Open Agenda

Health, Adult Social Care, Communities and Citizenship Scrutiny Sub-Committee

Monday 24 March 2014
7.00 pm

Supplemental Two Agenda

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The Guy's & St Thomas' (GST) papers are attached . GST presenters will be Elizabeth Palmer, Deputy Director, Assurance & Compliance and Katrina Cooney, Deputy Chief Nurse .

- Presentation on Quality accounts; mortality & complaints; (GST1)
- Complaints report Jan- Dec 2013 (GST2)
- Briefing paper on how Guy's and St Thomas' NHS Foundation Trust determines its nurses, midwifery and health visitor staffing levels (GST3)
- January Board report on nurse staffing (GST4)
- April Board report on nurse staffing (GST5)
- April workforce report (GST6)

The King's College Hospital (KCH) information on this item is has been combined with the paper circulated with previous agenda item; number 5.

9. Update on Health and Wellbeing Board Strategy 106 - 111

Papers attached.

Open Agenda

Agenda Item 4

Health, Adult Social Care, Communities and Citizenship Scrutiny Sub-Committee

MINUTES of the OPEN section of the Health, Adult Social Care, Communities and Citizenship Scrutiny Sub-Committee held on Monday 27 January 2014 at 7.00 pm at Ground Floor Meeting Room G02A - 160 Tooley Street, London SE1 2QH

PRESENT:
Councillor Rebecca Lury (Chair)
Councillor David Noakes
Councillor Denise Capstick
Councillor Rowenna Davis
Councillor Dan Garfield
Councillor Jonathan Mitchell
Councillor Michael Situ

OTHER MEMBERS PRESENT:

OFFICER SUPPORT:
Dr Ruth Wallis, Director of Public Health, Southwark Council
Sarah McClinton, Director of Adult Care, Southwark Council
Adrian Ward, Head of Performance, Adult Care, Southwark Council
Andrew Bland, Chief Officer NHS, Southwark Clinical Commissioning Group (SCCG)
Gwen Kennedy, Director of Client Group Commissioning, SCCG
Jill Webb Deputy Head of Primary Care (South London) NHS England
Tamsin Hooton, Director of Service Redesign, SCCG
Alvin Kinch, Healthwatch;
Tamsin Hooton, Director of Service Redesign, SCCG
James Hill, Head of Nursing , Guy's & St Thomas'
Nicola Wise, General Manager , Guy's & St Thomas'
Briony Sloper, Deputy Divisional Manager, Trauma, Emergency & Urgent Care , King's College Hospital .
Steve Davidson, Service Director, Mood Anxiety and Personality Clinical Academic Group , SLaM.

1. APOLOGIES

1.1 There were no apologies.

2. NOTIFICATION OF ANY ITEMS OF BUSINESS WHICH THE CHAIR DEEMS URGENT

2.1 There were none.

3. DISCLOSURE OF INTERESTS AND DISPENSATIONS

3.1 There were no disclosures of interests or dispensations.

4. MINUTES

4.1 The minutes of the meeting of 9 December 2013 were agreed as an accurate record.

5. MENTAL HEALTH AND ACCIDENT & EMERGENCY

5.1 The chair welcomed James Hill, Head of Nursing and Nicola Wise, General Manager , Guy's & St Thomas' ; Briony Sloper, Deputy Divisional Manager, Trauma, Emergency and Urgent Care , KCH ; Steve Davidson, Service Director, Mood Anxiety and Personality Clinical Academic Group , SLaM and Gwen Kennedy, Director of Client Group Commissioning Southwark CCG.

5.2 Gwen Kennedy, Director of Client Group Commissioning, opened by saying that there has been an increase in the numbers of people needing mental health service presenting at acute settings; a greater proportion are known to the service. She chairs a recently convened urgent care board sub group looking at the issue and one of the tasks is to understand the data more. She explained that formally there was an urgent care network managing diverts across the south east , with a task and finish group that developed an action plan; now pressures have been building again so there was a decision to reconvene this group to look across the system . A member asked if there was an action plan and the Director of Client Group Commissioning said that the group is looking at the former plan and have a draft action plan in development.

5.3 Steve Davidson, Service Director, Mood Anxiety and Personality Clinical Academic Group, SLaM commented that there have been some changes in home treatment since the Guys and St Thomas' paper was submitted and now emergency staff can make more clinical decisions which have improved assessment speeds.

5.4 A member commented that when she spent a shift with ambulance drivers they said the biggest issue was mental health; the drivers said that now patients have to be taken to Accident & Emergency, which is often chaotic, whereas formally they

could be taken to a police cell - which was a quieter place. Steve Davidson, SLaM, responded that mental health services think that a police station would be about the worst place to go, given the co-erosive nature of their involvement. James Hill, Head of Nursing, GST agreed and said that A & E is much better because patients can be assessed for physical needs. The member commented that she completely respected the clinical views expressed but the medics hated people in mental distress being obliged to join a big queue where people might be throwing up or violent .

5.5 James Hill said that Guys and St Thomas' are building a special suite so that people can be seen in a calmer environment. He explained that medical assessment is needed to see if mental health symptoms have a physical cause; for example delirium in older people can be a sign of infection.

5.6 Briony Sloper, Deputy Divisional Manager, Trauma, Emergency and Urgent Care, KCH said the Denmark Hill A & E department is not well set up for the volume and acuity of patients with mental health; it can be very difficult when a person turns up in an incredibly distressed state. The department are putting in more staff and building physical capacity. James Hill said that Guys & St Thomas are experiencing the same issues and that a lot of their overspend is around mental health.

5.7 A member referred to the work that scrutiny did in 2010 and the community survey about the closure of the crisis suite at the Maudlsey and the need to have a separate room at KCH Denmark Hill A & E. He commented that ultimately King's agreed, which he was pleased about. Briony Sloper commented that there are some people who use the rooms set aside, but these are not enough. Another member commented that the former crisis centre at Maudsley did offer this provision, and the community warned of the consequences of closure. Briony Sloper said that the A & E has neither sufficient space nor clinicians. A member asked her if rising need was caused by the increasing population, but she said it was about it is about acuity and emphasized that there has been a significant growth in acuity.

5.8 A member asked Briony Sloper what was driving the increasing acuity, but she said she couldn't comment on why. James Hill, GST, said the amount of people of people who need help with feeding and help to deal with social circumstances has increased. Gwen Kennedy added that the sub-group is looking at data and trends. A member asked if the economic pressure is contributing to the rise in acuity and everybody agreed it was. A member asked there was a rise in self harm and Briony Sloper said she did not think there was. Steve Davidson, SLaM emphasized that there is a 25 % increase in admissions and a member asked if this was higher in the city and he said it is. Briony Sloper said that was a particular problem with approved social workers.

5.9 A member commented that the reports indicated that patients with a mental health need will be seen within 30minutes. Briony Sloper said yes, that is correct: it is 30 minutes to be seen for mental health and 60 minutes for physical health - the total

journey through the system is 4 hours, from entrance to either leaving or admission to a bed.

5.10 Gwen Kennedy, Southwark CCG emphasized that there is a cohesive approach - we all coming together. A member referred to the move of Public Health to the council and asked where support to mental health could be best directed. Briony Sloper suggested that it might be better to ask service users and indicated that KCH are looking at the prior three months and asked what happened to those clients. She said that she wouldn't want to pre-empt this study.

5.11 The Director of Public Health referred to work completed by the UCL Institute of Health Equity, looking at the health impacts of the economic environment. This highlighted a probable increase in mental health problems. Young adults are also likely to be affected by low employment and income.

5.12 A member commented that the interim results from the scrutiny survey did indicate that people were going to A & E to access healthcare that doctors might be better placed to provide. He asked if the local E & E department thought this was an issue. KCH responded that Denmark Hill A & E do active streaming; there are GPs on site and the department also liaises with local GPs, however this is not a growth area. However A & Es are seeing people's who are coming out of hours , often really late because of work pressure. There is also a cultural change; people want treatment more immediately.

5.13 The chair invited resident Tom White to speak. He said that there is a rise in the number of people on wards with mental health problems and referred to vascular dementia. Tom raised concerned about the availability of mental health beds and referred to a temporary closure of a ward for older people which then became permanent, despite assurances he was given to the contrary. He also refereed to a case whereby the nearest place for a mental health bed was Manchester. Steve Davidson from SlaM agreed that there was a demand issue and that patients are being sent to Manchester, and commented that demand is unprecedented. He said that SlaM does not have the resources, and that the most they can do is work to get the model that delivers the best outcomes, but funding is far from what they would want it to be. He explained that SlaM is doing what they can do ensure that conditions do not deteriorate to a crisis point. Training is also being doing for nurses on wards so that there is more capacity to deal with mental health needs, and although this is not a huge investment SlaM does believe it will help. Gwen Kennedy added that the CCG have one plan for urgent care mental health and a longer strategic plan for mental health at a population level over 5 years.

5.14 A member asked when KCH Denmark Hill is going to open the dedicated mental health suite that has been in the pipeline for several years. KCH staff responded that there are two individual rooms already; the first phase has been completed. The second phase of the suite is reliant on the PFI provider agreeing to a change of use and there have been problems getting agreement and negotiating space in the Golden Jubilee Wing. Member expressed concern at this delay and referred to a survey the committee conducted which demonstrated that the community considered the provision of an adequate safe space for people in mental distress at the A & E department to be very important. Members referred to the £6.5 million

founding provided by central government to provide this dedicated mental health suite.

RESOLVED

The urgent care sub-group, looking at mental health, will provide the draft action plan.

The committee recommended the next administrative committee look at Mental Health as a review topic.

The committee will keep abreast of progress on the Mental Health suite at the Accident & Emergency clinic at King's Healthcare Trust, Denmark Hill Hospital – an update will be requested for the next meeting.

6. RESIDENT VIEWS : ACCESS TO HEALTH SERVICES IN SOUTHWARK

6.1 The chair explained that items 6 & 7, on the scrutiny survey and the GP Patient Survey would be taken together. The scrutiny project manager, Julie Timbrell, commented that the scrutiny survey sample was much smaller so the results could only be indicative, however many of the questions were similar to those asked by the GP Patient Survey , so the results could be cross referenced with the GP Patient Survey data , which could be interpreted with a high level of confidence in the results as it survey a large population sample. The scrutiny survey also offered an opportunity for people to comment on difficulties in open text responses, unlike the GP Patient Survey, where the questions were all closed.

6.2 Jill Webb, Deputy Head of Primary Care (South London) NHS England added that the GP Patient Survey had a population sample of 10,000 and was done by MORI and so the results could be relied on. She noted that when she came and presented the results of the last survey 74% of patients were satisfied that they could get a convenient appointment; this has now gone down slightly to 72%, whereas the interim scrutiny survey results indicated that 49% of respondents were satisfied with their appointment.

6.3 The Deputy Head of Primary Care commented that there is a review of contracting to get better results and a move towards more local contracting. A fund as been set up to enable practices to applying for extra money to look at improved access.

6.4 The chair commented that a number of people had spoken about visiting their doctor in connection with a long term condition and asked if this was the right place to access care. The Deputy Head of Primary Care responded that GPs are supposed to be gateway to care - but there is a team approach. Tamsin Hooton, Director of Service Redesign, SCCG, commented that doctors offer the core services for people with long term conditions. She commented that the SCCG has been encouraging people to get better at self management of long term conditions, for example there is register and improved care on diabetes and COPD. These is also a community based multiple disciplinary approach which emphasizes a tiered approach to accessing care. People with a long term conditions should be getting a

continuity of care from their GP - rather than going to acute care.

6.5 A member referred to a former plan for poly clinics, and asked if there are still plans for extended GPs, where people could have access to more extensive primary care for conditions such as diabetes. The Director of Service Redesign referred to the paper on Commissioning Urgent access to Primary Care strategy, circulated as a late item (14). She said that the terminology is now community hubs , but the model is very similar to poly clinics, and confirmed that this would allow for better community health care for people with long term conditions . The Deputy Head of Primary Care added that she thought their was more appetite for this model now.

6.6 The Director of Service Redesign went on to comment that the paper on Urgent Primary Care Access identified that there are problems with the booking system and inequitable access. The CCG have been considering the Lister Centre; the CCG preferred option is encouraging practices to come together in locality to offer extended access clinics.

6.7 A member commented that a quite a few of the practices have a link nurses who work with older people, and asked the Director of Service Redesign if she thought there was a role for more specialized nurses. She responded that there is an integrated nurse the role; and these practitioners work with people with a high level of risk.

6.8 Alvin Kinch from Healthwatch commented that they are planning to do rolling focus groups and they have already done two with the Latin American and deaf community, who both identified similar issues. Healthwatch will be taking some of the recommendations forward: for example on sexual health.

6.9 A member asked if there was sufficient capacity for people wanting appointments outside of work hours. The Director of Service Redesign responded that the capacity survey of G.Ps showed the CCG that there is capacity but it is not always mapped well to demand - for example too little Monday and Friday. The CCG are providing money to encourage doctors to work together to better match resources to demand. She added that the CCG do think they need to add more capacity to primary care and also make some improvements around telephone systems. The Deputy Head of Primary Care said there are some GP Practices that are outliers. She explained that more can be done with the GP Patient Survey data now as NHS England have been using the same questions for two years now. NHS England will be looking at data - and looking at practices with cause for concern, whether complaints, or access, or diabetic care.

7. GP PATIENT SURVEY : ACCESS TO HEALTH SERVICES IN SOUTHWARK

7.1 This item was combined with item 6.

8. PUBLIC HEALTH : ACCESS TO HEALTH SERVICES IN SOUTHWARK

8.1 Dr Ruth Wallis, Director of Public Health went through the paper on access to A & E.

8.2 The chair noted that there was no overall increase in attendance by local residents, but there had been a small increase in older people visiting A & E ; she asked if this was commiserate with population growth. Dr Ruth Wallis said that this is inline with the growth in the older population and the report identifies the need for better social care interventions. The chair asked if there is an expectation of a further growth in older people and what plans are in place. The Director responded that there are plans for the CCG and social care to gear up their interventions, which will include health checks, improved Diabetic care, better uptake of the flu jab and improved care for long term conditions. There will also be improvement in the housing stock to protect older people from cold.

8.3 A member noted the increase in mental health conditions and raised concerns about people being moved out of Maudsley Hospital. The Public Health Director commented that people with mental health problems are more likely to have other long term conditions and more work is going to be done on this. She added that sometimes people turn up at A & E who may not identify themselves as having a mental health condition, but it may be a component ; only a minority of people use specialist mental health services.

8.4 A member asked to what extent A & E is used by people coming from abroad, and if there was an influx of people not paying. The Public Health Director responded that this was not closely monitored or information that was local collected, however she did not think it was a big percentage but these figures may be recorded by the Department of Health; the ethos at A & E is to treat based on need. The chair indicated that this line of questioning can be pursued when King's College Hospital visit the next meeting to discuss the performance of the Emergency Department and acquisition of the Princess Royal University Hospital .

8.5 A member commented that there is some evidence from the survey that people do go to A & E when they can not access their G.P and asked the Public Health Director to comment. She responded that that there is nothing dramatic in data and it largely looks like people using A & E appropriately.

8.6 The chair asked the director to comment on presentations at A & E that might be open to being reduced. The Public Health Director commented that people with long term conditions are usually well diagnosed and controlled - for example diabetes and asthma , but other conditions are harder to manage , for example alcohol abuse and the links to violence and domestic abuse , another is epilepsy. There is work on long term conditions but some are complex and difficult to manage. The chair asked if more so investment in long term conditions would help and the Public Health Director agreed and added preventative interventions such as improved take up of flu jabs will also help.

8.7 A member reiterated that he was still considered that there was an issue with

access to G.Ps. The Director commented that there have been no new and dramatic changes to population usage of services- there will always be people who are less inclined to wait.

8.8 A member commented that flu uptake has been an issue for sometime and asked what is being done. The Director commented that there is a flu action group working with primary care. One of the issues is pre ordering supply and ensuring there is sufficient capacity. The Public Health Director was asked who this programme was targeted at and the percentage of coverage and she responded that it is over 70% uptake for older people and even higher for people long term conditions. A member commented that his recent experience , and that of his friends and neighbours was very good - there was better information and very good access.

8.9 A member noted the high level of delirium with concern and commented that in her experience (as a nurse) this takes a while to happen; this could be indicative of poor access. The Public Health Director undertook to get back with more detailed data.

RESOLVED

The Director of Public Health undertook to get back to the committee on the high increase in 2010/11 of emergency admission rates for delirium as a secondary co-morbidity, which climbed by 42.3% for Southwark patients. She undertook to provide details on the numbers of patients involved.

King's will be asked to provide figures on the number of people from outside the UK who use Denmark Hill Accident and Emergency.

9. ADULT SOCIAL CARE : ACCESS TO HEALTH SERVICES IN SOUTHWARK

9.1 Sarah McClinton; Director of Adult Social Care and Steve Davidson; SLaM Service Director - Mood Anxiety and Personality Clinical Academic Group, introduced the paper circulated.

9.2 A member asked if a more joined up approach to social care means doing more preventative work and officers agreed it did, commenting that there was commissioning of the community and voluntary sector and of Telecare; simple aids can make a big difference. The Director of Adult Social care said that Southwark are making progress with older people; the figures attest to this.

9.3 The Director of Social Care was asked about information and making every contact count, and she responded that the council have launched the single help line and the 'my support choices' website portal. There are specialist services tackling social isolation but other services will also signpost. There is also a

network commissioned by Age Concern that means that if one service visits an older person then there will be further contact and signposting. The member asked about visits to one stop shops or libraries and the Director of Adult Social Care said that the library staff have been trained in the 'my support choices' website. The chair requested more information on statistics on accessing the website and other places.

9.4 A member queried the statistic in paragraph 7 of the report which referred to older people's attendance at A & E and emergency admissions and asked officers to explain a little more. They responded that this is a comparison snap shot comparing data from October – December which shows a reduction across two different years. The member commented that the data was not that in depth.

9.5 Another member commented that the last paragraph of the report points to a lack of significant breaches on Mental Health assessments; however the report from Public Health shows an increase in mental health co-morbidities. The Director of Adult Social Care responded that this is not quite the same cohort - one is looking at access to mental health services that is high need and which crosses a threshold. SlaM Service Director added that there has been an increase in people presenting with mental health conditions, and often this is amongst people with co-morbidities who are finding it harder to cope and so getting mentally distressed. He said that there is a targeting of community services to try and meet this need better. The Director of Adult Social Care agreed that there was more that could be done and referred to the re-enablement service The Slam Medical Director said that the service is finding that increased social difficulties are prompting more visits to A & E. He agreed the Re-enablement service is for crucial in providing community and social support to try and reduce or prevent this.

9.6 A member asked how good the work with the voluntary sector is and the Director of Adult Social Care explained that there is a commissioning, with contract monitoring, and Adult Social care have also set up an innovation fund. The member went on to ask if the council look at outcome targets, for example A & E attendance. The Director of Adult Social Care said that the council does not use that as an outcome measure, as it is not the primary purpose - although the acute services do commission the Red Cross.

RESOLVED

More information will be supplied on the number of older people who have been accessing information at One Stop Shops, Libraries, via the 'single helpline' and through the website portal 'My Support'.

10. SCRUTINY FRANCIS INQUIRY RESPONSE REPORT

10.1 The chair invited comments on the attached draft report recommendations. A member commented that he was concerned that scrutinizing complaints could be

onerous for scrutiny and other members agreed that more capacity was needed, but that it was important for scrutiny to keep an eye on complaints, particularly as the Francis Inquiry highlighted their importance. There was a discussion on the need for support and whether this would be best provided from Public Health or Safeguarding in Adult Social Care; and it was decided to write to the cabinet lead directly and for her to nominate a named officer.

RESOLVED

A letter will be written to the cabinet lead requesting officer support to provide additional capacity to enable health scrutiny to analyze complaints received by Hospital Trusts, Adult Social Care, the CCG and GPs - point c.

Reports will be requested every 6 months from the Lay Inspectors - point i.

Adult Social Care will be asked to provide a 6 monthly report on providers which identifies any concerns . This will be part of the framework to share concerns between bodies with a regulatory role - point k.

An action plan will be developed to ensure the 'community and public have clear avenues and fora to raise concerns with scrutiny' - point l.

Health scrutiny will adopt the recommendations made by Francis for information requests in the case of 'major structural change' . These will be integrated into the Trigger Template, and will be used as appropriate, including when proposals for changes do not meet the threshold of a substantial variation - point m.

11. WORK-PLAN

11.1 This was agreed.

12. SOUTHWARK CLINICAL COMMISSIONING GROUP - INTEGRATED PERFORMANCE REPORT

12.1 The report was noted.

13. CATERING AT MAUDSLEY HOSPITAL AND THE LADYWELL UNIT AT LEWISHAM

13.1 The report was noted.

14. COMMISSIONING URGENT ACCESS TO PRIMARY CARE

14.1 Tamsin Hooton, Director of Service Redesign, introduced the report circulated by explaining that the CCG would like to invest in one practice with 8 to 8 access in up to four locations within a cluster. She said that the CCG are looking for public endorsement of this model.

14.2 Members asked where the cluster practices would be and she explained that they are considering a number of locations; likely ones include the present Lister Centre and Dulwich Hospital. Other possibilities are Guy's Urgent Care Centre and Bermondsey Spa. A member suggested new building developments, such as the Heygate. The Director of Service Redesign explained that a lot of the investment is in soft services and therefore the physical location is not fixed.

14.3 There was a discussion on the requirements for a substantial variation and the scrutiny project manager, Julie Timbrell, explained that this is quite subjective ; and the main criteria is if the committee thought a change would significantly impact on patients. If the committee considered this to be a substantial variation then the CCG would need to provide certain information, including a decision timeline, however most of this information has already been provided. A member commented that a major change would usually involve a 12 week consultation period and he would like to see more information on the CCG engagement plans. Members discussed whether this should be considered a substantial variation and decided it did not, however it was agreed that the CCG confirm that no services will be lost.

RESOLVED

The proposal on the commissioning of urgent access to primary care will not be deemed a substantial variation.

The committee will scrutinize the proposals at the 5 March meeting.

In future papers the CCG will provide assurances that the changes will not result in any loss of service and details of patient engagement.

Health, Adult Social Care, Communities and Citizenship Scrutiny Sub-Committee

MINUTES of the OPEN section of the Health, Adult Social Care, Communities and Citizenship Scrutiny Sub-Committee held on Wednesday 5 March 2014 at 7.00 pm at Ground Floor Meeting Room G02A - 160 Tooley Street, London SE1 2QH

PRESENT: Councillor Rebecca Lury (Chair)
Councillor David Noakes
Councillor Rowenna Davis
Councillor Dan Garfield
Councillor Jonathan Mitchell
Councillor Michael Situ

OTHER MEMBERS PRESENT:

OFFICER & PARTNER SUPPORT: Andrew Bland, Chief Officer NHS Southwark Clinical Commissioning Group
Gwen Kennedy, Director of Client Group Commissioning (SCCG)
Tamsin Hooton, Director of Service Redesign, (SCCG)
Deborah Klee, Independent Chair of Southwark Safeguarding Adults Partnership Board
Jon Newton, Service Manager , Children's and Adult Social Services , Southwark Council
Julie Timbrell, Scrutiny Project Manager, Southwark Council

1. APOLOGIES

1.1 Apologies for absence were received from Councillor Capstick. Councillors Situ and Mitchell gave apologies for lateness.

2. NOTIFICATION OF ANY ITEMS OF BUSINESS WHICH THE CHAIR DEEMS URGENT

2.1 There were none.

3. DISCLOSURE OF INTERESTS AND DISPENSATIONS

3.1 There were no disclosures of interests or dispensations.

4. MINUTES

4.1 The minutes of the previous meeting will be available at the next meeting. A draft summary of decisions has been published online.

5. VULNERABLE ADULTS ANNUAL SAFEGUARDING REPORT & PRESENTATION.

5.1 The chair invited the Independent Chair of Southwark Safeguarding Adults Partnership Board, Deborah Klee, Jon Newton, Service Manager and Gwen Kennedy, the CCG director responsible for safeguarding to present the Southwark Safeguarding Adults Partnership Board Annual Report 2012-13.

5.2 The Service Manager began by explaining that the report was led by the previous Independent Chair, Terry Hut. The report contains a response to the Care Bill, although things have now moved on. The report gives a statistical analysis of referrals; there has been a 6.6% rise, but 20 % requiring further investigation. This is comparable to national rise of 4%. There is work being done to determine thresholds, so we are comparable to partners.

5.3 The Independent Chair explained that she will be picking up on priorities for the coming year. She said that the first priority is to ensure the board is fit for purpose, this means the partners are really committed and that there is a strategy. One of the strategic priorities is getting the message out to the public. She reported that she is looking to have all the partners chairing each sub group, one is on quality and performance that the CCG director chairs. The board will also being looking at governance relationships with other boards, for example the Health and Wellbeing Board.

5.4 A member commented on the statistic noting that 8.1% of times the perpetrator is listed as ‘not known ‘and the 20.2% of times that the outcome was not determined / inconclusive and the larger number of ‘no further action’ recorded. The Service Manager said there could be a number of reasons for this; for example a police action so not everything is known. Follow up action could also include training. The Independent Chair said the board are doing work to get an outcome that people want - making 'safeguarding personal ' is focused on this and trying to ensure that the victim is involved in the resolution of what can be intimate family relationships .

5.5 A member commented that last year’s annual report to the committee picked up on

concerns that there were no alerts from hospitals, and that this year there are some, but they are still very low. The CCG Director reported that the CCG are working with hospital on adult safeguarding training, which is not as embedded as children's safeguarding. Hospitals also have now got safeguarding leads. It will take time to bed down but there are action plans. The Independent Chair added that the board are getting all the partners round the table to do self assessment.

5.6 The member followed up by asking if the board had looked at comparison statistics for referrals from other hospitals, and enquired about the seniority and attendance at the board from hospitals and other partners. The Independent Chair commented that sometimes incidents can enter different processes, for example 'serious untoward incident', or a police process rather than getting flagged up as a safeguarding alert. She said that she had approached SlaM about the right level of representation on the board and there is also an issue with police participation in Vulnerable Adults Safeguarding Boards across London. She went on to comment that representation should be at the right level of seniority , and actually the board need a balance of personal with operational responsibilities and strategic influence: people do need to understand the detail.

5.7 A member enquired further about SlaM and the METS poor attendance and the Independent Chair said that she is waiting for a meeting with SlaM's medical director. The CCG director said that this is being pursued and the she predicts it will improve. The Independent Chair said so far she had not met anybody from the Police and there had been no representation at meetings; however she understands that is to do with staff changes and will change. She added that she also chairs the London safeguarding chair network so that is helpful in highlighting problems such as London wide problems with the METs engagement. A member commented that John Sutherland, the Southwark Borough Commander, is due back and is proactive.

5.8 A member raised concerns with the higher number of financial abuse cases. She asked for the reasons, and if more community awareness would help tackle the issue. The Independent Chair commented that this could be caused by a combination of the recession and social problems. She said there is a high awareness of financial abuse amongst professionals , but lower awareness amongst friends and family , and the board will be running a campaign 'Don't turn your back ' , which will be encouraging people to look out for each other . The CCG director said that the CCG we will be holding sessions on adult safeguarding awareness raising.

5.9 A member commented on the number of 'Deprivation of Liberty and he said he was reassured that 20 were authorised and 16 refused -, however he noted that the report commented that the Department of Health are saying more should be processed and he asked for clarification. The Independent Chair explained that given the high levels of dementia the board would expect more people to understand and use the procedure.

6. COMMISSIONING URGENT ACCESS TO PRIMARY CARE

6.1 Tamsin Hooton, Director of Service Redesign, SCCG, introduced the report on 'Extended Primary Care in Southwark'. She explained that the SCCG have been looking at modelling an extended GP access offer, consisting of hubs in each neighbourhood open 8am to 8pm. The engagement exercises with the community so far have demonstrated overall support for plans, with key messages received from people on location, transport, access needs for primary care and the importance of communication.

6.2 A member commented that there are rumblings that the Lister Walk In Centre will close. The Director of Service Redesign explained that there will be no formal notification until the third week of April, however the CCG are talking about the possibility of decommissioning this service. The focus is on encouraging GPs to be working collectively to participate in local hubs, the present Lister Walk In Centre will almost certainly be used, and again Dulwich Hospital is a likely location.

6.3 The Director of Service Redesign was asked if this will improve access and she responded that we are looking at more integrated access - so there is not the present disconnect with local practices , as with the Lister.

6.4 A member commented the paper talks about a model with either two or four hubs; he thought there should be a minimum of three, ideally four. She explained that there are cost implications, but four does sit with the CCG community plans, however there are issues with rotas and capacity.

6.5 The Director of Service Redesign was asked about waiting periods, and the member said that he is increasingly thinking that there should be a minimum waiting period to see a GP of 5 to 7 days. He voiced concern that people are saying they have to wait two or three weeks to a see a GP. Other members agreed and commented that their constituents had raised similar concerns.

6.6 Andrew Bland, Chief Officer NHS Southwark Clinical Commissioning Group, responded by explaining that there is a London piece of work looking at developing standards. The London NHS 'Call for Action' talks about differential access - some people are prepared to wait for preferred doctors, while other people want to see any doctor soon. To do this practices will need to collaborate at a greater scale and the model proposed aims to deliver the change necessary.

6.7 A member asked to what extant Southwark can decide the standard of service. The CCG Chief Officer said that the CCG can offer extended services over and above the core standard - set by NHS England. He said it was important to engage with the 'Call for Action'.

6.8 A member pointed out sometimes that there is local conflict over the delivery of services, for example drug addiction services and needle exchange, and the role of pharmaceutical services.

6.9 The Director of Service Redesign was asked about SELDOC and she said there was a challenge bid to improve access, however this will be competitive, but even

if SELDOC do not receive the extra money the CCG will be meeting some recurrent costs to fund the initiative. Members emphasises the quality and importance of the SELDOC service.

7. SOUTHWARK CLINICAL COMMISSIONING GROUP (CCG) PERFORMANCE REPORT

7.1 Andrew Bland, Chief Officer NHS Southwark Clinical Commissioning Group introduced the CCG performance report.

7.2 A member commented on the KCH 4 hour wait target performance going down marginally and concerns about possible downward drift and asked about a scheduled visit to the Emergency Department at Denmark Hill. The Chief Officer commented that they will be visiting soon, but Friday's planned visit was going to be rescheduled.

7.3 A member said that she had been told by the Ambulance Services personal that on occasions hospitals will not admit from ambulances for thirty minutes to protect the four hour target. The Chief Officer explained usually patients are allowed to wait 15 minutes before being admitted - however there are 'black breaches' where patients have to wait more than 60 minutes to be admitted to the Emergency Department. He explained that the targets for the Ambulance Service and the 4 hour target are there to manage this interplay. He commented that he did not think abuse of ambulance waiting times are common, but that on occasions he thinks it does happen. He reported that there had been 8 black breaches reported, which is not a huge amount. The most important issue is patient safety.

7.4 The Chief Officer was asked if the figures for Princess Royal University Hospital (PRUH) are going to effect the overall KCH performance targets. He explained that the SCCG have agreed that they will closely monitor the figures supplied for both emergency departments managed by KCH; Denmark Hill site and PRUH. The SCCG are the lead commissioner for KCH, but they are really judged and responsible for local residents. A member asked for assurance that figures will continue to be available on local performance. The Chief Officer commented that the KCH will be reporting nationally on top line figures for all their sites, however the CCG will be focusing strongly on local performance and ensuring it is closely monitored and does not get worse.

8. REVIEW : ACCESS INTO HEALTH SERVICES IN SOUTHWARK

8.1 The chair introduced the draft report, and reported that the CCG had been invited to make comments and as a result of this some of the text had been amended, and a revised draft tabled. The project manager, Julie Timbrell, explained that the CCG had provided updated information on the 111 service, in particular they had explained that the London Ambulance Service had been awarded the new contract and that they were amongst the top 5 providers nationally.

8.2 The chair invited member to make comments. A member said that he thought that recommendations 3, 8 and 9 should emphasise the role of the CCG, and the committee agreed. The chair recommended a further amendment to recommendation 13 following comments from the CGG and that Public Health look at the reasons for increased acuity. A member queried the centrality of the Health and Well-being Board to lead on this and the chair invited comment from the project manager, who said increased acuity could be seen as a system problem and that the board did have a role as a systems leader. She commented that Public Health had sited some papers at the last meeting on the causes, and Public Health has research capacity. The CCG agreed with the recommendation and with the amendment that Public Health undertakes further work into the underlying causes of increased acuity.

8.3 Members queried the capacity of the committee to understand the data. The project manager commented that the Department of Health are doing work on in relation to Francis Inquiry to provide benchmarking on ward staffing levels to help scrutiny of hospital performance and this will be helpful to scrutiny. The chair said that that a letter had been written to the Leader about more resources for health scrutiny and she will be chasing a response.

8.4 A further recommendation was suggested on offering a minimum standard for patients accessing a GP appointment. The committee agreed and the CCG advised waiting for the outcome of the NHS England's Call for Action.

RESOLVED

Recommendation 3, 8 & 9 will be changed to emphasis the role of the CCG.

Recommendation 21 will be made clearer and will describe the support that the council currently offer to assess blue badge applications.

Recommendation 13 will include the amendment that Public Health carries out a piece of research into the reasons behind the increased acuity in Southwark.

Recommendation 26 will include an amendment saying that Southwark will consider an offer that ensures minimum standards of access for patients in Southwark in regards to contact with a GP, if appropriate following NHS England's Call for Action response.

9. REVIEW : PREVALENCE OF PSYCHOSIS AND ACCESS TO MENTAL HEALTH SERVICES FOR THE BME COMMUNITY IN SOUTHWARK

9.1 The chair said that a draft report will come to the next meeting.

10. WORKPLAN

10.1 This was noted.

11. PAPERS FOR INFORMATION

11.1 The update paper from Healthwatch was noted.

ACCESS TO HEALTH AND SOCIAL CARE SERVICES IN SOUTHWARK FOR SCRUTINY PANEL DISCUSSION

MY SUPPORT CHOICES - SUMMARY OF USE from 1 January to 28 February 2014

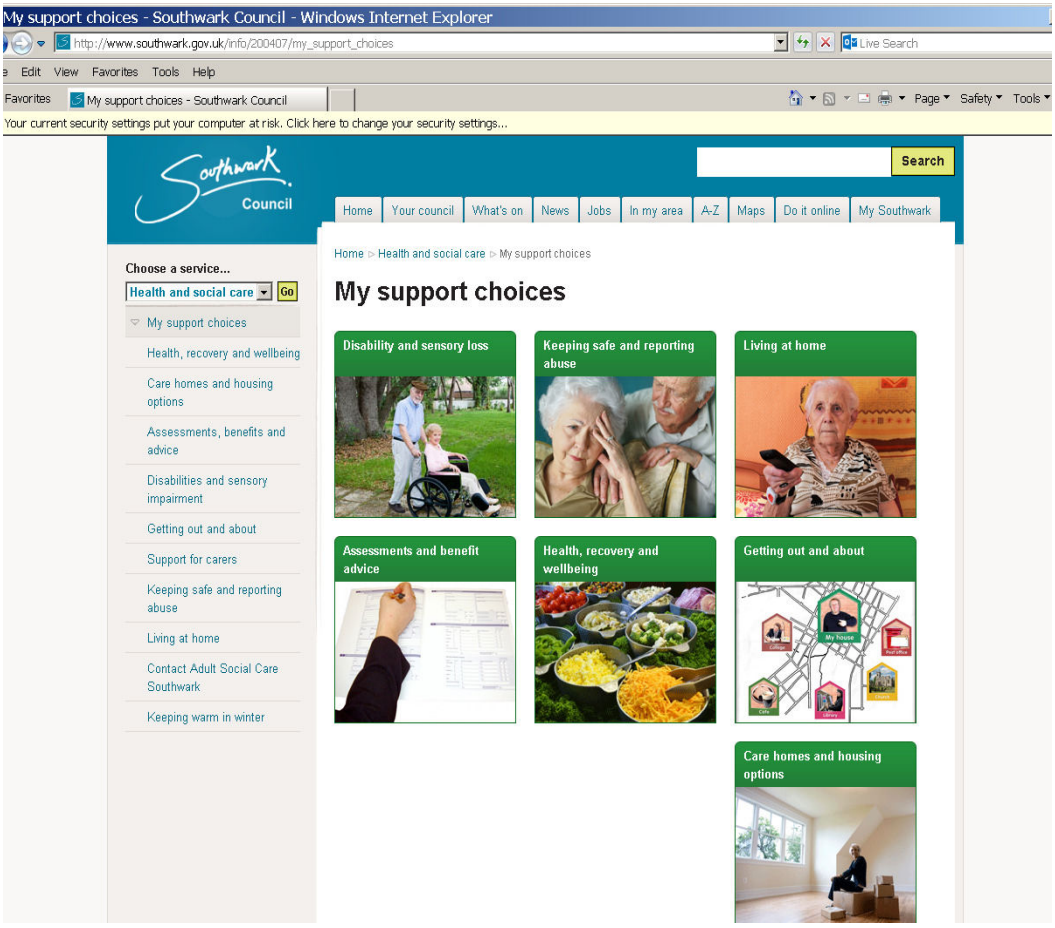
This information has been provided in light of the request for details of older people accessing information at One Stop Shops, Libraries, via the 'single helpline' and through the website portal 'My Support Choices'.

The report summarises the number of visits to the My Support Choices website.

My Support Choices is an online guide to adult social care and services in the community. It encourages self help and independence by allowing the user to click and explore a wide range of options and choices to meet their individual needs. It makes it easy to find out what services, advice, information and support is available to help people in their everyday life.

Providers, members of the public and staff can visit the site to find out about equipment available to aid independence in the home, assessments and benefits advice, safeguarding, getting out and about as well as other useful services, advice and information.

See screen print of the My Support Choices home page below.



The My Support Choices website does not identify users, so there is no way of telling the age, gender, ethnicity or providing information on people accessing the site, other than the numbers of visits to the different pages. Google analytics is used to process the number of views to the site.

For the period from 1 Jan 2013 - 28 Feb 2014, a total of **48,396** page views[1] were made by people seeking online information, advice or support via My Support Choices.

The My Support Choices home page received **9,661** page views.

Assessments and benefit advice received the highest number of page views **11,771** followed by Safeguarding - Keeping Safe and reporting abuse with **6,208** page views.

Keeping warm in winter received the lowest views at **91**. The explanation for this is likely to be the seasonal nature as no visits were recorded in the months before January 2014.

Total page views, including the other pages contained within My Support Choices are as follows[2].

Page title	**Number of page views**
Assessments and benefit advice	**11,771**
My Support Choices	**9,661**
Safeguarding - Keeping Safe and reporting abuse	**6,208**
Contact Adult Social Care	**3,863**
Disabilities and sensory loss	**3,383**
Care Homes and Housing Options	**3,007**
Health Recovery and well being	**2,937**
Support for Carers	**2,838**
Living at home	**2,383**
Getting out and about	**2,254**
Keeping warm in winter	**91**
Total page views	**48,396**

[1] A pageview is an instance of a page being loaded by a browser. The Pageviews metric is the total number of pages viewed; repeated views of a single page are also counted.

Google Analytics logs a pageview each time the tracking code is executed on a web page. Ref: https://support.google.com/analytics/answer/1006243?hl=en Pageviews – Analytics Help

[2] Pages in the My Support Choices website can be accessed from other web pages on Southwark Council's website and through external search engines i.e. Google, Bing, etc.

Agenda Item 5

King's College Hospital NHS
NHS Foundation Trust

Report to Southwark HOSC

24 March 2014

King's College Hospital NHS Foundation Trust Update

Contents

1. Update – Denmark Hill

The Denmark Hill site has not been negatively impacted by the acquisition of the PRUH, although Denmark Hill has its own problems. These are primarily around the pressures of emergency admissions and we are currently exploring ways in which we can relieve these pressures, by working in different ways. We are currently working on a detailed plan. We are meeting with commissioners next week to start discussing the options and will meet with you in the near future to share the plan. .

2. Update – PRUH

After the break-up of South London Healthcare Trust King's acquired the Princess Royal University Hospital, Orpington Hospital and services based at Queen Mary's Hospital and Beckenham Beacon. The inherited problems were numerous. Areas of key concern were poor performance, the PRUH Emergency Department, infection control rates, waiting times, demoralised staff and low patient satisfaction. Since 1 October we have been working hard to address these problems, but whole system change cannot happen overnight. We are making steady progress and will continue to do so. Some examples of where we are already making a difference across the Trust are detailed later in this document.

Orpington Hospital

Orpington Hospital was originally due to be closed and sold. King's made a case for its continued use and took over on 1 October 2013. There have been significant developments across the Orpington site since we took over management in October. Essential works have been completed including replacing the roof and refurbishing second and first floor wards.

One of the most significant improvements is the establishment of an elective orthopaedic centre. The centre comprises three theatres, two wards and an admissions lounge. Orthopaedic surgery specialisms include: hip, knee, foot, ankle shoulder, elbow and hand/wrist procedures. Patients previously treated at the PRUH and QMH sites are already

having orthopaedic procedures done at Orpington Hospital and Denmark Hill patients are offered the choice to have their procedures done at this dedicated elective centre.

We are also redeveloping other areas within Orpington Hospital with the aim of reducing pressure on the acute sites.

2.1 Productivity improvements

2.1.1 Better, Safer Hospital Week

The Trust has carried out two exercises under the 'Better, Safer Hospitals Week' banner. The first was at Denmark Hill and took place in January and the second has just taken place at the PRUH in March. These exercises were planned, internal incidents designed to establish an enhanced response to managing the emergency patient pathways andto review and learn where the pathway and processes are failing and understand the systems that do work.

During the exercise the improvements we saw in the care offered to our patients was significant. Patients on an emergency pathway into the hospital were seen and looked after much quicker than previously, and in a more appropriate setting. For example, opinions from consultants in various specialities were given in the emergency department, which helped to avoid inappropriate admissions. An impact was also seen in terms of no planned care was cancelled and patients were able to come into the hospital for treatment as arranged.

We saw a fantastic response from all service areas within the Trust and beyond, either through social services, or our referring hospitals. This meant that our teams were able to focus on providing care, rather than dealing with capacity issues.

These were whole system exercises, working in collaboration with local commissioners and other providers, such as clinical commissioners, local GPs and community services.

We learnt a great deal from both these exercises and a comprehensive review and action plan will follow both the Safer Faster Hospital weeks.

Exercises like these are used by many trusts to help identify a hospital's strengths and weaknesses so that improvements can be made. The launch of Safer, Faster Hospital was not in response to any untoward incident; rather, it was a deliberately planned week of heightened activity for the purpose of learning.

2.1.2 Other productivity improvements

There are a number of productivity improvement programmes currently running at the PRUH including:

- Improving the efficiency of theatres, extending hours and more effective scheduling
- Increasing the clinical availability of consultants
- A review of outpatient activity
- Length of stay – working with other healthcare providers to ensure earlier discharge from hospital
- Medical records – improving access to, and accuracy of medical records
- ICT – plans to introduce King's IT systems across all new sites, including electronic patient records

2.1.3 Elective gynae inpatient service

Since submitting the trigger template for the elective gynae inpatient service the position has changed. We are now looking at this service as part of a much wider plan for the entire Trust. Currently, we are operating a pilot programme, which affects a small number of patients: five patients per week in Southwark, four in Lambeth and three in Lewisham. We will use patient feedback form this pilot to inform future planning around this service.

The Trust-wide proposal, which will incorporate elective inpatient gynae services will be brought back to the HOSC and discussed in detail once fully formulated.

2.1.4 Nurse recruitment/ staffing levels

Vacancy factors on both the Denmark Hill site and at the PRUH are high and there is a dependency on bank and agency. Review of establishments has happened year on year at the DH site and the establishments flexed accordingly. Over the last five years we have increased the number of nurses and midwives employed at Denmark Hill to reflect increasing throughput of patients, and increase in acutely ill patients, but this year we have experienced more difficulty in recruiting nurses locally, which is thought to be due to a shrinking labour market in London.

We were aware through the clinical due diligence work undertaken for the acquisition, that the nursing establishment was too low at the PRUH, and in addition we have opened further wards at Orpington, and these factors have added to the recruitment challenge. We record the patient to nurse ratios daily at the PRUH aiming for in excess of 1 nurse to 8 patients, which is the ratio recommended for safe patient care.. The gap between vacancy and establishment is met through the use of bank and agency until the recruitment strategies that are in place increase the numbers of substantive staff.

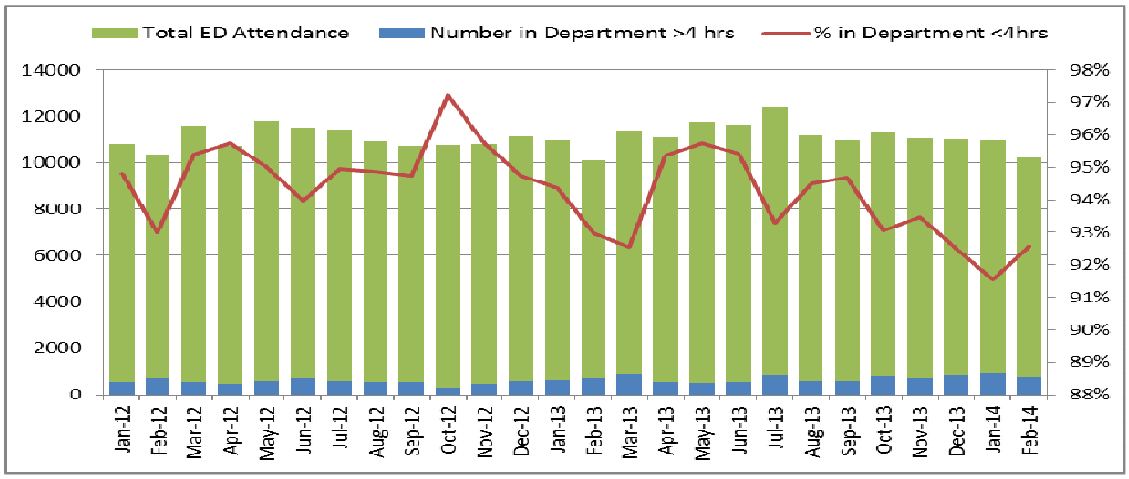
We are currently looking at our staffing demand and recruitment supply, and ways in which we can improve our recruitment systems. The focus of this work will be:

- Increasing the reach and success of our recruitment campaigns, including international recruitment
- Reducing ‘appointment to start date’ times and thereby getting staff into jobs more quickly
- Focusing on ‘hard to recruit to’ areas, such as critical care

In addition we will be establishing tighter controls on temporary staffing, alongside increasing substantive staff and continue to embed escalation of safety concerns pertaining to staffing levels. This particular piece of recruitment work will be completed this year.

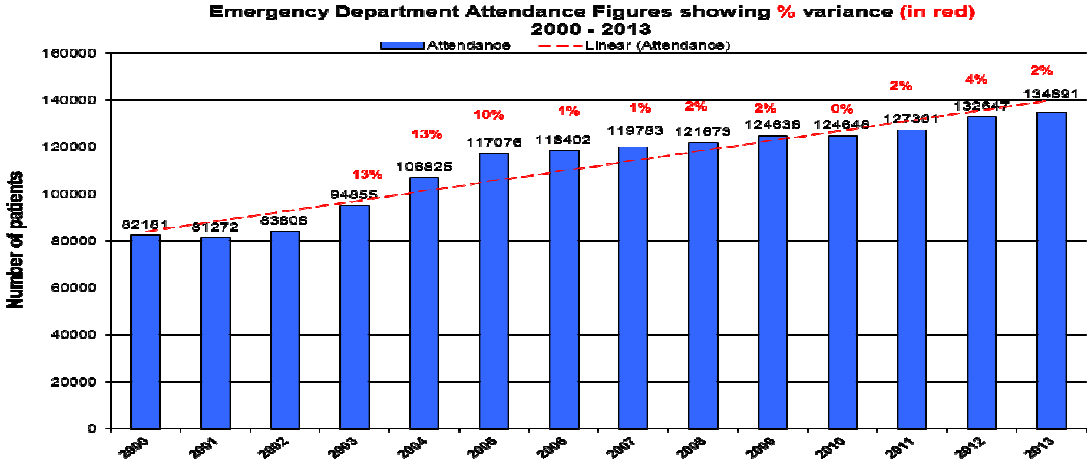
3. Update on Emergency Care performance at Denmark Hill

Performance has been challenged over recent months at the Denmark Hill (DH) site.

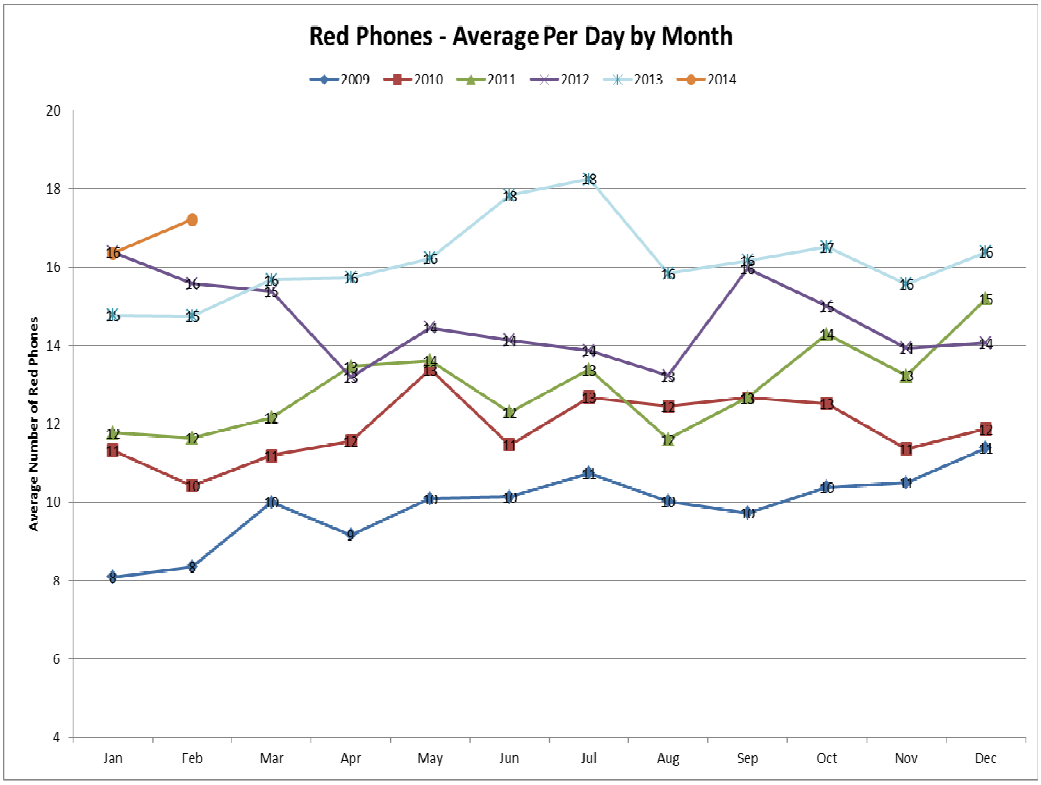


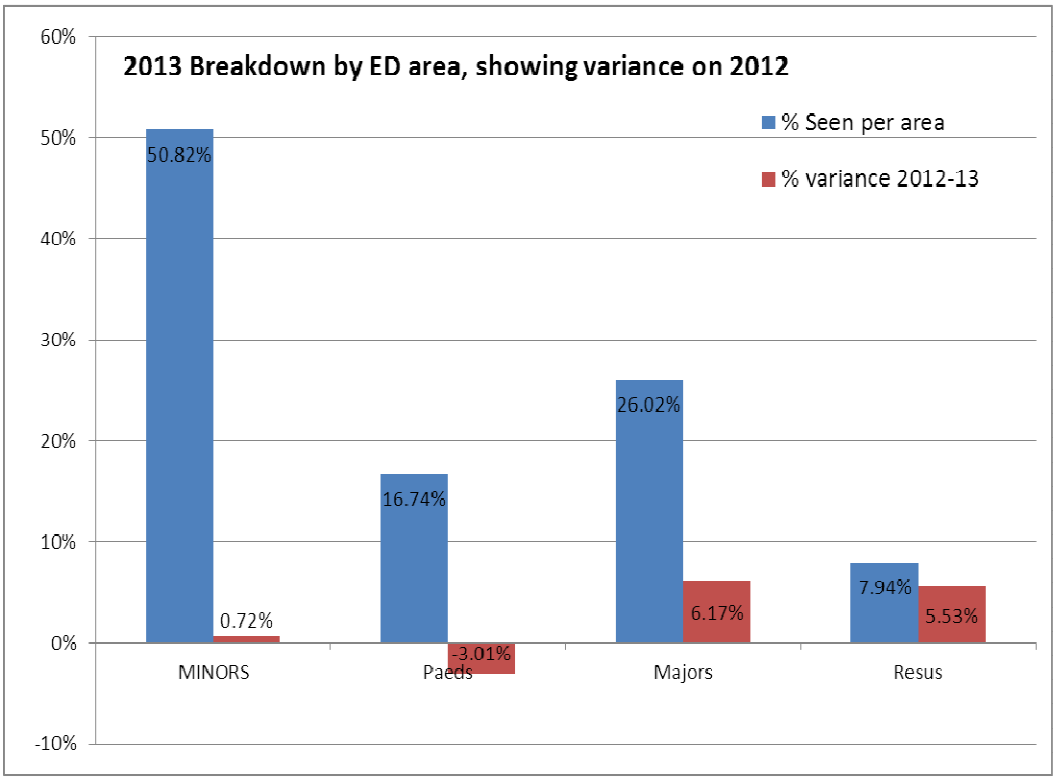
Main drivers have included:

- High attendance numbers to the Emergency Department (483 patients on Monday 17th March – our highest number ever recorded)



- High acuity of patients


Red Phones - Average Per Day by Month
2009
2010
2011
2012
2013
2014
Average Number of Red Phones
20
18
16
14
12
10
8
6
4
Jan
Feb
Mar
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec


2013 Breakdown by ED area, showing variance on 2012
% Seen per area
% variance 2012-13
60%
50%
40%
30%
20%
10%
0%
-10%
50.82%
0.72%
16.74%
-3.01%
26.02%
6.17%
7.94%
5.53%
MINORS
Paeds
Majors
Resus

- Lack of physical capacity in ED

- Lack of inpatient capacity

Action Plan

We have a detailed Recovery and Improvement Plan that is reviewed weekly at the Denmark Hill Emergency Care Board (ECB). Multiple stakeholders are present at this including commissioners and plans are very transparent and have clear timelines and progress updates.

The action plan is divided to cover 4 different elements of the patient pathway each containing multiple areas of work supported by all areas of the organisation.

A short summary of these are detailed below.

1/ Admission avoidance

- Re-direction at the front door of ED
- GP hot lines to key speciality teams
- Ambulatory emergency care pathways
- Rapid access clinics and theatre lists
- Specific focus on gerontology
- 111 pilot site
- Red Cross service

2/ Journey through the ED

- Live activity screen in waiting room
- Additional consultants and nursing staff
- Additional mental health staffing – consultants and nursing
- Rapid assessment and treatment model introduced – senior clinicians reviewing patients on arrival
- Access to key blood tests in the ED
- Increased Clinical Decision Unit capacity
- Urgent Care and primary care partnerships

3/ Flow within the hospital

- Additional nursing and phlebotomy staffing on the wards
- Mobile critical care team to support patients across the hospital
- Weekly capacity review of all in patients awaiting diagnostics
- Focus on Bed management
- Internal Professional Standards setting out expectations for ward round processes and frequency
- Additional critical care capacity
- Additional in patient capacity
- Elective capacity at Orpington
- Clear escalation pathways

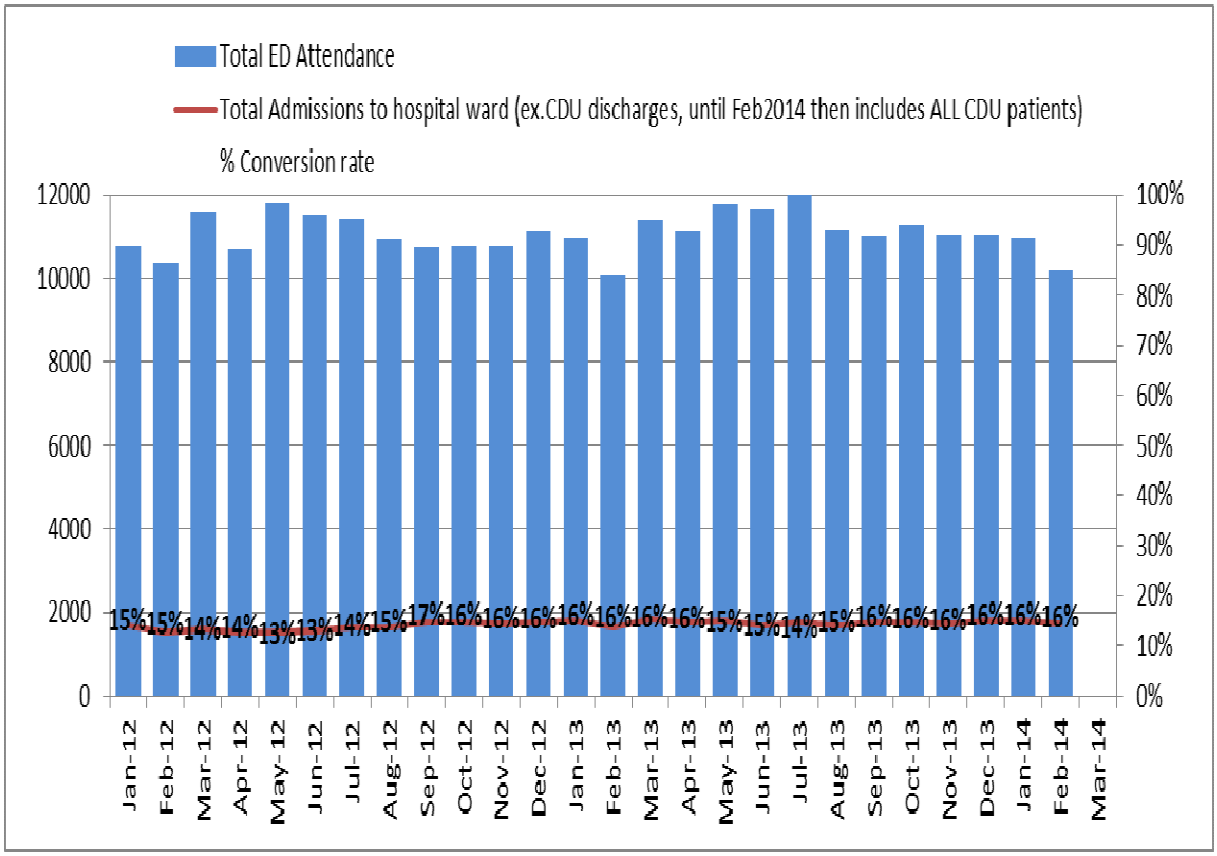
4/ Discharge planning and out of hospital care

- 7/7 working including pharmacy, and therapists
- Escalation processes for patients awaiting repatriation
- Medihome – increased capacity for support at home
- Frequent attendee reviews
- Joint working with community services and social care

Sustaining best practice and high quality care

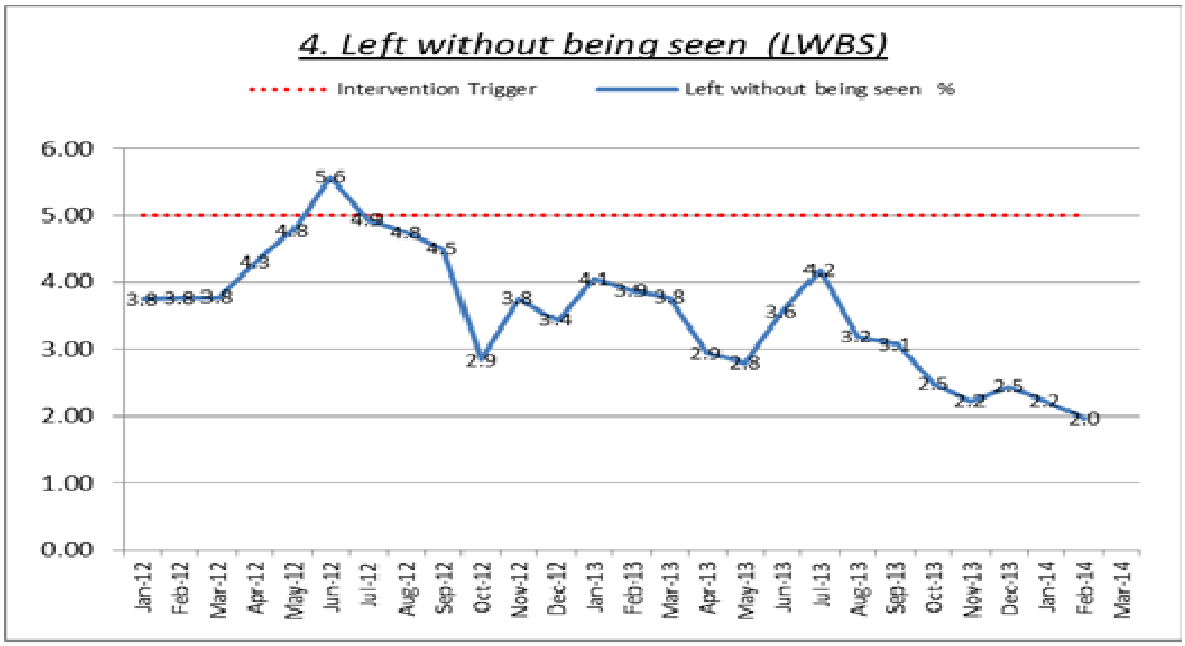
Above all other considerations is that we continue to deliver high quality, safe and effective care to the patients attending the ED at Denmark Hill.

Data that can be used as a proxy to demonstrate that despite performance pressures and capacity constraints we are still delivering high quality care to our patients are the conversion to admission rates. These show that despite increased acuity we are continuing to support ambulatory pathways of care, enabling patients to be managed with community input, rapid access clinics, next day surgical lists, medihome, red cross etc to avoid an admission into an acute hospital bed



Another measure we are required to monitor as part of the suite of clinical quality indicators is the percentage of patients who leave the ED without being seen. This has consistently fallen to a rate of 2% compared to a national target of 5% and we believe this corresponds to

the absolute focus we have on patients being seen by an ED clinician within one hour despite the pressures that overcrowding and acuity within the department place upon staff.



Figures on the number of people from outside of the UK who use Denmark Hill ED

We document overseas addresses as part of the registration process and the figures we have for emergency department attendances specifically for a 3 month period are:

- December 2013 = 24 overseas
- January 2014= 30 overseas
- February 2014 = 23 overseas

Any patient who is subsequently admitted to an inpatient bed is cross referenced with the KCH overseas team who review the patient's details to check qualification for NHS treatment and to pursue funding as necessary.

Progress report on Mental Health Suite

Organisational reconfiguration of KCH out patients to support the final phase of the mental health assessment suite and new main entrance opening

Update on Emergency Care performance at PRUH

Inherited position from South London Healthcare Trust

On 1 October 2013, when the management of the Princess Royal Hospital transferred to King's College Hospital NHS Foundation Trust, the Emergency Department had key issues that were of concern. These were highlighted during an earlier Assurance Visit which took place in May 2013. A series of recommendations were made as a result of that visit which highlighted that improvement was needed in various areas including: governance, safeguarding, staffing, quality, and culture. Since the acquisition, various action plans have been formulated and implemented, in order to address these issues.

Position March 2014/ mitigating actions

Post acquisition there was a requirement to prioritise key areas :

Culture

- Safety is paramount and actions to immediately support the delivery of high quality care and manage risk in the Emergency Department have been the priority.
- King's is embedding a culture where staff are actively encouraged to ask for support, identify and report risk.
- A strong and transparent governance structure is being built with adverse incident reporting, mortality reviews and complaint analysis.
- Low morale was evident after a long period of uncertainty and leadership changes. Ensuring staff are supported, listened to and when issues are raised actions are seen to be taken is central to our leadership approach.
- We have invited external support and peer review from multiple sources including – National Intensive Support Team, NHS England, CQC as we believe constructive challenge is vital to improvement.
- King's has an extremely strong level of expertise in safeguarding identifying and supporting both adults and children at risk. This has been transferred to the PRUH
- We have launched 'Internal Professional Standards' across the PRUH to clearly set out the response expected from staff to the ED as well as a set clarifying the process for ward round management – frequency and leadership
- KCH has taken a whole Trust, whole system approach recognising that the ED cannot work in isolation with integrated action plans, regular senior leaders meetings and external partner engagement.

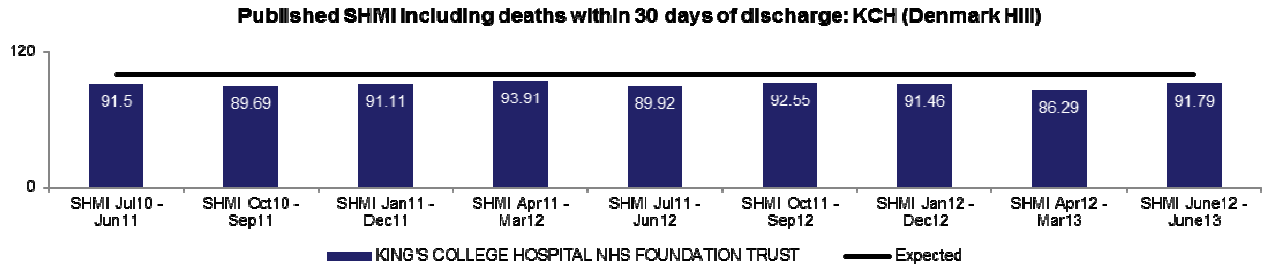
4. Quality Accounts

4.1 Mortality Rates

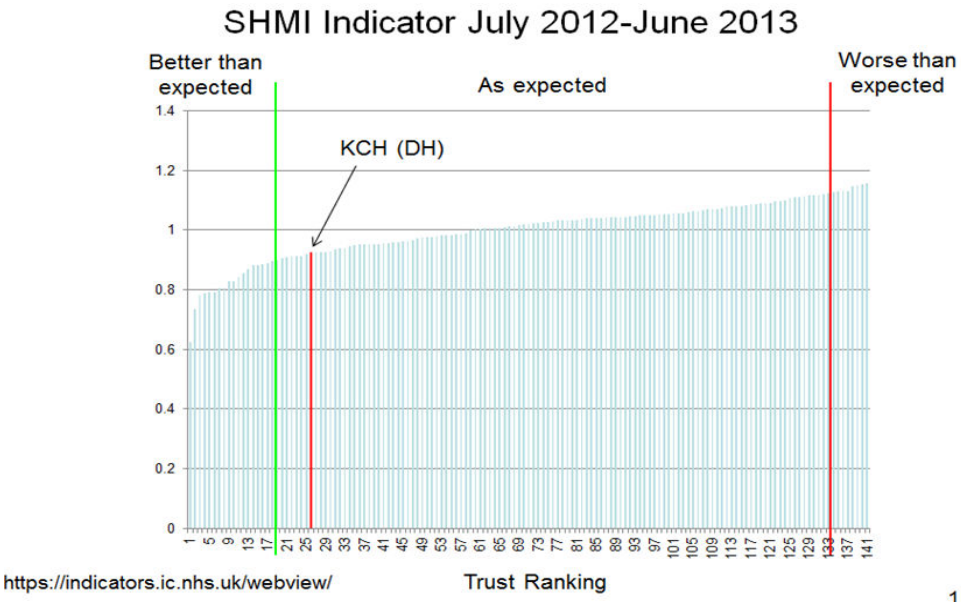
King's College Hospital has a long-established robust mortality monitoring process across the organisation and this approach is currently being rolled out across King's newly-acquired sites, including the Princess Royal University Hospital in Bromley.

As with all hospitals, King's data is sent nationally and run through complicated statistical models to be analysed against the expected level of mortality for our patients, and used to compare King's results against other similar organisations and groups of patients.

The key national measure of mortality is known as the Summary Hospital Mortality Indicator (SHMI) – this is the principal measure used by the Care Quality Commission. It is based on data from all patient deaths within the hospital and up to 30 days following discharge. It is risk-adjusted according to the severity of the patients' conditions and an overall score is derived. A score of 100 means that the same number of patients died who were expected to die. A score of below 100 means that fewer patients died than were expected to die based on the severity of their illness. King's College Hospital has been below 100 since this indicator was developed. Unfortunately, Princess Royal University Hospital data is not yet included, as it is still being disaggregated from South London Healthcare Trust data, so these results are for Denmark Hill only. We anticipate that Princess Royal data will be available late 2014.

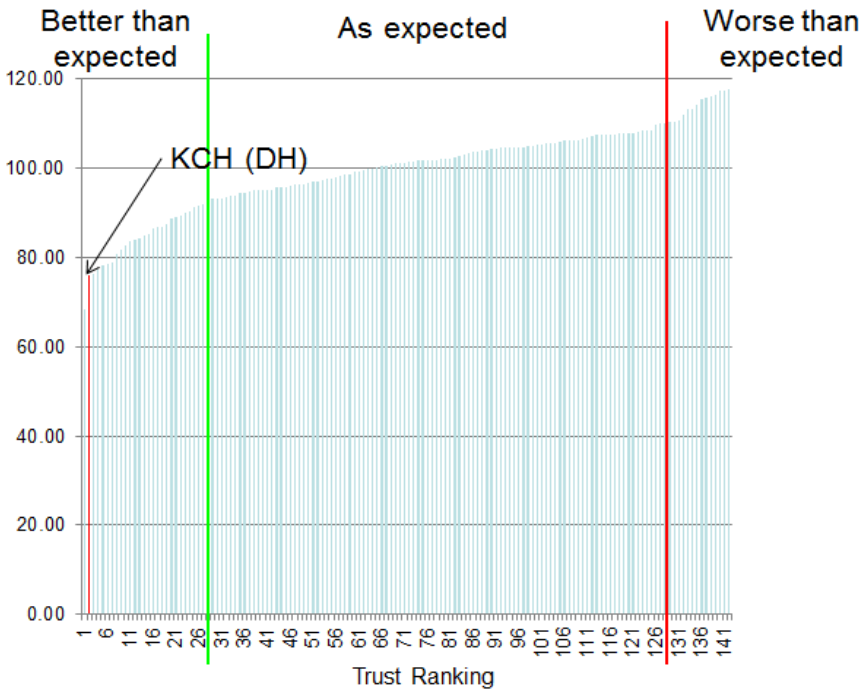


When compared against other Trusts nationally, King's consistently performs well.



A second commonly used national comparator measure is the Hospital Standardised Mortality Ratio (HSMR). This is produced by a group called Dr Foster, and is also used by the Care Quality Commission as an indicator of the quality of hospital care. Using this measure it can be seen that King's is one of the best performing Trusts nationally (again, this does not yet incorporate Princess Royal data).

Dr Foster Mortality Data Release: July 2012 - June 2013
Hospital Standardised Mortality Ratio (HMSR)



http://drfosterintelligence.co.uk/wp-content/uploads/2014/02/Dr-Foster-mortality-metrics-July-2012-June-2013.xls

4.2 Complaints

The Trust received 179 complaints at Denmark Hill and 74 at the PRUH between October and December 2013.

4.2.1 Denmark Hill

Headlines

- 179 complaints received in Q3, a decrease from Q2 (204), although there has been a rise in January and February

- 54% of complaints relate to inpatient care while 46% relate to outpatients (including ED)
- Outpatient complaints have reduced for a consecutive quarter
- YTD 45% performance in responding to complaints within 25 working days
- The first Serious Complaints Committee met in February 2014 – chaired by Faith Boardman, Non-executive Director. Membership also includes both Executive and Senior Clinical Staff

Complaint themes –Oct-Feb 13/14

- Complaints relating to communication with patients increased between Q2 and Q3
- Despite pressures on beds and cancellations of some elective procedures, numbers of formal complaints about patient cancellation remain relatively low

4.2.2 PRUH and other sites

Headlines

- 74 complaints received between Oct –Dec 13 which is a decrease from the previous two quarters (PRUH – 64; Queen Mary's, Sidcup – 8; Orpington Hospital – 2)
- However since January 14 there has been an increase in complaints in all areas
- 57% of complaints relate to inpatient care; 43% relate to outpatient care
- Since October, the response rate is 35% within 25 working days (previously 25%)
- 74 legacy cases transferred to King's in October 2013, and the majority of these have now been resolved. 13 complaints remain open

Complaint themes

- Complaints were significantly down compared with the previous two quarters but these have increased during January/February 2014
- There has been a particular increase relating to inpatient cancellations due to bed pressures at the PRUH as the result of rising emergency admissions, coupled with delays in opening up full capacity at Orpington Hospital
- It is interesting to note the fall in complaints about outpatient appointments/ cancellations since October, as these are now largely dealt with by the new PALS service

4.2.3 PALS

- A PALS service has been established and has been fully operational from 2 October 2013 based at the Princess Royal University site. The service covers the sites at PRUH, Queen Mary's Sidcup, Orpington and Beckenham Beacon. Oxleas NHS Foundation Trust provide an onsite PALS service at Queen Mary's Sidcup and signpost PALS enquiries to the PRUH team.

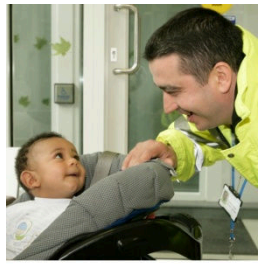
- Since October 1,482 PALS contacts have been recorded on Denmark Hill and 1,278 at the PRUH and other sites (although of these the majority relate to the PRUH site). The level of PALS activity at the PRUH is high compared with Denmark Hill.

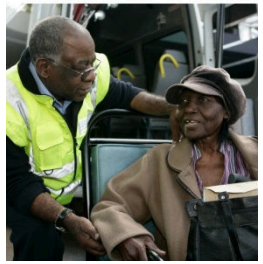
- For inpatients, the predominant issue at Denmark Hill relates to bed capacity and the knock on effect on waiting list delays and cancellation of elective surgery. At the other sites, there are similar issues, and in particular concerns about waiting times for elective admission for orthopaedics, general surgery and urology.

- For outpatients, at Denmark Hill, neurosciences and ophthalmology have the high numbers of PALS contacts. Outpatient services have been reconfigured across the other Trust sites, and moving across to new systems and ways of working has resulted in a higher number of PALS contacts in some areas, notably in ophthalmology and cardiology.

Guy's and St Thomas' NHS Foundation Trust

Southwark Scrutiny Committee
24 March 2014



showing we care

Guy's and St Thomas' NHS
NHS Foundation Trust

Achievements against quality and safety priorities 2013/14

showing we care

Guy's and St Thomas' NHS
NHS Foundation Trust

Quality Accounts: Progress update
Patient Safety

Quality priority	Objectives	Progress at Q3
Keep our patients safe and reduce the risk of harm	We will reduce pressure ulcers, with zero attributable grade 4 pressure ulcers across our hospital.	One grade 4 pressure ulcer acquired
	We will reduce moderate and severe harm events associated with falls by at least 10% in our hospitals and inpatient community services.	Achieving a 10% reduction (n=3) is likely.
	We will achieve our 2013-14 C.difficile target of no more than 47 cases during the year.	On target to achieve this.
	We will put in place an improvement programme to reduce the number of urinary tract infection associated with catheters.	Improvement programme in place.
	We will achieve 100% compliance with the WHO surgical safety checklist in all areas where our policy requires it to be used.	Significant improvement in compliance.
	We will have zero 'never events'.	One never event in May 2013

Quality Accounts: Progress update
Patient Safety

Quality priority	Objectives	Progress at Q3
Keep everyone informed about our performance	We will create a 'hub' of quality and patient experience information on our website, increasing the frequency, content and quality of data that we publish, including links to information about our services published by other organisations. Each hospital ward and community inpatient service will publish its Family and Friends Test results and provide regular updates on other performance and patient safety measures, including the number of days since the last patient safety incident and what has been done to prevent it happening again.	Content for 'hub' being finalised for publication before end of March. Achieved

Quality Accounts: Progress Update
Patient Safety

Quality priority	Objectives	Progress at Q3
Capture how we are doing	In line with our acute and community CQUIN we will embed the national patient safety thermometer in the hospital and roll this out to community services.	Achieved

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Quality Accounts: Progress Update
Clinical effectiveness

Quality priority	Objectives	Progress at Q3
Focus on quality standards from Board to ward	Weekly 'Board to Ward' quality reviews will be considered by the trust's executive directors. Board to ward quality improvement We will report progress via the quarterly Patient Experience and Safety Report	Non-executive directors and executive directors have been paired and allocated areas in acute and community services to visit and listen to patient and staff experiences. They will report back to the directorate management team and the Board of Directors. Quarterly Board report achieved.

Quality Accounts: Progress Update
Clinical effectiveness

Quality priority	Objectives	Progress at Q3
Improve communication between GPs and community nurses	We will see further improvement in consistent communication between the community nursing teams and patient's GP after initial assessment of a patient and following discharge.	Monitoring improvement has been a challenge due to limitations of the IT system.

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Quality Accounts: Progress Update
Clinical effectiveness

Quality priority	Objectives	Progress at Q3
Protect the future health of local children	We will continue this improvement programme and will achieve our CQUIN target to increase the proportion of MMR1 and pre-school booster immunisation.	Achieved

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Quality Accounts: Progress Update
Patient Experience

Quality priority	Objectives	Progress at Q3
Improve our complaints and PALS services	We will formally review both our complaints and PALs services and will recommend and consult on improvements to processes that will ensure rapid Trust-wide learning from the feedback we receive	A review and consultation was undertaken, the proposal to merge PALs and complaints has been put on hold pending national guidance following the Clwyd-Hart report.
	We will improve the timeliness and quality of our responses to complaints	A satisfaction survey is being carried out of all complainants where the complaint closed in 2013.

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Quality Accounts: Progress Update
Patient Experience

Quality priority	Objectives	Progress at Q3
Improving the care of vulnerable patients	•Focus on individualised care for patients with dementia including early assessment, identification and communication	Achieved. CQUIN dementia screening target met.
	•Caring for carers of patients with dementia	CQUIN achieved monthly carers survey established and actions being taken forward.
	•Achieve a 10% increase in referrals to the Dementia and Delirium Team (DaD)	Achieved.
	•Achieve a 30% increase in the use of the delirium bundle	Achieved. Currently 79-80 uses of the bundle per month.
	•Build on work achieved via Barbara's story to develop a culture of knowledge, understanding and empathy amongst staff and take the project forward to the next phase.	An evaluation has been completed and 5 further episodes of Barbara's story have been launched.

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Quality Accounts: Progress Update
Patient Experience

Quality priority	Objectives	Progress at Q3
Extend user involvement in our quality checks	•We will continually assess the quality of our care, through Safe in Our Hands Ward accreditation system carried out by our staff and governors. We will invite representatives from our local community to participate in assessments and feedback sessions •Following a pilot, further develop our mystery shopping programme and report our findings to the Board	Achieved. All inpatient wards completed the accreditation programme with the continued participation of our governors. Local residents and patients took part in the PLACE assessments. Achieved. Our mystery shopping programme has been rolled out to more than 14 locations and a new call quality assessor initiative developed. Quarterly updates are included in the Patient Safety and Experience report to the Board.

Quality Accounts: Progress Update
Patient Experience

Quality priority	Objectives	Progress at Q3
Achieve our hospital and community patient experience CQUIN targets	•We will roll out and embed the Friends and Family Test across our hospital wards and Accident and Emergency Department at St Thomas'	Achieved. The test is rolled out to inpatients, A&E and also maternity services in line with the 2013-14 CQUIN requirements. Work is ongoing to embed further in A&E and maternity.
	•Achieve our community patient experience CQUIN via a programme to roll-out near-time patient experience system across our community services	Achieved. Near-time feedback system has been rolled out to inpatient units and domiciliary care services (adults and children)

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Quality Accounts: Progress Update
Patient experience

Quality priority	Objectives	Progress at Q3
Improve our outpatient department efficiency	•Reduce the number of patients who 'do not attend (DNA)' or cancel their appointments •Reduce how long patients have to wait for their first appointment •Reduce clinic waiting times	While the profiled reduction has not been met there has been a reduction in DNA numbers. Comparing waits with 2012/13 there has been a reduction in long waits for a 1st appointment

Quality and Safety priorities 2014/15

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Quality and Safety priorities 2014/15: Patient safety *(DRAFT)*

Consolidation of progress in basic patient safety practices: including use of the WHO surgical checklist and the NHS Safety Thermometer; keeping numbers low through attention to detail, case working and root cause analysis.

Adoption of the London Quality Standards for emergency care: improving the timeliness and regularity of clinical review by consultants, better to support patients admitted as emergencies or identified as acutely unwell.

Quality and Safety priorities 2014/15: Patient safety *(DRAFT)*

Investment in IT to support real time tracking of clinical decisions: major improvements in the systems used to record patient location and condition and the interventions and decisions made by clinical teams

The handover project: bringing in new ways of working to ensure safe and seamless handovers as clinical acute care teams come on and off shift

Quality and Safety priorities 2014/15: Clinical effectiveness *(DRAFT)*

Partnership working: we will improve the way we exchange information with primary care, with a special focus on patients discharged to our local colleagues in Lambeth and Southwark.

Peer comparison and support: we will look to share clinical expertise across the trust and compare the effectiveness of specific approaches with colleagues in Kings Health Partners and the Shelford Group

Quality and Safety priorities 2014/15: Clinical effectiveness *(DRAFT)*

Build capacity in perioperative assessment: We will double our efforts to improve the preparation and management of vulnerable patient groups before, during and after surgery.

Community based services: improving the offer
Further work to develop district nursing, the Hospital @ Home, and proactive care to help patients with long term conditions manage their health

Quality and Safety priorities 2014/15: Patient experience *(DRAFT)*

Complaints and PALS: maintaining the focus and discharging the recommendations of recent national reports

Barbara's trust: Continuing our focus on recognising and being responsive to the experience of older people, especially those with dementia and delirium

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Quality and Safety priorities 2014/15: Patient experience *(DRAFT)*

Friends and Family Tests and other surveys: we will work to improve our scores about the positive experience of care across all settings

Full adherence to new principles of care for dying patients: management oversight to ensure good practice is adhered to

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Mortality

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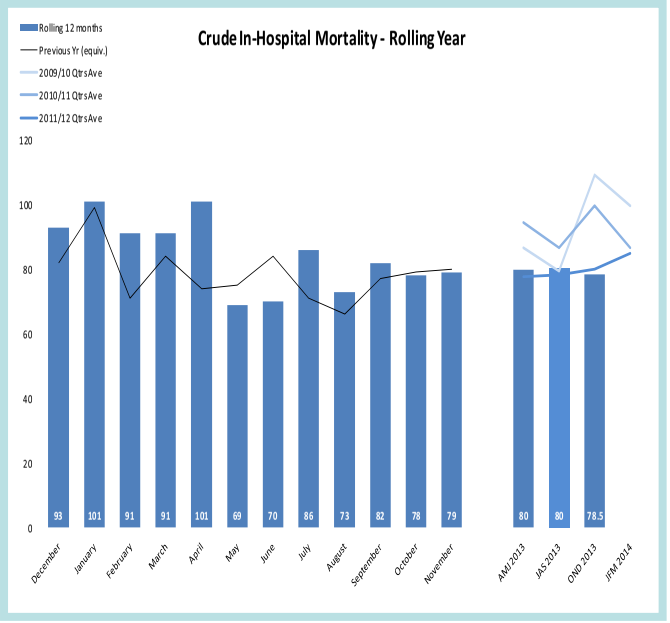
Mortality

Hospital Mortality
The number of patients dying in hospital during June – November 2013 averaged 80/month which is similar to the numbers in 2012 but less than that for 2011 and 2010. These deaths occurred mostly in patients admitted as emergencies and we did not see an excess of deaths in patients >75years.

Hospital Standardised Mortality Index (April - September 2013)
This remains at a low level compared to other NHS hospitals (Fig 1).

Weekend Emergency Mortality (April - September 2013)
The Hospital Standardised Mortality Rate for patients admitted as an emergency at a weekend remains low compared to other NHS London hospital (Fig 2).

Review and learning from deaths in hospital
We are piloting a new system so that all deaths of patients in hospital are reviewed both to identify any patient safety learning points and also (particularly for those deaths that are expected) the quality of end of life care management.



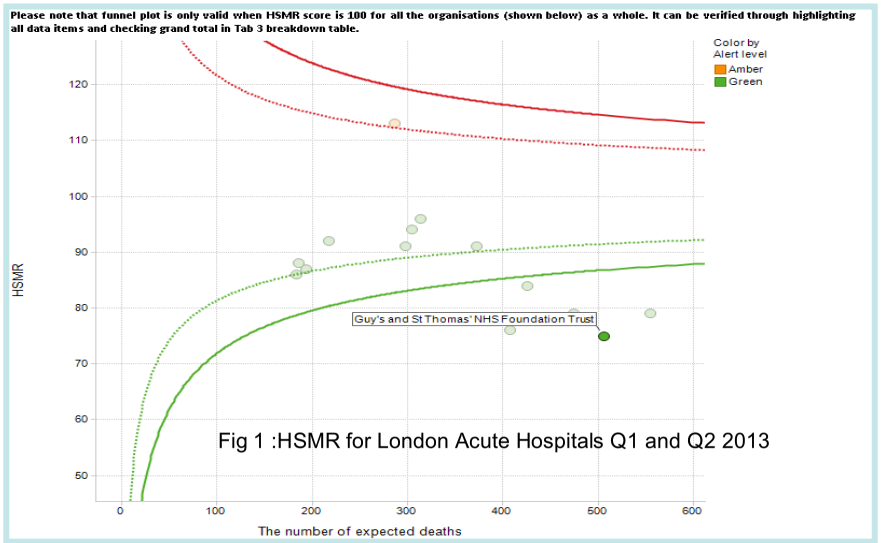


Fig 1 :HSMR for London Acute Hospitals Q1 and Q2 2013

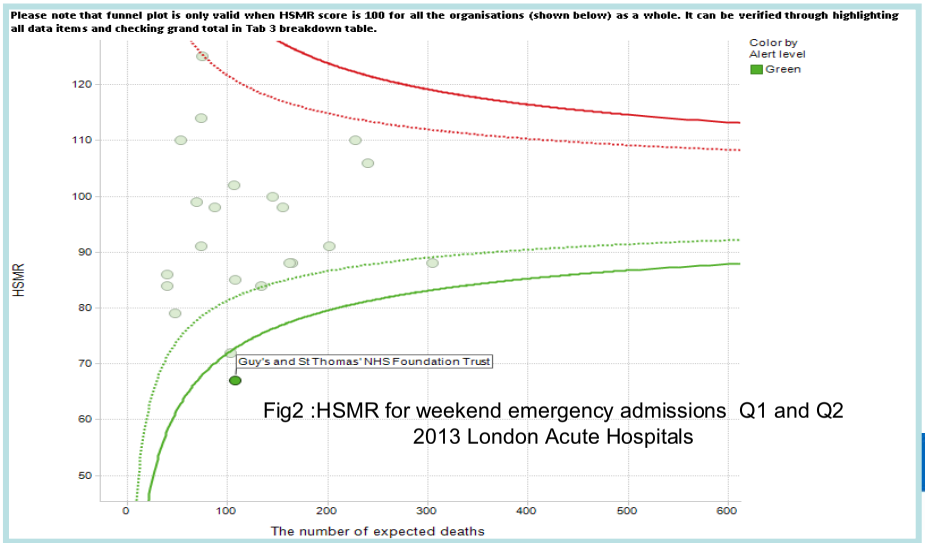
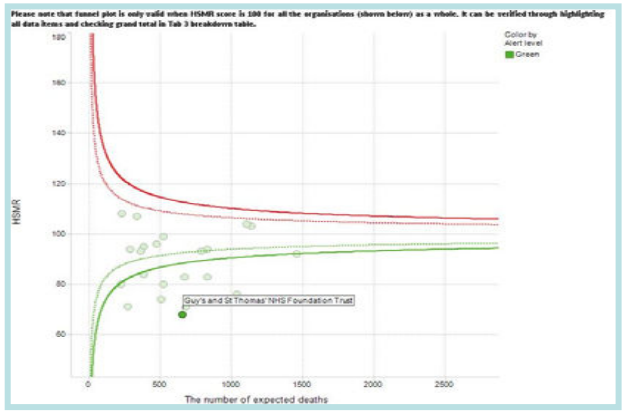


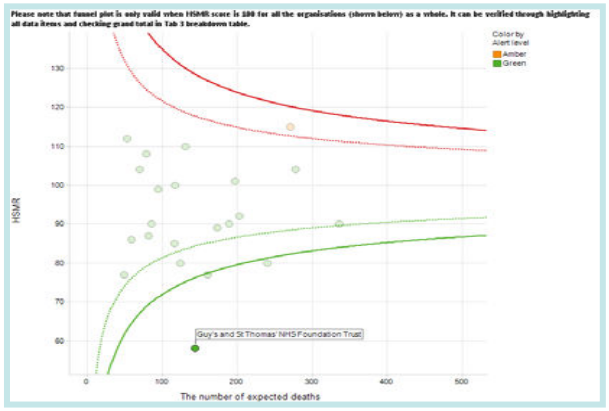
Fig2 :HSMR for weekend emergency admissions Q1 and Q2 2013 London Acute Hospitals

Mortality - Dr Foster Hospital Guide Trust of the year

HSMR 2013/14 for London Acute Hospitals



HSMR for weekend emergency admissions 2012/13 for London Acute Hospitals



The Dr Foster Hospital Guide 2013 uses a range of measures of mortality to rank hospitals in England for the year 2012/13. The GSTT score in each is given here, the NHS average is 1.00.

•Hospital Standardised Mortality Rate (HSMR)	0.67
•Standardised Hospital Mortality Index (SHIMI)	0.78
•Deaths following treatment for Low- Risk Conditions	0.32
•Deaths after surgery	0.74

Guy's and St Thomas' was the only trust in England rated better than expected for all four of these measures and was awarded the London Trust of the year.

Weekend Mortality
The guide looked at mortality following emergency admission of patients at weekends. Guy's and St Thomas' was one of eight hospitals that were identified as having very low mortality rates at weekends.

In December Guy's and St Thomas' were named in the Dr Foster Hospital Guide, an annual healthcare report, as the only trust in England to be rated as 'better than expected' for all four key mortality indicators:

HSMR (Hospital Standardised Mortality Ratio) – measures whether the number of patient deaths in a hospital is higher or lower than expected, HSMR is based on 56 conditions that account for 80% of deaths

SHMI (Summary Hospital-level Mortality Indicator) – based on all conditions, this includes deaths in hospital and deaths in the 30 days after discharge from hospital. Death in low risk conditions and deaths after surgery.

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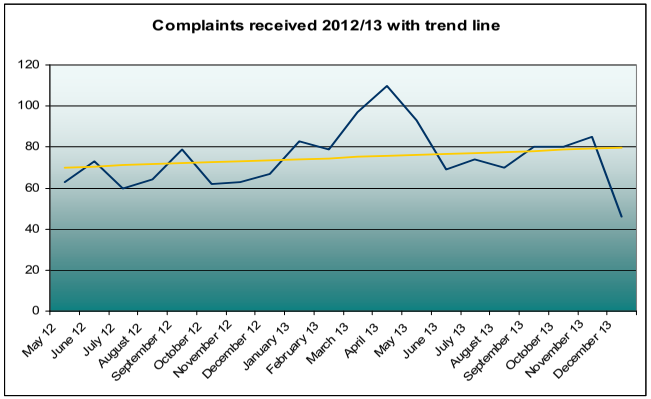
Complaints

The chart illustrates the overall upward trend in complaints across two years, 2012 and 2013.

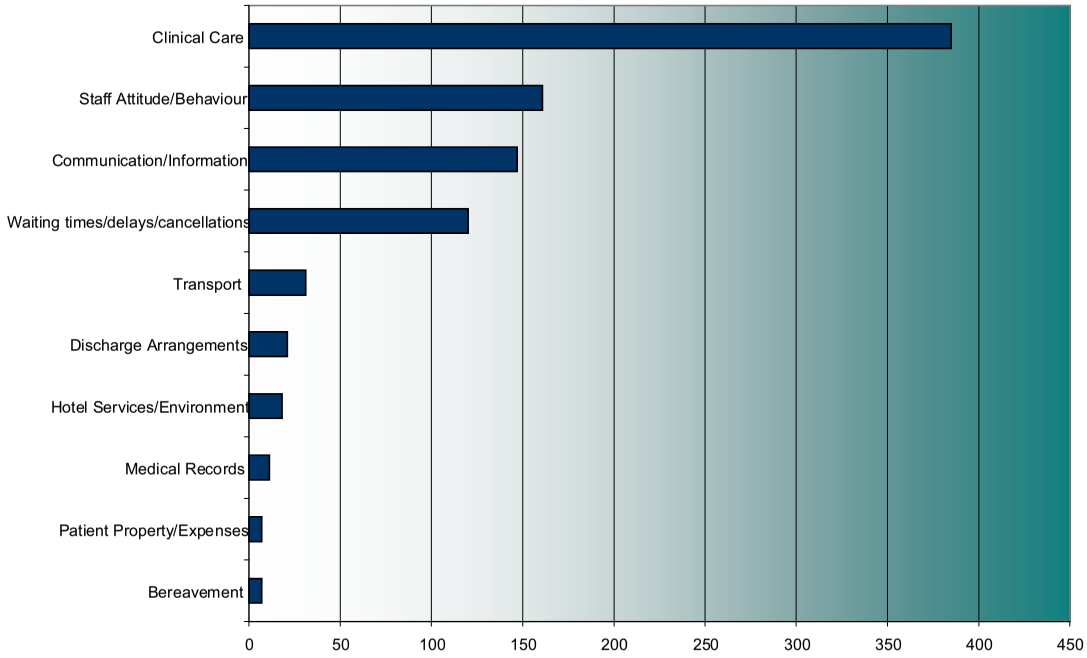
The supporting paper provides examples of complaints received and the action taken to improve care and services as a result.



The chart shows the subject of all complaints received by main subject during 2013, many complaints involve more than one subject.

The four most complained about areas are:
•clinical care
•communication/information
•waiting times/delays/cancellations
•attitude/behaviour of staff

The Trust numbers reflect the national picture for the main areas of complaint.



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Southwark Council
Overview and Scrutiny Committee

24 March 2014

Complaints report
January 2013 – December 2013
(Financial Q4 2012/13 – Q3 2013/14)

Status: A Paper for *Information*

Elizabeth Palmer
Deputy Director Assurance and Compliance

Guy's and St Thomas' NHS
NHS Foundation Trust

Southwark Scrutiny Committee

24 March 2014

A paper prepared by Sally Brooks, Head of Complaints, Risk and Litigation and presented by Elizabeth Palmer

Introduction

A formal complaint as part of the Local Authority and National Health Service Complaints (England) Regulations 2009 is described as *"an expression of dissatisfaction with an NHS service".* Patients or another party with consent of the patient can make complaints. In the event a person has died a complaint can be made by anyone deemed to have "sufficient interest". Complaints are received in writing, by email and by telephone. Once a complaint is received it is acknowledged within 3 working days, graded for severity, checked whether consent is required, logged on the department's database and then passed on for investigation. Timescales for completing the investigation are given to the investigator/s. On conclusion of the investigation the investigator will provide a report or a draft letter which is reviewed by the complaints department to ensure it answers all concerns raised and that includes any remedial actions to be taken to minimise the risk of recurrence. The Trust secretary reviews all complaint response prior to signing by the Chief Executive.

Complaints received over last 4 quarters from January 2013 to December 2013

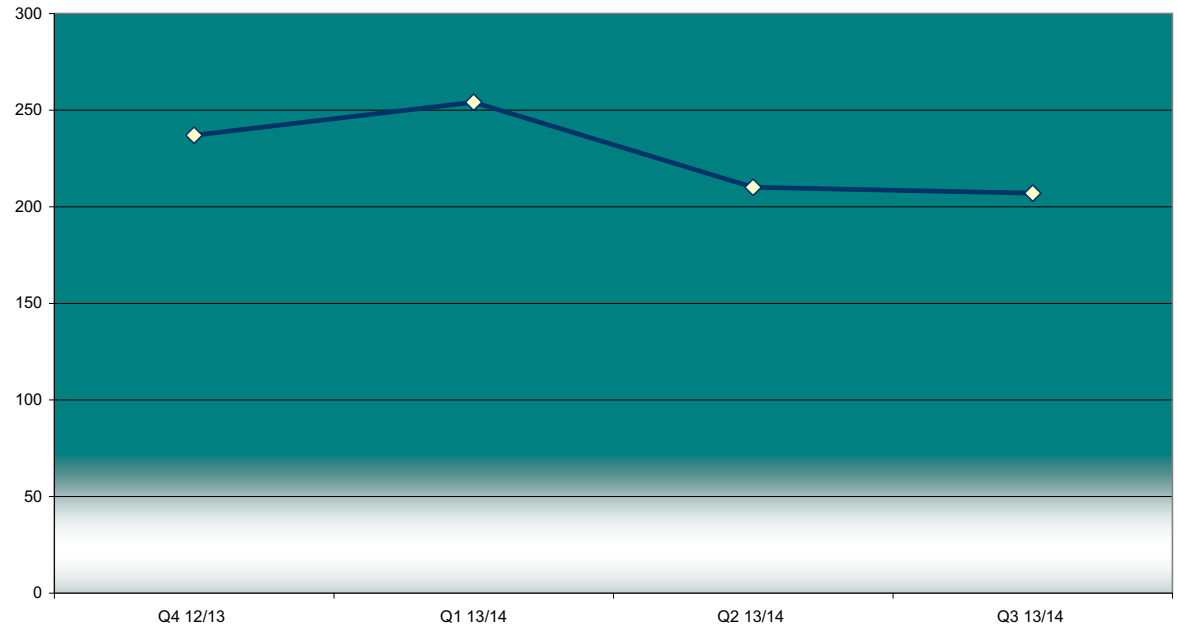

Table 1: Complaints received

Grading of complaints or severity

Complaints received are reviewed and graded in the complaints department using the Trust incident grading system, i.e. the AS/NZS 4360 categorisation protocol (risk matrix).

There were no serious or red-graded complaints across the Trust over the year however there were 121 (13%) moderate or orange graded complaints and 787 (87%) minor or green graded complaints.

Subjects raised in complaints

Clinical care is the most complained about issue at the Trust which is also reflected nationally. This covers a range of concerns which can be broken down as follows:

- Unhappy with clinical advice
- Concerns about clinical treatment
- Poor outcome
- Administration of treatment
- Inadequate discharge planning

The other subjects are fairly self explanatory apart from “waiting times/delays/cancellations” which are mainly about appointments and “hotel services/environment” which tend to be about accommodation and the physical environment of the hospital.

Figure 1 shows the subject of all complaints received by main subject over the 4 quarters (many complaints involve more than one subject). The four most complained about subjects of Clinical Care, Communication/Information, Waiting times/delays/cancellations and Attitude/Behaviour of staff are reflective of national figures.

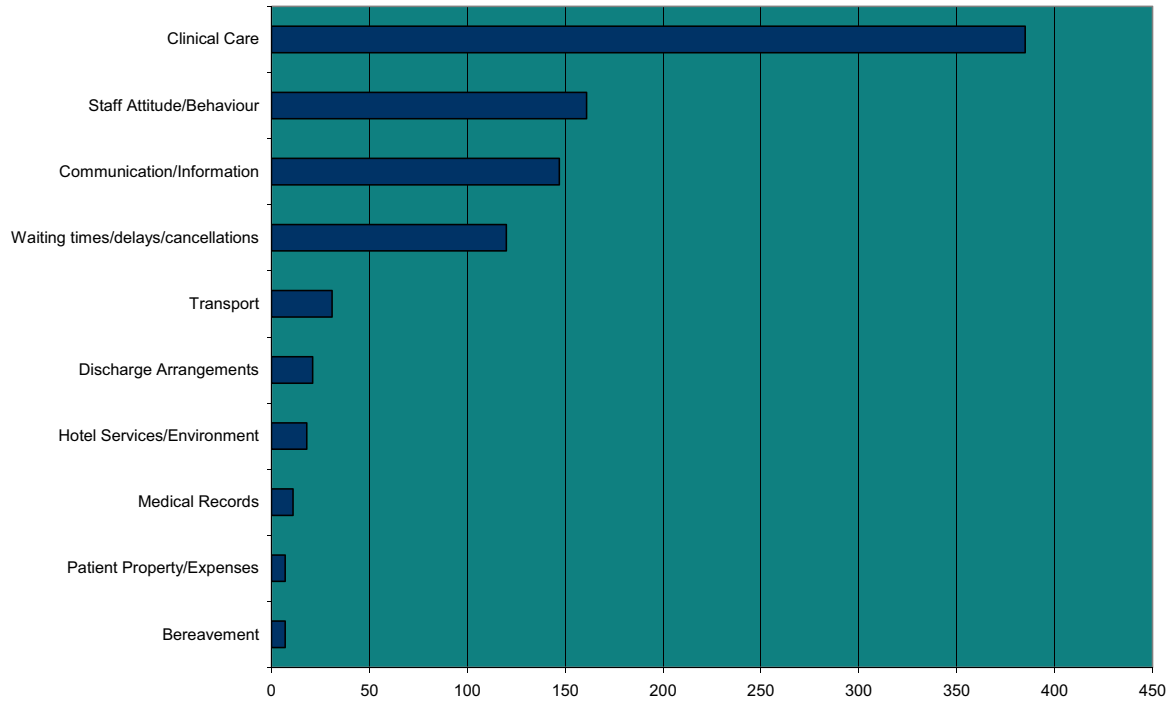

Figure 1: Complaints received by main subject of complaint

Figure 2 shows the number of the top four issues (main subject of complaint) received across the Trust over 2013.

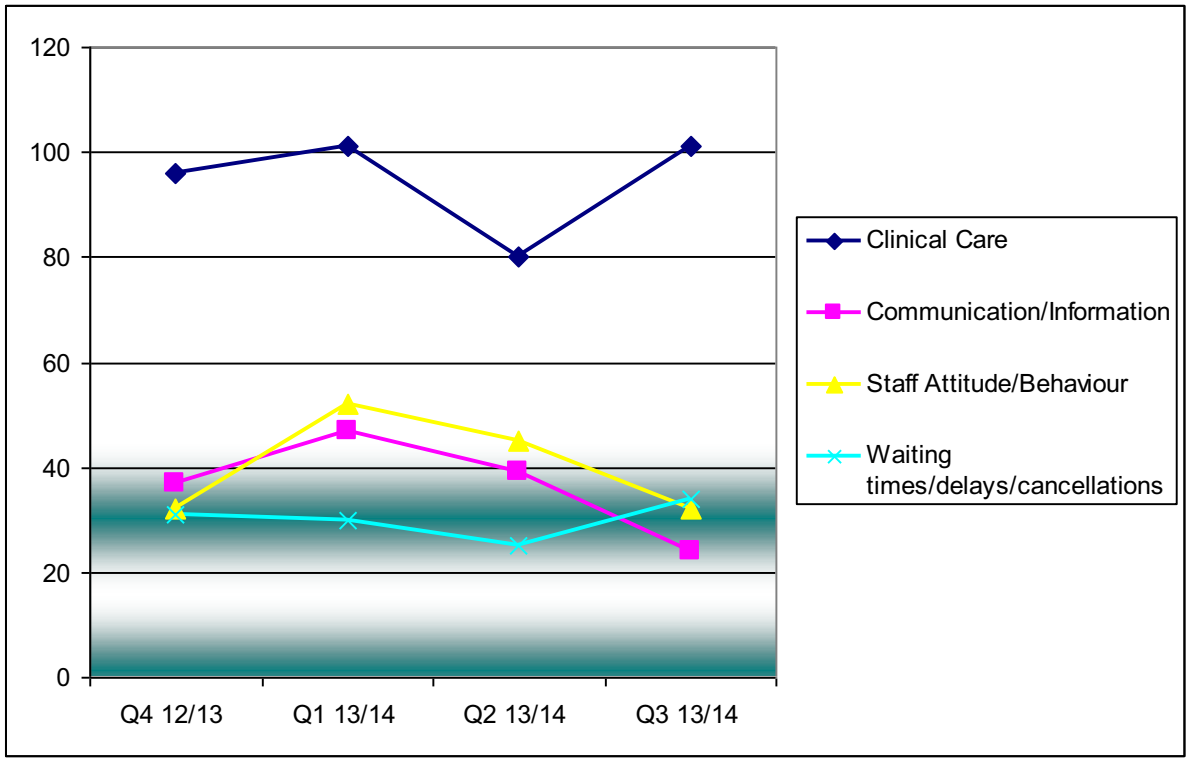

Figure 2: **Top 4 complaint subjects over previous 4 Quarters**

Complaint Examples

Example 1:
Patient was unhappy that a large scar was left on their forehead after a biopsy, especially after expressing their concern before the procedure.

Effect on patient
Patient felt distress and shock over the size of the wound when removing the dressing the next day as they had been instructed to do.

Action
The department is producing a photograph album that they can show to patients prior to surgical procedures so they know what outcome to expect.

Example 2:
The patient complained that they were discharged from hospital with only a two week course of oral steroids. After the two week course had been completed the patient became aware that the prescription should have been long term. On discovery of the error the GP prescribed further steroids.

Effect on patient
The patient was extremely anxious and distressed and questioned whether this error had caused deterioration in their condition. The patient was seen by the medical team and reassured that the other drugs in a complex regime would have compensated for the oral steroids being stopped. However this was potentially serious and action was taken to investigate and prevent it happening again.

Action
The error with the oral steroids occurred due to the design of the electronic discharge letter. The option to provide the steroid long term was not easily visible on the drop down menu of the electronic prescribing programme. As it is mandatory to provide the duration of the course for this particular steroid on the electronic prescription, 2 weeks was the option chosen, a note was made for the dosage to be reviewed in the outpatient clinic. The issuing of the discharge letter, which was not marked urgent, was delayed due to annual leave of the clinician's secretary and the note regarding "review of the dosage" was not seen.

The handbook for junior doctors has been updated to explicitly state the guidelines for the use of this steroid.

The information technology team will ensure that the field *'prednisolone long term maintenance tablets'* appears as an option high on the drop down menu list so it is clearly visible with the other timed options for prednisolone.

Example 3:
The patient advised they were unhappy about their discharge with a catheter from the Emergency Department, that they were given no advice on how to maintain it, also no spare catheter bags were provided.

Effect on patient
The patient was anxious and distressed at not being given any advice on how to maintain the catheter.

Action
The emergency department have introduced packs which contain guidance on managing the ongoing care of catheters and sufficient supplies.

Further learning from complaints

There are opportunities to identify common themes and trends as a result of both formal and informal complaints, PALS enquiries and a wide variety of other feedback mechanism within the Trust. A case study leading to improvements in services and care is described here, and is followed by examples of actions taken in response to themes from patient feedback.

Case study
The complaints department receive a consistent number of complaints about patient transport. Some of which are a significant cause for concern regarding lengthy waits in the transport lounge for patients with limited mobility. Two recent complaints involved patients receiving regular dialysis who had waits of 2.5hrs and 7 hours respectively. The contract standard with Savoy transport for a maximum wait is 90 minutes and clearly this was exceeded in both instances.

Both of these patients are wheelchair bound, one of whom is transported on a stretcher once in the ambulance due to having a pressure ulcer and fractured hip (awaiting repair).

These patients are transported to the dialysis unit at Guy's three times a week and they frequently experienced delays returning home after treatment. For the first patient a culmination of delays led to the complaint. The second patient frequently experienced shorter delays (exceeding the 90 minute standard) but this extreme delay was the catalyst for complaint.

The complaints were made by their relatives who were concerned about the patients' well being and whether their basic needs for food, fluids and toileting were being met.

The hotel services manager had a meeting with the relatives of the patient who experience the 7 hour delay to gain insight into the patient's experience of transport as a whole as well as the event leading to the complaint.

Actions

As a result of both complaints and an outcome of the meeting the following actions are being carried out.

- All drivers to check in with the transport reception on arrival to ensure transport staff are fully informed of the status of journeys and patients are not overlooked.

- Journeys are not to be aborted without authorisation from transport reception team.

- The introduction of a dedicated transport number for direct internal contacts and for contractors to make enquiries as to the status of journeys, to avoid delays in getting though and reduce the pressure on the incoming calls and booking line.

- Consistent notes to be put on the booking system where there are 'non standard' requirements.

- Stop direct contact with the transport contractors by non transport staff so that all matters relating to transport are dealt with by the transport team.

- Provision of a beverage vending machine easily accessible for both patients and the nurse present.

- Raise awareness with patient that they can ask the nurse or transport reception staff if they need food or drink or have any other requirements (including assistance with the lavatory)

- Clear guidelines on the provision and access to food for those patients who have had a prolonged wait.

- Review the roll-call system to ensure that a protocol is in place to deal with delays. This is to include an escalation process when problems cannot be handled at a local level.

- Customer service training for all frontline transport staff to ensure they can deal with adverse situations and use language and words that are appropriate.

- Liaison with all teams to ensure that they do not criticise or blame the failings of other departments of the trust and work together to resolve issues.

- In addition the patient transport team is currently in the process of re-tendering for services. One key element they are looking at is the waiting time for patients to go home after their appointment. Rather that the current 90 minutes standard (depart within 90 minutes of booking ready to travel) it is hoped to reduce this to 30 minutes. In anticipation of this a trial using this standard has begun and initial signs are that the trial is going well, with the overall waiting for patients improved.

Responses to themes from patient feedback
The surgical admissions lounge team are implementing staggered admission times with some surgical teams, with plans to roll this out for all surgical specialities in the future. The aim is to provide a calmer environment and allow for more patient centred care. Additional communication skills training has been arranged for their staff.

The Community Adult Services team arranged a team training day to raise awareness and explore the importance of good communication with patients and relatives, as well as within the team.

Recommendation:

The Overview and Scrutiny Committee is asked to:

- **Note the report for information / discussion**

Elizabeth Palmer 17 March 2014

Guy's and St Thomas' NHS
NHS Foundation Trust

Southwark Council
Health Scrutiny Committee

24 March 2014

Determination of staffing levels for nurses, midwives and health visitors at Guy's and St Thomas'

Status: A Paper for *Information*

Guy's and St Thomas' NHS
NHS Foundation Trust

Southwark Health Scrutiny Committee

Briefing paper on how Guy's and St Thomas' NHS Foundation Trust determines its nurses, midwifery and health visitor staffing levels

1.0 Introduction

At Guy's and St Thomas' we take very seriously the nurse staffing levels across the Trust ensuring they are reviewed regularly and adjusted to, wherever possible, match the acuity and dependency of all our patients.

Set out below is the process that we follow.

2.0 Setting staffing levels

All clinical areas have their nurse, midwifery and health visiting staffing levels reviewed by the Chief Nurse every six months. This takes place as a formal review with each sister or equivalent and their manager. In reviewing the staffing levels we discuss:

- National guidance
- Acuity and dependency of the patients and has there been any change
- Skills and experience of the staff in the team
- Strength in leadership
- Any external factors influencing the staffing profile
- Number of vacancies, sickness and maternity leave.

The staffing levels may then be adjusted, this is followed up and confirmed in writing.

3.0 Adjusting staffing levels

Although staffing levels are reviewed and set six monthly, we also have a daily system in place that monitors acuity and dependency using the safer care acuity tool, and ward sisters have the authority to uplift their staffing levels without seeking permission. Therefore it is not uncommon for staffing levels to be above the planned number.

4.0 Governance

4.1 The Chief Nurse reports formally to the Board every six months, and from April a monthly report will be available on the Trust's website setting out the current staffing position.

4.2 The Trust has undertaken an assessment against each of the 10 expectations set out in the Nurse Staff Guide "How to ensure the right people, with the right skills, are in

the right place at the right time" and can confirm the Trust is compliant (appendix one).

4.3 The Chief Nurse has appointed a Deputy Chief Nurse who is responsible for providing strong, effective leadership to the workforce agenda.

5.0 Conclusion

It is important to state that although we are satisfied with our approach and governance, there is no element for complacency and there is constant monitoring and actions taken to ensure staffing is safe.

The full Board reports are available for further information.

Attachments:

January 2014. Update on the Nursing, Midwifery and Health Visitor Workforce. Guy's & St Thomas NHS Foundation Trust Board of Directors

April 2014. Report on safe staffing levels for our adult inpatient acute wards, including Midwifery and Evelina Children's Hospital. Guy's & St Thomas NHS Foundation Trust Board of Directors

Eileen Sills CBE
Chief Nurse & Director of Patient Experience
17th March 2014

Appendix one

Response to National Quality Board's 10 expectations:

Expected	Trust Response
Board takes full responsibility for the quality of care provided to patients and, as a key determinant of quality, take full and collective responsibility for nursing, midwifery and core staffing capacity and capability	In place. The Board of Directors have in place a process for setting and monitoring nurse staffing levels. The Board of Directors receive regular updates from the Chief Nurse which will now be undertaken monthly. Staffing levels and patient acuity and dependency is monitored continuously and levels are adjusted as necessary. Nursing staff know they can escalate at anytime if they are concerned.
Processes are in place to enable staffing establishments to be me on a shift by shift basis.	There are a number of different processes in place to monitor shift by shift staffing: • ERoster • daily acuity • escalation procedures • daily sitrep monitoring
Evidence based tools are used to inform nursing and midwifery and core staffing capacity and capability.	We use the National Safer Care acuity tool supported by further acuity and dependency data.
Clinical and managerial leaders foster a culture of professionalism and responsiveness, where staff feel able to raise concerns.	In place through; • Trust policies • clinical leadership model • clinical Fridays • regular forums to meet senior staff • post Francis listening exercise
A multi-professional approach is taken when setting nursing, midwifery and care establishments.	All relevant staff are involved and the Chief Nurse works directly with ward sisters to review staffing establishments. There is a formal review six monthly.
Nurses, midwives and care staff have sufficient times to fulfil responsibilities that are additional to the direct care duties.	All establishments have a built in uplift to cover study leave, sickness and annual leave. All ward sisters are in a supervisory role.
Boards receive monthly updates on workforce information. Staffing capacity and capability is discussed at a public Board meeting at least every six months on the basis of a full nursing and midwifery establishment review.	In place.
NHS providers clearly display information about the nurses, midwives and care staff present on each ward, clinical setting, department or service on each shift.	On the patient status at a glance boards on each ward, the nurses on duty are clearly stated.
Providers of NHS services take an active role in securing staff in line with their workforce requirements.	In place. We have an active recruitment programme and work closely with LETBs to confirm our future workforce requirements.
Commissioners actively seek assurance that the right people, with the right skills are in the right place at the right time with the providers with	Not applicable to us but as required we will be able to demonstrate to our commissioners the systems we have in place.

whom they contract.	

Guy's and St Thomas' NHS
NHS Foundation Trust

Board of Directors Meeting

29th January 2014

(BDA/14/09)

Update on the Nursing, Midwifery and Health Visitor Workforce

Status:	A Paper for Information
History:	Board of Directors paper October and April 2013

Eileen Sills CBE
Chief Nurse and Director of Patient Experience

Guy's and St Thomas' NHS
NHS Foundation Trust

Board of Directors Meeting

29th January 2014

A paper prepared and presented by Eileen Sills CBE,
Chief Nurse and Director of Patient Experience

Update on the Nursing, Midwifery and Health Visitor workforce

Executive Summary

Purpose:

- To update the Board of Directors on the assessment made against the 10 expectations set out in the Nurse Staff Guide 'How to ensure the right people, with the right skills are in the right place at the right time!' Published by the National Quality Board and NHS Commissioning Board.
- To provide to the Board of Directors an overview of the size and shape of the Trust's non-ward based adult nursing profile.
- To provide the Board of Directors with an overview of the rational for the profile of the non-ward based workforce.
- To provide the Board of Directors with an assessment against the RCN's evidence of children's staffing.
- To bring to the attention of the Board of Directors any workforce risks.

Key Points:

- To demonstrate compliance with new staffing expectations and RCN children's staffing standards.
- It has been a very challenging exercise to capture accurately the exact make up of the non-ward based workforce, due to many roles working across specialties. It has however enabled us to undertake a comprehensive stocktake and to provide the Board with an understanding of the rational for the workforce we have and where the key recruitment challenges are, which is predominantly in critical care and theatres.

Implications:

- Although the emphasis on nurse staffing across the NHS has been at ward level, there are just as many risks within the non-ward based staffing. Therefore it is essential that we apply the same focus and priority on our ward staffing.

Recommendations:

- **The Board of Directors is asked to note the information contained in this report and the actions we have in place.**

1.0 Introduction

1.1 The following report to the Board of Directors is the third in a series of reports/updates on the nursing workforce. From the end of February 2014 the Board will receive a monthly performance report on nurse staffing.

1.2 The emphasis on ensuring safe nurse staffing levels has been reinforced with recent publications:

- Hard Truths – The Journey to Putting Patients First 'Hear the patient, speak the truth and act with compassion'. Published by Department of Health.
- National Quality Board report – How to ensure the right people, with the right skills, are in the right place at the right time. Published by NHS England.
- Defining Staffing Levels for Children and Young People's Services. Published by Royal College of Nursing (RCN).

1.3 This report addresses our compliance with the recommendations/expectations within these reports. However these and previous reports have focussed, quite rightly so, on staffing for inpatient areas. In recent years there has been a noticeable shift in both numbers and acuity of patients cared for in our non-ward based environments. Therefore it is just as important for the Board of Directors to understand the size and shape of our non-ward based nursing workforce. For the purpose of this report that will include all areas with the exception of Children's Services as this has been reported in earlier reports..

1.4 The report is split into three parts:

- **Part One:** Response to the National Quality Board's 10 expectations.
- **Part Two:** Assessment against the RCN's 16 core standards for safe children's staffing within Evelina London.
- **Part Three:** Overview of the non-ward based nursing workforce which identifies the key issues/risks with actions being undertaken.

Part One

2.0 Response to National Quality Board's 10 expectations:

Expected	Trust Response
Board takes full responsibility for the quality of care provided to patients and, as a key determinant of quality, take full and collective responsibility for nursing, midwifery and core staffing capacity and capability	In place. The Board of Directors have in place a process for setting and monitoring nurse staffing levels. The Board of Directors receive regular updates from the Chief Nurse which will now be undertaken monthly. Staffing levels and patient acuity and dependency is monitored continuously and levels are adjusted as necessary. Nursing staff know they can escalate at anytime if they are concerned.
Processes are in place to enable staffing establishments to be me on a shift by shift basis.	There are a number of different processes in place to monitor shift by shift staffing: • ERoster • daily acuity • escalation procedures • daily sitrep monitoring
Evidence based tools are used to inform nursing and midwifery and core staffing capacity and capability.	We use the National Safer Care acuity tool supported by further acuity and dependency data.
Clinical and managerial leaders foster a culture of professionalism and responsiveness, where staff feel able to raise concerns.	In place through; • Trust policies • clinical leadership model • clinical Fridays • regular forums to meet senior staff • post Francis listening exercise
A multi-professional approach is taken when setting nursing, midwifery and care establishments.	All relevant staff are involved and the Chief Nurse works directly with ward sisters to review staffing establishments. There is a formal review six monthly.
Nurses, midwives and care staff have sufficient times to fulfil responsibilities that are additional to the direct care duties.	All establishments have a built in uplift to cover study leave, sickness and annual leave. All ward sisters are in a supervisory role.
Boards receive monthly updates on workforce information. Staffing capacity and capability is discussed at a public Board meeting at least every six months on the basis of a full nursing and midwifery establishment review.	In place.
NHS providers clearly display information about the nurses, midwives and care staff present on each ward, clinical setting, department or service on each shift.	On the patient status at a glance boards on each ward, the nurses on duty are clearly stated.
Providers of NHS services take an active role in securing staff in line with their workforce requirements.	In place. We have an active recruitment programme and work closely with LETBs to confirm our future workforce requirements.
Commissioners actively seek assurance that the right people, with the right skills are in the right place at the right time with the providers with whom they contract.	Not applicable to us but as required we will be able to demonstrate to our commissioners the systems we have in place.

Part Two

3.0 Assessment against the RCN's 16 core standards for safe children's staffing within Evelina London:

3.1 The RCN published a set of 16 core standards for children and young people's services in 2013. As assessment has been undertaken against each of these standards within Evelina London, and is set out as follows. We will be undertaking the same exercise across all services that care for children outside of Evelina London, e.g. Dental.

3.2

Standard	Compliance
1. The shift supervisor will be in a supervisory role.	Compliant. All clinical areas have this built into their establishments.
2. Nurse Specialists and ANPs not included in bed side numbers.	Compliant. All our non-ward based specialist roles are not included in the bed side numbers.
3. One Nurse per shift will be trained in APLS/EPLS.	Compliant.
4. Minimum of 70:30 registered : unregistered staff in clinical areas.	Compliant. We have 87:13 registered : unregistered skill mix in our acute in-patients areas. Ratio is 50:50 in OPD area but overall we are above the 70:30 ratio.
5. 25% uplift in establishments to cover annual leave, sickness and study leave.	Compliant. All our ward establishments have individual uplifts set which is determined by the profile of the workforce. This is reviewed annually as part of business planning.
6. Two RN Child at all times in in-patients and day care.	Compliant.
7. Nurses should be trained in Children's Nursing with additional training for specialist services / roles.	Compliant. Although on PICU we currently have four RN Adult staff who are supervised and supported.
8. 70% of nurses should have appropriate training for the speciality (i.e. Intensive Care, Oncology and Neurosurgery).	Partially Compliant. For the only areas not compliant; Renal – 65% and Cardiac – 56%, training plans are in place.
9. Support roles should be used to ensure that RN are used effectively.	Compliant. Senior Nursing Assistant roles as well as bespoke Milk Kitchen roles for unregistered workforce are in place.
10. Unregistered staff have completed appropriate course and competency assessment.	Compliant. All unregistered staff are inducted, undertake a diploma programme supported by a set of competencies.
11. Number of University students should not exceed the agreed levels.	Compliant.
12. Patient dependency scoring tool in place.	Compliant.
13. Quality indicators measured and monitored for adjustments in nurse staffing levels.	Compliant. Discussed at Clinical Governance and a number of other weekly / monthly forums.
14. Access to a senior children's nurse. All Matrons must have RN Child.	Compliant. PNP team 24/7 as well as a team of Matrons and 1.8 wte Heads of Nursing.
15. Compliance with Safeguarding guidance.	Compliant. Staff do also attend external training sessions.
16. Children and Young People must have care from a skilled workforce and dedicated environment that meets their needs.	Compliant within ELCH. A full assessment is underway across all areas of the Trust where children are cared for outside of Evelina.

Part Three

4.0 Overview of the non-ward based nursing workforce:

4.1 Introduction
To accurately assess the size and shape of the non-ward based nursing workforce to ensure that it meets our requirements has been a difficult exercise for the following reasons.

- In many cases staff provide a service across different settings and therefore cannot just be associated to one clinical area, e.g. a clinical nurse specialist may work across outpatients and a clinical department or ward.
- Electronic Staff Record (ESR) system does not hold the data in the format we need and therefore data for this report has had to be collected manually.

Therefore at the time of writing, this section of the report is as accurate as we can make it.

4.2 The non-ward based workforce makes up for approximately 42% of our total nursing workforce.

4.3 It is important to state that the profile of our non-ward based staff, particularly in ambulatory areas, has changed in recent years to reflect the changing clinical needs of our patient population. An example of which is our dermatology and oncology services. The dermatology nurse-led day service replaced a 24 bedded inpatient ward and our chemotherapy and acute oncology service avoids patients having to be admitted. This has led to a significant increase in the acuity of our patients cared for within our ambulatory areas and at times acuity of our patients in these settings can match those of our ward environments. At present there is no tool to monitor the acuity and dependency of our patients in our out-patients settings, therefore we are developing our own.

4.4 In addition this workforce has also seen significant change and development to support the Trust's response to becoming European Working Time Directive (EWTD) compliant by nurses taking on advanced roles and developing a range of nurse-led services to meet activity and service changes. Income associated with all our nurse-led services across the Trust has doubled from £6m in 2007 to £14m in 2013.

4.5 The size and shape of our non-ward based workforce is often challenged when the total number is benchmarked with external organisations. This is not particularly helpful; as you will see from this section of the report this workforce is very varied. Therefore in future it is recommended that this workforce is separated out into key groups to ensure an accurate and fair review, especially if a benchmarking exercise is to be undertaken.

For the purpose of this report, the following areas have been reviewed:

5.0 Accident and Emergency
6.0 Critical Care
7.0 Theatres
8.0 Dialysis
9.0 Clinical Nurse Specialists
10.0 Consultants Nurse / Midwife
11.0 Specialist Teams
12.0 Imaging
13.0 District Nursing
14.0 Health Visiting
15.0 School Nursing
16.0 Matrons
17.0 Clinical Research Nurses
18.0 Practice Development Nurses
19.0 Ambulatory and Outpatient settings

5.0 Accident & Emergency

5.1 Workforce profile:

	Budgeted WTE	In post	Vacancy (inc Mat leave)
Trained	84.2	83.4	0.8
Untrained	14.8	14.8	0
Total	**99**	**98.2**	**0.8**

5.2 The nursing staff in the Emergency Department provide a 24/7 service and over the years the role of the nurse within A&E has changed considerably, with many now holding advanced skills and qualifications. They are able to diagnose, treat and discharge patients independently.

5.3 There is no validated workforce tool to determine staffing levels, however the Shelford Group have just commissioned a piece of work to create a tool, which the Trust has participated in. Early indications demonstrate that we have an effective and efficient workforce model.

5.3.1 Three years ago a new type of unqualified worker was introduced into the department. A number of Clinical Assistant Practitioners (CAPs) were recruited and trained to assist the nursing staff with a variety of basic tasks such as carrying out patient observations, performing ECGs and plastering of limbs.

5.4

Opportunities / Issues	Actions
• No longer a major trauma or stroke centre – could have implications for recruitment and retention which needs monitoring closely.	• We have explored nursing rotations with Kings to provide opportunities for staff to care for trauma patients. The development of other skills such as alcohol nurse pathways and band 6 junior emergency nurse practitioners have been implemented.
• High levels of maternity leave across all services within A&E.	• Recruiting to maternity leave vacancies and ensuring we utilise other opportunities to ensure stabilisation of the workforce.
• Local population increases due to Vauxhall housing development and other initiatives which may increase demand for services.	• Ensuring we have a robust workforce strategy to meet anticipated demand and change in patient referral pathways.

6.0 Critical Care

6.1 Workforce profile:
Includes Lane Fox, Victoria HDU, Intensive Care Unit, CC Response Team. & ECMO

	Budgeted WTE	In post	Vacancy (inc Mat Leave)
Trained	357.7	329.4	28.3
Untrained	16.9	15	1.9
Total	**374.6**	**344.4**	**30.2**

6.2 The Trust has 54 critical care beds this includes 2 flexible Overnight recovery beds). There are also 20 High Dependency beds across the Trust in Doulton, Page & Victoria wards

6.3 Critical care staffing has nationally recommended nurse to patient ratios. Level 3 patients (ITU patients) have a ratio of 1:1. Level 2 patients (mainly in HDU) have a ratio of 1:2.

6.4 For a unit of our size it is recommended that we have the budgeted equivalent as tabled in 5.1. Current vacancies total 30wte. These gaps are managed by staff working bank shifts and covering peak activity with agency staff.

6.4

Opportunities / Issues	Actions
• Recruitment - an acute shortage of specialist critical care nurses, particularly across London. • Retention of specialist critical care nurses. • Development of critical care service that impacts on workforce and require a further increase in nursing posts: - Increase in ECMO activity and development of service to expand to VA ECMO provision. - Need to establish and implement dedicated retrieval service. - Development and implementation of eICU. - Development of outreach intermediate care facility, linked with Lane Fox unit.	• Recruitment and retention strategy in place developed with the workforce team, HR, and the Trust's nurse recruitment lead.

7.0 Theatres

7.1 Workforce profile:
Includes Main theatres, CPOAU, SAL & DSU on both sites

	Budgeted WTE	In post	Vacancy (inc Mat Leave)
Trained	571.8	520.8	51
Untrained	34.4	24.7	9.7
Total	**606.2**	**545.5**	**60.7**

7.2 The department consists of 46 operating theatres across Guy's, St Thomas's and Evelina hospital. A surgical admission lounge (SAL) has been implemented on both sites and a centralised pre-operative assessment service (CPOAU) that is continuing to develop.

7.3 The preoperative medicine department delivers both inpatient and day case theatre facilities, alongside an anaesthetic service to patients receiving procedures in outlying areas across the Trust. Both elective and emergency operating take place in all areas.

7.3.1 In addition staff provide elective and emergency support to areas outside of the preoperative department including obstetric theatres, dental day surgery, endovascular, assisted conception and imaging which encompasses CT, MRI and PET scanners.

7.3.2 Each theatre is staffed according to the Association for Perioperative practice (AfPP) national staffing guidelines. A theatre sister is assigned per two theatres and is the included in staffing numbers 90% of the time. Each scheduled theatre session will have four registered theatre nurse/ODPs consisting of:

1. Anaesthetic assistant (Band5/6)
2. 2 x Scrub nurse (Band 5/6)
3. Circulating practitioner (Band5/6)

7.3.3 In theatre sessions where local anaesthesia is used staffing numbers are reduced accordingly as an anaesthetic assistant is not required.

7.4

Opportunities / Issues	Actions
• Recruitment - an acute shortage of specialist theatre nurses in particular across London. • A further need to expand the workforce due to the following developments: - Increasing demand for theatre sessions from all specialties in response to meeting cancer and 18 week targets - resulting in increased nurse vacancies. - Clinical innovation requiring development of new facilities - new theatre builds in line with expansion of services - resulting in increased nurse vacancies. - Retention of theatre support workers.	• Recruitment and retention strategy in place - developed in conjunction with the workforce team, HR and the Trust's nurse lead for recruitment. • Review skill mix conducted to convert band 6 posts to band 5 via attrition. - Band 5 posts easier to recruit - target met. • Need to review the theatre support workers band 2/3.

8.0 Dialysis Unit

8.1 Workforce profile:
Includes Astley Cooper, Acute, satellites and the community

	Budgeted WTE	In post	Vacancy (inc Mat Leave)
Trained	115.8	106.1	9.7
Untrained	27	25	2
Total	**142.8**	**131.1**	**11.7**

8.2 The renal unit currently has five dialysis areas; on-site is the Astley Cooper dialysis unit and an acute dialysis team covering inpatient dialysis on the Guy's and St Thomas' sites. Four areas are off site, Borough Kidney treatment centre which houses satellite dialysis and the community dialysis team, Tunbridge Wells kidney treatment centre, New Cross Gate and Camberwell.

8.3 The dialysis areas are all nurse led, they are managed by a band 7 sister/charge nurse supported by a matron. The units vary in size from 16 stations to 34 and run on two or three shifts per day. They are based in the community to keep patients near their homes to prevent travel into the main hospital site. The staffing ratio is 1:4 supported by senior nursing assistants all at band 3 levels. The workforce has been reviewed and some band 5 posts were taken out and replaced with band 3 to work at 70:30 ratio. Onsite is 80:20 ratio due to the dependency of the patients.

8.3.1 Our patients are outpatients and return to home, nursing home or to an in patient bed following treatment. The nurses look after the patients holistically and support them with the back up of community services. Community team (home dialysis) train patients on Peritoneal Dialysis and Haemodialysis to perform their own dialysis in their home. Areas such as this and acute areas require highly specialised nurses to be able to perform training and look after acutely ill patients. Recruitment for these posts is always internal from the other dialysis areas.

8.4

Opportunities / Issues	Actions
• Experienced dialysis nurses have been difficult to recruit.	• We have recruited nurses without dialysis experience and trained them, training can take up to 8-12 weeks before nurses can operate independently taking a cohort of patients, eventually some go on to take the renal course (for six months) to aid their development.
• Difficulty in attracting newly qualified nurses to take up a post in dialysis.	• A rotation programme has been run to aid this, where nurses can start on a ward area and then rotate into the dialysis unit when they have some experience.
• Increasing complexity and co-morbidity of our patients with increased dependency.	• A dependency score for dialysis is being considered to enable us to identify future workforce needs effectively.
• There are difficulties recruiting into maternity leave posts as the time required to train outweighs the benefits.	• All our staff join the bank as they also act as our only pool of bank staff and work in the other dialysis areas.
• Difficulties recruiting to Tunbridge Wells as posts have no London weighting (HCA), only 5% Fringe payment but an equally high cost area.	• Working with HR Business Partners to look at potential opportunities to address this issue.

9.0 Clinical Nurse Specialists (CNS)

9.1 Workforce profile:

Directorate	Budgeted WTE	In post	Vacancy
Abdominal Medicine & Surgery	14.2	10	4
Acute Medicine	14.3	9.1	5.2
Cardiovascular	28.3	22.1	6.2
Chief Nurse's Office	4.7	4	0.7
CLIMP	2	2	0
Community	19.2	34.3	6
GRIDA	41.9	41.7	0
Haematology & Oncology	47.4	42.8	4.6
Inpatient Services	7	5	2
PCCP	13.8	14.8	0.9
Surgery	6	6	0
Women's Services	6.5	6.1	0.4
Total	**205.3**	**197.9**	**30**

9.2 Clinical Nurse Specialists are employed across all services. This staff group is crucial in the implementation of the Cancer Reform Strategy, European Working Time Directive and the need to deliver an increased level of activity in a range of settings. The CNSs provide a vital clinical role throughout the Trust. They provide expert levels of direct care and shape and influence care at a variety of levels. This role is important in providing specialist clinical practice skills, patient advocacy, consultation, education, research and audit. They play a leading role in the development of clinical guidelines, protocols, screening and assessment tools, and program development. CNSs also provide consultation and education to other health care practitioners, and are involved in the generation and/or implementation of research findings appropriate to the client population group.

9.2.1 In addition, this workforce has been instrumental in the development of ambulatory models of care. Examples include Neurology, Oncology and Dermatology where treatments previously requiring inpatient stays are now provided on an outpatient basis.

9.2.2 This specialist and advanced workforce plays a key role in preventing acute exacerbations of conditions and reducing the need for hospital admissions through active management such as with assisting patients to choose healthy behaviours and reduce lifestyle risks. Examples include neutropaenic sepsis management, congestive heart failure, asthma, diabetes, angina and hypertension.

9.3

Opportunities / Issues	Actions
• To ensure the CNS role achieves a maximum of 75% of their time in clinical practice.	• A major productivity work based assessment has been undertaken. • Each CNS will be working with their Head of Nursing to review the outcome of the assessment. • All CNSs will be set individual productivity measures in this year's business planning.
• The CNS role has the opportunity to contribute effectively to the Fit for the Future programme.	• A focus on strengthening the CNS role in clinical coding is underway.
• A number of CNS roles are 'lone' practitioners leaving a temporary service gap should the CNS be away from work or leave the Trust.	• All directorates to have a resilience plan to manage any gaps in the service.

10.0 Consultant Nurse / Midwife

10.1 Workforce profile:

Directorate	Budgeted WTE	In post	Vacancy
Abdominal Medicine & Surgery	3.6	3.7	0
Community	0.8	0.8	0
GRIDA	2.7	2.9	0.1
Haematology & Oncology	3	4	0
Medical Specialties	1	1	0
PCCP	1	1	0
Women's services	1	2	0
Total	**13.1**	**15.4**	**0.1**

10.2 The Consultant Nurse / Midwife (CN/M) posts are one of the few nursing roles to be outlined and proscribed by the Department of Health. The expectation is that the post holder will be a clinical nursing leader, driving high quality service and standards as well as advancing clinical practice on both a local and a national scale.

10.2.1 The 4 integrated sub roles of the CN/M are:

- expert clinical practice (at least 50%)
- professional leadership and consultancy
- education, training and development
- practice and service development, research and evaluation

10.2.2 All CN/Ms have direct clinical roles, delivering individualised clinical care to patients on booked procedure or out-patients lists. They improve access and referral pathways for patients/ clients by designing and providing innovative services within their specialty. They enhance clinical care using advanced assessment, including diagnostics, prescribing medications, treatments and case load management for people living with chronic disease. This has made a considerable financial contribution to the Trust, as direct income, reducing length of stay and readmission, reducing waiting times and providing "one stop" services.

10.2.3 All CN/Ms are involved in education, many holding visiting lecturer positions at KCL or other HE institutions and/or leading specialist training and courses locally and beyond. Through research collaborations post holders are able to contribute to the R&D agenda; providing a link with HEIs and raising the profile of the Trust through publications and conference presentations.

10.3

Opportunities / Issues	Actions
• Potential opportunity for the CN/M role to make a greater contribution to medical productivity and support the changes occurring within the medical workforce. • A number of CN/M roles are 'lone' practitioners leaving a temporary service gap should the CN/M be away from work or leave the Trust.	• Review of CN/M job plans. • Review the need for further investment in these roles. • All directorates to have a resilience plan to manage any gaps in the service.

11.0 Specialist Teams

11.1 Workforce profile:

Name of Team	Budgeted WTE	In Post	Vacancy
Infection Control	23	23	0
Safeguarding Adults	8.6	8.6	0
Safeguarding Children (inc. community)	16.9	12.2	4.5
Site Nurse Practitioners	38.4	30.9	7.5
Tissue Viability Nurses	4	1	3
Discharge Team	10	6	0
Total	**100.9**	**81.7**	**15**

11.2 Within the Trust we have a number of specialist teams that contribute to improving patient outcomes, keeping patients safe and training the workforce.

11.3 These services are largely responsible for the overarching delivery of key Trust objectives and targets. They provide leadership and support to all staff and patients. Many of these services are key to the implementation of national requirements and statutory regulations.

11.4

Opportunities / Issues	Actions
• Ensuring we have sufficient resources within the TVN team to deliver the tissue viability CQUINS (pressure ulcers).	• Regular reviews of the CQUINS and robust plans in place to deliver the plan and recruit to the vacancies. • Having a robust site nurse practitioner plan to meet these changes.
• Ensuring we are able to adhere to the European Working Directive, supporting the reduction of junior doctors hours.	• To ensure that the SNPs are adequately trained and developed in the specialist skills to support the reduction in junior doctors. • The introduction of an advanced clinical nurse post who will work alongside the medical teams to deliver clinical care.
• An increase in the numbers of safeguarding adult/children cases has occurred over the last 12 months.	• Governance arrangements in place to mitigate this risk.

12.0 Imaging

12.1 Workforce profile:

	Budgeted WTE	In post	Vacancy (inc Mat Leave)
Trained	30	26	4
Untrained	19	18	1
Total	**49**	**44**	**5**

12.2 The role of imaging and, as a consequence, the role of the nurse within imaging has changed considerably in recent years. Many of our outpatients undergo considerable invasive procedures which, in the past, they would have been admitted for and therefore they need to have the appropriate level of care pre and post procedure. It is also important to note that at any point in time during the day there is at least a ward full of inpatients within the imaging department.

12.3

Opportunities / Issues	Actions
• The role of the nurse in imaging is changing – we need a comprehensive workforce plan that will enable us to respond to clinical/service changes.	• Workforce strategy to be written.

13.0 District Nursing

13.1 Workforce profile:

Locality	Budgeted WTE	In post	Vacancy
Bermondsey & Rotherhithe	23.8	21	2.7
Borough & Walworth	25.6	32.4	3.1
Dulwich	24.5	20.5	4
Lambeth North	27	25.2	1.7
Lambeth SE	39.5	33.4	6
Lambeth SW	43.5	42.1	1.4
Peckham & Camberwell	28.1	24.2	3.8
Total	**212**	**198.8**	**22.7**

13.2 The District Nursing Service aims to support people to remain as well as possible within their own homes and communities. Complex care is provided in community settings, including the care of some of our most vulnerable citizens and often in extremely challenging environments. District nurses support people to manage their long term conditions and are key professionals in planning, providing and managing this part of hospital care.

13.3 The service has 218 community staff nurses and specialist practitioners, organised as seven localities in different geographical locations in the community and undertake on average 26,000 visits every month. The service operates 8am-11pm, 7 days per week, 365 days per year.

13.4 The nurses work closely with GP practices and offer skilled nursing care to adults in their place of residence who are registered with a Lambeth or Southwark GP including residential care homes.

13.5

Opportunities / Issues	Actions
• Insufficient staff to meet service requirements.	• This is being reviewed as part of business planning and bids are being submitted to the commissioners. Support to district nursing services by seconding staff from other parts of the organisation. • In the short term cover has been increased.
• Strengthening standards and practice across all district nursing services.	• Increase the number of practice development nurses to support education and training.
• Being able to recruit skilled district nurses to support the increased work load with the move to care for patients within the home setting but also with higher acuity.	• The setting up of a district nursing task force to implement a robust workforce strategy for community nursing, locally as well as London wide.

14.0 Health Visitors

14.1 Workforce profile:
Includes new Health Visitor students

Locality	Budgeted WTE	In post	Vacancy
Bermondsey & Rotherhithe	10	10	0
Borough & Walworth	16.6	16.6	0
Dulwich	10.9	9.3	1.6
Lambeth North	14.7	14.7	0
Lambeth SE	25.7	23.7	2.0
Lambeth SW	21.3	8.4	12.9
Peckham & Camberwell	15	13	2.0
Total	**114.2**	**95.7**	**18.5**

14.2 Health visitors work with children aged 0 – 5 and families to enable them to get the best start in life and achieve their potential with additional support where this is required through evidence based interventions and in collaboration with other partners across social care.

14.3 The HV role includes the following:

- Assess the health needs of expectant mothers, children and families as well as the developmental progress of babies and children at the key stages as described in the Healthy Child Programme (2009).
- Undertake an additional assessment of the developmental progress of all children between the ages of 3 – 4 years subject to child protection and child in need plans, as well as those where there are safeguarding concerns but do not meet the threshold for social service intervention.
- Provide advice on a range of parenting and health factors such as breastfeeding, parenting, safety of the baby and child, infant feeding with particular emphasis on preventing childhood obesity from an early age.
- Provide additional advice and support for families with domestic violence, mental health and alcohol and substance misuse factors.
- Providing specific advice to parents on home safety so as to reduce the need to attend A&E.

14.4 The service is provided by generic health visitors, early intervention health visitors and supported by a combination of community staff nurses and nursery nurses.

14.5 Health visitors actively contribute to multidisciplinary work and assess the risk and protective factors, triggers of concern and signs of abuse and neglect in children. Health visitors are usually the only professionals providing support and advice to children and families who do not meet the threshold for social care, and this range of children is rising.

14.6

Opportunities / Issues	Actions
• Ensuring with the increasing number of student health visitors we have sufficient numbers of mentors to support. • Ensuring the clinical leadership support is available to support the qualified health visitors in the future.	• Review supervision model to ensure it meets the needs of an increasing number of students. • A review of clinical leadership support has been undertaken and an investment of 1.4 WTE has been added to the structure. • A senior professional lead will oversee the Health Visitor Strategy.

15.0 School Nursing

15.1 Workforce profile:

Locality	Budgeted WTE	In post	Vacancy
Bermondsey & Rotherhithe	4.6	4.6	0
Borough & Walworth	5.7	3.7	2
Dulwich	3.6	3.6	0
Lambeth North	4.8	4.8	0
Lambeth SE	5.9	3.9	2
Lambeth SW	6.8	6.8	0
Peckham & Camberwell	6.4	4.6	1.7
Joint immunisation team Lambeth Southwark (sit in B&W budget)	 3 1.8	 0 0	 0 0
Totals	**42.6**	**32**	**5.7**

15.2 School nurses, who are specialist public health practitioners, provide a range of services for school aged children and young people mainly in schools.

15.3 School nurses work in partnership with children, young people and their families to ensure that children's health needs are supported within their school and their community.

15.4 They provide services that are visible, accessible and confidential, which deliver universal public health and ensure that there is early help and extra support available to children and young people at the times when they need it. This includes services to help children and young people with illness or disability within the school and beyond.

15.5 The school undertakes the health assessment for children and young people where there are safeguarding concerns and contribute to multidisciplinary work to safeguard children and young people from harm.

15.6 One of the team leaders leads a team of nurses who provide the range of school age immunisations in all the schools across both boroughs.

15.7 School nurses make referrals to speech and language therapy, GPs, paediatricians and other specialists as required.

15.8

Opportunities / Issues	Actions
• The school nursing review highlighted that there are may be an insufficient number of school nurses within the Southwark team.	• A review of staffing has been undertaken. • This will be addressed through the Trust business planning and discussions with the commissioners.

16.0 Matrons

16.1 Workforce profile:

Directorate	Budgeted WTE	In post	Vacancy
Abdominal Medicine & Surgery	7	2.6	4.4
Acute Medicine	6	6	0
Cardiovascular	2	2	0
CLIMP	0.8	0.8	0
Community	12.9	8.9	0
Dental	4	4	0
GRIDA	7	7	0
Haematology & Oncology	7.4	7.4	0
Home Ward	4	0	0
Medical Specialties	3	3	0
PCCP	9.8	8	1.8
Surgery	2	2	0
Women's Services	8	6	2
Total	**73.9**	**57.7**	**8.2**

16.2 Matrons provide clinical leadership and support to Ward and Departmental Sisters/Charge Nurses to promote excellence in nursing and midwifery care to maintain and improve clinical standards.

16.3 Their role is extremely important in reducing and managing risk, identifying risks early and addressing the root causes. Within the nursing teams they are pivotal in ensuring that Trust values are upheld and that all patients are treated with compassion, dignity and respect. Their key responsibility is to ensure that the patient experience is of the highest quality and inspires patient and public confidence. This is achieved through high visibility, accessibility and surveillance. A minimum of 75% of their working activities are clinical. A number of Matrons, especially those in GRIDA combine their leadership role with running nurse-led services.

16.4

Opportunities / Issues	Actions
• All Matrons need to achieve spending 75% of their time in clinical practice.	• Directorates reviewing the role of the Matron as part of the Nursing Productivity workstreams which is a programme under Fit for the Future. Each Matrons role is under review dependent on clinical/service need.

17.0 Clinical Research Nurses

17.1 Workforce profile:

Directorate	Budgeted WTE	In post	Vacancy
Abdominal Medicine & Surgery	2	1	1
Cardiovascular	5	2	4
GRIDA	3	5.5	0
Haematology & Oncology	15.6	12.6	3
Medical Specialties	2	1	1
PCCP	5	2	3
R&D : NIHR	99.9	73.8	26.1
Women's Services	0	0.5	0
Total	**132.5**	**98.4**	**38.1**

17.2 The current Clinical Research Nurses at GSTT are funded externally by grants generated by research activity.

17.3 Clinical Research Nurses (CRNs) are thought to be the fastest growing group within the profession across the UK. This is reflected at GSTFT as the workforce has grown to approximately 130 posts spanning many therapeutic areas. This has been partly due to the recent growth of a solid research infrastructure across the UK which has supported the development of the CRN role and confirmed its importance. Much of this is funded by the National Institute of Health Research (NIHR) which was established by the Department of Health in 2006 to support world class research within the NHS. More recently the launch of the NIHR Research Nurse strategy 2013 aims to define both the impact of the CRN role on patient experience and career progression pathways. Work is ongoing to provide a cohesive national workforce through UK regional meetings in 2014 and Guy's and St Thomas' is hosting the inaugural London meeting in February.

17.4 The role of the CRN has greatly evolved supporting patients recruited into research studies either as part of their normal clinical pathway or to have access to novel treatments which are otherwise not available to them. Studies may also concentrate on the collection of data to provide greater information about a condition or population. The CRNs act as the patient advocate and ensures patient safety and adherence to research governance requirements at all times. They work alongside other members of the research and clinical teams to identify and screen patients who may be suitable to be treated within a research study. Additional responsibilities within the role include support with the informed consent process, investigational tests, medicines management, data collection and safety reporting.

17.5

Opportunities / Issues	Actions
• With the expansion of research activity there are opportunities to develop other roles to support the research agenda.	• A research workforce plan is in development and opportunities for secondments from general nursing are being created. • The introduction of band 3 assistant roles has been successful in certain research specialties.
• To lead nationally and internationally the nursing research contribution to the overall KHP research strategy.	• Work is underway to increase the profile of nursing research.

18.0 Practice Development Nurses (PDNs)

18.1 Workforce profile:

Directorate	Budgeted WTE	In post	Vacancy
Abdominal Medicine & Surgery	2.5	2.5	0
Acute Medicine	5	3.6	2.4
Cardiovascular	0.6	0.6	0
Chief Nurses Office	0	1	0
Community	1.6	1	0.6
Haematology & Oncology	0.1	0	0
PCCP	12	7.6	4.4
Surgery	1	1	0
Training & Education	3.4	3.5	0
Women's Services	3.8	3.6	0
Total	**30**	**24.4**	**7.4**

18.2 The number of PDNs has reduced over the years. They mainly work within inpatient areas. They provide training and development for all grades of nursing staff especially to our newly qualified staff who must have a six month period of preceptorship. They are a valuable resource which provides assurance that staff are competent as well as providing excellent nursing care.

18.3 Increasingly they have been actively involved in delivering simulation training as part of the multi-professional faculty within the SiM centre. This has been positively evaluated and it has been recognised by an investment of a non-medical lead to support the development of further programmes for non-medical staff.

18.4

Opportunities / Issues	Actions
• To develop further opportunities to generate income via the SiM centre non-medical training programmes.	• New non-medical lead now in post to take this forward.
• To scope further opportunities for PDNs to support Trust Wide educational / developmental work.	• Scoping PDN educational activity and mapping the Trust educational requirements to their activity.

19.0 Ambulatory and Outpatient Settings

19.1 Across our Trust we have a number of ambulatory and outpatient settings, many of which are nurse-led and prevent the need for patients to be admitted, for example, the Dermatology Day Centre and Chemotherapy Day Unit. It is this particular staff group that is difficult to un-pick as many of the staff who support these areas are already captured, for example, under the CNS heading. Further work is required to identify the core staffing within these areas.

19.2

Opportunities / Issues	Actions
• To ensure the robust recruitment of highly specialised Nurses to provide treatment/care in these specialities.	• A focus on talent spotting of staff interested in been developed into these post. • Increase opportunities for secondments and rotation into Ambulatory areas so increase the potential interest of staff to work in the fields of nursing. • Ensure we work closely with HR to have a workforce plan that addresses recruitment to these areas.
• To ensure we can provide education and training that is relevant to the service need of each of these departments.	• Head of Nursing to work with the Educational department and the HEI to develop educational programme that meet our needs. Several programmes are already in place.
• To have the right skill mix to ensure patient safety.	• Ensure we are following and national benchmarking related to staffing in outpatient areas. • Work has commenced on developing an outpatient acuity monitoring Tool.
• Have the ability to cross cover services with specialities in the event of planned and unplanned leave or increased demand.	• As part of reviewing nurses job plans, ensure that this is taken into consideration and training is given so staff can be flexed appropriately.
• To review the role of the nurse in the outpatient setting to ensure they take on a role which ensures 'every contact counts' to focus on public health, for example, smoking, alcohol and obesity.	• A project will commence as part of our 6Cs campaign.

20.0 Recommendation

The Board of Directors is asked to note the information contained in this report and the actions we have in place.

Eileen Sills CBE
Chief Nurse & Director of Patient Experience **16th January 2014**

Guy's and St Thomas' NHS
NHS Foundation Trust

Board of Directors

Date of Meeting 24th April 2013

Attachment

Report on safe staffing levels for our adult inpatient acute wards, including Midwifery and Evelina Children's Hospital

Status:	A paper for Report and Decision
History:	**Nursing workforce paper June 2012**

Eileen Sills CBE
Chief Nurse & Director of Patient Experience

Guy's and St Thomas' NHS
NHS Foundation Trust

Board of Directors

Date of meeting 24th April 2013

A paper prepared and presented by Eileen Sills, Chief Nurse & Director of Patient Experience

Report to the Board of Directors on the safe staffing levels for our adult inpatient wards, including midwifery and Evelina Children's Hospital

1.0 Introduction

There is now a requirement post the publication of the Francis Report, 2013 and the new nursing vision: Compassion in practice that all NHS organisations will take a 6 monthly report to their Board on the nurse and midwifery staffing levels and whether they are adequate to meet the acuity and dependency of their patient population.

This is not the first time that the Board of Directors have received a report from the Chief Nurse, the last one being in the summer of 2012 following a full review of ward staffing levels by Price Waterhouse Coopers, which led to an increase in 30 wte for our acute medicine and elderly care wards, a mix of qualified and unqualified staff.

For the purpose of this report it will focus on ward based staffing levels in the acute directorates, midwifery and Evelina Children's hospital, two further reports will be presented in the summer of this year which will cover the community workforce and the nurses and midwives who are non ward based. The reason for this is that further work in these two areas is underway.

2.0 Background

2.1 There is a greater focus now on ensuring that Trusts have the right size and shape of its nursing & midwifery workforce to meet the needs and expectations of its patients. Evidence which wasn't always available can now directly attribute failings in care and increased mortality rates to poorly staffed wards. Evidence also suggests that poorly staffed wards increase staff sickness, burnout and reduce staff well being all which have a direct consequence on outcomes of care, including experience. It isn't however just about the numbers of staff. Other factors which underpin safe dignified care include strong, empowered leadership at ward level, resources directed at supporting the ward leaders and the development and use of clinical and patient experience metrics.

2.2 The Trust has always taken its staffing levels of its wards very seriously, not just in terms of the need to grow the workforce in key areas but to also readjust its skill mix as it recognises that in recent years many areas have had near 100% qualified workforce. Over the past 8 years we have learnt a considerable amount about how to plan and ensure we have the right size and shape of the workforce, using a range of approaches which support the professional judgement of our staff. This has enabled us to safely adjust our skull mix and introduce a greater number of trained Nursing and senior Nursing Assistants. This is essential as we balance the need for safe care, delivered by competent practitioners against the current economic climate.

3.0 Our approach to assuring safe staffing levels on our adult wards

3.1 As far back as 2001 the Audit Commission recommended that establishment setting regardless of the method must be simple, transparent, integrated, benchmarked and linked to ward outcomes. There is no one recommended method but the utilisation of a range of approaches from using an acuity based tool which measures patient dependency, to a crude staffing ratio per bed model, supported by the professional judgement of the ward leader and their seniors. In addition the establishments must have built within them uplifts which enable the compliment of staff to absorb annual leave, short term sickness and study leave without the need to use temporary staff.

3.2 Within GSTT we use a number of methods to set ward establishments. Firstly we use the 'The Safe Nursing Care Acuity Tool', this measures the individual dependency of patients and uses generic multipliers to calculate the staffing required. Each ward is expected to record the acuity of the patient daily both on the patient status at a glance board and also on the electronic system. The electronic system enables us to have an overview of any ward whose acuity exceeds 10% of the staffing establishment. Notification triggers are sent to the senior nursing teams and a review of the dependency and available staffing takes place. An example of the data recorded is set out in appendix one which shows the acuity recording for a medical and a surgical ward for the month of February 2013.

3.3 We don't just use the acuity tool in isolation as experience tells us that acuity is often higher then the staffing levels, but adjustments don't need to take place as both the seniority and experience of staff on duty enables them to manage safely. Therefore when reviewing establishments it is important to take into account the skill mix, and strength in ward leadership. A ward leader must have an adequate number of deputies who can ensure safe, effective care throughout the 24 hour period.

3.4 Determining the skill mix between qualified and unqualified staff is not an exact science and requires a very good understanding of the patient population and nursing requirements to determine how many qualified staff versus unqualified staff can be safely deployed per shift. The RCN recommend as a minimum 65:35 split, but this is becoming increasingly difficult to achieve with many Trusts aiming for a 70:30 split if not higher. This is due to the increasing complexity of care, for example medication regimes and the number of intravenous drugs now given. Within GSTT many of our wards have reduced their skill mix from 100% qualified to 80:20 split if not in some cases lower. The decision to do this is taken with the ward team and signed off by the Chief Nurse. The one area that has seen a growth in its skill mix in recent years is acute medicine and elderly care, due to a sustained increase in the acuity and complexity of the patients admitted.

3.5 Last year Price Waterhouse Coopers supported us in developing a ward calculator, which enabled each ward to set its staffing levels per shift and to calculate for each ward the individual uplifts required to ensure the budget was set accurately. This exercise has been repeated as part of this years business planning. This is then tested against the numbers of patients a nurse would be allocated per shift and the available nursing hours per bed day.

3.5.1 There is currently no national recommendation on the number of patients per nurse. However in a recent European wide study 'RN4Cast' Professor Peter Griffiths is reported as saying that a 1:8 ratio would be unsafe and should be reported as a patient safety incident. Therefore in reviewing our establishments and the current acuity we would not want to go above 1:5 on average throughout the 24 hour period. This detailed review has highlighted that at present It is difficult to provide an accurate picture of the nurse to patient ratio's as this is also influenced as to how the ward sister organises her ward, and how patients are allocated. Therefore in the summer a further piece of work will be undertaken to understand the methods in place around patient allocation.

3.6 Following completion of the individual ward reviews this has been followed up by individual discussions with the Ward Sister/Charge Nurse, Head of Nursing and Chief Nurse to review the proposed establishments for the coming year and their current clinical indicators and patient experience performance. This has culminated in a final sign off, of the current ward establishments. With recognition that following the sign off of business plans or should the acuity or bed base change then these will be reviewed and as necessary readjusted. Appendix 2 sets out ward by ward the current establishments for 2013.

3.7 For the first time this year the directorate management teams were also asked to provide an assurance statement to the Chief Nurse that they felt their staffing levels were safe. All directorates have returned these statements and set out below is their assurance position.

- **Abdominal Medicine & Surgery** – within their funded bed base they have made a positive assurance return. However they have raised concern when their closed beds are opened regularly. They are attempting to address this as part of business planning. In addition within renal services they know that they can make progress to reducing their skill mix in some areas and workforce plans are being developed to address this.
- **Acute Medicine** – within their funded bed base they have made a positive assurance statement, however it is recognised that out of hours they do not have control over closed beds being opened and the placement of patients. In these cases the directorate may need to adjust staffing levels accordingly.
- **Cardiovascular** – cardiac: they have requested an increase in the ward establishments to manage the increasing acuity of their patients and support their ward sisters being supervisory. If this is supported then they will be able to provide a positive assurance statement, with the same caveat as both directorates above in terms of additional beds being opened. A further review of these establishments is to be undertaken. A positive position has been returned for the vascular wards
- **Oncology, Haematology & Thoracic** – have provided a positive assurance statement with the caveat about out of hours opening of beds and placement of patients.
- **Surgery** – they had provided a positive assurance statement.

- **Gynaecology** – a positive assurance statement has been received if the bed base remains within the funded establishment. As with the other directorates should their 4 closed beds be opened then the directorate cannot assume safe staffing levels unless adjustments have been made.

3.8 Although the establishments are set based on average acuity and occupancy there are times when additional staffing levels are required to 'special' patients and provide 1:1 observation. For example this would be to prevent a high risk patient from falling, patients sectioned under the mental health act, patients at risk of wandering or the acutely unwell patient who is unable to step up into an HDU bed. The use of specials is both a financial and quality burden on the ward as often they have to rely on the use of bank or agency staff, as these are often unpredictable short notice bookings. Although inpatient services employ a pool of staff this is inadequate to meet the needs of the organisation. Last year we spent £1.3 m on RMN and HCA specials and a case is currently being considered to employ our own pool of trained Senior Nursing Assistants to reduce the need for qualified RMN agency staff. This would reduce the cost pressure by 50% and improve the continuity and consistency of care.

3.9 Ward Supervision – In addition to ensuring that we have the right number of staff on duty it is also essential to ensure the ward leader is able to manage and supervise. The role is impossible if he or she is included in the patient allocation per shift. The Francis report recommendations make it clear that this is essential if you want to ensure the delivery of safe high-quality care. The supervisory role is about having the time to lead, support the staff and act as a role model and be visible to patients and staff. It is not a role which is to be based in the office. We have invested in the majority of our ward establishments, the requirement for our ward leaders to be in a supervisory role. With the clear expectation that they are clinically very visible. In the past 12 months we have put all of our ward leaders through a development programme to support this change. The cardiovascular directorate is waiting for the outcome of business planning to ensure the remaining 3 sisters on their cardiac wards are supervisory. This will then mean that 100% of our ward sisters are funded in a supervisory position. It is important to note that although this investment has been made we cannot always guarantee a ward sister can operate in a supervisory way if there are gaps on the rota due to unplanned absences.

3.10 Supporting our unqualified workforce – as we grow our unqualified workforce it is absolutely essential that they are fully supported, supervised, trained and feels part of the nursing team. We have put a framework in place which enables us to grow the number of unqualified staff who will now be known as Nursing and Senior Nursing Assistants to reflect their contribution to the whole nursing team. We have a new set of updated competencies, access to Diploma level 2 & 3 training and all directorates as part of their assurance statement have confirmed that their Nursing Assistants have been inducted are working towards completing their updated competencies and have had or have a date for their appraisal. We will also by May of this year have a central register of the training completed by this part of our workforce.

4.0 Our approach to ensuring safe staffing levels within Evelina

4.1 The workforce requirements for the Evelina Children's Hospital (ECH) are calculated using 2 tools. The RCN guidance "Defining Staffing Levels for Children's & Young People's Services"(RCN; 2003); which defines staffing levels for Neonatal and Paediatric Intensive Care services as well as specialist children's wards. This document is used by all the Specialist Children's Hospitals and is currently being reviewed. The updated guidance will be published in spring 2013. We also use

PANDA (Paediatric Acuity & Nursing Dependency Assessment tool) to score patient's acuity twice a day.

4.2. Within ECH the majority of our patients are managed using 1 nurse:3 patient's ratio or a 1 Nurse:2 patient's ratio if they require high dependency care. Within our Paediatric Intensive Care unit our ratio is 1:1. All of which are in line with RCN national guidance as discussed above. Within our Neonatal Unit, on neonatal intensive care (NIC), we do not meet the BAPM (British Association of Perinatal Medicine) standard of 1 nurse:1 baby for all our NICU cots. However, for the most recent service developments we have staffed our cots to meet these standards as we now see an increased number of very complex babies requiring 1:1 care. We would propose that future cot changes in this area be staffed at 1:1 ratio given the change in complexity of cases (i.e. Cardiac and complex surgical babies). This change in staffing levels to meet BAPM requirements is in line with practice in other large units nationally.

4.3 PANDA is an electronic tool based on the Department of Health criteria for paediatric high dependency and ward intensive care. The tool is used to score patients twice a day and to then calculate ward staffing levels based on RCN guidance as detailed above. We implemented the system in June 2012, however we identified that the system was categorising data inaccurately at the end of last year. It was over scoring HDU level therefore we have not been able to use the system to its full advantage. We have been working with Genysis and Great Ormond Street Hospital teams, who designed the tool to resolve this issue. We are currently re-testing the system and plan to go live later in April 2013.

4.4 Over the past two years we have reviewed our nursing establishment and skill mix to ensure that it is safe and in line with other specialist children's hospitals across the UK. Previously we had a 90-100%qualified; 10% unqualified workforce ratio. Review of other specialist Children's hospitals indicated that they had an average of 83:17 ratio. In 2010 we developed a workforce plan to make this change to our workforce over three years. This has enabled us to successfully introduce the Paediatric Senior Nursing Assistant role, and ensure that the new workforce is competent before we make changes to the qualified workforce. During this transition the budget has experienced a cost pressure which will now begin to reduce. The new role and course has been well evaluated and the second cohort will be starting in the spring 2013.

4.5 Within ECH, we have a team of Paediatric Nurse Practitioners who provide the senior nursing cover, bed management and specialist paediatric advice within the Trust predominantly out of hours. They lead the Paediatric Hospital at Night Team working very closely with Accident & Emergency to provide the specialist support required. This team is crucial to the operational functioning of ECH and the safety of patients throughout the 24hr period. Since the beginning of March 2013 we now have 2 PNPs on most shifts and we need to complete our recruitment to ensure that we have 2 on every shift. This enables them to review patients on discharge from PICU, as well as overseeing (with the medical teams) the complex medical and surgical patients in addition to the role as detailed above.

4.6 Over the last 2 months, one of the key challenges within ECH has been the number of vacancies and short term sickness. We currently have 56 vacancies, 37 of which are at Band 5 level. We have planned a series of recruitment campaigns over the spring and summer and are planning to look to recruit in Ireland to fill our more senior

posts within specialist areas.

4.7 The number of staff on Maternity leave is a constant challenge for the teams, across ECH, this equates to 5-7% of the workforce, but in some areas, it is as high as 10%, overall which equates to 30 posts across the children's hospital.

4.8 Given all the issues detailed above and assuming no further service developments or growth in activity the Directorate Management team has issued an assurance statement that staffing levels are safe.

5.0 Our approach to ensuring safe midwifery levels

5.1 The workforce requirements for the maternity unit have been calculated using a mix of 2 models, Birth-rate plus, supported by the more traditional method of calculating staff numbers based on ward activity and numbers.

5.2 Birth-rate plus is based upon the principle of providing one to one care during labour and delivery to all women, with additional hours being identified for the more complex deliveries. Where in adult services we undertake acuity recording daily, Birth-rate plus require the unit to record data for a period of 4 months, covering all aspects of midwifery care. In addition it also adds an additional 10% to the workforce requirements, which cover senior and expert midwifery roles. The outcome of the Birth-rate plus exercise at GSTT has identified that the ratio of midwives to women should be 1:27.5. It is currently 1:30 but at times of peak activity this ratio grows. It is recognised that 1:27.5 may be the absolute optimal number, that this is currently unaffordable. In addition NHS London had originally set a staffing ratio target of 1:28 for all midwifery units; this has now been revised to 1:30. Applying the 1:30 ratio consistently so that we can manage the peeks in activity will require us to grow by a 6.5 wte, however to fill the gap 3 'float' posts have been put in place.

5.3 There are further challenges within midwifery and that relates to the number of safe guarding cases, which often require additional specials and on average this equates to 4.94 wte Nursing Assistants, which is currently unfunded within the budget. It is hoped that this will be supported by the development of the Trust wide pool of staff trained to special patients with challenging behaviour.

5.4 A further challenge to this service is the average number of staff on maternity leave. On the Hospital Birth Centre this averages out at 11%, which is equivalent to 6.27 wte posts. These posts have to be backfilled and therefore there is always a significant cost pressure on the budget (refer to section 6.4)

5.5 Over the past 2 years the unit has successfully introduced the Maternity Support Worker; the post holders undertake a comprehensive training programme and are fully supported and supervised by their Midwives.

5.6 Given all of the issues above and with the ability to flex staffing levels as required the directorate management team have issued an assurance statement that staffing levels are safe.

6.0 Managing our staffing resource as effectively as possible

6.1 Effective recruitment – at present we have approximately 599 wte vacancies (from ESR) the majority at band 5. It is currently taking 16 weeks to recruit a nurse and the lack of a coordinated approach is hampering our ability to reduce the reliance on temporary staff and stabilise our workforce. There are a number of hotspots around vacancies in the Trust, Evelina and Critical Care having the biggest gaps. Evelina has a 31% shortfall across its 3 wards and Critical care has a 14.2% vacancy rate, although those in the recruitment pipeline reduce this to 5%, should all those offered jobs take up their posts.

6.1.1 To address this demand we have seconded a Matron into the Chief Nurses office to lead a Trust wide recruitment drive. She took up post on the 2nd April and her target is to appoint to all existing band 5 vacancies and to have a rolling recruitment programme to avoid the current shortfall being experienced again.

6.1.2 However this is reliant on the supply of appropriately trained nurses, and with the reduction in student nurse commissions within London there is real concern that within 12 months there will be a severe shortfall. This as the Board knows has been repeatedly raised at both London and a national level. At present we understand there are no plans to increase the number of commissions.

6.1.3 The Board through the workforce committee will be kept updated on our progress with recruitment.

6.2 Implementation of E-Roster – As a Trust we have invested in the implementation of an electronic roster system which will enable the effective allocation of staff to the shifts that are required to be filled. This will be fully rolled out across all inpatient areas by September. It is anticipated by improved rostering that the use of temporary staff will reduce, however it is difficult to identify by exactly how much. Those directorates that have already implemented the system have seen the benefits, one of which is a reduction in the amount of time it takes to complete the roster.

6.3 Reducing the use of temporary staff – our current use of temporary staff is too high, with on average £2.7m spend per month (£1.2m bank and £1.5m agency). This is due to the need to cover vacancies, maternity leave, sickness, increased acuity, additional Saturday working and additional beds being opened. We need to implement a range of strategies for this expenditure to reduce this year, including on going effective recruitment activities, establishment of a talent pool, appointing to a pool of staff to reduce the need for booking specials and reducing length of stay to reduce the need to open additional beds.

6.4 Managing maternity leave – The PWC review highlighted that on average we have 4% of our nursing & midwifery workforce on maternity leave at anyone time, this is currently unfunded within the ward budgets, therefore any member of staff going on maternity leave will lead to an immediate cost pressure at ward level. A solution needs to be found, as it is difficult to incentivise our ward leaders to mange their resources smartly when they are immediately starting with a financial deficit. The current overspend on the nursing budget this year equates to the financial gap generated by maternity leave.

7.0 Conclusion

We have undertaken a comprehensive ward by ward review of staffing levels to ensure they are staffed safely. This has also increased the understanding at ward level and all Ward Sisters and Charge Nurses have an understanding of their funded workforce resource, but that if required this will be adjusted to reflect the acuity and dependency of patients admitted. This will be reviewed every 6 months. This paper can assure the Board of Directors that it has safe staffing levels, however there is no element of complacency and there is a need to stabilise the workforce with an effective recruitment campaign and to ensure if the bed numbers increase that staffing is adjusted accordingly.

8.0 Recommendation

8.1 The Board of Directors is asked to:

- **Review and be satisfied that the appropriate level of detail and assessment has been undertaken to assure itself that the inpatient wards, midwifery and Evelina are safely staffed**
- **To formally sign off the current staffing levels and to note that two further reports will be presented on the community workforce and non-ward based nurses.**
- **To note and support the further ward by ward review of how patient allocation takes place to maximise the effectiveness of the team on duty and ensure that patients are cared for safely and compassionately**
- **To note the challenges around recruitment**
- **To note the financial pressures experienced at ward level due to maternity leave**

Eileen Sills CBE
Chief Nurse & Director of Patient Experience

24th April 2012

Appendix 1

Executive Dashboard: Acuity and Dependency

Ward:	Northumberland
Recommended Establishment:	37.41
Funded Establishment:	25
Occupancy:	96.5

		Acuity Scores						Patient Flow							Staffing															
		Level						Adm.	Disch.	Trans In	Trans Out	Ward att	Deaths	Escorts	Registered				Reg. Bank / Agency				Non-reg.				Non-reg. Bank / Agency			
Date	Beds	0	1a	1b	2	3	Daily Calculated								E	L	LD	N	E	L	LD	N	E	L	LD	N	E	L	LD	N
02/02/2013	27	10	9	7	0	0	36.22	0	1	0	0	0	0	0	0	0	7	5	0	0	1	2	0	0	2	1	0	0	2	1
04/02/2013	27	6	10	8	0	0	36.62	1	2	0	0	0	0	0	0	0	6	5	0	0	0	1	0	0	2	1	0	0	1	1
05/02/2013	27	9	11	9	0	0	42.55	4	5	0	0	0	0	1	0	0	3	3	0	0	3	0	0	0	1	0	0	0	2	2
06/02/2013	27	7	11	8	0	0	39.11	0	2	0	0	0	0	0	0	0	6	5	0	0	1	0	0	0	2	1	0	0	1	1
07/02/2013	27	6	8	5	0	0	27.64	3	5	0	1	1	0	0	0	0	7	5	0	0	1	1	0	0	2	2	0	0	1	1
09/02/2013	27	8	9	8	0	0	36.5	3	2	2	0	1	0	0	0	0	7	5	0	0	1	1	0	0	2	2	0	0	0	1
11/02/2013	27	9	9	8	0	0	37.29	2	1	0	0	1	0	0	0	0	7	5	0	0	0	0	0	0	3	1	0	0	2	1
13/02/2013	27	6	9	12	0	0	42.36	4	3	0	1	0	0	2	1	1	5	3	0	0	1	2	0	0	1	0	0	0	2	1
14/02/2013	27	10	8	8	0	0	36.38	3	1	1	1	0	1	0	1	1	6	5	0	0	2	1	0	0	2	1	0	0	0	1
15/02/2013	27	12	6	9	0	0	36.42	3	2	0	0	0	0	0	1	0	5	3	0	0	1	2	0	0	2	0	0	0	0	1
16/02/2013	27	10	9	8	0	0	38.08	2	1	2	1	0	0	0	0	0	7	5	0	0	1	2	0	0	1	1	0	0	0	0
18/02/2013	27	12	9	9	0	0	41.52	2	3	1	1	0	0	0	1	0	7	5	0	0	1	0	0	0	2	1	0	0	1	1
23/02/2013	27	13	1	12	0	0	34.29	0	0	0	0	0	0	0	0	0	7	5	0	0	0	0	0	0	2	1	0	0	0	0
24/02/2013	27	12	9	6	0	0	35.94	4	0	0	0	0	0	0	0	0	7	5	0	0	0	0	0	0	2	1	0	0	0	0
25/02/2013	27	11	9	6	0	0	35.15	0	3	0	1	0	0	0	0	0	7	5	0	0	1	1	0	0	2	1	0	0	2	1
26/02/2013	27	10	6	10	0	0	36.7	2	3	0	1	0	0	0	1	1	6	5	0	0	0	0	0	0	0	0	0	0	2	1
27/02/2013	27	7	7	11	0	0	37.89	2	2	0	0	0	0	0	0	0	6	4	0	0	1	1	0	0	0	1	0	0	1	0
28/02/2013	27	5	13	9	0	0	42.79	1	3	0	0	0	0	0	0	0	5	1	0	0	1	4	0	0	1	0	0	0	1	1
18	486	**163**	**153**	**153**	**0**	**0**		**36**	**39**	**6**	**7**	**3**	**1**	**3**	**5**	**3**	**111**	**79**	**0**	**0**	**16**	**18**	**0**	**0**	**29**	**15**	**0**	**0**	**18**	**15**
Multiplier		**0.79**	**1.7**	**1.86**	**2.44**	**6.51**																							
		128.77	**260.1**	**284.58**	**0**	**0**																							

Executive Dashboard: Acuity and Dependency

Ward: William Gull (STH)
Recommended Establishment: 46.53
Funded Establishment: 37.6
Occupancy: 95.6

		Acuity Scores						Patient Flow							Staffing																
		Level						Adm.	Disch.	Trans In	Trans Out	Ward att	Deaths	Escorts	Registered				Reg. Bank / Agency				Non-reg.				Non-reg. Bank / Agency				
Date	Beds	0	1a	1b	2	3	Daily Calculated								E	L	LD	N	E	L	LD	N	E	L	LD	N	E	L	LD	N
01/02/2013	28	4	8	15	1	0	47.1	0	4	4	0	0	1	0	0	0	6	3	0	0	0	0	1	0	1	0	0	0	1	1
02/02/2013	28	5	8	14	0	0	43.59	0	1	1	0	0	0	0	0	0	5	2	0	0	0	1	0	0	1	0	0	0	1	0
03/02/2013	28	6	8	15	0	0	46.24	0	0	0	0	0	0	0	0	0	5	3	0	0	0	0	0	0	1	1	0	0	1	1
04/02/2013	28	4	5	18	0	0	45.14	0	5	6	0	0	0	0	0	0	4	0	0	0	1	0	0	0	2	0	0	0	0	0
05/02/2013	28	5	7	15	0	0	43.75	0	3	2	0	0	0	0	0	0	5	3	0	0	1	1	1	0	2	1	0	0	1	0
06/02/2013	28	0	5	16	0	3	57.79	0	2	4	0	0	1	0	0	0	5	0	0	0	0	0	0	0	1	0	0	0	1	0
07/02/2013	28	4	8	16	0	0	46.52	0	1	1	0	0	0	0	1	0	5	3	0	0	0	0	1	0	2	1	0	0	0	1
08/02/2013	28	6	8	14	0	0	44.38	0	2	2	0	0	0	0	1	0	5	3	0	0	0	0	1	0	2	2	0	0	0	0
09/02/2013	28	7	7	15	0	0	45.33	0	1	1	0	0	0	0	0	0	5	3	0	0	0	0	0	0	1	1	0	0	1	1
10/02/2013	28	6	6	15	0	0	42.84	0	0	0	0	0	0	0	0	0	5	3	0	0	0	0	0	0	1	0	0	0	1	0
11/02/2013	28	6	5	16	1	0	45.44	0	4	5	0	0	1	0	0	0	5	0	0	0	1	0	0	0	3	0	0	0	0	0
12/02/2013	28	3	6	16	1	0	44.77	0	3	2	0	0	0	0	0	0	5	0	0	0	0	0	0	0	3	0	0	0	0	0
13/02/2013	28	5	7	16	0	0	45.61	0	2	2	0	0	0	0	0	0	5	3	0	0	1	0	1	0	1	1	0	0	1	1
14/02/2013	28	6	6	15	1	0	45.28	0	3	4	0	0	0	0	0	0	4	0	0	0	2	0	0	0	1	0	0	0	2	0
15/02/2013	28	4	8	14	0	0	42.8	0	3	4	0	0	0	0	0	0	3	0	0	0	3	0	0	0	0	0	0	0	3	0
16/02/2013	28	5	6	17	0	0	45.77	0	0	0	0	0	0	0	0	0	4	2	0	0	1	1	0	0	1	1	0	0	1	1
17/02/2013	28	5	7	14	0	0	41.89	0	1	0	0	0	0	0	0	0	5	3	0	0	0	0	0	0	2	2	0	0	0	0
18/02/2013	28	3	6	17	1	0	46.63	0	3	5	0	0	0	0	0	0	5	0	0	0	1	0	0	0	0	0	0	0	3	0
19/02/2013	28	5	6	16	1	0	46.35	0	2	2	0	0	0	0	0	0	5	0	0	0	1	0	0	0	1	0	0	0	2	0
20/02/2013	28	5	6	16	1	0	46.35	0	0	0	0	0	0	0	0	0	6	0	0	0	0	0	0	0	1	0	0	0	1	0
21/02/2013	28	2	3	19	0	0	42.02	0	0	2	1	0	1	0	0	0	5	0	0	0	1	0	0	0	1	0	0	0	1	0
22/02/2013	28	0	5	20	0	3	65.23	0	0	0	1	0	1	0	0	0	4	0	0	0	2	0	0	0	2	0	0	0	1	0
25/02/2013	28	0	2	23	0	3	65.71	0	3	4	0	0	0	0	0	0	4	0	0	0	1	0	0	0	2	0	0	0	0	0
26/02/2013	28	2	2	17	0	0	36.6	0	4	6	1	0	0	0	0	0	3	0	0	0	3	0	0	0	2	0	0	0	1	0
27/02/2013	28	1	3	21	0	0	44.95	0	4	4	1	0	0	0	0	0	5	0	0	0	0	0	0	0	2	0	0	0	2	0
28/02/2013	28	0	10	12	1	0	41.76	0	4	5	0	0	1	0	0	0	5	0	0	0	0	0	0	0	2	0	0	0	2	0
26	728	**99**	**158**	**422**	**8**	**9**		**0**	**55**	**66**	**4**	**0**	**6**	**0**	**2**	**0**	**123**	**31**	**0**	**0**	**19**	**3**	**5**	**0**	**38**	**10**	**0**	**0**	**27**	**6**
Multiplier		**0.79**	**1.7**	**1.86**	**2.44**	**6.51**																								
		78.21	**268.6**	**784.92**	**19.52**	**58.59**																								

Directorate	Ward	No of beds	WTE Establishment Qual	WTE Establishment Unqual	WTE Establishment Total	Skill mix ratio	Supervisory Time for Ward Sister WTE	Average acuity Feb 2013	WTE/bed	Weekday numbers on shift Qual	Weekday numbers on shift Unqual	Weekday numbers on shift Total	Weeknight numbers on shift Qual	Weeknight numbers on shift Unqual	Weeknight numbers on shift Total	Proposed business planning adjustments
Acute Admissions	Sarah Swift Ward	33	32.5	17	49.5	66%	1	53.58	1.22	6	4	10	5	2	7	
	Victoria Ward	25	28.8	12.8	41.6	69%	1	40.47	1.41	6	3	9	4	1	5	
	CDU/EMU/SAU	22	30.8	0	30.8	100%	1	17.54	1.29	7	0	7	7	0	7	This area subject to further review associated with emergency unit changes
Acute Medicine	Albert ward	28	24.1	14.4	38.5	63%	1	40.46	1.11	5	3	8	3	2	5	
	Hillyers ward	18	22.2	8.73	30.93	72%	1	31.04	1.38	4	2	6	3	1	4	Additional 8 unfunded beds opened for bed pressures
	Mark Ward	28	27.1	13.9	41	66%	1	43.14	1.19	6	3	9	4	2	6	
	William Gull Ward	28	25.1	13.5	38.6	65%	1	46.53	1.12	6	3	9	3	2	5	
Elderly Care	Alexandra ward	28	24.5	13.1	37.6	65%	1	45.92	1.09	6	3	9	3	2	5	
	Anne Ward	28	24.5	13.1	37.6	65%	1	48.87	1.09	6	3	9	3	2	5	
	Henry Ward	28	24.5	13.1	37.6	65%	1	48.32	1.09	6	3	9	3	2	5	
GI Unit	Endoscopy	N/A	23	3	26	88%	1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	
	GI Unit	51	58.02	14.79	72.81	80%	2	70.73	1.19	13	4	17	9	2	11	
	Nightingale Ward (5.5 Days)	24	14.66	1.86	16.52	89%	1	18.70	0.99	5	1	6	3	1	4	Increase of 3.8 x B5 posts & 1 x B3 & 1 B2, changing skill mix to 80:20
	Page HDU	4	13.99	0	13.99	100%	0.5		3.35	3	0	3	3	0	3	Increase of 2 x B5 posts
	Northumberland *		See GI Unit						N/A	N/A	N/A	N/A	N/A	N/A	N/A	
	Page *								0.00	N/A	N/A	N/A	N/A	N/A	N/A	
Haemodialysis	Acutes (6 days)	80	6	0	6	100%	0	N/A	0.13	N/A	N/A	N/A	N/A	N/A	N/A	
	Astley Cooper (6 days)	27	26	3	29	90%	1	N/A	0.75	8	2	10	0	0	0	
	Borough (6 days)	80	31	7	38	82%	2	N/A	0.4	N/A	N/A	N/A	N/A	N/A	N/A	
	Camberwell (6 days)	19	15	4	19	79%	1	N/A	0.79	N/A	N/A	N/A	N/A	N/A	N/A	
	Home Dialysis	N/A	6.3	1	7.3	86%	1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	
	New Cross (6 days)	16	13	3	16	81%	1	N/A	0.8	N/A	N/A	N/A	N/A	N/A	N/A	
	Tunbridge KTC (6 days)	24	21	6	27	78%	1	N/A	0.98	N/A	N/A	N/A	N/A	N/A	N/A	
Renal, Transplant & Urology	Aston Key	26	23.54	3	26.54	89%	1	22.86	0.95	5	2	7	4	0	4	Increase of 1 x B5 & 3x B2 posts, changing skill mix to 77:23
	Florence	26	23	3	26	88%	1	29.08	0.92	5	2	7	4	0	4	Not uncommon for more than 26 patients to be on the ward due to the increase in elective activity. Increase of 1 x B5 post & 3 x B2 changing skill mix to 77:23
	Patience Ward (excl day unit)	17	23.22	1	24.22	96%	1	20.12	1.2	5	0	5	4	0	4	Increase of 6 x B2 and decrease of 2 x B5 posts
	Patience Day Unit	5	1	0	1	100%	0	N/A	0.31	1	0	1	4	0	4	Increase of 1 x B2, 1x B5 & 1 x B6
	Patience Total (Ward & Day Unit)	22	24.22	1.0	25.22	96%	1	N/A	N/A	5	3	8	4	2	6	
	Richard Bright	22	28.07	1	29.07	97%	1	32.75	1.22	6	1	6	5	0	5	A planned reduction in B5 posts has been suspended due to the significant increase in transplant activity. Request for increase of 4x B2 - discussion to take place with Directorate management team. Often flex up to 25 beds
Cardiovascular	Becket ward	30	22.88	5	27.88	82%	0	26.10	0.83	6	2	8	3	1	4	
	Cardiac Care Unit	6	17	1	18	94%	0	N/A	2.31	3	0	3	3	0	3	
	Cardiac OPD	N/A	5	2	7	71%	0.5	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	
	Doulton ward	23	19	4	23	83%	0	22.25	0.83	4	1	5	3	0	3	
	Doulton HDU	10	27	2	29	93%	1	N/A	2.46	5	0	5	5	0	5	
	Evan Jones	16	14	8	22	64%	1	25.38	1.02	3	2	5	2	1	3	
	Luke Non Vbay	24							0.86	N/A	N/A	N/A	N/A	N/A	N/A	
	Luke Vbay	4							2.1	N/A	N/A	N/A	N/A	N/A	N/A	
	Luke Ward Total	**28**	**29.84**	**5**	**34.84**	**86%**	1	**40.57**	**1.09**	**6**	**2**	**8**	5	0	5	
	Stephen ward	33	23.3	5	28.3	82%	0	24.30	0.82	5	2	7	4	0	4	
Haem Onc	Dorcas	28	28.24	2.6	30.84	92%	1	29.46	0.88	6	1	7	4	1	5	
	Samaritan	25	29.77	6.53	36.3	82%	1	41.42	1.12	6	2	8	4	1	5	
	Hedley Atkins	24	30.52	7.31	37.83	81%	1	29.92	1.19	6	2	8	4	1	5	
Surgery	Alan Apley	22	27.16	4.16	31.32	87%	1	29.76	1.19	6	1	7	4	1	5	On a weekly basis 1 or 2 extra beds are opened. No additional staffing has been put in to business planning to accommodate this.
	Blundell	22	35.29	3.27	38.56	92%	1	40.32	1.48	8	0.5	8.5	5	0.5	5.5	
	George Perkins	28	25	9	34	74%	1	36.64	1.01	6	2	8	3	2	5	
	Esther (5 days)	16	10.5	4	14.5	72%	1	11.40	0.73	3	1	4	2	1	3	
	Sarah & Queen	43	44.5	9.6	54.1	82%	2	25.58	1.04	11	2	13	6	2	8	Staffing is based on 43 beds but the ward has capacity to go up to 54 beds, the additional beds are unfunded.
Women's	Gynaecology Ward	23	20.8	3	23.8	87%	1	28.48	0.94	5	1	6	3	1	4	
	Antenatal ward	19	14.06	3.61	17.67	80%		N/A		N/A	N/A	N/A	N/A	N/A	N/A	
	Home from Home Birth Centre	N/A	17.99		17.99	100%		N/A		N/A	N/A	N/A	N/A	N/A	N/A	
	Hospital Birth Centre	N/A	57.78	15.03	72.81	79%		N/A		N/A	N/A	N/A	N/A	N/A	N/A	
	Obstetric Theatres	N/A	8	0	8	100%		N/A		N/A	N/A	N/A	N/A	N/A	N/A	
	Postnatal ward	38	36.31	12.34	48.65	75%		N/A		N/A	N/A	N/A	N/A	N/A	N/A	
Dental	ADC & Oral Surgery	N/A	16.4	1	17.4	94%	0	N/A	0.63	N/A	N/A	N/A	N/A	N/A	N/A	
	Day Case Unit	N/A	7.1	0	7.1	100%	0	N/A	1.18	N/A	N/A	N/A	N/A	N/A	N/A	
	Dental Centre	N/A	19.4	0.8	20.2	96%	0	N/A	0.85	N/A	N/A	N/A	N/A	N/A	N/A	
	Oral Medicine & Orthodontics & Paediatrics	N/A	35.22	1	36.22	97%	0	N/A	0.89	N/A	N/A	N/A	N/A	N/A	N/A	
	Restorative	N/A	8.4	1	9.4	89%	0	N/A	0.28	N/A	N/A	N/A	N/A	N/A	N/A	
	Conservative	N/A	12.2	2	14.2	86%	0	N/A	0.32	N/A	N/A	N/A	N/A	N/A	N/A	
	Special Care & Sedation	N/A	11.01	1	12.01	92%	0	N/A	1.06	N/A	N/A	N/A	N/A	N/A	N/A	
	Clinical Skills	N/A	2	1	3	67%	0	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	
	Perio Implant & Prosthetics	N/A	18.91	1	19.91	95%	0	N/A	0.26	N/A	N/A	N/A	N/A	N/A	N/A	
	Dental Nurses						0									
	Senior nurses	N/A	7	0	7	100%	0	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	
ECH Paeds	Arctic (5.5 days)	6	5.2	2	7.2	72%	0.5		0.91	2	1	3	0	0	0	
	Beach Ward 13 beds 7 day	13					1		1.73	5	0	5	5	0	5	
	Beach SSU	13					0		0.99	5	1	6	2	0	2	
	Beach Dialysis	7					0		0.69	4	0	4			0	
	Beach Total	**33**	**44.28**	**1.0**	**45.28**	**98%**	**1.0**		**N/A**	**14.0**	**2.0**	16			0	
	Mountain Ward	40	92.08	3	95.08	97%	1		1.96	17	1	18	17	1	18	
	NICU In-charge, Admin & Float	N/A					1		N/A	3	0	3	3	0	3	
	SCBU	24					0		1.25	6	1	7	6	1	7	
	HDU	6					0		2.15	3	0	3	3	0	3	
	NICU	16					0		2.82	11	0	11	10	0	10	
	NICU Total	**46**	**122.68**	**4.9**	**127.54**	**96%**	**1.0**		**N/A**	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**	
	PICU						0									
	PICU Non Retrieval	18	117.1	0	117.1	100%	0.0		N/A	20	1	21	20	1	21	
	PICU Retrieval	N/A	10.0	0.0	10	100%	0.3		N/A	2	0	2	2	0	2	
	Savannah Cardiac	14					0.3		1.89	6	2	8	5	0	5	
	Savannah Neuro	16					0.4		1.63	5	1	6	6	1	7	
	Savannah Ortho	10					0.3		1.62	3.5	1	4.5	3.5	0	3.5	
	Savannah Total	**40**	**76.3**	**5.0**	**81.28**	**94%**	**1.0**		**N/A**	**14.5**	**4.0**	**18.5**	**14.5**	**1.0**	15.5	
PCCP - Critical Care	VHDU	6	21.19	0	21.19	100%	0		2.86	4	0	4	4	0	4	
	ICU	43	245.94	0	245.94	100%	0		4.69	47	0	47	47	0	47	
	Lane Fox	14	41.76	0	41.76	100%	0		2.15	8	0	8	6	0	6	
Community In-patients	Minnie Kidd House	28	10	21	31	32%				2	6	8	2	2	4	
	Pulross Inpatient Services	20	12.8	10.2	23	56%				4	3	7	2	2	4	
	LCCC Inpatient Services		10	10.8	20.8	48%								0	0	

Agenda Item 9

Item No.	Classification: Open	Date: 24 March 2014	Meeting Name: Health and Wellbeing Board
Report title:		Developing the 2014-18 Joint Health and Wellbeing Strategy	
Wards or groups affected:		All	
From:		Ruth Wallis, Director of Public Health	

RECOMMENDATIONS

1. The board is requested to:

   a) Agree the outline for the development of Southwark's Joint Health and Wellbeing Strategy for 2014 onwards
   b) Agree the outline framework of enquiry for the work going forward, as set out in Appendix 1

EXECUTIVE SUMMARY

2. The paper sets out work to date in refreshing the existing Health and Wellbeing Strategy, which was approved by the Health and Wellbeing Board in July 2013, as well as the key issues for consideration.

BACKGROUND INFORMATION

3. The local authority and clinical commissioning group are required by the 2012 Health and Social Care Act to produce and publish, through the health and wellbeing board, a joint health and wellbeing strategy. Southwark's Health and Wellbeing Board agreed a one year joint health and wellbeing strategy in July 2013, 'Building a Healthier Future Together'. An action plan was agreed in October 2013, and progress against this was set out at the December 2013 meeting of the Health and Wellbeing Board.

4. The primary purpose of the strategy is to improve health and wellbeing outcomes in Southwark and to reduce health inequalities. The strategy, which is a statutory obligation, is underpinned by a comprehensive assessment of the local population's health. In addition, successful development and implementation of the strategy will require shared leadership and commitment from across the local system.

KEY ISSUES FOR CONSIDERATION

1,000 Lives

5. The Health and Wellbeing board agreed in December 2013 to undertake a joint piece of engagement work, called 1,000 Lives. The work focuses on storytelling as a way to capture people's experiences of health and wellbeing and is based on interpretive phenomenological analysis. The findings from this work will be used to inform the joint strategic needs assessment (JSNA), and to produce an

understanding of health priorities and priorities for the strategy.

6. HealthWatch Southwark has been leading the 1,000 lives steering group and there has been involvement and input from all board partners to the approach. The engagement group has been working across the community, in community settings and in health, voluntary sector and local authority setting and services to talk with people about their life experiences of health and wellbeing. Community volunteers and volunteers from Kings College Hospital have also been involved in helping the steering group collect people's stories.

7. To date, the programme has captured more than 500 stories and experiences, with the team continuing to collect and analyse stories. The Lambeth and Southwark Public Health team, local authority research leads and the community involvement group from the Lambeth, Southwark and Lewisham Public Health collaborative have also been providing expert input on the feedback and analysis process.

8. The steering group is currently looking at where it can increase focused collection of stories from groups identified as likely to have significant health needs by the JSNA, who may be harder to reach or who have not so far engaged in this first stage.

JSNA steering group

9. The Southwark JSNA steering group has been established and brings together key clinical commissioning group, local authority and public health partners and is being led by the public health team.

10. The Health and Wellbeing Board is requested to establish a multi agency steering group bringing together representatives of all partners from the Health and Wellbeing Board to develop a joint strategy.

11. This partnership group will be responsible for developing the strategy. Part of the role of the strategy development group should be to ensure that outcome frameworks for public health, adult social care and NHS and clinical commissioning group outcomes are appropriately represented within the strategy. The focus of the strategy will be to achieve improved health and wellbeing, and reduce health inequalities.

12. The working group should meet monthly to develop an outline health and wellbeing strategy which includes outcomes for its implementation. It will be chaired by the Director of Public Health.

13. Key questions for the steering group in guiding strategy development will be:

    - What are the health and wellbeing needs of the population including inequalities?
    - How are these needs currently being met?
    - Where are the gaps
    - How do we improve outcomes for the population?

14. Analysis from 1,000 Lives engagement work and further development of the JSNA will assist the steering group to answer these questions. The JSNA will also bring forward evidence setting out which evidence-based interventions can

best meet the needs of the population. This will ensure that the interventions which form the basis of the strategy are evidence based.

15. The working group will need to set out the relationship of the strategy to other areas of local authority, CCG and partners business.

Strategic framework of enquiry

16. Appendix 1 sets out a headline summary of work to date in bringing together national and local policy, financial and performance issues. In capturing these, the framework seeks to set out the headline objectives partners are beginning to indicate the board and strategy should focus on, alongside potential success measures partners could use to track progress. It is proposed that the framework forms the basis of the work of the JSNA steering group and strategy development work going forward.

17. Emerging issues captured in the framework so far include the implications of national spotlights and requirements, such as the Better Care Fund, revised inspection framework across education, social care and health, as well as increasing demand for acute provision and national outcomes frameworks across health, public health, children's services and social care.

18. The framework has also been informed by the ongoing strategic planning developments in the council, CCG and local health provision, such as the Southwark and Lambeth Integrated Care programme. Initial discussions with board members are beginning to ensure further alignment across partners' respective planning frameworks, and these discussions will continue as the strategy is developed.

19. The framework also begins to capture the detail emerging from the ongoing JSNA and 1,000 Lives work, including the high levels of need of the local population, such as continuing high rates of childhood obesity, smoking and diabetes, as well as rising numbers of A+E attendances, and the impact of changing economic conditions. It is intended that the work of the JSNA steering group and ongoing stakeholder engagement work will further inform and influence the development of this strategic framework, for example in delving deeper into some of the issues highlighted.

20. The JSNA and 1,000 Lives feedback are also bringing to the fore the interdependencies between risk factors and vulnerabilities, including the compounding effect of inequalities in physical and mental health, as well as deprivation and disadvantage on individuals' health and wellbeing.

Policy implications

21. Southwark Council and Southwark Clinical Commissioning Group have a statutory duty under the 2012 Health and Social Act to produce a Health and Wellbeing Strategy for the borough through the board and to have regard to the strategy when commissioning and planning services. The agreed joint strategy will have implications for individual partner's strategies and delivery arrangements, including the Council Plan and clinical commissioning group operating plan among others.

Community and equalities impact statement

22. There are substantial health inequalities in Southwark and for Southwark residents compared with other areas. Those on lower incomes, with disabilities, some ethnic groups and those who are vulnerable and likely to suffer poor health and wellbeing and/or die young. There are also specific inequalities between gender, ethnicity and sexual orientation groups. The joint strategic needs assessment and evidence base used for strategy development is committed to identifying and reducing these inequalities, and to be informed by the extensive evidence-base of effective interventions to reduce these.

Legal implications

23. The board is required to produce and publish a Health and Wellbeing Strategy on behalf of the local authority and clinical commissioning group. The work outlined in this report will assist the board in fulfilling this requirement.

Financial implications

24. There are no financial implications contained within this report. Although, it should be noted that the new health and wellbeing strategy is likely to have implications for how local resources to improve health and wellbeing outcomes are deployed.

REASON FOR URGENCY

25. The 2014/18 joint health and wellbeing strategy needs to be in place by July 2014 to allow continuation from the 2013/14 strategy. The process for the development of the strategy needs to be agreed at this health and wellbeing board meeting to enable the steering group to undertake the necessary preparation work for submission of the proposed strategy to the July board meeting.

REASON FOR LATENESS

26. It was not possible to complete the necessary consultations across the council and with the Southwark Clinical Commissioning Group in order to finalise this report before the deadline for the circulation of the health and wellbeing board agenda.

BACKGROUND PAPERS

Background Papers	Held At	Contact
'Building a Healthier Future Together'	http://www.southwark.gov.uk/downloads/download/3570/joint_health_and_wellbeing_strategy_2013-14	Elaine Allegretti 020 7525 3816
Link: http://www.southwark.gov.uk/downloads/download/3570/joint_health_and_wellbeing_strategy_2013-14		

APPENDICES

No.	Title
Appendix 1	Strategic Framework of Enquiry – 2014+ Joint Health and Wellbeing Strategy

AUDIT TRAIL

Lead Officer	Ruth Wallis, Director of Public Health		
Report Author	Ruth Wallis, Director of Public Health		
Version	Final		
Dated	19 March 2014		
Key Decision?	No		
CONSULTATION WITH OTHER OFFICERS / DIRECTORATES / CABINET MEMBER			
Officer Title		**Comments Sought**	**Comments Included**
Director of Legal Services		No	No
Strategic Director of Finance and Corporate Services		No	No
Strategic Director of Children's and Adults' Services		Yes	No
Date final report sent to Constitutional Team/Community Council/Scrutiny Team			20 March 2014

Strategic Framework of Enquiry – 2014+ Joint Health and Wellbeing Strategy:

Southwark partners working together for....		
...Better health and wellbeing	**...Better communities and life chances**	**...Better care, better quality of life**
This priority is focused on providing effective population-based healthy lifestyle promotion (primary prevention) and includes action on wider determinants of ill health and poor wellbeing	This priority is focused on services for residents with multiple conditions, vulnerabilities or disadvantage; this includes the full spectrum of mental health provision	This priority is focused on ensuring services for those with health or care diagnoses are accessible over 7 days, equitable, personalised and well-coordinated, underpinned by a model of delivery that is proactive, preventative, and focused on out-of-hospital care
What do we want to achieve? - More people leading healthier lifestyles as result of accessing information, advice and support - Reduce key health inequalities experienced by residents of Southwark - More community 'health lifestyle' programmes and greater use of community 'networks' including voluntary and community sector, and pharmacies - Targeted action on and improved outcomes around key health and wellbeing priorities (obesity, smoking, alcohol, drugs, teenage conceptions)	**What do we want to achieve?** - Multi-agency locality working encompassing housing, community, health, social care and early help provision (focus on early intervention, and residents who are vulnerable or disadvantaged) - Improved self-management of physical and mental long term conditions, including community pathways - Enhanced risk stratification, improved diagnostic capacity and pre-emptive management of patients at risk of developing a long term condition - An integrated 'troubled families' service across health, education and social care	**What do we want to achieve?** - 7-day, accessible services, effective risk stratification of high risk patients, and proactive management support few emergency admissions and more out-of-hospital care - Well-integrated service for frail elderly and people with long term conditions - Integrated service for children and adults with SEND across health, housing, education and care - Social work models and transformation including multi-agency child protection and prevention services
How could we measure success? - Better take-up and reach of health checks and public health promotion/information - Wider use of every contact counts approach - Improved outcomes around key lifestyle concerns, eg obesity levels, number of smoking quitters, incidence of alcohol-related illness and attendance at A+E, and teenage conception rates - Reduction in potential years of life lost to causes amendable to healthcare - Improved education, employment and crime rates, including for vulnerable groups	**How could we measure success?** - Improved access to primary and community care - Improved quality and patient outcomes in primary care (including reduced variation) - Earlier diagnosis, with reduced waiting time for diagnosis, and referral to treatment, including improved rate of early dementia diagnosis - More people reporting feeling supported to manage their long term conditions; and better outcomes around long term conditions - Improved access, choice and quality for maternity and under 5 services - Improved outcomes for at-risk, safeguarding and looked after children (including early help cohorts) - Better outcomes around mental health, including access to community mental health services for vulnerable groups	**How could we measure success?** - Fewer emergency admissions, including fewer avoidable emergency admissions, and hospital admissions for residential/nursing home residents - A reduction in discharge delays out of hours, and increased effectiveness of reablement services - Fewer admissions to residential/nursing homes - More patients with ongoing health and care needs use personal budgets to achieve outcomes they want - User experience of integration - Increased proportion of patients on end of life care pathways supported to die in place of their choosing - More vulnerable children and adults live in a safe and stable home - More carers report satisfaction with services; and more people reporting they have as much social contact as they would like - Improved outcomes for those with dementia

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HEALTH, ADULT SOCIAL CARE, COMMUNITIES & CITIZENSHIP SCRUTINY SUB-COMMITTEE **MUNICIPAL YEAR 2013-14**

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Dated: December 2013