Trust Board in Common

BOARD
INTELLIGENCE

Agenda

Location
SECC, Royal Shrewsbury Hospital, Shrewsbury

Date
23 Sep 2025

Time
10:15 BST

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1	Welcome	Chair in Common	-
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Group Model – Case for Change

0. Reference Information

Author:	Nigel Lee	Paper date:	23 September 2025
Executive Sponsor:	Sarah Lloyd, Deputy Chief Executive & Director of Finance	**Paper written on:**	15 September 2025
Paper Reviewed by:	Joint Trust Boards – 5 Mar 25, 17 July 25. Joint Senior Leadership team – 4 July 25. Extensive staff and external stakeholder engagement (noted in papers) Shropcom Board – 4 Sep 25; SATH Board 11 Sep 25.	**Paper Category:**	Strategic
Forum submitted to:	Trust Boards in Common	**Paper FOIA Status:**	Full

1. Purpose of Paper

1.1. Why is this paper going to the Trust Boards in Common and what input is required?

This paper presents the case for change.

2. Executive Summary

2.1 Context

The Case for Change describes the ambitions of Shropshire Community Health NHS Trust and The Shrewsbury and Telford Hospital NHS Trust to form a shared leadership Group model. The Case aligns to the latest NHS England risk-based framework and national policy for shared leadership arrangements of NHS providers.

Following consideration by both Trusts Boards and further developed by extensive staff and stakeholder engagement, the Case for Change outlines key challenges faced, options for the model, benefits expected alongside expected areas of risk. It is recognised that the document presents an important but also early step in the process, and much work will be required to develop transition and implementation plans, as well as realise the breadth of benefits that can be achieved by working together as 2 Trust teams.

Group Model – Case for Change

2.2 Summary

- ▪ The Board is asked to review the Case for Change.

2.3. Conclusion

The Trusts Boards are asked to:

- • Review the Case for Change document and propose and further amendments.
- • Subject to any final updates, to approve the Case for Change on behalf of the Trusts.

3. Main Report

3.1 Introduction

3.1.1   During 2025, the 2 NHS Trusts (Shropshire Community Health NHS Trust and The Shrewsbury and Telford Hospital NHS Trust) have commenced discussions on forming a Group model, based on a shared leadership approach, and retaining 2 independent Trust organisations.   Early engagement with staff, through face to face sessions as well as surveys, has been important to inform plans and understand opportunities and risk. A range of additional engagement activities have also taken place with key stakeholders, including Health Overview and Scrutiny Committee, GP Board and patient representatives, and their feedback has also been taken into account.

3.1.2   The Case for Change document has been developed with continued advice and support from NHS England regional colleagues, and drafted in line with the recent national guidance on 'Assuring and Supporting Complex Change – Shared Leadership and/or Governance Arrangements of NHS Providers'. This has provided a framework for the case, and the sections in the document reflect this framework.

4.0 Next Steps

4.1   The production of the Case for Change is an important step. However, it is recognised that the document presents an early stage in the process, and much work will be required to develop transition and implementation plans, as well as realise the breadth of benefits that can be achieved by working together as 2 Trust teams. The next steps are outlined in the document and timetable, but include:

- Public joint Board session to review and approve the case (Sep 25).
- Submission of the case to NHS England for an assessment process (Oct/Nov 25). This will involve reviews with Trust directors.
- Development of the transition plan.

Group Model – Case for Change

- Continued communication and engagement, especially with staff from both Trusts.

The next phase will be overseen by the Group Transition Committee.

4.2   It is also timely to consider the joint work of the Trusts and the opportunities identified in the context of the recently published NHS 10 year plan and the imminent integrated, multi-year planning process.

5.1 Conclusion

The Trust Boards of Directors are asked to:

- Review the Case for Change document, and propose any further amendments
- Subject to any final updates, to Approve the Case for Change on behalf of the Trusts

Our case for
Establishing a Group Model

Table of contents

Developed using NHS England draft guidance - Assuring and Supporting Complex Change - Shared Leadership and/or Governance Arrangements of NHS providers.

Purpose of the document

This document outlines the case for establishing a Group model between The Shrewsbury and Telford Hospital NHS Trust (SaTH) and Shropshire Community Health NHS Trust (ShropCom). By forming a Group model, both trusts believe they can deliver better care for patients and a better experience for staff through joint working. A Group model will build on the strong foundations that already exist to continue to strengthen local services, improve resilience and performance and deliver value for taxpayers.

The aims of the Group model are to provide a united and stronger provider voice, that works together with partners, to respond to the collective challenges faced across Shropshire, Telford & Wrekin (STW) Integrated Care System (ICS), and neighbouring areas. Acting as one NHS and working at scale, the trusts believe shared leadership will address the clinical, performance and financial pressures and enable the shift towards a preventative and neighbourhood service to meet the needs of an ageing and growing population.

During Quarter four 2024/25, the ShropCom and SaTH Boards confirmed their commitment to explore the development of a Group model. During Summer 2025 the trusts have listened to staff, patient representatives and partners to inform this Case for Change document. The Trusts have worked closely with NHS England at every step of the journey and the outputs of the work are summarised and outlined in this document; this covers the case for establishing a Group model, opportunities for greater collaboration and the next steps required.

Executive summary

The Shrewsbury and Telford Hospital NHS Trust (SaTH) and Shropshire Community Health NHS Trust (ShropCom) already work together in partnership and have successfully delivered new and integrated ways of working. Most recently, this has been demonstrated through the development of the Virtual Ward, Outpatient Parenteral Antimicrobial Therapy (OPAT) and shared corporate services including Payroll and Finance. A Group model will further their ambition to deliver integrated services to benefit patients and colleagues.

Both trusts currently face different but important and interdependent challenges which, without action to address them, will worsen over time. These challenges include the need to sustain improvements in quality and patient experience, to develop new clinical models of care, ensure strong clinical leadership across whole patient pathways, and to continue to reform the workforce to deliver a more modern NHS that meets local needs. To deliver the aspirations of the national 10 Year Plan, and local transformation priorities, both trusts agree that accelerating their partnership will deliver better care for the communities we serve.

The trusts cover a large geography providing a range of services in Powys, Shropshire, Telford and Wrekin through to the Dudley area, covering a combined population of >600,000. The trusts have a unique opportunity to share learning and best practice across their geographies, working with multiple local authorities and integrated care systems. Their largest population is the Shropshire, Telford and Wrekin (STW) Integrated Care System (ICS), with a population of around 500,000 people, with a significant proportion being elderly and living in rural areas. The STW Integrated Care Board (ICB) commissions services from a number of NHS providers and GP practices, and there is close working with Shropshire and Telford & Wrekin councils. The system faces similar pressures as other rural counties, with prevalence of long-term conditions and health inequalities, which are further complicated by social determinants of health, rurality, and deprivation. A number of communities are dispersed with limited transport links and digital exclusion.

Whilst partnership working across the system is developing, it is also recognised that tackling strategic challenges, most recently set out in the NHS 10 Year Plan, requires a multi-agency approach. The two trusts have come together to determine how they can best address their shared and pressing challenges by working together and provide optimum benefit to the communities they serve.

The Case for Change sets out the significant benefits and outcomes, which have not only been developed by liaising with other trusts that have developed successful

groups, but also by engaging with our staff and local stakeholders. Delivering high quality, patient centred care, and an improved patient experience is the overarching priority. This can be achieved through:

- Better use of the trusts' collective assets to support the shift from hospital to community care
- Releasing capacity and resources to design new models of elective and urgent and emergency (UEC) care to improve discharges and flow
- Reducing duplication and inefficiency, through common policies and procedures where appropriate
- Investing in new and shared digital technologies and attracting new opportunities for research

Benefits will also be realised for our staff, such as sharing education opportunities, increasing resilience by closer joint working, and improving the overall offer for staff. A joint approach to using our collective resources, including investments, services and transformation will allow focused prioritisation decisions and improvements in efficiency. The alignment of strategic plans and objectives, through shared leadership will underpin the approach.

Working with our system partners, consideration has been given to the optimum collaboration model. It is recognised that ShropCom and SaTH have a long history of collaboration and, whilst acknowledging that other collaborative arrangements exist (with trusts in STW and more broadly), the two Boards agreed that the model most able to address the challenges and deliver the benefits would be a vertical integration between ShropCom and SaTH. The Boards also reviewed the optimum collaboration model against the recognised spectrum of the collaboration framework, agreeing the benefits should outweigh any disruption or cost. To harness the value in improved and aligned decision making, greater integration of care pathways and setting the conditions for both trusts to be able to contribute effectively to the priorities and opportunities in the NHS 10-year plan, a shared leadership model was recommended.

The trusts have been major contributors to the operational planning in 2025/26 as well as to the system Joint Forward Plan (JFP). Major building works are underway at SaTH and the Hospitals Transformation Programme provides a crucial opportunity to not only create a configuration for sustainable acute services but also acts as a catalyst for wider system pathway transformation. Transformation of pathways, both in the acute and community environments, are core components of the JFP, underpinned by a population health management approach and integrated neighbourhood working. Both boards recognise they cannot deliver this transformation in isolation and a shared leadership is critical to delivering the ambitious plans and realising the step-change in care for patients across the life course. The transformation programmes planned are fully aligned to national objectives.
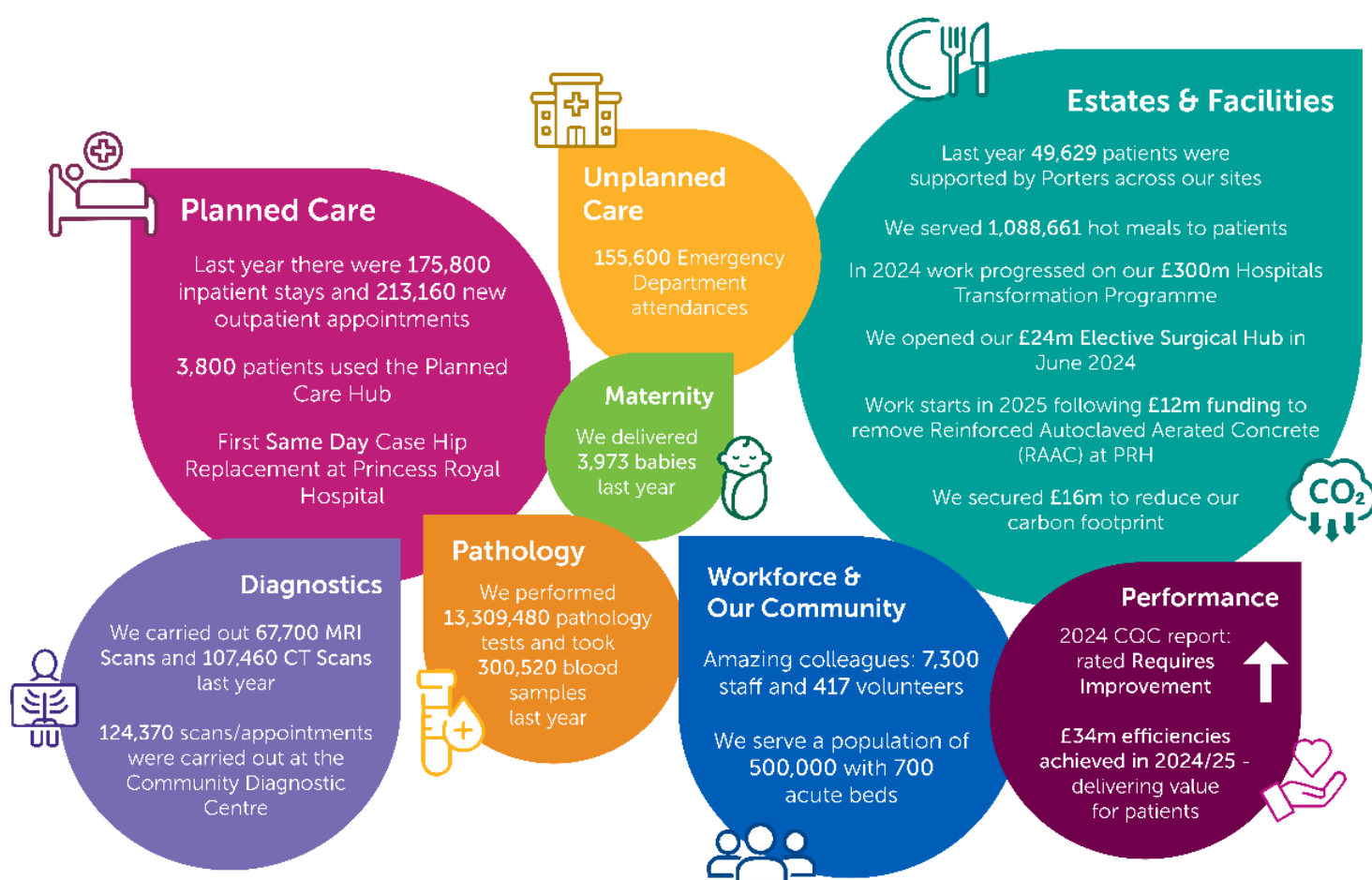
Listening events with staff and stakeholders, have been held during May-August 2025, and the feedback has informed the development of this Case for Change. It is recognised that transitioning to a Group model requires a careful and detailed plan, and a Transition Committee has been established to ensure a seamless transition and ongoing engagement. Both Boards recognise that there will be risks in this process, such as ensuring that there is sufficient leadership capacity and capability to manage the change and deliver the operational plan. In addition, bringing together two organisations with different cultures and identities will require careful support, whilst recognising the need to build joint governance arrangements, develop an operating model and set the strategic direction that staff from both trusts identify with. Continued engagement with teams and stakeholders will remain a cornerstone of the next phase of work and beyond.

The Group model alone is not a panacea for improving performance. However, it allows the trusts to use scale as a platform and an enabler for driving improvements in clinical, operational and financial performance. Both Boards are committed to driving quality improvement, developing more seamless patient pathways for residents of all ages, growing and supporting the workforce and redesigning models of care to deliver a more modern NHS. The Group model can both enable these efforts and amplify their benefit for all the communities we serve.

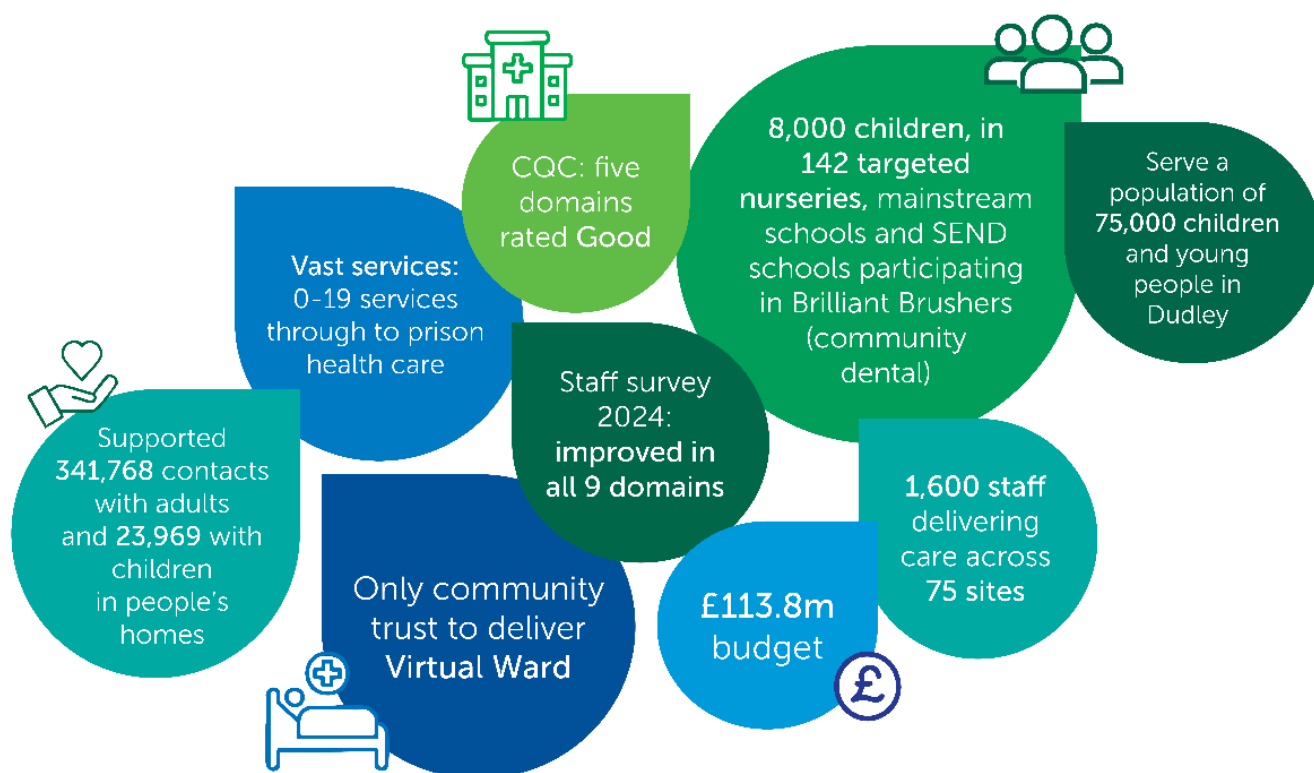# Section one: Problem identification and improvement opportunities

About the trusts

SaTH

Planned Care

Last year there were 175,800 inpatient stays and 213,160 new outpatient appointments

3,800 patients used the Planned Care Hub

First **Same Day** Case Hip Replacement at Princess Royal Hospital

Unplanned Care

155,600 Emergency Department attendances

Maternity

We delivered 3,973 babies last year

Estates & Facilities

Last year **49,629** patients were supported by Porters across our sites

We served **1,088,661** hot meals to patients

In 2024 work progressed on our **£300m** Hospitals Transformation Programme

We opened our **£24m** Elective Surgical Hub in June 2024

Work starts in 2025 following **£12m funding** to remove Reinforced Autoclaved Aerated Concrete (RAAC) at PRH

We secured **£16m** to reduce our carbon footprint

Diagnostics

We carried out **67,700** MRI Scans and **107,460** CT Scans last year

124,370 scans/appointments were carried out at the Community Diagnostic Centre

Pathology

We performed **13,309,480** pathology tests and took **300,520** blood samples last year

Workforce & Our Community

Amazing colleagues: **7,300** staff and **417** volunteers

We serve a population of **500,000** with **700** acute beds

Performance

2024 CQC report: rated **Requires Improvement**

£34m efficiencies achieved in 2024/25 - delivering value for patients

Data for 2024 calendar year unless otherwise stated

ShropCom

CQC: five domains rated **Good**

Vast services: 0-19 services through to prison health care

8,000 children, in 142 targeted **nurseries**, mainstream schools and SEND schools participating in Brilliant Brushers (community dental)

Serve a population of 75,000 children and young people in Dudley

Supported 341,768 contacts with adults and 23,969 with children in people's homes

Staff survey 2024: improved in all 9 domains

1,600 staff delivering care across 75 sites

Only community trust to deliver Virtual Ward

£113.8m budget

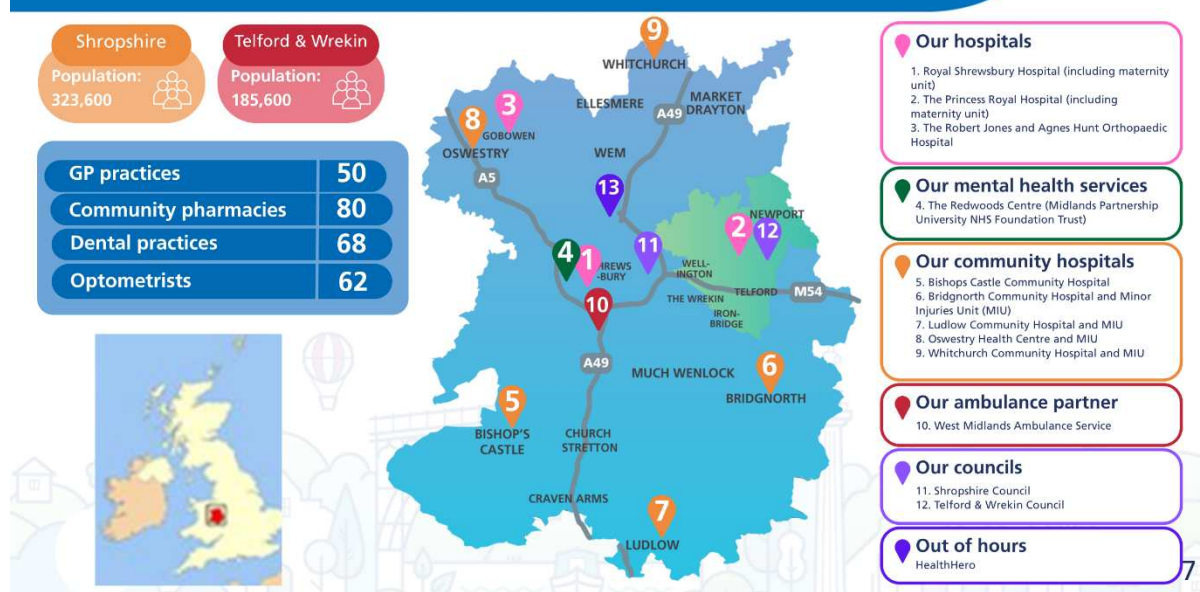*Data for 2024 calendar year unless otherwise stated*

Population

The Shropshire, Telford and Wrekin Integrated Care System (ICS) covers a large geographical area dominated by rurality with pockets of affluence and deprivation. There are two local authorities in the system, and two Place Partnership Boards. Both Places show an increasing ageing population and higher than national and West Midlands average. The number of people over the age of 65 now accounts for 25.3% of the total population in Shropshire. Telford and Wrekin saw one of the largest increases in population aged 65 plus in England between the 2011 and 2021 Census, with an increase of 35.7% (England 20.1%) – the highest increase of all West Midlands upper tier local authorities and the second highest of all 151 upper tier authorities in England. 27% of Telford's residents live in the most deprived 20% wards nationally, and one fifth of children live in poverty.

Shropshire Telford & Wrekin

Our local health and care landscape

Shropshire, Telford & Wrekin	
Population	c 500,000
Providers	The Shrewsbury and Telford Hospital NHS Trust (SaTH), Shropshire Community Health NHS Trust (ShropCom), Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust (RJAH), Midlands Partnership University NHS Foundation Trust (MPFT), West Midlands Ambulance Service Trust (WMAS)
GP Practices and PCNs	51 practices, 9 Primary Care Networks (PCNs)
Local authorities footprint	Shropshire Council, Telford and Wrekin Council
Allocation	£1.2bn
Underlying deficit	£115m as at year end 24/25 (reduced from £129.5m in 23/24)

The ICS is served by a small number of trusts, most of whom provide care mainly in STW. SATH is the largest Trust, providing care for STW plus a population of circa 40,000 in North Powys. ShropCom primarily focuses on community-based care for STW plus a population of 75,000 children and young people and their families in Dudley along with smaller services in Stoke and Staffordshire. RJAH is a specialist Orthopaedic Trust and provides secondary and tertiary services for STW, North and Mid Wales plus some regional and national services. MPFT spans both STW and Staffordshire & Stoke-on-Trent, whilst WMAS covers the West Midlands region.

Further description about the population covered by the Trusts is provided in supporting information.

Challenges

There are many things that the trusts do well, with fantastic staff working across many teams delivering great care for the communities we serve. Listening to our patients, staff and partners we recognise that some pathways and activities are not as efficient or effective as they could be both for patients and for staff. There are opportunities to redesign the way we work, to increase resilience in our services, reduce duplication or inefficiency and improve performance. Both trusts have ambitious plans to transform care and deliver a better experience for patients in the next three years. Many services are rated as Good, but both trusts share a commitment to becoming Outstanding.

Whilst recognising that local pressures in STW are generally reflective of the national picture, the shared problems that the trusts face, include:

- **Quality and patient experience.** The system, and especially SaTH, has been at the centre of some historic quality challenges (Care Quality Commission ratings, National Independent Review of Maternity Services). Since the COVID-19 pandemic, a range of sustained improvements have been delivered, such as an improved CQC rating for SaTH, Maternity, Children and Young People and End of Life services rated as Good, and a much improved financial performance at Trust and system level. ShropCom received a Good rating from CQC in 2019. All leaders, however, recognise that there is more to do and forming a Group would further strengthen opportunities for shared learning and to redesign the way care is delivered to provide the right care, in the right place, at the right time, with the right workforce.
- **Clinical models and leadership.** The system has a need to improve urgent and emergency care (UEC) and elective flow. Listening to feedback from patients and staff significant opportunities exist to improve discharge pathways, communication and the experience for both patients and staff when accessing services in both trusts. In several areas, staff work together across boundaries in spite of the organisational boundaries, not because of the framework and structures. Furthermore, a joint approach is vital to neighbourhood health service developments. Clinical leadership of the Group, and of both trusts, remains a core principle.
- **Integration.** Many services are based on traditional models of care and there is a need to better integrate services across all parts of the system, taking best practice from other parts of the UK and internationally. Relationships with GPs/PCNs are relatively under-developed, and there are opportunities for more joined-up clinical leadership between the Group and General Practice. Following the publication of the NHS 10 Year Plan (Fit for the Future: 10 Year Health Plan for England), NHS providers need to position themselves to deliver the Government's policy for the NHS based on the 'three shifts', especially focused on neighbourhood health, and new models of care will be

required. This is important in STW given the large geography and ageing population.

- **Regulatory.** The combination of performance, finance and quality factors has meant that the ICB and SaTH have significant ongoing regulatory scrutiny under the National Oversight Framework (now the NHS Performance Assessment Framework). Whilst recognising that a great deal of work has been done and improvements seen in the past 18 months (and STW ICB is expected to step out of the intensive support segment shortly), SaTH remains in segment five of the new framework. ShropCom is in Level two. The challenges faced are system challenges, and no partner can expect to improve in isolation. Working together as strong system partners and in the Group will be important to maintain the momentum of improvement, including steadily improving on the national assessment scale.

- **Workforce.** Both trusts have shared and long-standing workforce challenges (with a historic reliance on temporary staffing and Bank, exacerbated by staffing services in rural locations). Listening to feedback from staff, the workforce is facing significant pressures which can impact on morale, wellbeing and retention. In recent years both trusts have seen improvements in the People Promises through the annual Staff Survey, though there is more work to do in both organisations to build a culture where everyone feels they belong and has a voice. In 2024 the Chief People Officer for SaTH took on a joint role across both trusts and already both are benefitting from increased resilience within OD services and a shared approach to building a future, sustainable workforce. Benefits highlighted by staff through the engagement, include opportunities to further develop integrated teams, hybrid roles, increased resilience and sharing information, shared Bank and rotational opportunities. There will also be many opportunities as part of the neighbourhood health developments, for staff from both trusts. Recognising this is a time of uncertainty for staff in the NHS, a shared leadership team will also need to focus on ensuring the support, training and development is in place to enable this change towards becoming a more modern NHS.

- **Performance**. Although steady improvements are being made, performance in UEC and elective/Cancer care is comparatively poor. Whilst significant improvements in reducing lengthy waiting times for elective care have been made, the challenges remain significant, especially with the expected growth in patients >65. Within UEC, some patients are still unnecessarily referred to Emergency Departments (EDs), wait too long in EDs or have a longer length of stay in acute wards than could be achieved if alternative pathways and capacity were in place for patients. Listening to staff in the community, they also face demand with increasing numbers of patients with complex needs being admitted into community hospitals and services. Opportunities exist to redesign this model of care to help patients be seen in the right place, by the right workforce, at the right time.

- **Financial.** Trusts and system leaders recognise that our long-standing financial deficits are relatively high when compared to the national system allocation model, with challenged underlying positions. Although significant improvements have been realised, transformation is needed across the system to tackle the underlying issues of providing escalation care, high reliance on Bank and Agency costs and a historic lack of digital investment. There is a need to improve productivity, value for money, and reduce overhead costs whilst optimising opportunities for shared services. Whilst the Hospitals Transformation Programme will play a part in reducing some duplication of services, and indeed act as a catalyst for change to models of care across acute and community sectors, the challenges persist. Moreover, as set out in the NHS 10 Year Plan, greater investment (and a shift in resources) is required in primary and community services.

- **Partnerships**. Despite the system's small size, the number of providers, strategies and plans is high, and commissioning and partnering with trusts is more complex. Having fewer, but better aligned strategies and plans, through a shared leadership team, will make it easier and simpler to deliver the trusts plans and collaborate with other partners. Working more closely with local people and communities to gain their insights and views will also be a priority.

- **Strategic.** All organisations in STW are striving to make improvements in all the areas listed, but we recognise that nationally, regionally and locally, it is increasingly challenging to tackle the issues individually, and indeed many areas require multi-agency approaches. The recent annual British Social Attitudes survey report highlights the growing public dissatisfaction with the NHS and both trusts have a role in rebuilding confidence in the NHS, through transforming care. Both trusts recognise that the NHS 10 Year Plan offers both pressure and opportunity; enhanced transparency will bring continued scrutiny, but the shift to community-based care, digital integration, and innovation offer real prospects for continuing to rebuild trust, improving performance, improving patient care and experience and enhancing staff engagement and empowerment. Moreover, the national plans for allowing high-performing trusts more autonomy and different contractual models provide an exciting opportunity, and one that is more likely to be realised by working together.

Section two: Expected benefits and outcomes of collaboration

Any changes across ShropCom and SaTH, in terms of integrated leadership and different ways of working, need to result in things being better, not just different. The overall aim is to provide high quality, integrated, seamless care delivered through a supported, engaged and skilled workforce. Both trusts are committed to becoming a great place to receive care and a great place to work. Listening to patients, staff and partners there are significant opportunities to strengthen collaboration, transform clinical care and deliver consistent access to high quality services through sharing and adopting best practice. The trusts are seeking to leverage the benefits of scale in delivering sustainable services, creating a compelling offer for staff and delivering a step-change in productivity and performance. Across England, those Groups that are seen to be thriving are showing benefits in several areas, including:
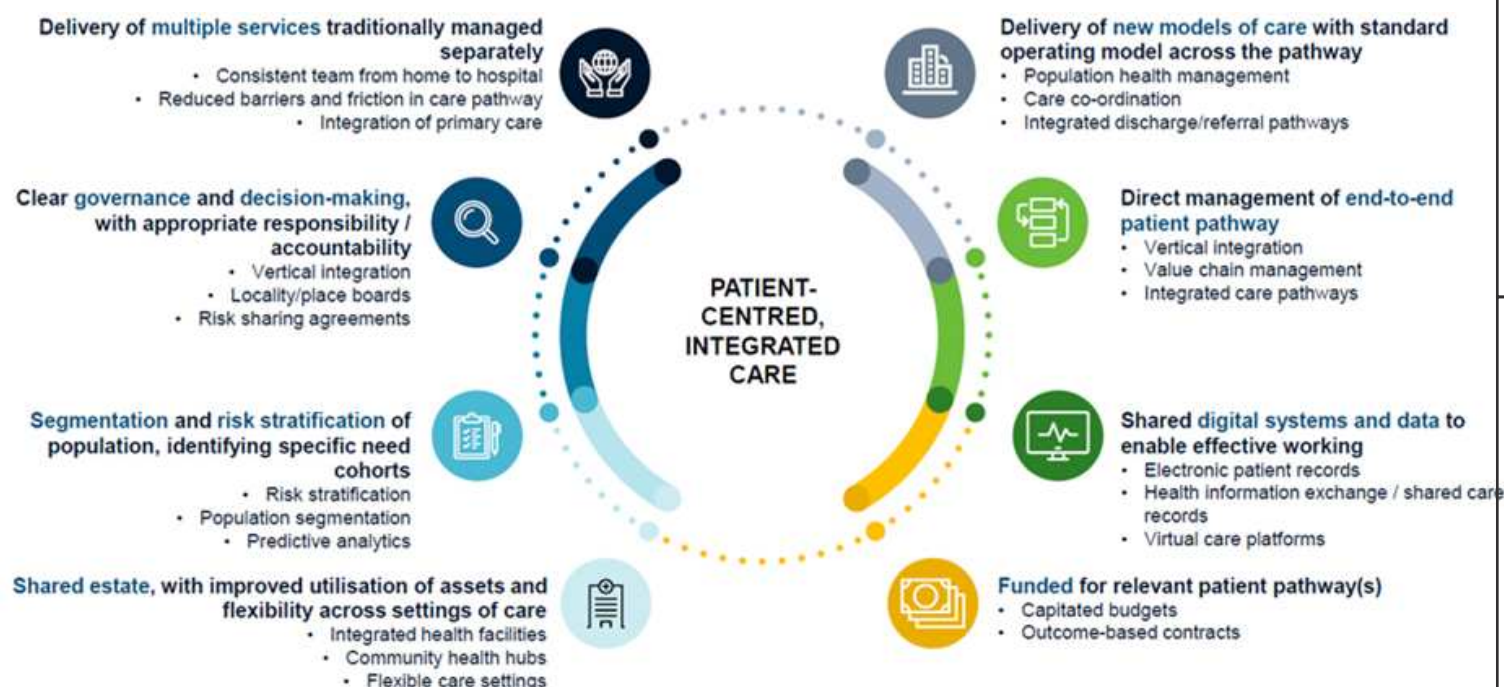
- More aligned clinical strategies
- Joined up clinical leadership
- Shared learning
- Joint prioritisation of investments in critical infrastructure
- Clearer routes towards clinical and financial sustainability
- Staff development and increased career opportunities
- Simplified governance and accountability arrangements.

Nationally, it is recognised that integrated models (especially through vertical integration) have the potential to improve care for patients and deliver the strategic goals of the NHS, to:

- Meet the healthcare needs of the population, including improved coordination and a focus on preventative care leading to reduced health inequalities and improved health outcomes, for adults as well as children and young people.
- Deliver the strategic shift from hospital to community (e.g., hospital at home, virtual care)
- Remove organisational barriers to flow (for example, admission avoidance, supported discharge), leading to improved UEC and elective performance with the potential to reduce patient harm and deconditioning
- Deploy staff and resources across settings of care to meet patient needs more efficiently and effectively and reduce duplication, leading to improved productivity and increased career and development opportunities
- Effectively manage risk and deliver value for money across patient pathways

- Be the best place to work with a consistent and improved staff experience.

The overall objective is to deliver patient-centred, integrated care, in the right place for the patient, at the right time, provided by the right people. Both Boards are committed to furthering a patient-centred approach to service delivery and care, as part of the move towards greater integration. Building on national learning, a range of intended outcomes are identified in the diagram below.

Delivery of multiple services traditionally managed separately
- Consistent team from home to hospital
- Reduced barriers and friction in care pathway
- Integration of primary care

Delivery of new models of care with standard operating model across the pathway
- Population health management
- Care co-ordination
- Integrated discharge/referral pathways

Clear governance and decision-making, with appropriate responsibility / accountability
- Vertical integration
- Locality/place boards
- Risk sharing agreements

Direct management of end-to-end patient pathway
- Vertical integration
- Value chain management
- Integrated care pathways

PATIENT-CENTRED, INTEGRATED CARE

Segmentation and risk stratification of population, identifying specific need cohorts
- Risk stratification
- Population segmentation
- Predictive analytics

Shared digital systems and data to enable effective working
- Electronic patient records
- Health information exchange / shared care records
- Virtual care platforms

Shared estate, with improved utilisation of assets and flexibility across settings of care
- Integrated health facilities
- Community health hubs
- Flexible care settings

Funded for relevant patient pathway(s)
- Capitated budgets
- Outcome-based contracts

These opportunities will be built into the Group Transition Plan (section 5), noting that work in some areas is already in progress between the trusts or at a system level. The Boards have identified important opportunities that are relevant to ShropCom and SaTH.

- Operating as a Group is critical to maximising the opportunities of working at scale. It binds trusts together and creates the framework that supports a single strategic vision and set of aligned priorities. This then translates into a shared commitment delivered by a unified leadership which can support rapid decision making when required.
- A Group model creates the conditions to establish a common set of standards built on existing best practice and drawing on experience from elsewhere. We have liaised with other Groups such as Lincolnshire and Black Country, with advice from NHS England, to learn from their work. These standards are then owned by all and form the basis of a shared commitment to the population.
- A Group model supports the development and deployment of a consistent delivery approach focussed on improving care quality and outcomes. This

consistency can then support the warranted variations in care that are needed to ensure it reflects population need at a local level.

- The governance structure adopted by a Group is a critical enabler of service transformation across whole pathways, to ensure sustainability of service delivery and the optimal use of resources. It supports the seamless delivery of patient care across providers, and the alignment of service provision to provide a consistent and cohesive offer to patients. This could be achieved through the development of an integrated care model for the Group, and coordinated planning of activity across multiple sites, addressing both local and system-wide needs.

- The Group model supports the development of a single strategic plan across multiple sites, addressing both local and system-wide needs and the development of a single set of investment decisions to support the delivery of service transformation at scale. Shared vision and values are critical to the delivery of truly integrated care models and continuity of care, but also to present a more coordinated approach to meeting the strategic objectives of the ICS, in accordance with the NHS 10 Year Plan.

- A unified Group helps to foster a cohesive culture by defining and emphasising shared values, promoting a collective identity to boost staff morale and building shared understanding and trust through common goals. It helps to remove silos, enabling coordination of services and resources and supports staff to work collaboratively across locations, enhancing flexibility and system efficiency. Listening to staff and patients, we are one NHS and a Group model breaks down unhelpful barriers. Our model will be clinically led (medical, nursing and allied health professionals), with the right support teams and networks in place.

- The prioritisation of resources through a common framework ensures this is used to the maximum benefit of the population as a whole, rather than to meet the needs of sometimes conflicting organisational priorities.

- A Group model streamlines decisions, allowing for faster decision making and implementation of policies, initiatives and enabling change, which is essential given the scale of local transformation needed

- A Group model is also the most effective way to address barriers to collaboration at scale, such as the sharing of information and financial flows that can be a barrier to transformation.

The table below draws together the main benefits and intended outcomes. These areas have been further informed by staff and stakeholder engagement, building on the work of the Boards and national learning.

| Benefits	Outcomes

Patient Experience	Accelerate shift of key services from hospital to community
• Address growing demand for health and care by playing an active system role, in preventative and proactive healthcare for people with long term conditions. • Maximise collective assets and resources to support the important shift towards community care and optimise neighbourhood health services. • Develop new models of care, with patients at the heart of their care, including care closer to home, continuity of carer and seamless pathways • Deliver a consistent best practice model of UEC with a particular focus on patients with long-term conditions and multi-morbidity (including frailty).	More seamless care and treatment through improved pathways Enhancement of neighbourhood health (multi-disciplinary teams (MDT), home first) for elective and urgent care pathways Fewer avoidable admissions through maximising home and community pathways Consistent advice and communications with patients and families – reducing the need to repeat information
Quality of care • Implement safe and sustainable care models in priority specialties (for example, Diabetes, Frailty and Cardiovascular Disease) to deliver clinical, financial and environmental sustainability. • Increased collaboration and scope of clinical responsibility across pathways. • Level up outcomes and access by optimising elective care pathways, making best use of collective capacity, improving access to services, reducing waiting times and enhancing patient care • Deliver better outcomes for people with complex conditions including Cancer at all stages of pathways, starting with earlier diagnosis • Deliver changes to UEC pathways and flow across the system, including expansion of alternatives to attendance/admission to hospital • Broader safety improvements – alignment of Patient Safety Incident Response Framework (PSIRF) priorities • Expansion and coordination of prevention activities • Optimise use of modern digital systems and technology – enhance development of single	Reduction in unwarranted variation in treatment times, outcomes of care, for adults and children & young people Common/aligned clinical standards, policies and standard operating procedures (SOPs) Improvement in performance standards: - Elective waiting times - Cancer waiting times - Emergency Department (4, 12 hours), ambulance handover times - Reduced length of stay in acute and community beds (through improved discharge and flow) ensuring patients return to their normal place of residence as quickly as possible to enable independence and prevent deconditioning. Improved prevention offer (supported by 'Making every

patient record, shared/integrated systems, plus coordinated use of Artificial Intelligence (AI), Robotic Process Automation (RPA) and wearable technologies	contact count' approach) – adults and CYP. Coordinated approach to the delivery of the single patient record and use of technology for patient care
Our People • Effective use of workforce skills and capacity supporting the easier movement of staff to improve service resilience and provide attractive career and development opportunities • Driving innovation and improvement through staff empowerment. Learning from each other's services and expertise • Improve the offer for staff, to train multi-disciplinary teams, develop and retain healthier and happier staff • Build upon the desired University Hospital status to accelerate research, training and innovation • Sharing knowledge and skills across the two organisations and building greater understanding of each other's services. Taking the excellence across both.	All staff able to access a wider range of education and training offers Increased opportunities for staff – for joint/rotational roles, career progression. Grow, attract and retain talent from area and beyond Improve access to clinical advice and support, recognising the different roles and responsibilities in community care Improved resilience, especially in smaller teams Expansion of opportunities for research and innovation
Our Resources • Realise the benefits of service transformation that are possible through shared services and maximising estates • Joint approach to investments based on Group strategy, NHS 10 Year Plan, STW Integrated Care Strategy and STW Joint Forward Plan • Further optimise joint negotiation, purchasing and investment power of the trusts, including in commercial opportunities. • Have an aligned approach to a range of corporate functions, including clinical and operational functions as well as strategy, transformation and planning functions. • Drive efficiency through leveraging opportunities to review services, building resilience and improving staff recruitment and retention through enhanced career opportunities. • Develop aligned Group strategies and plans (including clinical, People and Organisational	Prioritisation of resources and workforce to agreed local and national priorities Improvements in efficiency, productivity and value for money through economies of scale, clinical and non-clinical service reviews Continue to deliver on medium term financial plan Streamlined and faster decision making for operational as well as complex and strategic decisions Stronger opportunity to expand business/services in and out of county to deliver at scale (noting primary objective of

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Development), that meet the objectives of system strategies and plans	benefit to STW residents and Group). Set up the Group as a strong partner for the NHS and other organisations, for neighbourhood health and other collaborations Readiness for new models of commissioning and contracting

Reinforcing our role as Anchor Organisations

Both Trusts take their role as an anchor organisation very seriously, recognising that SATH and Shropcom, together with Telford & Wrekin and Shropshire Councils, are among the largest employers in STW. The Trusts have already made contributions to support local social and economic development (aligned to the themes in the nationally-recognised Health Foundation model below).
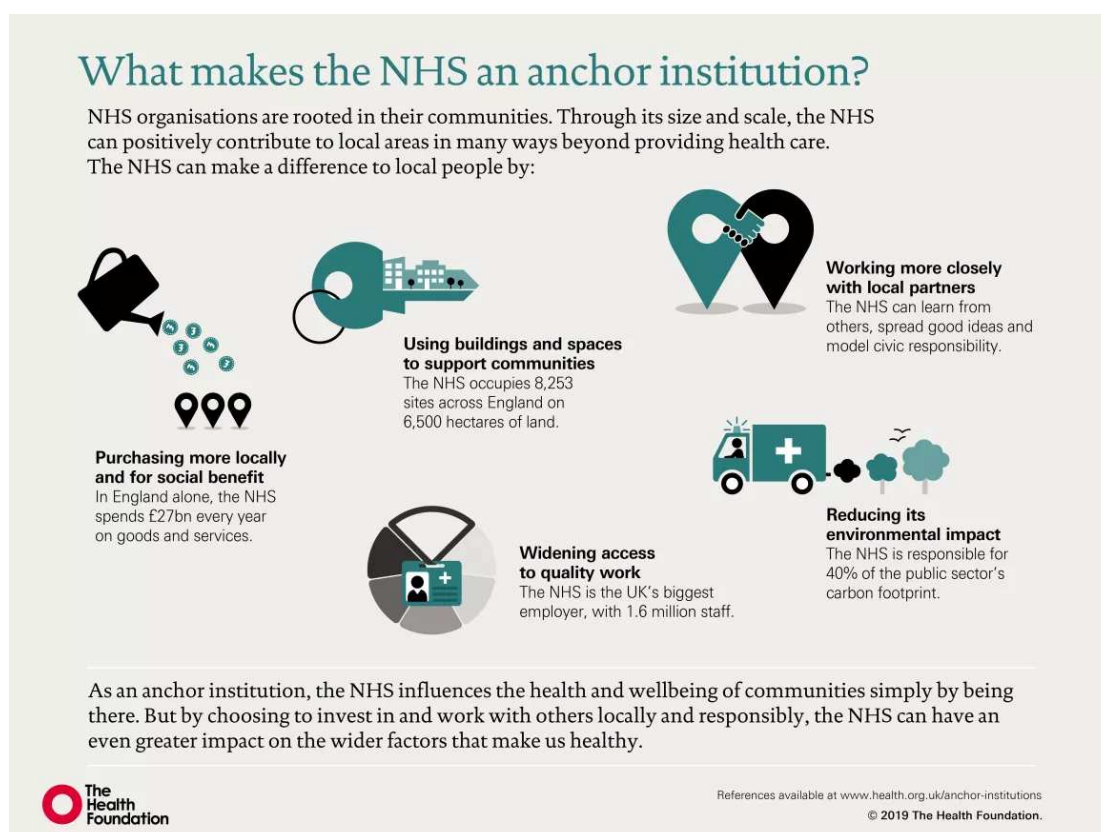
However, developments as part of the Group will provide further opportunities to make a strategic contribution to the local community and economy; and to add social value as an employer, a partner, in the way we buy goods and services, and in the impact we have on our environment.

Shared priorities

Both organisations have shared priorities, aligned with the national 10 Year plan:

- Deliver more care and resources in the community, supported by two thriving acute hospitals (hospital to community). The Group will play a leading role in transforming neighbourhood health services working with primary care and other partners.
- Neighbourhood Health Implementation Programme (formerly Local Care Transformation) and Hospitals Transformation Programme – both organisations need to be ready for 2028 and beyond.
- Increased focus on prevention and tackling inequalities through neighbourhood working (sickness to prevention).
- Developing our workforce – right staff, with the right skills, in the right places and at the right times.
- Collective focus on analogue to digital agenda, optimising the opportunities of vertical integration to streamline patient pathways.
- Modern clinical models and ways of working, with the right tools and environment.
- Supporting the health and wellbeing for staff.
- Building an inclusive workforce – everyone has a voice and is valued.

These priorities align fully with local (Place and ICS) and national objectives and priorities and are further detailed in section three.

Section three: Assessing the current landscape and identifying potential collaborative partners

STW System Strategy and Joint Forward Plan

Since ICBs were set up in 2022, the STW system has worked well together to develop and revise the Integrated Care Strategy and produce the Joint Forward Plan (JFP). All partners have had significant input into the work and the JFP represents a whole-system approach to transformation and improvement. Our system governance encompasses all the necessary components to allow for Place and Neighbourhood focus, collaboration between partners (NHS and Local Authority) and lines of reporting and accountability. In summary, the foundations and strategic ambitions are sound.
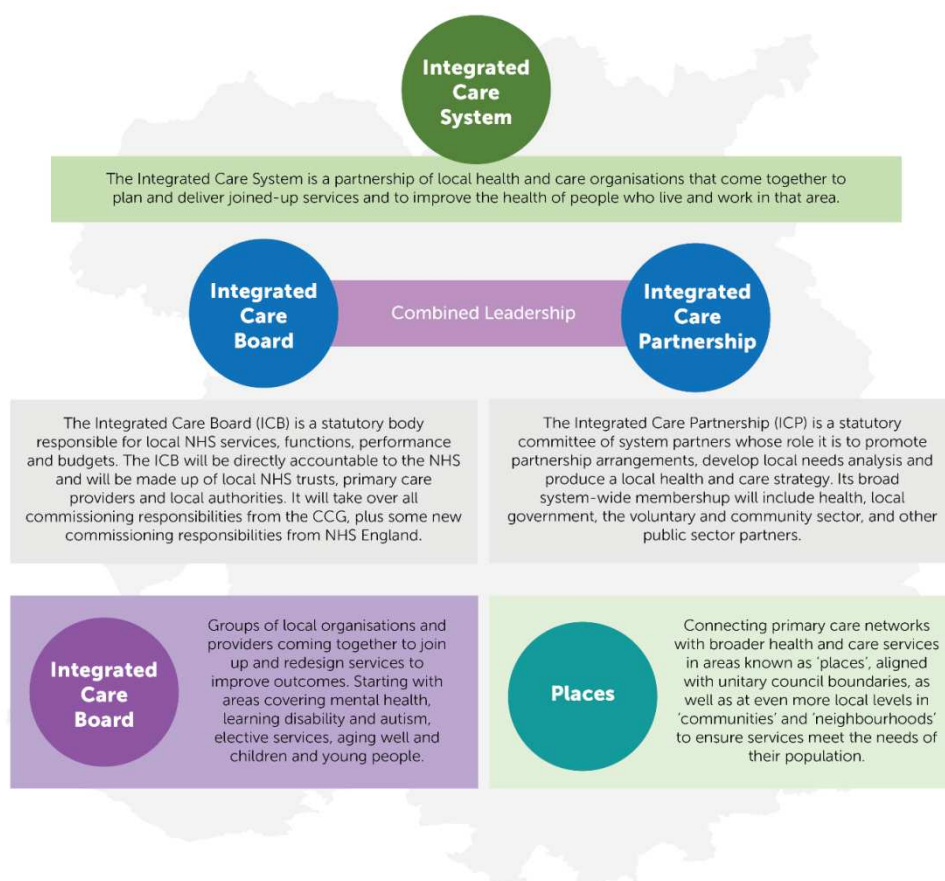

The three key elements of the STW JFP are:

1. Taking a person-centred approach (including proactive prevention, self-help, and population health to tackle health inequalities and wider inequalities). We are committed to working with service users, carers, and partners to support

our citizens to live healthy, happy, and fulfilled lives. This will mean supporting people to proactively look after their own health, putting a greater emphasis on preventing illness and staying well, but also providing the right care when and where they need it.

2. Improving place-based delivery, through integrated multi-professional teams providing a joined-up approach in neighbourhoods, supporting our citizens and providing care closer to home, where possible. The STW Local Care Transformation Programme (LCTP) brings together a collection of transformation initiatives that will deliver more joined-up and proactive care closer to home, supporting improved health and wellbeing for our population. This is encompassed by the local care vision of "adding years to life and life to years".

3. Providing additional and specialist hospital services through our Hospitals Transformation Programme (HTP). HTP is putting in place the core components of the acute service reconfiguration, agreed as part of the Future Fit consultation. It is helping us to address our most pressing clinical challenges and establish solid and sustainable foundations upon which to make further improvements.
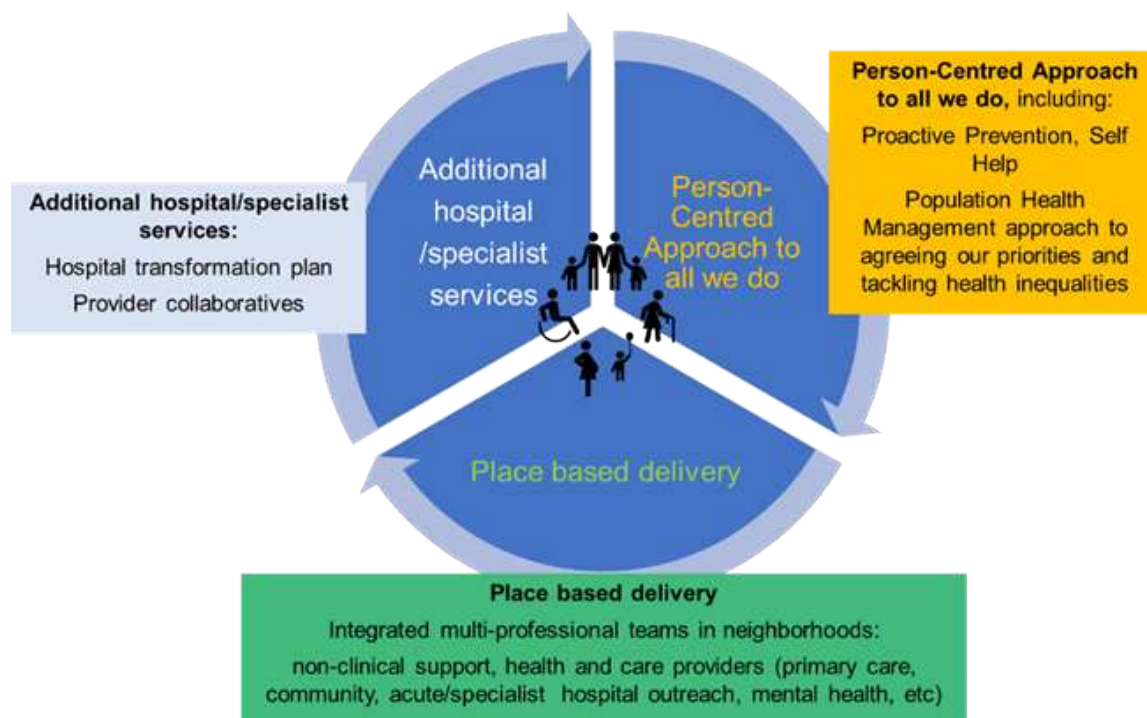
The plan highlights the work being undertaken across the ICS to improve the care we provide for the citizens of Shropshire, Telford and Wrekin. It is recognised that this is an ambitious plan which faces significant challenges; but it is also recognised that we must deliver our plan to improve the health and care services for our population through the strong commitment of all partner organisations, and by talking to and working with our communities.

The publication of the NHS 10 Year Plan outlines a strategy to transform the NHS through three key shifts: from hospital to community, analogue to digital, and sickness to prevention. It aims to improve patient care, enhance value for taxpayers, and make the NHS more efficient by leveraging new technologies and focusing on preventative care. The plan is underpinned by key enabling reforms, including strengthening accountability and introducing new incentives, as well as workforce transformation and addressing workforce challenges. The plan emphasizes the need for a long-term vision and commitment to deliver lasting change, drawing on the expertise of NHS staff and encouraging collaboration and learning across the system. It also acknowledges the importance of adapting to new technologies, medicines, and innovations to provide better care for all.

The STW ICS strategy and JFP contain many of these elements. Forming a Group model between ShropCom and SaTH will enable the organisations to realise these national and local ambitions accelerating the necessary improvement and change. Both Boards are ambitious for the future and are committed to working towards becoming an Integrated Health Organisation, working with partners.

Building on local collaboration

ShropCom and SaTH have worked ever closer over the last few years. Key areas and achievements of the two trusts working together in partnership are:

- Virtual Wards programme
    - Frailty – For those adults aged over 65 with a Clinical Frailty Scale (CFS) of 5+ who are experiencing a change in their usual health status which requires enhanced monitoring and intervention
    - Respiratory – supporting patients with a range of respiratory conditions – Acute Respiratory Infection (ARI), COVID, Bronchiectasis, Exacerbation of known respiratory conditions which require secondary level care within the community
    - Heart Failure – management of the heart failure pathway or in the instance of known cardiac dysfunction which requires acute intervention
    - General Medicine – For those patients where frailty doesn't apply, including Urinary Tract Infection, Cellulitis, Cancer, condition specific medical concerns agreed at point of triage
    - Surgical – For the step down from the Surgical Assessment Unit
- Community Respiratory Admission Avoidance and Early Supported Discharge service
- Outpatient Parenteral Antibiotic Therapy (OPAT) service.
- Improved discharge and flow through the Care Transfer Hub (with Adult Social Care)
- Alternatives to hospital admission and Urgent Community Response services
- Staff vaccinations for Flu and COVID-19
- Shared estates, including Audiology

- Shared or joint current board-level roles including Chair in Common and Chief People Officer, and most recently the appointment of a Chief Executive in common for ShropCom and SaTH.

Across providers, we have:

- Shared enabling services including Payroll and Procurement across STW NHS trusts.
- ShropCom and SaTH collaboration with the Robert Jones and Agnes Hunt Orthopaedic NHS Foundation Trust (RJAH) particularly in Musculo-skeletal service developments
- Activity with Midlands Partnership University Foundation Trust (MPFT) and Local Authorities, focused in STW on mental health, learning disability and autism services.
- Working relationships with various Primary Care Networks (PCNs) to provide ARRS (Additional Roles Reimbursement Scheme) services e.g. First Contact Physiotherapy

Additional collaborative arrangements exist which cross ICS boundaries, such as SATH's collaboration with University Hospitals of North Midlands Trust (UHNM) for a range of clinical services, RJAH's collaboration with Royal Orthopaedic Hospital Trust Birmingham, and ShropCom's work with MPFT for digital and estates services.

There are strong working relationships with local authority colleagues. STW has two thriving Place-based Partnership Boards, chaired by the Local Authority Chief Executives, and with all partner organisations represented. These forums will provide a cornerstone of the system's approach to neighbourhood working, bringing together Local Authority, Community, Primary and Secondary Care as well as voluntary and community sector (VCSE) partners. Additionally, ShropCom has a long history of working with local authorities, delivering successful 0-19 services for children and young people across multiple boundaries.

Potential partners for collaboration

We recognise that STW ICB is developing plans for cluster-based joint working across the STW and Staffordshire and Stoke on Trent (SSOT) footprint following the recent national announcements. Both ShropCom and SaTH have strong networks with neighbouring providers in SSOT. However, based on the provider landscape and geography, the challenges set out in section 1, alongside the national and local priorities, and local scale of transformation, the initial decision was made to focus on collaboration with STW-based NHS partner trusts. RJAH are pursuing specialist collaborative opportunities with the Royal Orthopaedic Hospital Birmingham (with a recent collaborative Memorandum of Understanding having been agreed), whilst also working closely with ShropCom and SaTH in a number of clinical and non-clinical service developments. MPFT already spans both STW and SSOT, and

whilst an ICB Board member, MPFT primarily works in SSOT for financial and governance purposes.

Taking account of the system's challenges and strategic ambitions, including areas set out in section 1, the Trusts' Boards agreed that a vertical integration would maximise the benefits and outcomes identified.

It is also recognised that many senior leaders in NHS England, STW ICB and other stakeholders also support this model, proposing that the two trusts would be more resilient and sustainable through integrated leadership, services and new ways of working. Bringing together the collective resources, expertise and leadership will ensure patients are treated in the right place, at the right time, by the right people.

The appointment of a Chair in Common across the two trusts in Autumn 2024 was an indication of the desire to accelerate integration locally. The recent appointment of a Chief Executive in Common will drive forward this important work. Both Boards now feel the time is right to deliver the necessary transformation across both organisations, with the completion of the HTP build phase in early 2028 as a key milestone. Furthermore, with executive vacancies in SATH, it is appropriate to review what the best option is for securing the necessary leadership capacity and capability in the local NHS system, before just seeking a "like for like" replacement. This is the opportunity to design a local approach that will best meet the needs of our communities and staff and help both trusts become amongst the top NHS organisations.

Both trusts have strengths and development areas (primarily linked to improvement opportunities in section one). Both Trusts are committed to taking forwards the areas of excellence in both organisations and to retain the breadth of knowledge and expertise in both acute and community services in the Group leadership structure.

ShropCom offers:

- Expertise in many services, especially community service delivery to drive forward the ambition of neighbourhood health and care
- Good regulatory compliance (such as CQC and NHS Performance Framework)
- Examples of creativity, innovation and delivering value for money within small, but responsive teams

SaTH offers:

- Scale in a number of corporate services, such as workforce and digital
- Expertise in many clinical specialties, with excellent clinical outcomes in many areas
- Strong education and training offer
- Recent track record of leading improvement methodology and transformation, for example in Maternity.

Our proposed Group model features central leadership responsible for strategic direction and governance, while local divisions and teams within each trust maintain operational management and ensure that delivery of care reflects the needs of patients at Place, integrated with local partnerships. The model emphasises standardising systems, policies, and procedures to enhance the conditions for collaboration, and optimise the models and quality of care. In summary, the Group model offers flexibility, resilience and opportunities for collaboration. Both Boards are determined that, as well as having a relentless focus on what is best for the local population, we should also seek to make it as easy as possible for our people to deliver the best high-quality integrated care.

Section four: Options for shared leadership and governance arrangements

The trusts have explored different options for achieving greater integration, with a clear focus on what is best for our patients. Nationally, there has been continuing focus on the need for NHS providers to work together. Whilst the guidance sets out a clear expectation that NHS trusts become part of at least one provider collaborative, it covered a wide range of collaborative forms with shared leadership models as one example. There are different ways in which shared leadership across multiple trusts can be delivered. The trusts considered the following model which is widely recognised in assessing a preferred option.

Spectrum of collaboration

Informal arrangements			Formal agreements			Group model
Informal collaboration	**Strategic collaboration**	**Committees**	**Joint ventures**	**Lead provider**	**Shared or joint leadership**	**Single provider/merger**
• May have advisory group • May have non-binding memorandum of understanding • High level shared principles for working together / collaboration • No shared decision-making - advisory / recommendations only • May make use of existing authority of individuals to make decisions for their organisation • Can be a stepping stone towards strategic collaboration	• Advisory group or leadership board • Memorandum of understanding / partnering agreement • Terms of reference for leadership board • Advisory group only or decisions through individual excercise of delegated authority • Shared information to discuss relevant matters • Joint decisions by consensus • Aligned decision making but not shared decision making	• May be statutory committees in common or statutory joint committee • Memorandum of understanding / collaboration agreement • Terms of reference for committee(s) • Collective exercise of delegated functions • Shared information to discuss relevant matters • Committees in common aligned or virtual joint decision-making • Joint committee shared decision-making by unanimous or majority voting	• Contractual or corporate • Management board • Contractual joint venture agreement or company documents • Services agreement • Principally a mechanism for service delivery • Can permit joint decision making on management board for contracted out services • Note restrictes NHS trust powers for companies	• Contractual joint venture • Main contract held by lead NHS provider • Alliance / consortium agreement • Sub-contracts between lead provider and other NHS / non-NHS providers • Principally a mechanism for service delivery • Can permit joint decision making on alliance / consortium management	• Same person or people lead each provider involved • Boards of NHS Trusts or FTs appoint same person to multiple posts • Enables aligned or virtual joint decision making • May enable actual joint decision-making if combined with a joint committee	• Governance and legal advice required to determine feasibility • Must comply with NHS England transactions guidance e.g. full business case and due diligence requirements • Internal and external approvals process • Statutory transfer document and legal agreements • Results in single board for organisation

In considering the merits of each option, key criteria were considered, which reflect the focus on the anticipated benefits (section 2). The boards agreed that the:

- Benefits of change must outweigh any potential disruption involved
- Changes should lead to improved decision making and more integrated care pathways
- Model should create more resilient and sustainable organisations, in performance, quality and financial terms

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- Changes be informed by the feedback from stakeholders and regulators.

Ultimately, the changes should support delivery of our strategic objectives and help deliver the three shifts set out in national policy.

As well as the criteria, guiding principles were identified that should apply across ShropCom and SaTH. These principles are:

- Clinically led and patient centred
- Centrality of care close to home, delivering the three shifts
- Empowered staff and quest for innovation
- Values based behaviours
- Local decision making
- Communication and engagement with patients, the public, partners and staff
- Standardised, evidence-based methods, protocols and practice, underpinned by common policies, procedures and approaches.

Why not continue with informal arrangements?

While it was recognised the greater integration between NHS providers, particularly ShropCom and SaTH, had delivered some improvements, it was agreed that the current way the organisations are designed can get in the way of delivering excellent care to patients. There is a collective ambition to go further and faster in improving the care and experience for all through greater integration. It was also recognised that some of our system's previous informal approaches to collaboration have not delivered the level of intended benefits at the scale or pace required.

Why not merge?

The merger option was considered but discounted. The evidence from other organisations that have moved to a Group model indicates that providers can deliver substantial benefits relatively quickly from working in collaboration at scale but without the costs, timescales and significant disruption associated with a merger. Limiting unnecessary expenditure and creating the conditions and cultural change for integration as swiftly as possible remain core factors. The potential of a merger could be considered in the future if the situation changes. However, a Group model is judged to be the best option to realise the intended benefits and deliver value for money for taxpayers at the current time.

What type of Group model is right for us?

There is no single Group model or legal definition, but these types of models tend to be distinguished by use of a centralised Group leadership whose role is to set strategy and oversee governance, standards and procedures for sites or service areas within the Group. Each site or service area is managed on behalf of the Group by a more operationally focused leadership team with some core centralised functions across the Group.

On 5 March 2025, ShropCom and SaTH Boards met to discuss the drive to move towards greater integration, the operating principles and benefits of closer integration. The different types of Group model were explored, and there was overriding support for the shared/joint leadership model. The outputs are summarised at Appendix 1. Group models across multiple trusts fit within our definition of a shared leadership arrangement with accompanying shared governance.

It was recommended that the two organisations should integrate as closely as possible, and the desire was to set the conditions for teams to integrate wherever the potential existed rather than limit the scope. This will mean the trusts have a joint Chair, CEO, Non-Executive Directors, and Executive team. The plan will also be to move to a joint Board of Directors meeting and joint Board Committee meetings.

Furthermore, both trusts recognise that optimising the opportunities will not be delivered through governance and structures alone. The importance of a shared vision and strategy, underpinned by culture and organisational development, are all well recognised, and further detail on some key areas of development is covered in section five as part of the implementation plan. Additionally, strong coordinated clinical leadership will be necessary to realise the Group's as well as the ICS's ambitions.

The initial recommendation has been fully supported by key stakeholders, such as STW ICB, other NHS partners, local authorities and NHS England.

Section five: Implementation and managing risk

The trusts recognise that alongside the opportunities and benefits of forming a Group, there are areas of risk that will need to be considered and mitigated. And to fully realise our ambitions, an implementation plan is vital both internally within the trusts and externally for stakeholders.

Risks associated with a Group model and mitigations

Transitioning to a Group model presents several potential risks that must be carefully considered. Identifying these risks effectively is crucial to outline and implement strategies that will mitigate these challenges. To inform this Case for Change, the trusts asked staff, patient representatives and partners to identify the issues and risks in forming a Group.
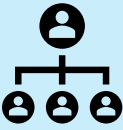
From a credibility and financial perspective, the integration could exacerbate existing financial deficits and undermine stakeholder confidence if not managed effectively. Proactive measures will enhance the resilience and sustainability of the proposed group model. Culturally and operationally, working with different organisational cultures and operational practices across multiples sites may lead to resistance and inefficiencies, potentially impacting staff morale and patient care. Fostering a shared vision and values is essential in alignment of the trusts' identities.

Externally and strategically, the two trusts have distinct identities, which could pose challenges in greater integration of services whilst maintaining the unique strength of each organisation; this could affect the overall strategic goals and external partnerships. This could also risk quality of care, if not properly managed, thus the importance of leading with a strong improvement methodology and ensuring effective quality and equality impact assessments with measurable outcomes. Becoming a better place to receive care and work, will be at the heart of any change delivered. Strategies that promote collaboration will aid in optimising resource utilisation and service delivery, thereby achieving strategic objectives and facilitating the smooth integration of the Group model.

It should be noted that whilst there are risks in creating a Group model, there are also significant risks if the trusts do not change. As highlighted in section one, a variety of challenges and opportunities exist, which will be significant for one or both trusts. There is recognition, neither trust can work in isolation and both need each other to deliver their ambitious transformation plans. Both trusts are keen to take action and lead their organisations into the future, to deliver a more modern NHS that better meets the needs of its communities. Realising the strength of combining capacity and expertise to meet these local and national ambitions.

The external regulatory and legislative context also presents risk. But with the publication of the NHS 10 Year Plan and associated priorities, and knowledge of developing plans for local ICB footprints, key strategic changes are understood, albeit with further definition to emerge. Maintaining close relationships with local, regional and national stakeholders will mitigate any surprises. However, many external factors would have affected the trusts regardless of any plans to form a Group, and the overriding opportunities would still take precedence.
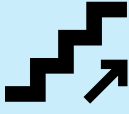
Key risks and planned mitigations are noted in the table below:

Risk	Description	Mitigation
Leadership capacity and capability	The current and future leadership structure does not have the right level of capacity and expertise to: - Develop the Group model and associated transition plan - Develop strategic plans to optimise the benefits of the Group in line with national and local policy - Lead and manage two trusts as a Group including providing the appropriate level of control and visibility across the two trusts - Manage regulatory compliance for two trusts	• Selection of an appropriate mix of acute and community trust leaders • Development of an effective operating model and governance structure to meet the needs of both trusts and transformation potential. • Clear transition plan, with phases, priorities and milestones • Continued recognition that the two trusts remain distinct and ensure capacity and focus on Care Quality Commission (CQC), NHSE and other compliance standards whilst recognising potential to combine capabilities. • Maintain capacity and capability of the two trusts senior leadership/divisional leadership teams, with focus on clinical leadership for both trusts • Empower and develop leadership, at all levels, through both trusts to deliver change
Clinical quality and safety	Focus on maintaining high levels of quality, safety and patient experience in both acute and community services is diluted by combining senior leadership	• Maintain strong clinical leadership, clinical governance and an 'equal voice' for both trusts within operational and Board quality governance structures.

		• Continued focus on patient care and experience – making things better not just different
Governance	Risk of a single Board and joint committee structure not providing clear governance routes and Board oversight to effectively manage both trusts	• Priority workstream in Q3 and Q4 25/26, to develop clear governance and assurance model for the Group, including decision making (and accountability) framework. • Take learning from other established Groups
Integration	Risk to current good areas of performance - clinical, quality, workforce, operational and financial are adversely impacted Fragmented service delivery despite integration goals, with increased financial and workforce challenges	• Establishment of correct structures, with mixed board level experience, balancing metrics • Coordination of the implementation progress in accordance with Transition Plan, with ability to adjust integration priorities/timetable if needed to prevent worsening positions - i.e. better not just different. • Need to recognise warranted difference and accept not everything will be/needs to be aligned where it doesn't add value
Operational	• The two trusts come from varying starting points and will have different implementation paces between one another, potentially hindering progress and negatively impacting the overall outcome. • A focus on standardising procedures within trusts covering different services (acute and community) may not always yield	• Trust Boards to agree key policy and process changes and opportunities to align. • It is essential to prioritise patients, staff, and financial resources to ensure sustainable progress. Effective communication and sharing of certain policies and procedures, where benefit is likely as soon as practicable, is vital to maintain clarity and

	positive results. Additionally, the lack of alignment in key policy areas could hinder the integration process. • Whilst focusing on integration of services across the group could potentially yield notable long-term benefits, this may result in declining performance due to a lack of operational grip and oversight, particularly during the transitionary period, which would add further pressure onto struggling services. In turn, this could create a disconnect between operational staff and senior management. • Risk of intense focus on key areas of performance i.e. UEC may dilute operational oversight of specialist services in both organisations but notably in the community trust	alignment among all stakeholders. • Senior level operational leadership (from both Trusts) to maintain performance management and delivery for 25/26 operational plan targets (supported by well-established system-wide work on Planned Care and UEC). Small number of partners involved should aid visibility of any risk. • A robust operating model will facilitate the integration process and help achieve the long-term vision of the Group model. • Establishing specific goals and timeframes to measure progress, along with developing a robust operating model and effectively communicating all policies and procedures, will support the integration process.
Culture	• The cultural risks primarily stem from the differences in identity among the two trusts, a lack of communication and understanding could lead to disengagement among staff and patients. Poor communication and engagement with the workforce could also have a longstanding negative impact on staff morale. • The potential negatives of siloed working will continue into a Group model if the appropriate stakeholders are not sufficiently	• Culture and OD programme, to support integration including opportunities to get to know and value each other - to leverage the strengths of the existing trust identities. Listening and involving staff. • Adopting best practice models should involve learning from previous challenges to avoid repeating past mistakes. Clearly articulate the long-term vision, as the Group model may not yield immediate significant

	engaged, leading to a potential ongoing cultural divide between the organisations, hampering further efforts to increase collaboration. • The Group feels 'acute'-centric due to size of organisation	benefits. Communication and engagement with staff and stakeholders to create a unified sense of belonging, shared understanding and trust. • Joint senior clinical and professional roles as an early step to bring clinical teams together • Board contains breadth of acute and community experience and understanding • Strengths of both trusts to be highlighted in Group partnership
Financial 🐷	• Financial barriers, current financial frameworks and lack of clarity on implementation costs pose risks to achieving opportunities. With the current financial frameworks in place across the two organisations, there are potential barriers to achieving the opportunities outlined. • The existing financial situation may not immediately support the implementation of best practices, leading to delays and possible overspend. This may also limit the benefit of working together as a Group rather than as separate trusts. • Lack of clarity regarding implementation costs, which could result in unforeseen expenses and financial strain. • Without an effective communication and engagement strategy there is risk of reduced staff	• Robust financial planning (Trust and Group) and clear communication with stakeholders about financial objectives, strategies and progress will help build and sustain trust and confidence in the Group's financial management. • Identification of potential financial risks early and the development of proactive mitigation strategies with appropriate investment, supported by training for staff to enhance their financial management skills. • Identification of potential areas of joint benefit in revenue and capital. • Communications and engagement across both trusts to build confidence of staff.

	retention, thus increasing temporary staffing costs	
Reputational 	• Potential impact on credibility, should the Group fail to deliver the anticipated outcomes, its reputation and trustworthiness could be compromised. Previous work to develop a provider collaborative and creation of a Committees in Common framework did not yield the results that leaders aimed for. • The urgency to implement changes within a constrained timeline heightens the risk of mistakes and inefficiencies, which may have further financial repercussions.	• Consideration of relevant investment to facilitate these changes, to deliver against the anticipated enhancements in performance or efficiency. • Appropriately resourcing the development of the transition plan and operating model will support successful delivery. • Clarity on early, medium term and long-term measurable deliverables to evidence the difference Group has made. To include: o Adopting a phased approach to changes will allow time to assess and adjust strategies as needed, reducing the risk of significant financial strain and its associated impact. Establishing specific goals and timeframes to measure progress is necessary for tracking the benefits realisation. Include measures that show stabilisation whilst moving into Group - ie Urgent community Response performance, Community length of stay, financial key performance indicators (KPI) (ShropCom) and other corporate measures, plus KPIs

		for safe care - UEC, Cancer and elective. Engaging stakeholders early to garner support and input will ensure that expectations are realistic and aligned to those of the Group.
Engagement and Partnerships	- Missed opportunities to engage community partnerships and not properly considering the impact of inadequate geographical infrastructure, such as transport/digital links. As a Group based on vertical integration, engagement with key external stakeholders, such as PCNs (GPs), local authorities and the ICB as well as our population will remain vital. - Concerns about the impact on strategic partners and the potential destabilisation of Place-level services. The opportunity is to strengthen these and provide a boost for the local health economy. - The expectation to achieve a wholly successful group model on the first attempt is high, and not having appropriate measurable targets for comparison could negatively impact the integration's perceived success.	• Engagement with all relevant stakeholders including staff from both Trusts and local communities as part of a communications and engagement plan. • Maintain and build upon the current relationships between SATH, Shropcom and primary care • Maintain and build upon the current relationships between SATH, Shropcom and local authorities • Develop correct sub board structure to ensure attention and focus on key relationships to support three shifts

An initial assessment of the consequence and likelihood is included below; these risks will continue to be monitored and reviewed throughout transition phase and beyond, initially through the Group Transition Committee.

A. Leadership capacity & capability – mitigated through selection of balanced leadership team and supporting capacity; effective governance and operating model.

B. Clinical Quality and Safety - mitigated through continued strong clinical leadership across both Trusts, Exec and Board governance.

C. Governance – priority workstream in Q3-Q4. Learning from other Groups

D. Integration – clear transition plan with priorities and leads.

E. Operational – mitigated through strong operational leadership, robust operating model and establishing clear joint/Trust goals and objectives.

F. Culture - mitigated through priority Culture and OD programme; articulating Group goals and vision; listening and involving staff. Adopting best practice models

G. Financial – mitigated though robust financial planning; sharing of opportunities to jointly benefit from revenue and capital schemes;

H. Reputational –mitigated through appropriately resourcing development of the transition plan, governance plan and operating model. Phased approach to implementation.

I. Engagement and Partnerships – mitigated through robust communication and engagement plan, involving one or both Trusts, with all system partners and local communities.
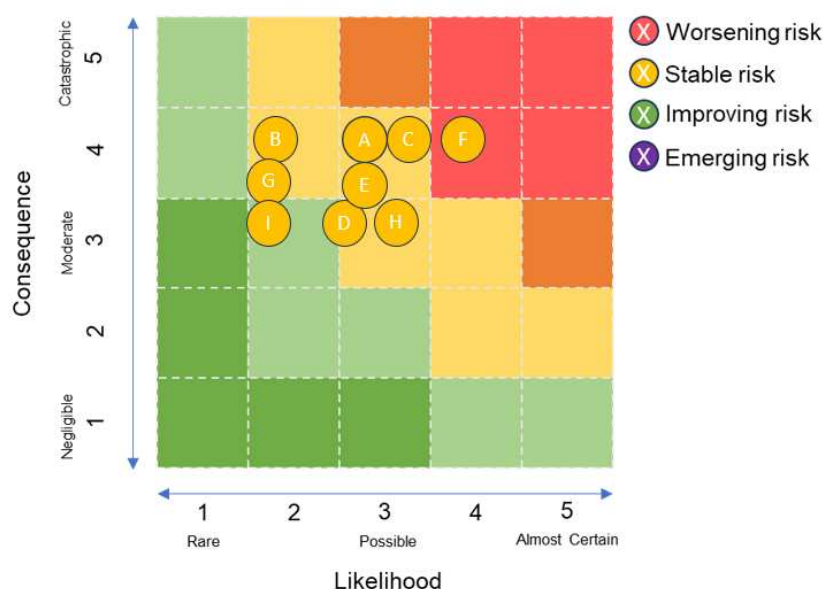
Adopting the Group model

The risk of not adopting the Group model is significant and multifaceted. Without a unified approach, the Group may fail to capitalise on the potential opportunities of

transforming health and care services, delivering high quality outcomes building on combined knowledge skills and experience, and achieving greater sustainability by working at scale.

The absence of a structured Group model could result in missed chances to forge robust strategic partnerships essential for working in local health economies and the broader integration agenda, leading to a disjointed approach where individual visions of the three organisations continue to diverge, lacking a coherent narrative and accountability mechanisms to support collaboration. Fragmentation could perpetuate historical barriers of competition and siloed development, impeding the establishment of a joint vision and commitment necessary for transformation change, overall limiting the extent to which these opportunities are able to be achieved.

It is therefore crucial to prioritise the adoption of a robust operating model that aligns governance, enhances capability, and fosters a culture of collaboration to ensure sustainable and comprehensive service delivery improvements.

Developing the Implementation Plan

The intention is to have a Group formally established in place by 1April 2026. This will include a single Board accountable for the performance of both trusts in the Group. The timetable consists of key milestones, with regular updates to Trust Boards and taking into account support and advice from NHS England.

Mar-May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26	Apr 26
Consultation with NHSE, ICB and Trust Boards Guiding principles developed Boards agree to move to a shared leadership Group model in principle, subject to engagement Engagement with NHSE for risk assessment & assurance process started	Partner and staff engagement start Case for change drafting started CEO in Common (Group CEO designate) post advertised	Board workshop to develop Case for Change – to continue Trust Boards input CEO in Common (Group CEO designate) appointed	Development of Case for change, including: - informal NHSE feedback - incorporate staff and stakeholder feedback - preparation for Trust Boards	GATEWAY: Boards formally ratify decision on preferred Group model Submission of final case for change to NHSE Commence Board committee model development	NHSE endorsement of Shropcom/ SATH Group model (Oct-Nov) Develop transition plan Align Group model objectives with medium term planning outputs	Board workshop to develop Group strategic aims and objectives Senior leadership team workshop to develop Group strategic aims and objectives	Prepare for Board Director appointment process (Non-Executive and Executive) Boards ratify board committee model	Develop shared/aligned board assurance framework Board committee model - Shadow form for Q4 2-25/26 Board Director appointment process – Q4	Planning for 2026/27 operational priorities and objectives	Finalise Group operating model including decision-making framework	Shropcom/SATH Group in place Group Board and Board committees structure in place

As with any major change programme, the transition will be underpinned by a detailed plan. Key deliverables and milestones are linked to key workstreams and priorities including:

- Leadership appointments

- o Appointment of Group CEO (completed in July 2025, and in post by 1 September)
  - o Appointment of members of the 'Group Leadership Board'
- Case for Change submission
- Group governance model – including decision making and accountability framework
- Group operational / delivery model – with clinical input
- Culture and organisational development programme
- Ongoing internal and external stakeholder communication and engagement
- Group strategic model – including vision, values, objectives, and priority areas
- Service delivery priorities for integration

A Transition Plan is being developed, which will develop the objectives and milestones of the workstreams and create a more detailed plan. The workstreams needed to develop the Case for Change and set the successful conditions to create the Group for a 'go-live' on 1 April 2026 are described in the governance and assurance section below and will be managed by the Group Transition Committee. The intention is to add further detail and workstreams to this plan (such as finance, data and digital) in due course. Learning from other Groups has been considered. Importantly, none of the workstreams will preclude important work already underway on development of shared services models, especially for corporate services at a system level or broader.

Governance and assurance

Implementing the transition will be overseen by the Group Transition Committee, which commenced on 17 July 25. The role of the Committee will be to provide assurance to both Boards as to progress with the Group Business Case submission to NHSE in a timely manner, and to agree and monitor for assurance, appropriate workstreams to bring about such progress, and workings of the Group. The Terms of Reference for the Committee have been endorsed by both Trusts' Boards and are included at Appendix 2. Responsibilities will include:

- Developing change management plans based on sound change management principles and practices
- Monitoring delivery of the work programme, identifying interdependencies, identifying early any issues likely to impede progress, managing risk and resolving issues
- Fostering a culture of collaboration, cooperation, and shared responsibility among the key partners
- Reporting to the Trusts' Boards of Directors.

Core members:

- Group Chair (Chair in Common)
- Chief Executive in Common

- ShropCom/SaTH Executive Director representatives
- Non-Executive Director representatives from ShropCom/SaTH
- Governance Leads from ShropCom/SaTH
- Programme Director/Project Lead
- Communications and Engagement Lead
- Other attendees: as required

The Trusts' Directors of Governance are working closely together to develop the group governance model, to reflect the separate status of the two trusts alongside the shared board leadership and also seeking appropriate legal advice. The governance structure and workstreams, reflecting the Group Transition Committee, are described below.
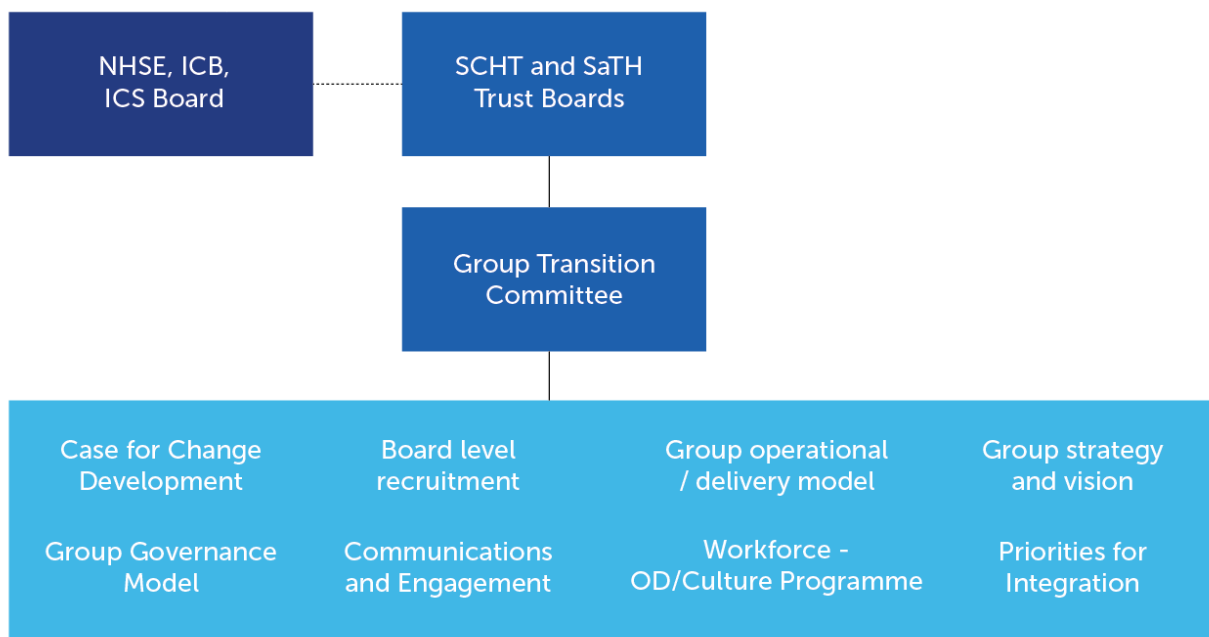
People and workforce

A well-led, well looked after, well-motivated and well engaged workforce will always deliver great patient care. We are focused on building a working environment where staff feel valued, cared for, and part of a team. The trusts recognise that investing in cultural and organisational development is key to the success of the Group and becoming amongst the top trusts to work for.

The priority areas for this workstream include:

- Holding Board development sessions (three joint Board sessions have been held between March and July 25, with sessions planned in Q3 and Q4).
- Regular engagement between leadership teams (touch point/1-to-1 meetings to improve mutual understanding, share priorities, concerns and feedback). Of note, a joint senior leaders' session was held in July with circa 100 leaders across both trusts.

- Getting the right people, in the right roles, recruited through an open, fair and transparent process. Following the successful CEO recruitment, Executive and NED recruitment will follow.
- Ensuring our people have the right infrastructure in place to operate in Group-level or joint roles safely, effectively and legally. An agreement will be in place to enable our people to share data and information relevant to their roles.
- Having cultures and values that align is essential to the success of the Group and we are committed to ensuring that our people in both organisations have the mindset, leadership, behaviours and culture to work in the new way.
- Development of joint training and professional forums to foster a clinically led culture of improvement.

A comprehensive Culture, Communications and Engagement Plan has been developed, and is included at Appendix 3, with a more detailed report on feedback at Appendix 4. It is recognised that communication, engagement and OD/ leadership are mutually supportive of each other and work very closely together .Planned activities are being aligned carefully to optimise the benefit for the teams and also recognise the demands on everyone's time.

Communications and engagement

Both trusts are committed to being open and transparent throughout the transition towards a Group and beyond. Communications and engagement was highlighted by staff, patient representatives and partners as a key enabler to the success of the Group and the delivery of the trusts' ambitions.

A Communications and Engagement Plan is in place and aims to:

- Keep stakeholders informed and involved as plans are developed and key milestones are met
- Build awareness of the benefits and opportunities of collaboration
- Build support from staff and partners to integrated working
- Involve people in developing the culture, vision and values for the proposed Group
- Build the reputation of a future Group, by sharing examples of improvement and innovation
- Develop meaningful involvement with patients, communities, staff and partners as new ways of working are designed to deliver the 10-Year Plan and Group priorities.

Both trusts have used a range of methods to communicate and listen to patient representatives, staff and partners to inform the development of the case for change. Recognising that both Boards will retain two statutory organisations, the listening exercise has focused on staff, partners and patient representatives in line with NHS England guidance. Activity has included:

- Staff engagement

- o A survey ran between 19 May and 1 August and 110 members of staff across ShropCom and SaTH participated
  - o Existing meetings: for example Staff Side meetings
  - o Face to face/ online listening events
  - o A collaborative event (4 July), bringing together c.100 staff from across ShropCom and SaTH
- Volunteers and patient representatives – through an online focus group
- Correspondence – both trusts have written to partners, patient representatives and local community groups, for example League of Friends, to inform them of the work and to offer meetings to answer any questions and understand any benefits or issues/risks
- Public Assurance Forum – correspondence and attendance on 21 July
- Patient and Carer Experience Panel (PACE) - correspondence and attendance on 8 August and PACE Children and Young People Group on 21 August
- Attendance at partner meetings and existing engagement opportunities, including the Primary Care Network Board and Joint Health Overview and Scrutiny Committee.

This listening exercise is only the start of the communications and engagement activity as the trusts seek to develop integrated working through a Group model. The trusts will continue to offer briefings to local community groups and use any existing engagement opportunities, to answer questions and seek feedback as the Group model develops. The senior leadership team will attend regular Public Assurance Forum and PACE meetings to involve patients and partners, across both trusts, in this important work.

Both trusts will continue to build relationships and joint-working with partner organisations, General Practice, MPs and councils. Regular updates will be taken to existing system and place meetings.

The Group model is primarily aimed to deliver integration and efficiency through a shared leadership structure, with a range of potential opportunities to redesign services to deliver better care and outcomes. Listening to the feedback of patient representatives and partners we will work to strengthen our involvement activity. Working together as a Group presents opportunities to share our collective expertise, skills and resources to build a meaningful approach to patient experience and involvement across both trusts. There is a shared commitment to ensuring that patients, communities, staff and partners are involved at every step in shaping the future priorities and transformation taking place.

The Communications and Engagement Plan is aligned with the overall Culture and Development Plan. Updates on progress will be regularly reviewed by the Transition Committee.

Conclusion

The NHS is at a crossroads and the NHS 10 Year plan sets out a range of challenges that all NHS trusts will need to meet.

Now, is the right time for ShropCom and SaTH to renew their focus and realign their priorities, leadership and resources to accelerate improvement and realise the step-change in care to deliver the national ambitions. Listening to patients, staff and partners there is a significant opportunity to work more collaboratively to improve the care and experience for patients and colleagues. By 2028, both trusts will have needed to mobilise to deliver the significant transformation across both community and hospital care to maximise the once in a generation investment in local services. However, the transformation does not stop there and both trusts are determined to becoming amongst the top trusts to receive care and work and to evolve into Integrated Health Organisations, working with partners.

To go further and faster, this Case for Change has set out the challenges, opportunities and risks that a Group will face. Change is not easy and the trusts will need to invest in strong leadership, build trust and understanding across teams and release the necessary investment to enable the three shifts. Group model alone is not a panacea for improving performance and quality. However, it allows the trusts to use scale as a platform and an enabler for driving improvements in clinical, operational and financial performance. Shared leadership and governance will facilitate joint decision making, at pace, to remove unnecessary barriers that patients, staff and partners face.

There is a shared understanding that these changes must make things better, not just different. A Group will focus on building the right environment, resources and culture that will enable everyone to redesign services around the needs of the patient. There is a collective desire across staff, patients and partners to develop better pathways for patients of all ages, improve quality and person-centred care, improve communication and support and empower the workforce.

The Group model, working in a shared leadership arrangement across the two trusts, can both enable these efforts and amplify their benefit for all the communities served.

Appendices

Appendix 1   Outputs of joint Trusts' Board session March 25

Appendix 2   Group Transition Committee TORs

Appendix 3   Culture and Engagement Plan

Appendix 4   Better Together Group engagement feedback report 18 Aug 25 /example engagement slide set

PAF Group feedback
slides 250721.pptx

Supporting information:

National Policy

In the last 4 years, a range of national guidance and legislation has been published, establishing Integrated Care Boards (ICBs) as statutory bodies and introducing a new legislative framework to foster collaboration between health and care system partners, including NHS Trusts. In parallel, guidance on provider collaboration, supporting complex change as well as building a shared purpose and vision have been introduced. Many of these documents are encompassed in draft national

guidance for Assuring and Supporting Complex Change - Shared Leadership and/or Governance Arrangements of NHS providers[1].

During 2024/25, Lord Darzi led an Independent Investigation of the National Health Service in England, publishing a report in September 2024. This was followed closely by a launch of a new 10-year plan to modernize the health service and address evolving needs. The goals are based on '3 shifts': from reactive care to preventative measures, from hospital-based care to community-based care, and from an analogue system to a digital one. And most recently in January 2025, operational planning guidance was published, including 2025/26 priorities as well as important guidelines for Neighbourhood health services and Elective reform.

NHS Trusts in Shropshire Telford & Wrekin have considered a number of collaborative arrangements.

Working together at scale: guidance on Provider Collaboratives (2021)

Prior to the implementation of the broader legislative framework, NHS England published guidance on provider collaboratives in 2021. This outlines the expected collaborative practices among providers, principles to support local decision-making, and various functional and organisational options that systems may consider in fulfilling the quadruple aim duties. By April 2022, NHS Trusts were mandated to participate in at least one provider collaborative. SATH has an established provider collaborative arrangement with University Hospitals North Midlands NHS Trust. SCHT?? And both SATH and SCHT work together with Robert Jones and Agnes Hunt Orthopaedic NHS Foundation Trust (RJAH) on Musculo-skeletal services development.

The guidance does not impose any specific obligations on certain types of provider collaboratives, and there are only limited restrictions on the functions they can perform. They should be inclusive and adaptable over time to include the most suitable arrangement of members to serve their populations and maximise the benefits of scale. When considering best practice and learning from other collaborations, it is clear that the form that NHS Trusts take across the NHS differs markedly - acute Trusts, community Trusts, mental health Trusts, combinations of these three types of Trusts, as well as partnerships with Local Authorities.   Similarly, the size of Trusts differs across the NHS. There is no direct correlation between the size or type of a Trust and its performance or ratings. And the form of collaboration also varies, albeit initial work between Trusts of similar service configuration (eg sets of acute trusts or sets of Mental Health Trusts) has been more prevalent.

Over recent years there has been a move to bring Trusts together into Groups. These consist of two or more Trusts, sharing varying degrees of leadership, governance and ways of working. Most do not entail a formal merger and as such

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[1] Assuring and Supporting Complex Change - Shared Leadership and/or Governance Arrangements of NHS providers. Draft NHS England guidance 2024.

the statutory organisations remain in existence. The Regulatory Frameworks for NHS Trusts relates to statutory organisations rather than any Group construct. Individual organisations are accountable for their statutory responsibilities, albeit they can deliver these through the Group arrangements.

Collaboratives are expected to collaborate with Place-based partnerships to support and enhance each other's work. Place-based partnerships coordinate the planning and delivery of integrated services locally, while provider collaboratives focus on scaling up and mutual aid across different locations, usually aligned with a local authority area. Within specific places, even more localised arrangements can be established around neighbourhoods to provide joined-up, proactive, and personalised care. The size and geography of ICSs influence the scale at which system objectives and activities should be implemented, compared to the responsibilities delivered at a local level. STW ICS has 2 established Place-based Partnership boards; some place-based planning takes place, but this remains limited in STW compared to some systems.

Operational Planning Guidance 2024/25 and 2025/26

The Operational Planning Guidance for the 2024/25 financial year emphasised collaboration by incorporating it as a recurring theme across various national objectives, such as achieving a balanced financial position, addressing quality and safety concerns, and supporting transformation initiatives. This collaboration involves collaborative arrangements with NHS organisations and broader system partners, particularly through provider collaborative agreements. The guidance reiterates the expectation that all NHS Trusts should be actively engaged in at least one collaborative effort aimed at fully realising the advantages of scale and transforming services for the future.

Guidance received for 2025/26 built upon the expectations for collaboration between providers, to enable improvements in operational and clinical productivity, move towards a balanced financial position, but also to set the foundations for a neighbourhood health model taking a population management approach. New models of care will be needed to realise the ambitions of the NHS 10 year plan, based on the 3 shifts:

1. moving care from hospitals to communities

2. making better use of technology (analogue to digital)

3. focusing on preventing sickness, not just treating it

The degree of integration and the governance arrangements that have been put in place, differs between Groups. It is recognised that not all have been successful, and some are already being unpicked or revised. Some however are seen to be thriving and having a positive impact for patients and staff. Lessons can be learnt from both scenarios.

The integration of services remains a common thread across government. This applies to the NHS (as seen in the approaches to the establishment of ICS', ICBs, ICPs, Integrated Care Strategies) but also in local government, as seen in the recent English Devolution White Paper which envisages the universal coverage of larger strategic authorities.

For many providers and systems, the primary objective of shared leadership arrangements is to enable and realise the benefits of closer collaboration, however we have seen a variety of drivers for these arrangements including:

•	as an important step to achieving strategic alignment and clinical support for closer collaboration between organisations

•	to allow more effective decision-making on key provider and system issues

•	to facilitate a move towards an operating model whereby strategic and/or operational oversight and decisions are made collectively between providers

•	to support horizontal and/or vertical integration

•	to improve the viability and/or sustainability of organisations

•	as a step towards a merger between organisations

•	to fill recruitment gaps

•	to leverage strong local leadership

•	to help support challenged organisations

A number of these factors will be relevant for STW ICS.

STW Population context
Our Population

Encompassing some of the most picturesque parts of England and Wales, the combined Trusts' catchment stretches from the Cambrian Mountains in the west, to Newport and the fringes of the Black Country in the east. Population of circa 500,000 in Shropshire Telford and Wrekin (STW) and a further 40,000 in North Powys.

The main towns include: Bridgnorth, Ludlow, Market Drayton, Oswestry, Shrewsbury and Whitchurch (in Shropshire); Newport, Telford and Wellington (in Telford & Wrekin); and Newtown and Welshpool (in Powys).

- For Shropshire Local Authority area, the population increased by 5.7%, from just over 306,100 in 2011 to around 323,600 in 2021, a similar rate to the overall population of the West Midlands (6.2%), but by a smaller percentage

than the overall population of England (up 6.6% since the 2011 Census). This area was the second-least densely populated local authority area across the West Midlands (after Herefordshire). The population has become older - between the last two censuses, the average (median) age of Shropshire increased by four years, from 44 to 48 years of age. This area had a higher average (median) age than the West Midlands as a whole in 2021 (40 years) and a higher average (median) age than England (40 years). The number of older people living in Shropshire over the age 65 was 82,000 (rising from 63,300 in 201). The number of people over the age of 65 accounts for 25.3% of the total population in Shropshire compared to 20.7% in 2011. In England this figure is 18.4%.

- For Telford & Wrekin Local Authority area, the population size has increased by 11.4%, from around 166,600 in 2011 to 185,600 in 2021. This is higher than the overall increase for England (6.6%) and the West Midlands (6.2%). The median age of the borough's population in mid-2022 was estimated to be 39.9 years. The borough saw one of the largest increases in population aged 65 plus in England between the 2011 and 2021 Census, with an increase of 35.7% (England 20.1%) – the highest increase of all West Midlands upper tier local authorities and the second highest of all 151 upper tier authorities in England.

About the Trusts:

The Shrewsbury and Telford Hospital NHS Trust (SaTH)

SaTH is a medium-sized acute trust, and the main provider of acute hospital services in STW and mid Wales. The main service locations are The Princess Royal Hospital (PRH) in Telford and The Royal Shrewsbury Hospital (RSH) in Shrewsbury which are located 20 minutes drive apart. Both hospitals provide a wide range of acute hospital services including accident and emergency, outpatients, diagnostics, inpatient medical care, critical care and maternity.

SaTH also provides services such as consultant-led outreach clinics in Telford, RJAH, at the Bridgnorth, Ludlow and Whitchurch Community Hospitals, as well as a Community Diagnostics Centre in Telford.

The Trust has a turnover of £650m and employs circa 7,900 staff; hundreds of colleagues and students from other organisations also work in our hospitals and SaTH is a major training provider for medical, nursing and Allied Health Professional (AHP) workforces. We benefit from around 300 volunteers, and our main charitable partners are the League of Friends of the Shrewsbury and Telford Hospital and the Lingen Davies Cancer Appeal which is based at The Royal Shrewsbury Hospital.

4 clinical divisions:

- Medicine and Emergency Care
- Surgery, Anaesthetics and Cancer
- Clinical Support Services
- Women's and Childrens.

Shropshire Community Health NHS Trust (ShropCom)

ShropCom provides community-based health services for adults, children and young people in STW, and the Brilliant Brushers Programme to children in Stoke and Staffordshire. The Trust provides services with people in their homes, and at over 75 sites in community settings and clinics. A very small number of people also receive inpatient care in the community hospitals at Bridgnorth, Ludlow, Whitchurch and Bishops Castle. The Trust employs circa 1,600 staff with a turnover of £130m.

ShropCom specialise in supporting people's health needs at home and through outpatient and inpatient care. The focus is on prevention and keeping people out of crisis so that they can receive the care and support they need at, or as close to home as possible.

Three clinical divisions:

Adults and Community Services Division, including:

- Community Nursing
- Community Therapy
- Specialist Services
- Inpatient Wards

UEC Division, including:

- Urgent Community Response – Rapid Response and Virtual Ward
- Minor Injuries Units
- Care Transfer Hub
- Diagnostics, Assessment and Access to Rehabilitation Treatment (DAART)

Children and Young People (CYP) and Planned Care Division, including:

- 0-19 services
- CYP therapy
- Children's Community Nursing
- Community Paediatrics
- Dentistry
- Musculoskeletal Service Shropshire and Telford (MSST)
- Outpatients and Advanced Primary Care Service (APCS)
- Covid Vaccination and School Aged Immunisations (SAIS)
- His Majesty's Prison (HMP)/Young Offender Institution (YOI) Stoke Heath

Appendix 1

Outputs of joint Trusts' Board session March 25
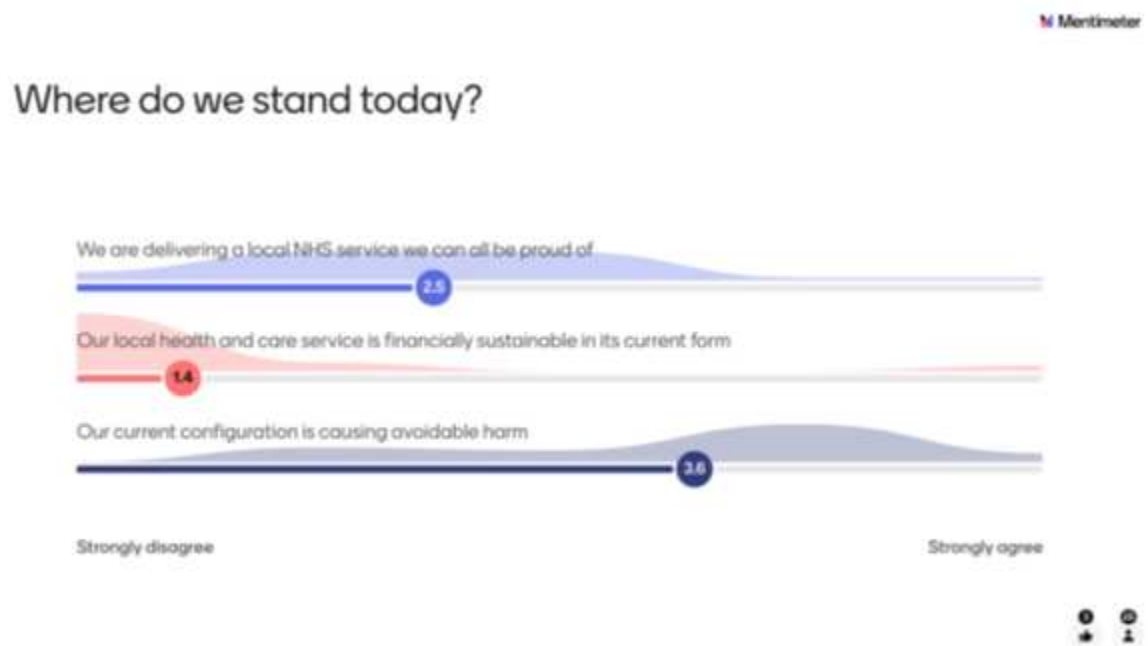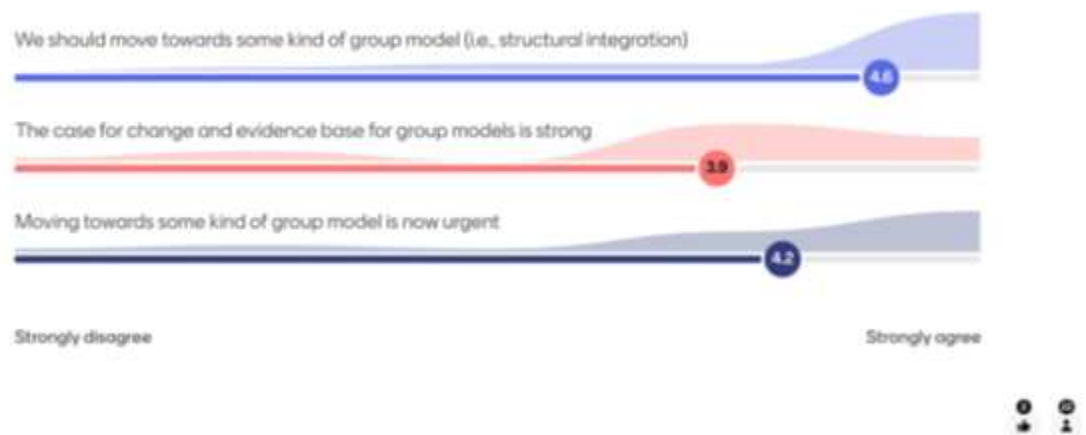
Which model do you favour?

19

4

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Informal collaboration	Strategic collaboration	Committees	Joint Committees	Lead provider	Shared/joint leadership	Single provider merger
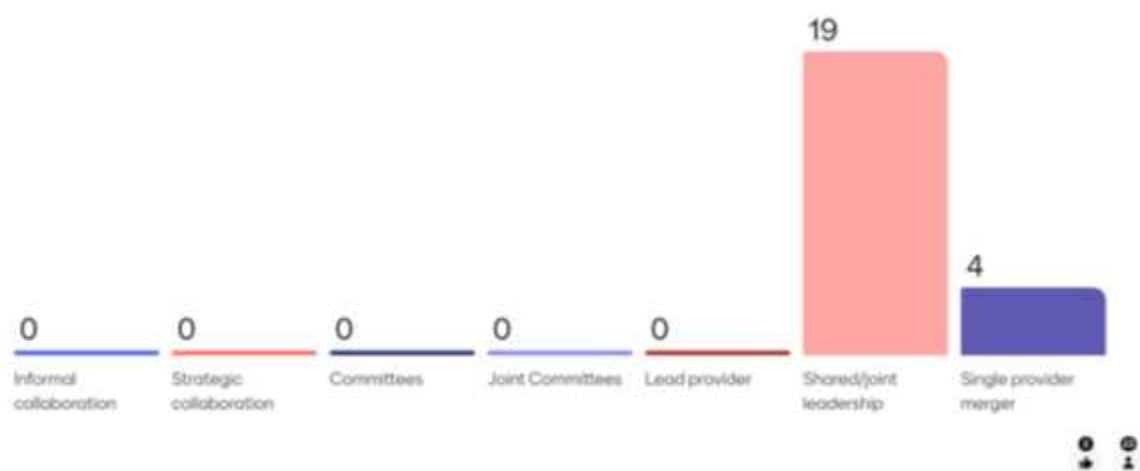
Where do you see the benefits of closer integration?

24 — Quality of care
19 — Continuity of care
15 — Use of resources/productivity
14 — Long-term sustainability
10 — Confidence/support of stakeholders
9 — Staff development/opportunities
9 — Innovation/change management
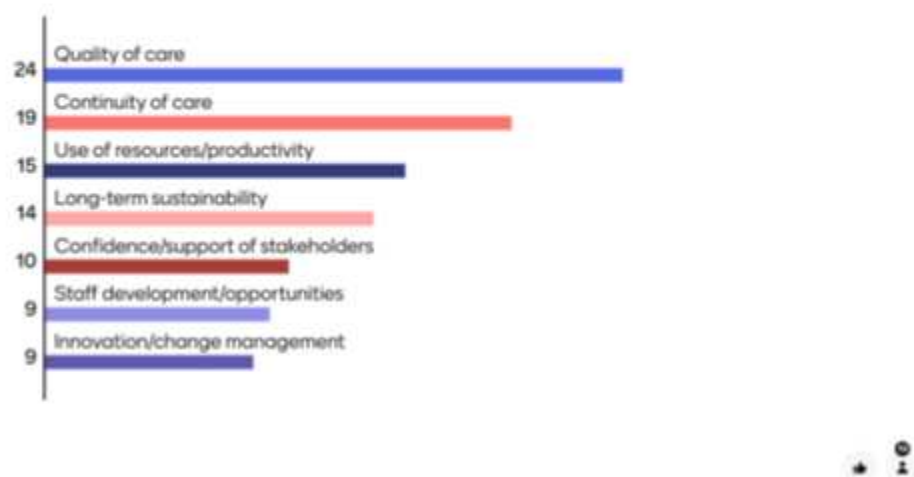
At our best, what is the essence of our distinctiveness?

52 responses

Draft Group Transition Committee (GTC)

Terms of Reference

1. Authority

The Group Transition Committee is established as a joint committee by the Trust Boards of both Shrewsbury and Telford Hospital NHS Trust (SaTH) and Shropshire Community Health NHS Trust (ShropCom). The Standing Orders and Standing Financial Instructions of the Trust Boards and the Group Partnership Working Agreement, as far as they are applicable, shall apply to the committee and any of its established groups, either jointly or individually.

The Group Transition Committee holds only those powers as delegated in these terms of reference and will report to each Board.

The Group Transition Committee is authorised to investigate or to have investigated and / or to seek further action or assurance in relation to any activity within its terms of reference. This includes referral of matters for consideration to another board committee or other relevant group.

2. Purpose of the Committee

The Group Transition Committee exists to scrutinise the robustness of and provide assurance to each Board on the development and delivery of a group model, the integration agenda and strategic aims and objectives for the benefit of our population.

The Group Transition Committee will be the lead committee for oversight of the development of the group model assurance document and the associated governance to develop a programme of integration focussed on the hospital transformation programme, the local care programme and shared services.

The committee will work with the other board committees to ensure that full oversight of the areas of responsibility is covered.

3. Membership

The members of the committee are:

(Chair) Non-Executive Director (Chair of SaTH and ShropCom)

Non-Executive Director (Vice Chair SaTH)

Non-Executive Director (Vice Chair ShropCom)

Chief Executive (SaTH)

Chief Executive (ShropCom)

Director of Strategy and Partnerships (SaTH)

Director of Finance (ShropCom)

Director of Governance (SaTH)

Director of Governance (ShropCom)

Director of Workforce and OD (SaTH & ShropCom)

Director of Communications (SaTH)

4. Attendance and Quorum

The committee will be quorate when four of the membership are present. This must include two Non-Executive Directors, and an Executive Director from each organisation.

By exception a deputy may attend on behalf of a member with the Chair's prior agreement.

If the Chair is unable to attend an alternative Chair will be nominated from one of the Organisations' Vice Chairs

Members should attend at least 75% of meetings each financial year but should aim to attend all.

The Chief Executive is the Executive Lead for the committee.

Other attendees may be invited to attend the meetings as appropriate.

5. Frequency

The committee will meet monthly for the first 12 months of establishment and will then be reviewed by each Board.

6. Specific Duties

The Group Transition Committee will:

• Consider and agree the strategic objectives of integration for onward approval of each Board

• Evaluate any risks associated with the delivery of strategic objectives and provide assurance to each Board that these risks are being effectively controlled and managed. If necessary, escalate such risks to ensure that timely and appropriate mitigation measures are implemented.

• Oversee the development of the outline, and subsequently, the full business case for a group model between SaTH and ShropCom

• Where appropriate the committee may request for deep dives to be undertaken to further understand any opportunities and risks of integration and any actions required

• Seek and receive assurance that all appropriate actions are being taken to ensure full participation in integration initiatives to support the move towards a group model

• Ensure that key enablers to the delivery of the integration agenda are carefully considered and included in the group integration plan and programmes of work and that these plans and programmes of work are appropriately aligned to the longer-term strategy, vision and values for the group.

• Review and provide assurance to the Board on those strategic objectives within the Board Assurance Framework, identified as the responsibility of the committee, seeking further assurance and actions where necessary. This may include the commissioning of 'deep dives' to identify the necessary improvements and actions.

• Agree and oversee the programme of work and establish any task and finish groups required to support its agenda.

7. Administrative support

The committee will be jointly supported administratively by the EAs of the Chief Executive for each organisation.

The committee will operate using a work plan to inform its core agenda.

Topical / emerging issues will be added to the agenda as required.

The agenda will be agreed with the committee chair and Executive lead prior to the meeting.

Agendas and supporting papers will be circulated no later than 5 working days in advance of meetings.

Items which miss the deadline for inclusion on the agenda may be added with permission from the chair.

Minutes will be taken at all meetings and circulated to members within 5 working days along with the action log and ratified by agreement of members at the following meeting.

8. Accountability and Reporting Arrangements

The chair of the committee shall report to the Board of each organisation after each meeting and provide an upward report on assurances received, escalating any concerns where necessary.

The committee will, where necessary, advise the Audit & Risk Committees of the adequacy of assurances available and contribute to the Annual Governance Statements.

The committee will refer any necessary issues outside its terms of reference, as appropriate, to the relevant board committee or other relevant group.

9. Monitoring effectiveness and Compliance with Terms of Reference

The committee will complete an annual review of its effectiveness and provide an annual report to each Board on its work in discharging its responsibilities, delivering its objectives and complying with its terms of reference, specifically commenting on relevant aspects of the Board Assurance Framework and relevant regulatory frameworks.

10. Review of Terms of Reference

The committee is established for an initial period of 12 months.

The Terms of Reference for the committee will be reviewed annually by the committee and submitted to each Board for approval and, together with the work plan, will be reviewed at each meeting of the committee to ensure they remain fit for purpose. The committee will on an annual basis review and approve the terms of reference and work programmes of all of its reporting groups.

Approved by:

Next Review Date:

Better Together

Culture and Engagement Framework Proposal for discussion: Group Model

Situation

The purpose of a culture and engagement framework is to align people, values, behaviours, leadership and organisational purpose to create a thriving and accountable culture. The primary focus of this paper is bringing together Shropshire Community Health NHS Trust (SCHT) and The Shrewsbury and Telford NHS Trust (SATH) under a Group model; however, it would be remiss to not also consider the overlap and alignment to other key workstreams (Appendix 2).

Leadership, Communication and Organisational Development (OD) are positioned as core enablers of this transformation—providing the behavioural, cultural, and strategic infrastructure necessary to deliver safe, compassionate, and high-performing care.

This is especially critical in the context of the Group model, where shared identity, equity, trust, and collaboration are essential for success. In developing the core components of this high-level plan (Appendix One) we have considered a number of national frameworks and strategies.

Background

The **NHS Culture and Leadership Programme** (Developed by NHS England and The Kings Fund) identifies the following core components:

- Discovery: Baseline diagnostic of culture using staff feedback, data and observation.
- Design: Co-created interventions to improve leadership and culture.
- Delivery: Implementation of changes and capacity building.
- Sustain: Embedding change and measuring impact over time.

This is underpinned by four key pillars.

1. Leadership behaviour and development

2. Compassionate, inclusive culture
3. Psychological Safety
4. Continuous learning and improvement

The NHS People Plan is a national strategy that sets priorities for employers and systems across four key themes: Looking after our People, Belonging in the NHS, New ways of Working and Delivering Care and Growing for the Future. The strategy is aligned with the **Long Term Workforce Plan (2023) and focuses on train, retain, and reform.**

The **NHS People promise** underpins staff engagement strategies, staff survey and wellbeing initiatives.
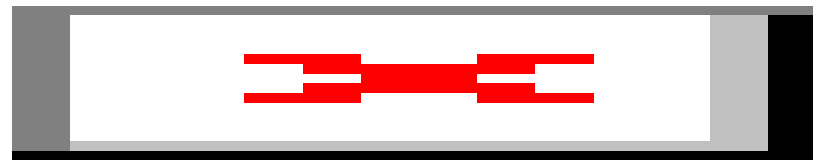
Civility and Respect framework focuses on encouraging respectful behaviours, tackling bullying and incivility. With core actions to set clear behavioural expectations, enable peer to peer accountability, leadership role modelling, creating psychological safe spaces. This should be integrated throughout all our workstreams.

NHS Impact framework is a structured approach to understanding, measuring, and demonstrating the impact of improvement work for improving patient care together. It is designed to help develop cultures of continuous improvement grounded in leadership capability building and measurement of outcomes. The 5 core components are: Shared purpose and direction, Leadership behaviours, People & Culture, Governance and infrastructure, Quality Management.

These collectively emphasise the importance of leadership behaviour, psychological safety, inclusion, and continuous improvement.

The **NHS Ten Year plan** published in July 2025 references the importance of having an engaged and motivated workforce to deliver the transformation and care to our local populations. It also refers to the Messenger report recommendations and further supports development of the right culture and leadership across the NHS underpinned by positive values/ behaviours, structured development, creating psychological safety and integration between services and staff groups.

Assessment

Culture and engagement frameworks will often be developed around a structure that covers the following key components:

- Building a foundation around the vision, values and overall goals.
- The enablers to support such as leadership commitment, psychological safety, equity and inclusion.
- Actions such as group engagement planning, listening mechanisms, reward and recognition.
- Outcomes and measures of impact such as staff / patient experience and retention, service improvement, patient outcomes.

The Joint People (& Culture) strategy is only as good as the actions people are taking to implement it, a shared culture connects individuals' motivation with organisational goals. It creates a sense of belonging where people can see how their work contributes, and cultural clarity enables consistent decisions at all levels- which is especially important when resources are tight and or rapid change is needed. Culture defines how things 'get done'- the unwritten rules and a transparent learning culture encourages innovation, and collective problem solving. Culture creates the emotional and behavioural foundation that makes change stick, keeps a workforce engaged and motivated, retained and energised. Leadership and OD are the delivery mechanisms that embed this culture—through capability building, co-creation, and behavioural alignment.

The feedback to date from colleagues has highlighted consistently the importance of communication, engagement and creating the right conditions for psychological safety. All these areas are fundamental to creating a culture that is unified, inclusive, high performing and future focused 2028 and beyond.

Recommendation

The purpose of this paper is to generate discussion, feedback and engagement to highlight the high-level milestones and indicative timeline to support the establishment of a Group Model (Appendix 1) alongside an awareness of further communication, OD and

engagement recommended as part of wider workstreams (Appendix 2). We also propose to discuss and review our plans with AQUA Alliance an NHS membership-based quality improvement organisation that works with health and care systems across the UK to improve quality, safety and leadership in healthcare. This is to ensure our plans are realistic, well thought through and ensures that the transformation is not just structural but cultural, behavioural and people centred. At a time of significant change, we recommend effective Leadership, Communication and OD capacity is available to support the change and culture programmes.

Appendix One

Step One: Build foundations and Readiness
Goal: To establish leadership alignment, governance and a clear shared vision

May- October 2025

Step Two: Engagement & Leadership alignment
Goal: Build leadership capability, psychological safety and common purpose

September 2025- March 2026

Step Three: Define and align Culture & Values
Goal: Create shared identity and ways of working across both Trusts

October 2025- April 2026

Step Four: Integration of practices
Goal: Align name, priorities, systems, processes and practices across both organisations

April 2026- March 2027

Step Five: Sustain the change Group Model/ readiness for 2028
Goal: Embed continuous improvement, innovation and cultural alignment

April 2026 - 2028

Step One:

Build a shared purpose and Vision/ Branding: Better Care, Better Together. Establish leadership alignment, and a clear shared vision. One NHS: Focused on patients.

Set up joint integration governance (Programme Board, relevant subgroups)

OD Diagnostic: Cultural assessment, values review, Staff Survey, EDI Data

Stakeholder impact assessment to agree engagement and feedback mechanism. Key aspects for each stakeholder to consider: Leaders- visible, inclusive, values led, Voice-mechanisms for feedback, Recognition, Learning & Development needs, Teaching, Involvement and Communication.

Step Two:

Structured leadership engagement programme.

Launch unified staff engagement and employee voice forums.

Design, communicate and involve on new group model structure.

Step Three

Shared Values and Behaviours: Co-create with staff to clearly define values and associated behaviours. Include patient advocate groups/ Volunteers/ staff networks/ staff side.

Design, engage and communicate values and behaviour framework

Embed values and behaviours into training, development, processes and recruitment etc.

Step Four:

1
Develop, engage and launch the **Joint People Strategy** aligned to Group goals.

2
Align identified key policies and procedures.

3
Start **integration of key systems**.

4
Launch unified staff offer: HWB, Education Learning.
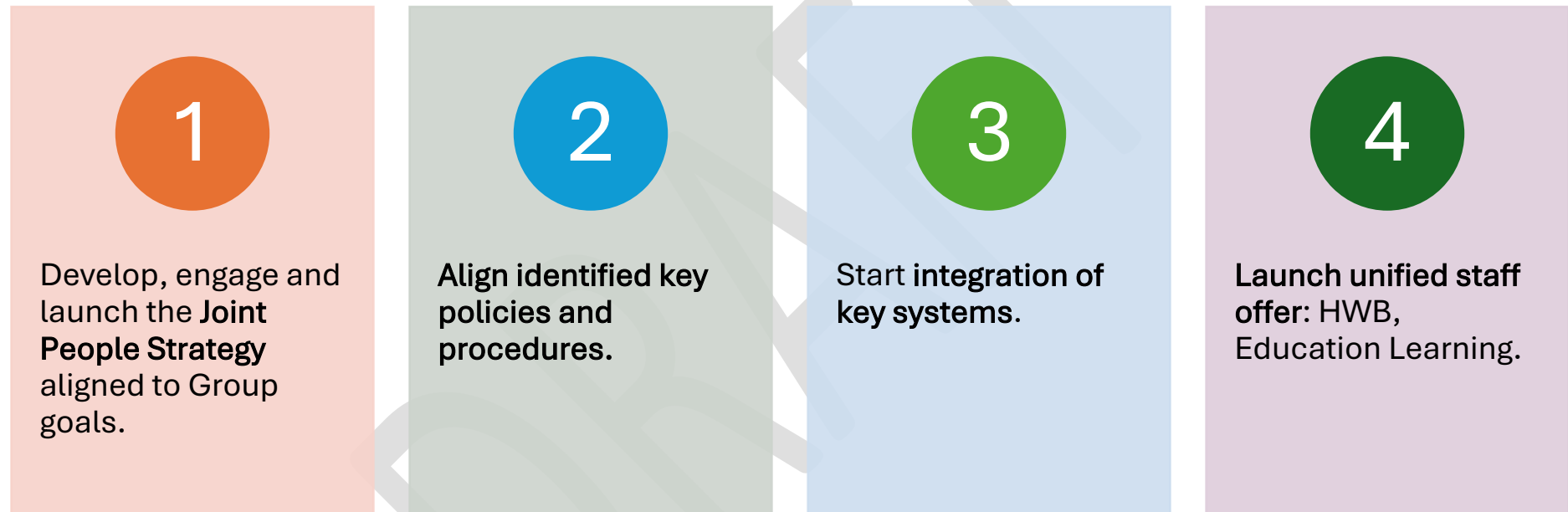
Step Five:

Evaluate OD impact via metrics: engagement, turnover, culture score, absence, FTSU data, pulse survey, EDI metrics, FFT, patient experience, advocacy staff survey.

Celebrate group formation with visible leadership and staff storytelling.

Launch continuous feedback loop.

Appendix Two

	Workstream Action	Group Model	Operational Plan	HTP/LCP	BAU
1.	**Build a shared purpose and Vision:** Better Care, Better Together Removing barriers for patients and staff. One NHS: Focused on patients *Be clear on the purpose and vision to give line of sight to the future.* *Incorporate branding/ Comms*	Step 1	X	X	X
2.	**Shared Values and Behaviours** Co-create with staff to clearly define values and associated behaviours. Engagement with others. (This needs to happen as part of design phase and after Discovery)	Step 1-3			X
3.	**Engagement Enablers/ Psychological safety** Stakeholder impact assessment to agree engagement and feedback mechanism. E.g. Leaders, comms, HR, Staff networks, staff, change agents, staff side, patient groups, patients, charity, university.	Step 1	X	X	X

	Key aspects for each stakeholder to consider: • Leaders- visible, inclusive, values led • Voice- mechanisms for feedback • Recognition • Learning & Development needs • Teaching • Involvement • Communication				
4.	**Cultural measures for impact** • Staff Survey results • Engagement scores • Absence and turnover data • Exit interviews/ stay • Speak-up data • Pulse surveys and listening events • Equality, Diversity and Inclusion (EDI) metrics • Risk log • Friends and Family Test • Patient experience ADD Patient measures	Step 1/5	X	X	X
5.	**Cultural Interventions-** actions to strengthen culture.				
	Early engagement roadshows- what is happening and why	Step 1		X	

-Staff -Patient groups - Volunteers - Community groups				
Culture workshops (Collaboration focus groups)– understand baseline, diagnostic	Step 2-3			
Developing our strategy/ priorities / values focus groups	Step2-3	X	X	X
Leadership Conference	Step 2/3		X	X
Team Charters Patient Charters	Step 4			X
Leadership Development				X
Civility & Respect Campaigns Internal/ external	Step 3			X
Recognition Events	Step 5			X
Culture / change champions	All/ Step 2		X	
Cultural team diagnostics				X
Regular Communication messages	All	X	X	X
Specific briefings for targeted feedback	All	X	X	X
Recognition/ celebrations of milestones	All/ Step 5	X	X	X
Coaching & Mentoring	Step 2	X	X	X
Structural alignment/ Job Design	Step 4		X	
Career coaching		X		X
Health & Wellbeing inc Psychology	Step 2-5	X	X	X
Management of Change		X	X	X
Education activities			X	X
Afina Team				X

	Bespoke OD Programmes for teams				X
	Alignment of policies	Step 4/5			
	On-boarding	Step 4			
	Research projects				X
	Promote academic funding/ development/ research as incentive				X
	Building Improvement capability			X	X
	Innovation hubs				X
	Trauma Informed approach				X
	Staff Survey/ People Pulse				X
6.	**Governance & Accountability** • Executive lead for Culture & Engagement (or Director lead) • Executive lead for patients' culture • Culture and Engagement Group/ steering Board • Regular updates to board on programme activities and indicators • Alignment to Joint People Strategy and Patient Experience Strategy	Step 1	X	X	X
7.	**Embedding culture into Systems** Ensure that culture is reflected in: • Recruitment and onboarding • Appraisal and objective setting • Reward and recognition • Policies	Step 4/5	X	X	X

	• Performance management • Internal communications • Change and transformation programmes • Teaching and learning • Research and Innovation				

DRAFT

Better Together Group Feedback Findings

1.0 Background

Shropshire Community Health NHS Trust (ShropCom) and The Shrewsbury and Telford Hospital NHS Trust (SaTH) are exploring the benefits of forming a Group model to increase resilience and continue to strengthen local services. This follows the approach taken by other NHS trusts across the country to improve care for patients through joint working and offer greater value for taxpayers.

Both trusts have worked together to listen to staff, partners and other stakeholders, in line with NHS England guidance. This feedback has informed the development of the Case for Change which will be taken to both trust Boards for approval. If the Boards approve the formation of a Group, the case for change will be taken to NHS England for assurance. This activity is expected to be during Autumn 2025.

This summary provides a thematic overview of feedback from staff and stakeholders during May-August to inform the Case for Change.

2.0 Engagement questions

The main questions of the engagement focused on:

- What are the benefits of becoming a Group?
- What are the issues/risks the trusts need to consider?
- What does success look like?

2.1 Engagement activity

Recognising that both Boards will retain two statutory organisations, the listening exercise has focused on staff, partners and patient representatives in line with NHS England guidance.

- Staff engagement
    - A survey ran between 19 May and 1 August and 110 members of staff across ShropCom and SaTH participated.
    - Existing meetings: for example Staff Side meetings/ attending Cascade/ Question Time
    - Face to face/ online listening events
    - A collaborative event (4 July), bringing together c.100 staff from across ShropCom and SaTH.
- Volunteers and patient representatives – through an online focus group
- Correspondence – both trusts have written to partners, patient representatives to inform them of the work and to offer meetings to answer any questions and understand any benefits or issues/risks.
- Public Assurance Forum – correspondence and attendance on 21 July

- Patient and Carer Experience Panel - correspondence and attendance on 8 August
- Attendance at partner meetings and existing engagement opportunities, see 7.0.

2.2 Ongoing engagement

This listening exercise was to help inform the case for change for the Group model. Both trusts are committed to ongoing engagement throughout 2025/26 and beyond as the Group progresses.

3.0 Report overview

This report summarises the feedback we heard during the listening exercise. Using a coding approach we have identified and summarised key themes. All feedback is anonymised.

4.0 Survey feedback

110 members of staff completed the survey with 48.18% from ShropCom and 47.27% from SaTH and 4.55% stating other, for example working across both organisations. The feedback included staff from a broad range of locations, including community locations, corporate centres and the acute buildings.
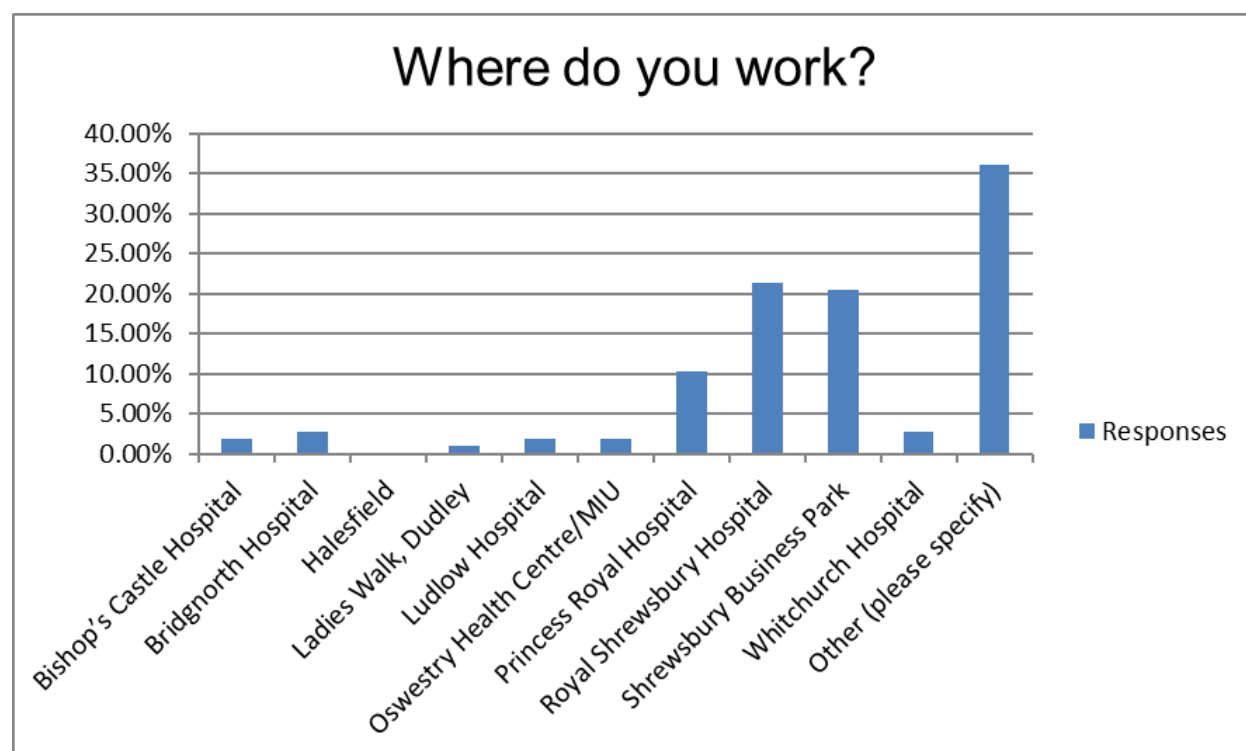
4.1 What opportunities do you think the Group model will bring for patients?

98 respondents answered this question. Key themes included:

- **Joined up care and services:** Many respondents highlighted the benefits of more joined up care, with integrated services and teams working together to

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provide a unified patient experience. Respondents frequently mention the need for joined up pathways, appointments and approaches to avoid duplication and fragmentation.

- **Seamless and streamlined pathways:** Many comments highlight the importance of seamless transitions between primary, secondary, acute, and community care. Streamlined patient journeys and simpler navigation of care pathways are seen as key improvements.
- **Improved communication:** Improved communication between teams, trusts, and care providers is repeatedly cited as essential for better patient outcomes and reduced duplication. Sharing records and systems is also emphasised.
- **Improved patient flow/discharges:** Respondents believe the changes can lead to improved flow through greater collaboration and communication. There was also feedback about breaking down barriers between teams through shared understanding.
- **Better access to services:** There is a strong focus on opportunities for services to be more accessible, including providing care closer to home through maximising estates, providing more local services, and easier access to the right care, at the right time by the right clinician.
- **Reduced waiting times:** Reducing waiting times for appointments, treatments, and transitions is a recurring opportunity.
- **Continuity and consistency of care:** Continuity of care, including sharing information and ensuring patients do not have to repeat their stories, is mentioned many times. Consistency in standards and care provision across the system is also valued.
- **Increased efficiency and reduced bureaucracy:** respondents mention opportunities to deliver more efficient models of care, with less bureaucracy, fewer handoffs, and more streamlined referrals and processes, ultimately leading to better outcomes.
- **Improved patient experience and outcomes:** A better overall patient experience, including easier transitions, improved outcomes and simpler pathways, is a key aspiration.
- **Information sharing and technology:** Investment in systems and technologies to enable better information sharing, shared digital systems, shared care records and improved communication between organisations.
- **No opportunities:** A small number of respondents state there are no opportunities/ benefits from collaboration. There are some concerns of the risks of a one size fits all approach being taken, a stretched workforce or the Group being a distraction.

4.1.1 Verbatim quotes

"I would hope that a more joined up process will improve patient flow through the very busyhealthcare system and improve outcomes."

"Very few, shaed mgrs will,lose sight of whats happening on the groundand more rules, policies will not work, a one size fits all is bad."

Survey: opportunities for patients

Themes	Mentions
Improved quality	1
Risk community care sidelined	1
Safer care	1
Worse care due to stretched services	1
Greater knowledge	1
Prevention/earlier intervention	1
Consistency	1
Right care, right place, right time	1
Reduce "lost to follow up" appointments	1
Improved remote care	1
Investment in systems/ digital/technology	1
Patient engagement/involvement in care	1
Simpler	2
Pooling of services	2
More equipment	2
Continuity of care	3
Improved outcomes	3
Reduced waiting times	3
Quicker care/faster access	5
Local services/ care closer to home	5
Shared records/systems/information	5
Improved access/accessibility to services	5
None	6
Easier navigation of care pathways	6
More efficiencies	7
Less bureacuracy/ streamlined processes	7
Better care / services/ experience	11
Improved communication	12
Improved flow/discharge	12
Cohesive care, pathways and standards	17
Seamless referrals/transition of care	17
Improved collaboration/ joined up care	23

4.2 What opportunities do you think the Group model will bring for staff?

96 respondents took part in this question. Key themes include:

- **Collaboration and joint working:** Respondents highlighted opportunities for mutual working, sharing knowledge, and reducing silo working. Some respondents value opportunities to work together across the whole patient pathway to improve care.
- **Efficiency and streamlining processes:** Some respondents highlight the benefits of reduced duplication, improving service delivery, and achieving economies of scale through collaboration. Employees seek smoother workflows and better resource utilisation.
- **Improved resilience:** Recognition that collaboration would provide more resilience to small teams. Also, that it will opportunities to increase access to consultant/clinical advice.
- **Career development opportunities:** Respondents recognise opportunities for career progression, access to training, and opportunities to work across entire pathways.
- **Improved communication:** Better communication across departments and organisations is a recurring theme. Access to shared digital systems will enable information sharing.
- **Culture:** Respondents highlight opportunities to remove the "blame culture" and to work together as "one NHS". Some participants highlight the importance of both trusts being equal partners and the need to take forward excellence from both organisations. A small number of respondents highlight perceptions and previous experiences of SaTH's culture as areas to be addressed/given reassurance on. Respondents also highlight the importance of building shared understanding and respect between teams.
- **Integration of systems and services:** Feedback suggests integrating systems to reduce barriers, improve records management, and enable seamless pathways and transitions between services.
- **Resource optimisation:** Respondents highlight the opportunities to make the most of the collective staff resource to deliver better care for patients and a better experience for staff. Opportunities include sharing resources and improving staffing levels to enhance operational efficiency and resilience within smaller teams.
- **Training and learning opportunities:** Access to shared training and development programmes is seen as a positive opportunity. Respondents seek opportunities for shared learning and skill enhancement.
- **No benefits:** A small number of respondents do not see any potential benefits of forming a Group. They mention risks of redundancies and job cuts, particularly in corporate teams. Alternatively, they highlight the risk that the benefits of integration are not realised due to capacity within teams or a lack of resource.

4.2.1 Verbatim quotes

"Engagement - the feeling/experience of being consulted with and being part of the solution.Collaboration - the sharing of knowledge/skills/best practices. Joined-up thinking, less workingin silos. Career/role/personal development opportunities.

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Bringing together processes/systemsachieving economies of scale/ability to negotiate lower costs with suppliers. To be an evenhappier, healthier, and more rewarding place to work."

"None - likely staff redundencies."

Survey: opportunities for staff

Horizontal bar chart titled "Survey: opportunities for staff". X-axis: Mentions (0 to 30). Y-axis: Themes.

- Improved parking: 1
- Working locally: 1
- Transparent leadership: 2
- Not sure/ N/A: 2
- Bulk buying: 2
- Share best practice: 2
- Better networks: 2
- Improved processes/systems: 3
- Service improvement: 3
- Access consultant/clinical support: 3
- Estates: 3
- Identity - one NHS: 4
- Job satisfaction: 4
- Better experience/environment: 5
- Other: 5
- Shared digital systems/information: 6
- Stronger/more resilient teams: 7
- Career opportunities: 8
- Communication/engagement: 9
- Improve whole pathway/shared risk: 9
- None: 10
- Staff utilisation: 14
- Shared approach/ understanding: 15
- Education/development: 15
- Efficiencies/reduced duplication: 17
- Collaboration/joint working: 28

4.3 What opportunities do you think the Group model will bring for communities?

86 participants answered this question. Key themes include:

- **Value for money:** Feedback emphasises the opportunities to improve efficiency through effective resource usage, service model delivery and

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reducing duplication. Aligning services with population needs and reducing health inequalities.

- **Improved access to care:** Some respondents highlight a Group model could improve access to services, through timely appointments and easier navigation of the system. Care closer to home is mentioned by many respondents. Suggestions include single points of contact and patients understanding the right services for their needs.

- **Joined-up and integrated care:** A recurring theme is the opportunity for a more joined-up and seamless system, with integrated pathways and cohesive care for patients.

- **Better patient outcomes:** Opportunities to improve health outcomes through continuous care, rehabilitation and more consistent service delivery.

- **Improved experience and outcomes** Feedback includes aspirations for improved community health, pride in local services, and greater engagement with residents. Some respondents highlight how better care and improved outcomes from preventative and joined up care with other partners will increase satisfaction and deliver the right care, right time through smoother pathways.

- **Improved communication:** Clearer communication and better information sharing are seen as critical to improving the experience and reducing confusion.

4.3.1 Verbatim quotes

"better quality of care and better waiting times"

"more joined up care, but caution if there is continued focused on the acute without the left shiftneeded to be more proactive."

"None that are clear"

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Survey: opportunities for communities

Themes	Mentions
Improved satisfaction	1
Investment in systems/digital	1
Single point of contact	1
Improved resources	1
More support	1
Other	1
Transparent messages	1
Targeted services reducing inequalities	1
Improved/ quicker referral routes	1
Less confusing	1
Improved safety	1
Timely appointments	1
Improved quality	1
None	1
No negative difference if transition smooth	1
Better rehabilitation	1
Not sure	2
Shared information and patient access	2
Reduced waiting times	2
Patients engaged in their care	2
Right care, right staff, right place, right time	2
Access to the right services for needs	3
Improved resources	3
Communication and engagement	3
N/A/ Not sure	3
Improved flow	3
Better patient experience	4
One NHS system	4
Improved health outcomes	5
None	6
Improved efficiency	6
Care closer to home	6
Consistent service/ continuity of care	7
Improved access	8
Improved pathways/processes	9
Value for taxpayers	10
Better care/better services	11
Improved collaboration/joined up care	16

4.4 Are there any issues the Boards need to consider and plan for?

84 respondents took part in this question. Key themes include:

- **Staff concerns around change, job losses and wellbeing:** A significant number of responses highlight the need to listen to and support staff through change and the uncertainty of job security. Some highlight the impact of organisational changes on wellbeing and morale. Mixed comments around opportunities for redeployment, travel and capacity/ratio of administrative staff. Staff highlight a need to feel valued.
- **Leadership, governance, and accountability:** Effective leadership, clear vision and priorities, supported by effective governance structures, and accountability are seen as critical. Suggestions include joint recruitment, board restructuring and ensuring leadership is not dominated by one trust.
- **Communication and engagement:** Clear, transparent, and timely communication is mentioned frequently as essential. Respondents call for a single, unified voice and effective engagement.
- **Financial pressures and resource allocation:** concerns about financial deficits, cost-cutting, fair distribution of resources, and the impact of SaTH's financial situation and reputation on community services are prevalent.
- **Digital systems and process integration:** Respondents highlight the incompatibility of digital systems, lack of shared records and a need for efficient IT solutions to support integration and release capacity. Equally, there is recognition a one size fits all approach may not be appropriate.
- **Collaboration and shared vision:** Need for genuine collaboration, shared goals, clear leadership and a unified vision of joined up care across pathways is highlighted. Some concern of the dominance of the acute and Board representation being needed from both trusts. Respondents stress importance learning from other Groups, working with partners and remaining flexible.
- **Organisational culture and integration:** Many comments focus on the challenges of merging two organisational cultures. Issues include reported experiences or perceptions of toxic environments, bullying, differing attitudes towards reporting risk and the fear of negative cultural traits spreading.
- **Community services and local needs:** Respondents emphasize the importance of maintaining focus on local needs, maintaining community hospitals, and not letting acute pressures dominate.

4.4.1 Verbatim quotes
"The Group model must be strategic, consistent and have robust improvements plan to share toall staff that are easy to understand and not lengthy."

"SCHT is a small trust and there is a belief that the acute Trust will not listen to the voice of theSCHT."

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"Incompatibilities of digital systems and poor efficiency of access.Addressing a lack ofaccountability from SaTH departments/wards when transferring patients that they havemedically misrepresented.An overall reduction in audit/tic box exercises that are neither productive or essential."
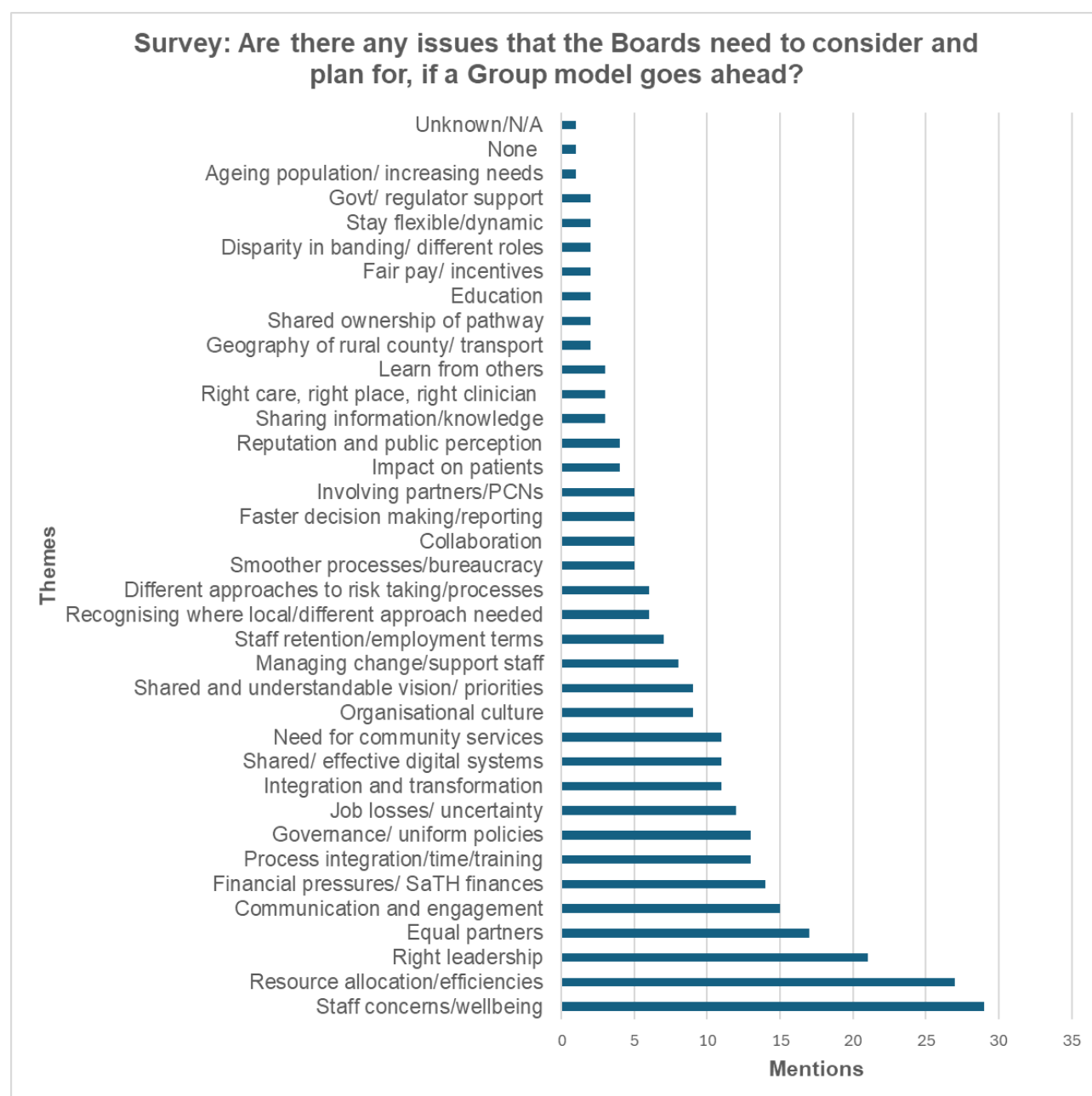
4.5 Are there any risks or barriers?

84 participants took part in this question. Key themes are:

- **Reluctance to change**: Staff reluctance and fear of the unknown are perceived as barriers to change.
- **Communication and engagement**: Clear vision and involving staff at all levels are highlighted as essential to building buy-in, collaboration and change. Respondents report a risk of top-down approaches leading to a decline in staff morale, loss of staff retention and poorer care.

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- **Resource allocation and investment**: Some concerns around effective use/availability of workforce, particularly around lack of financial resource for investment and workforce efficiencies whilst implementing change. Some respondents are concerned SaTH financial position might impact ShropCom.

- **Governance and pathways**: The need for streamlined governance and seamless pathways between community and secondary care is emphasised. Clear direction and consistent processes are necessary to ensure smooth transitions and avoid confusion among staff and patients. Providing a single point of contact was also seen as a benefit for patients and staff.

- **Capacity and operational risks**: Concerns around capacity and performance,

- **Concern around uncertainty**: Some concerns are raised around the level of uncertainty through change and fears of redundancies and increased workload. Some respondents stress the importance of supporting staff through change and effective resource utilisation to avoid negative impacts on patient care and staff wellbeing.

- **Cultural and structural challenges**: Differences in culture, the way risks are handled and processes are mentioned. Respondents talk of the risks of not streamlining processes and systems, but equally about ensuring flexibility is retained to allow necessary differences to deliver partnership working or population need.

- **Patient-centred care**: Ensuring patients do not experience disruptions in care during any change.

- **Equal partners**: Some respondents highlight importance of both organisations being equal partners and ensuring there is not dominance from an acute perspective to support the ambition of more care in the community.

4.5.1 Verbatim quotes

"still remain as two organisations and nothing really changes."

"Failure to engage people in the process will lead to mistrust. If it feels top down, people will notengage and will feel any change has been imposed."

"lack of staff support, down banded have a negative effective on staff morale which ultimatelyimpacts on patient care.happy staff =happy patients/residents."

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Survey: Are there any risks or barriers to consider?

Theme	Mentions
Learn from others	1
Disparity in bandings/roles	1
Empower staff	1
Gaps during transition	1
Avoid consultancy costs	1
Reputation	1
Worst of both trusts	1
No improvement/lack of change	1
None	1
Time/capacity for change	2
Politics/regulators	2
Too big	2
Bureaucracy/pace decision making	2
Right people, right skills, right place	2
Lots of issues/risks	2
Collaborative pathways	2
SaTH reputation/performance	3
Working with partners	3
Not recognising differences between trusts	3
Different levels of risk	3
Staff wellbeing	3
Patients/ population need/expectations	4
Support for staff/ change management	4
Lack of clear/shared vision/strategy	4
Cultural clashes	4
Lack of collaboration/culture change	4
N/A/ unknown	4
Lose focus on patients/impact patients	5
Morale	5
IT system integration	6
Capacity pressures	6
Staff retention/frequent changes/uncertainty	6
Job losses/downgrading	8
Inequality	11
Communication and engagement	11
Governance/structures/ leadership	14
Lack of buy-in/fear of change	15
Financial constraints	18
Resource utilisation	19

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5.0 Feedback from staff focus groups and briefings

A series of events were organised to capture feedback from staff. These included online briefings and online/face to face focus groups. An estimated 864 members of staff participated in the sessions. Comment cards were also provided for individual feedback.

Themes were similar to the survey feedback and the following tables outline the key themes mentioned.

5.1 What are the benefits of a group model?

Events: benefits of forming a Group

5.2 What are the issues or risks in forming a group?

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Events: issues or risks to consider

Theme	Mentions
Leadership	1
Align processes/policies/roles	1
SaTH reputation/performance	1
Access to GPs/social care	1
Risk of centralisation	1
Access to corporate services	1
Staff workload/burnout	1
Lose focus on patients/impacts care	2
Pressures in system	2
No real change	2
Complexity/confusion during change	2
Patient choice/empower	2
Training - access	2
Loss of identity	2
Different geographies	3
Staff wellbeing	3
Support for teams leading change	4
Different bandings/responsibilities	4
Culture differences	4
Volume of change/uncertainty	4
Digital systems - not one size fits all	5
Time/capacity for change	6
Work with partners/GPs	8
Inequality between trusts	8
Cost efficiencies/corporate/jobs	15
Communications and engagement	16

5.3 What does success look like?

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Events: what success looks like

Theme	Mentions
Reduced travel	1
Attracting research opportunities	1
Digitalisation community care	1
Improved tools/systems	1
Access to corporate support	1
Shared vision/objectives	2
Improved staff satisfaction/morale/respect	2
Improved reputation	2
Right time, right place, right staff	2
Share best practice/learning	2
Career opportunities	3
Timely care	3
Integrated care - whole pathway	3
Use of MIUs/ unplanned pathways	3
Reduced waiting lists/times	3
Shared estates/resources	4
System working - partners	4
Civility and respect/culture	4
Improved staff wellbeing	5
Improved retention/recruitment	5
Full staffing/staff utilisation	5
Single NHS - person focused	5
Public awareness/understanding	5
Opportunities for education and…	5
Improved resilience	5
Improved digital/shared systems/records	6
Investment/enhanced services	6
Equal partners	6
Left shift/care in community	7
Efficient services/value for money	7
Better care/experience/outcomes	9
Communications/engagement	10
Improved pathways/continuity for patients	11
Prevention/community care/neighbourhoods	11
Improved relationships/collaboration	14

6.0 Collaborative event for staff

On 4 July over 100 members of staff were invited, from across both trusts, to attend a collaborative event. Attendance included representation from clinical, nursing, maternity, Allied Health Professionals, chaplaincy, facilities, estates, corporate staff,

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Galvanise leadership participants and staff networks. The event was an opportunity to:

- Build trust by understanding similarities and differences
- Discuss the benefits and issues/risks of forming a Group
- Start work to form a shared purpose
- Look ahead to the future – what does success look like by 2028 and 2035
- Identify initial actions for 2025/26

6.1 Opportunities

Staff were asked: In two words what opportunities would a Group model bring?

6.2 Benefits of forming a Group

Collaborative event: benefits of forming a Group

Themes	Mentions
Standardisation	1
Reducing inequalities	1
Improved morale	1
Greater voice as partnership	1
Neighbourhood teams / primary care	1
Improved performance	2
Shared leadership	2
Less bureaucracy	2
Working with partners	2
Preventative care	2
Improved flow/ discharges	2
Reduced waiting times/ delays	3
Increased research	3
Better care	4
Staff retention/ recruitment	4
Access to consultants/clinical teams	5
Care closer to home/left shift	5
Career opportunities	5
Right time, right place, right staff	6
Digital investment	6
Better place to work	6
Service redesign across pathway	6
Shared vision/future focus	7
More respect and shared understanding	8
Improved communication and engagement	8
Reinvestment /expanded services	8
Shared estates/resources	9
Efficiencies/added value /productivity	9
Improved education and development	10
Shared digital systems/ records	12
Improved resource/staff utilisation	14
Sharing best practice/ information	15
Seamless pathways/ transition between care	15
Improved collaboration/joint working	16

6.3 Issues or risks for the Board to consider

Collaborative event: issues or risks to consider

Themes (top to bottom) with Mentions:
- Realistic — 1
- Loss of flexibility — 1
- Clinically led — 1
- Remote working — 1
- Overreliance on technology — 1
- Different geographies — 1
- Loss of identity — 1
- Investment in digital — 1
- Understanding of different trusts/services — 2
- Population needs/inclusive — 2
- Staff wellbeing/morale — 2
- Align processes/policies/restructuring — 2
- Culture differences — 2
- Digital systems - not one size fits all — 2
- Inequality between trusts — 2
- Duplication/gaps/bureaucracy — 3
- Clear roles/responsibilities needed — 3
- Volume of change/uncertainty/fatigue — 3
- Culture change needed — 4
- No change/does not work — 5
- Complexity/confusion/distraction — 5
- Finances — 5
- Time/capacity for change — 6
- Cost efficiencies/corporate reductions/job… — 6
- Working with other partners/primary care — 9
- Lose focus on patients/impacts care — 10
- Lack of communications and engagement — 16

6.4 What success looks like

Collaborative event: what success looks like

Chart showing Themes (y-axis) and Mentions (x-axis, 0–10):

- Better care / better patient experience: 9
- Efficient services/value for money: 7
- Improved communications and engagement: 6
- Shared leadership: 6
- Prevention/ community/ neighbourhood: 5
- Improved digital/ access to records: 5
- Integrated care across whole pathway: 5
- Shared vision/ priorities: 5
- Improved pathways/care: 4
- Improved relationships/collaboration: 4
- Share best practice/learning: 4
- Improved reputation: 4
- Redesign services across pathway: 4
- Improved staff resource: 3
- Improved staff satisfaction/morale/respect: 3
- Compassion/person-centred: 3
- Improved resilience in teams: 2
- Education/ development: 2
- Right time, right place, right staff: 2
- Shared estates/resources: 2
- Improved tools/systems/policies: 1
- Reduced waiting lists/times: 1
- Clinical excellence: 1
- Greater voice/influence: 1
- Benefits to local economy: 1
- Less complaints: 1

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7.0 Stakeholder feedback

We invited participants from the Public Assurance Group, including Healthwatch and Llais partners, patient representatives and volunteers from both organisations to attend an online focus group to discuss the Group Model and inform the development of the Case for Change. The event followed a similar structure to other engagement exploring benefits, issues/risks and understanding what success looks like. The event was led by Andrew Morgan, Chair in Common, with executive support from both trusts. 17 attendees participated in the focus group.

Further engagement activity also took place with presentations to the Public Assurance Forum, PACE, PACE Children and Young People Group, Primary Care Network Board and the Joint Health Overview and Scrutiny Committee.

Key themes included:

7.1 Benefits

- Integrated pathways across whole footprint
- Improved consistency and better working
- Care closer to home
- Seamless care and less waiting times in A&E
- Improved discharges and fewer readmissions
- Shared digital systems
- Shared vision and goals
- Reduced duplication
- Joint working, so a patient does not need to repeat information
- Having a single point of contact
- Easier to get information
- Shared staffing/expertise to improve care and experience
- Career development opportunities for staff
- Improved communication
- Better education to highlight importance of discharge letters

7.2 Issues/risks

- Acute (hospital) services may dominate executive attention
- Learning from past attempts at integration
- Current financial and operational challenges of the hospital trust
- Community may be overlooked in strategic planning
- Need to move away from hospital staff versus community staff
- Delays in transformation/improvements
- Need for communications and genuine engagement
- Patient information might get missed if transferred between services
- More confusing where to go – if more services/buildings
- Accessibility – not relying on digital communications

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- Is the timeline realistic/achievable?

7.3 What does success look like?

- Better quality of care
- Seamless referrals with right service, right time, right staff
- Closer working with patient groups/voluntary sector
- Volunteering opportunities across SaTH and ShropCom
- More volunteering, for example palliative home care, prescriptions, transport
- More patients supported in the community
- More community health and wellbeing hubs
- Focus on prevention
- Shared standards and rules whichever trust using
- Improved staff morale
- Culture – better place to work and receive care
- Happy, motivated, less stressed staff
- Greater training and development for all levels
- Improved flow from A&E to discharge
- Improved health and outcomes for patients
- Increased collaboration and improved pathways between primary, community and secondary care and other partners
- Better partnership working.

7.4 Verbatim quotes

"This needs to be the biggest priority."

"Great idea"

8.0 Next steps

This listening exercise is only the start of the communications and engagement activity. We continue to offer briefings to local community groups and use any existing engagement opportunities, including roadshows in the community and our hospitals, to answer questions and seek feedback as the Group model develops.

If proposals to form a Group are approved by both Governing Boards and NHS England during Summer/Autumn 2025 further engagement activity will help inform the vision, values and priorities of the Group. High level milestones include:

Milestone	Communications and Engagement	Summer	Autumn	Winter	Spring
Development, approval and submission of Case for Change to NHS England	To be reviewed at Trusts Boards Public summary of Case for Change				

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Meet the new shared Chief Executive*	Engagement with staff and existing stakeholder meetings				
Annual General Meetings	Both Boards to provide update on progress				
Developing a shared purpose/vision and values	Focus groups with staff/patients/communities to inform new vision and values and priorities				
Leadership Summit	Collaborative event				
Collaboration/focus groups	Focused on specific priorities/ shared services – opportunities to build collaboration/discussion				
Developing our strategy/ priorities	Focus groups with staff/patients/communities to inform strategy and plans				
Launching our Group/ vision and values	Communications				
Launch of Group priorities/operating plan	Communications				
Reward and recognition as a Group	Refining existing activity				

*subject to recruitment process and commencement dates.

Further communications and engagement plans are being developed to inform future phases. This will work alongside the Cultural Development programme.

9.0 Further information

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