The Queen Elizabeth Hospital King's Lynn
NHS Foundation Trust

REPORT TO THE BOARD OF DIRECTORS (IN PUBLIC)

RESPONSIBLE DIRECTOR:	REPORT FOR:		IMPACT ON BUSINESS:		
Jon Wade Chief Operating Officer	Decision		High	Med	Low
	Discussion	✓	✓		
	Information				
LEAD MANAGER:	**REPORT TYPE:**		**BAF REFERENCES & RAG:**		
Sarah Jones – Deputy COO	Strategic				
	Operational	✓			
	Governance		**RELATED WORK: (PREVIOUS PAPERS TO COMMITTEE)**		
PEER ASSIST:	**PEER REVIEW:**				
CQC Domain: (safe, caring, effective, responsive, well-led)	Responsive				

Meeting Date: 25th September 2018

Report Title: Options to release nurse staffing across the wards

Background & Context

Ensuring the QEHKL is staffed with the appropriate number and skill mix of clinical professionals is vital to the delivery of dignified care, keeping patients safe from avoidable harm and having a positive experience of the service.

There has been a gradual increase in vacancies over recent months, culminating in a current trust wide Registered Nurse (RN) vacancy level of 18.11%. It has been increasingly challenging for the trust to mitigate against the risks associated with high vacancy levels.

Following an unannounced visit to medical in-patient areas by CQC inspectors between 4th and 6th April 2018, the Trust reduced its in-patient bed capacity to support safe staffing and delivery of safe care. At the time of inspection, the Trust's Escalation ward (Leverington) was open with 32 patients. Over the course of the following week, 14 beds were closed with a full closure of the Escalation ward by 10th May. Additional non registered nursing staff were placed on two wards of concern to support care and have remained in place. Nursing staff allocated to support the care of patients on the Escalation ward returned to their base wards or departments as part of the funded establishment for their respective areas and temporary workers were deployed as required. The Trust has sustained the closure of this escalation area and its 32 beds since 10th May. Following the April 18 visit by CQC, two further unannounced inspections of wards were conducted with no concerns raised by CQC.

Historically the day fill rate of Registered Nurses during 2016 was 83.5 % since January 2017 to date the range has been 85.4% - 93.4% with an average of 88.7%. However during July and August the Trust has experienced difficulty in achieving the necessary fill rate in impatient areas through supply of temporary workers. The Chief Nurse highlighted concerns to the Board and Quality Committee In August that the fill rate of staff in the inpatient areas so far during that month had been extremely challenging and the potential impact this could have on both the delivery of care and the impact on staff. The Chair of the Quality Committee requested that a Quality enquiry be presented in October due to these concerns.

This paper outlines a review of the current nursing workforce both substantive and temporary and triangulates this information with complaint data to help demonstrate the impact of staffing shortages on the delivery of safe and dignified patient care.

The ongoing nurse staffing shortage at the QEHKL has to be considered a factor in the staff's ability to consistently deliver safe and effective care, as highlighted in the Trust's CQC Inspection Report of September 2018. There is therefore a need to urgently review the current nursing resource and review the options available to ensure patient safety is not compromised either in the immediate, short or longer term.

Following discussions to assist and support the Trust in reviewing safe staffing levels the NHSI safety and quality manager and NHSI Improvement director met with the Chief Nurse on September 12th and conducted a review of all impatient ward staffing, information relating to patient complaints over the period of June – August was also reviewed. There were 5 complaints received in August of the 41 overall with a theme of delays in the provision of fundamental care.

The trusts regulators and Improvement Director have recommended the closure of a ward to release substantive registered nursing staff to immediately reduce and mitigate the vacancy factor in the most challenged wards. These are Necton ward (43.82% vacancy), Terrington ward (43.13% vacancy) and Stanhoe ward (43.69% vacancy). Focus will then move to those wards with a vacancy factor for RNs of over 30%, those being Tilney, Newton, Windsor and MAU.

		Pre bed base changes			Post bed base changes			
		Registered Nurses						
Ward	Bed Numbers	Funded Establishment (WTE)	Vacancy (WTE)	Vacancy %	Allocation of staff (option 4)	Long term agency staff	Vacancy (WTE)	Vacancy %
Necton Ward	33	27.41	12.01	43.82%	3.00	1.50	7.51	27.40%
Oxborough Ward	33	25.00	8.00	32.00%				
Oxborough Ward (post option 4)	21	21.00	8.00		0.25	0.75	7.00	33.33%
Stanhoe Ward	33	25.59	11.18	43.69%	2.00	0.50	8.68	33.92%
Tilney Ward	28	21.01	7.38	35.13%		1.25	6.13	29.18%
West Newton Ward	28	19.84	7.02	35.38%			7.02	35.38%
West Raynham Ward	29	27.55	6.02	21.85%		0.20	5.82	21.13%
Windsor Ward	33	23.04	7.12	30.90%			7.12	30.90%
A & E	4	63.58	18.17	28.58%		3.00	15.17	23.86%
MAU	25	28.70	9.38	32.68%		2.50	6.88	23.97%
Terrington Ward	34	26.78	11.55	43.13%	3.00	1.00	7.55	28.19%
Unallocated regular agency						12.00	-12.00	
Medicine Division Total	**280/272**	**288.50**	**97.83**	**33.91%**	**8.25**	**22.70**	**66.88**	**23.51%**

The trust is exploring a number of options as described below, however, understanding the actual shortfall of registered nursing staff is key to decision making and therefore the current position in terms of ward staffing is set out below.

Current Ward Staffing

The trust currently has 132.99 wte vacancies within the frontline funded establishments. Sickness across the trust as at the end of August 2018 for RNs is 5.34%, and maternity leave accounts for an additional 3.46%.

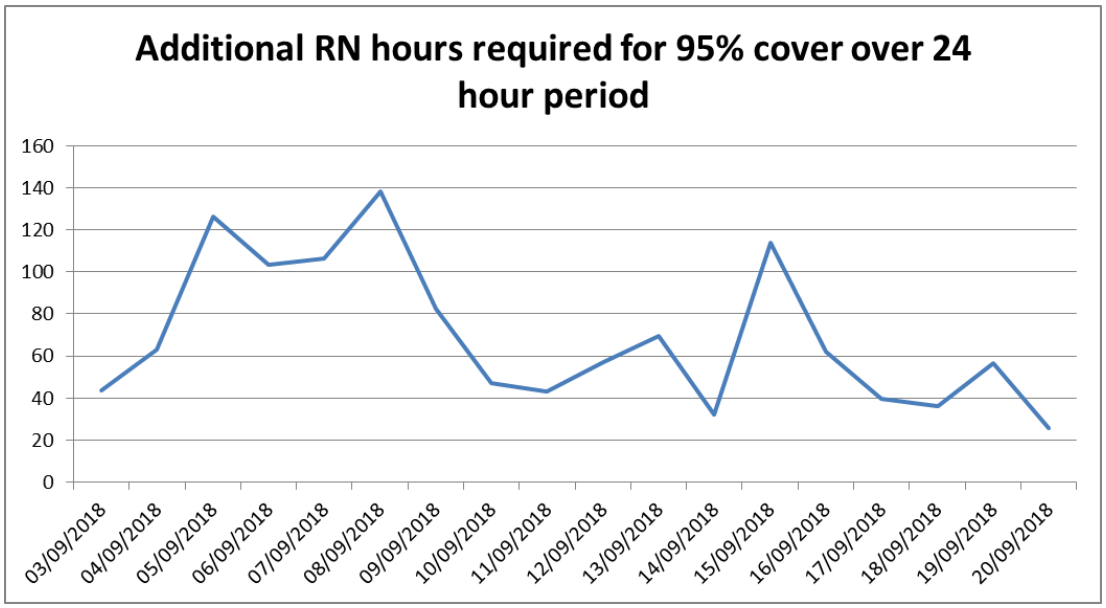
Reliance on temporary backfill can often be a cause for concern, however it should be noted that 35 agency nurses have worked within the trust for over 6 months and many for over a year. These nurses have worked an average of 110 shifts per week for the last 3 weeks (circa 1265 hours per week from a total of 2600 per week). This equates to approx. 33.7wte across all areas.

The trust has very recently engaged with a tier 5 agency, Thornbury, who have been able to provide RNs at short notice. Although high cost, the quality of nursing staff through Thornbury is good, and discussions are ongoing regarding longer term bookings. The cost of tier 5 agency staff is high and will have an impact on the trust forecast outturn.

Given the recent shortages, a detailed review of recent RN cover rates has been undertaken to establish the absolute number of RN hours that the wards are currently not able to fill.

A review of requirements has been undertaken by the Associate Chief Nurses in Divisions 1 and 2, and an assessment of RN hours required over each 24 hour period has been made.

Over the last 18 days, over all cover rates have improved, and assuming effective rostering is in place, the shortfall of RN hours is as follows (this includes on the day cancellations and sickness):



As can be seen, over the last 10 days the additional RN hours required to achieve a fill rate of 95% is between 25 and 114 per week, although at the time of the 114 hour shortfall (Sat 15th Sept) 24 beds were held empty, 2 bays on 2 wards, for the whole day/night.

The senior nursing team have maintained daily staffing huddles where staffing levels are RAG rated to ensure visibility across the organisation. This is reviewed 4 times daily.

Nurse staffing fill is reviewed at key points throughout the 24 hour period and reviewed at the Trust SITREP meetings, A daily staffing meeting occurs to review any 'redflag' incidents from the previous 24 hours and have a prospective view of staffing plans.

Enhanced oversight of the staffing levels is in place to provide support and escalation and resolve or minimise any situations without there being an impact on patient care or patient safety. This includes regular feedback to the CNO throughout the 24 hour day with daily review of any PALS interactions or complaints that are received relating to direct patient care and experience so immediate action and oversight can occur. A quality improvement methodology approach for a peer review process of all inpatient ward areas is being realigned will be implemented during October using a structured

framework with a focus on care and using external reviewers alongside internal peers. This is a model that has been successful at Colchester Hospital.

This analysis does show that in order to meet the 95% desired level, a number in region of 40-50 additional nursing hours each day would meet the vast majority of days requirement. This translates in 4-5 additional nurses per day. This does not allow for the ward managers to become fully supernumerary, so around 10 nurses per day is the actual required amount. However, it should be noted that there are days where the hours shortfall has been far more significant and planning needs to include an element of "flex" for any unforeseen staffing gaps.

Therefore based on the analysis of the two previous charts an additional 8-10 registered nurses are required based on hours and vacancy rates.

Options for consideration

Note that all options should be viewed as short term (likely to be 3 – 6 months) whilst an enhanced recruitment programme is rapidly and robustly implemented.

1. **No change to ward configuration– continue as is but increase the number of agency nurses contracted through the Thornbury agency**

The trust has recently employed 5 nurses through the Thornbury agency, a further 30 nurses working 54 shifts have been secured to work between now and the end of September. This equates to approx. 14 wte RNs.
The trust would need to consider the financial impact, however it is likely to have a smaller impact on trust finances than suspension of the elective programme (option 2).

2. **Close a surgical ward (Marham)**

This option would release 18.29wte RNs and 14.33wte Healthcare Assistants (HCAs) which is within the range required.

Marham ward has 33 beds (5 bays and 3 side rooms) and is the trusts elective ward. Two of the bays are "clean" orthopaedic elective bays, approx. 9 beds are used for other elective patients, including patients on a cancer pathway. The ward is routinely used to accommodate surgical emergency patients in addition to electives and usually has approx. 10-12 emergency patients at any one time.

In order to close Marham ward, these 12 emergency patients will require repatriating to surgical emergency wards, with the requirement for the medical outlier patients (currently 11) to be repatriated to medical wards.

This will require either a reduction in medical emergency admissions or an overall reduction in length of stay of approximately 0.25 days across all medical wards.

There will need to be an immediate suspension of the trusts elective programme, including patients on cancer pathways and patients deemed clinically urgent by consultants. These patients would require a transfer to neighbouring trusts for ongoing care and treatment. Initial discussions with

Addenbrookes and NNUH have taken place, Addenbrookes are unable to support with any capacity, and NNUH, although have no capacity available, would look to work with the QEH to ensure that urgent patients as described above are able to continue their pathways. It is possible that there will be delays incurred in the transfer of patients already booked for surgery at QEH, and it will be vital to ensure that neither their care nor outcomes are compromised as a result of this.

There are implications for the retention of staff across various areas:

- Health Education England has confirmed that there is a likelihood that our anaesthetic and specialist trainees in surgery would be offered a place at another trust after two weeks unless we can offer theatre time at another trust. Foundation doctors are similarly expected to be offered a position at an alternative trust fairly promptly due to the tight timescales within their curriculum.
- There is a risk around nurse retention by redeploying surgical elective nurses to medical wards, as skill sets will be different additional training could be required and some staff will not want to do this.
- Potential impact on consultant body is as yet unclear, anaesthetic staff will be underutilised, and theatre lists underutilised.
- Significant impact on ward nursing by disassembling the existing team – concerns around staff welfare, also around future recruitment and retention.

Other considerations include:

- The impact on patient experience for those patients who are unable to undergo surgery at their hospital of choice, and who may need to travel a considerable distance for their procedure
- The impact on the trusts Referral to Treatment (RTT) 18 week performance. The trust is currently achieving 83.74% of patients who waiting for fewer than 18 weeks for treatment against a national target of 92%. There are currently 132 patients waiting for surgery as an inpatient who have been waiting for over 40 weeks. There is a risk that a significant number of patients will wait for over 52 weeks for their procedure.
- Impact on trust finances – loss of elective income of circa £1m per month.

Initiatives to reduce the surgical bed base include the following:

Detail	Timescale	Expected impact
Major ears and DCR's to be moved to day surgery along with microscopy being moved down to day surgery.	w/c 24th Sept	2 beds
(Stone surgery)- Ureteroscopy activity undertaken in day surgery	w/c 24th Sept	1 bed
Changes to hot gallbladder pathway	w/c 24th Sept	0.5 bed
Lap chloes & hernia being undertaken in day surgery	w/c 24th Sept	2 beds
Consistency of post take ward rounds	Immediate	0.5 bed

Alternative use of trolleys/ chairs/ assessment area on SAU	27th Sept	0.5 bed
Suspension of inpatient elective non-urgent surgery	Immediate	7 beds
Total		13.5 beds

3. Close a medical ward (Oxborough)

This option would release 18.0wte RNs and 20.52wte Healthcare Assistants (HCAs) which is within the range of nursing staff required.

Oxborough is a 33 bedded general medical ward (5 bays and 3 side rooms) that accommodates medical/frail elderly patients.

In order to achieve this, a reduction in admissions of approx. 7 per day would be required, or a length of stay reduction of 0.7 days.

There is a significant benefit to releasing medical nurses as the current staffing issues are concentrated on medical wards, meaning minimal training is required. While the nursing staff currently working on Oxborough ward are a better match to the requirements of the medical wards, both in terms of experience and skill set, the same concerns exist regarding the impact of redeploying a ward team, and the impact it may have on staff morale and welfare.

There is also a significant benefit through the release of doctor time. There is currently an acute shortage of medical staff and no current substantive senior medical staff on Oxborough, although a substantive appointment has been made and will join the trust imminently. Closing the ward would have a positive impact on the day to day working and operational efficiency of the medical team, and support daily consultant review.

There may be an increase in the number of medical patients on surgical wards, however it is unlikely to result in the complete suspension of the elective programme and some urgent elective activity may be maintained. The proposal for the short term period in question is that the medical outlier patients are cohorted on Elm ward to support medical staffing. There would be a need to ensure that the gynae specialty side room bed is protected on Elm ward.

Detailed plans are currently being drawn up by Division 2 setting out how this reduction in emergency patient days could be achieved, as detailed below.

Detail	Timescale	Expected impact
Cease provision of service to un-commissioned alcohol dependency detox patients	w/c 24th Sept	3 beds
Relaunch of SAFER across medical wards	0 - 6 weeks	2 beds increasing to 15 by end Oct
Increase consultant ward rounds at Swaffham Cottage Hospital to 2 per week on arrival of new CoE consultant	24th Sept	1 – 2 beds
Implement MAU assessment zone	24th Sept	4 beds
More robust use of on call Consultant physician for decision making	Immediate	2 beds
Total		12 – 26 beds

4. A hybrid arrangement of all of the above

This is the preferred option and in summary:

- Increases nurse agency staff (eg include option 1)
- Reduces some elective capacity
- Reduces some medical capacity

The immediate securing of Thornbury agency staff. This will be an additional cost not included in the trusts year end forecast and should the required fill rate be achieved, an additional cost of £25K per week should be assumed.

This will support ward staffing and allow the cancer and urgent elective programme to continue whilst the following actions are put into place:

Detail	Timescale	Expected impact
Cease provision of service to un-commissioned alcohol dependency detox patients	w/c 24th Sept	3 beds
More robust use of on call Consultant physician for decision making	Immediate	2 beds
Increase consultant ward rounds at Swaffham Cottage Hospital to 2 per week on arrival of new CoE consultant	24th Sept	1 – 2 beds
Implement MAU assessment zone	24th Sept	4 beds
Major ears and DCR's to be moved to day surgery along with microscopy being moved down to day surgery.	w/c 24th Sept	2 beds
(Stone surgery)- Ureteroscopy activity undertaken in day surgery	w/c 24th Sept	1 bed
Changes to hot gallbladder pathway	w/c 24th Sept	0.5 bed
Lap choles & hernia being undertaken in day surgery	w/c 24th Sept	2 beds
Consistency of post take ward rounds	Immediate	0.5 bed
Alternative use of trolleys/ chairs/ assessment area on SAU	27th Sept	0.5 bed
Suspension of inpatient elective non-urgent surgery	Immediate	7 beds
Total		23.5 – 24.5 beds

These actions are expected to release a combination of beds on both medical and surgical wards within 1 week, and will enable the short term closure of capacity on both Marham ward and Oxborough. As is evident from the above table, there will be a small imbalance between the surgical and medical bed base reductions, and so an increase in medical outliers is to be expected. These will be cohorted on Elm ward to facilitate efficient and effective consultant review.

- The closure of 12 beds on Marham ward will release 4.2wte RNs and 4.2wte HCAs.
- The closure of 12 beds on Oxborough ward will release 4.07wte RNs and 6.13wte HCAs.

Redirecting these staff to medical wards for a short period combined with an increase in agency staff will provide the necessary RN staffing numbers given the current fill rates to achieve 95% cover of required RN hours across all wards.

This option will enable the cohort of elective patients on cancer pathways or deemed clinically urgent to continue to be treated at the QEH.

Contingency Plan

There is significant risk around achievement of the above plan. It requires the Trust to make pathway changes quickly that it has been unable to make over the past several months and years. Should the above actions either not take place in a timely way or not deliver the expected benefits in terms of bed reductions, a contingency plan will be activated.

It is recognised that while it has significant issues and large ramifications associated with it, option 2 (the closure of Marham Ward) is the most likely option that the Trust can hold for a period of time without wider system support. To mitigate some of the risk and impact to our patients, the NNUH have agreed to work with us to understand the ability to accommodate our cancer and urgent patients. The details have yet to be defined, so it cannot be guaranteed that a full solution can be put in place for this cohort of patients.

Further Actions

- Board review of this options paper on 25th Sept 18.
- Implement immediately achievable initiatives outlined above in the timescales set out.
- Agreement with all regulators required over the impact of suspending non-urgent electives including 52 week breaches and financial plans.
- Consider request external "risk summit" for all partners to review actions
- A communication plan will need to be created for both internal and external distribution.
- Rapidly establish a recruitment plan that delivers the RN hours required over a short time scale and enables the release of agency staff at the earliest opportunity.
- Ensure effective rostering is in place on all wards with matron oversight.
- Pursue additional initiatives identified as potentially having a positive impact on admissions, in order to rapidly create capacity for winter escalation. These are largely related to pathways not commissioned effectively within West Norfolk, including:
    - Patients with renal colic – could be managed within a community setting.
    - Stroke Early Supported Discharge – not commissioned therefore extends length of stay for this cohort of patients.
    - Neuro rehab – improving local provision would reduce delays in patients awaiting transfer to a specialist neuro rehab centre.
    - Patients admitted for social reasons.

    - Agree clear pathways of care for bariatric patients to reduce delays in discharge and therefore length of stay.
    - Review discharge pathways for Cambridgeshire patients.
    - Explore further moves from inpatient work to day case
    - Develop plans for use of private post-operative beds
    - Community based IV service
- Quality improvement peer review process for inpatient wards.
- Incorporate into revised winter planning
- Recruitment pipeline plans – Appendix 1
- QIA/HEIA and financial implications to be worked through for each model. – Appendix 2, 3 & 4.

Appendix 1

Recruitment Plan

During 2018 the Trust has been running successful large scale Health Care Assistant Recruitment and these have resulted in 30 -50 candidates being offered jobs on the day. We are now looking to take this model forward, at pace, for our nursing and AHP workforce where applicable. The detailed plans and supporting retention plans are outlined below

Supporting Retention Plans

In order to gain the maximum benefit of a concentration on recruitment we will be taking the following steps to reduce nurse turnover

- Visa payment - We have 23 overseas nurses who have visa renewals due by April 2019. These will cost the Trust £19,800 by financial year end. With an average leavers of 10 wte in registered nurses for the last seven months this represents an offset of two months turnover
- Internal moves – analysis of our exit questionnaires have demonstrated that 20% of our registered nurse turnover is from issues which are under our direct control ie opportunity to move with the organisation or flexible working. A streamlined internal move process has been developed for approval by senior nurses and JSCC w/c 21/912018.
- Flexible working – HR will run workshops through October with current ward managers and focus on known resignations to seek to review and retain. This will also form part of the key messages of new recruitment campaigns from October onwards, outlined below
- Retention collaborative – actions around exit questionnaires are included within the recruitment collaborative as well as the use of legacy nurses to support the new and developing nurse workforce. Analysis and support is also being focused on nurses first 12 months .

Registered Nurse Recruitment Plans

The Trust will be attending the UEA Health Careers Event in Norwich on 3 October 2018 and will be interviewing students for nursing positions at the event and have a further interview date planned for 11 October 2018. A newly qualified Staff Nurse advert is currently advertised with a closing date of 16 September 2018.

International recruitment interviews continue to take place in addition to this via Search Recruitment and Genepool agencies. The international recruitment programme is also being advertised again by the Trust on the NHS Jobs website to attract direct applicants which has resulted in successfully recruiting nurses from overseas with reduced costs without paying agency fees. The expected input of current agency work is included in Table 1

The vacancy position at the end of August 2018 represented 21 wte more RN in post than August 2017 however vacancies were increased by 1 wte due establishment increases in 2018. The aim of the enhanced recruitment is to support the Trust to reduce RN vacancies to below 100 wte by March 2019

Recruitment Event Planning

Preparing for recruitment events has been a 10 week process to reach interview stage – The proposal below seeks to reduce this to 6.

Week 1	Need for event identified and scope of event established. Resources for event/ post recruitment administration and enhanced induction availability identified Agreement on key dates advert closing date, interview dates, start date, incentives, promotional materials
Week 2	Post advertised for 2 weeks
Week 3	Advert closes and shortlisting completed. Interview invites by end of the week
Week 6	Interview date, offers on the day, ID Checks on the day, chase references, DBS and Occupational Health Clearance following event
Week 12	First intake for 4 week notice periods
Week 16	Second intake for 8 week notice periods

Nurse and AHP recruitment events will planned out for the year ahead so that interview dates are scheduled into key staff diaries in advance.

The first event will run w/c 29th October with further events running every quarter as standard with additional ad hoc as required.

As well as the focused resources the campaign will supported by incentives including

- Retention payments payable in instalments at 6 months, 12 months and 2 years and repayable if the nurse leaves within 2 years - £2000 per nurse
- Recommend a friend payments for current staff payable once the new starter has been in post 6 months and only if the staff member recommending is still in post. £500 per successful recommendation.

The predicted net impact of these actions is a positive movement of 60 wte in the registered nurse workforce by March 2019 which would support the Trust in the aim of reducing RN vacancies to below 100 wte. During the same time period in the last financial year the Trust reduced vacancies to 109 wte and for the last six months have delivered lower than predicted vacancies each month.

		Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18
Predicted wte vacancy		109.88	114.46	124.06	132.41	146.14	140.94	140.21
Actual wte vacancy		102.37	108.91	109.36	125.54	131.4	128.82	131.53

Table 1 – Net impact and timing of workforce plans for Registered Nurses

Action	Inflow wte	Outflow wte	Net change wte
Recruitment	+18.00		
August leavers		-8.00	
			+10.00
October			
Leavers		-7.00	
International Recruitment	+2.00		
Known start dates	+12.00		**+7.00**
November			
Leavers		-8.00	
International Recruitment	+1.00		
Known start dates			**-7.00**
December			
Leavers		-8.00	
International Recruitment	+15.00		
Known start dates			
From Recruitment Event	+8.00		**+15.00**
January			
Leavers		+1.00	
International Recruitment			
Known start dates			
From Recruitment Event	+12.00		**+13.00**
February			
Leavers		-8.00	
International Recruitment	+15.00		
Known start dates			**+7.00**
March			
Leavers		0.00	
International Recruitment	+15.00		
Known start dates			**+15.00**
Year End Movement Opportunity			**+60.00**

Assumptions

- Leavers average of 10 wte per month minus impact of visa renewal and internal changes

The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust

Appendix 2

Full Quality Impact Assessment

QUALITY IMPACT ASSESSMENT			
SUBJECT OF ASSESSMENT	Quality Impact Assessment for the proposal to close capacity to support ward staffing at the QEH		
REASON FOR PROPOSED CHANGE	Insufficient ward staffing to provide safe care at Queen Elizabeth Hospital		
Please list any relevant standards / regulatory / statutory requirements and confirm the proposal complies with these	Patients have a right to be cared for by appropriately qualified and experienced staff in safe environments. This right is enshrined within the National Health Service (NHS) Constitution, and the NHS Act 1999 makes explicit the board's corporate accountability for quality. Nurses and Midwives' responsibilities regarding safe staffing are stipulated by the Nursing and Midwifery Council (NMC), covering every registered nurse and midwife in the UK and in England, demonstrating appropriate staffing is one of the six essential standards that all health care providers (both within and outside of the NHS) must meet to comply with Care Quality Commission (CQC) regulation. The National Quality Board (July 2016) requires boards to ensure there is sufficient workforce and sustainable staffing capacity and capability to provide safe and effective care to patients at all times, across all care settings in NHS provider organisations. Patients also have a right under the NHS constitution to be treated within 18 weeks of referral by their GP.		
NAME OF ASSESSOR:	**Jon Wade**	**DATE**	**September 2108**

RISK INDICATORS	IMPACT		IMPACT DESCRIPTION	RAW RISK			MITIGATION STRATEGY	MITIGATED RISK			MONITORING	LEAD
	POSTIVE	NEGATIVE		C	L	Total		C	L	Total		
DUTY OF QUALITY												
Are both governance and practical arrangements in place to cover sharing of clinical details and notes? As the trust is largely dependent on a paper medical record system, the transfer of clinical notes to other trusts will be practically challenging and a work around will need to be devised to ensure that contemporaneous records are available for patients presenting via QEHKL ED patients presenting via ED.		X	May impact clinical care and outcomes.	2	3	6	Careful planning and recording of notes transfers.	2	2	4	Audit	Head of Business Support
Does the proposal improve nurse staffing? Closing capacity will provide additional RN and	X		The is a possibility that surgical elective RNs could choose to redeploy to other surgical vacancies at	3	4	12	Careful delivery of plans to ensure staff feel involved and not disempowered. Continued support	3	3	9	Workforce Committee	Director of HR & OD

HCA staff who can we redeployed to other areas in the Trust. An increase in agency staff will support the substantive workforce across all wards.			other providers, for example there is currently an acute surgical nursing shortage at the Sandringham Private Hospital. Displacing well established teams could impact on staff satisfaction and there is a risk that turnover for this cohort of staff will increase.				throughout period will be required.					
The trust may be unable to meet the requirements for theatre time for foundation trainees? Does this have an impact on other staff groups? Stopping routine elective work for a long period may impact adversely on both consultant surgeons and anaesthetists in terms of maintaining competencies, and potentially on the trust ability to retain medical trainees via HEE.		X	There is a risk that we may lose a significant number of staff which may impact on the trust ability to provide an emergency on call service.	5	3	15	Day surgery will be maximised however there remains a significant risk that the procedures routinely undertaken as inpatient work will be removed and therefore that surgeons will not undertake sufficient to satisfy the requirements of their governing bodies.	5	2	10	Performance Review Meeting	Associate Director of Operations

PATIENT SAFETY												
Is there timely access to surgery for clinically urgent patients? Clinically urgent patients would continue to be treated at the QEH.	No Change	No Change	No change to current arrangements.									
Does the proposal ensure experience/skills reflect patient clinical conditions? While the core skills of RN are similar it is recognised that the RN working with elective surgical speciality are different to those required for a RN in an acute medical area.	X		Staff not working in chosen speciality could adversely impact on staff satisfaction and morale. This could have a negative impact on retention with staff exiting organisation to seek positions in chosen speciality.	3	4	12	Additional training will be required for some nursing staff. This may be mitigated by the movement of other staff from the surgical division who have more experience caring for medical patients so that "best fit" moves are made, and that the impact on turnover is minimised.	3	3	9	Workforce Committee	Director of HR & OD

Is there timely access to patients for non-clinically urgent surgery in line with the NHS constitution? The proposal includes the suspension of all routine elective surgery. This will lead to an increase in waiting times for this group of patients and may lead to 52 week breaches of the 18 week RTT standard.		X	Both CUH and NNUH have confirmed no capacity for routine elective patients. There is a risk that not enough capacity can be secured with other providers. There is also a risk that patients may not be able/choose to travel to another hospital. Likely to impact on the trusts 18 week RTT performance and likely to have an adverse impact on the number of 52 week breaches . May result in patient harm.	4	5	20	Work closely with other providers to ensure the impact on patients is minimised. Activity is already being transferred to Sandringham Private Hospital (orthopaedics inpatients and urology outpatients and day cases). This would be maximised, also explore availability of capacity at other private providers.	4	3	12	Performance and Access	Chief Operating Officer

Performance & Access												
As yet no capacity has been identified for routine elective surgery. Any reduction in capacity will have an impact on the trusts 18 week RTT performance.		X	Will be a deterioration in performance against the 18 week RTT standard and an increase in 52 week breaches.	4	5	20	Capacity to be sought at other trusts and private providers, however this is reliant on patients agreeing to the transfer of their care to hospitals which may be some distance away.	4	4	16		Chief Operating Officer
Patient experience												
Does the proposal provide continuity of experience for patients? The proposal does not provide continuity of experience for patients currently on a routine 18 week pathway within the trust, where performance is already poor.		X	Patients may be unwilling to transfer their care to another provider, which may impact on the trusts 18 week RTT position and number of 52 week breaches. An increase in complaints is likely.	3	5	15	Dedicated resource to support patient communications such as hot line and up to date on going information available in different forms.	3	4	12	PALs	Chief Nurse

Does the proposal ensure receipt of safe, dignified care? The proposal would improve the trusts ability to provide safe and dignified care to medical emergency patients within the trust through increasing the numbers of substantive registered and unregistered staff on remaining ward areas that currently have high vacancy levels.	X		There is a risk around the amount of temporary backfill that will be utilised, although recognising the high number of agency staff that have worked at the trust for a long time, or are former employees of the trust.	2	3	6	Training may be required for some nurses.	2	3	6	Workforce Committee	Chief Nurse
Financial sustainability												
The loss of routine elective work would adversely impact on the trusts financial position by approx. £1m per month. Does the proposal support the trusts financial position?		X	There is a risk of an adverse impact on the trusts 18/19 financial position of approx. £X.	2	3	6	This could be mitigated in part by increasing day case work through main theatres, although there is limited capacity in the Day Surgery Unit to accommodate	2	3	6	Finance & Assurance	Director of Resources

							patients post-operatively.					
Reputation												
How does the proposal impact on the Trusts reputation? There will be a significant impact on the trust reputation as a hospital of choice for the local population.		X	Catastrophic loss of trust in the ability of the hospital to deliver services effectively to the public. Significant impact on staff moral which may impact on recruitment and retention. Creation of 'white noise' leading to an inability to effectively communicate with staff.	5	4	20	Communications with key stakeholders throughout the period, responsiveness to issues as they arise.	5	3	15	Communications Monitoring / HR	Chief Executive Officer

Appendix 3
Combined
Health Outcomes Impact Assessment
Health Inequality Impact Assessment
Sustainability Impact Assessment

Name of Project:	**Temporary Suspension of Elective Operating at QEHKL**	**Short Summary of Proposed Change:**
Project Sponsor:	**Jon Wade**	**Proposed temporary cessation of elective operating at the QEHKL**
Project Manager:	**Sarah Jones**	
Proposed Date of Implementation of Change	**September 2018**	

Summary of completion and review of sections in this form

Health Outcomes

Lead assessor completing form:	D Resoli	Reviewer	J Wade
Position	Interim Deputy COO	Position	COO
Date assessment completed	21/9/18	Date assessment reviewed	21/9/18
Signature		Signature	

Health inequalities

Lead assessor completing form:	D Resoli	Reviewer	J Wade
Position	Interim Deputy COO	Position	COO
Date assessment completed	21/9/18	Date assessment reviewed	21/9/18
Signature		Signature	

Sustainability

Lead assessor completing form	D Resoli	Reviewer	J Wade
Position	Interim Deputy COO	Position	COO
Date assessment completed	21/9/18	Date assessment reviewed	21/9/18

Signature		Signature	

Stage 1: screening questions

Step 1 Specify the people are affected by this change (patients)

How many people will be affected by this change?	Circa 330,000
What is their age range?	All ages – proposal affects both paediatric and adult patients
Where are they living? (locality or geographical area)	QEHKL Catchment: West Norfolk, North & North East Cambridgeshire South Lincolnshire
Any other features that help define the population who are affected by this change?	No
Are there any significant inequalities already **between** this group of people overall and other groups either within the Trust's catchment area, or elsewhere? *Please give reasons for thinking this is the case.*	No – proposal covers whole of Trust catchment
Are there any significant inequalities already **within** this group of people? *Please give reasons for thinking this is the case.*	There are recognised health inequalities within the Trust catchment. For example, 1) The Trust has a significant number of patients, with chronic and acute illnesses, for whom English is not a first language and for whom accessing healthcare may be a challenge. 2) The Trust has a significant number of patients with Long Term Care conditions 3) The Trust has a significant number of patients whom are also carers to other patients 4) The Trust's catchment is a mainly rural area, with limited transportation links between conurbations. Patients with limited mobility difficulties and limited fiscal means are likely to find it difficult to travel between locations to access healthcare.

	5) The Trust is already not meeting key performance standards, including RTT, A&E, Cancer Waiting Times, Stroke. Patients within the Trust's catchment are at risk of inequitable service delivery compared to other patients regionally / nationally.
Please describe the number and type of groups of people affected by the change who are either vulnerable or already subject to inequality.	Not applicable. This proposal affects the whole of the Trust's catchment. All patient groups are affected, including those already vulnerable or already subject to inequality.

Stage 2
In order to assess the individual the population health outcomes, across a Trust catchment, affected by this change (Health outcome impact assessment), the proposed change should be assessed against the NHS England Improvement and Assessment Framework. This framework should be used to assess Commissioner driven proposals for change, however, it is equally applicable to Provider driven proposals.

A copy of the framework is available at:
https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2016/05/technical-annex.pdf

Population health outcome	**Brief rationale for link between the change and the population outcome**	**Positive/ Negative/ Neutral Impact**	**Risk identified**
NHS E Outcome 105a: **Utilisation of the NHS e-referral service to enable choice at first routine elective referral** The 2016/17 NHS Mandate tasks the NHS with ensuring that people are empowered to shape and manage their own health care and make meaningful choices	By temporarily suspending routine elective operating at QEHKL, patient choice options are reduced.	Negative	Risk to patient choice
NHS E Outcome: 105d **People with a long-term condition feeling supported to manage their condition(s)** Supporting patients to effectively manage their own health, while reducing demand on NHS services (including by heavy users such as those with Long Term Conditions) is an ambition of the 5YFV.	By temporarily suspending routine elective operating at QEHKL, patients managing a long term condition for which elective surgery is a treatment, will be waiting longer.	Negative	Risk that patients whom have long term conditions may present as emergency cases
NHS E Outcome: 108a **Quality of life of carers** As set out in the Five Year Forward view – people and communities are often underutilised assets and renewable energy that the NHS and Care need to develop	By temporarily suspending routine elective operating at QEHKL, patients whom are carers for others will be waiting longer for treatment.	Negative	Risk that carers may be waiting longer for treatment, impacting both the carer and the person to whom they provide care

person centred and responsive services that building on communities strengths and deliver the best outcomes for people, their families and carers, and the communities they live and work in. The health status of carers plays an important role in their ability to support the individuals for whom they provide care.			
NHS E Outcome: 121 a, b, c: **Provision of high quality care** Providing high quality care for all is a fundamental principle for health and social care services. CQC rate the quality of care by asking five key questions. In hospitals these questions are asked for each core service. The five key questions – Is it safe? Is it effective? Is it caring? Is it responsive? Is it well-led?	By temporarily suspending routine elective operating at QEHKL, patients will be waiting longer for treatment. The Trust will be less responsive to the needs of patients However, by redeploying nursing staff from elective care to other duties, the Trust will be offering care that is safer and more responsive to patients requiring emergency inpatient treatment.	Neutral	
NHS E outcome: 122a **Cancers diagnosed at early stage** Diagnosis at an early stage of the cancer's development leads to dramatically improved survival chances.	By temporarily suspending routine elective operating at QEHKL, patients access to cancer care may be improved as resources are redirected from routine elective services to cancer care	Positive	
NHS E outcome: 122b **122b. People with urgent GP referral having first definitive treatment for cancer within 62 days of referral** Shorter waiting times can help to ease patient anxiety and, at best, can lead to earlier diagnosis, quicker treatment, a lower risk of complications, an enhanced patient experience and improved cancer outcomes. Improving cancer survival and patient	By temporarily suspending routine elective operating at QEHKL, patients access to cancer care may be improved as resources are redirected from routine elective services to cancer care	Positive	

experience are two of the three key ambitions in the report, “Achieving world-class cancer outcomes: a strategy for England 2015-2020”, published by the Independent Cancer Taskforce in July 2015.			
NHS E Outcome: 125b **125b. Women’s experience of maternity services** Patient experience is one of the three domains of quality care, along with safety and clinical effectiveness. To help service users make meaningful choices to achieve better health outcomes, progressing towards a person-centred NHS, services should strive to improve patient experience across the entirety of the maternity pathway, that is, antenatal, intrapartum and postnatal stages. The National maternity review ‘Better Births’ report outlined a vision for maternity services across England is for them to become safer, more personalised, kinder, professional and more family friendly; where every woman has access to information to enable her to make decisions about her care; and where she and her baby can access support that is centred around their individual needs and circumstances.	By temporarily suspending routine elective operating at QEHKL, maternity patient care may be improved as resources are redirected from routine gynaecology elective services to maternity and obstetric care	Positive	
NHS E outcome 127c **127c. Percentage of patients admitted, transferred or discharged from A&E within 4 hours** A&E waiting times form part of the NHS Constitution	By temporarily suspending routine elective operating at QEHKL, patient care may be improved as resources are redirected from routine elective services to emergency care, in support of the A&E Waiting Time standard. This may include nursing resources, bed	Positive	

The national operating standard is that 95% of patients should be admitted, transferred or discharged within 4 hours of their arrival at an A&E department.	resources and consultant resources.		
NHS E Outcome 127f: **Population use of hospital beds following emergency admission** Areas with a lower rate of emergency bed days are likely to have services in place which support people to remain independent and support timely discharge if they do have to be admitted to hospital. A higher proportion of patients using hospital beds as an emergency can be an indication of poor performing community, primary care or elective services.	By temporarily suspending routine elective operating at QEHKL, patients managing a long term condition for which elective surgery is a treatment, will be waiting longer. If this condition is exacerbated, the patient may present as an emergency. This could increase the population use of hospital beds following emergency admission.	Negative	Risk that patients on an elective waiting list awaiting treatment may be admitted as an emergency
NHS E Outcome 129a: **129a. Patients waiting 18 weeks or less from referral to hospital treatment** Waiting times matter to patients. Most patients want to be referred, diagnosed and treated as soon as possible. The NHS Improvement Plan (June 2004) set out the aim that no-one would have to wait longer than a maximum of 18 weeks from the time they are referred for a hospital operation by their GP until the time they have that operation. The mandate to the NHS sets the objective of maintaining and improving performance against core standards, which include the RTT incomplete pathway standard. The NHS Constitution sets out that patients can expect to start consultant-led treatment within a maximum of 18 weeks from referral	By temporarily suspending routine elective operating at QEHKL, patients managing a long term condition for which elective surgery is a treatment, will be waiting longer.	Negative	Risk that the 18wk waiting time standard will not be achieved. Risk of 52 week breaches

for non-urgent conditions if they want this and it is clinically appropriate.			

Stage 3
Health Inequalities impact
Assessing the likely impact of the change on inequalities

	Key points	**Positive/ Negative/ Neutral Impact**	**Risk identified**
Inequalities **between** the whole group affected by this change and other groups of people Please consider your answer under step (2) above	Not applicable – the proposal covers the whole of the Trust's catchment area, and therefore does not widen inequalities within the group affected.		
Inequalities **within** the group affected by the change Please consider your answer under step (2) above	There are recognised health inequalities within the group affected by the change. For example, 1) The Trust has a significant number of patients, with chronic and acute illnesses, for whom English is not a first language and for whom accessing healthcare may be a challenge. 2) The Trust has a significant number of patients with Long Term Care conditions 3) The Trust has a significant number of patients whom are also carers to other patients 4) The Trust's catchment is a mainly rural area, with limited transportation links between conurbations. Patients with limited mobility difficulties and limited fiscal means are likely to find it difficult to travel between locations to access healthcare. 5) The Trust is already not meeting key	Negative	See Stage 2 for risks identified See Stage 5 for risk assessment and mitigations

	performance standards, including RTT, A&E, Cancer Waiting Times, Stroke. Patients within the Trust's catchment are at risk of inequitable service delivery compared to other patients regionally / nationally.		

Stage 4
Sustainability impact
Please consider whether the change will do any of the following:

Area for assessment	Key points	Positive/ Negative/ Neutral Impact	Risk identified
Leadership, Engagement and Development			
Provide employment opportunities for local people?	By temporarily suspending routine elective operating at QEHKL, staff who are specifically trained to provide elective care interventions and treatments may seek employment elsewhere.	Negative	Risk of possible increase in staff turnover rate from staff groups affected by suspension of elective operating.
Offer employment opportunities to disadvantaged groups?	No impact	Neutral	
Promote and encourage a sustainable local economy?	No impact	Neutral	
Sustainable clinical and care models			
Minimise 'care miles' making better use of new technologies such as telecare and telehealth, delivering care in settings closer to people's homes?	The Trust's catchment is a mainly rural area, with limited transportation links between conurbations. Patients may have to travel further for treatment, increasing 'care miles'. Patients with limited mobility difficulties and limited fiscal means are likely to find it difficult to travel between locations to access healthcare.	Negative	Patients may have to travel further for elective care treatment during the period of suspension
Promote prevention of, and improve self-management of, long term conditions?	By temporarily suspending routine elective operating at QEHKL, patients managing a long term condition for which elective surgery is a treatment, will be waiting longer. Whilst there is impact upon the wider management of Long Term Conditions, there is no impact on the self-management of Long Term Conditions.	Neutral	
Provide evidence-based, personalised care that	No impact	Neutral	

achieves the best possible outcomes with the resources available?			
Deliver integrated care, that co-ordinates different elements of care more effectively and remove duplication?	By temporarily suspending routine elective operating at QEHKL, some patients care may have to be transferred to another provider. This increases the number of elements of care and introduces duplication	Negative	Patients transferring between providers may experience uncoordinated care
Carbon hotspots			
Support the Trust's objectives to reduce carbon emissions and become more sustainable?	No impact	Neutral	
Affect the use of energy or water? Affect pollution to air, land or water?	No impact	Neutral	
Commissioning and Procurement			
Will specific social, economic and environmental outcomes to be accounted for in procurement (if applicable) and delivery?	Not applicable	Neutral	
Will the change stimulate innovation among providers of services related to the delivery of the organisations' social, economic and environmental objectives?	By temporarily suspending routine elective operating at QEHKL, the Trust is considering alternative methods (innovations detailed in the main paper, pgs 6-8) to deliver services to its catchment population. These changes are likely to be embedded into the day-to-day operations of the Trust – extending beyond the period of suspension of elective operating.	Positive	
Will implementation promote ethical purchasing of goods or services and promote sustainable procurement e.g. the purchase of materials from sustainable sources?	No impact	Neutral	
Will implementation promote greater efficiency of resource use?	By temporarily suspending routine elective operating at QEHKL, the Trust will be creating closed / vacant inpatient bed capacity at the Trust. Dependent upon the location of these beds within the wider ward settings, this will be creating inefficiency. In addition, with a reduction in the number of elective cases, there is a risk that Surgeons and theatre staff (ODP, Anaesthetics etc) will	Negative	Risk of inefficient use of resources

	be under-utilised.		
Will implementation obtain maximum value from pharmaceuticals and technologies (medicines management, prescribing, and supply chain)?	No impact	Neutral	
Will implementation support local or regional supply chains?	No impact	Neutral	
Overall Corporate Vision: transport			
Provide / improve / promote alternatives to car based transport?	The Trust's catchment is a mainly rural area, with limited transportation links between conurbations. Patients may have to travel using car based transport	Negative	Risk of increased 'care miles' travelled by patients using cars.
Support more efficient use of cars (car sharing, low emission vehicles, environmentally friendly fuels and technologies)?			
Promote active travel (cycling, walking)?			
Affect vehicle use, mileage or other transport or travel activity?			
Overall Corporate Vision: buildings			
Improve the resource efficiency of new or refurbished buildings (water, energy, density, use of existing buildings, designing for a longer lifespan)?	No impact	Neutral	
Increase safety and security in new buildings and developments?			
Reduce greenhouse gas emissions from transport (choice of mode of transport, reducing need to travel)?			
Provide sympathetic and appropriate landscaping around new development?			

Stage 5 – Assessment of Risk
To be completed for any areas where a negative impact has been identified

Risk	Risk score	Mitigating actions	Mitigated risk score	Monitoring arrangements	Timescale for review	Responsibility for managing risk
Risk to patient choice	9 (3 x 3)	The Trust is arranging sub-contracts with Independent Sector Providers – to facilitate additional choice for patients	6 (2 x 3)	Volume of activity subcontracted to Independent Sector	Monthly	Chief Operating Officer
Risk that patients whom have long term conditions may present as emergency cases	12 (4 x 3)	GPs will be able to contact the Trust to request a consultant-led review of clinically urgent patients	4 (2 x 2)	Number of requests for expediting patients	Monthly	Medical Director
Risk of inefficient use of resources	20 (5 x 4)	This risk is unmitigated	20 (5 x 4)	Weekly Activity Tracker	Weekly	Finance Director
Risk that carers may be waiting longer for treatment, impacting both the carer and the person to whom they provide care	9 (3 x 3)	GPs will be able to contact the Trust to request a consultant-led review of clinically urgent patients – this definition will include carers	4 (2 x 2)	Number of requests for expediting patients	Monthly	Medical Director
Risk that patients on an elective waiting list awaiting treatment may be admitted as an emergency	12 (4 x 3)	GPs will be able to contact the Trust to request a consultant-led review of clinically urgent patients	4 (2 x 2)	Number of requests for expediting patients	Monthly	Medical Director
Risk that the 18wk waiting time standard will not be achieved. Risk of 52wk breaches	20 (5 x 4)	This risk is unmitigated	20 (5 x 4)	Performance monitoring arrangement will continue as business as usual	Weekly	Chief Operating Officer

Risk of possible increase staff turnover rate from staff groups disaffected by suspension of elective operating.	12 (4 x 3)	The suspension of elective operating is a temporary arrangement. Additional pastoral care, additional executive briefings and information will be supplied to teams affected by this proposal.	4 (2 x 2)	Staff Turnover in Division 1	Monthly	Human Resources Director
Risk of increased 'care miles' travelled by patients using cars.	10 (5 x 2)	The Trust is arranging sub-contracts with Independent Sector Providers – one of these providers is BMI Sandringham. This hospital is on the same site as QEHKL	9 (3 x 3)	This risk is not able to be monitored by the Trust		

Notes:

1. All areas of risk scoring greater than eight must be escalated in line with the Trust risk management process.
2. Monitoring arrangements can include review of complaints, incidents, serious incidents, use of clinical audit, observation and patient feedback.

Appendix 4

The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust

Financial Impact Assessment - Option 4

Option 4 *	September	October
	£s	£s
1. Securing Agency Staff via Thornbury	£41,418	£82,836
2. Reduce Elective Capacity Marham Ward mitigated by daycases	£6,271	£208,186
3. Medical reduction in beds required	£8,572	£38,574
4. Reduction in Non Pay Costs	-£6,000	-£12,000
Net (Deficit)/Surplus	**£50,261**	**£317,596**

* Note the above impact assessment excludes any impact of breaches or increased RTT wait times inc

November	December	january	February	March	Total
£s	£s	£s	£s	£s	£s
£92,040	£92,040	£92,040	£92,040	£92,040	£584,454
£198,780	£171,816	£198,780	£180,595	£190,001	£1,154,429
£38,574	£38,574	£38,574	£38,574	£38,574	£240,016
-£12,000	-£12,000	-£12,000	-£12,000	-£12,000	-£78,000
£317,394	**£290,430**	**£317,394**	**£299,209**	**£308,615**	**£1,900,899**

:urring penalties.