Moving Clinical Staff Project – November update briefing

Staff being moved across clinical areas and specialties is known to be a significant cause of stress for staff across the Trust.

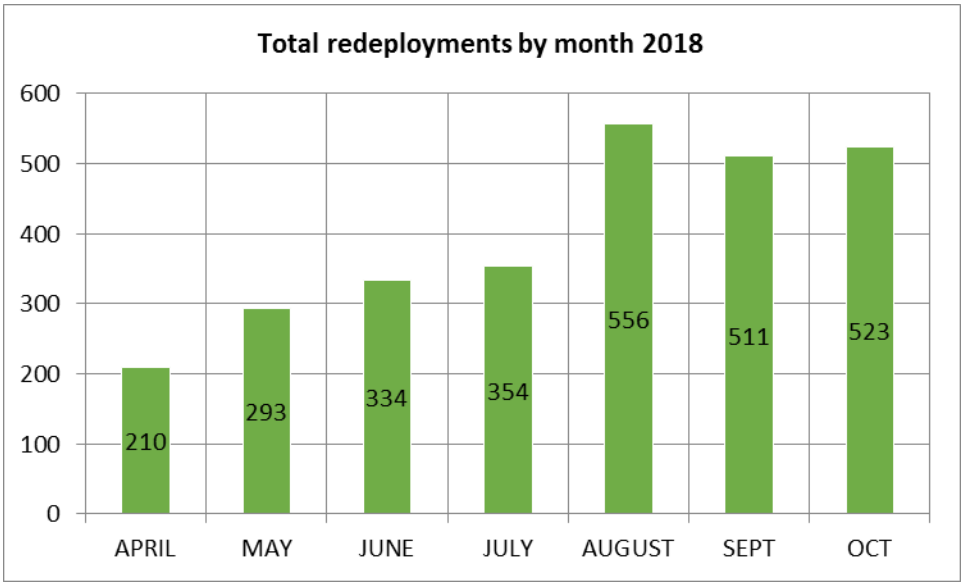
Earlier in 2018 a review was undertaken to which almost 1300 staff contributed, and the following (summarised from the full report) conclusions were drawn:

1. Staff moves are now a regular occurrence and will continue to be so until vacancies reduce or demand eases.
2. A high number of staff do not fully appreciate the factors driving the need for someone to be moved and view it as poor management.
3. Skills issues fell into 4 core categories: Environment in it being an unfamiliar setting; variation in what different staff do in different areas particularly around observation; clinical skills focusing on what are traditionally seen as every day skills for a ward based member of staff such as drug rounds or manual handling at a bedside and specialist skills, referring to higher level competencies such as with NIV, NG or some post-operative interventions.
4. A poor experience was characterised by a lack of all the things that a good experience did have;
    - Feeling welcomed and appreciated on arrival and being thanked
    - Introduced to staff on duty and who to go to if any questions
    - Being shown where things were and routine explained
    - Being checked on during shift and feeling included in the team.

Eight recommendations were put forward; many of these by staff who participated in the review and a steering group has been meeting monthly since September to take these forward. This report provides an update against each of these recommendations.

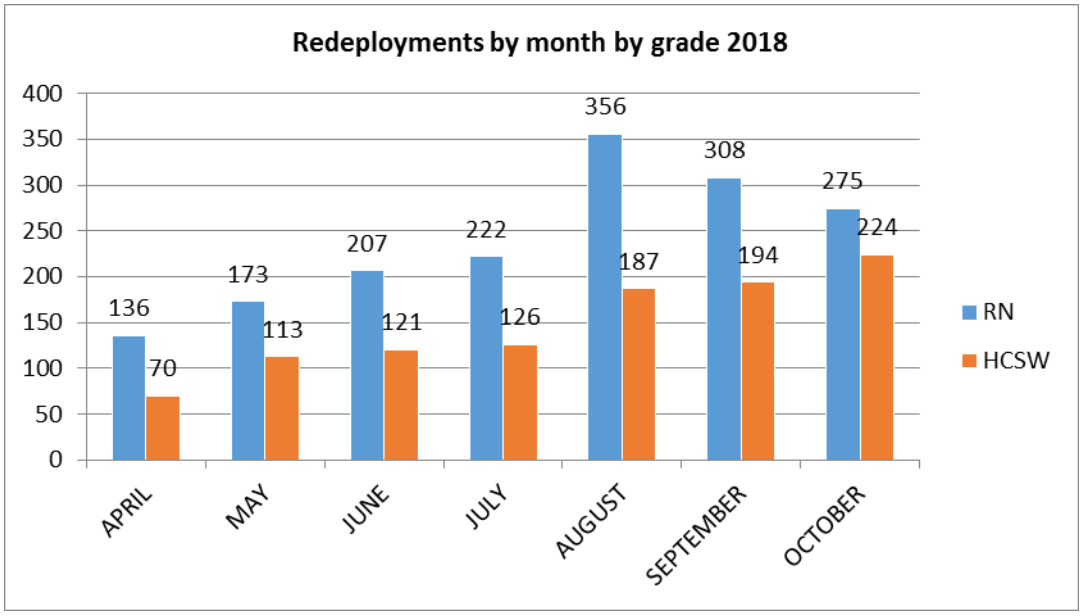
Recommendation 1: include staff moves Healthroster data within existing workforce and staffing reports.

Rather than include this data into workforce reports it was decided that it be provided to the steering group to assist with understanding hot spot areas and look at trends. The Nursing Informatics team have provided this and the steering group members have found both the data both interesting and at times surprising and unsurprising in equal measures. The original review looked at a 3 month data set and has now been broken down into key metrics by month to get a trend picture of which areas are needing staff the most and where these staff are coming from. (Redeployments = staff moved from their 'home' ward or department to work elsewhere).

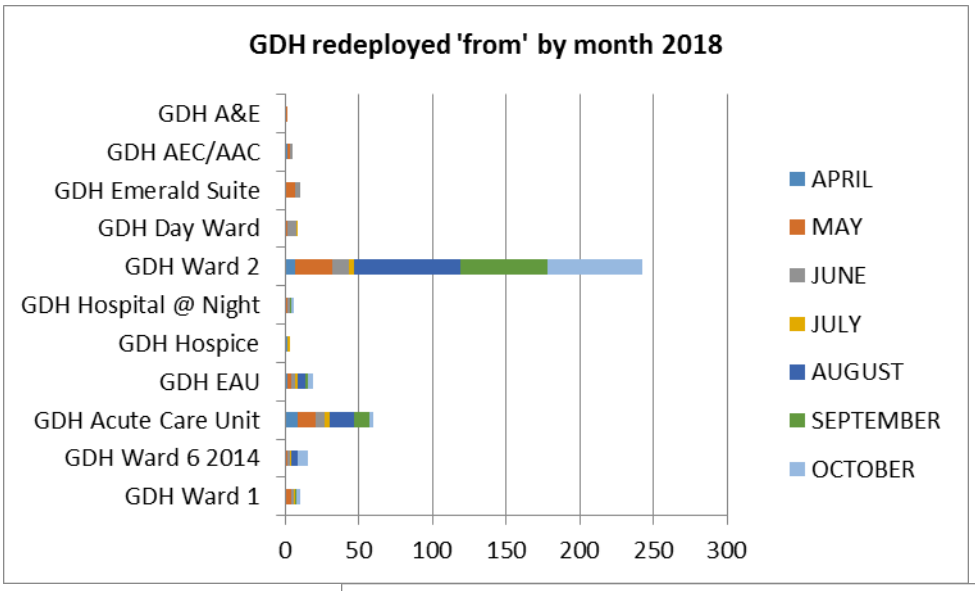


As expected the need for staff to be moved has not diminished and it has in fact continued to rise. August is usually a difficult month with school holidays and staff leave but September and October have continued to see high numbers of moves.

There can be seen to be a gradual and significant increase in the movement of HCSW proportionate to RNs.

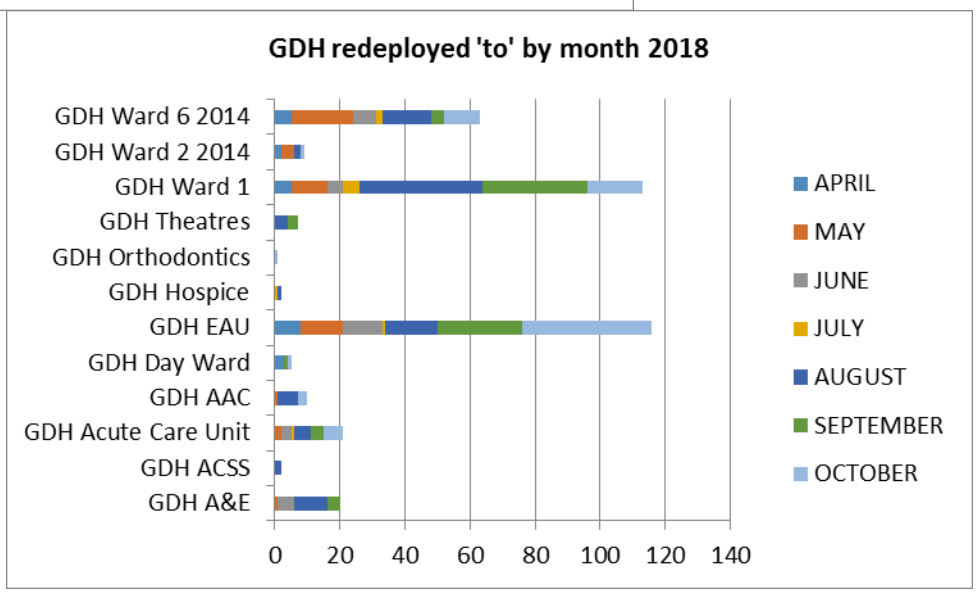


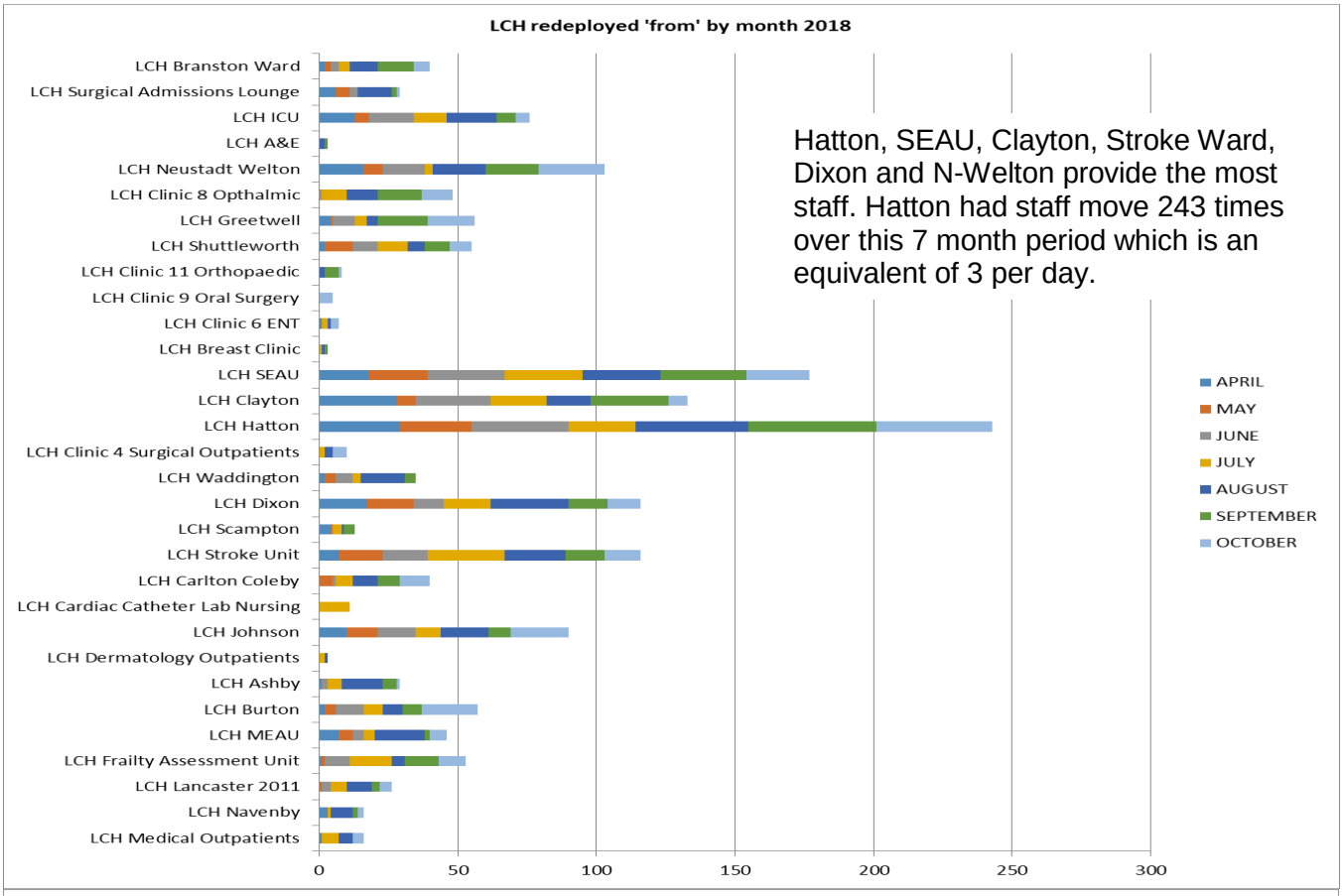
The following graphs show, by site where staff have been moved from and to. These tell us where the greatest demand is and also who is providing the greatest level of support.

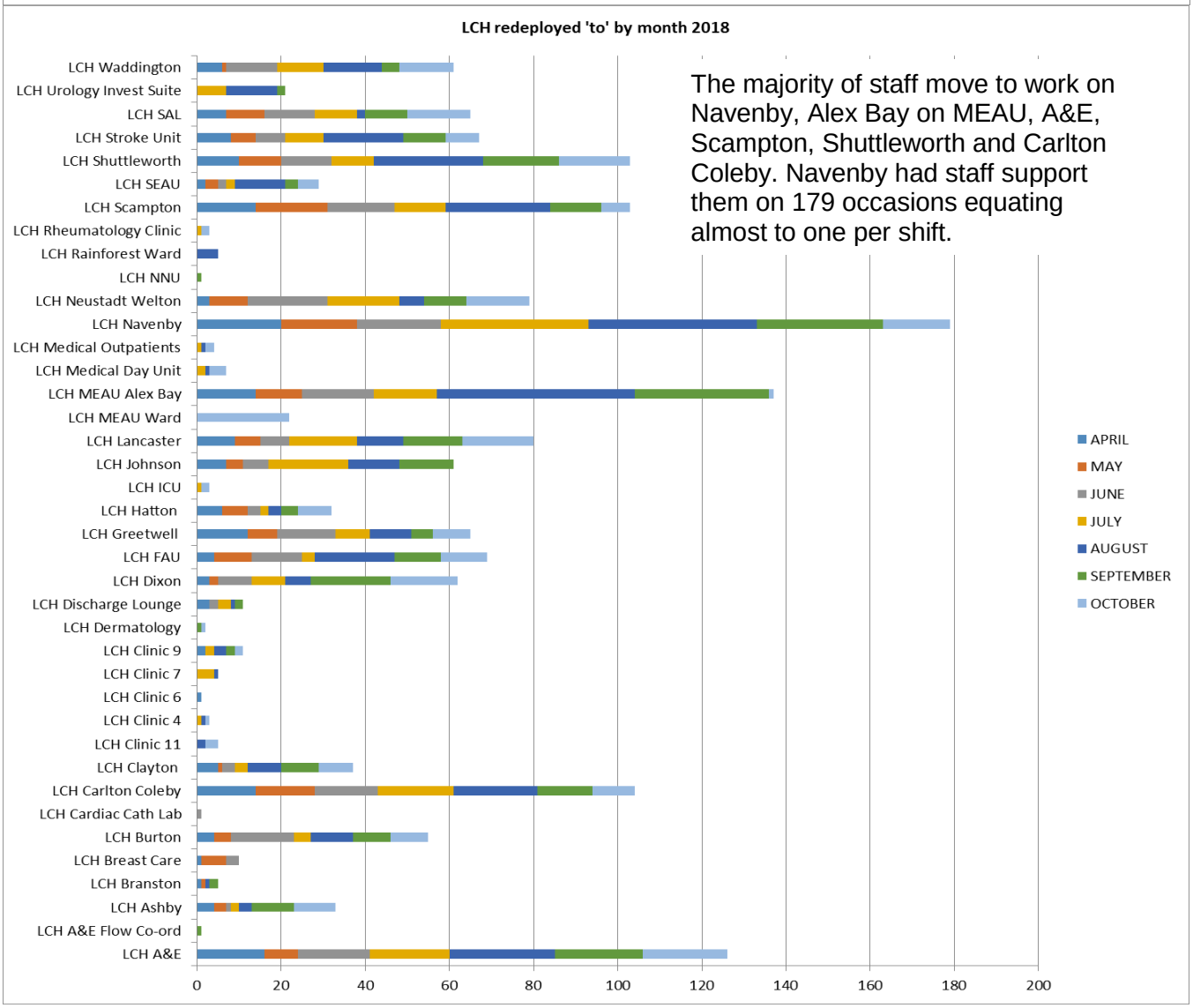


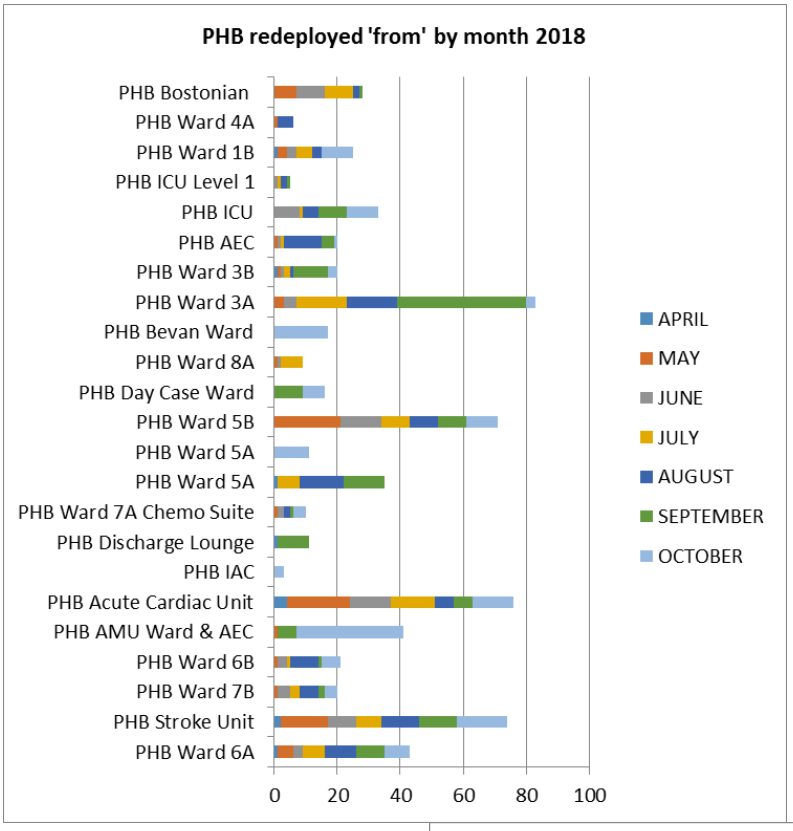
Ward 2 and ACU provide the most staff with Ward 2 averaging 35 moves per month over the 7 month period.

The majority of staff are moved to work on EAU, Ward 1 and Ward 6 averaging across the 3 some 40 staff per month between them.



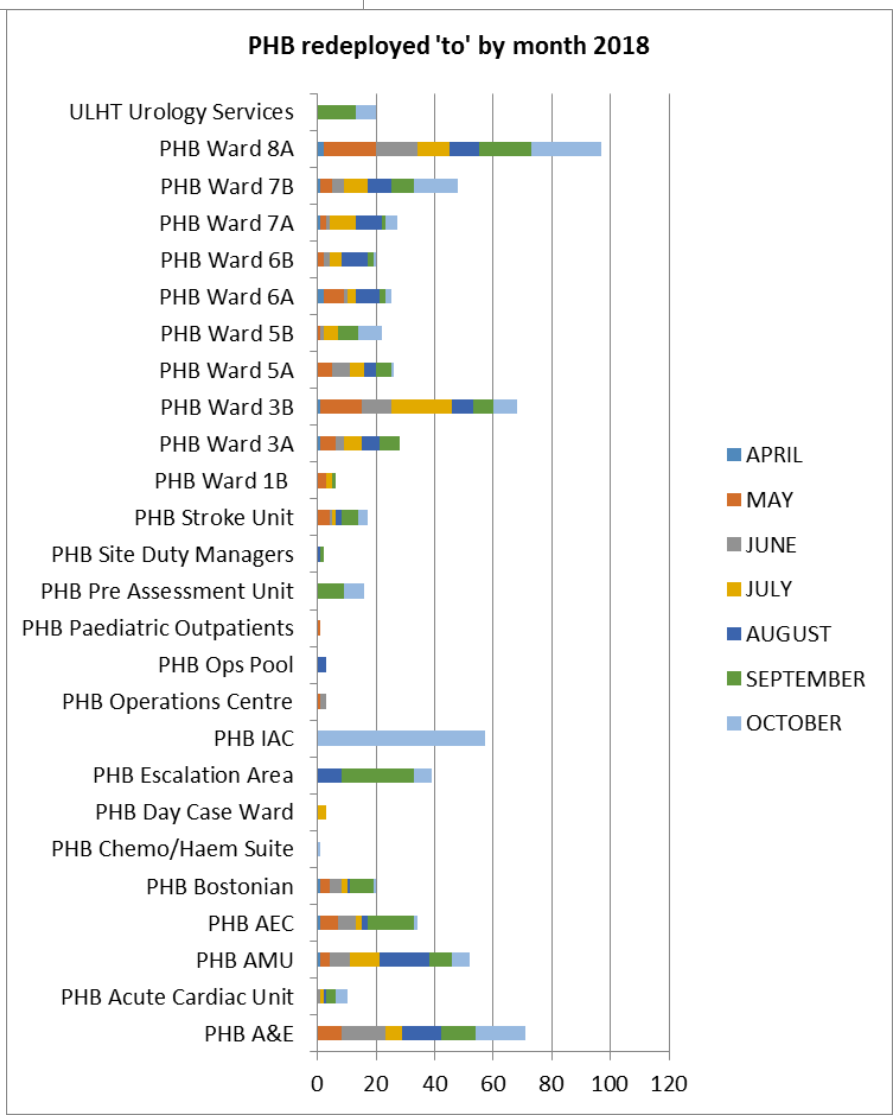

LCH redeployed 'from' by month 2018
LCH Branston Ward
LCH Surgical Admissions Lounge
LCH ICU
LCH A&E
LCH Neustadt Welton
LCH Clinic 8 Opthalmic
LCH Greetwell
LCH Shuttleworth
LCH Clinic 11 Orthopaedic
LCH Clinic 9 Oral Surgery
LCH Clinic 6 ENT
LCH Breast Clinic
LCH SEAU
LCH Clayton
LCH Hatton
LCH Clinic 4 Surgical Outpatients
LCH Waddington
LCH Dixon
LCH Scampton
LCH Stroke Unit
LCH Carlton Coleby
LCH Cardiac Catheter Lab Nursing
LCH Johnson
LCH Dermatology Outpatients
LCH Ashby
LCH Burton
LCH MEAU
LCH Frailty Assessment Unit
LCH Lancaster 2011
LCH Navenby
LCH Medical Outpatients
0
50
100
150
200
250
300
APRIL
MAY
JUNE
JULY
AUGUST
SEPTEMBER
OCTOBER
Hatton, SEAU, Clayton, Stroke Ward, Dixon and N-Welton provide the most staff. Hatton had staff move 243 times over this 7 month period which is an equivalent of 3 per day.


LCH redeployed 'to' by month 2018
LCH Waddington
LCH Urology Invest Suite
LCH SAL
LCH Stroke Unit
LCH Shuttleworth
LCH SEAU
LCH Scampton
LCH Rheumatology Clinic
LCH Rainforest Ward
LCH NNU
LCH Neustadt Welton
LCH Navenby
LCH Medical Outpatients
LCH Medical Day Unit
LCH MEAU Alex Bay
LCH MEAU Ward
LCH Lancaster
LCH Johnson
LCH ICU
LCH Hatton
LCH Greetwell
LCH FAU
LCH Dixon
LCH Discharge Lounge
LCH Dermatology
LCH Clinic 9
LCH Clinic 7
LCH Clinic 6
LCH Clinic 4
LCH Clinic 11
LCH Clayton
LCH Carlton Coleby
LCH Cardiac Cath Lab
LCH Burton
LCH Breast Care
LCH Branston
LCH Ashby
LCH A&E Flow Co-ord
LCH A&E
0
20
40
60
80
100
120
140
160
180
200
APRIL
MAY
JUNE
JULY
AUGUST
SEPTEMBER
OCTOBER
The majority of staff move to work on Navenby, Alex Bay on MEAU, A&E, Scampton, Shuttleworth and Carlton Coleby. Navenby had staff support them on 179 occasions equating almost to one per shift.



Wards 3A, 5B, ACU and Stroke Unit most frequently provide staff. Considerable reconfiguration changes makes it difficult to comment on specific areas.

The majority of staff are moved to work on Wards 8A, 3B, AMU and A&E. However IAC opened in October and has used very high numbers of redeployed staff in its early weeks to cover posts not yet recruited into.



Recommendation 2: Recirculate the staffing video made by Director of Nursing and have available for team meetings etc.
The original video was seen to be a little out of date following directorate and service changes and focused more on the implementation of the national safe staffing recommendations and how this is managed and reported on. The staff moves element is the next step on from this; the impact of making staffing safe across our sites. This video is being scheduled and we hope to launch it in the New Year.

Recommendation 3: Support SDM's and operational matrons on how to 'paint the picture' of the current situation.
This recommendation stemmed from staff feeling they were being 'ordered' to move and whilst explanations were given in terms of balancing risk and needs it was difficult to paint the overarching picture. On further discussion at the steering group it was felt that this could be captured in the video in recommendation 2.

Recommendation 4: Design a 'skills, experience and choice map' for staff to show where they have worked before and are confident to be moved to.
The discussion here was about the most appropriate skills being deployed and consideration of experience. On exploring further the group felt that rather than designing something new much of this information is already held within Healthroster and that by 'hovering' over someone's name skills and training can be seen. As such a separate skills map need not be developed but the principle of identifying the most suitable member of staff should be clear and can be incorporated into Recommendation 6.

However there was also considerable discussion about staff being able to 'hold up their hands' and say they don't feel confident or competent to work in a particular area but that they also have to accept and recognise that they may be required to move. We are not in the position to simply say *'I can't move'* and we have to shift to *'what do I need to do in order to be able to move?'* With having information now on where moves are happening the most a self-assessment approach was suggested and the group agreed a process built on recognised reflective tools. This is shown at Appendix 1 and will be launched in December with a view to reviewing after 2 or 3 months. It is hoped that this will support individuals in their own development (it can also be used at appraisals and for registered nurses be useful for revalidation), it will also support line managers in understanding the development needs of their team and collectively provide a wider training and development needs analysis.

Recommendation 5: Develop a programme of insight visits.
Insight visits were a popular suggestion with staff anecdotally sharing that after one shift they realised it wasn't quite as they imagined and had they known before they would not have been so anxious; however capacity to manage a programme of visits was a limiting factor and so the steering group suggested these be managed locally and individually between areas particularly with the new intelligence about where moves are happening most frequently. This also links with Recommendation 4 in that if a staff member has identified their own development needs an insight visit could be arranged.

Recommendation 6: Develop a checklist / SOP / risk assessment or protocol for decision making.
The group were somewhat reticent about having another checklist and decided that a simple statement or commitment of principles for decision making would be a good way forward; this could then be supported by the Director of Nursing's video in ensuring key issues are considered, how staffing risk is assessed and addressed and provides an expectation that skills, experience, confidence and respect are implicit within any staff moves decision. This statement / commitment is currently being drafted as the group wanted to have the underlying processes agreed first. The aim is for this to be completed during December and launched in the New Year.

Recommendation 7: Develop professional versions of 'welcome to the ward / department'
This recommendation was incorporated into Recommendation 8.

Recommendation 8: Develop 'must do induction' checklists
There was a great deal of debate and discussion about this action and it took into account that some areas already have checklists, some more detailed than others, there is also an agency checklist already in use. Time needed to be factored in as when someone is moved it inevitably means the ward or department is busy and short of staff so a checklist that is comprehensive but also easy to use and

not too detailed was wanted. It was also highlighted that whoever moves is going to have to remember lots of things when their head is probably already swimming, to say nothing of the natural anxiety if they have been moved to a new area. After a number of iterations and taking elements from existing checklists a draft was produced that was tested on a few occasions and is now to be formally launched and reviewed in a couple of months. This checklist is just for ULHT bank or substantive staff and is for inducting to a new area; it is not designed to be an organisational level induction such as is used for agency staff or for new substantive staff - these existing induction checklists need to continue. We called this a 'Welcome' rather than an induction checklist and is shown at Appendix 2. The plan is that these will be made available on wards and to download from the intranet; the responsibility for going through them must be seen as a joint one – the member of staff moving and the nurse in charge. The document is designed with space to 'scribble' and can be kept by the individual so they can refer to it should they forget a door code or a bleep number. Staff have said they hate having to ask things again and again and this will help with that.

An additional action

During the meetings line managers in particular described sadness when they have had negative feedback (such as seen on the ULHT Together Facebook page and comments from the review) and said they would want to know about any issues and concerns at the time so they could address them. This was unanimously agreed and from these discussions a 'How was it for you' feedback form was designed. (See Appendix 3). These will be launched in December and reviewed in 2 or 3 months along with the other tools developed. The plan with this feedback is for the template to be available on the ward and staff encouraged to complete and leave in an envelope for the manager or to send it through later. The manager can then not only pick up any issues raised individually but see if there are themes or trends. There was much debate about having a name or leaving it to be anonymous but the feeling in the group was that we need to encourage ownership of concerns and not be afraid to raise issues. Managers said that if there was a negative issue they would want to contact that member of staff personally to apologise and give assurance that it was being dealt with sensitively. Conversely it was recognised that this would also encourage positive feedback which is being seen more and more since the project was commenced particularly on the Facebook page. This of course doesn't preclude anonymous feedback but we felt that encouraging openness will in turn help with encouraging ownership amongst staff of their behaviour and drive a compassionate and supportive working atmosphere.

The steering group has had a wide membership, some in person and some 'virtual' contributing through email and Facebook. Reports and updates have been shared on the Facebook page and via internal communications and the project lead would like to thank everyone involved and for the co-operative nature of taking the recommendations forward.

Next steps

Action	**Milestone**
1. Launch: • Welcome • Reflective Template • How was it for you?	December Communication through 'Roundup' and various mailgroups and forums.
2. Film staff moves video	Film in December; launch in January 2019
3. Develop the principles / commitment statement for decision making about who to move.	Design and consult in December Launch in January 2019
4. Review tools	February / March 2019
5. Repeat survey	April / May 2019

Jennie Negus
Deputy Chief Nurse. November 2018

Appendix 1

Name:……..
Role:……
Ward / department:……

MOVING CLINICAL STAFF
REFLECTING ON SKILLS & KNOWLEDGE

This is a self-appraisal template using Gibbs' Reflective Learning Cycle (Gibbs G (1988) Learning by Doing) for you to think about and complete. Moving staff to other areas is a fact of life at present in the NHS (not just here at ULHT) and we all need to be prepared for this unless there are specific reasons otherwise. This can be used for any member of staff. Think about where you may be moved to and where ***you feel*** you may need some refresher or specific training to augment your existing skills and experience. Then discuss these with your line manager and agree how any gaps or development needs can be addressed.

Think about where staff from your ward get moved to most frequently:	
What skills, knowledge and experience do you currently have to be able to care for patients in those areas? (you will be surprised what is transferrable so consider all aspects of caring for patients and not just specialty skills)	
What worries you the most about being moved to work there? *(the induction and handover issues are being addressed separately so focus here on clinical skills , knowledge or experience)*	

What would help to ease and address those worries? *(e.g. insight visit, rotational period, shift swap, training)*	
Now have a discussion with your line manager and agree an action plan tailored to you.	

Date of discussion:……..

Don't forget to revisit this; by its very nature a cycle continues……..

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Appendix 2

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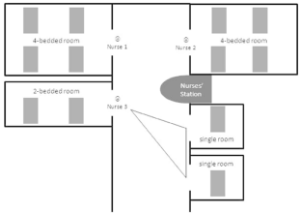
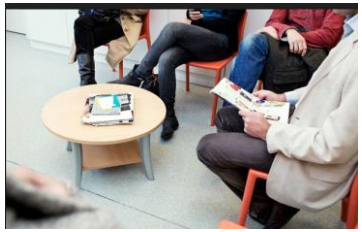
United Lincolnshire Hospitals
NHS Trust

MOVING CLINICAL STAFF
WELCOME
(This is your copy; feel free to scribble ☺)

Introductions		• Introduce everyone on shift • Who is in charge • Who is allocated to where • Who to go to for help	
Ward / department layout		• Show around the whole ward • Equipment and store rooms • Where other staff are working.	
Fire safety, Health & Safety and Security		• Fire alarms • Exits • Equipment • Evacuation procedures. • Muster Point • Local security / health & safety issues	
Telephones		• Ward numbers • Important contacts • Important bleep numbers.	

Resuscitation & key equipment	 	• Resus trolley • Portable suction • Hoists • Procedure trolleys • Observations kit. • Hypostop Box • Sepsis Box	
Door codes	 	• Treatment rooms • Sluice • Kitchen • Store rooms • Staff room • Linen room	
Staff rooms	 	• Where to leave personal valuables • Where to take a break & have a cuppa • Staff toilets	

My name:	I was welcomed by:
Ward:	Date:

MOVING CLINICAL STAFF
HOW WAS IT FOR YOU?

Appendix 3

Name:……..
Role:……
Ward / department:……
Date and shift:……

Understanding your experience when you have moved to another area is really important to the managers. Feedback whether good or bad helps to focus where improvements need to be made or practice celebrated and shared.

If you don't tell us we won't know, and if we don't know we can't make any necessary changes; so please, tell you story and leave this feedback for the manager of the ward or department you worked in.

What went well?	
What was not so good?	
What could be different next time?	