

Risk Assessment Template

Bradford Teaching Hospitals **NHS**

NHS Foundation Trust

Risk assessment number		Conducted by	Kelly Young Matron for the Neonatal Service Update Kay Rushforth and Sam Wallis	Date	30/09/2020 Updated / revised May 2021 Reviewed Nov 21 Reviewed Feb 22
Brief description of job/activity/objective being assessed			Staffing levels on BRI NNU: The neonatal service at Bradford is unable to provide nursing care sufficient to meet demand according to National Critical Care Service Spec / BAPM standards.		
Site	BRI	Location	Neonatal unit		

Step 1: Identify the hazards (Using bullet points write down here the potential hazards)

1. Staffing: Numbers

Non-compliance with the **Neonatal Critical Care Service Specification** related to nurse staffing based on agreed **BAPM** staffing standards that have been in place since 2011.

These staffing standards are supported by the **Neonatal Critical Care Review (NCCR)** commissioned by NHS England and published Dec 2019. <https://www.england.nhs.uk/publication/implementing-the-recommendations-of-the-neonatal-critical-care-transformation-review/> They are also a requirement of the CNST Maternity incentive scheme.

<https://resolution.nhs.uk/services/claims-management/clinical-schemes/clinical-negligence-scheme-for-trusts/maternity-incentive-scheme/>



BAPM_Guidance_on_
Cot_Capacity_and_u:

The NNU was subject to a national peer review on 7 November 2017. A serious concern was raised in relation to nurse staffing levels at the review. In response an increased staffing / skill mix model was proposed and approved in early 2018 with an aim to improve compliance based on average 80% occupancy for 31 cots.

Progress has been made but Network Peer review in November 2019 highlighted ongoing issues with staffing. Included as "Should do" in 2019 Trust CQC report. "The service should ensure neonatal nurse staffing meets national standards." <https://www.cqc.org.uk/provider/RAE/reports>



Bradford - Service
Review Summary.pdf

Update May 2021

Current funded establishment is inadequate to meet level of activity (as calculated by the Neonatal Nursing Workforce tool).

10.52 wte deficit. In addition there are vacancy rates equating to **16** wte at all levels (registered and non registered).

This means that 1:1 care cannot reliably be delivered to babies requiring intensive care and 2:1 care cannot reliably be delivered to babies requiring high dependency care.

Recruitment to a substantive Matron post unsuccessful

Current nursing vacancy gap from funded establishment is 15.79 WTE. The gap according to the NNU Workforce tool is 22.22 WTE with QIS gap -38.40WTE

2. Skill mix

The neonatal service currently has lower than the mandated (80%) of the nursing workforce holding the QIS (qualified in speciality) qualification.

Update May 2021

Currently 40.9% of RN workforce holds QIS qualification (January 2020). This is a deterioration since 2018/19 (previously 58%)

As newly qualified nurses (NQNs) join the workforce and the NNU reaches establishment the more dilute the QIS nurses become with fewer skilled nurses to care for babies in ICU and HDU. Only 2/4 QIS students will complete in 2021.

Ward Pressure

Category

Step 2: Decide who might be harmed and how (For each hazard you need to be clear about who might be harmed; it doesn't mean listing everyone by name, but rather identifying groups of people e.g. patients, nursing staff, porters, secretaries etc. and how they may be harmed)

Patients

Mortality and other quality of care outcomes are improved when the national standard for nurse staffing is achieved.

During shifts when there are insufficient nursing numbers / QIS trained to meet acuity and demand, then unless adequate mitigation is in place;

There is a potential risk to patient safety.

- Failure to monitor and treat patients appropriately which may lead to patient deterioration
- Failure to recognise deteriorating patients in a timely manner which may lead to prolonged hospital stay and/or permanent damage to the patients.
- Inability to accept in-utero transfers/babies from other hospitals within Y&H region that require intensive care treatment. These babies will need to be transferred out of region.
- Failure to educate and train nurses to a standard to deliver optimum care.

Update May 2021

- 3 Serious Incidents declared. 2 related to infection and potential IPC issues. 1 a delay in recognition of serious bleeding (action plans in place).

Staff

There is a risk to staff wellbeing from persistent exposure to excessive workload.

- Increased staff sickness rates
- Inability to recruit and retain staff

Update May 2021

- Rise in vacancy rate over last year suggestive of staff retention issues.
- Clinical Psychology report on Neonatal staff: 42% of staff have low levels of resilience, 1:5 at risk of emotional exhaustion

Update Nov 21

- Further rise in vacancy rate. OD team involvement, culture survey in circulation for all staff members with future work dependent upon results of survey
- To utilise nursing vacancy money through employment of AHP to support nursing team (2 year contracts).

Trust

Update May 2021

Reputational and financial cost of not being able to staff the neonatal service to safe levels.

1. Non-compliance with Maternity Incentive Scheme and CQC requirements / recommendations.
2. Inability to maintain sufficient activity to maintain NICU status
 - Neonatal income is paid via a daily tariff depending on level of care for each infant. Increased activity in terms of both days and level of care attracts higher income (this was temporarily switched to a block contract during the pandemic but tariff payments due to resume in 2022).
 - Neonatal transformation programme (2019) stipulates NICUs must provide >2000 intensive care days to maintain status. Units may lose NICU status if they are unable to deliver this level of activity. Bradford has previously been able to deliver 2000 days of intensive care with concomitant increase in staff but this dropped in 2019/20 and 2020/21 (see below). This is likely to be a result of high vacancy rates in 19/20 and nationwide reduction in activity during the pandemic of 20/21.
 - Activity (and income) would drop significantly further with a loss in NICU status as Bradford babies would require transfer to other units for their intensive care and no intensive care babies would be transferred in from elsewhere.
3. Commitment to additional neonatal nurse funding is part of the NHS long term plan. However the Neonatal Network report that Yorkshire and Humber has not obtained additional funding for this financial year. This is partly because of a perceived greater need elsewhere, but also because of high vacancy rates which have made the region less attractive for investment in increased establishment numbers. This decision will be reviewed yearly. Update Nov 21 **High vacancy rate will reduce through AHP employment (described above). The Neonatal Network to bid for LTP funding based on this years Vacancy rate (after employment of AHP)**

	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21
Intensive Care days	1600	1654	1884	2052	1857	1464

Step 3: Evaluate the risk and decide on the existing precautions and decide if there is a need for further precautions. (Having spotted the hazards, you then have to decide what to do about them. Listing existing control measures here or note where the information can be found e.g. existing policies, procedures, work etc.)

Existing control measures

Closing cots to maintain recommended staffing ratios / toolkit standards is sometimes the safest option but has itself a potentially harmful impact and risk to patients

- Bradford has network / regional responsibilities (alongside other NICUs) to provide neonatal intensive care to babies who require it.
- Closing cots to preserve ratios may mean a baby born in a non-NICU unit is either not able to be transferred (and therefore cared for in an inappropriate clinical environment) or may need to be transferred out of region / long distances (and this can be associated with harm).

Risk matrix

Table 3 – Impact / Severity	Catastrophic	5	5	10	15	20	25
	Major	4	4	8	12	16	20
	Moderate	3	3	6	9	12	15
	Low	2	2	4	6	8	10
	Negligible	1	1	2	3	4	5

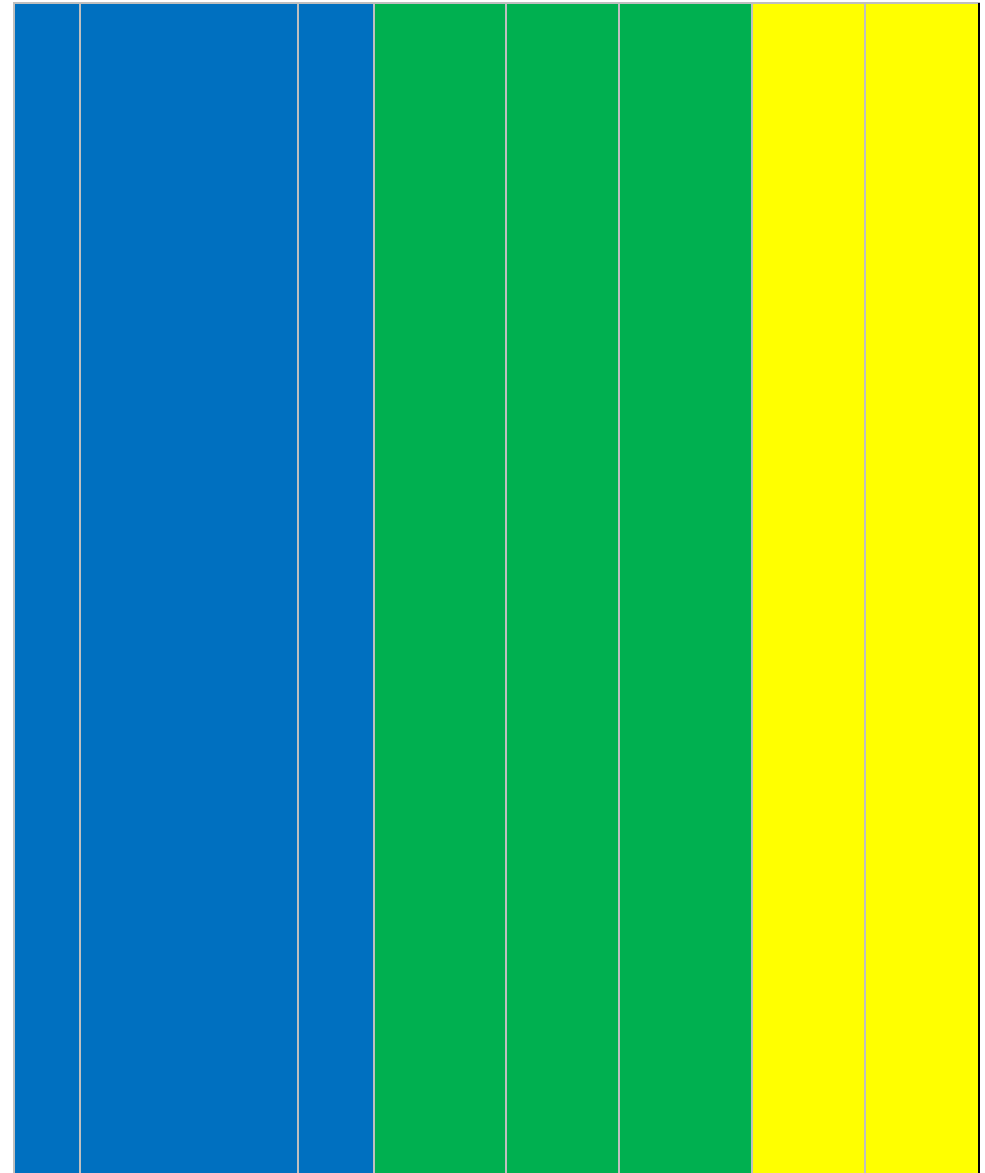
- Actual acuity of babies is not always reflected by current measures and it may be safe to admit additional babies without any detriment to current patients.

Bradford NICU must therefore balance it's responsibilities to look after the current patient cohort safely and the NICU demands of the regions.

Current mitigation:

Managing Acute demand

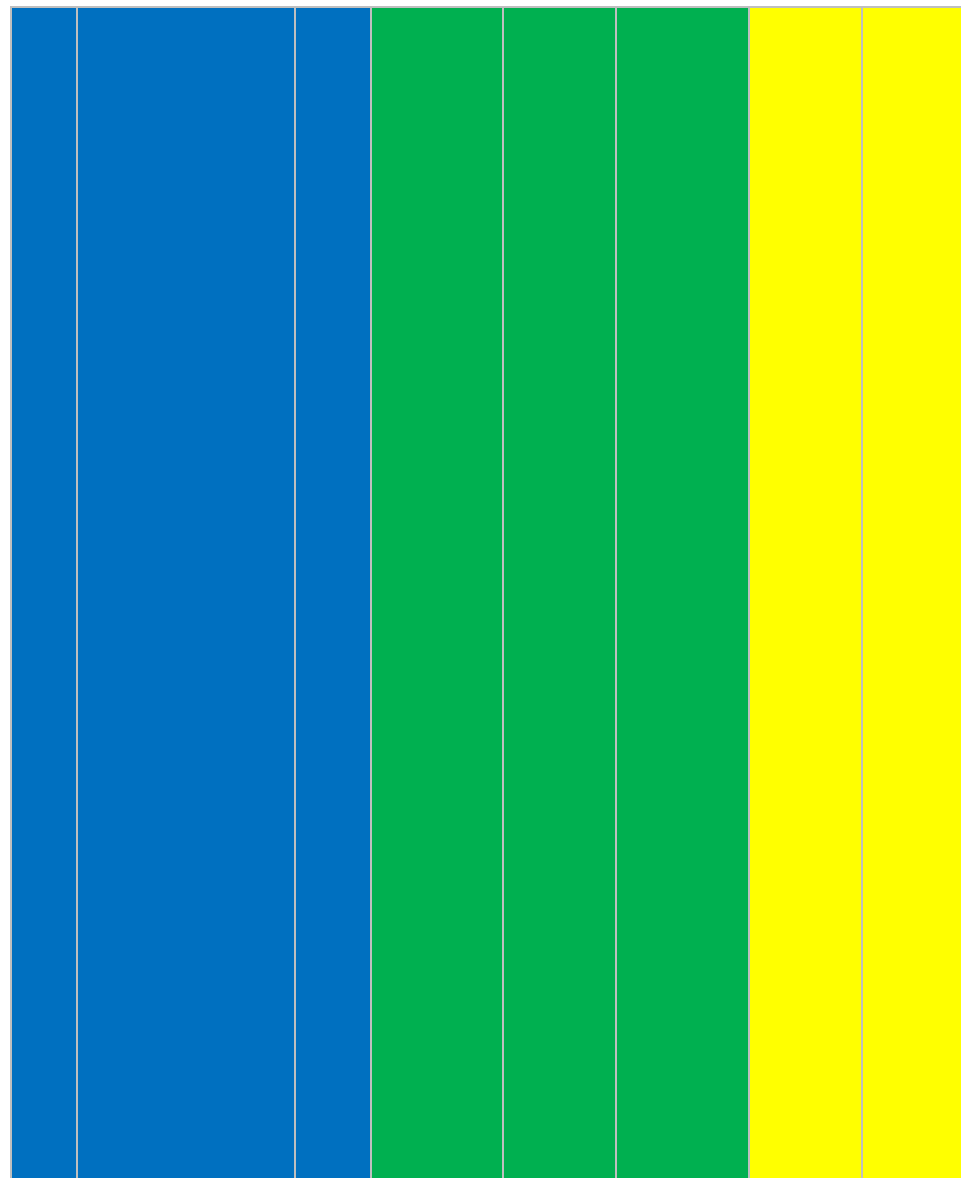
- Cots restricted to safe levels according to professional judgement. Shift by shift review of patient caseload and agreement between Consultant / Nurse co-ordinator. Aim to run cot base as per standards but some discretionary flexibility based on actual care needs of babies / families.
 - Ongoing work with Airedale NNU as part of collaboration to facilitate care of babies in most appropriate location
 - Neonatal co-ordinator takes a patient caseload if required. (should be supernumerary)
 - Daily risk assessment across children's service (in and outpatient) to redeploy staff as required.
 - Daily safety huddle (ADN, Matrons and Ward managers) to facilitate discussions related to redeployment and safety.
 - Daily NNU MDT safety huddle to ensure team are all aware of challenges with staffing, capacity and flow and where to focus actions within the service.
 - Potential for Matron/ and CNS to work clinically if needed
 - **Escalation to executive team when regional and local beds are very limited**
- Acceptance that running >80% capacity may be acceptable if regional NIC demand is such that these babies would have to be sent out of region / further afield. But that need to ensure that regional demand is shared fairly across NICs by close working relationship with Network / Embrace.
 - Management of neonatal flow in collaboration with Y & H ODN network and in conjunction with operational escalation matrix.



- TNR shifts are put out minimum of 6 weeks in advance (registered and non registered) Pulse agency approval is requested monthly and daily to cover short term sickness.
- In certain circumstances (and with approval)
 - TNR / nurses employed to increase total numbers of nursing staff and QIS skill mix on shifts.
 - Agency employed to maintain safety during periods of high acuity and activity
 -

Recruitment / Retention

- Twice yearly engagement in chief nurse team funded establishment review, to include completed Neonatal Workforce Tool to describe activity and acuity of previous year to support planning for the next year.
 - Work closely with ODN to monitor staffing numbers/training.
 - Neonatal Staffing strategy 1-5 year developed (2019+6; 2020+2; 2021+2 =10 nurses added to establishment.)
- Regular skill mix review. Ongoing development of key roles within nursing team. Ensure skill mix fits needs of service – distribution of numbers at different bands may change according to clinical need and ability to recruit.
 - Utilised a nursing post to support IPCC in NNU. Post for 1 year to undertake QI work
 - X2 trainee ANNP funding to commence Sept 2021
 - RNs eligible for qualified in speciality programme are supported and identified and can currently access programmes at University of Sheffield or University of Leeds. Under development is a Y & H ODN network QIS programme to commence 2020.
- Job advertisements are placed to reduce vacancies at band 3,4,5, 6 and 7
 - Timely management of recruitment to vacancies within the service.
 - Engagement with university recruitment and opportunities to engage students in employment opportunities
 - Showcasing and promoting neonatal service at trust recruitment events x 2 per year. (currently limited due to Covid restrictions)



- Social media engagement to share live job adverts.							
Risk rating taking into account existing controls							
Likelihood	5	X	Impact	3	=	Risk rating	15
Rationale							
<p>May 2021: Risk increased from 9 to 12.</p> <ul style="list-style-type: none"> - Unable to recruit to Matron post - Deterioration in QiS figures and concerns about adequate education / training for nurses - Recent Serious Incidents x 3 <p>Oct 21: Risk remains high</p> <ul style="list-style-type: none"> - Matron post recruited (Ruth Tolley) - However ongoing high vacancy gap with further resignations and low levels of recruitment. Escalated to Triumvirate. Plan to address developed but as at present the situation remains precarious the risk score should remain at least at 12. <p>Nov 2021 Risk increased to 15.</p> <ul style="list-style-type: none"> - Many leavers - Higher vacancy gap with further resignations - Matron off sick <p>Feb 2022</p> <ul style="list-style-type: none"> - High vacancy gap persists. Progress with some actions as below. Jamie Steele appointed as Deputy Assoc Director of Nursing for CBU to support 							
Target risk rating							
Likelihood	2	X	Impact	3	=	Risk rating	6
Rationale							

Risk = Table 2 - Likelihood x Table 3 - Impact		1	2	3	4	5	
		Extremely Unlikely	Unlikely	Possible	Likely	Almost Certain	
		Table 2 – Likelihood / Probability					

Table 2 – Likelihood / Probability				
1	Extremely Unlikely	Less than 20%	Once every two years or more	Rare / Low

Table 3 – Impact / Severity			
1	Negligible	No / Minor Injury / Minimal loss / No time off work	Low

2	Unlikely	20% to 39%	Once a year	Unlikely / Low to Medium
3	Possible	40% to 59%	Once a Month	Possible / Medium
4	Likely	60% to 79%	Once a Week	Likely / Medium to High
5	Almost Certain	80% or more	Once a Day or more	Almost Certain / High

2	Low	Minor Injury / Some loss / 7 or Less days off / Some Damage	Low to Medium
3	Moderate	Injury / 7 or more days off / Damage / Loss / RIDDOR Incident	Medium
4	Major	Long term injury / irreversible injury / serious damage or loss / RIDDOR Incident	Medium to High
5	Catastrophic	One or more fatalities / irreversible injury / substantial damage or loss / RIDDOR Incident	High

Step 5: Risk reduction action plan (Please list here what additional control measures are needed to reduce the risk to an acceptable level. You only need to complete this section when additional control measures are required)				
Risk assessment number		Brief description		Date 25/1/2019
Additional control measures required to reduce the risk to the lowest possible level:			Action owner/designation	Timescale
Submit paper to Trust to highlight current issues and rise in risk score with request for <ul style="list-style-type: none"> - Continuity of funding for next year to +2 (an increase in 12 nurses since 2019) - An increase in supernumerary status for NQNs from 6 weeks to 10 weeks to take into account the differences in care provided in ICU, HDU and SC. - 1 WTE educator funding extra to existing post (educator role not included in the calculation for workforce) 			Kay Rushforth / Jamie Steele Nov 21 50 overseas nurses to be recruited for the Trust. NNU to be part of recruitment. Oct 21: Paper submitted and accepted. However ongoing vacancy gap remains large no unable to recruit to establishment. Feb 22: Transformation plan drafted. For monthly review at Neonatal / Triumvirate meeting. Incorporates <ul style="list-style-type: none"> - Culture review with OD team - Recruitment / retention - Education / career progression - Network / LTP funding/spend and overview - AHP recruitment 2 x Educators recruited. Band 7 out for advert. AHP recruitment plan progressing well Additional nursing roles agreed. Good attendance / engagement at Network recruitment fair. Support from Network in developing MDT.	October 22

	Plan for Outstanding Neonatal Service (ONS) programme – in development	
Neonatal Staffing strategy developed and to be agreed with trust <ul style="list-style-type: none"> - Nurse staffing key part of this 	<p>Sam Wallis / Rob Guest</p> <p>Oct 21: Strategy written and submitted to CBU. Shared with Trust and Action plan developed.</p> <p>Feb 22: Staffing Paper to be submitted to People's Academy in March. Updated plan for Board approval May 22 as part of MIS submission (year 4).</p>	March-May 2022
Work with the Y+H Neonatal ODN to submit bid for National LTP funds for Neonatal nursing. <ul style="list-style-type: none"> - Commitment in NHS long term plan - Not approved for this year despite Bradford RAG rating red. 1 reason given was high vacancy rate across network - Therefore to concentrate on reducing vacancy rate over next 12 months. 	<p>Matron/Kay Rushforth/ODN</p> <p>Nov 21. New NNU workforce tool figures presented to ODN (see above) AHPs to be recruited (short-term contact) to reduce vacancy. ODN to submit for LTP funding</p> <p>Feb 22. Bid successful. >£500K recurrent funding secured. Further bid planned for next year.</p>	Complete
Staff support / retention / skills development work <ul style="list-style-type: none"> - Regular appraisals and offer of support. Aim to conduct exit interviews with all staff who leave the service. - Work with limited clinical psychology resource to seek feedback on team wellbeing. - Set clear expectations and provide structured support for newly qualified nurses with respect to skill development and career progression 	<p>Matron/ Band 7s/ Neonatal Educators/ Clin Psychology</p> <p>Oct 21: Limited progress as staffing shortages and limited Clin Psych input. OD team offering support to Band 7s. Plan to increase Clin Psychology provision.</p> <p>Feb 22: Clinical Psychology role going out to advert. OD team completed work but results delayed due to Omicron surge redeployment. Recent successful engagement at culture café's.</p> <p>Plan for Outstanding Neonatal Service (ONS) programme – in development. OD work to feed into this.</p>	April 2022
Revise Escalation policy / Capacity guidance to safely manage surges in demand. <ul style="list-style-type: none"> - Regular objective assessment of unit capacity and agree actions to maintain safe levels of activity. - Aim to transfer lower dependency babies to LNU/SCBUs with support from network. - Close liaison with network and maternity service on appropriate 	<p>Sam Wallis / Matron</p> <p>Oct 21: Drafted. Out for consultation.</p> <p>Feb 22: Escalation policy / guidance in use.</p>	Complete

management of in-utero and neonatal capacity and patient flow. - Neonatal co-ordinator takes a patient caseload if required.					
Review Badger staffing figures (dashboard) at Neonatal Operative group meeting monthly and escalate to network if Bradford NICU staffing not in line with other NICUs				Sam Wallis	In place
Residual risk					
Anticipated residual risk rating (Re-score your assessment based on the proposed additional control measures being implemented. This proposed / anticipated residual risk score will provide an indication of the potential / anticipated risk reduction that is likely)				Date added to risk register*	
				Date submitted to Risk.Assessments@bthft.nhs.uk	
				Reviewed Next review due	11/02/2022 11/05/2022
Likelihood	2	X	Impact	3	= Residual risk rating 6
Decision to accept residual risk					
Designation			Divisional Clinical Director W&C		Name

Risk reduction action guide							
Risk Rating			Action Level	*Risk register	Action time scale	Remedial Action Owner	Decision to Accept Risk
Green	Low	1 to 3	Observations	No	12 months or more	Ward / Department Manager	Ward / Departmental Management
Yellow	Moderate	4 to 6	Recommendations / Continuous Improvement	Yes	6 to 12 months	Care Group / Department Manager	Departmental Management
Orange	High	8 to 12	Further Additional Controls / Process, Task, Activity Review / Escalation	Yes	2 weeks to 6 months	Divisional Manager	Divisional Management
Red	Extreme	15 to 25	Major Review / Escalation / Prohibit	Yes	Immediate to 2 weeks	Executive Director	Executive Director via IG&R /Board