Board of Directors

28 January 2015

Briefing on the requirements for the Trust to comply with 'Hard Truths Commitments Regarding the Publishing of Staffing Data'

Director of Nursing Report - Six Monthly Report

Executive Summary

Purpose:

- To provide the Board with an update on its responsibilities for ensuring safe nurse staffing levels across the organisation.

Key Points:

- Guidance was published by the Chief Nursing Officer for England in November 2013 - How to ensure the right people, with the right skills, are in the right place at the right time ('Hard Truths') and the NICE guidance published in July 2014, Safe Staffing for nursing in adult inpatients wards in acute hospitals.
- In October 2014 NICE issued draft guidelines for safe midwifery staffing in maternity settings, the consultation period closed on 13 November 2014. The final guideline is expected to be published in February 2015.
- NHS England published a paper on 26 November 2014 in relation to Safer Staffing: A guide to Care Contact Time. The guidance provides a suite of toolkits to support organisations in making decisions to ensure safe staffing care for patients and service users.
- From 1 December 2014 an Associate Director of Nursing will be working with the HR and nursing teams to lead the recruitment and retention of nurses, managing the temporary staffing office and overseeing e-rostering and safer staffing.
- Boards must be able to demonstrate to their patients, carers and families, commissioners, the CQC and Monitor, that robust systems are in place to assure themselves that the nursing, midwifery and care staffing capacity and capability in the Trust is sufficient to deliver safe and effective care.
- Monthly staffing report attached to this paper.

Financial Implications, Risk and, mitigation:

- Investment in nurse staffing has previously been agreed and budget setting is currently taking place for 2015/2016. The Trust will continue to work on a 1 to 8 ratio in phase one and we are now moving into phase 2 which is the modelling work. Vacancies to present are an ongoing risk to patient care but the staffing resource is managed on a daily basis by senior nurses to ensure safety, in accordance with the Trusts escalation procedure.
- Due to staff changes within the Temporary Staffing Office there are key risks around not being able to continue with e-rostering, or providing bank and agency staff. This is currently being mitigated by the use of Agency staff to support the Temporary staffing office.
- Daily staffing meetings are held to review the situation with a designated staffing Matron of the week and weekend staffing is handed over to the Clinical Site Managers with details of shifts and agency support with back up plans. In times of extremis the Staffing Risk Matrix may be used for decision planning for staffing movements, but this must be with discussion with a senior nurse, matron or above.

- Recruiting experienced registered nurses and newly qualified remains a challenge. A robust recruitment strategy is now in place to fill the majority of registered nurse vacancies and aspirations to over recruit
- Recruitment of unregistered staff with an associated training programme continues
- Matrons and Clinical Site Managers are aware of the minimum staffing levels and mitigate with the available staff.
- E-rostering is now fully implemented in all the ward areas excluding maternity, this allows visibility of all areas and their daily skill deficits.
- Ward sisters are responsible ensuring rosters are completed in a timely manner, which is then reviewed and signed off by the matron if she is happy with both the safety and financial aspects of the roster.
- All shifts are automatically escalated to bank staff and the standard Agencies. The skill mix is reviewed one week in advance by the Associate Director of Nursing and where necessary escalated to Agencies who charge at premium rates. Staff moved around daily on the wards to equalise trained staff on duty to cover the wards.
- With the implementation of 12 hour shifts it was envisaged that the sisters would be supervisory, however due to the current pressure within the organization this is currently not possible. This is at a time when supervisory status to support ward staff would be at its most beneficial due to the current demands. In addition in order to meet these demands Sisters are being taken off management days to work clinically.
- Daily / hourly review of staffing and risk review based on experience and patient dependency / acuity by the matrons for each ward.
- Budget setting, as part of the budget setting process for 2015/16 the ward rotas have been costed at a ratio of 1 Registered nurse to 8 patients and in addition the ward sister achieving supervisory status. In order to ensure the costing is an accurate reflection of potential spend the out turn for 2014/15 has been used, which includes agency premium. This will be held as a risk budget for each cost centre guaranteeing there is no financial constraint preventing achieving the recommended nurse:patient ratio.

Recommendations:

- The Board is asked to receive the report for information and to note the work that is taking place to review ward nursing and midwifery establishments against patient acuity and dependency and the actions that are taking place at ward level and organisational level to support and improve nurse staffing.

Draft Ward Summary for Budget Setting 2015/16

Current Ward Configuration

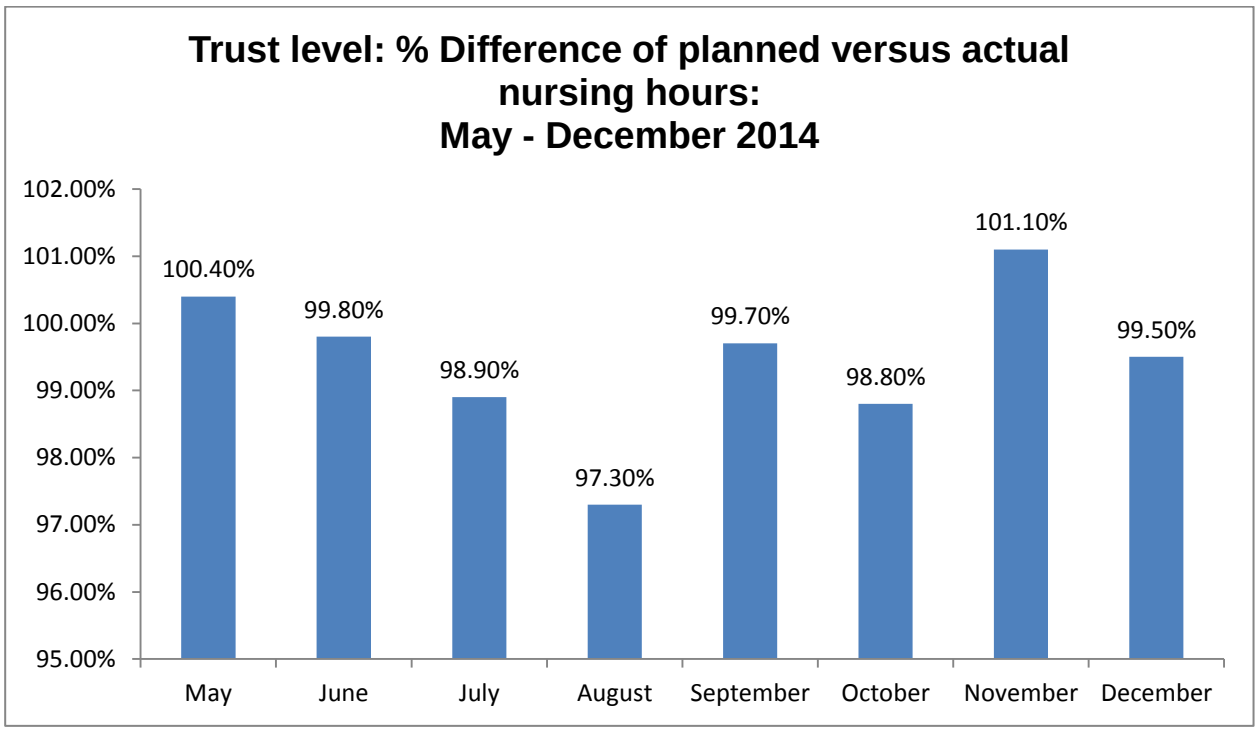
			Shifts		Skill Mix		Bed Ratio			2014/15 Budget	2015/16 Budget	Variance (Fav)/Adv
			RN	HCA	RN	HCA	RN	HCA				
Trauma & Ortho Ward 6A	30282	**Early**	4.0	4.0	50%	50%	6.3	6.3	**Beds**	25	25	**0**
		Late	4.0	3.0	57%	43%	6.3	8.3	**WTE**	30.14	31.31	**1.17**
		Night	2.0	2.0	50%	50%	12.5	12.5	**£'000**	986,899	1,004,817	**17,918**
Elective Ward	30283	**Early**	3.0	3.0	50%	50%	7.3	7.3	**Beds**	22	22	**0**
		Late	3.0	2.0	60%	40%	7.3	11.0	**WTE**	25.07	25.73	**0.66**
		Night	2.0	2.0	50%	50%	11.0	11.0	**£'000**	817,105	860,182	**43,077**
Surgery & Gynae Ward	30280	**Early**	4.0	3.0	57%	43%	7.5	10.0	**Beds**	30	30	**0**
		Late	4.0	2.0	67%	33%	7.5	15.0	**WTE**	27.31	28.33	**1.02**
		Night	2.0	2.0	50%	50%	15.0	15.0	**£'000**	905,352	951,132	**45,780**
EAU	30281	**Early**	5.0	4.0	56%	44%	7.2	9.0	**Beds**	36	36	**0**
		Late	5.0	4.0	56%	44%	7.2	9.0	**WTE**	38.04	37.36	**(0.68)**
		Night	3.0	2.0	60%	40%	12.0	18.0	**£'000**	1,268,712	1,252,776	**(15,936)**
Medicine Ward - 8A	30278	**Early**	4.0	3.0	57%	43%	7.5	10.0	**Beds**	30	30	**0**
		Late	4.0	2.0	67%	33%	7.5	15.0	**WTE**	26.13	28.33	**2.20**
		Night	2.0	2.0	50%	50%	15.0	15.0	**£'000**	897,198	966,029	**68,831**
Stroke & Elderly Care Ward	30252	**Early**	4.0	4.0	50%	50%	6.0	6.0	**Beds**	24	24	**0**
		Late	3.0	3.0	50%	50%	8.0	8.0	**WTE**	30.19	29.69	**(0.50)**
		Night	2.0	2.0	50%	50%	12.0	12.0	**£'000**	955,887	967,088	**11,201**
Medicine Ward - 9A	30279	**Early**	4.0	3.0	57%	43%	7.3	9.7	**Beds**	30	29	**(1)**
		Late	4.0	2.0	67%	33%	7.3	14.5	**WTE**	28.91	30.93	**2.02**
		Night	3.0	2.0	60%	40%	9.7	14.5	**£'000**	1,002,367	1,061,249	**58,882**

			Shifts		Skill Mix		Bed Ratio			2014/15 Budget	2015/16 Budget	Variance(Fav)/Adv
			RN	HCA	RN	HCA	RN	HCA				
Medicine Ward - 9B	30259	Early	4.0	3.0	57%	43%	7.5	10.0	Beds	30	30	**0**
		Late	4.0	2.0	67%	33%	7.5	15.0	WTE	26.61	28.33	**1.72**
		Night	2.0	2.0	50%	50%	15.0	15.0	£'000	888,835	932,167	**43,332**
MFFD Ward	30255	Early	3.0	4.0	43%	57%	10.0	7.5	Beds	10	30	**20**
		Late	3.0	4.0	43%	57%	10.0	7.5	WTE	8.71	29.57	**20.86**
		Night	2.0	2.0	50%	50%	15.0	15.0	£'000	288,042	934,916	**646,874**
GAU & Gynae Day Ward	30277	Early	1.0	1.0	50%	50%	0.0	0.0	Beds	0	0	**0**
		Late	1.0	1.0	50%	50%	0.0	0.0	WTE	4.46	4.45	**(0.01)**
		Night	0.0	0.0					£'000	129,628	143,807	**14,179**
Central Sickness	30228	Early							Beds	0	0	**0**
		Late							WTE	0.00	0.00	**0.00**
		Night							£'000	0	0	**0**
Sub Total General Wards		**Early**	**36.0**	**32.0**	**527%**	**473%**	**66.5**	**75.8**	**Beds**	**237**	**256**	**19**
		Late							**WTE**	**245.57**	**274.03**	**28.46**
		Night	**20.0**	**18.0**	**470%**	**430%**	**117.2**	**128.0**	**£'000**	**8,140,025**	**9,074,163**	**934,138**

General Points from the monthly staffing reports

1.1 The eight month trend (May – December 2014) of planned vs. actual nursing hours within our inpatient bedded areas, shows a stable trend of between 97.3% - 101.1% with the month of November being the highest since recording commenced, which is shown at figure 1. This is a combination of increased activity and patient dependency needs, requiring higher levels of nursing resource to safely staff our inpatient bedded areas.

Figure 1



1.2 As mentioned previously the Trust continues to work on a 1 to 8 ratio, the Trust is currently going through budget setting in phase one and we are now moving into phase 2 which is the modelling work. Vacancies to present are on an ongoing risk to patient care but the staffing resource is managed on a daily basis by senior nurses to ensure safety, in accordance with the Trusts escalation procedure

2. Red Flag Events

2.1 The Trust is required to report red flag events as and when they occur and although the Trust will be implementing the Safe Care Module from Allocate in the summer 2015, from discussions with neighboring Trusts the module takes 12 months to embed.

2.2 It has therefore been decided that in the interim we will work with an in house system. The information department has developed a 'Red Flag' App to sit on an iPad or computer desktop, which will involve a maximum of three clicks to report a Red Flag incident and these incidents will be stored on a Red Flag database. Once a Red Flag event has been reported the Director of Nursing, Associate Director of Nursing for that

area and Matron will receive an e-mail notification. It will be the responsibility of the Matron to ensure the Red Flag Event is actioned and will be able to acknowledge this on the App. This will be tested on one ward initially (ward 8A) before being rolled out.

2.3 Red Flag events are as follows:

- Unplanned omission in providing patient medications.
- Delay of more than 30 minutes in providing pain relief.
- Patient vital signs not assessed or recorded as outlined in the care plan.
- Delays in regular checks on patients to ensure that their fundamental care needs are met as outlined in the care plan. This is often referred to as 'intentional rounding' and involves checks on aspects of care such as the following:

  Pain: asking patients to describe their level of pain level using the local pain assessment tool.

  Personal needs: such as scheduling patient visits to the toilet or bathroom to avoid risk of falls and providing hydration.

  Placement: making sure that the items a patient needs are within easy reach.

  Positioning: making sure that the patient is comfortable and the risk of pressure ulcers is assessed and minimised.

- Less than 2 registered nurses present on a ward during any shift.
- A shortfall of more than 8 hours or 25% (whichever is reached first) of registered nurse time available compared with the actual requirement for the shift. For example, if a shift requires 40 hours of registered nurse time, a red flag event would occur if less than 32 hours of registered nurse time is available for that shift. If a shift requires 15 hours of registered nurse time, a red flag event would occur if 11 hours or less of registered nurse time is available for that shift (which is the loss of more than 25% of the required registered nurse time).

2.4 With regards to the last red flag (patient acuity alerts) this will be easily identified by the staffing matron for the day and can be reported via the app. Work is in progress with clinical areas of the importance of per shift acuity measurement.

3. Acuity and Dependency

3.1 The Trust has real time acuity and dependency data which records the patient level of care (see figure 2) on Swiftplus. A report has been set up which shows in an instance how many patients on each ward are under which level of care. Ward Sisters are responsible for ensuring that Swiftplus is updated as and when the patients level of care changes.

3.2 A pilot establishment review has been undertaken on Ward 8A and this has been carried out using the Shelford tool to match staff numbers against acuity and dependency of patients on a shift by shift basis. This pilot has demonstrated the need for further work to accurately record the levels of care and provided a baseline for the next phase of the safer staffing workplan.

Figure 2

Levels of Care	Descriptor
Level 0 (Multiplier =0.99*) WARD Patient requires hospitalisation Needs met by provision of normal ward cares.	**Care requirements may include the following** • Elective medical or surgical admission • May have underlying medical condition requiring on-going treatment • Patients awaiting discharge • Post-operative / post-procedure care - observations recorded half hourly initially then 4-hourly • Regular observations 2 - 4 hourly • **Early Warning Score** is within normal threshold. • ECG monitoring • Fluid management • Oxygen therapy less than 35% • Patient controlled analgesia • Nerve block • Single chest drain • Confused patients not at risk • Patients requiring assistance with some activities of daily living, require the assistance of one person to mobilise, or experiences occasional incontinence
Level 1a (Multiplier =1.39*) AMBER Acutely ill patients requiring intervention or those who are UNSTABLE with a GREATER POTENTIAL to deteriorate.	**Care requirements may include the following** • Increased level of observations and therapeutic interventions • **Early Warning Score** - trigger point reached and requiring escalation. • Post-operative care following complex surgery • Emergency admissions requiring immediate therapeutic intervention. • Instability requiring continual observation / invasive monitoring • Oxygen therapy greater than 35% + / - chest physiotherapy 2 - 6 hourly • Arterial blood gas analysis - intermittent • Post 24 hours following insertion of tracheostomy, central lines, epidural or multiple chest or extra ventricular drains • Severe infection or sepsis

Levels of Care	Descriptor
Level 1b (Multiplier = 1.72*) BLUE, BLUE D & BLUE CP Patients who are in a STABLE condition but are dependent on nursing care to meet most or all of the activities of daily living.	Care requirements may include the following • Complex wound management requiring more than one nurse or takes more than one hour to complete. • VAC therapy where ward-based nurses undertake the treatment • Patients with Spinal Instability / Spinal Cord Injury • Mobility or repositioning difficulties requiring the assistance of two people • Complex Intravenous Drug Regimes - (including those requiring prolonged preparatory / administration / post-administration care) • Patient and / or carers requiring enhanced psychological support owing to poor disease prognosis or clinical outcome • Patients on End of Life Care Pathway • Confused patients who are at risk or requiring constant supervision • Requires assistance with most or all activities of daily living • Potential for self-harm and requires constant observation • Facilitating a complex discharge where this is the responsibility of the ward-based nurse
Level 2 (Multiplier = 2.5*) HDU May be managed within clearly identified, designated beds, resources with the required expertise and staffing level OR may require transfer to a dedicated Level 2 facility / unit	• Deteriorating / compromised single organ system • Post-operative optimisation (pre-op invasive monitoring) / extended post-op care. • Patients requiring non-invasive ventilation / respiratory support; CPAP / BiPAP in acute respiratory failure • First 24 hours following tracheostomy insertion • Requires a range of therapeutic interventions including: • Greater than 50% oxygen continuously • Continuous cardiac monitoring and invasive pressure monitoring • Drug Infusions requiring more intensive monitoring e.g. vasoactive drugs (amiodarone, inotropes, gtn) or potassium, magnesium • Pain management - intrathecal analgesia • CNS depression of airway and protective reflexes • Invasive neurological monitoring
Level 3 (Multiplier = 5.5*) ICU Patients needing advanced respiratory support and / or therapeutic support of multiple organs.	• Monitoring and supportive therapy for compromised / collapse of two or more organ / systems • Respiratory or CNS depression / compromise requires mechanical / invasive ventilation • Invasive monitoring, vasoactive drugs, treatment of hypovolaemia / haemorrhage / sepsis or neuro protection