Overview & Scrutiny – 23rd November 2021

Member Questions to the Integrated Care System (ICS) (11 total)

1.	**Question from Councillor John Payne**
	I hope you will agree that your staff are your most valuable resource. I would appreciate it if you could convey to the Committee your views on the current position, in particular where are staff shortages impacting on the current provision of services and what action is the Trust taking to address this issue.
	Response from the ICS
	Yes, staff are definitely our most valuable resource and we are doing everything possible to continue to support all health and social care staff across the county. In particular recognising the many challenges the pandemic has created during the last 18 months. This includes a range of staff health and well-being measures, practical measures taken to date include ensuring all staff continue to take breaks and annual leave, ensuring good access to mental health support, subsidising meals, contributing to car parking costs etc. In terms of workforce pressures, in common with other parts of the country, these are being experienced across the health and social care system with particular challenges experienced in relation to the recruitment and retention of nursing staff within the NHS and domiciliary and care home staff within the adult social care sector. *Please also see answer to question 5 for more detail on the specific initiatives in place to support staff at both Gloucestershire Hospitals NHS Foundation Trust (GHFT) and South Western Ambulance NHS Foundation Trust (SWAST).* As a system we have worked together to take a number of further targeted actions. There is a system wide 'People Framework' that allows organisations to share staff when required. This was used during the first phases of the pandemic and, more recently, to enable staff to be shared across the system to deliver the vaccination programme. Specific actions taken to address workforce shortfalls include use of bank and agency staff, international recruitment, partnerships with the third sector, staff passports (to allow staff to work more easily across different parts of the system) and system wide recruitment and retention programmes.
2.	**Question from Councillor John Payne**
	Your "Live A&E waiting times" you publish on the internet does not provide information on waiting times, just that you will be triaged within 15 minutes. Triage is not treatment. The NHS statistic for September shows that only 60% of patients were seen within the 4 hour target, making GNHS Trust one of the worst performing trusts in the country. Could you please provide a breakdown of wait times at GRH and CGH, and do you count the time of triage as "receiving treatment"?
	Response from the ICS
	The 4 hour waiting time standard is a measure of the time period from a patient being booked into A&E and being discharged home or admitted to hospital.

	Triage is the process by which patients are assessed by a clinician and given a clinical priority using a recognised national triage score. Performance against the Emergency Department four hour standard is under daily pressure across the country. GHFT and system performance is currently in the 'middle of the pack' in terms of our relative position compared to other parts of England. *However all parts of the system continue to be committed to further improve this performance and further reduce waiting times.* Performance for the most recent week shows performance above 70% against the 4 hours *maximum* wait standard. In terms of the last full month, in October Gloucestershire Hospitals NHS Foundation Trust saw 62.2% of patients within a maximum of 4 hours or less. Taking all settings the Gloucestershire system saw 73.3% of patients in all settings within the maximum of 4 hours. Both GHFT and Gloucestershire's performance has improved compared to the previous month. In October, of the one hundred and eleven providers in England with a Type 1 A&E service, GHFT ranked 55th and Gloucestershire ranked 21st out of 42 systems (in terms of the overall percentage of attendances within 4 hours) and 17th in terms of type 1 activity.
3.	**Question from Councillor John Payne**
	As an outsider it is difficult to define the causes of the failure of GNHS Trust to provide and acceptable level of service, particularly A&E services. Could you please highlight what you see as the main areas of concern and how are these to be addressed.
	Response from the ICS
	GHFT aims to provide high quality, safe and effective urgent and emergency care services as part of the wider urgent and emergency care system in Gloucestershire. There are a number of factors impacting upon A&E performance at present, these include in particular: • The ongoing impact of the Covid-19 pandemic (in terms of additional infection prevention and control measures, the admission of Covid patients, Covid related staff absence etc.). • Pressure caused by discharge delays from hospital. This sometimes leads to delays in being able to admit patients from the Emergency Departments and can sometimes lead to Ambulances queuing as pressure builds during the day/into the evening. These high numbers of discharge delays are due in particular to the pressure upon out of hospital and home based onward pathways for patients and reflects the wider pressure upon community and adult social care services. *This continues to require a whole health and social care system response (see list of system actions below).* • Workforce pressures across all parts of the health and social care system (contributing to the above capacity issues).

	All system partners continue to work closely together to respond to these pressures and additional actions taken to date have included: • Putting in place additional doctors and nurses within the services provided by NHS 111, Out of Hours GPs and SWAST (i.e. increase in the trained doctors and nurses able to take call from patients). • Increased use of community and rapid response teams to support A&E, reduce unnecessary admissions to hospital and facilitate discharge. • Commissioning additional 'Discharge to Assess' care home capacity supporting more people to have their Adult Social Care or Continuing Health Care assessment in another setting to avoid a delay to hospital discharge (e.g. in a specially commissioned care home bed). • Commissioning additional home based care alongside additional respite care capacity. • The introduction of an Enhanced Independence Offer/Increase in 'Home First' capacity. This is a discharge pathway for individuals who are not safe to be discharged home without some level of support. The service is "therapy led" for a maximum of 10 days and works closely with the person to promote their independence. • All community hospital beds have been prioritised for acute hospital transfers including 'flexing' admission criteria to support those patients waiting assessment/home based pathways. • The use of patient cohorting areas within A&E during times of particular pressure. • Opening of additional inpatient escalation areas within the hospital during times of pressure. • The cancelling and rescheduling of some non-urgent planned surgery during periods of escalation. • The recruitment of a senior system lead for discharge and flow to co-ordinate the key programmes of work across the system and to manage daily escalation processes pertaining to flow. A wider set of actions is being taken by GCC, GCCG and system partners to help stabilise the domiciliary and care home markets (some of which are referenced above). These include: • Provider relief funding: providing additional funding to providers from the Covid Emergency Fund including helping to meet additional infection control, testing and workforce costs. • Actions to support retention and recruitment: Most of these are extensions of work already in development by our 'Proud to Care' team. They include activities to promote jobs, select and recruit staff, increase training opportunities for staff and the promotion of care as a career as well as recognition of the value of our care workforce.
4.	**Question from Councillor Dilys Barrell and Councillor Flo Clucas**
	Please could you tell us about the various types of Alert levels used in health care, in particular the Black Alert /Opel 4 / internal incident: • What are the criteria which trigger each of these levels of escalation? • Who do the Trust have to inform when they declare each level?

	• Which services are involved? • What actions are staff and partners expected to take in response to each level of escalation? • Is there any way CBC could help on these occasions?
	Response from the ICS
	There are two main reported escalation levels, a system escalation level and an individual provider escalation level. They both use the national Operational Pressure Escalation Levels (OPEL) definitions and these align with the National Resource Escalation Action Plan (REAP) comprising of 4 distinct levels: • OPEL 1 (Green) The local health and social care system capacity is such that organisation are able to maintain patient flow and are able to meet anticipated demand within available resources. • OPEL 2 (Amber) The local health and social care system is starting to show signs of pressure, focussed actions are required in organisations. • OPEL 3 (Red) The health and social care system is experiencing major pressures which are compromising patient flow and these continue to increase. Further urgent action required across the system. • OPEL 4 (Black) Pressure in the local health and social care system continues and there is increased potential for patient care and safety to be compromised. All available local escalation actions taken, external extensive support and intervention required. The status of the system is assessed each day by the submission of a set of data from each organisation which is put together through our daily reporting system in order to assess the overall positon. As a system we are currently at OPEL 3 (Red). All parts of the system are required to submit this data every day of the week. All parts of the health and social care system are covered by this process including NHS 111, SWAST, acute and community providers, social care etc. SWAST uses REAP levels Green through to Black to determine and communicate the escalation level. There is a system wide and individual NHS provider escalation plan which details each action which will be taken at each level of escalation to relieve the pressure upon the system. This is support by a series of escalation calls which take place each day and Gold (CEO level calls) which take place across the week. In terms of support during these periods of pressure CBC could continue to support our ‘Click or Call First’ campaign messaging to the public, regarding the use of Urgent and Emergency Care Services. The great majority of people with minor illness or injury are continuing to access services appropriately.
5.	**Question from Councillor Dilys Barrell**
	Staff must be working under enormous pressure at the moment. What measures are there in place to support their mental health? Are there any problems with staff shortages? Can you tell us about the measures you have in

	place to help retain staff and recruit new ones? Is this an area where CBC could help?
	Response from the ICS
	There are a number of initiatives in place to support the mental health and well-being of all NHS staff. These include access to a range of mental health support as well as wider health and well-being programme. The following summarises just some of the key initiatives in place within GHFT and SWAST. Examples of GHFT wellbeing initiatives include: ▪ a Staff Support and Advice Hub which staff can contact for support in relation to their psychological wellbeing, this is able to facilitate access to telephone counselling services and occupational health advice; ▪ the Trust has a large number of Trauma Risk Management (TRiM) Practitioners who are front line staff who have been additionally trained to identify and support those at risk of mental health problems in their teams; ▪ the Trust introduced Psychology Link Workers during the pandemic and these remain in place and are clinical psychologists who work with teams and individuals to support their mental health and psychological wellbeing. Examples of SWAST wellbeing initiatives include: ▪ wellbeing support provided by an in house Staying Well Service; ▪ access to formal based counselling, physiotherapy, coaching and alternative therapies to provide specialist support to retain and help with returning to work, like GHFT a Trauma Risk Management (TRiM) is available for when employees have attended a traumatic event; ▪ welfare cars have been made available; ▪ Employee Assistance Programme service app, providing access to 24/7 counselling support; ▪ long Covid support through Outreach Support Workers; ▪ psychological wellbeing packs shared with all employees. In terms of the establishment position SWAST are projected to have an over established position of 125 whole time equivalents (WTE) by the end of this financial year. In order to achieve this, they have recently recruited an additional 50 WTE paramedics in order to reduce the requirement for incentive and overtime shifts because it is recognised this will be contributing towards employees' fatigue. In terms of Gloucestershire SWAST are projecting a year end paramedic over establishment of 22. The issues in relation to system workforce challenges are covered in the earlier answer but in terms of areas where CBC could offer support, there is a particular need to ensure all NHS and social care staff continue to feel supported and valued during what we know will continue to be a challenging period. If there is any way the council could help to continue to communicate this through their public messaging would be very much appreciated.
6.	**Question from Councillor Dilys Barrell**

	Do you have the resources you need to cope with the increased pressure services are under? Can CBC work with you and help in any way? *(I am wondering about such things as giving residents information about appropriate use of services, e.g. when to use 111 or the use of "what 3 words" to pinpoint a location for ambulance staff)*
	Response from the ICS
	Additional national funding has been received by both the NHS and GCC to help ensure we are able to respond to the current pressures (with the GCC funding focussed upon further support to the ASC workforce). In particular this is being used to recruit additional staff and to purchase additional equipment in order to put us in the best possible position in order to be able to respond to the challenges the system faces this winter. It should be noted that as well responding to the urgent and emergency care pressures facing the system, this is also being targeted at furthering the progress already made in reducing the number of patients and the time patients currently wait for planned treatments (including diagnostics, cancer care and planned procedures/treatment). *Please see answer at 4. above regarding 'Click or Call First' campaign.*
7.	**Question from Councillor Flo Clucas**
	On 8th November at 11.50am, waiting time to be seen by a doctor in A&E at the RGH was 394 minutes (6hrs 56 minutes) with 94 people in the queue. At CGH, the waiting time was 84 minutes, with 30 people in the queue. At 12.32, there were already 15 ambulances queueing outside the A&E department. Emergency ambulances were not able to respond to many emergency (999) calls because so many are waiting outside A&E departments. It would help the Committee's understanding of the process if the Hospital Trust could please explain the escalation framework it uses: • How it judges when to declare a 'Critical Incident', a 'Reset Day' or any other kind of 'Incident'. Particularly as one was declared this week, prior to the Opel 4 declaration. • How it grades such incidents: for example by Number 1,2,3,4, or colour-Green, Amber, Red, Black - as in the national NHS Framework. Operational Pressures Escalation Levels (OPEL); or as Resource Escalation Action Plan (REAP), or by some other method? If so, can the Trust please define what it means by 'Alert', 'Internal Incident', 'Internal Critical Incident' and Reset Days and how these relate to the above?
	Response from the ICS
	The Trust has in place a detailed internal escalation policy which contains a series of triggers which prompt specific escalation actions. *The Operational Pressure Escalation Levels are as set out in the answer to question 4. above.*

	The Trust moves into 'Internal Incident' when a different level of response is required, this can for example mean that some routine activities (which do not contribute to responding to the immediate pressures) are stood down, that staff are redeployed or additional staff are called in to the hospital to help with the response. It also means that non-urgent meetings or training may be cancelled to release staff.
8.	**Question from Councillor Flo Clucas**
	The Hospital Trust is fined if it is unable to unload emergency ambulance patients within 30 minutes and fined even more when it is unable to unload them within one hour. Did the Hospital Trust inform the Ambulance Service, it's Commissioners, or any of its other partners, when it started to be unable to unload patients from emergency ambulances within the target times? Did this count as a formal alert within the above framework? If not, why not?
	Response from the ICS
	There are no financial penalties imposed for Ambulance Handover delays and SWAST receives no funding linked to this. This is not just a GHFT issue but rather a system issue as reflected in the system wide action plan and escalation processes. It is also important to emphasise that ambulance handover delays can also be seen as a symptom of the wider demand and capacity pressures being experienced across the health and social care system. Ambulance handover delays form a key part of the daily assessment of the pressures facing the system and inform the escalation level and actions.
9.	**Question from Councillor Flo Clucas**
	What communications took place between the Hospital Trust and SWAST management over the Hospital Trust's inability to unload patients within the target times and the impact this was having on the efficiency of the ambulance service? It was frequently taking between three and five hours to unload patients and peaking at between ten and fifteen hours. At times there were between 12 and 27 ambulances queuing outside GRH ED. On at least one occasion there were over 30 Class 1 Ambulance calls outstanding because there were no emergency ambulances available because they were all waiting to unload patients outside GRH ED.
	Response from the ICS
	Operational teams in both GHFT and SWAST are in regular contact with each other every day and the Trust has members of the SWAST team on site with them and has access to the SWAST system which gives details of the numbers of ambulance calls, ambulances on route to ED etc. The focus of the Trust and the wider system continues to be upon releasing ambulance crews as quickly as possible (see list of actions above). All patients are assessed upon arrival and monitored whilst they are awaiting treatment.
10.	**Question from Councillor Flo Clucas**

	What was the nature of the notice circulated to Hospital staff on 19 September? That situation was referred to again in internal notices on 23/24 September and again on 05 October. Was that some kind of internal escalation? If so, where in the escalation framework did it rank? 2, 3, or 4, or 'Amber', 'Red', or 'Black'?
	Response from the ICS
	This related to the Trust's internal escalation status, please see earlier response regarding the various levels of escalation.