NHS STW Integrated Care Board - Appendix Pack

MEETING

25 June 2025 14:00 BST

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ICB 25-06.176

System Board Assurance Framework (SBAF & SORR) ICB

Due to the size of these papers, appendices A, B, C and D can be found at this link: SBAF and SORR Appendices - 25 June 2025

Agenda Item

ICB 25-06.177

Health Inequalities

Appendix 1 – Quarter 4 2025/26 Programme Highlight Reports

Appendix 2 – 2025/26 Summary of Planned Action

Integrated Care System
Shropshire, Telford and Wrekin

NHS
Shropshire, Telford and Wrekin

Healthcare Inequalities Highlight Report

Report details:

Report Period: January – March 2025 (Quarter 4)
Date: 16th May 2025

Progress Summary (Year to Date)

Programme	Lead	Status
KLOE 1: Inclusive Recovery		
Elective Recovery	Maureen Wain	No deliverables identified in-year
Waiting Well	Mike Carr/Steph Wilson	5/5 deliverables completed = 100%
Urgent & Emergency Care	Gareth Wright	5/9 deliverables completed = 56%
KLOE 2: Mitigating Digital Exclusion		
Digital Transformation	David Maruta	3/6 deliverables completed = 50%
KLOE 3: Complete & Timely Datasets		
Collective Intelligence and Population Health Management Programme	Alexander Neale	4/5 deliverables completed = 80%
KLOE 4: Accelerating Preventative Programmes		
A System Approach to Smoke-free	Lorna Watkins	5/7 deliverables completed = 71%
Weight Management	Marlene Goncalves	24/25 deliverables completed = 96%
Drug and Alcohol	Claire Eagleton	5/7 deliverables completed = 71%
Learning Disability Annual Health Checks	Rachel Rogers	7/7 deliverables completed = 100%
Maternity & Neonatal Services	Sue Bull	14/19 deliverables completed = 74%
Severe Mental Illness (SMI) Physical Health Checks	Claire Parrish	6/6 deliverables completed = 100%
System Vaccinations	Stuart McClymont/ Wayne Jones	8/8 deliverables completed = 100%
Cancer Improvement	Imogen Darbhanga/ Sophie Yeomans	10/11 deliverables completed = 91%
Cardiovascular (CVD) Prevention	Lorna Watkins	7/9 deliverables completed = 78%
Children & Young People's (CYP) Asthma	Helen White	6/9 deliverables completed = 67%
Children & Young People's (CYP) Epilepsy	Helen White	6/10 deliverables completed = 60%
Children & Young People's (CYP) Diabetes	Marlene Goncalves	3/4 deliverables completed = 75%
Children & Young People's (CYP) Oral Health	Anna Hunt	9/12 deliverables completed = 75%
Children & Young People's (CYP) Mental Health	Barrie Reis-Seymour/ Anna Deacon	4/6 deliverables completed = 67%
KLOE 5: Leadership & Accountability		
Leadership Programme	Tracey Jones/Alex Mace	26/34 deliverables completed = 74%

Health Inequalities Group Highlight Report

KLOE 1: Inclusive Recovery

Using data to understand and address unwarranted variation in referral rates and NHS waiting lists and supporting people to wait well.

Elective Recovery Programme

Programme	Elective Recovery Improvement Programme	**Lead/s**	Maureen Wain, Director of Elective Care, Cancer and Diagnostics and Head of Service Improvement, NHS Shropshire, Telford & Wrekin ICB
Key/statutory health inequality targets	• Use waiting list data (pre and during pandemic), including for clinically prioritised cohorts, to identify disparities in relation to the bottom 20% by Index of Multiple Deprivation (IMD) and black and minority ethnic populations • Prioritise service delivery by taking account of the bottom 20% by IMD and black and minority ethnic populations for patients on the waiting list and not on the waiting list, including through proactive case finding • Use system performance frameworks to measure access, experience and outcomes for black and minority ethnic populations and those in the bottom 20% of IMD scores • Evaluate the impact of elective recovery plans on addressing pre-pandemic and pandemic-related disparities in waiting lists, including for clinically prioritised cohorts	**Responsible committee**	Planned Care Delivery Group (PCDG)

Brief Summary and Highlights

- Led by the ICB, a System Reforming Elective Care Group is being established with key stakeholders to oversee delivery of key actions being identified to enact the national Reforming Elective Care for Patients guidance released in January 2025. The following four working groups are also being established, which will report into the System Reforming Elective Care Group:
  - Empowering Patients
  - Care in the Right Place
  - Recovery and Delivery
  - Enablers

  A key focus of the guidance is around Health Inequalities improvement, setting out that delivering the 18 week standard and reforming elective care must be done equitably and inclusively. Although discussions around reducing Healthcare Inequalities will be part of the discussions for each group, the Empowering Patients Group will be the key vehicle to addressing healthcare inequalities in elective care. This working group, when established, will set a clear local vision for how health inequalities will be reduced as part of elective care reform, and ensure interventions are in place to reduce disparities for groups who face additional waiting list challenges. The group will also focus on patient awareness and communication, ensuring that patients and their carers are aware of their right to choose their care.

Discussions are ongoing with system providers and a workshop is being held on 15th May 2025 to further discuss the matrix for the working groups, with the potential for separate Recovery and Delivery groups to be undertaken internally within the individual Trusts.

- It has been agreed via Planned Care Working Group that system providers will share delineated performance reports and waiting lists split by ethnicity and IMD decile. On further discussion, it has been agreed by the group Chair that this information will firstly be taken to the Reforming Elective Care Group, with data packs then shared to Planned Care Delivery Board as part of the governance process. Receipt of this information will support standardising and receiving assurance on the disaggregation of elective waiting lists across all Trusts and will facilitate local discussions on waiting list prioritisation.

- Work is being undertaken with the Referral Management Centre to introduce a text messaging system for patients. Discussions are being held with the Healthcare Inequalities Team as part of the Integrated Impact Assessment (IIA) process to ensure equitable access for those without access to a mobile phone, or who struggle to engage with digital technology.

Planned deliverables (During the reporting period)	Due	Delivered? (Yes / No)	If not on-plan or not started, please reason why and what actions are being done to progress this?	If not on plan or not started, has this been escalated to the responsible committee?
No deliverables planned for this reporting period.				

Waiting Well Programme

Programme	Waiting Well	**Lead/s**	Mike Carr, COO & Deputy CEO, Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust (RJAH) Steph Wilson, Performance Insight and Improvement Manager, Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust (RJAH)
Key/statutory health inequality targets	Continue to address health inequalities and deliver on the Core20PLUS5 approach, for adults and children and young people	**Responsible committee**	MSK Health Inequalities Group Reporting into the Planned Care Delivery Group (PCDG)

Brief Summary and Highlights

- Local Authority colleagues from Shropshire and Telford have been in attendance of the RJAH-led Health Inequalities working group as part of discussions and action to signpost to available lifestyle services i.e. smoking cessation and weight management. This work will further evolve as part of ongoing transformation to improve the pre-operative pathway for patients into 2025/26.

- A roadmap for Health Inequalities continued focus at RJAH was shared with the system in April 2025. Waiting well clinical priorities will be part of pre-operative pathway transformation during 2025/26.

Planned deliverables (During the reporting period)	Due	Delivered? (Yes / No)	If not on-plan or not started, please reason why and what actions are being done to progress this?	If not on plan or not started, has this been escalated to the responsible committee?
Established STW MSK Health Inequalities Group	Q2	Yes		
STW MSK Health Inequalities Group Terms of Reference	Q2	Yes		
Lifestyle services embedded within Trust sites	Q4	Yes		
Lifestyle signposting embedded in MSK pathways	Q4	Yes		
Proposal taken to System Prevention and Health Inequalities Group for waiting well clinical priorities in 2025/26	Q4	Yes		

Urgent and Emergency Care Transformation Programme

Programme	Urgent and Emergency Care Transformation	**Lead/s**	Gareth Wright, Head of Clinical Operations (UEC), NHS Shropshire, Telford & Wrekin ICB
Key/statutory health inequality targets	• Expand coverage of high intensity use services as a cost-effective intervention to both manage A&E demand and address health inequalities. • Reduce admitted and non-admitted time in emergency departments, in particular arranging appropriate services for mental health patients requiring urgent care • Address inequalities in A&E using other initiatives to deliver on the Core20PLUS5 approach, as the most frequent users are highly likely to be from the Core20PLUS populations.	**Responsible committee**	System Urgent and Emergency Care (UEC) Delivery Group

Brief Summary and Highlights

- Data sharing arrangements recommenced between SaTH and British Red Cross in March 2025. This has enabled a new patient cohort to be identified for the Positive Lives Service leads to support.

  Information is presented quarterly by the British Red Cross on patients supported, which identifies any individuals specifically from Core20PLUS groups. Discussions will take place with British Red Cross around increasing their focus on support for those from Core20PLUS groups as part of the 2025/26 STW Healthcare Inequalities Implementation Plan. This will enable the recommenced data sharing process with SaTH to be embedded.

- Work relating to the introduction of an equitable approach to offering free, non-emergency patient transportation NEPTs) has experienced some challenges in that there is currently no national policy available linked to prioritisation. This has impacted on conversations being taken forward and has therefore

caused delays. Discussions continue to take place with the national team as a national policy, however, if no national guidance becomes available, a local policy will be considered.

An Audit has been undertaken in the meantime, led by the Quality Team, around the application of the eligibility criteria for NEPTs following concern that a standardised process is not in place within the hospital setting supporting discharges. The outcome of this audit will support the Team in progressing the new eligibility criteria which will consider inequalities.

Planned deliverables (During the reporting period)	Due	Delivered? (Yes / No)	If not on-plan or not started, please reason why and what actions are being done to progress this?	If not on plan or not started, has this been escalated to the responsible committee?
Positive Lives (High Intensity User Services)				
Outcomes of discussions around HIU service and access to data	Q2	Yes		
Increase activity within the Positive Lives initiative in partnership with the British Red Cross.	Q3	No	Following known difficulties in re-establishing the data flow with SaTH, which was exacerbated by SaTH's Data Warehouse challenges, the data sharing to British Red Cross recommenced in March 2025. Further time needs to be allowed to embed the new process. The aim is to hold discussions with the British Red Cross around focusing their cohort on the Core20PLUS populations as part of the 2025/26 STW Healthcare Inequalities Implementation Plan.	UEC Delivery Group has been kept updated on the position. No escalation required at this stage as deliverables will be set and tracked as part of 2025/26 UEC Improvement and Healthcare Inequalities Implementation Plans.
Supporting people with Mental Health in the Emergency Department				
Initial receipt/awareness of information on new ED Policy for mental health patients.	Q2	Yes		
New NHSE Midlands policy on escalation of long waits for MH patients implemented.	Q3	Yes		
COPD Targeted Winter Support				
Patients identified from Shrewsbury PCN for COPD support in Q3	Q2	Yes		
A new COPD focus of winter illness clinics delivered by primary care.	Q4	No	This project was unfortunately delayed due to national	UEC Delivery Group has been kept updated on the position. No

			funding being withdrawn. Extensive discussions have taken place with the ICB Health Inequalities Team and it has been agreed that this project will be revisited as part of plans for UEC improvement in 2025/26 and that it will form one of three priority projects in the 2025/26 STW Healthcare Inequalities Implementation Plan, with a targeted focus on patients living in the 20% most deprived areas across Shropshire and Telford & Wrekin.	escalation is required as clear milestones, actions and deliverables will be set and monitored as part of the 2025/26 STW Healthcare Inequalities Implementation Plan.
Equitable Approaches to Patient Transportation				
Agreed local NEPT eligibility criteria which takes into account inequalities.	Q3	No	This area has experienced challenges in that there is currently no national policy available linked to prioritisation, which has caused a delay in conversations being taken forward. This is being raised continuously via the national team. Work will continue to take place into 2025/26 to explore the possibility of a national or local policy and this will be monitored outside of the quarterly healthcare inequalities implementation plan monitoring process due to other priority projects being allocated for monitoring in the 2025/26 plan.	Regular updates are shared to the Sustainability Working Group due to the financial savings required within the ICB efficiency programme. Actions are in place to continue progressing this area and therefore no escalation is required at this stage.
Project Plan for implementing a local reimbursement scheme for travel to appointments.	Q4	No	The project has been unable to be realised due to challenges linked to the national initiative for reimbursement for renal	Regular updates shared to the Sustainability Working Group due to the financial savings required within the ICB efficiency programme.

			patients. Moving into 2025/26, any work relating to the removal of barriers relating to travel to appointments will be undertaken as part of Elective Reform and based on qualitative and quantitative findings.	
Equitable Approaches to Patient Transportation				
Delivered phase of Think Which Service Campaign which includes material accessible to Core20PLUS populations.	Q3	Yes		

KLOE 2: Mitigating Digital Inclusion

Ensuring face-to-face care is available for those who cannot access digital/remote services and implementing action to support populations to become digitally enabled.

Digital Transformation Programme

Programme	Digital Transformation Programme	**Lead/s**	David Maruta, Head of Digital, NHS Shropshire, Telford & Wrekin ICB Alexandra Mace, Healthcare Inequalities Partnership Lead Shropshire, Telford & Wrekin ICB
Key/statutory health inequality targets	• Providers offer face-to-face care to patients who cannot use remote services • More complete data collection is carried out, to identify who is accessing face-to-face, telephone, or video consultations, broken down by relevant protected characteristic and health inclusion groups • Systems take account of their assessment of the impact of digital consultation channels on patient access. • Implementing the framework for NHS action on digital inclusion	**Responsible committee**	Digital Delivery Group

Brief Summary and Highlights

- **Digital Inclusion Initiatives**: A set of strategic pillars and programmes have been agreed across the system linked to the System's Digital Strategy, aligned with national priorities. An ICS Digital proposal to address digital inclusion has been discussed and reviewed with system partners. Whilst this had initially intended to identify a series of digital inclusion design principals, this has instead focused on tangible improvement initiatives with a view to embedding digital inclusion more firmly in systematic design processes as part of 2025/26 improvement plans. As a result, several digital inclusion initiatives were been identified, with confirmed funding. The initiatives include:
  - NHSApp Adoption

- Patient Engagement Portals - Wayfinder
- Reasonable Adjustment Digital Flag
- Workforce Digital Skills*
- Resident's Digital Skills and Access

These initiatives will be mapped against the NHSE Digital Inclusion Framework to ensure they align with national standards and contribute effectively to improving digital access across the system. This will be incorporated into discussions with the ICB's Health Inequalities Team.

Work has taken place with the ICB Health Inequalities Team to bring together system partners and identify key priority improvement areas for 2025/26. This is with the aim of co-developing a 2-year Digital Inclusion Plan which will identify specifically improvement initiatives focused solely on mitigating against digital exclusion, taking into account how the system will ensure mitigations are in place to reduce the risk of excluding communities who are not digitally enabled amidst the increasing shift to digitally provided services. In aid of this work, two workshops were held in February and April 2025 with partners from across Local Authority, ICB, Trusts and Primary Care to understand:

- Work that is currently taking place to mitigate against digital exclusion.
- Opportunities for improvement and where partners felt we could collectively do more to improve outcomes for our digitally excluded communities.

The outputs of this work to date have led to a series of identified themes for improvement. These themes have since been used to generate ideas on tangible actions which could realistically be delivered by partners over the next two years. These project areas are currently being discussed and shared with broader stakeholders, such as the Voluntary and Community Sector, however, key areas of focus are likely to include:

- **Access to Digital Services**: Tracking the number of individuals and communities accessing digital health services, broken down by key demographic groups and health inequalities factors, as well as empowering people to use digital services through the use of targeted initiatives such as expanding on existing Digital Champion schemes and offers of free devices and data.
- **Digital Engagement**: Measuring patient engagement with digital tools, such as the NHSApp and patient portals, and identifying barriers to usage for those facing digital exclusion.
- **Digital Skills Gap Assessments**: Evaluating the digital skills gap across the workforce and local communities, with a particular focus on under-served populations (Core20PLUS) and those in need of digital skills training to engage effectively and benefit from the use of digital health services.
- **Impact on Health and Healthcare Inequalities**: In collaboration with the Business Intelligence (BI) and Performance teams, defining how to measure digital inclusion and exclusion, as well as the direct impact of digital inclusion efforts on reducing health inequalities. This will involve developing metrics to assess whether digital initiatives are helping to address disparities in access to care and health outcomes.

- ***Funding for Initiatives:** The establishment of a Digital Skills Network has been included within the ICBs Hard Decisions Framework and process due to the financial requirements and limited funding available. The paper was presented to the Hard Decisions Committee along with other ICB initiatives requiring funding. It is awaiting a decision once the committee has completed its scoring by the end of Quarter 1 2025/26.
- **System-Wide Digital Inclusion Group**: It has been agreed that a system-wide Digital Inclusion Stakeholder Group will be established to oversee and coordinate digital inclusion efforts across the ICS. This group will ensure alignment, share best practice, and monitor the progress of all initiatives agreed further to the Digital Inclusion Plan engagement and development work led by the ICB Health Inequalities Team. Membership and dates are being agreed, with a proposal to hold the initial meeting in June 2025.

- **Identified Digital Inclusion Measures**: It has been agreed to postpone work to identify digital inclusion measures until the establishment of the Digital Inclusion Steering Group. This is to ensure that the identification and agreement of measures for digital inclusion and exclusion are unanimously agreed with all key system partners for consistency.

- **Digital Accessibility Policy**: The Digital Accessibility Policy, written by the Communications Team, was reviewed at the Commissioning Working Group in April 2025. This policy aims to ensure that all digital services are accessible to everyone, particularly those facing digital exclusion. Feedback from the group is being considered to strengthen the policy, with input and support from the STW ICB Quality and Health Inequalities Teams to ensure a strong focus on Accessible Information Standards (AIS) and Health Literacy.

Planned deliverables (During the reporting period)	Due	Delivered? (Yes / No)	If not on-plan or not started, please reason why and what actions are being done to progress this?	If not on plan or not started, has this been escalated to the responsible committee?
Digital Inclusion as a Priority				
ICS Digital position paper describing the need for Digital Inclusion as a priority is agreed by ICB SLT	Q3	Yes		
Digital Inclusion is a key strand throughout System Digital Strategy	Q3	Yes		
Digital exclusion is incorporated into STW Integrated Impact assessment documentation	Q4	No	This work is now being taken forward by the ICB Quality and Health Inequalities Teams who are developing a new, user-friendly EQIA template alongside supportive guidance. This guidance will highlight digital exclusion, ensuring that the impact of digital access on different groups is considered in all relevant projects.	Not escalated as actions are in progress.
Digital Inclusion Campaigns, Awareness and Upskilling				
Paper approved by SLT on the establishment of a Digital Skills Network for staff across the system.	Q4	No	The establishment of a Digital Skills Network has been included within the ICBs Hard Decisions Framework and process due to the financial requirements and limited funding available. The paper was presented to the Hard Decisions Committee along with other ICB initiatives requiring funding. It is awaiting a decision once the committee has completed its scoring by the end of Quarter 1 2025/26.	Not escalated as actions are in progress.
Digital Inclusion Measures				
Agreed core 'digital inclusion measures' for measuring impact throughout 2025/26.	Q4	No	This work has been intentionally delayed so as to form part of the newly established Digital Inclusion Steering Group, with all key and relevant	Not escalated as actions are in progress.

			stakeholders involved in identifying and agreeing how the system will consistently measure digital inclusion and exclusion. This work has been in an early engagement phase, working with leads to identify core priority projects for 2025/26. This includes the identification and agreement of measures and methods/tools to monitor them.	
System-wide Design Principles for Digital Enabled Health and Care Services				
An ICS Digital proposal for ICS-wide digital inclusion design principles using the NHSE Digital Inclusion Framework	Q4	Yes		

KLOE 3: Complete and Timely Datasets

Improving our collection of ethnicity data across primary care, outpatient, A&E, mental health and community services to enable proactive population health management approaches using locally developed data dashboards and tools.

Collective Intelligence, KPIs and PHM

Programme	Collective Intelligence, Key Performance Indicators (KPIs) and Population Health Management (PHM)	**Lead/s**	Alex Neale, Senior Strategic Analytics Lead, NHS Shropshire, Telford & Wrekin ICB
Key/statutory health inequality targets	Continue to address health inequalities and deliver on the Core20PLUS5 approach, for adults and children and young people	**Responsible committee**	Analytics, Intelligence and Data Group reporting into the Population Health Management Group

Brief Summary and Highlights

- The Population Health Management/Health Inequalities Dashboard developed by the ICB's Business and Intelligence Team was launched in Quarter 4. Further updates are due to be made in May 2025 following feedback from User Testing. Information in the Dashboard aligns particularly to the mandated metrics included in the national Statement of Information on Health Inequalities. A key benefit of the Dashboard is that it supports visibility of any change in metrics over time. There has been praise for the ICB's Dashboard from the Regional NHS England Team.

  NHS England has commissioned NHS Midlands & Lancashire CSU to develop a national Health Inequalities Dashboard. This is being progressed and should be made available to ICBs in Quarter 1, 2025/26. This will complement the local Health Inequalities Dashboard, particularly by enabling access to benchmarking against comparable ICBs, and further support reporting against the Statement of Information metrics. On release, the focus of the ICB's local Dashboard can transition to be used primarily to inform and target service improvements at a local level.

- The Team continues to engage with System Trust providers around improved demographic data capture linked to health inequalities, particularly for their waiting lists. This information will subsequently be used to map to wider determinants of health inequalities.

Planned deliverables (During the reporting period)	Due	Delivered? (Yes / No)	If not on-plan or not started, please reason why and what actions are being done to progress this?	If not on plan or not started, has this been escalated to the responsible committee?
Improvement in Ethnicity Recording				
Agreed ethnicity recording Data Quality Improvement Plan (DQIP) in Provider Contracts.	Q2	Yes		
Provider ethnicity capture actions plans for improvement agreed.	Q2	Yes		
Providers held to account by ethnicity recording Data Quality Improvement Plan.	Q3	Yes		
Development of Tools and Dashboards				
Create a PHM/HI based Dashboard aligned to the national statement metrics, to support the standardised benchmarking approach being delivered by the MLCSU team.	Q3	Yes		
Implementation of Cross-system Data-sharing Platforms				
To allow the hosting of system partner data platforms and provide accessibility for self-serve analytics.	Q4	No	The ICB environment, the "White Label" System, has been created by the BI Team, but is still in the design and development phase. Once all data has been added, interoperability and access for system partners will be explored. Timescales now proposed are after mid-June, to enable SaTH's 2024/25 data once submitted to be incorporated. This will inform the future programme of work.	Regular updates are shared via the System Analyst, Intelligence Data Group and the System Digital Group. No escalation is required at this stage as plan to progress this piece of work will be revisited and refreshed following successful submission of SaTH's 2024/25 data.

KLOE 4: Accelerating Preventative Programmes

Driving forward preventative programmes aligned to the NHS Long Term Plan Prevention Priorities and Core20PLUS5 for Adults and Children & Young People.

A System Approach to Smoke-free

Programme	A System Approach to Smoke-free	**Lead/s**	Lorna Watkins, Strategy Development Manager, NHS Shropshire, Telford & Wrekin ICB
Key/statutory health inequality targets	Continue to address health inequalities and deliver on the Core20PLUS5 approach, for adults and children and young people (Smoking Cessation)	**Responsible committee**	System Tobacco Dependency Steering Group

Brief Summary and Highlights

- Meeting held with the Tobacco Dependency Manager at SaTH to start the process to initiate an engagement survey for staff. The survey aims to determine how many workers are dependent on tobacco and assess the potential benefits of regular Stop Smoking Clinics at the Trust's sites. Additionally, the possibility is being explored of incorporating questions about smoking habits into the onboarding process for new starters, with referrals to support services if needed.
- In Telford & Wrekin, although there are seven registered community pharmacies offering stop smoking services, only one is active in Donnington. Currently, consultations in Donnington are only available face-to-face. To address this, collaboration is taking place with the ICB Medicines Management Team to increase uptake and interest amongst additional community pharmacies to actively offer Stop Smoking Services, the plan is to target resource particularly for gaps in Core20 areas. The feasibility of initial telephone consultations is also being considered. Furthermore, discussions are taking place with the ICB Medicines Management Team around the potential for mailing Nicotine Replacement Therapy (NRT) to individuals who face accessibility challenges.
- For maternity services, SaTH's Smoking at the Time of Delivery (SATOD) figure for 2024/25 was 6.7%, which is 0.7% away from national target, this is a 2% improvement on last year. The figure is being reviewed by the Team to understand exact uptake from Core20PLUS communities. Key barriers to sustain quits and engagement identified by the service are mental health and social issues (for instance, anxiety). There is specific challenge to quit if family members are also smokers and for 2025/26 SaTH will be looking to target smokers in the household, as well as the expectant mother.
- Due to the increased volume of footfall in people accessing the service, sessions have increased at the Sunflower House in Shrewsbury to 2 days a week.
- The Mapping exercise of current smoking cessation support was completed in May 2025. This is due to be reviewed further at the Tobacco Steering Group in July 2025 to agree and take forward actions.

Planned deliverables (During the reporting period)	Due	Delivered? (Yes / No)	If not on-plan or not started, please reason why and what actions are being done to progress this?	If not on plan or not started, has this been escalated to the responsible committee?

Proposal for the establishment of a new system-wide smoke-free steering group	Q2	Yes		
Draft group purpose and terms of reference	Q2	Yes		
Established System Approach to Smoke-free Steering Group	Q3	Yes		
Agreed meeting terms of reference and scope	Q3	Yes		
Mapping exercise of current smoking cessation/support	Q3	Yes		
Agree priorities to progress within workstream	Q3	No	To be developed from the outcomes from the Mapping exercise. Completed mapping exercise is due to be reviewed further at the Tobacco Steering Group in July.	Not required - will be an outcome from the mapping exercise and the recruitment of the Clinical Advisor. Outcomes to be picked up as part of 2025/26 plans.
Targeting efforts towards most deprived areas using Core20PLUS5 to increase referrals into community pharmacies	Q4	No	To be developed from the outcomes from the Mapping exercise. Completed mapping exercise is due to be reviewed further at the Tobacco Steering Group in July.	Not required - will be an outcome from the mapping exercise. Outcomes to be picked up as part of 2025/26 plans.

Weight Management Programme

Programme	Weight Management Programme	**Lead/s**	Marlene Goncalves, System Development and Service Re-design Manager, NHS Shropshire, Telford & Wrekin ICB
Key/statutory health inequality targets	Continue to address health inequalities and deliver on the Core20PLUS5 approach, for adults and children and young people • DWMP: 2,000 eligible referrals • T2DR: 250 Annual Referral cap	**Responsible committee**	Type 2 Diabetes Remission Steering Group NDPP Steering Group

Brief Summary and Highlights

- A diabetes listening event, with a quality improvement lens, was conducted with the participation of partners across STW, where data regarding the population, demographics and deprivation was shared. In this event, different views were shared on how to evolve the diabetes service in STW, utilising the services already delivered by system partners. The attendance was varied including colleagues from community, primary and secondary care. Feedback was collated from this event, with a call-to-action approach used to establish new connections with those willing to contribute, therefore, taking the first steps in changing diabetes care across STW to ensure the 8 care processes are available and 3 treatment targets are met.

- A diabetes related survey is being conducted across STW giving the population a chance to have their say in diabetes care. A similar survey was conducted in 2023; however, the results did not provide a true reflection of the population. In the current survey, a new approach was adopted ensuring the survey is accessible to a larger number of people, with an aim to engage with under-served communities. This included providing a land line number for those who are not digitally enabled, ensuring the reading age of the survey reflected the national average, and promotion across secondary and primary care, community centres and community teams, schools, places of faith, cultural centres, etc. The survey will conclude on the 15th of May 2025, and so far, the pool of responses shows a wider range of aspects not captured in the previous survey.

- Although referrals remain slightly below the national target for the NHS Digital Weight Management Programme, the percentage of eligible referrals is high and is meeting target. A percentage breakdown between deciles, to include any changes between quarters, is being explored.

Planned deliverables (During the reporting period)	Due	Delivered (Yes / No)	If not on-plan or not started, please reason why and what actions are being done to progress this?	If not on plan or not started, has this been escalated to the responsible committee?
Receipt and analysis of referral data from all tier 2 weight management programmes to enable inequalities-based analytics and targeting.	Q2	Yes		
GP Forum Session delivered to promote local tier 2 weight management services and encouraging improvements with a Core20PLUS lens.	Q3	Yes		
Digital Weight Management				
Communications to practices, particularly those serving CORE20 populations, with reasons for ineligible programme referrals.	Q2	Yes		
Primary care team confirmed access to the DWMP online dashboard.	Q2	Yes		
Identified list of priority practices where referrals for Core20PLUS is low.	Q2	Yes		
Communication sent to practices in core20 areas	Q3	Yes		
Unused referral allocations re-distributed to Core20 based practice areas	Q3	Partially	Due to capacity constraints within the Primary Care Team, redistribution of allocations has been based on which Practices have requested additional allocations. This has been with the caveat that any additional allocation is used to target populations of highest need.	
Communication sent to practices in Core20 areas	Q4	Yes		
National Diabetes Prevention				

Dedicated Type 2 diabetes clinic launched - small numbers of young people <10	Q1	Yes		
Information shared and know your risk score evaluations at events in target communities e.g. Wellington Diabetes Bus	Q2	Yes		
Inequalities-Specific Communications issued - including targeted materials in multiple languages (Arabic, Farsi, Polish, etc.) and digital access to NDPP in 20+ languages via the Liva platform.	Q2	Yes		
Increased support offer for individuals with LDA e.g. support for face-to-face group settings and opportunities for participants to attend with carers/family members.	Q2	Yes		
Referral data analysed for target populations, with intelligence shared to inform plans.	Q2	Yes		
Actions identified for increasing uptake and support for individuals with LD	Q3	Yes		
Inequalities data first presented by provider at steering group by end of Q3	Q3	Yes		
Low referring GP's in core 20 communities issued with communications / contact to encourage uptake.	Q3	Yes		
Evaluation of Diabetes community bus event complete	Q4	Yes		
Partnerships established to support increase of referrals	Q4	Yes		
Collaborative projects initiated to support increase of referrals	Q4	Yes		
Type 2 Diabetes Path to Remission				
Target areas identified and plans informed through intelligence.	Q2	Yes		
Exploration of targeting pharmacies in CORE20 areas first for dissemination of information.	Q2	Yes		
Initial discussions had with Social prescribing/behaviour change service and actions determined	Q2	Yes		
Initial tailored communication material (posters, leaflets and videos) developed and published via VCSE with the intent of reaching Core20 communities	Q3	Yes		
Actions taken forward from pharmacy explorative work e.g. follow up directly with some CORE20 plus pharmacies	Q3	Yes		
Gap in resources (such as materials required in other languages or formats) identified with plans drafted to address	Q3	Yes		
Development of content that resonates with different cultural groups and addresses barriers to understanding diabetes care	Q4	Yes		

Drug and Alcohol

Programme	Long Term Plan (LTP) Prevention – Alcohol	**Lead/s**	Claire Eagleton, Lead Nurse for EDI, Shrewsbury and Telford Hospital NHS Trust
Key/statutory health inequality targets	Fully establish an Alcohol Care Team in an acute setting based on national criteria for implementation.	**Responsible committee**	Alcohol Care Team Steering Group Reporting into SaTH's Quality Oversight Committee

Brief Summary and Highlights

- A 7 day Alcohol Care Team (ACT) service at the Princess Royal Hospital is now in place. The service has 1 band 7 nurse, 1 band 6 nurse, 2 band 4 alcohol practitioners and an admin support.
- Service activity is disaggregated by demographic and further work has been undertaken to review and analyse local data to identify impact and potential inequality in access.
- There has been excellent joint working with community services to provide seamless support to individuals once discharged from acute services.
- A business case to sustain and expand the service across both hospital sites from 2025/26 was developed and submitted through relevant governance with a view to seeking a decision in Quarter 4. A decision is however still awaited.
- Targeted communications to promote ACT amongst the Emergency Department and medicine wards was undertaken in Quarter 3. This included distribution of information posters with team details, and members of the ACT attending departmental meetings. ACT are planned to feature in "Stronger Together" communications to highlight their impact on admission avoidance and appropriate specialist care.
- The ACT is now included in one of the workstreams of the Urgent and Emergency Care Transformation Programme which will assist in further strengthening pathways and referral processes within the Emergency Department and acute medicine. A task and finish group commenced in December 2024.
- Meetings have been set up with relevant stakeholders to progress the pilot project implementing the 'Blue Light Approach' for resistant to change drinkers. This included a meeting held with representatives from the High Intensity Service User (HISU) service, 'Positive Lives', to understand the support they offer for resistant to change drinkers within their current service.

Planned deliverables (During the reporting period)	Due	Delivered? (Yes / No)	If not on-plan or not started, please reason why and what actions are being done to progress this?	If not on plan or not started, has this been escalated to the responsible committee?
Alcohol Care Teams				
7-Day service	Q1	Yes		

0.2PA Clinical Lead in-post	Q1	No	Not yet in post but interested party currently being recruited via an expression of interest. Aim for May 2025 start date - outcome of business case may affect this process.	Yes
Service activity data available broken down by demographics e.g. deprivation, ethnicity, Age	Q2	Yes		
Business case taken to system panel	Q3	Yes		
Business case approved	Q4	No	Decision not yet received. Current funding due to end at end of June 2025.	Escalated via all available channels.
Targeted comms distributed to ED and acute medicine wards to increase referrals.	Q4	Yes		
Comms distributed to all staff within acute settings to strengthen referral pathways for community services.	Q4	Yes		

Learning Disability and Autism (LDA) Improvement Programme

Programme	Learning Disability and Autism (LDA) Improvement Programme	**Lead/s**	Rachel Rogers, Primary Care Support Specialist, NHS Shropshire, Telford & Wrekin ICB (for Annual Health Checks project only)
Key/statutory health inequality targets	Ensure 75% of people aged 14 and over on GP learning disability registers receive an annual health check in the year to 31 March 2025	**Responsible committee**	LDA Health Checks Working Group

Brief Summary and Highlights

- At the end of March 2025, 85.6% had been achieved for Learning Disability Annual Health Checks (LDAHCs) undertaken for those on Learning Disability registers aged 14 or over. This was against the national 75% target, showing STW well achieved this. This is a circa 35% increase on Quarter 3 figures.
- To support improved quality of Annual Health Checks (AHCs), a revised AHC audit form was trialled in January 2025. This is now being used.
- Quality visits/audits to four practices were undertaken in Quarter 4.
- The sharing of learning continues through the one-minute briefs to Primary Care.

Planned deliverables (During the reporting period)	Due	Delivered (Yes / No)	If not on-plan or not started, please reason why and what actions are being done to progress this?	If not on plan or not started, has this been escalated to the responsible committee?
Annual Health Checks for People with a Learning Disability				
Agreed baseline and target trajectory is set for 2024/25 AHC's	Q1	Yes		
GP Resource Pack to support LDAHCs updated and re-launched	Q1	Yes		
Comms. to General Practice to encourage capture of ethnicity for patients on LD registers	Q2	Yes		
GP websites updated in line with national accessibility guidance	Q3	Yes		
Delivery of LD awareness training to practices	Q3	Yes		
GP Practices requiring additional training and support identified	Q4	Yes		
Priority audits undertaken with learning shared across practices to improve quality of LDAHCs.	Q4	Yes		

Core20PLUS5 for Adults

Maternity & Neonatal Services

Programme	Maternity and Neonatal Services	**Lead/s**	Sue Bull, Senior LMNS Programme Lead, NHS Shropshire, Telford & Wrekin ICB
Key/statutory health inequality targets	Ensuring continuity of care for women from Black, Asian and minority ethnic communities and from the most deprived groups. This model of care requires appropriate staffing levels to be implemented safely.	**Responsible committee**	LMNS Programme Board

Brief Summary and Highlights

- A funding application was successfully submitted and approved by The Burdett Nursing Trust to support a 12-month pilot programme, to co-develop a nurse-led preconception education program. This will focus on training the workforce to improve reproductive health and reduce disparities across Shropshire, Telford, and Wrekin. The project will be in partnership with Shropshire Telford and Wrekin LMNS (including Shropshire Council and Telford and Wrekin Council) and Balance Fertility.

  Having **trusted professionals** deliver preconception education can make a **significant impact** by:
  - **Increasing Credibility and Trust** – People are more likely to engage with and act on advice from professionals they trust, such as midwives, nurses, and healthcare workers.

- **Providing Personalised, Evidence-Based Guidance** – Professionals can tailor education to individual needs, addressing risk factors, lifestyle changes, signposting to services and medical history for better preconception health.
- **Improving Health Outcomes** – Early intervention and informed decision-making can lead to **healthier pregnancies, reduced child mortality, better birth outcomes** and general health outcomes.
- **Engaging Fathers and Partners** – Trusted professionals can ensure that fathers and partners are included, improving **male fertility and shared responsibility** for reproductive health.
- **Reducing Health Inequalities** – Targeted education can support **vulnerable or underserved communities who generally experience worse health outcomes,** ensuring everyone has access to the knowledge and care they need.

The contract is awaiting sign off by the ICB Finance Team, the project is being drawn up and it is anticipated this can begin by the end of Quarter 1. The plan is:

- **Months 1-6: Development:** Stakeholder engagement, tailored curriculum (led by Balance fertility), define pilot group for training and training delivery, define the pilot targeted group (i.e. age range, location etc).
- **Months 6-7: Logistics**: Agree logistics i.e. venues, comms etc. for education delivery.
- **Months 7-12: Education sessions, evaluation:** delivery to pilot targeted groups, evaluation, and ongoing monitoring.

- A new contract to continue Baby First Aid and Baby Proofing Classes has been negotiated with Mini First Aid Limited during this quarter. This will cover the period from 1st April 2025 to 31st March 2026 and the scope of classes now also covers Shropshire residents. The number of classes has been increased to six sessions per month and these are to be delivered within Core20 areas within Telford and Wrekin and Shropshire. Some classes will also be provided in rural areas. Targeted delivery groups are Core20PLUS, rural communities, fathers, care leavers and teenage parents. Reporting is being developed to capture attendee demographics, particularly to monitor uptake from Core20PLUS communities.

- The Regional LMNS Data dashboard is now live, which includes regional data and comparisons.

- The EDI Midwife has commenced in post at SaTH.

Planned deliverables (During the reporting period)	Due	Delivered (Yes / No)	If not on-plan or not started, please reason why and what actions are being done to progress this?	If not on plan or not started, has this been escalated to the responsible committee?
LMNS Equity and Equality Action Plan (aligning to CORE20PLUS5)				
NHS EDI Midwife post out to advert	Q2	Yes		
Established LNMS Dashboard to support the future analytical work	Q2	Yes		
Refreshed LMNS Equity and Equality plan	Q3	No	Data is awaited to produce the perinatal equity analysis which will inform system priorities and the action plan. The timeline for the perinatal	Yes

			equity audit report now due Quarter 2, 2025/26, in line with LMNS workplan. A task and finish group has been set up to bring system partners together to share data.	
NHS EDI Midwife in post	Q4	Yes		
Smoke-free Pregnancy Incentive scheme				
Submission of expressions of interest	Q2	Yes		
Antenatal Education to women, birthing people, and families to support healthier pregnancies and best start in life				
Presentation of the 23/24 Baby First-aid quality improvement project to the Equality and Involvement Committee	Q1	Yes		
Booklet project approved by the system	Q2	Yes		
Provide antenatal education to women, birthing people, and families to support healthier pregnancies and best start in life	Q4	No	Antenatal classes are starting end of April 2025.	Yes
NSPCC parent's guide booklet developed.	Q4	No	Awaiting Purchase Order number to enable contract to be signed. Roll out of booklet now due end of Quarter 1, 2025/26, as per LMNS workplan.	Yes
To engage with and listen to women, birthing people and families from seldom heard groups about their experience of maternity and/or neonatal care				
Quarterly report on feedback and provider actions in response produced	Q2	Yes		
Co-produced digital MNVP service user feedback survey for each pathway developed.	Q3	Yes		
Fully funded MNVP workplan signed off by ICB which includes working with VCSE to reach out to seldom heard groups.	Q3	Yes		
MNVP lead to engage with local VCSEs and community groups to develop a network of volunteers from seldom heard groups to gain feedback using surveys.	Q3	Yes		
Annual MNVP communications and engagement plan agreed by LMNS.	Q4	No	Delays to recruitment however the MNVP lead now in post and is leading on this work – to be completed by end of Quarter 1, 2025/26	Yes
Midwife continuity of carer				

Appointment of new continuity of carer lead	Q2	Yes		
Explore with SaTH how to take forward continuity of carer	Q4	No	A quality insight visit took place on 24th April 2025 with a focus on Enhanced Continuity of carer. This is an ongoing action. Commissioning Enhanced Continuity of Carer is also part of the 'difficult decisions' conversation. A draft report on the quality insight visit will be taken to LMNS board. This will provide clarity on targeted work and personalised care provided by SaTH and then next steps can be agreed. Due date now Quarter 1, 2025/26, to reflect the above.	Yes
Baby First Aid				
Additional funding acquired for the continuation of Baby First Aid Classes.	Q3	Yes		
Baby first-aid classes will be offered universally across Telford and Wrekin (start for life funding), and will also include targeted groups – teenage parents, parents leaving the care system and the BAME community.	Q4	Yes		
Identifying the gaps to enable targeted approach				
Delivery of the Regional Data Dashboard project	Q4	Yes		

Physical Health Checks for Severe Mental Illness (SMI)

Programme Key/statutory health inequality targets	Severe Mental Illness (SMI) Physical Health Checks Reduce inequalities by working towards 75% of people with severe mental illness receiving a full annual physical health check, with at least 60% receiving one by March 2025	**Lead/s**	Claire Parrish, Service Manager, Midlands Partnership University Foundation Trust (MPUFT)
		Responsible committee	SMI Operational Group

Brief Summary and Highlights

- A focus has been on increasing the Team's ability to provide outreach to patients that Do Not Attend, those in nursing homes, and housebound patients.
- The SMI Team has been expanded to include an Advanced Pharmacist and a Sessional Psychiatrist. Part of their roles will be to support the MDT process for shared care agreements. These requests are usually for patients who have remained mentally well for a lengthy period, are able to manage their illness well and do not want to return to secondary services. Reducing individuals attending secondary care for advice which can be offered through primary care or in the community helps empower patients and enables secondary care appointments to be prioritised. The Pharmacist will also be able to support SMI nurses on medication queries and work with GPs and patients to support de-prescribing, where appropriate. This role will also enable foster close working relationships with GP Practices and their pharmacists.
- A support worker in Shropshire has set up football sessions at Shrewsbury Town for anyone with an SMI. However, there is a cost attached for the Service User of £4 per session. Work has been undertaken with both Local Authorities and Energize to build on fitness activity and seek opportunities for further grant funding which will offer free activities. Grants have been submitted for increased activities in both local authority areas, including football, cricket and gardening sessions.
- The tennis sessions have been extended for another year. Fiona Jones, the previous Chair and now Shropshire's representative on the LTA's Tennis Council stated "*That is terrific news. I went to the session on Wednesday, and it was really uplifting to see how much enjoyment and benefit the participants were getting from the session. It was one of the best things I have seen for a long time - thank you so much Claire for making this happen.*"
- Despite staff sickness in the SMI Team and 2 staff leaving the Physical Health Checks Clinic in Telford, the Team have worked together to ensure this has not impacted on patients. Clinics have continued to run with SMI supporting additional GP practices.
- Good news story received from Lifestyle Coaches in Telford: A young man who was not ready for the Stop Smoking Programme when they were in the clinic has since contacted them himself and, despite finding it challenging, he has completed the 12 week course.
- The Team are trying to improve referrals to social prescribing and have met with Shropshire Council to look at how this can be done in secondary SMI Physical Health Checks.

Planned deliverables (During the reporting period)	Due	Delivered (Yes / No)	If not on-plan or not started, please reason why and what actions are being done to progress this?	If not on plan or not started, has this been escalated to the responsible committee?
Achieving SMI Physical Health Check Targets				
Improved quality of health checks	Q1	Yes		
Increasing take-up of checks for individuals with SMI	Q1	Yes		
Development and delivery of opportunities working with partners e.g. public health on inequalities-based and lifestyle initiatives	Q1	Yes		

Outreach model implemented to support those who can't leave the house etc.	Q2	Yes		
Medication reviews supported by advanced pharmacist	Q3	Yes		
Rough Sleepers Mental/Physical Health Checks				
Increased clinic appointments/activity meaning reduced admissions to 136 suite, AandE and Redwoods – Rough sleepers	Q2	Yes		

System Vaccinations Programme

Programme	System Vaccination Programme	**Lead/s**	Stuart McClymont, SVOC/SPOC Manager, Shropshire Community Health NHS Trust Wayne Jones, Environmental Health Officer, Telford & Wrekin Council
Key/statutory health inequality targets	• A clear focus on Chronic Obstructive Pulmonary Disease (COPD) driving up uptake of COVID, flu and pneumonia vaccines to reduce infective exacerbations and emergency hospital admissions due to those exacerbations. • Put plans in place to maximise uptake of childhood vaccinations, including reducing inequalities. Increase vaccination uptake for children and young people year on year towards WHO recommended levels.	**Responsible committee**	Health Protection Quality Assurance (HPQA) Group

Brief Summary and Highlights

COVID-19 Vaccination Project

- The Team has continued to build on the relationships with patient groups to promote uptake, answer questions and myth bust. Different communication methods have been utilised for the continued messaging, including translated materials also shared with system partners to help engage those whose first language is not English and identify trusted voices. The Team has promoted uptake with easy to read materials, as well as a British Sign Language (BSL) video. They have also facilitated quiet spaces for vaccination at SCHT clinics for those who require a quieter setting.

- Additional COVID-19 vaccination capacity has been identified utilising MSOA, local and regional data, which included Ethnicity and IMD deciles, to ensure the anticipated demand could be met. This helped to ensure access to vaccination sites was as convenient as possible, looking to minimise travel times and distances for deprived, Ethnic and rural communities. Walk-in community-based vaccination clinics have been organised in several areas of high socio-deprivation with low uptake, locations included The Anstice in Madeley, Hub on the Hill, Park Lane Centre in Woodside, and Brookside. The Team have also linked in with the Council's Healthy Lives Team and attended events to promote COVID-19 vaccinations and offer vaccinations where suitable.

- Discussion has taken place with Maternity leads around vaccinations. Due to concern that this could impact sites being seen as a safe space for mothers, the leads are not willing to allow vaccinations or the Team to attend on site. However, they are having conversations with patients regarding vaccinations and have been provided with resources, which they are displaying.

- Respiratory nurses have conversations with patients on the benefits of vaccination at their clinics for those with chronic respiratory illnesses. The Team has attended several clinics for those with chronic respiratory illnesses to offer COVID-19 vaccinations.

- Support for PLUS Groups:

    - **People experiencing homelessness** - The Ark in Shrewsbury is an independent charity dedicated Daycentre for Homeless and vulnerable and has been visited and vaccinations offered. Establishing links with other Homeless organisations within STW is being looked into.

    - **People with a Learning Disability** – All Learning Disability homes and schools have been contacted to offer vaccinations on site and have been provided with information leaflets and posters.

    - **Prison populations** – The Team have worked closely with the local Prison to ensure eligible patients are offered a Covid-19 Vaccination. This was facilitated through the Lead Pharmacist for Vaccination Services who works closely with the site.

    - **Refugees** – Vaccinations have been offered to refugees who are eligible for a COVID-19 vaccination, to include a visit to the Nesscliffe site. Translated materials have been shared for display and to enable conversations on vaccinations to take place on the Nesscliffe base. Links are also being established with Shropshire Supports Refugees Charity to support and offer vaccinations to those who are eligible.

    - **Migrant workers** – Engagement has been undertaken with factories with large migrant workforces to display translated materials, recognising a sensitive approach is needed as not all those working in the factories are eligible for the vaccination.

    - **Gypsy, Roma or traveller communities** – The Team has contacted local Councils to assist and form part of initiatives within these communities. They have visited traveller sites to offer vaccinations and address any vaccine hesitancy.

HPV/MMR Vaccination Project

- Settings for interventions have been identified using data on vaccine uptake, deprivation data and published research on low-uptake groups.

- Educators in both Local Authorities have been delivering education sessions in schools, ahead of the year 9 booster programme, where additional resources have been made available to offer HPV and MMR mop-ups to Year 9 students and above.

- Additional clinics have been delivered in the community and in schools alongside the Year 9 booster programme, using communications developed by the Local Authorities. For example, one community clinic at the Interfaith Council Centre in Telford delivered 40 vaccines to 17 separate children at a Saturday clinic, which was heavily promoted by the Telford & Wrekin Health Protection Hub. Educative work is continuing through a variety of community groups, to include youth clubs.

- Educators have been providing training to key staff in schools and other settings to enable them to provide accurate information on the vaccines in the future, giving the project some longevity. They have also delivered some educative assemblies for Year 8 students ahead of this year's routine HPV programme

- The project has enabled closer working between the Local Authorities, the ICB, SAIS and the schools and other settings. In addition, the educators have built relationships which will prove useful for other health promotion work, and vaccination teams have used Local Authority contacts to gain greater access to the Electively Home Educated.

Planned deliverables (During the reporting period)	Due	Delivered (Yes / No)	If not on-plan or not started, please reason why and what actions are being done to progress this?	If not on plan or not started, has this been escalated to the responsible committee?
Covid-19 Vaccination service				
Equity Audit Report	Q2	Yes		
Developed plan and approach for improving uptake in PLUS communities	Q2	Yes		
Clinics are offered 7 days a week including evenings and weekends to support access	Q3	Yes		
Utilising national comms. material tailored including in other languages and easy-read	Q3	Yes		
Offering clinics via bookings but also walk-in to suit flexibility for local communities	Q3	Yes		
CYP Vaccination Pilot-bid for HPV and MMR vaccines.				
Finalised bid submitted to NHS England for CYP MMR and HPV Vaccination Pilot	Q2	Yes		
Outcome notification of bidding application for CYP MMR and HPV Vaccination Pilot	Q2	Yes		
Project Plan developed with clear deliverables for the forthcoming delivery period	Q3	Yes		

System-wide Cancer Programme (Early Cancer Diagnosis)

Programme	Cancer Improvement Programme	**Lead/s**	Imogen Darbhanga, NHS Shropshire, Telford & Wrekin ICB Sophie Yeomans, Cancer Transformation Partner, NHS Shropshire, Telford & Wrekin ICB
Key/statutory health inequality targets	75% of cases diagnosed at stage 1 or 2 by 2028.	**Responsible committee**	Cancer Programme Oversight Group (CPOG)

Brief Summary and Highlights

- During Quarter 4, the Cancer Programme Team continued to work with STW Cancer Champions (a Wave 1 NHSE Core Connectors Pilot Project) to progress work around engaging with the community and understanding insights. This will be utilised specifically in relation to work around Early Cancer Diagnosis.

STW Cancer Champions continue to raise awareness of cancer signs and symptoms and local screening services across STWs most under-represented and under-served communities. As of 17th March 2025, over 431 Champions have been provided with training including cancer signs and symptoms, risk and how to have a lifesaving conversation. The initiative is well known across the county and has received national and regional recognition. Delivery Partners have participated in numerous learning events and have extended the scope of focus to target Inclusion Health Groups, such as people in contact with the justice system and training members of organisations supporting people experiencing homelessness.

- Between January and March 2025, a pilot was undertaken by Woodside Medical Practice using a Smear Concern Checklist. This was linked to findings from Cancer Champions that the Checklist, previously created by Jo's Trust, has the potential to help people who are fearful of having a cervical screening test and can provide them with reassurance. Those that booked an appointment were sent an adapted version of the Smear Concern Checklist by the Practice. The Medical Practice found a 35% uptake of the survey and 10 people completed the evaluation form on the checklist. Findings from the evaluation showed that 100% of people found it useful to complete the pre-smear questionnaire, and positive feedback was received from patients around their interactions with nurses. The checklist will continue to be offered by the Practice.

- Screening assets, developed by the Cancer Programme Team and the ICB Communications Team, with the support of the Lingen Davies Centre, have been shared with local foodbanks. In addition to promoting screening opportunities, resources promote symptom awareness and adopting healthier lifestyles, to the more deprived communities.

- The Cancer Programme Team has continued to liaise with colleagues in the ICB BI Team around resources. This includes development of the Cancer Population Health Management Dashboard which is now readily available. This dashboard provides an overview of the demographics of patients diagnosed within STW and will support targeting work around health inequalities. The ICB BI Team are also developing a Cancer Referrals Dashboard which will provide an overview of referrals received into the secondary care provider (by tumour site), with a demographic break down of patients being referred onto these pathways.

- In Quarter 4, the Cancer Programme Team has engaged with health inequalities leads in the secondary care provider. These audits looks at the volume of patients accessing pathways, outcomes will be utilised in the upcoming Early Cancer Diagnosis Working Group, to influence programmes of work which will focus on health inequalities in cancer screening programmes.

- Throughout 2024/25 a range of education sessions focusing on individual tumour sites were delivered to primary care providers to enhance their knowledge of cancer. This included a GP focused face to face training session held in Quarter 3 and a face-to-face GP Education Event. At the event, secondary care consultants from across the Midlands provided cancer specific education on HPB Cancers, Haematological Cancers, Gynaecological Cancers and Sarcoma. These interventions will broaden the knowledge of clinicians within primary care settings and equip them to identify and diagnose cancers earlier. Education events to help raise GP awareness on differences in identifying symptoms and prevalence between patient groups will be considered by the Team for the 2025/26 plan.

- The Cancer Programme Team has developed a dedicated space on the already established Learning Management System (LMS) for cancer. A range of resources have been made available via the LMS, including links to accredited free training, guides shared by secondary care consultants and any locally

developed resources. Discussion will take place via the Early Cancer Diagnosis Group around developing specific resources linked to Core20PLUS communities, as part of 2025/26 plan.

Planned deliverables (During the reporting period)	Due	Delivered (Yes / No)	If not on-plan or not started, please reason why and what actions are being done to progress this?	If not on plan or not started, has this been escalated to the responsible committee?
Foster collaboration with System Partners and STW Cancer services				
Established partnerships with local health and community organisations to ensure collaborative and collegiate working, reaching seldom heard communities.	Q1/2	Yes		
Improving cancer diagnostic pathways				
Improve earlier diagnosis and FDS in cancer pathways by focusing on interface between primary and secondary care.	Q4	No	Due to validated data not yet being available in terms of staging and Faster Diagnosis Standard (FDS), the Cancer Programme Team are not able to commit to an improvement in these areas. The Team have however focused their work particularly on the interface between primary and secondary care in line with WMCA planning guidance.	The Cancer Programme Oversight Group is aware of workstreams, held by The Cancer Programme Team and data is monitored in various platforms.
Improve uptake and access of cancer screening programmes across the Shropshire, Telford, and Wrekin				
Quality data for identifying Health Equity in all cancer tumour sites.	Q1/2	Yes		
PCN's have an overview of their cancer screening data, to enable and own identification of patient populations who may be at risk of a health inequalities.	Q1/2	Yes		
Promote Screening Programme in foodbanks.	Q3	Yes		
Work with the local Cancer Champions network (set up to support Core20Plus5) to gain insights into community cancer concerns and support to deliver a cancer awareness project.	Q3	Yes		
Increase patient education around cancer; self-awareness, Symptom and Prevention Awareness.				
A range of patient educational materials sourced and shared for Cancer Campaigns.	Q3	Yes		
Generalised and targeted digital assets to be shared in general practice and the wider public to highlight symptoms of specific cancers	Q3	Yes		

Awareness campaigns delivered by cancer champions in line with the national cancer awareness months And capitalised by CPT to enhance wider dissemination of awareness messaging	Q3	Yes		
Generalised & targeted symptom awareness assets website link to adopting a healthier lifestyle and any prevention opportunities that the patient can access, including HPV vaccinations and cancer screening programmes	Q3	Yes		
Professional education on cancer topics				
Strengthen education offer to enable health care professionals, to access education appropriate to their own learning needs and which meets the needs of their specific communities	Q4	Yes		

Cardiovascular Disease (CVD) Prevention

Programme	Cardiovascular Disease (CVD) Prevention Programme	**Lead/s**	Lorna Watkins, Strategy Development Manager, NHS Shropshire, Telford & Wrekin ICB
Key/statutory health inequality targets	• Core20PLUS5: To allow for interventions to optimise management of blood pressure and lipids and minimise the risk of myocardial infarction and stroke. • Increase the % of patients with hypertension treated according to NICE guidance to 80% by March 2025 • Increase the percentage of patients aged 25–84 years with a CVD risk score greater than 20% on lipid lowering therapies to 65% by March 2025	**Responsible committee**	CVD Prevention Group *Reporting into the Health Inequalities and Prevention Group and Cardiology Transformation Group (currently stood down).*

Brief Summary and Highlights

- An evaluation of reach for the Community Blood pressure project has been conducted and taken to the hard decisions group. The evaluation supported that this targeted initiative is dramatically increasing the number of blood pressure checks being undertaken, with just under 4,000 additional patients having been added to the hypertension register since the service was established.

  The evaluation report looked at the period up to December 2024. It outlined that in 2023/24:
  - 61% of events and pop ups were undertaken in Core20 areas, rising to 74% in 2024/25.
  - For Telford, between August and December 2024, 20% of residents attending were from the most deprived areas, and there 27% of engagement was from ethnic minority communities (Asian communities (11.22%), followed by individuals from our Black communities (6.32%), other Ethnic communities (4.98%), Chinese (2.71%), not stated (1%)).
  - Less than 7.5% of the population of Shropshire lives within IMD deciles 1-3, the project recorded 10.4% attendance from within that IMD profile. All the attendees recorded within IMD deciles 1-2 were from Urban City and Towns, which is representative of the population in Shropshire. 75%

of attendees were White British, much lower than the 95% of Shropshire population, attendees from Black communities was at 11%, then Mixed White background 7% and other ethnic groups combined at 2%.

Funding has been granted for the project to continue for Quarter 1 2025/26 only at this stage. An outcome is awaited on any extension of the project for the remainder of 2025/26 form the hard decisions group.

- A celebration event was hosted by Telford and Wrekin Council to showcase the work done within the blood pressure project over the last two years. This highlighted further how the project has reached the more deprived communities:
  - Overall, 52 champions have been trained, with 24 active Blood Pressure Checkers.
  - Approximately 1 in 4 people checked have been from a Black, Asian or Ethnic Community.
  - Over 13% of people had undetected hypertension.
  - 262 po-ups have been delivered across 98 locations. These include faith and community venues.
  - The volunteering scheme has enabled more healthy lifestyles conversations

- The Project continues to progress support for Core20PLUS groups, with the following updates being shared. Continued outreach is dependent on clarification of the funding:
  - The Small Grant Scheme has helped extend the project reach to local communities, to include organisations supporting Core20PLUS groups, such as Maninplace and CultureKind,
  - Teldoc has been supporting Oakengates Town Council with text messages to eligible residents to attend the drop-in sessions.
  - The Health Promotion Outreach Officer has attended Veteran and Calm cafes over the last year. Unfortunately, members have not been able attend training to enable them to offer checks themselves at their groups.
  - The Health Promotion Outreach Officer has been to the Traveller Community in Donnington on 2 occasions and remain part of a working group bringing services to that community and is looking to engage with Donnington Medical Practice.
  - Shropshire European Organisation are offering checks to the Polish Community. Further work is to be considered on how to increase this offer.
  - Work undertaken around targeting people who have experience Domestic Abuse has been slow. The Health Promotion Outreach Officer has links with Cranstoun to attend their survivors and perpetrators sessions. A date to attend is being confirmed, which hopefully will be before the end of June 2025.
  - Plan is to continue work with GPs and PCNs with established regular signposting opportunities and identify any further opportunities with PCNs.

Planned deliverables (During the reporting period)	Due	Delivered (Yes / No)	If not on-plan or not started, please reason why and what actions are being done to progress this?	If not on plan or not started, has this been escalated to the responsible committee?
Community blood pressure project				
Successfully obtain sustainability funding for local targeted inequalities community case-finding.	Q1	Yes		
Updated outreach pathway and model integrating use of community pharmacy in targeting Core20PLUS groups	Q3	Yes		
Evaluation of impact	Q4	Yes		

Hypertension & Lipid treatment to target				
Confirmed list of outlier GP Practices for hypertension and lipid treatment with high proportions of Core20PLUS patients.	Q2	Yes		
local best practice for improving hypertension treatment collated and shared across General Practice	Q2	Yes		
CVD and Inequalities PLT delivered	Q2	Yes		
Provisional list of opportunities to explore to further targeted inequalities work in the CVD Prevention Programme	Q2	Yes		
Explore opportunities for Hypertension treatment	Q4	No	Due to the vacant post of the clinical lead opportunities have not yet been identified. Recruitment of the CVD lead is with the hard decisions group. The delay in recruitment of the lead, due to funding, is causing delays within areas of the project that require clinical input.	Yes
Workforce				
Recruitment of CVD Clinical Lead	Q4	No	Recruitment of the CVD lead is with the hard decisions group. However, the opportunity via the Medicine Management team to recruit a Clinical Advisor has been progressed and the successful candidate is due to commence in post in June 2025. This post will contribute to the CVD Prevention programme. The delay in recruitment of the CVD lead, due to funding, is causing delays within areas of the project that require clinical input.	Yes

Core20PLUS5 for Children and Young People

Asthma

Programme	Children and Young People's (CYP) Asthma • Address over reliance on reliever medications; and	**Lead/s**	Helen White, Development and Service Redesign Manager, NHS Shropshire, Telford & Wrekin ICB

Key/statutory health inequality targets	• Decrease the number of asthma attacks.	Responsible committee	Asthma Network Group

Brief Summary and Highlights

- A new CYP Asthma Clinical Lead is now in post and has been meeting with key stakeholders, including presenting at GP Informal Board and Nurse/GP Protected Learning Time (PLT) sessions. Funding has been extended for Quarter 1 2025/26 and currently sits within the Hard Decisions Process for future funding post Quarter 1.

- The CYP Asthma Clinical Network is established and has met twice. Three subgroups have been agreed to be set up, these being Clinical, Education and Health Inequalities. The Clinical and Education subgroups are underway. However, the Health Inequalities group is currently being scoped.

  The Clinical subgroup is focusing on improving the diagnosis pathway and the ICB has applied for funding to implement a CYP diagnostic pathway in the local Community Diagnostic Centre. The outcome of the application is expected mid-May. Ways to strengthen Primary Care are also being looked into, including how to explore a hybrid model across Primary Care, Community Diagnostic Centre and Secondary care.

- The Asthma Service has supported families from areas of deprivation and those with safeguarding concerns in a 'key worker' role with a targeted approach. The team has provided support to families; to attend appointments, provision of education regarding asthma treatment, clearly explained asthma management plans, advice regarding self-care/management and medication optimisation, remaining as a point of contact, ensuring equitable access to care, support with health literacy, acting as conduit between primary and secondary care. All of this is undertaken while liaising within the team around the child and information sharing across schools and services to safeguard CYP.

- Service users are signposted to Healthier Together website, which provides support and advice regarding access to services, health and support to stop smoking and improve air quality. The asthma service has uploaded videos regarding good asthma care, asthma management plans and inhaler techniques for easy access.

- GP practices in the following areas have been offered the opportunity to discuss/refer patients to the Community Children's Nurses (CCN) Asthma Service following the risk stratification process: Teldoc, Broseley Medical Centre, Craven Arms Medical Practice, Hollinswood & Priorslee Medical Practice, Ironbridge Medical Practice, Court Street Medical Practice, Marden Medical Practice, Plas Ffynnon Medical Centre, The Caxton Surgery, Severn Fields Medical Practice.

  These practices cover areas of deprivation across the county. Patients could be referred if they have received a recent review and do not meet the threshold for secondary care referral. Additionally, CCN asthma service accepts self-referrals from patients /carers and other professionals who have identified an unmet need for CYP in Shropshire, Telford and Wrekin.

Planned deliverables (During the reporting period)	Due	Delivered (Yes / No)	If not on-plan or not started, please reason why and what actions are being done to progress this?	If not on plan or not started, has this been escalated to the responsible committee?
Supporting Core20PLUS5 for CYP with Asthma				

Identification at risk patients (more than x6 inhalers in 12 month period)	Q2	Yes		
Clinical asthma Lead in post.	Q2	Yes		
Delivery of individualised care plan appointments.	Q3	Yes		
Implementation of school action plans supporting a reduction in inhaler use	Q3	No	Asthma audit completed in a school in North Shropshire successfully. Hoping to roll this out across more sites in Shropshire, Telford & Wrekin.	Yes
Re-establishment of Asthma Network Group with addressing inequalities discussed.	Q3	Yes	Asthma Clinical Network has been meeting quarterly and 3 subgroups have been established – Clinical, Education and Health inequalities.	Yes
Inequalities focused actions identified from the Network group	Q3	No	The network has agreed that a separate Health Inequalities subgroup is set up which is currently being scoped but will include agreed focused areas on smoking/vaping, housing and air quality.	
ED attendance data analysis of demographics e.g., deprivation & ethnicity complete	Q3	Yes		
Options identified following exploration of a business case to sustain resource	Q3	No	Funding has been agreed by the ICB for Quarter 1 – it is currently on the hard decision list and funding post Quarter 2 will be decided using this process - decision will be published by end of May 2025.	Escalated via all available routes and part of the hard decisions process
Explore development of a referral pathway into the community nurses for those GP who have the highest number of CYP attending acute care, with a focus on areas of deprivation	Q4	Yes		

Epilepsy

Programme	Children and Young People's Epilepsy	**Lead/s**	Helen White, Development and Service Redesign Manager, NHS Shropshire, Telford & Wrekin ICB
Key/statutory health inequality targets	Increase access to epilepsy specialist nurses and ensure access in the first year of care for those with a learning disability or autism.	**Responsible committee**	Currently under review

Brief Summary and Highlights

- The increase in Epilepsy Specialist Nurses (ESN) hours (band 8 - 0.2 WTE & band 6 - 0.2 WTE), enabled via ICB funding, alongside substantive Shrewsbury & Telford Hospital NHS Trust (SaTH) hours, has enabled increased patient access to ESN's.

  Enhanced psychological support has been arranged with the Paediatric Clinical Neuropsychologist currently available until June 2025 due to an extra 3 months' funding via Shropshire Community Health NHS Trust.

  Transition clinics to adult services continue alongside the Paediatric Consultant, Paediatric ESN and Adult ESN. Each of the 3 consultants undertakes up to 2 transition clinics per year. With additional funding, it is hoped that the Psychologist can also attend the transition clinics.

- Paediatric clinical neuropsychologist has been able to accept direct patient referrals from SaTH's Epilepsy service via ESN's. Eighteen referrals were received between May 2024 to November 2024, this included direct psychological intervention and/or neuropsychological assessment (including assessment of dyslexia as appropriate), signposting for further specialist neurodevelopmental assessment as needed, or other appropriate services. Routine outcome data has been collected, which has shown positive improvements in self-reported difficulties. There has been positive feedback from children/young people and their families.

- Collaborative working links continue between Paediatric ESN's and Adult ESN's. This includes linking in with Midlands Epilepsy forums and working groups in paediatric and adult epilepsy, as well as keeping knowledge up to date along with any changes within epilepsy treatments – such as new medication side effects identified in males using sodium valproate.

- "Me and Epilepsy" screening tool has been introduced for use in epilepsy clinics. Young people have been asked to complete the Tool before Consultant Clinic Appointments. The aim of this conversational tool is to facilitate conversations within clinic about emotional wellbeing and specific epilepsy related psychological need. This can be given to children over the age of 7 years and has been helpful to support further referrals to the Paediatric Psychologist. Of those who have completed the tool, 88% (n=51) reported that it was helpful. Reasons for not completing included: significant level of intellectual disability, no epilepsy diagnosis or they did not want to.

  New referrals are currently on pause due to patient capacity reached for Paediatric Clinical Neuropsychology Service. Screening may commence again once current patients have been discharged.

- The Team has worked to identify needs and making reasonable adjustments to try to enable successful clinic appointments or investigations for patients or their parents, examples include:
    - ESN's referring to the play therapist at SaTH for blood tests on children with LD.
    - A MRI head scan was required on child with severe autism. The ESN referred to the play therapist and the patient journey was adjusted to minimise time spent as inpatient for procedure, reducing stress to child with change of routine. Whilst the procedure was unsuccessful, the parent had a positive experience and maintained trust in the hospital that the child's needs were being taken care of.
    - Parent of patient being investigated for epilepsy, has Mental Health problems. This was impacting on the child not attending school daily, also reporting exclusion of child from activities such as trips and school disco. ESN liaised with school and parent to alleviate anxieties regarding possible seizure episodes. This enabled the child to continue with accessing school trips, extra-curricular activities and increased attendance at school.

- Epilepsy resources in other languages and easy read versions for LD patients have been identified and are being utilised.

- A Review Meeting has taken place which included a discussion around inequalities. The CYP Operational Group will be focusing on this area of work going forwards when the group is established.

Planned deliverables (During the reporting period)	Due	Delivered (Yes / No)	If not on-plan or not started, please reason why and what actions are being done to progress this?	If not on plan or not started, has this been escalated to the responsible committee?
Delivering the CORE20+ for CYP with Epilepsy				
Service extended to March 2025	Q2	Yes		
Service analysis of referral trends with demographic overlay (IMD and ethnicity)	Q3	No	Information to be gathered on demographic trends. To use Epilepsy12 audit information.	Yes
Themed discussion about inequalities held at review meeting.	Q3	No		
Outcomes / actions of exploration of business case.	Q3	Yes		
Exploring video platform options for sharing of patient videos to epilepsy service to aid quicker diagnosis and effective treatment for epilepsy	Q4	No	The decision regarding funding for the video platform by SaTH is still pending.	Yes
Enhanced MH Support for CYP with Epilepsy				
Enhanced psychological support within the service	Q2	Yes		
Me & My epilepsy screening tool introduced for use in epilepsy clinics	Q3	Yes		
Direct referral pathway commenced to Paediatric Clinical Neuropsychologist & Clinical Psychologist	Q4	Yes		

Delivery of PIEr workshops (psychology)	Q4	No	Recruitment of patient group to PIEr workshops has been challenging. These include concerns about missing school, examination period, parental anxiety around young people mixing with others in a group setting and parents taking time off work to take the young people to the venue. Team to explore if other options are available within a limited time frame due to availability of Paediatric Clinical Neuropsychologist/ESN's once 3 month funding ends June 2025. Consideration of hybrid approach (face-face and online).	Yes
Supporting transition to adult services				
Review undertaken of the transition process for CYP into Adult Epilepsy services.	Q3	Yes		

Diabetes

Programme	Children and Young People's (CYP) Diabetes	**Lead/s**	Marlene Goncalves, System Development and Service Re-design Manager, NHS Shropshire, Telford & Wrekin ICB
Key/statutory health inequality targets	• Increase access to real-time continuous glucose monitors and insulin pumps across the most deprived quintiles and from ethnic minority backgrounds; and • Increase proportion of those with Type 2 diabetes receiving recommended NICE care processes.	**Responsible committee**	Currently under review

Brief Summary and Highlights

- Outcome report from the GIRFT Deep Dive into CYP Diabetes services has been received and will inform future areas for prioritisation in the transformation programme. Key findings include:
  - STW has one of the highest proportions of CYP on Hybrid Closed Loops (HCL).
  - There is a lack of service provision for 18–25-year-olds.
  - Patient lists have been reviewed by ethnicity and deprivation deciles to enable a quality improvement approach to improving the number of children on insulin pump technology, aiming to identify and address inequalities. This good news story has previously been shared with members of the

Health Inequalities and Prevention Group, and was praised by NHS England when presented to the NHS England Health Inequalities Site Visit in January 2025.

- Proposal paper approved by Commissioning Working Group to ring fence the issue of Hybrid Closed Loops to 3 priority groups to include CYP for Quarter 1 2025/26 as a minimum whilst an affordable delivery plan is developed with SaTH for the remainder of the planned 4-year national implementation plan. SaTH have circa 70 patients on their waiting list, but these are not all CYP. Patients on the waiting list are actively risk stratified, the assessment criterion being applied includes date of birth and if the person is under-25 years of age. A working group is in place with ICB and SaTH colleagues to discuss and monitor the implementation of Hybrid Closed Loops, with input from Core20PLUS Ambassadors.

Planned deliverables (During the reporting period)	Due	Delivered (Yes / No)	If not on-plan or not started, please reason why and what actions are being done to progress this?	If not on plan or not started, has this been escalated to the responsible committee?
Delivering the CORE20+5 for CYP Diabetes Aim				
Analytical work to identify those young people in CORE20 for pump-start prioritisation	Q2	Yes		
Clinic slots for pump starts prioritised for young people in core 20.	Q3	Yes		
Barriers/concerns to pump therapy to be understood and actions to address identified	Q4	Partially	SaTH have developed a business case for additional workforce as they are at the limit of what they can deliver with current capacity. Status of the business case in SaTH/ICB approvals to be confirmed.	
Supporting CYP with Diabetes to access digital technology				
Outcomes/actions of exploring refurbished Trust laptops to support access to digital technologies	Q3	Yes		

Oral Health

Programme	Oral Health Improvement Programme	**Lead/s**	Anna Hunt, Consultant in Dental Public Health, NHS England - Midlands
Key/statutory health inequality targets	Tooth extractions due to decay for children admitted as inpatients in hospital, aged 10 years and under.	**Responsible committee**	Oral Health Network

Brief Summary and Highlights

- The government have announced a national supervised toothbrushing scheme which will enable expansion of current local schemes. This will specifically target provision to all children in IMD deciles 1 and 2. Local Authorities are working to implement the government's commitment. It is planned that progress will be monitored as part of 2025/26 STW Healthcare Inequalities Implementation Plan.

- As of the stocktake undertaken on 17th April 2025, in Telford & Wrekin, 53 settings were targeted and offered, but only 35 are currently participating, including one SEND school. In Shropshire, 36 settings were targeted and offered, but only 21 are currently participating. Settings have reported increasing number of children with additional needs or requiring 1-1 support, not school ready (i.e. not toilet trained) which makes supervised toothbrushing more difficult to implement. There can also be challenge in maintaining a setting's focus on supervised toothbrushing, particularly against conflicting priorities from Ofsted, or staffing issues.

- Several meetings have taken place with the 0-19 Service Lead to explore the challenges and barriers to distribution of the Brushing 4 Life packs in Telford and Wrekin. They reported that identifying the deprived families was proving one of the main challenges. Following the recent 5 year old data, Brushing 4 Life will be made a universal offer from Quarter 2.

Planned deliverables (During the reporting period)	Due	Delivered (Yes / No)	If not on-plan or not started, please reason why and what actions are being done to progress this?	If not on plan or not started, has this been escalated to the responsible committee?
Brushing 4 Life (provision of toothbrushes/toothpaste)				
Brushing 4 Life packs distributed by health visitors to CYP (0-24months) within most deprived areas **Shropshire:** pack 1s distributed per Q 89 pack 2s distributed per Q 178 **Telford and Wrekin:** pack 1s distributed per Q 214 pack 2s distributed per Q 428	Every Q	No	Quarter 4 data is not due to be reported until 20/05.	
Outcomes/actions from exploration of including distribution of packs into health visiting service contract.	Q4	TBC	To be confirmed. Same number of packs have been included for the target as the Local Authority have set for the 0-19 mandated visit KPIs.	
Annual 0-19 service oral health training delivered to all new HV & SN staff, include distribution of Brushing 4 Life	Q4	TBC	An oral health workforce training session for new staff was agreed. Annual update session for current staff planned for Quarter 4, information to be included in the Quarter 4 report.	
Oral Health Workforce Training				
Delivery of workforce training sessions to health visitors, school nurses, etc.,	Q1	Yes		
Brilliant Brushers (Supervised Toothbrushing)				

3 (Shropshire) & 3 SEND (Telford) new schools engaged with Brilliant brushers programme	Q3	Yes		
Exploratory work completed to understand barriers to settings participating in Brilliant Brushers	Q3	Yes		
Brilliant brushers – actions from exploratory work (barriers to participation) implemented	Q4	Yes		
Targeted Dental Activity				
Confirmed offer for target populations (additional dental activity)	Q2	Yes		
Inclusion groups withing locality identified for prioritisation (additional dental activity)	Q2	Yes		
Messaging shared within target communities	Q3	Yes		
Delivery of activity to CORE20 populations	Q3	Yes		
Social media marketing campaigns				
Delivery of a minimum of 2 campaigns and post weekly up-to-date oral health advice and information on social media platforms.	Q1	Yes		

Children and Young People's (CYP) Mental Health

Programme	Children and Young People's (CYP) Mental Health	**Lead/s**	Barrie Reis Seymour, Head of Commissioning, NHS Shropshire, Telford & Wrekin ICB Anna Deacon, Midlands Partnership University Foundation Trust (MPUFT)
Key/statutory health inequality targets	Improve access rates to children and young people's mental health services for 0-17 year olds, for certain ethnic groups, age, gender and deprivation.	**Responsible committee**	Mental Health Board

Brief Summary and Highlights

- A considerable amount of professional and public engagement had been undertaken as part of previous work to review, redesign and inform the recommissioning of a new Children and Adolescent Mental Health Service (CAMHS). This included local needs assessments, professional and public engagement, review of public and population health data, inequalities data and national best practice. Between January and March 2025 this was developed further still with an additional round of extensive engagement undertaken, those engaged with included children and carer forums, schools, children's groups, the voluntary and care sector, religious groups. Targeted engagement was also undertaken within some under-served children's communities, many in Core20 areas. Methods included a range of workshops, surveys, face to face conversations and social media campaigns. In parallel, scoping and research has been expanded open, looking into best practice models of care linked to prevention and earlier intervention.

Community engagement supported capturing from key local groups what is working well, areas for improvement and recommendations on how future services could be improved. Key groups identified to support include Looked After Children (LAC), Children with Special Educational Needs and Disabilities (SEND), young people in contact with the criminal justice system (YOT), and those who have experienced or at risk of Child Sexual Exploitation (CSE). The Engagement Report has been finalised and has been published on the ICB's website: Child and Adolescent Mental Health Services: Public Engagement Report of Findings

Focus on how to reach Core20PLUS communities has been considered and factored into the review and development of the new service model, with an integrated impact assessment currently being finalised as part of the new service redesign and evidencing anticipated impact on those with protected characteristics and wider determinants of health, and is used to underpin a number of specific developments in the new service model that set out to mitigate any recognised inequalities. One of the major inequalities areas recognised in this work is that the greatest proportion of demand on CYP mental health services is from children living in deprived areas for a wide number of reasons including cost & affordability, transport and accessibility, behaviours and family support. Similarly, the greatest proportion of missed appointments, or appointments where the child is not brought to their appointment, is for children again in areas of deprivation and so requires a targeted approach in differentia delivery models that can ensure these individuals are reached and support provided. Not to the same degree, but some similar issues exist for those children living in remote and rural locations with challenges around transport and access, although some semi-urban areas now also have challenges around regular transport links. This works aims address access barriers for the Core20PLUS community in the new service.

All feedback and scoping work is being consolidated and will inform the new proposed service delivery model. Reporting metrics and Key Performance Indicators (KPIs) will be developed, which will be split by ethnic group and areas of deprivation, linking back to monitoring outcomes.

- Mental Health Support Teams (MHST) took on 6 attrition Education Mental Health Practitioner (EMHP) trainees alongside the 4 trainees for Wave 10. All 10 trainees qualified, with 8 remaining working within MHST. 2 Children Wellbeing Practitioners (CWP's) trained within the BeeU Core Service joined MHST in March 2025. A Band 7 Team Manager has been recruited, starting in June 2025, after a long period of a vacant Team Manager post. The group provision has been strengthened and developed with further training planned to deliver more variety in the group programme. MHST Consultation is now able to be accessed by any professional working with CYP within MHST schools. MHST's are now active in 12/15 mainstream secondary schools in Telford and 18/20 in Shropshire with the roll out of Wave 12. MHST are active in specialist settings Queensway North in Telford and Woodlands in Shropshire.

Planned deliverables (During the reporting period)	Due	Delivered (Yes / No)	If not on-plan or not started, please reason why and what actions are being done to progress this?	If not on plan or not started, has this been escalated to the responsible committee?
Children and Adolescent Mental Health Service (CAMHS) Recommissioning				
Outcomes based commissioning around CORE20-5 is integrated into the service specification	Q3	Yes		
Pathway mapping and proposed model for new CAHMS service	Q4	Yes		
Mental Health Input for Family Hubs				
Agreed mental health input model for Family Hubs	Q3	No	This work is now being considered in conjunction with broadened exploration of VCSE involvement/offers. Work	Yes
Family hubs Mental Health input model implemented	Q4	No		

			continues to take place to review Mental Health input into community-based family hubs.	Completion will continue to be tracked outside quarterly reporting process.
Mental Health Support Teams (MHST) in Schools				
1 MHST training team due to be fully operational by January 2025.	Q4	Yes		
Wave 12 (4 trainee practitioners) to commence annual training	Q4	Yes		
Partnership for Inclusion of Neurodiversity in Schools (PINS)				
No deliverables planned for the reporting period.				

KLOE 5: Strengthening Leadership and Accountability

Embedding a culture of proactive commitment and accountability through designated responsible officers, robust governance, workforce training and awareness and supporting the NHS to positively impact on the broader social, economic and environmental determinants of health.

Leadership and Accountability Programme

Programme	Leadership and Accountability Programme	**Lead/s**	Tracey Jones, Head of Healthcare Inequalities and Alexandra Mace, Healthcare Inequalities Partnership Lead, NHS Shropshire, Telford & Wrekin ICB
Key/statutory health inequality targets	Continue to address health inequalities and deliver on the Core20PLUS5 approach, for adults and children and young people	**Responsible committee**	Health Inequalities and Prevention Group

Brief Summary and Highlights

- A substantive Health Inequalities Team was developed as part of the new operating model through the ICB Management of Change in 2024 to provide dedicated expertise in this area to the system and drive forward the health inequalities agenda. The team recruited to the Healthcare Inequalities Manager role in February 2025 with the successful candidate commencing in post 17th March. Due to recent national announcements that Integrated Care Boards (ICBs) are required to reduce running costs by 50%, all recruitment has been paused. This includes recruitment to the roles of Healthcare Inequalities Specialist Support Officer and Healthcare Inequalities Administrator role. At present, the ICB Health Inequalities Team is working at reduced capacity with a 40% vacancy rate. Recruitment will remain under review until the new ICB model is developed.

- Schedule 2N (the schedule which identified actions for Trusts to undertaken which will support in tackling inequalities in access, experience and outcomes) has been refreshed and simplified for the 2025/26 contractual year. This has been completed to ensure the schedule identifies all core requirements in line with national objectives, whilst cross-referencing to existing governance and reporting requirements to avoid duplication.

- Health inequality awareness presentations have been delivered by the Health Inequalities Team to the Early Cancer Diagnosis Group, ICB Strategy and Development Team and Primary Care Network (PCN) Digital & Transformation Leads.

- Discussions continue to take place with Cohort 3 Core20PLUS5 Ambassadors to offer advice, peer support and solutions to barriers. This includes linking in Ambassadors with relevant system partners, such as local schools and primary care settings who will be able to offer support such as co-developing projects or identifying data-sharing solutions to enable targeted efforts for screening.

- Work is taking place with Health Inequalities, Quality, Communication and Engagement and PMO Teams as part of a task and finish group to review and revise the ICB Equality and Quality Impact Assessment (EQIA)/Integrated Impact Assessment (IIA) tools, templates and processes. The task and finish group has utilised feedback from staff to improve the assessment process, refine impact assessment questions and develop draft supporting guidance to aid staff in considering impact on inequality.

- As part of influencing local procurement and commissioning processes, members of the ICB Health Inequalities Team are part of core process to review and work with local Commissioners on commissioning proposals, procurement tenders and Equality and Inequality Impact Assessments (EQIAs). This is to ensure that adequate consideration is given to any potential risk of widening existing inequality and identify appropriate actions to mitigate that risk.

- Work has taken place to commence drafting a year-end high-level evaluation of 2024/25 activity. The report aims to understand:
    - Whether recommendations from the previous year have been embedded
    - Progress against agreed deliverables and any key challenges contributing towards any delays in-year
    - Progress in working towards the intended improvement in patient and population health outcomes
    - Key priority actions for 2025/26 based on learning and the year-end position

- Work has commenced to understand current service offers, convene stakeholders, scope best practice and share learning in relation to key priority areas already identified for implementation in 2025/26. This has included ICB Health Inequalities Team attendance at regional Health and Justice Summit, the implementation of a local network for improved health literacy and engaging in discussions with key stakeholders on joint approaches to supporting the health engagement of inclusion health groups, such as Gypsy, Roma and Traveller Communities.

- Green Plan refreshed guidance was released in February 2025 with a submission date for a new System Green Plan by October 2025. Work is currently taking place with Providers and ICB subject-experts to develop elements of the plan. This work is on track to deliver to the planned timescales and will continue to form part of Quarters 1 and 2 within the Healthcare Inequalities Implementation Plan.

Good News Stories

- On Monday 13th January 2025, Regional NHS England Leads for Health Inequalities and Public Health attended Shropshire, Telford & Wrekin as part of their summative assessment of ICB's systems delivery of the HealthCare Inequalities agenda. Shropshire Telford and Wrekin were the third ICB to have a visit. It is the first time these visits have been undertaken and they are intended to supplement the quarterly stocktake reports on the ICB's Healthcare Inequalities Plan in addition to any requests on themed areas throughout the year.

  A range of themed discussions and showcase presentations were arranged, featuring colleagues from across the system who are actively and positively contributing to the five Operational Planning Guidance healthcare inequality objectives and the Core20PLUS5. This included presentations from strategic, analytical, and clinical staff on areas such as improving access to diabetic technologies for children and young people, reducing disparities in hypertension

treatment across Core20PLUS populations and the progress made on leadership and governance.

The initial feedback from the Regional NHS England Team described the day as extremely positive, noting particularly the vast range of colleagues who attended the day to share and discuss their work and the enthusiasm felt by all to make a difference to under-served and under-represented communities in Shropshire, Telford & Wrekin.

- In Quarter 3, Shropshire, Telford & Wrekin were invited to participate in a piece of sustainability research. This work was based on the positive impacts of programmes such as Core20PLUS Connectors and was undertaken by The Health Creation Alliance and National Voices, on behalf of the national Health Inequalities Improvement Programme. A series of interviews took place with the ICB Head of Healthcare Inequalities, Healthcare Inequalities Partnership Lead, Public Health and VCSE delivery partners to seek insights relating to the successful implementation, delivery and sustainability of the Shropshire, Telford & Wrekin Core20PLUS Connector Project (known locally as Cancer Champions). These insights feature heavily throughout the Core20PLUS Connectors Programme Sustainability Leading to System Change Report and Resource Kit, which were published in March 2025.

  Core20PLUS Connectors Programme: Sustainability Leading to System Change Report (download)
  Core20PLUS Connectors Programme: Connecting for Funding and Sustainability Resource Kit (download)

Planned deliverables (During the reporting period)	Due	Delivered (Yes / No)	If not on-plan or not started, please reason why and what actions are being done to progress this?	If not on plan or not started, has this been escalated to the responsible committee?
Architecture of Successful Delivery				
Complete Evaluation Report on 2023-24	Q1	Yes		
Part-established ICB HI Team	Q1	Yes		
Agreed local objectives for focus/priority in 2024/25	Q1	Yes		
Ratified Strategic HI Plan for 2024-25	Q2	Yes		
Updated governance (reporting and monitoring framework) 2024-25	Q2	Yes		
HI Team representation on key programme groups aligned to enhanced support priorities within the HI Plan	Q2	Yes		
PHI Board dates confirmed for 2024-25	Q2	Yes		
Agreed Schedule 2N for 2024-25	Q2	Yes		
Fully established ICB HI Team	Q3	No	Recruitment to posts within the ICB have been paused due to national announcements for ICBs to reduce running costs by 50%. This has resulted in the pausing of recruitment to Support and Administrator posts within the	Yes – alerted in February 2025 in advance of the Quarter 4 report due to anticipated delays in completion of Quarter4 deliverables.

			ICB Health Inequalities Team. Recruitment to posts will be under review subject to developments relating to ICB cost reductions.	
Part-complete evaluation	Q4	Yes		
Agreed 2025/26 Schedule 2N in Provider Contracts	Q4	Yes		
Peer Support and Development				
Evaluation outcome report section on education needs of staff	Q1	Yes		
Delivered ICB Board Development Session	Q1	Yes		
Agreed list of workshops and board development sessions for 2024-25	Q2	Yes		
Local Ambassador promotional webinar	Q2	Yes		
Staff applications for Core20PLUS Ambassadors	Q2	Yes		
Shro and Tel intranet pages are live	Q2	Yes		
ICB Virtual Huddle Health Inequalities Session	Q3	Yes		
Confirmed Cohort 3 Ambassadors	Q3	Yes		
Staff Induction Video embedded within HR processes	Q4	No	Work paused due to changes in team capacity across the ICB amidst national announcements and recruitment delays/pauses. Conversations are taking place to explore alternative options to delivering this project or achieving the intending outcome in 2025/26.	Yes – alerted in February 2025 in advance of the Quarter 4 report due to anticipated delays in completion of Quarter 4 deliverables.
Board Development Sessions held for main Providers	Q4	Yes		
Delivery of bespoke HI sessions for ICB departments.	Q4	Yes		
Inclusion Health Lunch and Learn	Q4	No	Work paused due to changes in team capacity across the ICB amidst national announcements and recruitment delays/pauses. This work will feature in the 2025/26 plan as part of a priority series of Lunch and Learn sessions.	Yes – alerted in February 2025 in advance of the Quarter 4 report due to anticipated delays in completion of Quarter 4 deliverables.
Green Plan Lunch and Learn	Q4-2025/26	No		

Embedding Systematic Approaches to Assessing Impact				
Updated IIA supporting guidance/examples	Q4	No	This work is being led jointly by a group of key stakeholders. Progress was delayed to ensure new updates relating to governance were incorporated within the new guidance and process documents. To be completed in Quarter 1 of 2025/26.	Yes
Collection of best practice IIAs	Q4	Yes		
Staff training for IIA completion	Q4	No	Work delayed due to changes in team capacity across the ICB amidst national announcements and recruitment delays/pauses. This work will feature in the 2025/26 plan as part of the peer support and development offer.	Yes – alerted in February 2025 in advance of the Quarter 4 report due to anticipated delays in completion of Quarter 4 deliverables.
Building the Business Case for Health Inequalities				
Health Inequalities Team as a core member to procurement panels	Q2	Yes		
Head of Health Inequalities core member of service review/investment group	Q2	Yes		
Standardised list of core Health Inequalities Questions in ITT Evaluation Question Sets	Q2	Yes		
Anchor Collaborative Improvement				
Briefing to Health Inequality SROs	Q2	Yes		
System Anchor Impact Workshop	Q3	No	Work paused due to changes in team capacity and delays in recruitment amidst national announcements for ICBs to reduce running costs by 50%. This work will feature in the 2025/26 plan. The extent to which the actions feature will be subject to priorities identified as part of the 2024/25 evaluation, taking into consideration the reduced capacity of the team longer-term.	Yes – alerted in February 2025 in advance of the Quarter 4 report due to anticipated delays in completion of Quarter 4 deliverables.
Completed self-assessment across system main providers	Q3	No		
Drafted strategy and action plan for improving anchor impact	Q4	No		
Green Plan recommendations for 2025/26	Q4	Yes		

For any queries in relation to this report, please contact stw.icbhealthinequalities@nhs.net

Integrated Care System
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Shropshire, Telford & Wrekin Integrated Care Board

2025/26 Summary of Planned Action to Tackle Inequalities in Access, Experience and Outcomes

1 Architecture for Successful Delivery as a System

- ICB Health Inequalities Team will provide leadership to co-ordinate and support the development of a refreshed high-level healthcare inequalities implementation plan which addresses all Core20PLUS5, Elective Reform and Operational Planning Guidance requirements which incorporates learning from 24/25 processes.
- ICB Health Inequalities Team will work with Providers to strengthen the consistency and triangulation of governance and accountability arrangements through Schedule 2N of the NHS Provider Contract.
- All System partners to develop data, intelligence and insights resources to demonstrate impact across Core20PLUS populations.

2 Targeted Interventions Based on Evidence

- Improve ethnicity and housing status coding.
- Support Primary Care to improve hypertension and lipid optimisation in CORE20PLUS populations with a specific focus on decreasing the percentage point difference between ethnic population groups.
- Flu vaccination uptake decrease percentage point difference between the most deprived 20% of the eligible population (IMD 1 and 2) and the average of the remaining eligible population (IMD 3 to 10).
- Increase early diagnosis rates (cancers diagnosed at stages 1 and 2) across all populations, and by at least as much in the most deprived areas as in least deprived areas.

3 Improved Integration and Partnerships

- Assess our systems maturity as an anchor institution and develop a programme of work to increase anchor impact for Core20PLUS population groups.
- Embed systematic approaches to prevention/lifestyle management, expanding on waiting well initiatives implemented within MSK Transformation to other priority clinical areas.
- Target increased quit rates through the integration of smoking cessation across primary care pharmacists, local authorities and secondary care utilising person centred and neighbourhood teams approaches.

- Working with the Population Health Management Group, develop our system wide knowledge and intelligence to agree further focused areas of intervention.
- Strengthen local pathway transformation and partnership approaches in the contexts of **digital inclusion**, inclusion health and adopting health and digital literacy practices.

4 Embedding Health Inequalities in Decision-making

- Implementing an audit of how healthcare inequalities are currently considered and developing action plans from findings.
- Strengthen health inequalities expertise within healthcare procurement process to offer better value for money against health inequality and social value criteria.

5 Ambassadorship

- Embed the CQC Framework for Reducing Health Inequalities within Communication, Engagement and Involvement processes and project delivery.
- **Build upon current peer support and development opportunities** to accelerate our ambition to normalise health inequalities into everyday business.
- Provide a focused offer of leadership and support to Primary Care Networks and Local Care Programmes in tackling inequalities during 2025/26.
- Embed the importance of health inequalities within staff induction processes.

Agenda Item

ICB 25-06.179

Finance Strategy

Appendix 1 - NHS STW Finance Strategy

Appendix 2 - MTFP and LTFP

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Medium-Term Financial Plan and Long-Term Financial Plan

24 June 2025

Medium Term Financial Plan (MTFP) – 3 Year Breakeven

The model delivers an underlying break-even position within three years (by 2027/28), using 2025/26 as year one of three.

Financial Plan £'m	24/25 Actual	25/26 Plan	26/27 Plan	27/28 Plan
System recovery plan trajectory	(115.0)	(83.8)	(40.3)	0

The MTFP assumes total system efficiencies of between 5 - 6% per organisation per annum after Year 1 (25/26).

Efficiency is achieved through a combination of Business As Usual (BAU) schemes and System Transformation schemes - circa 50/50 split.

Year 1 25/26

Break Even in 3 Years	SATH £M	RJAH £M	SCHT £M	ICB £M	Total £M
Organisational Plan before Efficiencies	(86.4)	(9.6)	(3.4)	(78.6)	(178.0)
Efficiencies	41.4	9.6	5.4	37.9	94.3
Organisational Plan after Efficiencies	(45.1)	0.0	2.0	(40.7)	(83.7)
Underlying position	(46.5)	(8.7)	0.9	(41.3)	(95.5)
Total % Efficiency Required	6.4%	5.9%	5.0%	7.3%	

Year 2 26/27

Break Even in 3 Years	SATH £M	RJAH £M	SCHT £M	ICB £M	Total £M
Organisational Plan before Efficiencies	(61.4)	(5.8)	(6.1)	(47.5)	(120.9)
Efficiencies	38.8	8.6	6.1	27.1	80.6
Organisational Plan after Efficiencies	(22.7)	2.8	(0.0)	(20.3)	(40.3)
Underlying position	(22.7)	(5.7)	(0.0)	(20.5)	(48.9)
Total % Efficiency Required	5.8%	5.1%	5.6%	5.4%	

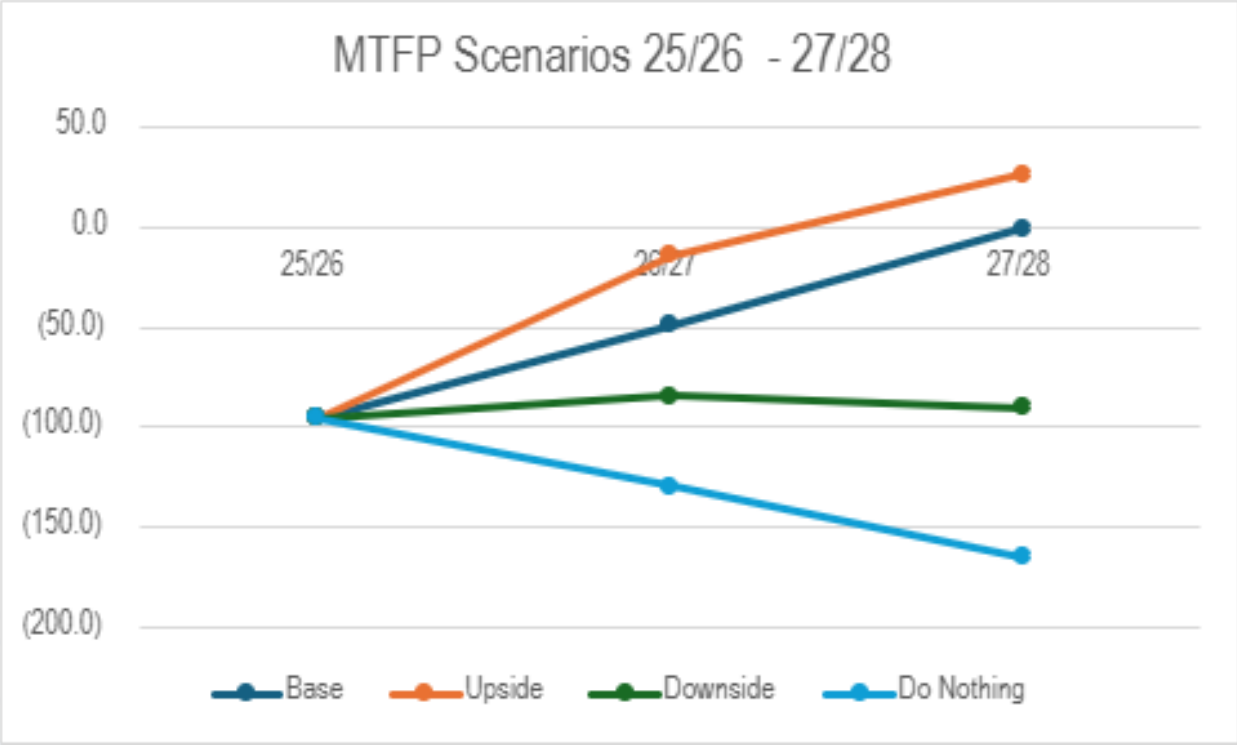
Year 3 27/28

Break Even in 3 Years	SATH £M	RJAH £M	SCHT £M	ICB £M	Total £M
Organisational Plan before Efficiencies	(38.7)	(3.0)	(6.4)	(27.9)	(76.0)
Efficiencies	38.7	9.1	6.3	30.3	84.5
Organisational Plan after Efficiencies	0.0	6.1	(0.0)	2.4	8.5
Underlying position	0.0	(2.4)	(0.0)	2.4	(0.0)
Total % Efficiency Required	5.8%	5.3%	5.6%	6.1%	

NHS England are expecting to publish updated national planning assumptions including policy on the pace of change in relation to distance from target allocations later in the year. The model will be refreshed to reflect these once known.

MTFP Scenarios

We have modelled our financial recovery under different scenarios to test the potential pace of recovery. The assumptions to describe the trajectories in the graph below are detailed to the right.



- The "Do Nothing" case assumes no efficiencies after 2025/26. In this case the system deficit would increase to £165m by 2027/28.
- The "Downside" case assumes an increased level of cost pressures and a reduced level of efficiency delivery (3.5%). In the downside case it would take around 8 years to reach breakeven.
- The "Upside" case assumes a reduction in the level of cost pressures and a slightly lower requirement for efficiency in 2026/27 and 2027/28. This does not materially improve the recovery trajectory beyond the Base case.
- In the next MTFP update scenario modelling will be expanded to cover:
  - Demand and Capacity Scenarios
  - Acute to Community shift modelling - Local Care Programme/Healthcare Models

Long-Term Financial Plan (LTFP) [1]

In addition to the MTFP, we have extended our modelling to reflect high level assumptions to give a view over a ten-year period. This allows us to look forward across the whole period of HTP delivery and beyond. The model assumes maintaining a break-even position.

	Year 4 - 28/29				
	SATH	RJAH	SCHT	ICB	Total
	£M	£M	£M	£M	£M
Opening Recurrent Plan	0.0	0.0	0.0	(0.0)	
Income/Allocation	5.3	3.6	0.5	49.8	
Inflation	(16.1)	(4.8)	(3.9)	(36.0)	
Cost Pressures/Investment	(38.2)	(8.4)	(6.9)	(19.6)	
Other	(1.1)	(0.2)	(0.1)	3.5	
Intra System	16.7	2.1	3.6	(22.6)	
Efficiencies	33.4	7.6	6.8	24.8	
Surplus/(Deficit)	0.0	0.0	0.0	0.0	0.0

	Year 5 - 29/30				
	SATH	RJAH	SCHT	ICB	Total
	£M	£M	£M	£M	£M
Opening Recurrent Plan	0.0	0.0	0.0	(0.0)	
Income/Allocation	5.3	3.8	0.5	49.8	
Inflation	(16.8)	(5.0)	(4.0)	(12.3)	
Cost Pressures/Investment	(39.5)	(8.7)	(7.1)	(43.3)	
Other	0.2	(0.2)	(0.1)	3.5	
Intra System	16.4	2.2	3.7	(22.6)	
Efficiencies	34.5	7.9	7.0	24.8	
Surplus/(Deficit)	0.0	0.0	0.0	0.0	0.0

	Year 6 - 30/31				
	SATH	RJAH	SCHT	ICB	Total
	£M	£M	£M	£M	£M
Opening Recurrent Plan	0.0	0.0	0.0	0.0	
Income/Allocation	5.5	3.9	0.6	60.0	
Inflation	(20.2)	(5.2)	(4.1)	(12.7)	
Cost Pressures/Investment	(40.6)	(9.8)	(7.6)	(47.4)	
Other	0.2	(0.3)	(0.1)	0.0	
Intra System	19.5	2.6	4.4	(26.5)	
Efficiencies	35.5	8.7	6.9	26.6	
Surplus/(Deficit)	0.0	(0.0)	(0.0)	(0.0)	(0.0)

	Year 7 - 31/32				
	SATH	RJAH	SCHT	ICB	Total
	£M	£M	£M	£M	£M
Opening Recurrent Plan	0.0	(0.0)	(0.0)	(0.0)	
Income/Allocation	5.7	4.1	0.6	62.4	
Inflation	(20.4)	(5.4)	(4.2)	(14.0)	
Cost Pressures/Investment	(42.6)	(10.2)	(7.9)	(48.6)	
Other	0.2	(0.3)	(0.2)	0.0	
Intra System	20.2	2.7	4.6	(27.5)	
Efficiencies	36.8	9.0	7.2	27.7	
Surplus/(Deficit)	(0.0)	0.0	(0.0)	(0.0)	(0.0)

	Year 8 - 32/33				
	SATH	RJAH	SCHT	ICB	Total
	£M	£M	£M	£M	£M
Opening Recurrent Plan	(0.0)	0.0	(0.0)	(0.0)	
Income/Allocation	5.9	4.3	0.6	64.9	
Inflation	(21.3)	(5.6)	(4.3)	(15.3)	
Cost Pressures/Investment	(44.0)	(10.6)	(8.2)	(49.9)	
Other	0.2	(0.3)	(0.2)	0.0	
Intra System	21.0	2.8	4.7	(28.6)	
Efficiencies	38.1	9.4	7.4	28.9	
Surplus/(Deficit)	0.0	0.0	0.0	(0.0)	0.0

NB: 'Intra System' is Growth & Net Tariff allocations passed to SaTH, RJAH & SCHT from the ICB

Long-Term Financial Plan (LTFP) [2]

	Year 9 - 33/34				
	SATH	RJAH	SCHT	ICB	Total
	£M	£M	£M	£M	£M
Opening Recurrent Plan	0.0	0.0	0.0	(0.0)	
Income/Allocation	6.1	4.4	0.6	67.5	
Inflation	(22.1)	(5.8)	(4.5)	(16.6)	
Cost Pressures/Investment	(45.4)	(11.0)	(8.5)	(51.3)	
Other	0.2	(0.3)	(0.2)	0.0	
Intra System	21.8	3.0	4.9	(29.6)	
Efficiencies	39.4	9.7	7.7	30.0	
Surplus/(Deficit)	(0.0)	0.0	0.0	(0.0)	0.0

	Year 10 - 34/35				
	SATH	RJAH	SCHT	ICB	Total
	£M	£M	£M	£M	£M
Opening Recurrent Plan	(0.0)	0.0	0.0	(0.0)	
Income/Allocation	6.4	4.6	0.7	70.2	
Inflation	(23.1)	(6.0)	(4.7)	(17.9)	
Cost Pressures/Investment	(46.9)	(11.5)	(8.9)	(52.8)	
Other	0.2	(0.3)	(0.2)	0.0	
Intra System	22.6	3.1	5.1	(30.8)	
Efficiencies	40.8	10.1	8.0	31.3	
Surplus/(Deficit)	0.0	(0.0)	0.0	0.0	0.0

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Shropshire Telford, and Wrekin Integrated Care System Finance Strategy 2025-2030

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1. Foreword and Introduction - why have we developed this strategy?

Managing Our Finances for a Sustainable Future

At NHS Shropshire Telford and Wrekin, we are committed to ensuring that every pound we spend delivers the greatest possible benefit for our communities. Strong financial governance and a culture of grip and control is essential to achieving this, and we work hard to ensure our financial decisions are both responsible and sustainable.

Our system has undergone substantial change in recent years. In April 2016, Shropshire CCG was placed into Legal Directions by NHS England, prompting significant work to strengthen financial governance. In 2021, Shropshire CCG merged with Telford and Wrekin CCG, and this was then followed by the creation of NHS Shropshire Telford and Wrekin Integrated Care Board (ICB) in July 2022.

Meanwhile, Shrewsbury and Telford Hospitals NHS Trust was placed into Quality Special Measures in November 2018 and in July 2021, it entered the Recovery Support Programme, alongside the ICB. As a result, our system is subject to close oversight. We have a System Integrated Improvement Plan which includes, amongst other things, a clear requirement to develop a sustainable approach to improving our financial position.

We have made significant investments to improve quality and safety at Shrewsbury and Telford Hospitals NHS Trust, and we will build on this through delivery of the Hospital Transformation Programme supported by the Local Care Programme. Our aim remains to move care closer to home, but we continue to face financial challenges. Right now, our system is spending more than its allocated budget, which means we must take decisive action to achieve financial recovery.

When looking across our broader System, our two Local Authorities in Shropshire and Telford and Wrekin are also reporting financial positions that are increasingly challenging each year with reliance on reserves to break even. Whilst this Strategy specifically refers to the NHS financial envelope, we are cognisant of pressures in our wider system and work closely with our Local Authority colleagues to ensure we make best use of the 'Shropshire, Telford and Wrekin Health and Care Pound.'

We operate in financially constrained times and therefore must seek to maximise efficiency and productivity opportunities to support our recovery. Instead of spending more, we need to focus on using our resources differently, allocating funding where it creates the most health value by focusing on improving quality outcomes for patients. Where application of our current resource allocation does not support this agenda, we will need to make some difficult decisions about future spend.

Aligning with NHS Priorities: The Three Shifts and Darzi Recommendations

Our financial strategy, in conjunction with the ICS integrated care strategy, digital strategy, workforce strategy and infrastructure strategy are designed to support the fundamental shifts

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required to create a more sustainable and high-quality healthcare system. This aligns with the NHS 'Three Shifts'[1], which focus on:

1. **Shifting care upstream** - Investing in prevention by using the six key principles of our Prevention Framework and approach to Integrated Neighbourhood Teams delivering early intervention, and proactive care to reduce the need for hospital treatment.

2. **Shifting care closer to home** - Expanding community-based services to ensure people receive care in the most appropriate setting, reducing health inequalities across our rural population.

3. **Shifting to a more integrated system** - Using technology to enhance integration e.g. by implementing digital projects such as shared digital care planning module through our One Health and Care System to support delivery of improved utilisation of virtual ward capacity using remote monitoring tools to enable all 3 shifts and deliver productivity and efficiency.

Our approach is informed by the recommendations made by Lord Darzi in 2024[2], which emphasise improving quality, efficiency, and patient-centred care. By investing in new models of care, digital innovation, and workforce development, we aim to create a system that is financially sustainable while delivering better health outcomes.

A Smarter Approach to Finance

To achieve this, we are rethinking how we allocate resources, and we have set ourselves a number of key aims. These are to:

1. **Achieve Financial Sustainability** – Establishing a balanced financial position within three years through targeted cost reductions, productivity and efficiency improvements, and resource realignment.

2. **Maximise Health Value from Investment** – Making sure that over time investment into the 'left shift' for prevention, community and digital, as a minimum matches the overall allocation growth uplift percentage (i.e. with funding directed toward interventions that support delivery of the 'left shift', improve patient outcomes, enhance system-wide efficiency, and support **preventative** and **community-based care).**

3. **Enable Transformation Through Strategic Investment** – Supporting service transformation, digital innovation, and workforce development to improve quality, efficiency, and care integration.

4. **Embed a Culture of Financial Stewardship** – Fostering a system-wide approach where every staff member takes ownership of financial sustainability and ensuring accountability and transparency in financial decision-making.

5. **Strengthen System-Wide Collaboration** – Work in partnership with local authorities, NHS providers, and community organisations to create an integrated approach to financial and healthcare planning.

[1] Project: The three shifts | Change NHS,
[2] Summary letter from Lord Darzi to the Secretary of State for Health and Social Care - GOV.UK

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Why We Have Developed This Strategy

This Finance Strategy and accompanying Medium-Term Financial Plan (MTFP) have been developed to address the deep-rooted structural, demographic, and operational challenges in Shropshire, Telford, and Wrekin. Developed in close collaboration with NHS providers, Local Authorities, and wider system partners, the strategy sets a shared vision for financial sustainability and system transformation to address our underlying deficit through tackling the drivers of excess cost which total over £129m[3].

Our aims through this strategy are to:

- provide a clear, honest account of our current financial position and the underlying drivers of our deficit.
- Present a credible, phased plan to return the system to financial balance over the next three years, which will also support the System's exit from level 4 of the National Oversight Framework (NOF4) and national recovery support programme.
- Demonstrate how the System's finances enable delivery of our broader system ambitions, in line with the three shifts noted by Lord Darzi.
- Ensure that the system's six prevention principles - Population Health Management, Person-Centred Approach, Learning and Evidence, Integration, Time, and Leadership – are embedded into financial decision-making.
- Ensure that a strategic framework for decision-making and capital prioritisation remains in place to ensure that every investment decision supports health improvement and value creation.

Ultimately, this strategy is about more than just controlling costs. It is about maximising how we use our funding to build a stronger and more equitable health and care system for the people of Shropshire, Telford and Wrekin; ensuring that every investment we make drives sustainable value, improves outcomes, and delivers on our shared vision for the future.

Thank you for your support as we work together towards a stronger, more financially resilient health system for the future.

[3] UEC, Workforce, CHC, Elective including Productivity, Community, Estates and Corporate Services

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Claire Skidmore, Chief Finance Officer & Deputy Accountable Officer
NHS Shropshire Telford & Wrekin

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2. Executive Summary

Where are we now?

Our system has, and continues to spend, more than both its allocated 'fair share' of resource and the revenue resource financial plan limit each year. Within current spend the system has identified £129m of excess cost drivers.

System Financial Position £'m	2019/20 Actual	2020/21 Actual	2021/22 Actual	2022/23 Actual	2023/24 Actual	2024/25 Actual	2025/26 Plan
Reported Financial Position	(93.4)	0.00	0.00	(65.2)	(72.5)	(12.1)	0.00
Underlying Financial Position	(44.5)	(66.5)	(62.1)	(83.1)	(129.6)	(115.0)	(99.4)
Historic Debt - each year (repayable)			(134.4)	(65.2)	(129.6)	(115.0)	(83.8)

Figure 1: System Historic Financial Performance

Where will we be if we do not take action?

Under a do-nothing scenario, with no efficiency delivery the system would exit 2025/26 with an underlying recurrent deficit of £95.5m which would increase in 2026/27 to £129.5m and in 2027/28 to £165.1m.

What are we going to do about it?

Our aim is to deliver an underlying break-even position within three years, using 2025/26 as year one of three, this includes addressing spend above our fair share of the national funding allocation. Total efficiency required to deliver this would therefore equate to around £85-£90m, 6% of system spend per annum of which circa 3% (£42.5m) is expected to be BAU efficiency and 3% is expected to be delivered through the Strategic Transformation Programme.

Financial Plan £'m	24/25 Actual	25/26 Plan	26/27 Plan	27/28 Plan
System recovery plan trajectory	(115.0)	(83.8)	(40.3)	0

Figure 2: System Recovery Plan Trajectory

We have identified over £129m excess costs across the system and this is where we are looking to identify solutions for cost reduction which then inform the development of the recovery plan, delivered through our Strategic Transformation Programmes.

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Strategic Transformation Programmes	Gross Financial Opportunity 25/26	Gross Financial Opportunity 26/27	Gross Financial Opportunity 27/28	Excess Spend Area the Solution Addresses
Operational Programmes				
Temporary Staffing (Total Opportunity £20m)	6.7	8.4	5.0	Excess Spend : Workforce
Continuing Healthcare (CHC) (Total Opportunity £30m)	15.9	10.1	7.0	Excess Spend : CHC
Elective Productivity Opportunity (Total Opportunity £16.9m)	10.9	1.0	5.0	Excess spend: Productivity
Provider Level Transformation Programmes				
Corporate back office/Non-clinical wte reductions (Total Opportunity £20m)	7.8	6.1	6.1	Excess Spend: Corporate back office / infrastructure
System-Level Transformation				
Urgent and Emergency Care (UEC) (Total Opportunity £37.5m)	8.0	14.5	15.0	Excess Spend: UEC
Local Care Programme (Total Opportunity £20m)		10.0	10.0	Excess Spend: UEC/Community
Hospital Transformation Programme (Total Opportunity £30m)			7.5	Excess Spend: UEC/Corporate Back Office
Vaccine Preventable (Total Opportunity £13m)		1.5	1.5	Excess Spend: UEC
Totals	42.6	43.2	52.1	

Figure 3: System Strategic Transformation Programmes

How Are We Going to Implement Our Plans?

The Shropshire, Telford, and Wrekin Integrated Care System (ICS) has set out a clear Strategic Finance Vision: to create a financially sustainable healthcare system that delivers safe, high-quality care, fosters innovation, and improves population health outcomes. This will be achieved by aligning data-driven decision-making with strategic investment and resource prioritisation to maximise health value. As noted in the foreword, the ICS has identified five strategic aims to deliver this vision.

A strategic decision-making framework underpins the implementation of our vision. It ensures that all financial and investment decisions are transparent, equitable, and focused on delivering maximum value (allocative, technical, and personal). This framework is embedded into annual planning cycles and allows for dynamic reprioritisation based on evolving needs and financial performance.

The ICS will implement its strategy through:

- Strengthened financial governance and collaborative financial management agreements.
- Alignment of contracts and incentives to system goals, including gainshare models and outcome-based payments.
- A system-wide approach to business case appraisal and benefit tracking.
- Investment in financial capability and leadership development for all staff groups.
- Enhanced data-driven decision support using integrated reporting, benchmarking, and forecasting tools.
- Rigorous capital prioritisation based on strategic impact, revenue reduction, and transformation potential.

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- Integrated risk management processes across financial, operational, and clinical domains.
- Testing planning assumptions within the MTFP including activity, income and growth assumptions across all Commissioners, English, and Welsh as part of the overall Demand and Capacity Model.
- Developing scenario modelling as part of the MTFP to support the implementation of the ICS care strategy, three shifts and prevention framework.

3. Where Are We Now?

3.1. Local Context

Population Demographics and Health Needs

NHS Shropshire Telford, and Wrekin (NHS STW) has a population of 533,587 (2024). Shropshire is predominately rural, whereas Telford and Wrekin is predominantly urban. By 2043 there will be an estimated 589,330 people in STW and 30% will be over 65 years old (currently 21%)[4].

Shropshire, Telford, and Wrekin presents a uniquely complex demographic profile[5], combining the challenges of a rapidly ageing rural population with the pressures of urban deprivation and health inequality. Shropshire has a significantly older population, with over 23% of residents aged 65 and above, and a projected 80% increase in dementia cases by 2035. This ageing demographic drives increased demand for long-term condition management, community-based care, and support for frailty and mobility-related issues, placing sustained pressure on both health and social care systems.

In contrast, Telford and Wrekin has a younger, more urban, and increasingly diverse population, but with higher levels of deprivation and associated health risks. Nearly a third of the population lives in the most deprived areas nationally, with above-average rates of childhood obesity, adult overweight, and mental health needs. These dual pressures across the system create a complex financial landscape, requiring a strategy that addresses both rising clinical complexity and widening health inequalities. Targeted investment in prevention, early intervention, and community-based models of care will be essential to managing future demand and achieving financial sustainability.

In addition, lifestyle-related risk factors and access issues present further pressure on the system. Both Shropshire and Telford and Wrekin have higher-than-average rates of obesity, alcohol-related admissions, and smoking in pregnancy, particularly in deprived communities.

Rurality

Rural isolation in parts of Shropshire limits access to primary and community care, with thousands of residents living more than 30 minutes from their nearest GP by public transport. This contributes to avoidable demand, widening health inequalities, and reinforces

[4] Shropshire Telford and Wrekin Integrated Care Strategy
[5] Local Health Challenges - NHS Shropshire, Telford and Wrekin

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the need for targeted prevention, improved service accessibility through Integrated Neighbourhood Teams, and through system-wide public health interventions.

The impact of serving a relatively small population over a large geography is not fully addressed by the current national funding allocation formula contributing to our current financial performance.

In response to the unique demographic and geographic challenges across Shropshire, Telford and Wrekin—including an ageing rural population, pockets of deep deprivation, and persistent health inequalities, our system is actively aligning its strategy to the national "three shifts": from reactive to proactive care, from hospital to community settings, and towards more integrated working. We are expanding prevention and early intervention through targeted lifestyle services and community outreach, particularly in rural and deprived areas. At the same time, we are shifting activity closer to home, increasing virtual ward capacity, remote monitoring, and enhanced care in primary and community settings to reduce reliance on acute services. To support this, we are building integrated pathways through the Local Care Programme and pooled resources across partners through the Better Care Fund, enabling us to plan and deliver care at system level, rather than duplicating services across health and care. This approach will allow us to deliver more responsive, equitable and financially sustainable care across a diverse and complex geography.

Service Provision

Our combined population is served by one acute provider (Shrewsbury & Telford Hospitals NHST - SaTH), one specialist provider (The Robert Jones & Agnes Hunt Orthopaedic Hospital NHS FT - RJAH), one community health provider (Shropshire Community Health NHST - SCHT) and one mental health provider (Midlands Partnership University FT - MPUFT). Our emergency ambulance provider is West Midlands Ambulance Service FT - WMAS.

This financial strategy is set out in the context of the NHS financial framework and business rules and is sensitive to the key interdependencies with our two Local Authorities, Shropshire and Telford and Wrekin, in terms of delivery of health and care services to meet the needs of the population.

System Historical Financial Performance

Our system has, and continues to spend, more than both its allocated 'fair share' of resource and the revenue resource financial plan limit each year. This financial strategy therefore has been set in the context of a material recovery trajectory to remove both the current financial deficit and the distance from target to 'fair shares' allocations. The table below sets out a summary of the historic system deficit. These deficits convert over time into historic debt which is also repayable. Current NHS business rules require a 0.5% (circa £5m) per year repayment until the system achieves financial balance.

System Financial Position £'m	2019/20 Actual	2020/21 Actual	2021/22 Actual	2022/23 Actual	2023/24 Actual	2024/25 Actual	2025/26 Plan
Reported Financial Position	(93.4)	0.00	0.00	(65.2)	(72.5)	(12.1)	0.00
Underlying Financial Position	(44.5)	(66.5)	(62.1)	(83.1)	(129.6)	(115.0)	(99.4)

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Historic Debt - each year is repayable			(134.4)	(65.2)	(129.6)	(115.0)	(83.8)

Figure 4: System Historic Financial Performance

System Achievements Finance

There have been several demonstrable successes in how system resources have been managed over the last three years. These have only been possible because of the partnership and collaboration that has driven decision-making over this time.

We are proud of our achievements which include:

- Successful award of £312m capital funding for the Hospital Transformation Programme. HTP will support financial recovery by addressing the additional costs of a split site acute model at SaTH through reductions to workforce and productivity improvements. Revenue savings are estimated to total £30m long-term which underpins our return to underlying financial balance across the medium to long term as set out in the MTFP.
- Successful award of NHS England capital to support system-wide investments including Elective Hubs (SaTH, PRH), Theatres programme (RJAH), Community Diagnostics Centre (SaTH, Hollinswood House), modular wards (SaTH, PRH/RSH), SCHT Sub-acute/rehab and recovery wards. These support the local care transformation programme and significant improvements to the hospital estate.
- We have also secured digital funding to reach minimum digital foundation level and to support the introduction of new Electronic Patient Record Systems in SaTH and RJAH.

  These key investments in capital support activity to meet the requirements of the demand and capacity model, performance and quality improvements and also support financial recovery through delivery and achievement of productivity benefits.

- The system has improved and sustained elements of grip and control through the implementation of the NHSE Grip and Control Checklist and HFMA financial sustainability checklist. In 2023/24 and 2024/25 financial governance processes have been self-assessed and externally reviewed across the system. In 2024/25 this formed part of the system Investigation and Intervention work programme. Key recommendations were implemented by all system organisations to enhance workforce controls such as establishment reviews, vacancy control panels and agency approvals. Enhanced financial controls are supporting financial recovery.

Other key enablers to support the delivery of financial recovery that we continue to deploy and develop further include:

- Continued openness and transparency in the sharing of financial models and information including in-year and longer-term modelling and risk registers.
- Tools that have been developed to support allocative efficiency and to aid decision making including prioritisation frameworks - Capital and Revenue (Strategic Decision-Making Framework).
- Implementation of the Productivity Oversight Group and organisation specific productivity dashboards. This group oversees productivity improvements through the use of (including but not limited to):
  - National NHSE benchmarking packs e.g. LOS, theatre, medicines, corporate staffing, temporary staffing.

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  - Workforce benchmarking information to support workforce productivity improvements.
  - Cost benchmarking - using model health system, reference costs and other available benchmarks including local provider data.
  - Taking a quality improvement approach to individual service reviews to identify productivity improvement opportunities.
- Oversight of delivery of system transformation programmes through the Financial Improvement Programme.
- Development and implementation of the SaTH 'Task Force' and Financial Recovery Group.
- Development of a System PMO function with standardised templates, business cases and systems.
- We have a well-established systemwide Finance Training and Development Council whose purpose is to create, develop and support the Finance community for the STW system. We are proud that all system organisations have achieved Towards Excellence Accreditation under the Future Focussed Finance Scheme.

Drivers of Excess Cost

The bridge in Figure 5 shows the key drivers of excess cost for the system based on adjusted cost growth from 2019/20 to 2023/24 i.e. the change observed in the system cost base across the period or where benchmarking against peer median indicates that there are additional costs above the mean against the existing funding envelope (e.g. estates and corporate services). The analysis represents the overall scale of opportunity for cost reduction against each of the key selected drivers, based on high level analysis, benchmarking and local data where available.

At the point of the review, we identified over £129m excess costs across the system which helps to inform where we look to identify solutions. Reduction/removal of these excess costs will help us address our 2024/25 exit underlying financial position of £115m.

The drivers of excess cost are:

- **Workforce** - additional structural costs of running two sites for SaTH which will be removed by the Hospital Transformation Programme and excess operational costs such as temporary staffing above the national benchmarks for bank and agency. (Noting that SaTH have made significant progress in reducing agency spend in 2024/25 and further reductions across all providers are planned for 2025/26.)

- **Urgent and Emergency Care Pathway** - the system is currently incurring the additional cost of delayed discharges as a result of excess cost of staffing which will be removed through the Hospital Transformation Programme supported by the Local Care Programme. National benchmarking also shows Same Day Emergency Care productivity opportunities.

- **Community Investment** - the system has already invested to support the left shift to community across 2022/23 to 2024/25, as part of the Integrated Urgent Care efficiency programme, we are testing the benefits realised from this investment and seeking to optimise the patient care value gained from the investment.

- **Continuing Healthcare** - national benchmarking based on actual 2024/25 expenditure showed that NHSSTW were spending £32m more than the average for CHC, this is addressed through the efficiency programme going forwards.

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- **Productivity** - national packs have been produced by NHS England supported by data available on the Model Health System website which show productivity opportunities across Elective, Non-Elective, Estates and Corporate Services.

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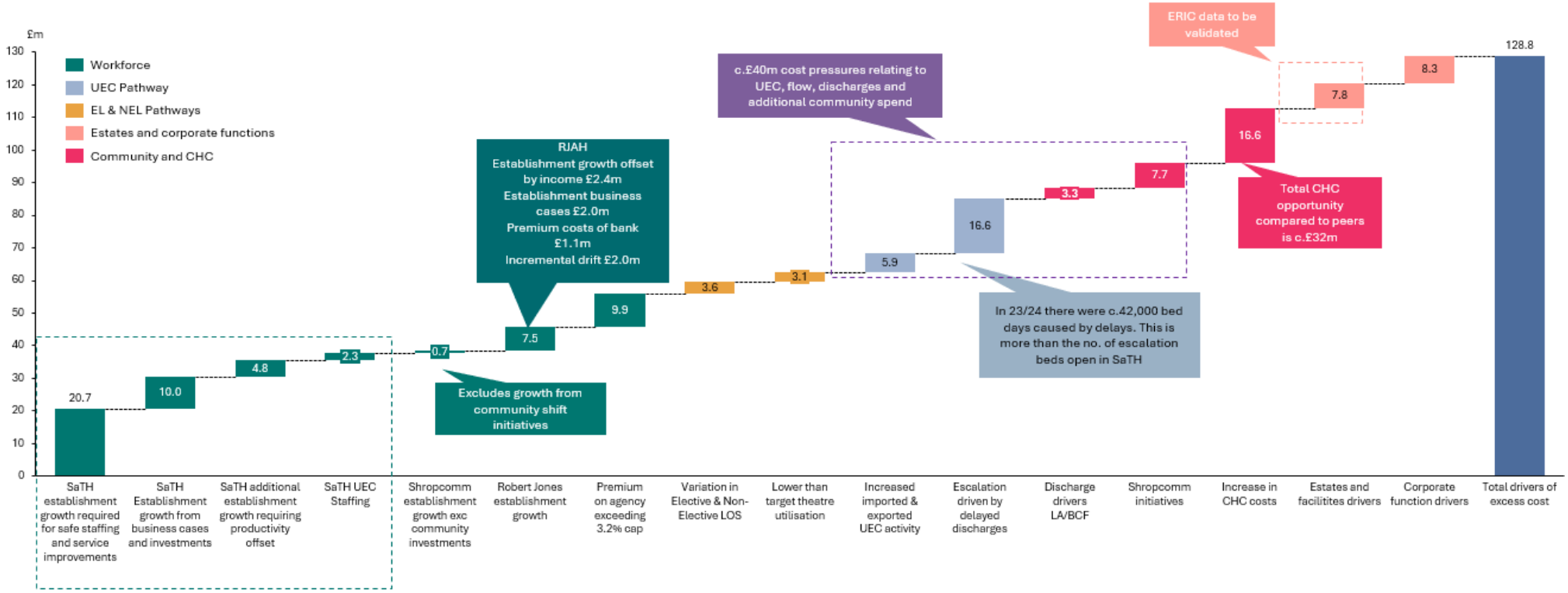

Figure 5: Drivers of Excess Cost

3.2. National Context

Elective Recovery

NHS STW has made measurable progress in delivering the national elective recovery agenda, exiting Tier 1 oversight in late 2023 and setting a clear trajectory to eliminate 65-week waits and deliver the national waiting time standards for Referral to Treatment Times. This has been driven by focused investment in Elective Hubs at SaTH, Theatres at RJAH and through productivity improvements including outpatient transformation, using advice and guidance and patient initiated follow up.

In 2025/26, the system will implement the updated NHS Standard Contract model, introducing clinically led, operationally owned elective activity plans with indicative volumes agreed at provider level. These plans will ensure a balanced approach between ambition and deliverability, supported by collaborative oversight across commissioners and providers.

Within this context, the System will take a more strategic, integrated approach to commissioning activity, including that from the Independent Sector (IS). Activity will be planned and contracted as part of the system-wide activity envelope, with defined thresholds, pricing, and quality expectations. Rather than acting as a reactive overflow mechanism, the independent sector will be deployed selectively to address specific capacity gaps, reduce long waits, and protect core NHS delivery. This positions the IS as a strategic partner, supporting the system to meet performance standards, maintain patient choice, and manage elective demand more flexibly and cost-effectively.

The System remains committed to delivering high-quality elective care in line with national expectations. In alignment with the NHS recovery plan, our financial strategy supports the phased restoration of elective waiting times to the 18-week Referral to Treatment (RTT) standard by March 2029. This is supported by capital investment in 2025/26 to support improvements in diagnostics and elective waiting times. This alongside sustained improvements in capacity released through productivity improvements including digital tools and working collaboratively with system partners to optimise elective pathways. Robust financial planning and close performance monitoring will be critical to ensuring we meet these national ambitions while maintaining financial sustainability.

Productivity

The NHS is prioritising productivity improvements to enhance patient care and ensure financial sustainability. In 2024/25, NHS England providing a comprehensive set of productivity opportunities to support system productivity and efficiency planning. Based on national benchmarking information the key opportunities for STW correlate materially to the drivers of excess cost as set out above - Temporary Staffing, Continuing Healthcare, Urgent and Emergency Care costs and Corporate Services opportunities.

For NHS STW, alignment with this national agenda involves implementing measures such as enhancing surgical efficiency, reducing reliance on insourcing, increasing community services utilisation e.g. through virtual ward, and strengthening and retaining the substantive workforce. By focusing on these areas, STW aims to improve patient outcomes, reduce waiting times, and achieve financial balance. These efforts are integral to the system's

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finance strategy, ensuring that resources are utilised effectively to meet the evolving healthcare needs of the population.

Workforce

NHS England productivity opportunity packs provided in 2024/25 show that temporary staffing is a key driver of excess cost and a significant productivity opportunity for STW. 2025/26 operational planning requirements set expected agency spend as no more than 2% of the overall total pay bill and bank spend as no more than 6.3% of the total pay bill. The MTFP planning assumptions set a system efficiency and spend target to comply with these limits as part of the recovery trajectory.

The System workforce (people) strategy sets out four key pillars - Train, Reform, Retain and Transform. The area most relevant to the finance strategy is the reform agenda which is focused on having the right workforce at the right place and the right time. Key priorities for the reform agenda are including but not limited to:

- replacing agency with bank, with agency spend targets of no more than 2% of total pay spend and bank spend targets of no more than 6.3% of total pay spend.
- reducing vacancies, sickness, turnover and unavailability.
- Reducing premium rates for bank and agency.
- Reviewing consultant job plans and use of flexible sessions.
- Optimising workforce productivity opportunities.
- Integration of workforce through system transformation programmes including corporate shared services.

UEC Demand

Urgent and emergency care (UEC) remains a national priority, with NHS England setting clear expectations to reduce A&E waits, improve flow and ensure timely discharge; particularly for patients with no criteria to reside in hospital. For Shropshire, Telford, and Wrekin, UEC pressures are a key driver of excess cost across the system, this strategy is aligned to our UEC strategy to remove unconventional care and therefore the excess costs associated with escalation.

Discharge delays and suboptimal use of community services, have led to sustained operational and financial strain on our acute provider. In response, the system is focused on maximising value from existing community investments, particularly through better utilisation of virtual wards and increasing urgent rapid response capacity. A core enabler of this is the delivery of our Local Care Programme, which brings together prevention, anticipatory care, and integrated neighbourhood teams to manage risk proactively and reduce avoidable admissions. By improving patient flow, strengthening community alternatives, and embedding a discharge-focused culture across settings, NHS STW aims to reduce avoidable spend, improve patient experience, and create the headroom needed to successfully deliver the Hospital Transformation Programme. NHS STW and SaTH will review the current activity volumes for UEC against the Hospital Transformation Programme business case and the progress and timing of the Local Care Programme/Healthcare Models to ensure that our capacity models align.

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Duty to Achieve System Financial Balance

NHS England publish a set of ICB and system finance business rules which the system is required to comply with each year, this requires the system to not spend more than the financial plan or allocated Capital[6] and Revenue[7] resource limits each year. NHS STW has a duty to achieve system financial balance.

Distance from Target - Pace of Change to Fair Shares Allocations

The NHS employs a 'fair shares' allocation model to distribute funding equitably across Integrated Care Boards (ICBs), ensuring resources align with population health needs. This approach involves calculating a target allocation for each ICB based on factors such as population size, age profile, and deprivation levels. The difference between an ICB's current funding (baseline) and its target is termed the 'Distance from Target' (DfT).

To address disparities, NHS England implements a 'convergence' policy, gradually adjusting allocations to move ICBs closer to their target funding levels over time. This method aims to balance equity with financial stability, avoiding abrupt funding changes that could disrupt service delivery. NHS England are currently reviewing the pace of change, convergence policy that sits as part of the movement to fair shares allocations, with a clear intention to accelerate the pace of change.

For NHS STW, an increase to the pace of change in a revised convergence policy could have significant implications for the financial recovery trajectory.

A summary of the 2025/26 Distance from Target (DFT) by allocation funding stream is detailed below:

	RECURRING Actual Allocation 2025-2026 £000	**NON-RECURRING** Actual Allocation 2025-2026 £000	**TOTAL** Actual Allocation 2025-2026 £000	Target Allocation 2025-2026 £000	Distance from Target Over/(Under) £000	Distance from Target Over/(Under) %
ICB Core	1,031,897		1,031,897	1,022,873	9,024	0.88%
Transfers from Service Development Fund		13,555	13,555	14,648	(1,093)	(7.46%)
ERF Core		25,371	25,371	24,867	504	2.03%
ERF Additional		13,824	13,824	21,242	(7,418)	(34.92%)
Discharge Funding		4,442	4,442	4,354	88	2.02%
Primary Care Co-Commissiong	112,960		112,960	111,741	1,219	1.09%
Specialised Commissioning	168,260		168,260	178,380	(10,120)	(5.67%)
Specialised Commissioning ERF Core		2,125	2,125	4,875	(2,750)	(56.41%)
Specialised Commissioning ERF Additional			0	2,120	(2,120)	(100.00%)
Deficit Support Funding		83,795	83,795	19,212	64,583	336.16%
Total	**1,313,117**	**143,112**	**1,456,229**	**1,404,312**	**51,917**	**3.70%**
Allocation adjustment required	**1,313,117**	**143,112**	**1,456,229**	**1,439,420**	**(16,809)**	**(1.17%)**
Remaining Distance from Target (within 2.5% tolerance)					**35,108**	**2.50%**

Figure 6: STW 2025/26 DFT to fair shares target.

[6] NHS England » Capital guidance 2025/26
[7] NHS England » Revenue finance and contracting guidance for 2025/26

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In 2025/26 NHSE released information on the DFT calculation to fair shares as detailed above. For NHS STW this means:

- excluding deficit support, the system is under target by £12.6m which is a product of being under target for Specialised Commissioning and ERF which is more than offsetting being over target in core programme allocation.
- In calculating the published DFT, the national team have then incorporated deficit support funding which results in an over target DFT position of £51.9m.
- Guidance to date suggests that there is a tolerance around the target of +/-2.5% for Systems therefore, to reach a £35.1m (2.5%) tolerance, the allocation reduction for NHS STW would be £16.8m (ie £51.9m - £35.1m)
- Hence, for the purpose of our modelling, we are working on the assumption that the pace of change policy would expect our DFT to reduce by £16.8m. This is more than accommodated in the MTFP in 2026/27, which has mapped a planned reduction to the current deficit of £40m+.

3.3. Providers – Challenges, Cost Base Changes and Where Does the ICB Spend Its Resource?

Provider Expenditure

Provider cost base changes from 2019/20 to 2023/24 are summarised in Figure 5 and excess spend opportunities for STW providers compared to benchmarks is detailed in Figure 3.

Providers across the system are operating within an increasingly challenging environment, facing both structural and emerging pressures to their cost bases. Inflationary impacts on pay, goods, and services, combined with rising demand and acuity within healthcare services, have significantly increased underlying expenditure. Although national funding uplifts have been made available each year, they have not fully offset the pressures faced at provider level, creating a material affordability gap across the system.

Key challenges include.

- delivering elective recovery while managing urgent and emergency care pressures and extensive improvement.
- workforce productivity and efficiency reduction targets in the context of workforce constraints driving higher bank and agency spend.
- rising energy and estates costs, and the need for ongoing investment in digital and infrastructure resilience.
- providers are carrying forward recurrent cost growth from COVID-19 related service expansions and operational adaptations, much of which is now embedded into baseline operations.
- performance challenges e.g. RTT, Cancer and UEC.
- quality challenges including minimum safe staffing levels, UEC waiting times, neonatal and maternity improvement plans, fragile services.
- financial constraints across Welsh commissioners which are expected to lead to a reduction in activity/income. **Welsh income accounts for just over 30% of RJAH's total income.** Activity/income planning assumptions will be regularly reviewed as part of the process to review and refresh the MTFP.

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The system recognises that managing provider cost bases will require a combination of continued efficiency delivery, service transformation, and demand management initiatives. Providers are supported through a coordinated programme of productivity improvement benchmarking to identify best practice opportunities, and system-wide service redesign to remove duplication and optimise clinical pathways.

In parallel, financial frameworks have already been strengthened through grip and control measures to ensure that cost pressures are transparent, consistently assessed, and collectively managed wherever possible, supporting a system-wide approach to financial sustainability.

ICB Expenditure

In the year ended 31st March 2025 NHS Shropshire, Telford and Wrekin received and spent a total of £1,447m for commissioning healthcare for its residents. The chart below shows a breakdown of the organisation's expenditure for the period:

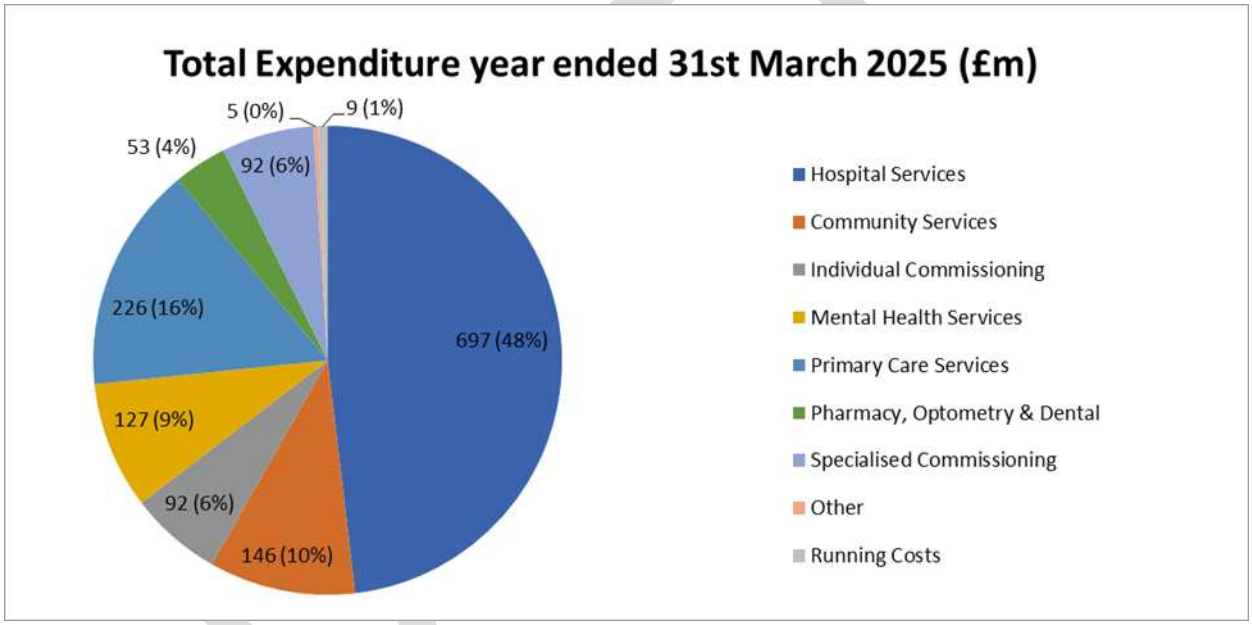

Figure 7: ICB Expenditure Y/E 31st March 2025 (£1,447m)

The proportion of spend on acute services (48% in 2024/25) is similar to that of other local Midlands ICBs.

Spend for Specialised Commissioning, Delegated Primary Care services, Pharmacy, Optometry, Dental and Runnings costs is in line with current allocations. Cost growth changes by ICB programme over time are summarised below.

ICB Spend Summary by Programme £m	2019/20 Expenditure	%	2024/25 Expenditure	%	% increase	2029/30 Expenditure	%	% increase
Acute	406	50.8%	697	53.5%	72%	611	45.8%	-17%
Community	80	10.0%	146	11.2%	83%	199	14.9%	47%
Individual Commissioning	58	7.3%	92	7.1%	59%	94	7.1%	3%
Mental Health Services	72	9.0%	127	9.8%	76%	133	10.0%	6%
Primary Care Services includes Prescribing	161	20.2%	226	17.4%	40%	283	21.2%	30%
Other	11	1.4%	5	0.4%	-55%	5	0.4%	0%
Running Costs	11	1.4%	9	0.7%	-18%	8	0.6%	-7%
Sub-Total excluding delegated	799	100.0%	1,302	100.0%	63%	1,333	100.0%	2%
Pharmacy, Optom and Dental	0		53			64		
Specialised Commissioning	0		92			111		
Total Spend	799		1,447			1,508		

Figure 8: ICB Expenditure Summary

To note, the table above includes an indicative ICB cost split by 2029/30 which assumes spend reductions in acute services based on the Strategic Transformation Programmes, increases to support the left shift inclusive of investment (subject to delivery of efficiency) into community. Prevention and digital are included under 'community' for illustrative purposes.

4. Where Will We Be If We Do Not Take Action?

4.1. Demand and Capacity Analysis

An acute and community system demand and capacity model has been developed for STW, this shows that there is excess capacity compared to demand (as demonstrated in the modelling completed for the HTP business case). This model has been populated with initial data based on 2023/24 provider information and is currently being tested and updated for the most recent data set. Use of the model will support the System in avoiding:

- inefficient use of financial and operational resources.
- Potential mismatches between demand and capacity.
- Limited foresight into cost pressures or demand spikes.
- Delayed strategic initiatives due to unclear resourcing needs.

Up to date modelling will be available by the end of June 2025 and will inform the next iteration of operational financial medium-term plans.

4.2. Do Nothing Financial Modelling

The do-nothing case is based on the agreed system MTFP planning assumptions (using the latest local and national available information) and states the position prior to any efficiencies. This is detailed below and shows that without action the System deficit remains significant.

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Year 1 25/26

Do nothing	SATH £M	RJAH £M	SCHT £M	ICB £M	Total £M
Organisational Plan before Efficiencies	(86.4)	(9.6)	(3.4)	(78.6)	(178.0)
Efficiencies	41.4	9.6	5.4	37.9	94.3
Organisational Plan after Efficiencies	(45.1)	0.0	2.0	(40.7)	(83.7)
Underlying position	(46.5)	(8.7)	0.9	(41.3)	(95.5)
Total % Efficiency Required	6.4%	5.9%	5.0%	7.3%	

Figure 9: Do nothing Year 1 25/26

Year 2 26/27

Do nothing	SATH £M	RJAH £M	SCHT £M	ICB £M	Total £M
Organisational Plan before Efficiencies	(61.4)	(5.8)	(6.1)	(47.5)	(120.9)
Efficiencies	0.0	0.0	0.0	0.0	0.0
Organisational Plan after Efficiencies	(61.4)	(5.8)	(6.1)	(47.5)	(120.9)
Underlying position	(61.4)	(14.3)	(6.1)	(47.6)	(129.5)
Total % Efficiency Required	0.0%	0.0%	0.0%	0.0%	

Figure 10: Do nothing Year 2 25/26

Year 3 27/28

Do nothing	SATH £M	RJAH £M	SCHT £M	ICB £M	Total £M
Organisational Plan before Efficiencies	(77.5)	(11.6)	(12.5)	(55.1)	(156.6)
Efficiencies	0.0	0.0	0.0	0.0	0.0
Organisational Plan after Efficiencies	(77.5)	(11.6)	(12.5)	(55.1)	(156.6)
Underlying position	(77.5)	(20.1)	(12.5)	(55.1)	(165.1)
Total % Efficiency Required	0.0%	0.0%	0.0%	0.0%	

Figure 11: Do nothing Year 3 25/26

5. What Are We Going to Do About It?

5.1. Overarching System Strategy – What Does the Future Look Like?

Integrated Care System (ICS) Vision and Ambition

The ICS vision and ambition, per the 2024 ICS Integrated Care Strategy[8], is that 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.

[8] Shropshire Telford and Wrekin Integrated Care Strategy (September 2024)

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.

Figure 12: ICS Core Purpose/Aims

The system's overarching strategy is to move towards a financially sustainable, integrated, and prevention-focused model of care, where population health outcomes are improved through earlier intervention, stronger community-based support, and better use of digital innovation. The future model will reduce reliance on hospital-based services, empower people to manage their health, and ensure seamless care across organisational boundaries.

Delivery of the system's six core principles for Prevention and Neighbourhood Working will be central to this future vision:

- Population Health Management: Using data to identify need, target interventions, and proactively manage health risks across defined populations.
- Person-Centred Approach: Designing care around the individual, ensuring services are responsive to personal needs, preferences, and circumstances.
- Learning and Evidence: Embedding continuous learning and applying the best available evidence to shape service design and improvement.
- Integration: Strengthening collaboration across health, care, and voluntary sector partners to deliver coordinated, holistic care.
- Time: Investing early in prevention to achieve long-term gains in health outcomes and financial sustainability.
- Leadership: Developing system-wide leadership that champions prevention, supports innovation, and drives cultural change.

Resources will be aligned and care pathways redesigned to embed these principles, ensuring prevention is a core function of all services, not a standalone programme. In support, the financial strategy will prioritise investment upstream and describe a sustained focus on health improvement and inequality reduction.

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Alongside community and prevention transformation, elective transformation will include elements of service redesign, improved productivity, the concentration of specialised services, and a stronger focus on digital innovation in line with the digital strategy. Workforce transformation as per the system workforce strategy, estates optimisation in line with the Infrastructure Strategy, and strategic use of data, supported by the development of a Data Strategy will be key enablers. System partners will work together on a collective footprint, with financial and operational plans aligned to a shared ambition of improved health outcomes, greater efficiency, and long-term sustainability.

In response to the growing demand for mental health services and associated financial pressures, the STW ICS has embedded mental health transformation within its wider financial and operational strategy. Key priorities include expanding access to community-based services, improving crisis response, and reducing avoidable acute admissions. The system is also working to integrate mental health support within primary care and neighbourhood teams to better manage risk and reduce reliance on high-cost specialist services. Targeted productivity improvements - including optimising Continuing Healthcare processes for mental health and learning disability patients - are being pursued to ensure value for money and sustainability. This transformation not only addresses cost pressures but also supports the delivery of more person-centred, preventive care, improving outcomes for individuals with mental health needs while relieving pressure on the wider health and care system.

5.2. National Drivers – Three Shifts

Our integrated care strategy and prevention framework is fully aligned to national policy expectations, specifically the three major shifts required for sustainable healthcare as per the Darzi recommendations.[9] These underpin the NHS 'Three Shifts'[10], which focus on:

1. **Shifting care upstream** - Investing in prevention by using the Strategic-Decision Making Framework[11] to inform the application of available growth funding using the six key principles of our Prevention Framework and approach to Integrated Neighbourhood Teams delivering early intervention, and proactive care to reduce the need for hospital treatment.

2. **Shifting care closer to home** - Implementing the Integrated Care Strategy and Prevention Framework inclusive of clinical service redesign to support expanding community-based services to ensure people receive care in the most appropriate setting, reducing health inequalities across our rural population.

3. **Shifting to a more integrated system** through our Digital strategy - Using technology to enhance integration e.g. by implementing digital projects such as shared digital care planning module through our One Health and Care System to support delivery of improved utilisation of virtual ward capacity using remote monitoring tools to enable all 3 shifts and deliver productivity and efficiency.

[9] Summary letter from Lord Darzi to the Secretary of State for Health and Social Care - GOV.UK
[10] Project: The three shifts | Change NHS,
[11] STW-Strategic-Decision-Making-Framework-Final-Nov-2024-COM005.pdf

5.3. Solutions Aligned to Key Drivers of Excess Cost

The system faces a fundamental financial challenge with a structurally high and rising cost base, driven by differential population demographics and access issues, working across two acute sites: growth in workforce, urgent and emergency care pressures, and productivity opportunities not yet taken. Therefore, our Medium-Term Financial Plan (MTFP) is underpinned by a structured set of System Strategic Transformation Programme solutions as set out in Figure 13 below. These address the key drivers across operational, provider, and system transformation and have been designed to address the root causes of financial unsustainability and support recovery to financial balance.

We have sought to ensure that we take learning from other Systems with regard to addressing key drivers of deficit, particularly those where they face similar challenges. Through active engagement with regional and national networks we also stay up to date with examples of good practice and emerging evidence and learning.

The strategic transformation programmes account for half of the planned efficiency across 2026/27 and 2027/28. In our modelling, overall efficiency is categorised as:

a) Business as usual efficiency which includes:

- The "do minimum" efficiency to offset 1.1% cost efficiency charged into the tariff cost uplift factor.
- Operational efficiencies including grip and control measures, improving productivity, value for money assessment. These include but are not limited to:
    - establishment reviews across all staffing groups.
    - System vacancy controls inclusive of budgeting and staffing within affordable establishments.
    - Temporary staffing expenditure controls: ensuring that bank and agency spend is within cap limits (inclusive of rostering and bank and agency premium rates).
    - Productivity efficiencies including:
        - transforming outpatients through increasing the use of advice and guidance, virtual/telephone appointments, patient initiated follow ups and adherence to best practice pathways.
        - Theatre efficiencies.
        - Workforce productivity efficiencies e.g. community services
    - Non-pay controls including the use of the triple lock, procurement efficiencies including the management of inflation rates through contracts.
    - High-cost drugs switches.

b) Strategic Transformation Programmes:

- Organisational transformation to deliver government reform:
    - New Model ICB operating model to deliver 50% ICB cost reductions.
    - Provider corporate, infrastructure and non-clinical workforce reform to deliver 50% reduction in workforce growth from 2019/20.
    - Provider level transformation to support the development of the Provider Collaborative.
- System strategic transformation programmes which all incorporate elements of workforce reform and digital solutions including robotic processing automation and use of artificial intelligence. Provider transformation is also embedded within the system Strategic Transformation Programmes.
    - Hospital Transformation Programme

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- Local Care Programme to incorporate delivery of the three shifts inclusive of Integrated Neighbourhood Teams and delivery of the Prevention framework.
- Urgent and Emergency Care Improvement Programme workstreams:
  - Acute Flow - led by SaTH to include SDEC.
  - Care Co-ordination - led by SCHT.
  - System Discharge - led by the local authorities.
  - Winter Planning - led by the ICB on behalf of the System.
- Elective including productivity, cancer and diagnostics, fragile services, reducing insourcing and outsourcing and maximising available system capacity.
- MSK Transformation
- Workforce reform inclusive of shared services, collaborative workforce solutions, new workforce models and workforce productivity
- Continuing Healthcare including solutions to transform childrens' mental health services and end of life care.
- Strategic Estates to improve utilisation and rationalise estate.
- Financial Improvement Programme to include Strategic Decision-Making Processes to ensure value for money including hard decisions, disinvestment, and decommissioning.

The table below sets out the gross opportunities for cost reduction as published in available national NHS productivity benchmarking packs or tools or gathered from local intelligence. The numbers in the table below are the total gross opportunity not taking into account any reinvestment that may be required to deliver the Strategic Transformation Programmes and also potential for overlap between the opportunity areas identified e.g. UEC opportunity costs will include temporary staffing costs.

The system has drafted multi-year efficiency scheme project initiation documents during early 2025 and is now moving into securing future year efficiency delivery. Delivery of the agreed system strategic transformation programmes is crucial to delivery of the MTFP and our route back to financial balance.

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NHS Shropshire, Telford and Wrekin

Integrated Care System
Shropshire, Telford and Wrekin

Strategic Transformation Programmes	Gross Financial Opportunity 25/26	Gross Financial Opportunity 26/27	Gross Financial Opportunity 27/28	Excess Spend Area the Solution Addresses and Source Information for the Opportunity
Operational Programmes				
Temporary Staffing (Total Opportunity £20m)	6.7	8.4	5.0	Excess Spend : Workforce - NHS England productivity opportunity 25/26 efficiency plan value and remaining opportunities phased into 26/27 and 2027/28.
Continuing Healthcare (CHC) (Total Opportunity £30m)	15.9	10.1	7.0	Excess Spend : CHC - ICB efficiency opportunity as per ICB productivity pack plus additional 25/26 non recurrent opportunity.
Elective Productivity Opportunity (Total Opportunity £16.9m)	10.9	1.0	5.0	Excess spend: Productivity - NHS England productivity packs, Elective utilisation, theatre productivity, LOS reduction, virtual appointment and PIFU outpatient opportunities, SCHT workforce productivity and rostering opportunities. Diagnostics and cancer productivity opportunities. Local System Transformation Programmes - MSK and Outpatient Supported by capital estates and digital investments.
Provider Level Transformation Programmes				
Corporate back office/Non-clinical wte reductions (Total Opportunity £20m)	7.8	6.1	6.1	Excess Spend: Corporate back office including Estates - NHS England productivity opportunity 25/26 efficiency plan value and remaining opportunities phased into 26/27 and 2027/28.
System-Level Transformation				
Urgent and Emergency Care (UEC) (Total Opportunity £37.5m)	8.0	14.5	15.0	Excess Spend: UEC - Local community investments to release acute costs into sub-acute wards, virtual wards, integrated discharge team and rapid response 2022/23- 2024/25. Local data - No criteria to reside, avoidable admissions, conversion rates, delayed discharges, escalation costs, urgent treatment centre costs, frailty costs. NHS England Productivity packs SaTH - NEL/A&E/SDEC opportunity
Local Care Programme /Prevention/Community and Primary Care (Total Opportunity £20m)		10.0	10.0	Excess Spend: UEC/Community - Ambulatory Care Sensitive avoidable admissions - national and local dashboard based on 2023/24. DHSC secondary prevention report issued in relation to productivity prevention/health inequalities - Smoking, Weight Management, Alcohol, CVD, Diabetes.
Hospital Transformation Programme (Total Opportunity £30m)			7.5	Excess Spend: UEC/Corporate Back Office - SaTH HTP Business case - 25% of the benefit's of HTP brought forward.
Vaccine Preventable (Total Opportunity £13m)		1.5	1.5	Excess Spend: UEC - Ambulatory Care Sensitive avoidable admissions - national and local dashboard based on 2023/24.
Totals	42.6	43.2	52.1	

Figure 13: Strategic Transformation Programmes

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5.4. Distance From Target (DFT) Over Fair Share of Allocation

Based on the 2025/26 latest published information STW has an allocation of £1.456bn (including deficit support funding) compared to a fair shares target of £1,404.3bn (with deficit support funding reducing) leading to a DFT of £51.9m. The expected pace of change in moving to fair shares allocations and closing the DFT will be published in spring 2025 after the comprehensive spending review.

The current MTFP assumes a 3-year breakeven trajectory in-year taking account of the movement to fair shares target and inclusive of an assumed removal of deficit support funding. The system strategic transformation programmes support an in-year breakeven recovery plan trajectory within the MTFP. Our modelling also extends the view of the recurrent underlying financial position into a long-term financial outlook of 5-10 years in order to include the projected impact of HTP.

5.5. MTFP, Route to Financial Balance, Scenario Analysis

Traditional Efficiency Savings Are Not Enough

An approach to financial planning that relies heavily on incremental efficiencies and reactive resource management, will not be fit for purpose for the MTFP. The financial impact of rising service demand, increasing complexity of needs, and limited flexibility within existing financial and workforce models is too great to be addressed through traditional methods of cost reduction.

A more fundamental shift is therefore required that aligns finance more strategically with transformation efforts and supports a long-term, system-wide view of value. This means:

- Redesigning financial models to support and accelerate the system transformation programmes[12].
- Aligning workforce planning and financial capacity to enable change, rather than constrain it.
- Investing in Local Care models to reduce pressure on acute settings and shift resources upstream alongside delivery of the six core principles for prevention.
- Using data, automation, and digital tools not only to improve productivity but to drive smarter, outcome-focused investment decisions.

The role of the Finance team is already evolving to deliver this fundamental shift. Finance leaders are working alongside clinical and operational teams to deliver the integrated care strategy through co-designing transformation plans, ensuring that the financial strategy enables, rather than restricts, service change. Investment frameworks, through the Strategic Decision-Making Framework, have been modernised to focus on outcomes and value rather than purely cost containment. Service Line Reporting (SLR) and benchmarking are being embedded systematically to support evidence-based decision-making at every level of the system.

[12] System Transformation Programmes include - Workforce, Urgent and Emergency Care, Local Care Plan, Elective Reform (including productivity), Shared Services, MSK Transformation, Financial Improvement Programme and System Integrated Improvement Programme.

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Scenario planning and financial modelling are being used more proactively to shape strategic choices, stress-testing the affordability and sustainability of new models of care. Capital and revenue plans are being aligned across organisations to remove fragmentation and support system-wide prioritisation of resources.

Additionally, finance teams are investing in capability development - building stronger skills in areas such as business partnering, data analytics, and commercial acumen - to equip the function to operate at the heart of transformation. A greater emphasis is placed on transparent financial reporting and open sharing of financial risks and opportunities, and we have strengthened trust and collaboration across the system.

Taken together, these actions position finance as a strategic enabler of change - actively shaping the future of health and care delivery, not just managing its costs. True sustainability will be achieved not through efficiency alone, but through a more intelligent, integrated, and value-driven approach to financial leadership.

Medium-Term Financial Plan (MTFP)

The system's medium-term plan models the delivery of a three-year recovery plan to achieve a break-even position (underlying). This assumes the achievement of significant efficiency and productivity improvements. Sensitivity analysis has been undertaken to test the robustness of the plan against a range of risks, including delays in activity recovery, inflationary pressures, workforce challenges, and changes to funding flows. The modelling shows that while the baseline plan is deliverable, there are material risks to that delivery if the scenarios crystallise. A continued focus on transformation, innovation, and cost management therefore remains critical.

Our aim is to deliver an underlying break-even position within three years, using 2025/26 as year one of three. High-level modelling suggests that in order to do this the System will need to deliver efficiencies of around £84m above an assumed annual 2.2% business as usual (BAU) efficiency. Total efficiency would therefore equate to around £85-£90m per annum, which equates to around 6% of System spend and 5% of Provider spend (split 50% BAU efficiency and 50% Strategic Transformation Programmes). The table below shows the summary MTFP recovery trajectory.

Financial Plan £'m	24/25 Actual	25/26 Plan	26/27 Plan	27/28 Plan
System recovery plan trajectory	(115.0)	(83.8)	(40.3)	0

Figure 14: Financial Recovery Plan Trajectory

Note: actuals exclude deficit funding support and additional allocations.
This takes into account the expected 2026/27 impact of an acceleration to the pace of change towards Fair Shares Allocations, assuming a requirement for a £16.8m reduction in allocation in 2026/27 and a further reduction in 2027/28 – subject to national guidance which is expected later in 2025.

Sensitivity analysis in terms of the upside, most likely and downside MTFP modelling shows that without full delivery of these solutions, there is a material risk of an ongoing recurrent deficit. Conversely, full delivery could create opportunities for strategic reinvestment and resilience against future pressures.

Base Case - Most Likely

The addition of system transformation schemes to BAU efficiency is fundamental to the base case which shows the most likely position based on the agreed system MTFP planning assumptions (using the latest local and national available information) and an agreed 5% efficiency to cover BAU efficiency and strategic transformation programme efficiencies (split 50% BAU and 50% Strategic Transformation Programmes).

2025/26 efficiency is 6% which is lower than 2024/25 efficiency of 7% of which 94% of which was delivered. Although this is a significant step up from 2023/24 and in order to achieve the recovery trajectory a similar rate of efficiency will be required to be maintained in years 2 and 3 of the model (6%).

Year 1 25/26

Break Even in 3 Years	SATH £M	RJAH £M	SCHT £M	ICB £M	Total £M
Organisational Plan before Efficiencies	(86.4)	(9.6)	(3.4)	(78.6)	(178.0)
Efficiencies	41.4	9.6	5.4	37.9	94.3
Organisational Plan after Efficiencies	(45.1)	0.0	2.0	(40.7)	(83.7)
Underlying position	(46.5)	(8.7)	0.9	(41.3)	(95.5)
Total % Efficiency Required	6.4%	5.9%	5.0%	7.3%	

Figure 15: Most Likely Year 1 25/26

Year 2 26/27

Break Even in 3 Years	SATH £M	RJAH £M	SCHT £M	ICB £M	Total £M
Organisational Plan before Efficiencies	(61.4)	(5.8)	(6.1)	(47.5)	(120.9)
Efficiencies	38.8	8.6	6.1	27.1	80.6
Organisational Plan after Efficiencies	(22.7)	2.8	(0.0)	(20.3)	(40.3)
Underlying position	(22.7)	(5.7)	(0.0)	(20.5)	(48.9)
Total % Efficiency Required	5.8%	5.1%	5.6%	5.4%	

Figure 16: Most Likely Year 2 26/27

Year 3 27/28

Break Even in 3 Years	SATH £M	RJAH £M	SCHT £M	ICB £M	Total £M
Organisational Plan before Efficiencies	(38.7)	(3.0)	(6.4)	(27.9)	(76.0)
Efficiencies	38.7	9.1	6.3	30.3	84.5
Organisational Plan after Efficiencies	0.0	6.1	(0.0)	2.4	8.5
Underlying position	0.0	(2.4)	(0.0)	2.4	(0.0)
Total % Efficiency Required	5.8%	5.3%	5.6%	6.1%	

Figure 17: Most Likely Year 3 27/28

Upside Case

The 'upside' case includes additional income assumptions for RJAH which will be secured subject to commissioner affordability, it assumes 100% delivery of efficiency and strategic transformation programmes and removes any assumed investment into activity growth, service development and quality improvements unless these are invest to save priorities.

The upside case also includes the removal of cost growth on MHIS/BCF/Primary Care Delegated (which would all be subject to changes in national guidance) and removal of High-Cost Drugs and prescribing growth. Even with the removal of all cost growth (including mandatory) and a 6% efficiency target the system model still requires a 3-year breakeven trajectory.

Year 1 25/26

Upside Case	SATH £M	RJAH £M	SCHT £M	ICB £M	Total £M
Organisational Plan before Efficiencies	(86.4)	(9.6)	(3.4)	(78.6)	(178.0)
Efficiencies	41.4	9.6	5.4	37.9	94.3
Organisational Plan after Efficiencies	(45.1)	0.0	2.0	(40.7)	(83.7)
Underlying position	(46.5)	(8.7)	0.9	(41.3)	(95.5)
Total % Efficiency Required	6.4%	5.9%	5.0%	7.3%	

Figure 18: Upside Case Year 1 25/26

Year 2 26/27

Upside Case	SATH £M	RJAH £M	SCHT £M	ICB £M	Total £M
Organisational Plan before Efficiencies	(61.6)	(8.0)	(6.4)	(14.5)	(90.4)
Efficiencies	38.8	12.2	6.1	25.4	82.4
Organisational Plan after Efficiencies	(22.8)	4.3	(0.3)	10.9	(8.0)
Underlying position	(22.8)	(1.8)	(0.3)	10.9	(13.9)
Total % Efficiency Required	5.8%	7.2%	5.6%	5.0%	

Figure 19: Upside Case Year 2 26/27

Year 3 27/28

Upside Case	SATH £M	RJAH £M	SCHT £M	ICB £M	Total £M
Organisational Plan before Efficiencies	(38.8)	(7.0)	(6.8)	(0.9)	(53.5)
Efficiencies	38.3	11.3	6.2	24.7	80.6
Organisational Plan after Efficiencies	(0.4)	4.4	(0.6)	23.8	27.2
Underlying position	(0.4)	4.3	(0.6)	23.8	27.1
Total % Efficiency Required	5.8%	6.8%	5.6%	5.0%	

Figure 20: Upside Case Year 3 27/28

Downside Case

The 'downside' case demonstrates the impact of slippage in the recovery trajectory; this is modelled as a 60% delivery in efficiency/strategic transformation programmes. Under the downside case it would take 8 years to breakeven. This sets out the necessity for a robust approach to both BAU efficiency and also Strategic Transformation Programme efficiencies.

Year 1 25/26

Downside Case	SATH £M	RJAH £M	SCHT £M	ICB £M	Total £M
Organisational Plan before Efficiencies	(86.4)	(9.6)	(3.4)	(78.6)	(178.0)
Efficiencies	41.4	9.6	5.4	37.9	94.3
Organisational Plan after Efficiencies	(45.1)	0.0	2.0	(40.7)	(83.7)
Underlying position	(46.5)	(8.7)	0.9	(41.3)	(95.5)
Total % Efficiency Required	6.4%	5.9%	5.0%	7.3%	

Figure 21: Downside Case Year 1 25/26

Year 2 26/27

Downside Case	SATH £M	RJAH £M	SCHT £M	ICB £M	Total £M
Organisational Plan before Efficiencies	(61.5)	(12.3)	(6.1)	(47.7)	(127.6)
Efficiencies	23.3	7.4	3.7	15.2	49.5
Organisational Plan after Efficiencies	(38.2)	(4.9)	(2.5)	(32.5)	(78.1)
Underlying position	(38.2)	(10.9)	(2.5)	(32.5)	(84.1)
Total % Efficiency Required	3.5%	4.3%	3.3%	3.0%	

Figure 22: Downside Care Year 2 26/27

Year 3 27/28

Downside Case	SATH £M	RJAH £M	SCHT £M	ICB £M	Total £M
Organisational Plan before Efficiencies	(54.6)	(16.5)	(8.9)	(60.0)	(140.0)
Efficiencies	23.7	7.0	3.9	15.4	50.0
Organisational Plan after Efficiencies	(30.9)	(9.5)	(5.0)	(44.6)	(90.0)
Underlying position	(30.9)	(9.5)	(5.0)	(44.6)	(90.1)
Total % Efficiency Required	3.5%	4.0%	3.3%	3.0%	

Figure 23: Downside Case Year 3 27/28

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6. How We Will Implement Our Plans

6.1. Strategic Finance Vision and Aims

The System Strategic Finance Vision is:

To create a financially sustainable healthcare system that enables safe, high-quality care, supports innovation, and improves health outcomes for the population of Shropshire Telford, and Wrekin.

We will achieve this by making data-driven decisions; prioritising and aligning capital and revenue resources to deliver the greatest health value.

We have set five strategic aims through which we will achieve our vision. These along with associated high-level objectives are listed below:

Key Strategic Aims

1. **Achieve Financial Sustainability** - establishing a balanced financial position within three years through targeted cost reductions, productivity and efficiency improvements, and resource realignment.
2. **Maximise Health Value from Investment** - Making sure that over time investment into the 'left shift' for prevention, community and digital, as a minimum matches the overall allocation growth uplift percentage (i.e. with funding directed toward interventions that support delivery of the 'left shift', improve patient outcomes, enhance system-wide efficiency, and support **preventative** and **community-based care).**
3. **Enable Transformation Through Strategic Investment** - supporting service transformation, digital innovation, and workforce development to improve quality, efficiency, and care integration.
4. **Embed a Culture of Financial Stewardship** - fostering a system-wide approach where every staff member takes ownership of financial sustainability and ensuring accountability and transparency in financial decision-making.
5. **Strengthen System-Wide Collaboration** - working in partnership with local authorities, NHS providers, and community organisations to create an integrated approach to financial and healthcare planning.

6.2. Financial Culture and Governance

The system will strengthen financial governance by embedding accountability for value and outcomes at all levels, promoting a culture supportive of financial sustainability alongside service excellence.

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Our ICS has a financial framework that our NHS system organisations have developed and signed up to as part of our System Collaborative Financial Management Agreement. Its key principles are:

- 'One model, one consistent set of assumptions' recognising that the position of each organisation will evolve and change transparently.
- Ensuring that the transparent and agile approach to financial planning continues across the system.
- Agreement to work together to use our resources flexibly and effectively, to deliver the system vision.
- Collectively working together as a system to manage opportunities, resources and risks including cost pressures.
- Being open and transparent with each other, sharing data and financial information.
- Use of a strategic decision-making framework to ensure best value use of resources including investments in line with system priorities.
- Ensuring no individual organisation loses out for doing something for the benefit of the wider system across health and social care.
- It is key we work collaboratively as a system to make sure that where costs are moving between organisations so that they are in the correct place, we work together to address any financial impact this has on the system.

Governance structures are already aligned across partners through our System Finance Committee and unified System Financial Improvement Programme, supported by standardised reporting, shared performance metrics, and transparent escalation routes. Formal financial governance sits alongside a strong culture of system financial leadership forums including Directors of Finance Meetings, Deputies Meetings, System Finance Group, System Finance, Productivity and Planning Group and our System Finance Training and Development Council. Our focus is on creating a financial communication and engagement strategy and joint training programme to support consistent interpretation of financial risks, opportunities, and actions.

Through our culture and governance, we aim to:

- Shift mindsets from cost control to value generation.
- Integrate finance into everyday decision-making at all levels.

We will implement this through the following mechanisms:

- Having **Financial Improvement Leads** within each programme area (e.g. UEC, Workforce, CHC) to embed financial thinking in operational decisions.
- Establishing a **Finance Business Partnering Development Programme** to upskill finance teams and deepen collaboration with service areas.
- Developing a comprehensive **financial recovery communication strategy**.
- Improving **oversight of financial recovery** through our monthly Financial Improvement Programme meetings with cross-functional representation to oversee progress and ensure financial rigour in programme delivery.
- Continuing to **assess the efficacy of our grip and control improvement measures** (inclusive of triple lock and system vacancy assurance panel), using the annual grip and control self-assessment. This will be reviewed by internal audit.

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6.3. Financial Incentives and Contracts

System financial flows and contracts will be reviewed and reformed to ensure they actively promote collaboration rather than competition between organisations. Aligned incentives will focus on achieving activity, quality, and efficiency targets as part of place-based and system-wide plans. Risk and gain-sharing agreements will be implemented where appropriate to distribute financial pressures and rewards fairly, supporting a "system first" approach.

Contracting teams across organisations will work jointly to embed these principles into annual contracting rounds.

Our aim is to align financial mechanisms with transformation outcomes.

We will implement this by:

- Updating the **System Collaborative Financial Management Agreement** as needed to describe the system approach for financial management, risk sharing and gain sharing and aligned payment incentives.
- Developing **contract payment mechanisms** to best support population health outcomes. This could include fixed, variable, and blended payment models.
- Agreeing the **financial framework** that best applies to each contract and payment mechanism, acknowledging the need to recognise the complexity of the arrangement in terms of the number of organisations involved and payment types.
- Developing **contracting frameworks** in conjunction with best practice models to best support contracting with system provider collaboratives and places.
- Redesigning **payment and incentive structures** in partnership with providers, including population health outcome-based elements (e.g. reduced admissions via the Local Care Programme (LCP)).
- Introducing further **gainshare models** (drugs gainshare already in place) for transformation programmes where financial savings are reinvested into further system improvements.
- Piloting **new contract forms** in key pathways (e.g. CHC, UEC, LCP) with evaluation metrics and timelines for wider rollout.
- **Testing and approving** all new contracting models before deployment, using the System Finance, Productivity and Planning Group to assess.

6.4. Business Case Management - Ensuring Investment Benefits Are Realised

The strategic-decision making framework will be used to assess all system-wide business cases, ensuring that all investment proposals are appraised using a consistent methodology that assesses financial return, service impact, and strategic alignment. Review processes will be embedded to scrutinise major investments pre-approval and post-implementation, with clear benefit tracking and ownership established. This process is undertaken by the ICB's Service Change Review Group.

We aim to ensure that all investments deliver clear, measurable benefits.

We will implement this by:

- Continuing to embed **standardised business case templates** and introductory papers to include the details of benefits measurement.
- Mandating **financial sign-off** by both business cases owners and all key programme leads for supporting functions including sign off by the designated finance lead.

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- Centralising **benefits tracking** through the System PMO, with accountability assigned to named programme owners, audit of delivery and reporting of variances.

6.5. Talent Management / People Development (All Staff)

The System will invest in a comprehensive people development strategy to build financial capability and leadership across all staff groups. This will include tailored financial training for clinicians, operational managers, and corporate teams, and succession planning for key financial and commercial roles. Our system-wide finance apprenticeship and graduate programme will also be expanded to grow future talent, supported by mentoring and coaching initiatives.

This will help us to build system-wide financial capability.

We will implement this by:

- Using our **Finance Training Development Council** to set out a clear plan for investing in our people to support ownership and enhance our culture of financial stewardship.
- Creating a financial **communication and engagement strategy**.
- Developing and delivering a **Financial Skills Curriculum** for non-finance staff, tailored to different levels of responsibility and to our local system.
- Accessing nationally and locally available **digital finance resources** to support delivery of finance workforce productivity improvement and skills development.
- Incorporating **finance and value metrics into annual performance reviews** for all senior leaders.
- Increasing the number of NHS partner organisations holding **Level 3 One NHS Finance** accreditation.
- Embedding the use of talent management tools and having a comprehensive **approach to talent management** across the system.

6.6. Data Led Decision Support – SLR, Benchmarking, Triangulation

Enhanced digital and analytical capabilities are a cornerstone of the financial strategy. The system will implement a consistent approach to costing methodologies and interpretation of national costing guidance to support Service Line Reporting (SLR) across providers, ensuring comparability and transparency of service-level financial performance. This will be compared to activity x tariff (based on national acute tariff cost modelling for SaTH and RJAH) to provide a detailed assessment of contract income versus activity x price versus current cost. This will support the development of productivity and efficiency plans.

National and regional benchmarking tools will be embedded into business planning processes. Triangulation of financial, activity, quality, and workforce data will be mandated for all major decision-making, with integrated dashboards available to system and place leaders to drive real-time performance oversight.

We aim to make data the foundation of all financial decisions.

We will implement this by:

- Investing in expanding **Service Line Reporting** across all major service areas, drawing on automated reporting tools where available nationally and developed locally where not yet available e.g. for community / primary care.

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- Utilising the national **Federated Data Platform** outputs, we will develop a local tool integrating activity, cost, outcomes, and workforce data into a single platform.
- Utilising regional/national **benchmarking dashboards**, updated regularly, drawing on data from national sources e.g. Model Health System, Model Hospital, GIRFT and local data e.g. Population Health Management Dashboard.
- **Triangulating datasets** through the annual operational planning processes and within the Integrated Performance Report to the Board.
- **Integrating forecasting and modelling** of demand to provide scenarios to inform degree of risk based on best and worst case.
- **Testing /evaluating the modelling** against the population need derived from population health analytics.

6.7. Strategic Decision-Making Framework (Prioritisation)

In the context of our recovery plan trajectory our Strategic Decision-Making Framework [13] is a key tool to ensure resources are allocated where they will deliver the best value in line the ICS core aims.

This framework provides a mechanism to maximise outcomes for the population within available resources (allocative efficiency). It ensures that we assess how services best deliver optimum outcomes (technical value) and the outcomes patients value (personal value). Where value is not demonstrated this tool provides a fair and transparent mechanism to support decommissioning and disinvestment decisions so funding can be best reallocated to maximise both population health value and value for money. This will ensure that all resource decisions are made to address the needs of our communities, to ensure that available growth is prioritised for investment into prevention and integrated neighbourhood teams to address our unique population health inequalities.

The Strategic Decision-Making Framework can be enacted at any time allowing for regular reprioritisation of resources to allow for flexibility to respond to changing operational and strategic pressures and priorities.

We will therefore ensure that our resources are allocated to the highest-impact initiatives.

We will implement this by:

- Utilising the strategic decision-making framework criteria to **assess investment and disinvestment decisions** as part of the annual planning cycles, with transparent scoring of all proposed initiatives.
- Utilising the strategic decision-making framework in year to support **reprioritisation of resources** as required to meet changing strategic and operational requirements.
- Using financial modelling outputs to **stress test high-priority investments** under different future scenarios.

6.8. Capital Prioritisation Framework

The Capital Prioritisation Framework ensures that capital investment is spent in line with the ICS core aims and strategy priorities including:

- supporting delivery of the three shifts

[13] STW-Strategic-Decision-Making-Framework-Final-Nov-2024-COM005.pdf

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- digital investment to support integrated care in line with the digital strategy.
- investment into our estate in line with the estate's infrastructure strategy
- shift to community through integrated neighbourhood teams.
- supporting delivery of the six core principles of the prevention framework.

This ensures that all capital investment is evaluated based on its potential to reduce future revenue pressures, including enabling service consolidation, service improvement and population health/quality outcome improvement, improving productivity (e.g. theatre and diagnostics modernisation), and elective reform in line with GIRFT recommendations.

We will therefore ensure alignment of capital investment with strategic and operational goals.

This will be implemented by:

- Refreshing the system-wide **10-year capital investment strategy** based on the Infrastructure Strategy, aligning it to the medium-term financial plan.
- Applying the **capital prioritisation framework**, scoring bids on clinical impact, sustainability, digital enablement, and transformation alignment through the annual operational planning processes and as part of the 10-year capital planning process.
- Continuing the oversight of capital prioritisation within available capital resource through the **Capital Prioritisation Oversight Group**, including clinical, digital, estates and finance representatives.
- Publishing an **annual capital investment plan** with clear rationale for all approved schemes and long-term pipeline visibility.

6.9. Risk Management

System-wide risk management processes are in place via the System Board Assurance Framework and Strategic Operational Risk Register, and we will continue to ensure that financial risks are identified early, assessed consistently, and mitigated proactively.

Risk registers will be integrated across finance, operational, and clinical domains, with regular scenario testing to anticipate pressures under different assumptions. Financial risk appetite will be formally defined and reviewed annually. Mitigation actions will be pre-agreed to support rapid decision-making if required.

Our aim is to proactively manage financial and transformation risk.

We will implement this by:

- Integrating **Risk Management**, linking financial risk to programme risk and organisational risk registers.
- Utilising the existing Financial Improvement Programme as an **operational risk and mitigation forum** to actively identify, monitor and manage risks specifically relating to financial delivery, productivity, and transformation.
- Using **real-time dashboards** with leading indicators (e.g. demand growth, productivity dips, cost spikes) to detect emerging risks early.
- Embedding **scenario planning and stress testing** into financial and transformation planning cycles.
- **Reducing risk exposure** through the development of a 'lessons learned' environment and more effective targeting of resources.

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6.10. Review and Test MTFP Planning Assumptions

We will comprehensively review and test the MTFP planning assumptions and generate scenario modelling to test the ICS integrated care strategy and the implementation of the three shifts. This will be done in parallel with the ongoing development of the System Demand and Capacity Model. The MTFP will also be regularly updated to include any changes in national policy that impact on the MTFP planning assumptions.

Our aim is to continuously and robustly test the planning assumptions within the MTFP.

We will implement this by:

- **Establishing the baseline for expenditure to support the three shifts** to enable monitoring of the changes in expenditure for prevention, digital and community and agree targets for increased investment in the baseline.
- **Identifying and agreeing the actions and priorities for STW providers to support the three shifts**.
- **Testing income and growth assumptions** across all Commissioners, English, and Welsh.
- **Developing scenario models alongside the demand and capacity model** to support the implementation of the system integrated care strategy.

7. Conclusion

The Shropshire, Telford, and Wrekin Integrated Care System (STW ICS) faces a complex financial and operational landscape shaped by demographic pressures, rising demand, national funding constraints, and the ongoing need to transform care delivery. This financial strategy sets out a clear, pragmatic plan to address these challenges - anchored in robust productivity improvement, targeted investment, and a commitment to delivering value for money across all areas of the system.

Through alignment with national policy priorities - including elective recovery, urgent care transformation, workforce reform, and the move toward fair share funding allocations - our strategy focuses on sustainable financial recovery, operational resilience, and improved patient outcomes. The strategy also recognises the critical importance of prevention, community-based care, and integrated neighbourhood models in reducing long-term system costs and enhancing health equity.

Delivery will require collective ownership across clinical, operational, and financial leadership. Our approach is data-driven, outcomes-focused, and designed to ensure the best use of public resources in delivering high-quality, accessible, and equitable care for the diverse populations we serve. This strategy is not just about restoring financial balance; it is about enabling a health and care system that is fit for the future.

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8. Glossary of Terms

- Please note that numbers in brackets indicate an adverse variance or a deficit position.
- NHS England via NHS Confederation provide an official online glossary of terms this website is regularly updated and can be found here - Acronym Buster | NHS Confederation

Abbreviation	Meaning
A&E	Accident and Emergency
BAU	Business as Usual
CCG	Clinical Commissioning Group
CFO	Chief Finance Officer
CHC	Continuing Healthcare/ Individual Commissioning
DFT	Distance from Target (Fair Shares Allocation)
DOF	Director of Finance
ERF	Elective Recovery Fund
FOT	Forecast Out-Turn
GP	General Practitioner
HTP	Hospital Transformation Programme
I&E	Income and Expenditure
ICB	Integrated Care Board
ICS	Integrated Care System
IS	Independent Sector
LOS	Length of Stay
LTFP	Long Term Financial Plan
MPFT	Midlands Partnership University NHS Foundation Trust
MSK	Musculoskeletal Services Shropshire and Telford
MTFP	Medium Term Financial Plan
NHS	National Health Service
NHSE	NHS England
NOF	National Oversight Framework
PMO	Programme Management Office
PRH	Princess Royal Hospital

Abbreviation	Meaning
RTT	Referral to Treatment Time
SaTH	Shrewsbury and Telford Hospitals NHS Trust
SCHT	Shropshire Community Health NHS Trust
SDEC	Same Day Emergency Care
SLR	Service Line Reporting
STW (NHS STW and STW ICS)	Shropshire Telford and Wrekin (ICS)
WMAS	West Midlands Ambulance Service

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RJAH	The Robert Jones and Agnes Hunt Orthopaedic NHS Foundation Trust
RSH	Royal Shrewsbury Hospital

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Agenda Item

ICB 25-06.182

Telford & Wrekin Integrated Place Partnership Briefing Report (meeting held on 15 May 2025)

Appendix 1 – TWIPP Annual Report 2024/25

Integrated Care System
Shropshire, Telford and Wrekin

NHS
Shropshire, Telford and Wrekin

Telford & Wrekin Integrated Place Partnership

Annual Report for 2024 / 2025

1. Introduction

1.1. Purpose

1.1.1. This is the Annual Report of the Telford & Wrekin Integrated Place Partnership (TWIPP) for the financial year 2024-25. It is intended to provide assurance that the committee has fulfilled its responsibilities as outlined in its Terms of Reference (TOR) and to review its performance over the period.

1.2. Governance

1.2.1. The production of an Annual Report is considered good governance practice and reflects the committee's commitment to transparency and accountability.

2. Role and Effectiveness of the Committee

2.1. Overview

2.1.1. The TWIPP is a formal committee of the Board. It operates under delegated authority as per the Constitution and Governance Handbook.

2.2. Terms of Reference

2.2.1. During the reporting period, TWIPP moved from a partnership meeting into a formal committee of the ICB. TWIPP operated under its new TOR from September 2024 and they were formally approved by the ICB in November 2024.

2.3. Scope of Responsibilities

2.3.1. The committee's responsibilities include:

- Agreeing and driving the delivery of proactive, preventative, high quality community centred health and care integration at place
- Focusing on reducing health inequalities, improving place-based proactive prevention and delivering seamless, accessible, safe, high quality community centred health and care services for all Telford and Wrekin residents

- Oversee the delivery of key priorities of thematic partnership boards
- Create task and finish group or working groups to develop and deliver action plans to deliver the agreed priorities for community centred health and care in Telford and Wrekin.

2.3.2. As the Committee continues to evolve and mature, further developments in terms of its responsibilities and role will be considered and included in the next iteration of the Terms of Reference.

2.4. Self-Assessment

2.4.1. TWIPP continues to assess its effectiveness at regular intervals to ensure alignment with its objectives and governance requirements.

2.4.2. Through the ICB's Annual Committee Effectiveness Survey, members were incredibly positive about the committee's effectiveness throughout the year with only two minor areas for improvement. These areas were:

- Matrix for managing matters across the year. A TWIPP forward plan was already in place but was not something that was promoted to members. Solution to address improvement - the TWIPP forward plan will be visible on the Committee's agenda and referred to within the action log when appropriate.
- At the end of the meeting allowing time for reflection on decision made and what worked well/not so well. Solution to address improvement - strengthen the final section of the meeting and build into the agenda moving forward so it is very clear to all members.

3. Committee Membership

3.1. Composition

3.1.1. The committee during 2024/25 comprised the following members:

- David Sidaway, Chief Executive of Telford & Wrekin Council and Chair of TWIPP.
- Cllr Paul Watling, Lead Cabinet Member for Adult Social Care and Health Systems, and Telford and Wrekin Residents Champion.
- Cllr Shirley Reynolds, Lead Cabinet Member for Children, Young People, Education, Employment and Skills.
- Jo Britton, Executive Director of Children and Families (Statutory DCS).
- Fliss Mercer, Executive Director for Adult Social Care, Housing and Customer Services.
- Simon Froud, Director of Adult Social Care.
- Helen Onions, Director of Health and Wellbeing (Statutory DPH).
- Louise Cross, Co-Chair of the Chief Officer Group.
- Richard Nuttall, Co-Chair of the Chief Officer Group.
- Simon Fogell, Chief Executive of Healthwatch.
- Claire Parker, Director of Strategy and Development, NHS Shropshire, Telford and Wrekin.
- Gemma Smith, Director of Strategic Commissioning, NHS Shropshire, Telford and Wrekin.
- Lorna Clarson, Chief Medical Officer (also responsible for Primary Care in ICB), NHS Shropshire, Telford and Wrekin.
- Dr Ian Chan, TELDOC PCN Clinical Director.
- Dr Derrick Ebenezer, Wrekin PCN Clinical Director.

- Dr Stefan Waldendorf, Newport and Central PCN Clinical Director
- Dr Nitin Gureja, South-East Telford PCN Clinical Director.
- Carla Bickley, Associate Director of Strategy and Partnership, Shrewsbury and Telford Hospital NHS Trust.
- Steve Ellis, Deputy Director of Operational Service Development, Shropshire Community Health NHS Trust.
- Cathy Riley, Managing Director, Shropshire Telford and Wrekin Care Group, Midlands Partnership Foundation NHS Trust.
- Mike Carr, Chief Operating Officer & Deputy CEO, Robert Jones and Agnes Hunt Orthopaedic Hospital.
- David Crosby, Chief Officer, Partners in Care.

3.2. Attendance

3.2.1. The quorum for meetings was 100%.

3.2.2. Attendance records for TWIPP since it became a Committee in September 2024 are available on request. In summary, organisational attendance was good across all members during 2024/25. Where attendance did not meet the agreed level of 75% as laid out in the Terms of Reference this was addressed directly with members. In some instances, representatives attended for a TWIPP member if they were not able to attend which enabled discussions and input from that organisation into the meetings.

3.3. Invitees and Contributors

3.3.1. Regular attendees included:

- Louise Mills, Service Delivery Manager for Health Improvement and Prevention, Telford & Wrekin Council

3.4. Frequency of Meetings

3.4.1. The committee met bi-monthly as per its TOR and met 5 times during the 2024/25 year; 4 of which were under the new terms of reference as a Committee of the ICB.

4. Assurance and Activities

4.1. Reviews and Approvals

4.1.1. The committee:

- Approved the TWIPP Terms of Reference on 12 September 2024 and its associated governance structure, including the TWIPP Neighbourhood Working Accelerator Group.
- Approved the TWIPP Strategic Priorities for 2024 – 2026 on 12 September 2024:
  1. Supporting General Practice by working together to reduce and manage demand for GP services/appointments
  2. Improving mental health services and support for children, young people and adults (prevention, early intervention and specialist services)
  3. Healthy Ageing (with a focus on preventing, reducing and delaying frailty).
- Approved the review of the Telford and Wrekin Ageing Well Partnership membership and focus on 07 November 2024.

- Approved the key areas of focus for the Health Ageing Strategic Priority of TWIPP on 30 January 2025.
- Endorsed the development of a system wide Healthy Ageing / Frailty Strategy.
- Endorsed the Energize Shropshire, Telford and Wrekin Place Expansion Proposal on 30 January 2025 and supported the development of the bid on 19 March 2025.
- Endorsed the Pharmacy First Programme focuses for the next financial year on 30 January 2025.
- Approved the key areas of focus for the Making Every Contact Count themed approach on 19 March 2025.
- Approved the key areas of focus for the Supporting General Practice Strategic Priority of TWIPP on 19 March 2025.

4.2. Risk Management

4.2.1. The Declaration of Interest Register for all TWIPP Committee Members is in place, monitored, updated frequently and is in accordance with the ICB's procedures.

4.2.2. The committee reviewed and monitored:

- Impact of not working together and collaborating.
- The impact of the Ageing Well Partnership membership not being representative of the population or the organisations involved in providing services.
- Impact of lack of funding for prevention as a system and its potential to be a barrier to innovative, proactive and preventative solutions being implemented.
- Impact of the increased in National Minimum Wage and National Insurance on the health and care sector, in particular the financial impact on the provider care market and local authorities.
- The impact of non-attendance at Committee Meetings.

4.3. Compliance and Oversight

4.3.1. The committee ensured adherence to relevant regulations, policies, and best practices in the following areas:

- Partnership working
- Declarations of Interest
- Risk Register

5. Conclusion

5.1. The committee concludes that it has effectively discharged its responsibilities in line with its TOR. It has provided appropriate oversight and assurance in all mandated areas during the reporting period.

5.2. Whilst quoracy has been achieved in the meetings, further work is needed to ensure that all key partners are able to attend every meeting.

5.3. Please refer to the TWIPP reports for the ICB meetings for more information on the progress of the Committee since its commencement in September 2024.

6. Recommendations

6.1. Review TWIPP's membership and TOR to ensure that all Committee members are able to attend the meetings and if not identify an appropriate substitute to enable the work to continue in their absence.

7. Appendices

None

Approved by the Chair of TWIPP, David Sidaway:

Signature: …D. Sidaway….. Date: 29/04/2025

Agenda Item

ICB 25-06.184

Equality, Diversity and Inclusion

Update

Appendix 1: Summary of the outcomes of the 90 day improvement challenge

Integrated Care System
Shropshire, Telford and Wrekin

EDI 90-day challenge outcomes

Project 1

No.	Project	Measurable Outcomes
1	**Consistency in Application:** Ensure System partners Boards awareness of racism and agree a System statement to support a consistent approach towards responding to and reporting of any racist incidents. This will help enable a process of highlighting unwanted racist behaviours and calling for their cessation.	**Leading Indicators-** formally reported at every STW Board meeting, prevalent issues reviewed quarterly / bi-annually. **Lagging Indicators-** number of incidents reported (increase in reports), staff survey results.

1) Board discussion summaries

Aim: Ensure System partners Boards awareness of racism	
Organisation	**Board discussion**
Telford and Wrekin Council	• A clear process in place for employees to report discriminatory incidents and a policy/process for managers to follow in responding to these. • Focus to continue to be on all types of [discriminatory] incidents. • Policy and how to report has recently been communicated as part of the Council's Leadership Training, • Continue to raise awareness amongst the wider workforce of how to report, and it was agreed that we ask Corporate EDI Steering Group to discuss additional ways that we could do this at their next meeting on 5 June.
Shropshire Council	• Awaiting update
SaTH	• Awaiting update
RJAH	• Draft anti-racism journey slides in progress • Board to receive updates on reported racist incidents (quarterly) • More promotion of how to report incidents in staff communications planned • Freedom to speak up posters more prominently placed and updated with new global majority FTSU champions • Linking outcomes of the Staff Survey 2024 with a survey monkey to understand experiences and what further support is needed • Working with the Ethnic Diverse Staff network group to understand lived experiences and promote awareness
SCHT	• Awaiting update

Project 2

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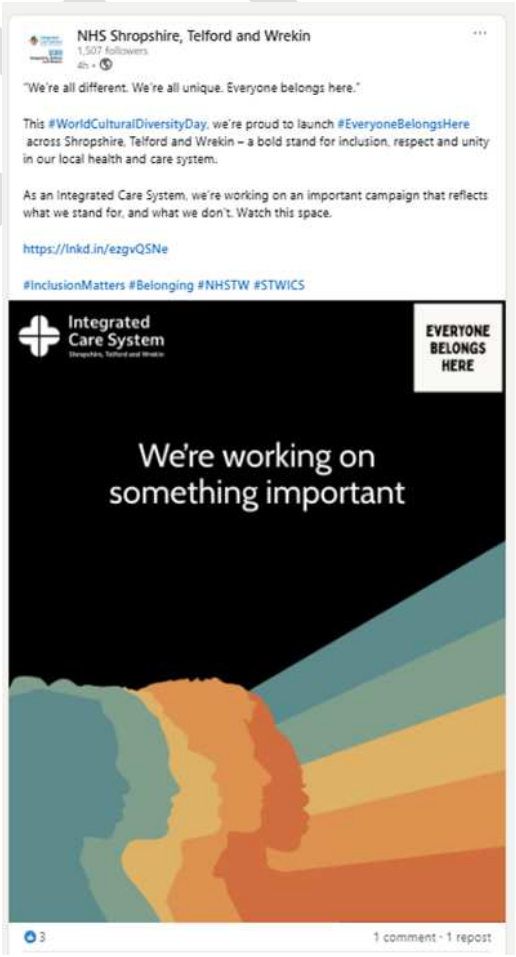
No.	Project	Measurable Outcomes
2	**Coordinated Communications Campaign** to launch in May to commemorate diversity month **Themes such as** "Stronger Together", "You're welcome, we are all part of STW, and this is what STW looks like", "We are safe", "Humanising services".	**Leading Indicators-** public and staff engagement with initial messaging, completion of all project tasks. **Lagging Indicators-** staff and employee engagement levels, recruitment numbers, picked up by local media, social media stats. Capture the change in the organization's approach as a result of the engagement.

1) Communication campaign overview

The coordinated communication campaign was launched on 21st May to coincide with World Day for Cultural Diversity for Dialogue and Development, through

- Engaging with the EDI Steering Group, EDI staff networks, and system communication colleagues
- Researching other systems' EDI campaigns for ideas generation

From this draft key messages and visual design concepts that could be consistently applied across system partners were shared and agreed. The final was developed and promoted by system partners, social media and the general media as well as specially to staff teams as follows.



- Designed to be bold, vibrant, and inclusive - capturing attention while celebrating the diversity within our ICS community.
- The variety of colours symbolises the vibrancy, cultural richness, and individuality within our diverse communities.
- The rainbow acts as a visual metaphor, often used as a symbol of unity, highlighting that while we may come from different backgrounds, we are united by shared values and common interests.
- While the primary focus is on addressing racism, we are equally committed to ensuring that all communities are represented.

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Integrated Care System
Shropshire, Telford and Wrekin

New 'Everyone Belongs Here' Campaign Launched to Champion Respect, Dignity and Fairness

20 May 2025

"We're all different. We're all unique. Everyone belongs here." That's the powerful message at the heart of a new campaign launched by health and care professionals across the Shropshire, Telford and Wrekin Integrated Care System (ICS).

Coinciding with World Day for Cultural Diversity, taking place on Wednesday 21 May 2025, the 'Everyone Belongs Here' campaign is a bold step forward in celebrating the rich diversity of our workforce and community, and in standing firmly against discrimination in all its forms.

Developed by colleagues from the NHS, local councils, and wider health and care partners, the campaign builds on ongoing efforts to strengthen the reporting of discriminatory incidents and to ensure consistent monitoring of these reports.

'Everyone Belongs Here' reflects the shared values of respect, inclusion, and compassion held within the local health and care system. It shines a light on the contributions of every individual working across the system, from frontline care to leadership roles.

Vanessa Whatley, Executive Lead for Equality, Diversity and Inclusion (EDI) and Chief Nursing Officer at NHS Shropshire, Telford and Wrekin, said: "Everyone Belongs Here' is grounded in our values. It champions kindness, celebrates difference, and recognises the vital role every member of our team plays.

"We believe in inclusion. We are proud to have a workforce that reflects many backgrounds and cultures - among our colleagues, hundreds bring with them heritage and experience from outside the UK. Their diverse perspectives enrich the care we provide every day."

Rhia Boyode, Chief People Officer for The Shrewsbury and Telford Hospital NHS Trust (SaTH) and Shropshire Community Health NHS Trust (Shropcom) added: "Our people are at the heart of everything we do. They answer phones, serve meals, deliver care, lead teams - and they do so with unwavering dedication. Every day, staff of all backgrounds show up to care for others. That's what makes our health and care system so strong.

"We stand united in the belief that diversity is our strength. Every individual -regardless of race, gender, religion, disability, sexual orientation or background -deserves to be treated with respect, dignity and fairness. We hope this campaign will create a meaningful and lasting impact - not just for our staff, but also for patients and the wider public."

As the campaign begins to roll out across the county, patients and the public will begin seeing its messages in local NHS, council and community settings. Everyone is encouraged to reflect on what it means to belong - and to carry those values into every interaction with our health and care professionals.

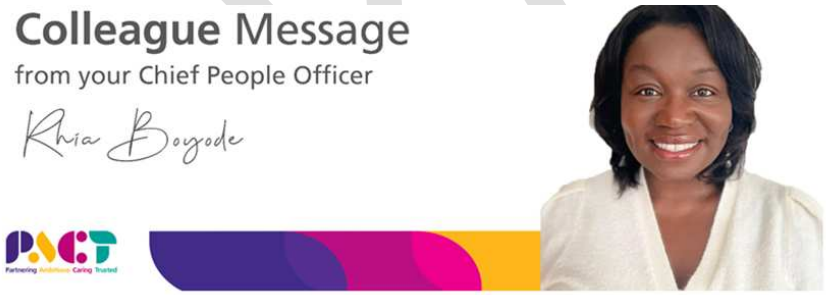
Vanessa added: "Discrimination of any kind has no place in our services. We are taking clear, decisive steps to protect and support our workforce, including robust policies and close work with partners such as the police to address racism and all forms of abuse or harassment.

"The 'Everyone Belongs Here' campaign is a clear statement of intent: to create a health and care system that is a beacon of compassion, safety and belonging for everyone."

For more information, please visit: Everyone Belongs Here - NHS Shropshire, Telford and Wrekin.

To read more about World Day for Cultural Diversity for Dialogue and Development | United Nations click here.

2) System partner promotion of the campaign



Dear colleague,

We're proud to share the launch of a powerful new campaign across the Shropshire, Telford and Wrekin Integrated Care System: 'Everyone Belongs Here'.

To mark World Day of Cultural Diversity on Wednesday 21 May 2025, this campaign celebrates the rich diversity within our workforce and communities and sends a clear and united message: We're all different. We're all unique. Everyone belongs here.

Currently in development by colleagues across the NHS, local councils, and care partners, this initiative reflects our shared values of respect, inclusion, and compassion. Whether on the front lines of care or in support and leadership roles, every one of us matters.

Together, we are taking a stand against discrimination in all its forms and we're hoping you can help.

Why this matters

Executive Lead for Equality, Diversity and Inclusion (EDI) and Chief Nursing Officer at NHS Shropshire, Telford and Wrekin, Vanessa Whatley, says: "Everyone Belongs Here is grounded in our values. It champions kindness, celebrates difference, and recognises the vital role every member of our team plays. We are proud to have a workforce that spans cultures, backgrounds and experiences - each bringing unique perspectives that enrich the

Shropshire Council | Search Shropshire Newsroom

21/05/2025 - Permalink

New 'Everyone Belongs Here' Campaign Launched to Champion Respect, Dignity and Fairness

Related topics: Community / Health / Partner organisations / Uncategorized

Celebrating the rich diversity within our workforce and communities

3) Media engagement

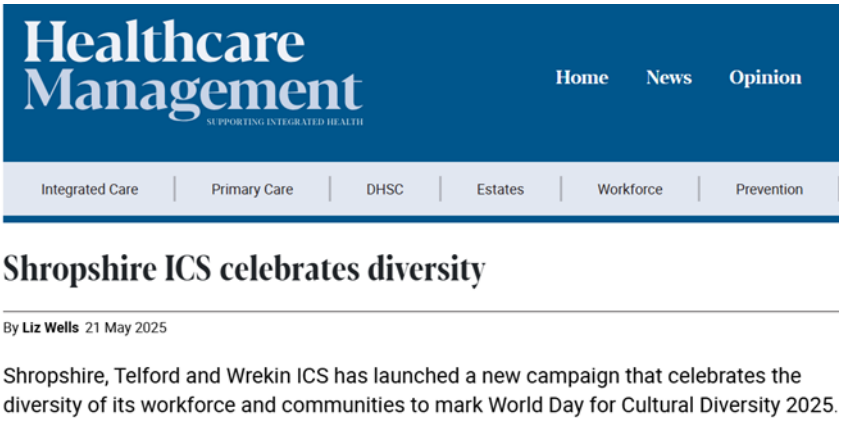
Shropshire Star plus

News | Sport | Entertainment | Your World | Puzzles

rs' letters | Feed a Family | Local Hubs | Crime | Politics | **Health**

New NHS campaign launched to champion respect, dignity and fairness

"We're all different. We're all unique. Everyone belongs here."



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Shropshire ICS celebrates diversity

By **Liz Wells** 21 May 2025

Shropshire, Telford and Wrekin ICS has launched a new campaign that celebrates the diversity of its workforce and communities to mark World Day for Cultural Diversity 2025.

4) Next steps

The EDI steering group and their networks will remain engaged with the direction of the ongoing campaign.

To humanise the campaign, we will feature authentic local role models from within our organisations and are currently engaging with volunteers. These individuals will reflect the real people behind our services so that colleagues feel represented but form connections and commonalities.

Feature personalised quotes from staff to highlight the real, lived experiences behind our commitment to EDI. These will add authenticity, demonstrate the personal and professional importance of EDI.

The ICS logo will be a consistent element across all visuals, reinforcing partnership and shared values

Launch of email banners for colleagues to use as part of their Outlook signatures.

Adaption and growth of the campaign, particularly around other aspects of the EDI agenda and to promote the reporting of discrimination.

The campaign will be evaluated.

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Agenda Item

ICB 25-06.187

Finance Committee

Appendix 1 – Tracked Changes to Committee TOR

NHS Shropshire, Telford and Wrekin

System Finance Committee
Terms of Reference

1. Constitution

1.1 The Finance Committee (the Committee) is established by the Integrated Care Board (the Board or ICB) as a Committee of the Board in accordance with its Constitution.

1.2 These Terms of Reference (ToR), which must be published on the ICB website, set out the membership, the remit, responsibilities and reporting arrangements of the Committee and may only be changed with the approval of the Board.

1.3 The Committee is an executive committee of the Board and its members, including those who are not members of the Board, are bound by the Standing Orders and other policies of the ICB.

2. Authority

2.1 The Finance Committee is authorised by the Board to:

- Investigate any activity within its terms of reference
- Seek any information it requires within its remit, from any employee or member of the ICB (who are directed to co-operate with any request made by the Committee) as outlined in these terms of reference
- Commission any reports it deems necessary to help fulfil its obligations,
- Obtain legal or other independent professional advice and secure the attendance of advisors with relevant expertise if it considers this is necessary to fulfil its functions. In doing so the Committee must follow any procedures put in place by the ICB for obtaining legal or professional advice
- Create task and finish sub-groups in order to take forward specific programmes of work as considered necessary by the Committee's members. The Committee shall determine the membership and terms of reference of any such task and finish sub-groups in accordance with the ICB's constitution, Standing Orders and Scheme of Reservation and Delegation (SoRD) but may not delegate any decisions to such groups.

2.2 For the avoidance of doubt, the Committee will comply with, the ICB Standing Orders, Standing Financial Instructions and the SoRD.

3. Purpose

3.1 To contribute to the overall delivery of the ICB objectives by providing oversight and assurance to the Board in the development and delivery of a robust, viable and sustainable system financial plan. ~~This includes:~~

- ~~financial performance of NHS STW~~
- ~~financial performance of NHS organisations within the NHS STW footprint~~

In doing so, the Committee will act with input and insight from Local Authority Partners.

3.2 The Finance Committee has no executive powers, other than those delegated in the SoRD and specified in these terms of reference.

4. Membership and attendance

4.1 Membership

4.1.1 The Committee members shall be appointed by the Board in accordance with the NHS STW Constitution.

4.1.2 The Board will appoint no fewer than four members of the Committee including one who is an Independent Non-Executive Member of the Board. Other members of the Committee need not be members of the Board, but they may be.

4.1.3 ~~In order to efficiently discharge the Committee responsibilities the Committee will subdivide its meeting into two parts; one looking at the responsibilities for NHS STW financial performance and the other looking at the responsibilities for the financial performance of the wider system.~~

~~Members for internal ICB responsibilities:~~

- ~~ICB Independent Non-Executive Director (Chair)~~
- ~~ICB Independent Associate Non-Executive Director – Finance (Vice Chair)~~
- ~~ICB Chief Finance Officer~~
- ~~ICB Director of Finance~~
- ~~ICB Chief Delivery Officer~~

Members of the Committee:~~for external ICS system responsibilities:~~

- ICB Independent Non-Executive Director (Chair)
- ICB Independent Associate Non-Executive Director – Finance (Vice Chair)
- ICB Chief Finance Officer
- ICB Director of Finance
- ICB Chief Delivery Officer
- SaTH Non-Executive Director
- SaTH Chief Finance Officer (or Deputy)
- Shropshire Community Health NHS Trust Non-Executive Director

- Shropshire Community Health NHS Trust Chief Finance Officer (or Deputy)
- RJAH Non-Executive Director
- RJAH Chief Finance Officer (or Deputy)
- MPUFT Chief Finance Officer (or Deputy)
- Shropshire Council – Finance Lead (or Deputy)
- Telford and Wrekin Council – Finance Lead (or Deputy)

4.1.4 Members will possess between them knowledge, skills and experience in:

• accounting.
• risk management.
• technical or specialist issues pertinent to the ICB's business.

4.1.5 When determining the membership of the Committee, active consideration will be made to diversity and equality.

4.2 Chair and vice chair

4.2.1 In accordance with the constitution, the Committee will be chaired by an Independent Non-Executive Member of the Board appointed on account of their specific knowledge skills and experience making them suitable to chair the Committee.

4.2.2 In the event of the chair being unable to attend, the ICB Lay Advisor who is Vice Chair will chair the meeting.

4.2.3 In the absence of the Chair, or Vice Chair, the remaining members present shall elect one of their number to Chair the meeting.

4.2.4 The Chair will be responsible for agreeing the agenda and ensuring matters discussed meet the objectives as set out in these terms of reference.

4.3 Attendees

4.3.1 Only members of the Committee have the right to attend Committee meetings, however all meetings of the Committee may also be attended by other invited and appropriately nominated individuals who are not members of the Committee. Other individuals may be invited to attend all or part of any meeting as and when appropriate to assist it with its discussions on any particular matter, including representatives from the health and wellbeing board(s), primary, secondary, mental health and community providers.

4.3.2 The Chair may ask any or all of those who normally attend, but who are not members, to withdraw to facilitate open and frank discussion of particular matters.

4.3.3 The Chair of NHS STW may also be invited to attend one meeting each year in order to gain an understanding of the Committee's operations.

4.4 Attendance

4.4.1 Where an attendee of the Committee (who is not a member of the Committee) is unable to attend a meeting, a suitable alternative may be agreed with the Chair.

5. Meetings, quoracy and decisions

5.1 Meetings

5.1.1 The Finance Committee will meet at least 4 times annually, except for August and December.

5.1.2 Arrangements and notice for calling meetings are set out in the Standing Orders. Additional meetings may take place as required.

5.1.3 The Board, Chair or Chief Executive may ask the Finance Committee to convene further meetings to discuss particular issues on which they want the Committee's advice.

5.1.4 In accordance with the Standing Orders, the Committee may meet virtually when necessary and members attending using electronic means will be counted towards the quorum.

5.2 Quorum

5.2.1 For a meeting to be quorate a minimum of 50% members is required, including the Chair or Vice Chair (or their deputy).

5.2.2 If any member of the Committee has been disqualified from participating in an item on the agenda, by reason of a declaration of conflicts of interest, then that individual shall no longer count towards the quorum.

5.2.3 If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken.

5.2.4 Decisions deemed by the Chair to be 'urgent' can be taken outside of the meeting via email communication, and with the agreement of a quorate number of members.

5.3 Decision-making and voting

5.3.1 Decisions will be taken in accordance with the Standing Orders. The Committee will ordinarily reach conclusions by consensus. When this is not possible the Chair may call a vote.

5.3.2 Only members of the Committee may vote. Each member is allowed one vote and a majority will be conclusive on any matter. Where there is a split vote, with no clear majority, the Chair of the Committee will hold the casting vote.

5.3.3 If a decision is needed which cannot wait for the next scheduled meeting, the Chair may conduct business on a 'virtual' basis through the use of telephone, email or other electronic communication.

5.3.4 Where any such action has been taken between meetings, then these will be reported to the next meeting.

5.3.5 The Committee may resolve to hold a meeting in confidential private session where:

- it would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted; or
- voting members and non-voting attendees of the Committee have conflicts of interest with items on the agenda such, that they would be required to absent themselves from the meeting.

Where items are discussed in private confidential session a separate agenda with papers and minutes will be created. Distribution of agenda, papers and minutes will be limited to those that are voting members with no conflicts of interest and those specifically invited attendees which will be agreed with the Chair.

6. Responsibilities of the Committee

6.1 The Committee's duties can be categorised as follows.

6.2 System financial management framework

- to set the strategic financial framework as part of the system finance strategy of NHS STW and monitor performance against it to develop NHS STW financial information systems and processes. These will be ~~to be~~ used to make recommendations to the Board on financial planning in line with the strategy and national guidance to ensure health and social inequalities are taken into account in financial decision-making.

~~6.3 Resource allocations (revenue)~~

- ~~recommend allocation of strategic resources to deliver the plan across the system determining what resources should be available to meet population need in each place and setting principles for how they should be allocated across services and providers~~
- ~~to develop an approach to distribute the resource allocation through commissioning and direct allocation to drive agreed change based on NHS STW strategy to advise on and oversee the process regarding the deployment of system-wide transformation funding~~
- ~~to work with ICS partners to identify and allocate resources where appropriate to address finance and performance related issues that may arise~~
- ~~to work with ICS partners to consider major investment/disinvestment outlined in business cases for material service change or efficiency schemes and to agree a process for sign off~~
- ~~to develop standing financial instructions for approval by the Board.~~

6.~~3~~4 National framework

- to advise NHS STW on any changes to NHS and non-NHS funding regimes and consider how the funding available to NHS STW can be best used within the system to achieve the best outcomes for the local population
- to oversee national ICB level financial submissions
- to ensure the required preparatory work is scheduled to meet national planning timelines

6.~~4~~5 Financial monitoring information

- ~~to develop a reporting framework for NHS STW as a statutory body, using the chart of accounts devised by NHSE and the integrated single financial environment (ISFE) and NHS STW as a system of bodies~~
- to articulate the financial position and financial impacts (both short and long-term) to support decision-making
- to work with ICS partners to identify and agree common approaches across the system such as financial reporting, estimates and judgements
- to work with ICS partners to seek assurance over the financial reports from system bodies and provide feedback to them (being clear on how this role interacts with that of the audit committee)
- to oversee the development of financial and activity modelling to support the ICS~~B~~ priority areas
- to oversee the development and delivery of the financial 'Recovery Plan', as part of the Financial Improvement Programme
- to develop a medium- and long-term financial plan which demonstrates ongoing value and recovery
- to develop an understanding of where costs sit across a system, system cost drivers and the impacts of service change on costs
- to ensure appropriate information is available to manage financial issues, risks and opportunities across the ICB
- to manage financial and associated risks by developing and monitoring a finance risk register
- To ensure risks associated with the remit of the Committee are incorporated in the System Board Assurance Framework and the Strategic Operational Risk Register as appropriate and oversight of mitigation and action on gaps in control is maintained.

6.5~~6~~ Performance

- to oversee the management of the system financial target ~~and NHS STW's own financial targets~~
- to agree key outcomes to assess delivery of NHS STW financial strategy to monitor and report to the Board overall financial performance against national and local metrics, highlighting areas of concern
- to monitor and report to the Board key service performance which should be taken into account when assessing the financial position.
- ~~monitor arrangements for risk sharing or risk pooling with other organisations i.e. Section 75 arrangements NHS Act 2006, NHSE delegated specialised services and Pharmacy, Optometry and Dental.~~
- ~~Recommend approval of healthcare contracts outside approved budgets to the Board.~~

6.6~~7~~ Communication

- to co-ordinate and manage communications on financial governance with stakeholders internally and externally

- ~~to develop an approach with partners, including NHS STW health and care partnership, to ensure the relationship between cost, performance, quality and environment sustainability are understood~~

6.~~7~~8 Capital

- Recommend allocation of strategic resources to deliver the plan across the system determining what resources should be available to meet population need in each place and setting principles for how they should be allocated across services and providers
- to monitor the system capital programme against the capital envelope and take action to ensure that it is appropriately and completely used
- to gain assurance that the estates and digital plans are built into system financial plans
- to ensure effective oversight of future prioritisation and capital funding bids

6.~~8~~9 The Committee has the authority to make the following decisions on behalf of NHS STW as set out in the Scheme of Reservation and Delegation:

- To approve policies and procedures specific to the Committee's remit which include, but are not limited to:

  a) Financial policies and procedures

7. Behaviours and conduct

7.1 ICB values

7.1.1 Members will be expected to conduct business in line with NHS STW values and objectives.

7.1.2 Members of, and those attending, the Committee shall behave in accordance with NHS STW's Constitution, Standing Orders, Conflicts of Interest Policy and Standards of Business Conduct Policy.

7.2 Conflicts of interest

7.2.1 In discharging duties transparently, conflicts of interest must be considered, recorded and managed.

7.2.2 Members should have regard to both the ICB's policies and national guidance on managing conflicts of interest.

7.2.3 All potential conflicts of interest must be declared and recorded at the start of each meeting. A register of interests must be maintained by the Chair and submitted to the Board. If the Chair considers a conflict of interest exists then the relevant person must not take part in that item, and the Chair may require the affected member to withdraw at the relevant point.

7.3 Equality and diversity

7.3.1 Members must demonstrably consider the equality and diversity implications of decisions they make.

8. Accountability and reporting

8.1 The Committee is accountable to the Board and shall report to the Board on how it discharges its responsibilities.

8.2 The minutes of the meetings shall be formally recorded by the secretary and submitted to the Board in accordance with the Standing Orders.

8.3 The Chair will provide assurance reports to the Board after each meeting and shall draw to the attention of the Board any issues that require disclosure to the Board or require action.

8.4 The Committee will provide an annual report to the Board to describe how it has fulfilled its terms of reference, details on progress and a summary of key achievements in delivering its responsibilities.

8.5 The following sub-committees and groups will report into this Committee:

- Capital Prioritisation and Oversight Group

8.6 ***Committee Business Cycle***

a. The Committee will develop and agree a business cycle at the start of each financial year to ensure delivery of its responsibilities.
b. This business cycle should be finalised no later than the end of Quarter 1, shared with Committee members, and formally approved by the Committee to support effective planning, prioritisation, and performance oversight throughout the year.
c. The business cycle shall be reviewed annually to ensure it remains fit for purpose and aligned with the strategic priorities of the ICB.

9. Secretariat and administration

9.1 The Committee shall be supported with a secretariat function which will include ensuring that:

- the agenda and papers are prepared and distributed in accordance with the Standing Orders having been agreed by the Chair with the support of the relevant executive lead
- attendance of those invited to each meeting is monitored and those that do not meet the minimum attendance requirements are highlighting to the Chair
- records of members' appointments and renewal dates and the Board is prompted to renew membership and identify new members where necessary
- preparation, collation and circulation of papers in good time
- good quality minutes are taken in accordance with the standing orders and agreed with the chair so that a record are kept of matters arising, action points and issues carried forward
- the Chair is supported to prepare and deliver reports to the Board

- the Committee is updated on pertinent issues/ areas of interest/ policy developments action points are taken forward between meetings and progress against those is monitored.

10.Review

10.1 The Committee will review its effectiveness at least annually. These terms of reference will be reviewed at least annually and more frequently if required. Any proposed amendments to the terms of reference will be submitted to the Board for approval.

Date of approval:

Date of review: 14~~21~~ April 2025~~4~~

Agenda Item

ICB 25-06.188

People Culture and Inclusion Committee

Appendix 1 - Annual Report for PCIC 2024/25

Integrated Care System
Shropshire, Telford and Wrekin

NHS
Shropshire, Telford and Wrekin

People Inclusion and Culture Committee

Annual Report for 2024/25

1. Introduction

1.1. Purpose

1.1.1. This is the Annual Report of the People Inclusion and Culture Committee for the financial year 2024/25. It is intended to provide assurance that the committee has fulfilled its responsibilities as outlined in its Terms of Reference (TOR) and to review its performance over the period.

1.2. Governance

1.2.1. The production of an Annual Report is considered good governance practice and reflects the committee's commitment to transparency and accountability.

2. Role and Effectiveness of the Committee

2.1. Overview

2.1.1. The People Culture and Inclusion Committee is a formal committee of the Board. It operates under delegated authority as per the Constitution and Governance Handbook.

2.2. Terms of Reference

2.2.1. During the reporting period, the committee operated under its TOR approved on March 2023.

2.3. Scope of Responsibilities

2.3.1. The committee's responsibilities include:

- The Committee's main purpose is to contribute to the overall delivery of ICB objectives by providing oversight and assurance to the Board in the development and delivery of the STW ICS People Plan and its People Agenda.

2.4. Self-Assessment

2.4.1. The committee assessed its effectiveness at regular intervals to ensure alignment with its objectives and governance requirements.

3. Committee Membership

3.1. Composition

3.1.1. The committee comprised the following members:

- Harry Turner – Chair STW ICS People, Culture and Inclusion, Chair RJAH
- Martin Evans - STW ICS People, Culture and Inclusion Vice Chair, Non-Executive Director RJAH
- Meredith Vivian – STW ICB Non-Executive Director
- Teresa Boughey – Non-Executive Director SaTH
- Trevor Purt - Non-Executive Director SaTH
- Alison Sargent - Non-Executive Director SCHT
- Stacey-Lea Keegan – CEO RJAH, ICS Chief Executive SRO for People & Workforce
- Rhia Boyode - Chief People Officer SaTH & SCHT, SRO for the Reform Portfolio
- Alex Brett - Chief People Officer MPUFT, SRO for the Transform Portfolio
- Denise Harnin - Chief People Officer and Culture Officer SRO Retain Portfolio
- Vanessa Watley – Chief Nurse STW ICB

3.2. Attendance

3.2.1. For a meeting to be quorate a minimum of 50% members is required including the Chair or Vice Chair (or their deputy), and one NED (NHS STW or provider). Attendance records for the financial year are detailed below:

Table 1: Meeting Attendance Record

Member	Meetings Attended	Total Meetings
Harry Turner	STW ICS People, Culture and Inclusion Committee Chair & Chair RJAH Board	1 Of 1*
Martin Evans	STW ICS People, Culture and Inclusion Chair (from November) Non-Executive Director RJAH	3 Of 3
Stacey-Lea Keegan	Chief Executive Officer RJAH, SRO for People and Workforce	3 Of 3
Teresa Boughey	Non-Executive Director SaTH	3 Of 3
Meredith Vivian	Non-Executive Director STW ICB	2 Of 3
Trevor Purt	Non-Executive Director Trust Board SaTH	0 Of 3
Alison Sargeant	Non-Executive Director SCHT	1 Of 3
Denise Harnin	RETAIN People portfolio Chief People Officer and Culture Officer RJAH and Exec SRO	3 Of 3
Rhia Boyode	REFORM and TRAIN People Portfolio Chief People Officer SaTH & SCHT SRO	2 Of 3
Alex Brett	TRANSFORM People Portfolis Chief People Officer MPFT and Exec SRO	3 Of 3
Vanessa Whatley	Chief Nursing Officer STW ICB	3 Of 3

*Please note Harry Turner only took over as chair part way through the year.

3.3. Invitees and Contributors

3.3.1. Regular attendees included:

- Ellen Shaw - STW ICB Strategic Workforce Lead
- Sarah Allen - Deputy Workforce Operations Director, SCHT

- Emma Wilkins - People Interim Director SaTH
- Sarah Davies- Director Health and Science Telford College
- Jan Heath - STW ICB Workforce Transformation Lead
- Alison Trumper – STW ICB Education and Training Lead
- David Crosby - Chief Executive Partners in Care
- Simon Balderstone - Deputy Director of People SCHT and SRO REFORM
- Amanda Battey - Workforce Transformation Senior Programme Manager, NHSE

3.4. Frequency of Meetings

3.4.1. The committee met three times, with one supplementary meeting held to discuss the new Terms of Reference.

3.4.2. The Committee will meet at least twice a year and arrangements and notice for calling meetings are set out in the Standing Orders 4.1. Additional meetings may take place as required.

4. Assurance and Activities

4.1. Reviews and Approvals

4.1.1. The committee did not review or approve any formal policies or strategies in the year.

4.2. Risk Management

4.2.1. The committee reviewed and monitored:

- Risks contained within the BAF and SORR
- Local risks populated within the local people risk register by members of the system people team and the SRO's of the four workstream areas.

4.3. Compliance and Oversight

4.3.1. The committee ensured adherence to relevant regulations, policies, and best practices in the following areas:

- Updates for each of the strategic pillars; Train, Retain, Reform and Transform have been provided at each meeting to provide oversight on delivery.
- ICS People Programmes Annual Report (June 2024)
- Progress and outcomes of System HR Review (January 2025)

5. Conclusion

5.1. The committee concludes that it has effectively discharged its responsibilities in line with its TOR. It has provided appropriate oversight and assurance in all mandated areas during the reporting period.

6. Recommendations

6.1. To note that the Terms of Reference have been reviewed and approved, which will support the further evolution, and improve effectiveness in the 2025/26 year.

7. Appendices

7.1. Appendix C: Key Documents Reviewed

Not applicable

Agenda Item

ICB 25-06.189

West Midlands Joint Committee

Appendix 1 - West Midlands Joint Committee Annual Report for 2024/25

Integrated Care System
Shropshire, Telford and Wrekin

NHS
Shropshire, Telford and Wrekin

West Midlands Joint Committee

Annual Report for 2024/25

1. Introduction

1.1. Purpose

1.1.1. This is the Annual Report of the West Midlands Joint Committee for the financial year 2024/25. It is intended to provide assurance that the committee has fulfilled its responsibilities as outlined in its Terms of Reference (TOR) and to review its performance over the period.

1.2. Governance

1.2.1. The production of an Annual Report is considered good governance practice and reflects the committee's commitment to transparency and accountability.

2. Role and Effectiveness of the Committee

2.1. Overview

2.1.1. The West Midlands Joint Committee is a formal committee, accountable to the six ICB Boards. It operates under delegated authority as per the Constitution and Governance Handbook.

2.2. Terms of Reference

2.2.1. During the reporting period, the committee operated under its TOR approved in March 2024.

2.3. Scope of Responsibilities

2.3.1. The committee's responsibilities include:

The joint committee has delegated authority from the ICB for the following:

- Preparation for the future joint collaborative arrangements with the other ICBs to support the delegation from NHSEI of primary care commissioning in accordance with section 13V and/or section 65Z6 of the NHS Act. This is with the expectation that the committee subsequently provides the joint governance oversight for such arrangements once they have been determined and subsequently approved by the ICBs.

- Preparation for the future joint collaborative arrangements to enable the delegation from NHSEI of specialised services commissioning (also in accordance with section 13V and/or section 65Z6 of the NHS Act). This is with the expectation that the committee subsequently provides the joint governance oversight for such arrangements once they have been determined and

subsequently approved by the ICBs, recognising that there will also still be an accountability for these arrangements back to NHSEI.

- Oversight and co-ordination of the commissioning arrangements for the six ICBs in respect of 111 and 999 services and any associated shared commissioning functions.

- Oversight and co-ordination of shared collaborative arrangements that may be determined by the ICBs (such as the co-ordination of clinical networks). This will include the production of proposals by the committee for approval by the ICBs for the appropriate alignment of accountabilities for any shared activities through the joint committee to the ICBs.

- Provision of a forum for collective discussion, agreement and decisions by the constituent members of the committee that is consistent with the delegated limits of each ICB's standing financial orders. So enabling the ICBs to collaborate on areas of work and opportunities that arise.

- Determination of the most appropriate commissioning governance and operation arrangements for any functions and services delegated to the committee by the six ICBs.

- Determination of the most appropriate working group arrangements, reporting into the joint committee to enable the efficient and effective operation of the responsibilities that have been delegated to the committee by the six ICBs.

2.4. Self-Assessment

2.4.1. The committee assessed its effectiveness at regular intervals to ensure alignment with its objectives and governance requirements, with the last annual governance effectiveness review completed in December 2024.

3. Committee Membership

3.1. Composition

3.1.1. The committee comprised the following members:

- David Melbourne – Chief Executive, NHS Birmingham and Solihull ICB
- Phil Johns - Chief Executive – NHS Coventry and Warwickshire ICB
- Simon Trickett – Chief Executive, Worcestershire & Herefordshire ICB
- Simon Whitehouse – Chief Executive, NHS Shropshire Telford and Wrekin ICB
- Peter Axon – Chief Executive, Staffordshire and Stoke on Trent ICB
- Mark Axcell – Chief Executive, Black Country ICB

3.2. Attendance

3.2.1. The quorum for meetings was
The joint committee will include the following members:

- The six ICB CEOs
- Consideration may be given to other members being in attendance at the committee. For example:
  - The Senior Manager for the West Midlands ICB CEOs office

- NHSEI commissioning representative;
- West Midlands provider collaborative representative;
- West Midlands public health representative
- Finance and Clinical representatives from the ICBs

4.2 If an ICB CEO cannot attend then they will send a representative with full authority to act on their behalf.

4.3 For decisions that are made in relation to collective discussion, agreement and decisions by constituent members of the committee that is consistent with the delegated limits of each ICB's standing financial orders, then quoracy is not required as members are contributing based on their own limits of delegation.

4.4 Similarly for recommendations / and or proposals that are being submitted for approval by the ICBs, quoracy is not required.

4.5 For decisions in relation to the collective delegation of functions and/or services then all ICB CEOs (or their designated representative) would need to be in attendance for the decision to be quorate. All decisions will also need to be made in accordance with the delegation agreement between NHSEI and the ICBs where this is appropriate.

4.6 The meeting will be chaired by one of the ICB CEOs – to be determined by the committee.

Attendance records for the financial year are detailed below:

Table 1: Meeting Attendance Record

Attendance of Member or representative acting on their behalf	Meetings Attended	Total Meetings
David Melbourne – Chief Executive, NHS Birmingham and Solihull ICB	10	10
Phil Johns - Chief Executive – NHS Coventry and Warwickshire ICB	10	10
Simon Trickett – Chief Executive, Worcestershire & Herefordshire ICB	10	10
Simon Whitehouse – Chief Executive, NHS Shropshire Telford and Wrekin ICB	10	10
Peter Axon – Chief Executive, Staffordshire and Stoke on Trent ICB	10	10
Mark Axcell – Chief Executive, Black Country ICB	9	10

3.3. Invitees and Contributors

3.3.1. Regular attendees included:

- Karen Helliwell - Transition Director – Specialised Services
- Jon Cooke - Director of Commissioning Finance – NHS England (Midlands)
- Dr Clara Day – Chief Medical Officer, NHS BSOL ICB
- Sally Roberts - Chief Nurse – NHS Black Country ICB
- Nakash Lewis – Director for Office of the West Midlands (OWM)
- Rebecca Woods – Head of Primary Care Commissioning, OWM
- Peter McKenzie - Head of Governance, NHS Black Country ICB

- Jonathan Brotherton - Chief Executive - University Hospitals Birmingham NHS Trust
  Alison Kemp – Interim Regional Director of Specialised Commissioning NHSE
- Jon Currington – Head of Acute Specialised Commissioning, NHSE
- Madi Parmar – Chief Finance Officer, NHS Coventry & Warwickshire ICB
- Paul Brown – Chief Finance Officer- Staffs & Stoke ICB
- Collette Marshall - Chief Medical Officer Representative – NHS England (Midlands)
- Melanie Coombes - Chief Executive – Coventry & Warwickshire Partnership NHS Trust
- Roz Lindridge - Regional Director of Commissioning – NHS England (Midlands)

3.4. Frequency of Meetings

3.4.1. The committee will meet when and as often as determined necessary by its membership.

3.4.2. The committee met ten times during the year, including no additional meetings convened for specific purposes.

4. Assurance and Activities

4.1. Reviews and Approvals

4.1.1. The committee reviewed and/or approved:

- West Midlands Neonatal Capacity Plan Report, on 20th March 2025
- Increase in minimum UDA rate to £33, primary care waiting list initiative and investment in oral health improvement team approved on 27th February 2025 (SSOT ICB)
- Joint Commissioning Group, Standing Financial Instructions limits approved on 25th February 2025
- Targeted 110% dental contract over-delivery, primary care waiting list initiative and increase in minimum UDA rate to £33 approved on 17th February 2025 (STW ICB)
- Targeted 110% dental contract over-delivery approved on 17th February 2025 (BSOL ICB)
- Targeted 110% dental contract over-delivery approved on 12th February 2025 (C&W ICB)
- Increase in minimum UDA rate to £33 and targeted 110% dental contract over-delivery approved on 22nd January 2025 (H&W ICB)
- West Midlands Neonatal Review was reviewed 8th November 2024, with support for next stage report to be presented at future committee.
- Westbourne contract direct award approved on 13th September 2024 (All ICBs)
- Dental Intermediate Minor Oral Surgery - Direct Provider Award, approved on 12th July 2024 (STW ICB)

4.2. Risk Management

4.2.1. The committee reviewed and monitored:

- Financial risk - Elective recovery fund
- Staffing risk - Attrition of key clinical staff, driving destabilisation

- Patient safety risk – Waiting lists are high, management through access to IMOS services

4.3. Compliance and Oversight

- The Committee is assured through its subgroups, including the Commissioning Groups for POD and Specialised Commissioning, as well as the Quality and Finance Groups that services within its remit are commissioned in accordance with relevant guidance and best practice.

5. Conclusion

5.1. The committee concludes that it has effectively discharged its responsibilities in line with its TOR. It has provided appropriate oversight and assurance in all mandated areas during the reporting period.

6. Recommendations

6.1. The Committee minutes/decision log to clearly identify any policies, plans, or reports that are being reviewed or approved.
6.2. To ensure quoracy, each of the six ICB CEOs is expected to attend Committee meetings or nominate a representative to guarantee ICB representation at every meeting.

7. Appendices

7.1. Appendix C: Key Documents Reviewed

Provider Direct Award, 13th September 2024
Regional Ambulance Handover, 13th September 2024
West Midlands Neonatal Capacity Review, 8th November 2024
Primary Care Investments Proposal, 9th December 2024
The Midlands NHS 111 Contract Update, 9th December 2024
MHLDA delegation and system opportunities, 10th January 2025
Joint Commissioning Group, Standing Financial Instructions Proposal, 25th February 2025
West Midlands Neonatal Capacity Plan Report, 20th March 2025

Agenda Item

ICB 25-06.190

Strategic Commissioning and

Productivity Committee (SCPC)

Appendix 1 - Strategic Commissioning Committee Annual report

Strategic Commissioning Committee

Annual Report for 2024/25

1. Introduction

1.1. Purpose

1.1.1. This is the Annual Report of the Strategic Commissioning Committee for the financial year 2024/25. It is intended to provide assurance that the committee has fulfilled its responsibilities as outlined in its Terms of Reference (TOR) and to review its performance over the period.

1.2. Governance

1.2.1. The production of an Annual Report is considered good governance practice and reflects the committee's commitment to transparency and accountability.

2. Role and Effectiveness of the Committee

2.1. Overview

2.1.1. The Strategic Commissioning Committee is a formal committee of the Board. It operates under delegated authority as per the Constitution and Governance Handbook.

2.2. Terms of Reference

2.2.1. During the reporting period, the committee operated under its TOR approved on 12 June 2024

2.3. Scope of Responsibilities

2.3.1. The committee's responsibilities include:

- Development of the Joint Forward Plan.
- The Committee will oversee the development and monitor the delivery of the System Improvement Plan to deliver financial balance.
- The Committee will provide oversight and assurance of any other activity delegated to it by the ICS Board or, at the discretion of the Chair, at the request of any system member organisation.
- The Committee will provide strategic oversight of commissioning of health and care services by the ICB/ICS, which includes Primary General Medical services (GMS) delegated to the ICB from NHS England.
- This includes recommendation of clinical and non-clinical system strategies within the Committee's remit to the Board for approval and approval of clinical and non-clinical commissioning policies and approval of contracting decisions within approved budgets.

2.4. Self-Assessment

2.4.1. The committee assessed its effectiveness at regular intervals to ensure alignment with its objectives and governance requirements.

3. Committee Membership

3.1. Composition

3.1.1. The committee comprised the following members:

- Cathy Purt — Committee Chair and Non-Executive Director, Shropshire Community Health NHS Trust
- Niti Pall — Deputy Committee Chair and Non-Executive Director NHS Shropshire Telford and Wrekin
- Nigel Lee — Chief Strategy Officer NHS Shropshire Telford and Wrekin and Director of Strategy and Partnerships Shrewsbury and Telford Hospital NHS Trust
- Claire Skidmore — Chief Finance Officer NHS Shropshire Telford and Wrekin
- Vanessa Whatley — Chief Nursing Officer NHS Shropshire Telford and Wrekin
- Lorna Clarson — Chief Medical Officer NHS Shropshire Telford and Wrekin
- Gemma Smith — Director of Strategic Commissioning NHS Shropshire Telford and Wrekin
- Mark Large — Non-Executive Director, Midlands Partnership NHS Foundation Trust
- Peter Featherstone — Non-Executive Director Shropshire Community Health NHS Trust
-
- Prof Trevor Purt — Non-Executive Director, Shrewsbury and Telford Hospital and Chair of Audit and Risk Assurance Committee NHS Shropshire Telford and Wrekin
- David Brown — Non-Executive Director Shrewsbury and Telford Hospital NHS Trust
- Jill Barker — Non-Executive Director Shropshire Community Health NHS Trust
- Nia Jones — Managing Director for Planning and Strategy, Robert Jones Agnes Hunt Orthopaedic Hospital NHS Foundation Trust
- Helen Onions — Interim Director of Health & Wellbeing Telford and Wrekin Council
- Rachel Robinson — Executive Director of Health Shropshire Council
- Lynn Cawley — Chief Officer, Healthwatch Shropshire
- James Venables — Deputy Director of Strategy & Commercial Development Midlands Partnership NHS Foundation Trust
- Dr Ian Chan — Clinical Director of TELDOC PCN
- Dr Mahadeva Ganesh — Medical Director Shropshire Community Health Trust

3.2. Attendance

3.2.1. The quorum for meetings was. Attendance records for the financial year are detailed below:

Table 1: Meeting Attendance Record

Member	Meetings Attended	Total Meetings
Cathy Purt, Committee Chair and Non-Executive Director, Shropshire Community Health NHS Trust	6	7

Niti Pall, Deputy Committee Chair ICB Non-Executive Director NHS Shropshire Telford and Wrekin	3	7
Nigel Lee, Chief Strategy Officer NHS Shropshire Telford and Wrekin and Director of Strategy and Partnerships Shrewsbury and Telford Hospital NHS Trust	7	7
Claire Skidmore, Chief Finance Officer NHS Shropshire Telford and Wrekin	5	7
Vanessa Whatley, Chief Nursing Officer NHS Shropshire Telford and Wrekin	2	7
Lorna Clarson, Chief Medical Officer NHS Shropshire Telford and Wrekin	2	7
Gemma Smith, Director of Strategic Commissioning NHS Shropshire Telford and Wrekin	5	7
Mark Large, Non-Executive Director, Midlands Partnership NHS Foundation Trust	5	7
Peter Featherstone Non-Executive Director Shropshire Community Health NHS Trust	5	5
David Brown Non-Executive Director Shrewsbury and Telford Hospital NHS Trust	2	2
Jill Barker Non-Executive Director Shropshire Community Health NHS Trust	1	1
Prof Trevor Purt, Non-Executive Director, Shrewsbury and Telford Hospital and Chair of Audit and Risk Assurance Committee NHS Shropshire Telford and Wrekin	1	2
James Venables, Deputy Director of Strategy & Commercial Development Midlands Partnership NHS Foundation Trust	2	7
Dr Mahadeva Ganesh, Medical Director Shropshire Community Health Trust	6	7
Dr Ian Chan, Clinical Director of TELDOC PCN	6	7
Helen Onions Interim Director of Health & Wellbeing Telford and Wrekin Council	3	6
Laura Tyler, Assistant Director Joint Commissioning Shropshire Council and NHS Shropshire Telford and Wrekin	4	6
Rachel Robinson, Executive Director of Health Shropshire Council	2	7
Nia Jones, Managing Director for Planning and Strategy, Robert Jones Agnes Hunt Orthopaedic Hospital NHS Foundation Trust	6	7
Lynn Cawley Chief Officer, Healthwatch Shropshire	2	3

3.3. Invitees and Contributors

3.3.1. Regular attendees included:

- Claire Parker, Director of Strategy and Development NHS Shropshire Telford and Wrekin.

- Dr Julie Garside, Director of Planning and Performance NHS Shropshire Telford and Wrekin
- Minesh Parbat, Chief Pharmacist NHS Shropshire Telford and Wrekin
- Stacey Norwood, Group Manager, ICS Joint Commissioning Place Based Commissioning, Procurement & Care Provider Quality Telford & Wrekin Council
- Laura Tyler Assistant Director Joint Commissioning Shropshire Council and NHS Shropshire Telford and Wrekin

3.4. Frequency of Meetings

3.4.1. The committee met monthly as per its TOR, with additional meetings held as needed.

3.4.2. The committee met seven times during the year, including five additional meetings convened for specific purposes.

4. Assurance and Activities

4.1. Reviews and Approvals

4.1.1. The committee reviewed and/or approved:

- Prevention and Health Inequalities Group approved on 12.6.2024
- NHS Shropshire Telford and Wrekin ICB Choice Policy approved on 12.6.2024
- NHS Shropshire Telford and Wrekin System Elective Access Policy approved on 12.6.2024
- Commissioning Working Group TOR approved on 12.6.2024
- Estates Strategy reviewed on 12.6.2024
- Digital Strategy reviewed on 12.6.2024 and update on progress 12.2.2025
- Joint Forward Plan 2024/25
- Briefed on development of Integrated Care Strategy
- Updated on development of finance strategy and data strategy
- Prevention and Health Inequalities Group updates – every 2 months
- Population health management group updates – every 2 months

4.2. Risk Management

4.2.1. The committee reviewed and monitored:

- The ICB Board Assurance Framework.

4.3. Compliance and Oversight

4.3.1. The committee ensured adherence to relevant regulations, policies, and best practices in the following areas:

- Provider Selection Regime Procurement process

5. Conclusion

5.1. The committee concludes that it has effectively discharged its responsibilities in line with its TOR. It has provided appropriate oversight and assurance in all mandated areas during the reporting period.

6. Recommendations

- Committee notes the work of SCC in 2024/25
- Notes the changes to Committee structure for 2025/26

7. Appendices

7.1. Appendix C: Key Documents Reviewed

Agenda Item

ICB 25-06.191

System Transformation and Digital Group

Appendix 1 – System Transformation and Digital Annual report

Integrated Care System
Shropshire, Telford and Wrekin

NHS
Shropshire, Telford and Wrekin

System Transformation Committee

Annual Report for 2024/25

1. Introduction

1.1. Purpose

1.1.1. This is the Annual Report of the System Transformation Committee for the financial year 2024/25. It is intended to provide assurance that the committee has fulfilled its responsibilities as outlined in its Terms of Reference (TOR) and to review its performance over the period.

1.2. Governance

1.2.1. The production of an Annual Report is considered good governance practice and reflects the committee's commitment to transparency and accountability.

2. Role and Effectiveness of the Committee

2.1. Overview

2.1.1. The System Transformation Committee is a formal committee of the Board. It operates under delegated authority as per the Constitution and Governance Handbook.

2.2. Terms of Reference

2.2.1. During the reporting period, the committee operated under its TOR approved on 24 April 2024

2.3. Scope of Responsibilities

2.3.1. The committee's responsibilities include:

- Development and implementation of the STW ICS Transformation Programmes, the Financial Improvement Programme & Enabling Workstreams
- The purpose of the Group is to provide oversight of and support to the development and delivery of the STW ICS Sustainability Transformation Programmes and Financial Improvement Programme
- Ensure that the programmes remain aligned to Joint Forward Plan and other System strategies as they emerge inc. the financial strategy and the clinical strategy and that programmes support delivery of the ten System pledges
- Oversight of interdependencies with the STW ICS operational groups specifically in relation to the System Transformation programmes through receipt of chair reports and escalated risks and issues
- Oversight of enabling groups and workstreams that contribute to the Transformation programmes and upon which the programmes are dependent to achieve the required outcomes
- Ensure delivery plans are developed that achieve accelerated implementation

- Development of a collective approach to delivery of transformation priorities, reframing the deliverables, impact evaluation and accountabilities
- Oversight of the Efficiency Programme to ensure alignment with the Sustainability Transformation Programmes
- Oversight of the Investment Panel to ensure that investment decisions remain aligned to the Financial Strategy and meet the requirements of the national Recovery Support Programme
- The Group will provide oversight and assurance of any other activity delegated to it by NHS STW or, at the discretion of the Chair, at the request of any system member organisation.

2.4. Self-Assessment

2.4.1. The committee assessed its effectiveness at regular intervals to ensure alignment with its objectives and governance requirements.

3. Committee Membership

3.1. Composition

3.1.1. The committee comprised the following members:

Simon Whitehouse	Committee Chair and Chief Executive, NHS Shropshire Telford and Wrekin
Claire Skidmore	Chief Finance Officer NHS Shropshire Telford and Wrekin
Lorna Clarson	Chief Medical Officer NHS Shropshire Telford and Wrekin
Stacey Keegan	Chief Executive Robert Jones and Agnes Hunt NHS Foundation Trust
Joanne Williams	Chief Executive Shrewsbury and Telford Hospital NHS Trust
Patricia Williams	Chief Executive Shropshire Community Health NHS Trust
Andy Begley	Chief Executive Shropshire Local Authority
David Sidaway	Chief Executive Telford and Wrekin Local Authority
Neil Carr	Chief Executive Midlands Partnership NHS Foundation Trust
Ian Bett	Chief Delivery Officer NHS Shropshire Telford and Wrekin
Nigel Lee	Chief Strategy Officer NHS Shropshire Telford and Wrekin and Director of Strategy and Partnerships Shrewsbury and Telford Hospital NHS Trust

3.2. Attendance

3.2.1. The quorum for meetings was 50%. Attendance records for the financial year are detailed below:

Table 1: Meeting Attendance Record

Member	Meetings Attended	Total Meetings
Simon Whitehouse Committee Chair and Chief Executive, NHS Shropshire Telford and Wrekin	7	10
Claire Skidmore Chief Finance Officer NHS Shropshire Telford and Wrekin	8	10
Lorna Clarson Chief Medical Officer NHS Shropshire Telford and Wrekin	0	0

Stacey Keegan Chief Executive Robert Jones and Agnes Hunt NHS Foundation Trust	7	10
Joanne Williams Chief Executive Shrewsbury and Telford Hospital NHS Trust – from Sept 24	4	6
Patricia Williams Chief Executive Shropshire Community Health NHS Trust	7	10
Andy Begley Chief Executive Shropshire Local Authority	3	10
David Sidaway Chief Executive Telford and Wrekin Local Authority	3	10
Neil Carr Chief Executive Midlands Partnership NHS Foundation Trust	7	10
Ian Bett Chief Delivery Officer NHS Shropshire Telford and Wrekin from July 24	4	7
Nigel Lee, Chief Strategy Officer NHS Shropshire Telford and Wrekin and Director of Strategy and Partnerships Shrewsbury and Telford Hospital NHS Trust	8	10

3.3. Invitees and Contributors

3.3.1. Regular attendees included:

Inese Robotham Chair Shrewsbury and Telford Hospital NHS Trust
Julie Garside Director of Planning, Performance and BI
Price Waterhouse Coopers representatives

3.4. Frequency of Meetings

3.4.1. The committee met monthly as per its TOR.

3.4.2. The committee met ten times during the year.

4. Assurance and Activities

4.1. Reviews and Approvals

4.1.1. The committee reviewed and/or approved:

- Operational Plan Performance
- System Improvement Plan
- Financial Improvement Plan
- Current Risks and Escalations
- UEC Improvement Plan
- Hospital Transformation Programme
- MSK Transformation
- Elective Reform

4.2. Risk Management

4.2.1. The committee reviewed and monitored:

4.3. Compliance and Oversight

4.3.1. The committee ensured adherence to relevant regulations, policies, and best practices in the following areas:

5. Conclusion

5.1. The committee concludes that it has effectively discharged its responsibilities in line with its TOR. It has provided appropriate oversight and assurance in all mandated areas during the reporting period.

6. Recommendations

- Notes the changes to Committee structure for 2025/26

7. Appendices

7.1 NA