Integrated Care System

Shropshire, Telford and Wrekin

# Joint Forward Plan

## Summary document







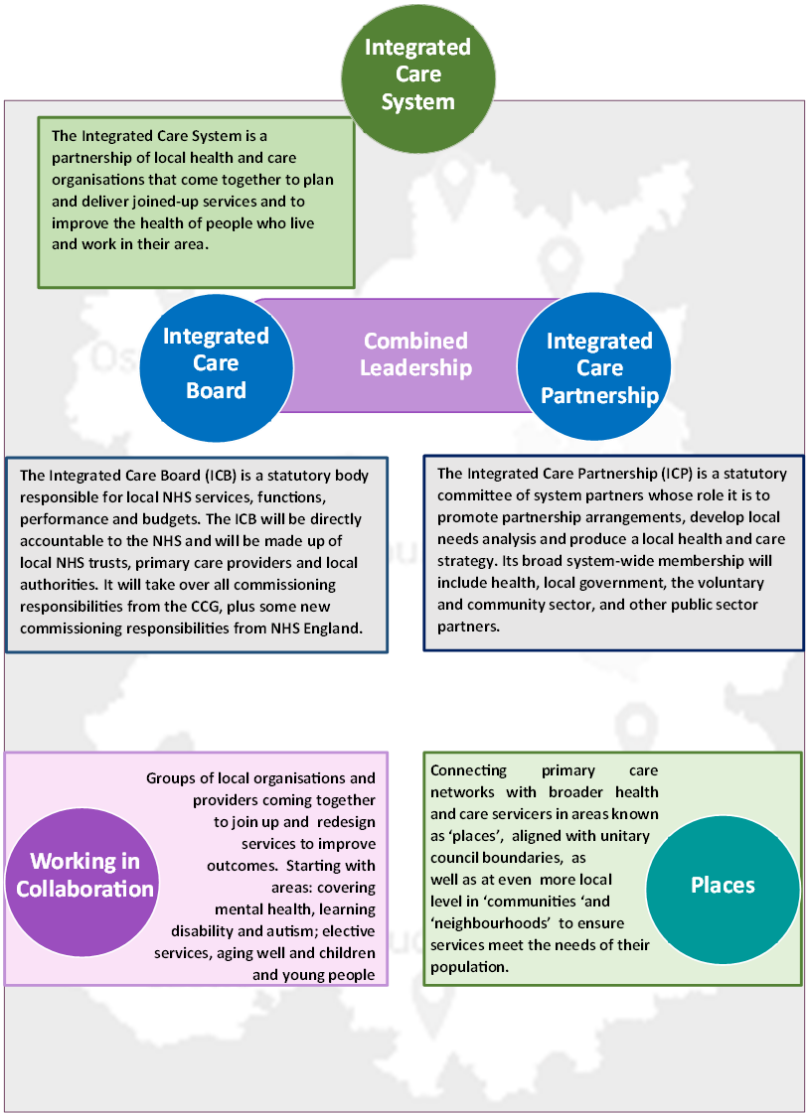






# The Joint Forward Plan for the Shropshire, Telford and Wrekin Integrated Care System

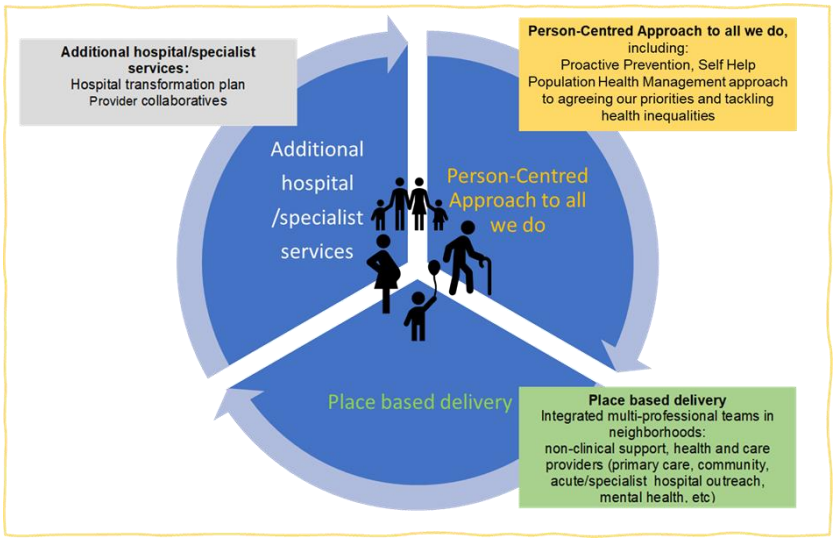
The Joint Forward Plan is a roadmap for how our system of health and care will be working with partners to continue to develop and review our system priorities, meet our distinct populations across Shropshire, Telford & Wrekin at “place” and “neighbourhood” localities and will continue to engage with our communities to ensure we take their needs into account whilst understanding the systems challenges too.




Our Joint Forward Plan has been developed through a collaborative approach with all system partners and wider stakeholders. It describes our system ambitions, which we can all relate to and more importantly work together to deliver. We continue to work collaboratively to improve local services putting people at the heart of everything we strive to achieve.

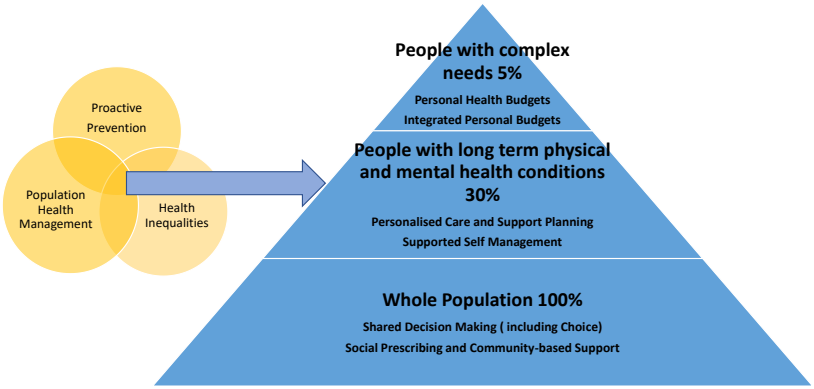
# What is in the plan?

The key elements of our plan are




# What will be different this time?

## 1. We are going to take a Person Centred Approach




We are starting with “us” as members of our communities and to enable people to access an abundance of non-clinical approaches to health and wellbeing in their own communities ( geographical, social, interest, etc ).

Our health and care services and agencies can then 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.

## 2. We are going to deliver at our places

Our places are Shropshire Integrated Place Partnership (SHIP) and Telford & Wrekin Integrated Place Partnership (TWIPP). SHIP 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 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.

The Local Care Programme will 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

This programme will also focus on improving integration across our partner organisations including GPs, community services, community mental health services, adult social care, care homes, home care services and voluntary organisations

## 3. We are going to provide additional and specialist hospital services and clinical priorities

The Hospitals Transformation Programme is putting the core components of the acute service reconfiguration agreed as part of the Future Fit consultation in place. It is helping us to address our most pressing clinical challenges, and establish solid and sustainable foundations upon which to make further improvements.

Our Clinical priorities are

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

# How are we going to deliver the Plan?

1. Taking a person-centred approach which includes:
    a) Empowering patients to live well, especially those with long term conditions
    b) Delivering through multidisciplinary teams, including primary and community care, VCSE, social care, public health and acute services
    c) Identifying and supporting people before they have a crisis of health care
    d) Utilising evidence- based interventions
    e) Managing different levels of need in the community and as close to home as possible, with the following principles:
2. Understanding the needs of our population, using all available data and risk profiling tools to identify areas of need.
3. Embedding prevention throughout all of our services, and investing in prevention with the knowledge and understanding of its significant return on investment and its place in supporting the wellbeing of our populations.
4. To use a neighbourhood / place based, case management approach, that meets the specific needs of the population served that aims to deliver care in the patient's own home or as close to home as possible.
5. integrated teams to deliver coordinated care, this is aimed at providing a joined-up team approach supporting continuity and ease of contact for people and their families that need support. Coordinated care also means working closely with our hospital colleagues across acute, speciality and community settings to ensure care is provided in the most appropriate setting as and when its needed.
6. To use a neighbourhood / place based, case management approach, that meets the specific needs of the population served that aims to deliver care in the patient's own home or as close to home as possible.
7. Integrated teams to deliver coordinated care, this is aimed at providing a joined-up team approach supporting continuity and ease of contact for people and their families that need support. Coordinated care also means working closely with our hospital colleagues across acute, speciality and community settings to
8. Development of the workforce, utilising all available skills whilst developing skills within teams specific to the population they serve, this includes the wider workforce, including the voluntary sector and all those needed to provide the best care possible.

We will:

1. Make best use of available technology to improve coordination of care, communication, understanding and monitoring of own health.

2. Workforce development through education and training and development of new roles and new ways of working through a competency-based approach.