

Royal National Orthopaedic Hospital Trust

Strategic Change Committee - Executive Summary

Report Title:	6 Monthly Staffing Capacity and Capability Report (Hard Truths Commitment)	
Date: 12/9/14	Author: Rebecca Maslin	Lead Director: Dr Julie-Anne Dowie
Is a decision required by the Board?	No	
Purpose of Paper:	To inform the Trust Board of the analysis into nurse staffing levels at the Trust.	
Key information and conclusions:	<p>This paper is presented to the Board following publication of <i>How to ensure the right people, with the right skills, are in the right place at the right time: a guide to nursing, midwifery and care staffing capacity and capability</i> (Nursing Quality Board, 2013).</p> <p>Nursing establishments have been reviewed on all inpatient areas except Alan Bray Unit (Intensive Care). These were analysed using a combination of the Shelford Group (2014) Safer Nursing Care Tool, professional judgement and occupancy/activity review.</p> <p>There is little difference between the current Whole Time Equivalent (WTE) and the indications following the review.</p> <p>Ward managers / lead nurse's act in a supervisory role following recommendations from Francis (2013) and the wards consistently achieve good staff to patient ratios.</p> <p>There continues to be a high vacancy factor in the clinical areas. There is a recruitment strategy in place, and bank and agency staff are utilised to cover the shortfall. There is a low percentage of unfilled shifts.</p> <p>The workforce metrics indicate issues around the use of temporary staffing and turnover though the quality metrics indicate positive patient feedback and safe care delivery.</p>	
Recommendations:	<p>There is no recommendation to adjust establishments based on this paper. However, the recent CQC report (2014) may have financial implications for staffing; particularly in regard to paediatrics.</p> <p>The Trust should consider the introduction of a paediatric acuity tool such as PANDA to review required staffing levels using a evidence based tool.</p> <p>Education should be used as a method to improve recruitment & retention and skill mix.</p> <p>This process should be repeated in 6 months' time, and possibly sooner on Margaret Harte Ward and Jubilee Rehabilitation. A detailed review should also be conducted on Alan Bray Unit.</p>	
Next steps:	This process should be repeated in 6 months' time, and possibly sooner on Margaret Harte Ward and Jubilee Rehabilitation. A detailed review should also be conducted on Alan Bray Unit.	
Statement from Legal Advisors (if applicable):	n/a	
Risk Assessment*:	n/a	

Links to Assurance Framework and Local Key Performance Indicator (KPI) Targets: (please tick as appropriate):

	✓ as appropriate
<u>Principal Objectives to support strategic aims</u>	
<i>(Linked to Strategic Aims and key performance indicator targets (KPIs) categories: Quality, Access, Finance, Management and Productivity)</i>	
1. Maintain clinical excellence – high quality outcomes for our patients:	
• Improve patient care by reducing avoidable infections and providing a clean, safe environment <i>(KPI Targets 1 – 8): Supports Strategic Aims 1 & 2</i>	<input checked="" type="checkbox"/>
• Provide safe and effective care, improving patient experience and clinical productivity <i>(KPI Targets 1 – 20): Supports Strategic Aims 1 & 2</i>	<input checked="" type="checkbox"/>
• Provide timely access to our services. Consistently achieve patient access national standards <i>(KPI Targets 10 – 17): Supports Strategic Aims</i>	<input type="checkbox"/>
2. Deliver our transformation programme to ensure clinical activity targets and financial targets are met and supported by high quality patient care that is also at the most efficient and effective level attainable <i>(KPI Targets 18, 20): Supports Strategic Aims 1 & 2 and supported by Transformation Programme</i>	<input checked="" type="checkbox"/>
3. Improve the quality of our buildings and facilities to ensure patients receive clinical care in an appropriate environment and staff work in facilities that are fit for purpose <i>(Linked to the Redevelopment Programme, including Redevelopment Business Case: Supports Strategic Aims 1,2,3 & 4)</i>	<input type="checkbox"/>
4. Provide timely, accurate and comprehensive clinical management information to a high standard of data quality <i>(Linked to the IM&T Strategy Implementation Plan): Supports Strategic Aims 2,3 & 4</i>	<input type="checkbox"/>
5. Improve workforce effectiveness and engagement to ensure that it is fit for purpose <i>(KPI Target 19); Supported by Organisational Development Programme and Supports Strategic Aims 1 & 2.</i>	<input checked="" type="checkbox"/>
6. Deliver planned in-year service developments <i>(Linked to the Integrated Business Plan, Annual Clinically Led Business Plan and Annual Operating Plan): Supports Strategic Aims 1, 2,3 & 4</i>	<input type="checkbox"/>
7. Maintain and update the RNOH Integrated Business Plan and continue to improve the planning process including 10 year clinical service, finance and estates plan securing the redevelopment of the Stanmore site <i>(Linked to the Integrated Business Plan): Supports Strategic Aims 1,2,3 & 4</i>	<input type="checkbox"/>
8. Further develop academic track record by delivering research and education developments in line with the Joint Academic Plan agreed with UCL <i>(Linked to the Joint Academic Plan): Supports Strategic Aim 3</i>	<input type="checkbox"/>
9. Further develop relationships and partnerships including insourcing, outsourcing and establishing RNOH@ other NHS provider sites <i>(Linked to: the Specialist Orthopaedic Alliance and UCL): Supports Strategic Aims 1,3 & 4</i>	<input type="checkbox"/>
10. Meet Foundation Trust milestones for the year: <i>Supports Strategic Aims 1,2,3 & 4</i>	<input type="checkbox"/>

6 Monthly Staffing Capacity and Capability Report (Hard Truths Commitment)

Introduction

The publication of the second Francis Report in 2013 highlighted potential issues around safe staffing levels at Mid-Staffordshire NHS Foundation Trust and lack of transparency was among the contributing factors. The response from the National Quality Board (NQB) (*How to ensure the right people, with the right skills, are in the right place at the right time: a guide to nursing, midwifery and care staffing capacity and capability*, 2013) requires hospitals to review staffing levels at least six monthly, using validated methods.

In line with the guidance, this paper draws on expert professional opinion and insight into local clinical need and context, and makes recommendations to the Royal National Orthopaedic Hospital NHS Trust (RNOH) Board which must be considered and discussed.

In line with the Timetable of Actions (NHS England and Care Quality Commission, 2014) this paper must:

- Be presented to and discussed at the public Board meeting
- Prompt agreement of actions which are recorded and followed up on
- Be posted on the Trust's public website along with all the other public Board papers

Methodology:

This staffing review was conducted during June/July 2014. Depending on the area in question, different methods were used. The adult inpatient wards (n=8) captured daily patient acuity data using the Safer Nursing Care Tool (Shelford Group, 2014) or the Acute Admissions Unit (AAU) Safer Nursing Care Tool (Shelford Group, 2014). The AAU version was only applied to the Short-Stay Unit, as it is designed to incorporate faster patient flow. Due to the existence of minimum staffing ratios for paediatrics (Royal College of Nursing, 2012), this area was reviewed differently. Instead of an acuity review, a detailed analysis of the historical patient occupancy and complexity (as there are different patient groups requiring either 1:3 or 1:4 qualified nurse to patient ratios) was conducted to calculate a suggested whole time equivalent (WTE). All wards completed a 'bottom-up' review, which involved the Ward Manager (validated by the relevant Lead Nurse/Matron) using professional judgement to identify the required staffing levels (by shift and by day of the week). This ensured triangulation occurred.

Expectations:

Appendix A outlines the RNOH status in regards to the 10 expectations outlined in the NQB paper (2013). The RNOH is meeting all requirements for safer staffing; however eRostering is not yet in place for the substantive staff, and this will be an improvement in terms of both governance and process.

Establishment review:

Table 1 (below) outlines the current establishment and the outcome of the different review methods. The final columns indicate a potential (indicative) requirement to reset ward establishments (where applicable), but in line with recommendations from the Shelford Group (2014) and NICE (2014), establishments should not be altered on the basis of a single review. The repeat should be conducted at another point in the year. Consideration of both sets of data should be made when revising nursing establishments.

Table 1: Establishment review summary

	Existing WTE	Acuity	Bottom-up	Activity/ occupancy	Indicative reset required	Indicative WTE
Spinal Cord Injury Centre	49.1	38.25	46.88	-	0	49.1
Angus Mackinnon Unit	25.93	20.98	28.56	-	2	27.93
Short-Stay Unit	50.33	35.60	52.39	-	1	51.33
Margaret Harte Ward	24.64*	18.98	31.19	-	3	27.64
Ward 4	30.81	22.29	30.27	-	0	30.81
Private Patients Unit	28.16	19.50	31.80	-	0	28.16
Duke of Gloucester	31.82	33.54	32.55	-	0	31.82
Jubilee Rehabilitation Centre	12.8	13.65	15.59	-	1.2	14
Coxen & Adolescent Unit	40.99	-	43.89	40.62	1	41.99

**Margaret Harte Ward is currently permitted to staff to WTE+1 (25.64) following consultation with the Director of Nursing.*

Notable commentary:

Spinal Cord Injury Centre

There were no ventilator dependent patients on the ward during the acuity analysis. If this had been the case, the acuity would have increased above the current WTE (50.20).

Angus Mackinnon Unit

As the layout of the ward includes 11 single rooms, staff availability can be challenging, and risks patient safety; particularly due to multiple staff requirements for some lengthy procedures (e.g. complex wound dressings, manual handling manoeuvres). Additional staff (particularly support staff on a late shift) would be useful to mitigate this risk. The occupancy of Angus Mackinnon was notably lower than normal during the first two weeks of data collection.

Short-Stay Unit

The activity and throughput continues to be higher on the short-stay wards when compared with the other wards. In July 2014, almost 50% of the adult NHS inpatient discharges were from the Short-Stay Wards (previous month = 40%). In the same period, only 63% of day case discharges were from these wards (previous month = 47%). When examining the data, it is clear there is a fluctuating reliance on Phillip Newman Ward at times to accommodate NHS day cases (n=83 in June 2014, n=8 in July 2014).

Margaret Harte Ward

The increase in spinal patients being admitted to the ward is placing increased strain on the staff. Since making some adjustments to the rostering process and the addition of an extra

nurse (using bank), the Senior Sister is more confident in her staffing management and patient safety.

Jubilee Rehabilitation

The placement of 'step-down' patients on Jubilee Rehabilitation has potentially accounted for the slight increase in patient acuity in the last year. The acuity levels should be monitored closely should the opening hours be reviewed again.

Coxen & Adolescent Unit

The 'in-year' variation on patient activity is significant yet expected; there are known peak and off-peak periods, often based around school holidays, parental preference and theatre/surgeon availability. The activity review suggests the staffing level is adequate, but indicates an adjustment in skill mix is required. Improved forecasting of bed occupancy will allow for more organisation of the rostering process. The recent CQC inspection report (2014) highlights discrepancies between the paediatric senior nursing structure when compared to the other areas. Depending upon the action taken in this regard, there may be financial implications.

Allowance for Leave

In 2012/13 the Trust created a central budget (referred to as the 'central pot') to fund long-term sickness, maternity leave and additional 1:1 staffing requirements (e.g. for patient's mental health reasons). The creation of this pot should allow wards to more easily organise leave and manage the roster. Each ward establishment has an uplift (headroom) applied to allow staff annual leave, study leave and short term sickness (three days per staff member). The uplift applied to each area is based on individual staff requirements (e.g. annual leave entitlements due to continuous NHS service), ward specific study requirements, as well as the in-year occupancy and planned ward closures. Although these were set up to 18 months ago, the turnover of staff has had minimal impact on the total leave requirement per ward. Only Margaret Harte Ward has had a notable increase in staff entitlements to additional annual leave (due to continuous NHS service).

In the case of short notice absence (e.g. sickness, carers leave, compassionate leave), the wards are expected to follow the 'escalation protocol' (see appendix B). This is a simple process map of the stages ward staff should take to ensure staffing levels remain safe. Ward staff can clearly see the order of escalation when they identify short notice reduced staffing levels. It is designed logically; and if followed properly, should encourage staff to attempt to resolve issues without resorting to bank/agency in the first instance.

Details of Supervisory Roles

In terms of ward establishments, the most senior nurse (e.g. Senior Sister/Charge Nurse, Ward Manager or Lead Nurse) on each ward is 'supervisory'. This was a phased change from 2012, and is in line with the recommendations from the Francis Report (2013). The expectation is that this role ensures this senior nurse is able to support the ward team, offer

educational/developmental opportunities and be visible to the patients within the ward environment. To allow time for management duties, 20% of their work time is backfilled within the establishment. For a full time Ward Manager, this equates to one day per week (7.5 hours) fulfilling non-clinical duties. In paediatrics, both the Ward Manager and Lead Nurse are supervisory; this is in line with the RCN (2012) requirements.

Ratios

Most ward establishments plan for 70% planned Registered Nurse to assistive staff. Two wards (Spinal Cord Injury Centre and Angus Mackinnon Unit) which employ specialist Rehabilitation Practitioners (due to the patient population) plan for 65% registered staff. Currently there is no recommendation to amend these figures. However, there may be an indication to review them in the future following consideration of falling Registered Nurse numbers (nationally) and the emergence of skilled and appropriately educated staff (e.g. Band 4 practitioners). Considering Table 2 overleaf, it is perhaps clear that there is already a difficulty in Spinal Cord Injury Centre (SCIC). SCIC requires qualified nurses to have specific competencies appropriate to the patient group; due to this, and the reputation of being a 'heavy' ward, it is often difficult to fill bank and/or agency shifts. In these instances, the ward increases the number of skilled non-registered staff in order to maintain safety. The SCIC Matron and Clinical Lead are currently reviewing the staffing and acuity on a daily basis due to a significant number of vacancies and long term leave. An action plan is in place to address the shortfall. The ward has restricted the type of patient accepted for admission to ensure safety (e.g. restricting the number of ventilator dependent patients).

Table 2: % Qualified Nurses on duty

Ward	Month		
	May-14	Jun-14	Jul-14
Spinal Cord Injury Centre	56.26%	47.91%	51.30%
Angus Mackinnon Unit	67.17%	68.62%	57.77%
Short-Stay Unit	69.08%	67.58%	66.34%
Margaret Harte Ward	68.98%	69.01%	71.22%
Ward 4	69.24%	71.95%	67.94%
Private Patients Unit	78.98%	76.02%	72.65%
Duke of Gloucester	71.76%	73.44%	72.78%
Jubilee Rehabilitation Centre	66.57%	69.59%	69.88%
Coxen & Adolescent Unit	78.33%	76.26%	78.93%

Financial requirement

There is no intention at this stage to amend the Nursing establishments in any area as a result of this review. This is because best practice requires acuity based analysis of staffing levels to be conducted at least twice during one year (to reduce likelihood of activity related under/over provision). The next review is advised to be undertaken in February 2015.

However, it is recommended that two wards are reviewed in approximately three months' time (November-December 2014) as the ongoing Transformation Programme (Jubilee Rehabilitation) and intentional (Director of Nursing approved) over and above establishment use of bank/agency (Margaret Harte) may impact on staffing requirements. The impact of the recent CQC inspection (2014) may have financial implications in regards to staffing.

Vacancies

There is an ongoing recruitment campaign in place, yet the Trust continues to have some difficulties recruiting and retaining staff. Where there are vacancies, the Temporary Staffing office achieves on average 90-92% fill rate (see Fig. 1. below) using either bank or agency staff. Although the reset of nursing establishments in 2012/13 resulted in additional substantive posts; difficulties recruiting have placed an increased burden on the non-substantive workforce.

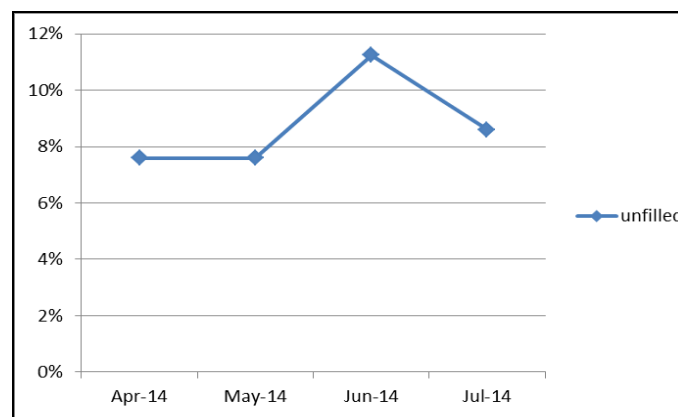


Figure 1: % Unfilled by Temporary Staffing

Details of workforce metrics

While the percentage of qualified staff and the availability of good temporary cover are potential indicators of high quality and safe care delivery, other workforce metrics provide more detail (see appendix C for the RAG criteria). When examined collectively, it is clear that the staffing issues on Spinal Cord Injury Centre and the Private Patients Unit are multi-focal, each scoring four red ratings (see table 3 overleaf). However, all wards except Margaret Harte have at least four amber and/or red ratings. Although at first glance the turnover on Private Patients Unit is alarmingly high, the Unit is actively working to address cultural changes.

Key Quality Measures

Table 4 (overleaf) outlines the quality metrics available for the wards taking part in this staffing review (RAG criteria can be found in appendix C). 'Compliments' are self-reported by the wards, and therefore it is not possible to RAG rate them. The Trust is trying to support a culture of incident reporting, and reporting is actively encouraged. For this reason 'number of clinical incidents' has not been RAG rated either. Due to the limitations of the safety thermometer in terms of tissue viability (discussed above) 'skin damage' excludes

incident reports relating to pre-existing pressure sores. It also excludes 'allergy to dressing'. The content of incident reports continues to be reviewed and actions made where appropriate.

Table 3: Workforce metrics (July 2014)

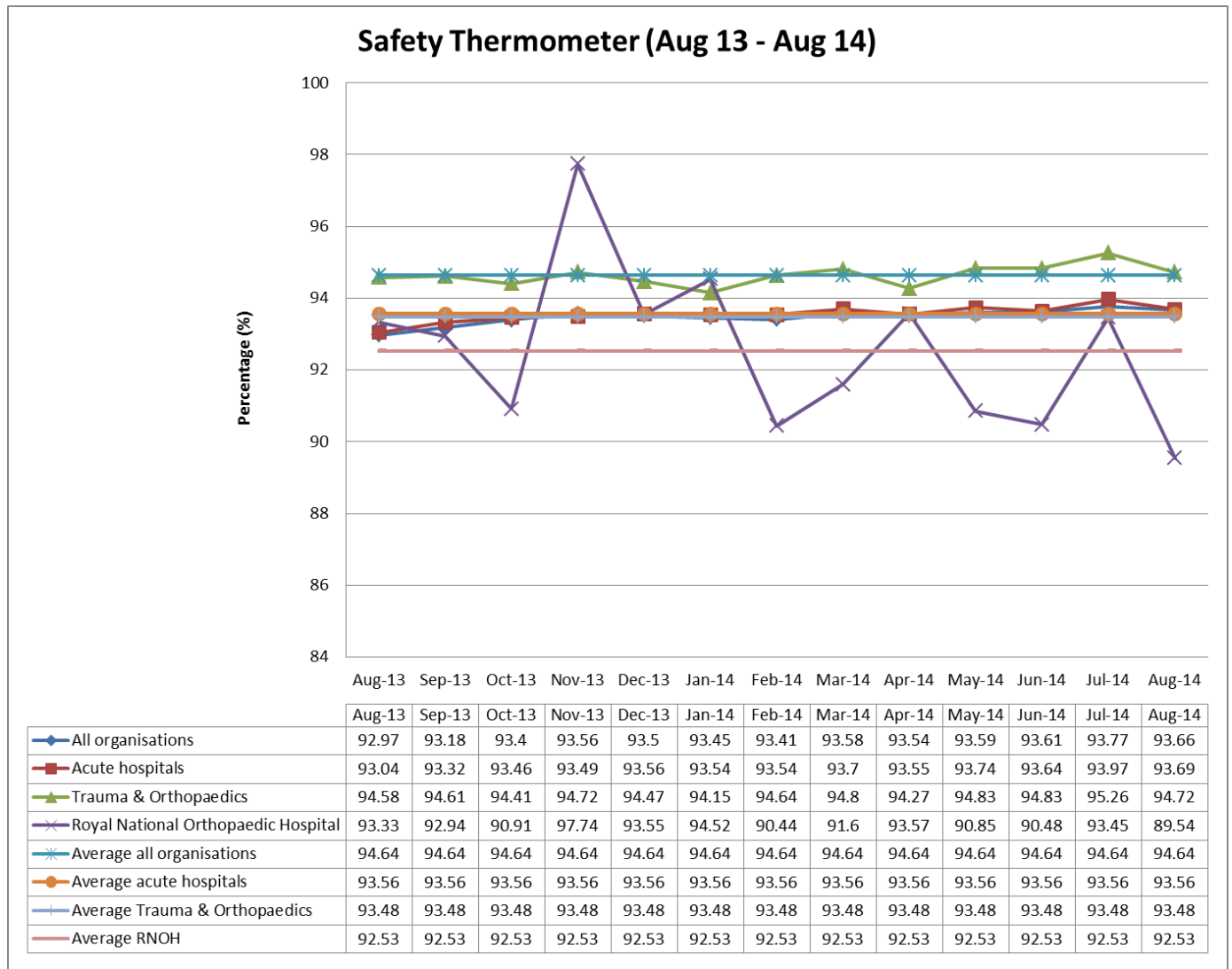
Ward	% Registered Nurses to Non-registered Ratio	Average Patients per Nurse (Day)	Average Patients per Nurse (Night)	Ward Vacancies (% of WTE)	Temporary Staff (as % of total)	Agency (as % of Temporary staff)	Ward Staff Turnover	Ward Staff Sickness Rate
Spinal Cord Injury Centre	51.30%	4.0	5.4	27.8%	34.57%	21.79%	22%	3.0%
Angus Mackinnon Unit	57.77%	4.0	4.3	9.1%	30.53%	44.16%	12%	0.0%
Short-Stay Unit	66.34%	3.5	4.6	13.6%	26.25%	45.57%	22%	2.2%
Margaret Harte Ward	71.22%	4.4	4.5	5.8%	22.29%	25.20%	4%	0.0%
Ward 4	67.94%	4.4	4.5	17.5%	23.17%	53.34%	4%	3.8%
Private Patients Unit	72.65%	2.1	2.8	27.5%	54.21%	51.47%	66%	0.0%
Duke of Gloucester	72.78%	4.2	5.7	24.4%	25.98%	31.32%	8%	0.0%
Jubilee Rehabilitation Centre	69.88%	6.5	8.6	15.6%	18.13%	3.43%	16%	7.4%
Coxen & Adolescent Unit	78.93%	3.1	3.6	10.5%	18.54%	73.34%	15%	0.0%

Table 4: Quality Metrics (July 2014)

Indicator:	Friends & Family Test Score	Friends & Family Test Response Rate	Patient Feedback Response Rate (inc. Day Cases)	Clinical Incidents	Serious Untoward Incidents (Sis)	MRSA Bacteraemia	Clostridium difficile	New Reported Surgical Site Infections	Patient Falls	Skin Damage	Complaints	Compliments
Ward:												
Spinal Cord Injury Centre	64	58%	63%	8	0	0	0	0	2	1	0	0
Angus Mackinnon Unit	63	57%	75%	10	0	0	0	0	1	1	0	7
Short-Stay Unit	81	35%	35%	9	0	0	0	0	2	1	0	22
Margaret Harte Ward	64	70%	71%	7	0	0	0	0	4	1	0	14
Ward 4	56	60%	58%	4	0	0	0	0	2	0	0	11
Private Patients Unit	N/A	N/A	N/A	3	0	0	0	0	1	0	0	0
Duke of Gloucester	87	71%	72%	6	0	0	0	0	2	0	0	9
Jubilee Rehabilitation Centre	78	93%	81%	2	0	0	0	0	0	0	0	2
Coxen & Adolescent Unit	64	65%	55%	8	0	0	0	1	1	2	0	25

The Trust participates in the monthly NHS Safety Thermometer audit. The following graph outlines the 'harm free' care achieved at the RNOH over the past year. The RNOH is currently below the national average for all organisations, acute hospitals and Trauma & Orthopaedics. Case complexity and the RNOH tissue viability service may be factors in this.

Figure 2: RNOH Safety Thermometer - Harm-Free Care (HSCIC, 2014)



The Trust was a 'Top Performer' on the 2013 NHS Staff Survey question 12d: "If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation". The RNOH remains in the national top 10 for this question; 89.6% of staff strongly agreed or agreed with the statement.

Recommendations:

This report concludes that staffing levels at the RNOH are acceptable, but there are issues in relation to vacancies, recruitment & retention and skill mix. This may be impacting adversely on the workforce and quality indicators. In cases of unusual trust wide case mix (e.g. due to reduced occupancy / ward closures / case mix) it may be possible to safely move staff from

one area to another. Staff movements should not routinely be ad hoc, and should be made with careful thought. The escalation protocol (appendix B) should be used to cover short notice absence. Long term moves may require formal consultation and staff morale and turnover should be reviewed closely and frequently. Exit interviews should also be conducted where appropriate.

The Trust is advised that a paediatric acuity tool should be used to assess the complexity and dependency of patients. The favoured tool is the PANDA tool (developed by Great Ormond Street Hospital), but this requires significant financial outlay. The Shelford Group have proposed a paediatric version of the Safer Nursing Care Tool (2014), however it is not yet known when this will be available for use.

Staffing for the Alan Bray Unit (ABU) has not been reviewed at this time; it is known that activity and dependency levels fluctuate significantly within the unit due to the variations in Intensive Care, High-Dependency and Children's High-Dependency. Staffing levels are flexed to reflect this. As a result of this and (at times) significant vacancies, there is a reliance on bank and agency. A detailed analysis (similar in method to the paediatric review) could be used to review the mix between Adult HDU (1:2), Adult ITU (1:1) and Paediatric HDU (ratio is complexity & age dependent). The ratio achieved on Alan Bray during July was 1:1.1.

Though staffing levels are acceptable, recruitment & retention and skill mix may be improved by creative planning regarding educational strategies. There must be clearer career pathways for all staff grades and support available for development. This will improve both workforce and quality aspects of the metrics highlighted in the report.

Conclusion

In summary, staffing levels at the RNOH are acceptable. Staff to patient ratios are achieved and care is of a high quality. Patient feedback reflects this. There are areas with ongoing staffing pressures, but systems are already in place to address this. No decision should be made on the nursing establishments solely on the basis of this review; it should be repeated in six months' time. Consideration of this and the subsequent review should provide evidence for any amendments to the nursing establishment.

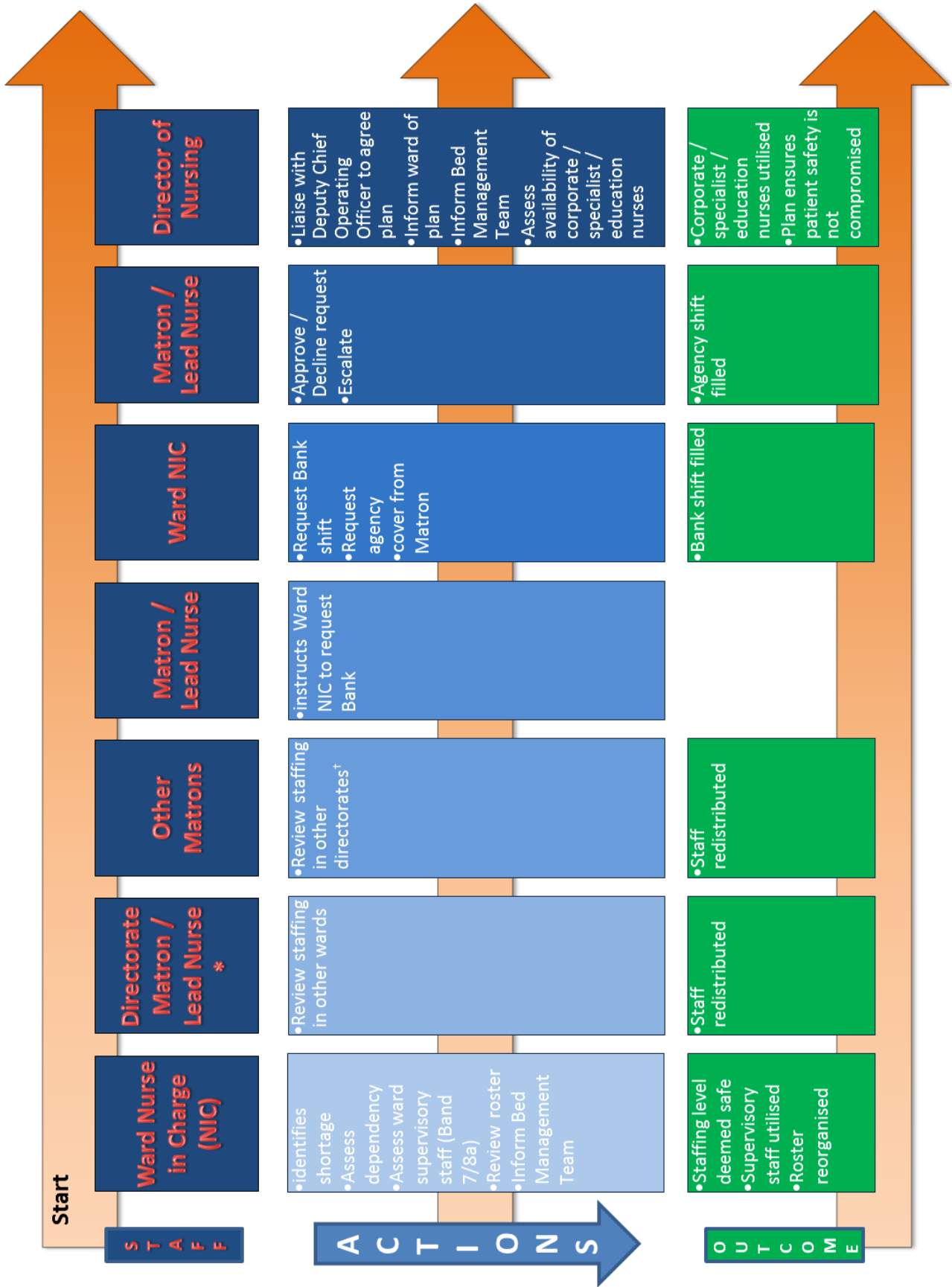
Report date: 12/9/14

Report compiled by: Rebecca Maslin (Project Nurse) on behalf of Dr Julie-Anne Dowie, Acting Director of Nursing.

Appendix A
Expectations 1-10 (NQB, 2013)

	RNOH Assurance
<p>Expectation 1: Boards take full responsibility for the quality of care provided to patients, and as a key determinant of quality, take full and collective responsibility for nursing, midwifery and care staffing capacity and capability.</p>	<p>Clinical Quality Review Group Performance Committee Staffing Reports to Board Balanced scorecard</p>
<p>Expectation 2: Processes are in place to enable staffing establishments to be met on a shift to shift basis.</p>	<p>eRostering for bank/agency management Escalation protocol Rostering policy Shift-by-shift reporting system</p>
<p>Expectation 3: Evidence-based tools are used to inform nursing, midwifery and care staffing capacity and capability.</p>	<p>Shelford Group (2014) Bottom-up (professional judgement)</p>
<p>Expectation 4: Clinical and managerial leaders foster a culture of professionalism and responsiveness where staff feel able to raise concerns.</p>	<p>Policies and procedures Employee assistance programme Listening event Visible posters display management team by department</p>
<p>Expectation 5: A multi-professional approach is taken when setting nursing, midwifery and care staffing establishments.</p>	<p>The Director of Nursing and Finance Director works in partnership to undertake the establishment reviews</p>
<p>Expectation 6: Nurses, midwives and care staff have sufficient time to fulfil responsibilities that are additional to their direct caring duties.</p>	<p>Supervisory ward leaders Centralised budget for managing long term leave Establishments allow for study leave, annual leave and short-term sickness.</p>
<p>Expectation 7: Boards receive monthly updates on workforce information and staffing capacity and capability, and is discussed at a public board meeting at least every six months on the basis of a full nursing and midwifery review.</p>	<p>Monthly report presented to Board 6 monthly report presented to Board</p>
<p>Expectation 8: NHS providers clearly display information about the nurses, midwives and care staff present on each ward, clinical setting, department or service on each shift.</p>	<p>Boards in every ward displaying up to date staffing information</p>
<p>Expectation 9: Providers of NHS services take an active role in securing staff in line with their workforce requirements.</p>	<p>Recruitment strategy Organisational development strategy Link to local LETB</p>
<p>Expectation 10: Commissioners actively seek assurance that the right people, with the right skills, are in the right place at the right time within the providers with whom they contract.</p>	<p>Commissioners presented with staffing papers as required Senior nursing representation at review meetings</p>

Escalation Protocol for Short Staffed Ward Areas



Note:

* Refer to Site Practitioner if out-of-hours and follow instructions

† For guidance on reallocating staff with different NMC registrations (e.g. adult / child) please see: Nursing and Midwifery Council, 2012. Role Boundaries. [online] Available at: <http://www.nmc-uk.org/Nurses-and-midwives/Regulation-in-practice/Regulation-in-Practice-Topics/Scope-of-practice/>. (Last updated: September 2014. Due for review: March 2015)

Appendix C
RAG Criteria

	Red	Amber	Green
% RN achieved	more than 10% less than target	between 1-10% reduction	1% less +
Day ratio	adult 1:9 paed 1:5 rehab 1:11 ITU 1:2	adult 1:7 paed 1:4 rehab 1:10 ITU 1:1.5	adult 1:6 paed 1:3 rehab 1:9 ITU 1:1
Night ratio	adult 1:10 paed 1:5 rehab 1:13 ITU 1:2	adult 1:9 paed 1:4 rehab 1:12 ITU 1:1.5	adult 1:8 paed 1:3 rehab 1:11 ITU 1:1
Vacancies (% of WTE)	>20%	6-20%	<6%
% Temporary Staffing (T/S)	>30%	15-30	<15%
% Agency as a % of T/S	>50%	25-50%	<25%
Ward Staff Turnover	>20%	6-20%	<6%
Ward Staff Sickness Rate	>8%	3-8%	<3%
Friends & Family Test Response Rate	<50%	50-70%	70%
Friends & Family Test Score	<50%	50-70%	170%
Real Time Patient Feedback Response Rate (inc. Day Cases)	<50%	50-70%	270%
Clinical Incidents	2	1	0
Serious Untoward Incidents (SIs)	2	1	0
MRSA Bacteremia	2	1	0
Clostridium difficile	2	1	0
New Reported Surgical Site Infections	2	1	0
Patient Falls			
Skin Damage			
Complaints	-	-	-
Compliments	-	-	-