Trust Headquarters

NHS
Lancashire Teaching Hospitals
NHS Foundation Trust

Board of Directors Report

Nurse and Midwifery Staffing Review:

Report to:	Board of Directors - Part 1	Date:	1st March 2018
Report of:	Nursing, Midwifery and AHP Director	Prepared by:	S Cullen

Status of Report (please tick):

For approval	X	For ratification	☐	For discussion		For information	

Executive Summary:

The purpose of this paper is to inform the Board of the outcome of the annual nurse staffing review undertaken in 2016/17. The process commenced in November 2017 and was concluded in January 2018.
A total of 40 ward and departments were reviewed using the following guidance:

- National Quality Board (2018) Safe, sustainable and productive staffing - An improvement resource for adult inpatient wards in acute hospitals
- National Quality Board (2017) guidelines on children, neonates and emergency departments
- RCN standards (2013) Defining staffing levels for children and young people's services.
- NICE Safe staffing for nursing in adult inpatient wards in acute hospitals (2014).
- British Cardiology Society (2011).
- British Association of Critical Care Nurses 2009 Standards for nurse staffing in critical care. (BACCN).
- Intensive Care Society - CoHre Standards for Intensive care units (2013).
- RCN Baseline Emergency Staffing Tool (2013).
- Regional Networks for Major Trauma (2010).
- British Association of Perinatal Medicine (2011).
- NICE 2015 Specialised Neurorehabilitation Service Standards Updated 30.4.2015.
- RCN Safe Staffing for Older People's Wards (2012).
- British Association of Stroke Physicians (2014).

The review has focused on three areas:

1. Safety critical.
2. Service expansion.
3. Enhanced level of care.

The review addresses the 'Must dos' from the 2017 CQC report in relation to staffing. The investment required to approve the professional recommendations following this review is £8.4m in addition to budget - this is £4m against forecast outturn.

The Board are asked to:

- Approve the contents of the annual staffing review 2017/18.
- Approve the financial model required to deliver the proposed staffing establishment changes.
- Approve the reporting of progress against the staffing plan and subsequent efficiencies to Financial Investment Committee.

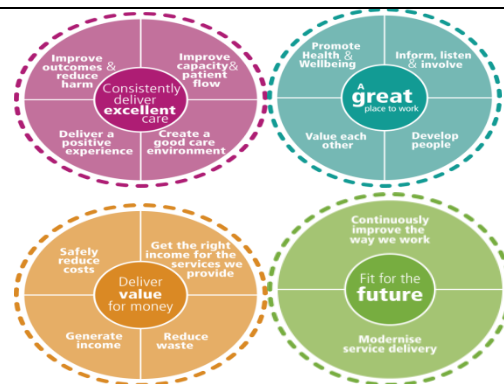
Trust Strategic Aims and Ambitions supported by this Paper:

Guidance Notes:

Aims

To offer excellent health care and treatment to our local communities	☒	
To provide a range of the highest standard of specialised services to patients in Lancashire and South Cumbria	☒	
To drive innovation through world-class education, teaching and research	☐	

Ambitions

Consistently Deliver Excellent Care	☒	
Great Place To Work	☒	
Deliver Value for Money	☒	
Fit For The Future	☒	

Risk Implications/threat to:

Finance & Availability of Capital	☐	System Resilience	☐
Escalation & patient flow	☐	Service Sustainability	☐
Quality, Safety & Patient Experience	☒	Seven Day Services	☐
Legal & Regulatory Compliance	☒	Achievability of Our Health Our Care	☐
Workforce	☐	IT and Cyber Security	☐
Building/Estates	☐	Reputational implications	☒
Equality, Diversity & Inclusion	☐	Other (Please state below)	☐

[insert details of any other risk implications/threats not listed above]

Risk Details

Ref No.	Risk Title	Current Score (LxC)	4T (Treat, Tolerate, Transfer, Terminate)
1292135	Risk to provision of safe and effective care delivery to patients due to a shortfall in registered nurses.	20	Treat
1292422	Maternity staffing	9	Treat

2195	Pressure on patient flows, bed capacity, bed escalation and occupancy may result in an adverse impact on patient and staff experience	20	Treat
1292139	Root cause analysis of pressure ulcer incidents has identified that the electronic documentation of skin condition and wound charts does not support accurate completion of appropriate assessment and care planning. Therefore inaccurate patient documentation is held.	9	Treat

Previous consideration

	Date	Views
☐ ARTE Committee		
☐ Audit Committee		
☐ Endowment Funds Committee		
☐ Education, Training & Research Committee		
☐ Executive Team		
☐ Finance and Investment Committee		
☐ Safety and Quality Committee		
☐ Workforce Committee		

Decision made by the Board

Decision	tick	Notes
Recommendation(s) accepted	☐	
Recommendation(s) partially accepted	☐	
Recommendation(s) not accepted	☐	
Decision remitted to a sub-committee	☐	
Decision suspended pending further info	☐	
Decision to be made at a future BoD	☐	

1.0 Introduction

1.1 The purpose of this paper is to report the output of the annual nurse staffing review for the year 2017/18 and to seek approval for the recommended changes to the nurse staffing establishments as a result of the review.

1.2 The outcome of the reviews is displayed as a whole summary in Section 11 and broken down into 3 core areas, these are described as; safety critical, service expansion and enhanced level of care.

1.3 The reviews adhere to the recommendations set out by the National Quality Board paper in 2016 How to ensure the right people, with the right skills, are in the right place at the right time and uses further guidance issued in 2017 for children and neonatal and 2018 for adult and emergency services.

1.4 The reports makes the following assertions:

- *Boards should ensure there is sufficient and sustainable staffing capacity and capability to provide safe and effective care to patients at all times, across all care settings in NHS provider organisations.*
- *Safe staffing is a fundamental part of good quality care and the CQC will, therefore, always include a focus on staffing in the inspection frameworks for NHS provider organisations.*
- *It is critical that Boards review workforce metrics, indicators of quality and outcomes and measures of productivity on a monthly basis as a whole and not in isolation from each other and that there is evidence of continuous improvements across all of these areas.*
- *Boards should ensure there is an annual strategic staffing review, with evidence that this is developed using a triangulated approach (i.e. the use of evidence-based tools, professional judgement and comparison with peers), which takes account of all healthcare professional groups and is in line with financial plans. This should be followed with a comprehensive staffing report to the Board after six months to ensure workforce plans are still appropriate. There should also be a review following any service change or where quality or workforce concerns are identified.*
- *NHS provider boards hold individual and collective responsibility for making judgements about staffing and the delivery of safe, effective, compassionate and responsive care within available resources.*
- *Boards should use this local quality monitoring to support their judgements and decisions about safe staffing.*

1.5 The staffing reviews have been undertaken with each Ward/Department Manager or deputy, Matron and Divisional Nurse and Midwifery Directors. Finance and workforce teams have also been part of the reviews, enabling sufficient challenge and scrutiny of the holistic workforce model and has enabled a clear view of the support required in the coming year for each ward, department and division.

1.6 The reviews provided leaders with the opportunity to scrutinise quality, safety and workforce metrics alongside staff and patient feedback and any additional issues or good practice associated with staffing and the wider provision of delivery excellent care with compassion.

1.7 The changing demographic of the hospital has also been considered and the increased occupancy, complexity of social needs and continuing health care requirements of our local population.

2.0 Context

2.1 The Board approved, in December 2016, the investment of £500k in Children services and £900k in Maternity services. Recruitment to this improved establishment continues.

2.2 Strategic nursing and divisional leadership has been strengthened by the appointment of:

- An Associate Director of Allied Health Professionals.
- A New Divisional Nurse Director post for Children and Critical Care.
- An Interim Divisional Nurse Director for Medicine.

2.3 The uplift within ward budgets was reduced in December 2016 from 25% to 23% to allow for continuous permanent recruitment to Maternity posts and to contribute towards the funding of the Maternity and Children staffing investment.

2.4 A new Safe Staffing Policy was launched in 2017 to support and guide staff in decision-making linked to safe staffing.

2.5 There is a clear evidence based link between Registered Nurse staffing and the quality of care experienced by patients, which is fully acknowledged in the NQB 2016 document.

2.6 The Care Quality Commission (CQC) in the April 2017 Lancashire Teaching Hospital report, identified a number of 'Should do' and 'Must dos' in relation to staffing these are detailed below with the response to each (in Italics). These are monitored through the Trust's Quality Improvement Plan through the Quality Delivery Group. These are:

- Consider improving the level of Physiotherapy staffing to meet the minimum expected standards – *a business case approach to AHP services has been agreed.*
- Ensure midwifery and support staffing levels and skill mix are sufficient in order for staff to carry out all the tasks – *the review in 2016 addresses this recommendation.*
- Ensure that any patients admitted to wards and assessed as Level 2 high dependency patients receive nursing care at a ratio of 1:2 in accordance with national standards – *this review addresses this recommendation.*
- Ensure that staffing levels in Neonatal are maintained in accordance with staffing guidelines – *Action completed and deep dive reported to Safety and Quality Committee, December* 2017.
- Ensure staffing levels in Children's services are maintained in accordance with national guidelines - *Board agreed initial investment in December 2016 and interim position addressed through this review. Further investment will be required pending successful recruitment to first phase investment.*
- The service should take appropriate actions to maintain safe nurse staffing levels across the surgical wards - *Recruitment successful and detailed as part of this review.*

3.0 Monthly reporting

3.1 A comprehensive monthly report is presented to the Safety and Quality Committee providing assurance in relation to the planned versus actual nurse and midwifery staffing, triangulated with patient experience and safety indicators. This report provides the opportunity to identify any areas of concerns and articulate actions taken.

3.2 Staffing levels are represented as percentage fill rates for each ward as submitted to NHS Choices each month. The fill rate is calculated from the number of actual hours worked by staff as a percentage of the number of hours required. The required hours are as agreed through the regular staffing and skill mix reviews. The sickness and maternity leave levels are also included in the analysis. This analysis is then converted in Care Hours per patient day (CHPPD).

3.3 The safety and quality metrics included in monthly reporting are:

- MRSA incidents.
- C.Difficile incidents.
- Falls incidents.
- Medication incidents.
- Tissue viability incidents.
- Safety thermometer – maternity and adults.
- Friends and Family.

3.4 In recognition of the risk associated with Maternity, Children's, Critical Care and Emergency Department services, these are disaggregated to ensure clear line of sight in these services.

4.0 Annual review

4.1 As per the NQB guidance, a six monthly review was completed in February 2017, identifying increases in health care support workers to mitigate the risk of registered nurse shortfalls due to vacancies. Further analysis was required to increase establishments as part of the annual review.

4.2 The annual reviews this year have taken place from November 2017 to January 2018. The reviews have included all inpatient areas including the Emergency Department, Critical Care and Children.

4.3 The Neonatal review, 2017, was presented to the Safety and Quality Committee in December 2017 and a decision made to continue to fund the service at the current level of British Association Perinatal Medicine (BAPM) compliance (Average of 83%) with the proposal of safeguarding resource to focus in this area and the development of a neonatal quality dashboard. A review in June 2018 will re-evaluate this decision and consider further plans relating to the provision of neonatal intensive care across the Sustainability and Transformation Partnership (STP) footprint. The resource associated with the safeguarding requirement is built into this paper.

4.4 The Maternity review will conclude in March 2018 and be presented to the April 2018 Board.

5.0 Review process

5.1 Each Ward and Unit Manager met with the Nursing, Midwifery and AHP Director, Deputy Nursing, Midwifery and AHP Director, Finance, Workforce and their Divisional Nurse Director and Matron.

5.2 The Matron for Safe Staffing and Productivity provided an overview of the budgeted establishment and the vacancy, sickness, maternity and training data relating to workforce.

5.3 Quality measures were reviewed for each area including pressure ulcer, falls, medication incidents, incidents of violence and aggression, complaints and Friends and Family feedback. The STAR quality assurance system, rating for each area was also triangulated.

5.4 The Ward Manager was given the opportunity to talk about any areas that were causing concern and address any issues relating to staffing and patient safety.

5.5 Safe care acuity data was then analysed, using the Shelford acuity rating - it was not possible to use this data in all areas, as the roll out of the new system was in progress. However, the discussion, value and requirements were discussed in detail including the ability to record red flags and individual patient needs. The roll out of Safe care is now complete.

5.6 The leadership function and ability of the team was then discussed including the overall skill mix, specifically the use of the Band 4 unregistered Assistant Practitioner role and Health Care Assistants.

5.7 National guidance and peer comparison was referred to in areas, where available.

5.8 Ward clerk and housekeeper functions were also considered and the standardisation of the quantity of these roles introduced as one WTE of each, with the exception of assessment units where broader hours of cover were included, accounting for the patient demand in these areas.

5.9 The final establishment was then agreed incorporating a moderate enhanced level of care provision built into the establishment, resulting in an establishment the Ward and Department Manager felt able to deliver care within the identified resource.

5.10 It is important to note, there will always be patients that require a significant level of care and/or security and this is not built into the establishment routinely given the cost associated with doing this. It was agreed this would be reviewed and an individual plan of care developed as required.

6.0 Professional Judgement

6.1 The NICE (2014) guidelines recommend the use of informed professional judgement to make the final assessment of the nursing needs of each clinical area - this review enacts the judgement of a number of senior nurses, considering professional guidance and safety and quality indicators to reach an agreement. It should be noted all ward/department managers signed off the staffing levels for their areas of responsibility.

6.2 Professional judgement considers patient and staff experience through the analysis of friends and family and complaints, vacancy and turnover in each area.

7.0 Professional Guidelines

The review also considered specialities with guidelines for safe staffing - this included Paediatrics, Critical Care, Stroke, Major trauma, Emergency Departments and Cardiology. These guidelines are presented in Appendix 1. The final establishment considers the guidance provided and applies a judgement in reaching the final staffing model.

8.0 Nurse to patient ratio

8.1 The ward establishments allow for Registered Nurse to patient ratios during the day range from 1:1 in level 3 areas, 1:2 in level 2 areas, 1:4 in acute assessment areas and 1:8 on general wards. For children, these ratios change to < 2 years of age 1:3 registered nurse, Children > 2 years of age 1:4.

8.2 Staffing at night on general wards is not planned on a 1:8 ratio - instead, the senior nursing team have made a professional judgement of ratio's not exceeding a 1:13 nurse to patient ratio. In higher care areas, staffing at night will remain consistent as in the day.

9.0 Registered to unregistered ratios

9.1 All inpatient areas have been reviewed against the benchmark of 60:40 registered to unregistered ratios as the level to which adult inpatient establishments should not fall below unless planned as the model of care.

9.2 A range of wards are below the 60:40 ratio - this is where the introduction of the Band 4 role provides a skilled mixed approach complementing the registered nurse. The Band 4 role has been built into the models of staffing as role substitution, developed through necessity to respond to the challenges of registered nurse recruitment. Feedback from teams is positive about the role and staff undertaking the training at this level report feeling part of a team that contribute towards the delivery of high quality patient care.

10.0 Care hours per Patient Day (CHPPD)

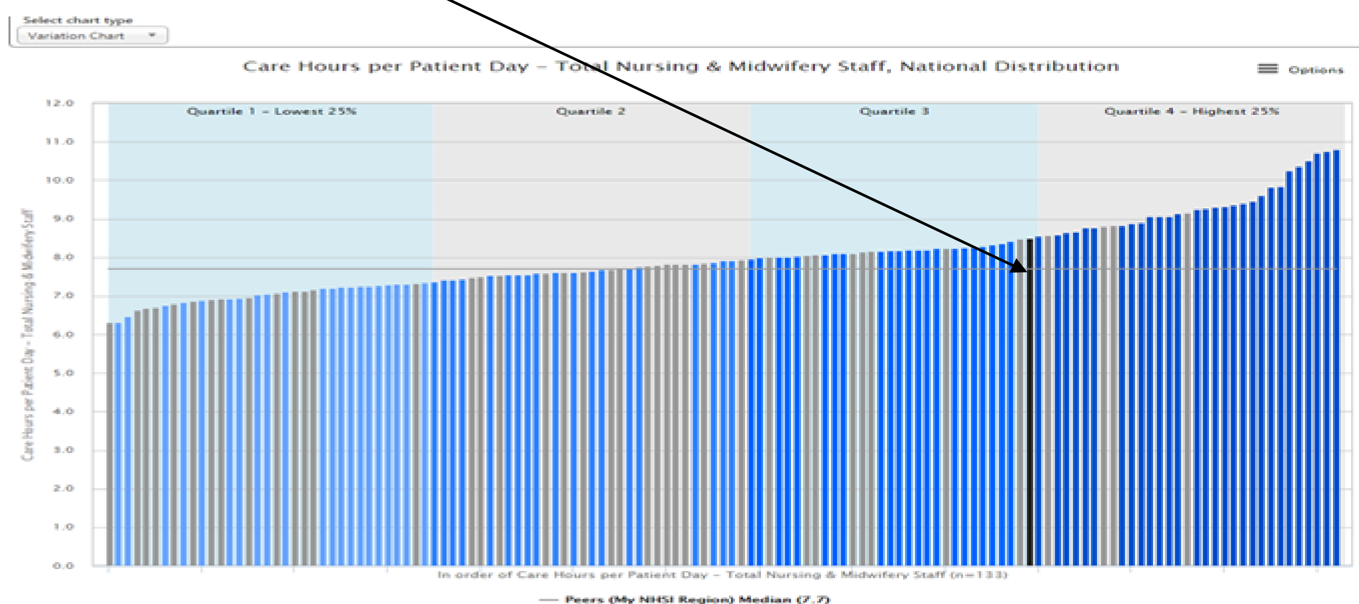
10.1 The Carter review identified 9 key practices that are the elements to a successful hospital. This is the concept of the Model Hospital. The report recommended that NHS Improvement devise a new set of metrics including Care Hours Per Patient day which can be used to describe both the staff required and the staff available in relation to the number of patients. This is calculated by adding the number of Registered and Unregistered nurses hours and dividing by the number of patients at midnight. This data is submitted as part of the UNIFY fill data upload on a monthly basis and is used as part of the monthly staffing reports.

10.2 The Trust sits on the upper third quartile 8.5 CHPPD when compared against all acute organisations. The range is 6.1 hours to 10.8 hours per patient.

10.3 It is recommended that CHPPD is not used in isolation but as part of a quality dashboard. Safecare also calculates CHPPD on a shift basis based on live data imputed.

10.4 Peer comparison using CHPPD – Model Hospital

Lancashire Teaching Hospitals



10.5 Analysis of the peer comparator suggests the high levels of 1:1 care provided through enhanced level of care as a result of high numbers of Delayed Transfer Of Care (DTOC) is contributing towards a third highest quartile position and we would expect this to reduce slightly, once the DTOC and occupancy levels decrease. In the meantime, it is important this high risk group of patients receive the care input they require whilst in the hospital.

11.0 Summary of Acuity Review

Ward/Dept	No of Beds	CURRENT FUNDED EST WTE	Professional Judgement	Acuity	STAR audit	CHPPD	Skill Mix	B4 mitigation	Nurse to Patient Ratio E	Nurse to Patient Ratio N
Medicine										
Barton	22	35.57	29.36	33.89	76%	7.5	43/57	Yes	1\11	1\11
Bleasdale	22	35.14	40.59	37.32	92%	7.5	38/62	yes	1\7.3	1\11
Brindle	28	43.68	49.59	49.01	50%	5.7	51/49	yes	1\7	1\14* +B4
Brindle Level 2	2								1\2	1\2
Cardiac Unit	10	21.05	21.65	17.32	94%	8.7	84/16	no	1\3.3	1\3.3
Coronary Care RPH	6	14.12	19.18	25.17	93%	10.6	94/6	no	1\2	1\2
Critical Care	28	187.47	179.18	no data		32.1	84/16	no	1\1	1\1
Emergency Decisions Unit	26	19.1	59.53	57.53	81%	n/a	46/54	yes	1\4.3	1\5.2
Emergency Department RPH	33	64.72	92.72	124.1	77%	n/a	75/25	no	1\3.3	1\3.3
Emergency Department CDH	17	28.32	21.7	29.4	78%	n/a	84/16	no	1\4.3	1\4.3
Hazelwood	19	29.66	36.57	32.36	95%	6.7	43/57	yes	1\6.3	1\9.5

Ward/Dept	No of Beds	CURRENT FUNDED EST WTE	Professional Judgement	Acuity	STAR audit	CHPPD	Skill Mix	B4 mitigation	Nurse to Patient Ratio E	Nurse to Patient Ratio N
Medical Assessment Unit CDH	30	52.92	58.37	no data	77%	8.1	57/43	yes	1\5.7	1\10
Neuro Rehab	12	29.92	29.11	18.61	96%	10.9	43/57	yes	1\6	1\12
Rookwood A	24	41.53	53.79	40.46	87%	7.4	33/67	yes	1\8	1\12
Rookwood B	24	39.66	44.03	41.85	77%	6.2	36/64	yes	1\8	1\12
Ward 17	30	43.18	55.51	48.11	86%	6.2	39/61	yes	1\7.5	1\10
Ward 18	28	45.52	59.53	40.91	86%	6.3	36/64	yes	1\7	1\9.3
Ward 19	28	50.99	51.49	no data	77%	8.1	42/58	no	1\7.5	1\10
Ward 20	22	39.34	44.85	35.85	81%	7.8	36/64	yes	1\7.3	1\11
Ward 21	25	41.74	51.49	37.68	79%	8	42/58	yes	1\6.3	1\8.3
Ward 23	28	61.91	76.75	46.76	71%	7.2	51/49	yes	1\7	1\9.3
Ward 23 Level 2	6				71%				1\2	1\2
Ward 24	32	74.45	69.86	no data	90%	8	31/69	yes	1\8	1\10.7
Ward 25	23	47.91	39.71	35.26	84%	6.7	62/38	no	1\5.4	1\13.5
Surgery										
Ward 2a	7	37.41	44.60	27.58	79%	10	87/13	no	1\7	1\7
Ward 2a Level 2	10				79&				1\2	1\2
Ward 2b	27	49.47	56.74	42.01	83%	6.7	53/47	yes	1\4.5	1\6.8
Ward 2c	17	26.95	32.63	26.33	79%	8.5	54/46	yes	1\4.3	1\8.5
Ward 3	19	29.23	29.11	26.96	85%	5.8	55/45	no	1\6.3	1\9.5
Ward 4	32	45.44	45.51	37.43	80%	6.5	55/45	yes	1\5.3	1\10.7
Ward 10	29	40.02	39.52	43.04	78%	6	58/42	no	1\5.8	1\9.7
Ward 11	18	41.57	44.03	31.11	78%	7.9	50/50	yes	1\6	1\9
Ward 11 HOBS	4				78%				1\4	1\4
Ward 12	32	57.27	47.72	45.32	76%	6.5	49/51	yes	1\6.4	1\10.7
Ward 14	24	43.75	44.42	40.75	85%	7.7	42/58	yes	1\4.8	1\12
Ward 15	26	42.42	50.92	41.06	89%	7.2	46/54	yes	1\5.2	1\8.7
Ward 16	24	42.68	44.42	39.51	71%	8	42/58	yes	1\4.8	1\12
Gynaecology	18	38.98	36.00	18.06	93%	7.3	63/37	yes	1\3.6	1\6
Leyland	25	34.67	30.10	22.57	92%	9.4	62/38	yes	1\6.3	1\12.5
Surgical Unit CDH	12	41.73	21.40	16.73	93%	8.8	59/41	yes	1\6.3	1\12.5
Major Trauma	10	18.1	31.40	15.94	97%	11.9	51/49	no	1\3.3	1\5
Ribblesdale	29	41.61	54.44	47.41	80%	7.8	48/52	yes	1\4.7	1\9.3
Children's and Young People										
Ward 8	30	84.51	72.00	56.97	78%	11.9	76/24	no	1\3.8	1\5

12.0 Summary of Essential Changes

12.1 A review of the Emergency Department and Urgent Care staffing was prepared and presented to the Executive team in December 2017 identifying an increase in the nurse to patient ration in the

Emergency Department. This was presented in detail to the Safety and Quality Committee in February 2018 and ratified as the model that is appropriate.

12.2 The areas that provide higher level care include Ward 2a, Brindle, Ward 23, Ward 21, CCU, and High Observation Bay (HOBS) on Ward 11. The patients in these beds require a ratio of one nurse to two patients. The establishments have been adjusted to reflect this.

12.3 Ward 10 and Hazelwood ward require an increase to meet the minimum standard of 1:8 nurse to patient ratio.

12.4 The Neurorehabilitation Unit currently has one manager over two units this requires one manager for each area.

12.5 Following the Neonatal Intensive Care review one Band 6 safeguarding practitioner is required to increase support in this area.

12.6 Paediatric leadership and paediatric assessment unit require an increase in establishment to move towards children guidelines for staffing.

12.7 Recognising children and critical care as a key services within our hospital, specific leadership at Nurse Director level was identified as requiring strengthening.

12.8 The total increase to budget for the essential changes equate to £ 3,408,611 per annum.

12.9 Safety Critical Investment - Breakdown

Summary of essential changes	Current Funded WTE	Current SIP	Proposed wte	Change to fundwte	Current budget	Crude forecast inc bank/agency	Revised Cost	Inc+/Dec- to Budget	Inc+/Dec- to forecast
ED	87.44	95.86	124.89	37.45	4,151,936	4,416,818	5,121,821	969,885	829,799
Ward 2A Neurosurgery	37.41	37.27	46.61	9.20	1,385,290	1,473,035	1,770,072	384,782	297,036
Brindle	43.68	45.22	51.53	7.85	1,451,013	1,576,395	1,713,442	262,429	137,046
Ward 8	81.71	73.88	85.71	4.00	3,033,583	2,679,264	3,182,248	148,665	498,875
Ward 23	61.91	59.80	78.75	16.84	1,947,248	2,431,884	2,457,352	510,104	25,468
Ward 21 Stroke	41.74	39.17	53.50	11.76	1,322,943	1,562,433	1,624,969	302,026	62,536
CCUs	35.70	35.65	41.43	5.73	1,409,556	1,411,098	1,662,691	253,135	251,593
MAU CDH	52.92	56.79	63.14	10.22	1,906,125	2,026,242	2,168,508	262,383	104,060
Ward 10 late shift extra B5				1.72			66,342	66,342	66,342
Hazlewood late shift extra B5				1.72			68,672	68,672	
Band 8c Paediatrics				1			77,798	77,798	
Band 6 Neonatal safeguarding				1			49,989	49,989	
NRU Band 7				1.23			52,403	52,403	
Total	**442.51**	**443.64**	**545.54**	**109.70**	**16,607,694**	**17,577,170**	**20,016,305**	**3,408,611**	**2,272,756**

13.0 Service Expansions

13.1 During the Workforce review, a number of service expansions have been identified that require formally recognising within the establishment.

13.2 The total increase to budget for the essential changes equate to £2,143,548 per annum.

13.3 Breakdown of service expansion:

Service Expansions	Reg/Unreg	Current Funded WTE	Current SIP	Proposed wte	Proposed Change to funded wte	Current budget	Crude forecast inc bank/agency	Revised Cost	Inc+/Dec- to Budget	Inc+/Dec- to forecast
MTW		18.10	25.73	33.01	14.91	563,711	930,515	941,111	377,400	-24,816
Ward 15 Vascular		42.42	43.08	51.92	9.50	1,270,987	1,468,698	1,508,732	237,745	40,033
EDU		19.10	40.33	64.29	45.19	683,106	1,535,399	2,211,509	1,528,403	676,111
TIA Ward 21	B4 1.72		1.72					50,783		
DOSA Gynae	B5 1.72, B4 0.49		2.21					80,642		
DOSA Neuro	B4 1.72		1.72					50,783		
DOSA Ward 3	B6 0.6, B5 0.43, B4 1.23, B3 2.46		4.72					149,385		
HOBS	B5 5.74,B2 5.74		11.48					362,812		
Telemetry Coronary care both	B5 -1.49		1.49					57,325		
Ward 17 neuro hot clinics	B3 0.63		0.63					17,442		
Crit Care FUP clinics	B7 0.25, B6 0.25		0.5					25,217		
CRCU Service Improvement	B7 1.0		1					53,502		
Crit care icnarc	B4 1.0		1					29,525		
		79.62	**135.61**	**149.22**	**69.60**	**2,517,804**	**3,934,612**	**5,538,767**	**2,143,548**	**691,328**

14.0 Time to Lead

14.1 The role of the ward manager is pivotal to the quality and outcomes of patient care. The impact and influence in the effectiveness of the day to day running of a ward cannot be underestimated. It has been reported in the RCN 2010 and Francis Report that the ward manager role in ensuring quality, safety and the patients experience.

14.2 Therefore, the current workforce reviews has allocated 80% time to lead and 20% working clinically as part of the team. Time to lead can be defined as any duty that contributes to the delivery of safety, effectiveness and experience. This may include but not exclusive to mentoring, clinical supervision, roster management, responding to clinical incidents, implementing improvements and

supporting staff. The ward manager role is pivotal to the experience of patients and staff and is expected to be highly visible and accessible to both groups.

15.0 Support staff – Housekeepers and ward clerks

15.1 The review identified discrepancies in consistency relating to ward clerk and housekeeper roles. The rationale to introduce a housekeeper to all ward areas is to reduce the time Health Care Assistants spend on non-clinical work, therefore, releasing time to deliver direct patient care. Hurst (2010) concluded that the introduction of housekeepers allowed nursing staff to provide more direct care to patients - the role of the housekeeper is to work as part of the ward team, under the direct supervision of the ward manager and in partnership with the domestic services. The housekeeper will co-ordinate non clinical services such as catering, cleaning, equipment and supplies. This can include ordering non clinical supplies, keeping the ward clean and tidy, serving and clearing meals, preparing snacks and drinks, reporting faults.

15.2 The review proposes all inpatient areas have one full time ward clerk and one housekeeper to support the day to day running of the ward. Some high turnover areas such as Medical Assessment unit and children's ward would require additional ward clerk services during out of hours and weekends.

16.0 Enhanced Level of Care

16.1 The changing demographic of the patients requiring care in hospitals is leading to an increase to enhanced levels of care. This is affected by the number of DTOC patients medically fit for discharge, waiting for the next placement. 75% of these patients were recognised as requiring an increased level of care in a point prevalence study. Reducing length of stay is likely to positively impact the amount of enhanced care requirement in the hospital setting, however, this must be viewed with caution given the dependency related to an aging population.

16.2 LTHTR is part of a national improvement programme with NHS Improvement, reviewing our processes of enhanced level of care. The staffing reviews have built in a moderate amount of enhanced level of care, to reduce the need to request additional staff on a regular basis. The principle of doing this is aimed at improving the efficiency and effectiveness of this group of staff and positively impact the safety and experience of both staff and patients by providing greater continuity within teams.

16.3 There is a group of patients not accounted for in the overall staffing reviews that will always require highly specialised interventions due to the extreme complexity of their conditions. These will continue to be managed on a case by case basis.

17.0 Overall Investment

Summary be Band	Reg/Unreg	Current Funded WTE	Current SIP	Proposed wte	Proposed Change to funded wte	Current budget	Trust Forecast Month 9	Revised Cost	Inc+/Dec- to Budget	Inc+/Dec- to forecast
Band 7		73.90	71.09	71.75	-2.15	3,953,819	3,803,348	3,840,445	-113,374	
Band 6		175.55	195.34	179.56	4.01	8,315,243	8,697,293	8,586,651	271,408	
Band 5		840.89	728.54	886.62	45.73	32,351,954	30,805,077	34,346,413	1,994,459	
Band 4		103.51	79.15	113.76	10.25	3,056,117	1,997,074	3,508,094	451,977	
Band 3		277.48	320.9	359.05	81.57	7,682,069	9,363,119	10,176,306	2,494,237	
Band 2		251.78	246.6	385.75	133.97	6,227,568	11,739,086	9,411,798	3,184,230	
A&C Band 2 (WC)		46.26	58.45	47.68	1.42	961,395	1,160,958	995,273	33,878	
Ancillary Band 2 (HK)		17.11	39.06	38.32	21.21	315,358	847,904	812,668	497,310	
Other Bands		20.26	42.18	16.46	-3.80	1,190,107		829,516	-360,591	
Other		-	0.60	-	0.00	-		-	-	
Total		**1,806.74**	**1,781.91**	**2,098.94**	**292.20**	**64,053,630**	**68,413,858**	**72,507,165**	**8,453,535**	**£4,093,307**
								Reduce sickness to 4%		**£-1.7m**
								Stop escalation		**£-2m**
Total investment required										**£300k**

17.1 The overall investment against forecast is £4,093,307. However, the current sickness levels for staff on inpatient wards exceeds the headroom built into budgets, currently set at 4%. Whilst short term sickness is not consistently covered using bank and agency staff, long term sickness absence is and this equates to a £1.7m saving opportunity should sickness be reduced in the ward areas from 6.53% to 4%.

17.2 The current use of up to 50 escalation beds leads to additional spend equivalent to circa £2m on pay and non-pay. The continuous improvement programme is focused on decreasing length of stay, in turn occupancy levels, leading to the cessation of escalation beds and in turn the additional spend associated with this.

17.3 Therefore, a planned reduction in sickness rates and the utilisation of escalation beds will have a positive impact on the amount of investment required. If sickness and escalation is reduced as planned that will have reduce the amount of investment to £300k – however, the lead in time for the identified improvements would be significant.

17.4 Clearly, the Continuous Improvement plan for the organisation, which the Board is sighted on, details the transformational improvement plan that will result in system wide efficiencies relating to

occupancy levels across the hospital. These will translate into further efficiency opportunities as they are implemented.

17.5 A staffing action plan has been developed, see below. A component of this action plan demonstrates areas that will offer efficiencies going forward. It should be noted, not all actions have efficiencies linked to them. The financial impact of some of the reviews is not yet known, however the Board will be kept appraised of progress through the Financial Investment Committee. Safety and Quality committee will continue to receive a monthly safe staffing paper.

18.0 Safe Staffing Action Plan 2018/19

Key	
Red	Missed deadline
Amber	On track to deliver
Green	Delivered
Grey	Savings not applicable

Number	Work stream & actions	Saving	Lead	Completion Date	RAG Status
1	**Enhanced Level of Care (ELOC)**				
	Member NHS improvement work stream ELOC		S. Cullen	27.1.18	
	Internal review against peer process		S. Cullen	28.2.18	
	Implement monitoring of bank spend on ELOC		S. Cullen	30.3.18	
	Attend London event		S.Cullen	11.4.18	
	Implement changes including policy and risk assessment		DND's	31.5.18	
	Implement use of reviews and matron approval in safe care		S. Cullen	31.5.18	
	Deliver reduction in ELOC	£TBC	S, Cullen	01.09.18	
2	**Non ward based nursing reviews**				
	Out Patient	£TBC	D. O'Mahoney	28.3.18	
	Theatres		D. O'Mahoney	30.5.18	
	Cancer Clinical Nurse Specialists	£TBC	A. Tomlinson	30.3.18	
	Non Cancer Clinical Nurse Specialists	£TBC	S. Cullen	30.4.18	
	Agree non ward based commitment to inpatient wards	£TBC	S. Cullen	30.8.18	
3	**Ward based staffing review 2017/18**				
	Ward establishments reviewed and staffing recommendations	**	S. Cullen	31.3.18	
	Role substitution opportunities explored and implemented – Band 4.	£750k		30.3.18	
	Reduction in Barton establishment	£106k	S. Cullen	30.2.18	
	ED Staffing review		S. Cullen	31.3.18	
	Neonatal staffing review		C. Atherton	31.12.17	
	Ward Manager time to lead agreed 0.8 WTE	£554k	S. Cullen	31.1.18	
4	**Nurse/Midwife bank Fill Rates**				
	Review of internal bank		K. Philips	30.4.18	
	Cease agency HCA use, outside of escalation areas	£140k	G. Naylor	31.8.18	
	Increase number of Registered Nurses and Healthcare Assistants on Bank		K. Philips	30.5.18	

	Continue to monitor fill rates against establishment in monthly safe staffing paper.		S. Cullen	ongoing	
	Model Hospital KPI review		S. Cullen	30.5.18	
5	**Returning to a zero outlier status**				
	Discharge Coordinators based on wards		A. Brotherton	28.2.18	
	Implement SAFER principles in all areas		DND's	30.4.18	
	Patient flow – key aim in patient experience strategy		S. Cullen	18.1.18	
	Reduction in 50 escalation beds	£2m	S. Hargreaves		
	Essential ward clerk role reviewed as part of staffing reviews		S. Cullen	31.3.18	
6	**Communication Plan**				
	Communicate 2017 recruitment progress to staff		G. Naylor	31.1.18	
	Bi Monthly recruitment bulletins		K. Philips	Ongoing	
	Nursing, Midwifery & AHP Strategy launch		G. Naylor	18.01.18	
7	**Matron and Daily staffing management**				
	Site, bed management and Hospital at Night review		S. Cullen	28.2.18	
	Remove matrons from site rota during day		S. Cullen	01.12.17	
	Remove Matrons from site late and implement weekend working at Chorley.	£102k	S. Cullen	30.7.18	
8	**Roster efficiency & safe care**				
	Build rostering dashboard into monthly Performance reviews		F. Button	28.2.18	
	Combine use of safe care and e rostering on dashboard		S. Cullen	15.2.18	
9	**Bed base re-established to meet specialty demand**				
	Establish working group		G. Naylor	26.1.18	
	Review activity data and establish bed base specialty requirements		S. Hargreaves	30.4.18	
	Agree priority areas vascular and paediatrics phase 1		G. Naylor	21.2.18	
	Vascular Length of stay reduction, bed base reduction - TBC	£TBC	S. Hargreaves		

** **Detailed amendments linked to efficiency explained below, reducing investment required.**

19.0 Risk

19.1 As part of the staffing review, a number of concessions have been assessed as being appropriate within the context of the suggested staffing models these include the list below. These have also contributed towards finalising a model that is as efficient as possible whilst addressing professional judgement recommendations.

- Standardising Ward Clerk/Housekeeper 1 WTE for each area except admission areas – corrects previously underfunded and over established areas.
- CCU – Band 6 - agree 12 hours per day as oppose to the recommended 24.
- CCU – no housekeeper as HCA dual role.
- Ward clerk in small units <1 WTE.

- ED CDH reduced by 1 RN per shift due to activity.
- MAU CDH nurse:patient ratio slightly higher at 1:4.3 due to fluctuations in activity.
- Built in the AP role to reduce the nurse:patient ratio, none exceed 1:8 planned.
- Stopped escalation of children's beds, previously increased to 40, now fixed at 30.
- Mitigated risk in children's services whilst recruiting to agreed interim investment in December 2016.

19.2 The new establishments and subsequent funding are reliant on a number of assumptions delivered.

- Maintenance of no fewer than current vacancy levels.
- Recruitment to substantive registered nurse vacancies positions.
- Risk assessed staged implementation in level 2 areas, paediatrics and those exceeding 1:8 on late shift and the spend associated with agency fill rates.
- Children's staffing is not yet achieving national guidance, further review and investment will be required in the next 12 months.
- Failure to reduce DTOC will limit the impact of enhanced level of care workstream.
- Quality and safety metrics in CCU maintained excluding concern.
- CQC assessment of staffing, concurs with professional judgement of staffing reviews.
- Neonatal quality and safety metrics maintained excluding concerns.
- The role substitution is not directly linked to deficits in quality and safety metrics.
- Emergency Department occupancy reduces.

19.3 The output of the staffing review will lead to a reduction in the staffing risk for nursing across all areas of the organisation and will positively contribute toward reducing the incidence of pressure ulcers, falls and improved patient experience.

20.0 Patient Experience

20.1 There is a direct correlation between the experience of patients and staff and staffing levels. The national patient surveys were examined as part of the reviews and the following findings considered.

- Children and Young people 2016 rank 65th/71.
- Emergency Department 2016 rank 57th out of 75.
- Inpatient 2016 rank 70th out of 83.

20.2 The outputs of these results demonstrate there is a requirement to improve in all of the areas in relation to patient experience. In January 2017, a 3 year Patient Experience and Involvement Strategy

was launched to address the findings of the surveys and a restructure of complaints handling is currently underway - we expect to see changes in surveys from 2018 onwards to reflect the focus on experience.

21.0 Conclusion

21.1 The staffing reviews 2017/18 have built upon a systematic approach which has delivered a greater level of detail and triangulation. With the exception of children's services, which are likely to require further assessment once recruitment to the November 2016 investment is complete, the establishments, when approved are fit to deliver excellent care with compassion.

21.2 The phased implementation of the new establishments will be risk assessed and will only incur additional agency costs in the level 2 areas, children and the late shift on Hazelwood and Ward 10 whilst substantive recruitment is taking place. However, the establishments will reflect the total investment required to reach the staffing levels recommended in this review.

21.3 The process has been undertaken and benchmarked against NHS Improvement and NICE guidance for safe staffing and has considered specialty guidance to ensure a triangulated approach with quality and safety measures. The evidence base demonstrating the direct correlation between staffing levels and patient and staff experience and safety is undisputable. Clearly, the leadership to deliver changes in culture that will change these experiences and improve patient safety is fundamental. Therefore, the approval to increase the establishment as outlined in this paper is an investment in our services at Lancashire Teaching Hospitals as a whole and will result in improved performance in a number of areas.

22.0 The Board is asked to

- Approve the contents of the annual staffing review 2017/18.
- Approve the financial model required to deliver the proposed staffing establishment changes this will require 292.20 WTE to be put into the nursing establishment.
- Approve the reporting of progress against the staffing plan and subsequent efficiencies to Financial Investment Committee.

Appendix 1 Safe Staffing Guidelines

This seeks to provide a broad overview of the guidance consulted and considered when applying the speciality guidance available.

Speciality	Guideline's	Recommendations
Adult inpatient areas	NICE Safe Staffing Guidelines	There is no single nursing staff-to-patient ratio that can be applied across the whole range of wards to safely meet patients' nursing needs. Each ward should determine its nursing staff requirements to ensure safe patient care. It then recommends on-the-day assessments of nursing staff requirements to ensure that the nursing needs of individual patients are met throughout a 24-hour period Recommends use of Shelford Safer Care Tool and endorses the use of Health Roster and SafeCare
Children's and Young Peoples Service	RCN standards (2013)) Defining staffing levels for children and young people's services	Children < 2 years of age 1:3 registered nurse: child, day and night. Children > 2 years of age 1:4 registered nurse: child, day and night The ward staffing complement must also have a supervisory ward sister/charge nurse and unregistered staff, who are not included in the above baseline bed side establishment. The following standards should be applied for all general inpatient wards as a minimum: • one Band 7 ward sister/charge nurse • one ward receptionist +/- admin support for sister • minimum of one health play specialist • one housekeeper • +/- one hostess. Skill mix should be balanced to meet the needs of the service and dependency/acuity of the children and young people requiring nursing care. In addition to the Band 7 ward sister/charge nurse, a competent, experienced Band 6 is required throughout the 24-hour period to provide the necessary support to the nursing team. This will provide an experienced nurse to advise on clinical nursing issues relating to children across the organisation 24-hours a day. High dependency care The nursing requirements for infants and children in NICU and PICU requiring high dependency care have been defined above. However, high dependency care is often provided outside of the intensive care unit in both specialist wards in tertiary hospitals and general wards in district general hospitals. The expertise and support for staff in these settings varies considerably, necessitating staffing for high dependency care to be based on local requirements as well as national guidance. While use of a children's high dependency care assessment tool can assist the assessment of staffing requirements for high dependency care, the following registered nurse-to-patient ratios should be applied regardless of the setting: • 0.5:1 registered nurse: patient for children requiring close supervision and monitoring following surgery, those requiring close observation for mental health problems or with single system problems. • 1:1 registered nurse: patient, where the child is nursed in a cubicle, has mental health problems requiring close

		supervision, or where the condition of the child deteriorates and requires intensive care. This higher ratio will also be required during the admission process until the child is fully admitted and stable.
Coronary Care units	British Cardiology Society (2011)	Recommends BACCN standards Staffing in the acute cardiac care unit should not fall below a ratio of one registered nurse to two patients.
Critical Care Units	British Association of Critical Care Nurses 2009 Standards for nurse staffing in critical care. (BACCN)	Critical Care units also require a number of staff to support the delivery of care to patients through: 1. Management of the unit by a designated lead matron, 2. Coordination of each shift by a supervisory/supernumerary senior critical care qualified nurse. 3. Additional supervisory/supernumerary support for every 10 beds. (BACCN/ICS recommendation: 21 – 30 beds = 2 additional supernumerary registered nurses). This is the minimum recommended and the current layout of the units plus the relatively junior/inexperienced workforce increases the need to provide additional support. The support includes assistance with admissions, transfers, ensuring patient care is driven forward to reduce length of stay or time spent at level 3 e.g. that there are no delays in weaning plans 4. Education and Training for staff - the recommended service specification is that 50% of staff on critical care units should be in possession of a post registration award in Critical Care Nursing. The BACCN/ICS recommendation is 1 for every 75 staff. Each Critical care unit should have a dedicated clinical educator. 5. Technical support – The vast amount of medical devices within the unit requires a level of technical expertise to maintain the day to day integrity of the machines in the clinical environment 6. Care support Health care assistants are required to support the provision of care in each area of the unit
Critical Care Units	Guidelines for the Provision of Intensive care services Core Standards for Intensive care units 2013	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 ICS levels of care) require a registered nurse/ patient ratio of a minimum 1:2 to deliver direct care Supports BACCN standards
Emergency Departments	RCN Baseline Emergency Staffing Tool (2013)	BEST recommends minimum nurse to patient ratios when planning nursing establishments or for use on a shift-by-shift basis. The Best tool reflects the following ratios. One registered nurse to four cubicles in either “majors” or “minors” One registered nurse to one cubicle in triage One nurse to two cubicles in the resuscitation area. 1 band 7 (or equivalent) registered nurse on every shift at all times Major trauma (2 registered nurses to 1 patient) Cardiac arrest (2 registered nurses to 1 patient) Priority ambulance calls (1 registered nurse to 1 patient) Family liaison (1 registered nurse to 1 patient’s family/carers) 1 Registered Children’s nurse per shift
Major trauma Network	Regional Networks for Major Trauma 2010	Major Trauma Peer review recommends one Band 7 RN per shift in the ED 24/7 to maintain Major Trauma status. Geography is also an important factor that affects the number of nurses required to provide visual observation of acutely unwell patients. A children’s nurse should be present in the departments during opening hours

		In the Major Trauma Centre, patients with multiple injuries should be located within dedicated trauma wards. Some patients with single system injuries may have their care needs best met by the appropriate speciality ward. Crucial to the delivery of safe, high quality care for trauma patients is the establishment of a critical mass of experienced staff. This requires a highly trained and experienced nursing workforce with the appropriate staffing levels, skills mix, ongoing education and leadership.
Neonatal Services	British Association of Perinatal Medicine (2011) Department of Health (2009)	The recommended staffing levels for neonatal services, minimum nurse to child ratio Intensive Care 1:1 High Dependency 1:2 Special Care 1:4 The DOH also produced best practice guidance for neonatal staffing which recommend a nurse co-ordinator on every shift (additional to those providing direct clinical care) and that units have a minimum of two registered staff on duty at all times (one which holds a qualification in the speciality)
Neuro Rehabilitation	NICE 2015 Specialised Neurorehabilitation Service Standards Updated 30.4.2015	Specialised rehabilitation services for Neurorehabilitation services per 20 beds require Hyper acute phase - 65-75% RN Level 1a -50-60% RN Level 1b – 35-40% RN At least 40% of nurse should have specific rehab training
Older People	RCN Safe Staffing for Older People's Wards (2012)	Recommends 1:5 – 1:7 nurse to patient ratio to deliver ideal, good quality care. 65:35% registered to un- registered skill mix.
Stroke	British Association of Stroke Physicians 2014 BASP	The Acute Stroke Unit provides sufficient trained nursing staff to provide high quality nursing care. In the first 72 hours of an acute stroke patient's admission, they will require more intensive monitoring and nursing input, requiring a minimum Level 2 nursing staff numbers to manage the acute stroke patient (2.9 WTE nurses per bed; 80:20% trained to untrained staffing ratio) is recommended. Thereafter a level of 1.2 WTE nurses per bed is appropriate.

Appendix 2 - NHS Improvement Resources

Area for Improvement	Description	Sources	Evidence
National Quality Board (2016) Improvement and Assessment Framework for Children's and Young People's health services			
Nurse Staffing Levels	Right staff Right Skills Right time and place	Supporting NHS providers to deliver the right staff with the skills at the right time (National Quality Board 2016)	Evidence-based workforce planning. Professional judgement. Compare staffing with peers. Mandatory training, development and education. Working as a multi-professional team. Recruitment and retention. Productive working and eliminating waste. Efficient deployment and flexibility, Efficient employment and minimising agency
National Quality Board (2017) Safe, Sustainable and productive staffing: An improvement resource for neonatal, children and young people services			
Nurse Staffing levels	Safe, Effective, caring, Responsive and Well-led care	National Quality board (Nov 2017)	Boards must ensure there is a strategic multi-professional staffing review at least annually (or more frequently if service changes are planned or quality or workforce concerns are identified), which is aligned to the operational planning process. In addition a mid-year review should provide assurance that neonatal services are safe and sustainable. This should assess whether current staffing levels meet the recommended levels and are likely to do so in future. Skill mix should be regularly reviewed to ensure that the most suitable staff are undertaking the correct roles and that they are available in sufficient numbers. Professional judgement should be used together with appropriate workforce and acuity tools. Data collected using BadgetNet and the neonatal nurse staffing tool (Dinning) should be used to calculate the required establishment according to the level of activity. This should be shared with the neonatal ODN. Training and development must be linked to annual individual appraisals and development plans and must be provided within the resources available to the team, to meet service needs. Organisations should recognise the increasing need for flexible working patterns to meet the fluctuating needs in neonatal services. All neonatal units should adhere to the pathways agreed with the ODN and specialised commissioning teams to ensure efficient working across the network. All neonatal units should input data into BadgerNet to enable national

			benchmarking. Areas of concern highlighted by parents/families or staff using workforce planning and analysis methods must be carefully scrutinised and appropriate actions taken to address them.
National Quality Board (2018)Safe, sustainable and productive staffing – adult inpatient wards in acute hospitals			
Nurse Staffing levels	Safe, Effective, caring, Responsive and Well-led care	National Quality board (Jan 2018)	A systematic approach should be adopted using an evidence-informed decision support tool triangulated with professional judgement and comparison with relevant peers. A strategic staffing review must be undertaken annually or sooner if changes to services are planned. Staffing decisions should be taken in the context of the wider registered multi-professional team. Consideration of safer staffing requirements and workforce productivity should form an integral part of the operational planning process. Action plans to address local recruitment and retention priorities should be in place and subject to regular review. Flexible employment options and efficient deployment of staff should be maximised across the hospital to limit the use of temporary staff. A local dashboard should be in place to assure stakeholders regarding safe and sustainable staffing. The dashboard should include quality indicators to support decision-making. Organisations should ensure they have an appropriate escalation process in cases where staffing is not delivering the outcomes identified. All organisations should include a process to determine additional uplift requirements based on the needs of patients and staff. All organisations should investigate staffing-related incidents and their outcomes on patients and staff, and ensure action and feedback.
National Quality Board (2017) Safe, sustainable and productive staffing An improvement resource for urgent and emergency care			
Nurse staffing levels	Leading change, adding value	National Quality board (Nov 2017)	A strategic staffing review must be undertaken annually or sooner if changes to services are planned. A systematic approach should be adopted using an evidence-informed decision support tool cross-checked with professional judgement and comparison with comparable peers. Safe staffing requirements and workforce productivity should be considered as an integral part of the operational planning process. Acuity and dependency may vary considerably within UEC settings. Staffing reviews should use decision support tools for the

			assessment and measurement of acuity, dependency and workload. Demand in UEC settings fluctuates through 24 hours, the week and with the season. Workforce planning should allow for this and reflect trends in activity. Contingency plans should enable flexibility of staffing to meet unexpected demand. Workforce planning should allow for role development/expansion and new ways of working while ensuring that fundamental care remains a priority. Staffing decisions should be taken in the context of the wider multi-professional team. A local dashboard should be used to assure stakeholders that staffing is safe and sustainable. The dashboard should include department-level quality indicators to support decision-making. Organisations should ensure they have an appropriate escalation process in case staffing is inadequate. Action plans to address local recruitment and retention priorities within UEC settings should be in place and subject to regular review. Flexible employment options and efficient deployment of staff should be maximised to limit the use of temporary staff. All organisations should have a process to determine additional uplift requirements based on the needs of patients and staff. All organisations should investigate staffing-related incidents and the outcomes for patients and staff, ensuring action and feedback.