Telford & Wrekin Co-operative Council

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Shropshire Council

NHS Shropshire, Telford and Wrekin

Integrated Care System Shropshire, Telford and Wrekin

Borough of Telford and Wrekin

Integrated Care Partnership

Wednesday 30 October 2024

2.00 pm

Council Chamber, Third Floor, Southwater One, Telford, TF3 4JG

Democratic Services:	**Sam Yarnall**	**01952 382193**
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Partnership Members: **A Begley, J Britton, L D Carter, L Cawley, L Cross, S Fogell, J Jeffery, A Burford, Sir N McKay, T Miles, C Motley, R Nuttall, H Osborne, L Picton, R Robinson, D Sidaway and S Whitehouse**

	Agenda	Page
5.0	**National and Local Policy Updates**	**3 - 88**
	To receive an update on the National Context from the Darzi report and the Health Mission and to receive an update on the prioritisation framework and plans to use the framework against the Integrated Care Partnership priorities.	
7.0	**Priority Areas of Focus**	**89 - 92**
	To consider how the pathway reflects the prevention shift outlined in the national and local direction and strategy.	

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Borough of Telford and Wrekin

Integrated Care Partnership Meeting

30th October 2024

Integrated Care Strategy Developments in Shropshire Telford & Wrekin Integrated Care System

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Organisation:	Integrated Care Partnership
Report Author/s:	**Nigel Lee - Chief Strategy Officer NHS STW, Claire Parker - Director of Strategy & Development NHS STW, Rachel Robinson - Executive Director of Health Shropshire Council, Helen Onions - Interim Director of Health & Wellbeing Telford & Wrekin Council**
Contact Details:	**via email**

1.0 Recommendations for decision/noting:

1.1 The Integrated Care Partnership (ICP) is asked to:

- **Approve the refreshed Integrated Care Strategy**
- **Note the associated outcomes framework**
- **Note the developing National strategic context**
- **Note the Strategic Decision-making Framework**
- **Note the developments in the system medium term plan, and next steps**

2.0 Purpose of Report

2.1 To provide updates to the ICP on developments in the Integrated Care Strategy, the Joint Forward Plan and key programmes of work. To consider the developing national context for Shropshire Telford & Wrekin Integrated Care System (ICS).

3.0 Background

3.1 The ICP is a statutory joint committee of the ICB and local authorities in the system. It brings together a broad set of system partners to support partnership working and develop an 'integrated care strategy', a plan to address the wider health care, public health and social care needs of the

population. This strategy must build on local joint strategic needs assessments and health and wellbeing strategies and must be developed with the involvement of local communities and Healthwatch. The ICB is required to have regard to this plan when making decisions.

3.2 The revised draft Integrated Care Strategy has been developed with a wide range of partners, and shared with Health and Wellbeing Board (HWBB) members from both Shropshire HWBB and Telford & Wrekin HWBB.

4.0 Summary of main proposals

4.1 As detailed in the recommendations.

- Approve the refreshed Integrated Care Strategy
- Note the associated outcomes framework
- Note the developing National strategic context
- Note the Strategic Decision-making Framework
- Note the developments in the system medium term plan, and next steps

5.0 Financial Implications

5.1 In the current challenging financial climate, it is important for NHS Shropshire, Telford and Wrekin ICB, alongside Council partners in the ICS, to demonstrate that it is making the most effective use of public money to commission the right care, in the right place, at the right time within the context of our resources in a safe, fair and transparent manner, and in order to deliver our statutory responsibilities, alongside meeting the needs of the Shropshire, Telford and Wrekin population.

6.0 Health, Social and Economic Implications/ Equality and Diversity Implications

6.1 Working through their ICB and ICP, ICSs have four key aims:

- improving outcomes in population health and health care
- tackling inequalities in outcomes, experience and access
- enhancing productivity and value for money
- helping the NHS to support broader social and economic development

15.0 Appendices

A ICP Presentation 30 Oct 24
B Integrated Care Strategy – final draft
C Outcomes Framework
D Strategic Decision-making Framework

Key Links

Lord Darzi report:

Independent Investigation of the National Health Service in England (publishing.service.gov.uk)

2024-2029 Joint Forward Plan

STW-24-29-Joint-Forward-plan-version-5.pdf

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Integrated Care System
Shropshire, Telford and Wrekin

NHS
Shropshire, Telford and Wrekin

Integrated Care Partnership

Nigel Lee

Claire Parker

30th October 2024

National and Local Policy Updates

To receive an update on the National Context from the Darzi report and the Health Mission and to receive an update on the prioritisation framework and plans to use the framework against the Integrated Care Partnership priorities.

National Strategic Context for Health and Care – October 2024

Labour Party Manifesto – Build an NHS Fit for the Future

Labour's third mission in government is: Build an NHS fit for the future, that is there when people need it

3 changes:

- Change so that more people get care at home in their community
- Change so that we have the workforce of the future, with the technology they need
- Change so we focus on prevention

Once in Government, commissioned Lord Darzi to conduct a review

Darzi Investigation of the NHS - 2024

Darzi Investigation of the NHS in England

The investigation explores the challenges facing the NHS and sets the major themes for the forthcoming 10-year health plan

Context for the Independent Investigation of the National Health Service in England

- **The National Health Service is in serious trouble:** The NHS is a much-treasured public institution embedded into the national psyche but is now in critical condition and experiencing falling public confidence
- **The health of the nation is worse**: increasing long-term conditions and worsening mental health, leading to a spike in 2.8m long-term sick from 2m, while the public health grant reduced by 25% and the public health body has been split into two
- **This is not a reason to question the principles of the NHS or to blame management:** managers have been "keeping the show on the road" and there is a virtuous circle where the NHS can help people back to work and act as an engine for national prosperity

- Independent Investigation of the National Health Service in England Independent Investigation of the National Health Service in England (publishing.service.gov.uk)

The challenges facing the NHS are interlinked…

Waiting time targets have been missed consistently for nearly a decade and satisfaction is at an all-time low

People struggle to see a GP despite more patients than ever being seen, the relative number of GPs is falling, particularly in deprived areas, leading to record low satisfaction

Community waiting lists have soared to 1million including 50,00+ people who had been waiting >1 year - 80% being children and young people. 345k people are waiting more than a year for **Mental Health** services

A&E is in an awful state and long waits contribute 14,000 additional deaths per year, while **elective waits have ballooned** with 15x more people waiting >1 year

People receive high quality care if they access the right service at the right time, without health deteriorating

- **Cardiovascular** mortality has rolled back as rapid access has deteriorated
- **Cancer** mortality is higher in part due to minimal improvement in detecting cancer at stage I and II
- **Dementia** has a higher mortality rate in the UK than OECD and only 65% of patients are diagnosed

Funding has been misaligned to strategy, with increased expenditure in acute driven by poor productivity

Too great a share of funding is on hospitals, increasing from 47% to 58% of the NHS budget since 2006, with 13% of beds occupied by people who could be discharged

The number of hospital staff has increased sharply, equal to a 17% since 2019, with 35% more working with adults and 75% more working with children

Patients no longer flow through hospitals properly leading to 7% fewer OP appts. per consultant, and 18% less activity for each clinician working in emergency

Four main drivers are identified…

It has been the most austere period in NHS history with revenue prioritised over capital

- 2010-2018 funding grew at 1% compared to long term average of 3.4%
- £4.3bn has been raided from capital budgets between 2014 and 2019
- £37bn shortfall of capital investment has deprived the system of funds for new hospitals, primary care, diagnostics or digital

The pandemic's legacy has been long-lasting on the health of the NHS and population

- The NHS entered the pandemic with higher bed occupancy, fewer clinical staff and capital assets than comparable systems
- NHS volume dropped more sharply than any other comparable health system, e.g. 69% UK drop vs OECD 20% in knee replacements

The voice of staff and patients is not loud enough as a vehicle to drive change

- Patients feel less empowered or secure and compensation claims stand at £3bn per year
- Priorities of patients have not been addressed, notably in maternity reviews
- Staff sickness is equal to one-month a year for each nurse or midwife
- Discretionary effort has fallen up to 15% for nursing staff since 2019

Management structures and systems have been subject to turbulence and are confused

- The 2012 Health and Social Care Act was disastrous
- The 2022 Act brought some coherence but there is a lack of clarity in responsibilities and in performance management
- Regulatory organisations employ 35 staff per trust, doubling in size in the last 20 years
- Framework of standards and financial incentives is no longer effective

Addressing these in the forthcoming 10-year health plan needs to include…

- **Re-engage staff and re-empower patients**, harnessing staff talent to deliver change and enabling patients to control their care
- **Change financial flows** to promote and **sustain the expansion of GP, MH and Community services** at a local level, embracing a **multidisciplinary neighbourhood care team model** that brings these services together
- **Improve productivity** in hospitals through improved **operational management**, **capital investment** and **empowering staff**
- Across the system, **tilt towards technology** through **digital systems**, especially for staff **outside hospitals**, and **embracing the potential of AI** for **care** and **life sciences**
- **Clarify roles and accountabilities** in NHS England and ICBs, **rebalancing management resource** with emphasis on the **capacity to deliver plans**, while **avoiding top-down reorganisation**
- **Direct effort** at aspects that will **drive national prosperity** by supporting people to **get back to work**, and **working with British biopharmaceutical** companies

Developing the 10 Year Health Plan

- 21st October – DHSC and NHSE launch of "Change NHS: help build a health service fit for the future: a national conversation to develop the 10-Year Health Plan".
- Built on 3 'shifts' - providing more care in the community so hospitals are able to treat the sickest patients, make better use of technology, and do more to prevent ill health
- Seeking feedback from public, and experts from across the health and care landscape
- ICB will coordinate events with the public, staff and stakeholders, alongside organisation responses. Vital that all ICS partners are invited to contribute

Alignment with STW Integrated Care Strategy & Joint Forward Plan

- Emerging national priorities and framework aligns well with the STW Integrated Care Strategy
- Initial cross-reference exercise carried out to compare JFP with Darzi themes
- Impact of national work is unknown at present (for 25/26 onwards) but all systems will undoubtedly need to prioritise investments and workstreams. STW has developed a Strategic Decision- making document to aid this process

Strategic Decision-making framework

- In the current challenging financial climate, it is important for NHS Shropshire, Telford and Wrekin ICB to demonstrate that it is making the most effective use of public money to commission the right care, in the right place, at the right time within the context of our resources in a safe, fair and transparent manner, and in order to deliver our statutory responsibilities, alongside meeting the needs of the Shropshire, Telford and Wrekin population.

- The decision-making process followed by the ICB when deciding what services and treatments to commission should be open and transparent. It is also important that the ICB engages with patients and the public on the future of local health services and consideration should be paid to NHSE guidance for major service change to assess requirements for engagement and/or consultation.

The aim of the policy is to: -

- a) Provide a rationale and process to allow services to be identified for review prior to any decision to decommission, disinvest or invest in services.
- b) Deliver best value for money by ensuring that local health care resources are directed to the most effective services for the local population.
- c) Ensure all commissioned services are monitored in terms of performance and health outcomes.
- d) Efficiency, demand management and fitness for purpose to allow for a robust decision to be made regarding continuation of that service.
- e) Contribute to the delivery of the ICB's commissioning plan and efficiency agenda, to ensure that resources are directed to the highest priority area to achieve the best possible health outcomes for the local population against available resources.
- f) Ensure all investment, decommissioning and disinvestment decisions are taken in a fully informed manner and follow a set procedure agreed by the ICB Board.
- g) Ensure that the way in which commissioning decisions are made reflect the ICB Operating Model and are in line with the commissioning cycle.
- h) Ensure the safety of patients remains paramount.

Strategic Direction Locally/6 Month Refresh

To receive an update on the local direction for the Integrated Care Strategy, Joint Forward Plan and the Outcomes Framework

Integrated Care Strategy 2022-2027

- Initial approval and publication in December 2022
- Update of narrative to reflect current position- keep strategy relevant
- No substantial changes
- Outcome data updated for 23/24
- Updated executive summary from DPH's

Next steps for integrated strategy

- Needs to align to the Government's 10 year plan to be published Spring 2025
- Review of outcome metrics to demonstrate impacts on our populations- the 'so what'
- Strategic prioritisation framework to applied to list of priorities to inform workplans more comprehensively

Joint Forward Plan

- Joint Forward Plan is a rolling 5-year system plan created to deliver the Integrated strategy set out by the Integrated Care Partnership (ICP)
- The JFP still focusses on these areas:
  - Person Centred care
  - Local care programme-Integrated neighbourhood approach and integrated pathways
  - Hospital Transformation
  - Enablers- Finance, digital, workforce and estates
- The Place plans are key to the delivery of the system strategy.
- The JFP will need to align to the Governments 10 year plan from Spring 2025.
- JFP and Darzi plan alignment work in progress to identify gaps

Progress against JFP

Area	Completed actions
Person centred care	• Work started on prevention strategies, development of neighbourhood working and embedding social prescribing • Person centred care Facilitation Team formed to co-ordinate and enable the approach in transformation programmes • Person centred care formed core element of Women's Health Hubs
Reduce health inequalities	• Developed dedicated health inequalities roles within ICB • Implemented regular health inequalities reporting including health inequalities dashboard
TWIPP	• Healthy weight strategy developed • Three family hubs opened • Perinatal mental health social prescribing in place via Public Health • SEND and Alternative Provision Strategy published • Autism Strategy co-produced with people with lived experience and launched • "Celebrating later life in Telford and Wrekin: A proactive prevention approach to active aging" published

Progress against JFP

Area	Completed actions
SHIPP	• Children and Young People integration test and learn sites expanded to all age delivery • Community and Family Hubs implemented
Primary care	• Action plan developed to deliver recovering access in primary care • Recommendations of the Fuller Report included in action plans • Prioritisation of primary care estates plan completed
Medicines Management	• Implementation of Antimicrobial Resistance Strategy • Programme of local medicines focussed projects implemented –CV disease, respiratory disease • Local commissioned service for medicines safety in primary care demonstrating improved safety monitoring of high risk drugs • Discharge medicines scheme promoted and referrals increased significantly • Promotion of use of community pharmacy to improve access to high quality services and advice
Voluntary and community services (VCS)	• VCS integrated into the approach at neighbourhood level • VCS integrated into governance structures

Progress against JFP

Area	Completed actions
Elective care	• Elective hubs for dedicated planned care resource implemented • Roadmap for health inequalities elective recovery principles developed • First phase of MSK transformation implemented • Community Diagnostic Centre implemented
Cancer	• Implemented FIT triage for patients referred on a 2ww colorectal pathways • Implemented Teledermatology pilot
End of life care	• Increased people identified on palliative care register and increased people with a personalised care plan • Established joint working arrangements with Hope House to support care for CYP with life limiting/threatening conditions
UEC	• Enhanced provision for high intensity users • Initial review of pre-hospital urgent care services completed • Expansion of the Integrated Delivery Team • Developed anti-microbial therapy in the community
Mental health, LD and Autism	• New Talking Therapies service model implemented • Updated CYP local transformation plan • Developed action plan to increase dementia diagnosis rate • Autism passport project implemented

Person Centred Care

- Person Centred Care:
  - Integrated Neighbourhood work continues across STW, projects in Highley, Oswestry, Telford and South Shropshire with health, care and Voluntary and Community Sector
  - Women's Health Hubs – with focus on perinatal care, sexual health and menopause based on a national core service specification
  - Building on the development of children's and family hubs to access a range of services where people live
  - Multidisciplinary team development at Bishops Castle Hospital- services to support people in their own community to access health and care- expanding the drop-in service- next steps to look at outpatient services
  - Consideration in service design to ensure reduction in travel for people in rural communities where possible
  - Healthy weight strategies for Telford and Wrekin and Shropshire approved at respective Health and Wellbeing Boards as priorities reflected in the system strategy.
  - Population Health Management board and Health Inequalities board utilise the JSNA(Joint Strategic Needs Assessment) and other available data to inform the INT work and SHIPP/TWIPP strategies
  - PCN (Primary Care Networks) development with innovative working with other partners and stakeholders- further development being led by PCN's input is critical to future steps
  - Proactive care model in place across STW- impact evaluation to support the acute beds designated in the HTP plan

Local Care

- Virtual ward and sub acute wards are business as usual- but assurance on utilisation is crucial to the system and HTP
- Two strands – Integrated neighbourhood approach aligned to Place strategies
- Integrated pathways (NHS integration) but including prevention- first focus Diabetes
- Cardiovascular prevention and CYP Asthma both priorities- programme initiation in development
- Framework of VCSE involvement being developed around sustainability and support, resource to support
- Focus on prevention
- Focus on communities
- Development of Community hubs (physical and virtual)
- Joint working with HTP programme on health and care models to commence November 24

Neighbourhood Approach (Team of teams)

Hospital Transformation

- Agreement to join the Local Care Transformation Programme and HTP models of care work into one meeting to develop the right community, primary care and neighbourhood models to align with the plans for HTP- capital project sits separately.
- Assurance that system transformation is supporting the bed model that forms the HTP plans in collaboration and informs the JFP and future system architecture and ambition.
- Ongoing work between SATH (HTP) and STW ICB with Powys Teaching Health Board on planned developments in Newtown. NB – aligns with Shropshire's support for the 'Marches Forward Partnership' work (work between Shropshire, Powys, Hereford & Worcester and Monmouthshire Local Authorities).

Enablers

- Estates strategy for NHS, including primary care, is developing further from the current JFP and will be a focus for 25/26 – will need further alignment with 10 year plan
- ICS Clinical strategy – improved cancer diagnosis, progress with MSK service, diabetes and mental health
- ICS Digital strategy actions commenced- SATH new Patient Admin System completed Apr 24. RJAH new Patient Admin System due late Autumn 24. Digital to be developed in the JFP during 25/26.
- Workforce strategy developed, aligned to NHS long-term Workforce plan commenced- workforce challenges improving in some areas. Planning needs to align with year 5 ambition for the system.

JFP development for 2025/26

- The JFP and the future 10 year plan work will be overseen by the ICB Strategy and Development Group involving system strategy leads and system partners.
- Jointly monitored and developed (e.g. working with Integrated Place Partnership Committees and Health & Wellbeing Boards)
- Some early positive signs of progress and impacts (see case studies)
- Further development of health inequalities as a ‘golden thread’ through the plan.
- Further strengthening of Prevention through the strategy and planning

Case 1- Women's Health hubs

- Telford GP practice developed a plan for improving access and experience for women's health
- Increased compliance in cervical screening to women previously reluctant with an ambition of 100% screening rate for all eligible women
- Practice nurse developing skills in relation to women's health and procedures such as ring pessaries
- Support for menopause developed and implemented with positive initial feedback

Case 2

Case Study – Integrated Practitioner Teams

- Presented by Healthy Lives Advisor- 27.07.2023
- Child had not attended school since October 2022, family had financial concerns, Child was presenting as aggressive, some hoarding at home taking place, and parent had serious illness
- Integration worked with DWP to provide financial advice, SFRS to support with hoarding and fire safety within the home, Autism West Midlands (both parents have ND diagnosis), GP, School and Healthy Lives Advisor
- Update from school: 01.07.2024 "child has had 3 "on calls" in total this term (events for considerable disruptive behaviour even after warnings). This is in comparison to the whole of last term where 15 on calls were issued and 35 internal truancy events. Child is doing brilliantly. Child also has (from this term) a total of 78 positive learning points, 16 points for positive contributions in lessons and 4 points for outstanding work (each worth 10 points each). Child has made progress and it is a pleasure to celebrate this with her……."
- Closed to integration following significant improvement in school attendance, attitude to learning, behaviour, acceptance of consequences for behavioural mistakes, relationships with peers, overall wellbeing
- Current school attendance is 95.83

Case 3 – Telford Falls Prevention

Community Preventing Falls through Exercise

- Public health funding to support the delivery of weekly 'Moving on' sessions in the community

- Mary joined the Falls Prevention class following an unsuccessful knee operation. Mary's walking has now improved, and she regularly attends the local Moving On session. She can now walk 2-3 miles at once; she volunteers and leads local walks close to where she lives.

"I feel good about the classes, they keep me going and allow me to do the things I do"

Case 4- Telford Supported Accomodation

Development of local 24/7 supported accommodation

- No provision locally for people with mental health needs resulting in out of area placements
- Multi-agency work to develop local option (including commissioners, housing, a local developer, operational health and care teams)
- Rehab teams involved in the local delivery of care and support
- Multi-agency approach to prioritising placements whilst ensuring compatibility and reducing risk

- **Impact for residents:**
  - ✓ Moving back to telford, closer to family, friends and support network
  - ✓ Have their own front door
  - ✓ Develop daily living skills and increasing independence in their own home

- **Additional community support;**
  - ✓ Re-location of a Calm Café to the same locality to enable residents to access this preventative support and access other community services
  - ✓ Connections to the Donnington Energize project which will provide residents opportunities to increase their levels of physical activity to secure wider health benefits

Acura Living - White Cottage Apartments (youtube.com)

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Shropshire Telford and Wrekin Integrated Care Strategy

Contents

Foreword

We want to make sure that everyone in Shropshire, Telford and Wrekin has a fair opportunity to have a great start in life and live happy, healthy, and fulfilled lives. The existing inequalities are simply not good enough, and many of these can only be addressed by partners working together.

Improved health and wellbeing will be achieved through better support and high-quality services, as well as by preventing people from becoming unwell and supporting them to live well in their communities. We recognise that we need to look beyond health and care services to understand the barriers and opportunities to living a healthier life and are committed to working with people and communities to address them.

Shropshire, Telford and Wrekin has a strong history of joint working across our Local Authorities, NHS Partners, the Voluntary and Community Sector and wider partners. Most recently our Health and Wellbeing Boards, Health Scrutiny, COVID-19 and Cost of Living responses demonstrate what can be achieved through collaboration. We continue to build the relationships needed to support our residents in enjoying the highest quality health and wellbeing for themselves, their families, and their communities.

This Integrated Care Strategy is built upon the priorities of each place's Health & Wellbeing Strategies and the findings of our 'Big Conversation'. Residents have raised concerns about difficulties in getting appointments, long waiting times, and trouble contacting services over the phone, with some areas highlighting accessing GPs. Transport and digital exclusion have also been raised as concerns. Residents told us there was a lack of awareness of how and where to get the right support for their needs. Overall, residents told us we need to work better together.

Partners within the Shropshire, Telford and Wrekin Integrated Care Partnership have heard these messages and are committed to thinking and working differently with each other and with our communities. Today, we have a unique opportunity to achieve this through joining up our services and taking a more preventative approach. That's what this Shropshire, Telford and Wrekin Integrated Care Strategy is all about.

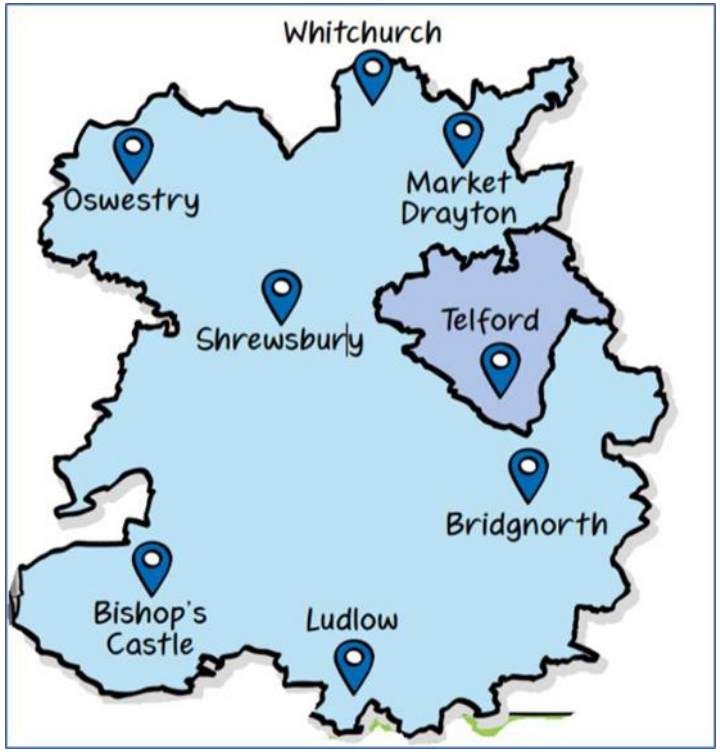
We look forward to working with all our communities to make Shropshire, Telford and Wrekin a place where everyone has the chance to live a long and healthy life. We know that more needs to be done to give everyone the very best start and every chance to live a long and healthy life. This includes working with partners in the wider economy to create good jobs and increase everyone's prosperity with investment in skills, housing, culture, and infrastructure. To have the best chance of achieving this, we need to think and work differently with each other and with our communities.

A greater emphasis on prevention is crucial to improving the quality of people's lives and the time they spend in good health. We recognise that not everyone has an equal chance of a happy, healthy long life and therefore we need to do more to tackle inequalities, including health inequalities.

As a Partnership, we are embracing our communities and community partners in our conversations, listening to what local people and our staff have to say, so that everyone in Shropshire, Telford and Wrekin is part of our shared purpose.

Chapter 1 - Overview of Our Integrated Care System

The Integrated Care System (ICS) brings together the health and care organisations in Shropshire, Telford and Wrekin to work together more closely. Our ICS is called Shropshire, Telford and Wrekin Integrated Care System (ICS). The ICS is responsible for planning health and care services in the local area and is made up of an Integrated Care Board (ICB) and an Integrated Care Partnership (ICP), which work in tandem to meet the needs of their population.



Shropshire, Telford and Wrekin ICS includes the following partners:

- NHS Shropshire, Telford and Wrekin Integrated Care Board (ICB)
- Shropshire Council (our Shropshire Place)
- Telford & Wrekin Council (our Telford and Wrekin Place)
- Shrewsbury and Telford Hospital NHS Trust
- Shropshire Community Health NHS Trust
- Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust
- Midlands Partnership University NHS Foundation Trust
- West Midlands Ambulance Service NHS Foundation Trust
- Primary Care Networks (PCNs):9 PCN's (4 in Telford and Wrekin, 5 in Shropshire)
- General Practice, Pharmacy, Optometry and Dentistry
- Healthwatch Shropshire and Healthwatch Telford &Wrekin
- Voluntary, community and social enterprise organisations across the county

We are an ambitious Integrated Care System, dedicated to making a real difference to the lives of local people.

We have previously engaged with our residents, patients, health and care staff, our local system partners, and the voluntary, community and social enterprise (VCSE) sector. Using this insight, we have developed ten pledges that will serve as the guiding principles for all our work.

Our pledges

The Integrated Care Partnership (ICP) operates as a statutory committee. Made up of partners from across the local area, including VCSE organisations and independent healthcare providers, as well as representatives from the ICB board. Our ICP is responsible for bringing together our system partners to develop a plan to address the broader public health, health and social care needs of our local populations and tackle health inequalities.

Our ICP aims to make home and the community the hub of care, ensure that services are person-centred and seamless, empower patients, promote health, and prevent illness where possible.

The ICP provides a forum for NHS leaders and local authorities to come together, as equal partners, with key stakeholders from across the system and community. Together, the ICP has produced this Integrated Care Strategy to improve health and care outcomes and experiences for the populations. This strategy is underpinned by a co-produced integrated 5-year plan called the Joint Forward Plan (JFP). The JFP informs our operating model, strategic commissioning intentions and operational annual plans.

Chapter 2 - Integrated Care Partnership (ICP) purpose and vision

(Our Vision is currently draft and will be developed and committed to in 2024/25)

Integrated Care vision and objectives

We want everyone in Shropshire, Telford and Wrekin to have a great start in life and to live healthy, happy and fulfilled lives.

We will work together with our communities and partners to improve health and wellbeing by tackling health inequalities, encouraging self-care, transforming services, and putting people at the heart of all we do.

Our ambition is to provide our communities across Shropshire, Telford and Wrekin with safe, high-quality services and the best possible experience from a health and care system that is joined up and accessible to all.

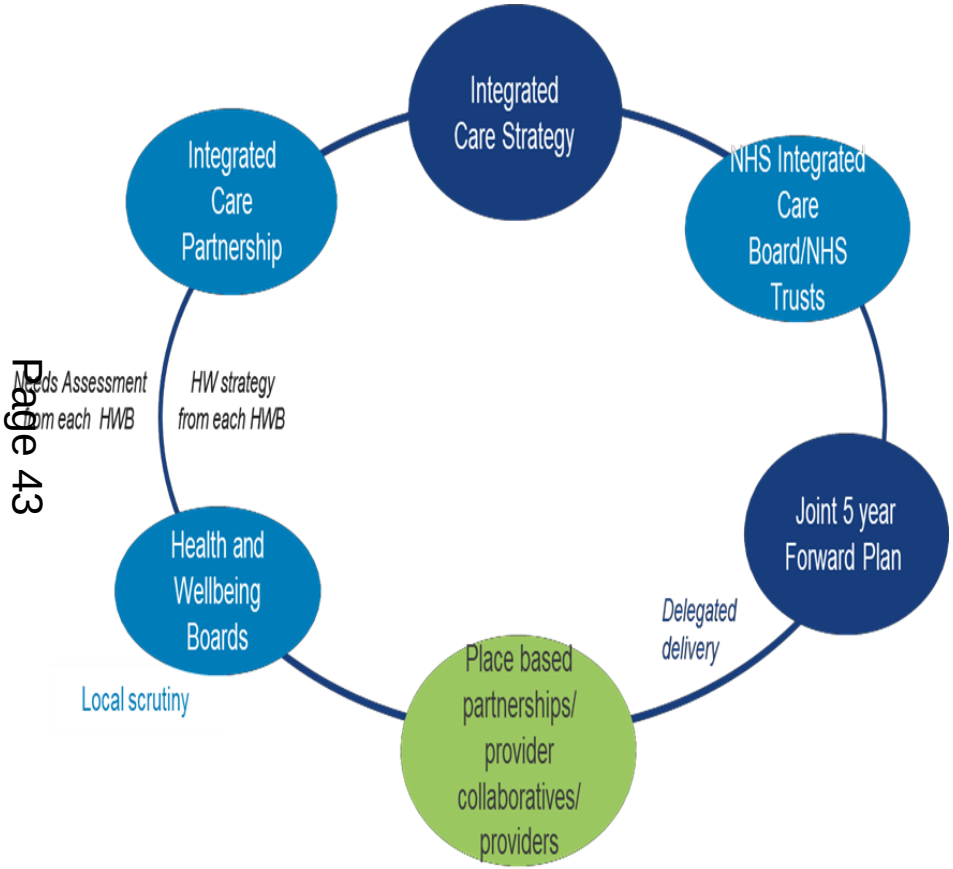
By transforming how and where we work, improving access to services, and using our resources in the very best way for our communities, we will meet the needs of our population now and in the future.

We will focus on our places and our communities to create truly integrated care, including working across our boundaries and borders.

Joining up health and care is not new – a lot of work has already been done towards this and we will build on this work. This includes building on the positive joint working we saw in the system throughout the Covid-19 pandemic.

Our four strategic objectives

Our cycle of development



This Integrated Care Strategy development through the ICP is a key step in setting out the high-level needs assessment and long-term health and wellbeing priorities for Shropshire, Telford and Wrekin. A clear governance, planning, and delivery cycle exists to support partnership working across the system. This development cycle will be complemented by a comprehensive consultation and engagement process to ensure co-design.

Integrated Care Strategy Priorities

(from JSNA's to inform the HWB strategies and the Joint Forward Plan)

Population Health 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

Inequalities Priorities

- 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

Health and Care Priorities

- 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

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Chapter 3 – Improve outcomes in population health and healthcare

Each Health and Wellbeing Board (HWBB) has a statutory duty to publish a Joint Strategic Needs Assessment (JSNA) to inform the development of the Health and Wellbeing Strategies.

The Telford & Wrekin Health & Wellbeing Strategy refresh proposals have been developed based on JSNA intelligence and informed by engagement, including about 3,000 residents contributing through a telephone survey and focus groups in 2022, as well as a resident survey in 2020 completed by about 5,500 residents. Further engagement and community consultation on the proposed health & wellbeing refresh priorities were undertaken in 2023.

The Shropshire Health and Wellbeing Strategy has been developed at a community level by engaging with the residents and local Town Councils using the data from the JSNA.

The ICP has consolidated the available intelligence from the HWBB strategies the system to inform the priorities for the interim Integrated Care strategy.

The JSNAs and population health intelligence, along with the interim Integrated Care Strategy, should guide system partners on areas of need, such as health and social needs, and the inequalities in our communities.

The Integrated Care Strategy has been developed with stakeholders through engagement into a five-year plan to support the commissioning and provision of services that meet the needs of the population.

The intelligence in this section shows the key themes and headlines from the JSNAs and the population health priorities for our places and our system.

Demographic and socio-economic headlines

Telford & Wrekin

Fastest population growth in the West Midlands (2011-2021 = 11.4% growth) and 2nd fastest growth nationally in 65+ years population (35.7%)

Population changing - becoming more diverse & ageing (median age now same as West Midlands at 39.6 years)

20% Telford & Wrekin residents live in 20% most deprived areas in England – circa 45,100 people (this is referred to as 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 is significantly worse than England average and there are significant inequalities gaps.

Shropshire

139,000 households - predicted to increase 28% by 2043.

23% of the population +65 years (18.5% England Age)

26% increase in Looked After Children (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.

Shropshire, Telford and Wrekin (STW) Area

Total Population in 2020 506, 737 (Shropshire 325,415 Telford 181,322). Male 49.5 % Female 50.5%. Across a total geographical area 3,487 square kilometres.

Average Annual Births 4,600 and Deaths 4,920.

Shropshire is predominately 66% rural (101 people/sq km) and 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%).

Population health priorities

Using evidence from our Joint Strategic Needs Assessments (JSNA) and our two Health & Wellbeing Strategies, the following shared priorities emerged:

- Give every child the best start in life (including healthy pregnancy).
- Encourage healthier lifestyles with a priority focus on unhealthy weight.
- Improve people's mental wellbeing and mental health.
- Reduce the impact of drugs, alcohol, and domestic abuse on our communities.

Key headlines from Shropshire, Telford and Wrekin's JSNA's

At a national level, the trend in ever increasing life expectancy noted throughout the 20th century, aided by improvements in public health approaches as well as advanced in treatment and medicine, gradually slowed, stalled and in some places declined over course of 21st century. While there were improvements seen in 2019, these were mostly undone by the COVID-19 pandemic, which caused life expectancy to fall sharply in 2020.This pattern is also evident across Shropshire, and Telford & Wrekin, with male life expectancy in both areas, and female life expectancy in Telford & Wrekin, appearing to peak in 2014. The latest 3-year figures (2020-2022) indicate that both females (82.1 years) and males (78.0 years) can expect to live a significantly shorter life than the national averages (females 82.8 years, males 78.9 years), and around two years shorter than their neighbours in Shropshire (females 83.9 years, male 79.8 years), who themselves can expect to live a similar length of life to the average person in England.

Healthy life expectancy provides insight into the burden of ill health within an area and shows the number of years a person can be expected to live in good health without disability or long-term illness. The latest figures (2018-20), again highlight the inequalities between two areas and between the different genders, with females in Telford & Wrekin expected to live just 60.3 years in good health, almost seven years fewer than their Shropshire neighbours (67.1 years) and three years fewer than the national average (63.9 years). For males, again, it is Telford & Wrekin that finds itself an outlier, with men expected to live just 57.6 years in good health, five years fewer than men from Shropshire (62.8 years) and the national average (63.1 years).

- The gap in life expectancy is driven by mortality from cardiovascular disease, followed by cancers, with Telford & Wrekin found to have significantly higher rates of premature (under-75) mortality from cardiovascular diseases and cancers considered preventable than the national average.
- Excess weight is the most significant lifestyle risk factor in the population, with over two thirds of adults living within both areas estimated to be overweight. Telford & Wrekin found to have significantly high levels of childhood excess weight and obesity.
- The level of alcohol related-hospital admissions in both areas significantly above the national average.
- Adult smoking rates in routine and manual groups in both Shropshire and Telford & Wrekin are a key driver of inequalities.
- Smoking in pregnancy is a particular issue for Shropshire and Telford & Wrekin, with levels of maternal smoking at birth significantly worse than England overall average. The highest levels are seen amongst younger mothers and those living in deprived communities.

- Mental Health is a key cause of poor health amongst our communities, with levels of poor mental health in children and younger people increasing.
- The physical health of adults with Serious Mental Illness is also a cause for concern, with both Shropshire and Telford & Wrekin having high rates of excess mortality in this group compared to the national average.

Wider determinants of health					
Public Health Outcomes Framework Indicator	Period	England	ICB/STW	Shropshire	Telford & Wrekin
Children in relative low income families (under 16s)	2022/23	19.8%	21.7%	18.9%	25.4%
School readiness: percentage of children achieving a good level of development at the end of Reception (age 5)	2022/23	67.2%	67.8%	67.6%	68.0%
School readiness: percentage of children achieving the expected level in the phonics screening check in Year 1 (age 6)	2022/23	78.9%	78.8%	77.5%	80.5%
First time entrants to the youth justice system - Persons aged 10 to 17)	2022	148.8	-	37.2	109.5
16 to 17 year olds not in education, employment or training (NEET) or whose activity is not known	2022/23	5.2	-	7.9	3.1
Adults with a learning disability who live in stable and appropriate accommodation (aged 18-64)	2022/23	80.5	-	88.1	77.3
Adults in contact with secondary mental health services who live in stable and appropriate accommodation (aged 18-69)	2020/21	58.0	-	71	59.0
Gap in the employment rate between those with a physical or mental long term health condition (aged 16 to 64) and the overall employment rate	2022/23	10.4	-	10.4	12.7
Gap in the employment rate between those who are in receipt of long term support for a learning disability (aged 18 to 64) and the overall employment rate	2022/23	70.9	-	70.1	73.4
Gap in the employment rate for those who are in contact with secondary mental health services and the overall employment rate (aged 18-69)	2021/22	69.4	-	70.2	69.6
The percentage of people in employment (aged 16 to 64)	2022/23	75.7%	76.9%	77.3%	76.0%
Sickness absence: the percentage of employees who had at least one day off in the previous week	2019-21	1.8%	-	2.2%	1.7%
Sickness absence: the percentage of working days lost due to sickness absence	2019-21	1.0%	-	1.0%	0.9%
Violent crime - hospital admissions for violence (including sexual violence)	2020/21 - 2020/23	34.3	-	18.3	19.9
Homelessness: households owed a duty under the Homelessness Reduction Act	2022/23	12.4	-	8.2	15.5
Social Isolation: percentage of adult social care users who have as much social contact as they would like (18+ yrs)	2022/23	44.4%	-	46.0%	41.1%
Social Isolation: percentage of adult carers who have as much social contact as they would like (18+ yrs)	2021/22	28.0%	25.3%	24.9%	26.4%

Compared to England | Better | Similar | Worse

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Wider determinants of health

Overarching Health Inequalities Outcomes					
Public Health Outcomes Framework Indicator	Period	England	ICB/STW	Shropshire	Telford & Wrekin
Male life expectancy at birth (1-year range)	2022	79.3	79.1	79.7	77.8
Female life expectancy at birth (1-year range)	2022	83.2	83.2	83.6	82.2
Male life expectancy at birth (3-year range)	2020-22	78.9	-	79.8	78
Female life expectancy at birth (3-year range)	2020-22	82.8	-	83.9	82.1
Male healthy life expectancy at birth	2018-20	63.1	-	62.8	57.6
Female healthy life expectancy at birth	2018-20	63.9	-	67.1	60.3
Male life expectancy at 65 (1-year range)	2022	18.7	18.9	19.4	17.8
Female life expectancy at 65 (1-year range)	2022	21.2	21.4	21.8	20.6
Male life expectancy at 65 (3-year range)	2020-22	18.4	-	19.3	17.8
Female life expectancy at 65 (3-year range)	2020-22	20.9	-	21.6	20.2

Overarching Health Inequalities Outcomes

Health inequalities : Key clinical areas: Maternity and early years Long Term Plan NHS prevention priority: healthy weight					
Public Health Outcomes Framework Indicator	Period	England	ICB/STW	Shropshire	Telford & Wrekin
Under 18 conception rate / 1,000	2021	13.1	-	12.5	19.5
Teenage mothers (under 18)	2020/21	0.60%	0.70%	-	-
Baby's first feed breastmilk	2020/21	71.7%	70.9%	74.8%	66.0%
Smoking at time of delivery	2022/23	8.8%	11.4%	-	-
Year 6 prevalence of overweight (including obesity) (aged 10 - 11) - 1-year range	2022/23	36.6%	34.6%	31.2%	38.9%
Year 6 prevalence of overweight (including obesity) (aged 10 - 11) - 3-year range	2020/21-2022/23	36.6%	-	31.7%	39.9%
Year 6 prevalence of obesity (including severe obesity) (aged 4-5) - 1-year range	2022/23	22.7%	21.1%	17.6%	25.3%
Year 6 prevalence of obesity (including severe obesity) (aged 4-5) - 3-year range	2020/21-2022/23	22.5%	-	17.8%	25.9%
Reception prevalence of obesity (including severe obesity) (aged 4-5) - 1-year range	2022/23	9.2%	9.8%	8.6%	11.2%
Reception prevalence of obesity (including severe obesity) (aged 4-5) - 3-year range	2020/21-2022/23	9.7%	-	9.1%	11.9%
Compared to England			Better	Similar	Worse

HI 5 key clinical areas: Maternity

Long Term Plan NHS prevention priority: healthy weight

HI 5 key clinical areas: Maternity

Long Term Plan NHS prevention priority: healthy weight

Health inequalities : Key clinical areas: Hypertension case finding					
Long term plan accelerate diabetes and CVD Primary prevention programmes					
Long Term Plan NHS prevention priority: healthy weight					
Public Health Outcomes Framework Indicator	Period	England	ICB/STW	Shropshire	Telford & Wrekin
Estimated overweight (including obesity) prevalence in adults (18+)	2022/23	64.0%	-	66.1%	66.4%
Recorded adult obesity prevalence (18+)	2022/23	11.4%	11.7%	-	-
Estimated adult obesity prevalence (18+)	2022/23	26.2%	-	28.6%	28.4%
Recorded diabetes prevalence (17+)	2022/23	7.5%	7.7%	-	-
Under 75 mortality rate from circulatory diseases considered preventable - 1-year rate	2022	30.8	32.1	-	-
Under 75 mortality rate from cardiovascular diseases considered preventable - 3-year rate	2020-22	30.1	-	27.3	36.8
Health inequalities : Key clinical areas: Early cancer diagnosis					
Percentage of cancers diagnosed at stages 1 and 2; - 1-year rate	2021	54.5%	-	56.7%	51.7%
Percentage of cancers diagnosed at stages 1 and 2; - 3-year rate	2019-2021	54.3%	53.7%	-	-
Bowel cancer screening coverage (aged 60-74)	2022/23	72.0%	74.6%	76.0%	71.40%
Bowel cancer uptake coverage (aged 60-74)	2022/23	70.2%	73.5%	-	-
Breast screening coverage (aged 53 to 70)	2022/23	66.6%	71.1%	-	-
Breast screening uptake (aged 53 to 70)	2022/23	65.4%	70.2%	-	-
Cervical cancer screening coverage (aged 25 - 49)	2022/23	67.0%	72.2%	-	-
Cervical cancer screening coverage (aged 50 - 64)	2022/23	74.9%	76.5%	-	-
Under 75 mortality rate from cancers considered preventable - 1-year rate	2022	49.6	49.9	-	-
Under 75 mortality rate from cancers considered preventable - 3-year rate	2020-22	50.5	-	40.1	60
		Compared to England	Better	Similar	Worse

HI 5 key clinical areas: hypertension case finding

LTP accelerate diabetes and CVD prevention programmes

Long Term Plan NHS prevention priority: healthy weight

HI 5 key clinical areas: Early cancer diagnosis

Health inequalities : Key clinical areas: Chronic respiratory disease					
Under 75 mortality rate from respiratory diseases considered preventable - 1-year rate	2022	18.2	13.2	-	-
Under 75 mortality rate from respiratory diseases considered preventable - 3-year rate	2020-22	17.0	-	10.6	20.1
Population vaccination coverage : Flu (at risk persons)	2022/23	49.1%	53.3%	57.3%	47.8%
Health inequalities : Key clinical areas: Severe mental illness					
Excess under 75 mortality rate in adults with severe mental illness (SMI) (aged 18-74)	2018-20	389.9%	-	477.6%	475.4%
Premature mortality in adults with severe mental illness (aged 18-74)	2018-20	103.6	-	89.0	134.4
Emergency hospital admissions for intentional self-harm	2022/23	126.3	103.1	92.0	121.2
Long Term Plan NHS prevention priority: Alcohol Care Team					
Admission episodes for alcohol-related conditions (narrow definition)	2022/23	475	-	507	571
Under 75 mortality rate from liver disease considered preventable - 1-year rate	2022	19.1	18.9	-	-
Under 75 mortality rate from liver disease considered preventable - 3-year rate	2020-22	18.7	-	18.1	19.1
Long Term Plan NHS prevention priority: NHS Tobacco Dependency programme					
Smoking prevalence in adults (18+)	2022	12.7%	12.4%	10.0%	16.7%
Smoking prevalence in adults in routine and manual occupations (aged 18-65)	2022	22.5%	21.5%	17.6%	26.5%
Smoking attributable mortality	2017-19	202.2	-	173.7	246.1
Smoking attributable hospital admissions	2019/20	1398	-	1,475	1,944
		Compared to England	Better	Similar	Worse

HI 5 key clinical areas: Chronic respiratory disease

HI 5 key clinical areas: Severe Mental Illness

Long Term Plan NHS prevention priority: Alcohol Care Team

Long Term Plan NHS prevention priority: NHS Tobacco Dependency programme

Deprivation, ethnicity and access to services

Deprivation - IMD 2019 Decile (IMD- Index of Multiple Deprivation)

Deprivation:

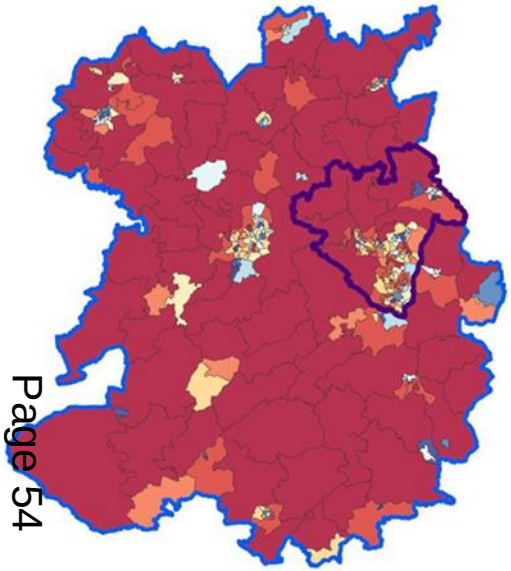
- Shropshire is a relatively affluent county which masks pockets of high deprivation, growing food poverty, and rural isolation.
- More than 1 in 4 people in Telford and Wrekin live in the 20% most deprived areas nationally and some communities within the most deprived in the country.

Ethnicity - % BAME 2011 Census (BAME- Black, Asian and Minority Ethnic)

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- IMD 2019 Decile



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.

What our residents have told us

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.

Our residents have said they wanted 'A person-centred approach to our care,' and this is central to all the work we are doing.

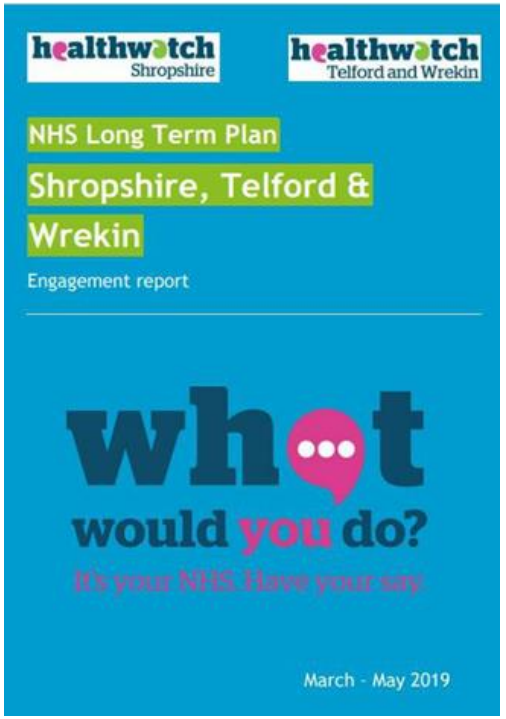
People are at the heart of everything we do and by delivering joined up services in both the acute and community settings we can give everyone the best start in life, creating healthier communities and helping people to age well.

The top 10 statements from all respondents for the Shropshire, Telford & Wrekin questionnaire which described the measures were the most important to our residents:

1. "Professionals that listen to me when I speak to them about my concerns."
2. "Access to the help and treatment I need when I want it".
3. "I want to be able to stay in my own home for as long as is it is safe to do so".
4. "I want my family and me to feel supported at the end of life".
5. "Choosing the right treatment is a joint decision between me and the relevant health and care professional".
6. "I want there to be convenient ways for me to travel to health and care services when I need to".
7. "Easy access to the information I need to help me make decisions about my health and care".
8. "Having the knowledge to help me to do what I can to prevent ill health".
9. "Communications are timely".
10. "I have to consider my options and make choices that are right for me".

Those who had long term conditions told us to focus on:

- Getting help and communications
- Impact of having more than one conditions



- Waiting Times
- Access to ongoing care and support
- Transport and Travel

When asked what our residents would do to, to be supported to live a healthier life? What can services do to provide you with better care and make it easier for you to take control of your health and wellbeing?

People told us that several things are important and should be priorities:

1. Access and timely intervention e.g., local services that people know about, that are available when people need them (including 24 hour) and that they can get to easily, including services that can help people to live healthy lives such as affordable gyms and social groups.
2. Tackling isolation and loneliness e.g., Making sure socially isolated people know what support is available to them and how to access it, including homeless people and people who do not have a named GP or relationship with services.
3. Consistent and reliable information and education for all ages e.g., reducing confusion by giving clear and consistent information that can be trusted, including information about services such as available appointments, and giving people a single point of contact to improve consistency, including appropriate signposting and offering information and advice (e.g., advice about medication).
4. Services working together, including information sharing and a flexible approach to working e.g., ensuring staff know what other services are out there and talking to each other, improved referral processes, social services and the NHS working together.
5. Building strong communities and investment in local people e.g., supporting and promoting local groups to enable and encourage people to get together, e.g., walking groups, dementia groups.

What our partners have told us

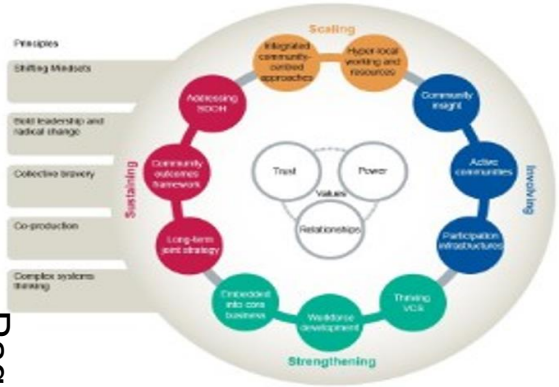
Together with the views of our partners, clinicians, staff and service users we can identify what is working well, what can be improved and what is important to them. This will enable us to plan, design and deliver health and social care services that are right for our local population of Shropshire, Telford & Wrekin.

Our clinical priorities identified through the HWBB consultations and engagement:

- Cancer
- Cardiac including hypertension.
- Respiratory
- Urgent and Emergency Care
- Diabetes
- Orthopaedics
- Mental Health

Chapter 4 - Tackling inequalities in outcomes, experience and access

Our approach

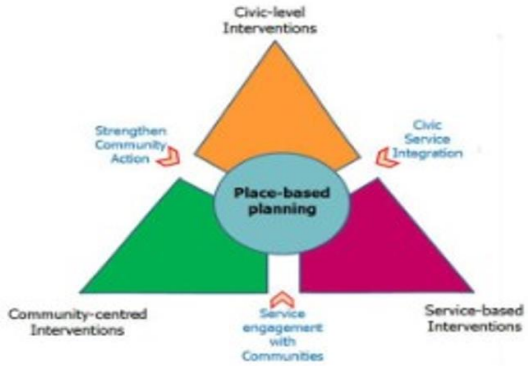


Community focused co-production

Place-based system wide

Intelligence-led

Equitable targeting



Intelligence-led population health management, including equity profiling for inclusion groups

Narrow the gap in service and support uptake and outcomes by proactively targeting people in inclusion based on equity profiling and engagement insight

Telford & Wrekin Co-operative Council

Shropshire together

Integrated Care System
Shropshire, Telford and Wrekin

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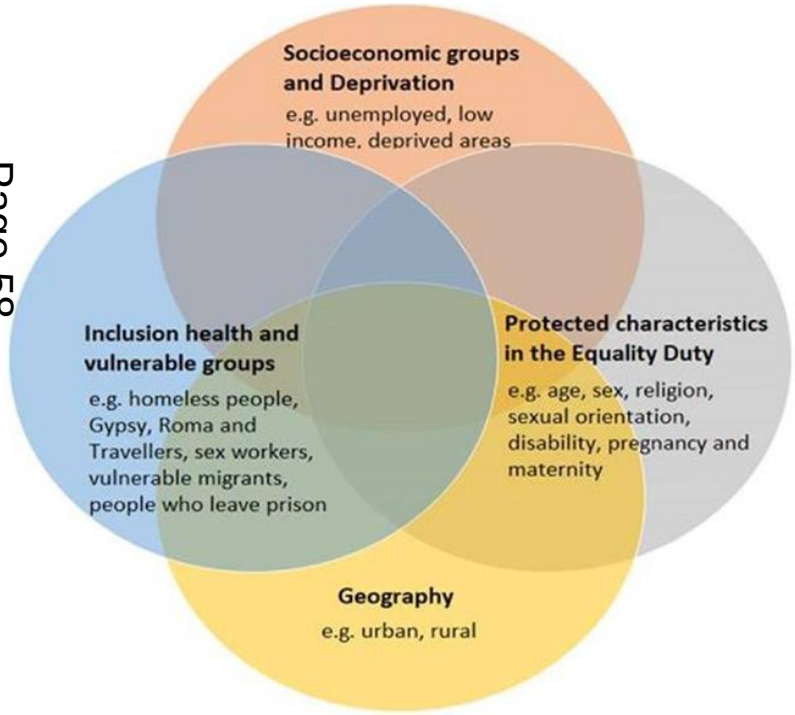
Inequalities and health inequalities

Inequalities in the wider determinants of health (such as housing, education, cost of living and access to green space) translate into health inequalities.

Health inequalities are unfair, systematic, and avoidable differences in health. Therefore, reducing health inequalities requires action to improve outcomes across all the factors that influence our health.

Approximately 10% of our health is impacted by the healthcare receive.



Inclusion groups

Clear focus where outcomes are poorest for people and families who are:

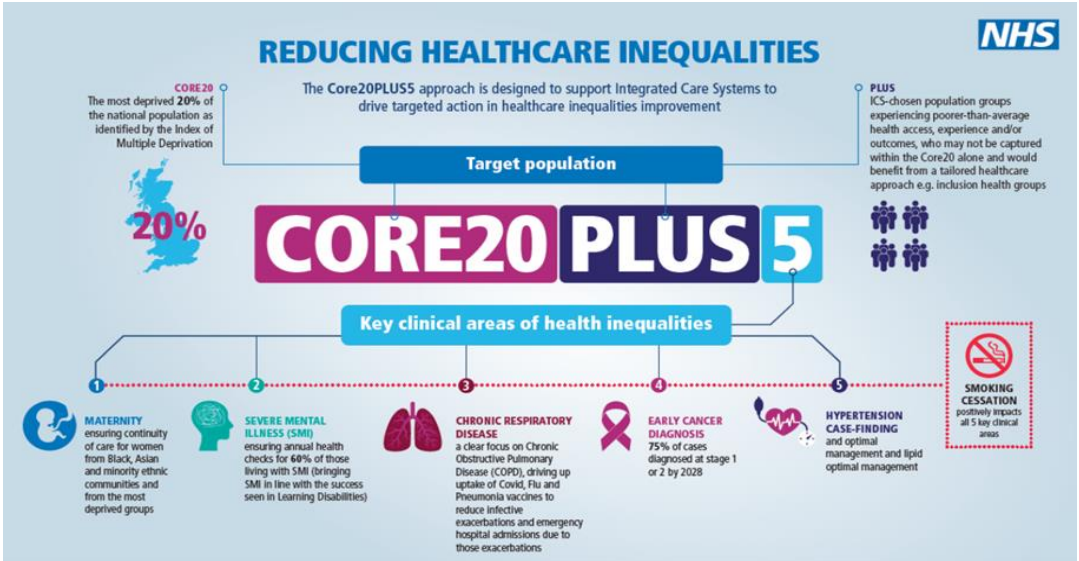
- from black and minority ethnic groups
- living in deprived communities, including rurally deprived
- affected by alcohol and drugs, including prescribed and OTC.
- victims and survivors of domestic abuse
- experiencing poor emotional and mental health
- living with physical disabilities, learning disabilities and autism
- living with sensory impairment
- within Equality Act protected characteristic groups
- at risk of exploitation
- LGBTQ+
- service personnel and veterans
- looked after children and care leavers.
- asylum seekers and refugees

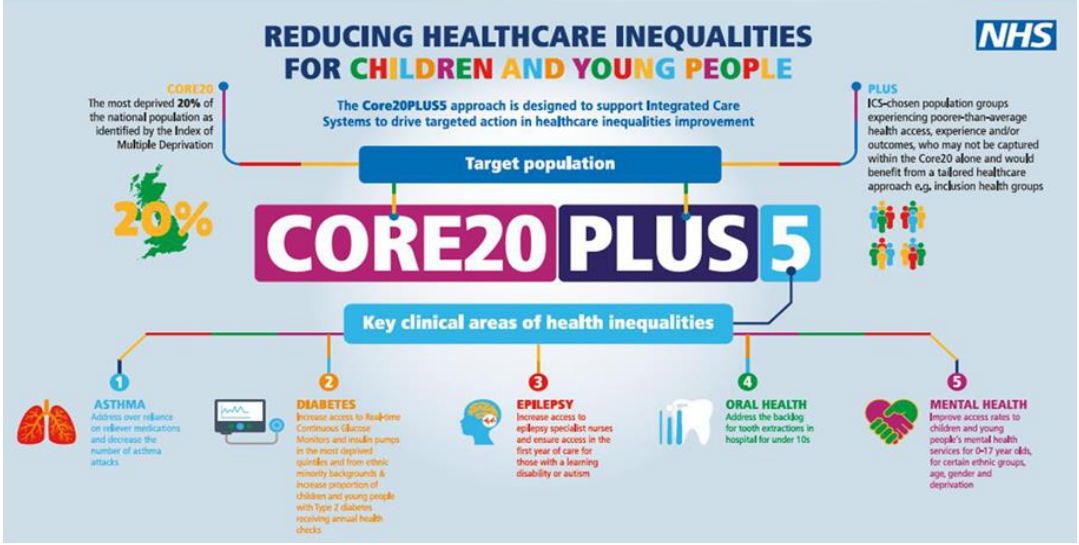
Overview of tackling in equalities

- Wider determinants of health, cost of living crisis, heat and fuel poverty, housing, employment, education and rurality.
- Inclusive, connected, healthy and sustainable communities.
- Healthy behaviours and lifestyles, with a focus on strengthening prevention.
- A person-centred approach that addresses holistic needs.
- Best start in life for EVERY child.

Health inequalities are widening, our partnership needs to focus on the root causes of health inequalities, the wider determinants, and address inequity of access to services for those most in need. We need to understand the multiple barriers people can face in accessing our services. We therefore commit to accelerate, targeted collaborative local action to reduce health inequalities, by the following priorities that tackle the wider determinants of health:

- Homelessness, healthy homes, poverty and cost of living, as well as positive work and employment.
- Ensuring every child has the best start in life by influencing a range of outcomes throughout the child's life and into adulthood.
- Improving equity of access to healthcare for those living in our most deprived areas, including rurally excluded as well as other forms of exclusion (for example Core20 plus 5 programme and a focus on healthcare preventable diseases). For adults, this includes hypertension, early cancer diagnosis, health checks for SMI and LDA, vaccinations, continuity of carer in maternity. For children, this includes epilepsy, asthma, and diabetes.



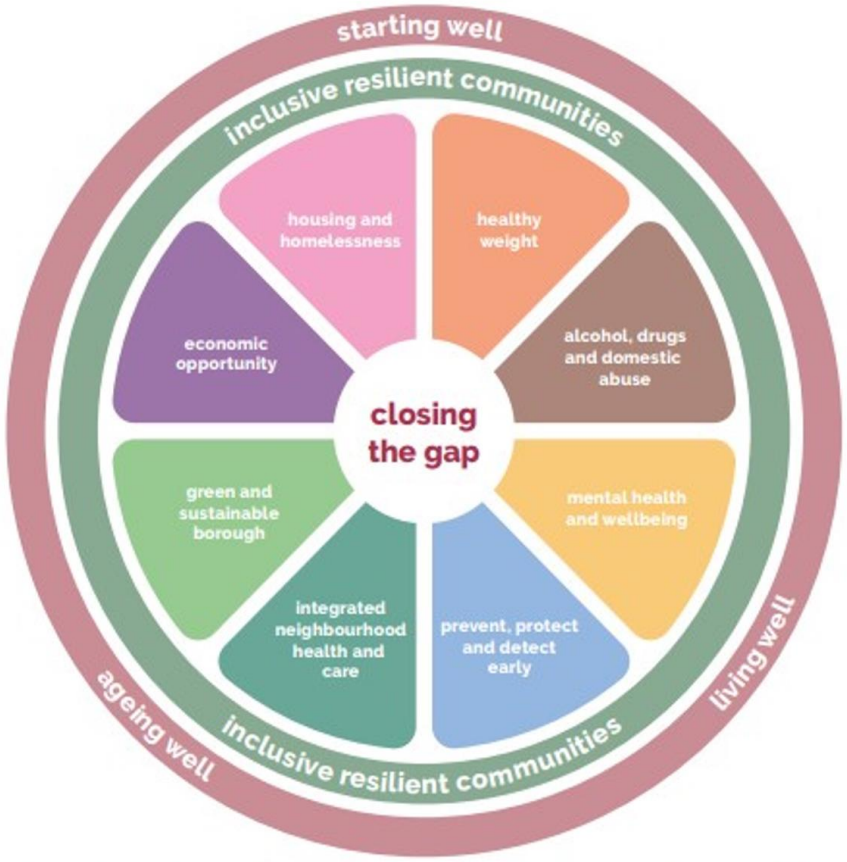


Health and wellbeing board priorities

Telford and Wrekin

Our vision - happier. healthier. fulfilled lives

Telford & Wrekin
Health & Wellbeing Strategy
Priorities



Borough Vision 2023 ambition – inclusive, healthy, independent lives

Shropshire Joint Health and Wellbeing Strategy priorities 2022-2027

Strategic Priorities Long-term aims and how we will achieve them	**Key areas of focus** Identified areas of health and wellbeing need in Shropshire
Joined up working	Workforce
Working with and building strong and vibrant communities	Healthy Weight and Physical Activity
Improving Population Health	Children & Young People incl. Trauma and ACEs (All-age)
Reducing Inequalities	Mental Health

Other – These form part of the Key Priorities			
Social Prescribing	Drugs and Alcohol	Smoking in Pregnancy	Housing
Suicide Prevention	Food Poverty	Killed and Seriously Injured on Roads	Air Quality
Exploitation			

Shropshire Inequality Plan

Wider Determinants	Healthy Lifestyles	Healthy Places	Integrated Health and Care
Marmot; (i) Create fair employment (ii) Ensure healthy living standard	Marmot; (iii) CYP and adults – maximise capability and control (iva) Strengthen ill-health prevention (lifestyles)	Marmot; (i)v Create healthy and sustainable places and communities	Marmot; (vi) Give every child the best start in life (ivb) Strengthen ill-health prevention (transformation/disease programmes)
Inequalities Work Programmes			
Embed health in all policies	Smoking/tobacco dependency	Air pollution	Restore NHS services inclusively
Housing – affordable/specialist/supported	Healthy weight	Planning	Rurality
Economy and skills	Physical activity	Culture and leisure	Mitigate digital exclusion
Workforce		Licensing	Datasets complete
Education incl. SEND		Food Insecurity	Strengthen leadership and accountability
Early years			Population health management
Post 16			Personalisation/personalised care
SEND			COVID and flu vaccination
LD&A/SMI			Annual health checks for people with:
Transports			Continuity of carer (Maternity)
			Chronic respiratory disease
Social Inclusion Groups	Social Inclusion Groups (Continued)	PCN health inequality plans	Hypertension case-finding
Domestic abuse	Drug and alcohol misuse		Diabetes
Exploitation	Looked after children		Children and Young People
Homelessness	Ethnic minority groups		Trauma informed workforce
Learning disability	Prisoners and their families		Healthy Start
Autism			Oral health
Gypsy and traveller families			Best Start in Life
Asylum seekers/refugees			Children/families in need
Unpaid carers			Complex need
Physical disabilities			Mental Health (MH transformation plan)
LGBTQ+			Suicide prevention
Services personnel and (families and veterans)			Social prescribing
			Integrated Impact Assessment (IIA)

Person Centred approach

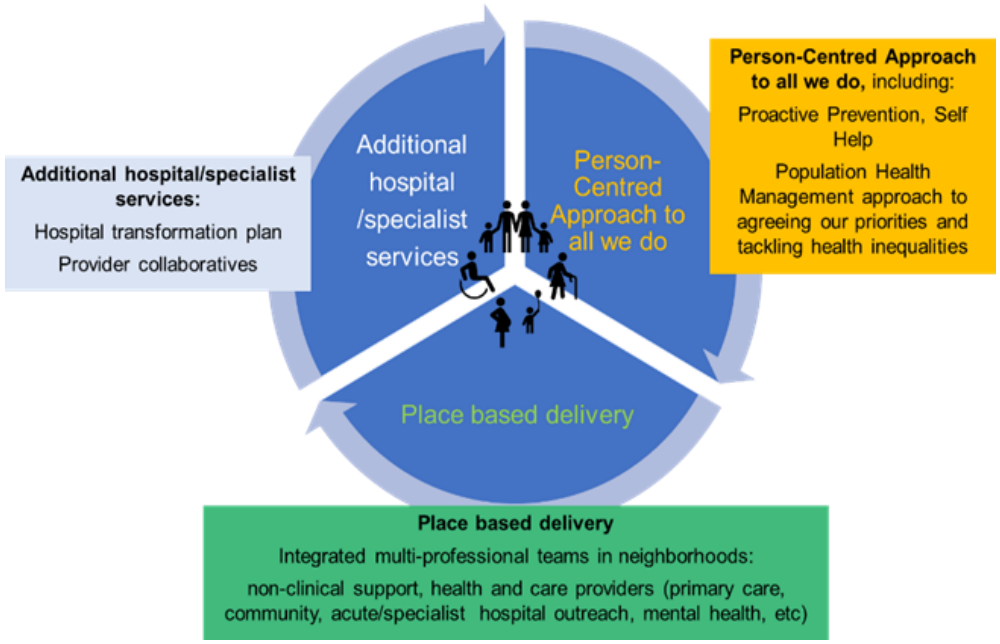
Person-centred care shifts away from professionals deciding what is best for a patient or service users, and places the person at the centre, as an expert of their own experience and lives. The person, and their family where appropriate, becomes an equal partner in the planning of their care and support, ensuring it meets their needs, goals, and outcomes.

With an emphasis on “doing with” rather than “doing to”, person-centred care runs through both individual and group settings, allowing users of services to be active not only in their own care but also in the design and delivery of services. This approach can improve both the experience and quality of care.

Key aspects of person-centred care include:

- Valuing people’s preferences and placing them at the centre of their care, considering people’s preferences, and chosen needs.
- Ensuring people are physically comfortable and safe.
- Providing emotional support involving family and friends.
- Ensuring access to appropriate care as needed, when and where they need it.
- Providing accessible information to empower individual to make informed decisions about their care and support.

Person-centred care also acknowledges the significant and proven link between non-clinical community support and improvement in health and wellbeing.



Chapter 5 – Support broader social and economic development

The Joint Forward Plan (JFP) integrates broader system collaboration. It outlines three key areas that system strategies must align with need to link to and show how they will under pin the priorities within the integrated strategy. The evolution of the 'Places' and provider collaboratives will have an impact on how services are delivered in the future, with enabling strategies clearly demonstrating how they will facilitate the system priorities. The JFP also illustrates how the system's operating model will achieve the outcomes and impacts of the strategic commissioning intentions.

Key components of the JFP include:

- Local planning and regeneration
- Climate and green planning
- Hospital Transformation Programme
- Local Care Programme included integrated approach to neighbourhood teams

Enabling strategies encompass:

- Workforce:
  - Our local people plan outlines and supports our system response.
  - Initiatives to support and nurture our people.
  - Fostering a sense of belonging in STW.
  - Implementing new care delivery methods.
  - Futures workforce growth strategies, with a focus on Nursing and Health Care Support Workers (HCSW).
- Digital:
  - Approval of a comprehensive digital strategy for the system.
  - Implementation of a Shared Care Record system.
  - Integration of advanced care delivery systems.
  - Remote monitoring capabilities.
  - Utilization of Artificial Intelligence to enhance care delivery.

- **Communications and Engagement:**
  - Approval of a Communication and Engagement plan.
  - The STW JFP serves as the operational framework for delivering the ICP's Strategy and its priorities, defining partnership narrative, approaches, methodologies, and key questions.
  - The Equalities Involvement Committee will guide and advise on ongoing dialogue and development.
  - Engagement with citizens will be enhanced through collaboration with Healthwatch and NHS/LA enabling workstreams.
- **Population Health Management:**
  - Development of a Population Health Management (PHM) Strategy to ensure accurate data, insights, and evidence to support system decision.
  - Establishment of an analytical 'engine room' to drive insighted and capacity building.
  - Grow analytical skills and capacity.
  - Implementation of a system-wide work programme grounded in the continuous development of JSNAs as foundation.

This structured approach ensures alignment across system-wide initiatives, fostering effective collaboration and strategic implementation of priorities to benefit our communities in Shropshire, Telford and Wrekin.

Provider Collaboratives

Provider Collaboratives will play an important role in enacting strategic priorities and delivering objectives commissioned for the healthcare system. These collaborations will build on a strong local commitment to partnership working and will develop to support specific areas of delivery where integration will produce better outcomes for the population. In particular collaborative delivery mechanisms will support providers of care to **Add value** to the ICS by:

- developing and **delivering collaborative approaches to specific challenges** within providers' gift to resolve
- developing **partnership relationships**, strengthening communication between providers, sharing approaches to challenges and opportunities
- addressing **efficiency, productivity and sustainability** through collaborative working, integration or the consolidation of service delivery or corporate functions
- **reducing inequalities of access and unwarranted variation**, where provider collaboration can best achieve this
- adopting some **commissioning responsibilities** within the ICS where this will align better with operational delivery and transformation**, improve decision making and accelerate change**

The Provider Collaborative will act as a key conduit for providers to work together as a single unit under which a range of "collaborations" will be developed to deliver outcomes commissioned by the ICB. These collaborations may form between internal STW ICS partners or across ICS borders where this brings benefits to our population.

Voluntary and Community Sector involvement:

Our system has made a commitment to our partners in the Voluntary and Community Sector that we will prioritise sustainable partnerships with a longer term view to support the delivery of outcomes through place and provider collaboratives. The cost-of-living crisis has had a major impact on our voluntary sector and yet they continue t deliver a range of excellent services to our populations.

Supporting prevention, management and wider determinants of health has a huge impact on people's lives, delivers a person-centred approach and offers excellent value for money. But VCSE services, whilst voluntary are not 'free' and the system has agreed to facilitate, support and evaluate the work our VCSE does to ensure that we can continue to have vibrant communities in the years to come.

Chapter 6 – Enhance Productivity and Value for Money

Our Integrated Care Partnership (ICP) will explore whether needs can be better met through arrangements such as the pooling of budgets, under Section 75 of the NHS Act 2006. Section 75 is a crucial for enabling integration and will play a central role in delivering our Integrated Care Strategy.

The term “left shift” is used to describe a strategic direction that promotes delivering more care in lower-cost, out-of-hospital settings, ideally at home, while emphasizing prevention. The underlying premise is that acute care tends to be more expensive and may become the default option when preventive services aren’t optimal in either capacity, capability, or delivery.

According to a recent point prevalence audit, nearly 20% of patients in acute care on the audit day could have been treated appropriately in “left shift” settings such as community hospitals, care homes, or in their own homes with additional primary care and social care support. However, this finding requires further analysis and integration into the Joint Forward Plan (JFP) to ensure that appropriate integrated primary and community services are being developed to support the ‘left shift’.

‘Left shift’ also encompasses prevention and early support services that operate below primary, community and social care. However, transitioning to a “left shift” approach will not occur automatically; it requires a conscious effort by the system to embrace change and recognise that the costs and benefits of this shift will not vary across different parts of the system.

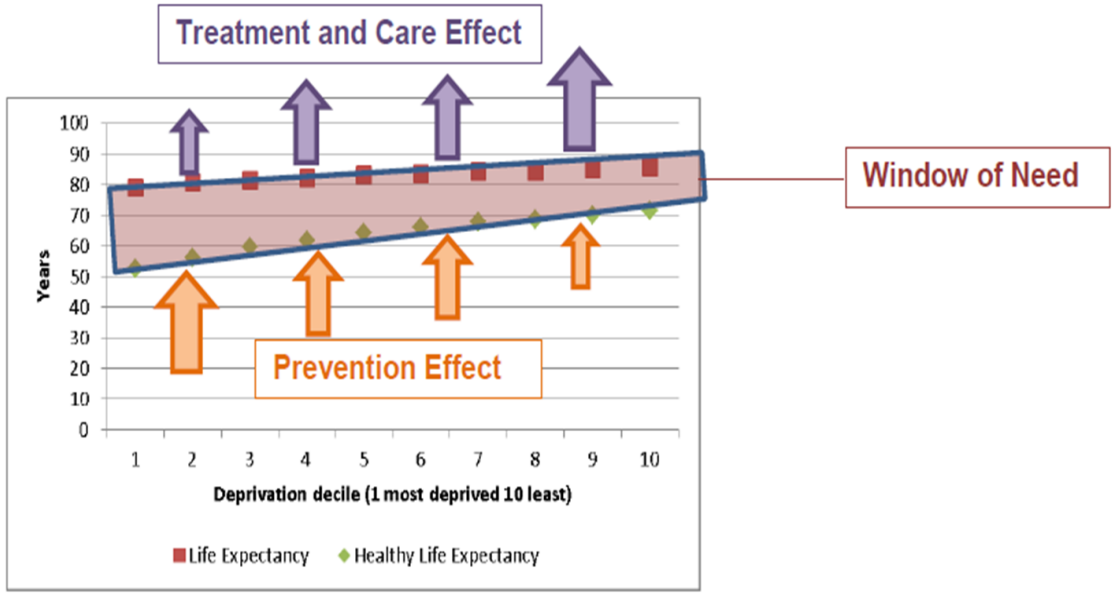
In summary, “Left shift” aims to:

- Close the Care and Quality Gap: By narrowing the gap between the highest and lowest standards of care and raising the overall quality standards for everyone.
- Close the Health Gap: Despite longer life expectancy, the majority of health issues premature deaths in our community stem from preventable diseases such as dementia, diabetes, certain cancers, and respiratory illnesses.

This strategic shift towards "left shift" is essential for improving healthcare efficiency, enhancing patient outcomes, and promoting healthier lives across our community.

Focusing on Prevention/early intervention:

- Reduces/preventing demand
- Delays health and care service need
- Delivers better Outcomes by extending Healthy Life Expectancy
- Reduces inequalities



Chapter 7 – Performance Monitoring and Scrutiny

High level outcomes for the system are broadly agreed upon, though they may evolve further consultation and co-production, and will be integrated into our operational and Joint Forward Plan (JFP). The Integrated Care Strategy will continue to be developed collaboratively with residents, partners, and stakeholders on an ongoing basis. This iterative process will support and inform the strategic commissioning intentions and priorities.

The Joint Forward plan will be refreshed annually, with the first year guiding the operational planning process and its fifth year developed in collaboration with the Strategy and Development Directorate, Health and Wellbeing boards, and the Integrated Care Partnership (ICP). Oversight of plan delivery will be the responsibility of the Integrated Care Board, supported by assurance from the Places and Provider Collaboratives as they evolve within the system operating model.

Additionally, scrutiny of the high-level strategy and the JFP will also be overseen by the Joint Health Overview and Scrutiny Committee to ensure alignment and effectiveness.

Outcome Focus – potential high level outcomes

The health of our population will be improved through a focus on....	Our Outcomes
The health of our RESIDENTS	1. We will increase healthy life expectancy across STW and narrow the gap between different population groups 2. We will reduce early deaths from preventable causes – cardiovascular and respiratory conditions, cancers and liver disease– focussing on those communities which currently have the poorest outcomes 3. We will improve life expectancy of those with Serious Mental Illness 4. We will increase the proportion of people in STW with a healthy weight 5. We will improve self-reported mental wellbeing 6. We will reduce the number of children & young people who self-harm 7. We will reduce alcohol related hospital admissions 8. We will reduce the proportion of pregnant women who smoke 9. We will lower the burden and minimise the impact of infectious disease in all population groups
The health of our SERVICES	1. We will increase the proportion of our residents who report that they are able to find information about health and care services easily 2. We will increase the proportion of our residents who report that they are able to access the services they need, when they need them 3. We will increase the proportion of our residents who report that their health and care is delivered through joined up services as close to home as possible

Outcome Focus – potential high level outcomes

The health of our population will be improve through a focus on....	Our Outcomes
The health of our STAFF	1. We will improve our ability to attract, recruit and retain our staff 2. We will improve staff training and development opportunities across all our partners 3. We will improve self-reported health and wellbeing amongst our staff 4. We will increase Equality and Diversity workforce measures in all organisations
The health of our COMMUNITIES	1. We will reduce the impact of poverty on our communities 2. We will reduce levels of domestic violence and abuse 3. We will reduce the impact of alcohol on our communities 4. We will reduce the impact of Adverse Childhood Experiences (ACEs) on our communities 5. We will reduce the number of young people not in education, training or employment 6. We will increase the number of our residents describing their community as a healthy, safe and positive place to live
The health of our ENVIRONMENT	1. We will increase the proportion of energy used by the estates of our partner organisations from renewable sources 2. We will reduce the total carbon footprint generated through travel of patients using our services 3. We will increase the use of active travel, public transport and other sustainable transport by our staff, service users and communities

Telford & Wrekin Co-operative Council

Shropshire together

Integrated Care System
Shropshire, Telford and Wrekin

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Integrated Care System
Shropshire, Telford and Wrekin

NHS
Shropshire, Telford and Wrekin

Strategic Decision-Making Framework

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1	9th October 2024	First version of the Strategic Decision-Making Framework

Table of Contents

1. **Executive Summary**

1.1 Integrated Care Systems (ICSs) are partnerships of health and care organisations that come together to plan and deliver joined up services and to improve the health of people who live and work in their area. They exist to achieve four aims:

1.2 Integrated Care Boards (ICB) are regularly required to make decisions on the best use of NHS resources on behalf of their local population. The ICB is responsible for making sure that taxpayers' money is spent wisely, so that our residents can have access to high- quality health services which help them to stay as healthy as possible.

1.3 In the current challenging financial climate, it is important for NHS Shropshire, Telford and Wrekin ICB to demonstrate that it is making the most effective use of public money to commission the right care, in the right place, at the right time within the context of our resources in a safe, fair and transparent manner, and in order to deliver our statutory responsibilities, alongside meeting the needs of the Shropshire, Telford and Wrekin population.

1.4 The decision-making process followed by the ICB when deciding what services and treatments to commission should be open and transparent. It is also important that the ICB engages with patients and the public on the future of local health services and consideration should be paid to NHSE guidance for major service change to assess requirements for engagement and/or consultation.

2. Aims of the Policy

2.1 The aim of the policy is to: -

a) Provide a rationale and process to allow services to be identified for review prior to any decision to decommission, disinvest or invest in services.
b) Deliver best value for money by ensuring that local health care resources are directed to the most effective services for the local population.
c) Ensure all commissioned services are monitored in terms of performance and health outcomes.
d) Efficiency, demand management and fitness for purpose to allow for a robust decision to be made regarding continuation of that service.
e) Contribute to the delivery of the ICB's commissioning plan and efficiency agenda, to ensure that resources are directed to the highest priority area to achieve the best possible health outcomes for the local population against available resources.
f) Ensure all investment, decommissioning and disinvestment decisions are taken in a fully informed manner and follow a set procedure agreed by the ICB Board.
g) Ensure that the way in which commissioning decisions are made reflect the ICB Operating Model and are in line with the commissioning cycle.
h) Ensure the safety of patients remains paramount.

3. Principles

3.1 This policy is designed to ensure that the ICB acts in accordance with a set of agreed principles and strong governance when they made decisions about services and are compliant with statutory frameworks at the time of consideration. Briefly these include:

- Equality and quality are the primary guiding principles.
  a) Ensuring the needs of service users are considered throughout.
  b) Better outcomes are achieved.
  c) Health Inequalities reduced.
  d) Equity of access to services.

- Efficiency to make more effective use of resources.
  e) Secure best value for money.
  f) Reducing variation wherever possible.
  g) Improving Productivity

- Processes for identification and evaluation should be:
  h) Systematic and robust.
  i) Transparent and inclusive.

- The process applied should be proportionate and ensure that there is provision for:
  j) Strong governance.
  k) Appropriate engagement and consultation.
  l) Consideration of challenge and appeal.

4. Process

4.1 Changes to currently commissioned services should be assessed using the prioritisation framework and aligned with the Commissioning Cycle. This will provide a consistent methodology that can be kept on record to support the decisions made by the ICB and will ensure that this is embedded as part of the ICB's strategic business and planning cycle.

4.2 There is no definition of service change in the NHS however commissioning decisions are required to be made for all changes to services both current and proposed. All service changes will need to consider the following:

- **Overall budget allocation for existing service provision**

- To prioritise or re-prioritise spend across and between the full range of ICB commissioned services.

- **Pathway redesign:**
  - To prioritise interventions or services within a defined care pathway, either in the context of introducing additional stages or disinvesting in some.

- **New resource allocation**
  - To prioritise new proposals for investment such as the introduction of new technologies or interventions.

- **Disinvestment:**
  - To prioritise proposals for service disinvestment.

- **Integration:**
  - To prioritise or re-prioritise services that can be delivered to achieve the ICBs integration duties.

- **Impact of decisions:**
  To pay due regard to the impact the commissioning decision will have across the population and provider landscape.

4.3 A standard template for assessment of proposals against the prioritisation framework will be used alongside the Service Change documentation considering the commissioning principles of NHSSTW ICB. (Appendix One). This is supported by a flowchart outlining the use of the prioritisation framework in the broader process which can be found under section 11.2 of this policy. A final draft priority rating should be decided upon according to the guidance within this flowchart.

4.4 Assessment of equity and quality is a statutory requirement and guidance should be followed accordingly. An Equality and Quality Impact Assessment (EQIA) and Integrated Impact Assessment (IIA) will be required for all proposed service changes. This process will be completed a separate document for all changes to services. This process is used to fully identify and mitigate any impact on quality or equality and will be taken through the Equality and Involvement Committee.

4.5 An overall rating will be decided based on the information provided within the prioritisation framework and included in the Service Change documentation. There will be 4 categories for this ranging from Very Low to Very High.

4.6 The Strategic Commissioning Committee will take due regard of the prioritisation rating given in the prioritisation framework, according to the ICB's Ethical Decision-Making Framework.

4.7 Where relevant, public engagement and/or consultation will form part of the decision-making process. The entire process, including recommended final categorisations based on evidence and actions resulting from this can be found in the Flowchart for Decision-Making under section 11.2.

4.8 A Service Change Review Group (SCRG) will be created as a working group of the Strategic Commissioning Committee, and all proposed service changes will be required to follow the process set out below. The Commissioning Working Group will review all proposals ahead of submission to the Strategic Commissioning Committee who will keep a formal record of proposals reviewed and the feedback given.

5. Decision-Making Triggers

5,1 There are several reasons why a decision would need to be made. Decision triggers are a critical part of the overall assurance process. There is not a definitive list of the triggers that would initiate this process, however, below is a list of those common triggers.

- Strategic Programme (local or national)
- Service Review
- New Guidance
- New Service
- Contract Expiring
- Contract Notices
- Quality Issue
- Feedback from people and communities
- Annual Planning
- The service is unable to demonstrate clinical and cost effectiveness.
- The service provided is not a statutory responsibility of the ICB
- The service is deemed low priority /of limited clinical value relative to other services that need to be protected or enhanced
- A needs assessment demonstrates existing services are not meeting the health needs of the population

6. Process for Relative Prioritisation

6.1 The relative prioritisation process should be used in conjunction with the Scheme of Reservation and Delegation. Each service change will require a rating to inform the decision regarding the priority of the service change proposed. This will be referred to as the Prioritisation Rating.

6.2 An overall rating will be decided based on the information provided within the prioritisation framework and included in the Service Change documentation. There will be 4 categories for this ranging from Very Low to Very High.

7. Prioritisation Elements

7.1 The prioritisation elements will align to the four aims of the ICB with an overarching element for strategic fit. Some aims have subheadings to make the evidence supplied more granular. This also impacts on how each element is weighted.

1. **Strategic Fit**
2. **Improve outcomes in population health and healthcare**
    - Clinical Effectiveness
    - Anticipated Health Benefits/Health Gain
3. **Tackle inequalities in outcomes, experience, and access**
4. **Enhance productivity and value for money**

- Cost effectiveness (inc. comparison to alternative models of care)
- Affordability (inc. opportunity costs)

5. Help the NHS support broader social and economic development.

7.2 The process of determining the Prioritisation Rating will be based on 7 elements. Each element will be weighted, and a score calculated based on a matrix. The combined score will generate the provisional Prioritisation Rating, and this will be reviewed and approved in accordance with the Scheme of Reservation and Delegation. Each element will require evidence as to why the rating has been applied

Strategic Fit

- Is the ICB mandated to commission the service?
- Is it a national 'must do'?
- Is it subject to National Institute for Health and Care Excellence (NICE) technology appraisal guidance (TAG)?
- How does the service fit with the delivery of current national targets for the ICB?
- How does the service align with the ICBs Strategic Commissioning Intentions, Joint Forward Plan, Clinical Strategy, ICP Strategy, HWBB Strategy, Workforce Strategy, Long Term Financial Plan, LTC Strategy, HTP, LCTP (including planned shifts of services/ activity to community/self-care/management)?

Clinical Effectiveness

- Assessment of the existing evidence and strength of the evidence that the service may be effective compared to other existing or standard treatments.

Anticipated Health Benefits/Health Gain

- Overview of the size of the potential benefits that the population accessing this service can expect, in terms of increase in life expectancy, improved quality of life in those with long-term conditions and recovery from acute illness or injury.
- Identify any specific needs by population.
- Consider Rural health requirements
- Impact on Health Inequalities
- Population Health Management – evidence of potential impact?

Impact on Health Inequalities / Delivering Health Equity

- Could this service act towards reducing health inequalities in the local area?
- Is it accessed disproportionately by a marginalised or deprived group/area or targeted at such?
- Evidence from Core 20 plus 5
- Evidence from JSNA's
- Evidence from Population Health Management Data

Cost effectiveness and Opportunity Costs

- Is there evidence or expectation of improved value for money?

- How does this compare, in terms of cost effectiveness, to alternative services/service models/different settings for the same patient group or conditions?
- Is there an opportunity for releasing resources for alternative uses? (resources include staff time, estate and finance). How does this affect system finances/other partners?
- What is the opportunity cost i.e. how much will the service or intervention cost per head of population per year?

Return on Investment

- What is the Return on Investment?

Help the NHS support broader social and economic development.

- How will the service engage the widest range of partners?
- Does the service have an impact on both the ICB and LA?
- Does the service align with the HWB?
- Population health management?
- Impact on social value?

8. Prioritisation Framework Weightings

8.1 Each service change will require a rating to inform the decision regarding the priority of the service change proposed. This will be referred to as the Prioritisation Rating, an overall rating will be decided based on the information provided within the prioritisation framework (above) and included in the Service Change documentation. There will be 4 categories for this ranging from Very Low to Very High and scores will be moderated by the SCRG.

8.2 Each prioritisation framework element will be weighted, and a score calculated based on the below matrix, the combined score will generate the provisional Prioritisation Rating, this will be reviewed and approved in accordance with the Scheme of Reservation and Delegation.

9.0 Prioritisation Rating Matrix

Prioritisation Framework Criteria Scorecard		Very Low	Low	High	Very High	Score = weighting x points
	Weighting	1	2	3	4	
Completion Note		Enter as 1	Enter as 2	Enter as 3	Enter as 4	
Strategic Fit	1	-	-	-	-	0
Clinical effectiveness	2	-	-	-	-	0
Anticipated Health Benefits/Health Gain	3	-	-	-	-	0
Impact on Health Inequalities	3	-	-	-	-	0

Cost effectiveness and opportunity costs	**2**	-	-	-	-	**0**
Return on Investment	**2**	-	-	-	-	**0**
Help the NHS support broader social and economic development	**2**	-	-	-	-	**0**
Total Score						**0**

9.1 Based on the weighting, the range for the prioritisation rating is between 15-62.

9.2 The following table shows how the individual weighted points drive the final prioritisation rating:

Minimal/ No investment 1	Minor investment 2	Moderate investment 3	Major investment 4
15 - 26	**27 - 38**	**39 – 50**	**51 - 62**

9.3 In-year changes that are proposed and rated as a priority could be added to a future commissioning list for prioritisation of resources in future years, this may be a useful process if service developments are proposed that cannot be resourced in year but could be prioritised as part of the planning process.

10.0 Scheme of Reservation and Delegation

10.1 This will form part of the overall decision-making process with formal decisions being made in the correct forum or by the correctly delegated individuals or groups.

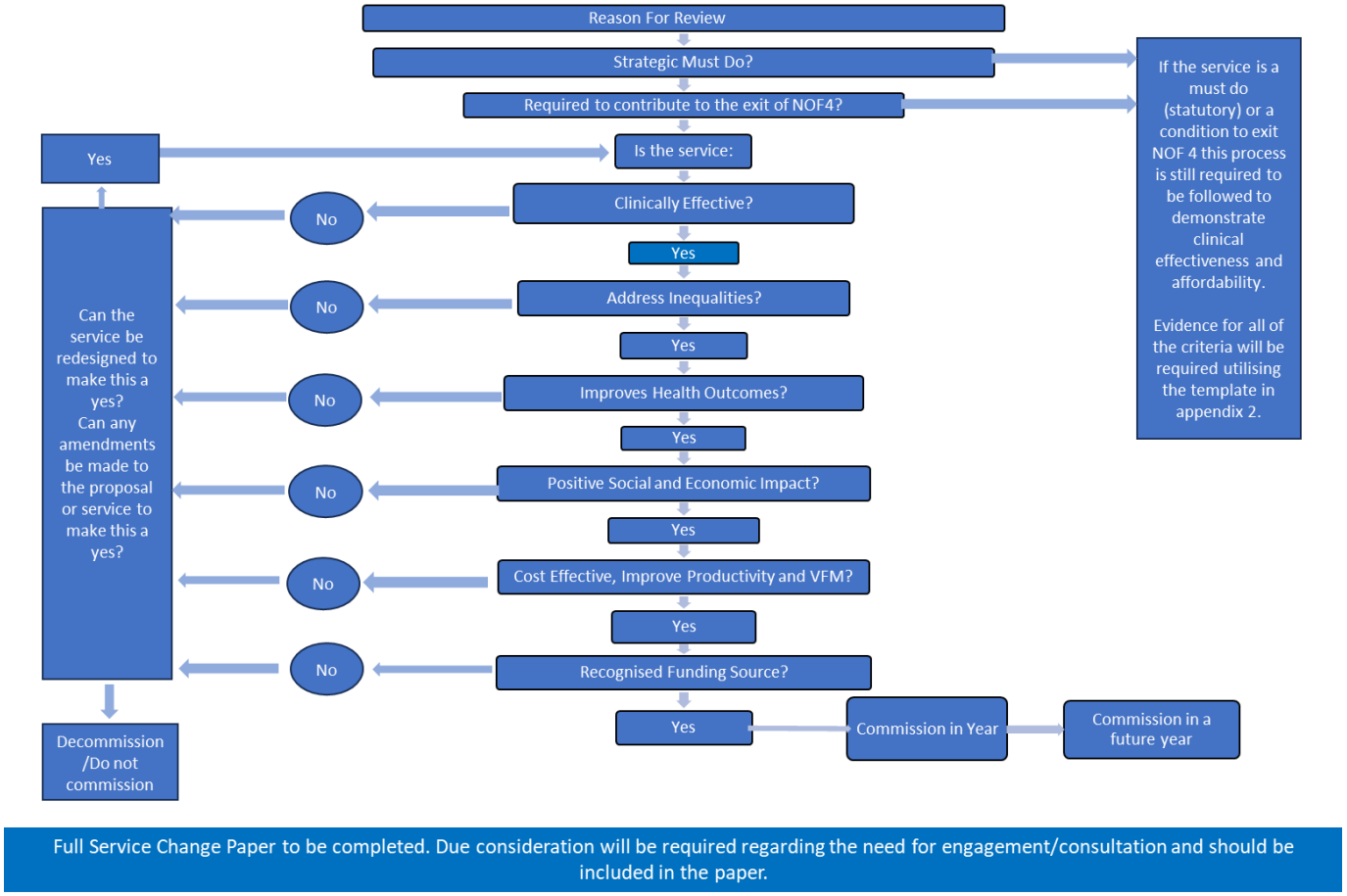
10.2 The below flow diagram will inform, with the use of evidence whether the recommendation is to commission or not it will also indicate on what population footprint is appropriate for the service. Following this a service change paper will be required for review at the Service Change Review Group (SCRG). This group will be created to increase the clinical and financial review to allow the group to assure the proposed prioritisation ratings indicated. Proposals should indicate where the subject matter experts have been involved and where sign off from an appropriate forum has been achieved. This will not remove the need for involvement of these functions in the development of the proposal.

10.3 Following the SCRG the paper will be submitted to appropriate decision-making forum in line with the Scheme of Reservation and Delegation.

11.0 Flowchart for Decision-Making

11.1 The below flowchart will be used to finalise the recommended commissioning decision.

11.2 The evidence used to rate the elements above will also be used to make the decisions required in the flowchart.



11.3 The above flowchart is used to confirm whether a service should be commissioned / continued or not. However, aligned with the ICB's Operating Model, consideration should be given to the way in which commissioning can be most effective including via individual providers, Provider Collaboration or Place.

12.0 Provider Selection Regime (PSR)

12.1 PSR is designed to make it straightforward for systems to continue with existing service provision where the arrangements are working well and there is no value in seeking an alternative provider. Where systems want or need to consider making changes to service provision the new regime will allow for a flexible, sensible, transparent, and proportionate process for decision-making that allows shared responsibility to flow through it.

12.4 The central requirement of the new regime is that arrangements for the delivery of NHS services must be made in a transparent way, in the best interests of patients,

taxpayers and the population.

12.5 There are three broad circumstances that decision-making bodies could be in when arranging services:

- **Direct award processes (A, B, and C)**. These involve awarding contracts to providers when there is limited or no reason to seek to change from the existing provider; or to assess providers against one another, because:
    - the existing provider is the only provider that can deliver the health care services **(direct award process A)**
    - patients have a choice of providers and the number of providers is not restricted by the relevant authority **(direct award process B)**
    - the existing provider is satisfying its existing contract, will likely satisfy the new contract to a sufficient standard, and the proposed contracting arrangements are not changing considerably. In addition, the service does not meet the test for 'considerable change' under Direct Award C, a service must not be materially different in character to the existing service, and the new contract must not exceed £500,000 of the lifetime value of the existing Contract or 25% higher than the lifetime value of the Contract. **(direct award process C).**

- **Most suitable provider process**. This involves awarding a contract to providers without running a competitive process, because the relevant authority can identify the most suitable provider.

- **Competitive process.** This involves running a competitive process to award a contract.

12.6 NHS Shropshire, Telford and Wrekin Integrated Care Board needs to comply with defined processes in each case to evidence their decision-making, including record keeping and the publication of transparency notices. STW ICB must consider five key criteria when applying direct award process C, the most suitable provider process or the competitive process. These are:

- quality and innovation
- value
- integration, collaboration and service sustainability
- improving access, reducing health inequalities and facilitating choice
- social value

13.0 Formal Decision-Making

13.1 The ICB will make commissioning decisions in line with the extant Scheme of Reservation and Delegation. The above process is designed to give a structure to inform the decision. Each element of the above process will determine the next step ultimately leading to the formal decision at the appropriate decision-making forum.

13.2 The process for relative prioritisation will score a proposal to indicate whether it is of high or low priority, this evidence will be crucial in running the proposal through the decision flow diagram. The decision flow diagram will inform whether the proposal should be commissioned or not, including de-commissioning or commissioning in future years.

13.3 The basis of the commissioning footprint will guide whether there is an opportunity to commission the service on a place or provider collaborative at scale and the final process of determining the most appropriate procurement process. All these elements will come

together to form the recommendation to the decision- making forum. Each element will be transparent and evidenced appropriately to allow the decision to be made in the most robust manner.

Appendix One: ICB Commissioning Principles

Core Principles

Principle 1: The values and principles driving priority setting at all levels of decision-making must be consistent.

Principle 2: NHSTWICB has a duty to provide a comprehensive healthcare service. Within that duty the NHS must meet all reasonable requirements for healthcare, subject to the duty to live within its allocated resources.

Principle 3: NHSTWICB has a responsibility to make rational decisions in determining the way it allocates resources to the services it directly commissions. It must act fairly in balancing competing claims on resources between different patient groups and individuals**.**

Principle 4: Competing needs of patients and services within the areas of responsibility of NHSTWICB should have an equal chance of being considered, subject to the capacity of NHSTWICB to conduct the necessary healthcare needs and services assessments. As far as is practicable, all potential calls on new and existing funds should be considered as part of a priority setting process. Services, clinicians, and individual patients should not be allowed to bypass normal priority setting processes.

Principle 5: Access to services should be governed, as far as practicable, by the principle of equal access for equal clinical need. Individual patients or groups should not be unjustifiably advantaged or disadvantaged on the basis of age, gender, sexuality, race, religion, lifestyle, occupation, social position, financial status, family status (including responsibility for dependants), intellectual / cognitive function or physical functions.

There are proven links between social inequalities and inequalities in health, health needs and access to healthcare. In making commissioning decisions, priority may be given to health services targeting the needs of sub-groups of the population who currently have poorer than average health outcomes (including morbidity and mortality) or poorer access to services.

Principle 6: NHSTWICB should only invest in treatments and services which are of proven cost-effectiveness unless it does so in the context of well-designed and properly conducted clinical trials that will enable the NHS to assess the effectiveness and/or value for money of a treatment or other healthcare intervention.

Principle 7: New treatments should be assessed for funding on a similar basis to decisions to continue to fund existing treatments, namely according to the principles of clinical effectiveness, safety, cost-effectiveness and then prioritised in a way which supports consistent and affordable decision-making.

Principle 8: NHSTWICB must ensure that the decisions it takes demonstrate value for money and an appropriate use of NHS funding based on the needs of the population it serves.

Principle 9: All NHS commissioned care for which NHSTWICB is responsible should be provided because of a decision by NHSTWICB. No other body or individual, other than those authorised to take decisions under the policies of NHSTWICB, has a mandate to commit NHSTWICB to fund any healthcare intervention unless directed to do so by the Secretary of State for Health.

Principle 10: NHSTWICB should strive, as far as is practical, to provide equal treatment to individuals in the same clinical circumstance where the healthcare intervention is clearly defined. NHSTWICB should not, therefore, agree to fund treatment for one patient which cannot be afforded for, and openly offered to, all patients with similar clinical circumstances and needs.

Principle 11: Interventions of proven effectiveness and cost-effectiveness should be prioritised above funding research and evaluation unless there are sound reasons for not doing so.

Principle 12: Because the capacity of the NHS to fund research is limited, requests for funding to support research on matters relevant to the health service must be subject to normal prioritisation processes.

Principle 13: If a treatment is provided within the NHS which has not been commissioned in advance by NHSTWICB save for those treatments approved by another responsible commissioner, the responsibility for ensuring on-going access to that treatment lies with the organisation that initiated treatment.

Principle 14: Patients participating in clinical trials are entitled to be informed about the outcome of the trial and to share any benefits resulting from having been in the trial. They should be fully informed of the arrangements for continuation of treatment after the trial has ended. The responsibility for this lies with the party initiating and funding the trial and not NHSTW ICB unless NHSTWICB has either funded the trial itself or agreed in advance to fund aftercare for patients entering the trial.

Principle 15: Unless the requested treatment is approved under existing policies of NHSTW ICB, in general it will not, except in exceptional circumstances, commission a continuation of privately funded treatment even if that treatment has been shown to have clinical benefit for the individual patient.

Appendix Two: Impact Assessment (IA)

Service Title		**ICB Lead**	
Executive Lead		**Clinical Lead**	

Service Details

Provider	
Service Description	
Contract Type / Duration	
Notice period required	
Cost per annum	
Cost per patient/service user	
Service metrics	
Reason for Consideration	
Other affected commissioners	

Assessment

Supporting information

Has the QIA been completed and submitted?	
Has the EQIA been completed and submitted?	

Please note: No submission will be considered at stage two without the QIA and EQIA having been fully completed and submitted alongside the IIA.

Recommendation

Decommission service	☐	Disinvest in service	☐	Continue service	☐
Invest in Service		Redesign Service			

Governance

Template completed by	
Date template completed	

For audit purposes please record the SCC decision below following the meeting:

Telford & Wrekin Co-operative Council

Protect, care and invest to create a better borough

Shropshire Council

Borough of Telford and Wrekin

Shropshire Health and Wellbeing Board

19th September 2024

Integrated Care Partnership (ICP) KPI and performance outcome monitoring update

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Organisation:	**Shropshire Council**	
Report Author/s:	**Jess Edwards** – Public Health Intelligence Manager, Shropshire Council	
Contact Details:	**Tel:**	**01743 258918**
	Email:	Jessica.Edwards@shropshire.gov.uk

1.0 Recommendations for decision/noting:

Committee is asked to approve:

1.1 That the Partnership review and comment on the outcome metrics including in this report

1.2 That the Partnership note the progress to date against the Integrated Care Strategy outcomes monitoring Framework and consider any additional or amended outcomes for consideration within the framework at the Partnership

2.0 Purpose of Report

2.1 This report provides an overview of the approach to Population Health Management (PHM) across the Integrated Care System. This report then specifically provides an update of the KPI and Performance Monitoring element of the work programme and specifically those metrics that relate to the Integrated Care Strategy which build on the Health and Wellbeing Boards, SHIPP and TWIPP Metrics.

3.0 Background

3.1 Population Health Management (PHM) is a way of working to understand current health and care needs and predict what local people will need in the future. It helps shape evidence-based actions to address these needs. This is used to inform and define commissioning intentions and planning of future services/ required outcomes for strategic planning/commissioning. It can also support those on the frontline, our local

communities and teams to understand and support actions to improve outcomes for example through local action planning and pathway redesign.

PHM uses historical and current data to understand what factors are driving poor outcomes in different population groups. The use of joined up data across local health and care partners and techniques like population segmentation and risk stratification can offer deeper insight into the holistic needs of different population groups and the drivers of health inequalities. Alongside the use of qualitative data sources and ad hoc research and evaluation as required.

At an Integrated Care System level, a Population Health Management Group has been established to oversee the work programme to deliver a population health management approach across the system. It is chaired by the Director of Public Health for Shropshire, with the vice chair the Director of Planning, Performance, BI & Analytics, and membership is comprised of the strategic lead and analytical lead for each partner organisation to drive the work forward.

Specifically, the purpose of the PHM group is to:

- To establish a system approach to embedding and leading Population Health Management approaches across all programmes of work and to co-ordinate the delivery of key programmes of work across the system including the prevention and inequalities

- To use all data (qualitative and quantitative and information, evidence of best practice to develop intelligence and insight in a systematic way to better understand, plan, deliver and ultimately improve our populations health and care whilst making best use of all available resources. This includes specifically informing strategy development and linking back into strategic plans

- To lead the approach across the system to benefits realisation, evaluation and monitoring of outcomes and impact

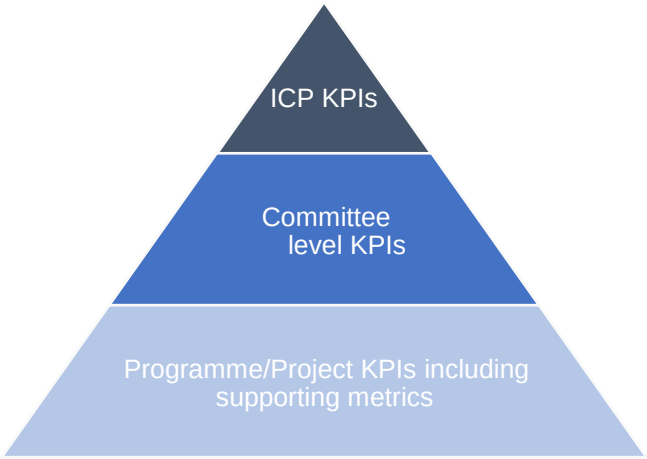
The PHM work programme is split into the following headings;

- Programme population health intelligence
- Health needs assessments
- Elective recovery
- KPI and performance outcome monitoring
- Modelling and forecasting
- Infrastructure

This report provides an update on the **KPI and performance outcome monitoring** element of the work programme and specifically the development of a framework for monitoring committee and Board level KPIs and outcomes including the Integrated Care Partnership outcomes.

KPIs and Monitoring including the Integrated Care Partnership Outcomes

A pyramid approach has been taken to monitor performance and impact of the Population Health Management programme. Multiple dashboards monitor programme delivery through key performance indicators and outcome measures. Key KPIs from programme dashboards will feed up to committee level and to the Integrated Care Partnership. The below infographics demonstrate this.

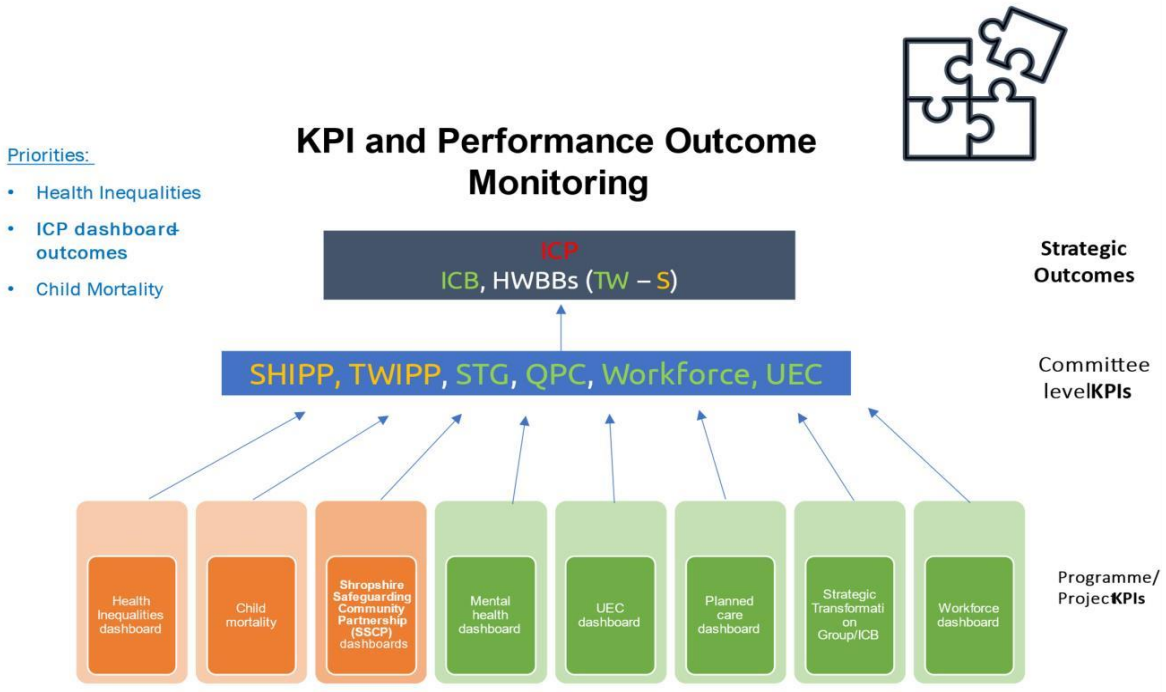


To determine a list of KPIs for reporting to the ICP Board, a long list of KPIs were collated from the:

- Shropshire Health and Wellbeing Board KPIs
- Telford and Wrekin Health and Wellbeing board KPIs
- SHIPP KPIs
- TWIPP KPIs
- Integrated strategy (owned by the Integrated Care Partnership)
- Committee level KPIs
- Programme/Project KPIs including supporting metrics

The list of metrics have been taken to each Board and Committee for consideration in draft before the final version is brought before this Partnership for sign off.

The Population Health Management Planning Group considered and agreed a short list of key performance indicators to report to the ICP board, as shown below.



Shropshire Council

Suggested ICP Board metrics

ICP Planning group met in June 2024. Agreed a short list of high-level metrics from a long list collated from both HWBBs, SHIPP, TWIPP and the Integrated strategy metrics

	KPI	Where from?	Metric
1	Increase healthy life expectancy in all people	Shropshire HWB strategy/ TW HW strategy/ Integrated Strategy	Healthy life expectancy at birth (male and female)
2	Improve life expectancy at birth and 65+ years	TW HWB Strategy	Life expectancy at birth and 65+ years (male and female)
3	Narrow the gaps in life expectancy and healthy life expectancy.	TW HWB Strategy/Integrated Strategy	Inequality in LE and HLE
4	Increase healthy life expectancy for those with Severe Mental Illness (SMI)	Shropshire HWB strategy/SHIPP/ Integrated Strategy/ TW HW Strategy	Premature mortality in adults with severe mental illness (SMI) and Excess under 75 mortality rate in adults with severe mental illness (SMI)
5	16-17s not in education, employment or training	Shropshire HWB strategy/SHIPP/ Integrated Strategy	16-17s not in education, employment or training
6	Excess under 75 mortality rate in adults with Severe Mental Illness (SMI)	Shropshire HWB strategy	Excess under 75 mortality for people with SMI
7	Improve infant and maternal health outcomes	TWC HW Strategy - Integrated neighbourhood health and care	Smoking status at the Time of Delivery
8	Improve infant and maternal health outcomes	SHIPP	Infant mortality rate
9	Diabetes treatment outcomes	Integrated Strategy	Treatment outcomes - diabetes care processes
10	Reduce preventable mortality	TWC HW Strategy - Protect, prevent and detect early	Under 75 mortality rate from cardiovascular diseases considered preventable
11	Reduce preventable mortality	TWC HW Strategy - Protect, prevent and detect early	Under 75 mortality rate from cancer considered preventable
12	Reduce preventable mortality	TWC HW Strategy - Protect, prevent and detect early	Under 75 mortality rate from causes considered preventable
13	E04b – Under 75 mortality rate from Cardiovascular diseases seen as preventable (2019 definition, 1 year range)	SHIPP	Under 75 mortality rate from Cardiovascular diseases seen as preventable (1 year range)
14	Reduce impact of ACEs on our communities	Integrated Strategy	Report at Place. Overarching position ICP level.
15	Increase the number of residents describing their community as a healthy, safe and positive place to live	Integrated Strategy	Number of residents describing their community as a healthy, safe and positive place to live
16	Increase the % of residents who report that they are able to access services they need, when they need them	Integrated Strategy	Tbc
17	Reduce carbon footprint generated through travel by patients to our services	Integrated Strategy	Carbon footprint of patients travelling to services
18	Early diagnosis and treatment for cancer	SHIPP	% cancers diagnosed at stage 1 and 2

While this first draft is brought before the Integrated Care Partnership to review, the expectation however is that the framework and the KPIs/Outcome metrics will be an ongoing development with senior leaders and members. Targets, tolerance and benchmarks will be set and clarified over the coming months with where possible, regular updates. Once agreed this dashboard would be published on the Intergrated Care System website. This will be the main source of performance information enabling greater insight, transparency and scrutiny of the ICS performance and delivery of its outcomes as set in the Integrated Care Strategy.

15.0 Appendices

A 10. Appendix A. ICP KPIs and Dashboard update - pr