NHS STW Integrated Care Board - Part 1 - Appendices Pack

MEETING

30 April 2025 14:00 BST

PUBLISHED
24 April 2025

Agenda

Location	Date	Time
Meeting Room 1, Wellington Civic Offices, Larkin Way, Tan Bank, Wellington, TF1 1LX	30 Apr 2025	14:00 BST

	Item	Page
1	System Board Assurance Framework (SBAF & SORR)	4
2	Shropshire Integrated Place Partnership Committee Chair's Report	5
3	The Neighbourhood Approach	40
4	Shropshire, Telford and Wrekin System Accountability and Performance Framework	107

Contents

	Item	Page
1	System Board Assurance Framework (SBAF & SORR)	4
2	Shropshire Integrated Place Partnership Committee Chair's Report	5
3	The Neighbourhood Approach	40
4	Shropshire, Telford and Wrekin System Accountability and Performance Framework	107

Agenda Item

ICB 30-04.156

System Board Assurance Framework (SBAF & SORR)

Due to the size of these papers, appendices A, B, C and D can be found at this link NHS STW Board Meetings - NHS Shropshire, Telford and Wrekin

Agenda Item

ICB 30-04.157

Shropshire Integrated Place Partnership Committee Chair's Report

Appendix A. ShIPP Strategic Plan for 2025-27

Integrated Care System

Shropshire, Telford and Wrekin

ShIPP Strategic Plan 2025/26 (approved 20.03.25)

March 2025

Prevention Framework and Strategic context

Shropshire Together supports the delivery of the Shropshire Plan , the STW Joint Forward Plan and the Joint Health and Wellbeing Strategy. It delivers the work through the Shropshire Integrated Place Partnership (ShIPP) by working collaboratively and integrating approaches to improve service delivery and population health. The recently agreed Prevention Framework provides more context and detail for how we will deliver our strategic plans. The Framework includes the following key priority areas:

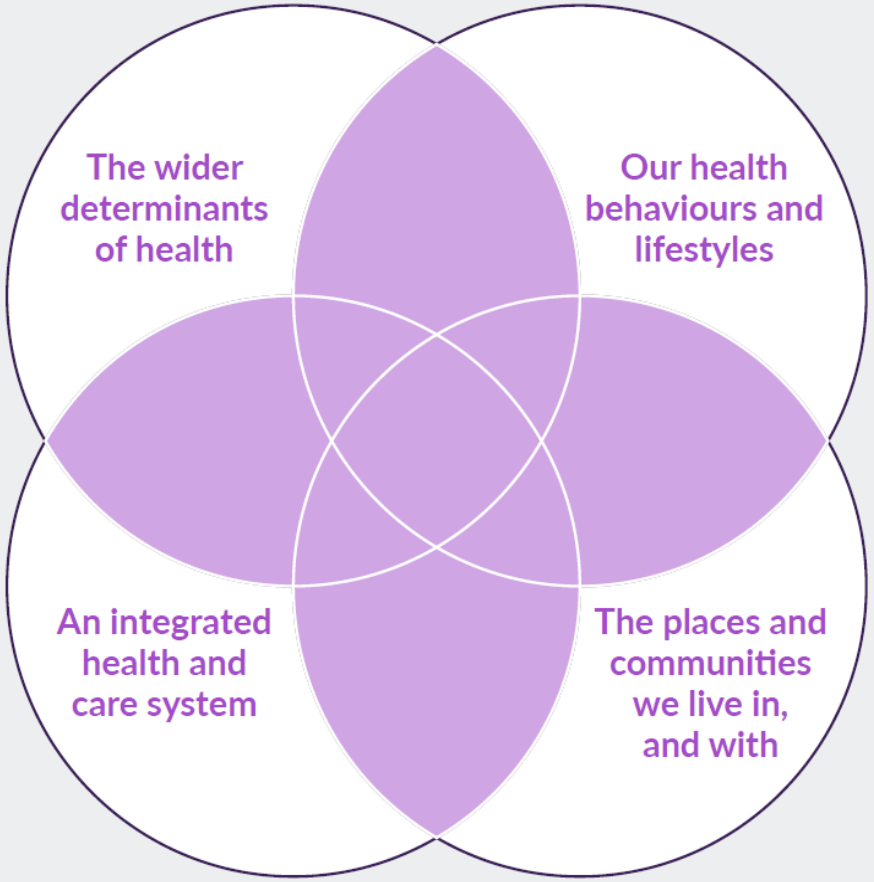
- **Priority 1: Access and One Shropshire**
  Ensuring a well understood front door with access to information and advice, that focusses on self-care.
- **Priority 2: Integration and One Shropshire**
  Enable communities and the voluntary and community sector to take more of central role in the development and delivery of prevention programmes, ensuring all age groups are at the centre of the implementation of the framework.
- **Priority 3: Person Centred Care**
  Embed Person Centred Care and approach across all organisations and partners.
- **Priority 4: Communities**
  Bolster the voluntary and community sector to work with partners across the system to support those in need.

Principles for service transformation and integration

STW has adopted the following principles for place-based working which have been developed by, the SROs for Population Health Management, Inequalities and Prevention:

- Take a **person centred approach** to all that we do; celebrating and responding to the diversity within our population.
- Ensure all programmes involve local people and embed **coproduction i**n all planning.
- Follow the Public Health England guidance described in the document **Place Based Approaches to reduce inequalities**, which involves 3 keys segments:
  - civic-level interventions, all aspects of public service from policy to infrastructure (including health in all policies)
  - community-centred interventions, asset (human and physical) and strength based community development
  - service-based interventions, including unwarranted variability in service quality and delivery (effectiveness; efficiency and accessibility), as well as embedded Brief Interventions and Making Every Contact Count pathways (including social prescribing).
- Seek to understand, take a **Population Health Management** approach, inclusive of **reducing health inequalities,** to all transformation.
- Recognise the importance **of system thinking** for all ages and families, ensuring that inequalities are addressed from pre-birth.
- Systematically undertake **integrated impact assessments** to determine how its delivery could better reduce inequalities and support protected groups (9 protected characteristics);
- **Value and support the community and voluntary sector** and consider how the voluntary sector can work alongside statutory services to reduce inequalities.
- Promote understanding of how to **prevent or reduce inequalities** for staff working in all partner organisations.
- Use **digital r**esources to remove geographical barriers to place based working.

Population Health System – what improves our wellbeing?



Source: Kings Fund Buck *et al* 2018

Delivering the ShIPP Plan – Actions to be delivered in 2024-25

- Develop delegated governance with the ICB, including updating the ToR SHIPP, as well as metrics and reporting
- Deliver Integrated Neighbourhood Teams/ Working across Shropshire, making the work business and usual
- Expand CYP integrated practitioner teams to ensure that all corners of the county and all schools are included, inclusive of:
  - Trauma informed approaches, Social Prescribing and Carers (underpinned by Person Centred Approaches)
  - Multi-disciplinary teams to include Social Care, Public Health Nursing, MPFT (Mental Health in Schools), voluntary and community sector and other partners
- Further develop Community and Family Hubs/ Health and Wellbeing Centres across Shropshire, including Women's Health and Wellbeing Hubs
- Primary Care Networks are supported by Multi-Disciplinary Teams and joint working including, to be developed together, through a jointly developed Neighbourhood Model – to connect with Community and Family Hubs and Health and Wellbeing Centres
- Development of communication and engagement tools and plans

Delivering the ShIPP Plan – Achievements – what actually happened

- New ToR for ShIPP and Governance – ongoing
- Integrated Practitioner Team for Children Young People and Families – BAU – covering whole county, delivered by NHS, Local Authority, VCSE partners
- 5 Operational Community and Family Hubs and 1 Health and Wellbeing Centre – 2 additional hubs in development (Whitchurch and South Shrewsbury), numerous mini-hubs
- Core offer and further developing offer in all hubs
- Joint working arrangements with VCSE, NHS in all hubs and additional grant funding supporting warm welcomes in our hubs
- Mental Health Care Planning Forums BAU and lessons learned fed into ShIPP subgroup
- Proactive Care up and running in the South - West PCN, developing lessons learned
- Dementia MDTs up and running in the South – East PCN, developing for county wide approach
- Women's Health and Wellbeing Hubs up and running in all 5 PCNs, with inequalities offer
- Communication Plan and Logo for Shropshire Together work
- Trauma – workshop and resetting priorities, paper due at HWBB in April

Delivering the ShIPP Plan – Achievements 24-25 (from the workshop)

Market Drayton Community Covenant in development	Endorsement of systemwide Healthier Weight Strategy
MSK digital app. Available to all STW residents and supports wider core20/25 priorities	Second year of Winter Illness Centre in Shrewsbury
Prevention Strategy work and conversations	Piloting workplace CVD health checks
JSNA Delivery – local approach (e.g. Highley)	Care Transfer Hub to improve hospital discharge process
Promoting the "How Can I help" approach	Collaborative pilot project to increase uptake of MMR and HPV vaccinations
Delivery of partnership for the inclusion of Neurodiversity in schools – ICB, LA, VCSA, PFA, Navigator Project funded by ICB/VCSA	Targeted asthma checks for high-risk people during the summer months to improve control so hoping for fewer infections in winter
Menopause lifestyle information sessions	Supporting non-responders for cervical screening so that they feel able to attend
Pain Management	Ask, Assist, Act culture change
Collaborative approach to supporting asylum seekers and people being re-settled in England that are temporarily accommodated within the County	Housing Workshop and Commissioned housing LIN for insights on future housing needs for Shropshire Council to be able to strategically plan
Quality Improvement support to care homes through Partners in Care, funded by the ICB	Beginning to work strategically on joint commissioning –place and system
Health Checks targeting core20+5 population in Shrewsbury	Linking the right areas together (frailty, falls, MSK, Care of the elderly) and coming up with joint responses and actions
Information sessions on healthy diet and lifestyle	Developing our Virtual Care offer

Delivering the ShIPP Plan 24-25, Continuing Development

- System approach to Social Prescribing
- Hub offer and mini-hubs – continuing to develop
- System approach to INTs (recognising a number of different MDTs, including Mental Health, Dementia, Proactive Care and Integrated Practitioner Teams)
- ShIPP Outcomes Dashboard – integrated look at data
- Continued governance development
- Diabetes pathway, Cardio pathway, MSK transformation

Integrated Care System

Shropshire, Telford and Wrekin

Shropshire Neighbourhood Working

March 2025

What is 'Place Based Care' and what are 'Partnerships'

Place Based Care

- Concept in integrated care systems (ICSs) that refers to a smaller geographic footprint within a system, which often aligns with a local authority area or patient flows for acute care.
- The goal is to reduce barriers (perceived or real) from institutional boundaries across a location to provide better joined up (integrated) care for individuals, families and communities.
- This approach shifts resources and decision making closer to the people that they affect.

Place Based Partnerships

- They are collaborative arrangements between organisations responsible for planning and delivering health and care services and others with a role in improving health and wellbeing.
- They are a key building block of ICSs and play an important role in co-ordinating local services and driving improvements in population health.

Source:
NHS Providers: Place-based partnerships - NHS Providers. Accessed on the 15th of January 2025.
Kings' Fund: Place-based Partnerships Explained | The King's Fund. Accessed on the 15th of January 2025.

STW Place Context

In Shropshire there are currently 5 Primary Care Networks which are aligned to our neighbourhoods. The role of Place in this context is delivered through Shropshire Integrated Place Partnership (ShIPP) board.

Ensure that local voices, (people, elected members, local services, primary care), are championed and part of developments and decision making

Understand, influence and develop local implementation of strategy and transformation programs, that takes into account need and local voices

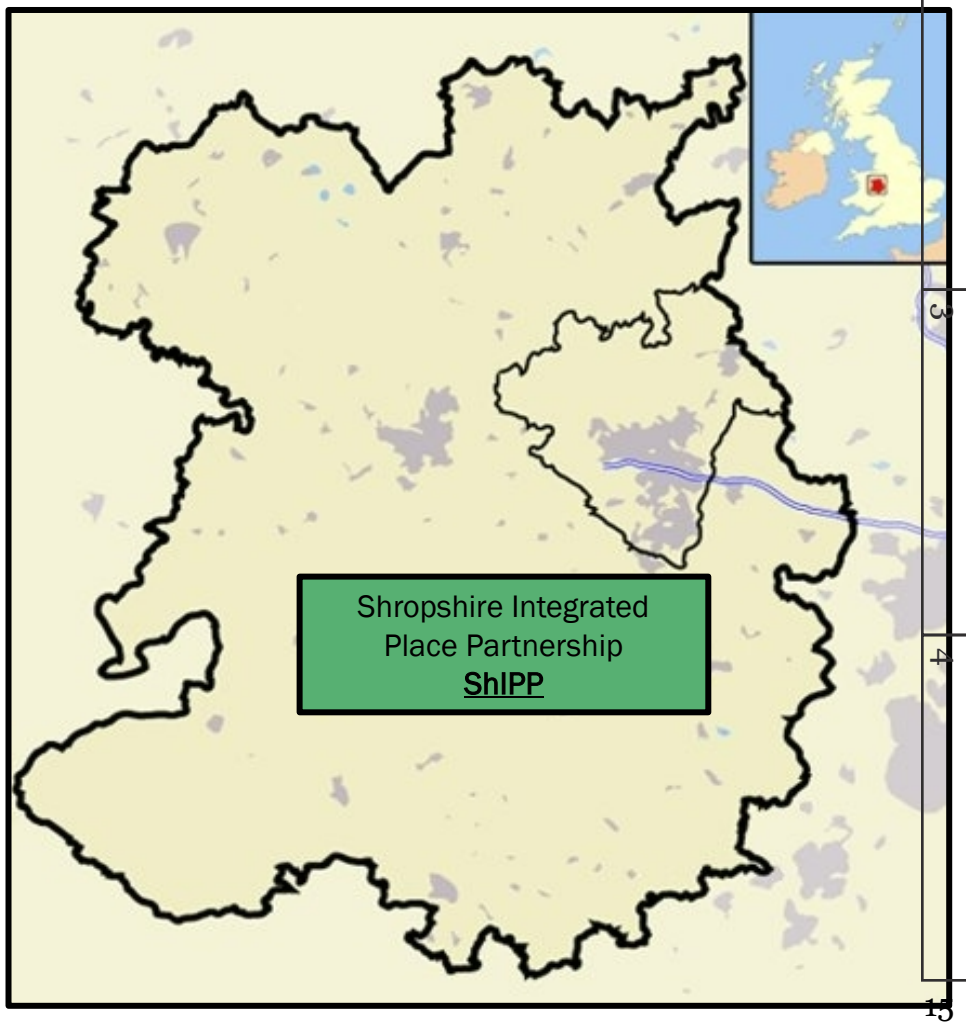
Increase focus on integration, prevention, inequalities and improvement of population health and wellbeing

Ensure that the voluntary and community sector play a central role in the health and wellbeing of local populations

Work with the ICB on developing governance, which is moving toward delegation of decision and finance to place and neighborhood.

Assess need and develop ongoing needs assessments (JSNAs and regular feedback loops)

Work with partners to align strategic priorities with need through strategic plans and actions



Roles and Responsibilities in Place

Integrated Care Board (ICB)

- **Strategic Commissioner** with the ambition of starting to delegate tactical commissioning and transformation based on delivering specific outcomes to Place and Provider Collaboratives as our key delivery vehicles over a period of **time.**

- **Development and Redesign skills and capacity** – the ICB Strategy and Development Team has a has a jointly funded Place leadership post with the Council and has aligned some of its project management resources to support the development of Neighbourhoods

Local Authorities

- **Senior Responsible Officers (SRO)** – The Local Authority Chief Executives are the SROs for Place. As SROs they have overall accountability for the delivery of the Place programme of work and its associated outcomes accountable to the ICB Board and Health and Wellbeing Boards. They are the Chairs of the Place Based Boards.

- **Chair of the Place Based Boards, ShIPP and TWIPP to ensure:-**

- agree, direct, drive and assure delivery of community centred health and care integration at Place.

- key focus on reducing health inequalities, improving proactive prevention and delivering seamless, accessible,

- safe, high quality community centred health and care services for all their respective residents.

System Partners

- **Proactively engage with the Place Based Boards and Neighbourhood Development Groups**

- **Influential role in developing local delivery solutions** with other partners, reducing duplication and joining up services where it makes sense to do so

- **Commitment to integrated and collaborative work,** enabling better use of resources and quality improvement, leading to more effective and efficient services.

- **Commitment to align provider service capacity and resources to agreed Place and Neighbourhood models**

- **Partners include:** Shrewsbury and Telford Hospitals NHS Trust - SaTH (Acute Trust), Voluntary, Community, and Social Enterprise sector (VCSE), Shropshire Community Health NHS Trust (Shropcom), Midlands Partnership Foundation NHS Trust (MPFT), Primary Care Services (General Practice, Primary Care Networks (PCNs), Pharmacy, Optometry and Dentistry), Robert Jones and Agnes Hunt NHS Trust (RJAH)

Work Programmes

System Programmes
Proactive Care through Integrated Neighbourhood Multi-Disciplinary Teams
Diabetes and Cardiology Transformation
Women's Health and Wellbeing Hubs
Musculoskeletal (MSK) Transformation
Healthy Ageing , Falls and Frailty
Urgent and Emergency Care (UEC)

Shropshire Integrated Place Partnership
Integrated Practitioner Teams (Team of Teams)
Community and Family Hubs
Culture Change
Adult Social Care (ASC) and Early Help Transformation

Enablers and Cross Cutting programmes
Data Intelligence
Person Centred and Trauma Approaches
Workforce
Digital

Integrated Care System

Shropshire, Telford and Wrekin

Core Components of Neighbourhood Health

January 2025

Core Component A

Population Health Management - 7 Step approach

1. Develop ICS System Outcomes
2. Develop metrics and measures
3. Develop Population segments
4. Identify Priority Cohorts
5 . Identify Impactable Interventions
6. Implementation
7. Evaluation

Establish top level segments, goals and priority areas

Establish needs at Place and Neighbourhood in priority area e.g. deprivation, ethnicity, conditions

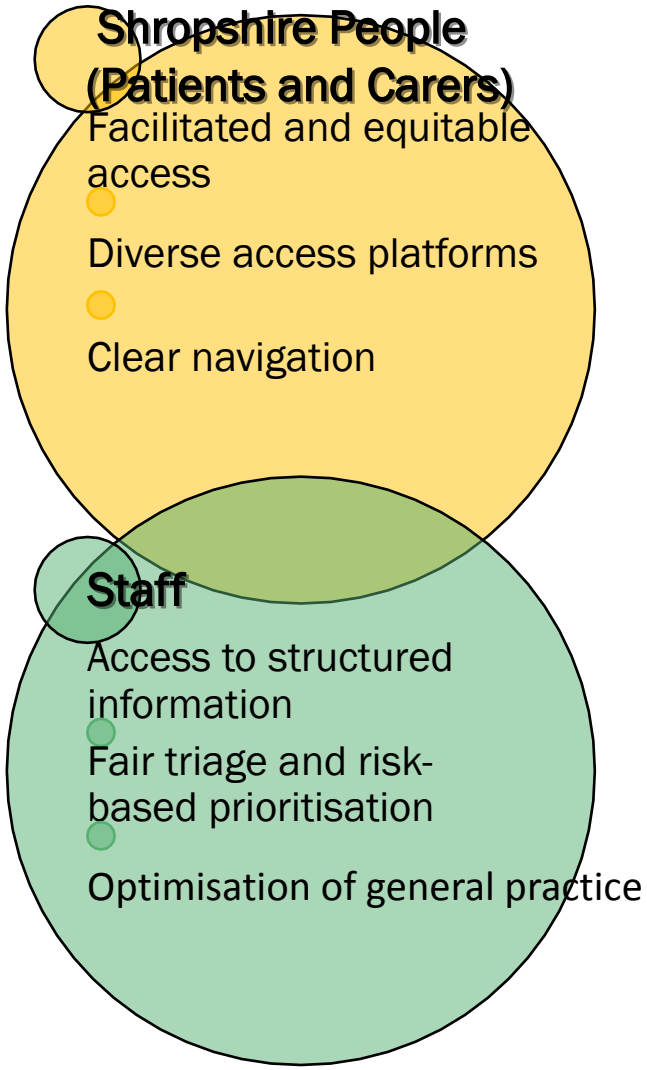
Establish the set of interventions that can meet the goals and who will benefit most at Place and Neighbourhood level. How can we join up existing community assets to best deliver those interventions.

Data driven approach and focused local health needs will contribute to tackling health inequalities.

Providing services closer to home, taking a person-centred neighbourhood approach

Local areas have different needs, core offers are tailored way to reflect this

Core Component B
Modern General Practice



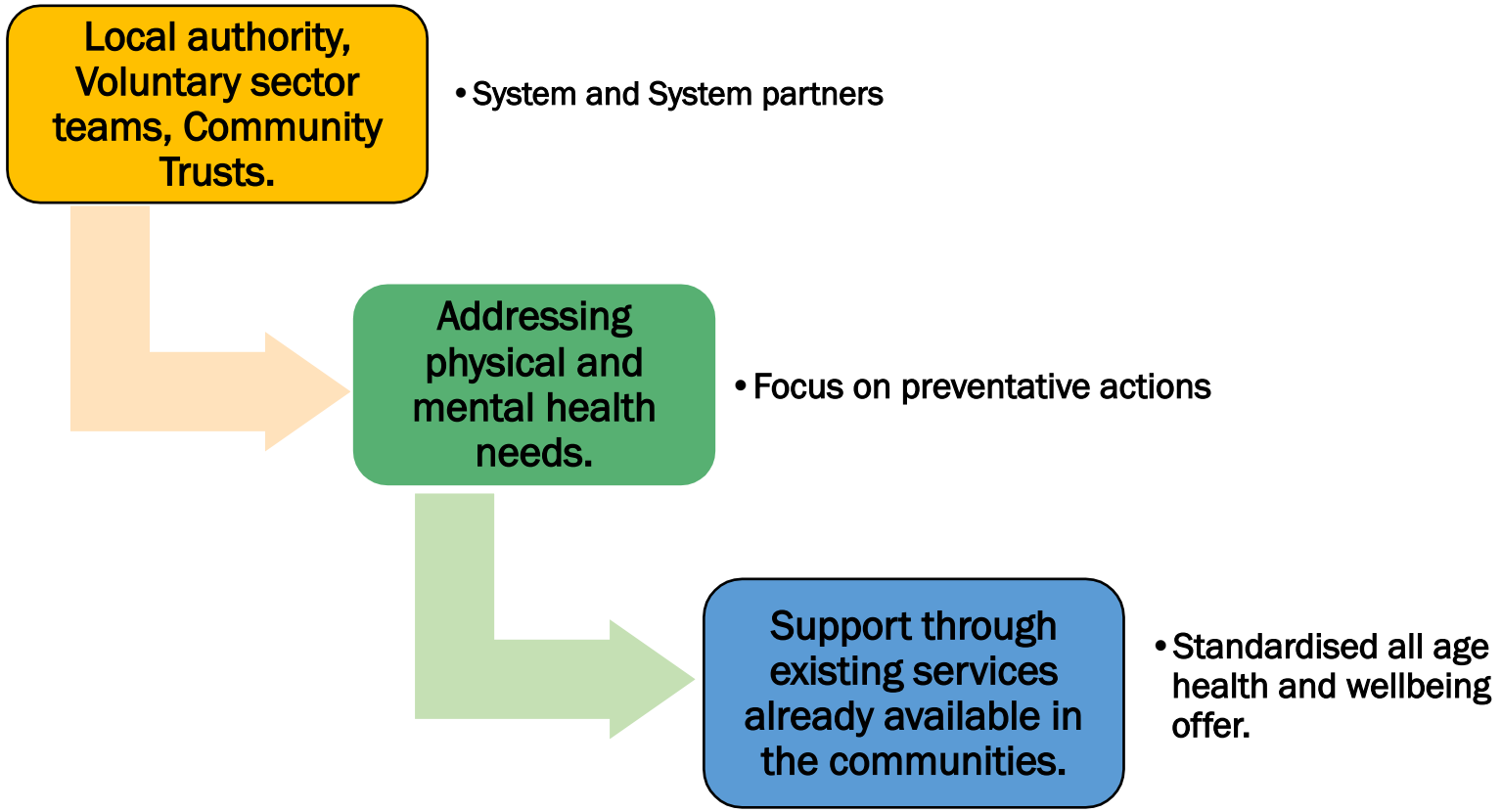
- The development and delivery of a **Modern General Practice** aims to allow the delivery of improved access and continuity of care, also, focusing on improving patient and carer experience.

- **Improved access** will facilitate patient and carer engagement with services allowing equitable access to services through different platforms (digital, in person and telephone) with emphasis on clear navigation and risk and complexity-based triage.

- Staff access to **structured information** regarding complexity of needs, should be organised by population segments and risk stratification in a single workflow, resulting in navigation and triage of needs in a fairly, enabling risk-based prioritisation. Therefore, optimising the use of general practice and the wide multidisciplinary team .

Holding Slide following release of NHS Neighbourhood health guidelines 25/26 released on 30/01

Core Component C
Standardising Community Health Services



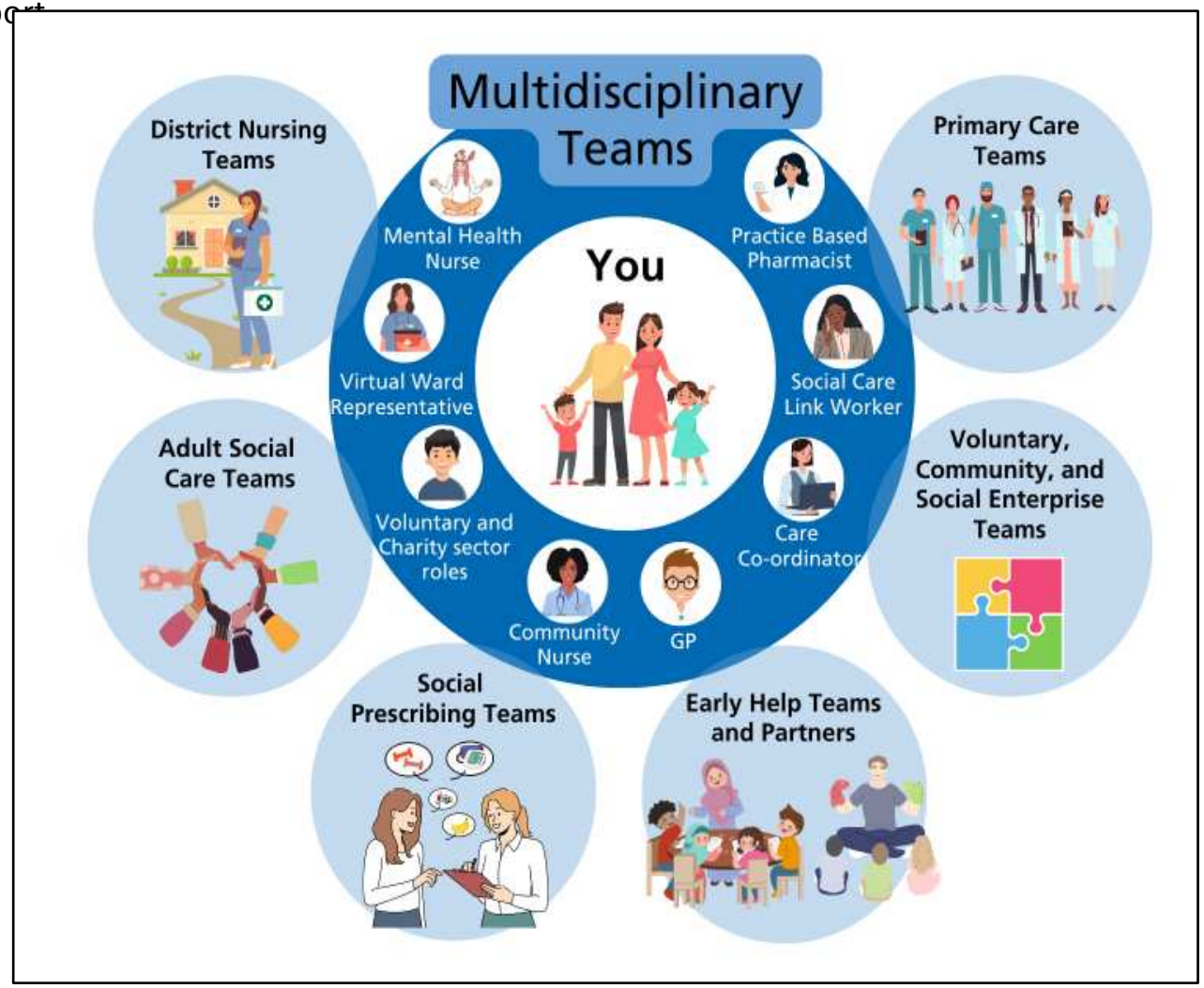
- **The System and System partners** are already working toward meeting this core component in collaboration with the community teams, **Local authority, Voluntary sector teams, community Trusts.** Focusing on **preventative work addressing physical and mental health needs.**
- Several community health services **already play an essential role in delivering neighbourhood health and care.** However, the new 2025/26 health guidelines highlight their importance and need to be commissioned as part of an integrated neighbourhood health offer.
- Support can be found through **existing services focused on both mental and physical health in the communities,** allowing a standardised all age health and wellbeing offer.

Holding Slide following release of NHS Neighbourhood health guidelines 25/26 released on 30/01

Core Component D

Neighbourhood Multidisciplinary Teams (MDTs)

‘Teams of teams’ work in neighbourhoods, they are not restricted by geographical boundaries and link together providing person centres, preventative proactive care and support.



- **Multidisciplinary coordination of care** for population cohorts with complex health and care or social needs who require support from multiple services and organisations.
- Deliver p**roactive, planned and responsive care**
- **Prioritise based on people’s needs** and opportunity for greatest impact.
- **Footprints optimise neighbourhood working** and partnership with LA.
- A **core team is assigned for complex case management**, with links to specialist resource as needed.
- **Assign a care coordinator to every person** or their carer in the cohort as a clear point of contact to improve both their experience and continuity of care.
- **Guidance on neighbourhood MDTs for children and young people** will be published in early 2025.

Neighbourhood approach - "Team of Teams"

Our collective efforts are geared towards better addressing the diverse needs of the local community, ultimately striving to build thriving neighbourhoods that cater to the unique requirements of the local population.

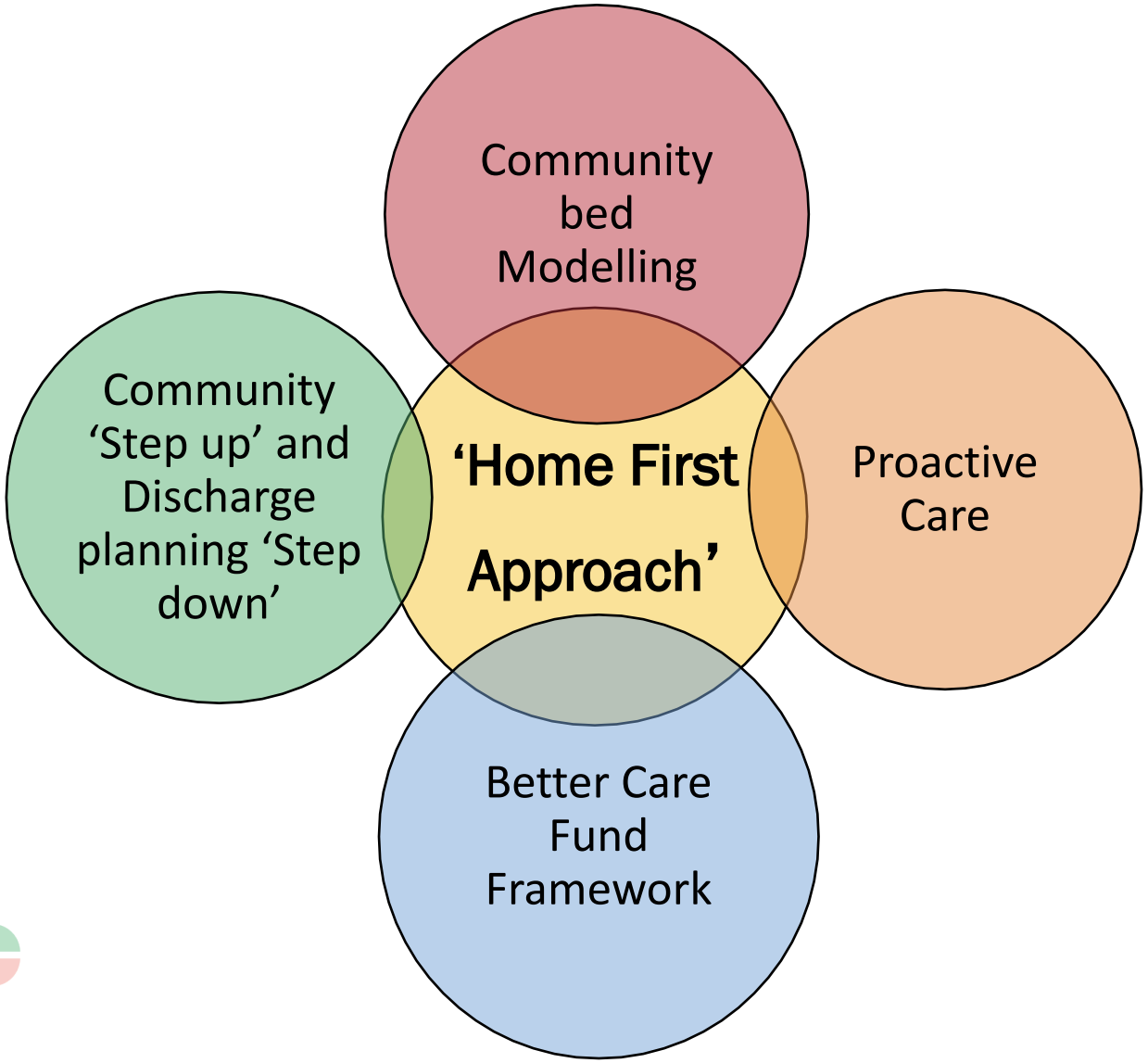
In neighbourhoods, we are committed to fortifying existing networks while forging new connections and fostering collaboration. By bringing together teams and services across health, care, the voluntary and community sector, businesses, and other key partners -including police, housing, and education - we aim to provide proactive, person-centred care.

Through resource pooling and information sharing, these teams can streamline access to services and provide more proactive, preventative and personalised approaches.

Various teams, sometimes referred to as 'a team of teams,' will operate within neighbourhoods with a range of different remits, for example multi-disciplinary teams (MDTs) supporting people with specific needs, one example is an MDT approach for people with frailty and multiple long-term conditions, as well as specialist teams focused on tackling local issues such as widening the range of activities available for local children.

Core Component E

Integrated Intermediate Care with a ‘Home First’ Approach



- **Short-term rehabilitation, reablement and recovery services taking a therapy-led approach** (overseen by a registered therapist) **working in integrated ways across health and social care** and other sectors.
- **Referrals can be made directly** from the community (step-up) or as part of hospital discharge planning (step-down, applying a ‘Home First’ approach, with assessments and interventions delivered at home where possible and working closely with urgent neighbourhood services.
- **Good operational case management systems and measure outcomes** (ref BCF policy framework for 2025/26 to ensure best use of resources.

Holding Slide following release of NHS Neighbourhood health guidelines 25/26 released on 30/01

Core Component F
Urgent Neighbourhood Services

Shropshire, Telford & Wrekin Virtual Ward

- **Standardise and scale urgent neighbourhood services** for people with an escalating or acute health need
- **Single point of access** to deliver a co-ordinated service.
- **Services align with services at the front door of the hospital,** such as urgent treatment centres and same day emergency care.
- **Ambulance service** senior clinical decision makers in a single point of access should **provide advice** and referral to appropriate services **either before ambulance dispatch or as part of a "call before convey" approach.**
- **Service footprints determined locally,** balancing scale of delivery with building on local relationships to ensure smooth referral pathways

Holding Slide following release of NHS Neighbourhood health guidelines 25/26 released on 30/01

Integrated Care System

Shropshire, Telford and Wrekin

ShIPP Proposed Priorities

ShIPP Priorities 2025-2027

1. Integrated Practitioner Teams
(Integrated Neighbourhood Teams)
Use learning from Proactive Care, Dementia MDT, Care planning forums, Integrated Practitioner Teams to develop a system approach to INTs for those with complex needs

2. Community and Family Hubs
Deliver Phase 2 (mini-hubs, evaluation, developing services – wider offer, digital offer, expansion of SEND & Autism offer, Women's H&WB Hubs)

3. Prevention – creating Left Shift
Falls (links with Frailty strategy and Healthy Ageing) – deliver an integrated falls pathway
Housing – delivering the Housing and Health Action Plan
Diabetes – develop and deliver an end-to-end NHS Pathway for Diabetes, with a focus on prevention
Mental Health – develop and deliver a CYP mental health prevention offer
Mental Health – System approach for CYP Prevention

Our approach to designing delivery solutions will continue to be:-

- Data driven - Using Population Health Management approaches (JSNA, Inequalities Dashboard, Vulnerability mapping)
- Clinically informed where appropriate
- Person centred - Provider agnostic
- Focus on addressing inequalities
- Building on work to date strengthening partnerships
- Programme Management and Clear Plans – holding each other to account
- Commitment to Place plans by partner Boards
- Based on what people tell us is important to them – focusing on participation lived experience & co design

ShIPP Deliverables 2025-2026

- Further develop and deliver Integrated Neighbourhood Teams (INTs), working across Shropshire;
- Further develop Community and Family Hubs/ Health and Wellbeing Centres across Shropshire, including Women's Health and Wellbeing Hubs
- Develop a Community Covenant in Market Drayton for the delivery of hub and joint working
- Develop a Community of Practice for Women's Health
- Develop End to End pathways for Diabetes and Falls
- Develop and invest in Children and Young People Mental Health Prevention
- Through joint commissioning, establish a robust Place Based joint commissioning framework, which includes Voluntary and Community Sector –infrastructure and local delivery
- Primary Care are supported by Multi-Disciplinary Teams; and are linked to Community and Family Hubs and Health and Wellbeing Centres
- Further develop communication and engagement tools and plans
- Continue to develop delegated functions as part of a Committee of the ICB
- Develop the Making Every Contact Count Approach of Ask, Assist Act, to be a key part of culture change across the system.
- Map system workstreams to ensure linkages and reduce duplication
- ShIPP to adopt 'the Pledge' to support integrated working

Enablers

The system will need to develop place-based key enablers in order for the priorities to be delivered. These are:

- Culture Change – Ask, Assist Act – as described above
- Developing a system Trauma Informed Approach (links to culture change)
- Communication, Engagement and Involvement
- Joint Development and Delivery of Population Health Management to inform place-based working
- Develop strong linkages with System Strategic Planning including, UEC, Planned Care, Local Care, Commissioning, Mental Health, and other transformation programmes

Culture Change – Developing our workforce to lead through neighbourhoods

Shropshire Together (formerly One Shropshire) and other Council and Partner led transformation programmes are signalling a new way of working, one that puts integration and partnership working at the heart of developments.

Shropshire Together highlights that a core part of integration includes the workforce taking an approach where services challenge themselves to ensure people have the support they need at the point of asking, or where colleagues recognise need.

This could be through a hub approach or through an individual organisation, and the routes through to the right support must be clear and well understood. In addition, where colleagues can support people then and there, they should feel confident and have the tools to achieve that.

Additionally, enhancing the skills of our workforce to work across organisations in a multi-disciplinary way requires dedicated time and effort. System organisations must commit to this way of working

ShIPP's Transformation programme is developing tools to support this work – building on the **Ask, Assist, Act Toolkit** developed by our Voluntary and Community Sector. This toolkit provides support for our staff to embed a making every contact count approach, with resources to ensure that people are able to find what they need at the first time of asking.

Integrated Care System

Shropshire, Telford and Wrekin

Offer and Ask – how do we make it happen – working together

Offer and Ask – ShIPP Pledge

As a ShIPP member our organisation will:

- Work with partners to deliver and embed the priorities
- Work with partners to develop and embed the Ask Assist Act Culture Change
- Work with partners to develop and embed our Trauma Informed Approach
- Work with partners to develop and embed a Population Health Management Approach, by sharing data, mapping services, sharing analysis and resource
- Support the development and resourcing of the voluntary and community sector to drive forward prevention and left shift

Organisational Transformation Offer/ Roles - DRAFT

Shropshire Council Offer

- Leadership – Chair ShIPP, Exec Director Public Health
- Programme Management – **Community and Family Hubs** (Including Programme Lead, Programme Manager, Operations), **Housing**
- Strategic Management (HWBB, ShIPP) & Place Commissioning
- Delivery – **Housing and Planning**
- Data and Performance – JSNA, Community and Family Hub Dashboard, Supporting the Inequalities Dashboard, Analysis for Population Health Management
- Communication and Engagement

Shropshire, Telford and Wrekin ICB Offer

- Leadership and Development – **Diabetes** End to End Pathway Development, **Falls** End to End Pathway Development**, CYP Mental Health Investment in Prevention** - Strategy Team and Commissioning
- Data and Performance – Leadership for Populational Health Management , Aristotle
- Communication and Engagement

Shropshire Primary Care Offer

- Leadership and Development – Clinical input into priorities, Membership at ShIPP and subgroup, support for the ShIPP Pledge

Shropshire Community Health Trust Offer

- Leadership and Development – **Integrated Neighbourhood Teams, Links to System Wide programmes including UEC**
- Delivery – **INTs, Diabetes, Falls, Housing**
- Data and Performance – Population Health Management, Sharing data
- Membership at ShIPP and ShIPP Subgroup

Shropshire & Telford Hospitals Offer

- Leadership – Chair ShIPP Neighbourhood subgroup
- Delivery – **INTs, Falls, Diabetes, Housing**
- Data and Performance – Support for Population Health Management, Sharing data
- Membership at ShIPP and ShIPP Subgroup

Midlands Partnership Foundation Trust

- Leadership and development – exploration of integration of care planning forum and proactive care
- Delivery – integrated approaches to improving **mental health** and prevention of mental health crisis, including working with hubs
- Membership at ShIPP and ShIPP Subgroup

Robert Jones and Agnes Hunt

- Leadership and development – exploration of integration of care planning forum and proactive care
- Delivery – supporting the delivery of integrated approaches
- Membership at ShIPP and ShIPP Subgroup

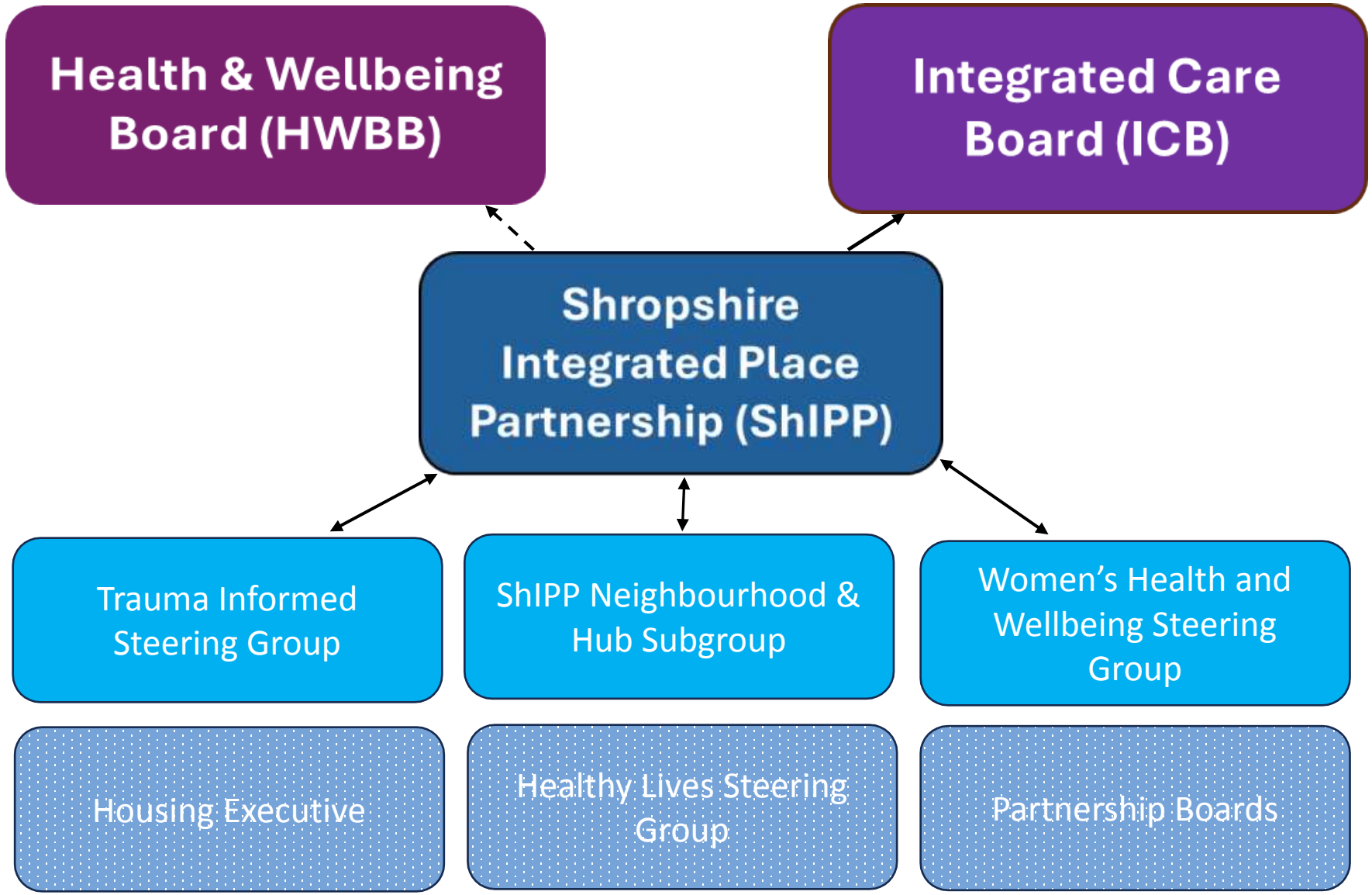
Key Actions – first 1-6 months

- Mapping System Work (including UEC, Planned Care, Primary Care, Transformation Pathways, Hubs, Provider Collaboratives, INTs and MSK) and ensuring linkages across Neighbourhood working – ICB Strategy Team well placed for this work
- Continue expansion work of existing programmes and priorities
- Continued development, use and understanding of system population health management approach; to drive delivery of care at PCN/ Neighbourhood level from 26/27, and to inform commissioning intentions

Standing Agendas for ShIPP and ShIPP Subgroup

- Update on current programmes of work (including risks and commissioning needs)
- Update on system mapping and alignment existing system wide programmes (e.g. UEC, Planned Care, Neighbourhoods, Primary Care, INTs)
- Population Health Management Progress (including analysis and health inequalities)
- Agreement of reports to ShIPP (highlight report)

ShIPP Governance



Integrated Care System

Shropshire, Telford and Wrekin

Appendix A Commissioning Intentions

Shropshire Council Commissioning Intentions

Market Position Statement

1. Demand management through strength-based, reablement and developing models and services that will support the principle to improve or maintain independence.
2. Create a versatile, cost effective and sustainable market at place.
3. Promote and develop inclusive access to all services.
4. Develop person centred support with choice and quality services.
5. Develop and promote information and advice.
6. Work across health, education, children and young people services and adult services to integrate our commissioning and market management.
7. Invest in early help, prevention and community services.
8. Improve and embed mental health and wellbeing across all services.
9. Support and develop the health, family/carer support and social care workforce.
10. Develop a sustainable market through innovative sustainable solutions.

ICB Commissioning Intentions

Areas of Focus	Rationale
• MSK – lead provider via Provider Collaboration • All Age MH/LDA • CYP – physical (asthma , epilepsy and diabetes and 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 • Integrated Urgent Care • VW, RR, DAART and OPAT • Community Transformation Programme (including Community Nursing, Preventative Proactive Care, Integrated NHS End to End Pathways, Integrated Neighbourhood Teams) • Community Bed Model • Ageing well – frailty, falls and dementia • Integrated Diabetes and Cardiovascular End to End Pathway redesign • Primary Care Access • Cancer • Diagnostics • Parity of esteem for inclusion health groups	• Improved outcomes for our populations • Reduction in health inequalities • Contribute to the delivery of the 3 shifts in the NHS 10 Year Plan: sickness to prevention, hospital to community, analogue to digital together with the ambitions of HTP and LCTP • Streamline pathways and access through Provider Collaboration. • Improve the primary, secondary and tertiary prevention offer across pathways • Improve performance against key national metrics • Contribute to the system financial improvement and alignment with the Medium-Term Financial Plan • Improve quality outcomes and patient experience.

Agenda Item

ICB 30-04.159

The Neighbourhood Approach

Appendix 1 - STW Neighbourhood Working Strategy summary document v1.2a SPC 9 Apr 25

Appendix 2 - STW Prevention Framework - draft

Integrated Care System

Shropshire, Telford and Wrekin

Shropshire, Telford & Wrekin (STW)
Draft Neighbourhood Working Strategy and Prevention Framework

Summary Overview

Contents

1. Context

2. STW Neighbourhood Approach

3. Core Components of Neighbourhood Health

4. Introducing an STW Prevention Approach

Appendices

A. The 6 core components - Neighbourhood Health guidance January 2025
B. Case Studies
C. ICP Prevention Slides

Integrated Care System

Shropshire, Telford and Wrekin

1. Context

NHS 10 Year Plan

The three shifts - An NHS fit for the future

The 10 Year Health Plan will set out how we create a truly modern health service designed to meet the changing needs of our changing population. This will be focused on the three shifts that the government, health service, and experts agree need to happen. This includes:

1. moving care from hospitals to communities *including neighbourhood health*
2. making better use of technology
3. focussing on preventing sickness, not just treating it, *including neighbourhood health*

Today highlighting two areas of progress in STW to seek to build agreement, further momentum and alignment and organisations role in the work

What is neighbourhood working?

Neighbourhood working is not new, it is something that has existed for many years both locally, regionally and nationally.

There is no single or accepted blueprint for a Neighbourhood, but some definitions/descriptions include:

- An approach that strengthens and re-designs community services to meet local needs, to include better coordination and communication locally.
- An approach that supports teams and services to work in a more integrated way across health, local authorities, VCSE and the community.
- Level of locality or Neighbourhood that tends to be between 30,000 - 50,000 people

Why is this approach needed? – NHS Neighbourhood Health Guidelines 2025.26

"There is an urgent need to transform the health and care system. We need to move to a neighbourhood health service that will deliver more care at home or closer to home, improve people's access, experience and outcomes, and ensure the sustainability of health and social care delivery. More people are living with multiple and more complex problems, and as highlighted by Lord Darzi, the absolute and relative proportion of our lives spent in ill-health has increased.

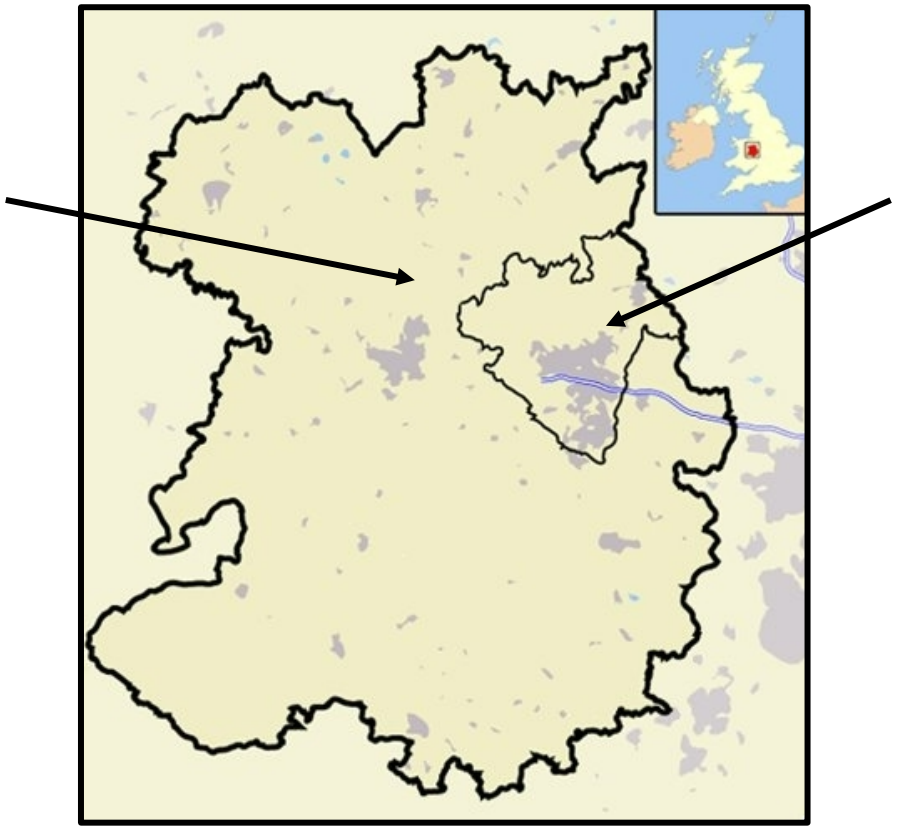
Addressing these issues requires an integrated response from all parts of the health and care system. Currently, too many people experience fragmentation, poor communication and siloed working, resulting in delays, duplication, waste and suboptimal care. It is also frustrating for people working in health and social care."

Shropshire, Telford & Wrekin Place Context

In STW there are **2 Place Areas – 1. Shropshire and 2.Telford & Wrekin** (coterminous with local authority administrative boundaries), **with Neighbourhoods aligned currently to 9 Primary Care Networks**. TW and Shropshire also have place plan or neighbourhood areas as defined by local communities 18 in Shropshire and similar in TW. The role of Place in this context, delivered through the two Place Boards which are sub-committees of the ICB, is:

Shropshire Integrated Place Partnership (ShIPP)

- Work with the ICB on developing governance, which is moving toward delegation of decision and finance to place and Neighbourhood.
- Work with partners to align strategic priorities with need through strategic plans and actions
- Increase focus on integration, prevention, inequalities and improvement of population health and wellbeing
- Ensure that the voluntary and community sector play a central role in the health and wellbeing of local populations
- Ensure that local voices, (people, elected members, local services, primary care), are championed and part of developments and decision making
- Understand, influence and develop local implementation of strategy and transformation programs, that takes into account need and local voices
- Assess need and develop ongoing needs assessments , Joint Strategic Needs Assessments (JSNAs) and regular feedback loops)



Telford Wrekin Integrated Place Partnership (TWIPP)

- Agree and drive the delivery of proactive, preventative, high quality community centered health and care integration at place.
- Have a key focus upon reducing health inequalities, improving place-based proactive prevention and delivering seamless, accessible, safe, high quality community centered health and care services for all residents.
- Understand how effectively the improvements in quality and safety are being driven forward. This is aligned to the quality statements set out by the Health and Care Act in 2022 and outlined in the Care Quality Commission Integrated Care System Assessment process.
- TWIPP is authorised by the ICB Board to:
  - Oversee the delivery of key priorities of thematic partnership boards
  - Agree key priorities for community centered health and care in Telford and Wrekin
  - Create task and finish groups or working groups to develop and deliver action plans to deliver the agreed priorities for community centered health and care in Telford and Wrekin

Strategic Planning and Delivery of Neighbourhood Working

Strategic Planning and Delivery of Neighbourhood Working

Shropshire Neighbourhood Planning and Delivery Group, a sub-group of ShIPP – Chair: **Carla Bickley, Associate Director of Strategy, SaTH**

T&W Neighbourhood Working Accelerator Group, a sub-group of TWIPP – **Chair: Helen Onions, Director of Public Health, Telford & Wrekin Council**

Integrated End to End NHS Pathways

Primary governance: System Health and Care Models Transformation Group**. Chair: Patricia Davies, Chief Officer SCHT**

End to end integrated pathway design across all providers/partners

Embed integration of 'NHS to NHS' services as part of the 'core service offer' for INTs

Resources

Neighbourhood Working

STW Place Leads (joint funded posts between ICB and Local Authorities)

ICB Primary Care Team

ICB Strategy & Development Team to support and facilitate

Other Local Authority Joint Posts and Transformation teams

Place level delivery teams and INTs

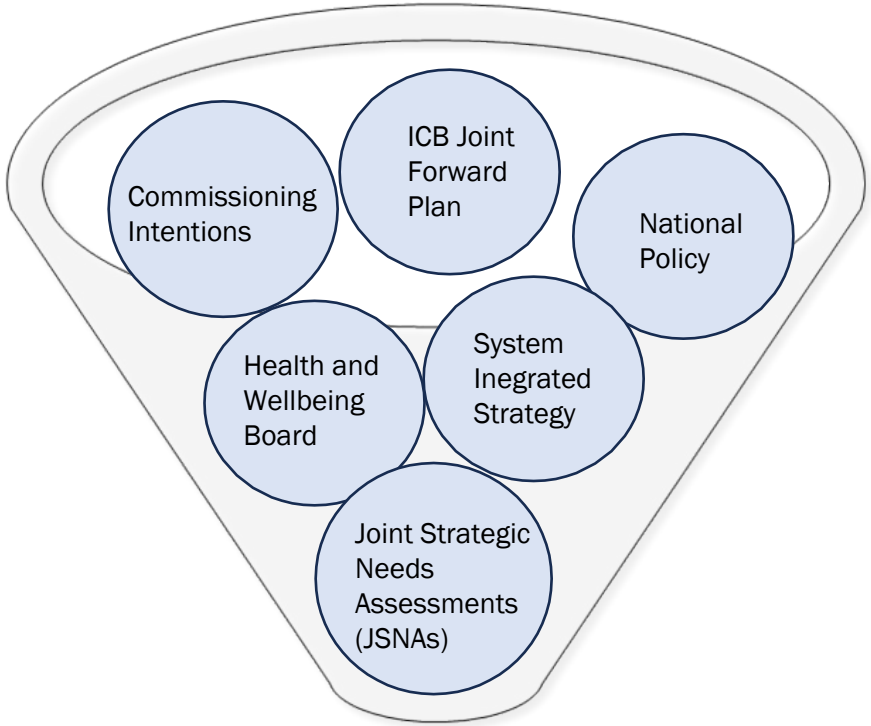
NHS Pathways

ICB S&D team to co-ordinate pathway design with appropriate clinical leadership (primary care and AHP)

SCHT as community provider to play key role in pathway design;

All partners to contribute to end to end pathway design

Alignment of System Strategic Planning and Priorities



Delivery Assurance at TWIPP and ShIPP → **Integrated Care Board**
Health and Wellbeing Boards

Delivery and coordination supported by ICB Strategy and Development Team and Place Leads working together through Neighbourhood Working accelerator groups

Develop and deliver programmes working with Primary Care Networks and relevant neighbourhood partners

System Aims:
- Improve outcomes in population health and healthcare
- Tackle inequalities in outcomes, experience and access
- Support broader social and economic development
- Enhance productivity and value for money

TWIPP Priorities:
- Supporting General Practice by working together to reduce and manage demand for GP services/ appointments
- Improving all-age mental health provision
- Preventing, reducing and delaying frailty

ShIPP Priorities:
- Integrated Neighbourhood Teams
- Community and Family Hubs
- Prevention and Left Shift
  - Falls
  - Diabetes
  - Housing
  - CYP mental health

NHSE guidance next steps for Neighbourhood health

- Whilst we await the 10 Year Plan **STW will continue to build on and strengthen the existing foundations and maintain the current momentum** for a neighbourhood health approach by making further progress to **standardise the 6 nationally defined core components of existing practice** listed below to achieve greater consistency of approach:-

  1. Population Health Management
  2. Modern General Practice
  3. Standardising community health services
  4. Neighbourhood multi-disciplinary teams (MDTs) including a nationally defined INT model for CYP
  5. Neighbourhood intermediate care with a 'Home First' approach
  6. Urgent neighbourhood services

  The specific details related to each of the above 6 core components are set out in Appendix 1.

- As a minimum impacts to be achieved in 2025/26 are **improving timely access** to general practice and urgent and emergency care, **preventing long and costly admissions** to hospital and **preventing avoidable long-term admissions** to residential or nursing care homes.

Integrated Care System

Shropshire, Telford and Wrekin

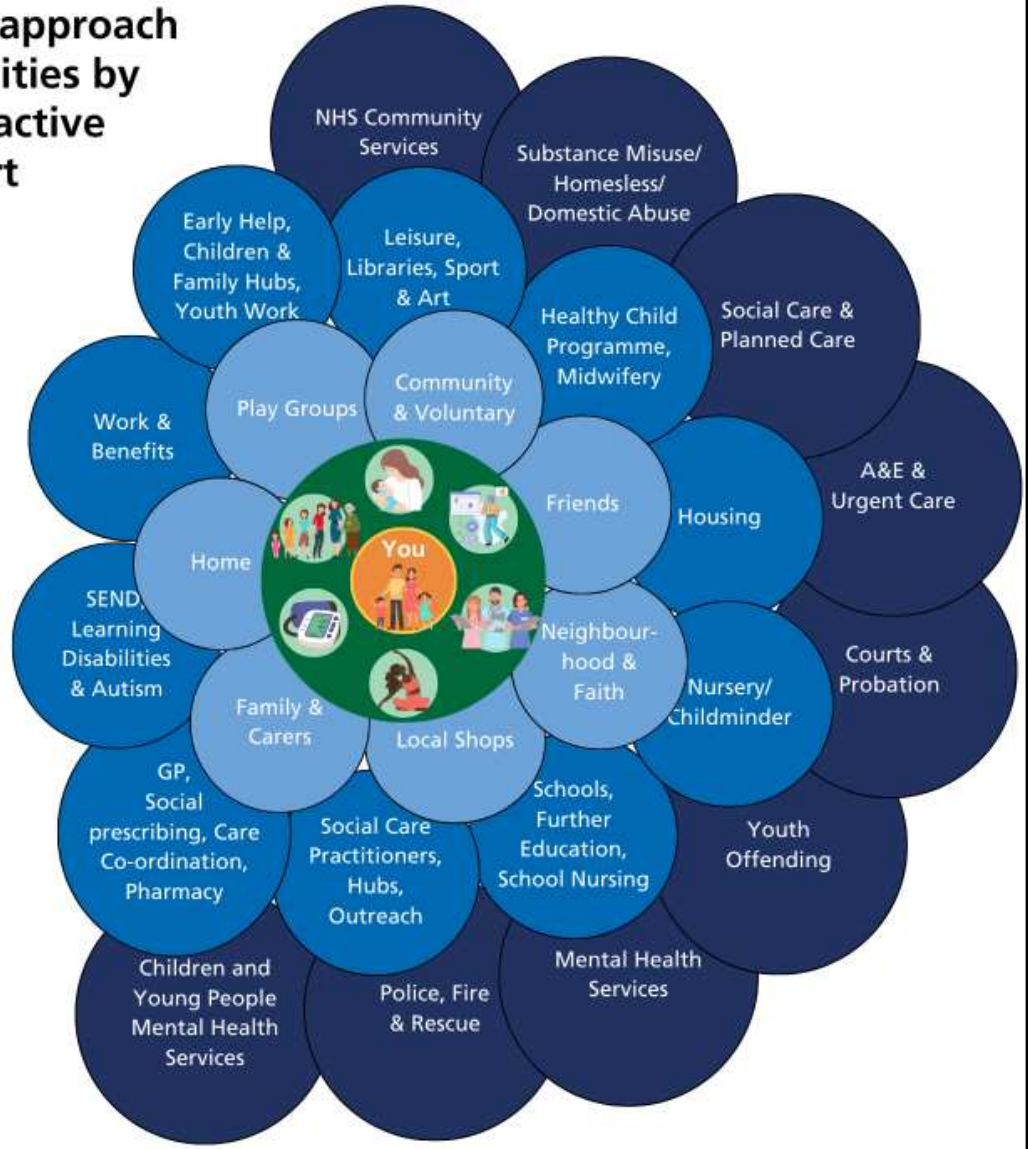
2. STW Neighbourhood Approach

Shropshire, Telford & Wrekin Neighbourhood approach

Our local care neighbourhood approach will cultivate thriving communities by focusing on collaboration, proactive healthcare, and holistic support

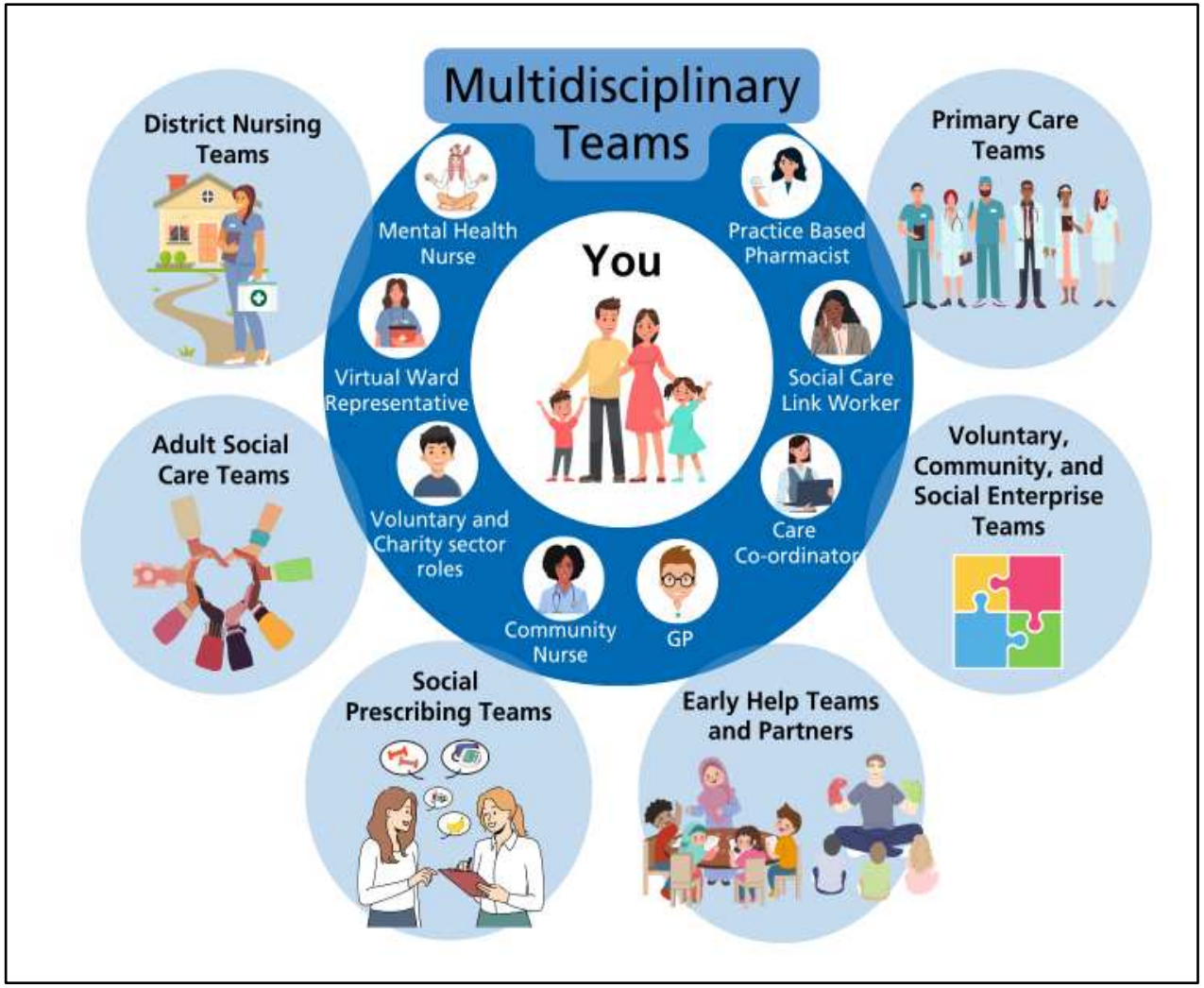
Our aims are to:

- Improve outcomes for children, young people, and families.
- Promote early diagnosis and prevent avoidable illnesses in the first place.
- Support people of all ages with self-care and managing long term conditions.
- Implement person-centred multidisciplinary care approaches.
- Achieve a greater emphasis and use of social prescribing.
- Ensure people can access the right help, at the right time, in the right place within the local community.



Neighbourhood Multidisciplinary Teams (MDTs)

'Teams of teams' work in neighbourhoods, they are not restricted by geographical boundaries and link together providing person centres, preventative proactive care and support.



- **Multidisciplinary coordination of care** for population cohorts with complex health and care or social needs who require support from multiple services and organisations.
- Deliver p**roactive, planned and responsive care**
- **Prioritise based on people's needs** and opportunity for greatest impact.
- **Footprints optimise neighbourhood working** and partnership with LA.
- A **core team is assigned for complex case management**, with links to specialist resource as needed.
- **Assign a care coordinator to every person** or their carer in the cohort as a clear point of contact to improve both their experience and continuity of care.
- **Guidance on neighbourhood MDTs for children and young people** will be published in early 2025.

Shropshire, Telford & Wrekin Principles for Neighbourhood Working

Population Health Management	Person Centred Approach	Learning and Evidence	Integration	Time	Leadership
• Working in a proactive, preventative, assets based, population health way that maximises health, wellbeing, independence, and self-care in or as close to peoples homes as possible, in order to reduce their need for health and care services.	• Ensuring that we take a person-centred approach, putting people at the centre of what we do.	• Building on what works and using learning and evidence, to develop a more comprehensive community based prevention offer which includes universal, early help, targeted and specialist system services.	• Working across service areas, integrating where possible, embracing partnership and collaborative working, creating a culture of working jointly across professions, organisations and teams for the benefit of our communities.	• Adopting a test and learn approach allowing projects time to evolve and deliver outcomes, embedding evaluation in all development programmes from the start.	• Collaborative local leadership with a shared vision, culture and values to support transformation.

Four Phases of Integrated Neighbourhood Working Development

Phase 1: Foundations and integrated practice	Phase 2: Population Health Management (PHM) with supporting infrastructure	Phase 3: Integrated and intelligence led practice	Phase 4: Full delegation for STW Neighbourhood delivery
Integrated Neighbourhood teams are defined around geography.	PHM established and embedded : deep understanding of community through data and community connections driving preventative approach	Joint workforce planning and workflow allocation in Neighbourhoods	Shared governance established (Clinical and Financial)
Processes for integrated practice are established and enacted across Primary Care, Community and Mental Health, and Voluntary Services	Estate plan for neighbourhoods agreed, with a focus on Community and Family Hubs where possible and opportunities of co-located 'team of teams'	Integrated services in place. Management of complex health in the community, Virtual Wards, Rapid Response, MDTs, Frailty and Proactive Care approaches	Full delegation of Neighbourhood resources into a shared budget, enabling integrated funding streams to deliver STW core offers
The population is understood with a sense of working in a team serving that population	Interoperable IT systems are in place enabling joint care planning and risk management.	Integrated care pathways in place and models of delivery designed to meet the needs of Neighbourhoods	Accountability for delivery established
Functioning Integrated Neighbourhoods in place	*PHM fully established, full digital interoperability and estate solutions confirmed*	*Integrated Neighbourhood teams plan its workforce to deliver care models*	*Integrated Neighbourhood teams delivering demonstratable system benefits and outcomes*

These phases have been created to establish a shared terminology for describing Integrated Neighbourhood Team maturity. They are also intended to assist Integrated Neighbourhood Teams in formulating development plans over time. It's important to note that these phases are not part of an assurance process.

Population Health Management - 7 Step approach

1. Develop ICS System Outcomes
2. Develop metrics and measures
3. Develop Population segments
4. Identify Priority Cohorts
5 . Identify Impactable Interventions
6. Implementation
7. Evaluation

Establish top level segments, goals and priority areas

Establish needs at Place and Neighbourhood in priority area e.g. deprivation, ethnicity, conditions

Establish the set of interventions that can meet the goals and who will benefit most at Place and Neighbourhood level. How can we join up existing community assets to best deliver those interventions.

Data driven approach and focused local health needs will contribute to tackling health inequalities.

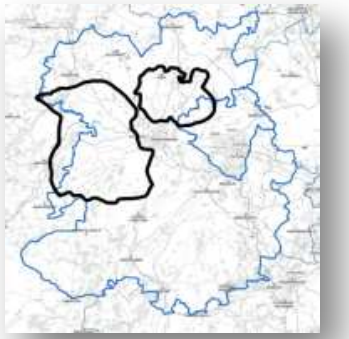
Providing services closer to home, taking a person-centred neighbourhood approach

Local areas have different needs, core offers are tailored way to reflect this

Shropshire Neighbourhoods

Total registered patients – 318,279 *(April 2024)*

Rural Alliance



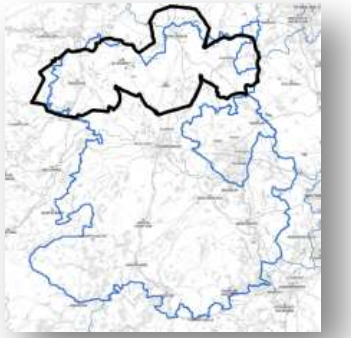
Population –26,312

Community Hubs
Links with North, Shrewsbury and Southwest

GP Practices

Clive, Knockin, Shawbury , Pontesbury & Worthen, Westbury

North



Population – 91,434

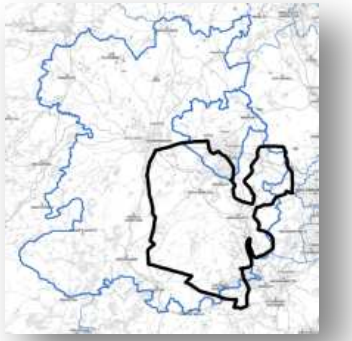
Community Hubs - NE & NW

NE - Raven House

NW – Oswestry Library

GP Practices
Churchmere Medical Group, Market Drayton, Plas Ffynnon, The Caxton Surgery, Wem & Prees, Cambrian Hodnet Medical Practice (LCS)*

South East



Population – 59,605

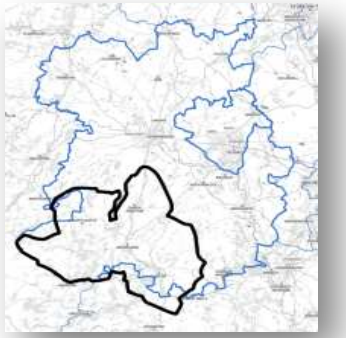
Community Hub

Bridgnorth Library

Highley Health & Well-being Centre

GP Practices
Albrighton, Alveley, Bridgnorth, Brown Clee, Cleobury Mortimer , Much Wenlock & Cressage, Broseley, Ironbridge

South West



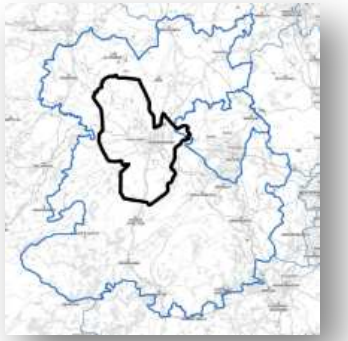
Population – 36,571

Community Hub

Ludlow Youth Centre

GP Practices
Bishops Castle, Church Stretton Craven Arms, Portcullis Surgery Station Drive Surgery, The Meadows

Shrewsbury



Population 104,357

Community Hub

Sunflower House

GP Practices
Belvidere, Marden, Marysville Riverside, Severn Fields, South Hermitage Surgery, Radbrook Green Surgery, Mytton Oak, Claremont Bank Surgery, The Beeches, Prescott Surgery

Partners involved in Neighbourhood Care – Local Authority, Voluntary Community and Social Enterprises (VCSE), Community Trusts; Midlands Partnership MHS Foundation Trust (MPFT), Shropshire Community Health Trust (SCHT)

Services Provided at Neighbourhood Level

Shropshire

Rural Alliance	Shrewsbury	South-West	South- East	North
Services are linked with North, Shrewsbury and South-West.	N1	N1	N1	N1
	N2	N2	N2	N3
	N3	N3	N3	N3
	N4	N4	N4	N4
	N5	N6	N6	N5
	N6	N7	N8	N6
	N8	N8	N11	N7
	N9	N9	N12	N8
	N11	N11	N14	N9
	N12	N12	N15	N14
	N14	N13	N16	N15
	N15	N14	N17	N16
	N17	N15	N18	N17
		N17	N19	
		N20		

System Level Services

System Level acute care services, e.g. Major Trauma, Orthopedic, Elective Care, Vascular, Cancer.

Place Level Services

Rapid Response , District Nursing, Women's Health & Well-being Hubs, Community & Family Hubs, Health & Well-being Hubs, Education Hubs

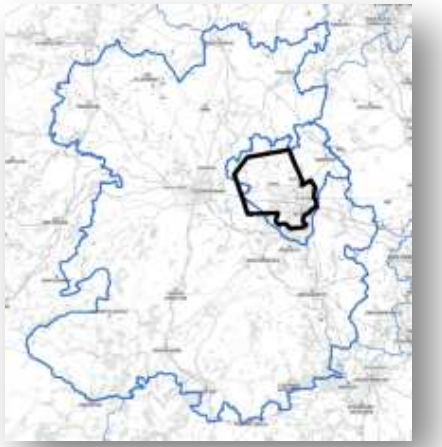
Neighbourhood Services (N)

1. Integration.
2. Family Hub Drop-ins (0-19)
3. Health Visiting Open Access Clinics
4. Parenting Support –virtual, phone line and monthly f2f
5. Breast Feeding Network
6. Shropshire Domestic Abuse Drop-in and Virtual
7. Support into Work (DWP/Enable)
8. Let's Talk Local – Adult Social Care (ASC)
9. Family learning Courses
10. Enable – developing a county wider virtual offer
11. Housing Support – county wider – virtual offer
12. Warm Space
13. Armes Forces Outreach
14. Stop Smoking Clinics
15. Blood pressure checks
16. Pilot of an all-age autism Hub
17. Shropshire recovery partnership – Youth Drug and Alcohol Outreach Team in all hubs once a month.
18. Dementia Multidisciplinary Team (MDT)
19. Heart Failure at home Multidisciplinary Team (MDT)
20. Proactive Care Multidisciplinary Team (MDT)

Telford & Wrekin Neighbourhoods

Total Registered patients – 196,605 *(April 2024)*

Wrekin

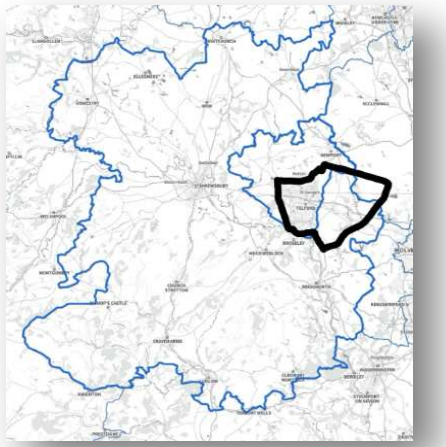


Population – 32,725

Community Hubs
Evergreen Family Hub

GP Practices
Hollinswood & Priorslee Surgery , Wellington, Dawley

TELDOC



Population – 65,151

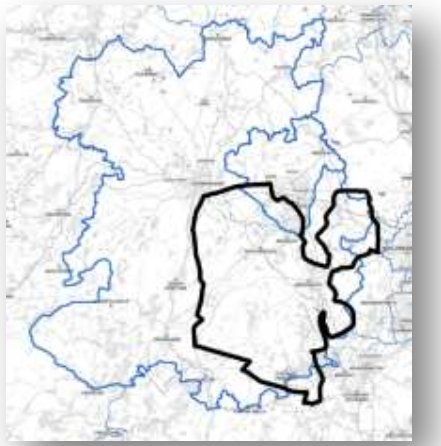
Community Hubs
Oak Family Hub
Cherry Blossom Family Hub
Hazel Family Hub

GP Practices
TELDOC is a Medical Practice that operates out of 6 sites across Telford and Wrekin:

- Malinslee
- Lawley
- Oakengates
- Madeley
- Hadley
- Leegomery

Shifnal & Priorslee Medical Practice (chosen to be part of Telford PCN)

South-East Telford

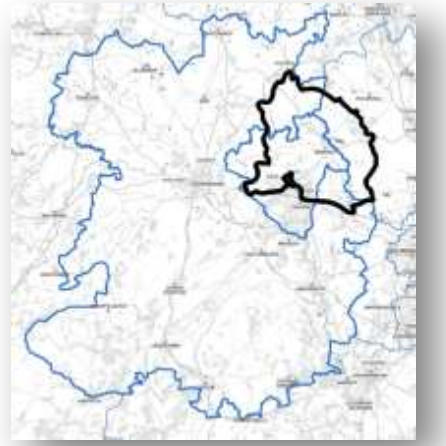


Population – 38, 675

Community Hubs
Live Well Hub Madeley
Walnut Family Hub
Silver Birch Family Hub

GP Practices
Court Street, Stirchley
Woodside, Ironbridge *(part of South-East Shropshire PCN)*

Newport and Central



Population – 60, 054

Community Hubs
Coming soon – Live Well/Family Hub

GP Practices

Wellington Road Surgery
Linden Hall Surgery
Shawbirch, Donnington
Charlton Medical Practice
(not part of PCN)

Partners involved in Neighbourhood Care – Local Authority, Voluntary Community and Social Enterprises (VCSE), Community Trusts; Midlands Partnership MHS Foundation Trust (MPFT), Shropshire Community Health Trust (SCHT)

Services Provided at Neighbourhood Level

Telford & Wrekin Place Level

Wrekin	TELDOC	South East	Newport and Central
N1	N1	N1	N1
N3	N3	N2	N5
N6	N4	N3	N6
N7	N5	N6	N8
N8	N6	N8	N9
N9	N7	N9	N10
N11	N8	N11	N11
N12	N9	N12	N12
N13	N12	N13	N13
N15	N13	N15	N14 (coming soon)
	N14		N15
	N15		

A range of Voluntary, Community and Social Enterprise Groups can be found across all neighbourhoods. To view specific services within those neighbourhoods please refer to Live Well Telford.

Illustrative examples of services provided at this footprint

System Level Services

System level acute care service e.g., major trauma, Orthopedic, Elective Care, Vascular, Cancer.
Same day urgent care services.

Place Level Services

Live Well Telford All Age Online Community Directory, Family Connect, Safeguarding (children and adults), Early Help and Support (CYP), Children in Care, Adult Social Care, Discharge Pathways, Rapid Response, Virtual Ward, Sexual Health Services, District Nursing, Community Therapy, Women's Health & Well-being, Domestic Abuse Service, Support into Work, Learn Telford, Housing Services, Healthy Lifestyles, Citizens Advice, Drug and Alcohol Services, Community Mental Health, antenatal and post-natal care, Hospice Care

Neighbourhood Services (N)

(i.e., only delivered in the Neighbourhood)

1. Primary Care – GP, Pharmacy, Dentistry, Optometry
2. Live Well Hubs
3. Family Hubs
4. Independent Living Centre
5. Digital Inclusion Drop Ins
6. Calm Cafes
7. All-Age Autism Hub
8. Welcoming Spaces & Warm Places
9. Adult Social Care Bookable Appointments / Pop-Ups
10. Energize Place Project
11. Armed Forces Community Cafes and Drop-Ins
12. Health Promotion and Prevention (e.g., blood pressure checks, vaccinations....etc.)
13. Social Prescribing and Care Navigation
14. Proactive Care Multi-Disciplinary Team
15. Libraries and Council First Point

System Roles and Responsibilities in Place and Neighbourhood Development

ICB

- **Strategic Commissioner** with the ambition of starting to delegate tactical commissioning and transformation based on delivering specific outcomes to Place and Provider Collaboratives as our key delivery vehicles over a period of **time.**

- **Development and Redesign skills and capacity** – the ICB Strategy and Development Team has a has a jointly funded Place leadership post with the Council and has aligned some of its project management resources to support the development of Neighbourhoods

Local Authorities

- **Senior Responsible Officers (SRO)** – The Local Authority Chief Executives are the SROs for Place. As SROs they have overall accountability for the delivery of the Place programme of work and its associated outcomes accountable to the ICB Board and Health and Wellbeing Boards. They are the Chairs of the Place Based Boards.

- **Chair of the Place Based Boards, ShIPP and TWIPP to ensure:-**

- agree, direct, drive and assure delivery of community centred health and care integration at Place.

- key focus on reducing health inequalities, improving proactive prevention and delivering seamless, accessible,

- safe, high quality community centred health and care services for all their respective residents.

- JSNA and Customer Programme/Adult and Children Transformation

System Partners

- **Proactively engage with the Place Based Boards and Neighbourhood Development Groups**

- **Influential role in developing local delivery solutions** with other partners, reducing duplication and joining up services where it makes sense to do so

- **Commitment to integrated and collaborative work,** enabling better use of resources and quality improvement, leading to more effective and efficient services.

- **Commitment to align provider service capacity and resources to agreed Place and Neighbourhood models**

- **Partners include:** Shrewsbury and Telford Hospitals NHS Trust - SaTH (Acute Trust), Voluntary, Community, and Social Enterprise sector (VCSE), Shropshire Community Health NHS Trust (Shropcom), Midlands Partnership Foundation NHS Trust (MPFT), Primary Care Services (General Practice, Primary Care Networks (PCNs), Pharmacy, Optometry and Dentistry), Robert Jones and Agnes Hunt NHS Trust (RJAH)

Integrated Care System

Shropshire, Telford and Wrekin

Next Steps and discussion

Integrated Care System

Shropshire, Telford and Wrekin

Appendices

Integrated Care System

Shropshire, Telford and Wrekin

The 6 core components

The 6 core components of existing Neighbourhood practice

1. Population health management	2. Modern General Practice	3. Standardising Community Health Services
• A **person-level, longitudinal, linked dataset** • Over time, **broaden to include other data** to enable analysis of population health outcomes, biopsychosocial risk drivers and health/care system resource use. • **Segment and risk stratify populations**, based on complexity and forecasted resource use. • Supported by a **system-wide Intelligence function** • **Complement with wider quantitative and qualitative insight** into groups that might be under-represented • **Compatibility and integration between** GP systems, digital social care records and other **clinical data provider systems.**	• **Support general practice to deliver improvements in access**, continuity and overall experience • **Streamline the end-to-end access journey**, making it quicker and easier to connect with the right health care professional, team or service, including community pharmacy and digital self-service options via the NHS app. • **People have the ability to access services equitably in different ways** (online, telephone and in person). • **Structured information gathering at the point of contact** and clear navigation and triage based on risk and complexity of needs. • **Staff have access to structured information** about the complexity of the presenting complaint and need.	• When designing, commissioning and delivering neighbourhood health, systems **use the national standardising community health services guidance** to ensure funding is used to best meet local needs. • **Care is planned to meet all health (physical and mental) and social care needs**. Service boundaries do not prevent seamless, joined-up care. • **Make use of the mental health PCN ARRS to improve primary care mental health** and access to community-based mental health services for people of all ages. • **For children and young people, join up with mental health services and mental health support teams in schools and further education.** • For people with co-occurring **drug and alcohol dependency, services engage with local authority commissioned substance misuse services.** • **Link in with VCFSE** sector support for adults, children and young people around mental health, social isolation and substance misuse.

The 6 core components of existing Neighbourhood practice

4. Neighbourhood MDT's	4a Neighbourhood MDTs for Children and Young People (requirements for 25/26)
• **Multidisciplinary coordination of care** for population cohorts with complex health and care or social needs who require support from multiple services and organisations. • Deliver **proactive, planned and responsive care** • **Prioritise based on people's needs** and opportunity for greatest impact. • **Footprints optimise neighbourhood working** and partnership with LA. • A **core team is assigned for complex case management**, with links to specialist resource as needed. • **Assign a care coordinator to every person** or their carer in the cohort as a clear point of contact to improve both their experience and continuity of care.	• Will provide integrated care that provides **timely access to specialist advice, including paediatric and mental health expertise, through primary care-led team working** • Aim to achieve **parity of esteem between mental and physical health** by embedding mental health expertise within MDTs, bridging the gap between primary care and children and young people mental health services (CYPMHS) • Will provide a **universal service available to all babies, children and young people** • **Will be made up of a core workforce with links to an extended team that enables access to additional specialist resource as needed** • **Case identification** – Using a PHM approach, GPs and other health and care professionals proactively identify children and young people who would benefit from additional support and refer them on to the MDT • **MDT case discussion and triage -** meeting brings together GPs, the designated paediatrician, the mental health professional(s) and other MDT members. • **Direct care -** Neighbourhood MDT clinics, located in the GP practice or other community settings, allow direct care to be delivered to children and young people who need it. Once a month, ideally delivered jointly by the designated paediatrician and the GP. For those requiring support with mental health needs, direct care enables earlier access. MDT clinics can also be used to integrate wider health and social support services, such as early years support or asthma specialists • **Professional knowledge sharing -** GPs are provided with increased access to the designated paediatrician and mental health professional(s) outside of the scheduled triage and case discussion meetings and clinics, for example, by email or phone. Neighbourhood MDTs also provide the opportunity for dedicated learning sessions • **Children and young people, family and carer engagement and health promotion -** Neighbourhood MDTs should provide focused support for local needs. • **Delivered at a neighbourhood and primary care network level.** • **A lead organisation typically needs to be** assigned as part of the ICB's provider selection process**.** They will be the contractual lead for the neighbourhood MDTs for children and young people **and will negotiate the services of other MDT members.**

The 6 core components of existing Neighbourhood practice

Integrated intermediate care with a 'Home First' approach	Urgent Neighbourhood Services
• **Short-term rehabilitation, reablement and recovery services taking a therapy-led approach** (overseen by a registered therapist) **working in integrated ways across health and social care** and other sectors. • **Referrals can be made directly** from the community (step-up) or as part of hospital discharge planning (step-down, applying a 'Home First' approach, with assessments and interventions delivered at home where possible and working closely with urgent neighbourhood services. • **Good operational case management systems and measure outcomes** (ref BCF policy framework for 2025/26 to ensure best use of resources.	• **Standardise and scale urgent neighbourhood services** for people with an escalating or acute health need • **Single point of access** to deliver a co-ordinated service. • **Services align with services at the front door of the hospital,** such as urgent treatment centres and same day emergency care. • **Ambulance service** senior clinical decision makers in a single point of access should **provide advice** and referral to appropriate services **either before ambulance dispatch or as part of a "call before convey" approach.** • **Service footprints determined locally,** balancing scale of delivery with building on local relationships to ensure smooth referral pathways

Other important considerations for Neighbourhood health

Secondary care contribution to neighbourhood health	Planning for a flexible workforce
• **Supporting continuity of care in the community for people under the care of a specialist hospital team** such as respiratory, diabetes, stroke or cardiology. This might include providing specialist input to neighbourhood MDTs through clinics delivered jointly in primary or community settings, using digital technology and infrastructure, or by establishing pathways into the hospital which avoid the emergency department. • **Supporting the development of hospital at home (virtual ward), single point of access and community diagnostic centres,** inc. providing clinical advice/oversight as required. • **Ensuring frailty services are joined up in all settings**, whilst maximising the delivery of these services within community settings. This will include the development of frailty-attuned hospital services ensuring they connect with community frailty provision to support integrated end-to-end frailty pathways, and support for care transfer hubs, which arrange support services to assist discharge from hospital for those with the most complex needs.	• **Connect as broadly as possible across local communities** to agree how best to use collective local resources. • Continue to **develop joint demand and capacity assessment, modelling and planning across health and social care**. • Include **joint bottom-up mapping of existing workforce** capacity, skills and capabilities across all partners/providers • A **user-centred approach to the design of teams,** including job planning across different settings. This may include **upskilling teams within the MDTs to cover multiple functions** that traditionally may have been delivered separately • **Ensure staff are aware of, and are involved** in building, the local neighbourhood service model • **Identify barriers and opportunities to better enable productive integrated working** so that staff have the skills and tools to safely work across organisational boundaries, ensuring best use of funding to meet local need, and improving workforce interactions and experience.

Integrated Care System

Shropshire, Telford and Wrekin

Case Studies

Community Hubs in action – Live Well Hub Madeley

Live Well Hub Video Click the link to see the Living Well Hub in Madely in action.

Case Studies

Abe's story

Abe was struggling in secondary school and had recently been permanently excluded.

Through the Integrated Neighbourhood Team meeting professionals looked at what they could do to support Abe better. They agreed:

- Joint working between The Early Help (THE) and the Education Inclusion Team
- Abe's mother was supported by The Early Help (THE) to access Parental Education Growth Support (PEGS)
- The neglect screening tool was completed jointly by all agencies involved
- A referral to Autism West Midlands (AWM) and The Children's Society (CLIMB) was made
- Tuition Medical Behaviours Support Services placement agreed.

Over the course of the next two months a significant change in Abe was seen. Abe was attending his placement (100% attendance rate), he was punctual and attending smart.

Outcome: Abe was supported back into education in a way that met his needs.

Chris' story

Chris had recently refused to attend school and school reported that they had concerns around their hygiene. Support had been offered through the Emotional Health and Wellbeing Service (BeeU) but Chris did not want to engage online.

Chris lives with their parents, and their father has Multiple Sclerosis. Professionals raised concerns that they did not have any adaptations in the home and the family were struggling financially.

The parents had not been able to engage professionals as they had not been offered home visits. The father was keen to be involved.

The Integrated Neighbourhood Team meeting professionals looked at what they could do to better support Chris and their family. They agreed:

- A Early Help worker and Chris' School Nurse completed a joint visit to the family home and completed a Wellfare Assessment.

From this visit further support was identified and put in place:

- Chris was support with his health needs
- Chris' school was able to offer them a reduced timetable
- The family were offered a financial assessment
- Chris' father was offered support for his Multiple Sclerosis (MS)
- Chris' mother was offered healthy lives advisor support

Outcome: Chris was supported back into education, Chris's family were able to access a higher level of benefits, Chris' father was support to manage his MS and the family are now able to engage with professionals who are now taking a holistic whole family approach.

Case Studies

Mary's story

Mary self-referred to the Healthy Lifestyle Service after visiting the Independent Living Centre in Telford Town Centre (Multi-Agency Community Outreach). She had gained weight since lockdown due to unhealthy food choices and was finding food preparation more difficult due to her arthritis, cooking from scratch was difficult. She felt isolated and found walking difficult due to the pain from her arthritis.

After just 6 sessions, Mary managed to make significant changes to her diet and was managing to cook healthy meals with the use of an air fryer. Mary was managing daily exercise which included walking and seated exercise at the Fit4All sessions.

Mary said "Thank you. Having somebody supporting me made all the difference and now I have completely changed my eating habits and am losing weight on a regular basis. My thanks go to Rachael as I know I wouldn't have done it without her help"

Outcome: Mary has achieved 16.5 pounds weight loss, is now exercising regularly and eating healthily. Mary no longer feels isolated and finds walking easier now. Mary has prevented, reduced and delayed her frailty with support from community services.

Dementia Multidisciplinary Team – South East Shropshire PCN

A 91-year-old lady with no formal Dementia diagnosis, was brought to the attention of the Dementia Multidisciplinary team, following a 111 referral to general practice after a 999 call and welfare check. This patient was referred due to concerns with self-neglect and issues regarding memory.

GP attempted various forms of patient engagement, through phone calls and home visit, however, the patient refused any further input, investigations or formal assessments.

Following the unsuccessful attempts of patient engagement this lady was referred to the Dementia Multidisciplinary Team. Adult and Social Care were also aware of this patient, therefore, concerns escalated given the potential risk.

Outcome: Adult and Social Care completed a Mental Capacity Assessment MCA, that resulted in the patient being deemed to lack capacity and a package of care was commissioned for support in the community.

Subsequently, this lady had a fall and following an admission, was then discharged to care home placement, assisted by previous actions triggered and facilitated through the Dementia Multidisciplinary Team.

Integrated Care System

Shropshire, Telford and Wrekin

ICP October 2024 Prevention

Integrated Care System

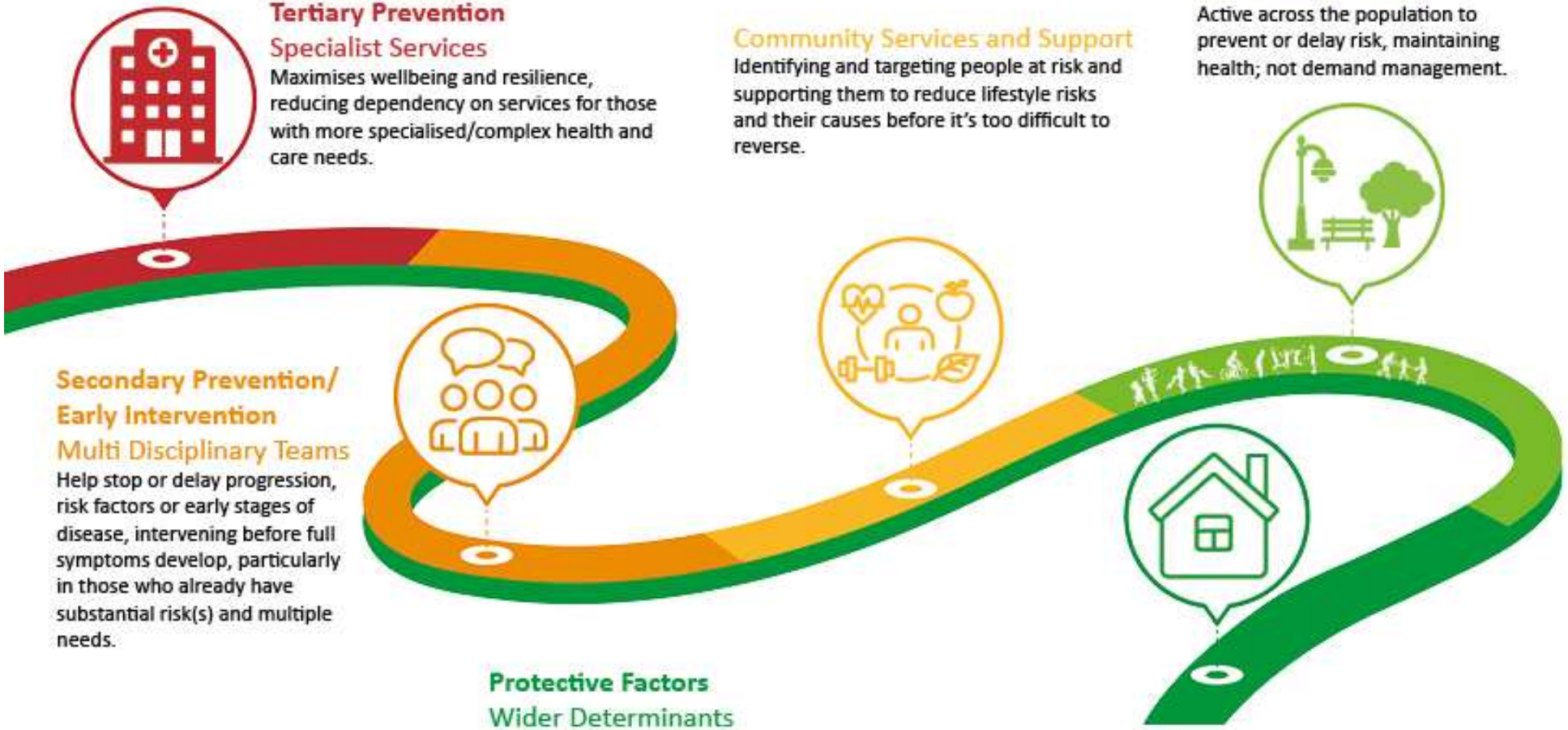
Shropshire, Telford and Wrekin

Prevention:
To consider how our pathways reflect the prevention shift outlined in the national and local direction and strategy.

Defining Prevention

What is prevention and how can services support this?

People being as healthy and well as possible at all stages of life; all services can help with this



Tertiary Prevention

Specialist Services

Maximises wellbeing and resilience, reducing dependency on services for those with more specialised/complex health and care needs.

Primary Intervention - Pre Risk/At Risk

Community Services and Support

Identifying and targeting people at risk and supporting them to reduce lifestyle risks and their causes before it's too difficult to reverse.

Universal Services

Active across the population to prevent or delay risk, maintaining health; not demand management.

Secondary Prevention/ Early Intervention

Multi Disciplinary Teams

Help stop or delay progression, risk factors or early stages of disease, intervening before full symptoms develop, particularly in those who already have substantial risk(s) and multiple needs.

Protective Factors

Wider Determinants

Support at all levels of need and includes access to good housing, education, outdoor spaces, social prescribing and the voluntary and community sector (VCSE).

Our Vision

Focus on developing strong communities where we can reduce inequalities, build the resilience of vulnerable people and families, and concentrate on driving system change so that every area has joined up, efficient local services which are able to identify people and families in need and provide the right support at the right time.

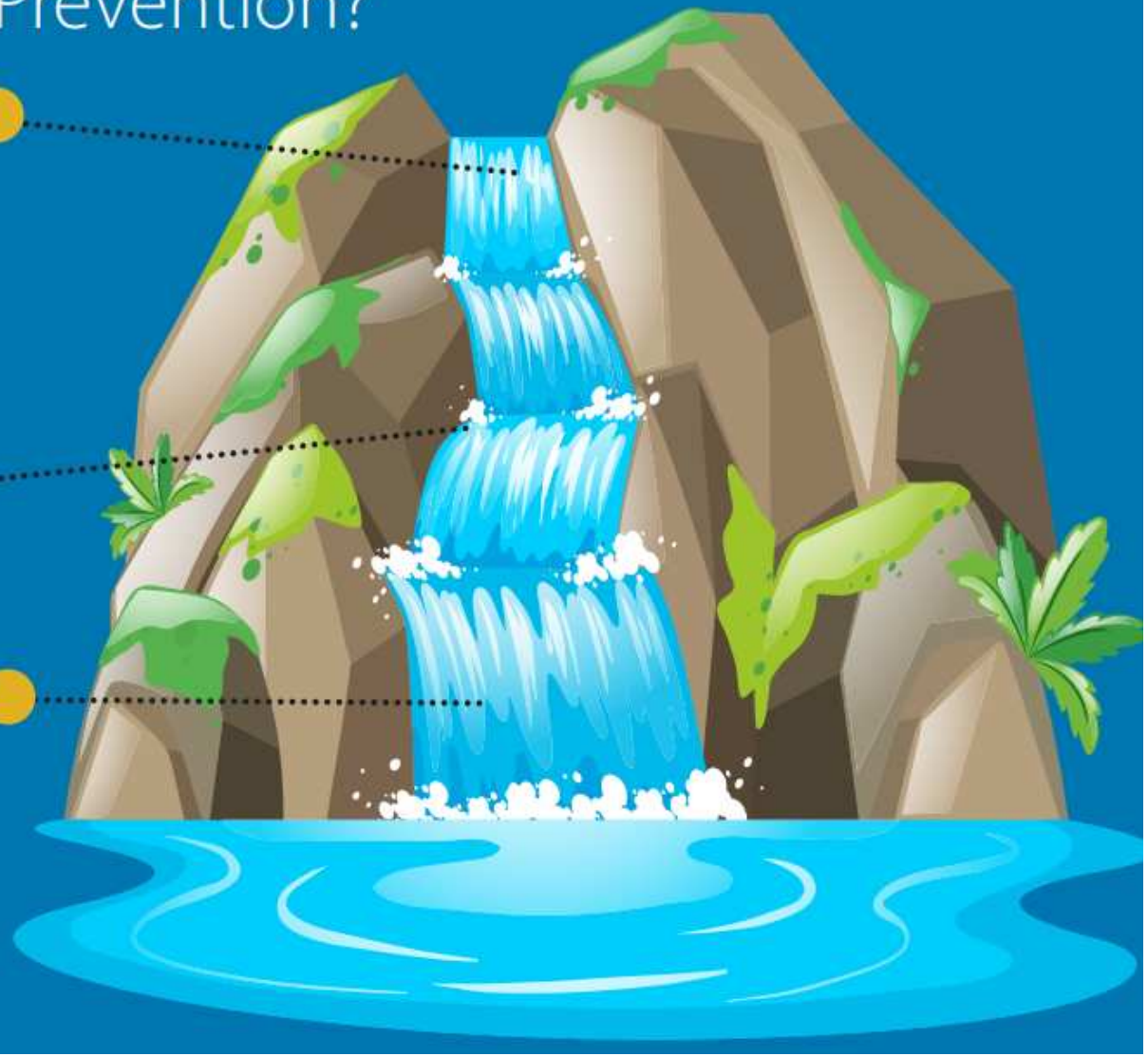
What is Prevention?

Prevention/Pre Risk
At risk or disease reduction at a population level. Maintaining Health. Not demand management

Early Intervention/ With Risk
Identifying people at risk and supporting them to tackle the risks before it is too difficult to reverse

Secondary Prevention
Prevention in those who already have substantial risk. Those with substantial risk.

Tertiary Prevention
Maximises wellbeing and resilience, reducing dependency on services in those with disease by promoting healthy lifestyle behaviours. Those with ill health needs



Case for Change

Case for Change

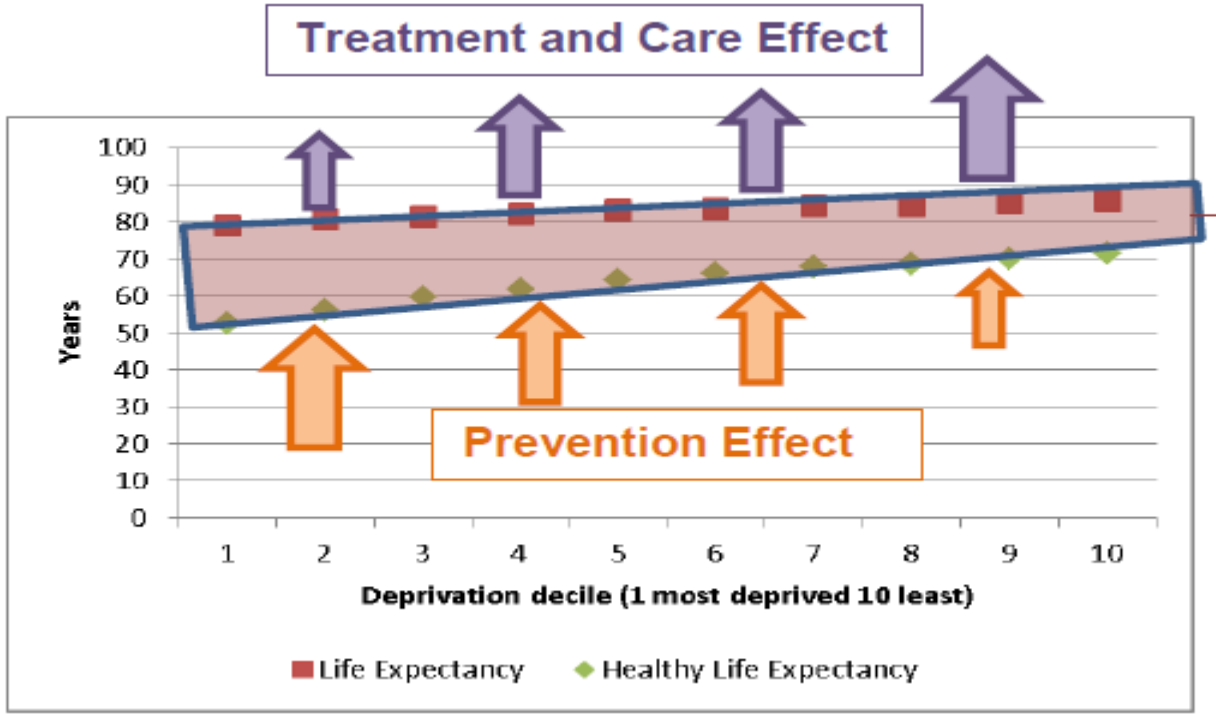
3 main reasons that the **evidence consistently shows Prevention is Better than Cure**:

1. **Improve outcomes** (quality and length of life) - live longer healthier lives increasing time spent in healthy life expectancy
2. It is the most **cost-effective** approach to improving outcomes - 'an ounce of prevention is worth a pound of cure' Prevention works – A review of international studies suggests investment in prevention have a significant long term social return on investment – **Around £14 Social benefit for every £1 across a broad range of areas**
   - Mental Health nationally costs £105bn a year. In Shropshire cost to health and social care for depression or similar common mental illness is an estimated £1,350 per adult per year. This includes treatment, loss of productivity, human costs and impacts on relationships
   - Diabetes costs an estimated £5,500 per person for health and care costs; which increases where people experience complications
   - Alcohol misuse costs £4.4billion nationally a year relating to alcohol related hard and anti-social problems
3. **Manages demand** – on specialist and more expensive services

Intervention	Return on Investment for every £1 invested to the wider health and social care economy
Teenage Pregnancy	£11 in healthcare costs
School Based: Smoking	£15
Parenting Programmes	£8 (over 6 years)
Keeping active: free use of leisure centres	£23 in quality of life, reduce NHS use and wider
Housing investments: warm safe homes	£70 (over 10 years to NHS alone)
Disadvantaged groups in work	£3 (reducing crime, homelessness and care)
Social Support: Befriending	£3.75 (mental health spend)
Motivational Interviewing	£5
Drug Treatment	£2.50
Mental Health Interventions	Between £1,26 and £39
Falls prevention	Between £1.37 to 7.34
Social Prescribing in Shropshire	£2.29
Smoking in Pregnancy	£5

Context and Evidence Base

- **Closing the Care and Quality Gap** *"To narrow the gap between the best and the worst whilst raising the quality bar for everyone"*
- **Closing the Health Gap** *"We are living longer lives but we are not living healthier lives. The overwhelming majority of ill health and premature death in this country is due to diseases that could be prevented"*



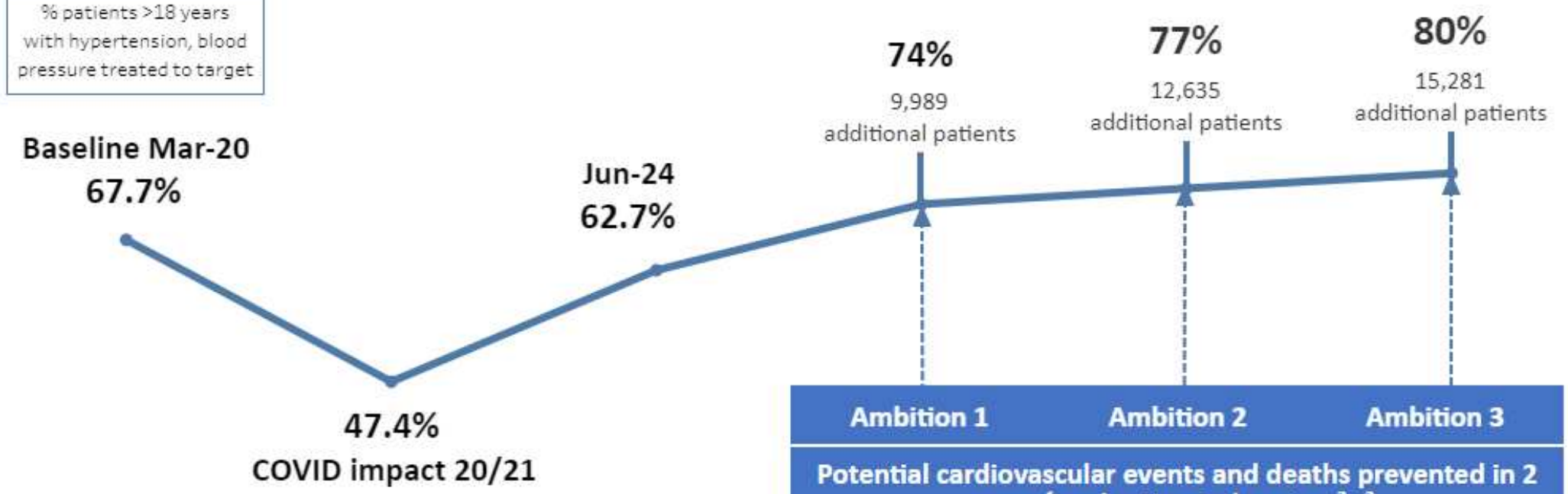
Focus on Prevention and preventing demand:

Extends Healthy Life Expectancy,
Reduces inequalities
Delays health and care service need

Size of the Prize- Shropshire and Telford and Wrekin
BP Optimisation to Prevent Heart Attacks and Strokes at Scale

UCLPartners Health Innovation

% patients >18 years with hypertension, blood pressure treated to target



Ambition 1	Ambition 2	Ambition 3
Potential cardiovascular events and deaths prevented in 2 years[1] and estimated savings[2] ,[3]		
60 heart attacks	76 heart attacks	92 heart attacks
£0.4M saved	£0.6M saved	£0.7M saved
89 strokes	113 strokes	137 strokes
£1.2M saved	£1.6M saved	£1.9M saved
48 deaths	61 deaths	73 deaths

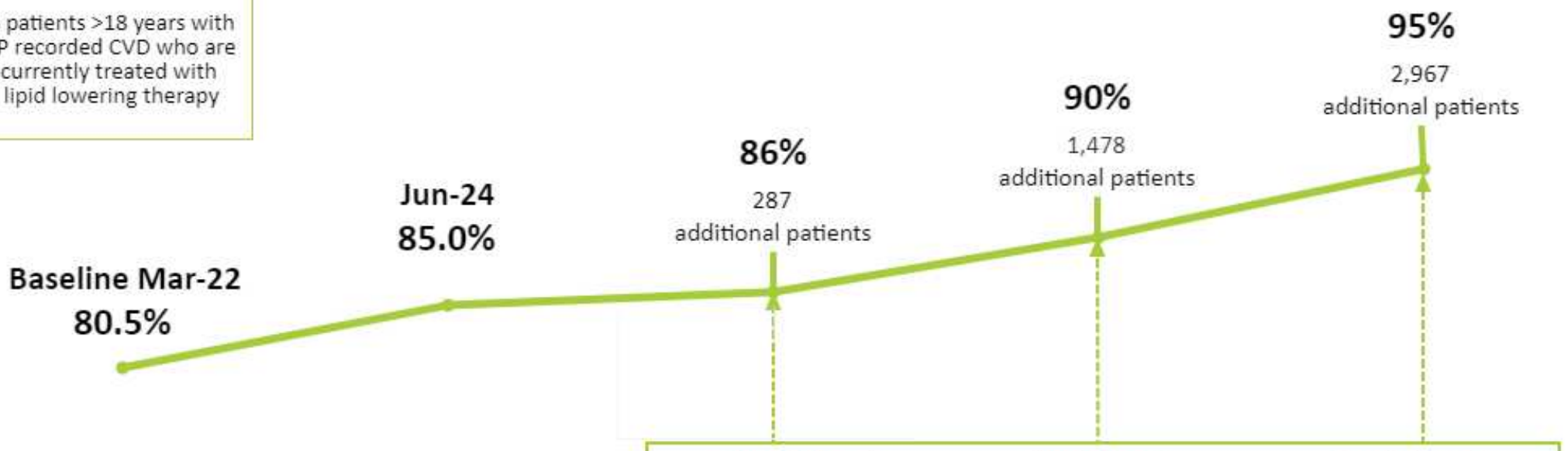
References
1.Public Health England and NHS England 2017 Size of the Prize
2.Royal College of Physicians (2016). Sentinel Stroke National Audit Programme. Cost and Cost-effectiveness analysis.
3.Kerr, M (2012). Chronic Kidney disease in England: The human and financial cost

Modelling
Data source: CVDPrevent. Briefing note: CVDPrevent online methodology annex v1 December 2022
Potential events calculated with NNT (theNNT.com). For blood pressure, anti-hypertensive medicines for five years to prevent death, heart attacks, and strokes: 1 in 100 for heart attack, 1 in 67 for stroke.

Size of the Prize- Shropshire, Telford and Wrekin ICB
Cholesterol Optimisation to Prevent Heart Attacks and Strokes at Scale

UCLPartners Health Innovation

% patients >18 years with GP recorded CVD who are currently treated with lipid lowering therapy



Ambition 1	Ambition 2	Ambition 3
Potential cardiovascular events and deaths prevented in 3 years[1,2,3]		
17 CV events	89 CV events	178 CV events
2 deaths	11 deaths	21 deaths

One hundred **strokes** = **£1,391,000** cost to the NHS
One hundred **strokes** = **£951,100** cost to social care*
One hundred **heart attacks** = **£746,600** cost to the NHS

References
1. Collin et al. (2016), Interpretation of the evidence for the efficacy and safety of statin therapy, *The Lancet*, 388, 2532-2561. DOI: https://doi.org/10.1016/S0140-6736(16)31357-5
2. Royal College of Physicians (2016). Sentinel Stroke National Audit Programme. Cost and Cost-effectiveness analysis.
3. Kerr, M (2012). Chronic Kidney disease in England: The human and financial cost

Modelling

Data source: CVDPrevent. Briefing note: CVDPrevent online methodology annex v1 December 2022

Potential events calculated with NNT (Collins, 2016). For patients with known CVD, lipid lowering medicines for five years to prevent cardiovascular events and death: 1 in 10 for cardiovascular events, 1 in 83 for mortality.
* Stroke costs to social care are given for the 1st year following stroke only.

ASH Ready Reckoner Summer 2024: Costs of smoking to society

ASH estimates that smoking costs Shropshire, Telford and Wrekin ICB £412M per year

12.4%

of adults in Shropshire, Telford and Wrekin ICB smoke, which is about 51.1K people.

Health (in white): £18.7M; 4.5%

Fires (in grey): £3.13M; 0.8%

IMPACT OF SMOKING ON PRODUCTIVITY

Smoking negatively affects earnings and employment prospects. The cumulative impact of these effects amounts to productivity losses of £234M.

HEALTHCARE COSTS DUE TO SMOKING

The combined cost of smoking-related medical treatment via hospital admissions and primary care services is £18.7M.

MORE STATISTICS ABOUT THE COST OF SMOKING

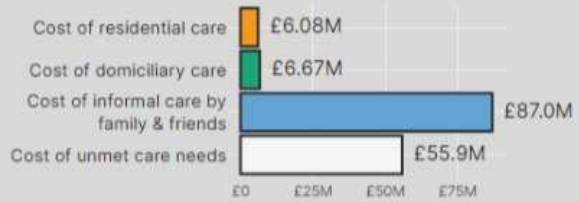
An estimated £124M is spent by consumers on purchasing tobacco (legal and illicit) annually in Shropshire, Telford and Wrekin ICB .

The national average spend on tobacco is around £2,486 per smoker.

The Green Book Quality-Adjusted Life Year (QALY) value applied to the intrinsic value of life gives an estimated loss of £319M due to premature deaths from smoking in Shropshire, Telford and Wrekin ICB . This figure is not included in any totals on this page.

SOCIAL CARE COSTS DUE TO SMOKING

Many current and former smokers require care in later life as the result of smoking-related illnesses. The estimated cost is £156M.

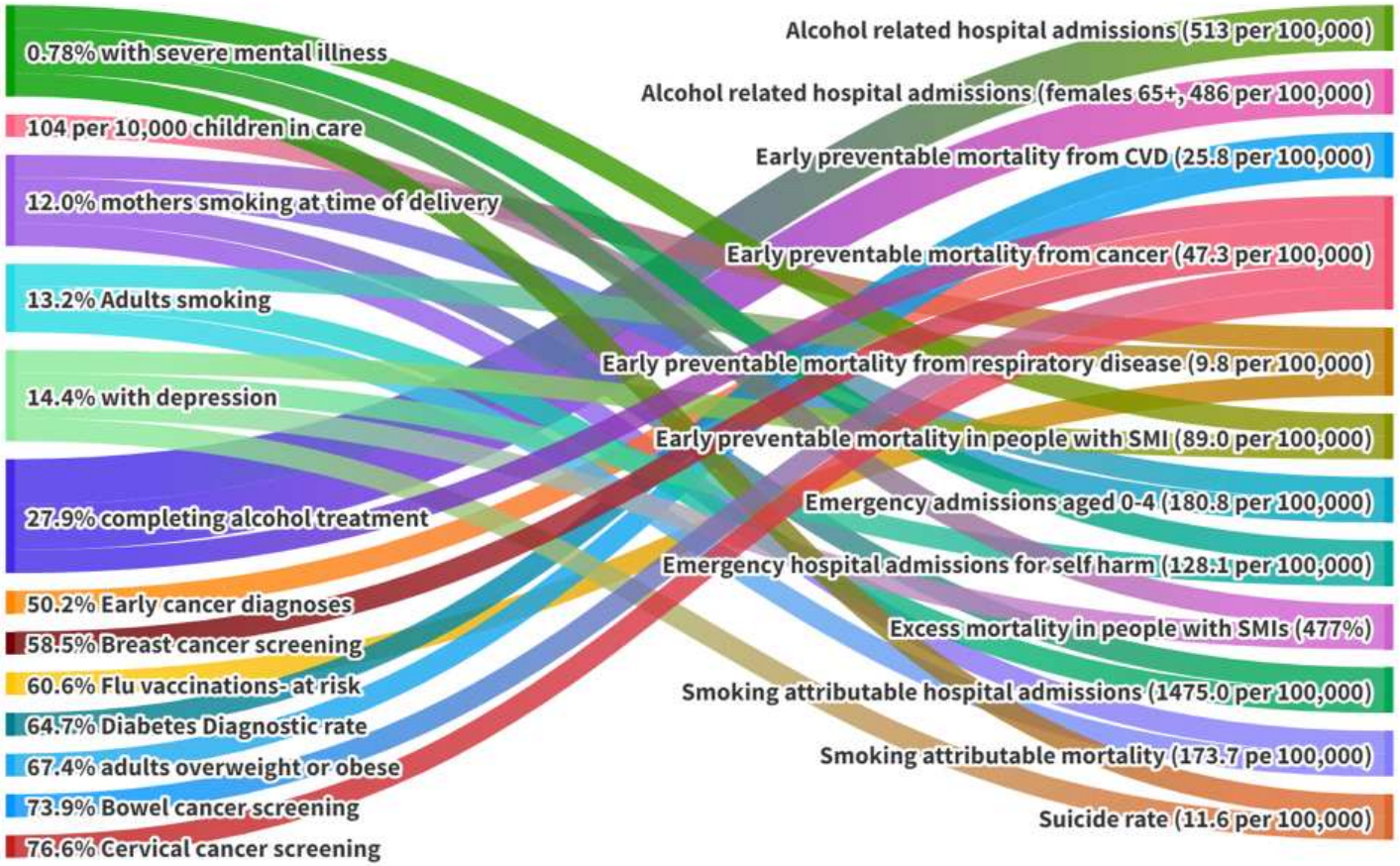


FIRE COSTS DUE TO SMOKING

Smoking materials are a major contributor to accidental fires. Smoking-related fires result in annual losses of £3.13M. About 19 Smoking-related fires are attended by the Fire and Rescue Service each year.

Revenue from cigarette and hand-rolled tobacco taxation (excluding VAT) only brings in about £64.1M per year

The chart below demonstrates that health behaviours lead to many adverse outcomes and put strain on health and care services.

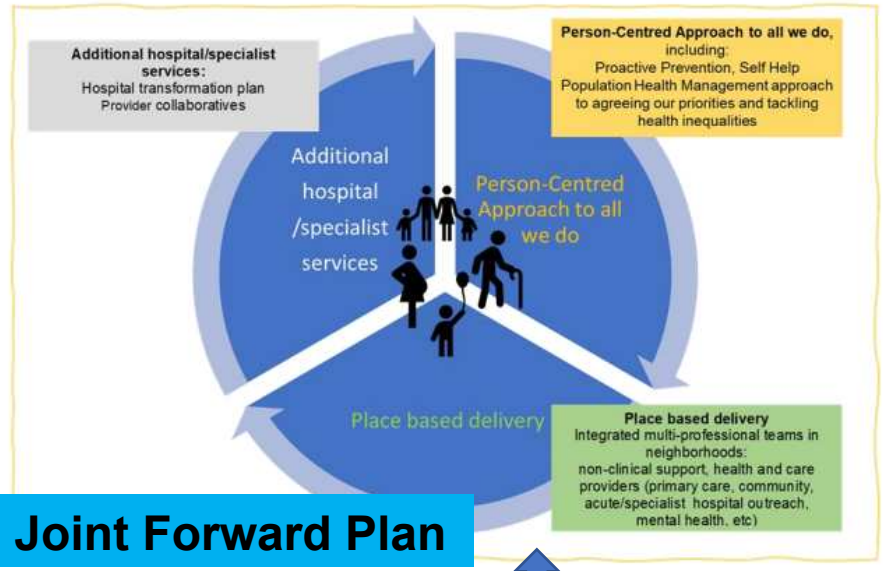


Click here to view the interactive version to view specific relationships.

Source: Flourish

Prevention as a Priority

System priorities and linkages across Boards



Joint Forward Plan

ICS Aims

- ✓Improve outcomes in population health and healthcare
- ✓Tackle inequalities in outcomes, experience and access
- ✓Enhance productivity and value for money
- ✓Help the NHS support broader social and economic development

Shropshire HWBB – Priorities

- Improving population Health
- Reduce inequalities
- Mental Health
- Workforce
- Working with and building strong and vibrant communities
- Joined up working
- Children & Young People (CYP) incl. Trauma Informed Approach
- Healthy weight and physical activity

Shropshire Plan

Healthy People
- Tackle inequalities
- Early intervention
- Partnerships
- Self-responsibility

Healthy Economy
- Skills and employment
- Safe, strong, and vibrant destination
- Connectivity and infrastructure
- Housing

Healthy Environment
- Climate change strategy and actions
- Safe communities
- Natural environment

Healthy Organisation
- Best workforce
- Absorb, adapt, anticipate
- Communicate well
- Align our resources
- Strong councillors

Shropshire Integrated Place Partnership (ShIPP) - Priorities

- Integrated response; tackling health inequalities
- Mental Health
- Workforce
- Building Community Capacity and Resilience
- One Public Estate
- Integrated Care and Support
- Children's and Young Peoples Strategy
- Prevention and Healthy Lifestyles
- Primary Care Networks
- Early access to advice and information

System Joint Commissioning Board

Shropshire Prevention Framework

- Access and One Shropshire
- Person Centred Care
- Communities
- Integration and One Shropshire

Delivery includes the development and implementation of community and family hubs

Prevention Matters:

Shropshire's Prevention Framework and System Action Plan

Working with and supporting people in Shropshire to live longer and healthier lives by taking a preventative approach to improving health and wellbeing outcomes.

Prevention Framework and Strategic context

One Shropshire supports the delivery of the Shropshire Plan , the STW Joint Forward Plan and the Joint Health and Wellbeing Strategy. It delivers the work through the Shropshire Integrated Place Partnership (SHIPP) by working collaboratively and integrating approaches to improve service delivery and population health. The recently agreed Prevention Framework provides more context and detail for how we will deliver our strategic plans. The Framework includes the following key priority areas:

- **Priority 1: Access and One Shropshire**
  Ensuring a well understood front door with access to information and advice, that focusses on self-care.

Developing a single directory, promoting physical activity to reduce isolation, workplace wellbeing and promoting a better built environment and outdoor spaces

- **Priority 2: Integration and One Shropshire**
  Enable communities and the voluntary and community sector to take more of central role in the development and delivery of prevention programmes, ensuring all age groups are at the centre of the implementation of the framework.

Bolster community activity and the VCSE Infrastructure to unleash the power of communities, health champions, build on business social responsibility, resource communities

- **Priority 3: Person Centred Care**
  Embed Person Centred Care and approach across all organisations and partners.

Embedding a trauma informed approach, ensuring a preventative approach across all pathways e.g cancer, early help transformation

- **Priority 4: Communities**
  Bolster the voluntary and community sector to work with partners across the system to support those in need.

Work with partners to use the data to proactively target early intervention and prevention, develop the culture and practice across the system to implement new ways of working to ensure everyone has responsibility for prevention

Our commitments

1. Proactively working with people of all ages, their families, and carers to improve wellbeing (eyes and ears on vulnerable people)
2. Ensuring that we take a person-centred approach, putting people at the centre of what we do
3. Work to develop a more comprehensive community-based prevention offer which includes universal, early help and targeted and specialist system services – One Shropshire
4. Work across service areas, integrating where possible, embracing partnership and collaborative working, creating a culture of working jointly across professions, organisations and teams for the benefit of our communities
5. Ensure evidence-based activity, population health data and other insight data (from services, locality JSNA, local consultations and the community) is used to inform planning and delivery; using data to find those most in need, focussing on inequalities
6. Adopting a test and learn approach, allowing projects time to evolve and deliver outcomes, embedding evaluation in all development programmes from the start

A community-centred approach to prevention and reducing demand on our care and support services

Strengthening communities

- Use of data and insight
- Place based projects (health inequalities and prevention)
- Live Well Hubs

Volunteer & peer roles

- Health Champions
- Feed the Birds (loneliness & isolation)
- Cancer Champions
- Blood Pressure Champions

Collaborations & partnerships

- Telford & Wrekin Integrated Place Partnership (TWIPP)
- Ageing Well Strategy
- All-age Carers Strategy
- Obesity Prevention
- Physical Activity

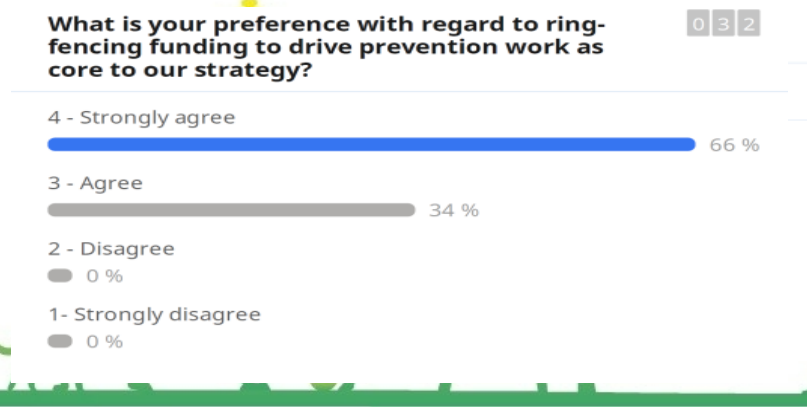
Connecting people to community resources & practical help

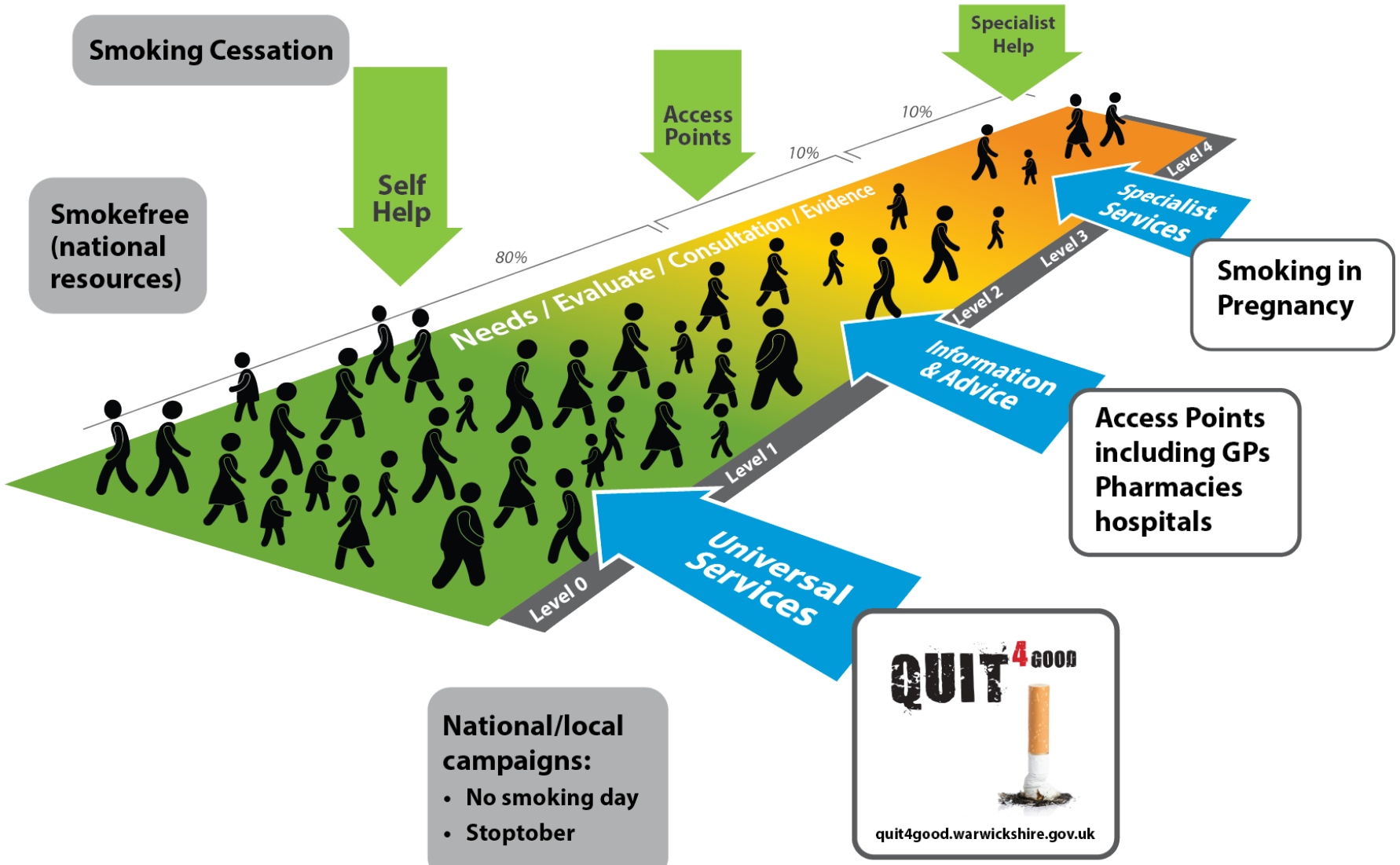
- Making Every Contact Count training / staff health & wellbeing
- Social Prescribing
- Healthy Lifestyles Services (Independent Living Centre & in the community
- Falls Prevention 'Moving On' classes
- Low level support for people leaving hospital

Opportunities

Opportunities :
Journey so far best practice

1. Strategic support for approach –ICP Strategy, HWBB Strategy, Partner Plans e.g. Shropshire Plan, West Mercia Police Prevention Strategy, Fire and Rescue, VCSE etc
2. Prevention Programmes
   - Public Health services: sexual health, drugs and alcohol, healthy lives team
   - Prevention Programmes Councils: Early Intervention (adults and children's), Let's Talk Local, Housing, Outdoor Activity and Green Spaces, Culture Leisure and Tourism
   - Childrens programmes: CHAST, Best Start, Test and Learn,
3. Working on pathways/integration within Council and NHS
   - MSK, falls, Mental Health, CVD, Trauma informed approaches, vaccination, screening
4. Health in all approach
5. Inequalities Plans
6. Targeted Shropshire Together Programme – Healthy Lives - Overall through the HWBB




Smoking Cessation
Smokefree (national resources)
Self Help
Access Points
Specialist Help
80%
10%
10%
Needs / Evaluate / Consultation / Evidence
Level 0
Level 1
Level 2
Level 3
Level 4
Universal Services
Information & Advice
Specialist Services
Smoking in Pregnancy
Access Points including GPs Pharmacies hospitals
National/local campaigns:
• No smoking day
• Stoptober
QUIT 4 GOOD
quit4good.warwickshire.gov.uk

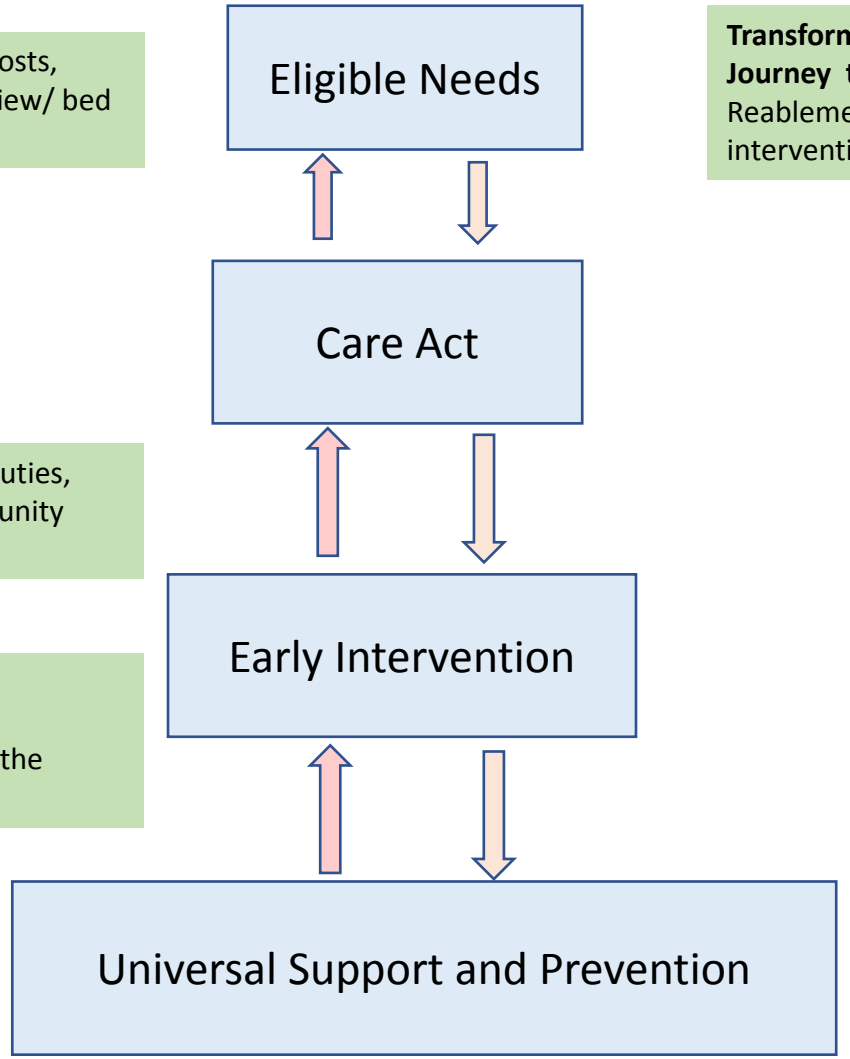
Adults - Transformation Projects to manage Demand

Commissioning: Care at Home / Market Shaping & Managing costs, complex care/ brokerage/ Technology VCD/supported living review/ bed hub/brokering for health/VCS support

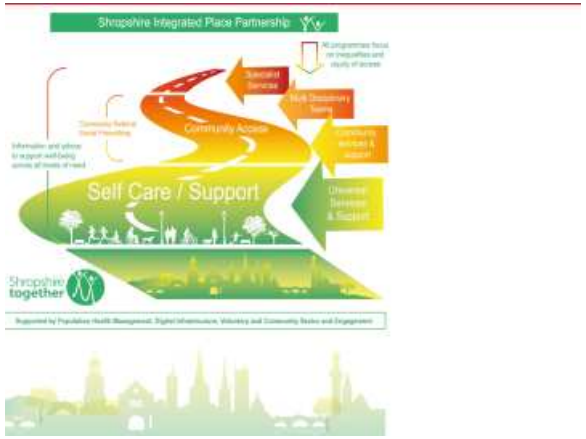
Assessment and Review - Strength Based Care Act statutory Duties, Support planning, Safeguarding Adults; utilising existing community assets

Reablement - Community and Hospital pathways. Optimising independence. Managing demand from hospitals.
Length of stay improved and increase of people going through the service.

Prevention - Public Health, One Shropshire, Neighbourhoods. Directory of services, community hubs and assets



Transformation required at ALL key points of the customer Journey to reduce the demand; Remodel the Front Door, Reablement Transformation and Care at Home to ensure early intervention and supporting needs at home in innovative ways



Front Door – FPOC Information, Advice & Signposting. Community Assets to support low level needs; Financial assessment online portal.

ASC Innovation week following 'Perfect day' trial. Impact 96 people of the waiting list through social prescribing, community support virtual care delivery.

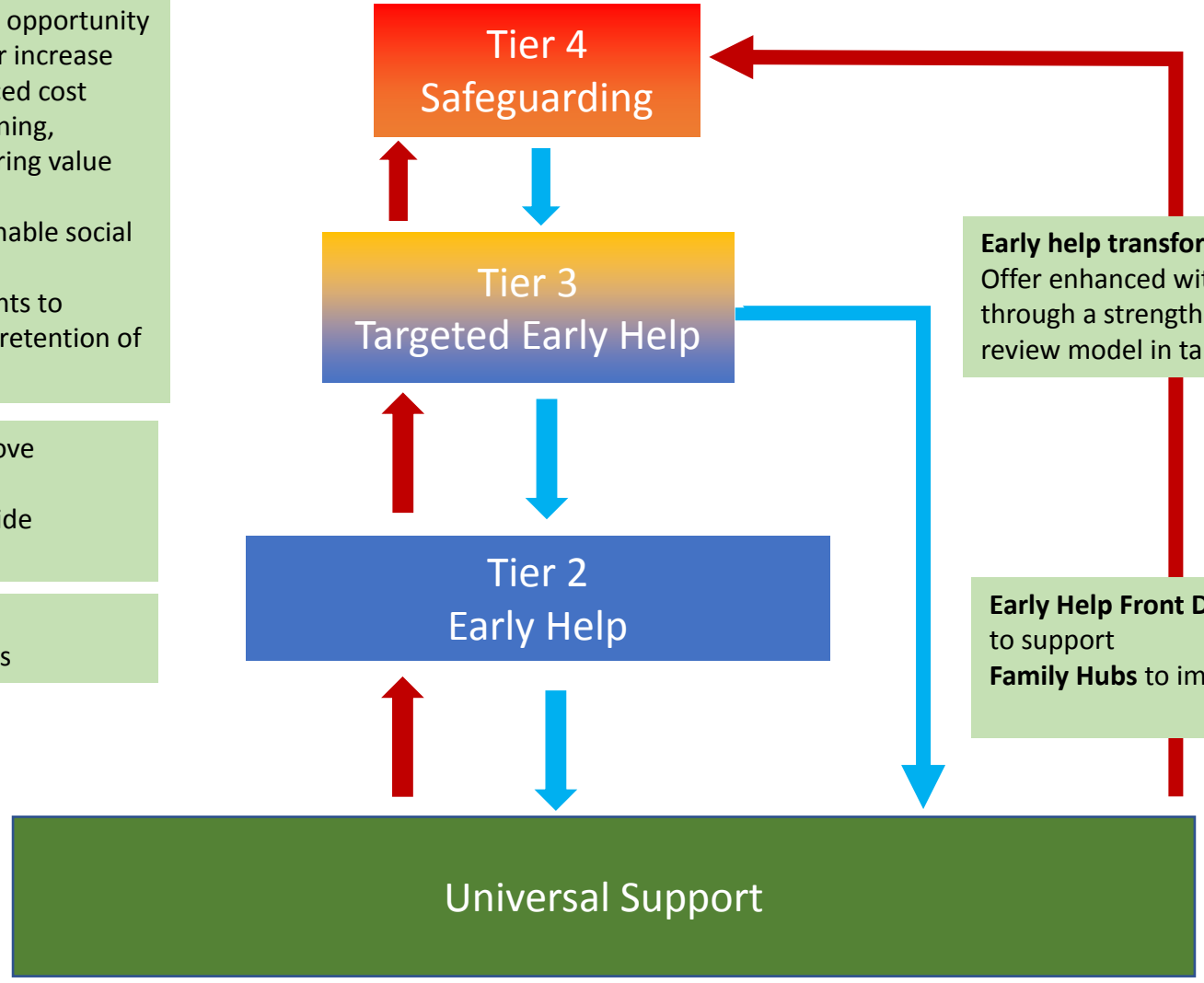
Children's Transformation – Projects to manage Demand

Stepping Stones to support step out of Tier 4 at earliest opportunity
Fostering recruitment and **residential growth** to further increase internal sufficiency to provide better outcomes at reduced cost
Commissioning project will ensure effective commissioning, brokerage, contract management of placements – ensuring value for money
Business support to review processes and systems to enable social work to be undertaken
Social care Recruitment project will look at improvements to recruitment process alongside HR, as well as improving retention of social work staff.

Early Help strategy to better target resources and improve understanding
Strengthening the Early Help Partnership - Systems Guide
Supporting Families -outcomes

Learning and Development Transformation to improve safeguarding language, thresholds and referral pathways

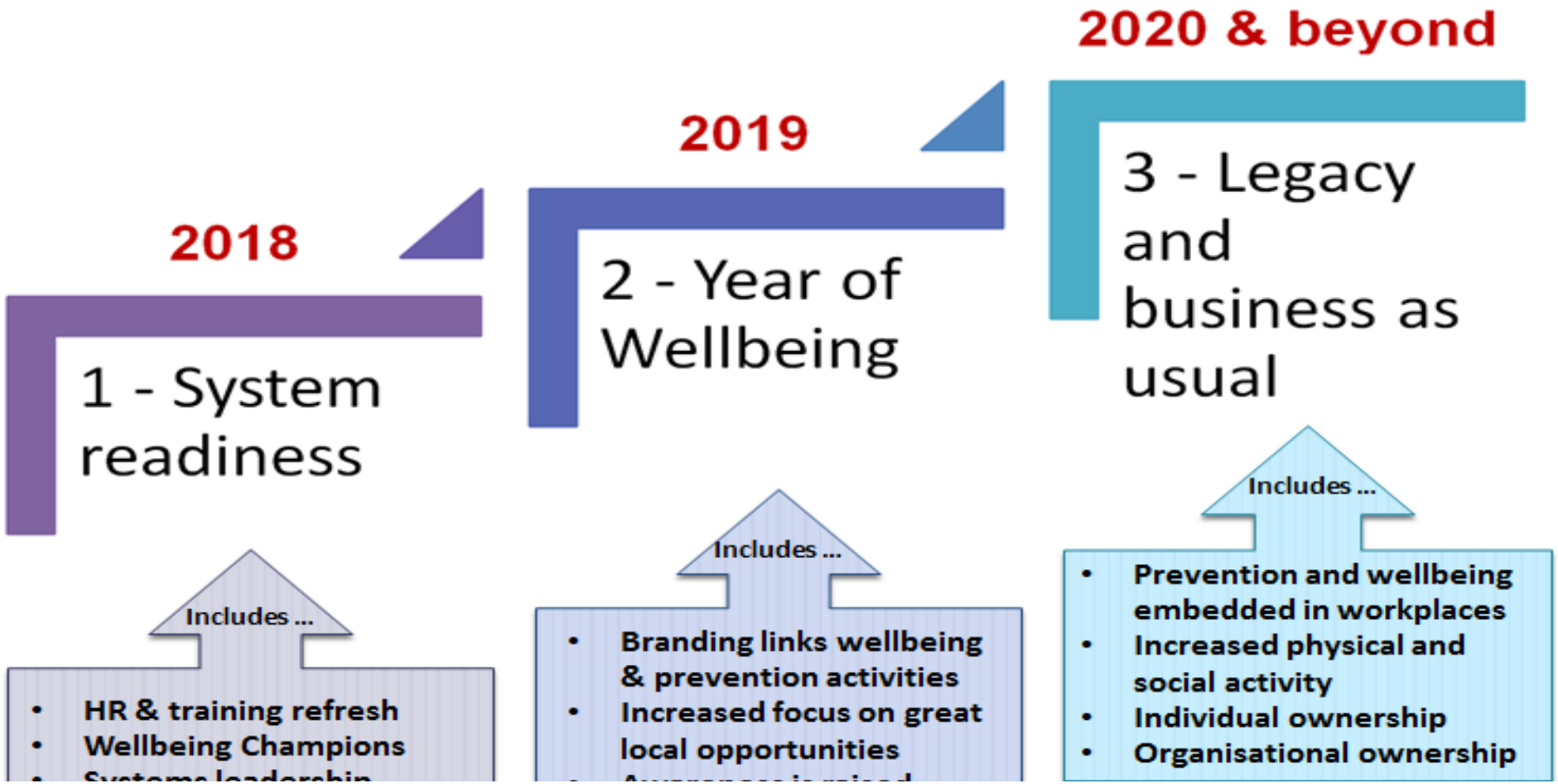
Community & Family Hubs which include Health visitor and Early Help drop ins
Integrated Practitioner Teams



Early help transformation - Targeted Offer enhanced with improved practice through a strengthened Assess, Plan, Do, review model in targeted early help

Early Help Front Door – EHAST to improve pathways to support
Family Hubs to improve pathways to support

Three-stage approach to embedding prevention



Case Study A public health approach to CVD

Avoidable deaths from cardiovascular disease were identified as increasing in a population the north of the County using evidence and insight identified through the JSNA.
Further analysis demonstrated the pockets of poorer outcomes, particularly in younger women, in some more rural wards and in particular ethnic minorities.

Work had already begun around ambulatory care and rehabilitation as part of the heart failure pathway, and a community echo pilot, also a review of stroke services was planned. However, the challenge was that these were happening in isolation at a clinical pathway level not collectively looking at cross cutting issues and bottom up from a community/population perspective where the solutions were multiple.
A public health approach was adopted to improving outcomes and reduce avoidable deaths focusing on both improving universal services and the defined population groups with the greatest need to reduce the health inequalities identified. It included end to end pathway action to prevent/reduce the occurrence of ill health, action to deliver appropriate health and care services and action on the wider determinants of health. It required working with communities and across partner agencies including the VCS and communities; including a prevention campaigns to cardiac rehab and defibrators .

The benefits of the **public health rather than only a more clinical approach alone are** a system end to end pathway view and action, integration of services, proactive/preventative. During the following 3 years rates fell by 20% during the period of intensive focus and action. This became the standard practice for addressing key pathways moving forward.

Telford & Wrekin Co-operative Council
Shropshire Council
Integrated Care System
Shropshire, Telford and Wrekin

Our local care neighbourhood approach will cultivate thriving communities by focusing on collaboration, proactive healthcare, and holistic support

Our aims are to:

Improve outcomes for children, young people, and families.

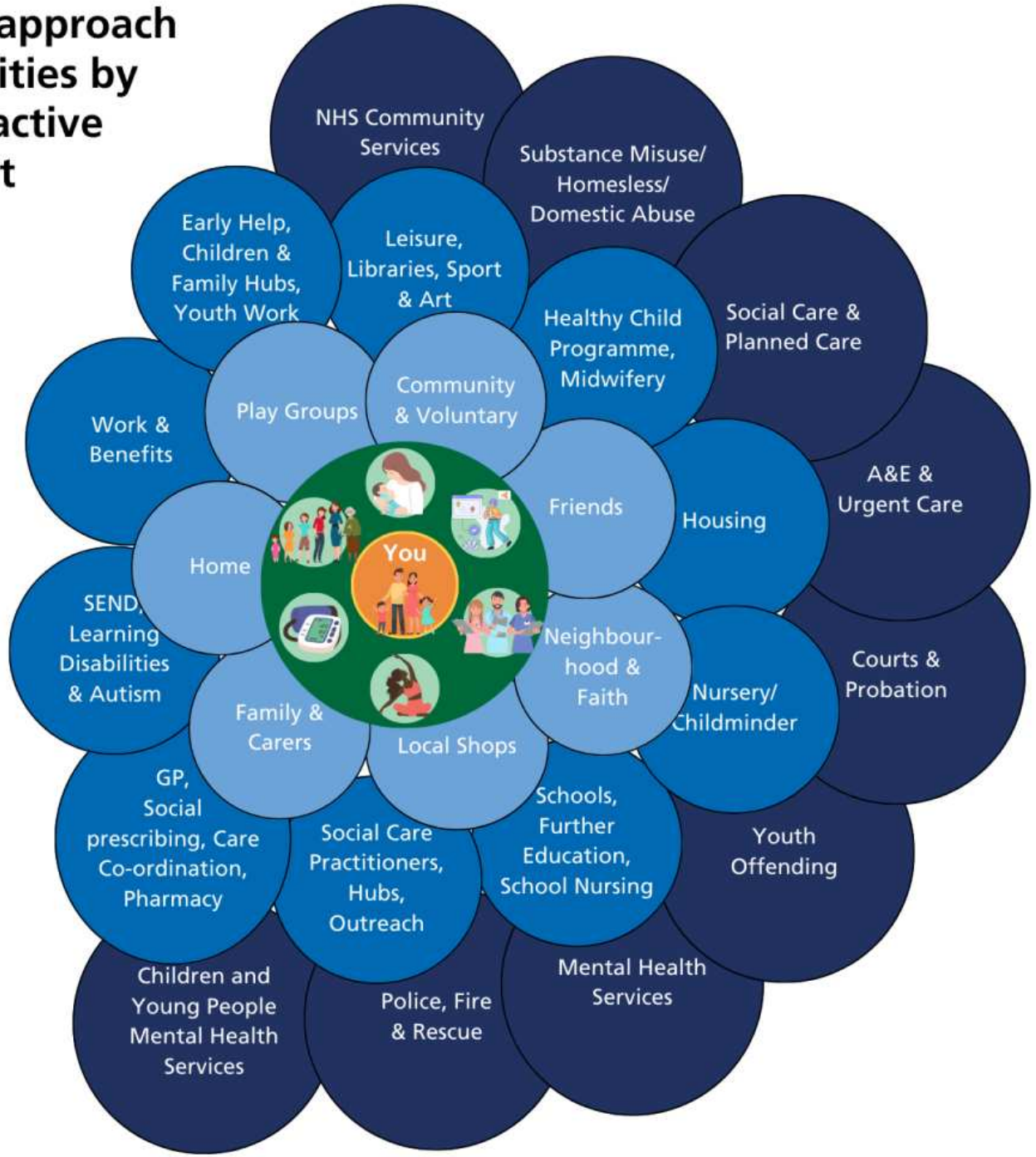
Promote early diagnosis and prevent avoidable illnesses in the first place.

Support people of all ages with self-care and managing long term conditions.

Implement person-centred multidisciplinary care approaches.

Achieve a greater emphasis and use of social prescribing.

Ensure people can access the right help, at the right time, in the right place within the local community.



Next Steps

Next steps

1. Take a public health approach/population health including prevention to the development/revision of strategies. E.g.
   - Frailty
   - Diabetes
   - ….CVD

2. Continue to develop and explore a systemwide framework approach to prevention through the prevention and inequalities group

3. Map current prevention investment (across all types of intervention) to track the left shift

4. Track the Return on Investment for Prevention in STW

Telford & Wrekin Co-operative Council

Shropshire Council

Integrated Care System
Shropshire, Telford and Wrekin

Integrated Care System

Shropshire, Telford and Wrekin

Prevention Framework and Priorities (Draft V1.0)

February 2025

Prevention as a Priority

- Prevention and the shift to prevention has been a consistent theme in the Strategic Direction across STW
- At the October 2025 ICP meeting – the Partnership agreed to :
  - Take a public health approach/population health including prevention to the development/revision of strategies such as CVD, frailty, cancer
  - Continue to develop and explore a systemwide framework approach to prevention through the prevention and inequalities group
  - Map current prevention investment (across all types of intervention) to track the left shift to increase investment and the commitment to prevention across the system (as outlined in the ICP Strategy.
  - Track the Return on Investment for Prevention in STW
- This aligns to the NHS shift to prevention. Sharing the draft framework today

Integrated Care Strategy Commitment & Priorities

Population Health Priorities

- Best start in life
- Healthy weight
- Mental wellbeing & Mental Health
- Reducing impact of drugs, alcohol and domestic abuse

Health Inequalities priorities

- Wider determinants:
  - homelessness
  - cost of living
- Inequity of access to preventative health care:
  - cancer
  - heart disease
  - diabetes
  - Health Checks for SMI & LDA
  - vaccinations
  - preventative maternity care

Healthcare priorities

- Person –centred integrated within communities
- Best start to end of life (life course)
- Mental, physical and social needs supported holistically
- People empowered to live well in their communities
- Primary care access
- Urgent and Emergency care access
- Orthopaedics

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

What is prevention and how can services support this?

People being as healthy and well as possible at all stages of life; all services can help with this

Tertiary Prevention

Specialist Services

Maximises wellbeing and resilience, reducing dependency on services for those with more specialised/complex health and care needs.

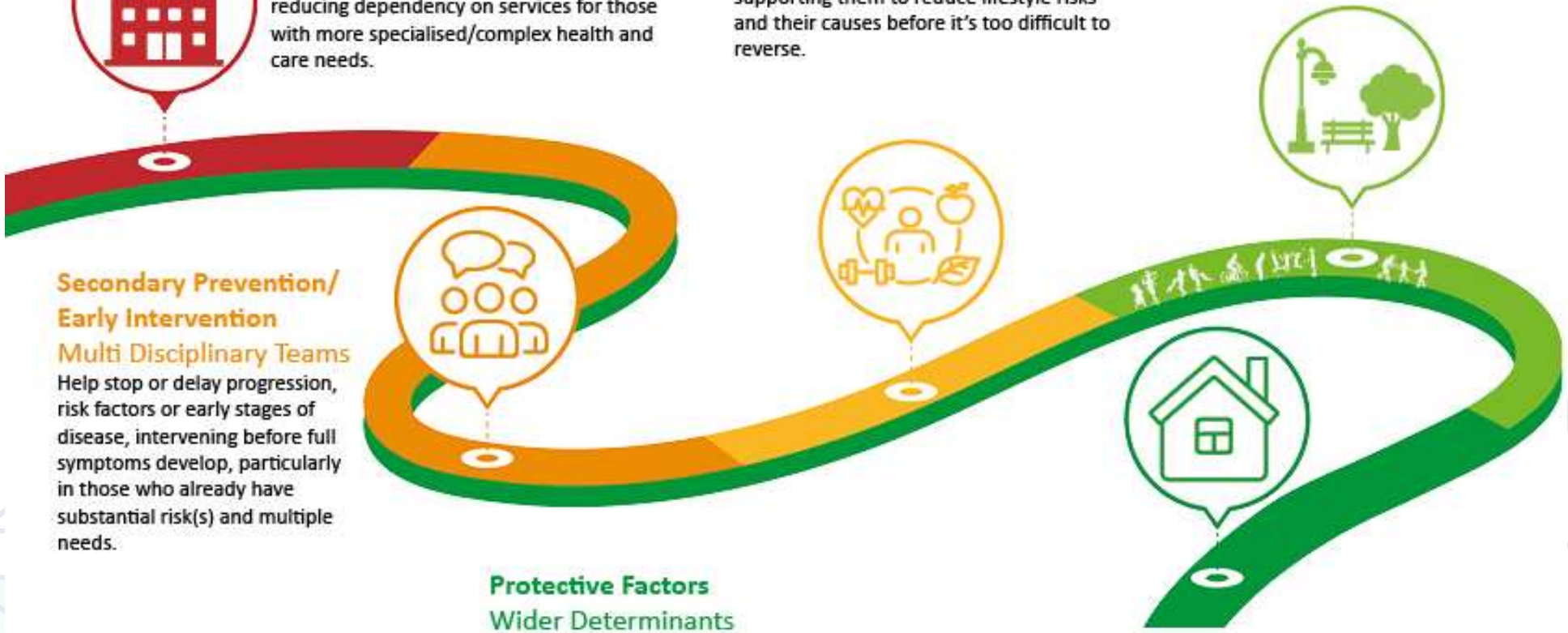
Primary Intervention - Pre Risk/At Risk

Community Services and Support

Identifying and targeting people at risk and supporting them to reduce lifestyle risks and their causes before it's too difficult to reverse.

Universal Services

Active across the population to prevent or delay risk, maintaining health; not demand management.



Secondary Prevention/ Early Intervention

Multi Disciplinary Teams

Help stop or delay progression, risk factors or early stages of disease, intervening before full symptoms develop, particularly in those who already have substantial risk(s) and multiple needs.

Protective Factors

Wider Determinants

Support at all levels of need and includes access to good housing, education, outdoor spaces, social prescribing and the voluntary and community sector (VCSE).

Our Vision

Focus on developing strong communities where we can reduce inequalities, build the resilience of vulnerable people and families, and concentrate on driving system change so that every area has joined up, efficient local services which are able to identify people and families in need and provide the right support at the right time.

STW Prevention Priorities - System Summary FOR DISCUSSION

Prevention is about helping children, young people and adults stay healthy, happy and independent for as long as possible - reducing the chances of problems from arising in the first place and, when they do, supporting people to manage them as effectively as possible - Prevent - Protect – Reduce - Delay

1. **Ensure residents can accessible information, advice, and support on healthy lifestyles and self-care**
   - Expansion of community prevention Healthy Lifestyles, community and workplace health checks and social prescribing offer – smoking, healthy weight etc
   - Further develop community support for emotional wellbeing and mental health, including social prescribing
   - Best Start in life – healthy pregnancy, women's hubs, oral health promotion etc.
2. **Enable and develop strong integrated neighbourhoods including development of community hubs and spokes**
   - Enable communities and the voluntary and community sector to take more of central role in place-based prevention programmes
   - Bolster community and VCSE Infrastructure to unleash the power of communities, health champions and volunteers, business social responsibility, resource communities
   - Integrated community hubs, including family hubs
3. **Embed Person Centred Care and approach across all organisations and partners**
   - Develop and train front line workforce to ensure MECC – communities, primary and secondary care
   - Expand social prescribing support and tackle inequalities in access and provision
4. **Comprehensive delivery of NHS prevention programmes (with effective targeting of inequalities core20plus5 programmes)**
   - Development of Alcohol Care Team and Tobacco dependency teams (maternity, inpatients, SMI), NHS weight management
   - National screening & immunisation programmes
   - Annual health checks for people with learning disabilities, physical health checks for those with SMI
5. **Focus prevention activities to reduce inequalities, working across the system to support those in need**
   - Intelligence-led targeting of the "core 20" and "plus" populations in NHS prevention programmes (see above)
   - Develop Health literacy programme, including training and awareness raising for staff, linked to the digital exclusion agenda
   - Improve access to NHS dentistry and early access to maternity
6. **Early detection and treatment for Long Term Conditions priorities**
   - Community Blood pressure checks, NHS Health Check, targeted lung health checks, early detection of cancer
   - Improving GP management of long term conditions e.g. diabetes care processes etc.

STW Prevention Priorities - System Summary FOR DISCUSSION

Accessible information, advice, and support on healthy lifestyles and self-care	Integrated neighbourhoods including community hubs	Person Centred Care across all organisations and partners
Healthy Lifestyles, community and workplace health checks and social prescribing offer, health champions – smoking, healthy weight etc	Enable communities and the VCSE to take more of central role in place-based prevention programmes	Develop and train front line workforce to ensure MECC – communities, primary and secondary care
Develop community support for emotional wellbeing and mental health, including social prescribing	Bolster community and VCSE infrastructure, including volunteering programmes	Expand social prescribing support and tackle inequalities in access and provision
Best Start in life – healthy pregnancy, women's hubs, oral health promotion etc.	Integrated community hubs, including family hubs	

Comprehensive delivery of NHS prevention programmes (with effective inequalities targeting)	Focus prevention activities to reduce inequalities, working across the system to support those in need	Early detection and treatment for Long Term Conditions priorities (with effective inequalities targeting)
Development of Alcohol Care Team and Tobacco dependency teams (maternity, inpatients, SMI), NHS weight management	Intelligence-led targeting of the "core 20" and "plus" populations in NHS prevention programmes (see above)	Community Blood pressure checks, NHS Health Check, targeted lung health checks, early detection of cancer
National screening & immunisation programmes	Develop Health literacy programme, including training and awareness raising for staff, linked to the digital exclusion agenda	Improving GP management of long term conditions e.g. diabetes care processes etc.
Annual health checks for people with learning disabilities, physical health checks for those with SMI	Improve access to NHS dentistry and early access to maternity	

Prevention Metrics

Overall track the increase in the proportion of System Budget Allocated to Prevention Activities ~ (Primary, Secondary and Tertiary)

1. We will increase the number of people who successfully stop smoking with a particular focus on smoking in pregnancy, manual workers and people with learning disabilities and mental illness.
2. We will decrease the number of people drinking to harmful and hazardous levels by improved identification and access to brief interventions and treatment, support and recovery
3. We will improve the identification and management of hypertension optimising clinical and non-clinical prevention treatment pathways. We will aim to increase the number of people identified with hypertension (BP>140/90) and the percentage of these who are treated to target.
4. We will improve respiratory outcomes by increasing uptake of flu vaccination with a particular focus on older people and adults with a pre-existing health conditions.
5. We will prioritise access to and quality of LDA and SMI Health-checks.
6. We will accelerate plans to tackle adverse infant outcomes by focusing on women with existing health conditions ensuring that there is good access to pre-conception advice and early booking.
7. We will accelerate the take up of all childhood immunisations including MMR
8. We will take steps to improve the oral health of children by maximising public health interventions and access to NHS dentistry
9. We will review our systems approach to child and adult obesity including community level interventions, NHS programmes and new pharmaceutical interventions
10. We will improve early diagnosis of cancer; we will commission a deep dive on local cancer screening uptake and performance as well as reviewing diagnosis with symptoms. This will set system baselines prior to any delegation of screening responsibilities
11. We will ensure early help for those with mental health conditions by improving access to talking therapies and CYP tier1 and 2 services.
12. We will reduce drug related death by optimising access to and benefit from treatment and recovery

Agenda Item

ICB 30-04.160

Shropshire, Telford and Wrekin System Accountability and Performance Framework

Appendix 1. System Accountability and Performance Framework v5 final

Appendix 2. Recovery Plan template Jan 2025

Integrated Care System
Shropshire, Telford and Wrekin

NHS
Shropshire, Telford and Wrekin

System NHS Accountability and Performance Framework – Final Draft

April 2025

Section 1: Overview

Purpose of document

The purpose of the Accountability and Performance Framework is to provide a governance structure across the Shropshire Telford & Wrekin system to ensure successful delivery of operational plans, national standards and effective reporting of improvement where recovery is required. It will be an integrated model that takes account of individual organisational accountability and performance governance but ensures delivery across the whole system. This framework is a key deliverable (4.2) for the System Integrated Improvement Plan agreed at the ICB in November 24.

The document outlines the respective ambitions across the following areas:

- Creating a mutual accountability culture
- Creating an integrated performance framework
- Regular reporting that is standardised and uses individual organisational reporting as much as possible
- Creating a consistent tiered approach to performance improvement and assurance
- System and NHSE Tier 1 / NHSE interface

Introduction

- The System's Accountability & Performance Framework (SAPF), System Board Assurance Framework (SBAF) and other wider governance arrangements when combined, are integral to the System's governance framework. The Framework is designed to enable a full and comprehensive oversight of the implementation of strategic and operational plans, including the delivery of programme (e.g. UEC or Elective), quality and financial improvement plans as required.

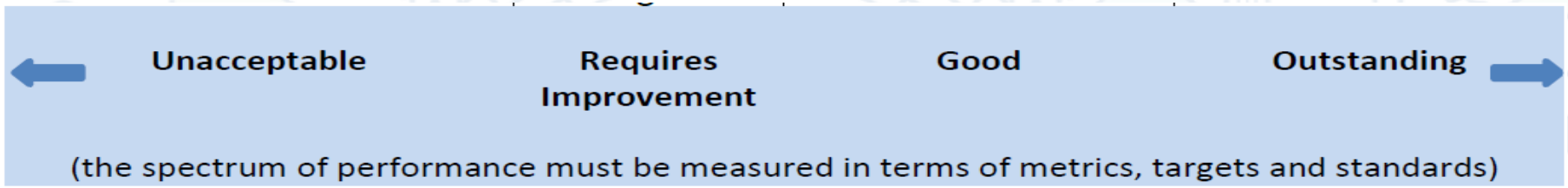
- The SAPF aims to foster a culture of individual responsibility and mutual accountability at all levels in the System and helps Boards, Directorates and Teams understand the roles they play in successful delivery of the System and Trust's objectives. The SAPF specifies the structure, systems and processes used to embed a performance management culture in all partners and identifies the responsibilities for performance management at both Trust and combined System level.

- A devolved mutual accountability structure is the objective for the system, with this managed via the SAPF. The underlying principles of this Framework are to ensure the delivery of individual Trust's strategies and corporate objectives are managed in a systematic way as fundamental components of the system wide strategies, operational plans and national standards.

The Performance Spectrum

- The spectrum of performance stretches from unacceptable at one extreme, to outstanding performance at the other, as illustrated:

Breach of requirements and/or multiple KPI targets across multiple domains	Non-compliance of requirements, not meeting several KPI targets, selected improvement standards or failure to meet improvement targets	Compliance with requirements, adoption of improvement standards and performance against KPI targets	Exceeding KPI targets, benchmarking and continued improvement



Creating a System Performance Culture

Overview

The System needs to promote an integrated performance culture that actively supports continuous improvement and can demonstrate grip and control of its overall performance and delivery.

Achieving a performance improvement culture

Level	Description	Impact
1	Disparate, uncoordinated approach	Duplicate effort, time consuming, difficult to consolidate, lack of trust in information.
2	Systematic performance measurement	Key performance information collected, efficient reporting of performance information
3	Effective performance reporting	A joined-up set of strategies/plans/objectives, clear objectives communicated and understood throughout the ICB, clear accountability established
4	Performance Management	Ownership is devolved, objectives are better understood, decisions are based on evidence, information is used to drive change and actions
5	Performance Improvement culture	Continuous improvement, employees empowered to utilise performance to drive change, plans reflect organisational capability, all plans linked to System vision/values/objectives

This can be used to assess where we are both as individual organisations and as a system (we may be at multiple levels within an organisation or across the system for different programme areas)

Objectives of the Performance & Accountability Framework

The SAPF sets out the systems and processes through which the system will support organisations / teams and manage the delivery of our strategic and operational goals, as well as ensuring that the regulatory and statutory requirements that apply to the system and its Trusts are met (including those outlined in the NHS Constitution).

The SAPF drives the implementation of best practice performance assurance processes throughout the system, aligned to organisational and IC Board committees, ensuring that:

- Accountability arrangements are in place across the system and individual Trusts to drive the delivery of all agreed objectives, targets, and standards. Performance is seen as a continuous process which is embedded in all aspects of organisational activity.
- Agreed performance objectives and targets are Specific, Measurable, Agreed, Realistic and Time bound (SMART) and transparent measurements are set to monitor performance.
- Timely information is available to enable appropriate understanding, monitoring, and assessing of the System and individual Trust's quality and performance, prompting appropriate action to be taken if performance is forecast to fall below set objectives and targets at both organisation and system level as required.
- All system partners and their respective Committees understand their roles and responsibilities and are supported and motivated to deliver, with a clear line of sight between their contributions and the overall success of the Trust and wider system.
- Action plans are developed as soon as risks to the achievement of required targets or standards and/or barriers to effective performance are identified within individual trusts and then, if necessary, aggregated by the ICB where system performance is affected.

Key Performance Management Principles

The following key management principles underpin this framework:

- **Focused on improvement** - All organisations, teams and staff members are encouraged to embrace a culture of continuous performance improvement and to speak up with suggestions and concerns. Initial interventions will focus on recovery to sustain improvement and will include actions to address the root causes of issues.
- **Transparent** – Clear and pre-determined performance measures and interventions. Organisations, teams and individuals will understand how performance is being assessed and what to expect if performance falls below acceptable levels.
- **Consistent** - Clear accountabilities through a uniform approach across the system, at different levels of the system and individual organisations will ensure that all parties are clear of where accountabilities lie.
- **Proactive** - Delivery focused on improved performance through an integrated and action-oriented approach, with thresholds for intervention that identify underperformance at an early stage so that it can be swiftly addressed.
- **Proportionate** - Performance management interventions and action are related to the scale of risk and maintains an appropriate balance between challenge and support.

Section 2: Responsibilities

System Wide Performance Management Matrix of Accountabilities & Responsibilities

To deliver the SAPF a stepped approach to performance management is required which clearly specifies roles, accountabilities, and responsibilities. It is essential that key targets, programmes, projects, and actions are disaggregated throughout the System and within Trusts and hierarchy to ensure delivery of targets at every level and across the system / organisation as a whole; to understand what is expected of them and the part they play in the overall success of the system and Trust.

	System	ICB	SaTH	RJAH	SCHT
Oversight	Integrated Care Board	Integrated Care Board	SaTH Board	RJAH Board	SCHT Board
Assurance Sub-Committee	System Quality & Performance Committee	Quality & Performance Committee /Finance Committee	Performance Assurance Committee / Finance Committee	Finance & Performance Committee	Resource & Performance Committee
Management Escalation	System Transformation Group	NHS STW Exec Team	Trust Exec Team	Trust Exec Team	Trust Exec Team
Management Delivery	Programme Delivery Groups	Senior Leadership Team	Divisional Performance Review Meetings	Directorate Performance Meetings	Directorate Performance Meetings

Organisational reporting

System reporting

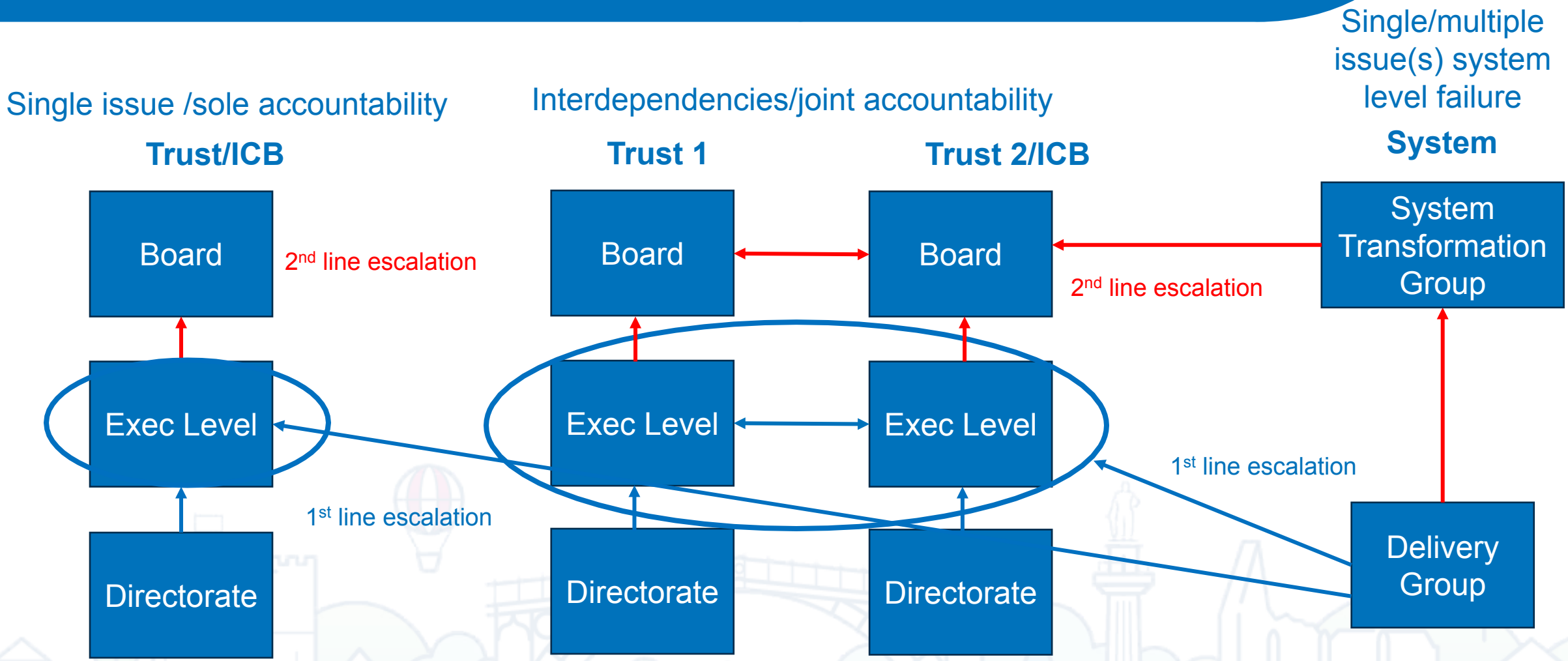
Trust / System Responsibilities & Accountabilities

- Individual Organisations failing one operational /national or more metrics – would have the responsibility for development of respective improvement plan(s) and recovery trajectory(ies) – these are already be required by internal provider Performance Management Framework (PMF).
- Individual Organisations have responsibility for delivering the recovery where it is solely within their gift to do so – monitored where appropriate via Contract Review Meetings
- If an Organisation can't recover alone then this should be raised via the appropriate Programme Delivery Group and System Planning & Performance leads can work with respective stakeholders to develop system performance improvement plans (SPIPs)
- SPIPs will be monitored via Delivery Groups and assurance provided by these groups to the ICB Quality & Performance Committee.
- Individual provider elements of any SPIP should also be tracked through the providers own PMF.

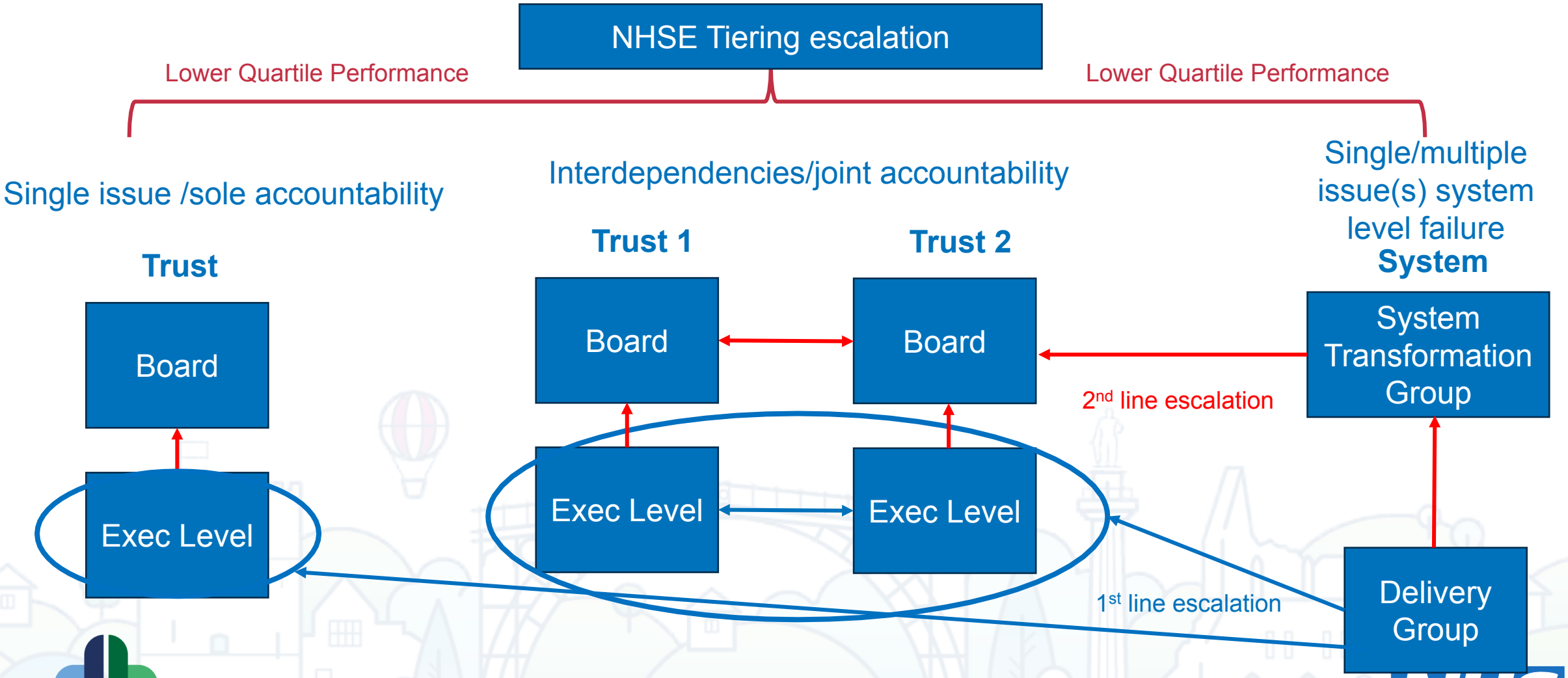
Trust / System Responsibilities & Accountabilities Cont..

- Recovery of performance should be overseen at individual Trust level ultimately by their own Board and Performance Sub Committee
- Where wider system performance is affected, the recovery should be overseen by the respective Programme Delivery Group
- Delivery Groups can escalate any concerns regarding individual organisational delivery to that org directly via the exec team (next slide). If there is multiple organisational failure the Delivery Group can escalate those concerns to all the necessary parties.
- Delivery Groups are responsible for identifying interdependencies within performance/plan delivery. They are best placed to oversee the collective delivery particularly if failure in one part of the system is as a result of action within another part.
- If the Delivery Group is unable to resolve issues of non-delivery directly then this would be escalated to the System Transformation Group.

Trust/System – Performance Delivery Responsibilities and Accountabilities - Schematic



Trust/System – NHSE Tier 1-2 Performance Delivery Responsibilities and Accountabilities - Schematic



Regular System Performance Reporting

What regular system performance reports do we produce:

Report	Frequency	Audience	Purpose	SRO
Integrated Performance Report	Bi-monthly	ICB Board	To provide performance updates to the board to give assurance, highlight areas for concerns and outline mitigating actions	Director of Planning and Performance
QPC report	Monthly	Quality and Performance Committee	To provide performance and quality updates to the committee to give assurance, highlight areas for concerns and outline mitigating actions	Head of Planning & Performance
Delivery group reports – system level	Monthly	Delivery group	To provide performance updates to the delivery group on KPIs to highlight areas for concern and seek assurance regarding mitigating actions in the form of plan on a page (see Appendix i) Provide standard reporting across delivery groups. Use standard performance improvement planning process.	Planning and Performance Leads
Delivery group reports – provider level	Monthly	Delivery Group	To provide assurance using standard plan on a page (See Appendix i) that either performance is being achieved or if not is in recovery and that is on track or to escalate risks and issues preventing recovery.	COOs
Tier one reporting	Weekly/ Monthly	NHSE	To provide updates against recovery trajectories for at risk KPIs	COOs

If we use a common performance update template across the system – it would allow for streamlined/consistent reporting as these could be used both within organisations and to report through to system delivery groups, then where necessary easily aggregated to give a system wide position – suggested template in Appendix i. The only exception would be Tier 1 reporting where NHSE dictate the format for each respective programme area.

Performance Improvement

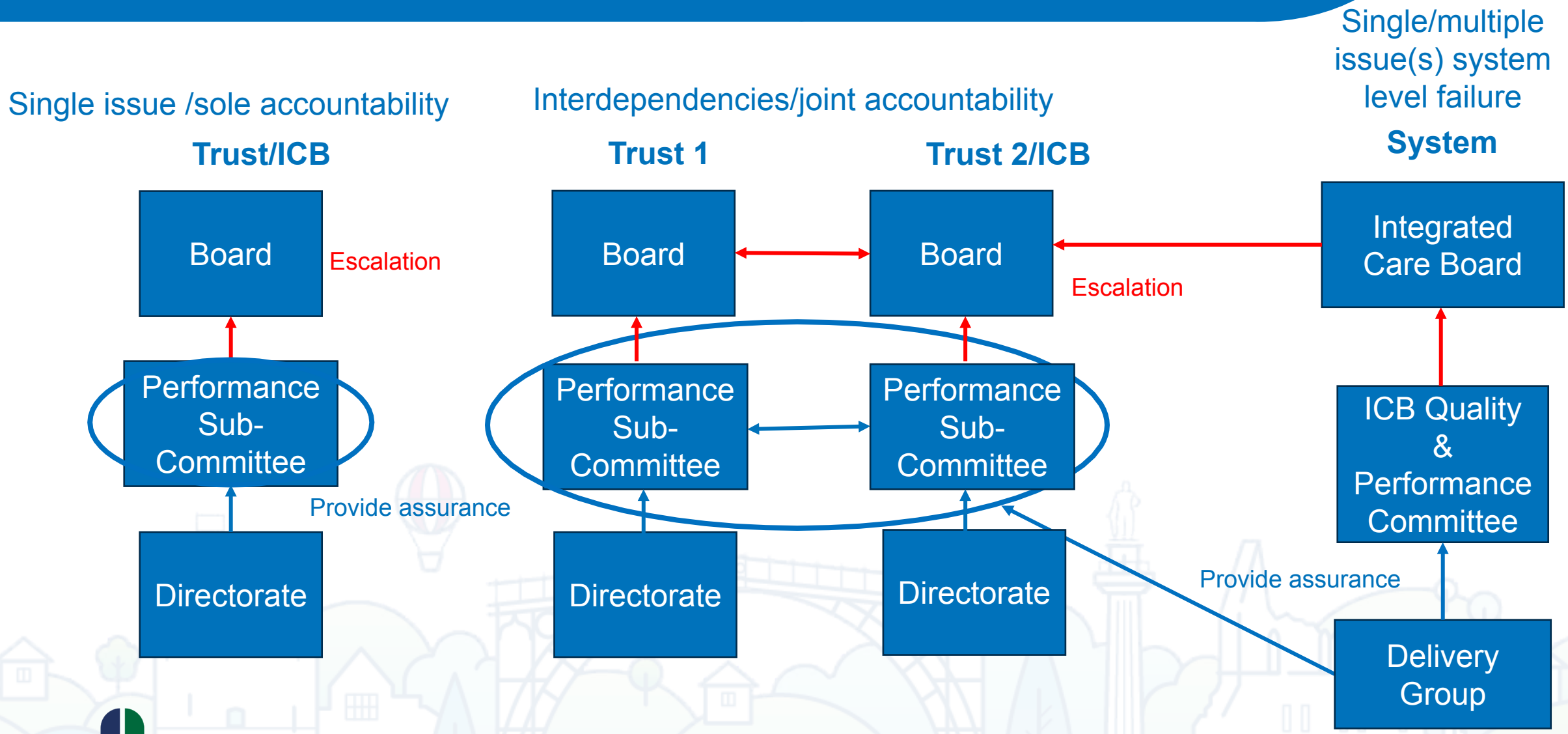
What is our collective role in performance improvement and assurance:

- Use performance reporting to monitor performance against key indicators and delivery of operational plans e.g. activity and take proactive forward look for the next 3months to anticipate issues, mitigate and reduce incidence of performance failure.
- Use continuous improvement methodology including regular look backs and lessons learned to be applied going forwards
- Identify where performance improvement plans are required using the criteria below:
  - Performing – no action required
  - 1 month under performance – monitor
  - 2 months under performance or failure predicted within the next quarter– Improvement plan required, and the nature of the failure is risk assessed (organisation or system level as required)
  - 3 months (or more quickly if assessed risk is high) without improvement since improvement plan in place- 1st level escalation to Exec level if single organisation, escalate to multiple execs if interdependencies/joint accountability and delivery group if system level failure.
  - Continued failure and no signs of improvement 2nd level escalation to System Quality & Performance Committee and System Transformation Group.

Performance Improvement

- Where a **system performance** improvement plan is required, this process should be followed:
  - Planning and Performance Leads to work with key stakeholders to develop the improvement plan using agreed template (**Appendix ii TBA**)
  - Collectively critique content of improvement plan (via Delivery Group) prior to sign off to ensure it will have the required impact
  - Once all responsible partners agree what needs to be in the plan, Planning and Performance Leads to submit a report to the ICB Commissioning Working Group for formal signing off of the plan
  - Planning and Performance Leads to attend Delivery Group to present the approved action plan
  - Once formally agreed Planning and Performance Leads hand the improvement plan over to the Delivery Group for oversight of delivery.

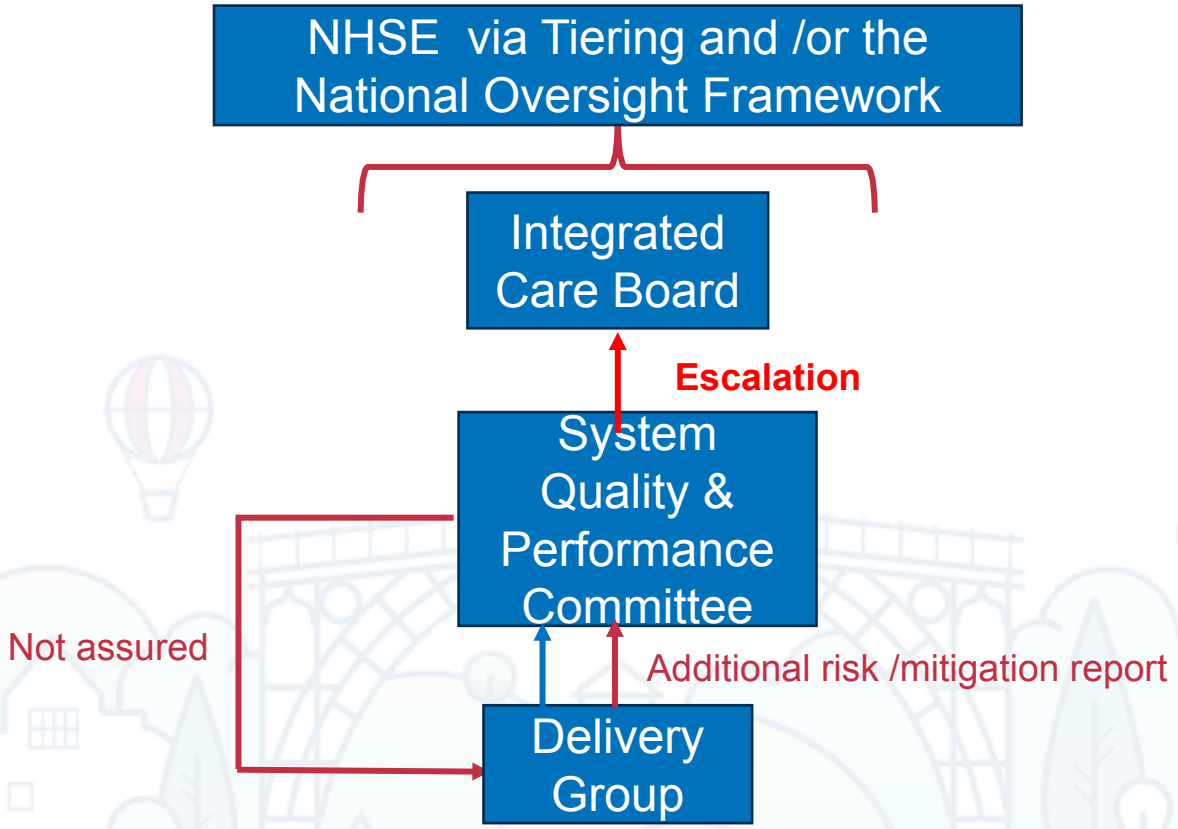
Trust/System – Performance Assurance Responsibilities and Accountabilities - Schematic



Where System Performance Assurance is not received

When System QPC is not assured by rate of improvement:-

- the respective delivery group will be required to provide a report that outlines the risks to delivery/ improvement and known mitigating actions.
- if no improvement within 3 months of this report, System QPC will escalate to the Integrated Care Board, unless when risk assessed, more urgent improvement is required e.g. patient safety/ estates e.g. fire safety.
- Continued failure will then also be managed by NHSE via Tiering / NOF (to be defined by new national framework)



Section 3: Appendices

PROGRAMME:		PROJECT NAME: Highlight Report		Level of PMO Support:		
SRO		Delivery Lead		Performance Lead	Specialities / Sub Dept.	
Informatics Lead		Clinical lead		Finance Lead	PMO Lead	

Trajectories and Actual

Date	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sept-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Plan												
Actual												

Focus Headlines

Delivered in September:

During October:

Longest Wait	National Target	Local Target

Graph

Performance Narrative

Queries/ Escalations

ii) Performance improvement plan template

See Excel template.

PROGRAMME:		PROJECT NAME: Plan on a Page		Level of PMO Support:	
Senior Responsible Officer		Delivery Lead		Performance Lead	R	Specialities / Sub Dept.	
Informatics Lead		Clinical lead		Finance Lead		PMO Lead	

Project Scope and Impact	Longest Wait	National Target	Local Target

Trajectories and Actual

Date	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sept-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Plan												
Actual												

Actions

High Level Key Milestones	Date

Graph

Key Risks	Score

Heading : XXXXXXXXXXXXXXXXXXXXRecovery Plan

Background to area needing improvement:	
Current position:	See charts "Current Performance" tab
Key risks identified & Mitigations:	

Current Performance - XXXXXXXXXXXXXXXXXXX

Updated: *31-Dec-24*

National Target		By when	
Actual			

Date	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Plan												
Actual												

Charts as appropriate

Recovery Action Plan - XXXXXXXXXXXXXXXXXXX

Key actions to be updated at regular intervals

Ref	Actions	Delivery	Lead	Update	Deadline	RAG
1	Example 1	Not Started				Red
2	Example 2	Delayed - Off Track				Amber
3	Example 3	Complete				Green
Other opportunities						
4						Amber

Revised Planned Trajectory of Actions

Month	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Revised Agreed Plan/Trajectory												

Risks -

Risks - Open	Risk Description	Existing controls	Existing sources of assurance	Gaps in controls	Likelihood Score	Consequence Score	Total Risk Score	Action plan / Mitigation	Target risk score for end of financial year
								MPFT are exploring options around submission of data	

Closed Risks	Risk Description	Existing controls	Existing sources of assurance	Gaps in controls	Likelihood Score	Consequence Score	Total Risk Score	Action plan / Mitigation	Target risk score for end of financial year
								MPFT are exploring options around submission of data on behalf of SYA or longer	

RISK MANAGEMENT MATRIX

	Likelihood				
Consequence	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost Certain
1 Negligible	1 VERY LOW	2 VERY LOW	3 VERY LOW	4 LOW	5 LOW
2 Minor	2 VERY LOW	4 LOW	6 LOW	8 MODERATE	10 MODERATE
3 Moderate	3 VERY LOW	6 LOW	9 MODERATE	12 HIGH	15 HIGH
4 Major	4 LOW	8 MODERATE	12 HIGH	16 HIGH	20 EXTREME
5 Catastrophic	5 LOW	10 MODERATE	15 HIGH	20 EXTREME	25 EXTREME

	1 – 3	Very Low risk
	4 – 6	Low risk
	8 – 10	Moderate risk
	12 – 16	High risk
	20 – 25	Extreme risk

	Consequence score (severity levels) and examples of descriptions				
Domains	1. Negligible	2. Minor	3. Moderate	4.Major	5. Extreme
Impact on the safety of patients, staff or public (physical/psychological harm).	Minimal injury or illness, requiring no/minimal intervention or treatment. No time off work.	Minor injury or illness, requiring minor intervention. Requiring time off work for >3 days. Increase in length of hospital stay by 1-3 days.	Moderate injury requiring professional intervention. Requiring time off work. Increase in length of hospital stay by 4-15 days. RIDDOR/agency reportable incident. An event which impacts on a small number of patients.	Major injury leading to long-term incapacity/disability. Requiring time off work for >14 days. Increase in length of hospital stay by >15 days. Mismanagement of patient care with long-term effects.	Incident leading to death. Multiple permanent injuries or irreversible health effects. An event which impacts on a large number of patients.
Quality/complaints/audit	Peripheral element of treatment or service suboptimal. Informal complain/injury.	Overall treatment or service suboptimal. Formal complaint. Local resolution. Single failure to meet standards. Minor implications for patient safety unresolved. Reduced performance rating if unresolved.	Treatment or service has significantly reduced effectiveness. Formal complaint. Local resolution (with potential to go to independent review). Repeated failure to meet internal standards. Major patient safety implications if findings are not acted on.	Non compliance with national standards with significant risk to patient if unresolved. Multiple complaints/independent review. Low performance rating. Critical report.	totally unacceptable level or quality of treatment/ services. Gross failure of patient safety if findings not acted upon. Inquest/ombudsman inquiry. Gross failure to meet national standards.
Human resources/organisational /development/staffing/ competence	Short term low staffing that temporary reduces services quality (1< day).	Low staffing level that reduces the services quality.	Late delivery of key objectives/service due to lack of staff. Unsafe staffing level or competence (>1 day). Low staff morale. Poor staff attendance for mandatory/key training.	Uncertain delivery of key objective/service due to lack of staff. Unsafe staffing level or competence (>5 days). Loss of key staff. Very low staff morale. No staff attending mandatory/key training.	Non-delivery of key objectives/service due to lack to staff. On-going unsafe staffing levels or competence. Loss of several key staff. No staff attending mandatory training /key training on an on-going basis.
Statutory duty/inspection	No or minimal impact or breach or guidance/statutory duty.	Breach of statutory legislation. Reduced performance rating if unresolved.	single breach in statutory duty. Challenging external recommendation/improvement notice.	Enforcement action. Multiple breaches in statutory duty. Improvement notices. Low performance rating. Critical report.	Multiple breaches in statutory duty. Prosecution. Complete systems change required. Zero performance rating. Severity critical report.
Adverse publicity	Rumours. Potential for public concern.	Local media coverage. Short term reduction in public confidence. Elements of public expectation not being met.	Local media coverage - long-term reduction in public confidence.	National media coverage with >3 days service well below reasonable public expectation.	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions raised in the House). Total loss of public confidence.
Business objectives/projects	Insignificant cost increase/schedule slippage	<5 per cent over project budget. Schedule slippage.	5-10 per cent over project budget. Schedule slippage.	Non-compliance with national 10-25 per cent over project budget. Schedule slippage. Key objectives not met.	Incident leading >25 per cent over project budget. Schedule slippage. Key objectives not met.
Financial Risk in relation to CCGs	Insignificant cost increase	1-2% over plan/target	2-5% over plan/target	5-10% over plan/target	>10% over plan/target
	On assessing impact, consideration will also be given to other key financial objectives including but not limited to cash management and receivables/payables control				
Service/business interruption/environmental impact	Loss/interruption of >1 hour. Minimal or no impact on the environment.	Loss/interruption of >8 hours. Minor impact on environment.	Loss/interruption of >1 day. Moderate impact on environment.	Loss/interruption of >1 week. Major impact on environment.	Permanent loss of service or facility. Catastrophic impact on environment.

OPTIONAL TAB

Meeting Name:

Meeting Date:

Attendees:

Name	Organisation

Actions Agreed:

Action		Lead	Complete

Meeting Date:

Attendees:

Name	Organisation

Actions Agreed:

Action		Lead	Complete