Integrated
Care System
Shropshire, Telford and Wrekin

Long Term Conditions Strategy 2024

December 2023 Version 2

Contents

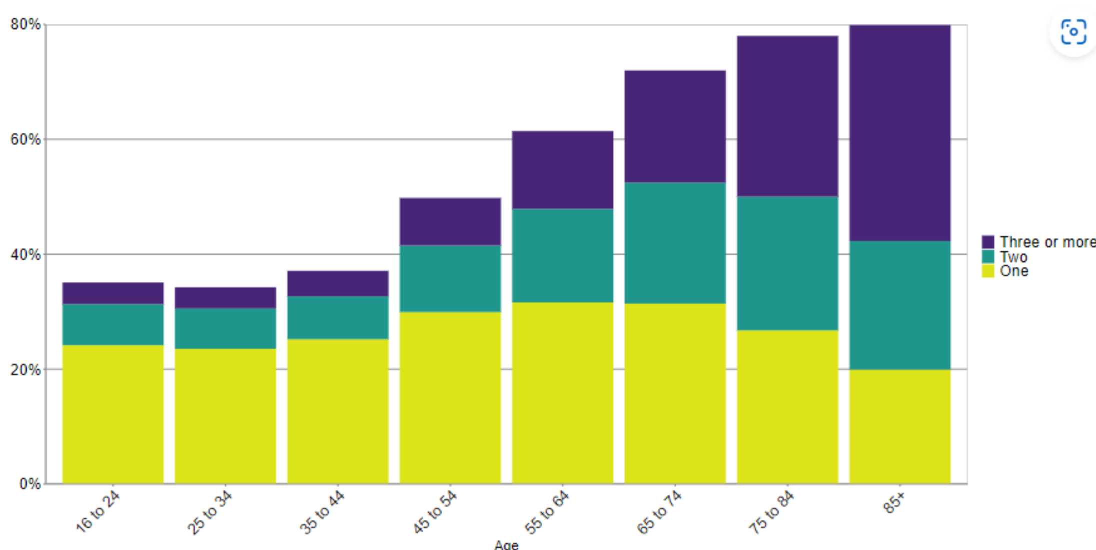
Introduction 3
Scope 5
Population Overview 6
Demographic determinants of Long-Term Condition prevalence (NHS digital People and Person Insight October 2023) 7
Risk Stratification 7
Care Utilisation and Cost for People with Long Term conditions 8
Overview of STW Population Health Pathways (NHS Model System October 2023 from June 2023 QOF data) 8
STW Potential opportunities relating to transformation of Long Terms Conditions 10
Emergency Admissions for Ambulatory Care Sensitive Conditions 10
Emergency Admissions from Care Homes 10
Emergency admissions for patients reliant on planned care 11
Key Focus Areas 12
1. Keeping People Healthy Through Primary and Secondary Prevention 13
2. Early Diagnosis, Early Intervention and Quality Treatment 14
3. Living With Long-Term Conditions 14
Commissioning Framework 15
Programme Governance 16
Next Steps 16

Introduction

In August 2023 the Department for Health and Social Care published a Major Conditions Strategy that sets out key initiatives for tackling ill health across conditions that are collectively the greatest contributors to long term ill health and mortality. This document starts with the principle that the model of care which sustained us for the past 75 years must evolve considerably to meet the needs of the public in 75 years' time. There have been significant changes in society and in the health of people since the establishment of the NHS and social care system in 1948. The health and care system has been enormously successful in driving increases in life expectancy by reducing the impact of infectious diseases (for example, through systematic and wide-ranging vaccine programmes) and then moved on to tackle early death from non-communicable diseases (through innovations in treatment and reductions in behavioural risk factors such as smoking).

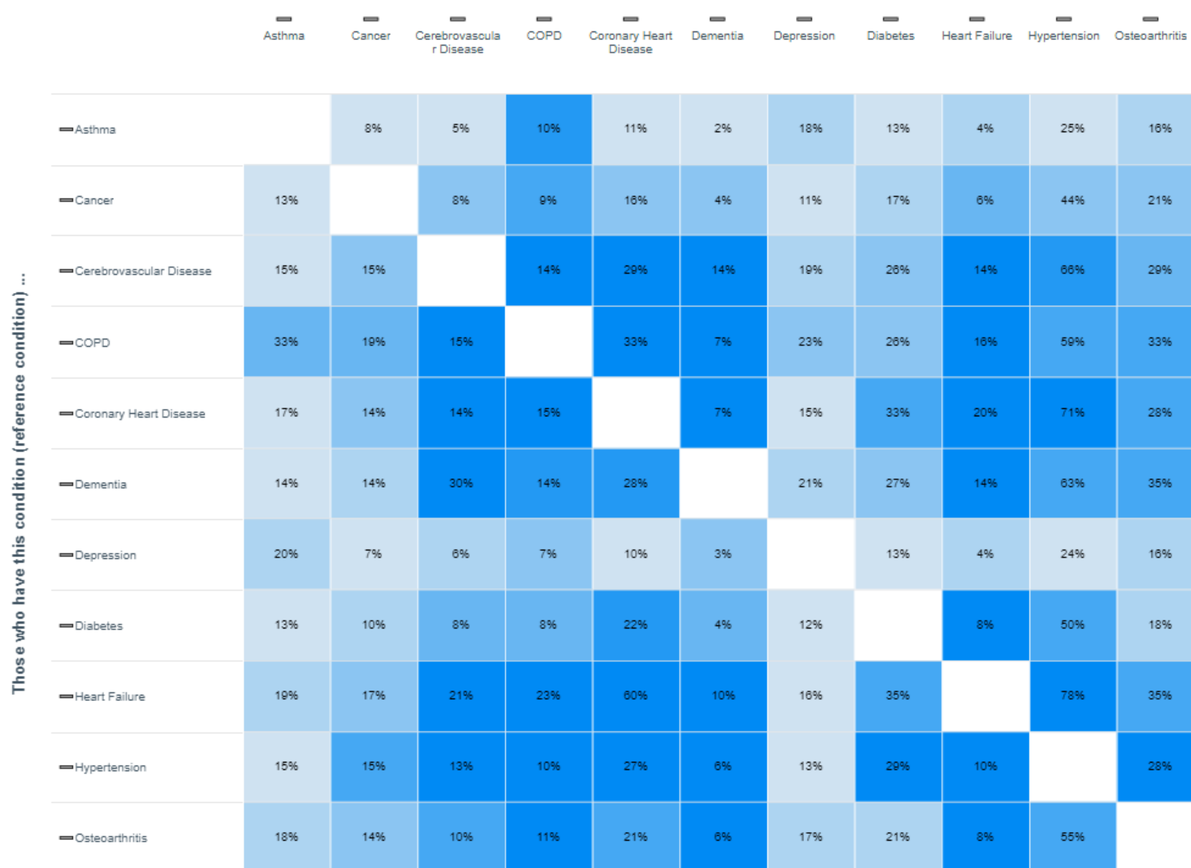
To continue to improve healthy life expectancy, we must now do more to promote good health and prevent, identify and treat non-communicable diseases as early and as effectively as possible. Compared to 1948, 1979 or 2010, individuals are living longer but for too many people that life is experienced with many years in poor health, for many, particularly those in live with deprivation, healthy life expectancy has not improved. Figure 1, demonstrates that as people are living longer the likelihood of having a long-term condition rises significantly for older age groups: most people in the 55-64 age group and older have at least one long-term condition, including 80% of people over 85, and a rapidly increasing proportion of the population for the over 65s.

Figure 1: proportion of age cohorts living with long-term conditions (GP Survey 2022)



As a result, people are spending a greater proportion of their lives with a long term condition which impacts on quality of life compared to a decade ago, while more and more people have multiple long-term conditions (MLTC); by 2035, two-thirds of adults aged over 65 will have 2 or more conditions and 17% will have 4 or more. Living with long-term conditions and MLTC is not solely a problem in older age groups. Since 2011, over half of new cases of MLTC each year occurred in individuals younger than 50 years, and the median age of complex MLTC onset dropped below 60. In addition, growing numbers of people living with multiple conditions have to contend with a health system that tend[s] to be organised along single disease or single organ lines. This can have a negative effect on their experience of care, as many report being frustrated with having to see multiple different healthcare professionals as a result of their multimorbidity and the potential for adverse drug effects grows as the number of drugs prescribed increases. Figure 2 shows the prevalence of comorbidity by some of the major condition groups.

Figure 2. Prevelance of Mulitmorbididty by Condition (Person and People Insight 2022/23)



The coordination of the prevention and care of LTCs and MLTCs needs a system wide approach that goes beyond traditional organisational boundaries The Institute of health equity has reported that that 80% of health is a result of where and how live and behave with housing, education, place of work etc being key social determinants of outcomes. (reference: https://www.instituteofhealthequity.org/resources-reports/fair-society-healthy-lives-the-marmot-review/fair-society-healthy-lives-full-report-pdf.pdf). Therefore, it is essential that interventions are in place long before people reach the doors of the GP or the hospital. To address this situation the Major Conditions Strategy begins with one question: **how should our approach to health and care delivery evolve to improve outcomes and better meet the needs of our population, which is becoming older and living with multimorbidity?**

Three key focus areas have been identified to support improvements in health outcomes and the quality of life for people with a Long-Term Condition or Multiple Long-Term Conditions, these are:

1. Keeping People Healthy Through Primary and Secondary Prevention
2. Early Diagnosis, Early Intervention and Quality Treatment
3. Living With Major Conditions

The aim of a system level long term condition strategy will be to develop plans against each of these focus areas that will contribute to the delivery the following overarching objectives:

- rebalancing the health and care system, over time, towards a personalised approach to prevention through the management of risk factors
- embedding early diagnosis and treatment delivery in the community
- managing multiple conditions effectively - including embedding generalist and specialist skills within teams, organisations and individual clinicians

- seeking much closer alignment and integration between physical and mental health services
- shaping services and support around the lives of people, giving them greater choice and control where they need and want it and real clarity about their choices and next steps in their care

This approach takes us away from single disease strategies but is entirely consistent with our wider shift towards integrated care. We have grown accustomed to planning our health and care delivery around treating a person based on an individual health condition, often with a workforce model that favours specialism and an incentive structure which focuses on single episodes of activity. In some areas this has been beneficial: our world-leading institutions in cancer are obvious examples of where deep subject specialism unlocks innovation and redefines both outcomes and the subsequent standard of care. The challenge is to retain these strengths while pivoting to a model that is built around whole-person care.

Scope

This document has been developed to set out the approach to the transformation of care for patients with long term conditions in Shropshire, Telford and Wrekin. This will not only consider all elements of the pathway from prevention, through diagnosis to ongoing management of a condition.

The Long-Term Conditions Strategy in conjunction with the Shropshire and Telford and Wrekin Health and Wellbeing Strategies and STW Clinical Strategy will identify and prioritise the initiatives that will transform care and support the delivery of many of the element of the Integrated Care Board (ICB) Joint Forward Plan (JFP). This strategy will be particularly important in developing or further enhancing place-based delivery and person-centred care.

The transformation of secondary and tertiary care is not directly within scope of this strategy as the key focus areas will be:

1. Keeping People Healthy Through Primary and Secondary Prevention
2. Early Diagnosis, Early Intervention and Quality Treatment
3. Living With Major Conditions

Across all 3 of these focus areas there will also be an aim to reduce inequalities in health outcomes, so the community people live in does not make it more likely they will experience ill health.

However, if the Long-Term Conditions Strategy transforms the delivery of care in these areas the impact on secondary and tertiary care will need to be assessed to account for changes to patient flow that will impact on hospital utilisation. As these changes take affect there will also need to a review of resource allocations as demand for healthcare services is shifted into different care settings.

This Strategy will begin with a summary and assessment of the current Long Term Conditions data for STW. It will then go on to describe the key focus areas for transformation and then some of the enablers needed to support the delivery of change.

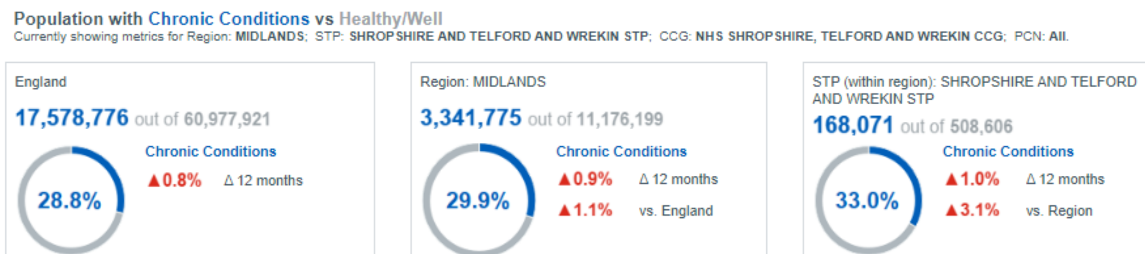
It is anticipated that this document will evolve over time from a means of engaging clinicians in the system in the development of initiatives in the three focus areas into a transformation programme for Long Term Conditions for the next 5 years.

Shropshire Telford and Wrekin Long Term Conditions Overview

Population Overview

The latest NHS England Population and Person Insight data shows that there are c168k people living in Shropshire, Telford, and Wrekin (STP) with a diagnosed long-term condition.

Figure 3. Proportion of Population with a diagnosed LTC compared to regional and national averages



This represents 33% of the population which is significantly higher proportion that the national average of 28.8%. The net annual growth in people diagnosed with a long-term condition is 1% which is again higher that national and regional averages. Figure 4 below show the proportion of patients with a LTC and the net growth in the number of patients with an LTC in the last 12 months.

Figure 4. PCN Overview of LTCs

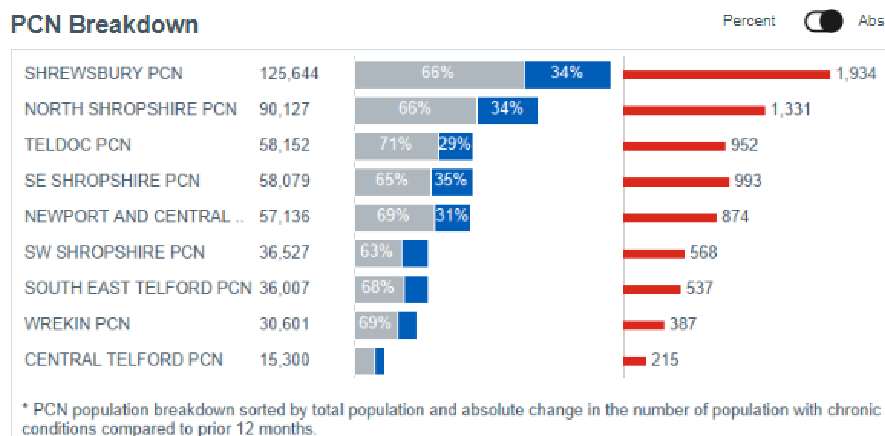


Figure 5 shows the number of diagnosed patients by Long-Term Condition in Shropshire, Telford and Wrekin. It should be noted that these conditions are not mutually exclusive, and a person may have more than one condition simultaneously.

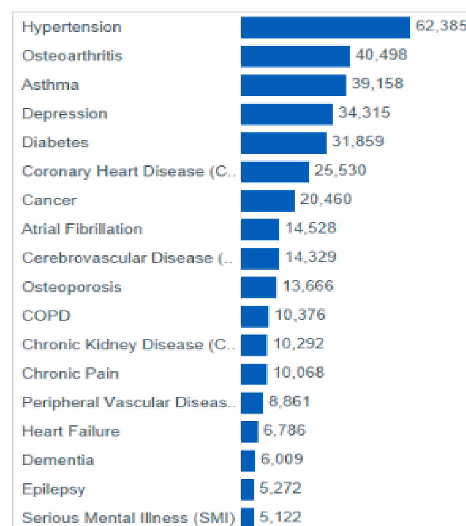
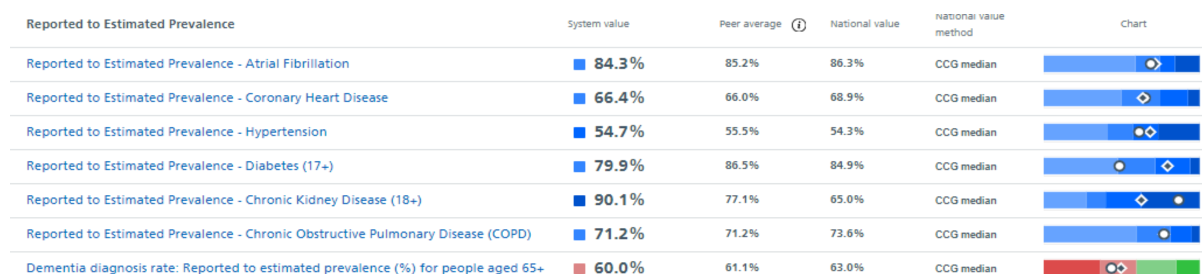


Figure 6 shows the estimated shows the reported prevalence against estimated prevalence for several long-term conditions.

Based on the data summarised in Figure's 5 and 6 it can be estimated that there are potentially the following numbers of undiagnosed patients by condition in STW:

- Hypertension – 51,664
- Diabetes – 8,014
- COPD – 4,201
- Dementia – 4,006

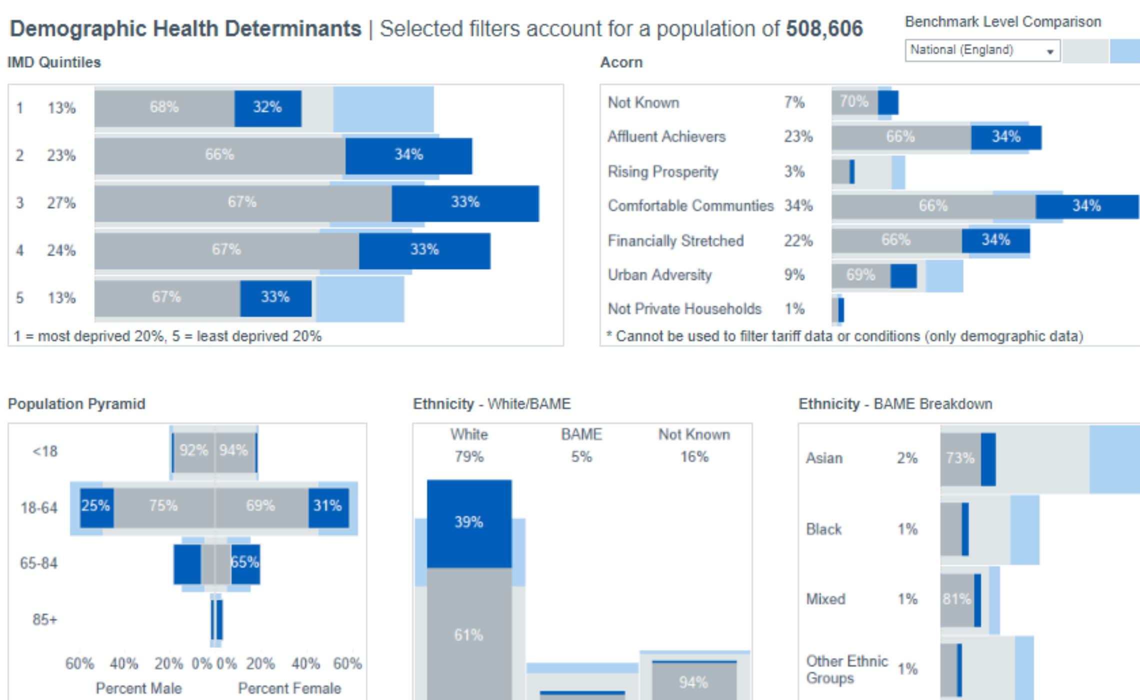
Figure 6 Reported prevalence against estimated by condition.



Reported to Estimated Prevalence	System value	Peer average	National value	National value method	Chart
Reported to Estimated Prevalence - Atrial Fibrillation	84.3%	85.2%	86.3%	CCG median	
Reported to Estimated Prevalence - Coronary Heart Disease	66.4%	66.0%	68.9%	CCG median	
Reported to Estimated Prevalence - Hypertension	54.7%	55.5%	54.3%	CCG median	
Reported to Estimated Prevalence - Diabetes (17+)	79.9%	86.5%	84.9%	CCG median	
Reported to Estimated Prevalence - Chronic Kidney Disease (18+)	90.1%	77.1%	65.0%	CCG median	
Reported to Estimated Prevalence - Chronic Obstructive Pulmonary Disease (COPD)	71.2%	71.2%	73.6%	CCG median	
Dementia diagnosis rate: Reported to estimated prevalence (%) for people aged 65+	60.0%	61.1%	63.0%	CCG median	

Detection rates are generally slightly below the national average for most measured conditions. Chronic Kidney Disease is significantly better than national and regional averages.

Demographic determinants of Long-Term Condition prevalence (NHS digital People and Person Insight October 2023)



Apart of age there is minimal variation in the prevalence of long-term conditions as a result of demographic determinants.

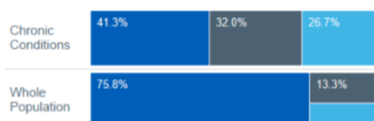
There are lower levels of prevalence in males aged 18-64 but this is likely a result of less health care contacts and less routine screening.

STW has a much lower proportion of people from BAME ethnic background and generally a younger population in these cohorts. This may affect the statistical significance of this data.

Risk Stratification

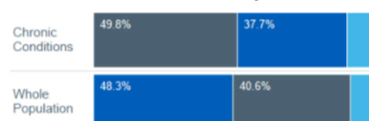
The NHS Person and Population Insight Dashboard shows that people living with a long term condition in STW are a greater risk of utilising Urgent and Emergency Care Pathways within a 12 month period. There are also more likely to have an emergency readmission within 30 days of discharge. Figure 7 shows the stratification of risk of emergency care utilisation within 12 months for three key metrics. The grey shading identifies the proportion of the population cohort at high risk and for each metric it is higher for the patients with chronic (Long Term) conditions

Likelihood of a Type 1 A&E Attendance within 12 months



Likelihood of an Emergency Admission within 12 months

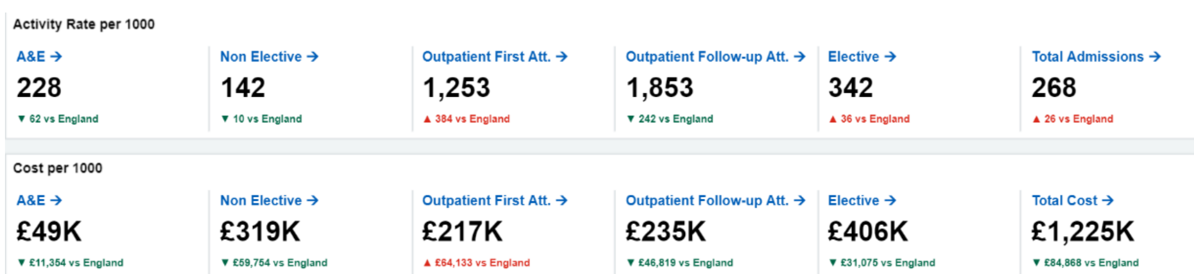
Likelihood of an Emergency Re-Admission within 30 days of discharge



Further analysis is available at the condition level which shows that for patients with diagnosis of COPD or dementia the proportion of the population group at high risk of urgent and emergency care pathway utilisation is in excess of 75%.

Care Utilisation and Cost for People with Long Term conditions

Point of delivery analysis of the utilisation and cost of care for patients with long term conditions living in STW is show in Figure 8 below. This is benchmarked against England averages at a rate per 1000 population



This analysis shows that utilisation and cost of emergency and non-elective pathways for patients with long term conditions is on or around the national average. This is a similar profile for elective admissions. For first outpatients appointments the utilisation and cost of activity for patients with Long Term Conditions is significantly higher for patients in STW with the follow up cost and utilisation being lower. This could indicate that there is an opportunity to transform primary and secondary care elective pathways to improve the effectiveness and efficiency of care for LTC patients. Indicatively a move to the national average cost and utilisation could save the system £3-5m per year depending on the case mix and acuity of patients. It would also potentially be better for patients if they were initially treated in the most appropriate setting as close to home as possible but then followed up more once in a secondary care setting.

Overview of STW Population Health Pathways (NHS Model System October 2023 from June 2023 QOF data)

The NHS Model System reports on a range of primary care clinical metrics related to the management and treatment of long-term conditions. These give an indication of the current opportunities in the system but represent a relatively small subset of all the data available to inform plan. A full set of metrics is included in Appendix 1 but the following sets out the pathways and the key areas for improvement:

1. **Lung health** – Smoking cessation is the key improvement area for the STW system across these pathways. Whilst STW has a lower proportion of smokers than the national average the number of smokers with a recorded offer of support and treatment is lower than the national average. Further to this, patients with any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma or SMI whose notes record smoking status in the preceding 12 months is lower than the national average.
2. **Cancer –** Bowel Screening coverage in Shropshire has been significantly better than Telford & Wrekin and both national and regional averages with the coverage figures being 67.4% in Shropshire and 63.0% in Telford & Wrekin compared with the national

and regional averages of 63.8% and 62.0% respectively. Cervical screening coverage figures is 78.1% in Shropshire and 75.5% in Telford & Wrekin compared with the national and regional averages of 76.1% and 75.6% respectively. Breast screening coverage is good across the system with coverage being 81.1% in Shropshire and 78.3% in Telford & Wrekin compared with the national and regional averages of 74.1% and 73.4% respectively. The number of cancers diagnosed at stage 1 or 2 is 51.4% compared to a national average of 54.9%. The national target is to have 75% of cancers diagnosed as stage 1 or 2

3. **Respiratory –** the proportion asthma patients with a record of spirometry and one other objective test is better than the national average. The number of patients with COPD offered a pulmonary rehab programme is also higher than the national average. Key opportunities for improvement are around the ongoing monitoring of patients especially the recording of exacerbations and an assessment of breathlessness.
4. **Circulation –** There are 15 pathway metrics relating to the circulation pathway and STW is below the national average on 10 of these. Key areas of variation are related to the treatment of patients with ACE, ARB or Beta Blockers. There are 14 primary care prescribing cost metrics and for 13 of these STW is prescribing less than other system. Primary Care prescribing is particularly low for coronary heart disease and Heart Failure. The only area where STW is above the national average is Rosuvastatin Calcium.
On discharge from hospital only 8% of patients access Cardiac rehabilitation and only 17% re discharge on one of the 4 pharmacological pillars in comparison to a national average of 51% and a national target of 60%. Utilisation of telehealth for the ongoing monitoring patients is extremely limited in STW. There may also be opportunities for improvement around the implementation of the stable chest pain pathway.
5. **Diabetes –** For the diabetes care eight care processes 26.% of patients are achieving all 8 which is significantly below the national average of 47.9%. The most checks with the highest variation from national averages are Foot Checks (-25%) Urinary Albumin (-10%) and BMI Checks (-7%). STW is above the national average for cholesterol and creatine checks. 44 of 51 practices in STW are significantly below the national average for the achievement of the 8 care processes. 9 of the 51 practices are significantly below the national average for the 3 treatment targets.
6. **Mental Health and Dementia -** In STW 15,200 people are accessing mental health services of which 4940 are children and young people. It is estimated that there are 3719 patients with dementia in STW, 2227 of which have a diagnosis. This makes the dementia diagnosis rate 59.8% which is lower than the national average of 62.1% and the target of 66.7%. 2140 adults are accessing IAPT services but this number has dropped by 6.6% in the last 12 months. The IAPT recovery rate for the whole population is 53% which is higher than the national average of 50%. However, the recovery rate for the BAME population is 49% which is below the national average and below the system average. 23% of patients are on the IAPT pathway for over 90 days. This is in line with the national average but is still a high proportion of patients. The number of children and young people accessing mental health services has increased 1.9% over the last 12 months to 4940. Admissions, Length of Stay and Number of bed days have all been dropping for this patient cohort and are below national average.
7. **MSK -** In STW the proportion of the population reporting an MSK problem is 20.7% in Shropshire and 19.9% in Telford and Wrekin. Currently this results in referral demand into MSK services of 560 per week which is 70 referrals a week less than the pre-covid average of 630. Despite this reduction in the number of referrals the rate per 10k of population of 11.9 remains significantly higher than the national average of 5.9 referral per 10k of population.

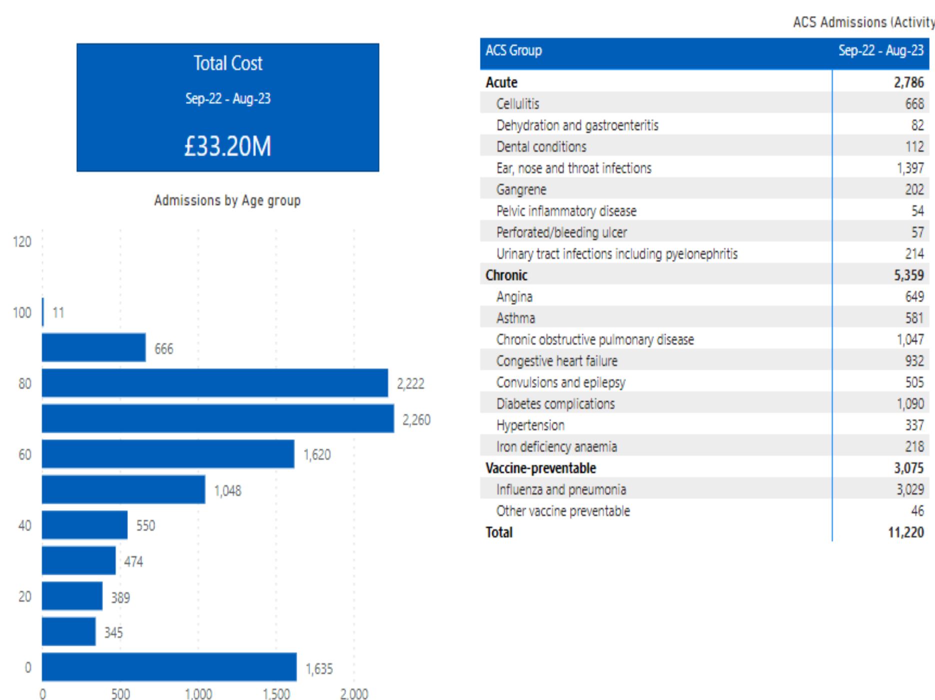
STW Potential opportunities relating to transformation of Long Terms Conditions

The opportunities identified in this section show how efficiency savings could be released from secondary care to support the transformation of pathways to more efficiently support and treat patients with long term conditions. These should be considered an example of some potential opportunities and it is anticipated that as work progresses on the development and implementation of this Strategy more opportunities will be identified.

Due to the nature of the analysis the opportunities should not be totalled as there is likely to be crossover of patients in the different data sets.

Emergency Admissions for Ambulatory Care Sensitive Conditions

STW is currently spending £33.2m in secondary care to treat health conditions for which adequate management, treatment and interventions delivered in a primary or community care setting could potentially prevent hospitalisation or speed up discharge.



ACS Admissions (Activity

ACS Group	Sep-22 - Aug-23
Acute	**2,786**
Cellulitis	668
Dehydration and gastroenteritis	82
Dental conditions	112
Ear, nose and throat infections	1,397
Gangrene	202
Pelvic inflammatory disease	54
Perforated/bleeding ulcer	57
Urinary tract infections including pyelonephritis	214
Chronic	**5,359**
Angina	649
Asthma	581
Chronic obstructive pulmonary disease	1,047
Congestive heart failure	932
Convulsions and epilepsy	505
Diabetes complications	1,090
Hypertension	337
Iron deficiency anaemia	218
Vaccine-preventable	**3,075**
Influenza and pneumonia	3,029
Other vaccine preventable	46
Total	**11,220**

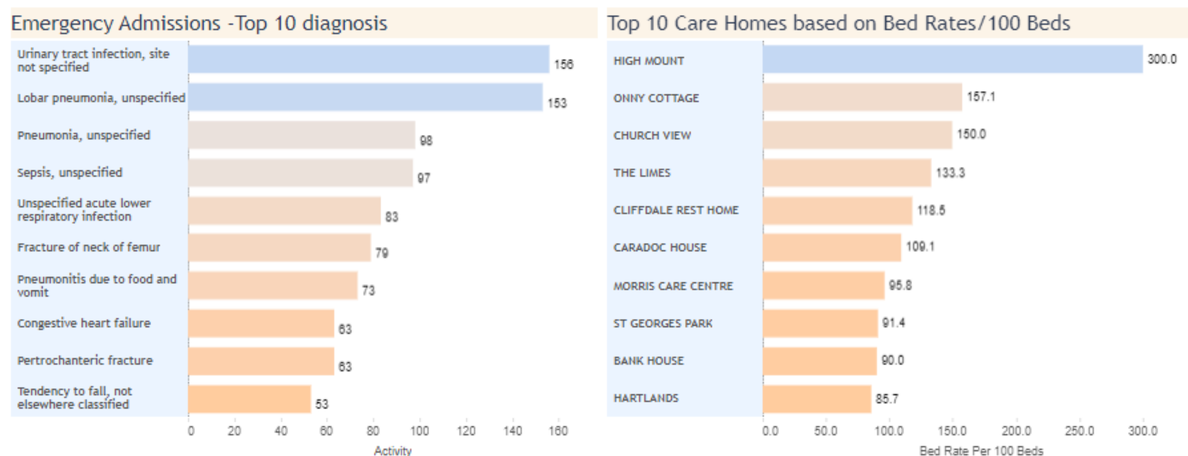
48% of Emergency Admission for Ambulatory Care Sensitive conditions are related to chronic conditions. There are particularly high number of admissions for diabetes complications and COPD.

Whilst the age profile shows that it is generally older people who have emergency admissions for these conditions that is a large number of admissions for young children

Emergency Admissions from Care Homes

Over the last 12 months there have been 2,158 emergency admissions from Care Homes at a cost of £9.5m. This is an average cost of £4,402 per admission as over 81% of these patients have a Length of Stay of more than one day. Figure 8 below shows the top 10 diagnosis for these emergency admissions and which care home they were referred from.

Figure 8 – Analysis of Emergency Admissions from STW Care Homes



Improved management of patients within care homes combined with greater utilisation of new care models such are virtual wards could reduced the level of emergency admissions form this care setting.

Emergency admissions for patients reliant on planned care

In the last 12 months 672 people with two of more long-term conditions have relied on unplanned care and have had 2 or more emergency admissions. Based on an the average costs of an emergency admission of £2500 per day and an average length of stay of 4 days the cost of treating these patients in this care setting is £13.5m.

It is noticeable in the data in figure 9 that there is a proportionally higher rate of patients in the younger cohorts for this population group.

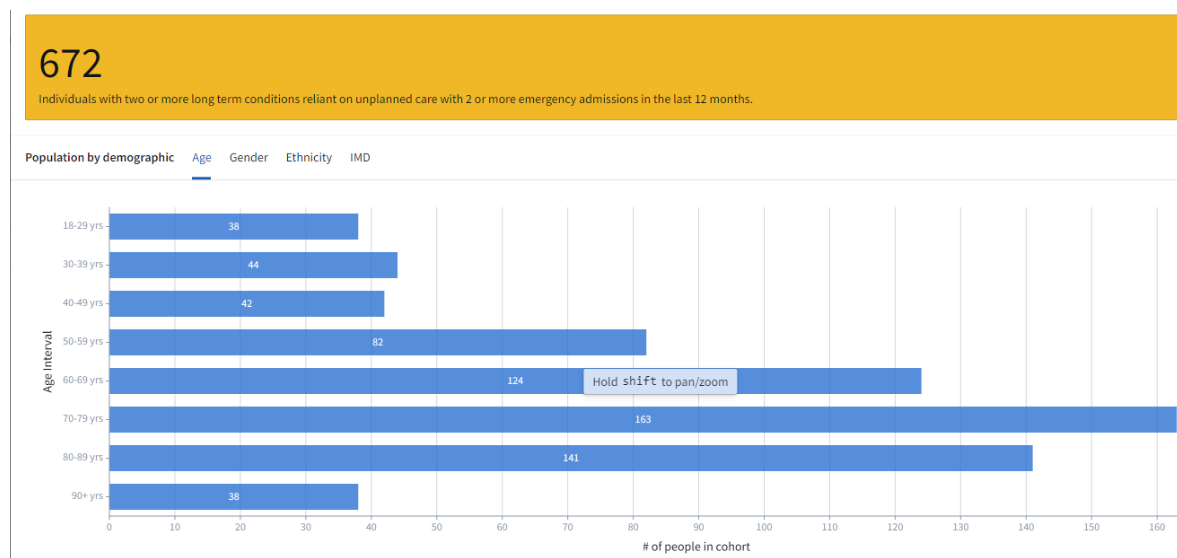
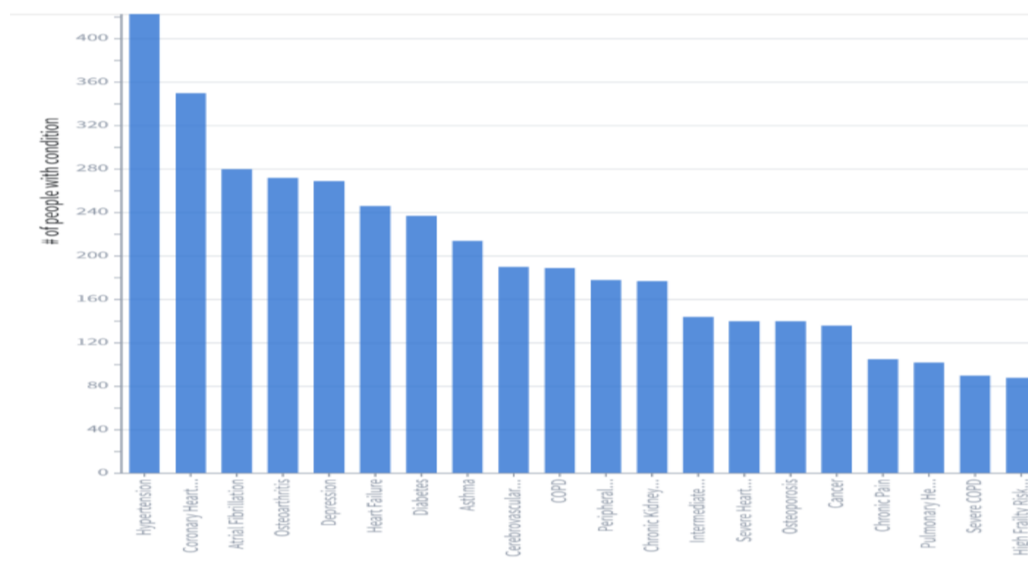


Figure 10 shows the breakdown of conditions for the people with two of more long-term conditions have relied on unplanned care and have had 2 or more emergency admissions. Conditions are not mutually exclusive and people can have more than one condition and more that 2 emergency admissions.

Whilst the breakdown of conditions shows circulatory disease to have the highest rate of admission the level of emergency admissions for depression is noteworthy.

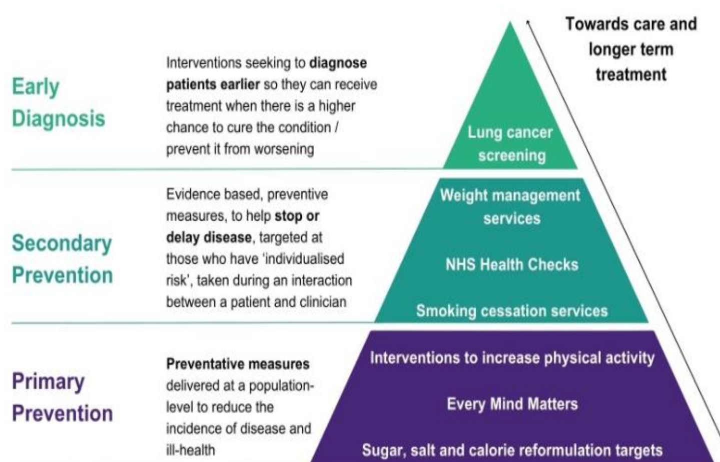
Figure 10 Breakdown by condition of the number of people with two of more long-term conditions who have had 2 or more emergency admissions



Key Focus Areas

There are many different definitions and configurations that can be used to define the categories of prevention and the segments of out of hospital care. It is proposed that to maintain alignment with the most current national health and social care policies STW adopts the definition set out in the Department of Health and Social Care Major Conditions Strategy (Aug 2023).

Figure 11 presents the definitions of preventative measures, from primary prevention, which is delivered at a population level, to secondary prevention which aims to help stop and delay disease for those at higher risk, and finally to diagnosing patients already with diseases earlier.



In addition to these preventative activities there will also be a focus on the ongoing treatment and care of patients who are already living with one of more Long Term Conditions

Based on these definitions the STW Long-Term Conditions Strategy will mirror the three national key focus areas of:

1. Keeping People Healthy Through Primary and Secondary Prevention
2. Early Diagnosis, Early Intervention and Quality Treatment
3. Living With Major Conditions

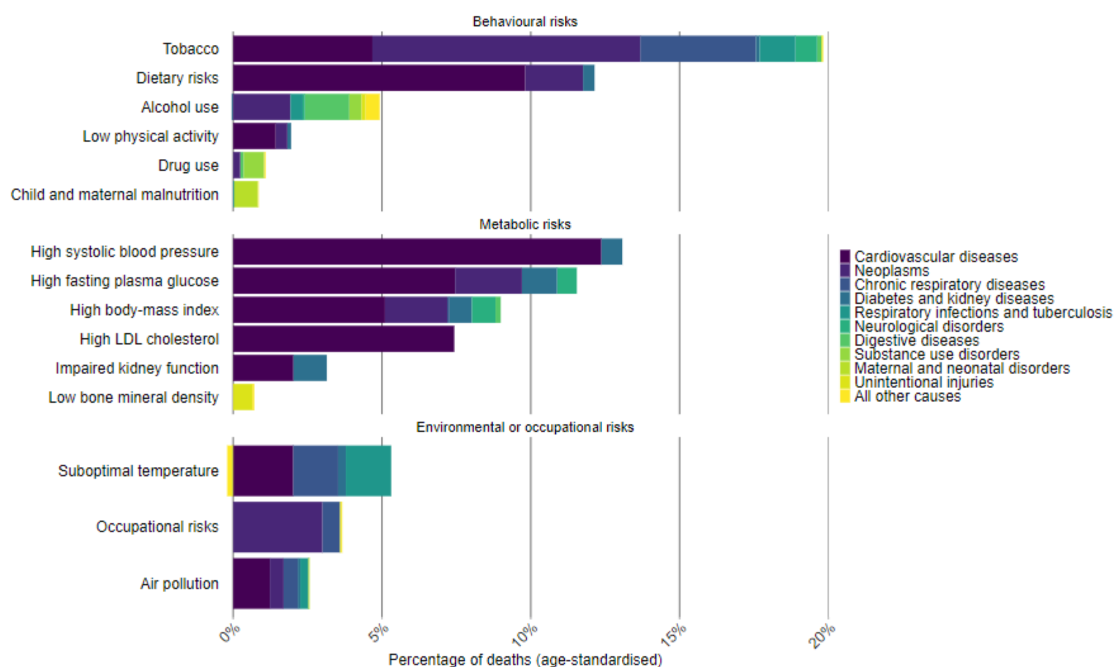
As this document develops it is anticipated that clear programmes of work will be developed for each of the three focus areas. In this draft of the document each focus area will be further defined and opportunities and potential priorities for STW identified.

1. Keeping People Healthy Through Primary and Secondary Prevention

Many behavioural, life course and social risk factors are formed early in people's lives. For example, the majority of smokers start smoking before turning 18, and people who start smoking at a young age lose on average 10 years of life expectancy. Smoking remains the biggest single cause of preventable illness and death, driving health disparities and directly contributing to developing all major groups of conditions - for instance, smokers are 25 times more likely to get lung cancer than non-smokers. Equally, poor diet and physical inactivity, which contribute to overweight and obesity, drive health disparities and a range of major groups of conditions. For instance, a woman living with obesity is more than 3 times more likely to have a heart attack than a woman of healthy weight (DHSC 2023)

We also know that tackling these risks can impact on a wide range of conditions. Forty per cent of dementia cases are potentially preventable or delayable if action is taken against 12 known risk factors across the life course. Approximately 42% of ill health and early death (measured in DALYs) in England is attributable to identified risk factors, many of which are preventable, including 9 out of 10 strokes. These can be physiological factors such as high blood pressure, or behavioural factors such as smoking tobacco. As shown in figure 12, tobacco, obesity and diet-related factors, low physical activity and alcohol and drug use account for most of the burden of ill health and early death that has been attributed to known modifiable risk factors (OHID 2023)

Figure 12: age standardised mortality attributed to risk factors, broken down by cause of mortality, England (OHID 2022)



The STW Health and Wellbeing Strategies and the ICB Interim Integrated Care Plan identify the following prevention priorities:

- **Obesity** - Excess weight is the most significant lifestyle risk factor in the population with the level of adult excess weight in both Telford & Wrekin and Shropshire are significantly higher than the England average. Unhealthy weight in children & young people in Telford & Wrekin is also worse than the national average.
- **Smoking** - Adult smoking rates in routine and manual groups in both Shropshire and Telford & Wrekin are a key driver of inequalities. Smoking in pregnancy is a particular issue for Shropshire and Telford & Wrekin, with levels of maternal smoking at birth significantly worse

than England overall, the highest levels are seen amongst younger mothers and those living in deprived communities.

- **Drugs and Alcohol** - The level of alcohol related-hospital admissions in Telford & Wrekin are also significantly higher than the England average.
- **Mental Health** is a key cause of poor health amongst our communities and levels of poor mental health in children and younger people is increasing. The physical health of adults with Serious Mental Illness is also a cause for concern with both Shropshire and Telford & Wrekin having high rates of excess mortality in this group compared to the national average.

Appendix 3 contains the headline prevention metrics for the system.

2. Early Diagnosis, Early Intervention and Quality Treatment

Identifying major conditions early means outcomes for treatment are far better and the negative impact on people's lives is much reduced. Identifying issues early can have enormous impacts on people's wellbeing - for example, by reducing the impact of a major condition, enabling people with MSK to remain in work (with all the associated mental and physical health benefits of employment), supporting someone through their first incidence of mental ill health or by increasing survival significantly for people with cancer.

In Mental Health Early Intervention in Psychosis (EIP) services for people experiencing a first episode of mental ill health can drastically improve health outcomes and prevent lifelong ill health. Similarly, A formal diagnosis unlocks access to care and support for the person with dementia, as well as their families and unpaid carers and empowers people to manage their condition and plan for the future. The national ambition is for at least two-thirds of people with dementia to have a formal diagnosis, but the pandemic has delayed progress.

Potential Headline Initiatives:

- Cardiac Screening – Arterial Fibrillation, Coronary Heart Disease and Heart Failure
- Diabetes screening
- Improve achievement of diabetic care processes – links to clinical strategy initiative
- Cancer Screening particularly in deprived communities
- Primary Care prescribing - initial focus CHD and Diabetes patients
- Implementation Risk Stratification as STW are one of the only health systems without a operational system in place

3. *Living With Long-Term Conditions*

The effective support and management of Long-Term conditions will increasingly require the management of complexity, and moving away from a single condition approach. For example, the ICS will need to adapt to manage the complexity of multiple conditions with the consequent need to co-ordinate clinical support across primary, community and secondary care - ensuring, for example, different medicines are used in ways that do not lead to adverse outcomes.

Secondly, the ICS will have to grapple with the complexity of integrating treatment, care and support into people's lives over the long term, with the likelihood of different periods of intensive support or treatment followed by periods where less support is needed, as well as moving between health and social care services. The health and care system will also need to a holistic approach to mental and physical health, supporting people to live well, maximising opportunities for recovery and rehabilitation where possible, and supporting people to manage their own health both through prevention and ongoing management Where recovery is not possible - for example, for people living with dementia - the health and care system will still focus on high-quality, integrated and personalised care, including social care.

- Long Term Conditions Anticipatory Care planning particularly in regard to Frailty and Planned Care patients
- Continuing Health Care Pathway review
- Care Home emergency pathway review
- Redesign of care pathways to reduce admission for ambulatory care sensitive conditions
- Discharge and Rehabilitation – Initial focus Cardiac Pathway
- Continue to deliver improvements in End-of-life care.
- Increase utilisation of new models of care such are virtual wards and consider opportunities for transforming existing models such as district nursing.
- Implementation of the diabetes plans developed by the Clinical Advisory Group

Commissioning Framework

It is proposed that to transform care for people with Long-Term Conditions across the three key focus areas the NHS standard commissioning cycle is followed. Currently the STW system is in the strategic planning phase (Purple) and through the development of this Strategy it is anticipated that by March 2024 priorities for 24/25 will be agreed and the system can move into the procuring services phase.

Courtesy of The NHS Information Centre for health and social care. Full diagram available at: www.ic.nhs.uk/commissioning

Within the system is anticipated that clinicians will identify and prioritise pathways for transformation using an evidence-based approach. Once the priorities have been decided it is proposed that for each pathway a service specification is developed to define scope and scale (including resources and workforce) of provision as well as the means of monitoring and assuring the system. This would include agreed metrics for measuring quality and clinical effectiveness. A sample service specification is included in Appendix 2.

To support the design and implementation of new care pathways it is proposed that a collaborative agreement is developed between providers who will be involved in the provision of pathways as defined by the service specifications. The objective of the collaborative agreement is to allow the myriad of providers involved in the delivery of care services for Long-Term Conditions to operate at scale whilst also maintaining their identify and authority as an organisation. This will be an overarching agreement for collaboration that new service specifications can be added to as the at scale Long-Term Conditions morel of care develops within STW. However not all services have to be added into the collaborative to allow it to continue to operate effectively.

Once a set of service specifications have been developed and the model of provision define until the collaborative agreement servicing can be procured and contracted with commissioners. The 23/24 standard contract for options for collaborative (Single or Multiple providers) can be view at this location NHS England » 2023/24 NHS Standard Contract. Implementation of these contracts may require formal procurement or variation to the current contracts in the system.

Programme Governance

It is proposed that this strategy is approved through the following governance route:

Once the Strategy has been approved it is proposed that whilst the provider collaborative is being developed the Population Management Group has oversight of the programme and is accountable to the ICB Board for progress through the ICB Strategy committee. Once formal collaborative arrangements are in place it is anticipated that this organisation can take responsibility for the delivery of the STW Long Term Conditions Strategy and be accountable directly to the Strategy Committee or another suitable sub group of the ICB Board.

It is proposed that for the development of the strategy four workstreams are established under the population health management group, each one led by a primary care clinician. These workstreams would include one for each of the key focus areas and one to provide commissioning support including the development of the collaborative agreement. A relationship matrix will also be developed to show how these groups interface and relate to other programmes of work across the STW system and the responsibilities that the LTC strategy working groups have to these other areas of work.

Next Steps

This document is the first draft of the Long-Terms Condition Strategy for Shropshire, Telford and Wrekin ICB. It sets out the national context under which it is being developed within and provides a population health overview of Long-Term Conditions within the STW system. The document then goes on to propose a structure for the strategy and some key focus area. To finalise this document it is suggested that the following actions are taken:

- The four workstreams proposed to be established under the PHM Board until the provider collaborative is operational.
- Each focus area is provided a data pack outlining the challenges and opportunities that that group needs to consider.
- Each of the key focus areas to prioritise a series of pathways for review and transformation. These are then included in this document as the priority initiatives for the next 2-3 years.
- Once the priority pathway for each group are agreed work will begin on the development of service specification that will allow the transaction of the new care model.
- The fourth workstream develops potential models of collaboration to support the delivery of the new service specification and arrangements for the transition of activity and finances into the new care model.