WHC LLP Board Papers- Part I

7th February 2020

Wiltshire
HEALTH AND CARE

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Working in partnership
Great Western Hospitals NHS Foundation Trust
Royal United Hospitals Bath NHS Foundation Trust
Salisbury NHS Foundation Trust

Wiltshire Health and Care Board Meeting - Part I
Themed Running Order

Venue:	Training Room 1, Chippenham Community Hospital
Date:	7th February 2020
Time:	10.00-13.00

WHC Board Members in attendance		
Richard Barritt	Interim Chair of Wiltshire Health and Care (Chair)	RB
Douglas Blair	Executive Member, Managing Director	DB
Lisa Hodgson	Executive Member, Chief Operating Officer	LH
Annika Carroll	Executive Member, Director of Finance	AC
Adibah Burch	Non-Executive Member, GP Representative	AB
Rebecca Carlton	Non-Executive Member, Royal United Hospitals NHS Foundation Trust ("RUH") Board Representative	RC
Kevin McNamara	Non-Executive Member, Great Western Hospitals NHS Foundation Trust ("GWH") Board Representative	KM
Lisa Thomas	Non-Executive Member, Salisbury Foundation Trust ("SFT") Board Representative	LT

Also In Attendance		
Katy Hamilton Jennings	Director of Governance and Company Secretary	KHJ
Becky Watson	Corporate Officer (minutes)	BW
Lina Middleton	Patient & Public Involvement Officer (for item 7 only)	LM
Kelsa Smith	Head of IT (for item 16 only)	KS
Claire Robinson	Interim Deputy Chief Operating Officer (for item 6 only)	CR
Ruth Anderson	Physiotherapist, Chestnut Ward	RA

Item No.	Agenda Item	Presenter	Verbal/ Paper	Published/ Unpublished	Information/ Discussion/ Decision
1	**Welcome, Introductions and Apologies**	**Chair**	**Verbal**	**Published**	**Information**
2	**Declaration of Interests**	**Chair**	**Verbal**	**Published**	**Information**
3	**Part I Minutes, Actions and Matters Arising**	**Chair**	**Verbal/ Paper**	**Published**	**Decision**
4	**Chairs Report**	**Chair**	**Verbal**	**Published**	**Information**
5	**Managing Director's Report**	**DB**	**Verbal**	**Published**	**Information**
Patient Focus					
6	**Service Spotlight – Ailesbury and Chestnut Ward Service Transformation**	**CR**	**Verbal / Presentation**	**Published**	**Information**
7	**Patient & Public Involvement**	**LM**	**Paper / Verbal**	**Published**	**Information**

	Plan Update				
Strategy					
8	**Q3 Delivery Plan Update**	**KHJ**	**Paper**	**Published**	**Information**
9	**Primary Care Networks (PCN's) update**	**DB**	**Verbal**	**Published**	**Information**
Service Delivery					
10	**Quality, Workforce, Performance and Finance Highlight Report** a) Quality, Workforce and Performance Dashboards b) Finance Dashboard (December 2019)	**AC/LH**	**Paper**	**Published**	**Information**
11	**IT Network Contract**	**KS**	**Presentation**	**Published**	**Information**
12	**Risk Report 15+**	**KHJ**	**Paper**	**Published**	**Discussion**
Governance					
13	**Emergency Preparedness, Resilience and Response Assurance Report**	**SO/GB**	**Paper**	**Published**	**Information**
14	**Information Governance update**	**KHJ**	**Verbal**	**Published**	**Information**
Highlights and AOB					
15	**Wiltshire GP Alliance Highlight Report - Extended Access contract**	**DB**	**Paper**	**Published**	**Information**
16	**Any Other Business**	**Chair**	**Verbal**	**Published**	**Information**
17	**Next meeting:** 1st May 2020, 10.00-13.00 Keir Room, Melksham Community Hospital				

Wiltshire Health and Care ("WHC")
Board Meeting

Item 1

Welcome, Introductions, and Apologies

VERBAL

Wiltshire Health and Care ("WHC")
Board Meeting

Item 2

Declaration of Interests

VERBAL

Wiltshire Health and Care LLP
Minutes of the Board Meeting - Part I

Venue:	Training Room 1, Chippenham Community Hospital
Date:	1 November 2019
Time:	10.00-13.00

WHC Board Members in attendance		
Richard Barritt (Chair)	Non-Executive Member, Patient Voice	RB
Douglas Blair	Executive Member, Managing Director	DB
Lisa Hodgson	Executive Member. Chief Operating Officer	LH
Annika Carroll	Executive Member, Director of Finance	AC
Sarah-Jane Peffers	Executive Member, Director of Quality, Professions & Workforce	SJP
Adibah Burch	Non-Executive Member, GP Representative	AB
Jim O'Connell	Deputy Non-Executive Member, Great Western Hospitals NHS Foundation Trust ("GWH") Board Representative	JO
Mark Ellis	Deputy Non-Executive Member, Salisbury Foundation Trust ("SFT") Board Representative	ME

Also in attendance		
Becky Watson	Interim Corporate Officer	BW
Giles Peel	Managing Director of DCO Associates – ***for item 10 only***	GP

Apologies		
Carol Bode	Non-Executive Member, Independent Chair	CB
Lisa Thomas	Non-Executive Member, Salisbury Foundation Trust ("SFT") Board Representative	LT
Rebecca Carlton	Non-Executive Member, Royal United Hospitals NHS Foundation Trust ("RUH") Board Representative	RC
Kevin McNamara	Non-Executive Member, Great Western Hospitals NHS Foundation Trust ("GWH") Board Representative	KM

Item No.	Agenda Item	Action Lead
1	**<u>Welcome, Introductions and Apologies</u>** RB welcomed attendees to the meeting. It was noted that apologies had been received from CB, RC, LT, and KM. However, LT and KM had arranged for deputies to attend on their behalves to represent SFT and GWH. There was no deputy in attendance to represent RUH. As such, the Board was not quorate for the purposes of formal decision-making, and it was therefore noted that any decisions made by attendees at the meeting would be subject to the subsequent approval by an RUH representative.	
2	**<u>Declaration of Interests</u>** RB asked Board members to declare any new interests. No new interests were declared.	

	It was noted that relevant interests of the deputies (JO and ME) had been recorded prior to the meeting. No conflicts of interest had been identified in relation to matters covered by the meeting agenda.	
3	**<u>Part I Minutes, Actions and Matters Arising</u>** **<u>Part I, Minutes</u>** Board members confirmed that the 'Part I' minutes of the previous meeting were a true and accurate reflection of the discussions held. It was therefore noted that these could be approved, subject to RC also confirming her approval by correspondence. **ACTION: ADMIN to seek RC's approval to the Part I minutes.** **<u>Part I, Actions</u>** The Board considered the 'Part I' action tracker. The following updates were noted: • **Action 79 (Audit Committee)** – It was noted that the issue giving rise to this action had been explored as part of the externally-facilitated well-led review, which the Board would discuss later in the agenda. • **Action 107 (Implementing a process to update physiotherapy patients that their referral had been received, and what to expect)** – LH advised that she was scoping the viability of the service sending out a text message to patients at the time their appointment was arranged. A business case for this was due to be brought to the Executive Committee for decision in December 2019. • **Action 121 (Risk regarding winter planning to be recorded on the operational risk register)** – It was noted that this action had been completed on 10 September 2019 and could therefore be closed. • **Action 122 (DB to write to the CCG to convey capacity concerns regarding winter planning)** – It was noted that this action had been completed on 16 September 2019 and could therefore be closed. DB advised that the CCG had acknowledged WHC's letter regarding capacity to support winter, and the letter had been a helpful mechanism to prompt system discussions on this issue. • **Action 123 (Agency forecast and effect on cashflow analysis)** – It was noted that this action had been completed in October 2019, and could therefore be closed. **<u>Part I, Matters arising</u>** There were no matters arising.	**ADMIN**

4	**Managing Director's Report** DB advised the Board that he had been involved in two key developments this quarter: • **Winter risk summit** – DB attended a Winter Risk Summit event to review the risks winter pressures posed to the Wiltshire system. It was noted that the outputs from the Winter Risk Summit meeting would be discussed later in the Board agenda, as part of the Winter Plan item. • **Long Term Plan for BSW** – DB advised that the BSW STP[1] was required to produce its own Long-Term Plan for submission to NHS Improvement and NHS England. As part of the planning process, DB advised that he had attended a meeting with the combined NHS England/ Improvement regional team on Monday 21 October, to support the development of the plan. It was noted that this topic was also due to be discussed later in the Board agenda, as part of the specific BSW LTP item.	
Scrutiny		
5	**Service Spotlight - Community Oxygen Services** SJP presented a "Service Spotlight" item, to explain the current situation with regards to oxygen service provision across the county. As part of this presentation, SJP highlighted the potential opportunities for improvement. SJP advised that she had selected to highlight this particular service area as: A. WHC's Delivery Plan for 19/20 included an objective to present a 'case for change' to the CCG with regards to expanding the provision of oxygen services in Wiltshire so that it covered the South of the county. B. This was a service area where a deeper understanding of the current situation by the WHC membership, and their consequent contribution and support to the case for change, would be beneficial. In terms of background, SJP advised that WHC presently ran a combined community COPD/ respiratory service. Since 2013/14, Wiltshire CCG had commissioned an Oxygen service in the north and the west of the county only. This being on the basis that SFT provided the community service to the south of the county. The Board was asked to note the current exclusions for the service. SJP delivered detail on: the current activity within the oxygen service; the range of patient types seen by the service; a sample of patient feedback; the financial costs (highlighting that oxygen provision costs had decreased by circa £60,000 per annum since January 2017); and the challenges – particularly noting the limited capacity within the service, and the fact that there were no commissioning arrangements in place to follow up patients with prescribed oxygen, but without a COPD diagnosis. SJP advised the Board of the clinical impact of prescribing oxygen to a COPD patient who did not need it, and flagged the high risk posed to patients and their families where a patient receiving oxygen continued to smoke. SJP prompted	

[1] Bath and North East Somerset, Swindon and Wiltshire Sustainability and Transformation Plan ("BSW STP").

	that, in both scenarios, it was important to follow-up patients receiving oxygen therapy to identify these risks, and to support an appropriate response. The Board noted that WHC was now reporting a greater number of incidents relating to patients who continued to smoke whilst on oxygen. SJP explained that there was not only a commissioning gap in relation to patient assessment and follow up for oxygen therapy, but also in relation to patients requiring non-invasive ventilation. SJP explained that, where an on-going assessment for non-invasive ventilation was required, at present, this could only be undertaken in the centre where it is initially prescribed and this is often a tertiary centre or GWH – emphasising that there was currently no support in the community for this. As a result of these accessibility difficulties, patients often did not attend their scheduled appointments. SJP presented two patient scenarios to the Board to support their greater understanding of the patient experience: • Patient B: A real-life patient on non-invasive ventilation, who had been visited by the WHC COPD/ respiratory team the previous day. This was an anxious patient living in the middle of Wiltshire, who had great difficulty getting to Bristol for follow-up appointments. SJP advised that as currently constituted, the community team did not have the skill-set, the specialist equipment or capacity required to monitor a patient on non-invasive ventilation. But they could, and this would save the patient the trips to Bristol, and potentially improve their quality of life. • Patient A: An individual who required non-invasive ventilation and oxygen, who had continued to smoke whilst on oxygen and non-invasive ventilation. They had high levels of primary care and ED attendance. The patient had been admitted earlier in the year, but had sadly passed away. Caring for this patient was complex, across multiple organisations. SJP explained that in respect of patients like this example, more could be done in the community – including using the community team in a coordinating role. JO queried whether there had been any demand analysis for oxygen services performed; based on risk stratification. SJP confirmed that data was available on patients currently receiving oxygen, but assumptions would need to be made with regards to increasing demand. JO also queried whether a patient could end up in a hospital bed because of their oxygen needs. SJP confirmed that a patient with oxygen needs would often be admitted to an acute hospital's high cost beds (ICU/ HDU) on the basis that if their CO_2 levels were elevated, they would need ventilation. The Board also noted the COPD care bundle that had been supported by the AHSN network, and it was noted that it was important to use that vehicle to get it right for the patient. JO queried whether the team could flex during the winter/ expand to take on additional capacity. The Board noted that there could be an opportunity to improve the capacity by linking with the rapid response team of the future. JO confirmed that he supported the development of a business case demonstrating the additional capacity needed to support the relevant demand;	

	such business case to clearly articulate the level/skill-set at which support was needed. To summarise the discussion, and it was noted that there were three areas that could benefit from improvement in this service area: 1. Resolving the inequity in the south that had occurred because of the commissioning history. 2. Considering where additional resource (skills/ capacity) could be placed in the community to support patient follow-up/ assessments, so as to reduce exacerbation/ risks. As well as considering support for people on NIV. 3. Ensuring the right use of oxygen in the system – broader, future population need., and to include oxygen support for people who require it for other conditions In terms of point 1, SJP confirmed that she was looking to SFT engage with community services to help define what could be done to expand the provision of the service to the South. ME agreed to take this question back to SFT to prompt an operational discussion. ME advised that the SFT respiratory team had been highly engaged with the AHSN. **ACTION: Mark Ellis (SFT Deputy) to convey the Board conversation regarding oxygen services to the SFT respiratory team to prompt their engagement with WHC in relation to building the case for resolving the inequity of oxygen service provision in the South.** RB queried whether the CCG would be surprised to hear the content of the discussion. SJP advised that she had conveyed these messages to the commissioners as part of contract review discussions the previous month. In terms of points 2 and 3 above, it was noted that this agenda item had highlighted the need to attain more evidence to support future proposals. It was noted that data to inform demand modelling should be available to build a broader business case. In addition, support was requested from the acute members on where they perceived the gaps to be – to inform a broader business case. It was agreed that the final case should articulate the benefits to the system and the patients being treated within the system. It was also noted that it was also important to aim for a parallel service between Swindon community and Wiltshire community. RB sought confirmation of when the Board would receive an update on the progress made in this area. DB confirmed that this would be provided to the Board each quarter as part of the delivery tracker update.	**ME**
6	**<u>Quality, Performance and Finance Report</u>** **<u>Quality of services</u>** SJP drew the Board's attention to the following key points from her quality highlight report: • **Datix** – Whilst WHC had been experiencing challenges in optimising Datix as	

	the new clinical management system, most anomalies had now been resolved. Crucially, WHC was now able to submit National Reporting and Learning System (NRLS) data. • **Duty of candour** – WHC was not reporting 100% across all areas, and, to address this, the quality team was working through the approach to candour with team leaders to investigate the rationale for the sub-optimal compliance. SJP confirmed that a further update would be provided to the Board if there were any concerns following that investigation. • **Incidents** – WHC had experienced an increase in medicines incidents in quarter two of this year, none of which had resulted in patient harm. SJP advised that this situation was being closely monitored by the Senior Nurse and Medicines Optimisation Pharmacist, and further processes for oversight had been implemented. SJP proposed that E-prescribing may be one solution as it would provide an extra layer of safety by reducing human error and providing prompts. SJP advised that central funding had been available to support some acute trusts to put in place E-prescribing, but community providers did not qualify for the funding at that time. In the meantime, SJP advised that an additional Medicines Optimisation Pharmacist would be starting with WHC in November 2019, and a key priority area for this person would be to develop and implement a WHC self-administration policy across in-patient areas. Board members queried what additional actions WHC could try to access funding for E-prescribing. LH advised that the delivery plan included an objective to seek agreement for a business case for use of SystmOne on the wards, and that this would be a necessary first step before being able to implement E-prescribing. AB queried the root cause of the overdue incidents, and both SJP and LH advised that there were a variety of contributory factors. To support more timely resolution, SJP advised that there was currently a focus on ensuring each incident had a clear lead, responsible for investigating and closing the incident. • **Workforce** – SJP advised that Oxford Brookes had agreed to once again support nursing student placements in Ailesbury unit. **<u>Financial performance</u>** AC drew the Board's attention to the following key points from her finance highlight report: • **Agency usage –** In September 2019, WHC saw a reduction in agency usage for the first time in 9 months. The same month saw an increase in permanent staffing levels. Overall, this reflected the efforts made across the Safer Staffing work streams, which now included a restriction for agency usage to cover HCA vacancies. AC confirmed that pressure continued to exist from enhanced care requirements on the wards and she was due to discuss this additional pressure with the CCG. • **Single Oversight Framework (SOF) -** NHSI had asked WHC to carry out and present the prescribed SOF calculations in relation to its financial performance. As such, WHC had started doing this. • **Cash flow table –** The cash flow table presented by WHC now included the adjusted cash level excluding Estates as well as the agreed minimum cash	

	tolerance level. There was now clarity as to where the soft FM estates contract should sit. It had been agreed that GWH would hold the contract for 18/19; 19/20. Cash would flow per this arrangement. • **Forecast –** The forecast in the M6 finance report had now been updated to include best case; worse case; and most likely scenarios. AC advised that within the forecast, the highest risks came from agency and estates. Should agency continue at the levels it was at present, and if no extra support for enhanced care could be agreed with commissioners, then the worst-case forecast could play out. LH emphasised that WHC did not restrict access to beds due to agency costs to ensure capacity within the system was maintained. This was why controls around agency usage and agency costs were being scrutinised and maximised through the Safer Staffing programme as highest priority. **Performance** LH drew the Board's attention to the following key points from her performance highlight report: • **Patient flow** – The weeks commencing 14 and 21 October saw the highest number of patients waiting for access to community capacity. To support flow, three community made events had occurred in the month, resulting in 35 discharges and improved flow. LH confirmed that these events would be at least bi-weekly from the second week of November 2019. In addition, agreement had been reached in relation to Acute Trust Liaison Staff working directly with WHC throughout winter. LH advised that this would provide the opportunity to clarify the conditions for Home First; to develop the criteria and work closely with IDS colleagues to ensure there was a common understanding and approach. • **Red 2 Green** – The implementation of red 2 green had commenced on Ailesbury and Chestnut units. This was having a positive impact in terms of activities for patients, but the benefit of reduce length of stay had not yet been seen. LH explained that the delays in inpatient beds were largely due to high numbers of patients waiting for packages of care and/or long terms placements. • **Wheelchair services** – LH advised that the CCG had accepted WHC's improvement plan and trajectory in relation to waiting times for wheelchair services, and were actively working with WHC to revise the service specification for the service, and to develop the use of personal wheelchair budgets.	
7	**Risk Report** KHJ drew the Board's attention to the following key parts of the risk report: • **Total risk profile** – The total number of risks on the WHC risk register had decreased from 71 to 65 during the quarter. • **12+ risk profile** – The number of 12+ risks had decreased from ten to five in the quarter on account of the completion of a number of key action plans reducing total risk scores. Two 12+ risks had been closed in the quarter; the risk relating to audit scrutiny, which had been transferred to the strategic risk	

	register; and the risk relating to lack of medical cover on Ailesbury and Chestnut units, which had been resolved completely due to the employment of medical staff. • **New 12+ risks** – One new 12+ risk had been added to the risk register in the last quarter, in relation to which the Board was well-versed (the capacity of WHC to provide additional support to the system in winter). This risk held a score of 16, and was sitting as the organisation's highest risk. The Board noted the current risk profile for the organisation, and confirmed it was content with the level of risk held by WHC in the circumstances, and WHC's management of the highest risks. JO queried how the risks being managed by the Member trusts were taken into account by WHC in evaluating its own risks. JO provided the example that GWH had a high scoring risk around DTOCs, and queried how that translated into the risks of WHC. DB acknowledged that the question regarding how system risks were appropriately captured was a valid one. Similarly, how service-risks reflected the interrelationships between organisations within the system. It was therefore agreed that consideration would be given to how WHC considered the broader system risks and reflected those in its own analysis of risk. **ACTION: WHC Executive team to consider how the major system risks are reflected in WHC's own analysis of risk.**	**DB/ KHJ**
8	**<u>Delivery Plan Tracker</u>** The Board noted the content of the Delivery Tracker, and the current state of progress against the defined actions. It was noted that of the 101 objectives, 24 were complete; 25 were on track for completion by the target quarter; 40 were on track for completion by the end of19/20; 8 were unlikely to be achieved by the end of 19/20; and 4 were no longer being pursued. *Red objectives:* When compared with the progress reported at the previous Board, it was noted that one additional objective had been flagged as red (objective 1.4.5). This objective related to the design of a falls pathway across Wiltshire, linked to the development of a rapid response service for the county. This objective had been classified as one that was dependant on endorsement by the CCG, and it was noted that the CCG had made it clear that they did not wish to commission a falls pathway until wider work had been carried out to scope the rapid response pathway (which would not be finalised in 19/20). In relation to the majority of the other red actions, it was noted that progress had been paused on account of decisions taken by the CCG. The Board noted this update. *Grey objectives:* One additional objective had been flagged as grey since the report in the last quarter (objective 3.5). This was on account of a more streamlined approach being proposed for the pursuit of sustainability objectives. The Board noted, and endorsed, this action being converted to grey.	

9	**Quality Assurance Committee Highlight report** SJP advised the Board that the Quality Assurance Committee had met on 18 October 2019. Both CB and RC had been in attendance, alongside SJP, LH, and KHJ. The key feedback from the meeting was reported to be: • The Committee was giving consideration to how quality data could most effectively flow within the organisation; through the Executive Committee; through the Quality Assurance Committee; and on to the Board. A workshop to consider this information flow had been diarised for 13 November 2019. • The Committee noted that a key priority for the organisation was how it developed its process for mortality reviews. The Committee noted that WHC was linked in with STP-wide conversations on this topic, and support was being received from Dr Chris Dyer, WHC's Medical Advisor, to help develop this process. The Board noted this update.	
Strategy		
10	**BSW Long Term Plan** DB reminded the Board that the BSW STP was required to provide a system response to the national Long-Term Plan for the NHS. In terms of the progress with that requirement, DB advised that the BSW STP Sponsor Board were convening an extraordinary meeting on Friday 8th November to formally sign-off their plan. A copy of a slide pack summarising the plan had been circulated to DB, which he projected so that this could be observed by Board members. The Board noted that the slide pack was 60-pages, and therefore it would not be possible to consider its content in full during the meeting. Accordingly, DB highlighted some key areas of the plan: • The Board noted that the STP had put forward an expression of interest to NHSE for Wiltshire to be an accelerated site. • The STPs top three priorities were noted to be: (1) Ageing well; (2) Learning Disabilities and Autism – noting that WHC has a Learning Disabilities team that needs to be appropriately knitted into the wider system; and (3) Mental health. • The STP's tops three priorities were to be underpinned by four foundational workstreams: (1) People; (2) Digital; (3) Population analytics; and (4) Estates. The Board noted the above update, but to ensure that the Board had a deeper understanding of the BSW STP's plan, RB asked DB to circulate the plan, together with a note highlighting those aspects of the plan that Board members should note or be concerned about. DB agreed. **ACTION: DB to circulate the BSW STP Long Term Plan to Board members,**	

	highlighting items that the Board should note/ be concerned about.	**DB**
11	**<u>WHC Winter Plan</u>** LH presented WHC's winter resilience plan for 19/20. LH advised that the version of the plan circulated as part of the Board pack had now been updated to take into account further decisions reached during the 'Winter Risk Summit', that took place following the circulation of Board papers. This additional detail was shared with the Board. LH explained that the winter plan acts as a live document, and as issues arise, the document is updated. LH highlighted the following key aspects of the WHC winter plan, together with highlighting the additional funding that had been agreed for community to support in winter: • **OPEL status** - WHC had proposed changing the basis on which its OPEL[2] status is measured. LH explained that, at present, WHC's OPEL status takes a view across the entire organisation. However, the feedback from acute providers, particularly SFT, had been that it was most relevant to appreciate the status of WHC's step down capacity at any time. As such, WHC was proposing to amend its OPEL status so that it reflected step-down capacity only. LH advised that if this change were to be approved, this could have a knock-on impact on the system's OPEL status, so this needed to be borne in mind. • **Flu** – LH advised that WHC's flu campaign had now started. • **Savernake beds** – Savernake beds that were brought into use in January 2019 were now permanent beds in 19/20. • Additional step-down beds had been agreed in the South. • Wiltshire council will be running discharge to assess beds, but these are expected to have an impact on pathway 2 flow. • **Additional resource to support home first pathways** – Funding for an additional 360 hours of support, per week, had been promised to support home first pathways. In relation to this scheme, JO asked whether, if these additional hours were successful, whether there would be scope to add more during the winter if this was deemed to be the best use of limited resources. Alongside this, three therapy posts (one for each locality), had been agreed to support the extra hours. • **Acute Trust Liaison** - It has been agreed the Acute Trust Liaison (ATL) staff would undertake an 'induction to community', and work under the direction of the WHC flow hub during this winter. LH advised that it was incredibly important to ensure patients were supported by the most appropriate pathway first time. LH explained that the ATL staff would be supported by a very	

[2] Operational Pressures Escalation Levels ("OPEL").

	experienced WHC nurse, who would direct the ATL resource. • **Trial under discussion with Wiltshire council in relation to "one decline" for an ICT bed**. RB asked LH to explain in one sentence how WHC was better equipped to support patients in winter this year compared with last year. LH advised that WHC would have access to more capacity this winter than last. It was noted that both DB and LH would support the WHC flow hub regularly throughout the winter. RB thanked LH for the update, and requested that LH circulate the updated version of the winter plan to Board members for formal approval. **ACTION: LH to circulate the latest version of the Winter Plan with board members for formal approval.**	**LH**
Governance		
12	**Any Other Business** No other business was raised. RB thanked attendees for their time and contributions to the Board discussions, and closed the meeting.	
Next Board meeting: **7th February 2020, 10.00-13.00** **Training Room 1, Chippenham Community Hospital**		

Part I

Wiltshire HEALTH AND CARE

NHS

Wiltshire Health and Care
Board Action Tracker

Please note that this tracker may have a filter switched on so that only "open" actions are visible.

N	Date Entered	Action	Assigned to	Status	Due date	Date closed	Notes
79	23.01.18	**Audit Committee chair** Agree a strategy for ensuring WHC can access an independent Audit and Assurance Committee chair.	CB	Can be closed			29/01/2020 - members meeting held on 28/01/2020 endorsed a revised board structure to include an independent non executive with financial expertise who could act as audit and assurance committee chair
107	03/05/2019	LH to implement a process of updating physiotherapy patients that their referral has been received and what to expect.	LH	Open	Jan-20		25/10/2019- Currently putting together a business case for a text message to be sent on receipt of a referral. This will come to the Executive Committee by December 2019.
125	01/11/2019	Mark Ellis (ME) to convey the Board conversation regarding oxygen services to the SFT respiratory team to prompt their engagement with WHC in relation to building the case for resolving the inequity of oxygen service provision in the South.	Mark Ellis (SFT deputy rep)	Open			29/01/2020 Email to ME to follow up
126	01/11/2019	WHC Executive team to consider how the major risks of its members are reflected in WHC's own analysis of risk	DB / KHJ	Can be closed			We will ensure that system impact, and therefore impact on member trusts, is clearly documented in relation to risks identified in WHC. Otherwise system risk is held by A&E delivery board and the STP.
127	01/11/2019	DB to circulate the BSW STP Long Term Plan to Board members, highlighting items that the Board should note/ be concerned about.	DB	Can be closed			Sent on 04/11/2019
128	01/11/2019	LH to circulate the latest version of the Winter Plan with board members for formal approval.	LH	Can be closed			This action was to integrate the actions agreed at the winter summit into the draft plan shared with board members in advance of the meeting, and then to circulate the combined document for approval. The technical fomalilty of signing off didn't happen, but the Board had approved the content in the meeting (so the substance of the final plan had been endorsed by the Board).

Wiltshire Health and Care ("WHC")
Board Meeting

Item 4

Chairs Report

VERBAL

Wiltshire Health and Care ("WHC")
Board Meeting

Item 5

Managing Directors Report

VERBAL

Wiltshire
HEALTH AND CARE

NHS

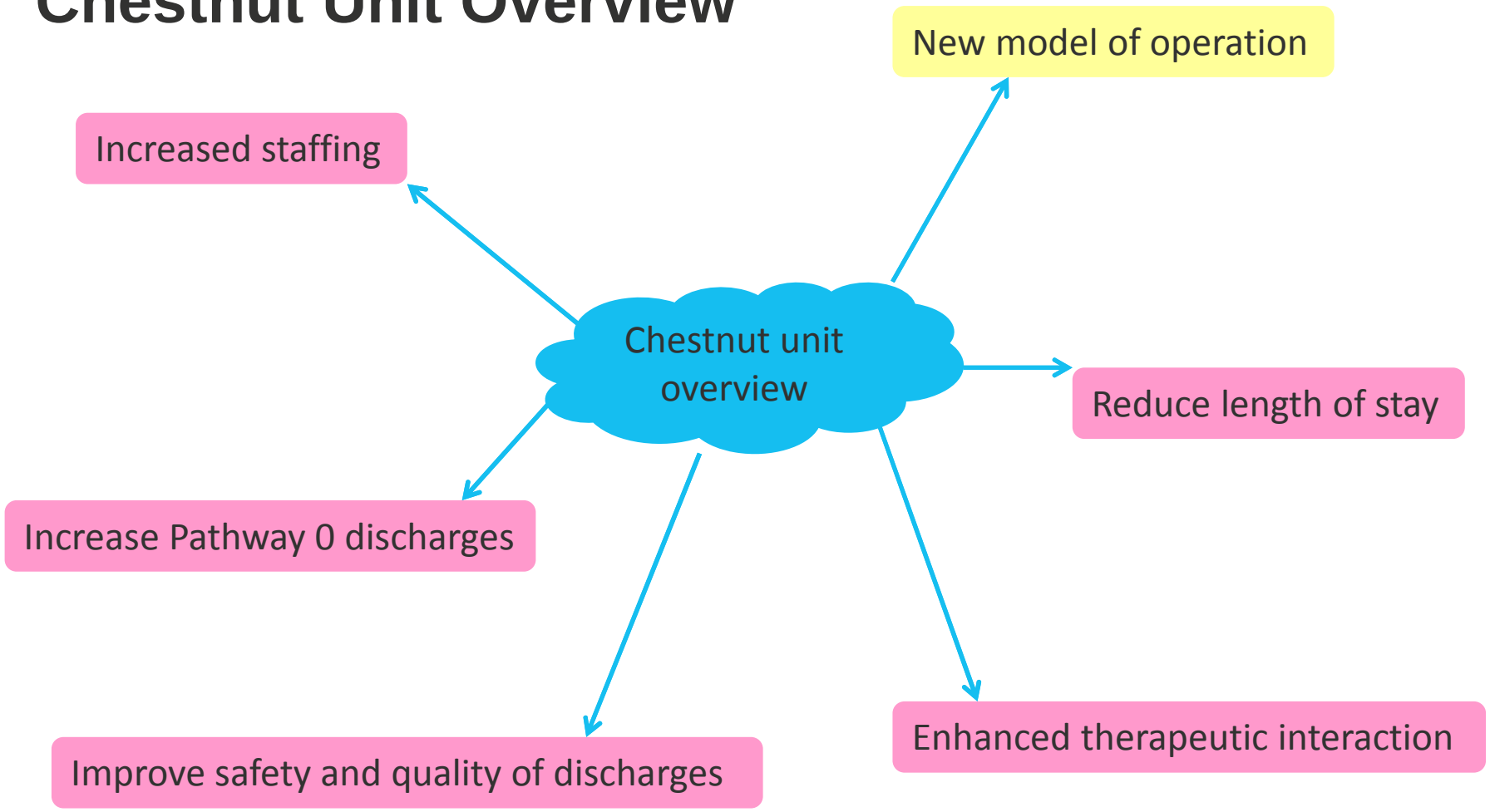
Chestnut Therapy

Presented by Clare Robinson & Ruth Anderson

Wiltshire HEALTH AND CARE

NHS

Chestnut Unit Overview

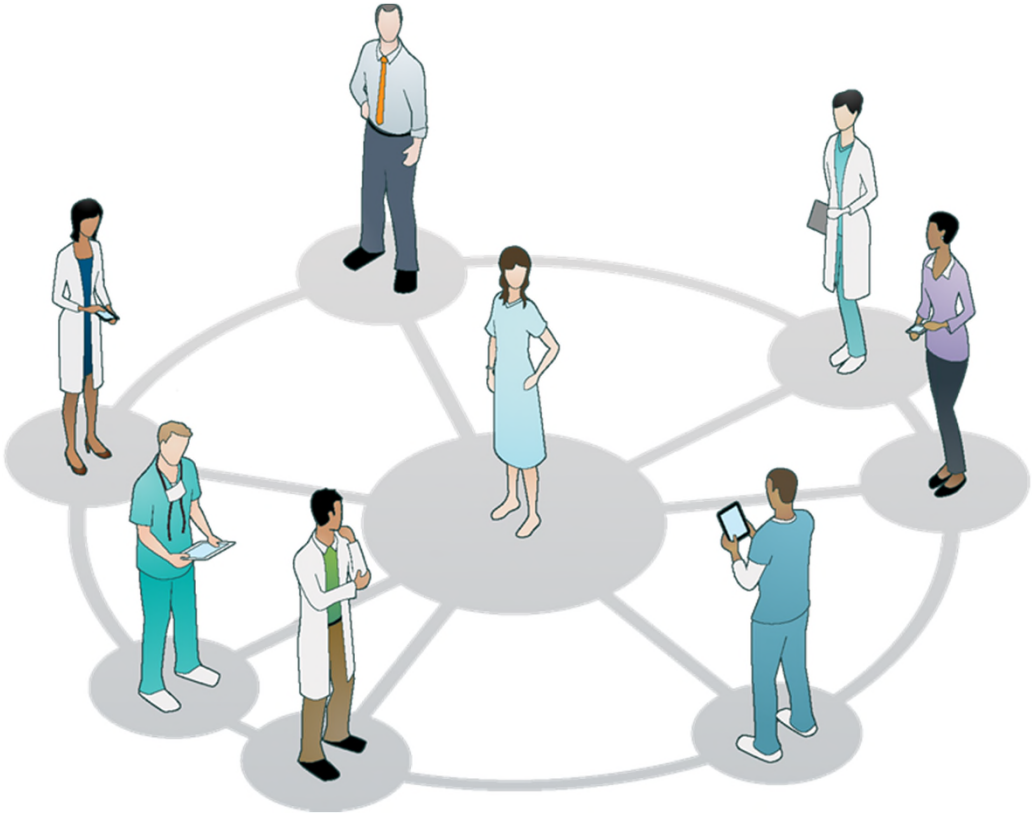


Wiltshire HEALTH AND CARE

NHS

Our Values

- **Patient Centred**
- Enablement
- Promoting Independence
- Fulfilment
- Proactive
- Resourceful
- Creative
- Fun!!!!



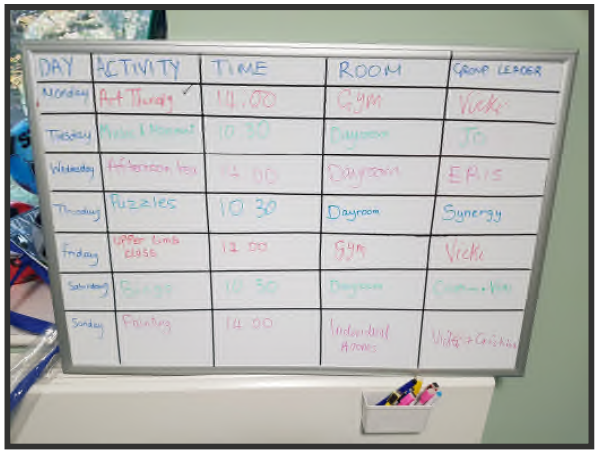
Staff

- ↑ Therapy Staffing Levels
- ↑ therapy time for patients
- Multidisciplinary Teaching
- Team work
- Fun!!

Wiltshire HEALTH AND CARE

NHS

Activities



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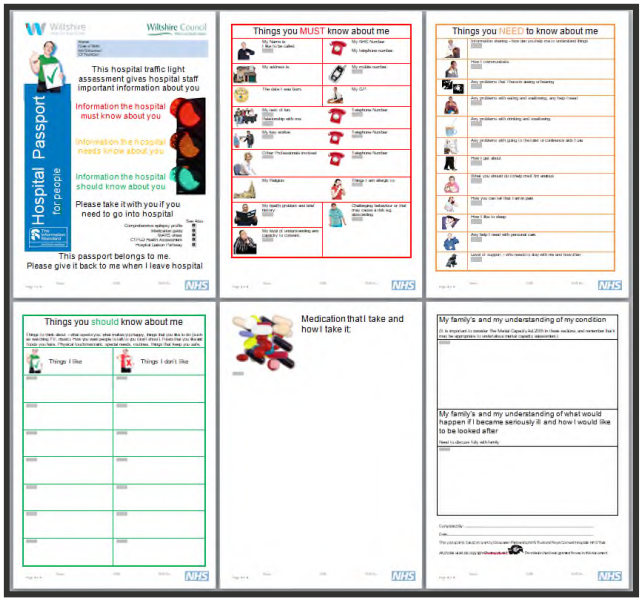
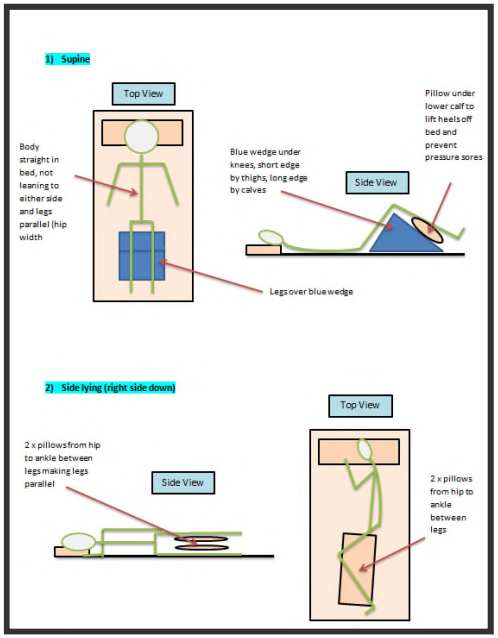
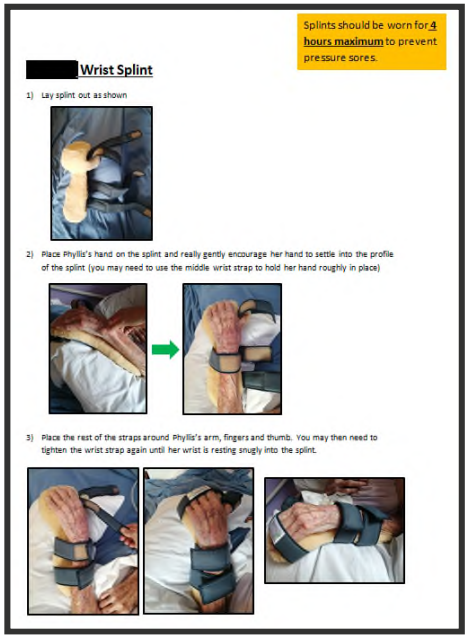
Therapy







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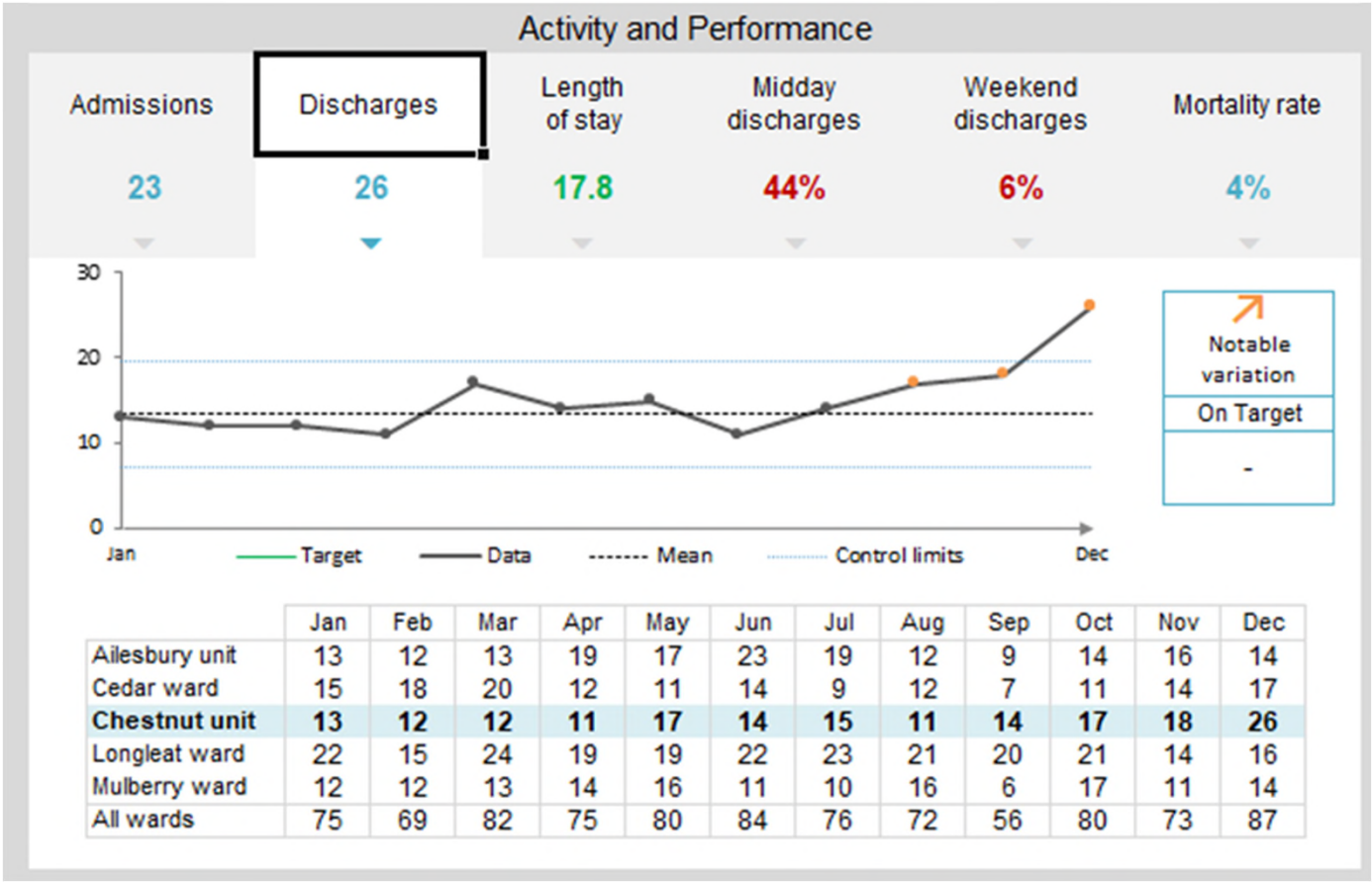
Discharges



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Ailesbury unit	13	12	13	19	17	23	19	12	9	14	16	14
Cedar ward	15	18	20	12	11	14	9	12	7	11	14	17
Chestnut unit	**13**	**12**	**12**	**11**	**17**	**14**	**15**	**11**	**14**	**17**	**18**	**26**
Longleat ward	22	15	24	19	19	22	23	21	20	21	14	16
Mulberry ward	12	12	13	14	16	11	10	16	6	17	11	14
All wards	75	69	82	75	80	84	76	72	56	80	73	87

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Going the Extra Mile

Case Study 1: Liaison with Orthopaedic Team

Case Study 2: Knee Fixed Flexion Deformity

Case Study 3: Cognitive Rehabilitation

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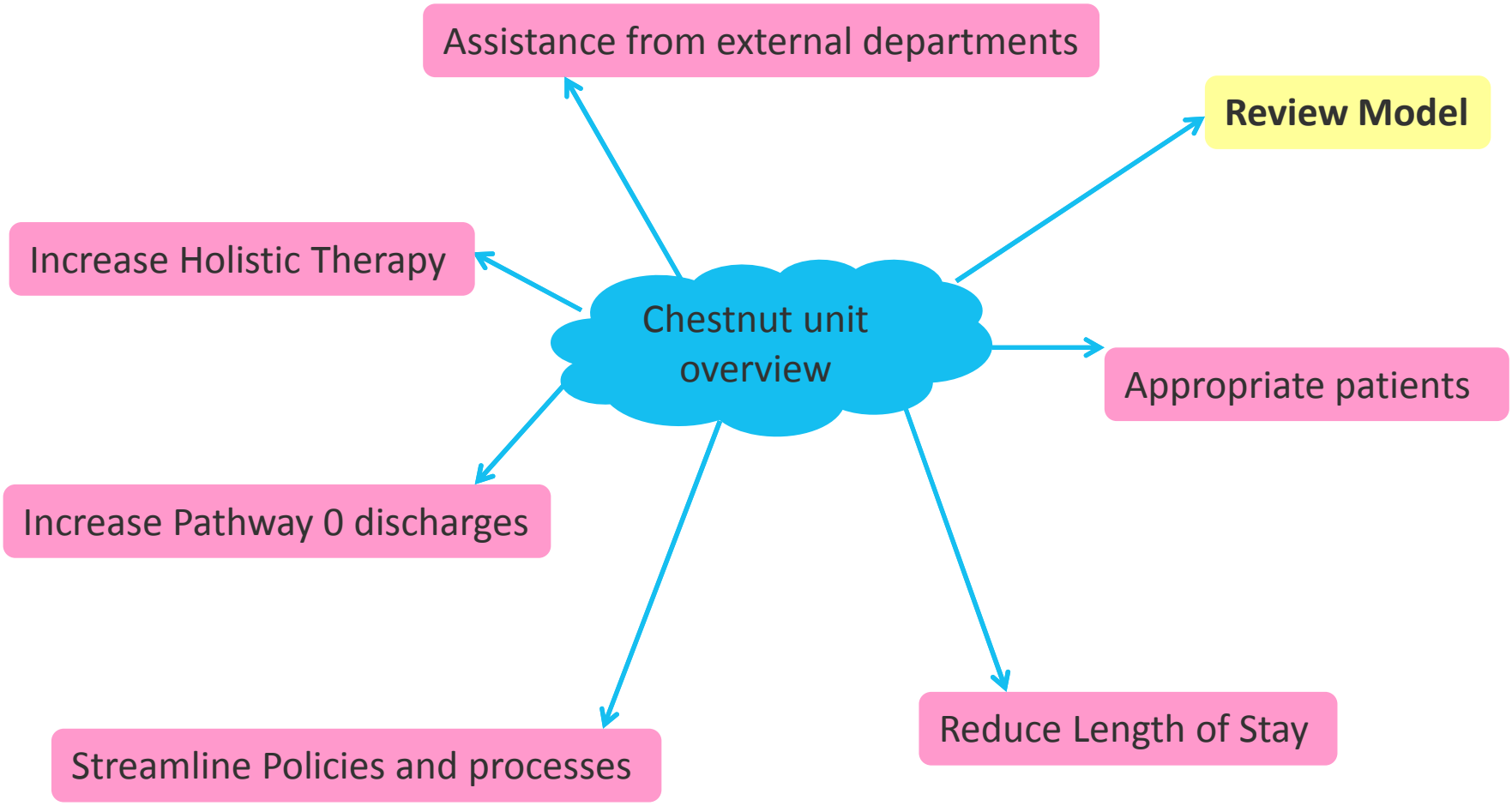
The Future



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Patient & Public Involvement Update

Delivery Plan

Main focus has been to create a strong foundation and get things in place in order to be able to deliver the PPI plan.

This has included:

- Understanding what mechanisms currently in place within Wiltshire Health and Care re PPI
- Ensuring robust interim FFT system in place
- Staff engagement and support
- Understanding E&D across Wiltshire Health and Care patient cohort
- Understanding and applying IG and consent
- Networking/finding support and partnership engagement

Objectives for 2020/21

Actions going forward:

- Embed FFT within all teams across Wiltshire Health and Care, improve return rates!
- Increased staff awareness/engagement
- Expanding network, collaboration with external organisations and their patient groups
- Developing databases for both patients and stakeholders that meet with IG and consent criteria
- Develop our own patient group.
- Review website – look to improve accessibility, navigation and content

Progress Report: Wiltshire Health and Care Delivery Plan, 2019-2020

Meeting:	**BOARD**
Date of Report:	**7 FEBRUARY 2020**

RAG key:	
	Delivery milestone achieved.
	Delivery milestone on track to be completed by target quarter.
	Delivery milestone off-track to be completed by target quarter, but actions in place to achieve milestone by the end of 19/20.
	Delivery milestone off-track to be completed by target quarter, and milestone unlikely to be achieved by the end of 19/20.
	<<NEW>> Delivery milestone off-track to be completed by target quarter, but actions in place to achieve milestone in 20/21.
	Delivery milestone no longer applicable because of national decision making/ other.

Type of objective key:		
Transformation (T)	•	Specifically funded transformation resource leading the delivery of the objective under the steer of a Programme Board sponsored by a member of the Executive Committee. Detail on the progress of these programmes provided as part of this report.
Project (P)	•	Organisational project resource supporting the delivery of the objective under the steer of a senior manager. In addition to project reporting, progress will be tracked through this report.
Service Development (SD)	•	New, defined piece of work being undertaken by one or more staff members within WHC's usual establishment as part of their annual work programme. Progress tracked through this report.
Business as Usual (BAU)	•	Work already part of WHC's usual delivery model. Work being undertaken by one or more staff members within WHC's usual establishment as part of their usual work programme.

Key:		
Lead	•	Person responsible for reporting to the Executive Committee on progress against objetcive.

SECTION 1: IMPLEMENTING A NEW MODEL OF CARE

	Topic/ Theme	#	Objective	Type	Reporting Lead		Q1	Q2	Q3	Q4	Q3 RAG	Objective KPI	Narrative to explain current position
1	**Start well, live well, stay well, age well**	**1.1.1**	• Increase the number of staff attending **Making Every Contact Counts training.**	**SD**	Head of Operations (Heather Kahler)		→	→	→	→		The number of staff having completed the MECC training should higher at Q4 19/20, than it was at Q4 18/19.	To date 276 staff have completed the Motivational Interviewing module, with 273 passing it and 3 failing which is a 99% pass rate. Currently 38 people are in the process of completing this module online.
		1.1.2	• Continue to use our systems and contacts to prompt **preventative discussion and lifestyle advice.**	**SD**	Head of Operations (Heather Kahler)		→	→	→	→			There are now 2 questions embedded onto the Core assessment on SystmOne relating to the support given to the individual relating to the management of their health condition and also their confidence in managing their health condition. These are mandatory fields to be completed with each new assessment.
		1.1.3	• Continue to maintain good access to treatment with over **92% of people treated within 18 weeks**.	**BAU**	Chief Operating Officer (LH)		→	→	→	→		Over 92% of incomplete waiters waiting under 18 weeks.	Performance maintained in Q2.
		1.1.4	• Define an optimal service model and pathway for **First Contact Physiotherapy** with primary care colleagues.	**SD**	Head of Service, MSK (CLJ)				✓			Service specification in place.	FCP service specification complete. Agreement with CCG and WHC contracts team to set up 1 week preparation period with PCNs who want a service charging £225 daily rate so that services can be recruited to and templates and training arranged prior to April 1st 2020 rollout.
		1.1.5	• Increase the number of areas where **First Contact Physiotherapy** is delivered.	**SD**	Head of Service, MSK (CLJ)					✓		Signed agreements to deliver First Contact Physios in multiple Primary Care Networks in place	Pilot data is being presented at a regional CSP meeting on 14 February 2020. Sharing learning with other BSW partners to optimise the model. FCP roles have started in Melksham (Jan 15th). Downton, Trowbridge, Malmesbury, and Wootton Bassett are planning to develop the role next. CLJ working with CDs re recruitment and service model. Recruitmnet day Jan 30th. 5 strong applicants.
2	**Live well with one or more long term conditions**	**1.2.1**	• Expand the provision of **structured education and digital self-management** support tools.	**SD**	Head of Service, Diabetes (Paul Mabey)			✓				Digital options available. Increase uptake of places	Pilot in place for type 2 working with CCG. Signposting to Type 1 course and read coding records on completion certificate. Direct booking from primary care. Further digital course available for type 2 in January, as not launched by supplier until that date.
		1.2.2	• We will contribute to the development of the '**whole life' pathway** to ensure the needs of patients with **Learning Disabilities** are recognised and addressed within the developing model of provision	**SD**	Head of Operations (Heather Kahler)					✓		Renewed service specification for LD services	Good dialogue opened with WCC, now part of the wider programme board. This remains ongoing.
		1.2.3	• Develop a **single unified pathway for diabetes**	**SD**	Head of Service, Diabetes (PM)			✓				Wiltshire diabetes pathway in place	Single Point of Access conversations in progress with RUH, SFT and WCCG. Internal diabetes processes within WHC being aligned.Single pathway in place for WHC.
		1.2.4	• Develop a **common model for the provision of specialist advice** and support for people with long term conditions	**SD**	Head of Service, Diabetes (PM)				✓			LTC model in place	Developing concept in diabetes pathway that can be used for other LTC's. Neuro meeting occurred to understand requirements. Work planned in Q4.
		1.2.5	• Reduce **wheelchair waiting times** so the 18-week RTT target is always achieved	**BAU**	Head of Service, MSK (CLJ)		→	→	→	→		RTT target achieved	Additional staff in post, huge improvement in RTT from 70 breaches to 21. All have future apt booked. Progress noted by CCG at CQPM Improvement to referral form (now electronic); improvent to patient information leaflet; shared with stakelhlders this month for final apparoval . Not there in year, but we will get there.
		1.2.6	• Reduce waiting times for patients waiting for **wheelchair repair.**	**SD**	Head of Service, MSK (CLJ)		→	→	→	→		As above	New admin processes helping to manage pt pathway more efficiently. Pt contacts in December are the highest for the whole year showing increased capacity now in the team; also reflected in the huge improvement in performance of referral triage to (87% within 2 days in Dec from 33% in Sept).
		1.2.7	• We will develop **personalised wheelchair budget systems**	**SD**	Head of Service, MSK (CLJ)					✓		A clear process is in place for PHB	Agreement with CCG for revised forms and implementation plan following NHS England guidance. 2 pt trials completed awaiting council meeting to agree joint process to enable pts to access PHB money.
		1.2.8	• We will introduce a stock management system for **wheelchairs**.	**SD**	Head of Service, MSK (CLJ)			✓				A robust stock management system is in place	Medical equipment Asset Management delay due to SFT IG issue. Contractual arrangements now agreed, will either be in place by the end of 19/20, or in early 20/21.
		1.2.9	• Develop a proposal for a Wiltshire-wide model for **community heart failure**, in partnership with the 3 cardiology depts.	**SD**	Chief Operating Officer (LH)			✓				Proposal for WHC to deliver enhanced HF services	A model has been developed but on hold pending CCG action. It now looks unlikely that the CCG will make a commissioning decision in this area in FY 19/20.
		1.2.10	• Case for change created which defines the benefits of **expanding the WHC Oxygen service** to south Wilts.	**SD**	Ella Purvis			✓				Case for change completed for WHC expand Community Oxygen service to South	Case for change completed. Now waiting for outcome of CCG bussiness case to BSW for investment to expand PR and O2 services in Wiltshire.

		1.2.11	• Provide commissioners with a costed options appraisal to **expand pulmonary rehabilitation.**	SD	Ella Purvis				✓			Costed options available to commissioners	Community options/ locations being considered - awaiting decision from CCG re expanding services, see above.
		1.2.12	• Put in place arrangements to support the use of **Diasend** for Wiltshire community patients.	SD	Head of Service, Diabetes			✓				Diasend used to support care	Costed proposal developed. Initial discussions with CCG indicated that they may not fund. Proposal submitted to WHC's P&P group in October 2019 for Executive Committee to consider funding options. Business case approved by Exeuctive Committee in January 2020.
3	**Support for complex comorbidities /frailty**	1.3.1	• Work with the CCG to develop a proposal for **pain management** services across Wiltshire	SD	Head of Service, MSK (CLJ)		✓					Proposal for WHC to deliver enhanced pain management service	The CCG have indicated that they are not keen to pursue this in 19/20. As such, the WHC Board has decided that WHC should no longer pursue this objective in 19/20.
		1.3.2	• Define the **pathway for the management of frail patients** outside of hospital, and present the funding requirements to commissioners.	SD	Chief Operating Officer (LH)			✓				Model in place	This is been led through BSW. Further work to be carried out by WHC COO to progress locally in 20/21.
4	**Accessible effective support in crisis**	1.4.1	• Robust improvement plan in place to deliver improved resilience in our **Minor Injury Units**.	SD	Head of Operations (Clare Robinson)		✓					MIU action plan in place	Action plan in place, and reviewed/reported quarterly to CCG. 1 amber action remaining, the rest are now green
		1.4.2	• Trialled **physiotherapists in MIUs**, evaluated impact of this by the end of Q4.	SD	Head of Service, MSK (CLJ)				✓			Outcome of trial known and agreed way forward	Excellent progress with the pilot. Physio staff fully able to assess, request Xrays , interpret, and signpost pts, One Physio also a NMP now in MIU. Staff have worked extra unsocialble shifts to support nurse numbers, teaching students and nursing staff. Weekly soft tissue injury clinic being used efffectively by nursing staff to assit in timely FU. New S1 system enabling staff to task GPs for urgent actions; improving urgent care across the system.
		1.4.3	• Work with commissioners to clarify the specification for **Urgent Treatment Centres** in Wiltshire.	SD	Chief Operating Officer (LH)			→				Clear plan for Urgent treatment Centres in place in Wiltshire	Awaiting clarity of commissioning intentions from the CCG. Have proposed short term project to commissioners to resolve. Update Q3: Task and finish group established by CCG, using proposals from WHC as basis from cross-system work. WHC engaged in this work.
		1.4.4	**PRIORITY** • Work as part of the Wiltshire Delivery Group to develop a proposal for an increase and streaming of **rapid response services**.	T	Band 8A Transformation Manager				✓			Agreed service model with commissioners, with clear plan for WHC's part in implementation.	Working as partner in the system as part of modelling phase.
		1.4.5	• As part of the design of rapid response services, we would look to deliver the full **falls pathway** across Wiltshire.	SD	Head of Operations (Clare Robinson)				✓			Proposal for WHC delivering a falls response service	A proposal was made to the CCG but is on hold pending outcome of rapid response design. Inpatient Services Falls Protocol being rolled out in Q4 along with further embedding of Enhanced Care Protocol. Update Q3: No change.
		1.4.6	• Proposal for the delivery of **IV therapy** in the patient's home for south Wiltshire.	SD	Chief Operating Officer (LH)		✓					Service in place to deliver IV therapy at home	On hold by CCG pending Rapid Response design. The WHC Board has confirmed that WHC should continue to remain ready to engage with this in anticipation that the commissioners are likely to confirm their intentions for developing a rapid response service at some point during 19/20.
5	**High quality person-centred specialist and acute care**	1.5.1	• **Red and Green** - By the end of Q2, we will have embedded red and green methodology fully on all inpatient wards.	SD	Service transformation Manager 8A Gemma Pugh			✓				Red & green in place. Complete BAU	Red and Green initiative implemented on all wards. Now BAU, will review in 3 months.
		1.5.2	• **Align the Acute Trust Liaison service** to the Wiltshire Patient Flow Hub.	SD	Chief Operating Officer (LH)			✓				Community in reach model in place	Agreement from commissioners that ATL function should align to hub during Winter. This has been put in place during Winter, and is working well.
6	**Good hand over and discharge planning and post support**	1.6.1	• We will **reduce the number of bed days** occupied by patients with an acute length of stay of 21 days or more waiting for discharge to Pathway 1 and Pathway 2.	BAU	Chief Operating Officer (LH)			→				Reduction in bed days for >21 day for Pathway 1 and 2.	Data issues prevent monitoring at present, as data does not exist at pathway level for all.
		1.6.2	• By Q3, we will **reduce length of stay** in community hospital beds to be in line with national benchmarks for 19/20 to release capacity for winter	SD	Chief Operating Officer (LH)				✓			LoS to be at 27 days in Q4	Plans in place to address: Reducing trend shown in data monitoring, with reductions in length of stay close to national avergae in December 2019.
		1.6.3	• Develop the Wiltshire **Patient Flow Hub** further to **increase coordination of Home First+ discharges.**	SD	Chief Operating Officer (LH)			✓				Agreement for increased resources for Home First coordination.	Home First coordination resources not commissioned substantively but have been obtained as part of additional winter scheme, being implemented during Q4.
		1.6.4	• **Align** the Wiltshire **Patient Flow Hub** with **Wiltshire Council patient flow processes**.	SD	Chief Operating Officer (LH)			✓				Agreed joint processes in place	Progress made and some SWs will be aligned with the hub from September.
7	**Effective rehabilitation and reablement**	1.7.1	• Complete the **roll out of the Home First + pathway with Wiltshire Council** in all localities.	SD	Chief Operating Officer (LH)		✓					Pathway rolled out in all areas.	Completed, now embedding and reviewed regularly
		1.7.2	• **Stroke rehabilitation** reviewed and proposal to increase rehabilitation at home.	SD	Chief Operating Officer (LH)			✓				Proposal for increased stroke rehab	Good work undertaken with ESD – however further funding required – proposal needs to be written.
		1.7.3	• By the start of Q1, we will define the preferred model for **clinical input into ICT beds**.	SD	Chief Operating Officer (LH)		✓					Preferred model defined.	Model defined. CCG agreed, but decision now reversed. This objective will therefore not be achieved, as CCG have decided on different approach in 2019/20.
		1.7.4	• Propose **new approach for fracture clinics.**	SD	Head of Specialist Services, Carol Langley-Johnson			✓				New model in place	Fracture clinic model submitted and agreed at Executive Committee in Sept 2019. CLJ is now the lead for roll out. BAU should follow in April 2020. System 1 unit being rolled out in March preparatory work indicating several opportunities for quality improvement staff keen to make system change.
8	**Person centred, dignified, long term care**	1.8.1	• By Q3, we will develop a proposal for **increased support to care homes** to prevent escalation.	SD	Head of Operations, Community Team (HK)				✓			There will be a Wiltshire wide care home model of support	Asking CCG to define their preferred model. This is still in discussion, however there is on-going work being undertaken to develop the support from community teams to care homes which have ICT beds. WHC are working alongside the CCG to deliver the Cathedral project model to reduce unnecessary admissions to hospitals from care homes.
9	**Support, control, and choice at the End of Life**	1.9.1	• Processes formalised to provide **care support** to patients who have a **diagnosis of a terminal illness** but who are not yet entering the final phase of life.	SD	Head of Operations, Community Team (HK)				✓			Formalised process as part of EOL pathway work.	Reablement team have committed to continued support for patients who have a terminal diagnosis but who are not entering the final phases of life. Case management lists and flagging of priority patients within these lists is becoming increasingly adopted by Community Team clinicians and is monitored by CSMs, assisted by monthly reporting from Informatic team.
10	**Integrated services to provide person-centred care**	1.10.1	**PRIORITY** • Review and reorganise management of caseloads in community teams and working with GP practices.	T	Service Transformation Manager, Gemma Pugh			→				Agreed case load numbers and processes to achieve in place	Caseload review complete. Jan/Feb feedback to teams, CCG and primary care. Scope transformational change project March April. Launch Project May 2020

SECTION 2: DEVELOPING OUR PEOPLE

Topic/ Theme	#	Objective	Type of objective	Reporting Lead		Q1	Q2	Q3	Q4	Q3 RAG	Objective KPI	Narrative to explain current position where objective off-track
Developing our People	**2.1**	• We will undertake an **agency diagnostic**, using an NHSI tool, to support on-going development.	**SD**	Head of People (Hanna Mansell)		✓					Agency diagnostic undertaken.	This has been completed through the safer staffing programme.
	2.2	• By Q2 we will **review and renew appropriate agency staff framework agreements**.	**T**	Director of Finance			✓				Agreements reviewed and renewed where appropriate.	Agency arrangements reviewed and priortisation agreed. Additional future work agreed. Market enagagement event led by HTE was held in December 2019 to explore longer term contractual options.
	2.3	• By Q2 we will **improve our board reporting** so that it includes additional information (including agency spends).	**SD**	Head of People (Hanna Mansell)			✓				Revised board reporting.	This is now complete. The revised workforce KPI report is in place and provided on a monthly basis, which includes greater detail of Recruitment, Retention and bank and agency usage.
	2.4	• By Q4 we will **implement E-roster** across all services at team level.	**T**	Safer staffing programme board					✓		E roster implemented	Inpatient wards and MIUs by end of 2019; community teams commenced during Q4. Some smaller specialist services may bridge into beginning of 2020/21.
	2.5	• By the end of Q4, we will have **increased the number of people recruited to our bank by 25%.**	**SD**	Head of People (Hanna Mansell)					✓		Bank numbers increased by 25%	As at Q3: The increase in flexible workforce has been 20.81%, which is a headcount of 31. This covers the full staff groups having a flexible workforce assignment. Aug 19 -149 (at 31/7/19) Jan 20 – 180 (at 31/12/19) Increase of 31 which equals 20.81%
	2.6	• By the end of Q4 we will **increase our voluntary workforce by 10-15%.**	**SD**	Head of People (Hanna Mansell)					✓		Volunteer workforce increased by 10-15%.	The work stream for increase of volunteers is due to commence in April 20. The majority of the 'one workforce' workstream has been delayed due to resourcing of the role to lead this forward. The post holder came in to post in Nov '19, and has been working on the background systems and processes for the volunteer service during this time to ensure we are able to encompass them in the 'one workforce' model. The delivery of the increase will commence from April 20.
	2.7	• Commence recruitment of **physiotherapy rotational posts** in three areas.	**SD**	Head of Service, MSK (CLJ)		✓					Rotational posts in place and recruitment commenced.	3 new graduates recruited for North rotation, ward/community & MSK. Preceptorship training going well; action learning sets working well; evaluation with staff in process now .. West rotation scoped but recent NHS job adverts were unsuccessful, readvertised. Ongoing recruitment.
	2.8	• Develop and deliver training from a **new education and training hub** at Savernake Hospital.	**SD**	Head of Learning and Developt (Vanessa Ongley)			✓				Training hub in place	A new traing hub is place and equipped at Savernake. An events timetable is starting to be delivered, including ward managers programme and bespoke/ additional skils training. Awaiting computer points to complete the work and support self directed study.
	2.9	• Develop and deliver an **Acuity and Dependency tool** across all community wards - aligned to e-rostering.	**T**	Safer Staffing Programme Board			✓				Acuity and dependency tool implemented.	Shelford Tool tested across all wards in August. This will be used again in October/November 2019 and again 6 months later.
	2.10	• By Q2, we will develop and **deliver Clinical Leadership pathways**.	**SD**	Head of Learning and Developt (Vanessa Ongley)			✓				New clinical leadership pathways in place	Clinical career development 'flowers' developed, supported by ward leadership training and senior leader management rg programmes. Q2 Milestone complete.
	2.11	• From Q1 we will implement a **new value based appraisal process**.	**SD**	Head of People (Hanna Mansell)		✓					New appraisal process in place	This is now complete and achieved in Q3. The revised system is now in place and managers training has been delivered. New system is live to use.
	2.12	• By Q2, we will review the current Advanced Nurse Practitioner/ Advanced Care Practitioner role and competency framework in community in-patient settings, and set out a revised proposal to maximise the potential of the role and the community hospital delivery model.	**SD**	Head of Learning and Developt (Vanessa Ongley)			✓				Review complete	Achieved.
	2.13	• By Q2, we will recruit **and embed medical doctors to support clinical leadership and delivery of the clinical governance agenda.**	**SD**	Head of People (Hanna Mansell)			✓				Medical doctors recruited.	Medical doctor recruited and in place with WHC. All policies which are under review are to review the requirements for medical staff, contracts and terms and conditions are all in place. The appraisal process for medical staff and responsible officer role will be aligned to RUH.
	2.14	• By Q2, we will review, and **implement the Health and Wellbeing charter**, through **health and wellbeing forums**. We will evaluate its impact through staff survey results.	**SD**	Head of People (Hanna Mansell)			✓				Reviewed and implement charter	This has now been ratified by the organisation and has been mobilised into operational delivery. Wellbeing forums launched in November 19. Following this, a cross section of staff from the organisation are now participating and leading the implantation of the charter. Q2 milestone complete.
	2.15	• Implement a performance review system with Health and Wellbeing an integral part of the process.	**SD**	Head of People (Hanna Mansell)		✓					Performance review system in place	As per 2.11.
	2.16	• From Q4, we will **align our SAFER staffing project to our health and wellbeing charter**.	**SD**	Head of People (Hanna Mansell)					✓		Outcomes of safer staffing aligned to charter.	The charter was presented and noted at November safer staffing board.
	2.17	• Up-skill key staff within the Human Resources and Learning & Development team to support and deliver **organisational development**.	**SD**	Head of People (Hanna Mansell)				✓			OD skills within HR and L&D team.	Training has been completed in HR and team member imminently completing the assignment stage to the CIPD OD qualification. OD approach to wards to be rolled out in Q3. This will be undertaken by the CSU with WHC HR and L&D staff shadowing the trainers to support their competence and confidence. This will then be extended across all wards during Q4 and into 2020/ 2021
	2.18	• Scope the development and delivery of **non-medical consultant roles in community settings** and produce a paper for consideration by our commissioners by the end of Q1.	**SD**	Chief Operating Officer (LH)		✓					Proposals produced.	Proposal was produced, relating to ICT in South, but not accepted.

SECTION 3: SUPPORTING OUR SERVICES AND PATIENTS WITH GOOD IT

Topic/ Theme	#	Objective	Type of objective	Reporting Lead		Q1	Q2	Q3	Q4	Q3 RAG	Objective KPI	Narrative to explain current position where objective off-track
Strengthening foundations	**3.1**	• By the end of Q1, we will have completed the migration of all N3 links on to more cost-effective and fit for purpose infrastructure (**HSCN**).	**P**	IT Project Manager (David Thompson)		✓					Migration complete.	Corsham and Malmesbury are now connected via HSCN. As such, all sites migrated to HSNC. Action Complete.
	3.2	• We will have established and begun a rolling replacement programme for our **desktop estate**.	**BAU**	Head of IT (KS)					✓		Rolling replacement programme in place.	Business as usual activity.
Supporting our teams to work efficiently	**3.3**	• By the end of Q4, all Wiltshire Health and Care computers will have **migrated to Windows 10**.	**P**	IT Project Manager (David Thompson)					✓		Windows 10 migration complete	Windows 10 rollout is underway with additional resource in place to support. Completion by end of March 2020 is an aggressive target but at this stage we hope to deliver within the expected timeframe.
	3.4	• An **Asset management system** for Wiltshire Health and Care's digital ICT will be in place by the end of Q3.	**P**	Head of IT (KS)				✓			New asset management in place.	System was installed 13 January 2020 and is in the process of 'discovering' assets. System reporting will be used to support Windows 10 planning and ensure licensing compliance.
	3.5	• We will have an agreed 'to be' **network design and migration plan**, and work will have begun to deliver it.	**P**	Head of IT (KS)				✓			Plan completed.	Specification was agreed and procurement took place, resulting in the award of a contract in December 2019 to Centrality. Cloud environment setup and migration activities are underway with a target of achieving separation from the GWH network by GWH contract end in June 2020.
	3.6	• We will have gone live with a dedicated **Wiltshire Health and Care intranet**.	**SD**	Comms and Engagement Lead (Emma Bye)		✓					Intranet in place.	New intranet went live in May 2019.
	3.7	• We will be in a position to run a competitive tender for a **new telephone system provider**.	**P**	Head of IT (KS)			✓				Tender process commenced.	Completion of this action is dependent on the new network being available. Priority is been given to resolving network issues, meaning that this objective will now not be achieved in 2019/20. This target will move to Q2 of 20/21.
	3.8	• We will have established a project to procure and implement the **new telephone system**.	**P**	IT Project Manager (Devid Thompson)				✓			Project in place.	Dependency on 3.7. As above. This target will move to Q2 of 20/21.
	3.9	• By the end of Q4, Wiltshire Health and Care will be **"fax free"**.	**P**	Project Administrator, (Trish Kidley)					✓		No fax machines in use.	Fax machines are no longer being used in any of the community or specialist services teams. The Patient Flow Hub continue to hold their fax as a backup whilst teething problems with the NHS Mail provision to care homes is ironed out. There was an issue with encrypted emails to non-NHS addresses being rejected. Work is taking place to facilitate all care homes having NHS Mail installed.
Supporting digitally enabled health care	**3.10**	• On-going participation and engagement in the **BSW STP interoperability programme**	**BAU**	Head of IT (KS)		→	→	→	→		On-going participation.	KS attending BSW STP Digital Board and TDA. Interoperability Board currently stood down. Operational representation agreed.
	3.11	• We will generate a specification outlining Wiltshire Health and Care's future **business intelligence requirements**	**P**	Head of IT (KS)				✓			Specification completed.	An STP-led collaborative procurement is underway to determine the future provider. Procurement is due to complete by end of February 2020. WHC has the option to take the selected system but is not required to do so.
	3.12	• If the commissioners confirm that they are supportive of a move to **SystmOne for our wards** by the end of Q1, we will initiate the project to implement this by the beginning of Q3.	**P**	Director of Infrastructure (VH)				✓				No agreement from commissioners in Q1, timeline will therefore slip. The WHC Board has confirmed that WHC should remain ready to engage with this so that if the commissioners decide that they would like us to proceed with systm1 implementation on the wards in 19/20, we are ready. Update Q3: No change.
	3.13	• **Support care homes delivering intermediate care to use SystmOne** as clinical system (ensuring our system is shared appropriately)	**P**	Director of Infrastructure (VH)			✓					Ready to support, but reliant on CSU/CCG action to roll out. The WHC Board has confirmed that WHC should remain ready to engage with this so that if the commissioners decide that they would like to proceed with systm1 implementation in care homes, in 19/20, we are ready. Update Q3: No change.
	3.14	• We will develop a project to provide a **text-based advice and guidance service for patients** (e.g. Diabetes patients) to help support appropriate condition management.	**SD**	Director of Infrastructure (VH)				✓				No capacity to progress on this to date. Objective to move into 2020/21.
	3.15	• We will **explore increased use of wearable technology and remote monitoring with partners.**	**SD**	Director of Infrastructure (VH)					✓			Part of a bid to participate in AHSN activity, led by CCG.

SECTION 4: SUPPORTING OUR PATIENTS AND STAFF WITH PHYSICAL INFRASTRUCTURE THAT BETTER MEETS NEED

Topic/ Theme	#	Objective	Type of objective	Reporting Lead		Q1	Q2	Q3	Q4	Q3 RAG	Objective KPI	Narrative to explain current position where objective off-track
Improve quality and efficiency of existing accommodation	**4.1**	• **Specialist community services (including lymphedema) co-located** on the Chippenham Community Hospital site. The first phase of **backlog maintenance and service consolidation works**.	**BAU**	Director of Infrastructure		✓					New accomodation for specialist services.	New accommodation is now in place.
	4.2	• The first phase **backlog maintenance** will have been completed and space planned to support efficient effective patient care in	**BAU**	Director of Infrastructure		✓					First phase works complete.	Phase now complete.

		Warminster Community Hospital.											
	4.3	• **Scoped options** for the provision of compliant, safe, **ward accommodation** in the **Warminster Hospital** building will be available.	**BAU**	Director of Infrastructure			✓				Options scoped	**Complete.** High level option scoped for NHS PS to seek funding.
	4.4	• We will facilitate a long-term sustainable **solution for the provision of soft FM services** across Wiltshire community sites.	**SD**	Director of Infrastructure			✓				Long term solution in place.	Dependent on GWH and NHS PS processes. Issues regarding payment mechanisms and level of financial information available from the current provider.
Transformed estate to support new models of care	**4.5**	• New lease negotiation for the community team within **Ludgershall Health Centre**.	**BAU**	Director of Infrastructure		✓					Negotiation complete.	Delayed due to GWH handing back the old lease. Tenancy at Will agreed. Lease still unable to be signed as practice have not accepted estate back from GWH**.**
	4.6	• New lease negotiation for additional space for the community team in the new Wiltshire Council Community Hub in **Tisbury**.	**BAU**	Director of Infrastructure		✓					Negotiation complete.	Agreement reached in Q1. IT issues agreed, installation underway. Final details of leaase still being agreed with WC.
	4.7	• Sufficient space available to deliver community **physiotherapy activity in the south** of Wiltshire, including Hydrotherapy, and the associated leases negotiated.	**SD**	Director of Infrastructure			✓					All details agreed final paperwork being checked before signing.
	4.8	• Sufficient space available to deliver **community diabetes and dietetic care in the south** of Wiltshire, associated leases negotiated.	**SD**	Director of Infrastructure			✓					All details agreed final paperwork being checked before signing.
	4.9	• We will work with Wiltshire CCG and their consultants to work up the detail for the business cases to deliver the **new integrated care centres in Devizes and Trowbridge.**	**SD**	Director of Infrastructure		→	→	→	→			WHC continues to be engaged in these programmes.

SECTION 5: FINANCIAL SUSTAINABILITY AND PRODUCTIVITY/ ENVIRONMENTAL SUSTAINABILITY

Topic/ Theme	#	Objective	Type of objective	Reporting Lead		Q1	Q2	Q3	Q4	Q3 RAG	Objective KPI	Narrative to explain current position where objective off-track
Financial sustainability and productivity	**5.1**	• **2.5% of our resources will be released** from planned expenditure for reinvestment to support services.	**BAU**	Executive Committee		→	→	→	→		Cost Improvement Programmes in place and delivery upon.	CIPs totalling 2.5% planned as part of budgets. On track in Q3.
Environmental sustainability electronic paysl	**5.2**	• We will establish a **sustainability group** within our governance structure.	**P**				✓					Sustainability will be progressed through existing workstreams within the organisation.
	5.3	• We will produce a **Sustainable Development Action Plan** for 19/20 for agreement by the Board	**P**	Ops delivery(supported by project manager - JN)			✓				We will embed Sustainability within existing workstreams defined through the 2019-20 Delivery Plan and infrastructure developments	As above.
	5.4	• We will develop a **sustainable Travel Plan** using The Health Outcomes of Travel Tool, and refresh our related policies.	**P**	Ops delivery (supported by project manager - JN)					✓			Data has been made avaliable. Analysis to follow.
	5.5	• We will communicate our **travel strategy** and related policies to all of our stakeholders, with particular attention being given to raising awareness of the low carbon travel alternatives available to staff, patients and visitors travelling to site	**P**	Ops delivery (supported by project manager - JN)					✓		Information to support sustainable travel plans will be made readily available to WHC staff.	A dedicated area for the intranet on sustainability has been launched in Q3. This provides information on topics such as: parking faciilties; bus stops; bycles racks; car share schemes - the intentionbeing to inform staff, and to encourage alternative transport us to single person/ single car.
	5.6	• We will develop a **'Paperless programme'** including a reduction in paper usage, printing, postage costs	**P**	Ops delivery (supported by project manager - JN)					✓		We will use existing workstreams collectively contributing to our 'Paperless Programme'. This will be monitored by reviewing spend on postage, paper and printing	Work going to on to identify the relevant data. In terms of initiatives underway, we have: • Improvement to windows 10 will help generally. There will be comms to support paperless ideas. • HR has started using electronic personnel records • The SARs process is becoming increasingly paperless (subject access requests) • Electronic payslips • App for ESR
	5.7	• We will develop an **engagement plan for our sustainability efforts** (to engage and encourage support for carbon reduction from staff, patients, visitors, suppliers and the local community).	**P**	Ops delivery (supported by project manager - JN)			✓				We will develop our internal communications tool 'intranet' to raise awareness of the 'Paperless Programme' and 'Travel'	Intranet updates are in design phase.
	5.9	• We will have reviewed and drafted **a plan to improve our data collection to support sustainability monitoring** and reporting within Wiltshire Health and Care.	**P**	Ops delivery (supported by project manager - JN)			✓					No progress due to capacity restraints.

SECTION 6: QUALITY FOCUS

Topic/ Theme	#	Objective	Type of objective	Lead		Q1	Q2	Q3	Q4	Q3 RAG	Objective KPI	Narrative to explain current position where objective off-track
Quality focus	**6.1**	• Throughout 19/20, Wiltshire Health and Care will collaborate with West of England Academic Health Science Network to **develop and implement an Early Warning Score for people with Learning Disabilities**.	**SD**	Director of Quality, Profess-ions, and Workforce		→	→	→	→		Early Warning Score developed and implemented.	Complete.
	6.2	• Wiltshire Health and Care will **increase the Public and Patient voice within the organisation by the development and delivery of a forum**.	**SD**	NEW Engage-ment Post			✓				Forum in place.	See 8.1 and 8.2 below.
	6.3	• In Q1 we will implement new clinical risk software to improve incident reporting and risk management.	**SD**	Director of Quality, Profess-ions, and Workforce		✓					New software in place.	Q2 WHC working closely with RL DATIX. The incident, risk, mortality modules have now been implemented and the yellow Fin software to support reporting is also in place. The first report has been uploaded to NRLS. Milestone completed in Q2.

SECTION 7: EQUALITY AND DIVERSITY (E&D)

Topic/ Theme	#	Objective	Type of objective	Lead		Q1	Q2	Q3	Q4	Q3 RAG	Objective KPI	Narrative to explain current position where objective off-track
Equality and Diversity (E&D)	**7.1**	• We will carry out a survey of how staff members feel about the E&D culture at Wiltshire Health and Care	**P**	Head of People (supported by Project Manager - JN)		✓					Survey carried out.	
	7.2	• We will produce an Equality and Diversity Action Plan for 19/20 for agreement by the Board	**P**	Head of People (supported by Project Manager - JN)			✓				Action Plan agreed by Board.	Milestone completed.
	7.3	• We will identify and build an E&D data set to support the delivery of our E&D Strategy and Action Plan.	**P**	Head of People (supported by Project Manager - JN)			✓				E&D data set identified and built.	Efforts are underway to increase the nature of the data captured through ESR. The newly designed and freshly implemented friend and family card now enables the orgaisation to capture diversity characteriiscs.
	7.4	• We will develop a communication and engagement plan to support the delivery of the E&D Action Plan.	**P**	Head of People (supported by Project Manager - JN)			✓					Due to capacity constraints, WHC will meet statutory and regulatory requirements, but there is insufficient resource to undertake a large piece of work in this area in 19/20.

SECTION 8: PATIENT AND PUBLIC ENGAGEMENT AND INVOLVEMENT

Topic/ Theme	#	Objective	Type of objective	Lead		Q1	Q2	Q3	Q4	Q3 RAG	Objective KPI	Narrative to explain current position where objective off-track
Patient and Public Involvement	**8.1**	• We will establish a patient and public involvement group for Wiltshire Health and Care (either by reaching agreement to extend the scope of an existing group or by developing one of our own).	**SD (with project elements)**	NEW Engage-ment Post			✓				Patient and Public Involvement Officer (PPIO) investigating opportunities to work with partners to build a patient forum.	PPIO investigating opportunities to work with partners to hear the patient voice. Staged approach; build network of contacts first; then create the forum.In Q3 the focus was on building the network of patient contacts steadily. New target date of patient forum: Q2 20/21.
	8.2	• We will hold patient and public involvement group listening events	**SD (with project elements)**	NEW Engage-ment Post			✓		✓			PPIO supporting the learning dIsabllity forum (created by the service), which started in Q2. This activity is currently supported by Wiltshire CIL (Centre for Indepndant Living), who advised that they wanted to step back. WHC PPIO will provide support to the learning disability forum going forward, to enable Wiltshire CIL to step-back. Further and broader listening events in 20/21.
	8.3	• We will draft a proposal for how we can involve patients and the local public in the following areas: staff recruitment and induction; when carrying out service specific workshops.	**SD (with project elements)**	NEW Engage-ment Post				✓				This proposal has not yet been written, due to the PPO propritising other activities. It will have a new taregt date of Q2 20/21. In the spirit of this objective, PPIO has created a number of easy read documents including a pictorial form for patients with learning disabilities to help with communication.
	8.4	• We will create and maintain a database of people who wish to actively participate in service development discussions and regularly communicate with them.	**SD (with project elements)**	NEW Engage-ment Post			✓					Network of patient contacts building steadily. IG advice being sought to formalise this into a database. New target date Q4 19/20, or Q1 20/21.
	8.5	• We will define our approach for how we will listen to the voice of children who use our	**SD (with project elements)**	NEW Engage-ment Post			✓					Approach not yet documented, but PPIO has been building up an understanding of where children service users are across WHC. PPIO has spoken to Safeguarding lead for children to understand the requirement.

		services.										Current friends and fmaily form has been improved so that children can easily use it as well. We would like to see how possible it is to made children's specific one. PPIO engaging staff to remind them how important it is that we hear the voice of children. The plan is to build this into the induction process. New target date Q2 20/21.
	8.6	• We will define our approach for how we involve our patients and the public in our Clinical Reference Group*. *Name now changed.	**SD (with project elements)**	NEW Engage-ment Post			✓				Patients are involved in the scrutiny of patient leaflets and guidance.	This process will follow once the database in 8.4 is created. New target date Q3 20/21.

Transformation Programmes: Overview

Rapid Response Services	**The Wiltshire Delivery Group** – a group of providers, co–chaired by the Managing Director of WHC, has been leading work to design an approach to rapid response to crises in the community. The overall high level design has been agreed, and more detailed modelling of activity and demand against the model is currently being undertaken. The programme is being supported by project management resource funded through the Better Care Fund. The overall outcome is to ensure that Wiltshire as a whole can meet the requirements of the NHS Long Term Plan for enhanced rapid response services, delivered in an integrated manner between health and social care. Wiltshire Health and Care's role is to participate fully in the design and to play its part in creating and implementing any additional and/or adjusted services, subject to commissioning decisions. The current timeline for detailed modelling and pathway design to be complete is end of 2019/20. **The demand on 'internal' change capacity is now likely to be something that needs to be picked up in 2020/21**.
Community caseload programme	Review and reorganise management of caseloads in community teams and working with GP practices. A programme of work has been established to focus on new approaches to the caseload of community teams. In particular, an audit of case load commenced in September 2019 to gather information on the type of interventions we complete, in what environment, by what band, and for what duration. In addition, work is ongoing alongside some emerging PCNs to explore closer ways of working between primary care and community services which would have a beneficial impact on caseload management. **The outcomes of the caseload audit have been analysed during Q3, and are being used to scope a more detailed transformation project for 2020/21**.
Safer Staffing Programme	The Safer Staffing Programme has been established to oversee and deliver improvements in the way in which staffing is planned and organised to ensure suitable levels of staffing is achieved within services. The particular objectives from the Delivery Plan included in this programme are: • By Q2 we will **review and renew appropriate agency staff framework agreements**. This has been achieved. • By Q4 we will **implement E-roster** across all services at team level. This will not be achieved, as implementation beyond MIUs and Inpatient Wards has been paused as more work is undertaken to complete the implementation in these areas. • Develop and deliver an **Acuity and Dependency tool** across all community wards. An enhanced care protocol is now in place and the Shelford tool has been tested and will be used every 6 months.

Wiltshire Health and Care ("WHC")
Board Meeting

Item 9

Primary Care Network's (PCN's) Update

VERBAL

Wiltshire Health and Care Board	**For information**
Subject:	**Quality, performance and finance quarterly report**
Date of Meeting:	**07 February 2020**
Author:	**Sarah-Jane Peffers, Lisa Hodgson, Annika Carroll**

1. Purpose

1.1 To provide an overview of the main issues arising from review of information about the quality and performance of Wiltshire Health and Care services and alert and advise the Board to issues by exception.

2. Issues to be highlighted to Board

2.1 The quality and performance dashboards are attached for the Board's information. The following issues are highlighted to the Board in relation to the quality of services:

ADVISE	**Incidents** 322 incidents overdue (160 overdue in November 2019), community teams have 123, with Trowbridge (35), Wilton (17), and Salisbury (25) having the highest number. However, Warminster has closed all incidents so there is likely to be learning between TLs. There is no correlation between the volume of incidents in month and the number that require closure. In-patient areas have 106 overdue with a significant number of these relating to incidents on Longleat (67). This has been caused by temporary leadership or a transition in the leadership and incidents not being allocated appropriately. The highest numbers of overdue incidents are those categorised as having no harm. Actions being put in place to address backlogs. **Serious Incidents.** A Serious Incident dashboard has been agreed and will be available from February 2020, this will give internal and external assurance on the number, themes of SIs, and our progression with the learning identified. **Friends and Family**- New approach to Friends and Family commenced from 1st December 2019. Workshop held on the 4th December 2019 to discuss new approaches to be adopted from April 2020, in line with the Public and Patient engagement plan. Due to the changes there has been a reduction in the number of returns for December and this has been noted nationally. However, they are aware of our current transition and do not expect any further action at this time. **Duty of Candour** continues to not reach the expected target of 100% across all stages. Upload to NRLS has also been lower than expected this month. This is thought to have occurred due to a change in the responsibility of TLs/ WMs, requiring them to recognise if an incident is a patient safety incident. This responsibility will be moved back to the Quality Team as the vacancy is filled. We still require mandatory tabs added to DATIX IQ and this will be achieved once the appropriate training has been undertaken, this is expected in February 2020. Teams/ wards with high numbers of overdue incidents and incomplete DOC will be visited to offer further training as required.

Quality Schedule 20/21; discussions are on-going with the CCG and is expected to be signed off by the end of February 2020. There is expected to be a reduction in reporting and more collaborative working.

CQUINs 20/21 have been published, there a likely to be 4 CQUINs relating to community services;
Malnutrition screening- Community in-patients
Pressure ulcer assessment- Community In-patients
Lower leg wounds- Community teams
Flu vaccinations- all patient facing staff (90% target)

IPC
We have experienced three bay closures all within December 2019. There have been 2 outbreaks of Diarrhoea and Vomiting (Confirmed Norovirus on one ward) and 1 for Respiratory symptoms (Confirmed Influenza A). A total of 11 beds were closed to new admissions (11 bed days lost).
There have been some really good examples of IP&C practice and learning including:

- containment of Influenza A on Longleat and isolation of contact patients;
- containment of Norovirus on Chestnut and Cedar;
- The collation of information by clinical teams given to IP&C.
- The response by Hotel Services to undertake post infection cleaning, sometimes at short notice.
- Good working relationships between Clinical, Hotel Services and IP&C teams.

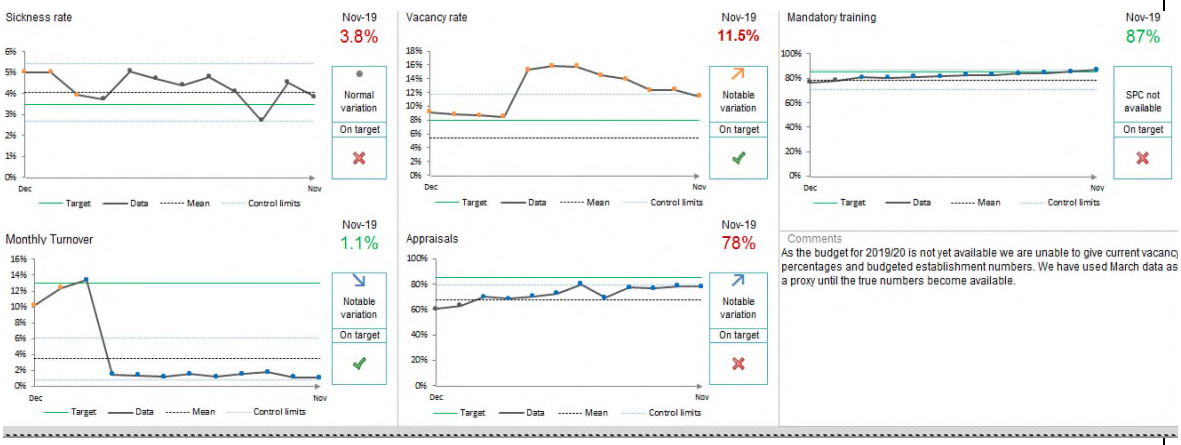
As always there is learning to be gained from outbreaks and a review of these will be undertaken at the next Inpatients Senior Nurses meeting with an extended invite to Hotel Services and Flow Hub teams.
BSW STP are also working together to align IPC policies as these incidents have recognised differences in approach.

Coronavirus- Central advice has been released and this has been circulated through WHC IPC nurse specialists.

Complaints- 100% complaints during October and November 2019 but dropped to 50% response compliance in December 2019. All complaints have been responded to but there was a 12-17 day delay in 3/6 complaints. All overdue complaints were related to care in in-patient areas; Ailesbury, Longleat and Mulberry wards.

Freedom to Speak Up Guardian; From January 2020, Gemma Pugh will commence as WHC's Freedom to Speak Up Guardian (FTSUG);
Gemma will be focusing on the following activity:

- Recruiting at least one other staff member to step forward and complete the national training.
- Training of champions which sit evenly (and are available through the night shifts) across the organisation for signposting
- Implementing learning taken from national training event
- Guidance on reporting and information keeping
- Buddying scheme (GP joining the regional teams later this month so will arrange this)
- Criteria for assessing our policy

	Workforce Improving position across all workforce targets  Flu vaccination target achieved 86% against a target of 80%. **Quality Improvement (QI) Approach** WHC under the leadership of Gemma Pugh (Service Transformation Lead) will enhance staff support and development in QI methodology, with a plan being put in place working in close alignment with plans being developed at SFT and GWH.
ALERT	**Freedom To Speak Up concern** raised in January relating to the estate utilised by Calne and Corsham community teams. Both areas have been reviewed and all actions will be monitored by the Director of Infrastructure through the EDIT POG
ACTION	None

2.2 The following issues are highlighted to the Board in relation to the financial performance:

ADVISE	**Intercompany Debtor** The legacy intercompany balance due from GWHFT, relating to periods 2016/17 and 2017/18, of £951k, remains outstanding, despite requests for settlement. The matter has formally been escalated to the GWHFT Director of Finance, and a joint position statement is being prepared to support final review, agreement and settlement. WHC continues to report a debtor of £951k for this matter. **Agency usage and enhanced care** The number of agency shifts used in the month increased by 149 shifts from November (843) to a total of 992 shifts in December. This increase was solely due to an increased need for enhanced care (1:1) support across the wards. WHC approached the commissioners in November to request funding for the on-going and increasing enhanced care need for patients across the community wards. Additional financial forecast information has been requested by the commissioner's Finance Committee in order for this to be considered.
ALERT	None
ACTION	None

2.3 The following issues are highlighted to the Board in relation to the maintaining performance against required performance standards:

ADVISE	• MIU Services ▪ Physio pilot progressing well. 6 month review to be produced in March 2020 ▪ Increased support given by MIU to OOH services during periods of winter pressures with positive feedback provided by OOH • Tissue Viability ▪ Dual appointment with Devizes PCN now in post ▪ Continence ▪ Contract to be reviewed with commissioning partners due to increasing referrals. • Community Teams ▪ Time & Motion study completed and initial feedback given to teams and WHC Executive. Action plan currently in development. ▪ Winter pressures, Work is continuing with Agincare to achieve the 360 contracted hours. All other avenues to increase capacity are been actioned. • Flow Hub ▪ Following some intensive work Delayed transfers of care within community hospital beds have reduced in recent weeks. ▪ Inreach nurse having a positive impact in ensuring the right pathway is selected first time. Seeking support from commissioners to secure permanent funding and extend to SFT & GWH. • Dietetics Service ▪ Work is continuing with SFT to explore strengthening the resilience within the Dietetics service.
ALERT	None
ACTION	None

3 Recommendation

3.1.1 The Board is invited to note the contents of this report.

Wiltshire Health and Care ("WHC")
Board Meeting

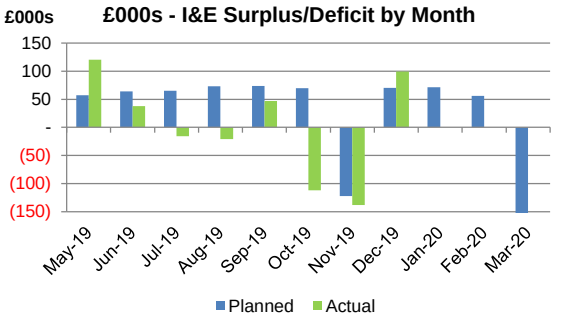
Item 10a

Quality, Performance and Finance Dashboards

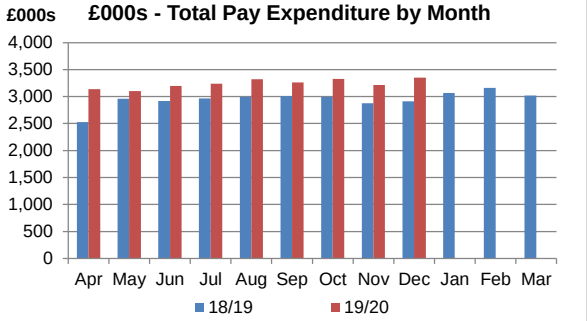
If you require a copy of this document please email whc.corporateservices.nhs.net

Finance Dashboard - December 2019

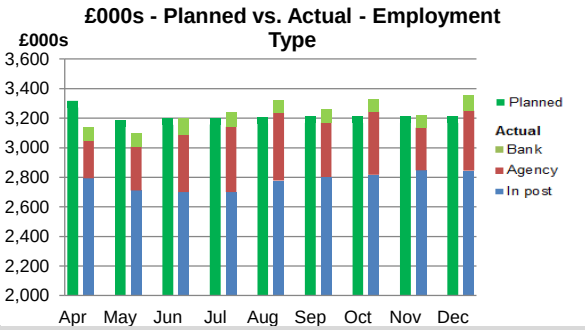
Income & Expenditure



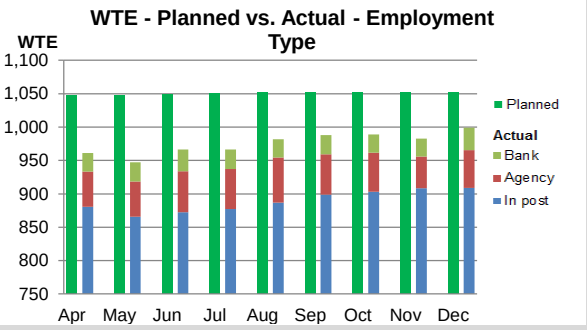
Pay Expenditure - £ - Total



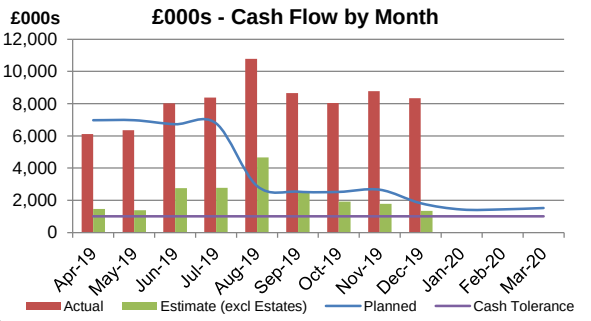
Pay Expenditure - £ - Employment Type



Pay - WTE



Cash



Best Practice Payment Code (BPPC)

BPPC % of bills paid in target	Current Month	Previous Month	Movement
By number	96%	91%	5%
By value	99%	58%	42%
Average number of days to pay an invoice			
Days	13	33	(20)

Forecast

	Full Year Plan £000s	Forecast Outturn Variance £000s		
		Best Case £000s	Most Likely £000s	Worst Case £000s
Operating Income				
NHS CCG Income	54,970	320	258	210
Other income	2,082	(360)	(381)	(410)
Total income	**57,052**	**(40)**	**(123)**	**(200)**
Operating Expenditure				
Pay	38,581	(30)	(79)	(260)
Non-Pay	18,471	230	209	0
Total Expenditure	**57,052**	**200**	**131**	**(260)**
Surplus/(Deficit)	**0**	**160**	**8**	**(460)**

NHSI Reporting

Metric	Definition	YTD	
		Ratio or %	Score
Capital service cover rating	Degree to which income covers financial obligations	N/A	N/A
Liquidity rating	Days of operating costs held in cash and cash equivalents	0.11	1
I&E margin rating	I&E surplus or deficit / total revenue	2.12%	1
I&E margin: distance from financial plan	YTD actual I&E surplus or deficit compared to YTD plan	-0.79%	2
Agency rating	Distance from YTD budgeted spend	108%	4

Cost Improvement Plan (CIP)

	YTD (Cumulative)			Annual Plan £000s	Annual Forecast £000s
	Plan £000s	Actual £000s	Variance £000s		
WH&C 2019/20 Savings					
Income	248	244	(4)	326	326
Pay	465	342	(123)	650	650
Non-Pay	220	265	45	316	316
Total income	**933**	**852**	**(82)**	**1,292**	**1,292**

Commentary

Overall: Wiltshire Health and Care reports an adverse year to date variance of (£333k) (M9, December) against a planned surplus of £350k, and an in-month surplus of £29k against a planned surplus of £70k.
Income: Reports an adverse variance due to lower than planned Home First Plus related funding, NCA income, Training related income and Enteral Feeding income, which is partly matched by reduced expenditure. In addition provisions of funding for additional VAT liabilities remain lower than planned.
Pay: Vacancies reduced in the month. However, an increase of agency usage was reported in the month due to enhanced care support requirements across the wards in December. Agency spend continues to exceed both vacancy levels and plan.
Non-Pay: The ytd underspend is driven by lower than forecast estates related expenditure for 2017/18 and 2018/19, which offsets particularly IT and telephony spend which exceeds plan.
Positives: A surplus was reported in December, with the most likely year end forecast still reporting a small surplus.
Negatives: Final 2018/19 VAT values are yet to be finalised and agreed with the Commissioner. The legacy debt owed by GWHFT remains unpaid and is in dispute. Enhanced care requirements continue with agency spend increasing in December.

Wiltshire
HEALTH AND CARE

NHS

Network Migration Update

Kelsa Smith – Head of IT

Wiltshire HEALTH AND CARE

NHS

Where are we now

- GWH have historically hosted WHC IT
- Mutually agreed this arrangement needs to end
- Potential for IG and Cyber security risks increase under existing model
- Current GWH contract ends 30th June 2020
- Preferred solution has been developed in consultation with BSW Technical Design Authority (TDA)

Wiltshire HEALTH AND CARE

NHS

Where we want to be

- IT that ‘just works’
- Cloud based
- Adaptable and future proofed
- Supports mobile working
- In line with local (BSW TDA) and national strategic ambitions
- Good value for money
- Compliant with national cyber security requirements

Wiltshire HEALTH AND CARE

NHS

Progress to date

- Specification developed in consultation with local IT stakeholders including GWH
- Tender process completed
- Contract awarded to Centrality Ltd ‘Connect’ product and support
- Migration activities have begun

Wiltshire HEALTH AND CARE

NHS

Deliverables & Timescales

Deliverable	Status
Procurement activity	Completed Jan 20
Project Governance and Board	Operational
Initial set up and configurations	Due for completion Feb 20
Migration Activity	Feb – May 20
Communications and Training	Ongoing
Business as Usual	July 20

Some slippage in programme which may continue. Being managed with current and future providers.

NHS

Wiltshire
HEALTH AND CARE

Working in partnership
Great Western Hospitals NHS Foundation Trust
Royal United Hospitals Bath NHS Foundation Trust
Salisbury NHS Foundation Trust

www.wiltshirehealthandcare.nhs.uk

Wiltshire Health and Care Board

For discussion

Subject:	**Risk Management Report**
Date of Report:	**16 January 2020**
Date of Board meeting:	**7 February 2020**
Author:	**Tom Blowers, Risk and Complaints Manager**
Exec Sponsor:	**Katy Hamilton Jennings, Director of Governance and Company Secretary**

1. Purpose

This paper sets out:

A.	**WHC risk summary profile**	*For information*
B.	**15+ risks on the risk register**	*For discussion*

2. Recommendation

The Board is asked to:

- Note the position with regards to WHC's 15+ risks, and confirm it is content that the organisation is taking sufficient steps to try to manage risk effectively, and within the organisation's risk tolerance.

3. Risk updates

Section A: WHC risk summary profile

Risk profile	December 2019	January 2020	Movement in month
Total open risks on WHC Risk Register	64	71	⇧
"Accepted" open risk on the WHC Risk Register	11	11	⇔
Total Risk Profile Score	601	566	⇩

Risk scoring profile for WHC's "live" risks

Profile of 12+ live risks <<24 January 2020>>

Net Risk = Impact x Likelihood

Impact						
5	Catastrophic	5	10	15	20	25
4	Major	4	8	12 **3**	16 **1**	20
3	Moderate	3	6	9	12 **2**	15
2	Minor	2	4	6	8	10
1	Negligible	1	2	3	4	5
	Likelihood	Rare	Unlikely	Possible	Likely	Certain
		1	2	3	4	5

Total combined risk score: 88

15+ Risk Movement

NB: See Section B for details of individual 15+ risks.

Risk movement: December 2019 to January 2020

Category	Position	Narrative
New 15+ Risks	**No movement**	• No new 15+ risks have been identified in month, or in the period since the last WHC Board meeting.
Escalated to 15+ Risks	**No movement**	• No risks were escalated to 15+.
Accepted 15+ Risk	**No 15+ risks accepted**	• No 15+ risks were accepted during the reporting period.
Closed 15+ Risks	**No movement**	• No risks scoring 15+ were closed in the reporting period.

15+ Risks (January 2020)

As of 16 January 2020, WHC has **one** 15+ risk on its Risk Register (Risk 80). See Section B for details.

Section B: 15+ risks, and progress with actions

Board:

1. Please confirm you are satisfied with the risk position.

	Brief description	Risk	Owner	Risk score	Service Delivery Area
1	**Cause:** Limited capacity **Effect:** WHC is unable to meet the expectations of commissioners and system partners in relation to supporting flow out of the acute setting. **Outcome:** This could impact on flow out of the acute hospital setting; impacting on LOS/ bed days in the acute setting. From the patient's perspective, this could result in the patient's expectations not being met, as they expect to be transferred to the community setting for care sooner than they can be.	 Risk 80 - updated post Executive Comm	LH	16	Operations

APPENDIX 1

Net risk appetite boundary (marked with a bold red line)

Impact		Net risk = impact x likelihood				
5	Catastrophic	5	10	15	20	25
4	Major	4	8	12	16	20
3	Moderate	3	6	9	12	15
2	Minor	2	4	6	8	10
1	Negligible	1	2	3	4	5
Likelihood		Rare	Unlikely	Moderate	Likely	Almost certain
Likelihood score		1	2	3	4	5

Title:	WHC2018/2019 Annual EPRR Board Report		
Author:	Gilesdeburgh1@nhs.net	**Ratified:**	
Version:	1	**Date:**	**Review: NA**

October 2018 – October 2019 Assurance Report:

Emergency Preparedness, Resilience and Response

Contents

1 Introduction

1.1 Legislation

The Civil Contingencies Act 2004 identifies Great Western Hospitals as Category 1 responder. The act identifies 6 statutory duties for Category 1 responders:

1. Risk assessment
2. Business continuity management
3. Emergency planning
4. Warning and Informing
5. Co-operation (with other responders)
6. Information sharing (with other responders)

1.2 Core Standards for EPRR

The NHS England Core Standards for Emergency Preparedness, Resilience and Response (EPRR) are the minimum standards which NHS organisations and providers of NHS funded care must meet. NHS England conducts an annual assurance process in line with these core standards. There is a requirement as part of this process to submit an annual board report detailing the return to the Board.

1.3 iRespond

iRespond: Modular Planning and Response System provides the framework and methodology for developing and delivering organisational resilience, inclusive of business continuity and incident response plans, training and exercising.

iRespond consist of 8 core components:

1. **iRespond Operational Checklist:** One or two sided operational incident specific checklists identifying key actions across multiple staff groups
2. **iRespond Governance Record:** Each operational checklist will have a linked governance record detailing provenance, exercise, review and amendment history
3. **iRespond Quick Reference Handbooks:** Service specific hard copy Quick Reference Handbooks will be tailored to specific service i.e. they will only have checklist relevant to that service

4. **iRespond Control Desk:** An open access spread sheet containing hyperlinks to all checklists, governance records, planned response, exercise and training plans

5. **iRespond Planned Response:** An integrated planning and communication framework used to develop operationally focussed plans when there is a planned change, or disruption, to service delivery.

6. **iRespond Training:** Modular training packages for key aspects of response

7. **iRespond Exercises:** Operationally focussed exercises designed to evaluate checklists and response structures

8. **iRespond Debrief:** Manageable debrief structure and process designed to capture sialinet points and translate these into actions for planning.

2 NHSE Core Standards Return

The assurance process is based on a RAG rated self-assessment which is then reviewed during a Confirm and Challenge Meeting with Wiltshire CCG.

RAG descriptors appear in the summary table below.

RAG	Descriptor	Number
Green	Green = fully compliant with core standard.	62
Amber	Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months.	2
Red	Red = Not compliant with core standard and not in the EPRR work plan within the next 12 months.	0

There are a total of 54 core standards applicable to Community services of which WHC meet 52.

This provides an overall compliance level of Substantially Compliant for WHC.

2.1 NHSE core standards improvement plan 2018/19

Core standard	RAG	Action	Deadline	Lead name
31 – Response Access to planning arrangements	Amber	All action plans can be accessed electronically from desktops. Delay in updating hard copies of checklists to staff. To note on call have been completed. This should be completed by the end of October 2019.	Oct 2019	Sarah Orr
49 – Business Impact Assessment	Amber	Work underway to review all BIA linked to planned maintenance response arrangements which have provided rich learning for updating BIAs.	June 2020	Sarah Orr

2.2 Developing organisational resilience

In the interest of transparency it should be noted that the NHSE Core Standards for Emergency Preparedness Resilience and Response are heavily focused on having paper plans. By identifying a core standard as green we have successfully evidenced that we have met the standard with an iRespond checklist.

However, it should be acknowledged that developing organisational resilience goes far beyond the production of a plan on paper.

Despite being substantially green in this year's assurance process there remains significant work to do in developing resilience in staff and services. The remainder of this report evidences the additional work the Resilience Team does to develop resilience.

3 iRespond Operational Checklists

iRespond Operational Checklist: One or two sided operational incident specific checklists identifying key actions across multiple staff groups / services.

iRespond Type	Total	No. published in report period	No. updated in report period
00: Business as Usual	22	5	12
01: Escalation	3	1	
02: Business Continuity	18	5	31
03: Incident	30	25	30
04: Major Incident	6	0	3

4 iRespond Planned Response

iRespond Planned Response: An integrated planning and communication framework used to develop operationally focussed plans when there is a planned change, or disruption, to service delivery.

Date	Serial	Name	Reason	Impact
05/10/19	06:004	Chippenham Electrical Works	Major upgrade to the electrical system at Chippenham	Possibility of 2 hour power outage No power to MIU and computer network room during MIU clinic hours
19/06/19	06:005	MIU Medway to SystmOne	SystmOne increases functionality and enables mandatory informatics to be complied	Potential for long delays due to system initial operability and staff unfamiliarity of the system
14/12/18	06:006	Network Connectivity Chippenham	Slow connectivity due to exceeding network capacity	Possibility of network failure due to overload

5 Incidents

iRespond Debrief: Manageable debrief structure and process designed to capture salient points and translate these into actions for planning.

Date	Incident	Type	Summary	Debrief serial
01/02/19	Snow	Severe Weather- Critical Incident	• A lot more snow than forecast. Full incident control team established the day before snow and until services were no longer impacted	09:001

6 iRespond Training Programme

iRespond Training: Modular training packages for key aspects of response

Name	Summary	Staff Groups targeted	Numbers trained
07:003 MIU CBRN Training	Overview of CBRN plans, identifying a contaminated patient and resulting actions	• MIU clinical staff • MIU Reception Staff	• 25
07:007 Incident Response the first 3 hours	Session focussing on structuring the first three hours of response and key roles in the Incident Response Team	• On Call Managers • On Call Directors	• 11
07:010 On Call Orientation for staff new to on call	iRespond and Incident Response	• On Call Managers • On Call Directors	• 5
07:014 Loggist	The importance off logging during an incident and key things to remember	• Community Team Admin staff • Senior trust HQ admin staff	• 12 • 6
07:003 CBRN	Outline of WHC responsibilities and actions	• On Call Managers • On Call Directors	• 5
00:008 Staffing Issues 00:009 Safe Staffing Levels and Agency Contact List	Overview of checklists and discussion of common issues	• On Call Managers • On Call Directors	• 9

7 iRespond Exercise Programme

iRespond Exercises: Operationally focussed exercises designed to evaluate checklists and response structures

Name	Date	Key benefits / learning	No. delegates
Ward Relocation Exercise	16/10/19	• Scenario of Cedar Ward being unusable due to fire damage. • Tested control team checklists and was a great learning experience • Exercise needed to be longer • Further training needed for Gold calls	9

8 Areas of focus 2018/19

Maintain hard copies of iRespond checklists
Review BIA template and work with teams to re-write BIAs
Develop further exercises to test the incident management checklists

Wiltshire Health and Care ("WHC")
Board Meeting

Item 14

Information Governance Update

VERBAL

Meeting:	WH&C Board	Date:	Feb 2020

Title:	**Highlight report from the Wiltshire GP Alliance Committee (WGPA Committee) "Improved Access" Contract.**

1. Introduction

The WGPA Committee was established as a sub-committee of WHC's Integration Committee in October 2018 to oversee the delivery of the Improved Access ("IA") contract, commissioned by Wiltshire CCG for the delivery of additional primary care appointments. 'Improved Access' is now referred to as 'Extended Access' by NHSE, though they are the same thing.

This paper summarises the key issues currently under review by the WGPA Committee (the Committee), which in the absence of the Integration Committee, should be drawn to the attention of the WH&C Board for assurance and information relating to the delivery of the Improved Access contract.

2. Attachments

- Utilisation rates
- Healthwatch report

3. Risks presently "live" on WGPA's risk register in relation to WGPA's successful delivery of the IA contract in line with contractual obligations

The projected impact of most risks has decreased as the service has bedded down. The main current risks are:

- A.02. D.01. E.03. The CCG has verbally indicated that it will extend the current contract for a further 12 months to Apr 2021, but has yet to follow-this up with a formal offer. The actual issuance of the main contract may not happen until April or May, as they will wait for the new format standard contract to be released in March and then adopt that. We have requested a more formal commitment from the CCG, as the lack of clarity affects confidence in the future provision of the service, and impacts contracts and planning for all participating practices. In particular, it affects those collaborations and WH&C who have employed staff specifically to deliver the programme, and for whom the lack of clarity is creating risk and uncertainty for employers and employees alike. The CCG will offer an exchange of letters as an intermediate step until contracts can be issued.

- E.01. Integrating with other provider organisations – this mainly relates to the provision of the Sunday Service, which consists of 14 GP appointments for 111 to book into. Uptake of the Sunday service is poor, averaging around 30-40%, although Medvivo find it to be a valuable service and do not wish to lose it. We have identified a potential solution that will be piloted from mid Feb, which is expanding the range of patient categories that can be seen on Sunday to include some higher-risk cases. This should improve utilisation

rates, and if not we have other options for making better use of the resource including additional support for care homes over the weekend.

- E.04. Practices being distracted by other priorities, eg PCNs. This continues to be a risk, however we have agreed with the Lead Clinical Director for PCNs that they would form a small steering group, that will work with the WGPA Committee, to improve coordination of efforts, and help ensure the EA service can evolve to suit the future requirements of PCNs ahead of time, to ensure a seamless transition in Apr 2021. This is also a good opportunity to drive at-scale initiatives and improve cross-system efficiency.

4. Potential new risks identified by the WGPA Committee recently

- B.02. West Berkshire CCG are combining the Extended Hours service with Extended Access (Improved Access) from Apr 2021. This impacts Lambourn Surgery, a Berkshire practice, that is part of the Kennet & Berks Collaboration that includes 4 Wiltshire practices, and for whom Lambourn currently provides EA cover for Wiltshire patients registered at their practice. The possible issues include either a reduction in funding for Lambourn's EA service, or potentially the withdrawal of Lambourn from the programme. There may be a short-term impact if clinics need to be re-scheduled or scaled back, but there should not be a major impact on ongoing services.
- D.04. Along with the ongoing need for formal extension of the current EA Contract, we need clarification of funding levels, including from W.Berks CCG who ultimately fund Lambourn practice to see Wiltshire patients.

5. Advise

- The Wiltshire model for delivering Extended Access has been recognised as being particularly effective, and presented as an example of good practice in the NHSE Regional roadshow to review primary care access, and in a national NHSE webinar.
- Wiltshire is consistently delivering 130%+ of target hours, and has hit targets without fail from day 1.
- The monthly contract review meetings with the CCG continue to go well, with the most recent being on 14Jan20. No issues or concerns with the delivery of the contract were raised, and the feedback remains very positive.
- WGPA commissioned Healthwatch to carry out an independent review of the EA Service. Their report has just been published (27/01/20) and is attached. It is clear that patients are very much in favour of the service, and appreciate access to appointments outside of core hours. Areas that we are keen to develop further include more active promotion of the service to patients, encouraging the use of digital approaches to support new models of care, and effective access to wider whole-system services.
- The future transfer of EA to PCNs (due Apr 2021) needs to incorporate arrangements for some form of central management to deliver at-scale working. This has been provided to date by the WGPA Committee. This benefits the CCG by minimising the number of organisations it needs to deal with to deliver consistent services across the county, and it delivers benefits to the wider healthcare systems as primary care is working at a similar scale to other major providers including WH&C, AWP, and Medvivo. This improves collaboration and cross-system working. The PCNs appear in favour of

this role continuing in future, although the mechanism for funding and staffing this needs to be developed.

- Utilisation levels are an ongoing area of interest – this is the proportion of appointments offered that get booked. These peaked in Oct & Nov at around 90% due to flu clinics which were well attended. The more typical utilisation rate is be around 75%. However following a review by the EA Leads, we believe that the utilisation of GP Appointments on EA is much higher, with many practices stating they are rarely if ever unused, and the overall uptake is being distorted by Nurse or other clinical appointments which by their nature are more likely to go unfilled. We are revising the reporting process to provide greater granularity on the true uptake levels with the aim of improving clarity and efficiency.

As part of our continual improvement work, we are developing the following areas:

- Simplify the reporting process, so that performance data is more timely and useful, but less onerous for practices to supply
- Improve promotion and awareness of appointments, particularly to those patient groups with most to benefit from appointments outside of core hours.
- Encourage use of digital consultation technology which will support better access to GPs outside core hours when a small number of individual clinicians need to cover a large geographic area
- Work with PCNs to ensure a smooth transition of the service to them in Apr 2021.
- Work with other providers to share best practice, reduce avoidable work, and ease pressure on the wider system

6. Alert

None.

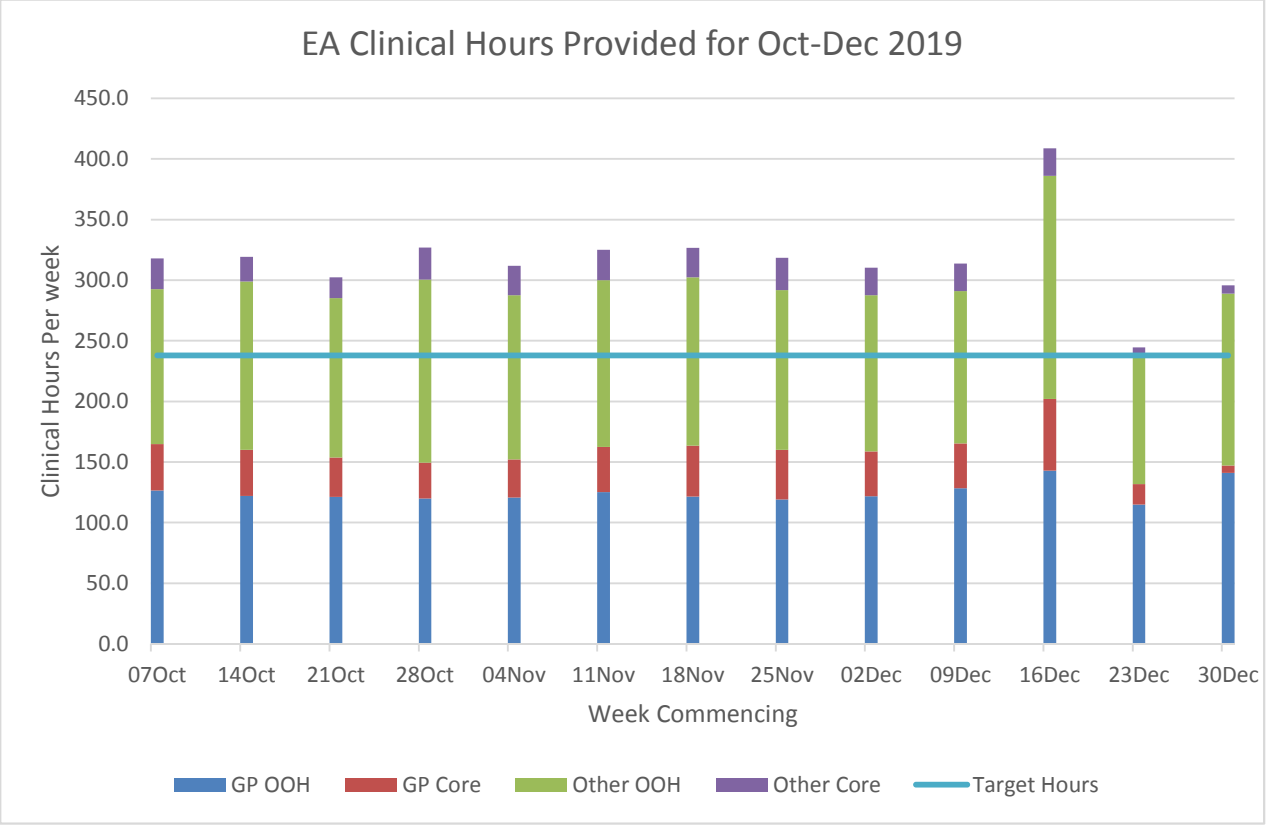
7. Action

- Gain formal confirmation of the extension of the current EA Service contract to Apr 2021, and ensure practices / employees are retained to deliver this.

WGPA – Extended Access

Activity and Uptake Data – Oct-Dec 2019.

- All collaborations continue to meet or exceed target hours.
- Targets still achieved each week in December despite 'flexible' delivery options.



Average weekly performance Oct-Dec 2019:

Actual Hours	**OOH**	**Core**	**Total**
GP	125.0	34.3	**159.3**
Other	136.8	20.9	**157.8**
Total	**261.8**	**55.2**	**317.1**
Target			238.0
% of Target			**133.2%**

% of Target	**OOH**	**Core**	**Total**
GP	52.5%	14.4%	**66.9%**
Other	57.5%	8.8%	**66.3%**
Total	**110.0%**	**23.2%**	**133.2%**
Target			100.0%
% of Target			**133.2%**

Utilisation

Utilisation Rates, Oct-Dec (all days)

Month	Uptake	Attendance	DNA	Appts/Hr
October	88.0%	95.0%	4.9%	4.3
November	81.8%	94.6%	4.7%	4.0
December	75.5%	95.6%	4.4%	3.4
Quarter Total	**82.6%**	**95.0%**	**4.7%**	**3.9**

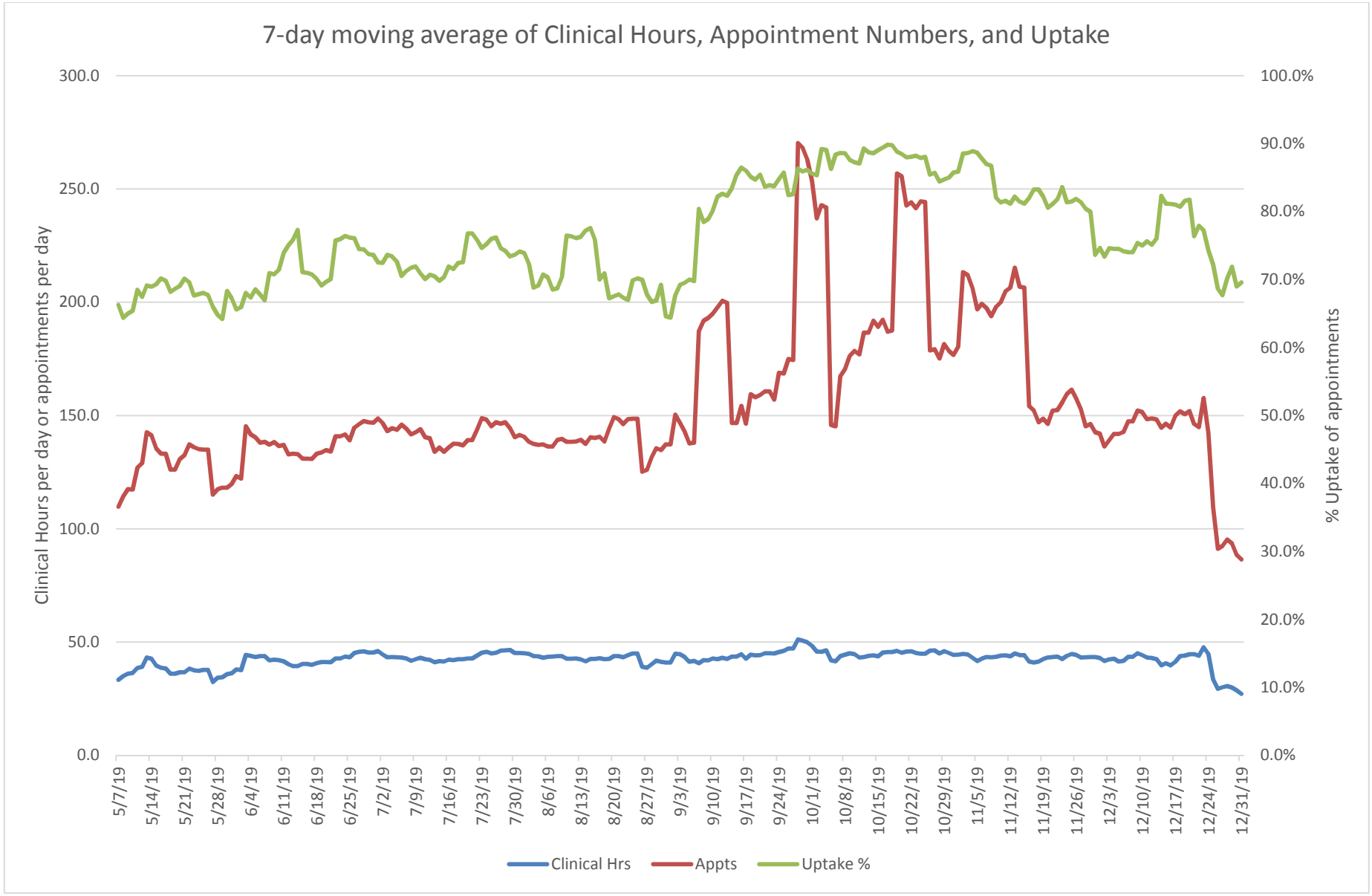
Utilisation Rates, Oct-Dec (Mon-Sat)

Month	Uptake	Attendance	DNA	Appts/Hr
October	88.5%	95.0%	4.9%	4.4
November	82.9%	94.6%	4.7%	4.0
December	77.3%	95.4%	4.5%	3.4
Quarter Total	**83.7%**	**95.0%**	**4.7%**	**3.9**

Utilisation Rates, Oct-Dec (Sun)

Month	Uptake	Attendance	DNA	Appts/Hr
October	55.1%	94.4%	5.6%	3.3
November	20.6%	90.0%	10.0%	3.3
December	39.6%	100.0%	0.0%	3.0
Quarter Total	**38.8%**	**96.7%**	**3.3%**	**3.2**

WGPA – Extended Access



healthwatch Wiltshire

What you told us about the GP Improved Access Service

January 2020

Contents

Report summary

What is this report about?

This report looks at access to GP services across Wiltshire with a focus on evaluating the Improved GP Access Service. This is a service that involves GP practices across Wiltshire working together to provide routine appointments for patients in the evenings and weekends.

What did we do?

This project had several elements aiming to gather information in different ways:

- We visited a range of GP surgeries across Wiltshire during daytime, evening and weekend hours and interviewed 173 patients.
- We carried out a mystery shopping exercise. Our volunteers called 14 GP surgeries on two dates and asked about evening and weekend appointments.
- We distributed a survey for staff which aimed to gather their views about the service. 85 staff members completed the survey.

What were the key findings?

- Access to evening and weekend appointments are valued by patients.
- Overall there was a greater preference from patients for early morning or evening appointments as opposed to weekend ones.
- Most patients said that they would be happy to see a nurse, paramedic or pharmacist where appropriate. There seemed to be increased awareness and confidence in the triaging process.
- 60% of the people we spoke to said that they would consider travelling to be seen at another surgery in some circumstances. However, there was concern that those who are unable to travel should not be disadvantaged.
- Improved Access appointments were used and managed in a range of different ways by different surgeries.
- Surgery staff were not clear about what Improved Access appointments were available at other surgeries and some reported difficulties booking these.
- Staff thought that the Improved Access Service had improved access for patients, but their views whether it was a good use of their time was more mixed.
- The people we spoke to reported high levels of satisfaction with the treatment they received at appointments.

Conclusions and recommendations

The report concludes that access to out of hours appointments is something that is valued by patients and should continue.

We make recommendations which mostly concern the implementation of the Improved Access Service and are based on the views of patients and staff.

Introduction

Access to GP services has been frequently reported to Healthwatch Wiltshire as a concern from members of the general public.

Healthwatch Wiltshire regularly hears from many local people about primary care services. While we heard many positive comments about the quality of treatment people received, getting an appointment has been reported to be an issue across Wiltshire. Because of this, primary care was made one of our priority areas in 2019.

In October 2018 a new "Improved Access Service" was commissioned by Wiltshire Clinical Commissioning Group and provided by the Wiltshire GP Alliance with the support of Wiltshire Health and Care. Under this scheme, GP practices across Wiltshire are collaborating to provide routine appointments for patients in the evenings and weekends.

We were pleased to be invited to work with the GP Alliance to evaluate this service and to hear how patients, GPs and other staff feel this is working, and to hear any suggestions they may have for further improvements.

Our volunteers

Healthwatch Wiltshire has a team of committed, trained volunteers. Our volunteers supported this engagement by attending surgeries and interviewing patients, calling surgeries to carry out mystery shopping, entering data and proofreading the draft report. Eleven volunteers contributed a total of 51 hours of their time.

Our volunteers June, Michael and Meg, who supported us on the project.

Our approach

This project had several elements which aimed to gather information in different ways.

1. Interviews with patients at GP surgeries

We designed a survey for patients attending GP appointments. We asked questions about their experience of making their appointment, and of their preferences about the time, location and the health professional they would like to see. We also designed a short follow-up interview which aimed to gather information about how their appointment had gone.

In selecting which surgeries to visit, we considered the need to cover different areas of the county including both rural and town GP practices, and we chose surgeries with a range of different ratings in the recent national GP Patient Survey*. We visited surgeries during the daytime, evenings and weekends. We asked patients there if they would be happy to speak to us and we completed our survey with those that were.

We used this approach with the aim of gathering views from a typical sample of local people in Wiltshire who are using GP services. We aimed to complete most surveys as a one to one interview with patients, as this provided opportunities to explore people's opinions further and to gain insights about the reasons behind people's views. Most patients completed the survey this way, but a small number completed the survey by themselves.

We carried out:

- 9 evening visits to 8 different surgeries
- 2 Saturday visits to different surgeries
- 4 daytime visits to different surgeries

During our evening and weekend visits we tried to prioritise talking to patients who were attending an Improved Access appointment. Approximately 80% of those were doing so, with the remainder being those attending extended hours or walk-in appointments.

2. Mystery shopping exercise

We carried out a mystery shopping exercise where we telephoned a further selection of rural and town GP surgeries across Wiltshire and asked about evening and weekend appointments. Our volunteers carried out this activity using a script that was the same for all surgeries. We called 14 different surgeries, making two phone calls to each surgery on different dates.

3. Staff survey

We distributed a survey for staff which aimed to gather their views about the service. This survey was circulated electronically to staff in any role that was involved with Improved Access appointments. The questions covered their views about the impacts of the Improved Access Service both for themselves and for patients.

* www.england.nhs.uk/statistics/statistical-work-areas/gp-patient-survey

Who we spoke to...

We completed a total of 173 interviews at GP surgeries. Ninety-nine of these were with patients attending evening or weekend appointments and 74 were with patients attending appointments during the day.

The charts show a breakdown of some demographic information about who we spoke to during daytime appointments and who we spoke to during evening and weekend appointments.

The demographics of those we spoke to were broadly typical of what we would expect to see for people attending GP services in Wiltshire.

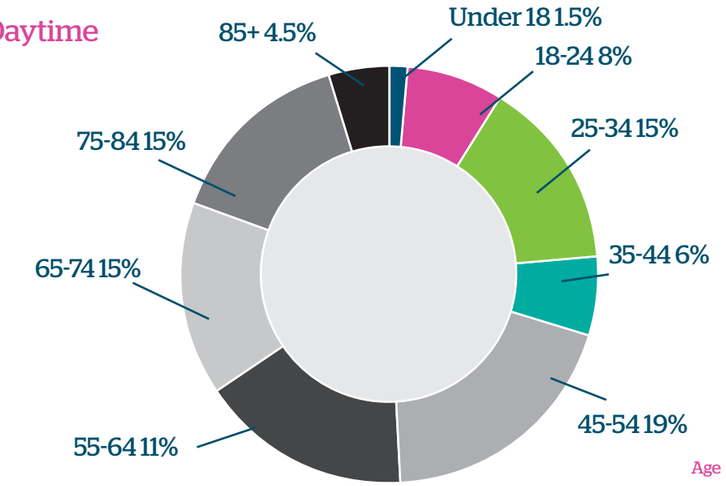
However, we were surprised there was not more difference in the age ranges of people attending daytime appointments as compared to those attending evening and weekend appointments.

Where did we go?

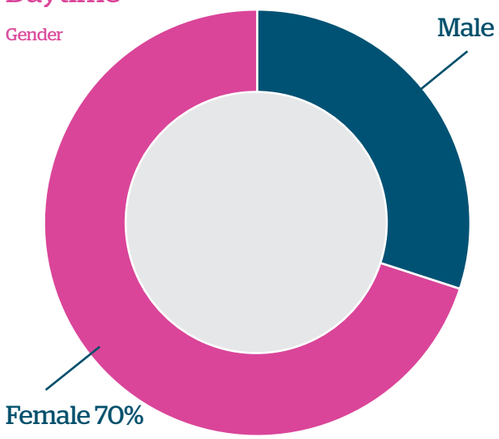
- Beversbrook Medical Centre, Calne
- Hathaway Medical Centre, Chippenham
- Old Orchard Surgery, Wilton
- Malmesbury Primary Care Centre
- Marlborough Surgery
- Salisbury Medical Practice
- Salisbury Walk-in Centre
- Southbroom Surgery, Devizes
- The Old School Surgery, Great Bedwyn
- Three Swans Surgery, Salisbury
- Tidworth Surgery (Castle Practice)
- Tinkers Lane Surgery, Royal Wootton Bassett
- Trowbridge Health Centre
- Westbury Group Practice

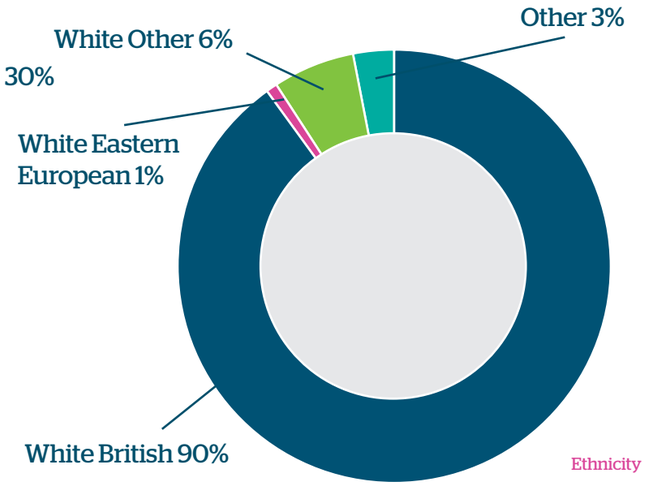
Demographics of patient respondents

Daytime



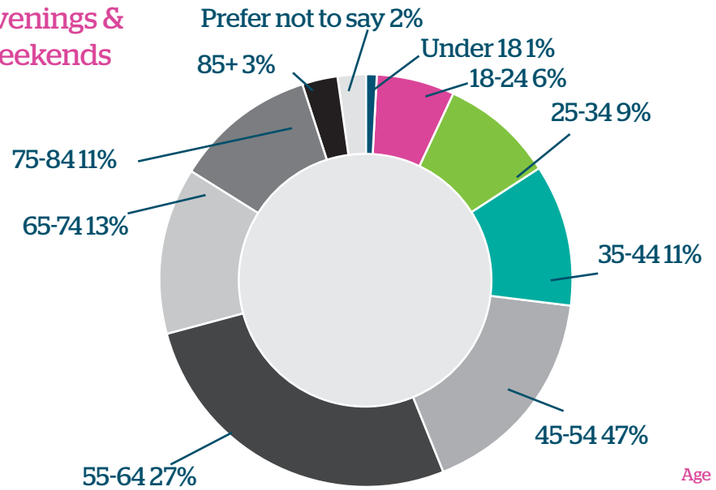
Age





Ethnicity

Evenings & weekends



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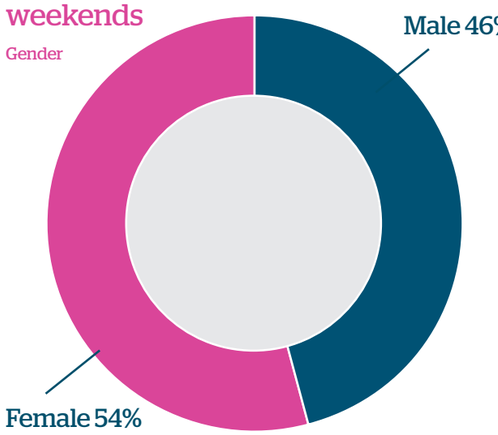
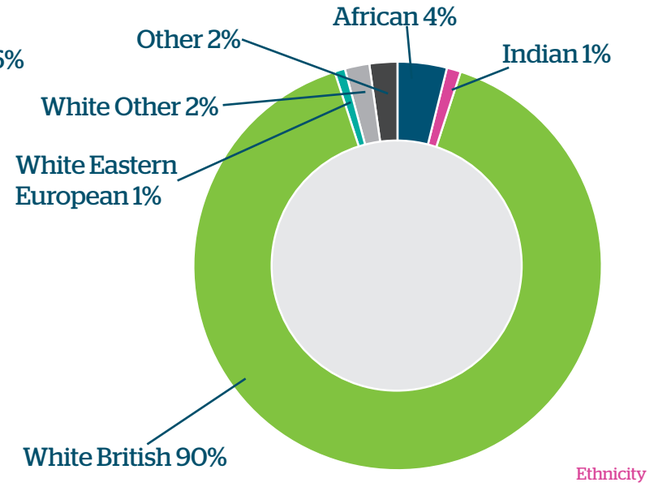
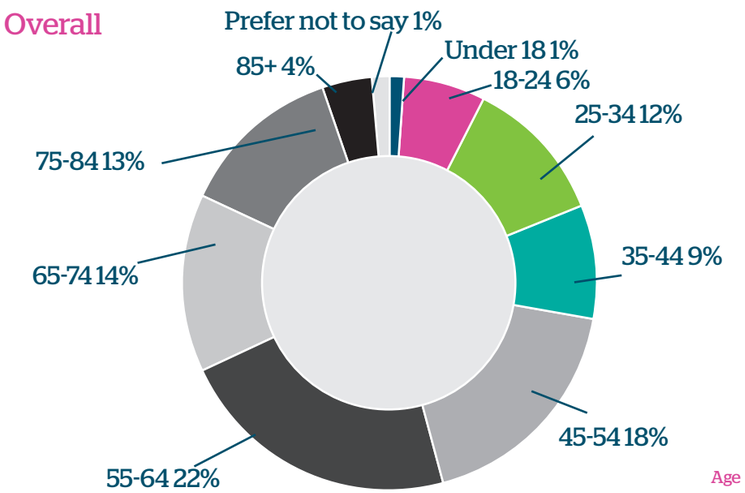




Ethnicity

Overall



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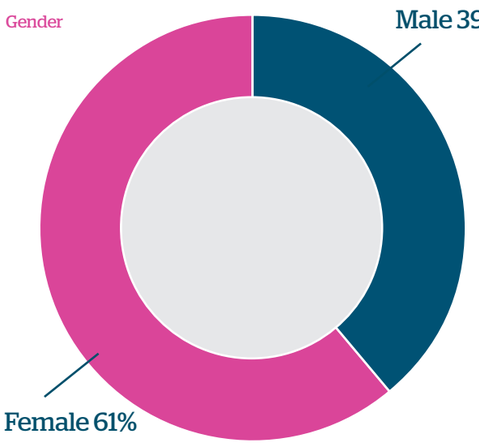
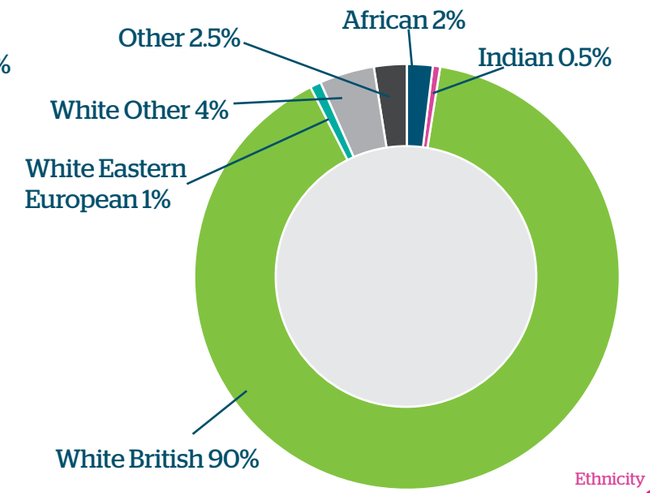




Ethnicity

Our findings

1. What did patients tell us?

Ease of attending their appointment

We asked patients at GP surgeries how easy it was to attend their appointment. We aimed to get an overall picture of how easy or difficult people found it to attend GP appointments and, where people said it was difficult, to identify the reasons for this.

Of those we spoke to who were attending appointments during the day, 87% said it was easy to attend their appointment, and 13% (9 people) said it wasn't. Of the nine who said they had difficulty, seven of these said that this was associated with transport and travel and two said that it was due to their work. Eight out of the nine people were attending their usual surgery and one was attending a different surgery from their usual one.

Of those attending evening and weekend appointments, slightly more (94%) said that it was easy for them to attend the appointment and 6% (5 people) said it wasn't easy. Of the five who reported difficulties attending their appointment, three gave the reasons as distance, one said it was due to a busy lifestyle and one said it was due to their medical condition. Of these five, one person was attending a different surgery from their usual one.

Where were people attending their appointment?

We asked people to tell us whether they were attending their appointment at their usual surgery or a different surgery. If they were attending a different surgery, we asked how easy it had been for them to get to.

Of the people we interviewed during daytime surgery hours, 80% were attending their own surgery. The remaining 20% (15 people) told us that they were attending a different surgery, this was usually a surgery within the same practice. Of these 15 people, seven said that it was easy to travel to the surgery, 7 made neutral comments, and one said it was difficult.

Of those we interviewed during weekend and evening appointments, 78% were attending their own surgery and 22% (24 people) were attending another surgery. Of these 24 people, nine of these people said that it was easy to travel to the surgery, 13 made neutral comments, and two people said it was difficult.

Of all those who had attended another surgery, most of them said that they travelled by car.

Views about attending appointments at a different surgery

We asked people when they thought it would be better to travel to see someone at another practice sooner, rather than waiting for an appointment at their own practice.

Of those attending daytime appointments:

- **40%** said they wouldn't want to and would rather wait
- **20%** said they wouldn't mind
- **17%** said they would if urgent
- **10%** said if they could be seen sooner
- **9%** said they would if surgery was close to them
- **3%** if the appointment was at a more convenient time
- **3%** said it would depend on the issue.

> For an issue that was not long term and I didn't need to see a specific doctor, then I'd be happy to travel anywhere locally.

Of those attending evening appointments:

- **38%** said they wouldn't want to and would rather wait
- **12%** said they wouldn't mind
- **29%** said they would if urgent
- **7%** said if they could be seen sooner
- **5%** said they would if surgery was close to them
- **5%** if the appointment was at a more convenient time
- **4%** said it would depend on the issue.

The results indicate that people would consider attending a different surgery and suggests that there are more patients who may be willing to attend another surgery than are currently doing so in Wiltshire. The most common circumstance where people said they might do this would be if the issue was urgent. Being able to be seen more quickly and the other surgery being relatively close by were also important to people.

Of those who said they wouldn't want to go to a different surgery, some said that this was because they had no difficulty accessing appointments at their own surgery and therefore couldn't see how this would be necessary. Others expressed a strong preference to be seen at their own surgery because they had confidence in the service they received there.

> No. I'm quite happy with the way it works here.

> Yes if it is a long wait and another practice is quicker. Would only be possible if you can travel.

How did people find out about out evening and weekend appointments?

For those attending evening and weekend appointments, 80% said that they were offered an appointment at that time and 20% said that they had requested one.

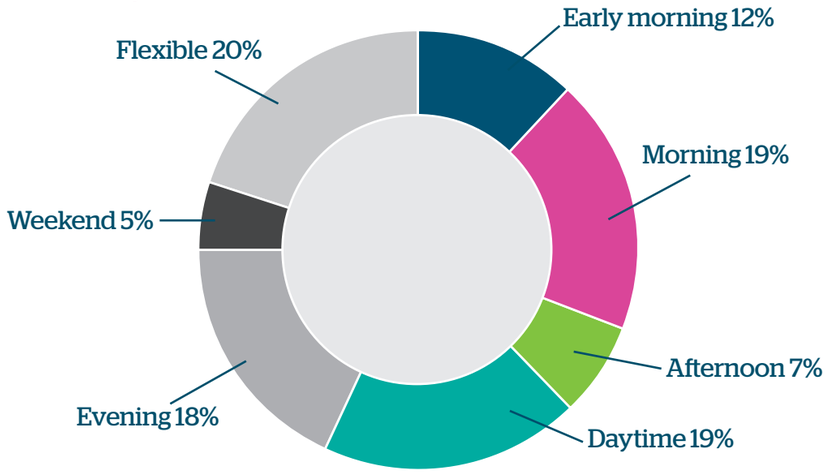
We asked patients attending daytime appointments if they had ever been offered an evening or weekend appointment. 67% of them said that they had never been offered one, and 33% said they had been offered one.

What time did people say they would prefer to come to appointments?

We asked people what time they would ideally prefer appointments. Some people identified more than one time that would be preferable, for example afternoons or evenings. An analysis of these results shows the times that patients told us were preferable.

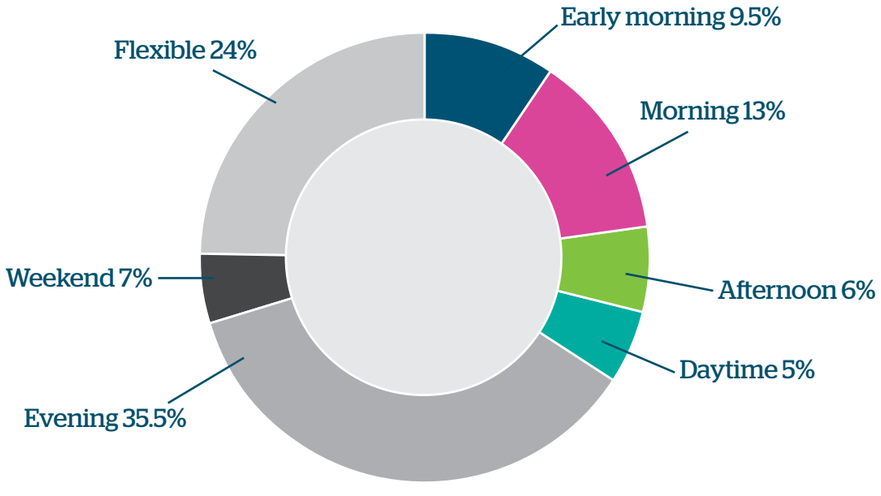
This chart shows preferences of the people we spoke to who were attending daytime appointments:

Preferences – daytime



This chart shows the preferences of people we spoke to who were attending evening and weekend appointments:

Preferences – evening & weekend



Among the patients attending appointments during the day, over a third of them expressed a preference for early morning, evening and weekend appointments as opposed to the daytime appointment that they were currently attending.

For out of hours appointments, a greater preference was expressed for early morning and evening appointments, as compared to weekend appointments. Patients who we interviewed who were attending on a Saturday did not express a clear preference for a weekend appointment.

A significant number of patients attending both daytime and evening and weekend appointments said that they could be flexible with the time they attended.

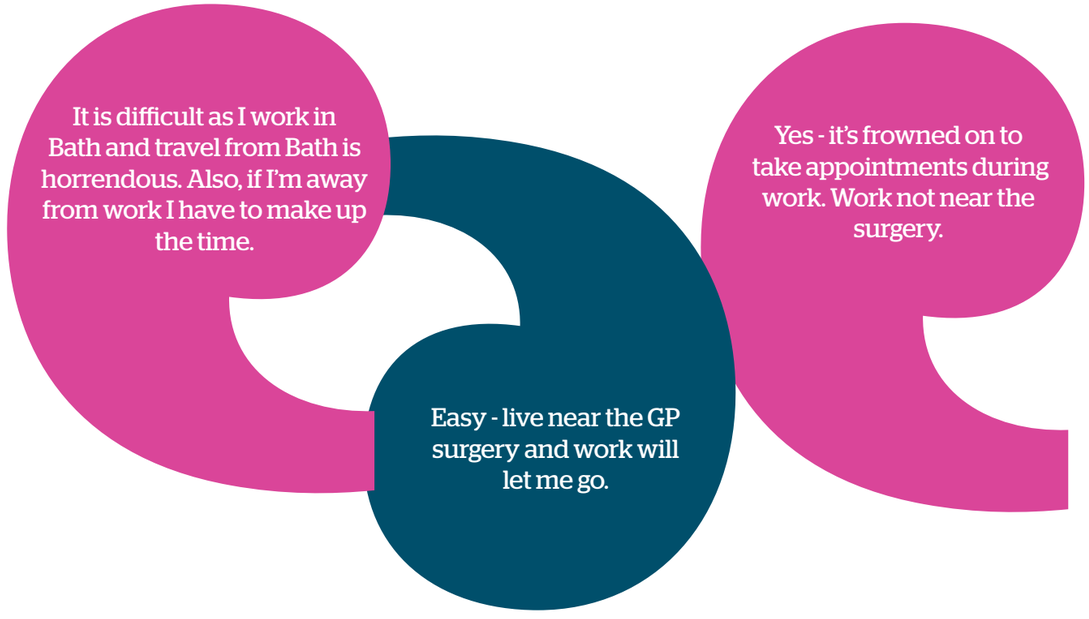
How did people's work affect attending appointments?

Of those people we interviewed attending evening and weekend appointments, 64% were in employment. We asked those people how easy it would be to attend an appointment during the day. 50% said that it would difficult, 28% said it would be easy and 22% made neutral comments.

The most common reason for not being able to attend during the day was difficulties leaving work for a protracted period where people's work was not near to their GP surgery. Those who said it was easy said that this was because they worked near the GP surgery and had a flexible employer, or they worked part time.

Of those attending daytime appointments, 50% were in employment. Of these, 38% said that it was difficult to attend during the day, 17% said it was easy and 44% made neutral comments. Those who said it was difficult said that this was due to a range of different aspects about their employment which included having fixed work commitments, losing pay, and being self-employed.

Additionally, three people said that their commitments to voluntary work made it difficult for them to attend daytime GP appointments and being at college was also mentioned by one person.



How did being a carer affect attending appointments?

We asked people if they cared for someone who required extra support during the day. Of the people we spoke to attending appointments during daytime hours 20% identified themselves as carers and this was 14% for people attending evening and weekend appointments.

We asked how being a carer affected people's ability to attend appointments. Of those who answered this question, 40% told us that being a carer made it more difficult to attend appointments with the main reason for this being given as being unable to leave the cared for person at certain times of day.

When we asked for general comments several carers said that they found telephone appointments useful.

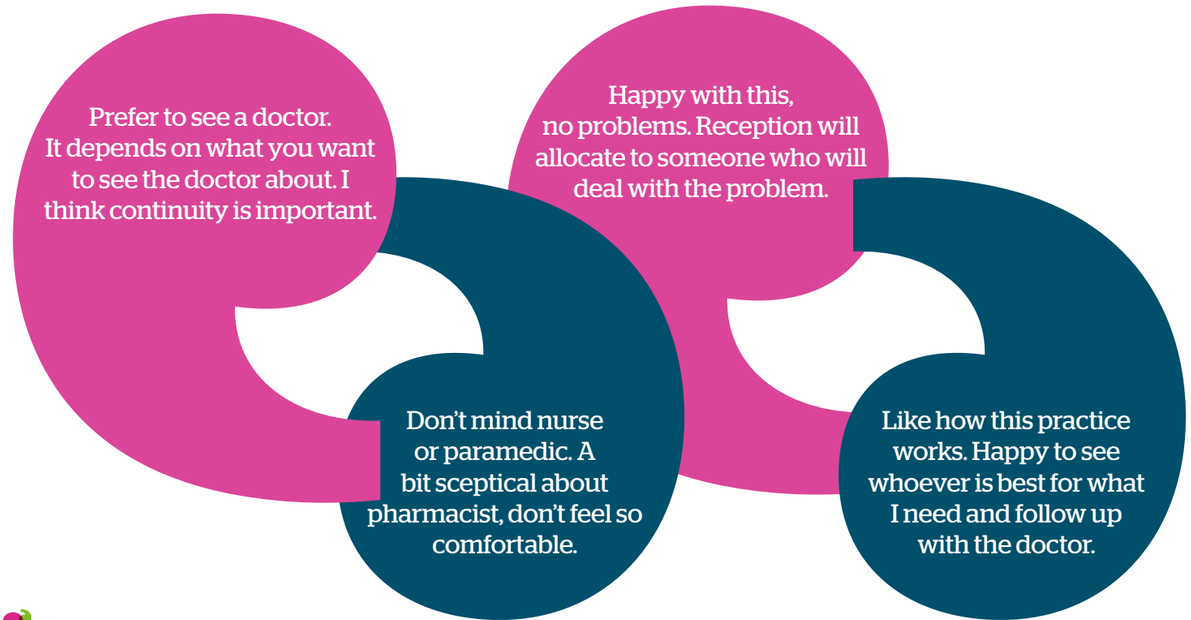
Choice of practitioner

We asked how patients felt about seeing a nurse, paramedic or pharmacist instead of a doctor. The vast majority of those we spoke to said they were happy to see another practitioner if they were able to deal with the issue. Of the practitioners we asked about, slightly more people said they were happy to see a nurse, and they were most unsure about seeing a pharmacist.

There were several positive comments about the triaging process in some surgeries and patients said that they understood this and said it worked well. This view was consistent across people attending during daytime and evening and weekend appointments. Overall:

- **88%** said they happy to see nurse, pharmacist or paramedic if appropriate
- **8%** said they prefer to always see a GP
- **4%** would see a nurse but were unsure about a pharmacist or paramedic.

There were some instances where patients said that they would prefer to see a GP, these were if they were having ongoing treatment for a long term condition, if they thought their issue was serious or if it was something very personal. Most people with long term complex conditions also said that they would prefer to see the same GP for continuity of treatment.



Comments about the process of getting an appointment

We asked what was good about the process of getting their appointment and a wide range of different things were identified. These included straightforward booking process, booking at reception desk, appointment being booked for them by a doctor or nurse, being able to get an appointment with the right professional, and being able to get an appointment quickly.

Several people mentioned that they thought it was good it had been recognised that their need for an appointment was urgent and that they had been given one quickly.

Overall, we received a greater number of comments about things thought to be good about the process of getting their appointment, than those which identified things that could be improved.

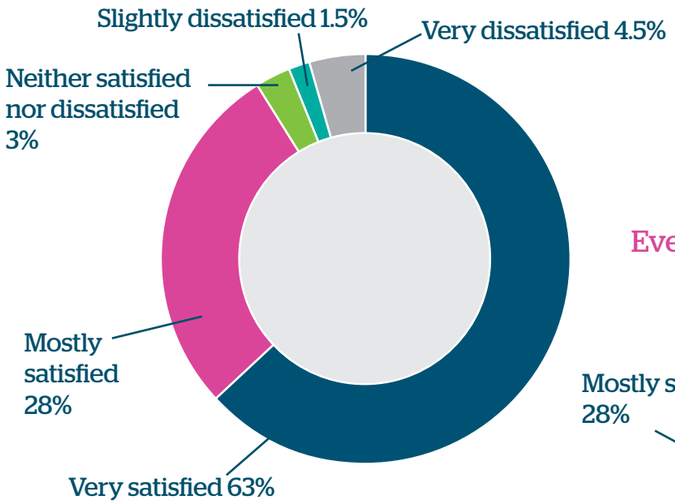
When we asked what could be improved about the process of getting an appointment, the things that were most commonly identified were the booking system for making appointments and access to an appointment sooner. The chart below is an analysis of the comments about what people thought could be improved.

	Evening & Weekend appointments	Daytime appointments	Total number of people
Booking system	7	8	15
A sooner appointment	9	6	15
Being able to get an appointment (No available appointments)	4	3	7
Being able to see a particular GP	1	1	2
More availability of weekend and evening appointments	1	0	1
Other	2	6	8

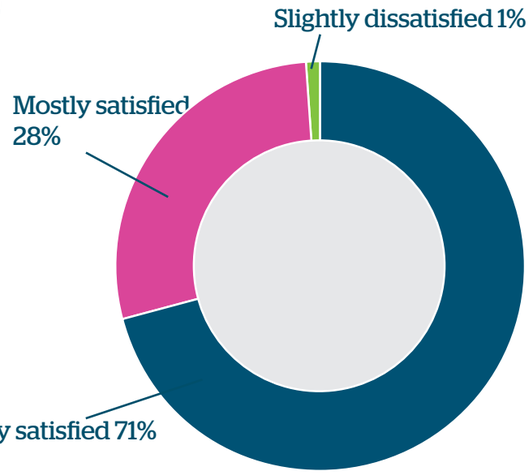
We asked people attending appointments to tell us over all how satisfied they were with the process of getting that specific appointment. Most patients reported that they were very or mostly satisfied. Those attending evening or weekend appointments were slightly more satisfied than those attending daytime appointments.

Satisfaction with getting an appointment

Daytime



Evening & Weekends



General comments about accessing appointments

We asked people if there was anything else they wanted to tell us about their experiences of using GP services generally. Most of the comments we received concerned access to appointments. We analysed these comments using a thematic analysis tool. We found that there were slightly more negative than positive comments about access to GP services. In total there were 138 comments, 55% of which were negative and 45% positive.

These comments appeared to reflect views and experiences of accessing appointments in general, as opposed to their experience of accessing a specific appointment.

While they seem to contradict what people said about their experience accessing specific appointments, there are several possible reasons for this. It might be that people are more likely to remember instances where they had difficulty getting an appointment. It should also be noted that in asking people about accessing specific appointments at doctors' surgeries, we were speaking to people who had been able to get an appointment.

People's general comments may have included several instances where they had tried to make an appointment but not been able to. This would not be captured in our interviews with patients who did have an appointment. It could have also been that these comments were reflective of a general high level of concern about being able to access appointments.

What did people say about how their appointment went?

In most cases, we interviewed patients about the process of making their appointment before they were seen. We then asked people to come back and tell us how their appointment went if they were willing and had time. We were surprised and pleased by the number of patients who wanted to come back and talk to us.

We carried out short follow-up interviews with a total of 117 patients. 61% of those who we had interviewed in daytime hours and 73% of those who we had interviewed at evening or weekend appointments, came back to give us feedback about how their appointment had gone.

Of those we spoke to during the daytime, 58% said that they were seen on time. 42% said they weren't, with waiting times ranging from five to 50 minutes. Of those attending evening and weekend appointments, 80% said that they were seen on time and 20% said they weren't, with delays ranging from five to 60 minutes. Most people we spoke to were not concerned about a short wait for an appointment. (Walk in patients were excluded from these figures as they do not have a fixed appointment time.)

The things that patients most commonly identified as being good about their appointment was knowledgeable and informative staff, competence, friendly manner, and listening.

In terms of what people thought could be improved, nine people identified something. Seven of these felt the waiting time could have been improved, one person felt they should have been given a specific medication, and one had seen someone not able to give the treatment needed and felt the triaging process should have been better.

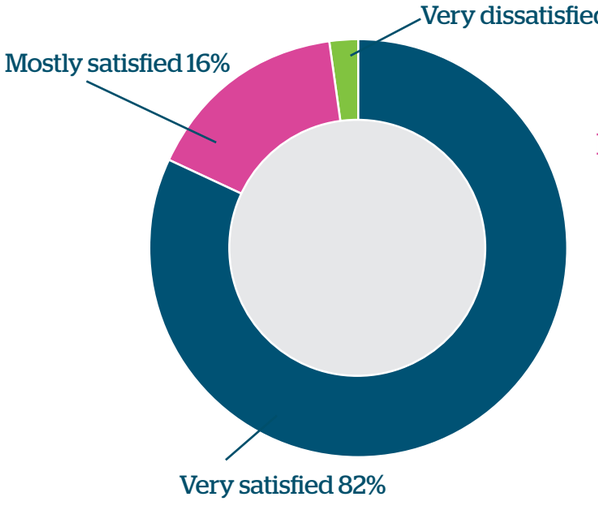
Regarding how any necessary follow up was being arranged, overall, we were told that it had been or was in the process of being arranged. There were two patients that said that this had not been fully completed. One reported difficulty making a follow up appointment within the time scale that the Dr had requested. One person said that they had not yet received the results of a blood tests.

We also asked patients to tell us overall how satisfied they were with how their appointment had gone. Overall very good levels of satisfaction were reported, and these were slightly higher for patients attending weekend and evening appointments compared to those attending during usual surgery hours.

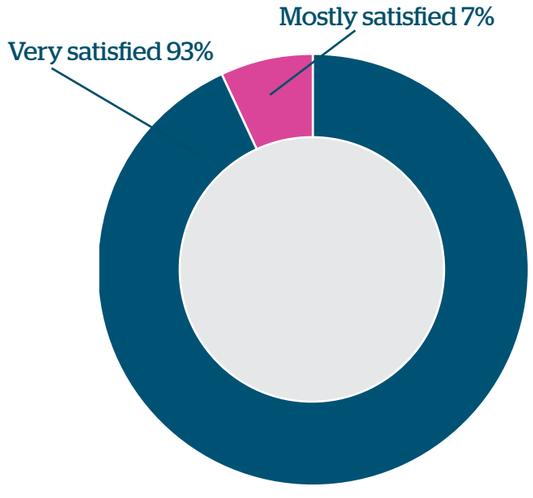
The below charts show how satisfied people said they were with their appointments:

Satisfaction with the appointment

Daytime



Evening & Weekends



Other things that people told us

We asked if there was anything else people wanted to tell us. A few things were mentioned that are not covered elsewhere in this report:

- Several people mentioned that they found telephone appointments useful.
- People reported that they did not like using Doctor Link as a way of accessing appointments, several people found it difficult to use and some said they didn't think it worked properly.
- Text reminders for appointments were mentioned as being a good thing.
- Some people didn't think that their surgery could cope with the demand in their local area.

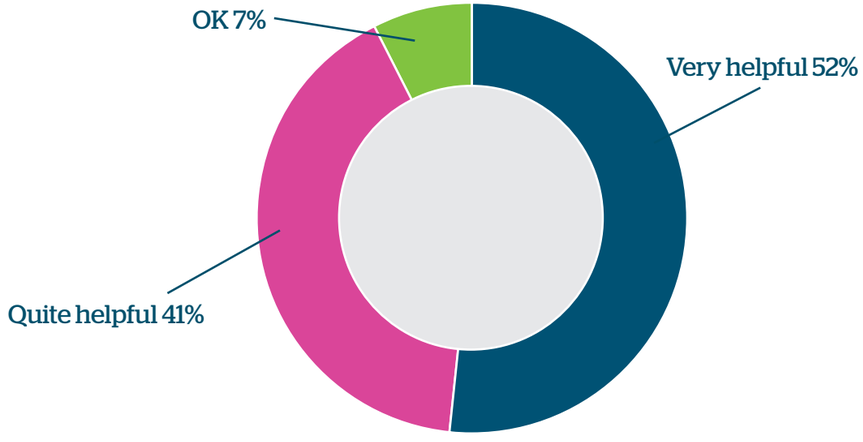
2. Mystery shopping – what did surgeries tell us?

Our volunteers carried out a mystery shopping exercise. We selected 14 surgeries across Wiltshire that served both rural and town areas and that we had not visited as part of this project. Our volunteers called each surgery twice on different days.

They asked the surgeries for information about what appointments were available at evenings or weekends. If they were asked for their name or why they needed an appointment they explained that they were a volunteer from Healthwatch Wiltshire and had been asked to call.

Overall, volunteers reported that people were happy to speak to them and that their calls were dealt with courteously and politely. We asked our volunteers to say how helpful they found the receptionist on each call. The chart shows their responses.

Helpfulness of staff



We found that knowledge about what was available differed considerably among receptionists. On some occasions we were transferred to more experienced staff who were able to give us more information. We considered that in these cases if we hadn't asked specifically about evening or weekend appointments, we would not have been told about them.

It was also evident from our calls that surgeries differed in how they booked evening and weekend appointments. For example, some surgeries told us that these appointments could only be booked with the person's own GP, while others said that they could be with a variety of practitioners. Some receptionists told us that appointments could only be booked by a GP and were unsure of what was available.

In 27 of the 28 calls, we were told that evening appointments were available. In most cases we were given times of evening surgeries and these covered both the extended hours and Improved Access appointment times. Overall, surgeries were clear about when they were opening in the evenings, although there were some cases where we had to be transferred to someone with more knowledge. Several surgeries told us that these appointments get booked up quickly.

We found that knowledge about what was available at weekends was much more variable:

- In 50% of calls we were told that these were not available.
- In 32% of calls we were told that they might be available, but the information about where and when was not clear.
- In 18% of calls we were told that these were available to patients and given clear information about when and where they were available.

We also found that information was variable about what might be available at different practices. No information was given about what might be available at other practices in 47% of calls. In 21% of calls some information was given, and in 32% of calls clear information was given about what was available and where.

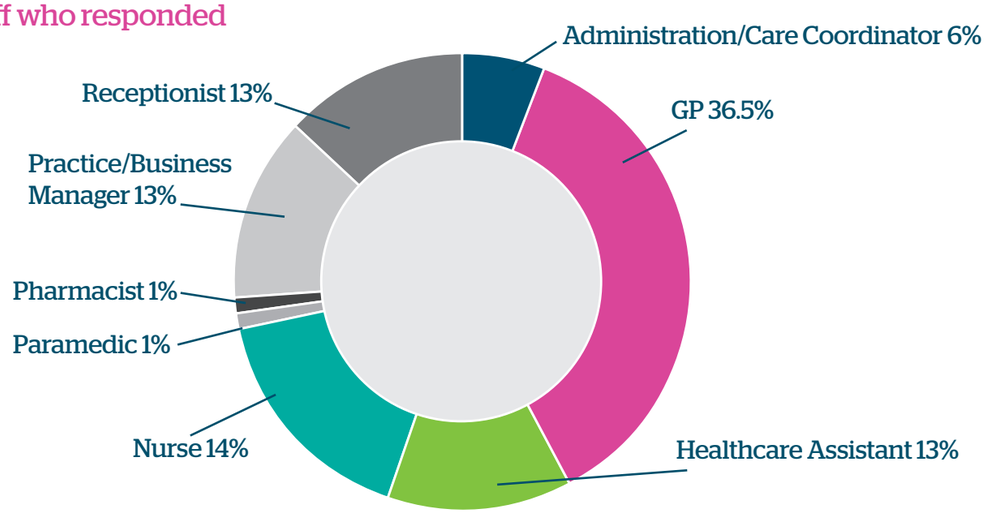
Where we were told about appointments at other surgeries, we asked if the staff there would be able to access to information they needed about the patients. In most cases we were told that they would if the patient had given prior consent for this to be shared.

Our volunteers making the calls also noted the wide range of different answerphone messages across surgeries and felt that some were more useful that others. They thought that this was something that might be worth looking into in more detail in the future.

3. What did staff tell us?

We designed an online survey that was circulated electronically to all staff involved in the Improved GP Access Service. The survey asked staff their views about the service and how they thought it affected them and their patients. Eighty-five staff from 35 different practices completed our survey. This chart shows a breakdown of survey responses by staff roles:

Staff who responded



What did staff think about the service?

We asked staff what they thought was good about the service for them as a staff member or practitioner. Staff mentioned more availability and flexibility of appointments for patients. They said that being able to have more appointments was good for them, and it was mentioned that it enabled them to see patients that they thought needed to be seen. Some staff said that the quieter, less pressurised environment benefited them. Being able to have longer appointment times was mentioned as being useful for seeing patients with chronic or complex conditions. Some staff mentioned that the additional funding and paid overtime benefited them.

> Allows time for more comprehensive consultations with patients as there are less interruptions and other things to deal with that you have working in the week.

> Gives patients more access, which reduces negative opinions about appointmentt availability.

> Sometimes gives more availability of appointments to offer to the patient. The flu clinics offered on a Saturday and smear clinics are always very popular.

We asked staff what difficulties they had experienced working in the service. Fifty-two of the 85 staff members who answered this question identified a range of difficulties.

Difficulties with IT systems was mentioned, particularly in seeing and booking appointments at a different surgery. It was mentioned that the system was complex to use and cumbersome.

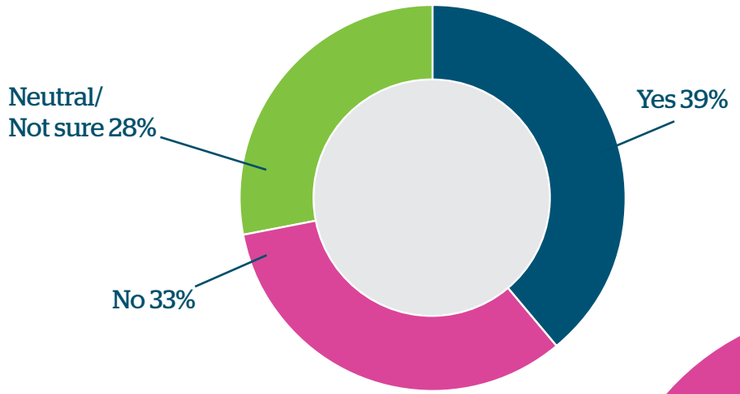
Staffing the extra hours was also mentioned as a difficulty for several surgeries including rota issues and cover. The impact on staff was mentioned including working long hours, tiredness, and impact on family life.

Poor take-up of appointments and patients not turning up for appointments was also raised. There was a feeling that practitioners' time and skill were not used to their full benefit.

> Feel there are a lot of wasted appointments with the service and clinicians not being booked to their full advantage.

We asked staff if they agreed that working in the Improved Access Service was a good use of their time.

Is Improved Access a good use of time?



> No - just more work, good for me as means good pay but actually not necessary, it is not used by working age adults as intended.

Of those who said they didn't think it was a good of use of their time, 18 were GPs.

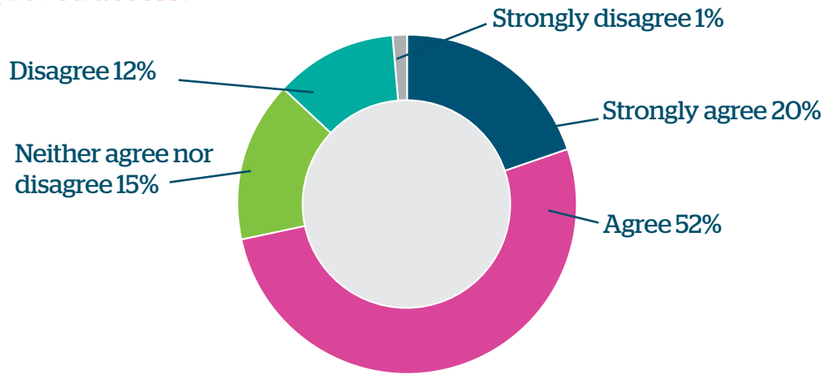
The reasons given why people didn't think this was a good use of their time was that Improved Access required more administration and reporting, non-attendance and low take-up, meaning that appointments were not fully utilised, particularly at weekends.

Some GPs felt that the service shouldn't be provided by GPs who were already overstretched.

> No. Lots of empty appointment slots. Feel guilty earning more money for working much less hard than I do in my normal working hours. I am an experienced nurse practitioner but the patients I see in improved access could be seen by a healthcare assistant most of the time.

We asked staff if they agreed the service has improved access to GP services.

Has it improved access?



Those who agreed said that it provided flexibility and access to working people and was useful for people who had difficulty attending during the day. Appointments for cervical screening, smoking cessation and child asthma reviews were areas that were identified as being useful. It was commented that feedback from patients had been positive.

The people who disagreed said they thought this was because they didn't have issues with access at their surgery. Some said their surgery was in an area with less people of working age.

Some practice staff said that they thought patients didn't like to go elsewhere. There were several comments from staff who said that they thought that evening appointments were more useful than weekend ones.

Benefits and drawbacks to patients

Staff said that they thought the benefits for patients were greater access to appointments, reduced frustration at not being able to get an appointment, flexibility of appointment times, not needing to take time off work, timelier appointments, and longer consultation times. They also thought that access to a range of things out of hours was of benefit, for example flu clinics and blood tests.

We asked if they thought there are any drawbacks for patients. The main one mentioned was travel time for patients and lack of continuity of care if they were going to have an appointment at another surgery.

They might not be able to have as good continuity for ongoing conditions, they need to travel further to be seen.

The patients really appreciate being able to see a GP out of normal office hours. I can do blood tests for patients who can't make the morning blood clinic in time.

It affords patients who can't take time off through work, the flexibility to see a clinician in the evening. In turn, this reduces the levels of frustration that the patients experience due to lack of appointments.

Conclusions

We found that access to GP services remains a concern among local people in Wiltshire. However, it is interesting that patients were more positive when we asked about their experience of arranging specific appointments. People expressed frustration with some systems for making appointments, particularly where patients were asked to phone at a specific time. This was inconsistent across practices.

Appointments in the evenings and weekends are clearly valued. Feedback from patients attending both Improved Access and other out of hours appointments was very positive regarding being able to access these appointments and their treatment during them. There appears to be a greater preference for appointments in the early mornings or evenings as opposed to weekends. Patients' awareness of, and ability to access these appointments, was inconsistent.

It was evident that different practices and surgeries manage their Improved Access appointments in a range of different ways. Information about what was available was not always clear from surgeries when we telephoned them. This might prevent patients being able to book these appointments. This was particularly the case for weekend appointments and for booking appointments at other practices.

Staff processes for booking Improved Access appointments were not consistent or clear. Some staff reported difficulties with IT which meant that they couldn't see or book appointments at other surgeries.

Most staff thought that the Improved Access Service has improved access to appointments for patients and highlighted several benefits of it to patients. Feedback about whether staff thought it was a good use of their time was more mixed. Some staff highlighted low take-up of appointments as the reason for this. Staff commented about the impact of providing this service on their work-life balance.

We found a significant number of people who said that they would be willing to travel to another GP surgery for appointments in certain circumstances. However, some patients told us that this would not be possible for them. Concern was expressed that people who are unable to travel, should not have less favourable treatment because of this.

Overall, there is confidence in the triaging process and most patients are happy to have appointments with a variety of different health professionals, according to what is needed at that time. This appears to be a shift from views shared with Healthwatch Wiltshire in the past where this was much more mixed. People still felt that long standing complex conditions required continuity of care from a GP.

Feedback about the quality or treatment people received and patients' satisfaction levels with how their appointment had gone was overall very positive.

Recommendations

We would like to make the following recommendations:

- Access to evening and weekend appointments is valued and should continue.
- IT processes for booking appointments in other surgeries should be reviewed and improved.
- Consideration should be given to offering more patients who are able to travel an appointment in a different surgery.
- Patients who are unable to travel should be prioritised to be seen at their own surgery.
- The availability and take-up of weekend appointments should be reviewed with a view to assessing whether there is potential to simplify and streamline access at weekends. If there is excess capacity, this could potentially be used for appointments at other times where there is local demand, for example early mornings.
- Clear information about what is available at weekends needs to be provided to surgery staff and to the public.
- All reception staff at surgeries should be provided with clear information and training about booking of evening and weekend appointments both at their own and other surgeries.
- Further consideration should be given on how to reduce the impact on staff whilst retaining an evening and weekend service.
- Recognition should be given regarding the very positive comments from patients regarding the overall quality of treatment.

Thank you

Thank you to all the individuals that stopped to share their honest thoughts. To the GP Alliance for working with us on this project and to the GP practices who supported us by facilitating our visits. Thanks also to our volunteers who gave their time to take part.

Responses

Jo Cullen, Director of Primary Care, BaNES, Swindon and Wiltshire CCGs

Many thanks for undertaking this work and sharing this final draft report with the Clinical Commissioning Groups as the commissioners of the Improved Access Service.

We appreciate the work carried out by your committed and trained volunteers, and recognise a number of your findings.

We also appreciate the honesty of the patients and staff members your team spoke to.

We would like to confirm that this service will be continuing on the same basis for 2020/21 and be delivered locally through the GP surgeries, now grouped into Primary Care Networks.

We are really interested to hear the patients' views, particularly about travelling to other local surgeries and seeing other members of the primary care team, other than GPs where appropriate.

You may be aware that as set out in Investment and Evolution: A Five-Year Framework for GP Contract Reform to Implement the NHS Long Term Plan, NHS England is undertaking a national review of access to general practice, which commenced in July 2019 for full implementation by 2021/22.

We appreciate the honesty of the patients and staff your team spoke to

The access review has one main objective: to improve patient access both in hours and at evenings and weekends and reduce unwarranted variation in patient experience. The review will support the development and implementation of a single coherent "extended access" offer. This review is ongoing, and the expectation had been an interim report this winter (not yet published).

We would welcome involving Healthwatch in any review of the service in line with any changes which are introduced as part of this national report.

Dr Lindsay Kinlin, Wiltshire GP Alliance

We are constantly trying to improve the quality and accessibility of primary care. With this in mind, we were very glad to invite Healthwatch to carry out an independent and impartial assessment of the innovative Improved Access Service.

Your work has provided us with an invaluable insight into the views of patients and staff alike.

The introduction of evening and weekend appointments was not without controversy at the time, and it is pleasing to hear that patients really value this additional access, particularly those who genuinely struggle to attend daytime appointments.

It's pleasing to hear that patients really value this additional access

Going forwards, we will use the lessons learned from your hard work to further develop and improve the service. In so doing, we hope to take some of the pressure off the wider NHS, and improve the quality and timeliness of patient care overall.

We would like to thank Healthwatch and your team of volunteers for this immensely helpful research, and we look forward to working with you again.

Appendix 1

Improved Access to General Practice Survey (For use in usual surgery hours)

Healthwatch Wiltshire would like to hear your views about using Improved access to General Practice.

Healthwatch Wiltshire is the independent champion for people using health and care services in Wiltshire. We listen to what people like about services and what they think could be improved and share their views with those who have the power to make change happen. The results of this survey will be collated and put into a report. All responses will be anonymised, and no individuals will be named in the report. The report will be used to influence the way the service further develops.

We'd appreciate it if you could take a few minutes to answer these questions.

Survey Number:

Location of Appointment:
Date of Appointment:
Approximate time of appointment:

1. How did you make this appointment?

2. When did you make this appointment?

3. Is it easy for you to attend this appointment?
   - Yes
   - No

If no, why not?

4. Is this appointment at:
   - Your usual GP surgery

   If so, how would you feel about having an appointment at a different surgery?

   - Another GP surgery

   If so, was it easy for you to travel to this appointment? How did you get here?

5. Have you ever been offered an evening or weekend appointment?

6. Ideally what time would you prefer appointments?

7. Are you in employment?

   - Yes

   If yes, how easy is it for you to attend daytime GP appointments?

   - No

8. Do you care for someone who needs extra support day to day?

   - Yes

   If yes, how does this affect your ability to attend appointments?

   - No

9. When do you think it's better travel to see someone at another practice sooner, rather than waiting to see someone at your own practice?

10. If you were offered an appointment with a nurse, paramedic or pharmacist instead of a GP, how would you feel about this?

11. What has worked well about the process of getting this appointment?

12. Is there anything that you think could be improved?

13. Overall how satisfied were you with the process of getting your appointment?
- Very Satisfied
- Mostly Satisfied
- Neither Satisfied nor Dissatisfied
- Slightly Dissatisfied
- Very dissatisfied

14. Is there anything else you'd like to tell us about your experience of using GP services?

About you:

It's important that we hear from a diverse group of people. We ask some questions about you so that we can identify any issues that affect different groups of people. This information is anonymous, and you do not have to answer any questions if you don't wish to.

15. Please tell us the town or village you live in?

16. Are you?

- Male
- Female
- Prefer to use my own term ……
- Prefer not to say

17. Is the gender different to the gender you were assigned at birth?

- Yes
- No
- Prefer not to say

18. Do you have a religion of belief?
- Buddhism
- Christianity
- Hinduism
- Islam
- Judaism
- Sikhism
- No religion
- Prefer not to say
- Other ……

19. What is your age?

- Under 18
- 18 - 24
- 25 - 34
- 35 - 44
- 45 - 54
- 55 – 64
- 65 – 74
- 75 – 84
- 85 +
- Prefer not to say

20. Are you?

- Bisexual
- Gay/lesbian
- Heterosexual/straight
- Asexual
- Pansexual
- Prefer to use my own term
- Prefer not to say

21. Do you consider yourself to have a health condition or disability?

- No
- Mental health condition
- Visual impairment
- Hearing impairment
- Learning disability
- Physical or mobility disability
- Prefer not to say

22. How would you describe your ethnic group?

African
Arab
Bangladeshi
Black British
Caribbean
Gypsy or Irish Traveller
Indian

Pakistani
White British
White Eastern European
Any other white background ……..
Any other mixed background ……..
Other ……..

The results will be collated and put into a report. All responses will be anonymised, and no individuals will be named in the report.

23. If you would like to be added to our mailing list, please provide your email or postal address:

All data will be held securely and in compliance with data protection laws. It will only be used for the purposes of carrying out Healthwatch Wiltshire activity. Your details will not be shared with any other organisation. You may withdraw your consent to us holding your details at any time by emailing info@healthwathchwiltshire.co.uk or calling 01225 434218.

Thank you for completing this survey.

Appendix 2

Improved Access to General Practice Survey (For use at evening and weekend visits)

Healthwatch Wiltshire would like to hear your views about using Improved Access to General Practice.

Healthwatch Wiltshire is the independent champion for people using health and care services in Wiltshire. We listen to what people like about services and what they think could be improved and share their views with those who have the power to make change happen. The results of this survey will be collated and put into a report. All responses will be anonymised, and no individuals will be named in the report. The report will be used to influence the way the service further develops.

We'd appreciate it if you could take a few minutes to answer these questions.

Survey Number:

Location of Appointment:
Date of Appointment:
Approximate time of appointment:

1. How did you make this appointment?

2. When did you make this appointment?

3. Is it easy for you to attend this appointment?
   - Yes
   - No

If no, why not?

4. Is this appointment at:
   - Your usual GP surgery

If so, how would you feel about having an appointment at a different surgery?

   - Another GP surgery

If so, was it easy for you to travel to this appointment? How did you get here?

5. Were you offered an evening or weekend appointment, or did you ask for one?

6. Ideally what time would you prefer appointments?

7. Are you in employment?

- Yes

If yes, how easy is it for you to attend daytime GP appointments?

- No

8. Do you care for someone who needs extra support day to day?

- Yes

If yes, how does this affect your ability to attend appointments?

- No

9. When do you think it's better travel to see someone at another practice sooner, rather than waiting to see someone at your own practice?

10. If you were offered an appointment with a nurse, paramedic or pharmacist instead of a GP, how would you feel about this?

11. What has worked well about the process of getting this appointment?

12. Is there anything that you think could be improved?

13. Overall how satisfied were you with the process of getting your appointment?

- Very Satisfied
- Mostly Satisfied
- Neither Satisfied nor Dissatisfied
- Slightly Dissatisfied
- Very dissatisfied

14. Is there anything else you'd like to tell us about your experience of using GP services?

About you:

It's important that we hear from a diverse group of people. We ask some questions about you so that we can identify any issues that affect different groups of people. This information is anonymous, and you do not have to answer any questions if you don't wish to.

15. Please tell us the town or village you live in?

16. Are you?

- Male
- Female
- Prefer to use my own term ……..
- Prefer not to say

17. Is the gender different to the gender you were assigned at birth?

- Yes
- No
- Prefer not to say

18. Do you have a religion of belief?

- Buddhism
- Christianity
- Hinduism
- Islam
- Judaism
- Sikhism
- No religion
- Prefer not to say
- Other …….

19. What is your age?

- Under 18
- 18 - 24
- 25 - 34
- 35 -44
- 45 - 54
- 55 – 64
- 65 – 74
- 75 – 84
- 85 +
- Prefer not to say

20. Are you?

- Bisexual
- Gay/lesbian
- Heterosexual/straight
- Asexual
- Pansexual
- Prefer to use my own term
- Prefer not to say

21. Do you consider yourself to have a health condition or disability?

- No
- Mental health condition
- Visual impairment
- Hearing impairment
- Learning disability
- Physical or mobility disability
- Prefer not to say

22. How would you describe your ethnic group?

African
Arab
Bangladeshi
Black British
Caribbean
Gypsy or Irish Traveller
Indian
Pakistani
White British
White Eastern European
Any other white background .....
Any other mixed background .....
Other .....

The results will be collated and put into a report. All responses will be anonymised, and no individuals will be named in the report.

23. If you would like to be added to our mailing list, please provide your email or postal address:

All data will be held securely and in compliance with data protection laws. It will only be used for the purposes of carrying out Healthwatch Wiltshire activity. Your details will not be shared with any other organisation. You may withdraw your consent at any time by emailing info@healthwathchwiltshire.co.uk or calling 01225 434218.

Thank you for completing this survey.

Appendix 3

healthwatch Wiltshire

Improved Access to General Practice - Survey for Staff

Healthwatch Wiltshire want to hear your views about your work in Improved Access to General Practice.

Healthwatch Wiltshire is the independent champion for people using health and care services in Wiltshire. We listen to what people like about services and what they think could be improved and share their views with those who have the power to make change happen.

We are talking to people who have used the Improved Access to GP Services, and to staff who are involved in providing it. Improved Access is a programme whereby practices are funded to provide additional appointments between 6:30 pm – 8:00 pm Mon-Fri, or Saturday mornings, or in some cases additional daytime services. In some areas, patients can book these appointments at a different practice to the one they are registered at.

The results of this survey will be collated and put into a report. All responses will be anonymised, and no individuals will be named in the report. The report will be used to influence the way the service further develops.

We'd appreciate it if you could take a few minutes to answer these questions.

1. Which practice do you work at?

2. What is your job role within this service?

3. What do you think is good about the service for you as a staff member or practitioner?

4. Are there any difficulties that you have experienced working within this service?

5. What do you think the benefits are for patients who use this service?

6. Are there any drawbacks for patients who use the service?

7. Do you think that working within this service is a good use of your time?

8. Do you agree that this service has improved access to GP services?

- [ ] Strongly Agree
- [ ] Agree
- [ ] Neither agree nor disagree
- [ ] Disagree
- [ ] Strongly Disagree

Please tell us the reason for your answer::

9. How would you like to see this service further developed?

10. Is there anything else you would like to say?

11. If you would like to be added to our mailing list, please provide your email or postal address:

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Wiltshire Health and Care ("WHC")
Board Meeting

Item 16

Any Other Business

VERBAL

Wiltshire Health and Care ("WHC")
Board Meeting

Date of Next Meeting

1st May 2020, 10.00-13.00

Kier Room, Melksham Community Hospital