NHS Shropshire, Telford and Wrekin Board – Date 24 September 2025 – Questions received from members of the public

QUESTION NUMBER	Submitted questions	Summary Response
Q1	**GP-Led Urgent Care Services** I believe there is still a significant number of FOI requests regarding GP-led Urgent Care that have been left in limbo by the ICB. Will the ICB now respond to these?	All FOIs that have been received have been responded to by the ICB. Information that can be shared under an FOI application has been made available and where there are legitimate reasons for an exemption to be applied, these have been made clear in responses back to the applicant.
Q2	Will the ICB outline to the public the model of care that will be used from 1st October in the GP Out-of-Hours service?	The model of care can be found within the Service Specification against which bids were put forwards as part of the procurement exercise. GP Out-of-Hours services will continue to be delivered as is from the same locations, with the same response times as per the specification. HealthHero will start to also utilise the options of video consultations as the service embeds as an option for those patients who wish to use it as an alternative. The public will see no change and all the staff delivering this part of the service have transferred across to the service. 80 Local GP's have also signed up to HealthHero to provide out-of-hours sessions. The Palliative Care line will also be delivered as at present via a separate dedicated phone number. The Care Coordination Centre Single Point of Access (CCCSPA) element of the service will operate during the same hours across 7 days a week and will focus on admission avoidance and alternatives to hospital, delivered by Advanced Care Practitioners who are prescribers with oversight and input from a GP. This differs from the previous model which was delivered via non prescribing clinicians with no senior clinical oversight. This has been commissioned to ensure that we are developing as many alternatives to hospital attendance and admission as possible to support the delivery of our system Urgent and Emergency Care Plan and in line with the ambition within the 10 Year Plan of the shift from hospital to community.

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		The CCCSPA model also includes work with West Midlands Ambulance Service to support the triage and alternative care pathways for Category 3 calls which will in turn ensure that, wherever, possible patients can be cared for in their own homes. The ICB also commissioned an Outbreak Service as part of the model in line with national best practice which will cover any infectious disease outbreaks across Shropshire, Telford and Wrekin. This is a new part of the service with only flu covered previously.
Q3	Will there be performance targets for clinicians that are the same or similar to those applied by Medvivo/HealthHero in its SW England service?	The performance targets are not set by the ICB. It is the responsibility (as with other NHS providers) of HealthHero how they manage the productivity of their teams to ensure patients can access timely care and support when required. However, it is important to note that as part of the procurement process, the ICB required all bidders to submit their capacity and demand models which included the time allocated to telephone triage and HealthHero's assumptions do not differ from the operational model of the previous GP Out-of-Hours service.
Q4	Has HealthHero been awarded any further funding to provide the Care Coordination Single Point of Access Service? (The lack of staff for this service, until a very few days ago, obviously caused concern about what service model was intended. An explanation of the model and any intended changes to it would be welcome.)	The funding for the CCCSPA model sits as part of the overarching block contract for the service. The CCCSPA will be delivered by Advanced Care Practitioners who are prescribers with oversight and input from a GP. This differs from the previous model by increasing the clinical input into this aspect of the service. Previously it was delivered solely via non prescribing clinicians with no senior clinical oversight. Information on what the CCCSPA is commissioned to provide can be found within the Service Specification. The ICB are aware that information relating to CCCSPA and the staff transfer processes was shared via social media. Unfortunately this was not an accurate reflection of the position where ongoing discussions were being held.

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		HealthHero have transferred staff who are eligible into the new service, have recruited new members of staff, and are also out to advert for remaining vacant posts. No additional funding has been made available over and above what was evaluated and put forwards as part of the procurement exercise.
Q5	Can the ICB report on progress in its evaluation of the (unexpectedly ceased) Falls Response service? Can the ICB rule out any plan to quietly award this contract to HealthHero?	The Falls Response Service was a time limited pilot using non recurrent NHS England money and there is no recurrent budget to commission this service. The evaluation of this service is not yet complete, but should this be a service the ICB wishes to commission in the future, this would need to be procured under the Provider Selection Regime (PSR). As this would be a new service, this would either need to be via a competitive procurement or Most Suitable Provider and the ICB would undertake market engagement when making the assessment of the recommended method of procurement. The ICB must comply with PSR Regulations, and we also must publish all contract awards on our website and via a system called Atamis. Therefore, all contract awards are publicly available.
Q6	**Healthy Ageing and Ophthalmology** Healthy Ageing is about more than services that respond to frailty. Can the ICB be mindful of this in its development and implementation of a Healthy Ageing strategy? A South Shropshire resident had cataract surgery in both eyes several years ago. This restored vision, and stopped what was becoming a pattern of increased falls and reduced mobility. Unfortunately, they now have bilateral 'Posterior Capsular Opacification' (colloquially known as	Thank you for the comment which we will be mindful of. We are working closely with local councils and their plans and support for the population around ageing. While the Healthy Ageing Strategy addresses the medical condition which is Frailty it is intended this will dove-tail with other support for people who would benefit from support, to prevent deterioration in partnership with the voluntary sector, councils, and primary care (including GP services, pharmacies, and optometrists)

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	'secondary cataracts'). The impact is much the same as the original cataracts and markedly affects quality of life. Two recent falls are probably related to poor vision, and other chronic conditions that affect balance add to the risk of future falls. This is a likely route to worse mobility and reduced quality of life.	
Q7	A visit to a local optometrist led to the PCO diagnosis and to a referral to Hereford Hospital for relatively straightforward YAG laser treatment. The referral was not acknowledged by Hereford. A follow up query from the resident led to the optometrist saying "Don't expect to hear from them for at least a year". The individual was advised by the optometrist that SaTH's waiting times would be similar, and it was probably better to remain on Hereford's waiting list. (The only communication from Hereford to date, several months on, is a text message to initiate a waiting list review). Is the ICB confident that it commissions adequate ophthalmology services?	There are a range of different community ophthalmology providers available, all with their own waiting times, and where someone goes is linked to patient choice. The pathway we have in place is that the optometrist, having identified a need for ophthalmology (in this case secondary to cataract surgery), refers the individual to the Referral Management Centre for ophthalmology, and that team then contacts the patient and offers the options/choice on where they can go, and current waiting times is usually part of that conversation when agreeing where to go and making a choice. The ICB is confident that we commission a good range of ophthalmology services and that choice is offered to all patients.
Q8	**Patient Experience and Transformation** A Shropshire resident has had serious chest pains and anomaly on ECG found in ED. Research shows that that non-heart attack chest pain can be significant to prognosis. The individual lost both their parents to heart attack when they were about the age this individual is now. If they have, for example, a re-entrant arrhythmia, this is treatable – but without treatment, could mean sudden death. The ED would not refer to Cardiology, and the individual has had to approach their GP for this referral. That non-direct referral has introduced significant delay for a high-	I can confirm that we have raised this with the Shrewsbury and Telford Hospital Trust. They have expressed how sorry they were to hear of this resident experience. The majority of referrals to cardiology do come from general practice who know their patients' medical history well. In urgent cases the Emergency department can make referrals to cardiology. Unfortunately, it is not possible to give a more specific response, but the Shrewsbury and Telford Hospital Trust PALS service would be happy to assist this resident if they get in touch. Please follow this link for contact details - Comments, Concerns, Complaints & PALS – SaTH

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	risk patient. Can the ICB as commissioners raise this with SaTH and ensure that direct referrals from ED are made according to clinical need?	
Q9	Also, there have been many previous assurances about improved cardiac care as part of Future Fit/Hospital Transformation Plan. Is there a Cardiology Cath lab in the current transformation plans?	The Shrewsbury and Telford Hospital Trust have confirmed that there is a plan for 2 Cath Labs at Royal Shrewsbury Hospital as part of the Hospital Transformation Plan.
Q10	The recent decision to close the two Rehabilitation and Recovery Units came as a surprise, with no public involvement (and apparently without joint decision making with NHS partners locally). Can the ICB outline how it satisfied its 'duty to involve'?	The Rehabilitation and Recovery Units (RRUs) were introduced 18 months ago as a required measure to support planned modular ward capacity at both hospital sites. As part of a broader, long-term approach to enhance care closer to home, and in line with the national NHS 10-Year Plan, these units are now gradually closing and will be returning to acute use in the near future. The transition does not represent a significant service change, but rather a planned shift in how care is delivered - building on what we've learned from engagement exercises and aiming to better meet the needs of our communities. The change was agreed jointly and in partnership. The ICB has been engaging regularly through system forums, staff consultations, and public involvement programmes (such as Change NHS and the Big Health and Wellbeing Conversation) and we remain committed to involving patients, carers, and the wider public as the changes are embedded. For more information, please refer to the FAQ document on the NHS Shropshire, Telford and Wrekin website.
Q11	How much money is saved by closing the RRUs and how much money is designated for immediate reinvestment in	Please be assured that this is not a cost-saving measure. The £3.6 million released from the closure of the RRUs is being reinvested

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	community services? (I.e. is this a cost-saving measure in the short-term?)	directly into strengthening community-based services. This includes enhanced therapy and reablement, the Care Transfer Hub, and the Urgent Community Response service. This scheme was never designed to achieve financial savings. Its primary aim is to improve urgent and emergency care pathways, enhance winter preparedness, and provide more personalised care closer to home, where we know people often recover more quickly and comfortably. To read more, please refer to the press release issued on 28 July, as well as the FAQ document for this programme.
Q12	Will the ICB consider commissioning additional rehab and recovery beds at community hospitals – which is arguably where some of those RRU beds should have been located in the first place?	Patients who would have previously used the RRUs are being supported through enhanced community rehabilitation at home, reablement, and use of community hospital beds or short-stay placements where required. We are actively reviewing community hospital capacity as part of the Out of Hospital model to ensure step-down and rehab support is available where clinically appropriate. Please refer to the FAQ document for further information.
Q13	Has the ICB considered the reduced access for Telford patients as the modular wards are now to be based only at RSH?	We recognise this concern. The siting of modular wards at RSH was determined by operational and clinical feasibility. To support equity of access, patients from across the county will continue to benefit from strengthened community services, expanded Urgent Community Response teams, and enhanced discharge planning. These services are designed to reach people at home, wherever they live, and reduce reliance on inpatient beds. In addition to the above, the PRH site will be increasing its capacity regarding acute beds and assessment capacity for frailty

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		For more information, please refer to the NHS Shropshire, Telford and Wrekin website.
Q14	Can the ICB provide a link to its written feedback from and analysis of the 'Big Health and Wellbeing Conversation' events of spring 2023? Does the ICB believe that these very general discussions provide adequate patient or public involvement for future service changes for years to come? If so, can you explain the basis for this belief?	The insight gathered from our engagement activity, including the Big Health and Wellbeing Conversation, is available on our website at: Programmes and Projects - NHS Shropshire, Telford and Wrekin. Whilst the Big Health and Wellbeing Conversation was an overarching programme of engagement, we also undertake more targeted and specific engagement focused on services and pathways. Most recently, this has included Child and Young People's Emotional and Wellbeing Mental Health Services and Healthy Ageing and Frailty. We are currently engaging with our population and communities on the Adult Mental Health Inpatient Services and all-age Autism and ADHD pathways to inform service design and development.