SAFER STAFFING – NURSING AND MIDWIFERY ESTABLISHMENT REVIEW

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Trust Board paper G

EXECUTIVE SUMMARY

This paper provides an overview of the Trusts results of the bi-annual review of nurse staffing and compliance with the National Institute for Clinical Excellence (NICE) safe staffing and National Quality Board (NQB) standards. This bi-annual review of nursing establishments supports the Trust's systems and processes to seek assurance around safe staffing levels to meet patient care requirements. The review includes adult and children's inpatient areas. This is a composite paper capturing both April 2018 and September 2018 reviews and will be presented to Trust Board on May 2nd 2019.

The reviews in 2018 confirmed that additional investment in nurse establishments was only required for RRCV to enable safe staffing of the Non-Invasive Ventilation (NIV) service at the Glenfield Hospital. A business case was supported by the UHL Revenue Investment Committee (RIC) in 2018 but not progressed through Star Chamber due to competing financial priorities, therefore nurse establishments are not currently compliant with NCEPOD standards for NIV patients albeit there has been increased spend on additional temporary nursing staff to ensure nurse staffing levels are compliant. A permanent solution is required and so the request for additional investment for the NIV service has been re-submitted for 2019/20.

No other CMGs required further investment in nurse establishments for 18/19.

The National Quality Board (NQB) and CQC released guidance on the 'Deployment of Nursing Associates in secondary care' in January 2019. The guidance must be utilised to support the setting and approval of clinical establishments where Nursing Associates are deployed. In line with the guidance (that coincided with the first UHL Nursing Associates completing their training) a full Quality Impact Assessment (QIA) has been completed with Executive sign off by the Chief Nurse. The QIA confirms that all plans for deployment of the first registered Nursing Associates across UHL have been systematically assessed for their impact on quality and safety and appropriate mitigation and Key Performance Indicators (KPIs) are in place to monitor the impact of the role.

The NQB also published 'Developing Workforce Safeguards' in October 2018. The document provides a comprehensive set of guidelines on workforce planning for all staff groups and includes new recommendations on reporting and governance approaches. Corporate Nursing has undertaken a gap analysis of the recommendations aligned to the nursing workforce. It has been concluded that there are no significant gaps between the national guidance and the reporting and governance arrangements that are currently in place for the nursing workforce.

In January 2019, the Trust joined the NHSi Retention Direct Support Programme (Cohort 4). This programme supports the Trust in relation to retention and recruitment of nursing staff, with a series of master classes, retention resources, staff engagement plans and

sharing of best practice nationally. We will receive dedicated support from NHSi throughout the programme which will support our next acuity review.

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 'Developing Workforce Safeguards'
3. Are we assured that the Trust will be safely deploying the first registered Nursing Associates?

Conclusion

1. Although challenges continue to ensure safe staffing across our ward areas due to the level of nurse vacancies, this is mitigated on a daily basis through the safe staffing meetings and silver nurse role and corporate nursing support.
2. The paper describes the establishment review process and its outputs.
3. The paper demonstrated the Trust is complaint with all the NQB requirements within 'Developing Workforce Safeguards' guidelines.
4. Our first registered Nursing Associates will be safely deployed across UHL.

Input Sought

The Trust Board is asked to:

1. Note the actions for each CMG area as laid out in the paper.
2. Support the overall priorities and next steps as set out in the paper.
3. 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	Curren t Rating	Targe t Ratin g	CMG
XXXX	There is a risk …			XX

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

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: [Insert here]

4. Results of any **Equality Impact Assessment**, relating to this matter: [Insert here]

Scheduled date for the **next paper** on this topic: [6 months]

5. Executive Summaries should not exceed **1 page**. [My paper does not comply]

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

1.0 BACKGROUND AND LINKS TO PREVIOUS PAPERS

This paper provides an overview of the Trusts results of the bi-annual review of nurse staffing demonstrating compliance with the National Institute for Clinical Excellence (NICE) safe staffing and National Quality Board (NQB) standards. This bi-annual review of nursing establishments supports the Trust's systems and processes to seek assurance around safe staffing levels to meet patient care requirements. The review includes adult and children's inpatient areas. This is a composite paper capturing both April 2018 and September 2018 reviews.

2.0 NATIONAL PLANNING GUIDANCE CARE CONTACT TIME

The Carter review, the NHS Five Year Forward View planning guidance and Developing Workforce Safeguards- NHSi 2018, make it clear that workforce plans must be consistent to optimise clinical quality and the use of resources. The Carter review highlighted variation in how acute trusts currently manage staff. It underlined that, in addition to good governance and oversight, NHS providers need a framework to evaluate information and data, measure impact, and enable them to improve the productive use of staff resources, care quality and financial control. Lord Carter's report recommended a new metric: care hours per patient day (CHPPD), as the first step in developing a single consistent way of recording and reporting staff deployments.

UHL has been collecting and publishing (in line with national requirements) CHPPD since May 2016 and we are now able to use this information in a more meaningful way as Safe Care Live was rolled out across all inpatient areas from November 2017.

Safe Care Live is a patient based acuity staffing tool which provides both live and predictive data to support Nurse Leaders in making professional judgements about ward safety, shift by shift. It allows us to compare staffing levels and skill mix to the actual patient demand in real time and provides visibility across all wards and areas.

3.0 METHODOLOGY

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. UHL have since January 2014, collected and published this data by ward monthly and it is received by both the UHL Executive Quality Board (EQB) and Quality Outcomes Assurance Committee (QOC).

Alongside this EQB and QOC, receive and review nursing workforce metrics, inclusive of indicators of quality and outcomes and measures of productivity on a monthly basis as a whole and not in isolation of each other in the Nursing and Midwifery Quality and Safe Staffing Report.

3.1 <u>Safer Nursing Care Tool (SNCT)</u>

Since September 2014 all clinical areas have collected patient acuity and dependency data utilising the Association of the United Kingdom University Hospitals (AUKUH) collection tool. However, the Trust is now utilising the Safer Nursing Care Tool (SNCT), as supported and detailed as the tool of choice by NHSi. The SNCT is a NICE endorsed

evidence-based tool which uses acuity and dependency to support workforce planning. Originally developed by AUKUH it is now hosted by and endorsed by the Shelford Group.

The tool uses a system of identifying patients according to acuity (how ill the patient is) or dependency (how dependent the patient is on nursing staff). This is detailed below:

Level	Description
Level 0	Patient requires hospitalisation. Needs met through normal ward care
Level 1a	Acutely ill patients requiring intervention or those with greater potential to deteriorate
Level 1b	Patients who are stable but have an increased dependence on nursing support
Level 2	Patients who are unstable and at risk of deteriorating and should not be cared for in areas currently resourced as general wards
Level 3	Patients needing advanced respiratory support and therapeutic support of multiple organs.

The patient acuity and dependency scores are collected electronically on the Nerve Centre nursing handover system 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 e-rostering system, patient centre information including admissions and discharges and additional tasks undertaken in different clinical areas.

3.2 Nurse Establishment Reviews

Following the Trust wide acuity assessment using acuity data from 1st October 2017 to the 1st October 2018, the Chief Nurse has led the nurse establishment reviews with each Clinical Management Group (CMG). The following quality indicators were reviewed as part of the establishment review process:

- Skill mix
- Nurse to bed ratio
- The ward monthly scorecard that includes quality indicators such as:

  - Incidence of hospital acquired pressure ulcers
  - Incidence of falls
  - Incidence of medication errors
  - Incidence of complaints relating to nursing care
  - Friends and family test results
  - Clinical Measures Dashboard

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

- The planned staffing on health roster and whether these appear 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.
- Does the acuity data and funded staffing levels match? This includes 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 are any increases required to meet the patient acuity.
- Numbers of vacancies and staff utilisation including sickness, study leave, maternity leave and annual leave percentage.
- Care Hours per Patient Day.

Staffing establishments must take into account the need to allow nursing, midwifery and care staff the time to undertake continuous professional development and to fulfil mentorship and supervision roles. Core principles in determining the nursing and midwifery establishments are detailed below:

- The ward sister role is supervisory 40% of their time and they use their time to direct care, and undertake frontline clinical leadership as well as supporting unfilled shifts.
- The deputy sister role is supervisory 20% of their time, to direct care and undertake frontline clinical leadership as well as supporting unfilled shifts and management tasks.
- 23% headroom is allocated to ward establishments to allow for annual leave, sickness, maternity leave, training and development (N.B. The RCN recommends 25%).

4.0 RECOMMENDATIONS FROM THE ESTABLISHMENT REVIEWS 2018/19.

A summary of findings and recommendations for each CMG review is detailed below. A summary of UHLs current nursing ratios and skill mix is included in Appendix 1.

It should be acknowledged that we have included a comparison of UHL nurse establishments against existing national guidance that states general wards to be at a ratio of one registered nurse to eight (1:8) during the day shift.

CMG shifts that are below the 1:8 (i.e. more than 8 patients to one registered nurse) are highlighted in grey. At present, there is no guidance to nurse: patient ratio during the night shift therefore if the staffing is below 1:8 this is due to reduced activity or increased dependency of patients who require a greater proportion of non-registered workforce. These levels of staffing have been agreed by the Chief Nurse and are based on professional judgement.

It is noted that NHSI have advised that providers should focus more on CHPPD as opposed to rigid ratios on the number of registered nurses per shift so this will not be included in future reviews.

4.1 Specialist Medicine (SM)

***Across Speciality Medicine, the establishments have all been set to a satisfactory level. There is no further investment requested or indicated at this review due to the number of vacant posts which is mitigated on a daily basis*.**

- The CMG are embracing new roles to support the registered nursing workforce, i.e. discharge support assistants, nursing associates and the use of pharmacy technicians. Successful international recruitment for registered nurses continues across the CMG
- ‘Over recruitment’ into housekeeper roles has occurred. The Head of Nursing has strived to ‘over recruit’ to HCA roles to support the ward teams but this has not yet been achieved but is work in progress.
- There is high use of ‘forget me not’ volunteers (for patients with dementia) meaningful activity co-ordinators and agency HCAs for one to one care due to the high numbers of frail elderly patients on the wards.

4.2 Emergency Medicine (EM)

Following the opening of the new emergency floor and ‘bedding down’ of new processes aligned to patient flow, the nursing establishments will need a further review in April 2019. The 2018 reviews highlighted inaccuracies in relation to the accurate recording of acuity across the ward based areas. With the implementation of the electronic Safer Nursing Care Tool, accurate recording of acuity will improve.

- Emergency Decisions Unit (EDU) has a large number of vacancies; however the establishment requires review based on the high number of Mental Health patients now being cared for (i.e. supervision / one to one care), as this was not originally included in the EDU establishments. The Head of Nursing will review the senior nursing leadership for care of Mental Health patients and present a proposal to recruit a Matron post specifically for this client group and the supporting agenda in April 2019.
- There is excellent support and input from meaningful activity coordinators across the Acute and Elderly Frailty Units; however it must be noted that the funding for these posts is from the nursing vacancies as this was deemed appropriate at the time.
- Some challenges in relation to the RN Children’s vacancies and increase in activity through children’s ED. The Head of Nursing has recruited 10 further Registered Children’s nurses since the opening of the new department. Rotational posts between the children’s hospital and children’s ED are very popular, and will continue.
- Main Emergency Department, the staffing needs review in light of the increase in cubicles in Majors and also the plan to keep the sub wait and other capacity open over winter. Head of Nursing will recalculate the bank and agency requirements for this increase in staffing with a proposal in April 2019.
- In respect of the quality indicators the matrons across the Emergency floor are monitoring the nursing metrics on a weekly basis, supporting and developing staffs knowledge across the suite of quality indicators monitored.

4.3 Renal, Respiratory and Cardiovascular (RRCV)

The establishments across the CMG are correct, but they are not funded adequately, some of this could be due to the fact that the establishments are set on short shifts and the majority of staff work long days. However a key issue is that although the

establishments have the correct wte, the required financial value behind this is not there. This has been 'hidden' previously, as the number of vacancies in the CMG has been greater, as these are reducing, financial issues are being highlighted associated with nurse staffing.

- This CMG is successful with its recruitment and retention of staff. There is no agency usage for nursing staff across the CMG, the CMG nursing budget was set at out turn which presents its own challenges, and in fact penalises CMGs for good workforce utilisation.
- Very positive FFT scores across the CMG and success in relation to HAPU, however challenge in relation to the increase in falls across the CMG, potentially due to the increased acuity and fragility of the patients received.
- There needs to be recognition of the increased acuity and demand at the GH site. The biggest challenge for the CMG is the increased level of bariatric and NIV patients being cared for at the site and the necessity to meet the NCEPOD requirements, a business case for increased investment was supported in 2018 but due to competing priorities needs further review in 2019, therefore there is increased spend to ensure patient safety.
- The Head of Nursing is reviewing CHPPD in her specialities with her speciality peers and report back at the next acuity review, and will also ensure completion of quality impact assessments when nursing investment is requested.

4.4 Cancer Haematology Urology Gastroenterology & General Surgery (CHUGGS)

No investment indicated across the CMG. However, there remains a high amount of vacancies across CHUGGS there is no indication for further investment at this time; however this will need continual review. The biggest area of challenge and focus for the CMG remains the recruitment and retention of staff into vacant posts utilising creative solutions to achieve this.

- The Head of Nursing has recruited discharge support assistants (band 3) for every inpatient ward area, and has allocated budget for Band 4 (Nursing Associate) roles into every inpatient ward establishment.
- A Band 7 developmental role has been introduced to support the future leaders (ward managers) of the areas, by retaining the staff retirees to support the younger generation
- Career pathways are being aligned to the future reconfiguration of services.
- There is a requirement to promote the multi-faceted skill set required for the complex patients in this service and this may need further investment in the future.

4.5 Musculoskeletal and Specialist Surgery (MSSK)

No investment indicated across the CMG; however the reoccurring theme is the use of the CMGs beds for other specialities which impacts on the retention of staff across the CMG because they have chosen to work in a speciality that they are not necessarily experiencing all of the time .

- Each trauma ward has a discharge nurse and a Band 3 discharge support worker, and the Head of Nursing has altered the skill mix on the trauma wards, increasing the

number of HCA staff in the area, to support RNs delivery of care to the complex patients.

- One trauma ward (ward 32 LRI) is now in its third year of being 'hospital acquired pressure ulcer **free**'. The CMG have implemented a developmental Band 7 spinal nurse specialist role, to support the complex spinal patients in this area.
- Trauma ward staffing is currently on the risk register in relation to the high number of vacancies. A second matron for elective orthopaedics has been recruited to support nursing leadership.

4.6 Children's Hospital

Due to the number of vacancies currently in the Children's Hospital and the key work streams required as detailed, no investment is indicated at this time; however this requires review in a further 6 months in April 2019. Recruitment remains a challenge locally and nationally and even if funding was agreed it would take some time to be able to achieve recruitment to new and existing vacancies.

- Further detailed review of nurse establishments is being undertaken in this area using a phased approach

  a) Phase 1, fill the vacancies and identify the gap in terms of acuity versus establishments.
  b) Phase 2 look at the recommended establishments based against the NHSI guidance 'Safe, sustainable and productive staffing for neonatal care and children and young people's services' (2018). Any gaps identified between current nursing establishments and the national guidance will need to be considered in the next establishment review due to commence in April 2019.

- The Head of Nursing is contacting peer groups and undertake benchmarking in relation to the ratio of Registered Nurses (Adults) who are working in children's areas having undergone a period of training in the care of children versus Registered Children's Nurses' to determine the safe or recommended ratio we need to align to in UHL.
- A review by the Head of Nursing into the number of nurses required to support Extracorporeal Membrane Oxygenation (ECMO) service is needed because of the high level of support required this winter from the Adult ITU (ITAPS) as well as the PICU at the Glenfield Hospital. The conclusions will be fed into the April 2019 nurse establishment review.
- There are nine Nursing Associates commencing in the children's hospital in March 2019 and the appropriate safeguards are in place to support safe implementation of this role.

4.7 Intensive Care, Theatres, Anaesthesia, Pain and Sleep

There is no recognised acuity tool to support theatres and critical care therefore staffing is set on the number of Level 2 and Level 3 patients. The focus is to concentrate on recruitment to vacancies, and review and progress the training requirements in line with the national Commissioning D16 standards for Adult Critical Care.

- For theatres, the CMG have produced a developmental pathway via the apprenticeship route within theatres growing Band 2 support workers into new roles and progressing towards level 5 ODP training. Investment for a Band 7 training facilitator to develop this unique initiative has been supported for recruitment in spring 2019.
- The CMG are welcoming the Nursing Associate role in theatre recovery and ITU.
- There has been no use of agency nurses across the ITUs during 2018.
- To note the ITU occupancy is at 95/96%, and the national average is 83/85%, although very busy units, there is no request for additional investment at this time.

4.8 The Alliance (UHL Pillar)

There is no recognised acuity tool to support day case and outpatient an area, therefore staffing is aligned to the planned elective activity as detailed in the local Service Level Agreements. Post this review, no additional investment is required

- The Head of Nursing is planning to benchmark against other similar NHS hospitals to ensure the Alliance is not an outlier in relation to staffing numbers and skill mix. The Alliance is working collaboratively across LLR on a range of workforce initiatives, and their focus is on developing new roles, assistant practitioners, nursing associates and expanding the scope of practice of the specialist nurse roles.
- The Nursing structure has been redesigned in order to strengthen its leadership and to provide capacity for activity moving out into the Alliance. Future plans include developing nurse leadership, providing more flexible shift options, ensuring the skill mix reflects the patient case load, providing mentorship and professional development for the staff, and developing staff engagement activities.

5.0 DEPLOYMENT OF NURSING ASSOCIATES IN SECONDARY CARE

The National Quality Board (NQB) released guidance on the ‘Deployment of Nursing Associates in secondary care’ in January 2019. The guidance must be utilised to support the setting and approval of clinical establishments where Nursing Associates are deployed. In line with the guidance (that coincided with the first UHL Nursing Associates completing their training) a full Quality Impact Assessment (QIA) has been completed with Executive sign off by the Chief Nurse. The QIA confirms that all plans for deployment of the first registered Nursing Associates across UHL have been systematically assessed for their impact on quality and safety and appropriate mitigation and Key Performance Indicators (KPIs) are in place to monitor the impact of the role.

5.1 CQC Briefing in relation to the safe deployment of Nursing Associates.

In January 2019, the CQC circulated a provider briefing outlining their expectations around the deployment of Nursing Associates (appendix 2). They have emphasised the need for organisations to understand that Nursing Associates are not Registered Nurses with the expectation that health and care providers must consider this when deploying them. As with the introduction of any new role, the CQC are not prescriptive about how Trusts deploy Nursing Associates. However, they will need assurance that using Nursing Associates is safe and supports the delivery of high-quality care.

The Trust must be able to clearly articulate how Nursing Associates are counted into the staffing establishment and to carry out regular staffing reviews after deployment, ensuring

that nurse-sensitive quality indicators are taken into account to improve quality and safety for people who use services. This will be monitored by the CQC via provider information returns. The Trust complies with this requirement through the existing work undertaken around our nurse acuity and establishment reviews and the implementation of assessment and accreditation in addition to the completion of the QIA as required by the National Quality Board.

The Trust must also develop local guidelines to ensure that existing staff understand the rationale for deploying Nursing Associates, the benefits of the role, and the process for escalating any concerns. This work has been completed alongside the updating of clinical policies and guidelines that will need to incorporate Nursing Associates (i.e. administrations of medicines). On inspection, the CQC will require evidence to ensure we have adopted a systematic approach to deploying nursing associates, ensuring that we have considered the risks to the quality and safety of care for people who use services.

6.0 DEVELOPING WORKFORCE SAFEGUARDS

The NQB also published 'Developing Workforce Safeguards' in October 2018. The document provides a comprehensive set of guidelines on workforce planning for all staff groups and includes new recommendations on reporting and governance approaches. Corporate Nursing has undertaken a gap analysis of the recommendations that are aligned to the nursing workforce. It has been concluded that there are no significant gaps between the national guidance and the reporting and governance arrangements that are currently in place for the nursing workforce.

7.0 NHSI RETENTION DIRECT SUPPORT PROGRAMME

The Trust is part of the NHSi Retention Direct Support Programme (Cohort 4). This programme supports the Trust in relation to retention and recruitment of nursing staff, with a series of master classes, retention resources, staff engagement plans and sharing of best practice nationally. We will receive dedicated support from NHSi throughout the programme which will support our next acuity review.

8.0 PRIORITIES AND NEXT STEPS

Although challenges continue to ensure safe staffing across our ward areas due to the level of nurse vacancies, this is mitigated on a daily basis through the safe staffing meetings and silver nurse role and corporate nursing support.

Implementation of Safe Care across the Trust has supported the provision of robust acuity monitoring and has highlighted areas that require focused support and training in understanding acuity scores and applications of these scores, which in turn supports the culture change necessary to move from numbers of staff to Care Hours per Patient.

There will be a continued focus on retention and recruitment across the CMGs and continued implementation and use of the Nursing Associate. Each CMG has also reviewed their nursing workforce, both qualified and unqualified in relation to their retirement profile, and have proactive plans in place to address this.

Investment is required for RRCV for the NIV business case was supported by RIC in 2018 but not progressed through Star Chamber due to competing priorities, therefore nurse staffing is not compliant with NCEPOD standards for NIV patients albeit the gaps are mitigated on a daily basis. All other areas have high levels of vacancies therefore no further investment indicated at this time. The next acuity review will be undertaken in April 2019 in line with National Quality Board standards. The Chief Nurse will review the methodology in line with national recommendations.

The Trust Board is asked to note the work currently being undertaken and accept assurance that there is sufficient nurse staffing capacity and compliance with national safe staffing guidance.

Appendix 1

Nursing Staff & Shift Pattern

Cost Centre	Ward	Establishment Shift Patten								Dec. Budgeted WTE Finance (Excl Bank/Agen)		Skill Mix		Comments Appendix one
		Qualified				Unqualified						RN	HCA	
		E	L	N	OC	E	L	N	OC	Qual.	Unq.			
	CHUGGS													
W69	LGH-Wd 20 Surgery	3	2	2		2	2	1		12.0	6.3	66	34	
W71	LGH-Wd 22 Female Surgery	3	3	2		2	2	2		14.4	11.3	58	42	Below 1:8 overnight, surgical ward, not always full overnight
W49	LGH-Wd 23 Surgery Admissions	2	2			2	2			4.4	5.1	46	54	
S75	LGH-Wd 26 Urology Surgery	3	3	2.5		3	3	2		16.7	13.4	56	44	Below 1:8 overnight, elective surgery ward, following review & professional judgement
W73	LGH-Wd 27 Surgery (& SACU)	5	5	3		3	3	3		23.8	18.5	56	44	
W72	LGH-Wd 28 Surgery/Urology Admission	5	5	3.5		3	3	2		19.7	16.6	56	44	
W70	LGH-Wd 29 Surgery Admissions	4	4	3		4	4	2		21.8	18.4	54	46	Below 1:8 overnight, ward budget revised and will be funded by the CMG
B24	LRI-Bone Marrow Transplant Unit	4	2	2		1	1			14.9	0.7	96	4	
B04	LRI-Chemo	7	6			2	2			10.4	2.0	84	16	
B22	LRI-Osborne Day Care	6	2			2	1			7.3	2.4	75	25	
W63	LRI-Surgical Assessment Unit Wd 8	6	6	5		5	5	4		30.7	24.5	56	44	
W64	LRI-Wd 22 Surgery	6	6	5		6	5	2		25.8	17.2	60	40	
B01/B02	LRI-Wd 39 Onc + OAU	4	4	3		4	4	2		23.0	14.0	62	38	
B06	LRI-Wd 40 Onc	3	3	2		2	2	1		16.6	12.7	57	43	Below 1:8 overnight, following review & professional judgement
B21	LRI-Wd 41 Haem	4	4	3		3	3	2		19.7	8.9	69	31	
N29	LRI-Wd 42 Gastro Med	5	4	3		3	3	2		20.9	13.9	60	40	Below 1:8 overnight, further review of establishment once acuity reporting more robust
N30	LRI-Wd 43 Gastro Med/Hepat	5	4	3		3	3	2		19.4	15.2	56	44	
	EM													
N40	LRI-A&E Paeds	11	11	12		7	6	6		42.9	20.1	70	30	
N15	LRI-Acute Medical Unit	11	11	11		11	11	10		63.0	48.7	70	30	
N99	LRI-AFU	4	4	3		3	3	3		22.3	21.3	70	30	
N41	LRI-ED	25	25	31		9	9	12		134.5	58.7	70	30	
N46	LRI-EFU	4	4	3		3	3	3		19.6	15.8	70	30	
N44	LRI-Emergency Decisions Unit	3	3	3		2	2	1		17.0	10.6	70	30	
N15	LRI-GPAU	2	2	2		1	1			63.0	48.7	70	30	
N33	LRI-SSU Emergency Admissions	5	5	4		5	5	3		27.5	19.9	70	30	
	SM													
N61	LGH-Brain Injury Unit	3	3	2		2	2	2		19.1	8.2	70	30	

N60	LGH-NRU Neuro Rehab	3	3	2		3	3	2		18.2	13.9	60 : 40	
N11	LGH - Wd 1 Day Case	5	5			4				8.0	3.3	60 : 40	
N56	LGH-Wd 3 Stroke Rehab	3	3	2		3	3	2		15.6	12.2	60 : 40	
N92	LRI-Hampton Suite	5	5	2		3	3	3		14.8	17.0	60 : 40	Below 1:8 overnight-following review & professional judgement- as altered skill mix area with AHP support.
N39	LRI-Infectious Diseases Unit	3	3	2		2	2	2		16.0	9.6	70 : 30	Below 1:8 overnight-following review & professional judgement, this is acceptable
N57	LRI-Stroke Wds 25/26	9	9	4		5	5	4		41.5	15.3	70 : 30	Below 1:8 overnight-following review & professional judgement, investment required in the future.
N58	LRI-Wd 21 Med	6	6	3		4	4	2		27.3	16.0	60 : 40	Below 1:8 overnight-following review & professional judgement
N36	LRI-Wd 23 Specialist Med	6	6	3		4	4	2		23.5	15.0	60 : 40	Below 1:8 overnight-following review & professional judgement
N24	LRI-Wd 24 Specialist Med	6	6	3		4	4	2		22.6	14.6	60 : 40	Below 1:8 overnight-following review & professional judgement
N84	LRI-Wd 29 Older People	6	6	3		4	4	2		23.8	16.8	60 : 40	Below 1:8 overnight-following review & professional judgement
N51	LRI-Wd 30 Older people	6	6	3		4	4	2		24.3	15.9	60 : 40	Below 1:8 overnight-following review & professional judgement
N31	LRI-Wd 31 Older People	6	6	3		4	4	2		25.2	16.3	60 : 40	Below 1:8 overnight-following review & professional judgement
N26	LRI-Wd 36 Older People	6	6	3		4	4	2		23.5	14.2	60 : 40	Below 1:8 overnight-following review & professional judgement
N38	LRI-Wd 38 Diabetes/Endocrine	6	6	3		4	4	2		23.5	15.3	60 : 40	Below 1:8 overnight-following review & professional judgement
	MSK												
W79	GH-Wd 24 Breast + Gen Surgery	5	4	2		1	1	1		12.0	5.7	60 : 40	Below 1:8, not a 7 day ward-23 hour stay
Y24	LGH-Wd 14 Elective Ortho	3	3	2		2	2	2		15.2	10.6	60 : 40	Below 1:8 - elective ward, rarely full to 20 beds overnight
Y23	LGH-Wd 18 Elective Ortho	5	5			2	2			14.1	5.2	60 : 40	
Y20	LGH-Wd 19 Elective Ortho (Prev Wd 16)	3	3	2		3	3	2		22.4	20.1	60 : 40	Below 1:8
Y22	LGH orthopaedic ward closed reopen in different way									8.1	6.9	60 : 40	
W95	LRI-ASU	3	4	2		1	1	1		20.6	6.9	70 : 30	Staffed appropriately for day case activity. Rarely full with elective patients overnight. However not staffed for outliers.
W23	LRI-Kinmonth Unit Head, Neck, ENT Surg	4	5	2		2	1	2		18.0	8.8	70 : 30	
W13	LRI-Wd 9 Spec Surg Admission	4	4	2		2	2	2		17.1	10.6	60 : 40	Below 1:8 overnight following review & professional judgement

Y13	LRI-Wd 17 Spinal/Trauma Ortho	4	4	3		4	4	3		21.6	24.5	70 : 30	
Y14	LRI-Wd 18 Trauma Ortho Admissions	5	5	3		4	3	3		24.9	20.2	70 : 30	Below 1:8 overnight following review & professional judgement
Y16	LRI-Wd 32 Trauma Ortho	5	5	3		4	3	3		20.5	19.5	70 : 30	
	RRCV												
C29	GH-CDU Cardiac admissions	16	16	16		11	11	8		87.5	62.0	70 : 30	
C27	GH-Coronary Care Unit	7	7	6		3	3	2		37.5	13.2	80 : 20	
C20	GH-Wd 15 Respiratory	5	4	3		4	4	2		23.4	19.0	60 : 40	Below 1:8 overnight, following review & professional judgement and NIV service transferred to W17
C21	GH-Wd 16 Respiratory	5	5	4		4	4	2		23.5	16.7	60 : 40	
C23	GH-Wd 17 Respiratory	7	7	5		4	4	3		37.3	18.5	70 : 30	
C19	GH-Wd 20 Cardiac & Respiratory	5	5	3		4	4	2		0.0	0.0	60 : 40	
W43	GH-Wd 23 (previously LRI-Wd 21)	7	7	5		5	5	4		32.5	23.8	60 : 40	
C38	GH-Wd 26 Thoracic Surgery	5	5	4		3	3	1		22.6	14.1	70 : 30	
C24	GH-Wd 27 Cardiology	5	5	3		3	2	2		24.2	13.9	60 : 40	Below 1:8 overnight, elective cardiac surgery ward
C30	GH-Wd 28 Cardiology	5	5	3		4	4	2		21.8	16.6	60 : 40	Below 1:8 overnight, elective carduiac surgical ward
C99	GH-Wd 29 Respiratory	4	4	3		3	3	2		18.5	13.2	60 : 40	
C35	GH-Wd 31 Cardiac Surgery	7	7	5		4	4	2		31.7	15.8	70 : 30	
C32	GH-Wd 32 Cardiology Procedures	4	4	2		3	2	0		15.0	6.4	60 : 40	
C31	GH-Wd 33 Cardiology	5	5	3		3	3	2		23.6	15.6	80 : 20	Below 1:8 overnight, elective surgery ward
C33	GH-Wd 33A Cardiology	3	3	2		2	2	2		15.8	10.6	60 : 40	Below 1:8 overnight, elective surgery ward
S21	LGH-Wd 10 CAPD Renal	5	5	2		4	3	2		23.6	14.1	60 : 40	Below 1:8 overnight, following review & professional judgement
S04	LGH-Wd 15 High Dependency Renal	4	4	3		1	1	1		20.5	5.3	80 : 20	
S05	LGH-Wd 15 Nephrology Renal	4	4	2		2	2	2		20.3	11.4	70 : 30	
S64	LGH-Wd 17 Renal Transplant	3	3	2		2	2	1		15.0	8.8	70 : 30	
	Children's												
C61	GH-Paed ITU - Children's Cardiac Intensive Care	9	9	9		1	1	1		50.3	4.8	90 : 10	
C41	GH-Wd 30 Childrens Cardiology	4	4	4		1	1	1		28.7	5.5	70 : 30	
D15	LRI-Childrens Day Care Unit on Wd 19	5	2			3				5.6	5.4	70 : 30	
D13	LRI-Childrens Intensive Care Unit	7	7	7		1	1	1		36.7	4.7	90 : 10	
D41	LRI-Wd 10 Childrens Surgery	5	5	2		3	3	1		18.9	8.5	70 : 30	Below 1:8 overnight, following review & professional judgement
D51	LRI-Wd 11 Childrens Med	4	4	3		2	2	2		18.9	10.0	70 : 30	
D12	LRI-Wd 12 Childrens Med	5	5	5		1	1	1		25.2	4.8	70 : 30	
D11	LRI-Wd 19 Childrens Surgery	10	4	2		6	3	1		19.6	8.4	70 : 30	
D17	LRI-Wd 27 Childrens Onc & Haem	7	5	3		3	2	1		23.3	5.7	70 : 30	

Code	Ward / Area											Ratio
	Womens's											
X37	LGH-Delivery Suite	16	15	15		6	6	5		87.8	29.1	80 : 20
X58	LGH-Gynaecology Service Unit					5	6			0.0	6.4	0 : 100
X13	LGH-NICU Neo-Natal Intensive Care	4	3	3		1	1	1		18.3	8.7	80 : 20
X62	LGH-Wd 11 Gynae Day Case	3	2			2	2			6.9	4.8	61 : 39
X63	Gynaecology Specialist Nurses	11		4		4				21.0	4.6	84 : 16
X57	LGH-Wd 31 Gynae	5	5	2		2	2	1		17.8	11.3	60 : 40
X50	LRI-Gynaecology Outpatients					5	1				6.4	0 : 100
X32, X34, X35, X39	LRI - Delivery Suite	27	26	16		6	6	6		127.8	50.4	80 : 20
X51	LRI-GAU (Gynaecology admissions)	4	4	2		2	2	1		16.6	9.8	70 : 30
X10	LRI-Neo-Natal Unit (Children's Neo-Natal Unit)	21	18	17		3	3	2		86.6	9.9	80 : 20
	Alliance											
V57	Coalville OPD	3	2			2	2					:
V60	Hinckley and District OPD	4	4			3	3			5.3	4.7	60 : 40
V68	Alliance Endoscopy (LBR,MTN,MKTHB,HKLY)	11	14			3	4			20.8	6.9	70 : 30
V59	Hinckley Surgical Unit	8	8			3	3			11.6	4.2	60 : 40
V52	Loughborough OPD	6	6			6	6			9.2	12.5	60 : 40
V51	Loughborough Surgical Unit	8	8			2	2			11.8	2.4	60 : 40
V64, V76	Market Harborough & Fielding Palmer OPD	3	3			3	3			2.8	1.9	60 : 40
V71	Melton & Rutland Outpatients	4	4			7	7			4.6	5.9	60 : 40
V72	Melton Surgical Unit	7	7			2	2			8.7	0.8	60 : 40
	ITAPS - ITU											
C60	GH-ITU - Glenfield (General and Cardiac Intensive Care)	29	28	27		4	4	2		130.2	13.0	90 : 10
A11	LGH-ITU	12	11	10		3	3			54.1	6.2	90 : 10
A10	LRI-ITU (Gen.Surgery,Haematology,Med,Max.Facial)	24	23	22		3	2	2		117.2	13.5	90 : 10
	CSI											
M18	Imaging Nursing Team (LRI,LGH,GH)	17	1		1					18.7	0.0	100 : 0
M25, R10	Nuclear Medicine (LRI,GH)	2.4								2.4	0.0	100 : 0
Q04	LRI-Outpatients	5				6				7.7	11.0	45 : 55
Q05	GH-Outpatients	3	2			7	4			8.0	12.4	35 : 65
Q06	LGH-Outpatients	7.3				10	2			8.2	15.5	31 : 69
R08	Measurement - Electrodiagnostics	0.5								0.5	0.0	100 : 0
R25	Pathology BTS	1.5								1.5	0.0	100 : 0
E22	LRI Pharmacy	2								3.0	0.0	100 : 0
E17	LRI Chief Pharmacist	0.1								0.6	0.0	100 : 0

	Qualified Shift Key
Above 1:8	(green)
Equal 1:8	(blue)

Below 1:8	
No Beds	

Cost Centre	Ward	Establishment Shift Patten										Dec. Budgeted WTE Finance (Excl Bank/Agen)		Skill Mix	
		Qualified					Unqualified							RN	HCA
		E	D	L	N	OC	E	D	L	N	OC	Qual.	Unq.		
	ITAPS - Theatres														
A53, A52	GH-GFD General Surgery Theatre, GH-Theatres - Cardiac Surgery		41			8		11			3	54.2	21.9	60 :	40
A51	GH-Glenfield Theatres - Recovery	10				2		3			1	23.9	6.9	60 :	40
A46, A47	Lgh Main Theatres, LGH-Orthopaedic Theatres		53 Weekdays + 26 Saturday + 17 Sunday	7 Weekdays + 6 Saturday + 6 Sunday	4	3		17 Weekdays + 8 Saturday + 5 Sunday	1	1	1	93.2	36.4	60 :	40
A69	LGH-LGH Theatre Recovery		19 weekdays + 7 Saturday + 4 Sunday	4 Weekdays + 1 Saturday + 1 Sunday	1	1		4 Weekdays + 2 Saturday + 1 Sunday	2	1	1	35.5	8.7	60 :	40
A32, A31, A37	Lri Surg Spec & Gen Surg Theat, Lri Emergency Theatre, LRI-Orthopaedic Theatres		76 Weekdays + 23 Saturday + 13 Sunday	54 Weekdays + 13 Saturday + 13 Sunday	7			24 Weekdays + 7 Saturday + 4 Sunday	4 Weekdays + 4 Saturday + 4 Sunday	2		144.0	45.4	60 :	40
A34	LRI-Dosa	4		3			3		3			6.7	7.8	60 :	40
A14	LRI-PACU (Recovery)	17		17	5.4		3		3	1		38.1	6.1	60 :	40

Care Quality Commission

Briefing for providers: Nursing associates

Introduction

The new role of nursing associate is being introduced in health and social care services in England. The Nursing and Midwifery Council (NMC) published Standards of proficiency for nursing associates in October 2018, which sets out the knowledge, skills and competencies required of nursing associates when they join the NMC register.

CQC recognises the current challenges facing the health and care sector: an ageing population, increased demand for services, financial constraints, and challenges to workforce supply, recruitment and retention. This requires innovative approaches and planning to ensure an adequate workforce for the future. The new role of nursing associate is intended to bridge a gap between health care support workers (and social care equivalent) and registered nurses. It has the potential to shape the workforce in the future and to demonstrate positive outcomes and experiences for people who use services across health and social care, their families and their carers.

From 28 January 2019, nursing associates will be able to apply for registration with the NMC and must uphold the NMC's Code of professional practice. They are also subject to revalidation in a similar way to nurses and midwives. As registered professionals, they are individually accountable for their own professional conduct and practice.

However, it is important to understand that nursing associates are **not** registered nurses and we expect health and care providers to consider this when deploying them. As with the introduction of any other new role, we are not prescriptive about how you deploy nursing associates, but we need assurance that using them is safe and supports you to deliver high-quality care.

We advise you to read the NMC's Standards of proficiency for nursing associates to understand this new role and the implications for your service. The NMC also recommends reading the standards alongside the Standards of proficiency for registered nurses, as they demonstrate how the two roles work together and how they differ. This will help you to understand how nursing associates can be appropriately and safely deployed within your service. There is also further guidance from NHS Improvement's resource: Safe, sustainable and productive staffing improvement resource for the deployment of nursing associates in secondary care. NHS Employers have also developed guidance for providers.

What you need to be aware of under the Health and Social Care Act

If you employ nursing associates, you need to be aware of some key areas.

Regulation 18: Staffing. The regulation requires you to deploy sufficient numbers of suitably qualified, competent, skilled and experienced staff to make sure that you can meet people's care and treatment needs, and meet the other regulatory requirements. This applies to nursing associates in the same way as employing other registered healthcare professionals. Our guidance explains how you can meet this regulation.

As with the introduction of any other new role, we expect all providers to adopt a systematic approach to deploying nursing associates. This should involve using evidence-based decision tools and professional judgement, and comparing with similar providers to determine the number of nursing associates and range of skills required to meet people's needs and keep them safe at all times. The approach should reflect guidance such as the NMC's Standards of proficiency for nursing associates, as well as the skill and experience of the nursing associate(s) and other staff who will be working alongside them.

Staffing levels and skill mix need to be constantly reviewed, and all providers should adapt and respond to the changing needs and circumstances of people using the service, particularly when introducing nursing associates to a workforce.

We expect you to clearly articulate how you have counted nursing associates into the staffing establishment and to carry out regular staffing reviews after deployment, ensuring that nurse-sensitive quality indicators are taken into account to improve quality and safety for people who use services.

We also expect you to develop local guidelines to ensure that existing staff understand the rationale for deploying nursing associates, the benefits of the role, and the process for escalating any concerns.

The standards of proficiency set out the procedures that nursing associates must be able to carry out at the point of registration with the NMC. However, we recognise that they may develop additional skills, knowledge and competencies within specific areas of nursing and/or service specialism and that their practice is not limited to their initial competencies. Therefore, nursing associates must have access to clinical or professional supervision, in line with the NMC's requirements.

Guidance from Health Education England and the NMC is clear that nursing associates can contribute more to people's care if they have received appropriate training and there is relevant clinical governance.

Nursing associates are regulated by the NMC in the same way as nurses and midwives. Under registration they will be expected to uphold the code and revalidate every three years.

Regulation 17: Good governance. This regulation requires you to have systems and processes to ensure that you can meet all regulatory requirements. It includes assessing, monitoring and mitigating any risks relating to the health, safety and welfare of people using services and others. Good governance also requires you to seek and act on feedback from people using the service, those acting on their behalf, staff and other stakeholders, so that you can continually evaluate the service and drive improvement.

If you are introducing the role of nursing associates into the workforce, your assurance and auditing systems or processes should assess and monitor whether this has improved the quality and safety of your services and the quality of people's experiences.

Regulation 12: Safe care and treatment. This regulation aims to prevent people from receiving unsafe care and treatment and prevent avoidable harm or the risk of harm. You must assess and mitigate the risks to people's health and safety during any care or treatment and make sure that staff have the qualifications, competence, skills and experience to keep people safe.

The regulation applies to nursing associates in the same way as other registered staff. This means that if you employ any nursing associates you should be able to demonstrate that they are suitably qualified, competent, skilled and experienced to assess the health, safety and welfare of people who use the service and to meet their care and treatment needs, as well as meet regulatory requirements. You must also be able to demonstrate that such assessments balance people's needs and safety with their rights and preferences, and include arrangements to respond appropriately and in good time to their changing needs.

Nursing associates and regulated activities

The following points detail current regulated activities. The position may change depending on changes to legislation.

Treatment of disease, disorder or injury (TDDI). This regulated activity must be carried out by, or under the supervision of, a healthcare professional (HCP) included on the TDDI list. At the time the NMC's register opened, nursing associates were not included on the TDDI HCP list.

However, nursing associates will commonly be working in a team alongside a registered nurse(s) and/or other HCPs that are included in the TDDI list. In these cases, TDDI applies to a registered provider in the same way as it applied before the nursing associate role was introduced. For example, where a provider registered to carry on TDDI employs a senior carer who completes some nursing-related tasks that they are competent to do under the supervision of a HCP. In cases where a provider employs nursing associates and/or other HCPs who **are not** in the TDDI list, the regulated activity of TDDI will not apply in the same way, as it would not have applied before the role of nursing associate was introduced.

To carry on activities under TDDI, the provider MUST deploy a healthcare professional included on the TDDI list. For example, under the current regulations, Care homes with nursing need to be registered for TDDI and need to employ a professional who is on the TDDI HCP list, for example a registered nurse. They can also employ nursing associates, with the provider ensuring that they are deployed appropriately to ensure that people who use services receive high-quality safe care.

Care homes without nursing can employ nursing associates, but they cannot carry out nursing activity unless delegated by a HCP from the TDDI list, for example a district nurse. This would be similar for domiciliary care agencies (DCAs). If a DCA provider wants to provide TDDI, they must employ a registered nurse (or other from the HCP list), otherwise nursing associates cannot carry out nursing care unless delegated by a HCP from the TDDI list, for example a district nurse.

Nursing care. This regulated activity applies to the provision of nursing care, including nursing care provided in a person's own home.

Nursing care is care carried out by, or planned, supervised or delegated by a (registered) nurse. This regulated activity does not apply to nursing associates unless the care is planned or supervised by a registered nurse, or is delegated to them by a registered nurse working for the same provider.

Accommodation for people who require nursing or personal care. Where a nursing associate is deployed in a setting under this regulated activity, any nursing tasks they carry out must be planned, delegated or supervised by a registered nurse or other listed healthcare professional. This is the same as the current situation for care staff.

For example, a nursing associate deployed in a residential care home will carry out nursing tasks that have been delegated by a healthcare professional employed by another provider, such as a district nurse. The nursing associate must ensure that they are competent to carry out such tasks and that the scope of their professional registration allows it. The provider of the care home must make sure that the staff they employ are suitably competent, qualified and supervised to provide this care.

Patient group directions

Patient group directions (PGDs) provide a legal framework that allows some registered health professionals to supply and/or administer specified medicines to a pre-defined group of patients, without them having to see a prescriber (such as a doctor or nurse prescriber). Supplying and/or administering medicines under PGDs should be reserved for situations where it improves patient care, without compromising patient safety.

As with the regulated activity of TDDI, only those professions listed in legislation can operate under a PGD. Nursing associates cannot operate under a PGD as they are not currently included within the legislation, but this may change in the future.

Medicines management

The standard of proficiency for nursing associates includes competencies required for administering medicines safely and making accurate drug calculations for a range of medicines. The NMC's Standards of proficiency for nursing associates provides comprehensive detail about the competencies that nursing associates must hold at the point of their registration.

Conclusion

From January 2019, the new role of nursing associate will be reflected in every aspect of CQC's regulation:

- When we register a provider, we will consider its understanding of deploying nursing associates.
- When we monitor and review provider information returns, we will look at nursing associates in workforce deployment.
- On inspection, we will want to see evidence that providers have adopted a systematic approach to deploying nursing associates, ensuring that they have considered the risks to the quality and safety of care for people who use services.
- We will take enforcement action where we find issues in relation to regulated activities and breaches of regulations.

We have reviewed our memorandum of understanding and joint working protocol with the Nursing and Midwifery Council to ensure that these take account of the new role of nursing associate.

January 2019