Appendix 1

Report of the Prevention, Primary Care, Urgent and Emergency Care, and Discharge Task and Finish Group

Date: 9 November 2022

Acknowledgments

The task and finish group have taken a view across the different aspects of the services and systems that contribute to preventing and avoiding people needing to be transported to hospital, being admitted to hospital and discharged from hospital. Through their work they have recognised the complexity and the many different moving parts involved, and that there is a lot of work being undertaken in Shropshire and Telford and Wrekin to identify and implement opportunities to reduce demand and improve the flow of patients and their experience and the experience of staff. They have appreciated the information and evidence that has been made available to them, including the sharing of knowledge and understanding of the current situation and future intentions. They see the related topics as key features for future strategies and plans across the Shropshire and Telford and Wrekin area, especially preventing need and reducing demand, and as such being the focus of health overview and scrutiny work in the coming years.

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Report

Introduction

Context
Ambulance response times in Shropshire have been moving away from the target levels required for the over the past couple of years. Response times in rural areas have historically been slower than in more urban areas and the difference has been maintained as response times have been getting longer. This reflects patterns and issues nationally.

Concern about the time it takes for ambulances to respond to calls has been growing locally and nationally, with regular media reporting on ambulances queuing outside of Emergency Departments (EDs) because they are unable to transfer their patients and respond to the next emergency call.

The members of the task and finish group have been clear from their first conversations about the topic that addressing the underlying symptoms including delays in ambulances transferring patients into EDs and avoidable visits to EDs by patients requires a system wide understanding of the causes and solutions within a complex environment. Having this will help to identify the most suitable and effective options that need to be explored and implemented to prevent attendance and admittance, and that improve the flow of patients through their time in hospital back to where they live in their communities.

With this clarity, the task and finish group scoped their work around three key stages:

- Primary Care and preventing ED attendance
- ED attendance and admission to hospital
- Preparing for discharge from hospital and discharge from hospital

The view from the national perspective
A recent report by the **Healthcare Safety Investigation Branch** (Interim Bulletin 16 June 2022) identified the need for the DHSC to lead a national response and conduct an integrated review of the health and social care system to identify risks to patient safety associated with the flow of patients in, through and out of hospital and to implement any changes necessary.

The **Royal College of Emergency Medicine** "12 hour stays in the Emergency Department"(June 2022) accompanying press release called on the government to look at Short medium and long term plans.

Dr Adrian Boyle, Vice President of the Royal College of Emergency Medicine is quoted in the press release, including:

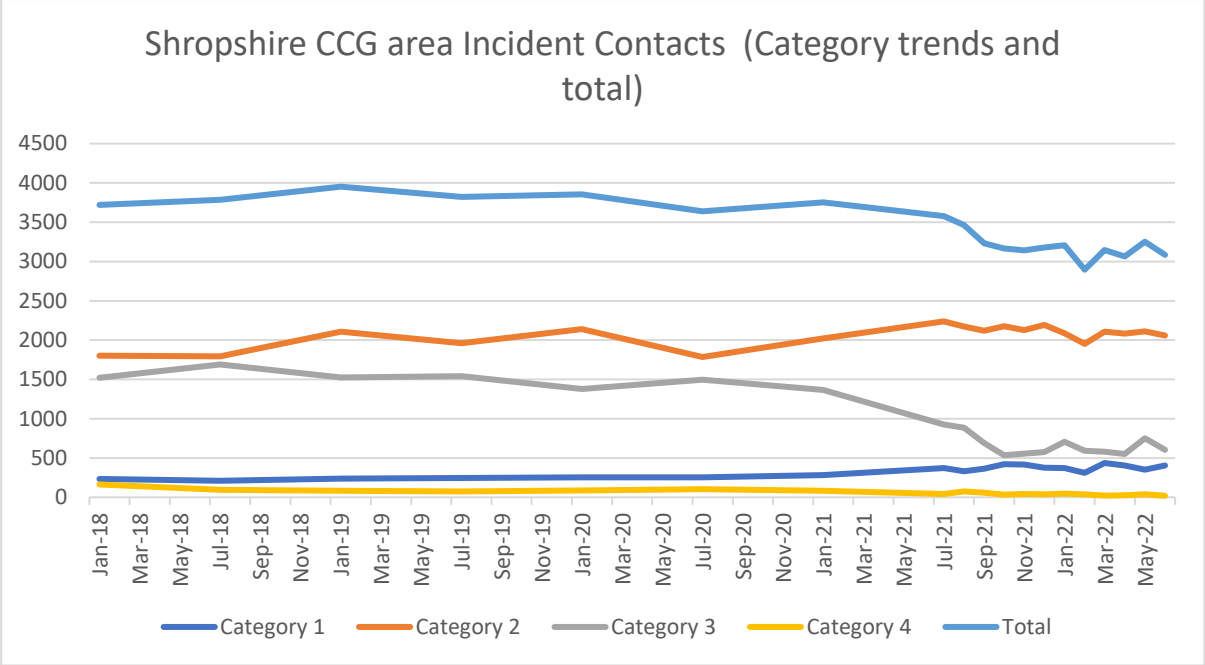
In the short-term, the government must set out a meaningful plan for social care that includes recruitment and investment in the social care workforce and paying a wage that values and reflects significance of their role. In the medium-term, the government must finally commit to publishing a fully funded long-term workforce plan that recruits new staff into the health service and includes measures to retain existing staff who are burned out and questioning their careers. Then will it be possible to open the 13,000 staffed beds required to drive meaningful improvement within the health service."

Analysis of Ambulance Response Times in the |Shropshire CCG area

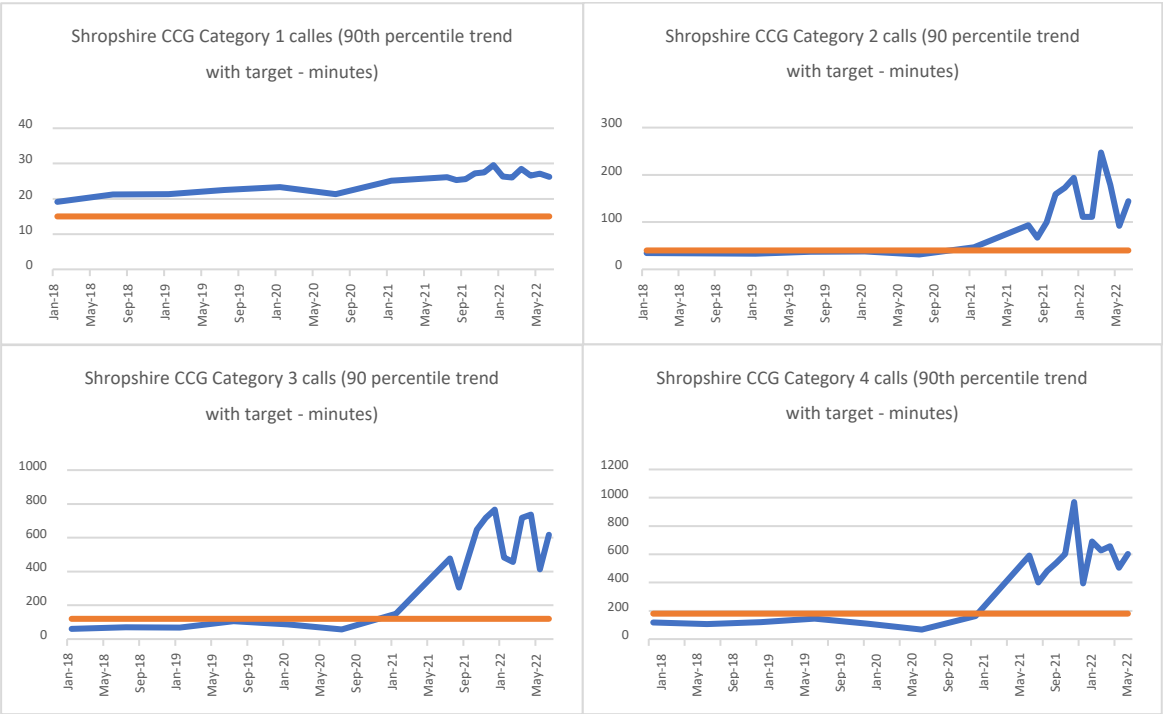
Category	Response	Target response time (mean)	Response time to 90% of all incidents
Category 1	An immediate response to a life-threatening condition, such as cardiac or respiratory arrest	7 minutes	15 minutes
Category 2	A serious condition, such as stroke or chest pain, which may require rapid assessment and/or urgent transport	18 minutes	40 minutes
Category 3	An urgent problem, such as an uncomplicated diabetic issue, which requires treatment and transport to an acute setting.; In some instance patients might be treated in their home by ambulance staff	n/a	2 hours
Category 4	A non-urgent problem, such as stable clinical cases, which requires transportation to a hospital ward or clinic	n/a	3 hours

Analysis of the West Midlands Ambulance Service (WMAS) response time data for Shropshire CCG area and the constituent postcode pre-fix areas demonstrates that response times in rural areas are longer than for urban areas. This has been a historic pattern that has continued over more recent years. It is important to note that WMAS performance is assessed over the whole of the geography it covers and not the individual constituent local authority areas.

The total number of WMAS incident contacts for the Shropshire CCG area look to have reduced over the past 12 months, mostly for the category 3 calls and to a lesser extent category 4 calls. This is shown in the top line in the chart below and in the grey and yellow lines for categories 3 and 4 respectively. Category 1 calls and category 2 calls have increased over the period of data, with the latter having by far the greatest number of incident contacts.



There has been a noticeable increase in the number of postcode areas where targets were missed and response times increased, with the results for January 2021 onwards in the data analysed standing out. During 2021 and 2022 the missing of targets and longer response times increased across all 4 call categories. This coincides with the increasing incidence of ambulance handover delays at A&E. The four charts below show the number of minutes achieved for 9 out of 10 incident contacts for the four different response categories with the orange line denoting the target level.



The visible and reported symptoms which triggered the commissioning of the task and finish group focused initially on ambulance response times. The task and finish

group quickly identified that the issues and the solutions were system wide and only as a system working together would effective and sustainable impact be realised.

1. Primary Care and preventing attendance at EDs

Factors influencing the demand at EDs and at acute hospitals overall were identified as:

- Access to GPs and/or patients not getting the answers they needed so they attend EDs
- Lack of understanding of the healthcare system and where services are available e.g. people who have moved from other countries may not have experienced primary care, including wider services at GP practices and services available at pharmacies, so attend EDs based on their previous knowledge and experience
- Covid vaccination experience showed that fewer young adults were registered with a GP practice and therefore could be more likely to attend EDs
- Avoidable conveyance of older people and those with an end of life (EoL) plan to hospital, which is via EDs, when they would be better remaining where they live, e.g. following a fall.

Access to Primary Care in rural areas and health services more widely is a challenge faced by communities, and in particular by people who do not have their own car and rely on community and public transport. Often this can be older members of rural communities who may be more vulnerable and have more health needs.

A fundamental challenge for the Shropshire Council area (and the more rural areas of the Telford and Wrekin) is how to provide access to services in predominantly rural area, with the acute hospital services centrally located in Shrewsbury and Telford, with community hospitals providing some services including midwife led maternity units, rehabilitation wards and minor injuries units (MIU) in Whitchurch, Ludlow and Bridgnorth, plus a MIU at the Oswestry Health Centre.

Whilst there are GP practices and pharmacies in towns and villages across the county, there are areas that are some distance from services, with no or limited public transport, and these same areas can also have challenges with digital connectivity which reduces options for services to be delivered and to be accessed differently. Similar issues exist for people who need to live in care homes, where accommodation could be located outside of the communities they have lived with social connections to family and friends.

The Fuller stocktake report 2022 has been shared with the task and finish group. The Shropshire Council Health and Adult Social are Overview and Scrutiny Committee were informed that Shropshire, Telford and Wrekin ICS have adopted it to inform the integration of primary care services locally. The report provides a number of case studies with examples of improved prevention/ deterrence of admission to A&E / hospital. Three case studies, summarised below, were of particular interest to the task and finish group members:

Streaming patients using systematic triage and clinical judgement and using this understanding to develop multi-site approach across different practices to ensure continuity of care for those with the highest levels of complexity and vulnerability, as well as enabling on the day access for who are generally well and for whom continuity is less important.
Question: Could a similar model work in Shropshire, if not operating already? For example across Primary Care Networks (PCNs), or practices operating across linked/multiple sites?

Manging demand and capacity across primary care by practices logging their on-the-day status online, with the CCG (at the time of the case study) supporting practices reporting capacity issues to find a solution. This has enabled some practices to develop an anticipated pressures reporting system to get ahead of demand and capacity issues the day before.
Question: Could the sharing of primary care data across the ICS avert pressures on specific parts of the primary care system freeing up appointments? Is it achievable in Shropshire and Telford and Wrekin?

Introducing an anticipatory care model to maximise people's wellbeing, maintain their independence, and empower people to make their own decisions about their care. Those eligible in the case study had moderate frailty and eight or more comorbidities or moderate/severe frailty who had not been in contact with a GP in the past 6 months. They received a holistic assessment and comprehensive multi-disciplinary team (MDT) review which developed recommendations based on the individual's need and wishes.
Question: Can health and social care services work more closely together to prevent admissions to hospital for those at a higher risk?

2. ED attendance and admission to hospital

Analysis of the nationally published ED performance scorecards focusing on the data for Shrewsbury and Telford Hospital Trust for April to July 2022 shows:

- Older patients spend more time in ED than patients in other age groups and are more likely to be admitted as an inpatient. Length of time in ED for these older patients could be symptomatic of patients waiting for a bed on a ward to be available.
- There were increasing proportions of people who attended ED who left before they received treatment. The smallest proportion of those leaving the department before treatment was completed were in the older age groups with July figures of 7% for 65 to 79 and 4% for 80+. This may be related to there being more likely to be admitted. The 18 to 34 age group had highest proportion at 20% of all attendances who left before they received treatment, followed by 35 to 64 with 13%, 14 to 17 and 0 to 4 with 12%, and 5 to 13 with 11%.
- The highest numbers and proportions of unplanned readmittance to ED in 7 days in July were in the 18 to 34 and 35 to 64 age bands with 10% (210 readmittances) and 7% (210) respectively. The highest proportion was in the 14 to 17 age band with 11%.
- The time to initial assessment for those arriving at ED by ambulance were longer than the national average in April and May 2022, with the figures for June and July showing marked increases that were much longer than the national averages. Time to treatment also increased for SaTH in June and July, moving above the national average.
- These results are part of the picture that illustrates the pressure on the Emergency Department, the impact on those arriving at the ED by ambulance, as well as the likelihood that those being admitted as inpatients via ED are more likely to be older or elderly people.
- Questions remain about those who leave the ED before being treated, and may need to form the basis of an ongoing focus to get greater clarity about:
  - Whether it is evidence that people did not need to be there and should have been looking for a service via Primary Care?
  - whether they presented to a different ED or represent at the same ED on later days?
  - Whether they needed to have treatment and are not getting it when they need it?
  - Whether there is or has been any follow-up on those who leave the ED before treatment across all age groups to understand their outcomes and experience?

Comparison of geographic provision

(Locations identified as geographic neighbours/sharing services, and family group local authorities)

Local Authority	Area (sq. miles)	Population (Census 2021)	Population increase	65+ population	Population density (per hectare)	Additional comments	Hospitals in the area (Acute and Community)
Shropshire	1,235	323,600	5.7%	25%	circa 1 person per hectare	Households are spread across all areas of the geography.	1x Acute Hospital (RSH) 3x Community Hospitals (providing MIU) 1x Health Centre (providing MIU)
Telford and Wrekin	112.1	185,600	11.4%	17.6%	5.7		1x Acute Hospital (PRH)
Powys	2,008	133,200	0.2%	27.7%	0.26	Large areas are not inhabited due to landscape/ geography	9x Community Hospitals (4 providing MIU)
Northumberland	1,936	320,600	1.4%	24%	0.6	97% rural 50% live in 3% of urban land in the SE of county Large areas are not inhabited due to landscape/ geography	1x Specialist Emergency Care 3x General Hospitals (Urgent Care Centres) 5x Community Hospitals (3 providing MIU) 1x new integrated health and social care scheme for patients requiring inpatient support for people following illness, injury or time in hospital) 1x NHS Centre
Cornwall	1,376	570,300	7.1%	25%	1.4	40% live in communities of less than 3000 people 4m tourists per year	1x Acute Hospital 1x Hospital with 24hr Urgent Care Centre 10x Community Hospitals (9 providing MIU)

Source: Various NHS websites for the different NHS Trusts. ONS Census 2021, Local Authority Websites

3. Preparing for discharge from hospital

Members of the task and finish group were informed that a range of requirements needed to be completed to enable the safe and effective discharge of a patient. As well as matters relating to medication and equipment having an impact, members were also informed about transport at discharge. They heard that transport arrangements for patients who are being discharged can take some time to be put in place, and that care homes will have a 'closing time' for admitting residents. As a result, this can mean that a patient identified as ready for discharge may not be discharged if transport cannot get them to the care home by the closing time for resident admission.

The task and finish group also sought to understand more about delayed discharges from acute hospitals, building on their understanding about the role of medication, equipment and transport in someone not only being identified as clinically fit for discharge, but also their inclusion on the 'ready to go list', i.e. where they have everything in place for their discharge.

They believe that whilst someone being clinically fit for discharge reflects the assessment of the health professionals in the hospital it should also be communicated alongside a clear view of the number and proportion of those clinically fit for discharge who are on the 'ready to go' list as this provides a true reflection of those who are ready to leave hospital with the different requirements and arrangements in place for their support, reablement and to be able to live as independently as possible.

Members learned that where care had been booked and confirmed for a patient who was subsequently not discharged as planned, the council has to pay for the 'booked for care'.

Social Care

Shropshire Council, as with all Councils, moved to "Discharge to Assess" during the pandemic, with in the region of 1,000 additional discharges during and post-covid compared to pre-covid.

A comparison of discharges that the council supported in Q1 2019/20 and Q1 2022/23 showed that the 2022/23 figure (788) was 57% greater than in the same period in 2019/20 (500).

Shropshire has a fairly high number of care home beds compared with other local authority areas in the region, but the issue is with the complexity of care needs. Often those being discharged have more complex care needs, they may be more poorly and potentially require 2 to 1 care. As a result, it can take more time to admit and settle in a discharged patient into a care home, with the care homes having a deadline after which they would not be able to accept a new resident.

The available care home beds are not just available for hospital support, they must be available for cases from the community via social care or for people who are arranging and funding their own care. This needs to be understood by all parts of the system.

It is very rare for a patient to be discharged out of hospital to a long-term placement. The reablement model is employed with the aim to help people regain their independence and not need paid for care, or to maximise their independence and reduce the amount of care they need. The council works with Shropshire Community Trust to ensure wrap-around therapeutic services are in place.

The reablement model is resource intensive, requiring a lot of officer capacity to carry out the assessment and reablement support (wrap-around therapeutic support). For domiciliary care at discharge the council runs the START service (Short Term Assessment and Reablement Team). This is the council's in-house step down and step-up (admissions avoidance). Community Hospitals (Bridgnorth, Ludlow and Whitchurch) have reablement wards which are part of the provision in the community.

In terms of the wider domiciliary care provision in the Shropshire Council area, there are in the region of 89 domiciliary care providers in the area. Members understood that one of the questions that is being considered is whether this is too many for them to be able to operate at scale.

Work is also progressing on how technology plays a role in supporting people to be more independent. Members heard that care providers are coming on board and seeking support to be able to adopt technology as part of the packages of care they provide.

Members raised concerns about the lack of clarity about the future of the three remaining community hospitals in the Shropshire Council area. Anecdotal information that has been shared with members that indicates the possibility of the facilities being closed, removing access to services from the communities in largely rural areas they serve, including the step-down beds in the rehabilitation wards.

Attracting and retaining staff

Members recognised the challenges of recruitment and retention within the system and the contribution that this has on the ability to provide services. They noted a range of factors that could impact on this.

The importance of access to rest breaks and refreshments and to toilet breaks to employee welfare was noted, as was the challenges of ensuring they can take place in services that are responding to demand, whether to an emergency call or due to the pressure on the service. For example, ambulance crews often operate from stand-off points rather than from a base location with facilities; waiting to transfer a patient at A&E, followed by a quick turnaround to a new call.

Members heard anecdotally that long shifts i.e. 12 hours long, may have unsustainable impacts on the workforce including a risk of burning staff out at a faster rate. It was also noted that:

- there is no childcare for shift workers at SaTH e.g. the privately owned nursery at the Royal Shrewsbury Hospital runs 9.00am to 5.00pm
- whilst not a recent development, the move away from nursing staff being able to work 2 nights a week to fit in with their children resulted in many leaving their roles

There is continued competition with other employment sectors for staff for some health and care roles, with retail and supermarkets often identified.

During the task and finish group's period of operation data was published by 'Skills for Care' (22 October 2022) on the social care workforce nationally and at the local level. 1 in 9 jobs in Shropshire was unfilled in 2021/22 which is c6%. Nationally the figure was nearly 11% in September 2022 and for the West Midlands it was 10%. Aligned with this is the rate of turnover which was 28% in Shropshire and 29% nationally, with the highest rates in care workers and direct care staff. Commenting on this situation both Skills for Care and Age UK identified improved pay (and conditions) being required.

For the 2022/23 year, before the cost-of-living crisis, Shropshire Council increased the fees it paid by 6% to enable an hourly rate of £10.40ph. In addition, the council pays above the rate for provision in more rural areas, reflecting the extra mileage requirements and the higher fuel costs.

The opportunity for more joined up approach to workforce matters across the system continues. The council has worked for many years with Shropshire Partners in Care (SPiC), and more recently with the Integrated Care System including looking at all age solutions, including how to make a career in Health and Care attractive to younger people already living in the area, or to attract young people to work in, move to and live in the area. Local recruitment fairs have been used, including to help with season demands such as winter pressures, in part recognising that some people will be interested in earning additional income in the run up to the festive period and into the new year.

Some continuing question related to the health and care workforce that Members reflected on were:

"Are the good things about care sector employment shared enough?" and,
"Do we know enough about what matters to health and care workers that need to be protected or put in place to attract them or to keep them in their roles?"

In terms of broader incentives to attract and retain health and care staff, a wider and more strategic challenge for the system partners recognised by the task and finish group is access to affordable and suitable accommodation for health and care workers, that is in the right place.

Members queried whether people in these roles can afford to live in the locations that provide them with good access to work, opportunities and services for them and their families, particularly in rural areas and areas with higher populations of vulnerable people or people that need more frequent access to health services and to support? Is enough understood about the challenges for current and future staff in terms of cost of living where they want to, where demand for services and support is now and the future, and the options and opportunities that could help?

Areas for further consideration relating to preparing for discharge from hospital:

How is the mobility and independence of inpatients maintained in hospitals? How is 'PJ paralysis' avoided?

Are there any places in the country where 24/7 care is fully operational? Where are the NHS locally with 24/7 care? What are the key drivers for success in 24/7 care and can these be replicated in Shropshire and Telford and Wrekin?

How much impact does the provision or non-provision of 24/7 care have on timely planned discharges from hospital?

How many patients on average are delayed nationally, regionally, and locally each day as a result of 24/7 care not being in place? For all three what does this represent as a proportion of all delayed discharges and planned discharges?

How many patients are delayed on average over a weekend nationally, regionally, and locally as a result of not being able to be discharged on a Friday due to 24/7 care not being available? For all three what does this represent as a proportion of all delayed discharges and planned discharges?

How can any gaps in staffing in the key professions that underpin 24/7 care be closed e.g. pharmacists, radiographers? Is doing this a practicable reality locally and what would the timescales be if it was? If 24/7 care cannot be realised locally, what innovations and interventions could help make the difference?

How does the number of acute hospital beds per head of population in Shropshire and Telford and Wrekin, plus taking account of the mid-Wales population, compare to the national averages and region averages, plus with other geographies with similar demographic profiles e.g. Northumberland and Cornwall?

For these same places, what are the numbers of reablement beds/community beds per head of population and how does this compare to the Shropshire and Telford and Wrekin area?

What is the strategy for local community-based services in the Shropshire and Telford and Wrekin areas?

What needs to be in place in the community to facilitate more timely discharge from acute hospitals that is not already in place? What needs to happen to help make this occur, and when?

Are reablement beds in community hospitals and beds in care homes in the right areas of the county e.g. where people who need reablement support live?

How do the number beds now and in the future compare to the current and projected increases in the 65+ population and the 85+ population?

Are there areas of Shropshire and Telford and Wrekin where access to community-based provision is lower? What impact does this have on people aiming to return to

these areas when they are discharged? What impact does this have on other areas of the county?

What role could or will virtual ward beds play in reducing the need for people to stay in acute hospital beds, community hospital-based rehabilitation beds, and care home beds?

What is the impact of the availability of suitable homes and accommodation for people to be discharged to – including issues related to timeliness of adaptations and access to the suitable equipment when it is needed – especially for the implementation and reach of the virtual ward?

Conclusions
The route into and out of hospital-based services is truly end-to-end with dependences and interdependences across the system affecting the flow of people and patients and how smoothly and effectively the different moving parts join up and work together. Speeding up or slowing down different parts of the system can have unplanned and unwanted impacts. However, what is clear is that preventing demand through improved health and wellbeing and through providing the care and support people need, particularly those who are more vulnerable and need greater access to services.

In the local area challenges associated with the providing services and access to services across a large geographic area with a dispersed rural population and an increasingly aging population, add further considerations to a moving and complex situation. Analysis of the Shropshire Council area population in recent years identified that older people made up a greater proportion of those living in rural areas (places with populations of less than 10,000 people), than the urban areas.

This can include higher costs to provide services reflecting:

- longer travel time per visit e.g. for domiciliary carers,
- transport requirements for people and patients to reach services,
- longer response times e.g. for ambulances to reach patients,
- incorporating rural proofing into service planning, provision and decisions.

Demography also plays a role in current and expected future demand. The above national average 65+ and 85+ populations and the projected increases in these populations are expected to result in continued rising demand for primary care, Emergency Department (ED) attendance and admission into acute hospital beds.

Against this backdrop a challenge to the whole system for coming years will be design, commissioning, and provision of services in the communities that people live in that helps to prevent them needing to access services, and where they do need to access services, it can be at home or as close to home as possible, unless their needs are such that they need care in an acute hospital setting.

Within a geographically large, primarily rural and sparsely populated area access to and awareness of the location and purpose of primary care and health and care services such as those in and minor injuries units. This more widely available provision, combined with awareness raising and improved health literacy, especially for the sections of the community identified as unnecessarily attending EDs who could have their health needs met in different ways, has the potential to help reduce demand in EDs and improve the timeliness of treatment.

To this end there needs to be mutually supportive strategies in place for current and future acute hospital services (the Hospital Transformation Programme), and a robust and comprehensive programme that has the local and community focus. This would need to take account of rural proofing issues and have cross system investment in a mixed provision that makes the most of the available developments in technology and infrastructure, and which organisations and groups are best placed to be commissioned to provide the services and support required.
Throughout this work the members of the task and finish group have maintained a strong view on the importance of the workforce in the delivery of the services now

and in the future. Recruitment and retention is an ongoing challenge in the system, from acute hospitals through to social care. What needs to happen to attract people to work and live in the area who have the right experience, skills, qualifications, and motivation for all of the different roles in the system, and help them want to stay and work in the area?

Whilst outside of the scope of the work task and finish group members are concerned about the impact of the cost of living crisis where people (especially those on fixed incomes or low incomes might be making hard choices about food and heating), combined with the expected increase in Covid 19 cases and potential for a challenging flu season, could set up a perfect storm for Urgent and Emergency Care, and the wider system which impacts on and is impacted by what happens through EDs and discharge from acute hospitals.

Recommendations
The members of the Task and Finish group are aware that there is considerable work underway in the system, as with other areas of the country, to reduce ambulance waits and pressure at EDs. If work that would deliver the recommendations is already planned or underway, please can this be set out in the responses to accepted recommendations including what is being done, the timelines for action, and how the impact and progress will be evaluated and when.

1. Recommendation: An evaluation should be completed to understand current and future need in different communities, the community capacity available to deliver social and health care, and based on this whether there are sufficient skills available in the community, and how to best close the gaps overall and in specific geographies.

2. Recommendation: Data sharing across all of the system partners needs to take place consistently and comprehensively to enable the achievement of shared outcomes. In this instance this needs to be for the end-to-end system and could be used to design, target and evaluate different programmes and initiatives including stratifying the population and identifying people with health needs e.g. those who would benefit from advanced care plans, those who would benefit from early intervention, or prevention.

3. Recommendation: A full pathway mapping exercise should be carried out using this data to understand the end-to-end pathways, the patient flows including the different inward and outward patient entry and exit points, and the different reasons for ambulance calls and ED attendance. This would help to identify opportunities to reduce/avoid ED attendance, calls for ambulances and admissions. (From access to primary care and preventing attendance at ED/avoidable calls for an ambulance, through ED and admission as an inpatient, to 24/7 care and discharge and capacity in the community for NHS step down beds/virtual wards, care home beds and domiciliary care).

4. Recommendation: A comprehensive programme of Health Literacy should be developed and implemented based on the insights and understanding developed through analysis of the data and intelligence on Primary Care and ED activity, the soft intelligence from primary research and engagement activity e.g. why people are going to ED, with a view to segmentation and targeted social marketing/behavioural economics to help raise awareness and change behaviours.

5. Recommendation: In the interests of transparency and developing greater understanding of what needs to be in place to enable effective discharge from hospital, reference to the numbers of those identified as clinically fit for discharge should be made alongside a clear view of the number and proportion of those patients who are on the ‘ready to go’ list.

6. Recommendation: A formal mechanism should be progressed that enables the structured rotation of staff into the different health and care roles in the

organisations and services within the ICS. This can help develop their understanding of how the whole system works together, promote the opportunity for a career for those looking for one (this may be clinical leadership and not just the progression into management), and help attract and retain staff in a competitive market.

7. Recommendation: That the Joint Health Overview and Scrutiny Committee maintain a robust view of the wider system and the component parts that impact on and are impacted on by the urgent and emergency care pathway, in particular following up on significant areas such as the development and transformation of local/community services including prevention, admission avoidance and post discharge reablement provision. This area should be a feature of the Integrated Care Strategy with delivery across all system partners and all geographic levels across Shropshire and Telford and Wrekin.