TRUST BOARD OF DIRECTORS – JULY 2015

NURSE AND MIDWIFERY STAFFING REPORT (REPORTING PERIOD JUNE 2015)

1. INTRODUCTION

In 2014 the Trust made its mandatory submission of nurse staffing levels as directed by the National Quality Board and the National Commissioning Board's publication 'How to ensure the right people with the right skills are in the right place, at the right time'. This data is published on NHS Choices as part of their Patient Safety in the NHS section, which incorporates a range of patient safety indicators including 'safe staffing'.

In 2014 the Trust Board agreed to a £4 Million investment in nurse staffing. The decision taken by the Board pre-dates, but reflects the principles contained within the 'Safe staffing for nursing in adult inpatient wards in acute hospitals' published by NICE in July 2014. A key principle of this guidance is the use of systematic evidence based approach to reviewing staffing levels underpinned by professional knowledge and experience.

On 11th June 2015, the Chief Nursing Officer (CNO) Jane Cummings circulated a letter to all Directors of Nursing. In this communication she confirmed that existing NICE guidance will continue to apply and shared the next steps to be taken to ensure the NHS is safety staffed. The contents of this letter will be reflected within our next 6 month staffing review.

In line with national guidance published in May 2014 the Board of Directors receive a monthly nurse and midwifery staffing report which:

- Provides detailed data analysis on a shift by shift basis of the planned and actual staffing levels across all in-patient wards
- Includes an exception report where the actual nurse staffing levels have either failed to achieve or have exceeded agreed local staffing thresholds.
- Triangulates the actual nurse staffing levels reported against a number of pre-determined patient outcome measures in order to evidence whether patient harm events have occurred as a result of nurse staffing issues being identified

2. NATIONAL REQUIREMENTS FOR STAFFING DATA COLLECTION

The report forms part of the organisation's commitment in providing open, honest and transparent nurse staffing information through the publication of this data both on the Trust and NHS Choices Websites. In addition to this the organisation is mandated to undertake a trust-wide nurse staffing review (Safer Nursing Care Tool) on a six monthly basis in order to seek assurance that current staffing levels are sufficient to accommodate the acuity and dependency needs of patients within our care. The trust-wide nurse staffing review was last presented to Board in April 2015.

3. SAFER NURSING CARE TOOL (previously called AUKUH)

Using the Safer Nursing Care Tool methodology the trust will commence its twice yearly data collection in August as part of the ongoing monitoring of patient's acuity and dependency levels and its association to nurse staffing levels. The summer data collection will commence on 3rd August, collected at ward level between 14-00 and 15-00, 7 days a week ending on Sunday 30th August. The work will be co-ordinated and overseen by Michelle Platt, Nurse Consultant for Critical Care, and reported in the six monthly board staffing paper in October 2015.

4. TRUSTWIDE OVERVIEW OF PLANNED VERSUS ACTUAL NURSING HOURS

The *overall* nurse staffing fill rate for June 2015 was 106.12% (103.79% May); this figure is inclusive of Registered Nurses / Midwives (RN/M) and Health Care Assistants (HCA) during both day and night duty periods. Table 1 provides further detail regarding nurse staffing fill rates by individual hospital site.

Table 1: Registered Nurse (RN) / Registered Midwife (RM) & Health Care Assistant (HCA) Fill Rates (%) June 2015

June 2015	Day	Day	Night	Night
Site Name	Average Fill Rate RN/RM	Average Fill Rate HCA	Average Fill Rate RN/RM	Average Fill Rate HCA
KMH	100.3%	100.0%	100.3%	107.3%
MCH	98.5%	108.9%	102.7%	135.5%
NWK	103.8%	96.1%	123.3%	96.7%

The overall fill rates across the three hospital sites maintained or exceeded agreed safe staffing thresholds.

In June, 4 wards (3 wards in May) recorded a RN fill rate of less than 90%. This includes Ward 33 who have been undergoing a planned reduction in beds and a matched reduction in staffing, as the Division worked towards a full ward closure in July. This has been monitored proactively by the Matron to ensure safe staffing levels against patient dependency and acuity are maintained. The details of the wards with the lowest fill rate are included in the divisional accounts.

5. DIVISIONAL OVERVIEW OF PLANNED VERSUS ACTUAL NURSING STAFFING FILL RATES

The Divisional Nurses, Matrons and Ward Sisters / Charge Nurses use the information from the Unify returns and triangulate with the Ward Assurance Framework to provide a comprehensive overview of each ward. This enables the whole nursing team to focus attention and resources on clinical areas that may require additional support or escalation.

5.1 EMERGENCY CARE AND MEDICINE

Table 2. Emergency Care & Medical Division Actual Nurse Staffing Fill Rates (June 2015)

Ward	Day Shift (Actual Nurse Staffing Fill Rate %)		Night Shift (Actual Nurse Staffing Fill Rate %)	
	RN	HCA	RN	HCA
EAU	94.17%	96.67%	97.37%	101.11%
22	102.78%	114.44%	100.00%	138.33%
23	98.67%	96.67%	97.50%	100.00%
24	99.44%	104.44%	97.78%	103.33%
33	78.89%	81.11%	80.00%	98.33%
34	100.00%	134.44%	100.00%	158.33%
35	112.78%	102.22%	100.00%	108.33%
36	102.78%	98.33%	100.00%	105.00%
41	98.89%	122.78%	100.00%	151.67%
42	100.00%	105.56%	98.89%	108.33%
43	109.58%	87.22%	109.17%	95.00%
44	102.22%	115.56%	100.00%	125.00%
51	98.89%	106.67%	100.00%	136.67%
52	97.08%	100.83%	101.11%	116.67%
STROKE UNIT	96.30%	91.21%	102.22%	100.00%
CHATSWORTH	88.89%	116.67%	107.95%	184.09%
LINDHURST	95.83%	101.67%	100.00%	122.27%
OAKHAM	118.33%	107.22%	100.00%	100.00%

The actual nurse staffing fill rates in June fluctuated between 87.22% (93.55% in May) and 184.09% (203.23% May). It is important to note that these fluctuations *do not include ward 33*.

Ward 33 was successfully closed for in-patients on 14th July, with a full formal closure and decommissioning of this area planned for 26th July. This is in line with the agreed bed reduction plan. The ward closure is very timely, due to the continued reduction of RNs on the ward and the subsequent risk this created (as recorded on the risk register). This positive

closure has enabled the remaining 5.8 WTE RNs and 13.6 WTE HCAs to be transferred into existing vacancies within the division; thus contributing to the reduction in staffing gaps and further reduce bank/agency spend. During this closure plan, beds were reduced to ensure safe staffing was maintained.

Care Quality Commission (CQC) concerns were raised about mixed sex in specialist areas - the respiratory support unit (ward 43) and the cardiac care unit (CCU/ward 23), which led to a full review of these areas. Single sex compliance has been implemented within ward 23. Further investigation into the situation on ward 43 established that it is commissioned for, and provides, a **level 2** service, and as such, gender mix within this area is permitted to ensure the acuity and dependency needs of our patients are met. In order to maintain full compliance with the commissioned level 2 beds within ward 43, the staffing levels have been increased to ensure a 1:2 nurse-to-patient ratio. This has led to an increase of 1 RN per shift which currently presents a cost pressure to the division until full recruitment and establishment is secured

There has been a reduction in the number of overfills for HCAs (both days and nights) for the 3rd consecutive month. Of the 15 medical wards at KMH, there were 8 overfills on nights (10 in May) and 5 overfills on days (6 in May). This has been achieved by a robust approach to assessment and re-assessment of patients who require Enhanced Observation.

Where possible, patients who require enhanced observation are cohorted together, to reduce the numbers of staff required; however, this is only possible if patients requiring observation are the same sex.

Under fill of unregistered staff on ward 43 was related to sickness, and was covered by using the reducing harms team and staff from other wards.

The overfill of RNs on Oakham Ward is related to 3 new starters working supernumerary as part of their induction. The RN underfill on Chatsworth is related to vacancies and sickness which are being managed by the Matron

The organisation continues to exceed the agreed fill rates in a number of areas which is in response to the increased acuity and dependency of patients on the wards; this is always more noticeable on nights as most areas drop by 1 HCA at night and they become no longer able to manage the levels of Enhanced Observations within the funded establishments.

Table 3. Newark Hospital Actual Nurse Staffing Fill Rates (June 2015)

Ward	Day Shift (Actual Nurse Staffing Fill Rate %)		Night Shift (Actual Nurse Staffing Fill Rate %)	
	RN	HCA	RN	HCA
SCONCE	105.00%	94.17%	135.00%	94.44%
FERNWOOD	100.00%	100.00%	100.00%	100.00%

Sconce ward at Newark has continued to maintain the reduction of 10 beds due to the staffing vacancy gap within this area. This reduction has enabled the number of RNs at night to be increased to 3, to ensure safe staffing levels within budget (in line with 'Keogh' recommendations and our other inpatient wards). This bed reduction and increased staffing has had a positive impact on reducing the number of falls, including falls with harm, for 2 subsequent months.

All other areas were maintained within the agreed thresholds.

6. PLANNED CARE AND SURGERY

Table 4. Planned Care & Surgery Division Actual Nurse Staffing Fill Rates (June 2015)

Ward	Day Shift (Actual Nurse Staffing Fill Rate %)		Night Shift (Actual Nurse Staffing Fill Rate %)	
	RN	HCA	RN	HCA
11	108.89%	97.78%	98.89%	91.67%
12	112.78%	104.44%	100.00%	98.33%
14/SAU	98.00%	85.42%	99.17%	97.42%
31	93.75%	90.56%	100.00%	133.33%
32	83.75%	112.22%	97.78%	116.67%
ICCU	110.00%	96.67%	108.33%	76.67%
DCU	100.00%	94.57%	89.58%	100.00%
NICU	122.50%	61.67%	100.00%	56.67%
25	90.48%	89.17%	97.22%	90.00%
Inpatient MATERNITY	104.84%	92.34%	105.73%	82.26%

For Planned Care & Surgery Division, the actual nurse staffing fill rates reported during May fluctuated between 56.67% (78.95% May) and 133.33% (193.55% May); the following section provides further information to explain the shortfalls/overfills.

NB: the role and function of the HCA in ICCU and NICU are very different to the general/adult wards. They provide less *unsupervised* direct patient care than HCAs on the adult wards, given the critical care needs of the patients. They work *alongside* an RN, providing care under their direct supervision, as well as providing a more general support role within the unit, to release the RNs from non-patient or indirect care duties. As such, their role across the 24 hour period is invaluable; however, if a shift is not filled (for whatever reason) the units have found from experience that bank/agency HCAs are not able to meet the needs of their patient group or the support function and so represent poor value for money. A decision is taken by the shift co-coordinator about whether any shortfalls would be

detrimental to patient care or the unit workload; given the issues described, the decision is often taken not to fill the shift with Bank and Agency.

The 5 adult surgical wards within PC&S continue to adapt and enhance the way they work together to provide support and staff (where required/possible) as a joint enterprise. As part of the joint working approach, the team of ward leaders decided to cohort many of their patients who required 'enhanced care', wherever possible and sensible. They share and compare their staffing rotas and work to ensure that as many gaps or shortfalls as possible are met from within the 5 wards.

On the Trauma & Orthopaedic Wards (11 and 12) the actual nurse staffing fill rates were largely within the agreed parameters. Ward 12 have enhanced their nursing skills in the care of confused and dementia patients so we cohort any orthopaedic patients requiring enhanced care on this ward – this explains some of the uplift in their daytime RN shift numbers. This ward team are also taking on the role of Trauma Co-ordinator out of hours so that our trauma patients and pathway have a fuller 7 day service (within their budgeted establishment).

The underfills of RNs on ward 31 and 32 are associated to the implementation of the new staffing baselines (as reported previously). Both wards have recruited (close) to their new establishment level; most of the new starters are student nurses recruited via the clearing house and will start work in September. Whilst the new staffing levels are being implemented, we ensure the ward is staffed to deliver minimum safe levels, but we don't use additional hours or B&A to make up this shortfall, unless the patient acuity and ward workload require additional RNs (above the *safe levels* of 3). Thus it is anticipated that the wards may continue to show a shortfall until the recruitment process is completed. Ward 32 is the ward (of this pair) where the 'enhanced care' patients are cohorted when possible. The ward has been affected by additional staff turnover and long-term sickness during June. In an effort to stabilise the ward team, and in response to 2 recent clinical incidents, the ward leader has been working a large proportion of clinical shifts, including some night shifts, during the month of June. This is to provide clinical leadership, especially out of hours, and to supplement the nursing hours available for patient care. This has reduced significantly his level of supervisory time during the month, but was a considered decision in response to a nursing shortfall.

The shortfall in HCAs on days on ward 14 reflects the wide range of services the ward team cover. A temporary gap in the colposcopy service has arisen and the ward leader and Gynaecology nurse specialist work together to meet this shortfall, and pull from the ward team where safe and possible. The ward has been open in its current format for 6 months and the ward leader, matron and divisional nurse are reviewing the staffing levels and workload patterns; some adjustments between the wards will be made during July to balance out acuity/dependency and staffing across the 5 surgical wards.

6.1 Maternity Staffing

The workforce tool of choice for maternity staffing is birth rate Plus which gives an overarching view of staffing - an optimum ratio is 1 registered midwife for every 28 births (1:28). For June the midwife to birth for funded establishment was 1:28.5 and 1:30 in post. The current gaps are 3.4 wte. community midwives and 3 wte. in-patient/acute midwives – all of these vacancies have either been filled or are in the midst of active recruitment.

On a day to day basis the acute unit staffing takes into consideration elective activity and number of inpatients, with a proxy marker of being able to provide 1:1 care for all women in established labour. The small overfills mirror activity levels within the in-patient unit and are always filled by our own staff working additional hours, and never through B&A. Community staffing is predominately based on clinic cover and there are no minimum staffing levels.

The shortfall in HCA is related to maternity leave and sickness, and, as with the NICU HCA, a decision is taken by the shift co-ordinator as to whether it is safe to leave an unfilled shift.

6.2 NINU Staffing

The overfill of RNs is largely related to the recruitment process – the unit have been very successful in their recruitment efforts during 2015. However, new starters rarely have previous neonatal nursing experience and require a lengthy induction and training process to ensure they can function as fully fledged RNs. 6 new recruits are going through the process of finishing their local induction/training and currently have 'supernumery' status. It is anticipated that most will have completed their competency assessments during August and all by September. *The reduced HCA fill rate has been explained above.*

6.3 Children's Ward Staffing (25)

Recruitment in Children's Nursing remains a challenge, nationally and locally. On ward 25, it has been further compounded by 6 members of staff (RNs) being on maternity leave. Due to the specialist nature of the ward, bank nurses are very rarely available and agency nurses are only used as a last resort (to maintain safety). The ward have 4 vacancies against their existing establishment (6+2) and then will work towards their 'Keogh' staffing levels (8+2). A recent recruitment campaign only delivered 2 recruits, so a new recruitment process, with improved advertising, is underway.

The remit and role of the reception team has been widened, and a review of the support role of the HCA in children's nursing is underway – it is anticipated that both of these developments will release time to care for RNs (more detail next month).

With regards to the underfill of HCAs, the nurse in charge of a shift takes a decision based on the anticipated workload and patient acuity of the 'short' shift. The bed occupancy on the ward is subject to wider variation than most adult wards; plus many of the patients will have one or both parents in residence. They use this workload information and apply their professional judgement about whether it is safe to leave a RCA shift unfilled.

7.0 ACHIEVEMENT OF PLANNED STAFFING REQUIREMENTS – ORGANISATIONAL CAPACITY & CAPABILITY

On a day to day basis the Divisional Nurses, Matrons, Ward Sisters and Charge Nurses are responsible for ensuring that their clinical wards and departments are safely and appropriately staffed to meet the acuity and dependency needs of patients within their care. Duty rotas and staffing levels are regularly reviewed by the Matrons. All the wards formally report their staffing levels to the Capacity & Flow Meetings, where clinical safety is considered as a whole hospital and risk assessments and clinical decisions are made to mitigate the greatest risks.

8.0 CORRELATION BETWEEN ACTUAL NURSE STAFFING FILL RATES AND PATIENT OUTCOMES

Detailed data analysis of the correlation between actual nurse staffing fill rates and patient outcomes (Appendix 1) shows there is a continued improvement in the number of medication related incidents reported - 31 for June (59 in May) . This is thought to also reflect the impact and outputs of the focused work undertaken by the Medicines Task and Finish Group and the focused preparation work for the CQC visit. The Emergency Assessment Unit (EAU) remains an outlier; however, there has been a 50% reduction in reported medicine incidents - 14 for May and 7 for June. This focused work will continue and monitored for sustainability.

The number of all falls continues to show a steady reduction, with 148 for June and 156 for May. The falls lead nurses are currently working with the new Deputy Director of Nursing to implement some of the best practice from other trusts.

There is an increase in avoidable pressure ulcers from 2 for May to 3 for June; one of the areas reporting an avoidable pressure ulcer is ward 32 who are also showing an underfill for RNs. The ward leader in primarily working clinical shifts and as such has reduced his supervisory to practice time to only 5%.

9.0 CONCLUSION

A daily monitoring process is now well established across the organisation to identify when areas are non-compliant with their actual staffing levels and what actions have been taken to rectify this. This information is available to the Director of Nursing and circulated as part of the regular bed capacity information across the organisation.

Staffing levels and ward assurance indicators now provide a comprehensive picture of each ward. This enables the Divisional Nurse, along with the Matron and Ward Sister / Charge Nurse to focus on areas that may require additional support or escalation. The Divisional Nurses, Matrons and Duty Nurse Managers work together to redeploy staff to support areas where there is a shortfall to minimise the risk to patients and ensure care is not compromised.

Analysis of our planned and actual nurse staffing levels demonstrates that the majority of wards fulfil the required standards for Safe Staffing. Where it is identified that a clinical area has fallen below, an exception report is generated by respective Divisional Nurse in order to gain a greater understanding of the reasons why this has occurred and to seek assurance that robust plans are in place to mitigate against further occurrences.

The reliance on temporary staffing solutions continues and is an operational and financial challenge within the organisation; however, it is being managed consistently and equitably across the nursing workforce. It is envisaged that the introduction of Allocate e-rostering will strengthen and improve off duty planning and have a positive impact on variable pay expenditure

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Appendix 1 Correlation Between Actual Nurse Staffing Levels and Reported Patient Outcomes – June 2015

Ward	Days %		Nights %		All Falls	Medication Errors	Avoidable Pressure Ulcers	Staffing Incidents	FFT (%)	FFT Star Rating	Sickness & Absence	Safety Thermometer Harms	
	RN	HCA	RN	HCA								All	New
EAU	94.17%	96.67%	97.37%	101.11%	11	7	0	0	0%	0	1.35%	0	0
Ward 11	108.89%	97.78%	98.89%	91.67%	4	0	0	0	41.8%	4.75	11.77%	0	0
Ward 12	112.78%	104.44%	100.00%	98.33%	10	0	0	0	19.8%	4.82	1.35%	0	0
Ward 14	98.00%	85.42%	99.17%	97.42%	1	0	0	1	20%	4.72	8.43%	0	0
Ward 22	102.78%	114.44%	100.00%	138.33%	7	0	0	0	40.7%	4.91	7.02%	3	0
Ward 23	98.67%	96.67%	97.50%	100.00%	3	0	0	1	47.2%	4.91	6.0%	0	0
Ward 24	99.44%	104.44%	97.78%	103.33%	5	0	0	0	53.2%	4.80	9.7%	0	0
Ward 31	93.75%	90.56%	100.00%	133.33%	0	1	0	0	28.1%	4.88	9.17%	1	0
Ward 32	83.75%	112.22%	97.78%	116.67%	5	1	1	0	27.5%	4.62	6.49%	0	0
Ward 33	78.89%	81.11%	80.00%	98.33%	7	3	0	0	2.73%	5.00	3.54%	1	0
Ward 34	100.00%	134.44%	100.00%	158.33%	7	0	0	0	70%	4.65	6.69%	0	0
Ward 35	112.78%	102.22%	100.00%	108.33%	5	2	0	0	62.1%	4.78	3.47%	3	0
Ward 36	102.78%	98.33%	100.00%	105.00%	6	3	0	0	22.6%	4.75	4.06%	2	1
Ward 41	98.89%	122.78%	100.00%	151.67%	0	1	1	0	114.3%	4.92	9.79%	1	0

Ward 42	100.00%	105.56%	98.89%	108.33%	3	1	0	0	45.1%	4.83	2.59%	0	0
Ward 43	109.58%	87.22%	109.17%	95.00%	3	1	0	0	47.1%	5.00	4.88%	1	0
Ward 44	102.22%	115.56%	100.00%	125.00%	11	1	1	1	56.4%	4.86	9.66%	1	0
Ward 51	98.89%	106.67%	100.00%	136.67%	6	2	0	0	17.9%	4.75	5.19%	2	1
Ward 52	97.08%	100.83%	101.11%	116.67%	12	0	0	0	40%	4.40	2.65%	1	0
Stroke Unit	96.30%	91.21%	102.22%	100.00%	15	5	0	0	50.6%	4.66	3.96%	1	0
ICCU	110.00%	96.67%	108.33%	76.67%	1	0	0	8			5.71%	0	0
NICU	122.50%	61.67%	100.00%	56.67%	0	0	0	0			7.40%	0	0
Ward 25	90.48%	89.17%	97.22%	90.00%	1	0	0	0			4.44%	0	0
Maternity	104.84%	92.34%	105.73%	82.26%	0	3	0	10			3.49%	0	0
DCU	100.00%	94.57%	89.58%	100.00%	1	0	0	0			0.37%	0	0
Chatsworth	88.89%	116.67%	107.95%	184.09%	5	0	0	2	77.8	4.86	6.19%	0	0
Lindhurst	95.83%	101.67%	100.00%	122.27%	6	0	0	1	95%	4.89	5.00%	0	0
Oakham	118.33%	107.22%	100.00%	100.00%	2	0	0	0	61.1%	4.64	4.03%	0	0
Sconce	105.00%	94.17%	135.00%	94.44%	8	0	0	0	65.7%	4.65	4.23%	0	0
Fernwood	100.00%	100.00%	100.00%	100.00%	3	0	0	0			8.00%	0	0
Total:					148	31	3	24				17	2