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

Document Information	
Document Title:	Shropshire, Telford and Wrekin Integrated Care System Finance Strategy, 2025-2030
Date:	June 2025
Owner:	Claire Skidmore; CFO, NHS STW

Version	Editor	Check point	Date
1.0	NG	Initial Draft	13.11.23
2.0	AS	Updated Draft	16.08.24
3.0	AS	Updated for System Director of Finance comments received	18.09.24
4.0	AS	Updated draft following receipt of feedback from System CFO, system finance committee and all organisations finance committees	13.03.25
5.0	AS	Updated following NHSE feedback and Strategy and Prevention Committee Feedback	25.04.25
6.0	AS	Updated following System CFO	07.05.25
7.0	AS	Updated following further comments from System CFO and NHSE Regional Team	14.05.25
8.0	AS	Updated following final feedback from all organisation Finance Committees	18.06.25
9.0	AS	Approval at System Finance Committee and recommendation to ICB Board for approval.	24.06.25
10.0	AS	Approval at NHS Shropshire Telford and Wrekin ICB Board.	25.06.25

Contents

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

Managing Our Finances for a Sustainable Future

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

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

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

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

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

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

Aligning with NHS Priorities: The Three Shifts and Darzi Recommendations

Our financial strategy, in conjunction with the ICS integrated care strategy, digital strategy, workforce strategy and infrastructure strategy are designed to support the fundamental shifts required to create a more sustainable and high-quality healthcare system. This aligns with the NHS 'Three Shifts'[1], which focus on:

1. **Shifting care upstream -** Investing in prevention by using the six key principles of our Prevention Framework and approach to Integrated Neighbourhood Teams delivering early intervention, and proactive care to reduce the need for hospital treatment.
2. **Shifting care closer to home -** Expanding community-based services to ensure people receive care in the most appropriate setting, reducing health inequalities across our rural population.
3. **Shifting to a more integrated system -** Using technology to enhance integration e.g. by implementing digital projects such as shared digital care planning module through our One Health and Care System to support delivery of improved utilisation of virtual ward capacity using remote monitoring tools to enable all 3 shifts and deliver productivity and efficiency.

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

A Smarter Approach to Finance

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

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

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

Why We Have Developed This Strategy

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

Our aims through this strategy are to:

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

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

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

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

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

2. Executive Summary

Where are we now?

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

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

Figure 1: System Historic Financial Performance

Where will we be if we do not take action?

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

What are we going to do about it?

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

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

Figure 2: System Recovery Plan Trajectory

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

Strategic Transformation Programmes	Gross Financial Opportunity 25/26	Gross Financial Opportunity 26/27	Gross Financial Opportunity 27/28	Excess Spend Area the Solution Addresses
Operational Programmes				
Temporary Staffing (Total Opportunity £20m)	6.7	8.4	5.0	Excess Spend : Workforce
Continuing Healthcare (CHC) (Total Opportunity £30m)	15.9	10.1	7.0	Excess Spend : CHC
Elective Productivity Opportunity (Total Opportunity £16.9m)	10.9	1.0	5.0	Excess spend: Productivity
Provider Level Transformation Programmes				
Corporate back office/Non-clinical wte reductions (Total Opportunity £20m)	7.8	6.1	6.1	Excess Spend: Corporate back office / infrastructure
System-Level Transformation				
Urgent and Emergency Care (UEC) (Total Opportunity £37.5m)	8.0	14.5	15.0	Excess Spend: UEC
Local Care Programme (Total Opportunity £20m)		10.0	10.0	Excess Spend: UEC/Community
Hospital Transformation Programme (Total Opportunity £30m)			7.5	Excess Spend: UEC/Corporate Back Office
Vaccine Preventable (Total Opportunity £13m)		1.5	1.5	Excess Spend: UEC
Totals	42.6	43.2	52.1	
STP savings Required		42.9	40.9	
Reinvestment Opportunity		-0.3	-11.2	

Figure 3: System Strategic Transformation Programmes

How Are We Going to Implement Our Plans?

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

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

The ICS will implement its strategy through:

- Strengthened financial governance and collaborative financial management agreements.
- Alignment of contracts and incentives to system goals, including gainshare models and outcome-based payments.
- A system-wide approach to business case appraisal and benefit tracking.
- Investment in financial capability and leadership development for all staff groups.
- Enhanced data-driven decision support using integrated reporting, benchmarking, and forecasting tools.
- Rigorous capital prioritisation based on strategic impact, revenue reduction, and transformation potential.
- Integrated risk management processes across financial, operational, and clinical domains.
- Testing planning assumptions within the MTFP including activity, income and growth assumptions across all Commissioners, English, and Welsh as part of the overall Demand and Capacity Model.
- Developing scenario modelling as part of the MTFP to support the implementation of the ICS care strategy, three shifts and prevention framework.

3. Where Are We Now?

3.1. Local Context

Population Demographics and Health Needs

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

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

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

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

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

Rurality

Rural isolation in parts of Shropshire limits access to primary and community care, with thousands of residents living more than 30 minutes from their nearest GP by public transport. This contributes to avoidable demand, widening health inequalities, and reinforces the need for targeted prevention, improved service accessibility through Integrated Neighbourhood Teams, and through system-wide public health interventions.

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

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

Service Provision

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

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

System Historical Financial Performance

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

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

Figure 4: System Historic Financial Performance

System Achievements Finance

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

We are proud of our achievements which include:

- Successful award of £312m capital funding for the Hospital Transformation Programme. HTP will support financial recovery by addressing the additional costs of a split site acute model at SaTH through reductions to workforce and productivity improvements. Revenue savings are estimated to total £30m long-term which underpins our return to underlying financial balance across the medium to long term as set out in the MTFP.
- Successful award of NHS England capital to support system-wide investments including Elective Hubs (SaTH, PRH), Theatres programme (RJAH), Community Diagnostics Centre (SaTH, Hollinswood House), modular wards (SaTH, PRH/RSH), SCHT Sub-acute/rehab and recovery wards. These support the local care transformation programme and significant improvements to the hospital estate.
- We have also secured digital funding to reach minimum digital foundation level and to support the introduction of new Electronic Patient Record Systems in SaTH and RJAH.
  These key investments in capital support activity to meet the requirements of the demand and capacity model, performance and quality improvements and also support financial recovery through delivery and achievement of productivity benefits.
- The system has improved and sustained elements of grip and control through the implementation of the NHSE Grip and Control Checklist and HFMA financial sustainability checklist. In 2023/24 and 2024/25 financial governance processes have been self-assessed and externally reviewed across the system. In 2024/25 this formed part of the system Investigation and Intervention work programme. Key recommendations were implemented by all system organisations to enhance workforce controls such as establishment reviews, vacancy control panels and agency approvals. Enhanced financial controls are supporting financial recovery.

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

- Continued openness and transparency in the sharing of financial models and information including in-year and longer-term modelling and risk registers.
- Tools that have been developed to support allocative efficiency and to aid decision making including prioritisation frameworks - Capital and Revenue (Strategic Decision-Making Framework).
- Implementation of the Productivity Oversight Group and organisation specific productivity dashboards. This group oversees productivity improvements through the use of (including but not limited to):
  - National NHSE benchmarking packs e.g. LOS, theatre, medicines, corporate staffing, temporary staffing.
  - Workforce benchmarking information to support workforce productivity improvements.
  - Cost benchmarking - using model health system, reference costs and other available benchmarks including local provider data.
  - Taking a quality improvement approach to individual service reviews to identify productivity improvement opportunities.
- Oversight of delivery of system transformation programmes through the Financial Improvement Programme.
- Development and implementation of the SaTH ‘Task Force’ and Financial Recovery Group.
- Development of a System PMO function with standardised templates, business cases and systems.
- We have a well-established systemwide Finance Training and Development Council whose purpose is to create, develop and support the Finance community for the STW system. We are proud that all system organisations have achieved Towards Excellence Accreditation under the Future Focussed Finance Scheme.

Drivers of Excess Cost

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

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

The drivers of excess cost are:

- **Workforce** - additional structural costs of running two sites for SaTH which will be removed by the Hospital Transformation Programme and excess operational costs such as temporary staffing above the national benchmarks for bank and agency. (Noting that SaTH have made significant progress in reducing agency spend in 2024/25 and further reductions across all providers are planned for 2025/26.)
- **Urgent and Emergency Care Pathway** - the system is currently incurring the additional cost of delayed discharges as a result of excess cost of staffing which will be removed through the Hospital Transformation Programme supported by the Local Care Programme. National benchmarking also shows Same Day Emergency Care productivity opportunities.
- **Community Investment** - the system has already invested to support the left shift to community across 2022/23 to 2024/25, as part of the Integrated Urgent Care efficiency programme, we are testing the benefits realised from this investment and seeking to optimise the patient care value gained from the investment.
- **Continuing Healthcare** - national benchmarking based on actual 2024/25 expenditure showed that NHSSTW were spending £32m more than the average for CHC, this is addressed through the efficiency programme going forwards.
- **Productivity** - national packs have been produced by NHS England supported by data available on the Model Health System website which show productivity opportunities across Elective, Non-Elective, Estates and Corporate Services.

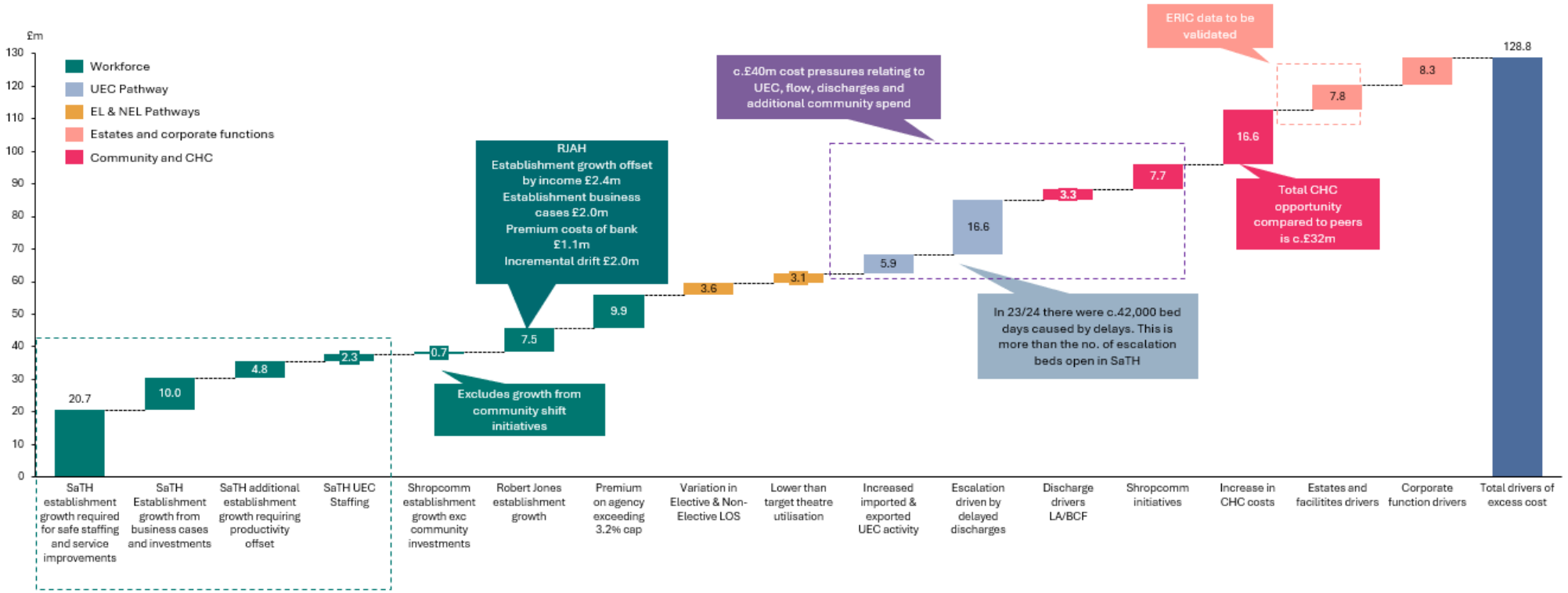

Figure 5: Drivers of Excess Cost

3.2. National Context

Elective Recovery

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

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

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

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

Productivity

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

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

Workforce

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

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

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

UEC Demand

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

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

Duty to Achieve System Financial Balance

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

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

Distance from Target - Pace of Change to Fair Shares Allocations

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

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

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

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

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

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

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

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

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

Provider Expenditure

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

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

Key challenges include.

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

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

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

ICB Expenditure

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

Total Expenditure year ended 31st March 2025 (£m)

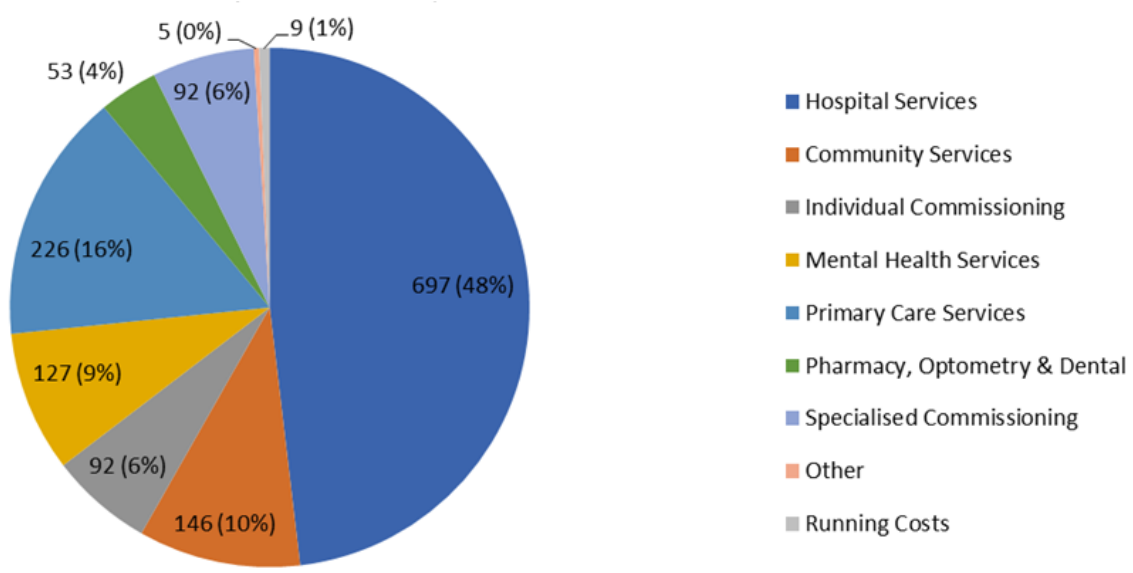

Figure 7: ICB Expenditure Y/E 31st March 2025 (£1,447m)

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

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

ICB Spend Summary by Programme £m	2019/20 Expenditure	%	2024/25 Expenditure	%	% increase	2028/29 Expenditure	%	% increase
Acute	406	50.8%	697	53.5%	72%	611	45.8%	-17%
Community	80	10.0%	146	11.2%	83%	199	14.9%	47%
Individual Commissioning	58	7.3%	92	7.1%	59%	94	7.1%	3%
Mental Health Services	72	9.0%	127	9.8%	76%	133	10.0%	6%
Primary Care Services includes Prescribing	161	20.2%	226	17.4%	40%	283	21.2%	30%
Other	11	1.4%	5	0.4%	-55%	5	0.4%	0%
Running Costs	11	1.4%	9	0.7%	-18%	8	0.6%	-7%
Sub-Total excluding delegated	**799**	**100.0%**	**1,302**	**100.0%**	**63%**	**1,333**	**100.0%**	**2%**
Pharmacy, Optom and Dental	0		53			64		
Specialised Commissioning	0		92			111		
Total Spend	**799**		**1,447**			**1,508**		

Figure 8: ICB Expenditure Summary

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

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

4.1. Demand and Capacity Analysis

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

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

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

4.2. Do Nothing Financial Modelling

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

Year 1 25/26

Do nothing	SATH £M	RJAH £M	SCHT £M	ICB £M	Total £M
Organisational Plan before Efficiencies	(86.5)	(9.6)	(3.4)	(79.9)	(179.4)
Efficiencies	41.4	9.6	5.4	39.2	95.5
Organisational Plan after Efficiencies	(45.1)	0.0	2.0	(40.7)	(83.8)
Underlying position	(46.5)	(8.8)	0.9	(41.1)	(95.5)
Total % Efficiency Required	**6.4%**	**5.9%**	**5.0%**	**7.6%**	**-**

Figure 9: Do nothing Year 1 25/26

Year 2 26/27

Do nothing	SATH £M	RJAH £M	SCHT £M	ICB £M	Total £M
Organisational Plan before Efficiencies	(61.6)	(8.3)	(6.1)	(47.7)	(123.7)
Efficiencies	0.0	0.0	0.0	0.0	0.0
Organisational Plan after Efficiencies	(61.6)	(8.3)	(6.1)	(47.7)	(123.7)
Underlying position	(61.6)	(14.4)	(6.1)	(47.8)	(129.9)
Total % Efficiency Required	**0.0%**	**0.0%**	**0.0%**	**0.0%**	

Figure 10: Do nothing Year 2 26/27

Year 3 27/28

Do nothing	SATH £M	RJAH £M	SCHT £M	ICB £M	Total £M
Organisational Plan before Efficiencies	(78.6)	(11.2)	(12.7)	(55.4)	(157.8)
Efficiencies	0.0	0.0	0.0	0.0	0.0
Organisational Plan after Efficiencies	(78.6)	(11.2)	(12.7)	(55.4)	(157.8)
Underlying position	(78.6)	(20.2)	(12.7)	(55.5)	(166.9)
Total % Efficiency Required	**0.0%**	**0.0%**	**0.0%**	**0.0%**	

Figure 11: Do nothing Year 3 27/28

5. What Are We Going to Do About It?

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

Integrated Care System (ICS) Vision and Ambition

The ICS vision and ambition, per the 2024 ICS Integrated Care Strategy[8], is that we want everyone in Shropshire Telford, and Wrekin to have a great start in life and to live healthy, happy, and fulfilled lives.

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

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

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

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

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

Figure 12: ICS Core Purpose/Aims

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

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

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

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

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

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

5.2. National Drivers – Three Shifts

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

1. **Shifting care upstream** - Investing in prevention by using the Strategic-Decision Making Framework[11] to inform the application of available growth funding using the six key principles of our Prevention Framework and approach to Integrated Neighbourhood Teams delivering early intervention, and proactive care to reduce the need for hospital treatment.
2. **Shifting care closer to home** - Implementing the Integrated Care Strategy and Prevention Framework inclusive of clinical service redesign to support expanding community-based services to ensure people receive care in the most appropriate setting, reducing health inequalities across our rural population.
3. **Shifting to a more integrated system** through our Digital strategy - Using technology to enhance integration e.g. by implementing digital projects such as shared digital care planning module through our One Health and Care System to support delivery of improved utilisation of virtual ward capacity using remote monitoring tools to enable all 3 shifts and deliver productivity and efficiency.

5.3. Solutions Aligned to Key Drivers of Excess Cost

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

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

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

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

a) Business as usual efficiency which includes:
   - The “do minimum” efficiency to offset 1.1% cost efficiency charged into the tariff cost uplift factor.
   - Operational efficiencies including grip and control measures, improving productivity, value for money assessment. These include but are not limited to:
     - establishment reviews across all staffing groups.
     - System vacancy controls inclusive of budgeting and staffing within affordable establishments.
     - Temporary staffing expenditure controls: ensuring that bank and agency spend is within cap limits (inclusive of rostering and bank and agency premium rates).
     - Productivity efficiencies including:
       - transforming outpatients through increasing the use of advice and guidance, virtual/telephone appointments, patient initiated follow ups and adherence to best practice pathways.
       - Theatre efficiencies.
       - Workforce productivity efficiencies e.g. community services
     - Non-pay controls including the use of the triple lock, procurement efficiencies including the management of inflation rates through contracts.
     - High-cost drugs switches.
b) Strategic Transformation Programmes:
   - Organisational transformation to deliver government reform:
     - New Model ICB operating model to deliver 50% ICB cost reductions.
     - Provider corporate, infrastructure and non-clinical workforce reform to deliver 50% reduction in workforce growth from 2019/20.
     - Provider level transformation to support the development of the Provider Collaborative.
   - System strategic transformation programmes which all incorporate elements of workforce reform and digital solutions including robotic processing automation and use of artificial intelligence. Provider transformation is also embedded within the system Strategic Transformation Programmes.
     - Hospital Transformation Programme
     - Local Care Programme to incorporate delivery of the three shifts inclusive of Integrated Neighbourhood Teams and delivery of the Prevention framework.
     - Urgent and Emergency Care Improvement Programme workstreams:
       - Acute Flow - led by SaTH to include SDEC.
       - Care Co-ordination - led by SCHT.
       - System Discharge - led by the local authorities.
       - Winter Planning - led by the ICB on behalf of the System.
     - Elective including productivity, cancer and diagnostics, fragile services, reducing insourcing and outsourcing and maximising available system capacity.
     - MSK Transformation
     - Workforce reform inclusive of shared services, collaborative workforce solutions, new workforce models and workforce productivity
     - Continuing Healthcare including solutions to transform childrens’ mental health services and end of life care.
     - Strategic Estates to improve utilisation and rationalise estate.
     - Financial Improvement Programme to include Strategic Decision-Making Processes to ensure value for money including hard decisions, disinvestment, and decommissioning.

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

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

Strategic Transformation Programmes	Gross Financial Opportunity 25/26	Gross Financial Opportunity 26/27	Gross Financial Opportunity 27/28	Excess Spend Area the Solution Addresses and Source Information for the Opportunity
Operational Programmes				
Temporary Staffing (Total Opportunity £20m)	6.7	8.4	5.0	Excess Spend : Workforce - NHS England productivity opportunity 25/26 efficiency plan value and remaining opportunities phased into 26/27 and 2027/28.
Continuing Healthcare (CHC) (Total Opportunity £30m)	15.9	10.1	7.0	Excess Spend : CHC - ICB efficiency opportunity as per ICB productivity pack plus additional 25/26 non recurrent opportunity.
Elective Productivity Opportunity (Total Opportunity £16.9m)	10.9	1.0	5.0	Excess spend: Productivity - NHS England productivity packs, Elective utilisation, theatre productivity, LOS reduction, virtual appointment and PIFU outpatient opportunities, SCHT workforce productivity and rostering opportunities. Diagnostics and cancer productivity opportunities. Local System Transformation Programmes - MSK and Outpatient Supported by capital estates and digital investments.
Provider Level Transformation Programmes				
Corporate back office/Non-clinical wte reductions (Total Opportunity £20m)	7.8	6.1	6.1	Excess Spend: Corporate back office including Estates - NHS England productivity opportunity 25/26 efficiency plan value and remaining opportunities phased into 26/27 and 2027/28.
System-Level Transformation				
Urgent and Emergency Care (UEC) (Total Opportunity £37.5m)	8.0	14.5	15.0	Excess Spend: UEC - Local community investments to release acute costs into sub-acute wards, virtual wards, integrated discharge team and rapid response 2022/23- 2024/25. Local data - No criteria to reside, avoidable admissions, conversion rates, delayed discharges, escalation costs, urgent treatment centre costs, frailty costs. NHS England Productivity packs SaTH - NEL/A&E/SDEC opportunity
Local Care Programme (Total Opportunity £20m)		10.0	10.0	Excess Spend: UEC/Community - Ambulatory Care Sensitive avoidable admissions - national and local dashboard based on 2023/24. DHSC secondary prevention report issued in relation to productivity prevention/health inequalities - Smoking, Weight Management, Alcohol, CVD, Diabetes.
Hospital Transformation Programme (Total Opportunity £30m)			7.5	Excess Spend: UEC/Corporate Back Office - SaTH HTP Business case - 25% of the benefit's of HTP brought forward.
Vaccine Preventable (Total Opportunity £13m)		1.5	1.5	Excess Spend: UEC - Ambulatory Care Sensitive avoidable admissions - national and local dashboard based on 2023/24.
Totals	42.6	43.2	52.1	
STP savings Required		42.9	40.9	
Reinvestment Opportunity		-0.3	-11.2	

Figure 13: Strategic Transformation Programmes

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

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

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

5.5. MTFP, Route to Financial Balance, Scenario Analysis

Traditional Efficiency Savings Are Not Enough

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

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

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

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

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

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

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

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

Medium-Term Financial Plan (MTFP)

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

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

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

Figure 14: Financial Recovery Plan Trajectory

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

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

Base Case - Most Likely

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

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

Year 1 25/26

Break Even in 3 Years	SATH £M	RJAH £M	SCHT £M	ICB £M	Total £M
Organisational Plan before Efficiencies	(86.5)	(9.6)	(3.4)	(79.9)	(179.4)
Efficiencies	41.4	9.6	5.4	39.2	95.5
Organisational Plan after Efficiencies	(45.1)	0.0	2.0	(40.7)	(83.8)
Underlying position	(46.5)	(8.8)	0.9	(41.1)	(95.5)
Total % Efficiency Required	**6.4%**	**5.9%**	**5.0%**	**7.6%**	

Figure 15: Most Likely Year 1 25/26

Year 2 26/27

Break Even in 3 Years	SATH £M	RJAH £M	SCHT £M	ICB £M	Total £M
Organisational Plan before Efficiencies	(56.4)	(6.1)	(6.1)	(45.5)	(114.0)
Efficiencies	33.6	8.8	6.1	25.1	73.6
Organisational Plan after Efficiencies	(22.7)	2.7	(0.0)	(20.3)	(40.3)
Underlying position	(22.7)	(5.8)	(0.0)	(20.5)	(49.0)
Total % Efficiency Required	**5.0%**	**5.1%**	**5.6%**	**5.0%**	

Figure 16: Most Likely Year 2 26/27

Year 3 27/28

Break Even in 3 Years	SATH £M	RJAH £M	SCHT £M	ICB £M	Total £M
Organisational Plan before Efficiencies	(33.5)	(3.2)	(6.4)	(25.0)	(68.0)
Efficiencies	33.4	9.2	6.3	27.3	76.4
Organisational Plan after Efficiencies	(0.0)	6.1	(0.0)	2.4	8.4
Underlying position	0.0	(2.4)	0.0	2.4	0.0
Total % Efficiency Required	**5.0%**	**5.3%**	**5.6%**	**5.5%**	

Figure 17: Most Likely Year 3 27/28

Upside Case

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

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

Year 1 25/26

Upside Case	SATH £M	RJAH £M	SCHT £M	ICB £M	Total £M
Organisational Plan before Efficiencies	(86.5)	(9.6)	(3.4)	(79.9)	(179.4)
Efficiencies	41.4	9.6	5.4	39.2	95.5
Organisational Plan after Efficiencies	(45.1)	0.0	2.0	(40.7)	(83.8)
Underlying position	(46.5)	(8.8)	0.9	(41.1)	(95.5)
Total % Efficiency Required	**6.4%**	**5.9%**	**5.0%**	**7.6%**	

Figure 18: Upside Case Year 1 25/26

Year 2 26/27

Upside Case	SATH £M	RJAH £M	SCHT £M	ICB £M	Total £M
Organisational Plan before Efficiencies	(61.6)	(8.2)	(6.4)	(14.4)	(90.6)
Efficiencies	38.8	12.4	6.1	25.4	82.6
Organisational Plan after Efficiencies	(22.9)	4.2	(0.3)	11.0	(8.0)
Underlying position	(22.9)	(1.9)	(0.3)	10.8	(14.2)
Total % Efficiency Required	**5.8%**	**7.1%**	**5.6%**	**5.0%**	

Figure 19: Upside Case Year 2 26/27

Year 3 27/28

Upside Case	SATH £M	RJAH £M	SCHT £M	ICB £M	Total £M
Organisational Plan before Efficiencies	(38.8)	(7.1)	(6.8)	(0.9)	(53.6)
Efficiencies	38.3	11.5	6.2	24.7	80.8
Organisational Plan after Efficiencies	(0.5)	4.4	(0.6)	23.9	27.2
Underlying position	(0.5)	4.3	(0.6)	23.8	27.0
Total % Efficiency Required	**5.8%**	**6.7%**	**5.6%**	**5.0%**	

Figure 20: Upside Case Year 3 27/28

Downside Case

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

Year 1 25/26

Downside Case	SATH £M	RJAH £M	SCHT £M	ICB £M	Total £M
Organisational Plan before Efficiencies	(86.5)	(9.6)	(3.4)	(79.9)	(179.4)
Efficiencies	41.4	9.6	5.4	39.2	95.5
Organisational Plan after Efficiencies	(45.1)	0.0	2.0	(40.7)	(83.8)
Underlying position	(46.5)	(8.8)	0.9	(41.1)	(95.5)
Total % Efficiency Required	**6.4%**	**5.9%**	**5.0%**	**7.6%**	

Figure 21: Downside Case Year 1 25/26

Year 2 26/27

Downside Case	SATH £M	RJAH £M	SCHT £M	ICB £M	Total £M
Organisational Plan before Efficiencies	(61.5)	(8.3)	(6.1)	(47.7)	(123.7)
Efficiencies	23.3	7.4	3.7	15.2	49.6
Organisational Plan after Efficiencies	(38.3)	(0.9)	(2.5)	(32.5)	(74.1)
Underlying position	(38.3)	(6.9)	(2.5)	(32.6)	(80.3)
Total % Efficiency Required	**3.5%**	**4.3%**	**3.3%**	**3.0%**	

Figure 22: Downside Case Year 2 26/27

Year 3 27/28

Downside Case	SATH £M	RJAH £M	SCHT £M	ICB £M	Total £M
Organisational Plan before Efficiencies	(54.7)	(12.5)	(8.9)	(60.2)	(136.2)
Efficiencies	23.7	7.1	3.9	15.4	50.1
Organisational Plan after Efficiencies	(31.0)	(5.4)	(5.0)	(44.7)	(86.1)
Underlying position	(31.0)	(5.5)	(5.0)	(44.8)	(86.3)
Total % Efficiency Required	**3.5%**	**4.0%**	**3.3%**	**3.0%**	

Figure 23: Downside Case Year 3 27/28

6. How We Will Implement Our Plans

6.1. Strategic Finance Vision and Aims

The System Strategic Finance Vision is:

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

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

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

Key Strategic Aims

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

6.2. Financial Culture and Governance

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

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

- 'One model, one consistent set of assumptions' recognising that the position of each organisation will evolve and change transparently.
- Ensuring that the transparent and agile approach to financial planning continues across the system.
- Agreement to work together to use our resources flexibly and effectively, to deliver the system vision.
- Collectively working together as a system to manage opportunities, resources and risks including cost pressures.
- Being open and transparent with each other, sharing data and financial information.
- Use of a strategic decision-making framework to ensure best value use of resources including investments in line with system priorities.
- Ensuring no individual organisation loses out for doing something for the benefit of the wider system across health and social care.

- It is key we work collaboratively as a system to make sure that where costs are moving between organisations so that they are in the correct place, we work together to address any financial impact this has on the system.

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

Through our culture and governance, we aim to:

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

We will implement this through the following mechanisms:

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

6.3. Financial Incentives and Contracts

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

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

Our aim is to align financial mechanisms with transformation outcomes.

We will implement this by:

- Updating the **System Collaborative Financial Management Agreement** as needed to describe the system approach for financial management, risk sharing and gain sharing and aligned payment incentives.
- Developing **contract payment mechanisms** to best support population health outcomes. This could include fixed, variable, and blended payment models.
- Agreeing the **financial framework** that best applies to each contract and payment mechanism, acknowledging the need to recognise the complexity of the arrangement in terms of the number of organisations involved and payment types.
- Developing **contracting frameworks** in conjunction with best practice models to best support contracting with system provider collaboratives and places.

- Redesigning **payment and incentive structures** in partnership with providers, including population health outcome-based elements (e.g. reduced admissions via the Local Care Programme (LCP)).
- Introducing further **gainshare models** (drugs gainshare already in place) for transformation programmes where financial savings are reinvested into further system improvements.
- Piloting **new contract forms** in key pathways (e.g. CHC, UEC, LCP) with evaluation metrics and timelines for wider rollout.
- **Testing and approving** all new contracting models before deployment, using the System Finance, Productivity and Planning Group to assess.

6.4. Business Case Management - Ensuring Investment Benefits Are Realised

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

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

We will implement this by:

- Continuing to embed **standardised business case templates** and introductory papers to include the details of benefits measurement.
- Mandating **financial sign-off** by both business cases owners and all key programme leads for supporting functions including sign off by the designated finance lead.
- Centralising **benefits tracking** through the System PMO, with accountability assigned to named programme owners, audit of delivery and reporting of variances.

6.5. Talent Management / People Development (All Staff)

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

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

We will implement this by:

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

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

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

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

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

We will implement this by:

- Investing in expanding **Service Line Reporting** across all major service areas, drawing on automated reporting tools where available nationally and developed locally where not yet available e.g. for community / primary care.
- Utilising the national **Federated Data Platform** outputs, we will develop a local tool integrating activity, cost, outcomes, and workforce data into a single platform.
- Utilising regional/national **benchmarking dashboards**, updated regularly, drawing on data from national sources e.g. Model Health System, Model Hospital, GIRFT and local data e.g. Population Health Management Dashboard.
- **Triangulating datasets** through the annual operational planning processes and within the Integrated Performance Report to the Board.
- **Integrating forecasting and modelling** of demand to provide scenarios to inform degree of risk based on best and worst case.
- **Testing /evaluating the modelling** against the population need derived from population health analytics.

6.7. Strategic Decision-Making Framework (Prioritisation)

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

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

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

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

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

We will implement this by:

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

6.8. Capital Prioritisation Framework

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

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

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

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

This will be implemented by:

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

6.9. Risk Management

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

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

Our aim is to proactively manage financial and transformation risk.

We will implement this by:

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

6.10. Review and Test MTFP Planning Assumptions

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

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

We will implement this by:

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

7. Conclusion

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

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

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

8. Glossary of Terms

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

Abbreviation	Meaning
A&E	Accident and Emergency
BAU	Business as Usual
CCG	Clinical Commissioning Group
CFO	Chief Finance Officer
CHC	Continuing Healthcare/ Individual Commissioning
DFT	Distance from Target (Fair Shares Allocation)
DOF	Director of Finance
ERF	Elective Recovery Fund
FOT	Forecast Out-Turn
GP	General Practitioner
HTP	Hospital Transformation Programme
I&E	Income and Expenditure
ICB	Integrated Care Board
ICS	Integrated Care System
IS	Independent Sector
LOS	Length of Stay
LTFP	Long Term Financial Plan
MPFT	Midlands Partnership University NHS Foundation Trust
MSK	Musculoskeletal Services Shropshire and Telford
MTFP	Medium Term Financial Plan
NHS	National Health Service
NHSE	NHS England
NOF	National Oversight Framework
PMO	Programme Management Office
PRH	Princess Royal Hospital
RJAH	The Robert Jones and Agnes Hunt Orthopaedic NHS Foundation Trust
RSH	Royal Shrewsbury Hospital
RTT	Referral to Treatment Time
SaTH	Shrewsbury and Telford Hospitals NHS Trust
SCHT	Shropshire Community Health NHS Trust
SDEC	Same Day Emergency Care
SLR	Service Line Reporting
STW (NHS STW and STW ICS)	Shropshire Telford and Wrekin (ICS)
WMAS	West Midlands Ambulance Service