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

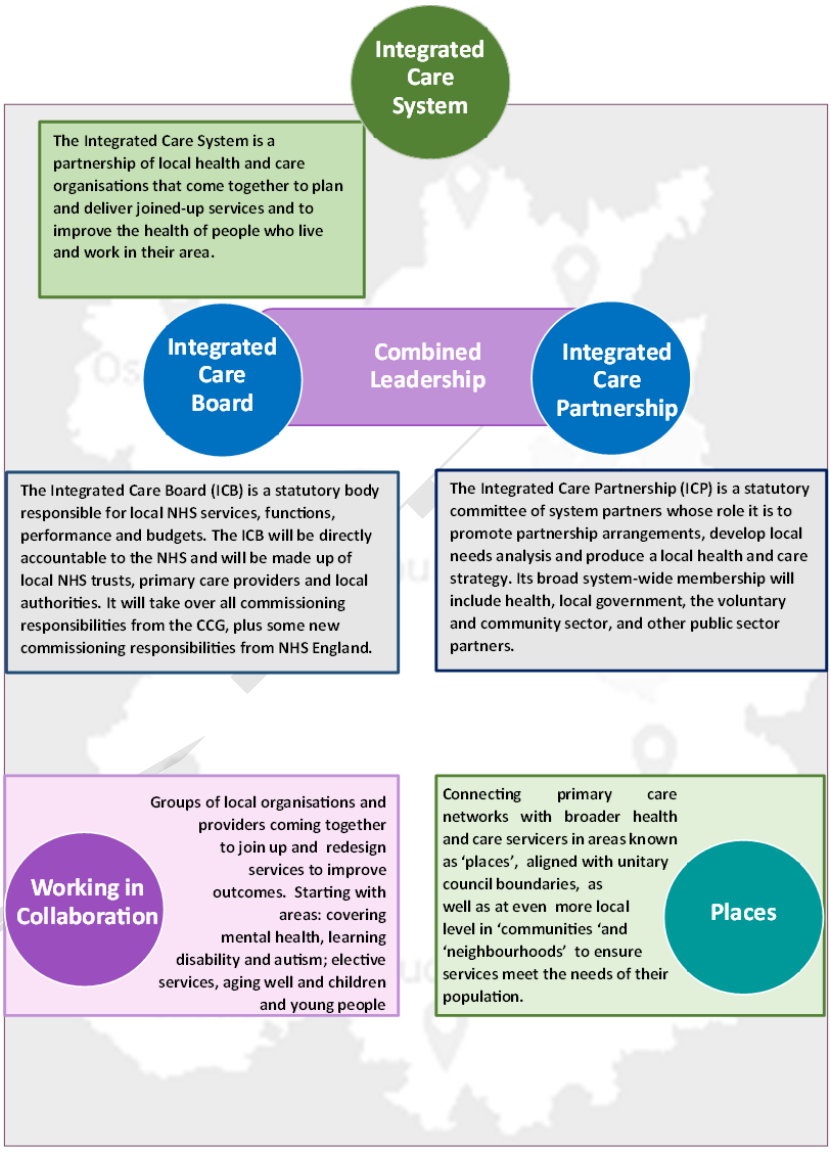
We must not forget that there are also key enabling factors that support the delivery of our plan, such as workforce, technology, research and innovation, the Green Agenda, and finance. This plan outlines the actions we will take in each of these areas.

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

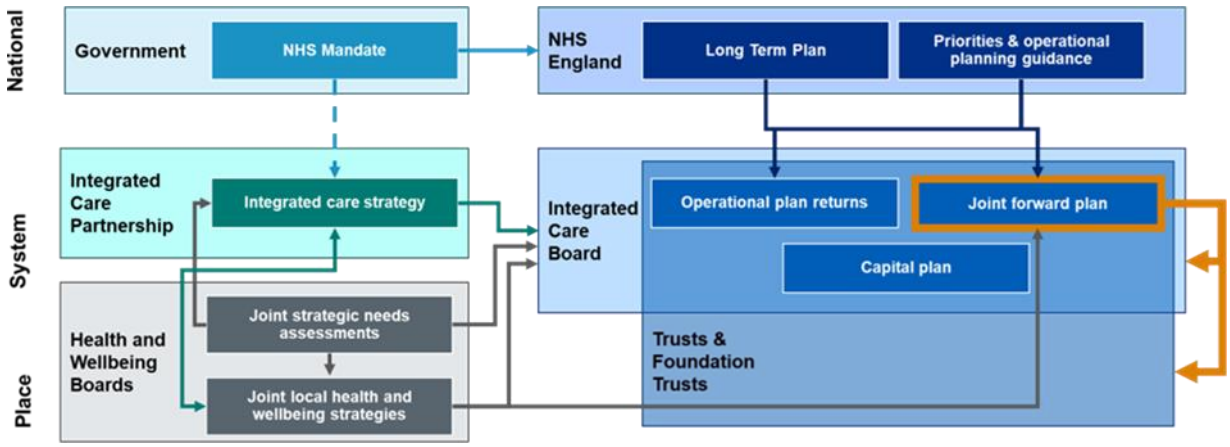
Our Integrated Care System has developed this Joint Forward Plan, which describes our system's ambitions, how our system will deliver these ambitions, and how we will facilitate joint action over the next five years. We have taken stock of the great work underway and aimed to provide a clear picture 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

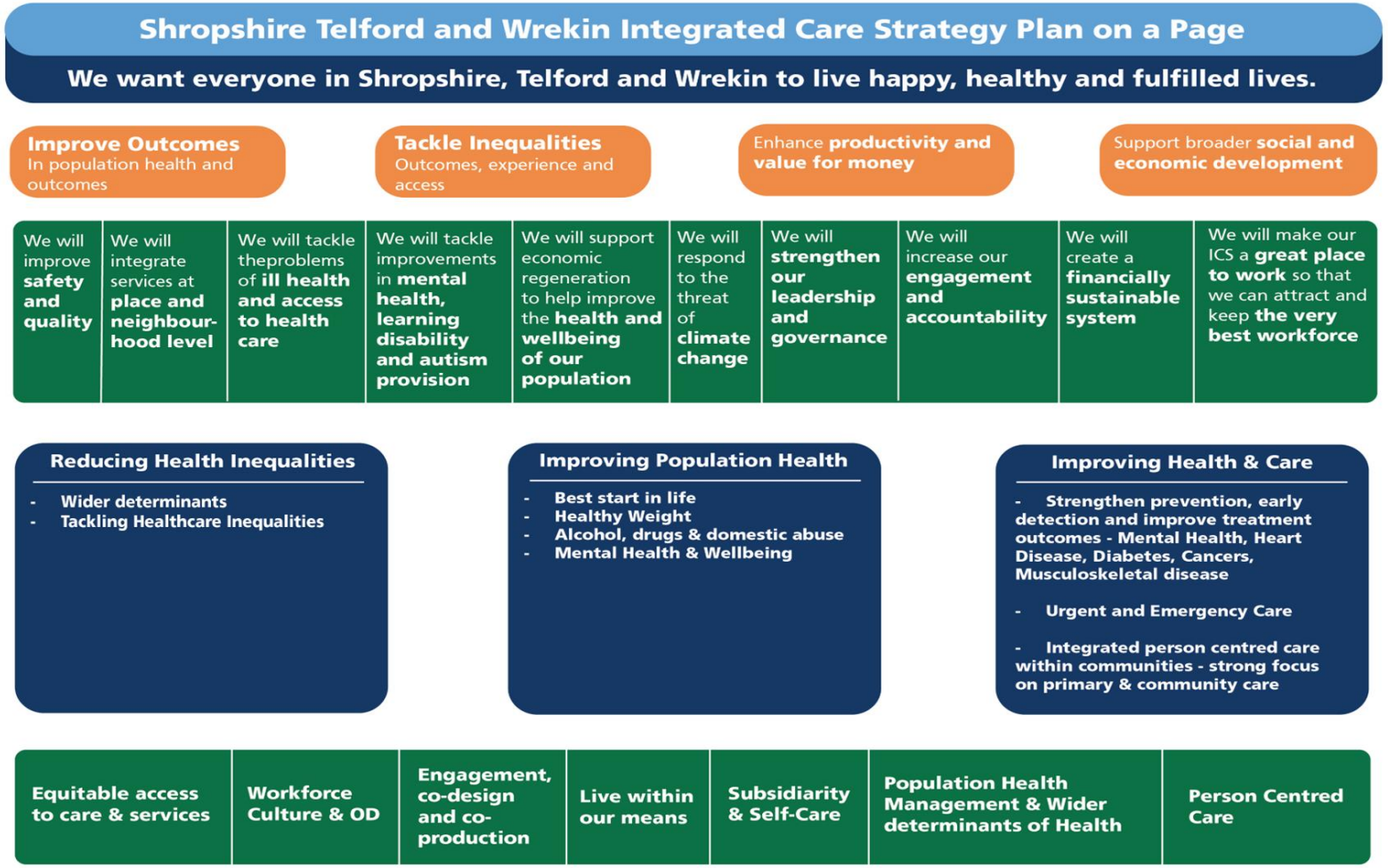
- **Our size:** We have significant opportunities to make large-scale changes, to shift our system culture and embed it in a manner that may not have been possible in a larger system.
- **Our leaders:** Leaders within the system have shown a significant willingness to rise to the challenge of being an 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.

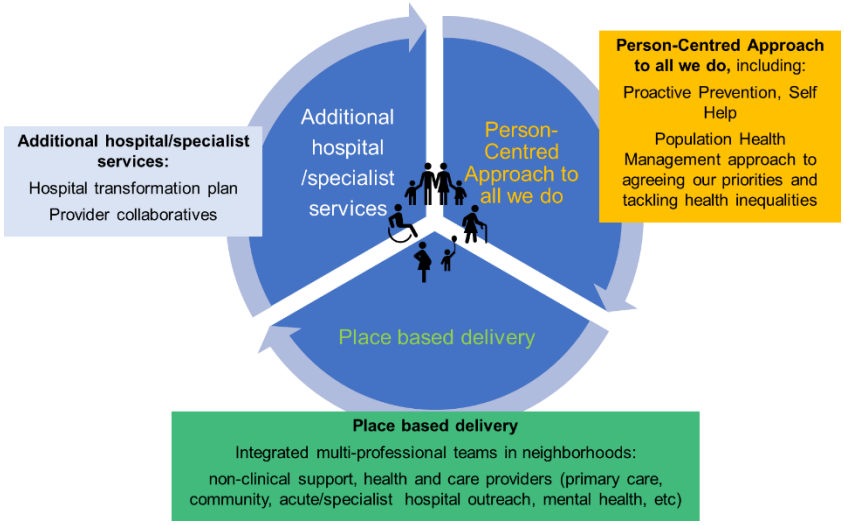
1.4 What do we want to achieve?

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	-	-

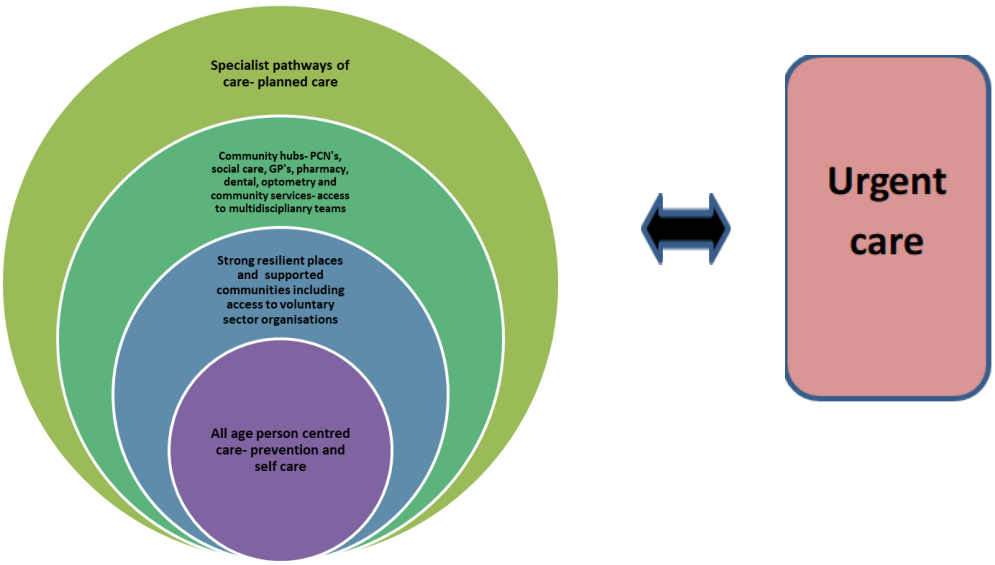
Case study – Healthy Lifestyles Service - part of the Teldoc Diabetes Pathway.

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:

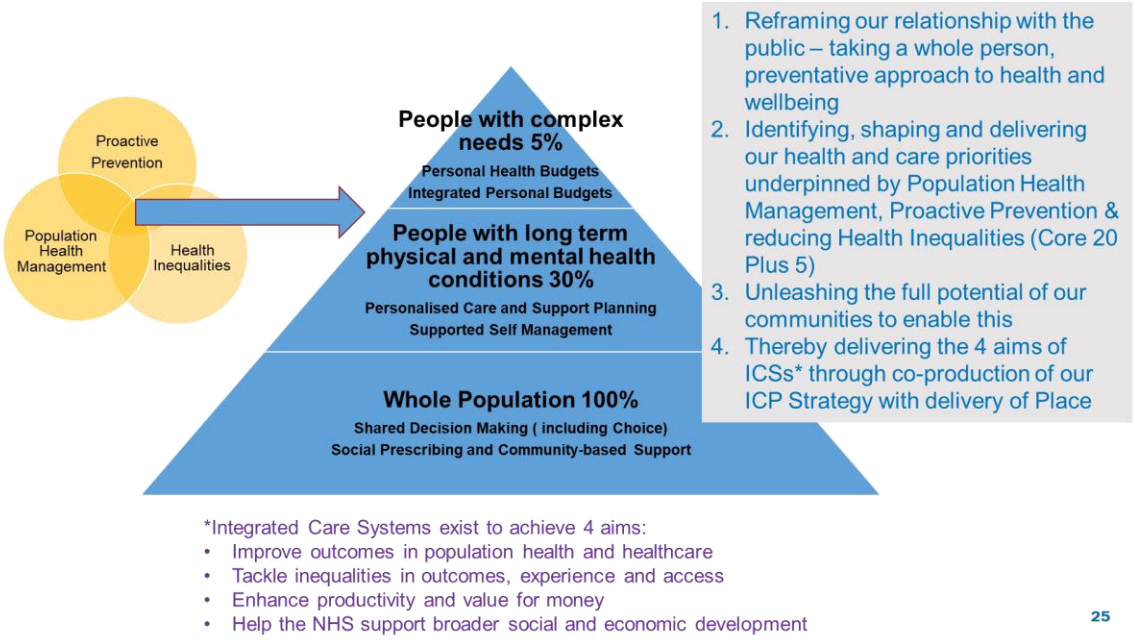
How will we monitor quality?	How will we measure and sustain quality?	How will we improve quality?
• Listening to those with experience of care. • System Quality Risk Register. • System risk escalation.	• Executive champions of quality health and social care coming together at System	• Integration of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

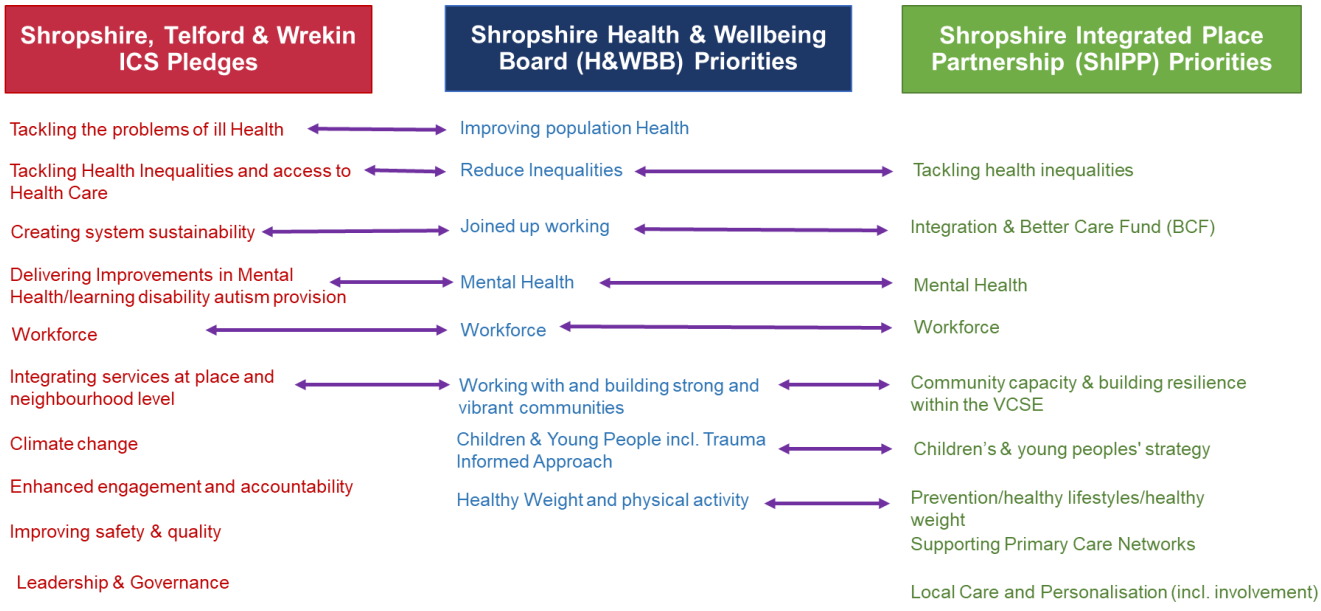
The Shropshire Health and Wellbeing Board acts to ensure that key leaders from the health and care system work together to improve the health and wellbeing of Shropshire residents. Board members collaborate to understand their local community's needs, agree priorities and work together to plan how best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

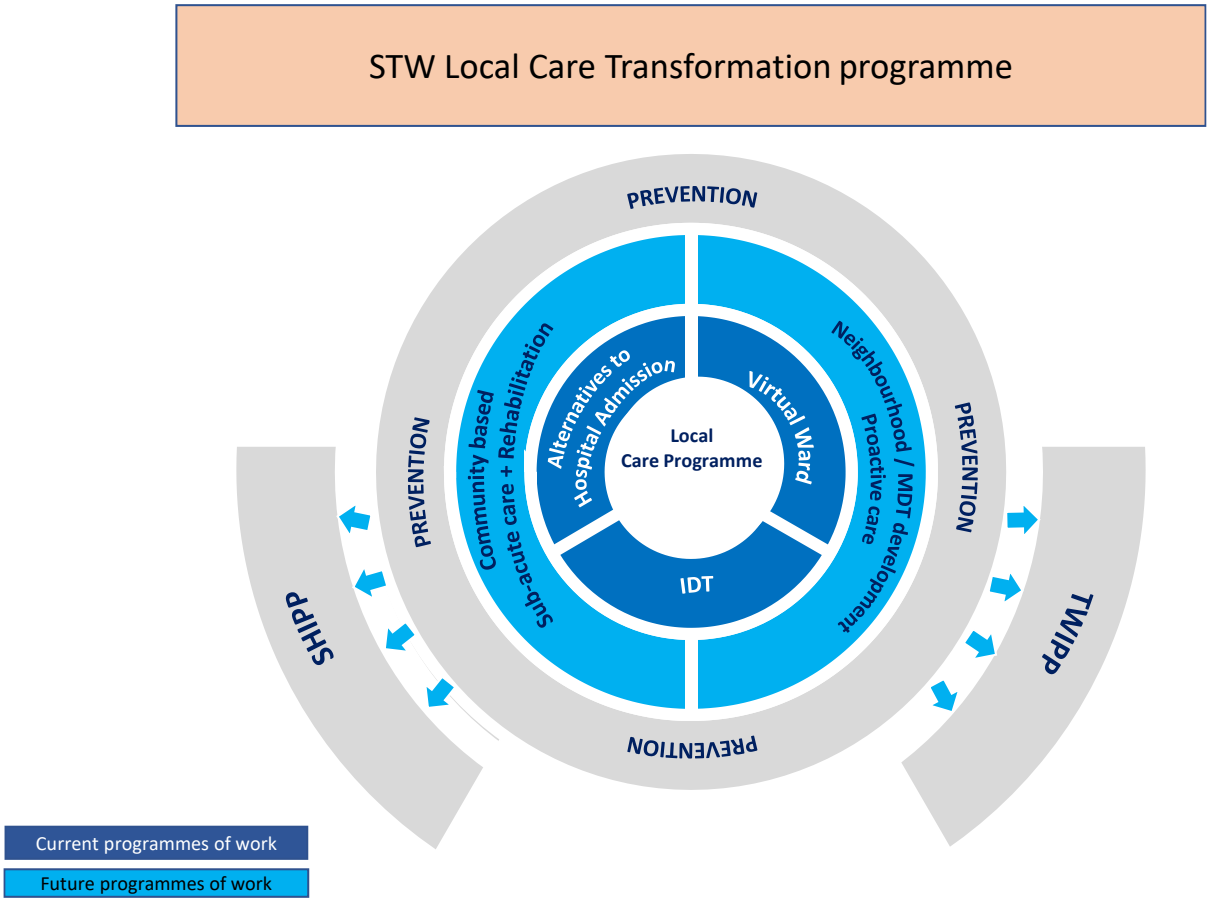
- **Implementing alternatives to hospital admission**, providing 2-hour rapid response in the community
- **Setting up of a Virtual Ward** providing sub-acute care in the place people call home that would otherwise need to be provided in an acute hospital, thereby providing an improved experience for 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

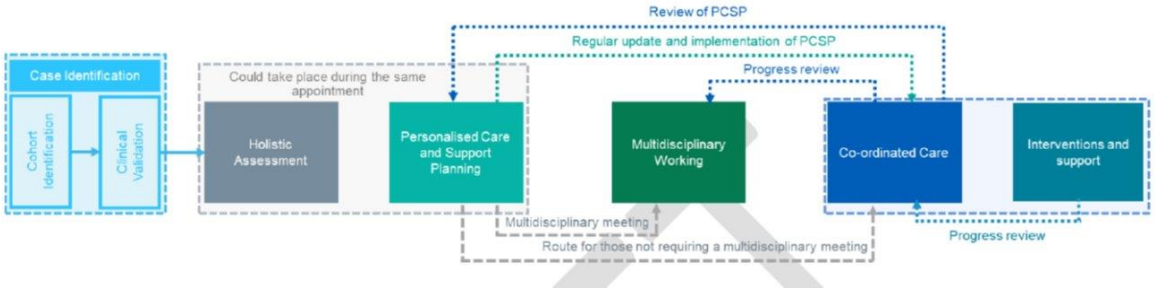
By delivering these six critical programmes of work we will:

- 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

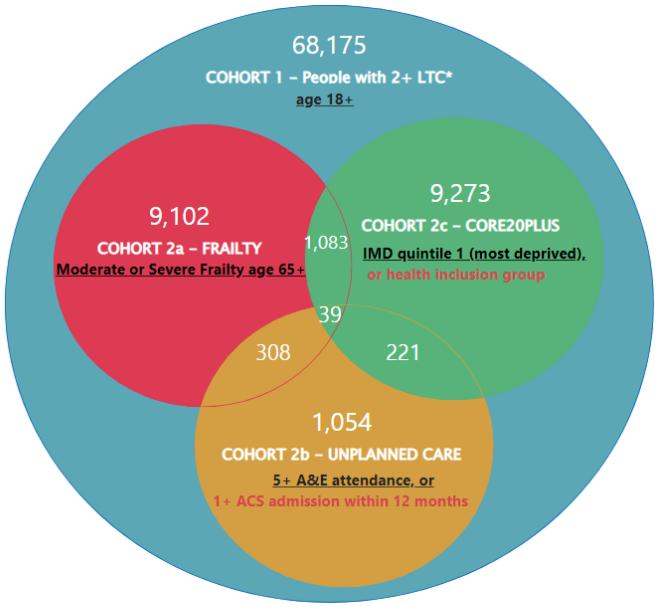
- Develop a deeper understanding of the needs of our population and make demonstrable progress in tackling health inequalities
- Focus rehabilitation services to help people maximise their functional outcomes and independence, focusing on the personal goals that matter most to patients
- Enable our staff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

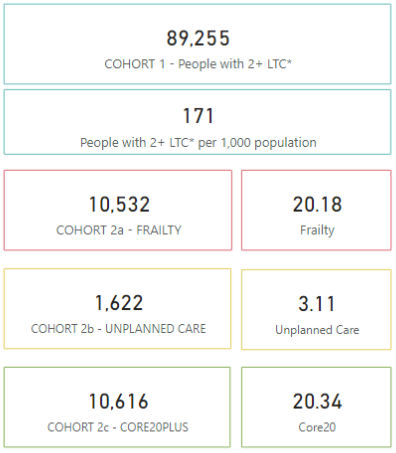
Proactive Care is a key workstream of the Local Care Transformation Programme (linked to programme 4). It is a model of care, delivered in the community, to a targeted cohort of patients with multiple long-term conditions who would benefit from integrated care to support management of their conditions.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

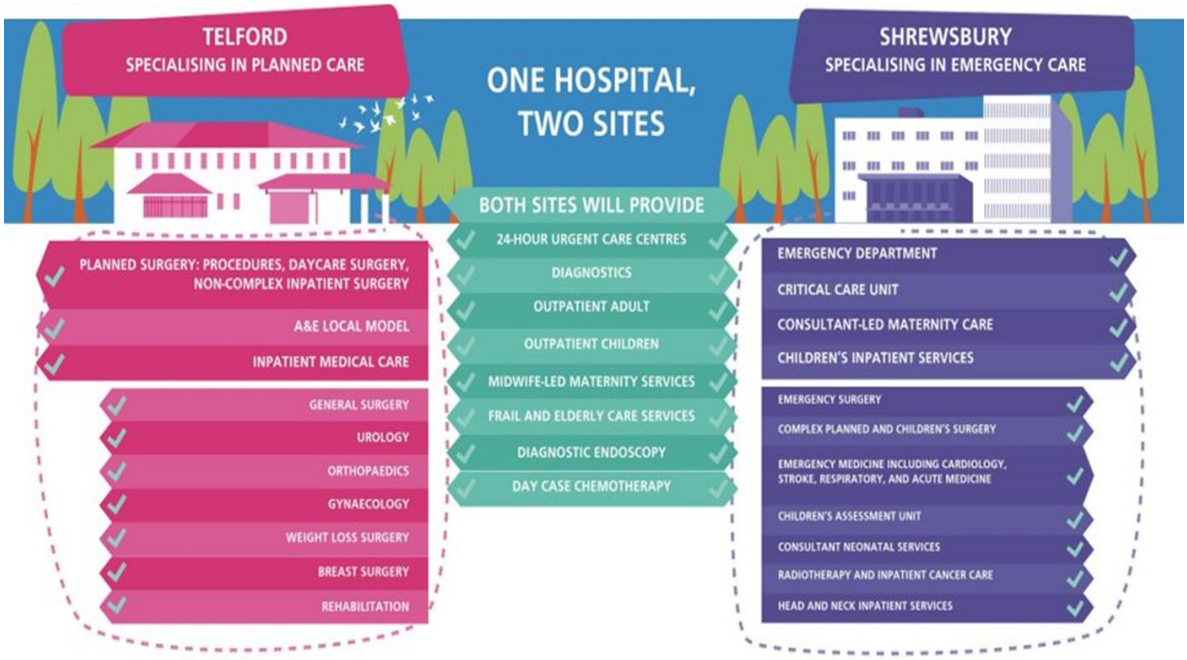
- We have two inadequately sized emergency departments, split site delivery of key clinical services (including critical care), insufficient physical capacity (particularly affecting planned services), mixing of planned and unplanned care pathways, and poor clinical adjacencies.
- The current clinical 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

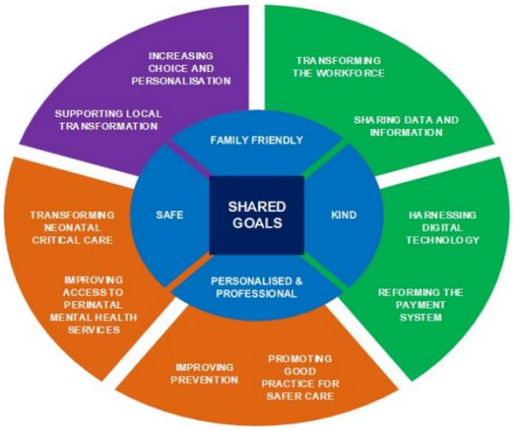
Maximised use of new technologies, approaches and innovation	Programme SRO, Clinical Lead and Programme Lead	2021-2027
Optimise use of available resource and value for money, including staffing, time, and clinic space	Programme SRO, Clinical Lead and Programme Lead	2021-2027
Contribute to system workforce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

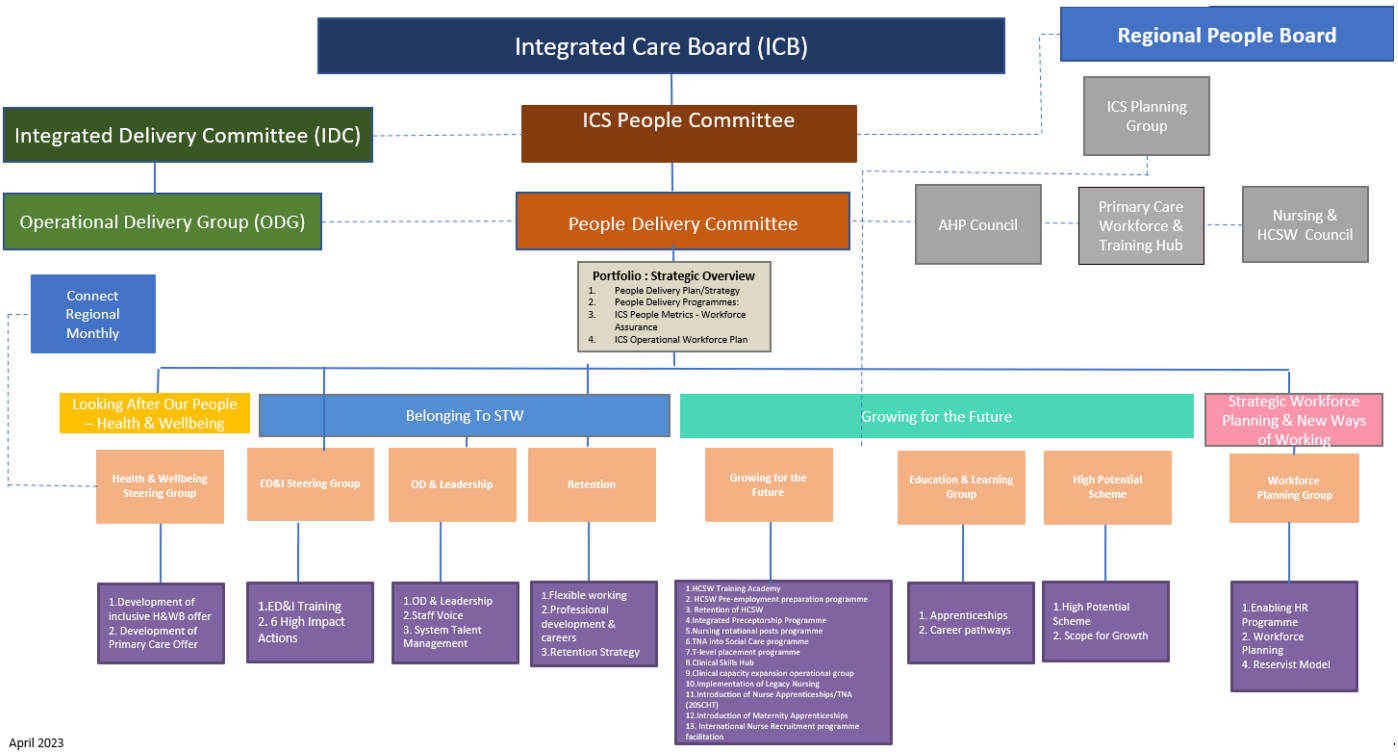
Recently our People Committee members and senior stakeholders have come together and co-created our People Strategy. This is a positive step towards working together with a shared strategic direction, underpinned by consistent and aligned organisational People delivery plans.

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.

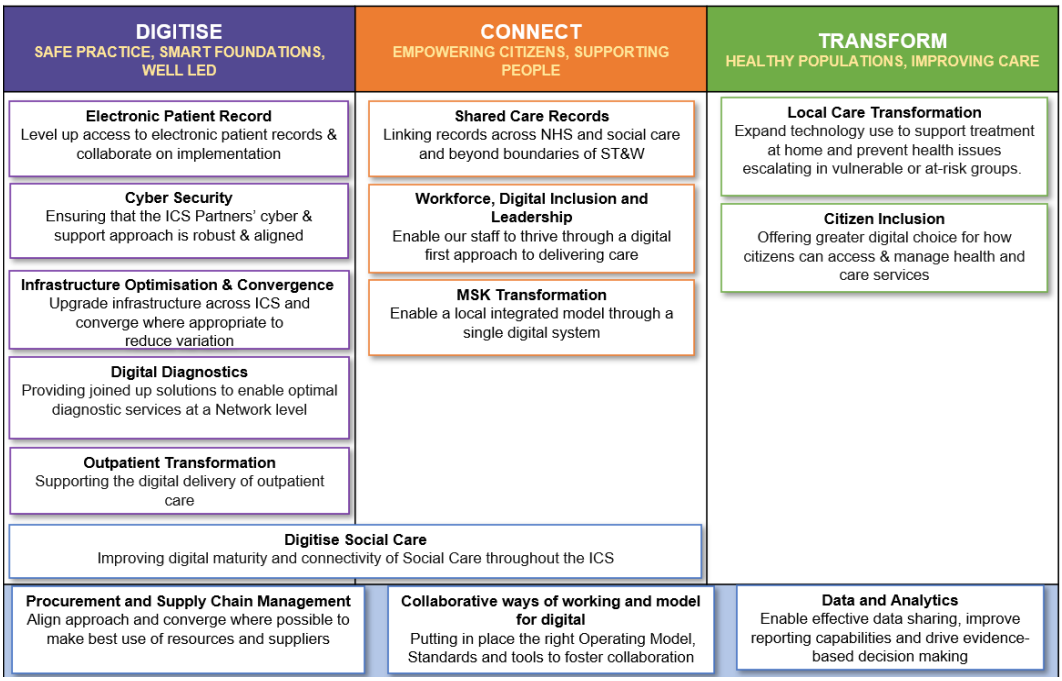
We recognise that there is a long way to go in our ICS digital journey, but by taking the initial steps to digitally transform and improve our technological capabilities, we are solidifying our commitment to excellence, and are aligned to the national focus to provide high quality care to patients, improving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

Give every child the best start in life (including healthy pregnancy)	Encourage healthier lifestyles with a priority focus on unhealthy weight	Cancer survival, hypertension and heart disease
Improving peoples' mental wellbeing and mental health	Dementia	Reduce the impact of drugs, alcohol, domestic abuse on our communities

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:

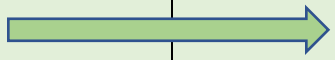
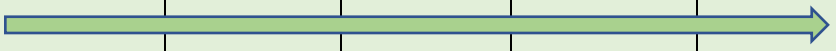
Action	Owner	Timescale
Establish our system baseline positions	TBC	TBC
Ensure that we have the right people delivering our net zero agenda	TBC	TBC
Consider how we can deliver care in a sustainable, balanced way	TBC	TBC
Harness digital technologies to approach a multifaceted challenge of delivering quality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

Tackling Inequalities	Recommendation	Action					
	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