Sherwood Forest Hospitals NHS
NHS Foundation Trust

Board of Directors

Subject: Nurse Staffing Report
Date: 14th September 2015
Author: Adele Bonsall Practice & Professional Development Matron
Lead Director: Susan Bowler- Executive Director of Nursing & Quality

Executive Summary

In line with national guidance published in May 2014 the Board of Directors receive a monthly nurse and midwifery staffing report of which:

- Provides detailed data analysis on a shift by shift basis of the planned and actual staffing levels across all in-patient wards
- Includes an exception report where the actual nurse staffing levels have either failed to achieve or have exceeded agreed local staffing thresholds.
- Triangulates the actual nurse staffing levels reported against a number of predetermined patient outcome measures in order to evidence whether patient harm events have occurred as a result of nurse staffing issues being identified.

The overall nurse staffing fill rate for August 2015 was 103.02%, (105.78 July 2015); this figure is inclusive of Registered Nurses / Midwives (RN/M) and Health Care Assistants (HCA) during both day and night duty periods. Table 1 provides further detail regarding nurse staffing fill rates by individual hospital site.

The average fill rates across two of the three hospital sites maintained or exceeded agreed safe staffing thresholds, while Mansfield Community Hospital (MCH) provided evidence of a reduced average fill rate, this was a slight increase from the previous month and is in relation to their increased establishments; they maintained the minimum staffing level of 1-8 patients.
In August, 12 wards recorded a registered nurse (RN) fill rate of less than 90%, this is an increase of previous months which involved 9 wards. The details of the wards with the lowest fill rate are included in the divisional accounts.

In response to the feedback provided by the Care Quality Commission (CQC) following their recent visit a decision was made to continue to use the safer nursing care tool on a daily basis, its aim is to provide a consistent confirmation and evidence to support the safe staffing of our wards and departments. At an operational level, it provides a structured approach to staff allocation and risk assessment, facilitating effective management of staffing levels, enabling all involved to make supported decisions relating to both the safety and quality aspects of care.

The medical division are currently trialling different methods to proactively manage staffing, the ward sisters, charge nurse and matrons are working closely together to provide a robust system of challenging and support to all ward areas. A twice weekly staffing review meeting is supported by a daily staffing coordinator, who is able to respond to the daily demands that arise due to the challenges staffing vacancies provide.

The medical matrons and divisional matron continue to support the recruitment process, both locally and internationally, the forthcoming months will see an increased permanent registered nurse workforce following success on visits to the Philippines, Romania, Rome and Spain.

Recommendation:- The board are asked to • Note the outcome of the UNIFY submission • Note the reduction in harms • Note that processes are in place and under review to manage the current risk in relation to nurse staffing.	
Relevant Strategic Priorities (please mark in bold)	
To consistently deliver a high quality patient experience safely and effectively	To develop extended clinical networks that benefit the patients we serve
To eliminate the variability of access to, and outcomes from our acute services	**To provide efficient and cost-effective services and deliver better value healthcare**
To reduce demand on hospital services and deliver care closer to home	
How has organisational learning been disseminated	The paper compiled in collaboration with Divisional Matrons and Matrons. The final paper is disseminated to Divisional Matrons and Matrons
Links to the BAF and Corporate Risk Register **Details of additional risks associated with this paper** *(may include CQC Essential Standards, NHSLA, NHS Constitution)*	Principle Risk 1:- Inability to maintain the quality of patient services demanded. Failure to maintain staffing levels that reflect the needs of patients and are sufficiently flexible to support variability in demand. Failure to maintain staffing levels that reflect the needs of patients and are sufficiently flexible to support variability in demand.
Links to NHS Constitution	
Financial Implications/Impact	Increase in agency expenditure to cover enhanced observation shifts
Legal Implications/Impact	
Partnership working & Public Engagement Implications/Impact	N/A
Committees/groups where this item has been presented before	The content of the paper are discussed at Nursing Workforce Development Group on a monthly basis
Monitoring and Review	Monthly review
Is a QIA required/been completed? If yes provide brief details	Yes for bed reduction plans

TRUST BOARD OF DIRECTORS – September 2015
NURSE AND MIDWIFERY STAFFING REPORT
(REPORTING PERIOD August 2015)

1. INTRODUCTION

In 2014 the Trust made its mandatory submission of nurse staffing levels as directed by the National Quality Board and the National Commissioning Board's publication 'How to ensure the right people with the right skills are in the right place, at the right time'. This data is published on NHS Choices as part of their Patient Safety in the NHS section, which incorporates a range of patient safety indicators including 'safe staffing'.

In 2014 the Trust Board agreed to a £4 Million investment in nurse staffing. The decision taken by the Board pre-dates, but reflects the principles contained within the 'Safe staffing for nursing in adult inpatient wards in acute hospitals' published by National Institute for Clinical Excellence (NICE) in July 2014. A key principle of this guidance is the use of systematic evidence based approach to reviewing staffing levels underpinned by professional knowledge and experience.

On 11th June 2015, the Chief Nursing Officer (CNO) Jane Cummings circulated a letter to all Directors of Nursing. In this communication she confirmed that existing NICE guidance will continue to apply and shared the next steps to be taken to ensure the NHS is safety staffed.
The contents of this letter will be reflected within our next 6 month staffing review.

In line with national guidance published in May 2014 the Board of Directors receives a monthly nurse and midwifery staffing report which:

- Provides detailed data analysis on a shift by shift basis of the planned and actual staffing levels across all in-patient wards.
- Includes an exception report where the actual nurse staffing levels have either failed to achieve or have exceeded agreed local staffing thresholds.
- Triangulates the actual nurse staffing levels reported against a number of predetermined patient outcome measures in order to evidence whether patient harm events have occurred as a result of nurse staffing issues being identified

2. NATIONAL REQUIREMENTS FOR STAFFING DATA COLLECTION

The report forms part of the organisation's commitment in providing open, honest and transparent nurse staffing information through the publication of this data both on the Trust and NHS Choices Websites. In addition to this the organisation is mandated to undertake a trust-wide nurse staffing review (Safer Nursing Care Tool) on a six monthly basis in order to seek assurance that current staffing levels are sufficient to accommodate the acuity and dependency needs of patients within our care. The trust-wide nurse staffing review was last presented to Board in April 2015.

3. SAFER NURSING CARE TOOL (previously called AUKUH)

Using the Safer Nursing Care Tool methodology the trust commenced its twice yearly data collection in August. This tool provides detailed and continuous monitoring of patient's acuity and dependency levels and its association to nurse staffing levels. The summer data collection commenced on 3rd August 2015, and was collected at ward level between 14-00 and 15-00, 7 days a week. The work was co-ordinated and overseen by Michelle Platt, Nurse Consultant for Critical Care, and will be reported and presented in the six monthly Board staffing paper in October 2015.
In feedback provided by the Care Quality Commission (CQC) following their June 2015 visit, they highlighted concerns about safe staffing within wards at Sherwood Forest Hospitals. This particularly related to the acuity and dependency requirements of patients, how these were

escalated and the match between patient required need and staff available to provide the care. A number of actions have been taken to immediately respond to these concerns, this includes;

- Continuing to use the safer nursing care tool on a daily basis. Its aim is to provide a consistent confirmation and evidence of patient acuity and dependency which is then matched against available staffing. At an operational level, it is a structured approach to staff allocation and risk assessment, facilitating effective management of staffing levels in real-time based on patient need. Enabling all involved to make supported decisions relating to both the safety and quality aspects of care and offers improved transparent evidence of the decision making process.
- Secondly, a review is being undertaken of the processes by which information is escalated through the nursing and trusts patient flow/bed management system to ensure that information is more responsive, transparent, and reflective of patient need related to their acuity and dependency. From a staffing perspective improved processes are expected to support more effective redeployment of our staffing resource.

4. TRUSTWIDE OVERVIEW OF PLANNED VERSUS ACTUAL NURSING HOURS

The overall nurse staffing fill rate for August 2015 was 103.02%, (105.78 July 2015); this figure is inclusive of Registered Nurses / Midwives (RN/M) and Health Care Assistants (HCA) during both day and night duty periods. Table 1 provides further detail regarding nurse staffing fill rates by individual hospital site.

Table 1: Registered Nurse (RN) / Registered Midwife (RM) & Health Care Assistant (HCA) Fill Rates (%) August 2015

August 2015	**Day**	**Day**	**Night**	**Night**
Site Name	Average Fill Rate RN/RM	Average Fill Rate HCA	Average Fill Rate RN/RM	Average Fill Rate HCA
KMH	92.4%	103.3%	97.0%	108.6%
MCH	82.4%	124.1%	99.5%	123.3%
NWK	98.4%	103.2%	96.0%	108.1%

The average fill rates across two of the three hospital sites maintained or exceeded agreed safe staffing thresholds, while Mansfield Community Hospital (MCH) provided evidence of a reduced average fill rate, this was a slight increase from the previous month and is in relation to their increased establishments; they maintained the minimum staffing level of 1-8 patients.
In August, 12 wards recorded a registered nurse (RN) fill rate of less than 90%, this is an increase of previous months which involved 9 wards.
The details of the wards with the lowest fill rate are included in the divisional accounts.

5. DIVISIONAL OVERVIEW OF PLANNED VERSUS ACTUAL NURSING STAFFING FILL RATES

The Divisional Nurses, Matrons and Ward Sisters / Charge Nurses use the information from the Unify returns and triangulate with the Ward Assurance Framework to provide a comprehensive overview of each ward. This enables the whole nursing team to focus attention and resources on clinical areas that may require additional support or escalation.

5.1 EMERGENCY CARE AND MEDICINE

Table 2. Emergency Care & Medical Division Actual Nurse Staffing Fill Rates (August 2015)

Ward	Day Shift (Actual Nurse Staffing Fill Rate %)		Night Shift (Actual Nurse Staffing Fill Rate %)	
	RN	HCA	RN	HCA
EAU	89.5%	94.9%	95.2%	100.5%
22	100.5%	100.0%	100.0%	101.6%
23	97.1%	103.2%	100.0%	100.0%
24	99.5%	112.9%	100.0%	124.2%
34	96.2%	105.4%	98.9%	104.8%
35	97.3%	116.7%	88.2%	135.5%
36	105.9%	98.9%	100.0%	103.2%
41	98.9%	133.3%	98.9%	158.1%
42	97.8%	102.2%	100.0%	117.7%
43	83.2%	86.6%	89.7%	93.5%
44	98.4%	146.8%	97.8%	159.7%
51	100.5%	118.8%	98.9%	141.9%
52	87.9%	95.6%	105.4%	127.4%
Stroke Unit	93.0%	97.1%	97.8%	102.4%
Chatsworth	85.5%	140.0%	100.0%	167.7%
Lindhurst	88.7%	100.8%	98.4%	102.2%
Oakham	73.8%	127.4%	100.0%	100.0%
Sconce	97.8%	102.2%	94.6%	112.9%

The actual nurse staffing fill rates in August fluctuated between 73.8% and 167.7%. The information provided below explains these rates and actions in place to both support and reduce them in the future.

There are 4 areas on the Kings Mill site whose rates were below the 90% fill rate, 3 of these in acute care areas and 1 on the delayed transfer of care ward (DTOC). The 3 acute areas each have the ability to fluctuate the staffing levels to respond to their patients' needs and the demands of their service. Emergency Admissions Unit (EAU) by reducing its bed occupancy rate, Ward 43 by the number of patients requiring level 2 care for Non-Invasive Ventilation (NIV) and Ward 52 by utilising the Registered Mental Health Nurses (RMN)'s based on the ward who do not ordinarily take a team

of patients. The DTOC ward shows an under fill at night and this has been enacted due to the need to maintain safety in the whole organisation, utilising the acuity and dependency tool a risk assessment has been completed when under fill has occurred and the DTOC area has been identified as the least risk.

The on-going challenge remains in relation to the need to increase the establishment on ward 43, to respond to the required 1 to 2 patient ratio compulsory for care of level 2 patients which was not included in the year's ward establishment or budget planning. This need was confirmed during the recent CQC visit. Whilst this requirement is to ensure that patients with the higher level of acuity receive appropriate attention, ensuring appropriate staff are always available to meet the heightened ration remains difficult due to the Trusts vacancy levels. The requirements however have been met.

The robust assessment and re-assessment of patients who required Enhanced Observation has continued and the reduced overfills of HCA's at night continues and is maintained at eight of the fifteen wards, while the day shift overfill sees a slight increase by one ward to seven of the fifteen wards. Where possible, patients who require enhanced observation are cohorted together, to reduce the numbers of staff required; however, this is only possible if patients requiring observation are the same sex and their needs can be met in a shared environment.

The medical division are currently trialling different methods to proactively manage staffing, the ward sisters, charge nurse and matrons are working closely together to provide a robust system of challenging and support to all ward areas. A twice weekly staffing review meeting is supported by a daily staffing coordinator, who is able to respond to the daily demands that arise due to the challenges staffing vacancies provide.

The medical matrons and divisional matron continue to support the recruitment process, both locally and internationally, the forthcoming months will see an increased permanent registered nurse workforce following success on visits to the Philippines, Romania, Rome and Spain.

The three rehabilitation wards at MCH show a reduced fill rate during the day, the matron is both aware and closely managing the situation, agreeing with the ward sisters to reduce back to their 3 registered staff numbers during the day as sickness, vacancies and annual leave has prevented them from enacting their increased establishment of 4 registered. The increased use of HCA's is evident in two of the three areas in a response to the reduced fill of registered staff.

Sconce ward at Newark has continued to maintain the reduction of 10 beds due to the staffing vacancies within this area. While this reduction has supported the vacancies the RNs at night have been increased to 3, to ensure safe staffing levels within budget (in line with 'Keogh' recommendations and our other inpatient wards). This bed reduction and increased staffing continues to have a positive impact on reducing the number of falls, including falls with harm.

The organisation continues to exceed the agreed fill rates in a number of areas for HCA's which is in response to the increased acuity and dependency of patients on the wards; this is always more noticeable on nights as most areas drop by 1 HCA at night and they become no longer able to manage the levels of Enhanced Observations within the funded establishments.

Table 3. Newark Hospital Actual Nurse Staffing Fill Rates (August 2015)

Ward	Day Shift (Actual Nurse Staffing Fill Rate %)		Night Shift (Actual Nurse Staffing Fill Rate %)	
	RN	HCA	RN	HCA
Fernwood	100.0%	104.8%	100.0%	103.2%

The areas now covered by the medical and surgical division have been added to their respective reports leaving Fernwood, who continues to maintain within the agreed thresholds.

6. PLANNED CARE AND SURGERY

Table 4. Planned Care & Surgery Division Actual Nurse Staffing Fill Rates (August 2015)

Ward	Day Shift (Actual Nurse Staffing Fill Rate %)		Night Shift (Actual Nurse Staffing Fill Rate %)	
	RN	HCA	RN	HCA
11	100.0%	100.0%	100.0%	158.1%
12	79.0%	119.4%	100.0%	101.6%
14/SAU	94.5%	95.2%	100.0%	91.4%
31/21	80.6%	97.3%	98.9%	103.2%
32	74.6%	101.1%	100.0%	100.0%
ITU	106.9%	74.2%	104.4%	67.7%
DCU	92.7%	82.0%	87.3%	85.7%
NICU	84.5%	83.9%	84.5%	61.3%
25	78.1%	96.0%	82.8%	74.2%
Inpatient Maternity	96.0%	96.0%	101.1%	86.3%

Within the Planned Care & Surgery Division, actual nurse staffing fill rates reported during August fluctuated between 74.6% and 106.9% for RNs and 74.6 and 158.1% for HCAs; the following section provides further information to explain the shortfalls/overfills.

NB: the role and function of the HCA in the Intensive Therapy Unit (ITU), Maternity and Neonatal Intensive Care Unit (NICU) are very different to the general/adult wards. They provide less unsupervised direct patient care than HCAs on the adult wards, given the critical care needs of the patients. They work alongside an RN/M, providing care under their direct supervision, as well as providing a more general support role within the unit, to release the RN/Ms from non-patient or indirect care duties. As such, their role across the 24 hour period is invaluable; however, if a shift is not filled (for whatever reason) the units have found from experience that bank/agency HCAs are not able to meet the needs of their patient group or the support function and so represent poor value for money. A decision is taken by the shift co-coordinator about whether any shortfalls would be detrimental to patient care or the unit workload; given the issues described, the decision is often taken not to fill the shift with Bank and Agency.

The 5 adult surgical wards within PC&S continue to adapt and enhance the way they work together to provide support and staff (where required/possible) as a joint enterprise. As part of the joint working approach, the team of ward leaders decided to cohort many of their patients who required ‘enhanced care’, wherever possible and sensible. They share and compare their staffing rotas and work to ensure that as many gaps or shortfalls as possible are met from within the 5 wards. This process has now been formalised and forms part of the Standard Operating procedure for Safe Staffing (in development).

On Trauma & Orthopaedics, the ward establishments are moving towards to the agreed Keogh staffing levels. The agreed staffing levels for Ward 11 are now 3+3 (days) and 3+1 (nights); for ward 12 the agreed staffing levels are 4+3 (days) and 3+2 (nights). The fall rates have been calculated

against these (new) staffing levels and are thus different to previous months. Ward 11 meet their actual nurse staffing fill rates within the agreed parameters. Ward 12 show an under fill rate against their *increased* establishment, reflective of their current vacancies; the actual number of hours worked does deliver *safe/minimum staffing levels of 3 RNs* on every day shift, with 7 shifts staffed at the new/higher level. Ward 11 have seen an increase of patients requiring enhanced observation (in line with an increase in trauma admissions) – half of the shifts during August required an additional HCA on nights (2 in total).

The under fills of RNs that continue on ward 31 and 32 are associated to the implementation of the new staffing baselines (as reported previously). Safe/minimum staffing levels of at least 3 RNs per day shift have been maintained throughout the month. Both wards have recruited (close) to their new establishment level; most of the new starters are student nurses recruited via the clearing house and will join the organisation in Mid-September. Following a period of induction and supernumery status they will start to have a positive impact on staffing numbers by mid/end of October 2015.

Whilst the new staffing levels are being implemented, we ensure the ward is staffed to deliver minimum safe levels, but we don't use additional hours or B&A to make up this shortfall, unless the patient acuity and ward workload require additional RNs (above the *safe levels* of 3).

6.1 Maternity Staffing

The workforce tool for maternity staffing is Birthrate Plus which gives an overarching view of staffing - an optimum ratio is 1 registered midwife for every 28 births (1:28). For August the Birthrate Plus tool calculations indicated a midwife to birth establishment of 1:28.3, with 1:29.8 in post. The current gaps are 3 whole time equivalents (WTE) community midwives with another 1.7 currently working their notice; all in-patient/acute midwives vacancies are recruited to. We are reviewing service delivery models to address the gaps in the community service and are actively recruiting for additional midwives.

On a day to day basis the acute unit staffing takes into consideration elective activity and number of inpatients, with a proxy marker of being able to provide 1:1 care for all women in established labour. The small under fill is related to a combination of vacancies, maternity leave and sickness. The shift co-ordinator, in conjunction with the senior midwifery colleagues, reviews expected and emergency levels of activity against staffing levels and agree any decisions to leave a shift with fewer than 10 midwives. Where shifts are filled, it is always with our own staff working additional hours, and never through B&A. There were no maternity unit closures during August.

6.2 NICU Staffing

The under fill of RNs is largely related to pre allocated holidays, sickness and adoption leave. This has been closely monitored against activity and dependency and hasn't compromised the safety or activity of the unit. There have not been any non-clinical transfers of neonates during August. The unit have been very successful in their recruitment efforts during 2015. However, new starters rarely have previous neonatal nursing experience and require a lengthy induction and training process to ensure they can function as fully fledged RNs. 6 new recruits are going through the process of finishing their local induction/training and currently have 'supernumerary' status, 2 of the new starters have decided to return to adult roles and the newly qualified member has just joined the team. It is anticipated that most will have completed their competency assessments during September.

6.3 Children's Ward Staffing (25)

Recruitment in Children's Nursing remains a challenge, nationally and locally. On ward 25, it has been further compounded by 5 RNs being on maternity leave. Due to the specialist nature of the

ward, bank nurses are very rarely available and agency nurses are only used as a last resort (to maintain safety). The ward have 4 vacancies against their existing establishment and then will work towards their 'Keogh' staffing levels. A recent recruitment campaign only delivered 2 recruits, so a new recruitment process, with improved advertising, is underway. This is still not achieving positive results for the service.

The *planned* staffing levels are reflective of the phase 1 of Keogh – moving from 6 RNs on a day to 7, and from 5RNs on nights to 6. The under fill of RNs is linked to vacancies and short term sickness within the ward. Activity and dependencies have been closely monitored to maintain safety; the escalation procedures are followed and safety measures are put in place as required and agreed (with silver/gold), including diversion of activity if necessary and unavoidable.

The remit and role of the reception team has been expanded, and a review of the support role of the HCA in children's nursing is underway – it is expected that both of these developments will release time to care for RN's, which is evidenced by the significant impact both reception staff who are now in place and their positive impact on the flow of the ward.

7.0 ACHIEVEMENT OF PLANNED STAFFING REQUIREMENTS – ORGANISATIONAL CAPACITY & CAPABILITY

Divisional Nurses, Matrons, Ward Sisters and Charge Nurses each have responsibility for ensuring that their clinical wards and departments are safely and appropriately staffed to meet the acuity and dependency needs of patients within their care.

Staffing levels are reviewed and signed off by the Silver On Call at each bed meeting during the day, against the baseline staffing and using the safer nursing care tool. They work with the Matrons and the Duty Nurse Manager to ensure that the staffing levels maintain clinical safety, including considering the whole hospital, any individual patient risk assessments; clinical decisions are then made to reduce or mitigate the greatest risks.

August has been a difficult month for many areas; it has seen demand for agency HCAs increase as the availability of bank HCAs has reduced (related to summer holidays). Close monitoring of rosters has been undertaken by all matrons, with close involvement from the divisional matrons. The nurse pool has recently advertised and shortlisted for HCA positions, interest remains high for these posts and both medical and surgical ward sisters/charge nurses have assist in the recruitment process.

A recruitment event is planned for 26th of September - stands for many of the ward and department areas will be on display and applicants will be taken through the recruitment process, interviewed and informed on the day. Previous events have been highly successful and the outcomes from this event will form part of the report next month.

8.0 CORRELATION BETWEEN ACTUAL NURSE STAFFING FILL RATES AND PATIENT OUTCOMES

Detailed data analysis of the correlation between actual nurse staffing fill rates and patient outcomes shows that August 2015 has seen an increase in Datix medication related incidents reported (101 in total). Many of these were categorised as grade 1 and causing no harm (n=84), while 17 were classified as grade 2 and 3 signifying mild to moderate harm. On-going work with the newly retitled Medications Action Group will support a more detailed analysis of the information and engage with the Professional Practice Development Team to share and support ward teams to improve.

The number of all falls (n=164) shows an increase for August - this is an increase of 29 from last month (July; 135). The falls lead nurses are currently working with the Deputy Director of Nursing to

implement some of the best practice elements identified by other trusts. While they await delivery of some the items identified they continue to review the data to further understand the reason for the falls and especially the increase noted this month. While the data available currently does not provide clear evidence of specific ward areas and enable triangulation with the staffing fill rate, it does give an insight into the peaks of occurrence and the graph clearly shows three peaks between the hours of 21.00hrs and 06.00hrs when staffing levels on most areas are reduced in line with the agreed night time establishment.

In August there have been 3 pressure ulcers recorded as avoidable; this figure remains largely static despite the continued effort of the expanded tissue viability team (TV). The three wards involved were Wards 24 and 34 who each had a grade 2 pressure ulcer and ward 43 who had a grade 3. The ward leaders in these areas continue to work with the TV team and their Matron to identify solutions to prevent further occurrences. It should be noted that each of the ward sisters/charge nurse have seen a significant increase in their clinical demands which in turn has reduced their supervisory capacity throughout the month.

9.0 CONCLUSION

A four times daily monitoring process is now well established across the organisation to identify when areas are non-compliant with their actual staffing levels and robust actions are taken to rectify any identified short falls. This information is made available to the Director of Nursing, Deputy Director of Nursing, Divisional Matrons and all members of the Silver on call rota and is circulated at the same time as the bed capacity data across the organisation (08.00hrs, 10.00hrs, 13.30hrs and 16.30hrs).

Staffing levels and ward assurance indicators now provide a comprehensive picture of each ward. This enables the Divisional Nurse, along with the Matron and Ward Sister / Charge Nurse to focus on areas that may require additional support or escalation.

The Divisional Nurses, Matrons and Duty Nurse Managers work together to redeploy staff to support areas where there is a shortfall to minimise the risk to patients and ensure care and quality is maintained and not compromised.

Analysis of our planned and actual nurse staffing levels demonstrates that the majority of wards fulfil the required standards for Safe Staffing. Where it is identified that a clinical area has fallen below, an exception report is generated by respective Divisional Nurse in order to gain a greater understanding of the reasons why this has occurred and to seek assurance that robust plans are in place to mitigate against further occurrences.

The reliance on temporary staffing solutions continues, and to reflect the poor fill and attendance rates over recent months the situation has recently required addition to the risk register. It is an operational and financial challenge within the organisation; however, it is being managed consistently and equitably across the nursing workforce. It is envisaged that the introduction of Allocate Health Roster will strengthen and improve off duty planning and have a positive impact on variable pay Expenditure

Recommendations
We ask the Board to note the analysis and information and the on-going actions taken and planned to ensure the Trust’s is responsive to the safe staffing requirements of wards and departments.

Adele Bonsall Practice & Professional Development Matron