

# Five Year Strategic Commissioning Plan

April 2026



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## Section 1 – Chair and Chief Executive Foreword

We are pleased to introduce this ambitious Five Year Strategic Commissioning Plan, which sets out how we will shape the future of health and care across Shropshire, Telford and Wrekin at a time of significant challenge, change and opportunity. Our population is growing and ageing, our communities experience some of the most striking inequalities in the region, and demand for services continues to rise year on year. Yet we also see extraordinary strengths in our neighbourhoods, our partnerships and our workforce. This plan is our commitment to harnessing those strengths to build a healthier, fairer and more sustainable future for the people we serve.

The next five years will mark a decisive shift in how we work. We are moving purposefully from a system centred around hospitals and reactive care to one that focuses on prevention, early help and support delivered much closer to home. Our integrated neighbourhood teams, strengthened community services, modernised primary care and expanding digital capabilities will together create a model of care that is more responsive to people's needs and more aligned to where they live their lives. This shift, supported by improved population health data, stronger clinical leadership and new ways of commissioning, will help reduce avoidable pressure on urgent and emergency care (UEC) to free up capacity for those who genuinely need hospital treatment. While we are committed to this shift and focus on integrated community-based care, we will continue to develop hospital services that are there when patients need them and are responsive to that need. Our collective approach to the Place agenda remains central to all of this, and we will work closely with our local authority partners to maximise this opportunity.

We know that inequalities in access and outcomes remain one of our most urgent challenges. Too many residents face poorer health simply because of where they live, their background, or the barriers they encounter navigating the health and care system – simply, this is unacceptable. Tackling these inequalities is central to this plan. With our partners across local government, the voluntary sector and communities, we will expand targeted prevention, strengthen early years support, improve access to screening and immunisation, and ensure that those with the greatest needs benefit first from new models of care. Our work with children and young people – including those with Special Educational Needs and Disabilities (SEND) – is especially important, and we remain committed to delivering earlier, more coordinated, and more effective support for families. We will be relentless in our drive to improve the mental health offer for local people and will build on the relationships and services that are offered locally.

Digital innovation will underpin much of this transformation. Better connected records, AI-enabled triage, remote monitoring and virtual wards will improve how people access services, support clinicians to make decisions and reduce duplication across the system. These tools will also help us anticipate need sooner, and design services around real-time insight. Importantly, our commitment to digital inclusion means ensuring people who cannot or do not wish to use digital routes still receive equitable and timely care.

Financial sustainability is essential to delivering our ambitions. Both Shropshire, Telford and Wrekin and our partner system in Staffordshire and Stoke-on-Trent face longstanding financial pressures, intensified by rising demand. This plan sets out a responsible, value-based approach to stewardship by directing investment towards prevention, neighbourhood models and digital transformation, reducing unwarranted variation, and embedding productivity and efficiency throughout the commissioning cycle.

By 2027, as we move towards a merged single organisation across Shropshire, Telford and Wrekin and Staffordshire and Stoke-on-Trent, we will strengthen our collective ability to manage resources fairly, transparently and for maximum population benefit.

None of this change is possible without our workforce. Across every service and profession, colleagues continue to demonstrate extraordinary commitment despite real pressures.

This plan sets out how we will support their wellbeing, enable new roles and ways of working, and build the skills, confidence and leadership needed for the future. We want our system to be a place where staff feel valued, where teams can innovate, and where the culture enables people to thrive.

Above all, this plan is about being ambitious in our unrelenting focus on improving the lives of the people and communities we serve. It reflects the voices of our partners, our clinicians, our voluntary sector, our staff and, most importantly, our residents. Over the next five years, we will keep those voices at the heart of our decisions through meaningful engagement and co-production. We will ensure transparency in how we prioritise, invest and measure progress. We will continue to champion a system that is compassionate, inclusive and focused on what matters most.

We are grateful to everyone who has contributed to shaping this ambitious plan. We look forward to working with you as we deliver it, together, on behalf of our communities.



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**Simon Whitehouse**  
ICB Cluster Chief Executive Officer  
NHS Staffordshire and Stoke-on-Trent  
NHS Shropshire, Telford and Wrekin



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**Ian Green OBE**  
ICB Cluster Chair  
NHS Staffordshire and Stoke-on-Trent  
NHS Shropshire, Telford and Wrekin

## Section 2 – Executive Summary

Over the next five years, NHS Shropshire, Telford and Wrekin will transform how health and care is planned and delivered, creating a system that is more proactive, more preventative, and more responsive to the diverse needs of our population. Our ambition is to shift the balance of care closer to home, reduce inequalities, modernise access through digital innovation, and ensure services remain financially and clinically sustainable. As we develop a joint operating model with Staffordshire and Stoke-on-Trent, this plan lays the foundations for a single strategic commissioning approach ahead of merger in 2027 – strengthening consistency, shared decision making and long-term system resilience.

Shropshire, Telford and Wrekin face a unique combination of challenges – rapid growth and diversity in Telford and Wrekin, an ageing and increasingly frail population across rural Shropshire, and persistent inequalities that shape health outcomes and access. Rising demand in mental health, SEND, urgent care and long-term conditions reinforce the need for a different way of working. This plan responds to that reality by embedding the principles of neighbourhood-based, multidisciplinary care, stronger prevention, and the smarter use of data and digital tools.

We will strengthen our integrated neighbourhood teams for adults and children, ensuring more people receive joined-up care in their communities – supported by urgent community response, virtual wards, intermediate care and improved care coordination. The aim is to reduce avoidable hospital use, improve flow for those who do require acute care, and support faster, safer discharge. Alongside this, primary care will modernise through improved digital access, expanded clinical services in GP practices, pharmacy and optometry, and better integration across pathways such as diagnostics, women's health and long-term conditions. Dentistry and optometry will evolve as full delegated functions transfer locally, expanding access and supporting preventive care.

Mental health, learning disability and autism services will be strengthened through more timely community support, reduced out-of-area placements, expanded support in schools, and trauma-informed approaches for children, families and those with complex needs. We will also prioritise earlier help for children and young people with SEND – improving access to therapies, reducing diagnostic waits, and delivering more support in schools and local settings. Across cancer, elective care and diagnostics, we will redesign pathways so that more activity is delivered in the community, waits are reduced, and patients experience faster, more personalised journeys from referral to treatment.

A core theme throughout the plan is prevention. Working with local authorities, the voluntary sector and communities, we will focus on improving lifestyles, tackling smoking and obesity, expanding health checks and screening, reducing alcohol-related harm, and improving early years and family support. Using population health data and the Core20PLUS5 framework, we will target the people and places most affected by poor outcomes – ensuring our system's efforts genuinely narrow inequalities.

Digital, data and technology will underpin the changes ahead, with the Shared Care Record, Federated Data Platform, remote monitoring, AI-supported diagnostics and NHS App functionality enabling more integrated, efficient and personalised care. These tools will help clinicians make better decisions, reduce duplication, and improve the experience of people navigating between services.

Delivering this transformation requires a sustainable financial position and a workforce with the right skills, capacity and support. Over the next five years, we will stabilise system finances through value-based decision making, better productivity, outcomes-based contracting and a clear shift of investment towards prevention and community-based care. At the same time, we will focus on recruitment, retention,

wellbeing and leadership development across the workforce, building a resilient and capable system able to deliver new models of care.

This plan sets a clear direction for the future – a health and care system that is more joined up, digitally enabled, neighbourhood-focused and financially sustainable. Most importantly, it is a system designed around what matters to local people – supporting them to live healthier lives, accessing the right care at the right time, and experiencing equitable, high-quality services wherever they live.



## About us

### Who we are

Shropshire, Telford and Wrekin Integrated Care Board (ICB) is the statutory NHS body responsible for planning, commissioning and overseeing health services for a population of around 509,200 people across a diverse rural and urban landscape. The ICB is responsible for commissioning services for our population while working closely with our partners, which consist of NHS providers, local authorities, primary care, independent providers and the voluntary sector, to improve outcomes, reduce inequalities and ensure sustainable, high-quality care.

Across the area there are 50 GP practices organised into nine Primary Care Networks (PCNs). The ICB also commissions community optometry and NHS dental services – delivered through a broad network of local practices. This integrated commissioning role enables the ICB to shape our services and develop wider system coordinated delivery plans that reflect the needs of our diverse population. As part of the ICB's Planning Requirements, this Five Year Strategic Commissioning Plan sets out a clear, long-term vision for improving health and healthcare across Shropshire, Telford and Wrekin. It aligns closely with the wider ICS Strategy, local Health and Wellbeing Board priorities and the three strategic shifts of the national 10 Year Plan – moving care from hospital to community, accelerating digital transformation, and strengthening prevention.

The plan is firmly outcome-focused, committing to measurable improvements in population health, reduced inequalities and better experience of care. It also connects the system's long-term ambitions already set out within the Joint Forward Plan and the NHS Long Term Plan, ensuring coherence between strategic direction and operational delivery.

In addition, the commissioning approach is designed to align with provider trust strategies and neighbourhood-level plans, creating a unified, system-wide framework that supports integrated, place-based models of care and setting the scene for shared accountability for improving outcomes.



## Purpose and role

**The ICB acts as a strategic commissioner focused on:**

- Improving population health outcomes
- Reducing inequalities
- Ensuring financial sustainability.

**Core functions:**

- Translating national/local priorities into commissioning intentions
- Convening system partners for integrated care
- Providing assurance on quality, performance, and finance.

## Principles and approach to strategic commissioning

As a strategic commissioner, the ICB plays a pivotal role in shaping a health and care system that meets the long-term needs of our population. Our remit extends beyond service planning and includes providing strategic leadership for population health, addressing inequalities, and ensuring that resources are deployed to deliver the greatest value and impact for our communities. To fulfil this responsibility, we must continue to strengthen our skills, capabilities, and ways of working, building the foundations that enable us to lead the system with confidence and effectiveness.

Delivering and evolving our Strategic Commissioning Plan will require an ambitious and forward-looking approach. This involves strong clinical and professional leadership, high-quality data and analysis, fair and transparent decision making about the use of NHS resources, meaningful engagement with our communities, and a commitment to continually improving how we work. The Strategic Commissioning

Framework outlines the key areas of focus that will help ensure we plan and organise health and care services in the most effective way for the people we serve.



As such, we will use a simple, continuous cycle to guide how we plan and improve services:



Function	What does this mean
<b>Strategic planning</b>	We assess local population needs, review evidence, and draw on insight from people and communities. This intelligence informs the design of appropriate support and helps us set clear commissioning priorities.
<b>Procuring and organising services</b>	We ensure that the most suitable organisations deliver the care our population requires. This includes developing robust contracts, monitoring quality, and ensuring services provide value for money.
<b>Monitoring, evaluation and improvement</b>	We assess performance, gather feedback, and use this learning to refine and improve services, ensuring they remain effective, responsive and continuously improving over time.

## How we work together across Shropshire, Telford and Wrekin

Shropshire, Telford and Wrekin have a long-standing commitment to strong strategic partnerships that improve health and wellbeing outcomes for their diverse communities. Effective collaboration with local authorities, NHS providers, the voluntary, community and social enterprise (VCSE) sector, and local people is fundamental to creating a system that is responsive, sustainable and genuinely person-centred.

At the core of our local approach is a shared commitment to working together. This is reflected in well-established, formalised relationships between local authorities, NHS trusts and our wider provider networks, PCNs, VCSE organisations and communities. These partnerships are built on mutual trust, shared priorities and a collective ambition to reduce health inequalities, strengthen prevention and deliver high-quality, integrated care. They are supported by several key system structures:

### Health and Wellbeing Boards

The Health and Wellbeing Boards in both Shropshire and Telford and Wrekin provide a crucial strategic forum where system leaders come together to shape shared priorities for improving population health and wellbeing. Operating at the interface between the NHS, local authorities, and wider public services, the Boards enable partners to jointly develop long-term strategies, align commissioning intentions, and oversee progress against system-wide outcomes. They play an essential role in promoting integration by bringing together statutory health and care bodies, the VCSE sector, and representatives of local communities to ensure that decisions are informed by lived experience and reflect local need. Through their focus on prevention, early intervention and tackling health inequalities, the Boards help to create the collective conditions required to deliver sustainable improvements across neighbourhood, place, and system levels, reinforcing their position as a key governance mechanism within the commissioning landscape.

### Place-based partnerships

The Shropshire Integrated Place Partnership (ShIPP) and the Telford & Wrekin Integrated Place Partnership (TWIPP) play a central role in shaping and delivering this plan by bringing together local partners – across the NHS, local authorities, public health, the VCSE sector and wider community services – to collaboratively design services that reflect the unique needs, assets and priorities of their local populations. Through a place-based approach, these partnerships enable decisions to be made closer to communities, ensuring that interventions are informed by local data, lived experience, and a deep understanding of neighbourhood-level variation. ShIPP and TWIPP act as engines for innovation, co-producing solutions with residents, supporting prevention and early intervention, and driving the left-shift towards integrated, community-delivered care. Their work strengthens alignment between system strategy and delivery on the ground, ensuring that commissioning intentions translate into responsive, person-centred models of care that improve outcomes, reduce inequalities and build long-term resilience within each place.

### Provider collaboratives

NHS trusts and wider system providers are increasingly collaborating to plan and deliver services in a way that reflects the realities of shared workforce pressures, rising urgent care demand, and the ongoing requirement to recover and stabilise elective services. Over the next five years, this collective approach will be critical to delivering the commissioning plan's aims of improving resilience, reducing unwarranted variation, and creating seamless pathways across organisational boundaries.

The evolving group model between Shrewsbury and Telford Hospital NHS Trust (SaTH) and Shropshire Community Health NHS Trust (SCHT) represents a significant step towards deeper integration, creating

opportunities for shared clinical leadership, aligned workforce planning, and more coordinated patient pathways across acute, community and intermediate care.

The continued collaboration with The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust (RJAH) can genuinely transform the way that musculoskeletal and orthopaedic services are delivered across our geography. There should be no limits to our ambition in this area to be the leading system, given the expertise, clinical leadership and innovation being demonstrated daily.

Alongside this, the cluster arrangements between Shropshire, Telford and Wrekin ICB and Staffordshire and Stoke-on-Trent ICB will further strengthen cross-system collaboration, supporting enhanced clinical networks between SaTH and University Hospitals of North Midlands NHS Trust (UHNM) and enabling closer alignment with Midlands Partnership University NHS Foundation Trust (MPFT) for mental health and learning disability services. Together, these developments foster a more coherent, system-wide operating model capable of pooling expertise, sharing resources, and jointly tackling pressing system challenges, ensuring that the commissioning intentions of the Five Year Plan can be delivered at scale and with greater impact for local communities.

### **Joint Commissioning Boards**

Joint commissioning between local authorities and the ICB is a fundamental enabler of the Five Year Strategic Commissioning Plan – ensuring that resources are used in a more coordinated and strategic way to meet the needs of people with complex, long-term or multiple conditions. By working collaboratively, Shropshire Council, Telford & Wrekin Council and the ICB can align priorities, reduce duplication and design integrated pathways that span health, social care, housing and the voluntary and community sector. Strong governance arrangements underpin this partnership approach – supporting shared accountability, transparent decision-making and the ability to take a system-wide view of demand and capacity across both places.

Pooled budgets, enabled through the Better Care Fund and Section 75 agreements, provide a flexible commissioning framework that allows investment to shift upstream into prevention, early intervention and community-based support. This improves outcomes and independence for residents while reducing reliance on acute services, supporting the wider system goals of improving flow, reducing pressure on UEC and enabling the left-shift central to this plan. Over the next five years, these joint commissioning arrangements will be critical to delivering sustainable models of care, supporting market stability, and creating a more integrated, person-centred offer across Shropshire and Telford and Wrekin.

### **Involving people and communities**

Involvement is central to how we work and is a core principle underpinning the Five Year Strategic Commissioning Plan. By meaningfully involving local people in the design, delivery and evaluation of services, we ensure that care is shaped by what matters most to residents and reflects the diverse needs of our communities. Working closely with the VCSE sector and a broad range of community organisations ensures that voices from all parts of the population, including those who are seldom heard, inform and influence decision-making.

Our commitment to engagement is strengthened through a wide range of mechanisms such as citizens' panels, focus groups, parent carer forums, community forums and targeted outreach, helping to build transparency, trust and shared ownership across the system. Over the next five years, this approach to co-production will be instrumental in shaping preventative, community-based models of care – tackling health inequalities, improving population health outcomes, and ensuring that commissioning decisions remain rooted in the lived experience and priorities of local people.

## Specialised commissioning

To support the government's 10 Year Plan ambition to establish ICBs as strategic commissioners, current NHS England (NHSE) specialised commissioning functions and services are expected, subject to legislation, to transfer from NHSE Specialised Commissioning to ICBs from April 2027 with only a small number of services retained at a national level by exception.

Throughout 2026/27, the ICB will continue to work closely with NHSE Specialised Commissioning Leads and regional commissioning teams to ensure a smooth transition of commissioning responsibilities. This includes active engagement in the development of the Offices for Pan-ICB Commissioning (OPICs), which will support ICBs across each NHS region to commission specified services efficiently and effectively, including commissioning at scale where this will improve patient outcomes.

As part of supporting system-wide pathway redesign, we will work with providers and NHSE specialised commissioning teams, as appropriate, to strengthen the continuity, quality, and sustainability of services. This will be underpinned by robust contracting arrangements with a strong focus on value, timely access to appropriate treatment, and improved outcomes for patients.

## Cluster working and future merger

During 2026/27, Shropshire, Telford and Wrekin ICB will begin working as a cluster alongside Staffordshire and Stoke-on-Trent ICB – laying the foundations for a future full merger by 2027. Over the coming years, the two ICBs will increasingly operate through shared planning, joint decision making and coordinated delivery, beginning with the bringing together of a single Five Year Strategic Commissioning Plan by April 2027.

Governance arrangements, outcomes frameworks and assurance processes will be progressively aligned to support consistent, system-wide oversight and reduce duplication. Provider collaboratives will also be brought into closer alignment – enabling more integrated service planning, shared workforce approaches and streamlined pathways across the wider geography. This phased approach will ensure that, by the time of formal merger, the system is already functioning as a coherent, unified commissioning footprint focused on improving outcomes and value for the populations it serves.

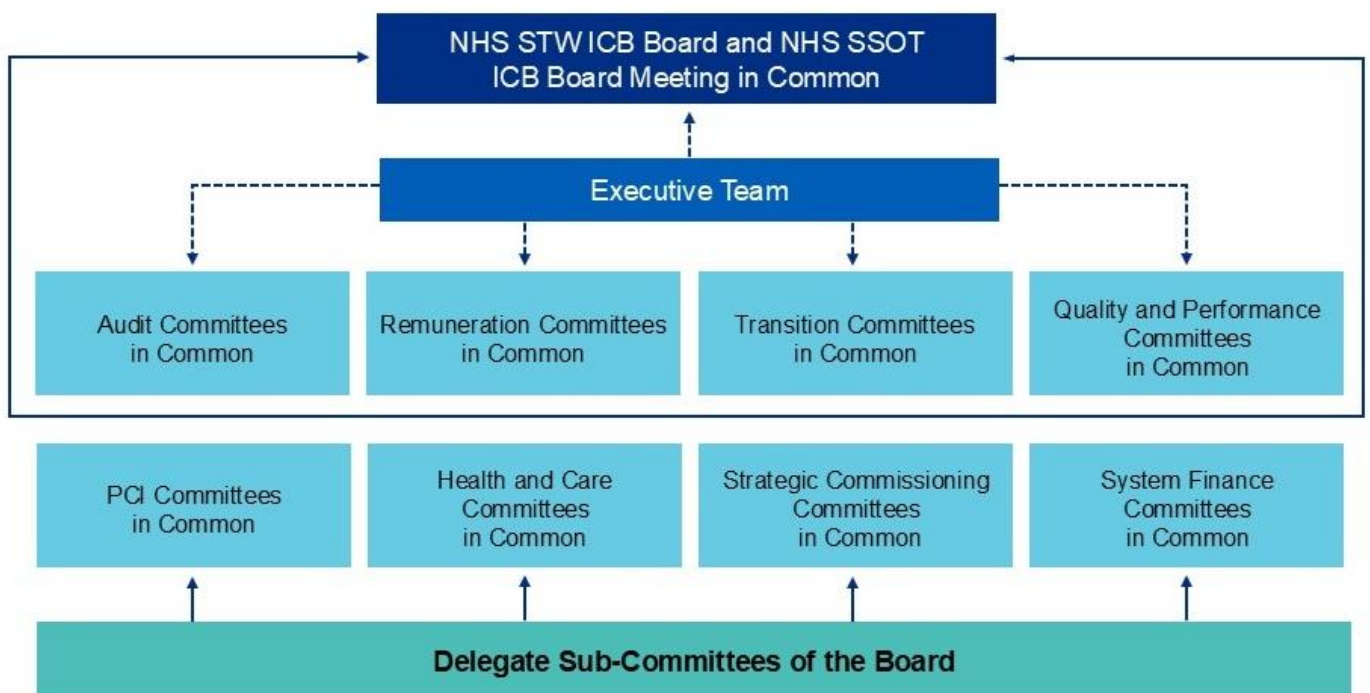


## Governance and accountability

The Five Year Strategic Commissioning Plan replaces the previous Joint Forward Plan by providing a more comprehensive, long-term and system-wide approach to planning, prioritisation and delivery. While the Joint Forward Plan set out annual operational intentions, this new plan fulfils the ICB's statutory duty to produce a clear, strategic commissioning plan that reflects population needs, aligns with national requirements and demonstrates how the system will improve outcomes, quality and value over time. It brings together intelligence, clinical priorities, financial strategy and partnership commitments into a single framework that guides decision making across the whole commissioning cycle.

In doing so, it ensures the ICB meets its legal responsibilities for transparency, public involvement and integrated system leadership, while providing a stable foundation for long-term transformation across Shropshire, Telford and Wrekin.

The ICBs are moving to a shared transitional clustering governance structure in anticipation of merger in April 2027. The structure, which is set out below, seeks to provide a transparent, streamlined assurance and decision-making process for both ICBs to deliver their respective five-year plans while they remain two separate statutory organisations. It will also allow a single staff structure to support it in the most efficient and effective way. The Boards of both ICBs are now meeting in common with new committees and sub-committees in common being created, which will move to joint committees as soon as is appropriate.



## Key enablers

### System leadership for population health

Effective leadership across the entire health and care system is critical to improving population health and reducing inequalities. Leaders across the system must understand how services interconnect, draw on robust data and insight, and work confidently with a wide range of partners to deliver improvements for the benefit of the population.

Population health leadership requires uniting organisations around shared priorities, emphasising prevention, and directing support to communities with the greatest need. It also involves influencing change without always having formal authority and balancing collaborative approaches with the responsibility to ensure quality, value for money, and decisions that serve the whole population rather than individual services or organisations. This is a significant shift in the way in which we must work as a system.

In Shropshire, Telford and Wrekin, our approach to population health is underpinned by robust system governance led by our Directors of Public Health and ICB population health management experts, feeding into system commissioning decisions and supporting robust evaluation of impacts. This will be further developed as part of the Cluster Operating Model.

### Clinical and professional leadership

Clinical and professional leadership is vital at every stage of strategic commissioning. This will ensure that clinical expertise is embedded and that commissioning decisions are grounded in evidence and best practice, support care that delivers the best outcomes, improve outcomes for the whole population, and support the effective use of resources. Through our existing Clinical Advisory Groups, leaders from across different clinical backgrounds provide expert oversight, shape our Clinical Strategy, champion value-based healthcare, and help identify clinical priorities using robust data and intelligence.

Over the next five years, we will build on and strengthen clinical and professional leadership at every level (including the expansion of the Health and Care Senate into Shropshire, Telford and Wrekin) to enable the commissioning and delivery of integrated and outcome-focused models of care aligned to the three shifts of the 10 Year Plan.

**Throughout the life of this plan, clinical and professional leaders will drive service transformation by:**

- Developing our Clinical Strategy and identifying clinical priorities using data and population health insight alongside ongoing evaluation of health outcomes
- Leading the top clinical priorities across the health and social care system
- Building leadership capability for commissioning
- Providing system leadership and fostering effective partnership working
- Embedding a culture of collaboration and stewardship.

## Our commitment to high-quality, safe care

High-quality, safe care underpins our commissioning approach across both ICBs. Over the next five years, our strategic commissioning will remain focused on improving outcomes, reducing avoidable harm, enhancing patient experience, and minimising unwarranted variation across all services.

This commitment is grounded in our statutory responsibilities and national expectations, including the NHS Constitution, the NHS Long Term Plan, the NHS Patient Safety Strategy and the Patient Safety Incident Response Framework (PSIRF). Quality and safety will be embedded in every commissioning decision, transformation programme and service model we develop.

### Our vision is for a health and care system where:

- Avoidable harm is minimised, with proactive risk identification embedded in everyday practice
- Outcomes are consistently high across all providers, geographies and population groups
- Inequalities in access, quality and experience are eliminated, ensuring fairness for the most disadvantaged communities.
- Learning is shared rapidly and consistently across organisational boundaries
- Patients, service users, carers and communities shape improvement, with lived experience central to decision making
- Providers operate within strong quality governance, supported by robust commissioning oversight and assurance.

## How we will deliver this

### Quality governance and oversight

We will maintain a transparent and effective system of quality assurance that reflects our role as a strategic commissioner.

### ICB Quality and Performance Committee

#### The Committee will continue to provide oversight and assurance across:

- Safety, effectiveness and experience
- Compliance with statutory duties
- PSIRF implementation and learning
- Provider quality risks and improvement plans
- Safeguarding
- Inequalities in outcomes, access and experience.

### Shared system quality model

#### Across the emerging cluster, we will develop a shared quality governance framework that:

- Aligns quality surveillance processes
- Aligns with national Quality Strategy
- Enables joint thematic deep dives
- Strengthens cluster-wide escalation routes
- Uses shared data and intelligence

- Supports integrated responses to risk.

## Provider assurance

### We will hold all commissioned providers to account through:

- Quality review meetings
- Contractual quality schedules
- Quality indicators and outcome measures
- Joint Quality Visits and service level assurance
- The Quality Framework for commissioned services
- Safeguarding and SEND Partnership Arrangements.

## Patient safety – embedding PSIRF

We will fully embed PSIRF across all providers, establishing a learning-focused, systems-based approach to incident response.

### Our priorities include:

- Ensuring providers deliver PSIRF-compliant incident response and annual safety improvement plans
- Improving the quality, timeliness and impact of investigations
- Strengthening triangulation of safety intelligence (patient safety investigations, complaints, claims, mortality reviews, workforce data and soft intelligence)
- Supporting providers to develop mature safety cultures based on openness and continuous improvement
- Developing system-level learning networks to share insights and good practice.

This will shift the system from reactive responses to proactive risk reduction, making patient safety a visible and integral part of everyday care.

## Clinical effectiveness

High-quality commissioning requires a strong focus on outcomes and evidence-based practice.

### Over the next five years, we will:

- Commission services aligned to national best practice, NICE guidance and Modern Services Frameworks
- Reduce unwarranted clinical variation through standardised pathways
- Implement outcomes-based commissioning where feasible
- Apply Quality Impact Assessments (QIAs) and Integrated Impact Assessments (IIAs) consistently across transformation, disinvestment and redesign
- Develop our health economic outcomes research approach for evaluating local health outcomes
- Strengthen clinical leadership across commissioning portfolios and provider collaboratives
- Embed personalised care and shared decision making in pathway design.

## Patient and carer experience

Patient and carer experience will be treated as a core indicator of quality.

### We will:

- Strengthen systematic collection and analysis of experience data

- Ensure insights directly influence commissioning decisions and service specifications
- Prioritise improvements in communication, access and navigation
- Amplify the voices of seldom-heard communities through targeted engagement
- Work with VCSE partners to develop accessible, culturally competent feedback routes
- Embed co-production in all major service redesign programmes.

## Reducing inequalities in quality and outcomes

Reducing inequalities is a statutory duty and a central component of quality.

### We will:

- Embed Core20PLUS5 across commissioning intentions
- Ensure that the ICB and provider trusts are compliant with the SEND Code of Practice (2015) and pending SEND reforms (2026)
- Use data and our population health management approach to identify variation in outcomes, experience and safety
- Commission targeted interventions for underserved groups
- Routinely apply Equality Impact Assessments (EIAs) and Integrated Impact Assessments (IIAs)
- Require providers to demonstrate reductions in variation across protected characteristics and deprivation
- Strengthen monitoring of access and waiting times for disadvantaged populations.

## Quality in new models of care and system shifts

### a. Hospital to community ('left shift')

#### We will ensure safer care through:

- Reliable escalation routes
- Safe discharge processes and intermediate care pathways
- Reduced harm from long stays and delayed discharge
- Strong governance for neighbourhood health models and virtual wards
- Measurable outcomes
- Seeking patient and carer experience.

### b. Analogue to digital

#### Digital transformation will enhance quality and safety through:

- Shared care records to reduce duplication and error
- Improved clinical decision making through better data
- Safety-tested digital triage and remote monitoring tools
- Digital inclusion initiatives to reduce inequality.

### c. Sickness to prevention

#### As preventing deterioration is a key safety intervention, we will prioritise:

- Early detection of long-term conditions
- Proactive management of high-risk groups
- Improved uptake of screening, immunisation and prevention programmes

- Community-based models that reduce avoidable harm.

## Safeguarding

### **We will meet all statutory safeguarding duties for adults and children by:**

- Maintaining robust safeguarding commissioning standards, statutory guidance and legislation
- Ensuring provider compliance with national frameworks
- Improving identification of exploitation, domestic abuse, neglect and mental capacity concerns
- Improving early identification of need to prevent escalation and higher-level intervention
- Implementing the Family First Partnership programme
- Working in partnership with local authorities and safeguarding boards across both ICB areas
- Ensuring ICB and provider compliance with the planning and implementation of guidance and legislative changes related to the Families First Partnership reforms.

## Quality risks and early warning

### **We will maintain a proactive approach to identifying emerging risks through:**

- Cluster-wide quality surveillance
- Soft intelligence and whistleblowing routes
- Real-time data (urgent and emergency care, staffing, acuity, complaints)
- Mortality surveillance and learning
- Horizon scanning for national and local risks.

Clear escalation processes will ensure timely action and support for providers.

## Quality improvement

### **We will foster a culture of continuous improvement through:**

- A system-wide approach aligned with PSIRF learning
- Provider collaboratives sharing expertise and resources
- Clear definitions of 'what good looks like' through outcomes dashboards
- Targeted support for high-risk or challenged services
- Workforce capability building in quality improvement and human factors.

## Measuring progress

### **We will monitor quality through a structured, data-driven approach, including:**

- Portfolio-level quality dashboards
- Outcome measures for commissioning intentions
- Safety indicators (such as harm reduction goals)
- Patient experience metrics
- Inequalities monitoring
- Quarterly thematic reviews.

## Data, analytics, and technology

Data, analytics and technology are integral in supporting ICBs to become strategic commissioners, enabling evidence-based, data-driven decision making. Advanced analytical tools, linked datasets and real-time intelligence allow commissioners to understand need, demand and outcomes and surface inequalities at a far deeper level than traditional activity reporting ever allowed.

The NHS Federated Data Platform provides a vehicle to strengthen this capability by securely connecting data across providers, care settings and geographies, giving a single, consistent view of the system. This supports everything from pathway redesign and resource allocation to early identification of risk, unwarranted variation and opportunities for prevention. When combined with digital tools, shared care records and automated reporting, commissioners can model future scenarios, evaluate impact, assess outcomes and design services that are more integrated, efficient and responsive to population needs.

## Intelligent payor capabilities

Intelligent payor capabilities mean being a smart commissioner - knowing what works, what doesn't, and how to spend resources wisely to improve care.

Intelligent payor capabilities are a critical component of modern strategic commissioning and central to delivering the ambitions of this plan. By strengthening our ability to use robust data, insight and population-level analytics, we can better understand demand, capacity, outcomes and provider performance across the system. This will enable us as commissioners to act proactively, shaping markets, managing resources and influencing provision towards high-quality, sustainable models of care that meet the needs of different population groups.

As we move towards more Place-based and neighbourhood-level delivery, intelligent payor functions will underpin multi-neighbourhood contracting approaches allowing us to commission at scale where appropriate, while tailoring services to the distinct characteristics and priorities of local communities. These arrangements create the flexibility to align funding with local need, support targeted interventions for complex populations, and incentivise collaboration across providers working within and across neighbourhood footprints.

The development and implementation of sophisticated contracting models such as outcomes-based contracts, alliance agreements and blended payment mechanisms, will further enable integration by fostering shared accountability and incentivising partners to work collectively towards agreed system outcomes. Embedding these models within multi-neighbourhood contracts will allow for shared risk and reward, support innovation, and encourage providers to focus on prevention, personalisation and improved population health rather than activity alone.

Payment reform plays a key role in this shift by aligning financial incentives with the broader goals of the Five Year Strategic Commissioning Plan – including reducing health inequalities, supporting early intervention, and ensuring resources flow into community-based, preventative models of care. Taken together, these capabilities allow commissioners to operate strategically, deploying resources in ways that maximise impact, reduce variation, promote collaboration and secure long-term sustainability across neighbourhood, place and system levels.

## Organisational development and capability building

Organisational development and capability building are fundamental to enabling the ICB to operate as an effective strategic commissioner over the next five years. As the system continues its shift towards long-term population health improvement, prevention, and integrated models of care, the ICB must invest in the skills, behaviours and structures required to lead this transformation confidently and consistently. This includes strengthening analytical capability to support population health management and predictive modelling, enhancing commercial skills to negotiate complex contracts and shape local markets, deepening clinical leadership to ensure commissioning decisions are grounded in evidence and outcomes, and expanding programme and change management expertise to drive delivery at scale. Building confidence and competence in data-led decision making is central to this, enabling teams to use insight to prioritise investment, improve productivity, and identify unwarranted variation.

Over the next five years, developing strategic commissioning leadership at every level within the ICB, across providers, and through place-based partnerships, will be essential to develop a workforce able to work across organisational boundaries.

Alongside this, a structured approach to talent development, skills frameworks and leadership pipelines will support workforce resilience and succession planning. By investing in these organisational capabilities, the ICB will build a confident, adaptive and high-performing commissioning function that can deliver high-quality, value-driven, integrated care and ensure the long-term sustainability of the system for the populations of Shropshire, Telford and Wrekin.

## Working with people and communities in Strategic Commissioning

We have a clear statutory responsibility to involve people and communities in the planning, development and delivery of health services. Under Section 14Z45 of the Health and Care Act 2022, ICBs must ensure that individuals – and their carers or representatives – are involved in the planning of commissioning arrangements, the development and consideration of proposals for change, and decisions that affect how those arrangements operate. This duty is central to our role as a strategic commissioner and will shape how we plan, prioritise and commission services over the next five years.

The NHS Constitution reinforces this obligation by emphasising public ownership of the NHS and accountability to the patients, communities and populations it serves. Meaningful involvement is therefore a core component of high-quality commissioning and effective system leadership.

### Strategic commissioning shaped by people and communities

As strategic commissioners, we are responsible for ensuring that services are planned, organised, funded and commissioned to meet the current and future needs of our population. Achieving this requires working in genuine partnership with the people who live in Shropshire, Telford and Wrekin, those who use services now and, in the future, and those who care for others.

### Engagement with people and communities will be embedded throughout the commissioning cycle

Insight from patients, carers, staff and communities will inform population health needs assessments, service design and redesign, commissioning intentions and specifications, implementation and mobilisation, and ongoing review and improvement. We recognise that lived experience brings essential insights, which will help us to innovate and to design services that are accessible, equitable and capable of improving outcomes and reducing inequalities.

## Working in partnership to reduce inequalities

Reducing health inequalities is a core objective of this commissioning plan. Our approach to involvement will therefore prioritise inclusive, two-way engagement with diverse and seldom-heard communities, asset-based approaches that build on community strengths, and the removal of barriers that prevent people from influencing decisions. Partnership with the VCSE sector will be central to this work – particularly in reaching communities experiencing the poorest outcomes and embedding lived experience into service design.

## Our approach to involvement across the commissioning cycle

To meet our statutory duties and strategic ambitions, we will apply a consistent approach to informing, involving, engaging and consulting people and communities.

- **Inform** – We will provide clear, timely and accessible information about commissioning plans, service changes and opportunities to be involved, using multiple channels and formats that meet diverse needs.
- **Involve** – We will involve patients, service users, carers and community representatives early in shaping commissioning decisions, ensuring that feedback is acknowledged and its influence clearly demonstrated.
- **Engage** – We will maintain ongoing dialogue with communities about health needs, priorities and experiences. Insight gathered will directly inform commissioning intentions, resource allocation and service improvement, with a strong focus on reducing inequalities.
- **Consult** – Where significant service changes are proposed, we will undertake formal consultation in line with statutory requirements, ensuring clarity of purpose, inclusivity and transparency in how responses inform final decisions.

## Embedding involvement in governance and delivery

The ICB has established clear principles for working with people and communities, supported by a local strategy within our Governance Handbook. These principles will be embedded across this Five Year Strategic Commissioning Plan, annual commissioning intentions, service specifications, transformation programmes, and all governance, assurance and decision-making processes.

We will monitor and evaluate the effectiveness of our involvement activity using both qualitative and quantitative measures. We will also publish information on how people and communities have influenced commissioning decisions and report progress through our annual reporting and assurance mechanisms.

## Hospital Transformation Programme

The SaTH Hospital Transformation Programme (HTP) represents a pivotal opportunity for the system to deliver safer, more efficient, and clinically sustainable acute services over the next five years. For the ICB, the success of the HTP is inseparable from achieving a meaningful left shift, strengthening prevention, early intervention, and community-based care to reduce avoidable demand on acute hospitals. Embedding this shift within the commissioning plan will enable the system to rebalance resources, prioritise population health outcomes, and ensure that acute capacity is protected for the most seriously ill patients.

By commissioning integrated pathways across primary care, community services, mental health, social care, and the voluntary sector, the ICB can create the conditions needed for the left shift to be realised at scale. This approach not only supports delivery of the HTP but also underpins long-term financial sustainability, workforce resilience, and improved patient experience across Shropshire, Telford and Wrekin.

In summary, this transformation is about much more than a ‘hospital’, it is the opportunity for healthcare transformation across our geography, and it is our collective responsibility to deliver on this for our residents.

## Looking ahead (five-year maturity)

Over the next five years, the ICB’s evolution, initially within a cluster arrangement with Staffordshire and Stoke-on-Trent ICB and progressing towards a planned full merger, will enable the system to operate with coherence, consistency and efficiency across a broader geographical footprint. This transition provides the foundation for a more unified commissioning approach, allowing the ICB to streamline functions, reduce duplication and strengthen its strategic influence while preserving local autonomy where it adds value.

As the system matures, greater independence will be devolved to neighbourhoods and provider collaboratives, enabling them to innovate, shape local delivery models and respond more dynamically to population need, supported by clear frameworks, enabling governance and proportionate oversight.

Strengthening joint commissioning with local authorities will continue to be a priority, particularly as the focus shifts further towards prevention, community resilience and addressing the wider determinants of health. By aligning local priorities and statutory duties, the ICB and local authorities will be able to drive a more coherent, whole-system response to issues such as housing, employment, education, family support and environmental factors. This will help ensure commissioning decisions are grounded in a deep understanding of what shapes people’s health and wellbeing. Enhanced governance arrangements will underpin this – ensuring clarity of accountability, constructive challenge and timely decision making, while enabling the system to accelerate transformation and deliver improvements in productivity and quality.

As additional delegated responsibilities transfer to the ICB – such as specialised commissioning, immunisations and vaccinations, screening programmes and the full spectrum of primary care, the organisation will move towards truly end-to-end commissioning. This will allow the ICB to set clearer standards across pathways, drive more consistent outcomes, and embed a system-wide commitment to equity, quality and value. Ensuring that these functions integrate seamlessly into existing structures will be central to creating a commissioning function that is modern, responsive and capable of supporting the long-term ambitions of the system.

Through this forward-looking approach, the ICB will create the environment needed for integrated, preventative and community-centred models of care to flourish, ensuring the system is prepared not only for current challenges but for the changing landscape of the next five years.

# Section 3 – Commissioning intentions, transformation and new care models

## Commissioning intentions for 2026/26 to 2030/31

This section sets out our Integrated Strategic Needs Assessment (ISNA), which helps us understand the health needs, inequalities and changing population trends across Shropshire, Telford and Wrekin. Understanding these needs, both now and in the future, is essential. It allows us to see which communities need more support, what is driving poor health, and where we should focus our resources to make the biggest difference. This insight is a vital part of our role as a commissioner, helping us plan the right services for our citizens and ensure they meet the needs of our population.

The section also outlines our commissioning plan for the period 2026/27 to 2030/31. It sets out the focus against our five major system shifts over the next five years – hospital to community, analogue to digital, sickness to prevention, improving access, and productivity and efficiency. Together, these shifts will help us move towards a more proactive, joined-up and community-focused health and care system.

## Population overview

Shropshire, Telford and Wrekin ICB covers two distinct but inter-connected local authority areas with different demographic profiles and growth patterns. Together, they form a population of just over 520,000 residents, characterised by a mix of rural communities, market towns and a rapidly growing urban centre.

Shropshire is a predominantly rural county with a steadily growing but ageing population. Recent estimates show the population increased from 329,558 in 2023 to 332,455 in 2024 – a rise of 0.9% driven largely by inward migration rather than natural growth. The county has a significantly older age profile, with higher demand for services related to long-term conditions, frailty and social care. Rurality also creates challenges around access, transport and digital connectivity.

Telford and Wrekin is one of the fastest-growing areas in the West Midlands. Between the 2011 and 2021 censuses, the population grew by 11.3% – rising from around 166,600 to 185,500. More recent estimates show continued growth, reaching 195,952 in 2024 – an increase of 1.8% in a single year. The area has a younger demographic profile, higher birth rates and greater ethnic diversity compared with Shropshire.

### Across the ICB footprint, our challenges can be summarised as follows:

- Population growth is strong, particularly in Telford and Wrekin – creating rising demand for maternity, children's services and primary care.
- Ageing is a major driver of need, especially in rural Shropshire – increasing pressure on community services, urgent care and adult social care.
- Health inequalities vary significantly – with pockets of deprivation concentrated in parts of Telford and Wrekin, while rural isolation affects access and outcomes in Shropshire.
- Migration patterns differ, with Shropshire seeing more inward migration of older adults, while Telford and Wrekin attracts younger families and has a more diverse population.

Together, these dynamics shape the commissioning priorities for the ICB – requiring a balanced approach that supports both an ageing rural population and a growing, diverse urban community.

# JSNAs, ISNA, PHIP and their relationship to the Shropshire, Telford and Wrekin Clinical Strategy

## Joint Strategic Needs Assessments

The Joint Strategic Needs Assessments (JSNAs) produced by local authorities provide the foundational, place-based understanding of population health needs, inequalities and wider determinants across Shropshire, Telford and Wrekin. They draw on local data, community insight and statutory public-health intelligence to describe need at a granular level, informing local planning and resource allocation.

### Telford and Wrekin JSNA

The Telford and Wrekin JSNA identifies a fast-growing and increasingly diverse population, with significant variation in health, deprivation and need across the borough. Population growth of 11.4% makes it one of the fastest-growing areas in the West Midlands, driven particularly by increases in children and young people aged 0–25. Around 17% of residents live in neighbourhoods among the most income-deprived nationally, contributing to marked inequalities in health outcomes and life chances.

The JSNA highlights rising diversity – 26% of school-aged children identify as non-White British. There is also increasing demand for support relating to Special Educational Needs and Disabilities (SEND), affecting 17.9% of children – above the national average. Key needs include moderate learning difficulties, speech and language challenges, and social, emotional and mental health issues.

Overall, the Telford and Wrekin JSNA provides a high-level picture of trends, inequalities and emerging pressures, supporting partners to plan services, target resources and address the wider determinants of health.

### Shropshire JSNA

The Shropshire JSNA presents a detailed assessment of the county's health, wellbeing and wider determinants. As a largely rural area, Shropshire faces challenges related to an ageing population, access to services, transport, digital connectivity and social isolation. Despite overall affluence, pockets of deprivation persist – with some communities experiencing significantly poorer outcomes.

The JSNA highlights rising need across children's emotional wellbeing, SEND and school readiness. The SEND population has grown rapidly, increasing by 32% post-pandemic, with a particularly sharp rise of 78% in children with Education, Health and Care Plans (EHCPs).

For adults, the JSNA highlights pressures associated with long-term conditions, mental health, employment, and lifestyle-related risks. Wider determinants such as housing, the local economy and community infrastructure are also examined given their influence on inequalities. In addition, Shropshire's 18 place-based JSNAs provide deeper insight into local priorities, assets and variation at neighbourhood level.

### ISNA

The ISNA incorporates intelligence from the JSNAs from both local authorities, integrating them with NHS datasets to produce a system-wide assessment of current and future health needs. It combines demographic trends, disease patterns, service-use data, workforce pressures and wider determinants to provide a comprehensive and comparable picture of need and health inequality headlines across the ICS.

We have taken a pragmatic approach to its first ISNA (used to inform this plan) based on the data and intelligence available. We will develop this over time using analytical methods such as segmentation, cohort modelling, cost-pressure forecasting and inequality analysis to identify variation in outcomes, unmet needs, system inefficiencies and capacity-demand mismatches. Scenario modelling will also allow

commissioners to test the implications of population change, long-term condition prevalence and service redesign.

The ISNA will also incorporate qualitative insight from patients, clinicians, local authorities and voluntary partners to enrich and enhance the quantitative analysis. This combined evidence will enable us to identify priority cohorts, set transformation goals, target resources effectively and evaluate to ensure commissioning aligns with future need and statutory duties around equality and prevention.

In essence, the ISNA provides the overarching insight that makes the Five Year Strategic Commissioning plan robust, data-driven and aligned with population health management principles.

### **Population Health Implementation Plan (PHIP)**

The Population Health Implementation Plan (PHIP) sets out how the system will utilise population health intelligence based on the ISNA findings to inform a practical and sequenced set of ambitions over a rolling five-year period. The plan outlines an associated programme of interventions over the same commissioning timeframe that will aim to deliver these ambitions.

Technically, the PHIP acts as the delivery blueprint to improve the health of the local population. It outlines the key metrics that the ICB has prioritised with system partners identified by the ISNA, along with the high-level aims and objectives of each programme of interventions. It uses a prioritisation matrix to identify the health metrics that will enable the ICB to effectively measure the impact of the programmes on the population's health.

Overall, the PHIP combines population-health intelligence with targeted, actionable programmes, ensuring the Five Year Strategic Commissioning Plan is coherent, data-driven and capable of driving meaningful population-level health improvement. At present the PHIP is a work in progress and still requires formal sharing and agreement with both Health and Wellbeing Boards. It will evolve over time to provide impactful interventions for all the key population needs and health inequalities for the people of Shropshire, Telford and Wrekin identified by the ISNA.

### **Clinical Strategy**

The ISNA provides the core analytical foundation for the Shropshire, Telford and Wrekin Clinical Strategy which in turn provides the strategic context for the PHIP. The Clinical Strategy provides the vision to enable the ICB to commission for the area's specific challenges, including rurality, an ageing population and persistent health inequalities.

The strategy is a prevention-focused, community-centred approach across the life course – Start Well, Grow Well, Live Well, Age Well and End Well.

Ultimately, the ISNA and PHIP ensure that the Clinical Strategy is both evidence-led and delivery-ready. Based on our clinical priorities in population need, it provides a structured, data-driven framework for implementing interventions that reduce inequalities, improve outcomes and support integrated, sustainable models of care.

All the above have been developed and form a coherent approach to the ultimate development of the Five Year Strategic Commissioning Plan.

### **Core20PLUS5 Framework**

The Core20PLUS5 Framework is an NHS England approach designed to reduce healthcare inequalities. It focuses action within the NHS towards supporting population groups which are nationally recognised as being more likely to experience health inequality.

### **This includes:**

- The most deprived 20% of the population (otherwise known as the Core20), as defined by the Index of Multiple Deprivation (2025)
- Locally defined PLUS groups (such as minoritised ethnic groups and people with learning or physical disabilities, amongst others) and inclusion health groups.

### **Within Shropshire, Telford and Wrekin, inclusion groups include:**

- People experiencing homelessness
- Those affected by drug and alcohol dependence
- Vulnerable migrants and refugees
- Gypsy, Roma and Traveller communities
- People in contact with the justice system
- Victims of exploitation, and other marginalised or seldom-heard groups.

These communities often face significant barriers to accessing care, contributing to poorer health outcomes and reduced life expectancy. By embedding Core20PLUS5 principles across all programmes, the ICB aims to improve access, experience and outcomes through targeted interventions and strengthened partnerships with local authorities, the VCSE sector and wider public services to address the broader determinants of health.

### **The framework also identified 10 priority clinical areas:**

- Maternity services
- Serious mental illness
- Chronic respiratory disease
- Cardiovascular disease
- Early cancer diagnosis
- Children and young people's asthma
- Children and young people's epilepsy
- Children and young people's diabetes
- Children and young people's mental health
- Children and young people's oral health.

To support our strategic planning process, a full review of data metrics aligned to [NHS England's Healthcare Inequality Priorities](#) and the Core20PLUS5 Framework has been completed. Where data is available, the analysis demonstrates variation between Core20PLUS groups and the general population. It also indicates trends of improvement in reducing known inequality gaps between population groups in access to, experience of, and outcomes from healthcare services.

It should be noted that several areas (marked with an asterisk\*) cannot be fully analysed at this time due to limited data availability. There are further data quality implications relating to ethnicity data due to limitations in the completeness and accuracy of local ethnicity recording.

Priority area	Metrics	Variation/gap		
		(Latest performance where disaggregated data is unavailable)	Trend period	Trend
Data quality	Percentage of records with valid ethnic codes, including not stated and not known	92.19% (variable by provider)	2024/25 – 2025/26	No change
Smoking cessation	Inequalities in smoking prevalence in adults (18+)*	<b>Higher in Core20</b>	2022 – 2023	<b>Gap widening</b>
Smoking cessation	Inequalities in smoking at time of delivery (SATOD) status	<b>Higher in Core20</b>	2024/25 – 2025/26	<b>Gap reducing</b>
Alcohol and drug use	Number of hospital admissions for alcohol-attributable conditions	<b>Higher in Core20</b>	2022/23 – 2024/25	No change
Obesity	Inequalities in percentage of adults classified as overweight or obese*	<b>Higher in Telford and Wrekin</b>	2022/23 – 2023/24	<b>Increasing</b>
Obesity	Inequalities in percentage of adults classified as overweight or obese*	<b>Higher in Core20</b>	2022/23 – 2023/24	<b>Increasing</b>
Obesity	Variation between percentage of referrals to the National Diabetes Prevention Programme (NDPP) from the most deprived quintile and percentage of Type 2 diabetes population from the most deprived quintile*	<b>Lower in Core20</b>	2024/25 – 2025/26	Not available
Elective care	The size of the waiting list and observed inequalities in waiting times across different population groups (18-week and 52-week waits)	<b>No variation between Core20PLUS groups</b>	2024/25 – 2025/26	<b>No change</b>
Elective care	Inequalities in rates of 'Did Not Attend'/'Was Not Brought' across services	<b>Higher in Core20</b> <b>Higher in minoritised ethnic groups</b>	2024/25 – 2025/26	No change
Urgent care	Emergency admissions (age-standardised)	<b>Higher in Core20</b>	2024/25 – 2025/26	<b>Gap widening</b>
Urgent care	Emergency admissions (age-standardised)	Lower in rural populations	2024/25 – 2025/26	N/A
Urgent care	Emergency admissions (all ages)	<b>Higher in Core20</b>	2024/25 – 2025/26	<b>Gap reducing</b>
Urgent care	Emergency admissions (all ages)	<b>Higher in minoritised ethnic groups</b>	2024/25 – 2025/26	<b>Gap widening</b>

Priority area	Metrics	Variation/gap		
		(Latest performance where disaggregated data is unavailable)	Trend period	Trend
Urgent care	Emergency admissions (all ages)	Lower in rural populations	2024/25 – 2025/26	N/A
Urgent care	Emergency admissions (people aged 0–18)	<b>Higher in Core20 and Higher in minoritised ethnic groups</b>	2024/25 – 2025/26	<b>Gap widening</b>
Urgent care	Emergency admissions (people aged 0–18)	Lower in rural populations	2024/25 – 2025/26	N/A
Learning disability	Percentage of patients aged 14+ on GP learning disability registers who have had an annual health check*	33.1%	2024/25 – 2025/26	<b>No change</b>
Learning disability	Number of people in a mental health inpatient setting who have autism*	25.4 per million of the population	2024/25 – 2025/26	<b>Increased</b>
Learning disability	Number of people in a mental health inpatient setting who have a learning disability*	20.3 per million of the population	2024/25 – 2025/26	<b>Decreased</b>
Learning disability	Percentage of people with suspected autism waiting more than 13 weeks for contact*	<b>Higher in ages 0–18</b>	2024/25 – 2025-26	<b>Increased</b>
Maternity	Deprivation and ethnicity gap in pre-term births	<b>Higher rates from Core20</b>	2023/24 – 2025/26	<b>Gap widening</b>
Maternity	Deprivation and ethnicity gap in pre-term births	<b>Higher rates in Black/Black British populations</b>	2023/24 – 2025/26	<b>Gap reducing</b>
Maternity	Inequalities in gestational age at booking (by 10 weeks)	<b>Lower rates in Core20</b>	2023/24 – 2025/26	<b>Gap reducing</b>
Maternity	Inequalities in gestational age at booking (by 10 weeks)	<b>Lower rates in Black/Black British populations</b>	2023/24 – 2025/26	<b>Gap reducing</b>
Adult mental health	Inequalities in patients achieving reliable recovery from talking therapies	<b>Higher in Core20</b>	2023/24 – 2025/26	No change
Adult mental health	Inequalities in patients achieving reliable recovery from talking therapies	<b>Higher in minoritised ethnic groups</b>	2023/24 – 2025/26	<b>Gap widening</b>
Adult mental health	Inequalities in proportion of people with serious mental illness receiving a full annual health check*	September 2025 – 53%	2023/24 – 2025/26	No change

Priority area	Metrics	Variation/gap	Trend period	Trend
		(Latest performance where disaggregated data is unavailable)		
Adult mental health	Inequalities in rates of Mental Health Act detentions	<b>Higher in Core20</b> <b>Higher in minoritised ethnic groups</b>	2024/25 – 2025/26	<b>Gaps reducing</b>
Adult mental health	Inequalities in rates of Mental Health Act detentions	Lower in rural populations	2024/25 – 2025/26	N/A
Adult mental health	Inequalities in use of restrictive interventions*	15 per 1,000 of the population	2024/25 – 2025/26	<b>Decreasing</b>
Chronic respiratory adult	Inequalities in pulmonary rehab completion rates *	89.9%	2024/25	Not available
Chronic respiratory adult	Inequalities in under-75 mortality rate from chronic lower respiratory disease	<b>Higher in Core20</b>	2023/24 – 2024/25	<b>Gap reducing</b>
Chronic respiratory adult	Inequalities in under-75 mortality rate from chronic lower respiratory disease	<b>Lower in minoritised ethnic groups</b> Lower in rural populations	2023/24 – 2024/25	N/A
Chronic respiratory adult	Inequalities in COVID-19 vaccination uptake	<b>Lower in Core20 and minoritised ethnic groups</b>	2023/24 – 2024/25	<b>Gap reducing</b>
Chronic respiratory adult	Inequalities in COVID-19 vaccination uptake	<b>Higher in rural populations</b>	2023/24 – 2024/25	n/a
Chronic respiratory adult	Inequalities in flu vaccination uptake	<b>Lower in Core20, Asian/Asian British and Black/Black British population groups</b>	2024/25	Not available
Cancer	Premature mortality from cancer considered preventable	<b>Higher in Core20</b>	2023/24 – 2024/25	<b>Gap widening</b>
Cancer	Premature mortality from cancer considered preventable	<b>Lower for minoritised ethnic and rural groups populations</b>	2023/24 – 2024/25	N/A
Cancer	Inequalities in percentage of cancers diagnosed at stage 1 and 2* (data is heavily caveated)	<b>Higher in Core20</b>	2023/24 – 2024/25	<b>Gap reducing</b>
Cancer	Cancer screening coverage – bowel cancer*	<b>Similar in Telford and Wrekin compared to England, Higher in Shropshire</b>	2024	Not available
Cancer	Cancer screening coverage – breast cancer*	<b>Similar in Telford and Wrekin compared to England, Higher in Shropshire</b>	2024	Not available
Cancer	Cancer screening coverage – cervical	<b>Higher in Shropshire and Telford and</b>	2024	Not available

Priority area	Metrics	Variation/gap	Trend period	Trend
		(Latest performance where disaggregated data is unavailable)		
	screening (people aged 25 – 49)*	Wrekin, compared to England		
Cancer	Cancer screening coverage – cervical screening (people aged 50 – 64)*	Similar in Shropshire and Telford and Wrekin, compared to England	2024	Not available
Cancer	Cancer screening coverage – targeted lung health checks*	Not available at the time of analysis	Not available at the time of analysis	Not available at the time of analysis
Cardiovascular disease (CVD) and adult diabetes	Premature mortality from CVD	Higher in Core20	2023/24 – 2025/26	Gap reducing
CVD and adult diabetes	Premature mortality from CVD	Lower in Minoritised Ethnic Groups	2023/24 – 2025/26	N/A
CVD and adult diabetes	Deprivation gap in myocardial infarction and stroke admissions	Higher in Core20	2024/25 – 2025/26	Gap reducing
CVD and adult diabetes	Deprivation gap in myocardial infarction and stroke admissions	Higher in Minoritised Ethnic Groups	2024/25 – 2025/26	Gap widening
CVD and adult diabetes	Inequalities in percentage of patients with CVD who have their cholesterol levels managed to NICE guidance	Higher in Core20, people with a learning disability and autism and people with serious mental illness	2024/25 – 2025/26	Gap reducing
CVD and adult diabetes	Inequalities in percentage of patients with CVD who have their cholesterol levels managed to NICE guidance	Lower in Black/Black British	2024/25 – 2025/26	Gap reducing
CVD and adult diabetes	Inequalities in percentage of hypertension patients treated to target	Higher in people with a learning disability and autism and with serious mental illness	2024/25 – 2025/26	N/A
CVD and adult diabetes	Inequalities in percentage of hypertension patients treated to target	Lower in Core20	2024/25 – 2025/26	Gap increasing
CVD and adult diabetes	Inequalities in percentage of hypertension patients treated to target	Lower in minoritised ethnic groups	2024/25 – 2025/26	Gap increasing
CVD and adult diabetes	Inequalities in rates of hypertension case finding	Lower in Core20	2024/25 – 2025/26	No change
CVD and adult diabetes	Inequalities in people with diabetes who have received all 9 of the care	Data unavailable by demographic group	Data unavailable by demographic group	Data unavailable by demographic group

Priority area	Metrics	Variation/gap	Trend period	Trend
		(Latest performance where disaggregated data is unavailable)		
	processes (including retinal screening)*			
Children and young people's (CYP) mental health	Access rates to CYP mental health services by protected characteristic or demographic group (0–17)	<b>Higher in Core20</b>	2024/25 – 2025/26	<b>Increasing</b>
CYP oral health	Inequalities in elective admissions of hospital-based tooth extractions due to dental caries, commonly known as tooth decay	<b>Higher in Core20</b>	2024/25 – 2025/26	<b>Gap widening</b>
CYP oral health	Inequalities in elective admissions of hospital-based tooth extractions due to dental caries	<b>Lower</b> in rural populations	2024/25 – 2025/26	No change
CYP asthma	Inequalities in prevalence of childhood asthma (under-18)	<b>Similar rates</b> in Core20 and some minoritised ethnic groups	2025	Not available
CYP epilepsy	Access to epilepsy specialist nurses in the first year of care for CYP with a learning disability or autism*	100%	2023/24	Not available
CYP diabetes	Inequalities in percentage of CYP with diabetes receiving all the recommended NICE care processes	<b>Lower in Core20</b>	2025/26	Not available
CYP diabetes	Inequalities in percentage of CYP with diabetes receiving all the recommended NICE care processes	<b>Similar in minoritised ethnic groups</b>	2025/26	Not available
CYP diabetes	Inequalities in percentage of CYP on continuous glucose monitoring	<b>No variation in access between Core20 groups</b>	2025/26	Not available
CYP diabetes	Inequalities in percentage of CYP on insulin pump	<b>No variation in access between Core20 groups</b>	2025/26	Not available
CYP diabetes	Inequalities in percentage of CYP on hybrid closed loop	<b>No variation in access between Core20 groups</b>	2025/26	Not available

We have drawn on all the above complementary sources of evidence and strategic direction to shape our Five Year Strategic Commissioning Plan and Strategic Commissioning Intentions.

Together, the JSNAs, ISNA, PHIP, Clinical Strategy and the Core20PLUS5 Framework provide a coherent and aligned foundation that ensures our plan is evidence-led, population-focused and strategically positioned to deliver meaningful improvements in health outcomes, reduce inequalities and support long-term system sustainability.

## Commissioning intentions

### Overview

Our commissioning intentions for 2026/27–2030/31 outline how we will target resources, reshape models of care, and deliver the five key system shifts – hospital to community, analogue to digital, sickness to prevention, improving access, and productivity and efficiency. These intentions are informed by the ISNA, detailed population health analysis, and system performance baselines across Shropshire, Telford and Wrekin. They demonstrate how we will meet our statutory responsibilities to improve outcomes, tackle inequalities, secure value for money, and align with national priorities such as the NHS Long Term Plan, the 10 Year Plan and the Medium Term Planning Framework.

### Principles

Our approach is guided by a set of core principles that shape how we plan, prioritise and commission services.

- **Resources will follow need**, with investment shifting from acute care towards prevention, community services and primary care where clinically appropriate.
- We will **standardise approaches wherever beneficial**, adopting a system-wide ‘do once’ methodology while maintaining flexibility at place and neighbourhood level.
- **Decisions will be made at the most appropriate level**, with greater delegation to neighbourhoods, places and provider collaboratives to support integrated, outcome-focused delivery.
- All pathways will **embed prevention, early identification and patient empowerment**.
- We will promote **integrated, multisector models of care**, encouraging co-produced pathways and seamless transitions between services.
- Commissioning decisions will be **driven by evidence and robust data**, including population health management, benchmarking and modern service frameworks.
- **Lived experience will be central**, informing service design, improvement and evaluation.
- We will prioritise **value and productivity**, reducing unwarranted variation, and supporting financial sustainability. Tackling inequalities will be a core requirement, with commissioning directly targeting variation in access, experience and outcomes in line with Core20PLUS5.
- We will **innovate in contracting**, expanding outcomes-based approaches, modern payment models and strategic prioritisation tools such as the Strategic Decision Making Framework.

### Golden threads across all intentions

All commissioning intentions are anchored in the wider strategic framework of the system, aligning with key strategies including the NHS 10 Year Plan, the Medium Term Financial Plan, the Joint Forward Plan, and the Clinical Strategy. They are also informed by our:

- Frailty, urgent and emergency care, cancer, inpatient quality, digital, data and engagement strategies
- the SHIPP and TWIPP delivery plans
- the ICS Strategy and its four statutory aims – National Oversight and Performance Assurance Frameworks, Estates and Infrastructure Strategy, and the Prevention Strategy.

Together, these documents provide the strategic context that shapes our desired outcomes, investment decisions and transformation priorities.

### Purpose of the commissioning intentions

The commissioning intentions are designed to translate the ISNA into clear priorities for 2026/27–2030/31 and to set out what is expected of providers, places, neighbourhoods and collaboratives. They guide decisions on where to invest or disinvest, support the shift towards a new system operating model – including neighbourhood working, provider collaboratives and emerging Integrated Health Organisations – and define the measurable outcomes and deliverables required across all pathways.

Through the delivery of these commissioning intentions, we aim to achieve measurable improvements in population health and significantly narrow inequalities in access, experience and outcomes.

We will shift more care closer to home by strengthening neighbourhood and community-based services and build a digitally-enabled system that reduces unnecessary reliance on face-to-face and hospital-based care – where it is safe and appropriate to do so.

Our approach will prioritise prevention, early intervention and proactive management of long-term conditions – while driving productivity and efficiency to support long-term financial sustainability. Ultimately, we will enhance our effectiveness as a strategic commissioner, underpinned by clear accountability, strong assurance processes and aligned system governance.

Our ambitions are set out based upon the following model in line with the requirements of the 10 Year Plan.



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# Hospital to community

## Planned timescales

- **In 2026/27**, the system will continue to roll out Integrated Neighbourhood Teams (INTs), establishing neighbourhood multidisciplinary teams for both adults and children. Community-based diagnostic capacity will increase, and urgent community services, including virtual wards, Urgent Community Response (UCR) and intermediate care, will become the default response for individual's escalating needs.
- **During 2027/28**, these models will expand, supported by stronger multidisciplinary working, simplified community access routes via the Integrated Care Coordination Centres, and the early rollout of community-based elective pathways in specialities such as ear, nose and throat (ENT), respiratory and gynaecology.
- **By 2028/29**, neighbourhood health models will be fully embedded, with a growing proportion of elective, diagnostic, frailty and rehabilitation services delivered outside acute hospitals. Home-based cancer treatments, enhanced support for care homes and expanded community pathways for chronic conditions will become part of routine provision.
- **From 2029/30 to 2030/31**, this shift will be consolidated. Hospital activity will increasingly reflect the left shift in care, with more preventative, proactive, and community-managed support leading to fewer admissions, shorter lengths of stay and greater resilience in out-of-hospital services. Neighbourhood teams will be strengthened through devolved budgets, pooled commissioning arrangements and expanded community capacity to ensure long-term sustainability.

## Our overarching ambition

We are committed to developing neighbourhood-based health models in close collaboration with our two Places, shifting towards proactive, preventative approaches that support people with a wide range of physical and mental health needs. These partnerships are essential for understanding population needs, setting shared priorities and integrating health and care services. Strong governance arrangements ensure regular oversight, meaningful stakeholder engagement and alignment with national expectations.

Our neighbourhood models will reduce duplication, create a more seamless experience for patients, and place greater emphasis on prevention, early intervention and reducing deconditioning. We will equip people with the tools and confidence to manage their own health wherever possible. Investment in our INTs will enable more care to be delivered within communities and in people's usual places of residence – both face-to-face and digitally – helping to prevent avoidable escalation and unnecessary hospital use.

Neighbourhood delivery will be coordinated through place-based partnerships and accelerator groups, aligned with local authority boundaries and natural patient flows. Progress will be monitored against national metrics, including outpatient activity, emergency admissions, bed days, ambulance conveyances, A&E attendances, GP appointments, community pharmacy contacts and patient-reported outcomes. Workforce engagement and staff experience will also be tracked to ensure effective multidisciplinary working and strong team culture.

# Transformation and new care models

## Neighbourhoods and urgent and emergency care

The Hospitals Transformation Programme (HTP) is a key enabler of the system's commitment to shift care from hospital to community settings over the next five years. Recent system initiatives, including the expansion of community-based rehabilitation services and the enhancement of the Urgent Community Response (UCR) service are already strengthening capacity to support people safely at home and reduce avoidable hospital admissions. These developments directly support the commissioning plan's priorities to embed prevention, improve flow, and grow integrated neighbourhood-level care models and provide a firm position on which to build upon as articulated within this plan.

We will continue to expand and embed our UCR offer delivered via SCHT, extending operating hours to midnight, seven days a week. This will increase access, reduce reliance on emergency departments (ED), and ensure vulnerable people receive timely intervention within their usual place of residence.

Virtual wards will remain a core element of the UEC pathway. We will further develop and optimise these models to support admission avoidance, earlier supported discharge and improved patient flow. Capacity will be aligned to system demand, with a particular focus on frailty, respiratory conditions, long-term conditions and stepdown from acute care. Virtual wards will contribute to reduced ED attendances, improved ambulance non-conveyance dispositions and more care delivered closer to home for high-risk and vulnerable groups. Integration with UCR, acute flow processes and neighbourhood teams will ensure a seamless, end-to-end pathway.

To simplify access and improve consistency for the public, we will standardise urgent care entry points by embedding Urgent Treatment Centre (UTC) models where appropriate and strengthening NHS 111 as the default route into urgent care. This will include enabling bookable arrival times into UTCs and Same Day Emergency Care (SDEC), where feasible.

We will designate and commission UTCs in line with national standards (or agreed exemptions), ensuring a consistent and reliable 'front door' for urgent care. This will divert appropriate activity away from Type 1 EDs, improve patient navigation and choice, and ensure equitable access across the system. Robust patient engagement will inform future service design and commissioning decisions.

We will build on our Single Point of Access (SPA) and Care Coordination Centre (CCC) by embedding these functions within the System Flow Centre (SFC), enabling a 24/7 service. Electronic referrals for urgent community services will be implemented for health and social care professionals, reducing duplication and multiple referral routes. The CCC will provide triage, coordination and, where clinically appropriate, direct case management to avoid ED attendance, ambulance conveyance and readmission. It will proactively utilise community services, expand community pathways and share data to inform future commissioning and service development. Through the SFC, we will better understand how to further expand Intermediate Care, UCR, virtual wards and SDEC to meet population needs in alternative settings, initially focusing on priority cohorts. Streamlined access to urgent services will also support greater efficiency and flexibility across the system.

We will align demand and capacity across intermediate care services to support more people at home and reduce reliance on bed-based care. This will improve flow, reduce length of stay, decrease the number of patients with no criteria to reside, and support timely discharge. Through place-based governance, including the Better Care Fund, we will further integrate social care, pharmacy, the voluntary sector and primary care. Neighbourhood health models and community hospitals will be used to deliver a fluid step-up and step-down model across the community pathway, supporting both discharge and alternatives to hospital admission.

The National Neighbourhood Health Implementation Programme (NNHIP), launched in October 2025, is a 12-month accelerator involving 43 sites, including Shropshire. Its first phase focuses on combining the

NHS biomedical model with a psycho-social approach, enabling holistic care and addressing wider barriers to health.

INTs are being established across five neighbourhoods, prioritising adults with complex long-term conditions and those at escalating risk. Delivery plans are informed by population health data and co-designed with stakeholders. The model emphasises co-management of long-term conditions, moving away from single condition pathways and drawing on trusted expertise within communities.

Although the national programme is centred on Shropshire, learning and opportunities are being mirrored in Telford and Wrekin. Alignment across the cluster is at an early stage, but the approach will be streamlined as the cluster matures. Neighbourhood health teams will become the default model for proactive urgent care and admission avoidance. They will deliver anticipatory care planning for high-risk cohorts – including frailty, multimorbidity, high-intensity- users and care homes. Working alongside the CCC, they will provide rapid review of deteriorating patients and strengthen links with wider partners such as the VCSE sector and local authority services. This aligns with national neighbourhood health guidance and the broader national agenda.

#### **This will be achieved through:**

- Using population health management segmentation and risk stratification to identify at-risk cohorts and develop proactive intervention plans for priority groups.
- Embedding multidisciplinary huddles and care coordination meetings at neighbourhood level, linked to the ICC for urgent escalation.
- Standardising anticipatory care planning and escalation plans for high-priority cohorts, including medication optimisation, and access to remote clinical support.
- Implementing a 'no wrong door' referral approach and using shared care records as a core multi-disciplinary team tool to reduce duplication and delays.

## **Dementia**

We will continue to aim to ensure that people living with dementia, and their carers, have the support they need post diagnosis including the knowledge and strategies to avoid going into crisis through a combination of specialist nursing and dedicated link workers.

We will ensure that dementia models of care are embedded in our emerging neighbourhood models of delivery. In 2026/27, we will implement across all our neighbourhoods the successful Dementia Multidisciplinary Team approach designed and piloted in South East Shropshire, which provides proactive identification, assessment and multi-agency coordination and management of people with dementia to reduce the risk of exacerbation and deterioration.

## **General practice**

We will continue to work closely with general practice deliver left shift through a portfolio of locally commissioned services designed to increase access to diagnostics such as electrocardiogram (ECGs), spirometry and fractional exhaled nitric oxide (FeNO) in primary care. We will also provide the clinical management and disease monitoring currently provided in acute settings.

In addition, to support our clinical strategic priorities, we will develop and implement a Quality Improvement Framework with a focus on early identification of diabetes, cardiovascular and renal disease to improve clinical management – aiming to prevent further deterioration or complications.

We will commission these services with a design aimed to promote collaborative delivery focused around our neighbourhoods.

## Community pharmacy

We will continue to work closely with community pharmacy as part of our delegated commissioning responsibilities, and in preparation for the full transfer of functions from NHS England on 1 April 2027. Community pharmacy will play an increasingly central role in delivering the left shift set out in the NHS 10 Year Plan – supporting a system where more care is delivered in community settings and fewer people need to attend hospital or general practice for routine or manageable conditions.

Community pharmacy will continue its transformation and integration journey, with a focus on expanding both new and existing clinical services. This will include broadening the scope of Pharmacy First into additional clinical areas, enabling pharmacists to manage a wider range of minor and acute conditions and reducing pressure on general practice and urgent care. We will also support the development of new services linked to prevention, early detection and screening, including cardiovascular risk checks, respiratory case finding, and targeted health promotion for high-risk groups.

In line with national expectations, community pharmacy will take on an enhanced role in medicines optimisation, including structured support for polypharmacy, reducing overprescribing, and improving adherence for people with long-term conditions. This will be aligned with further delegated functions and integrated into primary care pathways, ensuring pharmacists are fully embedded within neighbourhood teams and multidisciplinary models of care.

We will work with pharmacy providers to maximise the impact of Pharmacy First, ensuring it is consistently available, well publicised, and effectively linked to NHS 111, general practice, urgent care and digital triage systems. Community pharmacy will also contribute to anticipatory care, personalised care planning and proactive management of long-term conditions – supporting earlier intervention and reducing avoidable escalation.

## Dentistry

We will continue to work closely with community dentistry as part of our delegated commissioning responsibilities, and in preparation for the full transfer of functions from NHS England on 1 April 2027.

## Optometry

We will continue to work closely with community optometry as part of our delegated commissioning responsibilities, and in preparation for the full transfer of functions from NHS England on 1 April 2027.

Following the five-year Eyecare Transformation Programme (2021–25), the new Optometry First service launched in Shropshire, Telford and Wrekin in July 2025, will continue to deliver a range of integrated eye care services at neighbourhood level. The service is delivered across a wide geographical area through a network of local optical practices, coordinated by a single lead organisation (the Prime Provider) that oversees delivery and quality. It also includes a telemedicine hub, which acts as one central point of contact where patients and professionals can access advice, support, and specialist review remotely.

The Optometry First model supports the left shift of eye care from acute to community and incorporates first-contact care and monitoring low-risk eye conditions deemed suitable within primary care. The model utilises technology, imaging and diagnostics within the pathways to provide care closer to home and improves integration and delivery of local care. It supports prevention of sight loss through early intervention and timely treatment. Productivity is increased through the utilisation of skills, equipment, technology and estates that already exist in primary care optometry.

The success of this redesign programme has been underpinned by collaborative local working between primary care optometry and secondary care ophthalmology. The ongoing development over many years of local eye care networks has provided a foundation for education, peer support and an appetite for collective problem solving and improvement. It is anticipated that this culture of collaboration will encourage further innovation to build on the Optometry First model over the next five years.

We will be work with Business Intelligence (BI) colleagues to better understand data around eye health and sight loss from a population health perspective, so that the impact of interventions can be understood and provide insight for future planning.

In addition, core NHS sight testing services will continue to be provided locally for eligible patients through the General Ophthalmic Services (GOS) contract both within optometry practices and through domiciliary services. Alongside this, during 2026/27, it is anticipated that annual sight tests in special educational settings will be commissioned via GOS – as per the national NHS England specification.

## Mental health, learning disabilities and autism

Working with MPFT and our wider network of mental health providers, we will support the co-location of mental health teams within the Type 1 ED at the Royal Shrewsbury Hospital. This development will be informed by a system-wide needs assessment undertaken between 2026 and 2029. The aim is to shift away from reactive emergency mental health care within ED settings by diverting individuals to more appropriate specialist services, enabling Type 1 EDs to focus on physical emergencies and improving patient flow.

A review of current service provision will identify opportunities for efficiency and model optimisation. Delivery will be supported through resource realignment and national funding. These models will contribute to improved UEC performance and patient experience, including A&E four-hour and 12-hour metrics, ensuring people receive timely care that better meets their needs.

We will develop and embed 24/7 Mental Health Neighbourhood Models to ensure people experiencing poor mental health can access timely, local support as part of a wider multidisciplinary team. This approach will improve access and patient experience, strengthen integration with primary and social care, and reduce waiting times for individuals requiring immediate intervention.

We will further enhance the Mental Health Crisis offer by incorporating peer support and exploring opportunities to expand community crisis bed provision. This will create an integrated VCSE–NHS pathway with a preventative focus, simplified access routes, and a broader range of alternatives to A&E attendance and inpatient admission.

In partnership with system colleagues, we will continue to transform and commission services under the Inpatient Quality Transformation Programme (IQTP). This work will ensure that inpatient care is personalised, admissions are timely and purposeful, hospital stays are therapeutic, and discharge is effective. The programme will strengthen system-wide coordination, proactively address health inequalities, and drive continuous improvement across the inpatient pathway.

We will continue to implement the child and adolescent mental health services (CAMHS) Three Year Transition Plan following the re-procurement of the service. This includes embedding prevention, needs-led and trauma-informed practice, establishing a single point of access, developing clear pathways for children and young people (CYP) requiring mental health support, and reducing waiting times. The new service model will expand digital support options and improve access to early help information, tools, guidance and signposting.

### It will fully embed the iThrive principles:

- common language
- needs-led care
- shared decision making
- proactive prevention and promotion
- partnership working
- outcomes-informed practice

- reduced stigma
- improved accessibility.

Through this transformation, we expect to see reduced symptom acuity and escalation, improved resilience among CYP and families, and reductions in crisis presentations, admissions and A&E attendances. We will also prioritise Core20PLUS5 deliverables to reduce inequalities in access and outcomes across protected and underserved groups aged 0–17.

We will expand Mental Health Support Teams (MHSTs) in schools and colleges to achieve full national coverage by 2029. Full coverage means providing MHST support to all children and young people aged 5–18 in mainstream education – including primary, secondary, post-16, special schools, alternative provision, faith and independent schools, and pupil referral units. CYP who are temporarily absent or persistently/severely absent will also be within scope.

For eating disorder services, we will prioritise early identification, rapid access and needs-based care. Over the next five years, the ICB will ensure consistent, equitable access to specialist community eating disorder services, strengthen referral routes from schools, primary care and wider partners, and build a trained multiagency workforce able to recognise early signs and intervene promptly.

Commissioning will focus on expanding capacity within Community Eating Disorders Service for Children and Young People (CEDS–CYP), improving support for a broader range of presentations including Avoidant/restrictive food intake disorder (ARFID), and embedding trauma-informed, preventative approaches to reduce crisis escalation, hospital admissions and long-term harm. Our ambition is to shift from late, acute responses to proactive, community-based support that improves outcomes and reduces avoidable demand across the system.

## Special educational needs and disabilities (SEND) 0–25 years

When considering services commissioned for CYP with SEND there will be a continued drive to move care delivery closer to home, and in familiar and accessible settings such as schools. Based on local learning from the national [Early Language Support For Every Child](#) Speech and Language Therapy (SLT) programme, services such as SLT typically yield more positive outcomes when they are delivered in schools and early years settings rather than clinics.

This shift to work within school and early years settings results in better join up between education and health which is necessary to maximize the impact of services for CYP with SEND. Furthermore, the learning from the delivery of the cross-partnership programme for Partnership for Inclusion of Neurodiversity in Schools (PINS) reinforces the necessity of delivery of health services in schools, taking a system-wide approach.

This model of delivery is also evident in the nationally mandated Mental Health Support Teams service offer delivered by CAMHS. In line with the pending Schools White Paper (February 2026) which will set out SEND reforms, it is anticipated that one of the fundamental principles will be services delivered locally. This will further engender children’s health services to be delivered closer to home. Additionally, the Family First Partnership programme, which serves the SEND population amongst other vulnerable groups, sets out the requirement for Family Help to be delivered in the heart of the community by multidisciplinary teams and the Family Hubs agenda requires accessible support in the community.

## Electives and diagnostics

For elective services, we will begin a phased transformation programme to shift appropriate activity into community settings, starting with ENT, gastroenterology, respiratory, urology, cardiology and gynaecology. This will include implementing a consistent model of collective care approaches, standardising referral criteria across the system, maximising the use of Advice and Guidance, and

introducing clinical triage standard operating procedures for high-volume specialities. These changes will support the development of fully integrated, end-to-end pathways, reduce unwarranted variation, and shorten waiting times in line with the ambitions of the NHS 10 Year Plan. The programme will also incorporate digital pathway optimisation, increased use of remote monitoring where clinically appropriate, and the expansion of community-based elective hubs to deliver high volume, low complexity procedures outside acute hospitals.

We will continue to invest in our Community Diagnostic Centre (CDC) to expand access, streamline pathways and reduce reliance on hospital-based diagnostics, supporting the wider shift of care closer to home. This will include developing strategies to reduce geographic variation in access, ensuring equitable provision for underserved groups, including vulnerable and rural communities.

Our aim is to improve patient experience through simplified and faster diagnostic journeys, increase the number of straight to test pathways where clinically appropriate, and enhance GP direct access to diagnostics. In line with national expectations, we will extend CDC operational hours to 12 hours a day, seven days a week, increase capacity for imaging, physiological measurement and pathology, and strengthen digital interoperability to ensure results flow seamlessly into primary and secondary care systems. This will support earlier diagnosis, reduce bottlenecks in elective pathways, and contribute to the national ambition to diagnose more cancers at stages 1 and 2.

In musculoskeletal and orthopaedics, we will work with our RJAH, SaTH, SCHT and our wider provider network to transform the way that local services are delivered. Using the expertise and clinical leadership in our system this is an area where our ambition is to be class leading. There is no reason why this cannot be achieved within the timescale of this plan.

## Women's health

We will deliver a system-wide transformation in women's health and perinatal services that improves outcomes, reduces inequalities and ensures women and girls can access safe, high-quality care across the life course. Building on the ambitions of the 2022 Women's Health Strategy and the Maternity and Neonatal Three-Year Delivery Plan, we will reduce fragmentation between perinatal, gynaecology and wider women's health services by embedding women's health within neighbourhood models and aligned commissioning programmes. Priority action will focus on shifting high-volume, low-complexity pathways into community settings, reducing elective gynaecology waits and unwarranted variation, and strengthening continuity and coordination across reproductive health, pregnancy, postnatal and women's health needs at all life stages.

Our ambition is that Women's Health Hubs will be scaled and embedded within neighbourhood teams to provide integrated, multidisciplinary support including group consultations, where appropriate, covering menstrual health, menopause, contraception, pelvic health, urogynaecology and preconception care, supported wherever possible by Advice and Guidance, Community Diagnostic Centres (CDCs) and community pharmacy.

Reducing inequalities in women's health and perinatal outcomes will be a core system priority. A comprehensive Women's Health Needs Assessment, drawing on local intelligence, population health data and lived experience, will identify high-impact action areas across the life course and inform commissioning priorities, pathway redesign and improved ways of working across the women's health system. We are committed to listening to women and girls, families and communities, particularly those least well served by current services, and using their insight to shape service design, delivery and improvement. This intelligence-led and co-produced approach will focus effort where it will have greatest impact, including women from deprived communities, minority ethnic groups, rural populations and those with complex social factors. In perinatal services, this will include delivery of national safety and quality improvement programmes, embedding equity and anti-discrimination approaches, strengthening perinatal mental health, pelvic health and bereavement pathways, and improving access, experience and outcomes across the perinatal pathway.

## Analogue to digital

This section sets out how we will modernise health and care by expanding the use of digital technology across pathways and services. Digital tools already help people manage appointments, monitor their health, receive care at home and stay informed about their treatment. As demand and expectations continue to rise, the role of digital solutions will grow further, while we continue to protect and value the importance of face-to-face care for those who need or prefer it.

Digital technology is reshaping how people live, work and access services, and health and care are no exception. In recent years, digital innovations have made it easier for individuals to navigate the system, access timely support and take a more active role in managing their own health. As our population ages and the complexity of need increases, digital transformation will be essential to delivering faster, safer and more coordinated care.

When used effectively, digital tools reduce delays, support earlier intervention, and allow staff to spend more time with patients by streamlining administrative processes. They also improve the secure flow of information across teams and organisations, enabling more joined up decision making and reducing the need for people to repeat their story. Expanding digital capability will help us deliver more personalised care, improve access for underserved communities, and support the shift of care closer to home.

The ICB will strengthen and expand assertive and intensive outreach provision for adults with the most complex and enduring mental-health needs, ensuring timely, flexible and community-based support that reduces reliance on inpatient care and crisis services. Commissioning will prioritise multi-disciplinary teams able to deliver proactive, trauma-informed intervention for individuals who struggle to engage with traditional services, including those experiencing repeated crises, co-occurring conditions or significant social vulnerability. Over the next five years, the ICB will develop a consistent system-wide model that integrates with primary care, community mental-health services, police and justice services, housing, social care and the voluntary sector, enabling rapid response, continuity of care and personalised support. This approach aims to stabilise need earlier, prevent avoidable admissions, reduce out-of-area placements and improve long-term outcomes for adults with the highest levels of complexity.

## Our overarching ambitions

### Neighbourhoods and urgent and emergency care

The Care Coordination Centre (CCC) will play a central role in driving digital transformation by ensuring full interoperability across systems, enabling the seamless transfer of patients into the right services at the right time. This will reduce unnecessary reliance on clinical capacity and streamline operational processes. The CCC will draw on regional and national best practice in care coordination to embed consistent standards, improve information flow, and support real time decision making across the system.

New models of care will increasingly use technology to deliver hybrid, flexible and accessible services. Our hybrid pulmonary rehabilitation programme already demonstrates this approach by combining digital platforms with face-to-face sessions to improve access, adherence and outcomes for respiratory patients. For people living with long-term conditions, we will expand the use of remote monitoring, virtual consultations and data-driven insights to support personalised, proactive care. This includes scaling digital blood pressure monitoring, glucose monitoring, virtual cardiac rehabilitation and other remote clinical tools that help people manage their conditions safely at home.

In palliative and end of life care, we will strengthen digital integration through shared electronic records, Digital ReSPECT, and ensure coordinated, compassionate and timely support. For people living with frailty, we will implement the wider actions set out in the Shropshire, Telford and Wrekin Frailty Strategy to promote independence and reduce avoidable deterioration.

Across all pathways, digital solutions will be used to support earlier intervention, improve continuity of care, and reduce duplication. This includes expanding digital triage, improving access to online information and self-management resources, and ensuring that digital tools are accessible and inclusive for underserved communities.

## General practice

We will deliver the key digital developments required in General Practice, aligned to national expectations set out in the NHS 10 Year Plan and the GP Contract. This will include:

- **Delivering My NHS GP**, using AI-enabled triage and data-driven clinical pathways to guide people rapidly to the most appropriate service. This will ensure those who need an appointment can book one directly, while others are safely directed to selfcare, pharmacy, community services or urgent care as appropriate.
- **Transforming Planned Care**, giving patients a single digital space to manage all appointments, referrals, diagnostics and communications. This will streamline administrative processes, reduce referral to- treatment- times, and support more efficient coordination between primary and secondary care.
- **Managing My Health**, empowering people to manage their own health and the health of dependants by providing targeted access to prevention services, personalised health information, and digital tools that help reduce future demand before illness develops or worsens.
- **Prioritising Advice and Guidance (A&G)** before, or instead of, a planned care referral where clinically appropriate (excluding urgent suspected cancer). We will move towards all referrals in the 10 highest volume specialties going through A&G first, ensuring patients are managed in the right place and reducing unnecessary outpatient activity. -volume specialties going through A&G first, ensuring patients are managed in the right place and reducing unnecessary outpatient activity.
- **Expanding access to specialist advice and diagnostics**, working with system partners to increase direct access for general practice. When aligned with neighbourhood models, this will enable GPs to manage more patients without referral, support earlier diagnosis, and reduce pressure on hospital services.
- **Deploying ambient voice technologies** to reduce administrative burden and free up clinical time. Time released through automation and AI supported documentation will be reinvested into direct patient care, supporting improved access and continuity.
- **Implementation of Child Protection Information Sharing System (CP-IS) phase 2** to be implemented following the national work undertaken to create a more universal application programme interface between the National Summary Care Record and common Electronic Patient Records used within primary care. Further national work is being undertaken for EMIS and System1 (overseen by NHSE) for full integration of CP-IS which will require implementation locally.

In addition to these commitments, we will also deliver the wider digital requirements of the NHS 10 Year Plan and GP Contract, including:

- **Modern General Practice Access** – ensuring all practices have digital telephony, cloud-based clinical systems, and care navigation that directs patients to the right service first time.
- **Improved interoperability** – enabling seamless information sharing between primary care, community services, urgent care, mental health and hospitals.
- **Expansion of online services** – including prescription management, test results, appointment booking and personalised care plans.
- **Enhanced digital inclusion** – ensuring that digital tools are accessible to underserved groups, with alternatives available for those who cannot or prefer not to use digital channels.

- **Support for continuity of care** – using digital tools to identify and prioritise patients who benefit most from ongoing relational continuity.
- **Strengthening data quality and population health management** – enabling proactive identification of high-risk cohorts and targeted intervention at neighbourhood level.

Through these developments, general practice will become more accessible, efficient and proactive, supporting the left shift into community settings, improving patient experience, and ensuring digital transformation directly contributes to better outcomes for the population of Shropshire, Telford and Wrekin.

## Pharmacy

We will deliver key digital advancements in community pharmacy in line with national expectations, ensuring pharmacy is fully integrated into the wider digital ecosystem of primary and community care. This will include the development and rollout of the Single Patient Record, enabling pharmacists to access and contribute to real time clinical information. This will support safer prescribing, reduce duplication, improve medicines optimisation- and strengthen continuity of care across pathways.

We will implement national booking standards, enabling patients to book pharmacy services directly through digital channels, including the NHS App. This will support the expansion of Pharmacy First, contraception services, blood pressure checks and other clinical pathways, ensuring patients can access timely care without unnecessary GP or hospital attendance.

We will support the adoption of ambient AI technologies within community pharmacy to reduce administrative burden, improve documentation accuracy and free up pharmacist time for clinical care. This aligns with the national ambition to modernise the pharmacy workforce and enable pharmacists to operate at the top of their licence.

Digital enablement through the NHS App will be strengthened, ensuring patients can view pharmacy services, manage prescriptions, receive notifications, access test results and engage with personalised medicines information. This will also support digital inclusion by providing clear, accessible information for people managing long-term conditions.

In addition, we will deliver the wider digital commitments for pharmacy set out in the NHS 10 Year Plan and national guidance, including:

- **Full digitisation of pharmacy clinical services** – ensuring structured data flows into GP and hospital systems to support shared decision making.
- **Expansion of electronic prescribing and dispensing** – including increased use of EPS for acute prescriptions and improved digital repeat dispensing.
- **Improved interoperability** – between pharmacy, general practice, urgent care, community services and hospitals to support seamless care transitions.
- **Digital tools for medicines optimisation** – including polypharmacy reviews, adherence monitoring and personalised medicines support for high-risk cohorts.
- **Enhanced digital safety systems** – including clinical decision support tools, allergy alerts and automated safety checks.
- **Support for remote clinical services** – such as virtual consultations, digital follow-up and remote monitoring for long-term conditions.
- **Better use of population health data** – to identify patients who would benefit from pharmacy-led interventions such as cardiovascular risk management or inhaler optimisation.

## Optometry

We will promote the implemented regional Electronic Eyecare Referral system within local optometry practices – enabling a more efficient, digital referral process between optometry and ophthalmology. This replaced a historical paper referral system via general practice. Clinical information can be transferred electronically, with the capability to send full volumetric Optical Coherence Tomography (OCT) images.

We will encourage use of and continue to improve Optometry First services which includes a range of diagnostic tests and imaging, so these can be undertaken prior to referral. This will enable more rapid specialist clinical input from ophthalmology, where referral is required, avoid duplication of tests and avoid unnecessary referrals where they are not required. Referral pathways are more streamlined and efficient, and this digital capability will continue to be embedded in new pathways.

In addition, we will deliver the wider digital commitments for optometry in line with the aspirations of the NHS 10 Year Plan.

- We will introduce optometry independent prescribing into commissioned pathways, where appropriate to reduce demand on general practice and secondary care.
- We will expand community optometry roles within Optometry First pathways, commissioning digitally enabled services (urgent/minor eye conditions, cataract postop checks, glaucoma monitoring) to shift care closer to home and relieve hospital eye service capacity.
- We will expand the use of imaging and diagnostics (for example – OCT, fundus photography) within commissioned Optometry First services to enable secure transmission, viewing and virtual review by ophthalmology clinicians.
- We will use data to manage and improve eye care pathways, establishing dashboards and reporting for referral volumes, waiting lists, A&G uptake, and outcomes, consistent with NHS data and digital transformation priorities.

## Mental health, learning disabilities and autism

Digital transformation in mental health, learning disabilities, and autism will play a central role in delivering the ambitions of the NHS 10 Year Plan, improving access, personalisation, and the quality of care.

National guidance emphasises the expansion of digital tools that support early intervention, reduce crisis escalation and enable more joined-up, person-centred pathways. This includes wider use of shared electronic care records, digital care plans and real time information sharing across mental health, primary care, social care and education to ensure people do not have to repeat their story. We will look to expand the use of remote monitoring, virtual consultations and digital therapies will increase choice and flexibility, particularly for people who face barriers to attending in-person appointments.

For people with learning disabilities and autistic people, we will look to implement digital solutions which will support reasonable adjustments, communication preferences, sensory-friendly care and improved access to specialist advice. Enhanced use of digital decision support tools, risk stratification and population health data will help identify individuals at rising risk earlier, enabling proactive support and reducing avoidable crisis presentations.

Together, these developments will create a more inclusive, accessible and proactive model of care that improves outcomes and reduces inequalities for people with mental health needs, learning disabilities and autism.

## Special educational needs and disabilities (SEND) 0–25 years

As for the mental health and learning disability and autism population, the requirement for digital transformation of services and support for CYP with SEND is essential. As technology develops children with SEND can be better supported to meaningfully engage in the world around them.

As an example, there is valuable impact of electronic Augmentative and Alternative Communication (AAC) devices. The AAC Speech and Language Therapy service has seen a significant rise in demand for electronic AAC devices as the needs and complexity of our CYP population increases. Further to this, the use of electronic devices to support CYP with mental health needs are increasing, for example the use of AV1 Robots to support CYP who are experiencing emotionally-based school avoidance has proven effective to enable connectivity with school and classroom while a CYP is at home. These examples emphasise the need for digital innovation for CYP with SEND to be prioritised as a system.

Delivery of digital integrated record systems are essential to delivering the required progress for CYP with SEND. As set out in the Key Principles of SEND Reform (2025), shared systems will result in better care and better outcomes. We will endeavour to implement the digitisation of shared record systems – including Education, Health and Care Plans – to deliver on the pending SEND reforms and the Family First Partnership programme.

Further work is required to utilise digital systems effectively to manage data to inform commissioning and service delivery. Current information sharing processes rely on manual reporting. However, more advanced digital data systems which can consider place-based needs at a neighbourhood level would enable smarter use of public resources – as well as more effective forecasting of service needs for CYP with SEND.

### **Elective and diagnostics**

We will continue to work closely with our providers to expand and enhance the use of patient-initiated follow-up (PIFU), ensuring patients have a wider range of responsive and accessible follow-up options. This will include standardising remote consultations, remote monitoring and digital support tools across all major specialities. These developments will be supported by the introduction of AI-enabled triage, automated reminders, digital symptom tracking and other emerging technologies that help patients manage their own care and reduce unnecessary outpatient demand.

We will further roll out Advice and Guidance (A&G) to ensure referrals are consistently optimised through timely specialist advice and effective clinical triage. This will increase the proportion of patients managed in the most appropriate care setting and reduce avoidable outpatient appointments. In line with national guidance, we will work towards ensuring that the highest volume specialities routinely use A&G as the default route prior to referral, except where urgent suspected cancer pathways apply.

We will continue to deliver our outpatient transformation programmes, expanding the use of virtual appointments, digital preassessment, and community-based clinics supported by alternative technologies. This will include wider adoption of digital consent, online preoperative information, automated follow-up scheduling and personalised digital care plans. These changes will support the NHS 10 Year Plan ambition to modernise outpatient care, reduce unnecessary face-to-face activity and improve patient convenience.

We will accelerate innovation and technology adoption in diagnostics, implementing cutting-edge tools across the system. This includes evidence-based use of AI and machine learning to support image interpretation, pathology automation, risk stratification and earlier detection of disease. We will also expand the use of digital triage and straight-to-test pathways – ensuring patients move more quickly through diagnostic stages of their care.

In line with national diagnostics guidance, we will strengthen the use of the NHS App for diagnostics – enabling patients to receive real-time updates, manage appointments online, access test results more easily and receive personalised information about their diagnostic journey. This will improve transparency, reduce administrative burden and support more efficient patient flow.

### We will also:

- Expand interoperability between diagnostic systems, primary care and acute providers to ensure results are available in real time across the system.
- Support the development of digital clinical decision support tools to improve referral quality and reduce unwarranted variation.
- Increase the use of remote diagnostic technologies, such as home spirometry and ambulatory ECG monitoring.
- Strengthen digital inclusion initiatives to ensure all patients can benefit from digital elective and diagnostic innovations, including those in our rural or underserved communities.

Through these developments, we will create a more efficient, digitally enabled elective and diagnostic system that improves access, reduces waiting times, and supports the wider left shift of care into community settings.

## Cancer

We will harness technological innovation to transform the prevention, diagnosis and treatment of cancer. This is in line with national ambitions to diagnose more cancers at stages 1 and 2, and to deliver faster, more personalised care. This includes expanding the use of robotic-assisted surgery – enabling greater precision, shorter recovery times and improved outcomes. We will also scale the use of AI and machine learning to increase diagnostic capacity, support faster image interpretation, reduce reporting backlogs, and improve the accuracy of cancer detection across radiology, pathology and genomics.

Improving data sharing and interoperability will be central to this transformation. We will strengthen real-time information flow between primary care, diagnostics, acute providers and specialist cancer services – ensuring clinicians have access to complete and up-to-date records. Patients will increasingly use the NHS App to track symptoms, manage appointments, receive test results, access personalised information, and engage in remote monitoring during and after treatment. This will support earlier escalation, improved safety and more convenient follow-up.

A key enabler of this digital transformation is Cancer 360 – the national centralised cancer data platform designed to support patient tracking, treatment planning and pathway oversight. In 2025/26, Cancer 360 moved from pilot to initial adoption and expansion, with the intention that it will be rolled out across all NHS trusts. This will provide a single, integrated view of each patient's cancer journey, improve MDT coordination, support personalised stratified follow-up, and enable more accurate performance monitoring and pathway optimisation.

In addition, we will adopt wider digital innovations recommended in national cancer guidance, including:

- **Digital pathology networks** to support rapid image sharing and AI-enabled analysis.
- **Remote monitoring platforms** for people living with and beyond cancer – enabling personalised follow-up and reducing unnecessary outpatient visits.
- **Genomic decision support tools** to guide targeted therapies and precision medicine.
- **Digital risk assessment tools** to support earlier identification of high-risk individuals.
- **Enhanced screening informatics** to improve uptake and reduce inequalities.

## Maternity

Providers will continue to strengthen digital maturity in maternity and neonatal services in line with national standards – ensuring that women and birthing people can access joined-up, user-friendly digital information throughout their maternity journey. This includes delivering interoperable maternity records, enabling real-time data sharing across providers, and supporting digital tools for personalised care planning, risk assessment and safety monitoring.

Providers will also be expected to improve data quality, contribute to system-wide dashboards, and adopt innovations that enhance safety, reduce variation and improve the experience of families and staff.

## Sickness to prevention

We want to ensure that everyone in Shropshire, Telford and Wrekin has a fair opportunity to live a healthy, fulfilling life. We know that health inequalities persist across our area, and these differences have a real impact on people and communities. We will continue to work with partners to tackle what is unfair and preventable, focusing on the wider factors that shape health as well as the services people receive.

Improving health and wellbeing will come not only from high-quality, accessible care, but also from preventing illness, strengthening resilience and supporting people to live well in the places they call home. We recognise that many of the barriers to good health sit beyond traditional health and care services, and we are committed to working alongside local authorities, the voluntary and community sector, and our residents to understand these challenges and create the conditions for healthier lives across Shropshire, Telford and Wrekin

## Our approach to prevention

The NHS 10 Year Plan sets out a clear ambition to shift from reactive care to prevention, expand community and mental health services, reduce health inequalities, and embrace digital innovation.

These priorities align closely with the health needs of Shropshire, Telford and Wrekin and our challenges which can be summarised as follows:

- **Rurality and access** – A large rural geography means many residents face barriers to accessing timely care, creating demand for innovative, locally delivered services.
- **Ageing population** – Higher proportions of older adults lead to increased prevalence of multiple long-term conditions, frailty, and complex care needs.
- **Inequalities** – There are marked differences in health outcomes and life expectancy across the area, particularly between more deprived urban communities and rural localities.
- **Workforce pressures** – National and local challenges in recruiting and retaining clinical staff require more integrated, flexible and sustainable service models.
- **System transformation** – Delivering the neighbourhood health model and strengthening primary care are essential to reducing hospital demand and improving patient outcomes.

Prevention and the shift to prevention has been a consistent theme in the Strategic Direction across Shropshire, Telford and Wrekin with our collective vision being that we ‘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’. Prevention is also firmly embedded in our Clinical Strategy.

### Our jointly agreed key priorities that we will work collectively to deliver are as follows:

- Ensure residents can access information, advice, and support on healthy lifestyles and self-care.

- Expand 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.
- Enable and develop strong integrated neighbourhoods including community hubs and spokes.
- Enable communities and the VCSE 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.
- Embed person-centred care and approach across all organisations and partners.
- Develop and train front line workforce to ensure we make every contact count – communities, primary and secondary care.
- Expand social prescribing support and tackle inequalities in access and provision.
- Deliver NHS prevention programmes (with effective targeting of inequalities Core20PLUS5 programmes).
- Develop Alcohol Care team and Tobacco Dependency team (maternity, inpatients, serious mental illness), NHS weight management.
- Deliver national screening and immunisation programmes.
- Promote annual health checks for people with learning disabilities, and physical health checks for those with serious mental illnesses.
- 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 a 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.
- Prioritise early detection and treatment for long-term conditions.
- Deliver community blood pressure checks, NHS Health Check, targeted lung health checks, early detection of cancer.
- Improve GP management of long-term conditions (such as diabetes care processes) which will evolve over the coming years to include key roles for community pharmacy in managing these patients.

#### **The impacts of our ambitions will be measured by:**

1. Reviewing our systems approach to child and adult obesity including community level interventions, NHS programmes and new pharmaceutical interventions to **reduce the number of children and adults classified as obese.**
2. Reducing the smoking prevalence in adults, by **increasing the number of people who successfully stop smoking** with a particular focus on smoking in pregnancy, routine and manual workers, inpatients, and people with learning disabilities and mental illness and through the lung health screening programme.
3. **Decreasing the number of people drinking to harmful and hazardous levels** by improving identification and access to brief interventions and treatment, support and recovery.

4. **Improving the identification and management of hypertension** optimising clinical and non-clinical prevention treatment pathways. Our aim will be to increase the number of people identified with hypertension (BP>140/90) and the percentage of these who are treated to target.
5. **Improving respiratory outcomes by increasing uptake of flu vaccination** with a particular focus on older people and adults with pre-existing health conditions and targeting low uptake groups through neighbourhood approaches.
6. **Prioritising access to and quality of health checks** for people with learning disabilities and autism, and serious mental illness.
7. **Accelerating plans to tackle adverse infant outcomes** by focusing on women with existing health conditions and those less likely to access services early – to ensure that there is good access to pre-conception advice, early booking and screening.
8. **Accelerating the take up of all childhood immunisations** including MMR – with a particular focus on reducing inequalities in low uptake areas.
9. Taking steps to **improve the oral health of children by maximising** public health interventions and access to NHS dentistry.
10. **Improving early diagnosis of cancer** by commissioning 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. Ensuring **early help for those with mental health conditions** by improving access to talking therapies and CYP tier 1 and 2 services.
12. **Reducing drug-related deaths** by optimising access to and benefit from treatment and recovery.
13. Collaborating with the local authorities and VCSE organisations on the **best start in life delivery plans** aimed at improving the good level of development of children at the end of Reception.

## Vaccinations, immunisations and screening

Across Shropshire, Telford and Wrekin, joint working between the ICB, provider organisations, local authorities and the voluntary and community sector will be essential to deliver high-quality vaccination, immunisation and screening programmes. A coordinated, system-wide approach will ensure that services are accessible, equitable- and aligned to national expectations.

### As part of this approach, we will:

- Increase uptake of vaccinations and immunisations by expanding delivery in convenient local settings, enabling individuals and families to receive multiple vaccinations in a single visit. This will be supported by targeted outreach to underserved and high-risk populations to reduce inequalities in uptake.
- Maximise the digital capabilities of national programmes, using digital reminders, improved data flows, and NHS App functionality to support practices, streamline administration and increase population uptake across both immunisation and screening services.
- Prepare for the transfer of commissioning responsibilities from NHS England to ICBs from April 2027 – ensuring vaccinations, immunisations and screening services are commissioned responsibly, sustainably and in line with national standards.
- Review and develop screening services to improve uptake by ensuring capacity is located in the most appropriate and accessible settings, reducing barriers for eligible individuals across rural and urban communities.

- Establish system-wide governance structures by April 2027 for immunisation and screening programmes, ensuring transformation aligns with the NHS Vaccination Strategy, national service requirements and financial allocations.
- Participate in the regional strategic review of tuberculosis (TB) management, due for completion in December 2026, to strengthen cross system approaches to TB prevention, detection and treatment.

## Obesity

We will continue to develop our commissioning approach to obesity services in line with NICE guidance, which sets out a whole-system, tiered approach to prevention, early identification and treatment. This includes timely assessment, behavioural interventions, dietary support, physical activity programmes and access to pharmacological or surgical options where clinically appropriate.

We will initially focus on the commissioning of pathways for targeted groups at higher risk of obesity – including children, young people and underserved communities in line with the whole-system approach and Healthy Weight Strategy in our two Places. We will ensure strong links between primary care, community services, public health and specialist providers – with clear referral criteria, robust outcome monitoring and a focus on reducing health inequalities. Through this approach, we will deliver safe, effective and equitable obesity services that improve long-term health outcomes and reduce preventable disease across our population.

## Perinatal, maternity and neonatal services

Our aim in Shropshire, Telford and Wrekin is to ensure that all women and birthing people, babies and families can access high-quality and compassionate maternity and neonatal care. Services will be family-centred, culturally-sensitive and focused on reducing inequalities, improving outcomes and supporting positive experiences for every family.

We will continue to manage clinical quality risks and maintain strong oversight of maternity and neonatal outcomes. This includes monitoring performance, identifying areas for improvement and ensuring providers deliver safe, effective care.

To support this, a clear quality and safety framework will be in place across Shropshire, Telford and Wrekin:

- **Maternity dashboards** – Providers will maintain a maternity dashboard showing key safety and performance indicators, reviewed monthly to identify trends and trigger action where needed. Wider maternity and neonatal performance dashboards will also support system oversight.
- **Incident reporting and investigation** – All incidents, near misses and complaints will be reported and reviewed. Serious incidents including maternal deaths, neonatal deaths and severe brain injuries will be referred to the Maternity and Newborn Safety Investigations (MNSI) programme, with providers required to implement any recommendations. Internal reviews using the Perinatal Mortality Review Tool will include parent involvement and follow national standards.
- **Escalation protocols** – Clear escalation processes will be in place for times of pressure or reduced capacity, following the **ICB maternity escalation framework** and ensuring safe decision making and communication across the system.
- **Workforce governance and culture** – Providers will monitor midwifery, obstetric and neonatal staffing using Birthrate Plus and take action to address gaps, in line with national recommendations including the Ockenden Review. Providers will foster an inclusive, respectful and psychologically safe workforce culture, in line with national recommendations. They will support multidisciplinary teamwork, enable staff to speak up, and embed compassionate leadership. Actions to strengthen staff wellbeing, supervision and collaboration will be required to ensure a positive culture that underpins safe, high-quality care.

- **Service user voice** – Feedback from families, including through the Maternity and Neonatal Voices Partnership, will be central to service improvement and co-design.
- **Benchmarking and external review** – Providers will implement all applicable national recommendations and essential actions, including those from Ockenden, MBRRACEUK and regulatory requirements. They will maintain robust governance systems to track compliance, provide assurance of progress, and implement any required service changes at pace. Providers will also be expected to embed newly issued safety standards, national recommendation, update pathways in line with national updates, and demonstrate improvements through their quality reporting and safety dashboards.
- **Reducing inequalities** – The provider will commit to a population health management approach to maternity care – using data, intelligence and partnership working to understand population needs, target interventions and reduce inequalities. The provider will implement the Continuity of Carer and/or Enhanced Continuity of Carer model – embedding the Core20PLUS5 Framework and expanding community-based maternity care.

Through this approach, Shropshire, Telford and Wrekin will continue to strengthen maternity and neonatal services – ensuring they are safe, equitable and responsive to the needs of local families now and into the future.

## Long-term conditions and multi-morbidity pathways

Across Shropshire, Telford and Wrekin, we will continue to prioritise alongside our strengthened approach on prevention, proactive and personalised care for people living with long-term conditions. Our approach will build on the ambitions set out in our Clinical Strategy while moving over the next five years towards a fully integrated model for prevention and chronic disease management. This model reflects the principles of international best practice, including the National Framework for the Integrated Prevention and Management of Chronic Disease.

### Our programme of work will be underpinned by the following priorities:

- **Promoting prevention first** – Reducing lifestyle and other modifiable risk factors, working in a more systematic way across public health services and the NHS.
- **Proactive and preventative care** – Earlier identification of risk, systematic risk stratification and strong health promotion activity to prevent deterioration and reduce avoidable illness.
- **Person-centred care planning** – Care plans developed with individuals and their families, supported by digital tools that enable self-management, remote monitoring and personalised advice.
- **Integrated and coordinated care** – Multidisciplinary teams working through neighbourhood models to deliver joined-up support closer to home, reducing fragmentation and improving continuity.
- **Evidence-based clinical management** – Consistent application of NICE guidance across diabetes, respiratory disease, cardiovascular disease and other long-term conditions to ensure high-quality, standardised care.
- **Medication optimisation** – Regular structured reviews to reduce polypharmacy, minimise harm, and ensure treatments remain effective and appropriate.

This integrated model of care will align closely with our new approaches to frailty, palliative, and end of life care. By bringing together ‘teams of teams’ across primary care, community services, acute providers and the voluntary sector, we will create a seamless, end-to-end system for chronic disease management. Our aim is to support people to live well for longer, reduce inequalities, and ensure that care is accessible, coordinated and centred around what matters most to individuals and their families.

## Cardiovascular and renal metabolic (CVRM)

We will shift CVRM care from late, reactive treatment to early, proactive prevention through commissioning integrated, neighbourhood-based pathways that identify risk earlier, treat to target, and manage multimorbidity across cardiovascular disease, chronic kidney disease, diabetes, obesity and heart failure. This requires strengthened primary and community capacity to systematically case-find and optimise high-impact interventions, supported by essential diagnostics and consistent clinical standards.

Multidisciplinary hubs will reduce unwarranted variation across practices and rural communities, with Core20PLUS5 ensuring a sharp focus on inequality reduction. The goal is better, not more activity – fewer major cardiovascular events, reduced progression to end-stage kidney disease, and lower system pressure. Local modelling shows that improved secondary prevention could avert hundreds of events within three years and deliver a strong return on investment.

## CYP asthma

The CYP asthma pathway will provide a clear, consistent and evidence-based approach to the identification, diagnosis and management of asthma for children and young people. The pathway will include a standardised diagnostic process incorporating FeNO testing, spirometry and clinical assessment to ensure early and accurate diagnosis. A robust risk stratification tool will be embedded within General Practice to proactively identify high-risk CYP and ensure timely intervention.

For children with severe or complex asthma, multidisciplinary team reviews will be established to coordinate specialist input and optimise treatment. The pathway will be delivered in partnership with neighbourhood teams, Family Hubs, PCNs and wider community services to ensure support is accessible close to home.

To build a sustainable, skilled workforce, we will support multidisciplinary work and roll out asthma training across the system. We will also broaden engagement with training to ensure all professionals working with CYP, including schools, primary care, residential care settings and voluntary sector partners, have the knowledge and confidence to recognise and respond to asthma needs.

Preventative activity will be a core focus, with targeted work in areas of greatest need and attention to environmental triggers that contribute to poor asthma control. We will review data from the Digital Health Passport and explore opportunities for local implementation to support personalised care, symptom tracking and improved self-management.

The pathway will align with the five national priorities for CYP asthma – reducing environmental impact, ensuring early and accurate diagnosis, delivering effective preventative medicine, improving management of exacerbations and strengthening care for severe asthma. Primary care will be supported to deliver high-quality asthma reviews, personalised action plans and proactive follow-up.

## CYP epilepsy

The CYP epilepsy pathway will provide a comprehensive, proactive and equitable approach to the diagnosis, management and long-term support of children and young people living with epilepsy. A core component of the pathway is a strengthened risk management approach to mortality, including SUDEP (Sudden Unexpected Death in Epilepsy) – ensuring that CYP and families receive clear information, personalised risk assessments and timely access to epilepsy-specific services.

To build a skilled and confident workforce, we will deliver ongoing education and training for system partners, alongside practical resources for practitioners who come into contact with CYP living with epilepsy. This will increase awareness across schools, primary care, community services and social care, ensuring that epilepsy is recognised early and managed consistently.

The pathway will expand access to high-quality epilepsy care closer to home, supporting the left shift from hospital to community settings.

## Cancer

Our overarching ambition is to reduce the number of lives lost to cancer. This will be driven by three core goals – improving cancer survival, consistently meeting Cancer Waiting Time (CWT) standards, and enhancing patient experience and quality of life during and after treatment.

To achieve earlier diagnosis and deliver faster elective cancer pathways – supporting the national ambition for 75% of cancers to be diagnosed at Stage 1 or 2 – we will:

- **Commission faster, more efficient diagnostic and treatment pathways** – including one-stop or minimum stop clinics and straight-to-test models wherever possible. This will shorten time to diagnosis and treatment, improve outcomes, and reduce inequalities. We expect this to increase the proportion of cancers diagnosed at Stage 1 or 2, ensure compliance with the 28-day Faster Diagnosis Standard and the 31- and 62-day treatment standards, and reduce variation in early diagnosis by deprivation and geography.
- **Work closely with general practice to implement Jess’s Rule** – supporting GP teams to reflect, review and rethink when a patient presents three times with the same or worsening symptoms, ensuring timely referral and reducing missed opportunities for early diagnosis.
- **Prioritise Core20PLUS5 populations** – with targeted screening, outreach and diagnostic access for deprived, rural and underserved communities. We will use Core20PLUS5 data to identify the lowest performing cohorts and focus on narrowing the gap between the least and most deprived. Cancer mortality remains significantly higher in Core20 groups, and screening uptake is notably lower in Telford and Wrekin compared with Shropshire.
- **Increase HPV vaccine uptake across Shropshire, Telford and Wrekin** – working with local authorities and education partners to support the national ambition to eliminate cervical cancer by 2040.
- **Expand access to cervical screening self-sampling kits** – to improve convenience and uptake, particularly for groups who face barriers to traditional screening routes.

We will standardise cancer pathways using national Best Practice Pathways and embed National Best Practice Timed Cancer Pathways across elective services. This will improve productivity, reduce unwarranted variation, and ensure faster, more consistent and patient-centred care. Benefits will include shorter referral-to-treatment times, fewer unnecessary outpatient appointments, improved patient experience, and more equitable outcomes. We will monitor pathway performance by deprivation, ethnicity and age to maintain a strong focus on reducing inequalities.

We will also commission a range of best practice pathways, including the Non-Specific Symptoms (NSS) Cancer Pathway, nurse-led Local Anaesthetic Trans Perineal (LATP) biopsy, pathways for unscheduled bleeding in women on hormone replacement therapy (HRT), breast pain clinics, continued expansion of the faecal immunochemical test (FIT) and ongoing use of patient-initiated follow-up.

To improve outcomes and system flow, we will commission personalised cancer care, ensuring equitable access to psychosocial support, prehabilitation and survivorship services. These interventions will reduce complications, unplanned care and length of stay – while improving treatment tolerance and quality of life. We will strengthen patient activation, shared decision making and personalised navigation through cancer pathways. In addition, we will begin developing our approach to using genomic insights to inform individual risk scores and guide treatment decisions.

## Mental health, learning disabilities and autism

A shift from sickness to prevention in mental health, learning disabilities and autism is central to NHS priorities. In Shropshire, Telford and Wrekin, this means acting earlier, intervening sooner and creating the conditions for people to stay well in their communities. Our focus will be on strengthening early identification of need, using population health data to spot rising risk groups, and expanding access to

preventative support such as digital self-help tools, community-based wellbeing programmes, and proactive outreach for those most at risk of poor mental health.

For people with learning disabilities and autistic people, prevention also means ensuring timely annual health checks, personalised care plans, reasonable adjustments and improved access to physical health screening to reduce avoidable illness and premature mortality. We will work with schools, primary care, social care and the voluntary sector to build supportive environments that reduce crisis escalation, improve resilience and promote emotional wellbeing from childhood onwards. By embedding prevention across all pathways, we aim to reduce inequalities, avoid unnecessary hospital admissions and ensure people receive the right support as early as possible, enabling them to live healthier, more independent lives.

## Special educational needs and disabilities (SEND) 0–25 years

Early identification is fundamental to the prevention of escalation of need; it is noted locally that we are currently lacking diagnostic pathways for certain clinical areas. Therefore, the following areas will be prioritised for action over the coming five years.

- Learning disability
- Foetal alcohol spectrum disorder
- Functional neurological disorder
- Tics and Tourette's.

As identified in the recent Shropshire SEND Joint Strategic Needs Assessment, there is a high occurrence of obesity, or being underweight for children and young people with learning disabilities in our area. It is also acknowledged that there is not currently a public health preventative nursing model delivering care into some of our largest Special Schools (Severndale and The Bridge). Further consideration needs to be given to the model of nursing delivery in these settings.

In line with the Schools White Paper (published February 2026) which sets out the need for early, local, effective and shared care for CYP with SEND, we have a duty locally to focus efforts on preventative care to reduce escalation of need. When these needs are met early, there is a significant reduction in more intensive need required later – noting that the needs of the family holistically must be considered when addressing the needs of the CYP.

Much of the focus of the children's health workforce supporting CYP with SEND is ensuring that adults who spend the most time with CYP can utilise strategies of support to deliver positive outcomes. This is the case for children's therapies, nursing services and increasingly mental health support services. Therefore, it is essential that children's health services effectively utilise training and coaching approaches to ensure effective upskilling of families and education staff who support CYP with SEND.

It is essential that the children's health workforce is adept at upskilling partners to deliver effective outcomes for CYP. Health coaching approaches need to be formalised and considered meaningful contacts in the delivery of high-quality care.

This preventative-based approach will be a golden thread through the SEND and Families First Partnership programme.

## Dementia

Research shows more than 944,000 people in the UK have dementia – which is one in 11 people over the age of 65. This number is increasing because people are living longer – by 2030, the number is estimated to be more than 1 million. It is also estimated that more than one third of the population with the condition do not have a formal diagnosis.

Although there is no cure for dementia at the moment, an early diagnosis means its progress can be slowed down in some cases, so the person may be able to maintain their mental function for longer. A diagnosis helps people with dementia get the right treatment and support. It can also help them, and the people close to them, to prepare for the future.

#### **We will continue to embed our dementia vision which focuses on supporting:**

- Early help
- Assessment and diagnosis
- Living well
- When circumstances change.

We will aim to continue to identify people living with dementia as early as possible and increase the rate of diagnosis and the number of people who are living with dementia who have a tailored holistic Live Well care plan. We will ensure that their care plan is reviewed annually to ensure it reflects any changes in needs.

### **Women's health**

We will prioritise prevention and early intervention through strong partnership working and strategic alignment across the system – recognising the shared gains that can be achieved when common outcomes and high-impact action areas are identified across programmes. By aligning women's health and perinatal priorities with neighbourhood health, public health and wider system transformation programmes, we will maximise collective impact, reduce duplication and accelerate improvement.

This approach will support improved uptake of screening, preconception care, smoking cessation, weight management and pelvic health support, delivered through neighbourhood health teams and community partners. Workforce development, robust system governance and ongoing engagement with women, girls and communities will underpin delivery.

Through this integrated, intelligence-driven and person-centred approach, women's health and perinatal services will be embedded as a core component of neighbourhood care, supporting safer outcomes, reduced inequalities and sustainable system flow.

### **Children in care**

Children in care experience significantly higher levels of mental health need than their peers – driven by trauma, abuse, neglect and disrupted attachments. Statutory guidance (2015, updated 2022) requires ICBs, local authorities and NHS England to ensure that the health and wellbeing of looked-after children is prioritised, with sufficient resource allocated to meet their needs, including those placed in-area by other authorities.

Unmet mental health need leads to poorer long-term outcomes, increased crisis presentations, placement instability and escalating system costs. A shift from reactive, diagnosis-driven responses to proactive, trauma-informed support is essential to improve outcomes and reduce avoidable demand across health and care.

The ICB will invest in and expand trauma-informed, psychologically-led provision for care-experienced children and young people across Shropshire, Telford and Wrekin including those hosted from other areas to:

- Improve emotional wellbeing and mental health outcomes
- Reduce crisis escalation, placement breakdown and hospital admissions
- Strengthen multi-agency coordination and decision-making
- Ensure statutory compliance and equitable access for all looked-after children.

## **Delivery will be achieved through a coordinated suite of programmes:**

- Children in care with complex needs.
- NHSE CYP Developmental Service Specification implementation.

These programmes will enhance access to evidence-based therapeutic interventions, increase specialist capacity and embed trauma-informed practice within care settings.

Children with complex needs often require bespoke, multi-agency arrangements beyond standard commissioned provision. To ensure timely, clinically informed decisions, the ICB will:

- Establish a single consolidated process for all individualised commissioning decisions, including continuing healthcare, complex needs panels and EHCP-related funding.
- Strengthen clinical leadership, accountability and alignment across health, education and social care.
- Ensure consistent, transparent and timely decision-making for high-needs cases.

## **It is anticipated that this will result in:**

- Earlier intervention and reduced crisis demand
- Improved placement stability
- Reduced high-cost out-of-area placements
- Better long-term outcomes for care-experienced children and young people
- More efficient use of system resources.

## **Improving access**

This section outlines our system-wide ambition to guarantee timely, equitable and consistent access to high-quality care across all major pathways – including mental health, children and young people’s services, primary and community care, urgent and emergency care, elective services and cancer.

Our focus is on reducing long waits, strengthening digital routes into care, expanding early help and preventative support, and addressing the inequalities experienced by those who face the greatest barriers to accessing services.

## **Overall ambition**

Our overarching ambition is to ensure that people across all our care pathways including mental health, children and young people’s services, community services, urgent and emergency care, elective care and cancer, receive timely, fair and consistent access to high-quality support. We aim to meet or exceed national standards by cutting long waits, increasing early intervention and prevention, enhancing digitally enabled access, and prioritising action to reduce inequalities for those with the highest levels of need.

## **General practice**

We will work closely with our GP practices to deliver the requirements of the 2026/27 GP contract from April, ensuring that patients can access care easily and reliably – whether by phone, online or in person during core hours. A key expectation is that every patient will know on the day how their request will be managed, alongside increasing opportunities for people to see their preferred healthcare professional.

To support this, we will implement action plans that strengthen contract oversight, commissioning and transformation across primary care. This includes tackling unwarranted variation, identifying practices that need additional support to meet access or other contractual requirements, and ensuring that extra capacity is commissioned to meet demand during out-of-hours periods and seasonal surges, including bank holidays and weekends.

We will also maintain a strong focus on GP recruitment and retention to improve access to general practice. This will include:

- **ICB funded leadership roles** such as the GP Recruitment and Retention Lead, GP Marketing Lead, GP Trainee Differential Attainment Lead and First 5 GP Lead (supporting GPs in their first five years post CCT).
- **Four funded GP network groups** – First 5s, Mid-Career, Wise 5s and Sessional/Locum GPs – providing regular educational and networking opportunities.
- **An ICB-funded GP locum booking platform** to support retention by making it easier for locum GPs to find work.
- **Delivery of the GP Fellowship Scheme** for newly qualified GPs, which has been shown to prevent early workforce attrition.
- **Targeted marketing and outreach** to Foundation Year doctors, medical students and sixth form students to promote general practice as a career.
- **A regular GP newsletter** to strengthen professional community and connection.
- **A funded scheme encouraging sessional or salaried GPs to become GP partners**, supporting long-term workforce stability.
- **A funded support and development programme for newly qualified GPs** in their first post-qualification year.
- **Collaboration with local NHS trusts** to help recruit GPs into specific posts, including funding for associated training.
- **Support for PCNs** in recruiting ARRS-funded GPs.
- **Development of dedicated GP resources** on the Shropshire, Telford and Wrekin Training Hub website.
- **Surveying sessional and locum GPs** to understand under-employment and ensure better utilisation of this workforce.

Through this comprehensive programme, we aim to strengthen the resilience, capacity and sustainability of general practice, ensuring patients receive timely, high-quality care and that the GP workforce is supported to thrive.

## Dental

We will work closely with dental practices across Shropshire, Telford and Wrekin to deliver our contribution to the government's commitment to provide an additional 700,000 urgent dental appointments nationally, measured against the July 2023 to June 2024 baseline. Alongside this, we will support the implementation of post consultation dental reforms to ensure services are modernised, accessible and sustainable and meet pre-COVID routine access for adults and children.

We will also design and implement locally-led quality improvement approaches for dentistry – supported by strong clinical leadership and active communities of practice. These will help improve access, strengthen pathways for patients with high or complex needs, and ensure consistent standards of care. To underpin this work, a dental investment plan has been agreed, including targeted measures to increase capacity in priority areas such as urgent appointments.

### Our recurrent commitments include:

1. **Expanding the Shropshire and Staffordshire Oral Health Improvement Team** to deliver more targeted preventative programmes such as Brilliant Brushers to tackle the high rates of hospital tooth extraction in children.
2. **Providing dental checks in special educational settings** to improve access for children and young people with additional needs.
3. **Commissioning additional recurrent Unit of Dental Activity (UDAs)** in local dental access hotspots where poor delivery by existing providers is limiting availability.
4. **Commissioning UDAs within existing orthodontic contracts** to ensure patients receiving orthodontic treatment can access the full range of dental services they require.

## Optometry

We will continue to embed and expand our Optometry First approach, which provides a framework for commissioning and designing services that respond to rising demand in a sustainable way. This model establishes a coordinated, comprehensive primary eye care service as part of an integrated eye care system, enabling the primary eye care workforce to act as first contact practitioners and broadening the scope of care delivered outside hospital settings.

This approach ensures that patients are appropriately navigated away from other parts of primary care or redirected from hospital eye services, with referrals to secondary care made only when clinically necessary. It also enables patients currently on routine follow-up pathways in hospital or community ophthalmology services to be safely transferred to primary care, delivering faster, high-quality care closer to home and improving overall access.

### Our priorities include:

#### 2026/27–2027/28

- Completing phased roll out of Optometry First and embedding all pathways including cataract, glaucoma, medical retina, paediatric eyecare and the community urgent eyecare service (CUES).
- Incorporating optometry independent prescribing into CUES pathway to streamline and reduce demand on general practice and urgent eye clinic where prescribing is needed.
- Exploring potential for Single Point of Referral for eyecare referrals.

#### 2028/29 onwards

- Ongoing cycle of continuous improvement using service user and clinical feedback to improve Optometry First Service.
- Scope potential to further shift services from acute to primary care via Optometry First – for example dry eye, medical contact lens fitting, direct listing for cataract surgery and low vision services.
- Scope potential for further digital innovation using diagnostics and imaging with emerging technology across pathways of eye care.

In addition, core NHS sight testing services will continue to be provided locally for eligible patients through the General Ophthalmic Services (GOS) contract both within optometry practices and through domiciliary services. During 2026/27, it is anticipated that annual sight tests in SEND settings will be commissioned

via GOS, as per the national NHS England specification. This work is being led by Office of West Midlands on behalf of the six West Midlands ICBs.

## Community pharmacy

Ongoing development and transformation of the community pharmacy sector has already delivered significant improvements in access, outcomes and patient experience across our population. Building on this progress, we will continue to work in close partnership with community pharmacies to strengthen primary care access and expand the role they play within the wider system.

### Our priorities include:

- 1. Embedding pharmacy-first approaches** – ensuring patients can access timely advice and treatment directly from community pharmacies.
- 2. Strengthening relationships between general practice and community pharmacy** – to support seamless access to pharmacy services and improve patient navigation.
- 3. Introducing prescribing-based services in community pharmacies during 2026/27** – enabling pharmacists to manage a wider range of conditions and reduce pressure on general practice.
- 4. Expanding access to emergency contraception** – through community pharmacies to improve convenience and reduce barriers to timely care.
- 5. Maximising uptake of the Discharge Medicines Service** – helping to reduce medicines-related harm and prevent avoidable hospital readmissions.
- 6. Making HPV vaccination available in pharmacies** – for women and young people who missed vaccination in school settings.
- 7. Ensuring all community pharmacies enable prescription tracking via the NHS App** – giving patients real-time visibility of their medicines.
- 8. Ensuring all primary care services support online medicines requests and management** – improving convenience and reducing administrative burden.
- 9. Transitioning all messaging to NHS Notify** – with NHS App push notifications becoming the default method of communication.

Through these actions, community pharmacy will continue to play an increasingly central role in delivering accessible, preventative and patient-centred care.

## Elective services and diagnostics

Over the next five years, our ambition for elective services alongside our providers is to deliver faster, more reliable and more equitable access to planned care, ensuring patients receive high-quality treatment within clinically appropriate timeframes. We will focus on eliminating long waits, sustaining 65-week and then 52-week compliance, and reducing unwarranted variation across specialities. Elective pathways will become increasingly efficient through greater use of digital tools, streamlined triage, straight-to-test models and expanded use of patient-initiated follow-up.

We will strengthen community-based and virtual outpatient models to free up hospital capacity and improve patient convenience. Diagnostics will continue to expand through Community Diagnostic Centres, and the adoption of AI-enabled technologies to speed up reporting and improve accuracy. Our ambition is that, by the end of this period, elective services will be more resilient, more productive and more personalised, with improved patient experience, reduced inequalities and consistently strong performance across all key national standards.

We will be aiming to meet the national standards for elective care and diagnostics as outlined in the Medium Term Planning Framework – delivering change together 2026/27–2028/29:

Success measure	2026/27 target	2028/29 target
Improve the percentage of patients waiting no longer than 18 weeks for treatment	Minimum of 7% improvement or 65% whichever is greater	92%
Improve performance against the DM01 diagnostics 6-week wait standard	Minimum of 3% improvement or 20% whichever is better	1%

## Cancer

Over the next five years, our ambition for cancer services is to deliver earlier diagnosis, faster and more consistent pathways, and better outcomes for everyone, with a particular focus on reducing inequalities. We will work towards achieving the national goal of diagnosing 75% of cancers at Stage 1 or 2 by expanding one-stop and straight-to-test models, strengthening primary care referral quality, and embedding Best Practice Timed Pathways across all major tumour sites. Performance against the Faster Diagnosis Standard and the 31-day and 62-day treatment standards will be stabilised and improved through increased diagnostic capacity, more efficient elective pathways and targeted action in specialities with the longest waits.

We will also expand personalised cancer care, ensuring people have access to prehabilitation, psychosocial support and survivorship services that improve quality of life and reduce avoidable complications. Alongside this, we will intensify efforts to close the gap for deprived, rural and underserved communities by improving screening uptake, outreach and access to diagnostics. By the end of this period, cancer services will be more equitable, more responsive and more integrated, with measurable improvements in early diagnosis, treatment timeliness, patient experience and long-term survival.

We will be aiming to meet the national standards for cancer services as outlined in the Medium Term Planning Framework – delivering change together 2026/27–2028/29:

Success measure	2026/27 target	2028/29 target
Improve performance against cancer constitutional standards – Faster Diagnosis Standard	80%	80%
Improve performance against cancer constitutional standard – 31-day standard	94%	96%
Improve performance against cancer constitutional standard – 62-day standard	80%	85%

## Urgent and emergency care (UEC)

UEC performance across Shropshire, Telford and Wrekin remains among the most challenged in the country. Rising demand, an ageing and increasingly frail population, workforce shortages, limited community capacity and ongoing delays in discharge have created entrenched flow issues across the entire system. These pressures are reflected in poor emergency department performance, extended ambulance handover delays, high numbers of patients with no criteria to reside, and avoidable non-elective admissions.

Incremental improvements will not be enough. Sustainable recovery requires a fundamental redesign of the end-to-end UEC pathway, moving away from a hospital-centric, reactive model towards one that is proactive, neighbourhood-led and focused on flow. Restoring UEC performance is therefore a critical enabler for the wider elective, neighbourhood and productivity ambitions set out in this plan.

Over the next five years, UEC commissioning will prioritise whole-system flow from first contact through to discharge and recovery at home. All commissioning decisions will be tested against whether they improve flow, reduce avoidable admissions, shorten length of stay or accelerate safe discharge.

The system will adopt a 'home first' approach, treating admission avoidance and early supported discharge as core UEC functions rather than optional add-ons.

## Expected outcomes over five years

### System performance and flow

- Sustained improvement against national ED standards, including reductions in long-stay breaches.
- Reduced average ambulance handover times.
- Improved Category 2 ambulance response times.
- Fewer non-elective admissions per 1,000 population.

### Acute flow and discharge

- Reduction in average length of stay.
- Reduced time on no criteria to reside list.
- Increased proportion of discharges via Pathway 0 and Pathway 1.

### Community substitution

- Greater use of urgent community response, virtual wards and neighbourhood-based alternatives.
- Reduced ED attendances and ambulance conveyances for cohorts supported by neighbourhood teams.

### Patient experience and equity

- Improved patient experience across urgent care pathways.
- Reduced variation in access and outcomes for Core20PLUS5 populations.

### Delivery and phasing

UEC recovery will be treated as a system-wide priority. The pace and sequencing of broader transformation will reflect the need to stabilise urgent care flow and release acute capacity first. Commissioning decisions will be aligned to this principle, recognising that sustainable improvements in elective care, productivity and neighbourhood development depend on a functioning and resilient UEC system.

### Community services

Over the next five years, community services will be expected to deliver consistently strong performance that supports earlier intervention, reduces pressure on hospitals and improves outcomes for people with complex or long-term needs. This includes meeting clear standards for timely access to community nursing, therapies, rehabilitation and reablement, with measurable reductions in waiting times and unwarranted variation across localities. Services will need to demonstrate improved productivity through

better use of digital tools, streamlined pathways and more effective multidisciplinary working within neighbourhood teams.

Performance expectations will also focus on preventing avoidable admissions, supporting safe and timely discharge, and delivering high-quality care at home or close to home. Community services will be required to show year-on-year improvements in patient experience, equity of access and clinical outcomes, particularly for people with frailty, disabilities or multiple long-term conditions. By the end of the five-year period, we will expect community services to be more proactive, more integrated and more responsive, with clear evidence of their impact on population health and system flow.

We will be aiming to meet the national standard for community services waiting times as outlined in the Medium Term Planning Framework – delivering change together 2026/27–2028/29:

Success measure	2026/27 target	2028/29 target
Improve the percentage of patients waiting no longer than 18 weeks for community services	78%	80%

## Learning disabilities and autism (LDA)

Our ambition for LDA services over the next five years is to ensure timely, equitable and high-quality support across the whole pathway, with a strong focus on prevention, early intervention, and reducing avoidable hospital admissions.

We will undertake a full assessment of the actions required to improve access and outcomes for adults with a learning disability and/or autistic adults, supported by clear commissioning and service delivery plans. Delivery will rely on close partnership with local authorities and mental health providers, particularly in relation to housing, social care, community support and specialist health provision.

We will work collectively with system partners to reduce admission rates for children under 18, recognising that current numbers are very low. Our ambition is that any admission is an absolute exception, with all children supported safely in the community wherever possible. Local authorities and mental health providers will play a central role in delivering this ambition through strengthened early help, crisis support, and wrap-around care.

We will strengthen partnership working to ensure timely, safe and person-centred discharge for individuals who require an inpatient stay. This includes coordinated working between inpatient services, Community Learning Disability Teams, local authorities and the Transforming Care team. Our aim is to avoid unnecessary delays, prevent deterioration and ensure people return to the least restrictive setting as soon as clinically appropriate. This will include compliance with national requirements for Care (Education) and Treatment Reviews (C(E)TRs) and maintaining an accurate Dynamic Support Register (DSR) for adults and children at risk of admission.

We will continue to increase uptake of annual health checks (AHCs) for people aged 14+ with a learning disability, alongside ensuring completion of Health Action Plans (HAPs). Our ambition is to increase the proportion of completed HAPs beyond the current expected position of 81% for 2025/26. Improving AHC and HAP coverage will support earlier identification of health needs, reduce avoidable illness, and improve communication and outcomes for individuals. This aligns with national NHS requirements to reduce premature mortality and improve physical health outcomes for people with a learning disability.

For all-age neurodiversity (autism and ADHD), although there are currently no formal national planning requirements, we have completed a comprehensive pathway review in response to significant national and local challenges in capacity and access. This review, co-produced with service users, carers and professionals, will inform a new pathway from 2026/27, ensuring needs led pre and post-diagnostic

support and improved access. We will also incorporate recommendations from the national ADHD Taskforce and any future national reviews into neurodiversity services.

We will continue to work with commissioned providers to improve access to autism and ADHD assessments for both children and adults, recognising that demand significantly exceeds available resource. Access, equity and sustainability will be key considerations in future commissioning and pathway redesign.

We remain committed to ensuring that autistic people and people with a learning disability receive high-quality, person-centred mental health inpatient care when required. National evidence shows these individuals are more likely to experience mental health challenges, and therefore inpatient services must provide appropriate reasonable adjustments, personalised care planning and trauma-informed approaches. Their involvement in service design and quality improvement will help create more accessible, recovery-focused and efficient inpatient pathways. We will also continue to deliver improvements in LeDeR (Learning from Lives and Deaths) processes to ensure learning is embedded and inequalities are addressed.

We will be aiming to meet the national standard for learning disability and autism as outlined in the Medium Term Planning Framework – delivering change together 2026/27–2028/29:

Success measure	2026/27 target	2028/29 target
Reduce reliance on mental health inpatient care for people with a learning disability and autistic people	10% reduction each year	10% reduction each year

## Mental health

Our ambition for mental health services is to improve access, reduce unwarranted variation and ensure people receive timely, high-quality care in the most appropriate setting.

We will reduce the number of inappropriate adult acute mental health out-of-area placements (OAPs). A key barrier is the absence of a local Psychiatric Intensive Care Unit (PICU). To address this, capital has been allocated to develop a 12-bed PICU at Redwoods in Shrewsbury by 2028/29. This will support local access, reduce length of stay, and improve continuity and quality of care, working in partnership with Staffordshire and Stoke-on-Trent ICB to ensure regional flexibility.

Through the Inpatient Quality Transformation Programme (IQTP), we will work with Midlands Partnership University NHS Foundation Trust (MPFT) to reduce average length of stay. This will require strong collaboration with local authorities and the VCSE sector to improve discharge pathways and reduce the proportion of people who remain in hospital despite being medically fit for discharge. Reducing length of stay will also reduce reliance on OAPs and improve access to local beds.

We will work with acute providers to reduce the number of adults and children waiting excessive periods in A&E (12-hour UEC breaches), improving patient experience and supporting UEC care flow. This aligns with national NHS performance requirements for mental health crisis response and reducing avoidable delays.

We will continue to expand Talking Therapies to ensure timely access and improved performance against national metrics, including reliable recovery, reliable improvement and treatment completion rates.

We will expand Individual Placement Support (IPS) services in line with national ambitions to increase access to employment support for people with serious mental illness.

We will maintain access rates for specialist perinatal and maternal mental health services, building on our strong performance in recent years and ensuring continued compliance with national targets.

We will deliver improvements in CYP mental health access, in line with our remedial action plan, with full recovery expected by July 2026. This will reduce waiting times and improve access, supported by the rollout of the new CAMHS model.

We will continue to monitor and improve local mental health services not subject to national planning requirements, including:

- Community mental health services for adults
- Physical health checks for adults with serious mental illness
- Assertive outreach services
- Crisis pathways, including the Crisis Text service
- Liaison psychiatry in acute hospitals
- Adult mental health rehabilitation services
- Dementia and memory assessment services

Performance and quality will be monitored through provider contracts, with any concerns addressed through established contractual mechanisms to ensure access, safety and outcomes continue to improve.

We will be aiming to meet the national standard for mental health as outlined in the Medium Term Planning Framework – delivering change together 2026/27–2028/29:

Success measure	2026/27 target	2028/29 target
Expand coverage of mental health support teams (MHSTs) in schools and colleges (including teams in training)	77%	94%
Meet the existing commitments to expand NHS Talking Therapies – reliable recovery	51%	53%
Meet the existing commitments to expand NHS Talking Therapies – reliable improvement	69%	71%
Eliminating inappropriate out-of-area placements	Reduction each year	Reduce or maintain at zero

## Special educational needs and disabilities (SEND) 0–25 years

As identified in sections regarding learning disability and autism and mental health, access to services which support CYP with SEND needs to be improved. At present, lengthy waiting times for access to speech and language therapy (SLT) and neurodevelopmental diagnostic assessments often result in escalation of need. Additionally, there continues to be a national postcode lottery for access to diagnostic services for other conditions such as foetal alcohol spectrum disorder. However, while considering the importance of diagnosis, it is equally important to ensure that needs-led services are commissioned across the partnership to deliver the support required without relying on a diagnosis.

Accessible information can enable families and partners to support CYP with SEND whilst waiting for appointments. Efforts have been made to improve the information provision however more needs to be done to ensure that there is sustainability for digital platforms (such as the Healthier Together website) alongside a robust communication plan.

At present, children’s health services including SLT, occupational therapy, physiotherapy, child development centre and neurodevelopmental support in CAMHS offer telephone support. However, more

needs to be done to ensure high quality advice and support can be provided via calls and online in a timely way. This does not negate the need for face-to-face services but provides graduated support while waiting and can reduce the requirement for full referrals. CAMHS neurodevelopmental pathway drop-in sessions supported by local Parent Carer Forums have proved an effective way to deliver care in accessible environments – further roll-out of this approach is necessary across services to ensure timely support, preventing escalation of need.

Action needs to be taken to address processes regarding equipment, notably but not solely for those with physical disabilities and occupational therapy needs. A partnership approach is required to develop increasingly robust processes which ensure that equipment is recommended and procured in a timely way.

## Productivity and efficiency

The national 10 Year Plan places productivity and efficiency at the heart of NHS reform, recognising that the health service cannot remain sustainable without major improvements in how care is organised, delivered and supported through modern technology.

### Overall ambition

We will maximise the value of our resources by eliminating duplication, streamlining pathways, expanding the use of digital tools and reducing unwarranted variation, ensuring that every pound spent delivers better outcomes for local people. Improving productivity and efficiency is fundamental to building a sustainable health and care system. By simplifying how people move through services, cutting delays and using technology more effectively, we can release capacity, improve patient experience and enable staff to focus on delivering high-quality care. This will help us respond to rising demand, support our workforce and accelerate the shift towards prevention and community-based care.

Our ambition is to create a system where processes are efficient, digital solutions save time for both staff and patients, and services operate consistently and effectively across all settings. Productivity and efficiency are not standalone workstreams – they underpin every part of this plan and are essential to delivering better outcomes across neighbourhoods, Places and the wider system.

#### To achieve this in Shropshire, Telford and Wrekin, we will:

- **Deliver our system-wide efficiency programme** – aligning actions across urgent and emergency care, planned care, primary care, medicines optimisation, individual commissioning, integration and community neighbourhood transformation to maximise impact.
- **Strengthen value-based commissioning** – ensuring financial decisions prioritise prevention, neighbourhood models and reduced reliance on hospital-based care.
- **Use our Strategic Decision-Making Framework** – to ensure evidence-based commissioning decisions are undertaken including using a health economic value-based assessment.<sup>1</sup>
- **Reduce unwarranted variation** – by standardising pathways and sharing best practice so that people receive consistent, high-quality care regardless of where they live.
- **Eliminate duplication and improve flow** – through digital triage, Advice and Guidance, community triage, pathway redesign, UEC modelling and actions aligned to Discharge to Assess.
- **Maximise digital enablers for efficiency** – including Docman Connect, expansion of the NHS App, digital Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) and Electronic

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<sup>1</sup> [What is value-based healthcare? | HFMA](#)

Palliative Care Coordination Systems (EPaCCS) records, remote monitoring, virtual wards and continued development of integrated electronic patient records.

- **Improve medicines efficiency** – through increased biosimilar uptake, deployment of AnalyseRx®, robust medicines horizon scanning and implementation of the Single National Formulary.
- **Reduce avoidable hospital admissions** – by strengthening neighbourhood-based multidisciplinary teams, expanding risk stratification, early intervention and targeting prevention where it will have the greatest effect.

These actions will help us manage rising demand, support our workforce, reduce waste and reinvest resources where they will make the biggest difference for our citizens.

## Individual commissioning

In Shropshire, Telford and Wrekin, individual commissioning is a key driver of excess costs, this is supported by the nationally produced ICB productivity packs which benchmark spend per 50,000 head of population. Due to the demographic and rurality of our area, some of this excess cost is warranted and some of it is unwarranted.

The key areas of unwarranted variation to be addressed through the Five Year Strategic Commissioning plan are to develop and implement an improved quality offer for patients at end of life and to complex children not eligible for continuing healthcare. We will also take a different approach to market management in conjunction with local authority partners to reduce the overall cost of care to deliver better value for money for individual commissioning.

## Urgent and emergency care (UEC)

Aligning financial arrangements across UEC contracts will enable more strategic planning and a clearer understanding of future service requirements. Providers will continue to undertake robust demand and capacity forecasting across all urgent pathways, ensuring accurate modelling that can be regularly reviewed and refined.

The UEC Improvement Programme is delivered through a series of linked workstreams designed to strengthen demand management, access and flow. These improvements will enhance patient experience, increase ambulance capacity and support delivery of key UEC performance measures, including four-hour and 12-hour standards, while ensuring that we maximise investment into community services and reduce the reliance on our acute-based services.

## Elective care

Improving productivity and efficiency across planned care in Shropshire, Telford and Wrekin is essential to reducing waiting times, making best use of available capacity and ensuring patients receive timely, high-quality treatment. As demand continues to rise, we will redesign pathways to remove duplication, eliminate unnecessary steps and embed digital tools and modern clinical models to support more effective working.

To support new models of care, we will explore opportunities to commission lead provider models where these can improve coordination across speciality pathways, enhance patient experience and create the conditions for innovation, economies of scale and greater efficiency such as the planned MSK Provider Collaborative led by RJAH. From 2026, we will embed clear productivity and efficiency standards into provider contracts, including improved theatre utilisation, reduced follow-up appointments, increased use of patient-initiated follow-up (PIFU) and a greater proportion of procedures delivered as day cases or in outpatient settings.

We will also look to align the commissioning of the Independent Sector with our Acute providers to ensure capacity is managed in line with our ambitions and set clear Indicative Activity Plans (IAPs) and Activity

Management Plans (AMPs) to ensure that we have equitable access for our population when utilising elective services. These changes will help us treat more patients, deliver performance against NHS England metrics, reduce delays and deliver better value for the NHS.

## Primary care

Primary care across Shropshire, Telford and Wrekin will be strengthened through digital innovation, modernised estates, and continued workforce development, including new roles and skill mixes. This will enable primary care to meet rising demand, support people with long-term conditions and deliver sustainable, high-quality services at neighbourhood level. As practices increasingly work together through collaboratives and neighbourhood teams, Locally Commissioned Services (LCS) will need to evolve to support delivery of universal services at scale where appropriate.

## Medicines optimisation

We will take a system-wide lead on medicines finance, including developing the ICB's medicines-related cost improvement plan, setting efficiency targets within commissioned services, and establishing robust financial controls as neighbourhood health services mature. Our overarching aim is to support long-term financial stability across NHS services in Shropshire, Telford and Wrekin.

National Specialist Pharmacy Services publishes an annual medicines outlook that enables us to horizon scan for emerging cost pressures and opportunities to deliver efficiencies. The ICB spends around £136 million of total drug spend of which approximately £96 million is driven by primary care prescribing. Commissioning arrangements with general practice are already in place, and the service specification will be updated to reflect new cost-saving opportunities.

The ICB works closely with pharmacy teams across the acute, mental health and community trusts to share intelligence on high-cost medicines used in secondary care and to maximise opportunities for efficiencies across the system.

As neighbourhood health services develop, new financial controls will be required, supported by close collaboration between finance teams and the medicines optimisation function.

## Section 4 – Financial ambitions over the five years

Finance is more than balancing budgets; it is a critical foundation of strategic commissioning and population health improvement. By aligning resources to the greatest areas of need and value, finance ensures that every pound spent delivers measurable impact. This section sets out our financial vision, how we will deliver it, and the governance that underpins our approach.

This joint plan sets out a unified commissioning finance narrative for Shropshire, Telford and Wrekin (STW) and Staffordshire and Stoke-on-Trent (SSOT) over the next five years. It brings together the STW Finance Strategy (approved June 2025), the STW Joint Forward Plan (2025–2030), and SSOT's Joint Forward Plan Finance Strategy (2023–28) into a single, coherent framework.

The plan is firmly rooted in the Medium Term Planning Framework (2026/27–2028/29) and the government's 10 Year Plan, Fit for the Future. It embeds the three major system shifts, hospital to community, analogue to digital, and sickness to prevention, directly into commissioning, contracting, incentives and capital investment programmes.

### How finance supports the commissioning cycle

Finance is a key enabler across the entire strategic commissioning cycle and underpins the operating model by ensuring resources are aligned to priorities and deliver maximum value. During the planning stage, financial analysis and data-driven insights help identify cost drivers, inefficiencies, and opportunities to improve value. Budgets are aligned to strategic priorities, supporting the left shift to prevention, community-based care, and digital innovation. At the procurement stage, finance shapes contracts and payment mechanisms that incentivise outcomes, efficiency, and shared savings across providers.

Finally, in evaluation, financial performance is monitored alongside benefits realisation to ensure investments deliver measurable improvements in health outcomes, productivity, and equity. This integrated approach ensures finance is not just about control, it is a driver of transformation and sustainability.

Delivery of the commissioning plan set out in Section 3 will require significant changes in how resources are allocated, with greater investment moving towards neighbourhood models, proactive care and evidence-based prescribing. Our Finance Strategy enables this shift by aligning resources to high-value interventions, strengthening financial controls within neighbourhood health services, and supporting system partners to adopt efficient prescribing practices. This ensures that medicines optimisation contributes directly to delivering the wider system priorities and achieving financial sustainability across the ICB.

### Joint financial vision

**Our shared financial vision is to:**

- Return both ICBs to a sustainable financial position, no longer reliant on deficit support, by the end of the five-year planning period.
- Create some financial flexibility to fund key commissioning priorities
- Use value-based strategic decision making to guide resource allocation, supporting delivery of the 10 Year Plan's left-shift priorities and reducing spend in acute and resource-intensive settings.

### Context – challenges, opportunities and shared values

Both systems start this Five Year Strategic Commissioning Plan with significant financial challenges, but our Three Year Financial Operational Plan sets out a clear route to achieving financial balance. We share common cost pressures and opportunities to spend more effectively, which shape our focus, particularly in:

- urgent and emergency care
- workforce
- productivity and efficiency
- continuing healthcare.

To address these challenges, we have agreed a System Collaborative Financial Management Agreement, implemented via system-commissioned contracts. This means decisions about resource allocation and risk management are made collectively, underpinned by trust across organisations, places, and the wider system. This approach ensures a clear line of sight from problem identification to action and measurable outcomes.

## Strategic vision and key strategic aims

Our overarching ambition is to return both ICBs to a sustainable financial position, create headroom for strategic investment, and embed value-based decision making to support the 'left shift' and reduce reliance on acute and high-cost services.

### We will achieve this by:

- Making data-driven decisions to ensure transparency and accountability.
- Prioritising and aligning capital and revenue resources to deliver the greatest health value.
- Embedding financial stewardship across the system to support transformation and long-term sustainability.

## Key strategic aims

1. **Achieve financial sustainability** – Establish a balanced financial position through targeted cost reductions, productivity and efficiency improvements, delivery of transformation programmes and realignment of resources.
2. **Maximise value from investment** – Ensure that investment in prevention, community services and digital care grows in line with allocation uplifts. Direct funding towards interventions using a health economics approach to the delivery of value<sup>2</sup> to improve outcomes, enhance system efficiency and support preventative and community-based care.
3. **Enable transformation through strategic investment** – Use capital and revenue investment to support service transformation, digital innovation and workforce development, improving quality, efficiency and integration.
4. **Embed a culture of financial stewardship** – Foster a system-wide approach where all staff take ownership of financial sustainability, 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.

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<sup>2</sup> Value is assessed using best practice definitions of the assessment of economic value as set out by the Healthcare Financial Management Association - [What is value-based healthcare? | HFMA](#)

## Governance, assurance and financial rigour

Oversight and assurance are provided through the ICB Finance Committee, reporting to the ICB Board. This includes:

### Compliance with national frameworks

Ensuring adherence to the NHS 10 Year Plan, the Medium-Term Planning Framework and Financial Framework Business Rules. This includes:

- Delivering in-year capital and revenue resource limits (including the Mental Health Investment Standard and Dental ring-fence).
- Implementing efficiency and transformation plans to achieve a medium-term break-even position.

Assurance is supported by monthly finance, efficiency and transformation reports, alongside quarterly thematic deep dives (for example – Medium-Term Finance Plan updates, Staffordshire and Stoke-on-Trent finance undertakings, and programme-specific reviews such as medicines, continuing healthcare, Neighbourhoods and urgent and emergency care).

### Management of financial risks

Oversight of strategic and operational financial risks to ensure delivery of financial sustainability and compliance with in-year limits. Risk management is triangulated across:

- Efficiency and transformation plans
- Workforce considerations
- Operational performance standards
- Quality requirements
- Activity delivery.

### Audit Committee oversight

The ICB Audit Committee provides additional assurance to the Board. Its responsibilities include:

- Applying the Well-Led Toolkit, NHS Grip and Control Checklist, and HFMA Financial Sustainability Checklist.
- Monitoring implementation of external and internal audit recommendations and controls assurance.
- Conducting internal audit reviews of efficiency programmes and strategic transformation initiatives, ensuring benefit realisation and embedding lessons learned into future planning cycles.

## Financial priorities to support the Five Year Strategic Commissioning Plan

### System-wide financial approach

We will continue to manage our finances collectively as a system. Each year, we will refresh and agree the shared principles and behaviours that underpin delivery of our strategic commissioning goals. Local finance groups across Shropshire, Telford and Wrekin and Staffordshire and Stoke-on-Trent will provide oversight, coordination and support to ensure consistent application of these principles.

## Contracting approach

Our contracting model will be designed to support the outcomes we want to achieve across Shropshire, Telford and Wrekin and Staffordshire and Stoke-on-Trent. This will include:

- Using gainshare arrangements so partners benefit from shared improvements.
- Introducing year-of-care and outcomes-based payment models where appropriate.
- Responding to changes in the national NHS Payment Scheme.
- Ensuring a fair and transparent allocation of resources across partners.
- Embedding clear productivity measures, including improvements in:
  - Advice and Guidance
  - Follow-up ratios
  - Use of diagnostic hubs
  - Theatre utilisation
  - Length of stay
  - Day-case performance.

## Commissioning intentions

Our commissioning intentions will directly reflect the ICB's strategic objectives. Contract discussions will consistently embed the three system shifts – neighbourhood focus, prevention, and digital innovation – alongside our quality and performance standards.

## Commissioning for Value framework

Investment decisions will be grounded in evidence and value. A clear Commissioning for Value framework will guide when we invest in new services and when we disinvest or reshape existing resources. This framework will apply to both revenue and capital business cases and will draw on best practice health economic value evaluation methodology.<sup>3</sup>

## Financial improvement programme

To ensure long-term sustainability, the system will work towards a minimum annual improvement target of 2% efficiency and 2% productivity. This will be delivered through:

- Strategic commissioning-led transformation programmes – including neighbourhoods, digital and prevention
- Operational improvements – such as enhanced workforce planning and reduced reliance on temporary staffing
- System-wide efficiencies – including shared services and increased joint working across provider collaboratives.

## Capital investment approach

We will take a system-wide approach to prioritising capital investment, ensuring it supports long-term commissioning priorities. Capital funding will be directed towards:

- Diagnostics, including opportunities for new community diagnostic centres in Shropshire, Telford and Wrekin and Staffordshire and Stoke-on-Trent

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<sup>3</sup> [What is value-based healthcare? | HFMA](#)

- Elective recovery and urgent and emergency care
- Mental health and learning disability services
- Community and primary care infrastructure.

Capital planning will be fully integrated into the commissioning process and aligned with national guidance, including the Medium-Term Financial Framework and NHS England capital priorities. All schemes will go through a system-wide prioritisation process to ensure alignment with commissioning intentions and constitutional standards. Assurance will include clear approval points at key stages, clinical safety approval, compliance with Digital Technology Assessment Criteria (DTAC), and regular quarterly reports on benefits. This approach ensures transparency, value for money, and delivery of strategic objectives.

## Procurement approach

Our procurement activity will ensure best value for our population and full compliance with national rules, legislation and Standing Financial Instructions.

### We will:

- Ensure fairness, transparency and strong governance
- Embed sustainability principles, including a minimum 10% weighting for net zero and social value
- Require alignment with the NHS Net Zero Supplier Roadmap
- Include sustainability and social value requirements within commissioning specifications
- Publish annual forward procurement plans aligned to commissioning priorities.

## Revenue investment approach

All investments will be scored through the Strategic Decision-Making Framework to provide a relative prioritisation of investment with affordability using a health economic value-based assessment methodology.<sup>4</sup>

## Key performance indicators (KPIs)

### Achieve financial sustainability

- Annual break-even position
- Reduction in underlying deficit
- Compliance with 'Grip and Control' requirements.

### Maximise health value

- Return on investment
- Reduction in cost per outcome

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<sup>4</sup> [What is value-based healthcare? | HFMA](#)

- Compliance with the Commissioning for Value framework.

### **Enable transformation**

- Capital prioritisation and utilisation
- Adoption of outcomes-based contracting.

### **Embed financial stewardship**

- Financial governance assurance rating
- Internal audit substantial assurance.

### **Strengthen collaboration**

- Medium-Term Financial Plan triangulation
- Delivery of system-wide efficiency programmes.

## **Risks and mitigations**

All financial risks and mitigations will be monitored through the ICB Finance Committee and reported to the ICB Board via the risk register and Board Assurance Framework. This ensures robust oversight, timely escalation and effective mitigation of financial risks across the system.

## Section 5 – People and workforce

This sets out how we will develop, support, and sustain the workforce needed to deliver high-quality health and care services across Shropshire, Telford and Wrekin and Staffordshire and Stoke-on-Trent. It explains the challenges our systems are currently facing, including financial pressures and increasing demand, as well as the opportunities created through national workforce reforms and closer partnership working. It highlights the central role of workforce intelligence in the commissioning cycle, the importance of supporting our staff's wellbeing and development, and the actions we will take to strengthen leadership, capability, and collaboration across the system.

Looking ahead, the National Long Term Workforce Plan (expected summer 2026) will reset workforce ambitions, focusing on retention, wellbeing, skills, and productivity to enable sustainable, community-based, digital-first care models. To deliver this, our clustered ICB must transition from operational delivery to strategic leadership – convening partners, setting commissioning intentions, and managing demand through evidence-based planning. This shift requires workforce realignment, new capabilities, and cultural transformation.

### The role of workforce in the strategic commissioning cycle

The workforce – our NHS people – are the primary means through which patients receive care and represents the largest cost driver (approximately 70%). Having up to date workforce data covering experience and wellbeing, stability, supply, and future pipeline throughout the commissioning cycle is essential to ensuring safe, equitable, and sustainable services. A consistent focus on workforce enables responsible, data-driven commissioning aligned to statutory duties and health inequality objectives, shaping decisions at every stage of the cycle.

Given the scale of change signalled within our commissioning intentions, the future health and care landscape will require an agile, flexible workforce under the ethos of 'right staff, right skills, right place' (NQB 2016). To support our five key system shifts and deliver population-centred care models, workforce considerations must sit at the heart of our strategic commissioning approach.

As system leader and convener, the ICB plays a critical role in commissioning a strategically aligned, future-ready workforce – realigning capacity across sectors, directing investment in digital capability, and shaping deployment models that meet population health needs.

This includes:

- Commissioning for socio-economic impact through skills pipelines, apprenticeships, and employment pathways.
- Developing integrated neighbourhood and CYP workforce models in partnership with local authorities and providers.
- Embedding proactive, prevention-focused care through community-centred, home-first approaches.

The ICB must also ensure urgent care workforce models balance generalist and specialist roles, and that sufficient capability is commissioned to support wellbeing and self-management. Through these levers, the ICB enables a sustainable workforce that improves access, reduces inequalities, and relieves pressure on acute services across the systems.

### Enabling change and transformation

Our approach will combine system leadership, organisational development, and targeted workforce planning, alongside building internal ICB capability and looking after our workforce.

## System convening

This involves strengthening partnerships and collaboration across all our strategic partners, including NHS, primary care, local authority, social care, and voluntary and education sectors to co-design solutions.

## System and organisational development

- Commissioning multi-partner workforce strategy and plans, to support neighbourhood health and care models, and associated strategic risk management.
- Across Shropshire, Telford and Wrekin, significant progress is already being made to establish INTs, bringing care into the community and achieving the 'left shift' – reducing demand on our acute hospitals and leading on prevention strategies. This will be rolled out across all PCN footprints and is embedded within the workforce plans of acute and community providers.
- The Shropshire, Telford and Wrekin Pharmacy Workforce Strategy identifies key initiatives for bolstering community pharmacy, embedding the Pharmacy First approach and supporting the 'left shift'. It has been co-produced by members of the Shropshire, Telford and Wrekin Pharmacy Faculty and is now being developed into a programme plan designed to achieve transformation across the pharmacy workforce, delivered in collaboration with partners across both Shropshire, Telford and Wrekin and the region.
- The Shropshire, Telford and Wrekin Shared Services programme promotes a real shift in system working across the STW/SSOT cluster. The focus is on helping our workforce work more effectively and make better use of our shared resources, so we can offer improved opportunities for staff and deliver better outcomes for our population. The HR workstream prioritises temporary staffing including establishment of a collaborative bank, recruitment and occupational health.
- Implement organisational design, organisational development programmes, and cultural transformation to support transition across the system and within the ICB.

## Strategic workforce planning

- Strategic workforce leadership, workforce expertise and insights are needed to enable outcomes-based commissioning of new care and service models, and contract management.
- The ICB will continue to work with providers to ensure that their workforce plans continue to align to our priorities. The SaTH/SCHT group model facilitates much closer alignment between acute and community settings alongside the MSK Provider Collaborative led by RJAH.
- Workforce plans are being developed based on workforce modelling to determine shift in demand and supply that will inform our response to recruitment and retention including upskilling, 'grow your own' pathways, and 'skills passports' to facilitate cross-sector working and expansion of apprenticeship schemes.

## Socio-economic and anchor model

- Commissioning for reductions in health inequalities through workforce – including local skills supply, apprenticeships, and routes into health and care careers.
- Enabling implementation of the Get Britain Working White Paper and Work Well programmes via system partnerships.
- Strengthening well-established Anchor Employer approaches across the cluster and system.

## Internal ICB competency and capability

- Executive and board development will be key, alongside fostering an inclusive culture that champions education, wellbeing, and equality. Together, these actions will create a skilled, resilient, and agile workforce aligned to the ICB's strategic objectives.
- Building strategic commissioning capability across leadership, analytics, market shaping, and population health management, guided by the NHS England Strategic Commissioning Development Programme. This will strengthen our payor function, support delivery of the new operating model, and enable effective implementation of neighbourhood health and integrated health organisations.
- Engagement with the national strategic commissioning development programme to focus on improving commissioning capability at pace.

## Looking after our ICB workforce

Prioritising staff health, engagement, and inclusion is essential to reducing burnout, improving retention, and fostering a positive culture within the ICB and across the system.

By creating an environment where staff feel supported, heard, and valued, we will strengthen resilience, improve outcomes for patients, and enable sustainable transformation. This is of particular importance during reform and transition, as our workforce navigates the challenges associated with clustering and merger.

### Our focus includes:

#### Health and wellbeing

- Building on physical and mental health support provision and offers.
- Promoting flexible working arrangements to support work-life balance.
- Encouraging regular wellbeing check-ins and proactive interventions.

#### Engagement and voice

- Creating opportunities for staff to shape decisions through forums and feedback mechanisms (for example – Staff Survey and pulse checks).
- Recognising and celebrating achievements to build morale and motivation.
- Ensuring transparent communication about organisational priorities and changes.

#### Inclusion and belonging

- Further embedding equality, diversity, and inclusion in all workforce policies and practices.
- Offering training and development to strengthen and support inclusive leadership.
- Fostering a culture where every individual feels valued and respected.

#### Retention and development

- Investing in career pathways and continuous professional development.
- Supporting succession planning and talent management.
- Addressing workload pressures through workforce planning and resource allocation

## Section 6 – Enablers

### Digital, data and technology

Digital technology and effective use of data are fundamental to delivering high-quality, joined-up care across Shropshire and Telford and Wrekin. This is not only about having the right systems in place – it is about creating a culture where staff have the skills, confidence and tools to use information well, make informed decisions and continuously improve services.

Our ambition is as follows:

- Expand the Shared Care Record, integrate it with the NHS App and deploy the Federated Data Platform to provide real-time, linked datasets across health and social care.
- Implement national data platforms in line with agreed timelines, ensuring full interoperability across all local providers.
- Strengthen data sharing agreements and governance frameworks to safeguard privacy and support the safe, appropriate use of linked datasets.
- Build analytical capability and competence within the ICB, including health economists, analysts and data scientists, to interpret complex data and facilitate actionable insights for the system.
- Develop outcome dashboards and predictive analytics tools to support commissioning decisions and enable real-time monitoring of progress.
- Improve forecasting and modelling techniques using near real-time data to identify pressure points across hospitals, community teams, social care, pharmacies and urgent community response services.
- Use population health management tools to strengthen system-wide intelligence and shared understanding.
- Deliver the data infrastructure required, agreeing a fit-for-purpose data architecture and mobilising a plan to implement it across the system.
- Co-design digital solutions with clinicians and service users, ensuring they are intuitive, accessible and deliver meaningful benefits.
- Provide training and support for neighbourhood teams and provider collaboratives to embed digital tools into everyday practice.
- Automate low-value, repetitive tasks and scale approved digital therapeutics to empower patients and free up clinical capacity for more complex care.
- Explore and, where appropriate, develop AI-enabled solutions to support Advice and Guidance and patient-initiated follow-up (PIFU).
- Explore how we support virtual wards providing increased monitoring and digitising diagnostics to maximise capacity and improve productivity.
- Ensure all systems are cyber-secure, resilient and compliant with national standards.
- Enable at least 95% of appointments – after appropriate triage – to be available via the NHS App across all care settings.
- Adopt a 'digital by default' approach to support targeted, preventative interventions that improve outcomes and reduce demand.

- Support major acute providers, to secure approval for NHS business case investment in modern digital infrastructure and ensure all providers progress towards an integrated Electronic Patient Record (EPR) service.
- Support the implementation of Child Protection Information Sharing Service phase 2.
- Develop with partners a system wide SEND data dashboard to consider demand and support future planning of services to meet need.

## Estates and infrastructure including the Green Plan

Modern, flexible estates are fundamental to delivering integrated care across Shropshire, Telford and Wrekin and to supporting the shift from hospital-based services towards neighbourhood and community-led models. Our Estates Strategy sets out a vision for a well-planned, networked estate that supports multidisciplinary working, digital-first pathways, and sustainable service delivery across all parts of the system.

This includes the development of neighbourhood hubs that bring together primary care, community services and voluntary sector partners; Community Diagnostic Centres that improve access to tests and reduce waiting times; and modernised acute facilities that support elective recovery and strengthen urgent and emergency care. Alongside this, our system-wide Green Plan ensures that all estate developments embed sustainability, energy efficiency and low-carbon design.

Collectively, these changes will accelerate the 'left shift' from hospital to community, making care more accessible, proactive and closer to home, while helping us meet our net zero commitments.

- Align estates planning with commissioning intentions and the commissioning cycle – ensuring that investment decisions directly support our strategic priorities.
- Prioritise schemes that expand community and primary care capacity, enhance diagnostic provision, support elective recovery and strengthen urgent care resilience.
- Ensure all estates upgrades are fully aligned with digital infrastructure programmes, including the Shared Care Record, interoperable Electronic Patient Records and wider digital first pathways.
- Embed sustainability principles in every project – guided by our Green Plan – to reduce carbon emissions and support long-term environmental resilience.
- Work collaboratively with partners across the NHS, local authorities and the VCSE sector to deliver co-located services and neighbourhood models that reduce duplication, improve access and make best use of shared assets.

## Equality, diversity and health inequalities duties (ED&I / PSED / Core20PLUS5)

Equality, diversity and inclusion are essential to how we plan and commission health and care services as part of our strategic commissioning role and the commissioning cycle. We want everyone to be able to access good-quality care, and we use data, local insight and lived experience to understand what different communities need. This means working with people, not just planning for them, by involving patients, carers and community groups in shaping services and making sure diverse voices are heard.

We design our services so they work for everyone, especially those who may face barriers or have poorer outcomes, and we work with a wide range of providers, including voluntary and community-led organisations, to make this happen. Our workforce also needs to reflect the communities we serve, with inclusive leadership and decision-making.

To support this, we use Equality and Health Inequalities Impact Assessments to check for any unintended consequences, identify risks, and ensure decisions are fair and transparent whenever services are introduced, changed or redesigned.

## **Research, innovation and improvement**

Research, innovation and improvement are key to how we develop better, more effective health and care services, and the ICB has a duty to promote and support this work. We will do this by strengthening research activity across provider collaboratives and clinical networks, adopting proven innovations through national pathways, and using rapid evaluation and improvement methods to test, learn and scale new models of care.

We will also expand the safe and evidence-based use of digital tools and AI to enhance care, improve outcomes and support clinical decision-making. A Research and Innovation Strategy has been produced and agreed through the Staffordshire and Stoke-on-Trent, Shropshire, Telford and Wrekin Health and Care Research Partnership (SSHERP).

## **Safeguarding and responsibilities for vulnerable people**

Safeguarding is a core statutory duty and fundamental to delivering safe, high-quality care, and we will ensure strong arrangements are in place to protect both adults and children in line with the Care Act and Children Act. All commissioned services will be required to meet safeguarding standards and maintain appropriate training, supported by system-wide learning and intelligence to identify risks early. We will also strengthen support for people with complex needs, including those with learning disabilities and autism, to ensure they receive safe, appropriate and person-centred care.

The implementation of the Families First Partnership programme guidance will support early identification of need and intervention for families which all commissioned services will contribute towards.

The learning from safeguarding reviews – including Child Safeguarding Practice Reviews, Rapid Reviews, Domestic Homicide Reviews and Safeguarding Adult Reviews – will continue to be embedded across the system for sustained change, with assurance provided to each safeguarding partnership.

## **Emergency preparedness, response and resilience (EPRR)**

We are committed to keeping our population safe by ensuring strong EPRR across the health and care system. We work closely with our NHS providers and local partners, including local authorities, police, fire services and the Local Resilience Forum, to plan for major incidents and manage system pressures.

This includes making sure all providers meet national EPRR standards, maintaining robust business continuity, and ensuring effective surge planning and winter resilience arrangements are in place. By using real-time data and clear escalation processes, we can respond quickly and in a coordinated way to protect patients and maintain essential services.

## Section 7 – Risks and Mitigations

### Finance

Risk Number	Risk and description	Risk score (consequences x likelihood)	Mitigations	Target risk score (consequences v likelihood)	Committee/ICB oversight
1	<p><b>Delivery of the Revenue Financial Plan</b></p> <p>Failure to achieve planned financial balance due to rising demand, performance pressures, and cost challenges, including efficiency delivery.</p>	Likely 4 x Major 4 = High 16	<ul style="list-style-type: none"> <li>Refresh the Medium Term Financial Plan on a regular basis and the Long Term Financial Plan on an annual basis.</li> <li>Implement actions to support the delivery of the overarching Financial Strategy.</li> <li>Continue robust financial controls including pay vacancy control panel and non-pay discretionary spend controls, monthly monitoring including recurrent underlying.</li> <li>Accelerate delivery of efficiency and productivity programmes (minimum 2% annually for each).</li> <li>Maintain a risk reserve to offset unforeseen pressures where possible.</li> <li>Conduct scenario planning for inflation, cost pressures, performance and activity variations.</li> <li>Use collaborative procurement and contract renegotiation to secure best value.</li> <li>Prioritise revenue and capital investment/disinvestment to ensure value for money and support the 'left shift'.</li> </ul>	Possible 3 x Major 3 = Moderate 9	System Finance Committee in Common

Risk Number	Risk and description	Risk score (consequences x likelihood)	Mitigations	Target risk score (consequences v likelihood)	Committee/ICB oversight
			<ul style="list-style-type: none"> <li>Progress the agreed System Strategic Transformation Programme delivery, utilising the system-wide Financial Improvement Programme financial governance to track efficiency and productivity savings including Programme Management Office (PMO) support as required.</li> <li>Embed efficiency schemes into provider contracts with clear accountability.</li> <li>Use productivity information, best practice, benchmarking and digital tools to identify further opportunities.</li> <li>Apply dynamic activity modelling and demand management strategies.</li> <li>Invest in community and prevention programmes to reduce acute pressure including neighbourhoods, community and primary care.</li> </ul>		
2	<p><b>Delivery of the Capital Financial Plan</b></p> <p>Delays or overspend on capital projects impacting depreciation and financial sustainability.</p>	Likely 4 x Major 4 = High 16	<ul style="list-style-type: none"> <li>Continue to utilise a Capital Prioritisation Oversight Group with strong governance and assurance processes to ensure effective planning, oversight and management of capital.</li> <li>Prioritise system strategic capital to support delivery of the commissioning plan priorities and phased delivery to align with available funding envelopes and support performance and quality standards alongside digital transformation, constitutional standards, estates safety and 'left shift'.</li> </ul>	Possible 3 x Major 3 = Moderate 9	System Finance Committee in Common

Risk Number	Risk and description	Risk score (consequences x likelihood)	Mitigations	Target risk score (consequences v likelihood)	Committee/ICB oversight
			<ul style="list-style-type: none"> <li>Regularly review capital prioritisation against strategic objectives using the agreed capital prioritisation scorecards.</li> </ul>		
3	<p><b>Changes in national policy</b> Revenue and capital allocations or financial framework/business rules affecting planned trajectories and the NHS payment scheme.</p>	Likely 4 x Major 4 = high 16	<ul style="list-style-type: none"> <li>Maintain close engagement with NHS England and the Department of Health and Social Care for early visibility of changes.</li> <li>Build flexibility into financial plans to adapt to policy shifts.</li> <li>Develop contingency scenarios for funding reductions and NHS payment scheme changes.</li> <li>Work collaboratively with providers on the impact of national policy – for example referral to treatment times, breaking down block contracts, and marginal rates for urgent and emergency care activity.</li> </ul>	Possible 3 x Major 3 = Moderate 9	System Finance Committee in Common

## Workforce and people

Risk Number	Risk and description	Risk score (consequences x likelihood)	Mitigations	Target risk score (consequences v likelihood)	Committee/ICB oversight
4	<p><b>50% reduction in ICB running costs</b></p> <p>Potential capacity challenges in being able to deliver the full Five Year Strategic Commissioning ambition due to human resource and limited capacity following the voluntary redundancy process and management of change.</p>	Possible 3 x Major 4 = 12	<ul style="list-style-type: none"> <li>• Prioritise commissioning activity to focus limited capacity on the highest impact programmes.</li> <li>• Strengthen shared functions and pooled expertise across the system to reduce duplication.</li> <li>• Use standardised commissioning, business case and programme tools to streamline workload.</li> <li>• Improve forward planning and sequencing of work to avoid overstretching reduced teams.</li> <li>• Enhance digital tools and automation to reduce manual corporate workload and free-up staff for strategic tasks.</li> </ul>	Possible 3 x Major 3 = Moderate 9	Transition Committee in Common
5	<p><b>Back-office cost reduction in our NHS providers</b></p> <p>Potential capacity challenges in freeing up of resource to support the planning and delivery of the 'left shift' and service changes due to reduction in corporate capacity to cover pathway redesign and development of business cases.</p>	Possible 3 x Major 4 = 12	<ul style="list-style-type: none"> <li>• Prioritise transformation and 'left shift' programmes so limited corporate capacity is focused on the highest impact areas.</li> <li>• Strengthen shared corporate, analytical and Project Management Office functions across providers to reduce duplication and pool expertise.</li> <li>• Use standardised pathway redesign tools, templates and business case frameworks to streamline work and reduce workload.</li> <li>• Improve programme planning to sequence work realistically and avoid overstretching reduced corporate teams.</li> </ul>	Possible 3 x Major 3 = Moderate 9	Strategic Commissioning and Transformation Committee in Common

Risk Number	Risk and description	Risk score (consequences x likelihood)	Mitigations	Target risk score (consequences v likelihood)	Committee/ICB oversight
			<ul style="list-style-type: none"> <li>Enhance digital tools and automation to reduce manual corporate workload and free-up staff for transformation activity.</li> </ul>		
6	<p><b>Workforce shortages across sectors limit service delivery and transformation</b></p> <p>Rising demand, sickness absence, burnout and industrial action may reduce workforce supply across acute, community, primary care, mental health, learning disabilities and autism and social care.</p>	Possible 3 x Major 4 = 12	<ul style="list-style-type: none"> <li>Strengthen recruitment across all sectors including expanded training pipelines, apprenticeship schemes and 'grow your own' pathways.</li> <li>Improve retention through flexible working, wellbeing support and reduced administrative burden.</li> <li>Expand multidisciplinary teams to reduce pressure on scarce roles.</li> <li>Enhance sickness management and early intervention to reduce absence.</li> <li>Implement Health and Wellbeing Action Plans.</li> <li>Maintain system-wide contingency plans for industrial action.</li> <li>Use population health approaches and prevention to reduce avoidable demand.</li> <li>Strengthen cross sector workforce planning and shared roles across health and social care.</li> <li>Invest in digital tools and interoperability to improve productivity and free-up clinical time.</li> </ul>	Possible 3 x Major 3 = Moderate 9	People, Culture and Inclusion Committee in Common

Risk Number	Risk and description	Risk score (consequences x likelihood)	Mitigations	Target risk score (consequences v likelihood)	Committee/ICB oversight
7	<p><b>Insufficient GP numbers to meet population need</b></p> <p>There is a risk that general practice will not have sufficient GP numbers to meet the needs of the local population. Contributing factors include an ageing GP workforce, recruitment challenges in rural and deprived areas, high workload pressures, limited training capacity, increasing demand from an ageing population, and reliance on locum cover. Insufficient GP capacity may lead to reduced access, longer waits, increased pressure on urgent and emergency care, and poorer patient outcomes.</p>	Likely 4 x Major 4 = High 16	<ul style="list-style-type: none"> <li>• Expand GP recruitment and retention schemes.</li> <li>• Increase training and fellowship opportunities.</li> <li>• Strengthen multidisciplinary teams to reduce GP workload.</li> <li>• Targeted support for rural and high-need practices.</li> <li>• Workforce modelling aligned to population health needs.</li> </ul>	Possible 3 x Major 3 = Moderate 9	Strategic Commissioning and Transformation Committee in Common

Risk Number	Risk and description	Risk score (consequences x likelihood)	Mitigations	Target risk score (consequences v likelihood)	Committee/ICB oversight
8	<p><b>Cultural transformation and organisational development do not embed</b></p> <p>Organisational development (OD), leadership development and cultural change may not progress at pace across the ICB and wider system.</p>	Possible 3 x Major 4 = 12	<ul style="list-style-type: none"> <li>• Prioritise OD and cultural change within systemwide programmes so it remains a core enabler, not an add on.</li> <li>• Strengthen leadership development offers and ensure consistent access across all organisations and levels.</li> <li>• Use a clear cultural framework and shared behaviours to align teams and reduce variation.</li> <li>• Build OD capacity through shared expertise, communities of practice and targeted support to areas with the greatest need.</li> <li>• Improve communication and engagement so staff understand the purpose and benefits of cultural change.</li> <li>• Monitor progress through regular feedback, staff experience data and leadership indicators to adjust support quickly.</li> </ul>	Possible 3 x Major 3 = Moderate 9	People, Culture and Inclusion Committee in Common

## Delivery of 'left shift' – hospital to community, analogue to digital and sickness to prevention

Risk Number	Risk and description	Risk score (consequences x likelihood)	Mitigations	Target risk score (consequences v likelihood)	Committee/ICB oversight
9	<p><b>Failure to deliver neighbourhood health / 'left shift' due to system constraints</b></p> <p>The transition from hospital-centric care to neighbourhood-based, integrated community services may not be delivered effectively.</p> <p>Risks include insufficient community capacity, variation in primary care network (PCN) maturity, workforce shortages, digital and estate constraints, and lack of public understanding.</p> <p>Failure to deliver the 'left shift' would result in continued pressure on acute services, poorer patient experience, and inability to meet long-term demand.</p>	Possible 3 x Major 4 = 12	<ul style="list-style-type: none"> <li>• Phased implementation by neighbourhood readiness.</li> <li>• Strengthen community workforce and multidisciplinary teams.</li> <li>• Invest in neighbourhood hubs, diagnostics and digital tools.</li> <li>• Public engagement and codesign.</li> <li>• Standardised operating model for neighbourhood teams.</li> </ul>	Possible 3 x Major 3 = Moderate 9	Strategic Commissioning and Transformation Committee in Common

Risk Number	Risk and description	Risk score (consequences x likelihood)	Mitigations	Target risk score (consequences v likelihood)	Committee/ICB oversight
10	<p><b>Failure to reduce health inequalities across</b></p> <p>Failure to address these issues may widen gaps in outcomes, reduce life expectancy in priority groups, and increase pressure on acute and community services.</p>	Possible 3 x Major 4 = 12	<ul style="list-style-type: none"> <li>• Improve access in rural communities through mobile services, outreach clinics, and strengthened transport partnerships.</li> <li>• Prioritise areas of high deprivation using needs based resource allocation and targeted health improvement interventions.</li> <li>• Support PCN and neighbourhood maturity, including leadership development, capability building, and shared learning.</li> <li>• Reduce digital exclusion via digital literacy programmes and ongoing non digital access routes (phone, walk in, community outreach).</li> <li>• Strengthen workforce capacity through multi year workforce planning, multidisciplinary roles, and retention initiatives.</li> <li>• Improve data quality and analytical capability with standardised data processes, enhanced analytics capacity, and improved data sharing.</li> <li>• Increase engagement with underserved groups through culturally competent approaches, trusted community partners, and continuous feedback mechanisms</li> </ul>	Possible 3 x Major 3 = Moderate 9	Strategic Commissioning and Transformation Committee in Common

Risk Number	Risk and description	Risk score (consequences x likelihood)	Mitigations	Target risk score (consequences v likelihood)	Committee/ICB oversight
11	<p><b>Low uptake of screening and immunisation programmes</b></p> <p>There is a risk that screening and immunisation uptake remains below national targets. This due to factors such as:</p> <ul style="list-style-type: none"> <li>• Rurality</li> <li>• Transport barriers</li> <li>• Digital exclusion</li> <li>• Vaccine hesitancy</li> <li>• Limited outreach capacity</li> <li>• Variation in PCN engagement</li> <li>• Lower uptake among deprived or underserved communities.</li> </ul> <p>Persistently low uptake may lead to late diagnosis, preventable illness, widening health inequalities, and increased pressure on primary, community and acute services.</p>	Possible 3 x Major 4 = 12	<ul style="list-style-type: none"> <li>• Expand targeted outreach and mobile clinics.</li> <li>• Strengthen PCN and community pharmacy involvement.</li> <li>• Work with VCSE partners to reach underserved groups.</li> <li>• Improve data quality and population health analytics.</li> <li>• Tailored communications to address hesitancy.</li> </ul>	Possible 3 x Major 3 = Moderate 9	Health and Care Senates in Common

Risk Number	Risk and description	Risk score (consequences x likelihood)	Mitigations	Target risk score (consequences v likelihood)	Committee/ICB oversight
12	<p><b>Challenges in delivering the sickness-to-prevention system ambition</b></p> <p>There is a risk that the ICS will not achieve the shift from reactive, illness-based care to a proactive, prevention-focused model. This may occur due to:</p> <ul style="list-style-type: none"> <li>• Limited investment in prevention workforce shortages in public health and community services</li> <li>• Variation in neighbourhood maturity digital and data constraints</li> <li>• Insufficient population health capability</li> <li>• Low public engagement</li> <li>• Competing operational pressures in acute and primary care.</li> </ul> <p>Failure to deliver this shift would lead to continued high demand for urgent and emergency care, widening</p>	Possible 3 x Major 4 = 12	<ul style="list-style-type: none"> <li>• Increase investment in prevention and early intervention.</li> <li>• Strengthen neighbourhood teams and community hubs.</li> <li>• Expand population health analytics capability.</li> <li>• Work with VCSE partners to reach underserved groups.</li> <li>• Embed prevention objectives across all programmes and contracts.</li> <li>• Targeted communications and behaviour change campaigns.</li> </ul>	Possible 3 x Major 3 = Moderate 9	Health and Care Senates in Common

Risk Number	Risk and description	Risk score (consequences x likelihood)	Mitigations	Target risk score (consequences v likelihood)	Committee/ICB oversight
	health inequalities, poorer long-term outcomes, and reduced system sustainability.				
13	<p><b>Digital transformation not adopted at scale</b></p> <p>Key enablers: NHS App, remote monitoring, Electronic Patient Records, Docman Connect, Digital ReSPECT and triage tools, may not embed consistently.</p>	Possible 3 x Major 4 = 12	<ul style="list-style-type: none"> <li>• Provide clear systemwide standards and expectations for adoption of key digital tools across all providers and primary care networks (PCNs).</li> <li>• Strengthen training, onboarding and digital literacy support for staff to build confidence and consistent use.</li> <li>• Use targeted implementation support and clinical champions to drive uptake in areas with slower adoption.</li> <li>• Improve interoperability and integration so digital tools fit smoothly into clinical workflows.</li> <li>• Monitor adoption levels through dashboards and use data to focus support where gaps persist.</li> <li>• Engage patients and the public to increase awareness and use of tools such as the NHS App and remote monitoring.</li> </ul>	Possible 3 x Major 3 = Moderate 9	Strategic Commissioning and Transformation Committee in Common

Risk Number	Risk and description	Risk score (consequences x likelihood)	Mitigations	Target risk score (consequences v likelihood)	Committee/ICB oversight
14	<p><b>Insufficient digital capability and capacity across system partners</b></p> <p>Variation in digital maturity, infrastructure, and skills across providers and PCNs limits the ability to deliver ‘left shift’ models. This may result in inconsistent care, reduced efficiency, and inability to scale digital-enabled pathways.</p>	Possible 4 x Major 3 = 12	<ul style="list-style-type: none"> <li>Set clear systemwide digital standards and minimum capability requirements for all providers and PCNs.</li> <li>Target support and investment toward organisations with lower digital maturity to level up capability.</li> <li>Strengthen digital skills training and onboarding for staff to improve confidence and adoption.</li> <li>Improve interoperability and infrastructure so digital tools integrate smoothly into workflows.</li> <li>Use data and dashboards to monitor adoption and focus support where gaps persist.</li> <li>Engage patients and communities to increase use of digital-enabled pathways where appropriate.</li> </ul>	Possible 3 x Major 3 = Moderate 9	Strategic Commissioning and Transformation Committee in Common
15	<p><b>Data quality and population health management (PHM) limitations</b></p> <p>Poor data quality or inconsistent coding may undermine population health management, risk stratification and proactive care.</p>	Likely 4 x Major 4 = High 16	<ul style="list-style-type: none"> <li>Strengthen data quality standards and provide targeted support to practices and providers with coding gaps.</li> <li>Identify and implement training on accurate coding adopting national standards/best practice, improving data entry and use of PHM tools.</li> <li>Improve interoperability between systems and streamline volume of data flows to reduce duplication and inconsistencies.</li> </ul>	Possible 4 x Major 3 = 12	Strategic Commissioning Committee in Common

Risk Number	Risk and description	Risk score (consequences x likelihood)	Mitigations	Target risk score (consequences v likelihood)	Committee/ICB oversight
			<ul style="list-style-type: none"> <li>Use regular data quality audits and dashboards to identify issues early and focus improvement efforts.</li> <li>Implement a Data Strategy incorporating data quality standards.</li> <li>Further develop a shared PHM framework so all partners use consistent methods for risk stratification and proactive care.</li> </ul>		
16	<p><b>Development and Implementation of the National Data Platform</b></p> <p>There is a potential but yet unknown possibility that there may be issues with accessing local data during the transition process which may impact upon the ability to undertake effective PHM analysis.</p>	Likely 4 x Major 4 = High 16	<ul style="list-style-type: none"> <li>Document what will be needed locally.</li> <li>Explore at-scale solutions across the West Midlands.</li> <li>Identify resource and assessing necessary training required to facilitate transition.</li> </ul>	Possible 3 x Major 3 = Moderate 9	Strategic Commissioning and Transformation Committee in Common
17	<p><b>Planned care digital transformation does not reduce demand</b></p> <p>Digital pathways: Advice and Guidance, digital referrals and patient portals, may not be consistently used, limiting</p>	Possible 4 x Major 3 = 12	<ul style="list-style-type: none"> <li>Set clear expectations for consistent use of Advice and Guidance, digital referrals and patient portals across all providers and PCNs.</li> <li>Strengthen training and clinical engagement to build confidence in digital pathways.</li> <li>Use data to monitor uptake and target support to specialties or practices with low utilisation.</li> </ul>	Possible 3 x Major 2 = Low 6	Strategic Commissioning and Transformation Committee in Common

Risk Number	Risk and description	Risk score (consequences x likelihood)	Mitigations	Target risk score (consequences v likelihood)	Committee/ICB oversight
	reductions in unnecessary referrals and follow ups.		<ul style="list-style-type: none"> <li>Improve integration of digital tools into clinical workflows to make them the easiest, default option.</li> <li>Provide patient support and communication to increase use.</li> </ul>		
18	<p><b>Limited uptake of remote monitoring and virtual care</b></p> <p>Patients or clinicians may not adopt remote monitoring tools at scale, reducing impact on long-term condition management and admission avoidance.</p>	Possible 4 x Major 3 = 12	<ul style="list-style-type: none"> <li>Strengthen training and clinical engagement so staff feel confident using remote monitoring tools.</li> <li>Provide clear patient support, simple onboarding and accessible guidance to increase uptake.</li> <li>Target implementation support to practices, teams or specialties with low adoption.</li> <li>Improve integration of remote monitoring into existing workflows to make it easy and routine.</li> <li>Use data to track utilisation and focus improvement efforts where uptake is lowest.</li> </ul>	Possible 3 x Major 2 = Low 6	Strategic Commissioning and Transformation Committee in Common
19	<p><b>Digital exclusion widens inequalities</b></p> <p>Underserved groups may struggle to access digital tools, leading to inequitable access to care and poorer outcomes.</p>	Possible 3 x Major 4 = 12	<ul style="list-style-type: none"> <li>Provide non-digital alternatives to ensure services remain accessible for all groups.</li> <li>Expand digital inclusion support such as training, community outreach and assisted digital options.</li> <li>Work with VCSE partners to reach underserved communities and tailor support to local needs.</li> <li>Improve availability of devices, connectivity and safe digital access points in community settings.</li> </ul>	Possible 3 x Major 3 = Moderate 9	Strategic Commissioning and Transformation Committee in Common

Risk Number	Risk and description	Risk score (consequences x likelihood)	Mitigations	Target risk score (consequences v likelihood)	Committee/ICB oversight
			<ul style="list-style-type: none"> <li>Monitor uptake by deprivation, age, ethnicity and rurality to target support where exclusion is greatest.</li> </ul>		

## Delivery of improved access and performance

Risk Number	Risk and description	Risk score (consequences x likelihood)	Mitigations	Target risk score (consequences v likelihood)	Committee/ICB oversight
20	<p><b>Non-delivery of the urgent and emergency care access targets</b></p> <p>Sustained high demand, flow constraints, workforce shortages, delays in discharge and inconsistent use of community and virtual care alternatives. Failure to meet targets could lead to overcrowding, longer waits, poorer patient experience, and increased clinical risk.</p>	Likely 4 x Major 4 = High 16	<ul style="list-style-type: none"> <li>Strengthen front-door streaming, same-day emergency care and alternative community pathways to reduce avoidable attendances.</li> <li>Improve flow through enhanced discharge processes, community capacity and closer social care coordination.</li> <li>Target workforce support to high-pressure UEC areas and optimise multidisciplinary team models.</li> <li>Use real-time data and escalation frameworks to manage surges and maintain performance.</li> <li>Expand virtual wards and remote monitoring to reduce admissions and support early discharge.</li> </ul>	Possible 3 x Major 3 = Moderate 9	Quality and Performance Committees in Common
21	<p><b>Referral to treatment (RTT) – spinal waits</b></p> <p>Spinal pathways continue to experience long RTT waits due to high demand, limited specialist capacity, complex diagnostics, and constrained theatre availability.</p> <p>Delays in triage, imaging and surgical decision-making may further extend waits, leading to poorer patient outcomes,</p>	Likely 4 x Major 4 = High 16	<ul style="list-style-type: none"> <li>Strengthen spinal triage and optimise use of musculoskeletal (MSK) and advanced practice clinicians to manage demand earlier.</li> <li>Increase capacity through additional clinics, targeted insourcing/outsourcing and improved theatre scheduling.</li> <li>Streamline diagnostics and reduce delays in MRI and specialist review.</li> <li>Use demand and capacity modelling to prioritise high-risk patients and improve flow through the pathway.</li> </ul>	Possible 3 x Major 3 = Moderate 9	Quality and Performance Committees in Common

Risk Number	Risk and description	Risk score (consequences x likelihood)	Mitigations	Target risk score (consequences v likelihood)	Committee/ICB oversight
	increased pain and disability, and potential breaches of national RTT standards.		<ul style="list-style-type: none"> <li>Implement standardised referral criteria and advice and guidance to reduce inappropriate referrals.</li> </ul>		
22	<p><b>Psychiatric Intensive Care Uni (PICU) – capital</b></p> <p>There is a risk that insufficient capital funding prevents the development of a local PICU. Without a local facility, patients requiring intensive psychiatric care may continue face long travel distances, delayed access to specialist beds, and increased reliance on out-of-area placements leading to poorer clinical outcomes, higher costs, reduced family involvement, and operational pressures across acute mental health pathways.</p>	Likely 4 x Major 4 = High 16	<ul style="list-style-type: none"> <li>Strengthen the capital case using clear clinical, financial and operational evidence, including demand modelling and out-of-area cost analysis.</li> <li>Explore alternative funding options such as systemwide capital prioritisation or joint ventures.</li> <li>Enhance interim pathways through strengthened relationships with regional PICUs and improved transfer protocols.</li> <li>Build local capability by upskilling staff, improving crisis response models and using enhanced observation or step-up care where safe.</li> <li>Maintain engagement with NHS England and regional networks to align with future capital opportunities and strategic planning.</li> </ul>	Possible 2 x Major 3 = Low 6	Strategic Commissioning and Transformation Committee in Common
23	<p><b>Children and young people (CYP) mental health access targets</b></p> <p>Improvement Plan not achieved due to rising demand, workforce shortages,</p>	Possible 3 x Major 3 = Moderate 9	<ul style="list-style-type: none"> <li>Implement new model and expand early intervention and community-based support to reduce pressure on specialist CAMHS.</li> <li>Strengthen workforce capacity through targeted recruitment, retention and skill-mix models.</li> </ul>	Possible 2 x Major 3 = Low 6	Quality and Performance Committees in Common

Risk Number	Risk and description	Risk score (consequences x likelihood)	Mitigations	Target risk score (consequences v likelihood)	Committee/ICB oversight
	<p>long waits for assessment, and limited capacity across child and adolescent mental health services (CAMHS) and community services. Inconsistent early intervention, variable digital adoption and pressures in wider children's services may further delay access, leading to unmet need, poorer outcomes and increased crisis presentations.</p>		<ul style="list-style-type: none"> <li>• Improve triage, flow and demand management to prioritise high-risk CYP and reduce bottlenecks.</li> <li>• Use digital tools and remote support to increase reach and reduce waiting times where appropriate.</li> <li>• Enhance partnership working with schools, social care and VCSE organisations to support earlier identification and access.</li> <li>• Monitor access performance closely and target improvement support to areas with persistent delays.</li> </ul>		

## Patient and system engagement

Risk Number	Risk and description	Risk score (consequences x likelihood)	Mitigations	Target risk score (consequences v likelihood)	Committee/ICB oversight
24	<p><b>Planning timescales</b></p> <p>Prevented up front meaningful engagement with health and wellbeing boards, patients and the public and wider stakeholders and ongoing work required.</p>	Possible 3 x Major 3 = Moderate 9	<ul style="list-style-type: none"> <li>Strengthen forward planning and build longer lead in times for future cycles to enable meaningful early engagement.</li> <li>Use targeted, rapid engagement methods, such as focused workshops, virtual sessions and surveys to gather input within tight timescales.</li> <li>Maintain ongoing dialogue with health and wellbeing boards, VCSE partners, patients and the public outside formal planning windows.</li> <li>Develop a standing engagement framework so stakeholders can contribute continuously rather than only during planning rounds.</li> <li>Provide clear, timely communication on priorities and timelines to ensure stakeholders can prepare and participate effectively.</li> </ul>	Possible 2 x Major 3 = Low 6	Strategic Commissioning and Transformation Committee in Common
25	<p><b>Ongoing patient engagement</b></p> <p>To not sustain engagement with patients, carers and the public throughout the development and delivery of the 10 Year Plan may reduce participation, leading to commissioning decisions that do not fully reflect lived experience, local needs or</p>	Possible 3 x Major 3 = Moderate 9	<ul style="list-style-type: none"> <li>Establish a standing engagement framework with regular, predictable opportunities for patient and public involvement.</li> <li>Strengthen partnerships with VCSE organisations, Healthwatch and community groups to reach diverse voices.</li> <li>Use a mix of engagement methods such as digital, in-person and targeted outreach to maintain accessibility and reduce fatigue.</li> </ul>	Possible 2 x Major 3 = Low 6	Strategic Commissioning and Transformation Committee in Common

Risk Number	Risk and description	Risk score (consequences x likelihood)	Mitigations	Target risk score (consequences v likelihood)	Committee/ICB oversight
	health inequalities. This could weaken legitimacy, reduce impact and limit the plan's ability to deliver meaningful change.		<ul style="list-style-type: none"> <li>• Provide clear, ongoing communication on how feedback has shaped commissioning decisions to build trust and continued participation.</li> <li>• Embed patient and public representatives in programme boards and working groups to ensure continuous input.</li> <li>• Monitor engagement levels and demographics to identify gaps and target additional outreach where needed.</li> </ul>		
26	<p><b>Substantive service change/decommissioning</b></p> <p>There is a risk that the management of substantive service changes required for the 10 Year Plan is not delivered effectively due to limited capacity, complex interdependencies, regulatory requirements, and variable readiness across system partners.</p> <p>Poor coordination, unclear governance or insufficient programme oversight may lead to delays, inconsistent implementation, stakeholder challenge, and reduced ability to realise the intended</p>	Likely 4 x Major 4 = High 16	<ul style="list-style-type: none"> <li>• Strengthen programme governance with clear roles, decision-making structures and escalation routes for all service change activity.</li> <li>• Develop a systemwide service change framework aligned to statutory guidance to ensure consistent and compliant processes.</li> <li>• Use robust programme and project management support, including shared PMO capacity, to coordinate timelines and interdependencies.</li> <li>• Maintain early and ongoing engagement with local authorities, providers, Healthwatch and regulators to reduce risk of challenge.</li> <li>• Apply structured impact assessments (quality, equality, finance, workforce) to inform decision-making and ensure safe implementation.</li> <li>• Monitor progress through regular reporting and use data to identify emerging risks and adjust plans quickly.</li> </ul>	Possible 3 x Major 3 = Moderate 9	Strategic Commissioning and Transformation Committee in Common

Risk Number	Risk and description	Risk score (consequences x likelihood)	Mitigations	Target risk score (consequences v likelihood)	Committee/ICB oversight
	benefits of service transformation.				

# Glossary

Term	Definition
A&G	Advice and Guidance – Digital mechanism enabling GPs to seek specialist advice before referral.
AAC	Augmentative and Alternative Communication – Assistive communication technologies used to support individuals with communication needs.
AI	Artificial Intelligence – Digital tools supporting triage, decision-making and diagnostics.
ARRS	Additional Roles Reimbursement Scheme – Funding to expand multidisciplinary roles in PCNs.
BCF	Better Care Fund – Pooled NHS and local authority budget enabling integrated care.
CCC	Care Coordination Centre – System hub coordinating referrals, flow and urgent community care.
CDC	Community Diagnostic Centre – Local hubs providing diagnostics outside hospitals.
CEDS-CYP	Community Eating Disorder Service for Children & Young People.
CHC	Continuing Healthcare – NHS-funded support for complex long-term care needs.
Clinical Strategy	System-wide clinical direction structured around life course models.
Core20PLUS5	NHSE health inequalities framework targeting deprived and inclusion-health groups.

CP-IS	Child Protection Information Sharing System – National digital safeguarding system.
CQC	Care Quality Commission – National regulator for health and care providers.
CVRM	Cardiovascular and Renal Metabolic – Integrated approach to CVD, diabetes and kidney disease.
CYP	Children and Young People.
DSR	Dynamic Support Register – Identifies autistic or learning-disabled people at risk of admission.
DTAC	Digital Technology Assessment Criteria – Standards for digital product assurance.
ED	Emergency Department.
EIA	Equality Impact Assessment – Assessing equity implications of decisions.
ENT	Ear, Nose & Throat services.
EPaCCS	Electronic Palliative Care Coordination System.
EPR	Electronic Patient Record.
FDS	Faster Diagnosis Standard – Cancer diagnosis within 28 days.
FeNO	Fractional Exhaled Nitric Oxide – Used in asthma diagnosis.
GOS	General Ophthalmic Services – NHS-funded sight testing.
Green Plan	System sustainability and carbon reduction plan.
HFMA	Healthcare Financial Management Association – Provides value-based healthcare guidance.
HTP	Hospital Transformation Programme.
HWB	Health and Wellbeing Board.

ICB	Integrated Care Board.
ICS	Integrated Care System.
IIA	Integrated Impact Assessment.
INTs	Integrated Neighbourhood Teams.
ISNA	Integrated Strategic Needs Assessment.
JSNA	Joint Strategic Needs Assessment.
LDA	Learning Disabilities and Autism.
Left Shift	Shift from hospital-based to community-based models.
MHST	Mental Health Support Team (Schools).
MSK	Musculoskeletal services.
NNHIP	National Neighbourhood Health Implementation Programme.
NSS	Non-Specific Symptoms Cancer Pathway.
NTPS	NHS Payment Scheme.
OPEL	Operational Pressures Escalation Levels.
OPICs	Offices for Pan-ICB Commissioning.
Optometry First	Integrated eyecare model shifting work into optometry.
PCN	Primary Care Network.
PHIP	Population Health Implementation Plan.
PICU	Psychiatric Intensive Care Unit.
PIFU	Patient-Initiated Follow-Up.
PIN	Prior Information Notice.
PSIRF	Patient Safety Incident Response Framework.
QIA	Quality Impact Assessment.
QOF	Quality and Outcomes Framework.

RJAH	Robert Jones and Agnes Hunt Orthopaedic Hospital.
SDEC	Same Day Emergency Care.
SEND	Special Educational Needs and Disabilities.
SFC	System Flow Centre.
ShIPP / TWIPP	Shropshire Integrated Place Partnership / Telford & Wrekin Integrated Place Partnership.
SPA	Single Point of Access.
SSOT	Staffordshire & Stoke-on-Trent ICB.
TIC	Trauma-Informed Care.
TIF	Transformation Investment Funding.
UCR	Urgent Community Response.
UEC	Urgent and Emergency Care.
UTC	Urgent Treatment Centre.
VCSE	Voluntary, Community and Social Enterprise sector.
Virtual Ward	Remote monitoring model delivering hospital-level care at home.