CHESTERFIELD ROYAL HOSPITAL NHS FOUNDATION TRUST

Board – May 2018

EXECUTIVE SUMMARY AND BRIEFING PAPER

Agenda item : Annual Nurse & Midwifery Staffing Establishment Review	
Board sponsor: Lynn Andrews Director of Nursing and Patient Care	

Reason for the item: The paper provides assurance on safe nurse and midwifery staffing levels

Briefing on the item (recommendation):

The annual nurse staffing review across the inpatient ward areas, including children's and midwifery took place in April 2018. This focuses on a systematic review of 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.

There are three wards of note where following an assessment of acuity exceeded the current budgeted establishment: Manvers ward have had an increase in establishment since the last acuity which will improve the position going forward; Emergency Admission Unit due to the refurbishment and new way of working is reviewing the data collection tool; and the third area, Eastwood ward as part of the stroke pathway analysis is undergoing a MDT staffing review.

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

However, patient comments from 'we want to be' feedback is that staff are busy and need more nurses on duty but, express that they were looked after well by professional hard working staff. Patients' feedback remains lower in the Medical and Emergency Care Division which could correlate to the high number of registered nurse vacancies within the Division. A recurring theme from staff feedback is that they feel under pressure, with the National Patient Survey 2017 results supporting this finding.

The Head of Nursing in the Medical and Emergency Care Division is gathering additional information on four of the wards to further inform the nursing workforce requirements and speciality model of care.

One of the biggest challenges facing nursing and midwifery is the increasing complexity of the patient population and being able to meet this need with a skilled, stable workforce. This requires a constant focus on recruitment and retention with the Trust focusing on three main workstreams: attraction, recruitment and retention.

There are a high number of registered nurse vacancies which increases the level of risk associated with providing safe quality care. These risks are mitigated on a daily basis through operational management and use of flexible staffing. 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.

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

Recommendations:

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

- the recommendation to maintain the current establishment levels, following an in-depth 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

1.2 Failure to ensure the Trust learns from incidents and patient experience feedback will impact on the quality of care given to patients

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 2323 – Developing and delivering a sustainable workforce plan (Workforce & OD)

Risk 2090 – Failure to achieve compliance with NHSI agency price caps (Workforce & OD)

Risk 2122 – Nursing vacancies quality safety and financial impact (Division of Medicine)

Risk 2419 - Insufficient nurse staffing to cover additional capacity required for winter wards (Division of Medicine)

Risk 2122 - Nursing vacancies quality safety and financial impact (Division of Medicine)

Risk 2298 - Overnight staffing levels on Manvers/cardiology ward (Division of Medicine)

Risk 2273 - Haematology nurse staffing levels at nights and weekends on Hasland (Division of Medicine)

Risk 2404 - Nurse Staffing Vacancies on Eastwood ward (Division of Medicine)

Risk 2468 - Non-compliance against nurse staffing recommendations from NCEPOD NIV (non-invasive ventilation) (Division of Medicine)

Risk 2229 - Nursing staff with QIS qualification on NNU not meeting national guidance (Integrated Care Division)

2394 – Nurse staffing levels and poor skill mix poor due to vacancies, mat leave and sickness (Surgical Division)

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 of Directors – Annual Nurse and Midwifery Staffing Establishment Review

1. Introduction

1.1   It is good practice that Trust Boards undertake a nurse/midwifery staffing review annually, followed by a 6 monthly update.

1.2   This report presents the annual review and describes the approach taken which is in line with the National Quality Board (NQB); Safe, Sustainable and Productive Staffing guidance (2017, 2018) – 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 as per NQB guidance
- Section 2 – Key finds across the Divisions
- Section 3 – Conclusion and recommendations

## 2. SECTION 1 Nurse Staffing Review – Expectations as per NQB guidance

2.1   **Right staff** *Expectation 1*

2.2   A NQB recommended acuity tool the Safer Nursing Care Tool (SNCT) is used across the adult in-patient areas and is completed every three months in line with national guidance.

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.

3.2   There are two areas where the establishment if higher than the acuity, which is Murphy (short stay surgery) and Durrant (acute frailty), both are fast paced with a high patient turnover. Durrant ward in October 2017 developed a 6 bedded 'frailty' assessment bay which closes overnight; this has resulted in a reduction of acuity as the ward bed base reduced from 31 to 25. A review is taking place of the ward establishment needs taking into account the frailty assessment bay this will be confirmed, once the location of the frailty assessment unit and ward beds has been established. 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.

Nurse staffing paper May 2018

3.3 Graph 1 below shows the mean acuity for each ward, the establishment in June 2015 and increases in establishment to the current values. WTE acuity is represented by the bar on the chart for each ward with the mean acuity value shown at the bottom of each column. Where the mean acuity exceeded the establishment the bar goes above the marker.

Graph 1

Mean acuity June 2015 to January 2018

mean acuity to Jan 18 ◆ Est May 2015 ▲ Current Establishment
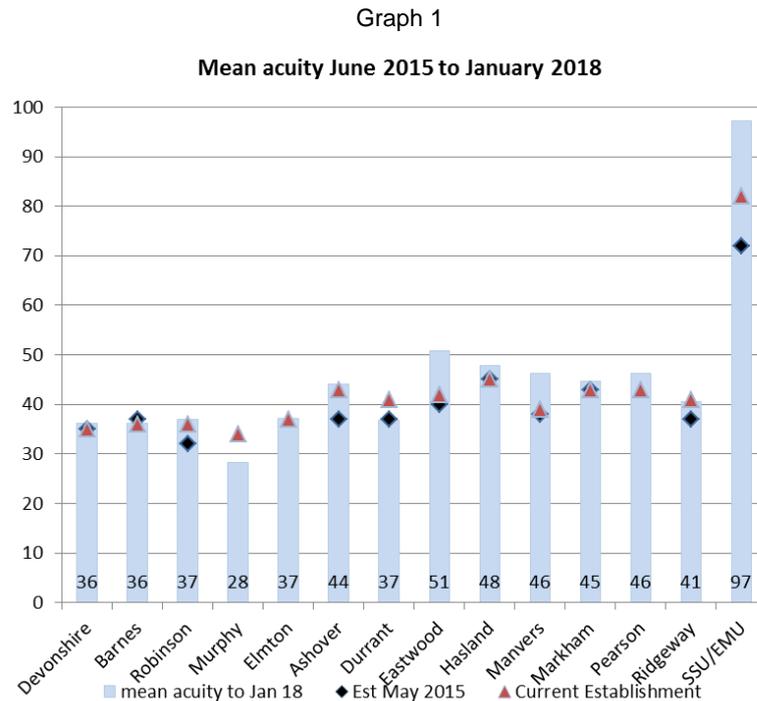
Note: changes in the establishment are shown between May 2015 (purple diamond) and the current establishment (orange triangle).

3.4 Since the last six monthly staffing review additional investment was agreed at Transformational Group (TG) in March 2018:

- Manvers ward 2.71 wte Registered Nuses (RN) (£107k) to provide an additional RN on the night shift
- Eastwood ward 2.36 wte Health Care Assistant (HCA) (£42k) to provide an additional HCA on the night shift. A temporary uplift whilst a full review of the service is undertaken
- Emergency Department (ED) 3.4 wte Emergency Nurse Practitioners (ENPs) (£202k will result in a saving of £44k against a reduction in agency nursing and medical staff)

3.5 There are three medical wards of note where the acuity exceeds the current budgeted establishment; Eastwood, Manvers and Emergency Management Unit/ Short Stay Unit (EMU/SSU).

As outlined in point 3.4 Manvers ward have had an increase in establishment since the acuity was completed in January 2018, this increase will be seen when the acuity data is next reported. Section 2 (points 17.2-17.5) provides additional information on Eastwood ward and EMU/SSU.

3.6 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, as described below.

3.7 **Elizabeth ward** (transitional care)
The ward has highly dependent patients, often with complex behavioral needs requiring increased levels of supervision. A tool known as Northwick Park, which is suited to assessing the level of input

required for patients based on dependency rather than acuity was completed in April 2016. At this point the data suggested the ward may need a further 3 wte (not differentiated between qualified and unqualified staff), further audits were repeated for periods of 8 – 12 weeks in April 2017 and March 2018, which showed a similar picture with an additional 2 wte required.

The Head of Nursing (HON) is not recommending at this time that additional staff are required based on triangulation of quality indicators and professional judgement.

3.8   Since June 2017 the discharge lounge (located at the end of Elizabeth ward) uses nine beds as an overnight discharge facility. These patients are managed by Elizabeth ward staff by utilising temporary staff on the early shift to support patient care needs prior to discharge home. A review is taking place to consider the future management of patients and whether this should sit with Elizabeth ward or the Operational Team who manage the discharge lounge facility.

3.9   **Emergency Department** (ED)
As part of the workforce planning a gap analysis has been completed against the draft NQB staffing guidance (2017): Safe, Sustainable, and Productive staffing for Urgent and Emergency services. The guidance recommends the utilisation of a decision support tool for the assessment and measurement of acuity, dependency and workload.

3.10   The department was piloting the use of a dynamic priority scoring system, however this was restricted as the EDIS system did not accurately capture acuity, based on NEWS scores. With the upgrade applied to EDIS in early April 2018, this data captured will form part of the 6 monthly review in October 2018.

3.11   **Intensive Care and High Dependency Unit** (ICU and HDU)
In line with the Intensive Care Society guidance the ratio of one RN to one patient in ICU and one RN to two patients in HDU is being maintained.

3.12   Nurse staffing is aligned to the Intensive Care Society guideline, where 50% of qualified staff are required to hold a specialist ICU qualification. Currently the unit is at 43% 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 staff.

4.   Staff to Patient Ratio Review

4.1   National guidance suggests there is an increased risk of harm to patients associated with a ratio of 1 RN to 8 (or more) patients during day hours. On the acute adult wards during the day shift all of the wards work with a ratio of 1:8 patients or less with the exception of Robinson ward that has a 1:9 ratio during the afternoon period due to skill mix changes within the teams.

4.2   Robinson ward is part of the Workforce Transformational project (see section 10) with the ward integrating Assistant Practitioners (APs) and trainee Nursing Associates (tNA) into the RN establishment. This has resulted in a reduction of the ratio of RNs to unqualified staff, as APs and tNA are classified nationally as unqualified staff.
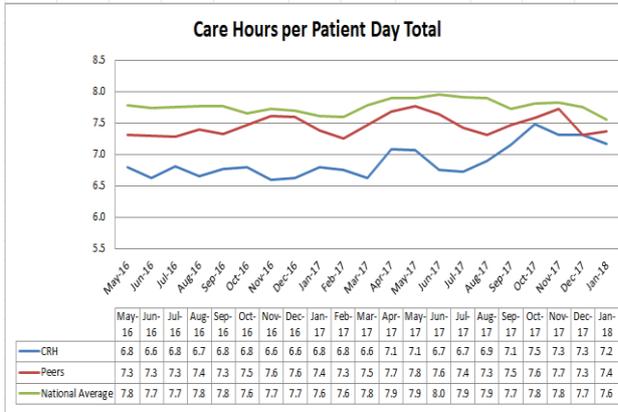
These changes are being carefully monitored via quality outcomes, workforce metrics, patient and staff experience dashboards.

4.3   The above information is exclusive of the supervisory ward Matron.

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.

Graph 2

Care Hours per Patient Day Total

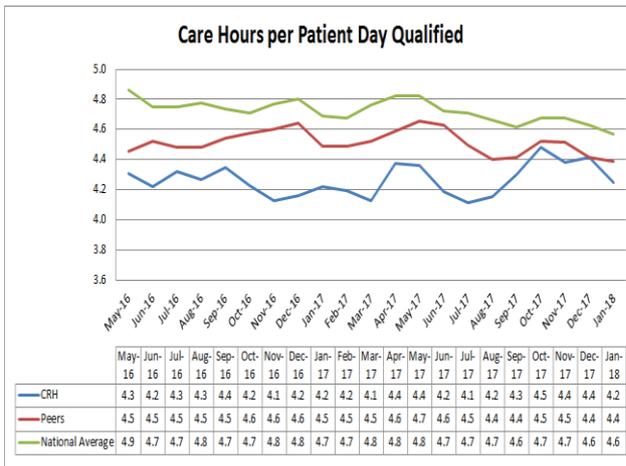|	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18
CRH	6.8	6.6	6.8	6.7	6.8	6.8	6.6	6.6	6.8	6.8	6.6	7.1	7.1	6.7	6.7	6.9	7.1	7.5	7.3	7.3	7.2
Peers	7.3	7.3	7.3	7.4	7.3	7.5	7.6	7.6	7.4	7.3	7.5	7.7	7.8	7.6	7.4	7.3	7.5	7.6	7.7	7.3	7.4
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	8.0	7.9	7.9	7.7	7.8	7.8	7.7	7.6

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

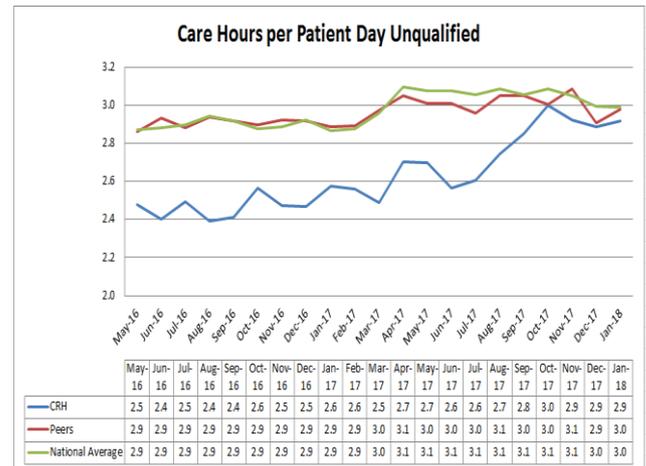Graph 3 CHPPD qualified, compared with peer Trusts and national average

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

* note Jan 2018 is the latest data available via NHSI model hospital dashboard

Graph 3

Care Hours per Patient Day Qualified

	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	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18
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	4.2	4.1	4.2	4.3	4.5	4.4	4.4	4.2
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	4.6	4.5	4.4	4.4	4.5	4.5	4.4	4.4
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	4.7	4.7	4.6	4.7	4.7	4.6	4.6	

Graph 4

Care Hours per Patient Day Unqualified

	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	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18
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	2.6	2.6	2.7	2.8	3.0	2.9	2.9	2.9
Peers	2.9	2.9	2.9	2.9	2.9	2.9	2.9	2.9	2.9	3.0	3.1	3.0	3.0	3.0	3.1	3.0	3.0	3.1	2.9	3.0	
National Average	2.9	2.9	2.9	2.9	2.9	2.9	2.9	2.9	2.9	3.0	3.1	3.1	3.1	3.1	3.1	3.1	3.1	3.1	3.0	3.0	

5.2   Trust level nursing and midwifery comparison CHPPD is outlined above (graph 2–4). There has been a gradual increase in CHPPD from an unqualified staff perspective from September 2017 to January 2018, although this has remained below or equal to that of our peer hospitals and below the national average. This is due to an increase in enhanced supervision to patients on the adult wards.

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. There is a risk of variation when using this 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 validity of the data is limited and is used alongside other patient outcome measures, to identify changes that might be needed.

6.   Patient Experience

6.1   The 'We Want To Be' survey results from October 2017 to March 2018, in response to the question '*in your opinion, were there enough nurses on duty to care for you during your stay on this ward*'

shows patients perceptions ranged from poor (score range 40-49%) to fair (score range 50-64%).

6.2 Integrated Care Division saw the highest scores ranging from excellent (score range 80%) to fair. The Medical Division saw consistently lower scores than other Divisions ranging from very poor to fair.

6.3 Comments from patients refer to caring, compassionate and efficient staff that go above and beyond. Patients also expressed that staff were busy and needed more staff on duty. The narrative feedback does not identify any reasons for the patients' perception of this. However, in contrast some patients referred to unfavorable staff attitudes and being left alone for periods of time.

6.4 Feedback remains lower in the Medicine Division which could correlate to the high number of RN vacancies; although temporary staffing are 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 RN vacancies, staff are re-deployed across the adult wards to support safe and efficient delivery of care. Whilst these operational controls and the use of flexible staffing ensure the Trust wider safer nurse staffing, this has a negative effect on staff morale.

7.2 A reoccurring theme that comes from the staff forum, Listening into Action (LiA) sessions and from informally speaking to staff is nurses continue to feel under pressure.

7.3 These findings are supported by the results of the NHS National Staff Survey 2017. The response rate for nursing/midwifery registered staff was 58.3% (overall Trust response rate 62.8%). The data breakdown for nursing/midwifery staff is not collated by the national centre, so data comparisons are against the 44 acute Trusts that use Picker as their survey provider.

7.4 The top three scores relating to nurse/midwifery staffing highlighted as being *significantly worse* compared to the rest of the Trust and other organisations that use Picker are seen below (table 2).

Table 2

Survey Question (questions as asked in the survey)	CRHFT Nursing/Midwifery		CRHFT average score (all other staff)		Picker Trusts Nursing/Midwifery	
	2017	2018	2017	2018	2017	2018
Don't work any additional unpaid hours per week above contracted hours	19%	24%	41%	44%	30%	43%
Able to do my job to a standard I am pleased with	64%	64%	72%	74%	77%	80%
Able to meet conflicting demands on my time at work	29%	31%	35%	39%	40%	46%

7.5 The narrative data from NSS reinforces the quantitative data with staff expressing; they can't give the care they want to, staff being moved to cover shortfalls on other wards affecting morale, being late off duty, high activity and operational pressures.

7.6 The top three scores that were *significantly better* across nursing/midwifery than the Trust average and which compare favorably against acute Trusts who use Picker as their survey provider are illustrated below (table 3).

Nurse staffing paper May 2018

Table 3

Survey Question (questions as asked in the survey)	CRHFT Nursing/Midwifery		CRHFT average score (all other staff)		Picker Trusts Nursing/Midwifery	
	2017	2018	2017	2018	2017	2018
Team members have to communicate closely with each other to achieve the team's objectives	83%	84%	75%	75%	83%	78%
Staff satisfied with support from colleagues	88%	87%	81%	81%	84%	80%
Have had training, learning or development in the last 12 months	89%	91%	68%	76%	87%	72%

7.7   The themes where results are more positive than the overall Trust relate to team working e.g. shared objectives, meet to discuss team effectiveness and communicate closely to achieve objectives.

The findings from the survey are feeding into local ward/department, Divisional and Trust wide action plans, with additional feedback and actions being taken via LiA and focus group work.

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 October 2017 to March 2018 against the same period the year before shows a positive picture:

* C.difficile low levels maintained with 8 post-72 hour infections, which is the same as the previous year
* Rate of E.Coli infections shows a 22% reduction
* Rate of inpatient falls per 1,000 bed days shows a 7.5% 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 a 9% reduction in the rate of pressure ulcers

9.   Right Skills – *Expectation 2*

9.1   **Skill Mix Review**

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

9.3   As part of the skill mix review an analysis was completed in April 2018 regarding the percentage of staff that have been qualified more than 2 years. The results demonstrate that from the 17 adult in-patient wards/departments, 16 of the wards/departments have greater than 50% of RNs being qualified more than 2 years, with the remaining 1 ward having 50% of staff qualified less than 2 years.

9.4   The position in Integrated Care Division records over 90% of staff being qualified greater than 2 years.

9.5   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 may not be working to the top of their license.

10.   Workforce Transformation

10.1   In line with the national thinking the Trust commenced a workforce transformation project for in-patient wards known as 'team around the patient' this is being piloted on six adult wards. This constitutes a ward skill mix change by augmenting the RN establishment with the introduction of highly skilled support roles e.g. Assistant Practitioner (AP), Nursing Associate (NA) and integrating the wider registered multi-professional team. Thus allowing qualified staff to spend more time using their specialist skills and take a lead in decisions about patient care.

10.2   In addition to these roles, the pharmacy technician role is being piloted on two wards from June 2018, along with successful evaluation of administration assistance who support the ward matrons and discharge coordinators.

10.3   This project is overseen by the Director of Workforce and Organisational Development with clear integration with safe nurse staffing.

11.   Mandatory training and development

11.1   Mandatory training

11.1.1   Nursing and midwifery staff complete the Trust corporate induction, the Essential Training Day for new starters. In addition RNs attend the 'Royal Way'; a three day program which includes key information, skills and knowledge required to care for our patients.

11.1.2   All nursing and midwifery staff are expected to undertake mandatory update training, compliance is monitored via Divisional governance groups, Strategic Workforce Group and reported to the People Committee.

11.1.3   Non-registered nursing and midwifery staff complete the Care Certificate program which encompasses nine taught days and a portfolio of competencies to achieve in practice. The Care Certificate is a Health Education England (HEE) requirement for new healthcare support workers which they must complete within 12 weeks. To support the non-registered staff to achieve this there are trained experienced HCAs to act as supervisors, role modelling best practice and assessing competence.

11.2   Training and development

11.2.1   Newly qualified RNs are supported through a 12 month preceptorship to enable their transition to confident, competent practitioners. On completion of the preceptorship RNs will commence from June 2018 on the staff nurse development program a career development framework tracker, which leads through a range of increasingly advanced competencies to achieve senior staff nurse status.

11.2.2   Following Trust Board approval in March 2018, a further four clinical educators posts were approved to work across the Medical and Surgical Division to provide increased support and supervision for new and experienced nursing staff. These posts are currently going through the recruitment phase.

11.2.3   All newly qualified Registered Midwives (RMs) are supported by the Lead Midwife for Clinical

Education through a 12-18 month program. This includes monthly "Reflect and Learn" sessions for example: group debriefing and clinical skills sessions. Midwives also have additional annual training that covers maternity emergencies, fetal monitoring, human factors, and anaesthetic update; this is taught alongside the Multi-Disciplinary Team (MDT).

11.2.4 A grant was secured from HEE to deliver additional maternity safety training, which included themes of patient safety, human factors, neonatal and maternity collaborative working and allowed the implementation of 'Saving Babies Lives' care bundle. The impact has been significant for example staff have reported: enhanced understanding of physiology of fetal hypoxia and increased ability in Cardiotocography (CTG) interpretation in clinical practice. The human factors awareness has been intrinsic to this change.

11.2.5 Both RNs and RMs are able to access leadership apprenticeships at certificate, degree and master's level through the Trusts leadership apprenticeship offer. This will form part of the senior staff nurse role development program which is laid out in the career development framework (as reference in point 11.2.1).

11.2.6 A Matrons Development program 'Lets Lead Together' will complete its final program by July 2018. One of the modules from the Matrons Development program that focuses on finance, staff management and effective rostering is currently being rolled out to all Sisters/Charge Nurses and is evaluating very positively.

11.2.7 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. These events have been evaluated exceptionally well, with the next one planned for May 11th 2018, to coincide with International Nurses Celebration week.

12.   Recruitment and Retention

12.1   Although recruitment activities are underway, the supply of RNs remains a challenge particularly in adult inpatient areas.

12.2   The recruitment and retention strategy is led by the Director of Workforce and Organisational Development. The nursing workforce coordinator maintains an overall plan of the actions, supported by senior nurses and Divisional human resource partners taking the lead on various initiatives.   Progress with this plan and the support needed is discussed monthly through the Workforce Delivery Group and reported through to People Committee.

12.3   Highlighted below are the three work-streams:

12.4   **Attraction**

12.4.1 This includes a plan to increase the attractiveness of our nursing/midwifery positions, for example:
- attendance at recruitment fairs across the South Yorkshire and East Midlands region to promote the Trust as a great place to work
- open days advertised through social media
- a review of how to present the benefits of working at the Trust and the NHS e.g. develop a total reward infographic
- submission of a bid to charitable funds for supporting materials that can be utilised at recruitment fairs for promotional purposes
- a leaflet drop across Chesterfield and South Sheffield postcodes with the 'We wish you

worked here' branding to encourage those who may be thinking of joining or returning to work at the Trust. This was supported by a letter sent to all recent leavers advising them of updates from the Trust such as our commitment to flexible working etc.

12.4.2   The advertising campaign is being reviewed to understand which actions have had the highest impact along with any potential funding investment required, which will provide long term savings through a reduction in agency staff.

12.5   Recruitment

12.5.1   There is a rolling advert for RN positions on NHS jobs, the Trust recruits newly qualified RN's through intakes in March and September. The nursing workforce coordinator works with the Divisions to promote the benefits of keeping in touch with new recruits to ensure they stay with us until appointment and feel welcomed. This has been supported by the introduction of a Facebook page for all new starters which has gathered a high volume of interest and supports us to keep our new recruits well informed.

12.5.2   The recruitment work-stream is in the process of reviewing the numbers in the recruitment pipeline on a monthly basis and monitor how many nurses stay with us until appointment, together with the reasons why they may choose to change to another employer.

12.5.3   The group will also review and analyse the turnover figures to understand the requirement to fill vacancies at the same pace as our turnover in order to maintain sustainable vacancy levels across the Trust. This work, will allow a decision to be made regards the potential need to progress further international nurse recruitment.

12.6   Retention

12.6.1   Retention is a key element of addressing the workforce position, to support the retention work a gap analysis has been completed against both NHSI and NHS Employer's retention toolkits which have been produced to support Trust's with their approach.

12.6.2   Operationally, the Trust has introduced many initiatives to support retention:
   - support for health and wellbeing
   - career development opportunities
   - increased engagement in relation to the staff survey
   - career clinics were introduced in April 2018 for RNs/RMs to access further advice and support for both personal and professional development purposes
   - conversations with those nearing retirement about flexible retirement options

12.6.3   All of the above areas have been discussed regionally in line with the East Midlands Workforce Optimisation project, which has facilitated a regional approach to attraction, recruitment and retention where relevant.

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

13.1   Productive working

13.1.1   The Trust has procured a new eRostering system called Healthroster (Allocate), the phased roll-out commenced late January 2018 and will be complete by December 2018, with the first department going live in July 2018.

Healthroster will further maximise roster efficiencies, functionality and productivity, with a benefits realisation plan being developed to contribute to the overall reduction in agency expenditure.

13.1.2   In addition the Trust will implement in Autumn 2018 SafeCare a module from Healthroster, which creates a live view of staffing that takes into account patient acuity. SafeCare will allow the Trust to compare staffing levels, skill mix to the actual patient demand, and provide visibility across wards and areas transforming rostering into acuity based daily staffing process. The system also supports 'Red Flags' and enables real time support and resolution of staffing concerns.

13.1.3   There are currently seven Key Performance Indicators (KPI's) in place, 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.

14.   Managing Staff Variance

14.1   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
- Utilisation of the Enhanced Support Team (virtual team that provides additional support to patients with severe dementia, cognitive problems and alcohol related withdrawals)
- Use of additional temporary staff, both registered and unregistered
- Matrons who are supervisory to the ward staffing numbers, working within the staffing establishment
- Cancellation of staff education/training sessions

14.2   **Staffing Safeguards**

14.3   A Staffing Safeguard dashboard was implemented in December 2017; this provides the Trust with a nurse/midwifery staffing position per ward, on a shift by shift basis and is reported twice a day alongside the Trusts operational position. It is defined by different levels e.g. green, amber and red and although the focus of reporting Staffing Safeguards is to reflect the current staffing position, it provides an opportunity to retrospectively review the information, to help inform staffing requirements.

14.4   This will be superseded later in 2018/19 by the implementation of SafeCare module which is outlined in point 13.1.2.

15.   Temporary Staffing

15.1   As at 31st March 2018, there were 117 wte RN vacancies if all RN vacancies were filled, along with the achievement of the sickness level target, this would release 0.8m savings. This assumes agency costs incurred to cover maternity leave. Although challenging for the Trust to achieve there is a proactive recruitment and retention plan described in section 12.

15.2   There was a reduction in agency spend from 2016/17 to 17/18 of circa 1.5m (graph 5) despite an increase in RN vacancies. However, the expenditure was higher than planned, the plans for further agency spend reduction in 2018/19 are:

- Bankshare with three local Trusts providing opportunities for wider access to bank workers

- Continued negotiation with agencies regarding costs
- Agency reduction target at Divisional level
- Actively working to migrate agency workers to NHSP bank or Trust posts
- Implementation of new eRostering system with further roster efficiencies

Graph 5

Trust Monthly Nursing Agency Spend £
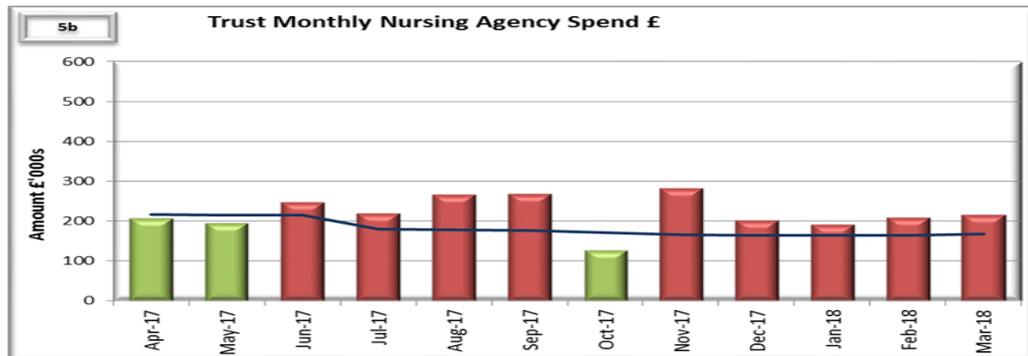
16. National Quality Board

16.1 The NQB published an improvement resource for both adult inpatient wards in acute hospitals and maternity services in January 2018; a gap analysis has been completed which demonstrates good levels of compliance, work continues to strengthen the Trusts position.

17. Section 2 – Key findings across the Divisions

The Divisional Heads of Nursing have reviewed and triangulated data e.g. acuity, skill mix, workforce and quality metrics, red flags, shifts requiring enhanced supervision and the number of risk assessments in place to make recommendations relating to nursing/midwifery establishments.

17.1 Medicine & Emergency Care Division

17.2 **Eastwood ward** (stroke ward) - The night staffing position is a challenge when the RN is required to attend ED to assist with thrombolysis for acute stroke admission. Several audits have been undertaken overnight to determine the frequency of referrals and the RN time spent off the ward. The results have shown a varying and unpredictable picture.

17.3 This information has been triangulated with other workforce and quality data, which resulted in a temporary uplift of an additional HCA on the night shift in December 2017. This was initially on a trial basis and has been expanded for a further three months, to allow a full review of the stroke pathway and MDT staffing requirements. A proposal will be taken to TG in June 2018.

17.4 **EMU/SSU** (acute admission unit) – SSU has recently been refurbished, with a new way of working implemented, this includes a designated assessment bay and a focus on SSU having short stay patients. The acuity tool has been reviewed to ensure it is appropriate and captures the rapid turnover of patients, however this is not available for January 2018 as ambulatory care admissions and discharge was included. This has been rectified for the next data collection.

17.5 The unit has seen an increase in patients with challenging behavioural care needs, with a subsequent need for additional levels of enhanced supervision. The nursing skill mix is being reviewed across the 24 hour period along with a retrospective review of the number of times enhanced supervision is required.

17.6 **Markham ward** (respiratory ward) – The National Confidential Enquiry into Patient Outcome and Death 'Inspiring change' – a review of the quality of care provided to patients receiving acute non-invasive ventilation was published in 2017. This included a number of recommendations which have been reviewed which demonstrated that the Trust is compliant with 4 of the 7 key recommendations, areas of non-compliance related to nurse staffing are:

- Staffing ratio of one RN to two acute NIV patients
- Staffing needs to allow vital signs to be completed at least hourly until respiratory acidosis has resolved

17.7 The Division are in the process of developing a business plan proposal to establish an acute respiratory unit, equipped with high dependency beds.

17.8 **Ashover ward** (care of the elderly ward) – The ward has seen an increase in activity from November 2017; with on average 30 admissions/transfers per week, along with patients presenting with increasingly challenging behaviour. The Head of Nursing is monitoring the number of occasions additional support has been required, and where risk assessments have been in place, to assess further needs.

17.9 **Recommendation -** There are no changes recommended at this time to the nursing establishments in the Medical and Emergency Care Division. However, there are four wards where additional information is being gathered to further inform the nursing workforce requirements and specialty model of care.

18. Surgical Division

18.1 The surgical wards are trialling different shift patterns with the APs working a twilight shift, to provide greater support during peaks of activity for example: patients returning from theatre, emergency admissions, medication rounds etc. The additional support provided by the APs ensures patients continue to receive essential care in a timely manner. This is being evaluated, which will also take in consideration the night staffing position across the Division.

18.2 **Recommendation -** There are no changes recommended at this time to the nursing establishments in the Surgical Division, however the HON is reviewing the night staffing position.

19. Integrated Care Division

19.1 **Midwifery Establishment**

19.2 Maternity services are experiencing a climate of transformation with the Maternity Services Review Better Births (2016). The main objective is that women should have continuity of the person looking after them during their maternity journey before, during and after birth. This will have implications for the Midwifery workforce in relation to how teams are configured and organised to enable Midwives to work flexibly across the hospital and community service.

19.3 Birthrate Plus is the recommended workforce planning tool for maternity services (NICE 2016). The methodology systematically assesses the numbers of midwives required within a given service, based on the acuity of women and their babies accessing maternity services.

19.4 The Trust last conducted Birthrate Plus in 2016, at this point the results confirmed that there has been a change in case mix since the previous audit undertaken in 2009. With the proportion of women assessed as low risk for maternity care decreasing, with a corresponding increase in women whose case is assessed as high risk.

19.5 Birthrate recommended 108 wte staff, with 90% of these being registered and 10% unqualified staff. When applying this to the Midwifery establishment the Trust is in line with the recommendations. The plan is to repeat Birthrate Plus audit later in 2018.

19.6 The maternity support worker role is well established whom undertake a range of clinical and administrative duties across the hospital and community services. In addition the Head of Midwifery has skill mixed a small proportion of the registered Midwifery establishment to trial a reception role in the community.

19.7 The changes put in place around community Midwifery locality bases has enabled the community Midwives and maternity support workers to work more efficiently, by decreasing the amount of time travelling and enabling mothers to have the option of appointments.

20. Monitoring of Midwifery staffing levels

20.1 The adequacy of Midwifery staffing is monitored by: four hourly recording of maternity service activity, acuity, staffing, Midwifery red flags and Staffing Safeguard reporting (point 14.2). This is in line with Royal College of Obstetricians (RCOG) recommendation from Safer Births.

20.2 Re-deployment of community Midwives to support activity in the hospital service is part of the escalation procedure for the maternity service. A twilight shift was implemented in December 2017 to reduce the reliance of community Midwifes. This has reduced the occurrences of the on-call community Midwife being called in to support the hospital service from 9 times in December 2017 to zero between January to March 2018.

20.3 There have been no suspensions of Maternity services of the past 6 months.

21. Paediatric Establishment

21.1 **Neonates**

21.2 The NICE quality standard (2010) in support of the *Toolkit for high quality neonatal services* (DH 2009) includes a standard for safe staffing in neonatal care.

21.3 The minimum standards for nurse staffing levels for each category of neonatal care are defined in the British Association of Perinatal Medicine (BAPM) guidelines and Toolkit for High Quality Service for Neonatal Care (2009). The Neonatal Unit (NNU) nurse staffing levels at CRHFT are based around these guidelines.

21.4 Data collection using BadgetNet is used to calculate the required establishment based on the neonatal toolkit; this was last reported in Q3 2017, table 4 outlines how the Trust compares against other local units with a similar caseload and designation.

The percentage of shifts staffed to the neonatal toolkit guidance fell in Q3, this directly linked to over cot occupancy which was reflected across the region. Daily safety huddles were commenced over this period and have continued, which includes senior staff from obstetrics, this supports the unit in decision making relating to cot capacity and prioritisation.

Table 4

Trust	*% shifts staffed to neonatal toolkit	% shifts with staff on who hold Qualification in Speciality	% shifts with supernumerary nurse in charge
Chesterfield Royal Hospital FT	49%	78%	46%
Rotherham NHS FT	37%	55%	0%
Barnsley NHS FT	66%	96%	0%
Doncaster Royal Infirmary	39%	88%	0%

Note: *ratio of registered nurses to neonates in different acuity categories.

21.5   The unit is not meeting the Qualification in Speciality (QIS); the recommendation is that 80% of RNs should hold the qualification, current compliance is 68%. This is a direct result of the reduction in course provision. It was anticipated that the unit would have reached the recommended level by August 2018, however due to impending maternity leave this is no longer achievable, the position will improve towards the end of 2018 and compliance reached by May 2019.

21.6   NNU underwent a peer review in January 2018, verbal feedback received was very positive, with the following areas highlighted for consideration: reduce reliance on the matron to provide short notice cover; increase the percentage of shifts where the nurse in charge is supernumerary and improvements in bereavement support. The Lead Children's Nurse has developed a draft improvement plan which is in the process of being implemented.

21.7   The NQB (November 2017) produced draft guidance: Safe, Sustainable and Productive staffing for Neonatal Care, a gap analysis has been completed which shows compliance of 9 out of the 10 proposed recommendations. The area of non-compliance was an annual multi-professional staffing review, this is completed for nursing staff independent to that of other team members, plans are in place to rectify this position. Once the final guidance is published the gap analysis will be updated accordingly and presented through appropriate governance forums.

22.   Acute Paediatrics (Nightingale ward)

22.1   The Royal College of Nursing (RCN) guidelines (2013) 'Defining Staffing levels for Children and Young People's Services' provide national guidelines on nursing staffing levels within acute paediatrics.

22.2   The RCN guidelines indicate a required ratio of 1:3 RNs 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 (HDU) the ratio is 1:2 RNs to children. Due to the increased supervision required for Children's Adolescence Mental Health Service they are categorised with the under 2 year old group.

22.3   A local audit against the RCN guidelines was last conducted in December 2017, which shows a similar picture to December 2016 (see graph 6).

Graph 6

Average percentage of shifts that meet the RCN guidelines
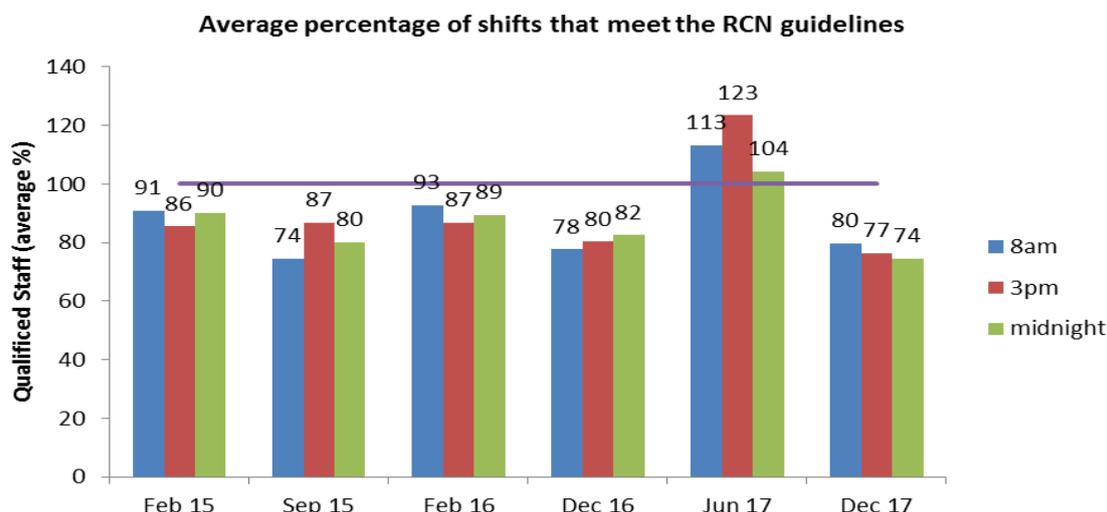
Note: Where the values go over the line (100%) the average number of qualified staff on shift was greater than the number of qualified staff required. All months below the line the number of qualified staff on shift did not meet the RCN guidelines.

22.4 From November 2017 to January 2018 acute paediatrics faced significant peaks in activity and acuity, which was reflected regionally and nationally. Additional support was provided for example: Senior Matron and ward Matron worked clinical shifts and managed patient flow; training leave was reduced; utilisation of flexible staffing and daily risk assessments were undertaken by the Senior Matron with subsequent adjustments made to the staffing rotas as appropriate.

22.5 Going forward to support the seasonal variation the ward is reviewing how staffing can be rostered more flexibly over the 12 month period to be able to better respond to seasonal peaks in activity.

22.6 Although the audit provides some useful information relating to activity it is limited as staffing levels are assessed against a child's age and not acuity, and consideration is not given to the unqualified workforce.

22.7 There are limited evidenced based nursing acuity and dependency tools available in paediatrics, the draft NBQ (November 2017): Safe, Sustainable and Productive staffing for Inpatient Children and Young People, references the Safer Nursing Care Tool which was due for release in 2017. In addition PANDA acuity and dependency assessment tool was referenced. The division are in the process of arranging a demonstration to inform the decision around what acuity tool is going to be used going forward.

22.8 A gap analysis has been completed against the draft NQB guidance which shows compliance of 10 out of the 12 proposed recommendations. Areas of non-compliance are; use of an evidenced based decisions support tool and a requirement that all children should have access 24 hrs per day to a registered children's nurse outside of paediatric services which is currently being scoped.

22.9 Taking into consideration quality outcomes, patient/staff feedback and professional judgement, at this time there are no changes recommended to the paediatric nursing establishments. However the Division are considering the leadership model relating to the hours dedicated to the Matron role.

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

23. Section 3 Conclusion and Recommendations

23.1   **Conclusion**

23.2   The annual nurse/midwifery staffing review across the inpatient ward areas has taken place. This focuses on a systematic review of 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.

23.3   One of the biggest challenges facing nursing and midwifery is the increasing complexity of the patient population and being able to meet this need with a skilled, stable workforce. This requires a constant focus on finding creative ways to recruit and retain staff.

23.4   There are a high number of registered vacancies which increases the level of risk associated with providing safe quality care. These risks are mitigated on a daily basis through operational management and use of flexible staffing. 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.

23.5   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 being undertaken across four wards in the Medical and Emergency Care Division to review the model of care and subsequent nurse workforce requirements, along with the Surgical Division reviewing the night staffing position.

24.   Recommendations

24.1   The Board are asked **to note**:
  - The content of the report

24.2   The 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

May 2018