Integrated Care System

Shropshire, Telford and Wrekin

Clinical Strategy Refresh 2026-2031

NHS STW January 2026

NHS Shropshire, Telford and Wrekin Clinical Strategy Refresh

Background

The Government's NHS 10 Year Plan focuses on prevention, stronger community and mental health services, tackling inequalities and using digital innovation. This closely reflects the needs of Shropshire, Telford and Wrekin.

- The area's large rural geography creates access challenges, while an ageing population drives rising demand for complex, long-term care.
- Significant health inequalities persist between deprived urban areas and rural communities.
- Ongoing workforce shortages add pressure to already stretched services, reinforcing the need for more integrated and sustainable models of care.

Together, these factors underline the importance of system transformation, particularly the Neighbourhood Health Model and strengthened Primary Care to reduce hospital demand and improve outcomes.

Our Vision

Our vision is to ensure that every person in Shropshire, Telford and Wrekin can live a healthy, fulfilling life supported by safe, high-quality, and joined-up health and care.

We will use clinical leadership, population health intelligence, and evidence-based practice to design and commission services that prevent illness, reduce inequalities, and empower people and communities to stay well and live independently for longer.

This vision reflects our shared commitment as an Integrated Care Board (ICB) and Integrated Care System (ICS) to transform health and care for the population of Shropshire, Telford and Wrekin, ensuring that clinical leadership is at the heart of every decision made.

Our Ambition

Through strong clinical leadership, partnership working, and intelligent use of data and population health insight, the following clinical strategy aims to:

- Prevent illness and intervene early to reduce avoidable demand
- Improve outcomes and quality of life for people with long-term conditions
- Reduce unwarranted variation and inequalities in access and outcomes
- Deliver care closer to home, making services more accessible and person-centred
- Embed innovation and sustainability as core principles of system design.

Clinical Strategy Stages

Start Well - Grow Well - Live Well - Age Well - End Well

Health needs and priorities vary at different stages of our lives; therefore, our clinical priorities are described across the life course:

- **Start Well** 0-5 years
- **Grow Well** 6-18 years
- **Live Well** 19-64 years
- **Age Well** 65+ years
- **End Well** All ages

Start Well: 0-5 years

The early years are crucial for lifelong health, but outcomes across Shropshire, Telford and Wrekin are mixed.

Healthy pregnancy behaviours, such as taking folic acid, avoiding smoking and alcohol, and early midwifery booking, are less common locally than regionally and nationally, particularly in Telford and Wrekin.

Infant mortality is higher in Telford and Wrekin, though Shropshire performs better; both areas show positive results for breastfeeding, low-birth weight and pre-term birth rates.

Vaccination uptake exceeds regional and national averages but still falls short of the 95% ambition - coverage is strong in Telford and Wrekin but lower in Shropshire.

Healthy weight and oral health remain challenges, with overweight/obesity in reception-aged children above national levels and significant dental decay, especially in Telford and Wrekin. Emergency admission rates for 0–4-year-olds are also higher than regional and national averages, despite comparatively lower A&E attendance.

How we will tackle our priorities:

We will focus on prevention, mental health, physical health and collaboration to improve outcomes in early childhood.

- Prevention efforts include:
  - Expanding access to pre-conception and early maternity care
  - Reducing smoking and alcohol use in pregnancy
  - Increasing breastfeeding and early postnatal visits
  - Boosting uptake of vaccinations and development checks, and
  - Promoting healthy environments to reduce childhood obesity.

- Mental health priorities centre on timely perinatal mental health support and early help for parents experiencing mental illness or substance misuse.

- For physical health, we will use population health data to identify and address inequalities in maternity care, reduce infant mortality, support early childhood development, improve dental health, and target children at higher risk of hospital admission.

- A collaborative approach will ensure services are shaped around children and families through Family Hubs, integrating community support, education and early intervention in partnership with parents and carers.

Grow Well: 6-18 years

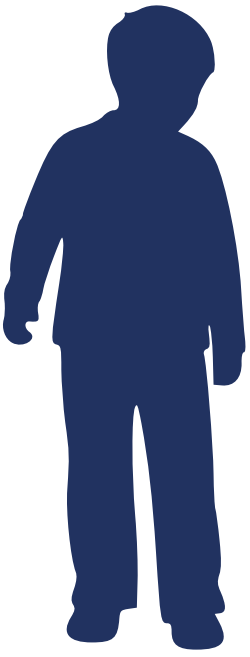
Childhood and adolescence are crucial periods where supportive environments and early intervention can shape lifelong health. However, many children in Shropshire, Telford and Wrekin face significant challenges, including higher rates of being in care and greater emotional wellbeing concerns compared with regional and national averages.

Health inequalities become more evident during these years, with elevated levels of social, emotional and mental health needs, substance misuse admissions, and alcohol-related admissions in Shropshire. Overweight and obesity remain widespread, particularly in Telford and Wrekin. Young people with long-term conditions such as asthma and diabetes often experience higher hospital admission rates locally, especially in Telford and Wrekin - highlighting the need for better support in managing their conditions.

Despite some positive indicators, such as lower admissions for self-harm, overall patterns show a clear need to strengthen support for physical, mental and social development to help all children achieve their full potential.

How we will tackle our priorities:

- We will strengthen prevention and safeguarding by promoting healthy choices, reducing obesity and Type 2 diabetes, improving oral health, tackling smoking, vaping, alcohol and substance misuse, and providing early, integrated support for children affected by adverse experiences.
- Working with partners through the Families First Programme will enhance safeguarding for the most vulnerable.
- In mental health, learning disabilities and autism, we will improve timely assessment and support for neurodiverse children and those with Special Educational Needs and Disabilities (SEND), expand preventive work in Child and Adolescent Mental Health Services (CAMHS), and ensure rapid access to routine and crisis mental health care.
- For physical health, new Integrated Neighbourhood Teams (INTs) will provide coordinated community support for children with complex needs.
- We will reduce health inequalities through children and young people Core20PLUS5, focusing on deprived communities and conditions such as epilepsy, asthma, diabetes and mental health.
- We will also work to lower hospital admissions linked to long-term conditions and risky behaviours and improve transitions into adult services.
- Across all areas, children and young people will be actively involved in collaboratively shaping the services they use.



Live Well: 19-64 years

Adulthood brings diverse life events and changing health needs, ranging from occasional Primary Care, for generally healthy adults, to coordinated, specialist support for those with complex conditions. Using population health management helps tailor services by identifying groups with similar needs and highlighting inequalities.

Empowering adults to take ownership of their health is essential, as around 40% of illness is preventable. Although people are living longer, many spend more years in poor health, particularly in Telford and Wrekin, where healthy life expectancy is well below national averages. Long-term conditions such as heart disease, diabetes, chronic kidney disease, asthma and musculoskeletal problems are more common locally, and suicide rates are higher despite slightly lower overall mental health prevalence.

Improving outcomes requires supporting healthier lifestyles, addressing social factors, and intervening early through proactive identification of risks - such as obesity, hypertension and undiagnosed cancers. Better use of shared records and risk stratification (a tool that categorises patients in low, medium and high-risk groups) will help predict need, prevent disease, and reduce the impact of long-term conditions across the adult population.

How we will tackle our priorities:

- We will prioritise prevention and early identification of health issues - promoting healthier lifestyles and supporting healthy ageing.
- Risk-based approaches will target those at greatest need, reducing premature illness and death from major long-term conditions and addressing inequalities, including in women's health.
- We will reduce the impact of musculoskeletal and mental health problems and improve early cancer detection.
- Mental health services will offer quicker access to routine and crisis support, with more annual physical health checks for people with learning disabilities, autism and serious mental illness.
- Across all areas, services will be shaped collaboratively with residents and people with lived experience.

Age Well: 65+ years

Ageing well is key to preserving independence and quality of life, with physical, mental and social activity helping to prevent frailty, dementia and isolation. Yet older residents in Shropshire, Telford and Wrekin spend many years in poor health, with large inequalities between the most and least deprived.

The area has a higher proportion of older adults than the national average, and many are living with frailty, increasing the risk of falls, hospitalisation and long-term care – even though frailty can often be prevented or managed.

While fall-related admissions are lower than nationally, dementia prevalence is higher in Shropshire and diagnosis rates are low across both areas.

Mental health needs frequently go unrecognised, and alcohol-related hospital admissions in over-65s are significantly higher, especially among women.

How we will tackle our priorities:

- We will focus on prevention by supporting older adults to stay active, connected and independent through community-based programmes that reduce frailty, prevent falls and tackle social isolation. Using population health insights, we will proactively identify those at risk and offer tailored support, while promoting positive attitudes toward ageing.
- For physical health, Integrated Neighbourhood Teams and rapid community response services will help people receive care at home, even during crises. We will reduce the impact of long-term and musculoskeletal conditions, expand personalised care for those with complex needs, increase access to comprehensive geriatric assessments and care planning, and work to lower avoidable falls and emergency admissions.
- In mental health, we will improve dementia diagnosis and support and increase access to talking therapies and crisis services for older adults, ensuring these are integrated into wider frailty care.
- Collaboration will be central, with older people actively involved in shaping how services are planned and delivered.

End Well: All Ages

High-quality palliative and end-of-life care ensures people can live as well as possible in their final stages of life, with care that reflects their wishes and supports families and carers. Personalised, advanced care planning improves wellbeing and symptom management by aligning care with what matters most to each person.
Most people prefer to die at home, and community-based palliative care and hospices play a key role in enabling this. Shropshire, Telford and Wrekin have slightly fewer hospital deaths than the national average and similar proportions of home deaths, though patterns vary by age. Although the area has fewer residents with three or more emergency admissions at the end of life than the national average, rates have risen over time, and admissions remain slightly higher for those under 75.

How we will tackle our priorities:

- We will improve early identification of people in their last year of life and offer personalised, values-based care through high-quality advance care planning. Population health management will help us address inequalities in access and outcomes for palliative and end-of-life care.

- Advance care plans will be strengthened, made digitally accessible to clinicians, and used to ensure care aligns with each person's wishes. We will ensure timely, high-quality palliative care for all, including children and young people, enabling more people to die with dignity in their preferred place.
- Community assets and social networks will be used to support people and families during end of life and bereavement. Partners and people with lived experience will be central to shaping local services.

The important role of our partners

Primary Care forms the clinical foundation of neighbourhood teams, providing continuity, proactive population health management and accessible support through GPs, community pharmacies, dental teams, optometrists and audiologists. These services play a vital role in prevention, early detection and supporting independence, particularly for older people.

Community Services act as system integrators, providing the infrastructure for Integrated Neighbourhood Teams and driving place-based, preventative models. Working with Primary Care Networks (PCNs) and the Voluntary, Community, Social Enterprise (VCSE) sector, they co-locate teams, embed relational care and enable seamless neighbourhood-level support.

Acute Services contribute specialist expertise, reconfigure pathways and deliver diagnostics and outpatient care closer to home. Through shared data and joint planning, they help shift the system from reactive to preventative, supporting integrated care across settings.

Mental Health Services embed psychosocial, preventative and recovery-focused care within neighbourhood models. Community mental health hubs offer accessible support, avoiding unnecessary A&E use. Mental health specialists bring crisis response and trauma-informed expertise and are embedded in neighbourhood teams.

Ambulance Trusts optimise urgent care pathways, collaborate with Primary and Community Services, support prevention and use digital tools to reduce avoidable conveyance.

VCSE organisations deliver community-based, socially focused support, bridging gaps for people facing inequality or complex circumstances and leading key prevention programmes.

Local Government provides public health expertise, democratic accountability, and responsibility for wider determinants, shaping shared population health plans and aligning social care and children's services with NHS priorities.

Adult Social Care is essential for personalised, consistent neighbourhood support, particularly for people with complex needs, co-leading proactive, preventative care.

Independent Sector Providers offer high-quality respite, learning disability and autism support, and residential and nursing care when needed.

ICB and Place-Based Partnerships provide the strategic commissioning and local decision-making needed to tailor neighbourhood health services, develop population health plans, align priorities and monitor outcomes based on local needs and assets.

How this will feel different to our patients and residents

Neighbourhood health: More of what you need for good health and wellbeing; closer to your home; planned around the needs of your community; and reducing the need to travel to hospitals unless absolutely necessary.

Seamless experience: Care should feel more like one fluid service enabled by digital shared care records keeping everyone informed about your care. The NHS App will become the 'front door' - shifting power to patients via AI-powered advice, appointment booking, self-referral, medicines management and care plans.

Stronger local voice: Neighbourhood plans and service design will be shaped by the voices of residents and community leaders, working with clinicians and managers, and using a strengths-based approach, to ensure build on community assets and better understand people's needs.

More proactive support: Early warning through data sharing, joined up teams, and dedicated 'population health' roles mean we can optimise care, identify risks and act on them before they become crises. We will use care-planning to ensure a personalised approach that will empower residents to take control of their health and the care they receive. We will use digital shared care plans and ensure everyone involved in their care can access them.

Increased prevention: We will focus on supporting people to make healthy choices and improve access to services which help to manage risk factors for disease, such as obesity. We will identify risk factors, such as hypertension, early and take action to treat and control these.

Improved management of long-term conditions: We will focus on early diagnosis of long-term conditions and better support for people to self-manage. We will improve monitoring to improve treatment and prevent complications through access to multi-disciplinary (MDT) support and working in partnership with hospital and community specialist teams. We will respond quickly where risk is rising to prevent crises and offer care in a community setting for a wider range of conditions that are currently managed in hospital.