 hrs. I was initially told that as a "worst case scenario" there would be a five-hour delay. I asked my wife if she wanted me to take her by car but she refused as she thought that an ambulance would be coming shortly.

After five hours we rang again and were told that they had allocated an ambulance but could not give a time. Unfortunately, she was now in too much pain to go by car and wanted to wait for an ambulance, which she still thought was on its way. My wife and daughter spoke to the ambulance service on a number of occasions during the afternoon explaining my wife's condition but still no ambulance came. The ambulance eventually came at 6.45pm, a delay of 11 hours 45 minutes. Although the ambulance crew did not say anything it was clear that they were concerned about her condition and took her in the ambulance.

The hospital identified sepsis due to a ruptured colon and continued to try and stabilise her for surgery; unfortunately, they were unsuccessful and she passed away in the early hours of Thursday morning on her way to the theatre.

The WMAS have advised me that the initial "worst case scenario" of 5 hours was generated by a computer algorithm and not by the call handler and they had decided to cease using it. They have also said that, in future, they will be honest with callers and advise if there is to be a delay so that they can make an informed decision whether or not to make their own arrangements for transport to the A&E.

I have my wife's hospital notes and it is clear that they thought she had a good chance of surviving the surgery but she died before getting to the theatre. I am convinced that if the WMAS had been honest and told me that there would be an unacceptable delay I would have got her to hospital in either my car or motorhome. I could have got her to hospital before 0900 hrs and the hospital would have had an additional 11 hours to stabilise her and operate and she would most probably still be alive today…."

- 'A man had chest pains and symptoms of a heart attack and his wife called the ambulance at 4.30am. His wife had to call again at 5am and then again at 5.30am and ambulance arrived at 8.30am. During these calls the ambulance call handler reassured her, saying that the ambulance was on its way. The man said that if they had known the ambulance would take 4 hours his wife would have driven to the hospital.'
- 'Our GP phoned for an ambulance for my husband at noon and it did not arrive until 8.30am 2 days later. We called every hour and the call handlers were actually quite rude to us. If we had known that they would take such a long time then we would have transported him there. When he arrived at PRH we were told he had terminal cancer within an hour of being there and he died shortly afterwards. He was kept waiting in the ambulance on arrival even though he was in so much pain. It was a mess up and I feel I have been robbed of time with him.'
- 'One early evening I felt unwell, as if with indigestion. I went upstairs to lie down, but the symptoms worsened and instead of suspecting indigestion, because of chest pains I began to suspect something more serious. My wife at about 21.30hrs decided to ring 111 but received an answer phone response stating that all lines were busy and to go online and log in the symptoms. At 21.40hrs I was in severe pain and clutching my chest as I lay on the bed. She then rang 999 and asked for an ambulance. The reply from the operative was to the effect that an ambulance was on the way, it would be blue lighted, and in the interim, all windows to the room should be opened, masks should be made available, and have someone watching out for the ambulance to guide them to the correct house. Nothing happened and during the ensuing hours my wife made a total of three calls, each time receiving the same reply, implying that the arrival of the ambulance was imminent. Eventually an ambulance arrived at about 05.15 hrs. This was a wait of some seven and a half hours. I do not recall this event. Staying with us at the time was my brother-in-law and have we not been led to believe that the arrival of an ambulance was imminent he

could have taken a chance and at least started to convey me to Shrewsbury Hospital, maybe meeting the ambulance on route and thus saving valuable time. But because of the misleading information we stayed put. …. The fault here lies with the information given by the control room staff who are no doubt working to a script laid out by a higher authority, and no blame could be attributed to them.'

Falls

In table 1 we identify 38 cases of people who rang for an emergency ambulance after falling. From these cases just over half gave an indication of how long they were lying on the floor, these are summarised in Table 2.

Table 2: Reported duration of lying on floor or ground while waiting

Falls	Hours on floor			
Age Group	0 - 5	6 - 10	11 - 20	21+
25 - 49		1		
65 - 79	1		1	1
80+	2	5	3	1
Not Known	2	3		1
Total	**5**	**9**	**4**	**3**

Of the 38 people who described the reason for calling an ambulance as a fall a number of these explained that the person was not injured but needed assistance in getting up.

- 'My 85-year-old disabled husband fell in the bedroom upstairs. Although we have a hoist I cannot take it upstairs and he cannot get up unaided so I had to call an ambulance to pick him up. We don't have any helpful neighbours and our son lives several hours away … I made the call at 7.30 am and the ambulance finally arrived at 01.15 the following day, a wait of 18 hours. He was not injured so I expected a long wait, but this was a very difficult time. When the crew arrived they were shocked at the wait and were extremely kind and helpful. More recently I had to call again in similar circumstances and this time the paramedics came within 15 minutes, so that was a very different wait and much appreciated.'
- 'My wife had a fall when moving from her bed to her commode. Her mobility is poor and I was unable to get her up, despite several attempts. I called the ambulance service for assistance at approx. 08.20. Her fall was not life threatening but I needed the service because ambulances carry the special inflatable cushions which can get a patient back to the sitting

position from which my wife could then get herself up to the standing position. The ambulance eventually arrived at approximately 16.20 - 8 hours later. The paramedics got her up in less than 10 minutes and did a series of checks which revealed that all was well, so it was not necessary for her to go to hospital. The following evening my wife's legs gave way when I was helping her get to the stairlift. Again, I couldn't get her up so had to call 999. This time the wait time was 6 1/2 hrs-again the checks revealed that no serious harm was done. Whilst my wife was never at risk of dying, spending 14 1/2 hours on the floor is not a pleasant experience, being unable to move to move, to go to the loo or get remotely comfortable. Overall, once the paramedics arrived, the care was excellent in every respect. However there really should be a more responsive system to cope with falls such as these. I understand that had these falls occurred on a weekday, a dedicated falls team could have responded more quickly but this team does not function at weekends.'

- 'I fell in the garden at 8.15pm on Saturday night. I knew I hadn't broken anything as I managed to crawl to make a phone call to 999 but I was stuck on a concrete floor outside. I told them that I had fallen but couldn't get up because of my artificial hips. My husband can't help as his is a tetraplegic in a wheelchair and I am his carer. I just needed somebody to help me get up. The ambulance service told me that I couldn't expect anybody to come until 3:30pm the following day and suggested I rang the Police. I did that and they told me to ring the ambulance service. After a few calls the Police agreed to attend but I had to wait 7 hours outside on a cold floor. ….'

- 'My neighbour asked me to help lift his wife off the bedroom floor as she had fallen getting of her commode. She is 10 stone, is in her 70s, has dementia and was a dead weight. Both she and her husband were weak because they had Covid. My neighbour was told help by the ambulance service would take 5 hours. We could not leave her on the floor that long, so, though at risk of her falling and risk to our own limbs and backs we pulled her onto the bed. In addition I was put at risk of Covid- but what were we to do?'

- 'A few weeks ago my elderly mother had a fall at home. She lives alone and has a pendant alarm so help was immediate from neighbours and an ambulance was called. She was unable to get up from the floor and was in distress. We were told the ambulance would be "4 to 8 to 12 hours." they were very grateful when I arrived and was able to cancel it as we managed to get her up and I checked that she was ok. However, she ought to have been able to have her a medical professional check her over. We are now terrified that she might have a fall or some kind of incident as we are reluctant to add to the pressures and also don't want to subject her to a long wait to see someone at a hospital that is 20+ miles away.'

We heard from an Independent Living Scheme about the need for a 'Falls Team in Shropshire' and from an organisation who supports adults with learning difficulties in their own homes about conflicting advice from the ambulance

service to that given by their own organisation of who can safely help a person who has had a fall.

- 'I am an Independent Living Coordinator and Manage an Independent living scheme for 55 plus, with [over 40] tenants. My tenants due to age and medical conditions are prone to falls and unplanned hospital admittance. In March 2022 I had a 76-year-old gentleman with Parkinson's Disease fallen on his kitchen floor, no obvious injuries at the time. Ambulance called at 10.00am approx., arrived 6pm - 8 hr wait, required hospital admittance, admitted 2 weeks. In June 2022 61-year-old male, diabetic, liver and kidney issues, fell onto the floor, ambulance called at 1.30pm arrived 12am, 11 hours wait. Tenant was lifted back up and settled. [Early] July 2022 same tenant, was attended by a Dr and an ambulance called due to health concerns, needed to be admitted but not life threatening at the time. Ambulance arrived on the 5th July at 8am. The outstanding call was spotted by 2 paramedics who had just come on duty and saw the ambulance required was still outstanding. This same tenant is currently still in hospital being treated, he is reluctant at the moment to return home for his fear of falling and not knowing how responsive the ambulance service will be. We desperately need a falls service in Shropshire. My tenant with Parkinson's firmly believes that the complications that followed to his heath were due not to his fall, but primarily to the wait for the ambulance service, and length of time he was on the floor. I should add I am not allowed to lift fallen tenants to risk of possible injury. There is also a pressure when a tenant has fallen, and they have no next of kin, that we are asked to stay with them, which we obviously would do, but this isn't always possible when it's an 8-hour delay and I have the responsibility of looking after 40 other tenants, who, could also fall at any time. Our tenants are issued with an alarm, and for those who need it assisted aids, but falls and ill health will still occur. Therefore, we are desperate to have the ambulance service back to it was before, but fundamentally a Falls Team in Shropshire would be hugely beneficial to prevent tenants suffering from long ambulance waiting times, which may then lead to hospital admittance, that otherwise could have been prevented if an uninjured tenant was able to be assisted back up within an hour.'

- 'We support vulnerable adults with learning disabilities in their own homes on a 1:1 basis, some of whom have falls at home. We have been directed by our OT that we should not be trying to get people to stand up and that our first port of call is to call for an ambulance to assess the person for injuries incurred and support to get up. The response that we have had has been very negative, one person who fell an incurred a head injury was given a waiting time of over 6 hours, another person who fell 10 - 15 hours and along with this we have been criticised as a provider because the ambulance service feel that it is our responsibility to get people up from the floor again, to the point where they have raised safeguarding alerts around neglect. I have raised this issue with my inspector and logged with CQC. The response from her has been that this is a growing problem, but

without a second staff member and prescribed equipment how are we supposed to get people from the floor, and we are not trained or qualified to assess for any serious injuries beyond regular First Aid Training'

Rapid Response Team

To help residents avoid being admitted to hospital Shropshire Community Health Trust runs a rapid response scheme.

"The Health and Social Care Rapid Response Team (HSCRRT) provided across Shropshire, Telford & Wrekin supports residents who are experiencing a rapid decline of their health and are in crisis and at risk of being admitted to hospital.

The team integrates Community Nurses, Social Workers, Physiotherapists, Occupational Therapists, Paramedics, Non-medical prescribers and Call Handlers into one team.

Residents can be referred to the team from a range of agencies such as the emergency department, West Midlands Ambulance Service, 111, GPs, Family Connect, community health and social care teams, care homes and the voluntary sector.

Residents are then assessed within two hours from being referred to the Rapid Response Team.

On receiving a referral, the team provides an immediate response to crisis using new, state of the art equipment as well as puts a plan in place to help resolve the health issue and prevent it from happening again – enabling residents to remain as independent as possible in their own home."[9]

One comment did refer to the Rapid Response Team

- 'I received a phone call from a friend asking for assistance as her sister had fallen getting out of bed, this was around 8.30am. On arrival at the house I found the lady in question on the bedroom floor. The first 999 call was sometime between 9.30am and 10am.The request was for assistance to help get the lady off the floor. This lady is 74 with mobility issues, [various health issues] making it impossible for us to her up. The call was passed to Rapid Response who sent one man with inflatable cushion to try to lift her, this was unsuccessful and he passed it back to ambulance service as urgent, this was around 12.45pm. Three further calls were made to 999 asking for the ambulance. I made the final call approx.9.45 -10pm telling them she was going in and out of consciousness the ambulance was dispatched immediately and arrived shortly after, a second ambulance was required with lifting equipment. One hour later the lady was finally off the floor and on her way to hospital. She had been on the floor waiting for help for 14 hours.'

[9] https://www.shropscommunityhealth.nhs.uk/news?itemid=10362

The last two experiences indicate that the social care agencies involved feel there is a misunderstanding within the ambulance service of the level of support the agencies can provide to their service users.

Quality of staff

Regardless of dissatisfaction with waiting times, almost everyone who commented on the ambulance service staff that attended were complimentary.

- 'The paramedics were amazing but were apologetic about how long it took them and said they hate it when they can't get to calls quick enough.'
- 'The call handlers and the paramedics were very helpful and pleasant.'
- 'Ambulance crew was great and took him to PRH. … 999 call handler sounded embarrassed about the waiting time.'
- 'Nice people and I felt sorry for them.''
- 'When the paramedics arrived, they were amazing and their care was exemplary.'
- 'I have nothing but praise for the ambulance crew.'
- 'Excellent, polite and professional and very friendly and communicated very well with each other. Really good teamwork… Very reassuring.'
- 'He had nothing but praise for the care he received from everyone, from the point of speaking to the two call handlers [through to discharge from hospital].'
- 'I've always found the ambulance crews friendly and caring.'
- 'I was very impressed by the ambulance crew when they arrived. They were extremely helpful and professional.'
- 'Ambulance service was amazing, made sure that lady was comfortable and had enough food and drink…'
- 'The ambulance staff that came and took him was caring and compassionate too.'
- 'We cannot fault the ambulance people and 999/112 they were very helpful and caring.'
- 'Paramedics arrived quickly and were very thorough and reassuring.'
- 'At all points the ambulance staff and rapid response team were kind, caring, thoughtful and professional, giving my father the time and reassurance he needed every step of the way. They were cheerful, pleasant and relaxed. To be honest, I don't know how they manage in such stressful times.'
- 'The paramedics were amazing.'

In one case the wife of a man who died from a cardiac arrest felt that the staff did not treat his case with the urgency that was required:

- "I believe that if my husband had had the correct care from the 2 Paramedics/Ambulance Drivers the morning [in] July 2022, he would have had a chance of survival. But from my initial call to 999 at 7.20am that morning and up to the time he went into cardiac arrest, he was failed and did not stand a chance.

  The ambulance did not arrive until an hour later. I have since heard that the operator that answered the call should have stayed on the line in case my husband went into cardiac arrest whilst waiting for the ambulance to arrive. I told the lady on the phone that my husband was struggling to breath and had crushing chest pains and clammy. He had 4 stents 11 years ago due to Angina and I said he thought it was a heart attack, but she did not stay on the line whilst waiting for the ambulance to arrive.

  My husband had moved into the conservatory on his hands and knees on the tiles to get cool as he was hot and clammy. He asked me to call my friend M. who lives 2 doors away to do CPR in case he did go into Cardiac Arrest as I was unsure what to do. I think time went on and he was reeling in pain, nearly an hour passed and the ambulance arrived. Now looking back, he was not given oxygen and he repeatedly kept gasping, I can't get my breath.

  They asked him his medical conditions and he gasped Asthma and Angina and mentioned the stents.

  The young lady attempted to shave his chest unsuccessfully, the ECG pads were coming away and had to be kept pressing down. His blood pressure was taken and oxygen levels. A comment was made levels were low but they are coming back. The ECG she advised indicated it did not look like a heart attack.

  She consulted with her colleague and after working on him for half an hour, his blood pressure dropped and they advised whilst no indication of a heart attack, there was some Cardio activity and they would take him to hospital.

  When I got into the ambulance with him, he had wires on him which I assume were monitoring his heart. A comment was made by the male colleague to my husband 'oh I see you had a pain then' as I assume the indicator had raised. But there was no urgency as the lady colleague stood by the side door, saying shall I drive a couple of times until she did get in Drivers side and drove off.

  My husband was in terrific pain all through and gasping, trying to catch his breath, but the male colleague again said, 'I do not think it's a heart attack' and still no oxygen was given. Should Heparin have been given but I do not know what was given to him prior to getting into the ambulance.

Then, as we left and the minutes passed he was getting worse. The male colleague asked my husband 'Have you got Hay Fever', my husband replied, I have never had it and I thought this was an odd question to ask when he was struggling to breath and he also told him he had pins and needles sensation up his left arm for past two weeks and a feather like feeling on his neck, to which he got no response. I was unaware of this as my husband had not talked to me about this.

He then at some point held onto his inhaler and told the man, I am having this not because of Asthma, but because I cannot breathe. (He only had mild asthma). Not long after this, he jolted, face contorted, gasped and the man lay him down. My initial thought was a stroke.

The man then knocked on the partition window to get the driver's attention.

She did not hear as it appeared she had earphones in her ears and he knocked again, until I said she cannot hear you and then he slid the screen across to get her to stop. I feel this is precious minutes wasted as we have now learnt it was a cardiac arrest and you only have 4-6minutes to do CPR or else brain damage occurs. I ask why is there no radio contact between the driver and colleague in the back?

We eventually stopped and I was told to get out and I was still unaware of the complexity of his situation. Sometime after another ambulance arrived and an ambulance car. Were the people who first attended my husbands qualified to deal with that situation?

Not sure after how long but we started off to the Hospital, blue lights this time, where he was worked on for 30 minutes by the team waiting for him. He never came too, but he wouldn't have would he as he would have been brain dead from time wasted knocking on driver's window, minutes wasted when those minutes could have saved his life.

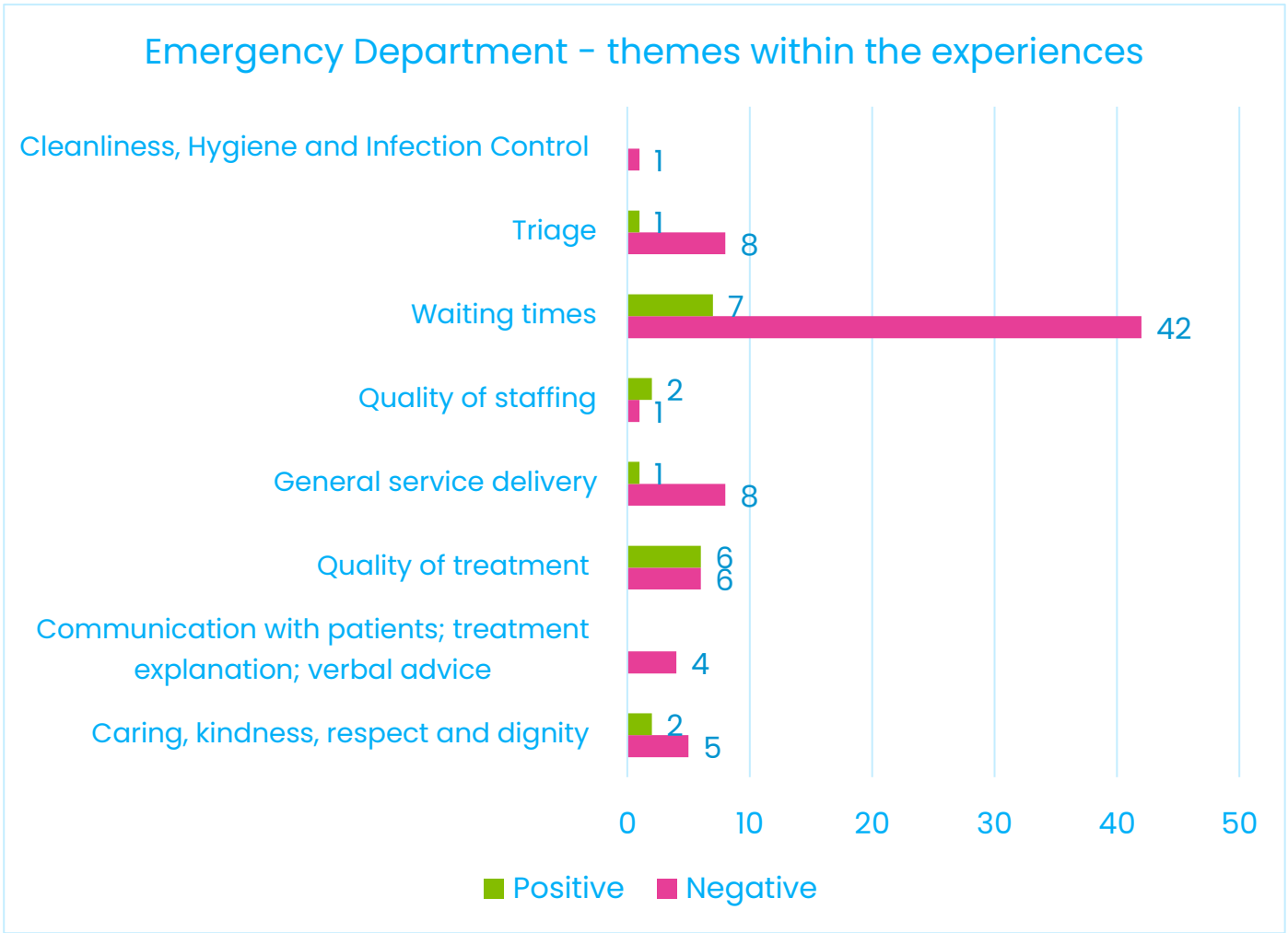
I am not a medical person but I know my husband was failed from the very minute I telephoned 999 to his final suffering moments and he did not deserve this at all …. I believe he would have at least had a chance of life if the correct procedures were followed that morning and they could see how serious this was and got him to hospital sooner to get the treatment he rightly needed, possibly for Heart Surgery.'

Emergency Department (ED or A & E)

74 people told us about their experience of an Emergency Department

- 15 people (20%) described a positive experience
- 4 people (5%) described a mixed experience, with both positive and negative aspects
- 55 people (75%) described a negative experience

Hospital	Positive	Mixed	Negative	Total
New Cross Hospital, Wolverhampton	0	0	1	1
Royal Stoke University Hospital	1	0	0	1
Princess Royal Hospital	3	1	25	29
Royal Shrewsbury Hospital	9	2	25	36
Wye Valley NHS Trust - Hereford	1	0	1	2
Not stated	1	1	3	5



Note. Each experience can include multiple negative or positive themes or a mixture of both.

Waiting in the Ambulance outside the Emergency Department

Twenty people, just over 12% of respondents, reported a long wait in the ambulance on arrival at the hospital but before admission:

- 2 up to 1 hour
- 7 between 1 and 2 hours
- 2 between 2 and 3 hours
- 1 between 3 and 4 hours
- 1 between 4 and 5 hours
- 2 between 5 and 6 hours
- 1 between 6 and 8 hours (but received specialist care in the ambulance)
- 4 people specified no time
- 1 person specified 10-hour wait was expected, so the crew took the patient to another hospital

A similar number of people told us about long waits to see a doctor once they were in the Emergency Department.

What people told us about their wait in an ambulance.

- 'Arrived Shrewsbury approx. 10pm, approx. 10 ambulances waiting ahead of me. Waited approx. Two hours in ambulance then was admitted to ambulance-controlled ward within Shrewsbury and given a bed in a holding ward. Paramedic staff took regular readings to check I was okay. After approx. Three hours, it was clear that nothing was moving and no patients were being moved into full A&E. As I was generally okay and able to walk etc, paramedic staff said it may be faster to move round from their unit into A&E, which I then did. Saw A&E admission nurse approx. 3am who took bloods etc and then put me into queue to see doctor. Nothing then happened until the hospital came to life approx. 9am.'
- 'Took her to the hospital where she waited in the ambulance until 4pm [from 10:30am]. Ambulance service was amazing, made sure that lady was comfortable and had enough food and drink.'
- 'Ambulance arrived within 45mins Mum assessed and stabilised Arrived princess Royal about 10am. Ten other ambulances there already, had to park in car park driveway. Triage Dr visited ambulance within 15 mins. Stroke specialist visited ambulance within 60 mins, ordered scan. Mid-afternoon mum still in ambulance, we returned home. Phone call around 6pm to say mum had been transferred to a waiting area in the hospital and was being cared for by paramedics Approx 9pm mum admitted to the stroke rehab ward. Discharged 48 hrs later, transport provided.'

- ‘GP called ambulance while I was at the surgery. It arrived 18:50 and took me to RSH. PARKED. along with many others until 22:20 when I needed the loo. Brilliant crew member recognised my biological distress & conferred with duty doctor. Was returned to a different ambulance. Doc came out 20 mins later having ordered opening of a day surgery bay and I was taken in. Tests during the night resulted in diagnosis of heart failure at 04:20am. Started on Bumetanide. BEST - calmness & concern of crew; RSH Doctor recognising the urgency of the case. WORST - seeing the traffic queue and realising I might not make it inside.’

Discharge from hospital

It is often reported that one of the issues creating the pressure on emergency services are lack of space in hospitals due to problems with discharging patients who are fit to leave hospital but need care, either in a residential home or in their own home.

As part of our call for people to share their experiences with us we asked to hear about the experiences of hospital discharge.

18 people told us about the discharge process and the post discharge support, 16 of these were negative experiences.

Delays in discharge

Several people reported delays:

- ‘My father was … in Whitchurch Community Hospital, where he stayed for 3 weeks, mostly because there wasn’t a care agency which could provide the care he needed.’
- ‘The delay with discharge was social care being put into place to assist her back in her own home.’
- ‘The delays in discharge (6 days) is another story!’

Discharge process

“The discharge process was awful. She was taken to the discharge lounge suddenly by a nurse who told while she was getting dressed this was happening. She was very upset and worried if relatives had been contacted to collect her. In fact they made one call but when it wasn't answered didn't try again. Luckily her niece visited that afternoon and found her in tears in

the discharge lounge. She was totally unprepared to go home, had spent no time out of bed apart from using the bathroom"

- 'My husband was in hospital for 10 days and during the week leading up to his discharge I contacted our local (Shropshire) physio/OT Neighbourhood team in the hopes that they could provide whatever aids he might need to facilitate recovery at home, such as raised toilet seat/grab rails etc. I was advised that they could not act until they'd had a referral from the hospital, at which point a home assessment would be made and all would go smoothly to facilitate a safe discharge - sadly nothing could be further from the truth. No such referral was made.'
- 'He was only in A&E for a few hours before I had a call to collect him. They had not assessed him but said "medically stable." He could not weight-bear at all. Had no strength to use any equipment, I only had a walking frame. He ended up spending 16 days in Whitchurch community hospital. Needing care package on discharge.'
- 'The discharge process for me was a mess, confused, unnecessarily long, distressing… I was told at one point there had been a disagreement or confusion about which doctor it had to be to sign me off - either a general medicine doctor or the max fax [maxillary fracture or facial injuries] doctor - A&E had been waiting for a general medical doctor to sign me off but they had refused.'
- 'He was taken to the Royal Shrewsbury Hospital but was sent home from A&E because "his baseline was not very different from his normal apart from increased pain." The OT at the hospital said that he could get into a chair, so he could get on to a commode. The whole point was that he could no longer walk safely to the toilet. A commode is a very unsubstantial, ill-balanced flimsy thing compared to a riser recliner. My father could not get on to a commode, but was very keen to get home, so this extremely disabled and vulnerable person was sent home. This decision, in my opinion, led to the next, inevitable crisis…'

Arrangements for post discharge medical follow up

"On the Sunday [son] was discharged and told he could carry on as normal and would receive an emergency MRI within 10 days. After 10 days no appointment was received so [mother] phoned the consultants secretary who couldn't get in touch with the epilepsy nurse. Gave number for the department who said it would be 10 weeks for an emergency appointment and the consultant shouldn't have said 10 days for an emergency scan. When [mother] spoke to the epilepsy nurse she said 5 weeks. Shortly after they received an appointment for an MRI a week later. She felt if she hadn't had chased she would still be waiting."

- 'Once it was agreed it wasn't a stroke and he was discharged there was no follow up advice given by the A&E Dr or any indication of what might have been wrong with him and what to do next. He was simply discharged and I came and picked him up.'
- 'Two days later, Called Shrewsbury Outpatient Department (OPD) appointments when I discovered that there would be no appointment and the discharge notes were wholly inaccurate (apparently I fell off a chair and had a soft tissue injury implying a bruise!!! omitting mention of excruciating pain and inability to bear any weight)'.

Arrangements for post discharge support

"My husband saw the hospital physio at around 3pm on Sunday - they would not commit to a date for discharge but he thought it would be Monday. Shortly afterwards I had a telephone call from the ward to say he was to be discharged shortly (on Sunday afternoon) and that transport had been arranged. I expressed concern because there had been no consultation with me (who would be his carer) and although he

was being discharged with a walking frame, there were no other aids provided. The nurse did then manage to obtain a toilet seat, without which he could not have safely used the toilet. Fortunately, I had obtained some urine bottles, and our son and a neighbour had brought a single bed downstairs for him. He would have been unable to climb the stairs which are steeper and narrower (we live in an old cottage) than the ones used for assessment at the hospital. He was given painkillers anticipating discharge that afternoon - it was 9pm before he arrived home, by which time the painkillers had worn off and he arrived home in considerable pain. The following afternoon, having used the urine bottles throughout the day, he needed to use the toilet, but then found he was unable to negotiate the steps into our downstairs toilet. I left a message for our neighbourhood team which was not picked up until the end of the day. Finally, a physio came out, technically at the end of her day, with a commode. The following day physios brought ripple mattress, bed rail, commode, and also did an assessment. They were unhappy that the only chair he could use was a swivel office chair - he could not have managed in our low lounge chairs, but had I been aware in advance I would have purchased a more suitable chair. My husband is 84, I am 79, and generally reasonably fit, but I felt totally ill prepared and vulnerable. Our neighbourhood team said that it had been an 'unsafe discharge"

- 'This lady lives alone and previously had no care. She was discharged with no care package put in place, still breathless when moving round (GP came out and she needed further antibiotics as chest infection not completely cleared) and using a Zimmer frame.'
- 'He was finally discharged from hospital, we were made to go collect him after asking for ambulance to bring him home for them to respond they are far too busy to bring him home … we as a family had only been told he

was being discharged on the day before, bearing in mind the house needed altering to meet his new needs.'

- 'What could have been done better? Arrange domestic support like walking aids, food and drinks.'
- 'Transferred to nursing home for rehabilitation for 4 weeks. Physiotherapy and occupational therapy visited only twice during her stay at nursing home. Discharged home with care package still unable to mobilise. Again, whilst at home little to no physiotherapy/occupational therapy visits (only visited twice since discharged home).'
- 'On discharge he was told the discharge team would contact him within 2/3 days. Three weeks after discharge he had heard nothing so contacted his GP, the GP was unaware he had had a stroke. GP gave him details of how to contact them. When he contacted them, they said his notes had been lost and they were very apologetic. Has now received a letter and seen by team the following Monday…'
- 'When he was released, he had no social care and his wife and daughter tried to care for him as he was bedbound. I phoned social services and they were very helpful however it took two weeks to get emergency care. My neighbour never fully recovered from the experience and later died.'

Key Findings

Ambulance Service

Wait Times

- Of those who told us about their experience of calling for an ambulance 107 people (66%) told us they were concerned with the length of time they had to wait while 27 people (17%) were pleased.
- Many respondents told us about how the wait they experienced affected the patient.
    - Some felt that there were serious consequences, including death of the patient and life changing irreversible damage
    - Others shared the discomfort and indignity of the patient that can result from a long wait

Transport arrangements

- 28 people (17%) made alternative arrangements to transport the patient to the Emergency Department. One person described using a taxi, the others were transported by relatives' or friends' cars.

  - 11 people took the decision themselves after waiting for an ambulance
  - 10 people were advised to use their own transport by either the ambulance service, their GP or the hospital
  - 6 people made the decision after being advised of the waiting times

- 4 people (2%) reported that they would have made the decision to transport the patient if they had been given better information about the estimated time of arrival (ETA) of the ambulance and in one case the family feel that if they had the patient would not have died.

Falls

- 38 people (%) described the reason for calling an ambulance as a fall. A number of these explained that the person was not injured but needed assistance in getting up. We heard from an Independent Living Scheme about the need for a 'Falls Team in Shropshire' and from an organisation who supports adults with learning difficulties in their own homes about conflicting advice from the ambulance service to that given by their own organisation of who can safely help a person who has had a fall.

Staff

- Nearly everybody who told us about the ambulance staff, 43 out of 44, described a positive experience of the care and support the staff gave.

Emergency Department

- 74 (%) people told us about their experience of an Emergency Department, 15 people (20%) described a positive experience, 4 people (5%) described a mixed experience, with both positive and negative aspects and 55 people (75%) described a negative experience
- Waiting times was the most frequently mentioned negative aspect, 42 out of the 74 people (58%) felt they waited too long to receive treatment.
- 20 people reported a long wait in the ambulance on arrival at the hospital but before admission, the longest reported wait was 8 hours.
- All of those who described details of their wait in an ambulance (4 people) felt cared for and supported.

Discharge from hospital

- 18 people told us about the discharge process and the post discharge support available, 16 of these were negative experiences. Five felt that the discharge was 'unsafe' or too hasty. Three described delays in discharge.

Service Provider / Commissioner Responses

Public Health

The Directors of Public Health for Shropshire and Telford & Wrekin have said,

(9 December 2022)

Understanding the lived experience of our residents is so important, it helps us to see beyond the data and hear the real impact these delays are having on people's experiences of care and outcomes. This independent report from Healthwatch highlighting these experiences needs to be at the heart of the planning and improving services and outcomes for our residents. We commend this report to our health and care system.

Shrewsbury & Telford Hospital NHS Trust

As provider of emergency and inpatient care.

The Director of Nursing at told us,

(21 December 2022)

Across the system we are seeing an increased challenge with ambulance delays which ultimately impacts on the care of our patients and local communities. As the report highlights, we at SaTH are unfortunately holding more ambulances, we are working closely with the Ambulance Trusts and system partners to address this. The pressures within the Emergency departments are complex and multi factorial, as a Trust we have more patients delayed in hospital who are waiting to move to their next destination for ongoing care, this has a direct consequences on our ability to deliver timely urgent and emergency care and ultimately impact on the Ambulance Service.

As a Trust we have several interventions which we are undertaking to support the urgent and emergency care service. We have launched an Emergency Transformation

Programme, this includes the development of an Acute Medical Floor on our RSH site, Same Day Emergency Care Services and an Ambulance Receiving Area. Additional plans are also in place for early 2023, these include assessment areas for specialty conditions, for example trauma, haematology and oncology, ensuring our patients are in the right place, to receive the right treatment at the right time. Other work is also ongoing to support timely discharge along with admission avoidance pathways.

Shropshire Council

As provider and commissioner of Adult Social Care

The Executive Director for people, who is responsible for Adult Social Care, told us,

(24 January 2023)

This report highlights the challenges faced right across the health care system in Shropshire and the experience of Shropshire people who use these services.

The council is one of a number of partners working to relieve pressure across the health care system, particularly on hospital admissions and ambulance call outs.

The discharge of patients from hospital, particularly older patients who often need other care and support to leave hospital, is a complex process and the numbers of patients "medically fit for discharge" are often not the same as those who are ready to leave hospital.

There are many reasons for this. For example - people become unwell again; they refuse a care package or placement, there's a family dispute often due to the extra caring responsibilities that come as a person is discharged; a delay in medication or discharge letters or in transport to take the person home from hospital. Around only one in five hospital discharges that are delayed are because social care is not in place. However, reducing further this will help reduce pressure on the system.

Social care is one of Shropshire Council's key responsibilities and it is putting every effort into supporting the health system to ensure discharges from hospital continue as smoothly and in a timely way as possible to help ease the recent winter and workforce pressures, as well as those created by the pandemic.

Among the steps the council has taken to support discharges from hospital are:

- 7 day a week working and supporting daily escalation system meetings, with staff taking on extra hours and giving up leave to ensure discharges happen on time
- Commissioning extra capacity to help find care home placements, domiciliary care and therapy support for those about to leave hospital

- Developing greater use of assistive technology to help people leave hospital sooner and stay in their own homes with support.
- Paying incentives to care providers who support timely discharges from hospitals
- Putting social workers and social prescribers into hospitals to support discharges and refer patients leaving hospital to other support services, often in the community
- Developed an incentive payment for carers
- At times of peak pressures in the system, the Council has mobilised extra resources to support discharges
- The Council's Rapid Response team is now working closer than ever with health colleagues to prevent hospital admissions
- Working with voluntary sector partners to create a winter support project for people leaving hospital and to help avoid hospital admissions
- Developed a trial responder service for people who suffer falls – this will inform a potential future service.
- Expanded our pioneering '2 Carers in a Car' initiative to cover an even bigger area at night. This means we can provide more support to more people when they need this at home.
- Transport support at times of a critical incident if an ambulance is not needed.

Care homes and domiciliary care providers have a key part to play and we continually work very closely with them to support recruitment and retention of their staff. We are also working with the care sector on redesigning the care at home model to ensure consistent and equal access to support.

Shropshire Council is absolutely committed to continuing to do what we can to help relieve the pressures on the health care system through supporting discharges from hospital and making community care accessible that can help prevent people needing to go hospital in the first place.

West Midlands Ambulance Service

As provider of emergency ambulance services

The Executive Director of Nursing and Clinical Commissioning told us,

(2 February 2023)

I would like to thank Healthwatch for their work on this report. I would also like to acknowledge the candour demonstrated with the respondents.

Reading this type of report generates mixed emotions; clearly there is a theme of people being treated well by our ambulance service, but also concerns of unacceptable delays waiting for an ambulance to arrive. For those people who have waited too long for an ambulance to respond, I am really very sorry, and we will do everything we can to improve this situation.

Most people rarely use an emergency ambulance service and often do so only at a time of significant need and often when people are most vulnerable.

As an emergency ambulance service, we have invested time and resources to ensure we have a service that is able to deliver excellent care to people that need it in a timely manner. Across Shropshire, Telford and Wrekin we have increased ambulance resource, with modern vehicles and equipment, qualified Paramedics and trained Technicians on every vehicle; our staff want to be out there responding to people at their time of need.

Despite this, we are constrained with levels of delay that in my career I never thought I would see. When we take people to hospital, we are often presented with a delay that means the ambulance will never be back on the road during that shift. We have patients stuck for hours in the back of ambulances outside hospitals meaning that the ambulance is unable to respond to the next patient.

In December 2022, we lost over 45,000 resourced hours due to delays at the 22 hospitals we serve, and 17% of these lost hours were at the two hospitals in Shropshire, Telford and Wrekin. These delays directly impact our ability to get to people who need us, and our staff find this distressing and unacceptable and I know colleagues in the hospitals and emergency departments also share this concern.

We need to ensure that all of our health and care services take on board the challenges we face, to ensure that we have seamless care without delay.

Telford & Wrekin Council

As provider and commissioner of Adult Social Care

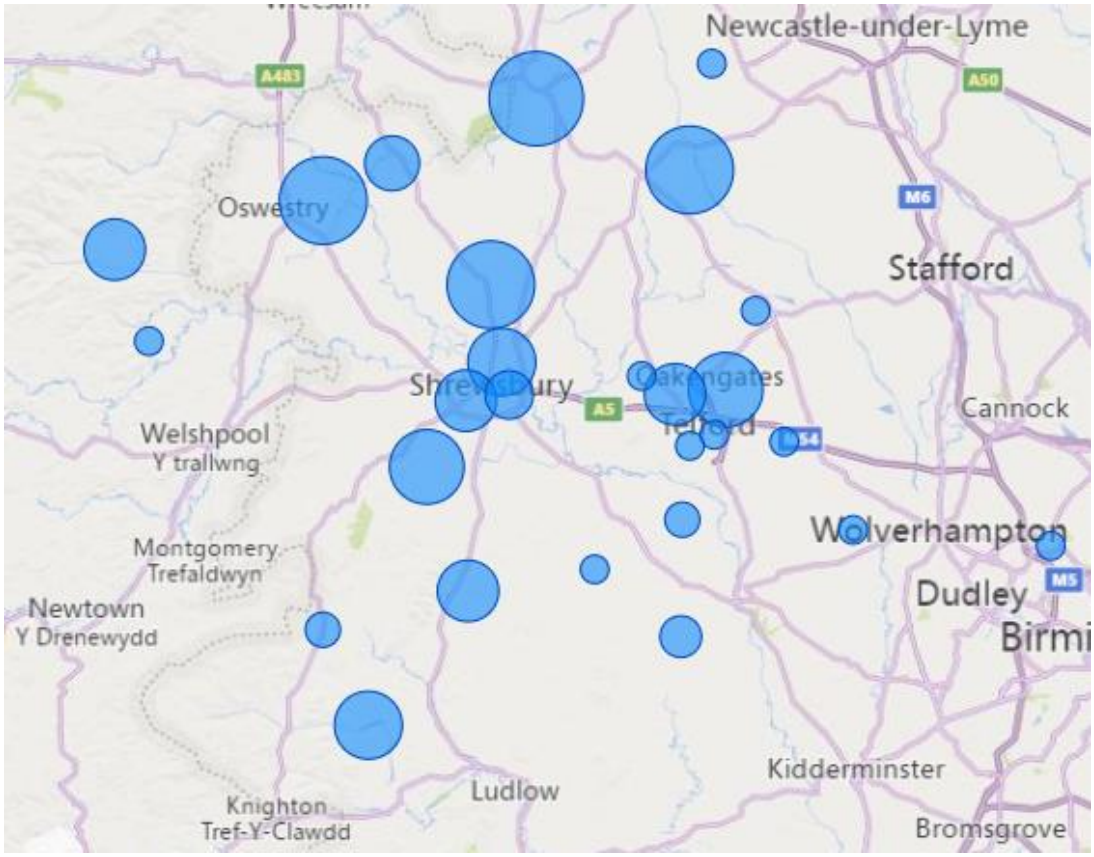
We have received no response from Telford & Wrekin Council in their capacity as commissioner of Adult Social Care in that area. If a response is received after publication it will be added to the report.

Appendix A – Demographics of respondents

Location

(Based on short postcode e.g. TF2 or SY12)

Total number of postcodes shared 130, largest bubble = 11, smallest = 1



Postcode Area		Postcode Area		Postcode Area		Postcode Area	
CW3	1	SY7	7	SY22	1	TF10	1
SY1	7	SY8	9	TF1	6	TF11	1
SY2	4	SY9	2	TF2	8	TF12	2
SY3	6	SY10	6	TF3	1	TF13	1
SY4	10	SY11	10	TF4	1	WS1	1
SY5	8	SY12	5	TF5	1	WV16	3
SY6	6	SY13	11	TF9	10	WV6	1
						Total	130

Age	Number
13 to 15	1
18 to 24	1
25 to 49	26
50 to 64	31
65 to 79	36
80+	8
Prefer not to say	1
Blank	64
Total	**168**

Gender	Number
Man	35
Woman	71
Blank	62
Total	**168**

Sexual Orientation	Number
Asexual	2
Bisexual	4
Gay man	5
Heterosexual / Straight	69
Lesbian / Gay woman	2
No	1
Prefer not to say	6
Blank	79
Total	**168**

Ethnicity	Number
Mixed / Multiple ethnic groups: Black Caribbean and White	1
White: Any other White background	2
White: British / English / Northern Irish / Scottish / Welsh	87
White: Irish	2
Blank	76
Total	**168**

Do you have a disability?	Number
Yes	13

Do you have a long-term condition?	Number
Yes	38

Are you a carer?	Number
Yes	20

Financial status	Number
I don't have enough for basic necessities and sometimes run out of money	5
I have just enough for basic necessities and little else	8
I have more than enough for basic necessities, and a small amount of disposable income, that I can save or spend on extras or leisure	43
I have more than enough for basic necessities, and a large amount of disposable income, that I can save or spend on extras or leisure	13
Don't know/prefer not to say	28
Blank	71
Total	**168**

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