Royal National Orthopaedic Hospital Trust

Strategic Change Committee - Executive Summary

Report Title:	September Staffing Report (Hard Truths Commitment)	
Date: 10th October 2014	**Author:** Rebecca Maslin	**Lead Director:** Dr Julie-Anne Dowie
Is a decision required by the Board?		No (Please delete as applicable)
Purpose of Paper:	To inform the Trust Board of the details and summary of planned and actual inpatient ward staffing on a shift-by-shift basis and to advise about wards (if any) where staffing falls short of what is required to provide quality care, the reasons for the gap, the impact and the actions being taken to address the gap.	
Key information and conclusions:	This paper is presented to the Board following publication of 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 (Nursing Quality Board, 2013). The information provided supports decision making; enabling the Board to evaluate risks, seek assurances regarding contingency planning, mitigating actions and incident reporting and ensure that the Executive Team is supported to take decisive action to protect patient safety and experience. During September 2014, the ratio between registered staff and patient occupancy was 1 nurse to 3.9 patients in the adult NHS acute inpatient settings. This indicates that the staffing levels did not fall below safe nurse staffing levels. Bank and agency usage has reduced in the last month and the percentage of unfilled hours has also reduced. There were four incident reports relating to ward staffing in September 2014. The main resulting issue was delayed medication administration. One medication error involved agency staff, and a 'skin issue' is being investigated as an RCA. The new online based staffing reporting tool has been launched (1st October 2014). The next paper will review the success of this process.	
Recommendations:	The Board/ Committee is requested to note the following: Without eRostering, the Trust continues to face challenges in regards to a lack of consistency and standardisation of roster management. The Trust should reconsider implementing eRostering due to the quality benefits such a system could offer.	
Next steps:	*n/a*	
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
Principal Objectives to support strategic aims *(Linked to Strategic Aims and key performance indicator targets (KPIs) categories: Quality, Access, Finance, Management and Productivity)*	
1. **Maintain clinical excellence – high quality outcomes for our patients**:	
• Improve patient care by reducing avoidable infections and providing a clean, safe environment *(KPI Targets 1 – 8): Supports Strategic Aims 1 & 2*	✓
• Provide safe and effective care, improving patient experience and clinical productivity *(KPI Targets 1 – 20): Supports Strategic Aims 1 & 2*	✓
• Provide timely access to our services. Consistently achieve patient access national standards *(KPI Targets 10 – 17): Supports Strategic Aims*	
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 *(KPI Targets 18, 20): Supports Strategic Aims 1 & 2 and supported by Transformation Programme*	✓
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 *(Linked to the Redevelopment Programme, including Redevelopment Business Case: Supports Strategic Aims 1,2,3 & 4)*	
4. **Provide timely, accurate and comprehensive clinical management information** to a high standard of data quality *(Linked to the IM&T Strategy Implementation Plan): Supports Strategic Aims 2,3 & 4*	
5. **Improve workforce effectiveness and engagement** to ensure that it is fit for purpose *(KPI Target 19); Supported by Organisational Development Programme and Supports Strategic Aims 1 & 2.*	✓
6. **Deliver planned in-year service developments** *(Linked to the Integrated Business Plan, Annual Clinically Led Business Plan and Annual Operating Plan): Supports Strategic Aims 1, 2,3 & 4*	
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 *(Linked to the Integrated Business Plan): Supports Strategic Aims 1,2,3 & 4*	
8. **Further develop academic track record** by delivering research and education developments in line with the Joint Academic Plan agreed with UCL *(Linked to the Joint Academic Plan): Supports Strategic Aim 3*	
9. **Further develop relationships and partnerships** including insourcing, outsourcing and establishing RNOH@ other NHS provider sites *(Linked to: the Specialist Orthopaedic Alliance and UCL): Supports Strategic Aims 1,3 & 4*	
10. **Meet Foundation Trust milestones** for the year: *Supports Strategic Aims 1,2,3 & 4*	

September Staffing 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 Nursing Quality Board (*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 collect and publically publish individual NHS inpatient ward staffing levels on a shift by shift basis.

In line with the guidance, this report ensures the Trust Board:

a) Receives an update containing details and summary of planned and actual inpatient ward staffing on a shift-by-shift basis
b) Is advised about wards where staffing falls short of what is required to provide quality care, the reasons for the gap, the impact and the actions being taken to address the gap

The information provided supports decision making, enabling the Board to:

1) Evaluate risks associated with staffing issues
2) Seek assurances regarding contingency planning, mitigating actions and incident reporting
3) Ensure that the Executive Team is supported to take decisive action to protect patient safety and experience

This report and the details within it can be found on the Trust website, and also via the NHS Choices page (Stanmore site). The detail from the recent in-depth establishment review is contained in the report '*6 Monthly Staffing Capacity and Capability Report (Hard Truths Commitment)'* which was presented at the September 2014 Trust Board.

a) Update:

This report has been compiled using the information provided by the wards in real-time. This means it is much easier to visualise staffing and patient load concurrently (either by attending a ward, or viewing real-time patient flow data). This allows the 'planned' number (calculated according to the ward budgeted establishment) to be flexed (up or down) to accommodate changes in activity, bed fill or dependency. Reporting is calculated in 'hours', rather than shifts, as there can be many different shift patterns. The impact of this ensures the reporting of differences (between planned and actual) take into account these changes and is more meaningful as a result. This is explained in detail in the June 2014 monthly report.

The detailed data from the RNOH inpatient wards comparing the flexed plan (in hours) and the actual hours worked can be found in Appendix A (Tables 4 and 5). This is broken into day and night, as well as by registered / non-registered staff.
As reporting has been ongoing for six months, and detailed analysis has been possible for five; it is now more meaningful to present some data in graphical and table forms. This permits clearer visibility of staffing concerns and the potential to notice trends.

Bank and agency continues to be heavily relied upon (see Figure 1 below). Generally, month on month, bank and agency had been on the rise, though in September there was a reduction (now at 22.5%).

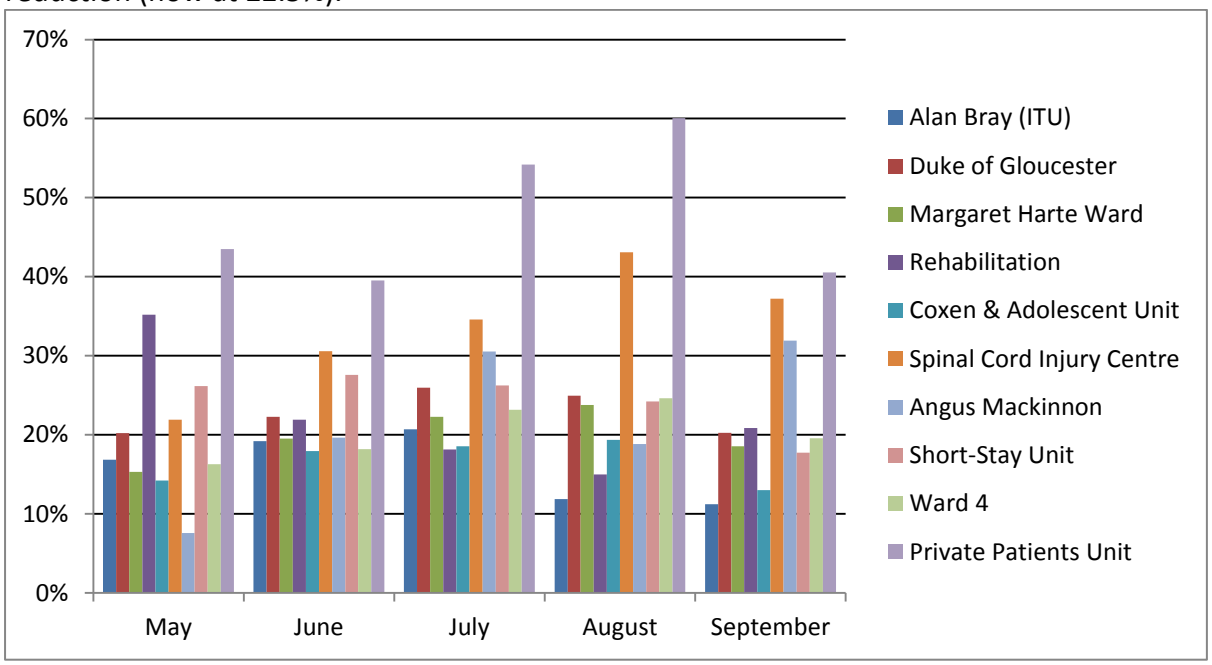

Figure 1: Bank & agency use as a % of ward staff

The Private Patients Unit (PPU) uses a higher percentage of bank and agency usage compared to the rest of the inpatient wards, but since August, this has reduced (from 60.08% to 40.54%). The reasons for requesting temporary staff are outlined in Table 1 (below); vacancies continue to account for the majority of requests.

Table 1: Reason for Bank/Agency Request

Adhoc Additional Work / Backlog	38
Long Term Sickness	208
Maternity / Paternity	22
Private Work	14
Short Notice Cover	65
Sickness	1
Specialing	7
Unplanned Bed Opening	1
Unplanned Theatre Over-run	6
Vacancy	1148
Grand Total	1510

The percentage of temporary staff coming from agencies rather than the RNOH Nurse Bank has fallen since August (see Figure 2 below). The summer is particularly challenging for obtaining temporary staff.

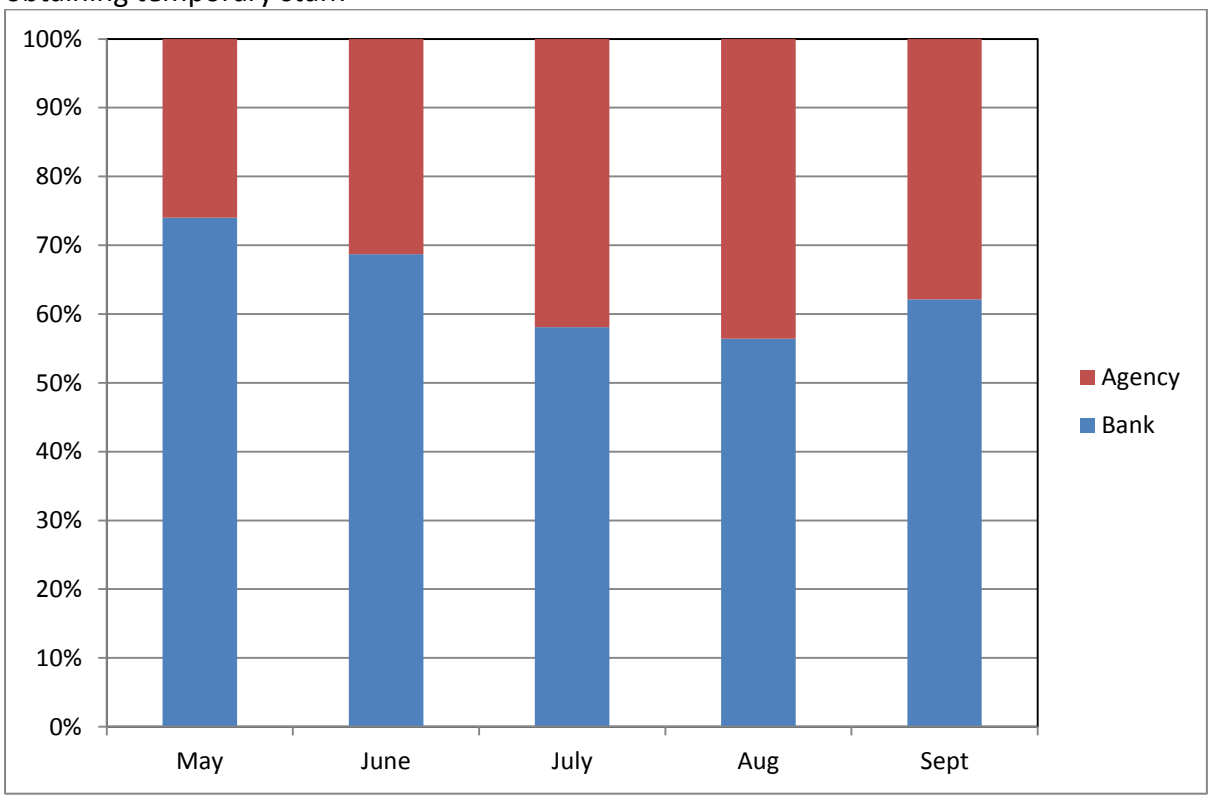

Figure 2: % temporary staff from agencies or Trust Nurse Bank

The rate of unfilled bank/agency hours also fell in September (see figure 3 below) though this remains above the figures achieved earlier in 2014/15.

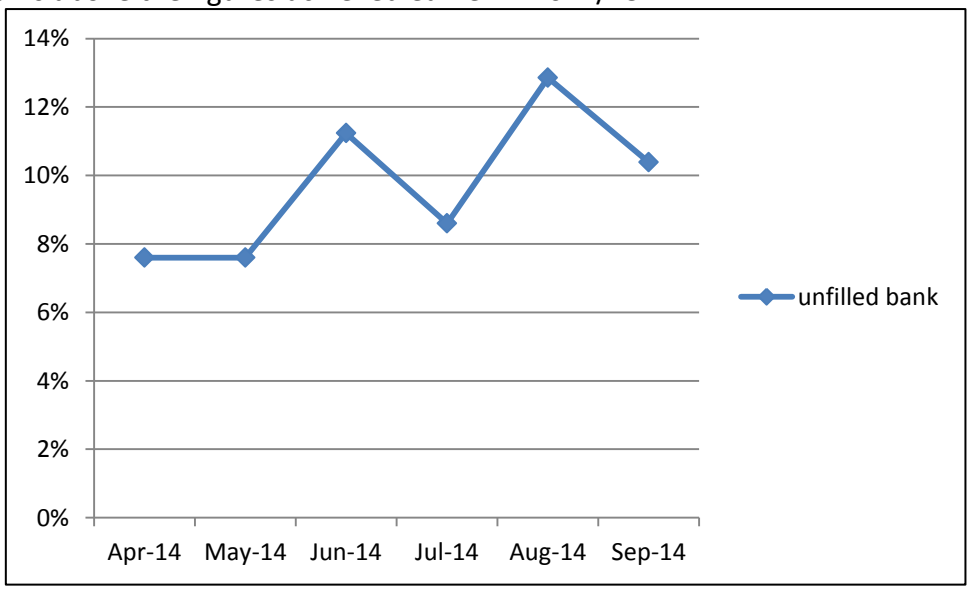

Figure 3: % of unfilled temporary staffing hours

The trust continues to maintain good ratios of nurses to patients. The adult acute ratio was 3.9 patients per nurse during September. Table 2 (see below) outlines the detail of the

ratios by shift (early, late, night). These figures are calculated by comparing the reported number of registered staff on duty to the occupancy figures at 8am, 3pm and midnight. The occupancy numbers do not include throughput, and in some instances it is known for ward throughput to be in excess of 100% (mainly Short-Stay Unit, Coxen & Adolescent Unit).

Table 2: September Average Nurse Ratios (patients per nurse)

	Shift			
Ward	**Early**	**Late**	**Night**	**All**
Spinal Cord Injury Centre	3.3	4.8	5.9	4.7
Angus Mackinnon	2.8	3.8	3.7	3.4
The Coleman Unit	2.9	3.0	3.3	3.1
Jackson Burrows Ward	3.2	4.0	3.8	3.6
Margaret Harte Ward	3.9	4.6	4.2	4.2
Ward 4	3.9	4.6	4.2	4.2
Duke of Gloucester	3.8	4.3	5.9	4.7
Ian Monro	1.8	2.2	2.7	2.2
Philip Newman	2.0	2.1	2.4	2.1
Alan Bray (ITU)	1.1	0.8	1.1	1.0
Rehabilitation	7.2	7.6	8.0	7.6
Coxen & Adolescent Unit	2.0	2.6	2.6	2.4

Following discussion with the Clinical Commissioning Group (CCG), the RNOH has also examined the actual skill mix obtained in terms of qualified staff to care staff. Table 3 outlines the detail for September.

Table 3: Qualified staff as percentage of total

Ward	Sep-14
Spinal Cord Injury Centre	50.46%
Angus Mackinnon	65.18%
Short Stay Unit (Jackson Burrows Ward & The Coleman Unit)	68.58%
Margaret Harte	68.23%
Ward 4	63.41%
Duke of Gloucester	71.16%
Coxen & Adolescent Unit	77.56%
Rehabilitation	67.55%
Private Patients Unit (Ian Monro & Philip Newman)	76.39%
Alan Bray Unit	97.45%

a) Advisory

In September 2014, one ward had less than 90% fill rates for Registered Nurses during the day shift (Spinal Cord Injury Centre). Although it has diluted the skill mix, patient safety was ensured by increasing the number of shifts available for non-registered staff. This included the Rehabilitation Assistants who are specifically trained in meeting the care needs for this patient group. The detailed chart at the end of this report shows the month on month

changes in fill rates (Figure 4). Patient safety is maintained by daily reviews of patient dependency and activity conducted by the Matron and Clinical Lead.

Clinical incidents have been reviewed; there were four incident reports relating to 'staffing levels' filed by the inpatient wards during September 2014. All directly related to ward staffing levels. These were in relation to skill mix and/or number of staff. There were no further comments relating to patients receiving sub-optimal care. One report filed by MRI Recovery noted that ward staff on Jackson Burrows were unable to collect a patient which compromised staffing levels in the MRI department. One incident was filed in regards to staff reluctance to move areas. This was the second such incident in two months. A communication has been sent to all staff from the Director of Nursing and HR outlining the Trust's view on this behaviour (see Appendix B).

Patient safety incidents (medication errors, pressure area care, slips, trip and falls and emergency calls) which may have had staffing as a contributing factor have also been reviewed. In September 2014, one medication error could potentially be attributed to skill mix (agency nurse involved) and one 'skin issue' is currently being investigated as an RCA and may indicate staffing as a factor. As the incident occurred over numerous days and in more than one departments it is difficult to conclude without the RCA findings.

The wards are aware of the high bank/agency use and a recruitment strategy is in place. A skill mix review is advised in addition to the acuity/dependency review (June 2014) which indicated that the current budgeted nursing establishment (WTE) is acceptable. Some areas should continue to consider alternative staffing groups to ensure staff with the right skills is in post to care for patients (such as Band 4 Assistant/Associate Practitioners).

The new online staffing reporting tool has been launched on the 1st October 2014. The October data analysis will be conducted using both the new and old methods to ensure the new system has the capabilities to comply with the requirements of this paper. It is not anticipated that there will be any significant issues. To ensure transparency is maintained, all staff with access to the RNOH Intranet (Grapevine) will be able to view the staffing data.

Without eRostering, the Trust continues to face challenges in regards to a lack of consistency and standardisation of roster management. Until eRostering is implemented, Matrons and Ward Managers need to ensure their staff are appropriately allocated leave (including study leave); preventing fluctuations in staffing levels as a result of poor roster management. An investigation will be undertaken to directly compare requests made with the nursing roster. Work has already begun on this by reviewing internal records of current establishments/vacancies and comparing them to the whole time equivalent total for bank/agency requests to cover vacancies. This is currently limited to Band 5, and is ongoing. It is also suggested that a comparison between 2014 and previous years be made to review the bank/agency trends. The Trust should reconsider implementing eRostering due to the quality benefits such a system could offer.

Until eRostering is implemented, the formulation of this report is based on manual processes and therefore risks discrepancies in data quality. As the process is validated by

the Project Nurse, Finance Department, Informations Team, Temporary Staffing Manager and the Director of Nursing (Acting), this risk is small.

Ongoing Plan:

The next phase of the ongoing project to ensure safe staffing levels will begin soon; in the absence of eRostering, roster management will be reviewed. This will involve standardising aspects of rostering practices across the nursing areas; including the formation of a standard template for recording a planned nursing rota, an audit of compliance against the rostering policy and a subsequent review of the rostering policy.

Report date: 10/10/14

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

Appendix A:

Table 4: % Fill rates by ward, month, and shift and staff group

Month	JUNE				JULY				AUGUST				SEPTEMBER			
Shift	Day		Night		Day		Night		Day		Night		Day		Night	
Ward	Average fill rate - registered nurses (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses (%)	Average fill rate - care staff (%)
SPINAL INJURIES UNIT	92%	94%	95%	100%	89%	96%	98%	98%	79%	95%	96%	98%	88%	99%	98%	98%
ANGUS MACKINNON WARD	97%	98%	99%	100%	96%	100%	99%	100%	93%	99%	100%	86%	96%	99%	100%	100%
SHORT STAY UNIT (JACKSON BURROWS WARD & THE COLEMAN UNIT)	96%	99%	99%	100%	98%	96%	98%	98%	97%	99%	99%	98%	96%	97%	95%	100%
MARGARET HART	96%	97%	99%	97%	95%	94%	100%	100%	97%	91%	100%	100%	96%	97%	100%	100%
WARD 4	96%	100%	100%	100%	97%	96%	100%	96%	92%	99%	97%	97%	94%	100%	100%	100%
DUKE OF GLOUCESTER	97%	99%	100%	100%	96%	97%	100%	100%	94%	96%	99%	100%	96%	99%	100%	100%
COXEN/ADU	94%	99%	100%	97%	99%	91%	100%	100%	94%	98%	99%	94%	98%	100%	98%	97%
REHABILITATION	100%	100%	100%	100%	99%	94%	100%	100%	99%	100%	100%	100%	100%	100%	100%	100%
ALAN BRAY UNIT	97%	100%	97%	-	99%	100%	100%	-	99%	100%	99%	-	99%	100%	99%	-
PRIVATE PATIENTS UNIT (IAN MONRO WARD & PHILIP NEWMAN WARD)	96%	91%	96%	95%	97%	93%	100%	98%	90%	90%	100%	98%	94%	100%	99%	100%

<80%	80-90%	100%	>100%

Table 5: Detail of hours planned and worked (September 2014)

Royal National Orthopaedic Hospital (Stanmore)		Day				Night				Day		Night	
Ward name	Specialty 1	Registered midwives/nurses		Care Staff		Registered midwives/nurses		Care Staff		Average fill rate - registered nurses (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses (%)	Average fill rate - care staff (%)
		Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours				
SPINAL INJURIES UNIT	110 - TRAUMA & ORTHOPAEDICS	2122.25	1870.25	1832.5	1816.5	1104	1080	1104	1080	88.1%	99.1%	97.8%	97.8%
ANGUS MACKINNON WARD	110 - TRAUMA & ORTHOPAEDICS	1545.25	1479.25	960.75	952.75	1068	1068	408	408	95.7%	99.2%	100.0%	100.0%
SHORT STAY UNIT (JACKSON BURROWS WARD & THE COLEMAN UNIT)	110 - TRAUMA & ORTHOPAEDICS	3463	3316.5	1557.5	1512	1762.5	1675	775	775	95.8%	97.1%	95.0%	100.0%
MARGARET HART	110 - TRAUMA & ORTHOPAEDICS	1433	1368	794	773.5	1125	1125	387.5	387.5	95.5%	97.4%	100.0%	100.0%
WARD 4	110 - TRAUMA & ORTHOPAEDICS	1961.48	1838.25	863.5	863.5	1087.5	1087.5	825	825	93.7%	100.0%	100.0%	100.0%
DUKE OF GLOUCESTER	110 - TRAUMA & ORTHOPAEDICS	1949	1873	798	790	1125	1125	425	425	96.1%	99.0%	100.0%	100.0%
COXEN/ADU	171 - PAEDIATRIC SURGERY	2301	2255.5	695.5	695.5	1512.5	1487.5	400	387.5	98.0%	100.0%	98.3%	96.9%
REHABILITATION	314 - REHABILITATION	791.75	791.75	372	372	432	432	216	216	100.0%	100.0%	100.0%	100.0%
ALAN BRAY UNIT	192 - CRITICAL CARE MEDICINE	3731	3706	186	186	3436.5	3411.5	0	0	99.3%	100.0%	99.3%	-
PRIVATE PATIENTS UNIT (IAN MONRO WARD & PHILIP NEWMAN WARD)	110 - TRAUMA & ORTHOPAEDICS	2275.5	2134	596	596	1262.5	1250	450	450	93.8%	100.0%	99.0%	100.0%

Appendix B:

Royal National Orthopaedic Hospital NHS
NHS Trust

Dear All Nursing Staff

It has been brought to my attention that on occasions when a clinical area has had a shortfall in nurse staffing due to short notice sickness absence or the inability to secure bank or agency nurses, the decision has been made to redeploy staff to an area that is experiencing low or inappropriate skill mix that could compromise patient care. It has been highlighted that in some instances to date staff have refused to be redeployed.

There will unfortunately be occasions when nursing staff are required to work in wards or areas that is not their usual place of work. Whilst, it is not an easy decision to make to move staff to another area; patient safety has to be the priority in these circumstances.

I recognise that this can sometimes lead to staff having some queries; where staff have queries or concerns they should raise these now with their relevant manager and these queries will be addressed. However it is important to note that once these queries have been considered and addressed, staff will then be expected to proceed to work in the requested areas. Equally it is important to highlight that when staff are requested to work in other areas, this is considered a reasonable management request.

As nurses employed in the organisation we have a duty of care to all the patients as well as our colleagues and in living our Trust values this is the right thing to do when the need arises.

There is a dedicated recruitment campaign in progress that is doing well and we are recruiting to our vacancies, however, there will always be sickness and this will need to be managed appropriately to ensure patient safety and care delivery. I know that as a workforce of highly skilled and caring professionals you will put your patient's first and assist whenever necessary if you are requested to work elsewhere other than your usual place of work due to shortfalls in nurse staffing.

Thank you in advance here for your continued support and co-operation.

Regards

Dr Julie-Anne Dowie, RGN/RSCN

Director of Nursing