Alder Hey Children's NHS
NHS Foundation Trust

Nurse Staffing Review

June 2014.

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Section 1. Staffing Review.

1.0 Executive Summary.

In November 2013 the Government responded to the Francis report, this response made reference to nurse staffing levels but stopped short of mandating exactly what those levels should be. This was followed quickly by the NHS Quality Board publication - ***How to Ensure the Right People, with the Right Skills, are in the Right Place at the Right Time (RPRSRT). November 2013***.

The guide details 10 expectations, 9 of which apply to provider organisations. The expectations are summarised in section 3 of this paper, followed by a current Trust position statement, summary of work in progress and challenges.

The paper clarifies the role of provider organisations and particularly Boards of Directors in decision making about nurse staffing. It also recognises that simply having enough numbers of staff in place is not sufficient, as leadership, training and development for staff; and a culture within organisations that supports staff to provide high quality care in a supportive and caring environment are also necessary.

This report describes; the Trust position in respect of progress since the previous July 2013 board staffing report, the position against the requirements of the RPRSRT report and current and future developments.

The current Trust position is greatly improved since July 2013 and this is demonstrated in the establishment figures provided. The report describes a range of recent and current developments underway to address the availability of staffing and challenges associated with recruitment. Follow through on implementation of these developments will ensure that the next board review in December and the monthly staffing shift reports will show continuous improvement.

2.0 Introduction.

Changes or deficiencies in the nursing & midwifery workforce can have a detrimental impact on the quality of care. Patient outcomes and particularly safety are improved when organisations have the right people, with the right skills, in the right place at the right time. This has been highlighted consistently in various reports, strategies and inquiries such as:

- Compassion in Practice
- the Mid Staffordshire NHS Foundation Trust Public Inquiry
- the Keogh Review into the quality of care provided by 14 hospital Trusts in England
- Don Berwick's *A promise to learn, a commitment to act: improving the safety of patients in England*
- The Cavendish review: an independent review into healthcare assistants and support workers.

In November 2013 the Government issued its full response to the 290 recommendations of the Francis Enquiry, which created a requirement for increased transparency in the way in which Trusts determine and meet nursing, midwifery and care staffing levels. It stopped short of mandating minimum staffing levels.

On 20th November 2013 the NHS Quality Board published the new guide to nursing, midwifery and care staffing capacity and capability – '*How to ensure the right people, with the right skills, are in the right place at the right time'.*

The RPRSRT guidance sets out its position for greater transparency in the way in which Trusts set and deliver nursing, midwifery and care staffing levels, along with a full description of Board and senior leaders accountability and responsibility.

The guidance makes clear it is the role of provider organisations to make decisions about nursing, midwifery and care staffing requirements, working in partnership with their commissioners, based on the needs of their patients, their expertise, and knowledge of the local context.

The guide recognises there is not a 'one size fits all' approach to establishing nursing, midwifery and care staffing capacity and capability, and this guide does not prescribe the 'right way', or a single approach, to doing so.

3. Defining Staffing Levels.

Crucially the guide does not mandate or define staffing levels, it advocates the use of evidence based tools combined with professional judgement and refers to a number of sources of standards and tools. There are only two of these relating to the care of children and the staffing levels that should be in place; Royal College of Nursing (RCN) Defining Staffing Levels for Children's and Young People's Services, updated July 2013 and the paediatric intensive care society standards. Nurse leaders at the Trust are applying both of these recommended documents in determining staffing levels.

Since publication of RPRSRT the National Institute for Health and Care Excellence (NICE) have been asked to develop guidelines and accredit tools for staffing levels that are commensurate with high quality care. It should be noted that the scoping of the NICE work demonstrates that it is focussed exclusively on nurse staffing in an adult care setting. The work will conclude by July 2014, but there is no indication as to whether NICE will undertake further work to extend the guideline to children's nursing.

The RCN standards set out **minimum** staffing ratio's as follows;

- Children under 2 years 1:3
- Children over 2 years 1:4
- Children in HDU 1:2
- Children in PICU 1:1

In addition to this Alder Hey is one of very few centres nationally providing extracorporeal membrane oxygenation (ECMO), the Alder Hey staffing standard for children on ECMO is currently 2 nursing staff to each child, 2:1.

In March 2014 NHS England and the Care Quality Commission (CQC) issued their requirements for implementation of the expectations set out in the NHSE publication and monitoring of implementation commenced in April and will conclude in June at which time provider organisations must demonstrate compliance.

Section 2 of this paper provides details of the expectations and includes a description of the current position at the Trust, work underway and identifies the challenges and risks associated with the expectation.

4. The Royal College of Nursing (RCN) Standards.

The RCN document provides one key standard that defines minimum staffing numbers by patient age or setting, noted above, and sixteen further standards that cover a range of factors delivering or supporting the delivery of nursing care.

The most recent review of nurse staffing at the Trust demonstrates compliance with the key staffing standard in appendix 1. An audit of compliance with the further sixteen standards has been undertaken and demonstrates full compliance with 11 of the 16 standards, the remaining 5 are all subject to developments in progress.

5. Changes since the July 2013 Staffing Review.

The review presented to the Board in July 2013 identified shortcomings in staffing establishments that were immediately rectified. An additional 20wte nurses were approved along with authorisation to recruit 14wte staff to the temporary winter ward on substantive contracts. These additional 34 nursing staff were recruited during August-November 2013.

Throughout the course of the year there have been further additions made as a result of business cases. Additional staffing in Neonatal Unit has been approved and implemented; a case for theatre staffing has been approved and is now in recruitment. Approval was given to create a pool of nurses who would be deployed to backfill maternity and long term sickness and to date 9 nurses have been recruited to this pool.

The staffing analysis shown in Appendix 1 identifies a **total growth of 43.22 wte** nursing staff (registered and non-registered) since July 2013.

Business cases that support HDU and AED establishment increases are pending and the business case for Safe at All Times, due for completion in September 14, will ensure compliance with RCN recommendations regarding the seniority of out of hours site managers.

Increases have been made to ward establishment uplift during the year, this is the amount of funding in the ward budget to cover annual leave, training and sickness absence. The RCN standards reflect previous Audit Commission recommendations of a minimum of 25% uplift.

Alder Hey ward budgets pre 2013 were uplifted by 19% and during 2012/13 and 2013/14 these are almost all now uplifted by 23%.

The uplift provides;

Annual leave cover	17%
Training cover	2%
Sickness cover	4%
Total	**23%**

If sickness levels rise above 4% the ward manager is required to stay within budget provided, in order to stay within budget it is likely that training standards will not be met. It is evident in training compliance data from the last 2 years that this has been a consequence of the 19% uplifts. The 23% uplift is a significant move toward achieving recommended levels.

The ward dashboard, identifying both staffing and quality performance data have been implemented in May 2014 and will be produced monthly for all wards.

6. Current Staffing Position.

Despite the significant investment in additional posts since the last Board staffing review in July 2013 the available establishment that is staff available to work as opposed to staff funded continues to present a challenge.

The table provided in appendix 1 shows that during May the total nursing workforce employed was 710wte. At this time there were 42 vacancies, 44 maternity leave posts and 62 staff through sickness, a total of 151 staff.

The table shown in appendix 2 shows the proportion of shifts in which staff numbers were lower than the agreed numbers required for the ward. This data template was provided by NHSE and represents information uploaded centrally which will be publicly available via the NHS Choices website imminently. It should be noted that in the case of a shift where numbers are lower than required and there is an inability to achieve the correct number through temporary staffing (nurse bank) a number of actions are taken to ensure that patient care is safe (see below) the data shows the total number of

shifts were staff numbers are lower than desired, but does not take into account the adjustments that are made to ensure safety.

- Temporary bed closure – beds closed for the shift/few shifts
- Supervisory/supernumerary staff deployed in the numbers
- Staff movement and using non registered staff to cover registered nurse shortfall.

Decisions regarding the management of staffing are taken on a shift by shift basis and involve senior nursing staff from ward managers to the Director of Nursing. It must be stressed that patient care is never left unsafe, but the resource required to address shortfall is high and creates an inefficient approach that senior managers have agreed they want to improve. With this in mind more recent corporate efforts to improve staffing levels have focussed on this aspect of staffing. Individual cases for staffing increases are being supported on a case by case basis.

Executives approved the creation of a nursing pool in April this year. The purpose of the pool is to have the flexibility to deploy staff into long term sickness and maternity posts without delay. To date 9 nurses have been recruited to this pool and more will be recruited as they become available.

Recent discussion has focussed on the loss of available workforce in the recruitment process, this is partly as a result of the lengthy delays in recruitment caused by external provider but additional delays are the result of our own internal processes to approve the post for recruitment initially. The decision has been made to move to “over-recruitment” in order to ensure that there is not a shortfall of staffing related to vacancies.

The resilience of the nurse bank has decreased in recent years, unfortunately this is partly attributable to our own systems and processes. The Trust is currently moving to NHS Professionals as provider of temporary staffing solutions and booking for nursing shifts went live very recently. NHSP have demonstrated comparative fill rates to the internal nurse bank but there is no restriction on numbers employed via the bank and weekly pay is available. It is believed that these benefits will increase the resilience of the bank by addressing these challenges and thereby improving bank fill rates.

Section 2. The 10 Expectations of the RPRSRT Guidance

Each expectation is accompanied by the latest Trust position and work in progress.

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.

This expectation makes it clear that the Trust Board is ultimately responsible for the quality of care and outcomes achieved and decisions regarding nursing, midwifery and care staffing lay with them. They must at any point in time be able to demonstrate to commissioners, Monitor and the CQC that systems and processes are in place to assure themselves that nursing, midwifery and care staffing capacity and capability is sufficient

Key Issues/Actions.

- Establishment reviews should be carried out every 6 months – evaluating the previous 6 months and forecasting the likely requirements for the next 6 months.
- Boards should sign off establishments for all clinical areas, articulate the rationale and evidence for agreed staffing establishments, and understand the links to key quality and outcome measures.
- Guidance on what should be contained in the Board papers is provided and is detailed in the highlighted section as follows:-

1. the difference between current establishment and recommendations following the use of evidence based tool(s).
2. what allowance has been made in establishments for planned and unplanned leave.
3. demonstration of the use evidence based tool(s).
4. details of any element of supervisory allowance that is included in establishments for the lead sister / charge nurse or equivalent.
5. evidence of triangulation between the use of tools and professional judgement and scrutiny.
6. the skill mix ratio before the review, and recommendations for after the review.
7. details of any plans to finance any additional staff required the difference between the current staff in post and current establishment and details of how this gap is being covered and resourced.
8. details of workforce metrics - for example data on vacancies (short and long-term), sickness /absence, staff turnover, use of temporary staffing solutions (split by bank /agency /extra hours and over-time), and information against key quality and outcome measures - for example, data on: safety thermometer or equivalent for non-acute settings, serious incidents, healthcare associated infections (HCAIs), complaints, patient experience/satisfaction and staff experience /satisfaction.
9. the paper should make clear recommendations to the Board, which would be considered and discussed at a public Board meeting.
10. actions agreed by the Board should be detailed in the minutes of the meeting, and evidence of sustained improvements in the quality of care and staff experience should be considered periodically.

- Monthly reporting to the Trust Board on staffing capacity and capability – providing details of actual staff available shift to shift versus planned. Exception reporting should highlight wards which frequently fall short of what is required, the reasons, impact and actions to address the issues.
- Boards should seek assurance on the processes in place to highlight risks caused by insufficient staffing capacity and capability.

Alder Hey Status.

- The Trust Board received a full review of nurse staffing in July 2013, which was the basis of investment in additional posts.
- An action plan based on the recommendations in the paper was produced and has been evaluated via the CQAC.
- Ward dashboards containing both quality and workforce information have been developed and are being implemented at the time of reporting.
- The work of the senior nurse team in recent month has focussed on plans for the new hospital, and relates to the Nurse Staffing project in the programme management system.
- Ward Manager aspiration meetings have been undertaken and Ward Manager appointments have been made.
- New Hospital ward establishments have been agreed and ward teams are being identified at the time of reporting.

Work in progress.

Requirements for full staffing review and the monthly reporting have been actioned and will be completed within the deadline.

Expectation 2

Processes are in place to enable staffing establishments to be met on a shift-to-shift basis.

This expectation sets out the requirement for the Executive Team to ensure that systems and processes are in place to support shift-to shift decisions, monitoring and actions to mitigate any identified problems. Key issues to note:

Key Issues/Actions.

- Daily reviews of actual staffing on a shift-by-shift basis versus planned staffing levels should take place between Sisters, Matrons, Heads of Nursing etc. and that where shortages are identified work takes place to seek a solution.
- E-rostering is seen as an enabler.
- Escalation policies & contingency plans should be in place to deal with times of increased pressure (high staff sickness; unfilled vacancies; increased dependency), staff know how to use them, and include a clear set of actions to be taken.
- Temporary staffing solutions should only be used to fill short term gaps.

Alder Hey Status.

Staffing is monitored through the bed meetings and shortfall is acted upon.

Escalation at Alder Hey has worked along similar lines to other provider organisations until recently, in that the process has been followed by senior nursing staff without documented policy or documented outcomes.

Very little agency nurse hours have been used in the Trust, until this most recent winter when a rise in agency usage has been evident.

Work in progress.

A desk top shortcut to a staffing spreadsheet is in development, which will act as a means for nursing staff to capture actual daily staffing and reasons/actions taken. This will provide an interim solution to support the delivery of monthly reporting and underpin decision making.

A nurse staffing policy which includes documented escalation processes is in development and expected to be implemented in late-summer.

The Trust is currently implementing to NHS Professionals bank which may help to increase temporary staffing availability through weekly payment to staff.

Expectation 3

Evidence-based tools are used to inform nursing, midwifery and care staffing capacity and capability.

This expectation recognises the complexity of determining nursing, midwifery and care staffing requirements and recommends that the numbers and skill mix of staffing is determined through triangulation of evidence based tools, and professional judgement & scrutiny.

Key Issues/Actions.

- There are a variety of evidence based tools available.
- In some areas there are no evidence based tools currently available.
- Leadership, management culture, team working on the ward, levels of education & training available to staff are also essential factors.
- Local contexts and patient needs need to be considered e.g. other support staff available, technology in place.
- NICE will be reviewing the evidence base and accrediting tools in this area.
- Determining numbers is not enough and professional judgement and local knowledge should also inform the skill mix of staff.
- Senior nursing and midwifery staff should be appropriately trained in the use of evidence based tools and interpretation of their outputs.

Alder Hey Status.

There are a number of dependency scoring tools on the market and senior nurses have evaluated a number of them. The SCAMP tool was selected and used in the 2013 review and is currently being implemented in all wards.

Work in progress.

SCAMP has been implemented and is live in all wards since May.

Expectation 4

Clinical and managerial leaders foster a culture of professionalism and responsiveness, where staff feel able to raise concerns.

This expectation highlights the impact that staff engagement has on patient outcomes and the importance that the organisational culture encourages and listens to staff.

Key Issues/Actions.

- Clear process in place to raise concerns including whistleblowing policies.
- Providers must comply with Duty of Candour requirements.

- Staff side representatives can provide support to ensure staff views are considered.
- Staff should feel supported to raise concerns.
- Line managers should ensure staff are managed effectively, they have constructive appraisals and clear objectives set.
- Teams should be wells structured with supportive line management at every level
- Technological advances can free up staff time to focus on delivering patient care.

Alder Hey Status.

The senior nurse leadership team are working closely with ward based staff to identify and act on any concerns

Work in progress.

The Raise it, Change it campaign was launched in May and is currently being embedded.
Staff will be able to see that change does occur as a result in order to feel supported and be confident to use it.
There is significant work progressing, in developing the use of IT systems, including Meditech 6, EPR, E prescribing.

Expectation 5.

A multi-professional approach is taken when setting nursing, midwifery and care staffing establishments.

This expectation sets out the roles and responsibilities for nursing, midwifery and care staffing capacity and capability, recognising the complex interdependencies between this group and other parts of an organisations structure and functions.

Key Issues/Actions.

- Directors of Nursing lead the process of reviewing staffing requirements, and ensure there are processes in place to actively involve sisters, charge nurses or team leaders.
- Papers to the Trust Board are as a result of team working and reflect an agreed position.
- Other Directors–Medical, Finance, Workforce and Operations have responsibilities in this area, recognising the clear interdependencies between professions and administrative support to non-clinical aspects of the nursing, midwifery and care staffing workload.
- Ward sister/charge nurses should be empowered to take responsibility for their clinical areas, with delegated authority to act, supported by their organisations.
- Non-Executive Directors must ensure robust systems and processes are in place to make informed and accurate decisions regarding workforce planning and provision; review data on workforce, quality of care and patient safety and hold Executive Directors to account for ensuring that the right staff are in the right place to provide high quality care and ensure impacts of decisions taken at Board level, consider staffing capacity and capability and quality and outcomes measures.

Alder Hey Status.

The Deputy Director of Nursing leads the nursing and midwifery staffing review processes which includes ward sisters, charge nurses and lead nurses.

Work in progress.

Staffing reviews will be discussed at Executive team meetings to ensure that the whole team are aware of any issues and concerns, and are able to support change or resource that may be required.

Expectation 6

Nurses, midwives and care staff have sufficient time to fulfil responsibilities that are additional to their direct caring duties.

This expectation sets out the need to ensure that establishments take account of the requirement for nurses, midwives and care staff, to undertake continuous professional development, and to fulfil mentorship and supervision.

Key Issues/Actions.

- Establishments should enable time for ward sister/charge nurses or team leaders to assume supervisory status.
- Establishment uplifts should allow for staff training and development; supervision and mentorship roles, including for students and for periods of induction of new staff; planned and unplanned leave.
- These uplifts should be determined by Trusts based on realistic estimations.

Alder Hey Status.

The funded establishment should provide sufficient uplift to cover annual leave, learning and development needs, sickness absence, this should be flexible and determined locally and take into account local sickness rates, skill mix and turnover rates. The Audit Commission recommend a minimum of 25% with flexibility for increased uplift as required. Alder Hey uplift rates vary between 19% and 23% and are fixed.

Work in progress.

Within the last year the majority of areas, with limited exceptions, have been increased to 23%

Expectation 7

Boards receive monthly updates on workforce information, and staffing capacity and capability is discussed at a public Board meeting at least every six months on the basis of a full nursing and midwifery establishment review.

This expectation aligns to the first expectation and reiterates the Boards accountability

Key Issues/Actions.

- Boards are accountable for patient outcomes they achieve within the staffing capacity and capability in place.
- Boards must assure themselves there are systems in place to regularly assure themselves that there is sufficient nursing, midwifery and care staffing capacity and capability on a shift-by-shift basis.
- Establishment reviews should be carried out every six months and all nursing, midwifery and care staffing levels and key quality outcomes measures should be discussed at Trust Board level in a public meeting. For those Trusts not already doing so they must start this process by April 2014 and discuss at a Public Board

meeting by June 2014.

- The Board should receive monthly reports on actual versus planned staffing on a shift-by-shift basis and outline areas where there are gaps, the impact and steps taken to address the issue.
- Reports should be published in a form accessible to patients and the public.
- By summer of 2014 it is expected that this data is collated alongside an integrated safety data set that will provide information down to ward level, where appropriate, and available by a single national website accessible to patients and the public.

Alder Hey Status.

The Ward dashboards developed since the 2013 staffing review includes the safety data set and shows a generalised view of staffing availability, versus funded establishment, based on staff unavailable through sickness, maternity leave or vacancies.

Work in progress.

The development of a tool to capture shift by shift data at ward level and record reasons for shortfall and action taken has been implemented, the first data was uploaded as required in June and will continue monthly.

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.

The drive for transparency of staffing information is key within this expectation, which sets out requirements for display of information to patients and the public.

Key Issues/Actions.

- Information should be displayed to patients and the public, which outlines what staff, are present and their roles.
- Information displayed should be visible, clear, accurate and helpful.
- Additional information such as a guide to uniforms and titles should also be considered for display – appropriate to local needs.
- Should be clear who is in charge within the ward, the named clinician and nurse in charge of a patients care displayed above the patient's bed.

Alder Hey Status.

This requirement to display information will be met by the end of June 2014.

Work in progress.

An immediate, temporary solution is being developed to have staffing levels on display in wards by the due date at the end of June.

Information relating to roles, uniforms etc. is being prepared to accompany the displayed levels.

Names of children are not displayed above beds, this is a result of concerns relating to safeguarding and medicine administration. This issue will be re-visited by senior nurses to identify if there are now new approaches that should be considered.

Expectation 9

Providers of NHS services take an active role in securing staff in line with their workforce requirements

This expectation sets out the responsibilities on providers, Local Education and Training

Boards (LETBs), and Health Education England (HEE).

Key Issues/Actions.

- Providers must actively manage their existing workforce and have robust plans in place to recruit, retain and develop all staff.
- Providers share staffing establishments and annual service plans with their LETB in order to inform education and training commissioning plans and strategies.
- Staffing establishment and annual service plans shared with regulators for assurance.
- Each provider must be a member, or represented on their LETB
- HEE is responsible for developing a Workforce Plan for England.

Alder Hey Status.

A Trust workforce plan has been developed to support our move to Alder Hey in the Park in 2015 and beyond, and explains and quantifies which services and groups face staffing challenges going forward; it also proposes ways in which this need might be met. Revised Health Education England (HEE) workforce planning system guidance issued April 2014 will form the basis of the plans going forward in time for their submission by to the LETB by 18 July 2014.

An active programme of recruitment of newly registered RSCN's is currently underway and the Executive Directors have supported the recruitment of graduates between now and the move into the new hospital.

The Board of Health Education North West has established and supports three Local Workforce Education Groups (LWEGs) whose purpose is to establish local priorities, identify local issues and generate ideas for transformational change in the healthcare workforce. The Trust's Medical Director is a member the of Cheshire & Merseyside LWEG.

Work in progress.

Senior nurses are aware of the potential retirement bubble with a significant proportion of the nursing workforce aged over 50 and still eligible for retirement at 55. Evidence from other organisations that have occupied new hospital premises suggests that there is a natural increase in retirement numbers associated with hospital moves. This work needs to include the senior nursing leadership team and specialist nursing cohort as almost all sit within this age range. This work is being addressed within the New Hospital Staffing project.

The Education, Learning & Development Strategy is currently under review, with a focus on the key areas of developing our future workforce and strengthening our partnerships with key educational providers and education commissioners.

Expectation 10 - Commissioner requirement for information

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.

This expectation although primarily aimed at commissioners, has implications for provider organisations

Key Issues/Actions.

- When setting local prices in contracts due consideration to impact on staffing should be made.
- Commissioners must monitor maintain a close dialogue regarding any issues related to service safety and staffing levels.
- Commissioners should seek assurance that Cost Improvement Programmes have clinical ownership within providers and do not threaten service quality.

- The 2014/15 standard NHS contract is expected to set out requirement for providers to report data on actual versus planned staff available on a shift-to-shift basis.

- Commissioners share intelligence with regulatory partners.

2.2

Care Quality Commission/NHS England Requirements

Section A.

The Board receives 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 report:

1. Draws on expert professional opinion and insight into local clinical need and context.
2. Makes recommendations to the Board which are considered and discussed.
3. Is presented to and discussed at the public Board meeting.
4. Prompts agreement of actions which are recorded and followed up on.
5. Is posted on the Trust's public website along with all the other public Board papers.

Section B.

The Trust clearly displays information about the nurses, midwives and care staff present and planned in each clinical setting on each shift. This should be visible, clear and accurate, and it should include the full range of patient care support staff (HCA and band 4 staff) available in the area during each shift. It may be helpful to outline additional information that is held locally, such as the significance of different uniforms and titles used.

To summarise, the displays should:

1. Be in an area within the clinical area that is accessible to patients, their families and carers
2. Explain the planned and actual numbers of staff for each shift (registered and non-registered)
3. Detail who is in charge of the shift
4. Describe what each member of the team's role is
5. Be accurate

Section C.

The Board:

1. Receives an update containing details and summary of planned and actual staffing on a shift-by-shift basis.
2. Is advised about those 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.
3. Evaluates risks associated with staffing issues.
4. Seeks assurances regarding contingency planning, mitigating actions and incident reporting.
5. Ensures that the Executive Team is supported to take decisive action to protect patient safety and experience.

6. Publishes the report in a form accessible to patients and the public on their Trust website (which could be supplemented by a dedicated patient friendly 'safe staffing' area on a Trust website).

Section D.

The Trust will ensure that the published monthly update report specified in Section C [i.e. the Board paper on expected and actual staffing], is available to the public via not only the Trust's website, but also the relevant hospital(s) profiles on NHS Choices. The latter can be achieved either by placing a link to the report that is hosted on the Trust website on the relevant hospital(s)' news feed on their NHS Choices webpage, or by uploading the relevant document to the relevant hospital(s)' NHS Choices news feed.

For Trusts with multiple hospital sites that have their own NHS Choices web pages, this will require the separate posting of the Trust Board report to each hospital news feed. However, this is likely to reach more patients given that patients tend to review hospital, not Trust, NHS Choices web pages. This approach will also allow you to highlight hospital-specific plans and achievements, which may be of particular interest to a public audience.

Given these requirements, the update reports should be written in a form that is accessible and understandable to patients and the public. This is likely to include ensuring that the information on staffing is not embedded within hundreds of pages of other Board papers.

Your own NHS Choices web editor(s), who already provide your Trust and hospital-specific content to NHS Choices, will be able to advise you further on their preferred mechanism for making these documents available on NHS Choices – either via a link or by uploading a pdf of the Board paper. NHS Choices will also be liaising directly with each Trust's web editors with further information.

Section E.

The Trust:
- Reviews the actual versus planned staffing on a shift by shift basis.
- Responds to address gaps or shortages where these are identified.
- Uses systems and processes such as e-rostering and escalation and contingency plans to make the most of resources and optimise care

Appendix 1

CBU	Ward Area	Bed Numbers	Funded Nursing Posts 07/13	Funded Nursing Posts 05/14	Difference 07/13 to 05/14	Funded RN/HCA Difference - / +	% Registered Nurses	Uplift included in establishment for absence cover	Age Profile - % under 2 years	Nurse to Patient Ratio	WTE lost through vacancies	WTE lost through mat leave	WTE lost through sickness	Total WTE lost	% of core staffing establishment available
Med Specs	C2	13	22.68	26.68	4.00	+	75%	23%	43%	1 : 3.25	4.54	1.00	0.83	6.41	76%
Med Specs	E3	14	23.34	27.14	3.80	+	73%	23%		1 : 3.54	4.36	1.90	1.78	8.11	70%
Med Specs	C3	12	18.63	18.63	0.00	No change	82%	23%	23%	1 : 3.96	0.66	1.55	3.31	5.69	69%
Med Specs	D2 Total	13	8.55	11.55	3.00	+	81%	23%	n/a	n/a	2.87	0.00	0.06	2.94	75%
Med Specs	Oncology Tota	25	36.06	36.06	0.00	No change	86%	23%	17%	1 : 4.05	2.32	3.00	3.68	9.08	75%
SCACC	HDU	14	57.88	57.88	0.00	No change	92%	23%	n/a	1 : 1.32	-0.97	10.84	5.22	15.17	74%
SCACC	PICU	22	144.08	144.09	0.01	+	94%	23%	n/a	1 : 0.81	-6.29	10.39	9.71	13.87	90%
SCACC	K1	35	14.67	14.67	0.00	No change	86%	23%	49%	n/a	0.20	0.00	1.48	1.76	88%
SCACC	K2	20	35.35	35.35	0.00	No change	88%	23%	n/a	1 : 3.22	0.47	0.00	4.92	5.52	84%
SCACC	K3	14	23.05	23.05	0.00	No change	83%	23%	42%	1 : 3.67	2.70	1.00	1.77	5.55	76%
SCACC	M3	14	22.12	21.48	-0.64	-	88%	23%	34%	1 : 3.72	-0.29	2.50	4.16	6.55	70%
SCACC	Neonates	12	20.10	25.79	5.69	+	92%	23%	n/a	1 : 2.54	3.67	1.92	0.28	5.88	77%
NMSS	E2	14	25.16	25.16	0.00	No change	89%	23%	13%	1 : 3.15	2.09	1.92	1.68	5.76	77%
NMSS	M2	5	16.59	16.59	0.00	No change	94%	23%	n/a	1 : 1.61	0.08	0.61	1.09	1.84	89%
NMSS	L2	16	14.68	18.48	3.80	+	96%	23%	25%	1 : 4.52	0.95	0.00	1.77	2.81	85%
NMSS	Neuromed	14	28.35	32.35	4.00	+	66%	23%	21%	1 : 3.29	0.05	0.00	3.16	3.31	90%
NMSS	Neurosurg	16	41.89	41.89	0.00	No change	83%	23%	35%	1 : 2.31	1.97	1.80	5.89	9.80	77%
NMSS	LTV/TCU	4	30.48	30.48	0.00	No change	n/a	23%	n/a	1 : 2.96	6.32	1.00	4.45	11.93	61%
ICS	MAU1	14	23.86	24.13	0.27	+	78%	23%	45%	1 : 3.76	5.00	1.80	2.33	9.23	62%
ICS	MAU2	10	0.00	18.74	18.74	+	71%	23%	45%	1 : 3.79	0.00	0.00	0.00	0.00	100%
ICS	AED Total	0	38.82	39.37	0.55	+	86%	23%	n/a	n/a	6.92	2.50	2.70	12.17	69%
ICS	Dewi Jones	7	20.27	20.27	0.00	No change	55%	23%	n/a	1 : 3.14	4.81	1.00	2.17	8.08	60%
			666.61	**709.83**	**43.22**						**42.43**	**44.73**	**62.44**	**151.46**	

Appendix 2

Staffing Data: Fill Rates by ward

(planned hours/divided by actual hours)		May-14											
		Registered - DAY			Registered - NIGHT			HCA - DAY			HCA - NIGHT		
Medical Specialties		Planned	Actual	%	Planned	Actual	%	Planned	Actual	%	Planned	Actual	%
C2	Cubicle Isolation, Mainly Respiratory	1426	1414.5	99%	1426	1150	81%	356.5	322	90%			
C3	Renal, Rheumatology, Haematology	1069.5	989	92%	1069.5	713	67%	356.5	345	97%			
E3	Gastroenterology, some Cystic Fibrosis	1426	1230.5	86%	1426	1058	74%	356.5	172.5	48%			
Oncology	Oncology Patients	1782.5	1886	106%	1782.5	1598.5	90%	356.5	264.5	74%			
Total		5704	5520	97%	5704	4519.5	79%	1426	1104	77%			
SCACC													
K3	Urology, General Surgery	1426	1242	87%	1069.5	954.5	89%	356.5	333.5	94%			
M3	General Surgery	1426	1150	81%	1069.5	885.5	83%	356.5	241.5	68%			
NEO	Neonatal Ward – 28 days and under	1782.5	1587	89%	1426	1345.5	94%	356.5	299	84%	356.5	207	58%
HDU	High Dependency Care	4634.5	2967	64%	4634.5	2886.5	62%	356.5	230	65%	0	23	
ICU	Critical Care	9269	7981	86%	9269	7877.5	85%	356.5	333.5	94%	356.5	310.5	87%
K2	Cardiac Surgery	2852	2323	81%	2495.5	1989.5	80%	356.5	241.5	68%	356.5	276	77%
Total		21390	17250	81%	19964	15939	80%	2139	1679	78%	1069.5	816.5	76%
NMSS													
E2	Orthopaedics	1426	1357	95%	1069.5	1023.5	96%	356.5	230	65%	356.5	195.5	55%
NMW	Neurology	1426	1380	97%	1069.5	1023.5	96%	713	575	81%	713	471.5	66%
NSW	Neurosurgery	2139	1920.5	90%	1782.5	1334	75%	356.5	356.5	100%	356.5	356.5	100%
L2	Plastic Surgery, ENT	1207.5	1092.5	90%	724.5	770.5	106%	241.5	161	67%			
M2	Burns	1069.5	885.5	83%	713	655.5	92%						
TCU	Transitional Care	356.5	356.5	100%	356.5	356.5	100%	1426	1426	100%	1426	1426	100%
Total		7624.5	6992	92%	5715.5	5163.5	90%	3093.5	2748.5	89%	2852	2449.5	86%
ICS													
MAU	General Medicine <48 hours stay	1426	1345.5	94%	1069.5	1023.5	96%	356.5	299	84%	356.5	345	97%
MAU2	General Medicine <48 hours stay	1069.5	1219	114%	1069.5	874	82%	356.5	287.5	81%	356.5	345	97%
DJU	Psychological Services	839.5	1012	121%	713	437	61%	839.5	816.5	97%	356.5	517.5	145%
Total		3335	3576.5	107%	2852	2334.5	82%	1552.5	1403	90%	1069.5	1207.5	113%
Total All		38053.5	33338.5	88%	34235.5	27956.5	82%	8211	6934.5	84%	4991	4473.5	90%