Integrated Care System
Shropshire, Telford and Wrekin

NHS
Shropshire, Telford and Wrekin

ICB Board – 31 January 2024– Questions received from members of the public.

<table>
<tr><th>Name, Date and Time</th><th>Submitted questions</th><th>Summary Response</th></tr>
<tr>
<td>Email
17/01/2024
12:48pm
David Sandbach</td>
<td>The percentage of A&E attendees for whom the transfer from A&E to an inpatient bed fell outside of the 4 hour ‘treat, transfer, discharge’ national target due to lack of appropriate bed availability is as follows:

<table>
<tr><th>Month</th><th>PRH</th><th>RSH</th><th>SaTH</th></tr>
<tr><td>Nov-22</td><td>35%</td><td>66%</td><td>51%</td></tr>
<tr><td>Dec-22</td><td>34%</td><td>62%</td><td>49%</td></tr>
<tr><td>Jan-23</td><td>36%</td><td>66%</td><td>51%</td></tr>
<tr><td>Feb-23</td><td>41%</td><td>68%</td><td>54%</td></tr>
<tr><td>Mar-23</td><td>36%</td><td>67%</td><td>51%</td></tr>
<tr><td>Apr-23</td><td>33%</td><td>65%</td><td>49%</td></tr>
<tr><td>May-23</td><td>32%</td><td>73%</td><td>52%</td></tr>
<tr><td>Jun-23</td><td>29%</td><td>76%</td><td>52%</td></tr>
<tr><td>Jul-23</td><td>34%</td><td>71%</td><td>53%</td></tr>
<tr><td>Aug-23</td><td>32%</td><td>65%</td><td>48%</td></tr>
<tr><td>Sep-23</td><td>32%</td><td>65%</td><td>50%</td></tr>
<tr><td>Oct-23</td><td>37%</td><td>65%</td><td>52%</td></tr>
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1) How many beds are in the core bed stock at RSH and PRH?

2) How many beds are in the reserve i.e. surge bed stock at RSH and PRH?

3) How many admissions from A&E are there at RSH and how many admissions from A&E are there at PRH?

4) Why does RSH perform so badly when compared to PRH?</td>
<td>Response provided by Sara Biffen (COO SaTH)

1. RSH have 387 core beds. PRH have 307 adult beds and 28 paediatric beds
2. There are 26 escalation beds at PRH and 25 at RSH
3. PRH averages 78 admissions per day, 84 averages 84 admissions per day
4. There are multiple factors affecting the varying performance between RSH and PRH including patient demographics, the overall bed base, the structure of specialities across both sites, UEC access pathways and the respective level of acute medicine assessment beds</td>
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<tr>
<td>Email
23/01/2024
17:35pm
David Sandbach</td>
<td><u>Question 1</u>
Preamble:
“Two modular ward facilities have <u>been procured</u> with <u>substantial investment</u> in both revenue and capital to expand the physical bed capacity within the system. The new facilities will be constructed at RSH,”</td>
<td>Response provided by Inese Robotham, Assistant Chief Executive, SaTH

a) There were significant complexities and interdependencies in the planning process due to the co-location with the HTP build and the timings of both planning applications.</td>
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	"The initial plan was for 64 beds to **come on-stream from Dec 2023**. Due to delays in the planning process, there is no clear delivery date for the modular ward facilities" **2. 2023/24 SYSTEM OPERATIONAL PLAN/ WINTER PLAN** **2.1. Sub acute wards** The implementation plan for sub acute wards has changed from the initial operational plan assumptions. The initial plan was for 64 beds to come on-stream from Dec 2023. Due to delays in the planning process, there is no clear delivery date for the modular ward facilities SaTH has developed an intermediate plan which delivers 20 beds from 2nd Jan 2024 and a further 26 beds available from 1st Feb 2024. Shropcomm (lead recruiter) confirmed confidence in the recruitment plan in order to deliver a mixed blend of permanent and temporary staffing to ensure these beds were available to these timelines. Risk remains (and is being mitigated) around the physical establishment of the beds This has had a material impact on the bed deficit for the winter months (see below). Source: 2. 2023/24 SYSTEM OPERATIONAL PLAN/ WINTER PLAN STW-Integrated-Care-Board-1-1.pdf (shropshiretelfordandwrekin.nhs.uk) **QUESTION:** a) Which organisation was responsible for the delays in the planning process? b) Have the wards actually been procured as reported in official minutes, is so where are they being stored and is there a storage cost? c) What is the nature of the delay? a) is the delay at the factory making the wards or b) organising delivery e.g. preparing the site for these wards or c) simply the result of poor NHS project management? d) Which organisation owns the wards? e) Why are both the wards to be located at RSH rather than one at PRH and one at RSH?	b) Yes, the wards modular ward units have been produced. The are stored with the manufacturer on their main site and have been inspected by SaTH. There are no storage costs being incurred. c) The nature of the delay is linked to the planning application process. d) SaTH e) There already are a number of modular builds located at the Princess Royal Hospital (PRH) site which means there is no suitable location adjacent to the main building to locate a modular ward. Relocation of renal services to Hollingswood House provided capacity for the Rehabilitation and Recovery Unit within the main PRH building. Also it is more cost effective to construct one multistorey build than two single storey builds. f) The optimum location for the modular build was identified following a robust option appraisal process. The location is on a site that will be separated from the major build by an existing site road plus significant hoardings that will be erected to create a substantial site compound away from the footprint of the building.

	f) The location for the modular ward/s on the RSH site is slap bang next to the location of the RSH extension. The net effect of this is that patients in the modular ward/s will be cared for next to a major building site. Would ICB members like it if this was to happen to their elderly frail relatives when as every involved knows that there are better alternative locations on the RSH site. g) Given the recent opening of two rehabilitation wards i.e. one at RSH and one at PRH, what is the plan for spending the £21.4 million capital allocated to the ICB / SaTH / ShropCom as part of the Governments policy for increasing capacity to cope with winter? Source: https://www.england.nhs.uk/2022/08/nhs-sets-out-package-of-measures-to-boost-capacity-ahead-of-winter/ For example once the modular wards are commissioned and operational will the two wards (which are within the foot print of RSH and PRH) be used as rehabilitation wards or will they be used for emergency take wards or will they be used for planned inpatient surgery or will they be mothballed? h) What is the difference between a Rehabilitation ward and a Sub-Acute ward. Are these terms interchangeable and do the ICB management know what they mean or are the people involved just tired and confused and cannot be bothered to communicate properly?	g) The £21.4m capital allocation is being spent on the modular build as intended. h) The term 'sub-acute ward' was replaced with 'Rehabilitation and Recovery Unit' following consultation with the public as the latter term was deemed more meaningful by the participants in the consultation.
Email 23/01/2024 17:35pm David Sandbach	**Question 2** **Preamble:** "By December 2023, we expect systems to have completed the comprehensive development of virtual wards towards a national ambition of 40–50 virtual beds per 100,000 population." Source: 20211223-B1160-2022-23-priorities-and-operational-planning-guidance-v3.2.pdf (england.nhs.uk) Allegedly the VW program will deliver the following reduction in demand for inpatient beds at RSH and PRH:	**Response provided by Claire Horsfield, Director of Operations & Chief AHP, SCHT** a) The Virtual Ward supported 455 patients for an episode of care in November and December 2023 that could have been potential admissions to the acute trust. b) The utilisation of the Virtual Ward and activity levels are reported through a weekly performance review of all UEC activity. A full review of the impact of VW is underway and

	     | | 30/11/2023 | 31/12/2023 | 31/01/2024 | 29/02/2024 | 31/03/2024 | | Virtual ward - revised forecast 2 day LOS | 10 | 10 | 14 | 14 | 14 | **QUESTION:** a) What actual impact did the VW program have on demand for admissions to RSH and PRH in November and December? b) Where is the published evidence that the VW program has made a difference to demand for SaTH inpatient beds? c) What is the actual average length of stay a patient can expect to have on a virtual ward i.e. 2 days or in reality is it much more? d) How much money is spent on providing a virtual ward service? e) How much money is spent per patient admission / episode in a virtual ward? f) Is the VW service a 24 / 7 service? If not what are the days and hours of operation i.e. is this service delivered on part day basis only and no night service. g) Is this service a 7 day service or a 5 day service. h) What is the actual local VW capacity. Is it 115 as noted in the official national data shown below or 435,552 ÷ 100,000 = 4.35552 x 40 = **174** VW beds. i) Does the official VW capacity figure of 115 include the virtual beds associated with the Integrated Discharge Team under the management of SaTH? If not how many virtual beds are part of the IDT facility, how many patients per month have an episode of IDT care and on average how long for and at what cost per episode. j) How many staff (WTE) are allocated to run the IDT and who are they employed by? k) How many staff (WTE) are allocated to run the VW program and who are they employed by?	will be reported through the UEC Delivery Board when completed c) The week up until 12th February 2024 the average length of stay was 12.7 days d) Yearly budget for 2023/2024 £2,4000,000 e) The money spent on each patient will differ dependant on the care they require. Some patients may need daily face to face contact and some patients may be able to be treated through telemedicine or through remote monitoring solutions f) The service runs from 8am – 8pm g) The service runs 7 days a week h) Maximum capacity is 167 i) The VW beds are not associated with the IDT beds, both services run separately j) There are over 14 clinicians in the IDT with a mix of 50% employed by SaTH and 50% employed by SCHT k) Target WTE for staffing is 61.5, this will be skill mixed appropriately to meet the needs of the service –The employer is SCHT l) Ongoing transformation and plans are in place to support the expansion of IDT and VW m) Shared through internal SCHT committees and board also IDC and Local Care Programme board n) Both schemes are reliant on integration of all services and partnership working across SCHT, SATH and both LA's o) SCHT provides performance figures via the NHS Foundry Platform which the ICB can access. This is also supported by information data

l) Have both of these tasks been completed: “Can confirm that **SHCT have plans in place for both VW and IDT expansion**. Future reporting and oversight arrangements need to be agreed between ICB and providers.” Source: page 198 https://www.shropshiretelfordandwrekin.nhs.uk/wp-content/uploads/STW-Integrated-Care-Board-Appendices.pdf

m) Which committee knows about these expansion plans and have they been signed off by a competent relevant governance committee.

n) Who is responsible for the success or failure of the government funded VW program and who for the IDT program?

o) In order to avoid any future corporate embarrassment for the ICB would it be beneficial for the ICB members to track the local VW case load performance using the official NHS data set below at future formal ICB meetings?

Name	Virtual Ward Capacity (see note 1)	Virtual Ward Capacity per 100,000 GP registered population aged 16 years and over (see note 2)	GP registered population aged 16 and over (see note 3)	Patients in a Virtual Ward (see notes 1 and 4)	Occupancy % (see note 5)
ENGLAND	11,805	23.0	51,396,905	8,586	72.7%
NHS Shropshire, Telford and Wrekin Integrated Care Board	115	26.4	435,552	90	78.3%

sharing agreement which has been signed off locally.

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Title:	Virtual Ward Capacity and Occupancy monthly statistics in England
Introduction:	The Virtual Ward Capacity and Occupancy statistics are Management Information. The data is reported by lead virtual ward providers in England. Data is collected by NHS England via the Virtual Ward sitrep which was launched in April 2022.
Definitions:	Where the monthly figure is reported, this represents the last sitrep data submitted in the relevant calendar month. For example, monthly published data for December 2023 is taken from the last sitrep submission of the calendar month, which was on 29th December 2023.
Geography:	Systems/Integrated Care Boards (ICBs) mapped to NHS England Regions.
Notes:	
1	Virtual Ward Capacity (number) which is also referred to as Virtual Ward 'bed' Capacity. This is the data reported in the final sitrep data submission by providers in the calendar month. (See also definitions.)
2	Virtual Ward Capacity per 100,000 GP registered population aged 16 years and over. A calculation where: Virtual Ward Capacity per 100,000 GP registered population = (Virtual Ward Capacity/Patients registered at a GP Practice) x 100,000
3	GP registered population (adult aged 16 years and above) for April 2023. Source: NHS Digital Patients Registered at a GP Practice. Patients Registered at a GP Practice - NHS Digital
4	The number of patients on a virtual ward, at 8am Thursday prior to the sitrep submission period. For example, 8am Thursday 21st December 2023 for December 2023 published data.
5	Virtual Ward Occupancy as a percentage of Virtual Ward Capacity. A calculation where: Occupancy = Patients in a Virtual Ward / Virtual Ward Capacity (%)

Source: https://view.officeapps.live.com/op/view.aspx?src=https%3A%2F%2Fwww.england.nhs.uk%2Fstatistics%2Fwp-content%2Fuploads%2Fsites%2F2%2F2024%2F01%2FMonthly-Virtual-Ward-Dec2023.xlsx&wdOrigin=BROWSELINK
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Email 23/01/2024 17:35pm David Sandbach
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<td>

Question3

Preamble:
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Response provided by Inese Robotham, Assistant Chief Executive, SaTH

a) The building is owned by the Borough Council

b) The opening times are 8am till 5pm for Phlebotomy and 9am till 5pm for Radiology Monday-Friday

c) The services will be increased in a phased approach from April 2024 with seven day opening from Q2 of 2024/25
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ICB Board – 31 January 2024– Questions received from members of the public.

David Sandbach @Yockletondave · 21h
Great news - now onward and upwards.

@sathNHS @ShropshireStar @BBCShropshire @NHSSTW

SaTH @sathNHS · Jan 19
✨ Exciting news from Telford's new Community Diagnostic Centre (CDC) ✨

Since opening in October 2023, the CDC has welcomed more than 13,000 patients for non-urgent diagnostic testing including the first ...
Show more

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QUESTION:

a) Who owns the building in which this facility is located in?
b) What are the opening hours?
c) When will it become a 7 day per week service?
d) What is the planned maximum radiological case load at the CDC per week and per year.
e) The CDC is a county service – is there any data about use by patient area of residence?
f) How many planned radiological procedures are carried out at the CDC and how many planned radiological procedures continue to be carried out at RSH / PRH.
g) Has this facility reduced the planned radiological work load at RJ&AH?
h) Is there any evidence that this development has improved emergency workflow through RSH or PRH?
i) Is the government funding for the CDC sufficient or is this service a contributing factor to the ICB financial worries?
j) Is it true the CDC will be used to treat private patients out of normal NHS opening times?
k) When can Shropshire citizens expect a second CDC?

d) Radiological capacity is 546 based on a five day week. This will increase in the second part of 2024/25 as the services expand to seven days.

e) Standard demographic data is available for the service which includes postcode of residence.

f) For 2023/24 12,000 procedures will be undertaken at CDC and 300,900 at PRH/RSH (these include CT, NOUS, MRI and X-Ray)

g) Currently, the impact of the CDC is not significant enough to reduce the required capacity at RJAH. This remains the planned impact for the CDC through 24/25

h) CDC capacity is mainly utilised for reducing backlog for routine waits, therefore to date there has been no impact as yet on emergency workflow at PRH and RSH

i) There are no plans to use the CDC to treat private patients

j) There are currently no plans to utilise the CDC facility for treatment of private patients

k) There are no current plans for a second Community Diagnostic Centre and we await further national guidance on whether there will be national resource made available to develop one.

Integrated Care System Shropshire, Telford and Wrekin

NHS Shropshire, Telford and Wrekin

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<td>Email
23/01/2024
17:35pm
David Sandbach</td>
<td><u>Question 4</u>

Preamble:

The last ICB papers contained around 436 pages. For comparison purposes here is a list of books with the same number of pages Books with 436 Pages — Foreword Reviews

QUESTION:
a) When are the papers issued to ICB members i.e. is it five days before the meeting or is it longer?
b) Do all the ICB members read all the papers used at the meeting?
c) Can the ICB papers be issued seven days before the meeting as a help to give old people like me time to read and understand the content therein.
d) The number of acronyms contained in the ICB papers is enormous. A glossary at the end of each agenda item would be very helpful; please can you give this some thought please.</td>
<td>Response provided by Alison Smith, Director of Corporate Affairs

a) The papers are issued to Board members and onto the ICB website 5 days before the meeting.

b) Report authors are asked to provide a covering report that outlines all the key areas for consideration in summary which should allow Board members to make decisions based on this content. All covering reports are consolidated into a pack with the agenda and minutes. In addition report authors can append more detailed information to allow Board members to look at the detail if they wish to and this is consolidated into an appendix pack.

c) Unfortunately due to the timing of up to date performance data not being available until the week the Board papers are issued means we are unable to bring the date of publishing forward. It is felt that to publish a full set of papers to meet 5 day deadline is more appropriate than issuing two sets on different days that could cause confusion. Equally it is our desire to ensure that the Board receives the most accurate data possible for its consideration.</td>
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		d) We do outline in report writing guidance that report authors clarify acronyms when first used in any written information.
Email 23/01/2024 17:35pm David Sandbach	**Question 5** **Preamble:** "Ethical concerns mount as AI takes bigger decision-making role in more industries" Source: https://news.harvard.edu/gazette/story/2020/10/ethical-concerns-mount-as-ai-takes-bigger-decision-making-role/ Funding to develop AI has been granted to the ST&W ICB membership. **QUESTION:** a) Does the ICB have an ethics committee to refer proposed AI developments to? b) How will the ICB involve patients and scrutiny committees in the process of developing, implementing and monitoring AI projects? c) Does the ICB have adequately trained professional staff in this area of computer science? d) Does the ICB plan to farm out i.e. sub contract responsibility for design and implementation of AI programs?	**Response to be provided by Nick White, Chief Medical Officer** a) No. This will be a strong recommendation as work on our digital maturity progresses. The resources and system commitment to a system Ethics Committee will be explored in 2024/25. b) We are still in our early in our system approach to digital maturity, including the related design and delivery processes for AI projects. Each ICS partner approaches design, development, implementation and reporting differently. As part of our system digital priorities for 2024/25, the resources and system commitment to a system approach to AI will be explored. c) AI technologies require a multi-disciplinary skillset including computer science alongside clinical informatics, data ethics and social science research, among others. As part of a system approach to AI, we will be guided by emerging resources such as the former-NHS Health Education England's "AI and Digital Healthcare Technologies Capability framework", The Alan Turing Institute, Federation for Informatics Professionals in

		Health and Social Care (FEDIP) and similar organisations leading in this fast moving capability with potential to contribute to improvements in health and care services. d) While there is no ICB plan to outsource the responsibility for the design and implementation of AI programmes, there is a need for system leaders to be aware of AI technologies, agree what we mean by 'AI' and provide education and support as we develop our data, digital and technology capabilities which includes the use of AI solutions.
Email 23/01/2024 17:35pm David Sandbach	**Question 6** **Preamble:** Director of Finance to circulate a briefing note re GP numbers and appointments delivered. **QUESTION:** a) To whom did the Director of Finance circulate this briefing note and when? b) Can members of the public have access to this document as part of the ICB papers in January? c) Is there anything in the briefing note which the ICB does not want the public to know?	**Response provided by Claire Skidmore, Chief Finance Officer** Minute No. ICB 28-06- 097 – Integrated Care System Performance Report Mr Harry Turner commented around the data of the number of GPs increased, but over the same period the number of appointments seem to have gone down, which the figures didn't tally. • Mrs Skidmore to ask the team to provide a statement specifically to map what has driven the changes and why they don't correlate. • Mrs Claire Skidmore to check with her team for clarification. Action – On-going The following statement was circulated recently to all Board members:

		The ICB Primary Care team have confirmed that there is no direct relationship between the number of GPs in post and the number of appointments in Primary care. This is for the following reasons: • *The category of 'Total Primary Care appointments' includes activity carried out by Direct Patient Care staff as well as GPs, with GP appointments making up around 50% of total appointments.* • *The count of number of GPs in post does not indicate the number of appointments that are unavailable due to annual leave and sickness.* *We have changed the way we report from November '23 to indicate whether monthly fluctuations are significant or whether normal variation. Since November, the total number of Primary Care appointments and the number of GPs in post are both showing normal variation. Further changes to Primary Care reporting will follow which will allow better measurement of access recovery.*
Email 23/01/2024 17:35pm David Sandbach	**<u>Question 7</u>** **Preamble:** "Rural Proofing in Health and Care Task and Finish Group Councillor Heather Kidd, Chair of the Rural Proofing in Health and Care Task and Finish Group, gave a presentation on their findings over the past six months. Members were advised that the members of the task and finish group had been clear from	**Response provided by Alison Lester, STW ICS Senior Transformation Manager** This preamble relates to a specific task group from Shropshire Council that focuses on inequalities of service provision between rural and urban areas.

	their first meeting about the topic, that addressing **any inequalities of service provision** between rural and urban areas required a system wide understanding of the opportunities and challenges" Source: https://shropshire.gov.uk/committee-services/documents/g4926/Public%20reports%20pack%2029th-Jan-2024%2010.00%20Health%20Overview%20and%20Scrutiny%20Committee.pdf?T=10 **QUESTION:** a) When was the Rural Racism report written and when was it circulated among the ICB membership? b) Has the rural racism report been shared with Shropshire Council scrutiny committee and with the T&W scrutiny committee? c) Why has this report not been placed in the public domain for interested members of the public to read and comment on?	The Rural Racism Report focuses on the workforce in STW not service provision. The primary aims from this piece of research, led by the University of Wolverhampton, were to gain a deeper understanding of the extent of racism and of experiences of racism experienced by health, medical and social care staff of perceived non-English heritage in NHS settings in the Shropshire, Telford and Wrekin area and to suggest ways forward for the organisations concerned to promote culturally inclusive behaviours in staff, patients and/or visitors. a) • First interim report received on 30 November 2021 • Second interim report received on 17th March 2022 • Final report received in November 2022 • The final report was shared with Interim Chief People Officer, Head of ICB People Team, and ICB Chief Nursing Officer • It was also shared and discussed at the ICS EDI Steering Group on multiple occasions and be used to support the work programme in this area. b) I have raised this query with the Consultation and Equality Officer, Telford & Wrekin Council who reports:

		I am not aware of it being shared with our Scrutiny (T&W). I would have thought that the board itself would be the route for doing this to the committee or maybe JHOSC (Joint Health Overview and Scrutiny Committee)? In terms of operational sharing, this has been shared with our EDI steering Group, Public Health and Insight Team but its value is limited for us as a standalone report. I raised the same query to the Performance and Research Specialist: Rurality and Equalities, Business Improvement – Data and Business Intelligence, Shropshire Council who reports: The findings from this University of Wolverhampton research report, which focusses particularly upon staff in hospital settings and primary care settings, will be referenced within the evidence base for the updates we will be making to our Annual Service User Diversity Report and Annual Workforce Diversity Report, now that we also have up to date Census figures to use in our comparator analyses. These reports are due end of March: they will be published on our website as part of our compliance with the Public Sector Equality Duty guidance. As such, the report does not in itself form a single piece of work to be reported separately to councillors, through Cabinet decision making

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		processes or through scrutiny committee processes. c) The report will be shared in the public domain alongside the associated action plan.
Email 23/01/2024 17:35pm David Sandbach	<u>**Question 8**</u> **Preamble:** The report on the winter plan shows that the original plan was based on a rose coloured view of the position to be faced in winter of 2023 /24 rather than a serious attempt to ensure proper preparations were in place. The two key components of the plan i.e. more bed physical capacity (64 beds in a modular ward) and arrangements to reduce demand for beds via the Virtual Ward initiative failed big time because of bad management and lack of grip by the ICB management. **QUESTION:** a) Why should the public pay for significant new investments i.e. Modular wards and Virtual Ward beds when the local NHS management cannot deliver on an a pre-greed ICB winter plan. b) Why must the public accept a revised plan which has substandard and dangerous clinical practices built into the plan – do the ICB members really want to kill folk because of poor standards? c) Why is the SaTH CEO and Chair of the Urgent & Emergency Care Committee telling the ICB meeting that she believes there will continue to be a bed gap in spite of what Mr Robinson had to say? d) During the meeting it was pointed out that the winter plan did not have any reference to the contribution GP services had to make. Last years winter plan included resources for GP's so why not this year's plan? e) Is Mr R. Dunshea right to express concern about the ICB having to deal "every year with this kind of difficulty coming up."	**Response provided by Inese Robotham, Assistant Chief Executive, SaTH and Gareth Robinson, Executive Director of Delivery and Transformation NHS STW** a) Both virtual wards and the modular build will provide appropriate care models and additional capacity to meet the healthcare needs of the local population and therefore are worthwhile investments. b) There are no plans to implement substandard and dangerous clinical practices. c) Based on the current numbers of escalation areas required within the acute sector, there remains a significant bed gap which requires mitigation through admission avoidance, internal efficiency and out of hospital pathway initiatives. d) The overall winter plan submitted as part of December 2023 Board Papers includes a significant documented section relating to Primary Care that reflects a significant response from GPs and Primary Care as a whole. Each year a small amount of additional funding is deployed

	f) Is Mr H. Turner right to point out that at an important governance meeting re the winter plan "we did not have the right people there." Is he right to suggest that this matter should not be reported on in future? g) Why do the SaTH Board waste resources to the detriment of the ICB membership as a whole.	to enhance capacity. Following a thorough review process, the UEC Delivery Board recommended deploying this to areas such as the VCSE, a falls service, additional admissions avoidance services and patient transport for discharges e) Pressures associated with increased demand (activity and acuity) are a standard characteristic of all health systems. This was a system partner led decision. f) The Winter Plan is overseen by the UEC Delivery Board and Integrated Delivery Committee on behalf of the Board g) The factors affecting the appropriate use of resources are significantly more complicated than outlined in this question
Email 23/01/2024 17:35pm David Sandbach	**<u>Question 9</u>** **Preamble:** Recommendation 3: Define which Local Care programmes/projects would be predominantly designed and delivered at Place and which at System/ICB. (Noting there would need to be collaboration and co-production between the two levels to ensure the interdependencies are addressed). Source: Agenda item ICB 29-11-127 When asked for a comment Mr D. Sidaway and Mr A. Begley responded diplomatically by saying that the "devil was in the detail" **QUESTION:**	**Response provided by Claire Parker, Director of Partnerships and Place NHS STW** The paper was prepared in collaboration with officers from both LA's and the NHS- the paper referred to a refresh of the Local Care programme and the next evolution of the place- based partnerships- currently chaired by executive LA officers in both TW and Shropshire. As a follow on to the governance report presented to the board separately, the Terms of Reference will be reviewed in collaboration with the partners over the next couple of months. The detail of the paper will be joint working by the officers of the LA's, NHS, including primary care, and VCSE- the

ICB Board – 31 January 2024– Questions received from members of the public.

	a) Was Agenda item ICB 29-11-127 written by a small group on NHS officers or was it a jointly written paper with colleagues from Shopshire Council and Telford and Wrekin Council? b) Who is responsible for highlighting the "devil" issues contained in the paper? c) When the devils has been excised from the paper will the ICB hold a service of thanks giving?	Director role responsible is Director of Partnerships and Place.
Email 29/01/2024 08:35am David Sandbach	**Minute No. ICB 29-11-129 Integrated Care System Performance Report** 129.1 Mrs Claire Skidmore presented the Integrated Performance Report highlighting two significant performance challenges as a system – urgent emergency care (UEC) and finance. • Finance, at Month 7 the ICS has a deficit of £89m, which is £44.5m adverse to plan, a variation from in-month plan of £10.5m in Month 7. NHS England has given the ICS a target to reduce their deficit to £57million. The total unmitigated risk reported at M7 is £91.7m. • A recent letter from NHSE asking all systems to review financial outturn (FOT) positions is currently being worked through at a system level, with a number of options being considered but no firm agreement yet. **Question 1** a) Where is the information concerning Month 8 why has it not been made public? b) Is the deliberate act of not publishing this information in breach of your standing orders and governance protocol?	**Response provided by Claire Skidmore, Chief Finance Officer** a) The Board meeting referenced was held on 29th November therefore the month 8 (November) information was not available at that time. b) When the Board met again in January, month 9 (December) data was available and therefore this was the most up to date position for consideration.
Email 29/01/2024 08:35am David Sandbach		**Response provided by Claire Skidmore, Chief Finance Officer** a) Yes b) The target (plan) has not changed however the System has reforecast its year end position and

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Finance

- At Month 9 the system has a deficit of £106.9m, which is £53.8m adverse to plan, a variation from in-month plan of £4.9m. This position includes additional industrial action costs from the December strike action.
- In Month 9 a change to the forecast has been enacted for all organisations. The reported forecast of £132.8m includes the additional estimated costs of December and January Industrial action of £3.0m. NHSE have confirmed recognition of a forecast deficit of £129.8m which excludes the additional industrial action impact. Individual and System Boards signed off the reforecast position in early January in advance of submission of the month 9 position.

An increased deficit of £38.1 million is 41.5% more than it was in month 7. A two bullet point financial statement is not good enough. The CEO and DoF must know that they operate under the Nolan principles of public life.

Question 2

a) Do the CEO & DoF have a duty of candour and honesty to the ICB membership and the public.
b) The NHSE £57 million target was set at month 7. Has this target been changed – if it has the ICB a public obligation to report this fact at the January meeting.

SaTH has a debt overhang of £178 million.

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Email 29/01/2024 08:35am David Sandbach

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On 16 May 2023 we made a section 30 referral to the Secretary of State in respect of the Trust's breach of its "breakeven duty" set out in paragraph 2(1) of Schedule 5 to the National Health Service Act 2006. The Trust had previously breached its five-year breakeven duty and reported an in-year deficit of £47.206 million in 2022/23, resulting in a cumulative deficit of £178.063 million at 31 March 2023.

Source: https://issuu.com/sath.nhs/docs/202223_-_sath_annual_report_and_accounts?fr=sZjc5NDYwMDQxMjU page 133

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Response provided by Claire Skidmore, Chief Finance Officer

a) The total historic accumulated debt for the CCG was £134m as quoted in its final annual report for the Part Year period in 2022/23.
b) The main area of System overspend in 2023/24 relates to the key cost drivers in SATH of escalation costs, elective activity costs and

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	The total debt figure facing the ICB is at least £307.8 million. **Question 3** a) How much debt did the ICB carry over from the CCG? "In terms of the wider system position, at month 10 the system reported a £33.6m adverse variance to plan (of which £21.3m related to the Trust as indicated above). The full year forecast outturn deficit was reported at £65.8m, £46.7m adverse to plan, although adjusting for non-recurrent items, the underlying deficit is forecast at £87.8m" Source: https://www.sath.nhs.uk/wp-content/uploads/2023/09/SaTH-AAR-2022-23_020823-v1a.pdf £129.8 million less £87.8 million = £42 million increase in debt since 2023. b) How much of this debt mountain is due to these factors pointed out by Mr Dunshea: 129.3 Mr Roger Dunshea, commented that overspends were usually driven by one of three things – being underfunded, if unit costs are high, or if the system is overperforming. He noted as a Non-Executive Director perspective it is difficult to know why there is overspending. He asked at future Board meetings if this could be drilled down into unit costs so the board can look to see why there is overspending. c) Is poor financial control another factor affecting overspends? d) Is general management incompetence mainly at the SaTH Board also a factor which drives overspends? NB The SaTH Board has, for at least the past ten years, never balanced it's books. The ICB membership are drinking from a poisoned chalice. Until the SaTH Board is stopped from accumulating debt nothing good will happen to substantially improve the NHS system in Shropshire. e) How much will the cost of debt will continue to rise? f) What are the repayment terms? g) Will divert resources from provision of frontline services?	staffing issues. The ICB also continues to forecast a variance to plan driven particularly by Prescribing and Individual Commissioning, where price increases have significantly outstripped planned inflation that was included in the original plan as per the national planning assumptions. c) Each System partner deploys their own financial governance and controls through which to manage and oversee expenditure e) Unclear re the question f) National guidance requires ICBs to repay their accumulated debt and we will factor repayment into our financial recovery plan g) Any pay back of debt will come from the wider system resource.

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Email 29/01/2024 08:35am David Sandbach	121.2 Minute No. ICB 29-03-069 – Follow up to Patient's Story: MSK Integration across STW. • Mr Mike Carr to present objectives and clinical outcomes of the MSK Transformation Programme to ICB once agreed by the MSK Transformation Board. • The Board were provided with an update that confirmed significant work was being undertaken that was underpinned by a large amount of clinical engagement with clinical colleagues from partner organisations. The high level workstreams have been presented and there is a plan to do a detailed program update at the Decembers Integrated Delivery Committee, then a fuller update to be presented at this Board in January 2024. **Question 4:** a) Where is Mr Carr's report? Not on the ICB January Agenda why not?	**Response to be provided by Mike Carr, Chief Operating Officer/Deputy CEO, RJAH** The MSK update was provided as part of Provider Collaborative update, agenda item ICB 31-01-010.
Email 29/01/2024 08:35am David Sandbach	• Mr Robinson confirmed that recovery plans have been to the Joint Health and oversight Scrutiny Committee. Mr Gareth Robinson to draft an information note for Board that can be appended to the minutes. **Question 5:** a) Can the information note be circulated to the JHSOC to verify the veracity of the briefing note.	**Response provided by Gareth Robinson, Executive Director of Delivery and Transformation** A briefing note is being prepared and will be circulated to Board members. We will also share it with JHOSC who can consider its future circulation.
Email 29/01/2024 08:35am David Sandbach	**Action: The Chair suggested enlisting the help of Healthwatch in a piece of work around assuring the Board through analysis of patient feedback that the system is picking up on thematic issues around veteran experience of services in STW. To be discussed outside of this meeting.** **Question 6:** a) Has this task been completed?	**Response provided by Gareth Robinson, Executive Director of Delivery and Transformation** This work is currently in progress with the scope being designed between T&W Healthwatch, Shropshire Healthwatch and NHS STW.

	b) If so what was the outcome?	
Email 29/01/2024 08:35am David Sandbach	• The latest position of right-sizing NHS STW (a national mandate to reduce the running costs of the organisation by 30%). The programme is well underway, and his intention is to present a more detail paper about the operating model at the January Board before the ICB enters a formal management of change consultation. **Question 7:** a) Where is the more detailed paper – not on the January agenda. "We are aiming to launch a management of change consultation on our structures in February for 45 days." b) Is this time table legal since detailed paper as promised is not available and the ICB structures have not been formally approved. 5.3 15 individuals from NHS Shropshire, Telford & Wrekin were successfully accepted into the programme, ranging from various departments across the ICB, Provider Trusts and Primary Care. This is an incredible achievement given the overwhelming interest the programme received and testament to the dedication of our staff in their applications. c) Are any of the 15 people likely to lose their jobs as a result of so called "right sizing" the ICB?	**Response provided by Beth Emberton, Programme Manager - Shaping the STW ICB** NHS Shropshire, Telford & Wrekin (STW) will present a final draft of the Operating Model at our April Board meeting. An engagement exercise with NHS STW staff is taking place from 6th February to 27th February 2024 to help shape and structure our future Operating Model. NHS STW launched a Management of Change Consultation with all staff on 6th February 2024. The consultation on the proposed structures will last 45-days in line with legislation and our management of change policy. The consultation will close at 11:59pm on 21st March 2024. Of the 15 STW Integrated Care System (ICS) Core Ambassadors, 9 of them are NHS STW employees. NHS STW must undergo a thorough Management of Change process and until its completion, we are unable to share any presumptions or preliminary information. Our focus will be on minimising redundancies while actively exploring opportunities to support any displaced staff. The timetable is compliant with all legislative requirements.

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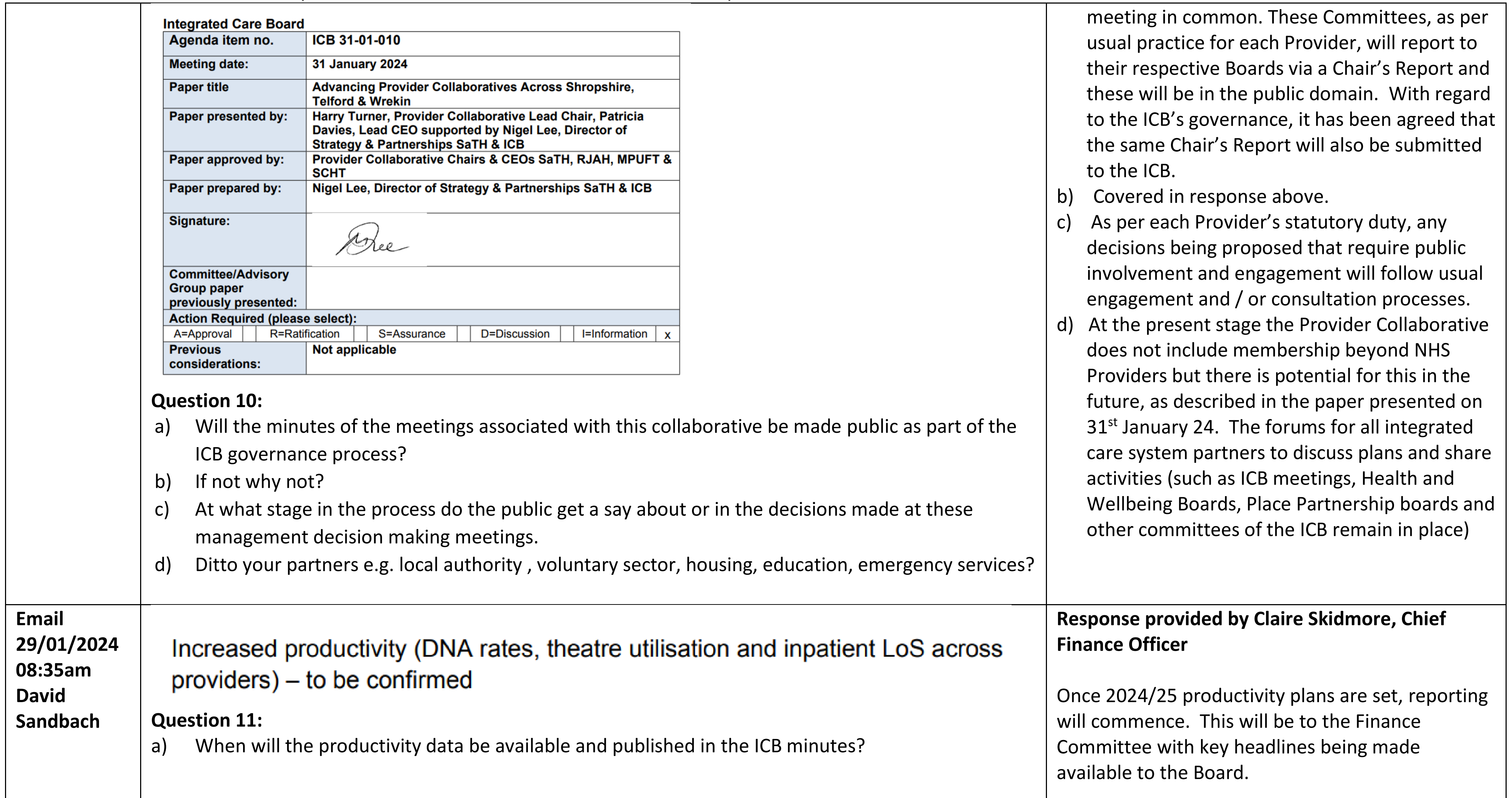
Email 29/01/2024 08:35am David Sandbach	Recruitment on going for all areas within Radiology to help fill current vacancies and to extend our current workforce due to the increase in demand, new recruits are due to start over the next few months. **Question 8:** a) What is the Radiology staffing as at January 2024 all members of the ICB? b) What is the planned establishment for financial year 2024 all members of the ICB?	**Response Provided by Sara Biffen COO SaTH** a) Radiology staffing: SaTH: 283.38 wte (Jan 2024) CDC: 10.13 b) Budgeted staffing for Radiology Centre and CDC 325.72 wte (plus additional overnight outsourced reporting)
Email 29/01/2024 08:35am David Sandbach	**The Outline Business Case (OBC) for the transformation of hospital services across The Shrewsbury and Telford Hospital NHS Trust (SaTH) has been formally approved** in the latest and penultimate stage of national approval. **Question 9:** a) When will the OCB be published and made available for members of the public to read? b) When will plans to cope with the disruption at RSH be made public e.g. there is a report about the helicopter landing pad being relocated Air ambulances to land on Shrewsbury football field for three years during hospital's £312m 'Future Fit' revamp | Shropshire Star c) When will the public be told about how existing parts of the RSH site will be used post completion of the HTP? d) When will the public be told about how the existing parts of the PRH site will be used post completion of the HTP?	**Response provided by Claire Skidmore, Chief Finance Officer** The HTP is at Full Business Case Stage. Further details will be shared in due course.
Email 29/01/2024 08:35am David Sandbach		**Response provided by Nigel Lee, Director of Strategy and Partnerships** a) The Provider Collaborative is being overseen by Committees of each Provider Board which are



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Integrated Care Board
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<tr><td>Agenda item no.</td><td colspan="10">ICB 31-01-010</td></tr>
<tr><td>Meeting date:</td><td colspan="10">31 January 2024</td></tr>
<tr><td>Paper title</td><td colspan="10">Advancing Provider Collaboratives Across Shropshire, Telford & Wrekin</td></tr>
<tr><td>Paper presented by:</td><td colspan="10">Harry Turner, Provider Collaborative Lead Chair, Patricia Davies, Lead CEO supported by Nigel Lee, Director of Strategy & Partnerships SaTH & ICB</td></tr>
<tr><td>Paper approved by:</td><td colspan="10">Provider Collaborative Chairs & CEOs SaTH, RJAH, MPUFT & SCHT</td></tr>
<tr><td>Paper prepared by:</td><td colspan="10">Nigel Lee, Director of Strategy & Partnerships SaTH & ICB</td></tr>
<tr><td>Signature:</td><td colspan="10"></td></tr>
<tr><td>Committee/Advisory Group paper previously presented:</td><td colspan="10"></td></tr>
<tr><td colspan="11">Action Required (please select):</td></tr>
<tr><td>A=Approval</td><td></td><td>R=Ratification</td><td></td><td>S=Assurance</td><td></td><td>D=Discussion</td><td></td><td>I=Information</td><td>x</td><td></td></tr>
<tr><td>Previous considerations:</td><td colspan="10">Not applicable</td></tr>
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Question 10:
a) Will the minutes of the meetings associated with this collaborative be made public as part of the ICB governance process?
b) If not why not?
c) At what stage in the process do the public get a say about or in the decisions made at these management decision making meetings.
d) Ditto your partners e.g. local authority , voluntary sector, housing, education, emergency services?
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meeting in common. These Committees, as per usual practice for each Provider, will report to their respective Boards via a Chair's Report and these will be in the public domain. With regard to the ICB's governance, it has been agreed that the same Chair's Report will also be submitted to the ICB.
b) Covered in response above.
c) As per each Provider's statutory duty, any decisions being proposed that require public involvement and engagement will follow usual engagement and / or consultation processes.
d) At the present stage the Provider Collaborative does not include membership beyond NHS Providers but there is potential for this in the future, as described in the paper presented on 31st January 24. The forums for all integrated care system partners to discuss plans and share activities (such as ICB meetings, Health and Wellbeing Boards, Place Partnership boards and other committees of the ICB remain in place)
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<td>Email 29/01/2024 08:35am David Sandbach</td>
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Increased productivity (DNA rates, theatre utilisation and inpatient LoS across providers) – to be confirmed
Question 11:
a) When will the productivity data be available and published in the ICB minutes?
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Response provided by Claire Skidmore, Chief Finance Officer
Once 2024/25 productivity plans are set, reporting will commence. This will be to the Finance Committee with key headlines being made available to the Board.
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Email 29/01/2024 08:35am David Sandbach	To ensure that we have a wide range of views from different perspectives, we will also use MSK patient data, to identify our service users, and ensure we then target our resources to contacting people in the right geography area and groups of people. ICB data to be received in January 24. **Question12:** a) Has the ICB an ethics committee which can ensure that the survey of patients is done on an ethical basis?	**Response to be provided by Simon Whitehouse, Chief Executive** The ICB does not currently have an Ethics Committee. Partners are expected to use their own governance routes to ensure that all aspects are taken into consideration. All work is the subject to the usual routes of scrutiny.
Email 29/01/2024 08:35am David Sandbach	Support the development of a single administrative function for MSST, reporting. **Question 13:** a) What is MSST – is it a serious disease people have not had warning of yet?	**Response provided by Gareth Robinson, Executive Director of Delivery and Transformation** MSST is the acronym for Musculoskeletal Services Shropshire & Telford.
Email 29/01/2024 08:35am David Sandbach	1.4. Following the system health inequalities evaluation presented to ICB Board in March 23, a system wide Prevention and Health Inequalities Board was established in September 2023, chaired by the Director of Health and Wellbeing, Telford & Wrekin Council. 1.5. The function of the Prevention and Health Inequalities Board is both to monitor the progress of the specific programmes currently being undertaken as they relate to the core health inequalities objectives in the NHS Operating Guidance and Joint forward Plan and to ensure greater collaboration takes place across the system. **Question 14** a) Will the minutes of the PHI Board be made public? b) If not why not?	**Response provided by Tracey Jones, ICB Lead Health Inequalities** The prevention and health inequalities board is not formally minuted, records of key actions are monitored via an action log. Regular updates are provided to the Board.

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Email 29/01/2024 08:35am David Sandbach	1.7. To measure the impact and progress of reducing health inequalities in Shropshire, Telford and Wrekin, an associated programme of work is nearing completion of a local data exploratory tool. This report details this tool which will allow measurement over time in relation to progress and impact in specific subgroups of the population currently experience greatest inequalities. **Question 15:** a) Has the data exploratory tool been considered as appropriate by a ICB ethics committee?	**Response provided by Tracey Jones, ICB Lead Health Inequalities** The population health and inequalities data tool currently being developed is not at an identifiable patient level.
29/01/2024 08:35am David Sandbach	Performance reporting for Primary Care access recovery is focused on 13 key metrics however, additional information is required to enable monitoring against all the metrics. Progress is being made in digital workstreams with all practices on course to have advanced telephony in place by March 2024. The Pharmacy First Scheme commences on 31st January to supply some prescription only medication appropriate to 7 conditions. With the expansion of blood pressure checks and provision of oral contraceptives, these schemes have the potential to remove 10 million appointments (nationally) from Primary Care. **Question 16:** a) Given comments about shortages of pharmacists in the ICB provider organisations are there enough pharmacists in the private sector? b) How do the ICB know the non NHS pharmacy workforce in Shropshire is not in a shortage situation?	**Response provided by Gareth Robinson, Executive Director of Delivery and Transformation** a) Workforce is a challenge for all sectors of healthcare, community pharmacy is no exception to this. The network of community pharmacies across the region is independently managing the sourcing of appropriate staff, the impacts of this is monitored through the unplanned closure reports that are collated by the pharmacy contract team at the Office for the West Midlands. The ICB is working with other organisations to support individual pharmacies to be able to deliver a robust service that can increase access and experience for patients and the public. Short term, employed and locum pharmacists and pharmacy teams are being supported with appropriate knowledge and training to ensure robust delivery of services across pharmacy core and supplementary opening hours. Medium term, national work is underway to increase the appropriate skill mix utilisation in

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		community pharmacy. This is being done with a number of consultations and possible legislative changes to allow other groups of pharmacy staff to undertake specific activities within pharmacy. Long term, system wide work is ongoing to support providers from all sectors of pharmacy to increase recruitment and retention in the region. Early indications show that there is good uptake for this service. Our short, medium and long term plans will allow the service to be expanded over time to maximise improved access. b) All pharmacies across Shropshire Telford and Wrekin are invited to take part in the national Community Pharmacy Workforce Survey. Nationally, there is a 95% response rate to this survey. The data from this survey is used at a local level to inform system wide workforce planning.
29/01/2024 08:35am David Sandbach	Urgent and Emergency Care is still in recovery and failing most national targets except for the 2-hour Urgent Community Response which consistently meets or exceeds the 70% target. There has been significant improving performance in the 'time to initial assessment within 15 minutes' which has been sustained through the winter period. A review of data comparing December 2023 and December 2022, shows improvement in multiple areas which suggests that patient's experiences in 2023 will have been 78 2 better than previous years. This will be presented to the Quality and Performance Committee in January. **Question 16:**	**Response provided by Claire Skidmore, Chief Finance Officer** Yes, and the QPC does have national and regional benchmarking where available to compare current performance for elective, cancer, UEC, primary care etc and that is included in the performance and quality reports. For example, the current SaTH Time to initial assessment within 15mins is now performing at 57.1% which is above the current regional average of 52.6% (@ 6.2.24).

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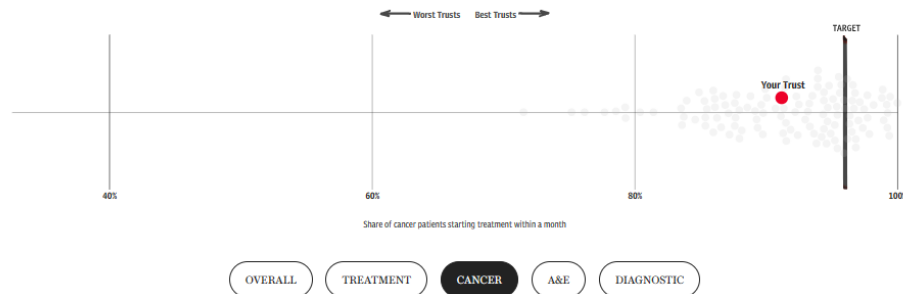
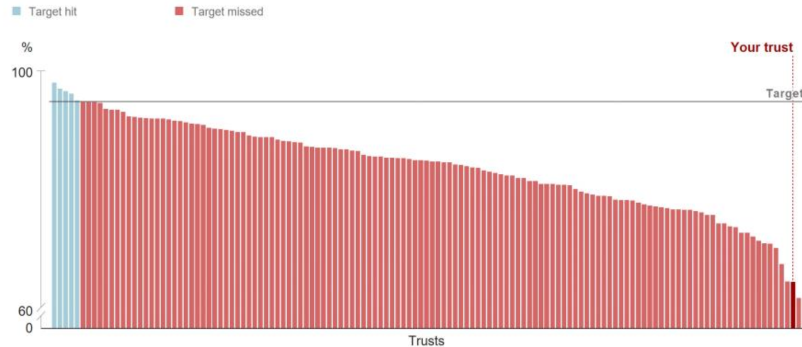
	a) Would it be sensible if the Quality and Performance Committees had this type of information to put ICB performance into some national context?	
29/01/2024 08:35am David Sandbach	**CHECK HOW YOUR TRUST IS DOING** Search your trust to see how it's performing and compares ENTER A POSTCODE OR HOSPITAL SHREWSBURY AND TELFORD HOSP × **Shrewsbury And Telford Hospital NHS Trust** We have ranked your trust as **105th out of 120** in England for its overall performance against key duties of care to its patients **COMPARE TRUSTS** Only 29 trusts out of 120 are treating enough cancer patients on time, but your trust is not one of them  OVERALL TREATMENT CANCER A&E DIAGNOSTIC Source: https://www.telegraph.co.uk/news/uk/best-nhs-hospitals-waiting-times-worst-trust-england-near-me/	**Response Provided by Sara Biffen COO SaTH** An average of 2.3 sessions were allocated per week to SaTH to utilise for inpatient elective orthopaedics. At present, some activity continues to be carried out at SaTH as further work is undertaken Utilisation of all theatre lists is planned to be above 85%

	 Source: https://www.sath.nhs.uk/wp-content/uploads/2019/02/17-Performance-Report-Month-09.pdf Requesting RJAH and SaTH finalise the plan for securing elective orthopaedic activity **Question 17:** a) Has this task been completed? b) When will this plan be made public? c) Will all ICB commissioned planed orthopaedic work be carried out at RJ&AH in what is left of 2023 / 24 and continued in 2024 / 25? d) How much additional productivity will accrue once the plan is implemented?	
29/01/2024 08:35am David Sandbach		**Response provided by Vanessa Whatley, Interim Chief Nursing Officer** A system action plan has been developed for *Clostridioides difficile*. SaTH has done a deep dive

	Quality • The System has exceeded its Infection Prevention and Control Metrics. C difficile has exceeded its annual national objective of 76 cases, with 99 cases to the end of November 2023. Quality assurance is provided by peer review visits but capacity issues at SaTH are preventing deep cleans. Other infection metrics are also exceeding objectives and relevant partners all have action plans internally which are monitored through Infection Prevention and Control Groups. **Question 18:** a) Is management incompetence the real reason for lack of deep clean activity at RSH and PRH? b) Are all areas affected or is it just in the A&E departments as previously reported?	into cases arising from the Trust. Next steps include a system *C difficile* action plan which has been worked up across the Trusts and a series of quality visits to support improvement and share best practice. Action plans have been increased following the communication regarding the new ribotype 955 and Sath successfully completed some deep cleaning in November/December. Other system partners have completed deep cleans. Assurance visits are currently underway by the ICB IP Nurse. High bed occupancy and hard pressed staff is a concern for the spread of C difficile and other healthcare associated infections and require frequent monitoring of practice and cleaning which SaTH and other trusts in the system have given assurance that they have put in place. Regionally and nationally there is a rise in C difficile cases.
29/01/2024 08:35am David Sandbach	Workforce • Workforce metrics show an improvement in the number of substantive staff in post against plan. At the end of November the plan has been exceeded by 607 WTE staff when considering the 3 Trusts combined, however, the positive variance to plan in month at SaTH is compensating for small under performance in SCHT. **Question 19:** a) Does the additional 607 WTE staff beyond plan have anything to do with the deficit of £129.8 million?	**Response provided by Alison Trumper, ICS Head of People Programmes** System overspend is multifactorial. The overarching key reasons for the overspend include. 1. requirement for bank and agency workforce for escalation spaces with patients attending ED and waiting to be admitted (SaTH 208wte shifts) 2. requirement for Shropshire Community Health Trust to open two sub acute wards co-located at SaTH

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		3. 'backfill' for international nurses (105wte) and trainee nurse associates (76wte) whilst they are supernumerary. 4. the cost of recent pay deals and industrial action has also had an impact on the financial position. The recruitment story at SaTH does play into the overspend. 2023/24 workforce plan was based on an assumption that the existing vacancy rate (at the time the plan was written) of 9% would remain the same throughout the year. However, due to a number of People Priority initiatives, SaTH's vacancy rate has reduced month on month since April 2023 with the latest figures as of December 2023, show SaTH's vacancy rate has reduced to 5.1%. Whilst SaTH's workforce growth with resulting vacancy reduction has all been within planned funded establishment, it is to be appreciated that as the workforce expands this comes with a risk of an element of unavailability due to unplanned sickness and planned maternity leave all of which require back fill from temporary workforce.