Belfast Health and Social Care Trust
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ANNUAL REPORT & ACCOUNTS 2020/21

Belfast Health and Social Care Trust
Annual Report and Accounts
for the year ended 31 March 2021

Laid before the Northern Ireland Assembly under Article 90 (5)
of the Health and Personal Social Services (NI) Order 1972
(as amended by the Audit and Accountability Order 2003)
by the Department of Health
on 15 July 2021

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CHAIRMAN'S FOREWORD

The 2020-21 Annual Report is unique. At no time in our history have health services across the world witnessed a pandemic such as the scale of Covid-19. Northern Ireland has not been immune from this and I am pleased, as Chairman of Belfast Health and Social Care Trust to recognise and celebrate the pivotal role this Trust has played in Northern Ireland's response to this pandemic thus far.

Covid-19 has challenged every aspect of modern day society like never before. And in terms of the health service, in many ways we became unrecognisable. But one aspect has remained steadfast throughout – the bravery, skill, and dedication of our staff. Moreover, it is more than fair to say this has been recognised and applauded right across society.

Under the leadership of Chief Executive, Dr Cathy Jack and in the space of a few short weeks, our teams were able to transform our response to the emerging and acute need. We reduced footfall across our sites, the Mater Hospital transformed to become Belfast Trust's Covid Hospital, we altered almost every service user's pathway, and increased critical care bed capacity to levels where over 200 patients with Covid-19 could receive potentially lifesaving intensive care.

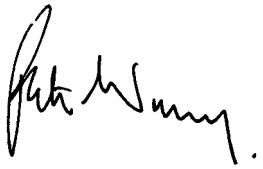
Since those early days of the pandemic in March 2020, we have faced three surges. The Trust's resilience plans have been more than stress-tested in the past 12 months and whilst we have withstood the pressure placed upon us, we have learnt a number of lessons that we will incorporate into future planning. Whilst unavoidable, and driven solely by the organisational imperative to keep service users and staff safe, some of the decisions were tremendously difficult to take. I know that many people in receipt of community support, or waiting on surgery have suffered due to a lack of access to care and that is a source of profound regret to everyone in the Trust. This global crisis impacted everyone in different ways and many suffered directly and indirectly.

But it also is to the great credit of staff that so much work continued. You will see as you read through the following pages how the past year has shown us the adaptability and ingenuity of our staff as they continued to provide many services in the face of the pandemic. This has included drive through clinics, virtual appointments and the use of technology to educate and inform our service users as all of us became accustomed to a new way of living.

Whilst social distancing guidelines did not permit a staff recognition event to take place in 2020 I cannot help but feel it would have been incredibly difficult to select winners for specific awards from a field so rich with talent, dedication and creativity. Every member of staff across health and social care should be recognised equally for the terrific role they played this year of all years.

I would like to thank my Non-Executive colleagues on the Board of Directors as well as Dr Cathy Jack, our Chief Executive, the Executive Team and all the Divisional Management teams for their continued support.

I commend this Annual Report to you as a snap shot of a period in history which we all hope, will never be repeated.



PERFORMANCE REPORT

PERFORMANCE REPORT

Performance Overview

The purpose of the performance overview is to provide a brief summary of the Trust, its aims and risks to the achievement of its objectives. It also provides an overview of the Trust performance over the past year.

Chief Executive's Statement

I am delighted and proud to present this Annual Report. During this time our health service has been tested unlike any other time in its history and through the dedication and courage of our staff, resilience of our contingency plans and quality of service delivery we have delivered care to those most in need during the Covid-19 pandemic. As we inch our way through recovery and rebuilding plans, we are mindful of the ever-present threat of Covid which will dictate what our services will look like in the immediate months and years to come.

Time and again our staff have gone above and beyond as they provided compassionate care to those who were ill with Covid and to their families, especially those who were unable to visit loved ones who have passed away. That pain is unimaginable but I am proud that our staff, even when faced with increasing demands prioritised the importance of compassion for those we care for. This is demonstrated by the exceptional feedback we have received from patients and their families.

Our teams across a range of services have adapted to the unexpectedly new restrictions on how we carry out our roles. This has not been confined to critical or acute care. Our community teams have carried out the extremely difficult work of providing care for patients who have Covid at home; district nurses expanded their roles significantly, social workers home schooled children who live in our children's homes just like every other parent during lockdown, and clinical and social care teams supported multiple nursing homes in outbreak. Our Patient Client & Support Services and our Estates staff saved lives. They have kept our sites running safely, even in the most challenging of times and none of this would have been achievable without our dedicated team at Coolmore Stores ensuring everyone had access to appropriate Personal Protective Equipment (PPE). We delivered 112,858,462 PPE over the past year.

Belfast Trust took on a regional role with the Nightingale Hospital and enhanced respiratory care at the Mater Hospital. Our outcomes are exceptionally good. For example, 148 patients with Covid were discharged from ICU and over the last year, 29 patients were treated successfully by our specialist teams in the Mater.

Our ICU Follow Up team are providing excellent multi-disciplinary care to patients who were admitted to ICU. Whilst Human resources have produced videos to guide and support staff through

the pandemic, provided expert occupational health support to staff, and were available to guide us through the myriad of unfolding advice for staff as we learned more and more about this deadly disease and how it could impact on our staff. There is much, much more to read in this Annual Report. This ability to diversify is indicative of many other examples across the organisation and demonstrates the ability we have to change approach whilst delivering results.

Whilst we are proud to have delivered high standards of care during the pandemic, it has not been without its challenges. Redirecting resources to fight the disease was the right thing to do but this has had an inevitable impact on other services where waiting lists have grown even further and surgery has been postponed with deep regret. Through our recovery and rebuilding plans, we are working with regional Health and Social Care partners to deliver these services based on clinical need. This has included the introduction of “Green (Covid minimal) Pathways” which will help isolate Covid-19 treatment from our complex and major surgery, which will take place at Belfast City Hospital on behalf of the region.

Whilst our focus has necessarily been on the Covid-19 pandemic, there is a long-term emphasis and commitment to ensure the health service remains financially sustainable. I can report that this year, in spite of extraordinary pressures, we met all of our financial commitments. The health and social care landscape has changed, however, as the demands on our services have grown to unprecedented levels. Health and Social Care will never be delivered in the same way as it was prior to this pandemic. It has never been clearer that major reform is required at all levels of the HSC system including addressing workforce issues, emergency care, waiting times and care in the community – and most particularly, care of older people and vulnerable younger people.

Whilst challenges will remain and new issues will arise, I am enthused and encouraged by the attitude of our staff in how they adapt and remain committed to continually improving and transforming service delivery. I have every faith that we will go from strength to strength given the determination, focus and courage of my 22,000 colleagues.

Trust Purpose and Activities

Belfast Trust is one of the largest integrated health and social care Trusts in the United Kingdom.

We deliver integrated health and social care to approximately 358,000 citizens in Belfast and provide the majority of regional specialist services to all of Northern Ireland.

We have an annual budget of £1.9 billion and a workforce of over 22,000 (full time and part time). Belfast Trust also comprises the major teaching and training hospitals in Northern Ireland.

Our Annual Activity

In a normal year the average activity levels across the Trust include:

- Delivers 329,000 District Nursing visits
- Delivers care to 7,300 people supported in their own homes
- Is responsible for 251 children on the Child Protection Register, 871 Looked After Children and over 3,500 children and young people in need.
- Delivers 185,000 + attendances at Emergency Departments
- Cares for 64,000 day case patients
- Cares for 20,000 elective inpatients
- Cares for 43,000 non-elective inpatients
- Cares for 562,000 outpatients, including 18,000 with procedures undertaken
- Delivers 18,000 critical care bed days including Paediatric ICU, Regional ICU, HDU and Special Care Baby Unit
- Delivers 8,200 Cardiology procedures
- Has over 130 partnerships + more than 1,000 contracts with community, voluntary and private sector organisations
- Is supported by 350 volunteers
- Staff liaise with and provide support and advice to carers through a network of family carers (estimated to be in the region of 40,000).

Where our services are based

Map Key

= Hospital Site

Muckamore Abbey Hospital is situated approximately 13 miles outside Belfast in Co Antrim

= Wellbeing and Treatment Centre (WTC)

G – Grove WTC
C – Carlisle WTC
S – Shankill WTC
BH – Beech Hall WTC
B – Bradbury WTC
K – Knockbreda WTC
H – Holywood Arches WTC

Our Vision

The vision for the Belfast Trust is to be one of the safest, most effective and compassionate health and social care organisations.

Our Values

The HSC Values were established to embed a core set of leadership values and associated behaviours across all Health and Social organisations in Northern Ireland. They were the result of a large-scale scoping exercise that received nearly 4,000 responses.

The Values define everything we do – how we work with each other and deliver our services. They reflect our commitment to provide safe, effective, compassionate and person-centred care.

The HSC Values are:

Working together

We work together for the best outcome for people we care for and support.

We work across Health and Social Care and with other external organisations and agencies, recognising that leadership is the responsibility of all.

Excellence

We commit to being the best we can be in our work, aiming to improve and develop services to achieve positive changes.

We deliver safe, high quality, compassionate care and support.

Openness and Honesty

We are open and honest with each other and act with integrity and candour.

Compassion

We are sensitive, caring, respectful and understanding towards those we care for and support our colleagues. We listen carefully to others to better understand and take action to help them and ourselves.

Our Corporate Themes

Our Corporate Themes support the achievement of the Trust's Vision and are well embedded throughout the organisation. The way that our services will be planned and developed from 2018 - 2021 are described under these five themes:

- **Safety, Quality and Experience** – the Trust will work with service users and carers to continuously improve Safety, Quality and Experience for those who access and deliver our services
- **Service Delivery** – the Trust will drive improved performance against agreed goals and outcomes in partnership with our service users and carers, staff and partners in the community and voluntary sectors
- **People and Culture** – the Trust will support a culture of safe, effective and compassionate care through a network of skilled and engaged people and teams
- **Strategy and Partnerships** – the Trust will work with partners to innovate and to develop strategies to transform health and social care in partnership with our service users and carers, staff and partners in the community and voluntary sectors
- **Resources** – the Trust will work together to make the best use of available resources and reduce variation in care for the benefit of those we serve.

The Trust Corporate Objectives to underpin these themes are:

- We will seek, listen and respond to service user and carer experience, including real-time feedback in order to inform and develop our services

- We will make our services safer and achieve agreed improvements across our safety improvement measures
- With our partners, we will encourage our population to play an active role in their own health and wellbeing
- We will support people with chronic and long term conditions to live at home, supported by carers, families and their communities
- We will optimise the opportunities for young adult care leavers through education, training and employment
- We will further develop safeguarding services in partnership with service users, parents, carers, communities and other agencies to enhance safety and welfare of vulnerable adults and children
- We will improve community support to enable more timely discharge for older people and those with chronic conditions
- We will deliver agreed improvements for our unscheduled care patients and develop services to avoid unnecessary admission
- We will deliver agreed elective care improvement each year, including acute, mental health and cancer services
- We will increase staff engagement in order to improve the delivery of safe, effective and compassionate care
- We will work with partners to innovate and to develop strategies to transform health and social care in partnership with our service users and carers, staff and partners in the community and voluntary sectors
- We will build a sustainable workforce, deploy our resources in an effective and efficient manner, invest in infrastructure which is fit for service delivery and achieve financial balance.

Challenges

Covid-19

Over the past 12 months Covid-19 has changed the face of health and social care in Northern Ireland beyond recognition. Our response to this challenge has been based on the principles of openness, compassion and working collectively.

During this time our primary aim and concern was to ensure capacity was available to deliver intensive and critical care, as well as recovery support to all patients who required it. The overarching ambition to never be at the point where care could not be provided was central to every decision taken and as a result the delivery model for health and social care will never be the same again.

The Covid-19 virus was first detected in Wuhan province, China in December 2019 and modelling suggested Northern Ireland would experience a rise in cases and admissions in April and May 2020. The Trust immediately took action to ensure preparedness for the pandemic while supporting service areas as they adapted in an effort to continue delivering care.

The Trust established specialist Covid-19 areas as a priority before the first patient presented. Initially, a dedicated ward in the Royal Victoria Hospital was reconfigured and staffed to treat the first Covid-19 patients in Northern Ireland. Processes were set up to immediately isolate and test any patient who attended with or developed symptoms.

A significant element of the testing program required an increase in our lab capacity, from a low base of 360 tests per week the Regional Virology Laboratory (RVL) can now process over 9,000 PCR tests over a seven day period. This was crucial to our management of patients in our hospitals and in maintaining safe staffing levels.

In late March 2020, as projections made clear the potential need for a rapid expansion in respiratory and critical care we took the decision to designate the Mater Hospital as Belfast Trust's Covid-19 acute site. Whilst this required a number of services to decant to other sites this decision ensured we had the capacity required to treat any initial surge of patients with Covid-19.

To coincide with this re-designation and their move to the Mater, our respiratory team, across a range of disciplines, recorded a video asking the public to follow public health messaging and to stay at home. The video went viral, reaching 8 million views on social media and appearing on news channels across the world. The emotion of the plea being delivered by those on the very front line of the response was central to the videos success.

The decision to re-designate the Mater also saw the Emergency Department closed to all but NIAS respiratory transfers which increased pressure on the Royal Victoria Hospital Emergency Department. In the first instance it was therefore critical that the RVH ED was redesigned to

separate Covid-19 from non-Covid-19 patients. Later we opened the Urgent Critical Care pathway within ED to triage patients more effectively and reduce capacity on the Department.

As admissions continued to rise, the Department of Health announced on 2 April 2020 that the Belfast City Hospital Tower Block would be re-designated as the HSC Nightingale Hospital for Covid-19 positive patients requiring Intensive Care Services. A significant multidisciplinary effort was required to improve electrical supply, expand oxygen capacity, procure specialist equipment and increase IT provision across the Tower Block. All of this was just as vital to our response as our clinical and nursing staff who answered the call of redeployment, returned from retirement or left training early to staff the beds at a safe level. This successful transformation allowed the Trust to potentially accommodate up to 230 critically ill patients with Covid-19 requiring ventilation and critical care.

To provide this increase in critical care patients a number of significant decisions were taken to release pressure on our services and create the capacity needed. A significant part of this was the postponement of elective surgery and we fully accept the anxiety that has caused. It cannot be easy to be told that your surgery has been postponed, especially when you do not know how long it will be before it is rescheduled. We apologise to the patients and families affected by this and have given assurances that patients have or will be rescheduled based on clinical need. Central to this is the designation of Belfast City Hospital as a regional centre for complex surgery which will maximise theatre capacity resulting in increased procedures as we work through waiting lists.

In the community we worked in partnership with local GPs to establish Beech Hall Health Centre as a Covid-19 community assessment hub, providing screening and health care for patients who were displaying symptoms consistent with Covid-19 but did not require hospital care. Additionally, the role of community and district nursing expanded dramatically as our Acute Care at Home Team delivered a wider range of care in people's homes than before. Their response to Covid and non-Covid issues has been exceptional and health and social care would not have been in the position to respond to the pandemic without their commitment to provide support to their service users.

On the same day, we followed Departmental advice and suspended visiting on all of our hospital sites. This was an incredibly difficult time, especially for our patients who faced an extended stay in hospital, and for those who sadly passed away in our care. Every effort was made to provide virtual visits through FaceTime and Zoom but we appreciate it was not the same as visiting in person. The safety of our patients, staff and visitors was paramount and this approach was regretfully necessary.

Partnership working was crucial in responding to the pandemic and in May 2020 we worked with Healthcare Ireland and the Ramada Encore to open a step down facility at the hotel to provide care for patients who were fit to be discharged from hospital but still required some clinical care before going home. Whilst this was not used to capacity it provided us with a significant increase in step down bed capacity to ensure those needing acute care could receive it in a hospital site.

As lockdown eased for most of society and acute Covid admissions declined from their peak the epicentre of the pandemic had moved from our hospitals to care homes. Throughout the pandemic, we have assisted care homes with thousands of items of PPE, guidance on infection, prevention and control and in ensuring safe staffing levels, which has included redeployment, where possible.

After the summer months Covid-19 admissions began to increase once again due to the general rise in transmission rates within wider society. HSC Nightingale was re-established, having been de-escalated over the summer, at the Belfast City Hospital Tower Block and other services scaled back to provide the bed and staffing capacity required to deliver Covid-19 care.

HSC Nightingale was formally stood down for a second time in April 2021 and all Covid-19 patients are currently cared for at the Mater Hospital as it remains the Covid-19 hospital for Belfast.

During the pandemic, in an effort to maintain the safety of our patients and staff a number of measures were put in place to minimise disruption to service delivery. Our IT team increased our server capacity to allow up to 1,400 people to work from home at any one time, reducing footfall in our sites and protecting non-clinical staff from exposure to the virus. This work also permitted us to hold virtual consultations in some service areas to maintain service delivery, where possible and through our virtual hospital, a small number of services were provided online, to create capacity within our acute sites and protect patients from exposure to Covid-19.

Equally, in Occupational Health measures ranging from staff testing to psychological support were put in place within a matter of weeks. This was crucial to ensuring our staff could get tested and, if the result was negative, return to work and continue to deliver services.

Management of our response to Covid-19

The Trust established a Covid-19 Oversight Group which leads on the Covid plan. This team works in partnership with the Senior Management Team of the Trust and oversees every aspect of our response to the pandemic, including what is happening in the community, in our hospitals, staffing, PPE stocks and testing in our laboratories.

We also have a specific community Covid-19 group which co-ordinates information pertaining to community services, including children's services, mental health and community learning disability.

Non-Covid services

At an early stage, the Trust took the decision to stand down outpatient and routine elective work to release staff to meet the increasing clinical needs of Covid-19 patients and to prevent patients coming to hospital sites for appointments. Where possible, clinicians have used telephone appointments to reduce the impact for patients.

Providing safe and effective care throughout the pandemic remained the Trust's top priority and as such there has been little impact in terms of emergency work.

The decision to postpone elective surgery was not taken lightly and we appreciate the anxiety our patients experienced as a result. We have already begun the process of recommencing elective surgery and it will be prioritised based on clinical need.

Staffing

In addition to specialist intensive care staff, other medical and nursing staff have been upskilled to work alongside the ICU trained staff caring for patients in intensive care.

We have put in place many measures to help our staff as we recognise that Covid-19 has the potential to increase psychological and physical pressures on staff. A number of helplines have been established, including an Occupational Health Advice Line and a confidential psychological support helpline. Staff have also been provided with guidance on looking after their mental health.

Regional guidance has been followed in terms of self-isolation for any member of staff suspected of having Covid-19 or whose family member is suspected of being Covid-19 positive, and for staff who required 'shielding' due to medical conditions, pregnancy or those over the age of 70. The Trust prepares a daily report on staff absenteeism as a result of the above, and uses this to arrange for appropriate testing to help staff return to work as quickly as possible. We have also enabled staff to work remotely where they are able to do so and where staff are required to work on hospital or community premises, social distancing guidelines are strictly followed.

Staff accommodation was organised by the Trust for staff who, for any reason, could not live at home or return home between shifts. Accommodation and meals were funded by the Trust.

Personal Protective Equipment

The availability of PPE to every member of staff who needs it is crucial, and we have established processes to ensure equality of access to PPE for all staff. The Covid-19 Oversight Group continuously reviews stock levels, usage and planned deliveries to manage the Trust's demands. This included ensuring local care homes who needed PPE from the Trust receive it.

Linked to PPE is the requirement to have staff appropriately fit tested for masks and we have trained all staff who may be required to wear masks of this nature.

Staff Testing/Labs facilities

The Belfast Trust Regional Virology Laboratory (RVL) worked hard to increase their testing capacity and turnaround times since the beginning of the pandemic. The RVL team, one of the first 12 UK Covid-19 testing sites, developed a testing platform in February 2020 and capacity has increased from 360 tests per week to over 9,000 tests per week. This has enabled the Trust to test staff as well as patients in line with regional testing guidance.

Swabbing for patient and staff testing was originally provided from two pods (in close proximity to

the Royal Victoria Hospital and Mater Emergency Departments) which were purchased specifically for Covid-19; swabbing was performed in the pods by Trust staff.

In April 2020, Belfast Trust testing on a larger scale became available at the Balmoral MOT Centre, creating a drive through facility for the testing of staff, and a small number of patients. We are deeply grateful to the Department for Infrastructure to agree to us using the site for this purpose until MOTs resumed in the autumn of 2020.

At this point staff testing moved to Knockbracken Healthcare Park where a purpose built facility has been established to maintain a drive through testing service.

Testing for the general public remains available in the SSE arena car park, which is run by the consultancy firm Deloitte and overseen by the Public Health Agency.

Covid vaccination program

The Non-Clinical Support Building on the Royal Victoria Hospital site was identified as one of seven regional vaccination centres across Northern Ireland. The first Covid-19 vaccination in Northern Ireland was delivered at the Royal on 8 December 2020 and it has now administered more than 100,000 doses.

In April 2021, a mass vaccination centre opened within the main auditorium of the SSE Arena. This is staffed and administered by the South Eastern HSC Trust and the Public Health Agency.

Human Resources and Occupational Health

Human Resources and the Occupational Health Service has provided a variety of supporting services to Belfast Trust staff during the pandemic whilst continuing to deliver its core services and functions. Testing staff for Covid-19 and identifying close contacts became an integral part of the service to ensure the number of staff absent due to self-isolation was limited. Several new services were setup in response to the pandemic.

In the early stages of the pandemic the service, initially setup a results team, who provided Covid-19 PCR results along with fitness to work advice directly to staff and their relatives. The service has evolved to include a text service delivery to transmit test results to employees and their relatives issuing 37,738 swab results.

The Occupational Health and Wellness Team advice line provided advice, guidance and support to staff and managers and made outbound wellness calls to staff who have tested positive for Covid-19. To date the team have received 28,005 advice calls and have made 4,584 wellness calls to staff.

Staff within the Contact Tracing Team have been responsible for the provision of a contact tracing service for Trust staff. The team have contact traced 1,683 confirmed cases amongst staff, which in turn has identified 1,114 close contacts. The team also work closely with Infection Prevention

Control colleagues in relation to outbreaks.

The Occupational Health service have assisted with the delivery of a psychological support line for staff throughout the pandemic. Additionally, a referral system is in place to enable managers to refer staff affected by Covid-19 for an urgent assessment.

Delivering quality services

While we recognise that Covid-19 has created significant challenges, the Trust has responded with innovation utilising the talents and flexibility of our staff to ensure patients continue to receive compassionate care. We constantly strive to improve and learn from best practice here and elsewhere. The following pages provide just a small sample of that work.

Safety, Quality and Experience

ICU Follow Up Clinic

The Belfast Trust ICU Follow Up Clinic was set up rapidly in response to the pandemic to assess and aid the recovery of patients who had Covid-19. Central to our service is our wide ranging multi-disciplinary team including:

- Consultations with a Clinician and Nurse
- Physiotherapy to assess ongoing rehabilitation needs
- Psychological support to address ongoing anxiety and trauma issues
- A full medication review with a member of the Pharmacy team
- Speech and Language support for ongoing issues after ventilation
- Dietician advice on getting the nutrition to support recovery.

Glaucoma

A new, innovative approach to providing continued assessment and monitoring of patients with glaucoma during the Covid-19 pandemic was established at our drive through facility in the Shankill Wellbeing Centre.

Providing continued assessment and monitoring for patients with glaucoma during the Covid-19 pandemic was necessary to mitigate the risk of sight loss and ensure that patients receive the timely treatment they may require.

Monitoring the pressure in a patient's eye, through a hand held machine, provided an accurate reading on how the condition has progressed and allowed us to triage patients for further treatment or appointments as necessary. The process also provided peace of mind for patients who know that the condition is not going unchecked and the risk of sight loss was considerably decreased.

Service Delivery

Rapid Testing at RVH ED

On 16 December 2020 we introduced the Lumira DX Rapid test to the Royal Victoria Hospital Emergency Department, which provides a diagnostic result for Covid-19 within twelve minutes.

As one of five early adopter sites, we have generated data to demonstrate the value this test can add when managing a busy Emergency Department in a pandemic. This allows us to more effectively isolate patients who return a positive Lumira test whilst ensuring those with a negative test can be seen safely.

Virtual Hospital

A diagnosis of Covid-19 can be stressful for both care-givers and patients. In order to ease that pressure, Belfast Trust have set up virtual Covid-19 wards for patients who can be safely discharged.

The Virtual Hospital aims to continue to provide an excellent standard of care beyond the hospital walls and into patients' homes. Behind this service is a multi-disciplinary team, consisting of specialist nurses, doctors, the emergency department, allied health care professionals and primary care.

Once admitted our team will contact the patient at home and monitor them through frequent contact as well as offering support and advice. If additional needs are identified, these will be discussed at the daily Multi-Disciplinary Team ward round.

The changing role of ICT

Traditionally ICT has provided resources for staff as they come to work but over the last year ICT has supported a growing number of staff across the Trust to work remotely. In February 2020 ICT began to distribute provisions across the service to increase remote access infrastructure for staff. When lock down began in March 2020, the number of staff across the Trust working remotely from home jumped from an average of 40 a day to a peak of 1,300. This jump was only possible with the infrastructure built out by ICT in February 2020 around datacentres, servers and security provisions, as well as the repurposing of end of life equipment to help support the demands on ICT systems.

Microsoft Teams has been a huge success for ICT during the pandemic with face-to-face meetings stopping overnight, this allowed staff to collaborate and work together seamlessly. The service is now embedded across the Trust, making meetings and virtual conferencing normal practice for staff.

Opening up the Nightingale Hospital was a huge task for the Trust and ICT were instrumental in helping services move out of Belfast City Hospital to other sites but also in opening the step-down facility at the Ramada Hotel in Belfast city centre and working with the independent clinics to support services.

The pandemic changed how ICT worked, relying on ICT staff and suppliers to help deliver unprecedented support for staff; a network connection in the Ramada Hotel running within 24 hours creating an extension of Belfast Trust systems in an outside facility.

ICT were crucial in the rollout of the Trust's vaccination programme for staff and for the public. Using the annual flu vaccination booking system as a base, ICT adapted a version specific to help staff book their Covid-19 vaccinations as the programme went live offering a simple and effective booking system that staff could access in work or at home.

People and Culture

Ask HR

Covid-19 had an impact on everyone, not least our staff who faced the pandemic from the front line and understandably had a lot of questions about how Covid impacted on them.

The Belfast Trust Human Resources Team produced a series of online videos with information on maternity pay, annual leave, social distancing, working from home and more. These coupled with our HR advice service, BWell app and Occupational Health helpline provided staff with a holistic HR service as they faced the pandemic.

#DoingOurBit

Belfast Trust has become the first Health Trust in Northern Ireland to sign up to #DoingOurBit – a free online fitness platform for health and social care staff.

#DoingOurBit started as a passion project for keyworker Julie Davis, who works as the Deputy Chief Operating Officer at the Clinical Research Network West Midlands. Julie, who is also an amateur power lifter, created the project when she saw the emotional and physical impact the pandemic was having on her NHS colleagues. She invited personal trainers to 'give back' to the hard-working NHS workers by providing free online workouts and wellbeing sessions. Since June 2020, 35 trainers have donated more than 45 workouts and over 90 NHS trusts have signed up to give over half a million NHS and social care staff access to the platform.

Belfast Trust is hoping the platform will support the physical and mental wellbeing of their staff.

The Trust, which has more than 22,000 staff, chose to offer #DoingOurBit to all colleagues to help keep them fit and well despite disruption to gym and exercise classes during the pandemic. Not only is the #DoingOurBit platform an ideal way to get active, it carries no cost to staff.

Strategy and Partnerships

Animated guidance for Paediatrics

The past 12 months have been difficult for everyone, especially young people who may not fully understand Covid-19, its implications and what it means to them. This is especially true for our Paediatric patients who may require ongoing treatment during the pandemic.

Our Children's team and the Public Health Agency have worked together to produce a series of animated videos educating young people on these issues, reducing anxiety and providing reassurance. Examples of these include "Coronavirus-Explained for Children", "Saying goodbye when someone special dies", "PPE explained for children" and "A kids guide to Ambulance Transfer."

Paediatric Living Donor

In June 2020, Belfast Trust announced the first paediatric living donor transplant since the Covid-19 surge in the UK or Ireland.

Inspired by the successful work undertaken by our adult Renal and Nephrology service, increasing deceased donor transplants during Covid-19, the paediatric team were incredibly proud to have reached this stage. Regrettably, living donor transplants were stood down during the Covid-19 surge.

Due to the pandemic, the Trust took steps to make sure we could proceed safely to protect our patients and staff. The efforts of the public to socially distance, stay at home and reduce the strain on the health service were vital to ensuring we had the capacity to deliver this service for patients who needed it most.

As the donor was an adult, this achievement is a result of collaboration between our paediatric team and those in the adult service at Belfast City Hospital, ensuring a smooth process.

Young People NI Website

The Young People NI website was created by the Royal Victoria Emergency Department in partnership with the Southern HSC Trust and the Adolescent Network NI. The aim of the website is to help support young people with a wide range of issues they might be experiencing, including mental health, drugs and alcohol, bullying and problems at home.

The idea came after the team introduced a pilot scheme to introduce an assessment tool in ED for doctors and nurses to use when a young person presents to the Emergency Department with possible mental health issues. The HEEADSSS strategy is the tool that is used to assess the risk to the young person and to help staff make decisions about what services they might need referred on to. The team felt that there was a wealth of information available online which meant it could

often be difficult for young people to find the support they were looking for and therefore decided to create a website which would detail services available to young people on a variety of issues.

It is hoped that the website will offer young people the options of accessing support services in their home and community before they reach a crisis point. It is anticipated that with continued success the initiative could be rolled out across the region.

Resources

Free catering

Our staff are the lifeblood of our organisation and it was important to us that staff were provided with the appropriate nutrition and hydration during their shift. For this reason, we made all meals and drinks in our canteens free of charge to staff from 1 April 2020 until the Autumn.

Whilst this came at a cost to the Trust financially, it was well received by our workforce. During the Autumn surge staff were provided with free sandwiches and hot drinks from our canteens.

Macular Building opening

The Ophthalmology Macular Service has opened a new modular unit on the Musgrave Park Hospital site. This unit has two injection rooms and an OCT retinal scanner. There are also parking spaces reserved for macular patients outside the unit.

The modular unit will help address the delays and anxiety of patients caused by restrictions in accessing the Macular Service at the Mater Hospital site.

The Macular Service at the Mater Hospital remains open and delivers treatment for patients with macular degeneration, retinal vein occlusion and diabetic retinopathy.

Performance Analysis

The Belfast Trust is committed to embedding effective organisational performance management arrangements to ensure clear and robust accountability and assurance arrangements to deliver better outcomes for patients and clients through a Quality Management System (QMS).

Performance within our QMS is managed through a tiered accountability process with comprehensive reporting against key performance standard and targets related to six quality parameters (safety, experience, effectiveness, efficiency, timeliness and equity). Reporting is provided through the Trust organisational structures ie. Trust Board, Executive Team (through the Chief Executive), Directorate and Divisional Teams. Risk and performance are examined through the QMS reporting structures and actions agreed as required.

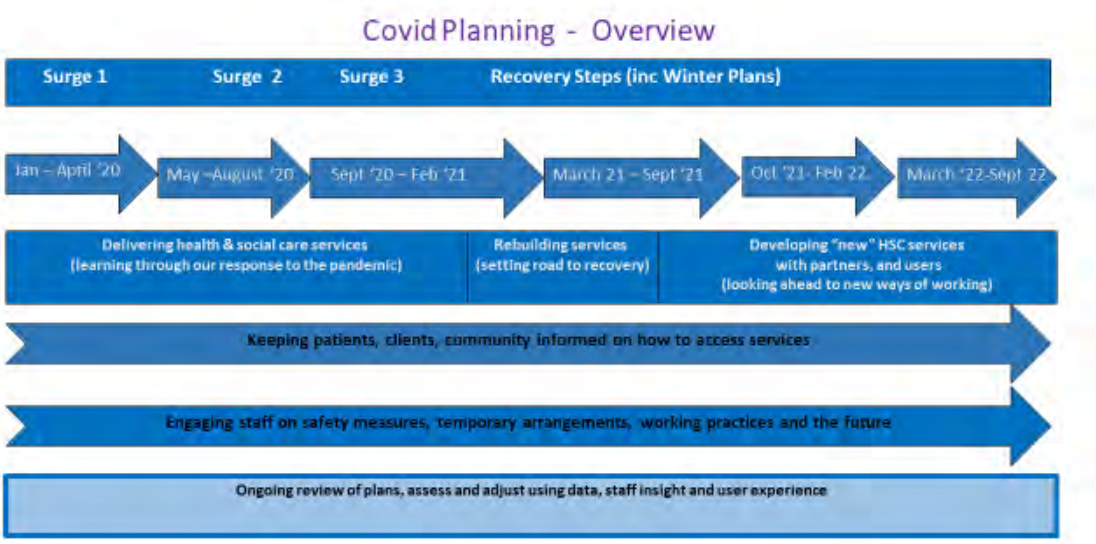
Trust services were significantly impacted in 2020-21 due to the Covid-19 pandemic and this also impacted on delivery against Performance targets.

Covid-19 Performance Management arrangements – Core funded activity and Re-build planning

Throughout 2020-21 the Trust had in place a daily and weekly reporting structure, the Charles Vincent Daily/Weekly SitRep, to provide Executive Team with a wide range of operational metrics to provide assurance, and facilitate decision making related to service delivery and planning in response to the pandemic.

Performance against Trust core Service and Budget Agreements activity was significantly affected during 2020-21 and it was recognised that targets should be re-set to take account of the impact of surges in the pandemic and resulting changes in capacity, along with limitations on capacity to maintain social distancing and other Covid-19 safety requirements.

A regional approach was adopted during 2020-21, with Trusts delivering to agreed service re-build plans, which took account of Covid-19 pressures. Monthly and quarterly activity targets were provided by Trusts with performance against these targets monitored regularly. In addition to internal capacity re-build, regional arrangements were established for Trusts to access Independent Sector facilities to provide cancer and time critical elective surgeries in a range of specialties.



In 2020-21, the Trust worked to deliver, as far as possible, the Ministerial Commissioning Plan Directions Performance (CPD) targets. These targets were rolled forward from 2019-20, as 2020-21 CPD targets were not issued due to the Covid-19 pressures.

In 2020-21, the Trust achieved or substantially achieved the following standards and targets:

- C-Difficile and MRSA – target to have less than or equal to cumulative 110 incidences of C-Difficile and 12 incidences of MRSA by 31 March 2021
- Breast Cancer 14-day wait
- Cancer Urgent 31 day pathway
- Hip Fractures <48 hours
- ED Triage <2 hours
- Mental Health discharges <28 days
- GP Out of Hours 95% of patients triaged <=20 minutes
- Mental Health discharges within 7 days
- Non-Complex patients with discharge – 6 hours
- Absence.

The Trust was not able to deliver against the targets set out below, with reduction in service delivery capacity impacting throughout the year because of Covid-19:

- ED patients treated, discharged or admitted within 4 hours, 12 hours
- Diagnostic – urgent tests reported within 2 days, numbers waiting 9 weeks and 26 weeks

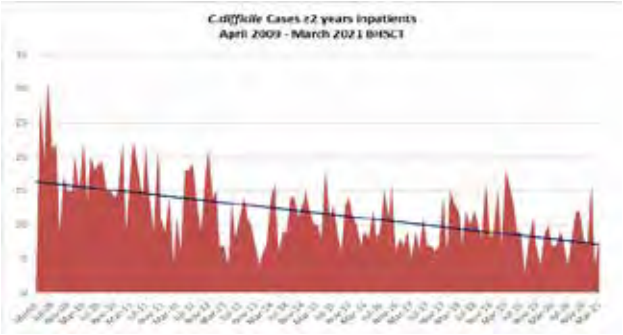
- Cancer 62 day pathway
- OP percentage of patients waiting no longer than 9 weeks; no patient waiting longer than 52 weeks
- IPDC percentage of patients waiting no longer than 13 weeks; no patient waiting longer than 52 weeks
- CAMHS 9 weeks and Psychological Therapies 13 weeks
- Direct Payments
- AHP – no patient waits longer than 13 weeks to first treatment
- Carers Assessments; 10% increase year on year
- Complex patients with discharge – 48 hour and 7 days
- Core funded IPDC and OP activity.

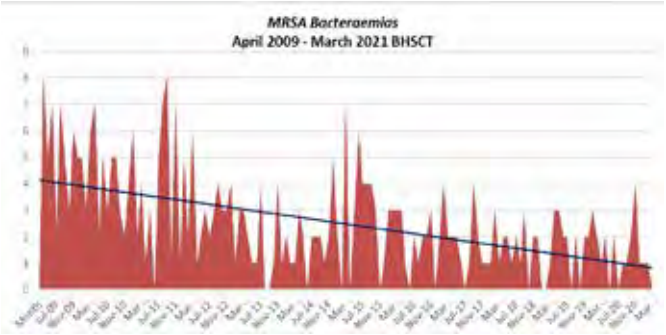
More details related to some of the standards and target areas are provided in the section below. Please note that the targets, as referenced above, relate to 2019-20 as new targets were not issued for 2020-21.

Performance: Healthcare Associated Infections (HCAI)

The Trust is striving to be one of the safest, most effective and compassionate Health and Social Care organisations. One of the top priorities for the Trust is to “reduce harm from Healthcare Associated Infection”.

The graphs below present the picture of the Trust’s performance in relation to Clostridium difficile and MRSA bacteraemia respectively from April 2018 to March 2021. It should also be noted that, from 2009 (tables below), there has been a downward trend in relation to MRSA bacteraemia and Clostridium difficile infections with a clear reduction in case numbers for both infections over time.





For the year 2020-21 we recorded 111 cases of Clostridium difficile against a target of 110. In total 16 incidences of MRSA bacteraemia were recorded against a target of 12.

In 2019-20, the Trust was also set a target for gram negative bacteraemia of 201 isolates and the outturn for 2019-20 was 240. In the year 2020-21 the number had reduced to 187.

There was a reduction in hospital admissions in 2020-21 compared to 2019-20, due to Covid-19.

Performance: GP Out of Hours Service

To have 95% of acute / urgent calls to GP OOH triaged within 20 minutes

There were 3,345 Urgent Calls between April 2020 and March 2021, of which 3,159 (94.4%) were triaged within 20 minutes. This is 0.6% below target.

Urgent calls of 3,345 for 2020-21 represent 4% of the 84,622 total GPOOH calls recorded by the Trust during the year.

Performance: Emergency Department

95% of patients attending any type 1, 2 or 3 emergency department are either treated and discharged home, or admitted, within four hours of their arrival in the department

There were 128,533 patients treated at ED between April 2020 to March 2021, compared to 185,404 for 2019-20.

At March 2021, 55% of Trust ED patients were seen within 4 hours of arrival.

No patient attending any emergency department should wait longer than 12 hours of their arrival in the department

The cumulative number of patients waiting more than 12 hours in 2020-21 was 7,373 (5.7%) of the 128,533 total attendances.

Urgent Care Centre (UCC)

As part of the development of the unscheduled care pathway an Urgent Care Centre opened on 14 October 2020. There were 18,800 attendances recorded between 14 October 2020 to 31 March 2021.

ED Triage

Unscheduled care: At least 80% of patients to have commenced treatment, following triage, within 2 hours

By March 2021 there were 101,434 ED patients triaged, of which 77,585 (76.5%) were seen by a consultant within 2 hours.

PERFORMANCE REPORT

Performance: Hip Fractures

95% of patients, where clinically appropriate, wait no longer than 48 hours for inpatient treatment for hip fractures

Overall 93% of patients presenting were treated within the target by March 2021.

The Trust has introduced a number of innovative changes to facilitate a more patient centred, efficient and effective fracture pathway. These include:

- Virtual fracture clinics have resulted in a liaison pathway with Belfast Trust and Northern Trust ED, which involves the review of ED x-rays to route the patient to the appropriate sub-specialist, and triage based on urgency. This ensures involvement of the most appropriate professional, whether physiotherapist, specialist nurse or sub-specialist fracture surgeon in the initial care of patients who were previously referred to be seen at fracture clinic on day of ED attendance
- Introduction of Block lists to allow better utilisation of General Anaesthetic (GA) sessions for patients requiring a GA
- Use of Musgrave Park elective theatre capacity to treat less complex but urgent fractures requiring overnight or short inpatient stay.

Performance: Diagnostic Waiting Times

The Trust measures against several targets in relation to patients waiting for diagnostic tests. Additional non-recurrent resources were made available in 2020-21 to help address waiting list pressures.

75% of patients should wait no longer than 9 weeks for a diagnostic test

In March 2021, 46% of patients waited less than 9 weeks for diagnostic tests.

No patients should wait longer than 26 weeks for diagnostic tests

In March 2021, there were 15,374 patients waiting in excess of 26 weeks.

All urgent diagnostic tests should be reported on within two days

In March 2021, there were 84% of urgent diagnostic tests reported within 2 days.

Performance: Cancer

All urgent suspected breast cancer referrals should be seen within 14 days

The Trust met the 14-Day Breast Cancer Target in 2020-21 with 100% of patients being seen within 14 days of referral at March 2021.

At least 98% of patients diagnosed with cancer should receive their first definitive treatment within 31 days of a decision to treat

Trust performance at March 2021 was 91%.

At least 95% of patients urgently referred with a suspected cancer should begin their first definitive treatment within 62 days

Trust performance at March 2021 was 47%.

Additional capacity was put in place in 2020-21 within the Independent Sector to support the downturn in Trust elective capacity as a result of Covid-19 restrictions. Alongside reduced capacity within the Trust there remains however an overall shortfall in cancer services capacity. The Trust continues to address these capacity shortfalls with our commissioner.

Cancer services are part of a UK Peer review process that occurs across each tumour site on a rolling plan. Recommendations from Peer review are discussed with the HSCB and action plans agreed to follow up.

Performance: Outpatients

50% of patients should be waiting no longer than 9 weeks for an outpatient appointment

At the end of March 2021 16% of patients on Trust's OP waiting lists were waiting no longer than 9 weeks for an outpatient appointment.

Nearly 425,000 Consultant led Outpatients attendances have taken place over the last year. There has been a significant shift to virtual – telephone and video – appointments from face to face in response to Covid-19 restrictions, although the totality of new and review activity was reduced overall by 23% compared to the previous year.

Performance: In-patients and Day-cases

55% of patient should wait no longer than 13 weeks for inpatient / daycase treatment

At the end of March 2021, 13% of patients on Trust's IPDC waiting lists were waiting no longer than 13 weeks.

No patient should wait no longer than 52 weeks for inpatient / daycase treatment

In total, 31,562 patients were waiting longer than 52 weeks for IPDC treatment at March 2021, representing a 95% increase from the position at March 2020.

The Trust admitted circa 54,000 elective inpatient and daycases admissions during the year. As with outpatients, elective IPDC activity was significantly affected by the impact of the pandemic, with reduced capacity. Additional capacity was put in place in 2020-21 within the Independent Sector to support the downturn in Trust elective surgical capacity as a result of Covid-19 restrictions.

PERFORMANCE REPORT

Some examples of the volumes of treatments we have provided for elective patients on our hospital sites are listed below for the period January – December 2020:

- 496 cardiac procedures
- 421 hip replacements, and 272 knee replacements
- 359 gall bladders removed with keyhole surgery
- Over 1,200 cataract procedures
- Over 373 Appendectomies
- 515 Surgical bowel procedures
- 5,500 endoscopies for bowel and gastric conditions
- 23,000 renal dialysis attendances
- 600 neurosurgical procedures on the brain
- 102 tonsillectomies.

Additionally the Trust has treated circa 35,000 unscheduled patients and some examples of treatments are included below:

- Over 690 strokes treated
- Over 1,730 chest infections treated
- 950 head injuries
- 400 heart attacks treated
- Over 1,700 COPD & asthma patients treated
- 5,000 births.

Performance: Mental Health Waiting Times

No patient waits longer than 9 weeks to access child and adolescent mental health services

There were 106 people waiting in excess of 9 weeks at March 2021.

No patient waits longer than 9 weeks to access adult mental health services

There were 123 people waiting in excess of 9 weeks at the end of March 2021.

No patient waits longer than nine weeks to access dementia services

There were 191 people waiting in excess of 9 weeks at the end of March 2021. For a period of several months, clinics were suspended in this service due to risks associated with Covid-19.

No patient waits longer than 13 weeks to access psychological therapies.

There were 1,101 people waiting in excess of 9 weeks at the end of March 2021.

Psychological Therapy services have continued to be constrained by a recognised shortage of specialist professionals in a range of service areas, and this is where the increase in waiting list numbers have occurred.

Performance: Direct Payments

Secure a 10% increase in the number of direct payments (DPs) to all service users, based on 2018-19 outturn

The Trust target for March 2021 was to have 946 patients in receipt of Direct Payments. There were 861 people in receipt of DPs at the end of March 2021.

The Trust commenced 219 new direct payment packages during the year, however, this was offset by 218 packages ceasing.

Performance: Allied Health Professional Waiting Times

No patient should wait longer than 13 weeks from referral to commencement of treatment by an allied health professional

There were 8,526 patients waiting in excess of 13 weeks at the end of March 2021, with the majority in Physiotherapy, Occupational Therapy and Podiatry.

Performance: Discharges – Mental Health

Ensure that 99% of all mental health discharges take place within seven days of the patient being assessed as medically fit for discharge

Cumulatively at March 2021, 497 patients (94.5%) were discharged within 7 days.

Performance: Carers Assessments

Secure a 10% increase to 3,324 assessments for Belfast Trust, in the number of carers' assessments offered to carers for all service users

The quarterly performance against target in the first 3 quarters was well below target, however 1,066 carers assessments were carried out between Jan-Mar 2021 and 2,575 were completed in total in the financial year.

PERFORMANCE REPORT

Performance: Complex Discharges

Ensure that 90% of complex discharges from an acute hospital take place within 48 hours

Based on the latest available data, 74.6% complex discharges were carried out within 48 hours.

Ensure that no complex discharge takes more than 7 days.

There were 337 Complex Discharge patients discharged in more than 7 days for the period April 2020 to February 2021.

The Community Service Plan is focusing on four key areas to support improvement in performance: Discharge to Assess; Domiciliary Care; Reablement; and Acute Care at Home, with the aim of reducing the number of complex delayed discharges.

Performance: Non-Complex Discharges

Ensure that all non-complex discharges from an acute hospital take place within 6 hours

In total 95.5% of non-complex discharge patients were discharged within 6 hours.

Performance: Absence

To reduce Trust staff sick absence levels by a regional average of 5% compared to 2017-18 figure

The Trust target was to reduce absence to 6.47% by March 2021.

At March 2021 the cumulative absence for the Trust was 7.59%. There continues to be strong focus on absence management within the Trust to reduce the overall absence level. Specific Covid-19 absence has been monitored throughout the year on a daily basis and is separately reported.

Performance: Children in Care

The Trust is subject to a number of standards in relation to looking after children under our care. The Trust meets these standards in most areas.

75% of Children Leaving Care aged 18, 19 & 20 years will be in education, training or employment

At March 2021 there were 78.2% of all care leavers aged 18, 19 and 20 in education, training or employment.

Performance: Renal Transplants

The Trust continued to deliver high numbers of renal transplants with 149 transplants carried out to 31 March 2021.

Quality and Safety

Quality of care and patient safety are the Trusts principal priority. Many new quality and safety initiatives are in place within the Trust using proven improvement methods. There are also some well accepted indicators of quality and safety that the Trust reports on regularly and these include mortality rates and readmission rates.

Mortality Rates

Crude percentage mortality rates during 2020-21 were 2.6% for the Trust against 2.9% for the peer group, this was a consistent picture with previous year's measurements. The Trust also used statistical modelling to analyse deaths, as crude rates do not take account of the many features of illness and disease and how these contribute to mortality rates. When these more refined statistical models were used they also show that the Trust compared well in terms of its expected and actual mortality rate. The data includes only non-Covid deaths.

Readmission Rates

Readmission rates were affected by many issues and not all were related to the quality of hospital care, however these are still an important indicator of quality of care. Readmissions are measured for those patients readmitted to hospital as an emergency within 30 days of a previous stay in hospital. The Trust had a readmission rate of 8% against a peer average of 9%.

Financial Resources

Size and Scale

The Belfast Trust had an operating expenditure budget of £1.9 billion in 2020-21 which makes it one of the largest healthcare Trusts in the UK in budgetary terms. The Trust employs over 22,000 (whole time equivalent) staff, including temporary staff, and manages an estate worth over £1.38 billion.

Financial Environment

Despite an increase to the 2020-21 budget compared to funding levels in 2019-20, the Belfast Trust, and Health and Social Care sector generally, faced difficult challenges in 2020-21 given the significant additional costs associated with the Covid response. Despite this, the Trust did manage to deliver recurrent pharmacy savings of £3.9m and a significant amount of non-recurrent slippage from new investments which weren't able to be progressed. As a result of the pandemic there were substantial cost reductions arising from the downturn in activity particularly in specialties where high cost consumables are used, and in estates where much of the work continues to relate to the repurposing of areas for Covid-19 services or to comply with social distancing and was funded from earmarked Covid-19 monies.

The ability to break even in 2020-21 has been achieved mainly through non-recurrent measures. Managing its finances with such heavy reliance on non-recurrent funding and without the assurance of a fully funded recurrent baseline poses a challenge for the Trust.

The Trust experienced cost increases during 2020-21 particularly in relation to costs associated with Covid-19 but also in growth of agency costs and high cost drugs, increased laboratories tests, and other advanced clinical technologies, children's community services and transition and resettlement care packages.

Transformation agenda continued via non-recurrent funding. Projects included enhancing multi-disciplinary teams in primary care, reforming community and hospital services such as cancer, stroke, paediatrics and implementing transformative change through initiatives such as diabetes care and prevention and medicines.

The Trust recognises that additional funding for the HSC will be further constrained in 2021-22 due to the additional financial pressures facing all public sector services as a result of the pandemic.

Workforce shortages and the associated cost and impact on services continues to be the Trust's main service and financial risk. The Trust is currently developing a strategy to try to address the nursing vacancy issue initially but recognises this will take time because of training and recruitment lead-in times so this will be a continuing and potentially increasing financial risk for the next few years.

Waiting times is perhaps the second most critical risk for the HSC at present with already unacceptable waiting times for both outpatients and inpatients/daycases rising significantly during the Covid-19 pandemic.

Financial Targets

While operating within this very challenging financial environment, the Trust has continued to improve the safety and quality of services for its patients and clients and was still able to achieve its statutory financial targets which are outlined below:

- Breakeven on income and expenditure
- Maintain capital expenditure within the agreed Capital Resource Limit.

The above achievements have been delivered through a combination of sound financial management, the concerted efforts of our staff and the continued implementation of the Trust's efficiency and reform programme.

Financial Governance

The Trust has continued to maintain sound systems of financial internal control which are designed to safeguard public funds and assets. The same high degree of security is maintained over Patients' and Residents' Monies and Charitable Trust Funds administered by the Trust. Our internal control framework relies on a combination of robust internal governance structures, policies and procedures, control checks and balances, self-assessments and independent reviews. The Chief Executive's assurances in respect of this area are set out in the Governance Statement for 2020-21.

In terms of financial management and control across the Trust, a detailed financial plan is prepared and approved by the Trust Board at the beginning of each financial year and budgets are allocated to Directorates. Financial performance is monitored and reviewed through detailed financial reporting to Directors on a monthly basis. An aggregate summary of the financial position to date and forecast yearend position is presented by the Director of Finance to Trust Board each month.

MORE – Maximising Outcomes, Resources and Efficiencies

Trust's MORE programme was established to ensure continued delivery of safe and responsive services, against a backdrop of increasing demand, rising cost pressures and year- on year efficiency savings targets.

The programme's focus is on securing efficiencies through enhancing productivity, changing the way services are delivered, modernising and driving improvements in health and social care, eliminating waste and maximising value for money. The focus of the MORE programme is essentially about ensuring the right care is delivered by the right person, doing the right thing, in the right place.

The programme has been successful in delivering around 3% year-on-year cash releasing/ productivity efficiencies over the past twelve years, totalling over £320m. The scale of challenges which the health and social care sector will face over the next few years is significant and 2021-22 is expected to be yet another difficult year from a financial perspective.

As always, the Trust will endeavour to ensure that the required changes are effectively managed through the continued successful operation of the MORE programme with its sound performance management, accountability and reporting frameworks.

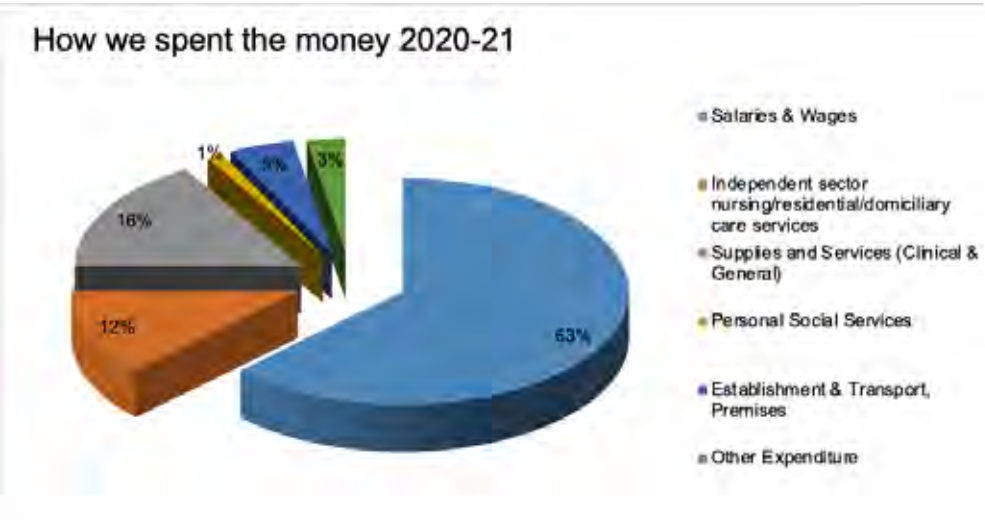
Income and Expenditure

The information below provides an analysis of Trust's income and a breakdown of expenditure in 2020-21.

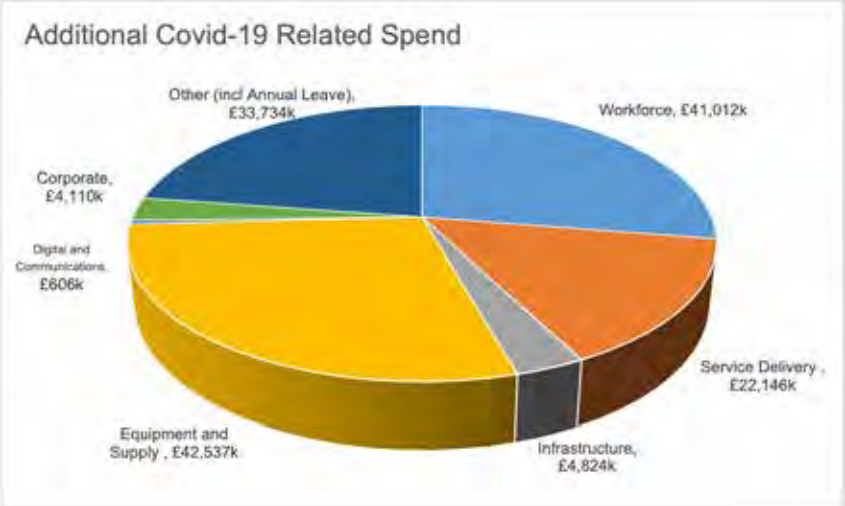
The majority of funding, almost 90%, comes from the Department of Health, through the Health and Social Care Board and the Public Health Authority. The Trust also receives funding for medical education and commercial research, from private patients and from clients in residential and nursing homes.

The money which the Trust receives is used to deliver health and social care services for the population of Belfast and a range of regional services such as cardiac surgery and neurosurgery for the population of Northern Ireland.

The chart below shows how the Trust spent this money in 2020-21. The largest cost incurred by the Trust is staff salaries, representing 63% of total expenditure. Within this pay total, the Trust spent £247 million on doctors and dentists, £353 million on nurses and midwives and £112 million on social work/social care and domiciliary/homecare staff. Significant non-pay costs include £298 million (16% of total expenditure) for clinical and general supplies such as drugs and medical equipment and £222 million (12% of expenditure) for residential, nursing and domiciliary care delivered by other organisations on the Trust's behalf.



There was significant additional expenditure this year associated with Covid-19. In total the additional spend amounted to £149m, including £42m PPE, £41m additional staffing costs (including £19m staff recognition payments), £22m service delivery costs, including financial support to care homes, domiciliary care and voluntary sector providers, and £29m for increased costs in respect of Annual Leave.



Investing in Staff

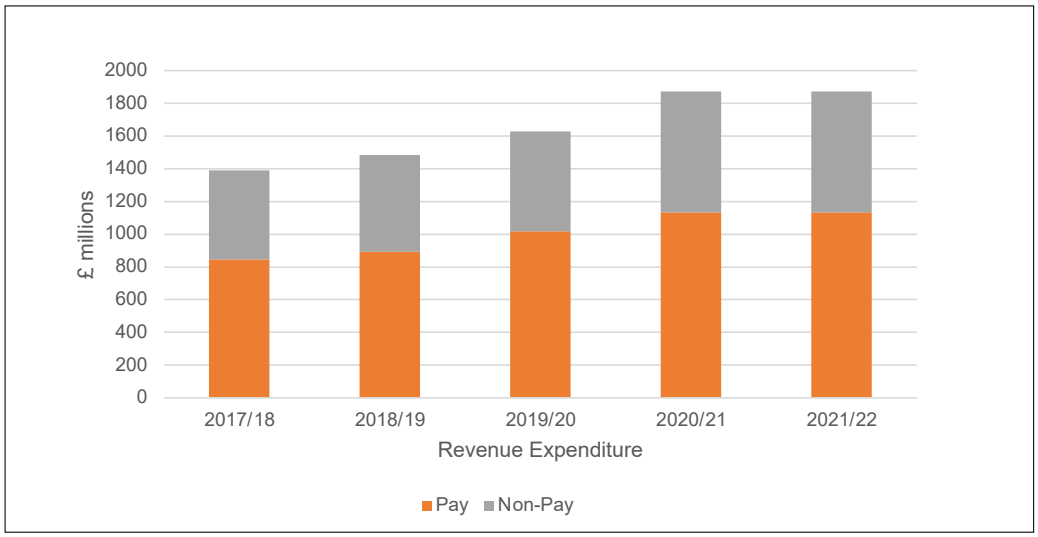
The Trust spends around £1.133 billion on staff salaries, employing around 22,000 staff (whole time equivalents) across a diverse range of professional groups. The Trust endeavours to ensure that staff are effectively deployed to improve the safety and responsiveness of our services. In addition to a number of Human Resources employee related schemes, the Trust provides taxable benefits through a number of salary sacrifice schemes as follows:

- Childcare Vouchers (following a HMRC review, this scheme is now closed to new entrants)
- Cycle to Work scheme
- Private Car Lease scheme.

In addition to providing direct financial benefits for staff through reduced taxation, these schemes aim to promote general overarching benefits in terms of enhancing the general health and wellbeing of staff.

Long Term Expenditure Trends

The table below shows the actual and forecast revenue expenditure, broken down by pay and non-pay categories, incurred by the Trust from 2017-18 to 2021-22.



While 2021-22 will continue to be financially challenging, there are no material uncertainties about the Trust's ability to continue operating as a going concern.

Investing in Facilities

Belfast Health and Social Care Trust has a fixed asset base of £1.38 billion. The Trust continues to maintain and develop this infrastructure to provide the facilities required to support patient and client care.

In 2020-21 the capital funding allocation for the Trust was £87.531m, of which £47.233m related to major specific capital projects and £40.212m was for various minor capital projects funded from the Trust's General Capital Allocation. This includes £0.086m for Research and Development, which under current accounting guidance is reported as revenue expenditure in the Trust's Final Accounts though funded and reported during the year as capital expenditure.

Expenditure on larger schemes included:

Capital Scheme	Expenditure £m	Total Approved Value of Project £m
ICT Schemes	19.7	19.7
RGH Maternity	13.0	78.792
Children's Hospital	7.3	353.970
Glenmona – replacement Separated Minors Unit	1.4	11.061

Other specifically funded schemes include, GP premises improvement schemes in Trust owned premises and the development of an RGH Energy Centre.

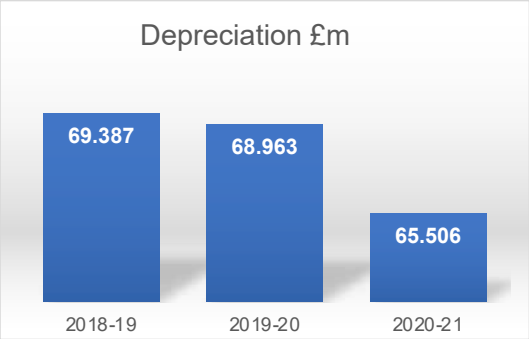
Design and enabling work for the new Children's Hospital is continuing and work on the Maternity Hospital is progressing on site.

In 2020-21 there has also been investment in numerous IT projects ranging from replacing ICT devices to virtual consultation and home reporting systems and improving the IT infrastructure and security.

General Capital expenditure included a number of schemes to refurbish Trust buildings to improve patient experience and also to replace a range of clinical equipment.

The capital requirements of the response to the Covid-19 pandemic were separately approved and funded through General Capital.

The Trust's funding and spending each year on specifically funded schemes fluctuates based on the number, scale and stage approved schemes have reached. General capital funding is allocated to the Trust each year by the DoH. The table shows the capital expenditure incurred by the Trust from 2018-19 to 2020-21. The figures for 2021-22 represent the Trust's opening capital allocation for 2021-22 and may change as the year progresses.



As a result of the Trust's capital expenditure and asset base, the Trust incurs depreciation charges each year as the asset value is written off. The depreciation charge, for which the DoH provide financial cover, is as follows for the last 3 years.

Research and Development

Research and development are core activities within the Trust, and new treatments or procedures are often made available for the first time to patients in the Trust through clinical trials. Staff from all professional groups who come up with new ideas to improve patient outcomes or experience will often try them out for the first time by conducting research.

Patients and clients of the Trust play a key role in the design of research studies, and increasingly act as members of the research team and play a critical role in making sure that the most important issues for patients are addressed through research. Staff within the Trust work closely with colleagues in partner organisations, including local universities, other Trusts, major charities and local and international companies to allow access to new treatments at the earliest possible opportunity in as many areas as possible.

All research projects taking place in the Trust are approved by an independent ethics committee, and by the Trust research office, which ensures that all research taking place within the Trust is conducted in line with proper ethical standards and all relevant legislation. Around 600 research projects are underway in the Trust at any time. These range from small studies designed to better understand aspects of patient experience through to large national and international clinical trials of new drugs, procedures or devices.

The Covid-19 crisis has brought national and global recognition to the essential role of healthcare research, and research within the Trust has contributed to the global race to find treatments and vaccinations for Covid-19 taking part in a number of the UK Urgent Public Health, nationally prioritised, Covid-19 studies that have resulted directly in new treatments for Covid.

Belfast Trust hosts a number of important elements of the regional Northern Ireland research structure, including the Northern Ireland Clinical Research Network, the Northern Ireland Clinical Research Facility, a Clinical Trials Unit and the Northern Ireland Cancer Trials Network. These provide support for research throughout all HSC Trusts. Funding for research within the Trust comes from a variety of sources, including Government, the EU, Research Councils, Charities and commercial partners. The findings of research conducted in the Trust influence the treatment of patients locally, nationally and internationally. The Trust was the Northern Ireland site for the delivery of the multicentre NOVavax Covid Vaccine Trial, recruiting nearly 500 participants. This drew on a successful team approach to research delivery across this whole NI research infrastructure. In January 2021 results of the trial were announced which showed it to be effective at preventing Covid-19 and it awaits filing to Medicines and Healthcare products Regulatory Agency (MHRA) for approval.

Donations and Fundraising

Charitable donations help us to improve the quality of care we provide to our patients and clients across the Trust.

During the year the Charitable Funds continued to engage in activities commensurate with its objectives. Over £1.1m was expended on charitable activities, in accordance with the Trust's policies and procedures in relation to expenditure from Charitable Funds.

Examples of improvements made across the Belfast Health and Social Care Trust as a result of donations, legacies and grants received during 2020-21 include:

- The purchase of iPads that were used during the Covid-19 pandemic to allow families to communicate with family and friends whilst in hospital and also for use in community setting for activities
- The purchase of a communication system used within the Emergency Department to allow instant communication with multi disciplines of staff without having to leave the patients side
- Upgrade and refurbishment of the Brachytherapy Unit in the Belfast City Hospital site with the purchase of associated equipment
- The purchase of computer equipment to facilitate virtual consultations and home working
- The purchase of a specialised exercise bike for children with complex health needs that can be brought to them in their home setting due to the restrictions on hospital visits due to Covid-19
- The provision of play specialist items for children while in hospital
- To fund research fellowships within paediatrics, to undertake non-profit research.

In March 2021 an amount of £3m was received from the Department of Health under Ministerial Direction to support the wider charitable and supportive work undertaken through the Charitable Funds within the Trust. Plans to utilise these funds in support of Trust staff will be developed and progressed during 2021-22.

If you would like to make a donation to the Trust to help us continue to enhance the experiences of patients and clients in our care, please contact:

The Charitable Funds Section,
1st floor, Dorothy Gardiner Unit
Knockbracken Healthcare Park
Saintfield Road, Belfast
BT8 8BH
Tel: 028 9504 5393
E-mail: charitabletrustfunds@belfasttrust.hscni.net

Public Sector Payment Policy - Measure of Compliance

The Department requires that Trusts pay their non-HSC trade payables in accordance with applicable terms and appropriate Government Accounting guidance. The Trust's payment policy is consistent with applicable terms and appropriate Government Accounting guidance and its measure of compliance is:

	2020-21 number	2020-21 value £000s	2019-20 number	2019-20 value £000s
Total bills paid	492,089	857,064	552,873	873,812
Total bills paid within 30 days of receipt of an undisputed invoice	456,694	779,883	481,221	778,675
% of bills paid within 30 days of receipt of an undisputed invoice	**92.8%**	**91.0%**	**87.0%**	**89.1%**
Total bills paid within 10 day target	388,769	666,353	391,891	638,761
% of bills paid within 10 day target	**79.0%**	**77.7%**	**70.9%**	**73.1%**

The Late Payment of Commercial Debts Regulations 2002

	2020-21 £
Amount of compensation paid for payment(s) being late	70
Amount of interest paid for payment(s) being late	0
Total	**70**

This is also reflected as a fruitless payment in the Assembly Accountability Disclosure Notes

Sustainability Report

The Trust has continually worked to improve the Estate alongside key partners such as the Conservation Volunteers, RSPB, Keep Northern Ireland Beautiful and the Belfast City Council. These collaborations have guided an Environmental Improvement Scheme at Musgrave Park Hospital incorporating a native planting scheme with biodiversity education to halt loss of biodiversity and encourage sustainable attitudes within the future generation in the local area. The Trust continues to actively seek suitable spaces to introduce further tree planting and most recently has been an active participant in the Belfast City Councils “Million Trees” initiative.

The Trust previously worked in collaboration with Queen’s University Belfast to commission a PhD study to facilitate the aims of the ‘’Making Life Better’’ public health strategy. The Trust have been working towards implementing recommendations outlined within the PhD such as increased green infrastructure on site, enhanced natural landscapes and additional walking facilities to make public spaces more accessible, decrease health inequalities and combat climate change.

Some Trust facilities have joined community biodiversity initiatives, which provide biodiversity training for staff and provide support to implement habitat features within their grounds. Additionally, other facilities across the Trust have incorporated vegetable planters and gardens as a positive patient experience and as an appealing green space for staff, patients and their visitors to enjoy time in nature.

The Trust has worked collaboratively alongside Advantage NI to develop ‘Ravine’, a nature-based social enterprise within Knockbracken Healthcare Park. This project provides employability training to young people facing mental health challenges and outdoor education opportunities to school children and local businesses, while they work to create and protect wildlife habitats on the Knockbracken site.

Reducing carbon emissions

The Trust is continuing to work towards the public sector Energy Management Strategy and Action Plan to 2030, this includes ensuring that all energy usage is monitored effectively to identify waste and opportunities for further efficiencies. As a Trust we continue to implement a wide range of carbon reduction projects such as installation of LED lighting, PV systems, heat pumps, solar thermal panels and battery storage.

The Trust continues to improve building management systems, which allow for better monitoring and control of heating, ventilation and air conditioning systems. This is crucially important to create the appropriate conditions for the delivery of patient care, improving patient safety in critical care areas and thermal comfort across the Trust.

Initiatives developed to support the Trust’s Travel Plan objectives to reduce car use have resulted in more staff cycling to work. Unfortunately, concerns about Covid-19 interrupted the steady

increase in staff travelling to work by public transport or car sharing but it is hoped that this will improve again in 2021-22. There has been a significant reduction in staff travel as a result of Covid-19 with many staff working from home, we would hope that this will present an opportunity to further reduce travel across the Trust and enable more sustainable health improving transport.

The Trust's fleet of electric vehicles has expanded to 14 to reduce vehicle emissions.

Responsible waste management

The Trust's waste management objective is to reduce the volume of waste produced in the Trust and to maximise recycling and recovery opportunities. In collaboration with our waste contractors, 85% of our clinical waste was converted to heat energy; 100% of food waste was used to produce Biogas and then converted to compost; and 99% of all household waste and dry mixed recycling waste was recycled or recovered by our waste contractor, after collection.

The Trust has introduced Warp It, a web based system that facilitates the swop or loan of furniture, equipment and other resources. This reduces waste disposal by finding new owners for items that a service may no longer require and removes the need to procure that item.

On behalf of the Belfast Health and Social Care Trust, I approve the Performance Report encompassing the following sections:

- Performance Overview
- Performance Analysis

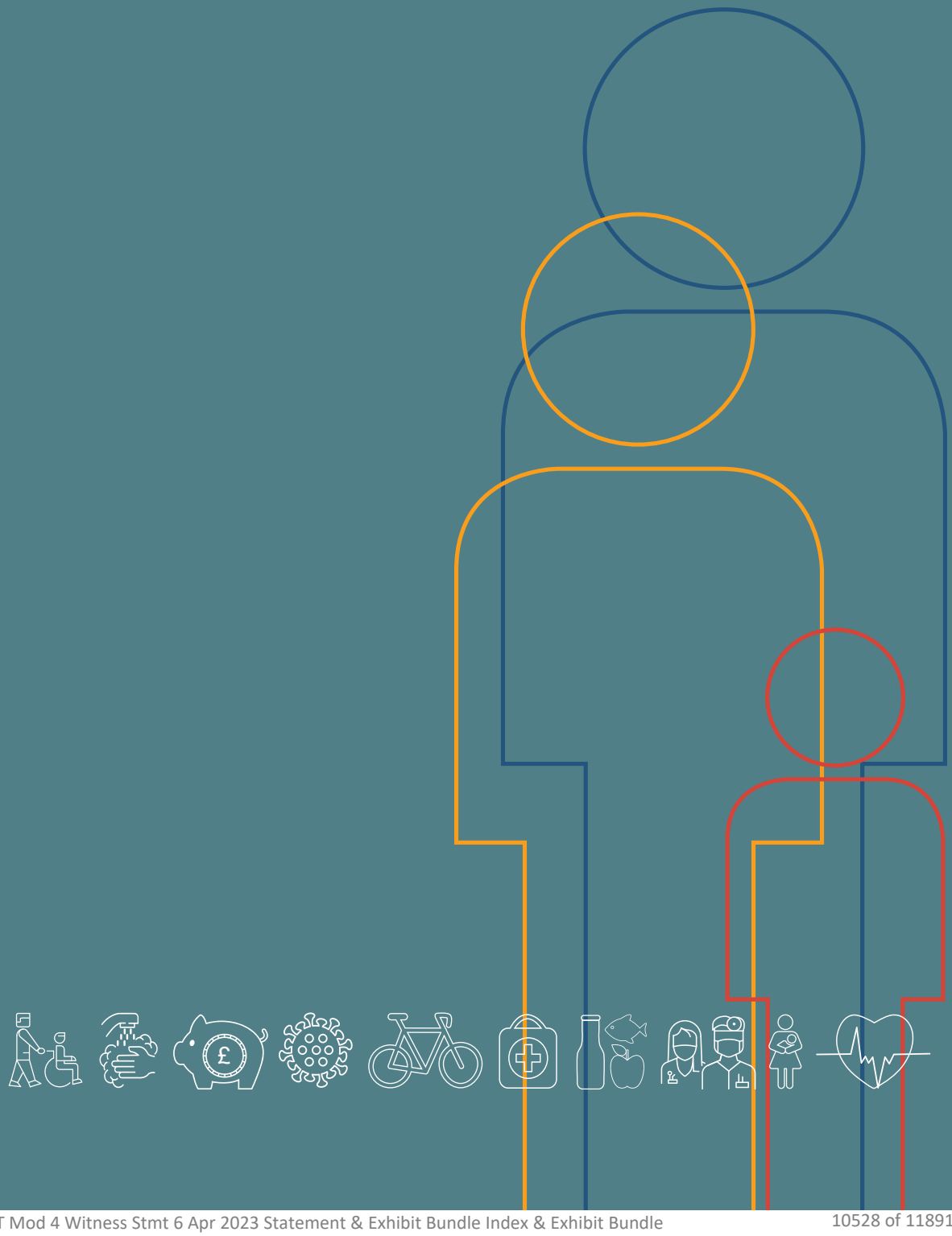
Cathy Jack

10 June 2021

Dr Cathy Jack
Chief Executive

Date

ACCOUNTABILITY REPORT



ACCOUNTABILITY REPORT

Overview

The purpose of the Accountability Report is to meet key accountability requirements to the Northern Ireland Assembly. The report contains three sections being, the Corporate Governance Report, the Remuneration and Staff Report, and the Accountability and Audit Report.

The purpose of the Corporate Governance Report is to explain the composition and organisation of the Belfast Trust's governance structures and how these support the achievement of the Trust's objectives.

The Remuneration and Staff Report sets out the Belfast Trust's remuneration policy for Directors, reports on how that policy has been implemented and sets out the amounts awarded to Directors. In addition, the report provides details on overall staff numbers and composition, and associated costs.

The Accountability and Audit Reports brings together the key financial accountability documents within the annual accounts. This report includes a statement of compliance with regularity of expenditure guidance, a statement of losses and special payments recognised in the year and the external auditor's certificate and audit opinion on the financial statements.

Corporate Governance Report

Non Executive Directors' Report

The role of the Trust Board is to consider the key strategic and managerial issues facing the Trust in carrying out its statutory and other functions. It is accountable, through the Chairman, to the Permanent Secretary at the Department of Health.

It is made up of a Chairman, seven non-Executive Directors, five Executive Directors and other Service Directors. The Department of Health appoints non-executive directors, with the approval of the Minister for Health.

Non-Executive Directors

- Mr Peter McNaney, Chairman
- Professor Martin Bradley
- Mr Gordon Smyth
- Mrs Nuala McKeagney
- Dr Patrick Loughran
- Ms Anne O'Reilly
- Mrs Miriam Karp
- Professor David Jones.

The Non Executives chair a number of oversight committees including the Audit, Assurance, Social Care, Remuneration and Charitable Funds Advisory committees.

The Audit Committee provides the Trust Board with an independent and objective review on its financial systems of internal control. Mr Gordon Smyth as Chair of the Audit Committee provides the Board with an Annual Report each year. This committee met four times during the year and members achieved 95% attendance. The Audit Committee completes the National Audit Office Audit Committee self-assessment checklist on an annual basis to assess its effectiveness. No performance related issues were identified by Audit Committee members during the year. The work of the Internal Audit and External Audit functions is fundamental to providing assurances on the on-going effectiveness of the system of internal financial control.

The Assurance Committee met on four occasions during the year and members achieved 84% attendance. It is comprised of Non-Executive Directors, Directors and the Trust Chief Executive and chaired by Mr Peter McNaney. The Assurance Committee's role is to assist the Board of Directors in ensuring an effective Assurance Framework is in operation for all aspects of the Trust's undertakings, other than finance. The Assurance Committee is also responsible for ensuring there is a robust system in place for identifying principal risks and significant gaps in controls/assurance for consideration by the Board of Directors.

The Social Care Committee, chaired by Ms Anne O'Reilly, reviews all internal and external inspection and regulator reports relating to Statutory Functions and Corporate Parenting. They provide assurance to the Board that recommendations have been accepted and that their implementation will be monitored by the Committee.

The Remuneration Committee is responsible for advising the Board on the remuneration of the Chief Executive and Directors of the Trust, guided by DoH policy and best practice. The Committee is chaired by the Trust Chairman, Mr Peter McNaney and includes two other Non-Executive Directors, Ms Anne O'Reilly and Mrs Nuala McKeagney.

The Charitable Funds Advisory Committee oversees the management and governance of funds in line with the Trust's Standing Financial Instructions. The Committee is chaired by Mrs Nuala McKeagney.

ACCOUNTABILITY REPORT

Directors' Report

The Trust Board consists of Executive Directors covering the core professional areas with voting rights and other Directors who make up the senior management of the Trust across the operational directorates.

Executive Directors

- Dr Cathy Jack, Chief Executive
- Mrs Maureen Edwards, Director of Finance, Estates and Capital Planning
- Miss Brenda Creaney, Director of Nursing and User Experience
- Mrs Carol Diffin, Director of Social Work/Children's Community Services
- Dr Chris Hagan, Medical Director (Interim until permanent appointment July 2020)

Directors

- Ms Bernie Owens, Director of Neurosciences, Radiotherapy and Muckamore Abbey Hospital
- Mrs Jacqui Kennedy, Director of Human Resources and Organisational Management
- Mr Aidan Dawson, Director of Specialist Hospitals and Women's Health
- Mrs Caroline Leonard, Director of Specialist Services
- Miss Gillian Traub, Interim Director of Adult Social and Primary Care (from 15 June 2020)
- Mrs Charlene Stoops, Director of Performance, Planning and Informatics
- Dr Brian Armstrong, Interim Director of Unscheduled and Acute Care
- Mr Stephen Boyd, Interim Director Surgery (from 8 December 2020)
- Mrs Janet Johnson, Interim Director Acute Services/Covid Organisational Group (from 25 November 2020)
- Mrs Marie Heaney, Director of Adult Social and Primary Care (until 30 June 2020)
- Dr Clodagh Loughery, Interim Director Surgery and Specialist Services (from 2 November to 7 December 2020)

A declaration of Board Members' interests has been completed and is available on the Trust's website www.belfasttrust.hscni.net. The Trust is required to disclose details of transactions with individuals who are regarded as related parties consistent with the requirements of IAS 24 – Related Party Transactions and this can be found at Note 20 to the Financial Statements.

The executive and senior management of the Trust, along with the Director of Finance have the responsibility for the preparation of the accounts and Annual Report. They have provided the auditors with the relevant information and documents required for the completion of the audit. The responsibility for the audit of the Trust rests with the Northern Ireland Audit Office.

In providing the auditors with the relevant information, the Directors have confirmed:

- That so far as they are aware, there is no relevant audit information of which the Trust's auditors are unaware
- That they have taken all the steps that they ought to have taken as directors in order to make themselves aware of the relevant audit information, and to establish that the Trust's auditors are aware of that information
- That the annual report and accounts as a whole are fair, balanced and understandable and that they take personal responsibility for the annual report and accounts and the judgements required for determining that it is fair, balanced and understandable.

The Trust's external auditor is the Northern Ireland Audit Office who have appointed Price Waterhouse Coopers to carry out the detailed audit work to support the C&AG's opinion. The notional cost of the audit for the year ending 31 March 2021 which pertained solely to the audit of the accounts is £77,000 made up as follows, public funds £72,000 and Charitable Trust Funds £5,000.

An additional amount of £1,655 was paid to the Northern Ireland Audit Office in respect of work carried out on the National Fraud Initiative. This is reflected within miscellaneous expenditure in note 3 to the financial statements.

Information Governance

Information Governance within the Trust provides a framework for handling personal information in a confidential and secure manner to appropriate legal, ethical and quality standards. The Trust aims to safeguard confidentiality and maintain data security ensuring staff can perform their role using key information governance principles and meeting legislative requirements.

The Trust continues to implement measures to comply with the UK General Data Protection Regulation (UK GDPR) and the Data Protection Act 2018. Within the year the Trust reported 16 data breaches to the Information Commissioners Office (ICO).

Sharing of information with third parties or other organisations is closely monitored and in compliance with the requirements of GDPR Article 30, the Trust would have a number of data access agreements and data sharing agreements in place to protect the use of personal data. This has proved to be a growth area of work this year as data sharing has increased with the number of COVID related projects.

The Trust works with the regulator, the ICO, to resolve any complaints received by them into how the Trust handles data. In 2020-21 the Information Governance department dealt with five complaints, three were upheld, one not upheld by the ICO and the remaining one required no further action by the Trust.

Complaints Management

In the patient-centred environment of the Belfast Trust, we encourage patients, relatives and carers to share their thoughts and experiences regarding the treatment and services that they receive.

We recognise the critical importance of having an effective process for investigating and taking appropriate actions in relation to comments, concerns, complaints and compliments about any aspect of care or treatment provided or commissioned by the Belfast Trust in hospital or community settings.

We work hard to ensure that complaints received by the Trust are appropriately investigated; responded to in reasonable timeframes and in a manner that reflects the key Trust values; and to make certain that learning from complaints is used to inform potential improvements for the future to help make our services the safest, most effective and compassionate they can be.

The Service User Experience Feedback Group – made up of senior staff from across the Trust – meets quarterly and discusses key issues associated with complaints and other types of communication from our patients, service users and carers. In particular, this Group focuses on the use of feedback to lead to Quality Improvement throughout the services we deliver. The Group also looks at Key Performance Indicators aimed at ensuring that the ways in which we deal with complaints are working effectively and reviews data to identify any trends in the reasons behind complaints.

The complaints department continues to provide training for staff on how to respond when complaints are raised - both face-to-face in wards and departments, and when complainants raise their concerns through the Trust's central Complaints Department.

The number of formal consented complaints received for the financial year 2020-21 was 1,161 of which 299 included Covid-19 related issues or concerns.

3,497 compliments were formally recorded across the Trust in relation to the specific themes monitored regionally by the Department of Health - Quality of Treatment and Care, Staff Attitude & Behaviour, Information & Communication and Environment.

A further 4,780 general compliments and expressions of thanks were also formally reported during the year.

Further information on the monitoring of complaints is contained in the Complaints Annual Report, which is published on our website. The Trust Complaints Team can be contacted at: complaints@belfasttrust.hscni.net or Tel: 028 9504 8000.

Statement of Accounting Officer's Responsibility

Under the Health and Personal Social Services (Northern Ireland) Order 1972 (as amended by Article 6 of the Audit and Accountability (Northern Ireland) Order 2003), the Department of Health has directed the Belfast Health and Social Care Trust to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The financial statements are prepared on an accruals basis and must provide a true and fair view of the state of affairs of the Belfast Health and Social Care Trust of its income and expenditure, changes in taxpayers equity and cash flows for the financial year.

In preparing the financial statements the Accounting Officer is required to comply with the requirements of Government Financial Reporting Manual (FReM) and in particular to:

- Observe the Accounts Direction issued by the Department of Health including relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- Make judgements and estimates on a reasonable basis
- State whether applicable accounting standards as set out in FReM have been followed, and disclose and explain any material departures in the financial statements
- Prepare the accounts on a going concern basis; and
- Confirm that the Annual Report and Accounts as a whole is fair, balanced and understandable and take personal responsibility for the Annual Report and Accounts and the judgements required for determining that it is fair, balanced and understandable.

The Permanent Secretary of the Department of Health as Principal Accounting Officer for Health and Social Care Resources in Northern Ireland has designated Dr Cathy Jack of the Belfast Health and Social Care Trust as the Accounting Officer for the Belfast Health and Social Care Trust. The responsibilities of an Accounting Officer, including responsibility for the propriety and regularity of the public finances for which the Accounting Officer is answerable, for keeping proper records and for safeguarding the Belfast Health and Social Care Trust's assets, are set out in the formal letter of appointment of the Accounting Officer issued by the Department of Health, Chapter 3 of Managing Public Money Northern Ireland (MPMNI) and the HM Treasury Handbook: Regularity and Propriety.

As the Accounting Officer, I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the Belfast Health and Social Care Trust's auditors are aware of that information. So far as I am aware, there is no relevant audit information of which the auditors are unaware.

Governance Statement 2020-21

Introduction/Scope of Responsibility

The Board of the Belfast Health and Social Care (HSC) Trust is accountable for internal control. As Accounting Officer and Chief Executive of the Trust, I have responsibility for maintaining a sound system of internal governance that supports the achievement of the organisations policies, aims and objectives, whilst safeguarding the public funds and assets for which I am responsible in accordance with the responsibilities assigned to me by the Department of Health (DoH).

Specifically, the Trust has the following key relationships through which it must demonstrate a required level of accountability:

- With HSC Board commissioners, through service level agreements, to deliver health and social services to agreed specifications. The Trust has established engagement processes with the HSC Board (which includes the Public Health Authority (PHA) for appropriate areas). For example, regular meetings are held with Local Commissioning Group (LCG) representatives and specialist services commissioners to discuss service issues and developments. The Trust and Commissioners have also established Locality Networks arrangements to focus on specific service delivery areas such as Unscheduled Care and Diabetes
- With local communities, through holding public board meetings, and publishing an annual report and accounts
- With patients, through the management of standards of patient care
- With the DoH, through the performance of functions and meeting statutory financial duties.

Compliance with Corporate Governance Best Practice

The Board of the Belfast HSC Trust applies the principles of good practice in Corporate Governance and continues to further strengthen its governance arrangements. The Board of the Belfast HSC Trust does this by undertaking continuous assessment of its compliance with Corporate Governance best practice by, for example, maintaining assessment against former controls assurance standards, or alternative new processes where available and completing an annual ALB Board Governance self-assessment and action plan. The Trust's self-assessment for 2019-20 was finalised and approved at Trust Board on 5 November 2020. The self-assessment covers a number of areas including Board composition and commitment; Board evaluation, development and learning; Board insight and foresight; and Board engagement and involvement. The 2019-20 self-assessment flagged an example of delay in escalation of serious concern to the Board. Actions to address this have commenced with a review of Social Care Governance arrangements, continued implementation and integration of a Quality Management System (QMS), revision of the Board Assurance Framework and a workshop to further develop and introduce effective use and understanding of risk appetite at all levels of the organisation to strengthen current arrangements.

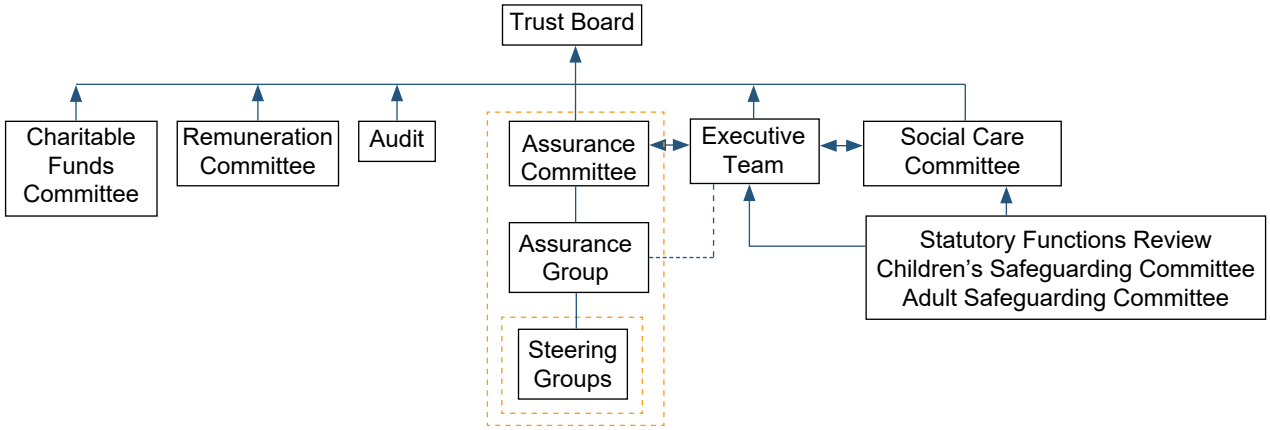
Governance Framework

The Board of the Trust exercises strategic control over the operation of the organisation through a system of corporate governance which includes:

- A schedule of matters reserved for Board decisions
- A scheme of delegation, which delegates decision making authority within set parameters to the Chief Executive and other officers
- Standing Orders and Standing Financial Instructions
- An Assurance Committee
- An Audit Committee
- A Remuneration Committee
- A Social Care Committee
- A Charitable Trust Fund Advisory Committee
- A Learning from Experience Steering Group
- A Governance Steering Group
- An Involvement Steering Group
- A Safety & Quality Steering Group
- A Service User Experience Feedback Group (incorporating complaints).

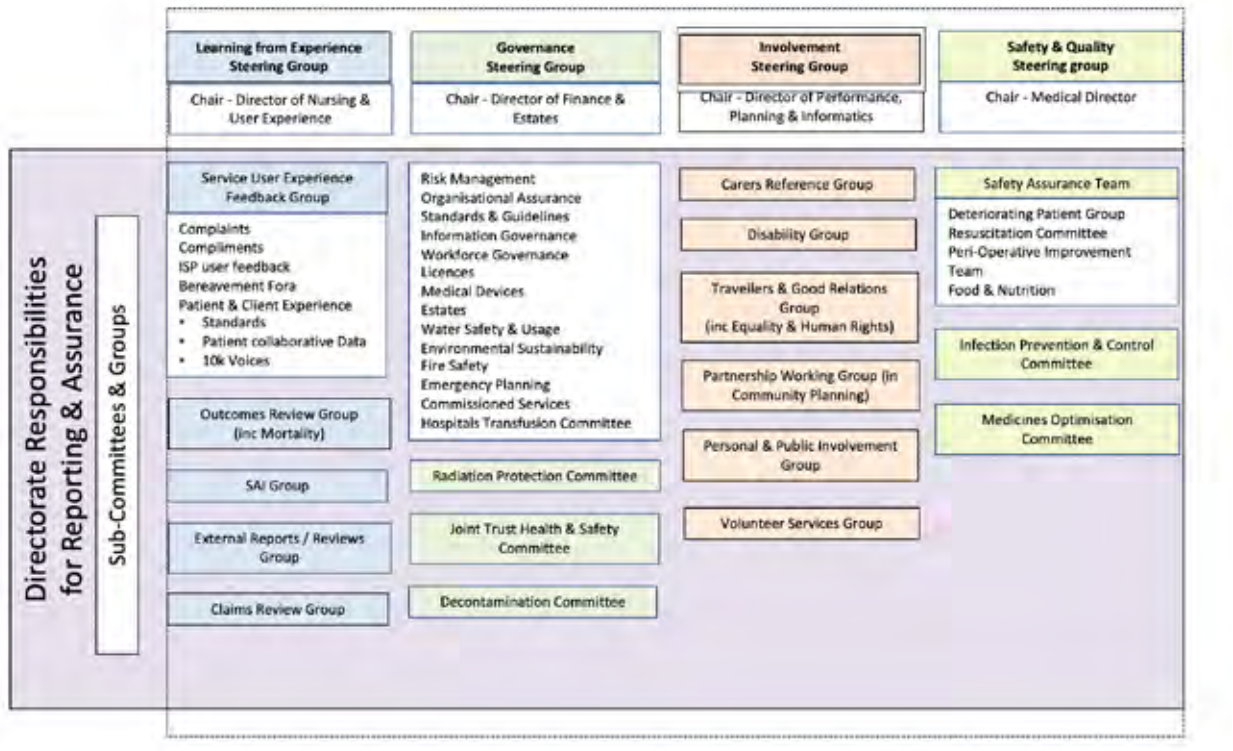
ACCOUNTABILITY REPORT

Trust Assurance & Accountability Organisational Overview



Five Corporate Themes				
Safety, Quality & Experience	Service Delivery	Strategy	People & Culture	Resources
Key Objectives				
Deliver Quality Improvement Plan 2017-2020, linked to Experience	Drive improvement across elective care, unscheduled and community services	Develop and deliver strategic change with partners	Implement Collective Leadership and Culture Strategy	Build infrastucture fit for purpose

Steering Groups and Assurance subcommittees



The role of the Trust Board is to consider the key strategic and managerial issues facing the Trust in carrying out its statutory and other functions. Throughout the year the Trust Board has been briefed on control issues by the Chairs of the Audit Committee and Assurance Committee. The Trust held five public Trust Board meetings, 14 confidential meetings and six Trust Board workshops during 2020-21. Standing agenda items included reports from the Chief Executive, performance, quality, and financial performance reports. An additional Trust Board workshop covering Real Time Patient/Staff Feedback was held on the 1 October 2020.

Trust Board attendance records for 2020-21 were as follows:

Non Executive Directors	No. of meetings attended	No. of possible meetings
Peter McNaney	5	5
Martin Bradley	5	5
David Jones	4	5
Nuala McKeagney	5	5
Paddy Loughran	5	5
Anne O'Reilly	5	5
Miriam Karp	5	5
Gordon Smyth	5	5
Executive Directors		
Cathy Jack	5	5
Brenda Creaney	5	5
Maureen Edwards	5	5
Carol Diffin	5	5
Chris Hagan	2	5
Directors		
Aidan Dawson	4	4
Marie Heaney	1	2
Caroline Leonard	4	4
Bernie Owens	5	5
Jacqui Kennedy	4	4
Charlene Stoops	4	5
Brian Armstrong	4	4
Gillian Traub	2	2
Janet Johnson	1	1

ACCOUNTABILITY REPORT

The Audit Committee provides the Trust Board with an independent and objective review on its financial systems of internal control. The Chair of the Audit Committee provides the Board with an Annual Report each year. This committee met four times during the year and members achieved 95% attendance. The Audit Committee completes the National Audit Office Audit Committee self-assessment checklist on an annual basis to assess its effectiveness. No performance related issues were identified by Audit Committee members during the year. The work of the Internal Audit and External Audit functions is fundamental to providing assurances on the on-going effectiveness of the system of internal financial control.

The Assurance Committee met on four occasions during the year and members achieved 84% attendance. It is comprised of Non-Executive Directors, Directors and the Trust Chief Executive and Chairman. The Assurance Committee's role is to assist the Board of Directors in ensuring an effective Assurance Framework is in operation for all aspects of the Trust's undertakings, other than finance. The Assurance Committee is also responsible for ensuring there is a robust system in place for identifying principal risks and significant gaps in controls/assurance for consideration by the Board of Directors.

The Remuneration Committee met twice during the year with 100% attendance. The Committee is chaired by the Trust Chairman and includes two other Non-Executive Directors. It is responsible for advising the Board on the remuneration of the Chief Executive and Directors of the Trust, guided by DoH policy and best practice.

The Charitable Funds Advisory Committee oversees the management and governance of funds in line with the Trust's Standing Financial Instructions. The Committee is chaired by a Non-Executive Director.

The Assurance, Remuneration and Charitable Funds Advisory Committees met in accordance with their Terms of Reference throughout the year and no performance related issues were raised by the Board Governance Self-Assessment.

Business Planning

Business planning and risk management is at the heart of governance arrangements to ensure that statutory obligations and ministerial priorities are properly reflected in the management of business at all levels within the organisation including a formal structure and process for development and approval of business cases to support significant areas of expenditure.

The Trust's 3 year Corporate Plan sets out the vision and purpose, core values and objectives that will shape the strategic direction and priorities. The Trust's overarching vision is to be one of the safest, most effective and compassionate health and social care organisations. The delivery of this vision is articulated through five corporate themes. These are:

- Safety, Quality and Experience

- Service Delivery
- People and Culture
- Strategy and Partnerships
- Resources.

The Corporate Plan and the Trust Delivery Plan (TDP) set out measures and targets to progressively deliver these corporate objectives.

The TDP is usually developed annually as a response to the Department's performance indicators and the Commissioning Plans of the Health and Social Care Board (HSCB) as set out in its Annual Commissioning Plan. The TDP reporting arrangements have however been put on hold during the pandemic and Trust has been reporting through financial plans and rebuild plans submitted to the DoH and HSCB.

While the Corporate Plan incorporates these Departmental/Commissioner targets, it takes a wider view of the organisational responsibilities of the Trust, setting a range of local targets and measures under each corporate objective. The Corporate Objectives and associated targets (regional and local) are cascaded throughout the Trust by:

- Directorate and Division Plans
- Service / Team Plans
- Individual Objectives.

This process forms an integral part of the Trust's Performance Management and Assurance Framework. Review and monitoring of progress against priorities and objectives (linked to DoH/ HSC Board priorities, the Trust corporate planning priorities (including the Trust Delivery Plan) is carried out through:

- Trust Board Performance Reports (related to key performance indicators), to provide assurance at Board level
- The Trust Quality Management Framework reports which are reviewed and includes regular accountability / review meetings with Directorates / Divisions to monitor progress against organisational and Directorate / Division key priorities
- Individual Personal Contribution Plans and Learning and Development Plans objectives through the Staff Development Review process to ensure learning and development supports the delivery of Directorate and organisational objectives.

ACCOUNTABILITY REPORT

Risk Management

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an on-going process designed to:

- Identify and prioritise the risks to the achievement of organisational policies, aims and objectives
- Evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.

The Trust is committed to providing high quality, compassionate services to patients and clients in an environment that is both safe and secure. The Trust Board has approved an Assurance Framework and a Risk Management Strategy and has established an Assurance Committee whose membership includes all Non-Executive Directors. This Committee reports directly to the Trust Board. The Assurance Framework outlines the Chief Executive's overall responsibility and accountability for risk management. The Framework also sets out a system of delegation of responsibility at Trust Board, Executive Team and Directorate levels. Whilst all clinicians, managers and Co-Directors are responsible for managing and controlling all elements of risk to which the Trust may have been exposed, there is a clear line of accountability through to Trust Board.

The Risk Management Strategy was last reviewed in July 2020. Risk management is at the core of the Trust's performance and assurance arrangements and the Assurance Committee, chaired by the Trust's Chairman, provides Board level oversight in this key area. This Committee, along with the Audit Committee, has scrutinised the effectiveness of the Risk Management Strategy.

The Trust acknowledges that it is impossible to eliminate all risks and that systems of control should not be so rigid that they stifle innovation and imaginative use of limited resources. Inevitably the Trust may have to set priorities for the management of risk. There is a need to balance potentially high financial costs of risk elimination against the severity and likelihood of potential harm. The Trust will balance the acceptability of any risk against the potential advantages of new and innovative methods of service. The Trust recognises that risks to its objectives may be shared with or principally owned by other individuals or organisations. The Trust involves its service users, public representatives, contractors and other external stakeholders in the implementation of the Risk Management Strategy.

Risk management is integral to the training for all staff as relevant to their grade and situation, both at induction and in service. To support staff through the risk management process, expert guidance and facilitation has been available along with access to policies and procedures, outlining responsibilities and the means by which risks are identified and controlled. Actions taken to reduce risk have been regularly monitored and reported with trends being analysed at Directorate, Corporate and Board levels.

Dissemination of good practice has been facilitated by a range of mechanisms including systems for the implementation and monitoring of authorative guidance, clinical supervision and reflective practice, performance management, continuing professional development, management of adverse events and complaints, multiprofessional audit and the application of evidence based practice. The Trust seeks to ensure that its medical workforce is equipped to provide the best health care that can be achieved through investment in education, appraisal, appropriate job planning and where issues arise that are appropriate to maintaining high professional standards these are dealt with using the appropriate procedures, involvement of National Clinical Assessment Service where necessary and regulatory bodies such as the General Medical Council and General Dental Council.

The Trust has a shared learning procedure which outlines common sources of learning and provides guidance to staff on types of learning and how to share within departments, across the Trust and regionally as appropriate.

Information Risk

Information Governance (IG) within the Trust provides a framework for handling personal information in a confidential and secure manner to appropriate legal, ethical and quality standards. Employees must be equipped to handle the many different information requirements relating to patients, clients and staff. The Trust aims to safeguard confidentiality and maintain data security ensuring staff can perform their role using key information governance principles whilst meeting legislative requirements.

An Information Governance framework is in operational within the Trust involving all Directorates. The Director of Performance, Planning and Informatics acts as the Senior Information Risk Owner (SIRO) and has a key role in considering how organisational goals will be impacted by information risks and how those risks will be managed. Information Asset Owners (IAO's) are nominated across the Trust and have responsibility for identifying and managing information assets and risk in their own areas. The Information Governance Board (IGB) and subgroups ensures involvement throughout the organisation in terms of the management of information risk, monitoring of data handling and development of good practice. The IGB oversees all aspects of IG including data protection, ICT security, records management, freedom of information, cyber security and data quality. This body takes responsibility for developing a culture of good practice that values, protects and uses information appropriately. Regular reports and an annual IG report are presented as part of the Trust's assurance structure. This is further supplemented by Organisational Assurance Statements for Information Governance and ICT.

The Trust continues to implement measures to comply with the UK General Data Protection Regulation (UK GDPR) and the Data Protection Act 2018. Within the year the Trust reported 16 data breaches to the Information Commissioners Office (ICO). It is important that we provide our staff with the necessary guidance and training to protect all our information and to ensure any data

breaches are reported within the statutory 72 hour timeframe to the ICO where required.

There have been challenges for IG staff providing mandatory data protection training as the pandemic meant that all training had to move to online platforms. However, despite this our eLearning was updated and the induction mandatory training programme was revised. This ensures that new employees continue to receive data protection training prior to starting their employment in the Trust. The number of staff who have received data protection training in the last three years has dropped to 50%. The IG department will continue to target staff who require training and provide regular information via the dissemination of a quarterly IG bulletin. The penalties for breaking data protection and associated laws are now significant. From an organisational point of view the mis-management of personal information can impact greatly on the reputation of the Trust. It is important that learning from data breaches is communicated throughout the organisation to improve our data handling practices and where appropriate recommendations received from ICO are implemented accordingly.

Sharing of information with third parties or other organisations is closely monitored and, in compliance with the requirements of GDPR Article 30, the Trust would have a number of data access agreements and data sharing agreements in place to protect the use of personal data. This has proved to be a growth area of work this year as data sharing has increased with the number of Covid related projects.

The Trust works with the regulator, the ICO, to resolve any complaints received by them into how the Trust handles data. In 2020-21 the IG department dealt with five complaints, three were upheld, one not upheld by the ICO and the remaining one required no further action by the Trust.

Since the introduction of GDPR in May 2018, the Trust experienced a significant increase in Subject Access Requests processed in 2018-19 and 2019-20. However whilst the number of requests has dropped in 2020-21, unfortunately, the complexity and volume of data requested along with staff absences has led to long delays in receiving information from some areas of the Trust. It is hoped that this will improve in 2021-22.

The Trust is committed to ensuring appropriate cyber security is in place and has a dedicated cyber team based within the IT department. There is a formal and comprehensive programme of work ongoing with the aim of securing compliance with the Network & Information Systems Regulations (NIS 2018). In addition the Trust has senior representation on the regional Cyber Security Programme Board and is actively engaged in their various business cases and implementation projects.

A cyber security incident took place at Queen's University Belfast (QUB) in February 2021. As the HSC has multiple contractual interactions with QUB, some concerning personal information, the HSC technology teams, with the backing of the HSC SIRO's, took a number of actions to reduce potential disruption to HSC services, and continue to liaise with QUB on the impact of the cyber incident. The impact on the HSC is being fully investigated, and there may be a financial risk in

relation to possible future liability, for potential claims for loss of personal data. As the breach occurred in a third party's systems the potential for liability is unclear and any financial impact is unquantifiable at present.

Fraud

The Trust takes a zero tolerance approach to fraud in order to protect and support our key public services. We have put in place a Fraud Policy and Fraud Response Plan to outline our approach to tackling fraud, define staff responsibilities and the actions to be taken in the event of suspected or perpetrated fraud, whether originating internally or externally to the organisation. Our Fraud Liaison Officer promotes fraud awareness, co-ordinates investigations in conjunction with the BSO Counter Fraud Services team and provides advice to personnel on fraud reporting arrangements. All staff are offered fraud awareness training in support of the Fraud Policy and Fraud Response Plan, which are kept under review and updated as appropriate or every five years.

The Trust continued to report all suspected/actual frauds to Trust Audit Committee during the period. In addition, the NIAO guidance on Covid-19 Fraud Risks has been shared with Trust senior managers to raise awareness of the increased risk of fraud.

Personal Public Involvement and Co-Production

The Trust remains committed to ensuring that the statutory duty for Personal and Public Involvement (PPI) is embedded into all aspects of its business, in line with the regional PPI Standards. The Trust also continues to work towards the implementation of the DoH Co-Production guide. A new BHSCT Involvement Strategy has been produced, which sets out the Trusts vision, commitment and integrated approach to Patient and Client Experience, PPI and Co-production.

The Trust continues to work on creating opportunities for PPI and co-production with service user and carers, with a particular focus on developing involvement in 6 strategic work streams, including No More Silos. PPI is included in the Trust Assurance Framework committee structure and reports via the Involvement Steering Group. PPI is reflected in the Trust Corporate Plan and is subsequently included in Directorate and Divisional management plans.

There continues to be a wide range of service user and carer engagement opportunities throughout the Trust, both corporately and within clinical Directorates, which allow people to become involved in the development, improvement and evaluation of Trust services. A virtual involvement network has been developed and involvement opportunities are regularly promoted with this network. An Involvement newsletter is now produced quarterly and circulated widely. With the Trusts ongoing commitment to Quality Improvement, there is a continued commitment to ensuring that PPI is core to this work.

In addition, there a number of Trust-wide User Forums and specific Service User groups facilitated by and linked to the Trust which can provide opportunities for service user and other stakeholders to engage in decision making, feedback processes and associated risk issues.

The Engage and Involve training was adapted for online delivery during Covid restrictions and a specific training session on supporting involvement during Covid, entitled “Putting the I in Covid”, was developed with colleagues from across the region. Online delivery commenced in November 2020 with 40 people participating in online training between then and the end of March 2021. During this period, 3,868 people accessed the Introduction to PPI e-learning session. A number of guides for supporting online involvement were developed with colleagues in other Trust - these included FAQ’s for involvement during Covid, involving hard to reach groups, making virtual meetings engaging, a guide to online questionnaires and facilitating virtual focus groups.

The Trust continues to participate in the Regional PPI Forum and related subgroups including, training and remuneration / reimbursement.

Assurance

The Assurance Framework describes the relationship between organisational objectives, identifies potential risks to their achievement and the key controls through which these risks will be managed, as well as the sources of assurance surrounding the effectiveness of these controls. The Assurance Framework incorporates the Risk Management Policy and establishes the context in which the Trust Management Plan was developed, as well as determining the mechanism through which assurances were provided to the Trust Board. The Assurance Framework lays out the sources of evidence which the Board will use to be assured of the soundness and effectiveness of the systems and processes in place to meet objectives and deliver appropriate outcomes. The Assurance Committee regularly challenges or seeks verification of the quality of evidence coming to it.

The Assurance Framework was reviewed and updated in 2020. The updated Assurance Framework was approved by the Assurance Committee of the Trust Board in July 2020. The Assurance Framework allows an integrated approach to performance, targets and standards, which include proportionate assurance arrangements, replacing the former controls assurance standards and quality standards for health and social care.

The Assurance Committee agenda and schedule of annual reports takes account of the Sub Committees structure. These committees report through the Assurance Group to Executive Team. They are generally expert groups that are responsible for developing assurance arrangements within specific areas of Trust activity and provide the necessary scrutiny of practice. At each Assurance Committee meeting, through the relevant Director, the Committee receives assurance reports from the following governance committees: Social Care Committee; Governance Steering Group; Learning from Experience Steering Group; Outcome Review Group; Service User Experience Feedback Group (including complaints); Safety and Quality Steering Group;

Involvement Steering Group as well as a litigation report encompassing clinical negligence and other claims. It also receives an annual Health and Safety report.

In addition, the Committee receives updates on the Safety and Quality Improvement Plan; on incidents and Serious Adverse Incidents; summary reports of RQIA unannounced hygiene inspections; RQIA thematic reviews and RQIA inspections of regulated providers. This taken with other internal assurances and the external assurances detailed under Sources of Independent Assurance means that the Board is satisfied that this level of assurance is of sufficient quality and meets its requirements. The Risk Register Review Group continues to meet on a quarterly basis, to scrutinise the evaluation of all significant risks arising from Directorate Risk Registers. Each Directorate has maintained and further developed systems to identify risk, assess impact and likelihood of harm occurring, and to maintain control in line with the Assurance Framework and the revised Risk Management Strategy. These risks are used to populate Directorate risk registers, which are updated on an on-going basis and which feed into the Belfast Trust's Assurance Framework Principal Risks and Controls.

Covid-19

The impact of Covid on the Trust's ability to meet changing healthcare needs, deliver routine health and social care services along with the staffing and financial resource implications are detailed throughout the Trust Annual Report.

In respect of the Trust governance, assurance and internal control framework these were amended/adjusted as appropriate and within the guidelines provided.

Internal Audit carried out an audit of Governance during Covid-19 during October 2020. The audit looked at the arrangements in the Trust during the initial surge of Covid-19 to ensure the Trust continued to operate with adequate and effective governance arrangements. Internal Audit provided satisfactory assurance as the Trust governance structures were enhanced to allow effective monitoring and accountability.

The Trust received DoH formal written cover for all unusual financial support payments made to suppliers and all expenditure in response to Covid-19 was in line with DoH authority and in accordance with MPMNI.

The Trust Audit Committee assessed the Trust's approach against the NAO Good Practice Guide for Audit and Risk Committees on Financial Reporting and Management during Covid-19. Learning was identified and recommendations made coming out of this review.

Sources of Independent Assurance

The Trust obtains Independent Assurance from the following main sources:

- Head of Internal Audit's Annual Report including an overall opinion on the system of Internal Controls
- Chair of Audit Committee's Annual Report to Trust Board
- Internal Audit – through a programme of annual audits based on an analysis of risk
- Northern Ireland Audit Office; NIAO provides assurance to the Assembly as the statutory external auditor to the Trust, a by-product of which is the report to those charged with governance which provides the Trust with detailed findings from their audit. Cognisance is also taken of any pertinent NIAO VFM reports.
- Regulation and Quality Improvement Authority (RQIA); through regular inspections and subsequent reports
- Medicines and Healthcare products Regulatory Agency (MHRA); through regular inspections and reports
- General Medical Council (GMC), General Dental Council (GDC), NI Medical and Dental Training Agency (NIMDTA) and various Royal Colleges.

All Belfast Trust Laboratories (BTL) are required to be accredited by United Kingdom Accreditation Service (UKAS) to ISO Standards. All sites are visited by UKAS annually to ensure compliance with the accredited standard. BTL are fully accredited throughout all seven disciplines across three hospital sites. BTL currently hold nine UKAS accreditation standard ISO 15189:2012 and our Public Health Laboratory are accredited to ISO 17025:2017.

The Trust's Regional Fertility Centre's Human Fertilisation and Embryology Authority (HFEA) licence was successfully renewed in March 2019 (this was due for further renewal in February 2021 but the licence has been extended until February 2022 in view of the impact of Covid on the HFEA's capacity to conduct site inspections). The Regional Fertility Centre was successfully reaccredited for ISO90001:2015 and the Regional Andrology Service successfully gained UKAS accreditation of ISO15189 having moved from CPA accreditation.

The MHRA radiopharmacy inspection in June 2019 identified a number of deficiencies with the Trust's radiopharmacy service and facility. The Trust developed and is implementing the remedial action plan. A business case was submitted to the Department of Health for a new Radiopharmacy building. This has been approved by the Department with an estimated completion date of 2025. The service has now secured the experience of an additional external PQS (Pharmacy Quality System) consultant and has successfully appointed a senior internal PQS post to assist in addressing the deficiencies identified in the MRHA inspection. The Trust continues to provide quarterly update reports to the MHRA around progress and activity statistics.

The Trust continues to work to ensure ongoing compliance with the Human Tissue Authority (HTA) requirements, and has put additional licensing arrangements in place to address the impact of EU Exit on the import of human tissue to the Trust and the associated HTA regulatory standards

The British Standards Institute (BSI) is the Notified Body who audits compliance of the Central Decontamination Units (CDU) in RVH and MPH as well as the Endoscopy Decontamination Unit (EDU) in BCH and RVH against the relevant Medical Devices Directives and ISO 13485 standard. The Trust is audited bi-annually. The Central Decontamination Units in BCH, MPH and RVH have been externally audited by BSI auditor to the new ISO 13485-2016 standard. MPH/RVH Central Decontamination Units and BCH/RVH endoscopy units successfully achieved accreditation to the new standard ISO 13485-2016.

The Trust engages proactively with all such reviews and the Board is assured that appropriate actions are taken by the Assurance Committee.

The Trust can confirm that it reviewed arrangements in place to ensure the timely and effective implementation of agreed National Institute for Health and Clinical Excellence (NICE) guidance where reasonably practical. Systems are in place to support identification of any risks associated with non or partial compliance and these are highlighted and recorded on appropriate risk registers including, when appropriate, the Corporate Risk Register/Principal Risk Document and are reported to the HSC Board as required.

Internal Audit

The Trust utilises an internal audit function which operates to defined standards and whose work is informed by an analysis of risk to which the body is exposed and annual audit plans are based on this analysis.

Internal Audit revised their audit plan in light of Covid-19 to ensure ongoing effectiveness of Trust internal controls. The audit plan was updated to include more advisory work and in particular reviewed the Trust's validation processes for payments made to independent sector homes, domiciliary care, supplier relief and voluntary organisations.

ACCOUNTABILITY REPORT

In 2020-21 Internal Audit reviewed the following systems:

AUDIT ASSIGNMENT	LEVEL OF ASSURANCE
FINANCE AUDITS	
Non Pay Expenditure	Satisfactory
Payments to Staff	Limited
Charitable Funds	Satisfactory
Travel & Subsistence Expenses	Satisfactory
Management of Resident Monies in 1 Independent Nursing Home	Unacceptable
Management of Community and Voluntary Contracts During Covid-19 (specifically the application of and compliance with regional directions during 2020-21)	Satisfactory
Substantive Follow Up of 2019-20 ERostering audit report	Satisfactory
ICT Procurement and Contract Management	Satisfactory
CORPORATE RISK BASED AUDITS	
IT – Line of Business (LoB) Applications audit	Satisfactory – 3 of the 4 sampled LoBs Limited – 1 of the 4 sampled LoBs
Recruitment (Non-Medical Staffing)	Limited
GOVERNANCE AUDITS	
Risk Management	Satisfactory
Retention of Board/Committee Minutes and Papers	Satisfactory
Governance During Covid-19	Satisfactory
Management of Fraud & Whistleblowing	Management of Fraud – Satisfactory Governance and Reporting around Raising Concerns/Whistleblowing processes - Limited

A number of advisory/non-assurance assignments were also carried out during the year namely – Independent Homes and Domiciliary Care Covid-19 Payments, Homecare Service, Governance & Management of Revenue Business Cases, Trust Fraud Risk Assessment Template and Substantive Follow up of 2018-19 Dr A compliance with guidance on private work.

In their annual report, the Internal Auditor provided satisfactory assurance on the adequacy and effectiveness of the organisation's framework of governance, risk management and control. The Head of Internal Audit noted that whilst Covid-19 has shaped and in some ways restricted the 2020-21 audit programme she was content there has been sufficient audit work conducted across the organisation's framework of governance, risk, and control to provide an annual assurance opinion in 2020-21.

Unacceptable assurance has been provided for one audit and limited or partially limited assurance has been provided in respect of four audits:

- Management of Residents Monies in Clifton Park Nursing Home received unacceptable assurance as significant issues were identified around the management of the bank account; queries over expenditure relating to two specific residents that require further investigation by the Trust; and residents agreements are not consistently in place
- Payments to Staff received limited assurance due to inadequate controls identified in timesheet processing, a drop in compliance with staff in post returns and inaccuracies in the Organisational Management (OM) structure
- Recruitment (Non Medical Staff) received limited assurance due to delays in approval of requisitions (average of 37 working days) along with no formal KPI's for the first four stages of the recruitment process within the Trust
- IT Line of Business (LoB) Applications received satisfactory assurance in respect of three of the LoBs sampled and limited assurance in respect of one of the LoBs sampled due to significant issues with the control environment
- Management of Fraud and Whistleblowing received satisfactory assurance in respect of management of fraud and limited assurance in respect of governance and reporting around raising concerns/whistleblowing processes.

Recommendations to address these control weaknesses have been or are being implemented. The Audit Committee have reviewed management responses to Internal Audit recommendations and monitor progress with the implementation of recommendations.

Internal Audit conduct formal follow-up reviews in respect of the implementation of the priority one and two internal audit recommendations agreed in the Internal Audit reports. Internal Audit presented a full report which showed that 76% of agreed actions were fully implemented and a further 24% were partially implemented.

Review of Effectiveness of the System of Internal Governance

As Accounting Officer, I have responsibility for the review of effectiveness of the system of internal governance. My review of the effectiveness of the system of internal governance is informed by the work of the internal auditors and the executive managers within the Trust who have responsibility for the development and maintenance of the internal control framework, and comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Trust Board, Audit Committee, Assurance Committee and sub committees, and a plan to address weaknesses and ensure continuous improvement to the system is in place.

Internal Control Divergences

Progress on Prior Year Control Issues - closed

Single Tender Actions/Direct Award Contracts (DACs)

In 2019-20 there were three DACs partially refused due to their retrospective nature totalling £38k unapproved expenditure. In the current year there have been no unapproved DACs. The Trust has worked closely with PaLS to identify and address any weaknesses in process to ensure future compliance in the area of contract management processes, particularly within Laboratories, Pharmacy and Estates where revised processes have been collectively agreed and implemented.

Domiciliary Care Services

As part of a regional piece of work on behalf of all HSC Trusts, the BSO Counter Fraud Services conducted a review of payments made to domiciliary care agencies by the Trust in recent years.

The review compared the actual hours paid by a variety of independent sector providers (ISPs) to their workforce against the actual hours paid by Trusts to those agencies. Variations were identified and the Trust subsequently conducted further verification of the findings with differing results.

The BSO review identified a range of issues and the DoH established an Oversight Scrutiny Committee to manage the next steps. The Trust actively participated in this work and have been progressing agreed actions as required. The NI Civil Service Internal Audit Service carried out a lessons learned review from a HSC wide perspective in relation to the structure of the investigative review and BSO Internal Audit also carried out in depth reviews of domiciliary care in Trusts in 2017-18. The BSO audits were finalised early in 2018-19 and the Oversight Scrutiny Committee has now concluded their work and a number of recommendations with a focus on driving forward procurement of social care services, and improving contract management including monitoring of service delivery. The Oversight Scrutiny Committee's Domiciliary Care Closure Report was issued in March 2021 and the mechanisms, including timelines, to ensure all recommendations are implemented have been set out.

Critical Care Building

In October 2012 one month prior to the programmed handover date of the Critical Care Centre, the main contractor reported corrosion in the sealed water systems. This resulted in the contractor replacing all five sealed systems at no cost to the Trust. Following handover of the Critical Care building in 2015, a series of works was required to bring the building into line with current standards and guidance. Occupation of the two Intensive Care Units and the Theatres floors was dependent on the completion of those works. In tandem with this an additional programme of works was also completed to improve the maintainability of the drainage systems and fire compartments.

ICU Department Level 5 and 6 - in April 2020, during the works programme to make level 5 and 6 ready for the transfer of ICU patients, the Trust commissioned a separate programme of work to repurpose the floors for use on a temporary basis to support non ICU patients as part of the Trust and region's Covid response. This delayed the ICU work required to upgrade systems to meet ICU standards. There was a final short delay of a month in 2020 when testing of the potable water identified an issue and some minor pipework upgrades were instructed.

Theatre Upgrade works Level 4 - the upgrading of theatre ventilation work has also experienced delay due to Covid as specialist teams were furloughed and there was an overall impact on the programme due to difficulties within the supply chain caused by the Pandemic.

Regional ICU services are now operating fully in the critical care building. The four Theatres located on Level 4 have been fully commissioned and are operational.

At this stage all floors in the critical care building should be in operation with the exception of the top three floors which are earmarked for use by the maternity service following the commissioning of the new maternity hospital and completion of the link corridor between the buildings. However, all ten floors of the critical care building are currently occupied, with the top three floors supporting the Trust in the management of winter pressures and the rebuilding of services post-Covid. Usage is shown as follows:

ACCOUNTABILITY REPORT

Level	Department	Occupancy Details Since Handover 2015
0	Plant & Service Tunnel	Operation since April 2015
1	Plant	Operational since April 2015
2	Accident & Emergency Department	Opened August 2015
3	Theatres	Theatres clinical commissioning complete January 2021. Theatre service commenced March 2021 (delayed due to redeployment of staff as a result of the pandemic)
	Endoscopy Decontamination Unit	Endoscopy Decontamination Unit operational 2017
4	Theatre & Emergency Department Office and Support Accommodation	Fully occupied September 2017
5	Intensive Care Units	ICU Operational November 2020
6	Intensive Care Units	ICU Operational November 2020
7	Maternity Bed Floor	Currently occupied by respiratory services (from 2020)
8	Maternity Bed Floor	Currently occupied by Trauma and Surgical services (from 2019)
9	Maternity Outpatient	Temporarily occupied by outpatient facilities to allow Trust to manage winter pressures (from December 2018)

Given delays in the scheme, the Trust has engaged legal opinion throughout the project.

The Trust continues to ensure that lessons learned are taken from this project and has completed a series of subject matter expert reviews on the new children's hospital scheme.

Paediatric attendances at Mater ED

During 2015-16 the Emergency Medicine Clinical Director raised a concern regarding staffing issues on the Mater site. At a meeting on 13 November 2015 between the Medical Director, Director of Unscheduled & Acute Care, the Clinical Director for Emergency Medicine and five ED Consultants who work in the Mater, it became apparent that these concerns were not solely related to staffing, but included patient safety concerns. The main patient safety concerns identified were the appropriateness of the ambulance "stand by" calls and care of paediatric patients at the

Mater ED consistent with the services available on site and in particular the ambulance arrivals after 6pm, when consultant staff were not always resident. This increasingly necessitated the consultant medical staff to have to frequently return to the site to support more junior medical staff and frequently to face clinical issues for which there was no wider specialist clinical support within the Mater Hospital. A decision was taken to temporarily suspend paediatric patient treatment at the Mater ED and ambulance by-pass protocols around trauma and certain critically ill patients were developed to maintain ongoing safety at the Mater.

In November 2017 a series of pre-consultation events were held with interested parties/ stakeholders internal and external to the organisation to help inform the future direction for the provision of paediatric emergency care in Belfast. These events attracted attendance from, community and voluntary groups, local schools, staff and Union representatives. A report on the outcome of these events has been produced.

Based on feedback from these events, a smart survey was developed and issued to all local schools. This was circulated to all parents and guardians of school-aged children via school communication systems. 222 responses where received from this survey. In addition a number of consultation meetings where held with local “sure start” organisations over April and May 2018.

We are content now to close this issue, as the Mater ED is currently closed to patient walk-ins due to Covid-19, with appropriate Ambulance divert arrangements in place.

COPNI Home Truths: Report on the Commissioners Investigation into Dunmurry Manor Care Home

The Commissioner for Older People for Northern Ireland (COPNI) announced an investigation into Dunmurry Manor Care Home (which is located in South Eastern Trust area) in February 2017 following family members and former employees raising serious concerns about the standards of care and safety of residents living with dementia in the Home.

The COPNI Home Truths (June 2018) report identified systemic and operational failures in respect of the standard of care and leadership at Dunmurry Manor Care Home and the awareness and responsiveness of the wider system to the situation within the Care Home. COPNI made 59 recommendations spanning 8 key areas – safeguarding and human rights, care and treatment, medicines management, environment and environmental cleanliness, staff competence and training/development, management and leadership, complaints and compliments, and accountability and governance. Of the 59 recommendations, 5 were directed to HSC Trusts.

The Trust has responded to the recommendations as part of the Department of Health’s action plan and an internal action plan is in place. The Trust will continue to work with the DoH and colleagues across the system to progress the regional implementation plan once the DoH reinstates the Dunmurry Manor Working Group and workstreams following Covid-19.

Following the Home Truths report, the DoH commissioned CPEA Ltd to undertake an independent review into the actions of the health and social care system around Dunmurry Manor Care Home. The Trust continues to await the full outcome of the CPEA Review. To date, only one workstream has published its review, which was the review into Adult Safeguarding. The Trust is a member of the DoH led Transformation Board and the HSCB led Interim Adult Protection Board which will take forward the proposed legislative and policy changes recommended in the CPEA Report. In addition, the Trust's own internal review of Adult Safeguarding being led by the Executive Director for Social Work will take into consideration the findings of the CPEA Review.

The CPEA Reviews into Complaints Management, Regulation, Assessment and Care Management, Care Home Providers and Commissioning are yet to published. When they are published the Trust will ensure that its own practice is self assessed against any recommendations, and any necessary changes are made.

Aspirgillus in Children's Haematology Unit, RBHSC

The Trust Board were initially advised of a probable cluster of nosocomial aspergillosis cases in the Children's Haematology Unit (CHU) Royal Belfast Hospital for Sick Children (RBHSC) in December 2019. It was further identified that there was one confirmed case and three probable cases between September 2019 and April 2020. As an initial response the CHU was closed in January 2020 for remedial work to its built environment and air handling units. It was hoped that this work would make the unit safer for children and reduce risk presented by aspergillus. However, in April 2020 a fourth child was diagnosed with probable aspergillosis and aspergillus was detected in a recently built isolation room for the first time.

The Trust Team worked with Public Health Agency, Health & Social Care Board and Department of Health on this issue. The Trust sought the help of external experts since the events of April 2020 to seek to further understand the risks presented to children in CHU by aspergillus and the built environment in order to ensure we provide the safest possible service to children under the care of the CHU team.

On 26 August 2020 the CMO wrote to advise that he was content with actions taken on the aspergillus issue in CHU and that he was content that the service resumed to normal on 14 July 2020 as indicated by the Trust. He further advised that aspergillus management would be improved if the Trust developed a specific Aspergillus Management Policy for the RVH site.

The Trust wrote to the Chief Medical Officer on 26 October 2020 to advise that it would develop a Trust–wide policy to mitigate the risks of nosocomial aspergillosis during periods of construction/ refurbishment. Work on this policy is underway.

Prof Tom Rogers, Professor of Microbiology Trinity College Dublin is co-author and Chair of the Aspergillus subcommittee of Health Surveillance Centre (HPSC) Scientific Advisory Committee, which produced the Irish guideline on managing this risk. Prof Rogers has agreed to peer review the Trust policy when it is available.

Review of Fit Testing Outcomes

On 3 June 2020, a member of Trust staff raised a query that they believed they were not fit tested correctly. It became apparent that Staff fit tested to respirator masks carried out by an external contractor within the last 6 months, during the Covid-19 surge period, had not on all occasions met the UK standard HSE282/28. The contractor inadvertently applied a setting not normally used in Northern Ireland (although used in RoI and in other parts of Europe), which should have been readjusted to the UK fit testing requirements. The Trust submitted an Early Alert to the DoH.

The PHA requested on 18 June that all Trusts undertake a validation and audit of all fit testing certificates from 1 January 2020 to date. A total of 1,341 staff were identified as having been fit tested to the incorrect guidance. Those staff were advised of the need to ensure their mask was re-fitted to the UK standard and were asked to book an appointment with the fit testing team on a dedicated telephone number. Of the 1,341 staff identified, 1,331 have been contacted and offered another fit testing slot.

We are content now to close this issue, as the 10 staff we were unable to contact, are not Belfast Trust employees, and we have contacted all appropriate staff agencies, without success.

Progress on Prior Year Control Issues - on-going

Lease Expenditure

Senior DoH officials have raised a regularity issue regarding non-compliance with lease policy with ALBs through the accountability process and at Accounting Officer level. Assurances have been sought from ALBs that robust processes and systems, including timed action plans to regularise the position, are in place to secure compliance with current lease policy and to ensure irregular expenditure does not occur. Belfast Trust has provided assurance to the Department that robust processes and systems are in place for the management of leasehold estate and that there are no risks to service continuity as a result of any non-compliance with lease policy.

A number of the lease arrangements which had been outstanding are now satisfactorily completed, however the Trust continues to have a few leases which to do not comply with DoH internal processes - these are currently being progressed. The Trust meets quarterly with DoH Strategic Investment Group and property issues are a standing agenda item.

Prompt Payment Performance

The achievement of the DoH Prompt Payment target of paying 95% of bills within 30 days of receipt is dependent both on procedures within BSO Accounts Payable Shared Service and appropriate actions by the Trust's nominated approvers. The performance trend over the last 3 years up to 2019-20 has been 88.5%, 90.0% and 87% respectively.

The compliance rate for the current year 2020-21 is 92.8% in terms of numbers of invoices and 91% in terms of invoice values. This greatly improved performance is as a result of the implementation of a pilot for Bank Agency Invoice processing with BSO Accounts Payable which achieved much improved processing times for this category of invoice. We anticipate this improvement will be maintained going forward following the Trust's recent decision to conclude the pilot and incorporate this facility into the BSO Service Level Agreement.

The Trust continues to work closely with BSO to ensure that all efforts to improve prompt payment compliance in other areas continue.

Financial Position

While the Trust achieved breakeven in 2019-20, much of the in-year reduction in the Trust's opening financial deficit was attributable to one-off, non-repeatable measures and non-recurrent funding. As a result, during 2019-20, the Trust had identified a 2020-21 opening funding deficit of around £50.3m, including £9.7m and £18.6m unmet 2018-19 and 2019-20 savings respectively. This position was communicated to HSCB for 2020-21 financial planning purposes at DoH level. The HSCB indicative 2020-21 allocation, issued in June 2020, did not include any recurrent or non recurrent funding to address any rolled forward unmet savings targets or inescapable pressures from previous years. DoH, through HSCB, also levied a new savings target comprising the Trust's equity adjusted share of a £50m regional general Trust savings target (£18.5m) and £3.89m of an £12m regional secondary care pharmacy savings. This resulted in an increase in the opening deficit from £50.3m to £72.7m.

The Trust declared that it would be unable to make any material cash-releasing savings in 2020-21 with the exception of additional pharmacy savings of £3.89m which would meet the regional pharmacy savings target in full. Furthermore, productivity savings would be required to cover a number of emerging pressures to avoid the underlying deficit increasing further. However, in developing the financial plan early in 2020-21, the Trust identified a significant level of non-recurrent expenditure reductions, of circa £51m, a significant element of which related to activity downturn associated with the Trust's Covid-19 response. This would reduce the in-year deficit to circa £18m which was included in the Trust's draft financial plan in July 2020.

The forecast position was amended a number of times to reflect the changing position in terms of available Covid-19 funding and the impact of the pandemic on Trust activity. The Trust submitted an analysis of Covid-19 related spend, along with proportionate business cases where appropriate. The Covid-19 spend amounted to £149m, including £29m for increased costs in respect of Annual Leave, £42m PPE, £41m additional staffing costs (including £19m staff recognition payments) and £22m service delivery costs.

The Trust experienced a significant reduction in elective activity and in areas such as estates where so much of the work continues to focus on the repurposing and social distancing works, the cost of which is funded separately through DoH Covid-19 monies. The ensuing underspends

against estates and other G&S budgets, as well as a reduction in the staff expenditure run rate compared with previous years, offset the Trust's residual underlying deficit and the Trust was able to deliver a break even position in 2020-21.

The Draft Budget for 2021-22 would suggest that funding for next year will be short of need. Furthermore, only 10% of the additional 2021-22 allocation will be recurrent in nature. The proposed allocation must cover the ongoing costs of Covid and rebuild. As a result, the Trust is expecting that its share of the budget will not be sufficient to address its significant underlying deficit or meet any emerging cost pressures next year. At the same time, the Trust is again likely to benefit from non-recurrent underspends, largely in goods and services, as activity levels gradually return to pre pandemic levels which may help reduce the anticipated Trust deficit in 2021-22. The Trust cannot continue to manage its finances with such heavy reliance on non-recurrent funding and without the assurance of a fully funded recurrent baseline.

The Assembly passed the Budget Act (Northern Ireland) 2021 in March 2021 which authorised the cash and use of resources for all Departments and their Arms' Length Bodies for the 2020-21 year, based on the Executive's final expenditure plans for the year. The Budget Act (Northern Ireland) 2021 also authorised a Vote on Account to authorise Departments and their Arms' Length Bodies' access to cash and use of resources for the early months of the 2021-22 financial year. This will be followed by the 2021-22 Main Estimates and the associated Budget (No. 2) Bill before the summer recess which will authorise the cash and resource balance to complete for the remainder of 2021-22 based on the Executive's 2021-22 Final Budget.

BSO Shared Service

Following previous Internal Audit unacceptable assurance levels in respect of the Payroll Service provided by BSO, the assurance level for each of the last 3 years up to 2019-20, was limited overall. In 2020-21 Internal Audit have provided a split Satisfactory/Limited Assurance; Satisfactory in relation to elementary or business as usual processes and Limited Assurance around end-to-end HSC Timesheet Processing, SAP/HMRC RTI Reconciliation, Overpayments and Holiday Pay. A new Payroll Quality Improvement Programme (PQIP) was approved by the Business Systems Forum in August 2020 to deal with the outstanding Audit Issues and other identified priority tasks in Payroll. It is acknowledged that formal identification of the issues and the Assurance structure which has been set up through PQIP is evidence of the developing maturity of the service. Belfast Trust are working closely with other HSC customers to provide support to BSO in addressing the ongoing issues.

Children's Hospital Executive Flagship Capital Project

In 2017, the DoH raised concerns around the management and governance of two separate elements of the Children's Hospital Executive Flagship capital project within the Trust. This was a direct result of increases in size and costs for the project and the timeliness of reporting these. The addendum was subsequently submitted on 19 April 2018 with additional correspondence in

August and September 2018. This highlighted the fact that, aside from with a moderate increase in clinical accommodation space, the cost of which would be within agreed tolerance levels, the cost increase was attributable to inflationary and construction industry price pressures along with increases in plant and communication space associated with both the constrained nature of the site and recent changes in building requirements. The Trust received approval for the addendum on 1 October 2018.

The Trust has strengthened its reporting arrangements, particularly with DoH, to ensure greater transparency in terms of the decision-making, accountability and approval process. In tandem with this, the Trust is reviewing the recommendation from other major capital projects to ensure any lessons learned, where relevant, are embedded within the Trust's project.

The New Children's Hospital project was advertised in OJEU in August 2019 and had been programmed to go to tender in November 2020. The Trust took the decision to delay releasing the documents until a further review on the tender was complete. This is to ensure that the lessons learned from both Trust led and other major capital schemes are reflected within the tender documentation. Given the complexity of the tender documents, and the additional assurances sought by the Trust in relation to the quality of documentation which was achieved through a new multidisciplinary approach between Trust Estates, CPD-HP and the Design team, this process has taken longer than anticipated and the tendering process has been delayed by a further three months. As a result of this strengthening of management processes and the provision of additional assurances, the Trust is providing DoH with an up-to-date financial assessment on the project based on a detailed review of financial information provided by our professional advisors, CPD-HP. At this stage, the project remains within the overall approvals level identified in the approved 2019 business case addendum. The tender documents were released at the end of May 2021.

Social Care Procurement

In order to minimise the risk of non-compliance with the Public Contract Regulations 2015 and achieve the actions set out within the DoH's HSC Strategic Procurement Action Plan 2015-2018, all DoH Arm's Length Bodies are extending CoPE cover for social and health care services in the Light Touch Regime. This was taken forward initially via a formally constituted project, the Social Care Procurement Implementation Project Board (SCPIPB), reporting to Regional Procurement Board (RPB). As an outcome of that project a Social Care Procurement Team was established within BSO PaLS to take forward procurement processes for health and social care services. In November 2018 the SCPIPB was dissolved and oversight transitioned into a more permanent structure with the introduction of the Social Care Procurement Board (SCPB). The SCPB reports to RPB and provides strategic oversight of the commissioning, planning, procurement and monitoring/ contract management of regional issues for social care and support services on behalf of all HSC organisations. This oversight aligns with the Regional Procurement Plan – Social Care as agreed by the RPB and spans all programmes of care. The Trust has representative membership of the SCPB and an action arising from the meeting of the SCPB in January 2019 was the updating of

the Regional Procurement Plan for Social Care Services to reflect timescales for inclusion of pre procurement activities.

The Regional Procurement Plan was presented to the Regional Procurement Board (RPB) in October 2020, and while the Board understood and accepted the plan and the accompanying caveats they have asked for an indication as to the additional resources required by organisations to implement the Regional Procurement Plan. A resource paper is currently being prepared by SCPB in response to RPB.

Serious Adverse Incident Reviews Outstanding

There has been a significant increase in incidents requiring review under SAI methodology.

Number of SAIs reported per calendar year	Total
2017	81
2018	96
2019	125
2020	162
2021 (as of April 2021) ie. 4 months	75

Once an incident is identified as meeting SAI criteria and is reported through to the HSCB a detailed review process will start. Depending on the review level identified by the commissioning Directorate and agreed with HSCB, this will require either a Significant Event Audit (SEA) or a Root Cause Analysis (RCA) process to be undertaken. (A Level 1 SAI requires a SEA to be undertaken, whilst Level 2 and 3 SAI's require an RCA to be undertaken).

The HSCB in their guidance currently outlines that a Level 1 SEA should take 8 weeks from reporting as a SAI to final report being submitted. A Level 2 RCA should take 12 weeks from reporting as a SAI to final report being submitted and a Level 3 RCA, due to the independence required and complexity, have a more negotiable timeline with the HSCB.

At March 2021 BHSCT had 205 outstanding SAI reports.

Level of Review	Number of Review Reports Outstanding
Level 1	166
Level 2	35
Level 3	4
Total	**205***

Note: *16 of these SAIs would be in relation to SAIs reported in 2018 or before.

ACCOUNTABILITY REPORT

Within the Trust when a Level 1 SAI is raised the commissioning Directorate is responsible for the set up and progress of the subsequent review. For a Level 2 SAI this requires a minimum of a SAI Chair to be identified to support the review that is independent to the Directorate where the incident occurred. A Level 3 SAI, depending on HSCB advice, can often require an entirely independent panel to the Trust.

Especially for Level 2 SAIs there has been a consistent challenge in getting staff identified to support this process, trained in RCA methodology and most significantly available to support a RCA review and commence within a reasonable time period. Over the last 3 years BHSCT has trained over 90 staff in RCA methodology, but even with this there has only been a relatively small number who have been consistently able to continue supporting SAI chairing. This has led to a reliance on sourcing external consultants to support this process either through the Leadership Centre or an External RCA provider. At March 2021, both were highlighting the pressure they were under meeting BHSCT requirements.

A number of SAI chairs who have undertaken SAI reviews on behalf of the Trust have fed back the need for additional resources in the initial stage of the review process to make sure all key information is gathered promptly.

The challenge the above situation brings is that a number of SAI reviews have been slow to commence and complete, with nearly all SAI reports being consistently completed well outside HSCB timelines. The Trust recognises any delays in completion of the SAI review process is difficult for our services users, families of our service users and staff. With the current situation and the number of SAI reviews significantly past HSCB guidelines the delay in update / completion of a SAI report is becoming more of a challenge.

This has been further impacted by Covid. Covid related SAIs are often outbreaks involving a number of patients / staff, so rather than having only one line of communication, there are multiple. For example one SAI reported in early 2021 requires over 20 lines of communication due to numbers involved. This creates challenges with ensuring effective service user / family engagement due to resource required on the identified patient liaison contact to commence engagement at earliest opportunity and then maintain regular updates.

It is concerning any delay in a SAI review creates a risk important learning is not identified and acted on at the earliest opportunity.

In 2019 The Trust introduced a further corporate peer review process of all SAIs to try and ensure there was a more comprehensive independent review and to help improve consistency in reports and maximised learning. With significant increase in SAI reports and limited peer review resource, peer review for Level 1 SAIs was temporarily stood down in February 2021 with Directorates asked to ensure robust review at Directorate level is in place and provide assurance learning has been maximised. This has been an attempt to reduce the backlog of reports awaiting approval.

SAI performance is presented and monitored at an established SAI Group that meets on a monthly basis and is chaired by the Medical Director. This group focuses on SAI reports that are significantly overdue. SAI numbers are also included as part of the quarterly Trust Incident & SAI report presented at Assurance Committee.

HSCB would periodically flag outstanding SAI reports. At a meeting in March 2021, HSCB flagged concern regarding the number of delayed reports and increasing trend in this regard especially over previous 6 months. A monthly meeting has now been set up with HSCB to monitor and support improved performance.

A Draft SAI business case is at final stages. It is anticipated this will secure funding to bring in additional staff to support the collection of relevant information and construct a draft time within a short timeframe from SAI notification being submitted. The business case also includes a proposal for a new software package to assist review panels with collation and analysis of information. It is intended that this support will place any SAI Review team in a better position at a much earlier stage to progress the review in a timelier manner. Additional resource has also been requested as part of this business case to identify additional service user / family liaison officers to assist the Trust in improved engagement and update process.

Hyponatraemia Inquiry

Following the publication of the 96 recommendations from the Inquiry into Hyponatraemia-Related Deaths (IHRD) nine different work streams were identified during 2018 and set up by the DoH.

These were:

- Duty of Candour
- Death Certification Implementation Working Group
- Duty of Quality
- Paediatric – Clinical – Collaborative
- Serious Adverse Incidents
- User Experience and Advocacy
- Training
- Workforce and professional regulation
- Assurance.

Work commenced with Departmental, Regional and Trust colleagues to ensure progress across a range of themes supporting implementation of the IHRD recommendations as appropriate. This work continued to February 2020 when it was paused due to the necessity to focus Trust and Regional resources to respond to the Covid-19 pandemic.

At the time of suspension of IHRD activity in the Trust, a total of 161 actions from the IHRD recommendations were being monitored by the Trust oversight group of which 33% were complete, 20% were on target and within timescales and 14% remain ongoing. The remainder of the actions were beyond the control of the Trust.

The work of the Trust Groups on IHRD remained paused throughout the financial year 2020-21.

The Groups focused on the work plan and other issues surrounding IHRD have recommenced in April 2021.

Neurology Recall Exercise

On 1 May 2018, the Belfast Trust recalled 2,529 neurology patients as part of an exercise to ensure that patients under a particular neurology consultant are receiving the best possible clinical care and are on the correct clinical pathway. This action followed an internal Trust review of a small number of the consultant's patients and a wider external review carried out by the Royal College of Physicians (RCP). In terms of the latter, a final report was received on 26 April 2018 and raised a number of concerns. Following receipt of the draft RCP report on 20 March 2018, the Trust, in collaboration with HSCB and PHA, took steps to address the concerns.

All 2,529 patients received individual letters on 1 May 2018, requesting that they contact a dedicated line to arrange an appointment with an appropriate consultant. As at 13 March 2019, all of the 2,529 (resident in NI) have been reviewed or offered a review. Three patients overseas have been contacted and offered funded appointments in their current location which they have declined. Arrangements have been made with these patients to make contact and book an appointment on their return to NI.

In addition, Belfast Trust invited 700 patients for a review appointment and these commenced the weekend of 3 November 2018. The Trust also agreed to undertake the review of patients from the Ulster Independent Clinic (300 patients). Out of 1,000 patients, 717 patients were reviewed, 199 patients declined an appointment, 51 did not attend 8 patients died before they had their appointment, 13 had alternative arrangements (i.e. already seeing another neurologist) and 12 patients were unable to be contacted despite repeated attempts.

The HSCB/PHA established a regional coordination meeting with all HSC Trusts and the two private providers for whom the consultant also worked. The DoH established an Oversight Assurance group and the HSCB is participating in the DoH review of neurological services.

The DoH has commissioned the following:

1. *RQIA to undertake a governance review of outpatient services with a particular focus on the neurology service in the Belfast Trust*.

   The Trust has completed and submitted a detailed response to the questionnaire as required as part of the RQIA review of outpatients. Members from RQIA and the Review team members

attended outpatients on each of the sites, RVH, BCH, MIH and MPH. They met various groups and teams of staff on week commencing 10 September 2018. Unannounced inspections have taken place in MPH, BCH, RBHSC, Mater and RVH outpatients during October and November 2018. RQIA gave verbal feedback to members of the Executive team on 6 December 2018. They have visited each hospital site in January 2019 and presented their findings to staff. The Trust received a draft report in November 2019 for factual accuracy checking. The Trust provided comments on factual accuracy and we await receipt of the final written report. Following the inspection stage, the Trust had initial meetings with RQIA representatives in regards adult safeguarding. An action plan was developed to provide assurance in this regard.

2. *RQIA to commission a review of all of this consultant's patient deaths over the past ten years.*

   The Review team has been established. No further updates have been received by the Trust as RQIA will report directly to DoH.

3. *An independent review, led by Brett Lockhart QC, into the Trust's handling of the concerns raised about this consultant from December 2016 to the decision to recall patients in April 2018.*

   The Trust has continued to submit relevant documentation to the Inquiry and provided any other information as requested. Staff continue to be interviewed by the inquiry. The Minister of Health announced on 11 December 2020 the conversion of the Independent Neurology Inquiry from a non-statutory public inquiry to a statutory public inquiry in Neurology. Trust staff are continuing to engage fully with this inquiry.

4. *BSO to conduct an audit of the interaction between the consultant's practice in the private sector and the HSC*.

   Internal Audit have completed this work and submitted their report to the Permanent Secretary who commissioned it. The Trust has an action plan in place to address the key findings of the report.

The DoH published the outcomes report for Phase 1 of Neurology recall on 19 December 2019. The Minister of Health announced, in the NI Assembly, both the publication of the Outcomes 2 Report and the 3rd Recall of patients on 20 April 2021.

Cohort 3 patient recall, going back to 1996, the commencement of the consultant's employment with the Belfast Trust, commenced in April 2021. This cohort is in relation to patients who were discharged between 1996 – 2012 and met certain criteria, alongside a number of patients that had not been reviewed as a 'young stroke' patient in the previous recall cohort due to the agreed criteria around age. The purpose of the recall is to review the medication a person is taking and to assure it is appropriate for their condition. Extra clinics have been set up to facilitate this and the plan is to have completed all telephone reviews within 4 weeks.

Additionally, the Trust has asked a number of GPs to confirm if 436 people remain correctly on certain non-neurological long-term medications, like Aspirin. If a GP would like the Trust to review any person they are unsure of, we will ensure that happens.

As at 2 May 2021, of the 209 patients recalled, 172 patients have been reviewed, 14 patients have appointments booked with 6 patients still to book an appointment.

GP returns received to date, totals 163, with 273 outstanding. Of the 163 returns, 85 patients need a review and 78 patients do not need reviewed.

As of 4 March 2021, there are 274 negligence claims made against the Trust and the Directorate of Legal Services (DLS) are acting on the Trusts direction as the client, in addressing them. Provision as needed is included within Note 15 to the Accounts.

Blood patching procedures

Separate to the neurology recall, Belfast Trust undertook a case note review of 66 patients who had a blood patch procedure under the care of Dr Michael Watt, and who did not have a clinical review as part of the recall process. The internal review established that 46 patients had care that was unsatisfactory and fell below a standard we would expect. Additionally, the review established that for 45 patients there was no clinical evidence to support that a blood patch procedure was required. Provision as needed is included within Note 15 to the Accounts.

Muckamore Abbey Hospital Adult Safeguarding

On 12 August 2017, an Adult Safeguarding incident involving a staff member and a patient occurred in the Psychiatric Intensive Care Unit (PICU) in Muckamore Abbey Hospital. When the CCTV footage of the incident was viewed further concerns about inappropriate care were identified and it became clear that the incident was not isolated. This resulted in a Level 3 Serious Adverse Incident investigation and a joint protocol (PSNI led) adult safeguarding investigation, which is ongoing.

A range of improvements have been implemented in Muckamore Abbey Hospital to provide patients with safe, effective and compassionate care. In addition, a range of systems and processes have been introduced to provide assurances throughout the organisation about the quality of care being delivered.

These systems and processes are summarised below:

Adult Safeguarding (ASG) Historic Investigation

- PSNI and Trust ongoing review of historic CCTV footage
- Adult Safeguarding and decision making/governance processes in place to ensure appropriate responses to any concerns identified about staff on historic CCTV footage
- Disciplinary processes underway.

Adult Safeguarding Procedures (ASG)

- Active use of Adult Safeguarding policy and procedures
- Audits of adult safeguarding systems and processes undertaken on regular basis
- ASG Review meetings in place at ward level and monthly ASG Forum.

CCTV

- CCTV in use across the site
- Weekly contemporaneous CCTV viewing by independent team
- Weekly feedback from CCTV viewing shared across the site.

Patient Safety

- Weekly review of patient safety metrics (Safety Report) with focus on restrictive practices
- Ward to Board reporting on patient safety metrics
- Live Governance processes in place to capture real time feedback from the clinical areas
- Enhanced day activities and opportunities for patients.

Staffing and Staff Support

- Stable and substantive senior management team
- Nurse staffing levels monitored and actively managed across site with rolling programme of recruitment
- Behavioural Assistants and Behaviour Specialists available across all wards
- Positive Behaviour Support ethos core to Care Planning.

From the outset, the Trust Board have been actively involved in the monitoring and support of measures to ensure safe, effective and compassionate care at Muckamore Abbey Hospital.

New Control Issues – Closed

Meadowland Wards – Musgrave Park Hospital

In early September 2020 RQIA had undertaken an announced inspection of Meadowlands Ward 1, focusing on adult safeguarding (ASG), and which RQIA advise comes on the back of three adult safeguarding referrals relating to the ward during July 2020. RQIA reported that they found staff knowledge and awareness in respect of the recognition and awareness of signs of harm, reducing opportunities for harm, and knowing how and when to report safeguarding concerns was variable. RQIA were also concerned of a potential underreporting of ASG incidents from the ward.

Subsequently the Trust commenced weekly Patient Experience Surveys of both Meadowlands Wards 1 and 2 starting from the 17 September 2020. Patient feedback has led to additional concerns especially in regards to compassionate care delivered overnight, and senior leadership visits highlighted poor non-adherence to IPC practices. In view of the above, new admissions to both Meadowland Wards were temporary suspended on the 22 September 2020.

Data analysis of Meadowlands Wards has included benchmarking with the National Intermediate Care Audit. Key findings, indicate:

- Length of Stay – longer
- % Discharged Home – similar
- Waiting Time to Access – longer
- Admission to Acute Hospital rate – lower
- Improvement in MBI score (measure of functional status) – similar.

The Trust has also carried out a review of all the previous Meadowland Reports. The conclusions & recommendations are as follows:

- Where possible patients should receive rehabilitation out of hospital
- There is requirement for proactive preventative rehabilitation – the recent establishment of a pilot Frailty Hub in Meadowlands demonstrates that such a service is possible
- Rehabilitation services should be streamlined to improve flow in and out, start earlier in the patient journey and aspire to better objective outcomes. These services should include a hospital inpatient bed based component and a proactive preventative component
- The pathway for the older person with a fragility fracture requires to be reviewed by a combined TOR/CoE group utilising validated data and clear objectives that are patient centred and not service centred
- A separate delirium pathway is essential to maintain flow and provide better care to patients affected by delirium
- A specialist inpatient unit should deliver its specialist service and not end up accommodating patients with other issues that impact on other patients accessing the service they need.

The Trust developed an internal Quality Improvement Plan which reflects actions associated with these concerns and improvements required. A weekly Safety Dashboard was also established to monitor the service and ensure Sensitivity to Operations and Anticipation and Preparedness.

On 22 October 2020 Meadowlands Ward 1 re-opened, with clearer admission guidance and appropriate support i.e. Fracture Rehab only. On 23 October 2020 we re-opened Meadowlands Ward 2 to manage non Covid-19 patients who have been deemed medically fit awaiting discharge

from hospital, but not as a Ward that previously admitted complex delirium & dementia patients.

The new referral criteria agreed for Meadowlands Fracture Rehab (Ward 1) has resulted in increased throughput and a decreased inpatient length of stay from 22 to 10 days, with Meadowland Ward 2 length of stay reducing from 35 to 9 days.

As at April 2021 all the Quality Improvement Plan recommendations have been fully implemented.

Family Planning Patient Review

Due to two women that used the Family Planning Service for an implantable contraception device having unplanned pregnancies, the Trust thought it necessary to review the care of 743 women that used the service between October 2017 and August 2020. A doctor failed to correctly insert an implant and the patients unexpectedly became pregnant.

A review of all patients seen by the doctor in the service for a primary insertion or replacement contraceptive implant from October 2017 to August 2020 was undertaken to ensure that there was no more implementation failure. The review period started in October 2017 because patients are advised that the implant is effective for 3 years. The doctor concerned was restricted from clinical duties in August 2020.

In total 743 women were affected by the issue. A recall of the women was agreed and completed with PHA/HSCB oversight. The Trust was able to make contact with 729 of the women. No further unplanned pregnancies were identified. The Trust was unable to contact 11 of the women and it was agreed with PHA/HSCB and primary care that a letter identifying the risk to them would be issued to their GPs. Three women had passed away due to unrelated issues.

The review exercise closed in February 2021 with agreed learning to be taken forward.

The service has reviewed its governance practices in place for family planning service and agreed with PHA that a new model of governance in FPS will be presented in May 2021 and agreed for implementation from June 2021.

New Control Issues – On-going

Valencia Ward – Knockbracken Healthcare Park

The Dementia Inpatient Service based in Valencia Ward, Knockbracken Health Care Park is a 8-10 inpatient ward for the assessment, care and treatment of people with dementia experiencing acute behavioural disturbance associated with their dementia, who cannot be managed safely in the community. All patients admitted are detained under the Mental Health Order and normally lack capacity to make decisions regarding their care needs. Over the last two years, the service has operated at reduced bed capacity for extended periods, and has been closed to admission.

RQIA carried out an unannounced inspection of Valencia Ward in February 2020 and wrote to the Trust in March 2020 to advise that they had identified six areas of improvement from the

inspection, which included four new areas for improvement one area for improvement re-stated for a second time and one area for improvement re-stated for a third time.

As a result of the inspection, RQIA were concerned that the quality of care and service within Valencia Ward was below the minimum standards expected in relation to incident management, adult safeguarding processes and leadership within the MDT. The findings were reported to senior management in RQIA, following which a decision was taken to issue a Serious Concerns letter relating to these three areas.

Recruitment and retention of staff has been a continuous challenge over the last number of years and the service has experienced a significant period of staffing instability July – September 2020 - the service had experienced a high turnover of nurse managers which has detrimentally affected leadership and governance. Service continuity has been compounded by the inability to recruit and retain registered nurses.

An unannounced leadership walkaround on the evening of 20 September 2020 identified a number of concerns in respect of Infection Prevention Control, PPE compliance, staffing levels, environment and patient care. As a result, an internal Quality Improvement Plan has been developed setting out a number of additional improvements over and above those set out within the RQIA QIP.

In addition, a review of adult safeguarding referrals June 2019 to September 2020, completed in October 2020, has identified the significant number of adult safeguarding referrals from the ward, of which 38% have involved staff including alleged assault, omissions of care and falsification of records. The review identified that Valencia Ward is a high risk environment in which the complexities of patients' needs and behaviours places them at increased vulnerability, and also identified that while progress has been made, the stable, consistent, dementia informed environment that is required by these patients is not currently in place.

A listening exercise with staff from Valencia Ward has demonstrated a high level of staff dissatisfaction and disengagement amongst staff which also presents as a significant risk to the service in relation to safety, culture and the ability to attract new staff.

The Quality improvement plan contained 57 actions and is almost fully implemented with 55 actions having been completed (97%). The two outstanding actions are in process:

1. Culture change and service development plan which is due to commence in April 2021 and Clear Model training (including dementia specific training) and team development in September 2021.
2. IT infrastructure order has been partially delivered, WIFI is in place but awaiting additional equipment.

The management of the ward has now moved to the Mental Health Directorate and they have implemented stabilised staffing with a reprofiled budget to increase senior staffing. It is anticipated that the ward will have a full staff complement by the end of April 2021. Other measures put in place include mandatory and specific training for safeguarding and incident management, weekly safety

brief with senior team and audits in place with resulted shared and displayed.

Royal College of Surgeons Invited Review of Cardiothoracic Surgery Service

The Royal College of Surgeons (RCS) carried out an invited Service Review of Cardiothoracic Surgery in March 2020 and provided initial feedback on a number of immediate concerns. The Trust received the final RCS report in summer 2020. A composite action plan has been developed. Risk summits were held in November 2020, and again in February 2021, with a wide range of key stakeholders including DoH, PHA, NIMDTA and GMC. Following the risk summit in February 2021, NIMDTA have placed the service on enhanced monitoring given concerns around the learning experience for surgical trainees. In addition, the RQIA wrote to the Trust in April 2021 seeking assurances around patient safety and quality. The Trust is currently working with the Leadership Centre and a number of other organisations to implement the action plan. As of 5 May 2021, of the 80 identified actions, 51 have been completed, 20 are in progress, 8 await start and one redacted issue is in progress.

Review of Governance across Division of Surgery

Following a number of SAI investigations within the Division of Surgery, a governance review was undertaken in September 2020 in order to highlight areas of good practice and areas where there is divergence. Feedback has been provided to this division to enable the report to be finalised and actions to be taken to improve and standardise governance practices across this Division.

Ophthalmology Review Backlogs and associated SAIs

Clinic capacity was reduced across the year 2020 as a result of the cessation of services during the pandemic and the requirement to maintain social distancing at clinics.

A number of SAIs were reported in February 2021 relating to patients with glaucoma who had come to harm as a result of a delay in their review appointment. The service also reported emerging issues in the macular and diabetic eye services, which were experiencing similar review backlogs, and delays in patients being seen. These are three time-critical services within ophthalmology.

A further SAI was notified that resulted in a delay in glaucoma patient being seen due to an administrative error in the grading of the referral letter. A further SAI occurred in March 2021 where 29 patients transferred back to the Macular service from the Independent Sector were lost to follow-up.

A number of measures have been taken to provide additional capacity and weekly monitoring arrangements were put in place. A recruitment process is currently ongoing for the recruitment of a new Glaucoma consultant. Following consultation with colleagues in Southern Trust, the service has been able to progressively increase capacity in the Southern Trust area towards pre Covid levels.

Progress has been made across all the identified backlogs. From 1 February 2021 the Macular review backlog has reduced from 3,013 to 1,468 patients. The total number of patients identified as part of the Early Alert of 10,607 patients has been reduced to 7,074 patients as of 29 April 2021.

In light of the SAI's regarding administrative process issues, a process mapping exercise was undertaken to review waiting list and booking systems and processes and no areas of concern were identified.

Non Compliance with Care Management Circular HSC (ECCU) 1/2010 within adult community services

Due to the impact of Covid-19 on Care Homes, workforce shortages and demand and capacity issues within the Commissioned Services Care Review and Support Team (CReST) and Community Social Work, the service is non-compliant with completion of annual care reviews, a delegated statutory function as stipulated in the Care Management Circular.

During the Covid-19 pandemic in 2020, the Public Health Agency and Department of Health issued guidance to achieve a reduction of footfall in Care Homes which included the cessation of annual care reviews from April 2020. In January 2021, the Chief Social Worker wrote to the Trust to advise that care reviews should recommence using a risk-assessed approach.

In response to the requirement to achieve Mental Capacity Act (NI) 2016 compliance for legacy cases by 31 May 2021, the adult community services management team assessed the dual demands of this work alongside the completion of annual care reviews. Following risk assessment, a determination was made to ring fence members of the CReST team to undertake MCA assessments and not to recommence routine care reviews post the last Covid-19 surge at the end of January 2021. Care reviews have however continued in Homes of Concern or if there is a change in presentation of a resident –38% of Care Home reviews were completed in the year 2020-21.

Due to a number of factors, the planned progress with completion of MCA legacy cases has not been realised and achievement of this work by 31 May 2021 deadline will not be achieved. Given the extended time required to achieve MCA it is proposed to realign the CReST team to support the recommencement of routine care reviews where the risks are potentially greater and more immediate.

An action plan and IPT to reinstate care reviews is being progressed in order to address this within 2021-22.

Mental Capacity Act (NI) 2016 Compliance

All HSC Trusts must demonstrate full compliance with the Mental Capacity Act in terms of completion of legacy cases by 31 May 2021. While full compliance has been achieved in mental health services, compliance will not be achieved within the timeframe in learning disability services and in adult community services. Individuals may bring forward legal challenge if compliance is not achieved.

There have been a number of challenges with achieving compliance with the MCA across services – impact of Covid-19, lack of staff capacity to complete assessments, unable to secure additional staff in the numbers required, competing priorities within community services, for example, annual care home reviews.

The Trust reports formally via two monthly returns to the Department of Health regarding progress with achieving full compliance by 31 May 2021. In January 2021, all Trusts wrote to the Chief Social Worker to alert him to the impact of Covid-19 on the Trusts' ability to comply with the Mental Capacity Act (NI) 2016 legislation.

In January 2021, the Learning Disability and ACOPS teams put together action plans to achieve MCA compliance for legacy cases by 31 May 2021. It is highly likely that this timeframe will not be met due to a range of additional factors:

- Unable to secure redeployed staff in sufficient numbers to undertake MCA work
- Unable to secure staff to work regular overtime
- Progress with completion of MCA across teams is slower than projected
- Introduction of Rule 6 reports has created additional time intensive work not factored into original plan
- Volume of work and time requirement associated with each assessment.

Services will continue to review the position in respect of MCA compliance and keep the MCA Steering Group and DoH up to date with progress.

Children with Disabilities – Failure of the Trust to meet its statutory responsibility to discharge a child from the Iveagh Centre into a community placement appropriate to a child's needs and within a reasonable timescale

The Iveagh Centre is a regional inpatient hospital for children with a learning disability requiring assessment and treatment. The timely discharge of patients from the Iveagh Centre is a regional priority in order to ensure that there is always a bed available should a child require urgent admission. In addition, a prolonged stay in a hospital setting is not in the best interests of a child once their treatment is completed.

The Trust has experienced difficulty with providing appropriate community placements for a small number of children during the course of this year who have remained in the Iveagh Centre when they have not required ongoing hospital treatment and care i.e. their discharge is delayed. This has led to Judicial Review Proceedings being taken by the families of these young people in respect of the Trusts absolute duty to provide accommodation in these circumstances. The Trust has been working collaboratively with the HSCB to progress options for these children through the

development of bespoke community placements and business cases have been completed and submitted to the HSCB and the DoH. However, it seems clear that a joined up approach between various NICS Departments, given the crucial role of the Housing Executive, is needed to resolve this issue.

The Trust has also worked with the HSCB and the other four Trusts to develop a strategic framework for children with disabilities which includes the need to develop a range of accommodation provision.

Looked after Children – failure to discharge all statutory functions in relation to looked after children

Due to the high number of social worker vacancies across Children's Community Services, 62 looked after children did not have an allocated social worker as required under the Children (NI) Order 1995 for a period of time during 2020-21. At the 31 March 2021, 35 children remained without a named social worker. Visits to these children have been undertaken via a duty rota consisting of staff from within the team where the vacancies are.

Under the Children (NI) Order 1995 there is also a requirement to visit every looked after child on a four weekly basis. During 2020-21, 77 looked after children did not receive a visit from their social worker in line with these requirements due to staff sick leave, Covid-19 concerns in foster families and vacancy gaps between staff leaving and new staff commencing employment. Similarly, 94 looked after children's reviews took place outside of the statutory timescales due to a combination of the same factors as outlined above.

The Directorate has continued to be proactive in respect of recruitment and has provided additional support for new staff to aid retention. However shortages of social workers, particularly in children's services, is a region wide issue and is linked to the insufficient number of social workers being trained annually. A Regional Workforce Review, led by the DoH, is underway to address this deficit over the next 5-10 years.

Conclusion

The Trust has a rigorous system of accountability which I can rely on as Accounting Officer to form an opinion on the probity and use of public funds, as detailed in Managing Public Money NI (MPMNI).

Further to considering the accountability framework within the Trust and in conjunction with assurances given to me by the Head of Internal Audit, I am content that the Trust has operated a sound system of internal governance during the period 2020-21.

Dr Cathy Jack
Chief Executive

Remuneration and Staff Report

Remuneration Report

Scope of the report

The Remuneration Report summarises the remuneration policy of Belfast Trust and particularly its application in connection with senior executives. The report also describes how the Trust applied the principles of good corporate governance in relation to senior executives' remuneration in accordance with HSS (SM) 3/2001 issued by the Department of Health (NI).

Remuneration Committee

The Board of the Trust, as set out in its Standing Orders and Standing Financial Instructions, has delegated certain functions to the Remuneration Committee including the provision of advice and guidance to the Board on matters of salary and contractual terms for the Chief Executive and Directors of the Trust, guided by Department of Health (NI) policy. The membership of this committee is:

Mr Peter McNaney: Chairman

Ms Anne O'Reilly: Non-Executive Director

Mrs Nuala McKeagney: Non-Executive Director

Remuneration policy

The policy on remuneration of the Trust Senior Executives for current and future financial years is the application of terms and conditions of employment as provided and determined by the Department of Health (NI).

Performance of Senior Executives is assessed using a performance management system which comprises of individual appraisal and review. Senior Executive performance is then considered by the Remuneration Committee and judgements are made as to any performance pay uplift in line with the Departmental pay circular and measured against the achievement of regional, organisational and personal objectives. The relevant importance of the appropriate proportions of remuneration is set by the Department of Health (NI) under the performance management arrangements for senior executives. The recommendations of the Remuneration Committee go to the full Board for formal approval.

Service contracts

All Senior Executives in the year 2020-21, except the Chief Executive and the Medical Director, were employed on the Department of Health (NI) Senior Executive Contract. The contractual provisions applied are those detailed and contained within Circulars HSS (SM) 2/2001, for those

Senior Executives appointed prior to December 2008, and HSS(SM) 3/2008 for those Senior Executives appointed in the Trust since December 2008.

The Chief Executive and the Medical Director are employed under a contract issued in accordance with the HSC Medical Consultant Terms and Conditions of Service (Northern Ireland) 2004.

Notice period

A period of three-months' notice is to be provided by either party except in the event of summary dismissal. There is nothing to prevent either party waiving the right to notice or from accepting payment in lieu of notice.

Retirement age

The Trust does not operate a general retirement age for its staff including Senior Executives. However, the Trust reserves the right to require an individual or group of employees to retire at a particular age where this can be objectively justified.

Retirement benefit costs

The Trust participates in the HSC Pension Scheme. Under this multi-employer defined benefit scheme both the Trust and employees pay specified percentages of pay into the scheme and the liability to pay benefit falls to the Department of Health (NI). The Trust is unable to identify its share of the underlying assets and liabilities in the scheme on a consistent and reliable basis. Further information regarding the HSC Pension Scheme can be found in the HSC Pension Scheme Statement in the Department Resource Account for the Department of Health (NI). The costs of early retirements are met by the Trust and charged to the Net Expenditure Account at the time the Trust commits itself to the retirement.

As per the requirements of IAS 19, full actuarial valuations by a professionally qualified actuary are required with sufficient regularity that the amounts recognised in the financial statements do not differ materially from those determined at the reporting period date. This has been interpreted in the FReM to mean that the period between formal actuarial valuations shall be four years. However, it has been noted in HM Treasury guidance that the validation and processing of some of the Schemes' data may not be finalised until after the 2020-21 accounts are laid. Schemes are not automatically required to reflect 2020 scheme valuation data in the 2020-21 accounts. The actuary reviews the most recent actuarial valuation at the statement of financial position date and updates it to reflect current conditions. The 2016 valuation for the HSC Pension scheme updated to reflect current financial conditions and a change in financial assumption methodology will be used in 2020-21 accounts. This 2016 Scheme Valuation also requires adjustment as a result of the 'McCloud remedy'. The Department of Finance have also commissioned a consultation in relation to the Cost Cap Valuation which will close on 25 June 2021. By taking into account the increased value of public service pensions, as a result of the 'McCloud remedy', scheme cost

control valuation outcomes will show greater costs than otherwise would have been expected. On completion of the consultation the 2016 Valuation will be completed and the final cost cap results will be determined.

Premature retirement costs

Section 16 of the Agenda for Change Terms and Conditions Handbook sets out the arrangements for early retirement on the grounds of redundancy and in the interest of efficiency of the service. Under the terms of Section 16 of the Agenda for Change Terms and Conditions Handbook staff made redundant who are members of the HSC Pension Scheme, have at least two years' continuous service and two years' qualifying membership and have reached the minimum pension age, currently 50 years, can opt to retire early without a reduction in their pension as an alternative to a lump sum redundancy payment of up to 24 months' pay. In this case the cost of the early payment of the pension is paid from the lump sum redundancy payment, however if the redundancy payment is not sufficient to meet the early payment of pension cost the employer is required to meet the additional cost.

Senior Employees' Remuneration (Audited)

Name	2020-21 Salary £000s	Benefits in Kind (to nearest £100)	Pensions Benefit (to nearest £1000)	Total £000s
Non-Executive Directors				
P McNaney	35-40	N/A	N/A	35-40
M Bradley	5-10	N/A	N/A	5-10
N McKeagney	5-10	N/A	N/A	5-10
Dr P Loughran	5-10	N/A	N/A	5-10
A O'Reilly	5-10	N/A	N/A	5-10
M Karp	5-10	N/A	N/A	5-10
G Smyth	5-10	N/A	N/A	5-10
D Jones	5-10	N/A	N/A	5-10
Directors				
C Jack	215-220	0	81,000	295-300
M Edwards	90-95	0	10,000	100-105
J Kennedy	90-95	0	14,000	100-105
C Hagan (1)	210-215	300	32,000	240-245
C Leonard	90-95	0	10,000	100-105
B Creaney	75-80	0	(1,000)	75-80
M Heaney (2)	20-25	200	N/A	20-25
A Dawson	90-95	0	9,000	95-100
B Owens	85-90	0	(4,000)	85-90
G Traub (3)	75-80	0	28,000	100-105
J Johnston (4)	35-40	0	21,000	55-60
S Boyd (5)	25-30	0	45,000	70-75
C Loughrey (6)	15-20	0	24,000	40-45
C Diffin	85-90	0	(2,000)	80-85
B Armstrong	100-105	0	64,000	165-170
C Stoops	80-85	0	16,000	95-100

(1) C Hagan was Interim Medical Director until July 2020 from which date he was appointed permanent Medical Director

(2) M Heaney retired on 30th June 2020 having previously held Director of Adult Social and Primary Care post

(3) G Traub appointed Interim Director of Adult Social and Primary Care from 15th June 2020, FYE £90-95k

(4) J Johnston appointed Interim Director of Acute Services from 25th November 2020, FYE £85-90k

(5) S Boyd appointed Interim Director of Surgery from 8th December 2020, FYE £85-90k

(6) C Loughrey appointed Interim Director of Surgery and Specialist Services from 2nd November to 7th December 2020

Senior Employees' Remuneration (Audited - Cont'd)

Name	2019-20 Salary £000s	Benefits in Kind (to nearest £100)	Pensions Benefit (to nearest £1000)	Total £000s
Non-Executive Directors				
P McNaney	35-40	N/A	N/A	35-40
M Bradley	5-10	N/A	N/A	5-10
N McKeagney	5-10	N/A	N/A	5-10
Dr P Loughran	5-10	N/A	N/A	5-10
A O'Reilly	5-10	N/A	N/A	5-10
M Karp	5-10	N/A	N/A	5-10
G Smyth	5-10	N/A	N/A	5-10
D Jones	5-10	N/A	N/A	5-10
Directors				
C Jack	200-205	0	38,000	240-245
M Edwards	90-95	100	20,000	110-115
J Kennedy	90-95	0	20,000	110-115
C Hagan (7)	30-35	0	40,000	70-75
C Leonard	90-95	0	20,000	110-115
B Creaney	75-80	100	(5,000)	70-75
M Heaney	90-95	1,500	(11,000)	80-85
A Dawson	90-95	0	20,000	110-115
B Owens	85-90	0	(10,000)	75-80
G Traub	N/A	N/A	N/A	N/A
J Johnston	N/A	N/A	N/A	N/A
S Boyd	N/A	N/A	N/A	N/A
C Loughrey	N/A	N/A	N/A	N/A
C Diffin	80-85	0	20,000	100-105
B Armstrong (8)	45-50	0	25,000	70-75
C Stoops	70-75	0	20,000	110-115

(7) C Hagan appointed Interim Medical Director from 14th January to 22nd January 2020 and from 4th February 2020, FYE £175-180k
(8) B Armstrong appointed Interim Director of Unscheduled and Acute Care from 14th October 2019, FYE £85-90k

The Benefits in Kind listed in the above tables relate to Leased Cars and Travel Expenses.

ACCOUNTABILITY REPORT

Senior Employees' Remuneration (Audited - Cont'd)

Pensions of Senior Management	Accrued pension at pension age as at 31/03/21 and related lump sum	Real increase in pension and related lump at pension age	CETV at 31/03/21	CETV at 31/03/20	Real increase in CETV
	£'000	£'000	£'000	£'000	£'000
C Jack	70-75 plus lump sum 195-200	5-7.5 plus lump sum 5-7.5	1,594	1,472	44
M Edwards	35-40 plus lump sum 70-75	0-2.5 plus lump sum (2.5)-0	652	615	11
J Kennedy	20-25 plus lump sum 40-45	0-2.5	428	395	16
C Hagan	45-50 plus lump sum 105-110	0-2.5 plus lump sum 0-2.5	974	900	36
C Leonard	35-40 plus lump sum 70-75	0-2.5	661	623	12
B Creaney	30-35 plus lump sum 95-100	0-2.5 plus lump sum 0-2.5	711	674	10
M Heaney	N/A	N/A	N/A	N/A	N/A
A Dawson	35-40 plus lump sum 70-75	0-2.5 plus lump sum (2.5)-0	672	633	12
B Owens	45-50 plus lump sum of 135-140	0-2.5 plus lump sum of 0-2.5	1,091	1,038	9
G Traub	25-30 plus lump sum 45-50	0-2.5 plus lump sum 0-2.5	381	347	19
J Johnston	30-35 plus lump sum 100-105	0-2.5 plus lump sum 2.5-5	795	739	26
S Boyd	25-30 plus lump sum 55-60	0-2.5 plus lump sum 2.5-5	484	432	33
C Loughrey	60-65 plus lump sum 155-160	0-2.5 plus lump sum (5)-(2.5)	1,369	1,302	13
C Diffin	35-40 plus lump sum 110-115	0-2.5 plus lump sum of 2.5-5	934	888	10
B Armstrong	40-45 plus lump sum 95-100	2.5-5 plus lump sum 5-7.5	869	773	64
C Stoops	20-25 plus lump sum 35-40	0-2.5 plus lump sum (2.5)-0	300	275	13

As Non-Executive Directors do not receive pensionable remuneration, there will be no entries in respect of pensions for Non-Executive Director.

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures and the other pension details, include the value of any pension benefits in another scheme or arrangement that the individual has transferred to the HSC pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost.

CETV are at year-end or date of retirement/resignation depending on which is earlier. CETVs are calculated within the guidelines prescribed by the Institute and Faculty of Actuaries.

Real Increase in CETV - This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (Including the value of any benefits transferred from another pension scheme or arrangement) and uses common market valuation factors for the start and end of the period.

The Trust is required to disclose the relationship between the remuneration of the highest paid Director in their organisation and the median remuneration of the organisation's workforce. The table below outlines this relationship.

	2020-21	2019-20
Median Disclosure (Audited)	**Salary**	**Salary**
Band of highest paid Directors total Remuneration	£215k - £220k	£200k - £205k
Median total remuneration	£31,365	£30,444
Ratio	6.93	6.65
Range of Staff Remuneration	£18,005-£217,750	£17,652-£239,790

The midpoint of the remuneration band of the highest paid director in the Belfast Trust in financial year 2020-21 was £217,500 (2019-20, £202,500). This was 6.93 times (2019-20, 6.65) the median remuneration of the workforce, which was £31,365 (2019-20, £30,444).

Total remuneration includes salary, non-consolidated performance-related pay, benefits in kind as well as severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

There is a small increase from 6.65 to 6.93 in 2020-21.

Whilst the Median figure has increased to £31,365 in 2020-21 due to a pay increase the banding of the highest paid director has also increased to £215k-£220k in 2020-21 (2019-20, £200k-£205k).

The few employees that receive remuneration above the highest paid Director would fall into the category of medical staff whose earnings would have additional allowances for their specialised roles and whose Gross earnings can vary from year to year.

Staff with negative Gross Pay have been omitted. Staff whose WTE were less than full time where made up to Full Time Equivalents. In line with previous years all the extracted figures were Annualised and a consistent approach was kept in both years. Staff with Whole Time Equivalents that skewed the totals were also removed ie. those who worked sessions or those less than 0.1.

The median remuneration does not take account of agency staff.

Staff Report

Managing Attendance

The Managing Attendance Team are committed to supporting employees and managers to ensure attendance is managed effectively in line with best practice, employment legislation and Trust and Regional absence management frameworks.

- From 1 April 2020 to 31 March 2021 sickness absence within the Trust was 7.59%
- During this period, 42.1% of all employee sickness absence was attributed to Mental Health related issues.

The Trust are committed to supporting employees to manage their mental, emotional and physical well-being through a wide range of initiatives such as:

- Staff Care, Belfast Recovery College, Clinical Psychology Services, Condition Management Programme, Stress Focus Groups, Here 4U, the Mind Ur Mind Toolkit, Menopause Toolkit and the provision of support information and literature
- The delivery of free Physical and mental health support information and advice to staff and the wider public through the bWell app and website and Fit For The Fight Resource
- Provide guidance on the application and implementation of the Management of Attendance Protocol and Toolkit for Managers to ensure best practice and a comprehensive, holistic approach to managing attendance
- Continuing to work with regional HSC and national NHS colleagues and Trade Union colleagues to ensure best practice, consistency and compassionate management of attendance at work issues
- Providing tailored support for managers through the provision of bespoke advice from a specialised Attendance Management HR team
- Delivering virtual, HR Drop-in clinics, health fairs, case conference meetings, absence review meetings, attendance at SMT meetings, mandatory and adhoc Attendance Management and MSS report training
- Daily Reporting to SitRep Team on Covid figures
- Regionally reporting on Covid-19 Figures to Department of Health and collating information on a daily basis for all Trusts
- Working in partnership with Occupational Health colleagues to establish urgent Covid-19 Clinics each Saturday
- Providing managers and staff guidance on all attendance matters related to Covid-19 and

ensuring consistency and clarity in recording and reporting absence related to Covid-19 via new regionally agreed Reporting Codes – "Public Services Duties Paid" – 1240 and "Risk Assessment Paid" – 1252

- In response to social distancing and PHA guidelines, we continue to ensure a seamless delivery of service i.e. conducting all meetings virtually and helping managers and staff with support and guidance on all matters related to absence
- Assisting managers with supporting staff returning to work following Long Covid.

For the period 1 April 2020 to 31 March 2021 the Attendance Management Team have:

- Provided Attendance Management training virtually including the delivery of 10 sessions of bespoke training and support
- In accordance with Covid-19 guide lines permitted Face to Face Training was delivered for 62 staff and managers
- Supported 69 ill health retirements, 78 ill health terminations and facilitated the completion of 70 successful redeployments
- Continue to provide reports and dashboards for managers to manage ongoing long-term sickness
- Initiated and attended both virtual and face-to-face case conference meetings incorporating Occupational Health, Employees and Management
- Managing of monthly email Correspondence to all managers of staff on Half Pay or No Pay in regards to Prevention of Overpayment in partnership with Finance and Payroll colleagues
- From April 2021, the Attendance Management Team plan to implement an absence improvement pilot within the Emergency and Out of Hours Service and the Surgical Services Division, with an aim to reduce their sickness absence rates by 1%. The pilot will involve collaborative working with Employees, Service Managers, HR& OD colleagues, Trade Union colleagues, mental health charities and other stakeholders.

Employment Equality and Diversity Plan

Equality and diversity are central to the Trust's overall purpose to improve health and wellbeing and reduce inequalities. Our aim is to ensure that the S75 Equality Action Plan and Disability Action Plan 2018-23 Plan supports the Trust's People Strategy of "caring, supporting, improving, together", whereby our people are at the core of everything we do for the benefit of the communities we serve. We wish to ensure that equality and diversity are embedded across our organisation and that our employment practices are fair, flexible and enabling so that each member of staff can reach their full potential.

Key areas of progress during the year include:

- Shortlisted for the Legal Island Equality and Diversity Award 2020 – Large Company
- Awarded Legal Island - NI Diversity and Inclusion Charter Mark AWARE
- Successful launch of BHSCT Ethnic Minorities Staff Network with agreed Terms of Reference and an Action Plan which is currently being implemented. We have commenced the production of monthly Podcasts with guest speakers covering topics of interest that affect our diverse workforce and the communities we serve
- A comprehensive programme of training is provided in partnership with Health & Social Inequalities and Employment Law teams and staff 1,166 staff have been trained since April 2020
- Continue to implement the Employment Equality and Diversity Plan 2017-2022
- Review of our Affirmative Action Programme as per outcomes from Article 55 2015-2018
- Equality, Good Relations and Human Rights e-learning programme for all staff is available
- Equality, Good Relations and Human Rights digital learning package available for new start pre-boarding - commenced April 2021
- Support and promotion of the regional LGBT Network and virtual participation in 2020 live Pride event
- We are currently co-producing LGBT Guidelines for Staff/Management and Service Users in conjunction with Trade Union colleagues, internal and external Stakeholders
- Continue to implement and review the BHSCT Equal Opportunity/Diversity and Inclusion Policy
- Provision of a confidential bullying and harassment support service for staff and support the Trust's Domestic Abuse Support Service
- Provide support to the Disability Steering Group to enable and support the employment of disabled persons
- Launch the Regional 'Disability Tool Kit' for Managers and Staff
- Develop and implement the Roll out of 'Positive Action 2 – Making it Work' employability initiative for people, pan disability
- Participate in the Getting on, Getting in, Getting Started Project Group.

ACCOUNTABILITY REPORT

Safety, Quality and Information Governance

HR continue to work to ensure that the Trust as an employer and service provider continues to meet our organisational goals and embrace regulation and best practice.

Some Key Areas progressed over the year include:

- HR Records Project consisting of three phases has continued
- Work is ongoing to review, update and maximise Electronic Data Records Management System (EDRMS) and explore Automated Intelligence (AI) upgrades
- The Safety, Quality & Information Governance Team has worked on a joint multi-disciplinary Project Team with the NISTAR Service, Department of Health and Regulatory Bodies in the Republic of Ireland to progress dual registration requirements for all relevant doctors and nurses involved in the transfer of critically ill patients from Northern Ireland to the Republic of Ireland. The team is currently working in conjunction with Service Directorates to consider a Dual Registration Records Monitoring system for the Trust. The dual registration requirement has been brought about following the EU exit on the 31 December 2020
- HR & OD Controls Assurance Standards self-assessment completed
- HR & OD Risk Register & Directorate Policy Index reviewed/updated
- HR & OD Workforce Governance Assurance Standards have been reviewed to include core HR & OD standards applicable to all HR Teams and a Shared Learning template has been devised to ensure shared learning within HR & OD Directorate.

Supporting Working Parents

The Trust aims to be a world leader in health and social care and to be exemplary in improving the working lives of our people, good childcare support is central to that. We have developed a Childcare Strategy aimed at supporting employees on their employment journey to maintain a healthy work life balance.

Interim, Emergency Childcare

Following the closure of schools, nurseries and other childcare providers in March 2020, the HR & Early Years Social Work Teams worked in partnership to provide interim emergency childcare to support our working parents. This enabled key, front line staff to continue to work and effectively manage their childcare needs. The Trust facilitated 342 children and 214 parents.

Following the re-opening of schools in September 2020, interim childcare guidance was developed for parents and managers with useful guidance that clarified procedures.

In January 2021, the Trust facilitated 28 children and 18 families following the January – April 2021

school closures. Whilst the children of key workers could attend school, a number of nurseries, childminders and usual childcare provision including family and friends plus after and pre-school wrap-around childcare were cancelled or curtailed.

Summer Scheme

Due to the Covid-19 pandemic, the 2020 Summer Scheme operated on a somewhat limited capacity in accordance with the public health message (at that time) being that the safest place for children was to be at home. The limited spaces available were reserved for essential childcare purposes and for those key workers who could not work from home. The Summer Scheme operated from 9 June until 11 August 2020.

In total 299 children and 176 families were facilitated.

Workforce Capacity during COVID-19

As a direct response to Covid-19 the Trust, in partnership with other HSC Trusts, delivered a HSC Workforce Appeal that sourced, screened and made “job ready” a supply of candidates for front line services to deploy to critical areas. This appeal required a complete redesign of normal recruitment processes and saw the timeline from application to start date, reduce from an average of 6 months to 4 weeks. In addition, all final year Doctors, Nurses and Allied Health Professionals on placement were “fast tracked” to employment following their professional registration. The Trust filled important roles with newly qualified staff who were already familiar with the Trust, the team, their clinical speciality and the patients and services users we serve.

International nurse recruitment was paused while travel restriction across the globe prevented entry to the UK. However when restrictions allowed the Trust to resume recruitment overseas we supported 173 nurses to relocate to Northern Ireland and take up vital roles in our service.

We are thankful to members of the military who provided much needed support during the pandemic. During this time they were integral members of the wider team and without their support we would not have provided the level of care we were able to.

ACCOUNTABILITY REPORT

Staff Redeployment

As the demand on health and social care increased there was a need to ensure essential services remained fully staffed and in response to this, staff were redeployed at a local service level in line with local Business Continuity Plans. In addition, there was an identified need to temporarily redeploy staff to priority areas across the Trust and this was undertaken by:

- HR Central Redeployment Team
- Nursing & User Experience Redeployment Team
- Allied Health Professions Redeployment Team.

The HR Central Redeployment Team redeployed a total of 118 staff, the majority of staff were from Allied Health Professions (AHP), Administrative & Clerical, Nursing & Midwifery, Social Services and Scientific workforce.

The Nursing & User Experience Redeployment Team redeployed 489 registrants and 77 non-registrants to Covid areas and associated increased bed capacity areas in response to the Covid surge. It should be noted that Mental Health, Learning Disability and Community Services redeployments were managed at a local service level. The service areas were leading and managing the set-up of the Community Covid Centre at Beech Hall in the first surge and the Step-down facility at the Ramada and redeployed their staff from the Day Centres to residential and supported living facilities.

The Care Homes were also a key priority area for the Adult Community & Older People Services Division.

The AHP Redeployment Team redeployed 414 staff from Physiotherapy, Occupational Therapy, Dietetics, Speech & Language Therapy and Podiatry. These included redeployments to other clinical areas/sites, the Nightingale ICU Turning teams, Intermediate Care Services, Covid Help Line, Covid Community Centre, Covid Vaccination Centre, Covid Testing Centres etc.

In partnership with our trade union colleagues we developed a document to support all our staff who have been redeployed during the pandemic. This document has been accessed over 5,500 times to date.

Staying Safe during Covid-19

In June 2020, in readiness for the Trust planning for a safe, staged return to the restoration and recovery of services across the Trust, it was recognised as business critical the need to continue to keep staff safe and well. To that end, the Trust established a Safe Working Environment during

Covid Steering Group to ensure a safe restart of services and to assure patients, clients and staff the Trust took all reasonable steps to ensure safety whilst minimising risk of infection, in line with guidance from the NI Executive, Public Health Agency and Health and Safety Executive.

The Staying Safe during Covid-19 Guide, was part of this work and was developed to provide both managers and staff with practical information and support to make sure work remains as safe as possible for us all. The guide was designed in partnership with key stakeholders, including HR/OD, Health and Safety, Infection Prevention and Control, Trade Unions, Occupational Health, Estates and IT. Its purpose is to continue to provide guidance on a safe working framework setting out the steps, actions and support in place for Managers and Staff to work safely and it will be updated according to any new guidance from the Public Health Agency, the Health & Safety Executive, and the Northern Ireland Executive.

Guidance on Working from Home during Covid-19

Cognisant of the unprecedented numbers of staff working from home, HR developed guidance for home working during Covid-19. This reflected the Trust's commitment as an employer to making every effort to support staff's physical and mental wellbeing, enabling staff to stay healthy and protect themselves, colleagues, patients and families as we continued to deliver services during the pandemic.

The home working document aims to provide interim guidance to both managers and staff as we continue to work hard to keep our staff safe and minimise the risk of the spread of Covid-19 and is reviewed at regular intervals and as government and Public Health Advice is updated.

Donations

Following lockdown in March 2020 the Trust was overwhelmed by the generosity of numerous local businesses who donated toiletries and food. All donations were greatly received by our front line staff.

To enable childcare providers to open in March 2020 owing to national shortages, it was necessary to acquire donations of PPE for these providers within private, community settings. The Improving Working Lives Team co-ordinated this and remain grateful to our community supporters including PRONI, local schools and supermarkets.

Staff Engagement

Measurement

Currently, our main means of measurement of staff engagement scores is via a regional staff survey that typically occurs every three to four years.

Engagement scores are calculated from the average scores from nine questions, over three different components of engagement. The three components of engagement are:

- Involvement
- Willingness to be an advocate for the Trust
- Motivation/ satisfaction.

The survey uses a five point Likert scale over the nine questions to generate average scores out of five.

Scores

There has been a slight increase in engagement scores over the past six years (albeit over 2 data points):

- In 2015 our Trust engagement score was 3.72
- In 2019 our Trust engagement score was 3.77.

Developments

There are plans to improve the frequency of data collection as well as to enable a drill down to a level that will enable more targeted support for teams. Scheduled regional staff surveys will continue to assess engagement scores and new quarterly 'Pulse' surveys will be issued to all staff to gather more frequent engagement data and to highlight areas of high or low staff engagement.

Improving engagement scores

The launch of our People and Culture Priorities 2021 to 2023 at the end of May 2021 will initiate an increased focus on the organisation building a culture that facilitates an engaged workforce. Our staff, through numerous surveys over the past two years, have identified that our priorities should be: Workforce (capacity and wellbeing), Leadership, Recognition and Engagement.

A dual approach to culture change will be applied. Firstly, by ensuring the necessary structure, governance and accountability systems are in place to track improvements. Secondly by encouraging and supporting staff on the ground to improve the culture within their teams.

Staff Turnover

The table below provides an analysis of staff turnover in the period, being defined as the number of leavers over the average number of staff in the period:

	2020-21	2019-20
Number of Leavers in period	1,225	1,396
Average Number of Staff (1)	19,911	19,479
Staff Turnover	6.15%	7.17%

(1) Staff turnover calculation is based on headcount of staff on permanent contracts and excludes staff on temporary or bank only contracts

The overall staff turnover total was 6.15% for the year 2020-21, which represents a reduction of 1.02% compared to last year's submission. The Trust continues to monitor staff turnover by Directorate to identify any trends.

Staff Composition by Gender (Audited)

The following table provides an analysis of the number of employed staff as at 31st March 2021

	Directors		Non Executive Directors		Senior Staff [2]		Other Staff		Trust Total [3]	
	Number	As %	Number	As %	Number	As %	Number	As %	Number	As %
Female	10	75%	3	38%	41	67%	16,787	77%	16,841	76%
Male	4	25%	5	62%	20	33%	5,150	23%	5,179	24%
Total	14		8		61		21,937		22,020	

2 Senior Staff - defined as Chairs of Division, Assistant/Co-Directors or equivalent

3 Total number of staff based on headcount figure of all contracted staff including temporary posts. Excludes bank only staff.

Off-Payroll Expenditure

The Trust had no off-payroll engagements during the year that meet the criteria as set out in Department of Finance circular FD (DoF) 02/20.

ACCOUNTABILITY REPORT

Staff Numbers and Related Costs (Audited)

The staff costs as reported in the financial statements are as follows:

Staff costs comprise:	2020-21			2019-20
	Permanently employed staff £000s	Others £000s	Total £000s	Total £000s
Wages and salaries	794,158	117,697	911,855	813,075
Social security costs	77,109	483	77,592	70,953
Other pension costs	143,525	843	144,368	133,193
Sub-Total	**1,01,792**	**119,023**	**1,113,815**	**1,017,221**
Capitalised staff costs	402	0	402	358
Total staff costs reported in Statement of Comprehensive Expenditure	**1,014,390**	**119,023**	**1,133,413**	**1,016,863**
Less recoveries in respect of outward secondments			(8,047)	(8,202)
Total net costs			**1,125,366**	**1,008,661**
Total staff costs of which:				
Belfast HSC Trust			1,133,413	1,016,863
Charitable Trust Fund			0	0
Consolidation Adjustments			(382)	(399)
Total			**1,133,031**	**1,016,464**

Staff Costs exclude £402k charged to capital projects during the year (2019-20 £358k)

The Trust participates in the HSC Pension Scheme. Under this multi-employer defined benefit scheme both the Trust and employees pay specified percentages of pay into the scheme and the liability to pay benefit falls to the Department of Health. The Trust is unable to identify its share of the underlying assets and liabilities in the scheme on a consistent and reliable basis.

As per the requirements of IAS 19, full actuarial valuations by a professionally qualified actuary are required with sufficient regularity that the amounts recognised in the financial statements do not differ materially from those determined at the reporting period date. This has been interpreted in the FReM to mean that the period between formal actuarial valuations shall be four years. However, it has been noted in HM Treasury guidance that the validation and processing of some of the Schemes' data may not be finalised until after the 2020-21 accounts are laid. Schemes are not automatically required to reflect 2020 scheme valuation data in the 2020-21 accounts. The actuary reviews the most recent actuarial valuation at the statement of financial position date and updates it to reflect current conditions. The 2016 valuation for the HSC Pension scheme updated to reflect current financial conditions and a change in financial assumption methodology will be used in 2020-21 accounts.

Average number of persons employed (Audited)

The average number of whole time equivalent persons employed during the year was as follows:

	2020-21			2019-20
	Permanently employed staff No.	Others No.	Total No.	Total No.
Medical and dental	1,575	499	2,074	1,940
Nursing and midwifery	6,587	1,469	8,056	7,523
Professions allied to medicine	3,290	132	3,422	3,255
Ancillaries	1,708	216	1,924	1,807
Administrative & clerical	3,228	514	3,742	3,578
Ambulance staff	0	0	0	0
Works	251	0	251	246
Other professional and technical	0	0	0	0
Social services	2,473	226	2,699	2,573
Other	0	0	0	0
Total average number of persons employed	**19,112**	**3,056**	**22,168**	**20,922**
Less average staff number relating to capitalised staff costs	6	0	6	6
Less average staff number in respect of outward secondments	65	0	65	62
Total net average number of persons employed	**19,041**	**3,056**	**22,097**	**20,854**
Of which:				
Belfast HSC Trust			22,097	20,854
Charitable Trust Fund			0	0
Consolidation Adjustments			0	0
			22,097	**20,854**

Staff Benefits

The Belfast Health and Social Care Trust has no staff benefits.

Retirements due to ill-health (Audited)

During 2020-21 there were 50 early retirements from the Trust, agreed on the grounds of ill-health (2020: 49). The estimated additional pension liabilities of these ill-health retirements will be £121k (2020: £124k). These costs are borne by the HSC Pension Scheme.

Reporting of early retirement and other compensation scheme – exit packages (Audited)

Exit package cost band	2020-21	2019-20	2020-21	2019-20	2020-21	2019-20
	*Number of compulsory redundancies		*Number of other departures agreed		Total number of exit packages by cost band	
<£10,000	0	0	0	0	0	0
£10,001 - £25,000	0	0	0	0	0	0
£25,001 - £50,000	0	0	0	0	0	0
£50,001 - £100,000	0	0	0	0	0	0
£100,001- £150,000	0	0	0	0	0	0
£150,001- £200,000	0	0	0	0	0	0
>£200,000	0	0	0	0	0	0
Total number of exit packages by type	0	0	0	0	0	0
	£000s	**£000s**	**£000s**	**£000s**	**£000s**	**£000s**
Total resource cost	0	0	0	0	0	0

Redundancy and other departure costs have been paid in accordance with the provisions of the HSC Pension Scheme Regulations and the Compensation for Premature Retirement Regulations, statutory provisions made under the Superannuation (Northern Ireland) Order 1972. Exit costs are accounted for in full in the year in which the exit package is approved and agreed and are included as operating expenses at note 3. Where early retirements have been agreed, the additional costs are met by the employing authority and not by the HSC pension scheme. Ill-health retirement costs are met by the pension scheme and are not included in the table.

Trust Management Costs (Audited)

	2020-21	2019-20
	£000s	£000s
Trust management costs	49,673	47,685
Income:		
RRL	1,804,979	1,606,742
Income per Note 4	102,150	116,480
Non cash RRL for movement in clinical negligence provision	(33,935)	(8,614)
Less interest receivable	0	0
Total Income	1,873,194	1,714,608
% of total income	**2.65%**	**2.78%**

The above information is based on the Audit Commission's definition "M2" Trust management costs, as detailed in HSS (THR) 2/99.

Accountability and Audit Report

Funding Report

Compliance with regularity of expenditure guidance

The Trust Management Statement (MS) and the Financial Memorandum (FM) which exists between the DoH and the Trust, outlines the framework in which the Trust will operate and details certain aspects of financial provisions which the Trust will observe.

The discharge of the responsibilities within the MS/FM is supported by the Standing Financial Instructions (SFIs) of the Trust. The SFIs are then further supported by finance policies and detailed financial procedures which must be kept up to date with DoH circulars as appropriate. This overall framework is designed to ensure that the Trust has assurance that the income and expenditure recorded in its financial statements have been applied to the purposes as intended by the NI Assembly and the financial transactions recorded in the financial statements of the Trust conform to the authorities which govern them.

Both Internal and External Audit provide an independent assessment of the Trust's adherence to this framework of financial governance and control, with the External Auditors providing an annual opinion on regularity within the certified financial statements of the Trust.

The Trust maintains a Gifts and Hospitality Register and there were no gifts made over the limits prescribed in Managing Public Money NI.

Statement of Losses and Special Payments recognised in the year

Losses and special payments are items of expenditure that the NI Assembly would not have contemplated when it agreed funding to the Trust. They are subject to special controls and procedures and require specific approval in accordance with limits set by the DoH. The limit delegated to the Trust, for approval of losses, differs depending on the type of loss but all losses and special payments, irrespective of value, require approval in line with the Trusts Scheme of Delegation. Losses over a particular threshold require approval by the DoH.

Long Term Expenditure

Details on long term expenditure trends are disclosed in the Financial Resources section of the Performance Report at page 36.

Losses and Special Payments (Audited)

Losses statement	2020-21	2019-20
Total number of losses	219	179
Total value of losses (£000)	706	557

Individual losses over £250,000	2020-21	2019-20
	£'000	£'000
Cash Losses	0	0
Claims abandoned	0	0
Administrative write-offs	0	0
Fruitless payments	0	0
Store losses	0	0

Special payments	2020-21	2019-20
Total number of special payments	249	330
Total value of special payments (£000)	7,455	10,535

Individual special payments over £250,000	2020-21	2019-20
	£'000	£'000
Compensation payments		
- Clinical Negligence (1)	2,491	3,652
- Public Liability	0	0
- Employers Liability	0	0
- Other	0	0
Ex-gratia payments	0	0
Extra contractual	0	0
Special severance payments	0	0

(1) 4 Clinical Negligence cases settled in the year at a value exceeding £250k being £776k, £470k, £569k and £676k respectively

Other Payments (Audited)

The Belfast Health and Social Care Trust did not make any other payments or gifts during the financial year.

Fees and Charges (Audited)

The Belfast Trust does not have material income generated from fees and charges.

Remote Contingent Liabilities (Audited)

There are no remote contingent liabilities of which the Trust is aware.

ACCOUNTABILITY REPORT

On behalf of the Belfast Health and Social Care Trust, I approve the Accountability Report encompassing the following sections:

- Corporate Governance Report
- Remuneration and Staff Report
- Accountability and Audit Report

Cathy Jack

10 June 2021

Dr Cathy Jack
Chief Executive

Date

BELFAST HEALTH AND SOCIAL CARE TRUST – PUBLIC FUNDS

THE CERTIFICATE AND REPORT OF THE COMPTROLLER AND AUDITOR GENERAL TO THE NORTHERN IRELAND ASSEMBLY

Opinion on financial statements

I certify that I have audited the financial statements of the Belfast Health and Social Care Trust for the year ended 31 March 2021 under the Health and Personal Social Services (Northern Ireland) Order 1972, as amended. The financial statements comprise: the Group and Parent Statements of Comprehensive Net Expenditure, Financial Position, Cash Flows, Changes in Taxpayers' Equity; and the related notes including significant accounting policies. These financial statements have been prepared under the accounting policies set out within them.

The financial reporting framework that has been applied in their preparation is applicable law and International Financial Reporting Standards as adopted by the European Union and interpreted by the Government Financial Reporting Manual.

I have also audited the information in the Accountability Report that is described in that report as having been audited.

In my opinion the financial statements:

- give a true and fair view of the state of the group's and of Belfast Health and Social Care Trust's affairs as at 31 March 2021 and of the group's and the Belfast Health and Social Care Trust's net expenditure for the year then ended; and
- have been properly prepared in accordance with the Health and Personal Social Services (Northern Ireland) Order 1972, as amended and Department of Health directions issued thereunder.

Emphasis of Matter

I draw attention to Note 5.1 of the financial statements, which describes the material valuation uncertainties for Land and Buildings due to the consequences of the COVID-19 pandemic. My opinion is not modified in respect of the matter.

Opinion on regularity

In my opinion, in all material respects the expenditure and income recorded in the financial statements have been applied to the purposes intended by the Assembly and the financial transactions recorded in the financial statements conform to the authorities which govern them.

Basis of opinions

I conducted my audit in accordance with International Standards on Auditing (UK) (ISAs) and Practice Note 10 'Audit of Financial Statements of Public Sector Entities in the United Kingdom'. My responsibilities under those standards are further described in the Auditor's responsibilities for the audit of the financial statements section of this certificate. My staff and I are independent of Belfast Health and Social Care Trust in accordance with the ethical requirements of the Financial Reporting Council's Revised Ethical Standard 2019, and have fulfilled our other ethical responsibilities in accordance with these requirements. I believe that the audit evidence obtained is sufficient and appropriate to provide a basis for my opinions.

Conclusions relating to going concern

In auditing the financial statements, I have concluded that Belfast Health and Social Care Trust's use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work I have performed, I have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the Belfast Health and Social Care Trust's ability to continue as a going concern for a period of at least twelve months from when the financial statements are authorised for issue.

The going concern basis of accounting for Belfast Health and Social Care Trust is adopted in consideration of the requirements set out in the Government Reporting Manual, which require entities to adopt the going concern basis of accounting in the preparation of the financial statements where it anticipated that the services which they provide will continue into the future.

My responsibilities and the responsibilities of the Trust and the Accounting Officer with respect to going concern are described in the relevant sections of this report.

Other Information

The other information comprises the information included in the annual report other than the financial statements, the parts of the Accountability Report described in that report as having been audited, and my audit certificate and report. The Trust and the Accounting Officer are responsible for the other information included in the annual report. My opinion on the financial statements does not cover the other information and except to the extent otherwise explicitly stated in my report, I do not express any form of assurance conclusion thereon.

My responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or my knowledge obtained in the audit, or otherwise appears to be materially misstated. If I identify such material inconsistencies or apparent material misstatements, I am required to determine whether this gives rise to a material misstatement in the financial statements themselves. If, based on the work I have performed, I conclude that there is a material misstatement of this other information, I am required to report that fact.

I have nothing to report in this regard.

Opinion on other matters

In my opinion:

- the parts of the Accountability Report to be audited have been properly prepared in accordance with Department of Health directions made under the Health and Personal Social Services (Northern Ireland) Order 1972, as amended; and
- the information given in the Performance Report and Accountability Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which I report by exception

In the light of the knowledge and understanding of the Belfast Health and Social Care Trust and its environment obtained in the course of the audit, I have not identified material misstatements in the Performance Report and Accountability Report. I have nothing to report in respect of the following matters which I report to you if, in my opinion:

- adequate accounting records have not been kept; or

- the financial statements and the parts of the Accountability Report to be audited are not in agreement with the accounting records; or
- certain disclosures of remuneration specified by the Government Financial Reporting Manual are not made; or
- I have not received all of the information and explanations I require for my audit; or
- the Governance Statement does not reflect compliance with the Department of Finance's guidance.

Responsibilities of the Trust and Accounting Officer for the financial statements

As explained more fully in the Statement of Accounting Officer Responsibilities, the Trust and the Accounting Officer are responsible for the preparation of the financial statements and for

- the preparation of the financial statements in accordance with the applicable financial reporting framework and for being satisfied that they give a true and fair view;
- such internal controls as the Accounting Officer determines is necessary to enable the preparation of financial statements that are free form material misstatement, whether due to fraud of error;
- assessing the Belfast Health and Social Care Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the Accounting Officer anticipates that the services provided by the Belfast Health and Social Care Trust will not continue to be provided in the future.

Auditor's responsibilities for the audit of the financial statements

My responsibility is to audit, certify and report on the financial statements in accordance with the Health and Personal Social Services (Northern Ireland) Order 1972, as amended.

My objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error and to issue a certificate that includes my opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

I design procedures in line with my responsibilities, outlined above, to detect material misstatements in respect of non-compliance with laws and regulation, including fraud.

My procedures included:

- obtaining an understanding of the legal and regulatory framework applicable to the Belfast Health and Social Care Trust through discussion with management and application of extensive public sector accountability knowledge. The key laws and regulations I considered included the Health and Personal Social Services (Northern Ireland) Order 1972, as amended and Department of Health directions issued thereunder;
- making enquires of management and those charged with governance on the Belfast Health and Social Care Trust's compliance with laws and regulations;
- making enquiries of internal audit, management and those charged with governance as to susceptibility to irregularity and fraud, their assessment of the risk of material misstatement

due to fraud and irregularity, and their knowledge of actual, suspected and alleged fraud and irregularity;

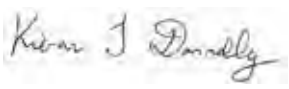
- completing risk assessment procedures to assess the susceptibility of the Belfast Health and Social Care Trust's financial statements to material misstatement, including how fraud might occur. This included, but was not limited to, an engagement director led engagement team discussion on fraud to identify particular areas, transaction streams and business practices that may be susceptible to material misstatement due to fraud;
- engagement director oversight to ensure the engagement team collectively had the appropriate competence, capabilities and skills to identify or recognise non-compliance with the applicable legal and regulatory framework throughout the audit;
- designing audit procedures to address specific laws and regulations which the engagement team considered to have a direct material effect on the financial statements in terms of misstatement and irregularity, including fraud. These audit procedures included, but were not limited to, reading board and committee minutes, and agreeing financial statement disclosures to underlying supporting documentation and approvals as appropriate;
- addressing the risk of fraud as a result of management override of controls by:
    - performing analytical procedures to identify unusual or unexpected relationships or movements;
    - testing journal entries to identify potential anomalies, and inappropriate or unauthorised adjustments;
    - assessing whether judgements and other assumptions made in determining accounting estimates were indicative of potential bias; and
    - investigating significant or unusual transactions made outside of the normal course of business.

A further description of my responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website www.frc.org.uk/auditorsresponsibilities. This description forms part of my certificate.

In addition, I am required to obtain evidence sufficient to give reasonable assurance that the expenditure and income recorded in the financial statements have been applied to the purposes intended by the Assembly and the financial transactions recorded in the financial statements conform to the authorities which govern them.

Report

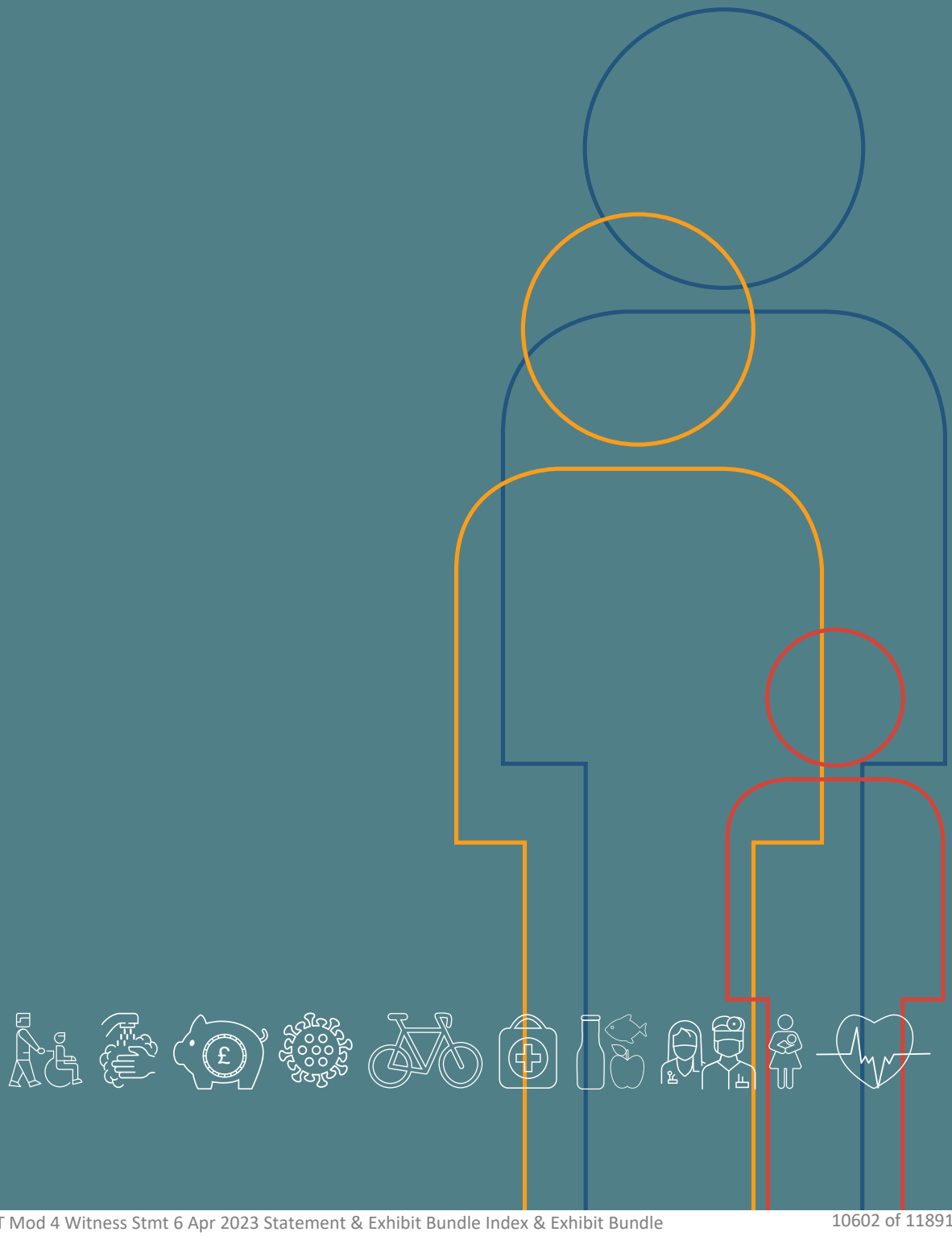
A report on the valuation of land and buildings is not considered necessary as the circumstances are beyond the control of management.



KJ Donnelly
Comptroller and Auditor General
Northern Ireland Audit Office
1 Bradford Court
Belfast
BT8 6RB

2 July 2021

FINANCIAL STATEMENTS



FINANCIAL STATEMENTS

Belfast Health And Social Care Trust

Accounts for the year ended 31 March 2021

Foreword

These accounts for the year ended 31 March 2021 have been prepared in accordance with Article 90(2)(a) of the Health and Personal Social Services (Northern Ireland) Order 1972, as amended by Article 6 of the Audit and Accountability (Northern Ireland) Order 2003, in a form directed by the Department of Health.

Belfast Health And Social Care Trust

Consolidated Statement of Comprehensive Net Expenditure for the year ended 31 March 2021

This account summarises the expenditure and income generated and consumed on an accruals basis. It also includes other comprehensive income and expenditure, which includes changes to the values of non-current assets and other financial instruments that cannot yet be recognised as income or expenditure.

		2021		2020	
	Note	Trust £000s	Consolidated £000s	Trust £000s	Consolidated £000s
Income					
Revenue from contracts with customers	4.1	91,461	91,128	99,461	99,033
Other operating income	4.2	10,689	15,059	17,019	17,237
Total operating income		102,150	106,187	116,480	116,270
Expenditure					
Staff costs	3	(1,133,413)	(1,133,031)	(1,016,863)	(1,016,464)
Purchase of goods and services	3	(535,355)	(535,355)	(485,057)	(485,056)
Depreciation, amortisation and impairment charges	3	(65,506)	(65,506)	(84,937)	(84,937)
Provision expense	3	(36,030)	(36,030)	(11,087)	(11,087)
Other expenditures	3	(135,175)	(136,219)	(123,629)	(125,700)
Total operating expenditure		(1,905,479)	(1,906,141)	(1,721,573)	(1,723,244)
Net operating expenditure		**(1,803,329)**	**(1,799,954)**	**(1,605,093)**	**(1,606,974)**
Finance income	4.2	0	1,083	0	1,304
Finance expense	3	(1,468)	(1,468)	(1,499)	(1,499)
Net expenditure for the year		**(1,804,797)**	**(1,800,339)**	**(1,606,592)**	**(1,607,169)**
Revenue Resource Limit (RRL)	22.1	1,804,979	1,804,979	1,606,742	1,606,742
Add back charitable trust fund net expenditure			(4,458)		577
Surplus against RRL		**182**	**182**	**150**	**150**

Other Comprehensive Expenditure

		2021		2020	
Items that will not be reclassified to net operating costs:		Trust £000s	Consolidated £000s	Trust £000s	Consolidated £000s
Net gain/(loss) on revaluation of property, plant and equipment	5.1/5.2/9	223	223	59,724	59,724
Net gain/(loss) on revaluation of intangibles	6.1/6.2/9	0	0	0	0
Net gain/(loss) on revaluation of charitable assets		0	11,096	0	(4,461)
Items that may be reclassified to net operating costs:					
Net gain/(loss) on revaluation of investments		0	0	0	0
Total comprehensive expenditure for the year ended 31 March		**(1,804,574)**	**(1,789,020)**	**(1,546,868)**	**(1,551,906)**

The notes on pages 123 to 156 form part of these accounts.

FINANCIAL STATEMENTS

Belfast Health And Social Care Trust

Consolidated Statement of Financial Position as at 31 March 2021

This statement presents the financial position of Belfast Health and Social Care Trust. It comprises three main components: assets owned or controlled; liabilities owed to other bodies; and equity, the remaining value of the entity.

		2021		2020	
	Note	Trust £000s	Consolidated £000s	Trust £000s	Consolidated £000s
Non Current Assets					
Property, plant and equipment	5.1/5.2	1,350,363	1,350,363	1,335,143	1,335,143
Intangible assets	6.1/6.2	24,875	24,875	10,912	10,912
Financial assets	8	0	57,411	0	46,982
Trade and other receivables	13	0	0	0	0
Other current assets	13	0	0	0	0
Total Non Current Assets		**1,375,238**	**1,432,649**	**1,346,055**	**1,393,037**
Current Assets					
Assets classified as held for sale	10	0	0	395	395
Inventories	11	20,604	20,604	20,341	20,341
Trade and other receivables	13	55,566	58,583	47,751	45,843
Contract assets	13	0	0	0	0
Other current assets	13	1,296	1,296	1,293	1,293
Intangible current assets	13	0	0	0	0
Financial assets	8	0	0	0	0
Cash and cash equivalents	12	13,272	14,214	22,039	23,170
Total Current Assets		90,738	94,697	91,819	91,042
Total Assets		**1,465,976**	**1,527,346**	**1,437,874**	**1,484,079**
Current Liabilities					
Trade and other payables	14	(331,789)	(331,487)	(263,370)	(263,457)
Contract liabilities		0	0	0	0
Other liabilities	14	(2,800)	(2,800)	(2,227)	(2,227)
Intangible current liabilities	14	0	0	0	0
Provisions	15	(33,014)	(33,014)	(28,996)	(28,996)
Total Current Liabilities		(367,603)	(367,301)	(294,593)	(294,680)
Total assets less current liabilities		**1,098,373**	**1,160,045**	**1,143,281**	**1,189,399**
Non Current Liabilities					
Provisions	15	(96,530)	(96,530)	(72,330)	(72,330)
Other payables > 1 year	14	(10,598)	(10,598)	(11,204)	(11,204)
Financial liabilities	8	0	0	0	0
Total Non Current Liabilities		(107,128)	(107,128)	(83,534)	(83,534)
Total assets less total liabilities		**991,245**	**1,052,917**	**1,059,747**	**1,105,865**
Taxpayers' Equity and other reserves					
Revaluation reserve		364,486	364,486	365,374	365,374
SoCNE reserve		626,759	626,759	694,373	694,373
Other reserves - charitable fund		0	61,672	0	46,118
Total equity		**991,245**	**1,052,917**	**1,059,747**	**1,105,865**

The notes on pages 123 to 156 form part of these accounts.

The financial statements on pages 119 to 156 were approved by the Board on 10th June 2021 and were signed on its behalf by;

Signed: Cathy Jack (Chief Executive) Date 10 June 2021

Belfast Health And Social Care Trust

Consolidated Statement of Cash Flows for the year ended 31 March 2021

The Statement of Cash Flows shows the changes in cash and cash equivalents of the Belfast Health and Social Care Trust during the reporting period. The statement shows how the Trust generates and uses cash and cash equivalents by classifying cash flows as operating, investing and financing activities. The amount of net cash flows arising from operating activities is a key indicator of service costs and the extent to which these operations are funded by way of income from the recipients of services provided by the Trust. Investing activities represent the extent to which cash inflows and outflows have been made for resources which are intended to contribute to the Trust's future public service delivery.

	Note	2021 £000s	2020 £000s
Cash flows from operating activities			
Net deficit after interest/Net operating cost		(1,800,339)	(1,607,169)
Adjustments for non cash costs		101,410	96,010
(Increase)/decrease in trade and other receivables		(12,743)	2,136
Less movements in receivables relating to items not passing through the NEA			
Movements in receivables relating to the sale of property, plant and equipment		0	0
Movements in receivables relating to the sale of intangibles		0	0
Movements in receivables relating to finance leases		0	0
Movements in receivables relating to PFI and other service concession arrangement contracts		0	0
(Increase) in inventories		(263)	(1,133)
Increase in trade payables		67,997	39,091
Less movements in payables relating to items not passing through the NEA			
Movements in payables relating to the purchase of property, plant and equipment		(11,057)	(1,584)
Movements in payables relating to the purchase of intangibles		0	0
Movements in payables relating to finance leases		0	0
Movements in payables relating to PFI and other service concession arrangement contracts		(33)	1,096
Use of provisions	15	(7,812)	(10,854)
Net cash outflow from operating activities		(1,662,840)	(1,482,407)
Cash flows from investing activities			
Purchase of property, plant & equipment	5.1,5.2	(65,192)	(84,302)
Purchase of intangible assets	6.1,6.2	(18,217)	(2,206)
Proceeds of disposal of property, plant & equipment		593	76
Proceeds on disposal of intangibles		0	0
Proceeds on disposal of assets held for resale		0	0
Drawdown from investment fund		1,750	0
Share of income reinvested		(1,083)	(1,304)
Net cash outflow from investing activities		(82,149)	(87,736)
Cash flows from financing activities			
Grant in aid		1,736,000	1,578,000
Cap element of payments - finance leases and on balance sheet (SoFP) PFI and other service concession arrangements		33	(1,096)
Net cash inflow from financing activities		1,736,033	1,576,904
Net increase/(decrease) in cash & cash equivalents in the period		(8,956)	6,761
Cash & cash equivalents at the beginning of the period	12	23,170	16,409
Cash & cash equivalents at the end of the period	12	14,214	23,170

The notes on pages 123 to 156 form part of these accounts.

FINANCIAL STATEMENTS

Belfast Health And Social Care Trust

Consolidated Statement of Changes in Taxpayers' Equity For the Year Ended 31 March 2021

This statement shows the movement in the year on the different reserves held by the Belfast Health and Social Care Trust, analysed into 'General Fund Reserves' (i.e. those reserves that reflect a contribution from the Department of Health). The Revaluation Reserve reflects the change in asset values that have not been recognised as income or expenditure. The General Fund represents the total assets less liabilities of the Trust, to the extent that the total is not represented by other reserves and financing items.

	Note	SoCNE Reserve £000s	Revaluation Reserve £000s	Charitable Fund £000s	Total Equity £000s
Balance at 1 April 2019		**722,218**	**306,335**	**51,156**	**1,079,709**
Changes in Taxpayers' Equity 2019-20					
Grant from DoH		1,578,000			1,578,000
Transfers between reserves		685	(685)	0	0
Comprehensive expenditure for the year		(1,606,592)	59,724	(5,038)	(1,551,906)
Transfer of asset ownership		0	0	0	0
Non cash charges - auditors remuneration	3	62			62
Movement - other		0			0
Balance at 31 March 2020		**694,373**	**365,374**	**46,118**	**1,105,865**
Changes in Taxpayers' Equity 2020-21					
Grant from DoH		1,736,000			1,736,000
Transfers between reserves		1,111	(1,111)	0	0
Comprehensive expenditure for the year		(1,804,797)	223	15,554	(1,789,020)
Transfer of asset ownership		0	0	0	0
Non cash charges - auditors remuneration	3	72			72
Balance at 31 March 2021		**626,759**	**364,486**	**61,672**	**1,052,917**

The notes on pages 123 to 156 form part of these accounts.

Belfast Health And Social Care Trust

Notes to the Accounts for the year ended 31 March 2021

Note 1 Statement of Accounting Policies

1 Authority

These financial statements have been prepared in a form determined by the Department of Health (DoH), based on guidance from the Department of Finance's (DoF) Financial Reporting Manual (FReM) and in accordance with the requirements of Article 90(2)(a) of the Health and Personal Social Services (Northern Ireland) Order 1972 No 1265 (NI 14) as amended by Article 6 of the Audit and Accountability (Northern Ireland) Order 2003.

The accounting policies contained in the FReM apply International Financial Reporting Standards (IFRS) as adapted or interpreted for the public sector context. Where the FReM permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the HSC body for the purpose of giving a true and fair view has been selected. The particular policies adopted by the HSC body are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

The PFI liability comparative figures shown within note 13 and 18 have been reclassified within the categories for less than and greater than 1 year, a smoothing effect to show a contained average figure for each year has been used to give a true and fairer view.

1.1 Accounting Convention

These financial statements have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and liabilities.

1.2 Currency and Rounding

These financial statements are presented in £ sterling and rounded in thousands

1.3 Property, Plant and Equipment

Property, plant and equipment assets comprise Land, Buildings, Dwellings, Transport Equipment, Plant & Machinery, Information Technology, Furniture & Fittings, and Assets under construction.

Recognition
Property, plant and equipment must be capitalised if:

- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential will be supplied to, the Trust;
- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably; and
- the item has cost of at least £5,000 (or less if so desired); or
- collectively, a number of items have a cost of at least £5,000 (or less if so desired) and individually have a cost of more than £1,000 (or less if so desired), where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

On initial recognition property, plant and equipment are measured at cost including any expenditure such as installation, directly attributable to bringing them into working condition. Items classified as "under construction" are recognised in the Statement of Financial Position to the extent that money has been paid or a liability has been incurred.

Valuation of Land and Buildings
Land and buildings are carried at the last professional valuation, in accordance with the Royal Institution of Chartered Surveyors Global Standards & UK National Supplement in so far as these are consistent with the specific needs of the HSC.

The last valuation was carried out on 31 January 2020 by Land and Property Services (LPS) which is an independent executive body within the Department of Finance. The valuers are qualified to meet the 'Member of Royal Institution of Chartered Surveyors' (MRICS) standard.

Professional revaluations of land and buildings are undertaken at least once in every five year period and are revalued annually, between professional valuations, using indices provided by LPS.

Land and buildings used for the Trust's services or for administrative purposes are stated in the Statement of Financial Position at their revalued amounts, being the fair value at the date of revaluation less any subsequent accumulated depreciation and impairment losses.

Fair values are determined as follows:

- Land and non-specialised buildings - open market value for existing use
- Specialised buildings - depreciated replacement cost
- Properties surplus to requirements - the lower of open market value less any material directly attributable selling costs or book value at date of moving to non - current assets.

Modern Equivalent Asset
DoF has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued. Land and Property Services have included this requirement within the latest valuation.

Assets Under Construction (AUC)
Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Assets are revalued and depreciation commences when they are brought into use.

Short Life Assets
Short life assets are not indexed. Short life is defined as a useful life of up to and including 5 years. Short life assets are carried at depreciated historic cost as this is not considered to be materially different from fair value and are depreciated over their useful life.

Where the estimated life of fixtures and equipment exceeds 5 years, suitable indices will be applied each year and depreciation will be based on indexed amount.

Revaluation Reserve
An increase arising on revaluation is taken to the Revaluation Reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease is recognised as an impairment charged to the Revaluation Reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure.

1.4 Depreciation

No depreciation is provided on freehold land since land has unlimited or a very long established useful life. Items under construction are not depreciated until they are commissioned. Properties that are surplus to requirements and which meet the definition of "non - current assets held for sale" are also not depreciated.

Otherwise, depreciation is charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. Assets held under finance leases are also depreciated over their estimated useful lives and the terms of the lease. The estimated useful
life of an asset is the period over which the Trust expects to obtain economic benefits or service potential from the asset. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. The following asset lives have been used:

Asset Type	Asset Life
Freehold Buildings	25 - 60 years
Leasehold property	Remaining period of lease
IT Assets	3 - 10 years
Intangible assets	3 - 10 years
Other Equipment	3 - 15 years

1.5 Impairment loss

If there has been an impairment loss due to a general change in prices, the asset is written down to its recoverable amount, with the loss charged to the Revaluation Reserve to the extent that there is a balance on the reserve for the asset and, thereafter to expenditure within the Statement of Comprehensive Net Expenditure. If the impairment is due to the consumption of economic benefits, the full amount of the impairment is charged to the Statement of Comprehensive Net Expenditure and an amount up to the value of the impairment in the Revaluation Reserve is transferred to the Statement of Comprehensive Net Expenditure Reserve. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would

have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited firstly to the Statement of Comprehensive Net Expenditure to the extent of the decrease previously charged there and thereafter to the Revaluation Reserve.

1.6 Subsequent expenditure

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure which meets the definition of capital restores the asset to its original specification, the expenditure is capitalised and any existing carrying value of the item replaced is written-out and charged to operating expenses.

The overall useful life of the Trust's buildings takes account of the fact that different components of those buildings have different useful lives. This ensures that depreciation is charged on those assets at the same rate as if separate components had been identified and depreciated at different rates.

1.7 Intangible assets

Intangible assets includes any of the following held - software, licences, trademarks, websites, development expenditure, Patents, Goodwill and intangible Assets under Construction. Software that is integral to the operating of hardware, for example an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset. Expenditure on research is not capitalised; it is recognised as an operating expense in the period in which it is incurred. Internally-generated assets are recognised if, and only if, all of the following have been demonstrated:

- the technical feasibility of completing the intangible asset so that it will be available for use
- the intention to complete the intangible asset and use it
- the ability to sell or use the intangible asset
- how the intangible asset will generate probable future economic benefits or service potential
- the availability of adequate technical, financial and other resources to complete the intangible asset and sell or use it
- the ability to measure reliably the expenditure attributable to the intangible asset during its development.

Recognition
Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the Trust's business or which arise from contractual or other legal rights. Intangible assets are considered to have a finite life. They are recognised only when it is probable that future economic benefits will flow to, or service potential be provided to, the Trust; where the cost of the asset can be measured reliably. All single items over £5,000 in value (or less if so desired) must be capitalised while intangible assets which fall within the grouped asset definition must be capitalised if their individual value is at least £1,000 each and the group is at least £5,000 in value (or less if so desired).

The amount recognised for internally-generated intangible assets is the sum of the expenditure incurred from the date of commencement of the intangible asset, until it is complete and ready for use.

Intangible assets acquired separately are initially recognised at fair value. Following initial recognition, intangible assets are carried at fair value by reference to an active market, and as no active market currently exists depreciated replacement cost has been used as fair value.

1.8 Non-current assets held for sale

Non-current assets are classified as held for sale if their carrying amount will be recovered principally through a sale transaction rather than through continuing use. In order to meet this definition IFRS 5 requires that the asset must be immediately available for sale in its current condition and that the sale is highly probable. A sale is regarded as highly probable where an active plan is in place to find a buyer for the asset through appropriate marketing at a reasonable price and the sale is considered likely to be concluded within one year. Non-current assets held for sale are measured at the lower of their previous carrying amount and fair value, less any material directly attributable selling costs. Fair value is open market value, where one is available, including alternative uses

Assets classified as held for sale are not depreciated.

The profit or loss arising on disposal of an asset is the difference between the sale proceeds and the carrying amount. The profit from sale of land which is a non depreciating asset is recognised within income. The profit from sale of a depreciating asset is shown as a reduced expense. The loss from sale of land or from any depreciating assets is shown within operating expenses. On disposal, the balance for the asset on the revaluation reserve is transferred to the Statement of Comprehensive Net Expenditure Reserve.

Property, plant or equipment that is to be scrapped or demolished does not qualify for recognition as held for sale. Instead, it is retained as an operational asset and its economic life is adjusted. The asset is de-recognised when it is scrapped or demolished.

1.9 Inventories

Inventories are valued at the lower of cost and net realisable value and are included exclusive of VAT. This is considered to be a reasonable approximation to fair value due to the high turnover of stocks.

1.10 Income

Income is classified between Revenue from Contracts and Other Operating Income as assessed necessary in line with organisational activity, under the requirements of IFRS 15 and as applicable to the public sector. Judgement is exercised in order to determine whether the five essential criteria within the scope of IFRS 15 are met in order to define income as a contract.

Income relates directly to the activities of the Trust and is recognised on an accruals basis when, and to the extent that a performance obligation is satisfied in a manner that depicts the transfer to the customer of the goods or services promised.

Where the criteria to determine whether a contract is in existence is not met, income is classified as Other Operating Income within the Statement of Comprehensive Net Expenditure and is recognised when the right to receive payment is established.

Income is stated net of VAT.

Grant in aid
Funding received from other entities, including the Department of Health and the Health and Social Care Board are accounted for as grant in aid and are reflected through the Statement of Comprehensive Net Expenditure Reserve.

1.11 Investments

The Trust does not have any investments.

1.12 Research and Development expenditure and the impact of implementation of ESA 2010

Research and development expenditure is expensed in the year it is incurred in accordance with IAS 38.

Following the introduction of the 2010 European System of Accounts (ESA10), from 2016-17 there has been a change in the budgeting treatment (a change from the revenue budget to the capital budget) of research and development (R&D) expenditure. As a result, additional disclosures are included in the notes to the accounts.

1.13 Other expenses

Other operating expenses for goods or services are recognised when, and to the extent that, they have been received. They are measured at the fair value of the consideration payable.

1.14 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

1.15 Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

The Trust as lessee
Property, plant and equipment held under finance leases are initially recognised, at the inception of the lease, at fair value or, if lower, at the present value of the minimum lease payments, with a matching liability for the lease obligation to the lessor. Lease payments are apportioned between finance charges and reduction of the lease obligation so as to achieve a constant rate of interest on the remaining balance of the liability. Finance charges are recognised in calculating the Trust's surplus/deficit.

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term. Contingent rentals are recognised as an expense in the period in which they are incurred.

Where a lease is for land and buildings, the land and building components are separated. Leased land may be either an operating lease or a finance lease depending on the conditions in the lease agreement and following the general guidance set out in IAS 17. Leased buildings are assessed as to whether they are operating or finance leases.

The Trust as lessor
Amounts due from lessees under finance leases are recorded as receivables at the amount of the Trust's net investment in the leases. Finance lease income is allocated to accounting periods so as to reflect a constant periodic rate of return on the Trust's net investment outstanding in respect of the leases.

Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised on a straight-line basis over the lease term.

1.16 Private Finance Initiative (PFI) transactions

DoF has determined that government bodies shall account for infrastructure PFI schemes where the government body controls the use of the infrastructure, and the residual interest in the infrastructure at the end of the arrangement as service concession arrangements, following the principles of the requirements of IFRIC 12. The Trust therefore recognises the PFI asset as an item of property, plant and equipment together with a liability to pay for it. The services received under the contract are recorded as operating expenses.

The annual unitary payment is separated into the following component parts, using appropriate estimation techniques where necessary:

a) Payment for the fair value of services received;
b) Payment for the PFI asset, including replacement of components and
c) Payment for finance (interest costs).

Services received
The fair value of services received in the year is recorded under the relevant expenditure headings within 'operating expenses'.

PFI Assets
The PFI assets are recognised as property, plant and equipment, when they come into use. The assets are measured initially at fair value in accordance with the principles of IAS 17. Subsequently, the assets are measured at fair value, which is kept up to date in accordance with the Trust's approach for each relevant class of asset in accordance with the principles of IAS 16.

PFI liability
A PFI liability is recognised at the same time as the PFI assets are recognised. It is measured initially at the same amount as the fair value of the PFI assets and is subsequently measured as a finance lease liability in accordance with IAS 17.

An annual finance cost is calculated by applying the implicit interest rate in the lease to the opening lease liability for the period, and is charged to 'Finance Costs' within the Statement of Comprehensive Net Expenditure.

The element of the annual unitary payment that is allocated as a finance lease rental is applied to meet the annual finance cost and to repay the lease liability over the contract term.

An element of the annual unitary payment increase due to cumulative indexation is allocated to the finance lease. In accordance with IAS 17, this amount is not included in the minimum lease payments, but is instead treated as contingent rent and is expensed as incurred. In substance, this amount is a finance cost in respect of the liability and the expense is presented as a contingent finance cost in the Statement of Comprehensive Net Expenditure.

Lifecycle replacement
Components of the asset replaced by the operator during the contract ('lifecycle replacement') are capitalised where they meet the Trust's criteria for capital expenditure. They are capitalised at the time they are provided by the operator and are measured initially at their fair value.

The element of the annual unitary payment allocated to lifecycle replacement is pre-determined for each year of the contract from the operator's planned programme of lifecycle replacement. Where the lifecycle component is provided earlier or later than expected, a short-term finance lease liability or prepayment is recognised respectively.

Where the fair value of the lifecycle component is less than the amount determined in the contract, the difference is recognised as an expense when the replacement is provided. If the fair value is greater than the amount determined in the contract, the difference is treated as a 'free' asset and a deferred income balance is recognised. The deferred income is released to the operating income over the shorter of the remaining contract period or the useful economic life of the replacement component.

Assets contributed by the Trust to the operator for use in the scheme
Assets contributed for use in the scheme continue to be recognised as items of property, plant and equipment in the Trust's Statement of Financial Position.

Other assets contributed by the Trust to the operator
Assets contributed (e.g. cash payments, surplus property) by the Trust to the operator before the asset is brought into use, which are intended to defray the operator's capital costs, are recognised initially as prepayments during the construction phase of the contract. Subsequently, when the asset is made available to the Trust, the prepayment is treated as an initial payment towards the finance lease liability and is set against the carrying value of the liability.

1.17 Financial instruments

A financial instrument is defined as any contract that gives rise to a financial asset of one entity and a financial liability or equity instrument of another entity.
The Trust has financial instruments in the form of trade receivables and payables and cash and cash equivalents

Financial Assets
Financial assets are recognised on the Statement of Financial Position when the Trust becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are de-recognised when the contractual rights have expired or the asset has been transferred.

Financial assets are initially recognised at fair value. IFRS 9 requires consideration of the expected credit loss model on financial assets. The measurement of the loss allowance depends upon the Trust's assessment at the end of each reporting period as to whether the financial instrument's credit risk has increased significantly since initial recognition, based on reasonable and supportable information that is available, without undue cost or effort to obtain. The amount of expected credit loss recognised is measured on the basis of the probability weighted present value of anticipated cash shortfalls over the life of the instrument, where judged necessary.

Financial assets are classified into the following categories:
- financial assets at fair value through Statement of Comprehensive Net Expenditure;
- held to maturity investments;
- available for sale financial assets; and
- loans and receivables.

The classification depends on the nature and purpose of the financial assets and is determined at the time of initial recognition.

Financial liabilities
Financial liabilities are recognised in the Statement of Financial Position when the Trust becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.

Financial liabilities are initially recognised at fair value.

Financial risk management
IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the relationships with HSC Commissioners, and the manner in which they are funded, financial instruments play a more limited role within the Trust in creating risk than would apply to a non public sector body of a similar size, therefore the Trust is not exposed to the degree of financial risk faced by business entities. The Trust have limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day to day operational activities rather than being held to change the risks facing the Trusts in undertaking activities. Therefore the Trust is exposed to little credit, liquidity or market risk.

Currency risk
The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and Sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

Interest rate risk
The Trust has limited powers to borrow or invest and therefore has low exposure to interest rate fluctuations.

Credit risk
Because the majority of the Trust's income comes from contracts with other public sector bodies, the Trust has low exposure to credit risk.

Liquidity risk
Since the Trust receives the majority of its funding through its principal Commissioner which is voted through the Assembly, it is therefore not exposed to significant liquidity risks.

1.18 Provisions

In accordance with IAS 37, provisions are recognised when the Trust has a present legal or constructive obligation as a result of a past event, it is probable that the Trust will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties.

Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using DoF issued discount rate as at 31 March 2021 of:

Rate	Time Period	Real rate
Nominal	Short term (0-5 years)	(0.02%)
	Medium term (5-10 years)	0.18%
	Long term (10-40 years)	1.99%
	Very long term (40+ years)	1.99%
Inflationary	Year 1	1.20%
	Year 2	1.60%
	Into perpetuity	2.00%

Note that PES issued a combined nominal and inflation rate table to incorporate the two elements, as included within DoH circular HSC(F) 40-2020. The discount rate to be applied for employee early departure obligations is -0.95% for 2020-21.

The Trust has also disclosed the carrying amount at the beginning and end of the period, additional provisions made, amounts used during the period, unused amounts reversed during the period and increases in the discounted amount arising from the passage of time and the affect of any change in the discount rate.

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

Present obligations arising under onerous contracts are recognised and measured as a provision. An onerous contract is considered to exist where the Trust has a contract under which the unavoidable costs of meeting the obligations under the contract exceed the economic benefits expected to be received under it.

A restructuring provision is recognised when the Trust has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with ongoing activities of the entity.

1.19 Contingencies

In addition to contingent liabilities disclosed in accordance with IAS 37, the Trust discloses for Assembly reporting and accountability purposes certain statutory and non-statutory contingent liabilities where the likelihood of a transfer of economic benefit is remote, but which have been reported to the Assembly in accordance with the requirements of Managing Public Money Northern Ireland.

Where the time value of money is material, contingent liabilities which are required to be disclosed under IAS 37 are stated at discounted amounts and the amount reported to the Assembly separately noted. Contingent liabilities that are not required to be disclosed by IAS 37 are stated at the amounts reported to the Assembly.

Under IAS 37, the Trust discloses contingent liabilities where there is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the Trust, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the Trust. A contingent asset is disclosed where an inflow of economic benefits is probable.

1.20 Employee benefits

Short-term employee benefits
Under the requirements of IAS 19: Employee Benefits, staff costs must be recorded as an expense as soon as the organisation is obligated to pay them. This includes the cost of any untaken leave that has been earned at the year end. This cost has been estimated using average staff numbers and costs applied to the average untaken leave balance determined from the results of a survey to ascertain leave balances as at 31 March 2021. It is not anticipated that the level of untaken leave will vary significantly from year to year.

Retirement benefit costs
The Trust participates in the HSC Pension Scheme. Under this multi-employer defined benefit scheme both the Trust and employees pay specified percentages of pay into the scheme and the liability to pay benefit falls to the DoH. The Trust is unable to identify its share of the underlying assets and liabilities in the scheme on a consistent and reliable basis. Further information regarding the HSC Pension Scheme can be found in the HSC Pension Scheme Statement in the Departmental Resource Account for the Department of Health.

The costs of early retirements are met by the Trust and charged to the Statement of Comprehensive Net Expenditure at the time the Trust commits itself to the retirement.

As per the requirements of IAS 19, full actuarial valuations by a professionally qualified actuary are required with sufficient regularity that the amounts recognised in the financial statements do not differ materially from those determined at the reporting period date. This has been interpreted in the FReM to mean that the period between formal actuarial valuations shall be four years. However, it has been noted in HM Treasury guidance that the validation and processing of some of the Schemes' data may not be finalised until after the 2020-21 accounts are laid. Schemes are not automatically required to reflect 2020 scheme valuation data in the 2020-21 accounts. The actuary reviews the most recent actuarial valuation at the statement of financial position date and updates it to reflect current conditions. The 2016 valuation for the HSC Pension scheme updated to reflect current financial conditions and a change in financial assumption methodology will be used in 2020-21 accounts.

1.21 Reserves

Statement of Comprehensive Net Expenditure Reserve
Accumulated surpluses are accounted for in the Statement of Comprehensive Net Expenditure Reserve.

Revaluation Reserve
The Revaluation Reserve reflects the unrealised balance of cumulative indexation and revaluation adjustments to assets other than donated assets.

1.22 Value Added Tax
Where output VAT is charged or input VAT is recoverable, the amounts are stated net of VAT. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets.

1.23 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Trust has no beneficial interest in them. Details of third party assets are given in Note 22 to the accounts.

1.24 Government Grants

The note to the financial statements distinguishes between grants from UK government entities and grants from European Union.

1.25 Losses and Special Payments

Losses and special payments are items that the Northern Ireland Assembly would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had HSC Trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure). However, the note on losses and special payments is compiled directly from the losses and compensations register which reports amounts on an accruals basis with the exception of provisions for future losses.

1.**26 Charitable Trust Account Consolidation**

The Trust is required to consolidate the accounts of controlled charitable organisations and funds held on trust into its financial statements. As a result the financial performance and funds have been consolidated. The Trust has accounted for these transfers using merger accounting as required by the FReM.

It is important to note however the distinction between public funding and the other monies donated by private individuals still exists.

All funds have been used by Belfast Health and Social Care Trust as intended by the benefactor. It is for the Charitable Trust Fund Advisory Committee within the Trust to manage the internal disbursements. The committee ensures that charitable donations received by the Trust are appropriately managed, invested, expended and controlled, in a manner that is consistent with the purposes for which they were given and with the Trust's Standing Financial Instructions, Departmental guidance and legislation.

All such funds are allocated to the area specified by the benefactor and are not used for any other purpose than that intended by the benefactor.

1.27 Accounting standards that have been issued but have not yet been adopted

The International Accounting Standards Board have issued the following new standards but which are either not yet effective or adopted. Under IAS 8 there is a requirement to disclose these standards together with an assessment of their initial impact on application.

The IASB have issued new and amended standards (IFRS 10, IFRS 11 & IFRS 12) that affect the consolidation and reporting of subsidiaries, associates and joint ventures. These standards were effective with EU adoption from 1 January 2014.

Accounting boundary IFRS are currently adapted in the FReM so that the Westminster departmental accounting boundary is based on ONS control criteria, as designated by Treasury. A similar review in NI, which will bring NI departments under the same adaptation, has been carried out and the resulting recommendations were agreed by the Executive in December 2016. With effect from 2022-23, the accounting boundary for departments will change and there will also be an impact on departments around the disclosure requirements under IFRS 12. ALBs apply IFRS in full and their consolidation boundary may have changed as a result of these Standards.'

IFRS 16 Leases replaces IAS 17 Leases and is effective with EU adoption from 1 January 2019. In line with the requirements of the FReM, IFRS 16 will be implemented, as interpreted and adapted for the public sector, with effect from 1 April 2022.

Management consideration of the impact on introduction of IFRS 16 on initial application remains under consideration and will be fully determined in 2021-22.

IFRS 17 Insurance Contracts will replace IFRS 4 Insurance Contracts and is effective for accounting periods beginning on or after 1 January 2023. In line with the requirements of the FReM, IFRS 17 will be implemented, as interpreted and adapted for the public sector, with effect from 1 April 2023.

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Belfast Health And Social Care Trust

Notes to the Accounts for the year ended 31 March 2021

Note 2 Analysis of Net Expenditure by Segment

The Trust is managed by way of a Directorate structure, each led by a Director, providing an integrated healthcare service both for the resident population, and in the case of specialist services for the Northern Ireland population. The Directors along with Non Executive Directors, Chairman and Chief Executive form the Trust Board which coordinates the activities of the Trust and is considered to be the Chief Operating Decision Maker. The information disclosed in this statement does not reflect budgetary performance and is based solely on expenditure information provided from the accounting system used to prepare the accounts.

TRUST ONLY	2021			2020		
Directorate	**Staff Costs**	**Other Expenditure**	**Total Expenditure**	**Staff Costs**	**Other Expenditure**	**Total Expenditure**
	£000s	**£000s**	**£000s**	**£000s**	**£000s**	**£000s**
Surgery and Specialist Services	192,865	125,796	318,661	182,326	132,437	314,763
Adult Social and Primary Care	224,771	207,997	432,768	208,529	186,982	395,511
Childrens; Community Services	53,817	34,907	88,724	52,255	32,221	84,476
Unscheduled & Acute Care	300,266	99,523	399,789	270,041	107,286	377,327
Specialist Hospitals and Women's Health	153,585	48,243	201,828	150,202	53,297	203,499
Patient and Client Support Services	61,948	14,645	76,593	59,265	15,108	74,373
Research & Development	9,034	900	9,934	8,851	1,446	10,297
Other Trust Service/Corporate Group	137,127	146,257	283,384	85,394	87,636	173,030
Expenditure for Reportable Segments net of Non Cash Expenditure	**1,133,413**	**678,268**	**1,811,681**	**1,016,863**	**616,413**	**1,633,276**
Non Cash Expenditure			**95,266**			**89,796**
Total Expenditure per Net Expenditure Account			**1,906,947**			**1,723,072**
Income Note 4			**102,150**			**116,480**
Net Expenditure			**1,804,797**			**1,606,592**
Revenue Resource Limit			**1,804,979**			**1,606,742**
Surplus against RRL			**182**			**150**

Service costs are allocated to each of the individual Directorates based on the services within that Directorate. Services are allocated to a Directorate based on similarity of nature of service provided. The table below provides a broad overview of the services within each Directorate.

Surgery and Specialist Services	**Adult Social and Primary Care**
Surgical Services	Learning Disability
Cancer Services	Mental Health
Specialist Medicines	Adult, Community & Older People
Pharmacy & Laboratories Services	Psychological Services
Unscheduled & Acute Care	**Patient and Client Support Services**
Anaesthetics, Critical Care, Theatres & Sterile Services	Environmental Cleanliness
Neurosciences, Imaging & Medical Physics ,Allied Health Professionals	Transport Services
Emergency Department, Medical & Cardiology Services	Catering, Portering & Security
Childrens Community Services	**Specialist Hospitals and Women's Health**
Children's Residential Services, Fostering & Adoption	Child Health Services
Children's Gateway and Safeguarding Services	Trauma, Orthopaedics & Rehabilitation Services
Children's Public Health, Community Nursing & Emergency Social Services	Maternity Services
Children With Disability Services	Dental, ENT and Sexual Health Services
Research & Development	**Other Trust Service/Corporate**
Commercial Research	Finance, Estates & Capital Development
Internal research (PHA funded)	HR & Organisational Development
	Performance, Planning & Informatics
	Other Trust wide expenditure, including centrally managed Covid-19 responses costs (e.g. PPE)

Belfast Health And Social Care Trust

Notes to the Accounts for the year ended 31 March 2021

Note 3 Operating Expenses

	2021		2020	
	Trust	Consolidated	Trust	Consolidated
Operating Expenses are as follows:-	£000s	£000s	£000s	£000s
Staff Costs [1]				
Wage and salaries	911,453	911,071	812,717	812,318
Social security costs	77,592	77,592	70,953	70,953
Other pension costs	144,368	144,368	133,193	133,193
Purchase of care from non-HSC bodies	222,616	222,616	195,981	195,981
Personal social services	20,244	20,244	17,795	17,795
Recharges from other HSC organisations	4,503	4,503	5,375	5,375
Supplies and services - Clinical	252,389	252,389	259,624	259,624
Supplies and services - General	45,497	45,497	14,163	14,162
Establishment	9,498	9,498	11,864	11,864
Transport	3,599	3,599	3,602	3,602
Premises	71,067	70,915	62,102	62,076
Bad debts	1,666	1,666	473	473
Rentals under operating leases	1,049	1,049	862	862
Interest charges	1,468	1,468	1,499	1,499
PFI and other service concession arrangements service charges	11,484	11,484	10,917	10,917
BSO services	10,350	10,350	9,914	9,914
Training	3,135	3,128	3,413	3,292
Patients travelling expenses	383	383	914	914
Other charitable expenditure	0	1,203	0	2,236
Miscellaneous expenditure	13,095	13,095	11,701	11,683
Non cash items				
Depreciation - Owned	55,108	55,108	57,616	57,616
Depreciation - PFI	6,144	6,144	6,214	6,214
Amortisation	4,254	4,254	5,133	5,133
Impairments	0	0	15,974	15,974
(Profit) on disposal of property, plant & equipment (excluding profit on land)	(117)	(117)	(76)	(76)
Provisions provided for in year	36,959	36,959	11,690	11,690
Cost of borrowing of provisions (unwinding of discount on provisions)	(929)	(929)	(603)	(603)
Auditors remuneration	72	77	62	67
Add back of notional charitable expenditure	0	(5)	0	(5)
Total	**1,906,947**	**1,907,609**	**1,723,072**	**1,724,743**

[1] Further detailed analysis of staff costs is located in the Staff Report on page 106 within the Accountability Report

During the year the Trust purchased £1.7k non audit services from its external auditor (NIAO), in respect of work carried out on the National Fraud Initiative.

Belfast Health And Social Care Trust

Notes to the Accounts for the year ended 31 March 2021

Note 4 Income

4.1 Revenue from Contracts with Customers

	2021 £000s		2020 £000s	
	Trust £000s	Consolidated £000s	Trust £000s	Consolidated £000s
GB/Republic of Ireland Health Authorities	213	213	827	827
HSC Trusts	1,024	1,024	304	304
Non-HSC:- Private patients	1,535	1,535	3,221	3,221
Non-HSC:- Other	4,632	4,632	2,961	2,961
Clients contributions	38,290	38,290	41,432	41,432
Seconded staff	8,047	7,746	8,202	7,985
Research and development	5,110	5,078	12,652	12,441
Other revenue from non-patient services	32,610	32,610	29,862	29,862
Total	**91,461**	**91,128**	**99,461**	**99,033**

4.2 Other Operating Income

	2021 £000s		2020 £000s	
	Trust £000s	Consolidated £000s	Trust £000s	Consolidated £000s
Other income from non-patient services	4,654	4,446	8,383	8,236
Charitable and other contributions to expenditure by core trust	3,667	3,667	0	0
Donations / Government grant / Lottery funding for non current assets	2,287	2,229	8,636	6,853
Charitable income received by charitable trust fund	0	4,636	0	2,148
Investment income	0	1,083	0	1,304
Profit on disposal of land	81	81	0	0
Total	**10,689**	**16,142**	**17,019**	**18,541**
Total Income	**102,150**	**107,270**	**116,480**	**117,574**

Belfast Health And Social Care Trust

Notes to the Accounts for the year ended 31 March 2021

Note 5.1 Consolidated Property, plant & equipment - 2021

	Land	Buildings (excluding dwellings)	Dwellings	AUC	Plant and Machinery (Equipment)	Transport Equipment	Information Technology (IT)	Furniture and Fittings	Total
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Cost or Valuation									
At 1 April 2020	110,763	1,007,939	35,831	89,420	206,305	11,555	74,334	9,670	1,545,817
Indexation	0	0	0	0	584	0	0	332	916
Additions	716	14,757	760	20,137	26,962	1,231	8,848	116	73,527
Donations/Government grant	440	430	0	0	515	0	862	5	2,252
Transfers	0	0	0	0	9	0	461	0	470
Impairment charged to the SoCNE	0	0	0	0	0	0	0	(2)	(2)
Disposals	0	0	0	0	(12,374)	(1,555)	(33)	0	(13,962)
At 31 March 2021	**111,919**	**1,023,126**	**36,591**	**109,557**	**222,001**	**11,231**	**84,472**	**10,121**	**1,609,018**
Depreciation									
At 1 April 2020	0	5,630	223	0	135,902	7,218	53,328	8,373	210,674
Indexation	0	0	0	0	400	0	0	293	693
Transfers	0	0	0	0	4	0	(4)	0	0
Impairment charged to the SoCNE	0	0	0	0	0	0	0	(2)	(2)
Disposals	0	0	0	0	(12,374)	(1,555)	(33)	0	(13,962)
Provided during the year	0	34,897	1,354	0	17,152	957	6,570	322	61,252
At 31 March 2021	**0**	**40,527**	**1,577**	**0**	**141,084**	**6,620**	**59,861**	**8,986**	**258,655**
Carrying Amount									
At 31 March 2021	**111,919**	**982,599**	**35,014**	**109,557**	**80,917**	**4,611**	**24,611**	**1,135**	**1,350,363**
At 31 March 2020	**110,763**	**1,002,309**	**35,608**	**89,420**	**70,403**	**4,337**	**21,006**	**1,297**	**1,335,143**
Asset financing									
Owned	111,919	982,599	35,014	109,557	59,189	4,611	24,611	1,135	1,328,635
Finance leased	0	0	0	0	0	0	0	0	0
On B/S (SoFP) PFI and other service concession arrangements contracts	0	0	0	0	21,728	0	0	0	21,728
Carrying Amount									
At 31 March 2021	**111,919**	**982,599**	**35,014**	**109,557**	**80,917**	**4,611**	**24,611**	**1,135**	**1,350,363**
Of which:									
Trust	111,919	982,599	35,014	109,557	80,917	4,611	24,611	1,135	1,350,363
Charitable trust fund	0	0	0	0	0	0	0	0	0

Any fall in value through negative indexation or revaluation is shown as an impairment.

The total amount of depreciation charged in the Statement of Comprehensive Net Expenditure in respect of assets held under finance leases and hire purchase contracts is £0 (2019 £0).

The fair value of assets funded from the following sources during the year was:

	2021	2020
	£000s	£000s
Donations	1,812	8,476
Government grant	440	0

RICS, IFRS, IVS & HM Treasury compliant asset revaluation of land and buildings for financial reporting purposes are undertaken by Land and Property Services (LPS) at least once in every five year period. Figures are then restated annually, between revaluations, using indices provided by LPS. The last asset revaluation was carried out on 31 January 2020. LPS have confirmed that, provided the relevant Indexation Categories supplied for the Effective Period 1 April 2020 to 31 March 2021 have been appropriately applied to the corresponding relevant asset classifications, as at 31 March 2021, then the restated 31 January 2020 land and building valuation figures remain appropriate at 31 March 2021.
The valuations were carried out by the following registered valuers; Mr Neil McCall MRICS, Mr Desy Monaghan MRICS, Mr Jonathan Maybin MRICS

As a result of the recent and ongoing COVID-19 pandemic events, and in line with current RICS guidance, LPS have advised that market evidence gathered as part of the recent 5-yearly valuation has attached to it, due to the worldwide impact of the pandemic, an increased level of subjectivity in terms of informing opinions of value. For the avoidance of doubt, this does not mean that figures cannot be relied upon, rather, the declaration of material uncertainty ensures transparency and provides further insight as to the market context under which valuation opinion has been prepared. Whilst at this stage there is no evidence of impairment as at year-end, the future impact of COVID-19 on land and building values cannot yet be accurately assessed therefore, the need for further future valuations will remain under consideration, subject to resources.

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Belfast Health And Social Care Trust

Notes to the Accounts for the year ended 31 March 2021

Note 5.2 Consolidated Property, plant & equipment - 2020

	Land	Buildings (excluding dwellings)	Dwellings	AUC	Plant and Machinery (Equipment)	Transport Equipment	Information Technology (IT)	Furniture and Fittings	Total
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Cost or Valuation									
At 1 April 2019	115,444	1,075,001	40,169	108,484	191,694	10,364	66,560	8,968	1,616,684
Indexation	0	0	0	0	3,050	134	0	18	3,202
Additions	80	16,996	222	32,767	17,431	1,732	7,242	622	77,092
Donations / Government grant	750	4,690	0	0	2,799	0	229	8	8,476
Transfers	0	51,831	0	(51,831)	(54)	0	398	54	398
Revaluation	3,661	69,174	2,230	0	0	0	0	0	75,065
Revaluation accumulated depreciation adj.	0	(186,516)	(6,696)	0	0	0	0	0	(193,212)
Impairment charged to the SoCNE	(14,059)	(11,306)	(72)	0	(1)	0	0	0	(25,438)
Impairment charged to the revaluation reserve	(981)	(15,226)	(134)	0	0	0	0	0	(16,341)
Reversal of impairments (indexn)	5,868	3,483	112	0	0	0	0	0	9,463
Disposals	0	(188)	0	0	(8,614)	(675)	(95)	0	(9,572)
At 31 March 2020	**110,763**	**1,007,939**	**35,831**	**89,420**	**206,305**	**11,555**	**74,334**	**9,670**	**1,545,817**
Depreciation									
At 1 April 2019	0	153,833	5,565	0	125,453	6,653	47,898	7,945	347,347
Indexation	0	0	0	0	2,091	95	0	16	2,202
Transfers	0	0	0	0	(51)	0	80	51	80
Revaluation accumulated depreciation adj.	0	(186,516)	(6,696)	0	0	0	0	0	(193,212)
Impairment charged to the SoCNE	0	0	0	0	(1)	0	0	0	(1)
Disposals	0	(188)	0	0	(8,614)	(675)	(95)	0	(9,572)
Provided during the year	0	38,501	1,354	0	17,024	1,145	5,445	361	63,830
At 31 March 2020	**0**	**5,630**	**223**	**0**	**135,902**	**7,218**	**53,328**	**8,373**	**210,674**
Carrying Amount									
At 31 March 2020	**110,763**	**1,002,309**	**35,608**	**89,420**	**70,403**	**4,337**	**21,006**	**1,297**	**1,335,143**
At 1 April 2019	**115,444**	**921,168**	**34,604**	**108,484**	**66,241**	**3,711**	**18,662**	**1,023**	**1,269,337**
Asset financing									
Owned	110,763	1,002,309	35,608	89,420	47,289	4,337	21,006	1,297	1,312,029
On B/S (SoFP) PFI and other service concession arrangements contracts	0	0	0	0	23,114	0	0	0	23,114
Carrying Amount									
At 31 March 2020	**110,763**	**1,002,309**	**35,608**	**89,420**	**70,403**	**4,337**	**21,006**	**1,297**	**1,335,143**
Asset financing									
Owned	115,444	921,168	34,604	108,484	43,034	3,711	18,662	1,023	1,246,130
On B/S (SoFP) PFI and other service concession arrangements contracts	0	0	0	0	23,207	0	0	0	23,207
Carrying Amount									
At 1 April 2019	**115,444**	**921,168**	**34,604**	**108,484**	**66,241**	**3,711**	**18,662**	**1,023**	**1,269,337**
Carrying amount comprises:									
Trust at 31 March 2021	111,919	982,599	35,014	109,557	80,917	4,611	24,611	1,135	1,350,363
Charitable trust fund at 31 March 2021	0	0	0	0	0	0	0	0	0
	111,919	982,599	35,014	109,557	80,917	4,611	24,611	1,135	1,350,363
Trust at 31 March 2020	110,763	1,002,309	35,608	89,420	70,403	4,337	21,006	1,297	1,335,143
Charitable trust fund at 31 March 2020	0	0	0	0	0	0	0	0	0
	110,763	1,002,309	35,608	89,420	70,403	4,337	21,006	1,297	1,335,143
Trust at 1 April 2019	115,444	921,168	34,604	108,484	66,241	3,711	18,662	1,023	1,269,337
Charitable trust fund at 1 April 2019	0	0	0	0	0	0	0	0	0
	115,444	921,168	34,604	108,484	66,241	3,711	18,662	1,023	1,269,337

Belfast Health And Social Care Trust

Notes to the Accounts for the year ended 31 March 2021

Note 6.1 Consolidated Intangible assets - 2021

	Software Licenses £000s	Information Technology £000s	Total £000s
Cost or Valuation			
At 1 April 2020	40,083	0	40,083
Indexation	0	0	0
Additions	18,652	0	18,652
Donations / Government grant / Lottery funding	35	0	35
Transfers	(470)	0	(470)
Revaluation	0	0	0
Impairment charged to the SoCNE	0	0	0
Disposals	0	0	0
At 31 March 2021	**58,300**	**0**	**58,300**
Amortisation			
At 1 April 2020	29,171	0	29,171
Indexation	0	0	0
Transfers	0	0	0
Revaluation	0	0	0
Impairment charged to the SoCNE	0	0	0
Disposals	0	0	0
Provided during the year	4,254	0	4,254
At 31 March 2021	**33,425**	**0**	**33,425**
Carrying Amount			
At 31 March 2021	**24,875**	**0**	**24,875**
At 31 March 2020	**10,912**	**0**	**10,912**
Asset financing			
Owned	24,875	0	24,875
Finance leased	0	0	0
On B/S (SoFP) PFI and other service concession arrangements contracts	0	0	0
Carrying Amount			
At 31 March 2021	**24,875**	**0**	**24,875**

Any fall in value through negative indexation or revaluation is shown as an impairment.
The fair value of assets funded from the following sources during the year was:

	2021 £000s	2020 £000s
Donations	35	161
Government grant	0	0

Belfast Health And Social Care Trust

Notes to the Accounts for the year ended 31 March 2021

Note 6.2 Consolidated Intangible assets - 2020

	Software Licenses	Information Technology	Total
Cost or Valuation	**£000s**	**£000s**	**£000s**
At 1 April 2019	37,957	0	37,957
Indexation	0	0	0
Additions	2,363	0	2,363
Donations / Government grant / Lottery funding	161	0	161
Transfers	(398)	0	(398)
Revaluation	0	0	0
Impairment charged to the SoCNE	0	0	0
Disposals	0	0	0
At 31 March 2020	**40,083**	**0**	**40,083**
Amortisation			
At 1 April 2019	24,118	0	24,118
Indexation	0	0	0
Transfers	(80)	0	(80)
Revaluation	0	0	0
Impairment charged to the SoCNE	0	0	0
Disposals	0	0	0
Provided during the year	5,133	0	5,133
At 31 March 2020	**29,171**	**0**	**29,171**
Carrying Amount			
At 31 March 2020	**10,912**	**0**	**10,912**
At 1 April 2019	**13,839**	**0**	**13,839**
Asset financing			
Owned	10,912	0	10,912
Finance leased	0	0	0
On B/S (SoFP) PFI and other service concession arrangements contracts	0	0	0
Carrying Amount			
At 31 March 2020	**10,912**	**0**	**10,912**
Asset financing			
Owned	13,839	0	13,839
Finance leased	0	0	0
On B/S (SoFP) PFI and other service concession arrangements contracts	0	0	0
Carrying Amount			
At 1 April 2019	**13,839**	**0**	**13,839**
Carrying amount comprises:			
Trust at 31 March 2021	24,875	0	24,875
Charitable trust fund at 31 March 2021	0	0	0
	24,875	0	24,875
Trust at 31 March 2020	10,912	0	10,912
Charitable trust fund at 31 March 2020	0	0	0
	10,912	0	10,912
Trust at 1 April 2019	13,839	0	13,839
Charitable trust fund at 1 April 2019	0	0	0
	13,839	0	13,839

Belfast Health And Social Care Trust

Notes to the Accounts for the year ended 31 March 2021

Note 7 Financial Instruments

As the cash requirements of the Belfast Health and Social Care Trust are met through Grant-in-Aid provided by the Department of Health, financial instruments play a more limited role in creating and managing risk than would apply to a non-public sector body. The majority of financial instruments relate to contracts to buy non-financial items in line with the Belfast Health and Social Care Trust's expected purchase and usage requirements and the Trust is therefore exposed to little credit, liquidity or market risk.

However the Trust's Charitable Trust Funds are exposed to market risk in its Common Investment Fund Investments of £57,411k as disclosed at note 8.

The only financial instruments held directly by the Trust as at 31 March 2021 are cash, trade and other receivables and trade and other liabilities. Details of these can be seen at Notes 12, 13 and 14 respectively.

Belfast Health And Social Care Trust

Notes to the Accounts for the year ended 31 March 2021

Note 8 Investments and loans

Note 8.1 Investments

	2021			2020		
	Non Current Assets £000s	Assets £000s	Liabilities £000s	Non Current Assets £000s	Assets £000s	Liabilities £000s
Balance at 1 April	46,982	0	0	50,139	0	0
Additions	1,083	0	0	1,674	0	0
Settlements	(1,750)	0	0	0	0	0
Impairments	0	0	0	0	0	0
Revaluations	11,096	0	0	(4,831)	0	0
Balance at 31 March	57,411	0	0	46,982	0	0
Trust	0	0	0	0	0	0
Charitable trust fund	57,411	0	0	46,982	0	0
	57,411	0	0	46,982	0	0

Analysis of expected timing of discounted flows

	2021			2020		
	Non Current Assets £000s	Assets £000s	Liabilities £000s	Non Current Assets £000s	Assets £000s	Liabilities £000s
Not later than one year	0	0	0	0	0	0
Later than one year and not later than five years	0	0	0	0	0	0
Later than five years	57,411	0	0	46,982	0	0
	57,411	0	0	46,982	0	0

Note 8.2 Market value of investments as at 31 March

	Held in UK £000s	Held outside UK £000s	2021 Total £000s	2020 Total £000s
Investment properties	0	0	0	0
Investments listed on Stock Exchange	0	0	0	0
Investments in CIF	57,411	0	57,411	46,982
Investments in a Common Deposit Fund or Investment Fund	0	0	0	0
Unlisted securities	0	0	0	0
Cash held as part of the investment portfolio	0	0	0	0
Investments in connected bodies	0	0	0	0
Other investments	0	0	0	0
Total market value of fixed asset investments	57,411	0	57,411	46,982

The investment above relate to the Common Investment Fund in respect of Charitable Trust Funds.

Note 8.3 Loans

The Belfast Health and Social Care Trust did not have any loans payable at either 31 March 2021 or 31 March 2020.

Belfast Health And Social Care Trust

Notes to the Accounts for the year ended 31 March 2021

Note 9 Impairments

	2021		
	Property, plant & equipment £000s	**Intangibles £000s**	**Total £000s**
Impairments charged / (credited) to Statement of Comprehensive Net Expenditure	0	0	0
Impairments which revaluation reserve covers (shown in Other Comprehensive Expenditure Statement)	0	0	0
Total value of impairments for the year	**0**	**0**	**0**

	2020		
	Property, plant & equipment £000s	**Intangibles £000s**	**Total £000s**
Impairments charged / (credited) to Statement of Comprehensive Net Expenditure	15,974	0	15,974
Impairments which revaluation reserve covers (shown in Other Comprehensive Expenditure Statement)	16,341	0	16,341
Total value of impairments for the year	**32,315**	**0**	**32,315**

Belfast Health And Social Care Trust

Notes to the Accounts for the year ended 31 March 2021

Note 10 Assets Classified As Held For Sale

	Land		Buildings		Total	
	2021 £000s	2020 £000s	2021 £000s	2020 £000s	2021 £000s	2020 £000s
Opening balance at 1 April	170	170	225	225	395	395
Transfers in	0	0	0	0	0	0
Transfers out		0	0	0	0	0
(Disposals)	(170)	0	(225)	0	(395)	0
Impairment charged to the SoCNE	0	0	0	0	0	0
Impairment charged to the revaluation reserve	0	0	0	0	0	0
Closing balance at 31 March	**0**	**170**	**0**	**225**	**0**	**395**

Non current assets held for sale comprise non current assets that are held for resale rather than continuing use with the business.

During the year ended 31 March 2021, the following properties were sold. Fair value at disposal date is shown below:

	£'000
McCartney House 529 Upper Newtownards Road	395

At 31 March 2021 there were no non current assets held for resale

Belfast Health And Social Care Trust

Notes to the Accounts for the year ended 31 March 2021

Note 11 Inventories

	2021		2020	
Classification	**Trust £000s**	**Consolidated £000s**	**Trust £000s**	**Consolidated £000s**
X-ray	222	222	339	339
Pharmacy supplies	12,471	12,471	13,934	13,934
Theatre equipment/supplies	5,511	5,511	4,281	4,281
Community care appliances	195	195	133	133
Laboratory materials	674	674	577	577
Fuel	367	367	360	360
Building & engineering supplies	656	656	717	717
Personal protective equipment	562	562	0	0
Provision for slow moving stock	(54)	(54)	0	0
Total	**20,604**	**20,604**	**20,341**	**20,341**

Belfast Health And Social Care Trust

Notes to the Accounts for the year ended 31 March 2021

Note 12 Cash and Cash Equivalents

	2021			2020		
	Trust £000s	CTF £000s	Consolidated £000s	Trust £000s	CTF £000s	Consolidated £000s
Balance at 1 April	22,039	1,131	23,170	15,266	1,143	16,409
Net change in cash and cash equivalents	(8,767)	(189)	(8,956)	6,773	(12)	6,761
Balance at 31 March	**13,272**	**942**	**14,214**	**22,039**	**1,131**	**23,170**

	2021			2020		
The following balances at 31 March were held at	Trust £000s	CTF £000s	Consolidated £000s	Trust £000s	CTF £000s	Consolidated £000s
Commercial banks and cash in hand	13,272	942	14,214	22,039	1,131	23,170
Balance at 31 March	**13,272**	**942**	**14,214**	**22,039**	**1,131**	**23,170**

Note 12.1 Reconciliation of Liabilities arising from Financing Activities

	2020 £000s	Cash flows £000s	Non-Cash Changes £000s	2021 £000s
Capital element of payments - finance leases and on balance sheet (SoFP) PFI and other service concession arrangements	13,431	(6,708)	6,675	**13,398**
Total liabilities from financing activities	13,431	(6,708)	6,675	**13,398**

Belfast Health And Social Care Trust

Notes to the Accounts for the year ended 31 March 2021

Note 13 Trade Receivables, Financial and Other Assets

	2021		2020	
	Trust £000s	Consolidated £000s	Trust £000s	Consolidated £000s
Amounts falling due within one year				
Trade receivables	3,721	3,721	2,433	2,433
Deposits and advances	0	0	1	1
VAT receivable	19,032	19,048	17,741	17,784
Other receivables - not relating to fixed assets	32,008	35,039	24,035	23,864
Other receivables - relating to property plant and equipment	805	775	3,541	1,761
Other receivables - relating to intangibles	0	0	0	0
Trade and other receivables	55,566	58,583	47,751	45,843
Prepayments and accrued income	1,296	1,296	1,293	1,293
Contract assets	0	0		0
Current part of PFI and other service concession arrangements prepayment	0	0		0
Other current assets	1,296	1,296	1,293	1,293
Carbon reduction commitment	0	0	0	0
Intangible current assets	0	0	0	0
Amounts falling due after more than one year				
Trade receivables	0	0	0	0
Deposits and advances	0	0	0	0
Other receivables	0	0	0	0
Trade and other receivables	0	0	0	0
Prepayments and accrued income	0	0	0	0
Other current assets falling due after more than one year	0	0	0	0
Total Trade and Other Receivables	55,566	58,583	47,751	45,843
Total Other Current Assets	1,296	1,296	1,293	1,293
Total Intangible Current Assets	0	0	0	0
Total Receivables and Other Current Assets	**56,862**	**59,879**	**49,044**	**47,136**

The balances are net of a provision for bad debts of £6,457k (2020 £4,995k)

Belfast Health And Social Care Trust

Notes to the Accounts for the year ended 31 March 2021

Note 14 Trade Payables and Other Current Liabilities

	2021		2020	
	Trust £000s	Consolidated £000s	Trust £000s	Consolidated £000s
Amounts falling due within one year				
Other taxation and social security	38,727	38,727	47,173	47,173
Trade capital payables - property, plant and equipment	53,956	53,608	42,551	42,551
Trade revenue payables	95,456	95,456	103,481	103,481
Payroll payables	123,099	123,099	60,862	60,862
Clinical negligence payables	457	457	300	300
VER payables	0	0	0	0
BSO payables	7,222	7,222	2,996	2,996
Other payables	12,632	12,678	5,834	5,921
Accruals and deferred income	240	240	173	173
Trade and other payables	331,789	331,487	263,370	263,457
Current part of imputed finance lease element of on balance sheet (SoFP) PFI and other service concession arrangements contracts	2,800	2,800	2,227	2,227
Other current liabilities	2,800	2,800	2,227	2,227
Carbon reduction commitment	0	0	0	0
Intangible current liabilities	0	0	0	0
Total payables falling due within one year	334,589	334,287	265,597	265,684
Amounts falling due after more than one year				
Imputed finance lease element of on balance sheet (SoFP) PFI and other service concession arrangements contracts	10,598	10,598	11,204	11,204
Long term loans	0	0	0	0
Total non current other payables	10,598	10,598	11,204	11,204
Total Trade Payables and Other Current Liabilities	**345,187**	**344,885**	**276,801**	**276,888**

Belfast Health And Social Care Trust

Notes to the Accounts for the year ended 31 March 2021

Note 15 Provisions for Liabilities and Charges - 2021

	Pensions relating to other staff £000s	Clinical negligence £000s	Other £000s	Total £000s
Balance at 1 April 2020	0	90,582	10,744	101,326
Provided in year	0	36,268	2,671	38,939
(Provisions not required written back)	0	(1,527)	(453)	(1,980)
(Provisions utilised in the year)	0	(6,947)	(865)	(7,812)
Cost of borrowing (unwinding of discount)	0	(806)	(123)	(929)
At 31 March 2021	**0**	**117,570**	**11,974**	**129,544**

Comprehensive Net Expenditure Account charges	**£000s**	**2021 £000s**	**2020**
Arising during the year	38,939	17,519	
Reversed unused	(1,980)	(5,829)	
Cost of borrowing (unwinding of discount)	(929)	(603)	
Total charge within Operating expenses	**36,030**	**11,087**	

Analysis of expected timing of discounted flows

	Pensions relating to other staff £000s	Clinical negligence £000s	Other £000s	Total £000s
Not later than one year	0	29,982	3,032	33,014
Later than one year and not later than five years	0	22,750	1,675	24,425
Later than five years	0	64,838	7,267	72,105
At 31 March 2021	**0**	**117,570**	**11,974**	**129,544**

Pensions relating to other staff is in relation to early retirement costs.

The provision for pensions is determined on the basis of information on current annual pension rates payable over average life expectancy derived from government actuarial tables and on payments made to HSC Pensions Branch. The provisions for Clinical Negligence, Employers and Public Liability have been determined by assigning probabilities to expected settlement values.

Belfast Health And Social Care Trust

Notes to the Accounts for the year ended 31 March 2021

Note 15.1 Provisions for Liabilities and Charges - 2020

	Pensions relating to other staff £000s	Clinical negligence £000s	Other £000s	Total £000s
Balance at 1 April 2019	0	91,403	9,690	101,093
Provided in year	0	14,747	2,772	17,519
(Provisions not required written back)	0	(5,596)	(233)	(5,829)
(Provisions utilised in the year)	0	(9,435)	(1,419)	(10,854)
Cost of borrowing (unwinding of discount)	0	(537)	(66)	(603)
At 31 March 2020	**0**	**90,582**	**10,744**	**101,326**

Provisions have been made for 4 types of potential liability: Clinical negligence, Employers Liability and Occupiers Liability and Injury Benefit. The provision for Injury Benefit relates to the future liabilities for the Trust based on information provided by the HSC Pensions Branch. For Clinical Negligence, Employer's and Occupier's claims the Trust has estimated an appropriate level of provision based on professional legal advice.

Analysis of expected timing of discounted flows

	Pensions relating to other staff £000s	Clinical negligence £000s	Other £000s	Total £000s
Not later than one year	0	27,100	1,896	28,996
Later than one year and not later than five years	0	14,734	1,717	16,451
Later than five years	0	48,748	7,131	55,879
At 31 March 2020	**0**	**90,582**	**10,744**	**101,326**

Belfast Health And Social Care Trust

Notes to the Accounts for the year ended 31 March 2021

Note 16 Capital and Other Commitments

16.1 Capital commitments

Contracted capital commitments at 31 March not otherwise included in these financial statements :

	2021 £000s	2020 £000s
Property, plant & equipment	22,360	19,511
Intangible assets	0	0
	22,360	19,511

16.2 Other financial commitments

The Belfast Health and Social Care Trust has not entered into any non cancellable contracts (which are not leases, PFI or other service concession arrangement contracts) in the current or previous financial year.

Belfast Health And Social Care Trust

Notes to the Accounts for the year ended 31 March 2021

Note 17 Commitments Under Leases (IAS 17 disclosures)

17.1 Operating Leases

Total future minimum lease payments under operating leases are given in the table below for each of the following periods:

Obligations under operating leases comprise	2021 £000s	2020 £000s
Land		
Not later than 1 year	0	0
Later than 1 year and not later than 5 years	0	0
Later than 5 years	0	0
	0	**0**
Buildings		
Not later than 1 year	998	594
Later than 1 year and not later than 5 years	1,575	1,322
Later than 5 years	118	193
	2,691	**2,109**
Other		
Not later than 1 year	108	101
Later than 1 year and not later than 5 years	149	201
Later than 5 years	0	0
	257	**302**

Total future minimum lease income under operating leases are given in the table below for each of the following periods.

Obligations under operating leases issued by the Trust comprise	2021 £000s	2020 £000s
Land & Buildings		
Not later than 1 year	483	472
Later than 1 year and not later than 5 years	210	210
Later than 5 years	1,314	1,366
	2,007	**2,048**
Other		
Not later than 1 year	0	0
Later than 1 year and not later than 5 years	0	0
Later than 5 years	0	0
	0	**0**

17.2 Finance Leases

The Trust have included within its fixed assets a number of land and buildings held under leasehold arrangements. Under accounting standard IAS 17 'Accounting for leases', the Trust have assessed these land and buildings to be finance leases in nature. However, the associated financial obligations of these finance leases are deemed insignificant and therefore no finance lease creditor has been recorded in the accounts in this respect.

Belfast Health And Social Care Trust

Notes to the Accounts for the year ended 31 March 2021

Note 18 Commitments Under PFI and other Service Concession Arrangement Contracts

18.1 Off balance sheet PFI and other service concession arrangements schemes

The Trust had no off balance sheet PFI schemes during 2020-21.

18.2 On balance sheet (SoFP) PFI Schemes

The total amount charged in the Statement of Comprehensive Net Expenditure in respect of the service element of on-balance sheet (SoFP) PFI or other service concession transactions was £11,484k (2020: £10,917k). Total future obligations under on-balance sheet PFI and other service concession arrangements are given in the table below for each of the following periods:

	2021	2020
Minimum lease payments	**£000s**	**£000s**
Due within one year	4,317	4,209
Due later than one year and not later than five years	8,875	9,487
Due later than five years	9,094	10,605
Total	22,286	24,301
Less interest element	8,231	9,700
Present value	**14,055**	**14,601**

	2021	2020
Service elements due in future periods	**£000s**	**£000s**
Due within one year	3,078	2,740
Due later than one year and not later than five years	4,717	5,073
Due later than five years	6,260	6,788
Total service elements due in future periods	**14,055**	**14,601**

The on balance sheet PFI schemes included above are as follows:

- Cancer Centre (25 year contract ending December 2030)
- Managed Equipment Service (MES) / ATICS (15 year contract ending September 2021)

Belfast Health And Social Care Trust

Notes to the Accounts for the year ended 31 March 2021

Note 19 Contingent Liabilities

Material contingent liabilities are noted in the table below, where there is a 50% or less probability that a payment will be required to settle any possible obligations. The amounts or timing of any outflow will depend on the merits of each case.

	2021 £000s	2020 £000s
Clinical negligence	4,877	5,112
Public liability	59	78
Employers' liability	294	354
Accrued leave	0	0
Injury benefit	0	0
Other	20	21
Total	**5,250**	**5,565**

A discount rate is applied by courts to a lump-sum award of damages for future financial loss in a personal injury case, to take account of the return that can be earned from investment. Currently the rate in Northern Ireland has to be set in accordance with principles set out by the House of Lords in Wells v Wells. The Department of Justice made a statutory rule on 29 April 2021 changing the rate, under the Wells v Wells framework, (from 2.5%) to -1.75%, with effect from 31 May 2021. The Department has also brought forward a Bill to change how the rate is set. The Damages (Return on Investment) Bill was introduced to the Assembly on 1 March 2021 and is currently at Committee Stage. Subject to the legislative process, it is anticipated that the Bill will be enacted early next year and the rate would then be reviewed under the new framework. There were three cases settled under a periodic payment order where the estimated impact of the change in discount rate has been included in the clinical negligence provisions figure. However, for cases not yet settled, it was not possible to quantify the additional financial liability at this stage as this is a significant task given the number of claims involved. As such, a review will be undertaken in 2021-22 to establish the increase in liability that has arisen from the decrease in discount factor as personal injury compensation will be inflated for existing future loss.

The Court of Appeal (CoA) judgment from 17 June 2019 (PSNI v Agnew) determined that claims for Holiday Pay shortfall can be taken back to 1998. However, the PSNI has appealed the CoA judgment to the Supreme Court. The Supreme Court hearing was scheduled for the 23rd and 24th June 2021 but this has subsequently been adjourned. Based on the position in the NHS in England, Scotland and Wales, an accrual at 31 March 2021 has been calculated by HSC management for the liability and is included in these accounts. However, the extent to which the liability may exceed this amount remains uncertain as the calculation has not been agreed with Trade Unions. The potential additional financial effect of this is unquantifiable at present.

The Trust utilises a system called Allocate to monitor Junior Doctors hours to ensure it reflects appropriate working patterns for trainee doctors and supports the Trust in adhering to the European working time directive and the new deal for doctors in training. The Hallett v Derby Hospitals NHS Foundation Trust in June 2019 brought a software algorithm issue to light in respect of these monitoring outcomes, in that the methodology by which NHS Trusts applied monitoring rules were incorrect. The algorithm has been corrected and released through a software update in April 2020. However, there is an implication that rotas previously determined to be compliant may no longer be compliant, thus giving rise to a potential financial liability. Until a review can be undertaken it is not possible to confirm if there have been any cases of non compliance, therefore, there is uncertainty around the number of instances of non-compliance (if any). As such, this cannot be quantified at this time. However, a further monitoring exercise is scheduled to take place during 2021-22 which will seek to bring to light any incidences of non-compliance. This information will then be reviewed by the Trust to determine further actions, including remuneration, where appropriate.

A cyber security incident took place at Queen's University Belfast (QUB) in February 2021. As the HSC has multiple contractual interactions with QUB, some concerning personal information, the HSC technology teams, with the backing of the HSC SIRO's, took a number of actions to reduce potential disruption to HSC services, and continue to liaise with QUB on the impact of the cyber incident. The impact on the HSC is being fully investigated, and there may be a financial risk in relation to possible future liability, for potential claims for loss of personal data. As the breach occurred in a third party's systems the potential for liability is unclear and any financial impact is unquantifiable at present

Note 19.1 Financial Guarantees, Indemnities and Letters of Comfort

The Belfast Health and Social Care Trust did not have any financial instruments at either 31 March 2021 or 31 March 2020.

Belfast Health And Social Care Trust

Notes to the Accounts for the year ended 31 March 2021

Note 20 Related Party Transactions

The Trust is required to disclose details of transactions with individuals who are regarded as related parties consistent with the requirements of IAS 24 – Related Party Transactions. This disclosure is recorded in the Trust's Register of Interests which is maintained by the Office of the Chief Executive and is available for inspection by members of the public.

During the year the Belfast Health and Social Care Trust entered into the following material transactions with the following related parties.

HSC Bodies

The Belfast Health and Social Care Trust is an arms length body of the Department of Health, and as such the Department is a related party and the ultimate controlling parent with which the Trust has had various material transactions during the year. During the year the Trust has had a number of material transactions with other entities for which the Department is regarded as the ultimate controlling parent. These entities include the Health and Social Care Board, the five HSC Trusts and the Business Services Organisation.

Non Executive Directors

Some of the Trust's Non-Executive Directors have disclosed interests with organisations which the Trust purchased services from or supplied services to during 2020-21. Set out below are details of the amount paid to these organisations during 2020-21. In none of these cases listed did the Non-Executive Directors have any involvement in the decisions to procure the services from the organisations concerned.

	Service Provided by Organisation	Payments to Related Party £000s	Income from Related Party £000s	Amounts owed to Related Party £000s	Amounts due from Related Party £000s
2020-21					
Northern Ireland Water	Water Services	1,565	0	147	0
Florence Nightingale Foundation	Nursing Education Charity	1	0	0	0
University of Ulster	Education & Training	353	70	165	0
Open University	Education & Training	38	0	0	0
Queens University Belfast	Joint appointments, premises, research	6,200	2,505	888	349
Queens Nursing Institute	Nursing Charity	0	0	0	0
Royal College of Nursing	Nursing Practice & Education	2	9	0	0
NI Social Care Council	Social Care Practice & Education	0	7	0	0
Northern Ireland Fire & Rescue Service	Fire & Rescue Services	0	20	0	0
2019-20					
Northern Ireland Water	Water Services	1,767	0	4	0
Florence Nightingale Foundation	Nursing Education Charity	0	0	0	0
University of Ulster	Education & Training	204	229	38	12
Open University	Education & Training	18	0	0	0
Queens University Belfast	Joint appointments, premises, research	6,530	2,828	2,022	87
Queens Nursing Institute	Nursing Charity	1	0	0	0
Royal College of Nursing	Nursing Practice & Education	2	31	0	6
NI Social Care Council	Social Care Practice & Education	0	8	0	0
Northern Ireland Fire & Rescue Service	Fire & Rescue Services	0	20	0	0

Belfast Health And Social Care Trust

Notes to the Accounts for the year ended 31 March 2021

Note 20 Related Party Transactions (Cont'd)

Interests in the above organisations were declared by the following Board members:-

Mr P McNaney (Chairman) is a Non Executive Director of Northern Ireland Water and member of the council of the University of Ulster.
Prof M Bradley (Non-Executive Director) is a visiting Professor Nursing for University of Ulster and an Honorary Master at the Open University; a Fellow of Royal College of Nursing and the Queens Nursing Institute, and is a Trustee of the Florence Nightingale Foundation.

Ms A O'Reilly (Non-Executive Director) is a Non-Executive Director for NI Social Care Council

Mr G Smyth (Non-Executive Director) is a Non-Executive Director for the Northern Ireland Fire & Rescue Service

Prof D Jones (Non-Executive Director) is a Professor at Queens University Belfast.

Transactions with these related parties are conducted on an arm's length basis. The purchase of goods and services are subject to the normal tendering processes under Northern Ireland Public Procurement Policy, Trust Standing Orders and Standing Financial Instructions. There are no provisions for doubtful debts against the related party balances owed. In addition, the Trust has not provided or received any financial guarantees in respect of any related parties identified.

Other Board Members and Senior Managers

In a similar way, some other Trust Board members and Senior Managers have disclosed interests in organisations from which the Trust purchased services in 2020-21. The details are set out below. Again, the officers listed had no involvement in the decisions to procure the services from the organisations concerned.

	Service Provided by Organisation	Payments to Related Party £000s	Income from Related Party £000s	Amounts owed to Related Party £000s	Amounts due from Related Party £000s
2020-21					
Employers for Childcare	Childcare charity	0	0	0	0
Healthcare Financial Management Association	Professional Body	1	0	0	0
2019-20					
Employers for Childcare	Childcare charity	1	0	0	0
Healthcare Financial Management Association	Professional Body	3	0	3	0

Interests in the above organisations were declared by the following Board members:-

Mrs J Kennedy (Director) is a Board member for Employers for Childcare
Mrs M Edwards (Executive Director) is a Trustee of HFMA and Chair of the NI Branch

Note 21 Third Party Assets

The Trust held £3,898,376 Cash at bank and in hand and £3,622,205 short term investments at 31 March 2021 which relates to monies held by the Trust on behalf of patients. This has been excluded from cash at bank and in hand figure reported in the accounts. A separate audited account of these monies is maintained by the Trust.

Belfast Health And Social Care Trust

Notes to the Accounts for the year ended 31 March 2021

Note 22 Financial Performance Targets

22.1 Revenue Resource Limit

The Trust is given a Revenue Resource Limit which it is not permitted to overspend

The Revenue Resource Limit (RRL) for Belfast Health and Social Care Trust is calculated as follows:

	2021 Total £000s	2020 Total £000s
HSCB	1,669,205	1,482,817
PHA	19,707	18,941
SUMDE & NIMDTA	22,659	22,220
DoH (excludes non cash)	0	0
Other Government Departments	0	0
Non cash RRL (from DoH)	95,266	89,796
Total agreed RRL	1,806,837	1,613,774
Adjustment for income received re Donations / Government grant / Lottery funding for non current assets	(2,287)	(8,636)
Adjustment for PFI and other service concession arrangements/IFRIC 12	905	1,067
Adjustment for PPE Stock	(562)	0
Adjustment for research and development under ESA10	86	537
Total Revenue Resource Limit to Statement Comprehensive Net Expenditure	1,804,979	1,606,742

22.2 Capital Resource Limit

The Trust is given a Capital Resource Limit (CRL) which it is not permitted to overspend.

	2021 Total £000s	2020 Total £000s
Gross capital expenditure	94,466	88,092
Less charitable trust fund capital expenditure	(2,287)	(8,637)
Less IFRIC 12/PFI and other service concession arrangements spend	(4,693)	(5,730)
(Receipts from sales of fixed assets)	(395)	0
Net capital expenditure	87,091	73,725
Capital Resource Limit	87,531	74,696
Adjustment for research and development under ESA10	(86)	(537)
Overspend/(Underspend) against CRL	(354)	(434)

Belfast Health And Social Care Trust

Notes to the Accounts for the year ended 31 March 2021

22.3 Financial Performance Targets

The Trust is required to ensure that it breaks even on an annual basis by containing its net expenditure to within 0.25 % of RRL limits

	2021 £000s	2020 £000s
Net Expenditure	(1,804,797)	(1,606,592)
RRL	1,804,979	1,606,742
Surplus against RRL	182	150
Break Even cumulative position (opening)	1,405	1,255
Break Even cumulative position (closing)	1,587	1,405

Materiality Test:

	2021 %	2020 %
Break Even in year position as % of RRL	0.01%	0.01%
Break Even cumulative position as % of RRL	0.09%	0.09%

Note 23 Post Balance Sheet Events

There are no post balance sheet events having a material effect on the accounts.

Date Authorised For Issue

The Accounting Officer authorised these financial statements for issue on 2 July 2021.

Account of monies held on behalf of Patients/Residents for the year ended 31 March 2021

Belfast Health And Social Care Trust

Accounts for the year ended 31 March 2021

Statement of Trust's Responsibilities in relation to Patients/Residents Monies

Under the Health and Personal Social Services (Northern Ireland) Order 1972 (as amended by Article 6 of the Audit and Accountability (Northern Ireland) Order 2003, the Trust is required to prepare and submit accounts in such form as the Department may direct.

The Trust is also required to maintain proper and distinct accounting records and is responsible for safeguarding the monies held on behalf of patients/residents and for taking reasonable steps to prevent and detect fraud and other irregularities.

FINANCIAL STATEMENTS

Belfast Health And Social Care Trust

Accounts for the year ended 31 March 2021

Account Of Monies Held On Behalf Of Patients/Residents

Previous Year	**RECEIPTS**		
£	**Balance at 1 April 2020**	**£**	**£**
3,610,225	1. Investments (at cost)	3,622,023	
2,985,091	2. Cash at Bank	3,169,198	
18,246	3. Cash in Hand	27,572	6,818,793
3,668,052	Amounts Received in the Year		4,067,898
11,798	Interest Received		182
10,293,412	**TOTAL**		**10,886,873**
	PAYMENTS		
3,474,619	Amounts Paid to or on behalf of Patients/Residents		3,366,292
	Balance at 31 March 2021		
3,622,023	1. Investments (at cost)	3,622,205	
3,169,198	2. Cash at Bank	3,883,753	
27,572	3. Cash in Hand	14,623	7,520,581
10,293,412	**TOTAL**		**10,886,873**

Schedule of investments held at 31 March 2021

Cost Price £	**Investment**	Nominal Value £	Cost Price £
3,622,023	Bank of Ireland		3,622,205

I certify that the above account has been compiled from and is in accordance with the accounts and financial records maintained by the Trust.

Director of Finance Maureen Edwards

Date 10 June 2021

I certify that the above account has been submitted to and duly approved by the Board

Chief Executive Cathy Jack

Date 10 June 2021

BELFAST HEALTH AND SOCIAL CARE TRUST – PATIENTS' AND RESIDENTS' MONIES

THE CERTIFICATE AND REPORT OF THE COMPTROLLER AND AUDITOR GENERAL TO THE NORTHERN IRELAND ASSEMBLY

Opinion on account

I certify that I have audited Belfast Health and Social Care Trust's account of monies held on behalf of patients and residents for the year ended 31 March 2021 under the Health and Personal Social Services (Northern Ireland) Order 1972, as amended.

In my opinion the account:

- properly presents the receipts and payments of the monies held on behalf of the patients and residents of Belfast Health and Social Care Trust for the year ended 31 March 2021 and balances held at that date; and
- the account has been properly prepared in accordance with the Health and Personal Social Services (Northern Ireland) Order 1972, as amended and Department of Health directions issued thereunder.

Opinion on regularity

In my opinion, in all material respects the financial transactions recorded in the account statements conform to the authorities which govern them.

Basis for opinions

I conducted my audit in accordance with International Standards on Auditing (ISAs) (UK), applicable law and Practice Note 10 'Audit of Financial Statements of Public Sector Entities in the United Kingdom'. My responsibilities under those standards are further described in the Auditor's responsibilities for the audit of the account section of this certificate. My staff and I are independent of Belfast Health and Social Care Trust in accordance with the ethical requirements of the Financial Reporting Council's Revised Ethical Standard 2019, and have fulfilled our other ethical responsibilities in accordance with these requirements.

I believe that the audit evidence obtained is sufficient and appropriate to provide a basis for my opinions.

Conclusions relating to going concern

In auditing the financial statements, I have concluded that Belfast Health and Social Care Trust's use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work I have performed, I have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the Belfast Health and Social Care Trust's ability to continue as a going concern for a period of at least twelve months from when the financial statements are authorised for issue.

The going concern basis of accounting for Belfast Health and Social Care Trust is adopted in consideration of the requirements set out in the Government Reporting Manual, which require entities to adopt the going concern basis of accounting in the preparation of the financial statements where it is anticipated that the services which they provide will continue in the future.

My responsibilities and the responsibilities of the Accounting Officer with respect to going concern are described in the relevant sections of this report.

Matters on which I report by exception

I have nothing to report in respect of the following matters which I report to you if, in my opinion:

- adequate accounting records have not been; or
- the account is not in agreement with the accounting records; or
- I have not received all of the information and explanations I require for my audit.

Responsibilities of the Trust for the account

As explained more fully in the Statement of Trust's Responsibilities in relation to patients'/residents' monies, the Trust is responsible for:

- the preparation of the account in accordance with the applicable financial reporting framework and for being satisfied that they properly present the receipts and payments of the monies held on behalf of the patients and residents;
- such internal controls as the Trust determines is necessary to enable the preparation of financial statements that are free form material misstatement, whether due to fraud or error;
- assessing the Belfast Health and Social Care Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the Trust anticipates that the services provided by Belfast Health and Social Care Trust will not continue to be provided in the future.

Auditor's responsibilities for the audit of the account

My responsibility is to audit, certify and report on the financial statements in accordance with the Health and Personal Social Services (Northern Ireland) Order 1972, as amended.

My objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error and to issue a certificate that includes my opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

I design procedures in line with my responsibilities, outlined above, to detect material misstatements in respect of non-compliance with laws and regulation, including fraud.

My procedures included:

- obtaining an understanding of the legal and regulatory framework applicable to the Belfast Health and Social Care Trust through discussion with management and application of extensive public sector accountability knowledge. The key laws and regulations I considered included Health and Personal Social Services (Northern Ireland) Order 1972, as amended;
- making enquires of management and those charged with governance on Belfast Health and Social Care Trust's compliance with laws and regulations;

- making enquiries of internal audit, management and those charged with governance as to susceptibility to irregularity and fraud, their assessment of the risk of material misstatement due to fraud and irregularity, and their knowledge of actual, suspected and alleged fraud and irregularity;
- completing risk assessment procedures to assess the susceptibility of Belfast Health and Social Care Trust's financial statements to material misstatement, including how fraud might occur. This included, but was not limited to, an engagement director led engagement team discussion on fraud to identify particular areas, transaction streams and business practices that may be susceptible to material misstatement due to fraud;
- engagement director oversight to ensure the engagement team collectively had the appropriate competence, capabilities and skills to identify or recognise non-compliance with the applicable legal and regulatory framework throughout the audit;
- designing audit procedures to address specific laws and regulations which the engagement team considered to have a direct material effect on the financial statements in terms of misstatement and irregularity, including fraud. These audit procedures included, but were not limited to, reading board and committee minutes, and agreeing financial statement disclosures to underlying supporting documentation and approvals as appropriate;
- addressing the risk of fraud as a result of management override of controls by:
    - performing analytical procedures to identify unusual or unexpected relationships or movements;
    - testing journal entries to identify potential anomalies, and inappropriate or unauthorised adjustments;
    - assessing whether judgements and other assumptions made in determining accounting estimates were indicative of potential bias; and
    - investigating significant or unusual transactions made outside of the normal course of business.

A further description of my responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website www.frc.org.uk/auditorsresponsibilities. This description forms part of my certificate.

In addition, I am required to obtain evidence sufficient to give reasonable assurance that the financial transactions recorded in the account conform to the authorities which govern them.

Report

I have no observations to make on this account.

KJ Donnelly
Comptroller and Auditor General
Northern Ireland Audit Office
1 Bradford Court
BELFAST
BT8 6RB
2 July 2021

FINANCIAL STATEMENTS

BT21-2441

MAHI - STM - 102 - 10650

MH&LD Summary 200 10

S C L L M T LH LTH L S BLT

C B L C SC C TH LT M CH

	M TH											
M L M TL	**L**	**M**		**L**		**S T**	**CT**		**C**		**B**	**M**
No of Disciplinary appeal cases							1	1	1	1	1	
No of grievance at stage 2	2	2	2	2	2	1		2	2	3		1
No of grievances stage 1	3	5	2	2	1	1	2	2	5	5	5	1
No. of Disciplinary cases	3	5	3	2	1	2				1	1	3
No. of Informal Resolution stage	2	2									1	
No. of investigations												11
No. of suspensions	3	3	3	3	2	3	3	3	3	3	3	3
No. of tribunal cases	3	5	3	3	3	2	2	1	2	2	2	2
rand Total												

	M TH													
M L S	**L**	**M**		**L**		**S T**	**CT**		**C**		**B**	**M**	**rand Total**	**ot approved**
Compressed Working	1		1		1	1					1	1		
Employment Break		1	1				2					1		1
Flexi time							1		1	1				
Flexible Retirement			1	1	2	1						2		
obshare														
Part time working	2		1	2	2		1				1	1		3
Term time working	15													1

L L M T	**Mar pr**	**pr May**	**May n**	**n l**	**l g**	**g Sep**	**Sep ct**	**ct ov**	**ov ec**	**ec an**	**an e**	**e Mar**	**rand Total**
Corporate Welcome	50.00	0.00	2 . 0	53. 0	5.00	3.30	100.00	.50	0. 0	. 0	2 . 0	1. 0	.30

L L M T	**Sep**	**ct**	**ov**	**ec**	**an**	**e**	**Mar**	**rand Total**
TAR ET BY MARCH 2010	0							
PCF Compliance	0.00							

	M TH												
TT C M M T	**L**	**M**		**L**		**S T**	**CT**		**C**		**B**	**M**	**rand Total**
Ill health redeployments	0	0	0	0	0	0	0	0	0	0	0	0	
Ill Health retirements	0	1	0	0	0	0	0	0	0	1	0	0	
Ill Health Terminations	1	0	1	1	0	1	0	0	1	0	1	1	
rand Total													

MAHI - STM - 102 - 10651

MH&LD Summary 200 10

S C SS BS C	L	to M	to	to L	to	to S T	to CT	to	to C	to	to B	to M
TAR ET BY MARCH 2010 5. 2												
OVERALL ABSENCE FOR MH&LD	5.5	5.3	5.	5.	.03	.15	.3	.52	.5	.	. 1	. 5
OVERALL ABSENCE FOR	3.1	2.2	1. 1	1.	1. 5	1. 1	1. 3	1. 2	1.	1.	1. 2	1.
OVERALL ABSENCE FOR LON TERM	2.	3.1	3.	.1	.1	.3	.5	.	.	.	.	.

	M TH												
	L	M		L		S T	CT		C		B	M	rand Total
gency spend		02	2 2 1 3	21 5	23 3 3	21	235 331	15 2	133 1 5		5 503	111 005	2 12 15

	M TH											
	L	M		L		S T	CT		C		B	M
T rnover rate	0. 0	0.5	0. 0	0.	1. 5	0.	0.1	0.33	0. 5	0. 5	1.3	0. 3
olling ont t rnover rate	.2	.0	.1	.0	.00	5. 1	5. 5	5. 2	5. 1	.1	.35	. 5

	M TH												
C TM T CT T	L	M		L		S T	CT		C		B	M	rand Total
ob Requisitions received	1	13		15	53	31	11	11	1		1	15	
Vacancies filled	1	12	13	11		11	1	15		1	1	12	

	M TH											
S LL M	L	M		L		S T	CT		C		B	M
M T TB M CH												
Nursing & Midwifery Ratio	1:3	1:3	1:3	1:3	1:3	1:3	1.3	1.3	0.	1.3	1.3	0.
H T TB M CH												
Allied Health Professions Ratio	:1	:1	:1	:1	5:15	5:15	.1	5.15	5.15	.1	.1	.1
CT TB M CH												
Admin & Clerical staff as of total staff	0. 1	0. 2	0. 1	0.	0. 3	0. 2	0. 0	0. 1	0. 2	0. 3	0. 2	0. 2

	M TH																									
	L		M			L				S T		CT				C			B		M		rand Total	
MB M T T L	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE	H C	T
Staff on Maternity Leave in month		3 .5	51	1.	2	3 .	0	33.	0	35.	1	35.	33	2 .	33	2 .53	3	32. 5	32	2 .3	0	3 .0	3	3 .	N/A	N/A
Staff returned from maternity leave in month	3	2.	12	10	5	3. 5		2.1		.53		2.	2	1.	5	.3		3.31	5	.	3	3	2	2		
Staff commenced maternity leave in month	3	2. 1	5	5	3	3	3	2.5				.1	5	5		. 3	1	1	11	. 2	5	. 5		.51		

MAHI - STM - 102 - 10652

MH&LD Summary 200 10

MAHI - STM - 102 - 10653

MH&LD Summary 200 10

	L		M				L				S T		CT				C				B		M		rand Total	
er of Starters	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE	H C	T
	1	15.53		3.	10	.1	10	.3	2	2 .23	5	.53	1	12. 3	12	10.	5	.			20	1 .	11	.55		

	L		M				L				S T		CT				C				B		M		rand Total	
er of Leavers	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE	H C	T
	11	.5	10	.5	11	10.1		.03	33	31. 3	1	1 . 1		2.2		5.3	1	11. 2	13	11.	25	23. 1	1	1 .		

M TH

	L		M				L				S T		CT				C				B		M		rand Total	
S L	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE	H C	T
Age Retirement	2	1.5	1	0.	2	2	3	3	2	1. 3	1	0.	1	0.55	3	2.5		2.51	5	3.	3	3	5	3.		
Caring for children																	1	0.								
Death																	1	1								
Disciplinary action											2	2														
End fixed term contract	1	0.2			1	1					2	2					5	2.5			12	12	1	1		
Family																					1	1				
Further education/training							1	1	3	3	2	2														
Ill Health Termination	1	1			1	0.	1	0.5			1	1					1	1			1	0. 5	1	0.		
Ill Health Retirement			1	0.5															1	0.	1	0. 1				
Other Employment		3.2		3. 1	5	.3	2	1.53	22	21.2	3	3			2	1.	1	1	3	2. 2	3	2. 5	1	1		
Personal					1	1					1	0.5							1	1	2	1.				
Premature/Efficiency																							5	.01		
Premature/Organisational change			1	1			1	1																		
Promotion			1	1													1	1					2	2		
Premature/redundancy											1	1														
nknown	3	2.	2	1. 2					2	2	2	0.	3	1. 3	1	1	1	1	2	2						
Widow/Widower Pension					1	1																				
Voluntary Early Retirement											1	1					1	1	1	1	2	2	2	2		
rand Total																										

M TH

	L		M				L				S T		CT				C				B		M	
ST ST	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE
	1	1 5.5	1 3	1 5 .23	1 2	1 1.	1	1 3.	1 0	1 5 .2	1 30	1 51.11	1 50	1 0. 2	1 5	1 .	1 52	1 3.1	1 3	1 .5	1 35	1 1.	1 2	1 52.1

MAHI - STM - 102 - 10654

MH&LD Summary 200 2010

S C L L M T LH LTH L S B L T

C B L C SC C TH LT M CH

M L M T L	M TH L	M		L		S T	CT		C		B	M
No of Disciplinary appeal cases							1	1	1	1	1	
No of grievance at stage 2	2	2	2	2	2	1		2	2	3		1
No of grievances stage 1	3	5	2	2	1	1	2	2	5	5	5	1
No. of Disciplinary cases	3	5	3	2	1	2				1	1	3
No. of Informal Resolution stage	2	2									1	
No. of investigations												11
No. of suspensions	3	3	3	3	2	3	3	3	3	3	3	3
No. of tribunal cases	3	5	3	3	3	2	2	1	2	2	2	2
rand Total												

M L S	M TH L	M		L		S T	CT		C		B	M	rand Total	ot approved
Compressed Working	1		1		1	1					1	1		
Employment Break		1	1				2					1		1
Flexi time							1		1	1				
Flexible Retirement			1	1	2	1						2		
obshare														
Part time working	2		1	2	2		1				1	1		3
Term time working	15													1

L L M T	Mar pr	pr May	May n	n l	l g	g Sep	Sep ct	ct ov	ov ec	ec an	an e	e Mar	rand Total
Corporate Welcome	50.00	0.00	2 . 0	53. 0	5.00	3.30	100.00	.50	0. 0	. 0	2 . 0	1. 0	.30

L L M T	Sep	ct	ov	ec	an	e	Mar	rand Total
TAR ET BY MARCH 2010	0							
PCF Compliance	0.00							

TT C M M T	M TH L	M		L		S T	CT		C		B	M	rand Total
Ill health redeployments	0	0	0	0	0	0	0	0	0	0	0	0	
Ill Health retirements	0	1	0	0	0	0	0	0	0	1	0	0	
Ill Health Terminations	1	0	1	1	0	1	0	0	1	0	1	1	
rand Total													

MAHI - STM - 102 - 10655

MH&LD Summary 200 2010

S C SS BS C	L	to M	to	to L	to	to S T	to CT	to	to C	to	to B	to M
TAR ET BY MARCH 2010 5. 2												
OVERALL ABSENCE FOR MH&LD	5.5	5.3	5.	5.	.03	.15	.3	.52	.5	.	. 1	. 5
OVERALL ABSENCE FOR	3.1	2.2	1. 1	1.	1. 5	1. 1	1. 3	1. 2	1.	1.	1. 2	1.
OVERALL ABSENCE FOR LON TERM	2.	3.1	3.	.1	.1	.3	.5	.	.	.	.	.

	M TH												
	L	M		L		S T	CT		C		B	M	rand Total
gency spend		02	2 2 1 3	21 5	23 3 3	21	235 331	15 2	133 1 5		5 503	111 005	2 12 15

	M TH											
	L	M		L		S T	CT		C		B	M
T rnover rate	0. 0	0.5	0. 0	0.	1. 5	0.	0.1	0.33	0. 5	0. 5	1.3	0. 3
olling ont t rnover rate	.2	.0	.1	.0	.00	5. 1	5. 5	5. 2	5. 1	.1	.35	. 5

	M TH												
C TM T CT T	L	M		L		S T	CT		C		B	M	rand Total
ob Requisitions received	1	13		15	53	31	11	11	1		1	15	
Vacancies filled	1	12	13	11		11	1	15		1	1	12	

	M TH											
S LL M	L	M		L		S T	CT		C		B	M
M T TB M CH												
Nursing & Midwifery Ratio	1:3	1:3	1:3	1:3	1:3	1:3	1.3	1.3	0.	1.3	1.3	0.
H T TB M CH												
Allied Health Professions Ratio	:1	:1	:1	:1	5:15	5:15	.1	5.15	5.15	.1	.1	.1
CT TB M CH												
Admin & Clerical staff as of total staff	0. 1	0. 2	0. 1	0.	0. 3	0. 2	0. 0	0. 1	0. 2	0. 3	0. 2	0. 2

	M TH																									
	L		M			L				S T		CT				C			B		M		rand Total			
MB M T T L	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE	H C	T
Staff on Maternity Leave in month		3 .5	51	1.	2	3 .	0	33.	0	35.	1	35.	33	2 .	33	2 .53	3	32. 5	32	2 .3	0	3 .0	3	3 .	N/A	N/A
Staff returned from maternity leave in month	3	2.	12	10	5	3. 5		2.1		.53		2.	2	1.	5	.3		3.31	5	.	3	3	2	2		
Staff commenced maternity leave in month	3	2. 1	5	5	3	3	3	2.5				.1	5	5		. 3	1	1	11	. 2	5	. 5		.51		

MAHI - STM - 102 - 10656

MH&LD Summary 200 2010

MAHI - STM - 102 - 10657

MH&LD Summary 200 2010

	L		M				L				S T		CT				C				B		M		rand Total	
er of Starters	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE	H C	T
	1	15.53		3.	10	.1	10	.3	2	2 .23	5	.53	1	12. 3	12	10.	5	.			20	1 .	11	.55		

	L		M				L				S T		CT				C				B		M		rand Total	
er of Leavers	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE	H C	T
	11	.5	10	.5	11	10.1		.03	33	31. 3	1	1 . 1		2.2		5.3	1	11. 2	13	11.	25	23. 1	1	1 .		

M TH

	L		M				L				S T		CT				C				B		M		rand Total	
S L	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE	H C	T
Age Retirement	2	1.5	1	0.	2	2	3	3	2	1. 3	1	0.	1	0.55	3	2.5		2.51	5	3.	3	3	5	3.		
Caring for children																	1	0.								
Death																	1	1								
Disciplinary action											2	2														
End fixed term contract	1	0.2			1	1					2	2					5	2.5			12	12	1	1		
Family																					1	1				
Further education/training							1	1	3	3	2	2														
Ill Health Termination	1	1			1	0.	1	0.5			1	1					1	1			1	0. 5	1	0.		
Ill Health Retirement			1	0.5															1	0.	1	0. 1				
Other Employment		3.2		3. 1	5	.3	2	1.53	22	21.2	3	3			2	1.	1	1	3	2. 2	3	2. 5	1	1		
Personal					1	1					1	0.5							1	1	2	1.				
Premature/Efficiency																							5	.01		
Premature/Organisational change			1	1			1	1																		
Promotion			1	1													1	1					2	2		
Premature/redundancy											1	1														
nknown	3	2.	2	1. 2					2	2	2	0.	3	1. 3	1	1	1	1	2	2						
Widow/Widower Pension					1	1																				
Voluntary Early Retirement											1	1					1	1	1	1	2	2	2	2		
rand Total																										

M TH

	L		M				L				S T		CT				C				B		M	
ST ST	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE
	1	1 5.5	1 3	1 5 .23	1 2	1 1.	1	1 3.	1 0	1 5 .2	1 30	1 51.11	1 50	1 0. 2	1 5	1 .	1 52	1 3.1	1 3	1 .5	1 35	1 1.	1 2	1 52.1

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ASPC DIR SCORECARD 201011

S C L L S C L M C S C S

C B L C SC C TH LT M CH

M L M TL	M TH pril	May	ne	ly	g	Sep	ct	ov	ec	an	e	Mar
No of Disciplinary appeal cases	0	0	0	1	2	2	2	2	2	2	2	
No of grievance at stage 2	2	2	2	3	3		3	5	3	2	2	
No of grievances stage 1	11	11	11	15	15	15	15	1	25	25	25	
No. of Disciplinary cases	12	1	1	25	2	30	25	21	21	1	20	
No. of Informal Resolution stage												
No. of investigations							1	20	20	1	1	
No. of suspensions					11	13						
No. of tribunal cases (Part time issue)	0	1	2	2	3	3	5	5	5	5		
rand Total												

M L S	M TH pril	May	ne	ly	g	Sep	ct	ov	ec	an	e	Mar	rand Total	ot approved
Compressed Working	1	2	3	1	2	5	2	2	1	2	3			1
Employment Break	5		3	0		5	3	2	0		1			
Flexi time	0	1	1	0	1	3	2	1	1	2	0			
Flexible Retirement					1	1				3				2
obshare	1	2	0	0	0	0	0	0	0	0	0			
Part time working		5	3	1	2	3		2	0	2	1			2
Term time working	3	0	0	0	0	0	0	0	0	0	0			

L L M T	Mar pr	pr May	May ly	ly Sep	l g	g Sep	Sep ct	ct ov	ov ec	ec an	an e	e Mar	rand Total
Corporate Welcome	. 0	. 0	2. 0	1.00									

L L M T	pril	May	ne	ly	g	Sep	ct	ov	ec	an	e	Mar	rand Total

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ASPC DIR SCORECARD 201011

T TB M CH													
PCF Compliance						52							

C S M M T M T	pril	May	ne	ly	g	Sep	ct	ov	ec	an	e	Mar	rand Total
Managers in attendance	0	0	0	0	13	0	12	0	1	0			
Cases Raised	0	0	0	0	13	0	1	0	2	0			

M TH

TT C M M T	pril	May	ne	ly	g	Sep	ct	ov	ec	an	e	Mar	rand Total
Ill health redeployments	0	0	0	0	1	0	0	0	0	1			
Ill Health retirements	1	1	2	1	1	1		5	2	1			
Ill Health Terminations	0	3	5	3	5	2	3		1				
rand Total													

S C SS BS C	pr	pr to May	pr to n	pr to l	pr to g	pr to Sep	pr to ct	pr to ov	pr to ec	pr to an	pr to e	pr to Mar
TAR ET BY MARCH 2011												
OVERALL ABSENCE FOR Social & Primary Care Services	0	0	0.	1.	. 1	. 1	.5	.5	. 2	.		
OVERALL ABSENCE FOR SHORTERM	0	0	0.55	0. 3	1.5	1.53	1.55	1.5	1.	1.		
OVERALL ABSENCE FOR LON TERM	0	0	0.23	0.	5.0	5.0	5.02	.	5.02	5.03		

M TH

	pril	May	ne	ly	g	Sep	ct	ov	ec	an	e	Mar	rand Total
gency spend		1	510	33 1	5 0	323 01	3 1 50	323 0	30 3 0	5 155	321 10		
Bank spend													

M TH

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ASPC DIR SCORECARD 201011

C TM T CT T	pril	May	ne	ly	g	Sep	ct	ov	ec	an	e	Mar	rand Total
ob Requisitions received	15		5		3	3	0	2	1	1	33		
Vacancies filled	15	21	2	21	1	1	22	2	21	25	13		

	M TH											
S LL M	pril	May	ne	ly	g	Sep	ct	ov	ec	an	e	Mar
M T T B M CH												
Nursing & Midwifery Ratio	:3	:3	:3	:3	:3	:3	:3	:3	:3	:3	:3	
H T T B M CH												
Allied Health Professions Ratio	5:25	5:25	5:25	5:25	:2	:2	:2	5:25	5:25	:23	:23	
C T T B M CH												
Admin & Clerical staff as of total staff	2.0	2.0	2.05	2.0	2.05	2. 2	2. 5	2. 2	2. 3	2. 3	2. 1	

	M TH																									
	pril		May		ne		ly		g		Sep		ct		ov		ec		an		e		Mar		rand Total	
MB M T T L	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE	H C	T
Staff on Maternity Leave in month	123	101.05	11	.3	122	101. 1	12	10 .31	11	.	11	. 0	11	100.	11	100.	130	113.22	15	130. 3	15	132.50				
Staff returned from maternity leave in month	15	11.3	1	13.20	13	10.	12	10.01	21	1 . 0	20	1 .20	1	13.	15	12.1		. 1	25	20.51	15	11.				
staff commenced maternity leave in month	12	.52	1	15.01	1	12. 1	13	11.35	20	1 .	22	1 .33	1	11.	23	20.1	23	1 .	21	1 . 0	15	12. 2				

	pril		May		ne		ly		g		Sep		ct		ov		ec		an		e		Mar		rand Total	
er of Starters	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE	H C	T

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	15	13. 5	21	15. 3	30	2 .35	21	1 .0	3	0.5	1	1 .0	1	1 .	21	1 . 1		5.	12	.23	25	2 .0				
er of Movers Starters	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE	**H C**	**T**
	1	1.00									1	0.52	3	3.00							1	1.00				
	pril		**May**		**ne**		**ly**		**g**		**Sep**		**ct**		**ov**		**ec**		**an**		**e**		**Mar**		**rand Total**	
er of Leavers	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE	**H C**	**T**
	1	1 .	23	1 .	22	1 . 5	1	11.35	1	5 . 1	2	22.0	23	20.2	22	1 .	13	10.	21	1 .	33	2 . 1				
er of Movers Leavers	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE	**H C**	**T**
											1	0.52	2	2.00												

M TH

	pril		**May**		**ne**		**ly**		**g**		**Sep**		**ct**		**ov**		**ec**		**an**		**e**		**Mar**	
ST ST	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE
	51	2 2.51		2 .33	50	3 3.15	50	3 2.	5122	15.32	510	3 .50	5105	01.	2	2 0.	5101	05.5	50 1	3 0.5	50	3 . 2		

M TH

	pril	**May**	**ne**	**ly**	**g**	**Sep**	**ct**	**ov**	**ec**	**an**	**e**	**Mar**
Cumulative Turnover rate (Excludes Temporary Career Break Doctors in Training and staff with a WTE Less than or equal to 0.03)	0.35	0.	1.1	1. 3	1.	2.31	2. 1	3.2	3.	3.	.20	
Rolling 12 month Turnover rate (Excludes Temporary Career Break Doctors in Training and staff with a WTE Less than or equal to 0.03)												

M TH

	pril		**May**		**ne**		**ly**		**g**		**Sep**		**ct**		**ov**		**ec**		**an**		**e**		**Mar**		**rand Total**	
S L	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE
Age Retirement		3. 3	5	.13		.1	3	2. 1		3.3		.12		.0		2. 0		3.5	3	3.00	1	0.2				
Caring for children																										

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Completion of training																									
Death	1	1.00	1	0.5	1	1.00														1	0. 5				
Disciplinary action					1	0.5							1	0.53						1	1.00				
End fixed term contract			1	0. 0	1	1.00			33	33.00	2	2.00	1	1.00	1	1.00	1	0. 0		1	1 .00				
Family			1	1.00																					
Full time education											1	1.00													
Further education/training	1	1.00							3	3.00	1	1.00							1	1.00	2	1.0			
Ill Health Resignation (Old Code)																									
Ill Health Resignation																									
Ill Health Retirement	2	2.00	1	0.	2	1. 0	1	0.	1	0.	1	1.00	3	2.55		3. 3	1	1.00	1	0.					
Ill Health Termination			2	2.00		3.31	1	0.	2	1.1	2	1.0	2	2.00	3	2.33	1	0. 3		.	2	1. 2			
OTHER DOMESTIC COMMITMENTS																									
Other Employment		5.53		5.	3	2. 0	5	.33	11	11.00		5.35	5	.5	2	2.00	2	1.3		5.53	3	3.00			
Personal	1	1.00	3	1.	1	0. 3	1	0. 0	2	2.00			1	0. 0		.	2	2.00	1	0.50					
Premature/ Efficiency	1	1.00																	1	1.00					
Premature/ Organisational change																									
Premature/ redundancy																									
Promotion																									
Redeployment																									
Secondment							1	0.50							1	1.00									
Transfer																									
nknown	3	3.00	3	2.20	2	0. 3	2	1.5	5	. 1			1	1.00			2	1. 0	2	2.00	5	.1			
Voluntary Early Retirement (Abated)																									
Voluntary Early Retirement												3.53	2	2.00	1	0.53									
Voluntary Redundancy																									
Widow/Widower Pension																									
rand Total																									

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ASPC DIR SCORECARD 201112

CT T L L S C L M C S C S
C B L C SC C TH LT M CH

M L M TL	M TH pril		May		ne		ly		g		Sep		ct		ov		ec		an		e		Mars	
	L	CL S	L	CL S	L	CL S	L	CL S	L	CL S	L	CL S	L	CL S	L	CL S	L	CL S	L	CL S	L	CL S	L	CL S
Disciplinary	11	2		3		3		0		0	5	3	5	2	1		3	0	3	0	2	0	2	1
Disciplinary		0	2	2	1	1	1	0	2	0	2	3	1	0	0	1	2	0	2	0	1	0	1	0
rievance S		11		3	10	1	12	0	11	1		0		0		0	11	0	1	3		2		0
rievance S	3	0	3	0	3	0	3	0	3	1	2	0	3	0	3	0	5	0	5	0	3	0	3	0
Industrial T	11	0	30	0	31	0	3	0	35	1		1		0		0	51	0	52	0		1		0
Investigatio	22	1	21	3	1	3	1	3	22	2	23	1	23	0	1		25	0	2	0	30	0	31	0
rand Total																								

M L S	M TH pril	May	ne	ly	g	Sep	ct	ov	ec	an	e	Mar	rand Total	ot approved
Compressed Working	0		1	1	0		1		0	2		3		3
Employment Break	5	5	2	1	2		5	0	1	1	2	2		2
Flexi time	2	2	2	0	2	0	0	1	0	0	0	0		
Flexible Retirement		5		1	3	1	3		2	1	2	2		
obshare	1	0	1	5	1	2	1	0	0	0	0	0		
Part time working	10	3		5	2	5		1	1		2	1		2
Term time working	5	0	0	0	0	0	0	0	0	0	0	0		2
Home Working	0	0	0	0	0	0	0	0	0	0	0	0		

L L M T	Mar May	May ly	ly Sep	Sep ov	ov an	an Mar	rand Total
Corporate Welcome	. 0	100.00	100.00	1. 0	0. 0	. 0	

L L M T	pril	May	ne	ly	g	Sep	ct	ov	ec	an	e	Mar	rand Total
T T B M CH ( )													
PCF Compliance													

C S M M T M T	pril	May	ne	ly	g	Sep	ct	ov	ec	an	e	Mar	rand Total
Managers in attendance	0	0	3	5	0	0	0	0		0	5	1	

Cases Raised	0	0	2	5	0	0	0	0	5	0	5	1	

	M TH												
TT C M M T	pril	May	ne	ly	g	Sep	ct	ov	ec	an	e	Mar	rand Total
Ill health redeploym ents	0	0	1	1	1	0	0	0	0	0	0	0	
Ill Health retirement s	1	3	1	2	2	3	1	1	1	0	1	1	
Ill Health Terminatio ns		5	1		0			2	2	0	0	3	
rand Total													

S C SS BS C	pr	pr to May	pr to n	pr to l	pr to g	pr to Sep	pr to ct	pr to ov	pr to ec	pr to an	pr to e	pr to Mar
TAR ET BY MARCH 2012												
OVERALL ABSENCE FOR Social & Primary Care Services	. 2	.52	.	.	.33	.1	.2	.3	.3	.3	. 1	.3
OVERALL ABSENCE FOR SHORTERM	2.	1.	1.	1.5	1.	1.	1.52	1.	1.	1.52	1.52	1.5
OVERALL ABSENCE FOR LON TERM	3.	.	. 5	.	.	. 5	. 5	.	.	. 3	.	.

	M TH												
	pril	May	ne	ly	g	Sep	ct	ov	ec	an	e	Mar	rand Total
gency spend		55 51	3 0 1	3 1	51 51	3 1 00	3 32	3 3 2	00 51	0 1	11	5 1 2	
Nurse Bank Spend													
Social Care Bank Spend	2	3 2	30		113 2		0	1		111 530	0	53 3	

	M TH												
C TM T CT T	pril	May	ne	ly	g	Sep	ct	ov	ec	an	e	Mar	rand Total
ob Requisition s received	1	5	20	23	2	2	31	5	2	3	0	5	
Vacancies filled	1	33	13	1	3	31	3	2	1	3	3	22	

	M TH												

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S LL M	pril	May	ne	ly	g	Sep	ct	ov	ec	an	e	Mar
M T TB M CH												
Nursing & Midwifery Ratio	:3	:3	5:35	5:35	5.35	5:35	5:35	5:35	5:35	5:35	5:35	:3
H T TB M CH												
Allied Health Professions Ratio	:23	:23	:21	0:20	0:20	0:20	0:20	0:20	:21	1:1	1:1	1:1
C T TB M CH												
Admin & Clerical staff as of total staff	2. 1	2. 0	2. 1	2. 0	2.	2. 0	2. 0	2. 0	2. 0	2.	2.	2.

M TH

	pril		May		ne		ly		g		Sep		ct		ov		ec		an		e		Mar		rand Total	
MB M T T L	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T
Staff on Maternity Leave in month	1 2	11 .3	12	105.	125	10 .2	11 .00	.13	110	1.0	110	3.	10	3.23	112	5.2	135	11 .23	113	.1	12	110.	131	115.		
Staff returned from maternity leave in month	15	11.5	1	1 .1	1	1 . 5	22.00	1 .33	21	1 .25	21	15.	13	.	15	12. 2	11	10.3	10	.2	1	11. 3	13	.		
staff commenced maternity leave in month		3. 1	1	13.23	1	11. 2	1 .00	11.2	1	1 . 5	12	10.5	1	15.2		.32	15	12.	13	11.	15	12.	1	1 . 0		

	pril		May		ne		ly		g		Sep		ct		ov		ec		an		e		Mar		rand Total	
er of Starters	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T
	13	12.3	22	20.1		.53	10	.23	0	.52	1	15.2	21	1 .15	1	13.30	10	.10	13	11.5	3	35.2	1	1 . 5		
er of ew Starts s itted after Mont ly Closedown					2	2.00			1	0.10			3	3.00												

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Total er of ew Starts	13	12.3	22	20.1	11	10.53	10	.23	1	. 2	1	15.2	2	21.15	1	13.30	10	.10	13	11.5	3	35.2	1	1 . 5		
er Movers Starters	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T
	1	1.00					1	1.00	1	1.00	1	1.00														
	pril		May		ne		ly		g		Sep		ct		ov		ec		an		e		Mar		rand Total	
er of Leavers	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T
	1	1 .2	1	1 . 3	1	1 . 0	1	1 .	3	.0	2	2 . 5	23	1 .31		3.	22	1 .03	31	2 .03	23	1 .	33	2 .52		
er of Leavers s itted after Mont ly Closedown					1	1.00			1	1.00	2	1.5	2	2.00												
Total er of Leavers	1	1 .2	1	1 . 3	20	1 . 0	1	1 .		.0	30	2 .02	25	21.31		3.	22	1 .03	31	2 .03	23	1 .	33	2 .52		
er of Movers Leavers	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T
	1	1.00			1	0.	1	1.00	1	0.50																

	M TH																							
	pril		May		ne		ly		g		Sep		ct		ov		ec		an		e		Mar	
ST ST	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T
	505	3 . 3	505	3 .	5031	3 3. 5	501 .00	32 .50	502	33 . 3	505	32 .	500	325.52	501	330.5		311. 0		30 .50	5020	30 . 5	551	20 . 5

	M TH											
	pril	May	ne	ly	g	Sep	ct	ov	ec	an	e	Mar
Cumulative Turnover rate (Excludes Temporary Career Break Doctors in Training and staff with a WTE Less than or equal to 0.03)	0.31	0.	1.13	1.51	2.03	2. 0	3.05	3.30	3.	3.	. 2	5.12

Rolling 12 month Turnover rate (Excludes Temporary Career Break Doctors in Training and staff with a WTE Less than or equal to 0.03)	. 1	. 0	. 2	. 0	.	. 5	. 3	.	.	. 5	. 1	5.12																
	M TH																											
	pril		May		ne		ly		g		Sep		ct		ov		ec		an		e		Mar		rand Total	
S L	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T
Age Retirement	5	.2		5.0		5.15	2	2.00	3	2.0	5	.10		5.2		2.	3	3.00	3	2.15		5.	13	10.22				
Caring for children																												
Completion of training							1	1.00																				
Death			1	1.00	1	1.00																						
Disciplinary action	1	1.00							1	1.00	1	1.00	1	0. 1			1	0. 3										
End fixed term contract										3. 0			1	0.	1	1.00	2	2.00	1	1 .00			1	0. 0				
Family			1	0.53																								
Full time education																												
Further education/ training									3	2.	2	1.50	1	1.00	1	0.53	1	0.32	3	1. 3	1	0. 0	1	1.00				
Ill Health Resignation (Old Code)																												
Ill Health Resignation																												
Ill Health Retirement	1	1.00	3	3.00	2	1.55	2	1.53	2	1. 0	3	2.5	1	0. 0	1	0. 0	1	0. 0			2	2.00	1	1.00				
Ill Health Termination		3. 0	2	1. 0	1	1.00	5	. 0		2.	2	1. 1	2	1.	1	0.	1	0. 3	2	1.0	2	1.2	2	2.00				
OTHER DOMESTIC COMMITMENTS																												
Other Employment		3.53	1	1.00		5.00		5. 0	11	.	11	.	5	3. 3	5	5.00		.02		.		.2		.5				
Personal			2	2.00	1	1.00	1	1.00	2	1.	3	3.00	3	3.00	1	1.00	1	0.53					1	0. 3				
Premature /Efficiency																												

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ASPC DIR SCORECARD 201112

Premature /Organisational change																									
Premature /redundancy																							2	2.00		
Promotion	1	0. 0									1	1.00									1	0. 5	1	1.00		
Redeployment																										
Secondment													1	1.00												
Transfer													1	0.50												
nknown	2	1.2	2	1.53			1	0.1	2	1.2			1	0. 1	2	1. 3							3	3.00		
Voluntary Early Retirement (Abated)			1	1.00									1	1.00	1	0.5										
Voluntary Early Retirement	1	0.5			3	3.00	1	0. 5	1	1.00	2	1. 0	1	0. 5			3	3.00			2	1. 3				
Voluntary Redundancy																										
Widow/Widower Pension									1	0. 5							1	1.00								
rand Total																										

MAHI - STM - 102 - 10670

ASPC DIR SCORECARD 201213

CT T L L LTS C L M C

C B L C SC C TH LT M CH

M L M T L	M TH pril		May		ne		ly		g		Sep		ct		ov		ec		an		e		Mars	
	L	CL S	L	CL S	L	CL S	L	CL S	L	CL S	L	CL S	L	CL S	L	CL S	L	CL S	L	CL S	L	CL S	L	CL S
Disciplinary	0	0	1	0	1	1	2	0	2	0	2	0	1	1	5	1		0		0	5	3		1
Disciplinary	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	0	2	0	3	1	2	1
rievance S		0	5	1	5	0		3	5	0	5	1	1	1	3	1	2	0	3	0	2	0		0
rievance S		0		0		0		3		0	5	3	0	0	1	0	1	1	0	0	2	0	3	0
Industrial T	0	0	2	0	2	0	3	0	3	0	3	0		0	3	1	3	0	3		32	0	32	0
Investigatio	2	0	2	1		0		0	10	0	11	1	3	3	33	1	35	2	3	1	30	2	3	0
rand Total																								

M L S	M TH pril	May	ne	ly	g	Sep	ct	ov	ec	an	e	Mar	rand Total	ot approved
Compressed Working		3	1	2	2	2	1	2	3		1	0		
Employment Break	3		3		1		2		1	1	0	3		1
Flexi time	1	0	2	0	0	1	0	1	0	2	0	2		
Flexible Retirement		5	2		5		0	1	0	2	1	1		1
obshare	0	0	0	0	0	1	0	0	0	0	0	0		
Part time working		1	2	3	2	3	2		1	3	1	1		
Term time working	51	0	0	1	0	0	0	0	0	0	0	0		1
Home Working	0	0	0	0	0	0	0	0	0	0	0	0		

L L M T	Mar May	May ly	ly Sep	Sep ov	ov an	an Mar							rand Total
Corporate Welcome	1. 0	3.10	5. 0	0.50	. 0	3. 0							

L L M T	pril Sept	Sept Marc											rand Total
T T B M CH ( )													
PCF Compliance	.30												

C S M M T M T	pril	May	ne	ly	g	Sep	ct	ov	ec	an	e	Mar	rand Total

MAHI - STM - 102 - 10671

ASPC DIR SCORECARD 201213

Managers in attendance				0	0		10		0	10		10	
Cases Raised		5		0	0		12	10	0	12	11	10	
	M TH												
TT C M M T	pril	May	ne	ly	g	Sep	ct	ov	ec	an	e	Mar	rand Total
Ill health redeployments	1	1	0	0	0	1	0	0	0	1	0	2	
Ill Health retirements	3		1	2	0	0	1	1	0	0	1	1	
Ill Health Terminations	1		3	1	3		2		2	2	2	3	
rand Total													

S C SS BS C	pr	pr to May	pr to n	pr to l	pr to g	pr to Sep	pr to ct	pr to ov	pr to ec	pr to an	pr to e	pr to Mar
TAR ET BY MARCH 2013												
OVERALL ABSENCE FOR Social & Primary Care Services	.31	.2	0.3	.	5.	.23	.03	.	.	.5	. 3	.
OVERALL ABSENCE FOR SHORTERM	2. 5	1.	0.25	1. 1	NA	NA	NA	NA	N/A	na	na	N/A
OVERALL ABSENCE FOR LON TERM	3.	.2	0.13	5.03	NA	NA	NA	NA	N/A	na	na	N/A

	M TH												
	pril	May	ne	ly	g	Sep	ct	ov	ec	an	e	Mar	rand Total
gency spend		531 55	1 1 1	01 231	50 3	3 1 0 2	55 2	0	30 12	52 150	3 0 1	1 5	
Nurse Bank Spend													
Social Care Bank Spend	0 50	5 035	2 13	200 0 0	212 0	100 0			130 5 2				

	M TH												
C TM T CT T	pril	May	ne	ly	g	Sep	ct	ov	ec	an	e	Mar	rand Total

ob Requisitions received		2	23	51	11	25			50	3	3	33	
Vacancies filled		33	2	31	3	1	35	23	2	53	3		

	M TH											
S LL M	pril	May	ne	ly	g	Sep	ct	ov	ec	an	e	Mar
M T TB M CH												
Nursing & Midwifery Ratio	:3	:3	5:35	5:35	:3	5:35	:3	:3	:3	5:35	:3	5:35
H T TB M CH												
Allied Health Professions Ratio	:22	:21	:21	:21	:21	:21	:21	0:20	0:20	0:20	0:20	1:1
C T TB M CH												
Admin & Clerical staff as of total staff	1.	1. 1	1. 0	1. 1	1. 3	1. 5	1.	1.	1.	1.	1.	1.

	M TH																									
	pril		May		ne		ly		g		Sep		ct		ov		ec		an		e		Mar		rand Total	
MB M T T L	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T
Staff on Maternity Leave in month	1	. 0		.30		2.	.00	1.52	2	.		.3	2	.		3.5				.2		. 0		.5		
Staff returned from maternity leave in month	1	. 1		.5	1	12.5	.00	2.	11	.	1	1 .22	10	. 2	11	.	10	. 3	1	12.0	13	10.	12	.		
staff commenced maternity leave in month		5.	1	11.25	13	11.53	.00	5.	1	13. 2	11	.	11	10.		5. 3		5. 1	10	.	10	. 2		. 3		

	pril		May		ne		ly		g		Sep		ct		ov		ec		an		e		Mar		rand Total	
	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T

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ASPC DIR SCORECARD 201213

er of Starters	31	2 .1	2	2 .05	23	20. 5		.1		.0	1	15.	25	22.1	1	15.	11	.33	35	25.	0	3 . 2	1	1 .00		
	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T
er Movers Starters			2	2.00	3	3.00	1	0. 3	3	3.00																

	pril		May		ne		ly		g		Sep		ct		ov		ec		an		e		Mar		rand Total	
	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T
er of Leavers	15	13.3	2	23. 3	23	1 .	3	5. 5	23	21.	1	15. 5	21	1 .2	22	1 .	23	1 .02	15	15.00	32	2 .52	25	23.15		
	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T
er of Movers Leavers			2	2.00	3	3.00	1	1.00	3	3.00	2	2.00														

M TH

	pril		May		ne		ly		g		Sep		ct		ov		ec		an		e		Mar		
ST ST	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T		
	1	355 .52	1	3551. 2	1 2	355 .	151.00	35 .25	1	35 5.	15	35 5.	1 1	35 2.	153	35 .01	1	35 . 0	1 1	35 .33	15	35 .	15	35 .30		

M TH

	pril	May	ne	ly	g	Sep	ct	ov	ec	an	e	Mar
Cumulative Turnover rate (Excludes Temporary Career Break Doctors in Training and staff with a WTE Less than or equal to 0.03)	0.3	0.	1.52	2.15	2. 5	3.1	3. 5	.25	5.13	5.20	5. 5	.3
Rolling 12 month Turnover rate (Excludes Temporary Career Break Doctors in Training and staff with a WTE Less than or equal to 0.03)	.05	.2	.33	5 .00	.52	.32	.2	. 5	. 5	. 0	.	.3

M TH

	pril		May		ne		ly		g		Sep		ct		ov		ec		an		e		Mar		rand Total	

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ASPC DIR SCORECARD 201213

SL	HC	T	HC	T	HC	T	HC	T	HC	T	HC	T	HC	T	HC	T	HC	T	HC	T	HC	T	HC	T	HC	T
Age Retirement		.00	3	3.00		. 3		.	11	10.3	3	1.		2.		5.0	5	3.		.00	1	1.00	1	12.5		
Caring for children											1	0.53														
Completion of training																										
Death			1	1.00							1	1.00														
Disciplinary action											1	1.00					1	1.00	1	1.00						
End fixed term contract			2	1. 0			3	1. 0													1	1 . 0				
Family																										
Full time education									1	0.53	1	0. 0														
Further education/training											1	1.00														
Ill Health Resignation (Old Code)																										
Ill Health Resignation																										
Ill Health Retirement	2	1. 0	3	2.2	1	1.00	2	1. 0					1	1.00	1	0.					1	0.53	1	1.00		
Ill Health Termination	1	1.00		3. 1	1	1.00				3. 0	2	1. 3	1	1.00	3	2. 3	2	1.	1	1.00	1	0. 3				
OTHER DOMESTIC COMMITMENTS																										
Other Employment	5	. 3		3. 1	3	3.00		5. 2	1	1.00	1	1.00		3. 0	3	2. 3		.		.00		.13	3	2. 5		
Personal	2	0. 1	1	1.00	1	1.00	1	0. 0			1	1.00					1	0. 2					3	2. 0		
Premature/ Efficiency																										
Premature/ Organisational change																										
Premature/ redundancy																										
Promotion			3	2.50			1	1.00	1	1.00	2	2.00	1	1.00												
Redeployment	1	1.00	1	1.00			1	1.00			1	0.53	1	1.00												
Resignation													3	2.52	3	2.1	3	2.	2	2.00	1	1.00	1	0. 3		
Secondment													1	1.00												
Transfer			1	0.			1	1.00			1	1.00	2	1.30		.00	2	2.00	1	1.00	1	0.53	2	2.00		
nknown			3	2.		5. 0	1	1.00	2	2.00	2	1.	3	2. 0					2	2.00	1	1.00				

Voluntary Early Retirement (Abated)			1	0. 1																					
Voluntary Early Retirement					1	0. 1	2	1. 1																	
Voluntary Redundancy							5	2.	3	3.00	1	1.00													
Widow/Widower Pension																							1	1.00	
rand Total																									

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ASPC DIR SCORECARE 20131

CT T L L LTS C L M C
C B L C SC C TH LT M CH

M L M TL	M TH pril		May		ne		ly		g		Sep		ct		ov		ec		an		e		Mars	
	L	CL S	L	CL S	L	CL S	L	CL S	L	CL S	L	CL S	L	CL S	L	CL S	L	CL S	L	CL S	L	CL S	L	CL S
Disciplinary		0	11	0	11	0		0	10	2	12	1	10			0		2	2	0		1		1
Disciplinary	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
rievance S		0	5	0		0	5	0	5	1		1		0		2		1		1		0	5	0
rievance S		1		0		0		0		0		1		3		2	2	1	1	1	1	0	1	0
Industrial T	3	0	3	0	3	0	3	0	3	0	35	0	30	0	31	0	30	0	30	0	31	0	31	0
Investigatio	3	1	3	3	5	0	3	2	3	5	1		3		2	5	2	5	2	3	23	2	2	2
rand Total																								

M L S	M TH pril	May	ne	ly	g	Sep	ct	ov	ec	an	e	Mar	rand Total	ot approved
Compressed Working	0	1		1	1	1	2	3		2		1		3
Employment Break	1	1	1	3	2	3	0	3	0	1	3	1		
Flexi time	0	2	2	2		3	0	0	0	0	1	1		
Flexible Retirement			2	3	3	3	2	2	2	3	2	1		1
obshare	0	0	0	0	0	0	0	0	0	0	0	0		
Part time working	5	5	2	3			2		1	1	2	3		
Term time working	2	0	0	0	0	0	0	0	0	0	0	1		
Home Working	0	0	0	0	0	0	0	0	0	0	0	0		

L L M T	Mar May	May ly	ly Sep	Sep ov	ov an	an Mar							rand Total
Corporate Welcome	. 0	0. 0	0.00	3.50	55. 0	5.00							

L L M T	pril Sept	Sept Marc											rand Total
T TB M CH ( )													
PCF Compliance													

C S M M T M T	pril	May	ne	ly	g	Sep	ct	ov	ec	an	e	Mar	rand Total

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ASPC DIR SCORECARE 20131

Managers in attendance		5	10		10		5				3		
Cases Raised		5	12	10	10		5						

	M TH												
TT C M M T	pril	May	ne	ly	g	Sep	ct	ov	ec	an	e	Mar	rand Total
Ill health redeployments	2	1	0	0	0	1	1	1	0	0	2	0	
Ill Health retirements	1	3	1	1	1	0		2	0	0	0	0	
Ill Health Terminations	1	0	0	1	1	2			3	1	5	3	
rand Total													

S C SS BS C	pr	pr to May	pr to n	pr to l	pr to g	pr to Sep	pr to ct H S	pr to ov H S	pr to ec H S	pr to an H S	pr to e H S	pr to Mar H S
TAR ET BY MARCH 2013												
OVERALL ABSENCE FOR Social & Primary Care Services	.1	. 2	.5	. 3	.	.	.	.02	.15	.30	.3	.
OVERALL ABSENCE FOR SHORTERM	2.	1.	1.	1.55	1. 2	1. 5	n/a	n/a	1.3	1.52	5.	1. 1
OVERALL ABSENCE FOR LON TERM	.35	. 2	.	5.0	5. 2	5.33	n/a	n/a	5.	5.	1.5	5. 5

	M TH												
		pril May	ne	ly	g	Sep	ct	ov	ec	an	e	Mar	rand Total
gency spend	0	5	25 301	2 2	0 3	51 0 5	0 1	0 0	0 5	11	35 0	515 23	
		ayroll Services ave een re ested to provide t e Ban spend fro cto er onwards											
Nurse Bank Spend	0	0	0	0	0	0	0	0	0	0	0	0	
Social Care Bank Spend	0	0	0	0	0	0	0	0	0	0	0	0	

	M TH												
C TM T CT T	pril	May	ne	ly	g	Sep	ct	ov	ec	an	e	Mar	rand Total

ob Requisitions received		1	3	10		2	2						
Vacancies filled	2	0	35	33		5	32						

	M TH											
S LL M	pril	May	ne	ly	g	Sep	ct H TS ata nly	ov	ec	an	e	Mar
Nursing & Midwifery Ratio	5:35	:3	:3	5:35	:3	:3	5:35	:3	:3	:3	:3	:3
Allied Health Professions Ratio	1:1	1:1	1:1	1:1	2:1	2:1	:22	:22	:22	:22	:23	:22
Admin & Clerical staff as of total staff	1. 2	1. 2	1. 0	1.	1. 3	1. 2	2. 3	2.	2. 2	2. 2	2.	2. 5

	M TH																									
	pril		May		ne		ly		g		Sep		ct		ov		ec		an		e		Mar		rand Total	
MB M T T L	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T
Staff on Maternity Leave in month		.05		.0		5.1	3.00	0.3	2	.	3	0.		1.	5	0.50	1	5. 0		2.25	5	1.55	3	0.1		
Staff returned from maternity leave in month		.	12	10.32	21	1 .33	.00	.	10	.2		5.3		.22	10	. 1	10	.2	12	11.2	1	11. 0	1	11. 3		
staff commenced maternity leave in month	11	. 5	13	10.		.10	.00	.22		.22		.		5.	1	1 .5		. 3	12	10. 0	12	10.25		. 5		

	pril		May		ne		ly		g		Sep		ct	H TS ata only	ov		ec		an		e		Mar		rand Total	
	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T
er of Starters	1	15.30	23	21.2	2	23.1	2	21.00		5 . 2	3	3 .25		.53	2	25. 2	1	1 .0	2	21.	3	3 . 3	21	1 . 1		
	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T
er Movers Starters	0	0.00	1	0. 3	0	0.00	0	0.00	0	0.00	2	1. 0					2	2.00								

	pril		May		ne		ly		g		Sep		ct	H TS ata only	ov		ec		an		e		Mar		rand Total	
	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T
er of Leavers	22	20.0	1	1 .12	1	1 .00	1	11.		.	2	23. 5	10	.50	15	13.00	2	20.35	20	1 . 1	35	30. 5	33	30.05		
	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T

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er of Movers Leavers	0	0.00	0	0.00	0	0.00	0	0.00	1	0. 0	1	0. 0					1	1.00	1	1.00			2	1. 0		
	M TH																									
	pril		May		ne		ly		g		Sep		ct	H TS ata only	ov		ec		an		e		Mar			
ST ST	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T		
	1 0	35 .20	11	53 3.	15	35 . 2	20.00	3 0 .00	15	35 . 0	15	35 2.32	31	3 30. 5	2	3 1 .20	311	3 2 .22	313	3 2 .	32	3 .2	320	3 3 .03		

	M TH											
	pril	May	ne	ly	g	Sep	ct H TS ata nly	ov	ec	an	e	Mar
Cumulative Turnover rate (Excludes Temporary Career Break Doctors in Training and staff with a WTE Less than or equal to 0.03)	0.55	0.	1.32	1.	5.	2.	2. 2	3.0	3.5	.03	. 5	5.0
Rolling 12 month Turnover rate (Excludes Temporary Career Break Doctors in Training and staff with a WTE Less than or equal to 0.03)	. 1	. 1		5. 3	5.	5.	5.55	5. 0	5.3	5. 3	5.	5.0

	M TH																									
	pril		May		ne		ly		g		Sep		ct		ov		ec		an		e		Mar		rand Total	
S L	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T
Age Retirement	10	.22	5	.3		.00	5	5.00	5	3. 3		3.														
Caring for children																										
Completion of training																										
Death in Service							1	0.50							1	0. 3	1	0.5								

Dismissal - Disciplinary Act.	1	1.00											1	1.00					1	1.00						
End fixed term contract					1	1.00			5	.10	2	1.2														
External Secondee Out																			1	1.00						
Family																										
Full time education	1	1.00							2	2.00	1	0. 0														
Further education/ training											2	2.00														
Ill Health Resignation (Old Code)																										
Ill Health Resignation																										
Ill Health - Retirement	1	0. 5					1	0. 0	1	0. 3			2	1. 0	2	2.00					1	0.5	1	0. 3		
Ill Health - Termination			3	2.0					1	0. 0			2	1.53	2	1.53	3	2.03	1	0. 3		3. 3		3. 3		
Medical Rotation																					13	12. 0				
OTHER DOMESTIC COMMITMENTS																										
Other Employment	1	0.50		3.1		.00	1	0. 0	1	1.00		3.50														
Personal			1	0.	1	1.00	1	0. 0																		
Premature /Efficiency																										
Premature /Organisational change																										
Premature /redundancy																										
Promotion	2	2.00	1	1.00			2	1.3			1	0.50														
Redeployment																										
Resignation	2	1.	3	2.	5	5.00	2	2.00	10	. 2	12	10.15	5	3.1		.5	1	10.3	1	1 .1	11	.12	1	1 . 1		
Retirement															2	2.00		5.5	1	1.00	5	3. 3	10	.1		
Secondment	1	1.00																								
Transfer	3	2.	1	0.55	1	1.00	1	0. 0	1	1.00	1	1.00														
Transfer To Other HSC Org.																	1	1.00			1	1.00				
nknown									2	1. 0	1	1.00														
Voluntary Early Retirement (Abated)					1	1.00																				

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VER - Actuarily Reduced																	1	0. 0							
Voluntary Early Retirement																									
Voluntary Redundancy																									
Widow/Widower Pension																									
rand Total																									

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LTS C L M C S C S

C B L C SC C TH L T M CH

C M T	M TH																											
	pril		May		ne		ly		g		Sep		ct		ov		ec		an		e		Mar					
	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T				
Staff in Post	51	3 5 .03	510	3 51.	511	3 52. 0	522	3 3.51	52	3 . 0	5	3 2.	5 2	3 0 .51	5 2	3 21. 1	55	3 0 . 3	55	3 05.	5 3	3 .	53	3 .1				
No of staff on perm contracts	2 0	3 52.3	2 5	3 . 0	2 0	3 52.	2 5	3 . 1	2	3 1.	31	3 .	32	3 .	33	3 0 .	32	3 01. 1	320	3 5.0	30	3 .0	30	3 5. 5				
No of staff on temp contracts	22	201. 5	225	203.3	221	200.01	23	215. 0	22	20 . 2	22	20 .50	235	210.	23	212. 2	230	20 .23	23	210. 0	23	210. 5	23	211. 3				

ew Starts	M TH																								rand Total	
	pril		May		ne		ly		g		Sep		ct		ov		ec		an		e		Mar			
	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T
No of New Starts	3	3 .	25	22.11	1	1 . 1	3	3 .5		3.3		.20	33	30. 2	3	2 .		.5	1	12.25	2	23.		. 0				
eason for ew Start																										
Cover Emp. Break/ npaid Leave																										
Cover External Secondment																										
Cover Family Leave							1	1.00																		
Cover For Annual Leave							1	1.00			1	1.00														
Cover For Perm. Vacancy			1	1.00																	1	0. 0				
Cover For Temp Internal Move																										
Cover Incre. Workload/Backlogs																										
Cover Pro ect																										
Cover Research Post																										
Cover Sick Leave	1	1.00																								
Locum																										
New Post	3	3.00	5	3. 5	1	1.00	11	.5		.		.1		.	2	1.5	2	2.00			11	10.31	2	1. 0		
Placement																										
Replacement	31	2 .	1	1 .	15	13. 1	1	12.	3	35.0	3	35.01	2	21. 3	31	2 . 3	5	3.5	1	12.25		5.25		.00		
Rotational	1	1.00					10	10.00	31	30. 0					1	0.50	1	1.00				.50				
Trainee																										

Leavers	M TH																								rand Total	
	pril		May		ne		ly		g		Sep		ct		ov		ec		an		e		Mar			
	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T
No of Leavers	15	12.35	20	1 .52	2	22.2	1	1 .25	5	5 .	25	1 .3	1	1 .2	2	1 . 0	12	10. 2	1	1 .0	2	25.0	1	1 .15		
eason for Leaving																										
Death in Service	1	1.00																								
Dismissal - Disciplinary Act.													1	0. 0												
Dismissal - Oth Subs. Reason																										
End of Fixed Term Cont./Event	1	1.00								5. 3											1	0. 0				
External Secondee Out																			1	1.00						
Ill Health - Retirement	2	1. 0		3.32	2	1. 3	1	1.00	5	3.5	2	1. 5					1	1.00			2	2.00				
Ill Health - Termination	3	1.5	3	1.	3	1.				5.1	1	1.00		3. 0	1	1.00	1	1.00			2	2.00	1	0. 5		
Medical Rotation									322	31 . 0											12	11. 0				
Mutually agreed Resig Scheme																										
Resignation	3	2.2		. 1	1	13.03	10	. 3	5	2. 1	15	11.20		. 5	1	12.	3	3.00	1	12.	5	.53		5. 0		
Retirement	3	2.	5	. 5		5.55	5	. 2	1	1 .2		2. 2	3	2.21		.		. 2	3	2. 0	3	1. 1		.00		
Transfer To Other HSC Org.	1	1.00	2	1. 0					10	10.00	3	3.00	2	2.00			1	1.00			3	2.50				
T PE																										
VER - Actuarily Reduced	1	1.00																	1	1.00						
VER - Efficiency of Service																										

	M TH																							
Maternity Leave	**pril**		**May**		**ne**		**ly**		**g**		**Sep**		**ct**		**ov**		**ec**		**an**		**e**		**Mar**		**rand Total**	
	H C	**T**	**H C**	**T**	**H C**	**T**	**H C**	**T**	**H C**	**T**	**H C**	**T**	**H C**	**T**	**H C**	**T**	**H C**	**T**	**H C**	**T**	**H C**	**T**	**H C**	**T**	**H C**	**T**
Staff on Maternity Leave in month		.30		.		1.53		0.		5.55	0	.1		0.		2. 3	103	.32	102	.31		3.13		0.03		
Staff returned from maternity leave in month		.0		.30	1	1 .5	11	.01	12	11.2		.25		.00	5	.33	10	. 0	10	.55	15	11.	1	12.5		
Staff commenced maternity leave in month	10	.	11	. 1	5	.3		.33	13	11. 1		.	11	10.20	1	12.1		.		.0	10	.2	11	.53		

	M TH											
T rnover	**pril**	**May**	**ne**	**ly**	**g**	**Sep**	**ct**	**ov**	**ec**	**an**	**e**	**Mar**
Cumulative Turnover rate (Excludes Temporary Career Break Doctors in Training and staff with a WTE Less than or equal to 0.03)	0.33	0.	1. 3	1.	2.10	2. 3	3.03	3.	3. 1	.31	.	.
Rolling 12 month Turnover rate (Excludes Temporary Career Break Doctors in Training and staff with a WTE Less than or equal to 0.03)	.	.	5.13	5.1	5.1	5.35	5.0	5.1	5.32	5.21	5.1	.

d in Clerical Staffing level	**pril**	**May**	**ne**	**ly**	**g**	**Sep**	**ct**	**ov**	**ec**	**an**	**e**	**Mar**
Admin & Clerical staff (Including Senior Executives) as of total Trust staff	1.	1.	1.	1.	1.	1.	1.	1.	1.	1.	1. 0	1. 0

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M L M TL	M TH																														
	pril			May			ne			ly			Septe er			cto er			ove er			ece er			an ary			e r ary			Marc		
	ew Cases	n oing	Closed	ew Cases	n oing	Closed	ew Cases	n oing	Closed	ew Cases	n oing	ew Cases	n oing	Closed	ew Cases	n oing	Closed	ew Cases	n oing	Closed	ew Cases	n oing	Closed	ew Cases	n oing	Closed	ew Cases	n oing	Closed	ew Cases	n oing	Closed
Disciplinary		0	0	3		1	3	10	2	3	11	3	15			12	3	2	13	1	3	1	3	1	1	1		1	0	0	20	0
Disciplinary Appeal	1	0	0	0	1	0	0	1	0	0	1	0	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
rievance Stage 1	0	0	0	2	0	1	1	1	0	2	1	1	5	0	1		3	1		1	0		0	0		0	0	0		0	0		0
rievance Stage 2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1	0	0	1	0
Industrial Tribunal	0	0	0	1	0	0	0	1	0	3	1	5		0	0		0	1		0	0	0	0	0	0	0	0	0	0	0	0	0	0
Investigations	12	0	1	2	11	1	3	12	1		1	3	1	5	3	1	3	2	1	1	2	15	0	0	1	0	5	1		0	15	0
Suspensions	0	3	0	1	3	0	1		0	1	5	0	0	5	0	5	2	0	3	0	0	3	0	1	3	0	0		0	0		1
Mediations	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1	0	0	1	0	0	1	1	0	0	0
rand Total																																

BS C C S M T	Mont													BS C T TS	C Mont													
	pril	May	ne	ly	g	sept	oct	nov	dec	an	fe				in o rs	pr to May o rs	pr to n in o rs	pr to l in o rs	pr to g in o rs	pr to Sep o rs	pr to ct in o rs	pr to ov in o rs	pr to ec in o rs	pr to an in o rs	pr to e in o rs	pr to Mar in o rs		
Mgrs in attendance at Case Conference Meetings	0	0	0	0	0	0	0	0	0	0			0	Overall Absence	.22	5. 2	5.	.0	.32	.	.5	.	. 1	.	.00	.0		
No of cases raised at Case Conference	0	0	0	0	0	0	0	0	0	0			0	Overall Absence for Short Term	1.21	1.1	1.11	1.15	1.1	1.25	1.30	1.33	1.33	1.3	1. 0	1. 1		

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Mgrs in attendance at Case Management Meetings	0	3		0	0	0	0	0	0	0			11
No of cases raised at Case Management Meetings	0	2		0	0	0	0	0	0	0			
Ill Health Redeployments	0	0	2	0		0	0	0	0	0			2
Ill Health Retirements	2	3	2	1	1	2	1	0	1	0			13
Ill Health Terminations	3	3	3	0	1	1		2	1	0			1
No of disciplinary hearings related to absence	0	2	0	0	1	1	0	1	0	0	2	1	
No of Temporary In ury Allowance applications	0	1	0	0	0	2	0	0	0	1			
rand Total													

Overall Absence for Long Term	5.01	.	.53	.	5.13	5.22	5.2	5.31	5.	5.5	5. 0	5.

H CT M S	**pril**	**May**	**ne**	**ly**	**g**	**Sept**	**ct**	**ov**	**ec**	**an**	**e**	**Marc**	**rand Total**
Number of Sessions Held	0	0	0	0	0	3	0	0	0	0			0
Number of Managers	0	0	0	0	0		0	0	0	0			
H CT M L S	**pril**	**May**	**ne**	**ly**	**g**	**Sept**	**ct**	**ov**	**ec**	**an**	**e**	**Marc**	**an**
Number of Sessions Held	0	0	0	0	0	0	0	0	0	0			0
Number of Employees	0	0	0	0	0	0	0	0	0	0			0

H TS eport T	**pril**	**May**	**ne**	**ly**	**g**								
Number of Sessions Held	0	0	0	0	1								1
Number of Attendees	0	0	0	0	25								25

M S T CTS

Mont	**pril**				**May**				**ne**				**ly**				**g st**				**Septe er**				**cto er**				**ove er**				**ece er**				**an ary**				**e r ary**				**Marc**			
	o eceived	**n oing**	**o Closed**	**o n Hold**	**o eceived**	**n oing**	**o Closed**	**o n Hold**	**o eceived**	**n oing**	**o Closed**	**o n Hold**	**o eceived**	**n oing**	**o Closed**	**o n Hold**	**o eceived**	**n oing**	**o Closed**	**o n Hold**	**o eceived**	**n oing**	**o Closed**	**o n Hold**	**o eceived**	**n oing**	**o Closed**	**o n Hold**	**o eceived**	**n oing**	**o Closed**	**o n Hold**	**o eceived**	**n oing**	**o Closed**	**o n Hold**	**o eceived**	**n oing**	**o Closed**	**o n Hold**	**o eceived**	**n oing**	**o Closed**	**o n Hold**	**o eceived**	**n oing**	**o Closed**	**o n Hold**
Modernisation Pro ects supported by HR	0	1	1	0	0	1	0	0	0	1	0	0	1	1	0	0	1	20	0	0	3	1	3	1	2	21	0	1	0	1		1	0	1	1	0		2		1	0	2	1	20	0	3	1	21	0	3

M S T

Mont	**pril**			**May**			**ne**			**ly**			**g st**			**Septe er**			**cto er**			**ove er**			**ece er**			**an ary**				**e r ary**			**Marc**			
ew osts	**o eceived**	**n oing**	**Co pleted**	**o eceived**	**n oing**	**co pleted**	**o eceived**	**n oing**	**co pleted**	**o eceived**	**n oing**	**co pleted**	**o eceived**	**n oing**	**Co pleted**	**o eceived**	**n oing**	**Co pleted**	**o eceived**	**n oing**	**Co pleted**	**o eceived**	**n oing**	**Co pleted**	**o eceived**	**n oing**	**Co pleted**	**o eceived**	**n oing**	**Co pleted**	**o eceived**	**n oing**	**Co pleted**	**o eceived**	**n oing**	**Co pleted**	**o eceived**	**n oing**	**Co pleted**
No of new posts received requiring desktopping																																						
No of new posts requiring full matching after at least months																																						
No of staff that have requested a review																																						
	nc anged	**ncrease**	**eferred for**	**nc anged**	**ncrease**	**eferred for**	**nc anged**	**ncrease**	**eferred for**	**nc anged**	**ncrease**	**eferred for**	**nc anged**	**ncrease**	**eferred for**	**nc anged**	**ncrease**	**eferred for**	**nc anged**	**ncrease**	**eferred for**	**nc anged**	**ncrease**	**eferred for**	**nc anged**	**ncrease**	**eferred for**	**nc anged**	**ncrease**	**eferred for**	**nc anged**	**ncrease**	**eferred for**	**nc anged**	**ncrease**	**eferred for**	**nc anged**	**ncrease**	**eferred for**
Outcome of full match of new post																																						
Outcome of review of new post																																						

Mont	**pril**			**May**			**ne**			**ly**			**g st**			**Septe er**			**cto er**			**ove er**			**ece er**			**an ary**				**e r ary**			**Marc**			

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C anged o s	o eceived	n oing	Co pleted	o eceived	n oing	Co pleted	o eceived	n oing	Co pleted	o eceived	n oing	Co pleted	o eceived	n oing	Co pleted	o eceived	n oing	Co pleted	o eceived	n oing	Co pleted	o eceived	n oing	Co pleted	o eceived	n oing	Co pleted	o eceived	n oing	Co pleted	o eceived	n oing	Co pleted	o eceived	n oing	Co pleted
No. of staff that have submitted a changed ob request	0	11		2	11		0	13		0		3	0	3	0	0	3	0	0	3	1	5	3	3	0	5	0	0		0	0	5	0	0	5	0
No. of staff that have appealed the outcome of their changed ob request banding (Review)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	0		0	0	0	0	0		0	0		0
	nc anged	ncrease	eferred for	nc anged	ncrease	eferred for	nc anged	ncrease	eferred for	nc anged	ncrease	eferred for	nc anged	ncrease	eferred for	nc anged	ncrease	eferred for	nc anged	ncrease	eferred for	nc anged	ncrease	eferred for	nc anged	ncrease	eferred for	nc anged	ncrease	eferred for	nc anged	ncrease	eferred for	nc anged	ncrease	eferred for
Outcome of changed ob requests	0		0	0		0		0	0	3	0	0	0	0	0	0	0	0	0	1	0	0	3	0	0	0	0	0	0	0	0	0	0	0	0	0
Outcome of changed ob reviews	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total																																				

	Mont																																			
	pril			May			ne			ly			g st			Septe er			cto er			ove er			ece er			an ary			e r ary			Marc		
o val ations	o eceived	n oing	Co pleted	o eceived	n oing	Co pleted	o eceived	n oing	Co pleted	o eceived	n oing	Co pleted	o eceived	n oing	Co pleted	o eceived	n oing	Co pleted	o eceived	n oing	Co pleted	o eceived	n oing	Co pleted	o eceived	n oing	Co pleted	o eceived	n oing	Co pleted	o eceived	n oing	Co pleted	o eceived	n oing	Co pleted
No of posts referred for ob evaluation	0	11	1	0	11	0	0	10	1	0	10	0	0		1	0		0	0		0	0		0	0		0			0			0			1
	nc anged	ncrease	eferred for	nc anged	ncrease	eferred for	nc anged	ncrease	eferred for	nc anged	ncrease	eferred for	nc anged	ncrease	eferred for	nc anged	ncrease	eferred for	nc anged	ncrease	eferred for	nc anged	ncrease	eferred for	nc anged	ncrease	eferred for	nc anged	ncrease	eferred for	nc anged	ncrease	eferred for	nc anged	ncrease	eferred for
Outcome of ob evaluations for changed obs/new post/RPA	1	0	0	0	0	0	1	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0
Outcome of review of ob evaluations for new posts/changed obs/RPA	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	1	0	0	0	0									0	0																					

M L S H B T T S	Mont												
	pril	May	ne	ly	g	Sep	ct	ov	ec	an	e	Mar	rand Total
No of Worklife balance applications received	5	1	10	1	1	1	21	12			13	5	22
No. of worklife balance applications approved	3	1		12	11	1	1				10	5	1
No. of staff availed of the Summer Scheme				50									50
No. of staff attended a Here event													

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No. of staff attended Health Fairs													
No. of Staff attended HR Roadshows / Clinics													
No. of staff attending Targeted HWB Interventions													

H LTH S C L LT S	Mont												
	pril	May	ne	ly	g	Sep	ct	ov	ec	an	e	Mar	Total
No. of Policy screenings completed	2	2	1	0	0	0	0	0	1	0	5	0	11
No of EQIA S completed	0	0	1	0	0	2	0	0	0	0	0	0	3

M L BLT	early												
	pril Sep	ct Marc	rand Total		isa ili ty								
No. of Disability Placements held													
No. of staff availing of Workable Programme Support													

L S T L L M T	pril		May		ne		ly		g		Sept		ct		ov		ec		an		e		Mar		Total	
	o ttended	o	o ttended	o	o ttended	o	o ttended	o	o ttended	o	o ttended	o	o ttended	o	o ttended	o	o ttended	o	o ttended	o	o ttended	o	o ttended	o	o ttended	o
Mandatory Equality Training (Target per ann)			11	5	31	0	0	0	0	0	51	13	2	1	2	11		10	25	11	13		31	1	233	
Managers Mandatory Absence Training	1	0	3	1		0	0	0	5	12	110		5	15	5		5	3	1	1	3	0	2	3	1	
Managers absence training refresher	5	0	0	0		0	0	0	0	0	0	0	1	0	0	0	0	1	0	0	0	0	0	0	13	1
Managers SDR training	0	0	10	1	0	0	2	3	0		2	2		5	3	12	0	0	0		2		0	5	2	
Full Recruitment & Selection Training	10	3	3	1	0	0		5	3			2		3		1			1	0	0	0	0	0	50	25
Recruitment & Selection Refresher Training e-learning		0	1	0		0	2	0	3	0	3	0		0	3	0	2	0	0	0	0	0	0	0	2	0
Coaching Skills for Managers	0	0	0	0	0	0	3	1	0	0	0	0	1	1	0	0	0	0	3	1	2	2	1	0	3	5
Engaging Manager programme	0	0	0	0	0	0	2	0	0	0			2	2	0	0	0	0	0	0	0	0	0	0		2
ILM 3 Introduction to Management	0	0	0	0	0	0	0	0	0	0	0	0	0	2	0	0	0	0	1	0	0	0	0	0	1	2
ILM 5 Managing for Success	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	0	0	0		0
Nursing Support Induction	0	0	0	0	12	0	0	0	0	0		0		0	0	0		0	0	0	0	0	0	0	2	0
Level 2 Cert Health Care Support	0	0	0	0	0	0	0	0	0	0	2	0		0	0	0	0	0	0	0	0	0	2	0		0
Level 3 Cert Health Care Support	0	0	0	0	0	0	0	0	0	0	5	0		0	0	0	0	0	0	0	0	0		0	1	0
Personal effectiveness and Development training (rouped)	2	2	112			10	3	5	0	2	120		5	13	5	22	1	11	2	5	0	5	0	1	3	10

	Mont												
	pril	May	ne	ly	g	Sep	ct	ov	ec	an	e	Marc	rand Total
Number of Team Values Workshops (Tr st ann al Target wor s ops)	0	2	1	1	1		15	11	5		5	0	5
Number of staff accessing Coaching (Tr st ann al Target for coac ees)	0	0	1	1	1	3	1	1	1	0	0	0	

	Mar May	May ly	ly Sep	Sep ov	ov an	an Mar	rand Total
Corporate Welcome	5. 0	5. 0	1.10	2.50	1.00		

	early	
	t ne	
PCF/ SF compliance (Tr st Target)		

L T C TS	ear	
HR Quality Standards- compliance		

Safer Recruitment & Employment Practice Audit compliance																																																
Working Time Regulations compliance																																																
Locum and agency Audits compliance																																																
HR Controls Assurance compliance																																																
Absence Policy Audit compliance																																																

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LTS C L M C S C S

C B L C SC C TH L T M CH

C M T	M TH																							
	pril		May		ne		ly		g		Sep		ct		ov		ec		an		e		Mar	
	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T
Staff in Post	52	3 1.2	51	3 1.25	503	3 .3	1	3 5 . 2	1	3 5 .0	5	3 . 2		3 55.		3 5 .15	2	3 . 0		3 0.02		3 . 2	510	3 .5
No of staff on perm contracts	2 5	3 .22	2 5	3 .	2 5	3 5 . 0	25	3 1.5	25	3 1.13	25	3 3 .51	2 5	3 52.15	2	3 53.25	2 3	3 3 .3	2 2	3 3.21	2 0	3 .00	2 2	3 5.
No of staff on temp contracts	232	212.0	232	211.	22	20 .	23	21 .2	235	21 . 2	231	210. 1	222	203.3	223	20 . 0	22	20 .55	22	20 . 1	22	205. 2	21	1 . 0

ew Starts	M TH																								rand Total	
	pril		May		ne		ly		g		Sep		ct		ov		ec		an		e		Mar			
	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T
No of New Starts	2	23.33	15	13. 3	1	12. 0	2	22.22	5	53.	31	2 .13	3	3 . 3	31	2 . 3	1	15.	3	3 . 0	3	3 .03	2	2 .		
eason for ew Start																										
Cover Emp. Break/ npaid Leave																					1	1.00				
Cover External Secondment																										
Cover Family Leave	1	1.00																			5	. 0				
Cover For Annual Leave																										
Cover For Perm. Vacancy					1	1.00					2	1. 3	1	1.00	1	1.00	1	1.00		.00			5	5.00		
Cover For Study Leave																										
Cover For Temp Internal Move																					1	1.00				
Cover Incre. Workload/Backlogs																										
Cover Pro ect																										
Cover Research Post																										
Cover Sick Leave																			1	0. 3						
External Secondee Back																	1	1.00								
Locum													1	1.00			1	0.0								
New Post	13	11.00		3. 0		3. 0		. 0		.50	12	10.	5	.50		3. 0		3. 0		. 0		3.	5	. 0		
Placement																										
Replacement	11	10.33	11	10.13		. 0	12	11. 2	15	13.3	1	15.	31	30.23	2	25.13		.00	25	23.	1	1 .0	1	1 .		
Rotational	1	1.00						.00	33	33.00							1	1.00			10	. 0				
Trainee																										

Leavers	M TH																								rand Total	
	pril		May		ne		ly		g		Sep		ct		ov		ec		an		e		Mar			
	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T
No of Leavers	22	1 .0	21	1 .	12	10.5	22	1 .	2	0. 5	33	2 . 5	1	15.21	25	22.	1	15.	2	21.	2	23.12	25	20.32		
eason for Leaving																										
Death in Service																					1	1.00				
Dismissal - Disciplinary Act.	2	2.00																								
Dismissal - Oth Subs. Reason																										
End of Fixed Term Cont./Event					1	1.00					2	1. 0														
External Secondee Out											1	1.00														
Ill Health - Retirement	2	2.00			1	0. 1			1	1.00	2	1.5	1	0.5			1	0.5	1	0. 0	2	1. 3	1	0.53		
Ill Health - Termination	1	0.50	1	0. 0	1	0. 1	3	1. 3	3	2.	1	1.00	2	1. 2	3	2.	3	3.00				3.	1	0. 0		
Medical Rotation	1	0. 0					2	1.5	32	31.50									5	5.00						
Mutually agreed Resig Scheme																										
Resignation	10	.	10	.1	1	0.	10	. 3		5.	1	1 .0		3.5	11	10.23		.00	13	11. 3	1	13.	13	10.2		
Retirement		5.03		. 0		.		5.5				. 0	10	.	10	.		3.	5	.2		2.		. 1		
Transfer To Other HSC Org.			1	1.00	1	0. 0	1	1.00									2	1.0					1	1.00		
T PE																										
VER - Actuarily Reduced																	1	1.00								
VER - Efficiency of Service																										
VER - Organisational Change													1	0.5	1	0. 0	1	0. 0								

Maternity Leave	M TH																								rand Total	
	pril		May		ne		ly		g		Sep		ct		ov		ec		an		e		Mar			
	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T	H C	T
Staff on Maternity Leave in month	1	2.	1	2.00	102	0.55	100	.3	5	3.	1	0.	3	2.1		.30	1	.1		.		. 2		.		
Staff returned from maternity leave in month	11	.22		.00		.00		.2	1	12.	15	13.03	5	5.00	11	10.1	15	12.		5.5	12	11.1		. 1		
Staff commenced maternity leave in month		5.33	1	1 .15		.01		.	13	11. 3	11	10.10	1	15.30		.	11	.2	5	3. 0		. 0		3. 0		

T rnover	M TH											
	pril	May	ne	ly	g	Sep	ct	ov	ec	an	e	Mar

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Cumulative Headcount Turnover rate (Excludes Temporary Career Break Doctors in Training and staff with a WTE Less than or equal to 0.03)	0.	0.	1.1	1.5	1.	2. 3	3.13	3.	.1	.5	5.0	5. 1
Rolling 12 month Headcount Turnover rate (Excludes Temporary Career Break Doctors in Training and staff with a WTE Less than or equal to 0.03)	.	.	.5	.	.	.	5.1	5.23	5.	5. 3	5.51	5. 1

d in Clerical Staffing level	pril	May	ne	ly	g	Sep	ct	ov	ec	an	e	Mar
Admin & Clerical staff (Including Senior Executives) as of total Trust staff	1.	1.	1.	1. 5	1. 5	1. 5	1.	1.	1.	1. 0	1. 1	1. 0

M L M TL — M TH

	pril			May			ne			ly			g st			Septe er			cto er			ove er			ece er			an ary			e r ary			Marc		
	ew Cases	n oing	Closed	ew Cases	n oing	Closed	ew Cases	n oing	Closed	ew Cases	n oing	Closed	ew Cases	n oing	Closed	ew Cases	n oing	Closed	ew Cases	n oing	Closed	ew Cases	n oing	Closed	ew Cases	n oing	Closed	ew Cases	n oing	Closed	ew Cases	n oing	Closed	ew Cases	n oing	Closed
Disciplinary	3		10	2	12	2	1	12		0	13	0	1	13	0	1	1	2		23	0	3	2	2	1	2	1	2	2	3	1	2	0	5	2	0
Disciplinary Appeal	1	0	0	2	1	0	0	3	0	0	3	0	0	3	0	0	3	0	0		0	1		0	0	5	0	0	5	0	0	5	0	2	5	0
rievance Stage 1	0	3	1	0	2	1	1	2	1	0	3	2	0	3	2	1	3	1	1	3	0			0	1	11	0	0	12		10		0	1	1	0
rievance Stage 2	0	1	0	0	1	0	0	1	0	2	1	0	0	3	0	0	3	0	0	0	0	0	0	0	0	0	0	0	2	0	0	2	0	0	2	2
Industrial Tribunal		3	0	3		0	2	13	0	0	0	13	3	13	0	0	1 2	0	0	1 2	0	0	1 2	0	2	1	0	0	1	0	0	1	0	0	1	0
Investigations	3	15	5	2	15	2	3	1	3	2	1	0	1	15	3	0	12	3	3	1	2	3	1		2		0	3	11	0	1	1	0	5	15	2
Suspensions	0		0	0	2	2	0	2	0	0	2	0	0	2	0	1	2	0	0	0	0	0	0	0	0	0	0	0		0	0		0			0
Mediations	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	1	1	0	0	0	0	0	0	0	0	0	0	0	1	0	1	1	1	1	1	1
rand Total																																				

BS C C S M T — Mont

	pril	May	ne	ly	g	sept	oct	nov	dec	an	fe		
Mgrs in attendance at Case Conference Meetings	0	0	0	0	0	0	0	0	0				
No of cases raised at Case Conference	0	0	1	0	0	0	0	0	0				
Mgrs in attendance at Case Management Meetings	0	0	0	0	0	0	0	0	0	0	0	0	
No of cases raised at Case Management Meetings	0	0	0	0	0	0	0	0	0	0	0	0	
Ill Health Redeployments		1	1		1		0	0	0				
Ill Health Retirements	2	0	1	1	1	2	1	1	1				
Ill Health Terminations	2	1	1			3	2	3					
No of disciplinary hearings related to absence	2	0	1	0	0	0							
No of Temporary In ury Allowance applications	0	0	0	0	0	0	0	0	0	0	0	0	
rand Total													

BS C T TS — C Mont

	in o rs	pr to May o rs	pr to n o rs	pr to l o rs	pr to g o rs	pr to Sep o rs	pr to ct o rs	pr to ov o rs	pr to ec o rs	pr to an o rs	pr to e o rs	pr to Mar o rs
Overall Absence	.	.00	.0	.12	.13	.2	. 0	.51	. 3	. 3		
Overall Absence for Short Term	1.51	1. 3	1.3	1.3	1.3	1.35	1. 1	1.	1.	1.51		
Overall Absence for Long Term	5.3	5.5	5. 1	5.	5. 0	5. 1	.00	.0	.1	.22		

H CT M S

	pril	May	ne	ly	g	Sept	ct	ov	ec	an	e	Marc	rand Total
Number of Sessions Held													
Number of Managers													

H CT M L S

	pril	May	ne	ly	g	Sept	ct	ov	ec	an	e	Marc	an
Number of Sessions Held													
Number of Employees													

H TS eport T

	pril	May	ne	ly	g								
Number of Sessions Held													
Number of Attendees													

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M S T CTS	Mont	pril				May				ne				ly				g st				Septe er				cto er				ove er				ece er				an ary					e r ary				Marc			
		o eceived	n oing	o Closed	o nHold	o eceived	n oing	o Closed	o nHold	o eceived	n oing	o Closed	o nHold	o eceived	n oing	o Closed	o nHold	o eceived	n oing	o Closed	o nHold	o eceived	n oing	o Closed	o nHold	o eceived	n oing	o Closed	o nHold	o eceived	n oing	o Closed	o nHold	o eceived	n oing	o Closed	o nHold	o eceived	n oing	o Closed	o nHold	e ased	o eceived	n oing	o Closed	o nHold	o eceived	n oing	o Closed	o nHold
Modernisation Pro ects supported by HR		1	1	1		3	1	3		0	20	2	5	0	1	0		0	20	0	5	0	20	1		1	20	0		0	21	0		0	21	0		0	1	3	3	1	0	1	1	3	1	1	0	3

M S T	Mont	pril			May			ne			ly			g st			Septe er			cto er			ove er			ece er			an ary			e r ary			Marc		
ew osts		o eceived	n oing	Co pleted	o eceived	n oing	co pleted	o eceived	n oing	co pleted	o eceived	n oing	co pleted	o eceived	n oing	Co pleted	o eceived	n oing	Co pleted	o eceived	n oing	Co pleted	o eceived	n oing	Co pleted	o eceived	n oing	Co pleted	o eceived	n oing	Co pleted	o eceived	n oing	Co pleted	o eceived	n oing	Co pleted
No of new posts received requiring desktopping																																				
No of new posts requiring full matching after at least months																																				
No of staff that have requested a review																																				
		nc anged	ncrease	eferred for	nc anged	ncrease	eferred for	nc anged	ncrease	eferred for	nc anged	ncrease	eferred for	nc anged	ncrease	eferred for	nc anged	ncrease	eferred for	nc anged	ncrease	eferred for	nc anged	ncrease	eferred for	nc anged	ncrease	eferred for	nc anged	ncrease	eferred for	nc anged	ncrease	eferred for	nc anged	ncrease	eferred for
Outcome of full match of new post																																				
Outcome of review of new post																																				

C anged o s	Mont	pril			May			ne			ly			g st			Septe er			cto er			ove er			ece er			an ary			e r ary			Marc		
		o eceived	n oing	Co pleted	o eceived	n oing	Co pleted	o eceived	n oing	Co pleted	o eceived	n oing	Co pleted	o eceived	n oing	Co pleted	o eceived	n oing	Co pleted	o eceived	n oing	Co pleted	o eceived	n oing	Co pleted	o eceived	n oing	Co pleted	o eceived	n oing	Co pleted	o eceived	n oing	Co pleted	o eceived	n oing	Co pleted
No. of staff that have submitted a changed ob request		0		0	0		0	0		0	0		0	0		0	0		0	0		0	0		0	0		0	0	5	3	0	5	0	0		1
No. of staff that have appealed the outcome of their changed ob request banding (Review)		0		0	0		0	0		0	0		0	0		0	0		0	0		0	0		0	0		0	0		0	0		0	0		0
		nc anged	ncrease	eferred for	nc anged	ncrease	eferred for	nc anged	ncrease	eferred for	nc anged	ncrease	eferred for	nc anged	ncrease	eferred for	nc anged	ncrease	eferred for	nc anged	ncrease	eferred for	nc anged	ncrease	eferred for	nc anged	ncrease	eferred for	nc anged	ncrease	eferred for	nc anged	ncrease	eferred for	nc anged	ncrease	eferred for
Outcome of changed ob requests		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3	0	0	0	0	1	0	0
Outcome of changed ob reviews		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

o val ations	Mont	pril			May			ne			ly			g st			Septe er			cto er			ove er			ece er			an ary			e r ary			Marc		
		o eceived	n oing	Co pleted	o eceived	n oing	Co pleted	o eceived	n oing	Co pleted	o eceived	n oing	Co pleted	o eceived	n oing	Co pleted	o eceived	n oing	Co pleted	o eceived	n oing	Co pleted	o eceived	n oing	Co pleted	o eceived	n oing	Co pleted	o eceived	n oing	Co pleted	o eceived	n oing	Co pleted	o eceived	n oing	Co pleted
No of posts referred for ob evaluation		0		0	0		0	0		0	0		0	0		0	0		0	0		1	0	5	1	0	0	5	0	0	0	0	0	0	0	0	0
		nc anged	ncrease	eferred for	nc anged	ncrease	eferred for	nc anged	ncrease	eferred for	nc anged	ncrease	eferred for	nc anged	ncrease	eferred for	nc anged	ncrease	eferred for	nc anged	ncrease	eferred for	nc anged	ncrease	eferred for	nc anged	ncrease	eferred for	nc anged	ncrease	eferred for	nc anged	ncrease	eferred for	nc anged	ncrease	eferred for
Outcome of ob evaluations for changed obs/new post/RPA		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	1	0	0	5	0	0	0	0	0	0	0	0	0	0	0

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Outcome of review of ob evaluations for new posts/changed obs/RPA	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0
Total	0	0	0	0	0							0	0	0	0	0	0	0	2	0	0	1	0	0	5	0	0	1	0	0	0	0	0	0	0	0	0

M L S H B T T S	Mont												
	pril	May	ne	ly	g	Sep	ct	ov	ec	an	e	Mar	rand Total
No of Worklife balance applications received	5	1	1	22	1	1	15						1
No. of worklife balance applications approved	5	13	13	1	1	10	15						153
No. of staff availed of the Summer Scheme													
No. of staff attended a Here event													
No. of staff attended Health Fairs													
No. of Staff attended HR Roadshows / Clinics													
No. of staff attending Targeted HWB Interventions													

H LTH S C L LT S	Mont												
	pril	May	ne	ly	g	Sep	ct	ov	ec	an	e	Mar	Total
No. of Policy screenings completed													
No of EQIA S completed													

M L BLT	early				
	pril Sep	ct Marc	rand Total		isa ili ty
No. of Disability Placements held	2				
No. of staff availing of Workable Programme Support					

L S T L L M T	pril		May		ne		ly		g		Sept		ct		ov		ec		an		e		Mar		Total	
	o ttended	o	o ttended	o	o ttended	o	o ttended	o	o ttended	o	o ttended	o	o ttended	o	o ttended	o	o ttended	o	o ttended	o	o ttended	o	o ttended	o	o ttended	o
Mandatory Equality Training (Target per ann)	1			3	2		0	0	0	0			10	3	1	1		2		1	1	2	1	3	1 1	33
Managers Mandatory Absence Training	0	0	2	0	5	1	0	0	0	0	12	2		5	2		0	0	10		0	0	2	1	0	25
Managers SDR training	3	0	0	0	1	1	2	1	15	0	1	1		0	1	3	2	1	11	2		0	1	1	1	10
Full Recruitment & Selection Training		2	3	0	0	0		2	3	0		0		1	12	2	3	1		1	0	2	2	1	3	12
Recruitment & Selection Refresher Training e-learning		0	12	0	0	0	0	0		0	10	0		0	5	0	5	0		0		0	1	0	3	0
SDR for Reviewees	0	1	3	1	0	1	0	0	32	1		1	0	0	0	0	3	1	0	1	5	1		1		
Attendance at Quality 2020 Level 1 (Tr st target Staff y st Marc)		0	2	0		0	1	0	3	0	12	0	2	0		0	31	0	5	0		0		0	351	0
Coaching Skills for Leaders	0	0	2	0	1	1	0	0	0	0	0	0	0	0	1	0	1	0	0	0	1	0	0	0		1
Engaging Manager programme	0	0	0	0	3	1	1	0	3	0	2	0		0		2	0	0	5	0	1	0	1	1	33	
ILM Level 2 Award in Leadership and Team Skills	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	1	0	2	0
ILM 3 Award in Leadership and Management	0	0	0	0	1	0	0	0	0	0	3	0	0	0	3	0	0	0	0	0	0	0	2	0		0
ILM Level 3 Award in Coaching	0	0	0	0	0	0		0	0	0	5	0	0	0	0	0	0	0	0	0	1	0	0	0	10	0
ILM Level Award in Leadership & Management	0	0	0	0	1	0	0	0	0	0	0	0	0	0	5	0	0	0	0	0	1	0	0	0		0
ILM 5 Award in Managing for Success	0	0	0	0		0	0	0	0	0	0	0	0	0	0	0	10	0	0	0	0	0	2	0	1	0
Nursing Support Induction	0	0	0	0		0	0	0	0	0		0	0	0	0	0	2	0	0	0	0	0	12	0	2	0
Level 2 Cert Health Care Support	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Level 3 Cert Health Care Support	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	0		0
Personal effectiveness and Development training (rouped)		2	3	2	1	12		3		3			5	10	1		3	3	22		2		13		35	

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	Mont												
	pril	May	ne	ly	g	Sep	ct	ov	ec	an	e	Marc	rand Total
Number of Team Values Workshops (Tr st ann al Target wor s ops)	0	1	3	2	2	0	0	0	0	1	1	1	11
Number of staff accessing Coaching (Tr st ann al Target for coac ees)	5	0		1	0	1	0	0	0	0	0	0	11

	Mar	May	ly	Sep	ov	an	rand Total
Corporate Welcome	. 0	5. 0	2.50	. 0	.00	.30	

WORKFORCE SOURCES & DEFINITIONS

Sources and definitions for staff numbers publications and statistics

Prior to December 2012: Human Resources Management System.

From December 2012 to December 2013: A combination of Human Resources Management System and Human Resources, Payroll, Travel & Subsistence System.

From March 2014: Human Resources, Payroll, Travel & Subsistence System.

These systems were/are maintained by Health & Social Care organisations and DoH had/have access to a restricted set of data variables from these sources.

Whole-time Equivalent (WTE) – this is calculated by aggregating the total number of hours that staff in a grade are contracted to work, and dividing by the standard hours for that grade. In this way, part-time staff are converted into an equivalent number of 'whole-time' staff.

Bank Staff – These staff are on 'as & when required' contracts to fill staffing shortfalls and maintain service delivery.

Occupational Families – these were previously termed as Terms & Conditions Group, e.g. Medical & Dental or Nursing, Midwifery and Health Visiting.

Professional & Technical Occupational Family – A term used to group all the Allied Health Professionals and also Clinical Scientists, Medical Technical Officers, Optometrists, Hospital Pharmacists, Clinical Psychologists and their support staff.

Allied Health Professional (AHPs) – A collective term used to describe physiotherapists, occupational therapists, speech & language therapists, radiographers, chiropodists/podiatrists, dietitians and orthoptists. This group used to be known as Professions Allied to Medicine (PAMs).

Generic Occupational Family – A term used to describe staff working in multidisciplinary roles.

Regional Services – This term is used to group the following organisations:
Business Services Organisation
NI Ambulance Service HSC Trust
NI Blood Transfusion Service
NI Guardian Ad Litem Agency
NI Practice & Education Council
NI Social Care Council
Patient Client Council
Public Health Agency
Regulation & Quality Improvement Authority
Health and Social Care Board

and from March 2014, NI Medical & Dental Training Agency

Agenda for Change (AFC) - Agenda for Change is a pay system with harmonised conditions of service throughout Health & Social Care and the NHS for all staff excluding doctors, hospital dentists and senior executives. This system is based on equal pay for work of equal value, based on job evaluation.

Sources and definitions for staff vacancies publications and statistics

Prior to March 2015:
DoH collected vacancies data via a survey twice a year, as at 31st March and as at 30th September. The survey was completed by Health & Social Care organisations.

Current Vacancy - A current vacancy is a post which at 31st March in a given year the organisation was actively trying to fill. Note that a post does not have to be unoccupied to be counted.

Long-term Vacancy - A long-term vacancy is a post which had been advertised on or prior to 31st December in a given year, but remained unfilled at 31st March the following year, provided that the organisation was still actively trying to fill it. Long-term vacancies are a sub-set of current vacancies. Note that the stipulation that a post had to be unoccupied to be counted has been removed from the definition.

Temporary Vacancy - A temporary post vacancy is a short-term post to cover for holiday periods and for staff on sick / maternity leave, or a post specifically created for a short-term period.

From March 2017:
DoH collects vacancies data from HSC organisations at the end of each quarter i.e. at 31st March, 30th June, 30th September and 31st December.

Vacancy - A vacancy as any position that is currently with the recruitment team and being actively recruited to. This will include those going through pre-employment checks, up to the point of a start date being agreed. Once a start date has been agreed with both parties (i.e. manager and applicant) this will no longer be classed as a vacancy. Vacancies that are on hold by managers are not included.

Vacancy Rate - The vacancy rate is the total number of vacancies expressed as a percentage of the total staff complement (i.e. vacancies plus staff in post).

Note about comparison of publications

Please note that older publications may have been produced using a different staffing basis from more recent publications. Where revisions to methodology have occurred, the trend data has been revised in the more recent publication only.

HSC Vacancies Actively Being Recruited at 31 December 2022

Table of Contents

Table 1

eneric	3	52	11		
Admin & Clerical		30	3		1 3 3
Estates Services Staff	1	5	3		
Support Services/ ser Experience	5	5	0		
Health Visitors		3	1		3
District Nurses		22	5		2
Paediatric Nurses		11	3		11
Mental Health Nurses		2			2 0
Learning Disability Nurses			5		
All Other Registered Nurses		1			1 5
Registered Midwives		125			12
Nurse Support	2				2
Midwifery Support					
Social Workers		5 1	1		5
Social Care Workers	325	2	2		1
Domiciliary Care Workers	55	0	0		55
Other Social Services staff	3 1	1 2	13		
Physiotherapists		1 5	1		1
Occupational Therapists		131			13
Speech & Language Therapists		5	5		2
Podiatrists		20			2
Dietitians			1		
Orthoptists		1	2		3
Radiographers			5		
Pharmacists			2		
Clinical Psychology		25	1		3
Scientist / Scientist Support / Medical Technical Officer / Assistant Technical Officer	3	53	10		12
Other Professional & Technical staff	20		10		302
Consultant				1	1
Locum Consultant				10	10
Associate Specialist / Staff rade / Specialty Doctor				5	5
Doctors in training (core trainees specialty registrars foundation doctors)					
Other Doctor					
Dental Officer				2	2

Table 1

HCPC Registered Paramedic			0		
Emergency Medical Technician	0	0	0		0
Ambulance Officer	1	13	0		1
Patient Care Services	1	0	0		1
Control Officer	0	5	0		5
Control Assistant		0	0		

Source: HSC Trusts & ALB's

Relates to Trust recruitment

Includes student/ training places in anticipation of pro ected vacancies arising from service developments promotional opportunities and associated backfill over a period of 12 months taking into account relevant training periods.

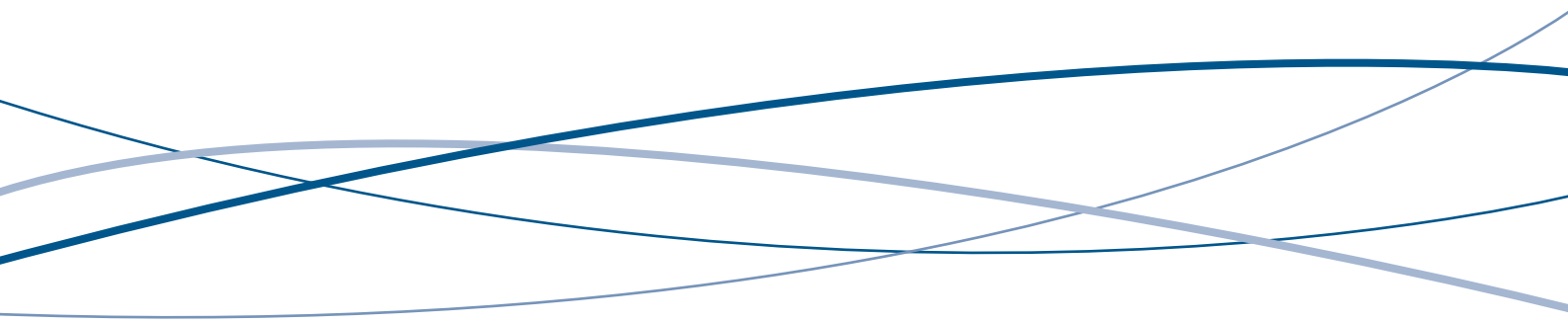
eneric	2			0	15	0	5	2	1	0	0	0	0	0	0	3	0	
Admin & Clerical	30	1	1 0	1 2	25	10	0	152		0	10	5	1	1	1	1	5	
Estates Services Staff	2	2	13	11	1	0	0	0	0	0	0	0	0	0	0	0	0	
Support Services/ ser Experience	130	3	10	2		5	0		0	0	0	0	0	0	0	0	0	
Health Visitors	3	12			12	0	0	0	0	0	0	0	0	0	0	0	0	
District Nurses		5			3	0	0	0	0	0	0	0	0	0	0	0	0	
Paediatric Nurses	3			22	35	0	0	0	0	0	0	0	0	0	0	0	0	
Mental Health Nurses	5	1	1	0	5	0	0	0	0	0	0	0	0	0	0	0	0	
Learning Disability Nurses	2	11		3	2	0	0	0	0	0	0	0	0	0	0	0	0	
All Other Registered Nurses		35	2	20	2	0	1	1	0	0	0	0	0	0	0	0	0	
Registered Midwives	2	31	2	32	11	0	0	0	0	0	0	0	0	0	0	0	0	
Nurse Support	120	201	103		11	0	2	0	0	0	0	0	0	0	0	0	0	
Midwifery Support	0	0	0		1	0	0	0	0	0	0	0	0	0	0	0	0	
Social Workers	115	121	103	13	105	0	0	0	0	0	0	1	0	0	0	0	0	
Social Care Workers	2	5	2	1	5	0	0	0	0	0	0	0	0	0	0	0	0	
Domiciliary Care Workers	33		51	23	3	0	0	0	0	0	0	0	0	0	0	0	0	
Other Social Services staff	12	1	1	3	10	0	0	0	0	0	0	0	0	0	0	0	0	
Physiotherapists	52	2	2	31	3	0	0	0	0	0	0	0	0	0	0	0	0	
Occupational Therapists	32	31	25	2	22	0	0	0	0	0	0	0	0	0	0	0	0	
Speech & Language Therapists	23		13	15	5	0	0	0	0	0	0	0	0	0	0	0	0	
Podiatrists			5	3		0	0	0	0	0	0	0	0	0	0	0	0	
Dietitians	1	12	3			0	0	0	0	0	0	0	0	0	0	0	0	
Orthoptists	1	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Radiographers	3		1	1	1	0	0	0	0	0	0	0	0	0	0	0	0	
Pharmacists	35	2	23	3	13	0	0	0	0	0	0	0	0	0	0	0	0	
Clinical Psychologist	2	32	1	5	13	0	0	0	0	0	0	0	0	0	0	0	0	
Scientist / Scientist Support / Medical Technical Officer / Assistant Technical Officer	0	21		25	13	0	1	0	0	0	0	0	0	0	0	0	0	
Other Professional & Technical staff	11	0	3	32	5	0	0	1	0	0	0	0	0	0	0	1	0	
Consultant	3	23		2	5	0	0	0	0	0	0	0	0	0	0	0	0	
Locum Consultant	5	0	0	2	3	0	0	0	0	0	0	0	0	0	0	0	0	
Associate Specialist / Staff rade / Specialty Doctor	1	1	3	11	2	0	0	0	0	0	0	0	0	0	0	0	0	
Doctors in training (core trainees specialty registrars foundation doctors)	0	5	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	
Other Doctor	2	2	2	15	2	0	1	0	0	0	0	0	0	0	0	0	0	
Dental Officer	0	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	
HCPC Registered Paramedic	0	0	0	0	0		0	0	0	0	0	0	0	0	0	0	0	
Emergency Medical Technician	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Ambulance Officer	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	
Patient Care Services	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	
Control Officer	0	0	0	0	0	5	0	0	0	0	0	0	0	0	0	0	0	
Control Assistant	0	0	0	0	0		0	0	0	0	0	0	0	0	0	0	0	

Figures are provisional and may abe sub ect to change.

Includes student/ training places in anticipation of pro ected vacancies arising from service developments promotional opportunities and associated backfill over a period of 12 months taking into account relevant training periods.

Former HSC Board staff have undertaken their functions from 1 April 2022 as part of the Department of Health s newly formed Strategic Planning and Performance roup (SPP). For consistency purposes vacancies actively being recruited to in SPP are included in this bulletin and noted as SPP in the table above.

A promise to learn – a commitment to act



Improving the Safety of Patients in England

National Advisory Group on the Safety of Patients in England

August 2013

Contents

Executive Summary

Place the quality of patient care, especially patient safety, above all other aims.

Engage, empower, and hear patients and carers at all times.

Foster whole-heartedly the growth and development of all staff, including their ability and support to improve the processes in which they work.

Embrace transparency unequivocally and everywhere, in the service of accountability, trust, and the growth of knowledge.

At its core, the NHS remains a world-leading example of commitment to health and health care as a human right – the endeavour of a whole society to ensure that all people in their time of need are supported, cared for, and healed. It is a fine institution. But the events at Mid Staffordshire have triggered a need to re-examine what the NHS does and determine how it can improve further. The only conceivably worthy honour due to those harmed is to make changes that will save other people and other places from similar harm.

Our job has been to study the various accounts of Mid Staffordshire, as well as the recommendations of Robert Francis and others, to distil for Government and the NHS the lessons learned, and to specify the changes that are needed.

The following are some of the problems we have identified:

- Patient safety problems exist throughout the NHS as with every other health care system in the world.
- NHS staff are not to blame – in the vast majority of cases it is the systems, procedures, conditions, environment and constraints they face that lead to patient safety problems.
- Incorrect priorities do damage: other goals are important, but the central focus must always be on patients.
- In some instances, including Mid Staffordshire, clear warning signals abounded and were not heeded, especially the voices of patients and carers.
- When responsibility is diffused, it is not clearly owned: with too many in charge, no-one is.
- Improvement requires a system of support: the NHS needs a considered, resourced and driven agenda of capability-building in order to deliver continuous improvement.
- Fear is toxic to both safety and improvement.

To address these issues the system must:

- Recognise with clarity and courage the need for wide systemic change.
- Abandon blame as a tool and trust the goodwill and good intentions of the staff.
- Reassert the primacy of working with patients and carers to achieve health care goals.
- Use quantitative targets with caution. Such goals do have an important role *en route* to progress, but should never displace the primary goal of better care.

- Recognise that transparency is essential and expect and insist on it.
- Ensure that responsibility for functions related to safety and improvement are vested clearly and simply.
- Give the people of the NHS career-long help to learn, master and apply modern methods for quality control, quality improvement and quality planning.
- Make sure pride and joy in work, not fear, infuse the NHS.

The most important single change in the NHS in response to this report would be for it to become, more than ever before, a system devoted to continual learning and improvement of patient care, top to bottom and end to end.

We have made specific recommendations around this point, including the need for improve training and education, and for NHS England to support a network of safety improvement collaboratives to identify and spread safety improvement approaches across the NHS.

Our ten recommendations are as follows:

1. The NHS should continually and forever reduce patient harm by embracing wholeheartedly an ethic of learning.
2. All leaders concerned with NHS healthcare – political, regulatory, governance, executive, clinical and advocacy – should place quality of care in general, and patient safety in particular, at the top of their priorities for investment, inquiry, improvement, regular reporting, encouragement and support.
3. Patients and their carers should be present, powerful and involved at all levels of healthcare organisations from wards to the boards of Trusts.
4. Government, Health Education England and NHS England should assure that sufficient staff are available to meet the NHS's needs now and in the future. Healthcare organisations should ensure that staff are present in appropriate numbers to provide safe care at all times and are well-supported.
5. Mastery of quality and patient safety sciences and practices should be part of initial preparation and lifelong education of all health care professionals, including managers and executives.
6. The NHS should become a learning organisation. Its leaders should create and support the capability for learning, and therefore change, at scale, within the NHS.
7. Transparency should be complete, timely and unequivocal. All data on quality and safety, whether assembled by government, organisations, or professional societies, should be shared in a timely fashion with all parties who want it, including, in accessible form, with the public.
8. All organisations should seek out the patient and carer voice as an essential asset in monitoring the safety and quality of care.
9. Supervisory and regulatory systems should be simple and clear. They should avoid diffusion of responsibility. They should be respectful of the goodwill and sound intention of the vast majority of staff. All incentives should point in the same direction.
10. We support responsive regulation of organisations, with a hierarchy of responses. Recourse to criminal sanctions should be extremely rare, and should function primarily as a deterrent to wilful or reckless neglect or mistreatment.

The NHS in England can become the safest health care system in the world. That will require unified will, optimism, investment, and change. Everyone can and should help. And, it will require a culture firmly rooted in continual improvement. Rules, standards, regulations and enforcement have a place in the pursuit of quality, but they pale in potential compared to the power of pervasive and constant learning.

A promise to learn – a commitment to act:
Improving the safety of patients in England

We do not need to recite the details of the tragedy of Mid-Staffordshire in this report. Many people probably died from avoidable causes, and many more suffered unnecessary indignities and harm. The details are catalogued for posterity in Robert Francis's historic report; and the story is now indelibly part of the history of the NHS in England[1].

The only conceivably worthy honour due to those harmed is to make changes that will save other people and other places from similar harm. It would add tragedy to tragedy if the nation failed to learn from what happened, and to put those lessons to work. Without ever forgetting what has happened, **the point now is to move on**.

Beyond doubt the NHS can do that, perhaps better than any other health care system in the world. The wave of concern that led to commissioning this report ought not to obscure the enormous strengths of the NHS, its positive achievements, or its even greater promise.

In its core and concept, the NHS has been and remains a world-leading example of commitment to health and health care as a human right – the endeavour of a whole society to ensure that all people in their time of need are supported, cared for, and healed. The vast majority of those who serve in the NHS – clinicians, staff, managers, executives, and boards, contractors and partners – try every day to help to the very best of their abilities, and with deep and appropriate pride in their mission. This Advisory Group recommends important changes that we believe will lead to an even better and safer NHS, but we do not thereby suggest that the NHS has fundamentally lost its way. It is a fine institution that can and should now become much better.

Our job from March 2013 through to July 2013 has been to study the various available accounts of Mid Staffordshire, as well as the recommendations of Robert Francis and others, to distil for Government and the NHS the lessons learned, and to **specify the changes that are needed**.

In announcing our work, the Prime Minister boldly suggested that we might help the NHS achieve "zero harm." We welcomed this ambitious call, but also agreed from the beginning that even the aims for improvement – what the NHS should strive to achieve and how quickly – would be subjects for our deliberations, and not set by others. We were formed as, and we remain, an independent Advisory Group, relying on our best thinking, not on outside instruction, for our findings.

We cannot and do not claim comprehensiveness in what we recommend. We knew that we would choose to remain silent on many of the Francis Report's 290 recommendations, and that we would not try to comment on everything important for the NHS to do next in the wake of Mid Staffordshire. Further, while we

[1] This report is focused on the NHS in England and where we say 'NHS' we are referring to the NHS in England. However, the lessons are applicable to other healthcare systems, both within the rest of the UK and worldwide.

wholeheartedly support changes in the configuration of services and detailed processes of care that will improve safety and quality, we do not in this report attempt to prescribe those changes. That is better left to commissioners and to the people who give care; they, not we, are the experts in care delivery.

We believe that the actions we propose are necessary, but they are not sufficient to secure a robust future for safety in the NHS. We are only one among many who will together help establish and maintain a better course. Indeed, several fine reports and studies overlapping our charge have appeared during the period of our work. Important among them is the recent Keogh Review, whose recommendations we endorse.

The problems

Motivating our recommendations are findings that we gathered from prior reports (those of Robert Francis and others), the statements of patients and other experts, the research evidence, and our own experience. Among the most important of these findings are the following:

1. **Patient safety problems exist throughout the NHS:** The Mid Staffordshire tragedy may be the most notorious recent lapse in care in the English NHS, but it is not unique. A few other trusts show signs that warrant prompt further scrutiny and, when appropriate, intervention, such as the Keogh review has recently ably modelled. More generally, like every other health care system in the world, the NHS experiences repeated defects in patient safety, and too many patients and carers suffer as a result. We feel strongly that, as for all healthcare systems, **the whole NHS should strengthen patient safety now and into the future**.
2. **NHS staff are not to blame:** Neither at Mid Staffordshire, nor more widely, is it scientifically justifiable to blame the staff of the NHS or label them as uncaring, unskilled, or culpable. A very few may be exceptions, but **the vast majority of staff wish to do a good job, to reduce suffering and to be proud of their work**. Good people can fail to meet patients' needs when their working conditions do not provide them with the conditions for success.
3. **Incorrect priorities do damage:** The Mid Staffordshire tragedy and wider quality defects in the NHS seem traceable in part to a loss of focus by at least some leaders on both excellent patient care and continual improvement as primary aims of the NHS (or to a misinterpretation by providers of the intent of leaders). In some organisations, in the place of **the prime directive, "the needs of the patient come first",** goals of (a) hitting targets and (b) reducing costs have taken centre stage. Although other goals are also important, where the central focus on patients falters, signals to staff, both at the front line and in regulatory and supervisory bodies, can become contaminated. Listening to and responding to patients' needs then become, at best, secondary aims. Bad news becomes unwelcome and, over time, it is too often silenced. Under such conditions organisations can hit the target, but miss the point.
4. **Warning signals abounded and were not heeded:** Information on the deterioration of the quality of care at Mid-Staffordshire was abundant. It appeared in both narration (complaints from staff, carers and patients) and quantitative metrics (such as significantly high adjusted mortality rates compared with rates throughout England). **Loud and urgent signals were muffled and explained away**. Especially costly was the muffling of the voices of patients and carers who took the trouble to complain but whose complaints were too often ignored.
5. **Responsibility is diffused and therefore not clearly owned:** Responsibility for oversight and remedy for quality and safety concerns was, and is still to some extent, diffused in the NHS in England, with that responsibility divided among many agencies, and with unclear or at times non-existent lines of

coordination, communication, pattern-recognition and follow-up for action. **When so many are in charge, no one is**.

6. **Improvement requires a system of support:** The capability to measure and continually improve the quality of patient care needs to be taught and learned or it will not exist. The NHS needs a considered, resourced and driven agenda of capability-building in order to generate the capacity for continuous improvement. That investment in human development is absolutely necessary if, when alarms ring as they did in Mid Staffordshire, people with their hands on the steering wheel are to have the knowhow to diagnose and fix the problems. **The most important single change in the NHS in response to this report would be for it to become, more than ever before, a system devoted to continual learning and improvement of patient care, top to bottom and end to end.**

7. **Fear is toxic to both safety and improvement:** Fear impedes improvement in complex human systems. Time and again, we see the harvest of fear in the Mid Staffordshire story, a vicious cycle of over-riding goals, misallocation of resources, distracted attention, consequent failures and hazards, reproach for goals not met, more misallocation and growing opacity as dark rooms with no data came to look safer than ones with light. "**Better not to know" became the order of the day**. A symptom of this cycle is the gaming of data and goals; if the system is unable to *be* better, because its people lack the capacity or capability to improve, the aim becomes above all to *look* better, even when truth is the casualty.

Even while asserting unblinkingly what is amiss, it is important to notice and celebrate the strengths of the NHS. Big changes are needed, but **we do not believe that the NHS is unsound in its core.** On the contrary, its achievements are enormous and its performance in many dimensions has improved steadily over the past two decades.

We have the data. Waiting times are shorter than 15 years ago, cardiovascular care and outcomes are far better, cancer care is improving fast and healthcare-acquired infection rates have plummeted. Stroke care in London reached world-class levels. From the beginning of this century, the UK has seen unprecedented investments in training staff in quality improvement, in measuring service and outcomes and in fostering collaborative improvement projects among hundreds of hospitals and ambulatory practices. Those investments have paid off. NHS experts have pioneered patient-driven health care designs, in new models of "productive wards" and "productive operating theatres," and in patient safety research. Innovation is abundant; the barriers have been more to spread of effective new models than to their creation. Most impressive of all, perhaps, has been the consistent dedication to helping their patients among the vast majority of NHS clinicians – doctors, nurses, pharmacists, allied health professionals, mental health professionals and many more – as well as non-clinical staff.

Society, in general, and leaders and opinion formers, in particular, (including national and local media, national and local politicians of all parties, and commentators) have a crucial role to play in shaping a positive culture that, building on these strengths, can realise the full potential of the NHS. When people find themselves working in a culture that avoids a predisposition to blame, eschews naïve or mechanistic targets, and appreciates the pressures that can accumulate under resource constraints, they can avoid the fear, opacity, and denial that will almost inevitably lead to harm.

In pursuit of such a culture, as the leaders whom we encountered in our work know, a measured and balanced response, anchored in science and evidence, serves the nation well. Even while leaders speak out clearly and with courage, as they should, when things go wrong, it is helpful to avoid drama, accusation and overstatement either in the Mid Staffordshire case or in other cases of lapses in patient safety. No single person, party, or administration caused the problems that need to be solved, and everyone can help guide the

next steps if they work together. Likewise, the media's role in uncovering and highlighting genuine problems has been and will remain invaluable, but, at its best, the media is also a key resource for public education and the encouragement of improvement.

The solutions

This litany of problems is, of course, tough to read. However, these concerns are not unique to the NHS; they occur in all large health care systems. Recognising them is the first step toward the repair; knowing what is going wrong gives us the opportunity to set things right.

Set out below are the principles of action that have guided us in our choice of recommendations:

1. **Recognise with clarity and courage the need for wide systemic change:** All improvement begins with clear recognition and acknowledgement of the need to improve. Building a better, safer NHS will benefit from that recognition and involvement from everyone who has a contribution to make to health and care – not just the directly funded NHS, but also contractors and partners, large and small healthcare businesses, social enterprises and voluntary organisations, local authorities, privately funded carers, and, of course, patients, carers and communities. Everyone.
2. **Abandon blame as a tool.** Trust the goodwill and good intentions of the staff, and help them achieve what they already want to achieve: better care and the relief of human suffering. Misconduct can occur and it deserves censure. But, errors are not misconduct and do not warrant punishment:
3. **Reassert the primacy of working with patients and carers to set and achieve health care goals.** Patient safety is better served when patients and carers are as actively engaged in healthcare as they want to be:
4. **Use quantitative targets with caution.** Goals in the form of such targets can have an important role *en route* to progress, but should never displace the primary goal of better care. When the pursuit of targets becomes, for whatever reason, the overriding priority, the people who work in that system may focus too narrowly. Financial goals require special caution; they reflect proper stewardship and prudence, but are only a means to support the mission of the NHS: healing:
5. **Recognise that transparency is essential and expect and insist on it at all levels and with regard to all types of information** (other than personal data). The most valuable information of all is information on risks and on things that have gone wrong; and among the most valuable sources of information are the reports and voices of patients, carers and staff. Everyone, including staff, should be free to state openly their concerns about patient safety without reprisal, and there is no place for compromise agreements ("gagging clauses") that prevent staff discussing safety concerns:
6. **Ensure that responsibility for functions related to safety and improvement are vested clearly and simply** in a thoroughly comprehensible set of agencies, among whom full cooperation is, without exception, expected and achieved:
7. **Give the people of the NHS – top to bottom – career-long help to learn, master and apply modern methods for quality control, quality improvement and quality planning.** The NHS has an obligation to assure their growth and support:
8. **Make sure pride and joy in work, not fear, infuse the NHS.**

In sum, the recommendations below reflect our view that the quality of patient care should come before all other considerations in the leadership and conduct of the NHS, and that patient safety is the keystone dimension of quality. The pursuit of continually improving safety should permeate every action and level in the NHS.

The Francis Report recommended numerous types of new regulation. Regulation, especially using intelligent inspection by experts, does have an important role in setting out what is expected, monitoring the extent to which those expectations are met, and taking action when they are not met. Clear and prompt response to alarming signals, such as have now been investigated in the Keogh study of some hospitals with significantly high mortality rates, is crucial for quality control.

However, regulation alone cannot solve the problems highlighted by Mid Staffordshire. Neither quality assurance nor continual improvement can be achieved through regulation based purely on technically specific standards, particularly where a blunt assertion is made that any breach in them is unacceptable.

In the end, **culture will trump rules, standards and control strategies every single time, and achieving a vastly safer NHS will depend far more on major cultural change than on a new regulatory regime**.

As a universal healthcare system, free at the point of use, with common goals, structures and systems, the NHS is unique in the world, and can do what no other system can. It has the potential to be the safest healthcare system in the world. The best responses to the Francis Report, the best routes to badly needed improvements, will build on the strengths of the NHS, not ignore them or take them for granted. This will take time to bear fruit and require many years of effort, many messages and many deeds. There is no easy fix, but the prize is worth the price.

A note on the nature of quality and patient safety

To help readers understand the recommendations that follow, we need to describe our perspective on quality and how this relates to safety and the causes of harm.

Many modern industries define "quality" as ''*the degree to which a system of production meets (or exceeds) the needs and desires of the people it serves*''. An effective quality management system includes *quality control* (to keep sound processes reliable on a daily basis), *quality improvement* (to decrease variation within and among NHS organisations so that the best becomes the norm) and *quality planning* (especially fostering innovative care models that can deliver better outcomes at lower cost).

Lord Darzi defined quality for the NHS as comprising three dimensions:

- Safety (avoiding harm from the care that is intended to help).
- Effectiveness (aligning care with science and ensuring efficiency).
- Patient-experience (including patient-centeredness, timeliness and equity).

All these dimensions count, but one among them – safety – emerges repeatedly as the most expected; patients, families and the public expect that the people and organisations that exist to help them will not hurt them. ''*First do no harm*'' is not just a slogan in health care; it is a central aim.

Yet, health care necessarily involves some risk. In seeking the benefits of modern medicine, patients may reasonably choose treatments that involve risk or cause side effects. People have chemotherapy knowing that

the effects are unpleasant. They accept the risk of the treatment in hope of cure or to prolong life. And, new treatments, even wondrous ones, always bring new threats to safety.

In addition to risks inherent in some treatments, there is also inescapable tension between the pursuit of safety and the pursuit of other healthcare priorities. If resources were infinite, many risks could be eliminated. But, resources are not infinite. Achieving a proper balance between risks and resources requires constant vigilance against reductions in resources – such as time, people or consumables – that raise risk to unnecessary and unacceptable levels. People at all levels of care and in all roles need to acknowledge this tension, so that dialogue remains clear, mature and open about how much risk to accept in pursuit of goals other than safety.

Even though hazards in care cannot be eliminated, harms to patients can be and should be reduced continually, everywhere and forever. The fight for safety is a never-ending struggle against entropy, engaged tirelessly and with focus against an enemy that continually emerges and re-emerges.

We distinguish three types of unnecessary risk of harm: risk of harm due to neglect or wilful misconduct: risk of harm due to failures in the system; and risk of harm from error. They are not the same. As Robert Francis has unequivocally shown, some harm is, indeed, due to neglect or to wilful misconduct. These rare sources of harm should be distinguished from the far more common kind: errors made by well-intentioned people or arising from failures in the system. Improving the reliability and safety of healthcare systems is a critical task for leaders. They need to differentiate carefully between error and neglect or wilful misconduct.

Error and neglect or wilful misconduct warrant different responses. Even apparently simple human errors almost always have multiple causes, many beyond the control of the individual who makes the mistake. Therefore, it makes no sense at all to punish a person who makes an error, still less to criminalise it. The same is true of system failures that derive from the same kind of multiple unintentional mistakes. Because human error is normal and, by definition, is unintended, well-intentioned people who make errors or are involved in systems that have failed around them need to be supported, not punished, so they will report their mistakes and the system defects they observe, such that all can learn from them. On the other hand, harm caused by neglect or wilful misconduct does warrant sanctions in health care, just as it does in other settings.

Recommendations

The recommendations that follow are grouped into nine categories:

I. The Overarching Goal

II. Leadership

III. Patient and Public Involvement

IV. Staff

V. Training and Capacity-Building

VI. Measurement and Transparency

VII. Structures

VIII. Enforcement

IX. Moving Forward

In the first eight sections, we provide the key recommendations and a brief narrative. These are followed by our suggestions for specific actions by named actors. In the "Moving Forward" section, we offer some summary views and suggest the highest priority actions.

I. The overarching goal

Recommendation

1. **The NHS should continually and forever reduce patient harm by embracing wholeheartedly an ethic of learning.**

Patient safety should be the ever-present concern of every person working in or affecting NHS-funded care. The quality of patient care should come before all other considerations in the leadership and conduct of the NHS, and patient safety is the keystone dimension of quality.

Be in no doubt, we are herein advocating a monumental challenge, which will require unprecedented acts of will by the political and executive leadership of the NHS, deep thought and action by everyone in the NHS, patience and understanding from our patients, politicians and media organisations, and courage from everyone to soak up the inevitable failures and lapses along the way.

While "Zero Harm" is a bold and worthy aspiration, the scientifically correct goal is "continual reduction". All in the NHS should understand that safety is a continually emerging property, and that the battle for safety is never "won"; rather, it is always in progress.

Quantitative targets and financial goals should not override protection of patients from harm. The Government, commissioners and health care providers should strive to strike a balance between minimising risk and allocating resources. Where scarcity of resources threatens to compromise safety, all NHS staff should raise concerns to their colleagues and superiors and be welcomed in so doing. This vigilance cannot come from regulation. It requires culture change and therefore countless, consistent and repeated messages and deeds over a period of years. It means living the values of the NHS Constitution. Goals and incentives should be clear, fully aligned, and focused on the interests of patients, with a high level of coherence across the system as a whole. The best way to reduce harm is for the NHS to embrace wholeheartedly a culture of learning.

Resource constraints will undoubtedly continue in the NHS. There are two ways to deal with this reality. One is by simply cutting budgets and thereby placing the burden on staff of caring with fewer resources. The other, better, way is through improvement – introducing new models of care and new partnerships among clinicians, patients and carers that can produce better care at lower cost. Only a culture of learning and improvement can follow that better way.

II. Leadership

Recommendation

2. All leaders concerned with NHS healthcare – political, regulatory, governance, executive, clinical and advocacy – should place quality of care in general, and patient safety in particular, at the top of their priorities for investment, inquiry, improvement, regular reporting, encouragement and support.

Leadership is about mobilising the attention, resources and practices of others towards particular goals, values or outcomes. The continual reduction of patient harm requires clarity and constancy of purpose among all leaders, from the front-line to the Prime Minister and across the whole system.

Leadership requires presence and visibility. Leaders need first-hand knowledge of the reality of the system at the front line, and they need to learn directly from and remain connected with those for whom they are responsible. Culture change and continual improvement come from what leaders do, through their commitment, encouragement, compassion and modelling of appropriate behaviours.

Society in general and opinion formers in particular, including national and local media, politicians of all parties, and commentators, have an opportunity to engage in and facilitate and mature, open and constructive conversation about improving safety in the NHS. This includes harnessing the goodwill of all NHS staff and avoiding generalised criticism of their intentions, motivations, skill or dedication.

Who	What
All staff and leaders of NHS-funded organisations	Every person working in NHS-funded care has a duty to identify and help to reduce risks to the safety of patients, and to acquire the skills necessary to do so in relation to their own job, team and adjacent teams. Leaders of health care provider organisations, managers, clinical leaders and Health Education England have a duty to provide the environment, resources and time to enable staff to acquire these skills.
All leaders and managers of NHS-funded organisations	All NHS leaders and managers should actively address poor teamwork and poor practices of individuals, using approaches founded on learning, support, listening and continual improvement, as well as effective appraisals, retraining and, where appropriate, revalidation.
NHS England	NHS England, through the NHS Leadership Academy, should designate a set of safety-leadership behaviours that can be used in leaders' hiring, in appraisals, in leadership development, and in promotion. The shift in leadership behaviour we think is required, and which could form the basis of a safety-leadership behaviour assessment, is provided in **Box 1.**
Leadership bodies[2] of NHS-funded organisations	All leadership bodies of NHS-funded health care providers should define strategic aims in patient safety, and should regularly review data and actions on quality, patient safety and continual improvement at their Board or leadership meetings.
Leadership bodies of NHS-funded organisations	Boards and leadership bodies should employ structures and processes to engage regularly and fully with patients and carers, to understand their perspectives on and contributions to patient safety.
Prime Minister and Government	Final responsibility for fostering a climate that supports learning and continual improvement in the NHS rests with the Prime Minister and the Government, who should so affirm repeatedly and forcefully.
Government and NHS organisations	The system should help patient representatives and community champions to become safety leaders, in part by offering them the opportunity to learn safety-leadership behaviours and skills.
Local Government Association	The Local Government Association should take lead responsibility for promoting better integration of the boundaries between health and social care in the interests of patient safety and encouraging local government to fulfil its scrutiny role effectively

[1] By Leadership Bodies we are referring to the variety of forms that different organisations use to run and lead themselves. These may be Boards, Committees or other structures.

Box 1

The shift in behaviour from leaders across the system that we need to see:

Leadership behaviours that increase risk and make healthcare less safe:

- Blame staff (even when they haven't been given the conditions for success)
- Fail to focus on the patient (often signalling instead that targets and costs are 'centre stage')
- Make bad news unwelcome (too often silencing it)
- Not heed signals and warnings that things are amiss
- Muffle the voice of the patients, their carers and their families and largely ignore their complaints
- Fail to listen to staff
- Diffuse responsibility and disguise who is in charge
- Offer no systematic support for improvement capability
- Game data and goals
- Lead by rules and procedures alone in a disengaged way
- Apply sanctions to errors
- Create fearfulness amongst colleagues and staff
- Ignore the development of the next generation of leaders
- Treat all problems as though they can be "fixed" with existing technologies or writing clearer procedures

Leadership behaviours that reduce risk and make healthcare more safe:

- Abandon blame as a tool
- Constantly and consistently assert the primacy of safely meeting patients' and carers' needs
- Expect and insist upon transparency, welcoming warnings of problems
- Recognise that the most valuable information is about risks and things that have gone wrong
- Hear the patient voice, at every level, even when that voice is a whisper
- Seek out and listen to colleagues and staff
- Expect and achieve cooperation, without exception
- Give help to learn, master and apply modern improvement methods
- Use data accurately, even where uncomfortable, to support healthcare and continual improvement
- Lead by example, through commitment, encouragement, compassion and a learning approach
- Maintain a clear, mature and open dialogue about risk
- Infuse pride and joy in work
- Help develop the leadership pipeline by providing support and work experiences to enable others to improve their own leadership capability
- Recognise that some problems require technical action but that others are complex and may require many innovative solutions involving all who have a stake in the problem

III. Patient and public involvement

Recommendation

3. **Patients and their carers should be present, powerful and involved at all levels of healthcare organisations from wards to the boards of Trusts.**

The patient voice should be heard and heeded at all times.

Patient involvement means more than simply engaging people in a discussion about services. Involvement means having the patient voice heard at every level of the service, even when that voice is a whisper. Evidence shows that patient safety improves when patients are more involved in their care and have more control. Patient involvement is crucial to the delivery of appropriate, meaningful and safe healthcare and is essential at every stage of the care cycle: at the front line, at the interface between patient and clinician; at the organisational level; at the community level; and at the national level. The patient voice should also be heard during the commissioning of healthcare, during the training of healthcare personnel, and in the regulation of healthcare services.

The goal is not for patients and carers to be the passive recipients of increased engagement, but rather to achieve a pervasive culture that welcomes authentic patient partnership – in their own care and in the processes of designing and delivering care. This should include participation in decision-making, goal-setting, care design, quality improvement, and the measuring and monitoring of patient safety. Patients and their carers should be involved in specific actions to improve the safety of the healthcare system and help the NHS to move from asking, "What's the matter?" to, "What matters to you?" This will require the system to learn and practice partnering with patients, and to help patients acquire the skills to do so.

Who	What
All NHS Organisations	Patients and their carers should be helped to establish effective relationships with their clinicians at every stage of their care, from GP surgery to hospital ward. (For example, there should be clear information about who is working on the ward and who will be each patient's primary nurse that day and night.)
All NHS Staff	Patients and their carers should always be given the opportunity to share their health concerns, histories, family situations, needs, preferences and hopes in order to help staff build effective partnerships during every stage of their care.
All NHS Organisations	Patients and (if the patient wishes) their carers should be involved as much as possible in their care planning. (For example, carers should be invited to and involved in ward rounds, multi-disciplinary meetings, Care Programme Approach meetings, discharge planning meetings and other significant clinical meetings.)
Commissioners and providers	NHS England, CCGs and provider organisations should ensure that a specific, named and recognised clinician, known to the patient, is responsible for the coordination of care for every patient at every phase of treatment regardless of setting.
All NHS organisations	Patients and their carers should always have access to and be given on request a clear, understandable and relevant summary of their health needs and preferences, which states how these needs will be met. This should include information about risks and alternatives and should allow them greater control of their healthcare.
Leaders of NHS organisations	It should always be clear who is responsible for patient safety concerns, and someone should be accessible to patients at every stage of treatment and 24 hours a day. When things do go wrong, incidents should be investigated appropriately and transparently, with the full involvement of the patient and their carers, who should be kept informed at every step of the way.
Leaders of NHS organisations	Patient feedback is instrumental to the measurement, maintenance and monitoring of safety; feedback should be collected as far as possible in real time and be responded to as quickly as possible.
Leaders of NHS organisations	Complaints provide vital information about the quality and safety of care and should be gathered and responded to in a timely way. The leaders of all healthcare organisations should continually improve their local complaint systems.
Government	We encourage further consideration of an independent national complaints management system that is easy to access and use, and that would also highlight and promote better practice and improvements in the NHS. We are aware that separate work is underway to look at the NHS complaints system, and we trust that appropriate recommendations will be implemented accordingly.
All NHS organisations	Patients and their carers should be represented throughout the governance structures of NHS-funded healthcare providers, for example by sitting on and actively participating in safety and quality committees. We encourage experimentation with full patient and carer membership on governing boards and on panels that hold boards to account. Patients and carers should be given appropriate support and training to take a full part in these structures, to understand safety science, and to contribute meaningfully.

Box 2: Actions for Patients and Carers

We seek to engage everyone in improving safety, as far as they can and wish to be involved. This includes patients and carers. Below are our suggested actions for them:

- Patients and carers should seek to establish relationships with healthcare staff and know their names. Patients and carers should seek to build constructive relationships with their caregivers and develop mutual respect, honesty and trust.
- Patients and carers should try to share their histories, family situations, needs and hopes to help staff build true and effective partnerships during their care. They should aim as far as possible, to become co-producers of their care.
- Patients should share their goals, participate in creating plans for their care, engage their families and bring carers or relatives to visit, particularly during ward rounds and other clinical meetings.
- Patients and their carers should alert those working in healthcare when care is not meeting their needs or when they see a practice that they feel is not safe.
- Patients should, when they wish, advise leaders and managers by offering their expert advice on how things are going, on ways to improve, and on how systems work best to meet the needs of patients. This may mean giving time to attend meetings, participating in sessions to learn how the health care system works, learning the "inside" language that they will encounter, and learning to speak effectively to "authority".

IV. Staff

Recommendation

4. **Government, Health Education England and NHS England should assure that sufficient staff are available to meet the NHS's needs now and in the future. Healthcare organisations should ensure that staff are present in appropriate numbers to provide safe care at all times and are well-supported.**

Everyone in the NHS should be able to come to work every day knowing they will be treated with respect, supported to do their work and expand their skills, and be appreciated for what they do.

Boards and leaders of provider organisations should take responsibility for ensuring that clinical areas are adequately staffed in ways that take account of varying levels of patient acuity and dependency, and that are in accord with scientific evidence about adequate staffing.

People should work in well-structured teams.

Who	What
NICE	NICE should interrogate the available evidence for establishing what all types of NHS services require in terms of staff numbers and skill mix to assure safe, high quality care for patients.
All leaders of NHS-funded provider organisations	Staffing levels should be consistent with the scientific evidence on safe staffing, adjusted to patient acuity and the local context. (This includes, but is not limited to, nurse-to-patient staffing ratios, skill mixes between registered and unregistered staff, and doctor-to-bed ratios.) Boards and leaders of organisations should utilise evidence-based acuity tools and scientific principles to determine the staffing they require in order to safely meet their patients' needs. They should make their conclusions public and easily accessible to patients and carers and accountable to regulators.
HEE, Government and NHS England	Health Education England should assure that they have commissioned the required training places to meet future staffing requirements working with Government and NHS England to ensure appropriate planning and resources.
All leaders and managers of NHS-funded provider organisations	The leaders of all NHS-funded organisations should foster good teamwork in care. They should ask teams to set challenging and measurable team objectives; facilitate better communication and coordination within and among teams; and encourage teams to regularly take time out to review their performance and how it can be improved.
All leaders and managers of NHS-funded provider organisations	Leaders and managers should actively support staff by excellent human resource practices, promoting staff health and well-being, cultivating a positive organisational climate, involving staff in decision-making and innovation, providing staff with helpful feedback and recognising good performance, addressing systems problems, and making sure staff feel safe, supported, respected and valued at work.
All leaders and managers of NHS-funded provider organisations	NHS organisations, working with professional regulators, should create systems for supportively assessing the performance of all clinical staff, building on the introduction of medical revalidation.
All leaders and managers of NHS-funded provider organisations	Each organisation should be expected to listen to the voice of staff, such as through department and ward level cultural and teamwork safety surveys, to help monitor the safety and quality of care and variation among units. (However, surveys of culture have not been scientifically validated as a performance metric and should not be used for this purpose.) Staff should all be free to state openly their concerns about patient safety without reprisal. There is no place for compromise agreements ("gagging clauses") in such cases.

Box 3: Actions for Staff

Many of our recommendations focus on actions needed by leaders, agencies and organisations. However, only the actions of front line staff, such as these listed here, can realise safe compassionate patient care and improvements to the healthcare system:

- Place the needs of patients, families and carers at the centre of all your work, treating them with courtesy and respect, and intervene if you see others who do not.
- Be a quality inspector, never knowingly passing on a defect, error or risk to a colleague or patient, putting things right where you can, and reporting everything, especially where you need help to put it right.
- Be willing to acknowledge and be open when something has gone wrong and make timely apologies and reparation where appropriate.
- Appreciate that your responsibility is not only to your patients but also to help continuously improve the healthcare system in collaboration with others.
- Treat your colleagues with respect and courtesy and seek to create supportive teams with common goals.
- Commit to learning about patient safety as a core professional responsibility and develop your own ability to detect problems.
- Be willing to speak up to leaders when you believe that a lack of skills, knowledge or resources places patients at risk of harm, and be willing to listen to others when they identify these risks.
- Celebrate and take pride in improvements to patient care.

A NOTE ON STAFFING RATIOS:

Our primary recommendation on staffing patterns is that NICE undertake as soon as possible to develop and promulgate guidance based on science and data. Such guidance, we assume, would include methods by which organisations should monitor the status of patient acuity and staff workload in real time, and make adjustments accordingly to protect patients and staff against the dangers of inadequate staffing. We also assume, and hope, that innovations will develop and continue in technologies, job designs, and skill mix that will and should change ideal staffing ratios, so that this role for NICE ought to be ongoing.

That said, and while NICE does its job, we call managers' and senior leaders' attention to existing research on proper staffing, which includes, but is not limited, to conclusions about ratios. For example, recent work suggests that operating a general medical-surgical hospital ward with fewer than one registered nurse per eight patients, plus the nurse in charge, may increase safety risks substantially. This ratio is by no means to be interpreted as an ideal or sufficient standard; indeed, higher acuity doubtless requires more generous staffing. We cite this as only one example of scientifically grounded evidence on staffing that leaders have a duty to understand and consider when they take actions adapted to their local context.

V. Training and capacity building

Recommendations

5. **Mastery of quality and patient safety sciences and practices should be part of initial preparation and lifelong education of all health care professionals[3], including managers and executives.**

6. **The NHS should become a learning organisation. Its leaders should create and support the capability for learning, and therefore change, at scale, within the NHS.**

The entire NHS should commit to lifelong learning about patient safety and quality of care through customised training for the entire workforce on such topics as safety science, quality improvement methods, approaches to compassionate care and teamwork.

The most powerful foundation for advancing patient safety in the NHS lies much more in its potential to be a learning organisation, than in the top down mechanistic imposition of rules, incentives and regulations. Collaborative learning through safety and quality improvement networks can be extremely effective and should be encouraged across the NHS. The best networks are those that are owned by their members, who determine priorities for their own learning.

[3] Wherever this report refers to healthcare professionals we are explicitly including clinicians and non-clinicians alike who are involved in the healthcare system. This therefore includes managers, executives and relevant Governmental staff.

Who	What
Training and Education regulators, providers and HEE	The commissioners, regulators and providers of training and education for healthcare professionals (including clinicians, managers, Boards and relevant Governmental staff and leaders) should ensure that all healthcare professionals receive initial and ongoing education on the principles and practices of patient safety, on measurement of quality and patient safety, and on skills for engaging patients actively.
Education regulators, providers and HEE	Professional regulators (such as the GMC and NMC) should continue and build upon their good work to date with undergraduate and postgraduate education providers and Health Education England to ensure that medical and nursing undergraduates and postgraduates become thoroughly conversant with and skilful at approaches to patient safety and quality improvement.
NHS England and partners	NHS England working with partners (Royal Colleges, HEE, NHS Leadership Academy and others) should encourage and expand structured programmes to equip NHS leaders with an in-depth understanding of safety and improvement, and of managing the spread of innovations and good ideas within and among organisations.
All NHS organisations	NHS-funded health care providers should invest in building capability within their organisations to enable staff to contribute to improvement of the quality and safety of services to patients. **Box 4** illustrates one sound view of the capability which should be expected from each level in an organisation. A properly resourced capability programme must be in place within 12 months.
NHS England and Government	NHS England should be given the resources to support and learn from existing collaborative safety improvement networks and to sponsor the development of new regional or sub-regional collaborative networks across the country, perhaps aligned to and working with the new Academic Health Science Networks.
All NHS organisations	Every NHS organisation should participate in one or more collaborative improvement networks as the norm.
NHS England	Improvement networks should include processes for monitoring and evaluation by the networks together with NHS England in order to understand what works and to assure that best processes are spread and scaled to benefit all patients in the system.
NHS England	NHS England should organise a national system of NHS Improvement Fellowships, to recognise the talent of staff with improvement capability and enable this to be available to other organisations.

Box 4

Suggested improvement skills required for each group in a provider organisation

Adapted from Kaiser Permanente

VI. Measurement and transparency

Recommendations

7. **Transparency should be complete, timely and unequivocal. All non-personal data on quality and safety, whether assembled by government, organisations, or professional societies, should be shared in a timely fashion with all parties who want it, including, in accessible form, with the public.**

8. **All organisations should seek out the patient and carer voice as an essential asset in monitoring the safety and quality of care.**

Patient safety cannot be improved without active interrogation of information that is generated primarily for learning, not punishment, and is for use primarily at the front line. Information should include: the perspective of patients and their families; measures of harm; measures of the reliability of critical safety processes; information on practices that encourage the monitoring of safety on a day to day basis; on the capacity to anticipate safety problems; and on the capacity to respond and learn from safety information. Data on staff attitudes, awareness and feedback are important resources to gain insights into staff concerns. However, it is counterproductive to use staff survey and attitude data as a performance management tool or to compare organisations.

Most health care organisations at present have very little capacity to analyse, monitor, or learn from safety and quality information. This gap is costly, and should be closed.

We believe that aggregated data may camouflage variation within organisations that would be revealed by intelligent fine-grained analysis at local level. Leaders need to seek out variation within their organisations (not just among organisations) if safety and quality are to be effectively monitored and improved.

There is no single measure of safety, but early warning signals can be valuable and should be maintained and heeded.

Who	What
All healthcare system organisations	Government, CQC, Monitor, TDA, HEE, NHS England, CCGs, professional regulators and all NHS Boards and chief executives should share all data on quality of care and patient safety that is collected with anyone who requests it, in a timely fashion, with due protection for individual patient confidentiality.
All healthcare system organisations	Government, CQC, Monitor, TDA, HEE, NHS England, CCGs, professional regulators and all NHS Boards and Chief Executives should include patient voice as an essential resource for monitoring and improving the safety and quality of care.
Commissioners	Commissioners should increase funding for NHS organisations to analyse and effectively use safety and quality information.
NHS-funded healthcare providers	Healthcare organisations should shift away from their reliance on external agencies as the guarantors of safety and quality and toward proactive assessment and accountability on their own part.
All NHS-funded healthcare providers	Providers should make use of peer review outside of formal systems – for example by partnering with other organisations – to facilitate learning.
All NHS organisations	Unless and until a better metric is developed, the NHS should use mortality rate indicators like the Hospital Standardised Mortality Rate or suitable alternatives as one of its ways to detect potentially severe performance defects worth investigating further. Mortality measurement should be used as a 'smoke detector' in a spirit of supportive and genuine inquiry, not used to generate league tables or similar comparisons.
All NHS organisations	Organisations should routinely collect, analyse and respond to local measures that serve as early warning signals of quality and safety problems such as the voice of the patients and the staff, staffing levels, the reliability of critical processes and other quality metrics. These can be 'smoke detectors' as much as mortality rates are, and they can signal problems earlier than mortality rates do.
All NHS-funded provider organisations	In addition to reporting aggregated data for the whole organisation, data on fundamental standards and other reportable measures, as required by CQC, should be reported by each ward, clinical department (and health care professional, where appropriate) within the Trust's Annual Quality Account. Leaders must understand the variation in their organisation, not just among organisations, in order to improve.

Box 5

Illustrating some of the suite of indicators that should be used by NHS organisations to assess safety improvement and variation. This data must be considered at ward/unit or other appropriate sub-organisational level in order to reveal the variation within an organisation.

At sub-organisational level

At sub-organisational level

The perspective of patients and their families	Measures of harm	Measures of the reliability of critical safety processes
Information on practices that encourage the monitoring of safety	Information on the capacity to anticipate safety problems	Information on the capacity to respond to and learn from safety information
Data on staff attitudes, awareness and feedback	Mortality rate indicators	Staffing levels
Data on fundamental standards	Incident reports	Incident reporting levels

At sub-organisational level

VII. Structures and regulation

Recommendation

9. Supervisory and regulatory systems should be simple and clear. They should avoid diffusion of responsibility. They should be respectful of the goodwill and sound intention of the vast majority of staff. All incentives should point in the same direction.

Delivering safe care is first and foremost the responsibility of providers, but having no regulation is not an option. Regulation should make clear the expectations that providers must meet, detect failings early, and take appropriate action when sub-standard care is found. The most effective regulation comes from a mixture of principles-based standards (developed by a process involving patients, carers and the public) and technical specifications where appropriate, supported by an inspection regime with true experts who are able to apply thoughtful judgement and the right actions in response.

The current NHS regulatory system is bewildering in its complexity and prone to both overlaps of remit and gaps between different agencies. It should be simplified.

The system needs to be agile, responsive and proportionate. This cannot be achieved through a series of prescriptive, technical standards that attempt to delineate between "acceptable" and "unacceptable" according to a tick-box or list. It can be achieved only through a well-resourced, highly coordinated, integrated and expert regulatory system employing intelligent and thoughtful inspection, able to apply both qualitative and quantitative judgement and take effective action when necessary. The same principles apply to oversight and performance management by commissioners and other supervisory bodies.

A high level of coherence is required across the system, with clear and fully aligned goals and incentives focused on the interests of patients at every level. All bodies involved in the oversight of health care providers need to actively avoid the creation of 'priority thickets' where providers become increasingly unclear about what they are doing and why, and where the goals they are supposed to achieve compete, conflict, or fail to cohere. Safety and quality stand the best chance when all of the drivers in the system – financial incentives, policies, regulatory strategies, use of competition, commissioning decisions, training, and organisational and professional norms – point in the same direction.

Who	What
CQC and NHS England	CQC should hold Boards responsible for ensuring that recommendations from patient safety alerts are implemented promptly. NHS England should complete the re-design and implementation of a patient safety alerting system for the health care system in England. CQC should assure that organisations respond effectively to these alerts except in the rare circumstances where organisations can demonstrate that implementation of an alert is not in the interests of specific patient groups.
CQC, Monitor and the TDA	The regulatory complexity that Robert Francis identified as contributing to the problems at Mid Staffordshire is severe and endures, and the Government should end that complexity. Further large-scale structural reform is not desirable at present; however, it is imperative that CQC, Monitor and the Trust Development Authority commit to seamless, full, unequivocal, visible and whole-hearted cooperation with each other and with all other organisational and professional regulators, agencies and commissioners.
Government	Government should continually review the extent of this cooperation, and, if cooperation fails, Government should act immediately and decisively.
Regulators, HEE, professional societies, commissioners	CQC, Monitor, TDA, professional regulators, HEE, professional societies, Royal Colleges, commissioners and others should streamline requests for information from providers so that they have to provide information only once and in unified formats. The same is true of inspections.
CQC	CQC should act as the coordinating hub for intelligence about quality and safety of care.
NHS England	NHS England should promptly coordinate the development of an explicit description of the systems of oversight and controls of quality and safety relevant to different types of provider organisations, identify any vulnerabilities in those systems, and, working with others, take action to correct them.
CQC	CQC should develop the "fundamental standards" recommended by Robert Francis, using a process involving patients, carers and the public. Where appropriate these should be specified as human rights standards or principles rather than in technical terms, with compliance to be determined through thoughtful judgement on the part of expert inspectors, informed by metrics. The actions to be taken in the event of breaches of fundamental standards should be consistent with the principles of responsive regulation – i.e. using a pyramid of enforcement, ranging from persuasion through to punishment.
Government	An in-depth, independent review of structures and the regulatory system should be completed by the end of 2017, once current proposed changes have been operational for three years (see **Box 6**).
Government	The Government should develop plans to allow for the permanent disqualification from relevant positions in the NHS of those at Director level or equivalent whose criminal liability is proven. This sanction is not to be used if someone is struggling in their current position or is facing intractable problems in achieving success. It is a sanction reserved for the worst conduct, and its availability as a sanction should act as a deterrent.
Government	The Government should ensure it is possible for healthcare support workers to receive training and development in order to meet clear codes of practice as is the case with medical, nursing and other professions.

Box 6

An independent review of NHS regulation should assess the weaknesses and strengths of the current system compared with various possible alternatives.

The independent review should assess the following:	The system should be compared with the following alternatives as a minimum:
• The extent to which the system is working	• Re-designation of CQC as a non-departmental public body accountable to Parliament rather than the Secretary of State
• Whether full and sincere cooperation and coordination have been achieved between the various agencies and bodies	• Merging regulators, or using an alternative model of non-government accreditation of healthcare organisations, perhaps modelled on the Joint Commission in the USA
• Whether the regulatory burden and cost is commensurate with the outcomes achieved	• Merging some or all of the organisational regulators so that responsibility for quality, patient safety, standards and outcomes are vested in one regulatory body and residual responsibilities are transferred to NHS England or other bodies (e.g. market and pricing responsibilities)
• Whether patients and those being regulated report that the system is effective and fair	• Consider if the current arrangements for public and community involvement and oversight of health and care, such as via HealthWatch and Health and Wellbeing Boards, are operating effectively and consider the case for revisiting earlier models like Community Health Councils

VIII. Enforcement

Recommendation

10. We support responsive regulation of organisations, with a hierarchy of responses. Recourse to criminal sanctions should be extremely rare, and should function primarily as a deterrent to wilful or reckless neglect or mistreatment.

We considered very carefully the balance that must be achieved to support staff and organisations to learn from error and improve their practice with the need to assure accountability to the patient for egregious acts or omissions that cause death or serious harm. These two approaches are not mutually exclusive but unintended errors must be handled very differently from severe misconduct.

We believe that legal sanctions in the very rare cases where individuals or organisations are unequivocally guilty of wilful or reckless neglect or mistreatment of patients would provide deterrence whilst not impeding a vital open, transparent learning culture. Our proposals aim to place wilful or reckless neglect or mistreatment of all NHS patients on a par with the offence that currently applies to vulnerable people under the Mental Capacity Act.

We take full notice that a lack of regulation and sanctions was not the main problem in Mid Staffordshire. Indeed there already exists a series of robust sanctions and powers available to regulators such as CQC and the Health and Safety Executive. These should be used properly and the bodies with those powers resourced appropriately.

Ultimately, by far the greatest benefit to patient safety will be achieved by increasing the skills and the knowledge of the many rather than penalising the very few. We do not support the punishment of organisational leaders, Boards and chief executives, or others for poor performance that occurs for reasons beyond their control. We do recommend penalties for leaders who have acted wilfully, recklessly, or with a "couldn't care less" attitude and whose behaviour causes avoidable death or serious harm, or who deliberately withhold information or provide misleading information.

Who	What
Government	The Government should create a new general offence of wilful or reckless neglect or mistreatment applicable both to organisations and individuals. Organisational sanctions might involve removal of the organisation's leaders and their disqualification from future leadership roles, public reprimand of the organisation and, *in extremis,* financial sanctions but only where that will not compromise patient care. Individual sanctions should be on a par with those in Section 44 of the Mental Health Capacity Act 2005.
Government	It is absolutely vital that any new legislation avoid criminalising unintended errors. An individual should not be convicted of this new offence unless it can be shown the failure was the fault of the individual alone and the individual was acting in a reckless or wilful manner. Liability should be proportionate to past conduct for both individuals and organisations.
Government	The Government should make it an offence for a healthcare organisation to withhold or obstruct the provision of relevant information to a commissioner, regulator, inspector, coroner or other person with a legitimate duty in relation to quality and safety of care.
Government	The application of any of the criminal sanctions referred should be based on the liability criteria set out in **Box 7**.
Government and CQC	Where an incident qualifying as a Serious Incident (as defined by NHS England) occurs, CQC regulations should require that the patient or carers affected by the incident be notified and supported. We do not subscribe to an automatic 'duty of candour' where patients are told about every error or near miss, as this will lead to defensive documentation and large bureaucratic overhead that distracts from patient care. However, patients should be given all the information they ask for. Research should be commissioned to study how proactive disclosure of serious incidents, and the process of engaging with patients in relation to less serious incidents, can best be supported.
NHS-funded provider organisations and professional regulators	Employers need to improve their support of staff around implementing guidance on reporting of serious incidents and professional regulators should take appropriate action when required. Organisations should demonstrate that they have in place fully functional reporting systems for serious incidents, that staff know how to use them, that the systems are used, and that appropriate action is taken in response to incidents, including provision of appropriate support to the affected patients and their carers.
Government	We do not support the creation of a statutory duty for healthcare workers to report beliefs or suspicions about serious incidents to their employer, as this duty is adequately addressed in relevant professional codes of conduct and guidance.

Box 7

Applying criminal sanctions, or indeed any sanctions, can be appropriate only in the very rare cases of neglect or wilful misconduct. In addition, where sanctions are considered appropriate we believe that the criteria below must be assessed and be met before those sanctions are applied:

Culpability	The extent to which the neglect or mistreatment of a patient is 'wilful', i.e. intentional, reckless or reflects a reckless 'couldn't care less' attitude.
Substitution	Whether the act or omission is unacceptable and would not be undertaken by a reasonable person or organisation in similar circumstances.
Degree of control for individuals	Only intentional behaviours under people's control (reflecting a reasonable degree of wilfulness or recklessness) should be sanctioned and **not** unintended error.
Degree of control for organisations	Only failure to create a reasonable safe system of care, or failure to act within its own system of care, or failure to adequately control those systems, or a reckless disregard for the well-being of patients should be sanctioned, and **not** when the organisation has taken all reasonable steps to achieve compliance.
Severity	The extent to the individual or organisation knowingly or recklessly puts the patient at risk of death or severe harm.
Liability should be proportionate to past performance	The test would be the degree to which the implicated actions are part of a pattern of ongoing and persistent failures to engage with, improve or address safety. This pattern will be taken particularly seriously where previous regulatory actions or managerial or supervisory warnings have been ignored or neglected by those concerned.
Liability should be proportionate to the level of control	The test would be the degree to which an individual (staff and/or directors) have control over the systems within which the implicated actions take place.

Formal guidance should be developed in the use of these liability criteria factors

IX. Moving forward

Our aim was to develop a **small and cogent set of principles and actions** that, in our best judgment and on the basis of existing evidence, would help move the NHS as fast as possible toward better, safer care. In this, we have only partially succeeded. Our core recommendations are few, but the actions we suggest are more numerous than we initially intended. We were led there by the complexity of the NHS, itself, as a national endeavour. Many actors touch and shape the NHS. No one of them holds the keys to improvement. All have opportunities and duties to help, and the system can afford few bystanders.

Some of our recommendations have the hard edge of requirement and enforcement. For example:

- Providers should act on patient safety alerts, and regulators should ensure that they do.
- Transparency ought not to be optional.
- Staffing levels should be adequate, based on evidence.
- Sanctions should apply to reckless and wilful neglect or mistreatment of patients.

However, **our most important recommendations for the way forward envision the NHS as a learning organisation**, fully committed to the following:

- Placing the quality of patient care, especially patient safety, above all other aims.
- Engaging, empowering, and hearing patients and carers throughout the entire system and at all times.
- Fostering whole-heartedly the growth and development of all staff, including their ability and support to improve the processes in which they work.
- Embracing transparency unequivocally and everywhere, in the service of accountability, trust, and the growth of knowledge.

Every single actor in the landscape of the NHS should review these commitments and act on them. Especially important steps are the following:

For Government and NHS England Leaders:

1. State and restate the primacy of safety and quality as aims of the NHS: Assure prompt response to and investigation of early warning signals of serious problems, and, when needed, assure remedy.
2. Support investment in the improvement capability of the NHS.
3. Lead with a vision. Avoid the rhetoric of blame. Rely on pride, not fear.
4. Reduce the complexity of the regulatory system, and insist on total cooperation among regulators. If they do not cooperate, restructure them.

For NHS Organisation Leaders and Boards:

1. Listen to and involve patients and carers in every organisational process and at every step in their care.
2. Monitor the quality and safety of care constantly, including variation within the organisation.
3. Respond directly, openly, faithfully, and rapidly to safety alerts, early warning systems, and complaints from patients and staff. Welcome all of these.
4. Embrace complete transparency.
5. Train and support all staff all the time to improve the processes of care.
6. Join multi-organisational collaboratives – networks – in which teams can learn from and teach each other.
7. Use evidence-based tools to ensure adequate staffing levels.

For System Regulators:

1. Simplify, clarify, and align your requests and demands from the care system, to reduce waste and allow them to focus on the most important aims.
2. Cooperate fully and seamlessly with each other.

For Professional Regulators and Educators:

1. Assure the capacity and involvement of professionals as participants, teammates, and leaders in the continual improvement of the systems of care in which they work.
2. Embrace complete transparency.

For NHS Staff and Clinicians:

1. Participate actively in the improvement of systems of care.
2. Acquire the skills to do so.
3. Speak up when things go wrong.
4. Involve patients as active partners and co-producers in their own care.

For Patients and Carers:

1. As far as you are able, become active partners in your healthcare and always expect to be treated as such by those providing your healthcare.
2. Speak up about what you see – right and wrong. You have extraordinarily valuable information on the basis of which to make the NHS better.

The NHS in England can become the safest health care system in the world. That will require unified will, optimism, investment, and change. Everyone can and should help. And, it will require a culture firmly rooted in continual improvement. Rules, standards, regulations and enforcement have a place in the pursuit of quality, but they pale in potential compared to the power of pervasive and constant learning.

Annex A: A note on our methodology

The Committee assembled was dominated in a majority by scientists – experts in organisational theory, quality improvement, safety and systems – and with a healthy minority of people currently in management positions within the NHS in England, though not deeply enmeshed in the time and occurrences of the Mid Staffordshire story itself. We included four Americans and one Scot, because of their deep familiarity with safety at the level of large health care systems, and, most important of all, three patient-advocates, people who, connected by their experiences of poor or variable patient care, have become vocal and eloquent voices for making sure that the NHS is seen and led through the eyes of patients and carers. To assure enough access to details of the Mid Staffordshire story and its context, we appointed a few Senior Advisors, upon whom the Committee could call as needed for information and suggestions.

We agreed to serve if, and only if, neither government nor NHS management nor, for that matter, any particular stakeholder group had or sought authority to censor or predetermine our findings. We had the Francis report, and a gracious Robert Francis, himself, to draw upon, but were under no obligation to endorse that report, or to accept, reject, or even comment upon any or all of its recommendations. We had a free hand.

Our deadlines were short and our methods respectful both of all the prior work of Francis and others and of the constrained, albeit enthusiastic, time of our busy members, all of whom volunteered without remuneration for this service. Our support from a Secretariat generously provided by the NHS was superb and facilitative. Our meetings were mostly biweekly and mostly virtual, with our American and Scottish members connected by videoconferences.

The bulk of the analyses was conducted by seven working parties established at our first meeting, each chaired by a Committee member, on the following topics: (1) Aims for Improvement, (2) Structures, (3) Measurement and Transparency, (4) Training and Capacity-Building, (5) Patient and Public Involvement, (6) Enforcement, and (7) Leadership. We established and maintained additional subsidiary efforts on (8) Staff and (9) Assuring Implementation. Working parties met between Committee meetings, and produced draft sections and recommendations under strict timelines, reviewed and discussed at the full Committee meetings. Senior Advisors and others made comments by invitation at nearly all Committee meetings.

Our recommendations were based on our best knowledge of the available evidence and our considered judgement.

We agreed to try to limit our final recommendations to a very small number, and to stay riveted on action as the goal. The "customers" for our recommendations, we agreed, would be several, including, but not limited to: (1) the Government (2) the senior executives of NHS England, (3) the leaders and staff of NHS-funded organisations (4) other clinical and executive leaders in the NHS, and (5) the public at large.

Annex B: Letters

Letter to Senior Government Officials and Senior Executives in the Health Service

Thank you for the opportunity to advise you and your colleagues on next steps toward a better and safer NHS. It is a privilege to be allowed to assist an organization for which I have such great respect, and it has been a pleasure to work with the talented and committed Advisory Group that you allowed me to assemble.

The full Report represents the unanimous views of the Advisory Group. I wish here to take the liberty of adding some personal comments and reflections for your consideration.

You are stewards of a globally important treasure: the NHS. In its form and mission, guided by the unwavering charter of universal care, accessible to all, and free at the point of service, the NHS is a unique example for all to learn from and emulate. Faults are to be expected in any enterprise of such size and ambition, and, as you know, the nation's leaders have the dual duty to continually, unblinkingly recognize and reduce those faults and at the same time to maintain and build confidence in the grand vision of the NHS.

The Mid Staffordshire tragedy and its sequellae offer the chance to do both. Thanks to Robert Francis, the nation can see directly some important problems, worth solving, not just in Mid Staffordshire but throughout the NHS. Our Report describes some of those problems. Among them are a partial loss of focus on quality and safety as primary aims, inadequate openness to the voices of patients and carers, insufficient skills in safety and improvement, staffing inadequate for patients' needs, and very unhelpful complexity and lack of clarity and cooperation among regulatory agencies. You, as leaders, can help to remedy every one of those problems and the others that we name. I hope and strongly suspect that you will do so.

In trying to achieve remedy, your most certain and productive pathways will be built on the enormous strengths of the NHS – its people, their commitment, its charter, much of its track record, and the affection and wisdom of patients and carers. I hope that you will invest even more than ever before in learning, growth, development, ambition, and pride. This is the route that can make the NHS a "learning organization" in every sense of the term, and it can unleash momentum for improvement that no simple, top-down, control-oriented, requirement-driven culture ever can.

This is not to excuse or ignore the whole story, as Robert Francis and we understand it. Very occasionally at the root of harm do lie willful, reckless behaviors or neglect that cannot be tolerated, any more than reckless driving can be. There is an important role for responsive regulation by experts, enforcement, and consequences in such circumstances. It is equally important to be alert to early warning signs of possible serious quality and safety problems, and to investigate and act on them. Your recent advisors – Robert Francis, Sir Bruce Keogh, and we – do converge in our recommendations for clarity, timeliness, and reliability in taking action when such alarms sound.

But, as I think you know, this – acting on rare and outlying behaviors and on exceptional cases of poor performance – though necessary, will not create an overall far safer and better NHS; it cannot.

A culture of learning can . And the likelihood of such a culture's thriving in the NHS depends, more than on anything else, on how you, the senior leaders, behave, speak, and invest.

This report is longer than I had hoped it would be. We had no choice; the NHS is complex and actors are inescapably interdependent. As you will see, however, we offer one distillation that you may wish to keep in mind as you peruse the whole. These are four guiding principles that, I suggest, should inform every step you take in these matters – in what you think, say, and do:

- Place the quality and safety of patient care above all other aims for the NHS. (This, by the way, is your safest and best route to lower cost.)
- Engage, empower, and hear patients and carers throughout the entire system, and at all times
- Foster wholeheartedly the growth and development of all staff, especially with regard to their ability and opportunity to improve the processes within which they work.
- Insist upon, and model in your own work, thorough and unequivocal transparency, in the service of accountability, trust, and the growth of knowledge.

Time and again in our Group's deliberations, every member used the word "culture" to diagnose both the faults of and the possibilities for the NHS. I urge you to focus on the culture that you want to nurture: buoyant, curious, sharing, open-minded, and ambitious to do even better for patients, carers, communities, and staff pride and joy. If you read our recommendations carefully, and act on them, I believe that you will have set your compass right.

Don Berwick

Letter to the people of England

Your government and the leaders of the English National Health Service did me the honor earlier this year of asking me to assemble and chair an Advisory Group to recommend some important actions that leaders, clinicians, professional bodies, government agencies and others could take to improve the quality and safety of care in the NHS.

I took that assignment with hesitation and humility. I am an American, not English, and cannot claim the detailed knowledge and cultural sensibility that would lead to the best advice. But I was given a chance to recruit a wonderful group of people as the Advisory Group – most of whom have direct experience of your NHS while the rest admire it from afar – and who worked hard together to understand the problems and craft good suggestions. These included scholars whose careers have been devoted to studying safety and the conditions for excellence, clinicians and managers who know the NHS well, and, most important, patient representatives who could draw on their own experiences and their families', some tragic and hopefully never-to-be-repeated. This group gave me confidence that we would stay on the right track.

Of course, as you know, one of the main motivations for this assignment was the notorious "Mid Staffordshire" tragedy, in which serious problems in a hospital developed that led to avoidable patient deaths and injuries. That event spawned over two years of inquiry by Robert Francis, and, in early, 2013, the "Francis Report," with over 1700 pages and 290 recommendations. Your Government and NHS leaders turned to our Advisory Group for ideas on how to accelerate improvement of care in the wake of Mid Staffs. Ours was not the only group at all; lots of teams and leaders were tackling the same concerns while we did our work.

Our full report is now here for you and anyone else to see. It contains some technical material regarding regulation, improvement science, and management, but I hope that lay readers will find it comprehensible and sensible. Toward that end, I would like to share a few personal reflections for you possibly to ponder, as follows:

You will have read much in the public press that may alarm you about the patient care in the English NHS. After all, things did go quite wrong at Mid Staffs, and, like others, we believe that problems in care often occur throughout the NHS. In that, however, I assure you that the same can be said of every health care system in the world. Health care is complicated, and, even when the staff and clinicians are doing their very best (which is most of the time), errors occur and problems arise for patients that no one intends.

What you do have in the NHS is something that most other nations in the world don't have: a unified system of care that is completely capable of identifying its problems, admitting them, and acting to correct them. That is the process now underway; that is the process that led your leaders to convene our Advisory Group; and that is the process that can and, I believe, will help the English NHS to emerge over time as one of the safest health care systems in the world.

That is not easy. And it gets even harder if the staff of the NHS experience a culture of fear, blame, recrimination, and demoralization. I hope that you resist such general negativity, in yourself and anyone else, and instead clearly point the way with energy and optimism toward the care that you and I want, and that the vast majority of people who work in the NHS want to offer.

In the Mid Staffs story and elsewhere, there are occasional cases of people who willfully or recklessly did some harm. That, of course, cannot be tolerated, and occasionally strong measures of enforcement are needed. There are also clearly occasional organizations for which early warning signals suggest that serious problems may exist. In such cases, your government and NHS leaders can and should promptly investigate, reach conclusions, and act.

But enforcement, even though needed, is not really the route to an overall ever better NHS – the NHS you want. Instead, our report says, bet on "learning." The English NHS is capable of vast and continual improvement of safety, quality, patient-centeredness, and even cost, if, and maybe only if, everyone involved engages in learning every day. The questions that come up in such a culture are ones like this:

- Whom do we serve, and what do they really want and need?
- How are we doing at meeting those needs?
- How do we know?
- What could we do differently that would do that better?
- Who knows something – a better model, maybe – that we could put to work here?

Imagine an NHS where everyone, all the time, was part of that journey, and has the respect and tools to improve. That's what our Group recommends, in part, as you will see in this report.

We are recommending four main principles to guide everyone in trying to build an even better "learning NHS." Here they are:

- Place the quality and safety of patient care above all other aims for the NHS. (This, by the way, is your safest and best route to lower cost.)
- Engage, empower, and hear patients and carers throughout the entire system, and at all times
- Foster wholeheartedly the growth and development of all staff, especially with regard to their ability and opportunity to improve the processes within which they work.
- Insist upon, and model in your own work, thorough and unequivocal transparency, in the service of accountability, trust, and the growth of knowledge.

In all of that you – patients, carers, and citizens – have a vital and exciting role to play. Your voice is key to the future. I hope that this report will give you more confidence in speaking up everywhere and all the time in a vital NHS, and will give those who care for you and want to help you the confidence and skills to invite you, hear you, and welcome you into authentic partnership.

Don Berwick

Letter to the clinicians, managers, and all staff of the NHS

First of all, thank you. For the nearly three decades that I have been able to observe and work with the NHS, nothing has impressed me more than you – the workforce of 1.3 million people who are trying to make real a vision of a vital, universal health care system, accessible to all, and free at the point of service. Your nation's commitment to health care as a human right and to healing as a shared mission is second to none in the world. And all of that is possible through you; only through you.

But, it gets rough sometime, doesn't it? Because you work in a publicly led and publicly funded system of care, you operate under a spotlight more intense than most professional communities ever do. And truth to tell, it doesn't always go so well. Every experienced clinician knows what it feels like to be involved in an error in care, despite one's very best efforts. And the abstract concept of a "system" that fails has concrete meaning in the life of every doctor, nurse, or therapist who couldn't find a crucial test result, became exhausted when staffing was inadequate to meet patients' needs, or watched a patient get an infection in a hospital.

When things go especially badly, as happened, for example, in Mid Staffordshire, and public and private sentiment heats up, it can feel especially rough. And, at its worst, problems like that can hurt morale, as people lose sight of how great the mission is and of how hard you are trying to do what's right.

I was asked by Government and your senior leaders to chair an Advisory Group to recommend what can be learned from recent instances of quality problems in the NHS, and how the system can more rapidly and certainly aim for improvements in patient care and safety. The Group comprised scholars with a special interest in health care quality, leaders familiar with the workings of the NHS, and, most important, patient representatives with personal experiences of both excellence and problems in care.

The resulting report represents our best effort at identifying changes that could help the English NHS become even more the effective, safe, and patient-centered system that you who work in the Service want it to be.

We have made numerous recommendations, some of which reflect the need to tighten surveillance of and response to serious problems in care, which need systemic fixes to help protect patients. As you well know, safety in any sector – aviation, roads, or health care – sometimes requires a commitment to reliability and adherence to proper standards. And some standards should be seriously enforced; the risks of not doing that are too great. In addition, when early warning signs from patients, carers, staff, or data suggest a possibility that serious problems exist in quality and safety, the Government and leaders of the NHS are duty-bound to investigate, reach sound conclusions, and take prompt action.

But, as you probably also know, real, sustainable, active improvement depends far more on learning and growth than on rules and regulations. And that is the balance we are suggesting that the NHS seek to strike – between the hard guardrails that keep things in proper order and the culture of continual learning that helps everyone to grow. A phrase that I believe I heard first in England captures that sense: "All Teach – All Learn." In such a culture, measurement is not a threat, it is a resource; ambition is not stressful, it is exciting; defects are seen as opportunities to learn; and curiosity abounds.

We are recommending four guiding principles, among others, to help the English NHS get better faster, and I urge you to think about these and ask how you can help incorporate them into your own daily work.

- Place the quality and safety of patient care above all other aims for the NHS. (This, by the way, is your safest and best route to lower cost.)
- Engage, empower, and hear patients and carers throughout the entire system, and at all times.

- Foster wholeheartedly the growth and development of all staff, especially with regard to their ability and opportunity to improve the processes within which they work.
- Insist upon, and model in your own work, thorough and unequivocal transparency, in the service of accountability, trust, and the growth of knowledge.

Our Group is urging leaders and the public at large to study, grasp, and act on these ideas, as well. We would hope to see the English NHS emerge as a vital "learning organization," with you, who work in and for it, experiencing pride and joy in pursuing the great mission you have chosen: to heal.

Don Berwick

Annex C: List of Advisory Group Members

The National Advisory Group on the Safety of Patients in England who contributed to this report:

Don Berwick KBE, MD, MPP, FRCP President Emeritus and Senior Fellow, Institute for Healthcare Improvement

Jo Bibby, Director of Strategy, Health Foundation

Maureen Bisognano, President and CEO, Institute of Healthcare Improvement

Ian Callaghan, Service User Lead, My Shared Pathway, Patient Representative

David Dalton, CEO, Salford Royal NHS Trust Foundation

Mary Dixon-Woods, Professor of Medical Sociology, University of Leicester

Jan Gould, Asthma UK, Patient Representative

Carol Haraden, Vice President, Institute for Healthcare Improvement

Jean Hartley, Professor of Public Leadership, Open University

Elaine Inglesby-Burke, Director of Nursing, Salford Royal NHS Trust Foundation

Lucian Leape, MD, Adjunct Professor of Health Policy, Harvard School of Public Health

Jenny Leggot, Deputy Chief Executive, Director of Nursing, Midwifery and Operations, University Hospital NHS Trust

Jason Leitch, Clinical Director, Health and Social Care Directorate, NHS Scotland

James Reason, CBE, Professor Emeritus, University of Manchester

Lisa Richards-Everton, Patient Representative

Stephen Singleton, CE and Medical Director, Zero Tolerance Healthcare

Charles Vincent, Director, Imperial College Centre for Patient Safety and Service Quality

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How to ensure the right people, with the right skills, are in the right place at the right time

A guide to nursing, midwifery and care staffing capacity and capability

Contents

Foreword

High quality, compassionate care is about people, not institutions. In every ward and clinic, in every hospital, health centre, community service and patient's home across the country, nursing, midwifery and care staff work to provide care and compassion to people when they need it – whether it is at the beginning, or end of their life; in times of illness or uncertainty; or as part of helping people with long term conditions to stay as healthy and live as independently as possible.

However, there have been examples of care in recent times which have been unacceptable. These have been as a result of individual and organisational failings. We must all find the provision of sub-standard and unsafe care to patients intolerable. We must do all we can to support our staff to provide high quality, compassionate care. And we must support organisations to be able to make the right decisions about their staffing needs and to create an environment within which staff are supported to care.

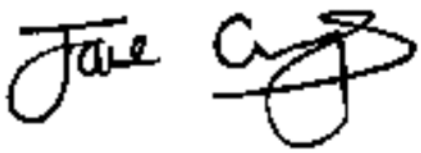
This guidance, which I have developed with my colleagues from the National Quality Board, seeks to support organisations in making the right decisions and creating a supportive environment where their staff are able to provide compassionate care. It sets out expectations of commissioners and providers in relation to getting nursing, midwifery and care staffing right so that they can deliver high quality care and the best possible outcomes for their patients. To a large extent, these expectations are about common sense and good leadership. We expect that all organisations should be meeting these currently, or taking active steps to ensure they do in the very near future.

There has been much debate as to whether there should be defined staffing ratios in the NHS. My view is that this misses the point – we want the right staff, with the right skills, in the right place at the right time. There is no single ratio or formula that can calculate the answers to such complex questions. The right answer will differ across and within organisations, and reaching it requires the use of evidence, evidence based tools, the exercise of professional judgement and a truly multi-professional approach. Above all, it requires openness and transparency, within organisations and with patients and the public. This guidance helps organisations to make those decisions by identifying tools, resources and examples of good practice. NICE will soon review the evidence and accredit evidence-based tools to further support decision-making on staffing.

Getting the right staff with the right skills to care for our patients all the time is not something that can be mandated or secured nationally. Providers and commissioners, working together in partnership, listening to their staff and patients, are responsible and will make these expectations a reality. As national organisations we pledge to play our part in securing the staffing capacity and capability you need to care for your patients.

I am grateful to my NQB colleagues for their commitment to this challenge and for working with me in setting out these expectations. I look forward to our continued work together and to seeing this guidance implemented across England for the benefit of our patients and staff.

Jane Cummings, Chief Nursing Officer for England



1 Expectations relating to nursing, midwifery and care staffing capacity and capability

Nursing, midwifery and care staff, working as part of wider multidisciplinary teams, play a critical role in securing high quality care and excellent outcomes for patients.

There are established and evidenced links between patient outcomes and whether organisations have the right people, with the right skills, in the right place at the right time. *Compassion in Practice*[1] emphasised the importance of getting this right, and the publication of the report of the Mid-Staffordshire NHS Foundation Trust Public Inquiry,[2] and more recent reviews by Professor Sir Bruce Keogh into 14 trusts with elevated mortality rates[3], Don Berwick's review into patient safety,[4] and the Cavendish review into the role of healthcare assistants and support workers[5] also highlighted the risks to patients of not taking this issue seriously.

That is why members of the National Quality Board, which brings together the different parts of the NHS system with responsibilities for quality, alongside patients and experts – and the Chief Nursing Officer, England, have come together to set out collectively the expectations of NHS providers and commissioners in this area.

[1] *Compassion in Practice,* NHS England, December 2012. Available at http://www.england.nhs.uk/wp-content/uploads/2012/12/compassion-in-practice.pdf
[2] *Report of the Mid-Staffordshire NHS Foundation Trust Public Inquiry,* The Mid-Staffordshire NHS Foundation Trust Public Inquiry, February 2013. Available at http://www.midstaffspublicinquiry.com/
[3] *Review into the quality of care provided by 14 hospital trusts in England: overview report,* Prof. Sir Bruce Keogh, NHS England, July 2013. Available at: http://www.nhs.uk/NHSEngland/bruce-keogh-review/Documents/outcomes/keogh-review-final-report.pdf
[4] *A promise to learn, a commitment to act: improving the safety of patients in England,* Don Berwick, Department of Health, August 2013. Available at: https://www.gov.uk/government/publications/berwick-review-into-patient-safety
[5] *The Cavendish review: an independent review into healthcare assistants and support workers,* Camilla Cavendish, Department of Health, July 2013. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/236212/Cavendish_Review.pdf

ACCOUNTABILITY & RESPONSIBILITY

EXPECTATION 1: Boards take full responsibility for the quality of care provided to patients, and as a key determinant of quality, take full and collective responsibility for nursing, midwifery and care staffing capacity and capability. Boards ensure there are robust systems and processes in place to assure themselves that there is sufficient staffing capacity and capability to provide high quality care to patients on all wards, clinical areas, departments, services or environments day or night, every day of the week.

Boards are actively involved in managing staffing capacity and capability, by agreeing staffing establishments, considering the impact of wider initiatives (such as cost improvement plans) on staffing, and are accountable for decisions made. Boards monitor staffing capacity and capability through regular and frequent reports on the actual staff on duty on a shift-to-shift basis, versus planned staffing levels. They examine trends in the context of key quality and outcome measures. They ask about the recruitment, training and management of nurses, midwives and care staff and give authority to the Director of Nursing to oversee and report on this at Board level.

Board papers are accessible to patients and staff working at all levels, and boards seek to involve staff at all levels and across different parts of the organisation, facilitating a strong line of communication from ward to Board, and Board to ward. Boards ensure their organisation is open and honest if they identify potentially unsafe staffing levels, and take steps to maintain patient safety.

Boards must, at any point in time, be able to demonstrate to their commissioners, the Care Quality Commission, the NHS Trust Development Authority or Monitor that robust systems and processes are in place to assure themselves that the nursing, midwifery and care staffing capacity and capability in their organisation is sufficient.

EXPECTATION 2: Processes are in place to enable staffing establishments to be met on a shift-to-shift basis. The Executive team should ensure that policies and systems are in place, such as e-rostering and escalation policies, to support those with responsibility for staffing decisions on a shift-to-shift basis. The Director of Nursing and their team routinely monitor shift-to-shift staffing levels, including the use of temporary staffing solutions, seeking to manage immediate implications and identify trends. Where staffing shortages are identified, staff refer to escalation policies which provide clarity about the actions needed to mitigate any problems identified.

EVIDENCE-BASED DECISION MAKING

EXPECTATION 3: Evidence-based tools are used to inform nursing, midwifery and care staffing capacity and capability. As part of a wider assessment of workforce requirements, evidence-based tools, in conjunction with professional judgement and scrutiny, are used to inform staffing requirements, including numbers and skill mix. Senior nursing and midwifery staff and managers actively seek out data that informs staffing decisions, and they are appropriately trained in the use of evidence-based tools and interpretation of their outputs. Staff use professional judgement and scrutiny to triangulate the results of tools with their local knowledge of what is required to achieve better outcomes for their patients.

SUPPORTING AND FOSTERING A PROFESSIONAL ENVIRONMENT

EXPECTATION 4: Clinical and managerial leaders foster a culture of professionalism and responsiveness, where staff feel able to raise concerns. The organisation supports and enables staff to deliver compassionate care. Staff work in well-structured teams and are enabled to practice effectively, through the supporting infrastructure of the organisation (such as the use of IT, deployment of ward clerks, housekeepers and other factors) and supportive line management.

Nursing, midwifery and care staff have a professional duty to put the interests of the people in their care first, and to act to protect them if they consider that they may be at risk, including raising concerns. Clinical and managerial leaders support this duty, have clear processes in place to enable staff to raise concerns (including about insufficient staffing) and they seek to ensure that staff feel supported and confident in raising concerns. Where substantiated, organisations act on concerns raised.

EXPECTATION 5: A multi-professional approach is taken when setting nursing, midwifery and care staffing establishments. Directors of Nursing lead the process of reviewing staffing requirements, and ensure that there are processes in place to actively involve sisters, charge nurses or team leaders. They work closely with Medical Directors, Directors of Finance, Workforce (HR), and Operations, recognising the interdependencies between staffing and other aspects of the organisations' functions. Papers presented to the Board are the result of team working and reflect an agreed position.

EXPECTATION 6: Nurses, midwives and care staff have sufficient time to fulfil responsibilities that are additional to their direct caring duties. Staffing establishments take account of the need to allow nursing, midwifery and care staff the time to undertake continuous professional development, and to fulfil mentorship and supervision roles. Providers of NHS services make realistic estimations of the likely levels of planned and unplanned leave, and factor this into establishments. Establishments also afford ward or service sisters, charge nurses or team leaders time to assume supervisory status and benefits are reviewed and monitored locally.

OPENNESS AND TRANSPARENCY

EXPECTATION 7: Boards receive monthly updates on workforce information, and staffing capacity and capability is discussed at a public Board meeting at least every six months on the basis of a full nursing and midwifery establishment review. Boards receive monthly updates on workforce information, including the number of actual staff on duty during the previous month, compared to the planned staffing level, the reasons for any gaps, the actions being taken to address these and the impact on key quality and outcome measures. At least once every six months, nursing, midwifery and care staffing capacity and capability is reviewed (an establishment review) and is discussed at a public Board meeting. This information is therefore made public monthly and six monthly. This data will, in future, be part of CQC's Intelligent Monitoring of NHS provider organisations.

EXPECTATION 8: NHS providers clearly display information about the nurses, midwives and care staff present on each ward, clinical setting, department or service on each shift. Information should be made available to patients and the public that outlines which staff are present and what their role is. Information displayed should be visible, clear and accurate, and it should include the full range of support staff available on the ward during each shift.

PLANNING FOR FUTURE WORKFORCE REQUIREMENTS

EXPECTATION 9: Providers of NHS services take an active role in securing staff in line with their workforce requirements. Providers of NHS services actively manage their existing workforce, and have robust plans in place to recruit, retain and develop all staff. To help determine future workforce requirements, organisations share staffing establishments and annual service plans with their Local Education and Training Board (LETBs), and their regulators for assurance. Providers work in partnership with Clinical Commissioning Groups and NHS England Area Teams to produce a Future Workforce Forecast, which LETBs will use to inform their Education Commissions and the Workforce Plan for England led by Health Education England (HEE).

THE ROLE OF COMMISSIONING

EXPECTATION 10: Commissioners actively seek assurance that the right people, with the right skills, are in the right place at the right time within the providers with whom they contract. Commissioners specify in contracts the outcomes and quality standards they require and actively seek to assure themselves that providers have sufficient nursing, midwifery and care staffing capacity and capability to meet these. Commissioners monitor providers' quality and outcomes closely, and where problems with staff capacity and capability pose a threat to quality, commissioners use appropriate commissioning and contractual levers to bring about improvements. Commissioners recognise that they may have a contribution to make in addressing staffing-related quality issues, where these are driven by the configuration of local services or the setting of local prices in contracts.

2 Introduction and purpose of this guide

In recognition of the ever increasing focus on nursing, midwifery and care staffing capacity and capability as a key determinant of the quality of care experienced by patients, the Chief Nursing Officer in England, members of the National Quality Board, and a cross-sector professional steering group have come together to set out system-wide expectations of providers and commissioners in this area. This 'How to' guide outlines these expectations and considers each one in detail, outlining why it is important, and providing some practical advice on how it can be met. This guidance has been written with providers and commissioners of NHS funded acute services, maternity, mental health, learning disabilities and community services, in mind.

Meeting the expectations outlined in the guide will go a long way to ensuring that organisations have nursing, midwifery and care staffing capacity and capability that is consistent with the provision of high quality care. However, establishing and maintaining adequate staffing capacity and capability is an inherently challenging process, and we recognise that not all organisations will be meeting the expectations set out in this document at the moment. Where this is the case, we expect organisations to have discussions at Board level as a matter of urgency about the actions that could be taken to meet these expectations. Chapter 9 – Next Steps, sets out how national regulatory and oversight organisations will take account of this guidance.

In the longer term, this guidance will be built upon by the work of the National Institute for Health and Care Excellence (NICE). NICE will be reviewing the evidence in this area, and will produce further guidance, and accredit tools to support staffing capacity and capability that is commensurate with high quality care.

There is no 'one size fits all' approach to establishing nursing, midwifery and care staffing capacity and capability, and this guide does not prescribe the 'right way', or a single approach, to doing so. Similarly, the guide does not recommend a minimum staff-to-patient ratio. It is the role of provider organisations to make decisions about nursing, midwifery and care staffing requirements, working in partnership with their commissioners, based on the needs of their patients, their expertise, the evidence and their knowledge of the local context. Rather, this guide aims to support providers and commissioners in meeting the expectations of people using their services by:

- suggesting some practical steps that organisations can take to meet the expectations and providing examples of good practice;
- signposting readers to existing tools and resources; and
- outlining the individual roles and responsibilities of different professionals involved in establishing and maintaining nursing, midwifery and care staffing capacity and capability.

In order to ensure that the nursing, midwifery and care staffing workforces can deliver the best care possible, a range of factors must be considered – simply having the right numbers of staff in place is not enough. To maximise the effectiveness of the workforce, organisations need strong and effective leadership, and to foster a culture that encourages people to take pride in their work. Staff need adequate training and development, and the organisation needs to support them to maintain their health and wellbeing. At a time when finances remain constrained, yet demand and public expectations of the health system are rising, it is vital that organisations look at how they use their available resources and workforce, and consider how things can be done more efficiently. Whilst this guide focuses on staffing capacity and capability, the importance of other factors in supporting a capable and effective workforce must not be overlooked.

Though this guide is focussed on nursing, midwifery and care staffing capacity and capability – following recent reports that identified particular issues with these professional groups – the principles outlined in this guide are applicable when assessing the appropriateness of clinical staffing in its broadest sense. Nurses, midwives and care staff make a unique and vital contribution to high quality patient care – but they are part of a much wider clinical team, and staffing needs must be considered in the round to ensure high quality care is delivered.

Throughout this guide, the following certain terms are frequently used:

- **High quality** – the accepted definition of 'quality' in the NHS comprises three components; care that is safe, care that is clinically effective; and care that provides as positive an experience for the patient as possible.

- **Wards** – we recognise that care is delivered in a variety of settings, such as wards, departments, clinical services, community settings. Throughout this document we have used the term 'ward' to denote all settings.

- **Capacity** – by this we mean the ability of staff present on any ward at any one time to provide care to patients.

- **Capability** – here we mean the skills, experience, knowledge and training of those staff present providing care to patients.

- **Care staff** – this includes assistant/associate practitioners, healthcare support workers, healthcare assistants, nursing assistants, auxiliary nurses and maternity support workers.

3 Accountability and responsibility for staffing capacity and capability

Expectation 1

Boards take full responsibility for the quality of care provided to patients, and as a key determinant of quality, take full and collective responsibility for nursing, midwifery and care staffing capacity and capability. Boards ensure there are robust systems and processes in place to assure themselves that there is sufficient staffing capacity and capability to provide high quality care to patients on all wards, clinical areas, departments, services or environments day or night, every day of the week.

Boards are actively involved in managing staffing capacity and capability, by agreeing staffing establishments, considering the impact of wider initiatives (such as cost improvement plans) on staffing, and are accountable for decisions made. Boards monitor staffing capacity and capability through regular and frequent reports on the actual staff on duty on a shift-to-shift basis, versus planned staffing levels. They examine trends in the context of key quality and outcome measures. They ask about the recruitment, training and management of nurses, midwives and care staff and give authority to the Director of Nursing to oversee and report on this at Board level.

Board papers are accessible to patients and staff working at all levels, and boards seek to involve staff at all levels and across different parts of the organisation, facilitating a strong line of communication from ward to Board, and Board to ward. Boards ensure their organisation is open and honest if they identify potentially unsafe staffing levels, and take steps to maintain patient safety.

Boards must, at any point in time, be able to demonstrate to their commissioners, the Care Quality Commission, the NHS Trust Development Authority or Monitor that robust systems and processes are in place to assure themselves that the nursing, midwifery and care staffing capacity and capability in their organisation is sufficient.

Why is this important?

- Boards of organisations are ultimately responsible for the quality of care they provide, and for the outcomes they achieve. The impact of nursing, midwifery and care staffing capacity and capability on the quality of care experienced by patients, and on patient outcomes and experience has been well documented, with multiple studies linking low staffing levels to poorer patient outcomes, and increased mortality rates.

- One study estimated that an increase of 1 registered nurse full time equivalent per patient day could save 5 lives per 1000 patients in intensive care, 5 lives per 1000

medical patients, and 6 per 1000 surgical patients.[6] In Prof. Sir Bruce Keogh's review of 14 hospitals with elevated mortality rates, he found a positive correlation between in-patient to staff ratios and higher hospital standardised mortality ratios (HSMRs)[7]

- Staffing capacity and capability can have a profound impact on patient safety - Don Berwick's recent review into patient safety emphasised the role of Boards and leaders of provider organisations in relation to staffing capacity and capability, stating that they should take responsibility for ensuring that clinical areas are adequately staffed in ways that take account of varying levels of patient acuity and dependency, and that are in accordance with scientific evidence about adequate staffing.[8]

- Patients need care every day of the week – not just Monday to Friday. Evidence shows that the limited availability of some services at weekends can have a detrimental impact on outcomes for patients, including raising the risk of mortality.[9] Appropriate nursing, midwifery and care staffing capacity and capability, together with other clinical staff, needs to be sustained 24 hours a day, 7 days of week, to maintain patient care and protect patient safety.

What does this mean in practice?

Board reporting

- **Boards request and receive papers on establishment reviews.** Carried out at least every six months, establishment reviews are critical to ensuring that the right people, with the right skills, are in the right place at the right time. They provide the opportunity to evaluate staffing capacity and capability over the previous six months, and to forecast the likely staffing requirements of wards for the next six months, based on the use of evidence based tools, and a discussion with ward, service and team leaders. Boards should sign off establishments for all clinical areas, articulate the rationale and evidence for agreed staffing establishments, and understand the links to key quality and outcome measures.

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[6] Kane RL, Shamliyan TA, Mueller C, Duval S, Wilt TJ. *The association of registered nurse staffing levels and patient outcomes: systematic review and meta-analysis. Med Care.* Dec 2007;45(12):1195-1204

[7] *Review into the quality of care provided by 14 hospital trusts in England: overview report,* Prof. Sir Bruce Keogh, NHS England, July 2013. Available at: http://www.nhs.uk/NHSEngland/bruce-keogh-review/Documents/outcomes/keogh-review-final-report.pdf

[8] *A promise to learn, a commitment to act: improving the safety of patients in England,* Don Berwick, Department of Health, August 2013. Available at: https://www.gov.uk/government/publications/berwick-review-into-patient-safety

[9] N Freemantle, M Richardson, J Wood, D Ray, S Khosla, D Shahian, WR Roche, I Stephens, B Keogh and D Pagano, *Weekend hospitalization and additional risk of death: An analysis of inpatient data. Journal of the Royal Society of Medicine, February 2012 vol. 105 no. 2 74-84.* Available at: http://jrs.sagepub.com/content/105/2/74

Papers to the Board on establishment reviews should aim to be relevant to all wards and cover the following points:

- the difference between current establishment and recommendations following the use of evidence based tool(s) (further detail provided under **expectation 3);**
- what allowance has been made in establishments for planned and unplanned leave (further detail provided under **expectation 6);**
- demonstration of the use evidence based tool(s) (further detail provided under **expectation 3**);
- details of any element of supervisory allowance that is included in establishments for the lead sister / charge nurse or equivalent (further detail provided under **expectation 6);**
- evidence of triangulation between the use of tools and professional judgement and scrutiny (further detail provided under **expectation 3**);
- the skill mix ratio before the review, and recommendations for after the review (further detail provided under **expectation 3);**
- details of any plans to finance any additional staff required (further detail provided under **expectation 9**)
- the difference between the current staff in post and current establishment and details of how this gap is being covered and resourced;
- details of workforce metrics - for example data on vacancies (short and long-term), sickness / absence, staff turnover, use of temporary staffing solutions (split by bank / agency / extra hours and over-time); and
- information against key quality and outcome measures - for example, data on: safety thermometer or equivalent for non-acute settings, serious incidents, healthcare associated infections (HCAIs), complaints, patient experience / satisfaction and staff experience / satisfaction.

The paper should make clear recommendations to the Board, which would be considered and discussed at a public Board meeting. Actions agreed by the Board should be detailed in the minutes of the meeting, and evidence of sustained improvements in the quality of care and staff experience should be considered periodically.

- **Regular updates to the Board** on staffing capacity and capability. Published monthly, these updates should provide details of the actual staff available on a shift-to-shift basis versus planned staffing levels, and the impact that this has had on relevant quality and outcome measures. These reports would highlight those wards where staffing capacity and capability frequently falls short of what is required to provide quality care to patients, the reasons for the gap, the impact and actions being taken to address it and to improve care.

Evaluating the risks

- Ensuring that adequate staffing capacity and capability is maintained can be a challenging and complicated process, and there will inevitably be times when it falls short of what is needed to provide high quality care to patients. Even where there appears to be enough staff, the skills of the workforce must be considered: a very dilute skill mix of registered nurses/midwives to care staff can compromise patient safety. In Professor Sir Bruce Keogh's review of 14 hospitals with elevated mortality rates, an over-reliance on non-registered staff and temporary staff was reported as a particular problem, and there were often restrictions in place on the clinical tasks temporary staff could undertake.[10]

- Boards should seek assurance that there are processes in place to highlight risks to patient care caused by insufficient staffing capacity and capability. They should seek assurance that escalation policies and contingency plans are in place for those times where staffing capacity and capability falls short of that required to provide a high quality service to patients. Further detail on the use of escalation policies is provided under **expectation 2.**

- Organisations should actively encourage all staff to report any occasions where any lack of suitably trained or experienced staff could have, or did, harm a patient. Because we know that staff under pressure are more liable to make errors, these locally reported incidents should be considered as patient safety incidents rather than solely staff safety incidents, and be routinely uploaded to the National Reporting and Learning System[11].

Being able to take decisive action

- Boards should ensure that the Executive Team is supported and enabled to take decisive action when necessary. Where potentially unsafe staffing capacity and capability is identified, escalation policies are important in outlining mitigating actions as part of contingency plans. In those situations where all potential solutions are exhausted, Directors of Nursing and the Executive Team should have the knowledge and expertise required to form a judgement on the course of action that best protects the safety of patients in their care. The closure of a ward or suspension of services as a final resort should always be carefully considered with alternative arrangements for patients identified as a priority.

[10] *Review into the quality of care provided by 14 hospital trusts in England: overview report,* Prof. Sir Bruce Keogh, NHS England, July 2013. Available at: http://www.nhs.uk/NHSEngland/bruce-keogh-review/Documents/outcomes/keogh-review-final-report.pdf

[11] More information on how to report incidents can be found at: http://www.nrls.npsa.nhs.uk/patient-safety-data/

CASE STUDY 1: University College London Hospitals (UCLH)

At UCLH the Executive Board receives regular updates about nursing and midwifery staffing and patient care.

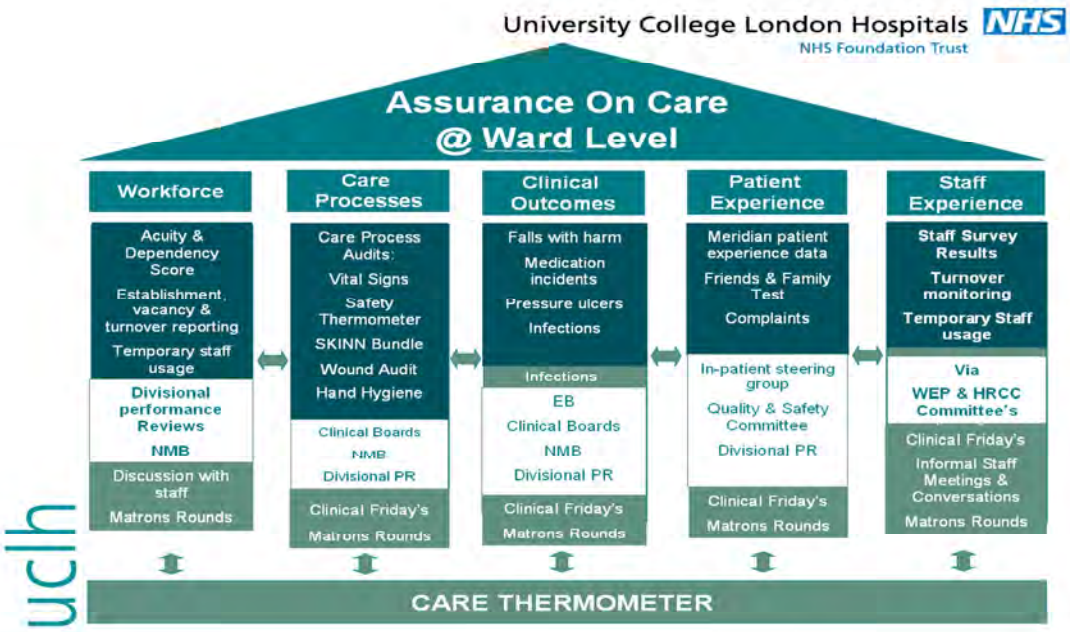
Ward establishments are set through a process agreed by the trust board and which utilises the Safer Nursing Care Tool to ensure that staff numbers are based on evidence based assessment of acuity and dependency.

Data are collected three times per year which is followed by a review of the data by the Head of Nursing, Head of Finance, Head of Workforce and Divisional Manager. This review triangulates professional judgement and ensures that the establishments are set at the right level for a particular ward.

Where an adjustment to the establishment is required this is then reflected in the following year's ward budget and is updated on the e-rostering system.

Staffing numbers are measured at the beginning of each shift and are displayed on the ward quality board at the entrance to each ward. Where the number of staff on duty is more than 1 nurse less that rostered, or each nurse has more than 7 patients to care for, the nurse in charge follows a standard escalation procedure which includes escalation to the chief nurse or one of her deputies over the full 24 hour period.

Nurse sensitive outcomes are measured and monitored via the care thermometer which is challenged at monthly meetings of the matrons and the nursing and midwifery board. This mechanism allows the leadership team to monitor process and outcomes measures that are sensitive to nurse staffing levels and provide assurance that the mechanisms for setting establishments are robust and effective.

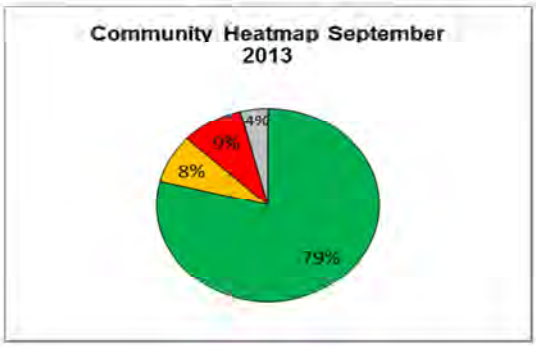


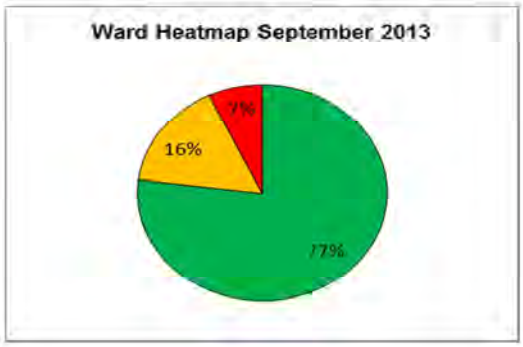
Contact: Katherine Fenton, Chief Nurse – [redacted]

CASE STUDY 2: Lincoln Partnership NHS Foundation Trust

Board Reporting - Use of a Heat Map, Cultural Barometer and Staffing Benchmarks'

For the last 18 months Lincolnshire Partnership NHS Trust has been developing and using a set of indicators that pull together reporting against CQC standards, patient experience, staff experience, and more recently the benchmarking of staffing. These indicators cover all clinical services (including wards and community services) and are in use from the ward to the Board. The 'Heat Map' report informs the Board and all staff within the organisation of the performance of the wards and community services utilising both pictorial and written methods. The report acts as an early warning tool and complements an '*under the skin*' approach to support services that need support and is also used to highlight improvement and exemplary practice.





Key: Outcome met Outcome mostly met Risk of outcome not being met no data

Underpinning the Heat Map the Trust uses the framework of the Provider Compliance Assessment (PCA) tool developed by the CQC. The Trust measures compliance across 16 outcomes which includes staffing measures which are presented to the Board and throughout the organisation using both pie charts and tables, showing compliance across individual outcomes for each ward/clinical area. Recently this internal regulation approach has been enhanced by the use of an internal cultural barometer, including questions about support, leadership, staff development and satisfaction, whether people feel able to raise concerns and transparently reported staffing ratios.

The report and approach highlights the requirement for listening to patients, staff and the public, a culture of open and honest communication, leadership at every level and not relying on one single process of assurance about care standards and quality. The approach supports the Board level requirement to monitor the quality of its services, to challenge poor performance and variation, and to incentivise high quality and performance improvement. Its use has supported the leadership development at all levels that is required to underpin good governance and high quality care.

Contact: Dr Julie Hall, Director of Nursing and Operations - [redacted]

Expectation 2

Processes are in place to enable staffing establishments to be met on a shift-to-shift basis. The Executive team should ensure that policies and systems are in place, such as e-rostering and escalation policies, to support those with responsibility for staffing decisions on a shift-to-shift basis. The Director of Nursing and their team routinely monitor shift-to-shift staffing levels, including the use of temporary staffing solutions, seeking to manage immediate implications and identify trends. Where staffing shortages are identified, staff refer to escalation policies which provide clarity about the actions needed to mitigate any problems identified.

Why is this important?

- Agreeing staffing establishments is the first part of an important process. Ensuring that establishments are met on a shift-to-shift basis is a vital step in ensuring that there is sufficient capacity and capability to care for patients on wards.

- Professor Sir Bruce Keogh highlighted this as a particular problem in his recent review into hospitals with elevated mortality rates; whilst staffing establishments in organisations appeared adequate in many instances, there were occasions when establishments were not met on wards on a shift-to-shift basis, compromising patient care.[12]

- Temporary staff form a key part of the nursing, midwifery and care staffing workforces. Using temporary staffing solutions when establishments cannot be met on a shift-to-shift basis can be an effective way of maintaining patient care, where the skills and capabilities of temporary staff match the requirements on the ward. However, an over reliance on temporary staffing can be costly, and lead to a lack of continuity in patient care. Ideally, substantive staff should be recruited to establishments, with temporary staffing solutions used to fill short term gaps only.

What does this mean in practice?

- **Daily reviews of the actual staff available on a shift-to-shift basis versus planned staffing levels** should occur between Sisters, Matrons and Heads of Nursing (and equivalent posts). Where shortages are identified, they work together to seek a solution – such as the pooling of staff from other clinical areas, or the deployment of bank or agency staff.

[12] *Review into the quality of care provided by 14 hospital trusts in England: overview report,* Prof. Sir Bruce Keogh, NHS England, July 2013. Available at: http://www.nhs.uk/NHSEngland/bruce-keogh-review/Documents/outcomes/keogh-review-final-report.pdf

- **E-rostering policies** can be an effective way of making the most of existing resources. NHS Employers has produced guidance that provides all the information an organisation will need to successfully implement an e-rostering system, which will allow them to embrace efficient and safe staffing by releasing more time for staff to deliver higher quality services, as well as helping to reduce expenditure on temporary staffing. E-rostering brings together management information on shift patterns, annual leave, sickness absence, staff skill mix and movement of staff between wards. This enables managers to quickly build rotas to meet patient demand. Employees are able to access the system to check their rotas and make personal requests, which should be balanced with service requirements. The guidance explains why e-rostering is beneficial, and explains how organisations can secure agreement to and implement an e-rostering programme.

  The guidance can be found at:
  http://www.nhsemployers.org/planningyourworkforce/flexible-workforce/agencyworkers/reducingagencyspend/e-rostering/Pages/e-Rostering.aspx

- **Using escalation policies and contingency plans** can provide a source of clarity at times of increased pressure (for example, when there are unusually high workloads, a particularly high level of patient dependency, exceptionally high staff sickness levels, or unfilled vacancies), and when staffing capacity and capability cannot be met on a shift-to-shift basis. Staff should be aware of the escalation policies in place, flag where they think staffing capacity and capability falls short of what is required (further detail is provided under **expectation 4**), and be able and prepared to use the escalation policies in place.

- Escalation policies should outline actions to be taken, the people who should be involved in decisions, in short, medium and long term staffing shortages, and outline the contingency steps where capacity problems cannot be resolved. Escalation policies are helpful in flagging capacity problems at an early stage, allowing organisations to adopt a proactive rather than a reactive response to problems identified.

4 Evidence-based decision-making

Expectation 3

Evidence-based tools are used to inform nursing, midwifery and care staffing capacity and capability. As part of a wider assessment of workforce requirements, evidence-based tools, in conjunction with professional judgement and scrutiny, are used to inform staffing requirements, including numbers and skill mix. Senior nursing and midwifery staff and managers actively seek out data that informs staffing decisions, and they are appropriately trained in the use of evidence-based tools and interpretation of their outputs. Staff use professional judgement and scrutiny to triangulate the results of tools with their local knowledge of what is required to achieve better outcomes for their patients.

Why is this important?

- Determining nursing, midwifery and care staffing requirements is a complex process, requiring input from all levels within the nursing and midwifery staffing structure. Using an evidenced-based tool is a critical part of making staffing decisions, and will ensure that these decisions are based on patient care needs and expert professional opinion.

- Using such tools is only one part of an approach to making staffing decisions; professional judgment and scrutiny is critical in evaluating the results from evidence-based tools, in light of patients' needs and knowledge of the local context.

- Simply determining the number of nurses, midwives or care staff required is only one part of the equation. The skill mix of the workforce should reflect patient care needs and local requirements, considering the experience and capabilities of the workforce employed. Evidence suggests that where there are lower levels of registered nurses, there are higher rates of errors in care[13, 14] and care is more likely to be 'left undone' when there are fewer registered nurses on a ward.[15,16]

- The right number and skill mix of staff alone will not ensure that high quality patient care is delivered; this depends upon a range of other factors, such as the leadership of an organisation, the management culture, the culture and team working on the ward, the

[13] McGillis Hall L, Doran D, Pink GH. *Nurse staffing models, nursing hours, and patient safety outcomes*. Journal of Nursing Administration. Jan 2004;34(1):41-45
[14] Blegen MA, Goode CJ, Reed L. *Nurse staffing and patient outcomes*. Nurse Researcher. Jan-Feb 1998;47(1):43-50.
[15] Kalisch B, Tschannen D, Lee H. *Does missed nursing care predict job satisfaction?* Journal of Healthcare Management. Mar-Apr 2011;56(2):117-131; discussion 132-113.
[16] Kalisch BJ, Tschannen D, Lee KH. *Do staffing levels predict missed nursing care?* International Journal for Quality in Health Care. Jun 2011;23(3):302-308.

level of education and training available to staff, and the organisational environment. Further detail is given under **Expectation 4.**

What does this mean in practice?

- **Using evidence-based tools** - there are a range and variety of tools available for use at present. Some of the tools that are currently in use, and a guide as to their use, is given in the table below. This is not intended to be a comprehensive list of the tools in use, and in the longer term, NICE will be reviewing the evidence base and accrediting tools in this area.

ACUTE SETTINGS

Safer Nursing Care Tool ™

The SNCT was originally developed in conjunction with the Association of UK University Hospitals (AUKUH), when it was known as the *AUKUH Patient Care Portfolio*. It has been widely used across the NHS, private sector and in some overseas hospitals. The Shelford Group commissioned a review of the tool and it has recently been relaunched as the *Safer Nursing Care Tool* (SNCT). It is available on the Shelford website at: http://shelfordgroup.org/resource/chief-nurses/safety-nursing-care-tool

The tool comprises two parts:

- An Acuity and Dependency Tool – this has been developed to help acute NHS hospitals measure patient acuity and/or dependency to inform evidence-based decision making on staffing and workforce. The tool sets out how to measure acuity and dependency of patients in a ward, what rules to follow to ensure that data are captured accurately, how to use this information to calculate total staff needed in a particular ward using nursing multipliers, and provides an example database which organisations can adapt for their own purposes.

- Nurse Sensitive Indicators (NSIs) – these have been identified as quality indicators of care with specific sensitivity to nursing intervention or lack of intervention. They can be used alongside the information captured using the Acuity and Dependency Tool to develop evidence-based workforce plans to support existing services or the development of new services. The Safer Nursing Care Tool demonstrates how NSI outcome data can be used alongside acuity and dependency information. If the SNCT and NSIs are used concurrently then it will be possible to relate ward staffing and nursing outcomes.

Work is underway to develop Safer Nursing Care tools for children's in-patient wards, acute assessment units, elderly acute care and elderly rehabilitation.

MATERNITY SETTINGS

Birthrate Plus®

Birthrate Plus® is the only national tool available for calculating midwifery staffing levels. It was developed 24 years ago and has now been applied in the majority of NHS Trusts in the UK and Ireland, being modified and developed to reflect changing models of care and working patterns.

- Using Birthrate Plus® enables individual Trusts to calculate their staffing requirements based on their specific activity, case mix, demographics and skill mix.
- It enables commissioners to compare the staffing, skill mix and models of care in their local providers with neighbours or units of a similar size.
- It provides workforce planners with robust data on which to commission student midwife numbers and advise on workforce establishments.

At its simplest Birthrate Plus® can provide any given service with a recommended ratio of clinical midwives to births in order to assure safe staffing levels. The methodology is based on an assessment of clinical risk and the needs of women and their babies during labour, delivery and the immediate post-delivery period. From these quantifiable needs of women Birthrate Plus® provides insights and intelligence to inform decisions about staffing numbers, staff deployment, models of care and skill mix.

Birthrate Plus® is available at http://www.rcm.org.uk/college/policy-practice/joint-statements-and-reports/

PAEDIATRICS

Great Ormond Street Hospital Paediatric Acuity and Nursing Dependency Assessment tool (PANDA)™

Developed by Great Ormond Street Hospital, the PANDA tool measures patient dependency and calculates nursing staff requirements based on the actual acuity and dependency of children.

Previously paper based, the new PANDA software version has been supported by NHS Innovations London and developed by Genisys Group.

It is available at: http://rfdesign-uk.com/testsite/panda/

CLINICAL NURSE SPECIALISTS PROVIDED SERVICES

Cassandra[TM]

Cassandra[TM] allows specialist advanced practice nurses to draw on a representative sample of their work and was a response to diary care exercise/time and motion studies in common use which did not adequately capture the complexity of the work. The Cassandra [TM] tool was developed by Dr Alison Leary by clustering data from a more complex dataset (Pandora). It has been used in several national studies and is now free to download as a spreadsheet from www.alisonleary.co.uk

Alexa Caseload Tool[TM]

The Alexa Caseload tool[TM] was developed by Dr Alison Leary with the National Cancer Action Team (NCAT) quality in nursing group. It is used to determine the optimum caseload of a specialist nurse against best practice. It is based on the work of lung Clinical Nurse Specialists but the methodology can be applied to Clinical Nurse Specialists who manage patients with other long term conditions. It uses previously modelled activity and national data to calculate a recommended caseload.
It is available at: www.alisonleary.co.uk or www.cancertoolkit.co.uk

ACUTE AND MENTAL HEALTH IN-PATIENT SETTINGS

Nursing Hours per Patient Day (NHPPD) [TM]

Developed in Western Australia the Nursing Hours per Patient Day tool is a nursing workload monitoring and measuring system that provides a guide to the number of nurses required for service provision in a specific clinical area. The model relies on clinical judgement to assess adequate staffing to deliver care on a day-to-day basis. The model is used to calculate the number of direct nursing hours required to provide patient care and can offer a framework to develop a nursing roster.

It can be found at: http://www.nursing.health.wa.gov.au/planning/workload_man.cfm

ACUTE, MENTAL HEALTH, LEARNING DISABILITIES AND COMMUNITY SETTINGS

Tools developed by Dr Keith Hurst - Dr Keith Hurst has developed a variety of tools to determine nursing requirements:

Professional Judgement Software[TM]

A quick and easy method: an expert group (clinical, workforce and finance) decides each ward's team size and skill mix using local intelligence.

Ward Staff Per Occupied Bed™

Another quick and easy method; ward managers draw relevant staff to occupied ratios from the national database and multiply occupied beds in their wards by the staffing multiplier. Separate multipliers are available for nurses and healthcare support workers. This method does not consider patient dependency/acuity.

Patient Dependency / Acuity Specialty Specific Tool™

Ward managers assess every patient at least daily for two weeks using the ADL dependency criteria. Daily averages are entered into software (selected according to clinical speciality). Ward staffing, therefore, reflects a clinical speciality's current workload and can be adjusted at any time. The software covers 28 clinical specialties. Managers also conduct an activity analysis and service quality audit. Ward workload index, staffing recommendations, ward staff activity and service quality can be benchmarked against same-specialty wards in the UK.

A community nursing tool with community care levels and multipliers is also available for use.

The software is available from [redacted]

A list of professional guidance is provided at **Appendix A.**

Evidence-based tools for mental health, learning disabilities and community settings

- The evidence base in relation to workforce planning and safe and effective staffing within mental health, learning disability and community settings is less established than that for acute care settings. Work is under way through *Compassion in Practice* Action Area Five to understand what workforce planning tools exist for these care settings and to pilot these tools or develop new tools.

    - **Mental Health -** A critical issue in mental health services is the therapeutic relationship and skilful interaction between staff and individual patients. The ethos, models of care and philosophy are also important factors in determining staffing establishments in mental health. The composition of the multi-professional team in mental health settings, for example the presence of occupational therapists and psychologists, will have a direct impact upon nurse staffing requirements.

- The guiding principles of workforce planning are applicable for all care groups, and some tools, for example the methodology developed by Dr Keith Hurst, are applicable to mental health services. Work is underway to pilot the Mental Health tool developed in NHS Scotland alongside Dr Keith Hurst's mental health / learning disabilities tool in mental health in-patient settings in England.

- **Learning Disabilities -** A UK-wide review of learning disabilities nursing supported by the four Chief Nursing Officers in the UK published in 2012[17] made recommendations related to workforce planning. Subsequent to this report a number of work streams and actions have commenced across the UK to influence workforce planning and education commissioning decisions in relation to learning disability nursing. All of the work streams report to the UK steering group chaired by Dr Ben Thomas. The Centre for Workforce Intelligence also undertook a strategic review of the learning disability nursing workforce.

- Through *Compassion in Practice* Action Area Five work is underway to pilot the NHS Scotland mental health tool and Dr Keith Hurst's tool for mental health and learning disabilities in learning disability in-patient settings. It is however recognised that the vast majority of learning disabilities care takes place in the community and work is also being taken forward to develop a tool for use in community settings. This work will consider the close working relationship between the nursing and social care workforce.

- **Community services -** The Community Nursing Strategy Programme brings together multiple organisations, including NHS England, the Department of Health, Health Education England, Public Health England and Queens Nursing Institute within a national programme led by the Chief Nursing Officer for England. Within the next two years, it aims to:

    - strengthen innovation;
    - support the workforce and improve commissioning practice for community, district and general practice nursing that enables care to be delivered closer to home; and
    - improve the outcomes for people with long term conditions, whilst simultaneously improving the experience of patients, carers and staff.

- The Queen's Nursing Institute is undertaking a review of workforce planning tools in community settings which is due to report at the end of December 2013.

[17] *Strengthening the commitment, The Report of the UK Learning Disabilities Nursing Review,* 2012, available at: http://www.scotland.gov.uk/Resource/0039/00391946.pdf

Interpreting results of tools and using professional judgment and scrutiny

- **Triangulation of results** from evidence-based tools is a vital step in establishing safe nursing, midwifery and care staffing capacity and capability. Staff should use professional judgement and scrutiny to interpret results from evidence based tools, taking account of the local context and patient needs. Some factors which can affect staffing requirements include:

    - The layout and design of the ward. For example, wards with multiple single rooms or bays may require higher staffing capacity and capability;
    - The number of ward clerks/ housekeepers and other support staff available;
    - Employing ward clerks and housekeepers on wards can reduce the pressure on nurses, midwives and care staff in undertaking administrative tasks;
    - Any travel requirements. For example, in community settings, staff may have distances to travel between visits. Establishments should include a proportion of time allocated to travel where necessary. Clinical visits should be planned to make most effective use of travel time;
    - The technological support available on wards. The adoption of new technological solutions can reduce the amount of time that nurses, midwives and care staff spend on paperwork, freeing them up to focus on direct caring duties;
    - The dependency and acuity of patients. High patient dependency will require higher capacity and capability of registered nurses and midwives; and
    - Patient throughput is another factor which needs to be considered when planning nursing, midwifery and care staff establishments.

- Professional judgment and knowledge of the local context and patient needs should also inform the **skill mix** of staff. Simply determining the numbers of staff required for each ward is not sufficient – it is important that the skill mix between registered and non-registered staff reflects the likely workload and skills required to care for patients locally. Healthcare Support Workers, Maternity Support Workers and Assistant / Associate Practitioners are key members of the nursing and midwifery team, and the skill mix used should maximise the potential contributions of all parts of the workforce. The considerations outlined above are equally relevant when considering the skill mix of staff.

- Employer organisations should have robust systems in place to govern the practice of all members of the nursing and midwifery workforce, including the accountabilities of Registered Nurses and Midwives in relation to the appropriate delegation of care. It is essential that all members of the nursing and midwifery team receive training for their role.

- Healthcare Assistants[18]/Support workers now make up around a third of the caring workforce in hospitals, and research suggests that they now spend more time than nurses at the bedside.[19] Health Education England (HEE) is leading work nationally to maximize the capabilities and contribution of Healthcare Assistants/Support Workers, which includes:.

  - establishing minimum training standards for Healthcare Assistants / Support Workers
  - progression routes for Healthcare Assistants / Support Workers to enter nurse training
  - increasing the number of healthcare apprentices

- The Royal College of Midwives has published guidance on the role and responsibilities of Maternity Support Workers available at: http://www.rcm.org.uk/college/your-career/maternity-support-workers/roles/

CASE STUDY 3: **Hertfordshire Partnership University Trust - 'Safe Staffing: Managed entry and exit policy for acute mental health services'**

Hertfordshire Partnership University NHS Foundation Trust acute mental health services updated its managed exit and entry policy, focusing on correct and safe staffing on acute admission wards for Informal patients entitled to leave the unit and Formal patients detained under the Mental Health Act.

The policy introduced the following principles:

- All service users admitted are screened and risked assessed for their potential to abscond from the unit based on their status under the Mental Health Act and their profile risk is combined with clinical judgement.
- 'Patient Status' at a glance boards for high risk absconders are utilised at handover and team meetings.
- A range of evidence-based tools interventions are available for use to assess acuity and risk, enabling staffing needs to be adjusted, these include including the Nursing Observed Intensity Sickness Scale and the Brøset Violence Checklist.

Early feedback suggests this policy is leading to safer services for both service users and staff.

Contact: Oliver Shanley, Deputy [redacted]

[redacted]

[18] Some organisations use the terms Nursing Auxiliaries, Nursing Assistants, Healthcare Support Workers and Healthcare Assistants.

[19] *The Cavendish review: an independent review into healthcare assistants and support workers,* Camilla Cavendish, Department of Health, July 2013. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/236212/Cavendish_Review.pdf

CASE STUDY 4: Derbyshire Community Health Services NHS Trust - 'Staffing for Quality: Joint Review of Community Nursing on behalf of Derbyshire Community Health Services NHS Trust and North Derbyshire CCG'

A review was established between Derbyshire Community Health Services DCHS and North Derbyshire CCG (NDCCG), as lead commissioner, to assess community nurse staffing levels following the publication the Francis Inquiry report, and in light of national and local priorities in relation to community nursing and the delivery of integrated care models.
In March 2013 following a review of staffing levels in their community hospitals, the DCHS Board approved increased funding. The review 'Staffing for Quality' was undertaken utilising an evidence-based tool (Hurst) and assessed against recent recommendations by the Royal College of Nursing (RCN) and national reports on the provision of elderly care.

A locally developed tool based on a model used in Central Essex to determine community nursing workload and dependency has been in use within DCHS for a number of years. Currently it is mainly used by the District Nursing sister to manage the weekly and daily work load of their teams (planned and urgent work), matching skills/competency to patient need. In some localities the Integrated Team Leaders use it across a number of teams to ensure efficient use of resources and manage their workforce. Recent development work has supported linking the tool with electronic patient records. DCHS is developing this further, linking with a Hurst review process, and e-rostering, system which will include a patient acuity tool.

Contact: Kathryn Henderson, Senior Clinical Advisor, [redacted]

CASE STUDY 5: Cumbria Partnership NHS Foundation Trust - 'Safer Nursing Care Tool: Community Hospital Review and Disrict Nurse Services Review'

In Summer 2012 the tBoard requested a review of two Community Hospital in-patient units which resulted in a recommendation to undertake a review across all 14 in-patient units. It was also agreed that the District Nursing team should be reviewed.

This review was commissioned in November 2012. The Safer Nursing Care Tool was used for the inpatient review and the audit results were benchmarked against 145 comparable best practice wards within England. In April 2013 all forty-six district nursing teams were audited.

The results of the reviews has enabled the Trust Board to understand the dependency and acuity of patients on each ward and in the community, the quality of care delivered and the staffing numbers, skill mix and competency required to care for the patient mix compared with the actual staffing levels. This has provided the Board and clinicians with an evidence base against which to allocate resources and has resulted in Ward Managers becoming supervisory and a Band 5 Registered Nurse post appointed on each ward in replacement (13 in total); there have also been additional Health Care Assistant's and Band 6 Registered Nurse roles appointed.

Contact: Esther Kirby, Deputy Director of Nursing, Quality and Patient Experience, [redacted]

CASE STUDY 6: Staffordshire and Stoke on Trent Partnership NHS Trust - 'Workforce Planning Toolkit'

Staffordshire and Stoke on Trent Partnership NHS Trust has developed an innovative Workforce Planning Toolkit to support its strategic workforce planning and operational deployment. Using a bottom up approach, it enables managers to work through an integrated workforce planning methodology in a systematic way using population/demographic demand, competency frameworks to match demand and a caseload management tool.

Features of the toolkit include a triangulation of multiple methods to establishing demand, and include business tools to link workforce planning with the Trust's overall strategic direction, as well as indications for improvements to the current deployment of staff and possibilities for workforce redesign.

The development of robust competency frameworks across the Trust is a key enabler to this toolkit which will ensure that staff are appropriately placed with the right skills, knowledge and competences to deliver the Trust's person-centred model.

Contact: Tina Cookson, Director of Operations (Adult Services) -[redacted]

CASE STUDY 7: 'The Role of Maternity Support Workers

The Royal College of Midwives (RCM) describes Maternity Support Workers (MSW) 'as any non-registered employee providing support to a maternity team, mothers and their families who work specifically for a maternity service' and who, with training and supervision, can provide information, guidance and support.

In Wrightington, Wigan and Leigh NHS Foundation Trust (WWL) MSW's deliver one to one practical parenting support and education to the 2% most vulnerable pregnant women and their families as part of the Integrated Health Service Team. These pregnant women can have complex needs, which may include safeguarding or mental health concerns. Support commences early in pregnancy and continues both on the maternity ward and for six weeks post natal. The MSWs provide training and support across a range of areas including baby bathing, breastfeeding, artificial feeding and associated sterilisation and safe sleep.

At Southend University Hospital Foundation Trust Infant Feeding MSWs are trained and empowered with the skills and knowledge to support women to continue to breastfeed for as long as possible. The MSWs were trained in the UNICEF Baby Friendly Initiative Breastfeeding Management and provide post-delivery support of up to six weeks by making contact with breastfeeding mothers upon transfer to the community. Within three months of introducing MSWs the continuation rate for breastfeeding had improved.

Although MSWs do not make clinical judgments their input under the direction of the midwife supports mother and baby.

5 Supporting and fostering a professional environment

Expectation 4

Clinical and managerial leaders foster a culture of professionalism and responsiveness, where staff feel able to raise concerns. The organisation supports and enables staff to deliver compassionate care. Staff work in well-structured teams and are enabled to practice effectively, through the supporting infrastructure of the organisation (such as the use of IT, deployment of ward clerks, housekeepers and other factors) and supportive line management.

Nursing, midwifery and care staff have a professional duty to put the interests of the people in their care first, and to act to protect them if they consider that they may be at risk, including raising concerns. Clinical and managerial leaders support this duty, have clear processes in place to enable staff to raise concerns (including about insufficient staffing) and they seek to ensure that staff feel supported and confident in raising concerns. Where substantiated, organisations act on concerns raised.

Why is this important?

- In general terms, the more positive the experience of staff within a Trust, the better the outcomes for patients and the organisation. Staff engagement has many significant associations with patient satisfaction, mortality, and infection rates. The proportion of staff working in well-structured teams, receiving well-structured appraisals and experiencing supportive leadership from line managers are all linked to patient mortality.[20]

- A key part of supporting staff is ensuring that the organisational culture encourages them to perform their job to the best of their abilities. For example, advances in technology can have a huge impact on the workload of nursing, midwifery, and care staff, enabling them to deliver effective care and freeing up their time to care for patients. Embracing such developments will allow staff the opportunity to fulfill roles to their maximum potential, and could affect the staffing establishments required.

- Being listened to, respected, and treated with the compassion and dignity they deserve has a huge impact on patients' experience of care, and contributes to higher quality care. It is vital that leaders and managers at every level create supportive, caring cultures, within teams and within organisations as a whole. As outlined in *Compassion in Practice,*

[20] Michael A West, Jeremy F Dawson. *Employee engagement and NHS performance*, 2012. Available at: http://www.kingsfund.org.uk/sites/files/kf/employee-engagement-nhs-performance-west-dawson-leadership-review2012-paper.pdf

nurses, midwives and care staff have a responsibility to demonstrate six key values – the 6Cs - in everything they do. These are care, compassion, competence, communication, courage and commitment.[21]

What does this mean in practice?

Supporting staff

- **Organisational culture** is key to ensuring that staff feel supported and enabled to fulfill their role to their maximum potential, and are able to raise concerns where necessary. Those with line management responsibilities seek to ensure that staff are managed effectively, with clear objectives set, constructive appraisals carried out, resulting in a workforce that feels valued. Teams should be well-structured, with supportive line management at every level of the organisation.

- The adoption of technological advances can enable nurses and midwives to deliver care more effectively, and can free up staff time to focus on delivering patient care. The Nursing Technology Fund has been established with this aim - £100 million of funding over two years will be available uniquely for new technology that will support safe, effective care. The new technology could include digital pens and other handheld mobile devices that allow staff to access the latest information about a patient's treatment whenever, wherever they are. These technologies will enable a swifter, more comprehensive understanding of a patient's care and conditions, reducing the time spent on form filling and bureaucracy, freeing up time for face-to-face patient care and contributing to safer care and better outcomes.

Ensuring staff are able to speak up

- Nurses, midwives and care staff are under a professional duty to put the needs of their patients first, and to speak out when they have concerns. This is made clear in the Nursing and Midwifery Council's (NMC) code. The Code is the foundation of good nursing and midwifery practice, and a key tool in safeguarding the health and wellbeing of the public. It highlights that the people in the care of Registered Nurses and Midwives must be able to trust them with their health and wellbeing, and that to justify that trust, nurses and midwives must:

    - make the care of people their first concern, treating them as individuals and respecting their dignity;
    - work with others to protect and promote the health and wellbeing of those in their care, their families and carers, and the wider community;
    - provide a high standard of practice and care at all times; and

[21] *Compassion in Practice,* NHS England, December 2012. Available at http://www.england.nhs.uk/wp-content/uploads/2012/12/compassion-in-practice.pdf

- be open and honest, act with integrity and uphold the reputation of their profession.

The code continues to apply to operational managers who keep their nursing or midwifery registration. The code is available at: http://www.nmc-uk.org/Nurses-and-midwives/Standards-and-guidance1/The-code/

- The NMC has also recently refreshed and re-launched guidance on raising concerns. This provides guidance for nurses and midwives on raising concerns, setting out broad principles that will help them think through the issues and take appropriate action in the public interest. The new edition includes information on recent legislation that offers protection to whistleblowers as well as updated information on where nurses and midwives can go to for further information. It is available at http://www.nmc-uk.org/Nurses-and-midwives/Raising-and-escalating-concerns

- **Whistleblowing policies** should be in place within providers of NHS services, supporting staff to raise concerns as and when they arise. NHS Employers provides guidance to support employers to implement and develop policies and procedures that are targeted at enabling NHS staff to report concerns appropriately. NHS Employers work closely with the National Whistleblowing Helpline launched in December 2011 which provides free, independent advice and support to staff within the NHS and Social Care.[22] The Helpline can be reached by calling 08000 724 725.

- Organisations should be open and honest when things go wrong. All providers of NHS services must adhere to **Duty of Candour requirements,** which require organisations to publish an annual declaration of a commitment to telling patients if something has gone wrong with their care.[23] The Duty of Candour has also been strengthened in the recently published Government response to the Report of the Mid-Staffordshire NHS Foundation Trust Public Inquiry, available at: https://www.gov.uk/government/publications?departments[]=department-of-health

- **Staff side representatives** working in organisations can provide support in ensuring that staff views are considered, for example through staff survey feedback, and can support them in raising concerns – including concerns around staffing capacity and capability. They can act on behalf of staff and represent staff views and concerns during regular meetings with the organisation's management team.

[22] Guidance produced by NHS Employers can be found at: http://www.nhsemployers.org/employmentpolicyandpractice/ukemploymentpractice/raisingconcerns/pages/whistleblowing.aspx

[23] Guidance on the Duty of Candour can be found at: http://www.nhsemployers.org/EMPLOYMENTPOLICYANDPRACTICE/UKEMPLOYMENTPRACTICE/Pages/DutyofCandourconsultation.aspx

CASE STUDY 8: The Royal Wolverhampton Hospitals NHS Trust - 'SafeHands' Programme supports safer staffing levels using real time information

SafeHands is a Department of Health part-funded innovation project using Real time locating software (RTLS) to improve patient safety.

RTLS uses infra-red and radio-frequency technology to monitor and measure real time patient and staff interaction based on RTLS badge co-location. It provides real time locating and visibility of patients with on screen alerts and audible alarms when a patient is leaving the ward unaccompanied or alone in an isolated area and can generate a live bed state. The hospital can understand the true dependency of patients allowing staff to prioritise and improve individual patient care.

The RTLS also monitors Hand Hygiene index (similar to compliance) by ward and real time locating of equipment across the Trust ensuring planned equipment gets to the patient in a timely manner allowing prompt commencement of treatment.

All of the data can be reported on including hours of care given to individual patients, by individuals or groups of staff and triangulated with patient condition, acuity, falls risk etc. This will support accurate costing of service provision, predicting and planning for future staffing levels and informed dialogue with commissioners.

The programme is being rolled out across all in-patient areas of the hospital.

"Virtual walls" mark out individual bed spaces to identify real time locations of badges.

The Badges attach to patients, staff, hand gels, soaps and equipment to track location, movement, interaction, passage of time and hand hygiene compliance.

Staff, patient, gel and equipment badges send radiofrequency signals indicating their current location to the virtual walls. Messages are sent to the software which interprets the messages and triggers rules and reports including patient staff interaction, equipment tracking and patient "Last Seen" timer.

Contact: Clare.Nash, Programme Manager – SafeHands, [redacted]

CASE STUDY 9: Stockport NHS Foundation Trust - Stockport District Nursing and the Dominic System (Domiciliary in the Community Care System)

In 2010 the District Nursing Service in Stockport moved forward to produce an electronic scheduling system tailor made to staff requirements. The system, later called 'Dominic', was initially developed to reduce medication errors, duplication of visits, ensure continuity of visit by the right nurse with the right skills and promote visits at the patient's choice of time

The system was fully launched in 2012, and all caseloads are visible to all staff. It can now:

- schedule visits weeks in advance;
- enable management of workload pressures by moving staff;
- predict peaks in demand enabling managers to forecast pressures;
- monitor the performance of the service by measuring outcomes for CQUINS/KPIs and local targets;
- reduce the amount of bank required; and
- introduce improved skill mix resulting in efficiency savings.

Further development in 2014 will include incorporating the Specialist Nursing Team so that communication and referrals are fully electronic.

Contact: Tina Roebuck, Clinical Lead - [redacted]

CASE STUDY 10: King's College London - 'Culture of Care Barometer'

Caroline Alexander, Chief Nurse, NHS England (London) is leading the work on Action Area 4 of Compassion in Practice and the Culture of Care Barometer is part of this work. The National Nursing Research Unit at King's College London have been commissioned to develop and pilot the tool.

The Barometer aims to:

- be short and quick to complete;
- complement, not duplicate, other measures or quality programmes;
- allow "ward to board" communication;
- act as an early warning system to identify care culture problems; and
- prompt reflection, to help identify actions required.

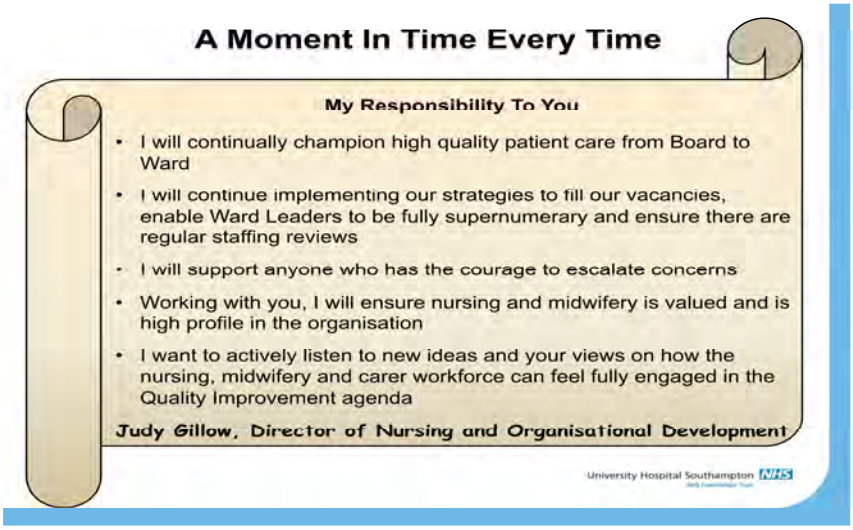
The Barometer is a short survey which captures staff views of resources to deliver quality care, support needed to do a good job. It aims to gauge whether the culture of care in different parts of an organisation is conducive to delivering compassionate patient centred care, signalling where there are opportunities to develop and improve.

Contact: Professor Anne Marie Rafferty - [redacted]

CASE STUDY 11: University Hospital Southampton NHS Foundation Trust - 'A Staff Compact: Roles and Responsibility Discussions'

The Director of Nursing and Organisational Development has developed with staff a compact which sets out her own responsibility to staff and their responsibility within the organisation and to the nursing profession.

The staff compact is utilised to stimulate discussions in training sessions around professional behaviours and how every action or intervention with a patient should reflect their role as a caring and compassionate nurse or midwife. It also sets out a clear commitment that the Director of Nursing and Organisational Development will champion high quality patient care from Board to Ward.



Contact: Judy Gillow, Director of Nursing and Organisational Development - [redacted]

***CASE STUDY 12*: Maidstone and Tunbridge Wells NHS Trust - 'Safer Staffing; Changes made to a respiratory ward following the use of the Safer Staffing methodology'**

Key quality indicators are reviewed monthly at performance meetings and at the Clinical Governance Overview Committee utilising the Quality, Effectiveness and Safety Trigger Tool (QuESTT). Two consecutive low QuESST scores, along with a further infection case, instigated an internal review of Whatman ward, a 28 bedded medical ward focused on respiratory care and providing non-invasive ventilation support (NIV), using the CQC Dignity And Nutrition Inspection methodology. The review included a matron external to the Directorate and a patient representative.

Demand for NIV support had increased and had not been reflected in staffing levels. Discussions with operational management resulted in one bay (6 beds) being closed; staffing levels were adjusted to improve the Registered Nurse:Patient ratio. A bespoke training programme ensured all staff were competent and confident with NIV management.

Data from Safer Staffing was reviewed daily and progress was monitored weekly by the Directorate, the Infection Prevention Committee, Chief Nurse and up to the Board via the Quality & Safety Committee. A Risk Summit chaired by the Chief Executive allowed the Directorate to identify what Corporate/Organisation level support was required.

Improvements include a decrease in the number of complaints, improved patient satisfaction and a reduction in the number of incidents. There has also been a reduction in staff sickness and turnover. All of these improvements have been sustained over the last 6 - 9 months.

Contact: John Kennedy, Deputy Chief Nurse [redacted]

Expectation 5

A multi-professional approach is taken when setting nursing, midwifery and care staffing establishments. Directors of Nursing lead the process of reviewing staffing requirements, and ensure that there are processes in place to actively involve sisters, charge nurses or team leaders. They work closely with Medical Directors, Directors of Finance, Workforce (HR), and Operations, recognising the interdependencies between staffing and other aspects of the organisations' functions. Papers presented to the Board are the result of team working and reflect an agreed position.

Why is this important?

- There are many complex interdependencies between nursing, midwifery and care staffing capacity and capability, and other parts of an organisation's structure and functions. A multi-disciplinary approach to reviewing and establishing staffing capacity and capability will help to identify these interdependencies and to ensure that decisions are not taken in isolation.

- Whilst responsibility for nursing, midwifery and care staffing capacity and capability resides with Directors of Nursing (or equivalent), other Directors – such as Workforce (HR), Finance, Operations and Medical – also have responsibilities in this area. For example, it is important to ensure that the impact on nursing, midwifery and care staffing of changes to the provision of medical care are discussed between the Medical Director, the Director of Nursing and Director of Operations before being implemented. It would also be important to consider the impact of issues such as medical, allied health professional or pharmacy vacancies on the nursing, midwifery and care workforce, together with the use of administrative staff to support the non-clinical aspects of the workload.

What does this mean in practice?

- Staff should be clear on individual **roles and responsibilities** in terms of nursing, midwifery and care staffing capacity and capability. Whilst recommendations on staffing capacity and capability presented to the Board should be the result of joint working and joint ownership of the issues, there are some distinct roles and responsibilities for different parts of the organisation involved in the staffing process, as outlined below. These are not intended to be comprehensive and will also change as innovation occurs and new roles develop.

NON-EXECUTIVE DIRECTORS OF THE BOARD

- Ensure there are robust systems and processes in place across the organisation to make informed and accurate decisions concerning workforce planning and provision.
- Review data on workforce, quality of care and patient safety on a regular basis and hold Executive Directors to account for ensuring that the right staff are in place to provide high quality care to patients
- Ensure that decisions being taken at a board level, such as implementing cost improvement plans, have sufficiently considered and taken account of impacts on staffing capacity and capability and key quality and outcomes measures
- Understand the principles which should be followed in workforce planning, and seek assurance that these are being followed in the organisation

CHIEF EXECUTIVE

- Ensure that the organisation has the right number of staff with the required knowledge and skills to provide safe and effective patient care
- Ensure that there is an agreed nursing and midwifery establishment for all clinical areas
- Ensure there are robust systems and processes in place across the organisation to make informed and accurate decisions concerning workforce planning and provision.
- Ensure that appropriate escalation policies are in place and action is taken when staffing falls below that expected
- Ensure workforce plans are clinically and financially viable, and that they inform education commissioning process in place through the Local Education and Training Board (LETB) and Health Education England (HEE)
- Ensure that the Executive Team have SMART objectives (specific, measurable, achievable, realistic, timely) aligned to staffing and that these are reviewed and performance tracked regularly.

EXECUTIVE BOARD MEMBERS

- Report to the Board on nursing, midwifery and care staffing capacity and capability, highlighting concerns and making recommendations where necessary. Workforce data should be triangulated with data on quality of care
- Where staffing capacity and capability is insufficient to provide safe care to patients and cannot be restored, undertake a full risk assessment and consider the suspension of services and closure of wards in conjunction with the Directors of Operations, Chief Executive and Commissioners
- Foster a culture of openness and honesty amongst staff, supported by nursing and midwifery leaders, where staff feel able to raise concerns, and concerns are acted upon

DIRECTOR OF NURSING

Develop the nursing and midwifery leadership team to ensure that they understand the principles of workforce planning and can use evidence based tools informed by their professional judgement to develop workforce plans and make staffing decisions on a day to day basis

Assure the Board that there are nursing and midwifery workforce plans in place for all patient care areas/pathways

On a monthly basis, report workforce information to the Board on expected vs actual staff in post on a shift-to-shift together with information on key quality and outcome measures

Ensure there is an uplift in planned establishments to allow for planned and unplanned leave and ensure absence is managed effectively

DIRECTOR OF WORKFORCE (HR)

Ensure that human resources support and policies are available to secure sufficient staffing capacity and capability to provide high quality care to patients

Ensure that there are systems and processes in place to capture accurate data on establishment, staffing levels and skill mix, staff movements, training and turnover to inform decisions on workforce planning

Develop and implement policies that support all staff working within areas of competence

Develop and implement a strategic recruitment plan to provide the required resources and fill current and future vacancies

CHIEF OPERATING OFFICER/DIRECTOR OF OPERATIONS

Ensure that the management of the organisation supports delivery of the workforce plan and there is sufficient staffing capacity and capability to provide high quality care to patients

Ensuring that there are systems and processes in place to capture accurate data on quality of care, patient pathways and volume to inform decisions on workforce planning

DIRECTOR OF FINANCE

Ensure that finance decisions which could have an impact on staff capacity and capability and patient outcomes are taken with consideration of staffing and workforce planning implications, and that these are reflected in any advice provided for decision to the Board, linking proposals to patient outcomes and quality

Ensure there are staff recruitment and retention strategies in place, and regularly review the effectiveness of these

Ensure that there are systems and processes in place to capture accurate data on establishment, staffing levels and skill mix, to inform decisions on workforce planning

NURSING LEADERS: HEAD OF NURSING / MATRON / SENIOR MIDWIFE

- Review and approve rosters submitted from wards
- Reallocate staff and authorise the use of temporary staffing solutions if necessary and where required
- Continuously review and monitor nursing, midwifery and care staffing capacity and capability across areas of responsibility
- Produce data / information to inform the Board and management of the organisation, and to inform workforce planning
- Hold Service Managers to account for having appropriate staffing capacity and capability on a shift to shift basis, and following escalation procedures where necessary

SISTER / CHARGE NURSE/TEAM LEADER

- Produce and manage safe and efficient staff rosters
- Measure quality of care and outcomes achieved for patients and the capacity and capability of staff on a ward-to-ward basis
- Respond in a timely manner to unplanned changes in staffing, changing patient acuity / dependency or numbers, including the request for and use of temporary staffing where nursing/midwifery shortages are identified
- Escalate concerns to line manager where staffing capacity and capability are inadequate to meet patient needs
- Understand the evidence based methodology used to determine the nursing and/or midwifery staffing in your area of responsibility

OTHER HEALTH AND CARE STAFF

- Complete data returns where requested about the staffing in your workplace to inform workforce planning decisions
- Participate in discussions and decisions regarding staffing in your clinical area
- Understand the agreed staffing capacity and capability are for your clinical area on a shift by shift basis
- Raise concerns regarding staffing and/or the quality of clinical care within your organisation when they arise

These roles and responsibilities only seek to cover responsibilities related to nursing, midwifery and care staffing capacity and capability, and are not exhaustive. They are not mandatory and should be read in the context of each organisation and its governance and management structures. It is important to empower ward Sisters/Charge Nurses to take responsibility for their clinical areas with delegated authority to act, supported by their organisations.

Roles will, over time, evolve and change as new innovations come into practice and these guidelines will need to be updated to take this into account.

CASE STUDY 13: NHS England – North - 'Investing in Behaviours'

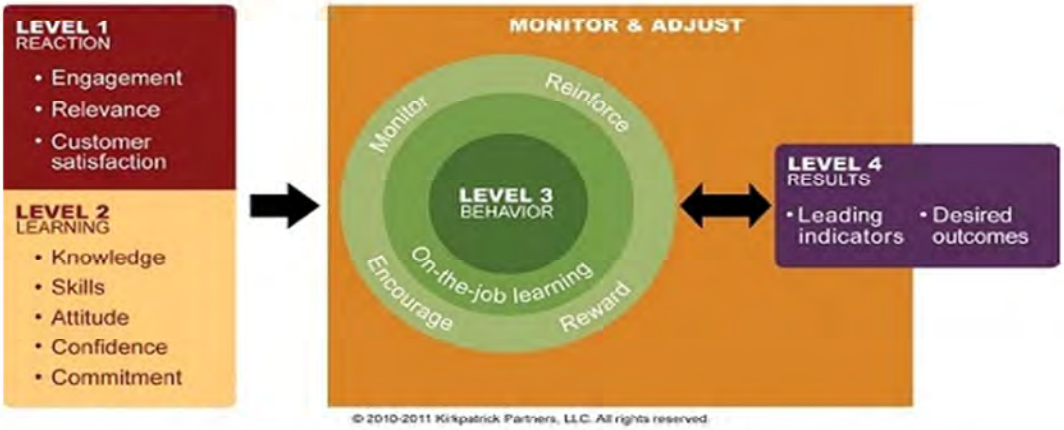
The 'Investing in Behaviours' programme was funded by the Health Foundation for the North East of England and is being taken forward as part of Action Area 3 of the Compassion in Practice Programme, which is led by Gill Harris, Chief Nurse, NHS England (London)

Conceived in July 2012, it is a product of the need to address issues raised by the Francis Inquiry; to underpin safety and quality improvement work with actions that address Human Factors and Behaviours.

During the 3 year improvement programme, 'Safer Care North East' clinicians leading improvement work recognised that focussing on systems and processes alone could only deliver improvements to a point – there was a need to address the fact that human error exists. A faculty of Human Factors was established and clinical teams worked with pioneers from the airline industry to develop the knowledge base of human factors in patient safety. It includes a new perspective on working as part of a team; the benefit this can have in terms of leadership, patient focus and utilisation of staff. Funded by the Health Foundation, an educational package was published in March 2013 including e-learning, workbook and trainers manual.

'Investing in Behaviours' has two elements; firstly it is underpinned by the Kirkpatrick evaluation model, which ensures that any action, intervention or training, delivered to support improvement, delivers behaviour change rather than just the acquisition of a technical or theoretical skill. The Kirkpatrick evaluation model is shown below:

THE NEW WORLD KIRKPATRICK MODEL



Secondly individuals and clinical teams are supported with 'Insights Discovery – Discovering Investing in Behaviours', a programme that delivers self-awareness and facilitates changes in individuals, in teams and organisations, focusing on engaging 'hearts and minds'.

The programme involves an assessment of organisational culture and Quality Indicators and identification of area(s) to change; Board Level expectations are set as a result of this and a multi-disciplinary corporate team leading the implementation of an improvement plan based upon Kirkpatrick model and facilitated by Human Factors awareness and 'Insights Discovery (Discovering Investing in Behaviours)' workshops. A reassessment of leading indicators during and following implementation to measure impact is undertaken.

There are currently eight acute organisations involved in the 'Investing in Behaviours' programme and they are seeing improvements in their projects.

Board level Insights 'Discovery (Discovering Investing in Behaviours)' workshops allow Boards to see that differences in individual personalities can lead to constructive as well as destructive behaviours in the Board room, which can impact on patient care.

Contact: Teresa Fenech. Deputy Director: Quality Assurance, NHS England (North) - [redacted]

Emma Nunez. Quality and Safety Manager, NHS England (North) [redacted]

Expectation 6

Nurses, midwives and care staff have sufficient time to fulfil responsibilities that are additional to their direct caring duties. Staffing establishments take account of the need to allow nursing, midwifery and care staff the time to undertake continuous professional development, and to fulfil mentorship and supervision roles. Providers of NHS services make realistic estimations of the likely levels of planned and unplanned leave, and factor this into establishments. Establishments also afford ward or service sisters, charge nurses or team leaders time to assume supervisory status and benefits are reviewed and monitored locally.

Why is this important?

- Undertaking continuous professional development is a key part of developing staff capability. It can improve the quality of care provided to patients, as staff who undertake continuous professional development are more likely to have up to date knowledge, skills and judgement. In order to maintain registration with the Nursing and Midwifery Council (NMC), nurses and midwives need to declare that they have completed:

  - 450 hours of registered practice in the previous three years; and
  - 35 hours of learning activity (continuing professional development) in the previous three years.[24]

- Fulfilling supervision and mentorship roles effectively is key to training the next generation of nursing, midwifery and care staff, and ensuring that student nurses and midwives are adequately supported throughout their training.

- Allowing staff the time to undertake these activities, whilst not compromising patient care, is likely to contribute to an increase in staff engagement and productivity. Patient and organisational outcomes are better where staff engagement is higher.[25]

- Strong and clear nurse leadership is central to the delivery of high quality care, and to ensuring that staff are well led and motivated. Allocating time for the Lead Sister/Charge Nurse/Senior Midwive/Community Team Leaders to assume supervisory

[24] Further information about staying on the NMC's register can be found at: http://www.nmc-uk.org/Registration/Staying-on-the-register/

[25] Michael A West, Jeremy F Dawson. *Employee engagement and NHS performance*. . Available at: http://www.kingsfund.org.uk/sites/files/kf/employee-engagement-nhs-performance-west-dawson-leadership-review2012-paper.pdf

status can help to ensure that leaders have sufficient time to co-ordinate activity on the ward, manage and support staff, and ensure standards are maintained.

What does this mean in practice?

- **Establishment uplifts** should reflect a realistic expectation by the organisation of the impact on staffing requirements of a range of factors:

  - **staff training and development**: the amount of time that staff may reasonably be expected to be absent from direct caring responsibilities to undertake mandatory training and continuous professional development;

  - **supervision and mentorship roles**: the amount of time that staff would realistically need to spend fulfilling mentorship roles (for example, of students) or supervision roles. Where new staff are recruited, or new/bank agency staff are used, time should be allowed for permanent staff to conduct a thorough induction;

  - **planned and unplanned leave**: based on the number of staff in post and the annual leave, maternity and paternity leave entitlements, realistic estimations of the number of staff likely to be absent at any one time should be made and reflected in establishment figures. Establishments should also have flexibility to allow for unplanned leave, such as sickness absence and carer leave; and

  - a realistic assessment of the time required by the lead sister / charge nurse or team leader to assume **supervisory status.** Many trusts have supported these staff to be supervisory full time. The NHS Trust Development Authority provides support, oversight and governance for all NHS Trusts on their journey to delivering what patients want; high quality services today, secure for tomorrow – and they expect that the lead sister, charge nurse or team leader should spend a minimum of two shifts per week assuming supervisory status. Cost Improvement Plans and other initiatives should enable the lead sisters/charge nurses or team leaders time to assume supervisory status.

CASE STUDY 14: Heart of England NHS Foundation Trust - 'Introducing Supervisory roles'

At Heart of England NHS Foundation Trust Sam Foster, Chief Nurse has undertaken a review of the ward sister/charge nurse role. A paper was shared with the Board setting out options for nursing including the creation of the ward sister/charge nurse supervisory role. This was endorsed by the Board who supported investment of £1.4m, creating and additional nurses of 60.48 full time equivalent(FTEs) which allowed for the ward sister/charge nurse to become supervisory.

To support the transition new job descriptions were produced and a training needs analysis was undertaken with ward sisters/charge nurses with a complementary development programme introduced to provide them with the skills required to undertake their roles.

In order to be able to measure success Key Performance Indicators (KPIs)were agreed and each ward sister/charge nurse is expected to report against these, the head nurses hold monthly performance meetings whereby the delivery of these are monitored.

Supervisory Ward Sister/ Charge Nurse

- KPI 1: 1% Reduction in short term sickness
- KPI 2: Implementation of e- JONAH and discharge CQUIN
- KPI 3: 100% Compliance with ADTs
- KPI 4: 0% Prevalence of hospital acquired pressure sores
- KPI 5: Demonstrable improvement in patient experience
- KPI 6: Sustained achievement of > 95% for nursing metric scores
- KPI 7: Implementation of nursing quality review bundle
- KPI 8: Sustained nursing staffing to agreed levels
- KPI 9: 100% Compliance with Infection Control policies and procedures
- KPI 10: To be set for each clinical area around Harm Free Care Reduction

The extensive preparation which has led to 'go live' in October 2013 is already yielding results – for example doctors are more engaged with ward sisters/charge nurses about the management of their patients creating a 'team' around the patient and the ward sisters/charge nurse feels more confident in challenging operational aspects to ensure they support best patient care.

Contact: Sam Foster, Chief Nurse [redacted]

6 Openness and transparency for patients and the public

Expectation 7

Boards receive monthly updates on workforce information, and staffing capacity and capability is discussed at a public Board meeting at least every six months on the basis of a full nursing and midwifery establishment review. Boards receive monthly updates on workforce information, including the number of actual staff on duty during the previous month, compared to the planned staffing level, the reasons for any gaps, the actions being taken to address these and the impact on key quality and outcome measures. At least once every six months, nursing, midwifery and care staffing capacity and capability is reviewed (an establishment review) and is discussed at a public Board meeting. This information is therefore made public monthly and six monthly. This data will, in future, be part of CQC's Intelligent Monitoring of NHS provider organisations.

Why is this important?

- Transparency should be at the heart of the NHS, and is a key mechanism for holding organisations to account for the outcomes they achieve with their available resources. As outlined in **expectation 1,** Boards are accountable for the patient outcomes they achieve with the staffing capacity and capability in place.

- As outlined earlier in the document, meeting establishments on a shift-to-shift basis can present difficulties at times of increased pressure. Boards are ultimately responsible for staffing capacity and capability, and must ensure that there are systems in place to regularly assure themselves that there is sufficient nursing, midwifery and care staffing capacity and capability on a shift-to-shift basis.

What does this mean in practice?

Board level discussions

- As outlined in **expectation 1**, establishment reviews should be carried out every six months. Components of papers to the Board on the establishment reviews were also set out under expectation 1.

- At least twice per year, all nursing, midwifery and care staffing levels, and key quality and outcomes measures should be discussed at Trust Board level in a public meeting.

This recommendation was made in *Compassion in Practice*[26], published in December 2012, so we expect Trusts to be doing this already. Where they are not, we expect them to start this process by April 2014 and discuss at a Public Board meeting by June 2014 at the latest.

Monthly reporting

- As outlined in **expectation 1,** on a monthly basis, the Board should receive a report on workforce information, outlining the actual staff available on a shift-to-shift basis versus planned staffing levels. The report should outline areas where there are gaps between these figures, the impact of this, and the steps being taken to address the issue. This report should be published in a form accessible to patients and the public.

- By summer 2014 this data will be collated alongside an integrated safety dataset that will provide information down to ward level where appropriate. This will be available via a single website covering the key aspects of patient safety and in a form accessible to patients and the public.

- Information published in this way will provide close to real time information of staffing at organisational level. It is not intended to replace established statistical publications by the Health and Social Care Information Centre on a monthly, quarterly and annual basis, which are official statistics that go through a rigorous validation process.

[26] *Compassion in Practice* is available at http://www.england.nhs.uk/wp-content/uploads/2012/12/compassion-in-practice.pdf

CASE STUDY 15: **Avon and Wiltshire Mental Health Partnership Trust - 'Board to Ward Quality Information System'**

The Avon and Wiltshire Mental Health Partnership Trust (AWP) has created a 'Ward to Board' quality information system, known as 'IQ'. Every ward and team completes a monthly self-assessment on key quality indicators which includes compliance with Care Quality Commission standards including a declaration on the 'suitability of staffing' outcome. Although minimum staffing requirements are known, managers are asked to assess against their professional judgement and to declare compliance or not.

The IQ system is accessible by every part of the Trust, including all Board members, and is reviewed in real time every fortnight by the Senior Management Team. Staffing issues are visible and addressed as required.

Contact: Hazel Watsons, Director of Nursing, [redacted]

CASE STUDY 16: **Guy's and St Thomas' NHS Foundation Trust - 'Board Update on Safe Staffing**

In April 2013 the Chief Nurse and Director of Patient Experience presented a paper to the Board of Directors. It highlighted previous Board reports, the need to report 6 monthly on nursing and midwifery levels and whether they are adequate to meet patient acuity and dependency.

The Board paper set out the approach to assuring safe staffing levels in acute adult wards and Evelina Children's Hospital using both professional judgement and a range of tools including:

- Safer Nursing Care tool
- RCN guidance 'Defining Staffing levels for Children's and Young People's Services'
- Paediatric Intensive Care services.
- Birth-rate plus tool (for maternity services)

Directorate teams were asked to provide an assurance statement to the Chief Nurse that staffing levels were safe. In addition the Chief Nurse met all ward sisters/charge nurses individually to discuss staffing, their concerns and whether what was being reported to the Board was accurate.

The Board paper also details how the Trust utilises its staffing resource effectively and the Board of Directors was asked to assure itself that staffing levels were robust, recognise that further work relating to the community workforce was to take place and the recruitment challenges.

Contact: Professor Eileen Sills CBE, Chief Nurse and Director of Patient Experience [redacted]

CASE STUDY 17: NHS England – North - 'Open and Honest Care: Driving Improvement'

'Open and Honest Care: Driving Improvement' uses data on quality of care, such as the Safety Thermometer and Friends and Family Test. It enables an organisation to understand what data is telling them about clinical safety and patient experience. Initially launched in the North West as the 'Transparency pilot' in September 2011 following a challenge by Jane Cummings (then Chief Nurse, North West) to a group of Directors of Nursing: 'What can nursing do to further improve quality, safety and patient experience and justify pride in the profession?'.

The transparency pilot measured the quality of nursing care delivered together with patient and staff experience in the area where harm occurred. The incidence of harm was published monthly together with the action taken to prevent a recurrence. This collaborative work identified pressure ulcers and falls as areas where an immediate, lasting impact could be made.

Nurses recognised that publishing the data they collected on pressure ulcers and patient falls would bring even stronger focus on patient safety, resulting in staff and patients in open, honest conversations about the quality of care. It offers the opportunity to make further improvements, by looking at things differently; enabling the organisation to be open and honest about care and how they are working to improve the quality of services provided.

The 'Open and Honest Care: Driving Improvement' process begins with a Trust Board signing a compact that endorses its involvement and commitment to openness; an agreement that it will use common data definitions and reporting templates, publish data in agreed formats at agreed times and proactively share with stakeholders (internal and external) and that the publication will form part of routine quality reporting in Part One of Trust Board meetings. There is also a commitment to publish further metrics as developed and agreed and to focus on the capacity and capability for improvement, not to apportion blame.

On a monthly basis there is a publication on the Trust website utilising a standardised template that has been designed with service users. Staff views about the harm events are collected and a future ambition is to identify the staffing levels that should have been deployed at the time compared with actual staff available. The first publication of Open and Honest Care: Driving Improvement takes place in November 2013.

Organisations involved in the transparency pilot have been able to demonstrate a reduction in pressure ulcers and falls. In addition they have demonstrated that this framework can easily shift to new priority areas.

Contact: Teresa [redacted]

Hazel Richards, Programme Directc [redacted]

Expectation 8

NHS providers clearly display information about the nurses, midwives and care staff present on each ward, clinical setting, department or service on each shift. Information should be made available to patients and the public that outlines which staff are present and what their role is. Information displayed should be visible, clear and accurate, and it should include the full range of support staff available on the ward during each shift.

Why is this important?

- In other industries, it is common practice for the people serving customers to be visible. If you travel on an aeroplane, you are clear that there is a pilot in charge of flying the plane, and a first officer there to assist the pilot. Air stewards and stewardesses introduce themselves, and make their role in serving passengers, and protecting their safety, known.

- When people use the NHS, they are often at their most vulnerable stage in life. By the very nature of healthcare, patients, their families, friends and carers place trust in the professionals looking after them, and rely on them to put their interests first. There is a strong argument that, in this unique environment and at the time of greatest need and vulnerability, transparency should be more important than in any other setting.

- Displaying information about the staff present on each ward on each shift is part of the broader agenda around improving transparency in health care. Other actions underway include displaying the name of the lead clinician and nurse in charge of patients' care above their beds, and ensuring that people outside of hospitals have a named clinician who is responsible and accountable for the care of that patient.

What does this mean in practice?

- Providers should have information on staffing on a shift-to-shift basis that is available, and accessible to patients. Organisations should display the numbers of staff in post on a shift-to-shift basis, piloting an approach to this. Plans should be implemented subject to evaluation of pilots.

- The information displayed should be helpful and accessible to patients, and could include: the numbers of staff present on the ward, department, service or setting; who is in charge; and what the different roles and responsibilities of staff on the ward are.

- It may be helpful to outline additional information that is relevant locally, for example, the significance of different uniforms worn by staff, and titles used, mean.

Case study 18: #Hellomynameis

During 2013, Dr Kate Granger, a senior registrar specialising in the care of older people, and who is also terminally ill, was an in-patient in NHS care and she noticed that only some members of the healthcare team looking after her introduced themselves. Kate wondered why this fundamental element of good communication (the introduction) seemed to have failed. She noted how members of healthcare staff know much about the patients in their care, but that this is not always reciprocated, and she pointed out that this tends to push the balance of power in favour of the healthcare worker. Given that people receiving treatment and care often feel vulnerable already, this imbalance creates an unhelpful and unfortunate gap.

Kate shared her views via twitter and suggested that getting to know people's names is the first rung on the ladder towards providing compassionate care. It is getting the simple things right that means that the more complex things follow more easily and naturally. As a result, the idea of #hellomynameis was born.

Since then people have taken steps in all manner of ways to ensure that this key bit of compassionate care; the introduction, happens. Some organisations have created name boards in their clinical areas headed 'Hello My Name Is…' and others have used it as they start their speeches at conferences and other events or placed it on name badges.

There is further work to do however. As Kate has pointed out, the NHS employs many, many people and a significant number of these people interact directly or indirectly with patients at some level. Influencing practice in this small way could have a major impact on the outcomes of care and treatment, especially the patient's experience of that care.

CASE STUDY 19: 'Implementing Safe Nurse Staffing Salford Royal NHS Foundation Trust'

At Salford Royal NHS Foundation Trust (SRFT) the Safer Nursing Care tool is used to determine nursing establishments to deliver safe quality care. The qualified nurse to patient ratio at SRFT of 1:8 is never breached. Sub specialty wards have a ratio higher than this. All wards in addition have a nurse in charge on all shifts.

The Safe Staffing Steering Group considers how SRFT shares information with patients and families in an open and transparent way, including the numbers of nursing staff on wards at each shift. To support this staffing boards have been introduced onto every ward/department.

The board identifies the coordinator for the area and the numbers of registered and non-registered nurses that the ward should have and the numbers they actually have for the shift. The board is displayed at the entrance to every ward and visible to patients/family and carers.

A senior nurse teleconference is held daily at 8.30am, chaired by the Deputy Director of Nursing to address any nurse staffing concerns. To support this, a daily nursing rota is produced and staffing is discussed at capacity meetings held four times daily.

SRFT will expand the project to look at staffing with community nursing.

Contact: Elaine Inglesby, Executive Nurse [redacted]

CASE STUDY 20: Wrigthington, Wigan and Leigh NHS Foundation Trust (WWL) – 'Using Staffing Display Boards'

An element of WWL's Nursing and Midwifery Strategy includes the need for transparency, and white boards at the entrance to wards have been introduced. These boards display the funded staffing establishment and the actual staffing levels on each shift and are visible to patients and visitors.

An escalation process means that should staffing levels fall below establishment this is picked up by the Ward Sister and Matron immediately. Two wards 'buddy' each other and will work together to resolve the staffing issue initially across the two wards with Matron reviewing all nurse staffing across the directorate. The Duty Matron has access to staff across the organisation and will move nursing staff as appropriate to ensure safe levels in all areas, in addition to securing additional nurses by utilising bank and agency.

Board papers include details of any staffing breaches to ensure the team are aware of issues and actions taken, offering an opportunity for further challenge and support.

Contact: Pauline Jones, Director of [redacted]

7 Planning for future workforce requirements

Expectation 9

Providers of NHS services take an active role in securing staff in line with their workforce requirements. Providers of NHS services actively manage their existing workforce, and have robust plans in place to recruit, retain and develop all staff. To help determine future workforce requirements, organisations share staffing establishments and annual service plans with their Local Education and Training Board (LETBs), and their regulators for assurance. Providers work in partnership with Clinical Commissioning Groups and NHS England Area Teams to produce a Future Workforce Forecast, which LETBs will use to inform their Education Commissions and the Workforce Plan for England led by Health Education England (HEE).

Why is this important?

- It is first and foremost an employer responsibility to ensure they have enough staff to provide a safe and high quality service for current and future patients. As outlined in this document, providers are required to produce establishment reviews and Annual Service Plans which set out the number and mix of staff that providers intend to employ that year, (including fill and vacancy rates and planned spend on temporary staffing). It is an employer responsibility to ensure that they have robust plans in place to recruit, retain and develop their staff, as well as managing and planning for any potential loss of staff through, for example, turnover, retirement and maternity leave.

- In order to make services sustainable, organisations have a key role to play in determining future workforce demands. It can take fifteen years to train a Consultant, and three years to train a nurse – so the NHS has to plan not just for the needs of patients today, but the needs of patients tomorrow.

What does this mean in practice?

Managing the current workforce

- It is the responsibility of Health Education England to secure the future supply of workforce through commissioning education and training places. The workforce plans that HEE will publish later this year will result in nurse training places commencing in September 2014, completing in 2017. It is then the responsibility of the providers of health care services to ensure they have sufficient supply (nurses and midwives) to meet patient demand. As well as recruitment, this requires providers to have effective

strategies in place to retain and develop the staff they employ, in order to reduce the numbers of qualified staff who leave the service. Without effective employment strategies in place, providers are forced to demand yet more supply (either from other parts of the UK or abroad), which takes time and money to produce. This is potentially an inefficient use of taxpayers' money, and a poor use of the investment we have made in people who have expressed a desire to work with patients.

Shaping the future workforce

- Each provider of NHS services is required to be a member of, or be represented on, their Local Education and Training Board, (LETB) which are committees of Health Education England. It is the role of the Governing Body of LETBs to ensure that education and training commissions reflect local need and national priorities, by directly involving employers and commissioners in these decisions. In order to enable LETBs to ensure that their plans reflect local needs, employers need to:

    - Share establishment reviews with their LETB so that they have a sound understanding of the current situation upon which to base any future investments, and with regulators (NTDA, Monitor and CQC) for assurance; and

    - Produce a future workforce forecast that sets out their anticipated needs, which will form the basis of LETBs education and training commissioning plans and strategies. These forecasts should be developed in partnership with local commissioners to ensure that they reflect local visions for services, and submitted to LETBs as set out in HEE's Workforce Planning Guidance. Further information is available at: http://hee.nhs.uk/work-programmes/workforce-planning/

    - Local LETBs will assess and aggregate the forecasts submitted by local providers, triangulate with local partners including commissioners and Health and Well Being Boards and submit to Health Education England; and

    - Health Education England will assess and aggregate the 13 investment plans from its LETBs and develop a Workforce Plan for England, ensuring that the £5 billion pounds that is spent on workforce reflects both local and national priorities as set out in by their Mandate.

8 The role of commissioning

Expectation 10

Commissioners actively seek assurance that the right people, with the right skills, are in the right place at the right time within the providers with whom they contract.
Commissioners specify in contracts the outcomes and quality standards they require and actively seek to assure themselves that providers have sufficient nursing, midwifery and care staffing capacity and capability to meet these. Commissioners monitor providers' quality and outcomes closely, and where problems with staff capacity and capability pose a threat to quality, commissioners use appropriate commissioning and contractual levers to bring about improvements. Commissioners recognise that they may have a contribution to make in addressing staffing-related quality issues, where these are driven by the configuration of local services or the setting of local prices in contracts.

Why is this important?

- Commissioners are responsible for ensuring that they commission high-quality services. The impact that nursing, midwifery and care staffing capacity and capability can have on patient safety has been well documented and should therefore be a key focus for commissioners. Commissioners should continually hold providers to account for ensuring that they deliver high-quality services, ensuring that they maintain sufficient staffing capacity and capability to do this at all times.

- Commissioners must commission high-quality care whilst also delivering value for public money. Where prices for the services they commission are set through local negotiations, rather than by national tariffs, commissioners have a responsibility to ensure that the local prices agreed mean that provision of safe, effective services remains viable.

What does this mean in practice?

- Commissioners set clear standards for quality and outcomes in their contracts, through services specifications and incorporating quality standards.

- As outlined in *Everyone Counts: Planning For Patients 2013/14*,[27] commissioners actively review and discuss the cost improvement programmes proposed by their major

[27] *Everyone Counts: Planning for Patients 2013/2014* is available at: http://www.england.nhs.uk/everyonecounts/

providers, ensuring that these have clinical ownership within the provider and do not threaten service quality.

- Commissioners have mature discussions with providers about local prices and efficiency requirements so that commissioner financial constraints do not inadvertently encourage providers to operate unsafe staffing levels.

- Commissioners monitor service quality and outcomes, alongside expenditure and activity levels, using the monitoring information which providers are required to supply under the NHS Standard Contract; this covers quality standards, complaints, serious incidents and Never Events, infections rates, clinical audit reports and patient and staff surveys. Commissioners maintain a constant and close dialogue with providers about any issues relating to service safety and staffing levels.

- Commissioners triangulate this data on service quality with provider reports on actual staff available on a shift-to-shift basis versus planned staffing levels. The NHS Standard Contract for 2014/15 is expected to set out new requirements on providers to report on this to commissioners.

- In liaison with regulators and NHS England Area Teams through Quality Surveillance Groups, commissioners use the levers set out in the NHS Standard Contract to address any provider issues with service quality and safe staffing. These levers include the ability to:

    - require remedial action plans to be agreed and implemented
    - report formally to the provider's Board and levy financial sanctions where such actions plans are not implemented
    - suspend services temporarily or terminate them permanently.

- In deciding whether to suspend or terminate services, commissioners balance risks and benefits carefully and work closely with providers to ensure that sufficient service provision can be maintained and that delivery of the normal service can be re-established as soon as possible, if necessary through a new provider.

- Commissioners share information and intelligence with their local commissioning and regulatory partners through their Quality Surveillance Group.

9 Next Steps

This document has set out expectations of providers and commissioners in respect of nursing, midwifery and care staffing capacity and capability and how those expectations can be met. Similar guidance may need to be developed for other parts of the health and care workforce.

This chapter sets out how the different organisations with responsibilities for regulating and supervising the system will reflect these expectations as they discharge their statutory responsibilities. This guidance has been developed in advance of further, evidenced based work which is being taken forward by NICE, more detail on which is set out at the end of chapter.

Leadership in provider organisations

These expectations are designed to support providers in taking the complex and difficult decisions that they must take to secure safe staffing to care for their patients and service users.

We would expect that each provider organisation would consider these expectations explicitly, and have a board discussion to assure itself that the systems and processes within the organisation met these expectations.

Establishing and maintaining adequate staffing capacity and capability is an inherently challenging process, and we recognise that not all organisations will be meeting the expectations set out in this document at the moment. Where this is the case, we expect boards to identify as a matter of urgency the actions that could be taken to meet these expectations.

Care Quality Commission (CQC)

The **CQC** is the regulator of the quality of health and care services in England. It is currently developing a new approach to monitoring, inspecting and rating providers. Staffing capacity and capability will be central to this new approach, and the expectations set out in this guide will be used to inform the development of their new approach to inspections, and subsequently, to inform their judgements and ratings for providers.

Monitor

Monitor is the sector regulator for health services in England. Their role is to protect and promote the interests of patients by ensuring that the whole sector works for their benefit. They have the ability to exercise a range of powers in relation to the licences issued to NHS-funded providers.

Monitor expects that NHS foundation trusts and aspirant foundation trusts should have the right people, with the right skills, in the right place at the right time. They should take the necessary steps to assure themselves and others that they do so. Monitor will act where the CQC identifies any deficiencies in staffing levels for foundation trusts.

NHS Trust Development Authority

The NHS Trust Development Authority (NHS TDA) provides support, oversight and governance for all NHS Trusts on their journey to delivering what patients want; high quality services today, secure for tomorrow. As part of this drive for sustainable quality across all NHS trusts the NHS TDA will support trusts to develop a constructive approach towards meeting the expectations set out in this guide.

Trusts will also be encouraged to continue to work in a transparent manner in sharing data and to liaise with Commissioners in the delivery of the expectations.

NHS England

NHS England has a dual role in respect of staffing capacity and capability: it is a commissioner of certain services (specialised, primary care, health and justice and veterans care); and it oversees the local commissioning system, supporting Clinical Commissioning Groups to meet their statutory responsibility for improving the quality of services and delivering the best possible outcomes for their communities.

NHS England will reflect relevant elements of these expectations in the NHS Standard Contract which is used by all commissioners for contracts with providers (other than for primary care services). In relation to its own commissioning, NHS England will design and commission services with a view to meeting the expectations in this guide, and particularly in line with expectation 10 on commissioning. Through assurance, NHS England will ensure that both statutory duties and delivery plans are being met by CCGs with challenge through evidence and agreed support where improvement is found to be required.

National Institute for Health and Care Excellence (NICE)

NICE will shortly begin work to develop evidence-based guidance that sets out safe staffing capacity and capability for the NHS. This guidance will be for use within NHS provider organisations, and to inform any practical tools that help calculate staffing capacity and capability.

It will begin by reviewing the evidence-base underpinning existing products, plus any new or additional relevant evidence, to develop staffing guidance. This guidance will enable existing tools and related products used in the NHS in England to be updated, if required.

By June 2014, NICE will have produced guidance on safe staffing in adult in-patient settings, including its view of existing staffing tools. This initial phase will be followed by further work to develop full accreditation of staffing tools against the evidence based guidance, and work on safe staffing in other settings, including maternity, A&E non-acute settings such as mental health, community services and learning disabilities settings. The focus of the work will be nursing and maternity staffing levels, but it will also take into account the wider context of other workforce groups and the importance of multi-disciplinary working in modern healthcare.

This guidance has set out some core expectations of providers and commissioners in respect of getting nursing, midwifery and care staffing right. They are based on available evidence, good practice and common sense. They aim to support and reinforce the ability and judgement of healthcare professionals and managers in making what are difficult decisions both on a daily basis, and with a longer term perspective. In using this guidance, working in the NHS, we must recognise that the roles staff perform, and the capacity and capability of staffing needed to provide care, like any other components of healthcare delivery, can and should be components for constant innovation. Across the NHS we must make sure that current approaches to staffing do not stifle bold ideas and innovation, such as the development of new healthcare professional roles; new forms of delivery of care that might significantly alter the patterns of needs and staffing requirements; and new ways to empower patients and carers to use their own skills and expertise to improve their care. Similarly, we must constantly look to the future, understanding how we can improve our care through the skills and expertise of our staff, not just those we currently employ, but the young professionals in training and as they enter their careers.

Appendix A: Professional Guidance

Below is a list of some known professional guidance on nursing, midwifery and care staffing capacity and capability. This list is not intended to be definitive or exhaustive.

The British Association of Critical Care Nurses (2009): *Standards for nurse staffing in critical care.* Available at:
http://www.baccn.org.uk/about/downloads/BACCN_Staffing_Standards.pdf

The Paediatric Intensive Care Society Standards for the Care of Critically Ill Children (4th ed) 2010. Available at:
http://www.ukpics.org.uk/documents/PICS_standards.pdf

The Association for Peri-operative Practice (2008): Available at:
http://www.afpp.org.uk/books-journals/books/book-119

BAPM Service Standards for Hospitals Providing Neonatal Care 3rd edition (2010). Available at:
http://www.bapm.org/publications/documents/guidelines/BAPM_Standards_Final_Aug2010.pdf

RCN Guidance

RCN (2006) *Setting appropriate ward nurse staffing levels in NHS acute trusts*. Available at: http://www.rcn.org.uk/__data/assets/pdf_file/0007/287710/setting_appropriate_ward_nurse_staffing_levels_in_nhs_acut.pdf

RCN (2010a) *Guidance on safe nurse staffing levels in the UK*. Available at: http://www.rcn.org.uk/__data/assets/pdf_file/0005/353237/003860.pdf

RCN (2010b) *RCN policy position: evidence based nurse staffing levels.* Available at: http://www.rcn.org.uk/__data/assets/pdf_file/0007/353239/003870.pdf

RCN (2012a) *Safe staffing for older people's wards: RCN full report and recommendations*. Available at: http://www.rcn.org.uk/__data/assets/pdf_file/0009/476379/004280.pdf

RCN (2013) *Defining staffing levels for children and young people's services*. Available at: http://www.rcn.org.uk/__data/assets/pdf_file/0004/78592/002172.pdf

NICE guideline

Safe staffing for nursing in adult inpatient wards in acute hospitals

Safe staffing guideline

Published: 15 July 2014
www.nice.org.uk/guidance/sg1

Your responsibility

The recommendations in this guideline represent the view of NICE, arrived at after careful consideration of the evidence available. When exercising their judgement, professionals and practitioners are expected to take this guideline fully into account, alongside the individual needs, preferences and values of their patients or the people using their service. It is not mandatory to apply the recommendations, and the guideline does not override the responsibility to make decisions appropriate to the circumstances of the individual, in consultation with them and their families and carers or guardian.

All problems (adverse events) related to a medicine or medical device used for treatment or in a procedure should be reported to the Medicines and Healthcare products Regulatory Agency using the Yellow Card Scheme.

Local commissioners and providers of healthcare have a responsibility to enable the guideline to be applied when individual professionals and people using services wish to use it. They should do so in the context of local and national priorities for funding and developing services, and in light of their duties to have due regard to the need to eliminate unlawful discrimination, to advance equality of opportunity and to reduce health inequalities. Nothing in this guideline should be interpreted in a way that would be inconsistent with complying with those duties.

Commissioners and providers have a responsibility to promote an environmentally sustainable health and care system and should assess and reduce the environmental impact of implementing NICE recommendations wherever possible.

Contents

Overview

This guideline covers organisational and managerial approaches to safe nurse staffing of inpatient wards for people aged 18 and over in acute hospitals. It aims to ensure that patients receive the nursing care they need, regardless of the ward to which they are allocated, the time of the day, or the day of the week.

The guideline focuses on wards that provide overnight care for adult patients in acute hospitals. It does not cover intensive care, high dependency, maternity, mental health, acute admission or assessment units or wards, or inpatient wards in community hospitals.

Who is it for?

- Hospital boards and senior management
- Commissioners
- Ward managers

Context

The Department of Health and NHS England asked NICE to develop evidence-based guidelines on safe staffing, with a particular focus on nursing staff, for England. This request followed the publication of the following reviews and reports.

- Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry (Francis 2013)
- Keogh review into the quality of care and treatment provided in 14 hospital trusts in England (Keogh 2013)
- The Cavendish Review, an independent enquiry into healthcare assistants and support workers in the NHS and social care setting (Cavendish 2013)
- Berwick report, A promise to learn – a commitment to act: improving the safety of patients in England. (Berwick 2013).

The need for guidelines on safe staffing, including nursing staff, was also highlighted in the following policy documents and responses:

- How to ensure the right people, with the right skills, are in the right place at the right time. A guide to nursing midwifery and care staffing capacity and capability (National Quality Board 2013).
- Hard truths. The journey to putting patients first (Department of Health 2013).
- Compassion in practice – nursing, midwifery and care staff – our vision and strategy. (Department of Health and NHS Commissioning Board 2012).

Focus of the guideline

This is the first guideline for this NICE work programme. It makes recommendations on safe staffing for nursing in adult inpatient wards in acute hospitals, based on the best available evidence. The guideline focuses on wards that provide overnight care for adult patients in acute hospitals. It does not cover intensive care, high dependency, maternity, mental health, acute admission or assessment units or wards, or inpatient wards in community hospitals.

In this guideline, nursing staff refers to registered nurses and healthcare assistants unless otherwise specified.

The guideline identifies organisational and managerial factors that are required to support safe staffing for nursing, and indicators that should be used to provide information on whether safe nursing care is being provided in adult inpatient wards in acute hospitals. (For further information, see the scope for the guideline.)

This guideline is for NHS provider organisations and others who provide or commission services for NHS patients. It is aimed at hospital boards, hospital managers, ward managers, healthcare professionals and commissioners. It will also be of interest to regulators and the public.

Those responsible and accountable for staffing for nursing in adult inpatient wards in acute hospitals, at an organisational and a ward level, should take this guideline fully into account. However, this guideline does not override the need and importance of using professional judgement to make decisions appropriate to the circumstances.

This guideline does not cover nursing workforce planning or recruitment at regional or national levels, although its content may inform these areas.

While we acknowledge the important contribution of a multi-disciplinary approach to ensure safe nursing care, staffing requirements in relation to doctors, specialist nurses and other healthcare professionals are not addressed in this guideline. They may however be covered in future staffing guidelines.

Related documents

The National Quality Board for England considers that nursing staff capacity and capability are the main determinants of the quality of care experienced by patients, and has issued guidance about what is expected of commissioners and providers in this area (See the National Quality Board's guide on how to ensure the right people, with the right skills, are in the right place at the right time. A guide to nursing, midwifery and care staffing capacity and capability). NHS England and the Care Quality Commission also recently published joint guidance to NHS trusts on the delivery of the 'Hard Truths' commitments on publishing staffing data regarding nursing, midwifery and care staff levels. In early 2014, the Department of Health consulted on introducing fundamental standards for health and social care providers to promote care that is safe, high quality, and puts patients first

(Department of Health 2014). The Department was analysing the responses at the time this guideline was published and a final version was not available. This guideline should be read alongside these documents.

Toolkits to support this guideline

The guideline will also be of interest to people involved in developing decision support toolkits and resources for assessing and determining safe nursing staff requirements. NICE offers a separate endorsement process to assess whether submitted decision support toolkits for informing nursing staff requirements comply with the guideline recommendations. Details of any tools that can help with implementing this guideline are listed alongside other resources.

Evidence to recommendations

When drafting these recommendations, the Safe Staffing Advisory Committee considered evidence from the systematic reviews, an economic analysis report and the additional reports described in the section on evidence. In some areas there was limited or no published evidence. In these cases, the Committee considered whether it was possible to formulate a recommendation on the basis of their experience and expertise. The evidence to recommendations tables detail the Committee's considerations when drafting the recommendations.

The Committee also identified a series of gaps in the evidence and formulated research recommendations.

The Committee considered the following factors when drafting the recommendations:

- whether there is a legal duty to apply the recommendation (for example, to be in line with health and safety legislation)
- the strength and quality of the evidence base (for example, the risk of bias in the studies looked at, or the similarity of the patient populations covered)
- the relative benefits and harms of taking (or not taking) the action
- any equality considerations.

Strength of recommendations

In general, recommendations that an action 'must' or 'must not' be taken are usually included only if there is a legal duty (for example, to comply with health and safety regulations).

Recommendations for actions that should (or should not) be taken use directive language such as 'agree', 'assess', 'calculate', 'ensure procedures are in place', 'record' or 'take'.

Recommendations for which the quality of the evidence is poorer, or where there is a closer balance between benefits and harms (factors that could be used or actions that could be taken), use 'consider'.

Recommendations

People have the right to be involved in discussions and make informed decisions about their care, as described in NICE's information on making decisions about your care.

Making decisions using NICE guidelines explains how we use words to show the strength (or certainty) of our recommendations, and has information about prescribing medicines (including off-label use), professional guidelines, standards and laws (including on consent and mental capacity), and safeguarding.

Assessing the nursing needs of individual patients is paramount when making decisions about safe nursing staff requirements for adult inpatient wards in acute hospitals. Consequently this guideline makes a series of recommendations that focus on safe nursing for adult inpatient wards in acute hospitals. Assessment of patients' nursing needs should take into account individual preferences and the need for holistic care and patient contact time.

This guideline begins with recommendations for the responsibilities and actions at an organisational level to support safe staffing for nursing in individual acute adult inpatient wards.

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 has to determine its nursing staff requirements to ensure safe patient care. This guideline therefore makes recommendations about the factors that should be systematically assessed at ward level to determine the nursing staff establishment. 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.

The guideline also makes recommendations for monitoring and taking action according to whether nursing staff requirements are being met and, most importantly, to ensure patients are receiving the nursing care and contact time they need on the day. The emphasis should be on safe patient care not the number of available staff. This includes recommendations to review the nursing staff establishment for the ward and adjust it if

required.

1.1 Organisational strategy

These recommendations are for hospital boards, senior management and commissioners. They should be read alongside the National Quality Board's guide on how to ensure the right people, with the right skills, are in the right place at the right time. A guide to nursing, midwifery and care staffing capacity and capability.

Focus on patient care

1.1.1 Ensure patients receive the nursing care they need, including specialist nursing, regardless of the ward to which they are allocated, the time of the day or the day of the week. This includes planning to locate patients where their clinical needs can best be met.

Accountability for ward nursing staff establishments

1.1.2 Develop procedures to ensure that ward nursing staff establishments (the number of registered nurse and healthcare assistant posts that are funded to work in particular wards) are sufficient to provide safe nursing care to each patient at all times.

1.1.3 Ensure that the final ward nursing staff establishments are developed with the registered nurses who are responsible for determining nursing staff requirements at a ward level and approved by the chief nurse (or delegated accountable staff). The board should retain organisational responsibility. (See the section 1.3 on setting the ward nursing staff establishment for recommendations on setting ward nursing staff establishments.) This includes when the ward establishment and budget are set.

1.1.4 Ensure senior nursing managers are accountable for the nursing staff roster that is developed from the ward nursing staff establishment.

1.1.5 When agreeing the ward nursing staff establishment, ensure it is sufficient to provide planned nursing staff requirements at all times. This

should include capacity to deal with planned and predictable variations in nursing staff available, such as annual, maternity, paternity and study leave (commonly known as uplift). Consider adjusting the uplift for individual wards where there is evidence of variation in planned or unplanned absence at a ward level.

1.1.6 When agreeing the ward nursing staff establishment, ensure capacity to deal with fluctuations in patients' nursing needs (such as seasonal variations indicated by historical records of nursing staff requirements) and staff unplanned leave or absences.

1.1.7 When agreeing the skill mix of the ward nursing staff establishment, this should be appropriate to patient needs and take into account evidence that shows improved patient outcomes are associated with care delivered by registered nurses (see recommendation 1.3.6).

Responsiveness to unplanned changes

1.1.8 Ensure that there are procedures to identify differences between on-the-day nursing staff requirements and the nursing staff available on a ward.

1.1.9 Hospitals need to have a system in place for nursing red flag events (see the section 1.4 on assessing if nursing staff available on the day meet patients' nursing needs) to be reported by any member of the nursing team, patients, relatives or carers to the registered nurse in charge of the ward or shift.

1.1.10 Ensure there are procedures for effective responses to unplanned variations in predicted patients' nursing needs or the availability of nursing staff at any time during the day and night. These procedures should include prompt action to enable an increase or decrease in nursing staff.

1.1.11 Action to respond to nursing staff deficits on a ward should not compromise staff nursing on other wards.

1.1.12 Ensure there is a separate organisational contingency plan and response for patients who require the continuous presence of a member of the

nursing team (often referred to as 'specialing' care).

1.1.13 Consider implementing approaches to support flexibility, such as adapting nursing shifts, nursing skill mix, assigned location and employment contract arrangements.

Monitor adequacy of ward nursing staff establishments

1.1.14 Ensure that there are procedures for systematic ongoing monitoring of safe nursing indicators (see section 1.5, monitor and evaluate ward nursing staff establishments) and formal review of nursing staff establishments of individual wards at a board level at least twice a year (and more often if there are significant changes such as ward patient characteristics). These procedures should include periodic analysis of reported nursing red flag events and the safe nursing indicators (see section 1.5, monitor and evaluate ward nursing staff establishments).

1.1.15 Make appropriate changes to the ward nursing staff establishment in response to the outcome of the review.

Promote staff training and education

1.1.16 Enable nursing staff to have the appropriate training for the care they are required to provide.

1.1.17 Ensure that there are sufficient designated registered nurses who are experienced and trained to determine on-the-day nursing staff requirements over a 24-hour period.

1.1.18 The organisation should encourage and enable nursing staff to take part in programmes that assure the quality of nursing care and nursing standards to maximise the effectiveness of the nursing care provided and the productivity of the nursing team.

1.1.19 Involve nursing staff in developing and maintaining hospital policies and governance about nursing staff requirements, such as escalation policies and contingency plans.

1.2 Principles for determining nursing staff requirements

These recommendations are for registered nurses in charge of individual wards or shifts who should be responsible for assessing the various factors used to determine nursing staff requirements.

1.2.1 Use a systematic approach that takes into account the patient, ward and staffing factors in box 1 to determine nursing staff requirements both when setting the ward nursing staff establishment and when making on-the-day assessments.

1.2.2 Use a decision support toolkit endorsed by NICE to facilitate the systematic approach to determining the nursing staff requirements (see the details of the process for assessing toolkits).

1.2.3 Use informed professional judgement to make a final assessment of nursing staff requirements. This should take account of the local circumstances, variability of patients' nursing needs, and previously reported nursing red flag events (see section 1.4 on assessing if nursing staff available on the day meet patients' nursing needs).

1.2.4 Consider using the nursing care activities summarised in tables 1 and 2 as a prompt to help inform professional judgement of the nursing staff requirements. Tables 1 and 2 may help to identify where patients' nursing needs are not fully accounted for by any decision support toolkit that is being used.

Box 1: Factors to determine nursing staff requirements

Patient factors

- Use individual patient's nursing needs as the main factor for calculating the nursing staff requirements for a ward. (The term patient nursing needs is used throughout this guideline to include both patient acuity and patient dependency.)
- Make a holistic assessment of each patient's nursing needs and take account of specific nursing requirements and disabilities, as well as other patient factors that may increase nursing staff requirements, such as:
  - difficulties with cognition or confusion (such as those associated with learning difficulties, mental health problems or dementia)
  - end-of-life care
  - increased risk of clinical deterioration
  - need for the continuous presence of a member of the nursing team (often referred to as 'specialing' care).

Ward factors

- Expected patient turnover in the ward during a 24-hour period (including both planned and unscheduled admissions, discharges and transfers).
- Ward layout and size (including the need to ensure the safety of patients who cannot be easily observed, and the distance needed to travel to access resources within the ward).

Nursing staff factors

- Nursing activities and responsibilities, other than direct patient care. These include:
  - communicating with relatives and carers
  - managing the nursing team and the ward
  - professional supervision and mentoring of nursing staff. Student nurses are considered supernumerary
  - communicating with and providing nursing clinical support to all healthcare staff involved with the care of patients on the ward
  - undertaking audit, and staff appraisal and performance reviews.

These activities and responsibilities may be carried out by more than one member of the nursing team.

Support from non-nursing staff such as the medical team, allied health professionals and administrative staff.

Table 1: Ongoing nursing care activities that affect nursing staff requirements

-	**Routine nursing care needs**	**Additional nursing care needs (about 20-30 minutes per activity)**	**Significant nursing care needs (more than 30 minutes per activity)**
Care planning	Simple condition and care plan	Complex condition or care plan (such as multiple comorbidities)	Attending multidisciplinary meetings
Direct contact and communication	Providing information and support to patients, including all emotional and spiritual needs	Complex multiple health needs	Difficulties with communication including sensory impairment or language difficulties

-	Routine nursing care needs	Additional nursing care needs (about 20-30 minutes per activity)	Significant nursing care needs (more than 30 minutes per activity)
Eating and drinking	Ensuring food and drink provided and consumed	Assistance with eating and drinking	Parenteral nutrition
Fluid management	8-hourly IV fluids	IV fluids more frequently than 8 hourly or blood components	Complex fluid management (such as hourly or requiring monitoring in millilitres)
Management of equipment	Simple intermittent (such as catheters, IV access)	Central lines, drains, stomas	Multiple lines, drains, ventilator support
Medication	Regular oral medication	IV medication or frequent PRN medication	Medication requiring complex preparation or administration, or 2 nursing staff
Mobilisation	No assistance needed	Assistance needed (such as post-op or during out of hours periods)	Mobilisation with assistance of 2 nursing staff
Observations	4 to 6 hourly	2 to 4 hourly	More frequent than 2 hourly
Oral care	No assistance needed	Assistance needed	Intensive mouth care needed (such as patient receiving chemotherapy)
Skin and pressure area care	Less frequent than 4 hourly	2 to 4 hourly	More frequent than 2 hourly or requiring 2 nursing staff
Toileting needs	No assistance needed	Assistance needed	Frequent assistance or 2 nursing staff needed

-	Routine nursing care needs	Additional nursing care needs (about 20-30 minutes per activity)	Significant nursing care needs (more than 30 minutes per activity)
Washing or bathing and dressing	Minimal assistance with washing, dressing and grooming	Assistance with some hygiene needs by 1 member of the nursing staff	Assistance with all hygiene needs, or needing 2 nursing staff

Abbreviations: IV, intravenous; PRN medication, medication administered as needed

Note: these activities are only a guide and there may be other ongoing activities that could be considered

Table 2: One-off nursing care activities that affect nursing staff requirements

-	Routine nursing care needs	Additional nursing care needs (about 20-30 minutes per activity)	Significant nursing care needs (more than 30 minutes per activity)
Admission	-	Admission assessment	Complex admission assessment
Care after death	-	-	Arrangements after the death of a patient, including support for relatives and carers
Discharge planning	Simple follow-up and transfer home	Coordination of different services	Organising complex services, support or equipment

-	Routine nursing care needs	Additional nursing care needs (about 20-30 minutes per activity)	Significant nursing care needs (more than 30 minutes per activity)
Patient and relative education and support	Routine teaching about condition, routine post-op care	Teaching about a significant new condition (such as diabetes, heart disease or cancer)	Teaching about a new complex or self-managed condition (such as dialysis, colostomies), or to patient or their carers or relatives who have difficulties with communication including sensory impairment or language difficulties
Patient escorts	Routine escorts or transfers for procedures	Escorting a patient off a ward for 20-30 minutes	Escorting a patient off a ward for more than 30 minutes
Procedures and treatments	Simple wound dressings, specimen collection	Catheterisation, nasogastric tube insertion, multiple wound dressings	Complex wound dressings (such as vacuum-assisted closure), tracheostomy care

Note: these activities are only a guide and there may be other one-off activities that also could be considered

1.3 Setting the ward nursing staff establishment

These recommendations are for senior registered nurses who are responsible for determining nursing staff requirements or those involved in setting the nursing staff establishment of a particular ward.

1.3.1 Set ward nursing staff establishments using the stages outlined in recommendations 1.3.2 to 1.3.8. This should involve the designated senior registered nurses at a ward level who are experienced and trained in determining nursing staff requirements. This process could be

facilitated by the use of a NICE-endorsed decision support toolkit.

Stage 1: Calculate the average nursing staff requirement throughout a 24-hour period

1.3.2 Routinely measure the average amount of nursing time required throughout a 24-hour period for each of the ward's patients. The measurement should take into account the patient factors and nursing care activities outlined in section 1.2 on principles for determining nursing staff requirements. It could be expressed as nursing hours per patient to ensure ward nursing staff establishments are derived from individual patient's needs. (A measurement of nursing hours per patient enables the nursing needs of individual patients and different shift durations of the nursing staff to be more easily taken into account than with a nurse-to-patient ratio.)

1.3.3 Formally analyse the average nursing hours required per patient at least twice a year when reviewing the ward nursing staff establishment.

1.3.4 Multiply the average number of nursing hours per patient by the average daily bed utilisation (the number of patients that a ward nursing team is responsible for during each 24-hour period). Using bed utilisation rather than bed occupancy will ensure that the nursing care needs of patients who are discharged or transferred to another ward during a 24-hour period are also accounted for.

1.3.5 Add an allowance for additional nursing workload based on the relevant ward factors such as average patient turnover, layout and size, and staff factors such as nursing activities and responsibilities other than direct patient care (see recommendations section 1.2 on principles for determining nursing staff requirements, box 1).

Stage 2: Determine required nursing skill mix and shift allocation

1.3.6 Identify the appropriate knowledge and nursing skill mix required in the team to meet the nursing needs of the ward's patients, with registered nurses remaining accountable for the overall care of patients. Base the nursing staff requirements on registered nurse hours, and consider which

activities can safely be delegated to trained and competent healthcare assistants. Take into account:

- the level of knowledge, skill and competence of the healthcare assistants in relation to the care that needs to be given
- the requirement for registered nurses to support and supervise healthcare assistants
- that improved patient outcomes are associated with a higher proportion of registered nurses in the ward nursing staff establishment.

1.3.7 Use average patients' nursing needs and the estimated time of day or night when care will be required to:

- design the staffing roster
- allocate nursing staff to care for specific patients during shifts.

1.3.8 Take account of the following factors (commonly known as 'uplift' and likely to be set at an organisational level, see recommendation 1.1.5):

- planned absence (for example, for professional development, mandatory training, entitlement for annual, maternity or paternity leave)
- unplanned absence (such as sickness absence).

The following diagram summarises the process of setting nursing staff establishments for an individual ward:

Summary of the process of setting ward nursing staff establishments

1. Average nursing staff requirement throughout a 24-hour period

Average nursing hours per patient

Use results of a systematic approach

x

Average daily bed utilisation

The average number of patients cared for in a ward per day

+

Additional workload in nursing hours per day

This should take into account:

- average patient turnover
- ward layout and size
- nursing activities and responsibilities, other than direct patient care

↓

2. Determine required ward nursing staff establishment and shift allocation

Use the care needs of patients and the time when care will be required together with professional judgement to determine:

- nursing skill mix
- allocation of nursing staff during shifts

Add an allowance for planned and unplanned absence (commonly known as uplift)

Note: This process of setting ward nursing staff establishments could be facilitated

by using a decision support toolkit

1.4 Assessing if nursing staff available on the day meet patients' nursing needs

These recommendations are for the registered nurses on wards who are in charge of shifts.

1.4.1 Systematically assess that the available nursing staff for each shift or at least each 24-hour period is adequate to meet the actual nursing needs of patients currently on the ward. The nurse in charge on individual shifts should make the on-the-day assessments of nursing staff requirements, which could be facilitated by using a NICE-endorsed decision support toolkit. Also take into account the patient factors outlined in section 1.2 on principles for determining nursing staff requirements, box 1 and tables 1 and 2.

1.4.2 Monitor the occurrence of the nursing red flag events shown in box 2 throughout each 24-hour period. Monitoring of other events may be agreed locally.

1.4.3 If a nursing red flag event occurs, it should prompt an immediate escalation response by the registered nurse in charge. An appropriate response may be to allocate additional nursing staff to the ward.

1.4.4 Keep records of the on-the-day assessments of actual nursing staff requirements and reported red flag events so that they can be used to inform future planning of ward nursing staff establishments or other appropriate action.

Box 2: Nursing red flags

- Unplanned omission in providing patient medications.
- Delay of more than 30 minutes in providing pain relief.
- Patient vital signs not assessed or recorded as outlined in the care plan.
- Delay or omission of regular checks on patients to ensure that their fundamental care needs are met as outlined in the care plan. Carrying out these checks is often referred to as 'intentional rounding' and covers aspects of care such as:
  - Pain: asking patients to describe their level of pain level using the local pain assessment tool.
  - Personal needs: such as scheduling patient visits to the toilet or bathroom to avoid risk of falls and providing hydration.
  - Placement: making sure that the items a patient needs are within easy reach.
  - Positioning: making sure that the patient is comfortable and the risk of pressure ulcers is assessed and minimised.
- A shortfall of more than 8 hours or 25% (whichever is reached first) of registered nurse time available compared with the actual requirement for the shift. For example, if a shift requires 40 hours of registered nurse time, a red flag event would occur if less than 32 hours of registered nurse time is available for that shift. If a shift requires 15 hours of registered nurse time, a red flag event would occur if 11 hours or less of registered nurse time is available for that shift (which is the loss of more than 25% of the required registered nurse time).
- Less than 2 registered nurses present on a ward during any shift.

Note: other red flag events may be agreed locally.

There is an illustration of process example on the NICE website to illustrate the use of recommendations in section 1.3 on setting the ward nursing staff establishment and section 1.4 on assessing if nursing staff available on the day meet patients' nursing needs.

1.5 Monitor and evaluate ward nursing staff

establishments

These recommendations are for senior management and nursing managers or matrons to support safe staffing for nursing at a ward level.

1.5.1 Monitor whether the ward nursing staff establishment adequately meets patients' nursing needs using the safe nursing indicators in box 3. These are indicators that evidence shows to be sensitive to the number of available nursing staff and skill mix. Consider continuous data collection of these safe nursing indicators (using data already routinely collected locally where available) and regularly analyse the results. (The section on safe nursing indicators gives further guidance on data collection for the safe nursing indicators.)

1.5.2 Compare the results of the safe nursing indicators with previous results from the same ward at least every 6 months. The comparisons should also take into account the specific ward and patient characteristics (such as patient risk factors and ward speciality). Reported nursing red flag events (see section 1.4 on assessing if nursing staff available on the day meet patients' nursing needs, box 2) should also be reviewed when undertaking this monitoring and prompt an earlier examination of the adequacy of the ward nursing staff establishment.

1.5.3 There is no single nursing staff-to-patient ratio that can be applied across all acute adult inpatient wards. However, take into account that there is evidence of increased risk of harm associated with a registered nurse caring for more than 8 patients during the day shifts. Therefore if the available registered nurses for a particular ward (excluding the nurse in charge) are caring for more than 8 patients during the day shifts, the senior management and nursing managers or matrons should:

- closely monitor nursing red flag events (see section 1.4 on assessing if nursing staff available on the day meet patients' nursing needs, box 2)
- perform early analysis of safe nursing indicator results (see section 1.5 on monitor and evaluate ward nursing staff establishments, box 3)

- take action to ensure staffing is adequate to meet the patients' nursing needs if indicated by the analysis of nursing red flag events and safe nursing indicators.

  In many cases, patients' nursing needs, as determined by implementing the recommendations in this guideline, will require registered nurses to care for fewer than 8 patients.

Box 3: Safe nursing indicators

See the section on safe nursing indicators for further information

Patient reported outcome measure

Data can be collected for the following indicators from the National Inpatient Survey:

- Adequacy of meeting patients' nursing care needs.
- Adequacy of provided pain management.
- Adequacy of communication with nursing team.

Safety outcome measures

- Falls: record any fall that a patient has experienced. The severity of the fall could be further defined in accordance with National Reporting and Learning System categories: no harm; low harm; moderate harm; severe harm; death.
- Pressure ulcers: record pressure ulcers developed or worsened 72 hours or more after admission to an organisation. The patient's worst new pressure ulcer could be categorised as grade 2, 3 or 4.
- Medication administration errors: record any error in the preparation, administration or omission of medication by nursing staff. The severity of the error should also be recorded.

Staff reported measures

- Missed breaks: record the proportion of expected breaks that were unable to be taken by nursing staff working on inpatient hospital wards.
- Nursing overtime: record the proportion of nursing staff on inpatient hospital wards working extra hours (both paid and unpaid).

Ward nursing staff establishment measures

Data can be collected for some of the following indicators from the NHS England and Care Quality Commission joint guidance to NHS trusts on the delivery of the 'Hard Truths' commitments on publishing staffing data regarding nursing, midwifery and care staff levels and more detailed data collection advice since provided by NHS England.

- Planned, required and available nursing staff for each shift: record the total nursing hours for each shift that were planned in advance, were deemed to be required on the day of the shift, and that were actually available, plus the bed utilisation during the same period.
- High levels and/or ongoing reliance on temporary nursing: record the proportion of nursing hours provided by bank and agency nursing staff on inpatient hospital wards. (The agreed acceptable levels should be established locally.)

Compliance with any mandatory training in accordance with local policy (this is an indicator of the adequacy of the size of the ward nursing staff establishment).

Note: other safe nursing indicators may be agreed locally.

Terms used in this guideline

This section defines terms that have been used in a particular way for this guideline.

Adult inpatient wards in acute hospitals

Wards that provide overnight care for adult patients in acute hospitals, excluding intensive care, high dependency, maternity, mental health, day care, acute admission or assessment units or wards. Other than these exceptions, the guideline covers all general and specialist inpatient wards for adults in acute hospitals.

Bed utilisation

The number of patients that the ward nursing team is responsible for during each 24-hour period. This includes patients who are discharged or transferred to another ward during the 24-hour period.

Decision support toolkit

A practical resource to facilitate the process of calculating the nursing staff requirements for wards or organisations. It may be electronic or paper-based.

Healthcare assistant

Healthcare assistants are all unregistered clinical staff working in hospital or community settings under the guidance and supervision of a registered healthcare professional. They may have a variety of titles such as healthcare support worker, nursing auxiliary and nursing assistant. In this guideline, the term healthcare assistants also includes assistant practitioners. The responsibilities of healthcare assistants vary, depending upon the healthcare setting and their level of training and competence.

Missed care

When a patient does not receive an aspect of planned care that has been assessed by healthcare professionals as being required. Care may be delayed, performed to a suboptimal level, omitted or inappropriately delegated.

Nursing hours per patient

This is how the measure of nursing staff requirements could be expressed. It represents the number of hours of nursing time (for both direct patient care and other nursing activities) provided by registered nurses and healthcare assistants per patient over a defined period. This is an alternative to expressing nursing time as a ratio of how many patients each nurse cares for. The 2 measurements are interchangeable. For example, a registered nurse or healthcare assistant working an 8-hour shift (after accounting for breaks) can contribute 8 hours of nursing time that day, which includes direct patient care as well as other necessary nursing activities.

Nursing red flag events

Events that prompt an immediate response by the registered nurse in charge of the ward. The response may include allocating additional nursing staff to the ward or other appropriate responses.

Nursing skill mix

The composition of the nursing team in terms of qualification and experience. This is typically expressed as a percentage of registered nurses to healthcare assistants. Nursing skill mix should also encompass individual clinical competencies and different areas of expertise and grades of registered nurses healthcare assistants.

Nursing staff

This refers to registered nurses and healthcare assistants, unless otherwise specified.

Nursing staff requirement

The nursing staff required by each ward. This should take into account all nursing care needs of patients, ward factors and staff factors including nursing activities other than direct patient care. This can be expressed as number of nursing hours.

Nursing staff roster

The daily staffing schedule for registered nurses and healthcare assistants to work on an individual ward.

Patient acuity

This refers to how ill the patient is, their increased risk of clinical deterioration and how complex their care needs are. This term is sometimes used interchangeably with the terms 'patient complexity' and 'nursing intensity'.

Patient dependency

The level to which the patient is dependent on nursing care to support their physical and psychological needs and activities of daily living, such as eating and drinking, personal care and hygiene, mobilisation.

Patients' nursing needs

The total nursing care needed by each patient on an individual ward that has been

assigned to the nursing profession. This term is used throughout the guideline to include both patient acuity and patient dependency.

Patient turnover

Rate of movement of patients into and out of a ward. This can be calculated by the number of patient admissions, discharges and internal transfers during a defined period of time.

Registered nurse

A registered nurse holds active registration with the Nursing and Midwifery Council with a licence to practise.

Nursing is a regulated profession for registered nurses, but they may appropriately delegate and supervise the delivery of nursing activities to healthcare assistants.

Safe nursing care

When reliable systems, processes and practices are in place to meet required care needs and protect people from missed care and avoidable harm.

Ward nursing staff establishment

The number of registered nurses and healthcare assistants funded to work in a particular ward, department or hospital. This includes all nursing staff in post, as well as unfilled vacancies or vacancies being covered by temporary staff. Ward nursing staff establishments are usually expressed in number of whole time equivalents.

Evidence

The Committee considered the following commissioned reports.

- **Evidence review 1**: Griffiths P, Ball J, Drennan J, Jones J, Reccio-Saucedo A, Simon M (2014) The association between patient safety outcomes and nurse/healthcare assistant skill mix and staffing levels and factors that may influence staffing requirements. University of Southampton.
- **Evidence review 2**: Simon M, Ball J, Drennan J, Jones J, Reccio-Saucedo A, Griffiths P (2014) Effectiveness of management approaches and organisational factors on nurse sensitive outcomes. University of Southampton.
- **Economic analysis**: Cookson G, McGovern A (2014) The cost effectiveness of nurse staffing and skill mix on nurse sensitive outcomes. University of Surrey.

The Committee also considered the following:

- **Expert paper 1**: Expert testimony presented to the Safe Staffing Advisory Committee.
- **Expert paper 2**: Patient testimony presented to the Safe Staffing Advisory Committee.
- **Expert paper 3**: Report from the Safe Staffing Advisory Committee sub-group meeting 11 April 2014.
- **Report on field testing of the draft guideline**

The evidence reviews, economic analysis and expert papers are available on the evidence reviews, economic analysis and expert papers are available on the NICE website.

Evidence review 1 focused on ward-level activities and considered the following review questions:

- What patient safety outcomes are associated with nurse and healthcare assistant staffing levels and skill mix?
  - Which outcomes should be used as indicators of safe staffing?
  - What outcomes are associated with tasks undertaken by registered nurses, healthcare assistants and other staff?

- Which patient factors affect nurse and healthcare assistant staffing requirements at different times during the day? These include:
  - patient dependency and acuity assessment and grading
  - patient turnover.
- How does the ward environment, including physical layout and diversity of clinical disciplines, affect safe staffing requirements?

Evidence review 2 focused on ward-level managerial activities and organisational level factors and considered the following review questions:

- What management approaches affect nurse and healthcare assistant staffing requirements?
  - What nursing staff supervisory and/or team management approaches are required?
  - What approaches for identifying required nurse staffing levels and skill mix are effective, and how frequently should they be used?
- What organisational factors influence safe staffing at a ward level? These include:
  - management structures and approaches
  - organisational culture
  - organisational policies and procedures, including staff training.

The economic analysis used the best available evidence and data from the UK to determine the relationship between nursing and skill mix and nursing sensitive outcomes. The cost effectiveness of altering staffing or skill mix was also assessed.

Expert paper 1 presented testimony from the topic specialist member on the experience of safe staffing in the New Zealand public health system.

Expert paper 2 presented testimony from the topic specialist lay member of the Committee.

Expert paper 3 presented a summary of a subgroup meeting of the Committee to explore the key patient factors and nursing needs that must be considered when calculating

nursing care requirements, and aspects of nursing missed care that could be monitored as red flag nurse staffing indicators.

The **Report on field testing of the draft guideline** presented results of testing the use of the draft guideline with nursing staff.

Gaps in the evidence

The Safe Staffing Advisory Committee identified a number of gaps in the available evidence and expert comment related to the topics being considered. These are summarised below.

- There is a lack of high-quality studies exploring and quantifying the relationship between registered nurse and healthcare assistant staffing levels and skill mix and any outcomes related to patient safety, nursing care, quality and satisfaction. All of the identified studies were observational and the majority were not for UK populations. Where evidence was available it tended to be associational with limitations due to confounding factors that affected the outcome.
- There is a lack of appropriately designed interventional studies relating to the outcomes of interest with appropriate control for confounding variables, such as studies designed to identify the outcomes associated with increasing numbers of available nursing staff. The outcomes identified generally report on failures of care rather than the more positive aspects of quality of care. There is also a lack of research on measures of missed care that could be routinely monitored and therefore easily collected and investigated.
- There is a lack of evidence from UK data that allows the effects of actual nursing staff that are present (as opposed to variations in nursing staff) to be readily determined.

- There is a lack of good quality research on the:
  - effect of different patient factors and patients' nursing care needs on the nursing staff requirement
  - indicators that are most sensitive to numbers of available registered nurses
  - impact of healthcare assistants (and the different levels of healthcare assistants) on the outcomes of interest
  - effect of ward layout and ward size on nursing staff requirements
  - relationship between time of day and patient-related outcomes
  - impact of ward-level team leadership and management (including supervisory roles and models of organising nursing care) on nursing staff requirements
  - influence of training approaches set at an organisational level.
- There is a lack of research that assesses the effectiveness of using defined approaches or toolkits to determine nursing staff requirements and skill mix. Only 1 study, which assessed 1 particular approach, was identified and this did not assess the frequency of its use. No evidence relating to other approaches was found.
- There is limited evidence about the effectiveness of management structures and organisational culture. There is some evidence from studies assessing the American Nurses Credentialing Center Magnet Programme, and the transferability of the principles and practices in this programme warrants further exploration.
- No evidence was found relating to organisational policies and procedures and nursing staff or nursing-sensitive outcomes in acute adult wards. Studies evaluating 'lean'-type approaches, such as the 'productive ward' and the elimination of non-productive care activities in order to help release more time for nursing care, were also not identified.
- There is a lack of economic studies exploring ward nursing staff establishments, requirements and skill mix. Any evidence identified is derived from countries with very different contexts and cost bases to the UK and therefore is of limited relevance to NHS decision-making.

- No economic evidence relating to ward environment, patient factors and their effect on nursing staff requirements was identified. No economic evidence was found that explored the relationship between ward-based management approaches (including the use of toolkits) and organisational factors and nursing staff requirements.
- There is a lack of data collection in relation to the wide variety of outcome variables at a ward level that would allow a detailed economic analysis of patient outcomes in relation to ward nursing staff establishments or requirements in the NHS. Patient level costing data were also limited, which hampered a clearer understanding of the cost implications of nursing staff changes and skill mix.

Research recommendations

The Safe Staffing Advisory Committee has made the following recommendations for research, based on its review of the evidence, to improve NICE guidelines and patient care in the future.

1 Relationship between staffing factors and patient outcomes

What is the relationship between the following factors and outcomes related to nursing care, patient safety and patients' and nursing staff satisfaction with the quality of care in the UK?

- Number of nursing staff
- Nursing skill mix
- Shift patterns

Why this is important

Insufficient evidence is available about the effects that nursing staff numbers, skill mix and shift patterns have on nursing care, and patient safety and satisfaction-related outcomes. Research is needed to compare outcomes from acute adult inpatient wards that use different staff numbers, skill mix, and shift patterns. Data should be collected on both positive and negative outcomes (such as number of complaints of missed care or satisfaction with quality of nursing care provided), and resource use and costs. Confounding factors (such as patient characteristics) should be controlled. This research would be best done using a cluster randomised controlled trial design.

The evidence from this research would help to establish whether there is an optimum number of nursing staff for different wards, and whether there are types of shift patterns and skill mix that are associated with the best outcomes for patients.

2 Factors affecting nursing staff requirements at

ward level

How do the following factors affect the nursing staff requirement at ward level in the UK?

- Patient factors
- Patients' nursing needs (sometimes referred to as acuity and dependency)
- Time of day
- Ward layout and size (including the use of single rooms)
- Ward level team leadership and management
- Organisational training approaches
- Organisational policies and procedures (for example, productive ward, Lean)

Why this is important

Insufficient evidence is available about the relationship between staffing, ward-level factors and patient outcomes. Prospective cohort studies should be conducted to examine the relationship between the factors above and both positive and negative outcomes relating to nursing care, patient safety, patients' and nursing staff satisfaction, resource use and costs. The studies should also examine if these factors act as an effect modifier and/or confounder of the relationship between staffing and outcomes. Research should control for other confounding factors (such as patient characteristics).

This research should provide evidence on the ward-level factors that should be included in approaches to determining nursing staff requirements, including decision support toolkits.

3 Using defined approaches or decision support toolkits

What is the effectiveness of using defined approaches or decision support toolkits to determine nursing staff requirements and skill mix on acute adult inpatient wards in the UK?

Why this is important

Insufficient evidence is available about whether using defined approaches or decision support toolkits for determining nurse staffing requirements has an impact on patient and staff outcomes.

Cluster randomised controlled trials or prospective cohort studies should be designed to compare outcomes relating to nursing care, patient safety, and patients' and nursing staff satisfaction on acute adult inpatient wards that use defined approaches or decision support toolkits to other approaches or professional judgement. Replicate studies should be carried out to provide evidence of reliability and validity.

These comparative studies should help to assess the value of using defined approaches and decision support aids, and to identify those that perform best.

Safe nursing indicators

Safe nursing indicator: Adequacy of meeting patients' nursing care needs

Data collection

Local collection could use the following National Inpatient Survey questions developed by the Picker Institute which contains a number of questions where patients' experience of care could be affected by the number of available nursing staff:

Patients' experience of nursing care on hospital inpatient wards

Q.23 Did you get enough help from staff to eat your meals?

Q.30 In your opinion, were there enough nurses on duty to care for you in hospital?

Q.40 How many minutes after you used the call button did it usually take before you got the help you needed?

Patients' experience of nursing care on hospital inpatient wards

Q.39 Do you think the hospital staff did everything they could to help control your pain?

Patients' experience of communication with nursing staff on hospital inpatient wards

Q.27 When you had important questions to ask a nurse, did you get answers that you could understand?

Q.34 Did you find someone on the hospital staff to talk to about your worries and fears?

Q.35 Do you feel you got enough emotional support from hospital staff during your stay?

Local collection of patient experience could use these questions to provide a more

frequent view of performance than possible through annual surveys alone, but please note NHS Surveys' request that local patient surveys are mindful of avoiding overlap with national patient surveys.

Outcome measures

Responsiveness to inpatients' personal needs.

Data analysis and interpretation

The annual national survey results for your hospital can be compared with previous results from the same hospital and with data from other hospitals (but be aware that comparison between hospitals is subject to variation in expectations of care between different populations). Data from more frequent local data collection, where available, can be compared with previous results from the same ward and with data from other wards in your hospital.

Safe nursing indicator: falls

People falling whilst admitted to hospital

Definition

A fall is defined as an unplanned or unintentional descent to the floor, with or without injury, regardless of cause (slip, trip, fall from a bed or chair, whether assisted or unassisted). Patients 'found on the floor' should be assumed as having fallen, unless confirmed as an intentional act.

Record any fall that a patient has experienced. The severity of the fall could be further defined in accordance with National Reporting and Learning System categories: no harm; low harm; moderate harm; severe harm; death:

- No harm: fall occurred but with no harm to the patient.
- Low harm: patient required first aid, minor treatment, extra observation or medication.

- Moderate harm: likely to require outpatient treatment, admission to hospital, surgery or a longer stay in hospital.
- Severe harm: permanent harm, such as brain damage or disability, was likely to result.
- Death: where death was the direct result of the fall.

Data collection

Proportion of people admitted to a ward who fall while in hospital.

Numerator: the number of reported falls for the ward.

Denominator: the number of occupied bed days for the ward.

Data source: Local incident reporting systems.

Outcome measures

Reported falls per 1,000 occupied bed days.

Data analysis and interpretation

Rates of falls should be compared with previous results from the same ward with caution, as not all falls will be recognised and reported, and because frequency at ward level may be too small for significant increases or decreases in these to be apparent. Rates of falls should not be compared with data from other wards or hospitals, because of differences in patient case mix and clinical specialties of the wards. Incident reporting systems may be affected by under-reporting. Periodic local collection of data on whether falls are going unreported will identify if changes in reported falls rates are true changes in actual falls rates or are affected by changes in completeness of reporting.

Although falls may be sensitive to the number of available nursing staff, falls prevention requires a multidisciplinary approach, and falls rates will also be affected by:

- availability of physiotherapy, occupational therapy, pharmacy and medical staff
- knowledge and skills of all healthcare professionals and support staff

- safety of the environment, furniture and fittings
- access to mobility aids and falls prevention equipment.

Safe nursing indicator: pressure ulcers

People acquiring pressure ulcers while in hospital

Definition

A pressure ulcer is a localised injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear. Record any pressure ulcer developed or worsened 72 hours or more after admission to an organisation. The patient's worst pressure ulcer could be categorised as 2, 3 or 4 according to the European Pressure Ulcer Scale (Defloor T et al. Statement of the European Pressure Ulcer Advisory Panel - pressure ulcer classification. J Wound Ostomy Continence Nurs 2005;32:302-6).

Data collection

Proportion of people admitted to a ward who develop a pressure ulcer (or have an existing pressure ulcer that worsens) while in hospital.

Numerator: the number of reported new or worsened pressure ulcers for the ward.

Denominator: the number of occupied bed days for the ward.

Data source: Local incident reporting systems.

Data on the number of patients in hospital with a pressure ulcer greater than category 2 (irrespective of location of origin) will also be collected for the NHS Outcomes Framework 2014/15 indicator 5.3: Proportion of patients with category 2, 3 and 4 pressure ulcers.

Outcome measures

Reported hospital-acquired pressure ulcers per 1,000 bed days.

Data analysis and interpretation

Rates of pressure ulcers should be compared with previous results from the same ward with caution, as not all pressure ulcers will be recognised and reported (distinguishing pressure ulcers from other skin lesions and grading them correctly is not always straightforward). In addition the frequency of pressure ulcers at ward level may be too small for significant increases or decreases to be apparent. Rates of pressure ulcers should not be compared with data from other wards or hospitals, because of differences in patient case mix and clinical specialties of the wards. Incident reporting systems may be affected by under-reporting. Periodic local data collection by specialist nurses/matrons visiting wards to carry out skin inspections can be used to cross-check with incident reports and Safety Thermometer data to assess if pressure ulcers are being correctly identified, graded and reported.

Although pressure ulcers may be sensitive to the number of available nursing staff, pressure ulcers prevention requires a multidisciplinary approach, and pressure ulcers rates will also be affected by:

- access to pressure ulcer prevention equipment and mobility aids
- availability of physiotherapy, occupational therapy, pharmacy and medical staff
- knowledge and skills of all healthcare professionals and support staff.

Safe nursing indicator: medication administration errors

People receiving the wrong medications whilst in hospital

Definition

A medication administration error is any error in the administration, omission or preparation of medication by nursing staff. This could include deviation from prescriptions, manufacturer medication information instructions or recommended local pharmacy procedures. The severity of the medication error should be recorded,

Data collection

Proportion of people admitted to hospital who experience a medication error while in hospital.

Numerator: the number of reported medication errors for the ward.

Denominator: the number of occupied bed days for the ward.

Data source: local incident reporting systems.

Outcome measures

Reported medication errors per 1,000 bed days.

Data analysis and interpretation

Rates of medication errors should be compared with previous results from the same ward with caution, as not all medication errors will be recognised and reported. In addition the frequency of medication errors at ward level may be too small for significant increases or decreases to be apparent. Reported medication administration errors should not be used as an indication of actual harm from medication error as wards with the most knowledgeable and vigilant nursing staff may be more likely to detect and report medication errors. Incident reporting systems may be affected by under-reporting. Periodic local collection of data on whether medication errors are going unreported will identify if changes in reported medication error rates are true changes in actual medication error rates or are affected by changes in completeness of reporting.

Although medication errors may be sensitive to the number of available nursing staff, medication errors prevention requires a multidisciplinary approach, and medication error rates will also be affected by:

- knowledge and skills of all healthcare professionals and support staff
- involvement of pharmacy and medical staff.

Safe nursing indicator: missed breaks

Nursing staff unable to take scheduled breaks

Definition

A missed break occurs when a nurse is unable to take any scheduled break due to lack of time.

Data collection

Proportion of expected breaks for registered nurses and healthcare assistants working on inpatient hospital wards that were unable to be taken.

Numerator: the number of breaks in the denominator that were unable to be taken.

Denominator: the number of expected breaks for registered nurses and healthcare assistants on inpatient hospital wards.

Data source: Local data collection.

Outcome measures

Proportion of missed breaks due to lack of time amongst nursing staff.

Safe nursing indicator: nursing overtime

Nursing staff working extra hours

Definition

Nursing overtime includes any extra hours (both paid and unpaid) that a nurse is required to work beyond their contracted hours at either end of their shift.

Data collection

a) Proportion of registered nurses and healthcare assistants on inpatient hospital wards working overtime.

Numerator: the number of registered nurses and healthcare assistants in the denominator working overtime.

Denominator: the number of registered nurses and healthcare assistants on inpatient hospital wards.

b) Proportion of nursing hours worked on hospital inpatient wards that are overtime.

Numerator: the number of nursing hours in the denominator that are overtime.

Denominator: the number of nursing hours worked on hospital inpatient wards.

Data source: Local data collection. Data are also collected nationally on the number of staff working extra hours (paid and unpaid) in the NHS National Staff Survey by the Picker Institute.

Outcome measures

Staff experience.

Safe nursing indicator: planned, required and available nurses for each shift

The number of planned, required and available nursing hours on hospital inpatient wards in relation to bed utilisation

Definition

The number of nursing hours which were planned in advance, deemed to be required during that shift and that were actually available and bed utilisation during this period.

Bed utilisation is defined as the number of patients that the ward nursing team is responsible for during each 24-hour period. This includes patients who are discharged or transferred to another ward during the 24-hour period.

Data collection

a) Proportion of total nursing hours for each shift that were planned in advance and that were actually available

Numerator: the number of nursing hours for each shift that were actually available and the actual bed utilisation.

Denominator: the number of nursing hours for each shift that were planned in advance and the expected bed utilisation.

b) Proportion of total nursing hours for each shift that were deemed to be required on-the-day and that were actually available

Numerator: the number of nursing hours for each shift that were actually available and the actual bed utilisation.

Denominator: the number of nursing hours for each shift that were deemed to be required on-the-day (calculated by following the recommendations of this guideline) and the actual bed utilisation.

Data source: local data collection, which could include data collected for the NHS England and the Care Quality Commission joint guidance to Trusts on the delivery of the 'Hard Truths' commitments on publishing staffing data regarding nursing, midwifery and care staff levels and more detailed data collection advice since provided by NHS England.

Outcome measures

Deviation between planned and available nursing staff; deviation between required and available nursing staff in relation to bed utilisation.

Safe nursing indicator: high levels and/or ongoing reliance on temporary nursing

Temporary nursing staff on hospital inpatient wards

Definition

Registered nurses and healthcare assistants who are working on adult inpatient wards who are not contracted with the hospital.

Data collection

a) Proportion of registered nurses and healthcare assistants working on adult inpatient wards who are on bank contracts.

Numerator: the number of registered nurse and healthcare assistant shifts in the denominator who are employed on bank contracts.

Denominator: the number of registered nurse and healthcare assistant shifts per calendar month to work on adult inpatient wards.

Data source: local data collection.

b) Proportion of registered nurses and healthcare assistants working on adult inpatient wards who are on agency contracts.

Numerator: the number of registered nurse and healthcare assistant shifts in the denominator who are employed on agency contracts.

Denominator: the number of registered nurse and healthcare assistant shifts per calendar month to work on adult inpatient wards.

Data source: local data collection.

Outcome measures

Expenditure (£) on bank and agency staff per inpatient bed.

Safe nursing indicator: compliance with any mandatory training

Compliance of ward nursing staff with any mandatory training in accordance with local policy

Definition

Nurses who are working on adult inpatient wards who are compliant with the mandatory training that has been agreed in line with local policy.

Data collection

Proportion of registered nurses and healthcare assistants working on inpatient hospital wards who are compliant with all mandatory training.

Numerator: the number of registered nurses and healthcare assistants in the ward nursing staff establishment who are compliant with all mandatory training.

Denominator: the number of registered nurses and healthcare assistants in the ward nursing staff establishment.

Data source: local data collection.

Outcome measures

% compliance with all mandatory training.

Finding more information and committee details

To find NICE guidance on related topics, including guidance in development, see the NICE topic page on acute and critical care.

For full details of the evidence and the guideline committee's discussions, see the evidence reviews. You can also find information about how the guideline was developed, including details of the committee.

NICE has produced tools and resources to help you put this guideline into practice. For general help and advice on putting our guidelines into practice, see resources to help you put NICE guidance into practice.

Update information

Minor changes since publication

September 2014

In box 2 (Nursing red flags) the 4th bullet has been changed to clarify that the delay or omission of regular checks is a red flag, and 'Less than 2 registered nurses present on a ward during any shift' has been moved to the end of the list.

The information on safe nursing indicators has been moved. Originally this was published as a separate file.

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National Quality Board

July 2016

Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time

Safe sustainable and productive staffing

This document has been developed by the National Quality Board (NQB), which comprises:

Care Quality Commission
NHS England
NHS Improvement
National Institute for Health and Care Excellence
Health Education England
Public Health England
Department of Health

Contents

Foreword

In 2013, the National Quality Board (NQB) set out 10 expectations and a framework within which organisations and staff should make decisions about staffing that put patients first.[1] Putting people first remains our collective and individual responsibility and is central to the delivery of high quality care that is safe, effective, caring and responsive.This NQB document builds on our 2013 guidance to provide an updated safe staffing improvement resource.

Key to high quality care for all is our ability to deliver services that are sustainable and well-led. In the past, quality and financial objectives have too often been regarded as being at odds with each other and therefore pursued in isolation. As set out in the Five Year Forward View,[2] it is vital that we have a single, shared goal to maintain and improve quality, to improve health outcomes, and to do this within the financial resources entrusted to the health service. This means a relentless focus on planning and delivering services in ways that both improve quality and reduce avoidable costs, underpinned by the following three principles:

- **Right care:** Doing the right thing, first time, in the right setting will ensure patients get the care that is right for them, avoiding unnecessary complications and longer stays in hospital and helping them recover as soon as possible.
- **Minimising avoidable harm:** A relentless focus on quality, based on understanding the drivers and human factors involved in delivering high quality care, will reduce avoidable harm, prevent the unnecessary cost of treating that harm, and reduce costs associated with litigation.
- **Maximising the value of available resources:** Providing high quality care to everyone who uses health and care services requires organisations and health economies to use their resources in the most efficient way for the benefit of their community – any waste has an opportunity cost in terms of care that could otherwise be provided.

As the Carter productivity and efficiency report[3] makes clear, improving **workforce efficiency** can benefit patient care through better recruitment and retention of permanent staff, better rostering, reduced sickness absence, matching work patterns to patient need, and reduced dependency on agency staff.

The development of new service models means building teams across traditional boundaries and ensuring they have the full range of skills and expertise to respond to patient need across different settings. As provider and commissioner organisations work together to develop Sustainability and Transformation Plans,[4] staffing decisions must support these new models of care.

All this represents a significant people challenge. Now more than ever we need to help staff improve and innovate, enabling new ways of working in an environment of growing demand and rapid change.

This safe staffing improvement resource can only set the context and offer support to local decision making. It is local clinical teams – and local providers and commissioners – who will ensure we continue to provide high-quality and financially sustainable services. The challenges we face are steep – but our teams have a track record of delivery when we work together and focus on putting patients first.

Policy Context

In February 2013, Sir Robert Francis QC published his final report of the inquiry into failings at Mid Staffordshire NHS Foundation Trust.[5] The report told a story of appalling suffering of many patients within a culture of secrecy and defensiveness, and highlighted a whole system failure. Compassion in practice,[6] the strategy for nurses, midwives and care staff (2012), the Francis report and the government response, Hard truths: the journey to putting patients first,[7] led to fundamental changes in how NHS provider boards are expected to assure they are making safe staffing decisions. The National Quality Board[8] in November 2013 set out these expectations in relation to getting nursing, midwifery and care staffing right. It provided a clear governance and oversight framework alongside recommended evidence-based tools, resources and examples of good practice, to support NHS providers in delivering safe patient care and the best possible outcomes for their patients. The National Institute for Health and Care Excellence (NICE) undertook work to produce guidelines on safe staffing for specific care settings, which led to the publication of Safe staffing for nursing in adult inpatient wards in acute hospitals[9] and Safe midwifery staffing for maternity settings.[10]

The Carter report[11] and the NHS Five Year Forward View planning guidance[12] make it clear that workforce and financial plans must be consistent to optimise clinical quality and the use of resources. The Carter report highlighted variation in how acute trusts currently manage staff, from annual leave, shift patterns and flexible working through to using technology and e-rostering. It underlined that, in addition to good governance and oversight, NHS providers need a framework to evaluate information and data, measure impact, and enable them to improve the productive use of staff resources, care quality, and financial control. Lord Carter's report recommended a new metric, care hours per patient day (CHPPD), as the first step in developing a single consistent way of recording and reporting staff deployments.

Jim Mackey, Chief Executive of NHS Improvement, and Professor Sir Mike Richards, Chief Inspector of Hospitals at the Care Quality Commission, stated in a letter to trusts[13] that provider leaders have to deliver the right quality outcomes within available resources. They reiterated their joint commitment to working together on a single national regulatory framework for this purpose.

Nursing and midwifery leaders have built on Compassion in practice to create a national nursing, midwifery and care staff framework, Leading change, adding value[14]. This framework is aligned to the Five Year Forward View, with a central focus on reducing unwarranted variation and meeting the 'Triple Aim' measure of better health outcomes, better patient experience of care and better use of resources.

The 2015 Shape of caring report[15] recommended changes to education, training and career structures for registered nurses and care staff. We need to continue this work and identify both nationally and locally how we maximise the capabilities and contribution of healthcare assistants/ support workers/nursing associates[16] to meet patient needs and provide fulfilling job roles and career pathways.

As an integral part of developing their Sustainability and Transformation Plans, local health and care systems need to develop local plans for how they will develop, support and retain a workforce with the rights skills, values and behaviours in sufficient numbers and in the right locations. This updated NQB safe staffing improvement resource provides advice and support to help NHS providers and commissioners as they go about this vital task.

About this document

The National Quality Board's 2013 guidance, How to ensure the right people, with the right skills, are in the right place at the right time: *A guide to nursing, midwifery and care staffing capacity and capability*[17] focused on supporting NHS provider boards to achieve safe nursing and midwifery care staffing. If we are to achieve the Five Year Forward View's ambitions,[18] [19] the principles contained in this guidance now need to apply to nursing and midwifery staff and the broader multiprofessional workforce in a range of care settings, and do so in a way that optimises productivity and efficiency while maintaining the focus on improving quality.

This document includes an updated set of NQB expectations for nursing and midwifery staffing to help NHS provider boards make local decisions that will deliver high quality care for patients within the available staffing resource. In preparing this document we spent time talking with and listening to directors of nursing and chief nurses (in both provider and commissioner organisations) and to other key stakeholders, at local meetings, national events and via correspondence, to understand the impact of the previous safe staffing improvement resource, and to share ideas and early drafts of this document. This engagement and the feedback received were important for testing and ensuring that this updated document continues to provide a helpful framework for NHS provider boards when they are reviewing staffing and making decisions.

The Carter report[20] identified that one of the obstacles to eliminating unwarranted variation in the deployment of nursing and healthcare support workers has been the absence of a single means of recording and reporting how staff are deployed. From May 2016, CHPPD is the principal measure of nursing, midwifery and healthcare support worker deployment. This data collection is an important first step in the journey to providing a single, consistent metric for NHS providers to record and report all staffing deployment.

Another Carter recommendation was to develop a model hospital so trusts can learn what 'good' looks like from other trusts and adopt their best practice. Through the work on the model hospital, NHS Improvement is developing tools including a live model hospital dashboard that collects and presents patient outcome measures and staffing information in a standardised way.

In Sections 1, 2 and 3, we have updated the 2013 NQB guidance by bringing it together with the Carter report's findings, to set out the key principles and tools that provider boards should use to measure and improve their use of staffing resources to ensure safe, sustainable and productive services.

In Section 3, we identify three updated NQB expectations that form a 'triangulated' approach ('Right Staff, Right Skills, Right Place and Time') to staffing decisions. An approach to deciding staffing levels based on patients' needs, acuity and risks, which is monitored from 'ward to board', will enable NHS provider boards to make appropriate judgements about delivering safe, sustainable and productive staffing. CQC supports this triangulated approach to staffing decisions, rather than making judgements based solely on numbers or ratios of staff to patients.

NHS provider boards are accountable for ensuring their organisation has the right culture, leadership and skills in place for safe, sustainable and productive staffing. They are also responsible for ensuring proactive, robust and consistent approaches to measurement and continuous improvement, including the use of a local quality framework for staffing that will support safe, effective, caring, responsive and well-led care. Appendix 1 shows measures that can be used alongside CHPPD to demonstrate and understand the impact of staffing decisions on the quality of care that people are receiving in acute inpatient wards.

Safe, Effective, Caring, Responsive and Well-Led Care		
Measure and Improve - patient outcomes, people productivity and financial sustainability - - report investigate and act on incidents (including red flags) - - patient, carer and staff feedback -		
- Implementation Care Hours per Patient Day (CHPPD) - - develop local quality dashboard for safe sustainable staffing -		
Expectation 1	**Expectation 2**	**Expectation 3**
Right Staff 1.1 evidence-based workforce planning 1.2 professional judgement 1.3 compare staffing with peers	**Right Skills** 2.1 mandatory training, development and education 2.2 working as a multi-professional team 2.3 recruitment and retention	**Right Place and Time** 3.1 productive working and eliminating waste 3.2 efficient deployment and flexibility 3.3 efficient employment and minimising agency

Publishing this updated NQB safe staffing improvement resource is the first step in a journey to developing other resources that will support NHS provider trusts with making staffing decisions that will deliver safe, effective, caring, responsive and well-led care.

NHS Improvement is also coordinating work to develop safe staffing improvement resources for a range of care settings including: mental health, learning disability, acute adult inpatients, urgent and emergency care, children's services, maternity services, and community services. The core principles underpinning this work are: to identify and review the best available evidence on safe, sustainable staffing; to be multi-disciplinary in approach to staffing; to be outcomes focused; to complete an economic impact assessment on any proposed safe staffing improvement resource; and to develop these staffing resources with the appropriate experts, focus groups and other key stakeholder groups, including patients, families and carers. NHS Improvement will begin to release these improvement resources later in 2016/17, with approval from the NQB.

As this safe staffing improvement resource is implemented and used by NHS provider boards, clinicians and frontline managers, through their feedback and engagement, we will review and evaluate the impact of this resource over the next year to 18 months, to inform plans for future publications.

Section 1: Safe, sustainable and productive staffing: measurement and improvement

Patient outcomes, people productivity and financial sustainability

Providing high quality care to all patients means that NHS organisations and health economies must use their available resources in the most efficient way possible for the benefit of their community. There should be individual and collective responsibility as an NHS provider board for deploying staff in ways that ensure safe, sustainable and productive services. There should be clear lines of accountability for all professional staff groups. There should be collaborative decisionmaking between clinical and managerial staff, reporting to boards. NHS provider boards should have a proactive approach to reporting, investigating and acting on incidents and to driving continuous improvement.

NHS provider boards will need to collaborate across their local health and care system, with commissioners and other providers, to ensure delivery of the best possible care and value for patients and the public. This may require NHS provider boards to make difficult decisions about resourcing as local Sustainability and Transformation Plans are developed and agreed.

In this context, 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.

To help optimise allocation of workforce resources and improve outcomes, NHS provider boards should implement in full the Carter recommendations, together with the findings from the model hospital and its equivalents for other care settings. This includes:

- using local quality and outcomes dashboards that are published locally and discussed in public board meetings, including the use of nationally agreed quality metrics that will be published at provider level
- developing metrics that measure patient outcomes, staff experience, people productivity and financial sustainability
- comparing performance against internal plans, peer benchmarks and the views of NHS experts, taking account of any underlying differences
- reducing wasted time by supporting and engaging staff in using their time in the best way possible to provide direct or relevant care or care support

- using national good practice checklists to guide improvement action, as well as taking account of knowledge shared by top performers.

Commissioners monitor providers' quality and outcomes closely, and where problems with staff capacity and capability create risks for quality, commissioners work in partnership with providers and consider how best to bring about improvements. Quality Surveillance Groups provide an opportunity for commissioners and local partners to work together to identify any risks to quality and safe staffing and coordinate actions to drive improvement.

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. While boards will use published national metrics to support the discharge of those responsibilities, more timely and more detailed local sources of data and information are typically available for local monitoring and improvement. Boards should use this local quality monitoring to support their judgements and decisions about safe staffing. While staffing capacity and capability are vital to all aspects of quality, they are particularly likely to affect specific quality indicators or measures. The NQB has developed recommendations for local providers to consider when monitoring the impact of staffing on quality: see Appendix 1.

Reporting, investigating and acting on incidents

High quality care produces excellent outcomes for patients, and is safe, effective, caring, responsive and well led. NHS providers should follow best practice guidance in the investigation of all patient safety incidents, including root cause analysis[21] for serious incidents.[22] As part of this systematic approach to investigating incidents, providers should consider staff capacity and capability, and act on any issues and contributing factors identified.

NHS providers should consider reports of the 'red flag' issues suggested in the NICE guidance,[23] [24] and any other incident where a patient was or could have been harmed,[25] as part of the risk management of patient safety incidents. Incidents must be reviewed alongside other data sources, including local quality improvement data (eg for omitted medication)[26] clinical audits[27] or locally agreed monitoring information, such as delays or omissions of planned care.

NHS providers should actively encourage all staff to report any occasion where a less than optimal level of suitably trained or experienced staff harmed or seems likely to harm a patient. These locally reported incidents should be considered patient safety incidents rather than solely staff safety incidents, and they should be routinely uploaded to the National Reporting and Learning System.

Staff in all care settings should be aware that they have a professional duty to put the interests of the people in their care first, and to act to protect them if they consider that they may be at risk.[28] Policies[29] should be in place supporting staff who raise concerns as and when they arise.

All NHS providers should have an identified Freedom to Speak Up guardian and should be able to demonstrate commitment to the principles in the Freedom to Speak Up Review of February 2015[30].

NHS providers should adhere to Duty of Candour requirements,[31] which require them to publish an annual declaration of their commitment to telling patients if something has gone wrong with their care and have support staff to deliver this commitment.

Boards should ensure that they support and enable their executive team to take decisive action when necessary. Commissioners, regulators and other stakeholders should be involved in

considering any decision to close a care environment, or suspend services due to concerns about safe staffing, and identifying alternative arrangements for patients should be a priority.

Patient, staff and carer feedback

NHS providers need a co-ordinated approach and the right leadership skills in place to drive continuous improvements in patient outcomes and productivity. They should do this by developing the appropriate culture and behaviours, where staff and teams are engaged in developing their organisations and they are supported, respected and valued.[32]

Boards must ensure that their organisations foster a culture of professionalism and responsiveness in healthcare professionals,[33] so that staff feel able to use their professional judgement to raise concerns and make suggestions for change that improves care. This includes ensuring the organisation has policies to support clinical staff to uphold professional codes of practice.

NHS providers should proactively seek the views of patients, carers and staff and the board should routinely consider any feedback relevant to staffing capacity, capability and morale, such as national and local surveys, stories, complaints and compliments.

As the Carter report says, good staff engagement and robust local policies and procedures should be in place to tackle bullying and harassment, and to address variation in sickness absence and staff turnover.

NHS providers should have a strong staff engagement plan, which routinely monitors the impact of their policies, demonstrates an understanding of the links between staff experience, patient experience and outcomes, and which supports staff retention, as documented by available research.[34] [35]

Staff should work in well-structured teams. They should be engaged, enabled to practice effectively and able to make changes to delivery of care to improve quality and productivity.[36]

When an establishment review has taken place within an organisation, the board should ensure it considers feedback from frontline staff as part of its assurance activities.

Section 2: Care hours per patient day (CHPPD)

CHPPD for nurse staffing in acute inpatients

From May 2016, all acute trusts with inpatient wards/units began reporting monthly CHPPD data to NHS Improvement. Over time, this will allow trusts to review the deployment of staff within a specialty and by comparable ward. When looking at this information locally alongside other patient outcome measures, trusts will be able to identify how they can change and flex their staffing establishment to improve outcomes for patients and improve productivity.

The introduction of CHPPD for nurse and healthcare support staffing in the inpatient/acute setting is the first step in developing the methodology as a tool that can contribute to a review of staff deployment. Work has begun to consider appropriate application of this metric in other care settings and to include other healthcare professionals such as allied health professionals (AHPs).

As with other indicators, CHPPD should never be viewed in isolation but as part of a local quality dashboard that includes patient outcome measures alongside workforce and finance indicators. The aim is to help ward sisters/charge nurses, clinical matrons and hospital managers make safe, efficient and effective decisions about staff deployment: see Appendix 1.

CHPPD is calculated by adding the hours of registered nurses and the hours of healthcare support workers and dividing the total by every 24 hours of inpatient admissions (or approximating 24 patient hours by counts of patients at midnight). CHPPD is reported as a total and **split by registered nurses and healthcare support workers** to provide a complete picture of care and skill mix.

Care hours per patient day =	Hours of registered nurses and midwives alongside Hours of healthcare support workers
	Total number of inpatients

During the pilot, data sets were used from 25 acute trusts, representing a variety of acute trust types from across England, testing a variety of local data collection methods to collate actual hours worked by registered nurses and support staff.

The pilot supported the future use of CHPPD at a national level by:

- developing consistent ‘rules’ for capturing data (eg whether or not to include senior supervisory sisters/charge nurses)
- considering how in future to capture important contextual factors that affect nurse workload (eg whether a ward has high or low levels of housekeeping and ward clerk support, percentage single rooms)

- undertaking in-depth reviews to understand the impact of acuity and dependency
- exploring the challenges of collecting accurate data on patient hours/days for the CHPPD metric denominator
- reviewing international best practice where nursing hours per patient day (NHPPD) are used, including Western Australia, New Zealand and South Africa.[37]

In testing the CHPPD data collection with 27 trusts before implementation in May 2016, it was found that, although collecting patient count at midnight did not capture all the activity on ward areas, it was the least burdensome on trusts and ensures consistency in the data for comparison. As NHS Improvement develops the CHPPD metric further with NHS providers, it will continue to review and refine ways of reflecting activity throughout the day.

NHS Improvement will be working with NHS providers to develop and inform the 2016/17 implementation plan for CHPPD. The programme's initial focus will be to assess and evaluate the acute inpatient data collection for nurse staffing by October 2016 to inform the next phase of implementation. In parallel, NHS Improvement will engage with providers to scope the development of the CHPPD metric for other care settings and consider application for other healthcare professionals, such as AHPs.

A robust process for review and evaluation will underpin NHS Improvement's programme to assure the validity of CHPPD and its impact in supporting frontline decisions about staff deployment, as well as to inform future plans.

Section 3: Updated NQB expectations

Triangulated approach to staffing decisions

Expectation 1	Expectation 2	Expectation 3
Right Staff 1.1 evidence-based workforce planning 1.2 professional judgement 1.3 compare staffing with peers	**Right Skills** 2.1 mandatory training development and education 2.2 working as a multi-professional team 2.3 recruitment and retention	**Right Place and Time** 3.1 productive working and eliminating waste 3.2 efficient deployment and flexibility 3.3 efficient employment and minimising agency

Implement Care Hours per Patient Day

Develop local quality dashboard for safe sustainable staffing

Measure and Improve

- Patient outcomes, people productivity and financial sustainability -
- Report investigate and act on incidents (including red flags) -
- Patient, carer and staff feedback -

Expectation 1: Right staff

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.

Boards should ensure there is an annual strategic staffing review, with evidence that this is developed using a triangulated approach (ie 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.

Safe staffing is a fundamental part of good quality care, and CQC will therefore always include a focus on staffing in the inspection frameworks for NHS provider organisations.

Commissioners should actively seek to assure themselves that providers have sufficient care staffing capacity and capability, and to monitor outcomes and quality standards, using information that providers supply under the NHS Standard Contract.

Boards should ensure:

1.1 Evidence-based workforce planning

- The organisation uses evidence-based guidance such as that produced by NICE, Royal Colleges and other national bodies to inform workforce planning, within the wider triangulated approach in this NQB resource (see Appendix 4 for list of evidence-based guidance for nursing and midwifery care staffing).
- The organisation uses workforce tools in accordance with their guidance and does not permit local modifications, to maintain the reliability and validity of the tool and allow benchmarking with peers.
- Workforce plans contain sufficient provision for planned and unplanned leave, eg sickness, parental leave, annual leave, training and supervision requirements.

1.2 Professional judgement

- Clinical and managerial professional judgement and scrutiny are a crucial element of workforce planning and are used to interpret the results from evidence-based tools, taking account of the local context and patient needs. This element of a triangulated approach is key to bringing together the outcomes from evidence-based tools alongside comparisons with peers in a meaningful way.
- Professional judgement and knowledge are used to inform the skill mix of staff. They are also used at all levels to inform real-time decisions about staffing taken to reflect changes in case mix, acuity/dependency and activity.

1.3 Compare staffing with peers

- The organisation compares local staffing with staffing provided by peers, where appropriate peer groups exist, taking account of any underlying differences.
- The organisation reviews comparative data on actual staffing alongside data that provides context for differences in staffing requirements, such as case mix (eg length of stay, occupancy rates, caseload), patient movement (admissions, discharges and transfers), ward design, and patient acuity and dependency.
- The organisation has an agreed local quality dashboard that triangulates comparative data on staffing and skill mix with other efficiency and quality metrics: eg for acute inpatients, the model hospital dashboard will include CHPPD.

Expectation 2: Right skills

Boards should ensure clinical leaders and managers are appropriately developed and supported to deliver high quality, efficient services, and there is a staffing resource that reflects a multiprofessional team approach. Decisions about staffing should be based on delivering safe, sustainable and productive services.

Clinical leaders should use the competencies of the existing workforce to the full, further developing and introducing new roles as appropriate to their skills and expertise, where there is an identified need or skills gap.

Boards should ensure:

2.1 Mandatory training, development and education

- Frontline clinical leaders and managers are empowered and have the necessary skills to make judgements about staffing and assess their impact, using the triangulated approach outlined in this document.[38]
- Staffing establishments take account of the need to allow clinical staff the time to undertake mandatory training and continuous professional development, meet revalidation requirements, and fulfil teaching, mentorship and supervision roles, including the support of preregistration and undergraduate students.[39]
- Those with line management responsibilities ensure that staff are managed effectively, with clear objectives, constructive appraisals, and support to revalidate and maintain professional registration.
- The organisation analyses training needs and uses this analysis to help identify, build and maximise the skills of staff. This forms part of the organisation's training and development strategy, which also aligns with Health Education England's quality framework.[40]
- The organisation develops its staff's skills, underpinned by knowledge and understanding of public health and prevention, and supports behavioural change work with patients, including self-care, wellbeing and an ethos of patients as partners in their care.
- The workforce has the right competencies to support new models of care. Staff receive appropriate education and training to enable them to work more effectively in different care settings and in different ways. The organisation makes realistic assessments of the time commitment required to undertake the necessary education and training to support changes in models of care.
- The organisation recognises that delivery of high quality care depends upon strong and clear clinical leadership and well-led and motivated staff. The organisation allocates significant time for team leaders, professional leads and lead sisters/charge nurses/ward managers to discharge their supervisory responsibilities and have sufficient time to coordinate activity in the care environment, manage and support staff, and ensure standards are maintained.

2.2 Working as a multiprofessional team

- The organisation demonstrates a commitment to investing in new roles and skill mix that will enable nursing and midwifery staff to spend more time using their specialist training to focus on clinical duties and decisions about patient care.
- The organisation recognises the unique contribution of nurses, midwives and all care professionals in the wider workforce. Professional judgement is used to ensure that the team has the skills and knowledge required to provide high-quality care to patients. This stronger multiprofessional approach avoids placing demands solely on any one profession and supports improvements in quality and productivity, as shown in the literature.[41]
- The organisation works collaboratively with others in the local health and care system. It supports the development of future care models by developing an adaptable and flexible workforce (including AHPs and others), which is responsive to changing demand and able to work across care settings, care teams and care boundaries.

2.3 Recruitment and retention

- The organisation has clear plans to promote equality and diversity and has leadership that closely resembles the communities it serves. The research outlined in the NHS provider roadmap[42] demonstrates the scale and persistence of discrimination at a time when the evidence demonstrates the links between staff satisfaction and patient outcomes.
- The organisation has effective strategies to recruit, retain and develop their staff, as well as managing and planning for predicted loss of staff to avoid over-reliance on temporary staff.
- In planning the future workforce, the organisation is mindful of the differing generational needs of the workforce. Clinical leaders ensure workforce plans address how to support staff from a range of generations, through developing flexible approaches to recruitment, retention and career development[43]

Expectation 3: Right place and time

Boards should ensure staff are deployed in ways that ensure patients receive the right care, first time, in the right setting. This will include effective management and rostering of staff with clear escalation policies, from local service delivery to reporting at board, if concerns arise.

Directors of nursing, medical directors, directors of finance and directors of workforce should take a collective leadership role in ensuring clinical workforce planning forecasts reflect the organisation's service vision and plan, while supporting the development of a flexible workforce able to respond effectively to future patient care needs and expectations.

Boards should ensure:

3.1 Productive working and eliminating waste

- The organisation uses 'lean' working principles, such as the productive ward,[44] as a way of eliminating waste.
- The organisation designs pathways to optimise patient flow and improve outcomes and efficiency eg by reducing queueing.
- Systems are in place for managing and deploying staff across a range of care settings, ensuring flexible working to meet patient needs and making best use of available resources.
- The organisation focuses on improving productivity, providing the appropriate care to patients, safely, effectively and with compassion, using the most appropriate staff.
- The organisation supports staff to use their time to care in a meaningful way, providing direct or relevant care or care support. Reducing time wasted is a key priority.[45]
- Systems for managing staff use responsive risk management processes, from frontline services through to board level, which clearly demonstrate how staffing risks are identified and managed.

3.2 Efficient deployment and flexibility

- Organisational processes ensure that local clinical leaders have a clear role in determining flexible approaches to staffing with a line of professional oversight, that staffing decisions are supported and understood by the wider organisation, and that they are implemented with fairness and equity for staff.
- Clinical capacity and skill mix are aligned to the needs of patients as they progress on individual pathways and to patterns of demand, thus making the best use of staffing resource and facilitating effective patient flow.
- Throughout the day, clinical and managerial leaders compare the actual staff available with planned and required staffing levels, and take appropriate action to ensure staff are available to meet patients' needs.

- Escalation policies and contingency plans are in place for when staffing capacity and capability fall short of what is needed for safe, effective and compassionate care, and staff are aware of the steps to take where capacity problems cannot be resolved.
- Meaningful application of effective e-rostering policies is evident, and the organisation uses available best practice from NHS Employers[46] and the Carter Review Rostering Good Practice Guidance (2016).

3.3 Efficient employment, minimising agency use

- The annual strategic staffing assessment gives boards a clear medium-term view of the likely temporary staffing requirements. It also ensures discussions take place with service leaders and temporary workforce suppliers to give best value for money in deploying this option. This includes an assessment to maximise flexibility of the existing workforce and use of bank staff (rather than agency), as reflected by NHS Improvement guidance.[47]
- The organisation is actively working to reduce significantly and, in time, eradicate the use of agency staff in line with NHS Improvement's nursing agency rules, supplementary guidance and timescales.[48]
- The organisation's workforce plan is based on the local Sustainability and Transformation Plan (STP)[49], the place-based, multi-year plan built around the needs of the local population.
- The organisation works closely with commissioners and with Health Education England, and submits the workforce plans they develop as part of the STP, using the defined process, to inform supply and demand modelling.
- The organisation supports Health Education England by ensuring that high quality clinical placements are available within the organisation and across patient pathways, and actively seeks and acts on feedback from trainees/students, involving them wherever possible in developing safe, sustainable and productive services.

Appendix 1

NQB recommendations for wider measures to monitor the impact of staffing on quality

The definitive judgement of a provider's quality is its CQC inspection rating. Alongside this, a range of metrics relevant to aspects of patient safety, clinical effectiveness and patient experience are suitable for both regulatory and public use, either to compare aspects of a provider's quality with other providers, or to measure changes in aspects of quality over time. All NQB partners are committed to ensuring metrics used for regulation and performance management are increasingly aligned into a 'single version of the truth' to reduce burden and ensure effective commissioning and provider oversight.

Here we offer guidance for local providers on using other measures of quality, alongside care hours per patient day (CHPPD), to understand how staff capacity may affect the quality of care. It is important to remember that CHPPD should not be viewed in isolation and, even alongside this suggested suite of measures, does not give a complete view of quality.

The suggested measures draw on data sources in most or all providers without additional collection, are likely to be already in use locally, and provide up-to-date information. The suggested indicators in this Appendix are best considered as 'balancing measures' where the impact of any changes in workforce capacity may become visible. They are not intended to include all aspects of quality; other quality indicators will be needed to provide a rounded view of the overall quality in a care setting and the wider systems and structures that support the delivery of care.

Given that the initial rollout of CHPPD is in acute inpatient settings, the examples and suggestions for other measures of how staffing capacity affects quality have been selected as particularly relevant to acute hospitals, but have been organised in a framework that could be applied to any setting. Even within acute hospitals these suggestions can and should be locally adapted: for example, specialist areas such as maternity units will need tailored metrics; providers with sophisticated data systems will have more options available to them; and specialist providers may have to develop monitoring more relevant to their specialties. Although initial collection of CHPPD relates to nursing staff, healthcare requires a multidisciplinary team approach, and the suggested list of quality indicators to use alongside CHPPD relates to a range of staff groups.

It is vital that boards read and hear staff and patient voices and the findings of incident and serious incident investigations alongside the suggested list of quality indicators so that the nature and causes of any issues can be rapidly identified and acted on.

NQB recommendations for monitoring the impact of staffing on quality in acute hospital inpatient settings			
	Rationale for using as a quality indicator alongside CHPPD	**Example indicators** *Italics = published indicator*	**Existing local sources**
Patient and carer feedback	Patient and carer feedback provides insight into the quality of their own care, and often extends into observations of the wider care environment and staff capacity	*Friends and Family Test (inpatient and maternity)* *National patient surveys overall rating of care and questions related to staff capacity*	Local patient FFT data[50] submitted to UNIFY (published monthly but earlier data available to providers) National patient surveys[51] Local complaints and compliments data
Staff feedback	Staff feedback provides insight into their own and their colleagues' capacity, capability and morale, and of their perception of the quality of care	*Staff Friends and Family Test (place to be treated/place to work)* *National staff surveys (place to be treated/ place to work and questions related to workload)* GMC trainee survey *(questions related to workload)*	Local staff FFT data[52] submitted to UNIFY (published monthly but earlier data available to providers) National staff surveys[53] Annual GMC trainee survey[54] Local staff 'barometers' or feedback routes Local incident reports of lack of sufficient staff numbers, capacity or skills[55]
Access to care	While staffing capacity will never be the sole factor, lack of staff capacity will affect access to care; for example, operations will be cancelled if any key staff in theatre or ward are unavailable	Cancelled elective operations – proportion of last minute cancellations *Those not treated within 28 days of a last minute cancellation*	UNIFY submissions (published quarterly but earlier data available to providers)
Completion of key clinical processes	Clinical process measures provide a very early indication of changes in the quality of care delivery, so action can be taken before outcomes are affected Processes are often the responsibility of a specific staff group, and so can help pinpoint staffing capacity issues for that group	Medication omitted for non-clinical reasons (registered nursing staff) Observations/Early Warning Scores not taken/calculated as planned (nursing staff) MRSA screening/decolonisation completion rates VTE risk assessment completion (medical staff) Mobilisation within 24 hours of surgery (AHPs) *National Clinical Audits (range of staff)*	Electronic prescribing systems Electronic patient records Electronic observation systems Pathology databases National Clinical Audits with continuous local data submission (eg Stroke Sentinel Audit) UNIFY submissions (published quarterly but earlier data available to providers) Local audits, CQuINS, process measures collected for local QI projects (eg Medication Safety Thermometer for omitted medication[56])

NQB recommendations for monitoring the impact of staffing on quality in acute hospital inpatient settings			
	Rationale for using as a quality indicator alongside CHPPD	**Example indicators** *Italics = published indicator*	**Existing local sources**
Harm during healthcare	While a wide range of measures need to ensure the system of care supports staff to do the right thing, some types of harm are particularly likely to be affected by staff capacity Pressure ulcer prevention typically requires constant nursing intervention in terms of skin care and position changes, and therefore monitoring of pressure ulcers can help pinpoint staffing capacity issues for that staff group Effective inpatient falls prevention relies on identifying underlying medical causes, medication review, early mobilisation, and nursing observation. Therefore monitoring falls can help pinpoint staffing capacity issues across medical, pharmacy, AHP and nursing staff	*Pressure ulcer prevalence* Pressure ulcer incidence *Prevalence of inpatient falls* Incidence of inpatient falls	Safety Thermometer data (published monthly but earlier data available to providers) alongside local assessments of data completeness[57] Local incident data on falls and pressure ulcers and subsequent investigations alongside local assessments of data completeness[58] *'Occurred in this trust'* field in National Hip Fracture Database Local data on post-admission transfers to orthopaedics as potential indicator of serious injury from falls

Notes on indicator presentation

This guidance cannot encompass detailed advice on how local quality monitoring is presented, but it is important local presentations help leaders and boards see where changes are significant rather than likely to be due to chance or anticipated seasonal patterns, including the use of appropriate denominators. In the best trusts, wards, leaders and the board use statistical process control techniques both to understand change and identify sustained improvement, rather than just looking at the month-to-month change.

Additional areas important for monitoring

Investigation and learning from patient safety incident and serious incident data

As set out in Section 1 of this document, *"Best practice guidance should be followed in the investigation of all patient safety incidents, including root cause analysis for serious incidents. As part of this systematic approach to investigating incidents, providers should consider staff capacity and capability, and act on any issues and contributing factors identified".* Summarising these findings is a vital part of contextualising any quantitative data used for quality monitoring.

Workforce metrics that provide a window on staff capacity

While this Appendix on quality monitoring does not encompass wider workforce metrics (these will be developed as part of the NHS Improvement work on the model hospital) provider boards may wish to consider the wider quality implications of some workforce metrics. For example, staff turnover and staff sickness rates, particularly stress-related absences, can be an indicator of workload pressures. An additional example is completion of mandatory training; this is a direct measure of training completion, but as staff capacity issues can lead to cancellations of mandatory training, it can also act as a proxy indicator for workload pressures.

Workload metrics that provide context to CHPPD

As set out in Section 3, Expectation 1.3 *"the organisation reviews comparative data on actual staffing alongside data that provides context for differences in staffing requirements, such as case mix (eg length of stay, occupancy rates, caseload), patient movement (admissions, discharges and transfers), ward design, and patient acuity and dependency."*

Selection criteria for wider measures to help monitor the impact of staffing on quality

Healthcare is delivered by people; there is arguably no aspect of healthcare quality that staff capacity and capability will not affect. But in suggesting metrics to accompany CHPPD, selections have to be based on those areas of quality where changes in staff capacity are most likely to have a visible impact. This means any suggested areas:

- need to have very recent data available to providers or act as a periodic more robust source to compare with more frequently collected local data
- need to have a rationale where it is plausible or is shown that staff capacity is the major, or one of the major, factors affecting the metric (including a rationale for whether capacity of all staff groups or specific staff groups would be expected to have an impact)
- need adequate numbers (statistical power) if any true improvement or deterioration is to be distinguishable from random variation within a reasonable period in a typically sized provider
- if used to compare providers, have to be confirmed as appropriate for that purpose (ie not affected more by patient characteristics, differences in data collection, etc than by differences in actual quality)
- if used for a provider to compare against its own baselines, need to have stable data collection and completeness, and may need adjustment for seasonal factors (eg comparing against equivalent seasonal period, not past quarter, etc.)

Appendix 2

Units of staffing measurement		
Type of measure	**Examples**	**How these can be used**
Staff to patient rates/ ratios	Care hours per patient day (CHPPD) reported as total and split by registered nurses and healthcare support workers to provide a complete picture of care and skill mix	CHPPD is a unit of measurement that can be applied to any aspect of staffing, registered staff and/or whole care team. The Carter Report defines CHPPD as registered nurse hours plus healthcare support staff hours in a 24-hour period, divided by number patients at midnight (as a proxy for 24 hours of a patient stay). The concept of CHPPD can be adapted to all other staff groups with time allocated to wards or units: for example, physiotherapy hours per patient day, occupational therapy hours per patient day, etc.
	Nursing hours per patient day (NHPPD)	NHPPD is a unit of measurement used in inpatient settings internationally. It is able to summarise variations in numbers of staff and numbers of patients over the course of a 24-hour period. It typically refers to the number of registered nursing hours available per patient.
Patient to staff rates/ ratios	x patients per registered nurse x service users on caseload x women per midwife per year one-to-one observation	Typically used as a 'snapshot' of current responsibilities or as an average of responsibilities over a longer period. Actual numbers of staff and of patients/women/ service users will tend to vary over the course of a day in inpatient settings and over days/ weeks in community settings.
Registered to unregistered staff rates/ ratios	xx% of team are registered nurses xx% of team are midwives x:y ratio of registered nurses/ healthcare assistants	Difficult to interpret in isolation from other units of measurement, as a higher percentage/ ratio can be achieved by reducing healthcare assistants or by increasing registered nursing staff, but does give an indication of staff that will require supervision by registered nurses/midwives, in addition to their direct responsibilities.

Units of staffing measurement		
Type of measure	**Examples**	**How these can be used**
Whole-time equivalents (WTE)	Ward/unit/team has xx WTE in post Ward/unit/team is funded for xx WTE	Provides a unit of measurement that overcomes local differences in the proportion of staff who work part-time, converting all part-time contracts into their whole-time equivalent, *eg two staff working 30 hours per week plus one staff member working 15 hours is the equivalent of two staff working 37.5 hours per week, therefore 2.0 WTE*
Head count	Ward/unit/team headcount is xx registered nurses xx healthcare assistants x physiotherapists x occupational therapists	Provides a unit of measurement that is important when counting activity every employed staff member has to undertake, regardless of how many hours they work, *eg mandatory training.*
Fill rates	The ward/unit/team had xx% of planned staff overall The ward/unit/team had xx% of planned registered nurse/ midwifery staffing The ward/unit/team had xx% of required staff overall The ward/unit/team had xx% of required registered nurse/ midwifery staffing	This was previously calculated by dividing actual staff by planned or required staff and multiplying by 100 to convert to a percentage. Difficult to interpret in isolation from other units of measurement, as previous plans may not reflect patient acuity/dependency on the day, and the percentage total cannot distinguish between 'aiming high but delivering less' and 'aiming low and delivering even lower.' Where registered nursing/midwifery staffing gaps are covered by a higher number of healthcare assistants, or where fluctuating numbers of staff are required for special observation, overall fill rates become even more difficult to interpret.
Headroom/ uplift	xx% uplift xx% headroom	Building in capacity to deal with planned and unplanned but predictable variations in staff available, such as annual leave, maternity and paternity leave, compassionate leave, jury service, sickness and study leave. If the headroom/uplift allowance is lower than actual requirements this can lead to greater use of temporary/agency staff.
Note: for all units of staffing measurement, creating averages over days, weeks or months can potentially be misleading: a ward/unit/team that fluctuates markedly between too few or too many staff to meet patients' needs on different days of the week, or from week to week, will not be able to deliver the same quality of care as a ward/unit/team where staffing is more consistent.		

Appendix 3

Methods of workforce planning		
Type of workforce tool	**Summary**	**Examples**
Acuity/ dependency models	Using a decision matrix, patients are categorised according to their requirements into levels of care with associated evidence-based staffing multipliers derived from wards delivering good quality care. In this way, it discriminates between patients with differing needs. Some models also factor in additional workload demands such as patient turnover.	Safer nursing care tool for adults, inpatient wards, acute admissions units, children and young people wards: http://shelfordgroup.org/library/documents/Shelford_Group_Safety_Care_Nursing_Tool.pdf Mental health and learning disability tools: https://hee.nhs.uk/hee-your-area/west-midlands/about-us/our-governance/our-letcs/mental-health-institute-letc/safe-staffing-tools-mental-health-learning-disability
The professional judgment model	Based on clinical staff views of the number of staff required for the usual patient casemix and usual activity on a particular ward/unit/ team (or in high dependency environments, the number of staff required for a typical patient)	Telford method http://www.who.int/hrh/documents/hurst_mainreport.pdf
Activity Monitoring tools	Uses care plans/care pathways and related nursing time. Data are collected based on the tasks undertaken/assigned to nurses, providing insights into the needs of and intelligence to inform decisions about staffing numbers, staff deployment, models of care, and skill mix.	Birthrate plus http://www.birthrateplus.co.uk/

Appendix 4

Key existing evidence-based guidance for nursing and midwifery staffing			
Title	**Summary**	**Link**	**Year**
Strengthening the commitment; the Report of the UK Learning Disabilities Nursing Review	A UK-wide review of learning disabilities nursing supported by the four Chief Nursing Officers in the UK, published in 2012, made recommendations related to workforce planning	http://www.scotland.gov.uk/Resource/0039/00391946.pdf	2012
Safe staffing for nursing in adult inpatient wards in acute hospitals	NICE inpatient guidelines	www.nice.org.uk/guidance/sg1	2014
Safe midwifery staffing for maternity settings	NICE maternity guidelines	www.nice.org.uk/guidance/ng4	2015
Mental health staffing framework: a practical approach	Mental health toolkit	https://www.england.nhs.uk/6cs/wp-content/uploads/sites/25/2015/06/mh-staffing-v4.pdf	2015

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[2] https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf

[3] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/499229/Operational_productivity_A.pdf

[4] https://www.england.nhs.uk/wp-content/uploads/2015/12/planning-guid-16-17-20-21.pdf

[5] http://webarchive.nationalarchives.gov.uk/content/20150407084003/http:/www.midstaffspublicinquiry.com

[6] https://www.england.nhs.uk/wp-content/uploads/2012/12/compassion-in-practice.pdf

[7] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/270368/34658_Cm_8777_Vol_1_accessible.pdf

[8] https://www.england.nhs.uk/wp-content/uploads/2013/11/nqb-how-to-guid.pdf

[9] https://www.nice.org.uk/guidance/sg1

[10] https://www.nice.org.uk/guidance/ng4

[11] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/499229/Operational_productivity_A.pdf

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[14] https://www.england.nhs.uk/wp-content/uploads/2016/05/nursing-framework.pdf

[15] https://hee.nhs.uk/sites/default/files/documents/2348-Shape-of-caring-review-FINAL.pdf

[16] http://www.healthwatchcambridgeshire.co.uk/sites/default/files/hee_nursing_associate_consultation_document.pdf

[17] https://www.england.nhs.uk/wp-content/uploads/2013/11/nqb-how-to-guid.pdf

[18] https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf

[19] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/499663/Provider_roadmap_11feb.pdf

[20] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/499229/Operational_productivity_A.pdf

[21] https://www.england.nhs.uk/patientsafety/root-cause

[22] https://www.england.nhs.uk/patientsafety/serious-incident

[23] http://www.nice.org.uk/guidance/SG1

[24] https://www.nice.org.uk/guidance/ng4

[25] https://www.england.nhs.uk/patientsafety/report-patient-safety

[26] https://www.safetythermometer.nhs.uk/index.php?option=com_content&view=article&id=3&Itemid=10

[27] http://www.hqip.org.uk/national-programmes

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[30] https://www.gov.uk/government/publications/sir-robert-francis-freedom-to-speak-up-review http://www.kingsfund.org.uk/sites/files/kf/employee-engagement-nhs-performance-west-dawson-leadership-review2012-paper.pdf

[31] http://www.cqc.org.uk/sites/default/files/20150327_duty_of_candour_guidance_final.pdf

[32] https://www.rcplondon.ac.uk/guidelines-policy/work-and-wellbeing-nhs-why-staff-health-matters-patient-care

[33] http://www.hpc-uk.org/assets/documents/10003771Professionalisminhealthcareprofessionals.pdf

[34] http://www.kingsfund.org.uk/sites/files/kf/employee-engagement-nhs-performance-west-dawson-leadership-review2012-paper.pdf

[35] http://qualitysafety.bmj.com/content/early/2013/07/08/bmjqs-2012-001767

[36] http://www.kingsfund.org.uk/sites/files/kf/employee-engagement-nhs-performance-west-dawson-leadership-review2012-paper.pdf

[37] http://ro.ecu.edu.au/cgi/viewcontent.cgi?article=7278&context=ecuworks

[38] Health Education England is developing a set of e-learning modules on safe staffing for sisters, charge nurses and team leaders that will be published in 2016.

[39] https://hee.nhs.uk/sites/default/files/documents/HEE_J000584_QualityFramework_FINAL_WEB.pdf

[40] https://hee.nhs.uk/sites/default/files/documents/HEE_J000584_QualityFramework_FINAL_WEB.pdf

[41] http://www.nhsbenchmarking.nhs.uk/CubeCore/.uploads/NAIC/Reports/NAICReport2015FINALA4printableversion.pdf http://www.ncbi.nlm.nih.gov/books/NBK269522

[42] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/499663/Provider_roadmap_11feb.pdf

[43] http://www.nhsemployers.org/~/media/Employers/Documents/Plan/Mind%20the%20Gap%20Smaller.pdf

[44] http://www.institute.nhs.uk/quality_and_value/productivity_series/the_productive_series.html

[45] Further support and guidance will be issued at a future date.

[46] http://www.nhsemployers.org/your-workforce/plan/agency-workers/reducing-agency-spend/e-rostering

[47] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/478691/Agency_letter_to_trusts_post_consultation_final.pdf

[48] https://www.gov.uk/guidance/rules-for-all-agency-staff-working-in-the-nhs

[49] https://www.england.nhs.uk/ourwork/futurenhs/deliver-forward-view/stp

[50] Local patient FFT can be used to measure change over time where providers have local insight into any changes in data collection and completeness, but cannot be used to compare providers with each other, as data collection will vary.

[51] National patient surveys can be used to compare providers with each other, so even though they are only published annually, they provide important context for local FFT data. National patient surveys include questions on patients' perceptions of sufficient staffing and questions that act as indicators of staff capacity.

[52] Local staff FFT can be used to measure change over time where providers have local insight into any changes in data collection and completeness but cannot be used to compare providers with each other, as data collection will vary.

[53] National staff surveys can be used to compare providers with each other, so though they are only published annually, they provide important context for local staff FFT data. National staff surveys include questions directly asking about staff perception of sufficient staffing, or that act as indicators of staff capacity.

[54] The annual GMC national training survey collects medical trainee feedback on a wide range of topics and pivotal issues, such as intensity of work (by day and night), work beyond rostered hours, an expectation to cope with clinical problems beyond the trainee's competence or experience and the ability to attend regular specialty-specific training.

[55] Data collected through incident reporting systems or as serious incidents should never be presented as though they represented actual incidents or actual harm; this is important not because they will inevitably have missing data (as this is true for many other data sources too) but because to do so is counterproductive to the purpose of incident reporting. To support this, NQB partners have committed to using metrics drawn from National Reporting and Learning System and serious incident data only to identify implausibly low levels or patterns of reporting that may indicate issues with providers' safety culture or reporting processes. In the context of quality metrics for local consideration alongside CHPPD there is another important reason not to present local incident rates as simple dashboard metrics; overstretched staff may be less likely to find time to report incidents and provider boards could take false reassurance from this. Methods for assessing levels of under-reporting include annual skin surveys for pressure ulcers (http://www.sciencedirect.com/science/article/pii/S0965206X15000935) and case note review and the FallSafe under-reporting survey (see https://www.rcplondon.ac.uk/guidelines-policy/fallsafe-resources-original) for inpatient falls.

[56] These local sources can be used to measure change over time where providers have local insight into any changes in data collection and completeness but cannot be used to compare providers with each other, as data collection will vary and there are a range of factors other than quality of care that will affect outcomes.

[57] Safety Thermometer data can be used to measure change over time where providers have local insight into any changes in data collection and completeness (eg annual skin surveys http://www.sciencedirect.com/science/article/pii/S0965206X15000935 but cannot be used to compare providers with each other, as data collection will vary and there are a range of factors other than quality of care that will affect outcomes (eg age-related risk of falling).

[58] Data collected through incident reporting systems or as serious incidents should never be presented as though they represented actual incidents or actual harm; this is important not because they will inevitably have missing data (as this is true for many other data sources too) but because to do so is counterproductive to the purpose of incident reporting. To support this, NQB partners have committed to using metrics drawn from National Reporting and Learning System and Serious Incident data only to identify implausibly low levels or patterns of reporting that may indicate issues with providers' safety culture or reporting processes. In the context of quality metrics for local consideration alongside CHPPD there is another important reason not to present local incident rates as simple dashboard metrics; overstretched staff may be less likely to find time to report incidents and provider boards could take false reassurance from this. Methods for assessing levels of under-reporting include annual skin surveys for pressure ulcers (see above), case note review and the FallSafe under-reporting survey (see https://www.rcplondon.ac.uk/guidelines-policy/fallsafe-resources-original) for inpatient falls.

Belfast Health and Social Care Trust

Reference No: TP064/11

Title:	**Nursing and Midwifery Roster Management**		
Author(s)	Margaret Devlin, Senior Manager Nursing Workforce Planning and Utilisation		
Ownership:	Brenda Creaney Executive Director of Nursing and User Experience		
Approval by:	Standards & Guidelines Committee	**Approval date:**	Insert date each committee approved
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Date	Version	Author	Comments
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Feb 10	0.6	Margaret Devlin	Out for consultation
July 10	0.7	Margaret Devlin	Minor changes following feedback from RCN.
Oct 10	0.8	Margaret Devlin	Minor Changes following feedback from Staff side
4th August 2014	V1.0.1	Patricia Sheppard	New policy template

1.0 INTRODUCTION / PURPOSE OF POLICY

1.1 Background

Effective rostering ensures that there is the nursing and midwifery staffing resource in to ensure patient safety and minimise clinical risk. This policy aims to ensure safe/appropriate staffing for all departments using fair and consistent off duties and to harmonise shift patterns across the Trust. This Roster Management Policy has been devolved for use by all nursing and midwifery staff either ward or department based to ensure safe/appropriate staffing for all departments using fair and consistent off duties.

1.2 Purpose

This policy outlines best and agreed practice in relation to the rostering of nursing and midwifery staff and should be read in conjunction with the Trust:

- Attendance Policy
- Worklife Balance Policies
- Study Leave Policy
- Authorisation Framework

The purpose of this policy is to maximise the nursing and midwifery staffing resource in to enhance patient safety and minimise clinical risk.

1.3 Objectives

- To ensure that the required number of inpatient beds are adequately staffed to meet elective and emergency demand.
- To assist in ensuring safe/appropriate staffing for all departments for all shifts using fair and consistent off duties.
- To improve monitoring of sickness and absence by department and/or individual, generating comparisons, identifying trends and priorities for action.
- To improve planning of clinical and non-clinical “non-effective” working days e.g. annual leave, sickness and study leave).
- To provide effective management of staffing establishment in the nursing and midwifery workforce across wards/departments.
- To improve the utilisation of existing staff and reduce bank and agency spend by enabling Ward Sister/Charge Nurse’s and other relevant managers to have clear visibility of staff contracted hours

2.0 SCOPE OF THE POLICY

This policy is for use by all nursing and midwifery and relevant managerial staff within the Trust. The policy will also be used as applicable by Human Resource and Finance staff.

3.0 ROLES/RESPONSIBILITIES

Individual staff member

The Individual staff member has a responsibility to:

- Be available to work in conjunction with the policies, guidance and procedures of the Trust
- Work contracted hours.
- Be aware of annual leave allocation
- Apply for leave appropriately and inform the manager of leave request in a timely fashion as indicated in the local policy.
- Attend all learning and development activity that is allocated on the duty roster.

- Endeavour to maintain their fitness to work.

The Ward / Area / Locality Manager

The Ward/Area/Locality Manager has the responsibility for;

- Maximising the use of the resources available to them and highlighting any concerns regarding a deficit between staffing availability and patient care needs to their line manager with robust supporting evidence.
- Proactively planning, in conjunction with line manager, for any known likely deficits in staffing resource e.g. maternity leave.
- Publish the duty roster in a timely fashion. The Ward Sister/Charge Nurse may delegate this duty but maintains accountability for it.
- Ensuring expenditure does not exceed the allocated budget in their ward, unit and departments (hereafter referred to as wards).
- Working collaboratively and flexibly with colleagues in other areas to best match available staffing to patient care needs.
- Reviewing establishments annually or where there are significant ongoing changes to patient acuity/dependency.

Assistant Service Managers (ASM) /Service Managers/Designated Deputies

The relevant ASM/Service Managers/designated deputies will approve the roster for publication as safe and effective and will undertake the monitoring of the wards off duty and approve all shifts where temporary staff is requested, in line with the Trust's authorisation framework.

4.0 KEY POLICY PRINCIPLES

Definitions

This policy is for use by all nursing and midwifery staff either ward or department based. It will also cover any relevant community based staff. It will assist with the production of off duties based on funded establishments agreed by the Service Group management team and development of local policies on safe staffing. **ALL** wards/departments will develop and publish their written ward based policies on staffing. (Appendix 1).

Key Policy Statement(s)

Policy Principles

4.1 All ward/department duties will commence on a Monday.

4.2 Off duty must be completed at least four weeks in advance of its start date. This will enable staff to better manage their personal arrangements.

4.3 All off duties should be composed to adequately cover 24 hours utilising permanent staff proportionately across all shifts.

4.4 Shifts given a high priority must be filled first, i.e. nights and weekends. Ideally bank will be used Monday to Friday to ensure the appropriate supervision and support.

4.5 For staffs that have contracts that allow for working non–standard shifts such as late starts, this should be highlighted to avoid misinterpretation.

4.6 In non intensive care / highly specialist areas, Band 7 staff should not normally work nights, weekends or bank holidays without the express authorisation of the Service Manager.

4.7 Each area must have a funded staffing level reviewed annually or in line with service reconfiguration. This establishment must be agreed by Service Group Management team and Service Group accountant

4.8 Each area should have an agreed level of staff with specific competencies on each shift, i.e. the ability to take charge, staff able to administer IV drugs etc as agreed with the Ward Sister/Charge Nurse's.

4.9 In areas where the workload is known to vary according to the day of the week, rostered staffing numbers and skill mix should reflect this.

4.10 The off duty of senior ward staff must be compatible with their commitment to Service Group requirements e.g. Ward Sister/Charge Nurse's meetings. In the Ward Sister/Charge Nurse's absence, there must be a designated nurse in charge who has been identified as having the required skills and competencies for a co-ordinating role and who has an overview of the whole ward.

4.11 Ward Sister/Charge Nurse and their deputies should work opposite shifts where possible to provide the optimum senior cover for the ward/department/area.

4.12 Ward Sister/Charge Nurse should be on duty were levels of activity in the area are at the highest. Generally this will be during day time Monday to Friday.

4.13 Ward Sister/Charge Nurse may be required to work one weekend per rota period, although this can be split days, and nights only for a specific reason – e.g. supporting of permanent night staff.

4.14 Ward Sister/Charge Nurse should have 40% of their working week (currently under review regionally) as dedicated to managerial and supervisory time to support staff, carry out appraisals, audit etc.

4.15 Student nurses should be rostered with their mentor for a minimum of 40% of the time. If their mentor is unavailable, an associate mentor should be allocated.

4.16 Shift patterns must be arranged, to allow staff to have two consecutive days off in the week.

4.17 Consideration must be given to flexible working, however, these needs to be fair and equitable for all staff and reviewed on a regular basis.

4.18 Staff will be required to work a variety of shifts and shift patterns as agreed by their Ward Sister/Charge Nurse's. Ward Sister/Charge Nurse must ensure that staff are compliant with the Working Time Regulations (WTR).

4.19 Staff may work long shifts, short shifts or a combination of both in order to meet the clinical requirements of the ward or department. Variations to these shifts may be worked but must be agreed with the Ward Sister/Charge Nurse and be in keeping with the WTR (Appendix 2).

4.20 A written record of local shift agreement will be kept for all variations in shifts and will be reviewed on a six monthly basis.

4.21 Rostering of night duty should be consecutive. No more than 4 nights in a row should be allocated to a staff member.

4.22 All shifts must include a minimum 30 minute unpaid break if > 6 hours and 60 minute unpaid break for shifts of > 12 hours.

4.23 The Ward Sister/Charge is responsible for ensuring that breaks are facilitated.

4.24 Breaks must not be taken at the end of a shift, as their purpose is to provide rest time during the shift.

4.25 Staff must have a minimum of one weekend off per four week off duty, in normal circumstances. Additional weekends off can be rostered if the ward requirements allow.

4.26 No staff member should work more than four consecutive 12-hour shifts (days & nights).

4.27 Non-Effective working days when staff are unavailable during the four week roster period should equate to approximately 22% (currently under review regionally with a view to increasing to 24%) of the funded staffing for the area (Appendix 3).

4.28 Where there is a requirement for a patient to be "specialed" an individual risk assessment should be undertaken to determine how best to met this need (Appendix 4).

4.29 Each ward should use employee on line or a request sheet/diary for staff to make requests for all types of leave. These requests will be considered in the light of service needs. Staff should indicate if request is essential or desirable (Appendix 5).

4.30 The term Annual Leave is to be used within the context of the Trust Leave provision in line with Agenda for Change Terms and Conditions of Service (Appendix 6).

4.31 Study Leave will be assigned in line with the Trust Study Leave Policy (Appendix 7).

4.32 Sickness must be communicated by telephone to the Ward/Area/Locality Manager with as much notice as possible, prior to the shift commencing (Appendix 8).

4.33 Once the off duty is complete and validated by the Ward/Area/Locality Manager and there are deficits where additional shifts which are required, every effort to fill the shift from existing Service Group resources should be made i.e. inter ward transfers. Only when all else fails, should Trust protocol be followed and bank be considered (Appendix 9).

4.34 Unsocial shifts should be distributed evenly and fairly in accordance with agreed contractual arrangements (Appendix 10).

4.35 New staff is entitled to a period of support and orientation to the Ward/Dept/Locality. Cognisance should be taken when planning the roster (Appendix 11).

4.36 When the Ward Sister/Charge Nurse completes the off duty it must be made available to the appropriate Service Group management team. The relevant Service Manger (SM) or Assistant Service Managers (ASM) should be made aware of:

- Any gaps which remain in the off duty after all of the steps outlined have been followed.
- Shifts which may need temporary staff cover. The option of sourcing cover from other areas must always be explored in the first instance.

A copy of the roster should be made available for all nurses to view at least 4 weeks prior to roster beginning. This copy will be signed and dated by the Ward Sister/Charge Nurse's. All changes made, after the roster has been approved by the Ward Sister/Charge Nurse's, will be clearly marked for audit purposes.

5.0 IMPLEMENTATION OF POLICY

5.1 Dissemination

Central Nursing and Midwifery team
Senior Nursing and Midwifery team
Directorate staff
Human Resources' managers

Trade Unions

5.2 Resources

Workshops for Ward Managers on good roster practice
Workshops on the E Roster System

6.0 MONITORING

The effectiveness of this policy will be monitored through the Roster perform system

7.0 EVIDENCE BASE / REFERENCES

Delivering Care: Nurse staffing in Northern Ireland (DHSSPS 2014)

8.0 CONSULTATION PROCESS

This roster policy was developed by the e roster implementation group consisting of representatives of all Service Groups. It has been consulted on by the Senior Nursing Team, HR, Finance and Staff side.

9.0 APPENDICES / ATTACHMENTS

Appendix 1	Local Policy
Appendix 2	Shift Titles
Appendix 3	Non-Effective Working Time
Appendix 4	One to One Care of Individual Patients (Specials)
Appendix 5	Staff Requests
Appendix 6	Annual Leave
Appendix 7	Study Leave
Appendix 8	Sickness
Appendix 9	Booking of Extra Shifts
Appendix 10	Unsocial Hours/Time Owing
Appendix 11	Changes to Published Rosters
Appendix 12	New Staff

10.0 EQUALITY STATEMENT

In line with duties under the equality legislation (Section 75 of the Northern Ireland Act 1998), Targeting Social Need Initiative, Disability discrimination and the Human Rights Act 1998, an initial screening exercise to ascertain if this policy should be subject to a full impact assessment has been carried out.
The outcome of the Equality screening for this policy is:

Major impact ☐

Minor impact ☐

No impact. ☐

SIGNATORIES

_____ **Date:** _____

Margaret Devlin
Senior Manager Nursing
Workforce Planning and Utilisation

_____ **Date:** _____

Brenda Creaney
Executive Director of Nursing and
User Experience

Appendix 1

LOCAL POLICY

These local polices will include:

- Minimum staffing levels (number of staff) and skill mix (experience of staff required) by shift and by day and this must be reviewed on an annual basis in conjunction with the Trust budget setting process
- The production of a roster for a four week period
- The production of off duty at least 4 weeks in advance
- Both Trust and local rules about all types of leave, and in line with the Agenda for Change terms and conditions
- Will take into account seasonal adjustments and peak periods. i.e. Flu season
- Ward specific requirements for example additional beds or level 2 patients or enhanced supervision
- The maximum number of requests that can be considered for days off on any single date
- How far in advance requests can be entered, in order to ensure that staff joining the team have a fair chance of adding their requests
- Spread the use of leave throughout the year
- Defining local rules with regard to number etc that are required to take leave in order to maintain the use of leave within the 12-16% parameter for weekly leave.

Any flexible working arrangements must be openly acknowledged and published, i.e. the number of part-time posts a ward can permit, the number of fixed days (personal patterns) that staff work, which can be safely accommodated per ward. Historical working arrangements should be taken into consideration but the needs of the service must be paramount.

The Trust supports the principles embedded in Improving Working Lives (IWL) regarding work life balance, flexible working and family friendly working. However this should be set against the need to ensure safe levels of staffing to maximise the quality of patient care and reduce clinical and non-clinical risk. The Trust will seriously consider requests for flexible working, but may decline them if this pattern cannot be accommodated into the business needs. Achieving adequate staffing numbers and skill mix is the main priority. All other

factors are secondary to this, including requests, preferences, team coverage and study leave.

Staff have a responsibility to take annual leave in a timely manner bearing in mind the needs of the service.

Appendix 2

SHIFT TITLES

For the purpose of this roster policy it has been agreed to designate a number of commonly used shift titles for Trust wide use;

- Long Day (LD) – a shift that is worked for the whole day (e.g., 7.45am -8.45pm)
- Early (E) – a shift that starts first thing in the morning and lasts for a half day (e.g., 7.45am -2pm)
- Late (L) – a shift that commences after midday (e.g. around 1.30pm) and ends a shift finish time in the evening
- Day shift (DS) – a shift ending before 6pm e.g. 5.15 pm
- Night duty (ND) – a night shift
- Twilight (TL) – A shift that runs from evening through to early night e.g. from 4-30pm-11pm or midnight

Shift start and finish time can vary in some areas and this should be addressed in local policies. The nursing and midwifery bank office should be informed of any variation in shift times to facilitate the bank office to inform staff of variation form the norm.

Appendix 3

NON-EFFECTIVE WORKING TIME

Non-Effective working days are days when staff are unavailable during the 4 week roster period. Funded establishments (FE) have a % built into each ward or department establishment for time out. The total percentage of these should equate to 22% (approximately):

- Annual Leave - should be 14%, parameters set to 12 – 16.0 %
- Sickness - should be below 3%
- Working Day i.e. Management day, non-clinical day - less than 2%
- Study Days – less than 3%
- Total – less than or equal to 22%

This is currently under review regionally and it has been suggested that as new services are funded the % should be increase to 24%

- Annual Leave - should be 15% parameters set to 12 – 16.0 %
- Sickness - should be below %%
- Study Days – less than 4%
- Total – less than or equal to 22%

Additionally it is proposed that the Ward Sister /Charge Nurse should be 100% supervisory.

There is no additional time out allocated Maternity/Special leave built into the roster. Maternity leave can only be replaced with temporary staff to the value of 60% of WTE from the point that the staff member goes on half pay.

In any rostering period:

- Lost contracted hours – contracted hours not used over a 4-week roster period, should be less than 1%
- Over contracted hours – hours used over those contracted to work should be less than 1%

- Additional duties – any duties allocated that are above the agreed staffing requirements for the ward should be flagged up by the Ward Sister/Charge Nurseto the appropriate Service Manager for approval as this will be above the agreed establishment/budget.

Appendix 4

ONE TO ONE CARE FOR INDIVIDUAL PATIENTS (SPECIALS)

The Use of Additional Staff to provide one to one care for individual Patients (Specials)

- Individualised risk assessment should be undertaken to determine the requirement for a patient to be “specialed”. As part of this assessment consideration should be given to aspects such as the patient’s physical location in the ward, their degree of mobility, etc which could mitigate against the need for one to one observation
- Where possible patients should be *specialed* out of existing staffing levels. Where this is not possible consideration should be give to the most appropriate grade of the staff member required to care for the patient.
- Consideration should be give to the availability of staff from within the Service group to provide the additional staffing resource required
- If no-one is available and **all** appropriate steps have been taken to find staff from within the Service group resources, permission to book a special from bank should be sought from appropriate manager
- The requirement to “special” a patient must be reviewed on a frequent basis and, as a minimum, daily and the rationale for the specialing or why it is no longer required recorded in the patient’s care plan

Appendix 5

STAFF REQUESTS

- Staff requests should be made via *Employee online* in areas were E rostering has been introduced.
- In the absence of E rostering request Books should be standardised across the Trust
- These requests will be considered in the light of service needs. Staff should indicate if request is essential or desirable.
- While every effort will be made to accommodate staff requests, it can **not** be assumed by staff that the off duty will be written to accommodate them. This includes essential requests. Service needs will take priority. Staff must be considerate of their colleagues, and the requirement that they are fulfilling their share of weekend and night shifts
- To ensure equity all staff should be allowed a maximum number of requests per rota which should be agreed locally
- Requests for specific shifts or days off or on can be made. These are known as personal patterns. Service requirements and equity for other staff members must be taken into account when applying these. They **must be agreed and reviewed regularly** by the Ward Sister/Charge Nurse as indicated in the local policy.
- Requests from staff, who typically make few requests, should be given over requests from staff that makes numerous requests which are given. Each request should be considered on merit.
- *Employee online* and request books should have a close date and no further requests accepted after this date, in order to prepare the roster.
- If staff rostered wish to change their off duty post publication a fair swap should be made with another member of staff of the same grade and can only take place with the Ward Sister/Charge Nurse's approval.

Appendix 6

ANNUAL LEAVE

The term Annual leave is to be used within the context of the Trust Leave provision in line with Agenda for Change Terms and Conditions of Service.

- Annual leave is allocated in hours for all members of nursing staff and is dependent on length of service in line with Agenda for Change Terms and Conditions of Service.
- The Ward Sister/ Charge Nurse/ Locality Manager, or designated deputy, must approve all Annual Leave.
- Each ward/area/locality should calculate how many registered and unregistered nurses and midwives **must** be given annual leave in any one week to prevent peaks and troughs in leave arrangements. An agreed number needs to be set and adhered to. Staff should be made aware of the need to maintain this number constantly throughout the year.
- No holiday bookings or travel arrangements should be made until the Ward/Area/ Locality Manager has sanctioned the annual leave requested. An annual leave card must be completed and signed prior to annual leave being taken.
- Annual leave requests for peak holidays will be shared equally amongst those requesting.
- If annual leave is not booked in blocks of weeks and is to be taken ad hoc, all leave must be used before 31st March of each financial year.
- Individual staff members are responsible for taking and appropriately managing their leave.
- Annual leave must be booked or cancelled before an off duty is planned. Annual leave requested after this can only be given if staffing levels permit, near to the day.
- Annual leave must be booked at least 6 weeks in advance, except in case of domestic emergencies, and authorised by the Ward Sister/Charge Nurse
- All requests for annual leave longer than 2 weeks must be made in writing. Every effort should be made to give at least 3 months notice if staff have a request for more than 2 weeks annual leave
- In general 50% of leave should have been taken by staff by the end of September. It is expected that staff should only have 25% of their leave outstanding at the commencement of the final three months of the annual leave year except:
    1. By prior arrangement with the line manager.
    2. Due to the needs of the service.
    3. As a result of ill health/maternity leave.

Appendix 7

STUDY LEAVE (REFER TO TRUST POLICY)

- Ensure that mandatory training/ Statutory training is balanced throughout the year and assigned per rota.

- Study leave will be assigned in line with the Trust Study Leave Policy, and for registrants, the Trust Post-registration Education Commissioning Framework.

Appendix 8

SICKNESS (REFER TO TRUST POLICY)

- Sickness must be communicated by telephone to the Ward/Area/Locality Manager with as much notice as possible, prior to the shift commencing. At this point, a time and date will be agreed for the individual on sick leave to maintain contact with ward Sister.
- If off-duty days follow on from sick days, the Ward/Area/Locality Manager must be kept informed of recovery and unless notified off-duty days can be reclassified as sick leave.

Appendix 9

BOOKING OF EXTRA SHIFTS (taking into account competency required)

Once the off duty is complete and validated by the Ward Sister / Charge Nurse /Area /Locality Manager and there are deficits where additional shifts which are required, every effort to fill the shift from existing Service Group resources should be made i.e. inter ward transfers. Staff can also be offered additional hours or overtime. Only when all else fails, should Trust protocol must be followed and bank be considered.

- Additional resource should not be sought if annual leave requests that exceed the documented acceptable level for the ward
- There should be no use of bank and agency for bank holiday shifts unless approved by the relevant Service Manager in conjunction with the Ward Sister/Charge Nurse's
- Bank and agency staff cannot be used to take charge of wards unless they are known to the ward, and have been assessed as competent to do so, and are willing to take charge. This must be approved by the Ward/Area/ Locality Manager
- Out of hours the Service Group arrangements must be followed for the booking of staff
- Night and weekend shifts should be covered by substantive staff whenever possible, without imposing unreasonable strain on these staff
- Study leave should not be covered by temporary staff
- Staff that have informed the ward that they cannot work specific dates or times should not be working these on the bank. Additionally staff should not be working bank shifts whilst on any form of special or sick leave in the Trust.

Appendix 10

UNSOCIAL HOURS / TIME OWING

- Unsocial shifts should be distributed evenly and fairly in accordance with agreed contractual arrangements
- Any additional time worked to be claimed back, must be documented at the time worked – date, time, reason addition time worked – and verifier by the person in charge of the ward. When claimed back should be recorded and signed by a manager. Staff should be paid after 13 weeks if unable to get time off in lieu.
- Documentation off time in lieu should be standardised

Appendix 11

CHANGES TO PUBLISHED ROSTERS

- It will be the responsibility of the Ward Sister / Charge Nurse / Area/ Locality Manager to amend off duties with non-effective shifts i.e. sickness, no shows, and additional duties.
- Shift changes must be kept to a minimum.
- Staff are responsible for negotiating their own changes once the off duty is completed. These changes must be approved by the Ward/Area /Locality Manager or designated deputy in their absence.
- All changes should be made with an equal grade, and with consideration for the overall skill mix of all shifts being changed.
- Mentor were they have a student, should not change their shift without ensuring the student either also changes or is allocated to another suitable mentor, and that this is written on the off duty.

Appendix 12

NEW STAFF

- New staff are entitled to a period of support and orientation to the Ward/Dept/ Locality. Cognisance should be taken when planning the roster.
- In addition, newly qualified staff should work with their preceptor during their induction period, to ensure that their induction is completed and objectives are met. Ward Sister/ Charge Nurse should follow the guidance contained in the Trust's Preceptorship Portfolio when planning the roster to accommodate the new registrant working with their Preceptor or designated deputy.
- Any new starters should be added to the roster in advance of their start date and off duty planned for them in a timely fashion.

Belfast Health and Social Care Trust

Project Plan

Implementation of Electronic Rostering for Nursing & Midwifery Staff

February 2012 V.3

CONTENTS:

Implementation of an Electronic Rostering System for Nursing & Midwifery Staff

1.0 Introduction & Background

Since its establishment the Belfast Trust has been exploring the potential benefits of electronic rostering for its nursing and midwifery workforce. During this time 2 snap shot "workforce efficiency assessments" have been undertaken by a system provider, each covering 3 ward areas, to quantify the potential benefits of such a system. The option of a regional approach to purchasing a system has also been explored given the economies of scale that would have resulted and the fact that all 5 Trusts were interested in electronic rostering as one means by which to improve their utilisation of the nursing workforce.

The projected "savings" which were identified by the Roster Assessments were viewed to be overly optimistic and this, in combination with the costs of purchase which were being cited at that time, deterred the Trust from progressing.

However, there have been a number of developments over the course of the last year which have led to the Trust reviewing this position:

- The potential costs of procuring a system have been revised markedly downwards by suppliers
- In order to drive down reliance on bank/agency the Trust is encouraging "helping out" between and across wards, specialities and sites. Co – ordinating this is very labour intensive and limited in its scope when relying on going from ward to ward to establish staffing compliments
- Related to the above point, 2 major incident live exercises have demonstrated how difficult & time consuming it is to establish the potential to shift staff resource to areas of greatest need when there is no central access to rosters
- The Trust has developed a Rostering Policy for Nursing & Midwifery staff but the monitoring of its implementation to ensure maximum benefit is very difficult when relying on only manual rostering systems

- Whilst much work has been undertaken to establish core nurse to bed and skill mix ratios for a wide range of specialities, without effective rostering (which electronic system will support) this work alone will not ensure appropriate staffing levels and mix per shift
- The progression of the Business Services Transformation Programme (BSTP) to a point where it can be ensured that, whatever electronic rostering system the Trust would procure and introduce, it will fully take account of BSTP requirements
- Other Trusts in NI have now progressed to procuring electronic rostering packages for their nursing & midwifery workforce and are at various stages of implementation/roll out.

In light of all of the above the Trust is now progressing to procuring an electronic rostering system. This Project Plan outlines how the implementation of the system will be supported and managed.

2.0 Funding the Project

2.1 Capital

The Trust has secured Capital Funding for the project through the Internal Capital Bid Evaluation process. This funding must be spent by the end of the current financial year i.e. 31st March 2012.

2.2 Revenue

It is anticipated that the introduction of electronic rostering will reduce demand for bank/agency staff. This will enable an element of the existing resource within the Trust bank office to be redirected to support the phased roll out of electronic rostering. To reflect this, the team will be renamed the:

Nursing & Midwifery Workforce Utilisation Team. (WUT)

The Senior Manager for Nursing Workforce Planning & Utilisation will project manage the implementation and this will be the key element of

her work plan for the remainder of this financial year and a significant element of it for the 2 subsequent years until roll out is complete.

The only additional resource, **funding for which will be sought from the service groups on a pro rata basis** reflecting the number of areas which will ultimately use the system, will be for an Electronic Rostering Manager. This will be a three year internal secondment post which it is anticipated will be desk top matched at Band 7. The proposed job description for this post is attached in appendix 1.

BHSCT IT colleagues have agreed that they will nominate an existing member of staff to link with the Project Team and have already provided expert technical input to the tender document.

BHSCT finance colleagues have agreed that they will allocate a dedicated payroll member of staff to link with the Project Team and support this critical element of implementation.

3.0 Current Situation

At present the nursing & midwifery rosters are drawn up manually by the ward/department manager, team leaders or their deputies. This manual process requires a significant time commitment and must take account of complicating factors such as skill mix, the European Working Time Directive (EWTD), contracted hours and annual leave.

The current process also results in:

- Often less than effective management of the Nursing/Midwifery establishment per shift;
- Often less than desirable levels of data quality, no means of assimilation of data relating to rosters for reporting & monitoring purposes and a very wide range of shift start/end times across the Trust with no easy means of checking for EWDT compliance;

- No automation of processes or interfaces of systems resulting in manual timesheets and bank/agency authorisation processes;
- The Trust's existing bank system has no means of interfacing with an entirely manual rostering process meaning that any gaps identified in rosters then have to be manually alerted to the bank office and similarly shifts filled by the bank office have to be manually entered in to the manual roster.

4.0 The Project Aim & Objectives

The overarching **aim** of the project is to:

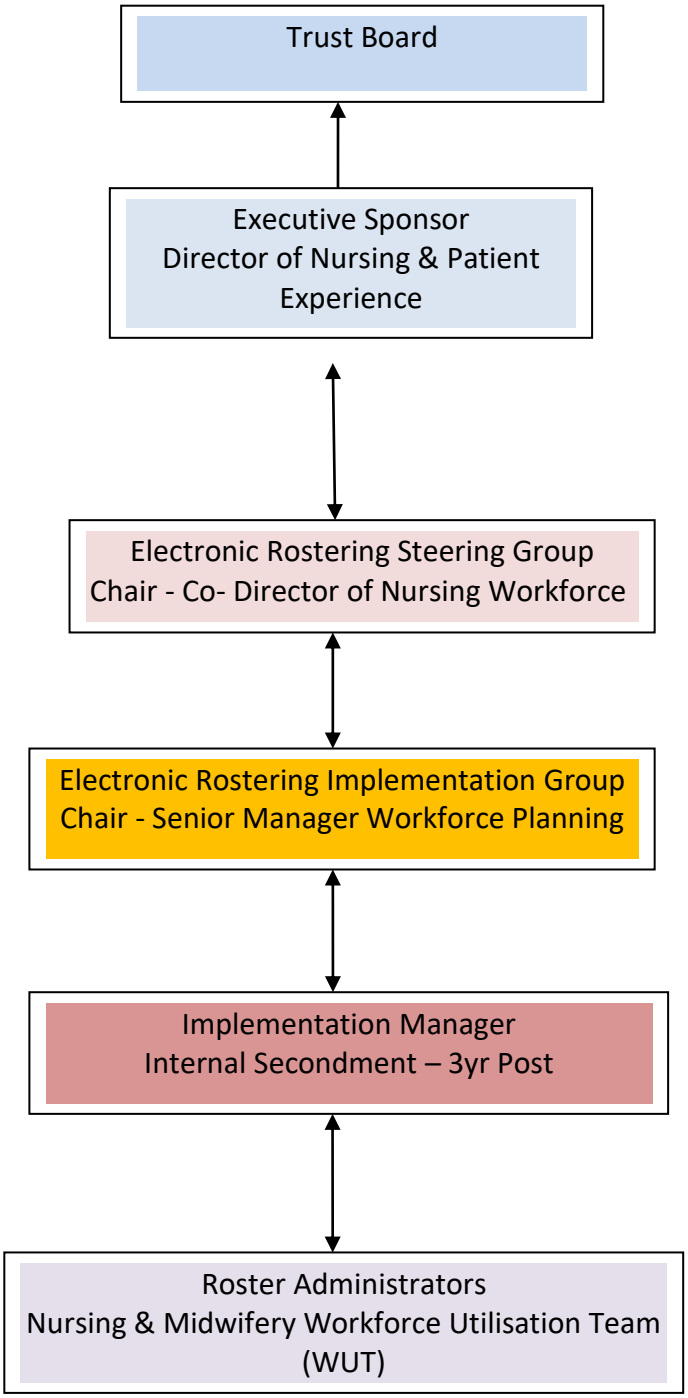
- *Implement an Electronic Rostering and Bank System for Nursing & Midwifery Staff which will support the most efficient and effective use of the workforce*.

The following **objectives** are designed to produce the outcomes required:

- Automate a number of existing manual processes:
  - Reducing the time Ward Sisters/Charge Nurses or their deputies have to spend creating the rota releasing more of their time to focus on improvements in quality, safety and patient experience
  - Reducing the time payroll staff have to spend processing timesheets and bank/agency payments
  - Reducing the time bank office administrative staff have to spend communicating allocations to ward/departmental areas
  - Provide accurate information
- Maximise the use of the existing staff resource on each shift and in so doing reduce the need for backfill/additionality
- Prepare those staff involved for working with a "self service" type system – a method of working which will become the norm with the BSTP implementation
- Co-ordinate training for all staff involved in the rostering system to the appropriate level for their usage and support them in implementing the new system

- Provide management information which will support the most effective utilisation of the nursing & midwifery workforce in the areas where the system is introduced
- Within the capital funding available , deliver electronic rostering to as many areas as possible where shift patterns cover the 24hr/5 – 7 day per week period within 36 months

5.0 Project Management and Governance Structures



6.0 Roles & Responsibilities

6.1 Project Executive Sponsor

This will be the Executive Director of Nursing & Patient Experience. She will provide updates to the Trust Executive Team on the progress of the project and will be the point of contact for the Chair of the Trust Electronic Rostering Steering Group. The Executive Sponsor will update Trade Unions on the progress of the project through the Trust Nursing Workforce group

6.2 Steering Group

For full membership of Steering Group see Appendix 1.

The **Electronic Rostering Steering Group** will be chaired by the Co – Director for Nursing Workforce who will hold overall responsibility for the delivery of the project.

The Company appointed to deliver the electronic rostering system will be known as the **supplier** and will be responsible to the Steering Group for delivery of the agreed system.

Senior Users. The system will directly impact on Finance and HR services and therefore these groups will be represented at a senior level (Co-director/ Service Manager).

Senior Customers. All 4 service groups will be represented on the Steering Group at a senior level (Co-director/ Service Manager). The representation will also reflect the importance of considering both the professional and managerial requirements by including Associate Director of Nursing/Midwifery representation and general manager representation

Specialists. Technical expertise will be provided by the Trust's IT Co – Director whose role will be to provide IT specialist advice. The Trust's BSTP Project Lead will provide advice regarding the linkages between the two projects. The BSO Head of Procurement will provide the Steering Group with Specialist Advice regarding the tender process.

Electronic Rostering Project Manager will attend all Steering Meetings.

6.2.1 Steering Group Terms of Reference

The Steering Group will:

Be responsible for directing the project, this includes approving project structures, plans and documentation and providing guidance to the Trust Project Manager and Project Team

Ensure the establishment of a Trust wide electronic rostering and Bank system within the agreed time scale and agreed budget

Facilitate and oversee the work of the Project Working Group and report on progress to the Trust Executive Sponsor

Be responsible for reacting in a timely manner to exception situations

Review each completed stage of the project, authorising progress to the next stage, ensuring that all stages are delivered in line with the agreed project plan, resources and timetable

Provide assurance that all products have been delivered satisfactorily and in a timely manner, and that all outcomes required to realise anticipated benefits have been produced

Ensure there is appropriate alignment with existing internal and external work streams that fall outside the scope of the project and exercise appropriate controls in relation to this when changes are being planned and implemented

Be responsible for approving the Communication Strategy for the Project and supporting the Project Manager in establishing and maintaining clear and agreed channels of communication with all stakeholders

Read papers, which will be circulated at least two days in advance of scheduled meetings, and associated information in order that decisions can be made in a timely and efficient manner at Steering Group meetings.

Contribute to the agenda which will include the following standing agenda items (among other items as appropriate):

- Progress against agreed project plan and anticipated benefits;
- Communication;
- Risks to the project;
- Project issues; and
- Resources;

Meet on a monthly basis to consider the work of the Project. Quorum group for the project requires presentation from All service groups to be present. Decision making requires a quorum to be present.

Working Group for the duration of the project

Authorise project closure and conduct post project review as required.

6.3 <u>The Electronic Rostering Implementation Group</u>

For full membership of the Implementation Group see Appendix 2. The Implementation Group membership has been selected to ensure that all affected work areas are represented and can share their expertise for the benefit of the project. This includes representatives from staff groups most affected by Electronic Rostering i.e. Service Groups, relevant functions in Finance and HR and IT who will act as leads for relevant work streams.

The **Implementation Group** will be Chaired by the Senior Manager, Nursing Workforce Planning. The Implementation Group Chair is responsible for setting up the Team, convening and chairing meetings, ensuring the activities and decisions of the group are recorded, progressing actions to a satisfactory conclusion. The Implementation Group Chair will work closely with the Steering Group chair to plan and implement all work to ensure it is in line with the project plan.

6.3.1 Terms of Reference for the Implementation Group

The Implementation Group will work closely with the Project Manager to plan and implement all work to ensure it is in line with the project plan.

The Chair of the Implementation Group will work closely with the Trust Lead and team member (work stream lead) to ensure that related work packages are completed on time for sign off by the Steering Group/Implementation Group as agreed. Relevant related issues to be raised at Implementation Group meetings

Service Group, HR, Finance and IT leads will be responsible for updating the Implementation Group Chair on activities undertaken and where necessary will be responsible for establishing and leading a sub-group for those activities

The Implementation Group's work will be carried out in tandem with work already proceeding under the remit of the HRPTS, FPL and Shared Services Projects

Implementation Group members are responsible for:

Consulting with and representing the views of their professional colleagues within the scope of the project, and keeping them informed of progress in line with the Communication Plan.

Advising, making recommendations and preparing exception reports and other required documentation for submission to the Steering Group for review, decision or approval;
Ensuring there is no duplication of effort between work streams in delivering interrelated products and that no work is overlooked;
Advising the Group of any forecast deviations outside the agreed project tolerances;
Managing project issues and risks and developing contingency plans, reporting on or escalating risks and issues to the Steering Group as appropriate;
Undertaking appropriate consultation with stakeholders; and
Ensuring that quality criteria and checking arrangements have been developed for all products and assist in monitoring the project.
The frequency of Implementation Group Meetings will be determined by the needs of the project; however as a minimum the Team will meet on a monthly basis.

- Co-ordinate the work of all work streams within the project structure, monitor progress and advise of relevant project issues;

- Prepare a range of reports for the Steering Group including highlight reports and exception plans when agreed tolerance levels are forecast to be exceeded.

6.4. Directorate Working Groups

The directorate working groups are in place to support, liaise and instruct service area managers and ward managers on the roll out criteria for electronic rostering. Key responsibilities include;

- Harmonise and agree shift patterns within their directorate;
- Communicate accurately and effectively within the directorate;
- Identify and agree shift priorities;
- Agree a common set of Directorate rules in line with the Roster Policy;
- Agree the Roll out criteria;
- Ensure all family friendly working patterns have been agreed, signed off and recorded appropriately with Human Resources;
- Liaise with finance departments to ensure funded establishments are correct and honour core nurse to bed ratios;
- Agree the authorisation of bank and agency usage within their directorate.

6.5 Project Manager

The Project Manager will act on behalf of the Steering Group in co-ordinating the work programme to an agreed timetable and budget. The Project Manager will have the authority to run the project within the constraints laid down by the Steering Group. Key responsibilities include:

- Ensure work proceeds in line with the agreed timelines for the Project;
- Monitor progress against the agreed project plan, secure approval of the Steering Group when required, and produce the outcomes required;
- Maintain an overview of risk and ensure appropriate action is taken to avoid, mitigate and manage risk;

- Ensure the development of an agreed communication plan and all other relevant project documentation for the programme are in place;
- Attend all Steering Group meetings;

6.6. Implementation Manager

The Implementation Manager will take forward the day to day management of the implementation of the project. They will manage the project team through the implementation phases of electronic rostering throughout the Trust and will take forward the work strands for the project. Key responsibilities include;

- Assist in the development of an agreed communication plan to gain buy-in and support from key project stakeholders;
- Plan and manage the workload of roster administrators;
- Report on the progress of the project to the Implementation Group and provide updates to the Project Manager for feedback to the Steering Group.
- Attend all Implementation Group meetings;
- Provide support to the Directorate Working Groups.

6.7. Roster Administrators

Roster administrators are responsible to the Implementation Manager for the phasing of the roll out plan and daily maintenance of the project. They will assist the ward managers in the gathering, dissemination and manual upload of reference data onto the electronic system in preparation for the development of duty rosters.

7.0. Implementation Phasing

Given the very large number of areas that electronic rostering will have relevance for in the Trust it will be necessary to develop criteria against which the sequencing of roll out will be determined. The ratification of these criteria and the resultant roll out plan will be agreed by the Steering Group on which all service groups are represented.

With regards to the pace of roll out, potential system suppliers have recommended a roll out rate of four wards becoming operational in the first month with six wards per month thereafter. Given the very limited additional resource that will be available to support this project (1wte Roster Manager) it is proposed to conservatively plan for a roll out rate of four wards per month. This will be increased to six per month if the downturn in bank/agency usage is sufficient to free up additional resource from the Workforce Utilisation Team or additional support from outwith the team becomes available.

APPENDIX 1 – MEMBERSHIP OF STEERING GROUP

Representative	Title	Role
Nicki Patterson	Nursing Co-Director Workforce Planning & Development	Chair
Ann McBrien	Co-Director Finance Resource Utilisation	Senior User Finance
Damian McAlister	Co-Director HR Pay, Partnership and Employment Relations	Senior User HR
Janet Johnston	Associate Director of Nursing & Acting Co – Director Acute Services	Senior Customer
Ruth Clarke	Associate Director of Midwifery/ Head of Midwifery & Maternity Services Manager	Senior Customer
Gillian Traub	Service Manager Cancer & Specialist Services	Senior Customer
Gabby Tinsley	Associate Director of Nursing & Service Manager Social & Primary Care	Senior Customer
Paul Duffy	Co-Director ICT	Specialist
Oonagh Burns	BSTP Project Lead	Specialist
Margaret Devlin	Senior Manager	Project Manager & Chair of Implementation Group

APPENDIX 2 – MEMBERSHIP OF IMPLEMENTATION GROUP

	Representative	Title
1	Margaret Devlin	Senior Manager Workforce Utilisation & Planning - Chair
2	Colm Quinn	Nursing and Midwifery Bank Manager
3	Roisin Mc Mahon	Roster Implementation Manager
4	Marie Heenan	HRMS Manger for Nursing
5	Sinead O'Hanlon	Dept. Nursing and Midwifery Bank Manager
6	Monica Molloy	Senior Manager HR
7	Martin Marley/Moyra Goodfellow Heather Kerr Joanne Gorman	Finance
8	Jon Simms	Senior Manager ICT
9	Gareth Rowley/Jan Pady	Representative from Allocate
10	Lesley Mitchell/Mary Gilleece	Clinical Coordinator for Nephrology
11	Joyce Shaw	Cancer and Specialist Services
12	Moira Kearney	Cancer and Specialist Services
13	Joe Mc Cambridge Catherine Harte Melanie Fitzpatrick	Trade Unions Representative
14	Paul Caddell Liz McAlea Paula Hughes	Ward Sister / Charge Nurse from each of the Service Groups
15	Angela Pollock	Specialist Hospitals & Women's Health
16	Patricia Sheppard Lorna Bingham	Acute Services
17	David Robinson	Cancer and Specialist Services
18	Ester Rafferty	Adult Social and Primary Care
19	Louise Hall	Adult Social and Primary Care
20	Phil Farrell	
21	Heather Kyle	

Appendix 1 Phase 1 Work Plan

		2011											
	Belfast Trust Electronic Rostering System	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
1.0	**Procurement Process**												
1.1	Develop Tender Specification												
1.2	Go out to tender												
1.3	Identify staff to select supplier												
1.4	Award Contract												
2.0	**Structures**												
2.1	Establish Steering Group												
2.2	Establish Working Group and any sub groups required												
2.3	Appoint Roster Manager												
3.0	**Implementation – Phase 1 first 6 months – 24 Wards**												
3.1	Identify priority areas for Phase 1 Roll Out and scope number of licenses required												
3.2	Identify data required to be uploaded on to the system												
3.3	Oversee assimilation of current bank staff on to the new system												
3.4	Ensure IT infrastructure is in place												
3.5	Train project staff and ward sister/charge nurse support officers in the use of the new system												
3.6	Train those who will be using & accessing the system: Service Managers Ward/Department Sisters & their deputies Ward Staff												
3.7	Scope any additional staff who need to be trained in the use of the system and arrange training for them												

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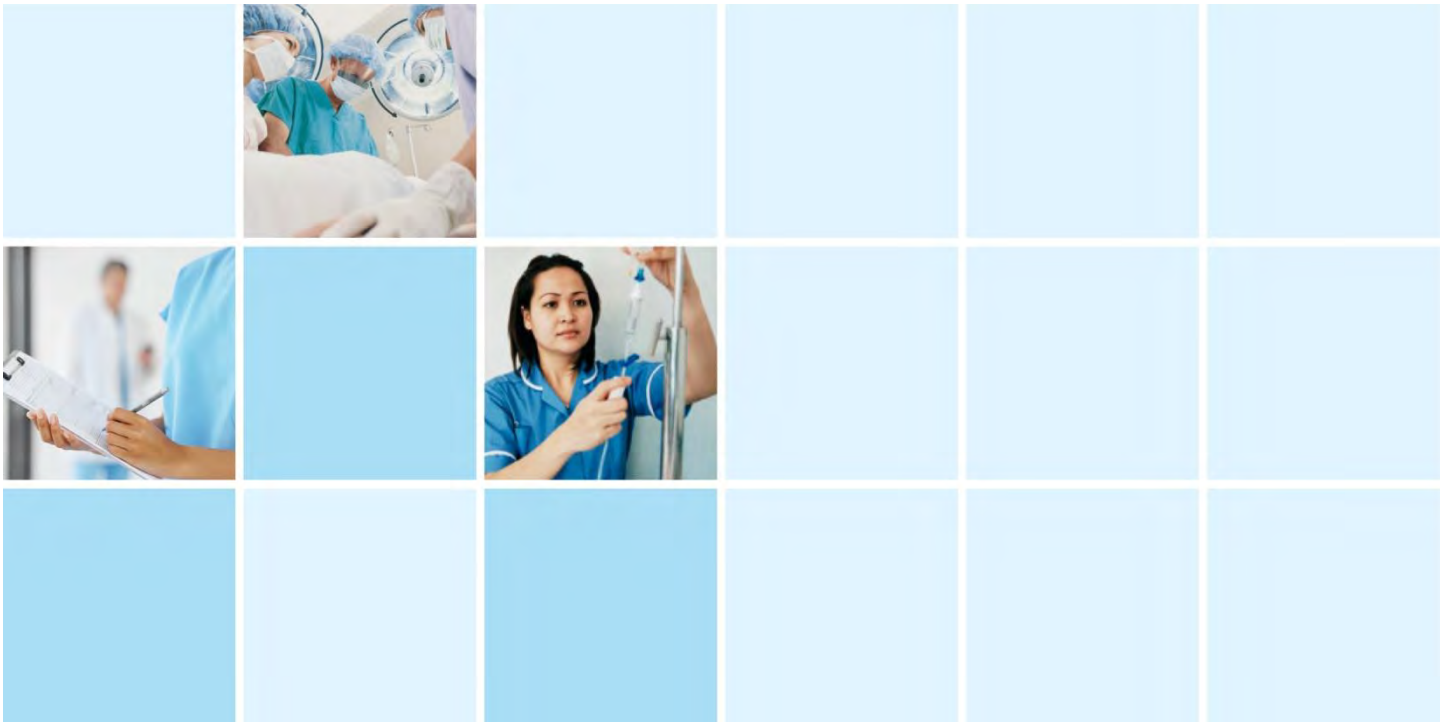
		2012											
	Belfast Trust Electronic Rostering System	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
1.0	**Procurement Process**												
1.1	Develop Tender Specification												
1.2	Go out to tender												
1.3	Identify staff to select supplier												
1.4	Award Contract												
2.0	**Structures**												
2.1	Establish Steering Group												
2.2	Establish Working Group and any sub groups required												
2.3	Appoint Roster Implementation Manager												
3.0	**Implementation – Phase 1 first 6 months – 24 Wards**												
3.1	Identify priority areas for Phase 1 Roll Out and scope number of licenses required												
3.2	Identify data required to be uploaded on to the system												
3.3	Oversee assimilation of current bank staff on to the new system												
3.4	Ensure IT infrastructure is in place												
3.5	Train Roster Administors												
	Train ward sister/charge nurse and support officers in the use of the new system												
3.6	Train those who will be using & accessing the system: Service Managers Ward/Department Sisters & their deputies Ward Staff												
3.7	Scope any additional staff who need to be trained in the use of the system and arrange training for them												

Allocate Software health right people. right place. right time.



Implementation Workshops - Healthroster

Version ALL1.0
Status Final
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Table of Contents

1 Document Purpose

The objective of this document is to provide the information required to implement Healthroster on-going.

2 Workshops

2.1 Workshop 1 – Cluster Kick Off (2 hours)

This workshop is for anyone in the cluster who will be involved in the e-Rostering project. It provides an introduction to e-Rostering and explains what will happen during the implementation of their ward/unit.

Task	Complete
• Ensure room is booked • Projector available • Mobilisation presentation prepared • **INSERT PRESENTATION** • Demo database prepared **Tasks:** • Request attendees bring list of time owing to workshop 2 • Holiday requests • Manual Roster •	

2.2 Workshop 2 and 3 – Data Gathering (1 Day) Data Input (1 Day)

During workshop 2 ward/unit information is gathered in detail, including staff details, rostering rules, checking ESR data is correct, establishment etc. Attendees should include the Roster Creator, Roster Approvers at both levels and Divisional/Directorate Managers. The Budget Holder should also attend if they differ from the other attendees.

Some of the tasks in these workshops may be carried out in one day depending on the size of the ward/unit.

Note: Run the dummy rosters without the ward/unit present and only show them once the e-Rostering Team are happy with the roster.

Task	Complete
Attendees: • Healthroster Administrator(s) • Roster Creators • Roster Approvers • Ward/Unit Manager (if different to the above) • Divisional Managers	

Task	Complete
Administration: • Confirm location of workshop • Confirm attendees • Confirm receipt of workbooks • Confirm availability of projector	
Tasks: If access to Healthroster is available then enter the following information directly into the system. The workbooks must be maintained and updated as the workshop progresses and sign off obtained. Collect (and input if facilities allow) the following data: ○ User names and job roles e.g. Roster Creators, Approvers, viewers – NB: prefix role in front of User Name, e.g. Roster Creator Jan Pady ○ Shift Details ○ Number of beds ○ Grade Types e.g. RN, HCA etc. ○ Template requirements e.g. E,L,N,LD: Use the standard 28 day – use the Grade where possible if not Grade Type ○ Competences ○ Valid Shift combinations and Rules ○ Staff changes ○ Staff personal details ▪ Telephone number ▪ Contact details etc. ○ Contract details ○ Global patterns ○ Personal patterns ○ Identify Teams ○ Identify order in which staff are to appear on roster ○ Identify students/trainees ○ Import annual leave requirements from ESR ○ Add Roster Budgets and Post WTE Budgets (optional) ○ Add and Link Cost Centre Codes (optional) ○ Extract Address & NMC sheet from ESR Gateway and send to ESR to complete • Time owing – Hours accounts • Complete Data Gathering Workbook • Obtain sign off of Workbook.	

Task	Complete
Data Gathering Sheet New v1.doc	
Auto Roster: • Create a roster using the information gathered and auto roster • Print off a copy of the roster and confirm with Roster Creator that it is a workable roster. **Steps to Creating a Roster for Healthroster Administrators** 1. Ensure people are loaded 2. Create Teams (in Optimiser) Edit Unit – Group Tab (if applicable) 3. Move staff to appropriate teams (if applicable) 4. Put people in correct order on roster (Edit Person Screen – Competences Tab – Off Duty Sort Index) a. Assign competences (My Staff - My Staff Details) b. This can be done in bulk if appropriate 5. Create shifts a. Remember the DO shift must start after the Night has finished b. All shifts might not be auto rostered **c. Check rules as you go for warnings** 6. Check Auto Roster Rules are set correctly for Rules that have been created – remember rules are assigned to logins a. Assign rules to individual logins as appropriate (Tools – Auto Roster Settings Manager) 7. Create Roster Template a. Name the roster as standard format – good practice to add the name of the ward/unit name on the template b. All rosters are 28 days c. If creating additional rosters i.e. Christmas, Easter etc. make sure the name is easily recognisable 8. Create Rules a. Don't forget inclusions and exclusions b. Ensure the Night rule is set correctly 9. Create Global Patterns a. Check that you have sufficient global patterns to cover the hours people work. Go to My Staff - View Staff Details to see hours 10. Create Personal Patterns (do this from My Staff Details - Add Personal Pattern) a. You may need to adjust the times of the shift(s) 11. Add a Roster from Template	

Task	Complete
12. Add non-effectives – use the Roster Analyser to check that sufficient has been created 13. Manually assign a selection of Requested Shifts for more accurate first pass 14. Manually assign shifts to individuals to check for errors 15. Run the Auto Roster – view the roster 16. Check Roster Analyser.	
Admin Tasks: Print off rules and shift patterns and add to sign off sheets for approval.	

2.2.1 Common Rules

General Restrictions:

- Max 3/4 nights in a week
- Max 8 nights in four weeks
- Max 3 LDs in a week
- Max 3/4 Lates in a week

Invalid Combinations

- Max 3/4 nights in a row
- Max 3 LDs in a row
- 2 days off after nights

Previous and Next Shifts

- Do not Use

Weekend Restrictions

- 1 weekend off in 4

Non-effective Rules

- A/L Max Concurrent episodes
- Global Non-effective rules – sickness requires certificate (medical)
- Max episode length for leave

Working Time Directive Rules (see section XX)

2.3 WORKSHOP 4 – ROSTER CREATOR TRAINING (1 DAY)

Task	Complete
Attendees: • Healthrster Administrator(s) • Roster Creators	
Administration: • Confirm location of workshop • Confirm attendees • Remind attendees to bring details of shift and holiday requests to the session • Ensure that Auto Roster rules are working • Ensure that logins are set up and working • Issue copies of Quick Reference Guides • Issue copies of User Guides • Issue copies of training exercises.	
Tasks with Healthroster Administrator 1. Review Staff Data spreadsheet a. Confirmation of all mandatory details and that others as appropriate are correct b. Obtain competence information and add to end of spreadsheet (do not forget to remove this before uploading people data but do remember to assign the competences once the people data has been uploaded) c. Note: hours available to work are the contracted hours, not what they would like to do/have been used to doing 2. Obtain information re Teams and order in which staff should appear on the roster a. This can be done using an existing roster 3. Shifts a. Confirm start and end times b. Confirm break duration c. Confirm Shift Short and Long Name (remember short name is what is printed on the roster) d. Check whether shift should be auto rostered and priority of auto roster	

Task	Complete
4. Establishment a. Confirm numbers and type of staff required on each shift b. Confirm number and type of competence required on each shift c. Confirm if optional shifts are required – these are normally only used by clinics 5. Personal Patterns a. Obtain personal pattern information (named shifts and adjusted times if appropriate) – remember personal patterns should only be for people who work the same shift on the same day every day they are available to work 6. Rules (Note: confirm if Policy has been ratified and explain rules accordingly) a. Work through the policy rules adding exclusions/inclusions as appropriate b. Review all other rules as per Rules and Competences workbook *Note: Rules are Pro Rata based on contracted hours* 7. Global Patterns a. Review Global Patterns and remove those that are not appropriate (e.g. those that may contain patterns which break rules) 8. Photocopy old rosters and current rosters – make note of any strange shifts with explanations. Question certain areas with them to understand the roster. Note: The Ward Sign off Spreadsheet must be kept up to date as this forms part of the sign off/approval process and is also useful for audit purposes.	

2.3.1 Roster Creator Training Activities

Task	Complete
Enter baseline roster **Attendees:** • Healthroster Administrator(s) • Roster Creators	
Administration: • Confirm location of workshop • Confirm attendees • Confirm projector	

Task	Complete
• Remind attendees that they need to bring their User documentation to the session	

Roster Creator Training, ensure that the following tasks are covered:
• Logging in to Healthroster
• Navigation and screen terminology
• Using the calendar
• Viewing and Editing People
  ○ People Search
  ○ Details Pane
  ○ Edit Person Form
  ○ Adding address details
  ○ Viewing work contracts
• Skills and Training
  ○ Adding a competence
  ○ Editing a competence
  ○ Deleting a competence
  ○ Adding competences in bulk
  ○ Extra competences
• Non-effectives
  ○ Adding a non-effective
  ○ Long term non-effectives
  ○ Assigning a non-effective in bulk
  ○ Editing a non-effective
  ○ Deleting a non-effective
• Viewing and Exporting Data
  ○ Changing Visible Columns
  ○ Exporting to Excel
• Managing Hours Accounts
• Teams
• Rostering
  ○ Adding a roster from a Template
  ○ Navigating the Roster Screen
  ○ Viewing Vacant Duties
  ○ Assigning Duties Manually
  ○ Assigning Long Day Shifts
  ○ Removing a Duty from a Person
  ○ Recording a Duty as a Request
  ○ Clear Duty Assignments
  ○ Adding Notes to a Roster
  ○ Closing a Roster to Requests	

Task	Complete
○ Assigning Requests and Non-effectives ○ Record Part Non Effective Part Day ○ Run Auto Roster ○ Manually Assign Remaining Duties ○ Swap Duties ○ Adjust Duty Times ○ Create Additional Duties ○ Revalidating Shifts in Bulk ○ Revalidating Shifts Individually ○ View Roster Analyser ○ Partially Approving a Roster ○ Fully Approving a Roster ○ Viewing Staff leagues ○ View Off Duty One Week Report ○ View Four Week Report ○ Ward Manager Report ○ Record Absences ○ Cancel a Duty ○ Record a Duty as Overtime ○ Record On Call Time ○ Checking Staff Hours ○ Daily Staffing and Incident Planning ○ Finalise Duties for Payroll ○ Unlock Timesheets ○ Run Finalise for Payroll Report ○ Run Sickness Report by Person by Reason ○ Run Additional Duties Report ○ Skills and Certificates Task Group ○ My Staff Unavailability Task Group	

2.4 Workshop 5 – Updating and Approving a Roster, EOL, Reports

1 day workshop per ward/unit, 2 units attending – 1 per session

Note: try to ensure that the Matrons attend this workshop if possible to assist with the resolution of any issues which may arise.

Task	Complete
Attendees: • Healthroster Administrator(s) • Roster Creators	
Administration: • Confirm location of workshop • Confirm attendees • Confirm projector • Handout relevant Quick Reference Guides • Issue Training Feedback Forms • Send Training Feedback Forms to Project Office or Project Lead.	

Tasks:
• Maintain previous month's roster
• Approve new roster
• Employee on-line Training
• Reporting
• Navigation and Terminology
• Using the Calendar
• Person Search
• Details Pane
• Edit Person Form
• Viewing Address Details
• Viewing Work Contracts
• Changing Visible Columns
• Exporting to Excel
• Navigating the Roster Screen
• Viewing Vacant Duties
• Viewing the Roster Analyser
  ○ Summary Tab
  ○ Details Tab
• Final Approval
  ○ Approve/Reject Roster
• Rosters Requiring Approval	

Task	Complete

• Finalising Roster for payroll
• Requesting Shifts from Bank (if appropriate)
• Viewing Staff Leagues Table
• Viewing off Duty One Week Report
• Viewing off Duty Four Week Report
• Ward Manager Report
• Filter Reports
• Management Reports
  ○ Sickness Report by Person by Reason
  ○ Additional Duties Report
  ○ Cancelled Duties Report
  ○ Finalising for Payroll Report
• Nursing Hours Per Patient Per Day (if appropriate)	

2.5 Workshop 6 – Approving and Analysing a Roster – ½ Day All Units in Cluster

Task	Complete
Attendees: • Ward Matrons (all units in cluster) • Roster Approvers at second level	
Administration: • Confirm location of workshop • Confirm attendees • Confirm projector • Handout relevant Quick Reference Guides.	
Ensure that the following activities are covered: • Navigation and Terminology • Using the Calendar • Person Search • Details Pane • Edit Person Form • Viewing Address Details • Viewing Work Contracts • Changing Visible Columns	

Task	Complete

• Exporting to Excel
• Navigating the Roster Screen
• Viewing Vacant Duties
• Viewing the Roster Analyser
  ○ Summary Tab
  ○ Details Tab
• Final Approval
  ○ Approve/Reject Roster
• Rosters Requiring Approval
• Viewing Staff Leagues Table
• Viewing off Duty One Week Report
• Viewing off Duty Four Week Report
• Ward Manager Report
• Filter Reports
• Management Reports
  ○ Sickness Report by Person by Reason
  ○ Additional Duties Report
  ○ Cancelled Duties Report
  ○ Finalising for Payroll Report.	

3 Hints and Tips

3.1 General

- Note: you do not need to enter data other than mandatory if you do not wish to – this can all be added at a later date
- Where there is a gender requirement, set the limit of Maximum Males rather than Minimum Females
- Create the personal patterns in My Staff/My Staff Details, display the Details Pane to confirm the hours are correct
- For people with Night Only contracts, adjusting the hours on the individual contracts will ensure they get higher priority in autorostering
- If a person works on 2 different wards/units assign 2 postings and 2 contracts
    - Select Person - Add Posting - Add Additional Work Contract Details
    - Change the working hours as appropriate
- When adding supernumerary staff use a different name for the shift, e.g. Super E (use SE). This way they won't be included in the numbers or E shift.
- Teams – when staff move from one team to another this needs to be done using Posting Reassignment if you want to maintain the history; this can be difficult for people who are on rotation.
- Use Location Based Rostering when you need to create the same shift twice
- Use the manual rosters to identify rostering problems
- Do not use minimum rules, use the opposite
- Make sure you have created 1, 2 and 3 shift long day global patterns
- When creating a shift priority – 0 is at the top – make sure you give all shifts a priority
- Naming conventions of rules – they do not always do what they say in the name field - make sure the name reflects the action
- Active Directory – If client requests information on 'Single Logon', refer them to a Technical Consultant, if they are existing users then the charge will be 1 day technical consultancy

3.2 Why Combined Shifts Don't Get Rostered When Running the Autoroster With the 'Process Duties Individually' Setting Active?

The individual pass looks at each vacant duty and tries to fill it without breaking rules. Combines are therefore not part of this as there are no vacant combine duties.

The only way that combines are done in the autoroster is via patterns – i.e. the pattern is telling MAPS 'this is a way the shifts can be assigned'. If you think about it, a combine is 2 shifts so it is not an individual duty – combinations of duties are only assigned in the autoroster when a pattern tells it to do so.

Instead, what you do is create 1 day patterns for the combine shifts (in addition to full week and part week patterns). This is very important for autorostering combines. Say your combine is a LD, that means:

LD, -, -, -, -, -, -

-, LD, -, -, - ,- ,-
-, -, LD, -, -, - , -

etc.

(obviously you don't need these for earlies / lates or other non-combine shifts)

This means that during the global pattern stage, it will try to assign these single combine (LD shifts) - as the autoroster will try to fit longer patterns first this happens right at the end, essentially being an 'individual pass' for the combines. Note that you need to make sure that the setting 'patterns must not be less than contracted hours' is turned off for these users (so these short patterns get tested).

3.3 Error Messages

3.3.1 Sorry, you do not have the authority to edit this person

- Firstly check that the User Type for the ward/unit has been created. If this has been done then it will not be visible in Reference Data – Organisation - Units Without My Unit Usertype
  - If you can see your new ward/unit listed here, highlight it then click on the 'Add My Unit Usertype' action button at the bottom of the screen to create the User Type
- If the User Type exists (i.e. is not in this list) you will need to check that it has been assigned to your user in MDA
  - Assign the User Type (found in the Visible Units folder), restart Healthroster and try again
- If the above does not work:
  - Start Optimiser, edit the unit and place an X at the **start and end** of the **Name** field
  - Save these changes then edit the unit once again and remove the X from the start and end – this removes any leading and training spaces around the unit name
- If this still does not work, delegate the user type in MDA and recreate.
- You MUST restart Healthroster before each attempt.

3.3.2 This Person is on another duty so is not available

- Go to Reference Data>Rules>Warnings & Violations
- Expend the Shift Restriction Rules and select rule 'This Person works Long Days and does not work this shift', click on the Edit Duty Rule action button at the bottom of the screen
- Make sure that 'Exclude from Global Patterns Candidate Selection' is ticked.

Change Control History

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			Author	Reviewer(s)	Approver
0.7	March 2011	Final draft.	Jan Pady/Simon Fletcher	All Allocate Implementation Consultants	Jan Pady/Simon Fletcher
1.0	April 2011	Reviewed and finalised for publication.		Penny Rivers	

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Allocate Software health
right people.
right place. right time.

DATA GATHERING WORKSHOP

UNIT NAME:_____

Please list the names of staff who will require access to the main system. This is usually the Ward/Unit Manager and Team Leader(s) and/or Ward Clerk(s).

Username (Network Login)	Name	Job Title	Telephone Number

Section 1 Shift Details

Please list each shift and the start end end time of each shift. Please state the length of any breaks and total length of the shift. Please state the shift priority, which is the order the shifts are rostered. For example, if nights are rostered first give these a priority of 1, etc. State any other types of staff who work on the ward and who should be included on e-rostering (eg ward clerk, occupational therapists, physiotherapists, activity workers, etc) and specify their usual shift start and end times.

	Long Name	Short Name	Shift Start Time	Shift End Time	Length of Breaks	Total Work Time (excluding Breaks)	Priority of Shift (1 to 5)
1a. Shifts (please add and delete as appropriate)	Early	E					
	Late	L					
	Night	N					
	Middle (9-5)	Mid					
	Long Day	E/L					
	Ward Manager	WM					
	Ward Clerk	WC					
	AHP (OT/Physio)	AHP					
	On Call	OC					

Additional Working Days (e.g. Clinical Nurse Specialist day – state day of week worked, times worked and individuals who work these)

Number of Beds: (where applicable)

Section 2 Ward/Unit/Service Requirements – Core Establishment

2a. Please state the number of people on each shift. This should be the agreed establishment rather than a minimum or desired staffing level.

Registered Nurses

	Shift Name	Mon	Tue	Wed	Thu	Fri	Sat	Sun
2b. Requirement	Early							
	Late							
	Night							

Health Care Assistants

	Shift Name	Mon	Tue	Wed	Thu	Fri	Sat	Sun
2c. Requirement	Early							
	Late							
	Night							

Other staff (including Ward Manager, Ward Clerk, Occupational Therapists, Physiotherapists, etc)

	Shift Name	Mon	Tue	Wed	Thu	Fri	Sat	Sun
2d. Requirement								

Ward/Unit/Service Requirements – Competences (specific skill that must be met on the ward/unit, e.g. minimum requirement of Staff Nurses trained in CPR/AED. Do not include mandatory training that is not critical for service delivery, e.g.Food Hygiene and Infection Control)

Please only include a minimum competence requirement if this is achievable on each shift. For example, if staff are not up to date with their Fire Safety training, do not include this competence until the majority of staff have received their refresher training.

Competence 1 Name: Take Charge (Day +/- Night)	Which Grade Type does it apply to?
Use the table below to record the minimum requirement for each shift and how important that this competence is met (high/medium/low priority)	

	Shift Name	Mon	Tue	Wed	Thu	Fri	Sat	Sun
2e. Requirement								

Competence 2 Name:	Which Grade Type / Person does it apply to?
Use the table below to record the minimum requirement for each shift and how important that this competence is met (high/medium/low priority)	

	Shift Name	Mon	Tue	Wed	Thu	Fri	Sat	Sun
2f. Requirement								

Competence 3 Name:	Which Grade Type / Person does it apply to?

Use the table below to record the minimum requirement for each shift and how important that this competence is met (high/medium/low priority)

	Shift Name	Mon	Tue	Wed	Thu	Fri	Sat	Sun
2g. Requirement								

Competence 4 Name:	Which Grade Type / Person does it apply to?

Use the table below to record the minimum requirement for each shift and how important that this competence is met (high/medium/low priority)

	Shift Name	Mon	Tue	Wed	Thu	Fri	Sat	Sun
2h. Requirement								

Competence 5 Name:	Which Grade Type / Person does it apply to?

Use the table below to record the minimum requirement for each shift and how important that this competence is met (high/medium/low priority)

	Shift Name	Mon	Tue	Wed	Thu	Fri	Sat	Sun
2i. Requirement								

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Competence 6 Name:	Which Grade Type / Person does it apply to?

Use the table below to record the minimum requirement for each shift and how important that this competence is met (high/medium/low priority)

	Shift Name	Mon	Tue	Wed	Thu	Fri	Sat	Sun
2j Requirement								

Section 3 Valid Shift Combinations and Rules

In this next section, please state usual shift combinations and rules. These can be applied to the auto roster settings.

Nights – Please circle and fill in below as appropriate					
State what is typically worked rather than what some individuals might request or what might be worked on an irregular basis. For example, if full-time staff generally work four nights in a row, please circle this. If staff usually do four nights but from time to time do more than four then still circle four. Ward/Unit Managers can still override any of the default settings.					
3a. What is the maximum normal number of Nights worked in a row? (Invalid Combination)	1	2	3	4	Other
3b. Would any shifts normally be worked the day before this/these night(s)? Circle either None, or the shift(s) it is okay to work beforehand. (Invalid Combination)	None (DO),	Early,	Late,	Long Day/Double Shift,	Other (please state)
3c. How many days off are required after this number of nights including sleeping day? (Invalid Combination)	2	3	Other:		
3d. Generally how many nights are worked in a 4 week period by each Band/Grade? If highly variable revisit Contract Restrictions and include there. (General Restriction)	Number Band 7 Ward Manager Band 6 Sister Band 5 Staff Nurse Band 3 Health Care Assistant Band 2 Health Care Assistant Other:				

3e. Are nights worked together within the week or split? (If highly variable record in Staff Details.) (Global Patterns)	TOGETHER / SPLIT

3f. Do your staff work to a pre assigned night rota? YES / NO
(If yes please provide the details below – attach additional details if necessary)

3g. What Night Patterns do staff normally work?

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	Applicable?
N	N	N	N	N	N	N	YES/NO
N	N	N	N	DO	DO	DO	YES/NO
DO	DO	DO	N	N	N	N	YES/NO
N	N	N	DO	DO	Day Shift/DO	Day Shift/DO	YES/NO
Day Shift/DO	Day Shift/DO	Day Shift/DO	Day Shift/DO	N	N	N	YES/NO

Staff Night Rota (if applicable)

	WEEK 1							WEEK 2							WEEK 3							WEEK 4						
PERSON NAME	MON	TUE	WED	THU	FRI	SAT	SUN	MON	TUE	WED	THU	FRI	SAT	SUN	MON	TUE	WED	THU	FRI	SAT	SUN	MON	TUE	WED	THU	FRI	SAT	SUN

Valid Shift Combinations and Rules Continued

Long Days / Double Shifts

Please complete this section if you would like the system to automatically roster staff to work long days (combined shifts). If staff only work long days on an exceptional basis or by request, ignore this section. Ward/Unit Managers can choose to assign long days manually if they are not rostered on a regular basis.

3h. How many Long Days are normally worked in a row? (Invalid Combination)	1	2	3	4	Other
3i. What shifts would normally be worked immediately before this/these Long Day(s)? (Invalid Combination)	None (DO), Early, Late Circle either None, or the shifts it is okay to work beforehand.				
3j. Would any shifts normally be worked immediately after this/these Long Day(s)? (Invalid Combination)	None (DO), Early, Late, Night Circle either None, or the shifts it is okay to work afterwards.				

Day Shifts

In this section state the number of day shifts that you would like the auto roster to apply. State what is the norm rather than what might be requested or worked on an ad hoc basis. For example, if you would prefer most people to only work a maximum of three earlies in a row, state this. Staff will still be able to request more than three and Ward/Unit Managers will still be able to manually assign more than three. If there are people who are an exception to any of these rules, please give details in section 4a. (Personal Patterns)

3k. What is normally the maximum number of Earlies in a row (state any exceptions)? (Invalid Combination)	1	2	3	4	5
3l. What is normally the maximum number of Lates in a row (state any exceptions)? (Invalid Combination)	1	2	3	4	5
3m. What is normally the maximum number of Earlies in one week (state any exceptions)? (General Restriction)	1	2	3	4	5

3n. What is normally the maximum number of Lates in one week (state any exceptions)? (General Restriction)	1	2	3	4	5
3o. Do people tend to do an Early shift before Days off and a Late Shift after Days off? (Global patterns) If YES, is this requirement essential (where possible)? (Essential – Shift Rule)	YES / NO Essential / Desirable				

Global Patterns and Typical Working Patterns
The e-Rostering system uses a set of typical and preferred working patterns to plan the majority of your roster. These patterns can apply to all staff within your department or particular staff groups. Considering the rules you have already provided, please answer the following questions so that the best set of patterns for your unit can be created.

3q. Would you be happy for Lates and Earlies to be regularly worked in very varied patterns? ie E L E L E or L E L E L	Yes / No
3r. Would you prefer for Lates and Earlies to be worked together where possible? ie E E L L L or L E L L E	Yes / No
3s. What is the maximum number of changes between shift type you would prefer in a full time week? ie E E L L L = 1, E L L L E = 2, L E L L E = 3, E L E L E = 4	1 / 2 / 3 / 4
3t. Should part time employees' shifts be kept together where possible? ie DO E L L DO DO DO or DO L DO DO E DO E	Together / Split
3u. If part time shifts are spread over a week, what is the maximum number of splits you would prefer? ie DO L L DO DO E E = 1 Split L L DO E DO DO L = 2 Splits	1 / 2 / 3
3v. Are there a number of preferred pairs of days when days off should be taken together? If so, when?	

Section 4 Personal Working Patterns and Part-time Staff

4. Are there any personal exceptions to the standard ward/unit rules? State who they are, what they do and the reason. Please indicate if it is part of a formal agreement or custom and practice. Restrictions to an employee's working hours and availability must be part of a formal agreement. If they are not the manager should be advised to perform this exercise with their staff. **Include part-time staff here and state number of days or nights worked per week.**

Examples include: Nights only staff, Days only, LD only, Not working Weekends

Name	Working Arrangement & Reason	Formal Agreement?
		Yes / No
		Yes / No
		Yes / No
		Yes / No
		Yes / No
		Yes / No

Section 5 Rostering Constraints

In this section, please state what is the normal practice rather than any unrealistic requirement that can not be achieved because of staffing levels. For example, do not state that two males are required on every shift if there are not enough males on the ward/unit to fulfil this requirement.

Weekends - Circle and fill in below as appropriate…						Check Within Single Roster
5a. What is the minimum number of weekends off required for Band 6 & 7 staff over a 4 week roster? (Weekend Rule)	One in Four	One in Two (Every Other)	Two in Four	Three in Four	Four in Four	YES / NO
5b. What is the minimum number of weekends off required for Band 2,3 & 5 staff over a 4 week roster? (Weekend Rule)	One in Four	One in Two (Every Other)	Two in Four	Three in Four	Four in Four	YES / NO
Gender Requirements - Circle and fill in below as appropriate						
5c. Are there specific gender requirements for each shift? (Gender Requirement Rule) **5d.** If YES, please list the gender requirement on each shift.	YES / NO					
Band 6 Cover - Circle and fill in below as appropriate.						
5e. Is it possible to have at least one Band 6/7 on shift every day? (Competence) **5f.** Is this an essential requirement? **5g.** Which shifts are most important to have covered by a Band 6/7?	YES / NO **(If NO, proceed to 5h)** YES / NO Early / Late / Night / Other If Other please state:					

Days Off - Circle and fill in below as appropriate.	
5h. Do people tend to have days off grouped together? (Global Patterns) **5i.** Are there any personal exceptions to this? **5j.** If there are exceptions, who are they and what do they do (e.g. work all weekends)? (Personal Patterns/exclude from General Restrictions)	YES / NO YES / NO
5k. Should people be rostered to have 1 day off before and after annual leave lasting 3 days or more? (Rest Before/After AL Rule)	YES / NO **Exceptions:** e.g. 9-5 workers
Mixing Days and Nights	
5l. Do people work days and nights within the same week (state any exceptions)? (Day or Night Rule)	YES / NO **Exceptions:**
Mixing Single Day Shifts and Combined Shifts	
5m. Do people work single shifts and combined shifts within the same week (state any exceptions)? (E/L Exclude Shifts)	YES / NO **Exceptions:**
Keeping Staff Apart	
5n. Are there any staff who should not work together (e.g. husband/wife, mother/daughter)? Also state if staff are rostered apart for other reasons (e.g. Band 6s do not work on the same shifts for management reasons). (Keep Staff Apart)	YES / NO **Please list:**

Annual Leave and Study Leave Rules

The e-Rostering system can be set up to limit the amount of annual and study leave instances at the same time. Warnings can be triggered for a Ward/Unit Manager in the rosters and for an employee when making a request via Employee On-Line (EOL). If triggered in EOL, the system will warn the person that their request may be denied as the normal number of annual leave/study leave requests have been exceeded during a given reference period.

6a. What is the maximum number of people allowed on annual leave and study leave at any one time? (Max Concurrent Episode)	Annual Leave: Study Leave: Please state if this is an overall number or if there are separate maximums for RNs, HCAs etc.
6b. What is the maximum single period length (in days) of Annual Leave that an employee is allowed to request?	

6c. What is the maximum number of absences due to annual leave and study leave that someone can request in a given period?		No. of instances	Reference Period Length
	Annual Leave:		
	Study Leave:		

Establishment Information

Please provide accurate information for the current financial year. Budget, post WTE values and cost centre information can be obtained from your Finance Department / ESR.

Unit/Ward Cost Centre	Code: Please state if there are multiple cost centres that apply to your ward/unit and provide details below.
Total Ward/Unit Budget	£ Please provide full staff cash budget for current financial year:

Post WTE Budget By Grade	Band 7: Band 6: Band 5: Band 4:	Band 3: Band 2: Band 1: Band 2 HK:	Band 3 A&C: Add others as applicable:

MAHI - STM - 102 - 10963

PLEASE BRING/CONSIDER THE FOLLOWING FOR YOUR FIRST WORKSHOP

1. **Attach the following documents to this sheet**
   - Current working and previous 28 day roster
   - List of staff who can Take Charge (Day / Night)
   - Leave entitlement
   - Planned annual leave
   - Planned study leave

2. **Verify Contract Settings / Restrictions (to be done during workshop)**

3. **State any personal patterns or shared patterns**

PERSONAL PATTERNS	WEEK 1							WEEK 2							WEEK 3							WEEK 4						
PERSON NAME	MON	TUE	WED	THU	FRI	SAT	SUN	MON	TUE	WED	THU	FRI	SAT	SUN	MON	TUE	WED	THU	FRI	SAT	SUN	MON	TUE	WED	THU	FRI	SAT	SUN

The information I have given in this document is complete and is true to the best of my knowledge.

SIGNED BY

Ward/Area/Team Manager **Implementation Consultant** **Date**

Employee Online – Log In & Viewing a Roster (Part 1 of 5)

A Logging in to Employee Online

1
Double click on the Internet Explorer link on your desktop to get to Trust intranet

2
Click on Intranet link to log in to Employee Online

3
Enter your username and password and click Login

4
The first time you login, you will be prompted to change your password

- Enter the password provided to you
- Choose a new memorable password
- Click on Change Password

Employee Online will open

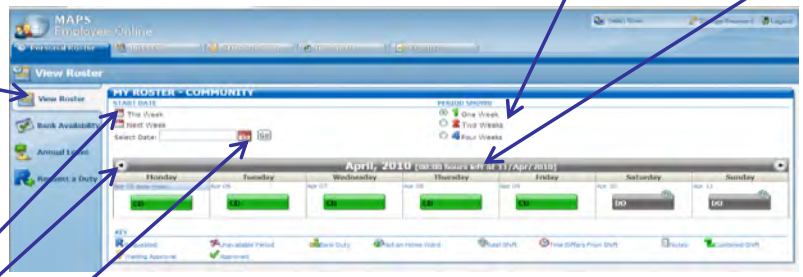
B Viewing Your Roster

1
Your roster will automatically appear when you log in. To return to this page click on „View Roster"

2
Change the view date in 3 different ways:

1. This Week / Next Week links
2. Using the navigation arrows
3. Selecting a specific date on the calendar

3
Choose period to view 1, 2 or 4 weeks

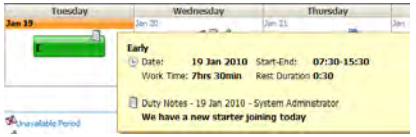


Note: the Expenses tab will only appear for those who have the licence and whose ward/unit has been activated for e-Expenses. Refer to separate User Guide for more information

4
Your long term hours balance at the end of the roster period are shown:

- „Hours Left" means you have hours that still need to be allocated
- „Hours Owed" means you are owed time in lieu

5
Hover over a duty to see the details and any notes



Release 1

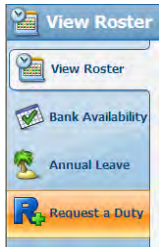
EOL2.5

Allocate Software MAPS health suite

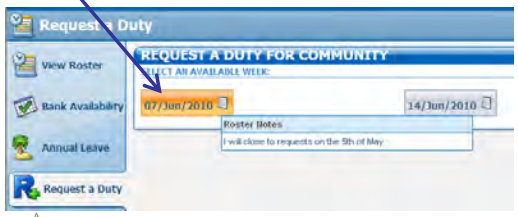
Employee Online – Requesting Duties & Study (Part 2 of 5)

C Requesting Duties

1
Click on Request a Duty from the left hand menu



2
Click on the week you wish to make a request.

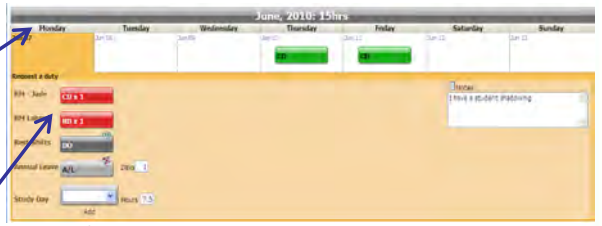


Note: You can only see the weeks that your Manager has opened to requests

If you work on a ward/unit that provides staff for other wards/units (e.g. physio), you can select the relevant shift group for your request.

3
Click on the day you wish to request a duty e.g. Monday

4
A selection of duties will appear. Click on the required shift / day off.



Note: If you wish to add notes do this before clicking on the duty

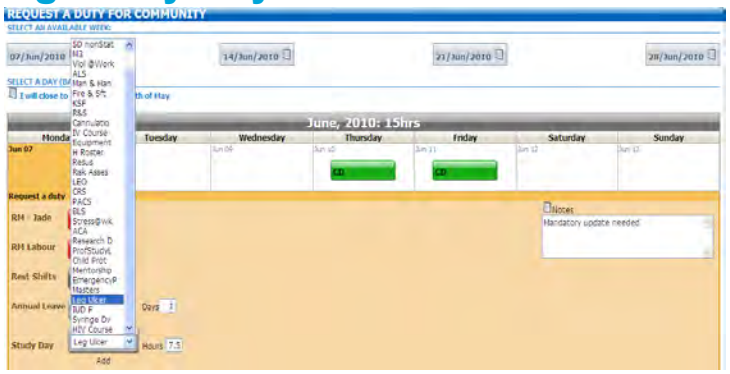
D Requesting Study Days

1
To request a study day, select from the drop down list

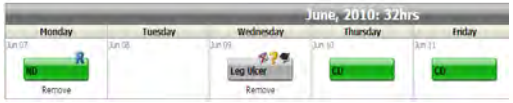
2
Write a note if necessary

3
Change the number of hours if different from the default

4
Click on Add



The requested will appear on your calendar:



E View/Edit Requests

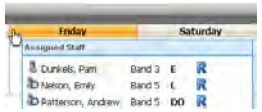
Click on the Remove link to delete a request

If the duty or study day request breaks a rule, a warning or violation will appear:

- A violation will tell you why the Request cannot be made

- A warning will tell you a rule has been broken and it is unlikely the request will be allowed

View requests made by other staff by hovering over the day on the request screen



Release 1

EOL2.5

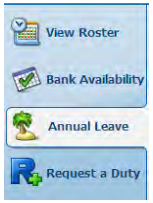
Allocate Software MAPS health suite healthroster

Employee Online – Annual Leave (Part 3 of 5)

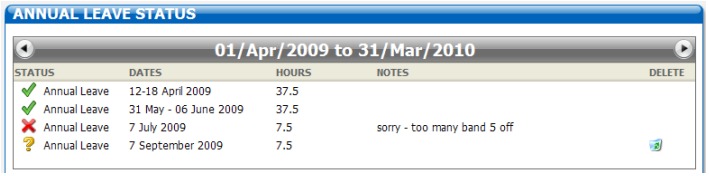
F Viewing and Requesting Annual Leave

1

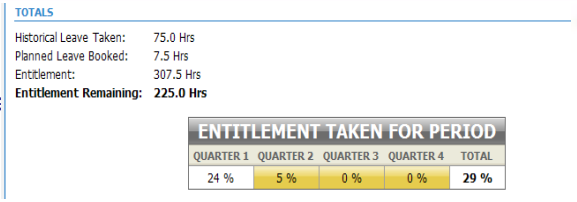
Click on Annual Leave from the left hand menu



A list of your current annual leave is visible. Icons show the annual leave status: approved, cancelled or requested.

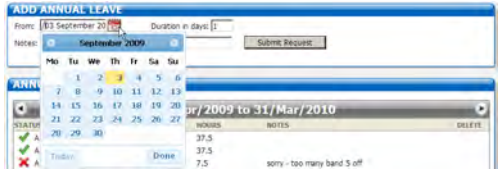


You can see the leave entitlement for the year and what is remaining.



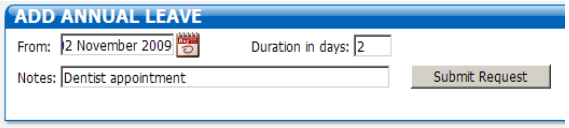
2

To make a request for annual leave use the calendar to select the start date



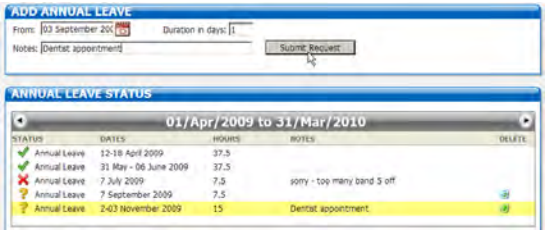
3

Enter the duration in days and add notes if required



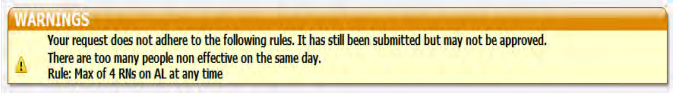
4

Click on Submit Request and you will be able to see your request.



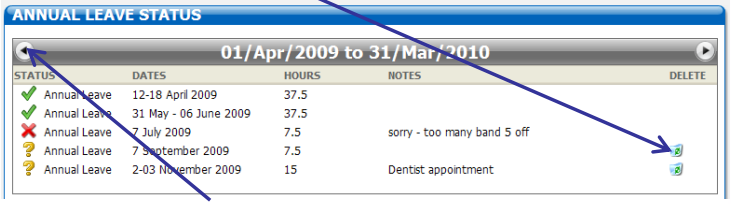
To change the dates or duration the original request will need to be deleted and a new request added.

A warning message will appear if your request breaks a rule



5

To remove the request click the Delete icon



6

To view a different leave year click on the arrows on either sides.

Release 1

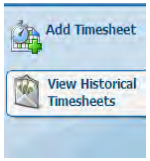
EOL2.5

Employee Online – Viewing Timesheets (Part 4 of 5)

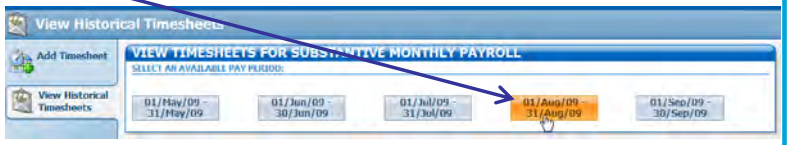
G Viewing Timesheets

1
Select the Timesheets tab

2
Select View Historical Timesheets

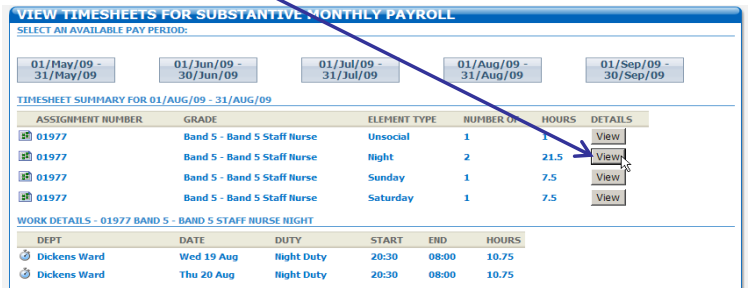


3
Select the appropriate payroll period



Details for the selected period are shown

4
Drill down on where the enhancements originate by clicking View



Details of the Department, Date, Duty, Start & End time and Hours for each shifts are shown

5
Drill down on details of the absence by clicking View

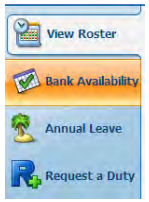
Release 1

EOL2.5

Employee Online – Entering Bank Availability (Part 5 of 5)

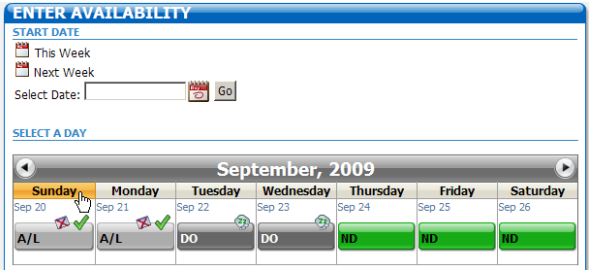
H Bank Availability

1
Click on Bank Availability from the left hand menu.

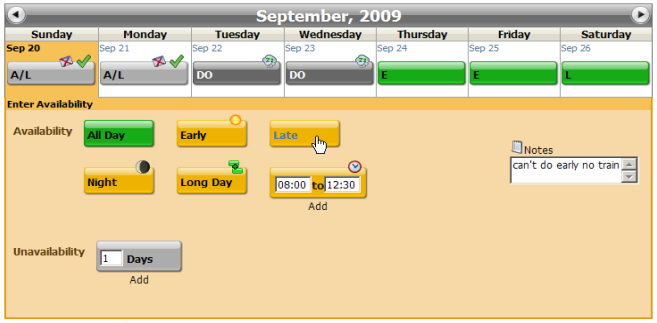


Note: You only have this option if you are registered in the Bank.

2
Find the right week and click on the day you wish to offer your availability for (similar to requesting a shift)



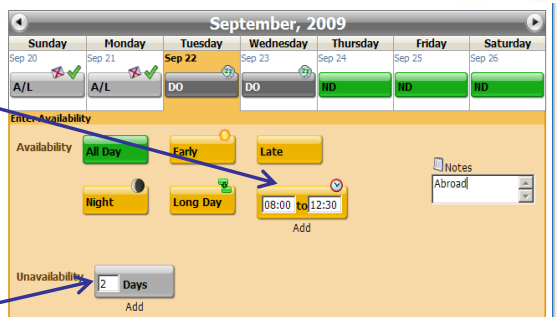
3
Click on All Day or the shift that you are available for, and write a note if necessary.



You can add multiple shifts for the same day.

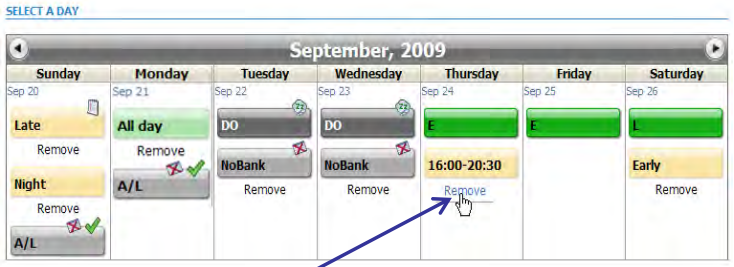
4
You can custom make availability choosing the exact time

5
Use the Unavailability option to block a day as no bank. Enter the length of unavailability and click on Add.



6
Availability is shown in faded green for "All Day" and yellow for any "Part Day".

Custom made availability shows the times.
Unavailable "NoBank" is grey.



Click on the Remove link to delete availability entered

Release 1

EOL2.5

HealthRoster

Approve & Analyse Rosters (v10)

User Guide

Version	ALL3.0
Status	Final
Issue Date	July 2016

Allocate Software

Table of Contents

Foreword

This Training Support Guide includes information regarding the management of rosters, specifically analysing and approving rosters, using HealthRoster v10. Key topics and functions are covered, enabling those responsible for approving rosters to practice the steps and functions shown to them during implementation and training sessions. It is a complete overview for those individuals who will be responsible for creating and managing rosters for their ward/unit/team.

This document is designed to support Roster Approvers post-training and ongoing. It is designed as a reference guide to be used with live data, but can also be used with a training database for ongoing training if required.

Please note: Images may vary from your live system, as may visibility and functionality depending on your license and user permissions.

1 Navigating Healthroster

The following sections cover key navigational functions.

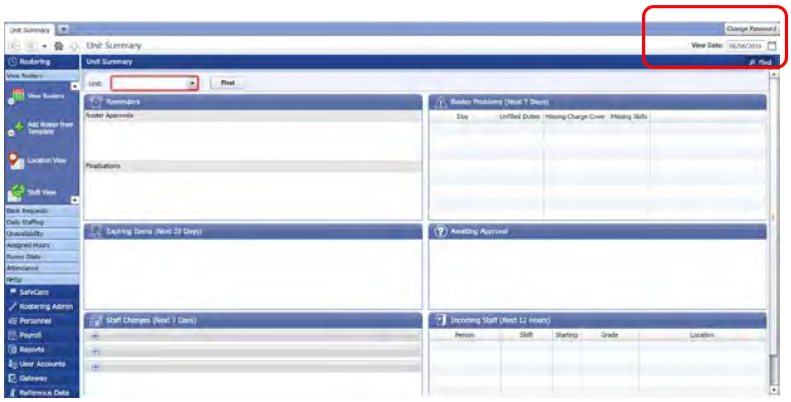
LOGGING IN TO HEALTHROSTER

1. Double click on the icon located on the desktop
2. Enter your **Username**
3. Enter your **Password**
4. Click on **Login**
5. Select the appropriate database

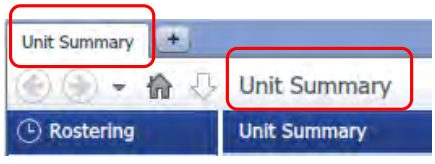
BASIC OPTIONS AND FUNCTIONS

The HealthRoster Screen has a consistent layout, designed to help you to navigate to key tasks and functions.

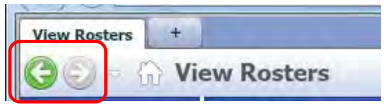
The **View Date** and a calendar icon always appear to the top right of the screen, as does the **Change Password** link (highlighted opposite).



The name of the current screen will be displayed on the first tab to the top left of the screen, as well as a heading, as shown opposite.

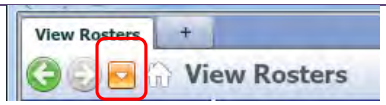


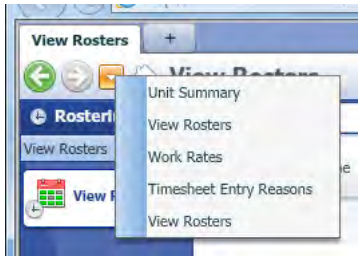
There are **Back** (a page) and **Forwards** navigation arrows always displayed to the top left of the screen, as shown opposite.



There is a **History** drop down list icon always visible to the top left of the screen, next to the navigating arrows (highlighted opposite).

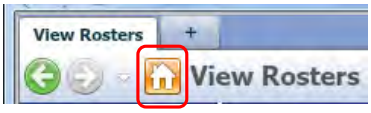
Click on this icon to see a list of the screens that have been visited recently.



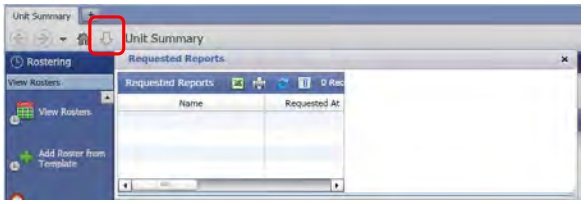


There is a **Home** button always visible to the top left of the screen (highlighted opposite).

Click on this button to navigate to your homepage (this will be the Unit Summary, by default).



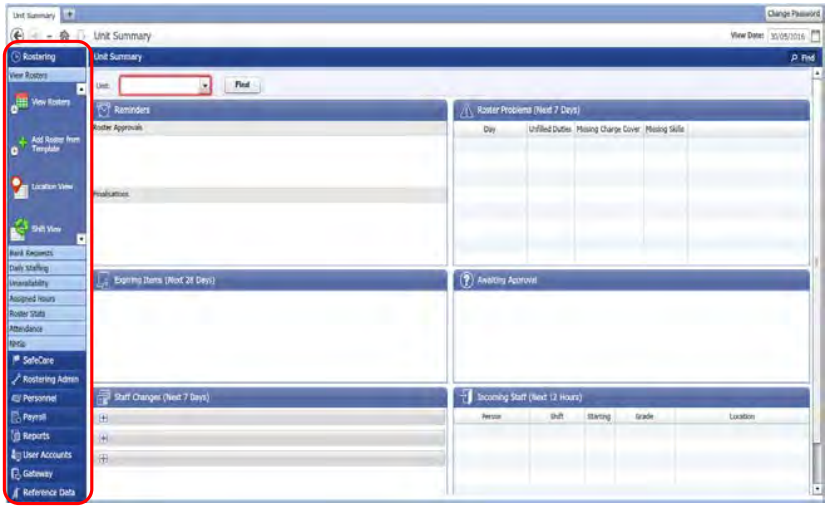
There is a Requested Report Icon which will list all extracted/requested reports for further access to open and view.



NAVIGATING TASKS AND SHORTCUTS

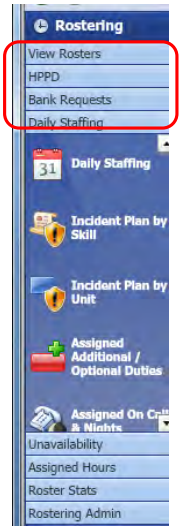
HealthRoster tasks and functions are grouped by topic. These groups are consistently displayed to the left of the screen.

Note: The groups and options that you can see will vary, depending on your User Permissions.



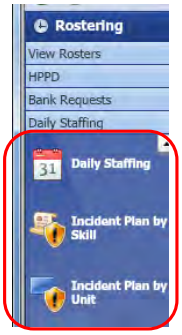
Groups of tasks are sorted into various **Master Groups**. These appear in dark blue, to the left of the screen (highlighted opposite).

Groups of task/screen shortcuts are sorted into various **Task Groups**. These appear in light blue, to the left of the screen (highlighted opposite).



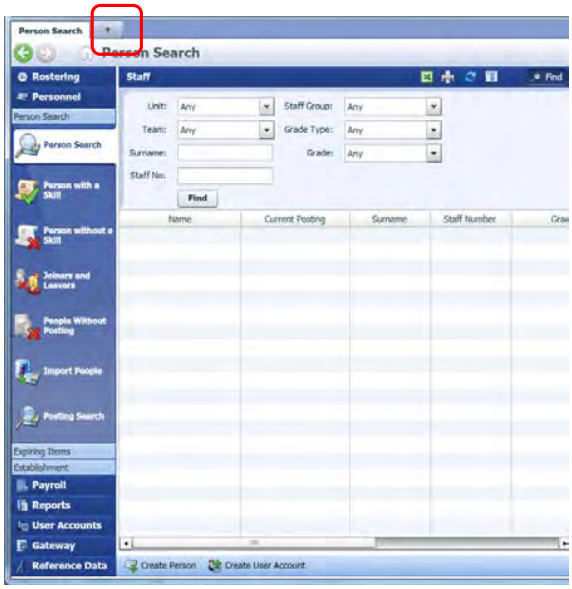
Within each Task Group you will find a number of **Shortcuts** (highlighted opposite).

Note: There are small arrows that allow you to navigate to further options up and down the list.

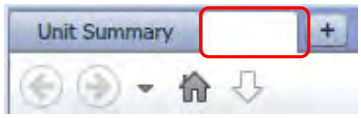


OPENING MULTIPLE WINDOWS

It is possible to have several windows open at the same time. This makes it much easier to quickly move from one screen to another, without having to reselect groups, shortcuts, filters etc.



Click on the **+** tab, next to the tab for your current screen (highlighted opposite).



A new blank tab window will open (shown opposite).

Click on the sub folder area you wish to work within, which will then label your new tab and secure the working area.

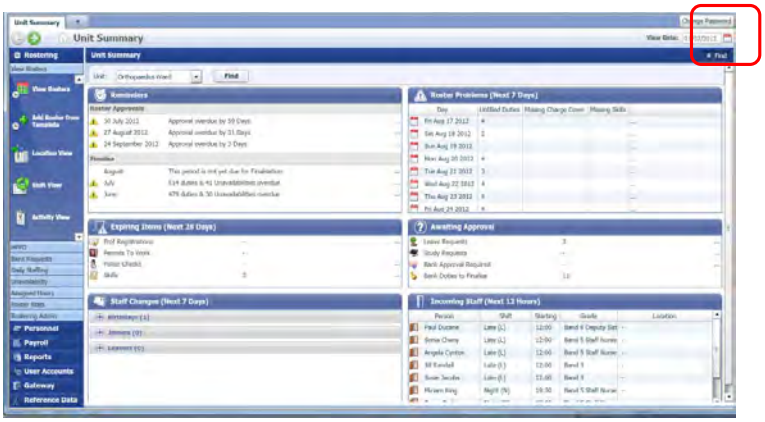
To close windows, hover over the window tab (shown opposite) and click on the red cross that appears.

USING THE CALENDAR

The calendar is a consistent feature to the top right of the HealthRoster view. You can use it to navigate to rosters and data past, present and future.

The calendar is always available in forms where there are fields which require a date to be entered.

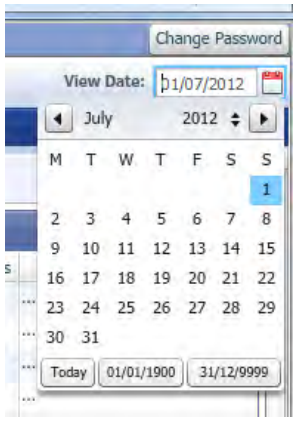
Click on the calendar icon (shown below) next to **View Date**, to the top right of the screen (highlighted opposite).



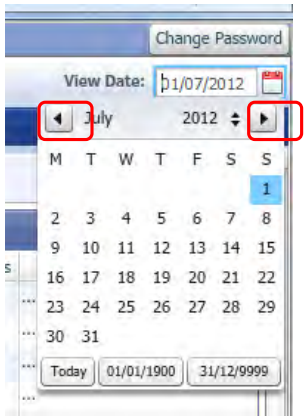
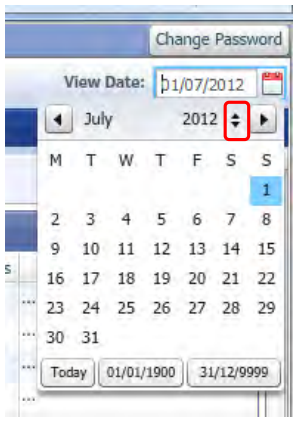
Today's date will be highlighted in the calendar.

There are buttons at the bottom of the calendar where you can automatically select the following dates:

- **Today**
- **01/01/1900** (start of time)
- **31/12/9999** (end of time)



Note: The 01/01/1900 is the start date of the database and it is used when something has no definite start date, i.e. it is assumed it has always existed.

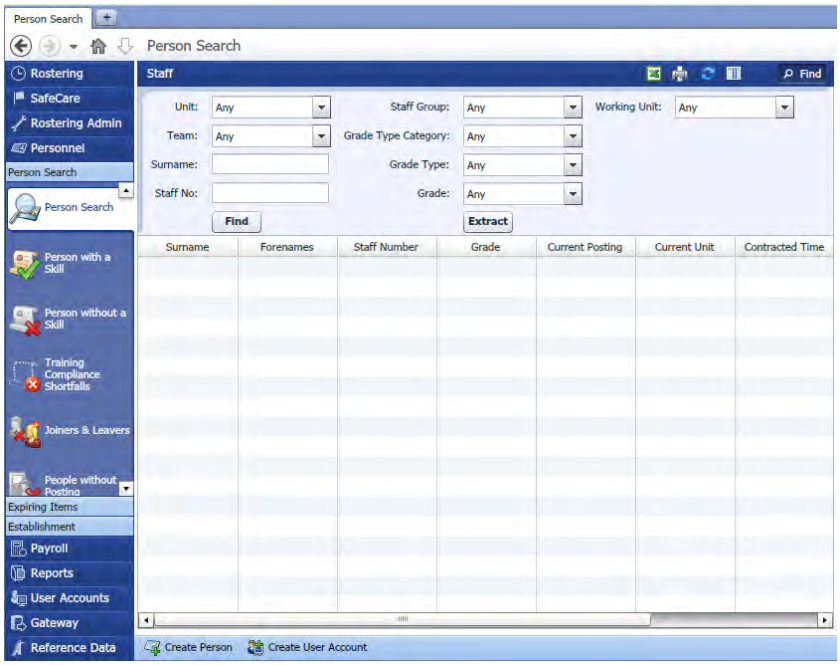
The 31/12/9999 date is used when something or someone has no definite end date, i.e. it is assumed it/they will always be there, until further notice. You can click on the arrows either side to move back and forth through the months (highlighted opposite). You can click on the up and down arrows to the right of the year to navigate back and forth through the years (highlighted opposite). You can click on a specific date in the calendar to select it.	 

USING FILTERS

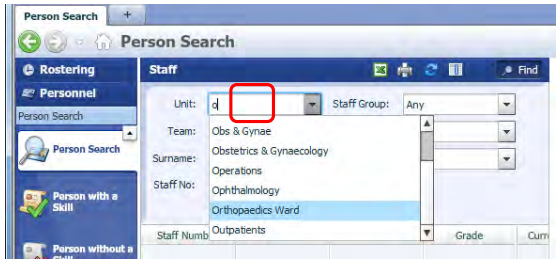
Filters are used throughout HealthRoster to help you to find a specific record, or a group of records that match your criteria.	

Note: The filter options available will vary from screen to screen.

For example, select the **Personnel** master group, then select the **Person Search** task group and shortcut.

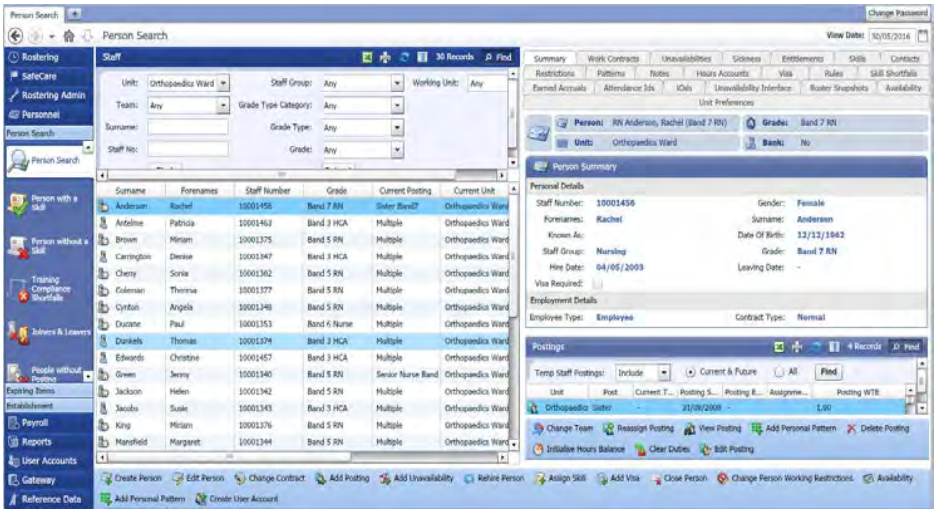


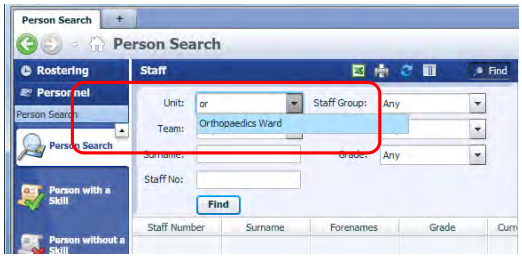
Select your ward/unit from the **Unit** drop down list by clicking on the arrow to the right of the filter field (highlighted opposite), then click on **Find.**



A list of all staff on your ward/unit will be returned.

When you highlight the name of a person in the returned list, the Details pane will be displayed to the right of the screen.



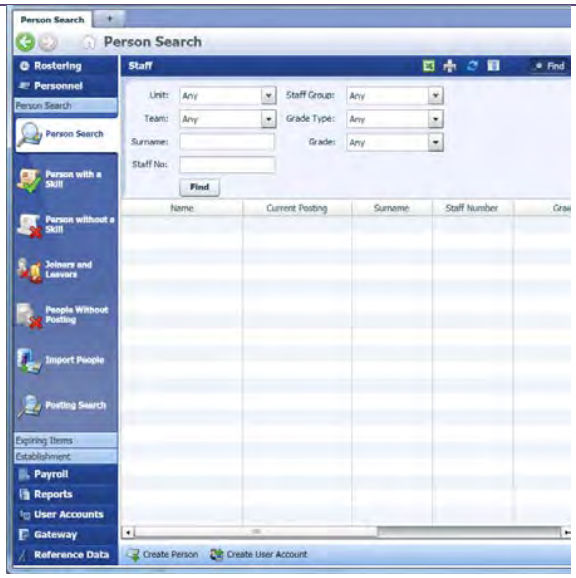
Note: You can use a combination of filters to make your search more specific. If you type one or more characters in a filter field, available matches will start to be displayed.	

CHANGING VISIBLE COLUMNS

It is possible to change the columns of data in each screen, and change the order in which they appear. **When you change the visible columns and the order in which they appear, this becomes your favourite and will always be the order of the data display, whenever you return to the screen where the changes were made.** You can change the visible columns in a screen wherever you see this icon: 	

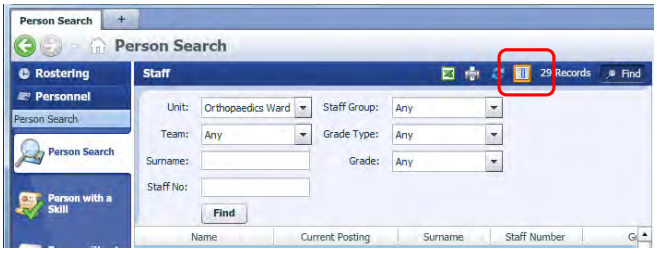
For example, select the **Personnel** master group, then the **Person Search** task group and shortcut.

Select your ward/unit from the **Unit** drop down list, then click on **Find**.

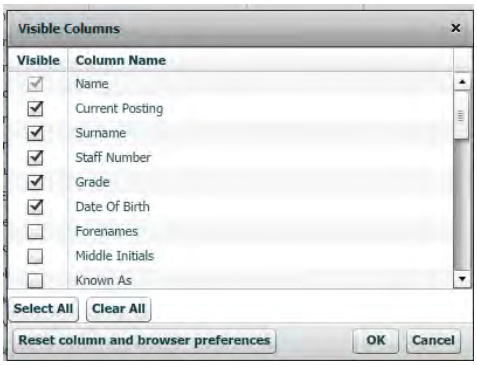


A list of all staff on your ward/unit will be returned.

The **Visible Columns** icon is located in the toolbar (highlighted opposite).



Click on the icon to open a new window, showing available options.

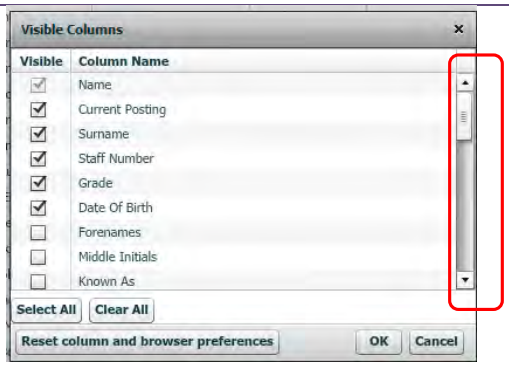
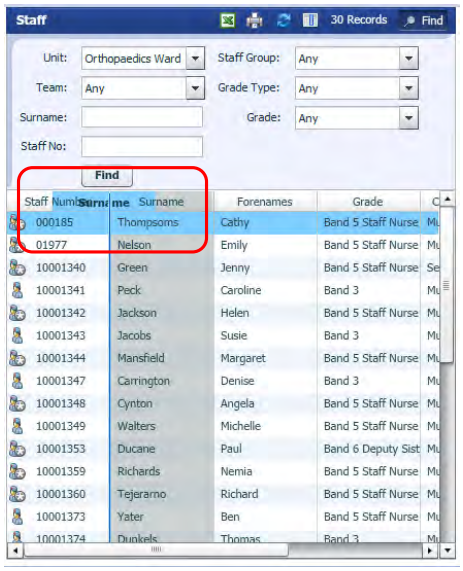


Use the scroll bar to view options (highlighted opposite).

Tick/untick as required.

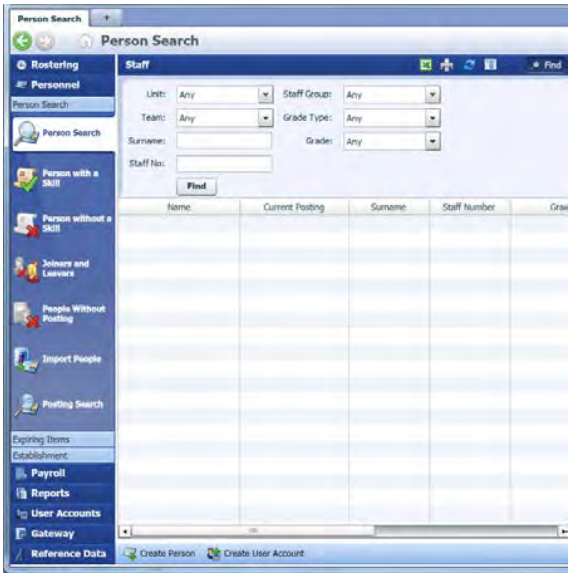
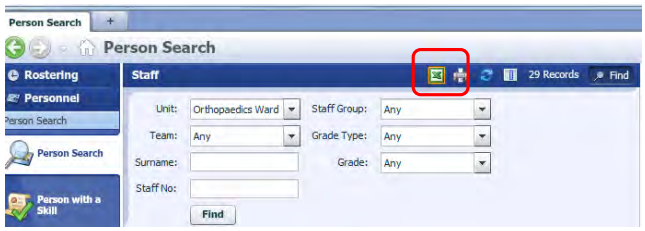
Note: There are also options to **Select All** or **Clear All**, or **Reset** to original settings.

Click on **OK** to save.

The order of columns displayed will change. You can change the order in which the columns are displayed by simply dragging them. For example, drag the **Surname** column to the left of the screen to become the first column of data, by clicking on the column heading.	 

EXPORTING DATA TO EXCEL

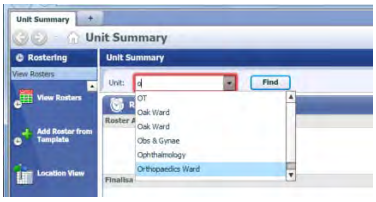
It is possible to export a list of data from HealthRoster to Excel, in order to keep specific records or create your own reports.	

When you navigate to a screen with filters, and have used them to search for a record or group of records, you can export the displayed data. For example, select the **Personnel** master group, then the **Person Search** task group and shortcut. Select your ward/unit from the **Unit** drop down and click on **Find.** A list of all staff on your ward/unit will be returned. The **Export to Excel** icon is located in the toolbar above the filters (highlighted opposite).  Click on this icon. The data will be exported to a new Excel spreadsheet, in the order in which it appears in HealthRoster.	 

USING THE UNIT SUMMARY

The Unit Summary screen will be your homepage by default.	

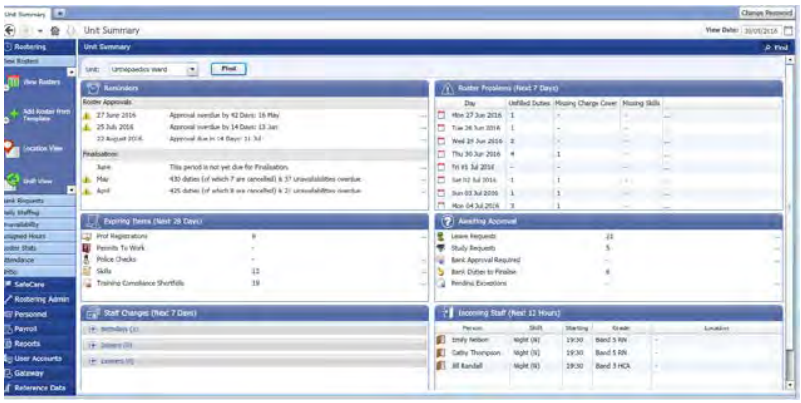
You may need to select your ward/unit from the drop down list, and click on Find:



Note: Entering the first letter of the ward/unit will take you to the full name,

Explore the following areas:

- Reminders
- Roster Problems
- Expiring Items
- Awaiting Approval
- Staff Changes
- Incoming Staff



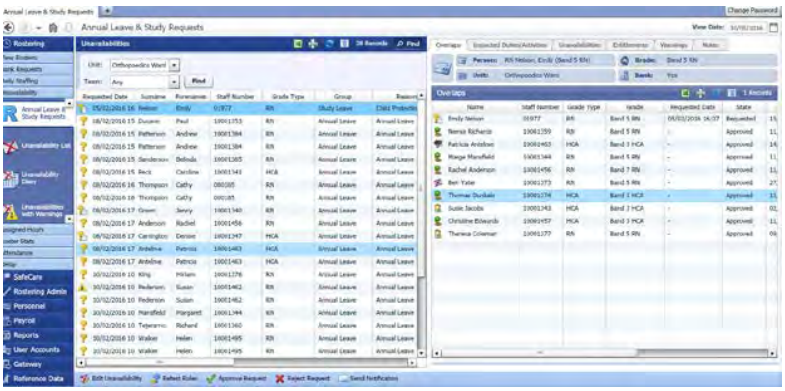
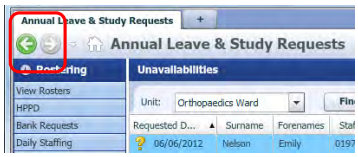
You can obtain more detail on some of the items displayed in the summary, where there is a ... (highlighted opposite).

Click on the ... links to drill down to more detailed summaries of the issues/items.

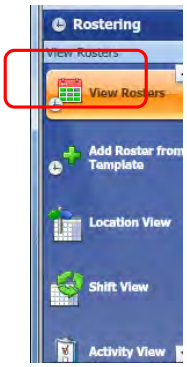
You will automatically be transported to the appropriate shortcut or view in HealthRoster.

For example, click on a Reminder ... link (as highlighted above and opposite) to be taken to the roster.

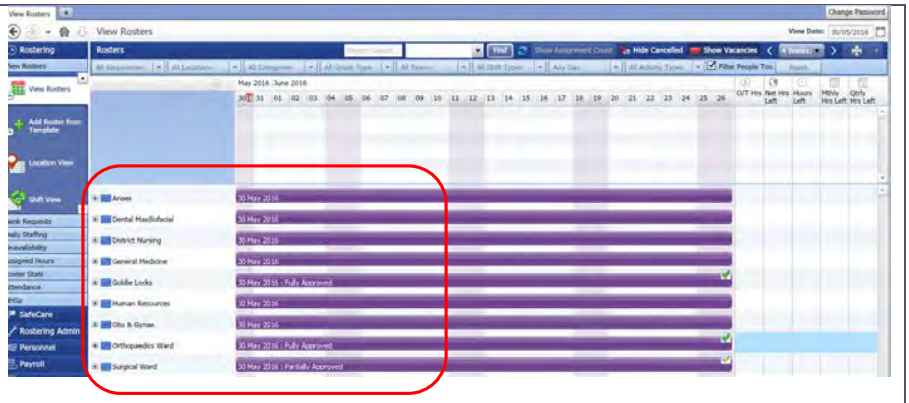
Or click on the Awaiting Approval Leave Requests ... link (highlighted opposite) to be taken to the Annual Leave and

Study Requests screen (below opposite). To return to the Unit Summary screen, simply click on the **Back** button (highlighted opposite).	  

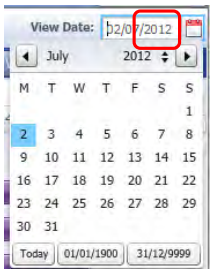
NAVIGATING TO A ROSTER

Select the **Rostering** master group and the **View Rosters** task group. Select the **View Rosters** shortcut (highlighted opposite). Any rosters for the ward/unit you have selected, valid for the View Date, will be displayed, represented	

by a **purple bar** (highlighted opposite).

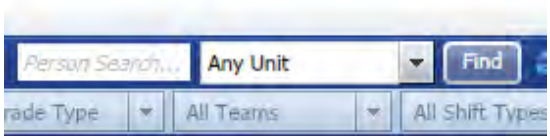


Click on the calendar icon to the top right of the screen to open the calendar and navigate to the **View Date** for the roster you are looking for.

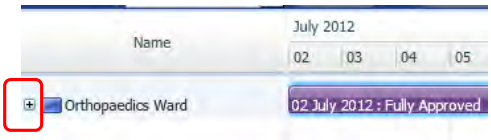


Note: Today's date is displayed by default

To view only 1 ward/unit roster select your ward/unit from the Unit drop down list and click on **Find**.



Click on the **+** next to the Unit name to open up the roster.



Note: You may need to click on the purple Roster Bar to highlight it and ensure that the roster opens.

2 Personnel Management: Viewing & Editing People Data

This section focuses on the Personnel master group, including how to view and amend/update staff details.

Note: Your permissions in this area may vary. Some tasks and functions detailed in this section may not apply to your role, and so you will not be able to see or do them.

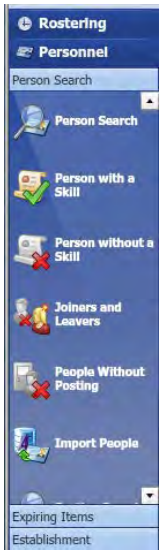
PERSONNEL MASTER GROUP OVERVIEW

Click on the **Personnel** master group.

Here there are up to three task groups available:

- Person Search
- Expiring Items
- Establishment

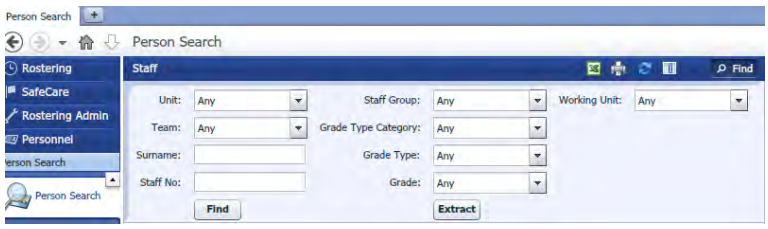
Explore the available shortcuts within each task group.



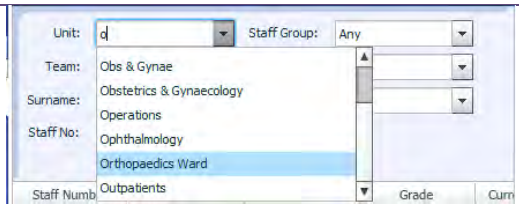
SEARCHING FOR A PERSON

Click on the **Person Search** task group and the **Person Search** shortcut.

You will be presented with a number of filters.

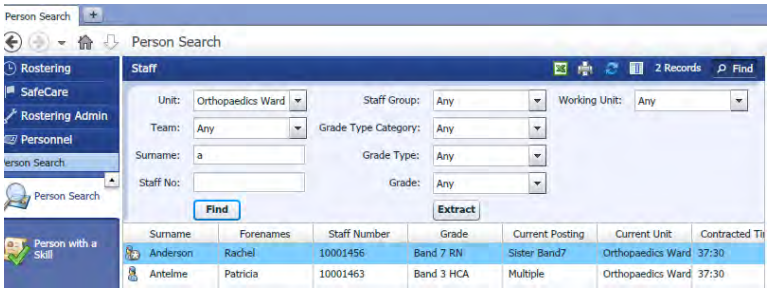


Select your ward/**Unit** from the drop down list.



You can enter the first letter of a person's surname in the **Surname** field and click on **Find**.

A list of matching records will be displayed.



Note: If you leave all filter fields blank and click on **Find**, a list of all staff on your ward/unit will be displayed.

DETAILS PANE – PERSON RECORDS

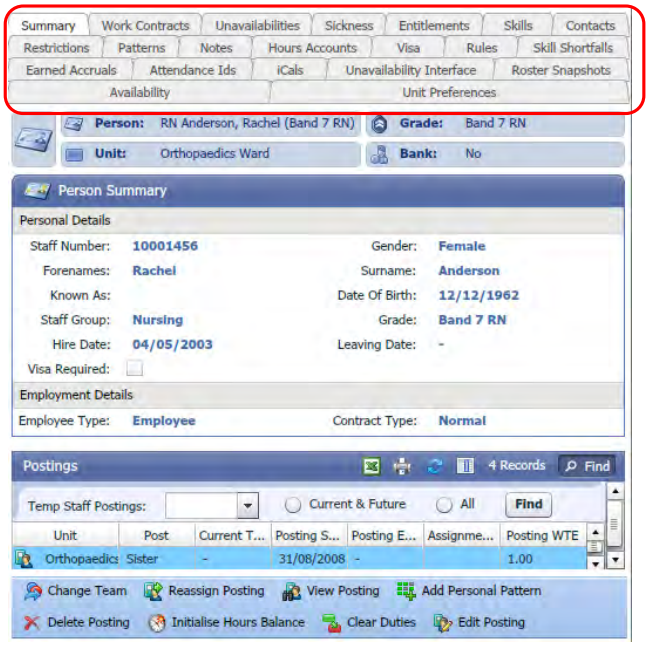
Full details of a record can be displayed and viewed without having to select another option or risk making changes.

To view a person's full staff record in HealthRoster, simply click on their name as listed to highlight it.

A **Details Pane** will appear to the right hand side of the screen.

There are various tabs available which enables you to navigate to specific information easily (highlighted opposite).

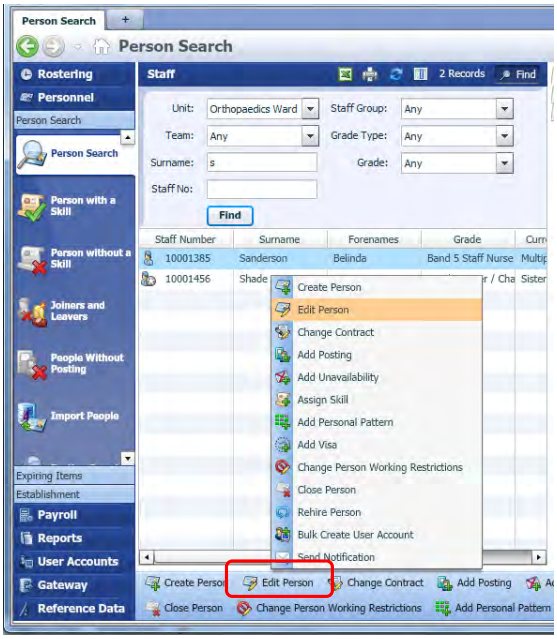
Click on each tab and explore the details held.



EDITING PERSON DETAILS

To edit a person's record, select **a person** from the list of people displayed (simply click on them to highlight).

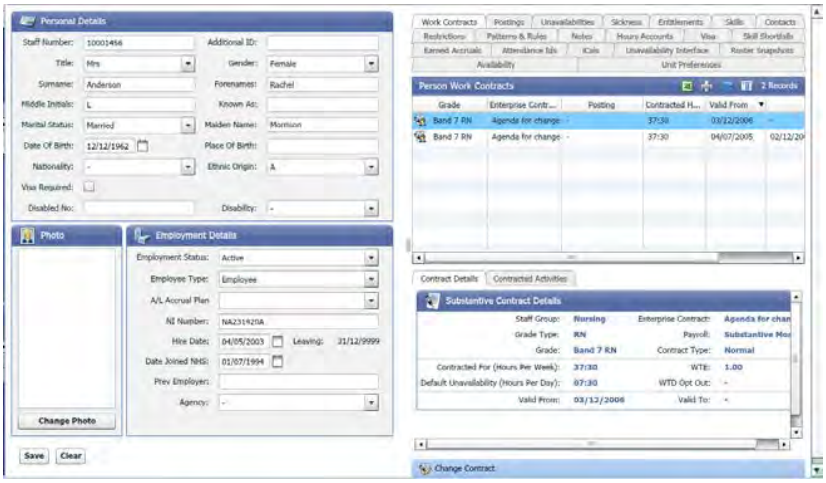
Click on the **Edit Person** action button at the bottom of the screen (highlighted opposite), or right click and select the option from the menu that appears.



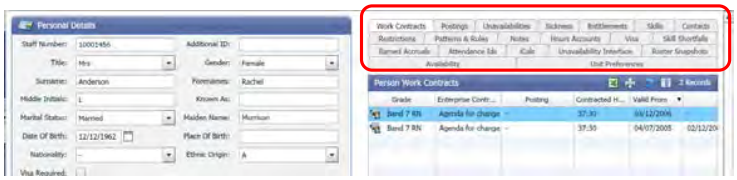
The **Edit Person** form will open.

You can make changes to Personal Details on the left hand side of the screen.

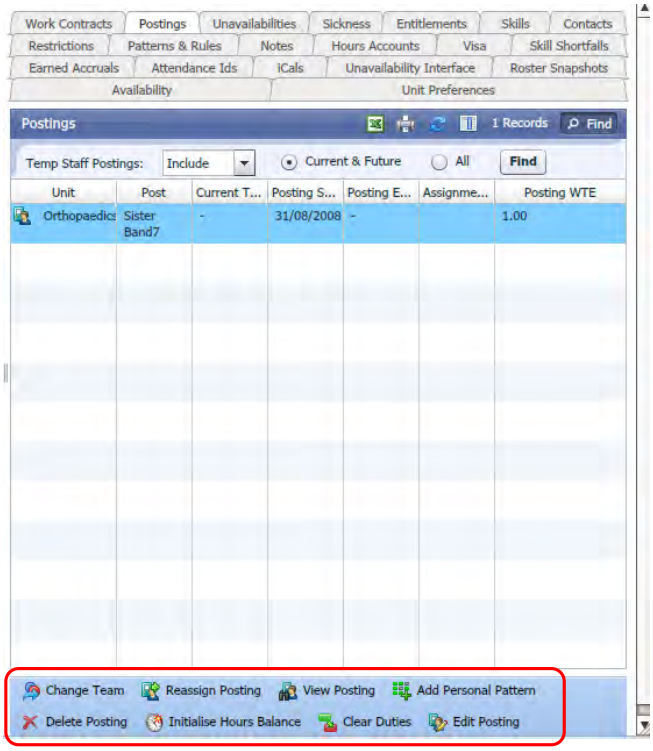
Click **Save** to save any changes.



You can select an alternative tab from the top right of the window, to navigate to different information (highlighted opposite).



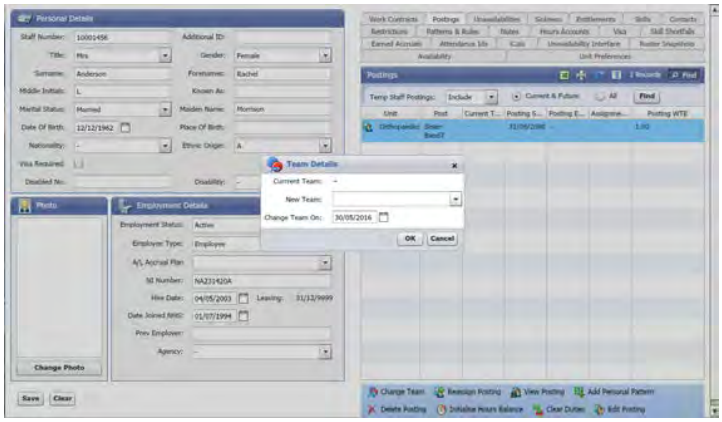
Note: Action buttons relevant to the screen/tab that are viewing will be shown at the bottom of the pane (highlighted opposite).



Select the appropriate action button for the change you wish to make – a new window will appear.

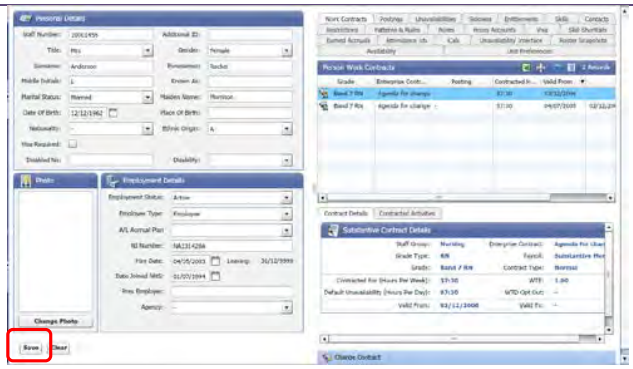
Select the options required to action the change.

Note: Use the calendar to select the correct date from which the change should take effect.



Click on **OK**.

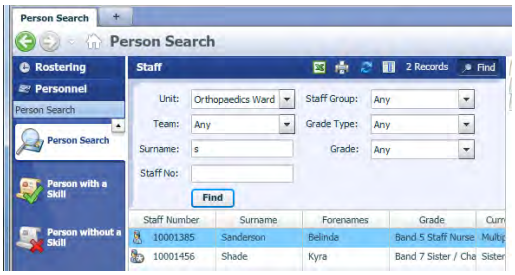
Click on **Save** in the main **Edit Person** view (highlighted opposite) and close the window.



VIEWING/EDITING WORK CONTRACT

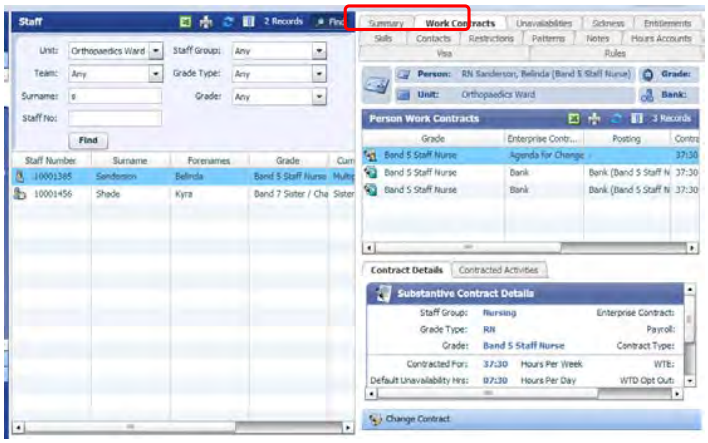
Note: The changing of posting or contract information, or working restrictions, should be carefully undertaken. It is important to ensure that the correct 'valid from' dates are entered for such changes, to ensure that historical data is not affected.

Use the filters in the **Person Search** screen to locate the record for the staff member whose details you wish to change.

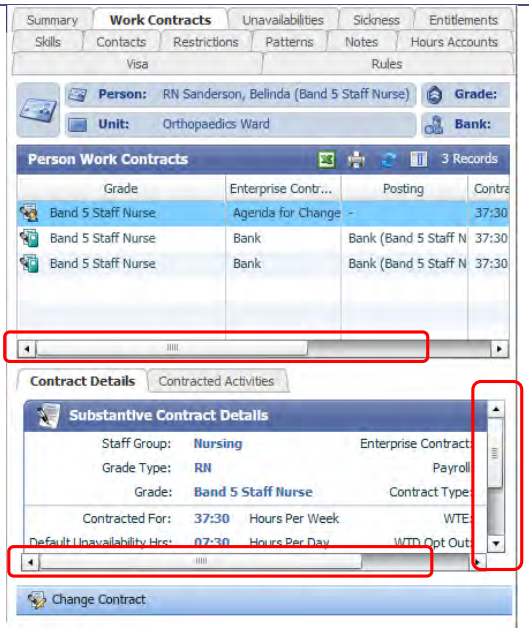


Select the person (click on their name to highlight).

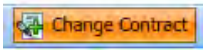
Select the **Work Contracts** tab in the Details pane that displays to the right of the screen (highlighted opposite).

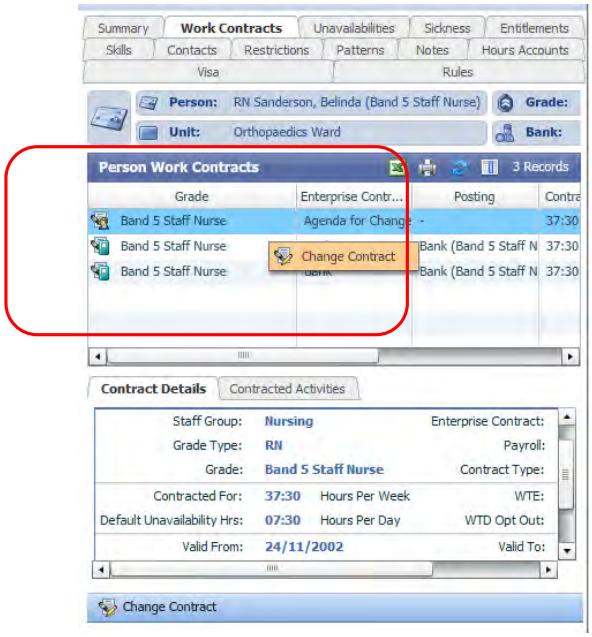


Note: There are scroll bars within the Details pane that can be used to view more information (highlighted opposite).



Select the Contract that needs to be changed and click on **Change Contract** at the bottom of the screen (or right click and select, as shown opposite).

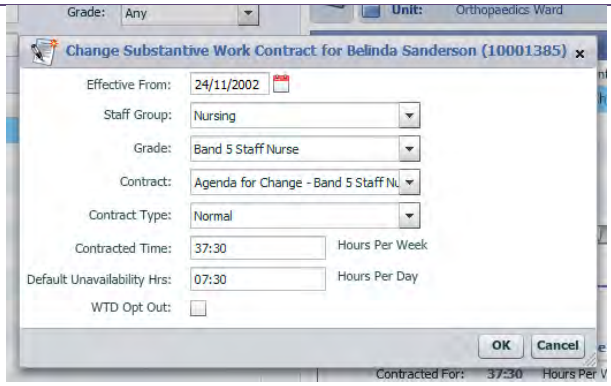




The Contract summary is displayed.

Ensure the correct **Effective From** date is entered. Click on the calendar icon and use the calendar to navigate to the correct date when the change takes effect.

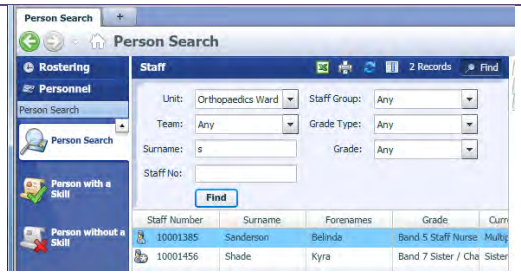
Work through the various fields to select the correct information for the change from the drop down lists.

Note: The **Default Unavailability Hrs** field requires you to specify how many work-time hours should be accounted for, by default, for a day of Unavailability (e.g. Leave, Sickness, or a Study Day). This will be 7.5 hours for example for a 37.5 hour contracted person who usually works 5 days per week. Click on **OK** to save changes, or **Cancel** to close the form without making changes.	

VIEWING/EDITING RESTRICTIONS

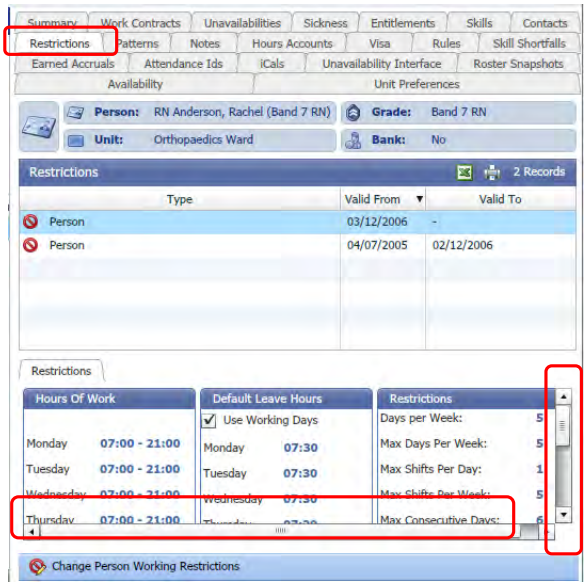
Restrictions are any limitations on the days and/or hours that people are available to work. **If a person cannot work nights, or only works week days, or can only work until a set time on certain days, these are set as Restrictions.** **Note:** The changing of working restrictions, should be carefully undertaken. It is important to ensure that the correct 'valid from' date is entered for such changes, to ensure that historical data is not affected. Use the filters in the **Person Search** screen to locate the record for the staff member	

whose details you wish to change.



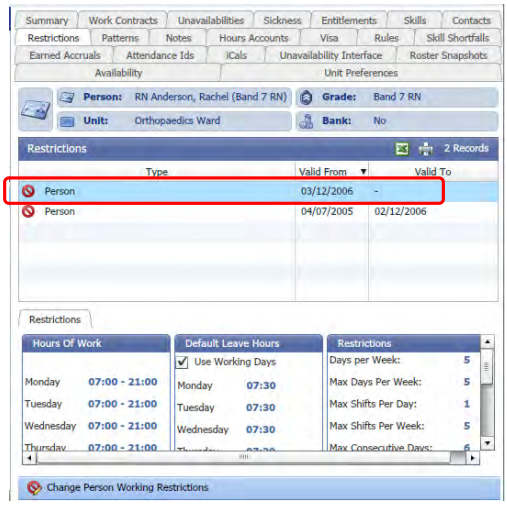
Select the person (click on their name to highlight).

Select the **Restrictions** tab in the Details pane that displays to the right of the screen (highlighted opposite).



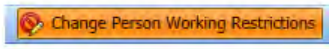
Note: There are scroll bars within the Details pane that can be used to view more information (highlighted opposite).

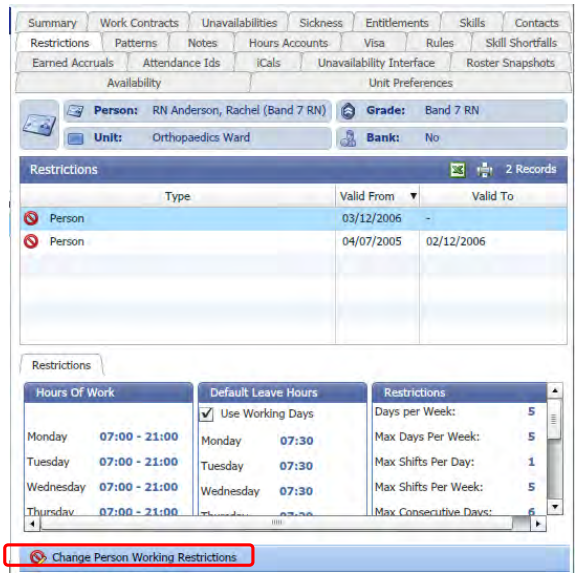
Select (click on and highlight) the set of restrictions that needs to be reviewed (highlighted opposite).



Note: If a person has multiple contracts/postings, more than one option will be displayed.

Click on **Change Person Working Restrictions** at the bottom of the screen (or right click and select, as shown opposite).





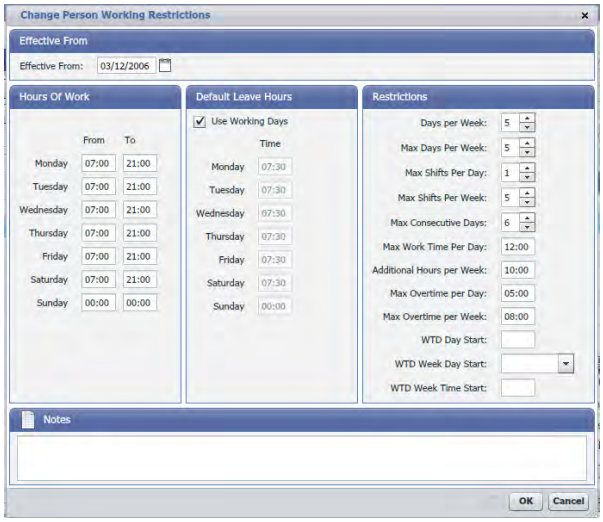
The **Restrictions** summary is displayed.

Ensure the correct **Effective From** date is entered. Click on the calendar icon and use the calendar to navigate to the correct date when the change takes effect.

Work through the various fields to select the correct information for the change.

Note: The **Hours Of Work** is set by default as From 00:00 and To 23:59. This shows that the person is available to work for 24 hours, i.e. they can work any time on such days.

Click on **OK** to save changes, or **Cancel** to close the form without making changes.

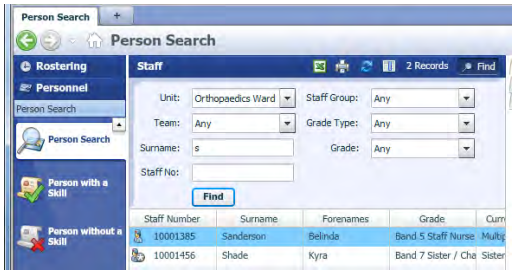


ADDING SKILLS

HealthRoster can be used to track people's skills, including training received, qualifications and professional registrations for clinical staff.

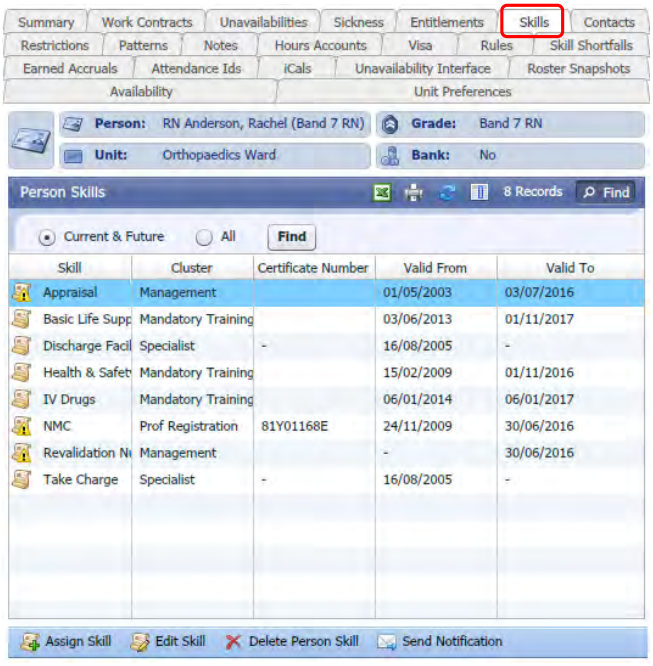
In HealthRoster, you can create the demand for people with specific skills on selected shifts. You can also use Skills records and reports to identify who needs training, and incorporate training and study days into the rosters.

Use the filters in the **Person Search** screen to locate the record for the staff member whose details you wish to change.



Select the person (click on their name to highlight).

Select the **Skills** tab in the Details pane that displays to the right of the screen (highlighted opposite).



You can filter the information display to show:

- Current and Future Skills
- All Skills

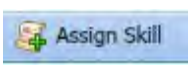
Select the appropriate radio button to filter (highlighted opposite).

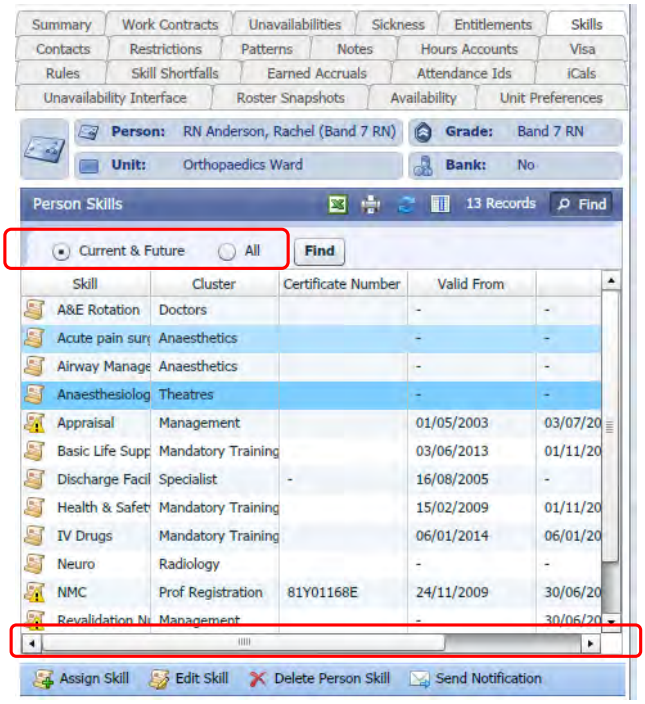
Note: There are scroll bars within the Details pane that can be used to view more information (highlighted opposite).

Skills that have expired are (dependent on your View Date), are displayed with a greyed-out icon:

Skills that are going to expire within the next 3 months are displayed with a warning icon:

Click on **Assign Skill** at the bottom of the screen (or right click and select, as shown opposite).





The **Assign Skill** form is displayed.

Select the **Skill Group** from the drop down menu, followed by the **Cluster** and the **Skill**.

Click on the calendar icon next to the **Valid From** field, and use the calendar to select a Valid From date.

Repeat the above step to select a **Valid To** date.

Note: The **Valid To** date should be the last date that the Skill is valid, not the day is it expired.

Select the **Date Gained**. This may be different to the **Valid From** date.

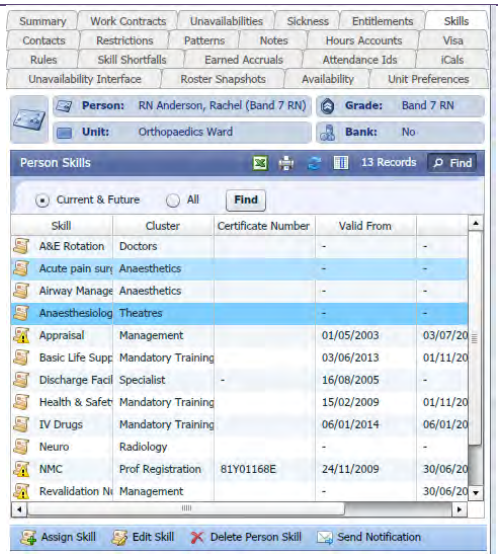
Select an **Obtained From Reason** from the drop down list.

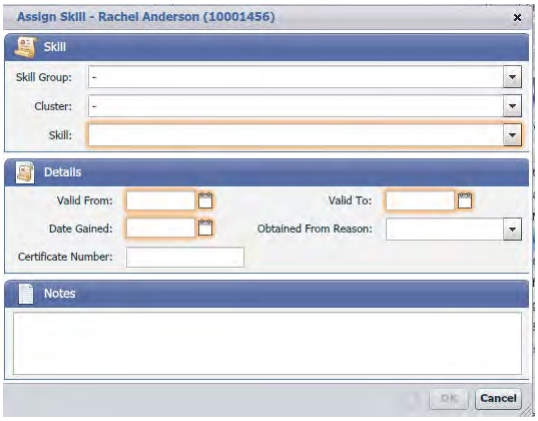
If applicable, enter a **Certificate Number**.

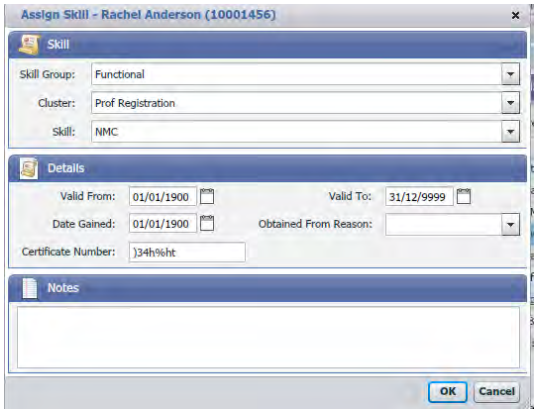
Note: Notes are free-text.

Click on **OK** to save.

The newly added skill will be displayed under the Skills tab in the Details pane.

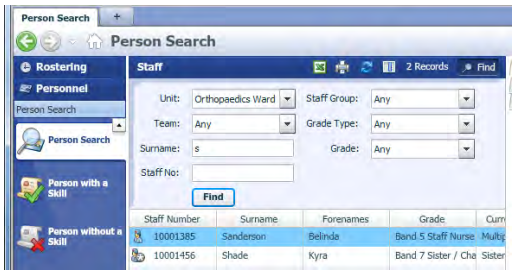






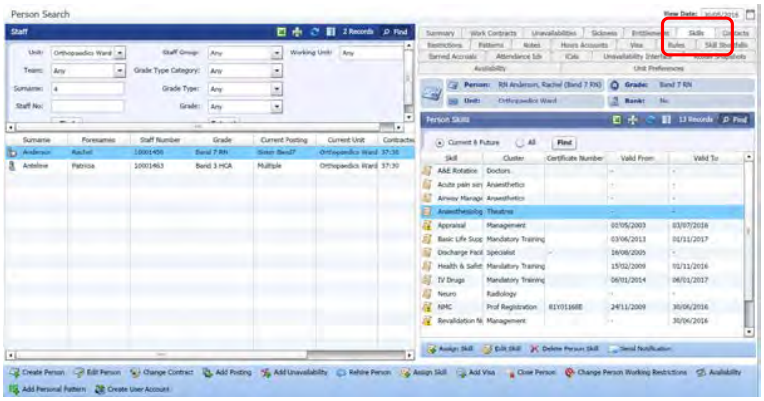
EDITING SKILLS

Use the filters in the **Person Search** screen to locate the record for the staff member whose details you wish to change.



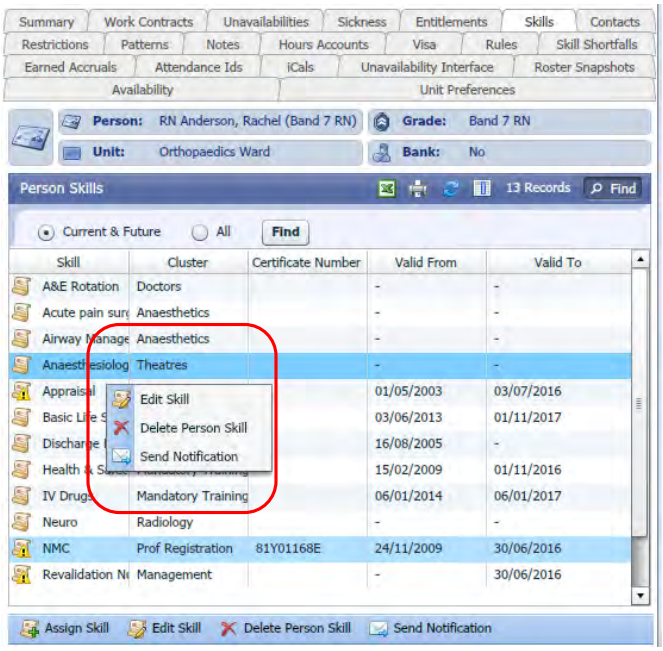
Select the person (click on their name to highlight).

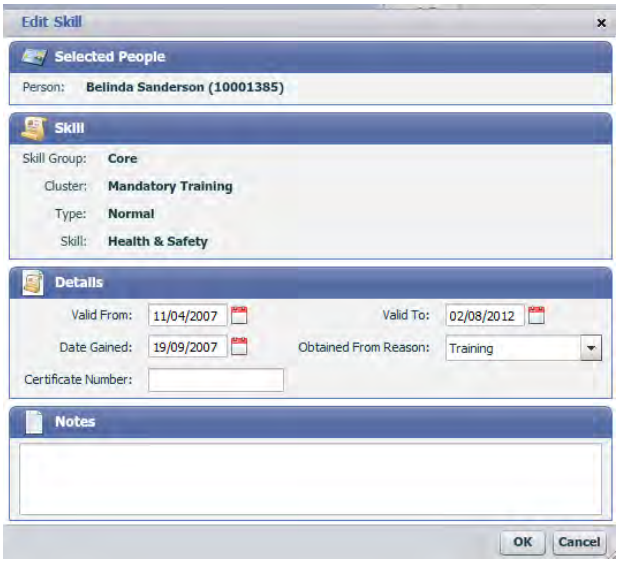
Select the **Skills** tab in the Details pane that displays to the right of the screen (highlighted opposite).



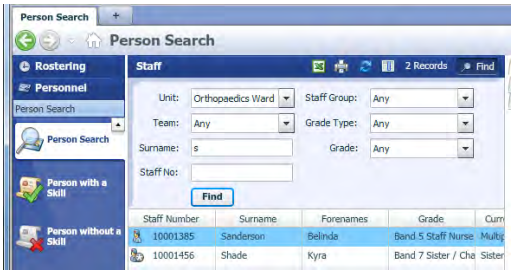
Click on / highlight the **Skill** that needs to be amended.

Click on the **Edit Skill** button at the bottom of the **Details** pane, or right click and select the option (highlighted opposite).



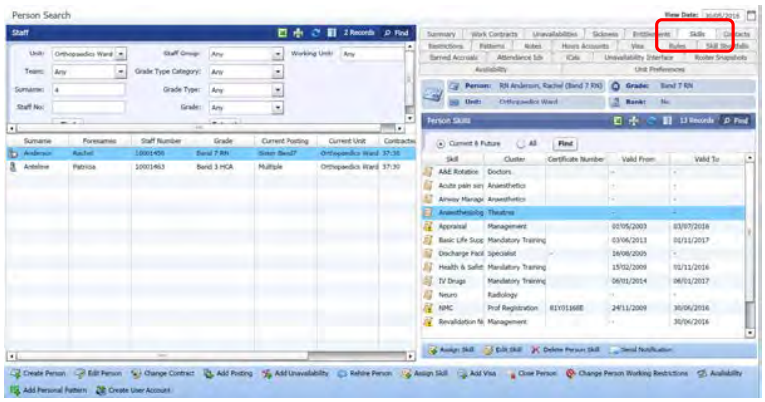
The **Edit Skill** form will be displayed. Change the **Details** as required then clock on **OK** to save.	

DELETING SKILLS (FROM A PERSON)

Note: You should only delete a Skill from a person's record if it was added in error (i.e. they never had it). **When a person's Skill expires, you should Edit the Skill to change the Valid To date.** **This will ensure that the record is accurate and that historical data and rosters are not affected.** Use the filters in the **Person Search** screen to locate the record for the staff member whose details you wish to change.	

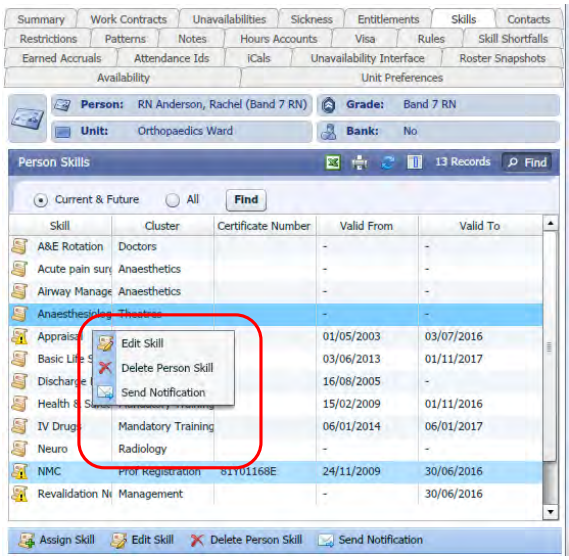
Select the person (click on their name to highlight).

Select the **Skills** tab in the Details pane that displays to the right of the screen (highlighted opposite).



Click on / highlight the Skill that you wish to delete.

Click on the **Delete Person Skill** button at the bottom of the **Details** pane, or right click and select the option (highlighted opposite).



A message will appear asking you to confirm or cancel the action.

Click on **OK** to save.

The skill will be removed.

ADDING SKILLS IN BULK

You can add the same Skill to multiple people at the same time.

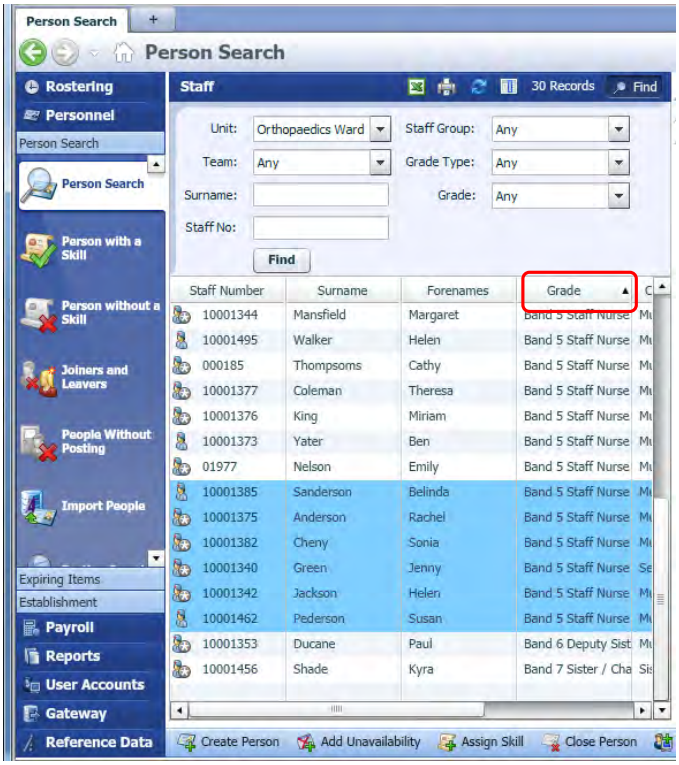
This is useful when several people attend the same training event.

Note: You can only add Skills to multiple people at the same time if the **Valid From** and **Valid To** dates are the same.

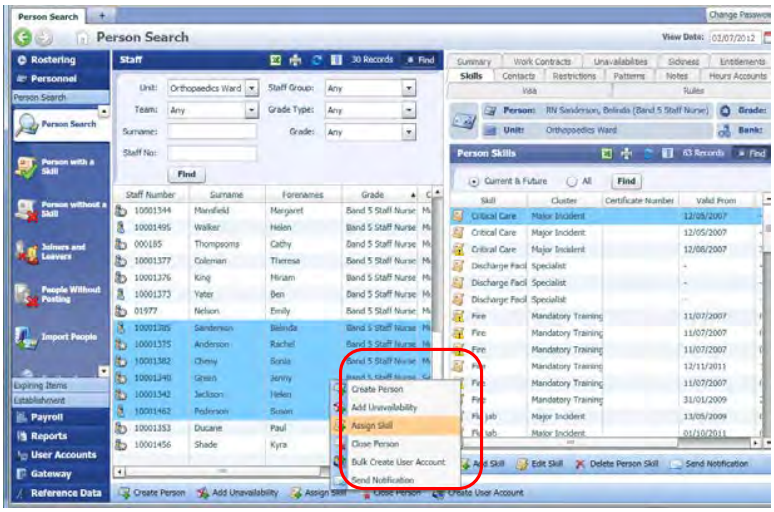
Use the filters in the **Person Search** screen to return a list of all staff for your ward/Unit, whose details you wish to change.

Note: You can click on a column heading to sort staff records in to a specific order, for example by Grade (highlighted opposite).

Use the CTRL key on your keyboard to highlight/select a number of people.



Click on **Assign Skill** at the bottom of the screen, or right click and select the option (highlighted opposite).



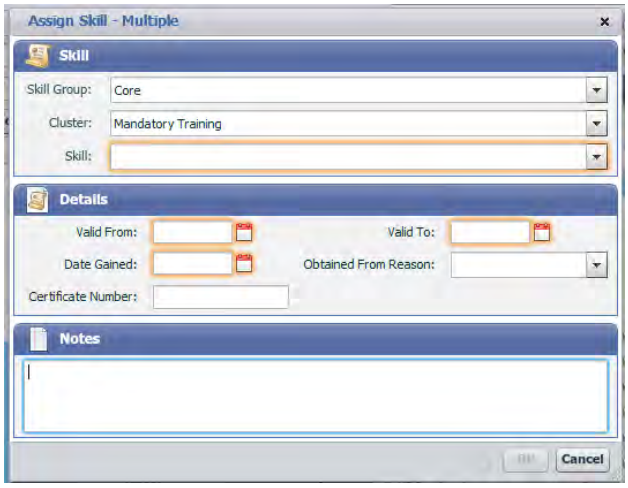
The Assign Skill form will open.

Complete the fields as appropriate to add the same Skill to all staff.

Note: You can only add a Skill to multiple people when the **Valid From**, **Valid To** and **Date Gained** dates are the same for all people.

Click on **OK** to save.

Note: You can check the skill has been added by selecting/highlighting staff individually and checking the **Skills** tab on the **Details** pane.



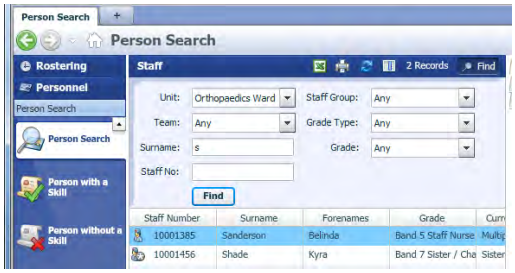
VIEWING INDIVIDUAL UNAVAILABILITY RECORDS

Unavailability episodes such as annual leave, sickness and study days can be viewed in the rosters.

It is also possible to run various reports on Unavailability, using filters to search for specific types of Unavailability, and/or within certain dates.

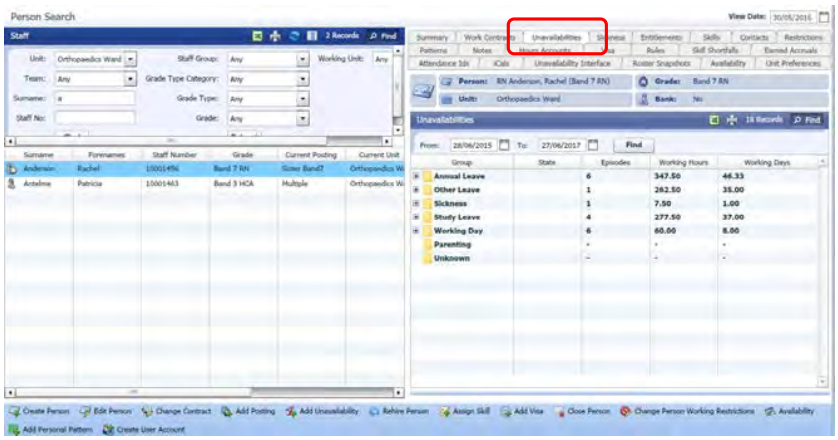
A summary of an individual staff member's Unavailability (past, present and planned) can also be viewed within a person's staff record in HealthRoster.

Use the filters in the **Person Search** screen to locate the record for the staff member whose details you wish to change.



Click on the person's name as it appears in the list to highlight their record, and select the **Unavailabilities** tab in the **Details** pane to the right of the screen (highlighted opposite).

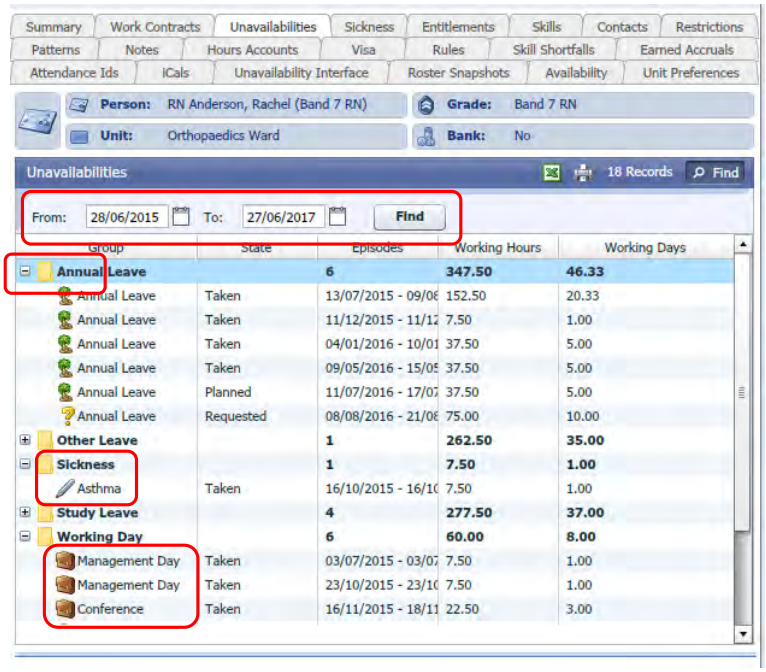
A series of folders will be displayed.



Click on the + to the left of each folder to open it and display all the recorded episodes.

Note: You can click on the calendar icon next to the **From** and **To** fields to open the calendar and choose a date range for the episodes you wish to view (highlighted opposite).

Remember to click on the **Find** button when you choose specific date ranges.

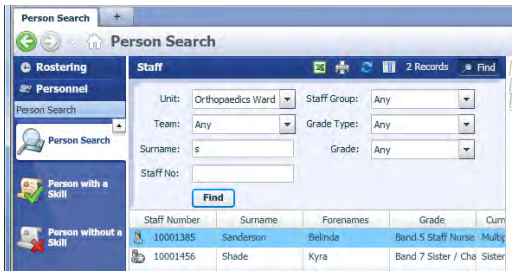


ADDING UNAVAILABILITY IN PERSON SEARCH

Unavailability can be added to a person within the rosters. It can also be added to a person's record at any time, which enables planned/future Unavailability such as annual leave, study days etc. to be recorded and scheduled in advance.

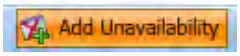
Episodes of Unavailability added to a person's record will automatically be populated in rosters when the roster for the period covering the episode is loaded.

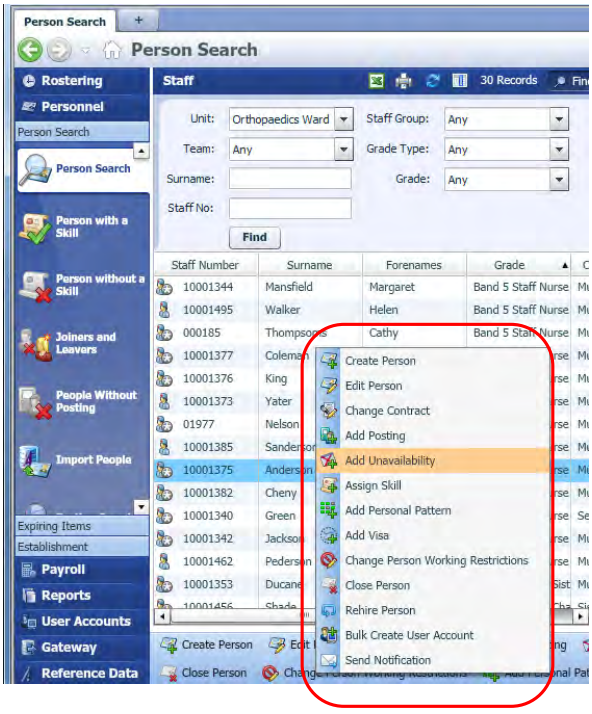
Use the filters in the **Person Search** screen to locate the record for the staff member to whom you wish to add an episode of **Unavailability**.



Select/highlight the name of a person in the **Person Search** screen.

Click on the **Add Unavailability** button at the bottom of the screen, or right click and select the option (highlighted opposite).





The **Add Unavailability** form will open.

Select the **Group** (e.g. Annual Leave) from the drop down list.

Select the **Reason** (e.g. A/L – Annual Leave) from the drop down list.

Select the **State** from the drop down list (highlighted opposite).

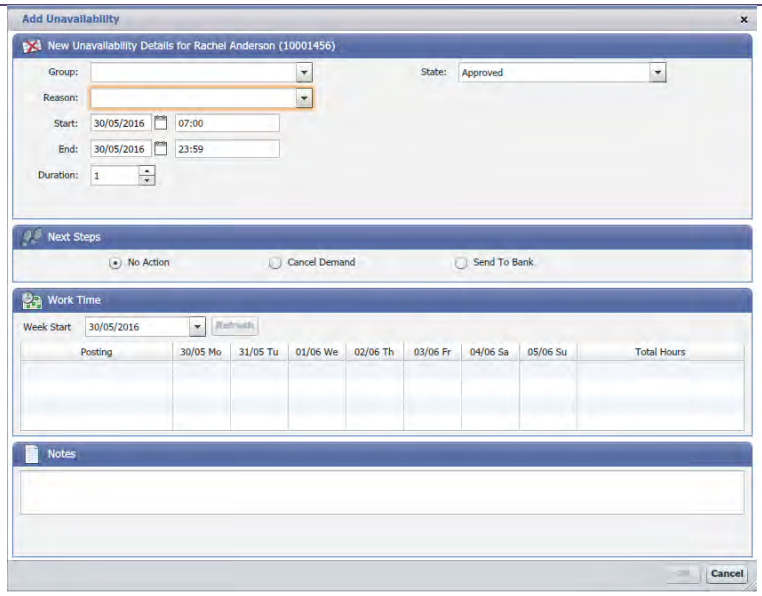
Note: The **State** refers to the status of the episode, i.e. whether it is **Approved** (confirmed), **Pencilled** (not yet confirmed) or **Cancelled**.

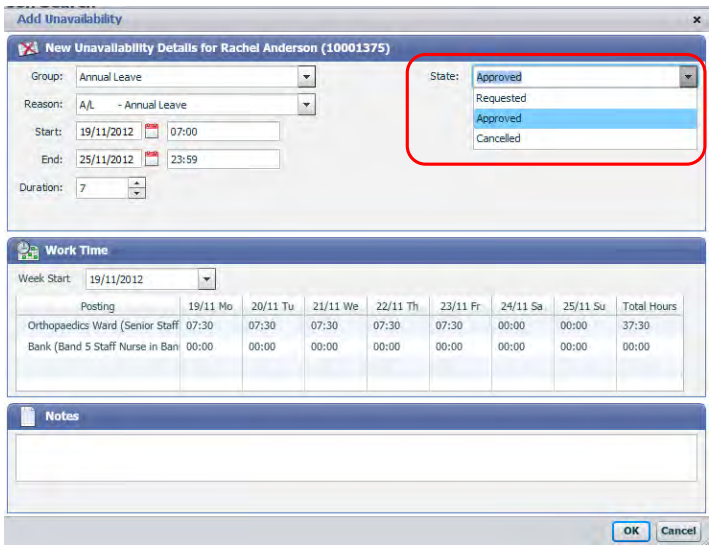
Cancelled is used when a planned or requested Unavailability is declined or cancelled (so when editing an episode).

Annual Leave and **Study Day Requests** made by a staff member via Employee Online are automatically given the **State** of **Pencilled**, pending approval or cancellation by the manager within HealthRoster.

Click on the calendar icon next to the **Start** field to open the calendar and select a date.

Note: The Start date of an episode of Unavailability should be the first day of absence/unavailability.

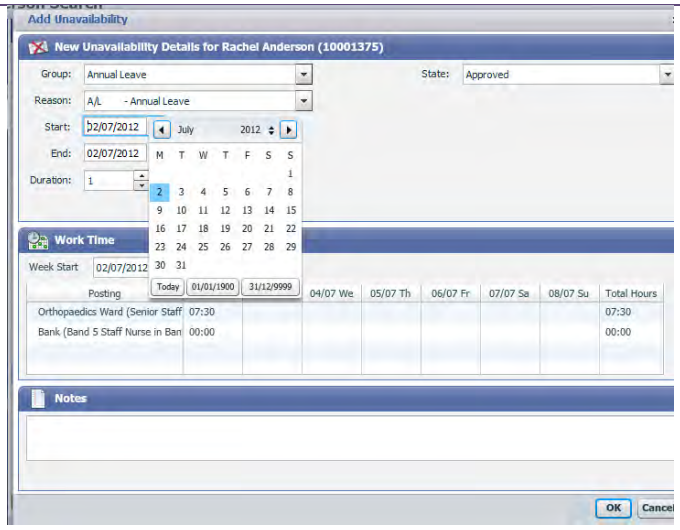




Click on the calendar icon next to the **End** field to open the calendar and select a date.

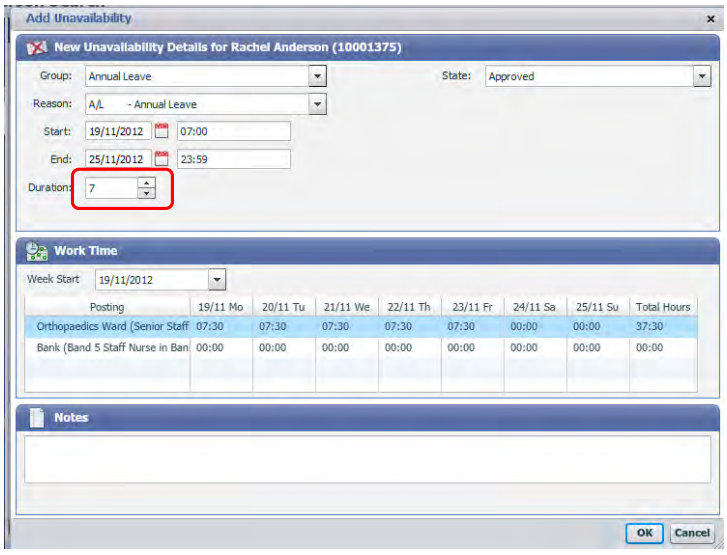
Note: It is important that the **End** date is the last day of absence, not the day the individual returns.

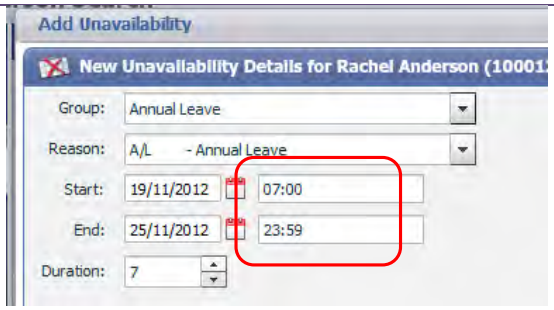
Note: You can enter the **Duration** (in days) using the arrows in that field (highlighted opposite) and the **End** date will be calculated for you.



The time fields to the right of the **Start** and **End** date fields (highlighted opposite) allow you to record a part-day episode of Unavailability. For example, a 2-hour supervision, or a half-day Study Day.

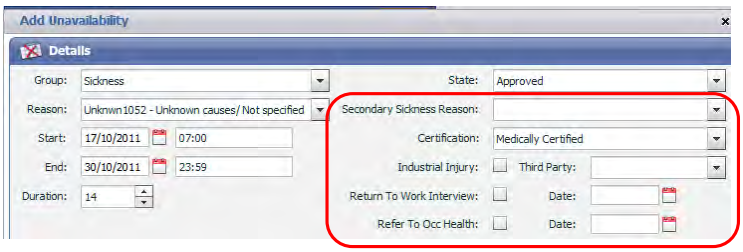
Note: If you need to ensure that a Night shift is not added on to a daytime study ensure you leave the end time default later than when the night shift starts.





Note: If you are adding an episode of **Sickness**, further options will be displayed at the top of the form (highlighted opposite):

- The **Secondary Sickness Reason** relates to ESR (NHS only) reasons
- There are rules that can be set around when a **Medical Certificate** should be presented, so it is important to complete this field correctly
- There is the option to record additional information such as Occupational Health referrals

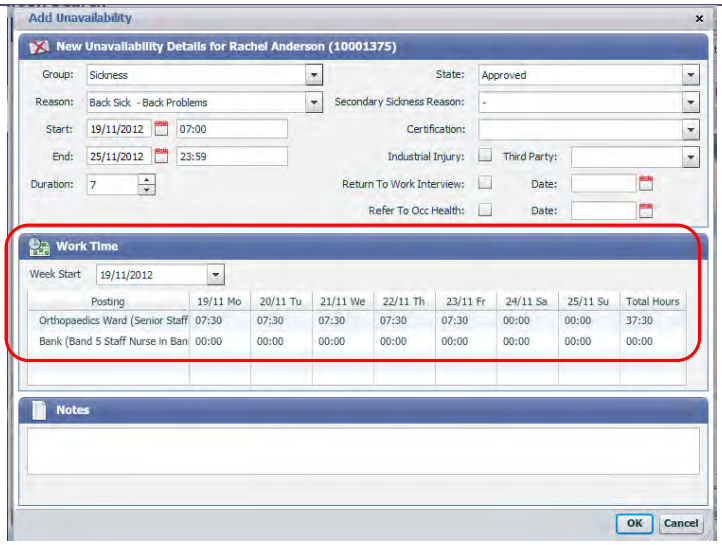


When the Start and End dates of an episode have been added, **Work Time Information** will be displayed at the bottom part of the form (highlighted opposite).

This shows the number of Working Time (contracted) hours the system has calculated are accounted for per day of the episode. Where a person has more than one Posting, a line for each will be displayed.

Note: This is based on the default **Contract** settings and the **Restrictions** of the individual, but can be overridden.

Note: To adjust the calculated hours, click on the number of hours and manually type in the correct figure.

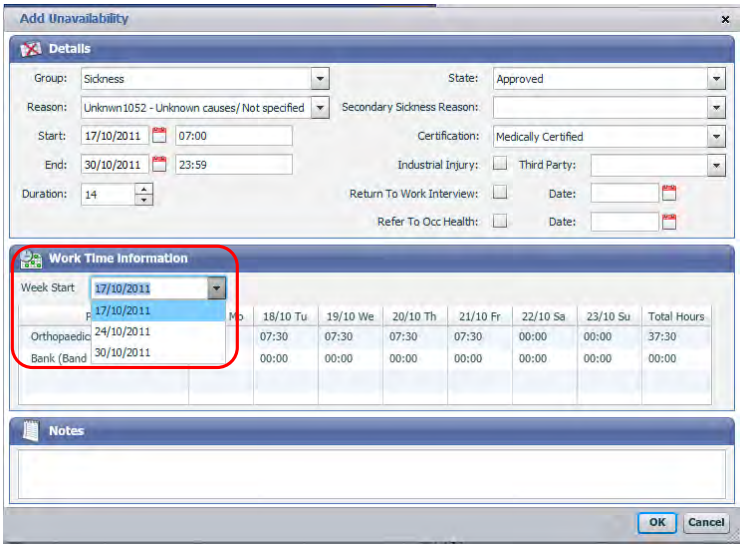


When an episode of Unavailability spans more than one week, it is possible to view the Work Time Information for each week within the episode.

Simply click on the arrow in field next to **Week Start** (highlighted opposite) and select each week in the drop down list, to check the calculated hours.

You can add **Notes** if required.

Click on **OK** to save.

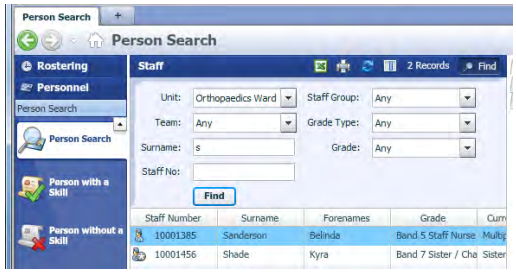


EDITING UNAVAILABILITY IN PERSON SEARCH

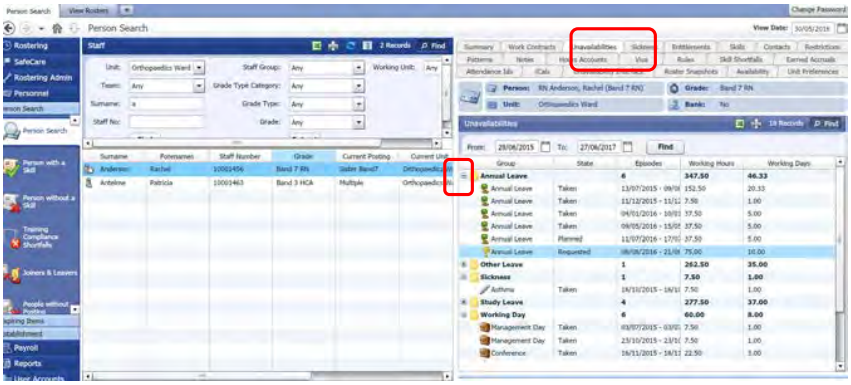
Episodes of Unavailability can be edited where they appear within a roster. They can also be edited within a person's staff record.

This ensures that planned/future Unavailability can be easily amended, and is not dependent on a roster.

Use the filters in the **Person Search** screen to locate the record for the staff member whose Unavailability you wish to amend.

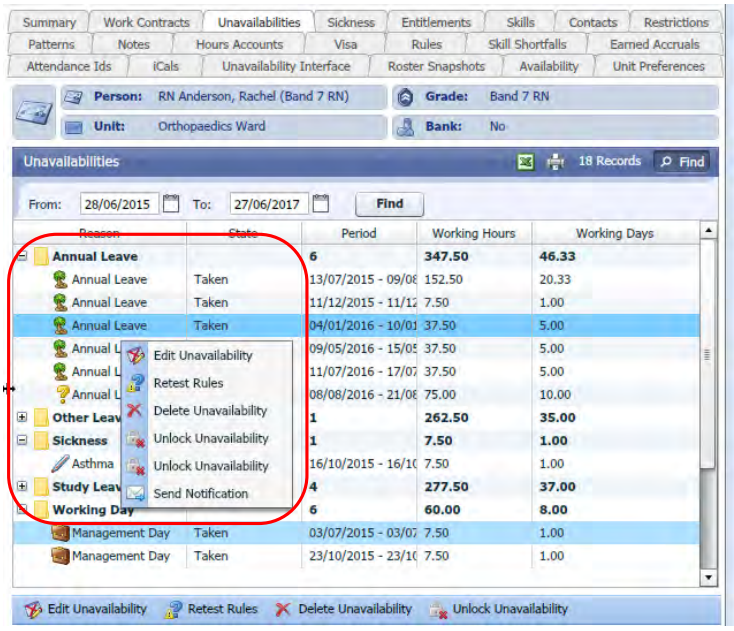


Click on/highlight the name of the person as it appears in the returned list.



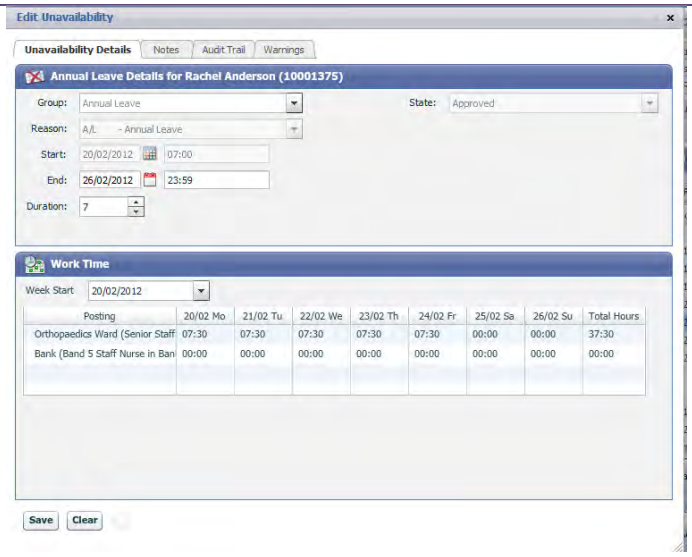
Select the **Unavailabilities** tab in the **Details** pane (highlighted opposite).

Expand the appropriate **Unavailability Group** folder by clicking on the **+** to the left of the folder (highlighted opposite).



Select/highlight the **Unavailability** episode that you wish to edit.

Click on the **Edit Unavailability** button at the bottom of the screen, or right click and select the option (highlighted opposite).

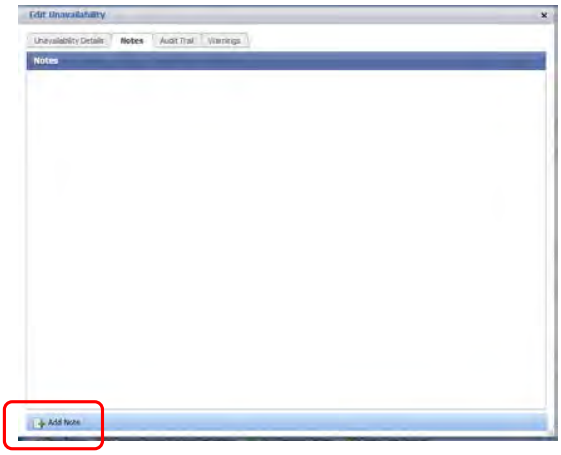


The **Edit Unavailability** form will open.

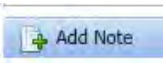
Make the required changes, for example changing the **Start** or **End** dates, or Start and End times.

Click on **Save**.

You can add **Notes** to an Unavailability episode. To do this, select the **Notes** tab in the Edit Unavailability form (shown opposite).



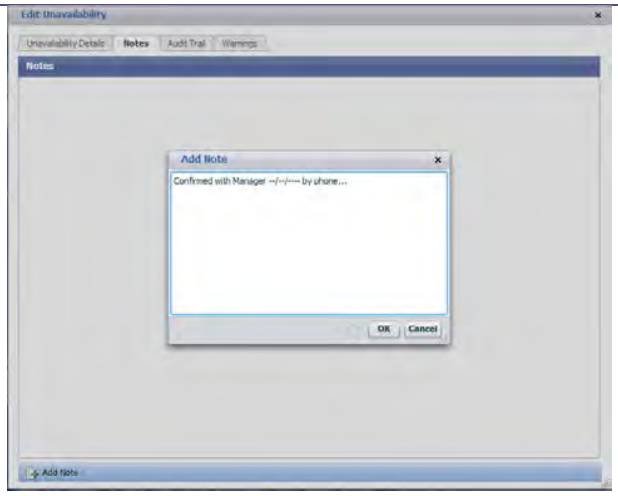
Click on the **Add Note** button at the bottom of the window (highlighted opposite).

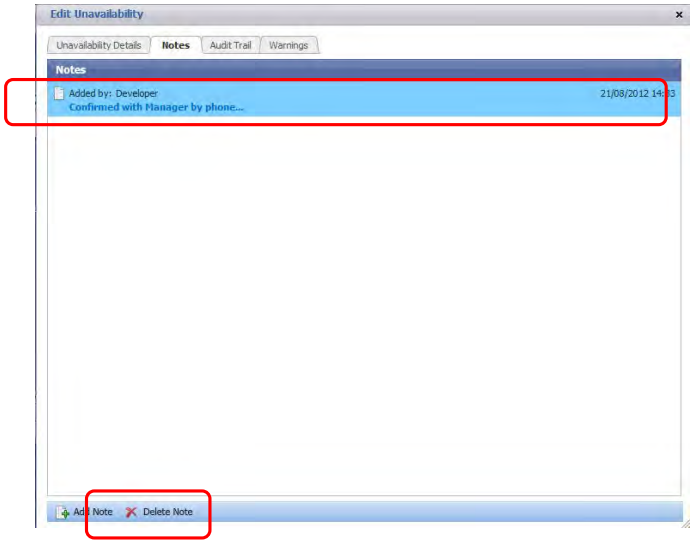


The **Add Notes** window will open.

Add the required notes in the text box and click on **OK** to save them.

The Note will be added and details of who added the note, and when it was added, will be displayed (as shown opposite).





Note: To delete a Note simply highlight the Note in the Notes tab screen, and click on Delete Note at the bottom (highlighted opposite).

It is possible to view an **Audit Trail** on Unavailability episodes. Simply click on the **Audit Trail** tab in the **Edit Unavailability** form, as shown opposite.

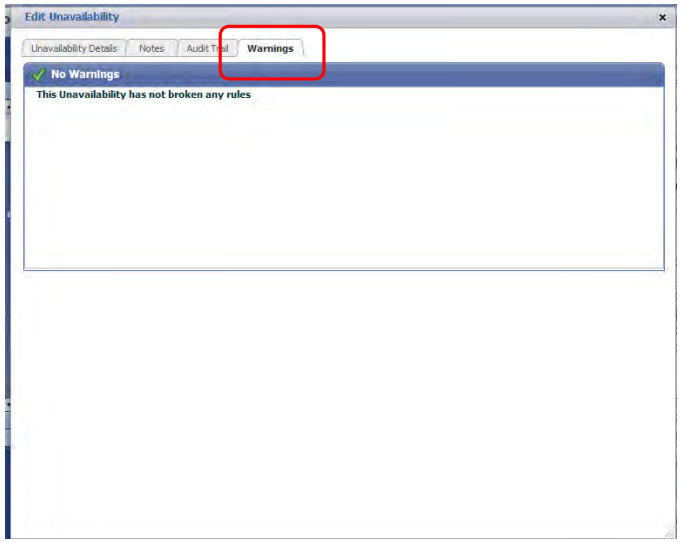
The **Audit Trail** pane should display any change events, who changed it, the date of the change, and the Lead Time.

Note: The **Lead Time** is the period of time before the start of the Unavailability episode that the change was made.

Unavailability Rules can be set up in HealthRoster. These are restrictions around a variety of things, such as:

- the maximum number of people who can be on leave or study at the same time
- the maximum length of annual leave episodes
- the maximum number of sickness episodes that a person is allowed before a warning is generated.

Outside of a roster, it is possible to view the



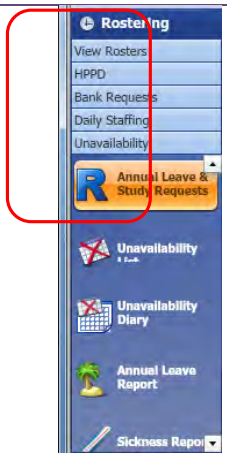
details of any warnings (rule breakages) associated with an individual episode. To view any warnings associated with an episode of Unavailability, select the **Warnings** tab in the **Edit Unavailability** form (shown opposite). If there are no Warnings, a message will confirm this.	

EDITING ANNUAL LEAVE AND STUDY DAY REQUESTS

Staff can make requests for Annual Leave or specific Study Days at any time via Employee Online. **If a roster exists for the period covering the request, it will appear in the roster with a ? icon on it, and can be Approved or Declined from the roster screen.** **Annual Leave and Study Day Requests made via Employee Online can also be Approved or Declined within a specific shortcut report. This means that Requests for the future can be approved and**	

planned for well in advance.

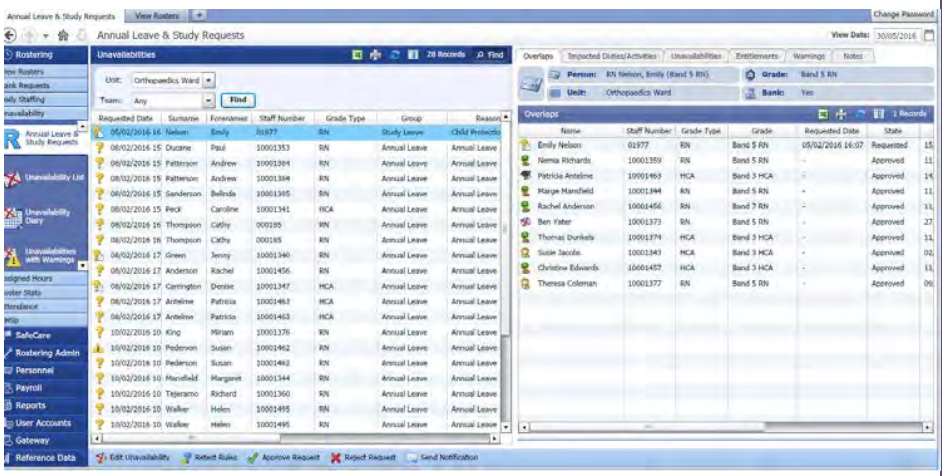
To view outstanding Annual Leave and Study Day Requests and Approve/Decline them outside of rosters, navigate to the **Unavailability** task group within the **Rostering** master group (shown opposite).



Select the **Annual Leave & Study Requests** shortcut.

Select your ward/Unit from the **Unit** drop down list and click on **Find**.

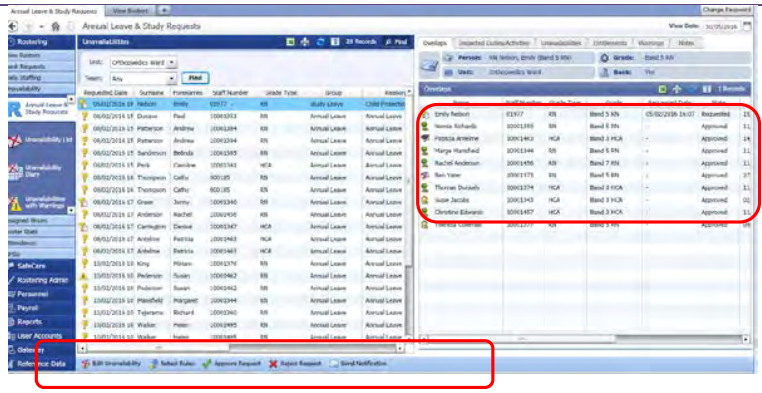
A list of all outstanding **Annual Leave** and **Study Requests** for your ward/Unit will be displayed (highlighted opposite).



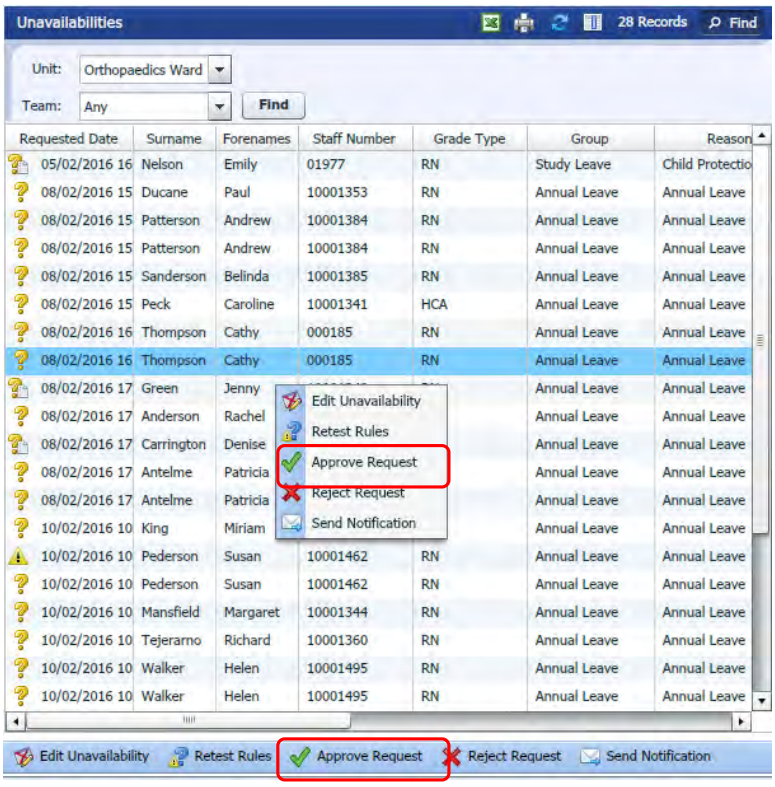
Note: They have a ? icon associated with them which means that they are 'pencilled' in (i.e., awaiting approval).

To **Approve** a **Request**, select/highlight the Request you wish to Approve.

Note: The **Details** pane to the right of the screen will show any **Overlaps**. These are episodes for other people at the same time (highlighted opposite).



Click on the **Approve Request** button at the bottom of the Details pane (Or right click option (highlighted opposite).



A message will appear, asking you to confirm if you wish to Approve the Request.

Click on **OK** to **Approve**.

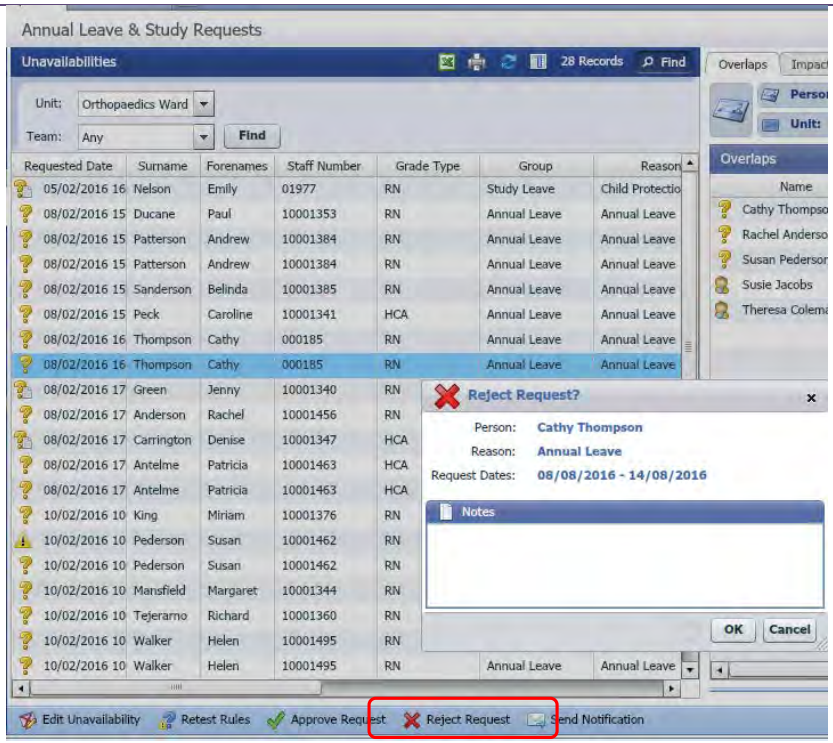
Note: The episode/Request will disappear from the Annual Leave & Study Requests shortcut screen, and can be found within the Details pane that displays the person's record (in the Person Search screen), under the Unavailabilities tab.	
The staff member will be able to see that the Request has been approved instantly in Employee Online.	
To **Reject**/decline a **Request**, select/highlight the Request you wish to Reject.	
Note: If you are Rejecting a Request, it is helpful to select the Notes tab and add a note explaining the reason for rejection. Click on the **Reject Request** button at the bottom of the Details pane (highlighted opposite). A message will appear, asking you to confirm if you	

wish to Reject the Request.

Click on **OK** to **Reject**.

Note: The episode/Request will disappear from the Annual Leave & Study Requests shortcut screen.

The staff member will be able to see that the Request has been Rejected instantly in Employee Online.

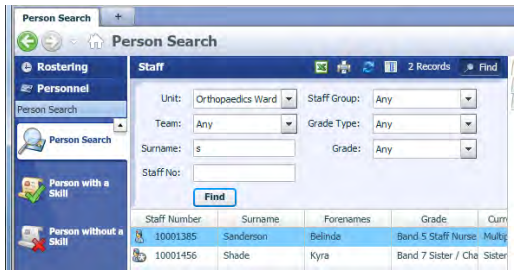
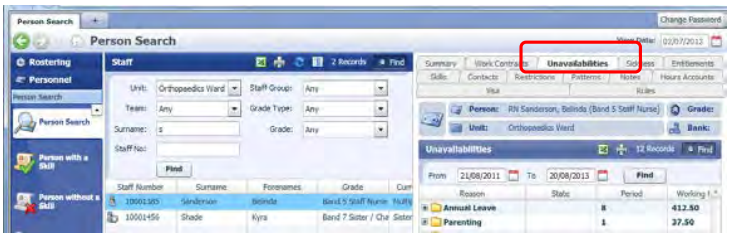


There are also tabs in which can be viewed:

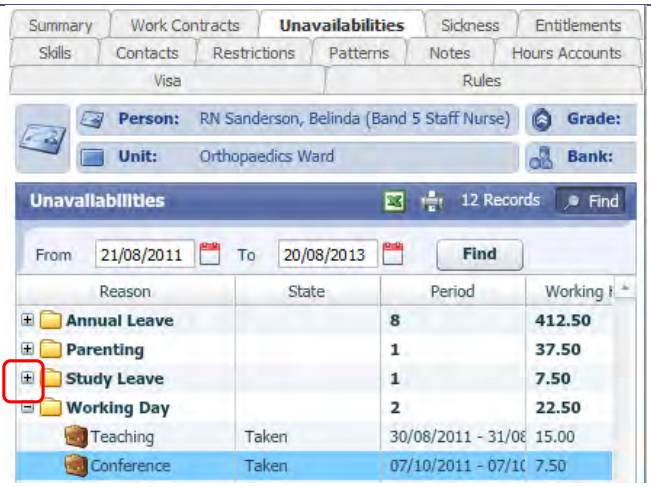
- A summary of **Impacted Duties/Activities** that this unavailability will cover
- A summary of **Unavailabilities** for the person
- A summary of the person's Leave **Entitlement**(s) and balance(s)
- Any **Warnings** associated with the Request, i.e. rule breakages
- Any **Notes**, added at the time the Request was made by the employee, or

added later by a Manager.	

DELETING UNAVAILABILITY IN PERSON SEARCH

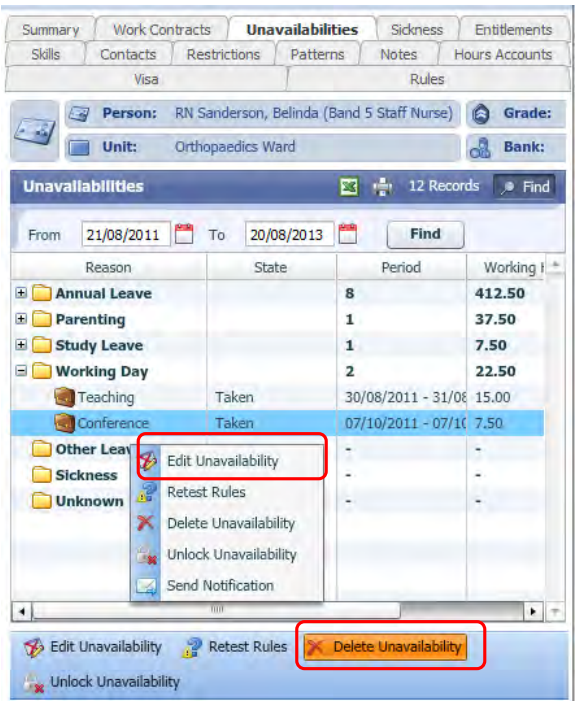
Unavailability episodes should only be deleted if they were originally added in error. **Episodes that were/are planned but then did/do not take place after all should be edited, and their State should be changed to Cancelled.** Use the filters in the **Person Search** screen to locate the record for the staff member whose Unavailability episode you wish to view and delete. Select/highlight the name of the person as it appears in the returned list. Select the **Unavailabilities** tab in the **Details** pane to the right of the screen (highlighted opposite). Expand the appropriate **Unavailability Group** folder by clicking on the **+** to the left of	 

the folder (highlighted opposite).



Highlight/select **Unavailability** episode you wish to delete.

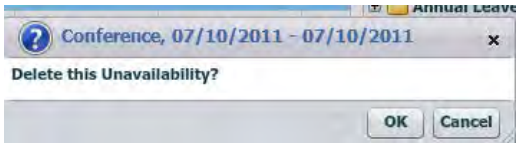
Right click and select **Delete Unavailability**, or click on the action button at the bottom of the **Details** pane (highlighted opposite).



A message will appear asking you to confirm the action.

Click on **OK**.

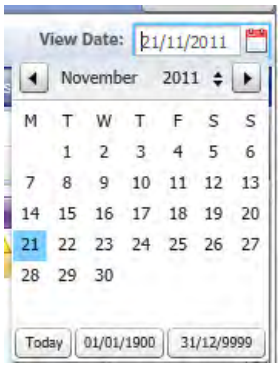
The Unavailability episode will be removed.



3 View and Manage Rosters

LOCATE ROSTER

Use the calendar to change the **View Date** to the date of the roster that you wish to analyse.



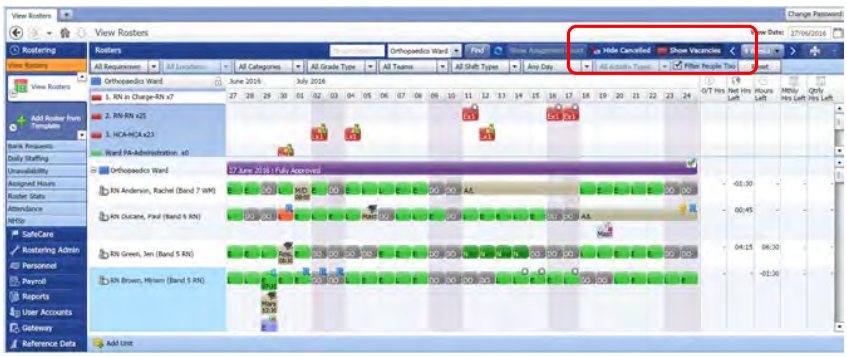
Click on the **Rostering** master group

Click on the **View Rosters** task group and the **View Rosters** shortcut

Select your ward/unit from the drop down menu located on the tool bar.

Click on **Find.**

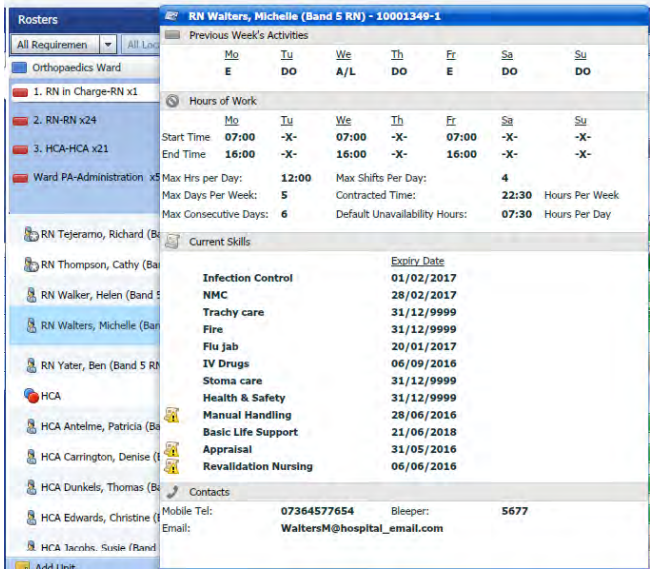
The roster for the selected period will be displayed.



Note: Click on the **Show Vacancies** button in the tool bar to view just the roster with assignments.

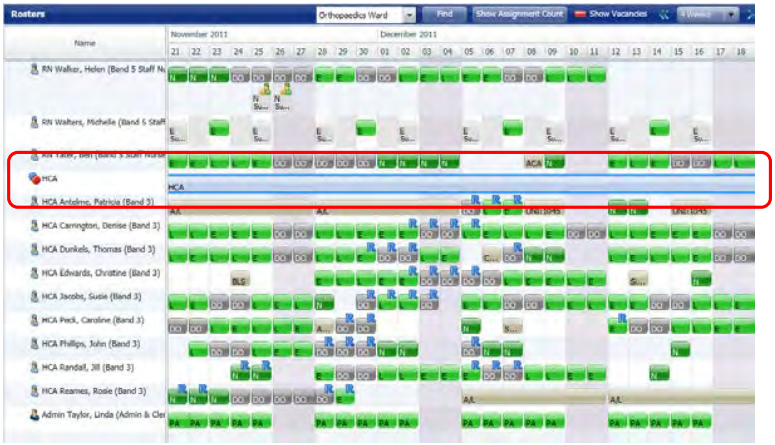
NAVIGATE ROSTER SCREEN

Staff are listed on the left hand side of the screen (grade order and alphabetically within their grade). Hover the cursor over the name of a person to view the tool tip which summarises their previous weeks activities, hours of work and current skills.

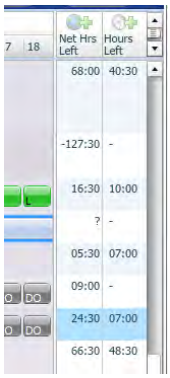


Click on a person's name to view appropriate action buttons at the bottom of the screen.

If the ward/unit uses teams, these are shown on the roster in the required order.



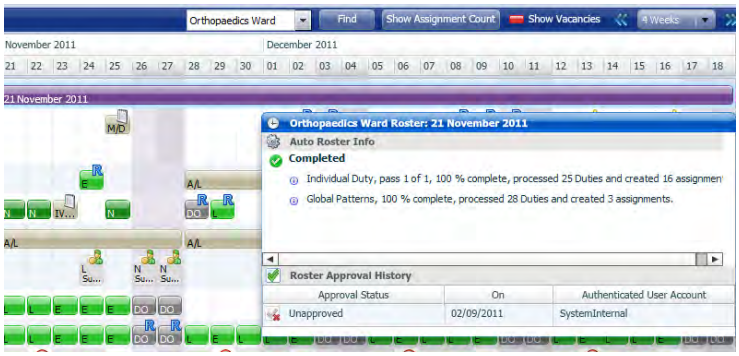
Net Hrs Left and **Hours Left** columns are displayed on the right hand side of the screen.



Hours Left shows the number of hours left to be rostered (or over) for the currently viewed rostered period (against a person's expected contracted hours for the period).

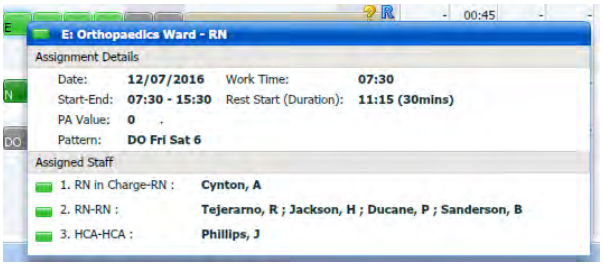
Net Hrs Left shows the number of hours left to be rostered (or over) to the last date of the current view period, from a fixed start date (against a person's expected contracted hours for the period).

Hover your cursor over the purple **Roster Bar** at the top to view **Auto Roster Info** and an Roster **Approval History**.



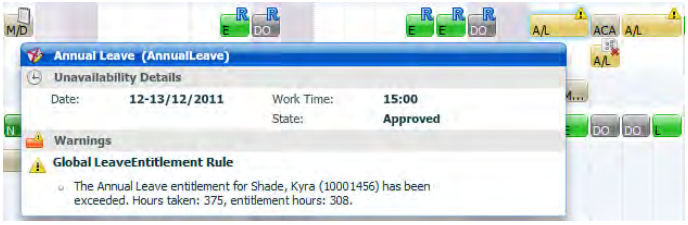
Click on the purple **Roster** Bar, or right click, to see appropriate action buttons at the bottom of the screen.

Hover your cursor over an assigned duty to view the tool tip.



Hover your cursor over an Unavailability to view the tool tip.

Hover your cursor over an assigned duty or Unavailability with warnings to view details of the rule that has been broken in the tool tip.



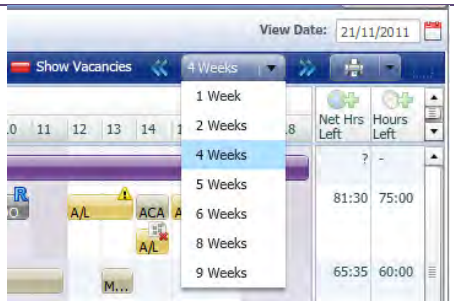
Note: Duties or Unavailability with warnings should be reviewed to check which rule(s) have been broken. Rules can be local or global. It is important to not assume that warnings on similar or consecutive duties are the same.

Change **Diary View** to the following, by clicking on the drop down list located on the tool bar:

- 1 Week View
- 2 Week View
- 4 Week View

- 5 Week View
- 6 Week View
- 8 Week View
- 9 Week View

Note: The Net Hrs Left and Hours Left values will recalculate for each view, as appropriate.



VIEW SKILL MIX SUMMARY BY SHIFT

Click on **Show Assignment Summary**, locate on the tool bar

A summary of the skill mix per shift, per day, is displayed.

The ratio shows the number of skilled (e.g. registered), to unskilled (e.g. unregistered) clinical staff. An asterisk indicates that take charge is covered.

Click on the **X** to the top right of the form to close it.

Week1		Mon 21	Tue 22	Wed 23	Thu 24	Fri 25	Sat 26	Sun 27
	E	2*-0	4*-2	3*-1	3*-2	4*-2	0-2	0-2
	L	3*-3	2*-2	3*-2	2*-1	2*-3	1*-1	1*-1
	N	2*-1	2*-1	2*-1	2*-1	2*-1	2*-0	1*-0
Week2		Mon 28	Tue 29	Wed 30	Thu 01	Fri 02	Sat 03	Sun 04
	E	2*-2	4*-1	1-2	0-2	5*-2	3*-1	0-2
	L	2*-2	1*-3	2*-1	3*-2	2*-2	1-1	2*-0
	N	2*-1	2*-0	2*-0	2*-1	1*-1	2*-0	1*-0
Week3		Mon 05	Tue 06	Wed 07	Thu 08	Fri 09	Sat 10	Sun 11
	E	4*-2	4*-2	5*-1	4*-1	5*-2	1-2	1-2
	L	3*-1	4*-1	2*-2	2*-2	3*-2	2*-1	2*-1
	N	2*-1	2*-1	2*-1	2*-1	2*-1	1*-0	1*-0
Week4		Mon 12	Tue 13	Wed 14	Thu 15	Fri 16	Sat 17	Sun 18
	E	3*-2	5*-2	2-1	0-1	3*-2	1*-1	1*-2
	L	3*-2	1-1	3*-1	4*-2	3*-2	2*-1	2*-0
	N	2*-1	2*-1	2*-1	2*-1	2*-1	1*-0	1*-0

VIEW VACANT DUTIES

Click on the purple **Roster Bar.**

Click on the **Show Vacancies** action button located on the tool bar.

Show Vacancies

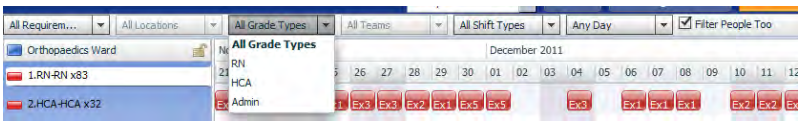
A summary of shifts not yet assigned will appear at the top of the roster.

Click on each **Requirement**.

Click on a **Vacant shift** to view details in the tool tip.

Use filters across the top of the Vacancies screen to sort the Vacant duties as required.

Note: The filters are dynamic, which means only the filters appropriate to the ward/unit's vacant requirements will show. For example, if there are no team-based requirements, the Team filter will not be displayed.



Single or combined filter options can be chosen. **Note**: Only filters that apply to the set up of your ward/Unit and Roster Template will be displayed.	

4 Analyse and Approve Rosters

A roster can be Partially Approved and Fully Approved. It will usually be partially approved by the person who creates the rosters and updates them on a regular basis, and fully approved by the manager.

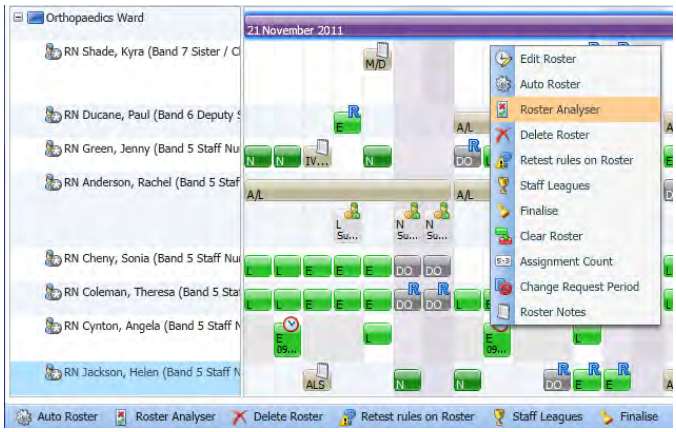
Partially approving a roster then makes it visible in Employee Online, so that staff can see what they are planned to work. Shift and day off requests can no longer be made via Employee Online once a roster has been partially approved. When a roster is fully approved, the data is included in the next data gathering for Roster Perfom, so the stats will be included in the KPI summaries and reports.

The Roster Analyser can be viewed at any point during the development of the roster, to enable an assessment of any issues and the quality of the roster to be made.

VIEW ROSTER ANALYSER

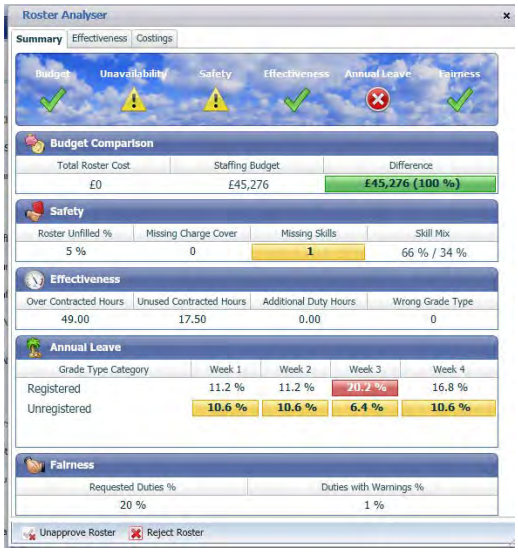
Click on the purple **Roster Bar.**

Right click and select **Roster Analyser**, or click on the action button at the bottom of the screen.

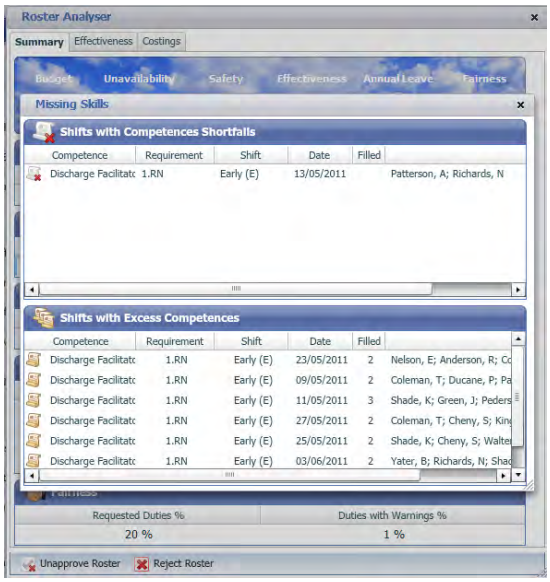


Explore the detail under the **Summary** tab.

The weather forecast image behind the header indicates whether the analysis of the roster shows it to be good or not against KPI/Analyser settings.



Note: You can drill down on some values to see a breakdown of the instances etc. that contribute to the analyser total figure.



Budget Comparison:

a) **Total Roster Cost** shows the cost of delivering the assigned duties, based on the mid-point of the salary ranges of the staff used

b) **Staffing Budget** shows the actual amount that the current budget allows for the period rostered for the ward/unit

c) **Difference** shows the difference between Total Roster Cost and the Staffing Budget

Safety:

a) **Roster Unfilled** % shows the percentage of the total required roster hours (the demand) that are left unfilled

b) **Missing Charge Cover** shows the number of individual shifts where the required competency (take charge cover) has not been met

c) **Missing Skills** shows the number of duties that do not have their required skills covered (excluding Take Charge).

Note: It also shows, when you drill down, the duties where there are more people with an actual skill than is required (this enables you to manage the assigned shifts more effectively).

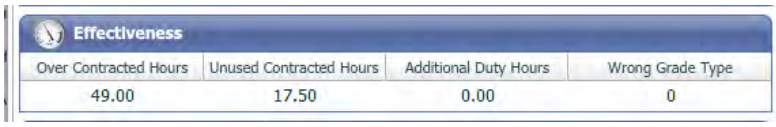
d) **Skill Mix** shows the assigned hours split by registered / unregistered staff

Effectiveness:

a) **Over Contracted Hours** are hours that have been rostered over the normal contracted hours of individuals

b) **Unused Contracted Hours** is a total of the hours that staff are still available to work against their contracted hours

Note: There should not be any that are greater than a whole shift.



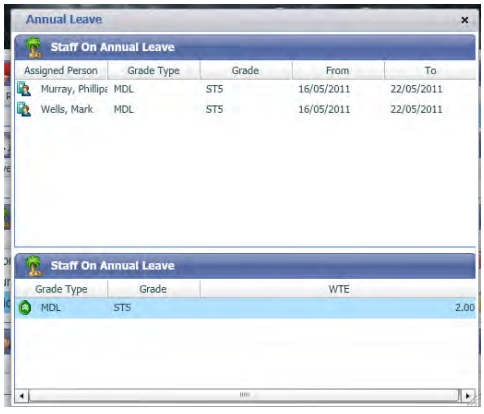
c) **Additional Duty Hours** are the total number of hours where additional shifts have been created

d) **Wrong Grade Type** shows the number of duties assigned to people whose Grade Type does match the requirement of the duty

Annual Leave:

Shows a summary of % of hours allocated to assigned Annual Leave within the roster, by week, and split between Registered and Unregistered staff

Note: Drill down on a value to show WTE details as well as person and duration of each leave episode.

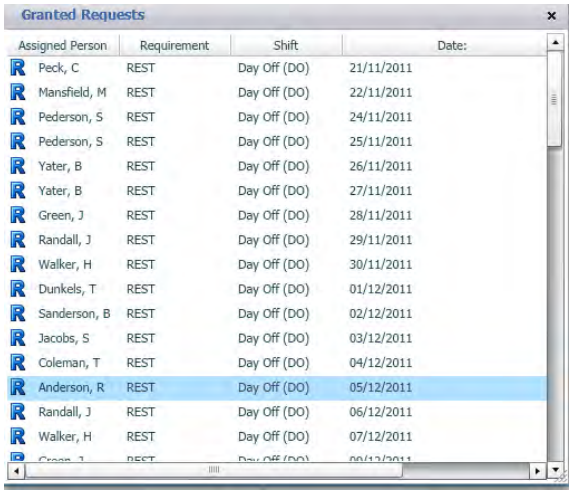


Fairness :

a) **Requested Duties %** shows the % of rostered duties and days off that are requests

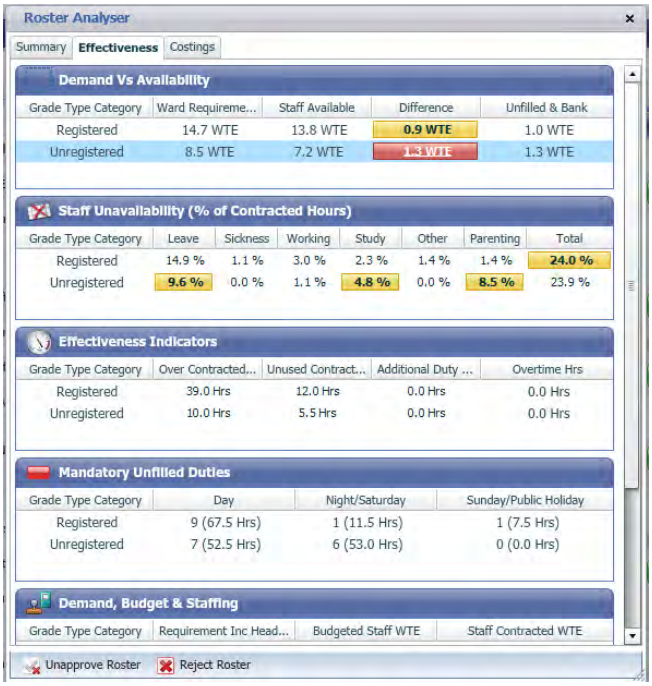
Note: You can click on the values for a breakdown of the detail.

b) Duties with Warnings
%shows the % of rostered duties that break rules and have triggered warnings



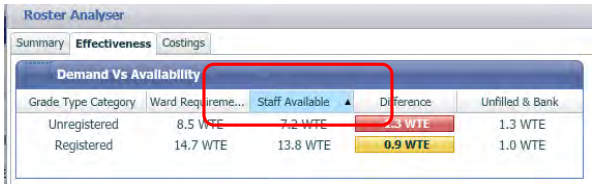
Click on the **Effectiveness** tab to view detail on the quality and effectiveness of the roster.

Note: You can click on a column header and sort the data within that column.



Demand Vs Availability:

Shows the actual demand for the ward/unit for the rostered period, against the availability of the staff, split by Grade Type Category.

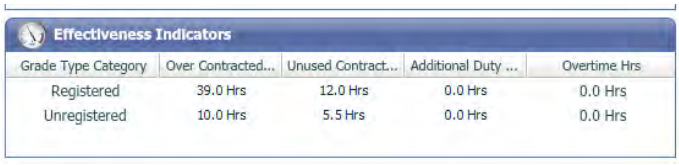


Staff Unavailability:

Shows a clear break down of the total availability of staff for the rostered period by type, split also by Grade Type Category.

Effectiveness Indicators:

Shows essential contracted hours data against additional and overtime hours used within the roster, by Grade Type Category



Mandatory Unfilled Duties:

Shows a break down of the required duties for the rostered period that have not been assigned (fulfilled) by type, and split by the Grade Type Category required to cover them

Mandatory Unfilled Duties

Grade Type Category	Day	Night/Saturday	Sunday/Public Holiday
Registered	9 (67.5 Hrs)	1 (11.5 Hrs)	1 (7.5 Hrs)
Unregistered	7 (52.5 Hrs)	6 (53.0 Hrs)	0 (0.0 Hrs)

Demand, Budget & Staffing:

Shows the required staff in WTE (according to the ward/unit demand in the roster template), against the budgeted staff in WTE, against the WTE of staff actually contracted. This is also broken down by Grade Type Category.

Demand, Budget & Staffing

Grade Type Category	Requirement Inc Head...	Budgeted Staff WTE	Staff Contracted WTE
Registered	18.9 WTE	16.3 WTE	18.1 WTE
Unregistered	10.9 WTE	8.5 WTE	9.4 WTE

Filled Duties:

Shows the number of duties filled; mandatory, optional and additional; for the rostered period, broken down by Grade Type Category.

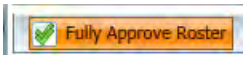
Filled Duties

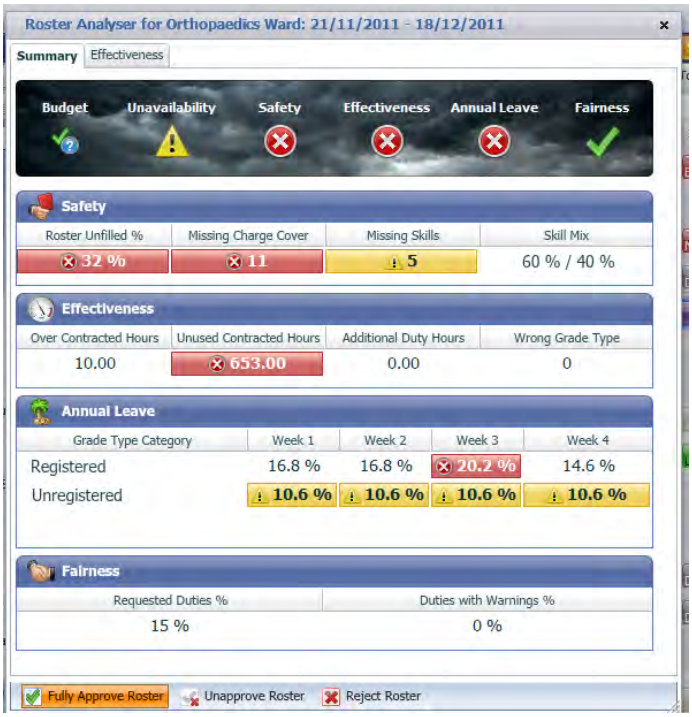
Grade Type Category	Mandatory Filled	Optional Filled	Additional Filled
OTHER	28	12	0
Registered	298	0	0
Unregistered	146	0	0

FINAL APPROVAL – APPROVE/REJECT ROSTER

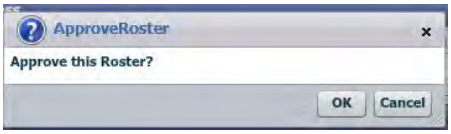
The roster should be Partially Approved and will require final, full approval from the Manager.

For the final approver to approve the roster select **Fully Approve Roster** at the bottom of the Roster Analyser screen.





Click **OK** on the message that pops up if you wish to continue.



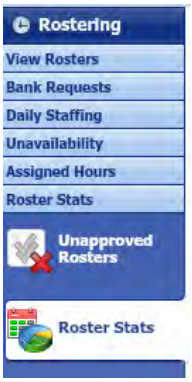
Click on the **X** to the top right of the Roster Analyser screen.

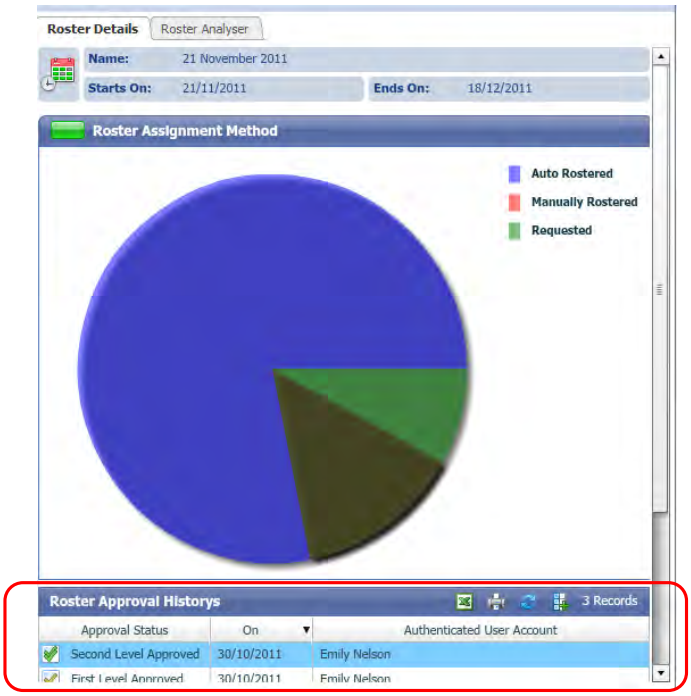
The status will be confirmed on the purple **Roster Bar** and two ticks will appear to the right of the Roster Bar.

Note: If the roster is not considered ready to be Fully

Approved, it can be Unapproved or Rejected. These options are displayed at the bottom of the Roster Analyser screen.	

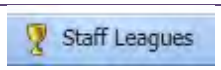
VIEW ROSTER STATS

Select the **Roster Stats** task group within the **Rostering** master group. Select the **Roster Stats** shortcut. Select the ward/**Unit** from the drop down list. Enter required **From** and **To** dates for the report. Click on **Find.** Statistics around the composition of the roster(s) will be displayed.	  

Further detail will be displayed in the Details Pane to the right of the screen. **The Approval Status /History is also shown at the bottom** **Note:** You can also view the Roster Analyser from this screen.	

VIEW STAFF LEAGUE TABLES

Navigate to the roster. Click on the purple **Roster Bar.** Right click and select Staff Leagues, or click on the action button at the bottom of the screen.	



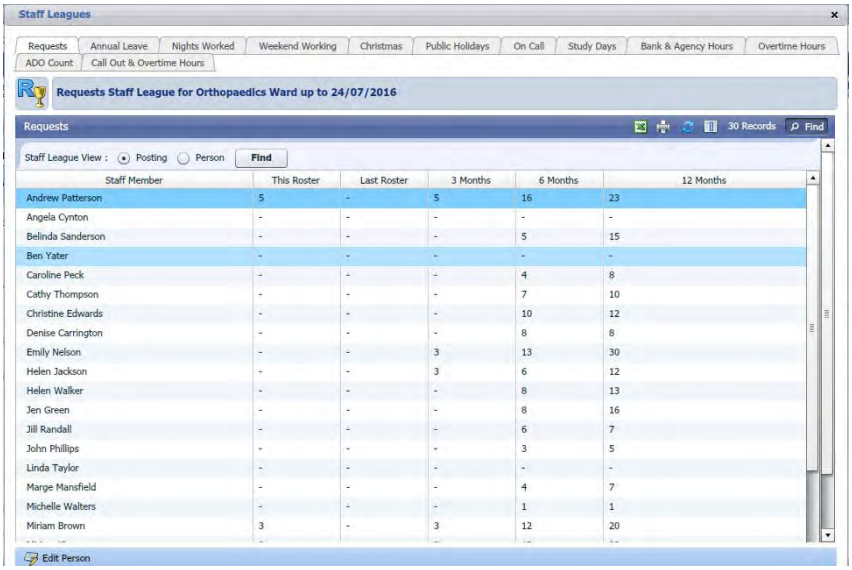
The Staff Leagues tables will open.

The following tabs are available:

- **Requests**
- **Annual Leave**
- **Nights Worked**
- **Weekend Working**
- **Christmas**
- **Public Holidays**
- **On Call**
- **Study Days**
- **Bank & Agency Hours**
- **Overtime Hours**
- **Call Out & Overtime Hours**

These leagues are useful when looking at fairness across rosters and the distribution of types of shift etc.

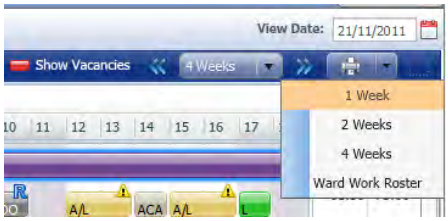
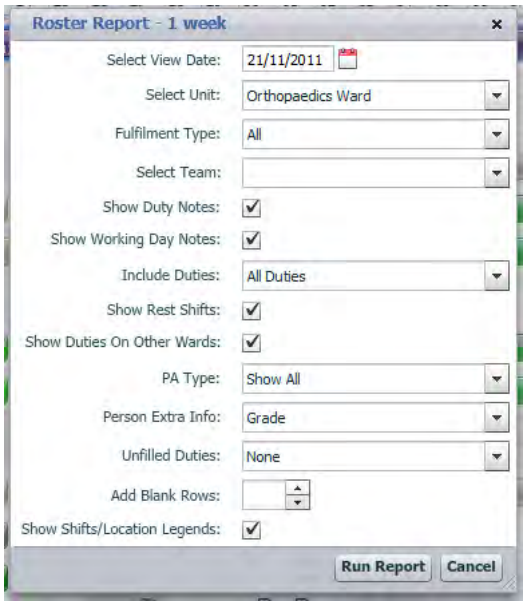
Note: The data can be sorted and exported to Excel.



5 Publishing a Roster

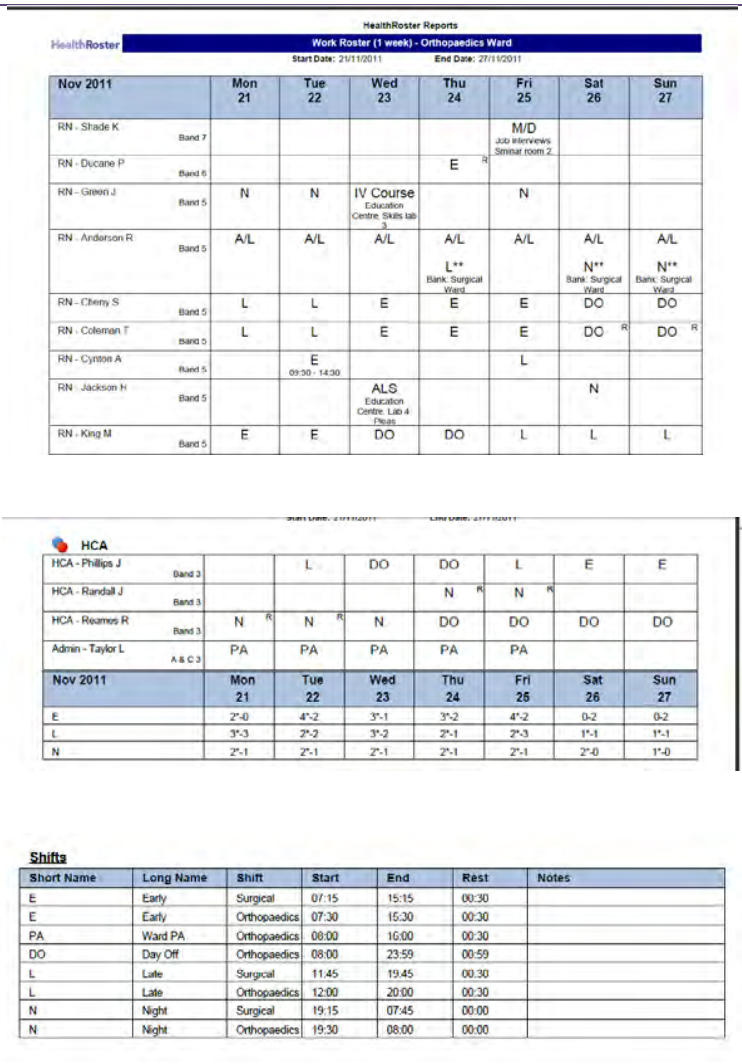
There are a number of print options for the roster, i.e. layout or number of weeks to view.

VIEW OFF DUTY ONE WEEK REPORT

Click on the purple **Roster Bar.** Click on the drop down menu next to the Printer icon located on the tool bar. Select **1 week** from the drop down list. A list of options will be shown. Complete the fields as appropriate. Click on **Run Report.**	 

Navigate through the print preview to view the skill mix summaries at the bottom of the roster.

View the unfilled duties list at the end, if you have selected to print them.



HealthRoster Reports

HealthRoster — Work Roster (1 week) - Orthopaedics Ward

Start Date: 21/11/2011 End Date: 27/11/2011

Nov 2011	Mon 21	Tue 22	Wed 23	Thu 24	Fri 25	Sat 26	Sun 27
RN - Shade K Band 7					M/D Job interviews Seminar room 2		
RN - Ducane P Band 6				E R			
RN - Green J Band 5	N	N	IV Course Education Centre: Skills lab 3		N		
RN - Anderson R Band 5	A/L	A/L	A/L	A/L L** Bank: Surgical Ward	A/L	A/L N** Bank: Surgical Ward	A/L N** Bank: Surgical Ward
RN - Cherry S Band 5	L	L	E	E	E	DO	DO
RN - Coleman T Band 5	L	L	E	E	E	DO R	DO R
RN - Cynton A Band 5		E 09:30 - 14:30			L		
RN - Jackson H Band 5			ALS Education Centre: Lab 4 Days			N	
RN - King M Band 5	E	E	DO	DO	L	L	L

HCA

HCA - Phillips J Band 3		L	DO	DO	L	E	E
HCA - Randall J Band 3				N R	N R		
HCA - Reames R Band 3	N R	N R	N	DO	DO	DO	DO
Admin - Taylor L A & C 3	PA	PA	PA	PA	PA		

Nov 2011	Mon 21	Tue 22	Wed 23	Thu 24	Fri 25	Sat 26	Sun 27
E	2*-0	4*-2	3*-1	3*-2	4*-2	0-2	0-2
L	3*-3	2*-2	3*-2	2*-1	2*-3	1*-1	1*-1
N	2*-1	2*-1	2*-1	2*-1	2*-1	2*-0	1*-0

Shifts

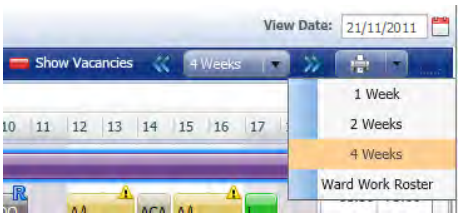
Short Name	Long Name	Shift	Start	End	Rest	Notes
E	Early	Surgical	07:15	15:15	00:30	
E	Early	Orthopaedics	07:30	15:30	00:30	
PA	Ward PA	Orthopaedics	08:00	16:00	00:30	
DO	Day Off	Orthopaedics	08:00	23:59	00:59	
L	Late	Surgical	11:45	19:45	00:30	
L	Late	Orthopaedics	12:00	20:00	00:30	
N	Night	Surgical	19:15	07:45	00:00	
N	Night	Orthopaedics	19:30	08:00	00:00	

VIEW OFF DUTY FOUR WEEK REPORT

Click on the purple **Roster Bar.**

Click on the drop down menu next to the Printer icon located on the tool bar.

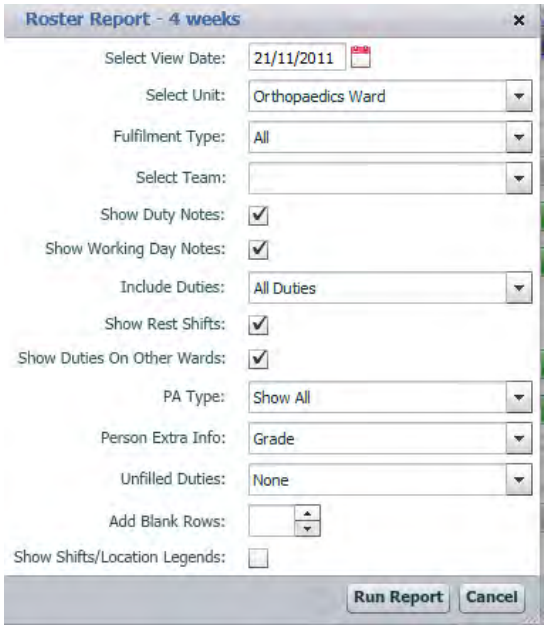
Select **4 weeks** from the drop down list.



A list of options will be shown.

Complete the fields as appropriate.

Click on **Run Report.**

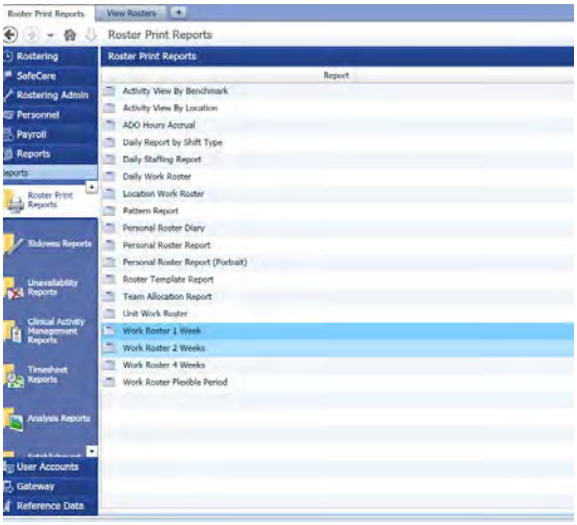


Navigate through the print preview to view the skill mix summaries at the bottom of the roster.

View the unfilled duties list at the end, if you selected to print them.

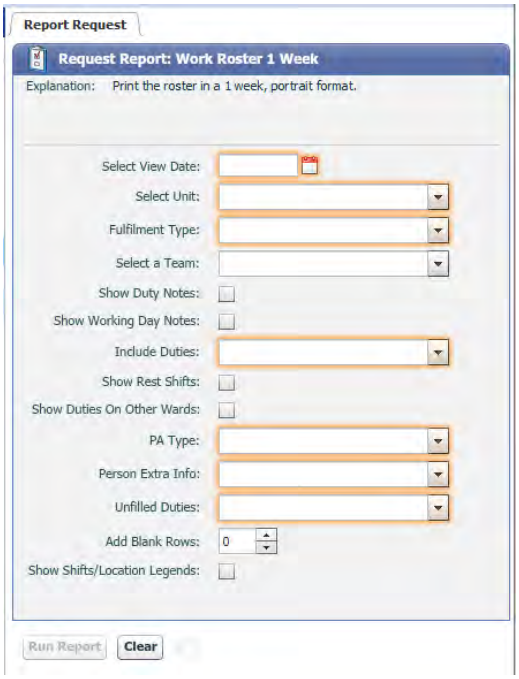
WARD/UNIT MANAGER WORK REPORT

Select the Unit Work Roster from the list of **Roster Report** options.



Complete the fields as appropriate.

Click on **Run Report.**



Note: You may need to navigate through the report to view the shifts with skills.

6 Reports and Summaries

FILTER REPORTS – STAFFING AND DUTY COVER

There are various reports that can be run from shortcuts within various task groups.

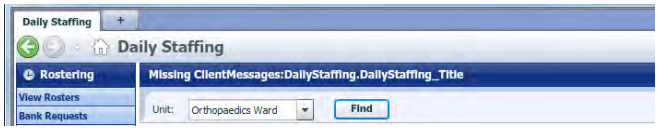
Daily Staffing Report

Select the Daily Staffing task group within the **Rostering** master group.

Select the **Daily Staffing** shortcut.

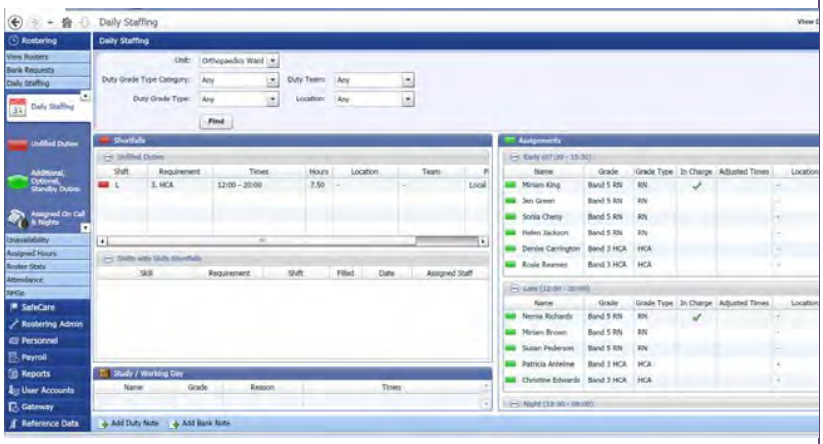
Select the ward/unit from the drop down list.

Click on **Find.**



Explore the report.

Note: The report content is based on the view date.



Staff Hours Report

Select the Assigned Hours task group within the **Rostering** master group.

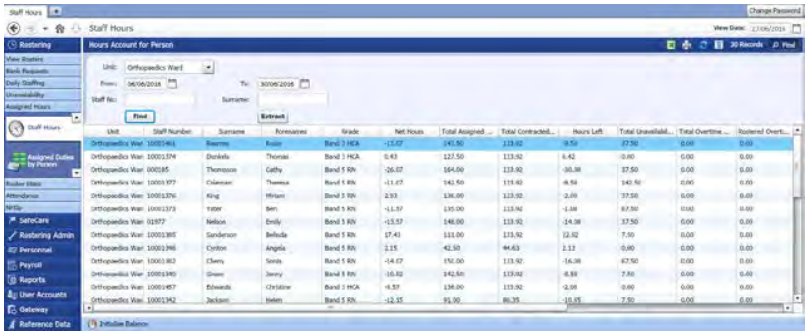
Select the **Staff Hours** shortcut.

Select the ward/unit from the drop down list.

Select the **From** and **To** dates required.

Click on **Find.**

Explore the report.



Assigned Duties By Person Report

Select the Assigned Hours task group within the **Rostering** master group.

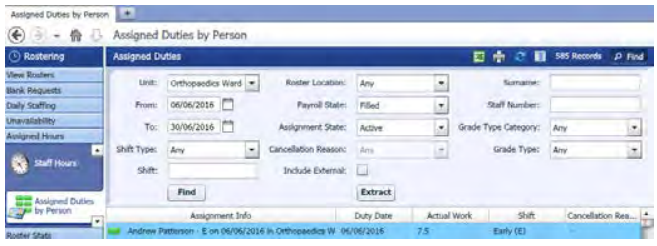
Select the **Assigned Duties by Person** shortcut.

Select the ward/unit from the drop down list.

Select the **From** and **To** dates required.

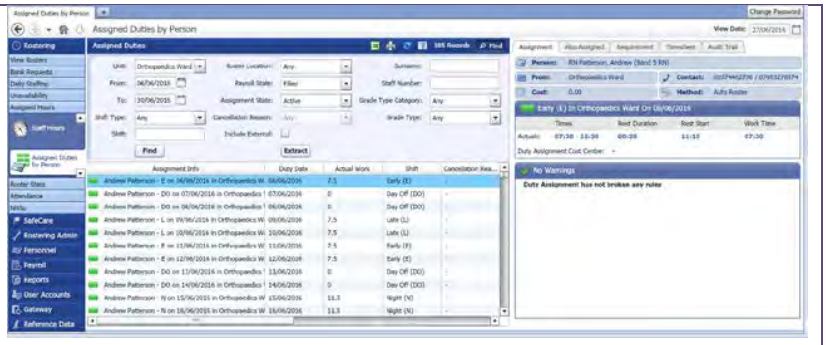
Explore/complete other available filters as appropriate.

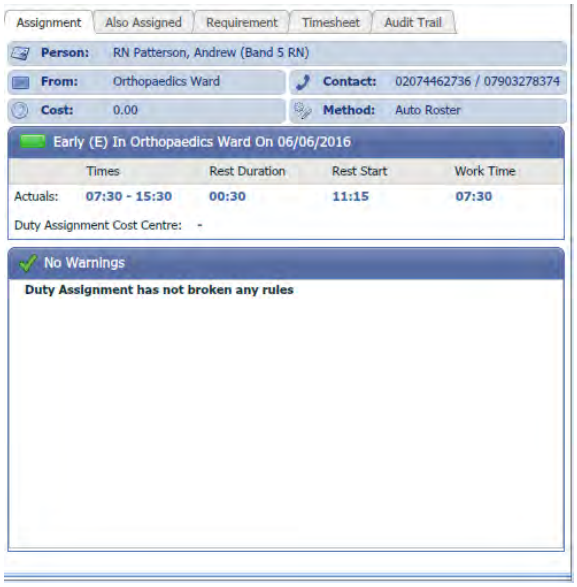
Click on **Find**.



There are various tabs in the **Details** pane to the right of the screen.

Click on/highlight an assignment record in the list in the main screen to view more specific details in the pane.





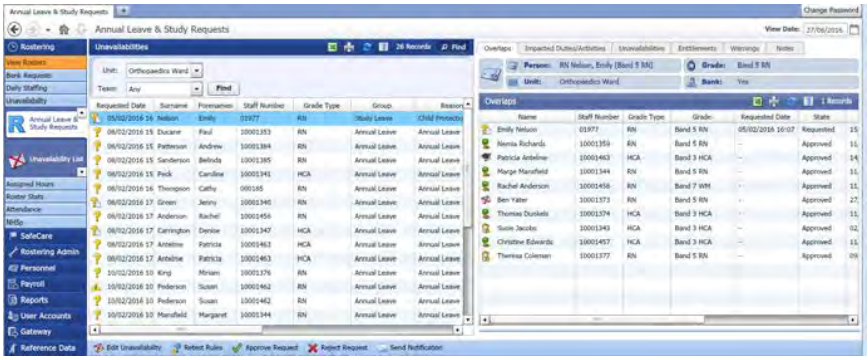
FILTER REPORTS – UNAVAILABILITY

There are various reports available within the Unavailability task group.

Annual Leave & Study Requests Report

Select the **Unavailability** task group within the **Rostering** master group.

Select the **Annual Leave & Study Requests** shortcut.

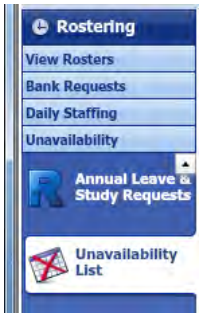


Select the ward/unit from the drop down list.

Click on **Find.**

Note: Click on a Request in the list to view available approve/decline options and other action buttons at the bottom of the screen.

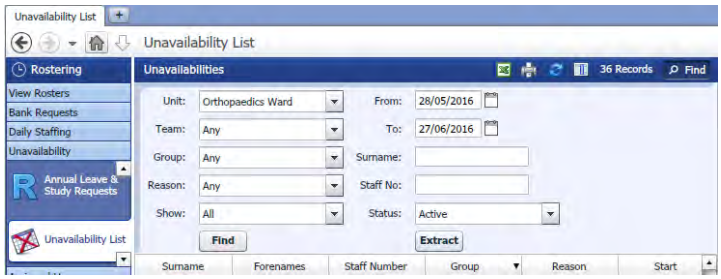
Any Overlapping unavailability for this request period is show to the right once the episode is highlighted.



Unavailability List Report

Select the **Unavailability** task group within the **Rostering** master group.

Select the **Unavailability List** shortcut.

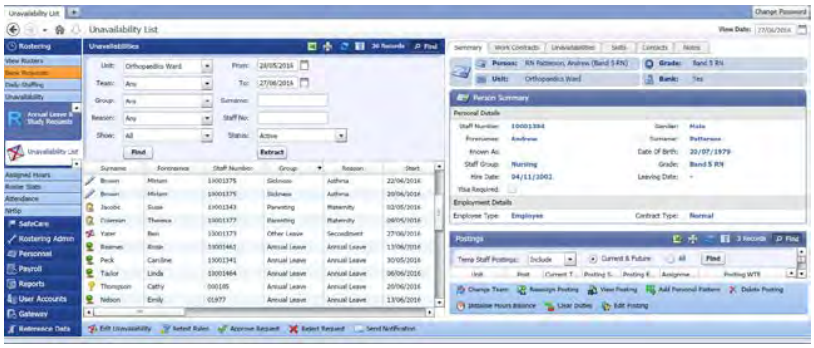


Select the ward/unit from the drop down list.

Select **From** and To dates as required.

Explore/complete other fields as required.

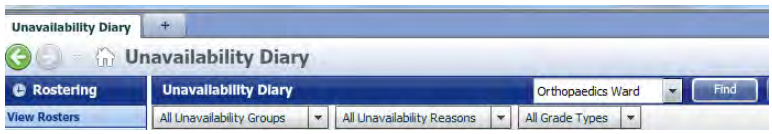
Click on **Find.**



Note: Click on an episode in the list to explore more specific information in the **Details p**ane to the right of the screen.

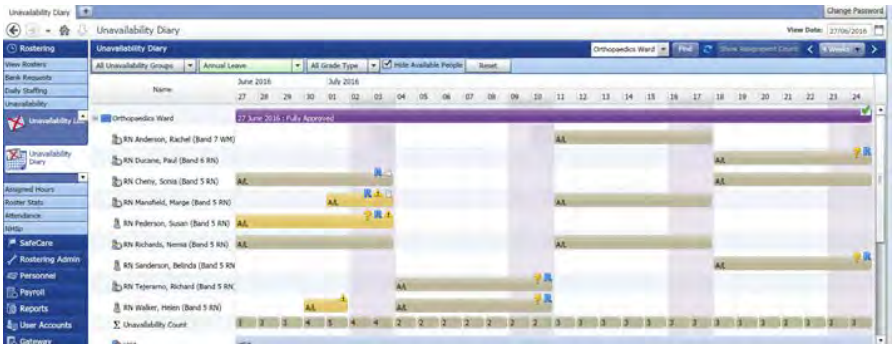
View available action buttons at the bottom of the screen.

Unavailability Diary



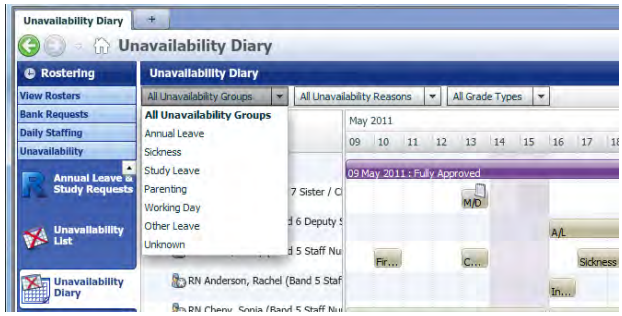
Select the **Unavailability** task group within the **Rostering** master group.

Select the **Unavailability Diary** shortcut.



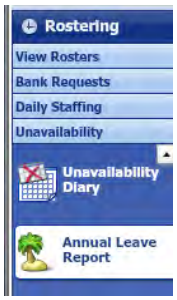
Select the ward/unit from the drop down list.

Click on **Find.**



You can use the filters to summarise the data within the report by Unavailability Group, Unavailability Reason, or Grade Type.

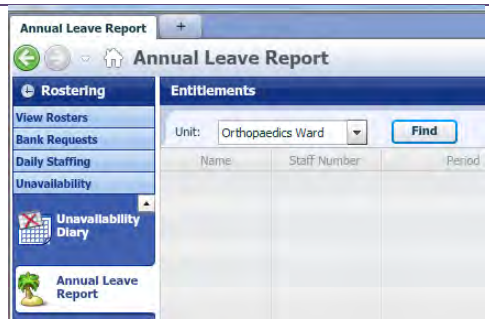
You can select specific items within these drop down lists, or all, and any combination.



Annual Leave Report

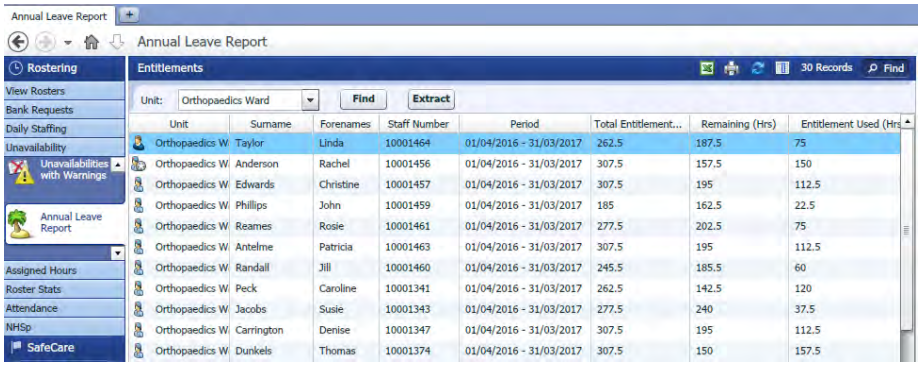
Select the **Unavailability** task group within the **Rostering** master group.

Select the **Annual Leave Report** shortcut.



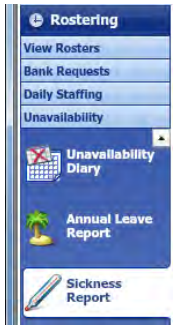
Select the ward/unit from the drop down list.

Click on **Find.**

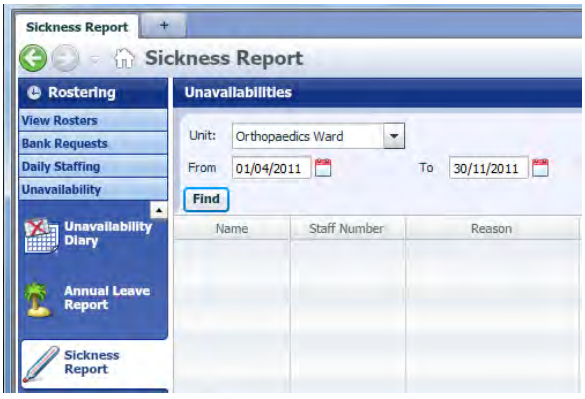


Sickness Report

Select the **Unavailability** task group within the **Rostering** master group.



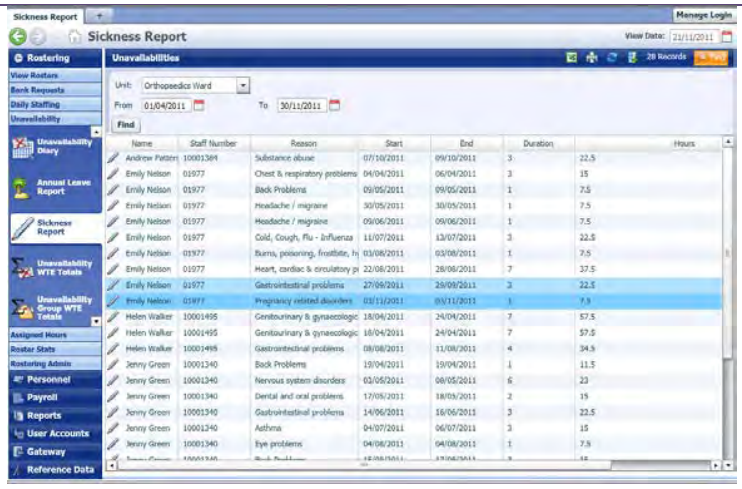
Select the **Sickness Report** shortcut.



Select the ward/unit from the drop down list.

Enter required **From** and **To** dates.

Click on **Find.**



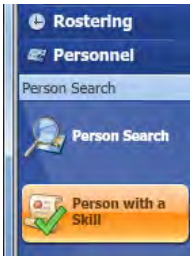
FILTER REPORTS – SKILLS

There are various reports available to enable the tracking of skills.

Person with Skill Report

Select the **Person Search** task group within the **Personnel** master group.

Select the **Person with a Skill** shortcut.

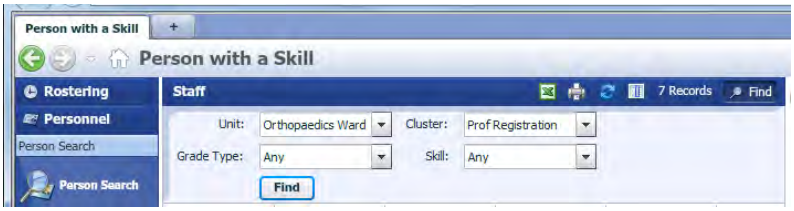


Select the ward/unit from the drop down list.

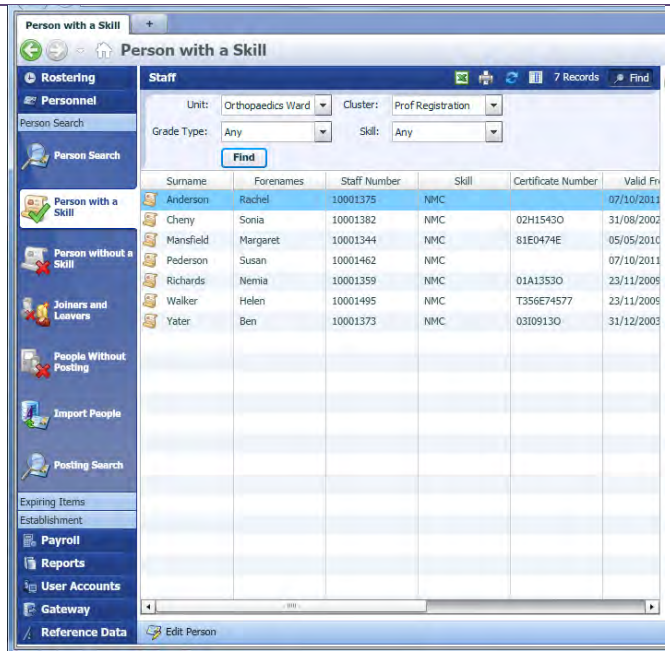
Select the skill **Type.**

Select the **Skill.**

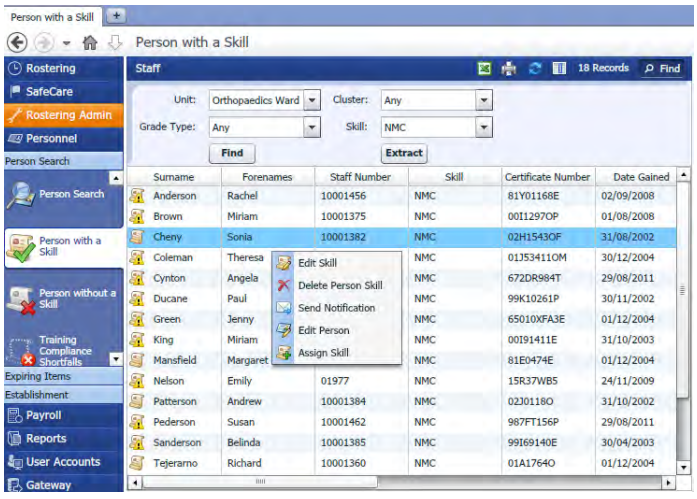
Click on **Find.**



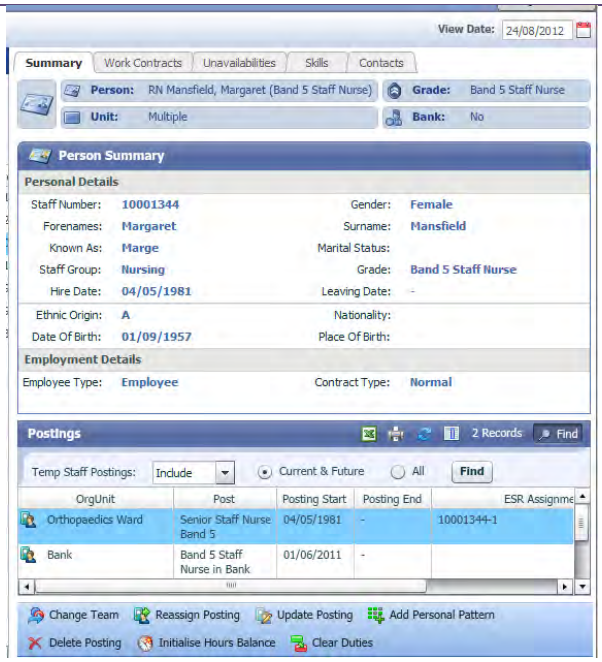
A list of matches will be returned.



Note: You can also add and edit skills from this screen, simply by highlighting the name of the person, right-clicking and selecting the appropriate option from the drop done list.



Select/highlight a record to view the **Details Pane** on the right hand side of the screen.



Person without Skill Report

Select the **Person Search** task group within the **Personnel** master group.

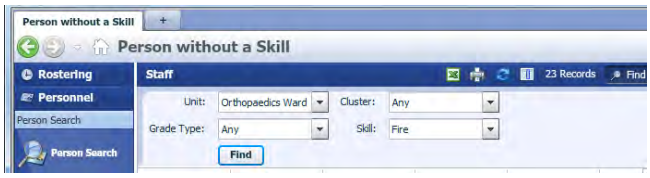
Select the **Person without a Skill** shortcut.

Select the ward/unit from the drop down list.

Select the skill **Cluster.**

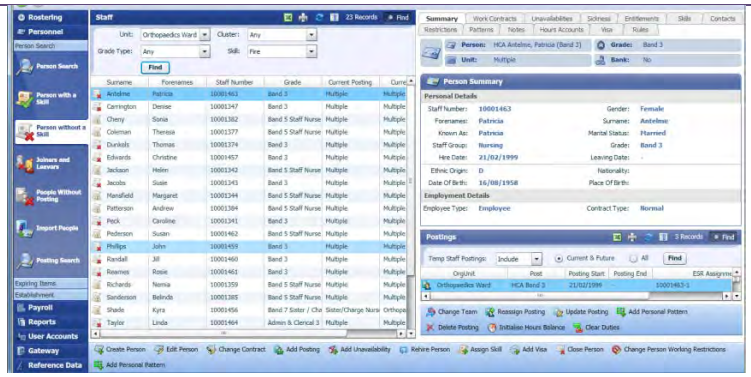
Select the **Skill.**

Click on **Find.**



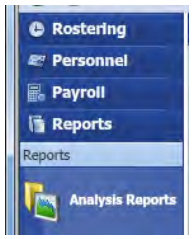
A list of matches will be returned.

Click on/highlight a record in the returned list to view more

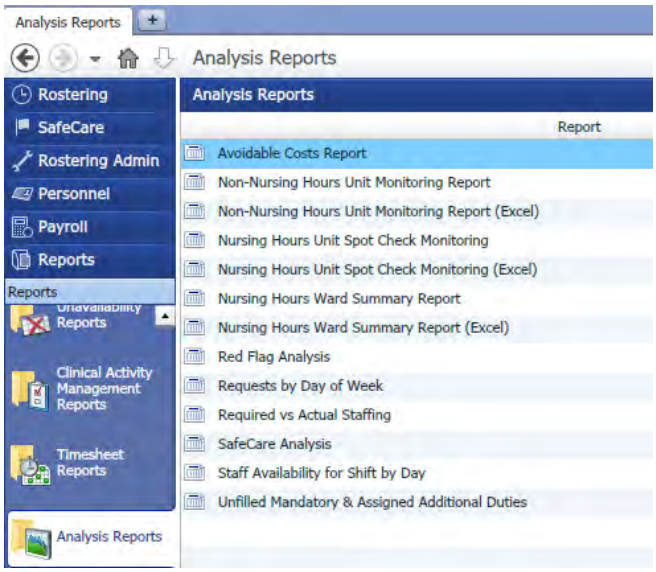
specific details in the **Details** pane to the right of the screen.	

MANAGEMENT REPORTS

There are various other reports available that can support management functions and requirements.

Select the **Reports** master group. Select the **Reports** task group. There are various reports that can be run from this master group. For example: Select the **Analysis Reports** shortcut.	 

A list of available reports in this category will be displayed.



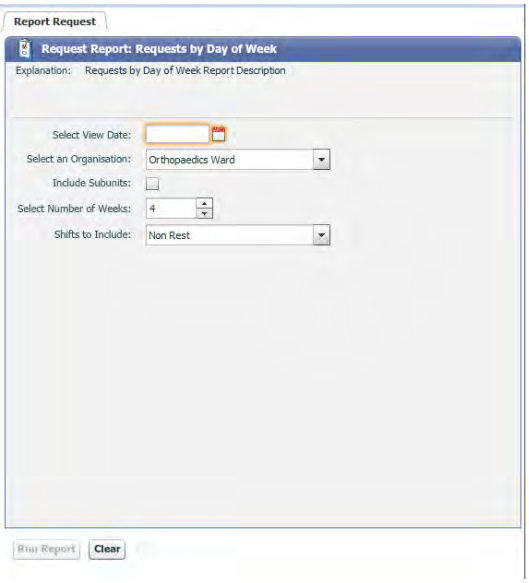
Click on/highlight the report you wish to run.

Report filters will be displayed to the right of the screen.

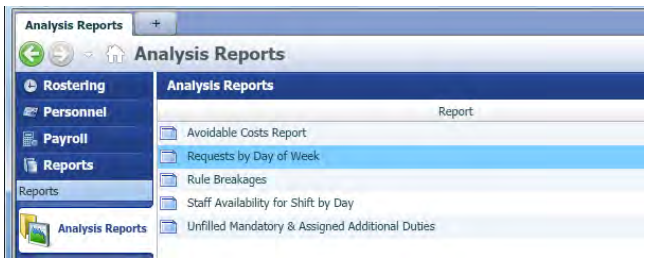
Complete the fields as required.

Note: Highlighted fields are mandatory.

Click on **Run Report.**

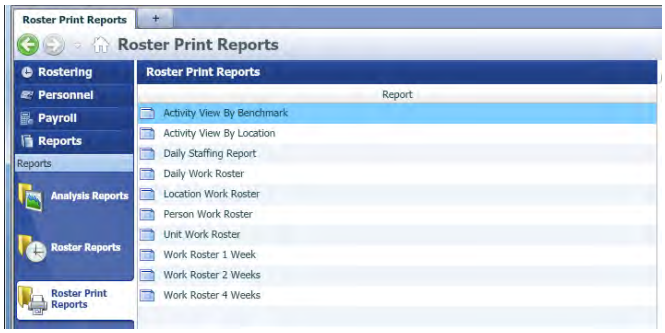


Analysis Reports include reports that are based on the content of live rosters.



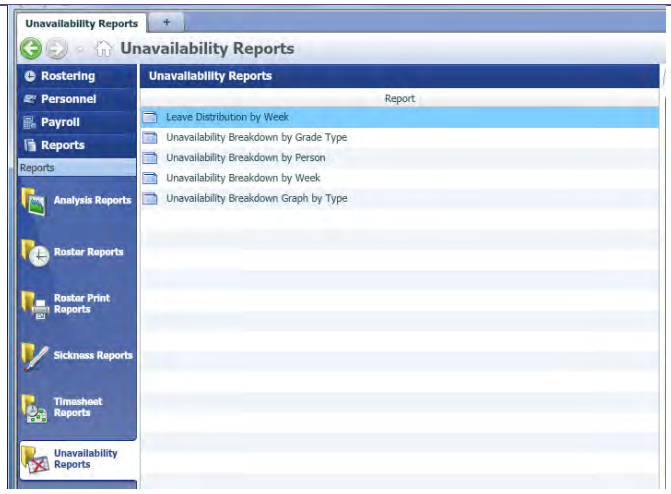
They focus on the quality and effectiveness of rosters.

Roster Print Reports include various views/formats for printed rosters.



Sickness Reports includes reports of various formats that enable sickness absence data to be drawn out across wards/units and across staff records and periods.

Timesheet Reports are usually run after rosters have been finalised to check the calculations and detail that will be extracted for payroll.

Unavailability Reports include reports that can draw out data on one or more types of Unavailability, across rosters and dates.	

Change Control History

Issue No	Issue Date	Description	Document Authorisation		
			Author	Reviewer(s)	Approver
ALL0.1	October 2011	First Interim Release for pilot	Penny Rivers	Jan Pady	
RR0-2	December	Interim of first GA release. Includes only RR0-2 functionality	Penny Rivers		
RR0-3	December 2011	First draft including functionality available RR0-3.	Penny Rivers		
RR0-7 ALL0.1	May 2012	First release revised format.	Penny Rivers		
ALL1.0	July 2012	Updated to RR8.			
ALL2.0	August 2012	Updated to RR10			
ALL3.0	July 2016	Updated to Version 10.6.1	Lisa Beadle		

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Issue No	Distribution Date	Notes	Recipient(s)
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Allocate Software health
right people. right place. right time.

MAPS HealthRoster Cluster Launch Meeting

Belfast Health and Social Care Trust

Presented by : Roísín Mc Mahon, Sarai Walsh, Lauren Graham, Tina McBride & Vikki Johnston



Agenda

- Identification of the Project Team
- Project Introduction
- Workshop Content
- Brief Overview of the system

Project Team

BHSCT Project Team

- Roísín McMahon, Implementation Manager
- Tina McBride , Roster Administrator
- Sarai Walsh, Roster Administrator
- Lauren Graham, Roster Administrator
- Victoria Johnston, Roster Administrator

Project Introduction

What are we trying to achieve?

Improve Off Duty Process

- Rosters quicker to produce
- Fairer rosters
- Clear visibility:
  - Staff hours remaining
  - Unavailability (sickness, study days, annual leave etc)
  - Staffing issues

More Efficient Off Duty

Actual results from one Trust:

Bank and Agency spend	44% decrease
Overtime spend	40% decrease
Fully utilised staff	45% increase
Vacant required duties	47% reduction

Allocate Software health right people. right place. right time.

Other Benefits of HealthRoster

Ward HR System

- Tracking and reporting annual leave
- Tracking and reporting sickness and absences
- Storing contact details – phone numbers, email addresses
- Visibility of establishment
- Tracking NMC's skill/competency expiries

Effective Rostering Brings Clarity

Understand gaps

- Are the ward duty requirements achievable?
- Are the ward skill requirements achievable?

Understand staffing issues

- Are there the correct numbers of staff?
- Do we have the right staff skill mix?
- Are staff restrictions causing overtime/Bank spend?
- Are staff being utilised effectively?
- Can staff be redeployed to other wards?

Lessons Learnt

- No Wards are the same
- Need dedicated time with , Ward Managers, Roster Creators and Assistant Service Managers
- Data cleansing takes longer than you think
- Accurate Ward shift requirements are critical
- Staff restrictions heavily impact on rostering effectiveness
- Software helps rostering but its not the answer on its own

Cluster 10 Units

- All 24/7 Areas in Muckamore Abbey Hospital

Cluster 10 Activities

- Workshop 1 = Launch/Individual Discussion
- Workshop 2 = Data Gathering
- Workshop 3 = Roster Creation
- Workshop 4 = Auto Roster
- Workshop 5 = Approve/Analyse
- Sign off

Workshop 2 – Unit Data Gathering

- 2 to 3 Hours
- Collect/Review Staff Data
- Identify Unit Requirements
  - Shift Names & Times
  - Shift Rules
  - Shift Patterns – Personal and Global
  - Other Requirements/Issues
- Unit Demand

People

- Staff Number
- Forename
- Surname
- Gender
- Contract Type
- Employment
- Current Ward
- Posting Start Date
- Posting End Date
- Posting Type
- Rostered Hours
- Date Joined NHS
- Date Joined Current Trust
- Max Hours per Day
- Standard Hours per Day
- Contract Hours per Week
- Max Shifts per Day
- Hours Available for Work
- Max Days per Week
- Competences

Contract Details

- Days and hours available to work, i.e. 00:00 – 23:59 = any time of day
- Number of shifts per day
- Number of days per week
- Maximum consecutive days per week
- Contracted hours per week

Shifts

Early	07.30-13.30 paid 6hrs
Late	13.00-20.30 paid 7hrs
Middle	07.30-16.45 paid 8.5hrs
Long Day	07.30-20.30 paid12hrs
Ward Manager	07.30-17.00 paid 8.75hrs
Night	20.00-08.00 paid 11hrs

European Working Time Compliance and Breaks

Shift Rules – Trust wide and Local

- Max 4 Requests per month
- Take Charge cover
- Max 1 weekend off in 4 weeks
- Max consecutive shifts
- Band Restrictions
- Keep Staff Apart
- Nights
  - Max 7 in a roster
  - 2 days off after Nights

Ward Demand

	Mon	Tue	Wed	Thurs	Fri	Sat	Sun
RN	E x 6 L x 4 N x 2	E x 6 L x 4 N x 2	E x 6 L x 4 N x 2	E x 6 L x 4 N x	E x 6 L x	E x 4 L x 3 N x 2	E x 3 L x 3 N x 2
HCA	E x 2 L x 2 N x 1	E x 2 L x 2 N x 1	E x 2 L x 2 N x 1	E x 2 L x 2 N x 1	E x 2 L x 2 N x 1	E x 1 L x 1 N x 1	E x 1 L x 1 N x 1
Ward Clerk	WC x 1	WC x 1	WC x 1	WC x 1	WC x 1	WC x 1	WC x 1

What do we need for Workshop 2?

- Copy of Last Manual 4 week roster
- Hours owing / owed by staff as at the start of the above Roster
- Annual Leave Entitlements and what is remaining for this year
- Any agreed staff patterns / working times outside the norm
- Budget Requirements for your area, per band and WTE
- Dates of achieved competencies

Workshop 3 – Roster Creation

- Need to bring Request Book, Annual Leave Book, Mandatory Training files plus any booked Study Days
- Navigation training
- Manual input of previous month's roster

Live data used

Workshop 4 – Auto Roster

- Rules confirmed and loaded correctly
- Review and validate unit requirements with staff
- Initial ‘dummy rosters’ created – evaluate, troubleshoot and tune
- Comparisons made with manual rosters
- Issues tracked
- Employee On Line

Workshop 5 – Approve/Analyse

- Roster Maintenance
- Analysing and Approving new roster
- Understanding reports
- Finalising shifts
- Tools to improve your roster

Live data used

Signing Off Rosters

- Review of worked rosters
- Confirmation of understanding

Note: This will not occur until rosters have been worked

Questions?

Thank You for Listening

HealthRoster

Belfast Health and Social Care Trust
caring supporting improving together

APPLICATION FOR HEALTHROSTER TRAINING & ACCESS

APPLICANT DETAILS				
Name:				
Belfast Trust Email Address:				
Job Title:				
Service Group:				
Manager's Name:				
Hospital Site, Location & Ward/Unit Name:				
Data Protection Training? **If No – Data Protection training can be completed as e-learning on the Trust Hub and by forwarding this document you agree to complete this training within the month	**Yes**		**No**	

Please indicate by using an **"X"** which Module the staff member requires access to and which level:

Healthroster Module	Ward Sister/Charge Nurse	Deputy Ward Sister/Charge Nurse	ASM/SM, Divisional Nurse	Band 5 View only	Band 3 Ward Support Officer	Read Only & Reports	NDL Access
Healthroster							
Employee Online							
Roster Perform							
SafeCare							

Please complete this form and ask your Line Manager to forward to E-Rostering-SM from their Belfast Trust email account, this will be considered proof of authorisation. Forms sent directly from applicants will be returned to follow correct authorisation process.

Once access has been approved, you will receive an email from a member of the E-Roster team to arrange a suitable date and time for training.

Code of Conduct

1) **Never disclose your password to anyone. If another individual knows your password, bring this to the attention of your manager immediately and change your password immediately.**
2) **Never log on with your password and allow another individual to access information.**
3) **Log off when you are not using the system.**
4) **Do not disclose information to unauthorised persons.**

ANYONE DISCLOSING INFORMATION OF A CONFIDENTIAL NATURE WILL BE SUBJECT TO DISCIPLINARY ACTION

respect & dignity openness & trust leading edge learning & development accountability

Approving and Finalising Rosters

As soon as the Ward Manager has created a roster they must 'Partially Approve' it in preparation for the Assistant Service Manager to 'Fully Approve' it.

All Rosters must be Fully Approved 4 weeks in advance of the duties being worked as per Roster Policy

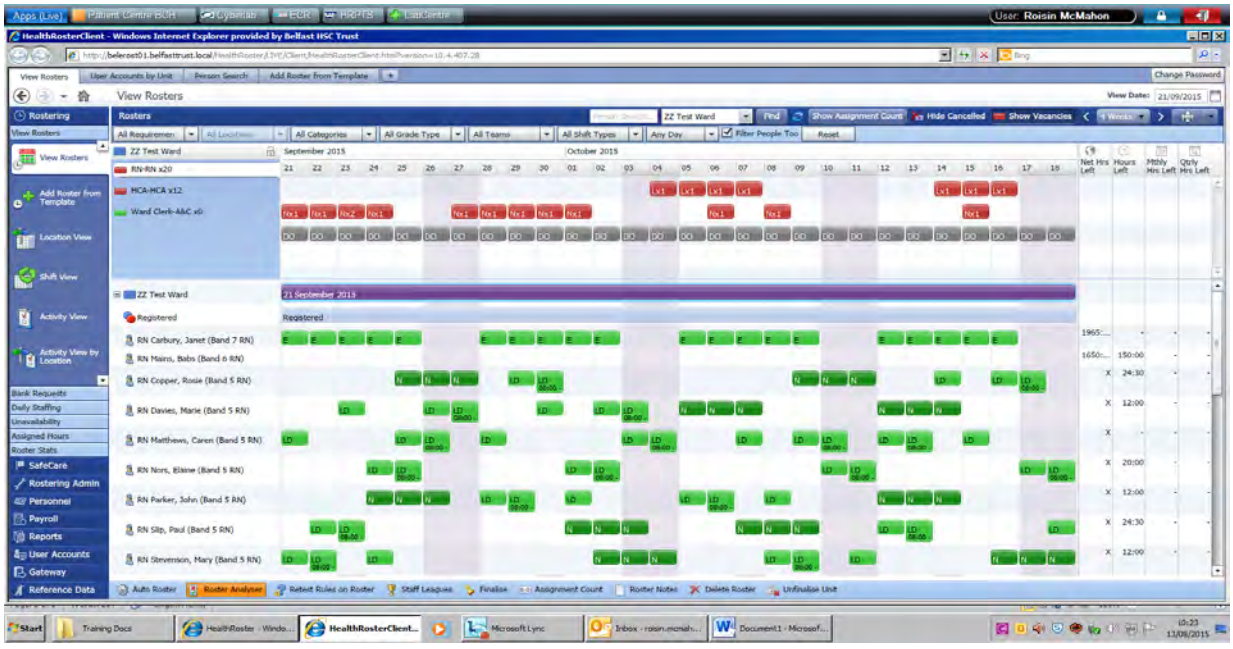
4.36 *When the Ward Sister/Charge Nurse completes the off duty it must be made available to the appropriate Service Group management team. The relevant Service Manger (SM) or Assistant Service Managers (ASM) should be made aware of:*

- *Any gaps which remain in the off duty after all of the steps outlined have been followed.*
- *Shifts which may need temporary staff cover. The option of sourcing cover from other areas must always be explored in the first instance.*

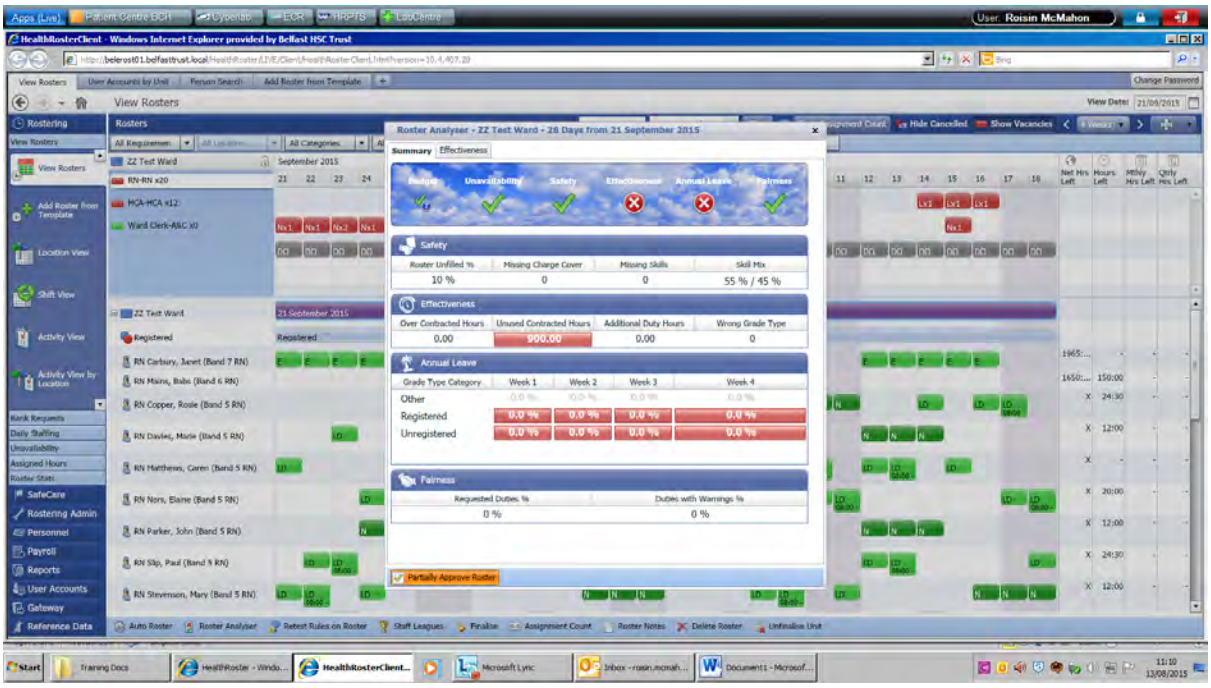
A copy of the roster should be made available for all nurses to view at least 4 weeks prior to roster beginning. This copy will be signed and dated by the Ward Sister/Charge Nurse's. All changes made, after the roster has been approved by the Ward Sister/Charge Nurse's, will be clearly marked for audit purposes.

Here is a reminder of how to 'Partially' and 'Fully Approve' your Rosters including Finalising shifts for payment.

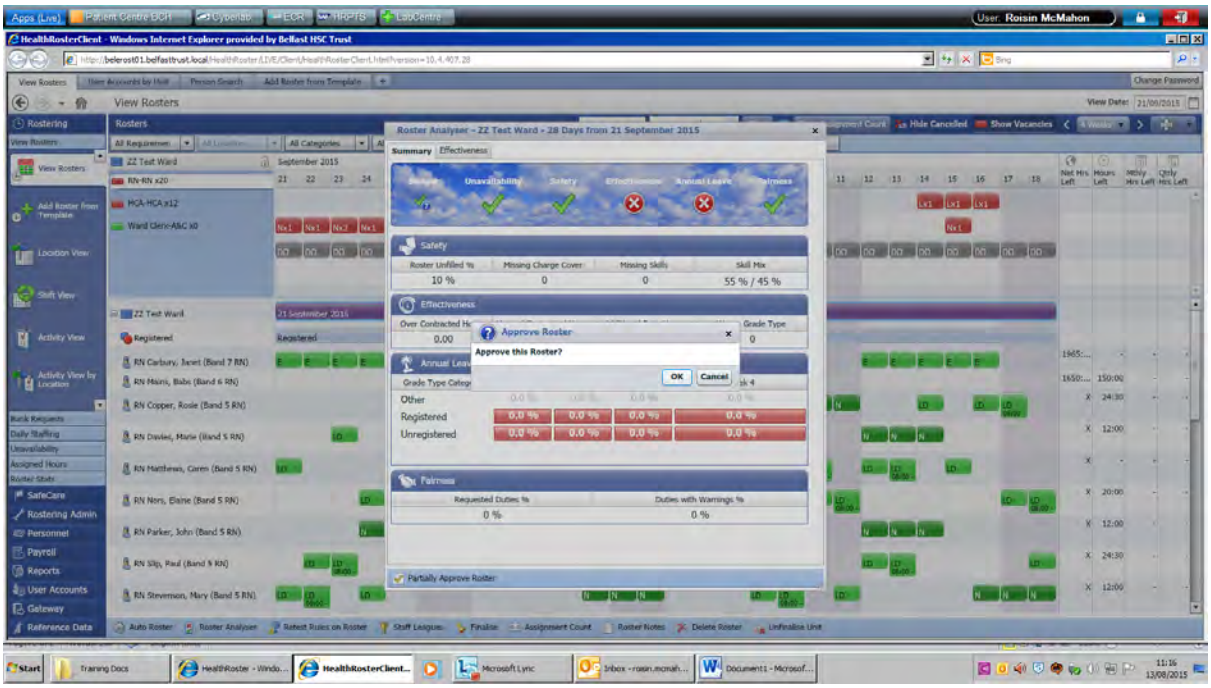
Highlight the Purple Roster Bar and you will see that the word 'Roster Analyser' appears at the bottom left hand side of your screen



Click the icon named 'Roster Analyser' and the following screen appears



This gives a summary breakdown of the Key Performance indicators captured by the Health Roster System. When you are in this screen you will see at the bottom left side of the Roster Analyser Box the words, 'Partially Approve Roster'. Click on this and another box appears asking if you want to partially approve the roster. Click OK

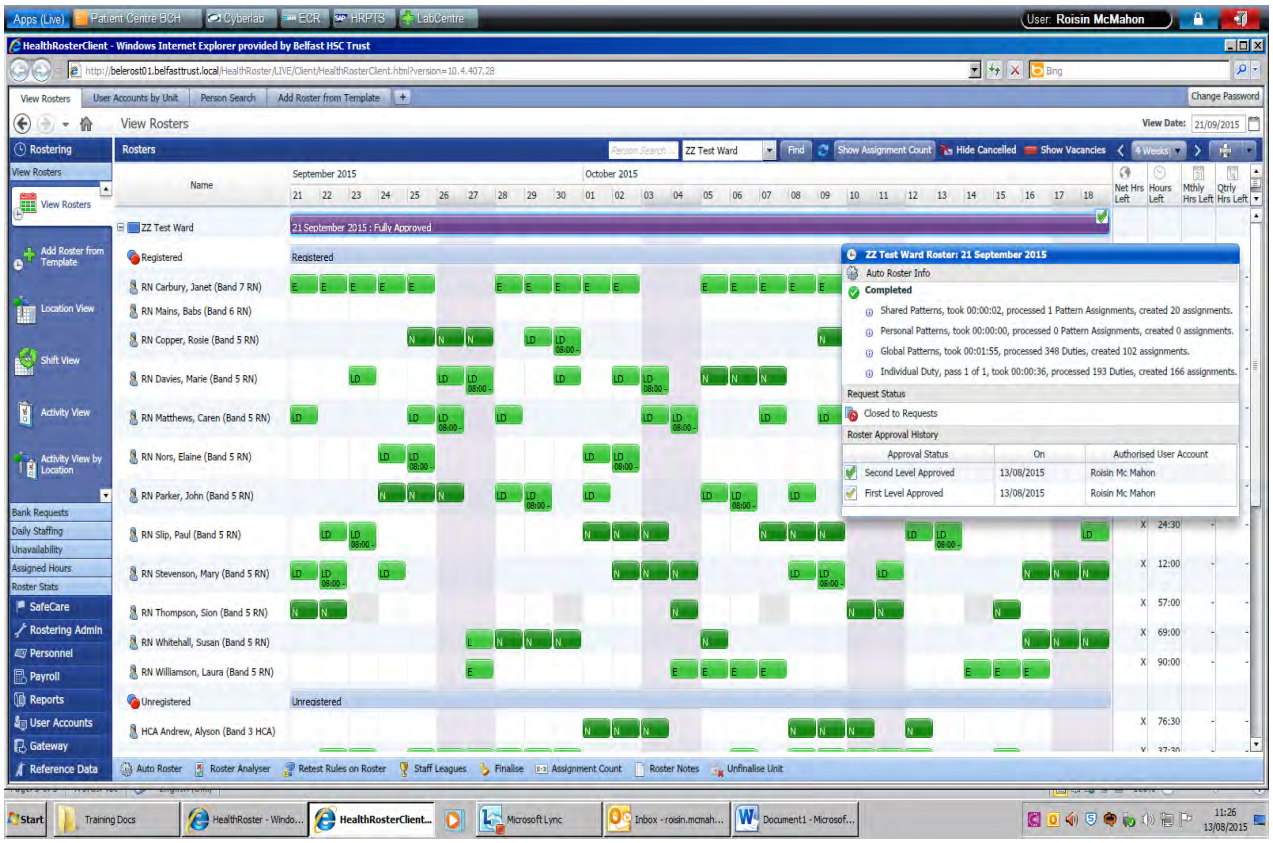


The next stage should involve the Assistant Service Manager and the process of 'Full Approval'. You will now see that the Analyser Box gives three options;

1. Fully Approve Roster
2. Unapprove Roster
3. Reject Roster

If the Assistant Service Manager is happy that the Ward Manager has done the best they can with the resource they have and have attempted to improve upon the areas highlighted in the key performance indicator analyser, then the option to 'Fully Approve Roster' should be selected. When you click on the option to 'Fully Approve Roster', a second box appears asking 'Approve This Roster?', if happy then click OK and the roster for 4 weeks will be published to all staff on line for them to view their off duty in advance of working. This is in keeping with the Work Life Balance Policy and the Roster Management Policy.

The Roster Bar now appears with two green ticks on it to show that it has been fully approved. If you hover over the roster bar with your mouse, it gives the Auto Roster Info, The Request Status and the Approval History



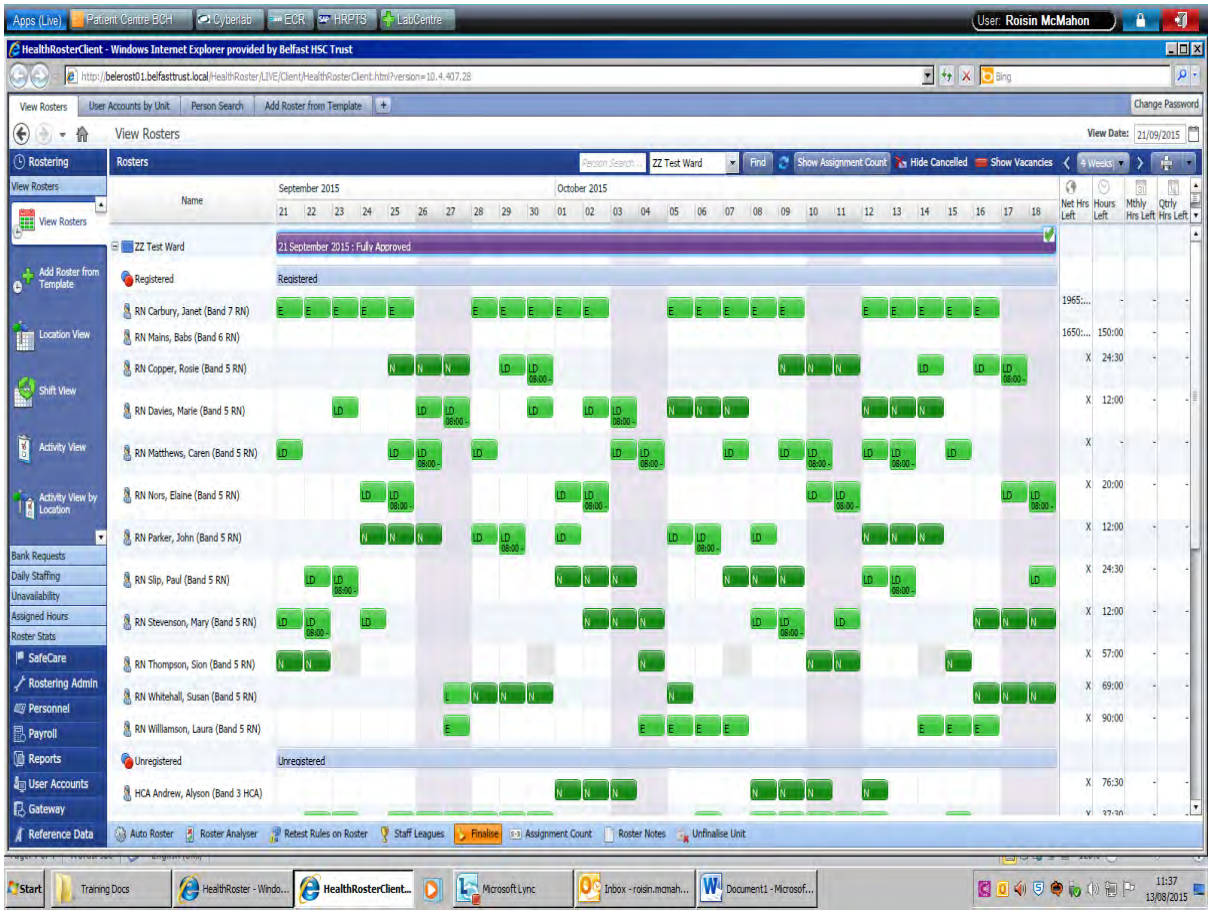
The roster is now fully approved and ready to be worked.

Finalising your Roster in Preparation for Payment

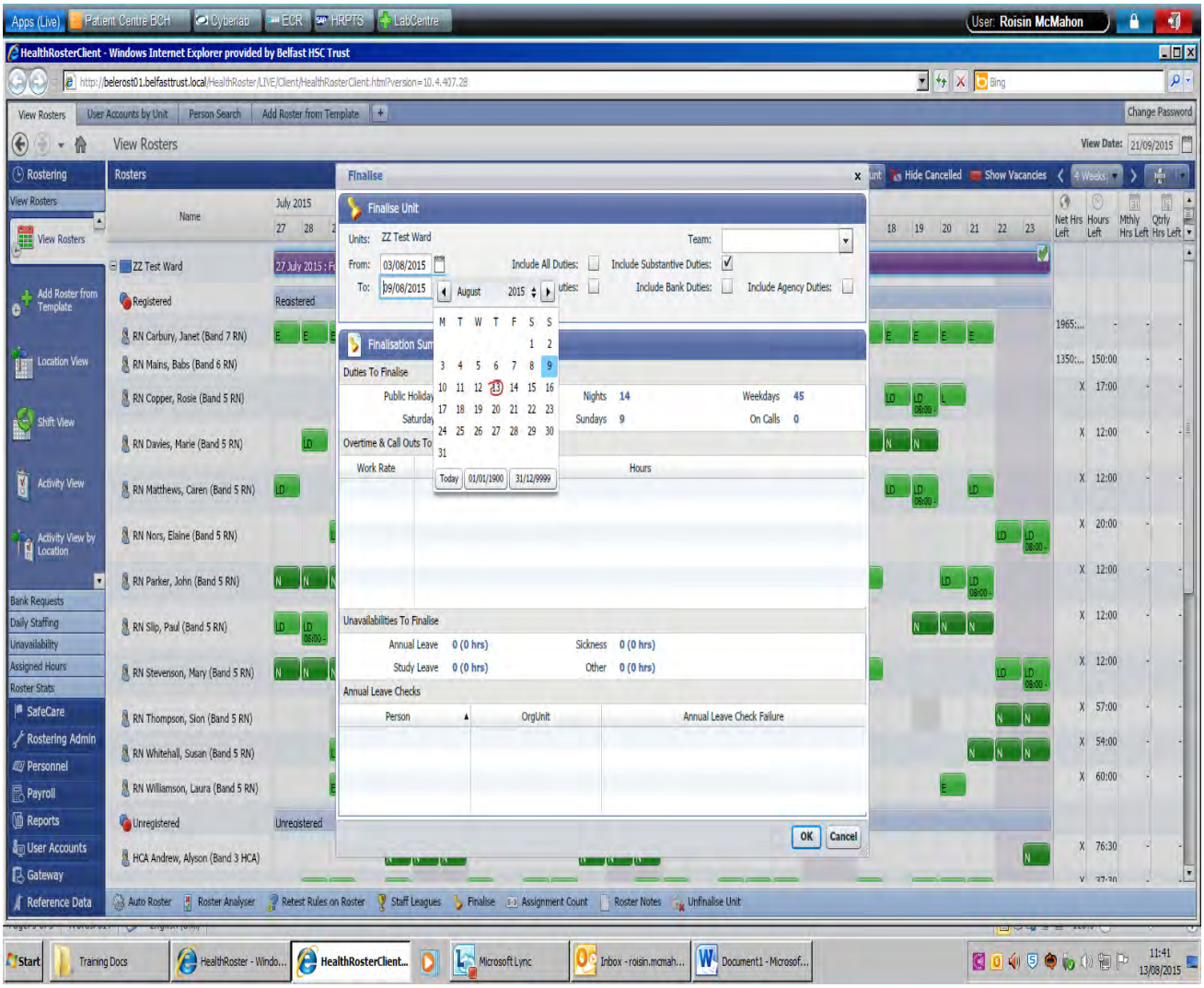
During training everyone is advised to retrospectively amend their roster on a weekly basis and finalise/lock down each week as you move through the month. This ensures accuracy and also makes the process less labour intensive at the end of the month when preparing for the pay extract.

Once you finalise a shift you cannot un-finalise it, so accuracy is important as this affects peoples wages.

Highlight the Purple Roster Bar and you will see that the word 'Finalise' appear at the bottom, middle aspect of your screen

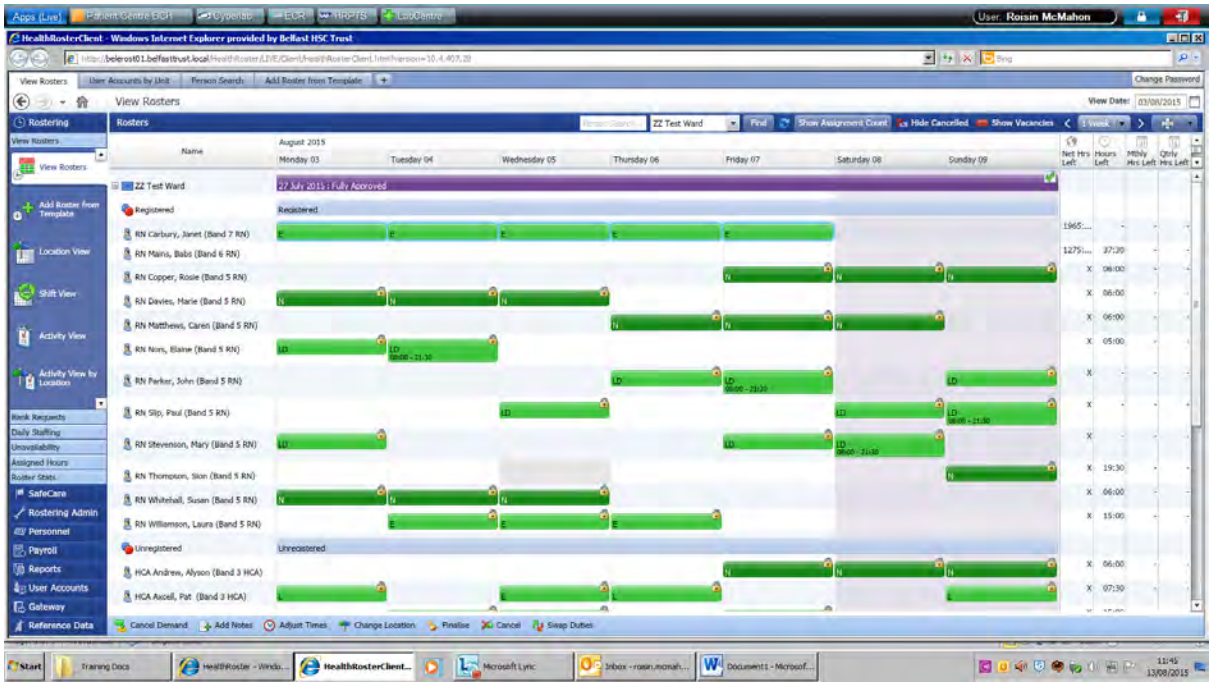


Once you have adjusted the first week finalise those shifts by clicking on the word finalise and then adjusting the dates as indicated in the following screen shot



This screen shot shows that we want to finalise the week from the 3rd August to the 9th August. (Remember you cannot finalise shifts that have not been worked yet) Click on the word 'OK' in the bottom right aspect of the Finalise Unit Box.

The box disappears and you can then go and check that there are padlocks on every other member of staff shifts except your own



You as the person finalising the unit cannot finalise your own shifts, this should be carried out by either your Assistant Service Manager or if you are the Band 6 finalising the roster, the Band 7 should be finalising your shifts.

When it comes to the end of the month you should only have a few days to amend and finalise as opposed to an entire months off duty.

Once everything has been finalised, you are now ready for payment.

If you are a new area that has only received training and are still submitting electronic timesheets, it is important that you notify the Roster Manager of inclusion on the pay extract from Health Roster or if you are continuing to use electronic timesheets for a short period of time. Lack of notification results in your staff not being paid for their enhancements.

IMPLEMENTATION OF AN ELECTRONIC ROSTERING SYSTEM FOR :

Nursing & Midwifery Staff

Belfast Health and Social Care Trust

INTRODUCTION & BACKGROUND

Since its establishment the Belfast Trust has been exploring the potential benefits of electronic rostering for its nursing and midwifery workforce. The Trust has developed a Rostering Policy for Nursing & Midwifery staff but the monitoring of its implementation to ensure maximum benefit is very difficult when relying on only manual rostering systems

Much work has been undertaken to establish core nurse to bed and skill mix ratios for a wide range of specialities, without effective rostering (which electronic system will support) this work alone will not ensure appropriate staffing levels and mix <u>per shift</u>

OTHER TRUSTS IN N.I . HAVE NOW PROGRESSED TO PROCURING ELECTRONIC ROSTERING PACKAGES FOR:

their nursing & midwifery workforce and are at various stages of implementation/roll out.

he rust has secured apital unding

nternal apital id valuation

. his funding must be spent

arch

CURRENT SITUATION

- At present the nursing & midwifery rosters are drawn up manually by the ward/department manager, team leaders or their deputies. This manual process requires a significant time commitment and must take account of complicating factors such as skill mix, the European Working Time Directive (EWTD), contracted hours and annual leave.

The current process also results in:

- Often less than effective management of the Nursing/Midwifery establishment per shift;
- Often less than desirable levels of data quality, no means of assimilation of data relating to rosters for reporting & monitoring purposes and a very wide range of shift start/end times across the Trust with no easy means of checking for EWDT compliance;

❖No automation of processes or interfaces of systems resulting in manual timesheets and bank/agency authorisation processes

❖**The Trust's existing bank system has no means of interfacing with an entirely manual rostering process meaning that any gaps identified in rosters then have to be manually alerted to the bank office and similarly shifts filled by the bank office have to be manually entered in to the manual roster**.

OBJECTIVES

- Automate a number of existing manual processes:
- Reducing the time Ward Sisters/Charge Nurses or their deputies have to spend creating the rota releasing more of their time to focus on improvements in quality, safety and patient experience
- Reducing the time payroll staff have to spend processing timesheets and bank/agency payments
- Reducing the time bank office administrative staff have to spend communicating allocations to ward/departmental areas
- Provide accurate information

- ✓Maximise the use of the existing staff resource on each shift and in so doing reduce the need for backfill/additionality
- ✓Prepare those staff involved for working with a "self service" type system – a method of working which will become the norm with the BSTP implementation
- ✓Co-ordinate training for all staff involved in the rostering system to the appropriate level for their usage and support them in implementing the new system
- ✓Provide management information which will support the most effective utilisation of the nursing & midwifery workforce in the areas where the system is introduced
- ✓Within the capital funding available , deliver electronic rostering to as many areas as possible where shift patterns cover the 24hr/5 – 7 day per week period within 36 months

WORKING WITH THE NEW SYSTEM

Staff will be able to request off duty as normal

Staff will be able to utilise the system to update information pertaining to them.
Data input on the E-rostering system for off duty must reflect the policy statement already agreed in the Rostering Policy for the BHSCT.

B.H.S.C.T.
Staff will no longer be required to submit extra duty payment cards, as the system links with BSTP so staff will be paid in real time in the same month as hours worked

		2012											
	Belfast Trust Electronic Rostering System	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
1.0	**Procurement Process**												
1.1	Develop Tender Specification												
1.2	Go out to tender												
1.3	Identify staff to select supplier												
1.4	Award Contract												
2.0	**Structures**												
2.1	Establish Steering Group												
2.2	Establish Working Group and any sub groups required												
2.3	Appoint Roster Manager												
3.0	**Implementation – Phase 1 first 6 months – 24 Wards**												
3.1	Identify priority areas for Phase 1 Roll Out and scope number of licenses required												
3.2	Identify data required to be uploaded on to the system												
3.3	Oversee assimilation of current bank staff on to the new system												
3.4	Ensure IT infrastructure is in place												
3.5	Train project staff and ward sister/charge nurse support officers in the use of the new system												
3.6	Train those who will be using & accessing the system: Service Managers Ward/Department Sisters & their deputies Ward Staff												
3.7	Scope any additional staff who need to be trained in the use of the system and arrange training for them												

Frequently Asked Question

Will payroll be using the e-Rostering system?

Yes, an interface will been set up between MAPS and BSTP

Will HR still remain responsible for updating staff personal details?

Yes, any alterations to staff details will still need to be amendments made via BSTP but will be fed to MAPS via the interface and will therefore also be reflected on the e-Rostering System.

Will the e-Rostering system replace all forms?

Yes it is intended that ALL pay related forms will be phased out as all details should be entered straight onto the system then information will interface to BSTP. Managers will need to keep the system as up to date as possible and all information will need to be correct prior to the payroll cut-off date.

Do individual units set their own parameters?

There are some general rules already pre-set into the system. Managers are able to set up particular rules suitable to them and once up and running will be able to see how effective their rules are and see any patterns or problems with requests etc.

If staff are moved to cover shifts in a different ward, can you see within the system where they have been working?

The system keeps a record of staff in your area and those that are working in other areas. You will be able to see where they were moved to and on which date days etc

Frequently Asked Question

Can you adjust hours of when staff went sick?

Yes, duty times can be adjusted and if more than half a shift remains it can be filled by somebody else

Can unit managers nominate somebody to cover for them if they are off?

It is suggested that they nominate 2 to 3 roster creators to cover in their absence. All changes that are made on the system are recorded and therefore will be an audit trail of who and when alterations were made.

Can you adjust hours of when staff went sick?

Yes, duty times can be adjusted and if more than half a shift remains it can be filled by somebody else

For further information please contact :

Roisin McMahon
E-Roster Implementation Manager
Phone: 07788 926590

Margaret Devlin
Senior Manager, Nursing Workforce Planning

HSC Belfast Health and Social Care Trust

Health Roster Combining E-Rostering and Staff Bank

MAHI - STM - 102 - 11108

Back ground

The Belfast Trust has procured 'Health Roster' which is a combined Roster / bank system and is currently being rolled out across the Nursing in the Belfast Trust.

Over the past 2 years work has been undertaken to establish core nurse to bed and skill mix ratios for a wide range of specialities, without effective rostering (which electronic system will support) this work alone will not ensure appropriate staffing levels and mix per shift

E rostering will assist the Trust to drive down reliance on bank/agency by is encouraging "helping out" between and across wards, specialities and sites. With out a rostering system co – ordinating this is very labour intensive and limited in its scope when relying on going from ward to ward to establish staffing compliments ward.

Roll Out Plan

Roll out has commenced on the Royal site.

It is anticipated that it will take 3 years to complete the roll out across all of nursing.

Ward s and department offering 24/7 services will roll out first .

Year 1

Royal Victoria Hospital Inpatient Services
Royal Belfast Hospital for Sick Children
Royal Jubilee Maternity inpatient Services
New Bank System online

Year 2

Belfast City Hospital Inpatient Services
Cancer Centre
Mater Hospital
Musgrave

Year 3

Knockbracken
Musgrave
Outpatients

What does this mean to you?

- **Directorate support to implement the programme.**
- **Directorate Champions**
- **Each Directorate has a subgroup to take forward the work of identifying Directorate specific rules**
- **Agree how compliance with EWTD will be achieved re 11 rest period**
- **Support for workshops – Roster creators must attend the 5 workshops which range from 2hrs to whole days over a 17day period**
- **Assistant Service Managers and Service Managers to attend workshop 5 which covers Roster Analysis and performance**
- **Identify your authorisation framework.**
- **Challenge practice /Accountability**
- **Establish your own set of KPI's for your Directorate**

MAHI - STM - 102 - 11109

Roisin McMahon
E-Roster Implementation Manager
Phone: 07788 926590

Margaret Devlin
Senior Manager, Nursing Workforce Planning
Phone: 9504 9973

Getting Started with RosterPerform

10.5.1 or above

Version: 1

Status: Final

Issue Date: Feb 2016

Contents

1 Foreword

This guide provides an overview of RosterPerform and how to get started with the system.

This document is not intended as a full functional guide for the system. For detailed information see the User Guide.

2 What is RosterPerform?

RosterPerform is an intelligent management dashboard focused on highlighting workforce operational issues when looking at data:

- **Now** so that immediate problems can be reviewed and fixed,
- **In the past** so that historic trends can be reviewed and resolutions can be put in place now and in the future.
- **The future** so that potential issues can be identified ahead of time with enough time to fix them.

The system also allows you to compare units locally within your organisation and nationally* which provides you with information about how an individual ward, department, division or Trust is performing compared to its peers.

The data for this is taken directly from the live HealthRoster system, i.e. the data from approved* rosters past, present and future. This is updated automatically overnight for an accurate view of performance and issues across the Organisation.

The HealthRoster data is then processed into metrics, to show managers exactly where issues lie. The metrics fall into six main categories; Safety, Fairness, Effectiveness, Unavailability, Establishment and Cost. These are summarised as follows:

Safety - The most important group. Focuses on problems with the cover achieved through approved rosters, i.e. has the right number and type of staff been allocated to meet clinical need? This is essentially showing the end result of the rostering process.

Fairness - Are we being fair to staff or breaking rules?

Effectiveness - Have we used our staff resources effectively?

Unavailability - Have we managed the absence of our staff efficiently?

Establishment - Do we have issues around the pool of staff in our establishment?

Cost – What is our total cost and avoidable cost based on WTEs?

*National Comparator information is as part of the Allocate-Insight Service.

3 Why is RosterPerform Needed?

Monitoring KPI's and proactively identifying any emerging workforce issues in relation to safe staffing, operational efficiency, unavailability and costs then reporting on these is key to running healthcare organisations.

If you are using HealthRoster but **not** RosterPerform then how can you monitor and report on your workforce issues to ensure that services are delivered safely, with minimum risk and with optimal use of staff?

At a high level, following are the benefits of RosterPerform:

- Gives you a view of the whole workforce across your entire organisation
- Provides data in a ready-to-use format anytime, anywhere
- Enables managers to use substantive staff more efficiently and reduce temporary staff usage
- Minimises operational risk by ensuring services are safely staffed
- Gives managers evidence that services are being run as effectively as possible
- Provides all data from one secure source
- Visibility – managers get a clearer view of the workforce and can drill-down on the staffing complement to identify and address issues before problems occur
- See peer comparisons locally and Nationally

In support of the above, following are a few of the key messages in the June 2015 Interim report: Review of Operational Productivity in NHS providers. An independent report for the Department of Health by Lord Cater of Coles:

"Workforce costs is a particular priority; just 1% improvement in workforce productivity could represent as much as £400m in savings."

"It is our view that unless workforce management and productivity are addressed, all other areas of opportunity pale into insignificance"

"I do believe there are significant benefits to be gained by helping hospitals, using comparative data, to become more productive."

"I have found two of the key obstacles to be

1. lack of quality data

2. the absence of metrics to measure relative performance"

4 Getting Started: Key metrics and Process

4.1 Identify key metrics to Monitor and Review In RosterPerform

It is important to identify the KPI's and metrics the organisation wants to monitor, review and report on, all the way from the ward to the board. To keep it simple it is recommended that a small set of metrics are selected and understood by all I.e., the executive board, managers, nurses and clinicians.

As a starting point key areas that could be focused on are:

	**Unfilled Duties** – The percent of vacant duties *(Metric group Safety)*
	**Unavailability** - The total unavailable time due to leave, broken down by the various leave types. (*Metric group* Unavailability)
	**Roster Approvals** – The percent of rosters that have been partially /finally approved by ward managers, along with approval lead times. (*Metric group* Effectiveness)
	**Additional Duties** - The percent of assigned duties that are in addition to the agreed template demand (*Metric group* Effectiveness)
	**Hours Balances** - The overall hours balance for a unit .I.e. the total of all over-contracted and under-contracted hours worked since rostering began. (*Metric group* Effectiveness)
	**Temporary Staffing** – The percent of temporary staff (both Bank and Agency) used on rosters. (*Metric group* Effectiveness)

For the full list of metrics that are available in RosterPerform, see the document: **RosterPerform Metric Descriptions UK,** In line with release 10.5.1. OR 10.5.2

4.2 Setup a Process

In order to effectively use RosterPerform and to realise the systems full benefits, it is important to have a robust process in place from ward to board as follows:

Partially Approve and Fully Approve – Rosters need to be approved by the Managers e.g. Ward Managers (Partial Approval) and Senior Managers e.g. Matrons (Fully Approved) in HealthRoster. If rosters are not approved then there is no managerial oversight or ownership. Roster quality is generally poor, as managers won't have viewed the analyser KPIs.

It impacts fairness as unapproved rosters don't show in Employee Online.

Rosters that are not even in part approved don't show safety/effectiveness KPIs in RosterPerform (as the rosters might still be draft) limiting wider visibility of problems in those areas.

Regular Review of outliers/action plans – Using the data from RosterPerform, there needs to be a regular review of the metrics at unit and division level by Managers, Senior Managers and other necessary stakeholders. Those units that breach the agreed thresholds **(See section 5.3 for setting thresholds)** need to be reviewed and an action plan agreed to resolve the problem.

In order to provide users access to the metric information in RosterPerform they need to be setup in RosterPerform. The users can then either login to view the data or more effectively be setup to receive scheduled notifications with the required data. **(See section 5.6 for creating and assigning users to notifications)**

Aware of outliers/action plans – On an agreed basis e.g. monthly the Board needs to be made aware of the outliers and the actions that have been put into place to resolve any breaches.

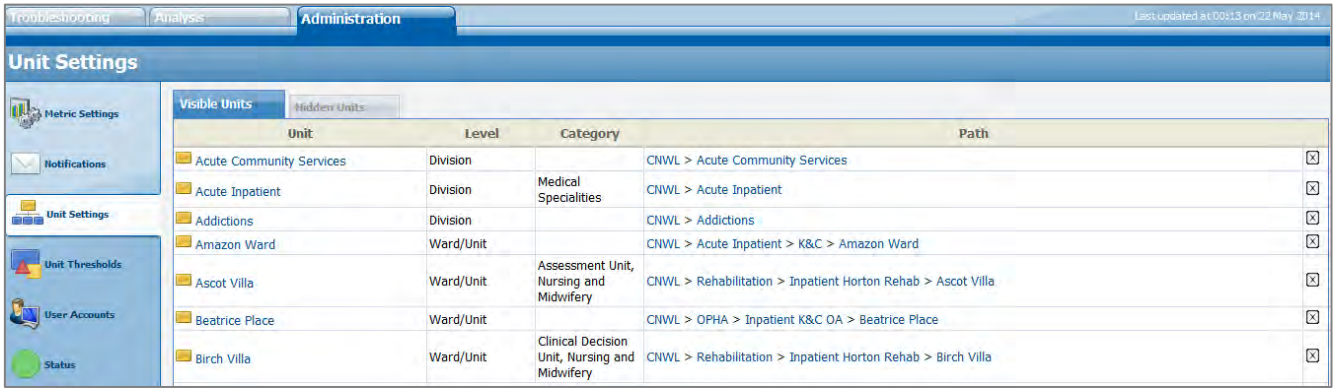
5 Setup RosterPerform

This section provides details on setting up various parts of RosterPerform to use the system effectively.

5.1 Using 10.5.1 Set Unit Visibility

Units which have not been fully implemented should be hidden as this will skew the figures and also affect the performance of the system.

Units can be hidden from within the Administration>Unit Settings area:



- To hide a unit click the ⊠ icon on the Visible tab
- To make a unit visible again click the ↶ icon on the Hidden tab

5.2 Using 10.5.2 Set Unit Visibility

Units which have not been fully implemented should be set to Visible Non Comparable if you still wish to see the data for those units or Hidden as this will skew the figures and also affect the performance of the system.

Following are the available visibility states:

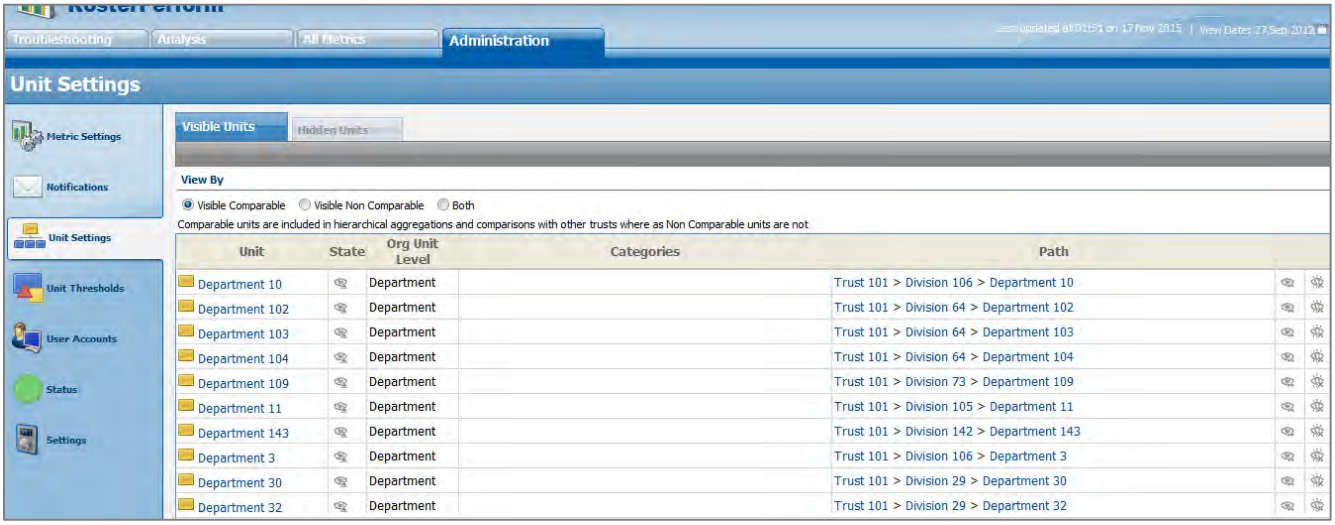
- Visible Comparable – These units are data gathered and aggregated up to department, division and trust level and used for local and national comparators
- Visible Non Comparable – These units are data gathered but not aggregated up or used for local and national comparators.
- Hidden - No data for hidden units is shown on the site.

Note: National Comparators are only available as part of the Allocate Insight Service.

The metric information for Visible Non Comparable Ward/Units is **only** available on the All Metrics page when the visible non comparable option is selected. All other views do not display any information for Visible Non Comparable units for the period it is set to be Visible Non Comparable.

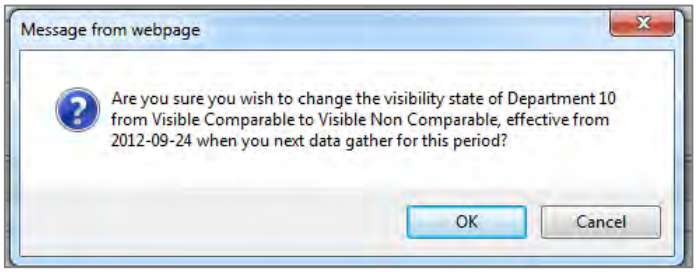
5.2.1 Managing unit visibility states

The visibility status of units is managed from within the administration tab in the unit settings area. You can toggle between Visible Comparable, Visible Non Comparable or Both on the Visible Units tab.



The units list displays a State column which shows an icon for the visibility of the unit on the selected 'View Date' in the top right hand corner. The page will always default to today's date when you first load the page.

A change to the visibility state will be effective from the start of the weekly period in which the 'View date' you have selected occurs. You will always get a confirmation message (shown below) when changing the visibility state which will allow you to cancel the change if you realise you have made a mistake.



After a change has been made to units visibility state in roster perform the re-aggregation of any data based on the change will occur when you next data gather for the period.

Indicates that the unit is Visible Comparable

Indicates that the unit is Visible Non Comparable

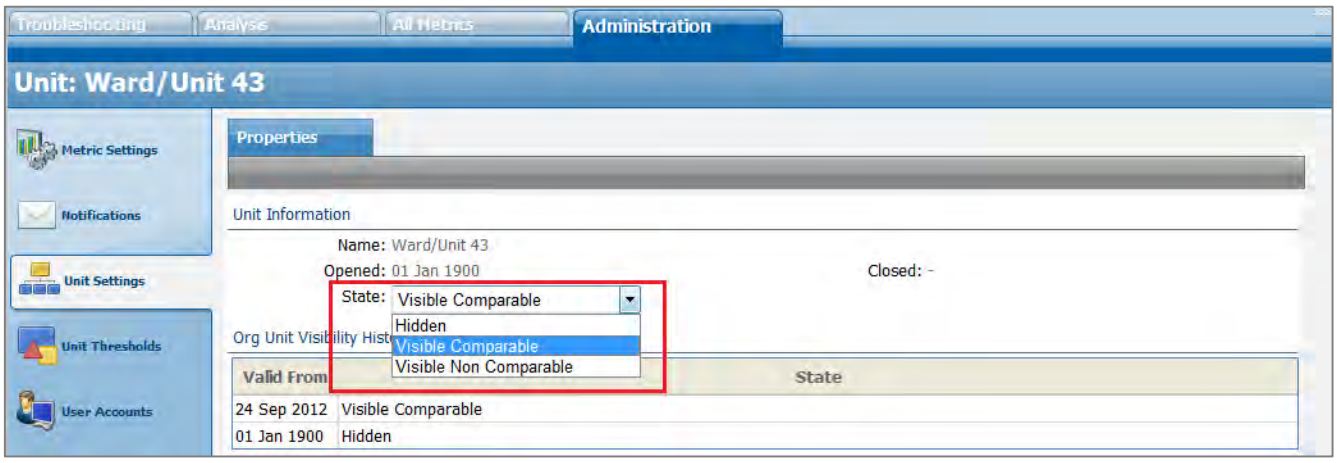
Indicates that the unit is Hidden

For Visible Comparable units, you can change the state to Visible Non Comparable or Hidden by click on the relevant icon on the far right of the list

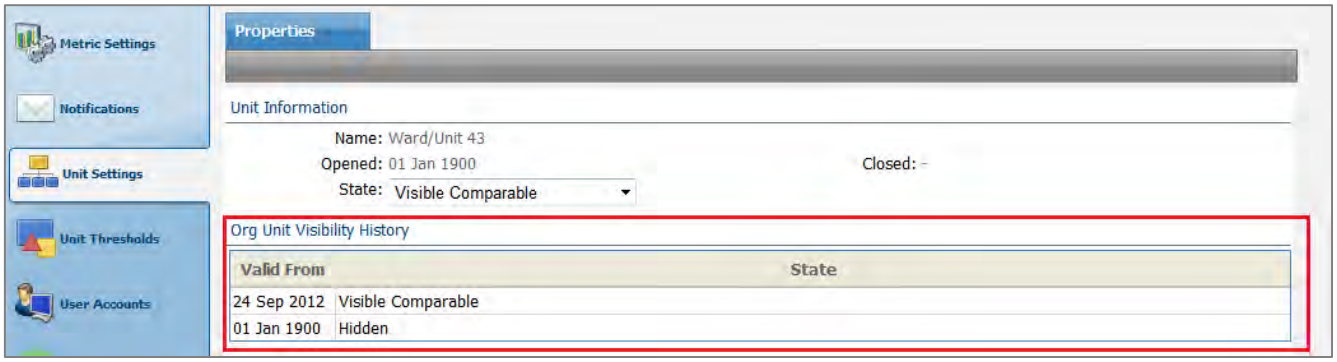
For Visible Non Comparable units you can change the state to Visible Comparable or Hidden by clicking on the relevant icon on the far right of the list.

For Hidden units; on the Hidden Units tab you can change the state to Visible Comparable or Visible Non Comparable by clicking on the relevant icon on the far right of the list.

You can also change the visibility of a unit by clicking on the unit name in the list which takes you to the unit's properties page:



On the same page you can also see a history of the changes that have been made to the visibility state:



The following table provides details of what will happen when the state is changed for structure units and rostered units:

State change	Rostered Unit	Structure Unit
Visible Comparable to Visible Non Comparable	Only the selected rostered ward unit becomes Visible Non Comparable	The selected structural unit and any other structured units and ward units that belong to it become Visible Non Comparable
Visible Non Comparable to Visible Comparable	The selected rostered ward/unit and any of its parents that are Visible Non Comparable (all the way to the top of the org structure) become Visible Comparable so that the data can be aggregated up.	The selected structural unit and any of its parents that are Visible Non Comparable (all the way to the top of the org structure) become Visible Comparable so that the data can be aggregated up.
Visible Comparable or Visible Non Comparable to Hidden	Only the selected rostered ward unit becomes Hidden	The selected structural unit and any other structured units and ward units that belong to it become Hidden
Hidden to Visible Comparable	The selected rostered ward/unit and any of its parents that are Hidden (all the way to the top of the org structure) become Visible Comparable so that the data can be aggregated up.	The selected structural unit and any of its parents that are Hidden (all the way to the top of the org structure) become Visible Comparable so that the data can be aggregated up.

Hidden to Visible Non Comparable	The selected rostered ward unit becomes Visible Non Comparable and any of its parents that are hidden become Visible Comparable.	The selected structural unit becomes Visible Non Comparable and any of its parents that are hidden become Visible Comparable.

Note: In HealthRoster, structure units should not be set up with rosters as these will not be visible in RosterPerform.

5.3 CONFIGURE METRICS

Before using the system it is important to ensure that the required metrics are visible. Also if you are using an upgraded system check that the default metrics have been applied prior to you making any changes to the metrics. To have the default metrics applied please contact Allocate Support.

The following changes can be made to the metrics from the Administration>Metric Settings area

- Make a metric visible or hidden
- Specify a different name/description for the metric from the default
- Specify which views the metric should be visible in
- Specify if thresholds should be used and change the default threshold values
- Reorder the Visible metrics list (This determines the order of the metrics in the views)

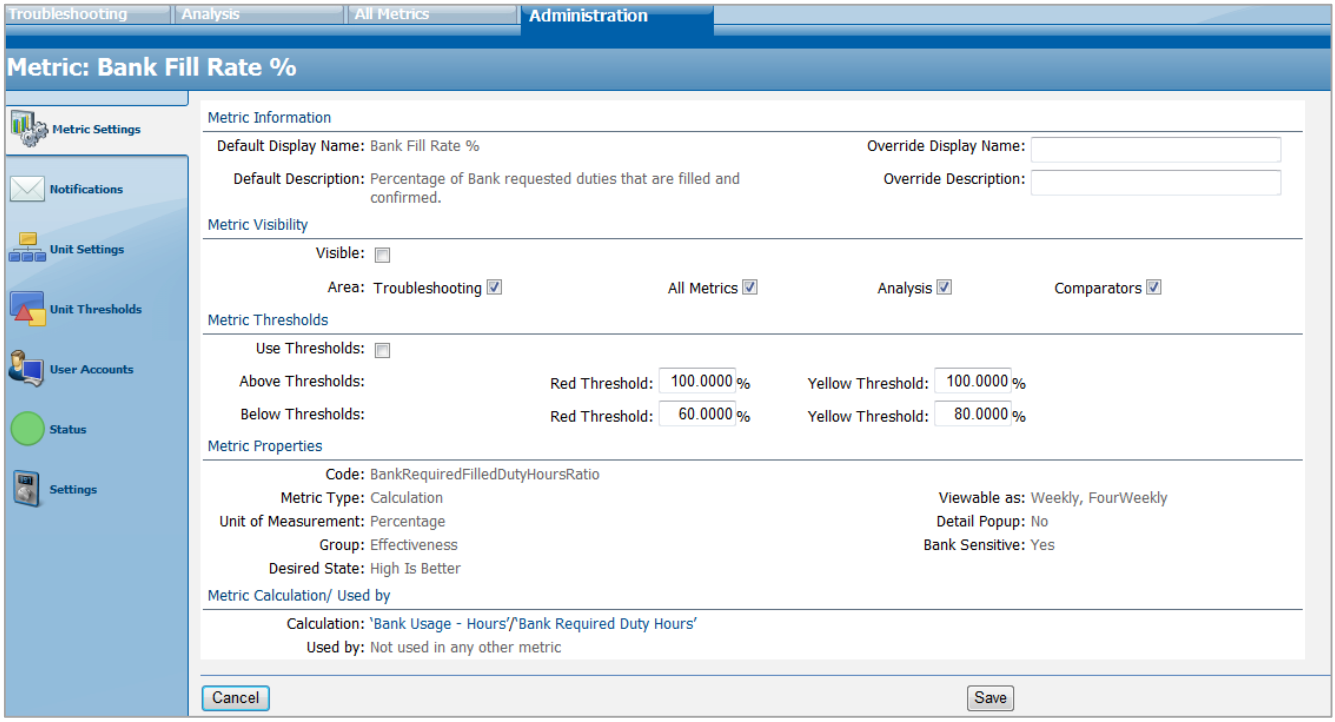
5.3.1 Make a metric visible or hidden

By default some metrics are set as visible and some as hidden. If the default metric settings file has been applied then the metrics felt as being most relevant for report would be visible. However if you require a metric that is hidden to be visible then this can be done by:

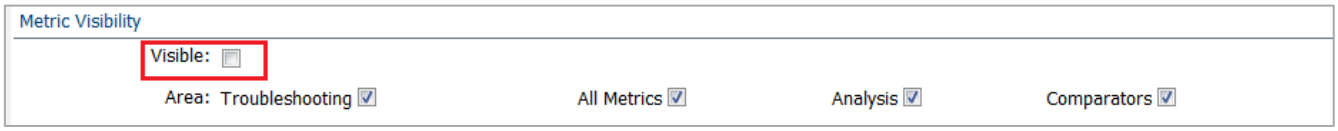
Click on the metric on the 'Hidden Metrics' tab:

Effectiveness	Bank Usage - Hours	Hours	0.0000	0.0000	False	Hours of Duties Filled by Bank Staff.
Effectiveness	Bank Fill Rate %	Percentage	100.0000 %	100.0000 %	False	Percentage of Bank requested duties that are filled and confirmed.
Unavailability	Staff On Parenting	Hours	0.0000	0.0000	False	Time on Parenting from substantive staff

This opens the metric details page.



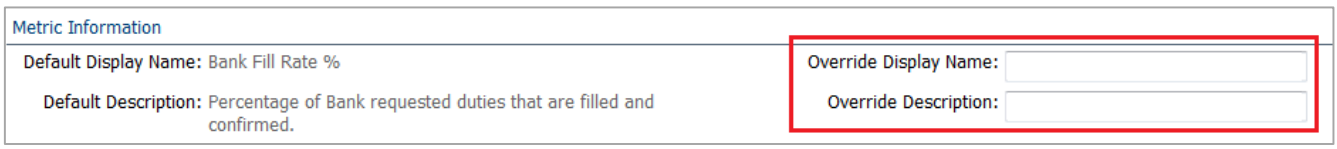
Tick the 'Visible' option in the Metric Visibility section:



This will then display the metric on the "Visible Metrics' tab.

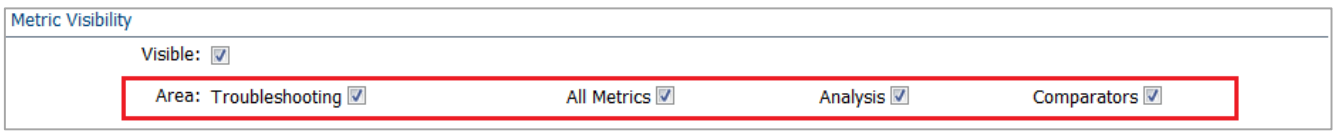
5.3.2 Specify a different name for the metric from the default

If you wish to change the default metric name or description, this can be done on the metric details page in the Metric information section:



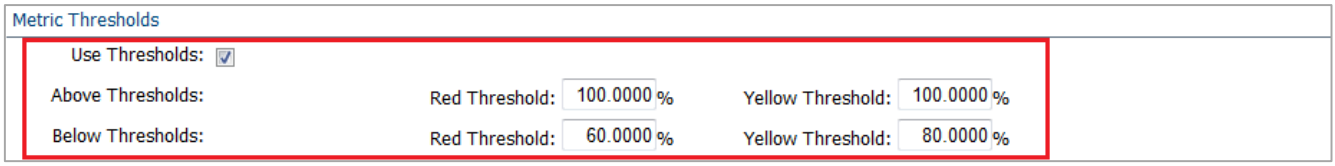
5.3.3 Specify which views the metric should be visible in

For any reason if you want to change which views the metric is visible in this can be done from within the Metric Visibility section. By default all weekly and 4-weekly metrics are available in all views:



5.3.4 Specify if thresholds should be used and change the default threshold values

By default for each metric whether or not to use thresholds and their default values are set, however this can be changed from within the Metric Thresholds section.



The Above red and yellow thresholds trigger if the unit exceeds the thresholds.

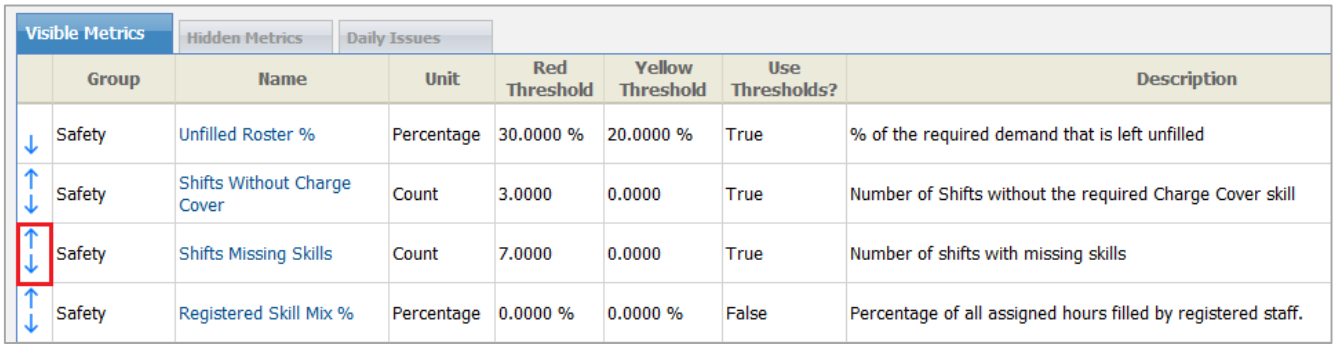
The Below red and yellow thresholds trigger if the unit falls below the thresholds.

When the 'Use Thresholds' option is ticked, the red and yellow thresholds will be used to show problem units, if unticked then Units will not be marked as red or yellow and no thresholds will be triggered.

Note: these

5.3.5 Reorder the visible metric list

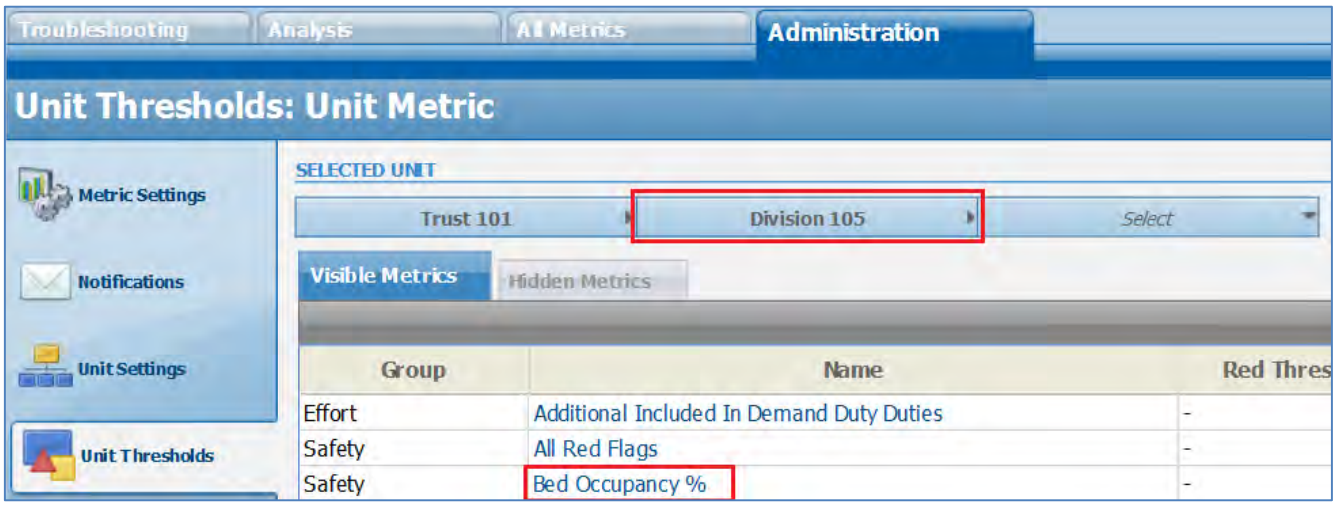
On the visible metrics tab the metrics can be reorder by clicking the arrows next to the metric. This order will then be reflected in the Troubleshooting and Analysis views.



	Group	Name	Unit	Red Threshold	Yellow Threshold	Use Thresholds?	Description
↓	Safety	Unfilled Roster %	Percentage	30.0000 %	20.0000 %	True	% of the required demand that is left unfilled
↑↓	Safety	Shifts Without Charge Cover	Count	3.0000	0.0000	True	Number of Shifts without the required Charge Cover skill
↑↓	Safety	Shifts Missing Skills	Count	7.0000	0.0000	True	Number of shifts with missing skills
↑↓	Safety	Registered Skill Mix %	Percentage	0.0000 %	0.0000 %	False	Percentage of all assigned hours filled by registered staff.

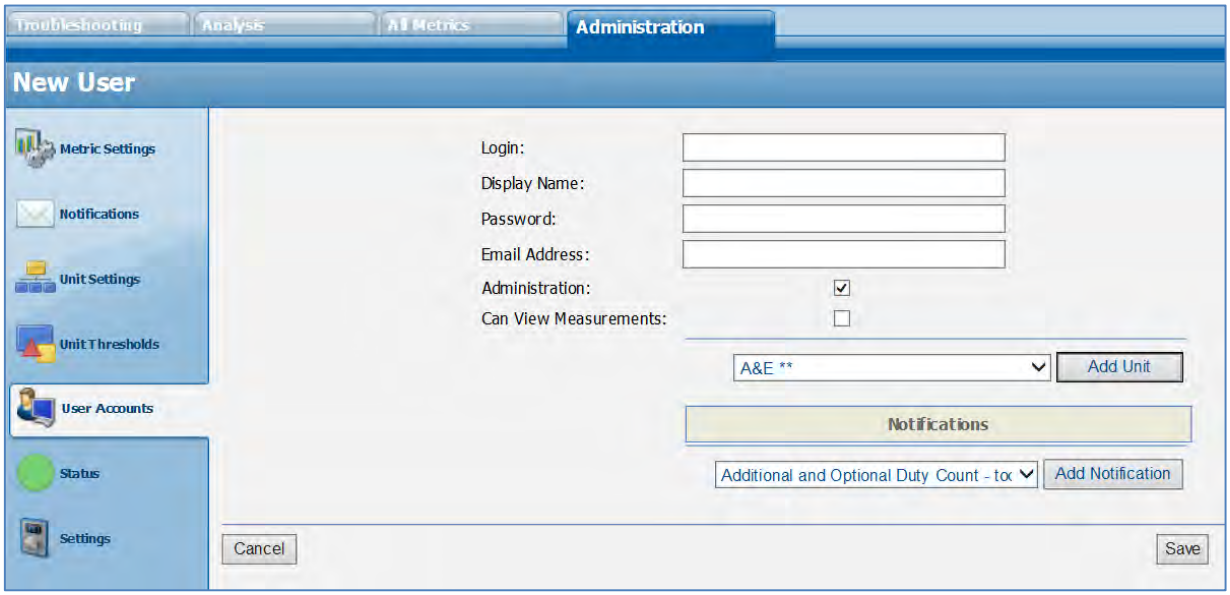
5.4 UNIT LEVEL THRESHOLDS

By default the unit's thresholds are taken from the main metric settings, however if you wish to you can change the metric thresholds for a unit from within the unit settings area by select the unit and then the metric to be set:



5.5 SETUP USERS

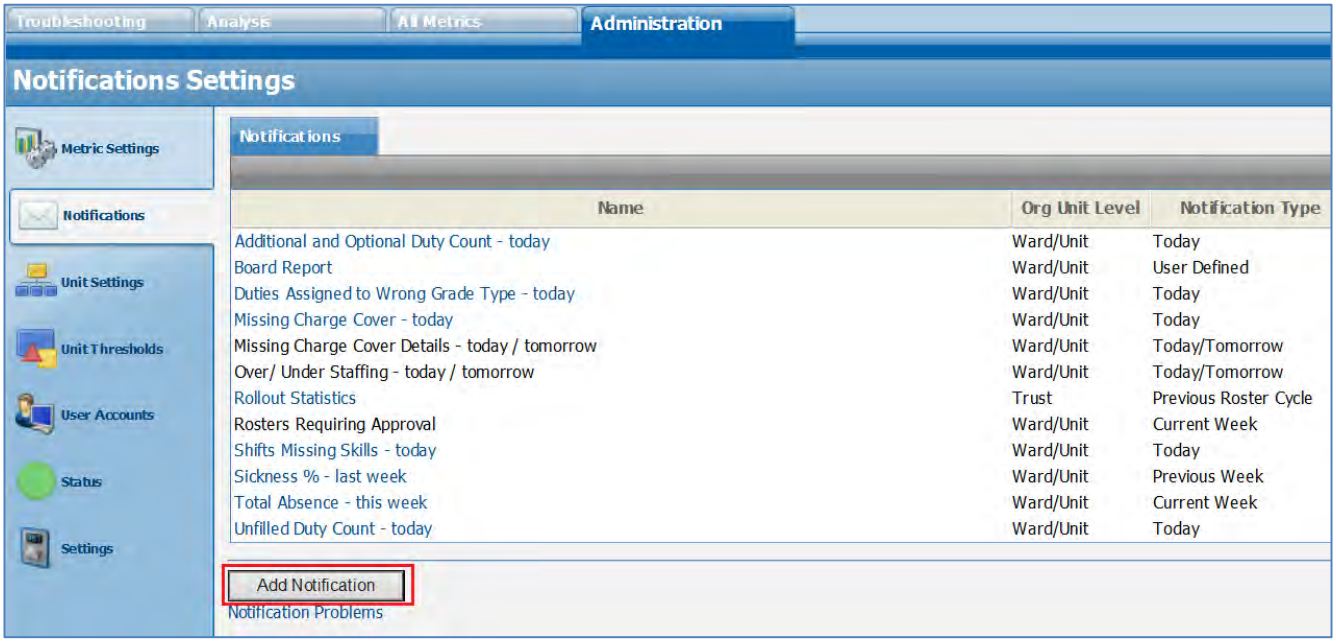
Users can be setup from within the Administration>User Accounts Area. To setup a user click 'Add User' button and provide the relevant user details. Set the units that you wish the user to see and the notifications you want them to receive.



5.6 SETUP NOTIFICATIONS

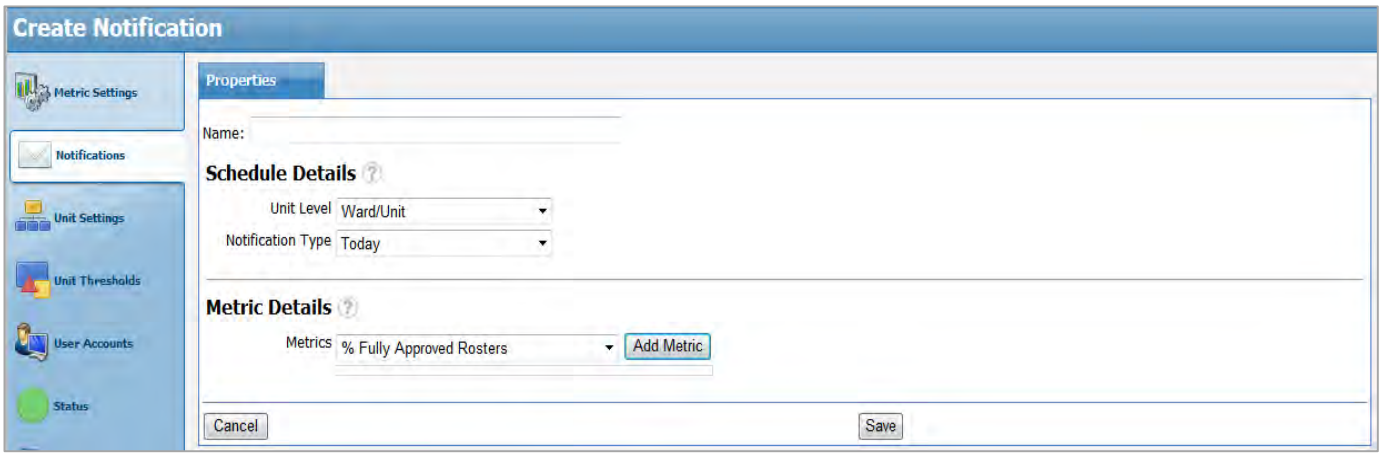
Notifications are the best way to push information out to users. From within the Administration >Notifications area you can setup notifications and then from the user accounts assign them to users.

There are default notifications that have already been set up which you can assign to users from their users account or create new notifications by clicking the Add Notifications button:



5.6.1 Adding a Notification

When adding or editing a notification, you will be presented with the below page:

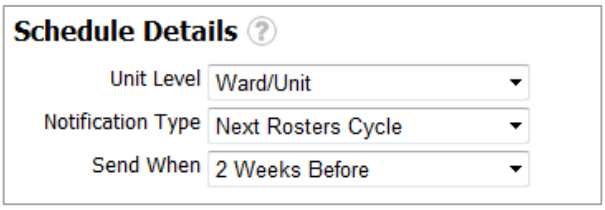


To create a new notification:

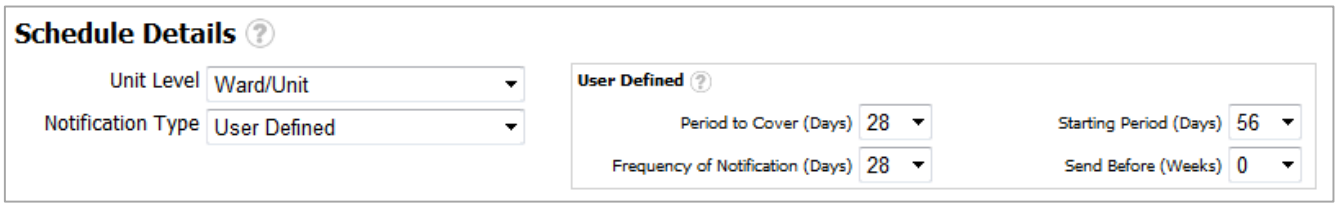
- In the 'Unit Level' dropdown list, select the org unit level for which you want the notification to be sent.
- In the 'Notification Type' dropdown list, select the type of notification to be sent. The following options are available:
    - **Today:** The notification will be sent daily
    - **Today/Tomorrow:** The notification will be sent daily, covering information for the current and next day
    - **Current Week:** The notification will be sent every 7 days, covering the current 7 day period
    - **Previous Week:** The notification will be sent every 7 days, covering the previous 7 day period
    - **Next Week:** The notification will be sent every 7 days, covering the next 7 day period
    - **Current Roster Cycle:** The notification will be sent every 28 days, covering the current 28 day period

- **Previous Roster Cycle:** The notification will be sent every 28 days, covering the previous 28 day period
- **Next Roster Cycle:** The notification will be sent every 28 days, covering the next 28 day period
- **User Defined:** Options to create other types of notifications

When the 'Next Roster Cycle' option is selected, you will be able to specify when the notification is to be sent i.e. Start of Current Period, 1 Week Before, 2 Weeks Before, 3 Weeks Before or 4 Weeks Before:



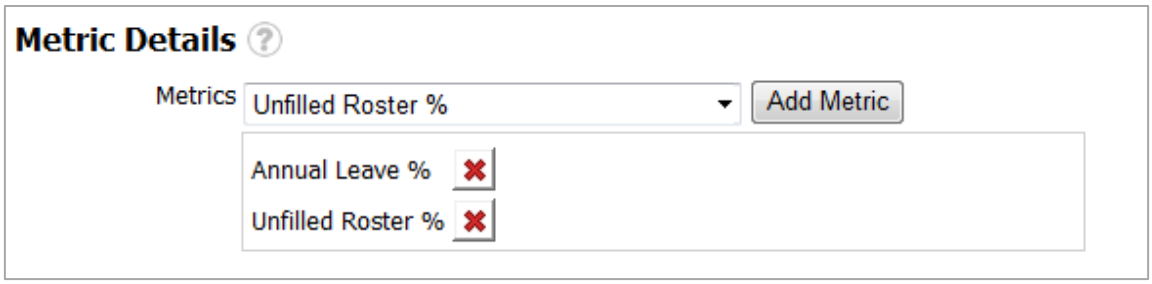
When the 'User Defined' option is selected, additional options are displayed and you can create your own custom notification:



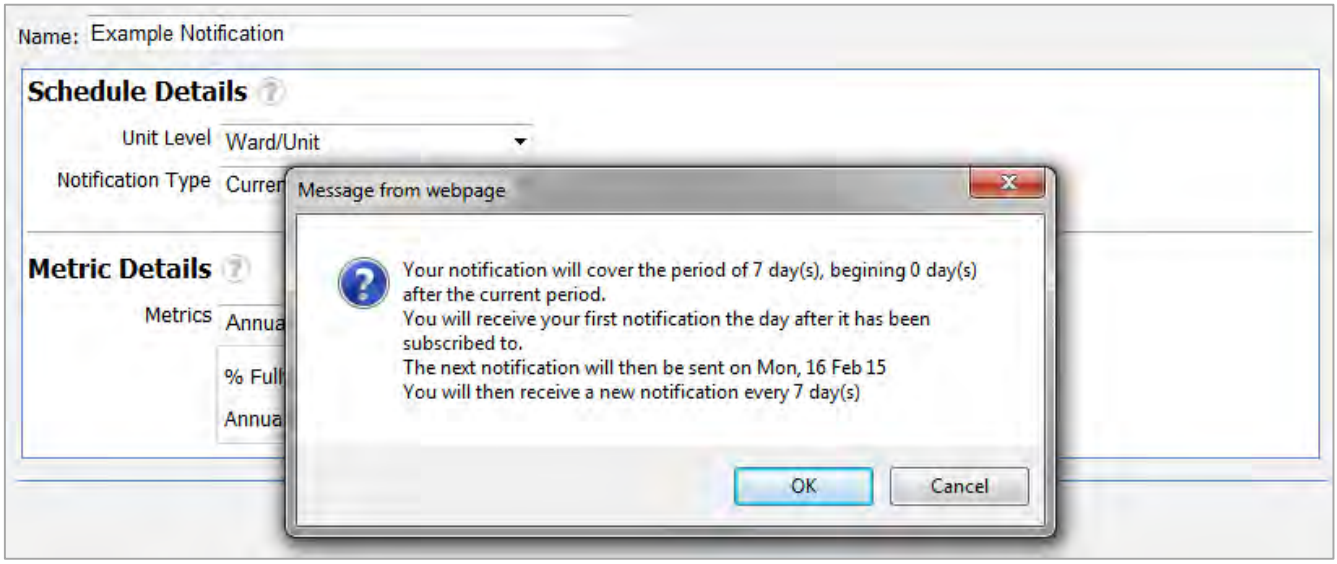
The following describes the user defined fields:

- **Period of Cover (Days):** The number of days the metrics in the notification should cover e.g. 1 day, 2 days, 7 days or 28 days. This determines the options available for the other parameters:
- **Starting Period (days):** The period of information to be sent e.g. 0 is the current period, -28 is the previous 28 day period and 28 is next 28 day period.
- **Send Before (weeks):** The number of weeks before the starting period the notification should be sent. This option is displayed when a positive starting period is selected.
- **Send After (weeks):** The number of weeks after the starting period the notification should be sent. This option is displayed when a negative starting period is selected.
- **Frequency of notification (days):** How often the notification is sent e.g. every day, every 7 days or every 28 days

Once the schedule details have been specified, select the metric/s to be added to the notification. . To save a notification, at least 1 metric needs to be selected. . When the notification is sent, based on the default threshold values that have been set for the metric, the background of the metric will be coloured red or yellow if the threshold value is breached.



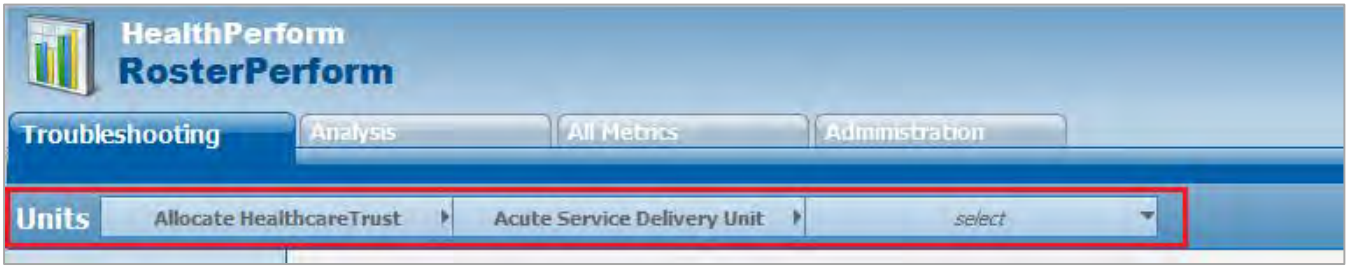
When the 'Save' button is clicked, you will be presented with a confirmation message that provides information about the notification as per the following example.



6 Overview of Key Views in RosterPerform

This section provides details about the key views available in RosterPerform. The views are grouped into 3 main areas: Troubleshooting, Analysis and All Metrics.

The data in the views are driven by the unit breadcrumb displayed below the main tabs:



In each view you can see data for the visible units you have been given access to.

Following is an overview about each area and the avaliable views:

Troubleshooting Area - The views in this area highlight operational issues using the red, amber and green traffic light system where red and amber indicate that the metric thresholds have been breached. For more details about a problem you can drill down further in the views. Each view defaults to the current period, however you can navigate to the previous periods or next period using the navigation controls.	
Daily Issues	The Daily Issues view shows problems for a certain day. It shows the performance for the date in question for five key metrics: Unfilled duty count, Shifts without charge cover, Shifts missing skills, Wrong grade type and Additional & Optional duties. This gives you clear visibility of issues that could be addressed that day.
Weekly Issues	The Weekly Issues view shows problems for a week split by each metric group. Default is current week. Problem units will be marked as either yellow or red depending on the threshold levels set for each metric within the metric group. Green indicates there are no problems within those Units. More details of the problem units can be viewed drilling down on the metric group bar. There is also a table which shows variance over a 2 week period.
Timeline	The Time Line view shows units with problems within each metric group over a 12 week period. (4 weeks historical and 8 weeks future) Problem units will be marked as either yellow or red depending on the threshold levels set for each metric within the metric group. Green indicates there are no problems within those Units.
Analysis Area – The views in this area provide further details of how units are performing on a weekly, 4-weekly and in some views on a 12 weeks basis. The views provide you with the ability to analyse trends, home in on where the problems actually lie and allow you compare units locally and nationally to see how units are performing against their peers.	
Timeline	Same as timeline above
Graphs	The graphs tab shows graphs for each metric. Each graph shows how the metric is performing over a 12 week period which allows you to identify any problem weeks and see the trends.
History	The History view shows yearlong trend graphs for each metric with a point for each 4 week roster period. As well as the trend for the selected year, there is the ability to compare this

	value with the local and or national means/medians for that year or the previous year.
Breakdown **(Available from 10.5.2)**	The Breakdown view provides detailed analysis information for Additional Duties allowing you to understand what is driving the figures and subsequently take appropriate action.
Scorecard	The Scorecard view shows how the unit's values compare to the median and mean values and provides ranking and quartile information to show how this unit scores compare to others locally and nationally.
Distribution	The Distribution view shows similar information to the Scorecard – i.e. the unit's value compared to the median and mean – but shows this graphically to display more information in terms of comparison to other units locally or nationally.
Outliers	The Outliers view provides visual information about how you are performing when comparing yourself locally or nationally with other units. The view is based on standard deviations and shows if you are within the norm, a positive outlier (performing better than the rest) or a negative outlier (not performing so well compared to the rest). I.e. unlike other views in RosterPerform, the colouring is not based on the metric thresholds, but instead whether the unit is a positive or negative outlier compared to its peers. This view can therefore simply highlight the units that need more help, as well as those that are performing well (and may have best practise that could be shared with the negative outliers).

All metrics
The All Metrics view provides you with information for all the visible metrics. For each unit shown in the view, if the metric threshold is breached the background of the cell is shaded accordingly. This view can be used for extracting metric information for reporting purposes. Within this view you can look at information for rostered units only or aggregated data for Trust, Division or Department levels. The All Metrics view is the only place where you can see information for the Visible Non Comparable units. **(Visible Non Comparable feature available from 10.5.2)**

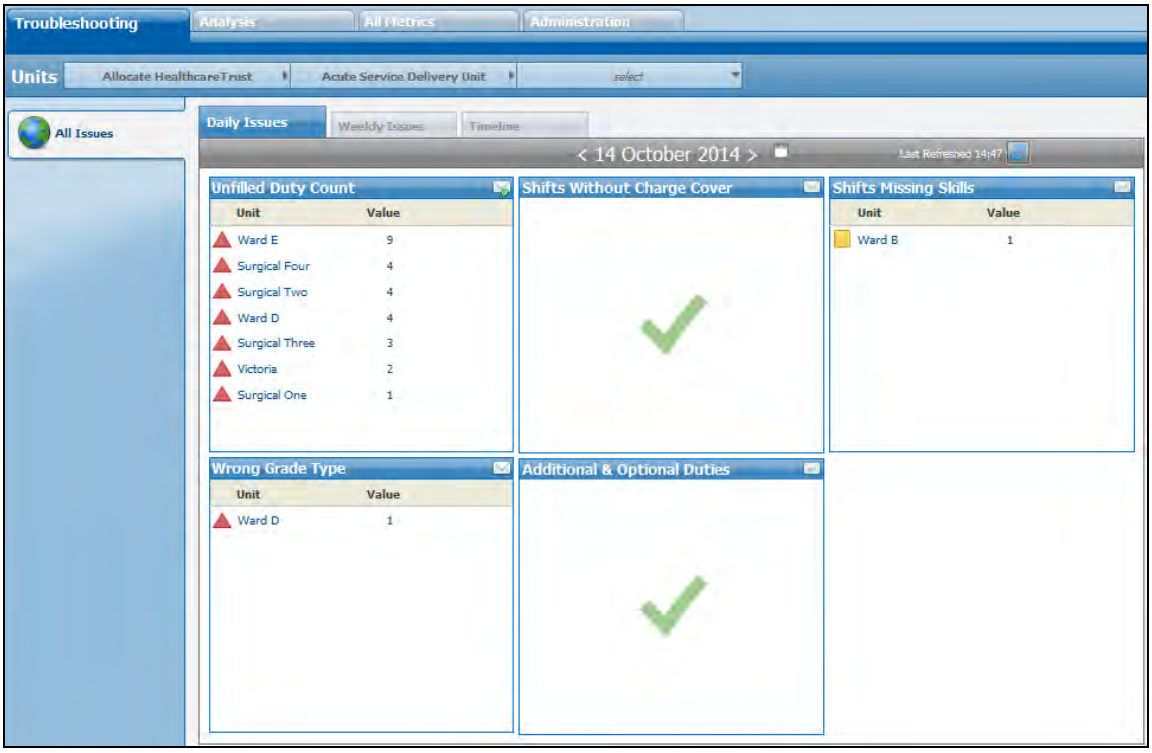
Note: All Drilldown data is shown realtime from HealthRoster

7 Details of Key Views in RosterPerform

This section provides further details of the views described in the previous section.

7.1 Troubleshooting Area - Daily Issues

The Daily Issues view shows the issues for a certain day. It will show the performance for the view date against five key metrics for the unit(s) which you have visible access to. This gives you clear visibility of issues that could be addressed that day.



The five metrics shown, each with a corresponding drill down are:

Additional & Optional Duties
Shows all assigned additional or optional duties (excluding trainees), i.e. duties in excess of the agreed demand. Drill downs show the shift, date, person assigned and reason

Unfilled Duties
Shows all mandatory and additional unfilled duties. Drilldowns show the shift, date, and grade type

Shifts with Missing Skills
Shows where competence requirements, excluding 'Take Charge', have not been filled. Drill downs show the shift, missing competence and people assigned.

Wrong Grade Type
Shows where a duty is filled by someone with a different grade type to the requirement (e.g. Nurse filling a Care Assistant duty). The drilldown shows the shift, date, duty / person grade types and assigned person

Shifts Without Charge Cover

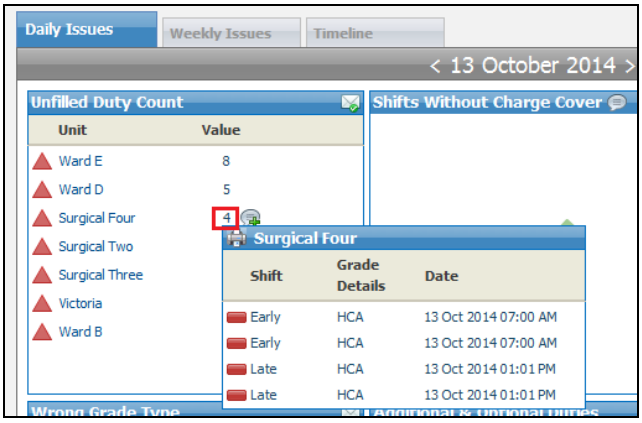
Shows duties where the Take Charge competence requirement has not been met. Drilldowns show the shift, date, and people assigned.

This daily staffing data is taken directly from the HealthRoster database, i.e. this is not gathered overnight.

The indicates that the unit has breached the red threshold.
The indicates that the unit has breached the yellow threshold.

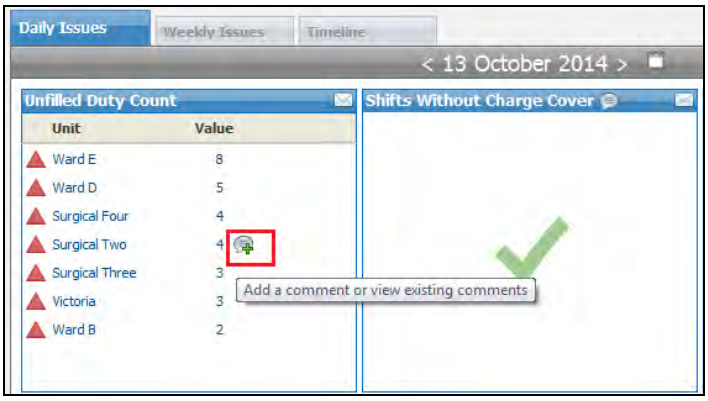
If there are no issues for any units for the day, a large green tick will appear in the display box for the metric .

To see drilldown information for a metric click on a value for the unit:



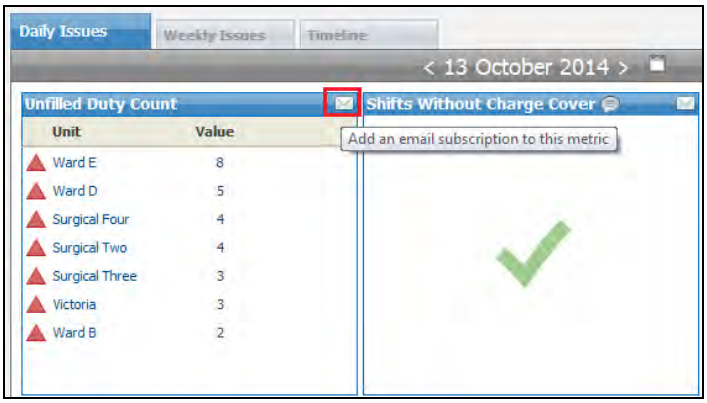
In this view comments can be added and viewed for units within the metric box.

To add a comment hover next to the unit value and click on the icon which appears:



Notifications can be subscribed to for each metric.

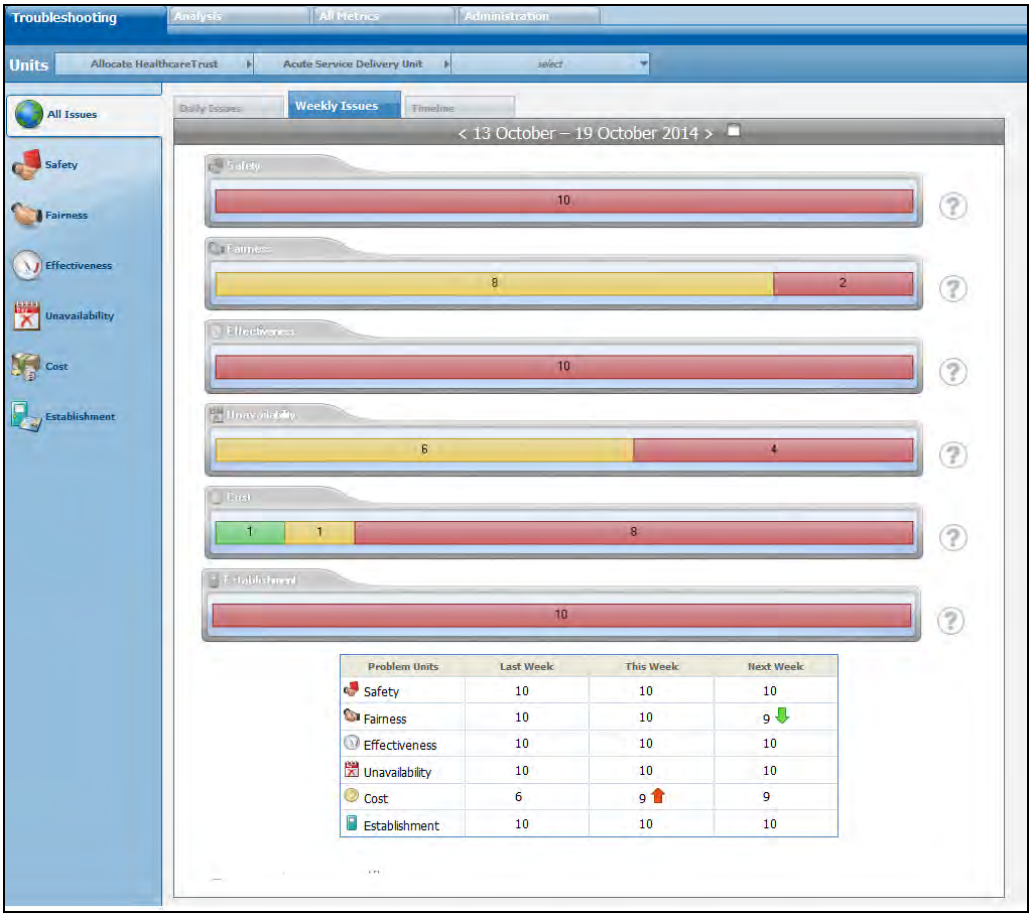
To subscribe to a notification click on the envelope icon:



A green tick  will appear on the icon once subscribed to. To unsubscribe, click on the same icon.

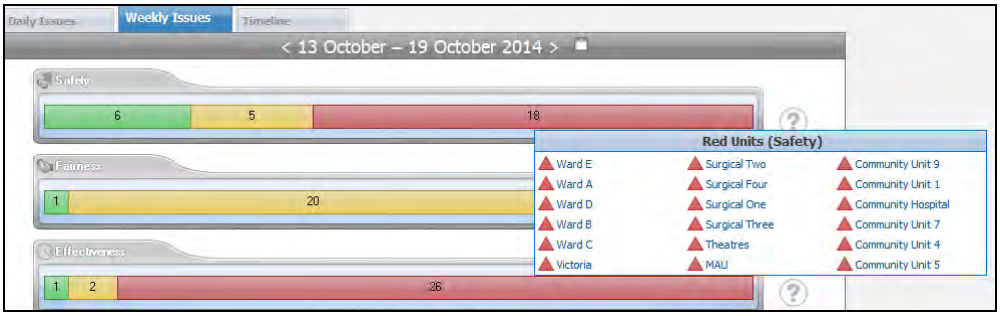
7.2 TROUBLESHOOTING AREA – WEEKLY ISSUES

The Weekly Issues view shows problems for a week. The user can view historic, current and future information by clicking on the navigational arrows which will move forward and backwards in week intervals. Default is current week. Problem units will be marked as either yellow or red depending on the level of threshold set for each metric. Green units indicate there are no problems within those Units.



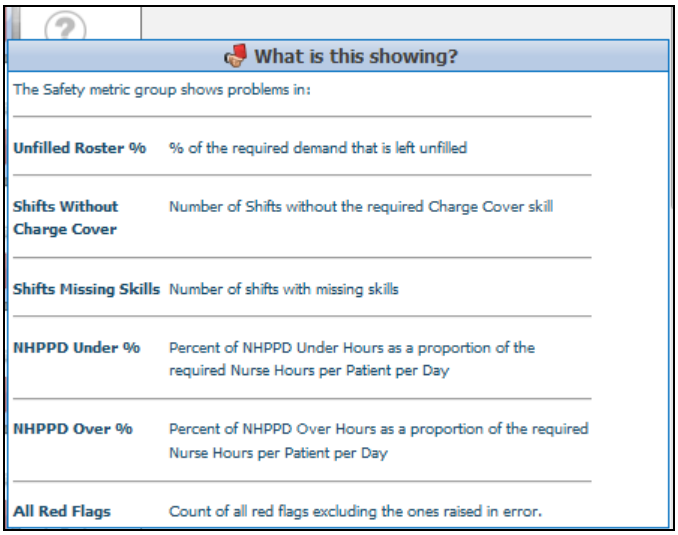
The Weekly Issues page shows All metric groups.

Each Metric group bar shows the number of green, yellow and red units in each metric group, for the week being viewed. By hovering the mouse over either the green, yellow or red part of the bar a tooltip will be displayed and will show a list of units in the relevant category.



By clicking on the unit name you will be taken to detailed analysis in the form of graphs. For more details see section 7.5 Analysis Area- Graphs.

By hovering over the icon you can see the information about the metrics which belong to the metric group:



The table beneath the bar's show the variance over a three week period:

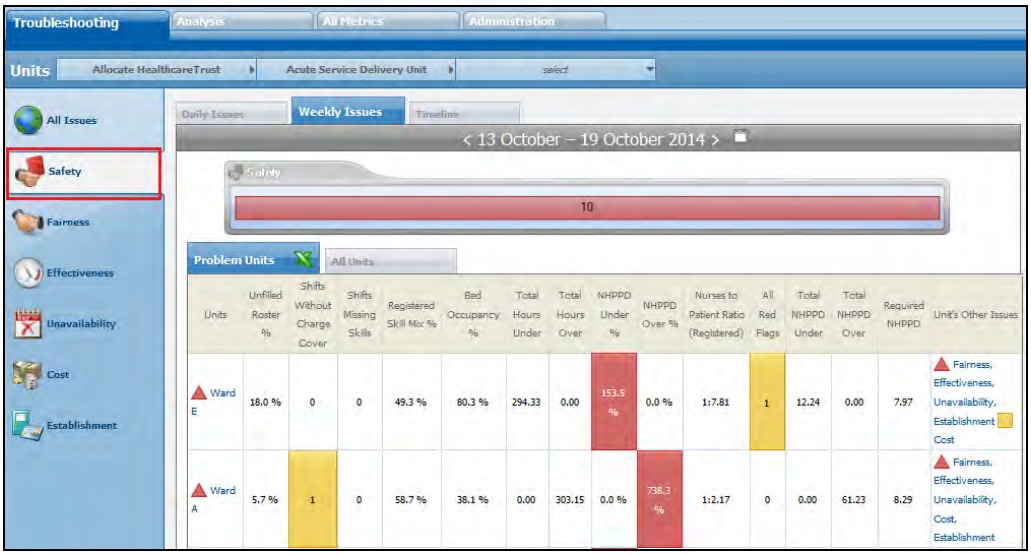
Problem Units	Last Week	This Week	Next Week
Safety	23	23	22 ↓
Fairness	29	28 ↓	27 ↓
Effectiveness	27	28 ↑	29 ↑
Unavailability	27	29 ↑	29
Cost	20	27 ↑	25 ↓
Establishment	28	27 ↓	26 ↓

The **Red** arrow indicates there has been an increase of yellow and red units from the previous week; the figure shown in the table is the total number of both yellow and red units that week.

The **Green** arrow indicates there has been a decrease in yellow and red units.

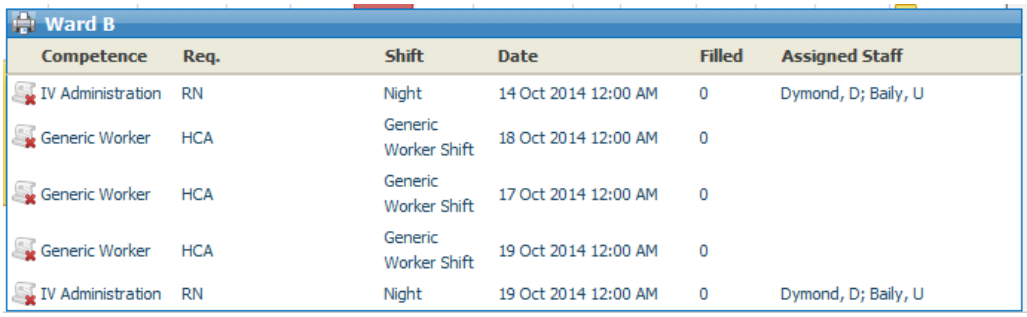
Where no arrows are displayed there has been no change.

By clicking on a metric group you can see a breakdown of the problem units:

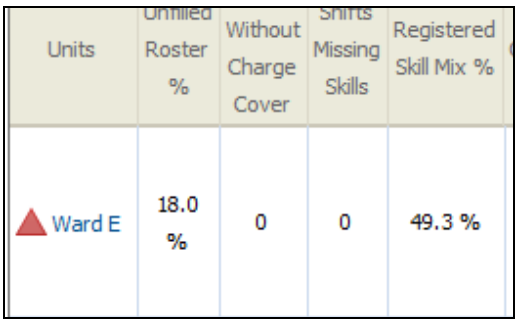


By hovering over a cell in the problem units grid a comments icon will appear in the top right hand corner allowing you to add a comment. Once a comment has been added you can view the comment by hovering over the * in the cell.

If the metric has an associated drill down then when you hover over the cell a ? will appear. By clicking on the icon further details will be provided regarding the value.

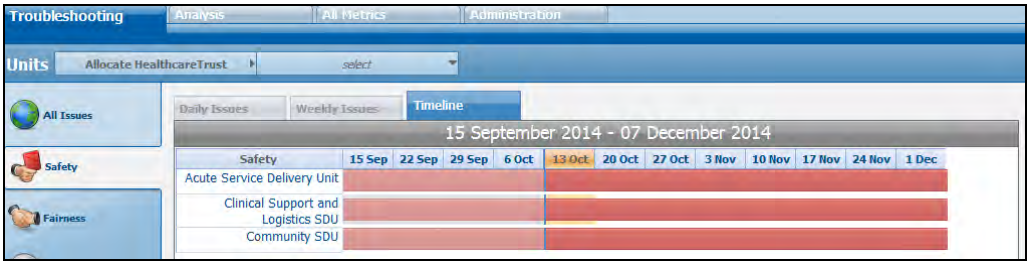


By clicking on the unit name, you will be taken to detailed analysis in the form of graphs. For more details see section 7.5 Analysis Area- Graphs.

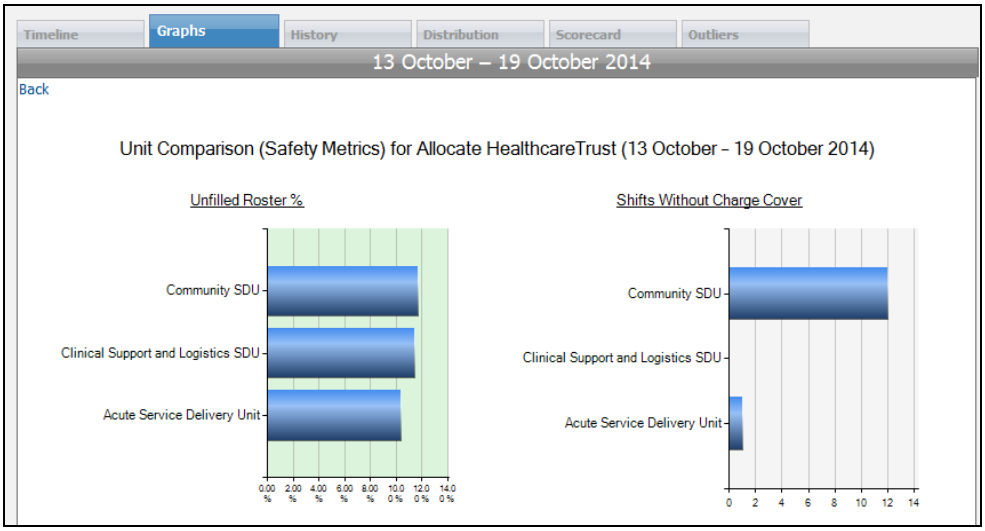


7.3 TROUBLESHOOTING AREA – TIMELINE

The Timeline view shows units with problems within each metric group over a 12 week period. (4 weeks historical and 8 weeks future)

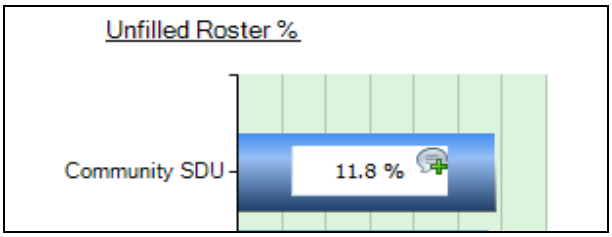


By clicking on a date in the Timeline view, you can see a comparison of all the sub units in that area for the week:



The background colour of the graphs is based on the threshold colours. For structural units however only the % metrics show the threshold colour for the background.

By hovering over the bar in the graphs, a value for the unit will be displayed and a comment can be added by clicking the icon:



7.4 ANALYSIS AREA – TIMELINE

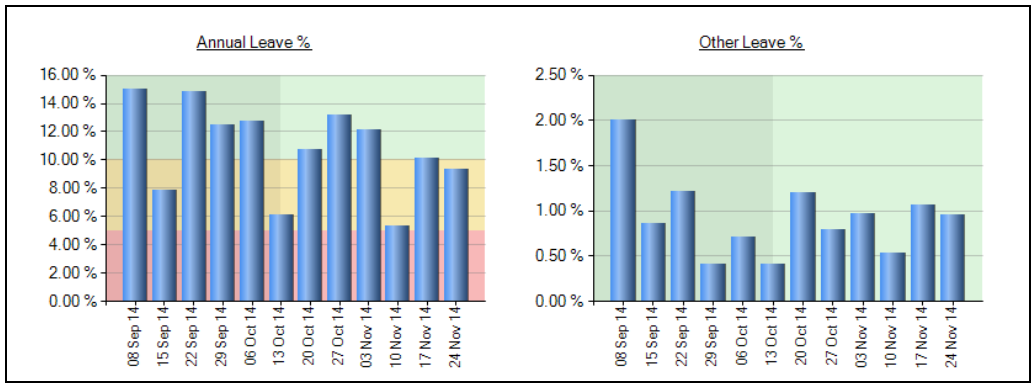
Same as Troubleshooting- Timeline

7.5 ANALYSIS AREA – GRAPHS

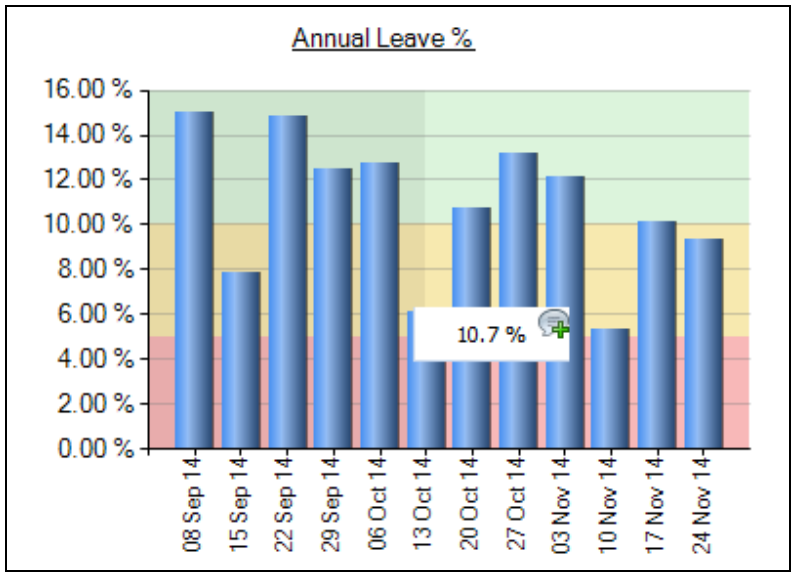
The Graphs tab displays graphs for the selected unit and metric group.

It shows a graphical representation of the metrics over a 12 week period. Historic periods are shaded grey.

Red/yellow/green thresholds are displayed on the background of each chart.

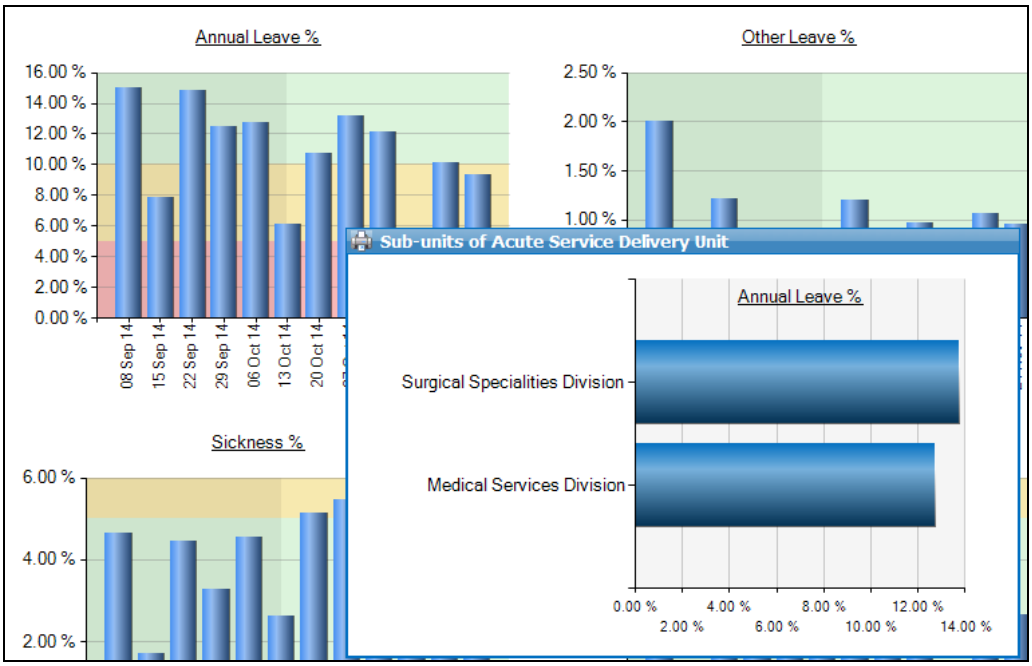


Hovering the mouse over a column in the chart will show the value of the column and allow you to add a comment by clicking the icon

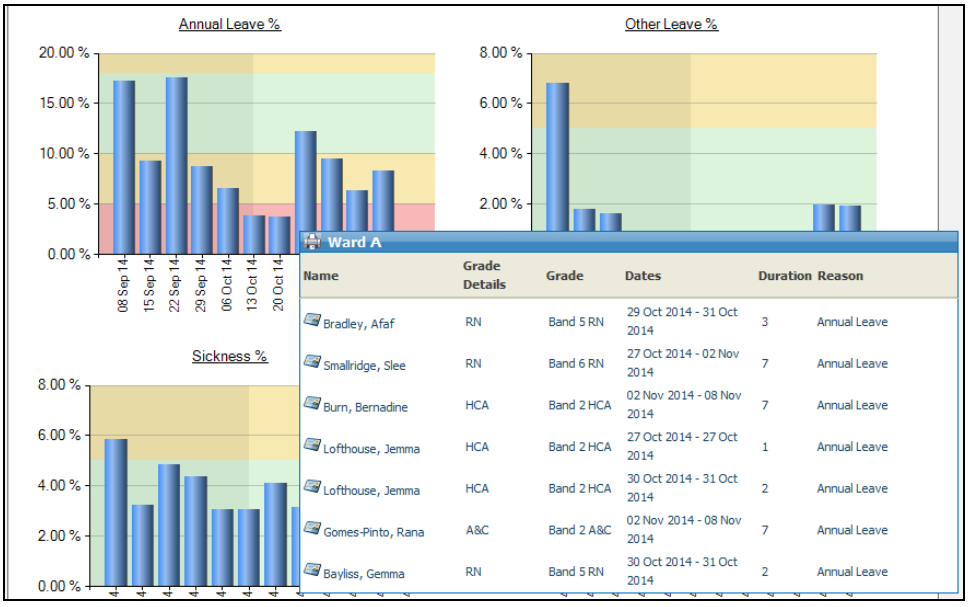


To view a comment made against a Graph data point, hover over the * which will be shown above the Bar.

Clicking on a column will show a breakdown of the sub units if the selected unit is a structural unit:



For rostered units, clicking on a bar in the graph will the underlying data:



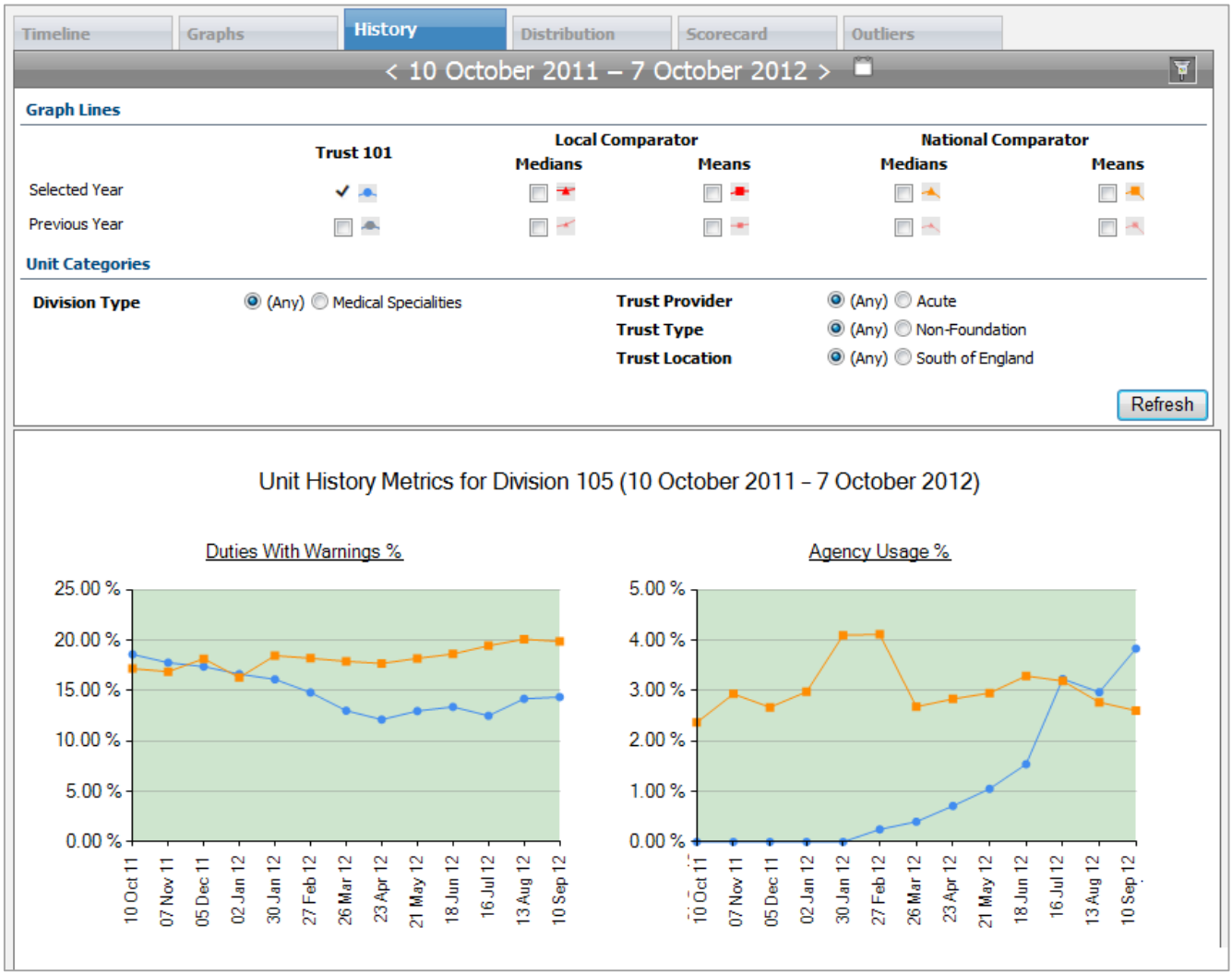
Name	Grade Details	Grade	Dates	Duration	Reason
Bradley, Afaf	RN	Band 5 RN	29 Oct 2014 - 31 Oct 2014	3	Annual Leave
Smallridge, Slee	RN	Band 6 RN	27 Oct 2014 - 02 Nov 2014	7	Annual Leave
Burn, Bernadine	HCA	Band 2 HCA	02 Nov 2014 - 08 Nov 2014	7	Annual Leave
Lofthouse, Jemma	HCA	Band 2 HCA	27 Oct 2014 - 27 Oct 2014	1	Annual Leave
Lofthouse, Jemma	HCA	Band 2 HCA	30 Oct 2014 - 31 Oct 2014	2	Annual Leave
Gomes-Pinto, Rana	A&C	Band 2 A&C	02 Nov 2014 - 08 Nov 2014	7	Annual Leave
Bayliss, Gemma	RN	Band 5 RN	30 Oct 2014 - 31 Oct 2014	2	Annual Leave

Clicking on the underlined metric name will open a larger version of the graph.

7.6 Analysis Area – History View

The History view shows yearlong trend graphs for each metric with a point for each 4 week roster period.

As well as the trend for the selected year (shown on the graph with a blue line ), there is the ability to compare this value with the local and or national means/medians for that year or the previous year. To add any one of these trend lines, tick the relevant box at the top of the section. The icon next to the box will show the colour of the trend line that will be displayed.



Dropdown allows you to look at 1 week or 4 week metrics; navigation arrows change the period viewed.

Changing the unit category options at the top of the section from 'Any' to a specific category will allow you to make like for like comparisons locally and with other Trusts.

For more information about the unit categories, see section 7.10 Filtering the History, Distribution, Scorecard & Outliers Views by Unit Category Information.

7.7 Analysis Area – Breakdown View (Available from 10.5.2 only)

Detailed analysis information has been added for Additional Duties on a new Breakdown tab to help understand what is driving the figures and subsequently take appropriate action.

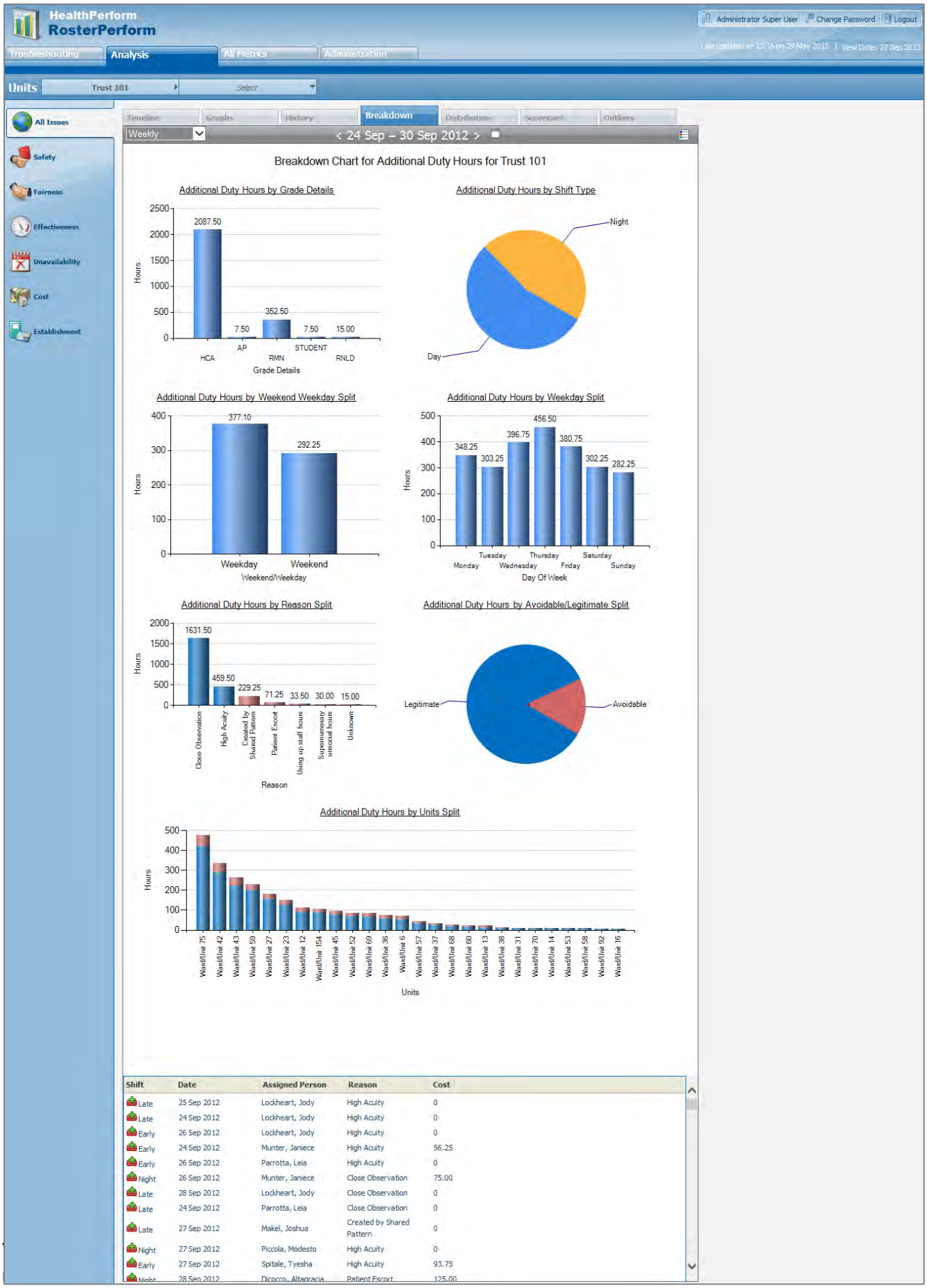
The new Breakdown tab is available from within the Analysis tab and also by drilling down to the details on the All Metrics tab for the following metrics:

- Additional Duties
- Additional Duty Cost
- Additional Duty Cost Per WTE
- Additional Duty Hours %
- Additional Duty Hours
- Additional Duty Count %

The breakdown tab shows the following information about additional duty hours for the selected period; weekly or 4-weekly:

Graph type	Description
Grade Details split	The additional duty hours split by the different grade types.
Shift Type split	The additional duty hours split by shift types.
Weekend/Weekday split	The average additional duty hours spit by those that were assigned to the weekdays and those to the weekend.
Day of Week split	Shows how the additional duty hours are split across the 7 days of the week.
Reason Split	The reasons why the additional duties were created. Those deemed to be legitimate are coloured blue and those deemed avoidable are coloured red.
Avoidable/Legitimate reasons split	The additional duty hours split by legitimate and avoidable reasons.
Unit split	If a structural unit is selected, shows the additional duty hours for each unit split by legitimate hours in blue and avoidable hours in red.

At the bottom of the breakdown down a tab a list of the additional duties shifts and their details which make up the graphs is displayed.

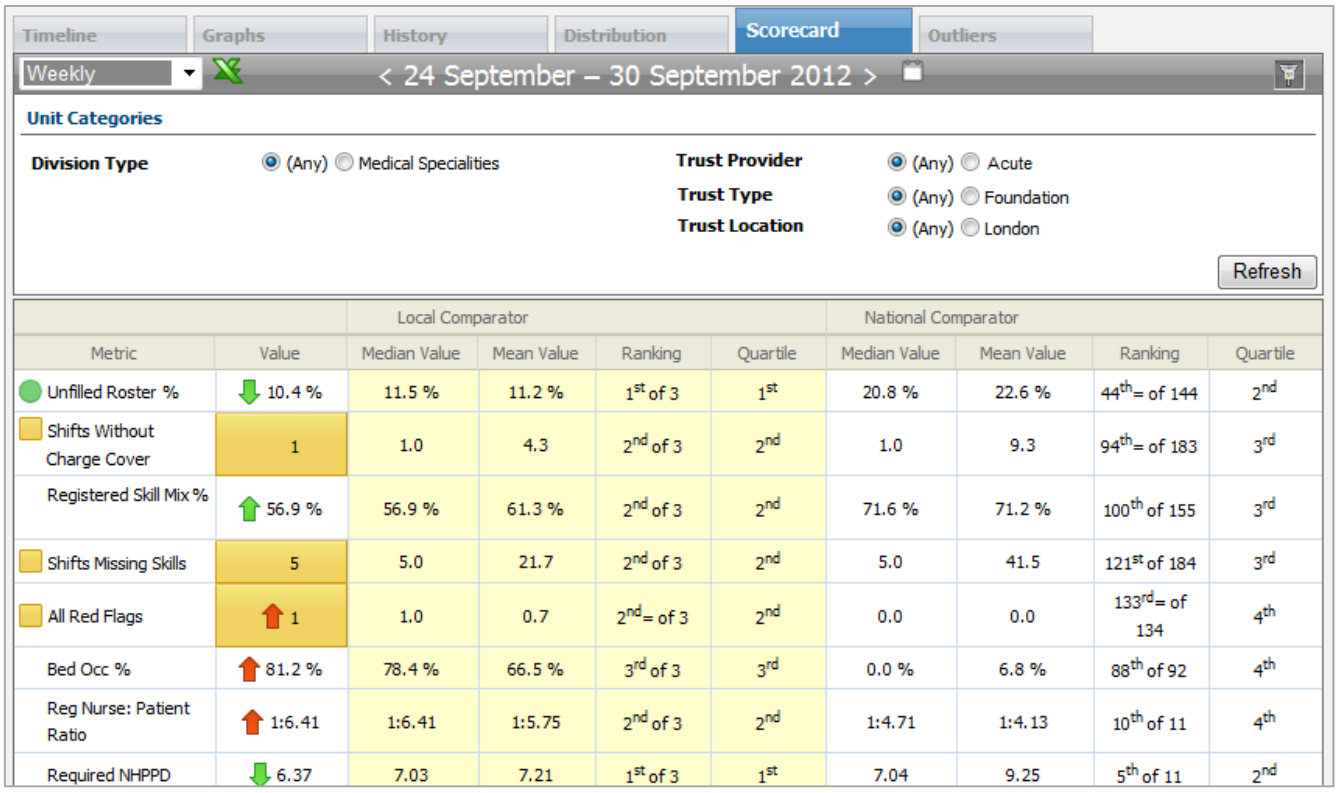

HealthPerform
RosterPerform
Administrator Super User
Change Password
Logout
Troubleshooting
Analysis
All Metrics
Administration
Units
Trust 101
Select
All Issues
Safety
Fairness
Effectiveness
Unavailability
Cost
Establishment
Timeline
Graphs
History
Breakdown
Distribution
Scorecard
Outliers
Weekly
< 24 Sep – 30 Sep 2012 >
Breakdown Chart for Additional Duty Hours for Trust 101
Additional Duty Hours by Grade Details
Hours
2087.50
7.50
352.50
7.50
15.00
HCA
AP
RMN
STUDENT
RNLD
Grade Details
Additional Duty Hours by Shift Type
Night
Day
Additional Duty Hours by Weekend Weekday Split
377.10
292.25
Weekday
Weekend
Weekend/Weekday
Additional Duty Hours by Weekday Split
348.25
303.25
396.75
456.50
380.75
302.25
282.25
Monday
Tuesday
Wednesday
Thursday
Friday
Saturday
Sunday
Day Of Week
Additional Duty Hours by Reason Split
1631.50
459.50
229.25
71.25
33.50
30.00
15.00
Close Observation
High Acuity
Created by Shared Pattern
Patient Escort
Using up staff hours
Supernumerary unsocial hours
Unknown
Reason
Additional Duty Hours by Avoidable/Legitimate Split
Legitimate
Avoidable
Additional Duty Hours by Units Split
Units
Shift
Date
Assigned Person
Reason
Cost
Late
25 Sep 2012
Lockheart, Jody
High Acuity
0
Late
24 Sep 2012
Lockheart, Jody
High Acuity
0
Early
26 Sep 2012
Lockheart, Jody
High Acuity
0
Early
24 Sep 2012
Munter, Janiece
High Acuity
56.25
Early
26 Sep 2012
Parrotta, Leia
High Acuity
0
Night
26 Sep 2012
Munter, Janiece
Close Observation
75.00
Late
28 Sep 2012
Lockheart, Jody
Close Observation
0
Late
24 Sep 2012
Parrotta, Leia
Close Observation
0
Late
27 Sep 2012
Makel, Joshua
Created by Shared Pattern
0
Night
27 Sep 2012
Piccola, Modesto
High Acuity
0
Early
27 Sep 2012
Spitale, Tyesha
High Acuity
93.75
Night
28 Sep 2012
Dicocco, Altagracia
Patient Escort
125.00

Similar to the Graphs tab, you can view a larger version of a graph by clicking on the title of the graph.

To copy the graph into Word, Excel etc., simply right click on the graph click copy and then paste it in your document/spreadsheet.

7.8 Analysis Area – Scorecard View

The Scorecard view in the analysis area shows how the unit's values compare to the median and mean values, and provides ranking and quartile information to show how this unit scores compare to others locally and nationally.



		Local Comparator				National Comparator			
Metric	Value	Median Value	Mean Value	Ranking	Quartile	Median Value	Mean Value	Ranking	Quartile
Unfilled Roster %	↓ 10.4 %	11.5 %	11.2 %	1st of 3	1st	20.8 %	22.6 %	44th= of 144	2nd
Shifts Without Charge Cover	1	1.0	4.3	2nd of 3	2nd	1.0	9.3	94th= of 183	3rd
Registered Skill Mix %	↑ 56.9 %	56.9 %	61.3 %	2nd of 3	2nd	71.6 %	71.2 %	100th of 155	3rd
Shifts Missing Skills	5	5.0	21.7	2nd of 3	2nd	5.0	41.5	121st of 184	3rd
All Red Flags	↑ 1	1.0	0.7	2nd= of 3	2nd	0.0	0.0	133rd= of 134	4th
Bed Occ %	↑ 81.2 %	78.4 %	66.5 %	3rd of 3	3rd	0.0 %	6.8 %	88th of 92	4th
Reg Nurse: Patient Ratio	↑ 1:6.41	1:6.41	1:5.75	2nd of 3	2nd	1:4.71	1:4.13	10th of 11	4th
Required NHPPD	↓ 6.37	7.03	7.21	1st of 3	1st	7.04	9.25	5th of 11	2nd

- Median Value is the sorted middle value in the set of units being compared
- Mean Value is the average value in the set of units being compared
- Ranking is the position of the value in the set of units being compared
- Quartile – is the quarter in which the value sits when ordered and divided into 4 where a value in the 1st quartile is better than a value in the 2nd quartile.

The unit's value is shaded amber/red if it exceeds the thresholds.

The green/red arrows indicate the trend compared to the previous 1 week / 4 week period for local comparators only– i.e. green arrows mean this metric is better than the last period; red means it is worse.

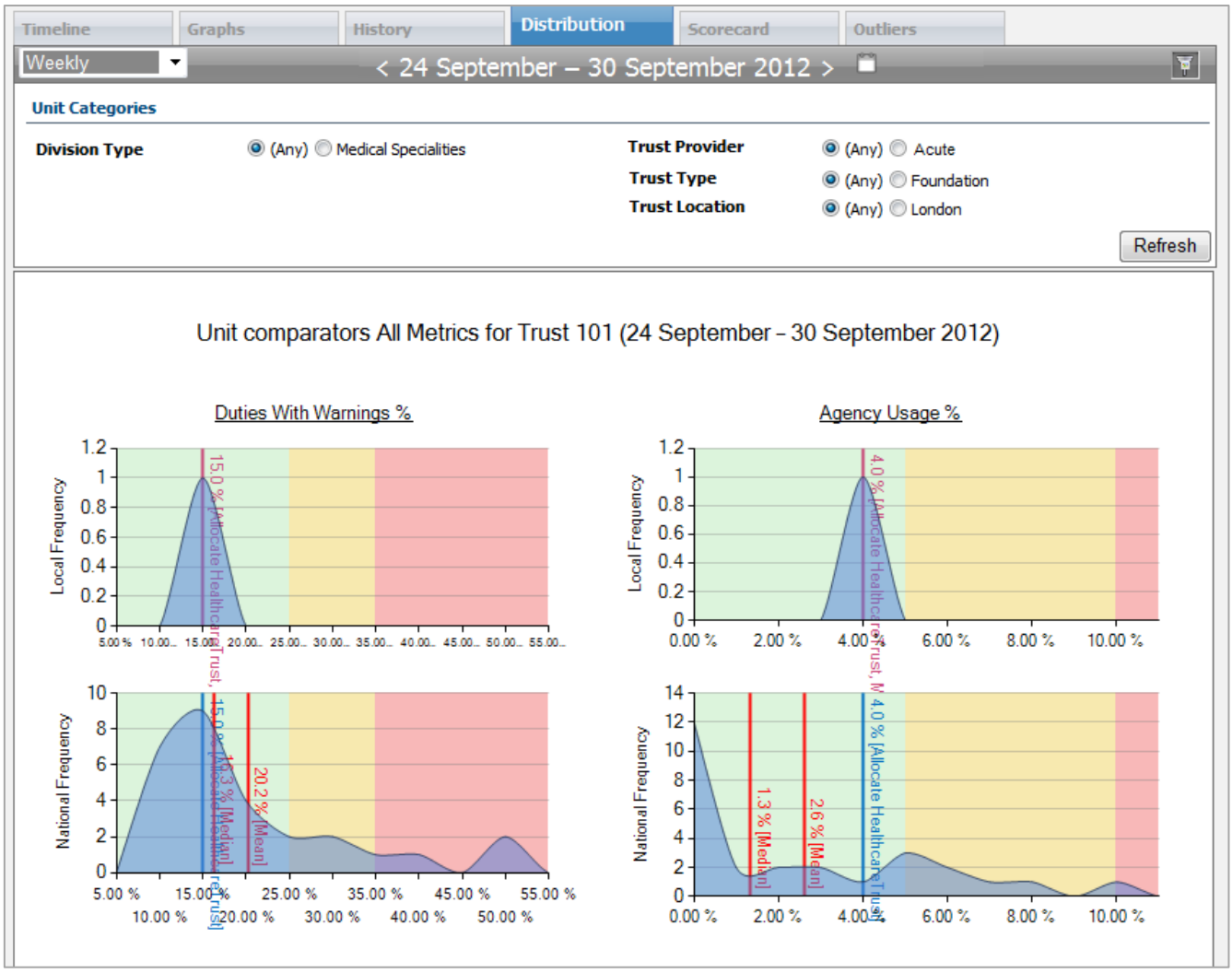
Dropdown allows you to look at 1 week or 4 week metrics; navigation arrows change the period viewed. The Excel button allows this data to be exported to Microsoft Excel.

Changing the unit category options at the top of the section from any to a specific category will allow you to make like for like comparisons locally and with other Trusts.

For more information about the unit categories, see section 7.10 Filtering the History, Distribution, Scorecard & Outliers Views by Unit Category Information.

7.9 Analysis Area – Distribution View

The Distribution view in the analysis area shows similar information to the Scorecard – i.e. the unit's value compared to the median and mean – but shows this graphically to display more information in terms of comparison to other units locally or nationally.



The national graph is placed directly beneath the local graph for easy comparison between local and national data.

On the graphs:

- A blue line shows the unit's value
- Red lines shows the median and mean values
- The backgrounds are shaded green/amber/red based on the thresholds set
- The blue background shape shows the distribution of the other units. The Y axis is frequency – i.e. how many units have this value. Peaks therefore mean many units are at this value, whilst troughs mean few units are at the value.

Clicking on the metric names shows a larger version of the graphs.

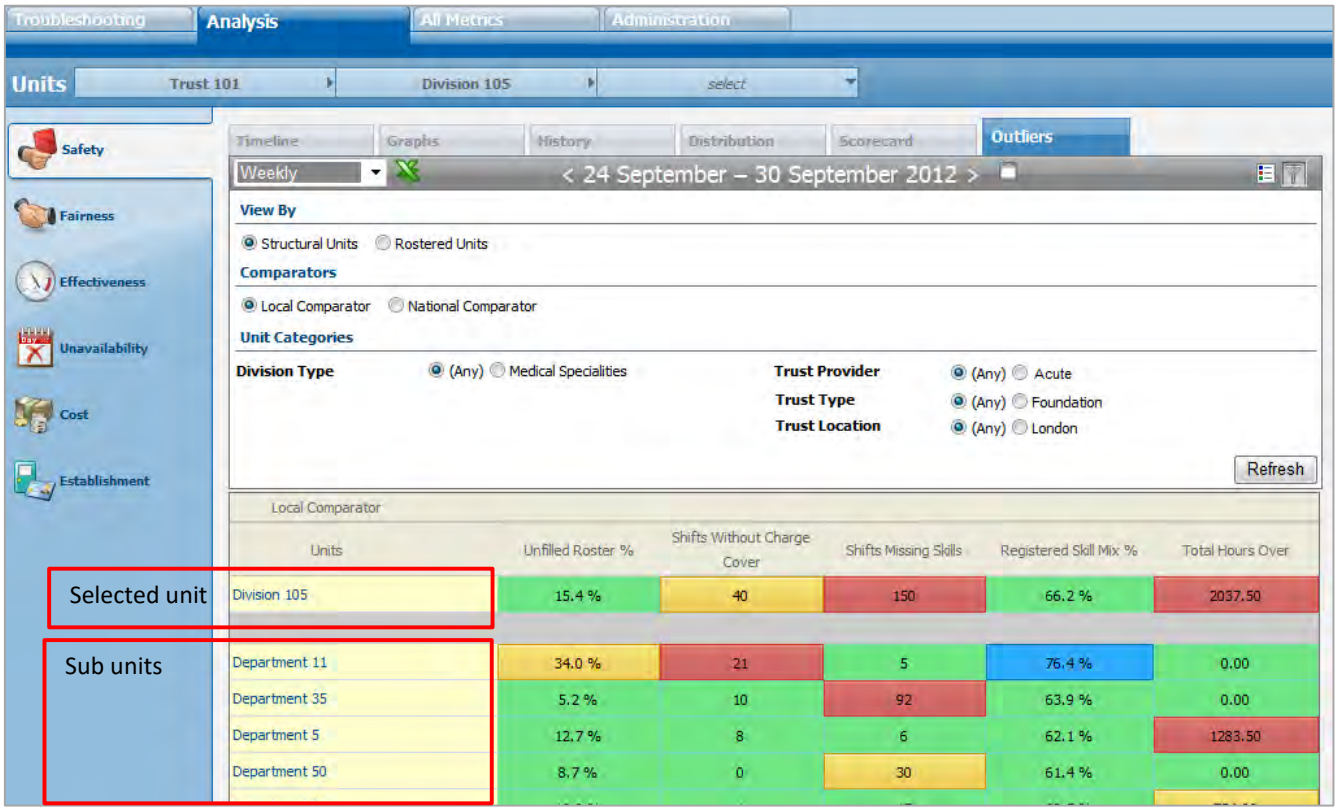
Dropdown allows you to look at 1 week or 4 week metrics; navigation arrows change the period viewed. The Excel button allows this data to be exported to Microsoft Excel.

Changing the unit category options at the top of the section from any to a specific category will allow you to make like for like comparisons locally and with other Trusts.

For more information about the unit categories, see section 7.10 Filtering the History, Distribution, Scorecard & Outliers Views by Unit Category Information.

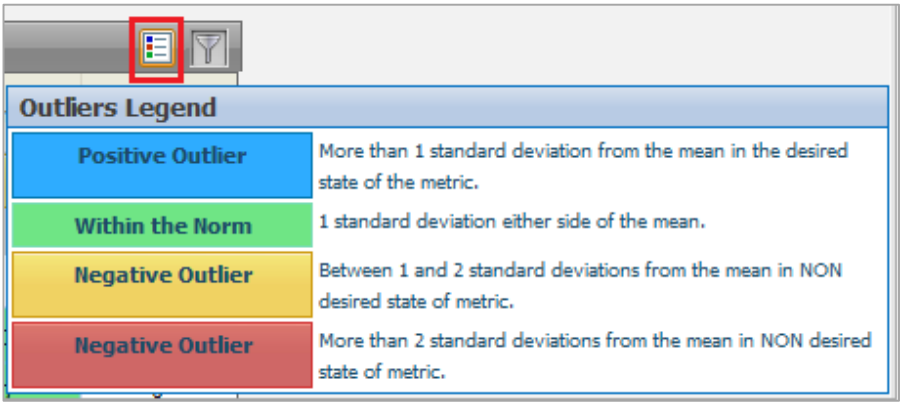
7.10 Analysis Area – Outliers View

The 'Outliers' view in the analysis area provides visual information about how you are performing when comparing yourself locally or nationally with other units. The view is based on standard deviations and shows if you are within the norm, a positive outlier (performing better than the rest) or a negative outlier (not performing so well compared to the rest). I.e. unlike other views in RosterPerform, the colouring is not based on the metric thresholds, but instead whether the unit is a positive or negative outlier compared to its peers. This view can therefore simply highlight the units that need more help, as well as those that are performing well (and may have best practise that could be shared with the negative outliers).



- Green indicates that you're within the norm (within 1 standard deviation from the mean).
- Yellow indicates that you're a negative outlier (between 1 and 2 standard deviations from the mean in the undesired direction of the metric state).
- Red indicated that you're a negative outlier (2 or more standard deviations from the mean in the undesired direction of the metric state).
- Blue indicates that you are a positive outlier (more than 1 standard deviation from the mean in the desired direction of the metric state).

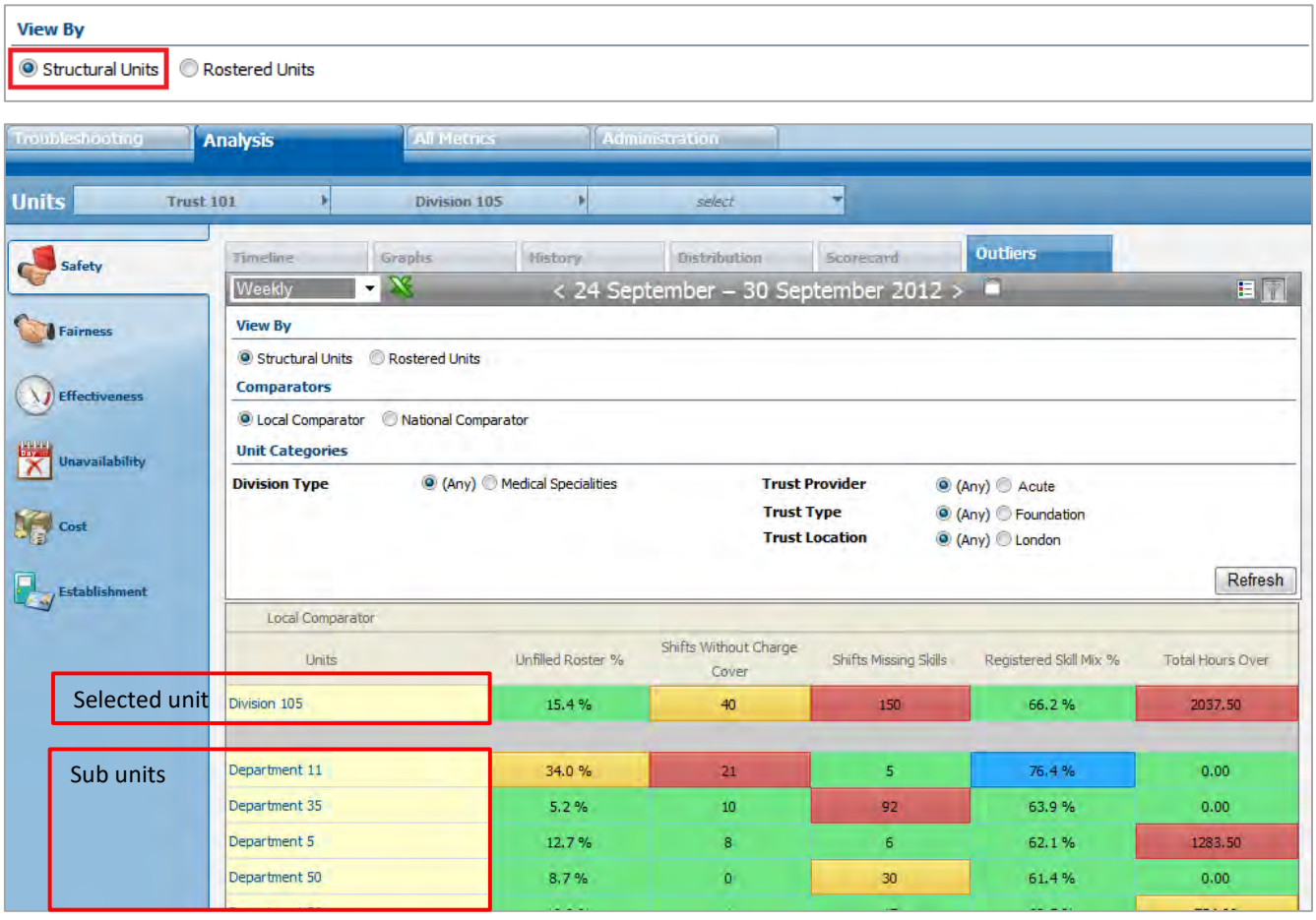
This information is also available by clicking on the legend icon in the top right hand corner of the view.



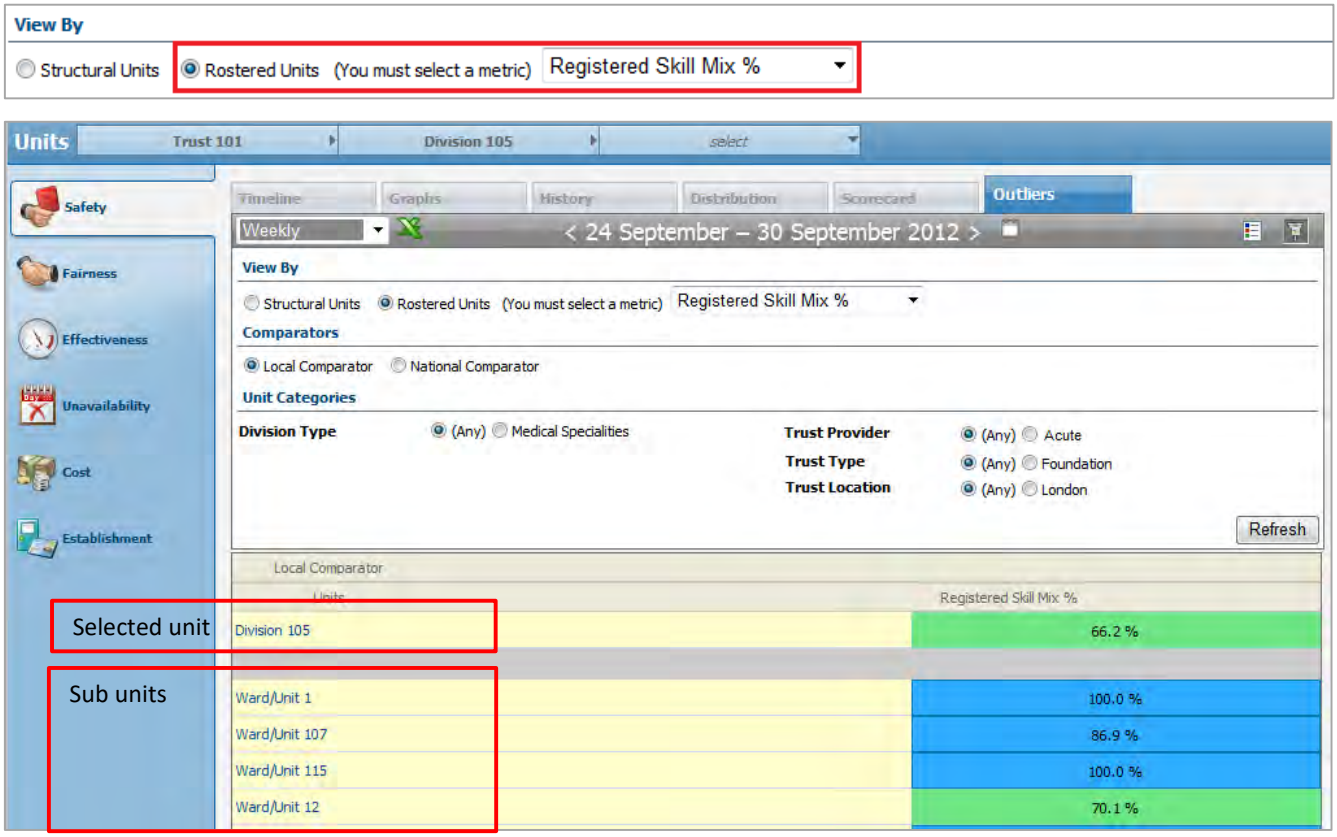
7.10.1 Filtering the Outliers view

The Outliers view can be viewed by Structural units or Rostered units and is driven by the unit bread crumb at the top of the page.

When the Structural units option is selected, the view shows information for the selected unit in the breadcrumb and one level below.



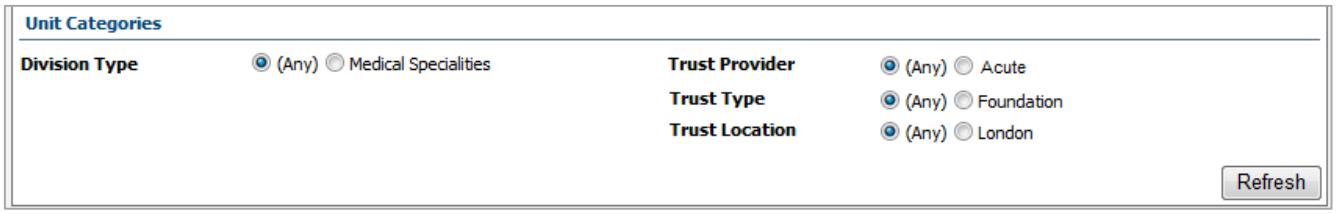
When the Rostered units option is selected, you will be prompted to select a metric. The view will show information for the selected org unit in the breadcrumb and all rostered units below the selected unit.



The Outliers view can be filtered by local or national comparators so that you can compare units within the Trust locally or with other Trusts. (Note: this option is only available if national comparators are enabled. Otherwise the outliers view shows local information.)

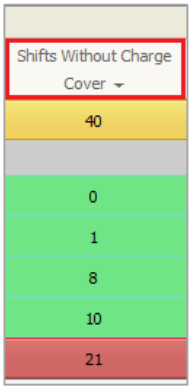
The Outliers view can be filtered by units categories for like for like comparisons. If filtered then unit colours is just based on the comparison against the filtered units, rather than against all units.

For more information about the unit categories, see section 7.10 Filtering the History, Distribution, Scorecard & Outliers Views by Unit Category Information.

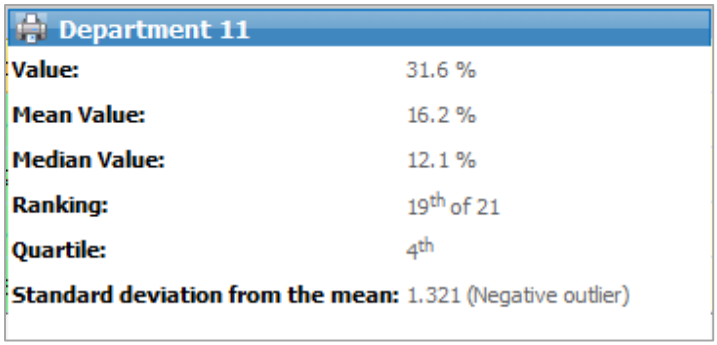


7.10.2 Additional Outliers view features

By clicking on the metric name, all units below the selected unit can be sorted when viewing by either the Structural Units or Rostered Units options.



By clicking on a metric value in the outliers view, addition information is displayed:



To export the outliers view click on the  icon.

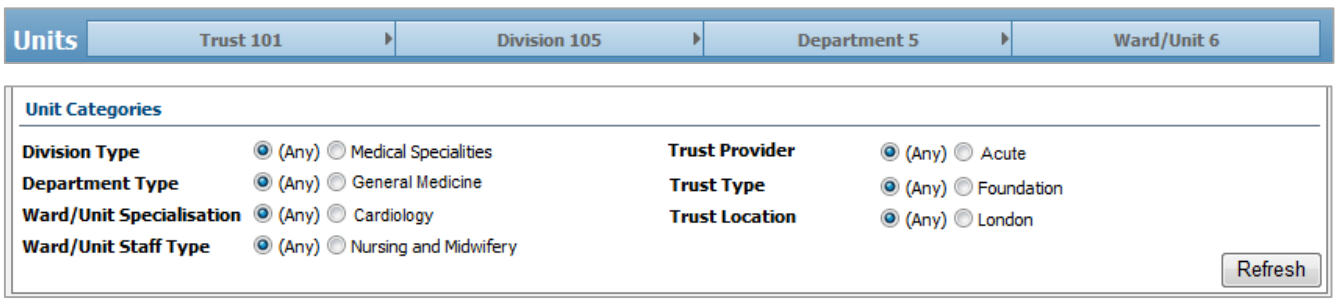
The Outliers view can be viewed for weekly or 4 weekly metric information.

7.11 Filtering the History, Distribution, Scorecard & Outliers Views By Unit Category Information

One of the key features of local and national benchmarking is the ability to filter the information by unit categories, so you can compare similar units for like for like comparison. This is important for certain metrics such as NHPPD or Skill Mix that will vary based on the type of unit.

The unit category options within the Outliers, Scorecard, Distribution and History views allow you to do just that. The unit categories are linked to the org unit and depending on the unit selected the relevant unit level option will be displayed.

In the following example a Trust, Division, Department and Ward/Unit is selected in the breadcrumb and therefore the associated unit categories as set up in HealthRoster is displayed in the filter panel.

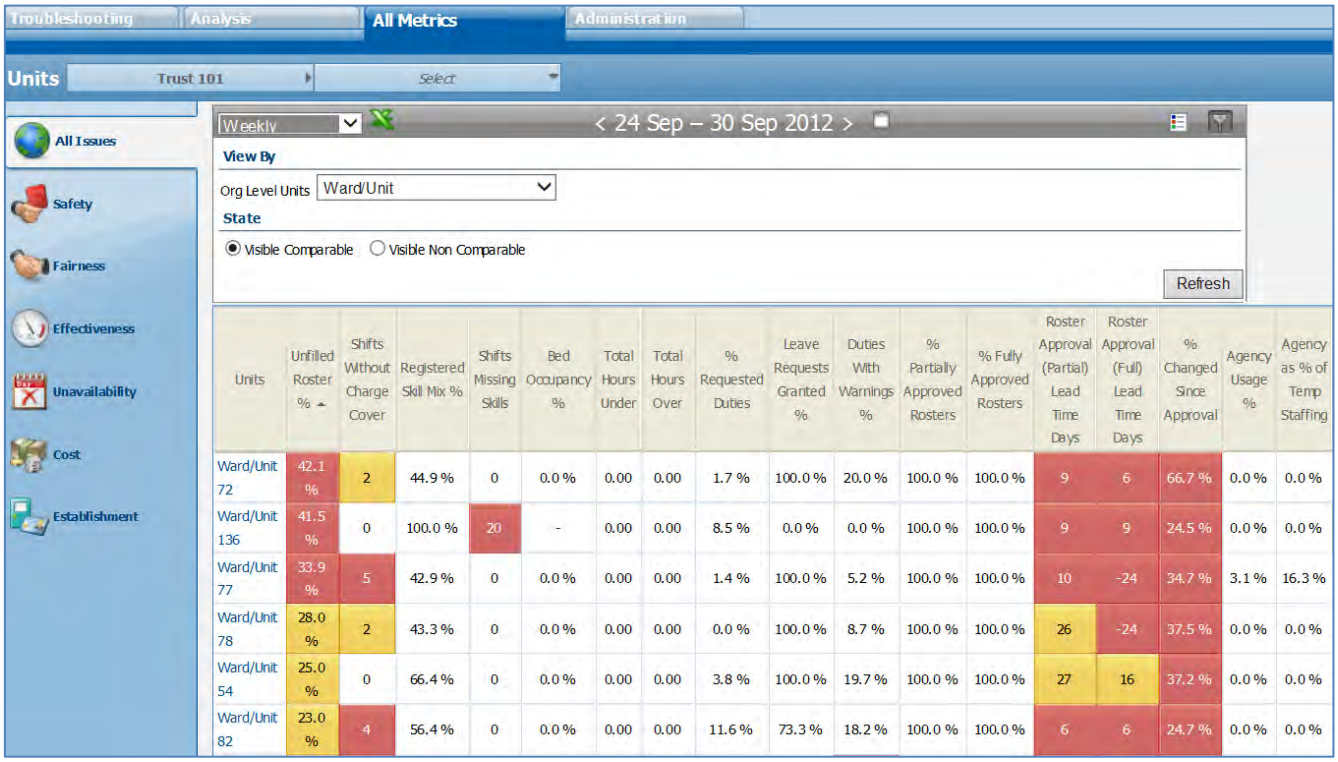


By changing the option from 'Any' to the specific unit category option, the information for both local and national comparators will be filtered.

For information on setting up unit categories in HealthRoster, see the document **HealthRoster - Setting org level types and unit categories**

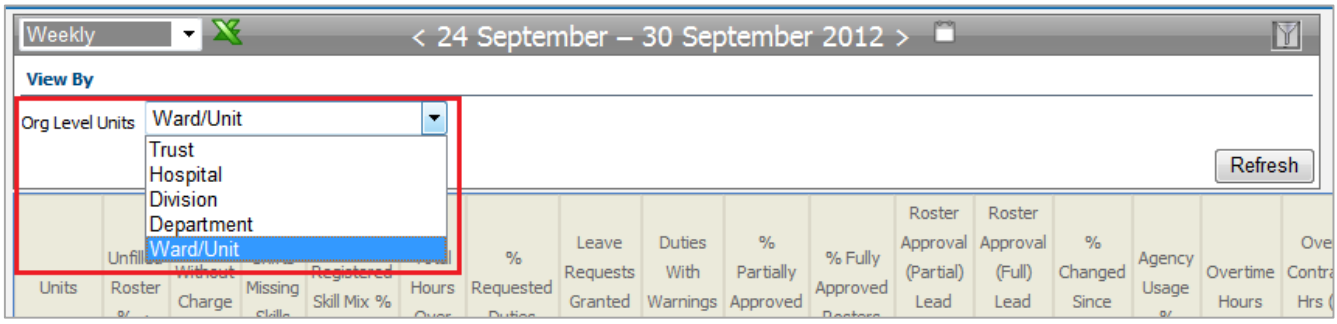
7.12 All Metrics View

The All Metrics view provides you with information for all the visible metrics. For each unit shown in the view, if the metric threshold is breached the background of the cell is shaded accordingly.



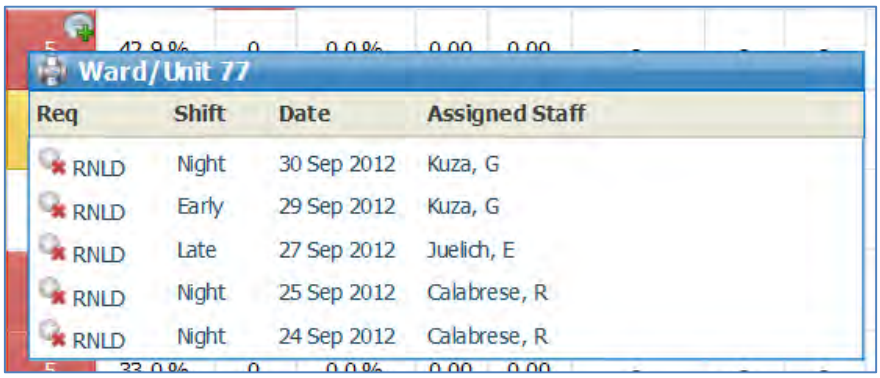
Units	Unfilled Roster %	Shifts Without Charge Cover	Registered Skill Mix %	Shifts Missing Skills	Bed Occupancy %	Total Hours Under	Total Hours Over	% Requested Duties	Leave Requests Granted %	Duties With Warnings %	% Partially Approved Rosters	% Fully Approved Rosters	Roster Approval (Partial) Lead Time Days	Roster Approval (Full) Lead Time Days	% Changed Since Approval	Agency Usage %	Agency as % of Temp Staffing
Ward/Unit 72	42.1 %	2	44.9 %	0	0.0 %	0.00	0.00	1.7 %	100.0 %	20.0 %	100.0 %	100.0 %	9	6	66.7 %	0.0 %	0.0 %
Ward/Unit 136	41.5 %	0	100.0 %	20	-	0.00	0.00	8.5 %	0.0 %	0.0 %	100.0 %	100.0 %	9	9	24.5 %	0.0 %	0.0 %
Ward/Unit 77	33.9 %	5	42.9 %	0	0.0 %	0.00	0.00	1.4 %	100.0 %	5.2 %	100.0 %	100.0 %	10	-24	34.7 %	3.1 %	16.3 %
Ward/Unit 78	28.0 %	2	43.3 %	0	0.0 %	0.00	0.00	0.0 %	100.0 %	8.7 %	100.0 %	100.0 %	26	-24	37.5 %	0.0 %	0.0 %
Ward/Unit 54	25.0 %	0	66.4 %	0	0.0 %	0.00	0.00	3.8 %	100.0 %	19.7 %	100.0 %	100.0 %	27	16	37.2 %	0.0 %	0.0 %
Ward/Unit 82	23.0 %	4	56.4 %	0	0.0 %	0.00	0.00	11.6 %	73.3 %	18.2 %	100.0 %	100.0 %	6	6	24.7 %	0.0 %	0.0 %

Within this view you can look at information for rostered units or aggregated data for Trust, Division or Department levels.



Please note that the correct org unit level needs to be set in HealthRoster for viewing the units at that level and drilldown information for a metric is only available for the ward/unit level.

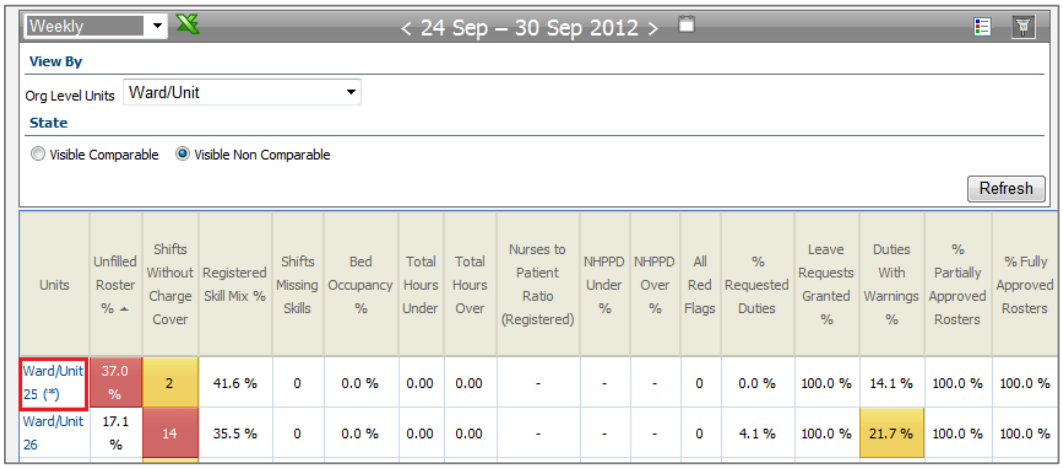
For Ward/Units, some metrics have drilldown information which provides you with the details:



For any changes to take affect the refresh button in the filter panel needs to be clicked. 

To export the All Metrics view click on the  icon.

The All Metrics view is the only place where you can see information for the Visible Non Comparable units. **(Visible Non Comparable feature available from 10.5.2)**

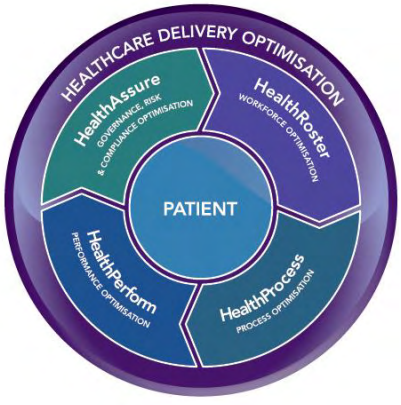


Safe Staffing Project

Project Initiation Document

Belfast Health and Social Care Trust

Version: 1.0
Status: In Progress
Issue Date: 13/4/16



Allocate Software

Contents

1 Introduction

1.1 Document Purpose

The purpose of this **Project Initiation Document** (PID) is to define the scope, methodology, approach, project procedures and controls, deliverables and responsibilities for the Safe Staffing Project Implementation Project at Belfast Health and Social Care Trust.

This PID, together with the contract, defines the baseline against which Allocate Software and Belfast Health and Social Care Trust will operate for the duration of the project.

The approval of this document is a prerequisite to the commencement of the implementation and must be approved by both parties. Until approval is received, resources will not be further allocated to the project.

Once the PID has been approved by signature of the representatives of the two organisations, any deviations from it and the Project Plan will be managed under Change Control, to be agreed by the Allocate Executive Sponsor and the Belfast Health and Social Care Trust Executive Sponsor.

1.2 Background

NHS England recently released a paper setting out 10 expectations for NHS Trusts in relation to operational procedures and standards of care. This project has been commissioned in response, to allow Belfast Health and Social Care Trust to provide assurance that they fully meet these new expectations.

Belfast Health and Social Care Trust has already implemented Allocate's HealthRoster product to all inpatient units. HealthRoster is a demand driven application that allows staffing levels to be set and monitored against fixed baseline-driven levels of demand.

The Trust is now preparing to implement SafeCare into all inpatient units. SafeCare takes into account patient numbers, and their acuity and or dependency to provide a dynamic demand, allowing Nurse Managers and Senior Managers to make evidence based decisions on staffing using real time information.

This is a major step forward and allows Belfast Health and Social Care Trust not only to fully ensure that it has the right staff with the right skills in the right place at the right time, but to clearly demonstrate that it is meeting one the key criteria set out in the NQB expectations; using evidence based tools to inform decisions on setting appropriate establishments as well as daily staffing levels on a shift by shift basis.

It will be possible using information from SafeCare, HealthRoster and RosterPerform to provide monthly reports to the Trust Board as to whether actual staffing levels were in line with planned, highlighting exceptions where level of care frequently falls below that required. This fulfils another key requirement.

Wards, Units and Teams will be able to display daily staffing information about numbers of staff Vs required staff, types of staff and who is in charge.

Daily staffing issues can be identified quickly, and the system used to identify other areas from where it may be possible to move staff. Senior management can quickly identify whether wards, units and teams are staffed safely, and intervene where necessary.

2 Project Definition

2.1 Objectives

The objectives of the Safe Staffing project at Belfast Health and Social Care Trust are as follows:

- To implement Allocate's SafeCare product across Allocate units defined within the Project Scope at Belfast.
- To implement SafeCare Live (Mobile and WardBoard) within Allocate inpatient units where the necessary hardware has been made available.
- To assist the organisation in developing and/or augment the following reports using evidence based data on required levels of staffing using data derived from SafeCare
    - Six monthly establishment report both for the Trust Board and General public
    - Reporting on Allocate units' planned Vs actual staffing levels
    - An exception report of units frequently falling below required levels of staff
- To review and modify if necessary procedures for creating, updating and maintaining rosters so that up to date information on staffing is available in as close to real time as practically possible
- To integrate the use of SafeCare into daily staffing reviews and escalation procedures with respect to staffing levels and skill mix on units

2.2 Required Outcomes - Critical Success Factors

- SafeCare is implemented within Allocate units defined within the Project Scope at Belfast
- SafeCare Live (Mobile and WardBoard) is implemented within units where the necessary hardware is made available and it is selected by Trust to be deployed.
- Rosters are created, approved and 2nd level approved by Site Lead (or DN/General Manager in their absence) no less than 4 weeks in advance of their start date
- Rosters created and approved are consistently in line with the Rostering Policy/Standard Operating Procedures
- Rosters are kept accurate and up to date, with changes being made retrospectively only by exception
- Staff to enter patient numbers and acuity levels consistently for Allocate for census periods on a shift by shift basis.
- Ward/Unit Senior Nurses use SafeCare to identify shortfalls both on the day and proactively, escalating shortfalls in numbers and skills to line managers where they are unable to resolve them
- Matrons/Site Leads, DNs and General Managers use SafeCare to monitor staffing levels at Department/Divisional level and identify shortfalls, and make use of HealthRoster and SafeCare to identify opportunities to redeploy staff
- The escalation procedure and contingency plan is fully understood by all management staff and routinely followed
- All wards display patient numbers in relation to planned levels either using SafeCare Live functionality, or via another reliable means where hardware has not been made available

- SafeCare, HealthRoster and RosterPerform are used to produce a monthly report for the Trust Board on planned Vs Actual staffing levels, and an exception report of units that frequently fall below the required levels of care, that is signed off by them to be considered accurate and meeting their needs
- Information on required staffing levels from SafeCare, and uplift requirements from RosterPerform is used as part of an evidence based toolkit to inform establishment and budget setting on a 6 monthly basis
- Information on establishment planning and planned versus actual staffing levels is made available to the general public

NOTE: For the points relating to six monthly establishment setting, it is possible that the next opportunity to demonstrate this may be August 2016, by which time the project will likely be expected to have completed. In this event, provided that the Trust Board are satisfied that they have the full capability to be able to do this, the success factors will be deemed to have been met.

2.3 PROJECT SCOPE

In Scope

- Implementation of SafeCare to Allocate inpatient units defined in the table below.
- Implementation of SafeCare Live to Allocate inpatient units where the necessary hardware has been made available
- Process mapping with respect to use of SafeCare for
    - Roster creation and approval
    - Roster updates and issue escalation – within hrs
    - Roster updates and issue escalation – out of hrs
    - Department handover – end of day shift
    - Department handover – end of night shift
- Assist the design and implementation of the following reports, using SafeCare data as part of evidence based tool kit
    - Planned Vs actual staffing levels
    - Exceptions where wards/units frequently fall below required staffing levels
    - 6 monthly establishment review
- Training for Senior Nurses, Matrons/Site Leads, DNs, General Managers, Site Nurse Practitioners, Director of Nursing and other key Board members
- Upgrade of Generic's live database to version 10.5.2 – if required.

Out of Scope

- Interfacing to any other non-Allocate products
- Implementation of HealthRoster itself to any further units not yet rolled out (due to the effect on the scope of work within the project)

2.4 ASSUMPTIONS

No.	Assumption
1. .	The Project Methodology is based on a 0.5 WTE Project Manager being committed to the project for the duration of the project.
2.	The project methodology is based on at least 1.0 WTE HealthRoster Administrator being committed to the project from the outset (this is in addition to the Project Manager's role). The consequence of having only one Administrator will extend the implementation and may not provide sufficient support during live implementation.
3.	The Client's IT Department will provide technical assistance as and when required during the project and will ensure that hardware (servers, PCs and peripherals such as printers and keyboards) is available and fit for purpose.
4.	Belfast Health and Social Care Trust will provide appropriate training facilities When necessary.
5.	Representatives from Finance, Payroll, Human Resources and StaffSide will be made available to provide support in the definition of a strategy to track the required outcomes of the project, as the rollout progresses across the Organisation and on-going.
6.	The latest release (at the time of installation) of the HealthRoster Product will be provided.
7.	There will be no bespoke System Configurations against the HealthRoster Product.
8.	All data cleansing will be the responsibility of Belfast Health and Social Care Trust Project Team members.

2.5 PRE-REQUISITES

- Allocate units included within the implementation must already have implemented HealthRoster to create and manage their rosters
- Allocate units included within the implementation must have all Float, Bank and Agency staff represented on the rosters

2.6 TOLERANCES

- The tolerance for any given task is one week against the baselined plan
- The tolerance for Stage 1 is set at 1 week in total
- The tolerance for Stage 2 is set at 4 weeks in total

3 Project Organisation and Approach

3.1 PROJECT ORGANISATION

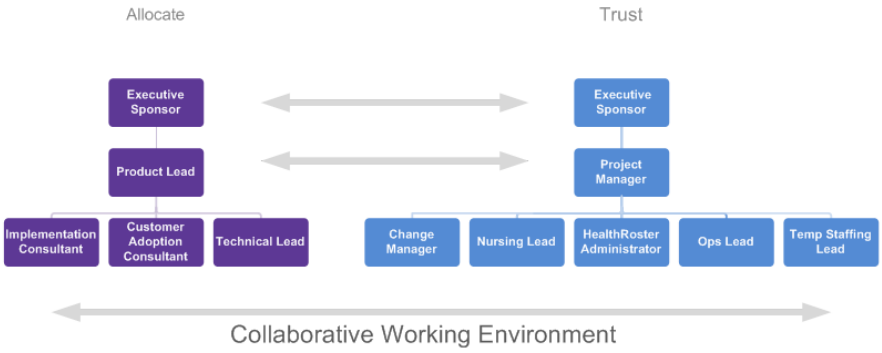
The project is divided into 3 management stages. Below is a brief overview. A description of each stage is contained in the Project Plan (see later):

Stage 0	Project Mobilisation
Stage 1:	Pre-Implementation – Understand how SafeCare will be used (Allocate) Definition of policies, processes and procedures, and reporting requirements
Stage 2:	Implementation of 4x early adopter unit as follows: Royal Victoria Hospital - 6B – Emergency Surgical - 6C – Emergency Surgical - 4E - Neurology - 4F – Neurosurgery.1

- The initial 1st Stage Plan will be produced by Allocate Project Lead, reviewed and then subsequently owned by the Belfast Health and Social Care Trust Project Manager going forward
- The Belfast Health and Social Care Trust Project Manager will be responsible for the production of the subsequent Stage Plans.
- Allocate will be responsible for facilitating the process mapping (Workshop – Understand how SafeCare will be used) and reviewing policies, processes and procedures and reporting requirements. Belfast Health and Social Care Trust will be responsible for facilitating Allocate access to all the necessary policies and procedures.
- Allocate will summarize the findings in a report and Belfast Health and Social Care Trust will be responsible for approving the changes and ensure that the approved changes are made to processes and policies.
- The four units in Stage 2 will be configured by Allocate, shadowed by Belfast Health and Social Care Trust staff.

3.2 PROJECT MANAGEMENT STRUCTURE

The key project roles are shown below:



Individual roles and responsibilities are included below. It is quite possible that within the Trust organisation, one person may fulfil more than one role.

3.3 KEY STAKEHOLDERS AND HOW ARE THEY ARE AFFECTED

Nursing Director	Changes to policies, processes and procedures. Changes to media and type of information that is reported. How decisions are made with respect to workforce delivery and dealing with issues.
Ops Director	Changes to policies, processes and procedures. Changes to media and type of information that is reported. How decisions are made with respect to workforce delivery and dealing with issues.
Finance Director	Implications for project on workforce planning and budgeted establishments.
Senior Nurses, DNs, GMs, HON/Ms	Processes and procedures for management of staff and dealing with escalations (within hours).
Senior Nurse Practitioners	Processes and procedures for management of staff and dealing with escalations (out of hours).
Temporary Staffing Office Manager	Processes and procedures for management of staff and dealing with escalations (out of hours).

3.4 INDIVIDUAL ROLES AND RESPONSIBILITIES

The following Belfast Health and Social Care Trust and Allocate resources are required for the delivery of the SafeCare Project.

3.4.1 Project Sponsor Belfast Health and Social Care Trust/ Allocate

Belfast Health and Social Care Trust Responsibilities	Allocate Responsibilities
• Defines/agrees project success factors • Supports roll-out across the organisation • Provides resources for the project • Attends Project Board Meetings • Reviews and approves key policies • Communicates with Executive Management Group • Final point of escalation within the organisation • Leads the performance management of rostering, against the agreed KPIs, to improve staff utilisation, reporting through Trust/Organisation performance mechanisms to the Board • Chairs Performance Management Meetings (recommend held monthly) • Delivers the agreed Benefits Realisation Plan • Ensures the implementation of intervention and recovery plans for wards / departments failing to meet KPIs, escalating to the wider Executive Team if required • Provides assurance to the Board that benefits are being realised from the use of SafeCare • Producing, agreeing and communicating Roster Policy	• Overall responsibility within Allocate for ensuring customer objectives are met satisfactorily • Defines/agrees project success factors • Available to attend Project Board meetings • Final point of escalation
Fulfilled By: Margaret Devlin	**Fulfilled By**: Nigel Robinson

3.4.2 Client Project Manager / Allocate Project Lead

Belfast Health and Social Care Trust Responsibilities	Allocate Responsibilities
• Management of project resources • Development and management of All work stream plans • Production of regular project status reports • Identification, escalation and resolution of risks • Ensure project remains on-time and on-budget • Communication of project progress to Executive Sponsor • Manage/co-ordinate Project Board Meetings • Attends weekly Project Team Meetings	• Overall responsibility within Allocate for coordinating the project activities and resources • Development of work stream plans • Attend Project Board meetings (during Phases 1 and 2) • Identification, escalation and resolution of risk • Communication of project progress to the Allocate Executive Sponsor

• Manage effective change and communication of project throughout the organisation • Actively manage detailed tasks as identified in the Project Initiation Document (PID) • Actively support the Users and Key Stakeholders • Communication plan development and implementation • Stake holder management • Identification of internal processes requiring change and action as appropriate.	
Fulfilled By: Roisin McMahon	**Fulfilled By**: Suzanne Rawlings
Reporting To: Margaret Devlin	**Reporting To**: Nigel Robinson

3.4.3 SafeCare Administrator(s) / Allocate Implementation Consultant

Belfast Health and Social Care TrustResponsibilities	Allocate Responsibilities
• Shadow the Allocate Implementation Consultant during Allocate Phases of the implementation • Act as a functional HealthRoster/SafeCare consultant and product subject matter expert internally for the organisation • Coordinate and deliver SafeCare training internally for the organisation • Provide advice and guidance to Key Users during data gathering exercises • First level of support for user queries • Attend Project Board Meetings if required • Attend weekly Project Team Meetings • Attend User Group Meetings • Administer and maintain the HealthRoster product suite data on-going • Organise and coordinate project activities with key users • Support the implementation and enforcement of new and existing policies and procedures • Monitor the approval of rosters feeding back to the appropriate managers where rosters have not been approved on time • Ensure the health roster system is configured in accordance with the Roster Policy • Ensure the HealthRoster system remains appropriately configured • Provide support and on-going training to the users of SafeCare • Liaise with the HealthRoster Support Team to resolve system issues as required	• Organise and coordinate project activities with key users • Provide advice and guidance to users during data gathering exercise. • Provide advice and guidance during transition and initial phase of the project • Conduct SafeCare Training for users • Conduct additional training where appropriate and agreed by the organisation (subject to approval via the change control process) • Provide expert knowledge in key HealthRoster/SafeCare functional areas • Conduct Business process analysis where required and feed back to Trust on issues/areas requiring change

• Pass on any recommendations/feature requests from implemented units.	
Fulfilled By: Roisin McMahon and Roster Admin Team	**Fulfilled By**: Lucy Savage
Reporting To: Margaret Devlin	**Reporting To**: Suzanne Rawlings

3.4.4 Change Manager

Belfast Health and Social Care Trust Responsibilities
• Identify where change is required within the organisation and lead the implementation of plans to bring about change • Participate in reviews of policies, processes and procedures • Assist with communication of change to stakeholders • Intervene where change is met with resistance and take steps to resolve issues and change hurdles • Monitor and report against KPIs, in conjunction with the Finance and Human Resources Teams and reporting through the Trust Rostering Performance Management Framework • Develop intervention and recovery plan for wards / departments failing to meet KPIs
Fulfilled By: Roisin McMahon and Margaret Devlin
Reporting To: Steering Group

3.4.5 Belfast Health and Social Care Trust IT Lead & Allocate Technical Consultant

Belfast Health and Social Care TrustResponsibilities	Allocate Responsibilities
• Provision of hardware and communications in accordance with the defined HealthRoster requirements • Creation and provision of required environments • Provision of technical equipment and support to the project team • Identification and resolution of technical issues in conjunction with Allocate counterpart • Plans and facilitate software upgrades (including operating system/network upgrades) • Provide copies of live database as required • Co-ordination of the remote access link.	• Provision of technical support and advice in the setup of the required environments • Load the HealthRoster software and pre-configured database • Train Belfast Health and Social Care Trust technical resources in Systems Administration and User Set-up functions • Provide advice and guidance Belfast Health and Social Care Trust to counterpart on resolution of technical issues • Plan and facilitate software upgrades.
Fulfilled By: John Clarke/Michael Kane	**Fulfilled By**: Allocate Software Support
Reporting To: TBC	**Reporting To**: Chris Colebrook

3.4.6 Human Resources Lead

Belfast Health and Social Care Trust Responsibilities

• Provide HR advice and intervention to improve staff utilisation, which could include:-
• Ensure HealthRoster and HR policies are working in parallel
  • Absence management programmes
  • Establishment reviews
  • Harmonising shift start, finish and break times
  • Increasing staff flexibility and availability
  • Contract/working patterns review.

Fulfilled By: Roisin McMahon
Reporting To: Margaret Devlin

3.4.7 Finance Lead

Belfast Health and Social Care Trust Responsibilities
• Assume a lead role in the establishment review process • Attend Project Board Meetings to communicate financial implications of the Project as the rollout progresses • Monitor compliance with the Trust's Uplift allowance • Monitor the Uplift allowance in light of findings throughout the project with other senior Board members to ensure that it is adequate and accurate • Work with information from the Project team, monitor and report on KPIs through the Trust's Rostering Performance Management Framework • Agree and sign off the staffing requirement for each ward/department with the Division / Directorate Manager / Modern Matron / Senior Nurse • Review the KPIs that affect the use of resources with the Division / Directorate Manager / Modern Matron / Senior Nurse to ensure that the staffing resource is managed efficiently • Provide up to date budget information.
Fulfilled By: Margaret Devlin
Reporting To: Steering Group

3.4.8 Belfast Health and Social Care Trust Administration Support

Belfast Health and Social Care Trust Responsibilities
Suggested activities could include: • Booking of rooms and equipment for training courses, workshops, meetings etc. • Scheduling of board meetings • Minutes of meetings • Printing and photocopying of documentation • Monitoring of support calls
Fulfilled By: Roisin McMahon
Reporting To: Margaret Devlin

3.4.9 HealthRoster Product Support

Belfast Health and Social Care Trust Responsibilities	Allocate Responsibilities
• First level support for Allocate user and technical queries • Liaise with appropriate Belfast Health and Social Care Trust/ Allocate staff to resolve issues • Log recurring issues and report to Allocate Customer Support	• Second and third level support as per the support and maintenance agreement between Belfast Health and Social Care Trust and Allocate
Fulfilled By: Roisin McMahon and Roster Team	**Fulfilled by**: Allocate Software Support
Reporting To: Margaret Devlin and Allocate Support Desk	**Reporting To**: Chris Colebrook

3.4.10 Matrons/Senior Nurses/DNs/SNPs

Belfast Health and Social Care Trust Responsibilities
• Monitor and approve the ward / department duty roster on completion (level 2 approval), using Roster Analyser and in line with the Key Performance Indicators, rejecting rosters that do not comply • Produce analysis reports on staffing, safety and quality in their area of responsibility using Roster Perform and other evidence based tools • Approve the use of temporary staff and additional duties, escalating where necessary in line with the Trust Escalation Policy and Contingency Plans • Provide guidance and support to the Ward / Department Manager or designated other in the creation of duty rosters, using the Key Performance Indicators as a reference • Notify the Division / Directorate Management Accountant of any additional hours agreed above the required staffing resource • Enforce the requirement with Senior Nurses of Units to display staff numbers, skill mix and person in charge so as to be visible by the public
Fulfilled By: Ward Managers and Assistant Servicer Managers
Reporting To: Service Managers

3.4.11 Ward / Unit / Senior Nurses

Belfast Health and Social Care Trust Responsibilities
• Ensure that a quality roster is produced, maintained and finalised in line with the Key Performance Indicators rejecting rosters that do not comply • Ensure that there are enough nurses in the right place at the right time, based on the agreed and funded skill mix, with the required competencies, to meet the needs of the service • Ensure the ongoing safe staffing of the ward, escalating concerns using SafeCare as an integral tool to notify them of issues • First level approve rosters • Nominate a Roster Creator and deputy and ensure that these staff are appropriately trained • Ensure a fair and equitable allocation of annual leave and study leave • Ensure that Allocate staff are aware of the local and Trust wide policies for rostering
Fulfilled By: Ward Managers
Reporting To: Assistant Service Managers

3.4.12 Roster Creators

Belfast Health and Social Care Trust Responsibilities

• Create rosters, ensuring compliance with:
  • Unit staffing requirements
  • Roster Policy requirements
  • KPIs
  • Associated HR policies
• Maintain rosters on a **daily** basis, ensuring the maintenance of an accurate governance record

Fulfilled By: Ward Managers
Reporting To: Assistant Service Managers

3.4.13 StaffSide Representatives

Belfast Health and Social Care Trust Responsibilities
• Work in partnership with the Project and Operational Management team through the implementation of HealthRoster • Contribute the development and implementation of the Roster Policy and the associated HR policies • Support staff through the implementation of HealthRoster and any associated management of change processes • Contribute to the project communication strategy.
Fulfilled By: Catherine Harte
Reporting To: Roisin McMahon & Margaret Devlin

4 Project Control

The project will be monitored and controlled in the following ways:

4.1 Project Steering Group

A project Steering Group will be formed during Mobilisation. Steering Group meetings will be held monthly. Representatives from all Key Stakeholder groups will be represented.

Terms of reference for the Steering Group will be produced by the Trust Project Manager, and reviewed and agreed at the first Steering Group.

The purpose of the Steering Group is to maintain general visibility of project progress, manage escalated risks and issues, and intervene by exception where necessary. The following items will normally be submitted by the Trust Project Manager and reviewed by the Steering Group.

- Latest Project Highlight Report
- Project Risk and Issues Log, clearly showing top risks and issues
- Project Plan
- Project Action Items
- Project Financials – Expenditure against Budget
- System Key Performance Indicators (KPI's) via Roster Perform.

Meetings will be minuted. The Project Manager is responsible for organising for minutes to be taken and distributed

The Project Steering Group Meeting will be held with the following people in attendance:

- Belfast Health and Social Care Trust Project Sponsor (Chair)
- Representatives from the Nursing Profession – Clinical Nurse Leads / Representatives from the Directorates
- Director or Assistant Director of Nursing (if not Project Chair)
- Representative from Finance
- Representative from IT as required
- Representative from HR
- Representative from Payroll / ESR
- Representative from Staff Side as required
- Belfast Health and Social Care Trust Project Manager and HealthRoster Administrator(s) / e-Rostering Lead
- Allocate Project Lead will attend – as required - for duration of the Implementation cycle and will then handover Belfast Health and Social Care Trust to Allocate Account Manager

- Allocate other representatives as required (optional).

4.2 Weekly Meetings

General project progress will be reported using a Project Highlight Report, produced weekly by the Trust Project Manager. This will contain a general descriptive overview of project progress, show performance against key milestones, and highlight key risks and issues and mitigating action.

Meetings will normally be held weekly during the project on agreed dates.

The purpose of this meeting is to review the highlight report and other progress informally against the plan, as well as risks, issues and actions. Risks will be escalated as necessary.

The Project Team Meeting should have the following people in attendance:

- Belfast Health and Social Care Trust Project Manager (Chair and minutes)
- Belfast Health and Social Care Trust HealthRoster Administrator(s)
- Belfast Health and Social Care Trust IT Representative as and when required
- Belfast Health and Social Care Trust Change Manager
- Allocate Project lead
- Unit Representatives based on current implementation plan

4.3 Weekly Allocate/ Belfast Health and Social Care Trust Update

A call will be held weekly between the Allocate Project Lead and Trust Project Manager for the duration of Stage 1 and 2, or until deemed no longer necessary.

The Allocate IC will also normally join the call. Where necessary, the Allocate/and Belfast Health and Social Care Trust project sponsor may also join the call, for example when there is a risk/issue that requires dealing with, where it is better to intervene early, rather than wait until the next project steering group.

Points of particular significance or consequence will be minuted, either through formal minutes, or by follow up confirmation via email.

4.4 Project Planning

This section describes the project planning controls that will be put in place for the duration of this project.

4.4.1 High Level Project Plan

The High Level Project Plan forms part of the Project Initiation Document (see later in document). Allocate key activities, milestones and deliverables will be outlined in the project plan.

The plan will be produced during the Mobilisation Phase by the Allocate Project Manager in conjunction with the Belfast Health and Social Care Trust Project Manager, and subsequently then be kept up to date by the Belfast Health and Social Care Trust Project Manager. The project plan will be reviewed and discussed regularly with the Allocate Project Manager.

4.4.2 Detail Level Stage Plan

The detail level stage plan for the Mobilisation stage (Stage 0), Stage 1 and Stage 2 will be produced at the outset of the project using MS Project (can be converted to Excel if required). This will be reviewed, agreed and base lined with the Trust Project Manager, and subsequently then be kept up to date by the Belfast Health and Social Care Trust Project Manager. The project plan will also be reviewed and discussed regularly with the Allocate Project Lead.

4.4.3 Continual Plan Review

All plans are subject to change. The project plan must be reviewed and updated continuously by the Belfast Health and Social Care Trust Project Manager and Allocate Project Lead. If changes are within the given tolerances for a task group or Stage, then any decisions for corrective action lie with the Belfast Health and Social Care Trust Project Manager.

If a task group exceeds it given tolerance, the Belfast Health and Social Care Trust Project Manager may make a decision as to whether this is a recoverable delay, and that the Stage tolerance overall will not be exceeded.

4.5 Handling of Exceptions

Once Stage tolerance has been exceeded, then a stage is deemed to be in exception. The Belfast Health and Social Care Trust Project Manager must prepare an Exception report, stating the:

- Nature of the exception and brief description of the cause
- Impact on timelines, resource, expenditure, benefit or quality
- Options available to remedy the issue
- Recommendation to the Board as to the best course of action

4.6 Risk and Issue Management

Risks and their mitigating action in place will be recorded using an Excel based 5/5 risk matrix (1-5 score for probability and 1-5 for impact).

Issues and their mitigating actions will also be recorded using an Excel based risk log, using categories High, Medium and Low to define the impact of each risk.

The risk and issue log will be reviewed and discussed as part of the weekly Allocate/ Belfast Health and Social Care Trust update call.

Key risks and issues that require senior intervention will be escalated to the relevant Project Sponsor(s) within Belfast Health and Social Care Trust and Allocate as and when required, either via the project Steering Group, weekly call, or via an ad hoc meeting if required.

4.7 COMMUNICATIONS

Key Communications throughout the project will be identified, logged and tracked using an MS Excel based Communication Plan. See Appendix C at the rear of this document for a copy of the initial Communications Plan.

The Communications Plan will state for each required communication:

- Owner
- Communication Description
- Media Used
- Delivered By (person/team)
- Intended Audience
- Date (or frequency for repeated communications)
- Any further comments
- Whether the communication has been delivered successfully

4.1 RESPONSIBILITY FOR CHANGE MANAGEMENT

To maximise the benefits available from implementing SafeCare, it will be necessary to review and if necessary change a number of key processes, procedures and policies. These include (but are not necessarily limited to):

- Creation and approval of rosters
- Daily maintenance of rosters
- Classification of each patient into patient types
- Entering of patient census data
- Escalation of issues/shortfalls with regards to staffing
- Rostering Policy
- Contingency plan for when staffing needs cannot be met
- Requesting and authorisation of temporary staff
- Creation and reviewing of monthly Board reports
- Budgeted Establishment reviewing and planning
- Recruitment and Retention policy
- Reports for Commissioners and general public

Whilst it is not the responsibility of any one person to ***own and carry out*** necessary changes All of the above, it is highly recommended that one person is assigned to ***ensure*** that ownership of the above is clear and that necessary change is being carried out and communicated as necessary.

5 Project Plan

5.1 General Description

The project is divided into four management stages (Stages 0 – 3):

Stage 0 - Mobilisation

Mobilisation is a combination of Project Startup and Initiation. This stage is known as Stage 0, since many stakeholders would take the stage in which units are first implemented to be Stage 1. Defining the Mobilisation Stage as Stage 0, to allow keeping naming in line with this reduces confusion.

During this stage, the project team(s) are assembled, the PID, Project Plan and Plan for Stage 1 and 2, as well as other project management documentation are put in place.

Key deliverables for Mobilisation Stage:

Deliverable	Brief Description
Signed Project Initiation Document	Defines the scope, methodology, approach, project procedures and controls, deliverables and responsibilities
Baselined Project Plan	Held within the PID, this describes activities and deliverables within the project stages, as well as key milestones. Other items relevant to the project plan (e.g. Assumptions, Critical Success Factors for project are held within sections of the PID)
Baselined Stage Plan	Provides the detail view of tasks, dependencies, resource required and timings for each task. Tasks are arranged into workstreams.
Baselined Risk and Issue Log	The initial risk and issues identified are entered into an Excel based Risk and Issue log, of which a copy is included in Appendix A. The Risk and Issue is a dynamic document that requires frequent updates. The original baselined version is kept in the PID only
Baselined Communications Plan	A list of communications identified at the start of the projects is held in an Excel based Communications Plan. The original baselined version is included within the PID in Appendix C
Initial Lessons Learned Log	Lessons learned from other implementations that Allocate can offer to assist with planning and control are included in an initial Lessons Learned Log. This is a dynamic document that is updated frequently throughout the project, particularly at the end of a project Stage

Stage 1 – Preparatory Tasks and implementation of Early Adopter Units

Stage 1 contains the necessary preparatory work that both allows for the implementation of SafeCare across Generic, and forms a framework of processes, policies and procedures within which to integrate the use of SafeCare.

Deliverable	Lead
Confirm Early adopter units and SafeCare configuration	ALL
Establishment Vs Ward Demand Vs Staff in Post Review completed and reviewed	ALL
Process Mapping - understand how SafeCare will be used - key points during day: Roster creation and approval Roster updates and issue escalation (within and outside hrs) Department handover (am and pm)	ALL/Trust
Review of Roster Policy in light of process mapping completed and any gaps highlighted for taking forward and addressing	ALL/Trust
Plan completed reviewed, agreed and baselined for Stage 2	ALL/Trust

5.2 KEY MILESTONES FOR MOBILISATION AND STAGE 1

Milestone	Baselined Date
Signed Project Initiation Document	9th June 2016
Process mapping completed and documented	TBC
Plan for Stage 2 agreed and baselined	TBC

Stage 2 – Implementation of Early Adopter Units

Four units have been selected as early adopters for SafeCare Ward and Live:

Royal Victoria Hospital

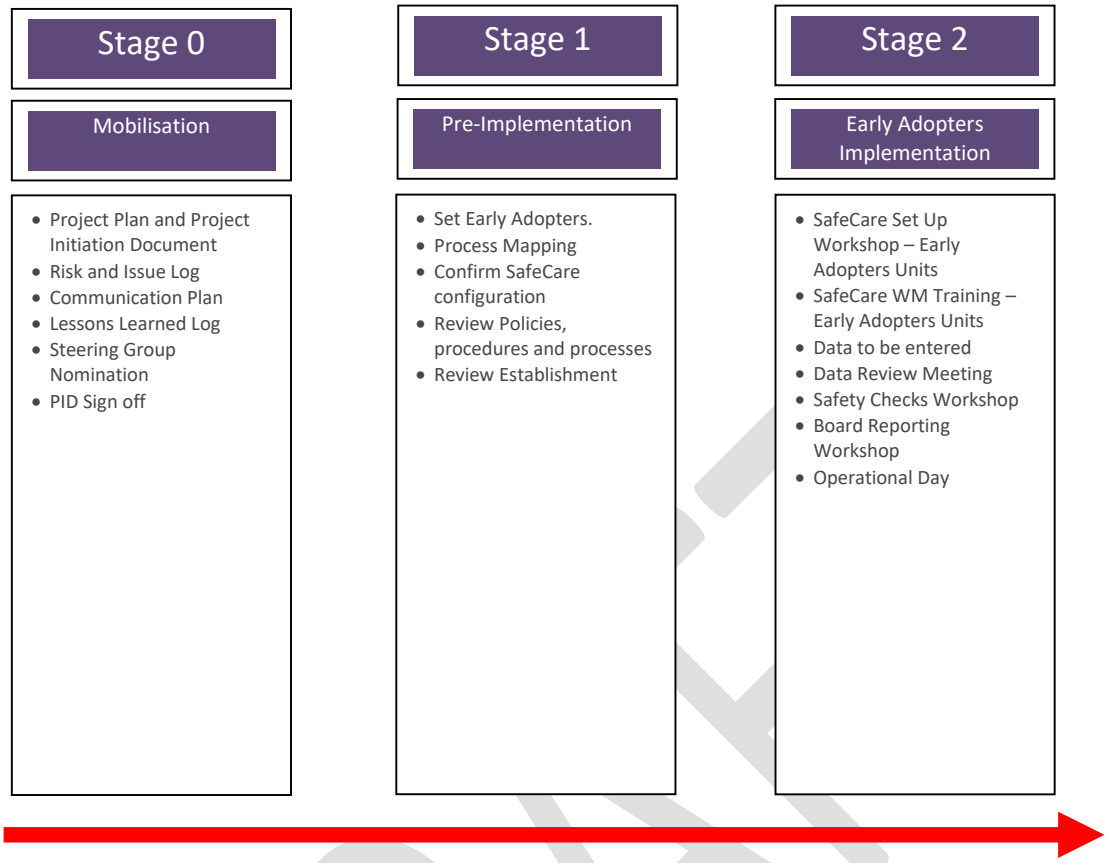
- 6B – Emergency Surgical
- 6C – Emergency Surgical
- 4E - Neurology
- 4F – Neurosurgery.

The main purpose of implementing these four units as Stage 2 is to allow any lessons to be learned that may inform planning for subsequent stages, involving the implementation to further units.

Deliverable	Lead
Early adopter units configured for SafeCare	ALL/Trust
Sen Nurses training to use SafeCare on early adopter units	ALL/Trust
Staffing levels generated by SafeCare reviewed by Clinical Managers and accepted to be accurate	ALL/Trust
Plan completed reviewed and handed over to ALL Support	ALL/Trust

5.3 KEY MILESTONES FOR STAGE 2

Milestone	Baselined Date
SafeCare predicted staffing levels validated with Clinical Managers	
Signoff checklist completed for: Royal Victoria Hospital - 6B – Emergency Surgical - 6C – Emergency Surgical - 4E - Neurology - 4F – Neurosurgery.	



6 Services Commercials

6.1 Introduction

Commercial considerations relating to this project are outlined in the contract. They cover the Consultancy Services provided by Allocate Software in the delivery of the HealthRoster products defined within the scope of this PID.

6.2 Extent of Allocate Participation

Allocates involvement with the project extends to the following activity:

- Implementation of 4 units including training and follow up support during Stage 2
- Participation in process analysis, documentation and review during Stage 1
- Participation in production of monthly and six monthly reporting during Stage 2
- Provision for a group training session for senior staff during Stage 2
- Delivering upgrades as necessary
- Attendance at project meetings (remote or on site depending on circumstances) during Stage 1 and 2
- Attendance at Project Steering Group during Stage 1 and 2 as required

Further participation within the project will be by agreement with Generic. The need will be assessed at the time, and ultimately lies at the discretion of Allocate.

6.3 Right of Substitution

Allocate will assign resources to tasks, matching the tasks to available consultants with the most appropriate skillset. Allocate endeavours to supply the same consultants for given tasks throughout the project to provide as much continuity as possible, but cannot guarantee this. At times it may be necessary to substitute a consultant for another with a similar skillset.

Allocate maintains the right to substitute a person assigned to a project with another suitable person should the need occur.

7 PID Sign Off

The Project Initiation Document (PID) has been reviewed and approved by the following representatives from the two parties:

Name	Role / Title	Signature	Date
Margaret Devlin	Senior Manager Nursing Workforce Planning	M.Devlin	16th June 2016
Roisin McMahon	E-Roster Implementation Manager	R McMahon	9th June 2016

8 Appendix A – Project Risks

Baselined Project Risks at time of PID signoff. Note that the Project Risk register is a dynamic document that is frequently updated.

9 Appendix B – Unit Schedule

The table below identifies the Units selected for implementation.

Directorate/ Division	Unit Name	Type	Notes
Surgical	Royal Victoria Hospital 6B – Emergency Surgical		
Surgical	6C – Emergency Surgical		
Neurology	4E - Neurology		
Neurosurgery	4F – Neurosurgery.		

10 Appendix C – Communications Plan

11 Appendix D – Contact Details for Key Project Board & Project Team Members

Name	Project Role	Title	Contact
Margaret Devlin	Belfast Project Sponsor	Senior Manager	07818552402
Roisin McMahon	Belfast Project Manager	Implementation Manager	07788926590
Suzanne Rawlings	Allocate Senior Project Manager		
Lucy Savage	Allocate Implementation Consultant		

12 Appendix E – Glossary of Terms

Term	Detail
PID	Project Initiation Document
Allocate	Allocate Software
WTE	Whole Time Equivalent
IT	Information Technology
KPI	Key Performance Indicator
HR	Human Resource
Unit	Ward or Clinic

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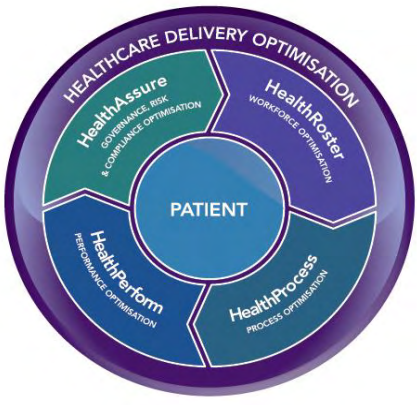
HealthRoster (v10) – SafeCare

SafeCare Ward

User Guide

Version: ALL5.0
Status: Release
Issue Date: July 2016



Contents

Foreword

SafeCare Ward can be used in any care setting. It allows nursing staff to capture actual patient numbers by acuity and dependency and see if their staffing levels match this demand.

This User Guide covers all elements and functionality of SafeCare Ward, from setting up SafeCare to outputs, and it is a complete overview for HealthRoster/System Administrators.

It is strongly recommended that HealthRoster/System Administrators read through the **whole** guide, since there is relevant information relating to their role and use of the system.

1 Introduction

1.1 About HealthRoster

HealthRoster has been specifically designed for Ward/Unit/Team Managers, Modern Matrons etc. to roster staff to an agreed duty requirement, view ward/unit staffing levels over time and also to have the ability to track, for example, levels of no-show, additional/agency duties etc., for the purpose of managing their rosters and staff on a day-to-day basis.

HealthRoster stores personnel data, providing visibility of a person's availability and contractual obligations. This information is used to support HealthRoster to provide information to Ward/Unit/Team Managers regarding staff availability.

By building rosters using HealthRoster, Ward/Unit/Team Managers are able to assign staff against a defined duty requirement using the Auto Roster function and simple drag-and-drop interface.

1.2 About SafeCare Ward

SafeCare Ward allows nursing staff to capture actual patient numbers by acuity and dependency, and see if their staffing levels match this demand.

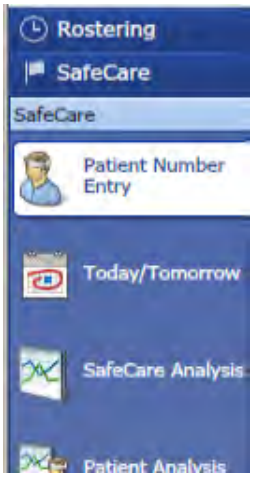
SafeCare allows you to:

- Action day-to-day staffing movements as well as inform longer-term resource and establishment plans
- Use the most suitable acuity and dependency model for each unit relevant to their specialty/service.
- Have clear visibility of staffing issues Trust/Organisation wide:
    - Where staffing does not match the required patient demand, not just in nursing hours but also skills
    - Temporary staff usage
    - Charge cover
- Provide reports to identify trends and causes, highlighting changes needed to ensure safe staffing levels.

NOTE: This is a licenced module and should only be used by customers with an appropriate licence.

2 Patient Number Entry

The Patient Number Entry Screen (SafeCare>Patient Number Entry) lets you view/enter Census data for each census within a selected date range for a ward/unit.



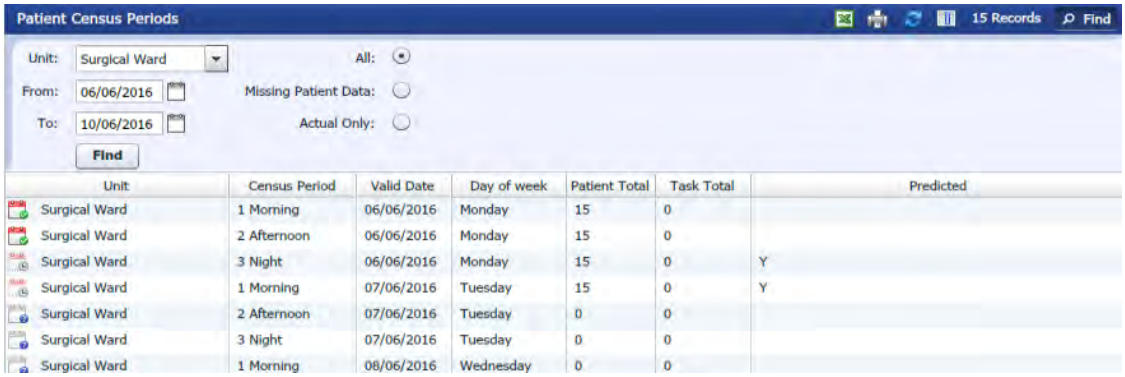
2.1 SEARCHING PATIENT DATA

There are three radio buttons to select from:

- 'All' – the default
- 'Missing Patient Data' – Brings up all census periods within the selected date range for which no data has been entered
- 'Actual Only' - Brings up all census periods within the selected date range where data has been entered as actual

The finder allows you to search for:

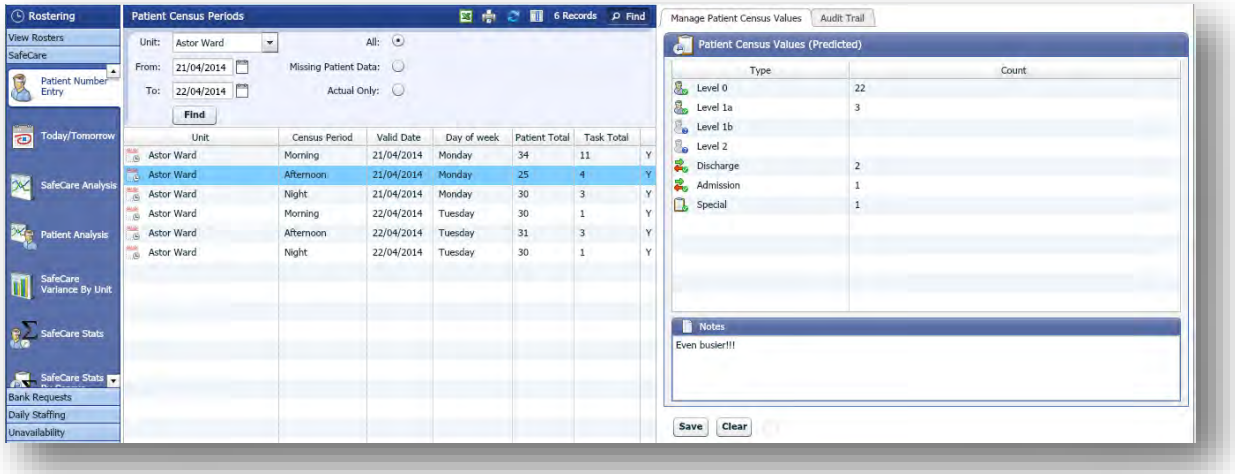
- **Unit Name** (rostered units only)
- The **Start Date** - defaults to a week ago
- The **End Date** - defaults to tomorrow
- **Census Status** – There are radio button options for:
  - **All** – Show all Census Periods (Actual, Predicted and 'No Entry')
  - **Missing Patient Data** - Show Census Periods where there are no entered patient numbers.
  - **Actual** – Show Census Periods where there are actual patient numbers.



- The icon shows if data has been entered as follows:
  - The data is entered and actual
  - The data has been predicted
  - The data has not been entered
- A 'Predicted' column shows Y if the Census is predicted

2.2 ENTERING PATIENT DATA

In the details pane you can enter numbers for each of the applicable Patient Types and/or tasks and/or notes for the Census Period selected. You can multi-select Census Periods to enter the same values for multiple Census Periods by holding down 'Ctrl' on your keyboard and clicking on multiple census periods.

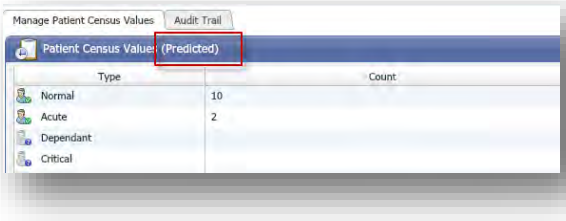


Censuses are automatically marked as 'predicted' or 'actual' when data is entered, based on the time of data entry:

- If the census data is entered ahead of the census entry buffer for that period (as set in reference data) it is set as 'predicted'

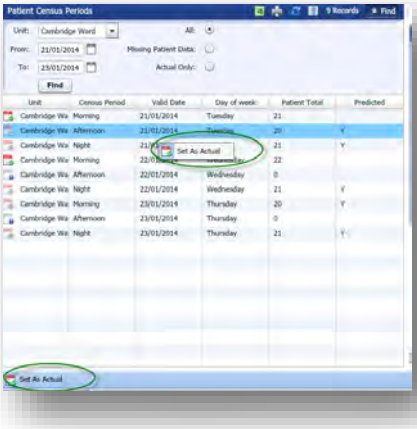
- If the census data is entered on or after the census time it is set as 'actual'. A buffer is used, so if the census is entered ahead of time within the buffer window it is still marked as 'actual'. The buffer is set in Reference Data>Settings>SafeCare>Patient Number Entry Period Buffer.

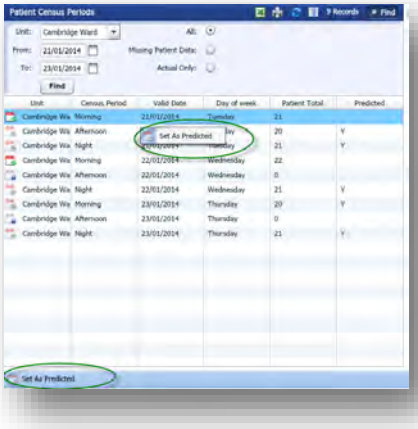
  The Patient Census Values header shows (Predicted) if relevant.



If you edit a 'predicted' census once it is in the past/within the buffer period, it automatically updates to 'actual' when saved.

In addition, censuses can be manually changed from 'predicted' to 'actual' using the action 'Set as Actual'. Similarly the action 'Set as Predicted' can change an 'Actual' status to 'Predicted'. You will only see one option for each census depending on its current status e.g. a census set as predicted will only display the option available to 'Set as Actual'.





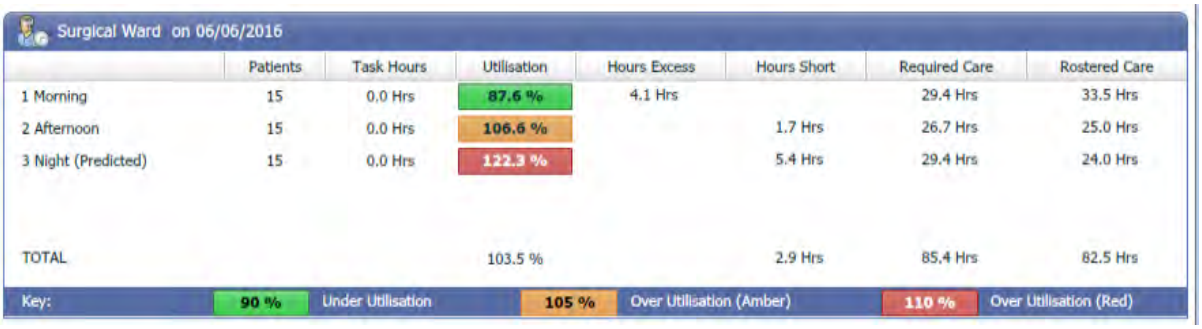
2.3 AUTOMATIC CENSUS PREDICTION

From Version 10.6.1, when a census period is entered, the same patient numbers will automatically be predicted for the next two census periods. Tasks and Notes will not automatically copy unless multiple census periods have been selected for entry.

If data has been set as predicted in either of the next two census periods, this will be overwritten by the automatic census prediction. Data set as actual will not be overwritten.

2.4 ANALYSING STAFFING LEVELS

There is a Staff Utilisation Analysis section at the bottom of the details pane where Patients Numbers are entered.



- **Census Period** will inform if the census values are 'actual' or 'predicted'
- The **Patients** column shows the total number of patients for the census period
- The **Task Hours** column shows the total number of task hours, based on the count of tasks entered
- The **Utilisation** percentage indicates the degree to which staff are being utilised

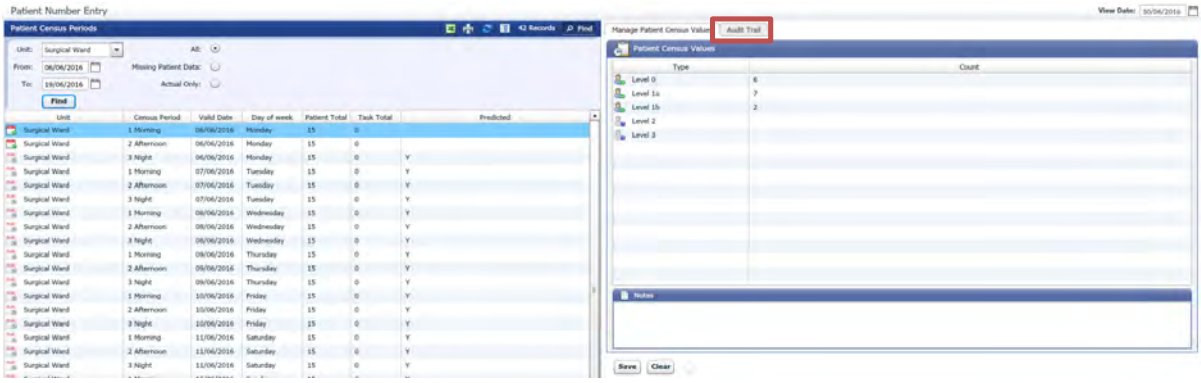
---

- *100% utilisation means rostered staffing exactly matches required staffing*
- *Less than 100% utilisation means that there are more rostered staffing hours than required*
- *More than 100% utilisation means that more hours are required than are rostered*
- *If one of the overutilization thresholds are exceeded (as set in referenced data) then utilisation will change to amber and then red accordingly to indicate a significant shortfall of nursing time*
- *If the underutilisation threshold is exceeded, utilisation figure will turn green to indicate a significant excess of nursing time*

- The **Hours Excess** column shows the rostered hours that are over the Required Care
- The **Hours Short** column shows the hours needed to reach the Required Care
- The **Required Care** column shows the hours needed, based on patient numbers and type, census period and base/specific CHPPD, shown on each census period and total for the day
- The **Rostered Care** column shows the hours being delivered on the roster for the day selected, shown for each census period and total for the day

2.5 AUDIT TRAIL

When a Census Period is selected, an audit trail can be viewed in the details pane.

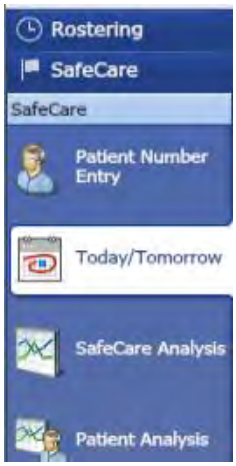


The **Audit Trail** shows all events which have affected the Census Period, e.g. the update of patient numbers or adding of notes.

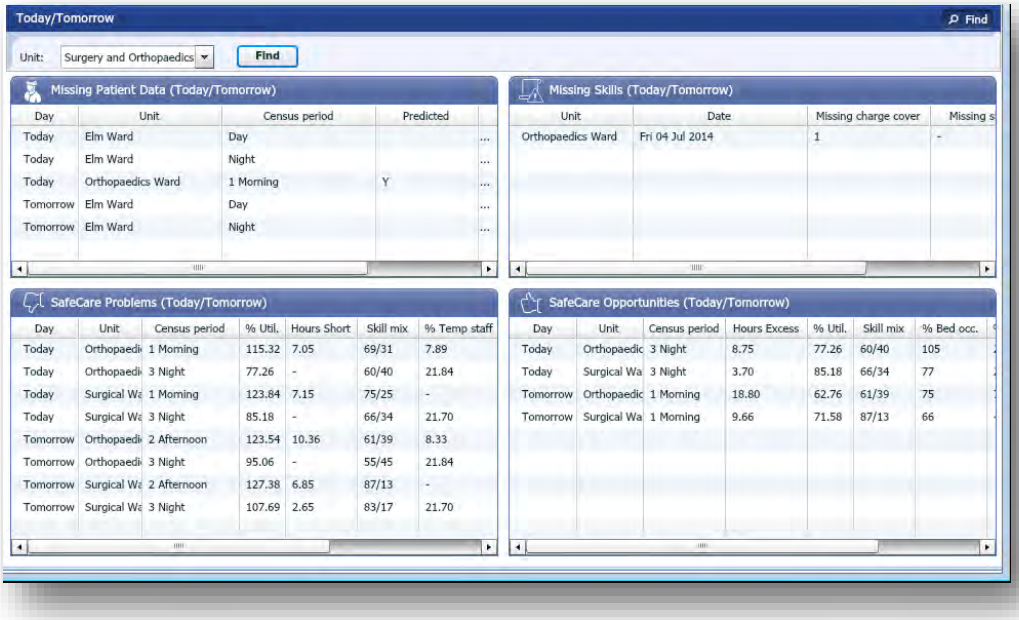
The Lead Time shows how long before the census time the change occurred. A positive figure indicates a change that occurred prior to the census time, and a negative number indicates a change that occurred after the census time.

3 Today/Tomorrow Tool

The Today/Tomorrow tool (SafeCare>Today/Tomorrow) is designed to give a daily overview of SafeCare data to operational management.



The unit finder selects the units to show, including structural units where all subunits are displayed. This means that information can be viewed, for example, for a whole division if the user has appropriate access.

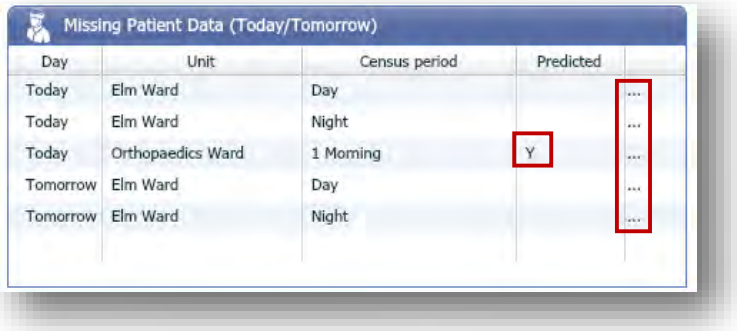


3.1 MISSING PATIENT DATA

Missing Patient Data shows the Census Periods which do not have patient data entered for today and tomorrow. It will also include censuses that, whilst entered, are marked as 'predicted'.

Predicted future censuses are not counted as missing patient data.

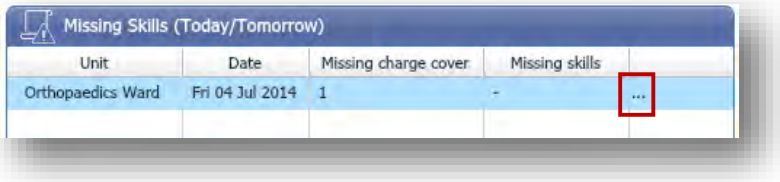
Clicking on the ellipsis link will take the user directly to the 'Patient Number Entry' screen.



3.2 MISSING SKILLS

Missing Skills shows units that have missing charge cover or other missing skills for today and tomorrow:

- Unit
- Date
- Missing Charge Cover count
- Missing Skills count
- Clicking on the ellipsis link will take the user to the Daily Staffing tool



3.3 SafeCare Problems

SafeCare Problems displays, for today and tomorrow, each Census Period where:

- The Unit is over utilised and over the red threshold set in Reference Data (refer to Section 7)
- The % temp staff assigned is over the threshold set in Reference Data (refer to section 7)

The columns displayed are:

- **Date**
- **Unit Name**
- **Census Period** - This is the name of the Census Period where the over utilisation occurs
- **Utilisation** - This is the over utilisation percentage
- **Hours Short** - Hours short for that Census Period, causing the over utilisation
- **Skill Mix** - Shows the % of registered to unregistered staff, based on the Grade Type Category.
- **% Temp Staff** – Shows the assigned temporary staff (bank/agency) as a % of the total assigned hours
- **Wrong Grade Type** – Shows the number of duties assigned to a member of staff of the wrong Grade Type
- **% Bed Occ** – Shows the % of beds filled, based on the number of beds set on the roster template
- Clicking on the ellipsis link will take the User to the Daily Staffing screen

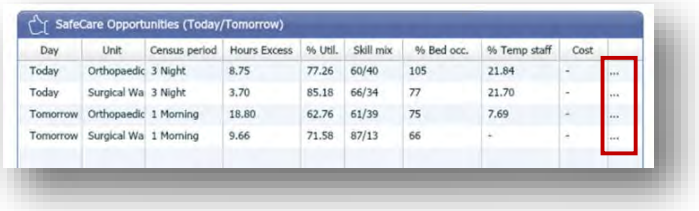
3.4 SAFECARE OPPORTUNITIES

SafeCare Opportunities displays, for today and tomorrow, each Census Period where staff are underutilised and under the green threshold set in Reference Data (refer to Section 7) for all the units searched.

The columns displayed are:

- **Date**
- **Unit Name**
- **Census Period** – The underutilised Census Period
- **Hours Excess** – The excess hours for the Census Period, causing the underutilisation

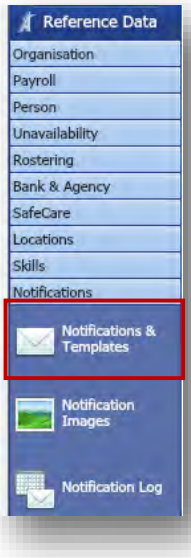
- **Utilisation %** - The underutilisation percentage
- **Total temp staff %** - The % of assigned hours that are staffed by bank and agency within the Census Period.
- **Cost** – This shows the lowest cost of an assigned person within the underutilised Census Period.
- **Skill Mix** – The % of registered to unregistered staff, based on the Grade Type Category
- **% Bed Occ** – The percentage of beds filled, based on the number of beds as set on the roster.
- The ellipsis at the end links to the Daily Staffing tool.


SafeCare Opportunities (Today/Tomorrow)

Day	Unit	Census period	Hours Excess	% Util.	Skill mix	% Bed occ.	% Temp staff	Cost	
Today	Orthopaedic	3 Night	8.75	77.26	60/40	105	21.84	-	...
Today	Surgical Wa	3 Night	3.70	85.18	66/34	77	21.70	-	...
Tomorrow	Orthopaedic	1 Morning	18.80	62.76	61/39	75	7.69	-	...
Tomorrow	Surgical Wa	1 Morning	9.66	71.58	87/13	66	-	-	...

4 Census Based Email Notifications

If an 'Actual' Census Period indicates 'over' or 'under' staffing for today, an automatic email will be triggered to show details of the analysis of the census.



There are six notification templates that can be enabled (these are disabled by default).

- Over and Under Staffing for Partial Approvers (will email 1st Approver of the roster)
- Over and Under Staffing for Full Approvers (will email 2nd Approver of the roster)
- Over and Under Staffing for a Fixed address (configurable)

CensusPeriodOverStaffingToFixedAddress	Census Period Over Staffing	Fixed Address	-	Patient Census Period	CensusP
CensusPeriodOverStaffingToFullApprover	Census Period Over Staffing	Full Approver	-	Patient Census Period	CensusP
CensusPeriodOverStaffingToPartialApprover	Census Period Over Staffing	Partial Approver	-	Patient Census Period	CensusP
CensusPeriodUnderStaffingToFixedAddress	Census Period Under Staffing	Fixed Address	-	Patient Census Period	CensusP
CensusPeriodUnderStaffingToFullApprover	Census Period Under Staffing	Full Approver	-	Patient Census Period	CensusP
CensusPeriodUnderStaffingToPartialApprover	Census Period Under Staffing	Partial Approver	-	Patient Census Period	CensusP

5 Outputs

5.1 SafeCare (Ward)

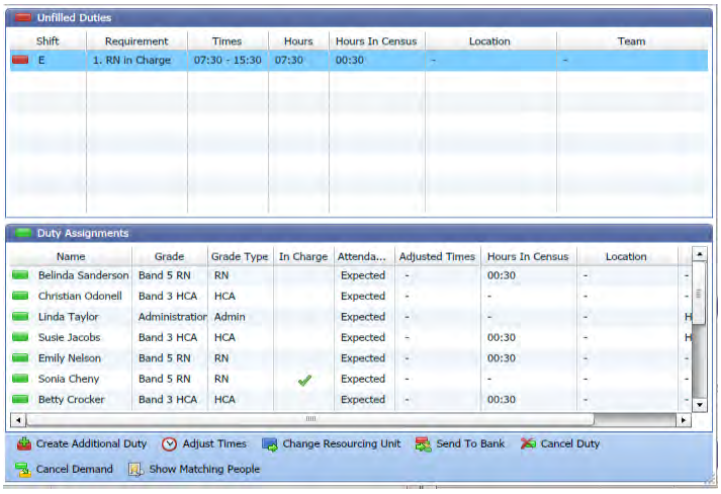
To view the SafeCare figures for a specific day on the roster, right click on a duty and select the 'SafeCare (Ward)' action button.

Alernatively this is shown in the details pane in Rostering>SafeCare>Patient Number Entry. The form displays, for each Census Period, the:

- **Number of Patients**
- **Tasks**
- The staff **Utilisation** percentage – details if there are too many staff or staff are required
- **Hours Excess** – Rostered hours that are over the required
- **Hours Short** – Hours needed to reach the required
- **Required Care** – Hours required based on Patients and Tasks entered into SafeCare
- **Rostered Hours** – The hours being delivered on the roster for the day selected

To view the utilisation for a different day, simply use the forward and back arrows in the header.

NOTE: Clicking on the 'utilisation' cell for a Census Period will launch the drilldown screen. The upper frame displays any unfilled duties, and the lower frame shows filled duty details. Actions can be performed on either, for example adding additional duties, sending to bank, cancelling demand, etc.



5.2 SAFECARE (DEPARTMENT)

To view the SafeCare figures for a specific day on the roster, click on a duty and select the 'SafeCare (Dept)' action button.

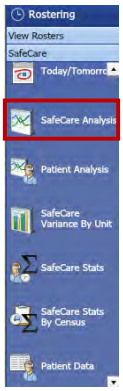
The 'SafeCare (Dept)' action displays the information below for the selected unit, and all other units within the same department (structural unit):

- **Census Periods** applicable to each unit
- **Number of Patients**
- **Tasks**
- The staff **Utilisation** percentage – This will detail if there are too many staff or staff are required
- **Hours Excess** – Rostered hours over the required hours
- **Hours Short** – Required hours over the rostered hours

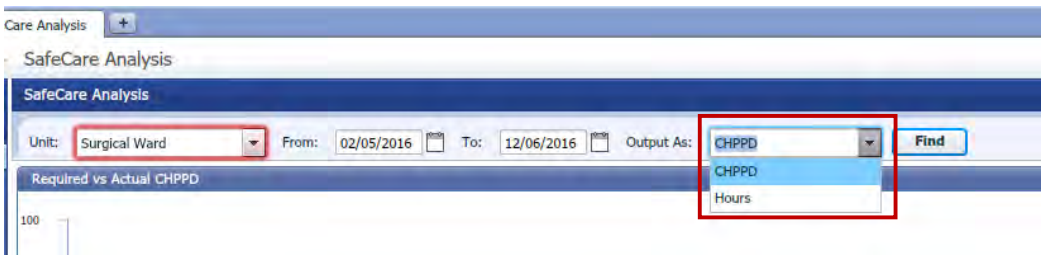
NOTE: Clicking on the 'utilisation' cell for a Census Period will open the drilldown screen.

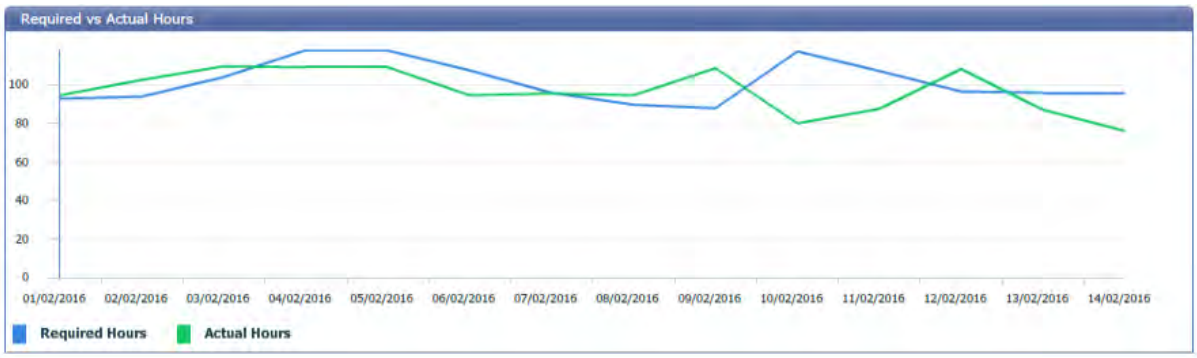
5.3 SafeCare Analysis

SafeCare Analysis gives an overview of SafeCare data over time, for a given unit, within a specified date range. The date range defaults to the two weeks prior to your set view date in HealthRoster. The values are shown when hovering over a data point. A data point marked (Not Actual) means at least one census period is either predicted or missing on that day.

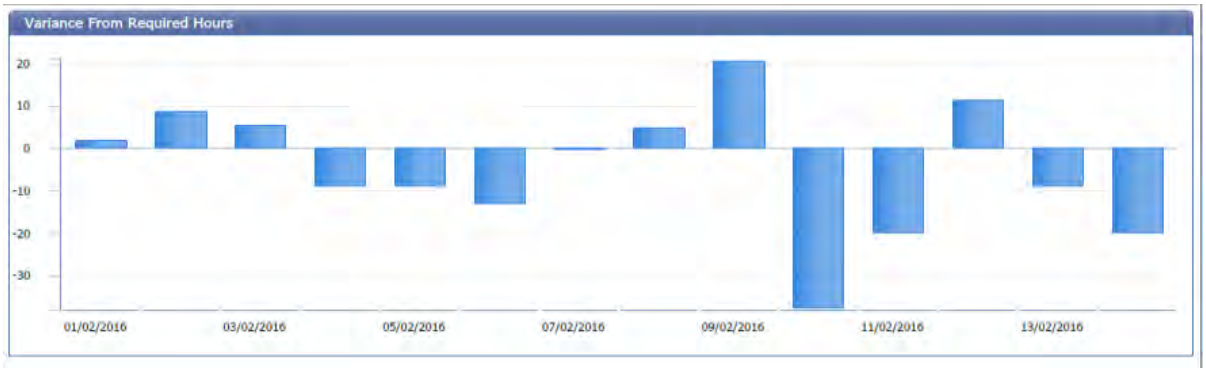


The SafeCare Analysis tools will display the data by unit in a period, in either CHPPD or Hours:

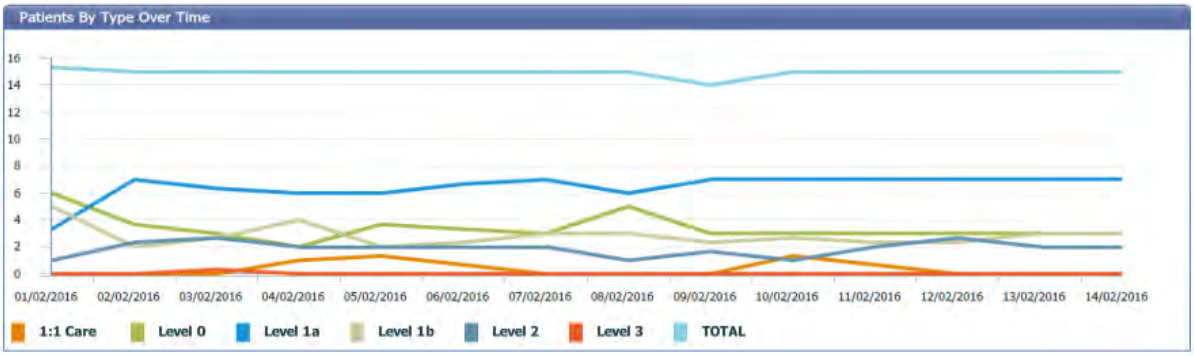




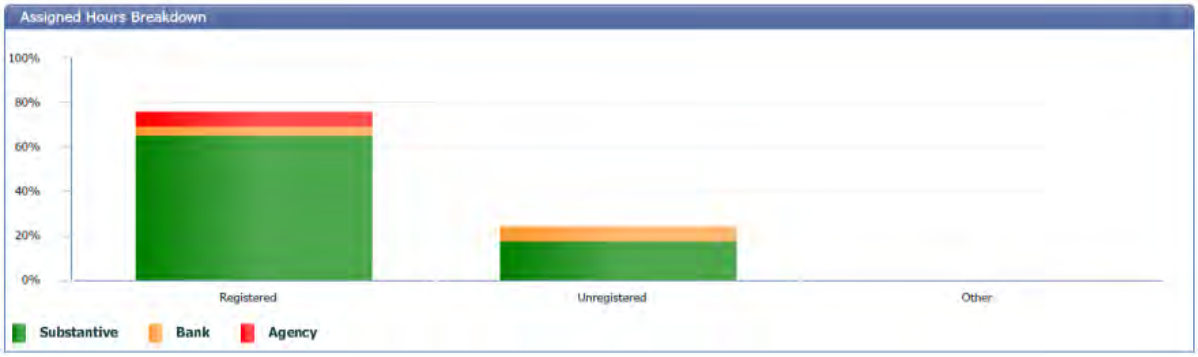
- **Required vs Actual CHPPD or hours** - This line graph shows the Required CHPPD/Hours vs Actual CHPPD/Hours



- **Variance From Required CHPPD/hours** – This bar chart shows the variance between required CHPPD and actual CHPPD over time for each day of the date range selected for the given unit. If the actual is less than the required, this will show is a negative figure, if more, then the figure will be positive.



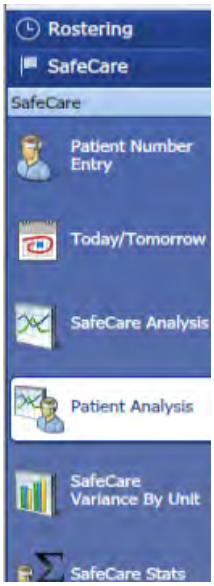
- **Patients by Type Over Time –** this line graph shows patient numbers for each Patient Type, for each day.



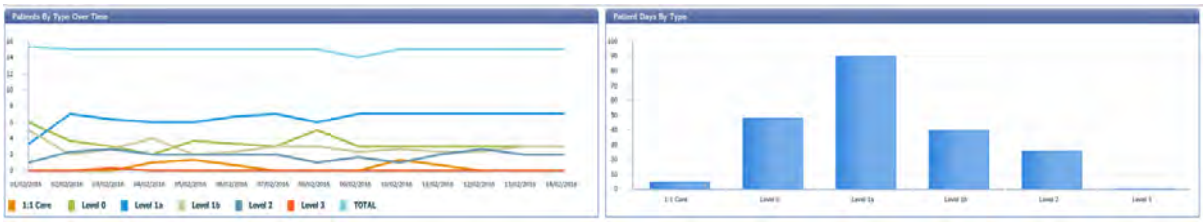
- **Assigned Hours Breakdown** – this shows a breakdown of the total rostered hours by registered/unregistered/other, in a stacked bar that splits substantive, bank and agency assignments.

5.4 PATIENT ANALYSIS

Patient Analysis gives an overview of the SafeCare patient data for a given unit during a specified date range.

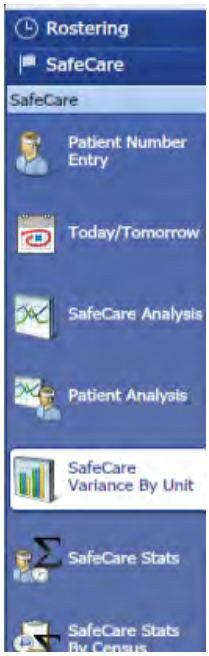


- **Patients by Type Over Time –** this line graph shows patient numbers for each Patient Type for each day over the specified time period.
- **Patients Days by Type –** this graph shows the number of patient days for each Patient Type over the specified time period.

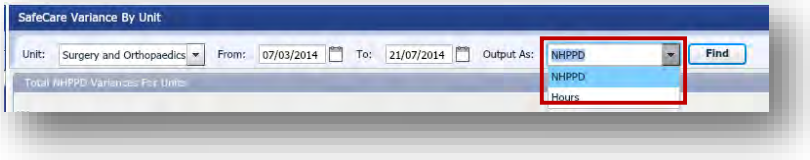


5.5 SafeCare Variance By Unit

SafeCare Variance by Unit gives an overview of the SafeCare data, for a given unit/department within a specified date range.



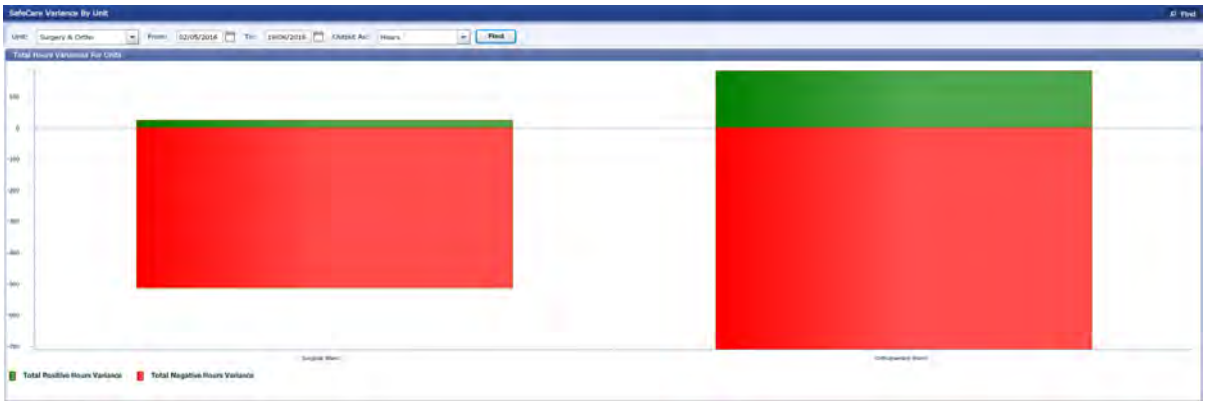
The SafeCare Variance by Unit report can be run in either CHPPD or Hours:



Designed to be run by structural unit, this report shows a graph for all subordinate rostered units, displaying two values:

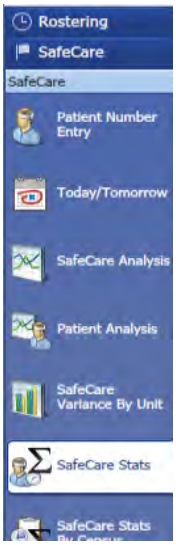
1. In green, the total positive variance from the CHPPD/Hours required (i.e. the total overstaffing, calculated for each day in the report and then summed)
2. In red, the total negative variance from the CHPPD/Hours required (i.e. the total understaffing, calculated for each day in the report and then summed)

3. Units can show both over and understaffing on this report because they may vary on different census days. If the two sections are equal size it shows that the staffing level on the unit is correct but staff are not always deployed in the right place at the right time.



5.6 SAFECARE STATS

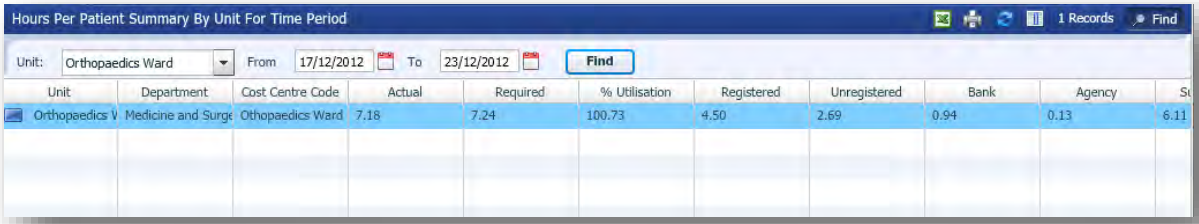
SafeCare Stats shows average SafeCare data across the date range specified for the selected unit. It may be run for a single unit or for a structural unit, providing outputs for all of its subordinates.



The report shows the required and actual CHPPD breakdown for:

- **Grade Type Category**
  - Unregistered
  - Registered
- **Staff Type**
  - Substantive (Unregistered, Registered, total substantive)

- Bank (unregistered, registered, total bank)
- Agency Bank (unregistered, registered, total Agency)



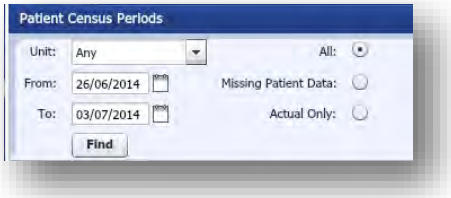
5.7 SAFECARE STATS BY CENSUS

The SafeCare Stats by Census tool displays SafeCare data on a census by census basis.

The SafeCare Stats by Census report has the same three radio button filters as the Patient Number Entry screen ('All', 'Missing Patient Data' and 'Actual Only').

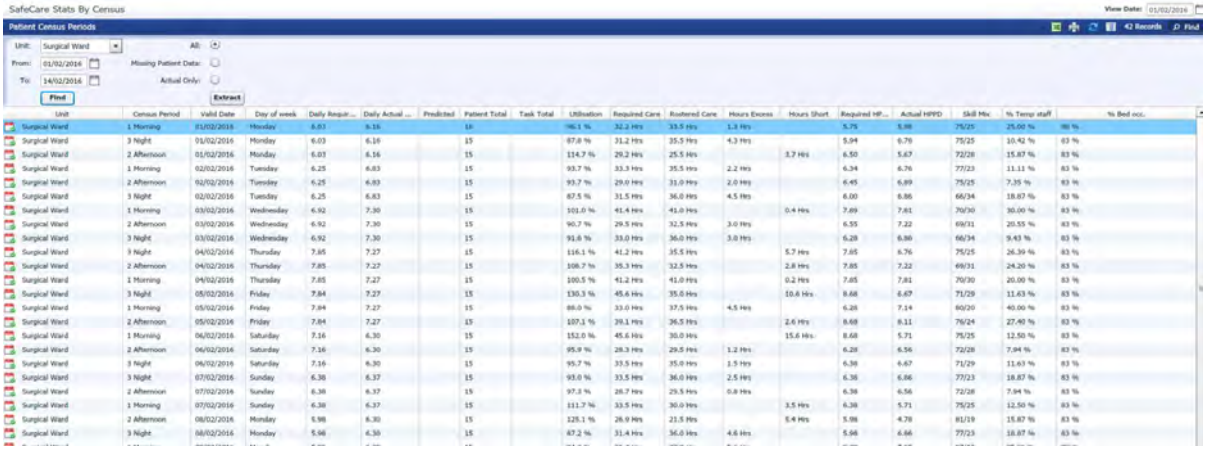
Other filters include:

- **Unit Name** (This can be a rostered unit or structural unit)
- The **Start Date** defaults to a week ago
- The **End Date** defaults to tomorrow



The report displays, for each Census Period, the:

- **Unit** - Unit name
- **Census Period** - Name of the Census Period
- **Valid Date**
- **Day of Week** - Weekday name for each Census Period
- **Daily Required CHPPD** – Required CHPPD across all census periods for the entry's date
- **Daily Actual CHPPD** – Actual CHPPD across all census periods for the entry's date
- **Predicted** – Shows 'Y' if the Patient entry was entered before the Census Period
- **Patient Total** - Total number of patients for each Census Period
- **Task Total** - Total number of Tasks for each Census Period
- **Utilisation** - Staff Utilisation percentage for each Census Period
- **Required Care** – Hours needed based on Patient Type, Census Period and base/specific CHPPD.
- **Rostered Hours** – The hours being delivered on the roster for the day selected
- **Hours Excess** – Rostered hours over the required CHPPD
- **Hours Short** – Hours need to reach the required CHPPD
- **Required CHPPD** – Required CHPPD for the census period
- **Actual CHPPD** - Actual CHPPD for the census period
- **Skill Mix** – the % of registered to unregistered staff, based on the Grade Type Category
- **Total temp staff % -** The % of assigned hours that are assigned to bank and agency staff within the Census Period
- **% Bed Occ** – the percentage of beds filled, based on the number of beds as set on the roster.



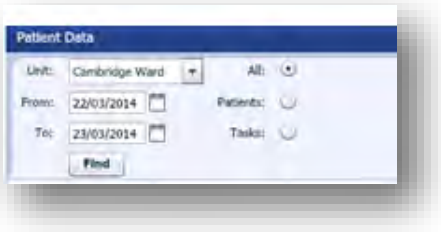
5.8 PATIENT DATA

Patient Data will report by census how many of each Patient and/or Task Type were recorded.

Filters on this report are as follows:

- **Unit Name** (rostered units only) – includes departments.
- The **Start Date** defaults to a week ago
- The **End Date** defaults to tomorrow
- **Type of Data** – There are radio button options for :
    - **All** – Shows all data (Patient and Tasks)
    - **Patients** - Shows Patient Data only numbers.

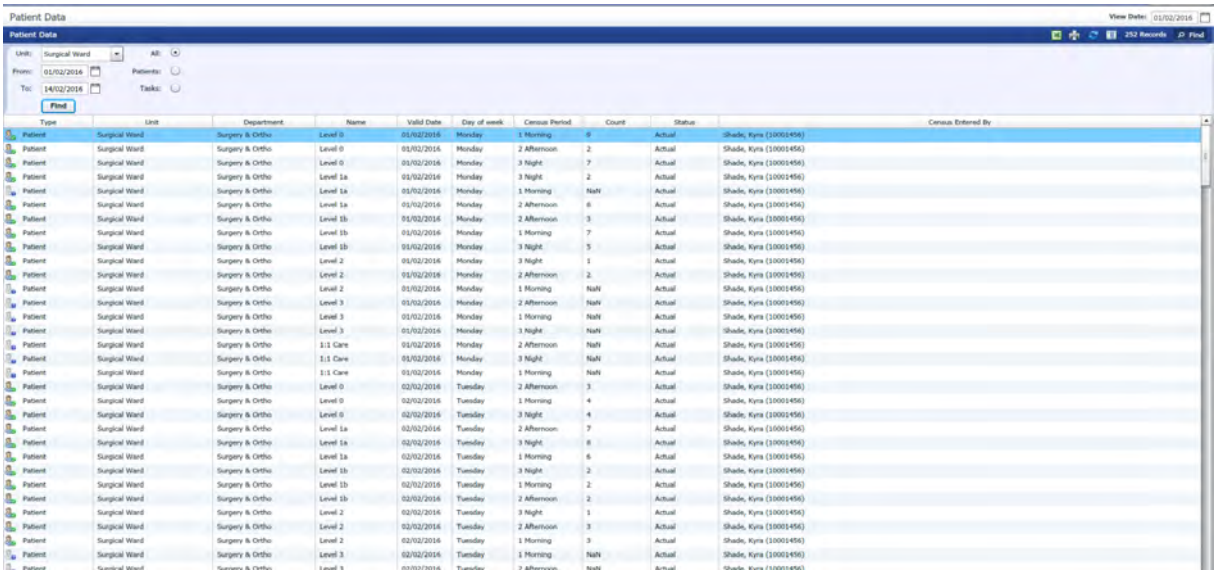
- **Tasks** – Shows Tasks only



Columns include:

- **Type** (Patient or Task)
- **Patient/Task Name**
- **Unit**
- **Department**
- **Date**
- **Day of Week**
- **Census Period**
- **Census Status** (no data entered, predicted, actual)
- **Census Entered By**
    - When no data has been entered, this shows who created the Census Period (if created automatically, will display 'System Internal').
    - Once data has been entered; this field will display who has made the latest change to that Census Period

      NOTE: If only one value is changed it will be assumed they have taken responsibility for all values saved at that time.



5.9 NON-NURSING HOURS UNIT MONITORING REPORT

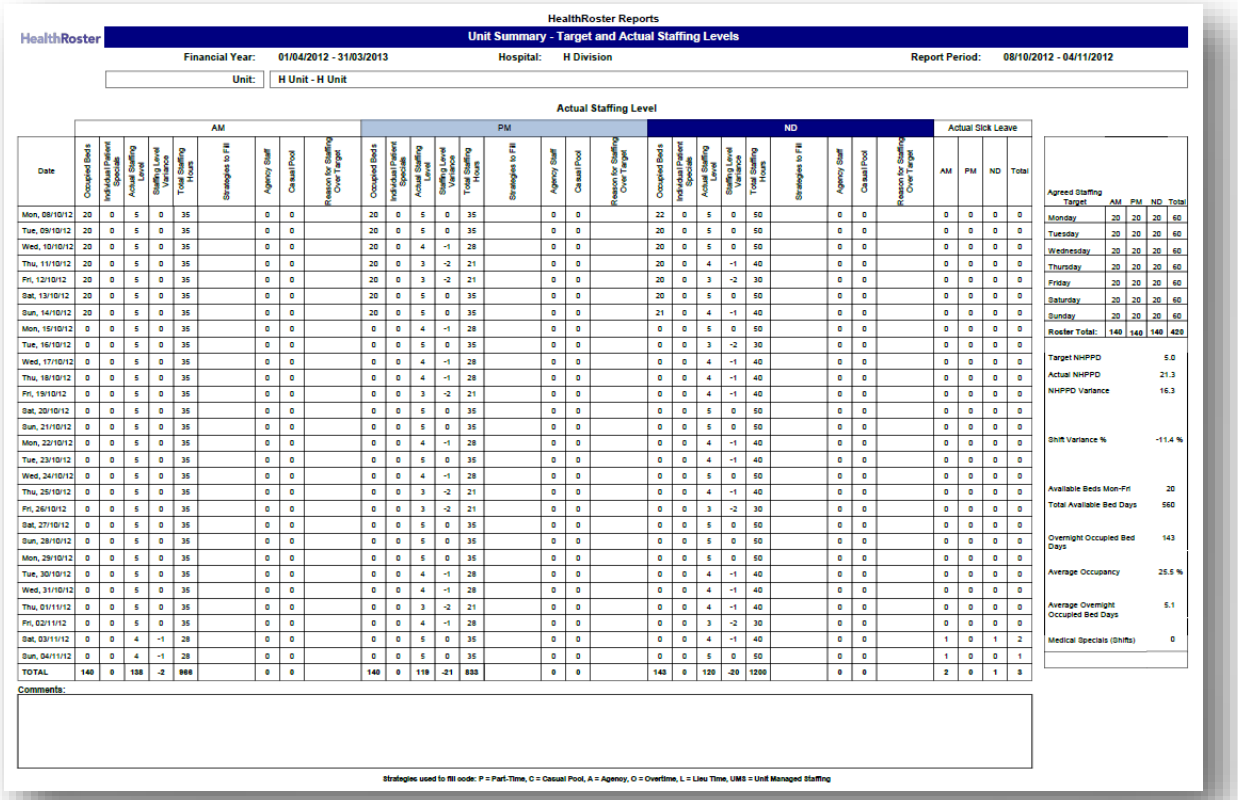
The Non-Nursing Hours Unit Monitoring Report shows patient data and rostered staff data.

The following reports options are available:

- **Unit**
- **Include Sub Units –** This is not available on this report at the moment
- **Start Date** – The end date defaults to 4 weeks after the start date
- **Census Period AM** - A list of the applicable Census Periods for the unit selected. The period selected determines what is shown in the AM section of the report.
- **Census Period PM –** A list of the applicable Census Periods for the unit selected. The period selected determines what is shown in the PM section of the report.

- **Census Period ND -** A list of the applicable Census Periods for the unit selected. The period selected determines what is shown in the ND section of the report.

The selected option values, other than the date, will be remembered across sessions for each user.
The report produces two pages; a table, and a page of graphs:



HealthRoster Reports

HealthRoster — Unit Summary - Target and Actual Staffing Levels

Financial Year: 01/04/2012 - 31/03/2013 Hospital: H Division Report Period: 08/10/2012 - 04/11/2012

Unit: H Unit - H Unit

Actual Staffing Level

Date	AM									PM										ND										Actual Sick Leave			
	Occupied Beds	Individual Patient Specials	Actual Staffing Level	Staffing Level Variance	Total Staffing Hours	Strategies to Fill	Agency Staff	Casual Pool	Reason for Staffing Over Target	Occupied Beds	Individual Patient Specials	Actual Staffing Level	Staffing Level Variance	Total Staffing Hours	Strategies to Fill	Agency Staff	Casual Pool	Reason for Staffing Over Target	Occupied Beds	Individual Patient Specials	Actual Staffing Level	Staffing Level Variance	Total Staffing Hours	Strategies to Fill	Agency Staff	Casual Pool	Reason for Staffing Over Target	AM	PM	ND	Total
Mon, 08/10/12	20	0	5	0	35		0	0		20	0	5	0	35		0	0		22	0	5	0	50		0	0		0	0	0	0
Tue, 09/10/12	20	0	5	0	35		0	0		20	0	5	0	35		0	0		20	0	5	0	50		0	0		0	0	0	0
Wed, 10/10/12	20	0	5	0	35		0	0		20	0	4	-1	28		0	0		20	0	5	0	50		0	0		0	0	0	0
Thu, 11/10/12	20	0	5	0	35		0	0		20	0	3	-2	21		0	0		20	0	4	-1	40		0	0		0	0	0	0
Fri, 12/10/12	20	0	5	0	35		0	0		20	0	3	-2	21		0	0		20	0	3	-2	30		0	0		0	0	0	0
Sat, 13/10/12	20	0	5	0	35		0	0		20	0	5	0	35		0	0		20	0	5	0	50		0	0		0	0	0	0
Sun, 14/10/12	20	0	5	0	35		0	0		20	0	5	0	35		0	0		21	0	4	-1	40		0	0		0	0	0	0
Mon, 15/10/12	0	0	5	0	35		0	0		0	0	4	-1	28		0	0		0	0	5	0	50		0	0		0	0	0	0
Tue, 16/10/12	0	0	5	0	35		0	0		0	0	5	0	35		0	0		0	0	3	-2	30		0	0		0	0	0	0
Wed, 17/10/12	0	0	5	0	35		0	0		0	0	4	-1	28		0	0		0	0	4	-1	40		0	0		0	0	0	0
Thu, 18/10/12	0	0	5	0	35		0	0		0	0	4	-1	28		0	0		0	0	4	-1	40		0	0		0	0	0	0
Fri, 19/10/12	0	0	5	0	35		0	0		0	0	3	-2	21		0	0		0	0	4	-1	40		0	0		0	0	0	0
Sat, 20/10/12	0	0	5	0	35		0	0		0	0	5	0	35		0	0		0	0	5	0	50		0	0		0	0	0	0
Sun, 21/10/12	0	0	5	0	35		0	0		0	0	5	0	35		0	0		0	0	5	0	50		0	0		0	0	0	0
Mon, 22/10/12	0	0	5	0	35		0	0		0	0	4	-1	28		0	0		0	0	4	-1	40		0	0		0	0	0	0
Tue, 23/10/12	0	0	5	0	35		0	0		0	0	5	0	35		0	0		0	0	4	-1	40		0	0		0	0	0	0
Wed, 24/10/12	0	0	5	0	35		0	0		0	0	4	-1	28		0	0		0	0	5	0	50		0	0		0	0	0	0
Thu, 25/10/12	0	0	5	0	35		0	0		0	0	3	-2	21		0	0		0	0	4	-1	40		0	0		0	0	0	0
Fri, 26/10/12	0	0	5	0	35		0	0		0	0	3	-2	21		0	0		0	0	3	-2	30		0	0		0	0	0	0
Sat, 27/10/12	0	0	5	0	35		0	0		0	0	5	0	35		0	0		0	0	5	0	50		0	0		0	0	0	0
Sun, 28/10/12	0	0	5	0	35		0	0		0	0	5	0	35		0	0		0	0	5	0	50		0	0		0	0	0	0
Mon, 29/10/12	0	0	5	0	35		0	0		0	0	5	0	35		0	0		0	0	5	0	50		0	0		0	0	0	0
Tue, 30/10/12	0	0	5	0	35		0	0		0	0	4	-1	28		0	0		0	0	4	-1	40		0	0		0	0	0	0
Wed, 31/10/12	0	0	5	0	35		0	0		0	0	4	-1	28		0	0		0	0	4	-1	40		0	0		0	0	0	0
Thu, 01/11/12	0	0	5	0	35		0	0		0	0	3	-2	21		0	0		0	0	4	-1	40		0	0		0	0	0	0
Fri, 02/11/12	0	0	5	0	35		0	0		0	0	4	-1	28		0	0		0	0	3	-2	30		0	0		0	0	0	0
Sat, 03/11/12	0	0	4	-1	28		0	0		0	0	5	0	35		0	0		0	0	4	-1	40		0	0		1	0	1	2
Sun, 04/11/12	0	0	4	-1	28		0	0		0	0	5	0	35		0	0		0	0	5	0	50		0	0		1	0	0	1
TOTAL	140	0	138	-2	966		0	0		140	0	119	-21	833		0	0		148	0	120	-20	1200		0	0		2	0	1	3

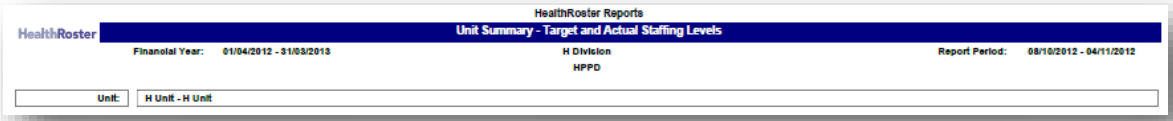
Agreed Staffing Target	AM	PM	ND	Total
Monday	20	20	20	60
Tuesday	20	20	20	60
Wednesday	20	20	20	60
Thursday	20	20	20	60
Friday	20	20	20	60
Saturday	20	20	20	60
Sunday	20	20	20	60
Roster Total:	140	140	140	420

Target NHPPD	5.0
Actual NHPPD	21.3
NHPPD Variance	16.3
Shift Variance %	-11.4 %
Available Beds Mon-Fri	20
Total Available Bed Days	560
Overnight Occupied Bed Days	143
Average Occupancy	25.5 %
Average Overnight Occupied Bed Days	5.1
Medical Specials (Shifts)	0

Comments:

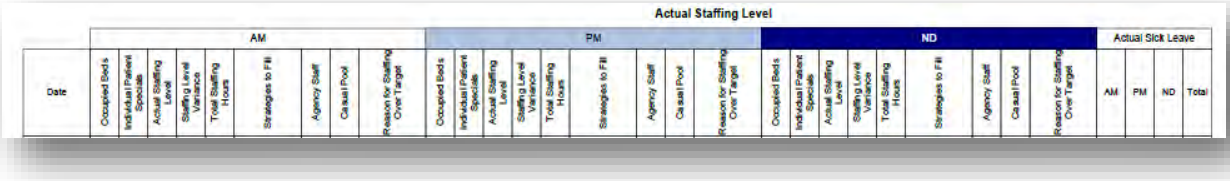
Strategies used to fill code: P = Part-Time, C = Casual Pool, A = Agency, O = Overtime, L = Lieu Time, UMS = Unit Managed Staffing

The header section of the report displays:



- **Financial Year** - The financial year based on the setting 'Start of Financial Year'.
- **Hospital Name** - The short name of the hospital. This is based on the org unit level set for that unit being 'Hospital'. This is set in Personnel > Establishment when creating or editing a unit in the 'Org unit level' field selecting 'Hospital'
- **LHD/Trust** - The short name of the LHD/Trust. This is based on the org unit level set for that unit being 'Trust'
- **Unit** - Shows 'Unit Short Name – Unit Long Name'
- **Report Period** - Displays the start date of the report and the end date (start date + 4 weeks)

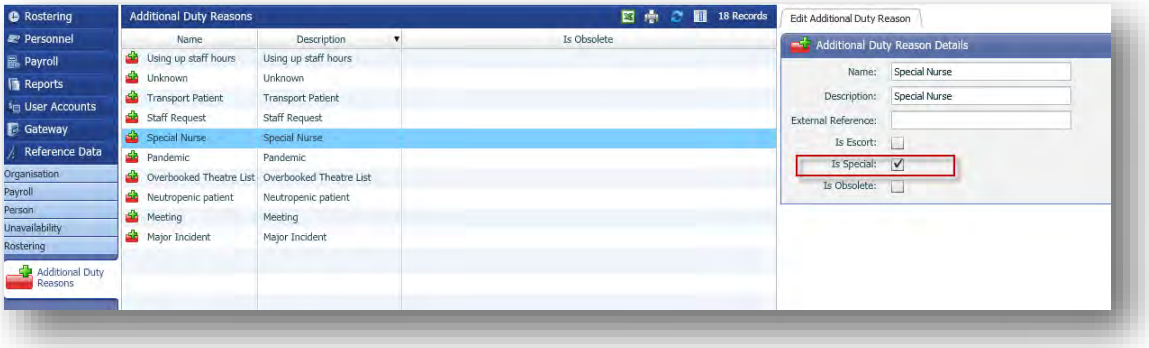
The main report table section of the report displays:

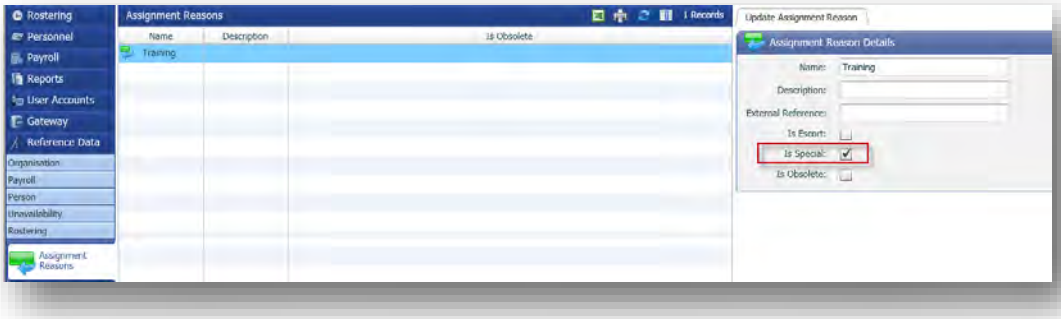


- **Column Header**: AM / PM / ND - Data is placed into these columns based on:
  - Rostering data based on the assigned shift's type, corresponding to Day, Evening (i.e. Late shifts must be set as Shift Type 'evening') and Night shift.

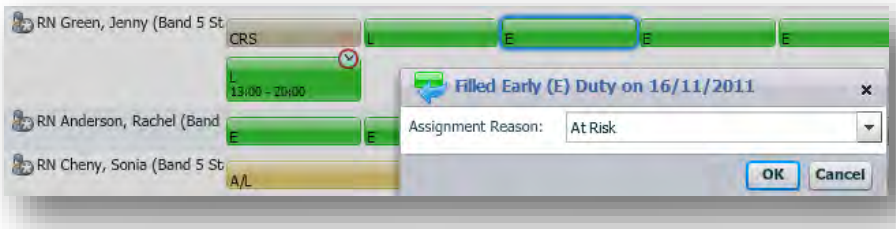
    NOTE: This report does not support combined shifts.
  - Patient data is based on the selected Census Period, as defined in the report options.
- **Date** - Always shows 28 days, from the Start Date of the report.
- **Number of Occupied Beds** - The total number of patients, of all Patient Types, for the Census Period.
- **Individual Patient Specials** - The count of assigned duties with the 'special' flag applied.

- Setting a duty as special is controlled by either the additional duty reason (if the duty is additional), or the 'duty assignment reason' (normally used if the duty is not additional), and is based on the 'is special' flag on these reasons:

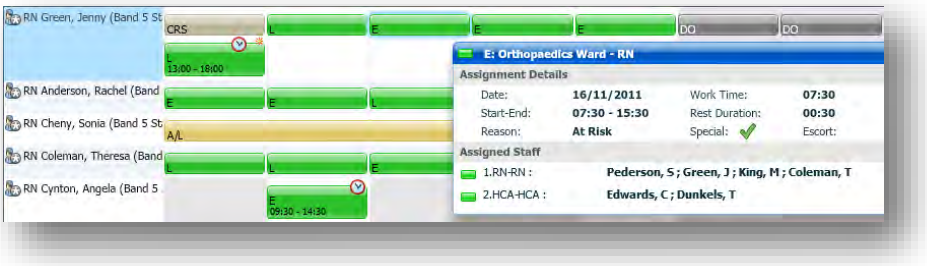




- Duty Assignment Reasons are set via a right click action 'Change Assignment Reason'



- If a duty has an additional reason / assignment reason that has a special flag, the tooltip displays it:

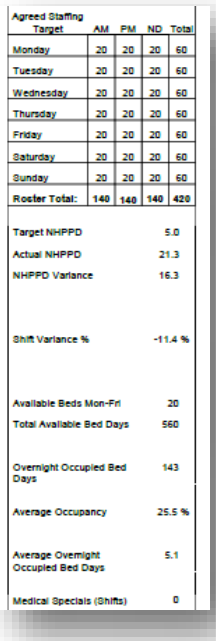


- When an additional duty is assigned, any 'Assignment Reason' takes precedence over the additional duty reason. This ensures that a scenario where an additional duty is created to cover a special, but the person assigned to the special is not the person on the additional duty but on a core duty, is covered correctly.

- **Actual Staffing Level** - Count of the total number of assigned people on that shift type. Whether to include people or not needs to be determined from the duty's 'include in CHPPD' status.
- **Staffing Level Variance**
  - Staffing Level Variance = Total Assigned staff – Specials – Demand
  - Total Assigned Staff = As per 'Actual Staffing Level'
  - Specials = As per 'Individual Patient Specials'
  - Demand = Actual Demand for that shift type, for duties where the Grade Type/Grade Type Category have the 'Use in CHPPD calculation' flag set.
- **Total Staffing Hours** – Shows the actual work time of the duties, including overtime casual and agency assignments.
- **Strategies to Fill –** This displays vacant duty notes, for duties where the Grade Type/Grade Type Category have the 'Use in CHPPD calculation' flag set.
- **Agency Staff Count** – This shows the assigned number of Agency Staff, only showing people whose Grade Type has the 'Use in CHPPD calculation' flag set.
- **Casual Pool** – This shows the count of the assigned number of Casual Staff, only showing people whose Grade Type has the 'Use in CHPPD calculation' flag set.
- **Reason for Additional Staffing** – This shows the additional duty reason(s) for duties where the Grade Type/Grade Type Category have the 'Use in CHPPD calculation' flag set. This also excludes duties marked with the 'special' flag

- **Actual Sick Leave – Broken Down by AM, PM and ND –** Shows the count of Cancelled Duties with a cancelled reason of Sickness, with shifts using Day/Evening/night shift types. This only shows people whose Grade Type has the 'Use in CHPPD calculation' flag set.

The side table section of the report displays:

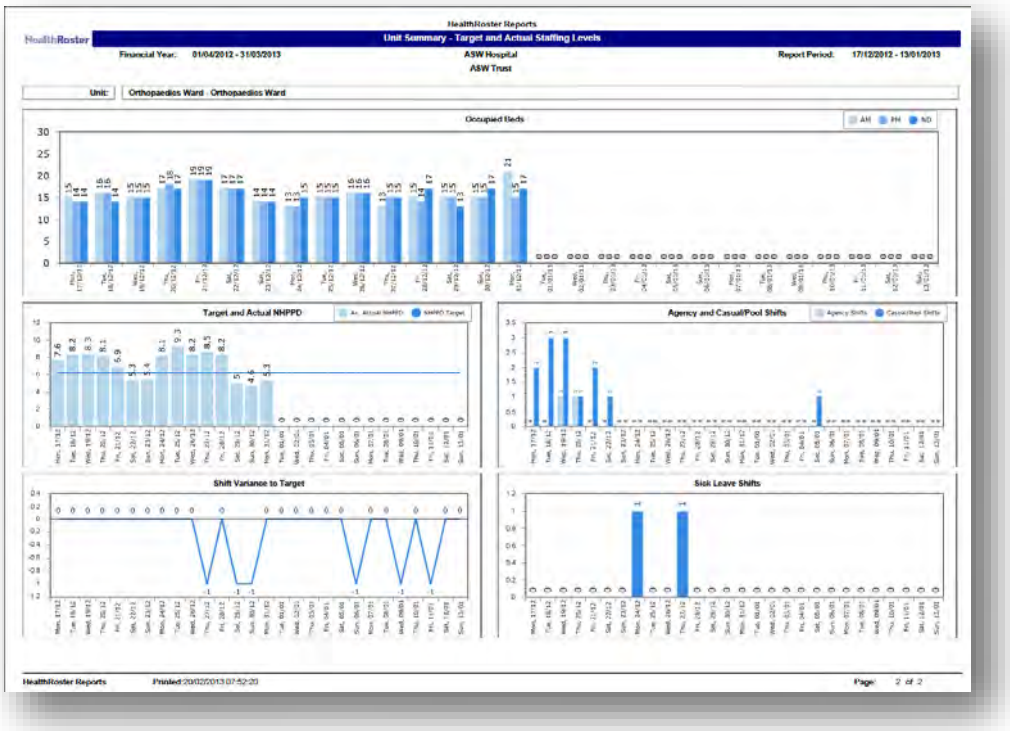


Agreed Staffing Target	AM	PM	ND	Total
Monday	20	20	20	60
Tuesday	20	20	20	60
Wednesday	20	20	20	60
Thursday	20	20	20	60
Friday	20	20	20	60
Saturday	20	20	20	60
Sunday	20	20	20	60
Roster Total:	140	140	140	420

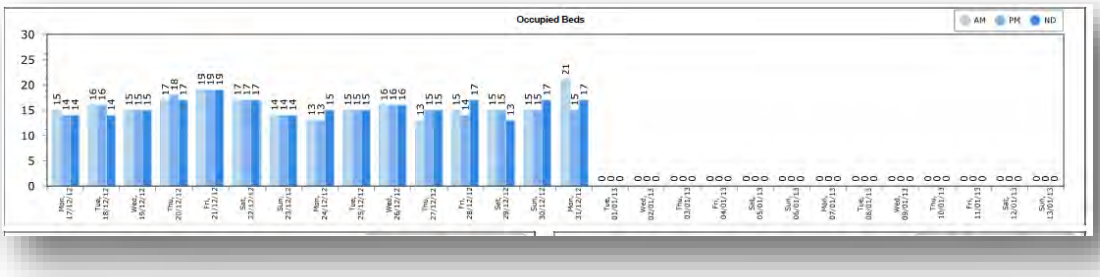
Target NHPPD	5.0
Actual NHPPD	21.3
NHPPD Variance	16.3
Shift Variance %	-11.4 %
Available Beds Mon-Fri	20
Total Available Bed Days	560
Overnight Occupied Bed Days	143
Average Occupancy	25.5 %
Average Overnight Occupied Bed Days	5.1
Medical Specials (Shifts)	0

Agreed Staffing Target Table – The total numbers of duties (excluding optional duties) by shift type (day (AM) / evening (PM) /(ND)) and day of the week, based on the roster demand, for duties where the Grade Type/Grade Type Category have the 'Use in CHPPD calculation' flag set.
Target CHPPD – The unit's base CHPPD, prorated if this value changes over the report period.
Actual CHPPD - Actual CHPPD = Total Staffing Hours (AM + PM + ND) / Total Night (midnight) Occupied Beds (for the 4 week reporting period)
Available Beds - Total number of available beds on the ward, from the roster's 'number of beds' field. This is prorated if multiple rosters with different values cover the report period.
Total Available Beds - Available Beds * 28 (for the 4 week report period)
Overnight Occupied Bed Days - The total number of occupied bed days based on the ND census period.
Average Occupancy - Occupied Beds as a percentage of total available beds
Average Overnight Occupied Bed Days – 'Total Overnight Occupied Bed Days' divided by 28
Medical Specials (Shifts) – shows the Count of any 'special' marked assigned duties shifts. Only shows people whose Grade Type has the 'Use in CHPPD calculation' flag set.

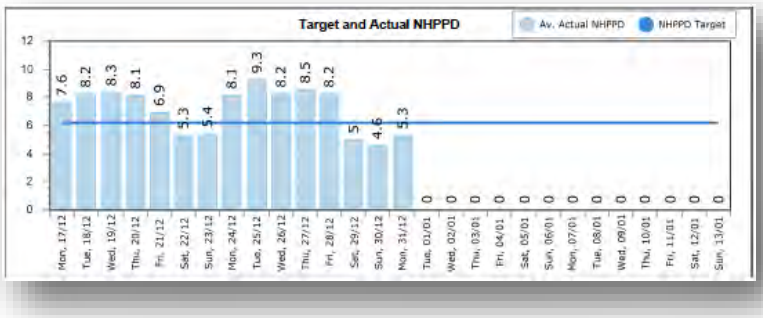
The graphs section of the report displays:



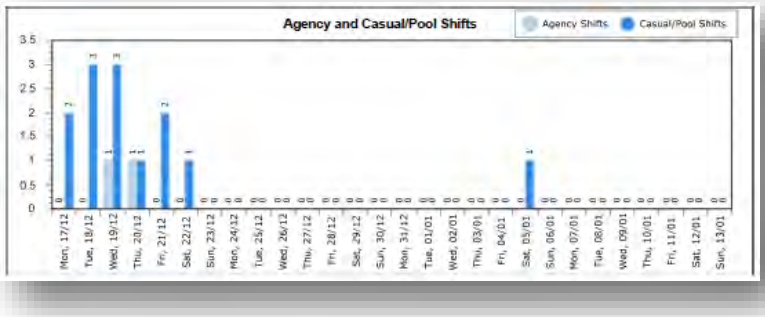
Occupied Beds - Bar chart for each day, with the number of patients from the AM / PM / Night Census Periods



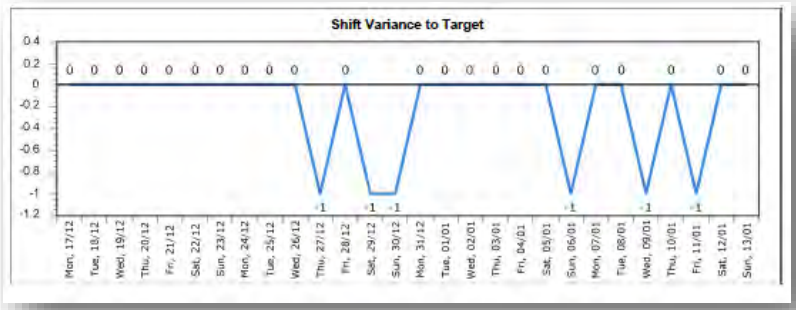
Target vs Actual CHPPD - Bar chart for the Actual CHPPD for each day; the line shows the unit's base CHPPD



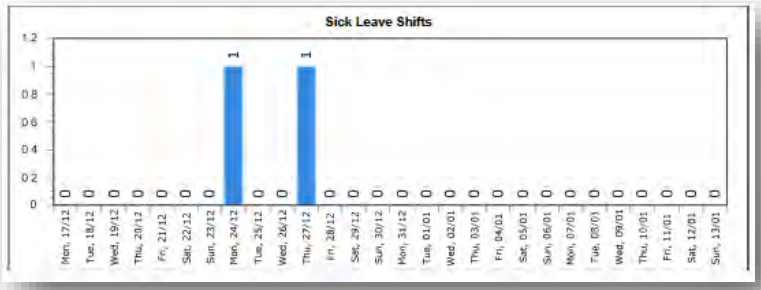
Agency and Casual Pool Shifts – This shows the count of duty assignments to agency/bank postings for each day.



Shift Variance to Target - This line chart shows the staffing level variance as per the ND census column.

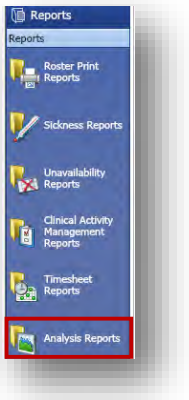


Sickness Line Graph – This bar graph shows a count of all cancelled duties with reason of sickness on each day.



5.10 NURSING HOURS UNIT SPOT CHECK MONITORING REPORT

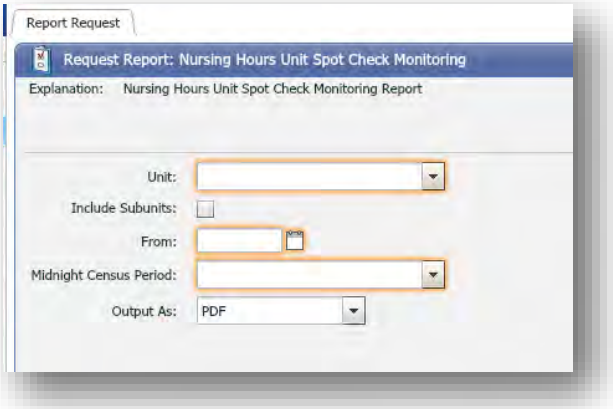
The Nursing Hours Unit Spot Check Monitoring Report shows patient numbers, 'special' duties, staff hours, and CHPPD information.



This report has the following report options:

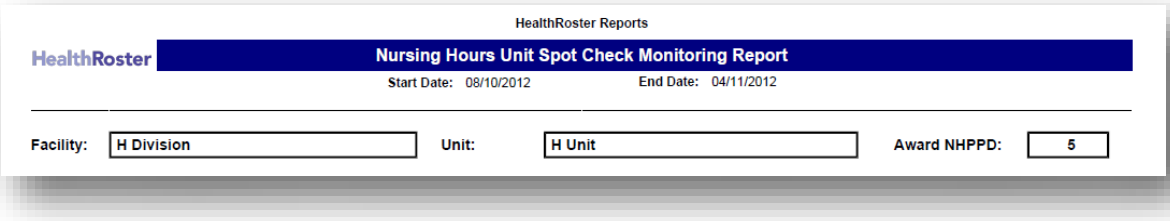
- **Unit**
- **Include Sub Units**
- **From** - The report always shows 4 weeks from this start date
- **Midnight Census Period** - Shows the list of Census Periods applicable to the specified unit, to determine what Census Period to use for this report.

  NOTE: It is expected that units using this report will only have one Census Period.

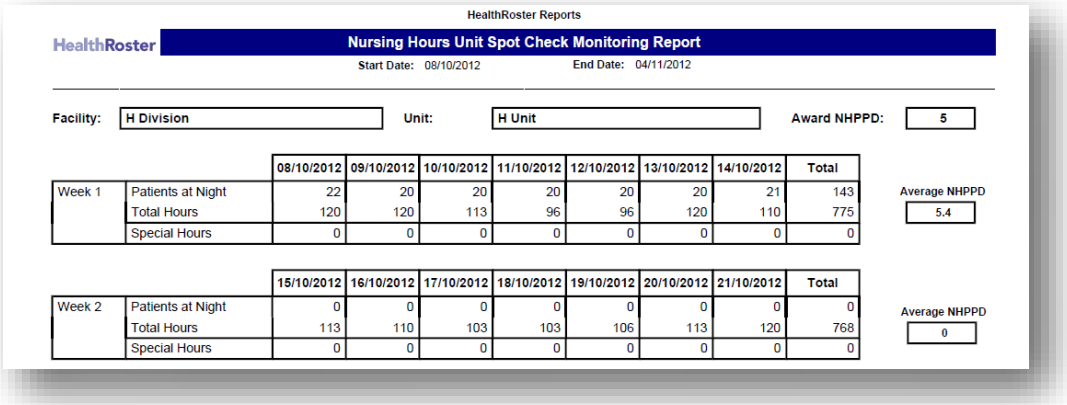


The report is made up of five sections:

- **Report Name –** Shows 'Nursing Hours Ward Spot Check Monitoring Report'.
- **Header-** Showing the Facility (Department Name), Ward Name (unit short title), and the Award CHPPD (Base CHPPD).



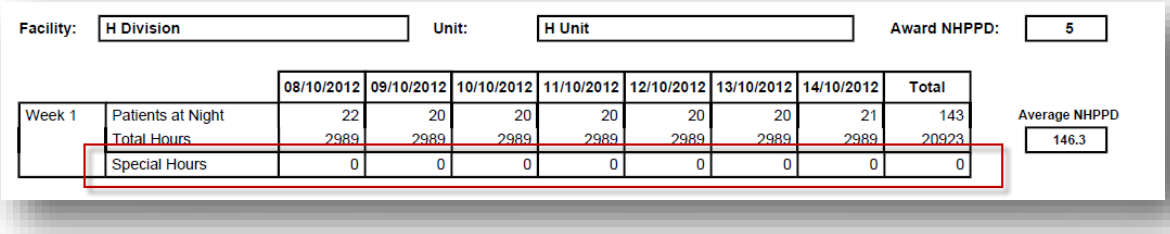
- **Daily Breakdowns** – Showing a 4 week period from the report start date, a table is shown for each week, and displays for each day the 'midnight' patient number, the total rostered hours for all appropriate Grade Types (with 'Assigned ADO' hours excluded). Hours included are determined from the duty's Grade Type requirement only if the 'Include in CHPPD' flag is set. A total is shown for each week, along with a weekly Average CHPPD (total hours/total patients).



		08/10/2012	09/10/2012	10/10/2012	11/10/2012	12/10/2012	13/10/2012	14/10/2012	Total	
Week 1	Patients at Night	22	20	20	20	20	20	21	143	Average NHPPD
	Total Hours	120	120	113	96	96	120	110	775	5.4
	Special Hours	0	0	0	0	0	0	0	0	

		15/10/2012	16/10/2012	17/10/2012	18/10/2012	19/10/2012	20/10/2012	21/10/2012	Total	
Week 2	Patients at Night	0	0	0	0	0	0	0	0	Average NHPPD
	Total Hours	113	110	103	103	106	113	120	768	0
	Special Hours	0	0	0	0	0	0	0	0	

- **Special Hours -** Shows the amount of hours assigned to duties marked as 'special' (CHPPD impacting duties only, as per the flag on the Grade Type). These hours are already included in the total, this is just highlighting those hours.

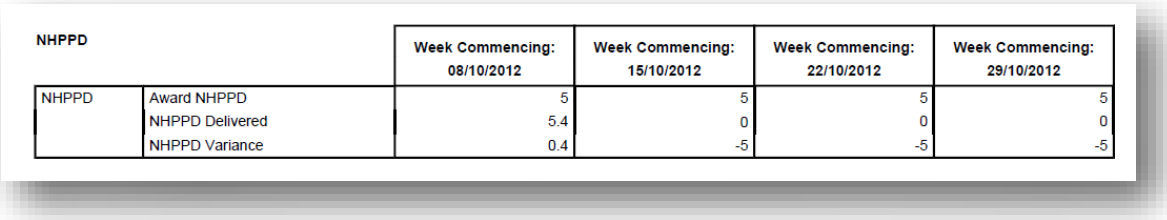


Facility: H Division Unit: H Unit Award NHPPD: 5

		08/10/2012	09/10/2012	10/10/2012	11/10/2012	12/10/2012	13/10/2012	14/10/2012	Total
Week 1	Patients at Night	22	20	20	20	20	20	21	143
	Total Hours	2989	2989	2989	2989	2989	2989	2989	20923
	Special Hours	0	0	0	0	0	0	0	0

Average NHPPD: 146.3

- **CHPPD section** – Shows for each week, over a 4 week period from the report start date, the Award CHPPD (base CHPPD value) which is static, the CHPPD Delivered and the CHPPD Variance



NHPPD

		Week Commencing: 08/10/2012	Week Commencing: 15/10/2012	Week Commencing: 22/10/2012	Week Commencing: 29/10/2012
NHPPD	Award NHPPD	5	5	5	5
	NHPPD Delivered	5.4	0	0	0
	NHPPD Variance	0.4	-5	-5	-5

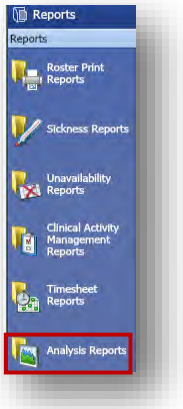
- **Year to Date Graph -** Shows the bar for the actual CHPPD Delivered for each week, starting at the Financial Year Start date, for 52 weeks. The actual value, to 1 decimal place is shown above the bar. A line is drawn to display the Award (Base) CHPPD

- **Hours section** – Shows for each week, over a 4 week period from the report start date and shows:
  - The **Total Hours Required** - the sum of the Night patient numbers for the week x Award CHPPD
  - The **Actual Hours** are the rostered hours for all appropriate Grade Types
  - The **Variance in Hours** is the Actual Hours minus Total Required Hours

Hours		Week Commencing: 08/10/2012	Week Commencing: 15/10/2012	Week Commencing: 22/10/2012	Week Commencing: 29/10/2012
Hours	Total Hours Required	715	0	0	0
	Actual Hours	775	768	751	731
	Variance in Hours	60	768	751	731

5.11 REQUIRED VS ACTUAL REPORT

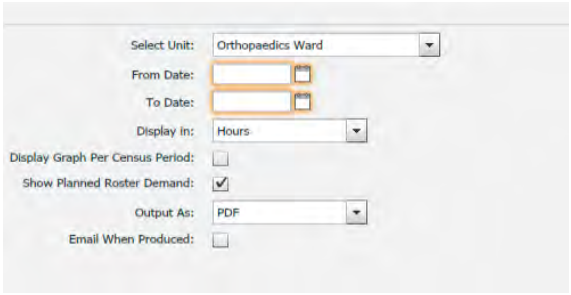
The Required vs Actual Report provides a comparison of Required and Actual CHPPD or hours each day over a specified time period. It also displays a breakdown of Actual Hours/CHPPD by Substantive, Bank and Agency.



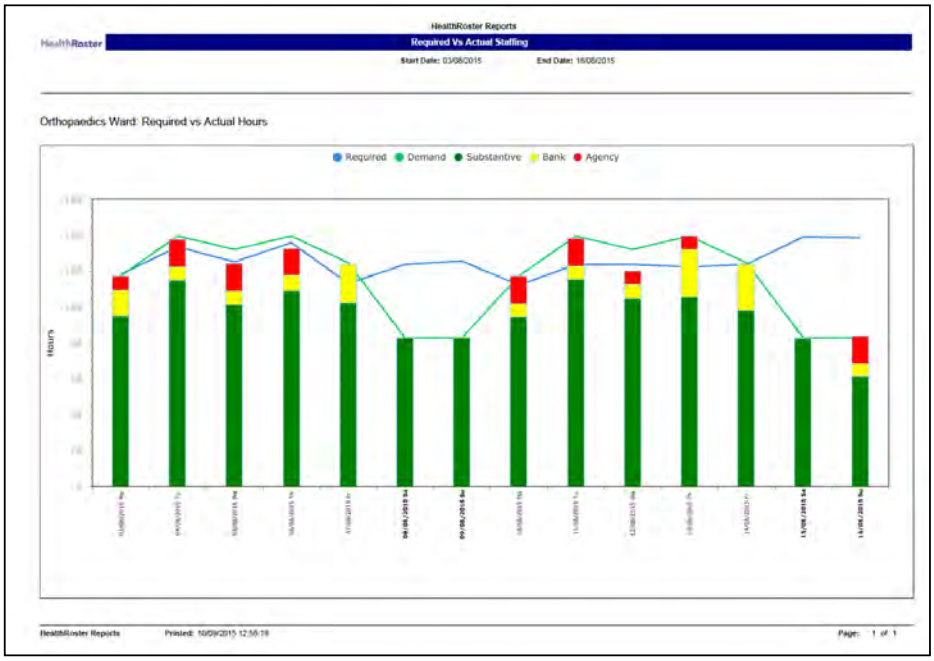
This report has the following options:

- **Unit**
- **From** and **To Date**: Specify the time period for which you wish to run the report
- **Display In:** Choose from Hours or CHPPD
- **Display Graph per census Period:** Tick to run the report by census rather than by day
- **Display Planned Roster Demand:** Tick to also display Planned demand, as set in the unit's roster template
- **Output As:** Choose output format
- **Email when Produced:** Tick to email current user when report is complete

NOTE: An email will only be sent if an email address is set for the current user account



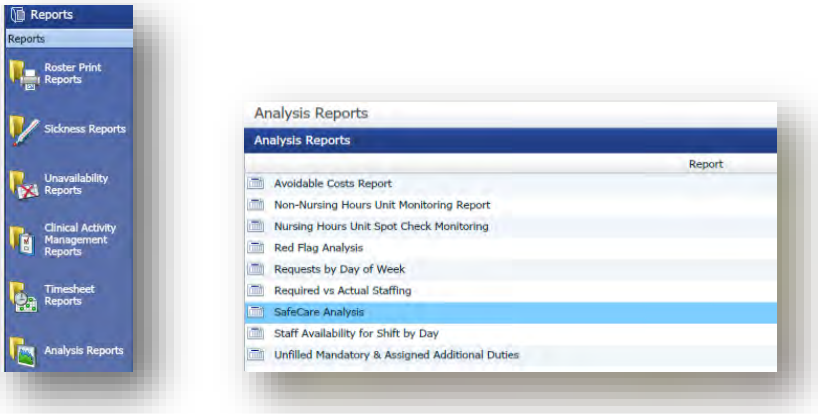
The Following Report will be produced:



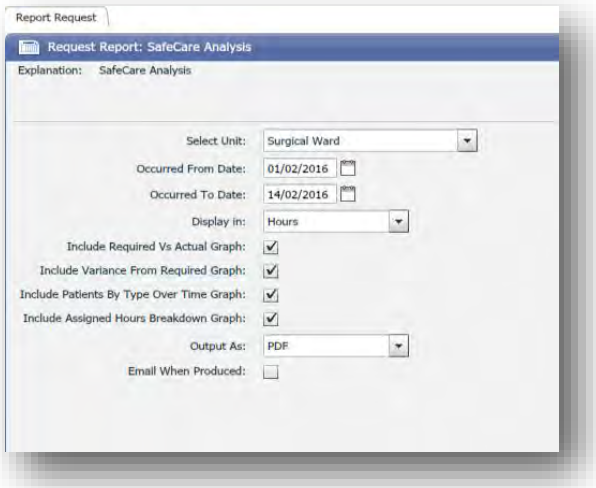
- The blue line represents required demand based on SafeCare calculations
- The green line represents planned roster demand
- The coloured bars represent actuals broken down by:
  - Green: Substantive staff
  - Yellow: Bank/NHSp Staff
  - Red: Agency Staff

5.12 SafeCare Analysis

SafeCare Analysis gives an overview of SafeCare data over time, for a given unit, within a specified date range.



- **Unit**
- **From** and **To Date**: Specify the time period for which you wish to run the report
- **Display In:** Choose from Hours or CHPPD
- **Include Required Vs Actual Graph:** Tick to include this graph on the report
- **Include Variance from Required Graph:** Tick to include this graph on the report
- **Include Patients By Type over Time Graph:** Tick to include this graph on the report
- **Include Assigned Hours Breakdown Graph:** Tick to include this graph on the report
- **Output As:** Choose output format
- **Email when Produced:** Tick to email current user when report is complete



The resulting report is a copy of the SafeCare Analysis report found in section 5.3. Please refer to section 5.3 for further detail.

5.13 Other Related Reports

Other reports related to but not affected by SafeCare data include the Assignment Summary Report and the Unify Report. These can be found by navigating to **Rostering > Assigned Hours**. Please refer to your HealthRoster User Guide for more information.

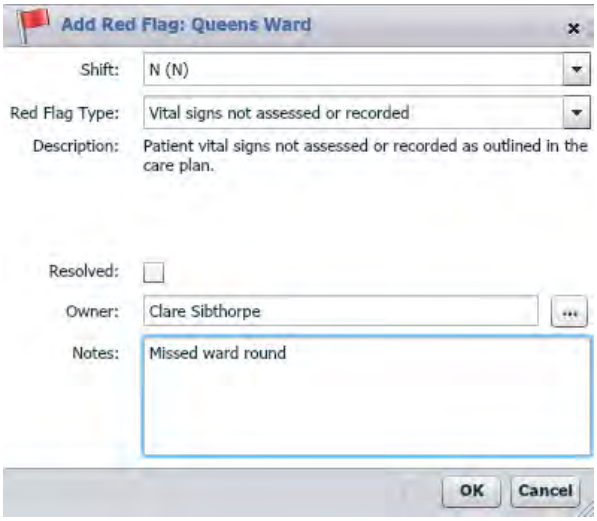
6 Red Flags

NICE Safe Staffing Guidelines released in July 2014 recommended that certain 'red flag' events are recorded if they occur and reported to the Board. The red flags feature has been added to SafeCare in line with this recommendation.

6.1 Raising a Red Flag in HealthRoster

Red Flags can be recorded in HealthRoster by right-clicking on the shift on which the red flag has occurred and selecting the new option 'Add Red Flag'.

This brings up the pop-up box below:



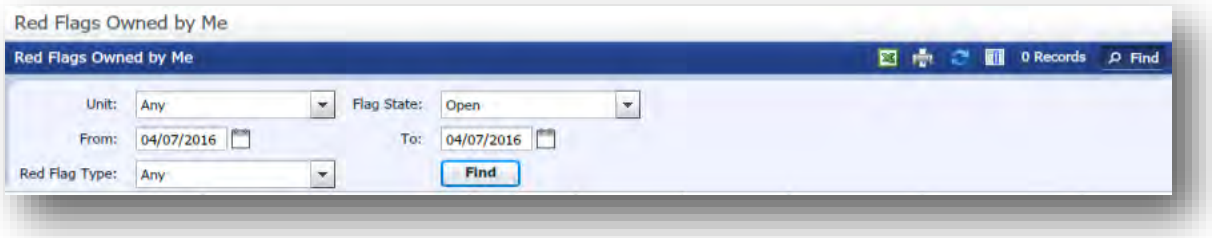
- **Shift:** Denotes the shift on which the red flag event occurred
- **Red Flag Type:** Selected from a drop-down list, this is the type of event that ahs occurred
- **Description:** Explains the meaning of the red flag type and when it should be used
- **Resolved Tickbox:** Should be ticked before saving if the issue requires no further action
- **Owner:** The person responsible for taking action. Defaults to the person 'In Charge'
- **Notes:** A free text box for explaining action so far. Recorded in a conversational format

Click 'OK to save and the red flag will then become visible on red flag management screens and reports.

6.2 MANAGING RED FLAGS I: RED FLAGS OWNED BY ME

Users can monitor and update red flags for which they have been set as the owner using the 'Red Flags owned By Me' tool: SafeCare > Red Flags > Red Flags Owned By Me.

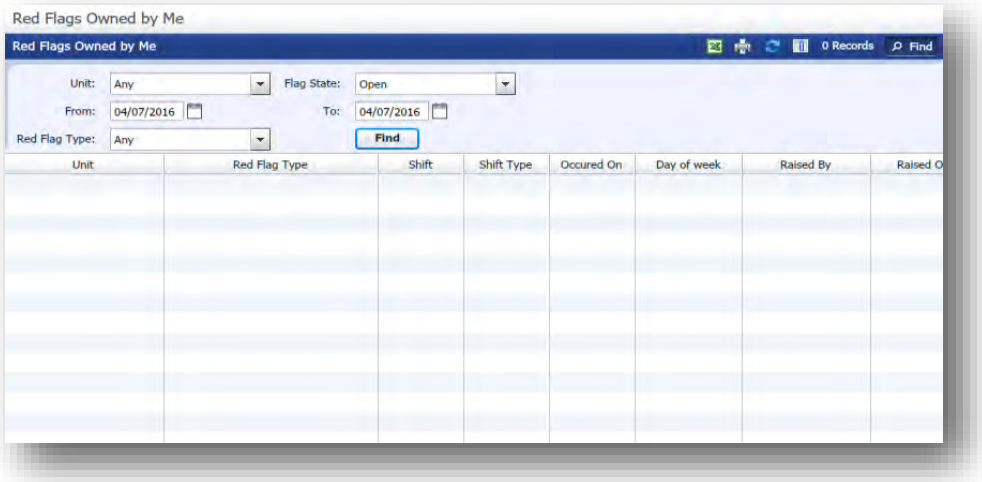
NOTE: This report was known as 'My Red Flags' prior to Version 10.5.2.



This screen has multiple filters that can be applied to this search:

- Unit: Allows selection of any units user has access rights to
- Flag State: Can be set as 'Any', 'Open', 'Resolved' or 'Raised in Error'
- From and To: The dates between which the system will search for red flags assigned to the user
- Red Flag Type: A single red flag type can be selected form those active in reference data

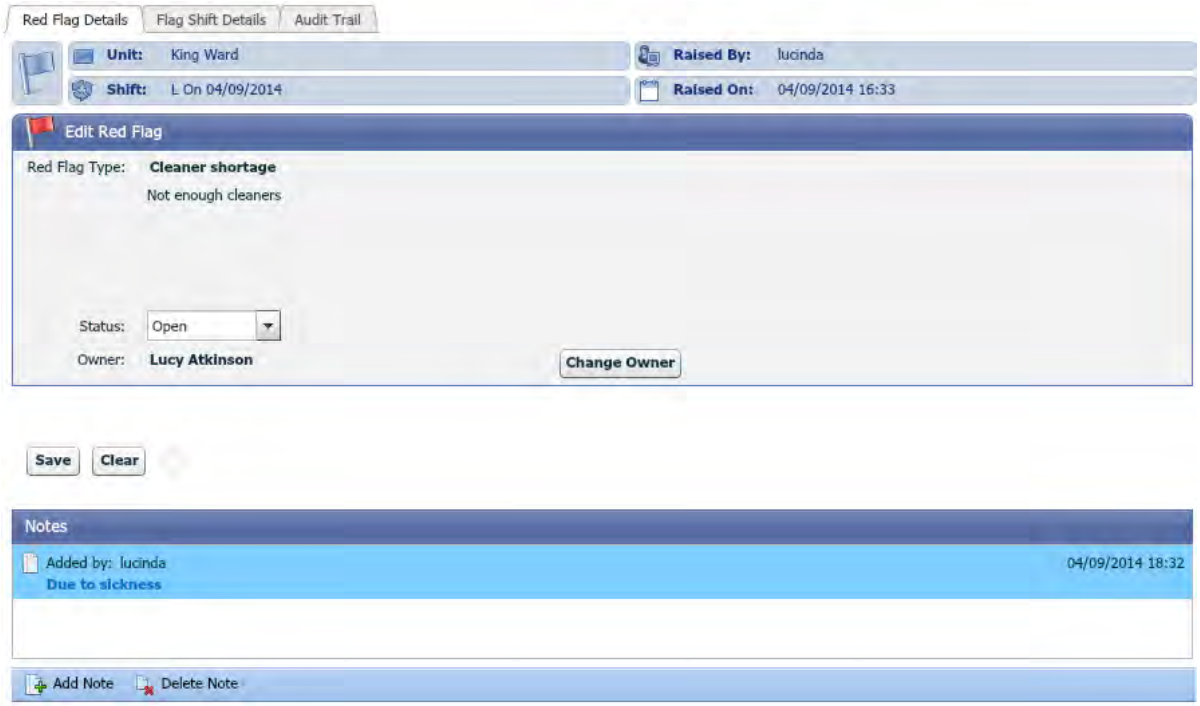
The results are shown in a series of columns:



- **Unit**
- **Red Flag type**

- **Shift**
- **Shift type**
- **Occurred On**: The date of the duty on which the red flag was raised
- **Day of the week**: The day of the week on which the duty occurred
- **Raised by:** The user who raised the red flag
- **Raised on**: The date on which the flag was raised
- **Status**: Can be 'Open', 'Resolved' or 'Raised in Error'
- **Owner**: The assigned owner of the red flag

To edit/amend a red flag, select it from the search results and the 'Red Flag Details' pane will appear on the right-hand side of the screen:



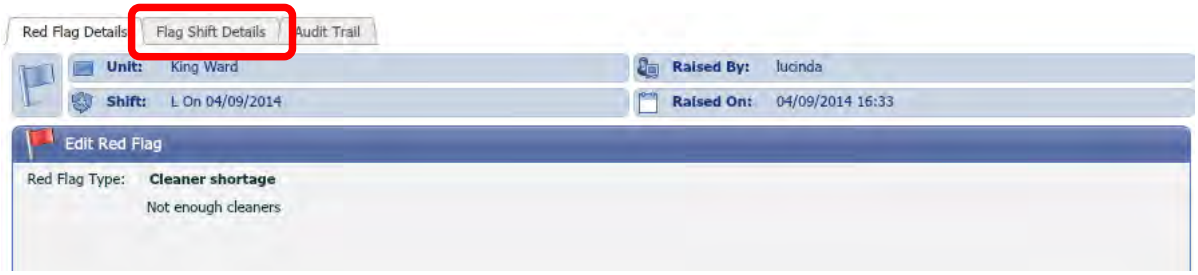
This gives further red flag details and also allows the user to edit the red flag Status and Owner. If these are changed, the user must press the 'Save' button in the middle of this pane for changes to take effect.

Red Flag Status can be:

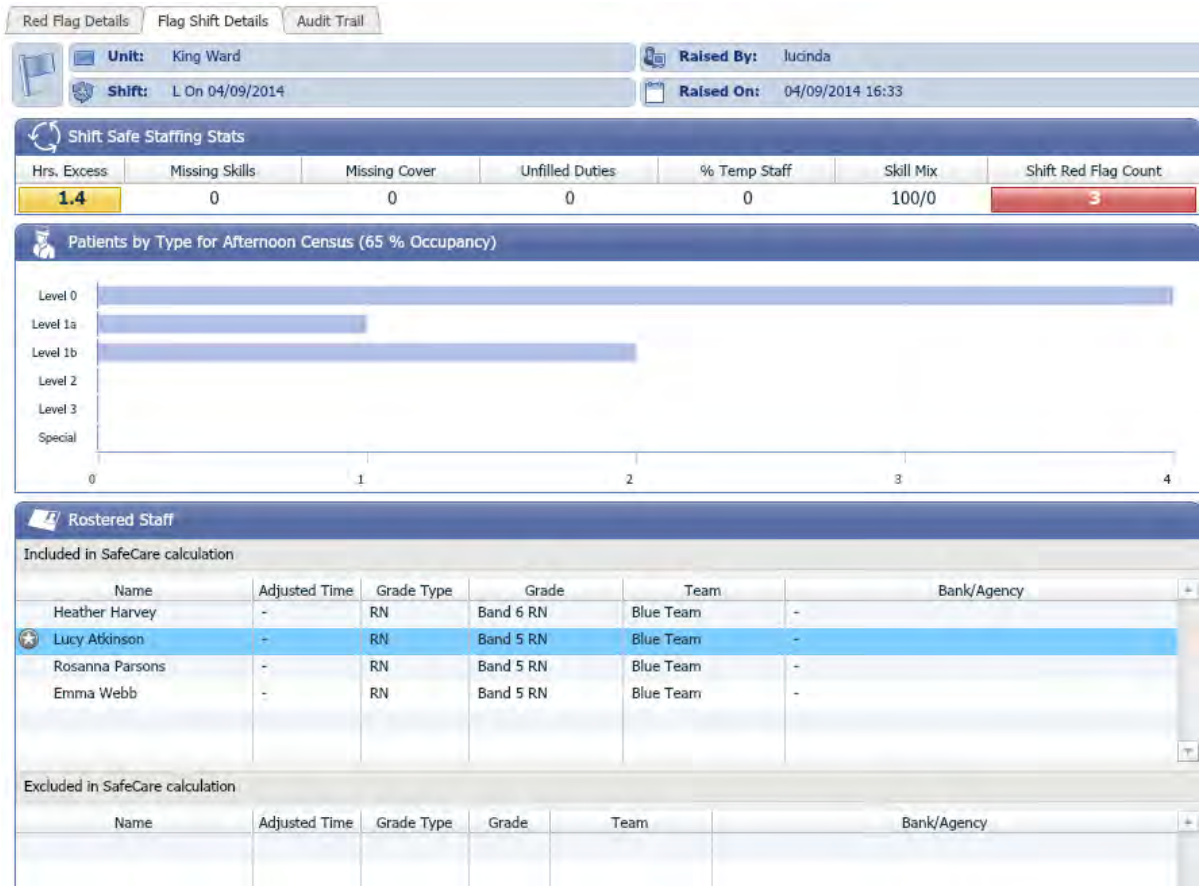
- Open – Action required to resolve
- Resolved – No further action needed
- Raised in Error – Red flag was mistakenly recorded. Changing the status to 'raised in error' will remove the flag from reports.

Users can also read, add and delete notes on the red flag which appear in conversational format towards the bottom of the details pane.

Further Details about the shift on which the red flag has occurred can be found in the 'Flag Shift Details' tab:



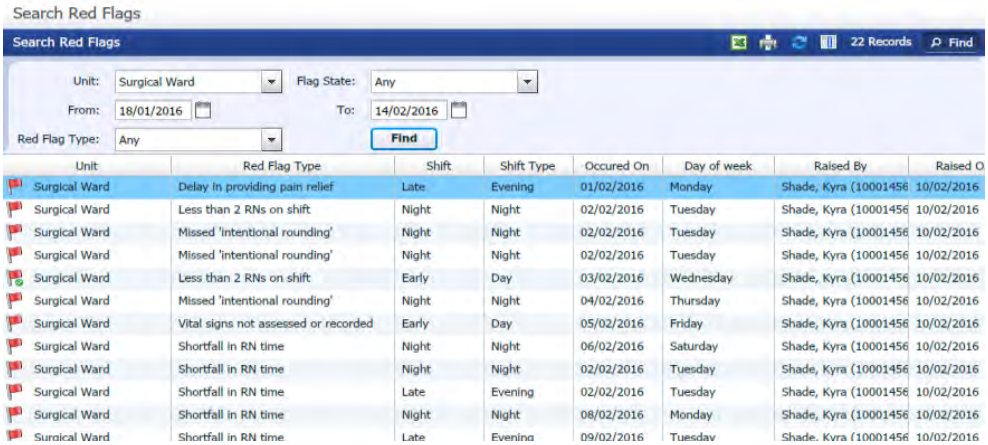
This screen gives a breakdown of Patient census outputs, a patient types bar chart and rostered staffing divided by those Included and Excluded from the SafeCare calculations.



Finally, the Audit Trail tab gives a history of all activity on the red flag since its creation including who made the change and when it was made:

6.3 MANAGING RED FLAGS II: SEARCH RED FLAGS

Users can also be given access to Search all red flags. The screen, search filters and additional information tabs are the same as for the 'My red flags' screens except the search will return all red flags in units the user has access to regardless of the owner. This access is primarily for use by clinical management to give an overview of red flag events in a ward, area or division.



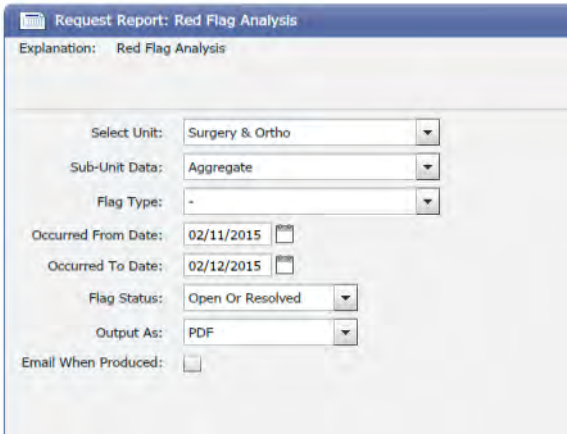
6.4 RED FLAG REPORTING

The Red Flags report can be found via Reports > Analysis Reports > Red Flags Analysis

There are several filters available when running this report:

- Unit: A single ward/unit or a structural unit (department/division/hospital) can be selected
- Sub-Unit Data: If a structural Unit is selected, an additional option is given to either Aggregate data for the unit or report for each ward separately

- Flag type – Defaults to ‘Any’
- Occurred On Start Date / End Date (defaults to the last month)
- Status - Defaults to Open or Resolved, but can be set to Open only, Resolved only - Raised in error is always ignored.
- Output – Can be excel, word or pdf



This report produces a series of graphics that cannot be manipulated but can be saved and/or copied:

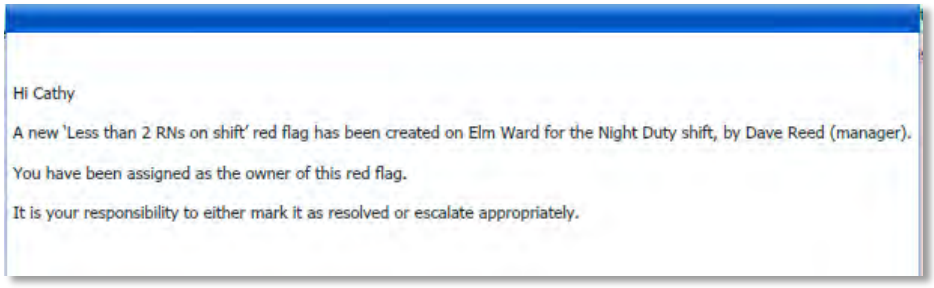
- **Total Flags over Time:** Line graph showing total flags on a week by week basis over the report time period
- **Flags By Type:** Bar chart showing total flags of each type during the report time period
- **Total Flags by Day of the week:** Bar chart showing total flags by day of the week
- **Flags by Shift Type:** Pie chart showing total red flags by shift type

6.5 RED FLAG NOTIFICATIONS

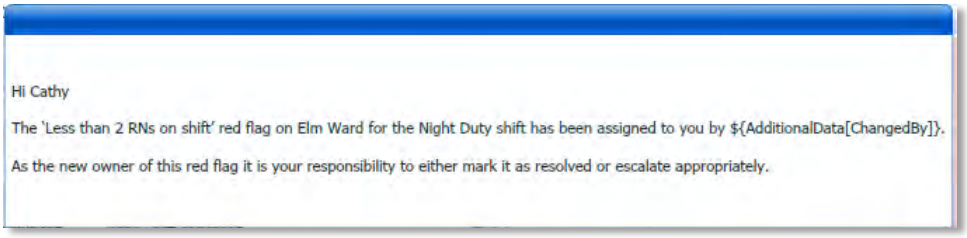
There are two notifications available for Red Flags. These are disabled by default.

FlagCreatedToOwner	Flag Created	Owner	Yes	Flag Event	NewRedFlagNotification
FlagUpdatedToOwner	Flag Updated	Owner	Yes	Flag Event	ChangeOwnerRedFlagNotification

- **FlagCreatedToOwner**: Send a notification to the set owner of a red flag when one is raised



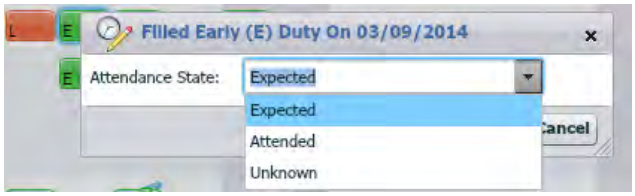
- **FlagUpdatedToOwner**: Send a notification to the new owner of a red flag when the Owner is amended



7 Attendance

The Attendance feature allows real-time tracking of whether expected staffing for the day attend their shifts in the form of a register. It also allows actual staffing rather than expected staffing to be used in SafeCare calculations providing a more accurate forecast of unit safety.

7.1 Marking Attendance



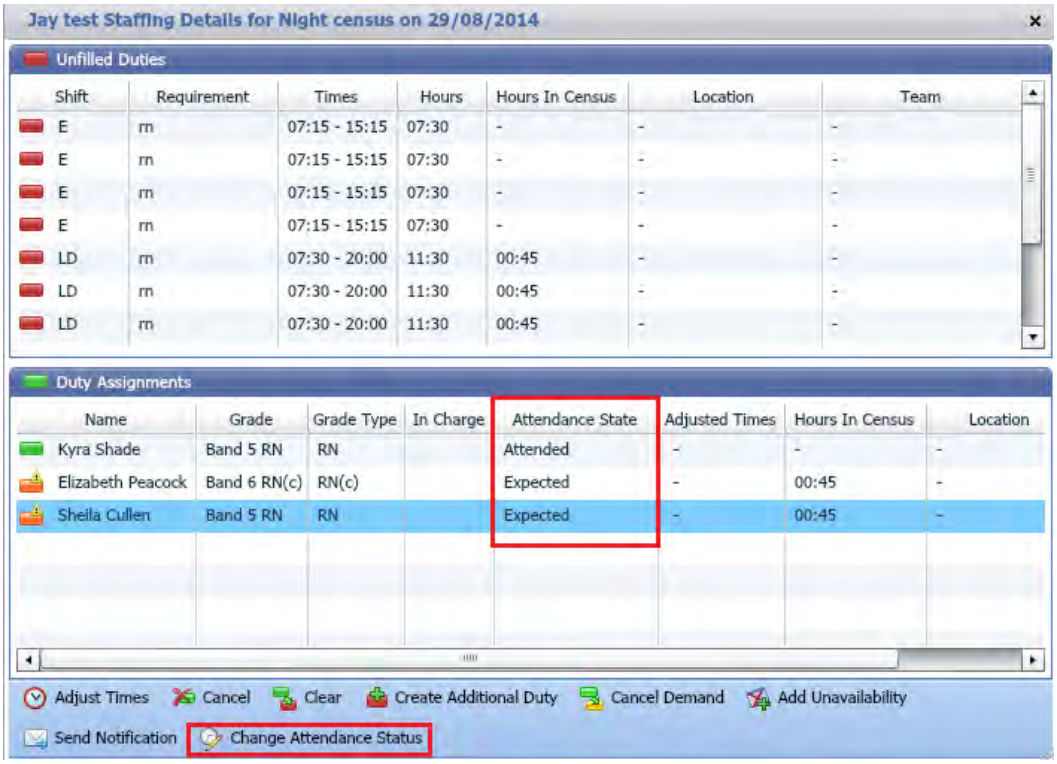
There are 3 possible attendance states a member of staff can be allocated:

- Expected: The default Attendance state, included in SafeCare calculations
- Attended: Selected when a member of staff has arrived, included in SafeCare calculations
- Unknown: Selected when a member of staff is expected for a shift but has not arrived at the start of their shift, not included in SafeCare calculations

NOTE: Shifts with Unknown Attendance status also cannot be finalised. This reduced the possibility of shifts being mistakenly finalised that were not worked, thus reducing risk of overpayments.

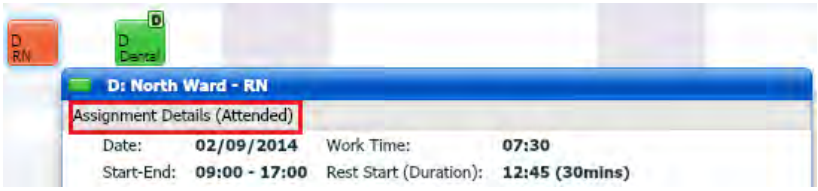
Attendance marking in the Roster can be found by right-clicking on the appropriate shift and selecting 'Update Attendance State'. To amend a member of staff's attendance status, the appropriate status should be selected from the drop-down and then Click 'OK'.

Attendance Marking in SafeCare can be found by clicking on the staff utilisation output to bring up the drill-down screen.

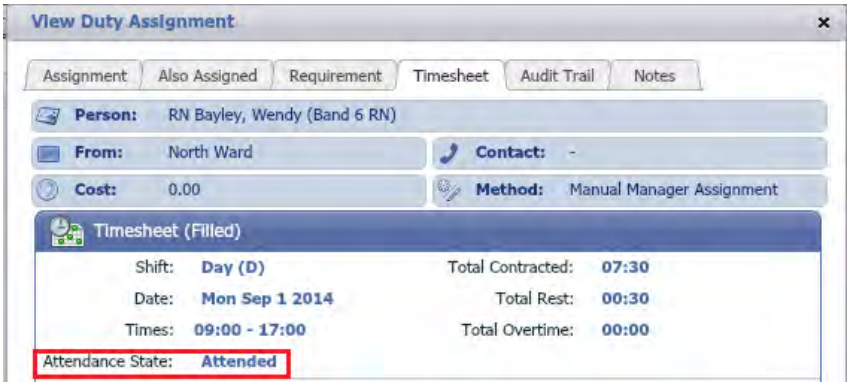


The current attendance state for each member of staff with shift time counting in that census period is shown in the 'Attendance State' column highlighted above. Attendance states can be amended by clicking on the 'Change Attendance State' button towards the bottom left of the drill-down screen and choosing the appropriate state from the drop-down as described above.

Once Attendance State has been changed to 'Attended' or 'Unknown' this will become visible in the tool tips pane when hovering over the appropriate shift on the roster for that member of staff.



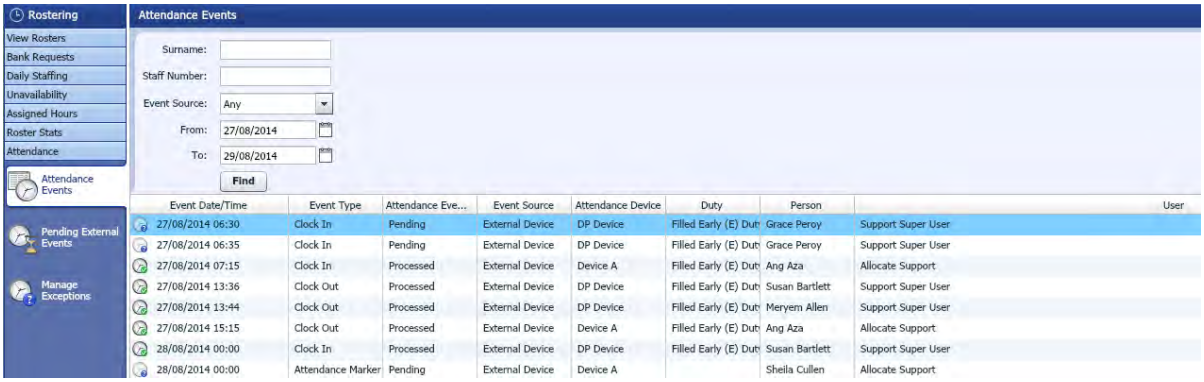
Attendance Status is also visible in the 'View Duty Assignment' screen under the 'Timesheet' and 'Audit Trail' tabs:



7.2 ATTENDANCE EVENTS

All Attendance Events can be viewed via: Rostering > Attendance > Attendance Events. The report produced can be filtered by:

- **Surname:** Attendance events for a specific member of staff by surname
- **Staff Number:** Attendance events for a specific member of staff by staff number
- **Event Source:** Useful if attendance states are also changed by e.g. timeclock
- **From and To Dates:** The timeframe within which you wish to search

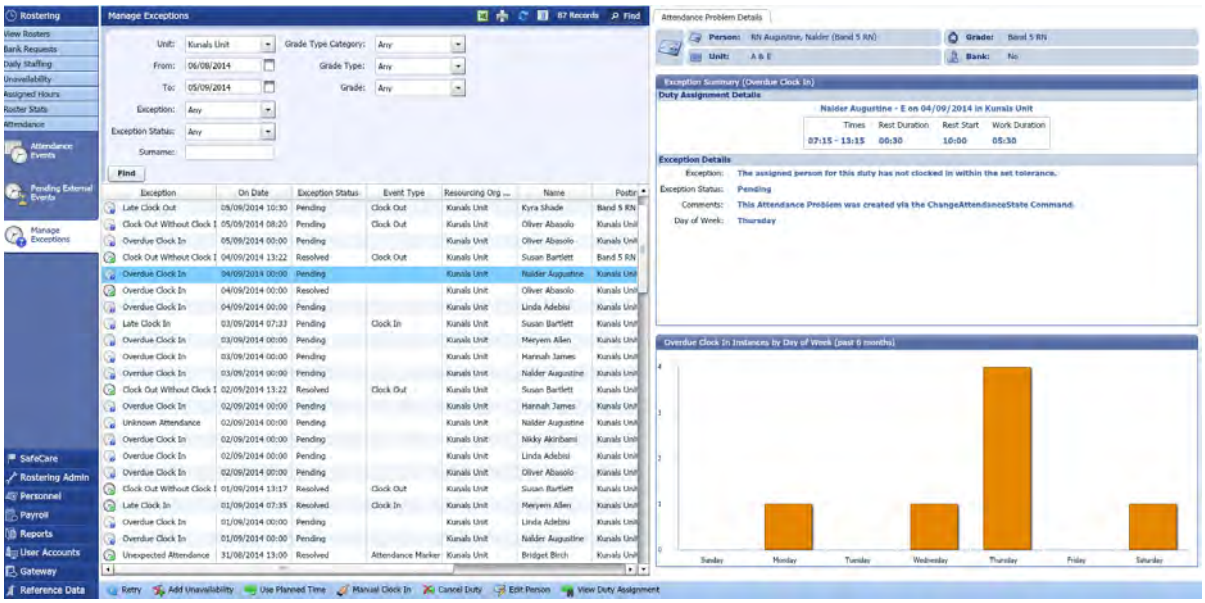


7.3 MANAGING EXCEPTIONS

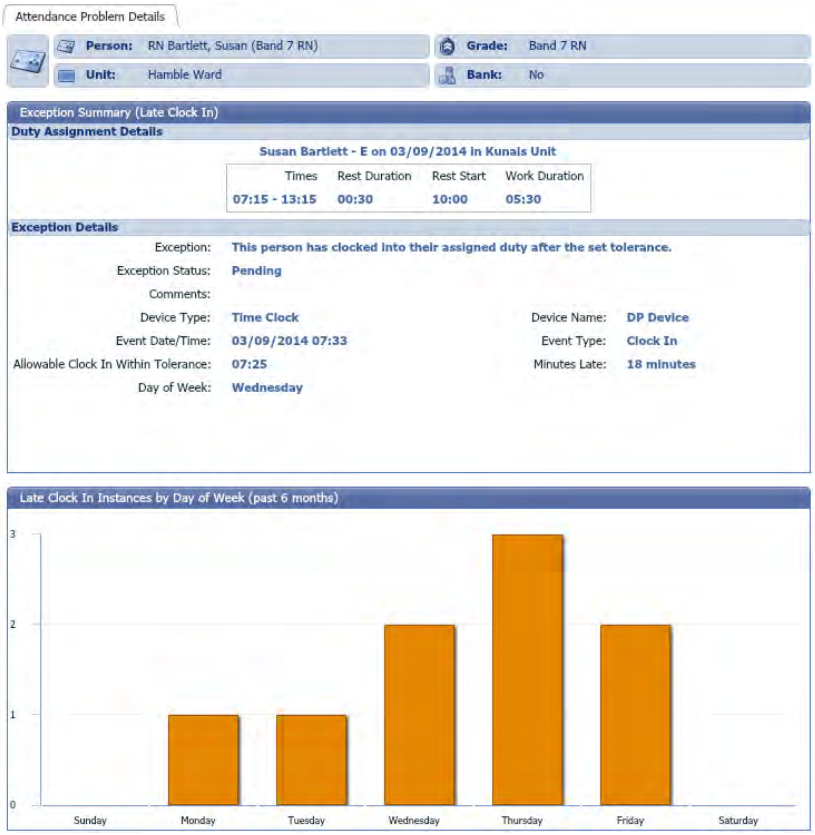
If a member of staff's attendance state becomes 'Unknown' then an exception is produced. These can be viewed via Rostering > Attendance > Manage Exceptions

The following filters can be applied to this report:

- **Unit:** View exceptions of a specific visible unit
- **From and To Dates:** Set the timeframe within which you wish to view exceptions
- **Exception:** Filter by exception type
- **Exception Status:** There are 3 possible exception states:
  - **Pending** – Awaiting action
  - **Resolved** – Exception closed and no further action required. Ensures finalisation can be completed
- **Surname:** View exceptions for a specific member of staff
- **Grade Type Category:** View exceptions for a specific grade type category e.g. 'Registered'
- **Grade Type:** View exceptions for a specific grade type e.g. 'RN'
- **Grade:** View exceptions for a specific Grade e.g. 'Band 5'



Once an exception has been selected, the details pane on the right hand side of the screen shows further information about the exception:



Exceptions can be resolved by one of three actions:

- **Change the Attendance Status** – The duty assignment can be updated to 'Expected' or 'Attended', thus resolving the exception. Once updated to expected or attended, the member of staff will once again count in the SafeCare calculations.
- **Add Unavailability** – if the staff member has e.g. called in sick, recording this appropriately on HealthRoster will cancel the shift and resolve the exception.
- **Cancel Duty** – If the manager decides the duty is no longer required, they can cancel it, thus resolving the exception

Once resolved, the 'Comments' section of the Exception details pane will display further information about the resolution:

Change Control History

Issue No	Issue Date	Description	Document Authorisation		
			Author	Reviewer(s)	Approver
ALL1.0	April 2014		Mara D'Mello		
ALL2.0	November 2014	Reviewed – minor cosmetic changes	Mara D'Mello	Penny Rivers	Penny Rivers
ALL3.0	November 2014	Addition of new 10.4.2 features	Kimberley Stafford		
ALL 4.0	December 2015	Update for 10.5.2 release	Kimberley Stafford		
ALL 5.0	July 2016	Update for 10.6.1	Kimberley Stafford	Jan Pady	

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Belfast Health and Social Care Trust

An Evaluation of SafeCare-Live Pilot

Roisin McMahon E Roster Implementation Manager

Tuesday 19th June 2018

CONTENTS:

Appendices:

Introduction and Background

In 2011 The Belfast Trust procured a rostering solution named Health Roster to assist in maximising and effectively utilising our existing resource. It enables Ward Sisters/Charge Nurses to plan a cost-effective workforce to meet the needs of patients and service users. Health Roster is a demand driven application enabling staffing levels to be set and monitored against a fixed baseline-driven level of demand.

In March 2014 *Delivering Care: Nurse staffing in Northern Ireland* set the strategic direction to create "*a workforce with sufficient nurses, with the right skills, in the right place to ensure the delivery of a compassionate, person centred, safe and effective service*" (E. Poots MLA 2014).

In 2015 Allocate Software Plc, providers of the rostering solution developed an evidenced-based tool named SafeCare-Live. SafeCare live takes into account patient numbers, and their acuity and / or dependency demand, allowing Nurse Managers and Senior Managers to make evidence based decisions on staffing levels using real time information.

The tool is part of Health Roster, which enables day-to-day operational changes to the roster to be made in real time and facilitates the redeployment of staff across wards to avoid under or over staffing.

The aim of SafeCare is to display daily staffing information about the numbers of staff versus the required staff, the types of staff and who is in charge. It provides visibility of staffing levels across wards and departments to assist in maintaining safe and compliant patient care based on patient numbers and acuity. It will highlight daily staffing issues so senior managers can quickly identify whether wards, units and teams are staffed safely and enable early intervention to rectify any deficits.

Following the successful implementation of Health Roster and the benefits realisation work undertaken by the Roster team, along with the recommended strategic direction of *Delivering Care: Nurse Staffing in Northern Ireland,* a decision to purchase SafeCare-Live was made so that an objective approach could be adopted to provide assurances that the right numbers of staff are available to deliver quality person centred care in Belfast.

Prior to the procuring of SafeCare-Live, the Trust did not have a tangible method of measuring or monitoring the acuity and dependency of patients to provide assurances of meeting their demands effectively, efficiently or safely.

Identification of Pilot wards and Baseline Data

In preparation for the implementation of SafeCare-Live to all General, Specialist Medical, and Surgical Adult In-hospital Care Settings, it was agreed that a pilot of four wards in the Royal Victoria Hospital be undertaken to identify a realistic roll out plan and to realise the potential benefits of use of this acuity/dependency tool.

The recommendation was to identify 'champion units' as early adopter wards where we could feasibly redeploy staff between each other. The areas chosen based on their excellent existing knowledge of Health Roster as well as being in similar specialities and close proximity to one another were wards 6B and 6C (Emergency Surgical) and 4E and 4F (Neurology and Neurosurgery) in the RVH.

Identification of Acuity Dependency Tool

The tool we chose to measure acuity dependency was the Safer Nursing Care Tool (SNCT), developed by the Shelford Group. The tool is recognised nationally and has been in use across the UK since 2013. The tool has been validated by Keith Hurst who continues to review and refine the efficacy of the multipliers to include other patient groups. Combining methods to arrive at optimal staffing levels is required so qualitative, quantitative and professional judgements can be applied to increase confidence in the recommended staffing levels.

In May 2013 the Shelford Chief Nurse Group recommended various methods available to calculate staffing requirements. One of these was the use of a Telford exercise. Telford has been used in the BHSC Trust to assess staffing requirement for some time. Whilst this is a useful workforce tool it falls short in highlighting or considering workforce intensity. Telford is a professional judgement model and can be used in conjunction with the SafeCare-Live to consider both the qualitative and quantitative issues that can contribute to fluctuating workforce intensity (Appendix 1 SNCT).

In order to establish what the base 'nursing hours per patient per day' (NHPPD) are consideration had to be given to the multipliers that sit as the base hours within the tool and the software to ensure that the comparative analysis is correct. The amount of whole time equivalents had to be converted into the number of hours, then further converted from per week to per day and finally removed the headroom.
This gave each multiplier within the SNCT NHPPD base care hours according to the dependency level as per each descriptor in the tool.

For the purpose of our pilot wards, the agreed tool with the SNCT used the definition of care levels for Adult In-Patient Wards (Appendix 2). This was a starting guide with encouragement to modify the descriptors to fit within each ward.

Data Collection and Introduction to the Software

With an agreed SNCT and the need to capture fluctuating acuity dependency scores in a 24 hour period, three census times or data collection entry times were identified in conjunction with their shift times or times when a handover of patients in each area would be discussed. The census periods were 30 minutes before and after:

07:30 hours to 08:30 hours
12:00 hours to 13:00 hours
19:30 hours to 20:30 hours

All four wards were asked to score each of their patients, three times a day to highlight if they had too many nursing hours or not enough nursing hours available to safely and effectively meet the demands. This data was collected over several weeks with support provided to understand the tool before considering the analysis of what had been collected.

Each ward was encouraged to identify tasks throughout the day showing the instances staff had to leave the ward possibly depleting the available nursing care hours required to meet the demand. (An example of census collection templates can be found in Appendix 3).

In conjunction with the acuity dependency scores being collected, a Telford exercise was carried out to ensure their funded establishment was aligned to their basic staffing requirements whilst meeting the recommendations of the national Nurse to Bed (NTB) patient ratio standards alongside an adequate and safe skill mix ratio/percentage.

After each ward agreed a state of readiness, all roster templates were aligned to the Telfords, competencies of staff added, shift times adjusted and demand per registered/unregistered staff assigned as per need. The software was then introduced as an addition to Health Roster with continued support on how to enter the data provided over a further few weeks.

Analysis and Interpretation of the Data

All the preparation work to improve understanding of the rosters, the funded establishment and use of the Safer Nursing Care Tool had been undertaken prior to the roll out across the four earlier implementer areas in the RVH. It quickly became apparent that not all areas fully understood how to use the tool.

For example, Ward 6B had no issue adapting to submitting their acuity dependency scores at the census times agreed, however at the outset the data was indicating that the ward had too many nursing hours which would support decisions to redeploy staff as their acuity levels were showing they did not need as many staff during various times of the day. However, the ward sister and her deputies voiced concerns that what the data was saying did not reflect the feeling on the ground.

	Patients	Task Hours	Utilisation	Hours Excess	Hours Short	Required Care	Rostered Care
Early	28	1.5 Hrs	85.5 %	6.5 Hrs		38.0 Hrs	44.5 Hrs
Late	28	2.5 Hrs	156.6 %		23.5 Hrs	65.0 Hrs	41.5 Hrs
Night	28	2.0 Hrs	64.2 %	39.4 Hrs		70.6 Hrs	110.0 Hrs
TOTAL			88.6 %	22.3 Hrs		173.7 Hrs	196.0 Hrs

Key: 90 % Under Utilisation | 105 % Over Utilisation (Amber) | 110 % Over Utilisation (Red)

The table above from 1st August 2016 provides information on ward 6B following collection of the acuity dependency throughout the day. RVH ward 6C can be seen below as a comparison from the same date.

	Patients	Task Hours	Utilisation	Hours Excess	Hours Short	Required Care	Rostered Care
Early	24	4.3 Hrs	96.0 %	1.1 Hrs		27.4 Hrs	28.5 Hrs
Late	25	4.3 Hrs	166.5 %		25.9 Hrs	64.9 Hrs	39.0 Hrs
Night	25	2.0 Hrs	77.6 %	14.7 Hrs		50.8 Hrs	65.5 Hrs
TOTAL			107.6 %		10.1 Hrs	143.1 Hrs	133.0 Hrs

Key: 90 % Under Utilisation | 105 % Over Utilisation (Amber) | 110 % Over Utilisation (Red

The first column highlights the shift types (Early, Late, and Night)

The second column shows the amount of patients throughout the day (28 people)
Task Hours, shows the amount of time when staff have been off the ward in each shift period. For example, there was a total of 1.5 hours during an early shift when staff were not available clinically. The tasks identified were for transfers to imaging or going to pharmacy. The 1.5 hours is deducted from the combined amount of available nursing hours in that early shift.

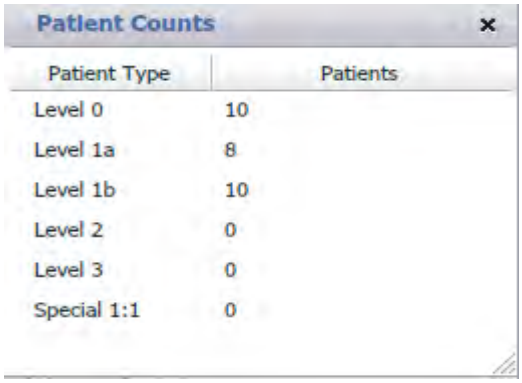
The Utilisation column is showing that they only utilised or needed 85.5% of the available nursing hours according to who was actually rostered and showed up for their shift that morning in comparison to what they actually needed based on the acuity dependency scores they submitted.
The acuity as per the SNCT and the agreed scores for the early shift and input into the software show the following:

Patient Counts

Patient Type	Patients
Level 0	12
Level 1a	4
Level 1b	12
Level 2	0
Level 3	0
Special 1:1	0

The Hours Excess column continues from the utilisation section. In the above case, it is indicating that they have 6.5 hours of available staff that are surplus to requirement according to the acuity. This is where a decision can be made to redeploy a member of staff for 6.5 hours to another ward who are short in nursing hours to help that area become safe or balance the workforce across the site as per patient need.

The next column is showing the hours short, which in the above only applies, to the late shift. The late shift is saying that for 28 patients and a deduction of 2.5 task hours that according to the acuity on the late shift, the ward are now over utilised by 156.6% indicating that they are short in the required amount of nursing hours per patient per day by 23.5 hours. This would how that in that state this ward is considered unsafe and needs staff redeployed to them to help them meet the patient needs.
Below shows the acuity for the late shift where you can see that there has been a change in the condition of the existing 28 people since the early shift showing why they are short in NHPPD.



The next column in the table is showing the required care hours based on the acuity submitted at the varying times of the day.

In the box above, 38 hours in total was needed to safely and effectively meet the needs of the 28 patients in ward 6B. You can see that the acuity dependency is increasing as the day goes on, up to needing 70.6 hours.

Comparing the required amount of nursing hours (above) to what is actually available as per the rostered staff in the last column (see below), that gives the over or under utilisation of the staff. In the night shift circumstance, we know that we need 70.6 hours of staff to be available to meet the acuity of the 28 patients on the ward and we actually have 110 hours available meaning that we are under utilising the current resource. This under-utilisation on that night duty shows there is an excess of 39.4 hours that is not needed. This provides evidence for redeploying the excess staff out of ward 6B into 6C or another similar environment as per skill and competency requirement.

Rostered Care
44.5 Hrs
41.5 Hrs
110.0 Hrs

Hours Excess
6.5 Hrs
39.4 Hrs

The bottom of the original table gives a total over the entire day of how the staff were utilised, the amount of excess hours, required care hours and rostered hours. Overall, it shows that this ward is safe with 88.6% of available staff being under-utilised, giving the excess total hours throughout the day as 22.3 hours, which should be used elsewhere. The ward needs 173.7 nursing hours to meet the demand based on the acuity levels. As per the rostered staff who were required (agreed in the Telford exercise to highlight the base demand), there are 196 available nursing hours.

	Patients	Task Hours	Utilisation	Hours Excess	Hours Short	Required Care	Rostered Care
Early	28	1.5 Hrs	85.5 %	6.5 Hrs		38.0 Hrs	44.5 Hrs
Late	28	2.5 Hrs	156.6 %		23.5 Hrs	65.0 Hrs	41.5 Hrs
Night	28	2.0 Hrs	64.2 %	39.4 Hrs		70.6 Hrs	110.0 Hrs
TOTAL			88.6 %	22.3 Hrs		173.7 Hrs	196.0 Hrs

Key:	90 %	Under Utilisation	105 %	Over Utilisation (Amber)	110 %	Over Utilisation (Red)

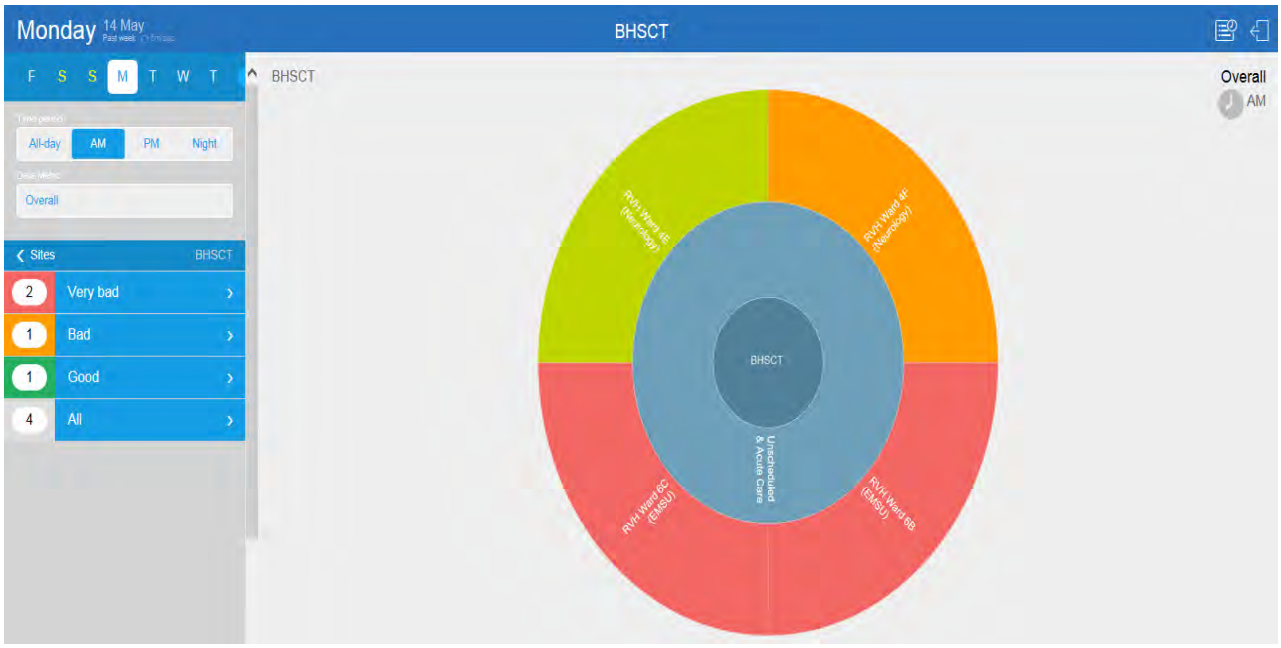
The decision makers in the Trust would have the below view as an example in SafeCare-Live

This sunburst is giving an overall view over the 4-adopter wards today (18th May 2018). Any area that is red indicates that they are unsafe or over-utilised or have a shortage of available of nursing hours.

The areas in orange are breaching the threshold between giving a warning to heading into unsafe territory. Again, this is a shortage of hours according to the acuity of the patients in each ward.

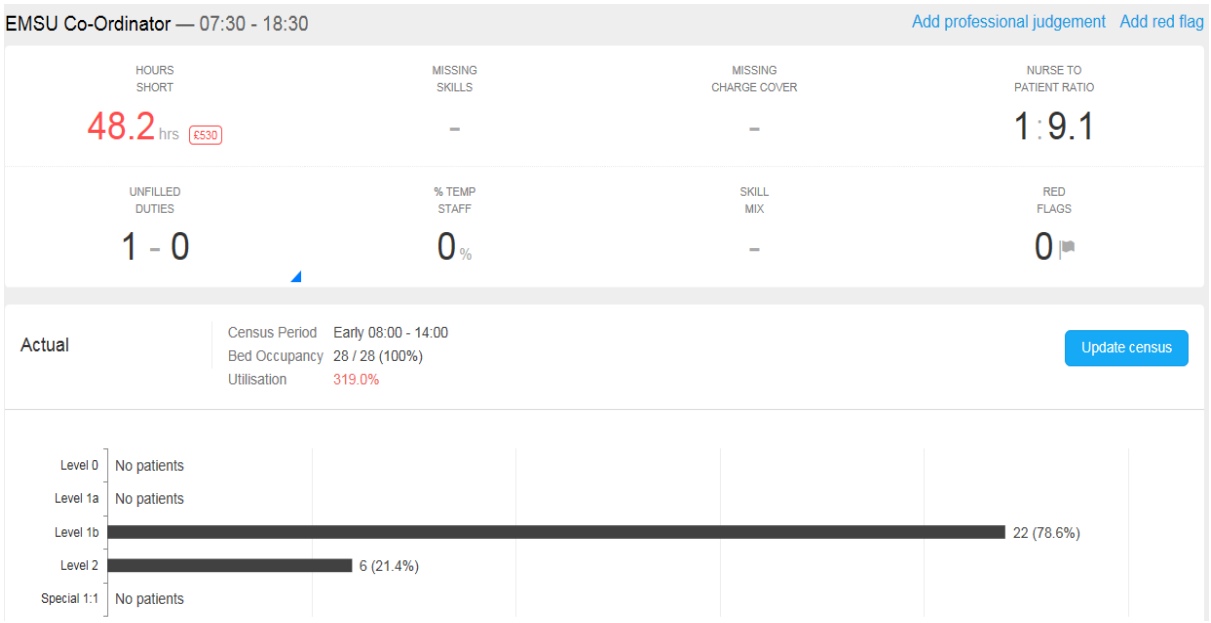
There are also two different shade of green one as seen above which shows they have excess hours, allowing staff to be redeployed to the areas that are in red for example. The other shade of green is duller in colour indicating that they have met the demand exactly as required.

The sunburst can be viewed on an overall basis or by each census period using the key on the left side of the screen (sunburst from Monday 14th May 2018 in the am census period)



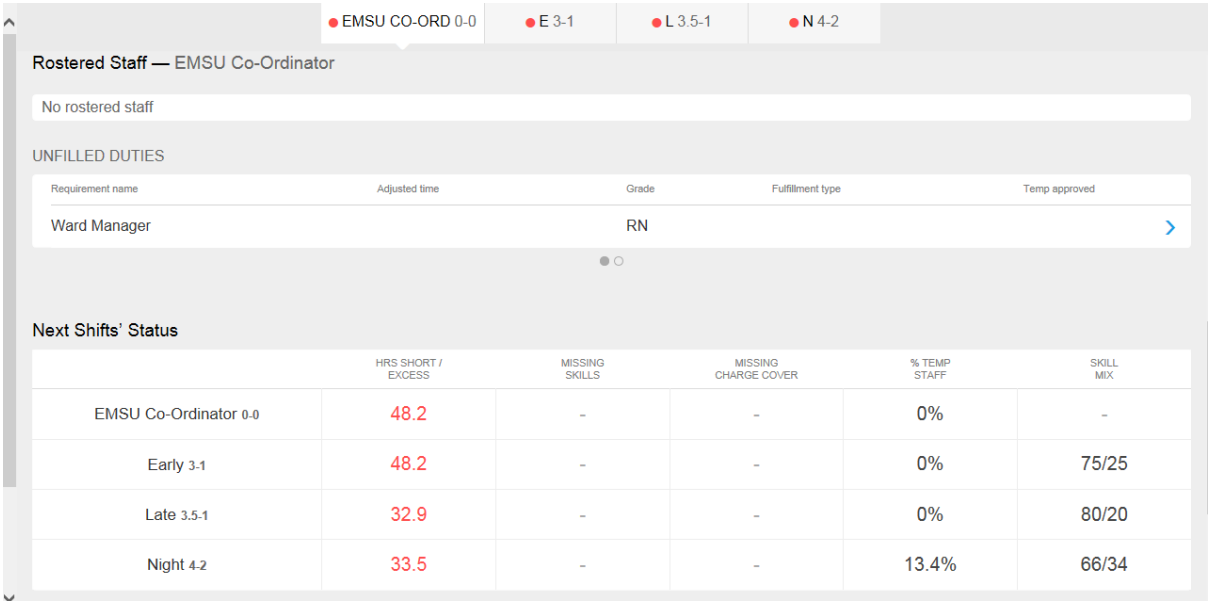
This management dashboard can give you an overall picture of the issues across the Trust in regards to safety and effective utilisation of the staff based on the acuity dependency of the patients.

By clicking into any of coloured areas in the sunburst, it can take you to the following information:



At a glance you can see the shortage on nursing hours, the issues with missing skills, the percentage of temporary staff cover, the amount of unfilled duties, if there is missing charge cover, the nurse to be patient ratio and the acuity dependency rating.

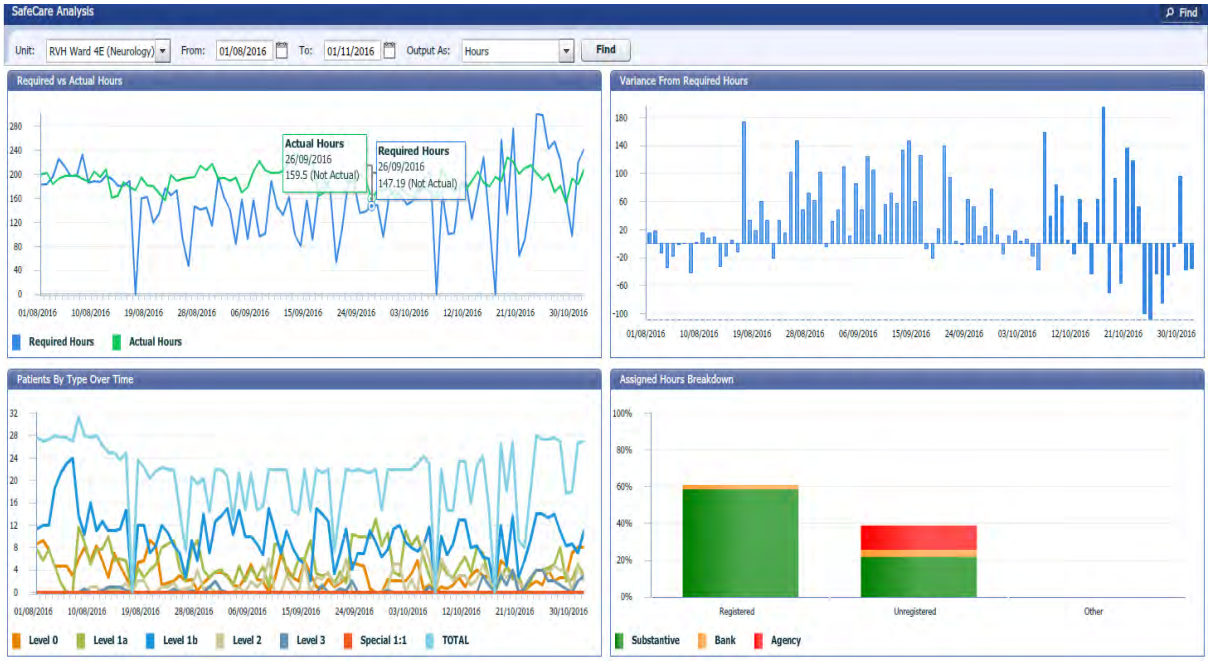
Scrolling further down this page also gives the below information: unfilled shifts and the projected shortage of hours pre census update.



Finally going to the bottom of the same page you can see immediately the unavailability of the staff on that given day.

By clicking on any of the blue triangles below each unavailability brings you into the specific staff details regarding the duration, reason and whom it pertains to.

Comparative Analysis

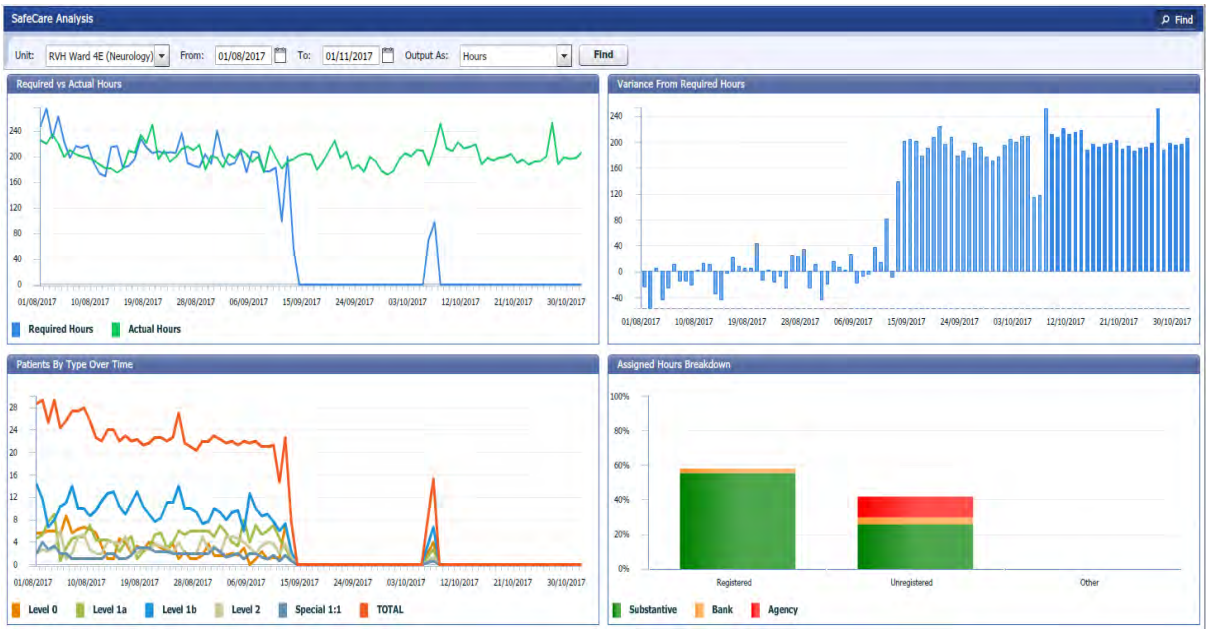


(*Ward 4E August to November 2016*)

The above information is looking at ward 4E during the early implementation phases. The top left hand box is showing a green staggered line that indicates that they had too many nursing hours assigned to what they needed as per their acuity, seen in the box immediately below it. This overall shows that the sister and charge nurse had in fact been scoring their patients based on their rich experience and that it was not reflective on the individual band 5 staffs perception of the same patients.

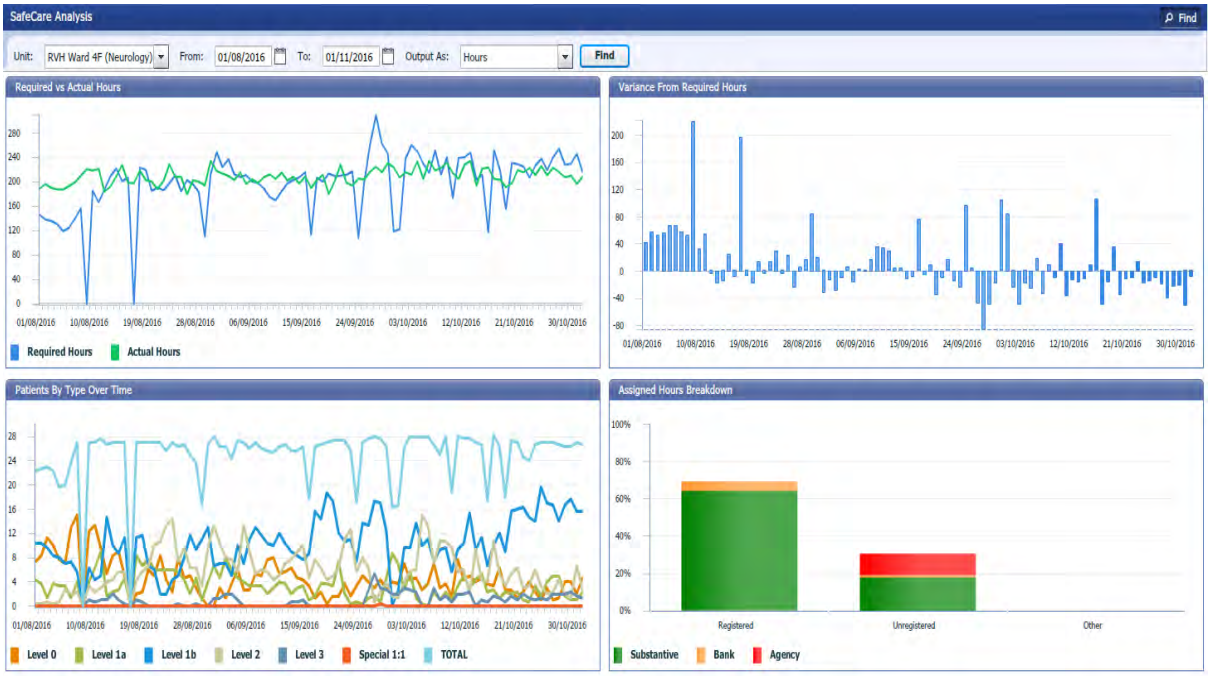
When looking at the same area a year later, as seen here below, the staggered green line is more in keeping with the acuity. It shows the occasions when there is a shortage of nursing hours but the overall indicators highlight that the band 5 staff are scoring their patients and this is giving a real feel for what is happening on the ground.

Something worth noting in the data tables below are that from September 2017 4E and 4F stopped using SafeCare due to a staffing crisis hence the lack of data. The plan is to recommence it in the coming months.



(*Ward 4E August to November 2017*)

RVH Ward 4F in 2016 mirrored 4E's findings in that they had too many nursing hours when the reality was that they were short of nursing hours. This highlights that the use of the tool was not being understood and additional support was required.



(*Ward 4F August to November 2016*)

When comparing the data to one year later, there was a clearer understanding of the tool and the required amount of nursing hours per patient per day is seen to being met on occasion, but mostly there was a fine line between minimal staff shortages and acuity and demand being met. The top right box in the diagram shows the spikes of when there is a shortage of nursing hours (graph below the line). The spikes above the line indicate too many nursing hours per patient per day, which is very evident of when they disengaged with the system and stopped scoring their patients.

Similarly to ward 4E in September 2017, a staffing crisis resulted in disengagement with the system resulting in a lack of data capture.

(*Ward 4F August to November 2017*)

Ward 6B also highlighted that the staff were unsure of the tool and were not using it correctly, as it was showing that they had too many nursing hours giving rise to possible redeployment when the demand was not being met.

(*Ward 6B August to November 2016*)

By August to November the following year you can see that there is a better understanding of the tool and this has now been embedded. Ward 6B struggle to meet the acuity dependency of their patients most days as they appear to be short of nursing hours but there is good use for redeployment of staff between 6B and 6C to rectify any shortfall.

(*Ward 6B August to November 2017*)

Ward 6C had a good understanding of the tool at the beginning and their data showed this, however, the staff still questioned what the information was showing when comparing it to how it actually felt. Below you can see that on most occasions they were running slightly under the required demand with some data not being submitted adding to the peaks and troughs in the graphs.

(*Ward 6C August to November 2016*)

With additional support and further cascading and cross auditing of the scoring, the outcome a year later is more consistent and in keeping with the fluctuating acuity dependency of this area. The evidence now points to not being able to meet the nursing hours per patient per day based on the acuity at this time.

Challenges and Outcomes

The above interpretation in the first year of the data, led to an overall disgruntlement and confusion of the actual outcomes. The software was showing across all four adopter wards that they were in excess of nursing hours and all glowing in bright green on the sunburst. Each manager stated that the system was wrong.

This resulted in a review by the vendor, which in turn compromised the validity of the data. Due to the lack of confidence in the system, disengagement started to occur.

The roster team were not happy with the training they received and were equally unsure about the multipliers, how the information measured up with the Telfords and if the output was in fact right or wrong.

Challenging the nursing teams on each of the wards was difficult for the roster administrators as they are not qualified nurses so understanding each areas complexities and nursing or patient needs resulted in a barrier.

There is one nurse lead in the roster team who was in a position to challenge perceptions.

What we found was that each ward was struggling to categorise their patients requiring further support.

Additionally individual expertise and perception was causing a subjective influence on the scoring of the patients.

An example of this was when challenging the output of the figures for the software as it showed they had too many nursing hours, it was realised that only the band 7 was scoring the patients and not the actual staff who were responsible for delivering the care. The experience of the band 7 assessed each patient based on her/his own knowledge and skill set instead of considering each individual staff members experience or perception.

When the SNCT was cascaded to the rest of the band 5 team, the utilisation quickly changed and it was giving a true reflection of the shortage of hours.

Teaching the tool and cascading this to all staff has presented its own difficulties within the rostering team and also for the ward staff in regards to time constraints.

The state of readiness for the implementation of SafeCare-Live has also been premature. All areas coming onto the system need to have a Telford exercise carried out in line with the funded establishment, a complete review of the roster, all mandatory training and additional skills added in as per competency to ensure right person, right place, right time, right skill.

There has also been a depleted resource and availability in the rostering team making implementation virtually impossible.

Whilst continued support with the adopter wards has been ongoing, 4F has disengaged and stopped using the software on a temporary basis due to a staffing crisis. They are still under review.

Since procuring the software, Normative-staffing phase one was underway giving priority in a depleted team to stabilising those areas. The positive aspect to this is that it has given the roster team the opportunity to review each of those areas and commence most of the preparatory work needed in anticipation of the implementation of SafeCare-Live.

To date a complete review of Learning Disabilities resource and demand has been reviewed and the SNCT introduced. Data is still being collected and the Nurse Development Leads have supported the staff to score accurately. The expected delivery of software is planned for August 2018.

Simultaneously a review is underway of all Mental Health departments with a plan to implement in September 2018.

The plan moving forward is to introduce the SNCT and commence the data gathering on all the wards on the Royal, City, Musgrave and Mater sites as per the roll out plan in appendix section four.

Recommendations

Before considering further deployment of this software there needs to be additional resource assigned to the E-Rostering team with a review of the SafeCare software from a training needs perspective.

Cascading the safer nursing care tool in advance with assistance of nurse development leads will help to reinforce the scoring of patient acuity.

Telford exercises need to be reviewed or carried out to establish the correct nurse to patient ratio, alignment with budgets and recommended skill mix as per Delivering Care initiatives.

Acuity dependency data collection over at least 30 days of each area needs to occur to confirm if the Telford exercise is correct and that the demand per shift is right.

All scoring needs to be undertaken by the band five staff nurses and audited by the sister or charge nurse to challenge thinking but to also identify additional training needs and support for those staff who perceive the situation to be worse than it actually is.

Rosters need to be properly maintained by sisters and charge nurses with analysis being carried out four weekly by the assistant service managers for accountability and accuracy of information that is reflected in SafeCare.

All training skills need to be manually assigned to individual staff in every ward in health roster by ward support officers. This resource if available will support sisters and charge nurses from an administrative perspective. The aim of SafeCare is to give assurances that we have the right person, in the right place, at the right time, with the right skill to meet the demand.

There needs to be buy in by senior managers to assist in communicating the benefits of this system. Staff need to be aware that there is the possibility of redeployment on a shift-by-shift basis across the affected directorate or department to balance the workforce before considering backfill.

During implementation of SafeCare, E-Rostering needs to still be able to cope with business as usual demands, as this provides assurances of accuracy of data from SafeCare.

With a current resource in the roster team of 5.2 WTE's and the business case to implement to all non 24/7 areas not agreed yet, we can phase the roll out per site and have all works completed by September 2019 providing training needs are met.

Introduction of Safe Care Live into RBHSC

Roisin McMahon

Belfast Health and Social Care Trust

caring supporting improving together

respect & dignity openness & trust leading edge learning & development accountability

What is SafeCare?

- Capture actual patient numbers by acuity and dependency
- See if their staffing levels match the demand.
- Action day-to-day staffing movements
- Inform longer-term resource and establishment plans
- Use the most suitable acuity and dependency model for their needs
- Use different models or multipliers for different wards
- Use reports to identify trends and causes, highlighting changes needed to ensure safe staffing levels.

HSC Belfast Health and Social Care Trust

caring supporting improving together

Safer Nursing Care Tool

- Definition of care levels are considered per dependency level: 1, 1a, 1b, 2 and 3.
- Each dependency level has a description or category of care requirements.
- It is not an exact science and is there to be modified to meet your needs.
- It is a template for you to build upon.

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Safer Nursing Care Tool

Patient Type	Multiplier	Patient Description	Base NHPPD	Nursing Hours per patient per day (24hrs)
Dep. 0	1.92	Requires Hospitalisation	4.39	8.43 hours per day
Dep. 1a	2.35	Potential to Deteriorate	4.39	10.32 hours per day
Dep. 1b	2.40	Dependent on Nursing Care intervention	4.39	10.54 hours per day
Dep. 2	2.62	Close Observation required	4.39	11.50 hours per day
Dep. 3	5.96	Unstable. Requires advanced support	4.39	26.16 hours per day

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Safer Nursing Care Tool

- Speciality specific multipliers for Children's and Young Person's wards were validated by Keith Hurst an independent researcher.
- To help make an informed decision of the multipliers to be used for SafeCare calculations.
- This information should be used by clinical staff and should be tested against professional judgement.

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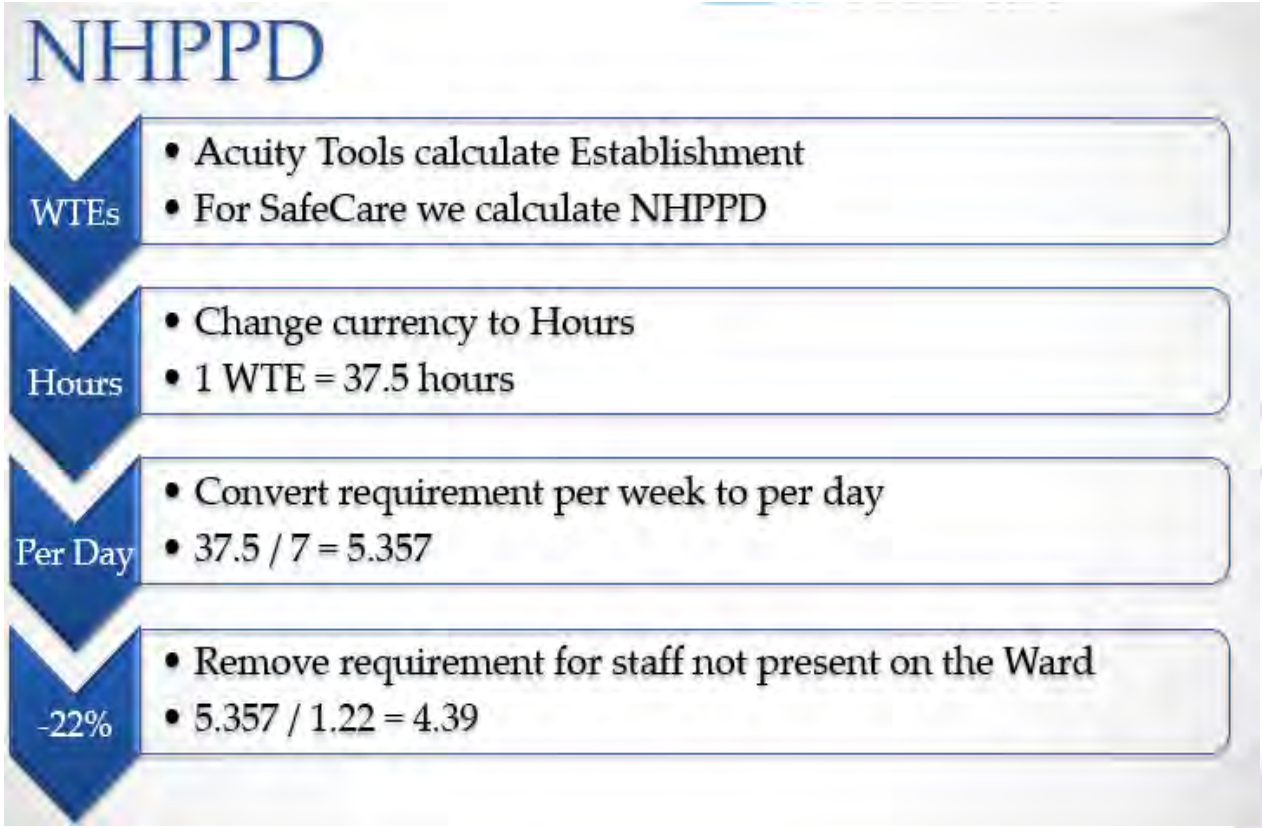

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Process Overview

- Three times a day a census is conducted
- Clinical staff on the Ward classify the patients on the ward and enter this data onto SafeCare
- SafeCare calculates the number of nursing hours required to care for the patients in the coming census period/shift
- SafeCare compares this to the number of Nursing hours available
- This is represented by the Staff Utilisation figure
- Staff can then make informed decisions on staffing and action some changes through SafeCare e.g. redeployments

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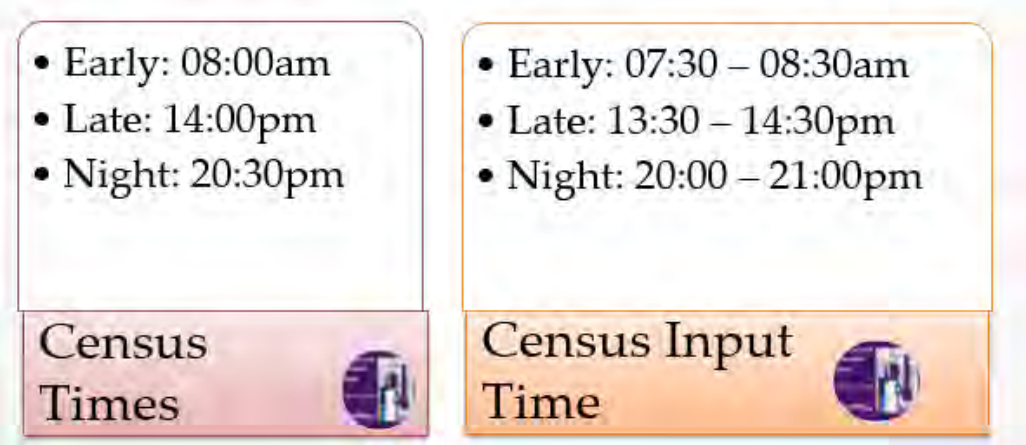
Census Periods and Times

- Census are the periods when Senior Nurses identify the patient acuity and dependency, recorded the results in SafeCare and perform analysis of results



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What is your role?

- Ensure data is entered for every census within the appropriate timeframe
- Ensure rosters are kept up-to-date in real-time
- Review patient classifications and challenge where needed to ensure data is accurate and consistent
- Review and utilise data outputs in SafeCare to support daily activity
- Use SafeCare to support identification of hotspots and redeployment opportunities

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Preparation

- All training records to be set against all staff in Health Roster
- Commence gathering census data to familiarise yourself with the Shelford acuity scores
- Identify who needs access to Safe Care Live and Health Roster
- Review the budgeted establishment
- Review demand templates
- Identify Task Types and Time Frames
- Review bank access and ensure this has been removed
- Ensure approvals are completed on time

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Safe Care Kick Off Meeting

E-Rostering Team

Belfast Health and Social Care Trust

What is SafeCare?

- Capture actual patient numbers by acuity and dependency
- See if their staffing levels match the demand.
- Action day-to-day staffing movements
- Inform longer-term resource and establishment plans
- Use the most suitable acuity and dependency model for their needs
- Use different models or multipliers for different wards
- Use reports to identify trends and causes, highlighting changes needed to ensure safe staffing levels.

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Safer Nursing Care Tool

3.2.9 Care Levels for Mental Health Acute wards

Dep. 1	Self-caring patients who can do most daily-living activities unaided. Minimal therapeutic care is needed. Likely to be a recovering patient about to go home.
Dep. 2	More dependent on ward staff for his/her personal care and safety. S/he may be able to complete some daily-living activities unaided. Previously close observation and therapetic care is tailing off.
Dep. 3	Ill and heavily reliant on ward team for her his/her safety and care. It's likely that s/he is agitated, unstable and unpredictable, posing a threat to him/herself and others. Close observation and therapeutic support are usually required. Could be sectioned.
Dep. 4	Desperately ill and dependent on the ward team for his/her care, safety and welfare. Highly likely to abscond, self-harm or injure others. Close observation and therapeutic attention is likely to feature heavily in the care plan. Probably sectioned.
Dep 4b	'Specialed' patients – requiring unbroken, one-to-one supervision by one or more staff.

3.2.10 Multipliers for Mental Health Acute wards

Speciality	Dep 1	Dep 2	Dep 3	Dep 4a	Dep 4b
Mental Health Acute wards	2.51	4.69	5.76	12.80	28.33

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Safer Nursing Care Tool

Patient Type	Multiplier	Patient Description	Base NHPPD	Nursing Hours per patient per day (24hrs)
Level 0	2.51	Generally Self Caring	4.39	11 hours per day
Dep. 2	4.69	More Dependent	4.39	20.59 hours per day
Dep. 3	5.76	Ill & Heavily Reliant	4.39	25.28 hours per day
Dep. 4	12.80	Desperately Ill and dependent	4.39	56.19 hours per day
Dep. 4b	28.33	Specialed	4.39	124.36 hours per day

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Safer Nursing Care Tool

Patient Type	Multiplier	Patient Description	Base NHPPD	Nursing Hours per Patient per day (24hrs)
Level 0	0.99	General ward Care	4.39	4.35 hours/day
Level 1a	1.39	Increased acuity	4.39	6.10 hours/day
Level 1b	1.72	Stable condition – increase dependency	4.39	7.55 hours/day
Level 2	1.97	Unstable condition – detailed observations	4.39	8.65 hours/day
Level 3	5.96	Intensive Care	4.39	26.16 hours/day

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Safer Nursing Care Tool

- Speciality specific multipliers for mental health acute wards were validated by Keith Hurst an independent researcher.
- To help make an informed decision of the multipliers to be used for SafeCare calculations.
- This information should be used by clinical staff and should be tested against professional judgement.

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NHPPD

WTEs
- Acuity Tools calculate Establishment
- For SafeCare we calculate NHPPD

Hours
- Change currency to Hours
- 1 WTE = 37.5 hours

Per Day
- Convert requirement per week to per day
- 37.5 / 7 = 5.357

-22%
- Remove requirement for staff not present on the Ward
- 5.357 / 1.22 = 4.39

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Process Overview

- Three times a day a census is conducted
- Clinical staff on the ward classify the patients on the ward and enter this data onto Safe Care
- Safe Care calculates the number of nursing hours required to care for the patients in the coming census period/shift
- Safe Care compares this to the number of nursing hours available
- This is represented by the staff utilisation figure
- Staff can then make informed decisions on staffing and action some changes through Safe Care e.g. redeployments

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Census Periods and Times

- Census periods identify the patient acuity.
- Census input times is the window of opportunity to , record the results in Safe Care and perform analysis of results

Census Times	Census Input Time
• Early: 08:00am • Late: 14:00pm • Night: 20:30pm	• Early: 07:30 – 08:30am • Late: 13:30 – 14:30pm • Night: 20:00 – 21:00pm

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What is your role?

- Ensure data is entered for every census within the appropriate timeframe
- Ensure rosters are kept up-to-date in real-time and compliant with policy
- Review patient classifications and challenge where needed to ensure data is accurate and consistent
- Review and utilise data outputs in SafeCare to support daily activity
- Use SafeCare to support identification of hotspots and redeployment opportunities

Belfast Health and Social Care Trust

Preparation

- All training records to be set against all staff in Health Roster
- Commence gathering census data to familiarise yourself with the Safer Nursing Care tool and acuity scores
- Review Telford and funded staffing levels
- Review demand templates and shifts
- Identify task types and time frames
- Review bank access and ensure this has been removed
- Ensure approvals are completed on time
- Identify who needs access to Safe Care Live and Health Roster

MAHI - STM - 102 - 11282

Telford

	Mon	Tues	Wed	Thur	Fri	Sat	Sun	Total for week	hours per shift		weekly hours per shift per level	Registered	Band 3	Band 2
Am												Registered	Band 3	Band 2
Registered								0	5.5		0	0		
Band 3								0	5.5		0		0	
Band 2								0	5.5		0			0
Afternoons														
Registered								0	4		0	0		
Band 3								0	4		0		0	
Band 2								0	4		0			0
Evening														
Registered								0	4		0	0		
Band 3								0	4		0		0	
Band 2								0	4		0			0
Night Duty														
Registered								0	11.5		0	0		
Band 3								0	11.5		0		0	
Band 2								0	11.5		0			0
										Sub total	0	0	0	0
										add 22%	0	0	0	0
										Total	0	0	0	0
										WTE	**0**	**0**	**0**	**0**
										NTB	**0**			0
									Total Beds		**23**			
									Skill Mix				**DIV/0**		**DIV/0**

To be entered

Automatically populated

MAH Task and Finish Workforce sub-group

1. Terms of Reference

The aim of the Sub-group is to support the MAH Task and Finish Group through the following actions:

To identify the workforce required on the MAH site as outlined below:

To identify the workforce required currently to deliver services

To identify the workforce required when the last remaining resettlement ward closes on the site

To identify the workforce required following the review of the services in the "Core" Hospital

This should identify the pressures and challenges that will be faced by the hospital staff and the impact these will have on the workforce e.g. recruitment issues, staff absence, registration etc.

Roles and Responsibilities of Group

To identify the workforce in your service area as outlined above

To agree a format for the provision of information

2. Membership of the Forum

There will be at least one representative from each area. If a member of the group is unable to attend, they must ensure that either a substitute attends or the information is provided to the HR Manager Modernisation & Workforce Planning in advance of the next meeting.

3. Timescale

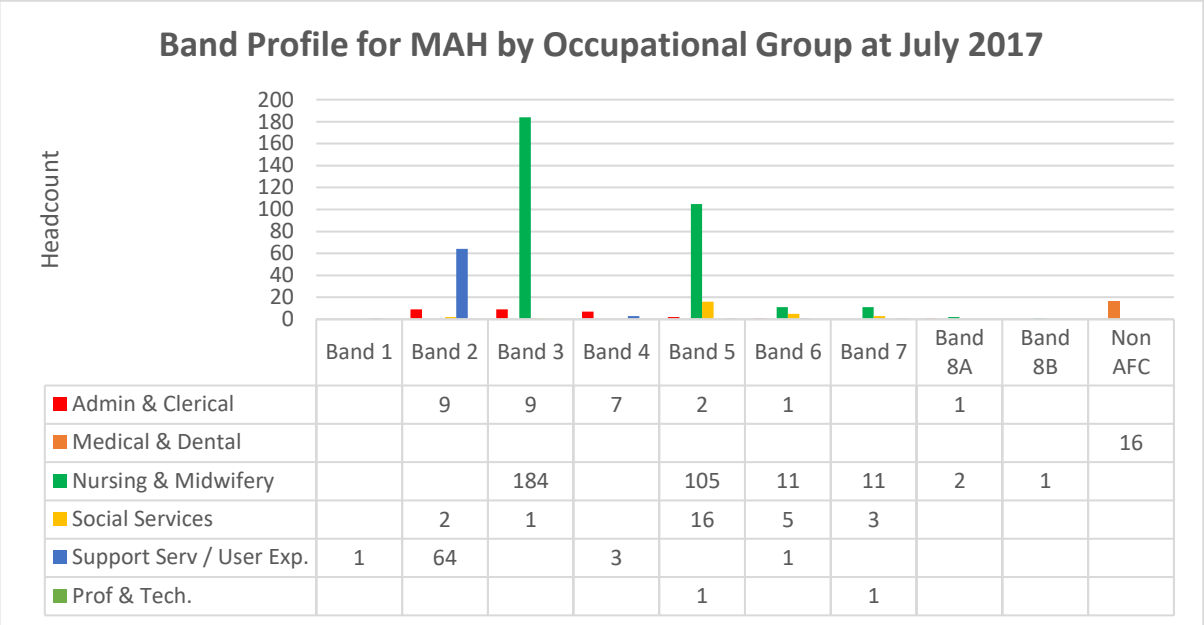
To be confirmed

Workforce Information for Muckamore Abbey Hospital

Muckamore Abbey Hospital comes under the remit of the Co-Director for Children and Learning Disability services. Responsibility for the day-to-day management of the hospital rests with the 8B Service Manager. Reporting to the Service Manager are 3 Assistant Service Managers (Band 8A) who are responsible for the wards in the hospital; Iveagh wards (children's services) and Day Care services, admin services and Nurse development. A Band 7 Nurse manages each ward. A team of 16 medical staff, including 9 consultants (1 temporary) who provide medical services to the hospital.

The staff information contained below is as at July 2017 and refers to MAH. The information on vacant posts and sickness absences are for the period 1 April 2016 to 31 March 2017.

There is 457 staff (400.27 WTE) working at the hospital. Of this total, 314 are nursing, including nursing support staff, 69 PCSS staff, 27 are social work/social care staff, 29 admin staff, 16 medical staff and 2 professional & technical staff.



	Band 1	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8A	Band 8B	Non AFC
Admin & Clerical		9	9	7	2	1		1		
Medical & Dental										16
Nursing & Midwifery			184		105	11	11	2	1	
Social Services		2	1		16	5	3			
Support Serv / User Exp.	1	64		3		1				
Prof & Tech.					1		1			

Chart 1

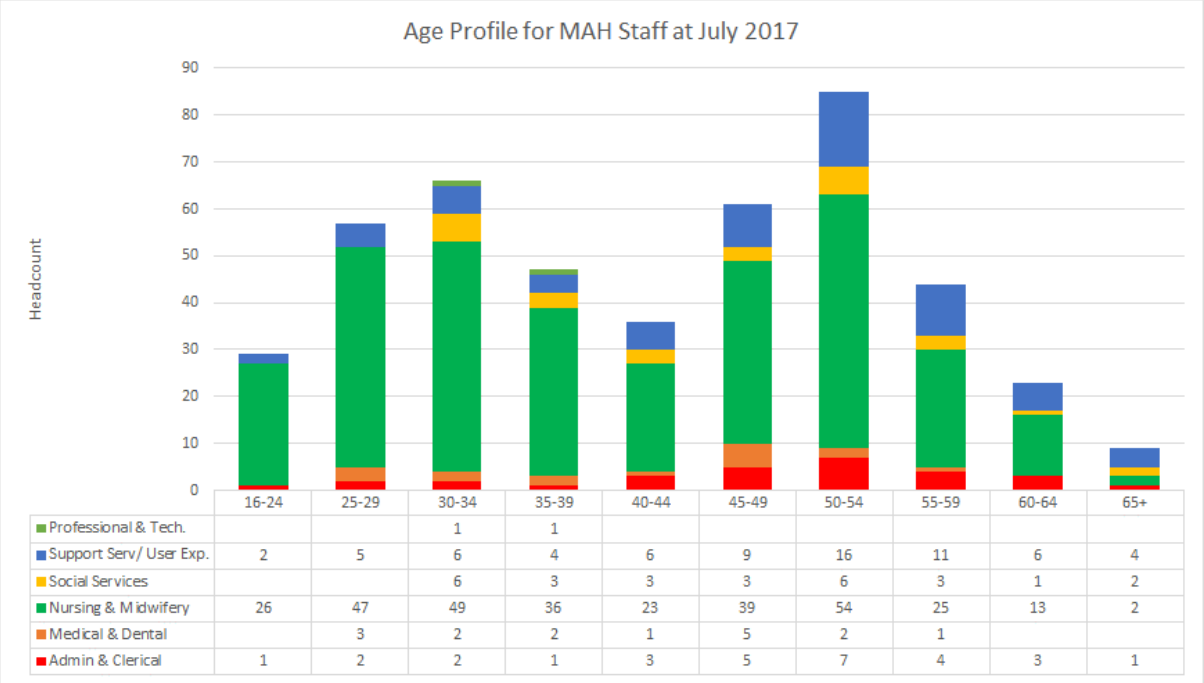
Age Profile

Chart 2, below shows that within the current workforce 161 staff are aged 50 and above who will be able to retire within the next 10 years. There is 76 staff who are aged 55 and above who will be able to retire in the next 5 years. This is 16.6% of the workforce and compares with the Trust figure of 18%. There is 32 staff, 7% of the workforce is aged 60 or above, which is marginally higher than the Trust wide level

of 6%. There is 85 staff aged 50-54, representing 18.6% of the workforce, which is higher than the Trust rate of 15%.

There is an even distribution of nursing staff across all the age ranges. However, it is worth noting that there is 94 nursing staff, including support staff, who are aged 50 and above, which is 30% of the total nursing staff working in the hospital and is similar to the Trust wide rate of nursing staff of 31.6% of staff aged 50+.

There is an even spread of age ranges amongst the medical staff, with only 3 staff being aged 50 and above in this group.



	16-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65+
Professional & Tech.			1	1						
Support Serv/ User Exp.	2	5	6	4	6	9	16	11	6	4
Social Services			6	3	3	3	6	3	1	2
Nursing & Midwifery	26	47	49	36	23	39	54	25	13	2
Medical & Dental		3	2	2	1	5	2	1		
Admin & Clerical	1	2	2	1	3	5	7	4	3	1

Chart 2

Staff Turnover

The staff turnover rates recorded in table 1 highlights the various rates for Learning Disability services with the Adult Social & Primary Care Directorate and the Trust. It is not possible to break down the information to reflect the MAH site.

Staff Turnover 1 April 2016 to 31 March 2017	
ADULT SOCIAL & PRIMARY CARE DIRECTORATE	5.61%
CHILDREN & LEARNING DISABILITY SERVICES	5.86%
TRUST WIDE	5.29%

Table 1

Recruitment

In total 26 vacancy requisitions, submitted by the Directorate, were not filled immediately during the year. Of these, 18 were recorded as being on hold; the reasons for this included an insufficient response and held due to vacancy controls. Six of the vacancies were recorded as being released, which means they are with the BSO Shared services Recruitment Team and in the process of being filled.

Due to difficulties experienced in recruiting temporary Band 3 staff for the resettlement wards it was decided to recruit permanent Band 3 staff to ensure that safe staffing levels were maintained on the wards. Staff recruited on these permanent contracts have been made aware that it is unlikely there will be sufficient vacant posts on the MAH site for redeployment, when the last resettlement wards close. Therefore, they will have to consider redeployment into sites in Belfast.

Starters and Leavers

New Starts

During the year there was 44 new staff employed at the MAH. Chart 3 illustrates the Bands and the occupational groups to which these staff were appointed. Unsurprisingly nursing staff accounted for the largest group of staff with 35 new starters.

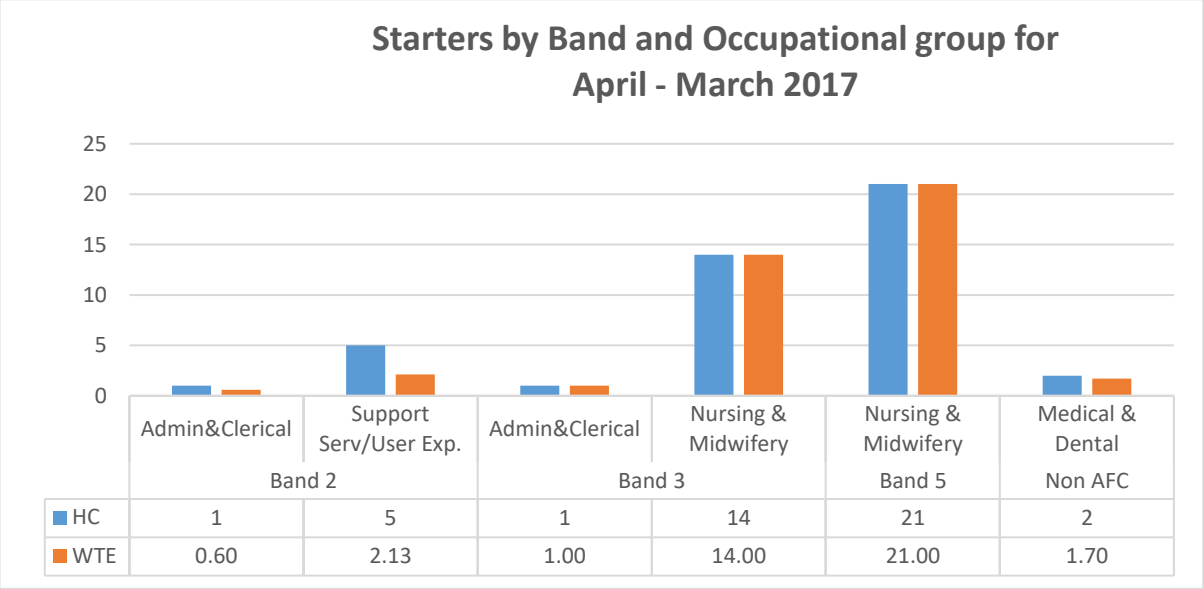


Chart 3

Leavers

Fifty-four employees left MAH during the year, which accounts for 11.8% of the workforce and is more than the 8.2% of the total workforce who left the Trust. Chart

4 highlights the reason for leaving recorded for each person. There was 11 retirements during the year and 7 staff left for reasons associated with ill-health.

Chart 4

Appraisals/SDRs

According to HRPTS 30 staff at MAH have had their SDR since April 2016. This does not mean that only 30 staff have had their SDR only that it has been recorded on the system for this number of staff. This represents 6.7% and compares with 22.7% across the Trust.

Sickness Absence

Over the year, 13,713 days were lost due to sickness absence, which represents a sickness absence rate of 12.34%. The absence rates for the Directorate and the Trust were 7.72% and 6.34% respectively. Table 2 highlights the top 8 reasons recorded for staff sickness absence. The WTE column illustrates the number of staff, on average, absent from work each day due to that reason.

Top 8 Reasons for Sickness Absence at MAH 1/04/16 -30/06/17

Absence Category	Absence Reason	Absence Hours	Absence Days	WTE
Mental Health	Stress	12,855.14	1,828.00	8.23
Mental Health	Depression	4,365.45	678.00	3.05
Tumours, cancers	Breast cancer	3,725.10	548.00	2.47
Mental Health	Anxiety	3,601.76	540.00	2.43
Mental Health	Stress-Work Related	3,412.60	487.00	2.19
Miscellaneous	General Debility	3,078.95	467.00	2.10
Mental Health	Grief/Bereavement	2,820.20	466.00	2.10
Accident/Untoward Incident at Work	Accident-work related	2,912.60	452.00	2.04
Total		**36,771.80**	**5,466.00**	**24.62**

Table 2

Reported Incidents

There was 3106 incidents reported at MAH during the year ending 31 March 2017. Table 4 below highlights the number of incidents were the nature of the incident was reported on more than 50 occasions.

Incidents by Severity at Muckamore Abbey Hospital 1 April 2016 to 31 March 2017

	Insignificant	Minor	Moderate	Major	Catastrophic	Tota
Physical abuse, assault or violence	934	1078	16	0	0	**202**
Self-harm	116	209	1	0	0	**326**
Disruptive, aggressive behaviour - other	109	27	1	0	0	**137**
Lack of suitably trained/ skilled staff	57	22	16	0	0	**95**
Fall on level ground	46	47	1	0	0	**94**
Suspected fall	28	38	0	0	0	**66**
Verbal abuse or disruption	42	21	0	0	0	**63**
Total	**1332**	**1442**	**35**	**0**	**0**	**280**

Table 4

Physical abuse, assault or violence was the most reported incident and accounted for 65% of all incidents.

Staffing Issues

Table 3 below highlights the disciplinary and grievance issues that have occurred since January 2016. There has been 6 disciplinary situations which led to 1 dismissal, 1 Final and 1 Formal Warning.

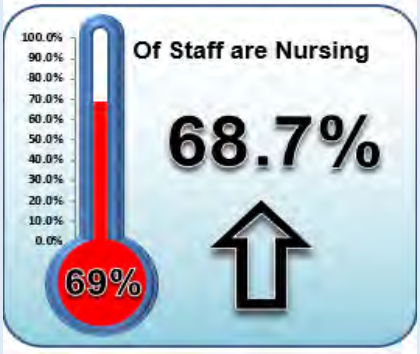
Disciplinary and Grievance Issues at MAH since January 2016

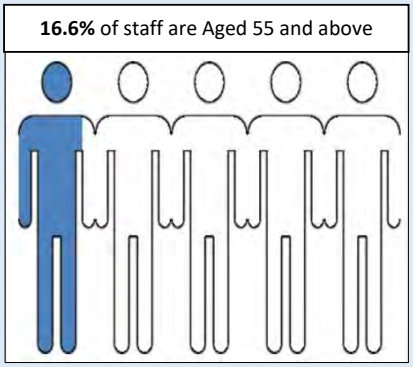
Activity	Number	Issue	Outcome
Disciplinary Investigation	6	3 - Breach of Rules	
		Attendance Management	
		Alcohol/drugs	
		Ill Treatment/Wilful Neglect	
Disciplinary Actions	6	3 - Breach of Rules	1 - No Formal Action
			1 - Hearing not yet Taken Place
			1 - Formal Warning
		Attendance Management	1- Final Warning
		Alcohol/drugs	1- Not yet heard
		Ill Treatment/Wilful Neglect	Dismissal
Grievances	7	7 - Unfair Treatment	4 - resolved informally
			3 - Hearing not yet Taken Place

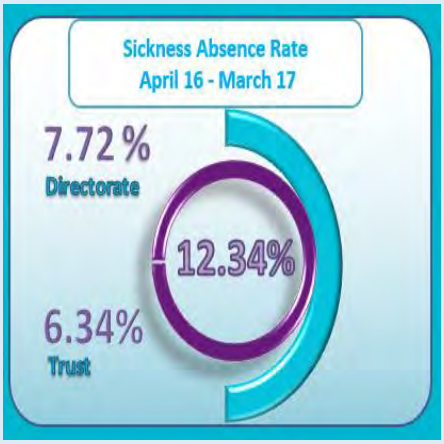
Table 3

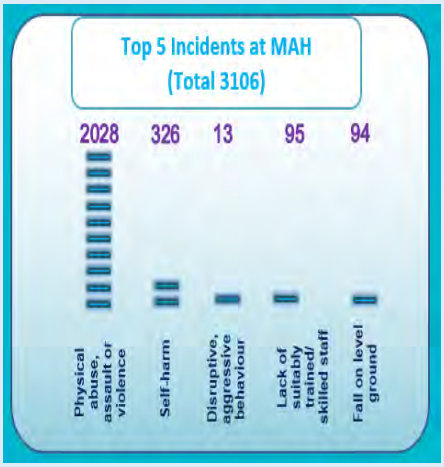
The 7 grievances have all been around allegations of unfair treatment. Four of the grievances were resolved informally, but there is no outcome for the remaining 3.

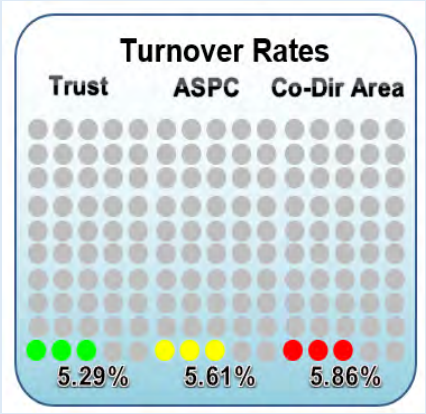
Muckamore Abbey Hospital Staff Information

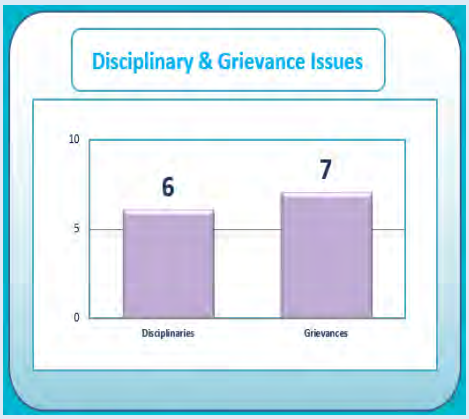












MAH Roster Analysis

Cranfield One

552.67 additional duty hours have been created over and above what is agreed as part of their funded establishment. The reason for these hours is recorded as 'specials'.

25% of the roster is unfilled probably due to their high sickness and maternity leave levels. The shifts not covered in the roster commencing the 13th November to the 10th December are; 54 early shifts, 66 late shifts, 44 twilights, and 13 night shifts.

It has been identified that the funded establishment is set at 26.25 WTE when they actually need 41.78 WTE as per a Telford exercise. This highlights a deficit of 15.28 WTE's before considering the reasons or increasing statistics for the unavailability of staff (sickness, maternity, annual leave etc).

The skill mix is 45% registered to 55% Unregistered.

The review of the roster has resulted in an improvement in the amount of the roster that is requested by staff showing staff engagement and that self-rostering and the implementation of the roster policies are improving. 37.88% of the roster has been auto-rostered. 9.95% has been requested by staff through employee on line. 52.17% has been manually rostered.

23% of the roster has rule breakages. (Rules are built on roster policy)

Cranfield Two

44 additional duty hours have been created over and above what is agreed as part of their funded establishment. The reason for these hours is recorded as 'specials'.

112 instances of the wrong grade being assigned to staff has occurred. The requirement has been for an LDA and they have filled the shifts with an RNLD. This isn't ideal and not cost effective in the long term.

19% of the roster is unfilled probably due to their high sickness and maternity leave levels. The shifts not covered in the roster commencing the 13th November to the 10th December are; 69 early shifts, 80 late shifts, 19 twilights, and 43 night shifts.

It has been identified that the funded establishment is set at 26:50 WTE when they actually need 53:12 WTE as per a Telford exercise. This highlights a deficit of 26.62 WTE's before considering the reasons or increasing statistics for the unavailability of staff (sickness, maternity, annual leave etc).

The skill mix is 30% registered to 70% Unregistered.

The review of the roster has resulted in an improvement in the amount of the roster that is requested by staff showing staff engagement and that self-rostering and the implementation of the roster policies are improving. 41.03% of the roster has been auto-rostered. 7.26% has been requested by staff through employee on line. 51.71% has been manually rostered.

19% of the roster has rule breakages.

MAH Roster Analysis

Cranfield PICU

139 additional duty hours have been created over and above what is agreed as part of their funded establishment. The reason for these hours is recorded as 'unknown or additional beds'. **241.97 unused** contracted hours have not been assigned to staff. Are they off sick or why have these not been recorded on the roster? Additional duty hours should not be created when there are so many unused contracted hours outstanding.

42% of the roster is unfilled probably due to their high sickness levels. The shifts not covered in the roster commencing the 13th November to the 10th December are; 50 early shifts, 76 late shifts, 11 twilights, and 45 night shifts.

It has been identified that the funded establishment is set at 22:50 WTE when they actually need 27:54 WTE as per a Telford exercise. This highlights a deficit of 5.04 WTE's before considering the reasons or increasing statistics for the unavailability of staff (sickness, maternity, annual leave etc).

The skill mix is 49% registered to 51% Unregistered.

The review of the roster has resulted in an improvement in the amount of the roster that is requested by staff showing staff engagement and that self-rostering and the implementation of the roster policies are improving. 44.5% of the roster has been auto-rostered. 7.96% has been requested by staff through employee on line. 47.49% has been manually rostered.

18% of the roster has rule breakages.

Donegore

204.62 additional duty hours have been created over and above what is agreed as part of their funded establishment. The reason for these hours is recorded as 'training'. **88.10 unused** contracted hours have not been assigned to staff.

27% of the roster is unfilled probably due to their high sickness levels. The shifts not covered in the roster commencing the 13th November to the 10th December are; 78 early shifts, 78 late shifts, 40 twilights, and 6 night shifts.

It has been identified that the funded establishment is set at 30 WTE. A Telford exercise needs carried out in this area to measure the actuals and identify the deficits.

The skill mix is 55% registered to 45% Unregistered.

The review of the roster has resulted in an improvement in the amount of the roster that is requested by staff showing staff engagement and that self-rostering and the implementation of the roster policies are improving. 22.04% of the roster has been auto-rostered. 6.81% has been requested by staff through employee on line. 71.14% has been manually rostered.

17% of the roster has rule breakages.

MAH Roster Analysis

Killead

Needs a complete review. Am having great difficulty getting access to ward managers and deputies to carry out this work.

325.80 additional duty hours have been created over and above what is agreed as part of their funded establishment. The reason for these hours is recorded as 'additional beds or unknown reasons'. **136.98 unused** contracted hours have not been assigned to staff. 49 occurrences of wrong grade types where an LDA shift has bene assigned to an RNLD.

21% of the roster is unfilled probably due to their high maternity and other absence reasons. The shifts not covered in the roster commencing the 13th November to the 10th December are; 47 early shifts, 58 late shifts, 42 twilights, and 35 night shifts.

It has been identified that the funded establishment is set at 40.98 WTE. A Telford exercise needs carried out in this area to measure the actuals and identify the deficits.

The skill mix is 31% registered to 69% Unregistered.

38.39% of the roster has been auto-rostered. 6.36% has been requested by staff through employee on line. 55.25% has been manually rostered.

30% of the roster has rule breakages.

Sixmile

118 additional duty hours have been created over and above what is agreed as part of their funded establishment. The reason for these hours is recorded as 'training'. 25 occurrences of wrong grade types where an RHLD shift has been assigned to an LDA.

22% of the roster is unfilled probably due to their high sickness levels. The shifts not covered in the roster commencing the 13th November to the 10th December are; 95 early shifts, 86 late shifts, 2 twilights, and 4 night shifts.

It has been identified that the funded establishment is set at 32.50 WTE when they actually need 44.33 WTE as per a Telford exercise. This highlights a deficit of 11.83 WTE's before considering the reasons or increasing statistics for the unavailability of staff (sickness, maternity, annual leave etc).

The skill mix is 59% registered to 41% Unregistered.

The review of the roster has resulted in an improvement in the amount of the roster that is requested by staff showing staff engagement and that self-rostering and the implementation of the roster policies are improving. 15.47% of the roster has been auto-rostered. 3.15% has been requested by staff through employee on line. 81.38% has been manually rostered.

23% of the roster has rule breakages.

MAH Roster Analysis

Erne One

504.55 additional duty hours have been created over and above what is agreed as part of their funded establishment. The reason for these hours is recorded as 'specials'. 30 occurrences of wrong grade types where an RHLD shift has been assigned to an LDA. 157.63 Unused contracted hours.

35% of the roster is unfilled probably due to their high sickness levels. The shifts not covered in the roster commencing the 13th November to the 10th December are; 105 early shifts, 127 late shifts, 52 twilights, and 41 night shifts.

It has been identified that the funded establishment is set at 25.50 WTE when they actually need 44.33 WTE as per a Telford exercise. This highlights a deficit of 21.95 WTE's before considering the reasons or increasing statistics for the unavailability of staff (sickness, maternity, annual leave etc).

The skill mix is 37% registered to 63% Unregistered.

The review of the roster has resulted in an improvement in the amount of the roster that is requested by staff showing staff engagement and that self-rostering and the implementation of the roster policies are improving. 42.99% of the roster has been auto-rostered. 11.62% has been requested by staff through employee on line. 45.38% has been manually rostered.

21% of the roster has rule breakages.

Erne Two

0.00 additional duty hours have been created. 152.13 Unused contracted hours remain outstanding. 26 occurrences of wrong grade types where an RHLD shift has been assigned to an LDA.

27% of the roster is unfilled probably due to their high sickness levels. The shifts not covered in the roster commencing the 13th November to the 10th December are; 59 early shifts, 61 late shifts, 21 twilights, and 27 night shifts.

It has been identified that the funded establishment is set at 26 WTE. A Telford exercise needs carried out in this area to measure the actuals and identify the deficits.

The skill mix is 40% registered to 60% Unregistered.

The review of the roster has resulted in an improvement in the amount of the roster that is requested by staff showing staff engagement and that self-rostering and the implementation of the roster policies are improving. 40.61% of the roster has been auto-rostered. 9.70% has been requested by staff through employee on line. 49.70% has been manually rostered.

13% of the roster has rule breakages.

MAH Roster Analysis

Continuous Improvement Work

- **Senior Management Engagement**
- **Review of Killead**
- **Telford exercise and demand templates to be aligned with outstanding areas**
- **Monitor for improvements going forward based on these statistics**
- **Identification of an acuity tool still ongoing.**