Integrated Care System
Shropshire, Telford and Wrekin

NHS
Shropshire, Telford and Wrekin

STW Integrated Care Board - Appendices

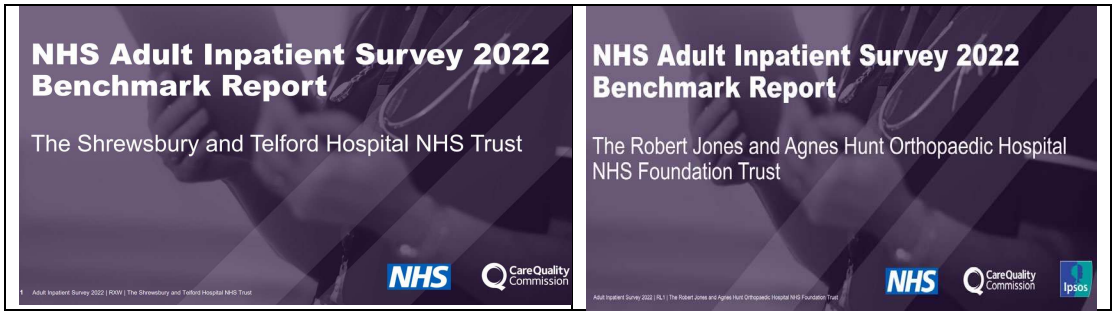
MEETING
29 November 2023 14:00 GMT

PUBLISHED
24 November 2023

Agenda

Location	Date	Time
The Reynolds Suite Holiday Inn Telford International Centre, St. Quentin Gate, Telford TF3 4EH	29 Nov 2023	14:00

Name, Date and Time	Submitted questions	Response
25/9/2023 – 12:03hr David Sandbach	**CQC Patient Survey** 1) Should the members of the ICB congratulate the RJ&AH on their results in the CQC patient survey? https://view.officeapps.live.com/op/view.aspx?src=https%3A%2F%2Fwww.cqc.org.uk%2Fsites%2Fdefault%2Ffiles%2F2023-09%2F20230912_aip22_Outliers.odt&wdOrigin=BROWSELINK **Better than expected trusts** Twelve trusts have been categorised within the highest bands, identified as 'much better than expected' and 'better than expected'. Trusts identified as achieving **'much better than expected'** results: • Liverpool Heart and Chest Hospital NHS Foundation Trust • The Christie NHS Foundation Trust • The Clatterbridge Cancer Centre NHS Foundation Trust • Royal Papworth Hospital NHS Foundation Trust • The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust • Queen Victoria Hospital NHS Foundation Trust	**Response to be provided by:** **Vanessa Whatley, Director of Quality and Safety/Deputy Chief Nurse** We are always pleased to have feedback from the people who use our services. It is very pleasing to see The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundations Trust highlighted as receiving better than expected results in their 2022 survey results.
25/9/2023 – 12:03hr David Sandbach	**Adult In-patient NHS Survey** 2) Given the ICB members have a overwhelming desire to assess and evaluate patient feedback could the ICB members agree to have the results of this data discussed at the next ICB meeting on the grounds that the ICB members are very keen to understand feedback from patients and are always grateful for the time patients contribute to this survey.	**Response to be provided by:** **Alison Bussey, Chief Nursing Officer** The ICB appreciates the time taken by patients to provide feedback on their experiences of using healthcare services locally. The results of the survey are presented to the specific provider Board for their consideration and used to support internal improvement in organisations. It is also presented to the ICS's System Quality Group (SQG) and ICB's

	https://nhssurveys.org/wp-content/surveys/02-adults-inpatients/05-benchmarks-reports/2022/The%20Robert%20Jones%20and%20Agnes%20Hunt%20Orthopaedic%20Hospital%20NHS%20Foundation%20Trust.pptx https://nhssurveys.org/wp-content/surveys/02-adults-inpatients/05-benchmarks-reports/2022/The%20Shrewsbury%20and%20Telford%20Hospital%20NHS%20Trust.pdf 	Quality & Performance Committee (QPC) with any key or exception reporting presented to the ICB Board.
22/9/2023 – 14:51hr Stephanie Thompson (Stroke Association)	**Stroke** 3) Given that stroke is a leading cause of death and disability, with stroke survivors leaving hospital with an average of 7 disabilities, many needing complex and life-long care and contributing to delays in discharge and pressures across the health and social care system, how does NHS Shropshire, Telford and Wrekin Integrated Care Board (ICB) plan to appropriately fund and resource the Integrated Stroke Delivery Network as the essential delivery mechanism for meeting guideline level standards of care and achieving the Long Term Plan's stroke commitments? What protection and security can you provide to the committed and valuable stroke network staff who are working tirelessly to improve the quality and safety of local services for this clinical priority?	**Response to be provided by:** **Gareth Robinson, Director of Delivery & Transformation** The ICB, SaTH and partners are working alongside Integrated Stroke Delivery Network (ISDN) to deliver the local Stroke Improvement Implementation plan 2023/24. The plan consists of local develops but also ISDN requirements. The improvement plan aligns to the ISDN priorities for 2023/24. Following the Integrated Stroke Delivery Network (ISDN) audit in February 23 and subsequent recommendations, the ICB, SATH and partners are working together to implement a number of Stroke improvements which includes the

		development of a business case to support staffing and rehabilitation for patients. The STW along with the Black Country, Stoke and Staffordshire Integrated Care boards have been successful in securing funding from NHS England to fund 60 placements for training of staff to offer psychological support to Stroke patients. Our patients will be primed to be engaged with rehabilitation and support to ensure that the patient's journey is seamless as they move through the pathway. By doing this we aim to demonstrate improvements in patient's feelings of anxiety, depression and sense of self, improved patient feedback and improved overall functional outcomes by embedding psychology based supportive conversational rehabilitation into the delivery of every patient interaction. The system continues to work through a number of improvements as part of its commitment to delivering the ISDN priorities.
25/9/2023 13:12hr Gill George	**Availability of Board papers** 4) Board papers for Wednesday's meeting appear to have been made available on the 'NHS STW BOARD MEETINGS' page within the last hour or two. This is unsatisfactory when Board questions are required to be submitted 48 hours before the meeting. Can Board papers be made available alongside meeting details in a timely way in the future? I believe five days has been the NHS norm in the past. It is obviously not practical for me or any member of the public to read this volume of paperwork between publication and 2 pm today.	**<u>Response to be provided by:</u>** **Simon Whitehouse, Chief Executive** We understand the importance of publishing NHS Shropshire, Telford and Wrekin Board papers 5 days prior to the Board in order to give the public an opportunity to submit questions 48 hours before the meeting, and this is our normal practice. Board papers were published on Friday, 22 September 2023, however, due to an error with one of the papers, the papers were taken down over the weekend and re-uploaded on Monday morning, 25 September 2023. We apologise for any inconvenience this may have caused.

25/9/2023 13:12hr Gill George	**Rurality** 5) What active steps are taken by the ICB to ensure that the needs of rural communities are considered in the planning and provision of local health care?	**Response to be provided by:** **Gemma Smith, Director of Strategic Commissioning** NHS STW is committed to working with people and communities and uses insight gained from engagement and consultation which provides rich intelligence that other performance data cannot, such as experience of a service, whether there are any barriers to accessing a service, or their views about a change in service. Involvement and engagement is a part of every stage in the commissioning cycle from planning and development right the way through to delivery. Equality Impact Assessments and Integrated Impact Assessments are undertaken at the beginning of the process of any transformation programme of work to help identify groups in the community that we especially need to hear from ie rural stakeholders identified, and we will demonstrate how we will involve and engage. The involvement and engagement process is planned around a clear timetable (identifying appropriate methods) and there is clear transparency around the process ensuring accessibility to all. Outcomes of the involvement and engagement are clear and demonstrate how this has informed decision making. This will include reports detailing what we have heard, the insights generated and how we have acknowledged or acted on the feedback from our citizens.

		We know that rurality increases health inequalities, so it is a key consideration when we are considering our approach to engagement and involving on service delivery. Working with our communities, as well as our partners, is vital if we are to make a long-lasting difference to the lives of people living and working in rural areas. We pay particular attention to hearing from people who face barriers accessing services (such as rurality) and have poorer experiences and outcomes – understanding their needs, challenges, aspirations – will enable us to work together to reduce inequalities and improve their health and wellbeing. We will continue to work with our partners and use all of our networks to reach our diverse communities, building on the relationships including with local businesses, faith and community groups, and educational settings.
25/9/2023 13:12hr Gill George	**Stroke care** 6) The SSNAP clinical audit of stroke data continues to show the stroke unit at PRH performing below average on many key indicators. This appears to have been a poorly performing unit for very many years. Particularly concerning is the 12.4% of patients receiving thrombolysis within an hour of clock start (i.e. within an hour of arrival at PRH, using the most relevant 'Team-centred' indicator) between April 2022 and March 2023. That 12.4% compares with 59.9% of patients nationally receiving thrombolysis within an hour of clock start. Time to treatment is of course a key determinant of outcome for stroke patients, and many of these patients will already have suffered harm whilst waiting for an ambulance. The 12.4% represents a sharp deterioration on previous years, but SaTH has consistently performed poorly on this measure.	**<u>Response to be provided by:</u>** **Gareth Robinson, Director of Delivery & Transformation** The ICB is committed with partners to improving local Stroke services for patients. Following the Integrated Stroke Delivery Network (ISDN) audit in February 23 and subsequent recommendations, the ICB, SATH and partners are working together to implement a number of Stoke improvements. These improvements are aligned to the ISDN stroke priorities 2023/24. Improvements include (but not limited to) improving the thrombolysis pathway for patients. Some of the changes that have been made within SaTH to improve the pathway for patients and subsequently their experience includes to date: -

	What steps is the ICB taking with SaTH to improve stroke care for patients in Shropshire, Telford and Wrekin? In particular, what steps are being taken to address time to thrombolysis	• A dedicated Thrombolysis suite has been introduced on the Acute Stroke ward, to minimise any delay to patient in treatment. • A dedicated ambulance bay outside the Acute Stroke ward for ease of access and to be able transfer patients safely to and from the ward or if critically unwell to another provider. • A pilot using the Air Ambulance is now being used to transfer patients to UHNM for time critical treatment instead of waiting on an ambulance. • There are now two ring fenced beds on the acute stroke ward to allow the most critical stroke patients and healthcare professionals ease of access to the stroke unit. • A new process has been implemented for repatriation of stroke patients, to ensure patients are received and transferred safely to the unit in a timely fashion. SaTH hold a monthly stroke meeting, all partners are invited. The group review any changes that have already been made and if necessary, make any further subsequent changes to ensure that they are working. The group will also discuss the progress of each action of the Stroke Improvement plan and any further ISDN guidance to ensure that the local plan remains aligned to the ISDN priorities.

25/9/2023 13:12hr Gill George	**Community Hospitals** 7) What is the likely timescale for the long-promised/ long-threatened commissioner-led review of community beds? This is now part of 'Cohort 2'? There is a growing view amongst communities in rural Shropshire that a local provider is deliberately running down community hospital inpatient services. There is a concern that possible solutions to staff shortages are ignored, and that related patient safety risks - including those arising from the current squeeze on the use of agency staff - are also ignored. The fear is that there is an intention of a 'fait accompli', of quietly allowing a crisis to emerge, with this to be used as a justification for closure of services before any meaningful assessment of patient need in rural Shropshire takes place. This would of course be wholly unacceptable. As commissioner, will the ICB encourage the organisation concerned to address these issues positively and with a sense of urgency?	**Response to be provided by:** **Gemma Smith, Director of Strategic Commissioning** Phase 2 of the Local Care Transformation Programme will include the review of the community beds across Shropshire, Telford and Wrekin alongside the development of the neighbourhood approach to care. This will also include the review of the model of care and other opportunities to deliver both community and bed based care within local communities. Any proposals about service provision will need to be informed by analysing the needs of the population and both engagement and co design with communities, staff, and stakeholders. NHS STW will be commencing this process working alongside Shropshire Council as commissioners in the coming months. This forms part of the system integrated care strategy and Joint Forward Plan alongside the commitment that our Community Hospitals are fully utilised and become thriving hubs supporting the needs of our local population. NHS STW recognises that there needs to be a solution to the physical estates as well as being clear on the configuration and integration of services that meet the population health need for rural Shropshire, and have commenced early discussions with NHS Property Services and Shropshire Community Health Trust in relation to the estate. NHS STW is also working closely with Shropshire Community Health NHS Trust to understand the current challenges and opportunities in relation to the Community Hospitals and have seen positive progress in international recruitment.

		We remain committed to working in partnership to commission and deliver services as close to communities as possible aligned to need.

Agenda Item

ICB 29-11-128

System Board Assurance Framework

NHS Shropshire, Telford and Wrekin

System Board Assurance Framework

2023/24

Version 2 November 2023

Risk Matrix

Consequence						
	5 Catastrophic	5 Low	10 Moderate	15 High	20 Extreme	25 Extreme
	4 Major	4 Low	8 Moderate	12 High	16 High	20 Extreme
	3 Moderate	3 Very Low	6 Low	9 Moderate	12 High	15 High
	2 Minor	2 Very Low	4 Low	6 Low	8 Moderate	10 Moderate
	1 Negligible	1 Very Low	2 Very Low	3 Very Low	4 Low	5 Low
		1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost Certain
	Likelihood					

	1 – 3	Very Low risk
	4 – 6	Low risk
	8 – 10	Moderate risk
	12 – 16	High risk
	20 – 25	Extreme risk

NHS SHROPSHIRE, TELFORD AND WREKIN STRATEGIC OBJECTIVES

1. Reducing Health Inequalities

- Wider determinants.
- Tackling health inequalities.

2. Improving Population Health

- Best start in life.
- Healthy weight.
- Alcohol, drugs, domestic abuse.

3. Improving Health and Care

- Strengthen, prevention, early detection and improve treatment outcomes – mental health, heart disease, diabetes, cancers, and musculoskeletal disease.
- Urgent and Emergency Care
- Integrated person-centred care within communities – strong focus on Primary and Secondary Care.

Strategic Aim: All			Risk Score 20 4 likely x 5 catastrophic
Strategic Risk No.1: Unable to sustain a culture of Strategic Collaboration and Partnership working and secure delivery of Integrated Care across the priority areas.			
If we are unable to develop and sustain a culture of collaborative working and build effective partnerships	***Then*** we will not be able to achieve our aims, focus on our priorities or deliver our objectives.	***Resulting*** in poor outcomes for our population, adverse impacts on our partner organisations and increased scrutiny of our effectiveness	

	Consequence	Likelihood	Score	Risk Trend
Current	5 Catastrophic	4 Likely	20 Extreme	⟺
Target	4 Major	3 Possible	12 High	

Risk Lead	ICB Chief Executive Officer	**Assurance Committee**	Board

System Controls	Assurances reported to ICB Board and Committees
Strategies and Plans • ICB Constitution • ICP Terms of Reference • Governance Handbook/Functions and Decisions Map • System Development Plan • Better Care Fund Plans • Primary Care Strategy • Clinical and Professional Leadership Programme • Integrated Care Strategy • Joint 5 year Forward Plan **Partnerships and Services** • Integrated Care Partnership • ICS Chief Executive Group • ShIPP • TWIPP • Health and Wellbeing Boards **Governance and Engagement Structures** • Integrated Care Partnership; Board of the Integrated Care Board and Integrated Delivery Committee • STW Mental Health Collaborative • GGI Review of ICB/ICS Governance Structures • ICB Strategic Partner on development of ICB Version 3.0	**First Line of Assurance** • Monitoring and oversight at ICB Executive Group and ICS Chief Executive Group **Second Line of Assurance** • Population Health Board **Third Line of Assurance** • Integrated Care Partnership Oversight • National Health Service England Integrated Care Board Establishment Assessment and Establishment Order

Gaps in Controls and Assurances	Actions and Mitigations to address Control/Assurance Gaps
1. Independent assessment (NHSE, CQC) 2. Development of Provider Collaborative and supporting Governance Structure	1. Complete self-assessment against NHSE/CQC regulatory Framework - Q4. 2a Interim ICS Director of Strategy leading development of STW Provider Collaborative – Q3. 2b CB CEO co-Chair of HWBB's. 2c Director of Partnerships and Place supporting delivery of JFP priorities and Integrated Place working.

Current Performance – Highlights
Development of Provider Collaborative and Partnerships is now progressing with some dedicated ICB capacity. An Action Plan is in development, to provide structure and timescales to the programme of work to develop the STW approach to collaboration by end of 2023.

Associated Risks on the System Strategic Operational Risk Register	
Risk no.	**Description**
	None Identified

Relevant Risks on System Partners Risk Registers
Description
SaTH - BAF 12 - There is a risk of non-delivery of integrated pathways, led by the ICS and ICP. MPFT – BAF B8 - There is a risk to service stability and equity, due to the fragmentary influence of Place Based Partnerships on service commissioning. Shropshire Council – Corporate Risk Register - Extreme pressures upon Partners (social care, health, and criminal justice) within the system impacting on Shropshire Council through increased expectation, demand, need and complexity.

Strategic Aim: All		Risk Score 25 Almost Certain 5 x Catastrophic 5
Strategic Risk No.2: Risk of not delivering sustainable services within available resources.		
If we are unable to adopt best practice and integrated modelling as rapidly as we need to.	***Then*** we will be unable to use our budgets and wider resources more effectively and efficiently and share risks and benefits.	***Resulting*** in challenges in service delivery for our population, poor health outcomes, and increased scrutiny of our effectiveness.

	Consequence	Likelihood	Score	Risk Trend
Current	Almost Certain 5	Catastrophic 5	25	↑
Target	Possible 3	Major 4	12 High	

Risk Lead	ICB Chief Finance Officer	Assurance Committee	ICB Finance Committee

System Controls	Assurances reported to ICB Board and Committees

Strategies and Plans
• System Financial Strategy, incorporating:
  ○ Healthcare Financial Management Association (HFMA) Financial sustainability checklist
  ○ Triple Aim framework
  ○ Value based decision making approach
• Financial Revenue Plan
• Financial Capital Plan
• Joint 5 year forward plan
• Efficiency and Transformation Plans
• General Practice Estate Programme
 	
Partnerships and Services
• ShIPP
• TWIPP
• Digital Board
• Estates Board
• People Board
• Planned Care Board
• UEC Delivery Board
 	
Governance & Engagement Structures
• Finance Committee
• Investment Panel
• Integrated Delivery Committee
• Audit Committee
	First Line
	• Monitoring delivery of System Financial Strategy and Financial Plan by CFO group
	• Standing Orders, Standing Financial Instructions and Delegated Financial Limits
	• Financial Accounting Performance Metrics
	• HFMA Financial Sustainability Checklist
	• Better Payment Practice Code
	• Productivity review informed by:
	  ○ Getting It Right First Time (GIRFT)
	  ○ Model Health System
	  ○ ICS Patient Level Information and Costing Systems (PLICS) dashboard
	  ○ Health Expenditure benchmarking tool (HEB)
	
	Second Line
	• Finance Report to Finance Committee
	• Integrated Performance and Finance Report to the Board
	
	Third Line
	• Monthly Integrated (Care System) Finance Return and Provider Finance Returns reporting to NHSE
	• Quarterly NHSE Financial Stocktake
	• NHSE Annual planning process (and triangulation of Finance, Activity and workforce planning)

Gaps in Controls and Assurances	Actions and Mitigations to address Control/ Assurance Gaps
1. Joint financial plan across ICS partners 2. Independent assessment (NHSE, CQC)	1. Develop financial sustainability plan 2. Complete self-assessment against NHSE/CQC regulatory framework

Associated Risks on the System Strategic Operational Risk Register	
Risk no.	**Description**
System Risk 8	Financial Plan 23/24
System Risk 9	Financial Sustainability

Current Performance – Highlights

Long term system financial model submitted at a high level in line with NHSE regional planning deadlines.

Detailed long-term demand and capacity model and medium-term financial plan underway - consultancy support procured.

Development of five-year transformation plans through Financial Improvement Programme Board and overseen by IDC.

Development of system financial strategy document to dovetail with long term financial modelling and development of ICB joint forward plan.

Contract rebasing exercise underway for in system contracts to agree contract arrangements and risks sharing framework for 24/25.

Relevant Risks on System Partners Risk Registers

Description

SaTH BAF 5 - The Trust does not operate within its available resources.

RJAH BAF 8 – Adverse impact of System Financial deficit.

Shropcom BAF 8.1 – Costs exceed plan.

MPFT BAF R1 - There is a risk to the financial sustainability of the Trust and Integrated Care System due to not delivering the future System and Trust Efficiency Plans resulting in a deteriorating underlying deficit position.

MPFT BAF R13 - There is a risk to the financial sustainability of the Trust and Integrated Care System due to not having an aligned Financial Strategy and Implementation Plan resulting in poor allocation of resources, financial restrictions and regulatory action.

Telford & Wrekin Council – Corporate Risk Register R2 - Inability to:

a) Match available resources (both financial, people and assets) with statutory obligations, agreed priorities and service standards.
b) Deliver Financial Strategy including capital receipts, savings and commercial income.
c) Fund organisational and cultural development in the Council within the constraints of the public sector economy.

Shropshire Council – Corporate Risk Register:

a) Extreme pressures upon Partners (social care, health, and criminal justice) within the System, impacting on Shropshire Council through increased expectation, demand, need and complexity.
b) Sustainable budget.

Strategic Aim: ALL			Risk Score 20 Likely 4 x Catastrophic 5
Strategic Risk No.3: STW is seeing a growing and ageing population; services and the workforce will need to adapt and shape to meet these needs. There is a risk that this capacity and capability will not be sufficient to meet population needs nor be able to focus on tackling identified and emergent health inequalities in every instance.			
If we are unable to find sufficient staffing or expert/technical resources in ICB and across all system partners.	***Then*** we will not be able to meet increase health inequalities in our services.	***Resulting*** in poorer outcomes for our population, adverse impacts on our partner organisations and increased scrutiny of our effectiveness.	

	Consequence	Likelihood	Score	Risk Trend
Current	Catastrophic 5	Likely 4	High 20	⇔
Target	Major 4	Possible 3	High 12	

Risk Lead	ICB Chief Nursing Officer	**Assurance Committee**	ICB Quality and Performance Committee

System Controls	Assurances reported to ICB Board and Committees
Strategies and Plans • 5 Year Forward Plan • System Development Plan • Inequalities Implementation Operational Plan • Primary Care Winter Plan • Integrated Care Strategy **Partnerships and Services** • CEO Group • Urgent and Emergency Care Board • Finance Advisory Board • ShIPP • TWIPP • Mental Health Delivery Board • Emergency Preparedness Resilience and Response Framework • System People Board • Local Maternity and Neonatal System • Primary Care Networks • System Quality Group **Governance and Engagement Structures** • Integrated Care System CEO Group • ICB Board • ICB Strategy Committee	**First Line of Assurance** • Routine Quality Monitoring and Triangulation by Quality Team • General Practice Appointment Data Monitoring • Performance Dashboard • Monthly Key Lines of Enquiry for areas of underperformance / concern • Monthly Oversight System Review Meetings • Monitoring and oversight by command structure **Second Line of Assurance** • Cancer and Planned Care Report to ICB Quality Safety and Performance Committee • Urgent and Emergency Care Report to ICB Quality and Performance Committee • Integrated Performance Report to ICB Quality and Performance Committee • Learning Disability and Autism Assurance Report to ICB Quality and Performance Committee • Performance Report to ICB Quality and Performance Committee • Annual Operating Plans to Finance Committee

• ICB Quality and Performance Committee • ICB System People Committee • ICB Strategy Committee • Integrated Care System Health Inequalities Board • Population Health Board	• Local Maternity and Neonatal System Report to ICB Quality and Performance Committee • Primary Care Quality reporting to Primary Care Commissioning Committee • Integrated Provider Report to ICB Quality and Performance Committee • Quarterly reporting to Board **Third Line of Assurance** • National System Oversight Framework • NHSE Quarterly System Review Meetings • Coare 20 +5 reporting to regional NHSE

Gaps in Controls and Assurances	Actions and mitigations to address Control / Assurance Gaps
1. Independent assessment (NHSE, CQC)	1. Complete self-assessment against NHSE/CQC regulatory framework - CQC - timeframe yet to be published nationally.

Current Performance – Highlights

- Health Inequalities – System Board focussed on Health Inequalities has been established. Additional ICB staff capacity fixed term secured. Improved partnership working including engaged Executive Lead in all providers.
- Population Health - Population Health analysts capacity secured in Planning and Performance Directorate. Population Health Board now reports into Strategy Committee to clarify assurance reporting lines.

Associated Risks on the System Strategic Operational Risk Register

Risk no.	Description
Risk 1	CYP Mental Health
Risk 3	Palliative Care/End of Life
Risk 4	Maternity Services
Risk 5	Urgent and Emergency Care
Risk 7	Diabetes Management
Risk 15	Acute Paediatric Pathway
Risk 16	C Diff

Relevant Risks on System Partners Risk Registers
Description
RJAH – BAF 3 - Failure to effectively promote equality, diversity, and inclusion. MPFT – BAF B4 - The Trust is committed to embedding equality and inclusion in everything we do **Shropshire Council – Corporate Risk Register:** a) Critical skills shortage impacting on Retention, Recruitment & Succession Planning. b) Extreme pressures upon Partners (social care, health, and criminal justice) within the System impacting on Shropshire Council through increased expectation, demand, need and complexity. c) Sustainable Budget (i.e. budget will not keep track with current population projections overlaid with level of need to the demography of the population and long term investment in preventive/demand management approaches needed).

Strategic Aim: ALL		Risk Score 16 Major 4 x Likely 4
Strategic Risk No.4: Inability to recruit, retain and keep our ICS Workforce well.		
If we are unable to provide the workforce to deliver clinical and non-clinical services due to inability to recruit, retain and keep our workforce well	***Then*** we will not develop our inclusive culture and effectively deploy a workforce with the necessary skills and expertise that meet service requirements	***Resulting*** in a failure to deliver services to the population of STW.

	Consequence	Likelihood	Score	Risk Trend
Current	4 major	4 likely	16 high	
Target	3 moderate	3 possible	9 moderate	

Risk Lead	ICB Chief Nursing Officer	Assurance Committee	ICB Quality and Performance Committee

System Controls	Assurances reported to ICB Board and Committees
Strategies and Plans • One People Plan Recommendations and Insights Report • Workforce Information Dashboards to consider Workforce Information (sickness, turnover, vacancies, staff in post, agency, and bank usage etc) • 5-year Joint forward Plan **Partnerships and Services** • People related workstreams being led by the ICS People Team **Governance & Engagement Structures** • System People Committee provides oversight of the development of our System People Strategy and annual programmes and Strategic Direction of Travel • System People Committee oversight of Annual Operational Workforce Planning Process to set Direction of Travel for next 12 months.	**First Line of Assurance** • Workforce information dashboards outputs **Second Line of Assurance** • People Plan Programme Progress Report to the People Committee of the Integrated Care Board

Gaps in Controls and Assurances	Actions and mitigations to address Control / Assurance Gaps
Gaps in Controls: 1 The System People Strategy and priorities are not agreed by system CEOs. 2 The System People Collaborative approach, including HRD SROs and refreshed operational delivery and oversight processes/meetings, is not agreed by system CEOs. 3 An appropriate and resourced structure – within the system People Team and through provider partner employers – is not agreed by system CEOs. 4 The System People Committee is not meeting regularly, and its authority and remit requires a refresh. 5 There is no consistent System Oversight of workforce metrics, workforce supply or the delivery of our People Strategy, or progress on the delivery of the 10 people outcomes. Gaps in assurances: 2) Regular minutes from the System People Committee.	1 Finalise our ICS People Strategy and priorities by September 2023. 4 GGI Making Meetings matter review includes System People Committee – due to report in September 2023. ½/3/CEO decisions on system people collaborative approach, structures, and resources – following discussion papers taken to CEOs meetings and HRD meetings for consideration. 4. Refresh of the System People Committee as the Oversight Function. 5. Refresh of the People Delivery Committee as the Operational Delivery Programme Board. 2. see (4) above

Current Performance – Highlights
Paper presented to CEOs with options/proposal for consideration.

Associated Risks on the System Strategic Operational Risk Register	
Risk no.	**Description**
Risk 10	ICB Financial staff capacity
Risk 12	Chief People Officer for the System
Risk 13	Deputy Chief People Officer capacity
Risk 14	Capacity to deliver 10 people pledge outcomes

Relevant risks on System Partners Risk Registers
Description
SaTH – BAF 3 - If the Trust does not ensure staff are appropriately skilled, supported and valued this will impact on our ability to recruit/retain staff and deliver the required quality of care. SaTH BAF 4 - A shortage of workforce capacity and capability leads to deterioration of staff experience, morale, and well-being. RJAH – BAF 1 – Lack of effective engagement with workforce. RJAH – BAF 2 - The workforce does not have the required capacity and capability. Shropcom – BAF 3.1 – Recruitment challenges. MPFT- BAF F1 - There is a risk to the health and wellbeing of staff due to existing workforce shortages, high acuity and demand, and the long-term effects of the pandemic; leading to staff burnout, absence and increased turnover.

MPFT – BAF F2 - There is a risk to the delivery of Trust services due to national workforce supply issues and
skills shortages; leading to an inability to recruit and retain sufficient numbers of clinical, technical and managerial staff.
Telford & Wrekin Council – Corporate Risk Register – R3 - Losing skills, knowledge and experience (retention & recruitment) in relation to staffing.
Shropshire Council - Corporate Risk Register - Critical skills shortage impacting on Retention, Recruitment & Succession Planning.

Strategic Aim: ALL			Risk Score 16 High Major 4 x Likely 4
Strategic Risk No.5: Lack of capacity and strategy to develop and use digital and data systems to enable efficient and effective care across the ICS			
If we are unable to develop and use our Digital and Data Systems.	***Then*** we will not be able to make informed decisions, develop Integrated Services that are digitally enabled and monitor their effectiveness against our aims.	***Resulting*** in challenges in service provision, staff dissatisfaction, and poorer health and care outcomes for our local population.	

	Consequence	Likelihood	Score	Risk Trend
Current	Major 4	Likely 4	High 16	⟺
Target	Moderate 3	Possible 3	Moderate 9	

Risk Lead	ICB Chief Medical Officer	Assurance Committee	ICB Strategy Committee

System Controls	Assurances reported to ICB Board and Committees
Strategies and Plans • Integrated Care Strategy • Joint Forward Plan • Population Health Roadmap • Joint Strategic Needs Assessments **Partnerships and Services** • Population Health Management Board • Digital Transformation Board • TWIPP • ShIPP **Governance & Engagement Structures** • Integrated Delivery Committee • Strategy Committee	**First Line of Assurance** • Routine progress reports from key workstreams • Regular Population Health Management Workstream Update to the Population Health Board • Regular Inequalities Workstream Update to the Population Board **Second Line of Assurance** • Population Health Report to Integrated Delivery Committee
Gaps in Controls and Assurances	**Actions and mitigations to address Control / Assurance Gaps**
Gaps in controls: 1. Digital Strategy in place 2. Joint information and data strategy across ICP 3. Independent assessment (NHSE, CQC) 4. Identified resources to support delivery of the Digital Strategy Gaps in Assurances: 5. System digital governance	1. Digital Strategy Board approval scheduled September 2023 2. Develop information and data strategy across ICP 3. Complete self-assessment against NHSE/CQC regulatory framework 4. Consideration of system resources for support delivery of the Digital Strategy 5. Develop system digital governance following adoption of Strategy

Current Performance – Highlights
Draft Digital Strategy has been developed and scheduled to be presented to Board on 27 September for approval.

Associated Risks on the System Strategic Operational Risk Register		
Risk no.	**Description**	**Current score**
	None identified	

Relevant risks on System partners Risk Registers
Description
SaTH BAF 7A - Failure to maintain effective cyber defences impacts on the delivery of patient care, security of data and Trust reputation. SaTH BAF 7B - The inability to replace implement modern digital systems impacts upon the delivery of patient care. RJAH BAF 6 - IT unable to support new ways of working. RJAH BAF 7 – Loss of data/unable to restore services following a cyber-attack. MPFT BAF R14 - There is a risk that the appropriate cyber security controls are not in place services following a cyber-attack. Shropshire Council - Corporate Risk Register - Critical skills shortage impacting on Retention, Recruitment & Succession Planning

Strategic Aim: ALL			Risk Score 16 major 4 x likely 4
Strategic Risk No.6: Inability to respond strategically to ICS objectives due to the impact of external factors beyond the influence of the ICS. for example, EPRR, Climate change, economic and political changes.			
If we are unable to respond collectively to the external challenges facing our local area.	***Then*** we will not be able to meet our ICS objectives to improve the health and wellbeing of our population.	***Resulting*** in poorer outcomes for our population and with further pressure on Health and Care services.	

	Consequence	Likelihood	Score	Risk Trend
Current	Major	Likely	16 High	
Target	Major	Possible	12 High	

Risk Lead	ICB Chief Executive	**Assurance Committee**	ICB Board Audit Committee - EPRR

System Controls	**Assurances reported to ICB Board and Committees**
Strategies and Plans • Integrated Care Strategy • 5 year Joint Forward Plan • Health and Wellbeing Strategies **Partnerships and Services** • TWIPP • ShIPP • Provider Collaboratives • ICS Chief Executives Group • Networks **Governance & Engagement Structures** • Integrated Care Partnership and Integrated Care Board and associated committees • ICB – agreed values and behaviours • Health and Wellbeing Boards	**First Line of Assurance** • Joint Strategic Needs Assessments • Workforce mapping **Second Line of Assurance** • Population Health Board report to ICB Integrated Delivery Committee **Third line of Assurance** • Health and Wellbeing Boards
Gaps in Controls and Assurances	**Actions and mitigations to address Control/Assurance Gaps**
Gaps in Controls: 1. Strategic partnership focus on broader social and economic development of the area has been limited to date. Gaps in Assurances: 2. No clear committee that has this oversight in its remit.	1. Population health management approach needs to be adopted. 2. GGI review of meetings and governance structure – phase 1 October 2023

Current Performance – Highlights
• GGI review phase 1 due to report proposed revised governance structure for ICB/ICS in October 2023.

- Population Health - Population Health analysts capacity secured in Planning and Performance directorate. Population Health Board now reports into Strategy Committee to clarify assurance reporting lines.

Associated Risks on the System Strategic Operational Risk Register	
Risk no.	**Description**
	None identified

Relevant risks on System partners Risk Registers
Description
Shropshire Council – Corporate Risk Register: a) Delivery of the Economic Growth Strategy b) Extreme pressures upon partners (social care, health, and criminal justice) within the system impacting on Shropshire Council through increased expectation, demand, need and complexity.

Strategic Aim: ALL		Risk Score 12 High Major 4 x Possible 3
Strategic Risk No.8: Patient and Public Involvement		
If the ICB fails to meet its statutory duty to involve patients and the public in planning and commissioning arrangements, and in the development of proposals to change or cease existing services.	***Then*** services will not be tailored to local people's health and care needs.	***Resulting*** in potential judicial review and not meeting the population health needs and increasing health inequalities in the local population and leading to poorer health outcomes.

	Consequence	Likelihood	Score	Risk Trend
Current	Major 4	Possible 3	High 12	
Target	Moderate 3	Unlikely 2	Moderate 8	

Risk Lead	ICS Director of Communications and Engagement	**Assurance committee**	Integrated Delivery Committee Equality and Involvement Sub Committee

System Controls	Assurances reported to ICB Board and Committees
Strategies and Plans • Integrated Care Strategy • 5 Year Forward Plan • Big Health and Wellbeing conversation comms and engagement plan socialised and approved by Board. • Communications and Engagement Strategy for STW ICB approved by the Board. **Partnerships and Services** • Presence of Healthwatch for both areas at Board meetings and Quality and Performance Committee. • System Involvement and Engagement Network established. • Communications and Engagement teams working jointly across ICB, ICS and Providers providing more capacity and expertise in planning and delivery. • Board meetings are held in public and board papers published to the ICB website to increase transparency. • Substantive ICS Director of Comms and Engagement now appointed and overseeing ICB and ICS functions. • System-wide Integrated Impact Assessment (IIA) tool developed to streamline the way we identify the impact of change on equality groups.	**First Line of Assurance** • Reporting on Engagement as part of wider reporting and decision making at IDC, SC and Q&P Committee **Second Line of Assurance** • Reporting to Equality and Involvement Sub-Committee. EIC now receiving comms and engagement plans from commissioners and Integrated Impact Assessments (IIA), Chair provides reports to IDC. **Third Line Assurance** • Health and Overview Scrutiny Committees (HOSC) • NHSE Annual ICB assessment includes component on statutory responsibility to engage with the local population and partners.

Governance & Engagement Structures • Integrated Care Partnership and Integrated Care Board and associated committees. • Reports to Governing bodies/Committees require section completing on Patient involvement. • Equality and Involvement Sub-Committee as part of ICB Governance. • Non-Executive Director for Inequalities in place on Board to act as specific check and balance with regard to patient involvement.	
Gaps in Controls and Assurances	**Actions and mitigations to address Control/Assurance Gaps**
Gaps in Controls: 1) Limited engagement capacity within the comms and engagement team Gaps in Assurances: None	1a) CSU comms and engagement capacity is used when required. 1b) People's network established to enable ongoing engagement on a regular basis.

Current Performance – Highlights
Limited capacity continues to be a challenge.

Associated Risks on the System Strategic Operational Risk Register	
Risk no.	**Description**
	None identified.

Relevant risks on System partners Risk Registers
Description
MPFT – BAF P2 - There is a risk that the Trust will not be able to adequately measure and respond to the experiences of our service users due to the limitations of the current feedback systems and approaches. This may impact on the Trust reputation due to reduced confidence in the ability to learn, respond, and improve services in response to customers voice/views.

Agenda Item

ICB 29-11-131

System Level Primary Care Access Improvement Plan

Integrated Care System
Shropshire, Telford and Wrekin

NHS
Shropshire, Telford and Wrekin

STW ICB System-level Primary Care Access Improvement Plan

November 2023

Contents page

Executive Summary

Following the publication of the Delivery plan for recovering access to primary care in May 2023, integrated care boards (ICBs) are required to develop system-level access improvement plans. This aligns with their leadership responsibilities and accountability for commissioning general practice services and delivery as well as, from April 2023, community pharmacy, dental and optometry services.

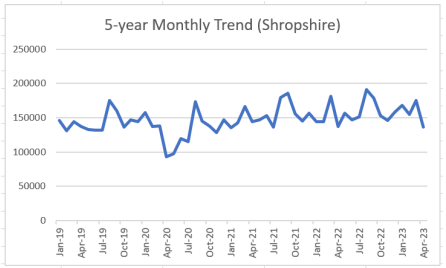
National guidance was published at the end of July 2023 detailing the required contents of the system level plan.

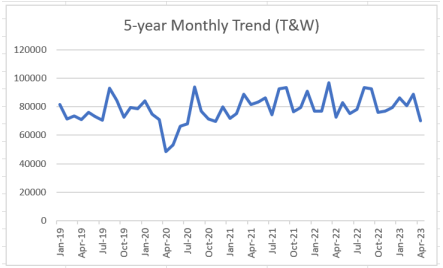
The STW Primary Care Access Improvement Plan sets out our ambition to improve local access to general practice, maintain and improve patient satisfaction and work to streamline access to care and advice.

Executive Summary

Where we started

Primary Care have been working hard to return access to pre covid levels as well as increasing the access available to patients. We now see around 2.86m appointments a year with an offer of over 9% more appointments than we had pre covid with 7 out of 10 patients being seen face to face, as seen below:





Overall the STW position with GP survey results are good and two STW practices were amongst the top 10 practices in the Midlands Region in the 2023 GP Patient survey receiving a congratulations message from the Regional Medical Director for Primary Care. Our response rate for these GP Surveys is currently 41%.

Executive Summary

What are we going to do

Our NHS Access & Recovery Plan is underpinned by the 4 national pillars, Empowering Patients, Implementing Modern General Practice, Building Capacity and Cutting Bureaucracy. Within Primary Care here is a highlight of the things we are doing to and where we aim to be:

Empowering Patients

- Roll out of the NHS App functionality to 90% of Practices by March 2024 (compared to 75% for the National plan)
- Increase all patient self referral activity by 50%
- Increase usage of the Community Pharmacy service to the 81 Community Pharmacies across STW

Implementing Modern General Practice

- As an ICB we encourage all Practices to apply for funding to move to a Modern General Practice Model with 21 out of 51 Practices currently engaging by implementing this. We plan to:

Executive Summary

- Improve Digital Telephony across the system by offering call queuing, call back, call routing and integration with clinical systems for all STW practices.
- Offer improved online access for patients across all Practices.
- Improve care navigation, assessment and response of our Practices.

Building Capacity

- Increase Healthcare Professional workforce across STW.
- Improve GP Retention across STW and improve current retention of clinical staff.
- Work with Practices and PCNs to increase and improve our level of Practice Nurse.
- Continue to develop and implement our STW wide Estates Strategy to ensure all of Primary Care is fit for purpose
- Ensure Primary Care as a higher priority with all plans of new housing developments across the Region

Executive Summary

Cutting Bureaucracy

- Work with Secondary Care to improve the Primary Care/Secondary Care interface
- Improve onward referrals of patients across the system
- Offer all Practices the ability to be part of the National GP Improvement Plan with tailored and intensive support offered to help improve services.
- Clear points of contact for patients across the system
- Ensure complete care for patients when being seen in Primary Secondary Care including patients having everything they need when being discharged.

Throughout this plan you will see the detail around the current position of STW, the work we are doing to improve and maintain services, what we plan to achieve throughout this plan and also all risks that we have identified. This includes an overview of PCN and Practice priorities that have been identified and actions that have been put in place around those priorities.

Introduction

General Practice is one of the most dynamic and innovative parts of the health service. We saw this in the rapid and comprehensive rollout of the NHS COVID-19 vaccination programme.

Since March 2020, when the Covid-19 pandemic was declared, our health and care system has come through the most challenging few years in its recent history. The pandemic changed the way we worked, lived and how our health and care was delivered. As a system, we have learned a lot about working together and trialled and tested new ways to provide services, many of which remain and improve access for patients. However, the pandemic has also exacerbated our challenges and the demand for services which we now need to work through together and ensure access to care and advice is streamlined.

Like many parts of the NHS, General Practice is under intense pressure. Where demand is greater than capacity, it means General Practice can't always be effective and patient experience and access is negatively impacted.

The core purpose of the STW General Practice Access Plan is to demonstrate how we can mitigate the crisis facing primary care through a shared vision for improving access and quality of care.

It is important to note that NHS STW are receiving support as part of the national Recovery Support Programme which provides focused and integrated support to work through local complex challenges with a key focus on financial recovery.

Vision

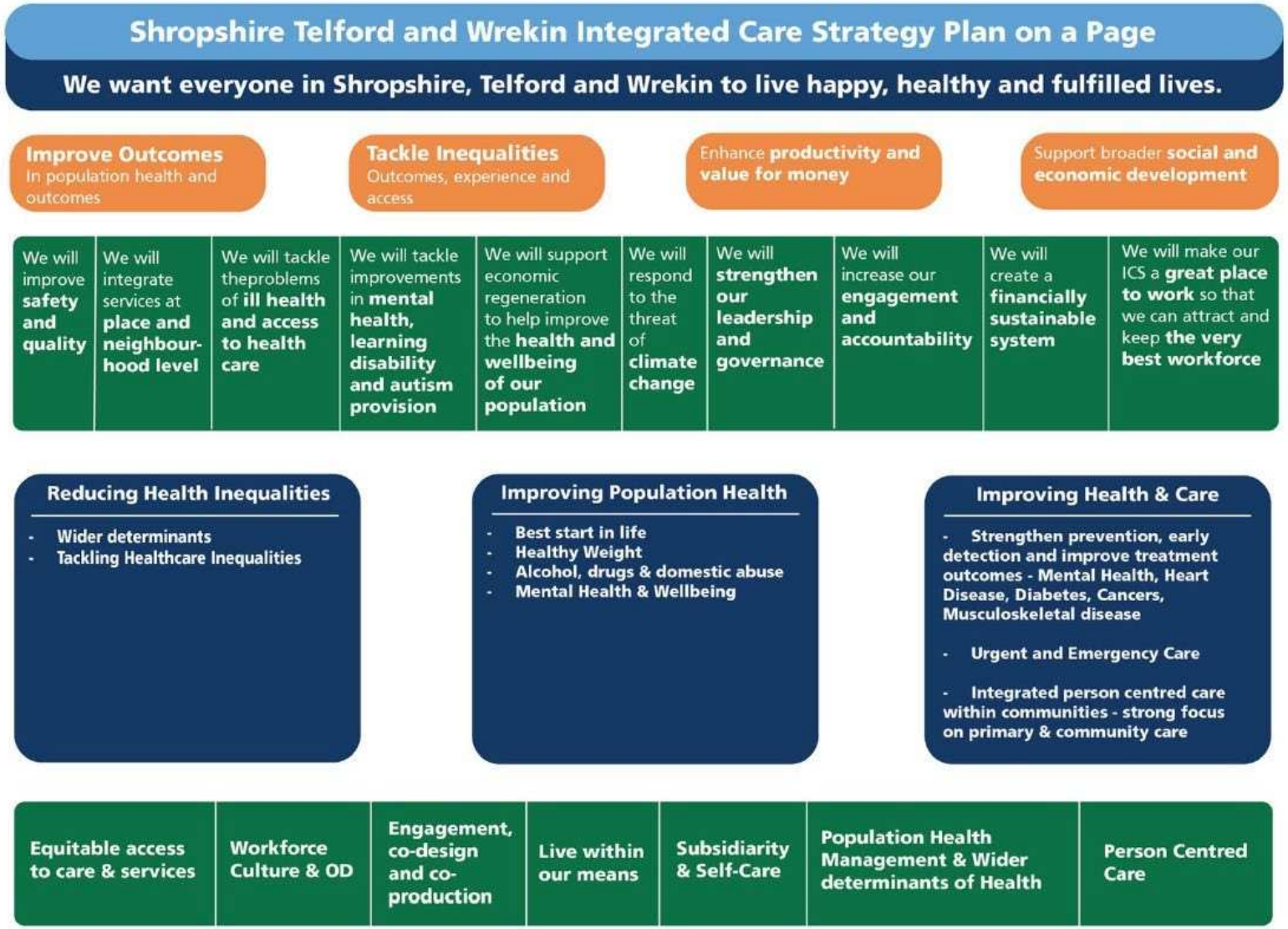
The Shropshire, Telford & Wrekin (STW) Integrated Care System (ICB) has developed this Primary Care Access Improvement Plan to outline how our health and care system will work together to improve access to General Practice.

We want everyone in Shropshire, Telford and Wrekin to have good access to general practice services and be able to access good quality care when they need it. We will work together with Primary Care Networks, General Practices, our communities and partners to improve access and streamline access to care.

NHS STW will encourage the implementation of a modern approach to general practice that makes it easier for patients to contact their practices by phone or online and supports practices to rapidly assess the nature and urgency of requests by involving the whole practice team. This is Modern General Practice Access.

STW Integrated Care Strategy Plan on a page

STW ICS Vision, Pledges and Strategic Priorities are summarised in the diagram below:



Why do we need a GP Access Recovery Plan?

- The **Fuller Stocktake report 'Next Steps for Integrating Primary Care'** (May 2022) built a broad consensus on the vision for integrating General Practice with 3 essential elements:

  1. streamlining access to care and advice;
  2. providing more proactive, personalised care from a multidisciplinary team of professionals; and
  3. helping people stay well for longer

- This remains the national intent. But before the wider reforms necessary to achieve this vision can be implemented, **the pressure needs to be taken off general practice and the 8am rush tackled.**

- The national plan requires systems to focus their improvement plan on:

  'streamlining access to care and advice'

- It has 2 central ambitions:

  - ***To tackle the 8am rush and reduce the number of people struggling to contact their practice.*** *Patients should no longer be asked to call back another day to book an appointment.*

  - ***For patients to know on the day they contact their practice how their request will be managed.***

STW Data – Summary Headlines 1/2

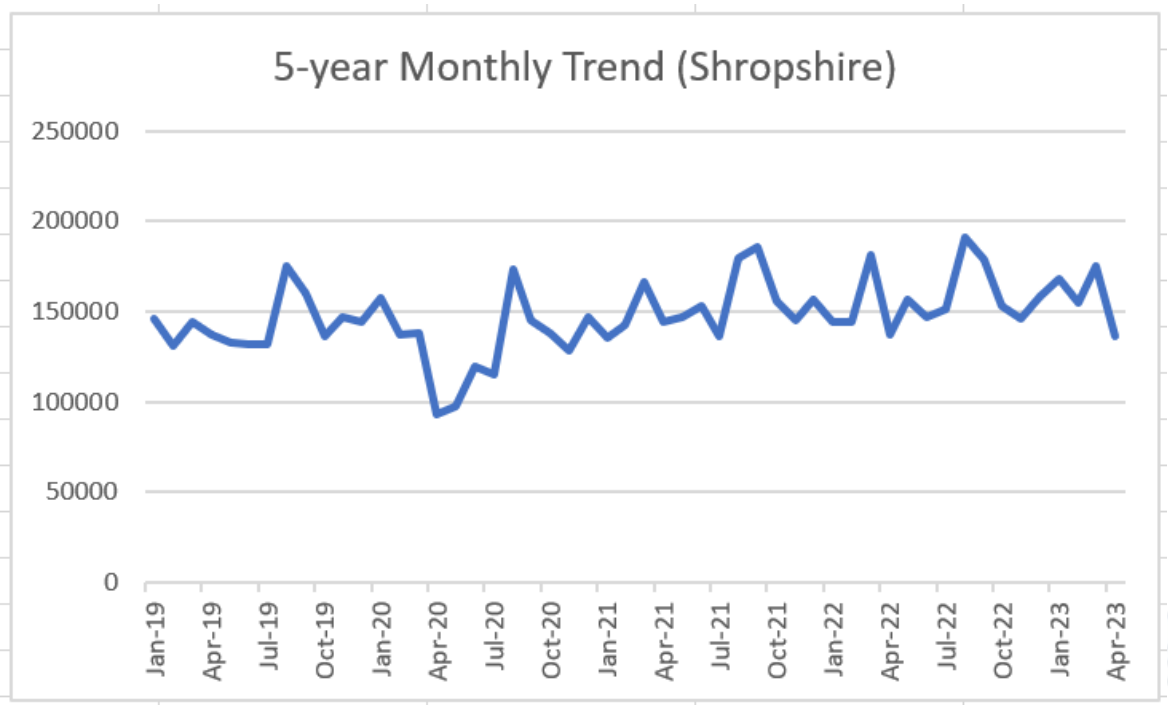
- General practice in Shropshire, Telford & Wrekin, comprises of 51 practices (37 Shropshire, 14 T&W) operating from over 70 sites.
- There are 8 PCNs ranging in size from 31,000 to 127,000.
- In 2022 General Practice delivered around 2.86 million appointments a year (1.88m Shropshire, 977k T&W).
- Appointment data shows that there are more appointments in General Practice now than pre-pandemic an increase of 9%.
- In July 2023 7 out of 10 patients seen face to face, 55% of patients in T&W and 52% in Shropshire were seen same day/next day, but perceptions are that you can't get an appointment - media coverage and social media reinforce this.
- In January 2021 general practice provided 207,515 appointments increasing to 254,312 in January 2023, an increase of 22.55%.
- If people think they can't get a GP appointment, they go elsewhere such as to A&E. In STW, we have some of the most stretched A&E departments in the country, impacting on waiting times and ambulance delays.

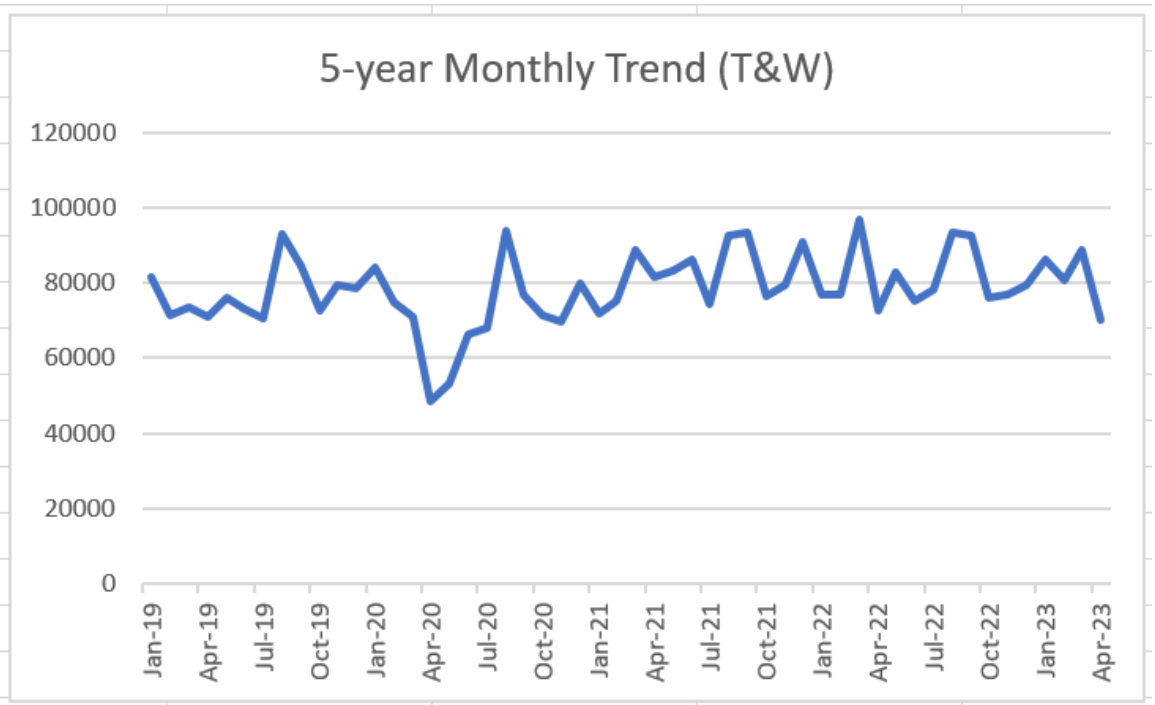
STW Data – Summary Headlines 2/2

- The Nationally GP Patient Survey is used to measure patient satisfaction and is a key metric for the Primary Care Access Recovery Plan (PCARP).
  - Overall the STW position is good and above national average.
  - However, STW is showing on trend in line with the national and regional picture with a decrease in overall patient satisfaction.
  - Two STW practices were amongst the top 10 practices in the Midlands Region in the 2023 GP Patient survey receiving a congratulations message from the Regional Medical Director for Primary Care.
  - There is local variation which needs to be addressed with Telford Practices showing lower patient satisfaction than Shropshire practices.

STW Data - General Practice appointment capacity trend last 5 years

There are more appointments in General Practice now than pre-pandemic with 7 out of 10 patients seen face to face.





STW Data - What do we know about patient experience of GP access in Shropshire, Telford & Wrekin

National GP Patient Satisfaction Survey 2023

- The GP Patient Survey (GPPS) is an England-wide survey, providing data about patients' experiences of their GP practices.
- **In STW 15,236 questionnaires** were sent out, and 6,194 were returned completed. This represents **a response rate of 41%.**
- The survey contains a number of questions related to access and quality of care.
- NHSE published the results for 2023 in July which incorporates field work undertaken between January and April 2023.
- Results are available at national, ICS, PCN and practice level.

Survey considerations:

- Sample sizes at practice level are relatively small.
- The survey is conducted annually and provides a snapshot of patient experience at a given time.
- Insight from GPPS is just one element of evidence we use when considering patients' experiences of general practice in order to identify potential improvements and highlight best practice.

STW Data - GP Patient Satisfaction Survey Trend pre pandemic to 2023

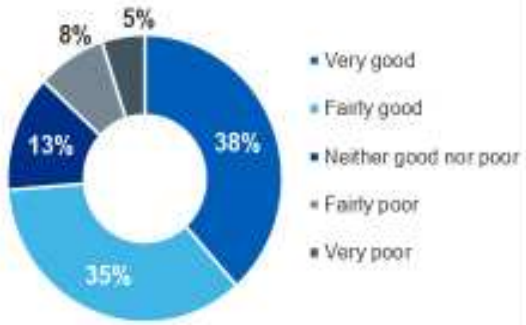
Overall experience of GP practice

SHROPSHIRE, TELFORD AND WREKIN ICS

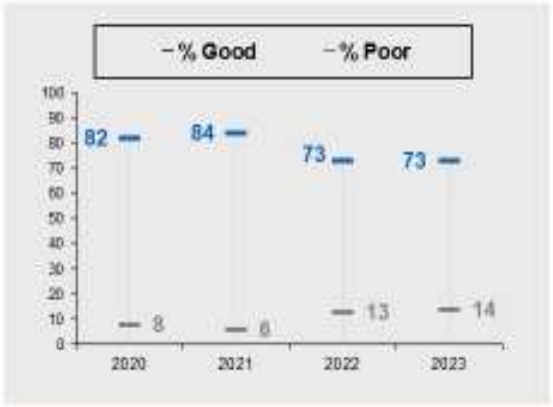
GP PATIENT SURVEY

Q32. Overall, how would you describe your experience of your GP practice?

ICS result



ICS result over time



PCN range within ICS – % Good

Comparison of results

	ICS		National	
	Good	Poor	Good	Poor
	73%	14%	71%	14%

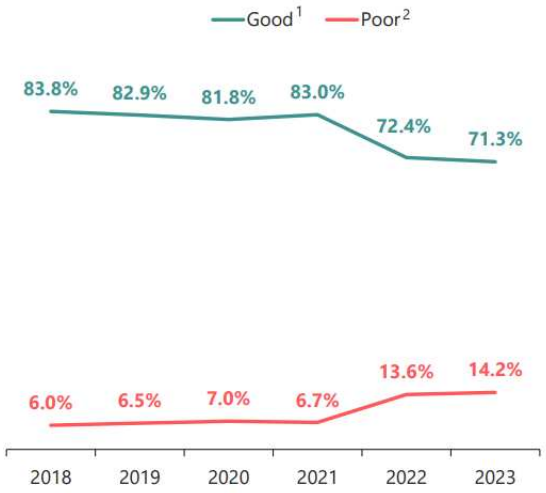
%Good = %Very good + %Fairly good
%Poor = %Very poor + %Fairly poor

Base: Asked of all patients. National (749,020); ICS 2023 (6,116); ICS 2022 (6,015); ICS 2021 (6,933); ICS 2020 (6,107); PCN bases range from 233 to 1,756

Ipsos

STW results remain above the national average but on trend with the national and regional picture showing a decrease in overall patient satisfaction.

National Trend



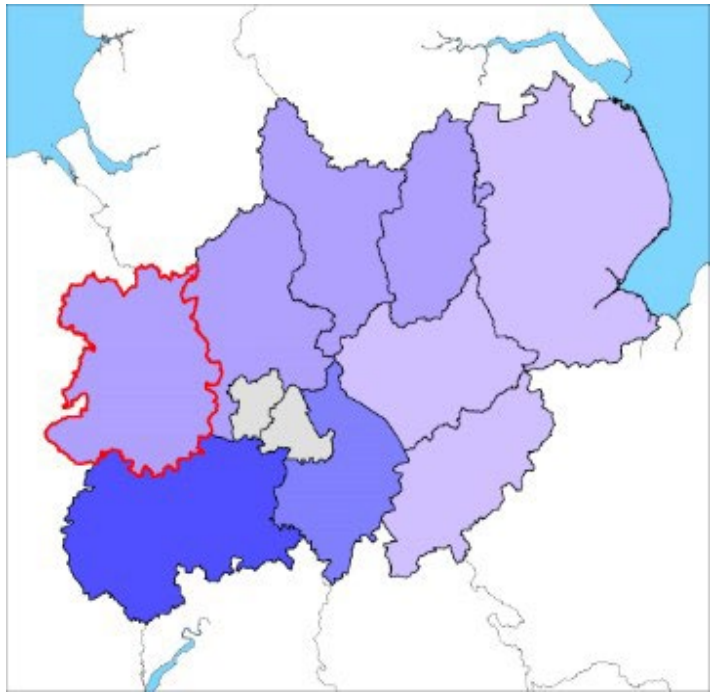
NHS

STW Data - GP Patient Satisfaction Survey Regional picture

Overall experience: how the ICS results vary within the region

GP PATIENT SURVEY

Q32. Overall, how would you describe your experience of your GP practice?



Overall experience of GP practice
% Good

- 75.6 to 80.1
- 73.1 to 75.6
- 71.2 to 73.1
- 68.0 to 71.2
- 62.6 to 68.0

Results range from

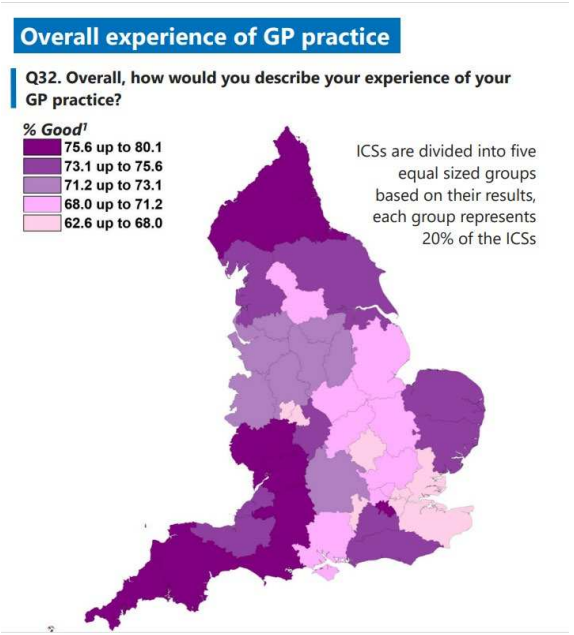
63%

to

76%

ICSs across England are divided into five groups (quintiles) based on their results, as shown in the key. The map shows the ICS results within this region based on these groups (the ICS represented by this pack is highlighted in red).

Comparisons are indicative only: differences may not be statistically significant



%Good = %Very good + %Fairly good

Base: Asked of all patients. ICS bases range from 6,116 to 46,211

STW Data - Summary of GP Patient Satisfaction Survey Results 2023 by Shropshire Primary Care Networks

		National GP Patient Survery Result Question			
PCN/Practice	Registered Population	Q1. Find it easy to get through to someone on the phone	Q4. Find it easy to use the GP practice website to look for information or access services?	Q16. Satisfied with the appt (s) you were offered.	Q32. Overall described experience of GP practice as good.
National		50%	65%	53%	71%
South West Shropshire PCN	37,241				
The Meadows Medical Practice		95%	96%	80%	95%
Bishop's Castle Medical Practice		94%	82%	68%	91%
Craven Arms Medical Practice		92%	79%	78%	94%
Portcullis Surgery		85%	84%	71%	88%
Station Drive Surgery		70%	73%	68%	79%
Church Stretton Medical Practice		73%	78%	52%	73%
South East Shropshire PCN	59,538				
Brown Clee Medical Practice		97%	100%	96%	100%
Cleobury Mortimer Medical Practice		96%	89%	84%	95%
Alveley Medical Practice		92%	72%	82%	92%
Albrighton Medical Practice		74%	82%	78%	90%
Much Wenlock & Cressage Practice		78%	82%	44%	83%
Bridgnorth Medical Practice		24%	72%	43%	78%
Highley Medical Practice		76%	53%	53%	64%
Ironbridge Medical Practice		62%	61%	45%	70%
North Shropshire PCN	91,554				
The Caxton		82%	90%	68%	83%
Cambrian Medical Practice		50%	61%	61%	80%
Churchmere Medical Group		41%	72%	57%	73%
Pfas Fynnon Medical Centre		79%	78%	58%	86%
Wem & Prees Medical Practice		51%	50%	38%	66%
Market Drayton Medical Practice		20%	46%	33%	60%
Hodnet		89%	93%	69%	85%

The boxes in blue in the table highlight where practices score the same or higher than the national average. **Most of the 38 practices in Shropshire score considerably higher than the national average.**

PCN improvement plans include targeted interventions where practice scores are lower.

Hodnet is not a member of a PCN but their patients receive PCN DES services via North Shropshire PCN

STW Data - Summary of GP Patient Satisfaction Survey Results 2023 by Shropshire Primary Care Networks

PCN/Practice	Registered population	National GP Patient Survey Result Question			
		Q1. Find it easy to get through to someone at the GP practice on the phone?	Q4. Find it easy to use the GP practice's website to look for information or access services?	Q16. Satisfied with the appt(s) you were offered.	Q32. Overall, described experience of GP practice as good.
NATIONAL		*50%*	*65%*	*53%*	*71%*
Shrewsbury PCN	128,274				
Knockin Medical Practice		99%	87%	78%	97%
The Beeches Medical Practice		83%	87%	68%	90%
Westbury Medical Practice		88%	63%	67%	84%
South Hermitage Surgery		83%	69%	66%	83%
Marysville Medical Practice		80%	77%	57%	83%
Broseley Medical Practice		81%	68%	65%	83%
Pontesbury and Worthen Medical Practice		57%	85%	60%	84%
Belvidere Medical Practice		70%	71%	55%	89%
Clive Medical Practice		74%	73%	49%	80%
Prescott Surgery		57%	74%	56%	86%
Marden Medical Practice		58%	82%	51%	80%
Riverside Medical Practice		64%	67%	58%	75%
Radbrook Green Surgery		47%	68%	60%	83%
Mytton Oak Surgery		35%	71%	43%	75%
Severn Fields Medical Practice		25%	56%	31%	63%
Shawbury		74%	72%	60%	82%

The boxes highlighted blue in the table highlight where **Shrewsbury PCN practices score the same or higher than the national average. Most practices score considerably higher than the national average.**

The PCN improvement plan includes targeted interventions where practices scores are lower.

Shawbury is not a member of a PCN but their patients receive PCN DES services via Shrewsbury PCN

STW Data - Summary of GP Patient Satisfaction Survey Results 2023 by Telford & Wrekin Primary Care Networks

		National GP Patient Survery Result Question			
PCN/Practice	Registered Population	Q1. Find it easy to get through to someone on the phone	Q4. Find it easy to use the GP practice website to look for information or access services?	Q16. Satisfied with the appt (s) you were offered.	Q32. Overall described experience of GP practice as good.
National		50%	65%	53%	71%
Teldoc PCN	6,327				
Teldoc PCN		15%	50%	33%	57%
Shifnal & Prioslee		29%	52%	31%	51%
SE Telford PCN	38,204				
Court Street Medical Practice		80%	89%	70%	83%
Stirchley Medical Practice		16%	51%	34%	61%
Woodside Medical Practice		48%	72%	59%	70%
Wrekin PCN	31,845				
Hollinswood Medical Practice		62%	58%	58%	76%
Dawley Medical Practice		20%	31%	25%	53%
Woodside Medical Practice		11%	35%	29%	42%
Newport and Central PCN	58,814				
Shawbirch Medical Practice		78%	78%	70%	91%
Linden Hall Surgery		40%	64%	48%	82%
Wellington Road Medical Practice		25%	57%	59%	85%
Donnington Medical Practice		19%	40%	28%	49%
Charlton		5%	52%	25%	45%

The boxes highlighted blue in the table highlight where T&W practices score the same or higher than the national average. **Most practices score less than the national average on one or more of the survey questions.**

T&W have higher levels of deprivation. There is published evidence showing links between deprivation producing higher demand on GP services and a poorer perception of services received. Telford & Wrekin practices have a proven higher level of deprivation and we are working with them to improve patient experience.

The PCN improvement plan includes targeted interventions where practices scores are lower.

Charlton is not a member of a PCN but their patients receive PCN DES services via a contract with a neighbouring practice.

STWT Data - What patients told us through engagement

As part of ongoing engagement with our population, key themes for GP were:

Concern over difficulty getting an appointment (e.g. especially post-covid, appointments run out by 8:05 am) (192/22%)

Consider providing easier and quicker access to appointments (e.g. short waiting times, avoiding having to call multiple times) (115/13%)

Consider improving access to face-to-face appointments (e.g. instead of phone appointments) (106/12%)
Concern over long waiting times to get an appointment (103/12%)

"Easier access to face to face and phone consultations" (75 – 79, female, Shropshire)

"Improve appointment waiting times. I am waiting six weeks for an appointment" (65 – 69, female, Shropshire)

"Being able to see my doctor when I want to. The surgery needs to open later in the evenings and weekends" (60 – 64, female, Shropshire)

Summary of Findings:

- **Out of the 2,445 respondents who were registered with a GP, more than half rated GP services as very good or good.**
- Key areas of concern include the availability of appointments, choice of appointment times and the availability of and access to mental health services.
- Suggestions to improve access to appointments were shared, with the need for easier and quicker appointment booking and the availability of more face-to-face appointments highlighted.

NHS STW will work with PCNs, Healthwatch and partners to continue to receive patient feedback in year.

Our Plan - How we will improve access to Primary Care

- Primary Care Access Recovery
- Empowering Patients
- Implementing Modern General Practice Access
- Building Capacity
- Cutting Bureaucracy

- Tackle the 8am rush
- Easier and quicker for patients to get the help they need
- Continuity of Care

Headline work areas

- PCN and Practice Improvement Support
- Primary/Secondary Care Interface
- Community Pharmacy
- Digital Development
- Transformation Support
- Workforce
- Estates
- Communication and Engagement
- Health Inequalities
- Equality, Diversity and Inclusion
- Assuring Delivery
- Risks and mitigations

How we will improve Access to Primary Care?

The NHSE Primary Care Access Recovery Plan (PCARP) is underpinned by 4 pillars:-

1. Empowering patients	**2. Implementing Modern General Practice Access**
3. Building capacity	**4. Cutting Bureaucracy**

Our plans in each of these areas are set out in the following slides

Pillar 1 - Empowering Patients - *Investing in tools they can use to stay healthy and manage their care without needing to see their GP*

Improving information and NHS App functionality - roll out of existing NHS App functionality to 90% of practices by March 2024. Compared to the National plan which sits at only 75%

Aim: Give more of the public access to four existing functions:

- to view their prospective clinical records (including test results);
- to order repeat prescriptions;
- see messages from their practices as an alternative to text messaging; and
- manage routine appointments

In STW, the NHS App has over 168,000 log-ins a month and 214,878 STW people have signed up. All of STW practices will offer this functionality by March 2024.

- National interest has been shown with the local success of 98% of practices (50/51 practices) offering patients prospective on-line access to their records at 31st October 2023.
- At end of September 2023 47% of GP patients aged 13 years+ registered for the NHS App.
- 73% of STW practices offer patients the ability to order repeat prescriptions online.
- 82% of practices have enabled secure messaging through the NHS App.
- 80% of practices have enabled patients to book and manage routine appointments, such as smear tests, B12 injections and vaccination clinics.

Pillar 1 - Empowering Patients

Increasing self directed care

Aim: Increase self referral activity by 50%

For some conditions general practice involvement is not necessary if it is clear to patients where to get care and it is clinically safe to do so directly. This is more convenient for patients and frees up valuable practice time.

This is already a reality for some conditions, but we will increase the number of self-refer options, guided by clinical advice.

Clinical pathway	STW Timeline for delivery
Optometry	September 2023
Selected Community musculoskeletal services	January 2024
Audiology for older people including hearing aid provision	June 2024
Community podiatry	September 2024
Falls	July 2024
Although in the national plan, NHS STW currently has no plans to introduce self referral pathways for community equipment, wheelchair services or weight management	

Pillar 1 - Empowering Patients

Community pharmacy

Currently community pharmacy is an underutilised resource across the ICS. There are 81 community pharmacies with a highly trained clinical workforce that could be utilised to increase capacity, boost access and improve experience for patients.

Incorporating prescribing into the new undergraduate pharmacy curriculum realises further opportunities with community pharmacy as the availability of prescribers in the workforce increases.

The future vision is for community pharmacy to be deeply integrated and utilised within primary care systems, enabling:

- Seamless referrals from general practice
- Greater system capacity
- More care to be delivered in the community
- Increased patient choice
- Innovative methods of service delivery

There are challenges to realising this future vision:

- Workforce challenges within the pharmacy sector
- Public awareness of the care available through community pharmacy
- Perceived professional standing of community pharmacy within healthcare systems.

Ongoing work is focussed towards overcoming these barriers.

Pillar 1 - Empowering Patients

Expand the community pharmacy offer

Common Conditions Service will launch before the end of 2023, subject to national consultation, enabling pharmacists to supply prescription-only medicines, including antibiotics and antivirals to treat 7 common health conditions (sinusitis, sore throat, earache, infected insect bite, impetigo, shingles, and uncomplicated urinary tract infections in women). Once scaled up, it anticipated to make up 3% of all appointments.

Blood pressure check service – Good blood pressure control helps to reduce heart attacks and strokes. Introduced in 2021 there is further national funding to expand this offer and support increased activity

Oral contraceptive service - enables community pharmacies to manage ongoing oral contraceptives for women. Over 50,000 oral contraceptives are prescribed each year in STW, we estimate a quarter of women taking oral contraceptives could be using this service by 2024.

Independent Prescribing Pathfinder Programme
STW ICB is recruiting 3 pharmacies as part of this national pathfinder programme which will see community pharmacists prescribing using NHS services for the first time.

IT Connectivity Between Pharmacy and GP Practice
Investment for interoperable digital solutions to streamline referrals, provide additional access to relevant clinical information from the GP record, and share structured updates quickly and efficiently following a pharmacy consultation back into the GP patient record.

Pillar 2 - Implementing Modern General Practice Access

- The central ambition is to tackle the 8am rush by implementing Modern General Practice Access which has 3 components:

Better digital telephony	Simpler online requests	Faster navigation, assessment and response

- Clinically urgent requests should be assessed on the same day
- When the request is not urgent, an appointment, if needed, should be scheduled within two weeks.

- Makes it easier for patients to contact their practices by phone or online and supports practices to rapidly assess the nature and urgency of requests by involving the whole practice team.
- This approach is a major change to how many practices have traditionally worked.
- Patients may be asked to provide more information about their issue when they make a request, but in return the practice team can better assess their need and tell them on the day how their request will be handled, based on clinical need and respecting their preference for a call, face-to-face appointment or online message.

Pillar 2 – Implementing Modern General Practice Access

Better Digital Telephony

- During the 8am rush an average-sized practice can receive over 100 calls in the first hour of opening on a Monday.
- The ambition is to put an end to people getting engaged tones when they call their practice.
- Frustration of long waits on the phone without information can affect the caller's interaction with reception staff when they do get through.
- This occurs when practices have analogue phone systems with a fixed number of lines and no call management system.

STW ICB received £479,000 to support the transition to cloud based digital telephony for all 17 practices (16 Shropshire, 1 T&W) currently on analogue systems or in unsuitable evergreen contracts

Digital Telephony Functionality

- **queuing:** enables practices to manage multiple calls, patients are notified of queue position and wait time, and never get an engaged tone
- **call-back:** patients have the option to be called back when they are higher in the queue
- **call-routing:** supports directing patients to the right person or team (eg a medicines team serving the whole PCN)
- **integration with clinical systems:** allows practice staff to quickly identify patients and find relevant information with less searching.

Pillar 2 – Implementing Modern General Practice Access

Simpler Online Requests

- While people will always be able to ring their practice, we want to make online requests easy and dependable.
- Practices are required contractually to provide online access. However, this was introduced during the pandemic when practices did not have time to fully implement systems.

We have received **£488,000** in 2023/24 to make high quality online digital tools available to practices. We are developing a plan with our practices in readiness for a national procurement framework for this to be launched in Dec 23/Jan 24

- Practices that have implemented this new approach say most patients find it more convenient to go online to make a request and are often happy to get a response the same way.
- These practices find that far fewer patients request face-to-face appointment
- It also means many requests can be dealt with without an appointment, which can be quicker for patients and practices, and means those patients who need an appointment get one sooner.
- When more people go online, this frees up the phones for those who prefer to call and spreads work across the day

Pillar 2 – Implementing Modern General Practice Access

Faster navigation, assessment and response

- The aim is to make it easier for people to contact their practice and to make getting a response the same day the norm, so patients know how their request will be dealt with.
- Care navigation becomes a critical role as it is estimated that 15% of current GP appointments could be navigated to self-care, community pharmacy, admin teams or other more appropriate local services.
- Other patients can be directed to the most appropriate practice staff member for assessment and response, without first being seen by a GP.

A new national Care Navigation Training programme was launched in summer 2023 with one place for each PCN and practice. At end of September, **35 staff from 29 practices (20 Shropshire, 9 T&W) have completed this training.**

- A key element of navigation is identifying those patients who would like or benefit from continuity and this is part of the national training.
- National evidence shows that relational continuity yields significant benefits for patients, systems and staff, and is especially important for patients with multiple or complex conditions.59
- The care navigator role improves continuity; this may be as simple as asking if the patient would like to wait for a preferred staff member or using flags in a patient's notes to direct them to a certain staff member.

Work has been ongoing to increase referrals from General Practice to Community Pharmacy using the Community Pharmacist Consultation Service (CPCS). During September 2023, **41% of practices used CPCS to refer 507 patients to community pharmacies**

Pillar 2 - Implementing Modern General Practice

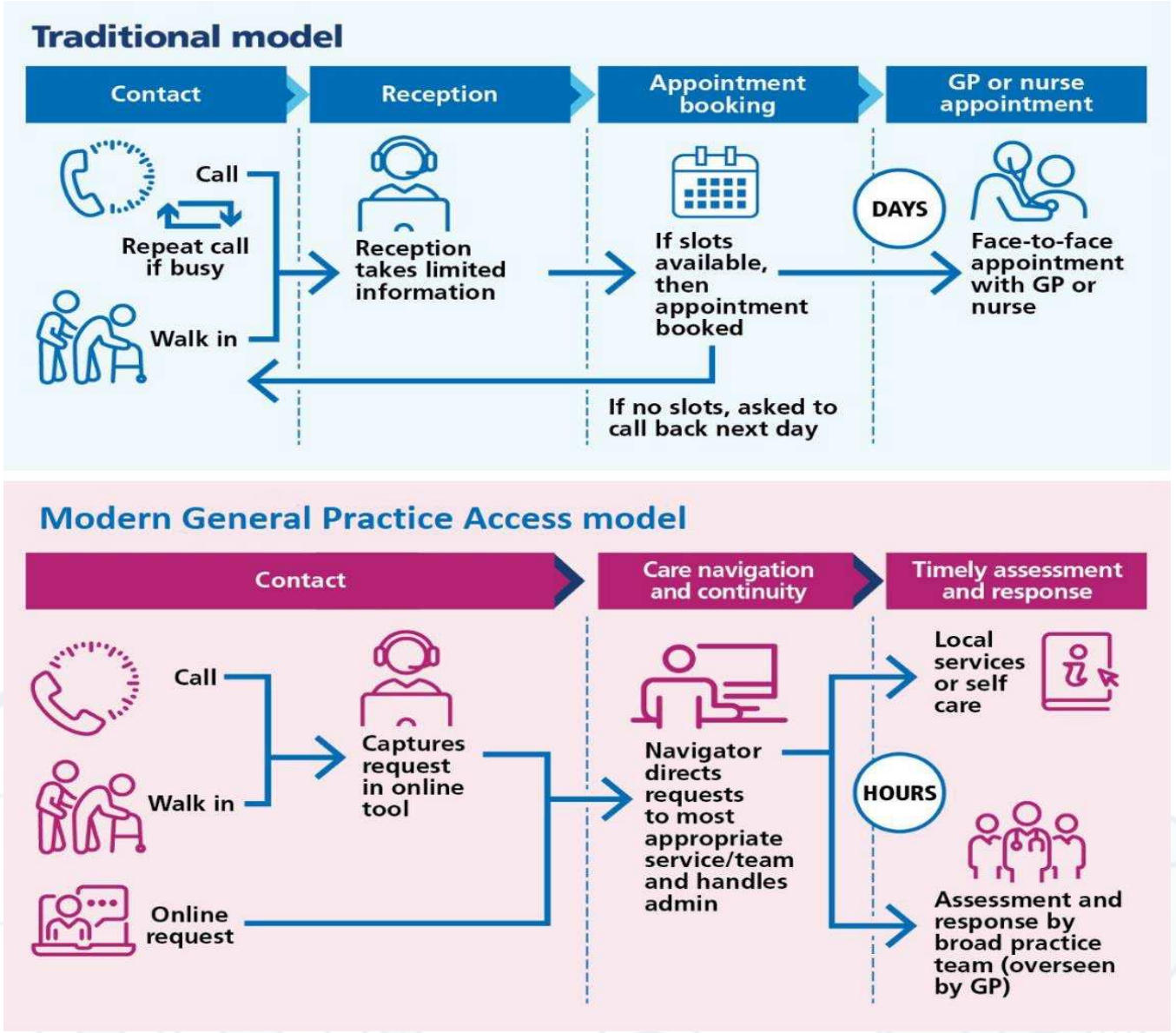
Examples: Digital Tools

- Cloud digital telephony including call back, call queuing
- Online consultation available with online forms
- Online appointment booking for non-triage appointments
- Patients can use NHS App to order prescriptions, book routine appointments etc
- Website compliant with the national useability guidance
- Direct booking of appointments by 111 into practice slots available - 1:3000 registered practice population

Examples: Practice processes

- Processes to review appointment, telephony and online data to understand and match demand and capacity
- Collecting data from the patient regarding needs at point of contact
- Care navigation system to direct to other appropriate services
- Improved processes for non-patient workload to release capacity e.g. online prescription requests, online registration, electronic repeat prescriptions
- Use of different consultation modes depending on need and patient preference
- Use of online messaging and text messages to contact patients
- Community pharmacy referral process
- Using digital tools to support effective practice processes
- Effective use of PCN Additional roles and clear referral criteria
- Patient communication process to inform about the change to new model.

Pillar 2 - Implementing Modern General Practice Access



Pillar 2 - Implementing Modern General Practice Access

PCN Capacity and Access Improvement Plans

In March 2023, NHSE published the new PCN contract which requires PCNs to produce a Capacity and Access Improvement Plan (CAIP) and introduced a PCN Capacity and Access Payment (CAP).

This plan has 2 components:-

1. baseline starting point against a set of metrics
2. a PCN and individual practice improvement plan setting out the changes they intend to make to address the following 3 areas:-

    I. patient experience of contact;
    II. ease of access and demand management; and
    III. accuracy of recording in appointment books

All 8 PCN improvement plans were signed off by ICB Executive Team at the end of July 2023.

- They included all the required actions of the PCNs and covered all related aspects of the national access recovery plan.
- They demonstrated a correlation between the areas where practices scored lower or were non compliant from their baseline start point assessment and the improvement actions in their plan.
- STW PCN CAP payment, created through repurposed PCN incentive payment funding, totals £2m for 23/24.
    - 70% is being paid in 12 equal monthly instalments.
    - 30% is paid at year end based on an assessment by the ICB of PCN evidence of the desired impact of the changes. PCNS need to demonstrate improvement in all 3 of the required areas (left) to receive their full 30% payment.
- A summary of the individual PCN improvement plans are at Appendix 1.

Pillar 2 - Implementing Modern General Practice Access

Local activity to improve access is aimed to make it more straightforward for people to get the care that they need when they need it. Improvement plans and communications focus on raising trust and awareness of:

- New healthcare professionals in practices
- The increased offer from pharmacists
- New access routes and systems – from triage to online forms
- New digital solutions – NHS App, improved GP practice websites, digital registration, and access to GP records.

Pillar 3 - Building Capacity

- The NHS Long Term Workforce Plan 2023 includes General Practice and the wider primary care contractors.
- Shorter term, as practices improve access, they will have to manage more patient requests and optimise the use of the full practice team.
- It also means **we need to continue to build total general practice capacity.**
- The **immediate growth will be in the broader practice team,** strengthening the foundation for more multidisciplinary working in the future.

Larger multi-disciplinary teams

- Since 2019 STW PCN additional roles have grown the total number of clinical and direct patient care staff in general practice by over **234 full time equivalent (fte) staff** (July 2023).
- Further recruitment by the end of March 2024 to the full £12m PCN ARRS allocation for 2023/24 will grow this number even further to **260 fte.**
- The STW Primary Care Training Hub and Clinical Facilitators work closely with all PCNs supporting these areas providing access to preceptorship programmes, advanced practice training, CPD, peer support and clinical supervision.
- A breakdown of the PCN ARRS roles plans by job roles is at Appendix 2.

Pillar 3 - Building Capacity

GP Recruitment and Retention

- GP numbers have steadily dropped over recent years to a level that is not consistent with a robust GP workforce
- In September 2023 there were 305 headcount and 237 FTE fully-qualified GPs
- Although the headcount number has remained fairly constant over recent years, the number of FTE GPs has reduced by 17% over the past 8 years from 285 to 237.
- Although there are a high number of GP trainees on the STW GP Training Scheme, it will take time for these doctors to work their way through

We have plans in place to bring new **doctors** into general practice, retain those working today and encourage recent leavers. These plans are set out in the STW General Practitioner Strategy and Action Plan. Examples include:

- 6 GP leads supporting the development of recruitment and retention initiatives from pre career choices through to GPs considering retirement or a career change
- Fellowship programmes for the newly qualified
- Mentorship programme for both Fellows and more experienced GPs
- Marketing GP as a career to medical students and final year doctors
- Persuading/enabling GP Trainees (particularly International Medical Graduates) to work in STW after qualification
- Working with practices to identify recruitment support needs/advice
- GP Education Leads organise GP led CPD.

Pillar 3 - Building Capacity

General Practice Nurse (GPN) recruitment and retention

The number of GPNs has dropped slightly in recent years to 222 headcount, which equates to 155 fte (July 2023), of which 71 are Advanced Nurse Practitioners (ANP) equating to 56 fte.

The national picture for this profession is also reflected across STW in that a significant number of GPNs are at or nearing retirement age.

STW GPN Development Strategy outlines specific objectives to support supply, recruitment and retention. The associated action plan includes:-

- Facilitating student nurse placement in primary care
- Supporting newly qualified nurses into general practice alongside preceptorship programmes such as The Fundamentals of GPN, new to practice and GPN Fellowship programmes
- Developing Health Care Assistants
- Facilitating access to the Nurse Associate Apprenticeship programme
- Upskilling GPNs to Advanced Practice levels
- Education and development forums
- Peer support networks, access to CPD and funding
- clinical supervision and development of the Professional Nurse Advocacy programme.

Pillar 3 - Building Capacity

Non-Clinical Staff Groups

STW Training Hub support the non-clinical workforce with training and education opportunities that aim to upskill, improve capability and capacity across the general practice workforce.

An annual Training Needs Assessment helps to identify key development priorities including leadership management, care navigation and staff mental health & wellbeing.

As well as funding individual, bespoke training requests, PCNs are also supported to deliver non-clinical training during Protect Learning Days, subject to available funding.

Pillar 3 - Building Capacity

ICB General Practice Estates Strategy

We have 51 practices operating from over 70 premises. We know that many practices are at or reaching capacity in terms of space, particularly with the increase in the workforce through the PCN additional roles staff.

We also know that a significant proportion of our General Practice estate is not fit for purpose.
The current Primary Care Estates Strategies were completed in 2020 as individual strategies for the then separate CCGs.

Work has been ongoing on the development of the next revision of the Primary Care Estates Strategy – this time focussed on an individual PCN basis rather than on an individual practice basis and taking into consideration the PCN plans related to clinical and non-clinical workforce and the impact of the additional roles staff.

- The PCN plans will contain a list of developments prioritised by the PCNs.
- This work is now nearing completion and we know that the capital investment requirement is going to be significant, at a time when there is currently no source of NHS capital.
- The plans will be collated to form an ICB General Practice Estates Strategy in November 2023, they will then go through an ICB prioritisation process, having regard to that of the PCNs also. This will ensure that should new capital become available, we can ensure that this funding is targeted to the most urgent developments.
- The final stage will be for the General Practice Estates Strategy to be incorporated into the overarching ICB Estates and Infrastructure Strategy due for completion March 2024.

Pillar 3 - Building Capacity

Higher priority for primary care in housing developments

- As practice teams grow, there will be an associated need to invest in the GP estate.
- We know that many practices have reached or exceeded current capacity in terms of space to deliver core GP services. Some are in old and/or converted residential dwellings.
- There is no source of NHS capital of sufficient scale for building extensions or new builds (which is unlikely to change before the next Government spending review in 2025).
- NHSE has indicated that the government will update planning obligations guidance to ensure that primary care infrastructure is addressed by local planning authorities

- We work closely with both local Councils as part of normal planning processes and has invested in additional technical capacity in 2023/24 to ensure that Section 106 and Community Infrastructure Levy (CIL) applications are routinely made as part of the planning process to secure healthcare infrastructure funding from housing developers.
- This has been particularly successful in Shropshire with a pipeline of over £2.5m secured between now and 2034. There are a further 5 applications planned for 23/24.
- Telford & Wrekin Council has a different approach which makes securing health infrastructure investment from housing developers less successful.
- We are in discussion with Telford & Wrekin Council to explore ways in which this could be addressed.
- In the meantime, we will develop 6 T&W s106 applications in 2023/24 against planned housing developments
- We are working with Shropshire Council to explore options for joint estates solutions outside of s106 and CIL

Pillar 3 - Building Capacity

Key Deliverables and Timelines for Elective Backlog Recovery 2023/24

Key standards

- No patient should wait over 65 wks for elective surgery by end of March 24
- 75% of patients who have been urgently referred by their GP for suspected cancer are diagnosed or have cancer ruled out within 28 days
- GP referral for suspected cancer to treatment should take no longer than 62 days.

In response:

- Pathways have been reviewed/revised to ensure they are as short as possible and patients are seen in the right place
- Providers appropriately balancing the provision of capacity between cancer, urgent and elective patients
- Additional capacity has been commissioning from the independent sector and in sourcing providers
- Consultants are undertaking additional sessions
- Mutual aid support
- Increased patient choice with use of DMAS and latterly PIDMAS

Key Deliverables and Timelines for increasing GP Direct Access to Diagnostics 2023/24

GPs currently have direct access to the following diagnostics:

- MRI – Head (including brain), Knee, Spine
- CT - Chest, Abdomien, Pelvis, KUB
- NM - Bone, Lung
- Plain Film - All body parts.
- Ultrasound – Abdomen, Pelvis, Groin, Neck, Testes, Urinary tract, Thyroid
- The suspected lung cancer pathway has dedicated CT slots.

Plans are being developed to offer a walk-in service for chest x-rays, with a view to this being operational from early 2024.

The Community Diagnostic Centre Phase 1 opened in Telford in October 2023 which provides the opportunity to explore further options for GP direct access. The ICB will work General Practice to determine which pathways would be most beneficial to explore.

Pillar 4 – Cutting Bureaucracy

Improving the General Practice/Secondary Care Interface

- The NHSE ambition is to reduce time spent by practice teams on lower-value administrative work and work generated by issues at the primary-secondary care interface. Practices estimate they spend 10% to 20% of their time on this.

- ICB chief medical officers are required to establish a local mechanism, which will allow both general practice and consultant-led teams to raise local issues, to jointly prioritise working with Local Medical Committees, and to tackle the local high-priority issues.

- In the 2023/24 contract NHSE significantly streamlined the PCN contract financial incentive targets from 36 to 5 indicators to enable practices to focus on improving patient experience and to create the capacity to deliver the changes in this plan.

In November 23, STW will launch a **General Practice/ Secondary Care Interface Oversight Group** chaired by the Chief Medical Officer with membership from Medical Directors of all 4 local secondary care providers, the GP Board and the Local Medical Committee. Meeting monthly, a key priority of the group is to develop a joint plan to address:

- **Onward referrals**: if a patient has been referred into secondary care and they need another referral, for an immediate or a related need, the secondary care provider should make this for them, rather than sending them back to general practice
- **Complete care (fit notes and discharge letters**): trusts should ensure that on discharge or after an outpatient appointment, patients receive everything they need, rather than leaving patients to return prematurely to their practice
- **Call and recall**: for patients under their care, NHS trusts should establish their own call/recall systems for follow-up tests or appointments.
- **Clear points of contact:** single routes for general practice and secondary care teams to communicate rapidly: e.g. single outpatient department email for GP practices or primary care liaison officers in secondary care.

PCN and Practice Access Improvement Support Offers

National GP Improvement Support Programme (GPIP)
Introduced in May 2023, this programme consists of 3 tiers of support to help general practice deliver change. These offers are underpinned by a set of principles to ensure change is clinically led, data-driven, evidence-based and measurable.

- **Tier 1 Universal Offer** of online support resources and is open to everyone. NHS England have run a series of webinars on each of the key areas of this plan, including learning from peers.
- **Tiers 2&3 Intensive and Intermediate** support programmes are designed to help practices in the most challenging circumstances or those that simply feel they do not have the capacity or bandwidth to plan a path towards a Modern General Practice Access approach. The intensive is a 6 month programme, the intermediate a 3 month programme. Both options involve hands-on support, a data diagnostic and a tailored analysis of demand and capacity.
- It is anticipated that the above programmes will be repeated in 2024.
- There are also national PCN digital transformation and leadership development programmes.

- We are liaising with targeted practices to encourage sign up for these programmes which are voluntary.
- STW practices have found the timing of this offer challenging with 17 practices unable to engage because the enrolment criteria requires they are on cloud based digital telephony.
- Capacity to participate is also an issue as the only source of funding for backfill for the 26 and 13 week programmes is the PCN CAIP.
- So far, **STW have 1 Shropshire and 1 T&W practice on the Intensive Programme and 1 Shropshire and 3 T&W practices on the Intermediate Programme**.
- So far, no PCNs have signed up for the national programmes due to capacity and/or eligibility.

PCN and Practice Improvement Support Offers

Support Level Framework

- The Support Level Framework (SLF) is an element of the national GP Access Recovery Plan to be organised and funded locally. It is a diagnostic tool intended to support practices in gaining an understanding of what they do well, what they might wish to do better, and where they might benefit from development support to achieve those ends.
- It is delivered through a 3 hour one off facilitated conversation with members of the practice team including a senior GP. The aim is to agree priorities for improvement and develop an action plan to address these areas over the forthcoming year.
- The outcome of the SLF can be used to inform which national support programme might be most beneficial for an individual practice to apply for. The associated action plan should be reviewed by the practice at 3 monthly intervals.

NHS STW has commissioned the Shropshire/ Staffordshire GP Support Team to deliver these quality improvement sessions. They are already a commissioned service, are experts in quality improvement diagnostics and the team are known to practices.

The aim is that all practices not participating in the national support programmes will have completed the SLF by no later than Q1 2024/25.

This support offer will be delivered in phases. The Primary Care Team is targeting the most challenged practices for this support offer. However participation is voluntary so the offer is open to any practice wishing to participate.

So far, 15 practices (11 Shropshire and 4 T&W) have committed to engage in this conversation via this local offer, with 3 now complete. Five additional SLFs will be completed as part of the national offer totalling 20.

PCN and Practice Improvement Support Offers

Transformation and Transition Funding

- It is recognised that that ahead of moving to the Modern General Practice Access model, the existing appointment book needs to be reduced ahead of time to provide good capacity at the launch of the new approach.
- NHSE have provided additional funding for additional short term workforce capacity at time of 'go live' for practices that commit to significant transformation transitioning from one operating model to another.
- It is accepted that not all practices will be able to implement all elements of the Modern General Practice Access model in this financial year. NHSE have indicated that the ICB will receive a similar financial allocation in 2024/25 and therefore the Primary Care Team are working with practices to manage the deployment of the available transition funding over the 2 years.

NHS STW has received **£379,000** NHSE transition funding for 2023/24. The national estimate of funding per average sized practice is £13,500.

The first phase of practice funding applications were received in August 2023 resulting in **15 practices receiving approval (9 Shropshire and 6 T&W) and committing £227,000 of funding (£133,079 Shropshire and £93,914 T&W).**

In signing up for this funding, practices commit to:-

- use the funding allocated to support the transition to the Modern General Practices Access model
- implement the proposed changes by the end of March 24
- track and report to the ICB relevant data to establish the impact of the changes
- ensure that there is no duplication of funding with other GP Access Recovery funding streams

A second wave of invitations to apply for this funding has recently taken place with a further 8 practices applying. This will now be an open offer to practice to encourage applications and use of the full allocation.

Communications and Engagement Plan

The ambition for communications and engagement is to make **navigation clearer and easier to understand** for patients and staff. **A robust delivery plan has been developed to promote key messages and achieve objectives** at both place and within local communities across STW.

The communications plan will **dovetail into the multimedia behaviour change campaign for winter (Think Which Service)**. This integrated PR and marketing campaign has been informed by **local research to build confidence in health and care services, to educate on how and when to use services and showcase the benefits** of doing so.

The insight used to inform this campaign, as well as the data collected during the county's Big Health and Wellbeing Conversation for the Joint Forward Plan, has helped to structure messaging and allowed us to **be highly targeted in addressing the strongest concerns for each audience**, as well as the channels used to communicate, with a clear call to action.

The communication materials will **be shared on an ongoing basis for feedback with our People's Network** for the county, which comprises over 400 residents engaged in health and care issues. We will also **socialise materials with General Practice colleagues**, as well as with PPGs**,** to ensure we have considered the patient voice and have created the most effective and impactful communications for audiences.

Communications and Engagement Delivery

Resources will be used to **build understanding** externally but to also **support staff to hold conversations with patients**; to help them to understand what different healthcare services do; what different members of the General Practice team can help with; how practices are moving towards more digital access routes; and why they may be seen by someone other than a GP or nurse.

Our ambition is to **support and enhance patient and staff understanding of the new ways of working** in General Practice through sustained internal and external communications (and across multimedia channels) tied in with the national resources on three key components:

Digital Access: to build knowledge and confidence in the NHS App and digital access routes.

Wider Practice Team: to explain there is now a much broader range of staff in the practice team. Greater knowledge will help practices increase use of these roles, protecting GP time.

Wider Care Available: to help the public better access the right care by explaining when, why and how to access self-care advice, community pharmacy, general practice, NHS 111, 111 online and A&E (linking in with the winter campaign 'Think Which Service').

Health Inequalities National Context

The NHS Long Term Plan places preventing ill-health and reducing health inequalities at the heart of the NHS.

Tackling health inequalities is a core priority for the NHS, as people from deprived backgrounds are more likely to develop long-term health conditions, suffer poor health and experience reduced life expectancy.

The NHS Prevention Programme commits to supporting people to keep healthier, for longer. This includes helping people make healthier lifestyle choices and treating avoidable illness early on.

1. Weight Management
2. Alcohol
3. Tobacco
4. Cardiovascular Disease
5. Stroke
6. Cancer
7. Respiratory
8. Mental Health

The National Healthcare Inequalities Improvement Programme (HiQiP) asks systems to focus on five priority areas:

1. Restoring NHS services inclusively
2. Mitigating against digital exclusion
3. Ensuring datasets are complete and timely
4. Accelerating preventative programmes (including the initiatives outlined in the NHS Prevention Programme, Core20PLUS 5 Key Clinical Areas for Adults and Core20PLUS 5 Key Clinical Areas for Children & Young People.
5. Strengthening leadership and accountability.

CORE20PLUS5

NHS

Health Inequalities System Commitments

Shropshire, Telford & Wrekin Integrated Care System (ICS) pledges to tackle the problems of ill health, health inequalities and access to healthcare through a shared approach to ensuring health inequalities are mainstream activity that is core to, and not peripheral to, the work of the NHS.

- 2023/24 Health Inequalities Implementation Plan sets out 20 priority objectives, aligned to the national key lines of enquiry and Core20PLUS5 Clinical Areas for Adults and Children and Young People.
- STW has enacted system governance changes following an internal review in Q4 2022/23, with the commencement of a dedicated Prevention and Health Inequalities Board Chaired by Local Authority Director of Public Health. Membership includes Executive Leads from all Providers, including PCNs.
- Support offered by ICB Health Inequalities Lead and Project Manager to Executive Leads in Provider organisations (including PCN Health Inequalities Leads) to assist in progressing the health inequalities agenda and making connections across Providers.
- Introduction to Health Inequalities Understanding and Awareness session delivered to ICB staff. A central resources page is available on the internal website for all system staff to access further training and resources, ensuring staff are supported in delivering duties under 2012 Act.
- STW have developed with partners one system-wide Integrated Impact Assessment (IIA) which provides consistency in the system approach to considering impact and involving the public. The IIA widens the traditional EQIA addressing the 9 protected characteristics under PSED to include duties regarding factors such as social exclusion, socially deprived communities, quality, travel and access and climate change.

Health Inequalities – Enablers to Better Access

STW 2023 Patient Satisfaction Survey Results shows that when results are grouped at a PCN level, all Shropshire PCNs were above the national average whereas Telford based PCNs showed below the national average for up to 10/19 questions with three below the national average for 'Overall how would you describe your experience of your GP practice'.

- Empowering patients through providing Accessible Information, Encourage Shared Decision-Making, Promote Health Literacy, Enable patients to access their medical records, test results, and health information electronically.
- Engage in Regular Communication by making it easy for patients to reach out with questions or concerns and provide opportunities for follow-up appointments and discussions to track progress.
- Health & Wellbeing Coaches, Social Prescribers and Care Coordinators in place who are supporting many different cohorts of patients including those living with cancer, those isolated, and patients most at risk of developing long term conditions to make lifestyle changes.
- Improving and supporting increased use of online access for those who are digitally able (plus through connections to digital literacy support) and reducing telephone traffic will ensure quicker access for those that need a traditional route.
- Increasing levels of Friends and Family responses to provide a richer source of feedback for Practices to review and act upon.
- Supporting GP Practices to improve ethnicity recording for all patients but in particular those with a Learning Disability or Autism to support a Population Health Approach and inform targeted action to improve access for underserved communities.

Health Inequalities - Action

The ICB leads a number of projects which align closely to the Core20PLUS5 National Approach for Tackling Healthcare Inequality.

Each project focuses solely on supporting communities living in higher levels of socio-economic deprivation, those from diverse ethnic backgrounds, inclusion groups or people with protected characteristics.

These are delivered collaboratively across ICS partners, including working closely with PCNs and GP Practices to embed and streamline partnership working and better integration with our community and voluntary sector and thereby support to reduce pressures on Primary Care but ultimately improve patient outcomes.

- Data Teams are supporting the development of a Population Health Management Approach, working with Primary Care to inform targeted intervention.
- Each PCN has developed a targeted Health Inequalities Plan based on their local population need. There are a number of projects that specifically focus on practices with the highest deprivation levels and proportionally greater numbers of seldom-heard patients.
- PCNs are working in collaboration with partners such as local colleges, Local Authorities, the community and voluntary sector and Healthwatch to progress this work. Examples include exercise offers with Shrewsbury Town FC, Mental Health outreach through local Food Banks and targeted work to improve cancer screening with those with a Learning Disability or Autism.
- Community-based ICS-led projects focused solely on inequalities are exploring data solutions to share consented health data back to General Practice
- System CVD Prevention Clinical Lead recruited to lead support on preventive action, working closely with Primary Care to utilise best practice methods and processes for risk stratification.
- Local engagement pieces are working closely with PCNs to pilot recommendations to reduce barriers to access e.g. Core20PLUS Connectors – a volunteer-led project which aims to raise awareness of cancer signs, symptoms and screening services in underserved communities and communicate barriers to access to NHS organisations. Current joint working between PCNs and VCSE to pilot tools to improve screening uptake in rural, ethnic and LD&A communities.
- The ICB Prevention and Health Inequalities Team has supported Primary Care workforce to express interest in the National Core20PLUS Ambassador Programme (an opportunity for development and learning). A local peer support will be established to further embed health inequalities knowledge and action within Primary Care.

Equality, Diversity and Inclusion

The ICB, via the implementation of this Plan, will ensure that vulnerable, marginal and minority patient groups are supported in maximising their access to General Practice.

The Primary Care Team works closely with the ICB People Team and is a key stakeholder attending the Systemwide EDI steering group to ensure that, strategic EDI objectives are translated into specific, General Practice targets and actions.

Through a sense of belonging, we aim to create an inclusive culture which encourages different perspectives and celebrates diversity.

The ICB will embed inclusion as one of the key principles that runs through everything we do.

The STW ICS EDI steering group provides effective leadership overseeing the delivery of:

- NHS EDI improvement plan, ensuring progress toward achievement of the 6 high impact actions and Long-Term Plan priorities., including engagement with staff networks to combine the protected characteristics who face similar challenges in the workplace.
- Values based leadership for inclusion and decision-making using equality indicators. Transforming employee lifecycle by embedding diversity through targeted interventions.
- Drive progress on Workforce Race Equality Standard and Workforce Disability Equality Standard action plans

Assuring Delivery - Governance

- ICBs are required to submit their system improvement plans to their public boards by November 2023 with a further update in February or March 2024.
- The NHSE has put GP Access recovery on the same national priority status as elective and UEC recovery.
- We have reviewed our governance structure to ensure it reflects the priority status of GP access recovery and there is a direct line of sight to Board.
- We have formed a new **Primary Care Improvement and Transformation Board**, chaired by the Chief Medical Officer.
- The Board reports into the system Integrated Delivery Committee (IDC) in line with the established reporting arrangements for Elective and UEC Recovery Boards. The IDC reports into Board.

The Board has 3 primary areas of oversight which include primary care in its widest definition to include General Practice, Pharmacy, Optometry and Dentistry:-

1. Ensuring development and implementation of the system GP Access Recovery Plan.
2. Primary Care Transformation e.g. Fuller Report 'Next Steps for Integrating Primary Care'
3. Pharmacy, Optometry and Dentistry – oversight of the delivery of development plans and monitoring of service delivery in partnership with the Shared Commissioning and Contracting service provided by BSOL

The Terms of Reference and organogram of the Primary Care Improvement and Transformation Board governance structure is provided at Appendix 3.

Assuring Delivery – Measures of success

How will we know we are making an impact?

NHS STW will

- mirror the measures used nationally to show the local position against the metrics set for the key access improvement measures (shown on the next slide)
- develop our own local metrics and a new performance data pack to measure additional key local success measures (draft shown slide 54)
- meet with PCN leads to monitor delivery against the agreed Capacity Access Improvement Plans on a quarterly basis, October/November 2023 and February 2024, before the end of year review.
- work with PCNs and practices to receive patient satisfaction feedback in year
- review patient feedback received from Healthwatch and other local partners.

NHS STW has recruited a new Primary Care Analyst to monitor Primary Care Access metrics and support wider General Practice data collection and review.

Assuring Delivery – General Practice Improvement Dashboard – Metrics and Monitoring

Key Measures	Workstream	Metric Description	Workstream lead	National target/Regional/ STW target	Data source	Frequency
Headline Metrics	Pharmacy	# of Pharmacy First/Common Conditions Service , Oral Contraceptives consultations delivered	James Milner	TBC - understanding required of national and local baseline to	NHSBSA Calc	Monthly
		# of Blood Pressure consultations delivered	James Milner	TBC - total BP consultataions	NHSBSA Calc	Monthly
		# of additional PF/CCS (2) , OC (3) & BP (4) consultations delivered	James Milner	Baseline to measure # - TBC	NHSBSA Calc	Monthly
	Transformation	Appointments within 2 weeks - all appointments	Alec Gandy	85% (current lower threshold for ACC-08 achievement) (March 24)	GPAD	Monthly
		Appointments on same day if need is urgent (1) - All appointments	Alec Gandy	~40% but TBC (March 24)	GPAD	Monthly
	Digital	# of practices on digital telephony	Antony Armstrong	>90% on CBT by March 2024	ICB assessment	Quarterly
		% of practices with high quality online/workflow tools	Antony Armstrong	20% March 2024 ambition Definition of high quality TBC	TBC	TBC
Manifesto Metrics	Contracting	# of additional GP appointments (national: 50 million with baseline 307m; shares appts 357m; regional	Emma Pyrah	N: 50 m R: 9.8m (Mar 24) notional only	GPAD	Monthly
	Workforce	# of Direct Patient Care staff	Phil Morgan	N: 37,321 (March 2024) R: ~5,109 - notional	NWRS NHS Digital	Monthly
		# of additional GPs	Phil Morgan	N: 40,526 (March 2024) R: TBC	NWRS NHS Digital	Monthly
ONS survey questions	Contracting	Ability to get through to GP practice on the same day (%)	Emma Pyrah	National data only	ONS/PCOR	Bi-monthly
		Ease of contact (%)		National data only	ONS/PCOR	Bi-monthly
		Satisfaction with GP practice (%)		National data only	ONS/PCOR	Bi-monthly
		Know on day how request will be managed (%)		National data only	ONS/PCOR	Bi-monthly
	Transformation	Making contact with GP online (%)	Emma Pyrah	National data only	ONS/PCOR	Bi-monthly

The National team are to confirm targets and how best to capture the data required.

Assuring Delivery – General Practice Improvement Dashboard – Metrics and Monitoring

Local Metrics and the new performance management data pack

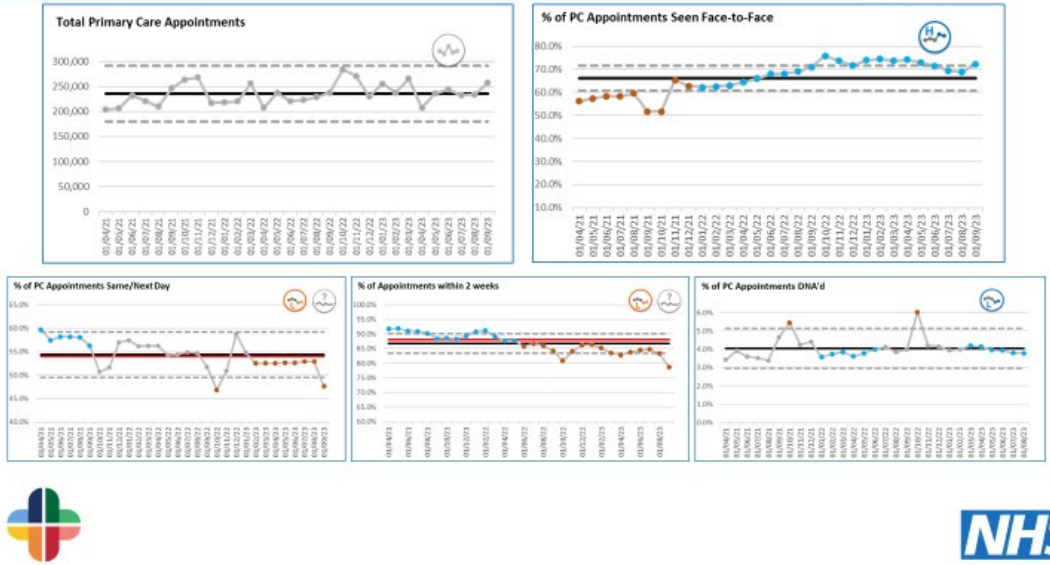
Digital
#/ rate of online consultations 1000 reg pop
#/referral rate to CPCS 1000 reg pop
#/% practices on cloud based telephony
#/% practices whose web site meets national ' what good looks like'
#/% of practices with full call management functionality enabled
Workforce
additional ARRS staff vs plan
National/Local support programme
#/% practices signed up for intensive/intermediate
#/% practices signed up for care navigator training
PCN signed up for care navigator training
PCN signed up for Digital Transformation training
#/% of practices signed up for the Support Level Framework
#/% of practices applied for transition funding

Sep 23 – Primary care

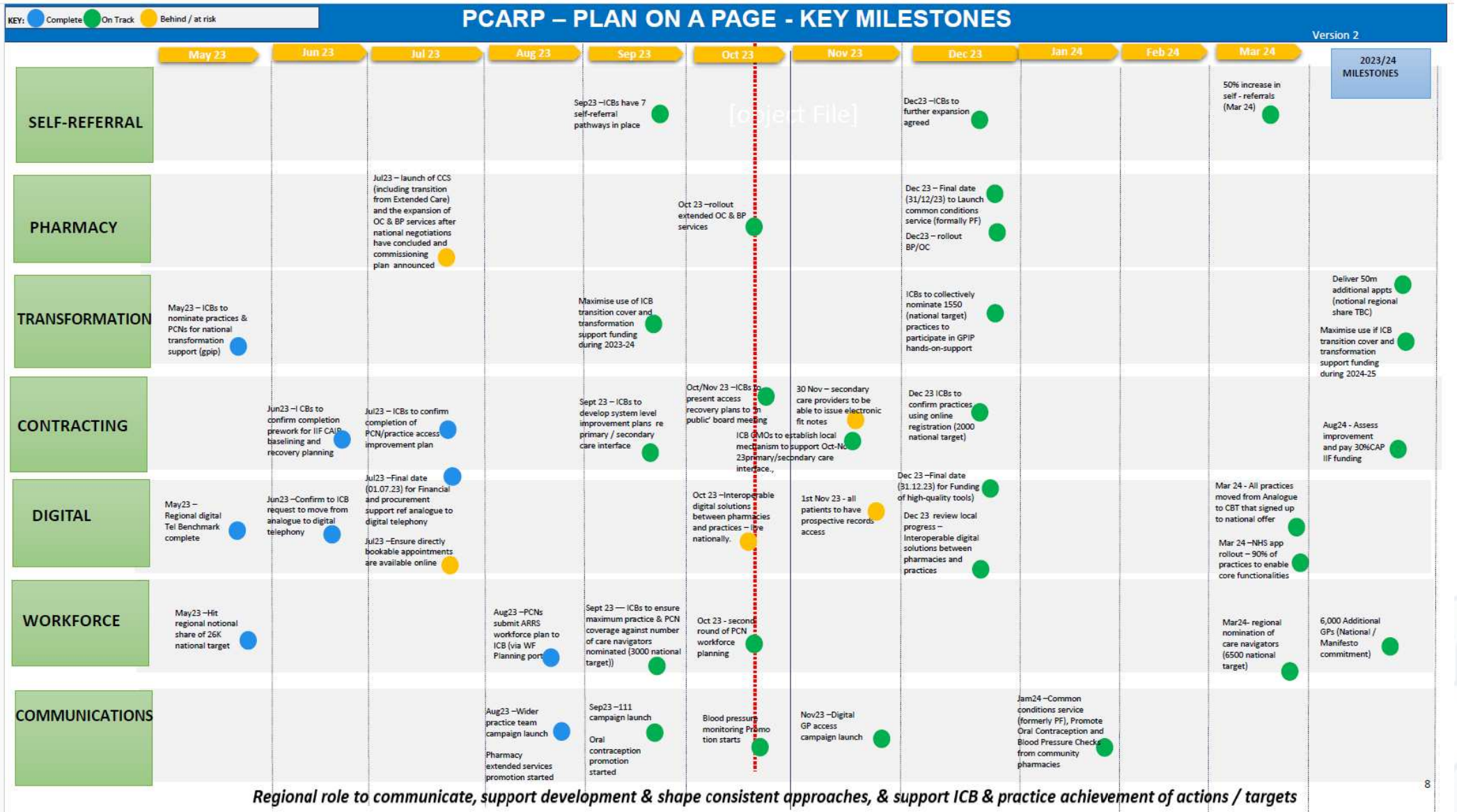
STW Primary Care Performance measures

Primary Care	Metric Type	Plan	Target	Actual	Actual Variance Vs Plan	Actual Variance Vs Target	Latest Month	Target Type	SPC Variation	FTD Variance
Appointments in General Practice - Total	STW	244974	-	257662	5.2%		Sep-23	-		0.3%
Appointment Same day/Next Day %	STW	-	54%	47.6%		-11.8%	Sep-23	National		
Appointment with 2 weeks %	STW	-	88%	78.6%		-10.8%	Sep-23	National		
No of GP appointments within 2 weeks	STW	-	215577	202614		-6.0%	Sep-23			15.6%
No of GP appointments same or next day	STW	-	132286	122704		-7.2%	Sep-23			17.7%
ARRS - Headcount	STW			329			Sep-23	National		
ARRS - FTE	STW			250			Sep-23	National		
No of GPs in post (FTE)	STW			300			Aug-23			
% Referrals to Community Pharmacy Consultation Service	STW		315	507		61.0%	Sep-23	National		
% using the NHS App for accessing General Practice (Mar24 Target)	STW		90%	41%		-54.4%	Sep-23	National		
Increase in on-line consultations	STW	-	2623	4698		79.1%	Sep-23	National		

Primary Care appointments (Sep 23)



Assuring Delivery – General Practice Improvement Dashboard – Key Milestones



Assuring Delivery – General Practice Improvement measures for PCNs

Below is a local timeline to show how the ICB are identifying and monitoring agreed milestones that PCNs and Practices have put in place to improve access across Primary Care in STW.

Assuring Delivery – General Practice Improvement measures for PCNs

PCN CAIP Update call

All PCNs have been met with to discuss ongoing plans on work around their Capacity and Access Plans and any support they need to achieve milestones

Wave 2 Transitional Support Meeting

Second wave of meetings with Practices who submitted their Transitional Support Applications for wave 2

Transitional Support final process

Following Wave 1 & 2, a final process to be put in place for receiving any further applications from Practices around Modern Practice support funding

Further CAIP review calls

PCNs that are having problems with achieving their Capacity and Access improvement milestones have the opportunity of a further meeting to support these plans

Final PCN CAIP meetings

Following all PCNs Capacity and Access Improvement plans, the ICB will meet with each PCN to discuss and review actions that have been completed and put in place

Key risks for Delivering Improvement

The key risks to delivery of access improvements have been identified below and mitigated as shown in appendix 4.

1. The GP Access Recovery Plan does not address the underlying core problem that demand in primary care outstrips capacity even though more appointments are provided now than before the pandemic.
2. The PCN/practice GP Access support funding is non-recurrent which makes implementing long term workforce/capacity solutions difficult
3. Many of STW GP Practices scored higher than the national average in the 2022 and 2023 GP Patient Survey access related questions, some significantly. This makes achieving 'significant improvement' as described in the national guidance difficult.
4. Increasing usage of digital patient access routes is difficult where digital infrastructure/ broadband capability is low. This is particularly the case in our more rural areas.
5. Patient reluctance to embrace digital access modes or to see alternative health care professionals
6. Capacity of PCN and Practice staff to engage with and enact change, particularly during the increased demands of winter. There is no additional system winter monies for additional General Practice capacity this year.
7. Workforce shortages/ difficulties in recruiting staff especially clinicians.
8. Estates – shortage of space in practices to accommodate additional staff. No NHS capital funding source to enable extension of existing premises or new build
9. Funding.

GP Access Improvement Financial Summary 2023/24

Funding Stream	Total STW Non Recurrent Allocation
PCN Capacity and Access Payment	£2,000,000
Practice Transformation and Transition Funding	£379,000
Practice Digital Telephony Funding	£479,000
Practice Digital Tools Funding	£488,000
System Development Fund	
GP Fellowships	£309,000
GP Retention	£98,000
Supporting GP Mentors	£73,000
Practice Nurse Measures	£25,000
PCN Transformation	£152,000
Community Pharmacy expansion	£60,000
Primary Care Training Hub	£103,000
PCN Additional Roles Reimbursement Scheme	£12,000,000

We have undertaken due diligence processes to ensure that these funding streams are being utilised for access improvement in line with the national requirements and that there is a no duplication of funding requests between workstreams

A summary of PCN and Practice expenditure is shown in Appendix 5.

Integrated Care System
Shropshire, Telford and Wrekin

NHS
Shropshire, Telford and Wrekin

Appendices

November 2023

Appendix 1 - Summary PCN Capacity and Access Improvement Plans 2023/24 - Shropshire

PCN	Shrewsbury
No. practices	16 (Belvidere, Marden, Marysville, Riverside, Severn Fields, South Hermitage, Radbrook Green, Mytton Oak, Claremont Bank, The Beeches, Pontesbury & Worthen, Prescott, Westbury, Clive, Knockin and *Shawbury)
Clinical Director	Dr Charlotte Hart
PCN Population	128,374

Key areas of focus

- Improve ease of use and functionality of websites
- Improve availability and uptake of Friends and Family test
- Introduce a care navigation digital desktop aid to standardise and improve care navigation in all Practices including supporting training
- Increase usage of local Community Pharmacy Consultation Service to increase usage
- Provide tailored local content promoting access routes to replace national communications on waiting room screens
- Provide additional support from the PCN Management team to the two lowest performing practices, with shared learning from the two highest performing practices
- Provide standardised communication materials for Practices to share with their Patient Participation Groups to increase public knowledge and understanding of access routes
- Improve uptake of online consultation access route

Key areas of focus (continued)

Shrewsbury Primary Care Network is proposing four additional projects to run alongside their Access Improvement Plan

1. Winter Illness Service

With an initial focus on respiratory conditions, pilot a centralised service to provide additional support to practices from the autumn bringing additional acute capacity into General Practice.

2. Digital Triage Hub

Working with a small number of pilot Practices, to provide additional clinical and administrative staff to handle weekend digital triage requests (currently turned off).

3. Back Office Centralisation

Commencing with notes summarising, employ staff at a PCN level to standardise and centralise certain administrative functions to release capacity in Practices.

4. Pharmacist led Virtual longer term condition clinics

Roll out of end-to-end management of patients with chronic long terms conditions including medication reviews and subsequent treatment changes to provide additional capacity in Practices to focus on those for whom a virtual review is not appropriate.

Appendix 1 – Summary PCN Capacity and Access Improvement Plans 2023/24 - Shropshire

PCN	South West Shropshire
Number of practices	6 (Bishops Castle, Church Stretton, Craven Arms, Portcullis, Station Drive and The Meadows).
Clinical Director	Dr Deborah Shepherd
PCN Population	37,241

Key Areas of Focus

- Ensure practices are making maximum use of all digital telephony functionality
- Engage with Patient Participation Groups to help understand the challenges patients face and what the practices are doing to address them.
- Monitor friends and family feedback data and endeavour to increase response rates to inform quality improvements.
- All practices will use NHSE supplied website audit tool and toolkit for website improvement to ensure websites are easy to access and navigate as well encouraging use of online consultation routes, appointment booking etc.

Key areas of focus (continued)

- Enable one member of staff from each Practice to attend NHSE supported care navigation training and develop a care navigation resource pack
- Increase the number of patients registered with the NHS App in all Practices.
- Practices in the PCN are compliant with national guidance on appointment mapping.
- Purchase of digital dashboard to allow real time performance data monitoring of capacity and access and other performance indicators across the PCN.
- Increase the uptake of online consultations

Appendix 1 - Summary PCN Capacity and Access Improvement Plans 2023/24 - Shropshire

PCN	North Shropshire
No. practices	6 (Cambrian, Churchmere, Drayton, Plas Ffynnon, The caxton, Wem & Prees
Clinical Director	Tim Lyttle (from 1st Dec Dr Simon Jones and Dr Nick Von Horsberg)
PCN Population	91,554

Key areas of focus

- Ensure full cloud based digital telephony functionality is utilised
- Ensure that telephony data is routinely reviewed to inform impact and areas for further improvement
- Increase the uptake of online consultations working with Patient Participation Groups to champion usage and promote via digital and other comms routes
- Improve the standard, content and ease of use of websites
- Ensure all are compliant with Friends and Family requirement
- Establish a workforce subcommittee to aid with identifying clinically high pressure areas, practices under pressure and overall clinical mix requirements. The workforce committee will support the PCN management team with staff recruitment, induction, appraisals (including personal development plans) and the organisation of staff wellbeing support.

Key areas of focus (continued)

- Purchase digital support system (Ardens) collectively as a PCN which will report on and collate appointment data, working closely with GPAD to ensure appointment data is correctly mapped and will therefore meet contractual requirements and the PCN can address appointment usage, wastage and efficiency.
- Explore the potential for the PCNs systems, management team and processes to align and comply with the SCC systems. The aim is that the PCN and its practices will have sufficient real-time data management systems to proactively manage peaks in Primary Care demand, and these will be continuously developed and considered when looking at workforce, recruitment and rotas.
- Working with external partners and agencies to create a remote Pharmacy Technician service for the PCN that supports the practices with medicine reconciliation through their Docman systems, general medicines related tasks and the increasing burden of sourcing alternatives for patients.

Appendix 1 - Summary PCN Capacity and Access Improvement Plans 2023/24 - Shropshire

PCN	South East Shropshire
No. practices	9 (Albrighton, Alveley, Bridgnorth, Broseley, Brown Clee (with Ditton Priors), Cleobury Mortimer, Highley, Ironbridge, Much Wenlock & Cressage
Clinical Director	Dr Jessica Harvey
PCN Population	59,938

Key areas of focus

- Improving telephony functionality via increasing awareness of callback function and implementing in practices that don't have it
- Improved signposting and care navigation support proposed for Practice reception/ admin teams.
- Increase patient awareness of alternative medical professionals across the Practices (for example – ARRS staff)
- All SES PCN member Practices achieved above the National Average in 2022 regarding the provision of online consulting, however, the PCN's Digital Technician will engage with those practices who currently offer limited provision.
- The PCN plans to utilise it's Clinical Pharmacists to increase access to appointments for patient medication queries/ concerns by creating pre-bookable telephone consultations.

Key areas of focus (continued)

- Establish a Holistic Health Centre for the Highley population, enabling increased medical services not just from the General Practice, but a more combined health approach from staff within the PCN and hopefully, those allied health professionals such as midwives and health visitors also attending the centre. In creating an environment for health and wellbeing it is hoped that this will lead to improved patient engagement with services, overall improved health outcomes for the local population and increased satisfaction of the patient experience.

Appendix 1 - Summary PCN Capacity and Access Improvement Plans 2023/24 - T&W

PCN	South East Telford
No. practices	3 (Woodside, Stirchley and Court Street)
Clinical Director	Dr Nitin Gureja and Dr Melanie Thompson
PCN Population	38,204

Key areas of focus

- Making the practice websites user friendly, encouraging patients to use this as one of their default methods to access GP services, easing demand at the front door and on the phone.
- Monitor patient experience using patient surveys.
- Create a process within the PCN to analyse and act on feedback.
- Increase online appointments
- Implement Patient Triage across the PCN
- Utilise GP community pharmacy consultations to reduce demand for minor ailments

Key areas of focus (continued)

- Standardise and map appointment slots correctly, for improved reporting and monitoring, across the PCN
- Collate and analyse PCN practice level appointment data and review appointments monthly to ensure appointments are mapped to the most appropriate appointment category to improve accuracy of data

Appendix 1 - Summary PCN Capacity and Access Improvement Plans 2023/24 - T&W

PCN	Wrekin
No. practices	3 (Wellington, Hollinswood, Dawley)
Clinical Director	Dr Dez Ebeneezer, Dr Rohit Mishra, Dr Navneet Singh
PCN Population	34,845

Key areas of focus

- Recruit care navigators to help with Quality Outcomes Framework recalls etc so patient do not need to call the practice to make an appointment ie reduced phone incoming volumes.
- Refresher training on care navigation for admin team to ensure that patients are seen by the most appropriate member of the clinical team
- Recorded welcome message to divert callers to website.
- Improved signposting and care navigation support proposed for Practice reception/ admin teams.

Key areas of focus (continued)

- Hollinswood - Noted poor satisfaction with practice website on the last GP patient survey. To make improvements to the website to improve satisfaction.
- Dawley - Working with NHSE on intensive GP Improvement Programme looking at appointment appropriateness, smoothing patient flow
- Dawley - Introduction of a cloud based telephony system with upfront messaging and options to divert patients to appropriate service/department.
- Increased use of clinical streamer to deal with each contact. Roll out of Floery linked staggered and escalating invites for Quality Outcomes Framework registers so patients don't need to call the practice to make an appointment
- Dawley - Introduction of an urgent care hub to work with Duty Doctor and to support call handlers.
- Wellington - Using hybrid of e-consults to divert phone traffic. Also prerecorded message to divert to online consultation options. Telephony system call back functionality to be enabled.

Appendix 1 - Summary PCN Capacity and Access Improvement Plans 2023/24 - T&W

PCN	Teldoc
No. practices	2 (Teldoc, Shifnal and Priorslee)
Clinical Director	Dr Ian Chan and Dr Rashpal Bachu
PCN Population	63,217

Key areas of focus

- Patient Participation Group (Teldoc; S&P) to conduct patient survey with specific focus on experience of telephone contact; website ease of use
- Exploit Website to increase range and number of contact options/conversion rate
- Benchmark website conversion - review Feb 2024; User satisfaction to be included as part of survey; trend of 'access' related complaints to be monitored.
- Increase on the day bookable appointments
- Test call queueing options against volume/band width
- Full review of appointment mapping across the PCN to improve access to appointments

Appendix 1 - Summary PCN Capacity and Access Improvement Plans 2023/24 - T&W

PCN	Newport and Central
No. practices	4 (Donnington, Linden Hall, Wellington Road, Shawbirch)
Clinical Director	Dr Stefan Waldendorf
PCN Population	58,814

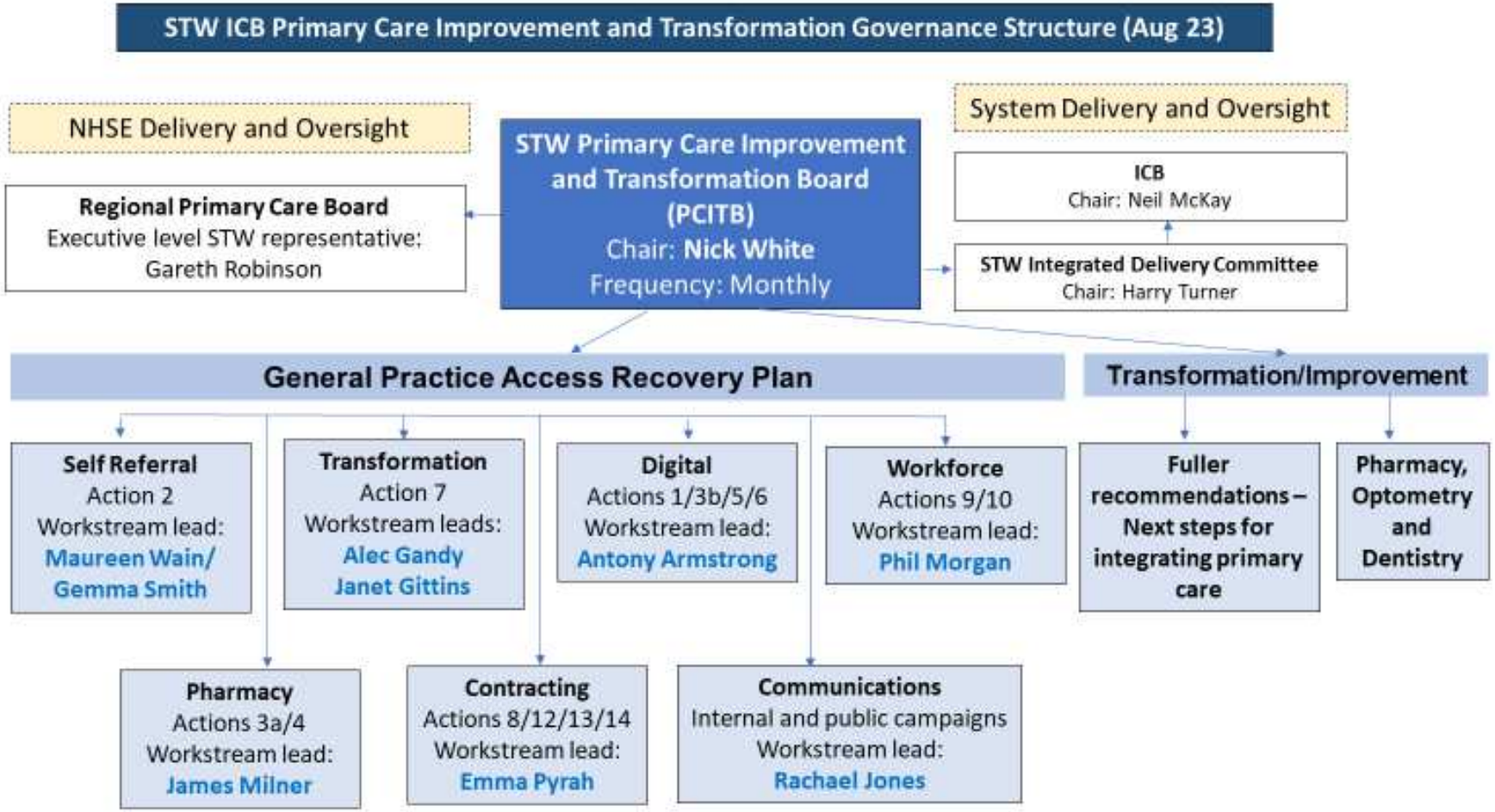
Key areas of focus

- Improving telephony functionality
- Improving website functionality and ease of navigation
- Improving care navigation skills and competencies
- Mapping pathways and identifying blocks and pinchpoints
- Trialling an Acute Capacity Overspill Service
- Maximising the utilisation of the full online messaging and consultation functionality offered by AccuRX
- Expand the use of the Community Pharmacy Consultation Service (CPCS)
- Patient Comms campaign to promote digital access routes

Appendix 2 – Summary of PCN Additional Roles by Staff Group and full time equivalent (Sept 2023)

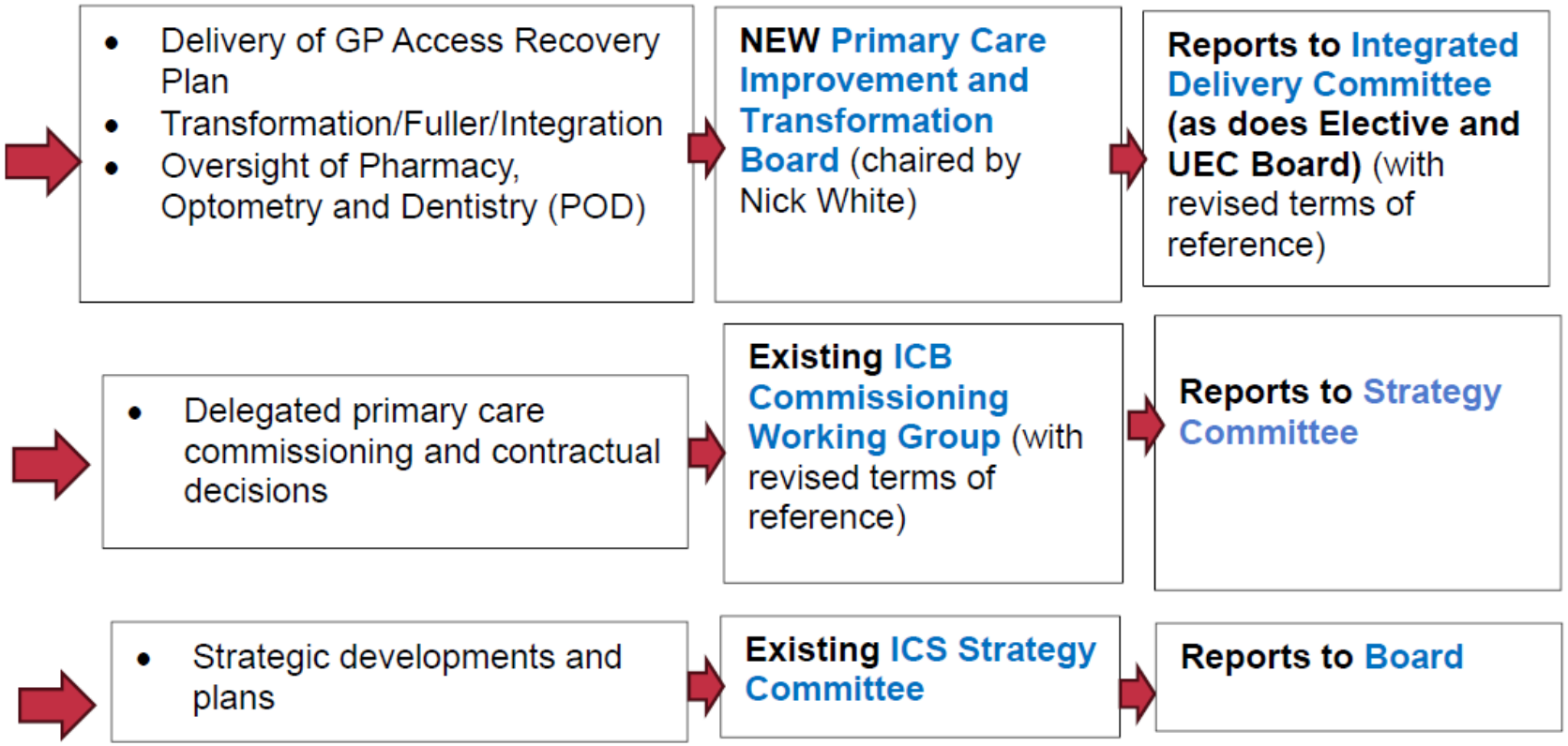
Role	No.	Role	No.
Advanced Paramedic	4	MHP Band 6	1
Advanced Pharmacist	0.5	MHP Band 7	7
Advanced Clinical Practitioner Nurse	7	MHP Band 8	1
Advanced Physiotherapist	1	Nursing Associate	5
Care Coordinator	46	Occupational Therapist	2
Clinical Pharmacist	34	Paramedic	17
Dietician	4	Pharmacy Technician	14
Digital and Transformation Lead	8	Physician Associate	11
First Contact Physio	16	Social Prescribing Link Worker	40
General Practice Assistant	13	Trainee Nurse Associate	2
Health and Wellbeing Coach	14		
Total	**247.5**		

Appendix 3 – Primary Care Improvement and Transformation Board Governance Structure



Appendix 3 – Primary Care Improvement and Transformation Board Governance

Proposed Primary Care Commissioning Governance



Appendix 3 - Terms of Reference of the Primary Care Improvement and Transformation Board

1. Role and responsibilities

The Primary Care Improvement and Transformation Board (PCITB) will provide oversight of delivery of STW Primary Care Improvement and Transformation Programmes aligned to delivery of commitments within the NHS Long Term Plan, the Government's mandate to NHS England, Delivery Plan for Recovering Access to Primary Care and the Fuller review including ensuring integration and alignment with emerging key national Primary Care Policy. Primary care in the above context includes General Practice, Pharmacy, Optometry and Dentistry.

The PCITB will:

- Oversee the implementation of the 'Delivery Plan for Recovering Access to Primary Care' (May 2023) and progress against key deliverables and milestones.
- Assure (with workstream leads) the ICS Integrated Delivery Committee of overall progress towards targets and deliverables.
- Shape, monitor and maintain strategic direction for the products and services delivered under the programme.
- Support and monitor the delivery of the objectives of the Primary Care Access Recovery Plan and its seven workstreams.
- Ensure alignment across multiple programmes, products and workstreams, removing blockers and resolving tensions.
- Oversee digital delivery against and alignment with core policy initiatives.
- Oversee delivery of the Fuller recommendations 'Next steps for integrating primary care' in line with national policy and ensure alignment with other STW transformation programmes where appropriate.
- Oversee the implementation of local strategies, plans and integration of pharmacy, optometry and dentistry.
- Ensure cohesive communications and messaging to senior internal and external stakeholders.
- Oversee the financial position of the delivery plan for recovering access to primary care.
- Identify and resolve dependencies and issues across portfolios and the wider system.
- Review escalated risks and issues and assure and agree plans for mitigation.
- Act as a collaborative vehicle to bring views together across STW and to co design integrated approaches to Primary Care.
- Prioritise key deliverables and co-ordinate internal and external demands e.g. prioritisation and pipeline.
- Receive briefings from other teams and programme boards on key changes.
- Ensure the continuous improvement of services through the identification of learnings and implementation of good practice.

Appendix 3 - Terms of Reference of the Primary Care Improvement and Transformation Board

2. Membership

- Chair: ICB Chief Medical Officer
- Co Chair: ICB Executive lead for Primary Care
- ICB Associate Director of Primary Care
- GP Access Recovery Workstream leads x 7
- GP Board nominated member
- PCN nominated representative
- Primary Care Finance Business Partner
- ICB Quality lead for primary care
- ICB BI lead for primary care
- Local Network representation for Pharmacy, Optometry and Dentistry

Other representatives as agreed with the Chair as required by agenda items.

3. Cadence and reporting

- Meetings will be held once every month (day/time to be confirmed).
- The agenda will be split into 2 parts. The first part will be dedicated to oversight of the implementation of the General Practice Access Recovery plan. The second part will be dedicated to primary care transformation programmes and key updates and developments in pharmacy, optometry and dentistry.
- The agenda and supporting papers will be circulated to all members ahead of the meeting; with the agreement of the Chair, items of urgent business may be added to the agenda after circulation to members.
- The PCITB will report directly to the ICS Integrated Delivery Committee; a Chair's summary will be presented to each Committee.
- The PCITB shall make whatever recommendations to the Integrated Delivery Committee it deems appropriate on any area within its remit where action or improvement is needed.
- These Terms of Reference are subject to review at least annually on the understanding they need to be dynamic and respond to change in the external environment as we move forward.

Appendix 4 - Key risks to delivering Improvement

Risk	Mitigation
The GP Access Recovery Plan does not address the underlying core problem that demand in primary care outstrips capacity even though more appointments are provided now than before the pandemic	• The Modern General Practice Access model and expanding patient access routes and alternatives to General Practice such as the community pharmacy offer will provide some additional capacity. • ICB continues to support with recruitment and retention initiatives to increase General Practice and wider MDT capacity • Explore all opportunities to expand the estate available to General Practice to provide face to face care and accommodate additional roles • Continue to proactively address the Elective backlog to reduce the demand on General Practice that this causes

Appendix 4 - Key risks to delivering improvement

Risk	Mitigation
The PCN/practice GP Access support funding is non-recurrent which makes implementing long term workforce/capacity solutions difficult	• PCN Additional Roles funding for 2023/24 has been confirmed as going in the baseline for 2024/2025 which means it becomes recurrent enabling PCNs now to recruit to permanent posts. • Use the additional non recurrent funding as an opportunity to pilot new models to collect the evidence for business cases for ICB permanent funding.
Many of STW GP Practices scored higher than the national average in the 2022 and 2023 GP Patient Survey access related questions, some significantly. This makes achieving 'significant improvement' as described in the national guidance difficult.	• PCN improvement plans targeted to areas where performance is lower. • The ICB will take into account the starting point of PCNs and practices when they assess the level of improvement achievement at year end.

Appendix 4 - Key risks to delivering Improvement

Risk	Mitigation
Increasing usage of digital patient access routes is difficult where digital infrastructure/ broadband capability is low. This is particularly the case in our more rural areas	• Short term – ICB digital lead to support PCNs and practices to fully utilise all national digital funding routes. • Medium to long term – ICB has a Digital Strategy which recognises the need to invest in digital infrastructure. • The ICB will take into account the suitability and availability of digital solutions to improve access in each PCN when they assess the level of improvement achievement at year end.
Patient reluctance to embrace digital access modes or to see alternative health care professionals	• National comms campaign. • Proactive ICB communications campaign and resource pack for practices to support messaging to change public perception that seeing a GP face to face is always necessary

Appendix 4 - Key risks to delivering improvement

Risk	Mitigation
Capacity of PCN and Practice staff to engage with and enact change, particularly during the increased demands of winter. There is no additional system winter monies for additional General Practice capacity this year	• We will proactively signpost PCNs and practices to national GP Improvement Support Programme and funding sources • PCN CAP payment is identified as a source for practices to secure backfill to participate in the national support programmes. • GP Support Team commissioned to provide a one off 3 hour facilitated quality improvement session to help inform practice areas to focus on and the relevant actions to address
Workforce shortages/ difficulties in recruiting staff especially clinicians	• Significant focus on Attracting, Recruiting and Retaining GPs via the refresh of the STW GP Strategy. • Support package to attract PCN additional roles advertised as part of recruitment documentation. • Focus on 'growing your own' to support more rural PCNs where recruitment is particularly challenging. • Practices and PCNs supported to access Nurse Associate Apprenticeship to support GPN succession planning. • Learner placements in primary care are facilitated to support future recruitment intentions. • Employing newly-qualified initiatives

Appendix 4 - Key risks to delivering improvement

Risk	Mitigation
Estates – shortage of space in practices to accommodate additional staff. No NHS capital funding source to enable extension of existing premises or new build	• PCN Workforce and Estates Strategies due for completion November 2023 • Ensure that GP estates needs are reflected in the ICS Infrastructure Strategy • Work with both Councils to ensure all avenues to access non NHS capital funding are explored for GP premises expansion or new build • Continue to lobby NHSE for the restart of national capital funding programmes for General Practice
Funding	• The Primary Care Team regularly signpost PCNs and practices to available external sources of funding and encourage uptake. • The ICB's significant deficit position means that there is no unallocated ICB funds to provide additional funding for General Practice Access

Appendix 5 – Summary of PCN Capacity Access Expenditure

Shrewsbury PCN	North Shropshire PCN	South West Shropshire
Support funding to practices for: ▪ Backfill attendance at Peer Review meetings ▪ Administrative time to review accuracy of GPAD recording ▪ Resources to review approach to and promote NHS App, Online Appointment booking, Friends & Family and Register with a GP services ▪ Upgrade Practice websites ▪ Release Reception staff for Care Navigation training ▪ Support and train reception team to use the new Care Navigation Desk Aid **PCN level support for:** • Premises costs, non-ARRS staff costs and equipment relating to the development and delivery of a Winter Illness Centre • Additional PCN Management resource to support delivery of the CAIP • Waiting rooms screens in all Practices and a local, tailored comms approach to messaging • Purchase of Care Navigation desk aid for all Practices.	**Support funding to practices for:** • Local use to improve access • Costs of additional clinical support and locum support • Costs attached to improvements / upgrades to existing cloud based telephone systems • Improvements and upgrades to websites • Investment in software such as MJOG to support Friends and Family feedback and other targeted patient surveys. • Staff training support in areas such as care navigation and signposting. **PCN level support for:** • PCN new website development • Staff Well-Being and resilience support • Tools to support data extraction and management - Ardens Manager and Ardens • Additional Management and admin cover to benchmark, formulate plans and initiatives, monitor progress, share best practice, peer review and evaluation of outcomes.	**Support funding to practices for:** • Promotion of the NHS App & online access • Upgrade practice websites • Support telephony improvements **PCN level support for**: • New PCN software and data dashboard produced to improve, review and monitor data. This intelligence will inform improvement plans and future service delivery.

Appendix 5 - Summary of PCN Capacity Access Expenditure

Newport & Central PCN	SE Shropshire PCN	SE Telford PCN
Support funding to practices for: ▪ Support to Practices in increasing usage of the NHS APP ▪ Administrative time on GPAD ▪ Resources to review approach to promoting NHS App, Online Appointment booking, Friends & Family and Register with a GP services ▪ Upgrade Practice websites ▪ Release Reception staff for Care Navigation training **PCN level support for:** • Additional PCN Management resource to support delivery of the CAIP • Full review of call processes across the PCN to improve patient access • Website design across the PCN • Drive patient online contacts via AccuRX • Increase PCN Care Navigation training and support	**Support funding to practices for:** ▪ Backfill for Practice staff to attend meetings ▪ Support for practices to improve telephony ▪ Resources to review approach to and promote NHS App, Online Appointment booking, Friends & Family and Register with a GP services ▪ Review and upgrade Practice websites ▪ Release Reception staff for Care Navigation training **PCN level support for:** • Review and improve PCN usage of Pharmacy services • Additional PCN Management resource to support delivery of the CAIP • Improve usage of the Community Pharmacy service • Establish a Holistic Health Centre service for PCN patients (namely in Highley)	**Support funding to practices for:** ▪ Ensure all practice websites are user friendly ▪ Resources to review approach to and promote NHS App, Online Appointment booking, Friends & Family and Register with a GP services ▪ Actively promote Friends and Family ▪ Release Reception staff for Care Navigation training **PCN level support for:** • Promote and improve online usage with patients • Review online appointment systems and plans • Improve usage of the Community Pharmacy service • Full review into appointment books

Appendix 5 - Summary of PCN Capacity Access Expenditure

Teldoc PCN	Wrekin PCN	
Support funding to practices for: ▪ Resources to review approach to and promote NHS App, Online Appointment booking, Friends & Family and Register with a GP services ▪ Continue to review and improve websites ▪ Support and train reception team to use the new Care Navigation Desk Aid **PCN level support for:** • Increase % of appointments bookable online • Increase eConsult usage • Full test of call queue process • Review appointment mapping across the PCN	**Support funding to practices for:** ▪ Review of practices telephony ▪ Resources to review approach to and promote NHS App, Online Appointment booking, Friends & Family and Register with a GP services ▪ Review and upgrade Practice websites for each Practice ▪ Increase Care Navigation within Practices ▪ Review and improve access to extended hours **PCN level support for:** • Promote online patient access and review usage • Improve usage of the Community Pharmacy service • Urgent Care Hub established across the PCN • Increase patient signposting • Review PCN Friends and Family responses	

Agenda Item

ICB 29-11-132.1

Quality and Performance Committee minutes for meetings held on 27 July and 28 September 2023

NHS Shropshire Telford and Wrekin
ICS Quality & Performance Committee Meeting

Thursday, 27th July 2023 at 2.00pm to 4.00pm

Via Microsoft Teams

Present:

Meredith Vivian	Chair & Non-Executive Director, NHS STW
Alison Bussey	Chief Nursing Officer, NHS STW
Tracey Slater	Associate Director of Quality, NHS STW
Sharon Fletcher	Senior Perinatal Quality Lead/ ICB Patient Safety Specialist/Interim Senior Quality Lead for SaTH, NHS STW
Julie Garside	Director of Quality Performance, NHS STW
Rosi Edwards	Non-Executive Director, SaTH
Jill Barker	Associate Non-Executive Director, SCHT
Claire Hobbs	Director of Nursing Clinical Delivery and Workforce, SCHT
Anne MacLachlan	Clinical and Care Director, MPUFT
Hayley Flavell	Director of Nursing, SaTH
Hassan Paraiso	Deputy Medical Director, SaTH
Sara Reeves	Deputy Director Quality, MPUFT
Brian Rapson	Information Office, Healthwatch Shropshire
Liz Noakes	Director of Public Health, Telford, and Wrekin Council
Simon Fogell	Chief Executive, Healthwatch Telford & Wrekin

Attendees:

Sue Bull	LMNS Programme Manager, NHS STW
Sylvia Barnes	Quality Team Administrator, Note Taker, NHS STW

1.0 Minute No. QPC-23-07.104 – Welcome/Apologies by: Meredith Vivian

1.1 The Chair of the Committee welcomed members and attendees to the meeting and introductions were made.

1.2.1 Apologies:

Apologies were received from:

- Vanessa Whatley – NHS STW – Tracey Slater/Sharon Fletcher representing.
- Lynn Cawley – Healthwatch Shropshire – Brian Rapson representing.

2.0 QPC-23-07.105 - Members' Declarations of Interests

2.1 Meredith Vivien advised his wife is a haematology clinical nurse specialist, and SaTH haematology service is identified in the Performance Exception Report. There were no other declarations or conflicts of interest noted.

3.0 Minute No. QPC-23-07.106 - Minutes of Meeting held on 29th June 2023

3.1 The minutes of the meeting held on 29th June 2023 were reviewed and accepted as an accurate record subject to the following:

3.2 Julie Garside asked item 6.1 is amended to Angie Parkes advised the 4-hour target is off track and an improvement *trajectory* is required.

3.3 Julie Garside asked item 6.6 lack of knowledge is amended to *lack of awareness*.

3.4 Julie Garside asked item 6.10 is amended to update on the procurement of dementia diagnosis service failing *which resulted in a provider not being appointed*.

4.0 QPC-23-07.107 Matters Arising and Action Log

4.1 Actions have been updated and are outlined on the action log.

4.2 QPC-22-10.39 - System Quality Metrics –This action has become clouded with suicide rates, however, should be regarding the excess death rate of people with serious mental illness. Liz Noakes advised NHSE have released a report on high rates. Julie Garside to discuss further with Tracey Jones and Alison Bussey.

Action: Julie Garside to discuss excess death rates of people with serious mental illness with Tracey Jones and Alison Bussey and feedback to the September meeting.

4.3 QPC-23-03.40 – Performance Exception Report – This action was closed as it is a known cost pressure for the ICB. A new action opened for Brett Toro-Pearce, how are we ensuring patients on the ADHD waiting list are aware of available choices to enable an informed choice.

4.4 Simon Fogell commented that at the time of the previous discussion he flagged the issue of people with serious mental illness being over-medicated.

4.5 Anne MacLaughlan confirmed that she signs off care group serious incidents, including those linked to unexpected death, and wished to assure the committee that over-medication is not a theme, any reported cases are reviewed by a psychiatrist.

4.6 Anne MacLaughlan discussed concerns where suicide is conflated with serious mental illness, the latest national confidential enquiry into suicide and self-harm report states that only 27% of suicides are known to mental health services. There is a time-lapse in data, with the latest report containing 2020 information. The report contains good learning for suicide prevention generally hosted by both local authorities and MPUFT are working on a suicide prevention plan for people using their services.

5.0 Minute No. QPC-23-07.108 - System Quality Risk – Tracey Slater

The report was taken as read, a discussion took place, and the following key points were highlighted:

5.1 *Maternity Risk* - Tracey Slater advised the maternity risk was updated after the meeting papers were distributed. The action plan demonstrates the projected versus the actual delivery and that SaTH are ahead of schedule in relation to the number of actions that are evidenced. There has been an improvement in the position of delivered actions not yet evidenced. Work continues to address outstanding actions from both reports, in partnership with all system stakeholders and in line with agreed timescales. Sylvia Barnes to circulate the updated risk register with the meeting minutes and updated action log.

Action: Sylvia Barnes to circulate the updated risk register with the meeting minutes.

5.2 Hayley Flavell confirmed there is a robust plan around Ockenden actions, 10 actions are not yet dated due to external dependencies, such as national guidance. All work undertaken is tabled at public Board and the Ockenden Board Assurance Committee, there is nothing currently at risk.

5.3 *Children and Young Peoples (CYP) Mental Health Services* – This risk has had minor updates and a summit is planned for 7th September.

5.4 *Diabetes Management* – Progress continues with the creation of a clinical advisory meeting and a decision of the top 5 priority pathways.

5.5 Funding has been agreed for continuous blood glucose monitoring and the process to transfer patients onto this technology.

5.6 Meredith Vivian queried that some actions were due to be completed in June 2023, however the report does not contain any updates. Tracey Slater to discuss with Vanessa Whatley.

Action: Tracey Slater to discuss actions requiring updating on the risk register with Vanessa Whatley.

5.7 Meredith Vivian added the diabetes risks remain high and the Committee would like to see progress and momentum. Rosi Edwards agreed that we need to start seeing metrics of outcomes to recognise when we are having an impact on the health of our patients.

5.8 Julie Garside advised the quarterly diabetes update contains a dashboard with all outcomes and is updated on a quarterly basis.

5.9 Meredith Vivian noted the report contains details of practices who are not currently achieving their target and asked if we know the reason why. Julie Garside is meeting with Emma Pyrah next week to understand how the primary care section can be developed and incorporated into the performance report and will update the Committee in September.

Action: Julie Garside to meet with Emma Pyrah to ascertain the reasons why 9 practices are not achieving the diabetes target.

5.10 Simon Fogell asked Shropshire and Telford and Wrekin practices are detailed separately in future reports for clarity.

5.11 *Acute paediatric pathway* – SOAG is monitoring this on a regular basis. SaTH have commenced the Paediatric Transformation Group in June 2023, key actions include the introduction of Sepsis Trust's paediatric tools and have shown some improvement in compliance. Further improvement is anticipated as further data becomes available.

5.12 The PTAC meeting is a milestone in addressing issues as a collective and developing its plan. A full update is expected to SOAG in July 23.

5.13 System CDI risk is currently being worked on by the ICS IPC and AMR Group, will be reported to SQG in September and come to the QPC meeting in September. As a system, we are currently reporting 33 CDI cases against a trajectory of 8 cases, 83% over trajectory. SaTH, SCHT and RJAH have shared their CDI strategies to enable a system-wide CDI Strategy to be developed for further discussion and updating at future IPC and AMR Group meetings.

5.14 Tracey Slater advised an enhanced discussion is needed to decide as a system what is required to overcome these challenges. Meredith Vivian suggested a position is received from SQG to ensure that the correct questions are being asked and the correct answers provided.

5.15 Hayley Flavell advised that high cases of CDI are being reported nationally, SaTH are currently reporting an outturn of 22 cases against a year-end target of 32 cases, however, was unsure of other healthcare associated infections such as E coli across the system. Hayley Flavell has previously advised that SaTH are working closely with the region and looking internally at cleaning, sampling, and education. CDI ward rounds have been reinstated and a review of what can be done differently regarding antimicrobial prescribing. A wider piece of work is required with system colleagues to understand what is happening pre-hospital or pre-provider in the community, primary care and prescribing. Clare Hobbs agreed that our system is matching the national picture and a system approach is needed.

5.16 Tracey Slater agreed to discuss with Vanessa Whatley. Hayley Flavell asked that E coli is also included in the discussion due to catheter-associated infections and how UTIs are managed initially.

Action: Vanessa Whatley to report back on proposed work for a system-wide approach which is appropriate to address infection prevention and control (IPC) measures for healthcare acquired infections.

5.17 Alison Bussey commented we have a system-wide IPC group, and this will be discussed at SQG to provide assurance to this committee.

The Committee:

- Discussed the risks for ongoing progress/action.

6.0 Minute No QPC-23-07.109 – Performance Exception Report – Julie Garside

The report was taken as read; key points of discussion were:

6.1 Julie Garside wished to note that some progress has been made with no criteria to reside and the length of stay and we are looking to maintain that position.

6.2 Meredith Vivian noted the report is scattered with positive moments and wished to reflect that good work is happening which is having a positive effect.

6.3 Meredith Vivian asked providers if this data is what they would expect to see on the delivery of performance targets and recognise the work being described. Julie Garside added the caveat that some data is reported as a system position or registered population and providers should be able to recognise the direction of travel. Meredith Vivian understood that may be the position regarding absolute numbers, but providers should be able to recognise trends and messages.

6.4 Hayley Flavell advised the report does not identify the challenges within the acute and the increased waits in ED, utilisation of corridors to care for patients due to overcrowding. There have been strides to improve the position, but it remains a fragile department which impacts getting patients admitted and to the correct destination.

6.5 Rosi Edwards confirmed the report contains recognisable information and is helpful as the data is so current.

6.6 Page 29, paragraph 4 *Recovery rates are variable but have struggled to meet the 50% target due to the number of complex patients who had previously been waiting for Talking Therapies being discharged from the service due to not meeting the service criteria for low mental health* - Rosi Edwards asked for clarification. Anne MacLaughlan advised there are multiple factors such as the patient has recovered, difficulties have become more complex, substance misuse has increased, or physical health has deteriorated. Rosi Edwards added the worry is that the patient is getting worse whilst they wait. Anne MacLaughlan explained that previously waits were accumulating for the most complex cases, a company called SILA has been employed for Shropshire

which has brought down waiting times by around 50%. The service is now far better commissioned and led.

Action: Anne MacLaughlan to provide a report on Talking Therapies service at the September meeting.

6.7 Julie Garside advised that if a person's condition deteriorates or becomes more complex, we need to ensure they get timely access to what is needed so that the journey can be mapped to make sure that no one falls through the cracks.

6.8 Anne MacLaughlan discussed a new risk which has been raised; national guidance has advised that therapists are upgraded, and no funding has been allocated in MPFT or ICB budget-lines. There is a real risk that excellent therapists will be lost locally.

Action: Julie Garside to add to the system risk register.

6.9 Meredith Vivian asked if performance information is discussed elsewhere. Julie Garside confirmed some elements are, the information is being aligned with the emerging functions of programme Boards. UEC is discussed at UEC Operational Delivery Group and Board, elective cancer and diagnostics is discussed at the Planned Care Board, dashboards are discussed at the Mental Health and LDA Partnership Board. Two areas have been highlighted where further work is required: CYP physical health and community services. Julie Garside is championing CYP physical health with the CYP Board. Discussions are taking place regarding designing a community dashboard to reflect community services which can also feed into individual programmes.

6.10 Liz Noakes commented we have information on access to primary care but not necessarily quality. Some information for example on diabetes or CVD would be held in that forum where our system could potentially be outliers. Julie Garside added that this will be included in her discussion with Emma Pyrah.

6.11 Meredith Vivan asked if the quality impact is questioned when performance data is reviewed i.e., where cancer targets are not being achieved by a long way, what is that telling us about the focussed attention around the quality. Julie Garside has discussed this with Vanessa Whatley previously, the integrated performance report is being developed for the Board and is assisting with making the link between quality and performance. Tracey Slater advised the quality team has an agenda section at Joint Contract Review meetings where provider performance and the impact of quality, for example long waits and harm reviews is discussed.

The Committee:

- Noted the content of the report and provided any feedback for incorporation into future reports.

7.0 Minute No. QPC-23-07.110 – System Quality Metrics – Sharon Fletcher

The report was taken as read; a discussion took place with the following key points highlighted:

7.1 Sharon Fletcher advised this month's report is risk focused, some items have been covered thoroughly in the risk register discussion earlier and a full report will be tabled in September.

7.2 One amber risk is contained in the report, maternity care which shows an improving picture and one red risk, CYP which has neither improved nor declined.

7.3 Four extreme risks; imaging shows a decreasing trend, urgent care, diabetes management and paediatric pathways showing similar trends.

7.4 Meredith Vivian advised this report details 11 practices are not achieving the diabetes target and the System Quality Risk paper details 9 practices.

7.5 Sharon Fletcher advised there are still places available at the ICS PSIRF event being held 28th July which will be attended by local authorities, hospices, public health, SaTH and RJAH. Sharon Fletcher thanked everyone for the commitment they have shown to the event which will give a steppingstone into how we correlate quality, safety, and performance.

The Committee:

- Considered the quality metrics with performance metrics and system risks.

8.0 Minute No. QPC-23-07.111 - Exception Report - System Quality Group Chairs Update – Alison Bussey

The report was taken as read.

8.1 Alison Bussey advised it was an unusually quiet meeting, hence the shorter report this month.

8.2 Meredith Vivian asked what the thresholds for risks are to determine they require discussion at SQG. Alison Bussey advised there is no particular threshold, risks are identified in a number of ways such as the performance report and understanding the level of the risk. The is discussed at SQG and recommendations provided prior to tabling at QPC via the risk register.

The Committee:

- Considered the alerts in this report and further assurance required.
- Accepted the report.

9.0 Minute No QPC-23-07.112 Deep Dive Planned Care Including Screening – Julie Garside

The report was taken as read, a discussion ensued, and the following key points were highlighted:

9.1 Julie Garside advised that Gloria Onwubiko has left the ICB and Maureen Waine, new Interim Director of Elective services, is on annual leave. This information was prepared by Gloria Onwubiko and Maureen Waine.

9.2 Julie Garside advised this update is important as it shows the first quarter for deliverable of elective care; eliminate the over 78 week wait, 62 day backlog and faster diagnosis standard. Excellent progress has been made with long waits, however one additional patient, affected by industrial action in July, will be added to the over 78 week wait for RJAH, making a total of 3.

9.3 Good progress has been noted on the 65 week wait, which is ahead of plan. NHSE colleagues are pleased with the progress however further improvement in cancer will be required to enable a step down from Tier 1 escalation to Tier 2.

9.4 Julie Garside provided an update on the 62 day backlog; at 23rd July, 334 patients were waiting over 62 days for treatment, which is ahead of trajectory.

9.5 Challenges remain for 5 faster diagnosis standards, we are behind trajectory. The ambition for FIT testing was 80% of the update by primary care by July, the actual current position will be just over 70%. Primary care colleagues do seem to be utilising

the FIT test, however the corresponding reduction in request for colonoscopies has not been seen, which adds pressure into the diagnostic service. Work continues with primary care colleagues to understand what is driving this behaviour.

9.6 Particular challenges are noted with the take-up of dermatology and work is ongoing to attain an improvement. A tele-dermatology service is being piloted and progress is monitored by a system wide Task and Finish Group.

9.7 Haematology are working to develop clinic templates to optimise capacity with current workforce.

9.8 Head and Neck are also reviewing clinic templates to increase Faster Diagnosis Standard.

9.9 Increased scanning capacity will be available from July to bring forward patients and reduce the backlog.

9.10 Liz Noakes thanked Julie Garside for the succinct report and noted that screening was not included in the paper. Although the only current issues with screening is regarding inequality and prevention, it would be good to have a slide in a future report. Julie Garside confirmed that an update was provided at the June meeting and agreed that an end of quarter summary and status update will be included in the next report.

Action: Julie Garside to request Maureen Waine include a screening update in the next report

9.11 Meredith Vivian thanked Julie Garside, Gloria Onwubiko and the team for their hard work, and added that although we are not achieving all targets, looking back over the previous months, numbers were astronomical and great progress is noted.

9.12 Meredith Vivian alluded to the summary section regarding patients' willingness to travel out of the county/region and willingness to transfer care to another provider remains a challenge, and asked if capacity is available elsewhere. Julie Garside responded that capacity depends entirely on the speciality, some MSK or spinal patients have been willing to travel to London. Some specialities have capacity issues nationally post-COVID and tend to ensure that their own patients receive treatment before opening out to other areas and providing mutual aid. Regional NHSE colleagues are supporting mutual aid and advise where capacity is available, which assists with informing patients. SaTH and RJAH continue to offer the choice to patients who have been waiting long periods which involves huge administration pressures.

9.13 Meredith Vivian asked Liz Noakes if work is being undertaken with Shropshire and Telford and Wrekin VCSEs and Lingen Davies to reach marginalised groups regarding cancer symptoms. Liz Noakes confirmed that 107 cancer champions have been trained locally to date to provide information to the community and interest is being received.

9.14 A MSK pathway event was recently held by clinicians, Telford and Wrekin local authority were pleased to be invited to explain how they can support communities to lose weight and signpost appropriately. A strong interface is noted in health checks, closer working was noted between the physical health team, MPUFT, and lifestyle team, Telford and Wrekin local authority is ongoing.

The Committee:

- Noted the report content.

10.0 Minute No. QPC-23-07.113 – LMNS Programme Board Update – Sue Bull

The report was taken as read.

10.1 Sue Bull advised the fetal medicine service will cease today due to staffing challenges, however since the report was submitted, a referral SOP has been agreed and is now in place for patients wishing to access the fetal medicine service at SaTH.

10.2 From the first Ockenden report, 47 out of 52 actions have been implemented equating to 91% which is a real positive message and SaTH are currently ahead of schedule in relation to the number of actions that are evidenced and assured.

10.3 The midwife to birth ratio was 1:25 which is reassuring.

10.4 Sue Bull wished to highlight current staffing levels; a deficit of 15% of the workforce which may increase to 22% due to staff maternity leave. SaTH have implemented measures to maintain levels by holding weekly staffing meetings, workforce plan and recruiting to specialist roles.

10.5 Maternity and Neonatal Independent Senior Advocate (MNISA) commenced employment at the ICB today and is currently undertaking training. This is an important role to ensure that families are heard and have someone to turn to when required.

10.6 Merdith Vivian asked for confirmation the MNISA role is only funded until the end of this financial year. Sue Bull confirmed this is a pilot scheme involving 9 or 10 ICBs, NHSE will then evaluate and advise if this will be rolled out nationally.

10.7 Meredith Vivian wished to note the tremendous work that is being carried out at SaTH on actions for evidence and assurance.

10.8 Rosi Edwards recognised all the information and thanked Sue Bull for the succinct report.

10.9 Regarding smoking at delivery, Rosi Edwards recognised that no funding is available within the system. Sue Bull advised the LMNS maternity commissioner is working closely with ICB commissioners, nicotine replacement therapy (NRT) and the funding that needs to be in place.

10.10 Hayley Flavell added that if SaTH do not obtain funding for NRT, they will not achieve Clinical Negligence Scheme for Trusts (CNST). The deadline for CNST year 5 submission is the end of November. SaTH are at significant risk without the NRT, £750,000 was not received for year 3 of CNST. This also carries significant reputational damage as it is a measure of safety. New guidance has just been released which adds more layers of complexity.

10.11 Meredith Vivan asked for this risk to be escalated to the ICB. Alison Bussey advised this is part of the LMNS Programme Board chaired by Nick White and is actively being pursued.

Action: Meredith Vivian and Alison Bussey to discuss how this item is appropriately escalated.

10.12 Jill Barker asked what complaints and compliments are being received for this service. Sue Bull confirmed Maternity Neonatal Voices Partnership (MVNP), part of the LMNS system, gather a lot of information and work very closely with SaTH. Currently working through the NHSE delivery plan for maternity and neonatal services which includes listening to families and their feedback. More information regarding patient feedback will be included in the next LMNS Programme Board Update report. Sue Bull added that a business case has just been agreed to fully fund MVNP to enable them to develop a workplan and work closer with SaTH and users of the service.

Action: Sue Bull to include user feedback on experience of care and effects caused by its collection in the next report.

10.13 Alison Bussey wished to note the ICB has not received any complaints about maternity services. Hayley Flavell advised the publicly streamed monthly Ockenden Assurance Committee, chaired by Catriona McMahon and Maxine Mawhinney, had a dedicated section regarding complaints and user feedback a couple of months ago. What has

been carried out in practice to provide assurance, the issues had been listened to and improvements made was also included in the discussion. Hayley Flavell offered to share the information with Sue Bull if required. The Ockenden report requests MVNP works with the provider to ensure that complaint-response templates are user-friendly, which has been evidenced and assured. Regular meetings are held with MVNP to discuss soft intelligence. Hayley Flavell suggested information from FFT, MVNP, compliments/complaints and surveys is triangulated.

10.14 Hayley Flavell confirmed maternity long-term sickness is under review and availability challenges due to midwives who will soon be commencing maternity leave. Proactive work is being undertaken to recruit to substantive posts, rather than fixed-term maternity cover.

10.15 Meredith Vivian asked Tracey Slater to share the previous Patient Insight report with Sue Bull to detail how information is gathered and presented.

Action: Tracey Slater to share the previous Patient Insight report with Sue Bull.

The Committee:

- Noted the report and item for escalation.

11.0 Minute No. QPC-23-07-114 Healthwatch Shropshire Update – Brian Rapson

A verbal update was provided.

11.1 Brian Rapson advised a report regarding experience of the complaints process is currently being drafted and is hoped to be published shortly.

11.2 A diabetes survey, launched approximately 6 weeks ago regarding care and people's experience of diabetes care, is due to close at the end of this month and findings will be shared across the system.

11.3 Domestic homecare will be focussed on in August, SCHT are assisting with providing details of people who currently receive domestic homecare. Conversations have taken place with providers of the service and discussions will also take place with local authorities.

11.4 Preliminary conversations have been held regarding gathering patient's experience of virtual wards and MPFT in-patient wards at Redwoods. Meredith Vivian added that virtual wards is a major piece of work for SaTH and SCHT and for our patients. To understand how it feels as a recipient of the service will be interesting and important to ensure the service develops and progresses for greater effect.

11.5 Meredith Vivian reiterated that it would be useful for Healthwatch representatives to provide a list of key items prior to the meeting so that thoughts and feedback can be given towards the planned areas of work.

11.6 Hayley Flavell advised a digital patient story regarding the virtual ward is being tabled at SaTH and SCHT Board meetings in August involving 2 patients.

The Committee:

- Noted the update.

12.0 Minute No. QPC-23-07-115 – Healthwatch Telford & Wrekin Update – Simon Fogell

A verbal update was provided.

12.1 Simon Fogell advised Healthwatch England have published a report today regarding the impact of cancellations across the NHS which has been picked up by the national media. Information is available via the following link:

https://www.healthwatch.co.uk/news/2023-07-27/cancellations-nhs-care-are-having-serious-impacts-two-thirds-patients

12.2 Diabetes UK have published Diabetes is Serious report based on PCN data, which details that STW ICB has the lowest level nationally of provision of essential annual checks. Information is available via the following link: https://www.diabetes.org.uk/get_involved/campaigning/diabetes-is-serious

12.3 Information has been received regarding access to mental health teams, some reports of people being turned away even when demonstrating they are upset. Anne MacLaughlan advised the Access Helpline is where issues are listened to and signposted accordingly i.e., calm cafés, crisis cafes, Samaritans or recommend the caller sees their GP the following day. All callers are asked to call back and advise on progress. Caller expectations were discussed, Anne MacLaughlan confirmed that the initial phone message the caller hears has been looked at to provide clarity, however it is very difficult as the one telephone number serves multiple functions. It could act as an escalation if deemed appropriate following triage or the caller could be referred to another service, especially out of hours.

12.4 Anne MacLaughlan asked both Healthwatch colleagues to forward information on complaints/comments received so this can be discussed along with a further review of the initial recorded message on the Access Helpline.

Action: Simon Fogell and Brian Rapson to forward patient feedback regarding the Access Helpline to Anne MacLaughlan.
Once received, Anne MacLaughlan to review the feedback and re-look at the Access Helpline recorded message to assist with managing public expectations of the service.

12.4 Comments have been received about long waits for audiology and what is happening regarding a new provider as Specsavers are no longer delivering the service. It has been advised that a new provider will not be commissioned until April 2024. Julie Garside explained a specification was received to procure an AQP for audiology, however there is an issue with part of the pathway which needs to be resolved prior to procurement. The issue is clearing earwax prior to the audiology appointment. If the formal procurement process is not followed in its entirety, Specsavers could start court proceedings.

13.0 Minute No. QPC-23-07.116 – Evaluation of Meeting

13.1 Meredith Vivian encouraged members to feedback comments and/or observations they may have about the meeting or any improvements they wish to see. Please send comments to sylviabarnes@nhs.net

14.0 Minute No. QPC-23-07.117 – Items for Escalation/Referral to Other Board Committees

14.1 Meredith Vivian and Alison Bussey to discuss how NRT funding is appropriately escalated.

15.0 Minute No. QPC-23-07.118 – Any Other Business

15.1 No additional items were raised.

Date and Time of Next Meeting

Thursday 28th September 2023 at 2.00pm to 4.00pm via Microsoft Teams.

SIGNED ……. DATE …….

NHS Shropshire Telford and Wrekin
ICS Quality & Performance Committee Meeting

Thursday, 28th September 2023 at 2.00pm to 4.00pm

Via Microsoft Teams

Present:

Meredith Vivian	Chair & Non-Executive Director, NHS STW
Vanessa Whatley	Director of Quality and Safety/Deputy Chief Nurse, NHS STW
Sam Cook	Deputy Director of Performance, NHS STW
Rosi Edwards	Non-Executive Director, SaTH
Jill Barker	Associate Non-Executive Director, SCHT
Claire Hobbs	Director of Nursing Clinical Delivery and Workforce, SCHT
Anne MacLachlan	Clinical and Care Director, MPUFT
Kara Blackwell	Deputy Chief Nurse, SaTH
Mahadeva Ganesh	Medical Director, SCHT
Sara Reeves	Deputy Director Quality, MPUFT
Brian Rapson	Information Office, Healthwatch Shropshire

Attendees:

Paul Cooper	Designated Adult Safeguarding Lead, NHS STW
Hayley Cavanagh	Senior Quality Lead, NHS STW
Rob Grant	Associate Director of Safety, Risk and Compliance, MPUFT
Liz Walker	Head of Medicines Quality and Optimisation, NHS STW
Sylvia Barnes	Quality Team Administrator, Note Taker, NHS STW

1.0 Minute No. QPC-23-09.119 – Welcome/Apologies by: Meredith Vivian

1.1 The Chair of the Committee welcomed members and attendees to the meeting and introductions were made.

1.2 Meredith Vivien advised for a number of reasons there are a large quantity of papers which has been quite hard work. Vanessa Whatley, Sam Cook, Julie Garside and Alison Bussey to review future agendas to ensure they are manageable.

1.3 Vivien Meredith asked that future papers include an executive summary advising the report content to provide detail and highlight key points to note.

1.2.1 Apologies:

Apologies were received from:

- Alison Bussey NHS STW – Vanessa Whatley representing.
- Tracey Slater NHS STW – Vanessa Whatley representing.
- Julie Garside NHS STW – Samantha Cook representing.
- Paul Kavanagh-Fields RJAH – Kirsty Foskett representing.
- Hayley Flavell SaTH – Kara Blackwell representing.

- Liz Noakes Telford and Wrekin LA
- Sara Ellis-Anderson SCHT
- Simon Fogell Healthwatch Telford
- Lynn Cawley Healthwatch Shropshire – Brian Rapson representing.
- Liz Lockett MPUFT – Anne MacLachlan representing.

2.0 QPC-23-09.120 - Members' Declarations of Interests

2.1 There were no declarations or conflicts of interest noted.

3.0 Minute No. QPC-23-09.121 - Minutes of Meeting held on 27th July 2023

3.1 The minutes of the meeting held on 27th July 2023 were reviewed and accepted as an accurate record.

4.0 QPC-23-09.122 Matters Arising and Action Log

4.1 Actions have been updated and are outlined on the action log.

4.2 QPC-23-07.107 – Action Log *How are we ensuring patients on the ADHD waiting list are aware of available choices to enable an informed choice.* Vanessa Whatley advised a regional extraordinary quality meeting has been held as this is a national issue, the Midlands have been proactive in collating information. Tracey Jones and Helen Rowney are leading this piece of work and an initial meeting to include Vanessa Whatley is being arranged to build the risk around the issue of how we ensure the diagnosis is made safely. Further meetings will include medical input. Vanessa Whatley confirmed this will be discussed at System Quality Group, added to the risk register and brought back to this meeting.

4.3 QPC-23-07.108 - System Quality Risk *Julie Garside to meet with Emma Pyrah to clarify if 9 or 11 practices are not achieving the diabetes target and ascertain the reasons why. Also, request that Shropshire and Telford and Wrekin practices are detailed separately in future reports for clarity.* - Rosi Edwards asked if we are aware of the reasons why practices are not achieving the diabetes target. Vanessa Whatley suggested this item remains open to ensure this information is included in Fiona Smith's quarterly report later in the meeting.

4.4 QPC-23-07.109 - Performance Exception Report. *Anne MacLaughlan to provide a report on Talking Therapies service at the September meeting.* Anne MacLaughlan provided a verbal update. Performance dropped due to a change in data coding which was expected and discussed at the ICB contract review meeting. Performance has not increased as much as the ICB had hoped; Anne MacLaughlan has discussed this with the new service operations manager as this is part of the transformation of employing more data analysts, who has advised that in the next financial year, data recovery will be seen.

4.5 Vivien Meredith asked Anne MacLaughlan to provide a briefing note regarding an update of performance and data recovery for the October meeting.

Action: Anne MacLaughlan to provide a briefing note of performance and data recovery at the October meeting.

4.6 QPC-23-07.109 - Performance Exception Report *National guidance advises therapists should be upgraded, however no funding has been allocated in MPUFT or ICB budget-lines; there is a risk of losing therapists locally. Julie Garside to add to Risk Register.* Vanessa Whatley to ascertain which Board has been approached to add to the Risk Register.

Action: Vanessa Whatley to ascertain which Board has been approached to add to the Risk Register

4.7 QPC-23-07.113 – LMNS Programme Board Update *Meredith Vivian and Alison Bussey to discuss how the risk can be appropriately escalated that if SaTH do not obtain NRT funding, they will not achieve Clinical Negligence Scheme for Trusts.* Vanessa Whatley advised that Sharon Fletcher has provided an update; the service is being managed as cost pressures to SaTH whilst the ICB and LMNS are establishing a more robust funding stream. We will not receive saving babies lives care bundle, which is one of the safety actions of the CNST submission, without it. This is a national and regional issue and a solution is being sought. Item to remain open for further updates.

4.8 QPC-23-07-115 – Healthwatch Telford & Wrekin Update *Review the complaints/comments information from Simon Fogell and Brian Rapson and re-look at the Access Line recorded message to assist with managing public expectations of the service.* Anne MacLaughlan advised that no patient feedback was received. Brian Rapson confirmed that no patient feedback had been received in Shropshire. Anne MacLaughlan to contact Simon Fogell for an update.

5.0 Minute No. QPC-23-09.123 - System Quality Risk – Vanessa Whatley

The report was taken as read, a discussion took place, and the following key points were highlighted:

5.1 Meredith Vivian advised of discussions at the Integrated Care Board meeting yesterday on system mortality rates. What we do with that information is very important, as it tells a great deal about how our services are working towards providing safe, high-quality care for our population. Discussions included how this committee could use the information as a lens by which we might focus more attention on some of these fundamental key areas of risk.

5.2 Vanessa Whatley added that it was right for the report to go to Board however the important part is what discussions have taken place beforehand, Healthwatch will be really helpful advising how the information will be perceived by the public and any potential questions that may be raised so that answers can be prepared in advance as much as possible but key is that the system needs to demonstrate how we are acting on the information.

5.3 Vanessa Whatley advised that since risks have been added to the risk register, it has been quite dynamic however current risks have remained the same over the previous couple of months. Key points of update are required for some such as acute paediatric pathway, which is being reviewed at SOAG so a reduction is anticipated.

5.4 *Maternity Risk* – even though this has reduced and would usually be managed at a group level, executives feel this should remain on the register until CQC have revisited.

5.5 Rosi Edwards commented that maternity services are progressing well, and it is perfectly reasonable to keep it on the risk register just to make sure that everyone is satisfied until CQC have re-inspected.

5.6 Meredith Vivian advised that sometimes a risk register can look frozen and asked that any dates included are reviewed to ensure we have the most current position available and see movement even if the score is unchanged. External validation/measure is needed for maternity issues.

5.7 *Urgency and emergency care* - Meredith Vivian asked why the target risk score for end of financial year is unpopulated. Vanessa Whatley has requested this information several times and feels the leads are reluctant as it is difficult to predict.

5.8 Mahadeva Ganesh asked for clarification the system has the highest rates of neonate and stillbirth rates and acknowledged that progress has been made, however what lessons have been learnt and actions taken to make significant progress. Rosi Edwards advised that all deaths are looked at in great detail by the head of maternity and any learning is taken straight away, they are also reviewed by HSIB at the same time so are scrutinised.

5.9 Vanessa Whatley advised the CDOP process has been reviewed externally and a lot of good work is going on in the background. A number of recommendations have been made, the papers are going to System Quality Group next week and the following month the Child Death Review Annual report is also going to System Quality Group. The thematic summary will help for the last year and there will be a quarterly report. Due to a change of CDOP Chair, process has dropped off, however governance is being reestablished and Mahadeva Ganesh's team have worked really hard to make that happen.

The Committee:

- Discussed the risks for ongoing progress/action.

6.0 Minute No QPC-23-09.124 – Performance Exception Report – Sam Cook

The report was taken as read; key points of discussion were:

6.1 Meredith Vivian noted the report contained a useful executive summary.

6.2 Sam Cook advised UEC performance is very challenged and that is in part due to industrial action and annual leave. That has impacted on performance in the last two months, which is a bit of a setback because previous to that, performance was tracking against trajectory. A lot of work is going on in the background to understand that and a revised improvement trajectory plan will be received.

6.3 Good progress is noted with elective planned care and especially long waits. As of mid-September, SaTH remain in Tier 1, but it is expected that they will be moved to Tier 2 for elective because of improved end of Q1 delivery for 104 and 78 weeks however, will remain in Tier 1 for cancer. NHSE are expected to move to fortnightly instead of weekly monitoring by the end of September. Scrutiny on cancer performance remains and deep dive packs are updated on a weekly basis. Focus remains on meeting the 62-day standard, which remains very challenged for SaTH. For 78 weeks, the system has been congratulated by NHSE on being the best performing in the region. Cancer waits are well below trajectory.

6.4 Good progress is noted with perinatal mental health appointments within 6 weeks and additional information was received after the report was written; 53% in July which increased to 64% in August.

6.5 Following a question from Meredith Vivian, Sam Cook confirmed STW is an outlier for ambulance handover targets beyond what has been seen in the region. Work is ongoing to understand the reason why and will form part of that recovery.

6.6 Kara Blackwell advised there are a lot of DTAs in the department causing onward flow through the hospital and discharge. Some issues are masked by the underlying bed gap at SaTH. Work is ongoing with the system around different models of care, utilising virtual wards more and modular builds.

6.7 Rosi Edwards noted the hospital transformation plan is looking to the future regarding more space and better location. The difficulty is with discharging patients, it is not good for the patients to stay in hospital longer than medically required as they become deconditioned and may even acquire a hospital infection.

6.8 Clair Hobbs added the no criteria to reside numbers that sit both in community hospitals and in SaTH particularly, is far higher than it should be, which doesn't help with flow. A lot of time is taking pulling patients out of ED who should never have been signposted there in the first place.

6.9 Sara Reeve advised of improvements in eating disorders and the four week waits. Sam Cook confirmed she did not have the eating disorder information.

6.10 Vanessa Whatley wished to highlight the fast-track information, a new addition to the report content, which details the longest days between outcome and the package approval is 16 days, which is a long time. 132 referrals were received in August, this

has impacted a lot of people. Vanessa Whatley suggested this be reported as a trend so that improvement and deterioration can be seen. Sam Cook agreed. Vanessa Whatley added that conversations have indicated that rural patients are included, however this is inequality.

Action: Sam Cook to include fast-track trends in future reports to identify improvement and deterioration.

6.11 Meredith Vivian advised these reports contain worrying information with targets being missed and asked if the Committee is doing enough. Anne MacLaughlan advised that as a provider and feeding into this Committee, it provides a lever to ask her organisation what is happening with any issues reported.

6.12 Rosi Edwards advised that this Committee looks at what the system can do and what it needs to reflect on regarding what is happening in a provider, where the provider alone is unable to progress the issue. It brings the system together to focus on particular areas such as A&E and diabetes. Pathways are really important, and diabetes in particular is a significant issue as we are the worst performing system. If we review what we as a system are doing and why things are not happening as we would wish, we may be able to do something about it.

6.13 Sam Cook asked if information is presented in a way that enables the Committee to explore issues and understood that reports contain a wealth of information and are very lengthy. Currently the ICB pulls the data together for the system, however it would be good if providers could contribute their own intelligence in future reports, Sam Cook asked for suggestions on how to take this forward.

6.14 Sara Reeve agreed and would be happy to meet with Sam Cook and others to understand where focus is required, this is a sensible way forward.

6.15 Jill Barker asked if we have enough input from primary care. Meredith Vivan added that pathways require primary care input and asked for a discussion with Vanessa Whatley outside of the meeting.

Action: Meredith Vivian and Vanessa Whatley to discuss how to engage with primary care colleagues at this Committee.

6.15 Mahadeva Ganesh commented that public health representation is missing from this Committee as the future is prevention rather than cure. Meredith Vivian advised that Liz Noakes from public health usually attends meetings, and questioned if we have the wider public health influence and pressure.

The Committee:

- Noted the content of the report.

7.0 Minute No. QPC-23-09.125 – System Quality Metrics – Vanessa Whatley

The report was taken as read; a discussion took place with the following key points highlighted:

7.1 Vanessa Whatley advised next month a full quarterly review will be tabled.

7.2 Maternity post-partum haemorrhage rates had greatly improved however have gone up slightly, rates are still around the national average. Vanessa Whatley to discuss with LMNS colleagues to understand why.

Action: Vanessa Whatley to discuss with LMNS colleagues why post-partum haemorrhage rates have increased slightly.

7.3 Ambulance waiting times are still a concern, quality metrics will be monitored going into winter and harm reviews are carried out by the trust. SaTH consultant is looking at a harms model based on length of time waited.

7.4 No additional paediatric deaths since March 2023 that have been recorded as serious incidents and the actions are ongoing. PTAC are reviewing survey results, movement is expected , only two incident actions remain.

7.5 SaTH, RJAH and SCHT have all breached their annual C diff objectives, some cases are patients that have been admitted from other organisations and recurred after a period of having normal bowel movements. Community cases are being reviewed to see the path taken through various healthcare in the system. A system action plan has been devised, learning is being identified and taken forward. SaTH have a deep clean programme which is absolutely critical for C diff control.

The Committee:

- Considered the quality metrics with performance metrics and system risks.

8.0 Minute No. QPC-23-09.126 - Exception Report - System Quality Group Chairs Update – Vanessa Whatley

The report was taken as read.

8.1 Vanessa Whatley advised this report is from the August System Quality Group meeting and a new risk was presented in relation to CDI cases. The system is currently 83% over trajectory, reporting 33 cases against a target of 18 and annual target of 76 cases. This is part of the NHS Standard Contract. The ICS IPC and AMR Group oversee this risk and a system CDI Action Plan is being developed.

8.2 Vanessa Whatley asked if Sara Reeve could provide an update on the CQC inspection as the final report has been received since the Chairs Update report was written.

8.3 Sara Reeve advised a paper will be presented to System Quality Group next week. The CQC report was published on the 20th September 2023, the rating to the service was not part of that review, so remains as inadequate for core services. Full assurance received from CQC that MPUFT have met the requirements of the seven points of the Section 29a warning notice and work continues on the action plan.

8.4 Anne MacLaughlan commented that Paul Cooper, ICB safeguarding and Raphael Chichera, Senior Quality Lead, visited the wards last week, the visit concentrated on sexual safety. Positive verbal feedback was received, sexual safety is a focus for MPUFT too.

The Committee:

- Considered the alerts in this report and further assurance required.
- Accepted the report.

9.0 Minute No QPC-23-09.127 Understanding Deaths for People with MH Needs – Rob Grant

The report was taken as read, a discussion ensued, and the following key points were highlighted:

9.1 Meredith Vivian apologised this report was not tabled when originally received by the Committee.

9.2 Rob Grant advised the report was originally presented within the trust back in May, and it was shared with the system. A huge amount of changes have taken place since then in terms of national reports, strategies and other things.

9.3 The data is from 2020 and 50% of the data was unvalidated because during the COVID period, there was a huge backlog in terms of coroner's being able to conclude cause of death. This is still being seen today. The benefit of having a cause of death enables us to both categorise and support learning and is still limited at the moment,

we do have a strong SI process that goes through the STW Care Group. Weekly meetings are held with Anne MacLaughlan and the team to review new deaths and commence clinical review, staff support and other things.

9.4 Evidence driven by NCISH and NICE guidance advise traditional ways currently used to review and assess risk in mental health is no longer considered effective for determining suicide, suggesting only a 5% efficacy. Guidance advises risk assessment scales are replaced by risk formulation and safety planning however, does not provide details of risk formulation and psychosocial assessment for example.

9.5 Safety planning is being undertaken nationally however the report will not be available until at least March 2024, leaving a gap for mental health organisations supporting people who are at risk of suicide.

9.6 Learning from Deaths reports show a strong correlation between family feedback and the lessons learnt through SI reviews, which is positive.

9.7 When service users start to disengage from services, how to effectively re-engage with people; one suggestion was face to face appointments were prioritised.

9.8 Where different organisations are included in the patient's pathway, work was undertaken on how processes be strengthened for inpatients and in the community. Work performed with the substance misuse service to recognise gaps and cross boundaries, engaging families was key, especially following bereavement. Links are made with family liaison officers who can provide onward support once the patient leaves MPUFT services.

9.9 Rob Grant showed a document of 5 key workstreams for MPUFT which align strongly with the system plan:

- Skilled workforce – how to prepare people with the confidence to have suicide conversations with both families and service users.
- Risk formulation and safety planning – suicide focussed risk formulation, safety planning and engaging users and their carers in safety plans.
- Family and carer engagement - triangulation of care, understanding and overcoming barriers to confidentiality due to staff feeling uncomfortable sharing information in case it could breach confidentiality, post suicide support.
- Targeted input – supporting high risk groups, high risk times such as transitions in care e.g. onward referral.
- Monitoring – engaging with real-time surveillance, incident monitoring, review and learning from deaths.

9.10 Vanessa Whatley asked Rob Grant to share the document so that Sylvia Barnes can forward to Committee members.

Action: Rob Grant to send Sylvia Barnes the Key Workstreams document for forwarding to Committee members.

9.11 Suicide Prevention Conference will take place 21st February 2024, invites will be extended to partners across the system to engage as many people as possible, further information will be circulated in due course.

9.12 Meredith Vivian asked if the planned outreach work such as face to face meetings is feasible as it will be very resource intensive. Anne MacLaughlan answered this is about a change of mindset, as previously, staff felt they had to do a risk assessment, then document the risk assessment had been done rather than you must engage with the family to create a safety plan. This will involve a change of mindset for clinicians and fits in well with PSIRF and patient safety.

9.13 Community teams have commenced triangle of care audits on all wards. The benefits are involving carers and family in the care, where there is consent, knowing what we can update getting the message through.

9.14 Rob Grant added that during COVID 19 period, people got out of the habit of holding MDTs and delivered care individually for many reasons. This is bringing people back to the basics of if unsure, use MDT colleagues, this communication is key in

supporting people to understand risk and decide collectively the most effective response.

9.15 Meredith Vivian asked Rob Grant to attend a meeting in 6 months to assess progress.

The Committee:

- Noted the report content.

10.0 Minute No. QPC-23-09.128 – Patient Group Directives – Liz Walker

The report was taken as read.

10.1 Liz Walker advised the requirement for ICBs to authorise PGDs is likely to grow considerably with the responsibility for Pharmacy, Optometry and Dental Contracting. Pharmacy and Dental are often reliant on PGDs for delivery of patient care and/or enhanced services, hence the need for a robust process.

10.2 The number of PGDs that require ICB authorisation are accumulating, the volume could become quite problematic. This policy details how to authorise PGDs, but also what we expect from providers around how they are going to develop them, their sign off and responsibilities.

10.3 Meredith Vivian asked if this differs from Birmingham and Solihull's policy and is it compliant with NICE guidance. Liz Walker confirmed it is compliant with NICE guidance and only slightly differs from Birmingham and Solihull's version to reflect staffing and additional governance in our organisation.

10.4 Meredith Vivian asked that within the policy, Quality Committee is amended to Quality and Performance Committee.

10.5 Meredith Vivan confirmed this policy is approved by the committee.

The Committee:

- Approved the policy.

11.0 Minute No. QPC-23-09.129 Deep Dive - Mental Health & Learning Disabilities and Autism – Brett Toro-Pearce

11.1 Brett Toro-Pearce experienced IT issues and was unable to join the meeting. This report is to be moved to the October meeting.

12.0 Minute No. QPC-23-09.130 – Safeguarding – Paul Cooper

The reports and policies were noted.

12.1 Paul Cooper advised of very minor changes to the policies. There have been changes in governance structures, meaning even minor changes are now required to be tabled at committee meetings.

12.2 Due to the expansion in the individual commissioning team, following the successful business case, there is good dialogue between the new team and particularly the new case review team. A whole day event will take place in November where Paul Cooper is delivering training in adult safeguarding, adult supervision, call to protection and Mental Capacity Act for the whole team which will provide an opportunity to promote these policies.

12.3 Meredith Vivian asked if the annual report just concerned Shropshire. Paul Cooper confirmed the report is for both Shropshire Telford and Wrekin. The statement was provided by Ivan Powell, independent chair from Shropshire. In section two, the structure of the partnership gives an outline of the requirements and demands and the differences in the structures between Shropshire Telford and Wrekin.

12.4 Paul Cooper wished to highlight section three, which details green rating from NHSE regarding safeguarding commissioning assurance toolkit.

12.5 Safeguarding adults policy – No comments were received, approved.
12.6 Safeguarding supervision policy – Meredith Vivian advised this policy refers to the ICS and asked if it should be ICB. Paul Cooper discussed initial communications when the organisation was formed stating it would be called ICS, which subsequently shifted to ICB. Meredith Vivian advised that if this policy is for the ICS, all partners would need to be involved. Paul Cooper to amend policies to state ICB.

Action: Paul Cooper to amend all policies from ICS to ICB.

12.7 Safeguarding supervision policy – approved.
12.8 Safeguarding declaration – Meredith Vivian asked that Governing Body be amended to Board.

Action: Paul Cooper to amend Governing Body to Board within the safeguarding declaration.

12.9 Court of protection policy – No comments were received, approved.

The Committee:

- Approved the policies.

13.0 Minute No.QPC-23.09.131 Insight Report inc Experience of Care Update – Hayley Cavanagh

13.1 Hayley Cavanagh advised this report is a joint effort with Angie Porter and Nicky Blaney. Interrelations show themes that other teams in the ICB, such as medicine's management and PALS, are seeing.
13.2 The report is split into clinical voice, which is NHS to NHS (N2N) report and patient voice, the complaints panel.
13.3 The top themes have remained the same over the last two or three quarters. Issues around discharge, access and waiting times for services and medication issues. A number of the medication issues relate to medication on discharge, these are being pulled out to be looked at and addressed separately.
13.4 NHS 2 NHS concerns meeting held with SaTH, have medicines management attendance from both SaTH and ICB teams and primary care. Concerns are also fed into the Medicine's Safety Group and links with the Care Home Forum. Quality Team members are giving direct feedback on N2N concerns received from care homes.
13.5 Increase noted in NHS 2 NHS concerns being received from community pharmacy, due to medicine's management involvement. Practices are encouraged to contact SaTH directly as some of the issues are around communication.
13.6 Increase has been noted for N2N concerns around suboptimal care during quarter one, some very specific items such as the frequency of pessary changes, diabetic foot pathway and where there has been patient harm. These will feed through the SI and incident reporting process.
13.7 N2N reports have been received regarding the eyecare pathway, issues with treatment delays and the ophthalmology service, further details will be included in quarter two report once an after-action review has been undertaken. This will be an opportunity to learn and make improvements to the eye care pathway based on the N2N reports and two serious incidents that have come through to the quality team. This is a good example of how intelligence that comes through a number of routes is joined up.
13.8 Hayley Cavanagh advised similar themes are being seen in patient voice, such as access to GP, MSK and mental health services.
13.9 The Accessible Information Standard policy is included in the patient voice section for information.
13.10 Meredith Vivian asked are the high numbers of discharge issues because of the numbers of patients or due to an inherent weakness or floor. Vanessa Whatley advised SaTH are reviewing discharge issues as part of PSIRF with a large meeting being held today and a further one next week. The system has complex cases and multiple

partners involved in discharge; however this issue does require remedying as the outcome for patients is potentially harmful.

13.11 Anne MacLaughlan advised of discharge issues being reviewed as part of the acute mental health service national document. Early identification of the discharge date and getting everyone around the table for discharge planning reviews is key.

13.12 Meredith Vivian asked if the bottle-neck caused by poor flow in to and out of services is the issue. Anne MacLaughlan agreed and advised MPUFT have low bed bases the same as SaTH which causes a huge squeeze on the system. Each ward should be 85% but are usually at 110%. Kara Blackwell added that SaTH bed occupancy is above national recommendations for safe care. Everyone is so busy that things slip causing issues in relation to safety for discharge.

13.13 Mahadeva Ganesh thanked Hayley Cavanagh for a huge amount of work on the report and advised that junior doctors are pressurised by nursing staff to discharge patients. It would be nice to see in future reports what actions are being taken regarding the data and improvements that have been made.

13.14 Meredith Vivian asked Vanessa Whatley, Kara Blackwell and Anne MacLaughlan to provide information of what work is underway to address these specific recurring themes.

Action: Vanessa Whatley and Kara Blackwell to advise the committee what work is currently underway to address discharge issues.

13.15 Hayley Cavanagh confirmed that funding has been obtained for the next phase of Improving Experience of Care and wished to highlight the current progress aspect of the report and the co-production of at least two recommendations to go to System Quality Group.

The Committee:

- Noted the report content.

14.0 Minute No.QPC-23.09.132 Diabetes Quarterly Report – Fiona Smith

14.1 Vanessa Whatley noted that some of the metrics are not moving, risks have remained the same since it was developed and asked if any help needed. Fiona Smith advised primary care and their input into care processes requires work and there is currently no clinical support or lead from SaTH.

14.2 Rosi Edwards noted the system is the worst performing as detailed in the Diabetes UK report; of the nine care processes for type 1 diabetes, we are 12.6% against 23% for England.

14.3 When questioned regarding the amount of medical input from SaTH, Fiona Smith confirmed there was none. A clinical advisory group was set up and only SaTH podiatry are involved. Fiona Smith added that Nick White has had conversations with John Jones. Rosi Edwards advised she will follow up on this.

14.4 Fiona Smith advised a meeting is being held with directors and primary care clinical leads to discuss the issue that primary care do not feel low-risk foot screening is part of the GMS contract, discussions to unblock this will be held.

14.5 Mahadeva Ganesh commented that this is very preventable, and we are the outlier for the maximum number of amputations. We need to proactively engage primary care to deliver the service and the community to manage it.

14.6 Fiona Smith commented that non-urgent diabetic appointments are currently 12 months at SaTH. STW is the only system where primary care are advising it is not their responsibility to provide low-risk foot screening.

14.7 Fiona Smith raised concern that diabetes is a clinical priority within the system, but it does not feel like it is currently. This is recognised and resources are required to be put in place, financial and contractual arrangements are being reviewed to enable the system to move forward.

14.8 Meredith Vivian wished to note that GPs are concerned with patient safety and good treatment of their local populations and asked who is leading this work form the organisation. Fiona Smith was unsure.

Action: Meredith Vivian to discuss the anxiety of being an outlier regarding diabetes transformation with Simon Whitehouse and feedback to the next meeting.

14.9 Mahadeva Ganesh wished to add that Shropshire is an outlier regarding obesity in children aged 6 to 11 years as quite a few are going into maturity-onset diabetes, causing eye and feet issues.

The Committee:

- Noted the report content.

15.0 Minute No. QPC-23-09.133 Lucy Letby Learning and Update – Vanessa Whatley

15.1 Vanessa Whatley advised this is the first meeting since the Lucy Letby verdict, Board reports have already acknowledged the shock and horror of the crimes committed, and the families ordeal. As a committee she emphasised the need to reflect if we are doing everything that we can or is anything else needed going forward. What do we want to see in either performance or quality metrics to help us gain assurance that our organisations are appropriately allowing freedom to speak up and have the right culture. Organisational culture was at the root of the failure to act.

15.2 Rosi Edwards advised that we deal with vulnerable people who need to trust all staff, so partly it is freedom to speak up and people must feel their worries are going to be received well and constructively, staff and managers need to be made aware. Work is required with professional bodies to assist with the understanding of what needs to be done to protect them and their members, to inform that if concerns are received a quick response is required and that may mean suspension. Staff need to be informed they have not necessarily already been judged, just that quick action is required as a protective measure. It needs to be fair to staff and to people whose colleagues have concerns about but also protect patients.

15.3 Anne MacLaughlan added that when staff raised concerns, it is for the Board to reflect as people were not listened to, they were shut down and we cannot be complacent.

15.4 Meredith Vivian agreed with Anne MacLaughlan and advised an ICS Freedom to Speak Up Guardians Forum is being convened to work out how best to work together as a group of people to share ideas, issues, learning commonalities of trends and themes.

15.5 Vanessa Whatley advised it is about believing the unbelievable and what high level metrics or oversight are required.

15.6 Mahadeva Ganesh added this is a forgotten aspect of learning from deaths, the focus is mostly what went wrong with the process or clinically, what went wrong in the system or culturally is not discussed. We need to improve the culture of the organisation being transparent and as deemed in safeguarding terms, being curious. Learning from the Lucy Letby case is still unknown.

15.7 Meredith Vivian concluded that previous discussions regarding mortality rates and learning from deaths is part of the big picture and how we learn from the Lucy Letby case will form part of further discussions.

16.0 Minute No. QPC-23.09.134 Healthwatch – Brian Rapson

16.1 Brian Rapson advised diabetes and domestic care reports have been shared with the system for response. Once a response has been received, these will be published.

16.2 Enter and View visits are planned for Redwoods and some Shropdoc locations.

16.3 A visit was undertaken on SaTH acute medical floor and the report is due to be written shortly. Lynn Cawley has had discussions with Vanessa Whatley regarding how these reports are fed into the system. Vanessa Whatley confirmed the reports will be tabled

at System Quality Group for discussion with partners about actions and coordination of what action can be taken. Results of those discussions will then come to this Committee.

17.0 Minute No. QPC-23-09.135 – Evaluation of Meeting

17.1 Meredith Vivian encouraged members to feedback comments and/or observations they may have about the meeting or any improvements they wish to see. Please send comments to sylviabarnes@nhs.net

18.0 Minute No. QPC-23-09.136 – Items for Escalation/Referral to Other Board Committees

18.1 No items were identified for escalation or referral to other Board Committees.

19.0 Minute No. QPC-23-09.137 – Any Other Business

19.1 No additional items were raised.

Date and Time of Next Meeting

Thursday 26th October 2023 at 2.00pm to 4.00pm via Microsoft Teams.

SIGNED …… DATE ……

Agenda Item

ICB 29-11-132.3

Finance Committee minutes for meetings held on 11 August and 3 October 2023

NHS Shropshire, Telford, and Wrekin
ICB Finance Committee (Section 1) Meeting
Friday 11th August 2023 at 10.30am
Via Microsoft Teams

Present:

Name	Title
Trevor J McMillan (Chair)	Non-Executive Director NHS STW
Claire Skidmore	Chief Finance Officer NHS STW

Attendees:

Gareth Robinson	Directory of Delivery and Transformation NHS STW
Laura Clare	Deputy Director of Finance NHS STW
Cynthia Fearon	Corporate PA NHS STW (Note taker).

Apologies:

None

Minute No. SFC-23-07.001 – Introduction and Apologies

1.1 The Chair, **TMcM**, welcomed everyone to the meeting. **CF** confirmed that there were no apologies received.

Minute No. SFC-23-07.002 – Declarations of Interests

2.1 No declarations of interest were noted.

Minute No. SFC-23-07.003 – Minutes from the Previous Meeting held on: 26th June 2023

3.1 **TMcM** asked if there were any points to be raised about the minutes of the previous meeting. There being no amendments, the minutes were taken as a true and accurate record.

Minute No. SFC-23-07.004 Matters Arising and Action List from Previous Meetings

4.1 **TMcM** referred to the action list from the previous meeting:

Actions outlined on the action log, were reviewed, and updated accordingly.

Minute No. SFC-23-07.005 - ICB M3 Finance Overview

Report received as read.

LC highlighted that NHS STW ICB has a 23/24 deficit financial plan of £11.8m. This is part of an overall system deficit plan of £57.1m and within the context of a NHSE requirement to continue to strive for break even.

LC added that at M3 the ICB is reporting a £158k favorable position against the year-to-date plan. There is a £22k adverse variance in month. The full year forecast outturn remains in line with the full year plan at this stage. **LC** emphasized that the year-to-date variance is predominantly attributable to non-recurrent impacts.

LC explained that the net non-recurrent benefits from prior year are being partially offset with a non-recurrent overspend due to an assumption that we will not receive the anticipated Welsh elective recovery income in the plan. The forecast position currently assumes that this will be forthcoming. The System continues to pursue this with NHSE colleagues.

LC stated that in Month 3 we have also started to see the benefit of the implementation of the new allocations policy with some non-recurrent slippage on both allocations and cost pressures agreed in the plan now factored into the position.

LC highlighted that the year-to-date position does currently assume that we will receive the planned English elective recovery income. Current data available indicates that the system is below the planned position but is meeting the overall target. **LC** added In line with current guidance and until further data is available, it is assumed that income will be forthcoming. This assumption will be monitored closely as data is reviewed regularly. There has also been a recent announcement that ERF guidance will be amended due to the impact of Industrial Action in April. the team will work through the implications of this for the financial position.

LC stated that as part of the planning round a discussion took place with NHSE to highlight that due to different payment arrangements in Wales our system was losing out on the equivalent of £2.7m of Welsh ERF income. (£1m SATH, £1.7m RJAH). It was therefore agreed that the ICB would hold this income assumption in its plan and that NHSE would help in exploring this inequity of income.

The ICB is currently forecasting breakeven against the submitted plan but there remains significant financial risk, particularly around delivery of efficiency plans and delivery of the elective recovery plan.

LC highlighted that the ICB underlying plan submitted has a deficit of £26.9m. At M3 the forecast underlying position looks to be an improvement due to the £2.9m last minute planning adjustment from NHSE being treated as recurrent, plus the additional efficiency that has been identified in Individual Commissioning is treated as recurrent. **LC** added that this takes the ICB underlying forecast to a deficit of £21.9m. This position will continue to be carefully monitored. **LC** mentioned that the majority of year-to-date variances are non-recurrent in nature, relating to prior year benefits/hits, non-recurrent in year slippage on allocations or adverse variances on non-recurrent assumptions such as the Welsh ERF income. **LC** stated, as the year progresses, the underlying forecast as well as the in-year position will be closely monitored.

TMcM queried from the main report, the current situation regarding the People Team. **CS** explained that it remains a cost pressure due to lack of funding identified across the system. The forecast spend for the year is around £400k though around half of that amount has been offset through the use of income non-recurring allocations. **CS** added that the system CEOs continue to discuss the workforce plan delivery model.

The System Finance Committee noted the following:

- The M3 headlines for the ICB financial position (small favourable variance year-to-date (£158k) but with high risk around FOT delivery)
- The key drivers of the risk presented and actions to reduce or mitigate those risks.
- The level of unmitigated financial risk currently reported alongside the forecast position (£15.8m).

Minute No. SFC-23-07.006 - Efficiency Plan Update

Report tabled at the meeting.

GR highlighted from the report that the ICB efficiency plan was submitted as part of the final financial plan on 4th May with an overall savings target of £26m. **GR** added that the value represents the most challenging efficiency target the ICB has faced and equates to around 5% of the underlying non system expenditure.

GR highlighted that there have been significant efforts to date to identify schemes to meet the efficiency target and plans are now in place to deliver £21m of savings (81% of plan). Robust monitoring processes have been set up to track delivery and progress is reported through to the monthly Sustainability Working Group and onto the system Financial Improvement Group. **GR** emphasised**,** despite efforts to date, there remains £4.8m of unidentified savings plans which now urgently need to be addressed.

GR stated as at month 3, confidence in the delivery of 'identified' schemes has improved and the majority of plans are forecast to achieve with a high level of certainty. Programmes of work are on track and a positive variance of £600k is reported against plan, this is mainly due to the savings that have been reported within the individual commissioning programme of work however at this stage it is uncertain if the trajectory will continue at the same rate in the coming months.

GR highlighted that progress has been made in recent weeks to reduce the value of the unidentified gap from £8.026k to £4,833k this is recognised as a positive step forward however there is further work to do to bridge the remaining gap and this is an area of high risk until all plans are identified.

GR emphasised in order to urgently address the £4.8m unidentified gap, weekly 1-1 meetings have been taking place with senior leads within the Delivery and Transformation team to review spend across each budget line and to assess value for money, each department is being encouraged to reduce their spend by 5% where possible. In addition, the financial improvement programme group continue to source new opportunities though 'model hospital' and other benchmarking initiatives which help to identify areas of unwarranted variation.

GR stated that the NHSE Regional Finance team have stipulated that 90% of efficiency targets should be identified and 'in delivery' by the end of September. In order for this to be achieved there will need to be a combined effort across all teams to complete the actions required. The PMO team will support leads to progress with the pace and to help unblock risk.

GR added that weekly 1-1 meetings will continue to pursue all opportunities to further reduce the unidentified gap with progress tracked through to the Sustainability Working Group which is chaired by himself (Executive Director for Delivery and Transformation).

TMcM queried when we would see a significant change in closing the efficiency gap. **GR** responded that we should see a significant change in month four or five. **TMcM** also asked where do you look to next to find savings? **GR** responded that there were still some areas to work through though noted caution as there is likely to be little flexibility remaining that would not mean a service impact if funding were to be removed.

It was agreed that **GR** would provide an efficiency update for section one at the next scheduled meeting.

***Action: GR to** provide an efficiency update report for section one at the next scheduled System Finance Committee meeting.*

The System Finance Committee noted the following:

- Month 3 efficiency delivery and progress made since May 2023 towards bridging the gap in the unidentified savings plans.
- The actions that are in place to reduce the unidentified savings further and risk associated with the remaining gap.

Minute No. SFC-23-08.007 – Any Other Business

There was no other business for discussion under this agenda item.

Meeting closed at 11.12pm.

Date And Time of Next Meeting

Thursday 3rd October 2023, 2.00pm via Teams.

NHS Shropshire, Telford and Wrekin
Integrated Care System Finance Committee (Section 2) Meeting
Friday 11th August 2023 at 11.45
Via Microsoft Teams

Present:

Name:	**Title:**
Trevor J McMillan OBE (Chair)	Non-Executive Director NHS STW
Claire Skidmore	Chief Finance Officer NHS STW
Jonathan Gould	Deputy Director of Finance Shropshire Community Health NHS Trust
Craig MacBeth	Chief finance Officer - RJAH
Adam Winstanley (deputising for HT)	Deputy Director of Finance (Operational) – SATH
Peter Featherstone	Non-Executive Shropshire Community Health NHS Trust
Sarah Lloyd	Chief Finance Officer Shropshire Community Health NHS Trust
Chris Sands	Chief Finance Officer - MPFT

Attendees:

Gareth Robinson	Director of Delivery and Transformation NHS STW
Laura Clare	Deputy Chief Finance Officer NHS STW
Cynthia Fearon	Corporate PA NHS STW (Note Taker)

Apologies:

Sarfraz Nawaz	Non-Executive - RJAH
Mark Salisbury	Operational Director of Finance RJAH
Helen Troalen	Director of Finance Shrewsbury and Telford Hospitals NHS Trust

1.0 Minute No. SFC-23-07.001 Introductions and Apologies

1.1 The Chair, **TMcM,** welcomed everyone to the meeting and apologies were received as noted.

2.0 Minute No. SFC-23-07.002 Members' Declarations of Interests

2.1 No Declarations of Interest in addition to those already declared were noted.

3.0 Minute No. SFC-23.07.003 Minutes of the Previous Meeting held on: 27th June 2023.

3.1 **TMcM** asked if there were any points raised within the minutes of the previous meeting. There being no amendments, the minutes were taken as a true and accurate record.

4.0 Minute No. SFC-23.07.004 Matters Arising and Action List from Previous Meeting

4.1 The action list from the previous meeting was reviewed and updated accordingly.

5.0 Minute No. SFC-23.07.005 - ICS M3 Finance Overview

5.1 **Report received as read.**

CS highlighted that the report outlines the M3 position, but we are currently finalising the M4 position so if there are any pertinent highlights these will be raised as we discuss the report.

CS highlighted at M3 the STW system has a deficit of £33m and is reporting a £7.6m adverse variance to the plan submitted. The main area of overspend is in SATH and relates to ongoing staffing above funded levels, continued areas of open escalation space and associated enhanced care support as well as the impact of strike action. **CS** added that there are smaller overspends at both RJAH and SCHT and a small favourable variance to plan at the ICB, mostly due to prior year benefits. **CS** added that at Month 3 system agency expenditure is exceeding plan by £4.1m (£15.7m spend YTD v's £11.5m plan) and is exceeding the agency cap by £8.9m (cap is £6.8m YTD).

CS stated the system is reporting a forecast break-even position against the financial plan submitted but there is significant high risk to delivery and to the recovery trajectory to the end of the year. The main areas of risk are related to:

- Delivery of efficiency plans, particularly identifying plans to deliver the system stretch target submitted in the financial plan.
- Delivery of the elective recovery plan and achieving associated income built into the financial plan for both English and Welsh income.
- Risk of increasing system costs without a clear system operational and expenditure plan associated with hospital discharge.

CS stated that for all organisations the plan gets harder to deliver later into the year due to efficiency phasing and assumptions around efficiency closure.

CS stated that for the ICB there is a focus on CHC and prescribing as risk is increasing in these areas. Discussions are progressing on Welsh ERF income with the national NHSE team, and this will be reported at committee as the conversation develops.

CS invited provider organisations to update on individual positions.

SL stated that SHROP COM have got a small adverse variance at month three. The key driver is the position on agency spend. Reducing agency spend will have an impact on SATH escalation capacity and flow. **SL** added that before taking action to reduce SHROP COM's agency spend we also have to consider the broader system position and the impact it will have within the system. **SL** stated that SHROP COM will also be off plan for month 4.

SL highlighted that SHROP COM anticipates that there will also be pressures from their elective activity plan, due to challenges around the phasing of the plan and delivering the step up in the plan in M4 onwards.

AW stated one of the big concerns for SATH is regarding escalation. The risk increases moving from month 3 to month 4 (there is a lot more escalation in month 4) and there was a reduction to SATH's plan due to efficiency phasing. **AW** added that SATH are currently using a lot of agency staff to cover both medics and nursing, due to the number of vacancies. However, SATH have undertaken a recruitment drive and will be filling a number of those roles on a permanent basis. Which will help to reduce the agency cost significantly in the upcoming months. The use of of framework agency has improved in recent months and now only really exists within paediatrics. There are issues around use of agency for junior doctors, trying to recruit substantively wherever possible.

AW mentioned that the system stretch efficiency for SATH all sits in M12 and has not yet been fully identified which presents a significant risk**.**

CM stated that the RJAH plan signed up to was far more stretching than anybody would like as there are no contingencies in place which is not ideal. RJAH currently have issues regarding workforce and vacancies which remains a huge challenge. RJAH are hoping to recruit internationally particularly for nurses. Also, some substantive new starters (staff in theatres) have to undertake competence training, so their roles are still being covered or supported by agency staff until they complete their competency training. This is all impacting on RJAH's spend. Also, the impact of the industrial action from junior doctors over recent months has impacted significantly on RJAH's elective activity delivery. Some mitigation has been received on English ERF income but there is no mitigation for Welsh income.

CS stated that the level of financial risk for the system is currently double the planned deficit.

PF asked if recruitment is taking us above budgeted establishment and is there a report that goes anywhere that reports on establishment versus actuals? Does this go to the workforce committee so that can see the drivers of any variance?

CM stated every organisation has their own way of reporting this information, in RJAH there is a tolerance of recruiting over establishment where there are training lead times, sickness/absence etc. In the long term it reduces agency costs.

PF suggested this needs to be done across all organisations. CS stated that these reports should exist in the workforce arena so we can have a look to see what we can pull from there for inclusion in our reports.

GR responded to **SL** earlier comment on decision making on rapid response. This is a really valid point. When we make decisions about beds, we fully understand the cost implications. On the virtual ward side, we have made decisions not to incur premium agency cost. For rapid response there is an assumption that this is based on redistributing existing staff and it is not clear that there is agency being used. Need to make sure this is clear for operational decision making.

PF asked if we are making the most of the funding being deployed for virtual wards?

GR stated that SATH and Shrop Com have done a great job in getting virtual wards up and running but now need to work on this system collaborative work together. IDC are overseeing delivery and ensuring that we are maximising the benefit of funding being deployed (eg. virtual wards)

Action: GR to bring an update to the next meeting on IDC overseeing delivery of use of the virtual wards and the funding being deployed. Will ask for SATH/SCHT colleagues to join for the presentation.

CS stated that she had received a very detailed letter from Nicola Hollins - NHSE regarding 2023/24 Financial Performance, Controls and Governance**. The letter has very clear expectations on plans and evidence around controls and governance. CS** explained that she will need to formally respond by letter to Nicola by the 25th August 2023, to explain:

- The governance structure and TOR for financial recovery in our system.
- A response to cover granular detail of financial controls in place and an outline of approach, methodology and evidence of impact for a number of control items.

CS stated system colleagues are already working on self-assessments based on the controls in the original planning letter but this letter gives a lot more areas that need to be looked at. A regular report on controls will need to be brought to this meeting.

TM stated that the letter does outline an extensive exercise. The role of this committee is to get assurance on how the ICB is overseeing the entire system but also what is happening in individual providers without impinging on autonomy.

Action: CS to formally respond to Nicola Hollins letter by the: 25th August 2023 and to also share letter with System Finance Committee.

System Finance Committee:

- To note the M3 headlines for the system financial position (£7.6m YTD overspend against plan and assumption that FOT will deliver to plan)
- To note the key drivers of the risk presented and actions to reduce or mitigate those risks.
- To note the level of unmitigated financial risk currently reported alongside the forecast position (£56.6m).

6.0 Minute No. SFC-23-07.006 ICS Financial Risk Update

Report received as read.

6.1 **CS** stated that the system Board Assurance Framework (BAF) is currently under development and is being reviewed by the Good Governance Institute. Once agreed, a copy of the system BAF and particularly the finance related risks will be presented to the System Finance Committee. **CS** emphasised that these risks will be high level and will be underpinned with a system operational finance risk register.

CS highlighted that the current draft of the system operational finance risk register was circulated with papers for this meeting for review and comment from the finance committee members so that it can be refined and presented in line with the new BAF, once completed.

CS stated that the operational risk register shows high level overarching financial risks and action plans and includes detail of the quantified financial risks reported on a monthly basis.

CS highlighted that there are three core risks flagged which are:

- Risk to delivering the 23/24 financial plan
- Risk to delivering a long-term financial recovery trajectory to break even
- Risk around capacity and skills within the system finance team community

PF noted that the first risk is more of an issue than a risk as its now certain that we won't meet the financial plan for 23/24. There is far more that we can do with risk 2 around the longer-term plan and would like to see more on that.

CS stated that while we are reporting that we will deliver the financial plan but with significant risk then risk 1 is still a risk. When we enact the FOT change protocol then this will change the narrative on risk 1.

CS also agreed that we should show how we are reducing the risk on the longer-term plan with the work that we are doing.

PF asked at what point the committee would need to review the FOT change protocol. CS stated that at the moment we only have the 22/23 protocol, a new one is being worked up by NHSE but we expect it to be very similar.

Action: CS and LC to review the protocol and bring an update on the process to next month's finance committee.

The System Finance Committee:

- To note the draft operational finance risk register
- Comment on the content of the risk register so that amendments can be included before it is used as the underpinning document to the new system BAF.

7.0 Minute No. SFC-23.07.007 ICS Medium Term Planning Update

Report received as read.

7.1 **LC** highlighted that at the May finance committee there was a paper presented on a 'do nothing' scenario which gave some kind of insight into the level of deficit we would see if nothing happened. This gave the PMO figures to work with in terms of a high-level target.

In order to have a proper financial recovery plan it needed to be built from bottom up, starting with a demand and capacity model, building in interventions and the finances would be the results of that work.

Over the last couple of months there have been many discussions with NHSE, and the system has sought to engage an external consultancy firm to build up a detailed demand and capacity and resulting medium term financial plan. Outputs are expected by November which should inform the operational planning round for 24/25.

In the meantime, we have agreed that we will provide a 'top down' view to the NHSE regional team, this will be a very financial driven exercise with high level assumptions. There is an expectation from NHSE that break even should be achieved by the end of 2026/27. We need to be clear whether this trajectory is deliverable for our system or when we can deliver break even.

LC mentioned that all organisations are working with Jill Price to work up the system bridge and NHSE slide pack, which is being reviewed at SFG and Deputies weekly meetings. Final submission of the bridge and slide pack will be submitted to NHSE towards the end of September to early October 2023, which will need to be supported at individual finance committees but also at System Finance Committee. It is important to recognise that this is a system level return, and we will not be asking finance committees to agree to a financial plan value.

CS highlighted that the work is not a formal return and is merely an indication to NHSE that finance committees support the work that has been done. It will also be taken to a private session of the Board to ensure Board are aware.

The System Finance Committee:

- To note the current process in place to deliver a system wide demand and capacity model and subsequent finance and workforce plans and the need for a detailed system planning timetable.
- To note in the meantime the ask from NHSE for a high level 'top down' medium term financial plan submission and the August and September deadlines.
- To note and help to accommodate the potential need for a September extraordinary meeting to sign off submission of the planning slide pack to NHSE.

8.0 Minute No. SFC-23.07.008 Efficiency Plan Update

Paper tabled at meeting.

8.1 **GR** stated the efficiency plan was submitted as part of the final financial plan on 4th May 2023 and has an overall target of £70m. This value represents the largest and most challenging efficiency target the system has faced and equates to 6.7% of the underlying expenditure.

GR mentioned that there has been significant effort from across the system to date to identify schemes to meet the target and plans are in place to deliver savings of £63m (86% of plan). **GR** added that robust monitoring processes have been set up to track delivery which will be reported through organisations own governance mechanisms and onto system Financial Improvement Programme (FIP) Group. **GR** mentioned that despite the work to date, there remains £10m of plans that are yet to be identified and this presents a high level of risk to the systems finance position.

GR highlighted that at month 3, confidence in the delivery of 'identified' schemes has improved and the majority of plans are forecast to achieve with a high level of certainty. However, year to date there is an adverse variance to plan of £187k which is mainly due to the shortfall of expected savings within SaTH and the de-escalation of beds. Mitigations are in place to address this, and action plans are being agreed within the UEC Delivery board.

GR emphasised to urgently address the £10m unidentified gap, weekly 1-1 meetings have been taking place across departments to review spend and assess value for money, each department is being encouraged to reduce their spend by 5% where possible and this has resulted in a further £2.1m of potential savings which will start to be added into the forecast position from next month.

GR stated that the Financial Improvement Programme group continue to push forward with the opportunities that are in the pipeline and following up actions with designated SRO's. FIP will also continue to source new opportunities though 'model hospital' and other benchmarking initiatives which help to identify areas of unwarranted variation in our system.

GR highlighted that NHSE Regional Finance teams have stipulated that 90% of efficiency targets should be identified and 'in delivery' by the end of September, in order for this to be achieved there will need to be a combined effort across all teams to complete the actions required with SRO's leading on the delivery. The PMO team will continue to support leads to progress with the pace and to help unblock risk where possible.

GR stated that alongside monitoring this year's delivery, PMO are working towards developing a set of pipeline efficiency plans which will form part of the Medium-Term Financial Plan.

CM noted the % of recurrent savings forecast and that we need to keep an eye on that figure at the committee as that is most important. **CS** requested that there is further information included in future reports to show the recurrent versus the recurrent plan and the non-recurrent versus the non recurrent plan

GR updated that there is a lot of work underway on identifying the system stretch schemes in each individual organisation. Work is also underway to identify schemes for 24/25 and beyond as part of the medium-term financial plan development.

Action GR to ask that Kate Owen includes recurrent/non recurrent in next month's report.

The System Finance Committee:

- To note Month 3 efficiency delivery and progress made since May 2023 towards bridging the gap in the unidentified savings plans.

- To note the actions that are in place to reduce the unidentified savings further and risk associated with the remaining gap.

9.0 Minute No. SFC-23.06.009 Any Other Business

9.1 There were not items for discussion.

TMcM stated that there are clearly challenges ahead and joint working will be critical. **TMcM** thanked everyone for their contributions.

Date and Time of Next Meeting

Tuesday 3rd October 2023, 3.15pm via teams via Teams.

NHS Shropshire, Telford, and Wrekin
ICB Finance Committee (Section 1) Meeting
Tuesday 3rd October 2023 at 2.00pm
Via Microsoft Teams

Present:

Name	**Title**
Claire Skidmore (Deputising for TMcM)	Chief Finance Officer NHS STW
Laura Clare (Deputising for CS)	Deputy Director of Finance NHS STW

Attendees:

Gareth Robinson	Directory of Delivery and Transformation NHS STW
Angus Hughes	Associate Director of Finance – Decision Support
Cynthia Fearon	Corporate PA NHS STW (Note taker).

Apologies:

Trevor McMillan	Non-Executive NHS STW
David Bennett	Non-Executive NHS STW

Minute No. SFC-23-09.001 – Introduction and Apologies

1.1 The Chair, **CS**, welcomed everyone to the meeting. **CS** stated apologies as noted for the meeting,

Minute No. SFC-23-09.002 – Declarations of Interests

2.1 No declarations of interest were noted.

Minute No. SFC-23-09.003 – Minutes from the Previous Meeting held on: 11th August 2023

3.1 **CS** asked if there were any points to be raised about the minutes of the previous meeting. There being no amendments, the minutes were taken as a true and accurate record.

Minute No. SFC-23-09.004 Matters Arising and Action List from Previous Meetings

4.1 **CS** referred to the action list from the previous meeting:

Actions outlined on the action log, were reviewed, and updated accordingly.

5.0 Minute No. SFC-23-09.005 - ICB M5 Finance Overview

Report received as read.

5.1 LC explained that at month 5, the ICB are reporting a £10.5m deficit which is a £3.8m adverse position against the year-to-date to the plan. The full year forecast outturn reported remains in line with the full year plan but with significant risk highlighted. **LC** added that this is being discussed as a system and with NHSE.

At month 5 **LC** explained that the ICB deteriorated considerably from month 4, specifically in the areas of prescribing and CHC. The issues around both these areas have been seen specifically around the region and nationally. Which relates to predominantly price increases.

In month 3 **LC** stated, (that is the latest data we have for prescribing data), there has been an overall 18% increase in spend compared to the same period in the previous year.

Regarding the Efficiency programme, **LC** highlighted that the ICB position is currently £400k below plan year-to-date. The unidentified stretch target is phased into the plan from Month 5 onwards which makes the programme more challenging in future months.

LC added that there is currently unmitigated risk of £23.8 million at month 5. If that amount is added to the forecast, it would give a total deficit to plan of £35.6 million by the end of the year. **LC** stated the detail behind the forecast is within this report and the accompanying appendixes.

LC mentioned that Simon Whitehouse called an urgent meeting, regarding month 5 figures, with all senior leads within the ICB. This was to review the key drivers of spend beyond the plan and agree mitigating actions that will be taken to improve the forecast. **LC** added, the key things that are being looked at by the ICB are:

- CHC
- Prescribing
- Discharge expenditure – conversations are ongoing with LAs. We are awaiting the outcome of a funding bid lodged with the Department of Health and Social Care.
- Efficiency programme - there are currently a number of actions to address the balance of unidentified schemes which are being monitored by the Sustainability Working Group and the weekly Delivery and Transformation meetings.
- Elective Recovery – a lot of work is happening across the system to finalise a view on where we think we are at with elective recovery. This is both in terms of operational conversations about the potential waiting list at the end of the year as well as financial conversations about the maximisation and distribution of elective recovery fund income.

The System Finance Committee:

- Noted the M5 headlines for the ICB financial position (£10.5m YTD deficit, £3.8m adverse position to plan, forecasting delivery of plan but with significant risk)
- Noted the key drivers of the risk presented and actions to reduce or mitigate those risks.
- Noted the level of unmitigated financial risk currently reported alongside the forecast position (£23.8m).
- Noted that if the current unmitigated risk was added to the reported FOT this would give a position of a £35.6m deficit for the ICB for the year.

Minute No. SFC-23-09.006 - Corporate credit card paper

Report received as read.

AH stated that NHS STW ICB has entered into a new agreement for the use of corporate credit cards to cover low value expenditure items incurred within the organisation. Annual spend is estimated at c.£20k. These cards will replace the existing use of Allpay prepaid cards owing to the limitations of where these cards can be used – principally hotels and marketing expenditure.

AH mentioned that the typical expenditure which will be charged to these cards relates to travel, hotels, training, marketing, and communications. **AH** added that a direct award has been made to a framework provider – NatWest.

AH emphasized that all appropriate controls are in place for budget holder sign off etc.

The System Finance Committee:

- Approved the new Corporate Card provider and associated policy for use within NHS STW ICB.

Minute No. SFC-23-09.007 - ICB Medium Term Finance Plan

Report received as read.

LC stated that PA Consulting are now engaged in the system and working to develop a robust demand and capacity model that links to workforce and finances. **LC** added that the work is scheduled over a 10 – 12-week period.

LC highlighted that in parallel with the demand and capacity work, system DOFs and deputies are working with Nikki Greenwood from NHSE Intensive Support team to develop a system financial strategy document so that the narrative around financial recovery sits alongside the financial modelling.

After mentioning at the last SFC that the NHSE regional finance team had requested the submission of a slide pack outlining a first draft of the medium-term financial recovery plan and associated information this report is now presented to this meeting for consideration. **LC** stated that the report has gone to all provider organisations for review in their respective Finance Committees. **LC** emphasized that this report is not for formal sign off from this committee or from the provider organisation's respective committees. It is to provide early sight of the work required for planning over coming months. **LC** stated that the report had been submitted to NHSE, noting that it had not been considered by the System Finance Committee at that time and flagged that work continues on numbers for future years which will be woven into the modelling being developed by PA consulting.

CS stated that we need to find a balance locally of what can be delivered operationally but also to bring the finances back to balance. She noted that she had spoken to Trevor McMillan about this, and he is really keen to start to have conversation about what that means for the ICB.

LC mentioned the transformation work that Kate Owen is involved in, which outlines scale of opportunities in various areas. **GR** stated that he has a planned face to face session with his team to walk through this piece of work.

CS mentioned that PA Consulting has been invited to an ICB Senior Leadership Team meeting to give an update on the finance model and the interventions.

***Action: LC** to share this Finance Committee report at next week's SLT as part of the documents for that meeting. To give a background to the work PA Consulting is currently undertaking.*

CS flagged that there was an error on the governance structure slide, that **LC** shared as part of this report. The investment panel should be shown as reporting into the IDC not SFC.

***Action: LC** to amend the governance page of the report.*

CS suggested that PA should present their work to the System Finance Committee (section 2), when it is completed.

***Action: CF** to invite PA Consulting to present the outcome of their modelling work to a future section 2 meeting*

The System Finance Committee:

- Noted the current process in place to deliver a system wide demand and capacity model and subsequent finance and workforce plans.
- Noted in the meantime the ask from NHSE for a high level 'top down' medium term financial plan submission and the submission that had been drafted.
- Noted the work ongoing to develop the high-level model with further years to inform a trajectory to break even.
- Noted that the medium-term financial plan will be constantly updated based on the outputs from PA Consulting modelling and the detailed development of the 24/25 operational plan.
- Noted that in parallel a system financial strategy narrative document is being produced to sit alongside the financial model and will be presented to finance committee at a future meeting.

Minute No. SFC-23-09.008 – Efficiency Update

Report received as read.

The ICB's efficiency plan was submitted as part of the financial plan on 4th May and had a plan to deliver £26m of savings during 2023/24. **GR** explained that the target included an original 'unidentified' value stretch target of £4.1 million for the ICB.

GR highlighted that there is a residual risk of between £1.7m to £2.1m for which valid opportunities have yet to be found. Further work needs to be done within the delivery and transformation team to address this.

CS stated from SFC point of view we need to see a potential pipeline of what the team might be able to transact.

CS suggested that GR should look at some of the drivers of current overspend, for example, CHC. There may be potential opportunities that could generate cost improvements that we may want to consider. i.e., fast tracks.

The System Finance Committee:

- Noted Month 5 efficiency delivery and progress made towards bridging the gap in the unidentified savings plans.
- Noted the actions that are in place to reduce the unidentified savings further and risk associated with the remaining gap.

Minute No. SFC-23-09.009 – Any Other Business

There was no other business for discussion under this agenda item.

Meeting closed at 14.47pm.

Date And Time of Next Meeting

Thursday 26th October 2023, 2.00pm via Teams.

NHS Shropshire, Telford and Wrekin
Integrated Care System Finance Committee (Section 2) Meeting
Tuesday 3rd October 2023 at 2.00pm
Via Microsoft Teams

Present:

Name:	**Title:**
Claire Skidmore (Deputising for TMcM)	Chief Finance Officer NHS STW
Laura Clare (Deputising for CS)	Deputy Chief Finance Officer NHS STW
Jonathan Gould	Deputy Director of Finance Shropshire Community Health NHS Trust
Peter Featherstone	Non-Executive Shropshire Community Health NHS Trust
Helen Troalen	Director of Finance Shrewsbury and Telford Hospitals NHS Trust
Mark Salisbury	Operational Director of Finance - RJAH

Attendees:

Kate Owen	Head of PMO – NHS STW
Cynthia Fearon	Corporate PA NHS STW (Note Taker)

Apologies:

Trevor J McMillan OBE (Chair)	Non-Executive Director NHS STW
Chris Sands	Chief Finance Officer - MPFT
David Bennett	Non-Executive NHS STW
Sarah Lloyd	Chief Finance Officer Shropshire Community Health NHS Trust
Gareth Robinson	Director of Delivery and Transformation NHS STW
Craig MacBeth	Chief finance Officer - RJAH

1.0 Minute No. SFC-23-09.001 Introductions and Apologies

1.1 The Chair, **CS,** welcomed everyone to the meeting and apologies were received as noted.

2.0 Minute No. SFC-23-09.002 Members' Declarations of Interests

2.1 No Declarations of Interest in addition to those already declared were noted.

3.0 Minute No. SFC-23.09.003 Minutes of the Previous Meeting held on: 11th August 2023.

3.1 **CS** asked if there were any points raised within the minutes of the previous meeting. There being no amendments, the minutes were taken as a true and accurate record.

4.0 Minute No. SFC-23.09.004 Matters Arising and Action List from Previous Meeting

4.1 The action list from the previous meeting was reviewed and updated accordingly.

5.0 Minute No. SFC-23.09.005 - ICS M5 Finance Overview

5.1 **Report received as read.**

LC highlighted, that at M5 the STW system is reporting a £23.1m adverse variance to the plan submitted (£59.2m deficit against a £36.1m deficit plan). The SATH overspend continues in line

with previous months in a number of areas of expenditure and in Month 5 there is also a deterioration in the ICB position due to overspends in both prescribing and CHC.

LC stated all organisations are forecasting delivery of plan with significant unmitigated risks. At month 5 that stands at £81.8 million.

LC stated agency expenditure is exceeding the plan by £7.9 million, over the agency cap of £13.9 million. **LC** added **that** all organisations are working through updating risk values and developing phased mitigation plans for the year to discuss and agree a realistic forecast position with NHSE through the FOT change protocol.

LC mentioned that there was a significant meeting last week withs CEO, CFOs and DoFs to review organisations figures. Weekly updates will continue and will be reported back to CEOs and NHSE. **CS** explained that Rob Cooper from NHSE is leading on this piece of work.

System Finance Committee:

- Note the M5 headlines for the system financial position (£59.2m YTD deficit, £23.1m adverse to YTD plan).
- Risk of £81.8m.
- **Note** that all organisations are working hard to develop phased mitigation plans to mitigate as much of the current risk as possible and agree a forecast position with NHSE.

6.0 Minute No. SFC-23-09 .006 ICS Efficiency Update

Report received as read.

6.1 **KO** highlighted that the system efficiency plan was submitted as part of the financial plan on 4th May and has an overall target of £70m. Additional stretch which totalled £15m in May 2023.

KO stated further details of figures and narrative is included iin the report, circulated for this meeting.

KO explained that, we are currently reporting an adverse variance to plan of just over £4 million. Most of the underperformance is due to SATH around the escalation costs.

KO stated that the plan is now split between re-current and non-recurrent. **KO** added the biggest risk at the moment is the overall unidentified stretched target, which currently £8.1 million pounds.

The System Finance Committee:

Note Month 5 efficiency delivery and progress made since May 2023 towards bridging the gap in the unidentified savings plans.
Note The actions that are in place to reduce the unidentified savings further and risk associated with the remaining gap.

7.0 Minute No. SFC-23.09.007 ICS FOT Change Protocol

Report received as read.

7.1 **LC e**xplained that given the level of risk and lack of assurance that the plan can now be delivered, it is highly likely that the system will need to enact the FOT change protocol with NHSE.

LC stated in the absence of a 23/24 FOT change protocol being issued by NHSE, the system is working through the documentation published in November 2022 and has opened discussions with the NHSE regional team. **LC** added that the system will therefore follow the guidance in this document but with the caveat that this is currently subject to review and potential re-issue by NHSE.

LC highlighted that STW has recently provided a detailed response to the NHSE regional team regarding the system self-assessment against additional controls outlined in both the planning letter and recent correspondence regarding financial governance and control. Copies of letters have been circulated in the pack for this meeting.

Regular meetings have taken place with Nicola Hollins CS and **HT** regarding forecast for SATH.

LC emphasised that work continues to ensure that every effort has been taken to mitigate risk and that collectively the system has a forecast that is the best position that it can get to in 23/24. This position will show a phased mitigation plan to year end with clear leads/timescales that will be carefully monitored. The system will only enact the FOT change protocol and submit a formal application to NHSE once it is clear that every possible route of mitigation has been explored and implemented.

CS stated that everything that we are doing is in line with the protocol. Nicola Hollins mentioned to **CS** that she does not expect any material changes to what has been issued for the protocol.

HT stated that if a NED was present at this meeting, she would be expecting them to be pushing us for a timescale around this. **HT** raised concerns that it manifests through SATHs numbers, but it is System piece to land the bed model and income forecasting. **CS** responded that she doesn't think that we are at a point where we are ready for that now.

HT stated that she has concerns regarding the bed model of the availability of out of hospital capacity, with the local authority, this effects SATH's bottom line. **CS** stated that is part of the actions that has come out of the CEO meetings**. CS** added that Rob Cooper is picking up actions with provider organisations.

The System Finance Committee:

- Note the FOT change protocol issued by NHSE in 22/23 and that this is subject to review and potential re-issue from NHSE.
- Note that given the level of financial risk highlighted in delivery of the plan it is now highly likely that the FOT change protocol will need to be enacted.
- Note the steps involved and work being done across the system to develop an in year financial recovery plan.
- Note that updates will be brought to the finance committee as the financial recovery plan development and NHSE discussions progress.

8.0 Minute No. SFC-23.0.008 - ICS Medium Term Planning Update

Report received as read.

81 **LC** highlighted that a full financial recovery for STW will be a multi-year programme to which we need to turn our focus urgently. **LC** stated, at the System finance committee meeting in August a briefing paper was presented that outlined the work to be done on updating a system medium term financial plan.

LC highlighted, that It was agreed that the work on finance will be most robust when set alongside similar trajectories for activity and workforce. Therefore, PA consultancy group have been engaged by the system to develop a robust demand and capacity model that links to workforce and finances and pulls in the Hospital Transformation Programme (HTP) modelling alongside the Local Care Programme.

LC stated, that this work is now underway and being completed over a 10 –12-week period, support has also been secured from the national NHSE demand and capacity team to provide technical expertise and oversight.

LC explained that the plan has been developed using a number of high-level assumptions that match up with current HTP modelling work. All assumptions are being reviewed constantly in line with the most up to date information available, benchmarking and NHSE guidance.

LC highlighted risk around 23/24 plan delivery is currently built into the scenarios in the model based on the Month 4 position reporting. Significant work is currently underway with all system partners to review all 23/24 mitigation plans to develop a robust and realistic forecast outturn position for 23/24 for discussion and agreement with NHSE.

LC stated, that the template and slide pack to be submitted demonstrates that if the system delivered its financial plan this year and then delivered a 2.2% a year BAU efficiency, the system would still have a £165.4m deficit by the end of year 3. This is in comparison to a NHSE expectation of break even in that timeframe. **LC** added, that they have agreed with NHSE, that we would submit this last week, subject for it to go to System Finance Section Two today. But will work collectively on future years, to show a more realistic efficiency trajectory for each financial year. Hopefully, the work with PA consulting will give some of those answers.

CS stated that we need to start work on getting things done on a realistic trajectory. i.e. what is realistic and what is deliverable.

PF stated that the figures are huge and asked how are we comparing to other ICBs. **CS** responded that the data set that she has seen, Year-to-date at month 5 we are the worse in the country for deficit when compared to allocations**.** We all so have challenges with the acute services. **CS**, added all ICBs across the country are challenge but in different ways. **HT, stated the way** are services are set up within this area may drive at more costs in comparison to other areas. **HT** added that she is not sure whether we are funded enough in this area.

PF queried; how do we get better funding for Shropshire. **CS** explained that the funding allocations is nationally driven. **CS** stated we are due a refresh of that, in a couple of years' time. We are keeping close to Hereford and Worcester ICB as they experience similar challenges with their services within the rural areas. **CS** added, we need to make the case for funding when it's appropriate and also address productivity and efficiency that can be managed internally.

CS stated that ICS Medium Term Plan went to all partner organisation committees. Overall, Partners organisations said the Medium-Term Plan was received well and have expressed that they would like to be kept up to date of next steps and sign off.

CS stated when she spoke to Trevor, he said he would like to have regular updates on the Mid-term Review to this committee - meeting. If not monthly, Bi-monthly.

Action Regular updates to be provided to this committee, monthly or Bi-monthly,

The System Finance Committee:

- Note the current process in place to deliver a system wide demand and capacity model and subsequent finance and workforce plans.
- Note in the meantime the ask from NHSE for a high level 'top down' medium term financial plan submission and see attached the proposed September submission.
- Note the work ongoing to develop the high-level model with further years to inform a trajectory to break-even.

9.0 Minute No. SFC-23.09.009 Any Other Business

9.1 **LC** mentioned that there is a regional deputy ICB group, that look at a number of areas of topics. They were nominated by John Bailey of NHSE to present to the regional group and particular that SATH look at their underlying position. **LC** stated **that they got some really good feedback to what they presented and Were commended on the processes they currently have in place.**

Date and Time of Next Meeting

Tuesday 26th October 2023, 3.15pm via teams via Teams.

Agenda Item

ICB 29-11-132.5

Strategy Committee minutes for meetings held on 11 October 2023

NHS Shropshire Telford and Wrekin
Strategy Committee

Wednesday 11 October 2023 at 2pm.
Via Microsoft Teams

Present:	
Cathy Purt	Chair and Non-Executive Director, Shropshire Community Health NHS Trust
Mark Large	Non-Executive Director, Midlands Partnership NHS Foundation Trust Partnership Foundation Trust
Nigel Lee	Interim Director of Strategy and Partnerships Shrewsbury and Telford Hospital NHS Trust
Liz Noakes	Director Health & Wellbeing Telford & Wrekin Council
Nia Jones	Deputising for Craig MacBeth, Finance Director Robert Jones Agnes Hunt Orthopaedic Hospital NHS Foundation Trust
Nick White	ICB Chief Medical Officer

In Attendance:	
Edna Boampong	ICB Director of Communications and Engagement
Gemma Smith	ICB Director of Strategic Commissioning
Ben Rogers	Director of Psychological Services, MPFT
Masood Ahmed	ICB Deputy Chief Medical Officer
Jonathan Gould	Deputising for Sara Lloyd Director of Finance Shropshire Community Health Trust
Colin Anderson	Deputising for Steve Grange MPFT
Angus McGregor	Consultant Shrewsbury and Telford Hospital NHS Trust
Sally-Anne Smith	Corporate PA and Minute taker

Minute No. SC-11.10.064 Introduction and Apologies:

64.1 The Chair opened the meeting of the STW Strategy Committee and welcomed everyone. It was noted that agenda item Digital Strategy would precede the other agenda items as Dr Masood Ahmed would need to leave to attend another meeting.

The following apologies were noted:

Prof. Paul Kingston	Non-Executive Director, Robert Jones Agnes Hunt Orthopaedic Hospital NHS Foundation Trust
Sarah Lloyd	Director of Finance Shropshire Community Health Trust
Julie Garside	ICB Director for Planning and Performance
Claire Skidmore	ICB Director of Finance
David Brown	Non-Executive Director, Shrewsbury and Telford Hospital NHS Trust

Minute No. SC-11.10.065 Digital Strategy:

65.1 Cathy Purt commented that Dr Masood Ahmed had been asked to present the Digital Strategy at the last ICB Board Meeting and invited him to speak, the following was noted:

65.2 Dr Masood Ahmed explained that this is a public facing document which would provide an overview to our population regarding what our intentions are. He explained that underpinning the Digital Strategy is a significant amount of work, that will create the Road map.

65.3 Masood Ahmed told the committee that in order to action and provide oversight of the Road Map he had met with Nigel Lee Chair of the Digital Delivery Group, and as part of the work of that group they would review the procurement strategy and timelines of some of the major investments, a costed plan and be very clear about various projects within our digital portfolio.

65.4 Masood Ahmed noted that the other key discussion at the ICB Board Meeting was about developing an operating model where we have a strategic and supportive group of digital capabilities at an ICB level. He explained that a Chief Digital Information Officer would represent Digital at a Board level. This also included a Programme Director role, to pull together all the various work streams and make sense of those and the interdependencies.

65.5 Masood Ahmed noted from a Digital Clinical Leadership perspective, while previously we had a CIO for the System, they were looking to appoint a CCIO and then a CNIO, CAHPIO ANCD CPIO as part time clinical leadership roles.He noted that from a pharmacy perspective, as we look to deliver our Digital Strategy, we are going to need support from Digital and Clinical Leaders across the board from different backgrounds.

65.6 Nigel Lee confirmed that he would be Chairing the Digital Delivery Group on behalf of Louise Barnett, who was already chairing the UEC Board. Nigel Lee said that he was also carrying out a part time role working with ICB colleagues on the Strategy.

65.7 Mark Large noted that the language is about reporting, which is something to think about. He also felt they would be limited by the capacity of Organisation for Change.

64.9 Nia Jones asked, what was the status of the document, was it not approved because it needed further work, or was it in effect noted but an expectation of work by a certain time, and what time frame is the ICB looking for that to be completed.

65.8 Masood Ahmed explained that he was asked to bring it back to the next Board meeting, and therefore because the context was not provided, he would provide a briefing paper.

65.9 Jonathan Gould asked, when we think about the Delivery Group is it Digital Leads from the organisations.

65.10 Masood Ahmed replied that all our providers are represented, including Digital leads and the Local Authorities.

65.11 Ben Rogers asked, how do we get assurance that it cuts through all of our other Strategies. He also noted that Masood Ahmed had not mentioned psychological professions.

65.12 Masood Ahmed said that they were looking at reprovisioning the funding that they had and how they would take their numbers from one Digital Clinician to four, he explained that they had also set up special interest groups for Digital Clinicians.

65.13 Nick White commented that it would be a good idea if you appointed as many different backgrounds as possible.

65.14 Cathy Purt asked Masood Ahmed if we are learning from others.

65.15 Masood Ahmed confirmed that this was the case.

65.16 Nigel Lee suggested that all partners represented on this committee were represented in the Digital Delivery Group. He also asked the Chair if they could bring the Road Map to this committee to illustrate how that aligns to the Strategy, and how it draws and aligns to the Clinical Strategy and works to support the objectives of the Joint Forward Plan.

65.17 Masood Ahmed agreed with Nigel Lee. He was happy to do that, but suggested a caveat in terms of time and how we present that to you.

65.18 Cathy Purt felt that this was a really good suggestion and as a committee supporting this, it was noted that all approved. Cathy Purt to ensure that also at Board level they agree to support this as well.

Action: Nigel Lee asked the Chair if they could bring the Road Map to this committee.

Action: Cathy Purt to support the Road Map is brought to the committee.

Action: Cathy Purt to ensure that at Board level they agree to support this as well.

Minute No. SC-11.10.066 Declarations of Interest:

66.1 Members were asked to confirm any new interests that needed declaring or any existing conflicts of interest that they had relating specifically to the agenda items.

There were no further conflicts of interest declared.

The Register of Board Members Interests can be found at: Register of Interests - NHS Shropshire Telford and Wrekin (shropshiretelfordandwrekin.nhs.net)

Minute No. SC-11.10.067 Minutes and action list from the meeting held on 20 September 2023

67.1 The minutes of the Extraordinary Meeting held on 9th August, were approved as an accurate record and the Chair signed them off.

67.2 The minutes of the meeting held on the 20th of September were also approved as an accurate record and the Chair signed them off.

67.3 **Actions:**

67.4 Nigel Lee updated committee members regarding action reference No. SC-18-05.043 Provider Collaborative Development and noted that although not quite consummate, they did have existing provider collaborations already in place at SaTH including a collaboration with UHNM. He mentioned that Robert Jones and Agnes Hunt were also exploring a collaboration with the Royal Orthopaedic, however, he was not sure of the current status. He noted that Cathy Riley from MPFT is Chairing work with multiple partners looking at Mental Health, not just NHS Partners but Local Authority as well as one or two other providers.

67.5 He explained that from an NHS England stance, the provider collaborative arrangement between the four NHS Trusts is an important step forward and a paper was submitted to NHS England in August, which included a lot of discussion at Chair/Chief Executive level, including ICB Chair and /Chief Executive and NHS England.

67.4 Nigel Lee explained that the objective was to form a committee in common format. This was initially planned to be in place by the end of October/early November 2023 in shadow form and would then sit monthly. He pointed out that the committees would initially shadow and then turn into a formal committee in common.

All other actions noted as complete or on-going.

Minute No. SC-11.10.068 Histopathology Transformation

68.1 Dr Angus McGregor introduced the item and after the presentation Committee members were invited to ask questions and/or comment:

68.2 Angus McGregor explained that the presentation had been produced using a document which had set out a National Strategy to address performance issues in histopathology, or cellular pathology as it is locally referred too. He said that one of the elements was a request to ICBs to have carried out optimisation exercises in histopathology, by a date prior to when the report was issued. Angus McGregor told the committee that he been in contact with Nick White and was invited to attend this meeting.

68.3 Angus McGregor noted that at SaTH, the pathology service is currently one of the best nationally and certainly in the region. He explained that one graph in the document demonstrated that the urgent turn-around time for SaTH work has been consistently either the best or one of the best labs in the region.

68.4 Angus McGregor noted that unlike other areas where performance is a real issue, we start from a good position. He explained that he had deliberately not included the RJAH cellular pathology, as this was a specialist niche orthopaedic pathology service. He said that in the other five elements of the plan, he had set out where we are and where we need to get to. He noted that we are able to maintain a consultant workforce, which is the single biggest determinant of success as a service.

68.5 Angus McGregor referred to the last two points and explained that they had been successful in getting national and regional funding to support significant investment in digital reporting. He explained that in primary and secondary care across the patch

for pathology and radiology and other services, we have funding in place and digital is just about to go live.

68.6 Cathy Purt asked if we do the transformation what is the impact you are going to have on the other services across STW and how will that impact on the clinical strategies.

68.7 Angus McGregor explained that he felt there is a direct link to cancer, he said it was about building some strong clinical pathways, not just to support cancer, but also for patients with chronic lifelong diseases, Angus McGregor said that they would try to build that capacity in parallel.

68.8 Cathy Purt asked if he thought by doing the transformation, he would release any resources that could then be used by the hospital transformation programme in other ways.

68.9 Angus McGregor thought the strategy that could work well is using what we have here and to recruit and develop a reporting service that could support other areas in the region and bring in resource in terms of being a net exporter of cellular pathology, brain power and perhaps an importer of income that helps our financial position rather than releasing resource.

68.10 Nia Jones pointed out that because of the very specialist nature to network nationally for it to succeed. She also noted the other aspect was around limbs work, without losing sight of the connectivity to the histopathology, we need to reference it.

68.11 Angus McGregor apologised for appearing to marginalise the service.
He felt strategically in terms of pathology networking, we have got a lot of urgent thinking to do, particularly around how the two cellular pathology services in our system want to engage with those in other parts of the region. He said that we need to make sure that whatever we do in STW, we maintain the level we have got rather than risking anything else.

68.12 Nigel Lee noted two points, firstly, about that opportunity for releasing resource, he said that alongside other diagnostics, there is a probable continued year on year increase. He explained that he would work with Angus McGregor, he felt there is a bit about also just making sure that we record how we are continuing to cope with that workload, with the existing resource, as that in itself is continuing to be efficient.

68.13 Nigel Lee felt that the system is a really strong pathology partner, he noted that our network with Stoke and the two Cheshire hospitals who have a set up called North Midlands and Cheshire Pathology Service are bringing a strong set of abilities to that network partnership. He also felt that the digital strategy needs to keep checking in with this committee because it is utterly vital for that perspective.

68.14 Cathy Purt asked, how are we taking our Primary Care colleagues on the journey for histopathology transformation.

68.15 Angus McGregor explained that pathology has got a very small primary care input of about 5% of our total activity, the cellular pathology service is largely targeted at more specialised care and secondary care. He thought the ICE Project is the best

way into that to get engagement with primary care, to unlock the benefits of electronic requesting and reporting to tighten that up.

68.16 Cathy Purt though that we have been able to engage primary care but stated that if we do not take the GPs with us on the journey, there will be concerns regarding the service.

68.17 Angus McGregor responded by saying his reticence was not that, he thought in other areas of pathology, particularly in blood sciences and biochemistry, they have been working quite hard to engage in primary care, use for a bigger share of the service than the secondary care sector. He was aware that primary care colleagues are stretched, so it was important we get it right.

68.18 Cathy Purt noted we are re looking to see how you progress with it and how it will actually work into the clinical strategy that Nick White brought to the meeting (before September one) and how it dovetails in.

Minute No. SC-11.10.069 MCAP Update

69.1 It was noted that that the MCAP update had already been discussed prior to this minute by Gemma Smith.

Minute No. SC-11.10.070 Any Other Business

70.1 Cathy Purt asked if the committee felt that the meetings were too frequent, or if this was going to be part of the Good Governance Review.

70.2 Gemma Smith suggested to the committee that they hold the meeting in November, for a shorter period of one hour, whilst they worked through what they wanted the Strategy Committee to be in the future.

70.3 Cathy Purt asked the committee's opinion on this suggestion.

70.4 Nigel Lee said he thought it might be an opportunity and could work with Gemma Smith, Claire Parker and other members within the Joint Forward Plan, he noted that there were a significant set of work streams under the Joint Forward Plan. Nigel Lee suggested that we make sure we are aware from a strategy committee point of what is being done in a strategic sense to align to that Joint Forward Plan and especially over the next couple of meetings, and that we remind everybody that these are key deliverables that we have got set forward.

70.5 Nigel Lee noted that we have just reset the work with Liz Noakes chairing on the Prevention and Health Inequalities committee, he said it felt like a really important theme, particularly from a system perspective, how best we deploy key aspects of that at place. He thought it useful for this committee to get a flavour on this.

70.6 Liz Noakes also felt the meetings were frequent. She agreed with Nigel Lee and noted in terms of the Health Inequalities and Prevent the group agreed to report through to the Delivery Committee and through to the Board, and the Population Health Management Group report through to this committee which overlaps in both of those areas, and with this committee as well.

70.7 Cathy Purt suggested that Nigel Lee and Gemma Smith action this as part of the Good Governance.

70.8 Mark Large referred to the Good Governance, he said that as we are in a setup phase where there are lots of strategies being considered, once we have got the strategies approved and we are going through a programme of work, then perhaps we do not need as many meetings, but for the moment we keep going.

70.9 Cathy Purt noted that meetings would continue until 8th of November.

70.10 Cathy Purt also pointed out that that was the date when Clinical colleagues would attend.

70.11 Nicholas White confirmed that they would be joined by Ben Rogers from MPFT and Ian Chan from Primary Care. Ganesh Mahadeva from ShropCom and Paul Kavanagh Fields Chief Nurse from RJAH. He was awaiting confirmation from John Jones and Hayley from SATH to confirm their representative.

70.12 Cathy Purt asked Gemma Smith to create a more clinically focused agenda when the Clinicians attend the meeting to be held on 8th November.

70.13 Gemma Smith referred to Nigel Lee's comment regarding the ongoing PA consulting work around capacity and demand, she said that whilst it was not necessarily a strategic piece of work across the system and obviously linking the HTP with the local care transformation programme, there was a level of detail underneath regarding some of those assumptions, she asked if there might be a place where they can present the work that they are doing and get the system feedback at the next meeting if people will be supportive of that.

70.14 Cathy Purt agreed with Gemma Smith's suggestion, and noted if it can dovetail into some of the other enabling strategies, they had going.

70.15 Gemma Smith asked if they could have a half hour slot on the agenda.

70.16 Cathy Purt agreed to this suggestion.

Action: Cathy Purt suggested that Nigel Lee and Gemma Smith action this as part of the Good Governance.

Action: Cathy Purt noted that meetings to continue as they were currently until 8th November, at which point the committee would decide if the meetings could be reduced to one hour.

Action: Cathy Purt asked Gemma Smith to create a more clinically focused agenda.

Action: Gemma Smith suggested a half hour slot on the agenda to get system feedback on the PA Consulting work

Date and time of next meeting: Thursday 8 November 2023 at 2.00pm

Agenda Item

ICB 29-11-132.7

Primary Care Commissioning Committee Chair's Report for meeting held on – 4 August.

NHS Shropshire, Telford and Wrekin
Primary Care Commissioning Committee Part 1 Meeting

Friday 4 August 2023 at 9.30 a.m.
Via Microsoft Teams

Present:

Mrs Niti Pall	**Non-Executive Director (Chair)**
Mr Nick White	**Chief Medical Officer (Deputy Chair)**
Mr Gareth Robinson	**Executive Director of Delivery & Transformation**
Mr Roger Dunshea	**Non-Executive Director**

Attendees:

Mr Simon Whitehouse	**Interim Chief Executive Officer**
Mrs Laura Clare	**Deputy Director of Finance**
Ms Emma Pyrah	**Associate Director of Primary Care**
Dr Julian Povey	**Primary Care Partner Member**
Mrs Janet Gittins	**Partnership Manager**
Mr Alec Gandy	**Partnership Manager**
Mr Phil Morgan	**Primary Care Workforce Lead**
Ms Jane Sullivan	**Senior Quality Lead**
Ms Sara Edwards	**Lead & Programme Manager, Training Hub**
Mrs Bernadette Williams	**Primary Care Lead for Contracting & Delegated Commissioning**
Mrs Lynn Cawley	**Chief Officer, Healthwatch Shropshire**
Mrs Chris Billingham	**Corporate PA; Minute Taker**

Apologies:

Mrs Claire Skidmore	**Chief Finance Officer**
Mrs Julie Garside	**Director of Planning & Performance**
Ms Claire Parker	**Director of Partnerships & Place**
Dr Ian Chan	**Primary Care Partner Member**
Ms Angharad Jones	**Finance Business Partner**

Minute No. PCCC 23-08.41- Apologies for Absence

1.1 Apologies received were as noted above.

Minute No. PCCC 23-08.42 – Members' Declarations of Interests

2.1 Members had previously declared their interests, which were listed on the ICB's Register of Interests and were available to view on the website at: Register of Interests - NHS Shropshire, Telford and Wrekin (shropshiretelfordandwrekin.nhs.uk)

Minute No. PCCC-23.08.43 – Minutes of Meeting held on 2 June 2023

3.1 The minutes of the meeting held on 2 June 2023 were approved as a true and accurate record of the meeting provided the following amendments are made: -

References to DMS within the report should be replaced with GMS.

Page 11 – Reference to Mrs Skidmore saying "intimated" should say "stated".

Page 12 – There was an inaccuracy regarding the statement that "the Committee decision was to utilise the funds elsewhere in the ICB". Mrs Skidmore believes that the Committee did not agree that decision and the statement should stop after the statement "It was agreed to decommission the service".

Minute No. PCCC-23.08.44 – Actions Raised from Previous Meetings and Matters Arising

4.1 The Action Tracker was reviewed and updated as appropriate.

PCCC-22.10.19: Extension to Practice Boundaries: Item to be closed.

PCCC-22.10.21 Implementation Plans – Enhanced Access from 1 October 2022: No August updates.

PCCC-22.10.23: Supporting PCNs Through Winter: Item to be closed.

PCCC-22.10.26: Finance Update: No August update.

PCCC-22.12.36: Ethnically Diverse Staff Survey: Findings and action plan presented to August Committee.

PCCC-23.02.05: Proposal to Change PCCC Agenda Structure:
August Update: Mr White advised that this is a continuing piece of work around governance of the Primary Care Commissioning Committee (PCCC), where the Committee sits in the structure, and how people on the call can be best utilised, particularly with regard to what may constitute conflicts of interest.

There is no requirement for PCCC to be a stand-alone Committee – it can be part of another Committee. The organisation has an Elective Care Board, a UEC Board, and needs a Primary Care Board.

The meeting discussed the work being done by the Good Governance Institute (GGI). Mr Whitehouse advised that GGI have mapped out the numbers of meetings and where those meetings report to, highlighting areas of confusion and areas that work well. They will be working with us for the rest of this financial year, carrying out development work with the Chairs of our formal Committees.

PCCC-23.02.06 Albrighton Medical Practice – Application to Reduce Practice Boundary: Update provided.

PCCC-23.02.07 2022/23 Month 9 Primary Care Financial Position: Close Action.

PCCC-23.06.31 Actions Raised from Previous Meetings and Matters Arising:
Dr Povey referred to out of area patients and visits, advising that Practices can choose to accept patients who are registered outside their boundaries. That is part of the GMC contract. There is a requirement on NHS England to provide visits to patients who are registered in Practices as out of area patients because that requirement does not fall on the Practice they are registered with. Most people would be dealt with out of hours via 111 and Out of Hours but it must be acknowledged that there is a gap in what we commission as an ICB as we do not commission a home visiting service for in hours requirements for out of hours registered patients and that needs to be acknowledged as a risk.

PCCC-23.06.34 – Hodnet Medical Practice Request for Boundary Change:
No update provided.

PCCC 23.06.36 – Finance Report: Item complete and will be closed.

PCCC-23.06.38 – GP Access: Update provided. Item ongoing.

Minute No. PCCC-23.08.45 – Lantum Contract (Flexible Pools) Renewal

5.1 One of the requirements from NHS England regarding the workforce allocation received by the ICB via the System Development Funding (SDF) is to procure a system or process that enables the ICB to increase the use of digitally enabled, flexible staff local pools. There is an element of discretion about how the funding can be used but we must be able to show how we are enabling staff to work flexibly, for locums to be able to work, and for Practices to be able to identify locums.

5.2 Lantum was commissioned several years ago. The end of the second year of the contract is approaching and this paper sets out the current position regarding that contract and is recommending – notwithstanding some concerns that we have – that Lantum is recommissioned.

5.3 The current contract ends in December 2023. The data set out in the paper clearly shows that there is a challenge as to whether this is value for money. Updated data from July suggests that usage has increased but this could be due to summer holiday period where staff leave increases therefore more need for locum cover.

5.4 The contract value for this current year was circa. £90k. Negotiations took place with Lantum to reduce the cost of the contract for December 2023 - December 2024 to circa. £50k plus booking fees.

5.5 The nominal funding we receive from NHSE is £120k. The suggestion is that we spend less than half of that.

5.6 Lantum is a nationally approved supplier used by 18 ICBs across England, including a number of our fellow ICBs in the Midlands. The platform provides good functionality for both Practices and locums and significantly reduces the administration carried out by Practices. Practices do not pay for use of the platform.

Nearly all NHS STW Practices are signed up to the platform and a significant number of GPs are authorised and approved to work on the platform. However, the challenge has been to increase usage.

The low usage is probably because the majority of Practices in our system have, and continue to have, their own local arrangements for sourcing locums which work well. Although Practices were keen to use Lantum, it was not a significant challenge for them to identify locums therefore the service has been viewed by most Practices as an additional help rather than their first port of call, hence the usage has not been as high as we would have wished.

5.7 The ICB has a significant number of GPs and a small but growing number of nurses, ANPs and other clinicians who are approved to work on the platform therefore in terms of supply of staff there is not an issue.

5.8 A survey of Practices was carried out and Practices expressed interest in using the platform to book nurses and ANPs.

5.9 A GP Locum Champion, Dr John Cramphorn, was recently appointed and part of his role is to try to increase usage of the platform.

5.10 Details of ways in which to improve value for money are outlined within the report and the proposed quote from Lantum of circa. £50k includes a licence for each Practice costing £65 per month.

5.11 Mr Whitehouse asked whether budget and resource was available. If not, then renewal of the contract must be agreed through internal funding mechanisms. Mr Morgan confirmed that funding and resources are in place.

5.12 Mrs Clare confirmed that the funding is available via an allocation from NHSE. However, she expressed certain concerns.

She questioned whether this service was necessary if Practices do not utilise it as their first option, and it is being used as a result of a directive received from NHSE. She noted from the paper that the funding is now not ring-fenced and queried whether the funds could be put to better use.

She also expressed concern regarding the procurement risk and queried whether that risk has been assessed. If the Committee agrees that the contract with Lantum should be renewed, we must satisfy ourselves that there is no risk around that direct award.

5.13 Dr Povey agreed with Mrs Clare's concerns regarding a direct award being made to Lantum without a procurement exercise, especially if certain features of the contract were being changed. In addition, he made the following points: -

- He requested clarification of paragraph 2.1 within the report which stated that excess funding will be spent on other workforce initiatives.

- Lantum had a data breach in June where 3,200 personal records were breached. He queried whether this had been raised with them to establish any actions taken as a result.

- If only 8 Practices are using the platform, a possible option may be to ask Practices whether they wish to "opt in" to use it. Paying a monthly licence fee for 51 Practices

to have access to a system which is only being utilised by 8 Practices does not represent value for money. It would seem more sensible to give Practices the opportunity to "opt in" or "opt out".

Mr Whitehouse left the meeting at 10.00 a.m.

5.14 Mr White also expressed concerns around value for money and whether the uptake in usage during August was sustainable. He queried whether the decision to renew the contract must be taken today or whether it could be deferred for a short time to see whether usage continues to increase.

5.15 Mr Dunshea supported all of the comments made during the discussion and also referred to the importance of triangulation between the Executive team, the Finance function and the relevant departmental team to make sure that such points are covered before a paper is submitted to Committee.

5.16 Ms Pyrah confirmed that the data breach had been raised with Lantum who have confirmed that remedial action was taken. The breach related to data that was held before the ICB entered into a contract with Lantum, therefore our data was unaffected. This has been shared with our Chief Information Officer who was comfortable that all necessary action had been taken.

5.17 Discussion took place regarding the above points, key outcomes of which were: -

- The contract did not represent value for money. However, a decision must be made as to how it is decommissioned in light of NHSE's request that we have a digital platform.

- If the funding is not ring-fenced money, consideration must be given as to whether it is utilised elsewhere, e.g., workforce and improving GP access.

- Dr Pall confirmed the decision of the Committee was to decommission this service subject to obtaining NHSE support for the ICB not having a digital platform.

Minute No. PCCC-23.08.46 – Finance Report

6.1 The Finance report as at Month 3 was taken as read.

Mrs Clare asked Committee members to note that the format of the report had changed slightly to match it to overall ICB Finance reporting.

6.2 At Month 3, there is an approximate £1m year-to-date underspend in Primary Care in its entirety, mainly due to a non-recurrent favourable variance in prescribing. At the end of every financial year, the Finance team must estimate what the prescribing costs will be for that year as the data is two months behind. That information is now included in the forecast.

The ICB has taken over responsibility for Podiatry, Optometry and Dentistry budgets (POD). At Month 3 there is a small overspend, mostly due to a technical issue around allocations.

That overspend is expected to disappear in future months as the allocations are agreed at Chief Executive level. There is however a small overspend on Optometry year to date and this will be monitored as additional data is received.

The capital plan is currently on track. £883k of Primary Care capital is split between IT projects and GP improvement grants for estates projects across Primary Care. The efficiency schemes linked to Primary Care are over-achieving by £82k per year to date and it is forecast that they will over-achieve by the end of the year. Again, that is predominantly down to prescribing.

6.3 Mrs Clare invited questions.

6.4 Mr Dunshea referred to the layout of the report and suggested that it might be useful to separate risks and opportunities.

He referred to page 35 of the pack relating to enhanced service payments paid on account based on 2019/20 activity levels and queried the risk in terms of it being reviewed in 2023/24.

Ms Pyrah replied that an amount is paid every month to protect cash flow in Practices and any under or over payment is reconciled at the end of the month based on actual activity. The payment is still at 2019/20 levels but will be re-based for next year as we return to business as usual.

Mr Dunshea then referred to page 36 of the pack which referred to the Additional Roles Reimbursement Scheme and a £1.5m additional requirement. He queried the risk of not getting that money.

Mrs Clare confirmed that in previous years, provided the expenditure could be evidenced, the funding was released by NHSE. We are currently forecasting that all of the predicted spend in ARRS will be funded through NHSE. The situation will be monitored on a monthly basis and any concerns that the funding will not be forthcoming will be drawn to the attention of the Committee.

Mr Dunshea asked whether this report could be enhanced to include activity data. Mrs Clare confirmed that Dr Garside was working with her team regarding activity and performance data that can be added into the report. Mrs Clare will pick this up with Dr Garside.

ACTION: Mrs Clare to liaise with Dr Garside regarding the inclusion of activity data in the Finance report.

6.5 Dr Pall suggested that it would be useful for the next Committee to see the prescribing budgets for the following year to understand this year where the underspend came from and also any pressures on prescribing that may arise next year, particularly with regard to high-cost drugs.

ACTION: Mrs Clare to speak to Angharad Jones and the Medicines Management team in order to provide detail around prescribing budgets in the next report to PCCC.

Minute No. PCCC-23.08.47 – Workforce Report

7.1 ***Results of GP Survey***

Mr Morgan's report summarised the work undertaken in the Spring by Primary Care Commissioning, a company who carried out 5 surveys on behalf of the ICB.

In July 2022 the General Practitioner Strategy was approved by the Committee. One of the key recommendations of that strategy was that more needed to be known about the challenges facing GPs. The results of the surveys were summarised in the report. The information gathered will help to refresh and re-launch the GP Strategy using the data gathered from the surveys.

A survey of trainees was carried out to which over half of GP trainees responded. The survey was designed to establish whether they wanted to stay, whether they were interested in becoming a partner, where they were going to work as a locum and any issues about work/life balance.

The main survey was of fully qualified GPs with approximately one third of GPs responding.

The final survey was of Practices as employers of GPs. Results showed that many Practices were struggling to recruit GPs.

The overall recommendation from the report was to ask Committee to note that the surveys had uncovered many issues, challenges, and recommendations.
The Committee were asked to agree that those findings should form the basis of a comprehensive review of the GP Strategy which will be presented to PCCC in October.

Discussion took place regarding the desire of many GPs to have portfolio careers which includes GPSI, educational work, management, etc. and steps being taken to encourage that portfolio work to retain our doctors in a different kind of way. Locations such as Gloucestershire have been partnering with universities to start establishing certain portfolios.

Mr Morgan confirmed that the main objective of one of the GP Lead roles shared by Dr Tim Lyttle and Dr Adam Pringle is to offer advice and support to GPs to develop portfolio careers. Their role is to build up a resource database to share with other GPs. However, those GP Leads are only funded one day a month therefore there is a limit to what they can do.

Mr Dunshea referred to information within the report that GPs typically work 6 sessions a week, or approximately 3 days a week. Dr Povey clarified that that was the normal working pattern for GPs. The 6 sessions were clinical sessions. GPs will be working further sessions in a week but that would be for administrative and professional development.

Discussion took place regarding the issues in Primary Care, and highlighted the following key points which may drive GPs away from working 5 days a week: -

- Workload and pressures have both risen dramatically.

- The job is overwhelming and there are many tasks performed by GPs that could be done by automation or carried out by other people.
- More consideration should be given to how women are encouraged to stay within the workforce.

In response to comments raised during the discussion, Mr Morgan confirmed that: -

- The ICB has a GP female Lead, Dr Nicky Harrison, who is actively considering how to support female GPs.
- The full time / part time issue is a trend across the country. None of our newly qualified GP Fellows are working full time - all are choosing to work part time. There are many reasons for that, but it *is* a trend.
- Job advertisements are an issue and could be of a better standard.
- There is only sufficient funding for the GP Leads for one day a month and it is non recurrent, so they are on fixed term contracts. In October when the revised Strategy and action plan is brought to Committee, members will be made aware of several initiatives it is hoped to develop over the next 12 months.

ACTION: Mr Morgan to research the GP portfolio work carried out by Gloucestershire.

7.2 ***Results of Primary Care Ethnic Diversity Survey***

The survey was developed by Humberside LMC and was used with their permission. It was carried out in the Spring of this year with all Primary Care staff and General Practice staff.

It was made clear that the survey was about ethnic diversity, not just staff from ethnic minority groups. The survey had 216 responses. Key points of the survey were: -

- Many staff from ethnic minority backgrounds had experienced racism. They do not think it is always dealt with appropriately and they are not necessarily confident in speaking up about it.

- Staff believed that they have been treated differently due to their ethnic background and have experienced discrimination and inappropriate comments from both colleagues and patients.

- It is clear that there are issues to address both in terms of patient and colleague views and experiences. Within the appendix, the system objectives illustrate issues that Dr Priya George is taking forward across all providers. In this report, Primary Care objectives linked to system objectives are identified.

- One of the challenges that we have not yet been able to address is encouraging and creating a working group that is owned and staffed by Practice staff. Mr Morgan has agreed with Dr George that one of the key challenges is to develop a working group made up of Practice Managers and possibly GPs and other staff to review the Primary Care objectives and how they are used to create an action plan.

Discussion followed regarding the extent of the problem, and a suggestion was made that Practices should be encouraged to treat racism in the same way they treat physical violence and de-register patients who are racist.

Dr Pall referred to the ICB's duty of care to the people it represents and suggested that pastoral care should be in place for staff together with an action plan for those affected to access that care.

Committee members agreed that this subject should be escalated to Board level to make the public fully aware of our concerns in this area.

Mr Robinson suggested that a discussion should take place with colleagues from Healthwatch but wished there to be no doubt that this is the ICB's responsibility to drive forward. We must ensure that this is linked into the Board's programme of work on equality, diversity, and inclusion to avoid separate programmes of work taking place but addressing similar issues. This is a local, national and system issue and we must ensure that any work done within Primary Care is consistent with that.

However, he did not think that the report quite set out the actions required and believed that it is incumbent on himself, Ms Pyrah and Mr Morgan to consider actions to be taken with the capacity available within the confines of the system work already under way. Discussion should also take place with Healthwatch colleagues as to whether there is a role in this for them.

Mrs Cawley confirmed that she had already discussed this with Dr George and was supportive of this issue. A page has been added to the Healthwatch website providing information as to how staff can speak to a Freedom to Speak Up Guardian.

ACTION: Mr Morgan to submit a report detailing the action points from his August report to a future Committee.

7.3 ***NHS Long Term Workforce Plan – Implications for General Practice***

Sara Edwards' report highlighted the implications of the long-term workforce plan published in June, and the implications for Primary Care.

Government funding of £2.4m is attached to delivery of the long-term plan which is based around three pillars – train, retain and reform. Further details are contained in the appendix of the report.

The ICB workforce and training team currently supports many of the elements within the plan which indicates a large acceleration of most areas, plus a widening of them. The challenges around this are many.

Estates to accommodate the plans will be key. Creating learning environments for all new learners will be a challenge and will put pressure on the number of educators and supervisors required to support the plan. Support will also be required in terms of administration, project support, IT, etc. which will be a challenge in terms of capacity.

It is hoped that further alignment with the ICS People team, their resource, and programme of work will be possible to create additional capacity.

Mr White observed that key to this is making sure that all the training is carried out within Shropshire. Evidence suggests that people stay where they train or return to where they trained.

Minute No. PCCC-23.08.48 – GP Access

8.1 ***GP Access Recovery Plan – Progress Update***
Ms Pyrah's report was taken as read.

The first chapter of the report describes the governance arrangements being put in place which will mirror the national and regional governance. Consideration is being given to introducing a Primary Care Improvement and Transformation Board which will have the same priority status in the ICB as Elective and UEC Boards. The remit of the Board would be GP Access Recovery, Transformation and oversight of Pharmacy, Optometry and Dentistry which was delegated to the ICB from 1st April 2023.

The report then describes specific actions being taken and progress of some of the key asks within the plan.

All the PCN improvement plans have been received and signed off. However, further conversations are required with one PCN to improve the detail of their plans. Our allocation of funding for moving to cloud based telephony has been confirmed. The Practices have been named and Anthony Armstrong, ICB Digital Lead, is actively working with those Practices to make sure that the work is completed by the deadlines in the national plan.

We continue to encourage GP Practices and PCN'S to sign up to the national improvement support programmes.

A self-assessment has been carried out and submitted to NHSE against the six specified pathways in the NHS long term plan. Plans are in place for some, but for the majority of them we have no plans. Further work is required, and Ms Pyrah is liaising with the Director of Elective Care and the Director of Strategic Commissioning.

Work has commenced on the primary/secondary care interface and creation of a plan to transfer secondary care work carried out in primary care back into secondary care. Discussions have taken place, but further work is required.

Mr Morgan is working with PCNs to make sure that they have plans in place for spending their ARRS money, recruiting people into those roles, and ensuring that their allocation is used by the end of March.

The Primary Care team is working with Practices regarding their application for the national transition and transformation funding, which supports them with additional capacity to move from one operating model to another in terms of accessing General Practice.

Information is contained within the report regarding access improvement plans. A summary of the plans is contained in the appendix to the report together with details of the monitoring report and the risk register.

Earlier this week, the national team published the system improvement plan guidance. Primary Care must submit a system improvement plan to the Board in November and the aim is to have a first draft available early in September.

Discussion took place regarding the PCN improvement plans which appeared to be different in some areas in terms of their ambition.

The Committee queried how consistent PCNs had been in preparing their plans. Mr Dunshea referred to the rag rating and the plans currently all being rated Green, and queried how sustainable that would be.

Ms Pyrah replied that the PCNs had all taken a different approach because each Practice and PCN must consider their own individual population and practice needs. There is a difference in their approach, but they do comply with the national ask.

There is always a possibility that the rag ratings may change. That depends on the demands placed on Practices and PCNs during the winter but at the moment she was confident that they will do what they have said they will do.

Dr Povey referred to the national GP support programme. The programme is about moving to a model of total triage where all patients are triaged in electronic form either by filling in the form themselves or by the Care Co-ordinator filling in the form and then a Care Navigator signposting patients either to alternative places to be seen or to members of our team to be seen.

However, many patients will not like this approach and many doctors do not feel comfortable with it. In Shropshire there are a limited number of places to send patients to which will impact on patient satisfaction because it is not the model that patients want. The backfill and the capacity to carry out the programme is quite limited in Shropshire, and patient complaints about lack of continuity and not seeing their preferred doctor will increase.

Mr Dunshea referred to governance of the process and asked Ms Pyrah to ensure that future reports provide financial data to advise Committee of the costs of the programme and asked if the GP Board has a role in this.

Ms Pyrah confirmed that the GP Board *will* have a role. Recruitment is currently taking place to a two-year position to chair the GP Board and it is intended that the Chair of the GP Board is part of the governance of the Primary Care Improvement and Transformation Board and oversees the improvement and transformation, and/or a nominated member of the Board.

8.2 ***GP Patient Satisfaction Survey Results 2023***

The results for this year were informed by field work undertaken between January and April.

The report showed a comparison between this year and last year. Compared to the national average NHS STW are on par or better than, but when considered at individual PCN level there is a stark difference between Shropshire and Telford and Wrekin in terms of performance, and the Primary Care team will be using that information to work with those individual Practices and PCNs. A decline has been noted in certain areas, which is a concern.

Dr Pall asked if any triangulated data exists on health outcomes in the areas where there is lower patient satisfaction.

Mr White confirmed that the data could be made available.

A conversation had taken place at ICB Board regarding health outcomes as part of a discussion around population health management and he was tasked with presenting to the ICB Board in September. Activity around triangulation has commenced and consideration can then be given to what interventions and outcomes are not happening.

8.3 GP Access Performance Report – May 2023 Data

Mr Gandy's report was taken as read.

A call has been arranged at the end of September for himself, Mr Robinson, Ms Pyrah and Mrs Gittins to review the report to make it more meaningful. A considerable amount of work is being done around access which must be included in the report. Main points to note are: -

- Appointments are increasing.
- Remote appointments and people who are seeing non-GP clinicians is also increasing.
- NHS STW is in line with the UK average. 83.83% of patients are seen within 2 weeks and 52.65% are seen within 2 days or by the next day.
- Referrals to the Pharmacy service are gradually increasing.

Mr Gandy invited questions.

Mr Dunshea observed that the report needed development in terms of presentation and suggested that if Mr Gandy wished to circulate some draft ideas, he would be happy to consider them.

Mr Robinson commented that presentationally, the report was excellent. The discussion taking place at the end of the month will be more focussed upon what we do differently as a result of the insight this information provides.

ACTION: Mr Robinson to update a future Committee regarding GP access after the discussion at the end of the month has taken place and an action plan is in place.

Minute No. PCCC-23.08.49 – Risk Register (General Practice)

9.1 Dr Pall referred to the Risk Register which contained red risks and asked whether they needed to be discussed at today's meeting.

9.2 Ms Pyrah intimated that there has been no material change to the risks, which had existed for some time. There have been no changes since the last time they were reviewed by PCCC and there are no new red risks.

9.3 Dr Pall asked the Committee to note the risks and direct any questions they may have to Ms Pyrah via email.

Minute No. PCCC-23.08.50 – Any Other Business

10.1 There was no other business.

For Information Items

11.1 The Primary Care Team Work Programme Progress Report was submitted to the Committee for information.

11.2 Prior to the Part 2 meeting taking place, Mr White referred to the conversations that usually took place with Dr Chan and Dr Povey regarding conflicts of interests.

11.3 If Dr Chan was present, he would be required to exclude himself because of a conflict with one of the papers. Dr Povey was invited to attend Part 2 unless he chooses to exclude himself as he had no conflicts of interests for any of the papers to be discussed.

Agenda Item

ICB 29-11-132.8

Integrated Delivery Committee minutes for meetings held on 9 October 2023

STW Integrated Delivery Committee

Open Minutes of the Meeting

Held on 09 October 2023

Present	Initials	Present	Initials
Harry Turner (Chair)	HT	Julie Garside	JG
Gareth Robinson	GR	Paula Davies	PD
Jan Heath	JH	Kate Owen	KO
Sara Biffen	SB	Gemma Smith	GS
Maureen Wain	MW	Lorna Gibson	LG
Claire Horsfield	CH	Elizabeth Walker	EW
Jonathan Rowe	JR	Matthew Neal	MN
Emma Pyrah	EP	Cathy Riley	CR
John Baily	JB	Mike Carr	MC

Apologies

Tanya Miles	TM
Masood Ahmed	MA
Simon Froud	SF

Notes

Maya Dhanda	MD

Minute No Date & No. Format	Title
IDC-09.10.001	**Introduction and Apologies*** Apologies received from: • Tanya Miles • Masood Ahmed • Simon Froud
IDC-09.10.002	**Declarations of Interest*** • No declarations of interest.
IDC-09.10.003	**Minutes from the previous meeting held on 11 September 2023 and extraordinary meeting held on 22 September 2023** • A1 – Agreed. • A2 – Agreed.
IDC-09.10.004	**Matters arising and action list from previous meetings*** • A1 - Action log reviewed. • A2 – Action log reviewed, with following action below. **Action**: Claire Horsfield will send action updates for action log (A2) to MD/JH.
IDC-09.10.005	**IDC Chair's Report (September 2023)** • Approved and taken as read.

IDC-09.10.006	**System Operational Plan Dashboard – Julie Garside** • Papers received and taken as read. • The Committee noted the pressures around UEC from impacts following annual leave and industrial action has contributed to deterioration in performance particularly around ambulance handovers and 4hour. • Activity is consistent, detailed work being done around Tier 3, type 3 increase in activity at PRH as well as reviewing non-elective admissions - the demand and capacity group is feeding that through the UEC Operation Group. • Quarter 2, 4days length of stay (NCTR) is maintained and to be monitored as pressures begin to come in. • CAT2 Performance September – coming back down. • Local Improvement Trajectory – ahead, still off national target once local plan is delivered it will be achieved by year end. • Planned Care (long waits) – Positive - SaTH have been taken out of Tier 1 for elective care. • Value Weighted Activity – significantly impacted by industrial action at RJAH (off track) and working through Planned Care Board to understand the bridges to mitigate for the rest of the year. • Diagnostics – ahead of plan with the exception of endoscopy, there is a known business case going through SaTH but has been delayed and once resolved this will go through internal governance to aid in demand and capacity where needed for endoscopy. • Follow-up position is now picked up by the outpatient transformation group, however there is 2months improvement with performance at 3.7%. • Local plan at 4.4% but showing month on month improvement and is now picked up via the outpatient transformation group. • Mental health and autism – gradual but sustained improvement around dementia diagnosis and CYP axis. • Concern around Talking Therapies - there have been some counting issues but the recovery plan requested in June is currently outstanding; Cathy Riley informed that the narrative plan has been received this week and trajectories are being done this week. • ARRS post – slightly behind plan but no cause for escalation, reason it is behind plan is due to difficulty in finding suitable applicants. • Will the delay in the ARRS plan impact on winter pressures, activity assumptions and manage spend to the finance assumptions end of year? • In terms of the impact in activity Julie flagged that the investigation currently being done on type 3 will help better understand this area including targeted practice visits but cannot answer in terms of financial flows at this current time.
IDC-09.10.007	**Planned Care Board Update – Maureen Wain** • Papers were received and taken as read. • 104 waits – 1 waiting, being managed - all providers are in good position. • 78 weeks – 10 waiting, being managed all providers all in good position. • 65 weeks – on track, there are some pressures due to Industrial Action, support is still being received from NHSE and therefore going to map out what that will look while moving forwards in coming months

	• Outpatients Transformation – Improvement trajectories are being refined and all of the organisations are expected to meet national standards by March 24 and are happy with how it is moving so far. • Patient choices – current national changes and now have responsibility to provide 5 providers to all of our patients and doing this through RAS and TRACS as routine. There are formal accreditation and changes that we do need to do and that will be formalised before the end of March. • Cancer – Background work to improve the growth in the transformation team to be able to work closely on prevention and diagnosis and transforming the pathways with our providers and then working without GP community in terms of living with and beyond cancer. • Katy Lewis is working hard on the cancer strategy and is currently reviewing this, where the team structure going forwards will align very closely to the cancer strategy. • FDS – nothing to note by exception, SaTH had forecast to be around 70%~ for milestone 1 and very close to the FDS target. • FIT testing – improved and are around the 80% target, which improves the patient pathway in terms of tumour group. • Value weighted activity - there is a lot of work going on outside of this forum to better understand exactly where each organisation is off track, we are off track by £2.2 million collectively, however there are some counting and coding issues which are being worked on and hoping to close those gaps. • Maureen noted that the Tier 1 support has not been removed, as a consequence of that it was noted that in August, STW were the top performer for 104 and 78 weeks. • Also noted was the industrial action impact on an overall impact on the number of breaches, particularly in RJAH and if the industrial action continues that this is cited as a key risk to delivery of our elective care standards. • Cancer remains at Tier 1 and weekly calls continue. • PIDMAS started within STW – time consuming but all are doing what they can from a national perspective.
IDC-09.10.008	**UEC Board Update – Gareth Robinson** • Verbal update provided. • Sub-acuteWard Oversight Group is meant to report into the UEC Delivery Board, but the previous UEC Board was stood down due to critical incident therefore no update. • Sub-acute Wards; Delayed due to planning permission & recruitment issues the first stream of beds (worst case scenario) are as follows: - PRH; 20 beds 02 Jan 24. - RSH; 16 beds 01 March 24. • Second stream of beds are as follows: - RSH; 16 beds 01 April 24. • Gareth, Sara, and Gemma are working on a set of actions to try to bring forward the above dates in parallel with a financial projection for the year, the significant delay will impact on the escalation beds. • PRH - the physical infrastructure at PRH would not allow opening of the beds to happen until January due to all of the moves that are happening at the sub-acute ward at PRH.

	• RSH – A degree in flexibility in dates (March/April 2024) as the onboarding of staff could be brought forward but there is a possible risk that Gemma is working on to progress. • Winter period – the impact on the delays on the sub-acute ward there will be a reduction in beds, causing difficulty in winter. • Workforce – mitigations in place and operating with an agency to get to a position faster as long as the estate is in position where we can do that from both RSH and PRH. • Gareth Robinson asked the Chairs permission for: - the IDC to receive a virtual report rather than waiting for the next UEC Delivery Board - a summary report to be submitted at the Oversight Group on Monday. - assurance to be had at the next IDC on all of the actions that were identified for the 9th with the milestone plan, risk plan around staffing. • The Chair requested that Gareth Robinson ensure members from the ICB meetings are fully sighted on the above through a formal meeting. • Performance position – reviewed on a weekly basis on the 3 key pieces of data that are driving performance oversight through NHSE. • From the UEC performance metrics the 3 areas that are overseen by NHSE are Cat 2, 12hour breaches and 4 hour performance regionally/nationally on a weekly basis and shown improvement from January – June across all areas. • Deterioration from July - August around 12 hour breaches and Cat 2 performance related to industrial action and leave period. • There are 3 areas of focus for all of the operational teams; virtual ward, core internal SaTH processes and the Winter plan. • Challenges related to the core internal SaTH process are in the social care capacity and virtual ward having the greatest unused capacity. • Discharge pathways – on plan within the system operating plan. • Impact of Virtual Ward – was expecting an equivalent of 45 escalation spaces within SATH released as a result of the virtual ward; not delivering. • Work underway from Shropcomm to understand the data and what the drivers are on delivery but unclear if it is a recoverable position. • Virtual Ward work underway due to the significant issues from a clinical/operational position with financial implications on running additional escalation capacity and to mitigate the loss of the virtual ward capacity ensuring the position is back on track and the likelihood to deliver through winter. • 4hour performance – recent improvements made/seen. • Expected to have significant improvement around estate work, rota changes, extended UTC hours, admissions avoidance, and the winter plan during October, November, and December. • Winter plan – Expected significant changes (front door), winter funding did not receive this year with the areas of focus going towards the admission of evidence and keeping people in roles, which is positive. • The submission of the improvement plan to NHSE and DHSC has been resubmitted, has been worked through with partners and mapped into the UEC improvement program to ensure there is one plan to work from only. **Action**: Gareth Robinson to ensure a summary paper is submitted to the next UEC Delivery Board (November). **Action**: Chairs report to include the alert around virtual ward with mitigations around the delay in sub-acute ward capacity and non-admitted for performance and overall performance. • Lorna raised that for the UEC 3 areas of work (virtual ward, core internal SaTH processes and Winter plan) there are exit criteria and metrics for SaTH that are

	tracked. The 15minute triaging and meeting criteria to reside are part of the SaTH exit criteria for UEC in terms of how that is monitored. • Virtual Wards – piece of work commissioned around the bed position and likelihood of meeting that which Lorna is picking up with Simon. • There are some resourcing from regional colleagues that are supporting UEC and can share this information on who is on patch for SaTH to support on the non-admitted position.
IDC-09.10.009	**Financial Improvement Programme – Kate Owen** • Paper received and taken as read. • £70 million efficiency target with a number of programs and cost saving initiatives that are in place to help to achieve, the report focuses on the month 5 position against the plan the position to date as of today. • Identified stretch target start of the year is £15 million. • Month 5 reporting adverse variance to the plan of £4 million due to underperformance at SaTH relating to the escalation costs which have been discussed in this meeting, there are a number of actions in place to mitigate and recover and on-going work that is being overseen through the UEC Delivery Group. • Slippage with the local cost improvement programmes are being overseen within each of the respective organisations (detail within appendix). Not envisaged that these will have material impact on the forecast in year. • Main focus - Identified plans of FIP; ICB have been working with system partners to identify and develop further opportunities to help bridge this unidentified gap. • The Committee noted the good progress made with the newly formed medicines value group and the number of PIDS being developed and robust savings plans are being put forward to help to delivery further savings in year. • The value of the unidentified plans is reduced from beginning of the year £15 million down to £8.1 million in month 5. • All plans identified totalled at 89%; NHSE requested that we meet 90% of plans by month 6 and confirmed we are likely to meet this target. • FIP meetings are now being chaired by Simon Whitehouse who has asked for full attendance from each of the providers to help achieve the remaining forecast and target between now and end of year. • The chair mentioned that this is a priority for the balance for the year. • Gareth confirmed there have been updates following the figures from the report today that month 6 will achieve above 90% on all plans identified but also raised at FIP there are significant risks attached to what remains roughly £2.4 - £2.5~ million that remains for the ICB with processes in place. • It was highlighted in FIP there are significant risks around the delivery of the stretch target component of SaTH numbers due to challenges that SaTH are facing on delivering the internal efficiency programme.
IDC-09.10.010	**HTP Update – Matthew Neal (Director of Hospital Transformation Program - SaTH)** • Matthew Neal presented slides around the Hospital Transformation Program update to the Committee and the progress made so far. • Works around the outline business case at SaTH (early 2023) approval given to the strategic outline case in August last year. • A lot of work undertaken around the pathway designs and designed of the new hospital buildings. • Patient community and surrounding community are involved on sites on the development and holding clinical and staff workshops around the plans. • Outline business case has been submitted to government and are awaiting the outcome; continued progress on business case while waiting for outcome.

	• Enabling works at the back end of this year but then start the main implementation next year with hope that the new model will be in place by winter 2026. • Plans – PRH site will be a site specialising in planned care. • Plans – RSH a lot of work underway with a number of engagement events throughout the last few months. • Plans submitted to the Shropshire Council planning portal leading through into the approval process and implementation by late 2026. • RSH – aging and configuration of the estate requires improving and if not improved there could be a risk through future disruptions to services. • New build near to the outpatient's block but wrapping around to the emergency department; better clinical adjacency between the services and emergency department (easy access). • Includes a Childrens centre including enlarged children's assessment unit children's inpatient oncology and surgical services and adult oncology and haematology ward with increased single accommodation; 74% of the building having single rooms. • PRH – similar process as RSH and held some focus groups around plans for travel and transport as this is a significant issue for communities. • Building - sustainable building solutions in terms of the plans to have solar panels and to ensure that the building itself is Net Zero ready. • A phase approach on carrying out the development so that the full operation of the hospital is maintained throughout as key requirement to work with contracting partners. • Delivering full business case hopefully to go through ICB end of year including enabling works to carry out also. • Lorna raised if the new hospital rebuild is going to be future proof in terms of the demographic and the requirements of the of the population by the time it's built and how that's been thought through. • Matthew confirmed that we have built in flexibility with template style wards as healthcare changes and technology changes that the ability to adapt to meet future demographics in healthcare technology is able. **Action**: The chair requested that Matthew Neal to show the Board at RJAH and to have this slotted into the agenda.
Papers submitted for Information and to be taken as read	
IDC-09.10.011	**TWIPP Chairs Report* - Jonathan Rowe** • No update from TWIPP as no meeting in September.
IDC-09.10.012	**SHIPP Chairs Report* - Tanya Miles** • Report received and taken as read.
IDC-09.10.013	**MH LDA Chairs Report* – Cathy Riley** • Report received and taken as read.
IDC-09.10.014	**Vaccination Programme Update – Steve Ellis** • Report received and taken as read.
IDC-09.10.015	**Primary Care Improvement & Transformation Update – Emma Pyrah** • Report received and taken as read.
IDC-09.10.016	**Any Other Business*** • The chair raised that there has been some late submissions of reports to this meeting and if there were issues in reporting to the dates this meeting is held.

	• If this meeting is required to be moved to help meet report deadlines this change can be made. • Jan Heath confirmed that the IDC meetings will be cancelled as one admin has now left the organisation and therefore the meetings will be reissued in order to add papers directly to the meeting invite to reduce email traffic. **Action:** JH to cancel and reissue IDC meeting invites**.**
	Date and Time of Next Meeting – 13th November 2023 14:00 – 16:00

	ACTION / DECISION LOG – OPEN				
Date & Ref No	**Action**	**Owner**	**Date Due**	**Update**	**Completed date**
IDC-09.10.003	**Matters arising and action list from previous meetings*** **Action**: Claire Horsfield will send action updates for action log (A2) to MD/JH.	**CH**	**13.11.23**		
IDC-09.10.004	**Action Log – A1** **Action:** Gareth and Edna to pick up on finding resource to support progression of the booklet in terms of the directory of services to be within the acute within SATH.	**GR**	**13.11.23**		
IDC-09.10.008	**UEC Delivery Board Update – Gareth Robinson** **Action**: Gareth Robinson to ensure a summary paper is submitted to the next UEC Delivery Board (November). **Action**: Chairs report to include the alert around virtual ward with mitigations around the delay in sub-acute ward capacity and non-admitted for performance and overall performance.	**GR** **GR**	**13.11.23** **13.11.23**		
IDC-09.10.010	**HTP Update – Matthew Neal** **Action**: The chair requested that Matthew Neal to show the Board Oswestry and to have this slotted into the agenda.	**HT**	**13.11.23**		
IDC-09.10.004	**Any other business** **Action:** JH to cancel and reissue IDC meeting invites.	**JH**	**13.11.23**	**Complete**	**31/10/23**

	PREVIOUS - ACTION / DECISION LOG – EXTRAORDINARY				
Date & Ref No	**Action**	**Owner**	**Date Due**	**Update**	**Completed date**
IDC-22.09.004	**Investment Panel – Laura Clare** **Action**: Gemma McIver to report any approval from the oversight meeting to the UEC Delivery Board around the anticipated dates on planning assumptions and reopening of beds.	**GM**	**03/10/23**	**All Updated on 12/10/23:** UEC delivery group postponed due to Critical incident. Plan is for all milestone plans to go through Sub-Acute Wards Steering Group, which is Chaired by the SRO Sara Biffen, and then forwarded to UEC Board via SRO sign off to compliment current governance structures.	**On-going 31/10/23**
	Action: Gemma McIver to circulate the revised EQIA through to the UEC Delivery Board once risks and mitigations have been reviewed.	**GM**	**09/10/23**	GMc has emailed Sara B as SRO and updated that: This has been reviewed through our internal SCHT sub-acute wards delivery group so in order to not circumnavigate the governance structure can we take through for further review at the Sub-Acute wards steering group meeting which will then feed UEC Board?	
	Action: Gemma McIver to include Julie Garside onto the oversight meeting next week.	**GM**	**09/10/23**	GMc emailed Sara Biffen as SRO to request that the invite list is extended if she deems appropriate.	**Query**
	Action: Paula to liaise with Michael to receive the task and finish plan that includes consumables kits for purchasing.	**PD**	**09/10/23**	**Outstanding**	

	Action: Gemma McIver to share the Comms plan at the next UEC Delivery Board. **Action**: Sara Biffen to confirm if there are any issues in terms of the expectation from NHSE in terms of the number of beds on what was originally offered and what is being delivered. **Action**: To build the baseline benefits case, with a comparison on the current position and the expected position. **Action**: Review the benefits case 6 months down the line to review. **Action**: Julie Garside to include the milestone plan at the oversight group.	**GM** **SB** **GM** **GM** **JG**	**09/10/23** **09/10/23** **09/10/23** **31/03/24** **09/10/23**	To follow through governance – GMc updated SRO and asked that current comms plan is reviewed initially in steering group. Plan is for Edna who is lead for the sub-acute comms plan to present at steering group then once signed off and supported oversight to share with UEC Board. **Outstanding** **Outstanding** **Outstanding** **Outstanding**	**TBC** **On-going 31/10/23**

	PREVIOUS ACTION / DECISION LOG – OPEN				
Date & Ref No	**Action**	**Owner**	**Date Due**	**Update**	**Completed date**
IDC-11.09.007	**Local Care Transformation Programme | VW Escalations**				

	Action: Simon Froud to send Claire Horsfield the detail of the patients who did not fit the criteria for VW.	**SF/CH**	**09.10.23**	**Outstanding.**	
	Action: CH and S to audit on the single point of access directory of services particularly around care home residents are not leaving care homes in an ambulance unless really needed.	**CH/SF**	**09.10.23**	**Updated on 09.10.23:** Sarah Robinson has linked in to ensure that all is up to date.	**Closed.**
	Action: CH to check if single point of access have a full understanding of VW criteria.	**CH**	**09.10.23**	**Updated on 09.10.23:** VW team linked in with Shropdoc.	**Closed.**
	Action: CH to audit the Shropcomm directory of services to ensure it is up to date and reflects the VW evolution and to contact SPA in terms of theirs to then feedback at the next IDC on timescales and accuracy.	**CH**	**09.10.23**	**Updated on 09.10.23:** Fedback to Octobers IDC.	**Closed.**
	Action: GR will then pick up with Sharon who leads Shrop Doc and other contracting arrangements to ensure auditing are picked up with SPA.	**GR**	**09.10.23**	**Updated on 09.10.23:** Complete.	**Closed**
	Action: CH to provide a booklet in terms of socialising DOS as part of the board/ward round process to ensure awareness on alternatives there are from SaTH to refer out into DOS.	**CH**	**11.12.23**	**Updated on 09.10.23:** CH require an extension of 2 months to complete; action extended (11.12.23).	**ONGOING.**
	Action: SB to link with BL who is doing a piece of work around the improvement resource on a review of the SPA activity, which will be valuable.				
	Action: LG to provide the methodology around the coding tool in terms of referrals with the 2 medical directors from another region for CH.	**BL**	**09.10.23**	**Updated on 09.10.23:** SPA is working well, the quality of data suggests not, on-going work.	**ONGOING.**
		LG	**09.10.23**		**Closed.**

	Action: The chair has requested that CH to bring back to this IDC an update on the following: - the learning that LG can bring in terms of the analytical approach around pathways - what are the pathways that can be built within this, - what we think is the patient's quantum of additional patients could be better cared for through VW due to the constraints of culture, communication understanding - Provide an assessment in October	**LG**	**09.10.23**	**Updated on 09.10.23:** Friday at 12:30pm (1hr) session around sharing learning on coding, pathways, and data etc. **Updated on 09.10.23:**	
IDC-11.09.008	**Planned Care Board – Maureen Wain** **Action**: SB to ensure the new changes mentioned around the 65 week challenges is built into the trajectories/metrics for visibility when it is submitted to the Outpatients Transformation meeting (Wednesday) and Planned Care Board (Friday). **Action**: MW and SB to pick up on the discussions with UH&M collaboration work in terms of cardiology in helping facilitate different options together.	**SB** **SB/MW**	**13.09.23** **09.10.23**	**Updated on 09.10.23:** **MW to pick up at the end of meeting.**	
IDC-11.09.009	**UEC Board Update – Gareth Robinson** **Action:** GR with will provide an update report following Friday's UEC Delivery Board via email for this Committee. **Action**: JG will check the original operational plan to confirm if the sub-acute beds were factored in for 4months of impact and will feedback to SB	**GR** **JG**	**09.10.23** **09.10.23**	**Updated on 09.10.23:** UEC Delivery Board was cancelled, unable to provide. **Updated on 09.10.23:** Complete.	**Closed.** **Closed.**

	Action: SB to report to the UEC Delivery Board (September) on the following areas in terms of the sub-acute move for SaTH and wards; milestone plan, the recruitment/strategy plan, the EIA, risk register and fully detailed business case. **Action**: SB to then provide a summary update following the UEC Delivery (September) to be presented at the next IDC (October). **Action**: LG would like to see sight of the draft press statement and for SaTH colleagues, SF to provide. **Action**: GR will table the concern around unsafe discharges to the operational leads meeting on Wednesday for specific operational responses.	**SB** **SB** **SF** **GR**	**25.09.23** **09.10.23** **09.10.23** **13.09.23**	**Updated on 09.10.23:** Superseded from new action. **Updated on 09.10.23:** Complete. **Updated on 09.10.23:** Complete.	**Closed.** **Closed.** **Closed.**
IDC-11.09.010	**Primary Care Improvement & Transformation Board – Emma Pyrah** **Action**: EP to amend the terms of reference to include the assurance has to go through the Quality and Performance Committee and the IDC oversee the delivery of the extended recovery primary care access. **Action**: The existing IDC terms of reference will need to be updated to reflect that from EP's paper. **Action**: GR and EP will discuss on where type 3 access into A&E is best suited.	**EP** **JH** **GR/EP**	**09.10.23** **09.10.23** **09.10.23**	**Updated on 09.10.23:** EP to discuss the assurance part with Julie as she has returned from leave. **Pending updated ToR for PCITB** **Same as above actions – pending ToR.**	**11/12/23**
IDC-11.09.011	**Financial Improvement Programme – Kate Owen** **Action**: CH will provide an update to GR regarding the identified plans on delivery from Shropcom following the last financial	**CH**	**09.10.23**	**Updated on 09.10.23:** **Discussed on agenda item**	

	improvement group and what will come next at the next meeting and the likelihood of closure. **Action**: Claire Skidmore will check what is captured in the risk register broadly whether that be a finance risk and will ensure that this thread is captured through for clarity. **Action**: GR will link SF to Brett Toro-Pearce to have a discussion around ensuring the spend with CHC is accounted for under the right place.	**CS** **GR**	**09.10.23** **09.10.23**	**Updated on 09.10.23:** **Action to be picked up offline as CS is not online.** **Updated on 09.10.23:** GR has picked this action up.	**Closed.**

Actions from the previous meeting | 14 August 2023					
IDC-14.08.005	**Matters arising and action list from previous meetings** **Action:** The Chair has requested that the MSK £20 million spend to be presented at the 'Planned Care Board' and updates on management of work, works underway and how those land into regular work.	**MW/JB**	**On-going**	**Updated on 14.08.23:** It will go through the Planned Care Board and then to the next IDC (Oct). MW to include within the paper the following: - The current position of the MSK program. - The program of work set out in IDC back in March. - Comparison on what was set out in March to now. - Ensuring the purpose of the above is stated to ensure we are on tack with expected programme of work. - Understand how the £20 million within the medium	**09.10.23**

	Action: Maureen Wain and Jo Banks to work together and update at the next IDC meeting with clarity on the direction to how the £20 million is secured into future medium term financial plans	**MW/JB**	**On-going**	term financial plan is broken down into constituent parts. **Updated on 14.08.23:** This information to be included within the paper that will follow.	**09.10.23**
IDC-14.08.006	**Local Care Transformation – Lisa Keslake** **Action**: Lisa Keslake (LK) to circulate the draft ToR to Committee members. **Action**: LK to action the following areas and to update the recommendations to be bring back to IDC once arranged: 1) The direction of travel needs to be contingent on a clear and understood plan from both IDT, VW and RR and Betty Lodge from the operational groups to understand this is in place. 2) The current program risks are being identified and not in terms of the individual program itself but in terms of leadership, resourcing etc. 3) The UEC Operational group is happy to accept and all mechanics, ToR changed etc. 4) LK will discuss with Betty Lodge in formalising the IDT reporting from LCTP into the UEC forum.	**LK** **LK**	**11.09.23** **11.09.23**	**Updated on 11/10/23:** To be sent separately. **Updated on 11/10/23:** 1) Superseded by forthcoming meeting between GR, PD, LB (16th Oct) re transfer of cohort 1 initiatives from LCTP to UEC. 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. 2) This action would benefit from being split between cohort 1 and cohort 2 noting that cohort 1 is transferring out of LCTP and that cohort 2 is in the process of being scoped/mobilised. Leadership and resourcing arrangements for VW specifically to be discussed as part of meeting on 16th	

	Action: Urgent piece of work for SB / LK to discuss and understand how to improve referrals including: 1) Understand the cause of inappropriate referrals through discussion with clinical leads 2) Understand the scale of opportunity by pathway to determine where to target clinical champions for maximum impact 3) Identify BI resource required to support that data analysis by reprioritising the work of existing available resource 4) Understand the contribution of VW and IDT so far against the 151 beds	**SB/LK**	**11.09.23**	Oct (GR, PD, LB). Leadership and resourcing arrangements for cohort 2 to be covered in scoping process (cohort 2 governance route is to the ICB strategy committee). 3) To be confirmed following 16th Oct meeting (GR, PD, LB) 4) Superseded by forthcoming meeting between GR, PD, LB (16th Oct) re transfer of cohort 1 initiatives from LCTP to UEC. 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. **Updated on 11/10/23:** 1) SCHT to pass feedback to SaTH – owner Claire Horsefield SHCT. 2) SaTH to conduct analysis based on opportunity – owner Sara Biffin SaTH. 3) SaTH/SCHT to advise resource required. 4) Analysis underway by LCTP as part of quarterly review of progress in achieving 'left shift' requirements for HTP– governance route is to HTP	

	5) Understand the slippage on spend within VW that should release additional resource			Programme Board and ICB Strategy Committee. 5) LCTP were asked to undertake analysis of VW spend to date – findings shared with SW and agreed to hand over to Claire Skidmore for further review of accounting and apportionment approaches (this was agreed 22nd September).	
IDC-12.07.011	**Financial Improvement Programme** **Action**: GM/KO to document detail on how communication is managed, clear on various decisions and being able to put them into the plan, risked assessed to provide to Jonathan but to come through to FIP regularly as a degree of confidence; submit first document for 21 August at FIP. **Action**: Jonathan Rowe and Claire Skidmore to document around detail on intervention, value, assumptions on which they have been based on and the impact of making those decisions.	**KO/GM** **JR/CS**	**On-going** **On-going**	**Updated on 14.08.23:** Kate spoke to Shropcomm around the plans that are in place to put forward into the efficiency programme and is awaiting details this week to be able to feedback through into the pipeline. **Updated on 14.08.23:** Related to the discharge funding position the chair will this up with Jonathan and Claire separately.	**09.10.23** **09.10.23**
IDC-12.07.012	**Planned Care Board** **Action:** MW to provide a gap analysis on where we are now, expected position to be, actions to forward to be 'on track' for 2023 – 2024 and some medium term financial plan to be detailed at the next IDC.	**MW**	**11.09.23**	**Updated on 14.08.23:**	

Actions from the previous meeting (July 2023)					
IDC-12.07.004	**Matters arising and action list from previous meetings** **Action: Corporate Services Review –** GR will provide a full update on the escalation and support in completing the data analysis at next month's IDC. **Action**: Note taker to append letter exchange between SF and GR to the minutes of this meeting around services impacted by the Hospital Discharge Funding (HDF) **Action**: MD to include onto the August agenda Hospital Discharge Funding update on impacts of lost capacity and any upcoming risks associated. **Action**: A recovery plan that is required from the planned care board to be reported on next month in terms of providers bridging the gap between the activity levels and the financial benefit (c£250k).	**GR** **MD** **MD** **MW**	**14.08.23** **14.08.23** **14.08.23** **14.08.23**	Delayed pending further discussions with SCHT and SaTH nominated leads	
IDC-12.07.007	**Virtual Ward update – Lisa Keslake** **Action**: LK and SB to pick-up on the following points at the joint SaTH and Shropcomm Provider Transformation Committee: ○ Key measures are to track to reduce the beds on step down referrals, what needs to be looked at are the conversion on length of stay savings and the bed closure savings, which potentially the VW team can assess. ○ In terms of escalation beds, decisions need to be made on the delivery of VW in the output measures of the bed closures. **Action:** GR, JG, SB to perform the assessment of the system operational plan assumptions and if they turn into bed closures.	**LK/SB** **GR/JG/SB**	**14.08.23** **14.08.23**		

	Action: GR and SB to do an assessment of the financial implications of delayed recruitment into vw including IDT and where funding has been used if not on recruitment to be presented at the next IDC in August. **Action:** LK will provide a highlight report to the next IDC for local care in totality and an updated risk register, which will provide visibility on tension points on competing priorities. **Action**: GR and LK to pick up on having some BI resource to the local care programme.	**GR/SB** **LK** **GR/LK**	**14.08.23** **14.08.23** **14.08.23**		
IDC-12.07.010	**Financial Improvement Programme** **Action**: The Chair would like: - To know what the recovery looks like around stretch / low confidence for the importance of the IDC. - To know if the work that has commenced is sufficient to reduce stretch / low confidence next month by £1, £2 or £3 million and to include predictions for the month after. - Detail on the recovery figure to know that it will delivery against the target. - **Action**: Delays on the corporate services side to be picked up with Lorna Gibson tomorrow.	**KO** **GR/KO**	**14.08.23** **15.08.23**		
Actions from the previous meeting					
IDC-12-06.010	**Financial Improvement Programme – Jan Heath** **Action: Corporate Services Review –** GR to escalate to CEOs in light of delays due to challenges in completing the data analysis	**GR**	**10.07.23**	The paper has been drafted for escalation to the chief execs and will be submitted shortly today.	Action paused until tomorrow

					once GR and LG meet.
IDC-12-06.011	**UEC Board Update – Gareth Robinson** **Action**: LT will chase Shropshire Council on an update for the delivery of the Reablement work.	**LT**	**10.07.23**	An updated position will be presented to STW Ops meeting on Wednesday and therefore a paper will be taken to Chief Execs.	**12.07.23**
IDC-10-05.006	**Local Care update** **Action:** LK/GS to discuss the respiratory work and where this currently sits and that priority resource is in place. **Action**: JR requested that LK provide an update at the Telford Wellbeing Board in June 2023.	LK/GS LK	12.06.23 June	Clair Hobbs will confirm and will update GR later today.	14.08.23
	ACTION / DECISION LOG – CLOSED				
Date & Ref No	**Action**	**Owner**	**Date Due**	**Update**	**Completed date**
IDC-11.09.006	**System Operational Plan Dashboard** **Action**: Lorna Gibson to liaise with Julie Garside to firm up the UEC performance metrics with the RSP performance metrics of SaTH.	**LG**	**09.10.23**	**Updated on 09/10/23:** Shared SCPs for Urgent Care at the IRM working group.	**Closed.**
IDC-22.09.004	**(Extraordinary meeting) Investment Panel – Laura Clare** **Action**: Gemma McIver to circulate the revised QIA with members of this Committee. **Action**: Gemma McIver to provide further mitigation in relation to workforce to Lorna around international nursing.	**GM** **GM**	**09/10/23** **09/10/23**	**Updated on 12/10/23:** Circulated to all members of IDC.	**Closed.** **Closed.**

	Action: Gemma McIver and Gareth Robinson to ensure that workforce risks/solutions are communicated not just via SaTH but to all. **Action**: Gemma McIver to provide Gareth Robinson with an update on the when the benefits plan will be complete for IDC, the milestone plan to be submitted to the UEC Delivery Board prior the 3rd October and to include who is leading on it and those required to be involved to ensure it is robust.	**GM/GR** **GM**	**09/10/23** **09/10/23**	GMc & Lorna conversation has taken, and the workforce model has been shared. Ongoing discussions through various forums including UEC Delivery Group and Board and via the Sub-Acute wards steering group. GMc emailed Gareth 09/10/2023 re ICB input and support with benefits realisation and also to update plans on sharing through steering group in line with governance	**Closed.** **Closed.**
IDC-11.09.003	**Minutes from the previous meeting held on 14 August 2023** **Action**: Kate Owen will link in with note taker to amend the anomaly mentioned on page 7 of the minutes around £50 million unidentified plans. **<u>Vaccination Programme</u>** **Action:** GR will bring forward his reporting into IDC vaccination against the expedited timeframes and for JH to let Steve know.	**KO** **GR/JH**	**09.10.23** **09.10.23**	**Complete** **Complete**	**Closed.** **Closed.**
IDC-11.09.005	**IDC Chair's Report (August 2023)** **Action**: The Chair will circulate the IDC Chair's Report (August 2023) so that the committee can approve the report.	**GR**	**Today**	**Updated on 20.09.23:** IDC Chair's report (August 2023) amended and circulated to members of the Committee.	**Closed**
IDC-11.09.008	**Planned Care Board – Maureen Wain**				

	Action: JH to update the Chairs report through to the Board (to note) relating to the position of cardiology, fragility of the service, cancer performance, valuated activity, the impact on the ERF, the issue around October delivery of outpatient bookings and PIFU.	**JH**	**10.10.23**	**Complete.**	**Closed.**
IDC-11.09.009	**UEC Board Update – Gareth Robinson** **Action**: JH to update the Chairs report on the significant risk around the potential ceased services that could result patients not moving through pathways at numbers that are high enough that may cause critical / major incident.	**JH**	**Complete**	**Complete**	**Closed.**
IDC-11.09.012	**Investment Panel Update – Claire Skidmore** **Action**: Maya Dhanda to set-up an Extraordinary IDC meeting in the next week.	**MD**	**09.10.23**	**Updated on 23.09.23:** Action complete; Extraordinary IDC meeting set up.	**Closed**
IDC-14.08.008	**STW MSK Strategy Engagement Day Outputs** **Action**: JB will discuss with Mike Carr on how MSK ties into the phase one plan and a timeline on quick wins. **Action**: Jo Banks will update Mike Carr around the areas that are 'off track' and the significant risk around the investment made with little return. **Action:** Jo Banks to work with Stacey (SRO) and Maureen Wain to reset the MSK program around what was previously signed off as an IDC against the delivery timelines and to submit through the Planned Care Board.	**JB** **JB** **JB/MW**	**Complete** **Complete** **Complete**	**Updated on 14.08.23:** Confirmed by Maureen in absence of Jo and Mike, that the strategy presented at MSK Board was agreed. MW will ensure the above was wrapped up.	**All Actions closed**
IDC-14.08.009	**Vaccination Programme** **Action**: SE to provide the outcome following the request for an equity audit at the Health Protection and Quality Assurance Board to IDC post September meeting.	**SE**	**09.10.23**	**Updated on 14.08.23:** In absence of Steve Ellis, Claire Horsefield gave an update; there has been an acceleration of the	**Closed.**

				vaccination programme, target dates brough forward program starts today. The team were made aware not last week, but the week before, and our formulating plans in order to be able to reach the cohorts. Cohorts of patients have changed, working together with primary care colleagues.	
IDC-12.07.011	**Financial Improvement Programme** **Action**: KO to provide overall summary for ICB senior leadership team for awareness purposes.	**KO**	**Complete**	**Updated on 14.08.23:** Kate updated ICB SLT and will provide awareness.	**Closed.**
IDC-12.07.013	**MSK Transformation ToR – Mike Carr** **Action**: CS will ensure MC receives the detail on the £20 million spend.	**CS**	**14.08.23**	**Updated on 14.08.23:** Clarie Skidmore to meet with Simon Collings and Julie at the end of this week to ensure which spend it is as there are two spends that are there once confirmed which spend it is Jo Bank's to feed information to Mike Carr and MSK Board, as Mike is absent from this meeting today. **Updated 13.09.23 via email response:** Claire Skidmore, Julie G and Simon C met with Mike C and Craig M and talked through the £20m. Julie and	**Closed**

				Simon are now picking up further action with Mike and his team.	
IDC-12-06.010	**Financial Improvement Programme – Jan Heath** **Action:** Financial Deep Dives - GR to update CEOs on proposal to hold financial deep dives for SaTH, Shropcomm and RJAH	**GR**	**10.07.23**	**Updated on 14.08.23:** GR confirmed that financial deep dives have been scheduled for SaTH, Shropcomm and RJAH.	**Closed.**
IDC-10.05.008	**Planned Care Board Update** **Action:** GO to provide a short briefing note to the Chair of IDC on the end of financial year for the 104 and 78 week performance and then a separate briefing note to Chairs and Chief execs on the 78 week breaches.	GO	12.06.23	Complete.	Closed.
IDC-17-04.007	**Digital Costed Plan** **Action**: SS to organise a meeting with GR, MA, LC, RG, NL to discuss funding streams.	SS	Ongoing	SS to arrange meeting asap.	Closed.
IDC-17-04.010	**Financial Improvement Programme Update** **Action**: GR to share the paper on BCF that is currently being prepared for CEO's.	GR	Ongoing	**Updated 12.06.23:** GR will append to the minutes.	Closed.
IDC-23-03.005	**MSK Update** New model of care scoped July 2023: MC to ensure to present a clear update on where the model of care will likely to be, and the impact assessments and workforce and finances	MC	Ongoing 12.06.23	**Update 17.04.23 –** GR to pick up all actions with MC outside of meeting and roll over actions for June 2023.	Closed.

	were there is opportunity to consider whether to accelerate this further into the year and build within the 23/24 plan. Improvements to be made in the model of care for 2023/24. MSK governance is required to be re-written; not fit for purpose for membership and terms of its scope in terms of future work to be done. Resources also to be looked at for the MSK programme – MC to liaise with CS. MC to invite a member from the procurement to sit on the MSK group due to changes to services can change equipment and to meet to ensure no contracts are extended and what the impact is elsewhere. Support needed going forward from ICB for programme and with a real stock take needed with colleagues across the system.	MC/CS MC/PD ALL	Ongoing Ongoing Ongoing	**Update 12.06.23:** Actions were addressed with Mike during the strategy day around the way the model of care and governance comes together.	Closed. Closed. Closed.
IDC-12-06.007	**Operational Plan Delivery Dashboard – Julie Garside** **Action:** JG to circulate month 1 operational plan summary presentation and high level metrics to members of this group.	**JG**			**Closed**
IDC-10.05.008	**Planned Care Board** **Action**: JG to report on a monthly basis on the performance against the system operating plan trajectory at the IDC meetings.	JG	12.06.23		Closed
IDC-10.05.009	**UEC Board update** **Action**: GR to include issues regarding clarity of workstreams and changes within SCHT in the next Chair's report	GR	12.06.23		Closed

	Action: GR to send the Recovery Plan link to JR.				
IDC-17-04.013	**Virtual Ward Performance Update** **Action**: LK to liaise with JG, BL, and SB in developing a benefit reporting framework and discuss with GR prior to submission to the next IDC in May 2023.	GR/LK/JG /SB/BL	12.06.23		Closed
IDC-17-04.003	**Action:** BTI SROs & PMs to confirm through monthly updates that: QIAs are being updated and that the total value of financial benefit including monthly phasing is confirmed. Also, BTI SROs to consider the opportunities to apply stretch financial targets to programmes. **Action:** Check with EB that EQIAs are completed for BTIs at the appropriate point	JH/KO JH/KO	Closed	Complete: Updated IIA now available online	12.06.23
IDC-13-02.006	Local Care: A benefits realisation framework be formally signed off by the LCTP board, HTP, operational teams including SB, LAs (JR and TM), JG on behalf of the system operational planning process and the System Finance Group and brought back to the IDC for final approval. The framework to include a 5-yr programme aligned to HTP setting out both operational and financial impact and the detailed model of the budgets impacted, by how much and when, in terms of growth avoidance and cost out. The framework also to include a monitoring mechanism including KPIs, trajectories and reporting	NL/LK	Closed	**Update 13.3.23** - NL/GR agreed that the timeline for this is no longer necessary as it has been affectively supplemented with the system planning. NL to do a 5-year version for OBC that will need IDC sign off for it to go to the Board in line with the HTP requirements. HTP Business Case to the ICB on 31 May 2023 and to check that timeframes allow to submit	17/04/23

				between ICB and IDC in time as no room for June 2023 sign off. GR and NL agreed on a documented update position in April to know the risks between April and May in closing action down. LK to work on HTP Business Case for ICB 31 May 2023 and to map out Governance timeline to ensure no Committees are missed for sign off.	
IDC-13-02.010	78 week waits GO to share weekly updates on the position to IDC	GO	Closed	**Update 17.4.23** Agreed weekly updates no longer required – action closed	17/04/23
IDC13-02.020	AOB There will be a need to bring forward a paper regarding he potential for an extension of the single point of access service, which will be submitted to the investment panel – GR to brief HT	GR	Closed	**Update 17.4.23** SPA paper scheduled to June IDC	17/04/23
IDC-22-10.008	Digital Delivery Update • Discuss at the Strategy Committee and agree deliverables to sit within the remit of the IDC • GR speak to Nicola Dymond regarding the digital strategy	GR GR	Closed	**Update 13.3.23** - On-going - GR to pick up with ND when she returns from absence. **Update 17.04.23 –** Dr Masood Ahmed can update on the digital delivery update going forwards.	17/04/23

IDC-13-03.004	JH to give information to Alison Smith regarding SHIPP and TWIPP and to build into 2023/24 governance review.	JH	Closed	**Update 17.04.23 –** Started in the last couple of weeks – Jonatan should be in touch from the Governance Institute and to ask JH to link in with AS to ensure that SHIPP and TWIPP were built into the existing Governance review.	17/04/23
IDC-13.03.007	**Provider Collaborative Business Case** GR to liaise with SA to ensure early conversations are being picked up with the provider collaborative work. SA to amend the provide collaborative business case report and to update with the factual information as necessary. GR agreed that Shropcomm 'young children people services' should be included in the provider collaboration work as soon as possible and for AW to be engaged from day one. SA to action this.	GR/SA SA SA	Closed	**Update 17.04.23 –** GR confirmed these actions are now closed.	17/04/23
IDC-23-03.009	**Virtual Ward – Pharmacy and Primary Care related issues** Pharmacy and governance related issues to be reviewed by oversight group and the local care programme to provide assurance. Update on this at next meeting. GR noted there were a list of concerns to be addressed through IDC. AW confirmed that a review of the concerns	AW/LW AW	Closed	**Action completed**	17/04/23

	would be done in line with tomorrow's meeting and an update be provided to the IDC. NL would liaise with and Sara Biffen, Karen Evans and Saskia Perrott-Jones, clinical lead at SaTH to ensure they were up to date with the process. AW and LK to look at reporting and reviewing KPI's on a monthly basis to IDC and also through Q&P Committee. Agreed GR would meet with LK separately to move this work forward in relation to BI support for the programme.	NL AW/LK GR/LK		**Action completed.**	Closed
IDC-23-03.010	**Financial Improvement Programme Update** The agenda item entitled 'financial improvement programme' to be on every IDC agenda as a standing item going forward. The QIA element to ICB system wide to be included on the IDC agenda going forward. KO advised for FIP programmes would go through the QIA process. All programme Board SRO's to ensure that their programmes have gone through a rigorous QIA process and KO to add a note into the FIP update around QIAs which is presented to the IDC. JH to arrange a meeting with finance and operational leads from each organisation to step through each big-ticket item to provide consensus with a quick turnaround. JH also to liaise with colleagues to ascertain the best representative for local care.	SS/SK KO ALL KO JH	Closed	**Action complete.**	Closed.

IDC-23-03.011	**78 week waits** JH would note in the Chair's update that the 78 week wait paper had been received at IDC for information as part of the weekly update.	JH	Closed	**Action complete.**	Closed
IDC-17-04.003	**Minutes of the previous meeting** **Action**: Laura Clare will send an update to the bullet point around 'accounting identifying issue' for agenda item 'Financial Improvement Programme Update'. **Action**: reference to SIP spelling to be corrected to CIP (Cost Improvement Programme)	LC MD/SS	17.04.23 10.05.23	**Complete.** **Complete.**	Closed Closed
IDC-17-04.006	**Outpatients Deep Dive** **Action:** The Planned Care Board update to confirm that the OP benefits model including both financial and activity levels has been completed beyond 2023/24 and that plans are in place to deliver the benefits. Also, to confirm that core efficiency measures (e.g., session utilisation, booking rules etc) are captured and monitored.	GO	10.05.23	**Updated on 10.05.23:** Actions taken to Planned Care Board on 11 May 2023 and will bring back in IDC in June.	Closed.
IDC-17-04.007	**Digital Costed Plan** **Action:** MA to send presentation to JR.	MA		**Updated on 10.05.23:** Met with JR colleagues and starting to align the digital plan with LA's.	Closed.

	Action: Masood to be included in further IDC meetings.	MD		**Updated on 10.05.23:** MD to invite MA to IDC meetings.	Closed.
IDC-17-04.013	**Virtual Ward Performance Update** **Action**: Previous pharmacy and primary care issues raised with VWOG to be addressed in writing and submitted to GR.	LK	21.04.23	Provided to GR on 25.04.23.	Closed.
IDC-10-05.006	**Local Care update** **<u>Virtual Ward updates</u>** **Action**: JG / ICB to provide agreed data set to LK.	JG	12.06.23	Complete.	Closed.
IDC-10.05.007	**Finance Improvement Programme** **Action:** Risk to corporate services review to be included in the IDC Chair's Report for escalation to the ICB	JH	12.06.23	Complete.	Closed.
IDC-10.05.11	**IDC Draft Forward Plan – Gareth Robinson** **Action:** JH to update the IDC Draft Forward plan to include the following items: - HTP deep dive to be removed to avoid doubling up on governance and briefed where appropriate. - Mental Health and LD monthly updates to be included. - CYP to be included occasionally (not monthly). - Outpatients' transformation item to be part of a 'one off' deep dive. - MSK Transformation to be part of a 'one off' deep dive.	JH	12.06.23	Complete.	Closed