

TRUST BOARD PUBLIC – JANUARY 2014

 Agenda Item Number: 12/14  
 Enclosure Number: (7)

<b>Subject:</b>	Nursing safe staffing
<b>Prepared by:</b>	Nicky Lucey, Deputy Director of Nursing Code A Lead Nurse for Workforce
<b>Sponsored by:</b>	Julie Dawes, Director of Nursing
<b>Presented by:</b>	Julie Dawes, Director of Nursing
<b>Purpose of paper</b>	<ul style="list-style-type: none"> <li>α To share the findings of the August 2013 Ward Based Staffing review</li> <li>∞ Update Trust Board on the next steps of ward based staffing, taking into account the latest publications and guidance.</li> </ul>
<b>Key points for Trust Board members</b>  <i>Briefly summarise in bullet point format the main points and key issues that the Trust Board members should focus on including conclusions and proposals</i>	<p>Ward nursing safer staffing levels, that enable care provisions are of acceptable quality and safety standards, has been highlighted as key concerns from the Francis report, Keogh Reviews and CQC inspections.</p> <p>In response NHS England published in November 2013 clear guidance on safer staffing, which has been strengthened further by the Secretary of State for Health support, outlines 10 recommendations that it expects all NHS providers to implement.</p> <p>This paper provides a full briefing on ward based staffing review findings through:</p> <ul style="list-style-type: none"> <li>- Review of Registered Nurse (RN) to patient ratios against national guidance.</li> <li>- Outcome of August 2013 ward based staffing review</li> <li>- MOPRS ward based staffing review update against national guidance.</li> <li>- A full review of the current position against achieving supervisory leadership for ward leaders.</li> <li>- An overview of PHT against the 10 recommendations from the National Quality Board on ward based staffing.</li> </ul>
<b>Options and decisions required</b>  <i>Clearly identify options that are to be considered and any decisions required</i>	<p>To note the current situation of ward staffing and the new national expectations of service providers.</p> <p>To agree way forward for workforce planning for ward based nursing staff, as in the recommended summary.</p>
<b>Next steps / future actions:</b>  <i>Clearly identify what will follow the Trust Board's discussion</i>	<p>To incorporate the agreed actions into the Trust business planning cycle and Trust board reporting, as part of the workforce planning and quality monitoring in the Trust.</p>

<b>Consideration of legal issues (including Equality Impact Assessment)?</b>	
<b>Consideration of Public and Patient Involvement and Communications Implications?</b>	

<b>Links to Portsmouth Hospitals NHS Trust Board Strategic Aims, Assurance Framework/Corporate Risk Register</b>	
<b>Strategic Aim</b>	Strategic Aim 1: To deliver safe, high quality patient centred care Strategic Aim 4: Be a hospital whose staff recommend the Trust as a place to work and a place to receive treatment.
<b>BAF/Corporate Risk Register Reference (if applicable)</b>	1.1, 1.2, 1.3, 1.4, 1.9, 4.1, 4.3
<b>Risk Description</b>	
<b>CQC Reference</b>	CQC Outcome 13, regulation 22 CQC Outcome 14, regulation 23 CQC Outcome 4, regulation 9 CQC Outcome 5, regulation 14 CQC Outcome 7, regulation 11 CQC Outcome 8, regulation 12 CQC Outcome 9, regulation 13 CQC Outcome 21, regulation 20

<b>Committees/Meetings at which paper has been approved:</b>	<b>Date</b>
SMT	15/01/2013

## 1.0 Introduction

PHT has agreed with the Executive Team (EMT) the approach for ward based nursing staffing levels, which reflect the RCN Safe staffing levels in the UK (2010). This includes:

- ∞ Twice a year review of ward based staffing using an evidence based tool
- ∞ Staffing reviews consistently use the same triangulated methodology (acuity/dependency tool; professional judgement; benchmarking with comparators)
- ∞ Implement where possible supervisory time for ward leaders
- ∞ Support ward leaders with administrative support, where possible
- ∞ Skill mix to reflect the needs of the patients in line case mix and activity

This paper covers a full review of the ward based nursing staffing levels, including:

- ∞ August 2013 ward based staffing review against 8:1 ratio (patients to registered nurse).
- ∞ August ward based staffing review outcomes
- ∞ Review of older people's ward based staffing against national guidance
- ∞ Ward leader supervisory allocation, as of August 2013
- ∞ 10 recommendations of NHS England National Quality Board publication ("How to ensure the right people, with the right skills, are in the right place at the right time: a guide to nursing, midwifery and care staffing capacity and capability" November 2013)

(Note: the focus of this paper is upon the inpatient facilities and maternity. The issue of non-ward based staffing is not covered in this paper).

## 2.0 Current Patient to Registered Nurse Ratio

Recent research by the Florence Nightingale School of Nursing and Midwifery at King's College London found operating a general medical or surgical acute hospital ward with more than eight patients per registered nurse increased the risk of harm (HSJ August 2013). New published safer staffing recommends that the nurse to patient ratio is more appropriate to use as a general guide and local professional judgement must be used when reviewing ward staffing levels skill mix and ratios, taking account of local ward activity and case-mix requirements. Nationally the focus has identified specific issues within adult inpatient ward areas, which this report covers. However there is also an on-going need to complete full staffing reviews on paediatric (using an acuity/dependency tool ward areas or national network guidance for Neonatal Intensive Care) and maternity areas (using midwife to birth ratios).

Table 1 below shows PHT adult general wards calculated as each shift and an average RN (Registered Nurse) to patient ratio over the 24 hour period. Table 2 shows the more specialist wards RN to patient ration.

**Table 1: General wards**

Ward	Acuity/Professional Judgement	Beds	Patient:RN Early	Patient:RN Late	Patient:RN Night	Patient:RN average
E2	High volume activity	30	7.5	7.5	10	8.3
E3	High volume activity	32	6.4	8.0	10.7	8.4
D7	Complex multi-access urology & vascular patients	36	6.0	6.0	9.0	7.0
C5	Specials within establishment. High volume activity	36	7.2	7.2	9.0	7.8
C6	Mixed specialties (Cardiology, Gastroenterology and Respiratory) High volume activity	36	7.2	7.2	12.0	8.8
E7	High volume activity	28	6.0	7.5	10.0	7.8
E8	Respiratory High	36	7.2	7.2	12.0	8.8

Ward	Acuity/Professional Judgement	Beds	Patient:RN Early	Patient:RN Late	Patient:RN Night	Patient:RN average
	volume activity					
D1	Medicine	18	7.0	7.0	10.5	8.2
Ark Royal	Rehabilitation community facility	20	7.3	7.3	10.0	7.8
Cedar	Rehabilitation community facility	22	7.3	7.3	11.0	8.5
F4	Medium volume activity	34	5.7	8.5	11.3	8.5
G2		29	5.8	7.3	9.7	7.6
G3		30	6.0	7.5	10.0	7.8
G4		21	5.3	7.0	11.5	7.9
D3	Complex older persons surgery	30	5.0	7.5	10.0	7.5
D4	Spinal patients	26	6.5	6.5	8.7	7.3
D5		28	7.0	7.0	9.3	7.8
D6		32	8.0	8.0	10.7	8.9

**Table 2: High Care or Specialist areas**

Ward	Specialism	Beds	Patient:RN Early	Patient:RN late	Patient:RN Night	Patient:RN Average
SAU	Assessment unit	28	7.0	7.0	9.3	7.8
SHCU	High Care	10	3.3	2.5	3.3	3.0
CHOC	Cancer and Hematology	39	4.3	4.9	6.5	5.2
RHCU	High Care	10	2.5	2.5	2.5	2.5
G6	Renal	10	2.5	2.5	3.3	2.8
G7	Renal	10	2.5	2.5	3.3	2.8
G9	Renal	20	2.9	2.9	4.0	3.3
MAU	Assessment unit	58	3.9	3.9	4.8	4.2
D8	High acuity airway patients	27	5.4	5.4	9.0	6.6
C7	Coronary Care	23	3.8	3.8	4.6	4.0
F2	Hyper acute stroke unit	30	6.0	6.0	7.5	6.5
F3	Stroke Rehabilitation	25	5.0	6.3	12.5	7.9
F1	Under 65 Rehabilitation	11	5.5	5.5	5.5	5.5
D1	Acute Head Injury specials	22	5.5	5.5	7.3	6.1

The full updated ward based reviews as of August 2013 are located in appendix 1 in the attached document. The output from the August ward based staffing review was followed budgets resetting, including a revised forecast. Therefore was review required based upon the updated position and any service changes. This commenced in December 2013 and is due to report in February 2014.

### 3.0 Summary of August 2013 safer staffing review

Appendix 1 documents the details the results of the 2013 AUKUH and compares to previous years and the 'run rate' establishments set for 2013/2014. To note the budget setting exercise was a financial exercise and not a full review following the agreed methodology. Full assessment has now taken place and it is suggested that some budgets are re-balanced, releasing some investment to wards currently not meeting the required nurse staffing levels. Table 3 below highlights key recommended changes from the August 2013 ward based staffing review.

**Table 3: Summary of August 2013 review recommendations**

Disinvestment	Reinvestment	Rationale
Medicine CSC 3.79 band 5 1.6 band 2. Approx budget = 114K	1.2 wte band 5 to D8 = 36K  1.2 wte band 5 to D7 = 36K	This will cover Mon – Fri and increase N:B ratio from 1.32 to 1.35 (AUKUH 1.38)  This will cover Mon – sun and increase N:B ratio from 1.22 to 1.26 (AUKUH 1.32)
Renal CSC 0.4 band 2 Approx budget = 7K	1.65 wte band 5 to G3 and G4 = 49K	To provide increase RN cover for key shifts when high level of activity i.e. ward rounds etc
<b>Total available = 121K</b>	<b>Total reinvest = 121K</b>	

Further work is underway within Surgery and MOPRS wards to improve shift efficiencies and address the outstanding deficits in ward based staffing.

Since this review all areas have also reviewed shift patterns and some areas have changed to a mixed model of longer shifts and shorter shifts. This has enabled the areas to release staffing resources to support the complex ward needs in the modern healthcare setting through:-

- Supporting release of staffing to support supervisory leadership to lead on quality for patients and staff experience.
- Supporting increase in staff breaks between shifts, supporting staff experience.
- Ensure shifts support patient needs for continuity of care alongside quality of care and value for money.

These shift changes have only been implemented since November/December 2013 and therefore any impact continues to be monitored using quality and staff metrics, such as workforce statistics and safety/experience statistics.

#### 4.0 RCN Safe staffing for Older People's wards gap analysis

The RCN guidance for Older People's wards recommended implementation of: increased registered nurses staffing skill mix; improvements in nurse to patient ratios; access to additional budgeted staffing resources when required; specific older persons skills and knowledge training and education; improved supervision for healthcare support workers; care indicators relevant to older persons are monitored. This was presented to SMT in 2012/13 as part of a business case prioritization, of which part investment of 360K was allocated to MOPRS for 2013/2014.

The CSC has made the professional judgment to prioritize the investment to improve overall staffing numbers. Resulting in the skill mix of RN to HCSW not resolved in 2013/2014. Whilst this improves the staffing numbers of shifts it does not achieve full compliance against the RCN 'Safe staffing for older people's wards'. Some further improvements may be achieved through the proposed roster efficiency changes. In 2014/15 business planning the CSC will consider and put forward any further investment needed, aligned to any strategic/operational changes planned for the future. Details of this assessment are in appendix 3.

#### 5.0 Supervisory Leadership

Each inpatient ward has, as part of its structure, a band 7 Ward Leader (titled Senior Sister/Charge Nurse). The Ward Leaders part of the ward establishment and is responsible for the following:

- ∞ Patient experience: safety, quality standards

- ∞ Ward staffing resources: HR management, recruitment, retention, learning and development (including students training) and rostering for approximately 35wte/ward average plus visiting students (University and Military)
- ∞ Financial management: including stores, Workforce budget, equipment and patient valuables
- ∞ Pharmacy management: drug administration and storage
- ∞ Access: patient flow (timely quality admission and discharge)
- ∞ Governance: audits, incident investigations, complaints and family involvement management
- ∞ Innovation and improvement projects: Releasing Time to Care Bundle, new care pathway development.

The Ward Leader is mostly counted as part of the clinical team (i.e.: in the staffing numbers with a clinical caseload of patients) for 80% of their time. Most have an allocated management day one day a week but give it up if there are staffing issues, to ensure patient care standards.

The demands are growing for the Ward Leader alongside the growth in evidence to support the Ward Leader being supervisory. In 2001 *Implementing the NHS Plan (NHS Executive)* outlined the need for professional leadership at senior ward level to get "the basics right". The Senior Charge Nurse/Sister review by the Department of Health Scotland (*Leading Better Care 2008*) clearly set out the need to resolve issues with the understanding of the role and the need to alleviate the role from the increasing administrative duties. The Royal College of Nursing (*Breaking down barriers, driving up standards- 2009*) identified the requirement for increased supervisory time for the Ward Leader alongside making the role clear in its responsibility for overseeing patient care in the clinical area. Recently lessons from the Mid Staffordshire enquiry and other reviews of care have highlighted the need for senior leadership free to supervise and lead care.

In January 2012 EMT considered the following costs of the implementation of a supervisory ward leader, however full investment was not made due to prioritization of needs. CSC's were able to revisit financial affordability of releasing where possible ward leaders to undertaken supervisory roles. MSK revisited options as part of their savings to disinvest in one area to reinvest into a pilot of supervisory for ward leaders, which is being evaluated as a research project into the outcomes of this investment. Through budget setting Medicine retained full supervisory leadership in two ward areas.

The resulting situation with regard to the 2013/2014 'Supervisory Ward Leader is:

Ward	Budgeted Supervisory Time	Ward	Budgeted Supervisory Time	Ward	Budgeted Supervisory Time
E2	20%	Ark Royal	60%	D1	100% (10k gap)
E3	20%	Cedar	60%	D2	100% (10k gap)
SAU	20%	F1	60%	D3	100% (10k gap)
D7	60%	F2	60%	D4	20%
SHCU	20%	F3	60%	D5	20%
F5/6/7	60%	F4	60%	A5/6	20%
C5	100%	G2	60%	D8	20%
C6	100%	G3	60%		
C7	40%	G4	60%		
E6/7	40%	G6	20%		
E8	40%	G7	20%		
D1	40%	G9	20%		

The benefit to the organization would be noted in care outcomes, length of stay, staff experience and patient experience, which is measurable through the Trust current reporting mechanisms. In addition the ward leader supervisory role supports the operational function of a department, supporting the Trust in achieving its overall aims and objectives.

The National Quality Board (Department of Health) published in November 2013 a paper called '*How to ensure the right people, with the right skills, are in place at the right time: a guide to nursing, midwifery and care staffing capacity and capability*'. This paper sets out the expectations of providers to provide staffing to meet the needs of patients, taking lessons from the various recent published reviews (Compassion in Practice<sup>1</sup>; Mid-Staffordshire NHS Foundations Trust Public Inquiry<sup>2</sup>; Professor Sir Bruce Keogh review<sup>3</sup>, Don Berwick's review into patient safety<sup>4</sup>, Cavendish review of healthcare assistants<sup>5</sup>).

The following outlines the expectation and PHT review in response.

**6.1 Expectation 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 and capability.**

Summary of expectation for boards to assure in place and are actively involved in:

- ∞ Agreeing staffing levels.
- ∞ Consider impact of initiatives (such as cost improvement plans, reconfiguration of services).
- ∞ Monitoring of staffing levels, planned and actual.
- ∞ Receive and discuss regular reports on staffing related outcome measures (recruitment, retention, and training).
- ∞ Give authority to the Director of nursing to oversee and report on nursing, midwifery and care staffing capacity and capability and be assured robust systems are in place to enable the reporting upon this.

PHT meets the requirements of expectation 1, evidenced by:

- ∞ A clear process in place to review staffing levels, following nationally recognized methodology
- ∞ Quality impact assessment and risk assessment processes in place for any cost improvement plans, or service reconfiguration
- ∞ Process in place to monitor vacancies and staffing levels through performance reviews and workforce reporting
- ∞ Integrated performance report to the board includes workforce reports on recruitment and retention. In addition CSC staffing workforce statistics are reviewed at the CSC performance reviews.
- ∞ Director of Nursing (DoN) holds a board level responsibility as a voting Executive board member with full authority to oversee and report on nursing, midwifery and care staffing capacity and capability

**6.2 Expectation 2: Processes are in place to enable staffing establishments to be met on a shift-to shift basis.**

Summary of expectation for the Executive team is:

- ∞ Policies and systems in place, such as E-Rostering and escalation policies to support expectation.
- ∞ DoN and their team monitor shift-by-shift staffing levels, including temporary staffing and any trends.
- ∞ Where staffing shortages are identified staff can refer to escalation policies.

PHT meets the requirement of expectation 2, evidence by:

- ∞ E-Rostering and escalation policies through good roster guidance and duty matron support in place.
- ∞ Lead Nurse Workforce in place to oversee and monitor shift-by-shift staffing levels and trends, providing reports and escalation of any issues.
- ∞ Clear escalation of any staffing concerns in core hours through the senior nursing structure and out of hours through the duty matron rota.

**6.3 Expectation 3: Evidence-based tools are used to inform nursing, midwifery and care staffing capacity and capability.**

<sup>1</sup> Compassion in practice, NHS England, December 2012

<sup>2</sup> Report of The Mid-Staffordshire NHS Foundation Trust Public Inquiry, February 2013

<sup>3</sup> Review into the quality of care provided by 14 hospitals trusts in England: overview report, Prof. Sir Bruce Keogh, NHS England, July 2013

<sup>4</sup> A promise to learn, a commitment to act: improving the safety of patients in England, Don Berwick, Department of Health, August 2013

<sup>5</sup> The Cavendish review: an independent review into healthcare assistants and support workers, Camilla Cavendish, Department of Health, July 2013

Summary of expectation is:

- ∞ Evidence-based tools are used in conjunction with professional judgement and scrutiny to inform staffing requirements, as part of the wider workforce planning.
- ∞ Senior nurses actively seek data to inform staffing decisions and are trained in the use of evidence-based tools.

PHT meets the requirement of expectation 3, evidence by:

- ∞ Methodology used to review staffing is based on latest evidence-based tools (e.g. Shelford Group AUKUH and RCN safer staffing tool, midwifery guidance on birth to midwife ratios).
- ∞ All senior nurses are updated each year on the latest guidance and training provided as required to senior leaders within teams.

#### **6.4 Expectation 4: Clinical and managerial leaders foster a culture of professionalism and responsiveness, where staff feel able to raise concerns.**

Summary of expectation is:

- ∞ Organization supports and enables staff to deliver compassionate care.
- ∞ Staff work in well-structured teams, enabled to practice effectively.
- ∞ Staff have supporting infrastructure in place, including IT, ward clerks and supportive line management.
- ∞ Nursing, midwifery and care staff have a professional duty to raise concerns, supported by managers ensuring processes are in place for them to do so.

PHT partly meets this expectation, evidenced by:

- ∞ Trust values, which support the patient at the centre of everything the Trust does.
- ∞ Team structures in place and reviewed alongside any reconfiguration.
- ∞ Most wards have ward clerks, although a gap in some areas to the level of cover – gap in meeting requirement.
- ∞ IT hardware gap in some areas, currently under the remit of the IT strategy – gap in meeting requirement.
- ∞ All care staff have clear line management and processes in place to encourage any raising of concerns (e.g. incident reporting, whistle blowing policy)

#### **6.5 Expectation 5: A multi-professional approach is taken when setting nursing, midwifery and care staffing establishments.**

Summary of expectation is:

- ∞ DoN leads the process of reviewing staffing requirements, which involve sisters/charge nurses, senior nurses/ team leaders.
- ∞ DoN work closely with Medical Director, Directors of Finance, Workforce and Operations, recognizing the interdependencies, with staffing papers presented to the board are the result of team working.

PHT meet this expectation, evidenced by:

- ∞ Methodology of staffing includes professional judgement involving sisters/charge nurses, senior nurses and team leaders.
- ∞ DoN works closely with all executive colleagues to agree and finalize staffing recommendations to the board.

#### **6.6 Expectation 6: Nurses, midwives and care staff have sufficient time to fulfill responsibilities that are additional to their direct caring duties.**

Summary of expectation is:

- ∞ Staffing establishments enable care staff time to undertake continuous professional development (CPD) to fulfill mentorship and supervision roles.
- ∞ Planned/unplanned leave realistic estimations are incorporated into staff establishments.



- ∞ Staffing establishments enable ward senior sisters/charge nurses supervisory time, which is monitored and reviewed locally.

PHT meet this expectation, evidence by:

- ∞ Staffing establishments incorporate additional requirements for CPD to enable the fulfillment of mentorship and supervision roles.
- ∞ Leave cover is incorporated into the baseline establishment as part of the methodology applied in reviewing staffing levels.
- ∞ All senior ward leader roles have an element of supervisory time; with a clear strategy to monitor this and increase as required in key areas (see section 5.0 of this paper).

**6.7 Expectation 7: Boards receive monthly updates on workforce information, and staffing capacity and capability is discussed at a public Board meeting at least every six months on the basis of a full nursing and midwifery establishment review.**

Summary of expectation is:

- ∞ Boards receive monthly updates on workforce, including the number of actual staff on duty compared to plan over the last month, the reason for gaps, actions to address gaps and any impact of gaps on quality.
- ∞ Boards receive every six months an establishment review, which should be at the public section of the board.
- ∞ Staffing information will form part of the Care Quality Commission (CQC) and Monitor intelligence review of provider organisations.

PHT currently do not meet this requirement and will need to put in place actions to meet this. To date staffing establishment reports have been presented and discussed at Senior Management Team (SMT) and Executive Management Team meetings (EMT).

**6.8 Expectation 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.**

Summary of expectation is:

- ∞ Information should be made available for patients/ public that outlines which staff are present and what their role is.
- ∞ Information should be displayed so that it is visible, clear, accurate and include the full range of staff available on the ward for each shift.

PHT currently do not fully meet this requirement. The 'safety crosses' from the Portsmouth Quality Bundle are currently displayed to in public areas on the wards, noting staffing levels from a broad perspective. Therefore a new process will need to be implemented to demonstrate this and enable reporting to the board.

**6.9 Expectation 9: Providers of NHS services take an active role in securing staff in line with their workforce requirements.**

Summary of expectation is:

- ∞ NHS service providers must ensure robust systems in place to recruit, retain and develop all staff.
- ∞ Organizations must share staffing needs and annual service plans with Local Education and Training Boards (LETBs) to help determine future workforce requirements, in addition to sharing this with their regulators for assurance.
- ∞ Providers to work in partnership with Clinical Commissioning Groups (CCGs) and NHS England area teams to provide future workforce forecast, which LETBs will use to inform education commissions and the workforce plan for Health Education England (HEE).

PHT partly meets this by:

- ∞ Robust recruitment, retention and development processes are in place for nurses, midwives and care staff with clear reporting and monitoring of any future gaps and strategies to address these.

- ∞ PHT shares and discusses its workforce needs with LETBs, including reviewing of commissions.
- ∞ Workforce planning forecast has been partly shared with CCGs and this is an area for further development.

**6.10 Expectation 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.**

Summary of this expectation:

- ∞ Commissioners to specific in contracts the outcomes and quality standards they require and actively seek assurance that sufficient nursing, midwifery and care staff capacity and capability are in place to meet these.
- ∞ Commissioners monitor quality and outcomes closely and where appropriate use contractual levers to bring about improvements if required.
- ∞ Commissioners recognize they have a contribution to make in addressing staffing-related quality issues, where these have been driven by the configuration of local services or setting

PHT works closely with the CCGs and report on all quality and outcome metrics are required. PHT recognize that reporting on specific nursing, midwifery and care staff workforce outside of the current reporting arrangements maybe required and will work closely with CCGs to ensure the required information is provided.

## 7.0 Summary

In summary this comprehensive review of the current position of nursing staffing and the new national guidance has highlighted the gaps for consideration in the 2014/15 business planning cycle and the future workforce planning aligned to the Trust strategy. These gaps conclude as recommendations:-

- i) Revisit ward based nursing in adult acute ward areas in line of the updated staffing review due February 2014.
- ii) Continue to support MOPRS staffing review to meet the complex demands of the older population.
- iii) Continue to support supervisory leadership status through any re-investment into ward staffing.
- iv) Implement new processes to fully meet the National Quality board expectations on care staff, specifically act on expectation 4, 7, 8 and 9. In addition PHT works closely with the CCGs to support expectation 10.