

CHESTERFIELD ROYAL HOSPITAL NHS FOUNDATION TRUST
BOARD OF DIRECTORS – May 2017
EXECUTIVE SUMMARY AND BRIEFING PAPER

Agenda item: Safe Staffing levels for the adult in-patient wards, including Children's and Midwifery inpatient Services

Board sponsor: Lynn Andrews Director of Nursing and Patient Care

Reason for the item: The paper provides assurance that the Trust has safe nurse staffing levels

Briefing on the item

This paper focuses on a systematic review of nursing/midwifery staffing through an assessment of acuity and professional opinion triangulated with quality indicators, patient and staff experience.

A nationally recognised acuity tool utilised across the adult wards, identified three wards where the acuity is noticeably above establishment; with further work in progress to inform the workforce requirements.

The emphasis is on safe patient care and not the number of available staff per patient. On the acute adult wards during the day shift all of the wards work with a ratio of less than 1:8 patients, which is in line with national guidance. The recommended skill mix ratio across adult in patient areas is 65:35 (qualified to unqualified), the majority of the adult wards at CRHFT work at around a 60:40 split.

Following the recommendations from the Birthrate Plus review in 2016, to facilitate skill mix changes the midwifery support workers role has been implemented.

Across the paediatric areas the Neonatal Unit staffing levels are based on the British Association of Perinatal Medicine guideline (2011), to which the Trust is broadly compliant. The acute paediatric ward acuity is linked to the Royal College of Nursing guidelines; the acuity audit in December 2016 showed a decline in compliance, which related to the significant increase activity and acuity, which was seen nationally. A number of measures were put in place to maintain patient safety over this period.

There has been an improvement in the outcome indicators comparing performance during September 2016 to February 2017 against the same period the year previous.

The 'We want to be' feedback from patients relating to nurse staffing was classified as 'poor', narrative feedback does not identify any reasons for this perception. This is however in contrast to the local and national survey results which has an equivalent rating of 'good'.

A recurring theme from staff feedback is that they feel under pressure, this is supported by the NHS National Staff Survey (NNSS) 2017. The NNSS results highlighted areas where nursing/midwifery scores are significantly worse than the Trust average for example: working additional unpaid hours, the ability to do the job to the standard they want to and in meeting conflicting demands. More positive scores are themed around good team work working, the opportunities for training/professional development and feedback/actions taken following incidents. This could suggest despite the pressures being felt by staff there is evidence of good ward and departmental leadership.

Due to firstly, the high number of registered vacancies and secondly, the need to release staff to support additional bed capacity which impacts on efficient and effective team working it remains challenging to determine if nurse staffing levels are appropriate. Taking this into consideration, the Director of Nursing and Patient Care is satisfied that the establishments are within acceptable levels; recognising that further work is being undertaken on two wards to review the nurse staffing levels and workforce requirements.

Board are asked to note the contents of the report and approve:

- the recommendation to maintain the current establishment levels

Related strategic outcome(s):

- 1: To be rated as 'outstanding' by the CQC
- 2: To have a solid foundation of core acute services meeting all national standards
- 3: To have effective partnerships – locally through more integrated care and regionally through networked clinical service models
- 4: To be in the top 20% of all NHS employers for staff experience as measured by the national staff survey and our own Your Voice survey
- 5: To have from NHS Improvement a financial sustainability risk rating of '4' and a 'green' governance rating, and to be deemed 'well-led' by NHS Improvement
- 6: To be in the top 20% of NHS providers for PLACE scores and to reduce CO² emissions from 11,298 tonnes to 10,634 tonnes (2% per year); to have an IM&T capability that is fit for purpose for 2018 and beyond

Board Assurance Framework (BAF) risks relating to this item:

- 4.1 failure to develop and embed a sustainable and affordable workforce plan
- 4.9 failure to improve staff experience and engagement, impacting on recruitment, retention and morale

Other risks relating to this item:

- Risk 1903 - Failure to recruit to our vacancies, particularly in nursing and medical workforce.
- Risk 1909 - Developing and delivering a workforce plan to ensure future sustainability of the Trust's workforce
- Risk 2090 - Failure to achieve compliance with NHSI agency price caps
- Risk 2122 - Nursing Staff Cost Pressures - Bank & Agency Spend (Medicine & Emergency Care)
- Risk 2050/2239 – Temporary/winter wards staffed with bank and agency staff (Medicine & Emergency Care & Surgery)

Financial impact: Through better understanding of staff resourcing and allocation to assist in reducing the financial impact.

Equality impact: No direct impact

Environmental impact: No direct impact

Partnership working: Partnership organisations relating to workforce recruitment/rotational posts. Temporary staffing (agencies).

Report to the Board on the safe staffing levels for the adult in-patient wards, including children's services and the women's health unit

1. Introduction

- 1.1 It is good practice that Trust boards undertake a nurse/midwifery staffing review annually or more frequently if changes to services are planned. The key elements of this approach are: using a systematic evidence-based approach, exercise professional judgment to meet specific local needs, benchmarking with peers and taking into account national guidelines. This approach is also recommended by National Institute Clinical Excellence (NICE) guidance (2014).
- 1.2 This should be followed up with a comprehensive staffing report after 6 months to ensure plans are still appropriate.
- 1.3 Following the six monthly nurse staffing review in October 2016 the Hospital Leadership Team (HLT) requested supporting papers outlining the case for additional staffing, subsequently the following additional investments have been agreed:
- Enhanced Nursing Support Team 5.8wte Health Care Assistance (£140)
 - ED 6wte RNs (£224), 10wte HCA's (£264) and to support training of 5wte Assistant Practitioners/Associate Nurse posts (£170k)
 - EMU/CDU 5.56wte registered nurse (£207k)
- 1.4 This report presents the annual nurse/midwifery staffing review. It outlines the approach that is taken to ensure that there is sufficient nursing and midwifery capacity and capability across the in-patient areas to meet the needs of patients and to maintain safe staffing.
- 1.5 This report is covered in three sections:
- Section 1 – Nursing and Midwifery establishment review
 - Section 2 – Key finds across the Divisions
 - Section 3 – Going Forward - National Guidance

2. Section 1 - Nursing and Midwifery establishment review

- 2.1 A National Quality Board recommended acuity tool the Safer Nursing Care Tool (SNCT) which measures patients' acuity/dependency has been in use across the adult in-patient areas at Chesterfield Royal Hospital Foundation Trust (CRHFT) since June 2014. Data was collated monthly for the first year (June 2014 to June 2015) to achieve a base line position and is now completed every three months in line with national guidance, including a robust validation exercise. The latest data collection occurred in January 2017.

3. Acuity - Adult Wards

- 3.1 The mean acuity for each ward is outlined below in graph 1; this shows the whole time equivalent (wte) establishment in September 2015 and subsequent increases in the establishment to the current values. The mean acuity is greater than the establishment in 12 of the 14 wards; with the exceptions being Murphy and Durrant. Murphy's acuity has been consistently below the establishment with Durrant's being below the establishment on two occasions over the past 12 months (acuity has been measured on four occasions over this time period).
- 3.2 Murphy ward was remodeled as a combined surgical and orthopaedic short stay ward in December 2015, taking direct admissions from the Emergency Department (ED). It has a fast pace and high patient turnover with an average length of stay of no more than 72 hours. A limitation of the SCNT tool

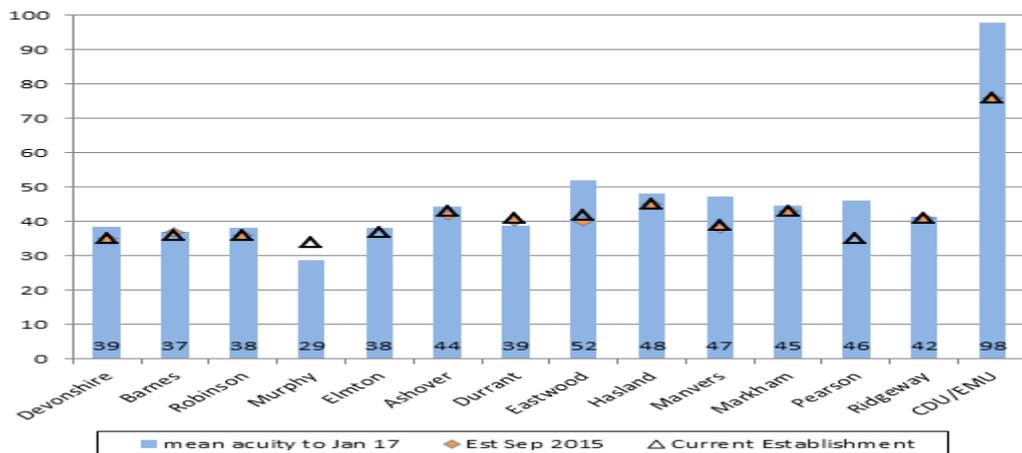
is that it does not capture patient turnover and therefore cannot reflect fully the nursing establishment requirements of such wards. This pace of activity warrants a higher nursing establishment than the acuity implies, therefore there are no plans to alter the establishment as a result of the acuity.

- 3.3 Durrant ward is an acute frailty/care of the elderly ward which has a high patient turnover following rapid assessment and interventions and the limitations of the SNCT tool equally apply to this ward. There have been times throughout the previous 12 months where additional beds (up to 3) have been opened to assist with Trust capacity and they are also a high user of the Enhanced Nursing Support Team (covered in section 3.13). There are no plans to alter the establishment as a result of the acuity.
- 3.4 All of the other wards acuity is above the funded establishment.

Across the medical wards over the last 12 months the acuity scores have been stable with the exception of the Emergency Management Unit/Clinical Decisions Unit (EMU/CDU) which increased significantly in January 2017; this was due to operational pressures with CDU having dependent patients being admitted rather than short-stay patients. The other three data collection points over the previous 12 months although scoring above the establishment have been stable. Following a risk assessment in May 2016, the nurse staffing levels on the night shift was increased by two qualified nurses; the uplift in staffing was substantively agreed at the Hospital Leadership Team (HLT) meeting in March 2017. The increase in night staffing levels as initially temporary are not reflected in the funded establishment as seen in graph 1, but will be visible when the acuity audit is completed in April 2017. The increase in the funded establishment will increase from 76wte to *82wte (see notes).

- 3.5 Pearson ward is a 33 bedded general medical ward which opened in late December 2015, to initially provide additional capacity for seasonal pressures, with later agreement that the ward would remain open on a permanent basis. The nurse staffing levels since the ward opened in December 2015 have been identical to those on Ashover ward, although the funding was not aligned until April 2017, hence the lower establishment seen in graph 1. The correct funded establishment of 43wte will be visible when the acuity audit is completed in April 2017.
- 3.6 It is therefore reasonable to conclude that acuity remains consistent across the adult wards.

Graph 1
Mean acuity March 2015 to January 17



Notes

Changes in the establishment are shown between September 2015 (orange triangle) and the current establishment (purple triangle). The value at the top of each column of the graph is the current WTE establishment. The value at the bottom of each column is the mean acuity – where the column is above the establishment marker, the acuity for the ward was greater than the establishment. * the funded establishment used in graph 1 is rounded to the nearest wte

3.7 There are three medical wards of note where the acuity exceeds the current budgeted establishment; Eastwood, Manvers and EMU/CDU which are highlighted in section 2, 4.1.1, 4.1.2, 4.1.3.

3.8 The SNCT acuity tool cannot be applied on Elizabeth ward, Emergency Department (ED) and the Intensive Care Unit (ICU)/High Dependency Unit (HDU); therefore different methods are used, which are described below.

3.9 **Elizabeth ward**

The ward provides transitional care for patients who are medically fit for discharge but require complex discharge packages either in their own homes or in further healthcare settings.

3.10 The ward has highly dependent patients often with complex behavioural needs requiring increased levels of supervision. A tool known as Northwick Park which is more suited to assessing the level of input required for patients such that it is based on dependency rather than acuity was initially piloted in January 2016 and completed in April 2016.

3.11 The data suggested the ward may need a further 3wte Health Care Assistants (HCAs), the staff and the Head of Nursing (HON) professional judgment did not feel additional HCAs were required at that time, plus the quality indicators for the ward are generally good apart from falls incidence that increased in February 2017. The HON continues to monitor the falls incidence and compliance with the falls bundle.

3.12 **Emergency Department (ED)**

ED uses the dynamic priority scoring system which was introduced in January 2017. This categories patient in relation to the priority they need to be seen by the doctors and the level of nursing care required. The sum total of triage scores will provide an indication of the acuity in the department at a given time; this overall score is recorded at regular intervals throughout the day to allow analysis to be carried out. It is intended to review this data in June 2017 to help further inform the workforce plan.

3.13 **Intensive Care and High Dependency Unit (ICU and HDU)**

ICU and HDU continue to remain staffed at the levels supported by the Intensive Care Society guideline. To ensure 50% of the registered staff have an appropriate critical care specialised qualification, the unit has supported additional places via the networks critical care course. In addition to cover both units there is a clinical educator role which has been fundamental in supporting the newly qualified and overseas registered nurses.

4. **Staff to Patient Ratio Review**

4.1 There is no single nurse staff-to-patient ratio that can be applied across all adult inpatient wards. The emphasis is on safe patient care and not the number of available staff per patient. However, there is evidence of an increased risk of harm to patients associated with a ratio of 1 registered nurse to 8 (or more) patients during day hours. There is no recommended staffing ratio for night duty, although the Royal College of Nursing (2009) noted that a ratio of 1:11 would be reasonable, however, this has not been adopted by NICE.

4.2 On the adult wards at CRHFT during the day shift all of the wards work with a ratio of less than 1:8 patients. With the exception of the Elizabeth ward which is modeled on transitional care, this ward runs at 1:8 during the day shift ward. This has not altered since the preceding report.

5. **Skill Mix Review and New Models of Care Delivery**

5.1 The recommended skill mix ratio currently across adult in patient areas is 65:35 (qualified to

unqualified), with this being higher in areas such as Intensive Care Units, Emergency Departments and Acute Assessment areas. At CRHFT the nursing skill mix varies with the majority of the adult in patient areas working broadly at a 60:40 registered to unregistered split.

- 5.2 Going forward the skill mix ratio will need to be re-consider nationally as there are additional roles in development such as the nursing associate role which intends to support nursing teams to work more efficiently. The surgical division have also begun to reconfigured elements of the workforce and have successfully implemented the Ward Practitioner role with those individuals now progressing on to do the Assistant Practitioner training.
- 5.3 Nationally there is a recognition of the need to consider a wider multidisciplinary team when looking at the size and composition of staff for any setting, but to date nationally there is little workforce modelling or planning evidence on how this can be successfully achieved.
- 5.4 As part of the workforce transformational plan the 'Model Ward' project is examining new models of care initially being piloted across four wards aiming to develop an inter-professional ward establishments tailored to the needs of patients. This project is overseen by the Director of Workforce and Organisational Development with clear integration with safe nurse staffing.

6. Enhanced Nursing Support Team

- 6.1 The Enhanced Nursing Support team (ENST) is a dedicated team of HCA's that provide a level of increased supervision to patients, predominately with severe dementia, cognitive problems, high risk of falls, and alcohol related withdrawals. The team have received specific training and reside in a virtual ward managed by the Older People's Matron; this provides a flexible workforce with staff being allocated on a shift by shift basis.
- 6.2 It is noted in the Lord Carter review Operational Productivity and Performance in English NHS acute hospitals: unwarranted variations (2016) that all Trusts should be implementing the guide on enhanced care which is being developed by NHS Improvement.
- 6.3 CRHFT have already made significant progress in implementing such a model and is compliant against a checklist that was released by NHSI in September 2016.
- 6.4 An evaluation of the benefits of the team was presented to the Transformational Steering Group (TSG) and HLT in November 2016, this also highlighted that the demand for enhanced nursing support from the wards had exceeded capacity of the ENST; therefore it was recommended and approved that the ENST was expanded by 5.8wte. The additional posts have been recruited to with the majority of staff in post. A further evaluation against the defined KPI's will be completed in August 2017.

7. Outcome Monitoring

- 7.1 There are a number of quality outcome measures that are monitored which should be consider in conjunction with nurse staffing levels.
- 7.2 Outcome indicators comparing performance during September 2016 to February 2017 against the same period the year before shows:
- Hospital acquired C. difficile infections per 1,000 bed days shows a 25% reduction (0.9 compared with 0.12 infections per 1,000 bed days)
 - Rate of inpatient falls per 1,000 bed days shows a 8% reduction
 - Rate of hospital acquired pressure ulcers (grade 2-4) per 1,000 bed days shows a 12% reduction

- The proportion of patients identified with a new harm via the Safety Thermometer shows no change and remains better than the national average
- FFT Inpatient and day-cases, the % of patients who would recommend shows a 1.3% increase

7.3 There has been an improvement in the reduction of patient harms and the focus for improvement is in line with the quality strategy.

7.4 Patient and staff experience have also been taken into account as outlined below.

8. Patient Experience

8.1 Comments from Family and Friends Test (FFT) and 'We want to be' in relation to nurse staffing refer to observations of nursing staff being busy and the potential need for more staff, also expressing the staff as being friendly, helpful and efficient despite being busy.

8.2 The 'We want to be' survey scores from September 2016 to February 2017 shows that patients perception of nurse staffing consistently remains one of the lowest scoring areas, rating as 'poor' (40-49%), with the exception of November 2017 which scored a slightly higher a rating of 'fair' (68%). The patient's perceptions of nurse staffing levels are low across all Divisions with Medicine and Emergency Care seeing particular low scores between January to February 2017.

8.3 However, this is in contrast to the local in-depth inpatient survey and the national survey.

8.4 The quarterly local in-depth inpatient survey, which surveyed patients discharged in October 2016, had an overall score of 7.2 out of 10 which would equate to a rating of 'good' in the 'We want to be' survey.

8.5 In addition the national survey (2015) saw the Trust scoring 7.2 which is similar to other Trusts nationally, but at the lower end (the lowest scoring Trust was at 6.5 and the highest scoring was 9.3). The Picker results for the national survey (2016) show the Trust is in line with the Picker average (Trust = 41% and Picker = 40%) of those patients who felt there was not enough nurses on duty.

8.6 Although the 'We want to be' feedback scores are classified as 'poor', the local in-depth and national survey results for 2015 and 2016 position CRHFT in line with other Trusts with an equivalent score of 'good'. The narrative feedback from the 'We want to be' survey does not identify any themes or reasons for the patients' perception of nurses being busy and needing more staff. However, the patient's feedback was particularly low in January and February 2017 in the Medicine and Emergency Care Division which could correlate with operational pressures and additional bed capacity being open.

9. Staff Experience

9.1 A re-occurring theme from staff that comes from the staff forum and from informally speaking to staff is that ward based nursing/midwifery staff continue to feel under pressure. Although findings are indicative this feedback is supported by the findings of the NHS National Staff Survey 2016 (NNSS).

9.2 The NNSS was undertaken from September to the end of November 2016 and the final results were published in March 2017. The response rate for nursing and midwifery registered staff was 26%* compared to the Trust response rate of 34%. The data breakdown for nursing/midwifery staff is not collated by the national centre, so data comparisons are against the 45 acute Trusts that use Picker as their survey provider (total of 98 acute Trusts participated in NHSS).

9.3 Below (table 2) are the top three scores highlighted as being *significantly worse* across

nursing/midwifery than the Trust average and compared against those acute Trusts who used Picker as their survey provider.

Table 2

Survey question (questions as asked in the survey)	CRHFT Nursing/Midwifery staff	CRHFT average score (all other staff)	Picker Trusts Nursing/Midwifery staff
Don't work any additional unpaid hours per week above contracted hours	19%	41%	30%
Able to do my job to a standard I am pleased with	64%	72%	77%
Able to meet conflicting demands on my time at work	29%	35%	40%

- 9.4 The narrative feedback from the NNSS reinforce the quantitative data; with nursing and midwifery staff expressing that they feel frustrated not being able to give the care they want to, working additional unpaid hours and the increase in operational pressures.
- 9.5 These findings correlate to feedback around staff wellbeing for example: 66% of the nurses/midwives that participated reported that in the last 3 months they had come to work when not feeling well enough to perform duties (57% Trust wide, 60% Picker Trusts); with 52% (40% Trust wide, 43% Picker Trusts) commenting that they have been unwell due to work related stress in the last 12 months.
- 9.6 The top three scores that were *significantly better* across nursing/midwifery than the Trust average and compared favorably against those acute Trusts who used Picker as their survey provider are detailed below in table 3.

Table 3

Survey question (questions as asked in the survey)	CRHFT Nursing/Midwifery staff	CRHFT average score (all other staff)	Picker Trust Nursing/Midwifery staff
Team members have to communicate closely with each other to achieve the team's objectives	83%	75%	83%
Staff satisfied with support from colleagues	88%	81%	84%
Have had training, learning or development in the last 12 months	89%	68%	87%

- 9.7 The majority of the survey results that were better than the Trust average were themed around training

and professional development, incident reporting/action taken, utilising patient/service user feedback, and team-working. This could suggest despite the pressures there is evidence of good ward/departmental leadership.

- 9.8 The findings identified from the NNS are being linked into the Trust wide and local Divisional actions plan for example: flexible working practices and Listening into Action particularly focusing on improving working practices and health and well-being. A key element will be to explore further what the issues are, in particular completing a review of the unpaid hours.

10. Managing Staff Variance

- 10.1 There continue to be vacancies across most of the adult in patient wards in the Medical and Emergency Care Division and the Intensive Care/High Dependency Unit with recruitment plans mapped out to March 2018. In conjunction with the need to use temporary staffing to fill vacancies and short term sickness, the increase in Trust capacity has also led to additional reliance on temporary staffing through the use of the Bank and agency.

- 10.2 To address the day to day demands there are a number of ways that variances with nurse staffing levels are managed to ensure wards are staffed safely, these are:
- Utilisation of the ENST, section 3.13
 - Use of additional temporary staff, both registered and unregistered
 - Matrons who are supervisory to the ward staffing numbers, working within the staffing establishment
 - Moving staff around the trust
 - Cancellation in staff education/training sessions

11. Section 2 – Key findings across the Divisions

11.1 Medicine & Emergency Care Division

11.2 Eastwood Ward

- 11.2.1 Eastwood ward (stroke unit) has 2 hyper acute beds, 14 acute beds and 20 rehabilitation beds which are used flexibly dependent on the case load requirements. The ward has a number of Allied Health Professionals (AHP) who undertake daily living assessment, mobilisation and support with manual handling.
- 11.2.2 The wards ratio of nurse to patient at night is 1:12 and at times lower if the senior nurse is required to attend the ED to assist with thrombolysis for an acute stroke admission. An audit completed between November 2015 and January 2016 to assess the frequency of referrals showed the occurrences ranged from 25 to 4 per week, in addition the time and duration of the senior nurse being off the ward varied. Due to the unpredictability of the thrombolysis activity it was not recommended that additional night staff were required and the HON has looked at alternative ways of covering the e.g. operational night matrons and moving staff from other wards. An audit of the number of times and duration that a senior nurse spends in ED is being repeated for 3 months commencing in May 2017 to analysis the current position.
- 11.2.3 The ward has a high registered nurse vacancy rate and uses a combination of bank and agency nurses (some agency nurses being block booked), ward Matron working clinical shifts, along with moving qualified and unqualified staff from other wards and Allied Health Professionals (AHP's) supporting the ward to deliver direct care.

- 11.2.4 Due to ongoing challenges with recruitment urgent interim measures have been put in place which includes: registered nurses being released from other wards for a 6 month period, development of a fast track competency framework for both Trust and agency staff, increase in ward administration support and a recruitment plan to include advertising for Assistant Ward Practitioners along with a registered nurse specialist rotational programme.
- 11.2.5 In addition for a 6 month period the skill mix on the ward is being adjusted by increasing the number of unregistered staff on the day shift. This interim measure is supported by the nursing team on Eastwood ward who would prefer to have unqualified staff who are part of the ward team being fully aware of how the ward operates, rather than temporary staff. A quality impact assessment will be outlined in a proposal that is being taken to TSG in June 2017. The position is expected to improve slightly with 2wte registered nurses being in the recruitment phase.
- 11.2.6 Eastwood ward is part of the transformational workforce 'Model Ward' project which is described in section 3.12. It is felt that the ward is ideally positioned to benefit from this project given the need for a multi-disciplinary workforce; this is a medium to longer term plan, but the interim measures described above moves towards this concept.

11.3.1 **Manvers Ward**

- 11.3.2 Manvers ward (cardiology) has 10 coronary care beds (CCU) and 22 adult cardiology beds, with the nature of CCU being a more intensive care setting, patients require a higher level of care over the 24-hour period. However, patients who are unstable and need to undergo certain cardiac procedures are transferred to specialised local centers. Therefore, for the nurse staffing levels to reflect that of a specialised CCU is not required.
- 11.3.3 On review the HON has assessed that there are the correct number of staff on duty during the day and across the ward beds overnight. The acuity of the patients on CCU on occasions requires additional staff; this becomes a particular challenge during the night shift when a registered nurse escort is required for external transfers and internally for emergency procedures.
- 11.3.4 The HON developed a proposal that was presented to TSG to increase the registered nurse workforce on the night shift. The case of need was declined as the audit findings of the number of external and internal escorts did not support the reported activity. The HON is reviewing alternative options, as well as expanding the audit reviewing the percentage of time registered nurses are away from the ward escorting patients, not getting paid breaks and working unpaid additional hours.

11.4.1 **Emergency Management Unit & Clinical Decisions Unit**

- 11.4.2 EMU/CDU is a 54 bedded combined unit which accepts medical and surgical emergencies from ED and GPs for assessment, stabilisation and transfer for onward care or discharge. There is also an outpatient ambulatory care facility attached to the ward which investigates and treats patients; preventing the need to admit to an inpatient bed.
- 11.4.3 To support the increase in admissions overnight there has been an agreed uplift in the registered nursing establishment of 5.56wte which will allow for an additional two qualified nurses to be rostered on the night shift.
- 11.4.4 The HON is reviewing the leadership structure across EMU/CDU which will involve the Matron and Sister/Charge nurse roles. This is felt necessary due to the size of the unit and associated number of staff, the plan is to have this completed by June 2017.

11.5 **Emergency Department (ED)**

- 11.5.1 The ED has 10 stretchers, 2 pit stop rooms, 8 cubicles, 1 adolescent cubicle and 2 paediatric cubicles, one 3 bedded and 1 single bedded paediatric resuscitation room. There are 4 'see and treat' rooms at the front of the department to triage and treat minor injuries.
- 11.5.2 ED has various shift patterns that supports the profile of attendances, this was reviewed in October 2016 and felt to be appropriate. When the department is facing high demands staff from other areas are sent to support with patient comfort rounds and observations.
- 11.5.3 As part of the workforce model phase 1 an additional increase of 10wte Health Care Assistance (HCAs), 5wte registered nurses and a clinical educator was approved in October 2016. In addition funding to support the training of 5wte Assistant Practitioners/Associate Nurses, which supports the future workforce model in ED. The appointment of the additional HCAs will facilitate the 'chaser role' being covered 7 days per week; this role undertakes a variety of tasks that will free up the registered nurse in charge to work clinically.
- 11.5.4 Phase 2 of the workforce model will be reviewed alongside the impact of Derbyshire Health United (DHU) streaming project and other patient flow work that is underway across the Trust and the wider health community, as this will have potential impact on the workforce requirements. Consideration will be made regarding the use of Assistant Practitioners that are in training as they will be able to undertake some of the roles traditionally undertaken by registered nurses. In addition the results of the dynamic priority scoring system will help inform the workforce plan (see section 3.9).

11.6 **Winter Pressures ward**

- 11.6.1 Portland ward was opened at the end of December 2016 to provide additional capacity over the winter months. Nurse staffing to support the ward was planned in advance and consisted of permanent Trust staff from the Medical and Emergency Care and Surgical Division, as well as temporary staff.
- 11.6.2 Staff have fed-back a positive experience on Portland ward, which is felt to be due to a number of factors: improved planning of how long the ward was going to be open facilitated better planning of the workforce e.g. nursing, AHPs, support staff and a dedicated medical team; the ward leadership team was identified in advance which enabled them to meet the permanent staff who were being transferred from other wards before the opening of the ward.
- 11.6.3 However, by releasing staff to support additional bed capacity there was a subsequent increase in temporary staffing across the medical and surgical wards, which did not enable a full complement of skill mix and establishment, and therefore impacting on efficient and effective team working.

11.7.1 **Recommendation**

There are no changes recommended at this time to the nursing establishments in the Medical and Emergency Care Division. However, as highlighted above there are a number of areas where additional information is being gathered to further inform the workforce requirements.

12. **Surgical Division**

- 12.1 The acuity across the surgical wards has been consistent over the past 12 months with the acuity scores almost being in line with the ward establishment, with the exception of Murphy ward (short stay surgery) a high patient turnover ward (outlined in section 3.2).
- 12.2 ICU/HDU are staffed to the levels supported by the Intensive Care Society guidelines (2013).

12.3 To support the workload during the early part of the evening a twilight shift was established over twelve months and continues to be evaluated well by the ward staff.

12.4 The Ward Practitioner support role have been successfully implemented and is a core part of the ward team, this has allowed the registered nurse to focus on more complex patient care issues. Three of the surgical wards are pilot wards in the 'Model Ward' transformational project.

12.5.1 **Recommendation**

There are no changes recommended at this time to the nursing establishments in the Surgical Division.

13. **Women's & Children's Division**

13.1 **Midwifery Establishment**

13.1.1 Birthrate plus is a framework for workforce planning and decision making for maternity services which is endorsed by NICE, this is used along-side the midwife to birth ratio.

13.1.2 The Trust commissioned Birthrate Plus to undertake a review of midwifery staffing levels in 2016, which recommended that 108wte staff were required to provide clinical care across all areas of the maternity service. Birthrate Plus suggest a registered to unregistered skill mix of 90:10, the skill mix percentage is not a recommendation but a rationale for having a sensible skill mix that does not reduce the midwifery establishment to an unsafe level.

13.1.3 When applying this skill mix to the staffing recommendations for the maternity service provided by the Trust, 97.38wte registered midwives and 10.82wte un-registered support staff are required. The current funded establishment for midwives to provide direct clinical care is 96.66wte, with the rostered clinical shifts being undertaken by the maternity Matron and lead midwives this gap has reduced to 0.2wte.

13.1.4 To facilitate the skill mix suggested by Birthrate Plus, there are 7wte maternity support workers in post with 5 wte having completed the training programme. Therefore, the current deficit between Birthrate Plus recommended and actual staffing level for support workers is 3.82wte.

13.1.5 The midwifery support workers have been working in the community midwifery service undertaking a range of task and duties that were previously undertaken by qualified midwives, the midwife time realised has been re-deployed to the birth centre. A comprehensive evaluation of the midwifery support workers will be evaluated in September 2017 using quantitative and qualitative outcome measures to assess the impact and the feasibility of recruiting additional support staff in other areas.

13.2 **Midwife to Birth Ratio**

13.2.1 The midwife to birth ratio of 1 to 28 has been quoted in national guidance, based on the number of women giving birth at CRHFT 2016/17, the crude midwife to birth ratio is 1 to 29. This is comparable to other maternity services provided at a District General Hospital, without tertiary fetomaternal specialist service.

13.2.2 However, this blanket recommendation is being challenged by Heads of Midwifery at a national level as this does not include the support staff. If the midwifery support worker posts were included at CRHFT the ratio would be 1 to 28.

13.2.3 Midwifery red flag event reporting was implemented in October 2015, in line with NICE recommendations. A midwifery red flag event is an indication that midwifery staffing levels may be

inadequate. There were 49 reported red flags between the periods of September 2016 – March 2017, with the vast majority of these occurring at the birth center. These related to the supernumerary midwife in charge being allocated patients when staffing levels required support.

- 13.2.4 There have been no occasions when admissions to the maternity unit or the homebirth service have been suspended.
- 13.2.5 There have been no clinical incidents in the maternity service over the last 6 months that were classified as meeting the criteria to be reported to STEIS.
- 13.2.6 The friends and family feedback from patients is generally very positive with a high number of respondents recommending the service, the overall score over the past 6 months of those who would recommend the maternity service was 94.5%.
- 13.2.7 **Recommendation**

There are no changes recommended at this time to the midwifery establishments, with the Head of Midwifery providing assurance to the Director of Nursing and Patient Care that midwifery staffing levels are of a safe standard.

13.3 **Paediatrics Establishment**

- 13.3.1 The Neonatal Unit nursing staffing levels is based on the British Association of Perinatal Medicine (BAPM) guidelines. The Royal College of Nursing (RCN) guidelines 'Defining Staffing levels for Children and Young People's Services' provide national accepted guidelines on which nursing staffing levels within acute paediatrics are measured.

13.4 **Neonates**

- 13.4.1 The cot bed base is split into 11 special care, 2 intensive care and 1 High dependency cot. The occupancy is variable and has shown a lower fill over the last few years with uncertain aetiology. This may be linked to the full implementation of the National Toolkit requirements for all infants to be cared for on a level 3 unit; CRHFT being a level 2 unit.
- 13.4.2 The nurse staffing levels in the Neonatal Unit are broadly compliant with BAPM guidelines. The only area of non-compliance relates to the ability to ensure that the nurse in charge is supernumerary; this is achieved in the mornings but not across other shifts. Compliance shows overall for the last 6 months: October 2016 at 83% (due to unexpected sickness), November to December 2016 90%, January 2017 97%, in February the percentage fell to 54% as a result of exceptionally high occupancy (over this period the nurse in charge managed a caseload) and returning to 97% in March 2017.
- 13.4.3 Local benchmarking (table 4) confirms that Chesterfield compares well in terms of staffing levels to units of other similar caseload and designation. Bank/agency use remains minimal and non-compliance to ensure a supernumerary band 6 is on every shift is comparable to other providers.

Table 4

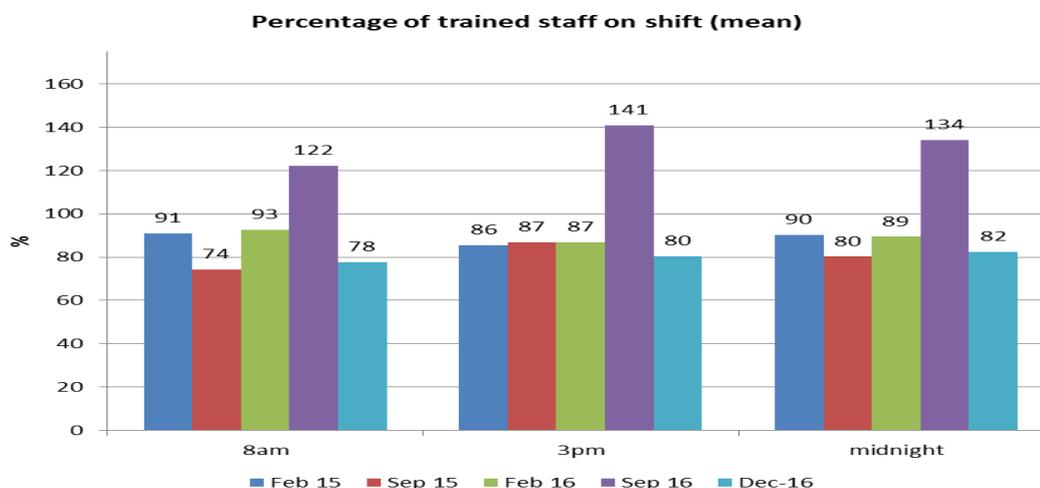
Location Name	Incomplete shifts	% shifts Staffed to toolkit	%shifts QIS to toolkit	%shifts with Team Leader	% Nursing shifts covered by Bank	Avg (Mean) Variance from compliance	Avg (Median) Variance from compliance	Additional nurse shifts needed to make all shifts compliance
Chesterfield	0	76.91	89.89	4.78	0.98	0.77	0.8	67.6
Rotherham	0	50.68	78.55	7.24	2.14	0.24	0.1	298.7
Barnsley	0	76.91	90.3	0	.77	.86	.9	92.3
Doncaster	0	67.22	89.99	0.55	1.26	0.62	0.5	155.2

* Please note this is the latest data available this was produced in August 2016

13.5 Acute Paediatrics

- 13.5.1 The ward is commissioned to provide 20 inpatient beds across a 7 day week with two HDU level 1 beds and 6 day care beds, 12 hours a day, 5 days a week. When staffing establishment runs at full capacity there is some geographical flexibility to open a small number of additional beds when required and staffing numbers allow.
- 13.5.2 The Royal College of Nursing (RCN) guidelines (2013) are currently the only standard upon which acute paediatric nursing levels can be measured. Acute paediatric services are waiting for staffing guidance to be published from NHSI.
- 13.5.3 The RCN guidelines indicate a required ratio of 1:3 nurses for all children under two and 1:4 for all over two years of age over the 24hr period. For the provision of paediatric High Dependency Care (HCDU) the required ratio is 1:2 nurses to children.
- 13.5.4 On the ward there are young people who are under the joint care of Children's Adolescence Mental Health Service (CAMHS) and acute paediatric care. These young people often require increased nursing supervision, to reflect the acuity needs CAMHS young people have been categorised with the under 2 year old group.
- 13.5.5 The most recent acuity monitoring using the guidance described in section above was conducted over 4 weeks in December 2016. This audited the number of children on the ward at three time-periods, using the following categories: age, CAMHS, HDU, Day case, ward attenders, numbers of admissions for preceding 8 hours and external escorts against actual staffing in place.

Graph 5



- 13.5.6 The data in September 2016 should be viewed with caution as there was an unusual reduction in activity and acuity. This therefore prompted a further audit to be undertaken in December 2016, which showed a decline in compliance against the RCN staffing guidelines.
- 13.5.7 In November and December Nightingale ward (acute paediatrics) faced significant peaks in patient activity and acuity, which was reflected both regionally and nationally. The position was compounded further by the limited paediatric intensive care unit (ICU) HDU beds availability nationally, which resulted in CRHFT having higher numbers of ICU/HDU patients than commissioned.
- 13.5.8 This was managed by: the Senior Matron working closely with medical colleagues with several Multi-Disciplinary Team (MDT) ward rounds daily which provided a robust system for multi-professional checks; completion of risk assessments of staffing requirements against children's need; staff working flexibly, including working additional hours, cancellation of annual/study leave; the Senior Matron working clinically shifts (which would not have been included in the audit above graph 5). Over this period Nightingale ward was one of few paediatric wards across the region who did not shut due to operational pressures.
- 13.5.9 Over the past 6 months there has been one incident categorised as high which following an initial investigation did not require a full root cause analysis review, two complaints relating to nursing care following investigation no patient care concerns were identified. Family and Childrens feedback scores remain consistently high at 100% delivery.

13.5.11 **Recommendation**

Taking into consideration quality outcomes, patient feedback and professional judgement, at this time there are no changes recommended to the paediatric nursing establishments. The acuity audit is being repeated in June 2017.

14. **Section 3 – Going Forward – National Guidance**

- 14.1 The National Quality Board produced a consultation document in January 2017, *Safe, sustainable and productive staffing – An improvement resource for adults inpatient wards in acute hospitals*, with the final publication being expected within the next few months. The recommendations from this report have been outlined in appendix 1, CRHFT position mapped out against the recommendations. Out of the ten recommendations the Trust is fully compliant against 8 with partial compliance against the remaining two, these being:

- Considering the wider registered multi-professional team - *with work is in progress at CRHFT with the 'Model Ward' concept*
- Staffing requirements and workforce productivity forming part of the operational planning process needs - *improvements in the alignment of this with nurse staffing review is required*

- 14.2 The Lord Carter, 2016 paper outlines a national measure of nurse staffing - Care Hours Per Patient Day (CHPPD) which will measure care according to how much time nursing staff spend with patients. The National Quality Board's, refreshed guidance identifies the Model Hospital dashboard as being available to review staffing measures, however this data needs to be further refined to enable meaningful benchmarking of nurse staffing levels with similar Trusts.

15. **Next Steps**

- 15.1
- Manvers and Eastwood ward audits are being repeated which relate to concerns around nurse staffing levels overnight
 - Explore further the results from the NNSS relating to nursing/midwifery staff in particular focusing on nursing staff working unpaid hours, and develop solutions to resolve the issue

raised by staff

- Evaluation of ENST against the defined KPI's August 2017
- Acuity audit to be repeated in June 2017 on the acute paediatric ward
- Review of additional 'uplift' requirements to be completed by June 2017

16. Conclusion

- 16.1 Safe nurse staffing levels build and link into the workforce development strategy and plan which is being led by the Director of Workforce and Organisational Development.
- 16.2 This paper focuses on a systematic review of nurse/midwifery staffing through an assessment of acuity and professional opinion triangulated with quality indicators, patient and staff experience to ensure safe staffing levels are built into ward budgets. Following this review there are no requests to increase the nurse/midwifery staffing establishment at this point.
- 16.3 Due to firstly, the high number of registered vacancies and secondly, the need to release staff to support additional bed capacity which impacts on the ward skill mix and the efficient and effective team working, it remains challenging to determine if nurse staffing levels are appropriate. Taking this into consideration, in the professional opinion of the Director of Nursing and Patient Care they are satisfied that the establishments are within acceptable levels; recognising that further work is currently being undertaken across two wards in the Medical and Emergency Care Division to review the nurse staffing levels overnight and workforce requirements.

17. Recommendations

- 17.1 Board are asked **to note**:
- The content of the report
 - The further work being undertaken in Medicine and Emergency Care to review establishments on Manvers and Eastwood ward
 - Further work being undertaken to understand results from the National Staff Survey
 - Evaluation of ENST against the defined KPI's August 2017
 - Acuity audit to be repeated in June 2017 on the acute paediatric ward
 - Review of additional 'uplift' requirements to be completed by June 2017
- 17.2 Board are asked **to approve**:
- The recommendation to maintain the current establishment levels

Bridget O'Hagan
Deputy Director of Nursing and Patient Care

May 2017

References:

Safe, sustainable and productive staffing. An improvement resource for adult inpatient wards in acute hospitals, Consultation document, (2017), National Quality Board.

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Royal College of Nursing, (2013), Defining Staffing Levels for Children and Young Peoples Services.

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Appendix 1

Recommendations - NQB Safe, sustainable and productive staffing – An improvement resource for adult inpatient wards in acute hospital (Jan 2017)

The improvement resource is based on the National quality Board's expectations to ensure safe, effective, caring, responsive and well-led care, on a sustainable basis that ensure the right staff with the right skills are in the right place at the right time. It builds on NICE guidelines on safe staffing for nursing in adult inpatient wards, and it is informed by NICE's comprehensive evidence reviews of research and subsequent evidence reviews focusing specifically on staffing levels and outcomes, flexible staffing and shift work.

Outlined below are the National Recommendations from this guidance and CRHFT's position.

National Recommendations	CRHFT Position April 2017
In determining nurse staffing requirements for adult inpatient settings:	
A systematic approach should be adopted using an evidence-informed decision support tool triangulated with professional judgement and comparison with relevant peers.	Completed annually and reviewed 6 monthly, evidence based decision tool of acuity completed 4 times a year. Peer review of staffing levels not completed as yet as 'Model Hospital' dashboard data not available. Benchmarking against other Trusts does take place on occasions with different specialities.
A strategic staffing review must be undertaken annually or sooner if changes to services are planned.	Undertaken annually with a 6 months review.
Staffing decisions should be taken in the context of the wider registered multi-professional team.	Progress is being made with the Model Ward transformation project. As part of the staffing review on Eastwood (stroke ward) the wider MDT workforce was considered.
Consideration of safer staffing requirements and workforce productivity should form an integral part of the operational planning process.	Needs to be aligned as part of the annual planning process
Action plans to address local recruitment and retention priorities should be in place and subject to regular review.	Local recruitment and retention actions plans are produced within the Division and regularly reviewed during monthly Assurance meetings and Trust wide as part of our Workforce Delivery Group. In addition to the above, the Trust has a managing supply project plan which includes an overall a strategic plan for recruitment and retention across the Trust. This project plan has clear milestones which are monitored on a monthly basis through our Transformation Delivery Group.

<p>Flexible employment options and efficient deployment of staff should be maximised across the hospital to limit temporary staff.</p>	<p>The Trust provides flexible employment options through the employment of either bank only workers or multi post-holders who can be employed substantively and work additional hours flexibly through the bank. A key workforce objective for 17/18 is to continue to develop and grow the bank, both in nursing and other areas, to encourage a flexible workforce that meets the needs of the service and delivers high quality patient care. In addition to flexible employment, the Trust has a clear flexible working policy which is available to all staff and encourages a leadership approach which recognises the benefits of working flexibly where possible.</p>
<p>A local dashboard should be in place to assure stakeholders regarding safe and sustainable staffing. The dashboard should include quality indicators to support decision-making.</p>	<p>Produced monthly and is part of a safe staffing paper that goes to QAC.</p>
<p>Organisations should ensure they have an appropriate escalation process in case staffing are not delivering the outcomes identified.</p>	<p>Escalation plans in place, available on the intranet. Monthly basis quality indications are reviewed via IPR and staff fill rates patient harms are triangulated against nurse staffing levels/'Red Flags', this is reported to QAC on a bi-monthly basis.</p>
<p>All organisations should include a process to determine additional uplift requirements based on the needs of patients and staff.</p>	<p>Review in progress to be completed by June 2017. This will become an annual process.</p>
<p>All organisations should investigate staffing related incidents, their outcomes on staff and patients and ensure action and feedback.</p>	<p>Part of the RCA process, staffing levels are reviewed if appropriate.</p>