

## **Appendix 3: Division of Clinical Services June 2016**

### **Critical Care and HDU**

The units now operate as a combined unit in relation to staffing.

**Critical Care Unit:** – The Unit is split into 2 areas, a 19 bedded Post-Operative Critical Care Unit (POCCU) and an Intensive Care Unit (ICU) with 11 individual rooms, six of which include isolation capacity. There is potential for future increases in capacity, 1 side room in ICU and 4 corner beds within POCCU.

An agreement to open the additional side room and 2 further POCCU beds was agreed in principle as part of this year's annual planning but this has not been realised due to difficulties in recruiting additional medical cover at Registrar level due to lack of successful candidates.

There has, however been success with an increase in nurse staffing in anticipation of the additional three beds opening. Whilst waiting for the increase in medical staffing, the additional recruited nursing staff will be utilised to drive down costs in relation to bank and agency spend. There is also a reported addition the Unit's declared amount of level 3 beds, which has been increased from 14 to 18 to reflect more accurately the level of acuity within the Unit.

A further staffing review will be completed prior to February 2017 when it is expected that additional registrar cover will be in place. If achieved, a decision will be made on whether to opening the additional 3 beds afterwards.

### **Thoracic HDU**

HDU is a 4 bedded unit based on Cedar Ward but has been under the direct management of the Matron for Critical Care since October 2015. Since the transfer of management, staff have rotated between the two units to improve levels of staff competence between the thoracic and cardiac specialties.

### **Key staffing change since December 2015**

In March 2016, an organisation change review in relation to Critical Care Staffing was completed. This involved a review of the Band 4 Intensive Care Assistant role. It was agreed that all ICAs (9.1wte in total) be relocated into other roles within the Trust with the aim to replace the role with the same number of band 5 RNs. This has been completed successfully.

### **Funded establishment and actual staffing**

The current staffing establishment as of March 2016 has been mapped according to the Guidelines for the Provision of Intensive Care Services (2015) developed by the Faculty of Intensive Care Medicine (FICM) and the Intensive Care Society (ICS). This provides a baseline of how the Unit is staffed according to the standards. The staffing establishment is based on ensuring that the standards below will be achieved;

#### **Intensive Care Society Staffing Standards**

- Level 3 patients (level guided by ICS levels of care) require a registered nurse/patient ratio of a minimum 1:1 to deliver direct care
- Level 2 patients (level guided by the ICS levels of care) require a registered nurse/patient ratio of a minimum of 1:2 to deliver direct care.

- Each designated Critical Care Unit will have an identified lead nurse who is formally recognised with overall responsibility for the nursing elements of the service e.g. Band 8a Matron.
- There will be a supernumerary clinical coordinator on duty 24/7 in Critical Care Units.
- Units with greater than 10 beds will require additional supernumerary (this person is not rostered to deliver direct patient care to a specific patient) registered nursing staff over and above the clinical coordinator to enable the delivery of safe care. The number of additional staff per shift will be incremental depending on the size and layout of the unit (e.g. multiple single rooms). Consideration needs also be given during events such as infection outbreak
- Each Critical Care Unit will have a dedicated Clinical Nurse Educator responsible for coordinating the education, training and CPD framework for Critical Care nursing staff and pre-registration student allocation. 1 per 75 staff
- All nursing staff appointed to Critical Care will be allocated a period of supernumerary practice.

In order to meet the standards above, the number of supernumerary staff within LHCH is as below

- Band 8b Critical Care Manager
- Band 8a Critical Care Matron
- 3 Band 7 Educators
- 3 Band 7 Outreach Team
- 2 Advanced Practitioners

**(10 in total)**

#### **Unit Co-ordinator and Team Leader Staff (Band 6/7)**

- 1 Band 7 Senior Co-ordinator each shift
- 1 ITU Team Leader and 1 Support Nurse (to support multiple single rooms as above)
- 1 POCCU 1 Team Leader
- Plans to provide a supernumerary team leader for POCCU 2 is in place dependent on successful recruitment of additional band 6 nurses

**(27.0 wte in total – based on all staff working long days)**

#### **Staff required for delivery of direct patient care (including Critical Care and HDU)**

18 Level 3 Beds (1:1 ratio)	107.8
16 Level 2 Beds (1:2) ratio	47.9

**(155.7 RNs)**

Based on all sections above, to achieve a fully compliant staffing model against Intensive Care Society Standards, Critical Care would require **192.7wte** to deliver a 34 bed unit with 18 level 3 and 16 level 2 beds.

In the last period, staffing plan reflected a reduction in the amount of declared level 3 beds on

Saturdays and Sundays. As weekend operating has become a regular occurrence and the NHS is working towards a 7 day working model, the new plan represents no planned reduction in terms of capacity at weekends.

#### Opening of additional 3 beds

Depending on successful recruitment of six new anaesthetic registrars for Critical Care, the intention is to increase the amount of level 3 beds to 21. The level of RN staff required to achieve this would increase by 17.4 to **220.3wte**. However as the Unit employs a range of staff who work long days and thus 1 additional shift per week is gained, the future staffing level has been agreed at **205.09wte**

#### Critical Care Staffing by Band

The new staffing establishment for Critical care by each band is identified below. It includes all staff including the Management Team, Outreach and Advanced Practitioners.

	Band 8b	Band 8a	Band 7	Band 6	Band 5	Band 3	Band 2
Funded WTE	1.0	2.0	17.78	37.42	146.89	2.67	19.13
Recruited to	1.0	2.0	16.94	26.84	144.49	2.67	18.61
In Post	1.0	2.0	16.94	26.84	113.69	2.67	16.63
Variance	0	0	-0.84	-10.58	-33.2	0	-2.5

\*As of 14th July 2016, current RN staff in post is 160.47

#### Actual activity vs. capacity set by staffing establishment

The actual staffing levels required for both Critical Care and HDU vary from shift to shift depending on patient acuity and occupancy. All shifts are monitored daily to ensure they are staffed safely. This is reported monthly to trust Board and externally via Unify with rationale provided for numbers being over or under 100%.

#### HDU

	Jan 2016	Feb 2016	March 2016	April 2016	May 2016	June 2016
RN Days(E/L)	97.4*	101.2	100	100	100	100
RN Nights	94.4*	98.9*	100	100	100	100

\*on some shifts 5 patients were cared for using 2 RNs and 1 ICA

#### Critical Care

	Jan 2016	Feb 2016	March 2016	April 2016	May 2016	June 2016
RN Days(E/L)	98.3*	98.9*	100.6	100.7	101.8	100.4
RN Nights	99*	98.3*	99.9*	100.7	101	99.2

\*Slight variances relate to when ICAs were used to care for patients and overseen by Team Leader/ other RN

In order to set capacity at an appropriate level, the average level of acuity over a two year period has been identified as 21 level 3 patients – the target the Unit is aiming to achieve by February 2017 with the opening of a further three level 3 beds.

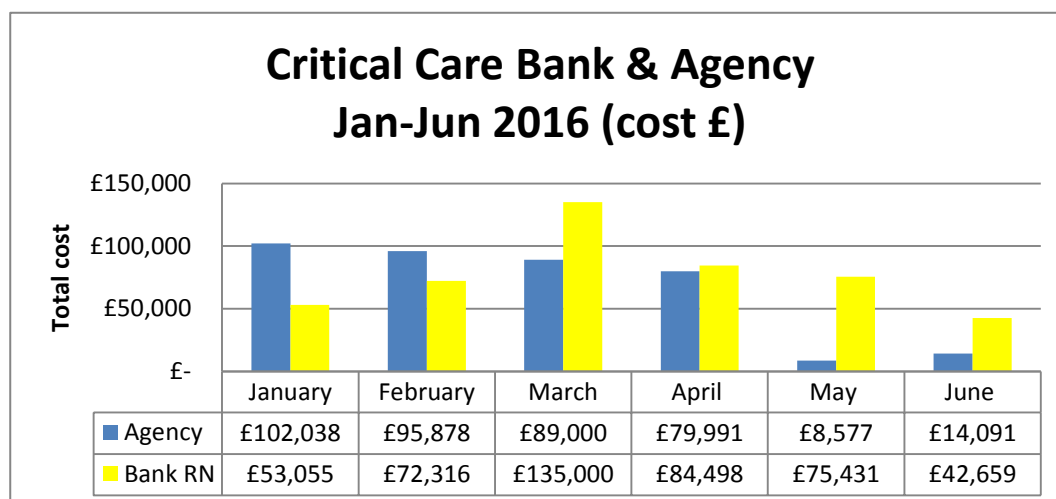
### Bank and Agency spend including variance against pay budget

Due to the level of vacancies within the unit and an increased level of activity above what is set by the staffing establishment, the Critical Care Unit has historically had to rely on using additional temporary staffing to meet the demand. A number of successful measures have been undertaken to address the shortfall of substantive staff by;

- Rolling 2 weekly recruitment process and flexible recruitment process to allow faster recruitment times
- Skill Mix review – removing the Band 4 role and replacing directly with Band 5 staff
- Reducing sickness and turnover in line with Trust targets
- Incentivising the use of bank nurses over the use of agency nurses by introducing weekly bank pay and reviewing the rate of pay
- Implementation of the new electronic rostering system

As a result of the improvements identified above, the use of agency staffing has reduced significantly, especially since May 2016.

At the peak of agency use in June 2015, £220K was spent within the month, by comparison in June 2016, £14,091 was spent in month.



### Bank and Agency spend including variance against pay budget

#### Outturn for 2015 -6

Staff Group	Balance ( end March 2016)
Bands 5-7 substantive staff	(£699,186)
Bank staff	+ 746,263
RN Agency use	+ 1,421,551
With adjustments to other staff positions	(118,344)
Balance	+ <b>£1,350,284 overspent</b>

## Opening Balance for Q1 of 2016/7

All agreed additional budget for increased staffing in Critical Care will be phased during the year. During Q1 no additional funding has yet been received. The substantive staffing budget has been adjusted (reduced) to create specific funding lines for bank and agency spend which has been based of predicted use.

Staff Group	Balance ( end March 2016)
Substantive staff	+ 240,851
Bank staff	(21,232)
RN Agency use	(142,340)
With adjustments to other staff positions	(25,339)
Balance	<b>+ £51,940</b>

For Q2-4 as agreed additional funding will be added to the budget and the unit continues to perform significantly better against predicted agency use, a balanced budget is fully expected to be achieved by year end.

## Registered Nurse /Health Care Assistant % split:

RN/HCA Split December 2014	RN/HCA Split June 2015	RN/HCA Split Dec 2015	RN/HCA Split June 2016
84/16	83/17	83/17	*90/10

\*After ICA posts conversion to RN posts

## Registered Nurse to Bed Ratio per shift:

RN : Patient Dependency Ratio	
Level 2	1:2
Level 3	1:1

## Workforce Information:

Absence rate % (Jun 2016)	Absence rate % (YTD)	YTD Turnover rate (YTD)	Mandatory Training % (Dec 2015)	PDRs % (May 2015)
3.48	4.52	7.49	95	67

## Ward Occupancy Rates YTD:

	% Average Rate
<b>Ward Occupancy</b>	
Critical Care	85.7
HDU	84.1

## Quality Indicators/ Exceptions (1<sup>st</sup> Jan 2016 to 30<sup>th</sup> June 2016)

	Number	Action
<p>Medication Errors:</p> <p><i>Equates to 21.9 per 10,000 Bed days</i></p>	10	<p>2 relate to confusion with renaming of oxycodone and oxynorm. Learning discussed at grand round and within Critical care. Changes to EPR being made to make clearer and ensure names tally with CD book</p> <p>4 relate to misreading EPR prescription due to complexity in how it has been described. E.g</p> <ul style="list-style-type: none"> <li>• Rifampicin 300mg to give 600mg</li> <li>• Prescribing of pre-med but no location identified</li> <li>• Timing of drugs</li> <li>• Review of medications when transferring from POCCU back to ward</li> </ul> <p>All have been discussed at med errors committee and referred to EPR users Group</p> <p>Other errors relate to human error in misreading of labels, and not completing usual checks prior to administration</p>
Falls	2	<p>1 patient slipped between bed rails when restless. Unforeseen incident – staff education on risk and positioning of bed rails.</p> <p>2<sup>nd</sup> patient assisted to floor whilst being rolled on bed. This was caused by positioning of slide sheet on dolphin mattress which creates a slippery surface.</p>
Avoidable Pressure ulcers	3	<p>3 avoidable pressure ulcers reported relating to 2 patients</p> <p>1 patient sustained blisters to both heels (classed as 2 separate ulcers) relating to type of slide sheet used and technique. This has resulted in purchasing a new type of slide sheet and improved education on their use.</p> <p>1 was device related when patient was being nursed in prone position. Learning from incident disseminated.</p> <p><b>Feedback from incidents relayed to staff at TV meetings and via staff huddles</b></p>
<p>Complaints</p> <p>3 Critical Care 1 HDU 1 Radiology 1 Path Labs 2 OPD</p>	8	<p>The Division is involved in 8 complaints, 2 are cross division and 1 is primarily owned by RLBUHT Radiology Dept.</p> <p>2 of Critical Care complaints are now presumed closed and relate to communication and questions about delivery of care. Open complaint relates to routine transfer of patient to a welsh hospital which was not the preference of the relative. Awaiting final response.</p> <p>2 OPD complaints relate to communication and waiting times, in part due to improvement works. Full explanations provided to patients involved and staff aware to improve communication process during disruptions.</p> <p>HDU complaint is primarily related to surgery performed which led to post op complications leading to a death. Final response being drafted to Husband.</p> <p>Pathology complaint related to technicalities of cross matching a patient with a complex rhesus group. Currently being drafted</p>

### Friends and Family Test:

Number completed Jan16 to Jun 16	Average monthly net promoter score
	100%

### Comments Made by Patients

Only 1 negative comment have been received via FFT for Critical Care. This related to the noise levels on the Unit which caused difficulties in communication.

A range of positive comments are included below.

- Fantastic
- Great care
- Excellent place
- Attention and service
- Look after you, can't do enough for you
- Treated with Kindness
- So Good!
- Great Hospital
- Excellent Care
- Treated well kept informed
- Everyone is superb
- Excellent care
- Care is really good
- Staff are really good, can't fault anything
- Good service
- I like them all!
- Great place
- Excellent

### Exception Report Summary:

In terms of safety, both the Critical Care and HDU units have ensured that patients have been cared appropriately and safely according to their level of acuity. This is reflected demonstrated by the low level of adverse incidents considering the high complexity of the area and the receiving of very positive patient and family feedback.

Significant reductions have been achieved in use of agency spend due to the skill mix review involving the ICA role and agreement of a new staffing plan in preparation for the opening of new beds. By comparison, in June 2016 there was a 20 fold decrease in the use of agency when compared to June 2015. The significant reduction in agency use also appears to have had a significant effect on staff experience. This has seen sickness turnover levels fall substantially from their peak in 2015 and now within Trust targets.

## Outpatients Department:-

The Outpatients consists of 21 Consultation rooms, 2 interview rooms, and 1 ECG room. It caters for a wide range of specialities including Cardiology, Thoracic, Respiratory, Cystic Fibrosis, Congenital and Oncology. Patients attend from all over the country but mainly from Merseyside, Wirral, Isle of Man and North Wales.

The Outpatients redesign work is currently underway. During renovation, capacity will not be affected. When completed, capacity will then increase to 28 Consulting Rooms.

Within the Outpatients Department, the Clinical Nurse Practitioners (CNP) work alongside the staff of Outpatients to support and advise where appropriate. The Matron for Clinical Services also provides senior leadership to the Outpatients Team. Since the appointment of the Matron, the RN establishment has been reduced by 1.0wte to 2.6wte. A new band 6 OPD Manager has been recruited who is working closely with the matron for Clinical services and Deputy Divisional Head of Operations to drive through efficiencies and improvements within the Outpatients Department.

When the OPD redesign is complete with anticipated efficiencies such as an electronic patient calling, the current establishment of HCAs will be reviewed. Until then, current HCA vacancy is being left unfilled.

### Funded establishment and actual staffing (This does not include Admin or CNP staff)

FTE Dec 2014	FTE June 2015	FTE Dec 2015	June 2016
12.45	11.85	10.02	10.05
RN 3.6	RN 3.4	RN 2.4	RN 2.4
HCA 8.85	HCA 8.45	HCA 7.62	HCA 7.65

### Planned staffing required for each shift

Day	
Mon - Fri	Each day a minimum of 1 RN is available to run the pre-investigation clinic with a minimum of 7.0wte HCAs to co-ordinate individual clinics. An escalation process of issues is in place from the allocated RN on duty, to the Lead CNP or to the Matron / Head of Nursing

### Staffing spend including variance against pay budget end of year 2015/6

	Pay Year End Variance (underspends in brackets)
Substantive Staffing Bands 2-6	(40,862)
Bank	0
Agency	0
Total £	<b>(40,862)</b>

### Bank and Agency spend including variance against pay budget opening Q1 2016

	Variance as at Month 3
Substantive Staffing Bands 2-6	(17,822)
Bank	0
Agency	0
Total	<b>(17,822)</b>



## Professional Judgement Tool:

Prof Judgement Jun 2016
2.3 wte RN (may rise to 3.0wte when additional rooms open)
8.8 wte HCAs required (may reduce following improvements in technology – electronic calling systems and self-check in)

## Workforce Information:

Absence rate % (Jun 2016)	Absence rate % (YTD)	YTD Turnover rate (YTD)	Mandatory Training % (May 2015)	PDRs % (May 2015)
6.49	2.82	0	100%	100

## Patient Activity Data (Jan 2016 to June 2016)

Outpatient's activity continues to perform above plan for 2016 year to date. Currently this is **+2.2%** and is driven mainly by over performance within Cardiology Clinics

A review of the CNP role is currently being undertaken to assess if any quality or efficiency improvements can be achieved through review of working processes. The review will scope out different areas where the CNPs may increase responsibility and includes;

- Review of the surgical pre-op pathway with an improved PFCC focus and introduction of "pre-hab" concepts
- Increase productivity in amount of patients seen in each clinic
- Introduction of nurse lead post PCI Clinics
- Introduction of CNP review for Private patients
- Introduction of the pre-anaemia Service

The Review will be complete by September 2016.

## Quality Indicators/ Exceptions (Jan 2016 to June 2016):

	Number	Action
Medication Errors:	0	Nil
Falls	0	Nil
Pressure ulcers	0	Nil
Complaints	2	<p><b>Patient 1</b> incurred a delay in clinic. This was highlighted to the OPD manager after 1.15 hours who established that the patient had been missed from the clinic list due to human error. Staff instructed to approach patients in waiting area on a regular basis especially whilst improvement works in progress. Staff also informed that they must cross check and validate against EPR.</p> <p><b>Patient 2</b> experienced a longer than expected wait due to confusion relating to a patient with same name. this was identified quickly but resulted in patient missing time for exercise tolerance test.</p>

### Friends and Family Test:

Number completed Jan 2016 to June 2016	Average monthly score %	June score %
734  (Ave 122 per month)	92.41	95

Outpatient's FFT scores fell as low as 41.5% during March when Improvement works were in progress. Direct feedback was sought from patients and families which identified frustration in loss of the Tea Bar and some challenges with communication processes. An action plan was implemented which has resulted in improved communication. Patient are now visited in the waiting area and provided with regular updates on waiting times. A fridge has been installed temporarily which offers patients to obtain free cold drinks during their stay.

### Some positive comments

- Brilliant staff and service
- Nice helpful staff
- My son has Down syndrome. Dr X is very patient and reassures him all the time through consultation.
- Very professional service
- Very good care and attention from doctors and nurses
- The nurse was very thorough & courteous throughout pre assessment. Very happy with the discussion & information provided.
- My time here was most pleasant. All the staff were extremely helpful. The waiting area was busy, however this did not delay my appointment. Would recommend this hospital.
- Staff are lovely and the service was excellent
- The service was of high standard all the staff were extremely helpful.
- Excellent doctor and all staff very polite

### Comments for improvement

- Renovation made setting complicated
- Noisy waiting area
- Terrible waiting times. Staff overrun with too much work!!
- Work being carried out, not much privacy near reception booking in
- Doctors running late, but was kept informed how long
- Building work being done makes waiting area look like an airport. Badly organised, poor staff running around looking for patients all morning
- Missing the tea bar, seating not good.

### Exception Report Summary:

The Outpatient's Department is safe in relation to staffing. The Outpatient's Staffing Team have worked closely with the CNPs, Medical Staff and the Divisional Management Team to ensure it has operated safely during renovation work. This is supported by zero incidence of harms such as falls and medication errors.

Patient and family experience was adversely affected in February and March when renovation work was at its height resulting in a fall in FFT score. This has since improved following implementation of an action plan to improve experience.

The Outpatient's budget shows an over performance to its plan with no reliance on bank or agency usage.