CHESTERFIELD ROYAL HOSPITAL NHS FOUNDATION TRUST

Board – November 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 on safe nurse staffing levels

Briefing on the item:

Trust boards are required to undertake an annual nurse staffing review, followed by a 6 monthly update to ensure that plans are still appropriate. A detailed skill mix review was undertaken and presented to Board in May 2017. This report presents the six monthly follow up and describes the approach taken which is in line with the National Quality Board (NQB): Safe, Sustainable and Productive Staffing guidance (2017).

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.

Following the recommendations from the Birthrate Plus review, to facilitate skill mix changes the midwifery support workers role has been implemented with evaluation to date being positive.

Across the paediatric areas the Neonatal Unit staffing levels are based on the British Association of Perinatal Medicine guideline (2011), benchmarking data from the Yorkshire and Humber neonatal network reports that Chesterfield Hospital are in line with the network and national average for the percentage of shifts staffed to the neonatal toolkit standard and shifts with a team leader. The acute paediatric ward acuity is linked to the Royal College of Nursing guidelines; the acuity audit in June 2017 showed an increase in compliance from the position in December 2016.

There has been an improvement or the position has been maintained in five of the six quality outcome indicators against the same period the year previous.

The 'We want to be' feedback from patients Trust wide relating to nurse staffing over the past seven months has improved from a rating of 'poor', to a mixture of 'fair and good'. This has also been reflected in the quarterly local in-depth inpatient survey results. Comments from patients refer to being looked after well by professional hard working staff, but express that staff are busy and need more staff on duty. Patients' feedback remains lower in the Medical and Emergency Care Division which could correlate to the high number of qualified nurse vacancies.

A recurring theme from staff feedback is that they feel under pressure, the LiA pulse check survey reports that nursing staff are feeding back that there needs to be a reduction in staff shortages and the need for permanent staff on the ward. To improve communication with nursing and midwifery staff relating to the workforce, monthly briefings commenced in September along with a staff summit being held in December.

There continues to be a focus on nursing recruitment and retention, with fortnightly action-orientated meetings with the Director of Workforce and Organisational Development (W&OD) and Director of Nursing and Patient Care, along with senior members of the nursing and W&OD team.

Key actions include:

- ongoing presence at recruitment fairs, university open days and on-site local open days with interviews held on the day
- flyer designed to mail to selected postcodes in Chesterfield, North Derbyshire and South

Sheffield. This includes addresses of qualified nurses who have worked at the Trust and left in the last 5 years, as appropriate
- plans in place to introduce career clinics for staff members thinking about career options, to promote opportunities across the Trust
- internal transfer process has also been relaxed to facilitate quicker staff moves
- staff summit scheduled for 1 December to discuss issues and ideas with staff. Topics include flexible workforce, gen-gagement, apprenticeships and model ward

There are a high number of registered vacancies the Director of Nursing and Patient Care is assured that we are continuing to provide the delivery of safe patient care within the staffing compliment available which increases the level of risk associated with providing safe care. These are mitigated on a daily basis through operational management and use of flexible staffing. Therefore it remains a challenging to determine if nurse staffing levels are appropriate at all times.

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 three medical wards to review the nurse staffing levels and workforce requirements.

Recommendations:
Board are asked to note the contents of the report and approve:
- the recommendation to maintain the current establishment levels, following a review including professional judgement

Related strategic outcome(s): ✓

√	1: Providing high quality, safe and person centred care
√	2: Deliver sustainable, appropriate and high performing services
	3: Building on existing partnerships and creating new ones to deliver better care
√	4: Support and develop our staff
√	5: Manage our money wisely, foster innovation and become more efficient to improve quality of care
	6: Provide an infrastructure to support delivery

Board Assurance Framework (BAF) risks relating to this item: **completed**
1.1 inability to meet regulatory core standards in respect of essential quality and safety standards will have an impact on the quality of care of our patients and regulatory CQC compliance
4.1 failure to develop and embed a sustainable and affordable workforce plan that delivers the right people in the right place at the right time with the right skills

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 (Med & Emergency Care)
Risk 2050 – Temporary/winter wards staffed with bank and agency staff (Med & Emergency Care)

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, children's and midwifery services

1. Introduction

1.1 It is good practice that Trust Boards undertake a nurse/midwifery staffing review annually, followed by a 6 monthly update to ensure that plans are still appropriate. A detailed review was undertaken and presented to Board in May 2017.

1.2 This report presents the six monthly follow up and describes the approach taken which is in line with the National Quality Board (NQB); Safe, Sustainable and Productive Staffing guidance (2017) – outlined in table 1.

Table 1 - National Quality Board: Safe, Sustainable and Productive Staffing

Expectation 1	Expectation 2	Expectation 3
RIGHT STAFF	**RIGHT SKILLS**	**RIGHT PLACE AND TIME**
1.1 Evidence based workforce planning	2.1 Mandatory training, development and education	3.1 Productive working and eliminating waste
1.2 Professional Judgement	2.2 Working as a multiprofessional team	3.2 Efficient deployment and flexibility
1.3 compare staffing with peers	2.3 Recruitment and Retention	3.3 Efficient employment and minimising agency

1.3 This report is in three sections:

- Section 1 – Nurse staffing review - expectations set out in the NQB guidance
- Section 2 – Key finds across the Divisions
- Section 3 – Conclusion and recommendations

2. SECTION 1 Nursing Review – Expectations set out in the NQB guidance

2.1 Right staff *Expectation 1*

2.2 A NQB 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 - 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 July 2017.

3. Acuity - Adult Wards

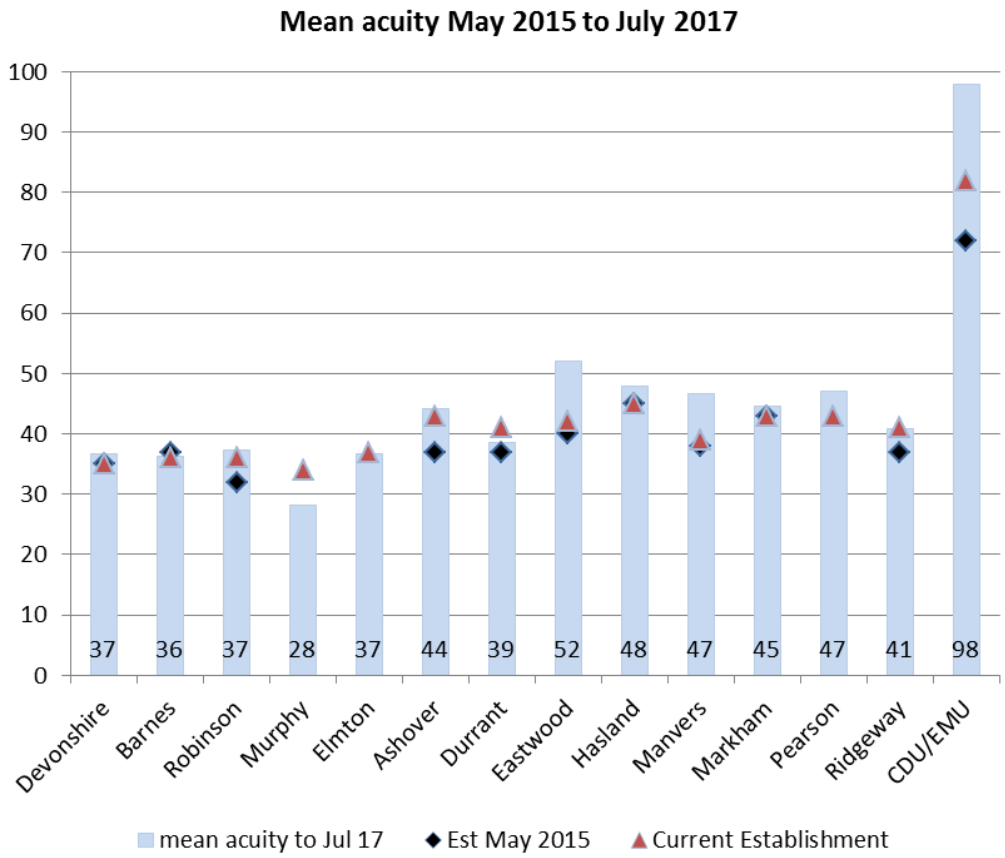
3.1 The mean acuity for each ward is outlined below in graph 1; this shows the whole time equivalent (wte) establishment in May 2015, and subsequent increases in the establishment to the current values. The mean acuity is greater than the establishment in 12 of the 14 wards; with the exceptions being Murphy and Durrant. Murphy's acuity has been consistently below the establishment with Durrant's being below the establishment on three out of four occasions in the past 12 months.

3.2 Murphy (short stay surgery) and Durrant (acute facility) ward are both fast paced, with a high

patient turnover. It is acknowledged that 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.

3.3 All of the other wards acuity is above the funded establishment. Across the adult 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.

Graph 1



Note Changes in the establishment are shown between May 2015 (purple diamond) and the current establishment (orange triangle). 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

3.4 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.

3.5 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.

3.6 **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. In addition, since June 2017 the ward utilises nine beds as an overnight discharge facility.

3.7 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 completed in April 2016. At this point the data suggested the ward may need a further 3wte Health Care Assistants (HCAs). A further audit was repeated from February – April 2017 which showed a similar picture with an additional 2wte required.

The Head of Nursing (HON) did not feel at this time additional staff were required based on triangulation of quality indicators and professional judgement. However, with the changes to the ward model e.g. nine beds being utilised overnight as a discharge facility the plan is to repeat the audit for a longer period before concluding.

3.8 **Emergency Department (ED)**

ED have used a new dynamic priority scoring system which was introduced in January 2017. This categorizes patients in relation to the priority they need to be seen. 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. Following 6 months of implementation and evaluation of the tool it has been identified further training is required to embed effective use before the data can be relied upon. However, it is proving useful to identify trends.

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

In line with the Intensive Care Society guidance the ratio of one registered nurse to one patient in ICU and one registered nurse to two patients in HDU is being maintained.

3.10 Nurse staffing is aligned to the Intensive Care Society guideline, where 50% of staff are required to hold a specialist ICU qualification. Currently the unit is at 38% compliance with nursing staff on the unit accessing all available intensive care courses across the network, it is estimated that the unit will be compliant in 18 months' time. Due to the technical skills required in the ICU/HDU there is a dedicated clinical educator which is fundamental in supporting newly appointed staff.

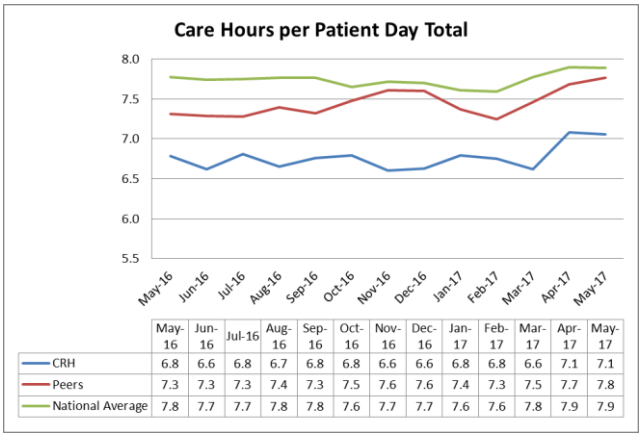
4. Staff to Patient Ratio Review

4.1 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. On the adult wards at CRHFT during the day shift all of the wards work with a ratio of 1:8 patients or less. There is no recommended staffing ratio for night duty.

5. Care Hours Per Patient Day

5.1 The Lord Carter Operational Productivity in NHS Providers 2016 paper outlines a national measure of nurse staffing Care Hours Per Patient Day (CHPPD), which measures care according to how much time nursing staff spend with patients and to enable external peer to peer reviews.

Graph 2



	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17
CRH	6.8	6.6	6.8	6.7	6.8	6.8	6.6	6.6	6.8	6.8	6.6	7.1	7.1
Peers	7.3	7.3	7.3	7.4	7.3	7.5	7.6	7.6	7.4	7.3	7.5	7.7	7.8
National Average	7.8	7.7	7.7	7.8	7.8	7.6	7.7	7.7	7.6	7.6	7.8	7.9	7.9

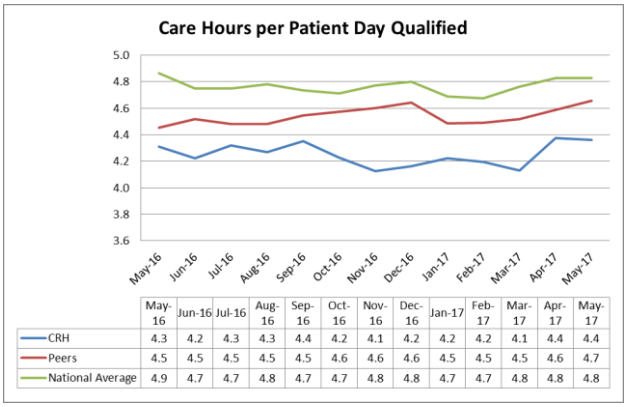
Graph 2 CHPPD both qualified and unqualified, compared with peer Trusts and national average

Graph 3 CHPPD qualified, compared with peer Trusts and national average

Graph 4 CHPPD unqualified, compared with peer Trusts and national average

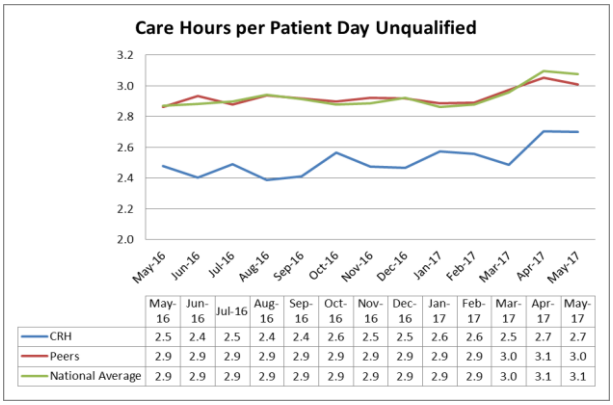
* note May 2017 is the latest data available

Graph 3



	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17
CRH	4.3	4.2	4.3	4.3	4.4	4.2	4.1	4.2	4.2	4.2	4.1	4.4	4.4
Peers	4.5	4.5	4.5	4.5	4.5	4.6	4.6	4.6	4.5	4.5	4.5	4.6	4.7
National Average	4.9	4.7	4.7	4.8	4.7	4.7	4.8	4.8	4.7	4.7	4.8	4.8	4.8

Graph 4



	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17
CRH	2.5	2.4	2.5	2.4	2.4	2.6	2.5	2.5	2.6	2.6	2.5	2.7	2.7
Peers	2.9	2.9	2.9	2.9	2.9	2.9	2.9	2.9	2.9	2.9	3.0	3.1	3.0
National Average	2.9	2.9	2.9	2.9	2.9	2.9	2.9	2.9	2.9	2.9	3.0	3.1	3.1

5.2 Trust level nursing and midwifery comparison CHPPD is outlined above (graph 2–4), data taken from the NHSI model hospital dashboard. Against this a comparison has been completed that identifies the qualified nursing and unqualified establishment wte gap between CRHFT and peers which equates to 55wte in total (17 qualified nurses and 38 unqualified staff).

5.3 It is important to note that CHPPD does not take into account acuity, turnover of patients, case mix and other activity for example supporting students and any other non-direct care time activity. There is also a risk of variation when using as a benchmarking tool in isolation e.g. are other Trusts housekeepers included, matrons (who are supervisory to practice) being included in the numbers etc. The information therefore needs viewing with caution and needs to be triangulated with other data.

5.4 The current nursing and midwifery dashboard that is reported to Quality Assurance Committee (QAC) is being further developed and will include the planned CHPPD against establishment and monitor against actual position. This will be implemented by January 2018.

6. Patient Experience

6.1 The 'We Want to Be' survey shows that patient perception of nurse staffing over the past seven months Trust wide has increased from a rating of 'poor' (40-49%) in March to 'fair' (50-64%) in September, with July and Augusts rating being 'good' (65-79%). The scores have fluctuated across the Divisions with Medicine and Emergency Care seeing consistently lower scores than the other Divisions ranging from very poor (under 40%) to fair (50-64%).

6.2 The quarterly local in-depth inpatient survey asks patients if there were enough nurses on duty, the results from April – June 2017 show an increase in score of 7.7 from 7.2 (January to March),

Medicine and Emergency Care had a lower score of 7.3 compared to the Surgical Division at 8.1. Overall the score equated to a rating of 'good' when compared to the 'We want to be survey'.

6.3 The Trust does not do a quarterly inpatient survey in July – September as the National Inpatient Survey is sent out to patients who were discharged in July 2017.

6.4 Comments from patients refer to being looked after well with caring, hardworking and professional nurses. Patients also express that staff were busy and needed more staff on duty. The narrative feedback from the 'We want to be' survey does not identify any themes or reasons for the patients' perception of this.

6.5 Feedback remains lower in the Medicine and Emergency Care Division which could correlate to the high number of qualified nurse vacancies; although temporary staffing is in place staff from the bank/agency are often not familiar with ward routines and Trust policies thus potentially causing delays in care interventions.

7. Staff Experience

7.1 As a result of the number of registered nurse vacancies, staff are re-deployed within the adult wards to support the safe and efficient delivery of care. Whilst these operational controls and the use of flexible staffing have ensured the Trust wider safer nurse staffing, this has a negative effect on staff morale and team functionality.

7.2 Reoccurring themes that come from the Staff Forum and from informally speaking to staff is that ward based nurses continue to feel under pressure.

7.3 Feedback via the LiA pulse check survey shows a large number of nursing staff feeding back that there needs to be an increase in staffing numbers, reduction in staff shortages and the need for permanent staff on the ward/department. The majority of the feedback was from the adult in-patient areas.

7.4 Over the past six months there has been 'Your Voice' surveys conducted in the Medical & Emergency Care and Surgical Division. Acknowledging, that the overall response rate was low, the national friends and family test score was higher from the registered nursing staff in comparison to the overall Divisional response.

7.5 To improve communication with the nursing and midwifery staff relating to the workforce, monthly briefings commenced in September that outlines key actions being taken around recruitment and retention. A staff summit is being held in December 2017 which aims to give staff opportunities to contribute to discussions, share ideas, gain further understanding on the work and initiatives underway and the workforce plan and vision.

8. Outcome Monitoring

8.1 There are a number of quality outcome measures that are monitored and considered in conjunction with nurse staffing levels. Below outlines the outcome indicators comparing performance during April to September 2017 against the same period the year before shows:

- C. difficile low levels maintained
- Rate of E. Coli infections shows a 19% reduction
- Rate of inpatient falls per 1,000 bed days shows a 15% 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 0.6% increase
- There has been an 11% increase in the rate of pressure ulcers

8.2 The increase in pressure ulcer prevalence has been seen between July to September, the Senior Matrons have been involved in non-participant observation of practice which has been fed into a task and finish group, to inform the quality improvement plan.

9. Headroom Allowance

9.1 Whilst ensuring that annual leave is managed efficiently nursing and midwifery establishments should include headroom allowance, to allow for the efficient management of planned and unplanned leave to ensure that absences are able to be managed effectively. An example of this includes: annual leave, study leave and sickness/compassionate leave.

9.2 Carter report (2016), stated that there was a variance nationally around headroom allowance, and suggested that the allowance should be between 22% and 25%, with Trusts needing to take into consideration when setting this past sickness, annual and study leave.

9.3 The Trusts headroom allowance was set at 26%, and following a review in September 2017 a revised allowance broken down between qualified and unqualified staff of 22.9% - 24.4% for qualified nurses and 22.1% - 23.1% for unqualified staff has been set. The variance relates to the study leave allowance which is based on essential training, newly qualified nurses, specialty specific training requirements and team training days. Additional study leave relating to post basic education will be factored in following a Training Needs Analysis (TNA) currently being completed (see point 13.2).

This will be reviewed on an annual basis.

10. Right Skills – *Expectation 2*

10.1 Skill Mix Review

10.2 Appropriate consideration is given around the skill mix required to deliver services as safely, efficiently and effectively as possible.

10.3 As part of the skill mix review an analysis was completed in September 2017 regarding the percentage of staff that have been qualified more than and less than 2 years. The results demonstrate that from the 17 adult in-patient wards/departments, 14 of the wards/departments have greater than 50% of the registered nurses being qualified more than 2 years, with the remaining 3 wards/departments having 50% of staff qualified less than 2 years. The position in Integrated Care Division records over 90% of staff being qualified greater than 2 years.

10.4 It is acknowledged that although it is beneficial to undertake this exercise, it is limited in relation to the amount of assurance provided. For example: you could have a staff member who has been qualified for a number of years but has not acquired the necessary clinical or managerial competencies.

10.5 Subsequently, a staff nurse competency framework was developed for newly qualified registrants up to a senior staff nurse level, which includes managerial objectives and clinical skills and competencies. Ward Matrons and Clinical Educators are in the process of working through these

competencies with staff.

11. Workforce Transformation

11.1 The Trust has commenced on a journey of workforce transformation for in-patient wards known as the Model Ward, which is being piloted on 6 adult wards. This constitutes a ward skill mix change by augmenting the registered nurse establishment with the introduction of highly skilled support roles e.g. Assistant Practitioner (AP), the Nursing Associate (NA), and integrating the wider registered multi-professional team.

11.2 Subsequently, the ratio of qualified to unqualified staff is changing. These decisions are made around skills needed to deliver care looking at the wider multi-professional team and professional judgement. This project is overseen by the Director of Workforce and Organisational Development with clear integration with safe nurse staffing.

11.3 In addition to the workforce transformational project, a number of wards in the Medical and Emergency Care Division who are faced with the high levels of registered nurse vacancies have undertaken a skill review by: firstly, increasing the number of unqualified support workers and secondly, increasing the number of ward sisters/charge nurses from two to three to facilitate senior nursing leadership. These changes are being carefully monitored via quality outcomes, patient and staff experience.

12. Mandatory training, development and education

12.1 Mandatory training

12.2 All staff are expected to undertake mandatory update training as set out in the TNA, compliance of attendance is monitored through the Workforce Delivery Group and reported to the People's Committee.

12.3 All nursing and midwifery staff that commence employment complete the Trust corporate induction, as well as registered nurses attending the 'Royal Way'; a three day programme - with midwives undergoing local induction plans. In addition registered nurses have a specific induction in line with the wards/departments specialty requirements.

12.4 Unqualified staff complete the Care Certificate a 9 day programme. This supports the focus on high quality fundamentals of care delivery and is in preparation for new workforce model for unregistered staff, providing innovative new career pathway for nursing and other healthcare professions.

13. Development and education

13.1 In addition to mandatory training, there is a range of clinical skills and educational training delivered by the education centre.

13.2 Currently post basic education for registered nursing staff is limited, a review of the attendance data for university courses accessed by registered nursing staff over the past 2 years highlights that registered nursing staff have completed mentorship, critical care and neo-natal course but access to adult specialist programmes e.g. accident and emergency nursing, respiratory nursing courses etc. are not evident. The Head of Practice and Professional Development is working with the Divisions to complete a TNA by December 2018 to facilitate future planning.

13.3 A Matrons Development programme 'Lets Lead Together' commenced in September 2016 with the final programme completing in March 2018. This has been led, developed and facilitated by the Director and Deputy Director of Nursing and Patient Care and the HON/M.

13.4 Plans are in progress to develop the programme for sisters/charge nurses commencing in April 2018 – ahead of this one of the modules that focuses on finance, staff management and effective rostering is being rolled out over the next three months, which is evaluating very positively.

13.5 Earlier in 2017, the maternity service submitted a bid to the maternity safety training fund, and secured funding for additional training, with midwifes benefitting from a number of training courses e.g. by March 2018 all midwifes will have attended human factor training and a masterclass on foetal monitoring.

13.6 The Way Forward events have become a recognised event at CRHFT, and are attended by circa 50 senior nurses/midwifes to: celebrate and share good practice; discuss, debate and subsequently plan how to operationalise national policy and professional nursing issues; receive training and to hear from senior leaders both internally and externally. These events have been evaluated exceptionally well, with one being planned to coincide with Nurses Day Celebrations in May 2018.

14. Recruitment and Retention

14.1 The recruitment and retention strategy is led by the Director of Workforce and Organisational Development (W&OD), with a continued focus on nursing recruitment and retention. There are fortnightly action-orientated meetings with the Director of Nursing and Patient Care, Director of W& OD and senior members of the nursing and W&OD team.

Key actions include:

- ongoing presence at recruitment fairs, university open days and on-site local open days with interviews held on the day
- flyer designed to mail to selected postcodes in Chesterfield, North Derbyshire and South Sheffield. This includes addresses of qualified nurses who have worked at the Trust and left in the last 5 years, as appropriate
- plans in place to introduce career clinics for staff members thinking about career options, to promote opportunities across the Trust
- internal transfer process has also been relaxed to facilitate quicker moves
- staff summit scheduled for 1 December to discuss issues and ideas with staff. Topics include flexible workforce, gen-gagement, apprenticeships and model ward
- increased use of social media to advertise vacancies
- meeting students in their first year in training and publicising the opportunities at CRHFT
- monthly recruitment workshops at the Education centre
- cross divisional rotational programmes
- retention conversations with leavers and current staff to establish what issues/initiatives would support them stay at the trust
- conversations with those nearing retirement about flexible retirement options
- buddy system for all newly appointed to keep in touch between appointment, start date and beyond employment
- to support temporary staffing NHSP incentives and overtime offer revised to encourage existing staff and bank workers to work additional hours

Progress is monitored through the Workforce Delivery Group and reported to the Peoples' Committee.

15. Right Place, Right Time – *Expectation 3*

15.1 Productive working

15.2 eRostering is a key enabler for effective and efficient deployment of staff, there are seven key performance indicators (KPI's), which are reported on a monthly and quarterly basis to Senior Matrons, Divisional management teams and Executive Directors to facilitate exception reporting at both Divisional and assurance meetings.

15.3 The compliance of the KPI's continues to be stable with good compliance e.g. net hours balance is less than one percent of available hours. Focus remains on encouraging staff to take their annual leave at regular intervals throughout the year and roster managers to manage this within the KPI target levels of 14.5 to 17.5%.

15.4 The Trust is in the process of procuring a new eRostering system which will further maximise efficiencies, productivity and functionality of rostering.

16. Care Contact Time

16.1 Care Contact Time (CCT) is a way of looking at how nursing staff spend their time during a particular shift; it helps us to understand the range of elements that make up the various roles. Information is gathered directly from nursing and unqualified support staff using a prescribed data collection instrument. Members of the team complete a template describing the type of activity during a shift, every 5 minutes.

16.2 CCT data was last gathered in February 2017, which is being used as a baseline to evaluate the ongoing changes with the workforce transformation project the Model Ward (see point 11), with the audit being run in November 2017 across the pilot Model Wards. In addition in October 2017, CCT audit was used as part of the evaluation framework for the midwifery support role with data currently being analysed (see point 21.4).

17. Managing Staff Variance

17.1 To address the day to day demands there are a number of ways that variances within nurse staffing levels are managed to ensure wards are staffed safely, these are:

- Daily staff meetings – where decisions are made around re-deployment of staff, taking into consideration staff skills to achieve best mix
- Utilisation of the EST (see point 18)
- Use of additional temporary staff, both registered and unregistered
- Matrons who are supervisory to the ward staffing numbers, working within the staffing establishment
- Cancellation in staff education/training sessions

18. Enhanced Support Team

18.1 The Enhanced Support Team (EST) is a dedicated team of HCA's that provide a level of increased supervision to patients, (predominately patients with severe dementia, cognitive problems, high risk of falls, and alcohol related withdrawals). The team receive 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.

18.2 In November 2016 the team had an uplift of 5.8wte HCA's to expand the team to meet demand. A further evaluation of the EST against defined quality and financial KPIs was presented to HLT in September 2017 with clear benefits realisation identified.

19. National Quality Board

19.1 The NQB in November 2017 released for consultation Safe, Sustainable and Productive Staffing Improvement resources for Urgent and Emergency Care, Children's and Young People and Neonatal Care services. The Trust will be replying to the consultation and considering what can be implemented ahead of the final guidance being released.

20. Section 2 – Key findings across the Divisions

20.1 Medicine & Emergency Care Division

20.2 **Eastwood ward** (stroke ward) - 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. Several audits have been completed to assess the frequency of referrals, the time and duration of the senior nurse being off the ward which is unpredictable and varied. The latter audit completed in June 2017 showed a similar picture.

20.3 The above information was triangulated with other information for example: patient acuity, which is consistently higher than the funded establishment; CHPPD is lower than peer stoke wards, high levels of registered nurse vacancies, 50% of admissions to the ward are overnight and staff experience is reported as being poor due to not having adequate staff to deliver care to patients - coupled with the nurse vacancies.

20.4 Subsequently, an uplift in establishment of 2.36wte HCA's for the night shift was approved on a trial basis, with an evaluation being completed by March 2018.

20.5 **Manvers ward** (cardiology and CCU beds) - with the nature of CCU being a more intensive care setting, patients require a higher level of care. The pathway for patients at CRHFT who are unstable and need to undergo certain cardiac procedures are transferred to specialised local centers. Therefore, the nurse staffing levels to reflect that of a specialised CCU is not fully required.

20.6 On review the HON 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.

20.7 The HON developed a proposal that was presented to TSG in October 2017 to increase the registered nurse workforce on the night shift. TSG were supportive in principle but requested a bed modelling exercise to be undertaken to establish how many CCU beds are required, and for this to be considered alongside the Cardiology Consultant business case with the potential impact on ward activity this may bring. The revised proposal is being taken to TSG in December.

20.8 **Emergency Management Unit/Clinical Decision Unit (CDU)** – CDU has recently been refurbished, with a new model/way of working implemented, this includes a designated assessment bay and a focus on CDU having short stay patients. As a result the acuity tool is being reviewed to

ensure it is appropriate and captures the rapid turnover of patients.

20.9 **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 three wards where additional information is being gathered to further inform the nursing workforce requirements.

21. Surgical Division

21.1 Three of the surgical wards are part of the 'Model Ward' transformational project (see point 11), and have successfully embedded the ward practitioner role, with a number of assistant practitioners and nursing associates undergoing training. Work continues to integrate the registered multi-professional team. The administration support role has been piloted on a number of wards and has proven beneficial; this is being considered across other wards.

21.2 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 (point 3.1). Triangulated alongside other staffing information, patient and staff feedback and quality outcome measures the HON has confirmed that there are no changes recommended at this time to the nursing establishment.

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

22. Integrated Care Division

22.1 Midwifery Establishment

22.2 Birthrate Plus is a framework for workforce panning and decision making for maternity services which is endorsed by NICE.

22.3 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 suggested that 90% of these staff should be registered midwives and 10% should be unqualified support staff. 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.

22.4 Subsequently, to support the skill mix recommendation Midwifery Support Workers (MSW) were recruited to undertake a range of clinical and administration roles, with currently 6wte in post with plans to recruit a further 2wte. Therefore the current deficit between Birthrate Plus recommendations for registered midwives is 0.72wte and unqualified support staff is 2.82wte, which is an improvement from when the audit was conducted in 2016.

22.5 An evaluation of the MSW by midwives and patients has been completed using questionnaires and telephone interviews. The feedback received has been positive, and the value of the role in supporting with infant feeding being highlighted by many patients. As highlighted in point 16.2 CCT data is being analysed, this will facilitate further evaluation and development of the role.

23. Monitoring of midwifery staffing levels

23.1 The adequacy of midwifery staffing is monitored by; four hourly recording of maternity service activity, acuity and staffing on the birth centre and midwifery red flags.

23.2 As part of the staffing escalation process community on-call midwifes are re-deployed to support the birth-centre, this is enacted once all other options have been exhausted. This has occurred on 13 occasions over the last 6 months with the duration never being longer than 6 hours. Concerns were raised by the community midwives about being called in to support the birth-centre whilst on-call. In response to these concerns, staff views were canvased on different working hours, with the majority of staff responding that they wished to retain the current arrangements.

23.3 Midwifery red flags are an indication that staffing levels may be inadequate. What constitutes a red flag has been set nationally, in addition to this a local indicator has been established which relates to the supernumerary coordinator on the birth-centre being allocated patients. The supernumerary status of the coordinator on the birth-centre is the highest trigger of a red flag event, occurring on 38 occasions over the past 6 months.

23.4 The HOM has considered the above points and has made the decision to re-deploy midwifery hours from the community to the birth-centre. This has followed a review of workload in the community, combined with skill mix changes with the implementation of the MSW role; this will not require additional funding.

24. Paediatrics Establishment

24.1 Neonates

24.2 The Neonatal Unit (NNU) nursing staffing levels are based on the British Association of Perinatal Medicine (BAPM) guidelines.

24.3 The Yorkshire and Humber Neonatal Network benchmarking data reported in August 2017 confirms that Chesterfield Royal Hospital is above the network and national average for the percentage of shifts staffed to the neonatal toolkit standard and the percentage of shifts with a team leader.

Table 2 - Yorkshire & Humber Neonatal Network benchmarking data

Location Name	*% Shifts Staffed To Toolkit	**% Shifts QIS To Toolkit	% Shifts with Team Leader
Chesterfield Royal Hospital FT	74.18	77.47	42.31
Rotherham NHS FT	35.71	66.48	0
Barnsley NHS FT	87.85	100	0
Doncaster Royal Infirmary	42.20	84.44	0
Calderdale & Huddersfield NHS FT	64.09	72.38	27.07
Airedale General Hospital	28.57	96.15	0
Grimsby, Diana Princess of Wales	90.66	95.60	0
Pinderfields General Hospital	56.04	72.53	38.46
Scunthorpe General Hospital	92.86	86.26	0
York District	84.07	83.52	0
Network Average	**65.63**	**83.48**	**10.78**
National Average	**61.28**	**74.78**	**28.44**

* The ratio of registered nurses to patients in different acuity categories

** the above plus the number of registered nurses with the specialist qualification

24.4 Currently the unit is not fully compliant with the Neonatal specific level qualification; the recommendation is that 80% of registered nurses should hold this qualification, currently the unit is at 68%. The decrease in compliance is a direct result of the reduction in course provision. It is anticipated that by August 2018, the compliance will have increased to 82%.

25. Acute Paediatrics

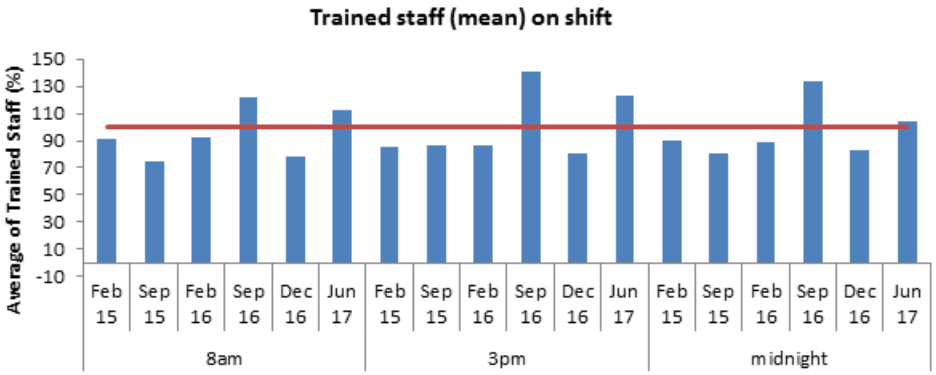
25.1 The Royal College of Nursing (RCN) guidelines (2013) 'Defining Staffing levels for Children and Young People's Services' provide national guidelines on which nursing staffing levels within acute paediatrics are measured. They are currently the only standard upon which acute paediatric nursing levels can be measured. Acute paediatric services are waiting for staffing guidance to be published from NHSI.

25.2 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.

25.3 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.

25.4 The most recent acuity monitoring using the guidance described in the section above was conducted in June 2017. 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 – activity monitoring against RCN guidelines



25.5 Where the bar goes above the red line the available staffing levels, on average, matched or exceeded the staff required. This occurred on 6 of the 18 data collection periods, all in the same data periods (Sept 2016 and June 2017).

25.6 In September 2016 there was an unusual reduction in activity and acuity; this prompted a further audit to be undertaken in December 2016, which showed a decline in compliance. Over this period acute paediatrics faced significant peaks in patient activity and acuity, which was reflected both regionally and nationally.

25.7 Taking into consideration quality outcomes, patient feedback and professional judgement, at this time there are no changes recommended to the paediatric nursing establishments.

25.8 **Recommendation** - There are no changes recommended at this time to the midwifery/nursing establishments in the Integrated Care Division.

26. Section 3 Conclusion and Recommendations

26.1 Conclusion

26.2 This paper focuses on a systematic review of nurse and 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 and midwifery staffing establishment at this point.

26.3 There are a high number of registered vacancies the Director of Nursing and Patient Care is assured that we are continuing to provide the delivery of safe patient care within the staffing compliment available which increases the level of risk associated with providing safe care. These are mitigated on a daily basis through operational management and use of flexible staffing. Therefore it remains a challenging to determine if nurse staffing levels are appropriate at all times.

26.4 Taking this into consideration, in the professional opinion of the Director of Nursing and Patient Care is 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 workforce requirements.

27. Recommendations

27.1 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

27.2 Board are asked **to approve**:

- The recommendation to maintain the current establishment levels, following a review including professional judgement

Bridget O'Hagan
Deputy Director of Nursing and Patient Care

November 2017