Shropshire, Telford and 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

Sir Neil McKay
Shropshire, Telford & Wrekin ICS Chair

Endorsed by:
List all system partners and add logo's here

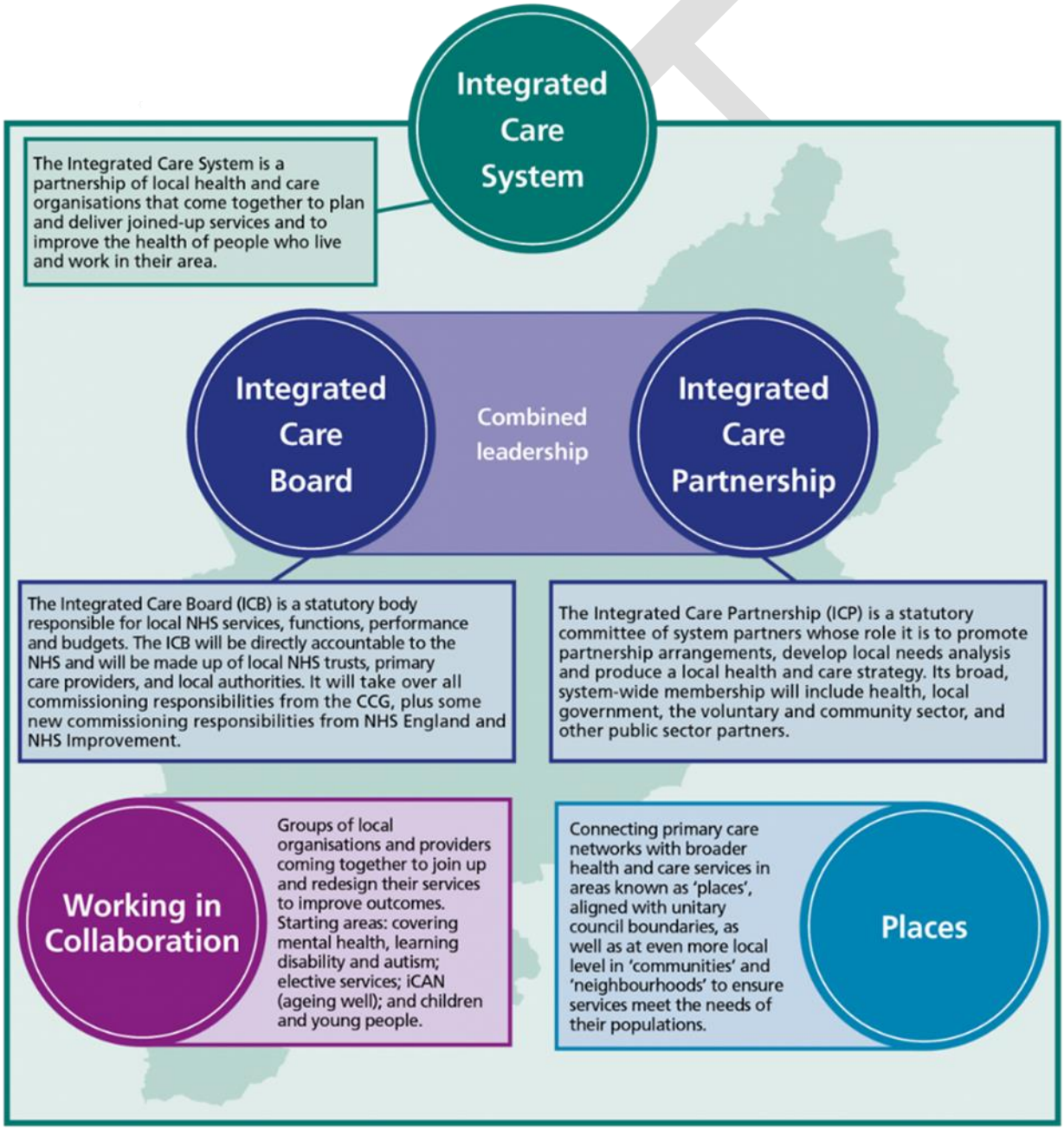
Executive Summary

To follow in Final draft

Chapter 1: Our Integrated Care System (ICS)

1.1 Background

Our system of health and care working with partners will continue to develop and review our system priorities to 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. (re-doing with STW map)

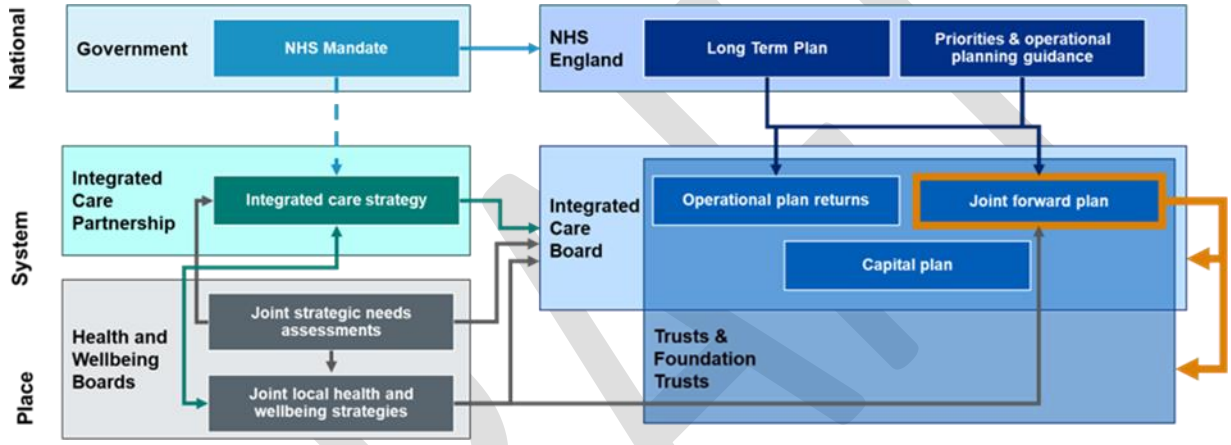


Our Joint Forward Plan has been developed through a collaborative approach with all system partners and wider stakeholders. It describes our system ambitions, which we can all relate to and more importantly work together to deliver. We continue to work collaboratively to improve local services putting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

The Health & Care Act 2022 requires each Integrated Care Board (ICB) in England to produce and publish a Joint Forward Plan (JFP).

We have developed our JFP in partnership with our Health and Wellbeing Boards and 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' health overview and scrutiny committees.

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 and we have been working with our Healthwatch organisations to hear what our residents are telling us.

'A person-centred approach to our care,' was one of the things they have asked for and this is central to all the work we are doing. People are at the heart of everything we do and by delivering joined up services in both the acute and community settings we can give everyone the best start in life, creating healthier communities and helping people to age well.

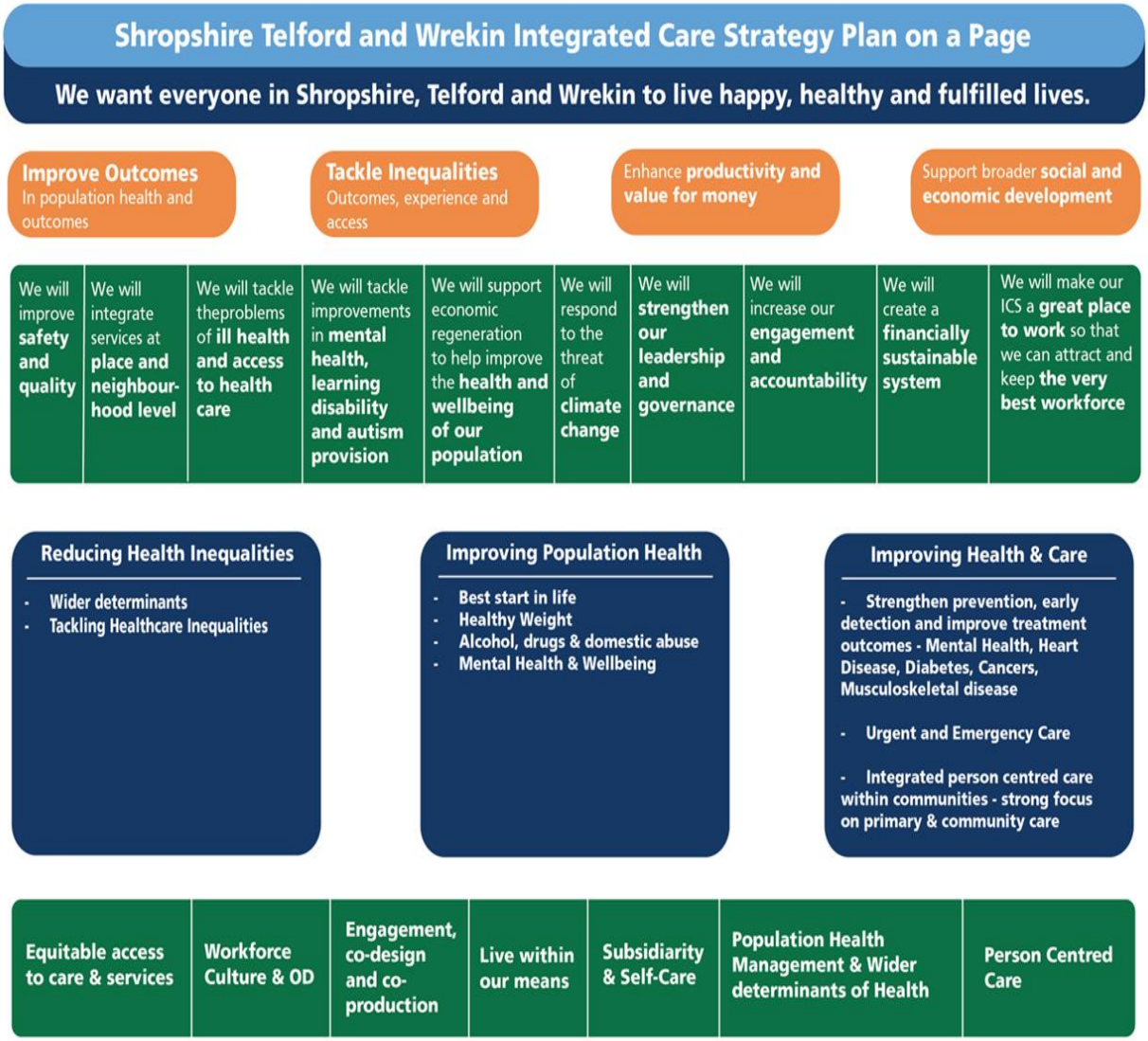
1.2 Vision and Pledges

Shropshire, Telford & Wrekin brings together local health and social care organisations working to a shared vision and our ten pledges.

Our vision:

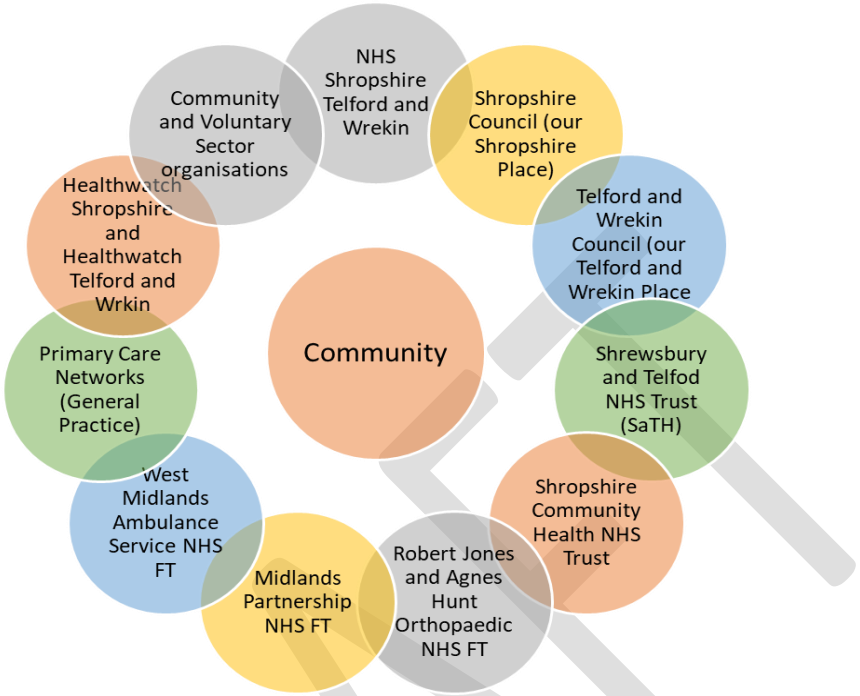
"We want everyone in Shropshire, Telford and Wrekin to live healthy, happy and fulfilled lives."

Our Pledges and Strategic Priorities:



System Narrative

Shropshire, Telford & Wrekin's Integrated Care System brings together health and social care organisations across the county.



We want all our residents in Shropshire, Telford and Wrekin – children, adults of working age, and older people, to live in good health for a long as possible throughout their life. We will help them to live independent lives with a greater emphasis on preventing illness and staying well, but also providing the right care when and where they need it.

Shropshire, Telford and Wrekin is a beautiful place to live and work, but there is more to do to improve people's lives. We know that some people are more fortunate than others, and that there are differences in services across the county which we need to reduce. Together we need to tackle the cause 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 modern day health and care.

We acknowledge we need to do more to support people lead happier and healthier lifestyles by encouraging people to be more physically active, manage their weight or change habits such as smoking or alcohol abuse. This will help reduce the growing demand on our services, staff and resources, making it easier for people to get an appointment, as some are waiting longer than we would like for treatment, and some are spending longer in hospital than they need to.

Our health and care system has come through the most challenging few years in its recent history, from March 2020, when the pandemic was declared in relation to the global spread of Covid-19. 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, the importance of community and wellbeing. However, mental health and well being particularly for our children and young people has reached unprecedented demand, as has the backlog of planned operations and medical interventions.

Community organisations, charities and local people all contribute towards building and providing valuable services to improve quality of life. Health and care services available in the community need to be co-ordinated across the system, to avoid duplication or gaps in care. We need to listen to our communities about what services are best provided locally especially when geography and transport limit access.

We remain firmly committed to utilising and developing a thriving and diverse community and voluntary sector who we can work in partnership with to support local people. We know that by joining up local services and working in collaboration with local people and our voluntary sector, we can achieve much greater benefits for our community and improve our financial sustainability. This joining up of services was demonstrated with the delivery of the Covid-19 vaccination programme. Our system delivered high numbers of vaccinations and was one of the highest England and Wales in delivery of the vaccination to our most vulnerable groups, including those with a learning disability and/or autism.

We recognise that we can only deliver our plans through the work of our hard working health and social staff, carers and volunteers. They are the ones who will work with our partners to make our plans happen; they are our biggest asset and they deserve the best support we can give. We are committed to continually engaging with them, and also critical to this with the public and the service users themselves, to further develop our plans, ensuring the involvement of everyone in future conversations around proposals for change.

Opportunities, Strengths, and Challenges

Being one of the smallest ICSs in the country presents us with challenges, but also with great opportunities.

We understand our population, and as a small system we can act together in a cohesive, agile, and collaborative manner to achieve our aims.

We know we must capitalise on our opportunities and strengths, which are summarised below:

- **Our size**: We have significant opportunities to make large-scale changes, to shift our system culture and embed our 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 across our two 'Places' means we are well positioned to understand and 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.

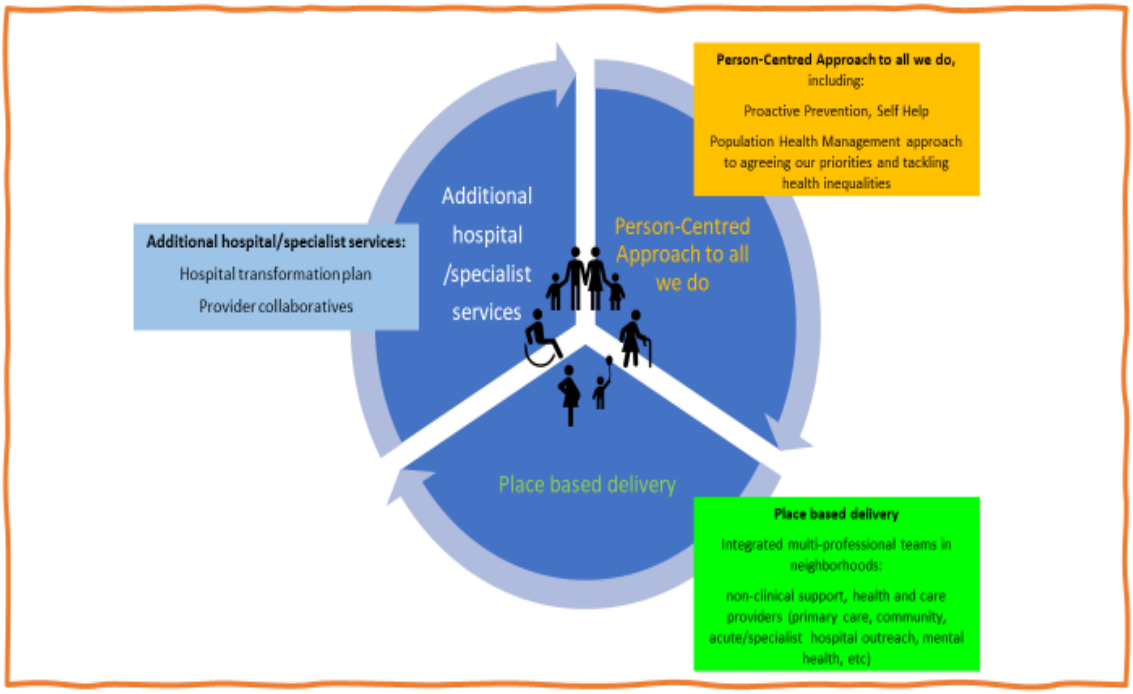
We are very aware of the challenges we face. In addition to the inequalities within our system, and our financial challenges, we must also tackle specific challenges associated with how health and care services are currently operating:

- **Quality**: Despite making significant improvements since the last Care Quality Commission (CQC) inspection, Shrewsbury and Telford Hospital (SaTH) remains rated as 'inadequate' and is in 'special measures' for quality reasons. The 'Independent Review of Maternity Services at SaTH' (Ockenden Review 1 and 2) have been released with clear and major implications for how we manage safety and quality.
- **Service Recovery:** Challenges remain in delivering several constitutional standards, with Urgent and Emergency care (UEC) and Elective inpatient services (planned surgery and procedures) are struggling to meet demand due to workforce and estates constraints, further exacerbated by industrial action in late 2022 and early 2023.
- **Workforce:** Our whole system faces significant challenges in recruitment and workforce shortages creating further operating and service restoration challenges, particularly in relation to Elective Inpatient and Cancer activity. The workforce across primary care is also challenged particularly the recruitment of GP's.
- **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.

1.3 What we aspire to

The three core elements of our plan:

- Person centred approach
- Place based delivery
- Additional hospital/specialist services



Our health and care priorities in our Integrated Strategy:

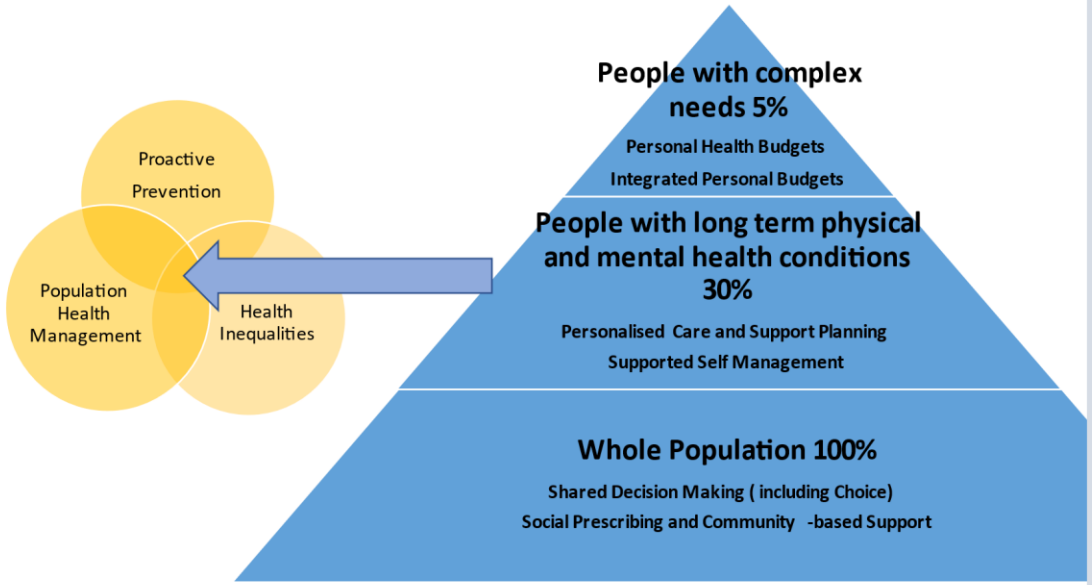
Population Health Priorities	Inequalities priorities	Health and Care priorities

• **Best start in life**
• **Healthy weight**
• **Mental wellbeing &** mental health
• Dementia
• **Preventable conditions –** hypertension, heart **disease and cancer**
• **Reducing impact of drugs, alcohol and domestic abuse**
	• **Wider determinants:**
	  • Homelessness
	  • Housing
	  • Cost **of living**
	• **Inequity of access to preventative health care:**
	  • Cancer and cancer screening
	  • **heart disease & screening**
	  • **diabetes**
	  • Annual health checks **for** Severe Mental Illness **&** Learning Disabilities and Autism
	  • Vaccinations and immunisation
	  • **preventative maternity care**
	• **Deprivation and Rural Exclusion**
	• Digital exclusion
		• **Proactive approach to support independence**
		• **Person – centred integrated within communities**
		• **Best start to end of life (life course)**
		• **Children and Young people physical and mental health and a focus on SEND**
		• **Mental, physical and social needs supported holistically**
		• **People empowered to live well in their communities**
		• **Primary care access** (General Practice, Pharmacy, Dentists and Opticians)
		• **Urgent and Emergency care access**
		• **Clinical priorities e.g. MSK, respiratory, diabetes**

Integrated Care System
Shropshire, Telford and Wrekin

NHS
Shropshire, Telford and Wrekin

1.4 Our approach to person-centred care



1. Reframing our relationship with the public – taking a whole person, preventative approach to health and wellbeing
2. Identifying, shaping and delivering our health & care priorities underpinned by Population Health Management, Proactive Prevention & reducing Health Inequalities (Core 20 Plus 5)
3. Unleashing the full potential of our communities to enable this
4. Thereby delivering the 4 aims of ICSs * through co-production of our ICP Strategy with delivery at Place

*Integrated Care Systems exist to achieve 4 aims:
- Improve outcomes in population health and healthcare
- Tackle inequalities in outcomes, experience and access
- Enhance productivity and value for money
- Help the NHS support broader social and economic development

How we will implement a Person-Centred Care approach

We will apply the following approach to each of our priority programmes of work:

- Involve the full range of people who can contribute from the outset:
  - 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
  - Representation from Person-Centred Facilitation Team
- Identify the opportunities to reduce inequalities
- Identify the opportunities for proactive prevention – non-clinical first & trauma informed
- Identify the opportunities for self-management – non-clinical first
- Implementation of the accessible information standard
- Demonstrate progress through a programme management office (PMO)

Proactive Prevention

The system wide Proactive Prevention approach builds on what is already in place at both a system and place level across Shropshire and Telford and Wrekin.

This approach sits across all ICS programmes of work.

It will provide:

- A common purpose – working to achieve a common goal of a system wide model of Proactive Prevention that is centred around a person's strengths and community assets, self-care and early intervention and advice (preventing an escalation of needs).
- Common language and clear communication messages – we will not use jargon and will contact people in a way that is appropriate to their needs.
- Principles of working – all organisations across the system sign up to pledge to work in this way, including co-production with residents, our service providers and organisations who purchase services.
- Consistent ways of working – making sure we are giving a consistent and mutually agreed message across all partners.
- Consistent decision making based on the model – making sure we are upholding the ICS's values and principles and reducing any potential for duplication across the system.
- Focus on prevention - there is a focus on the prevention offer and peoples' strengths and community assets at all times unless otherwise indicated.

- A shared culture with a shared set of values, standards, and beliefs.
- An all-age approach.
- A basis from which person-centred designed integrated pathways can be co-produced and implemented.
- Multi-agency intelligence - we will gather and use information and intelligence from a variety of sources to support and inform decision making.
- Residents have a better understanding of how services can be accessed and how they operate.

Potential Impacts

The Proactive Prevention model outlined above is central to the success of the ICS and the delivery of an agreed set of ICS community outcomes:

- Communities will be connected and empowered.
- People will be enabled to make healthy lifestyle choices.
- People will stay healthy for longer.
- People will feel supported throughout their lives, especially at times of crisis and at key moments in their lives.
- Clinical/Care outcomes for patients will be optimised.
- Services will be available closer to home, based on the health and care needs of the person.
- Services will be responsive and innovative, engaging with and involving local people and workforce, and making use of technology where appropriate.
- Service delivery will make best use of local resources and be adapted to meet the needs of local communities and populations.

1.5 Our approach to Integration

placeholder

1.6 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

Duty to improve quality of services

Quality strategic aims objectives

Add from strategy

How we will monitor quality?

- System Quality Risk register
- System Risk escalation
- System Quality metrics at Place.
- System Quality Group has clear terms of reference with a feed to Regional Quality Group
- The Quality and Performance Committee seeks assurance against the risks with partnership of key agencies across the ICS in line with national guidance.
- Learning from deaths, infant mortality & LeDeR
- PSIRF and learning from incidents as a system and beyond driven by patient safety specialists and other experts in human factors.

How we will measure and sustain quality?

- Exec champions of quality health and social care coming together at System Quality Group to drive quality services forward across the ICS and beyond.
- Contacts and local quality requirements
- Clearly defined System Quality Metrics
- Themed quality visits
- Patient experience: Partnering with Healthwatch, Co-production
- Quality accounts

How we will improve quality?

- Integration of quality improvement expertise into system priority programmes
- Rapid learning from incidents and themes across partners
- Finding out what works through Quality Improvement Projects with partners across the ICS, eg falls.
- Focus on personalised palliative and end of life care.

Aging well though support of care homes and domiciliary care to deliver the highest possible care they can.
Ensuring quality care is accessible to all, no matter background, creed or location though strategic integration of quality and Core20PLUS5.

Duty to address the particular needs of victims of abuse

Safeguarding priorities
Insert Shrops and T&W priorities
Effective multi-agency working though Safeguarding Partnerships
Executive Leadership and champions
Learning from events

How we will protect people from abuse?

Domestic Abuse
Sexual Abuse
Domestic Violence Duty
Child Sexual Exploitation
Criminal Exploitation.
Looked after children
CDOP

How we will support victims of abuse?

Commissioning services based on existing resources and robust population information
Linking with the voluntary sector
Linking local and NHSE commissioned services
Listening to victims and their needs
Criminal Justice Partnership

How we will support children and young people who have suffered abuse?

Building pathways based on knowledge and information
Working with schools and education establishments
Meeting the needs of looked after children
Engaging CYP in our plans

How we will know our approach is working ?

Robust multi-agency data sets to triangulate crime, social care and health data.
Working with Healthwatch and experts by experience.
Working in safeguarding partnerships to gain intelligence on changing themes in abuse and the prevention measures needed as a dynamic process.

Our Aspiration - Creating outstanding quality by: (needs editing by Quality team)

- Commitment to true patient centred , personalised care where patients have ownership of their own care, but also routinely inform development and delivery of future services based on the learning of their lived experiences. (Theme at engagement events)
- Driving a culture change within our organisations to work in an integrated way, with a single understanding of integration. Reducing medical models of care when appropriate.
- Strengthening of integrated multi-disciplinary working across these organisations to ensure our population receive care in the right place at the right time (inclusive of acute and community health services, Primary Care (all services), Social Care, Domiciliary Care and Private Providers).
- Change approach to develop a dynamic system that strengthens individuals' ability to selfcare.
- Streamlined care with robust pathways to ensure with sufficient capacity for planned care designed to improve patient experience and outcomes.
- Support people in crisis with the right care, at the right place. Making sure people can navigate a simplified urgent care system to meet both physical and mental health needs.
- Aspiration that all providers reach 'outstanding' levels of care for our communities

- Quality concerns and risks are shared at weekly quality huddle meetings; monthly quality team meetings; Quality Committee (QC) and Performance, Planning and Quality (PPQ)committee.
- Quality exception reports are received and discussed monthly at Board. Any key risks or quality concerns are also escalated to QSG, NHSE, NHSI and CQC as appropriate.

1.6.3 What we plan to deliver to improve quality over the next 5 years

Place holder for VW

1.7 Our approach to tackling Inequalities

Placeholder

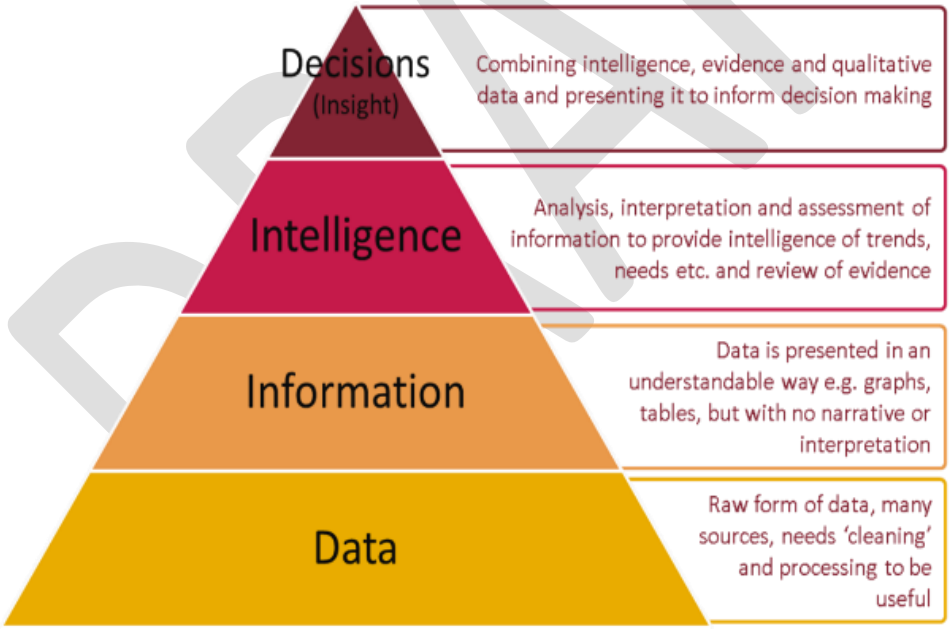
1.8 Our Population Health approach

Place holder for Population health explanation

Population Health Management (PHM)

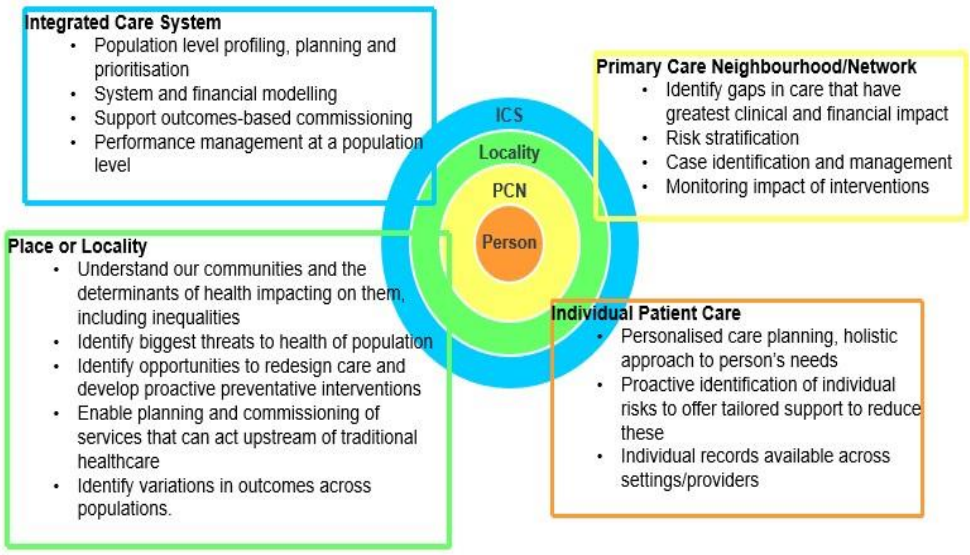
Population Health Management (PHM) is the approach needed to improve population health. It is a person centred, data driven approach that seeks to improve the physical and mental health of people over their lifetime. PHM allows the system to use all the data, intelligence and insight from our area to 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 pro-active approach that enables people who are healthy and well to remain healthy and well; as well as to monitor people who have increasing risk of ill health, and to support and enable people to improve this risk.

Transforming data to intelligence and decision making; (gov.uk)



Understanding population need, understanding our local people and their motivations, insight from health and care professionals (including the VCSE), and a good understanding of evidence-based solutions, will provide our system with a solid foundation for good decision making and improved health and wellbeing.
As the diagram below demonstrates, the benefits of PHM can be realised at all levels of planning and delivery from personalised care to strategic decision making.

Diagram 2 – system benefits of population health management (Public Health England)



Population Health Priorities

System leaders in conjunction with local stakeholders and the public are setting our ambitions and priorities for PHM over the next 5 years. It is clear that population health management includes an open and continuing dialogue with the people who use our services and those who deliver our services, and as such, we expect our priorities to respond to these continuing conversations over the next five years.

Our population health priorities:

- 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

1.8 Our Commitment to Communication & Engagement

(needs editing by EB/JR)

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

Our communities have told us that it is critical we keep talking to them, that the events are visible and well planned and that the communities can see that their contributions are meaningful whilst understanding the significant challenges our system faces.

Our vision for engaging and communicating with our communities

We will ensure that the process of engagement, communications, involvement and consultation with all our stakeholders is delivered in line with best practice. Making sure we are joined up in the way we engage, from communicating our key messages through to codesign and co-production, promoting how we are transforming local health and care services for people living in Shropshire, Telford and Wrekin.

Our aims

Good communications, engagement and involvement with stakeholders will mean:

- Increased awareness of STW as a system and increase understanding of our aims, objectives and priorities
- Staff and the public will have a clear understanding about the direction of travel towards a more joined up health and care system and what it means for them.
- Involvement of all key stakeholders in shaping the services we plan, commission and deliver
- Our involvement activities will shape our plans and this will be demonstrated through our 'you said, we did' approach
- Regular, clear communication about our plans that are easy to understand and access
- Greater community support helping to tackle inequalities, support behaviour changes and improve health and wellbeing
- We will share system successes and opportunities across our workforce so people understand the benefits of joined up working and what it offers everyone both staff and the public.

Our approach

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. Our approach will be guided by core principles from the 'Ladder of Citizen Participation' which is designed to:

1. **'inform' stakeholders**
2. **'engage' with stakeholders in open discussions**
3. **'co-design/ co-produce' services with stakeholders**

Seldom heard groups

We will involve local residents who are less likely to give their views on health and care services and strive to identify and engage with these groups and to endeavour to reduce inequalities.

The nine protected characteristics are:

- **age**
- **disability**
- **gender reassignment**
- **marriage and civil partnership**
- **pregnancy and maternity**
- **race**
- **religion or belief**
- **sex**
- **sexual orientation**

In addition, we recognise that we need to involve all of the local residents of Shropshire, Telford and Wrekin and also focus on rurality, specific professions including military and farming and areas of higher deprivation in our activity. (Theme from engagement events)

Engaging with our staff

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.

As a system we recognise the voluntary sector is well placed to meet the challenges ahead and deliver the support required by communities and individuals with the greatest needs. Understanding the contribution to the economy and wider society is important alongside gaining an understanding of local needs and the issues service users are highlighting.

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 and 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

How we have engaged to inform our Joint Forward Plan

Placeholder

1.9 Our commitment to research and innovation

Placeholder

1.10 Our commitment to Green Sustainability

(Needs review of data and plan)

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. The NHS aims to provide health and high-quality care for all, now and for future generations. This requires a resilient NHS, responding to the health emergency of the pandemic, protecting patients, our staff, and the public. The NHS also needs to respond to the health emergency that climate change brings, which will need to be embedded into everything we do now and in the future.

The two key net zero targets for the NHS set in the 'Net Zero' (NHSEI, 2020) paper: 100% by 2045 for the NHS Carbon Footprint Plus (see below), with an ambition for an 80% reduction (compared with a 1990 baseline) by 2036 to 2039.

Both Telford and 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.
Key milestones 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:
    - moving outpatients clinics to telephone/video calls, delivering over 80,000 virtual consultations
- 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, 100% of RJAH waste was diverted from landfill

The STW system 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:

1. Established our system baseline positions
2. Ensure that we have the right people delivering our net zero agenda
3. Consider how we can deliver care in a sustainable, balanced way
4. Harness digital technologies to approach a multifaceted challenge of delivering quality care outcomes, improving the quality of our care and diagnostics, reducing waste, and optimising our building services
5. Encourage our communities to avoid contributing to our carbon output
6. Focus on our supply chain's commitments to achieving net zero
7. Develop decarbonisation plans, continuing our transition to renewable energy, and in the interim making every kilowatt of fossil fuel energy count
8. Adopt practices to avoid creating waste that persists in nature, and recycling those we cannot.
9. Adapting our services to meet the challenges of climate change and extreme weather events
10. Encourage biodiversity

Chapter 2: Our population

In line with the NHS Forward Plan our approach to population health and business intelligence 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 Council's provide the Joint Strategic Needs Analysis for each of our places. These inform the Health and Wellbeing Strategies for each of our places and subsequently our interim Integrated Strategy approved March 20th 2023 by the Integrated Care Partnership.

The Integrated Strategy for Shropshire, Telford and Wrekin can be found here:

https://www.shropshiretelfordandwrekin.nhs.uk/wp-content/uploads/NHS-STW-Interim-Integrated-Care-Strategy-V-9.0-2.pdf

2.1 Background

Shropshire, Telford & Wrekin is recognised as a good place to live and work, with a good sense of community and volunteering, and the population we serve as diverse, with challenges set by our geography and demography.

Demographics & geography:

- 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, with significant health inequalities clearly apparent, particularly in Telford & Wrekin, whilst recognising there are health inequalities in specific neighbourhoods across the county.

Deprivation

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

Ethnicity

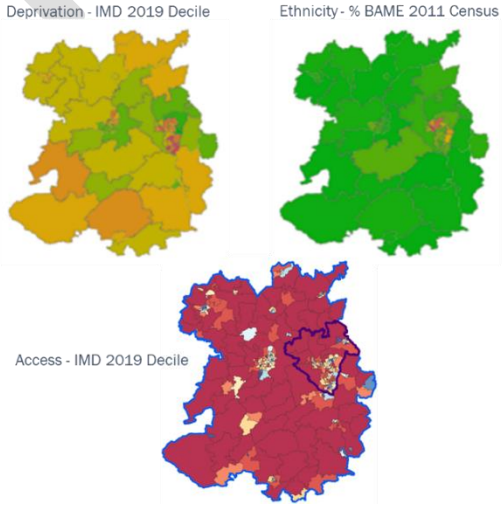
- In Shropshire, in 2011 there were approximately 14,000 people (5.6%) from BAME and other minority ethnic groups. Data suggests this has increased particularly in Eastern European populations.
- In Telford and Wrekin 10.5 % of the population from BAME and other minority ethnic groups, however more recent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

Access

- The access domain highlights significant areas of Shropshire, Telford and Wrekin that have the lowest level of access to key services including GP services, post office and education

Cost of Living

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



2.2 Data

Demographic and socio-economic headlines

Telford & Wrekin

- Fastest population growth in the West Midlands (2011-2021 = 11.4% growth). 2nd fastest growth nationally in 65+ population (35.7%)
- Population changing - becoming more diverse & ageing (median age now same as WMs at 39.6 years)
- 27% Telford & Wrekin residents live 20% most deprived areas in England – circa 45,100 people (= NHSE CORE20) significantly higher than the England average and just over a fifth (21%) of children and young people are living in poverty
- Life expectancy at birth & at age 65 for men and women significantly worse

Shropshire

- 139,000 households - predicted to increase 28% by 2043
- 23% of the population +65 years (18.5% England Age)
- 26% increase in LAC 2019/20 to 2020/21
- 44,969 people are 30 minutes or more by public transport to the closest GP
- An estimated 3,740 people are currently living in care home settings in Shropshire, with this figure likely to increase in the future
- The relatively affluent county masks pockets of deprivation, growing food poverty, health inequalities and rural isolation, with the county overall having a low earning rate

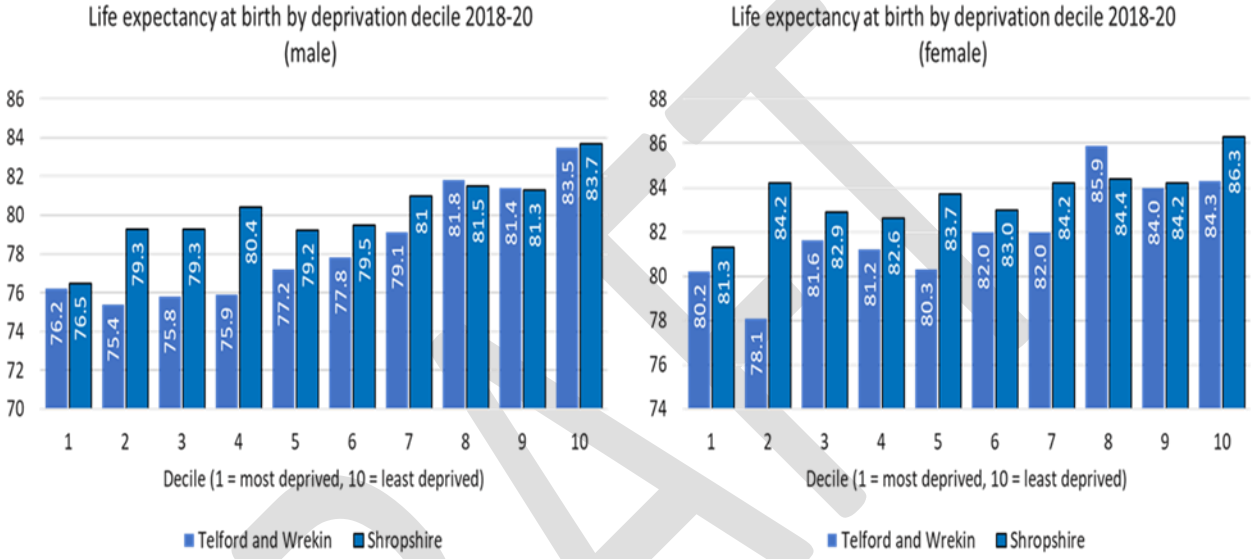
STW Area

- Total Population in 2020 506, 737 (Shropshire 325,415 Telford 181,322)
- Male 49.5 % Female 50.5%
- Across a total Area 3,487 sq km
- Average Annual Births 4,600 and Deaths 4,920
- Shropshire is predominately 66% rural (101 people/sq km) Telford and Wrekin is predominantly urban (620 people/sq km)
- By 2043 there will be an estimated 589,330 people in STW - 30% will be over 65 (currently 21%)
- There are over 155 care homes in the area with more than 4,320 beds
- Across STW there are 88,000 people with a long term limiting illness (18%)

Inequalities in life expectancy

In both Shropshire and Telford and Wrekin life expectancy at birth is lower in the most deprived areas than in the least deprived areas.

However, life expectancy at birth in the most deprived parts of Telford and Wrekin is considerably lower than in the most deprived parts of Shropshire.



Key causes of mortality relating to inequalities gap.

Causes	Shropshire		Telford & Wrekin	
	Males	Females	Males	Females
CVD	19%	26%	31%	22%
Cancer	20%	34%	17%	27%
Respiratory	11%	25%	15%	27%
Contribution of top three causes to total gap	**50%**	**85%**	**63%**	**76%**

Source https://analytics.phe.gov.uk/apps/segment-tool/

CVD, cancer and respiratory disease are the top three causes of death which contribute to the local life expectancy gaps between the most deprived and most affluent 20% within the two local authority populations.

Chapter 3: Place Based Integrated Care

3.1 System approach to prevention & place-based care

There are significant demographic and social pressures that will drive demand on public services in future years. There is also widespread recognition that a move towards prevention and early intervention is essential to sustain the provision of public services in the future, as illustrated by the following statement from the NHS Five Year Forward View:

'If the nation fails to get serious about prevention then recent progress in healthy life expectancies will stall, health inequalities will widen, and our ability to fund beneficial new treatments will be crowded-out by the need to spend billions of pounds on wholly avoidable illness... the future health of millions of children, the sustainability of the NHS, and the economic prosperity of Britain all now depend on a radical upgrade in prevention and public health.' ***Despite this, only around 4% of the UK health budget is spent on prevention.***

The individual, social, and economic impacts of preventable ill health are extensive and have significantly worsened during the pandemic. Pre pandemic around forty percent of the burden on health services in England was potentially avoidable if we had taken action to tackle the causes of these conditions. This only represents a fraction of the total cost to the country though, when we look more widely at the costs of people being unable to work due to preventable ill health.

Our system is unified in our vision to improve prevention, care and outcomes for people living in Shropshire, Telford and Wrekin through our 'places' using an integrated place-based approach that helps build resilient communities and delivers the right services at the right time. Partners are keen to understand need, plan, deliver and evaluate how our services are supporting the improvement of outcomes for the population of Shropshire, Telford & Wrekin, from prevention through to placed based and specialty services. This involves Primary Care, Community, Social, Voluntary & Community Sector along with Public Health.

Although Shropshire, Telford & Wrekin have different demographics and unique populations the approach used to develop their delivery models is based around the following key components:

1. Taking a person-centred approach as described in Chapter 2, 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:
        i. Community based support and social prescribing
        ii. Shared decision making and enabling choice
        iii. personalised care and support planning iv. Supported self-management
2. Understanding the needs of the population, using all available data and risk profiling tools to identify areas of need in which to best target available resources and evidenced based interventions.
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. 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.

The expected outcomes from our integrated approach to out of hospital care across Shropshire, Telford & Wrekin are that we:

1. Understand our individual localities and provide services and care based on need, helping our population to continue to enjoy a long and fulfilling quality of life. (Theme from engagement event)
2. That our populations feel supported and more involved and able to manage their own health and care where possible, developing community resilience and confidence
3. That we always make best use of our collective primary, community and hospital resources to provide care as close to home as possible.
4. That we have a workforce who are competent, capable and have capacity to meet the increasing demands required.
5. That we are as efficient as possible by utilising available technology, providing the right care in the right place, first time, reducing duplication and opportunity for error.

3.2 Our approach to prevention & tackling inequalities.

(placeholder check of information)

Shropshire, Telford and Wrekin leaders recognise the need for health and care services to shift their focus from 'fixing disease' towards 'maintaining health and wellbeing, keeping people as healthy as possible for as long as possible; the challenge is how to put this into practice. There is great potential for local partners to work together to address this issue.

Not only is it a financial imperative but it is also central to reducing inequalities in health. Those in the poorest communities experience the worst health, largely due to the impact of social conditions on preventable risk factors. For example, about half the differences in male death rates by socioeconomic status can be accounted for by differences in smoking rates.

Prevention through Lifestyle and Healthy Behaviours

Care for people with long-term conditions accounts for £7 in every £10 of health and social care expenditure. Much of this is preventable. Prevention means taking action to reduce avoidable disease and health problems

which can reduce our ability to live fulfilled and productive lives and that may otherwise increase our need to rely on health and social care services. Eight specific risk factors are responsible for most of the chronic disease burden; smoking, poor diet, obesity, physical inactivity, alcohol consumption, and the cardiovascular risk factors (high blood pressure, high cholesterol and high blood sugar).

Mental Health and Emotional Wellbeing

At least 1 in 4 of the population experience a mental health problem at some point in their life with 75% of illnesses starting before the age of 18 years. Good or well managed mental health has strong links with physical health, social participation, developing relationships, education, training and building resilient communities.

Vaccinations, immunisation and screening update for Covid vaccination programme

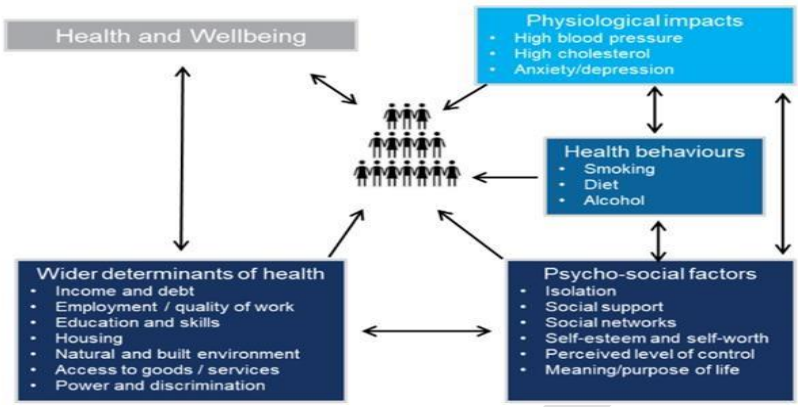
It is important for as many children as possible to complete the childhood vaccination schedule in order to protect them from a range of serious and potentially fatal diseases. Vulnerable and older people are recommended to have an annual flu vaccine as they are more likely to develop potentially serious complications of flu. Screening ensures appropriate early identification and treatment to reduce their risk and/or any complications arising from the disease or condition, thus saving future unnecessary procedures and cost to the system.

Substance Misuse

Poor physical and mental health, unemployment, and homelessness are some of the individual harms caused by substance misuse with criminal activity including anti-social behaviour and family breakdown identified harms that impact on those around the individuals and their families.

The system is committed to understanding inequalities and supporting our population across the breadth of opportunities, as described in the diagram below.

Causes and factors of inequalities:



The system recognises that working together in place, with Primary Care, the voluntary and community sector, community services, care and council services, business and people themselves, we can take a pro-active approach to identifying risk in the population and supporting people to reduce their risk.

Proactive prevention begins in childhood, our plan recognises 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.

This also impacts on the long-term health and major illnesses such as cardiovascular disease, stroke, cancer, diabetes, liver and respiratory diseases (Bellis et al, 2014).

Proactive prevention through the life course can be threaded through our place-based programmes of work and developing resilient communities.

3.3 Our Places

Place based delivery

Role of Place

Place is defined by NHS England as being a geographic area that is defined locally. In Shropshire, Telford and 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 (SHIP) and Telford & Wrekin Integrated Place Partnership (TWIPP). Both SHIP 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, SHIP and TWIPP are accountable to, and rooted in, communities.

The role of SHIP and TWIPP is to lead on the delivery of integrated care at a place level to reduce health inequalities, reduce duplication and to improve outcomes for the local population. They will also support and help progress the delivery of integrated care at place through provider collaboration and ensuring differing models of provision to meet the needs of the population in a sustainable way.

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, 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.

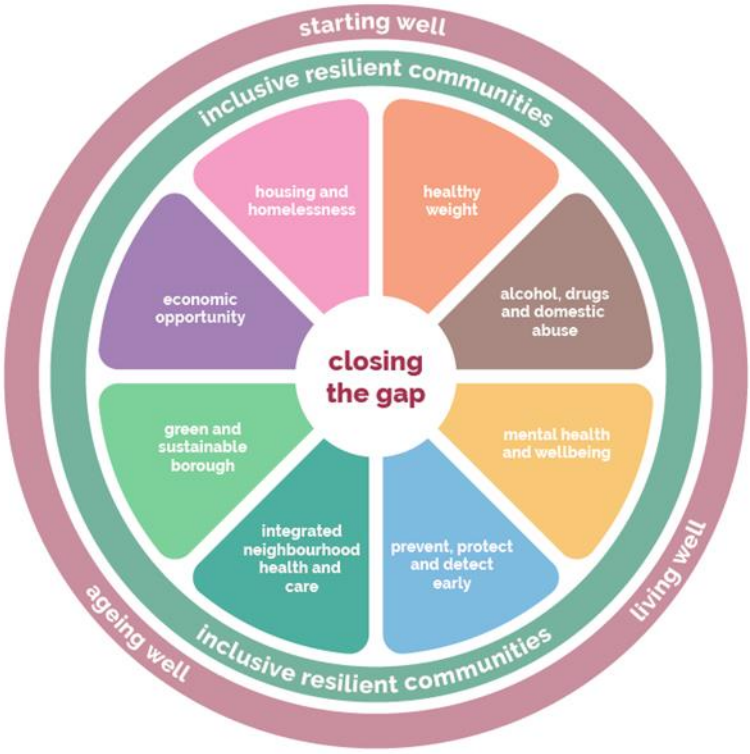
As our system matures the role of place will also further develop. Over the next 3 years it has been identified that the following strategic deliverables will be needed to ensure that place is able to achieve its outcomes for residents effectively and efficiently.

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

3.4 Telford and Wrekin

Telford & Wrekin Health and Wellbeing Strategy

Telford & Wrekin Health and Wellbeing Board is refreshing its strategy priorities and the updated strategy will be approved in June 2023. The priorities proposed (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.



Inclusive resilient communities – The Council's Building Safer and Stronger Communities programme is aimed at protecting vulnerable children, young people and adults most at risk of being exploited and becoming the victims and/or perpetrators of crime while addressing crime in the most vulnerable areas of the borough. The programme takes a public health approach to violence prevention

and the investment is shaped by the Building Safer, Stronger Communities Delivery Plan, with an aligned outcomes framework, which that covers the following six priority areas:

- Education & Skills
- Housing Standards
- Crime Reduction
- Environmental Crime & Anti-Social Behaviour
- Community Resilience
- Health Inequalities

Green and sustainable borough. Our aim is for the whole Borough to be carbon neutral by 2030. Through the Telford and Wrekin Borough Climate Change Partnership we have identified 6 areas of focus: transport, energy, buildings, agriculture, forestry and other land use, industry, learning, communications and public engagement. The Partnership have an action plan with clear deliverables that is updated regularly and can be accessed through the Council's website: http://www.sustainabletelfordandwrekin.com/what-the-borough-is-doing/telford-and-wrekin-borough-climate-change-partnership

Economic opportunity – at present this is mainly focused on the Cost of Living Support for our residents and businesses.

- Info for residents and businesses https://www.telford.gov.uk/info/21827/help_and_advice_with_benefits_and_finance
- Cost of Living Strategy: The strategy sets out the 4 key r key elements of the Council's response to the cost of living crisis:

a) Directly providing targeted support to help residents and organisations most affected by the cost of living crisis;
b) Working in partnership to coordinate support locally and maximise the impact;
c) Raising awareness of the support that is available across Telford & Wrekin;
d) With other councils and partners, making the case to Government for increased and sustained investment into long-term solutions to the cost of living crisis.

The strategy summarises the extensive support already delivered or funded by the Council, a mix of long-standing services that have been in place for more than a decade, and newer schemes introduced during Covid, or more recently as the cost of living crisis has started to have an impact.

Housing and Homelessness - Telford & Wrekin Council's Housing Strategies recognises that a decent place to live is the foundation on which people build their lives.

- Specialist and Support Accommodation. The provision of good quality specialist and supported accommodation is a part of creating a place

where all citizens can live well in Telford & Wrekin. Our vision is to secure the best quality of life we can for our older and vulnerable citizens both now and in the future. This means delivering a range of housing that enables people to live independently, with support and care where necessary. The Strategy outlines the objectives to achieve this:

Making the best use of existing accommodation by utilising Disabled Facilities Grant to fund works and adaptations that will enable people to remain in their own homes, and live independently, for as long as possible whilst reducing the need for social care.

- Developing a range of new build specialist and supported accommodation over the next 10 years, that is tailored to reflect the identified needs within our local communities.
- Ensuring that support and care services, delivered by registered providers as well as the community, to people within supported housing as well as those living in mainstream housing, are effective in promoting people's wellbeing and independence.
- Homelessness. A good quality home makes health, employment, educational achievement and a happy family life much easier to obtain. But financial difficulties and some national policies make it harder for some households to find and maintain a roof over their heads. Telford & Wrekin Council and its partners across the statutory, community and voluntary sectors continue to work together to prevent and tackle homelessness and rough sleeping in the borough. The 'Strategy to address homelessness and rough sleeping 2022 – 2025' outlines the approach and also highlights a key goal of early advice and intervention which sits at the heart of preventing homelessness.
- Managing the market. The Council's Market Position Statements (adults and children and young people) outline the demand for care and how that demand may change over time. The Council have committed to commission services that maximise independence, make full use of our communities' strengths and assets and enable people to live the lives they want to lead regardless of age or ability. The Council have also committed to achieving permanency and stability for all children and young people through our provision and those of our partners. Through market development and working with partners we aim to achieve these commitments.

Alcohol and drugs – The government published a ten year National Drug Strategy in December 2021, setting out ambitious plans to reduce the supply and demand for drugs and deliver a high-quality treatment and recovery system. The strategy also addresses problematic alcohol use and provides a framework for local areas to address alcohol and drug related harms in their local communities. Telford and Wrekin Alcohol and Drugs Strategy currently runs to May 2023 and work has

begun on the refresh, addressing 4 strategic priorities to improve outcomes as shown below:

Prevention • Increase resilience to prevent more young people starting using drugs • Target vulnerable young people to prevent problematic use of alcohol and other drugs • Intervene early with families with alcohol and other drug problems • Prevent escalation into problematic use of alcohol and other drugs	**Harm Reduction** • Reduce drug related deaths • Reduce drug related hospital admissions • Reduce alcohol and drug related harm in communities • Reduce blood borne viruses amount people who inject drugs
Treatment • Further improve treatment outcomes • Increase treatment access by people drinking problematically • Address physical and mental health needs • Improve treatment access for people leaving prison and in other parts of the criminal justice system	**Recovery Support** • Improve access to housing, education, employment and training opportunities • Support the grown of a local, diverse and inclusive and sustainable Recovery Community • Expand the design and delivery of interventions by people with lived experience • Increase the numbers accessing local mutual aid groups.

Domestic abuse – the DA Act 2021 gives key duties to local authorities and their partners and the vision of the Telford & Wrekin Domestic Abuse Strategy is that partners working together can end domestic abuse in our communities in all its forms, ensuring that everyone who is affected can access the help and services they need. Key commitments and outcomes of the strategy are:

Key deliverables of the strategy include: ongoing needs assessment, shared polices and partnership training programme, violence against women and girls interventions, awareness raising in schools, White Ribbon Campaign, community ambassador programme, commissioning and delivery of new service and support offer for victims, their families and perpetrators with Cranstoun and West Mercia Women's Aid, review and strengthening of criminal justice response.

The other areas of focus for the health and wellbeing strategy priorities are covered in the TWIPP plan sections below.

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.

The TWIPP vision is aligned to the Health and Wellbeing Strategy vision of:
"Working together for children, young people and adults in Telford and Wrekin to enable them to enjoy healthier, happier and more fulfilling lives"

In order to achieve this vision the partnership has agreed a set of priorities that will be delivered in accordance with TWIPP's principles as illustrated in the diagram on the right.

TWIPP brings together a complex set of community centred approaches and activities under the same strategic vision and principles of working to achieve the following shared outcomes:

- Care closer to home
- Integrated and seamless services
- The right information and advice at the right time
- One conversation and one point of contact

TWIPP's strategic priorities are:

1. Population Health – supporting people to be healthier for longer with a focus on those who have the greatest need, whilst maintaining and effective universal offer for everybody.
2. Prevention and Early Intervention – working with people, families and carers to proactively prevent, reduce and delay reaching crisis and needing to access health and care services
3. Integrated response to inequalities – working together to tackle inequalities - ensuring reducing inequalities is embedded in our strategic decision making, investment decisions and service delivery.

4. Working together stronger - delivering joined up, high quality, accessible health and care services which connect and empower children, young people and adults to stay healthier and more independent for longer
5. Primary Care Integration - working together to support our Primary Care sector to meet demand and provide high quality accessible services.

For a copy of TWIPP Strategic Plan for 2022-23 please see Appendix X. may need amending

TWIPP's strategic priorities are aligned to the Integrated Care Strategy as well as the Telford and 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.

Shropshire, Telford & Wrekin ICS Priorities	**Telford and 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 SEND	Best start in life SEND & transition to adulthood
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	Prevent, protect and detect early • Closing the gap	Reducing preventable diseases through early diagnosis, immunisations, screening and improving the reach of services

• Diabetes • Health checks SMI & LDA • Vaccinations • Preventative maternity care		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 deliverables and associated outcomes that TWIPP would expect to be included in ICB delivery plans. Within these deliverables are system wide, place based and neighbourhood level focuses. TWIPP will play a different role at each level:

- At system level TWIPP will:
  - Understand the Telford and Wrekin population priorities and ensure these are address within ICB strategic and operation plans;
  - Support the delivery of the place based elements of system wide deliverables and seek delegated authority to manage them where appropriate;
  - Champion the voice of Telford and Wrekin residents; and
  - Seek assurance that the needs of Telford and Wrekin residents affected by system wide deliverables are met and their outcomes achieved.
- At place level TWIPP will:
  - Prioritise the outcomes for local people that matter the most;
  - Use intelligence to inform delivery;
  - Drive the delivery of place based and neighbourhood level deliverables; and
  - TWIPP members will hold each other to mutual accountability to deliver - ensuring the work is in accordance with TWIPP's principles as well as meeting their targets and achieving their outcomes.

Outcome	Deliverables	
	Year 1 – 2 (2022 - 2024)	**Year 3 – 5 (2024-2027)**
Reducing the impact of preventable diseases (coronary heart disease, diabetes and cancer) on our residents Services planned / developed based on intelligence (quantitative and qualitative)	• Development of Healthy Weight Strategy • Delivery of 'Live Well' programmes aimed at encouraging healthy lifestyles and improving mental wellbeing • Delivery of the wider Health Protection programmes • Delivery of the place based elements of the system wide strategy for cancer (including early cancer diagnosis) • Support the place based elements of development of a system wide diabetes strategy including improving access for the most deprived and the proportion of Type 2 receiving recommended NICE care processes. • Deliver the place based elements of the National NHS Objectives for 2023/24 for prevention and health inequalities (see Appendix A) • Expansion of the JSNA to include other organisations' intelligence to support place based and system wide planning (to include quarterly updates to TWIPP).	• Deliver the place based elements of the National NHS Objectives for 2024/25 for prevention and health inequalities • Continued expansion of the JSNA to include other organisations' intelligence to support place based and system wide planning (to include quarterly updates to TWIPP).
Residents are able to help themselves/ those they care or by accessing information, advice and guidance at a time and place to suit them.	• Sufficiency and quality audit to be completed on: ○ Place based information, advice and guidance offer to look to deliver better together. ○ Access to universal, prevention and specialist services (including primary care / dental services) ○ Audit to include what the barriers to access are and any digital challenges.	
A health and care system that is focussed as much on preventing illness as treating it	• Promote and challenge the system to ensure that the Integrated Care Strategy and associated 5 year plan has a focus on prevention and consistent use of language across the system	
Communities are equal partners in the design and delivery of health and care services	• Intelligence from the VCSE sector is utilised and embedded at place and system. • Ensure that people with lived experience co-produce the delivery of our strategic plans and service developments through the development and	

	implementation of a place based Co-Production Charter.	
Reduction in health inequalities at both system and place level	• Delivery of the Core20Plus5 programme (including the ambition for CYP) • Delivery of programmes to improve awareness of and reduce inequity of access to vaccination, screening and health checks	
All residents are able to access universal, prevention and specialist services and barriers are overcome.	• Delivery and evaluation of the health inequalities funded projects.	• Utilise the outcomes of the sufficiency and quality audit to implement appropriate changes to reduce access barriers.
Improve children and young people's outcomes and narrowing of the inequalities gap	• Deliver Start for Life and Family Hub transformation programme • Deliver the local programmes supporting children to maintain a healthy weight • Deliver improved social, emotional and mental health services for children and young people in Telford and Wrekin	
Improve children and young people's outcomes who have special educational needs and disabilities (see draft strategy for specific outcomes)	• Consult on the draft co-produced SEND and Alternative Provision Strategy for 2023-2028 • Implement the Strategy's and achieve the desired outcomes in its 7 priorities: 1. Localised high-quality provision 2. Early identification and help 3. Participate in decisions 4. Systems that makes sense 5. Data informed and intelligence rich 6. Supportive alternative provision offer 7. Children and young people feel valued and visible in their community *N/B once the strategy is finalised their top 3 strategic deliverables can be included in this document*	
People with learning disabilities, in Telford and Wrekin are enabled to throughout their life achieve greater independence, contribute to and make and connections with people in their local communities, and live well in Telford and Wrekin	The Learning Disability Strategy 2021-2025 has a wide range of deliverables to support its desired outcomes. The key ones at present are: • Increasing the number of people with learning disability in training and employment • Increasing the number of people with learning disability to live independently in their own home • Reducing the number of people with learning disabilities in In-Patient settings • Increasing the number of people with learning disability who have had an annual health check Recognising the health inequalities experienced by people with learning	• Review the Learning Disability Strategy using intelligence and update it to reflect the needs at the time. •

	disabilities and working across the system to address them. Development of an in depth learning disability all age, system wide dashboard.	
Autistic children, young people and adults, have a sense of purpose, aspiration and belonging in their local communities. Autism friendly borough	The Autism Strategy 2023-2028 has a wide range of deliverables to support its desired outcomes. The key ones at present are: • Increasing the number of autistic people in training and employment • Increasing the number of autistic people who have had an annual health check • Recognising the health inequalities experienced by autistic people and working across the system to address them. • Reducing the number of people awaiting an autism diagnosis, and the time between referral, diagnosis and support (supporting a model of "waiting well")	• Development of an in depth autism all age, system wide dashboard.
Improve the mental health and wellbeing of our communities	• Development of a place based Mental Health Strategy, co-producing it with people with lived experience. • Embedding the Mental Health Partnership Board • Supporting the Mental Health Alliance to continue to help shape multi-disciplinary mental health support. • Working with developing provider collaboratives to ensure they meet the needs of residents within Telford and Wrekin.	
Telford is a place where our resources and community capacity fits the needs of our local ageing population.	• Develop and implement a place-based community health model for improving public health outcomes for older people – Age Friendly Communities Framework with a focus on active participation (physical, creative, social, volunteering and the wider determinants) • Development of a place based Ageing Well Strategy, co-producing it with people with lived experience • Implement the system wide Dementia Strategy at place.	• Develop a new integrated dementia model of care
All models of care in the community focus on proactive prevention and early intervention	• Implementation of Local Care Transformation Programme integrated discharge workstream • Implementation of Local Care Transformation Programme Virtual	• Implementation of Local Care Transformation Programme Neighbourhoods workstream • Implementation of the Local Care Transformation Programme Respiratory

	Ward workstream • Implementation of Local Care project looking at sub-acute/post-acute care models and the Integrated Therapy Service workstream	/ Long Term Conditions workstream
Delivering joined up, high quality, accessible health and care services	• Pilot approaches to integrated pathways at place	
GPs in Telford and Wrekin are supported to implement the Fuller Report.	• Support with developing integrated neighbourhood teams linked to the Local Care Transformation Programme's Proactive Care Workstream • Support with practical cross system functions e.g. data analysis and BI, estates and workforce planning, ensuring primary care is included and aligned with these functions for the system • Supporting time for GP leadership development and participation in the system	
	• Support Primary Care to meet their 2023-24 access requirements including: ○ Patients are offered assessments equitably across all modes of access ○ Patients can access their health information online without having to contact their practice by 31 October 2023 ○ All practices are using cloud based telephony national framework to mitigate the national digital switchover by 2025. • Support Primary Care to meet their target to recruit to additional roles by March 2024.	

Our aspirations

From population intelligence we are aware that the following areas will also be key deliverable that we have aspirations to improve over the next 5 years. These areas are in their infancy and further details will follow in later iterations of this plan.

- Children and Young People's Emotional and Mental Health Services
- …….more to add for final draft

3.5 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.

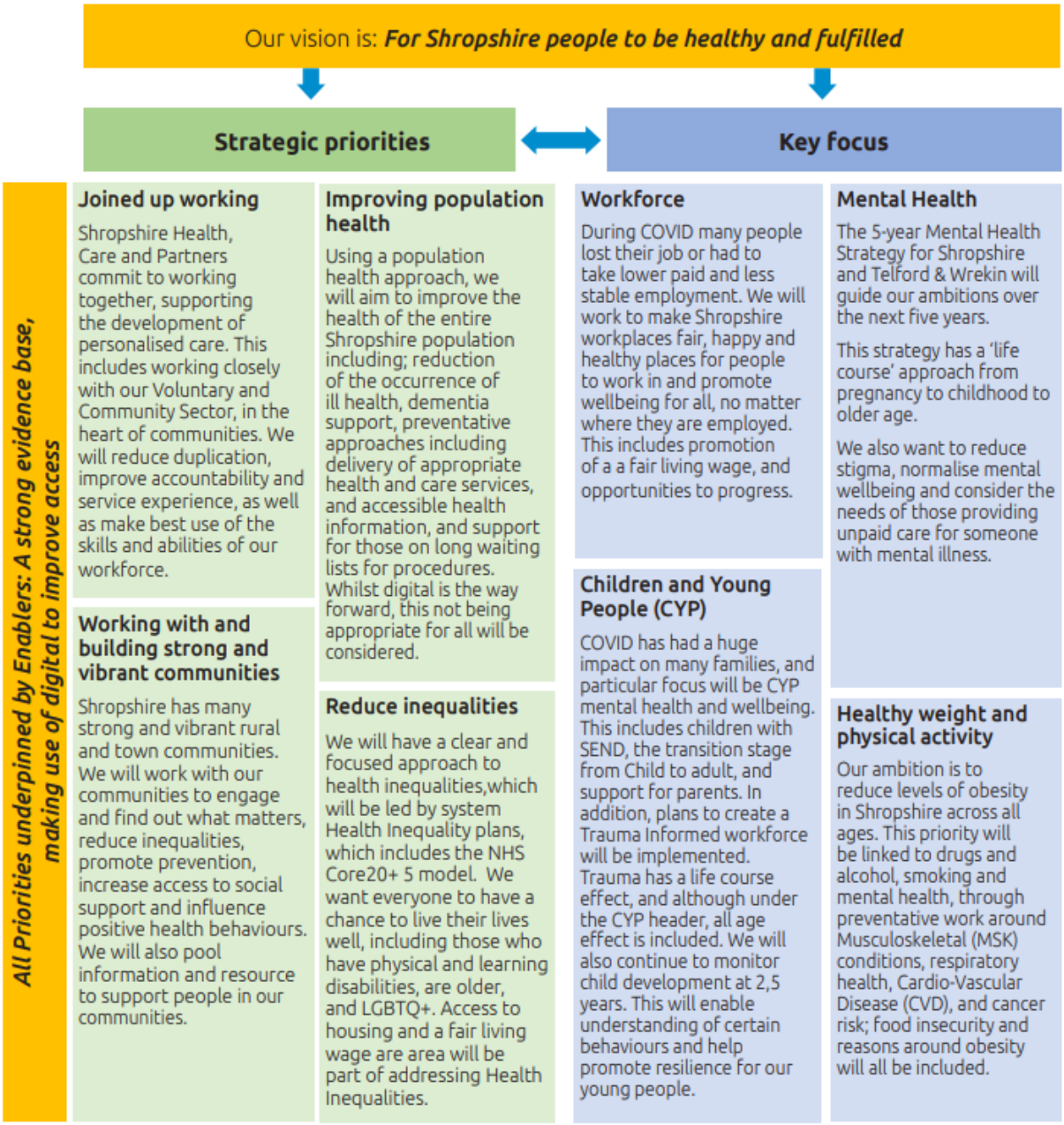
Health and Wellbeing Boards must produce a Joint Health and Wellbeing Strategy (JHWBB) based on the needs of local people.

The JHWBB strategy 2022-27, sets out the long-term vision for Shropshire; it identifies the immediate priority areas for action and how the Board intends to address these.

Our aims are:

- To improve the population's health and wellbeing
- To reduce health inequalities that can cause unfair and avoidable differences in people's health
- To help as many people as possible live long, happy and productive lives by promoting health and wellbeing at all stages of life
- To ensure that prevention is at the heart of improving health and wellbeing, and to reduce ill health and the associated demand on health and care services
- To provide democratic input into the integrated care system
- To work with our communities and population to lead their role in improving their own health and wellbeing

The HWBB Priorities listed below will drive our work for the next 4 years.

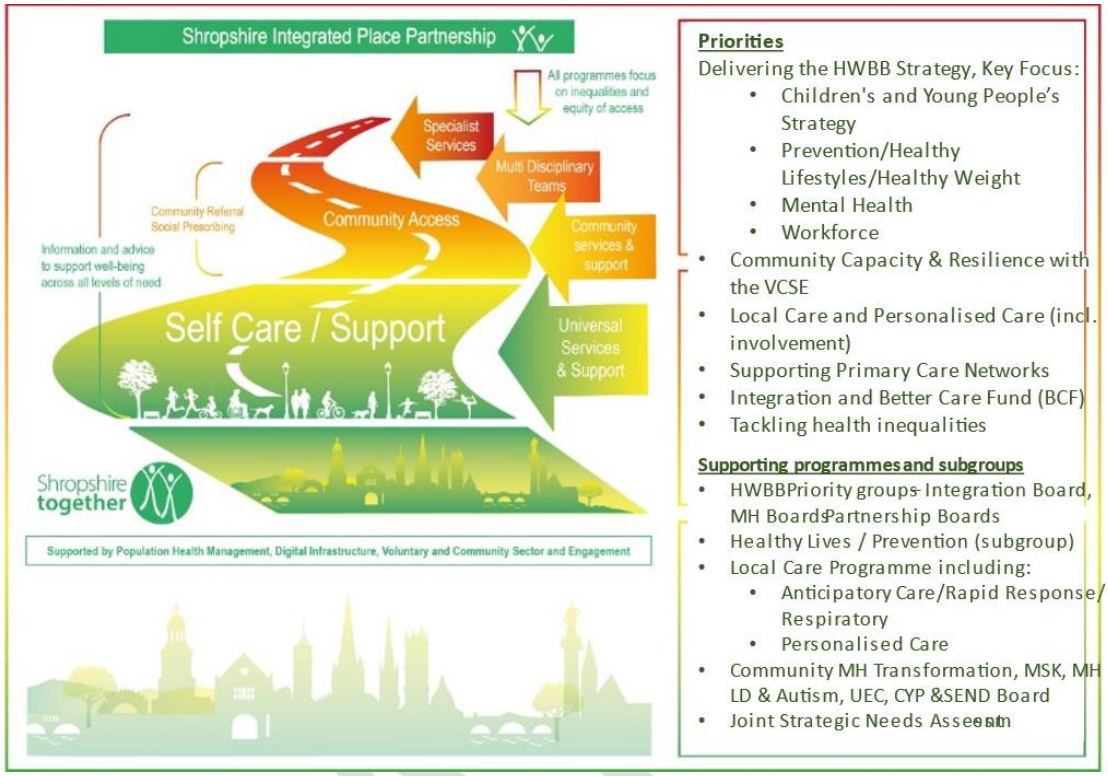


The priorities of Joint Health and Wellbeing Strategy are developed in response to the Shropshire Joint Strategic Needs Assessment (JSNA). The Needs Assessment fulfils a statutory duty to identify areas of health and wellbeing need through the examination of national and highly localised data. In Shropshire 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, the Shropshire Integrated Place 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.

Delivering successful place based integrated care is reliant on community capacity; communities supporting families and individuals to have a good, healthy, life and have the resilience and capacity that enables them to feel part of their community and to contribute to a collective sense of local well-being. Our role as public and voluntary & community services is to support local areas to flourish in this way, and to provide additional levels of support and care activities where and when they are needed. By working with communities to build resilience and by developing grass roots support we will ensure that there is a first line of support in place that prevents or delays escalation of the needs of individuals and reduces the demand on acute and intensive interventions.



Shropshire Integrated Place Partnership

SHIPP Integration Model

This model focusses on the strengths of people and communities as a cornerstone of how we will work. Our programmes will focus first on supporting people to help themselves; followed by ensuring there is high quality, integrated, easily understood universal services for people to access when they need it; and high quality, integrated, easily understood specialist services available when they are needed.

Integrated Care System
Shropshire, Telford and Wrekin

NHS
Shropshire, Telford and Wrekin

SHIPP Deliverables for 2023 – 2024 – Local Care

- **Delivering an all age Local Care Programme across communities in Shropshire; improving access to health, care and wellbeing services and community support. This includes:**
  - Expanding the current Local Care programme and aligning services across health, care and the voluntary and community sector
  - Using the Shropshire Integration Model to integrate services where possible, and working in partnership where integration is not possible, to deliver multi-disciplinary approaches in local communities
  - Unleashing the power of communities and the voluntary and community sector and maximizing their power to support people to maintain their independence and wellbeing at home
  - Using public sector estate in our communities to best effect, collocating in local communities where possible (see case studies below)
  - Delivering specific elements of the Local Care programme in a collaborative and integrated way, including:
    - **All age integration test and learn sites**
    - **Social prescribing, children and young people, families, and adults**
    - **Rapid response, including falls response and prevention**
    - **Virtual ward**
    - **Respiratory**
    - **Proactive Prevention**
    - **Neighbourhoods**

Enablers for the delivery of place-based programmes
- Locality Joint Strategic Needs Assessments (18 Place Plan areas) Ongoing Development
- Embedding Personalised Care/ Person Centred Care in all transformation programmes
- Supporting Primary Care
- Development of Trauma informed approaches across the workforce
- Making best use of technology

Board alignment
- Health and Wellbeing Board
- Population Health Management Board
- Demand Management Board
- Local Care Board
- Local Shropshire

SHIPP Deliverables for 2023 – 2024 – Local Care

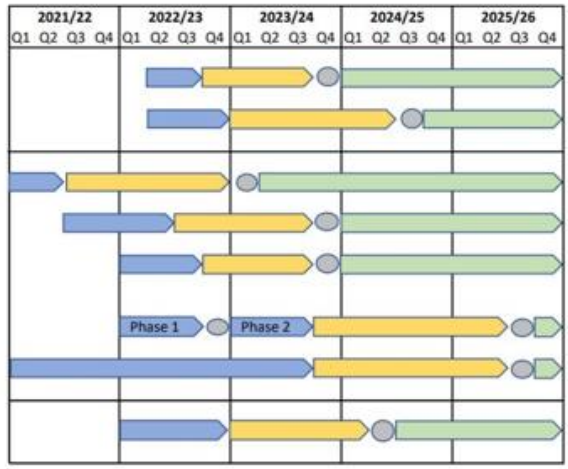
What will be delivered in 23/24:

- 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, inclusive of:
  - Trauma informed approaches, Social Prescribing and Carers (underpinned by Personalised Care)
  - Multi-disciplinary teams to include Social Care, Public Health Nursing, MPFT (Mental Health in Schools), voluntary sector and other partners
  - Grant funding for additional community activity for children, young people and their families (working with Town and Parish Councils)
- Develop more Health and Wellbeing Centres; Oswestry, Highley, Ludlow, Shrewsbury, that include MDT approaches (as per below)
- Primary Care Networks are supported by joint working and integrated approaches on Proactive Care, Neighbourhood, Integrated Discharge and Social Care Hubs (including reablement), and Rapid Response , to be developed together, through a jointly developed Neighbourhood Model – to connect with Health and Wellbeing Centres (timeline from NHS led Local Care below)
- Social Prescribing expansion into A&E, midwifery, children, young people and families and local health and wellbeing centres

SHIPP Deliverables for 2023 – 2024 – Local Care – to be updated

Local Care Transformation Programme Phasing (January 2023)

Workstream	Lead Partner
Anticipatory Care	ICB
Neighbourhoods (Adults & Children)	Shropshire LA / Telford & Wrekin LA / Shropcom
Alternative to Hospital Admission	Shropcom
Virtual Ward	Shropcom
Integrated Discharge Team - inc. Integrated Therapy/AHP Service/Social Care/ Reablement	Shropcom / SaTH
Community Bed Based Model	ICB
Community Hosp Medical Model	Shropcom
Integrated Care Home Intervention - linked to Community Bed Based Model & Neighbourhoods	Shropshire LA / Telford & Wrekin LA



Key:
Design & Testing | Implementation | Evaluation | Business As Usual

SHIPP Deliverables for 2023 – 2024 - Oversight

- Coproduction and codesign – as much as is possible, involving the people who use services in transformation, service design and service improvement
- Better Care Fund – Prevention, Admission Avoidance and System Flow
- System transformation work
  - Carers and carers support services,
  - Mental Health
  - Health pathways such as Diabetes, CVD, MSK,
  - ensuring prevention and personalised care is embedded within programmes
- Inspection regimes including SEND and CQC
- Shropshire Inequalities Strategy and Ongoing Delivery
- Healthy Weight Strategy and Action Plan and support delivery of the Whole System Approach

Case Studies – Communities delivering real health and wellbeing improvement

The Centre - Oswestry

The Centre, Oak St, Oswestry has organically developed over the last few years as a vibrant community wellbeing centre. The space is used by Shropshire Council Early Help, the Integration Test and Learn site – which is a collaboration of health and care services, supporting children, young people and families, youth clubs, Osnosh (details in blue), New Saints Foundation (the Power of Ten - details in green aside) and other voluntary and community organisations.

The vision is for the Centre to continue to grow its community offer in partnership with a range of organisations providing a fantastic space for the community to receive support and to thrive.

OsNosh CIC

- OsNosh are passionate about bringing 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.
- They started with community meals, providing a "pay as you can" offer. Their work involves supporting the local voluntary sector through providing opportunities for volunteers to work in the kitchen, learn new skills in cooking and working with the local residents. OsNosh provide a welcoming space for everyone within our community to sit down together and help fight food waste.
- At the beginning of the Covid-19 pandemic, Osnosh received a small amount of funding from Shropshire Council and space at the Centre in Oswestry, delivering meals to a handful of people. This service swiftly grew to supporting over 200 people. Since the easing of restrictions, Osnosh offers share tables, takeaway hot meals and community events and regular community meals, and have seen their volunteer workforce growing to include 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.

The Power of 10

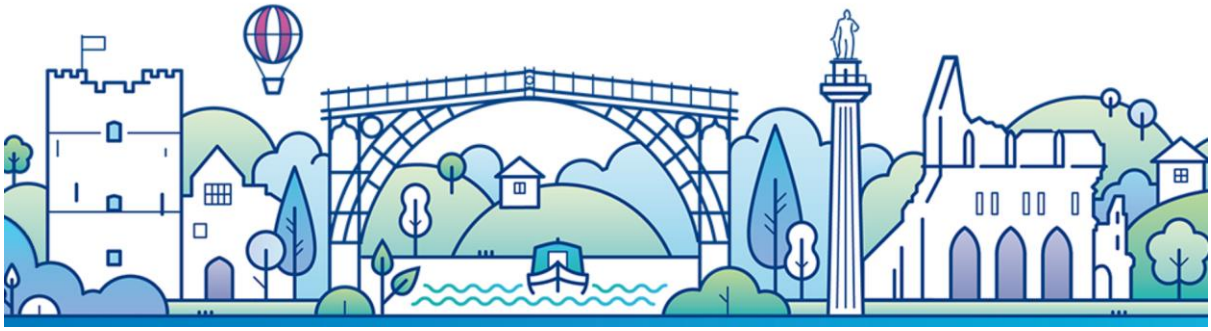
This project forms part of an 'Early Intervention' Pilot aimed at developing more effective collaborative working between the statutory and community sector to improve outcomes for local people. Delivered from the Centre, a ten-week programme delivered in partnership and led by The New Saints FC Foundation (TNSFC Foundation) to ten 'secondary level' young people on the verge of exclusion, based on co-design principles and 'invitation' criteria agreed in partnership with Marches Academy Trust and West Mercia Local Policing Team, using a central theme of sport/physical activity (in particular football and boxing) as the 'hooks' to engagement

System priorities and linkages across Boards

Shropshire, Telford & Wrekin ICS Pledges	Shropshire Health & Wellbeing Board (H&WBB) Priorities	Shropshire Integrated Place Partnership (ShIPP) Priorities
Tackling the problems of ill Health	Improving population Health	
Tackling Health Inequalities and access to Health Care	Reduce Inequalities	Tackling health inequalities
Creating system sustainability	Joined up working	Integration & Better Care Fund (BCF)
Delivering Improvements in Mental Health/learning disability autism provision	Mental Health	Mental Health
Workforce	Workforce	Workforce
Integrating services at place and neighbourhood level	Working with and building strong and vibrant communities	Community capacity & building resilience within the VCSE
Climate change	Children & Young People incl. Trauma Informed Approach	Children's & young peoples' strategy
Enhanced engagement and accountability	Healthy Weight and physical activity	Prevention/healthy lifestyles/healthy weight
Improving safety & quality		Supporting Primary Care Networks
Leadership & Governance		Local Care and Personalisation (incl. involvement)

Local Care

Local care
"Adding years to life and life to years"



The STW Local Care Transformation Programme (LCTP) brings together a collection of transformation initiatives that will deliver more joined up, integrated 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 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. Wrapped around these new models of care, will be new ways of supporting people who are vulnerable, frail or have a range of complex health and wellbeing needs. At the heart of Local Care, is a person centered proactive approach to care that helps people to live well and stay well, maximising independence and fulfilment in life.

The LCTP will deliver on its' ambition to deliver more joined up and proactive care closer to home through six critical programmes of work:

1. Avoiding hospital admissions through provision of wider services including rapid response
2. Implementing a 'discharge to assess' model
3. Opening 250 'Virtual Ward' beds
4. Employing a person centred and proactive care approach
5. Developing our approach to neighbourhoods
6. Reviewing community based services for sub-acute care and reablement & rehabilitation.

These six critical programmes of work are described in more detail below.

1. Avoiding admissions to hospital for patients where care is better received in another setting
2. Implementing a 'discharge to assess' model to support patients to safely return home where any ongoing care needs can be assessed
3. Opening 250 virtual ward beds, initially focusing on patients with frailty, respiratory and cardiovascular, 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
4. Employing a person centered and proactive care approach focused on keeping people well and preventing avoidable health issues for those at high-risk of a non-elective hospital admission
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 centered and proactive care – empowering communities to support health and wellbeing – making best use of community based assets in the widest sense
6. Reviewing community based services for sub-acute care and reablement & rehabilitation to make best use of our available resources, including our staff and our physical assets including community care settings

By delivering these six critical programmes of work we will:

1. Expand community based services and provide suitable alternatives to hospital based care

2. 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
3. Respond swiftly to those in crisis to avoid unplanned hospital admissions
4. Ensure a focus on proactive care and early intervention that promotes good health and wellbeing
5. Develop a deeper understanding of the needs of our population and make demonstrable progress in tackling health inequalities
6. Focus reablement and rehabilitation services to help people maximise their functional outcomes and independence, focusing on the personal goals that matter most to patients
7. 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

Primary Care Networks and General Practice

Placeholder – need to engage with GP board on content with PC team and medicines optimisation

Next steps for integrating primary care: Fuller stocktake report' was published by NHSE in May 2022. It makes recommendations for the development of primary care, and its integration into local neighbourhood communities, to help address the current challenges to primary care delivery and improve the care and experiences received by patients.

Primary care is the cornerstone for delivery of healthcare to our population. For many it is the first point of contact when accessing healthcare; for some the ongoing relationship with their GP and primary care team is crucial; for the system the "specialist generalist" contributes a breadth of knowledge and support which underpins more specialist and specific services.

However, 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. Change has accelerated since the Covid-19 pandemic began, and ongoing impacts of this, such as challenges to both urgent and planned secondary care services, have resulted in reduced satisfaction in primary care access and care for both patients and staff, despite the heroic efforts of the primary care team to deliver care. These challenges are now threatening the sustainability of our primary care services.

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. The proposal is for integrated primary care services which provide 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. The ambition therefore is to take a system-led approach to drive improvements and to develop Integrated Neighbourhood Teams (INTs) that move beyond PCNs as a fundamental building block of an ICS. Delivery of this ambition will require primary care leadership, support, and system-led investment in transformation capacity.

There are four key areas of focus:

1. Development of integrated teams in neighbourhoods, bringing together previously siloed teams to work differently together to improve patient care for populations. These teams may be built around PCNs but involve a range of professionals from many backgrounds – wider primary and community care, secondary care, social care and voluntary services. It requires a shift to a more holistic psychosocial model of care provision, aligned to a population-based approach. Each team member retains responsibility for delivering their part of the patient's care, but this is provided in a coordinated and integrated way.

2. Improving same day access for urgent care. The Fuller report acknowledges the conflict between providing rapid access to urgent care in the community at the same time as ongoing care for those who need it. It proposes changes to the ways people access urgent care via a single integrated community urgent care pathway, which is reliable, streamlined and easy to navigate, but which can provide alternative ways to access urgent care to meet the needs of different groups.

3. Personalised care for those who need it. This recognises the importance of providing continuity of care for those who will most benefit – those who have multiple long-term conditions and/or complex needs, where continuity of care has been shown to improve outcomes. This way of providing care would allow focus on "what matters to me" not "what is the matter with me."

4. Prevention. The primary care team should work with local communities and local authorities, wider primary care team and voluntary services, making effective use of relevant data to focus on prevention and early intervention to improve people's health and wellbeing.

We will need to consider how to take the Fuller recommendations forward; not all will be appropriate for the needs of our local communities, or may need to be delivered in different ways in different places to meet local need, and we will need to prioritise which areas to work on first. GPs must lead and support any changes proposed, ensuring we maintain stability in primary care.

The system will need to invest in local leadership to support change. There is a need for clarification of the role of PCN CDs, beyond the current basics in the PCN contract; local provision of sufficient protected time to meet the leadership challenges of working in Integrated neighbourhood teams and development of aspiring leaders. GPs and PCNs will need support to work with other system providers at scale.

Areas where the system may be able to support the enablement of primary care include building relationships and capabilities around improvement and transformation; quality improvement; digital, data and analytics; physical infrastructure, workforce planning and transformation and service design.

Key actions for the ICS and place-based boards to support implementation of the suggested improvements include:-

1. A system-wide approach to managing integrated community urgent care
2. Enabling PCNs to develop integrated neighbourhood teams
3. Co-design and put in place infrastructure and support for integrated neighbourhood teams
4. Supporting a primary care forum and representation
5. Supporting the development of Primary Care Networks and leadership
6. Primary care workforce planning embedded in system workforce plans
7. Developing a system-wide estates plan for primary care
8. A development plan to support the sustainability of primary care

Community Pharmacy, Optometry and Dental

Placeholder

Community and Voluntary Sector

Placeholder

Ambitions

Transformation

Long term contracts

Chapter 4: Our Clinical Priorities

(place holder for clinical priorities- diabetes, MSK, cardiovascular, UEC, Cancer)

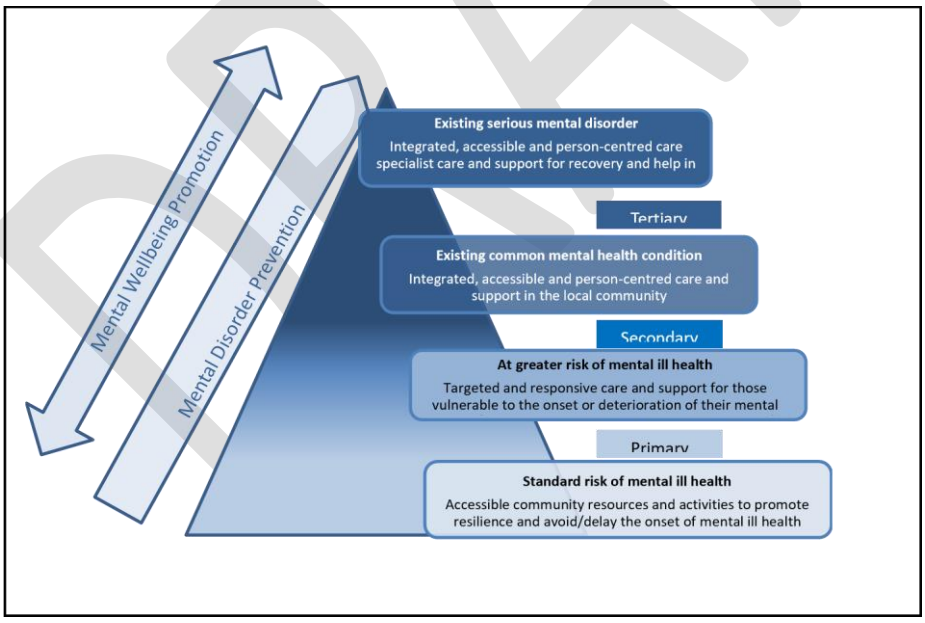
Clinical Priority 1 – Urgent and Emergency Care
Clinical Strategy Priority 2 – Cancer
Clinical Strategy Priority 3 – Cardiac Pathway
Clinical Strategy Priority 4 – Diabetes
Clinical Strategy Priority 5 – Musculoskeletal (MSK)
Clinical Strategy Priority 6 – Mental Health

4.1 Mental health (this section needs updating and aligning with CP)

This section sets out what we understand to be the main population needs concerning mental health. It includes public health data concerning life expectancy, common mental health conditions, and serious mental health conditions and includes data from local service usage which highlights the local challenges this plan aims to address.

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.

By taking a population approach to mental health which includes three levels of mental disorder prevention and mental wellbeing promotion (primary, secondary and tertiary) outlined below we can see that the population mental health can be broadly stratified into four levels, those that have a standard risk of mental ill health (where prevention is most helpful) through to those at greater risk and finally those with common or more serious mental health disorders (where promoting mental wellbeing is most helpful).



The outcomes of public mental health practice include;

Mental disorder prevention **1. Primary prevention aims to prevent mental disorder from happening in the first place by addressing risk factors** **2. Secondary prevention involves the early identification and treatment of mental disorder/complex behavioural needs.** **3. Tertiary prevention involves prevention of relapse and any associated impact of mental disorder including reduced life expectancy from physical illness, health risk behaviour, suicide and stigma**
Mental wellbeing promotion **1. Primary promotion involves promoting protective factors for mental wellbeing 2. Secondary promotion involves early promotion of mental wellbeing in people with recent reduction in mental wellbeing/emergence of behavioural needs.** **3. Tertiary promotion involves promotion of mental wellbeing in people with longstanding poor mental wellbeing/complex behavioural needs.**

Within a population based approach services have a resource that has evolved to meet demand vs resources distributed against population health intelligence at the primary care network level. There would be a strong focus on community assets including the well-being and mental health dimension. This leads to better information sharing and localised access to agreed pathways embedded in primary care. There may be innovative electronic solutions to support easier access to self-help for example with social prescribing.

Central to a strengths based approach is community asset mapping and identifying strengths and gaps locally. A social development approach (pick most deprived areas and target developments) linking to known community assets will be adopted. This may require joined up focus on:

- Adverse Childhood events – Prevention + Trauma based approach
- Partnership working with schools, voluntary sector, charities
- Support to voluntary sector so that they can continue e.g. governance and longer term funding for stability
- Use of population health intelligence to target wider determinants of mental ill-health e.g. isolation, problem gambling, rough sleeping
- Targeting known cohorts of people with links between physical health + mental health such as people with long term conditions

Supporting this approach will require some of the following:

- re-alignment of professionals traditionally working in secondary care, such as doctors being located in PCNs which we envisage will lead to better relationships and more visible, robust clinical leadership.
- Estates requirement to be fully understood to enable co-location of services to PCNs where it makes sense – due to: e.g. geography (Newport vs Telford), and service type (dementia, IAPT LTC). What cannot happen is colocation for colocation's sake which may in turn destabilise smaller, less well resourced teams.
- Recognition that in social prescribing pharmacist role is key
- MH Input into Ageing Well + Frailty + shared care approach on MH/PH + End of Life (EOL)
- Building on the great work in the compassionate communities e.g. dementia (Newport), EOL
- Digital – one care plan, apps, communications (electronic)
- Multi-agency /service response, e.g. substance misuse, rough sleeping, bereavement and suicide prevention
- Future PCN enhanced service links to mental health

It is important to recognise the cultural shift required for system leaders and front line teams to work in new ways. For our system there are challenges that are local and specific, including:

- Geography (variation + dispersed population + pockets of deprivation)
- Equality of Access (poor transport links)
- Hidden population inequality
- Baseline of very low investment in mental health = higher caseloads & less capacity
- Workforce issues – recruitment and retention of nursing, Drs (all types), SaLT etc
- Cultural changes - partnering, working together at different levels
- Digital baseline is very low
- Challenged ICS – quality + finance
- Data / Information sharing is not robust
- Frailty – increasing demand on existing services
- Workforce planning – shift from org's (acute → community) Skills/risk appetite
- Supporting the community to have robust assets / fill gaps
- Up-skilling of primary care in mental health
- Making mental health everyone's business

The people receiving care from our mental health services face one of the major health inequalities of our time. On average, men and women in contact with specialist mental health services (with a serious mental health

condition) have a life expectancy 22.8 years and 19.6 years less than the rest of the STW population respectively. Whilst this inequality represents a long known national public health concern, figures for men and women, in the STW, are some of the lowest in the country and the lowest of other comparable systems with similar populations.

There are significant opportunities for early intervention for those most at risk of developing serious physical illness such as circulatory disease, respiratory disease or cancer.

Trauma informed approaches

A consistent theme to emerge from the engagement meetings was 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 link between trauma and mental health

There is increasingly strong evidence that supports the view that trauma is linked to mental health conditions, for example:

- Trauma is strongly linked to adult psychosis and a wide range of other forms of mental distress
- the more adverse life events people experience prior to the age of 18, the greater the impact on health and well-being over their lifespan
- Experiencing two or more trauma has a 'loading dose effect' that increases the likelihood of experiencing psychosis
- People in low-socioeconomic groups and from minority ethnic communities have higher risk of experiencing trauma.
- Poverty is the most powerful predictor of mental distress because it predicts so many other causes,
- Black people are over-represented in the mental health system. They are more likely to experience negative or adversarial pathways to care, to be diagnosed with psychotic disorders and to receive compulsory treatment
- People in contact with mental health services who have been sexually or physically abused in childhood typically:
    - have longer and more frequent hospital admissions,
    - are prescribed more medication
    - are more likely to self-harm and are more likely to attempt to kill themselves than o people without experiences of childhood abuse

Applying trauma-informed principles to mental health

We aim to ensure that the following characteristics are visible across our services:

- They are strengths based;
- They reframe complex behaviour patterns in terms of its function in helping survival and as a response to situational or relational triggers;
- People understand the impact of trauma on a person's ability to survive in the present moment. Crucially, this entails a shift from thinking "what is wrong with you" to "what happened to you" ;

- The critical roles of racism, sexism, homophobia, ageism and poverty and their relation to one another are recognised. Survivors in crisis are not viewed as manipulative, attention seeking or destructive, but as trying to cope in the present moment using any available resource;
- Staff do not fear asking about trauma, and do so in ways that are respectful of potential re-traumatisation;
- People are forewarned about trauma questions, and can choose not to answer;
- Trauma information is integrated into treatment plans so that people can be referred to trauma-specific services (if wanted);
- Staff receive support to help them focus on trauma, and steps are taken to build a sense of community and shared responsibility staff who may have themselves experienced trauma feel safe;
- We aim to reduce or eradicate coercion and control, including medication as restraint, verbal coercion, threats of enforced detention, withholding information, restrictive riskaversive practices, disrespectful and infantilising interactions and Community Treatment Orders.

Currently mental health services in STW face a growing challenge of providing care and therapy for people who have complex mental health needs. Many service users require long periods of care with frequent and sometimes long admissions to hospital. There is also a significant demand for psychological input but with limited availability of practitioners, delays in access or significant waiting times. Service users with complex presentations are often stuck in a series of sequential, short-term interventions. This can exacerbate people's problems and lead to a 'stuckness' in services, with a sense of 'nothing working' and hopelessness for both services users and providers. This can manifest in waiting times, bed use, and 'revolving door patients' with sometimes very expensive out of area treatment options being used.

In Shropshire there are examples of women who have experienced significant adversity in their lives, and in the absence of effective care pathways in their developing years, have 'progressed' in complexity of need and now require longer term specialist care, sometimes out of area in expensive placements far from their homes, friends and families. The 8% of the Shropshire Telford and Wrekin population who use mental health services are disproportionally using 25% of A&E attendances and 18% of urgent A&E attendances plus 14% of elective appointments. Targeting these individuals through pro-active case management would not only help to save lives, but produce significant savings to the wide health and care economy.

The single most significant predictor that an individual will end up in the mental health system is a history of childhood trauma. The more severe and prolonged the trauma, the more severe are the psychological and physical health consequences. Complex Trauma is a major public health problem, with enormous cost implications. There is a large cohort of individuals presently in the mental

health services that do not have formal 'diagnosis' of mental illness yet experience extreme and disabling levels of distress. The need to better understand and develop services for these individuals is paramount, as they can fall between services.

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.*** It is not easy for members of the helping professions, and society in general, to face the fact that sexual abuse and other forms of violence and maltreatment towards children are much more common than we like to believe. Despite recent "scandals" we still have difficulties facing the enormity of childhood abuse in our society. There are significant numbers of Looked After Children in STW, with high numbers requiring intensive residential care, which represents a real opportunity to redesign current pathways and make a significant preventative impact on their chances of recovery.

In STW we have yet to develop an overarching strategy to support and help people who are survivors of childhood trauma, and we have no clear strategic recognition of the huge significance of complex trauma in understanding mental health problems. Currently, there are committed workers doing some valuable work with clients, and some services who provide relevant interventions. In recognition of the importance of this emerging evidence base to the core offer of mental health services a group has been established to report into the MH Cluster Group and advise on future service and workforce implications. E aim to address this in the transformation of CYP and community adult services.

Additionally, we are going to evaluate a new approach to strengthen the support to families in difficulty. A new pilot service in Telford and 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. This approach supports a focus on trauma and understanding ACE history which is relevant to Telford as an area where significant child sexual abuse has been identified (i.e. Operation Chalice).

Within this overarching ambition sit a number of objectives that focus on particular cohorts or outcomes.

1. For children and young people (CYP) we will commit to fully implementing the CYP Local Transformation Plan to meet the emotional and wellbeing needs to 0-25year olds.
2. For people aged 14-65 experiencing first episode psychosis, to ensure that the full range of NICE-recommended interventions (in line with the 5 Year Forward View implementation plan) are available in all areas.

3. By 2020 the STW will provide an effective crisis resolution and home treatment team service that is resourced to operate in line with recognised best practice – delivering a 24/7 community-based crisis response and intensive home treatment as an alternative to acute in-patient admissions. This will be part of one single integrated and coordinated urgent care pathway, with crisis café, crisis house and sanctuary. Out of area acute placements will essentially be eliminated for acute mental health care for adults.
4. The in-patient crisis pathways for all adults, children and people with learning disabilities will be reviewed to ensure purposeful admissions, minimum length of stay and appropriate number of beds according to population need. Environments will be fit for purpose, providing safe, humane and homely sanctuary for recovery. This will be complemented with alternative models of care to deflect admissions, thus ensuring least restrictive approaches and environments are used, and that liaison services are embedded and available across all sites.
5. The pathways for more specialist services (for example people in forensic pathways, rehabilitation and for people with complex needs, attachment and trauma and people with learning disabilities) will be reviewed to include use of current estate and capital investments, actual needs and evidence based contemporary models to support the optimum personal recovery outcomes.
6. Community services will have access to real-time patient level service data to underpin planning and work flow. There will be greater focus on asset-based approaches and community integration, and the recovery college will be fully implemented and available to all service users, and viewed as an asset supporting community resilience.
7. By the end of 2019/20 we will have a new strategy for people with learning disabilities and autism which sets out the expected services for people based on early access to assessment and an intensive support model for people to live in their own homes.
8. We will review the community pathways model to identify how they integrate into a place based model of care, in line with aspiration of the NHS Long Term Plan to have new models of integrated community care. This will include using the additional investment in the LTP to ensure the Early Intervention in Psychosis service meets nationally mandated standards and developing new services to support people with complex needs, closer to their homes.

Outcome driven care

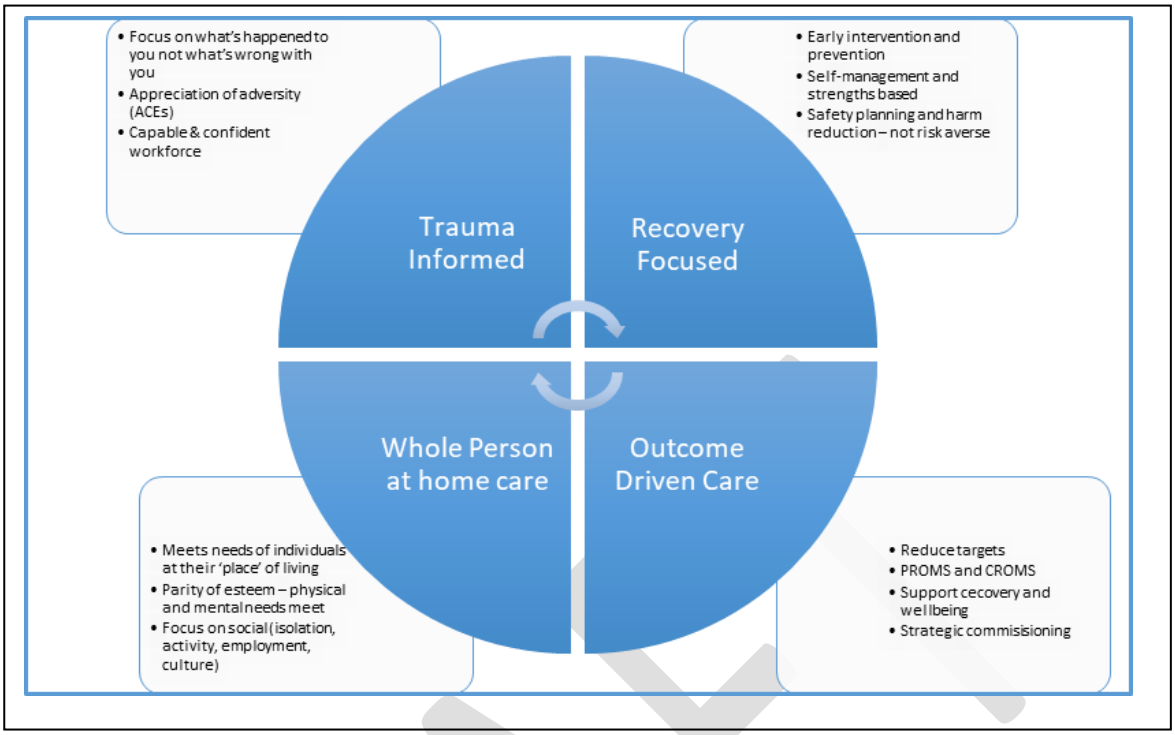
Our engagement with colleagues and stakeholders has raised the question of how useful the current performance and contracting system is to hold the providers to account, and challenged us to think about whether or not it is not fit for purpose. The use of Key Performance Indicators and activity performance indicators is

perceived as being unwieldy, overly bureaucratic and too prescriptive. People have shared the view that too much of their valuable clinical time is spent on 'feeding the system' with a focus on process rather than outcomes (i.e. are people actually improving and getting better). Attempts have been made to deliver outcomes through the contracting process and there is recognition to move towards a system where outcomes are routinely collated to be able to demonstrate the 'experience' and the 'effectiveness' of service quality.

The ICS will agree a smaller number of outcomes used across services, which add value to the care delivery process and assist with the recovery of people in care. The outcomes approach adopted will aim to be:

- **clinically relevant, so that they are seen to add value for clinicians as a routine part of their clinical practice and continuous quality improvement;**
- **reflect what people who use the service (and their families) want;**
- **culturally appropriate and culturally reliable;**
- **aligned with system-wide objectives;**
- **measurable using metrics with established reliability and validity; and**
- **be inclusive of physical, social and mental wellbeing data.**

The diagram below illustrates how we visualise the relationship between trauma informed care, that supports recovery within a holistic model and the relationship to outcomes driven commissioning:



We will support the ICS wide approach to adopt a system wide universal outcomes framework which includes the use of clinician and personal reported outcomes, linked to electronic patient records for immediate and real-time feedback.

We will also make effective use of all data sources across health and local authorities to ensure that a future STW MH Dashboard reflects the whole person in their lives, and not just the clinical aspects. There are examples (e.g. Shropshire Local Authority) where single case approaches are being developed to join up all available information about whole families to be able to predict where help is required at earlier stages.

The table at Appendix 6 describes the road map or implementation plan for each of the enabling work-streams to support the strategic priorities.

4.10 Links with Urgent & Emergency Care for Crisis Care

The model for responding to people requiring urgent care or crisis response is well developed and access to Home Treatment Teams (HTT) is available. The current HTT are resourced to operate 24/7 and have received Royal College of Psychiatry quality accreditation for one part of their service.

There is one crisis house, to offer a short-term alternative to inpatient admission and good community provision offering some form of alternative to admission. However, across the pathways there is a lack of shared data and understanding of what within the system is working well and what is not. For this reason, urgent care and reviewing crisis care pathways is a priority so that less people end up in crisis, and more are able to access earlier forms of help and support so that they can better self-care and manage their emotional and mental health.

Fundamentally, we want to see an acute and urgent care system were:

- No-one, anywhere in our services, waits more than 4 hours for mental health assessment in crisis.
- Once assessed, people are placed immediately in accommodation suitable for their needs. For most people, this should be their own home, with sufficiently intensive home treatment support. For some, it could mean a short-stay crisis house. For a minority, it will mean acute inpatient care.
- No-one stays longer than they need to in acute inpatient care. There are no “delayed transfers of care” due to lack of step-down support.
- No-one is admitted to an acute overspill bed outside our area.
- We are fully prepared for 2021 ambition where NHS 111 are equipped to deal with mental health crisis.
- We can meet the needs of people with learning disabilities and autism.People have a choice in where they can access help before a crisis unfolds (crisis cafes, peer support, improved self-help).

4.11 Children's Health and Emotional Wellbeing (this section need updating)

The vision is for all children and young people to grow up healthy, happy and safe within supportive families and caring networks. We want them to have the best health, education and opportunities to enable them to reach their full potential. Our main priority is to keep children and young people safe and give them the best start in life.

The Children and Young People's Local Transformation Plan (CYP LTP) has identified programmes of work and the system capacity at which implementation can realistically take place.

The programmes have been mapped against the iThrive Framework and are listed below and further developed in the subsequent narrative:

Programme No.	Link to stepped care model	Programme Title
1	Self-Support	Improving awareness and understanding of emotional health and wellbeing in CYP for all CYP, families and professionals.
2		Improved availability and consistency of family information to support children and families.
3	Consultation	Timely and visible access to appropriate practical
	and Advice/guidance	help, and support and treatment.
4		Focussing support on vulnerable CYP and their networks.
5	Getting help	Evidence-based care interventions and outcomes.
6		Develop our workforce across all services.
7	Getting more help	Ensure strong partnership working and system wide governance.
8		Fully involving Children, Young People and Families.
9	Getting Intensive help	Improved crisis care.

The CYP LTP will continue to be the main vehicle for delivering transformation in children and young people's services.

4.12 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.

Many older people experience psychosis, depression, anxiety and other mental health conditions that are part of the 'core offer' of specialist mental health care.

The prevalence of dementia among people living in care homes has increased, from 56% of residents of care homes to around 70% over the past 20 years. Rising demand is creating a pressure on specialist mental health services for people with dementia. We are increasingly aware of the complex patterns of comorbidities which physically and mentally unwell elderly people experience. A patient with a cognitive impairment and in a hospital-bed is much more likely to be in an acute hospital bed than in a psychiatric hospital. Any admission to hospital, for a person with dementia, creates a serious risk of a dislocating effect, such that they may never return home.

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.

We will continue to provide older peoples mental health services, and will 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. We also need to work more closely with the acute general hospital care system to ensure high quality, timely discharges for people experiencing mental health problems.

There is an existing dementia strategy and we will continue to work up the actions required to meet the rising demand for these services which are inextricably linked to our aging population.

4.13 Learning Disabilities and Autism

People with learning disabilities and autism are amongst some of the most vulnerable and socially excluded members of our community.
Nationally, it is estimated that up to 2.4% of the population have a learning disability (DOH 2001). For the Trust's Learning Disability Directorate, this equates to a population of around 26,600 people who may require access to our services.

Service models for Community Learning Disability Teams are driven by Learning Disability
Professional Senate Guidance (2015) and underpinned by the Golden Threads of Transforming Care
(Building the Right Support, NHS England (2015). They are characterised by:

- Quality of life – people should be treated with dignity and respect.
- Keeping people safe – people should be supported to take positive risks whilst ensuring that they are protected from potential harm. The Care Act 2014 provides a statutory framework to "make safeguarding personal".
- Choice and control – people should have choice and control over their own care and support services and be regarded as equal partners in decisions about every aspect of their life. • Support and interventions should always be provided in the least restrictive manner. • Equitable outcomes, comparable with the general population, by addressing the determinants of health inequalities outlined in the Health Equalities Framework

The CCG's and LA's have LD/ASD commissioners who are responsible for understanding the needs of the LD/ASD population, commissioning arrangements, developments to meet gaps in service, and subsequent identification of future commissioning intentions.

An overview of the present arrangements are:

- Midlands Partnership NHS Foundation Trust provides physical and mental health, learning disability and adult social care services. The offer in Shropshire is adult and children's mental health and learning disabilities.
- There are a dedicated children and young people learning disability team as part of the BEE U services provided by Midlands Partnership Foundation Trust (MPFT). Within the team are behaviour specialists with approximate caseloads of 18 individuals but the team are currently holding one vacancy.

- The Intensive Support Team provides highly specialised assessment, formulation of need, intervention and support, enhancing that provided by the Community Learning Disability Teams (CLDT).
- The Community Learning Disability Team (CLDT) provides care to adults in Shropshire and Telford & Wrekin. A range of community and outpatient services are offered. The community LD team offer care and intervention to the adults with a diagnosed LD and or Autism but not a primary diagnosis of autism with behaviours that challenge.
- The CLDT do not have a specific forensic team but have nurses and a psychologist who have experience working with individuals with a forensic background.
- Adult Forensic Team - The newly formed community forensic service is a small bespoke service that offers services to Telford & Wrekin forensic patients with a diagnosis of Autism.
- A mental health trust that sits outside of the footprint supports autism diagnosis in Shropshire whilst in Telford and Wrekin the service is provided by a third sector provider (the Autism Hub) with MPFT providing clinical input
- Two complex care teams are based in Clinical Commissioning Groups (CCG) that provide Continuing health care for complex patients
- Autism hub in Shropshire provides drop in support

To address the commissioning gaps identified it is proposed that an all age model of Enhanced Support is commissioned. To avoid confusion with the existing Intensive Support Team service, the proposal will refer to an All Age Enhanced Support Team (EST). It is anticipated that new ways of working will improve care in the community, regardless of age and diagnosis, which in turn will lead to reduced hospital admissions.

The commissioned principals for an EST service are:

- A population-based service, geographically relevant to local needs
- An integrated team of health and social care experts, based in local communities
- Provide a single care planning and intervention pathway and review process across different professionals with data sharing protocols allowing seamless and timely information sharing
- Enable services to collaborate on developing lifelong care plans that structure and tailor an individual's journey and include periods of deterioration in presentation - 'Predicting the Unpredictable'
- Develop strong partnerships with regards to employment, education, housing, health and voluntary organisations, the criminal justice system and independent providers.
- Assist in the improved quality of life and care for people who require complex care packages
- Develop key principles and aims set out in the NHS Long Term Plan

The benefits of working as closely as possible with partners include:

- Delivery of informed reasonable adjustments across locality universal health and social care services.
- Recognition and management of health inequalities
- Opportunities for early identification of need and intervention
- Developing the capacity of universal pathways to support people with Learning Disabilities wherever possible and appropriate
- Improve patient experience through a reduction in duplication and repeated processes between Health and Social care teams
- Effective triaging and signposting of people into Specialist Learning Disability Services supporting early intervention
- Identification of people with the most complex needs in each locality supports targeting of support and preventative planning.
- Increase the available options to support people with the most complex needs as close to home as possible
- Develop local unplanned respite model

Meeting the needs of people with Learning Disability and Autism will be set out in a new STW strategy being developed for February 2020.

4.15 Services for People with Severe Mental Illness

These services support people who have serious mental health problems outside the acute phase of illness. They can work to prevent deterioration in people's mental health – and reduce the risk of acute care ever being needed. They can also work to reconnect people with their lives before they developed their mental health problems. This will mean different things for different people.

People who are in employment should expect to keep it. Employers should be supported to keep on, or take on, people with experience of mental health problems. People who have been in education should expect to be supported to resume education. People whose role is in the home and family should be supported to maintain those responsibilities – or to take up those responsibilities again. People whose lives have been difficult for some time may have no stable life to return to, and will need longer and more complex support to gain and regain the skills and the structures their lives will need. Some people may need support to secure stable housing.

This emphasis on employment will require not only individual casework, but also general development work with employers – encouraging employers to retain and recruit people who experience mental health problems, and reassuring them as

to the support which will be available if problems do arise. The Centre for Mental Health[1] have reviewed the evidence on this topic, and estimate that Individual Placement Support could save as much as £20,000 per person over a five year period. The MH LTP expects a doubling in the access to IPS (Individual Placement and Support) and STW have first wave service (run by Enable) and second wave services in development. There are also (non IPS) services such as Designs in Mind (a CIC located in Oswestry), and the Wild Teams, (Shropshire LA) which provide very effective services supporting people to regain confidence in preparation for future employment, recreation of leisure pursuits.

Rehabilitation and recovery therefore requires a wide range of skills and services – both community and residential. Many of these do not need to be limited to people with mental health problems – indeed, there is a great deal to be said for services whose specialist function is housing, benefits, family support, employment support catering for everyone.

For a minority of people who have serious mental health problems, support will need to be over a very long period: many years, sometimes a lifetime. We understand this, and this strategy will not change that. If people need indefinite support to manage their mental health problems, then that is what we will provide.

However, for most, services' ambition should be very clearly towards gradually moving people out of specialist mental health support – and into the structures which provide social support for all of us:
jobs, homes, friends, work, a role in the community.

Access to appropriate, affordable and safe housing is key to a person's recovery.

Having your own home, and moving to full and active citizenship, pursuing your own dreams and 'living life to the full' should be the goal of rehabilitation and recovery. At present, the balance of our services is too tilted towards long-term support through a bed-based model of care, and not enough towards prevention, or real recovery. This risks increasing rather than reducing the stigma of mental illness, as too many people look to specialist mental health services as their main "community" for too long. This also takes up resources which are very much needed for other aspects of mental health care.

For all people using services, it will be important to identify factors which could lead to relapse, and for care coordinators to ensure things are in place which can

[1] Priorities for mental health – economic report for the NHS England mental health taskforce *(Centre for Mental Health, 2016) available at: https://www.centreformentalhealth.org.uk/priorities-for-mental-health-economic-report*

minimise the risk of relapse. Ensuring a focus on self-management for all people experiencing mental health conditions should be explained at the start of treatment, to encourage independence, and to reduce unnecessary and sometimes harmful attachments to services. Many people who have been in mental health services report recovering their health and wellbeing despite the help of services, and we are only too aware of the possibility of services becoming overly paternalistic and risk averse, and would seek to minimise this happening at all costs.

We are therefore considering work to develop:

- An increased emphasis on peer support. There is considerable evidence that many people do not just equally well, but better, if the main focus of their ongoing support is from their peers, rather than professional services. In addition to the effect on individual service users, impacts have also been observed on the wider mental health system (reducing costs, improved outreach and engagement, improved provider attitudes and quality). The Centre for Mental Health, in a review of the economic impact of peer support, estimated a benefit:cost ratio somewhere between 3.8 and 4.8:1. This will be linked to the new service development around integrated community mental health teams where we expect to see much higher numbers of people with lived experience working within our services.

  We are considering promoting this model by the expansion of supported networks of peer support workers. This will, of course, need to incorporate proper arrangements for the governance, support, and supervision of peer support workers, and of peer supporters themselves.
- An increasing 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.

The following principles underpin the approach adopted by the ICS:

- Our planning assumption is that we will continue to meet the Mental Health Investment Standard (MHIS) in future years which means MH spend will grow in line with the CCGs' allocations.
- Assumptions around growth and tariff uplift are as per the latest CCG financial 5 year plans.
- Indicative LTP transformation funding is per the NHSE & NHSI tool, recently awarded national MHFYFV funding is also included.
- The plan includes a number of potential investments to achieve objectives in the MHFYFV/ LTP ambitions; as well as a cost pressure relating to ASD.
- Mental Health is expected to breakeven CCGs' and must deliver actions to reduce costs across the length of the plan to do so.

- Further work is needed to more accurately quantify investments needed and cost reductions and efficiencies required to fully achieve the LTP for MH.

The improvements we expect to see from our priorities are highlighted below:

Strategic Ambitions			
Prevention	**Resilient Communities**	**Care and Support**	**Crisis**
Promote good mental and physical health and prevent progression / escalation of mental health conditions.	**Develop resilient, emotionally healthy communities where people are open about their emotional and mental wellbeing**	**When people need care and support, we will provide it in in the right place, at the right time**	**Fewer people will experience a mental health crisis and if they do, they will receive care at home or in a place close to their home**
The impact of achieving our ambitions on the four priority groups?			
People experiencing common emotional and mental health problems	**People experiencing psychosis and complex needs**	**For children and young people**	**For people with dementia**

More people will: • **Know where to access help early** • **Recover faster from their conditions** • **Have improved confidence and resilience** • **Have meaningful activities in their life** • **Have good social networks with family and friends** • **Experience less discrimination** • **Have better physical health**	More people will: • **Live longer than they do today** • **Find activities that make them feel better about themselves** • **Believe their life has meaning** • **Form social bonds with neighbours and family** • **Live in places where they feel comfortable** • **Be employed**	More young people will: • **Feel less stigmatised and connected with people like themselves** • **Have the skills and resilience to understand adversity and life challenges** • **Have a positive outlook for their future** • **Feel more able to cope with moving into adult life Improve their confidence and independence**	More people will: • **Feel independent where they live for longer** • **Be able to socialise in their community** • **Have independent daily activities** • **Maintain meaningful relationships** • **Have carers that are well supported**

As the plan makes clear in a number of areas, successful implementation of the *Five Year Forward View for Mental Health and the NHS LTP* is dependent upon establishing services which are sustainable for the long-term. That sustainability is predicated on evidence which shows the savings realised across the health and care system outweigh the investment needed to deliver services. In order to ensure that this fundamental economic case is met, it will be critical for local organisations to agree how they will share both the costs of investment and the proceeds of savings and efficiencies – including how savings will be identified, especially where they accrue in other areas of the health system, and reinvested into mental health services.

These savings are based on evidence of physical health improvements for people with long-term conditions when co-morbid mental health problems are treated in an integrated way. Reduced healthcare utilisation in, for example, A&E attendances, short stay admissions and prescribing costs will release funds to enable continued investment in these new services. The conditions for which there will be the greatest reduction in cost are those for which depression or anxiety co-morbidity leads to a 50-100% increase in physical healthcare costs. The strongest evidence is in diabetes, COPD, cardiovascular disease and for some people, chronic pain and medically unexplained symptoms. It is expected that over the longer term, fewer complications will result in reduced demand across the pathway.

We also plan to reduce the need for out of area placements (through strengthened community teams and rehabilitation pathway) and through concerted efforts to reduce the suicide rate (financial cost estimated at £1.2m per death). Detailed analytic work has been undertaken to demonstrate the impact of mental health on early death, and the utilisation of acute physical health services.

4.13 Children, Young People, Families and SEND (Special Educational Needs and Disabilities)

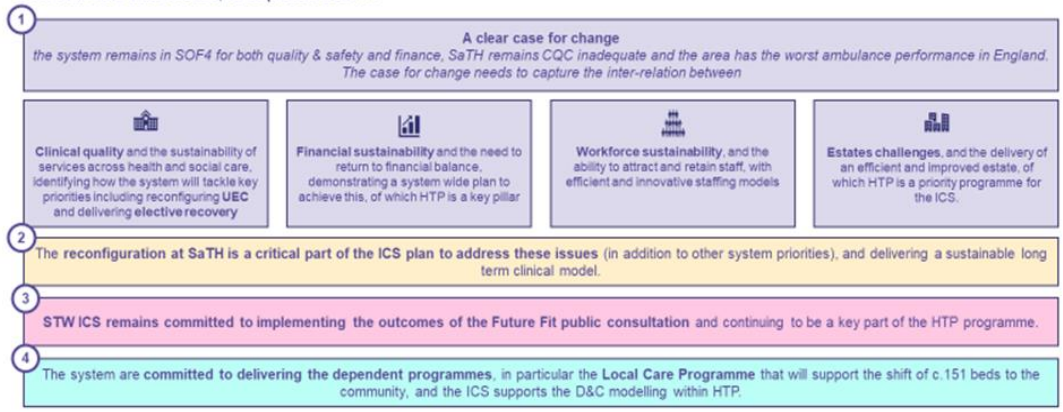
Place holder

Chapter 5: Acute Care Development

5.1 HTP (place holder)

Our Hospital Transformation Programme is a key part of the bigger picture for our patients and communities.
We want all residents in Shropshire, Telford & Wrekin and mid Wales to live healthier, longer lives.
We are committed to tackling health inequalities and helping people to stay independent and well.

The critical role that the HTP plays within the ICS strategy and future delivery of health care across Shropshire, Telford & Wrekin and mid Wales, is depicted below:



To realise our ambition, we need to transform our current models of care to ensure we can better meet the needs of our current and future population. We have established two principal programmes that will drive the transformation of health and care services for our communities.

The Local Care Programme (transforming services in our local communities) 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

The Hospitals Transformation Programme (transforming services across our acute hospital sites) 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. Key benefits include:

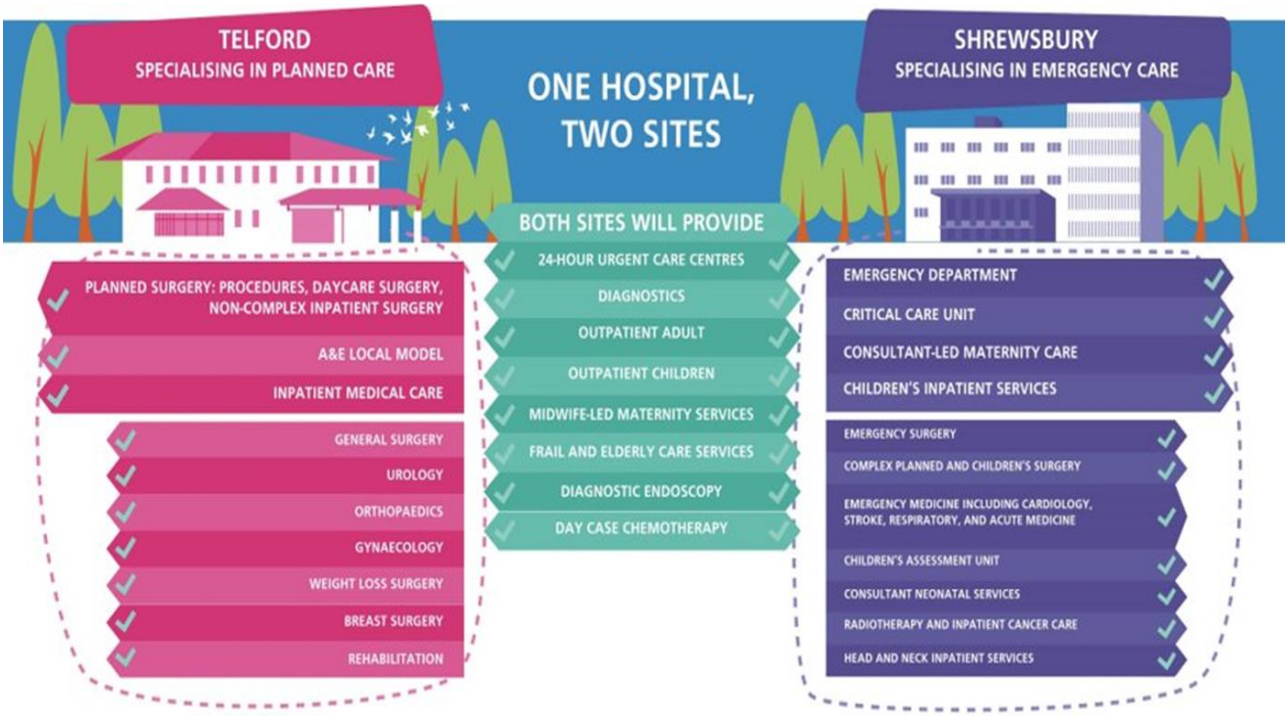
- Dedicated Emergency Department with immediate access to medical and surgical specialities
- Ring-fenced planned care services supporting the needs of our population
- A much better environment for patients, families and staff
- Improved integration of services for local people

We need to change because we face multiple long-running challenges that mean we need to change how services are configured and supported so that we can meet the needs of our patients.

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.

Additional challenges are that

- the current clinical model is not fit for purpose for the current population because of an outdated service configuration, our workforce situation is not sustainable if we continue to duplicate services across both sites,
- Our population needs 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



A vital step forward for all of our patients, families and communities

- Really exciting progress, enabling us to move forward towards the agreed acute service reconfiguration, address the most pressing clinical challenges and secure a significant investment in our local health system
- Enhanced and more effective emergency care delivered through a new contemporary Emergency Department and 24/7 enhanced urgent care services (A&E Local Model in Telford) – immediate access to specialist teams; better patient outcomes; shorter waiting times; faster ambulance handovers
- Improved planned care delivered through dedicated facilities - services operate throughout the year; fewer cancellations and delays for operations; shorter waiting times; better patient experience; seamless integration with our health and social care partners
- Designed in a sustainable way and with a step-by-step approach in mind, so that further scope can be added later – our overall longer term ambitions remain the same

5.2 Elective Care

Place holder

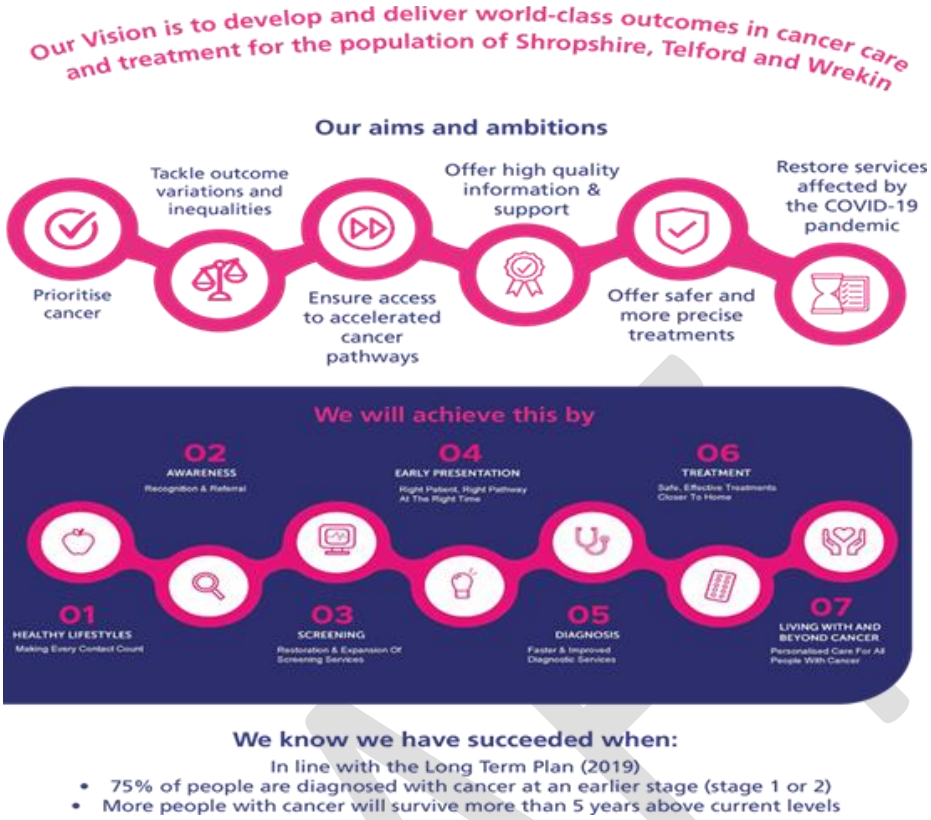
5.3 Maternity Services (place holder)

5.5 Cancer Services

The NHS Long Term Plan (2019) stipulates that by 2028, 55,000 more people with cancer will survive more than 5 years above current levels. To do this, by 2028, 75% of people will be diagnosed with cancer at an earlier stage (stage 1 or 2). This ambitious plan requires local health care systems to work collaboratively to implement changes which will bring about significant improvements in the lives of people diagnosed with cancer and enable more people to live full lives beyond cancer.

As a system we are committed to working together 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 and Wrekin (STW). This is particularly relevant to some childhood and rare cancers where specialised care needs to be centralised in larger cancer units.

It is clear that we have significant variation in both early diagnosis and outcomes for our population and this strategy sets out a clear vision for how we will address this and make improvements. The evidence base on the causal factors of cancer are clear and we know that 4 in 10 cancers are preventable. 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.



5.5 End of Life Care

It is the commitment of Shropshire Telford and Wrekin Integrated Care System that for people nearing the end of their life receive high

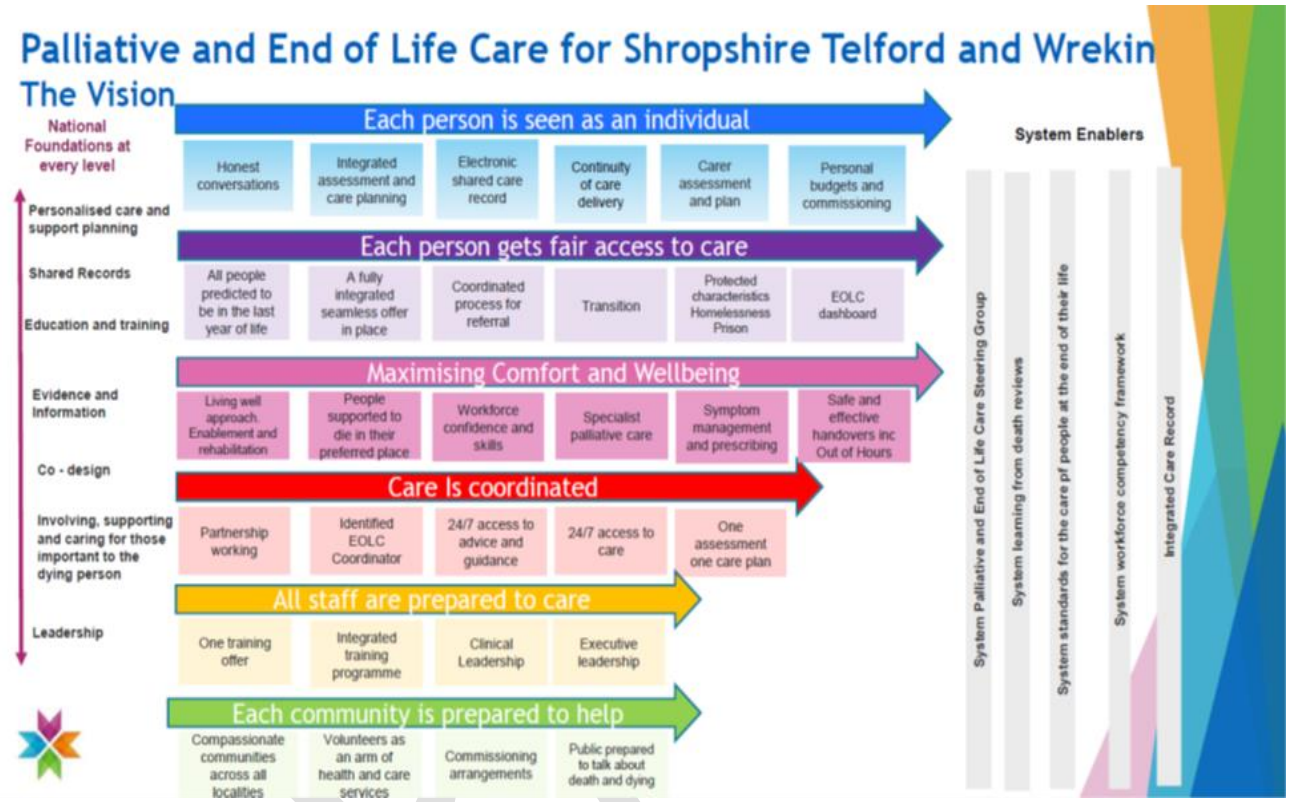
quality and compassionate care and are supported to live well and to die with dignity in a place of their choosing.

In Shropshire Telford and 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, to ensure that people are better supported to live as well as possible by identifying people earlier on in their last journey of life and to anticipate care needs that can be planned for in advance.

We will be open and honest about the challenges that this may present, particularly as our hospitals have been rated inadequate for End of Life Care Services by the Care Quality Commission, we will not shy away from the collective responsibility we have to work collaboratively to enable the improvements needed.

The learning from the pandemic has given health and care staff the experience of how working together across organisations can provide solutions and allows change to happen quickly, this is the approach we will continue to support and as the Shropshire Telford and

Wrekin Integrated Care System becomes a statutory body in 2022, this collaborative and partnership working will be essential to how health and care services are shaped for the future



Chapter 6: Our People Plan

6.1 The context for our workforce Placeholder

6.2 What our workforce looks like

6.3 Headlines from 5-year People Plan

6.4 Where We Are Now and Where we are Headed (update?)

1. Attract, Recruit and Retain

We are working collectively to develop a unique offer for our people that provides our workforce with a diversity of opportunity and makes the local health and care system a better place to work so more staff stay and feel able to make better use of their skills and experience for patients through:

- **flexibility and improved work-life balance with a focus on health and wellbeing,**
- **clearly articulated development opportunities including peer support, mentoring and volunteering opportunities, experience in different settings, the provision of an expert bank of experienced/retired staff to offer coaching and mentoring support,**
- **clearly articulated and flexible career pathways that are multigenerational providing more routes into the NHS, pathways starting at apprenticeship level with a defined employment and training offer including degree nursing and social work apprenticeships**
- **creating an agile and empowered workforce able to respond to the rapid technological advances and the changing healthcare needs of our local population. Roles will become more fluid and role boundaries may blur and mutually beneficial joint appointments will be explored along with opportunities to work together with academic institutions and industry.**

- **developing a system wide retention strategy with a range of opportunities available to our workforce**
- **our workforce is often working in very challenging environments and we need to support them to build resilience and provide opportunities that will ensure positive physical and mental health of our people.**

We have worked together as opportunities have arisen and had some early success. We have now established a health and social care apprenticeship scheme with rotations supported from system partners. We have also successfully recruited international nurses through the Global Learners Programme and established a Shropshire Physician Associate Internship Programme with partnership across acute and primary care.

We recognise that developing centralised approaches to recruitment planning and management is crucial to our long term aims. We have therefore prioritised work on developing a collaborative bank and are scoping the opportunity for creating shared HR services. We see these innovations as fundamental to developing our strategic and management capacity and capability.

We have an agreed system-wide approach to apprenticeship levy sharing in place and will be launching this over the next few months. We are working collaboratively as a system, to grow clinical placement capacity across the system through a shared portal and outreach support from Trust based Clinical Placement Facilitators to new placement partners.

2. Culture and Leadership

The importance of creating the right culture and inclusive and collaborative leadership is a core underpinning strategy. We aim to support having visible and engaged leaders across all levels of the organisations that are thinking and working as a system. 93 of the 116 nursing homes within our locality were rated as good by the CQC, with two out of the three acute and community providers also rated as good within the Well-Led domain. However, there are challenges within our system, for example, the 2018 staff survey highlighted that just under half (43%) of our staff within health believe that their managers are visible, just over a third (36%) believe that the work that they do is valued by their managers and leaders and only one fifth (19%), believe that there are good lines of communication throughout the organisations within our System.

In addition, we need to pay attention to the experiences of our staff as those that completed the 2018 survey highlighted the gap between white and BAME perceptions relating to equal opportunities (88% vs. 39% respectively). Therefore, the aspiration across the ICS is to develop and sustain a culture where each member of our system feels valued, understand the work they do in its widest context and are connected across boundaries and hierarchies. We will support our people to manage change

effectively, building people-centric approaches and improve experience for staff, patients and communities.
We plan to develop a system wide talent management evaluation and process, mirroring the national pilot and with support of West Midlands Leadership Academy and we will develop system networks and a system leadership programme.

3. Quality Improvement

A system wide QI approach is central to our leadership and OD strategy and has the potential to accelerate the improvements in care and efficiency described in the LTP. We want every member of our ICS system to feel they have an important part in improving the care we provide.
To achieve our aims we will support:

- **Developing a suite of methodologies**
- **Ensuring engaged committed leadership**
- **Training in quality improvement methodology**
- **Sharing of good quality data and information**
- **Be clear about time and expectation to engage in improvement activity**

4. Education and Development

Our LWAB took a decision earlier this year to pool workforce development funding and align that money to the priorities in the ICS. The second tranche of monies will also go to strategic priorities as well as supporting some known high priority local needs.
We have implemented the trailblazing ODP apprenticeship programme alongside Staffordshire University with the first cohort commencing in September 2019.
We recognise that we need digital technology to enable our workforce to work more effectively; the provision of electronic devises, shared care records and readily available secure wifi across all health and care settings along with implementation of new digital technologies such as wearable and smart enabled monitoring devices, tele-healthcare and advances in genomics and artificial intelligence and robotics will all, if implemented and utilised effectively provide our workforce with more time to invest in the patient relationship and ensure more responsive diagnosis and treatment. We are working in collaboration with the digital enabling work stream to respond to the recommendations in the Topol Review to develop the digital capability and readiness of our workforce as identified in our implementation plan. We are also factoring in digital advances such as speech recognition software into our workforce modelling, for example SaTH have planned reductions in medical secretary workforce.
We have delivered a range of upskilling programmes; LGBT+, mental health skills development programme including trauma, mental health first aid,

medication monitoring, end of life including mouth care skills such as 'taste for pleasure', ReSPECT train the trainer programme, pharmacy training, independent prescribing, physical assessment and clinical observation skills for carers, making every contact count with behavioural change training (MECC plus), spirometry, smoking cessation in pregnancy.

We have delivered a range of new and extended roles; Frailty Intervention Team, Shropshire

Physicians Associate Internship Programme, Rotational Health and Social Care Apprenticeship Programme, Emergency Care Practitioners, Critical Care Support Worker, Assistant Theatre Practitioner, Clinical Simulation Fellows, Neighbourhood Ambassador to support transition to new place based model of care, the development of an End of Life volunteer scheme has attracted national recognition and enables many more terminally ill patients to receive support at their most vulnerable time.

5. Workforce Planning and Modelling

Chapter 8: Digital (placeholder needs updating)

8.1 Background

Technology has changed our world in radical ways in the last decade, but healthcare has lagged behind leaving citizens wondering why the seamless delivery of services provided by business is not available when they need care and support from health and social services. It doesn't have to be this way…

Annie's Story:

Annie is a 76-year-old widow living alone in Church Stretton. She has a history of chest problems and four years ago had a heart attack. She has attended accident and emergency at the Royal Shrewsbury Hospital on four occasions in the last four years and on two of those occasions had a prolonged inpatient stay. During November she has not gone out of the house because of her chest and became so anxious because of her breathlessness that she contacted the emergency services at 6 o'clock on Thursday night. She was attended by paramedics who had a tablet device enabling access to the shared digital space. Her place of residence was in a registered 4G zone enabling them to use real-time access. The paramedics could access this data under the ICS data governance standards in keeping with Annie's previously obtained consent. Annie's COPD Escalation Plan that explains how her chest problems should be managed was accessed and the paramedics undertook the triage checks in the plan. Measurement of her blood oxygen levels and basic observations suggested that if a reversible component to her breathlessness could be effectively treated, the paramedics would not need to transfer her to the Royal Shrewsbury. Medication (nebulised salbutamol) was administered according to the plan and after 30 minutes her blood oxygen levels and vital signs showed a significant improvement. According to the plan, the paramedics were able to settle. Annie at home, automatically notify her GP of the visit, update the plan author (Specialist Respiratory Nurse at RSH) and book a district nurse visit the following morning. Annie was asked whether she wanted to use the ICS patient portal but she did not feel she had the skills to do this.

The story outlined above depends upon existing technology but requires a reorientation of how service is delivered to take advantage of that technology.

The ICS's digital agenda details our blueprint for a digital future, one that underpins the needed transformation in Health and Social Care, to ensure our ICS can deliver the better outcomes outlined in this document.

8.2 Vision statement for Digital Enablement:

Enabling the best possible care by making the right information available to the right people, at the right time and in the right place.

Busy clinicians have to make numerous decisions every day as they try to solve problems for patients. By having the right information available in the right format this process of decisionmaking can be made easier and safer. By insuring the patient has a view of the same data they become co-producers of their own health.

Common scenarios allow the development of customised sets of information from the patients records across the health and social care sectors, which can be built up beforehand automatically to enable carers and patients to make good choices.

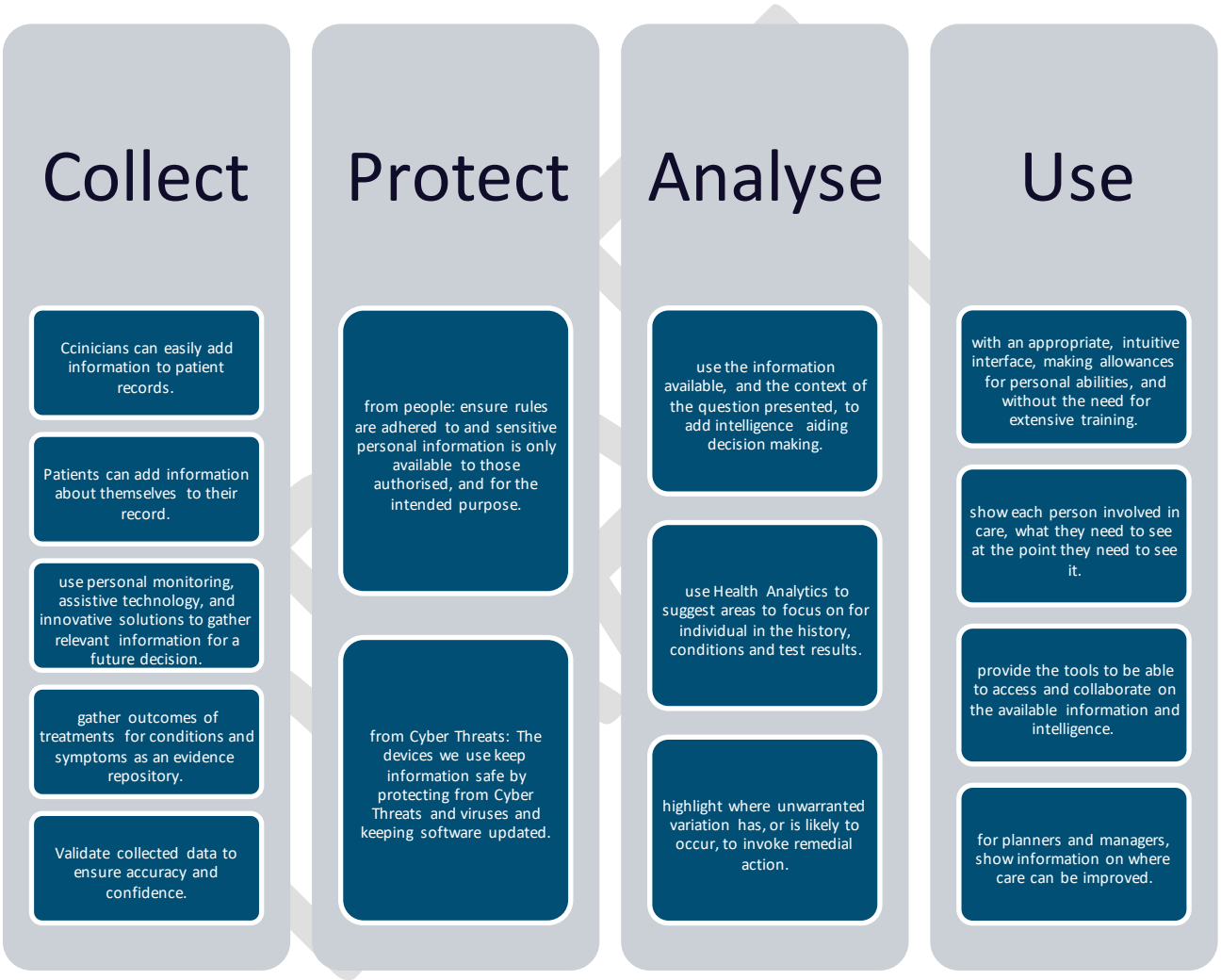
Health and social care all too often excel in dealing with problems at integrating clinical and social information together enables a proactive approach aimed at encouraging wellness.

An enormous amount of information is collected about us as citizens by health and social care providers. Patients are often surprised that this information is not shared by all those who treat them. The essential steps outlined below require a trained workforce comfortable with digital technology as a tool for health care delivery. Many technical issues require addressing including network connectivity, the right device for various users, including patients and training of carers in patients.

An Integrated Clinical Record is an essential foundation of joined up 21st century care. Data is taken from source systems under strict sharing agreements to form the

integrated care record. That information can be reformulated to best suit the context in which various care scenarios happen. In addition to immediate patient facing care the information also helps in ensuring that citizens are provided with the information they need to remain well and independent. Presenting information in a clear and accessible fashion for all those that need it is essential.

The steps involved are outlined below…
The basic steps on how we aim to make the right **information** available:



8.3 Digital as an Enabler of Change

Our Digital Strategy includes the use of technology for research, innovation and a change in culture within the ICS to provide a more connected workforce and population across all health and care services. Our Digital Strategy embodies a

set of technology principles that can be utilised in solving the clinical information agenda, rather than a "to do" list for organisations.
The Digital Strategy is an overarching document supporting each member of the ICS's own digital strategy. The Digital strategy gives organisations a focus which they can work towards, giving a common vision to overcome system problems. Furthermore, the Strategy will provide organisations with a set of objectives in which all major IT programmes and projects should align as part of their outline – guiding all organisations along different paths but to the same destination.

8.4 Understanding of population need

Increasingly our citizens now expect services to be available digitally, so we must offer them the opportunities to access help and support in the way they wish – as this also delivers savings for providers. But not everyone is comfortable or able to access digital services and we must work hard to ensure that these citizens are not disadvantaged and marginalised.

In Shropshire, with an older demographic, it should not be assumed that digital is not utilised. A recent Ofcom study: "Adults Media Use and Attitudes", it found that only 33% did not use the internet, decreasing slightly for those over 75 with 52% using the internet. The trend towards a fully digital future is inevitable.

8.5 What we are excelling at (examples of best practice where relevant)

Across STW we have some excellent examples of the use of technology for change. Shropshire and Telford Council have been using Dynamics 365, a Microsoft CRM, for several years – with many organisations across the Country looking to them for advice and support.
SaTH, the CCG's, CSU and RJAH all feed data into a tool called Aristotle, which helps inform the many complex decisions needed of system managers every day.
We are also part of an EU trial to utilise Internet of Things (IoT) technology, working with Samsung to install devices into over 300 homes to benefit the residents, carers and other support networks for those who might benefit. Shropshire is one of only two locations in the Country to be notably involved, striving to do things differently as it's the right thing to do for everyone in the county.

8.6 What we need to improve

To take the best care of our citizens, and to allow them to take the best care of themselves, we need to have the best information at our fingertips.

8.6.1 Innovate the current process of care.

- The information that usually initiates the start of care is the citizen noticing symptoms and contacting their GP. We should be able to start care earlier if we start collecting information on behalf of the citizen while they are still well, and detecting when something indicates a problem, before it becomes physically noticeable.
- Utilise and learn from comparable occurrences and successful treatments elsewhere to optimise probabilities of the best outcomes for each individual.
- Fast and reliable devices and network connectivity to give access to required information.
- Training –staff and residents need to have the time and training available to them, on how to make the most of new technology solutions

8.6.2 Protecting the citizen information

- Monitor usage to ensure personal data is only used appropriately
- Monitor our devices and networks to ensure they stay protected and protect the personal data visible on them.
- Reduce the use of personal information stored on paper, reducing the risks of untraceable security breaches.
- Training – ensure each individual is aware of their responsibilities on what data they are and are not allowed to access and share.

8.7 Ambitions of the Digital Programme

To have a joined up digital strategy, that promotes modern integrated technology. The strategy is focussed upon creating paperless services and ensuring health and social care professionals have access to the information they need to support patients.

Patients and citizens are empowered through technology to be able to access a connected infrastructure from health and social care services. To be able to interact with the NHS using modern technology to access and receive support from the services they need.

Collaborative working across organisations to digitally enhance pathways. Ensuring the 'Future Fit' programme brings an opportunity to improve the digital maturity of the local health and social care system.

Using the innovation, commissioning, risk stratification and research to design services that are fit for the population and their needs. The co-ordination of system level data and intelligence across health and care.

A focus on the resources to deliver the fundamental digital building blocks to support this programme safely and efficiently.

To enable the service re-design programmes using IT in support of these to use the skills and applications available locally, nationally adopted and evidenced to make a difference. This will develop the local offering to support the rurality of our population and services. This may include telehealth and eConsultations.

In developing this work the ICS will use the following principles:

1. 'Nothing about me, without me' – the patient voice must be at the heart of all provision
2. General practice should be the 'focus of integrated services'
3. Specialist expertise is an essential component of effective integrated services
4. The delivery of integrated services will rest primarily on extended roles for nurses and AHPs
5. Integrated services must incorporate social care
6. Future integrated services should bring together the full range of primary care services

8.8 What delivery of the ambitions will mean for our staff, public and patients

Planned care vision.

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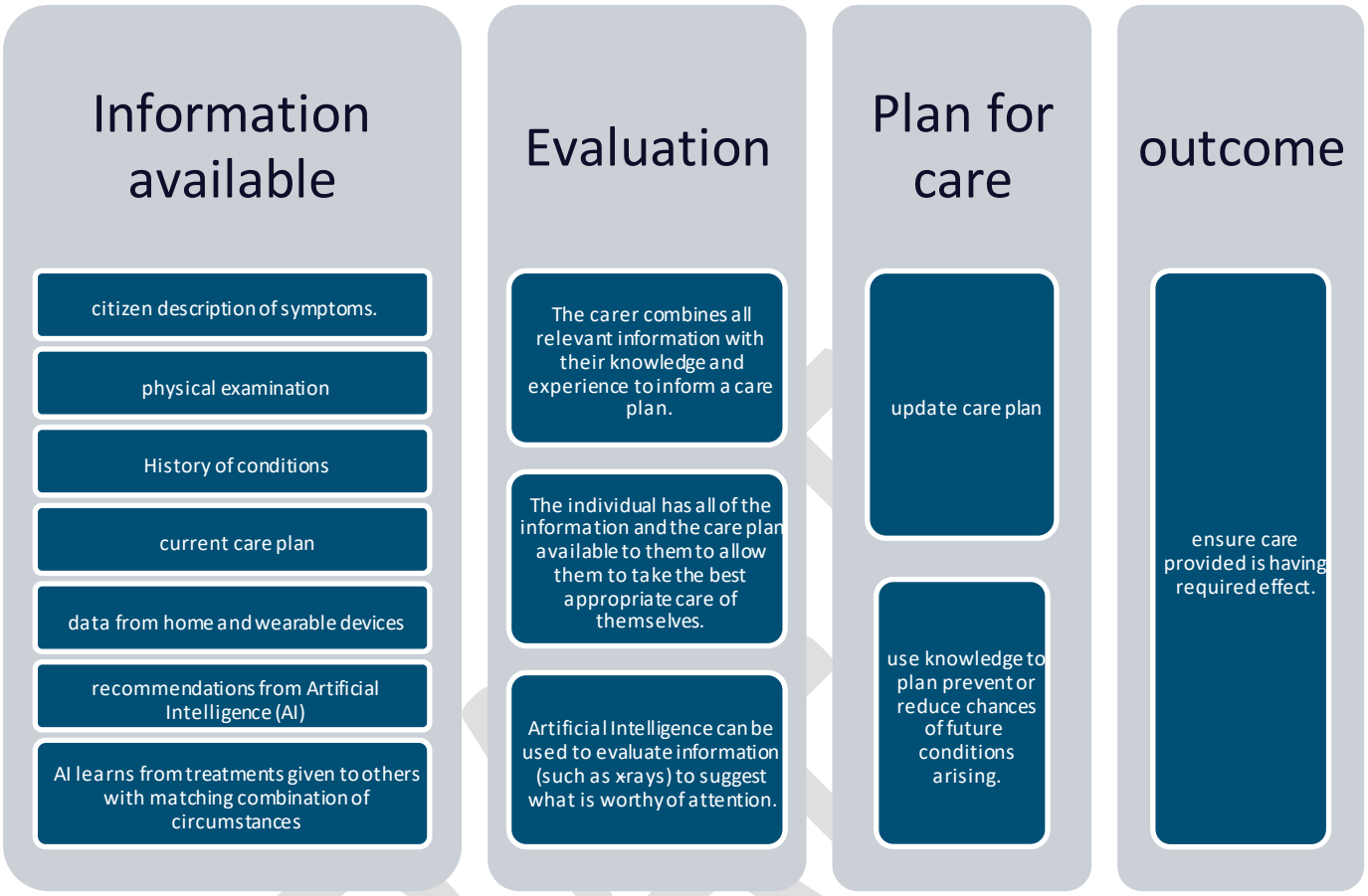

To make this possible, we need to:

- **Ensure all care organisations have records stored electronically, and available to share with the citizen and other approved organisations.**
- **Integrate the care information, and allow a care plan to be created between different services and the citizen**
- **Make it possible for carers to access the required information at the time and location that they need it, by implementing widespread internet access across the county, and providing mobile devices to staff.**
- **Allow individuals to use approved wearable devices to upload useful data such as pulse rate and blood pressure to their own personal health record for use by themselves and their carers.**
- **Add anonymised data to regional and national population health systems to enable others to benefit from successful treatment plans.**

Patients Will have more access to their own health information, with guidance on self-care provided when appropriate. Patients will be empowered to make more decisions, with more information, in a more timely way,	**Staff** Will have the ability to collaborate in ways previously unimaginable, with data and information available when needed. Increased digital literacy to be confident in the benefits of digital systems, with the ability to conceptualise what's possible as technology
than ever before.	evolves.
Public Better informed on how care is managed with signposting to the most suitable contacts. Information about preventative care provided to those that might benefit.	**Our "System" across Shropshire, Telford & Wrekin** Clear picture available of whole system performance rather than measurement of isolated silos. An improved culture of collaboration.

8.9 Where Innovation is being considered and implemented

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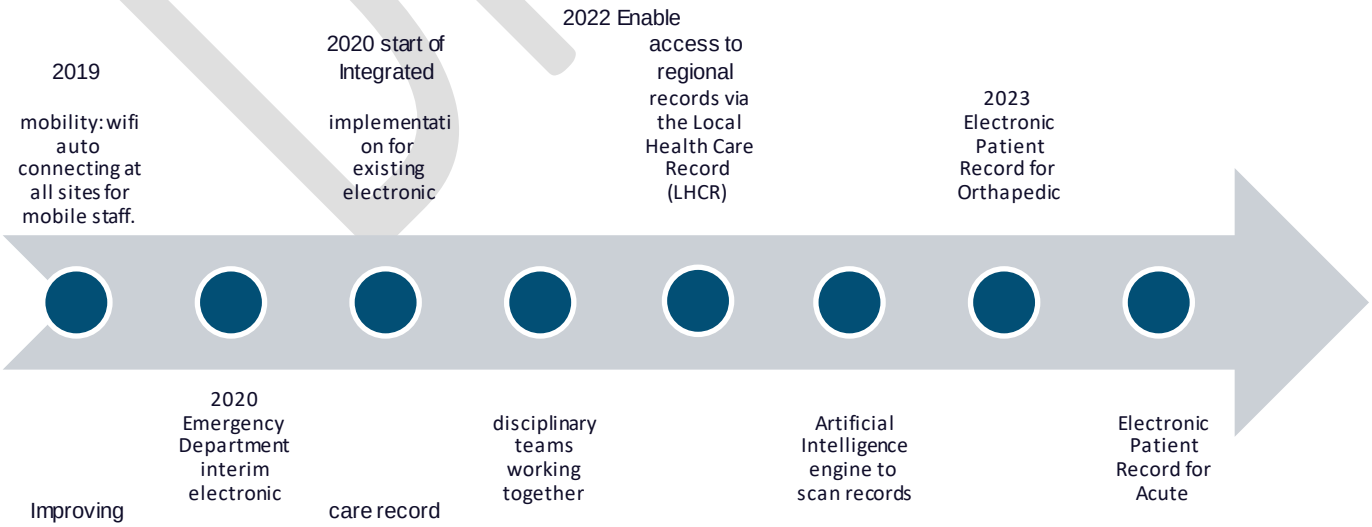
Other leading-edge advances may rely on a foundation of digital infrastructure and commitment within partner organisations to meet minimum standards.

8.10 The timeline over the next 5 years



	systems.	project.	hospital
	2021 Multi-	2022 Pilot of	2024
system for patient information and flow optimisation.	using online collaboration tools	for related symptoms to assist clinician	hospitals

8.11 The Digital Enablement Group have agreed to focus on four main areas.

- **Electronic Records: Providing as much relevant patient information to carers in electronic format as possible**
- Move the acute hospitals towards an Electronic only system of storing patient records
- Move the Orthopaedic hospital towards a new Electronic patient record system.
- Join up citizen information from the organisations that already have electronic systems to present a single view of all records for each patient. This will be the Integrated Care Record (ICR)
- Link with other areas on our borders in the national initiative for the Local Health Care Record (LHCR)
- Ensure the patient/citizen is able to access and contribute to their own health record to enable them to understand and play a part in their own health and wellbeing.
- **Analysis: With access to information, we want to be able to learn from it to improve outcomes for each individual, eventually using tools such as AI to search for matching diagnoses with the most successful treatment.**
- **Governance: Ensure we have the correct rules in place followed, to protect citizen data at the highest level, and at the same time ensure that it is available for use to provide the best care for the citizen and the population.**
- **The technical parts: set the standards to ensure the citizen information is secure on the devices used, and when in transit across the network. Also utilise best practice across the organisation to manage the technical estate to the highest standards.**

- Ensure devices are secure and protected from intrusion
- Networks are responsive at all required locations
- Mobile staff work towards being 'always connected' to information, patients and colleagues.
- Digital starts to become 'invisible', and viewed as essential to the care, not an obstruction.

8.12 What implications will there be for our workforce, estates and digital programme

Our workforce will be asked to work in new ways, with the system if we hope to improve services and be more efficient. This is likely to be the most significant change to our workforce for many years. The Topol review sets out a digital vision of the future for the NHS, detailing the types of technology that will simply be a part of normal working life over the coming years. The Topol review documents the type of jobs that will be a routine part of NHS life, with many differing widely from our current experience and knowledge.

Artificial Intelligence (AI) is already making a big difference to people's lives as it can scan through billions of images looking for traces of cancers, with greater accuracy than a human as it can learn and retain far more information. That's not to say AI will replace humans, it is still a distant technical leap until machines can have the level of compassion of free thinking required to be a true clinician, but there are times when technology can excel our own abilities and these should be utilised for the greater good of patients and staff.

A common training package, or at least packages with overlapping methodologies, should be implemented for staff to give them all a common understanding of technology and how it can benefit their work. Staff need to see digital as a tool to treat and care better, not fear it and shy away from change. This will require a change of workforce culture, the scale of which has never been seen before – certainly not across STW. Working with our HR colleagues, we will help staff to be better and learn more – delivering a learning culture that's not scared to say, "what if..."

Working digitally will require a shift in our estate's strategy, as technology can enable staff from across STW to work anywhere and with anyone. Further to that, they will no longer need to be physically located together, with video conferencing, shared digital workspaces and assets a common part of our working lives. The change in space required for staff should mean an increase in capacity for patient focussed spaces, with collaboration space for staff across STW taking over antiquated offices and inefficient buildings.

Digital teams across partner organisations will be virtual, sharing competencies and spreading resource loads to meet peak demands and harness efficiencies. A floating 'pool' of Digital project managers and technicians to ensure the right projects are prioritised to benefit the system as a whole.

8.13 How we will ensure sustainability and measure our success

NHS organizations across STW have their digital maturities measured regularly, which gives a good gauge to measure success. The reality is that across STW we have a mixed picture, with some organisations excelling and others in need of support.
As a collective, we are supporting those organisations who need help to improve their digital outlook and have accessed NHS Digital funding for several projects, with more planned for 2019, 2020 and beyond.

8.14 Empowering people to use technology and digitally enabled care

Supporting health and care professionals
Digital will enable Health and Care professionals to work in new ways, with boundary free access to the data we need – as long as it's shared safely, securely and ethically. We need to give those who provide care the opportunity to work in the best way for those they care for, whether that's in the community but accessing support remotely, in an acute setting whilst keeping a local GP up-to-speed, or as a collective across organisations to discuss a complex set of needs for a patient; digital can enable this and we're putting the tools in place to make the impossible possible.

Supporting clinical care
The Marches Integrated Care Record will aim to support flowing care with integrated messaging using mobile technology that links carers in all settings in functional teams. You might be a district nurse in Ludlow looking at a leg ulcer but you are connected to the rest of the patient's team. Send a photograph securely to the tissue viability nurse in the Royal Shrewsbury Hospital. He isn't sure but knows that the patient's ulcer is related to peripheral vascular disease so the query is passed on to the vascular team. Through technology we can shorten or abolish queues and get patients through the uncertain phase of not having a treatment or plan in place.

Improving population health

By using health analytics the pattern of disease across the county can be understood and a systematic approach to improving the health of our community be adopted. Much focus falls upon a very small portion of the population who consume large amounts of healthcare resource either because they are frail requiring support for multiple systems that are failing or because they have problems not amenable to the medical model which require an integrated psychological and social approach. More invidious are those sections of the population that do not access care when it is appropriate. An example of this would be support for smoking cessation in pregnant women. In one Australian study, 95% of infants born with moderate or severe brain injury came from a pregnancy with adverse antenatal factors.

8.16 Improving clinical efficiency and safety

Clinical efficiency depends upon having the right information available in the right format at the right time in the right place. Furthermore standard tasks can be provided with a level of quality assurance by using workflow. Digitally delivered workflow enables the use of communication technology such as a workflow app so that tasks are presented in the correct order to the correct team member. Very significant amounts of community team time are consumed in meetings and care planning, but much of this can be aided and reduced with automated workflow.

Safety is enhanced where protocols are presented to carers that guide them to ensure quality care is delivered. There has to be a balance between prescriptive rigidity and a lighter touch guide and support for clinical judgement. Understanding the patient's history, allergies and medication is an important underpinning of safe healthcare delivery.

Chapter 9: Estates

9.1 System Estates Strategy and planned delivery

Placeholder

Chapter 10: Financial Sustainability & Productivity

Placeholder

10.1 Introduction

10.2 Financial assumptions

Appendix Item A: List of Acronyms

Acronym	Meaning
BAF	Board Assurance Framework
BAME	Black, Asian and minority ethnic
BAU	Business as Usual
BI	Business Intelligence
BTI	Big Ticket Items
CCG	Clinical Commissioning Group
CDH	Community Diagnostics Hub
CEO	Chief Executive Officer
CQC	Care Quality Commission
CYP	Children and Younge People
DHCS	Department of Health & Social Care
DTOC	Delayed Transfers of Care
G2G	Getting to Good
HTP	Hospital Transformation Programme
ICB	Integrated Care Board
ICP	Integrated Care Partnership
ICS	Integrated Care System
IG	Information Governance
JSNA	Joint Strategic Needs Assessment
LMNS	Local Maternity and Neonatal System
LTP	Long Term Plan
MDT	Multi-Disciplinary Team
MIU	Minor Injury Units
MOU	Memorandum of Understanding
MPFT	Midlands Partnership Foundation Trust
MSK	Musculoskeletal
MTAC	Maternity Transformation Assurance Committee
NHSE	National Health Service England
NHSI	National Health Service Improvement
NQB	National Quality Board
ORAC	Ockenden Report Assurance Committee
PCN	Primary Care Network
PHM	Population Health Management

Acronym	Meaning
QIP	Quality Improvement Plan
QSC	Quality & Safety Committee
RJAH	The Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust
ROS	Readiness to Operate Statement
ROP	Recovery Oversight Programme
RSP	Recovery Support Programme
SaTH	Shrewsbury & Telford Hospital NHS Trust
SDP	System Development Plan
SFH	Sherwood Forest Hospitals NHS Trusts
ShIPP	Shropshire Integrated Place Partnership
ShropCom	Shropshire Community Health NHS Trust
SOAG	SaTH Safety Oversight and Assurance Group
SOF4	Segment 4 of the System Oversight Framework
SOP	Standard Operating Protocols
SRO	Senior Responsible Officer
TWIPP	Telford & Wrekin Integrated Place Partnership
UEC	Urgent and Emergency Care
UHNM	University Hospitals of North Midlands
UTC	Urgent Treatment Centres
VCSE	Voluntary, Community & Social Enterprise
WMAS	West Midlands Ambulance Service