Buckinghamshire Healthcare NHS
NHS Trust

BOARD MEETING JULY 30TH 2014

Title	Safe staffing –Hard Truths commitment 2014
Responsible Director	Carolyn Morrice
Purpose of the paper	To report on the timetable of actions to meet the Care Quality Commission and NHS England *Hard Truths commitment* regarding the evaluation and publishing of staffing data
Action / decision required (e.g., approve, note, support, endorse)	The Board are asked to approve the actions taken and proposed meet the Hard Truths commitment

Links to BHT Business and Risks

Implications and issues to which the paper relates (please mark in bold)					
Patient Quality	**Financial Performance**	**Operational Performance**	Strategy	FT Application	New or elevated risk
Legal	**Regulatory/ Compliance**	**Public Engagement /Reputation**	Equality & Diversity	Partnership Working	Other

Annual Objectives	This relates to : Objective 1 - Improving quality, safety and patient experience Objective 2- Employ, engage and develop high calibre staff
Links to BHT Board Assurance Framework/Corporate Risk Register	
BAF/Corporate Risk Register Reference	Impact on BAF 1a,2a, 3a, 4a, 5a, 6a,9a, 11b Impact on CRR 1, 4, 10, 15, 16 - Patient safety, care and experience are compromised due to the level of nurse vacancies across the Trust leading to increased reliance on temporary staffing, long waits for elective outpatient, emergency, day case and inpatient access. This also threatens delivery of national waiting times standards and emergency access targets.
Risk Description	There is a risk to patient mortality and the quality of care if there is insufficient adequately trained and resourced nursing staff to provide safe care to patients.
CQC	• CQC Outcome 13, regulation 22 • CQC Outcome 14, regulation 23 • CQC Outcome 4, regulation 9 • CQC Outcome 5, regulation 14 • CQC Outcome 7, regulation 11 • CQC Outcome 8, regulation 12 • CQC Outcome 9, regulation 13 • CQC Outcome 21, regulation 20
Author of Paper	
Noel Scanlon, Interim Deputy Chief Nurse	
Presenter of Paper	
Carolyn Morrice, Chief Nurse and Director of Patient Care Standards	
Other committees / groups where this paper / item has been considered	
Nursing & Midwifery policy Board, Directors forum	
Date of Paper	
	July 17, 2014

Board Meeting July 30th, 2014

1. PURPOSE OF PAPER

1.1 To share progress on real time monitoring of Ward Based Staffing and related interventions, and

1.2 Update Trust Board on the next steps of ward based staffing, taking into account the latest publications and guidance.

2. BACKGROUND

BHT has agreed the approach for ward based nursing staffing levels, which reflect the RCN Safe staffing levels in the UK (2010). This includes:

2.1 Twice a year review of ward based staffing using an evidence based tool

2.2 Staffing reviews consistently use the same triangulated methodology (acuity/dependency tool; professional judgement; benchmarking with comparators)

2.3 Implement where possible supervisory time for ward leaders

2.4 Support ward leaders with administrative support, where possible

2.5 Skill mix to reflect the needs of the patients in line case mix and activity

3. OPTIONS AND DECISIONS REQUIRED

To note the current situation of ward staffing and the national expectations of service providers.

4. INTRODUCTION

4.1 BHT are committed to publishing staffing data on a monthly basis in the following ways (see Appendix one and NQB Guidance for full details):

4.1.1 A Board report describing the staffing capacity and capability, following an establishment review, using evidence based tools where possible to be presented to the Directors forum every six months. *This was delivered in December 2013 following Keith Hurst's review of Ward staffing in September of that year. A further review commenced in June 2014 following training of ward leaders which took place on May 13th and 14th, 2014.*

4.1.2 Information about the nurses, midwives and care staff deployed for each shift compared to what has been planned to be displayed at ward level. *Ward Staffing displays have been in place since February, 2014. These reflect real time staffing levels of Registered Nurse (RN) and non RN staff against agreed plans and the name of the RN in charge of that shift.*

4.1.3 A Board report containing details of planned and actual staffing on a shift by-shift basis at ward level for the previous month. *This is attached and will hereafter be presented to the Board every month*

4.1.4 The monthly report must also be published on the Trust's website, and Trusts will expected to link or upload the report to the relevant hospital(s) webpage on NHS Choices. *Following approval of this approach by the Directors forum a link to the hospital web site has been placed on NHS choices.*

4.1.5 The Board should receive a report every six months on staffing capacity and capability which has involved the use of an evidence-based tool (where available), includes the key points set out in NQB report page 12 and reflects a realistic expectation of the impact of staffing on a range of factors. *This was delivered in December 2013 following Keith Hurst's review of Ward staffing in September of that year. A further review is taking place during June 2014 (June 9 – July 4) following training of ward leaders which took place on May 13th and 14th, 2014.Subsequent reviews of Childrens Nursing, Midwifery, Critical care – Adult and Neonatal, Community Nursing and Emergency Nursing are in train. A full report of this work will be presented to trust board before the Autumn.*

4.2 On July 15th NICE produced final guidance on nurse staffing which the Chief Nurse has noted as being consistent with the approach taken by the trust since 2013. This paper relates some aspects of this in more detail.

5. WARD STAFFING

5.1 Ward capacity and capability

This paper offers a report on:

5.1.2 The difference between the ward staffing assigned and planned establishment and details of how this gap was covered and resourced as monitored in real time in the month of **June 2014** and

5.1.3 Evidence of triangulation between the use of tools and professional judgement and scrutiny.

5.2 Ward staffing, shortfalls and remedial measures

5.2.1 Ward staff complete a return for each shift indicating compliance or deviation from the previously agreed minimum safe staffing levels. Ward staff will exercise clinical judgement to manage staffing resources taking into account patient acuity, clinical workload, dependency of all patients, additional demands such as planned and emergency admissions and discharges, consultant ward rounds, MDT meetings and case conferences, any individual patients who require closer monitoring because of their unstable clinical condition, confusion or mental disturbance and adjust or reassign the available nursing resources accordingly.

At this point the nurse in charge will have a further dialogue with colleagues on other wards and Matrons before rationalising their report and uploading the safe staffing report to the Qlick system. This leads to an electronic alert report of any ward which has declared itself to be 'unsafe' for any shift in the forthcoming or current 24 hours. This report is e-mailed and picked up in real time on the Blackberry PDAs of Matrons and Associate Chief Nurses with a copy to the Chief Nurse.

If Matrons and Associate Chief Nurses are not already aware of this on their rounds the following escalation process (figure1) will lead to a review of staffing for the affected area, re-assignment of resources from other wards, an adjustment of demand, e.g. by delaying admissions or transferring higher dependency patients to other less pressured settings, summoning staff who are on call or on rest days, adjusting the duty roster for that day or as a last resort requesting bank or agency nurses to provide cover.

Figure 1: Staffing Escalation Flow Chart 6.5

5.2.2 Appendix 1 indicates that no unsafe staffing levels were declared during the month of June on the UNIFY return submitted on July 15. On each occasion unsafe staffing levels were declared by Ward staff, senior nursing staff intervened to adjust capacity or demand to ensure patients were not put at risk.

5.2.3 During June the system shows several departments reporting sub planned staffing levels, mostly for unqualified care staff - Health care assistants and Nursery nurses respectively. Associate Chief Nurses have affirmed that at no time did this put patients at risk or could it be considered ‘unsafe’. There is clear evidence that these areas are still safe and mitigating actions were taken in light of staffing levels falling below planned levels. A full breakdown of the wards and department affected is shown below:

- **Florence Nightingale House Hospice, Stoke Mandeville Hospital** have a shortage of HCA’s particularly at night, so, on occasion, have been using RN’s to cover the HCA shifts. Matron is currently looking advertising for more HCA’s which will resolve the issue.

- **National spinal injuries centre, Stoke Mandeville Hospital.** The figures are based on the new establishment figures from the staffing uplift which occurred earlier this year. NSIC are actively working on increasing our nursing complement to reflect these new numbers. This has led to the qualified nursing numbers to be below those in the planned fields, but this is mitigated by ensuring there are extra Health Care Assistants and Bank nurses on duty. NSIC has recently appointed 11 overseas qualified nurses, all of whom are awaiting their PINs (Nursing and Midwifery council registration numbers) and as such are not working as trained nurses, but they are adding to the increased percentage of HCA’s.
The Centre has recruited above HCA establishment on fixed term contracts, in order to mitigate patient safety by ensuring that there enough staff to carry out basic patient care. Whilst not ideal, this has ensured that NSIC does not compromise on patient care.

- **Trauma and Orthopaedics Wards 1 & 2**, **Stoke Mandeville hospital** reported sub planned staffing levels for unqualified care staff on day duty - Health care assistants - however the Associate Chief Nurse and Matron have affirmed that at no time did this put patients at risk or could it be considered ‘unsafe’. On each occasion additional Registered Nurses were deployed to make up the shortfall. Recruitment efforts are ongoing to fill these positions.

- **Ward 3, Childrens Ward, Stoke Mandeville Hospital:** This month, Children's Ward 3 reported sub planned staffing levels for unqualified care staff on night duty - Health care assistants and Nursery nurses - however the department is exploring how best to utilise unqualified staff and currently only deploys RNs on night duty. Consequently at no time was the ward ‘unsafe’. Unfortunately, RN actual staffing levels fell below 95% this month, however this was countered by lower occupancy levels than usual. Ward managers were therefore able to adjust the roster across the 24h continuum to keep all of the in patients safe at all times.

- **Ward 5, Clinical Haematology / Oncology, Stoke Mandeville Hospital:** Following the establishment review in January 2014 we have been actively recruiting to our qualified nurse posts to meet the new qualified nurse ratio and gradually reducing our HCA establishment to meet the new requirements. Due to the rapidly changing acuity and dependency on ward 5 there are occasions when additional HCA or qualified staff are required for meeting national standards of care e.g. neutropenic sepsis (minimum of 1 nurse for 2 patients). For high intensity chemotherapy administration we need to ensure there are 2 chemotherapy trained nurses on each shift.
  We continue to recruit to our qualified nurse posts and are awaiting 2 new starters in September. Once these staff are settled into post we hope to be able to roster 3 qualified nurses onto nights regularly.

- **Ward 12A Elective Surgical Unit, Wycombe Hospital:** Ward 12A RN actual staffing levels on night duty fell below 95% this month, however this was countered by lower occupancy levels than usual. Ward managers were therefore able to adjust the roster across the 24h continuum to keep all of the in patients safe at all times. Further recruitment efforts and co-ordination of the Elective surgical pathway will lead to improved utilisation and nurse recruitment in coming months.

- **Neonatal intensive care, Stoke Mandeville Hospital** reported sub planned staffing levels for unqualified care staff - Health care assistants and Nursery nurses - however the Associate Chief Nurse and Matron have affirmed that at no time did this put patients at risk or could it be considered ‘unsafe’. Occupancy in the 18 cot Neonatal unit was not always 100% and additional Registered Nurses and Midwives were deployed to make up the shortfall where it was considered essential. Recruitment efforts are ongoing to fill these specialised positions.

- **Intensive care unit, Wycombe hospital:** The shortfall for unqualified staff (88% during day and 73% at Night) is due to 1 HCA being on long term staff sickness and the member of staff being redeployed to another job within the department. The shortfall was safely met by the nurse in charge and other qualified members of the nursing team for delivery of nursing care/roles. A new person is being recruited into post.

- **Intensive care unit, Stoke Mandeville Hospital**: Qualified staff during day shortfall (91%) was met by using staff on management days and Practice development team to help deliver care for patients. There is a shortfall of qualified staff due to trying to set up the Outreach service 24/7 and staff leaving or taking a career break. There is an on going recruitment process - 3 new members of staff started in June. Each requires 6 weeks supernumerary period for induction to critical care, so are not counted in the qualified staff numbers but by working each shift with a mentor they are learning the role and able to help support with delivery of nursing care for patients.
  HCA short fall during day and at night was due to one member of staff being on Maternity leave. A new staff member has been appointed on fixed term contract to cover this. Unqualified staff focuses on putting away stores and liaising closer with housekeeper for cleaning and tidying roles, when appropriate.
  If at any time the short fall was deemed unsafe with current qualified staff on shift, permission was sought to go to High Cost agency and when this was not able to be filled, it was ensured the unit was made safe by staff being supported by matron or Clinical Lead for Critical Care.

  At no time was patient care compromised due to lack of staffing on either WGH or SMH ICU.

5.2.4 As this is a new system the process of learning with Ward Sisters and Staff nurses often involves Matrons and Associate Chief Nurses challenging assumptions, being creative across the unit with nursing resources and recognising that enriching the skill mix provides opportunities to make the ward safe even if the roster is not as it was originally published. The information department have therefore interrogated respondents to ensure that the return is accurate

5.2.5 E-mail alerts three times a day to senior nursing teams alert them to any wards declaring 'unsafe' so an immediate discussion can take place and mitigating actions put into place.

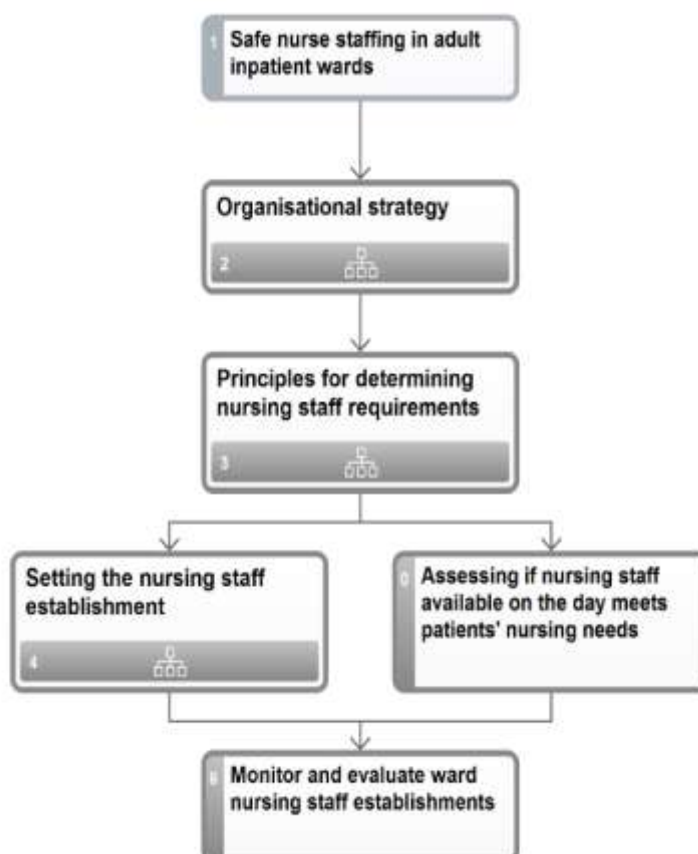
5.2.6 It should also be pointed out that as the trust Qlick systems monitors safe / unsafe staffing levels and the UNIFY return (Appendix 1) requires a commentary of planned v. actual staffing levels which is clearly a higher value, a careful review of each individual line was made to ensure that the return does reflect planned v. actual staffing levels.

5.2.7 Please note this will often show over 100% for the shifts as the return is looking at planned rotas versus actual staff that were on duty.

Reviewing this with the Associate Chief Nurses examples were given where if escalation beds are opened, acuity is higher than normal or a patient needs specialing then they will assign more staff than the rota states but this is a day to day professional judgement. As this return is then converted to hours in some cases just having 10 hours more over the month can look like 8% over planned.

5.3 NICE Ward staffing guidance

5.3.1 On July 15th NICE issued final advice to the NHS on how to make the right decisions about nursing staff requirements to provide safe care for patients on adult inpatient wards in acute hospitals[1]. The guidance recognises that Patients' needs differ from day to day and there is no single staff : patient ratio that can be safely and adequately applied across the wide range of wards in the NHS. The committee concluded that when each registered nurse is caring for more than 8 patients this is a signal to check that patients are not at risk of harm.



[1] http://www.nice.org.uk/Guidance/SG1

5.3.2 The 1:8 ratio was used by Lynne Swiatczak, Chief Nurse as the starting point for ward establishment setting in 2013/14. This was then consolidated by utilising the professional judgement of ward leaders when applying the Keith Hurst SNCT evidence based tool. This triangulation of benchmarked ratios, professional judgment and evidence based methodology has been the approach taken by the trust since last year and continues to be the approach adopted in the current round of nurse staffing reviews taking place this summer.

5.3.3 The NICE guideline states that patient needs must come first when making decisions about safe staffing for nursing on acute wards. It sets out 'red flag events' which warn when nurses in charge of shifts must act immediately to ensure they have enough staff to meet the needs of patients on that ward. 'Red flag events' include patients not being provided with basic care such as pain relief or help to visit the bathroom. An appropriate response could be to provide more skilled nurses or increase numbers of staff. The guidance will be studied closely by the nursing body to ensure that the existing Qlick system is sensitive enough to comply with this guidance.

5.3.4 The guideline also identifies measures that can be used by management to help determine whether staffing on each ward is meeting expected standards. These 'safe nursing indicators' include incidents affecting patient safety such as falls and pressure ulcers or staff reported outcomes such as missed breaks and overtime. The existing set of BHT nursing sensitive indicators reflect some of these metrics however more work needs to be done to embed these as a visible, reliable measure in assessing the outcome of nursing services upon patients, relatives, staff and carers.

5.3.5 NICE notes that implementing this guideline is unlikely to have significant financial impact in many trusts, as they may simply need to adapt their processes to work out where nursing staff should be at any given time.

5.3.6 Detailed work on mapping these costs will be forthcoming over coming months as the outcomes of safe staffing reviews emerge and the savings associated with staff investment on reducing errors, untoward events and reducing length of stay begin to be quantified.

5.3.7 To support use of the guideline a new endorsement process will be applied to staffing decision support toolkits to highlight those that are consistent with the recommendations. NICE has also issued separate information for members of the public to explain the guideline and help make sure they are aware of the quality of care they deserve.

5.3.9 The Chief Nursing Officer for England, said: "Each ward needs the right team of staff to provide high quality care for their patients and their individual needs. This doesn't happen by accident – it requires an evidence based approach, clinical judgment and regular monitoring, with the flexibility to quickly adapt to changing circumstances.

NICE have brought together expert evidence to produce a set of guidelines that hospitals can use to ensure that patients are always at the centre of every staffing decision."

5.4 Quality and outcome measures - Ward dashboards

5.4.1 All wards have Quality dashboards comprising key clinical quality safety measures so that staffing levels can be triangulated with any safety measures to assess the impact of staffing levels on patient outcomes.

5.4.2 Key quality and outcome measures - for example, data on safety thermometer or equivalent for non-acute settings, serious incidents, pressure ulcers, falls, medication administration errors, healthcare associated infections (HCAIs), complaints, patient experience / satisfaction and staff experience / satisfaction are monitored routinely.

6. SUMMARY

6.1 This paper has described progress on real time monitoring of Ward Based Staffing and related interventions.

6.2 Twice a year review of ward based staffing using an evidence based tool comprising Staffing reviews which consistently use the same triangulated methodology (acuity/dependency tool; professional judgement; benchmarking with comparators) will follow over forthcoming months.

7. OPTIONS AND DECISIONS REQUIRED

This paper asks Board :

To note the current situation on ward staffing and the national expectations of service providers.

8. NEXT STEPS / WAY FORWARD:

Board is asked to note:

8.1 The Chief Nurses approach to evaluating Nursing and Midwifery staffing requirements and considering at more length the organisational, strategic and financial implications of recent NICE guidance and

8.2 Refinement of the Qlick real time safe staffing monitoring tool to reflect safe, planned, optimal and actual staffing

Authors:
Carolyn Morrice – Chief Nurse
Noel Scanlon – Interim Deputy Chief Nurse

9. APPENDIX 1: UNIFY RETURN JULY 15, 2014 – STAFFING: NURSING, MIDWIFERY & CARE STAFF – JUNE 2014

				Day				Night				Day		Night	
Hospital Site Details		Main 2 Specialties on each ward		Registered midwives/nurses		Care Staff		Registered midwives/ nurses		Care Staff		Registered midwives/nurses		Care Staff	
				Total monthly								Average fill rate			
Hospital Site name	Ward name	Specialty 1	Specialty 2	planned staff hours	actual staff hours	planned staff hours	actual staff hours	planned staff hours	actual staff hours	planned staff hours	actual staff hours	registered nurses/mid wives (%)	care staff (%)	registered nurses/mi dwives (%)	care staff (%)
Amersham Hospital	CHA Ward	REHABILITAT'N		1350	1320	900	1665	600	590	300	570	97.8%	185.0%	98.3%	190.0%
Amersham Hospital	HEB	REHABILITAT'N		900	1095	1125	1470	600	630	300	580	121.7%	130.7%	105.0%	193.3%
Amersham Hospital	WSC Unit	REHABILITAT'N		1350	1365	1350	1957.5	600	620	300	600	101.1%	145.0%	103.3%	200.0%
Buckingham Hospital	BCH Ward	REHABILITAT'N		900	855	900	900	600	600	320	320	95.0%	100.0%	100.0%	100.0%
Florence Nightingale Hospice	FNH Ward	PALLIATIVE MEDICINE		900	1155	900	645	600	650	300	250	128.3%	71.7%	108.3%	83.3%
Marlow Hospital	MH Ward	REHABILITAT'N		900	900	577.5	577.5	600	600	300	300	100.0%	100.0%	100.0%	100.0%
Stoke Mandeville Hospital	BURNS UNIT	PLASTIC SURGERY		690	690	149.5	149.5	345	345	345	345	100.0%	100.0%	100.0%	100.0%
Stoke Mandeville Hospital	STA	NEUROLOGY		4050	3652	1350	2377.5	2405	2160	600	1260	90.2%	176.1%	89.8%	210.0%
Stoke Mandeville Hospital	STD	NEUROLOGY		1800	1627	1125	1410	900	810	600	570	90.4%	125.3%	90.0%	95.0%
Stoke Mandeville Hospital	STF	NEUROLOGY		450	418	142.5	142.5	380	350	140	140	92.9%	100.0%	92.1%	100.0%

Stoke Mandeville Hospital	STG	NEUROLOGY		1350	1260	900	1365	650	610	300	580	93.3%	151.7%	93.8%	193.3%
Stoke Mandeville Hospital	STJ	NEUROLOGY		850	772.5	675	930	600	600	310	310	90.9%	137.8%	100.0%	100.0%
Stoke Mandeville Hospital	W1	TRAUMA & ORTHOPAEDICS		2250	2880	1800	1702	1200	1480	900	1250	128.0%	94.6%	123.3%	138.9%
Stoke Mandeville Hospital	W10	GENERAL MEDICINE		1800	2332	900	900	900	1190	600	580	129.6%	100.0%	132.2%	96.7%
Stoke Mandeville Hospital	W16a	GENERAL SURGERY		1575	1875	900	1155	900	900	600	600	119.0%	128.3%	100.0%	100.0%
Stoke Mandeville Hospital	W16b	GYNAECOLOGY	OPHTHALMOL OGY	1350	1642	450	952.5	600	890	600	580	121.7%	211.7%	148.3%	96.7%
Stoke Mandeville Hospital	W3	PAEDIATRICS		2303	2139	144	149	2148	2139	55	34.5	92.9%	103.8%	99.6%	62.7%
Stoke Mandeville Hospital	W4	GASTROENTERO LOGY	RESPIRATORY MEDICINE	1350	1732	900	990	600	590	600	600	128.3%	110.0%	98.3%	100.0%
Stoke Mandeville Hospital	W5	CLINICAL HAEMATOLOGY	RESPIRATORY MEDICINE	1575	1635	450	825	800	640	550	640	103.8%	183.3%	80.0%	116.4%
Stoke Mandeville Hospital	W6	RESPIRATORY MEDICINE		2250	2250	1125	1357.5	1200	1210	600	570	100.0%	120.7%	100.8%	95.0%
Stoke Mandeville Hospital	W7	GERIATRIC MEDICINE	ENDOCRINOL OGY	1350	1522	450	915	600	600	600	600	112.8%	203.3%	100.0%	100.0%
Stoke Mandeville Hospital	W8	GERIATRIC MEDICINE		1350	2152	900	1200	600	900	600	890	159.4%	133.3%	150.0%	148.3%

Buckinghamshire Healthcare NHS
NHS Trust

Stoke Mandeville Hospital	W9	GENERAL MEDICINE		1350	1732	450	892.5	600	840	600	610	128.3%	198.3%	140.0%	101.7%
Thame Hospital	THC Ward	REHABILITAT'N		900	885	352.5	352.5	600	580	10	10	98.3%	100.0%	96.7%	100.0%
Wycombe Hospital	CCU2A	CARDIOLOGY		1800	2145	450	855	900	1200	300	290	119.2%	190.0%	133.3%	96.7%
Wycombe Hospital	W12A	GENERAL SURGERY		900	1020	450	750	563	510	370	370	113.3%	166.7%	90.6%	100.0%
Wycombe Hospital	W12B	TRAUMA & ORTHOPAEDICS		1350	1395	450	1095	600	580	300	560	103.3%	243.3%	96.7%	186.7%
Wycombe Hospital	W12C	UROLOGY		900	1140	900	855	600	600	290	290	126.7%	95.0%	100.0%	100.0%
Wycombe Hospital	W5B	GERIATRIC MEDICINE		900	1260	900	930	600	590	600	600	140.0%	103.3%	98.3%	100.0%
Wycombe Hospital	W8	GENERAL MEDICINE		2700	3067	900	1500	1200	1830	300	780	113.6%	166.7%	152.5%	260.0%
Stoke Mandeville Hospital	SM ITU	CRITICAL CARE MEDICINE		3855	3855	555	440.5	3630	3630	330	290	100.0%	79.4%	100.0%	87.9%
Stoke Mandeville Hospital	NNU	CRITICAL CARE MEDICINE		2520	2590	840	322	2520	2534	840	364	102.8%	38.3%	100.6%	43.3%
Wycombe Hospital	WH ITU	CRITICAL CARE MEDICINE		2024	2024	330	291	1914	1991	165	121	100.0%	88.2%	104.0%	73.3%
Stoke Mandeville Hospital	SM ROTH	OBSTETRICS		2940	2940	1680	1680	2100	2100	1260	1260	100.0%	100.0%	100.0%	100.0%