Nursing and Midwifery Bi Annual Establishment Review

Author and Sponsor: Julie Smith, Chief Nurse   **Trust Board paper K**

Executive Summary

Context

Through the National Quality Board (NQB) 'A guide to Establishing Nursing, Midwifery and Care Staffing Capacity and Capability' was published in November 2013 which set out the 10 principles commissioners and providers should adopt when determining nursing and midwifery staffing. There is clear evidence (supported by National Institute for Clinical Excellence (NICE)) that levels of registered nurses and midwives impact on the provision of care and outcomes. This paper sets out the approach to understanding and reviewing safe nursing and midwifery staffing at UHL and the outputs from that process.

Questions

1. Does the Trust have a robust process for reviewing the nursing and midwifery staffing levels?
2. Is the Trust meeting the 10 key requirements of the NQB report?

Conclusion

1. The paper describes the establishment review process and its outputs.
2. The paper demonstrated the Trust is complaint with all the NQB requirements.
3. There are two CMGs identified as requiring an increase in nursing establishments at this time, RRCV and MSS.

Further acuity reviews will be undertaken every six months and in line with the Hard Truths principles this will be reported to Trust Board. This will involve the same detailed methodology and be led by the Chief Nurse.

The importance of six monthly establishment reviews is predicated on the fact that the Trust continues to see a growing acuity/dependency of patients across a number of adult wards. The previous investment in ward establishments has had a positive impact, ensuring wards are within the acceptable staffing range. However, there is still a significant challenge surrounding recruitment to vacancies which will continue to be an area of focus and planning to ensure all recruitment opportunities and strategies are optimised.

Acuity and dependency will continue to be the ultimate driver to ensure sustained safe staffing levels.

Input Sought

The Trust Board is asked to:
1. Support the implementation the actions for each area as laid out in the paper
2. Support this process continuing to be undertaken every six months and in line with the Hard Truths principles this will be reported to Trust Board. This will involve the same detailed methodology and be led by the Chief Nurse.

For Reference
Edit as appropriate:

1. The following **objectives** were considered when preparing this report:

    Safe, high quality, patient centred healthcare   [Yes /~~No~~ /~~Not applicable~~]
    Effective, integrated emergency care   [Yes /~~No~~ /~~Not applicable~~]
    Consistently meeting national access standards   [~~Yes~~ /No /~~Not applicable~~]
    Integrated care in partnership with others   [~~Yes~~ /No /~~Not applicable~~]
    Enhanced delivery in research, innovation & ed'   [Yes /~~No~~ /~~Not applicable~~]
    A caring, professional, engaged workforce   [Yes /~~No~~ /~~Not applicable~~]
    Clinically sustainable services with excellent facilities [Yes /~~No~~ /~~Not applicable~~]
    Financially sustainable NHS organisation   [Yes /~~No~~ /~~Not applicable~~]
    Enabled by excellent IM&T   [Yes /~~No~~ /~~Not applicable~~]

2. This matter relates to the following **governance** initiatives:
    a. Organisational Risk Register   [~~Yes~~ /No /~~Not applicable~~]

    If YES please give details of risk ID, risk title and current / target risk ratings.

Datix Risk ID	Operational Risk Title(s) – add new line for each operational risk	Current Rating	Target Rating	CMG
XXXX	There is a risk …			XX

    If NO, why not? Eg. Current Risk Rating is LOW

    Any risks associated with staffing are provided within each of the CMGs individual risk registers.

    b. Board Assurance Framework   [~~Yes~~ /No /~~Not applicable~~]

    If YES please give details of risk No., risk title and current / target risk ratings.

Principal Risk	Principal Risk Title	Current Rating	Target Rating
No.	There is a risk …		

3. Related **Patient and Public Involvement** actions taken, or to be taken: N/A

4. Results of any **Equality Impact Assessment**, relating to this matter: N/A

5. Scheduled date for the **next paper** on this topic: March 2017 Trust Board

6. Executive Summaries should not exceed **1 page**.   [My paper does /~~does not~~ comply]

    7. Papers should not exceed **7 pages.**   [My paper does /~~does not~~ comply]

University Hospitals of Leicester NHS Trust

Paper To: Trust Board

Paper From: Julie Smith, Chief Nurse

Date: 6 October 2016

Subject: Safer Staffing – Nursing and Midwifery Establishment Review

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1.0   Background

There is clear evidence (supported by National Institute for Clinical Excellence (NICE) that levels of registered nurses and midwives impact on the provision of care and outcomes.   Much work has been undertaken to support organisations to determine the right nursing and midwifery staffing to enable competent, safe, compassionate care which provides a good experience for patients and staff.

Similarly, we know that going beyond the numbers is important. This requires taking account of the skill mix, use of technology, the nature of the 'contact time' spent in direct clinical care, the contribution of others such as ward clerks and allied health care professionals as well as the local leadership, culture and environment.

1.1   National Publications/Requirements

Through the National Quality Board (NQB) 'A guide to Establishing Nursing, Midwifery and Care Staffing Capacity and Capability' was published in November 2013 which set out the 10 principles commissioners and providers should adopt when determining nursing and midwifery staffing.

The 10 principles for Trusts set out in 'A Guide to establishing Nursing, Midwifery and Care Staffing Capacity and Capability':

1.   Boards take full responsibility for the quality of care provided to patients and as a key determinant of quality, take full and collective responsibility for nursing, midwifery and care staffing capacity and capability.
2.   Processes are in place to enable staffing establishments to be met on a shift to shift basis.
3.   Evidence based tools are used to inform nursing, midwifery and care staffing capacity and capability.
4.   Clinical and managerial leaders foster a culture of professionalism and responsiveness, where staff feel able to raise concerns.
5.   Multi professional approach is taken when setting staffing levels.
6.   Nurses, midwives and care staff have sufficient time to fulfil responsibilities that are additional to their direct caring duties.
7.   Boards receive monthly updates on workforce information and staffing capacity and capability and is discussed at a public board meeting at least every six months on the basis of a full nursing and midwifery establishment review.

8.   NHS Providers clearly display information about the nurses, midwives and care staff present on each ward, clinical setting, department or service on each shift.

9.   Providers of NHS Services take an active role in securing staff in line with their workforce requirements.

10. Commissioners actively seek assurance that the right people, with the right skills, are in the right place at the right time within the providers with whom they contract.

Together with the Department of Health (DH), National Institute for Clinical Excellence (NICE) were commissioned to publish guidance on establishing safe staffing in a variety of settings and to date NICE have:

- Published a guideline to support safe staffing for nursing in adult inpatient wards in acute hospitals (July 2014)
- Published guidelines for safe midwifery staffing for maternity settings (February 2015)
- Launched a consultation on safe staffing for Nursing in Accident and Emergency Settings (May 2015)
- A plan to develop further guidelines for mental health inpatient settings

Care Contact Time Guidance was issued in November 2014 which sets out an expectation that all Trusts in England will measure their nurse contact hours to inform six monthly Board acuity reports.

2.0   Measures of Safe Staffing

2.1   Planned Versus Actual Staffing

Since June 2014, planned versus actual staffing levels for nursing, midwifery and healthcare support in acute, mental health and community settings with inpatient overnight beds has been published monthly on NHS Choices. Limitations of the original data were recognised and a RAG rating of the published data was not supported at that time as it was not deemed to be meaningful. Most specifically, we could not quality assess the planned staffing levels on a shift by shift basis. UHL have since January 2014, collected and published this data by ward monthly and it is received by both Executive Quality Board (EQB) and Quality Assurance Committee (QAC).

2.2   Safe Staffing: RAG Rating

Making RAG rated safe staffing indicators available alongside other healthcare indicators on the NHS Choices website was a key milestone to achieve by spring this year and discussions with partner organisations (including DH, CQC, NHSI, NICE, and HEE) have taken place to agree a set of proxy measures to form an overall RAG rating.

Some measures may be derived from a range of workforce indicators already in existence, including:

- The staff sickness rate (taken from ESR and published by HSCIC)
- The proportion of mandatory training completed (National Staff Survey Q1)
- The completion of a PDR in the last 12 months (National Staff Survey Q3)
- Staff views on staffing when asked if 'there are enough staff at this organisation for me to do my job properly?' (National Staff Survey Q7)
- Patient views on staffing when asked 'were there enough nurses on duty to care for you in hospital? (National Patient Survey Q30)

Our current methodology to do this is through the ward review tool and this is being reviewed and updated in response to the national requirements.

3.0　Nursing and Midwifery Establishment Reviews

3.1　Background and Approach to Establishment Reviews

Since September 2014 all clinical areas started to collect patient acuity and dependency data utilising the Association of the United Kingdom University Hospitals (AUKUH) collection tool. The AUKUH acuity model is the recognised and endorsed model by the Chief Nursing Officer for England. It is important to note that this tool is only applicable to acute adult ward areas. The patient acuity and dependency scores are collected electronically on the nerve centre nursing handover and Matrons and the senior nursing teams validate this data on morning board rounds and unannounced visits to clinical areas. The data collected has been triangulated with staffing information from the electronic rostering system and patient centre information including admissions and discharges and additional tasks undertaken in different clinical areas.

Following the Trust wide acuity assessment undertaken in June and January, formal establishment reviews have been undertaken with each Clinical Management Group (CMG) during December and January. The reviews are led by the Chief Nurse and have full input from the Deputy Chief Nurse, Heads of Nursing, Head of Midwifery, Matrons and Ward Sisters/Charge Nurses.

Whilst the establishment reviews focus on the acuity/dependency results, these are not reviewed in isolation. Experience and best practice identifies that a wider suite of quality indicators needs to be considered to allow more informed approaches in respect of ensuring the Trust staff are in place to provide high quality, safe and compassionate care.

This approach to establishment review allows for open discussion, for professional judgement to be applied alongside the triangulation of quality data with acuity/dependency data.

The following quality indicators are all reviewed as part of the establishment review process:

- Skill mix
- Nurse to bed ratio
- Incidence of hospital acquired pressure ulcers
- Incidence of falls

- Incidence of medication incidents
- Incidence of complaints relating to nursing care
- The friends and family test results
- Ward metrics

During this process the Chief Nurse also used the below points as lines of enquiry and each area was required to go through each point ward by ward through a confirm and challenge process to enable decision making regarding recommended staffing levels on each ward.

- The planned staffing on health roster and whether this appears appropriate based on professional judgement.
- If the ward staffing budget allows the planned staffing levels to enable an effective roster.
- Comparison between the funded budget/skill mix and that suggested within the acuity.
- Consideration was given to areas where the acuity data and funded staffing levels do not match. This included tasks not captured as part of the acuity data, nurse to bed ratios, skill mix, ward dashboard/ward review tool information, triage/chaired/day case areas staffed within ward establishments.
- The feasibility of transferring resources/budget if the staffing levels are in excess of the acuity.
- Whether budgeted establishments are adequate to meet the patient acuity and if an increase is required to meet the patient acuity.
- The role of the assistant practitioner for areas where an increase of registered nurses are proposed.
- Inclusion of supernumerary/supervisory time for Ward Sisters to provide effective leadership at ward level.
- The proportion of long days on the roster.
- Numbers of vacancies and staff utilisation including sickness, study leave, maternity leave and annual leave percentage.

3.2 Summary of Key Points from Establishment Reviews by Clinical Management Group

3.2.1 Emergency and Specialist Medicine (ESM)

Ward/Area	Outcome	Actions
Neurological Rehabilitation Unit	Current establishment is satisfactory.	Review potential to reduce skill mix to meet patients' rehabilitation needs in line with national guidelines.
Brian Injury Unit	Current establishment is satisfactory.	Ensure that all activity including ward attender activity is captured in acuity review.
Ward 1 day case	Review not undertaken as currently no tool available locally or nationally.	Develop mechanism for capturing acuity data for this area
Wards 23, 24, 29, 30, 31,	Acuity showed a slight	Review again in six

36, 37 ,38	shortfall in some areas – overall felt to be appropriate.	months. Review how the meaningful activity co-coordinators are captured as part of the workforce.
Stroke Wards 25, 26	Current establishment is satisfactory.	Review how we are capturing the hyper acute stroke acuity as part of the review.
Ward 34	Acuity showed a slight shortfall – felt to be safe.	Review again in six months.
Ward 35 (IDU)	Acuity showed a slight shortfall – felt to be safe.	Review how other similar units are capturing nursing requirements as part of acuity data for patient requiring full barrier nursing and isolation.

Overall in ESM the greatest challenge is the level of vacancies.

Additional Actions agreed
- Priority of Trust Wide recruitment to be given to ESM base wards
- Progress monthly payment of recruitment enhancement
- Scope the role of pharmacy technician within the ward team
- More focus on recruitment and retention

3.2.2 Renal, Respiratory and Cardiovascular

Ward/Area	Outcome	Actions
Clinical Decisions Unit (CDU)	Acuity data difficult to capture accurately for this area due to ambulatory patients. Increased demand in this area and concerns in some areas of quality data along with professional judgement. This area requires an uplift in staffing 5.5wte band 5 and 5.5wte band 2.	Immediate uplift of staffing on a temporary basis 5.5wte band 5 and 5.5wte band 2. Work with e-rostering team to develop more robust acuity capture.
Coronary Care Unit (CCU)	Current establishment is satisfactory.	Ensure that all activity including ward attender activity is captured in acuity review.
Ward 15 (Respiratory)	This ward has developed into a more specialist unit providing the non-invasive ventilation for up to 15 patients. Acuity supported by professional judgement	Recognise the changing specialist requirements of this ward. Uplift the staffing over time as recruitment allows to an

	shows this area to require additional 5.4wte band 2 uplift	additional 5.4wte band 2.
Wards 16,26,29,31,32,33,33A, 34,21,10,15A,17, 15N	Current establishment is satisfactory.	Review again in six months.
Ward 20	Current establishment is satisfactory.	Review how we are capturing the hyper acute stroke acuity as part of the review.
Ward 27	Acuity showed a slight shortfall – professional judgement felt to be safe.	Review again in six months.
Ward 28	Acuity showed a slight shortfall – felt to be safe.	Review again in six months.

3.2.3 Cancer, Haematology, Urology, Gastroenterology and General Surgery

Ward/Area	Outcome	Actions
Bone Marrow Unit, LRI Wards 40, 41 LGH Wards 22, 23,26, 28, 29, SAU	Current establishment is satisfactory.	Review again in six months.
Osborne Assessment Unit (Oncology)	Acuity scores suggest an increase in staffing is required.	Review skill mix. Review acuity method collection to ensure all activity is captured.
SACU Ward 27 LGH	Current establishment is satisfactory.	As this area has a revised staffing model, monitor and review again in six months.
Ward 22 LRI	Acuity scores suggest an increase in staffing is required to maintain 30 beds.	Reduced by 4 beds 30 – 26. New experienced ward sister.
Ward 42 LRI	Current establishment is satisfactory for funded beds. Additional 4 beds staffed on temporary basis.	Recruit to additional beds on a permanent basis.
Ward 39 LRI (Oncology)	Current establishment is satisfactory for 14 beds.	Review funding of additional 4 beds (up to 18). Longer term benchmark against peer review standards.

Additional Actions agreed

- Active recruitment to all vacant posts
- Apply closer scrutiny to the acuity data capture on nerve centre to ensure improved accuracy

3.2.4 Musculoskeletal and Specialist Surgery

Ward/Area	Outcome	Actions
Ward 7 LRI	Current establishment is satisfactory for inpatients. Temporary additional nurse in post 10-6 to support time to triage <15 minutes.	Need to capture the acuity data for triage. Funding for 1.7wte band 6 required to support ongoing triage.
Kinmonth (Specialist Surgery)	Acuity suggesting a shortfall which professional judgement supports.	Trial a twilight shift to support the acuity in the evenings - requires 1.2 wte band 5.
Ward 17 LRI (Spinal)	Acuity much improved but still showing a small shortfall.	0.7 WTE Band 2 1.0 wte Housekeeper Would support the remaining gap.
Ward18 LRI (Trauma)	Acuity scores suggest an increase in staffing is required.	0.6wte Band 2 Review registered nurse position in six months.
Ward 32 LRI (#NOF)	Shortfall in acuity supported by professional judgment.	2.0wte Band 5 required to meet the acuity.
LGH Wards 14,16,19	Current establishment is satisfactory.	Review again in six months.
GH Ward 24 (Breast)	Current establishment is satisfactory.	Shift change within current establishment to support acuity at night.

3.2.5 Women's and Children's

Women's

Ward/Area	Outcome	Actions
LGH Wards 3!, 11 & GAU (Gynaecology)	Current establishment is satisfactory.	Review again in six months.
LRI Maternity LGH Maternity	Ratio Midwives to births remains at 1:29. No recognised tool to measure acuity. Professional judgement and other data suggests a higher acuity in particular at LGH.	External Birth Rate Plus staffing review to be undertaken.
LRI & LGH Neonatal	No acuity tool available. Improved establishment.	Review again in six months.

Children's

Ward/Area	Outcome	Actions
GH and LRI all paediatric wards	Acuity data is not being accurately recorded and the set establishment does not match the budget.	Review again in six months when further work has been completed.

3.2.6 Intensive Care, Theatres, Anaesthesia, Pain and Sleep

- Work towards the nurse in charge of intensive care being supervisory 24/7
- Review the training allocation and application in line with the D16 standards for Critical Care
- Recruit to the uplifts in establishments for Theatres

3.2.7 Overall priorities

- Continued focus on recruitment
- Consider how more supervisory time can be allocated to ward sister in line with the national ambition of fully supervisory ward sister
- Improve the robustness of acuity data collection
- Implement the actions for each area as laid out in the paper
- Review the findings and recommendations from the maternity Birth Rate Plus review

4.0 Conclusion

There are two CMGs identified as requiring an increase in nursing establishments at this time, RRCV and MSS.

Further acuity reviews will be undertaken every six months and in line with the Hard Truths principles this will be reported to Trust Board. This will involve the same detailed methodology and be led by the Chief Nurse.

The importance of six monthly establishment reviews is predicated on the fact that the Trust continues to see a growing acuity/dependency of patients across a number of adult wards. The previous investment in ward establishments has had a positive impact, ensuring wards are within the acceptable staffing range. However, there is still a significant challenge surrounding recruitment to vacancies which will continue to be an area of focus and planning to ensure all recruitment opportunities and strategies are optimised.

Acuity and dependency will continue to be the ultimate driver to ensure sustained safe staffing levels.