Sherwood Forest Hospitals NHS
NHS Foundation Trust

Trust Board of Directors

Thursday 27th November 2014

Six Month Nurse Staffing and Establishment Report

1 Introduction

1.1 The Trust Board have previously received extensive reports in relation to Nursing and Midwifery staffing at Sherwood Forest Hospitals. In January 2014, the Trust Board agreed to a nurse staffing investment of £4 Million to; significantly increase the overall numbers of Registered Nurses and create a 70/30% skill mix ratio. This case was approved with associated funding to implement and invest over a two year period.

1.2 Each month the Trust Board receive reports for the requirements of the National Quality Board in relation to the 'Safer Staffing' (NQB November 2013) guidance and the recently published NICE guidelines 'Safe staffing for nursing in adult inpatient wards in acute hospitals' (NICE July 2014).

1.3 This paper further provides the Trust Board with an update in relation to acute nursing and midwifery staffing in inpatient areas within the Trust, as outlined in the guidance published by the NHS Quality Board and NHS England, *'How to ensure the right people, with the right skills, are in the right place at the right time'. (2013).* This guidance clearly articulates individual board member's responsibilities in relation to ensuring safe staffing levels. It is intended to bring to the attention of the board any actual or potential nursing and midwifery workforce risks to enable the Trust to demonstrate compliance with new staffing expectations and guidance. A full summary of the position by ward has been provided within Appendix 1 of this document and includes comparative data analysis against a nationally recognised acuity and dependency workforce tool.

2 Analysis of Planned versus Actual Ward Staffing by Shift

2.1 The trust records planned versus actual ward staffing on a shift by shift basis. There is a national requirement to collect this information in hours rather than by shift given the current widespread variation in shift patterns nationally. NHS England are of the opinion that this provides a comparable denominator when comparing and contrasting planned versus actual staffing performance across organisations.

2.2 Analysis of the planned versus actual ward staffing information over the preceding 6 months (May – October) is contained within Tables 1-3 and is illustrated as a whole, by site and division. Further analysis of the number of shifts reported that did not achieve plan are included as a percentage and range from 1.6% – 5.6%.

2.3 This information whilst detailing the planned and actual staffing levels at the beginning of the shift and does not account for the redeployment of staff thereafter. In

addition this information does not consider variation in patient acuity or dependency which may have been higher or lower on the actual shift compared to when the shift was planned

Table 1 Nurse Staffing - Planned versus Actual Trustwide. May – October 2014

Registered Nurses / Midwives			Health Care Assistants			Total Staff		
Total Number of shifts	Number of shifts plan not met	% of shifts plan not met	Total Number of shifts	Number of shifts plan not met	% of shifts plan not met	Total Number of shifts	Number of shifts plan not met	% of shifts plan not met
66026	2092	3.2%	45630	1479	3.2%	111656	3567	3.1%

Table 2 Nurse Staffing - Planned versus Actual Hospital By Site May – October 2014

Registered Nurses / Midwives			Health Care Assistants			Total Staff		
Total Number of shifts	Number of shifts plan not met	% of shifts plan not met	Total Number of shifts	Number of shifts plan not met	% of shifts plan not met	Total Number of shifts	Number of shifts plan not met	% of shifts plan not met
Kings Mill Hospital								
60014	1977	3.2%	38700	1192	3%	98714	3169	3.2%
Mansfield Community Hospital								
3436	67	1.9%	3802	215	5.6%	7238	283	3.9%
Newark Hospital								
2576	42	1.6%	3128	72	2.3%	5704	114	2%

Table 3 Nurse Staffing - Planned versus Actual By Division May – October 2014

Registered Nurses / Midwives			Health Care Assistants			Total Staff		
Total Number of shifts	Number of shifts plan not met	% of shifts plan not met	Total Number of shifts	Number of shifts plan not met	% of shifts plan not met	Total Number of shifts	Number of shifts plan not met	% of shifts plan not met
Emergency Care & Medicine Division								
54579	1131	2%	30173	663	2.1%	84752	1796	2.1%
Planned Care & Surgery Division								
26899	913	3.3%	15356	744	4.8%	42255	1657	3.9%
Newark Hospital								
2562	42	1.6%	3111	72	2.3%	5673	114	2%

3 **Planned versus Actual measured in hours (UNIFY Report)**

3.1 The Trust is mandated to upload its nursing and midwifery workforce information to NHS Choices via a UNIFY report. This data is part of CQC's Intelligent Monitoring of NHS provider organisations.

3.2 The UNIFY report for nurse staffing has been registered within the expected time period, month on month since May 2014.

3.3 Table 4 provides the trust level overview on the number of occasions where wards either fell below the 90% planned versus actual levels or exceeded the 110% planned versus actual threshold.

Table 4 The Number of Occasions Where Wards have exceeded The Actual Staffing Levels

Planned versus actual in hours	Below 85% Day	Below 85% Night	Over 110% Day	Over 110% Night
Registered Staff	6 / 186	0	25/186	6 /186
HCA	5 /186	19/186	49/186	75/186

3.4 Detailed data analysis is undertaken on a monthly basis by the Divisional Matrons in order to understand and provide assurance regarding any wards that have fallen below the

fill rate threshold. This is formally reported within the monthly board staffing paper. The main reasons for shortfalls include:

- Existing nursing resources being stretched by the need to open additional, 'un-established' beds to meet increased demand for in-patient care; EAU, Ward 54, Day Case Unit (opened at weekends x 3 in month of September).

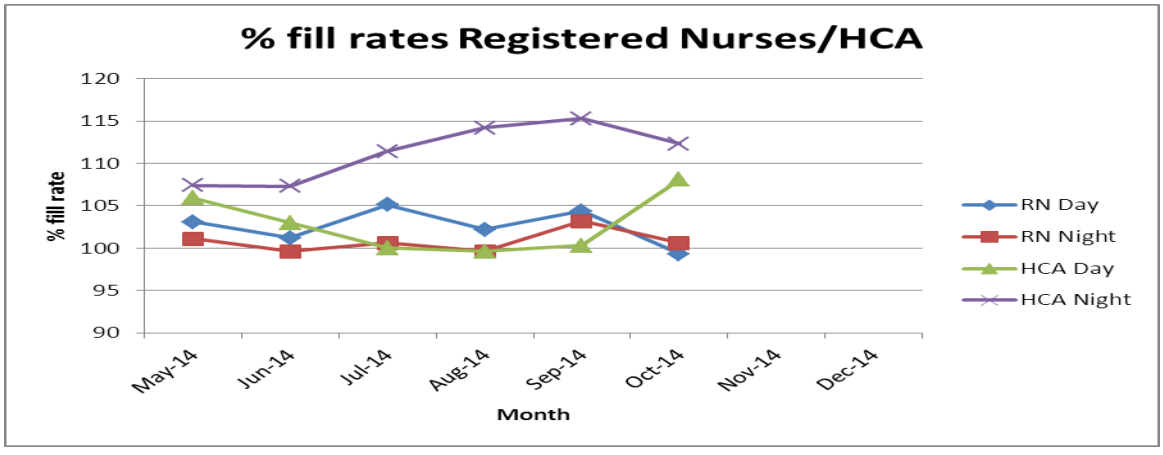
- Maternity **-** The variation between the planned and actual staffing resources required within maternity services was in response to the variation in activity experienced, and current vacancies within the RM workforce. During periods of increased activity, midwifery resources were flexed between the in-patient and community midwifery teams. All shifts were risk assessed by the unit co-ordinator to ensure quality and safety standards were being maintained at all times.

- Some areas have had a shortfall due to vacancies, maternity leave or short-term sickness that cannot be filled by temporary staff. Many areas will cross cover, so there may appear to be a short fall that is deemed acceptable as staff will be redeployed from other areas within the divisions to maintain core levels of safety. Some areas appear to have a shortfall but an assessment felt the staffing levels were appropriate for the level of patient needs or the number of patients.

- Cardiology \ward 23- variation indicates the planned staffing was not met, however the staffing levels available were appropriate for the demand at that time. This was monitored closely by the Divisional Matron. There is currently an assessment of whether the funded staffing levels exceed the demands of the patients, as cardiology care has become less invasive and intensive.

3.4 The following graph (Graph 1) illustrates the overall actual % fill rates for Registered Nurses / Midwives (RN) and Health Care Assistants (HCA) between May - October 2014. Analysis of this data whilst being a composite of the three hospital sites does evidence there has been a high utilisation of Health Care Assistants to mitigate some of the RN shortfalls and to manage the acuity and dependency needs of patients within our care.

Graph 1. Registered Nurse / Health Care Assistant Fill Rates – May – October 2014



3.5 Planned versus actual staffing data has been displayed in ward and department areas for the last six months. We are currently pursuing a more professional format to replace the laminated paper, whilst trialling incorporating the staffing information into the ward communication boards.

3.6 Individual ward rosters and the UNIFY information are published each month via the monthly Trust Board Staffing Papers (public papers) and via NHS Choices.

3.7 All Divisions have a system in place for escalation of concerns related to staffing in real-time. Divisional systems ensure that staff are redeployed across Divisions and where required across hospitals to meet the acuity and dependency requirements of patients.

4 **Quality and Safety**

4.1 Examples of reasons for staffing shortfalls include: short notice sickness, carers/bereavement leave, staff moved to another area, vacancies, non attendance of temporary staff (Bank or Agency) and temporary staff cancelled due to lower patient dependency.

4.2 Matrons continuously review nurse and midwifery staffing and associated gaps, implementing appropriate actions to ensure the staff numbers across the wards is appropriately matched to the care and dependency of patients at that time. Examples of actions taken include: use of non-ward based staff supporting care delivery, co-locating dependent patients together, Matrons working in the discharge lounge, staff moving from another area, role substitution or a decision taken not to cover due to the dependency of patients.

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4.3 Escalation processes ensure that both immediate risks and longer term risk are identified in real-time to make certain that contingency actions and plans are comprehensive.

4.5 Patient acuity and dependency will vary on a shift by shift basis. Moving staff between wards and departments to meet patient acuity and dependency is an appropriate action to ensure that patient safety and quality care is delivered. This will result in a difference between the planned numbers of staff on the duty roster, which is developed approximately six weeks in advance, and the actual number of staff on shift. A proportion of the gaps between actual and planned staffing levels identified within the report are a result of proactive movement of staff to meet patient acuity and dependency in other wards.

4.6 Triangulation of this information to the Ward Assurance Framework and Nursing Metrics shows for the period between May and October 2014 that

:

- There have been zero Grade 4 pressure ulcers (hospital acquired)
- There have been zero Grade 3 pressure ulcers (hospital acquired)
- From a falls perspective we have reported 10 falls as serious incidents
- We reported 8 medication related incidents that incurred harm

- Over the 6 month period we reported 98% of falls risk assessments being completed on admission (Data source Nursing Metrics)

4.7 Summary

In summary, the Trust has set up a mechanism to ensure compliance with NQB guidance for reporting nursing and midwifery staff numbers through to the Board of Directors and to make the information available for the public on the Trust web site. The UNIFY data and ward rosters demonstrate shift by shift staffing levels have been predominantly met but matrons do have to work consistently to assess and mitigate potential risks. There has been a higher use of HCA's, particularly during the night. During the week commencing 19th November 2014, an assessment of 1-1 care and requirments being is undertaken by a Matron.

Workforce Position

5 Establishing Safe Staffing Levels

5.1 The National Institute for Health and Care Excellence (NICE) has published its review of safer staffing tools for general inpatient areas. There are plans for NICE to undertake reviews of tools within other patient groups over the next 12 months (the Trust has contributed to the A&E and Maternity consultations). The organisation has a duty to ensure staffing levels are sufficient to maintain safety and provide quality care.

5.2 At SFH ward establishments are based on a number of methodologies:

- Professional Judgement
- Royal College of Nursing guidelines
- Royal College of Midwives and Birthrate plus (Maternity)
- Safer Nursing Care Tool (SNCT)
- Professional Specialty Guidance (i.e. Intensive Care Society Standards 2009, British Association of Perinatal Medicine Guidance).

5.3 There is no single nursing staff-to-patient ratio that can be applied across all adult inpatient wards. However there is evidence there is an increased risk of harm to patients associated with a ratio of 1 RN to 8 or more patients. Currently all areas at Kings Mill Hospital are meeting 1:8 ratio's, although, some areas within Medicine are reliant on bank and agency staff to maintain these ratios. The same ratios are being maintained during the night.

5.4 Shift staffing levels; including the use of temporary staffing solutions are monitored and recorded at least three times a day with the template distributed by email to a wide mailing list. The Director of Nursing and the team routinely monitor shift-to-shift staffing

levels, including the use of temporary staffing solutions, seeking to manage immediate implications and identify trends. Where staffing shortages are identified, staffs have escalation plans which outline the actions needed to mitigate any problems identified. This information is included within the distributed template.

5.5 During October all ward leaders met with the Divisional Team, Director of Nursing and Director of Operations to agree the ward nursing staff establishment (number of Registered Nurses and Health Care Assistant posts that are funded to work in a particular ward) are sufficient to provide safe nursing care to each patient at all times. Capacity to deal with planned and predictable variations in nursing staff available were agreed, as well as the importance of good nurse staff rostering.

5.6 Midwifery staffing levels are determined through a number of factors. Midwife to birth ratios are calculated more crudely by using those only involved in direct care and would therefore exclude those highlighted as specialist or management roles. On current birth figures we estimate that our birth for the year 2014/15 will be 3488, an increase of 5.3% on the same period last year and on current establishment numbers the current ratio would be 1:28. Appendix 2 describes our midwifery staffing position.

5.7 In Adult Critical Care there is national specialty guidance which clearly determines the ratio of staff to patient, based upon dependency of the patient. These guidelines are utilised by our Critical Care area, supported by professional judgement.

5.8 Cot numbers within our neonatal unit have been reduced to meet perinatal guidelines. To ensure safe care is delivered it was been agreed the unit will not exceed 8/9 cots (depending on dependency but not to exceed 9) until staffing levels are increased. The geography and design of the unit makes it challenging to oversee and cross cover a larger number of babies. To increase cot numbers will require investment to meet Neonatal toolkit standards. With the lower cot levels we are conpliant with staffing guidance

5.9 Within the nurse staffing case for investment (January 2014) the Trust Board agreed to a £400K investment in paediatric nursing. We have subsequently appointed to additional the posts.

5.10 Although all establishments are set using the methodology described, there are occasions when additional staffing levels are required to provide 1:1 supervision of a patient or cohort of patients. This is particularly evident at SFH due to the layout of our wards in which we have 50% single rooms and long corridors. This additional requirement is to ensure patient safety and is identified as a requirement by ward staff in discussion with Matrons / Lead Nurses. Examples of when this additional staffing may be required include, patients at high risk of falls, patients with mental health needs or under a mental section, patients at risk of wandering, patients with a deprivation of liberty plan in place, safeguarding or patients who have just stepped down from a critical care environment. Matrons review this requirement on a daily basis but this is challenging to manage. We have introduced an enhanced needs risk assessment, which when recently assessed by the Director of Nursing and Director of Operations was found to be in use.

5.11 The establishment for each ward includes the provision of a Ward Sister role in a supervisory status. This meets the guidance following the Francis review into Mid Staffordshire NHS Trust, which recommended the ward manager role should be 100% supervisory. Within Medicine many of the Ward sisters / Charge Nurses are not able to forfil supervisory status as they are being utilised to meet the staffing shortfalls. This is not as evident within surgery. To support the current cost pressures associated with the use of bank and agency staff, it has been decided that supervisory status will be supported for 2 days per week until 31st March, 2015, when the situation will be reviewed.

6 **Safer Nursing Care Tool**

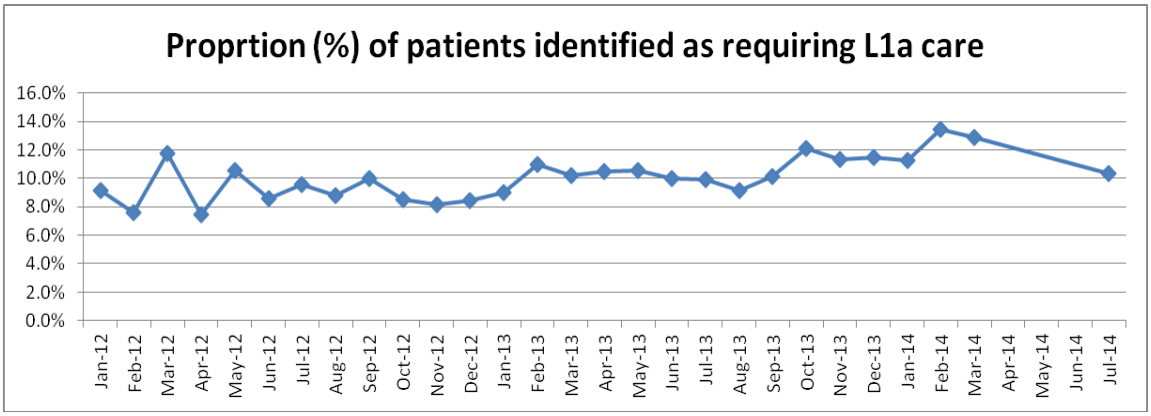
6.1 The 'Safer Nursing Care Tool' (formerly - The Association of UK University Hospitals, AUKUH) is a nationally developed and validated acuity / dependency tool specifically designed to measure nursing work load and estimate staffing requirements. The tool is widely used across the NHS and is accepted as 'the' standard means of assessing and monitoring ward/unit staffing levels.

6.2 Data pertaining to levels of care was collected from across all inpatient wards across the Trust over a 28 day period (7th July to 3rd August 2014). Nursing teams were advised of the importance of achieving 100% compliance with regard to data collection thus assurance could be provided regarding the reliability of the findings. Ward-based nurse data collectors recorded the levels of care required for every patient in every bed space on their wards at 1400-1500hrs, using descriptors provided. The number of trained data collectors was deliberately kept to a minimum to ensure data accuracy and consistency.

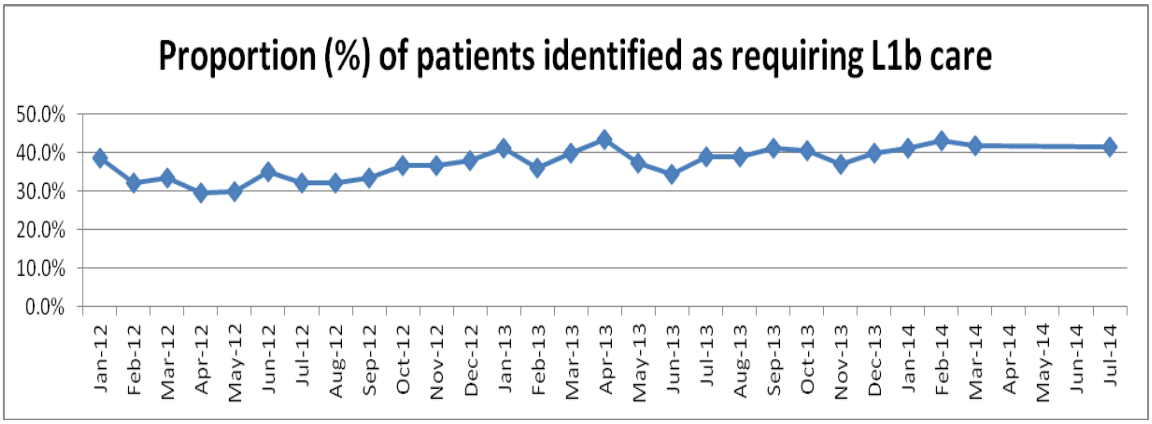
6.3 All wards, with the exception of one, achieved the minimum data collection of 20 days. The majority of wards achieved 100% compliance with 28 days of data entry. Compliance with data entry across the Trust was 97% overall which indicates that the findings are reliable overall. Prior to this audit, compliance with data entry was approximately 60%. A minimum of three data sets are required before changes to establishments should be made, so caution should be applied when making direct comparisons between current and historical audit reports.

6.4 Acuity level (patients requiring level 1a care) was recorded as 10.3% on this occasion against a background range of 7-14% (January 2012 to March 2014 when data was collected daily). Dependency level (patients requiring level 1b care) was recorded as 41.6% against a background range of 29-43% from the same period. The results for levels 1a and 1b are presented in the run charts below. True comparison is problematic because previous analyses are based on an incomplete database

Graph 2. The Proportion of Patients Identified As Requiring Level 1A Care



Graph 3 The proportion of Patients Identified As Requiring Level 2B Care



6.5 The results from the Safer Nursing Care Tool (SNCT) audit undertaken in July 2014 are included in Appendix 1 of this document

Comparative analysis of the SNCT information to that of the total number of staff in post indicates that out of the 24 wards audited:

- 14 Wards demonstrate a surplus of staff (WTE)
- 10 Wards demonstrate a deficit of staff (WTE)

Caution should however be urged with regard to this analysis given that the SNCT is a twice yearly audit and is undertaken at a pre determined point in time that may not capture the true variation in acuity and dependency of patients within our care. In addition the SNCT methodology calculates the overall staffing resources required and does not factor in any Registered Nurse and Health Care Assistant skill mix variations into the equation. The Keogh investment will support a number of wards who currently display a deficit.

7 Managing Safer Staff Levels

7.1 Previous papers presented to Board of Directors details the process that has been established to collect the planned and actual nursing and midwifery staffing as required by the NQB Guidance.

7.2 Each division has a clear process in place to manage the dependency of patients which may include moving staff from other areas, role substitution and use of temporary staff to address the provision of safe staffing levels.

7.3 The three key drivers for shortfalls in actual staffing are vacancies, sickness and dependency.

7.4 Those areas with high sickness absence levels actively manage this absence in line with the Trust policy. Matrons monitor progress to reduce sickness absence levels and report actions taken through their professional reporting structure. The new sickness and abscence policy has greatly assisted the management of ward staffing

7.5 Temporary staff are utilised to provide cover where there is a shortfall of staff. We have achieved a month on month increase in overall fill rates (May – October). The average fill rate for shifts across the Trust during October is as follows;

- Bank Health Care Assistant: 80%
- Agency Health Care Assistant: 11%
- Bank Registered Nurse:17%
- Agency Registered Nurse: 75%

The above information illustrates high fill rates for HCA shifts, which is symptomatic of the workforce supply challenges for qualified staff, but also due to the increase in numbers of bank HCA available. There is a heavy reliance on agency RN shifts. Caution should however be urged regarding the above figures given that there is a variance in fill rates across individual specialities and wards.

8 Workforce Supply

8.1 The Board of Directors have been provided with previous information in terms of the challenges facing the Trust in terms of workforce supply.

8.2 As a result we have experienced specific challenges in terms of workforce supply across a number of specialities including midwifery, neonatal, paediatric and general medicine. We have successfully recently recruited to a number of positions within maternity, neonatal and paediatrics however the recruitment of Registered Nurses across our adult general medical wards continue to be an on going challenge.

8.3 Recruitment to Registered Nurse (RN) positions continues to present a challenge to the organisation and has reflected a national trend. The release of national guidance regarding RN to Patient Ratio have had a significant impact as many NHS Trusts has

increased their overall numbers of RN's resulting in insufficient resource to satisfy overall demand.

Over the last six months, we have adopted a number of recruitment strategies in order to increase our overall RN numbers;

- Appointment of a Practice Development Matron to lead on nurse recruitment across the organisation
- Appointment of a Practice Development Nurse to strengthen in house preceptorship programmes
- Aligning our clearing house timescales to that of other NHS Trusts locally
- Attendance at local jobs fairs
- Sourcing Registered Nurses from across the European Union (EU) via a formal contracting agreement with two international recruitment agencies. To date (January – October 2014) we have successfully recruited and appointed 27 Registered Nurses from across Spain, Portugal, Greece and Italy across a range of wards and specialities within the organisation. Of those appointed. 19 have completed their super-nummery phase of their induction and are now practising independently. A formal evaluation of phase one of our overseas recruitment campaign has been undertaken with the overseas nurses and their respective Ward Sisters / Charge Nurses in order to review progress and identify lessons learned moving forward. It has been agreed we offer the overseas nurses HCA contracts once we have confirmation of their pre-entry onto the register and during this period they undertake their induction and competency package, moving RGN status when registration and sign off is complete. This is believed to help attraction and retention.
- Explored return to practice opportunities and demand locally
- Facilitated our own recruitment Open Day on Saturday 19th October, 2014 in which we offered 9 RN positions

8.4 Since January 2014 - 96 Newly Qualified Nurses have been recruited, a further 16 have been recruited for January 2015. (This was a smaller cohort.)

In preparation for August 2015 student nurse cohort, a team attended the University of Nottingham recruitment fair on 22nd October, to raise the profile of Sherwood Forest as an first employer of choice for newly qualified nurses

The recruitment of a Preceptorship Support Nurse on a secondment in January 2014 with the aim of:-

- Developing and implementing a Preceptorship Programme which includes time management, medicine management, discharge planning. The Divisional Nurses also attend a session introducing themselves and their teams. The newly qualified nurses then attend focus groups every 6-8 weeks. This allows a regular touch point where trust updates can be given and any issues can be "nipped in the bud" and

resolved. More recently the International Nurses have been added to the programme to give them structure to the start of their career at SFH

- Consistency of supernumerary periods for Newly Qualified Nurses across the organisation
- Working clinically alongside Newly Qualified staff
- Workshops/ drop in sessions for preceptees and preceptors to support them through the Preceptorship workbook
- Undertaken focus groups with 3rd year student nurses to understand what attracts individuals to their first job after qualifying. Overwhelming the quality of the Preceptorship and the level of support from the ward team came out the strongest.

To date the programme has evaluated very well both from the perspective of the ward sisters and the preceptee's.

Going forward a task and finish group have been developed to create a new Preceptorship Workbook to reflect the trust Quality for All Values and Behaviours & the 6 C's. The recruitment substantively to the Preceptorship Support Nurse post will be undertaken early December 2014.

8.5 The New Nursing and Midwifery Induction programme commenced in September 2014. The Director of Nursing opens each 4 ½ day induction programme and gives a clear message that staff are able to come and speak to us about the possibility of an internal move if they feel they have chosen a clinical environment that is not suitable to them. The programme has Quality for All values threaded through the week with the consistent message of trust priorities and the individuals in clinical practice who can help and support them as a new member of the team.

9 **Vacancy levels**

9.1 Vacancy levels fluctuate across the wards and departments over time. As at the end of May we reported 83.09 WTE Registered Nurse and 61.84 WTE Health Care Assistant vacancies in comparison to 60.87 WTE Registered Nurse and 50.69 WTE Health Care Assistant vacancies during October. Further work is currently on-going between HR and respective divisions in order to validate these figures given that a number of wards are at differing points between their baseline establishment and the first milestone of the nurse staffing establishment plan (Keogh). We have consciously made a decision not to substantially recruit into HCA positions to ensure our current staff are protected whilst we move from a 50:50 to a 60:40 RN:HCA skill mix (Keogh).

9.2 Appendix 1 of this report details the number of staff in post against the baseline budgeted establishment (October 2014). It should be noted that this does not include any staff that are planned to commence in post. Further work is on-going to include this information

9.3 Planned Care and Surgery have very few vacanices. A number of their wards are moving to the second stage of the Keogh recommendations of a 60:40 skill mix.

9.4 There are some wards within Medicine of concern which are requiring very close monitoring and discussion. Ward 33 is an area of concern and is being closely monitored and managed. Ward 41 and 42 work together to support and maintain their skill mix, as does Ward 43 and 44. Ward 22 has been reviewed and is currently utilising additional registered nurses to support the higher dependacy of patients. Ward 36 is a shorter stay, winter ward.

9.5 The overall turnover within the last 6 months within nursing and midwifery has been 4.5%. This turnover does not include staff who move within the Trust. The exit interview response for nursing is very low, with minimal information to make informed judgments. Matrons have requested that the opportunity to become more involved in exit interviews. They have proposed they offer individual exit interviews when the ward leader receives the letter of resignation. If a more confidential interview is requested it is proposed they are offered an interview with another matron or Anne Burton. The information will then be forward to Staff Support & Benefits Advisor for collation of data.

10 **In Conclusion**

10.1 A validated process for the reviewing of nursing and midwifery staffing levels across the Trust has been implemented, utilising where available nationally recognised tools in order to inform establishment requirements.

10.2 It is vital that the Trust continues the focus on recruitment and retention of the nursing and midwifery workforce in order to ensure that the staffing needs of clinical areas and patients are met, but a lot of activity has been in place to reduce the vacancy factor.

10.3 The Trust meets the 1:8 RN: Patient ratio

10.4 There are fewer vacancies than 6 months ago, but these predominatly sit within Medicine. Planned Care and Surgery are moving to a 60:40 RN: HCA skill mix follwing the Keogh decision to move to a 70:30 skill mix.

10.5 It is intended that the Board of Directors will receive a more extensive template with the 'Keogh' numbers within the next 6 month report. This has been completed and is currently being validated by the individual departments; HR, Finance and Divisions

10.6 In line with NQB requirements detailed nursing and midwifery staffing paper will be provided in May 2015, which will be informed by the next acuity and dependency measurements scheduled for Februry 2015.

11. Recommendations

11.1 The Board of Directors are asked to note the information contained in this summary report and the work undertaken to maintain safe staffing levels and move toward the Koegh investment.

Susan Bowler

Executive Director of Nursing

Appendix 1; Nursing Establishment – Analysis of Budgeted Establishment / Staff in Post versus Safer Nursing Care Tool (SNCT)

ECM	Area	Current Budgeted Establishment 31-Oct 2014	Current Staff in Post 19.11.2014	Vacancies Current Establishment 19.11.2014	SNCT wte July 2014	Variance against Staff in Post
Cost Centre	*Ward*	*Totals wte*	*Totals wte*	*Total wte Vacancies*	*Total wte*	*( ) = wte surplus*
EH34022	22	32.22	27.95	4.27	40.00	12.05
EC34023	23	43.91	38.68	5.23	28.00	(10.68)
EC34024	24	33.25	28.97	4.28	28.00	(0.97)
EG34033	33	33.49	23.24	10.25	36.00	12.76
EG34034	34	32.67	26.72	5.95	34.00	7.28
ES34035	35	34.37	28.20	6.17	34.00	5.80
ES34036	36	34.03	23.49	10.54	23.00	(0.49)
EH34035	41	32.41	27.39	5.02	21.00	(6.39)
EG34042	42	32.83	26.36	6.47	36.00	9.64
EC34043	43	36.66	36.29	0.37	29.00	(7.29)
EC34044	44	32.06	29.76	2.30	31.00	1.24
EH34051	51	33.86	30.05	3.81	29.00	(1.05)
EH34052	52	40.82	31.96	8.86	31.00	(0.96)
EH34053	Stroke Unit	71.58	57.64	13.94	65.00	7.36
	Sub Totals KMH	*524.16*	*436.70*	*87.46*	*465.00*	*28.30*
ER34145	Oakham	29.40	19.36	10.04	27.00	7.64
ER34144	Lindhurst	26.78	26.40	0.38	25.00	(1.40)
ER34122	Chatsworth	28.68	24.84	3.84	20.00	(4.84)
	Sub Totals MCH	*84.86*	*70.60*	*14.26*	*72.00*	*1.40*
	ECM Overall Totals	*609.02*	*507.30*	*101.72*	*537.00*	*29.70*
PCS	**Area**	**Current Budgeted Establishment 31-Oct 2014**	**Current Staff in Post 19.11.2014**	**Vacancies Current Establishment 19.11.2014**	**SNCT wte July 2014**	**Variance against Staff in Post**
Cost Centre	*Ward*	*Totals*	*Totals*	*Total wte Vacancies*	*Total*	*( ) = wte surplus*
PG34221	21	42.56	43.11	(0.55)	31.00	(12.11)
PG34231	31	31.27	30.32	0.95	30.00	(0.32)
PG34232	32	31.59	29.27	2.32	31.00	1.73
PO34211	11	32.52	31.01	1.51	31.00	(0.01)
PO34212	12	31.46	30.26	1.20	37.00	6.74
PM34214	14	37.56	34.61	2.95	23.00	(11.61)
	PCS Totals	*206.96*	*198.57*	*8.39*	*183.00*	*(15.57)*
Newark	**Area**	**Current Budgeted Establishment 31-Oct 2014**	**Current Staff in Post 19.11.2014**	**Vacancies Current Establishment 19.11.2014**	**SNCT wte July 2014**	**Variance against Staff in Post**
Cost Centre	*Ward*	*Totals*	*Totals*	*Total wte Vacancies*	*Total*	*( ) = wte surplus*
CS34176	Sconce	39.74	30.70	9.04	30.00	(0.70)
	Newark Totals	*39.74*	*30.70*	*9.04*	*30.00*	*(0.70)*
	Trust Totals	*855.72*	*736.58*	*119.14*	*750.00*	*13.42*

Appendix 2

MIDWIFERY, NURSING AND SUPPORT STAFFING 2014-15

Appropriate staffing levels and skill mix across midwifery, nursing and support staff are essential for providing a safe maternity service.[1] This paper outlines midwifery, nursing and support staffing requirements in line with recommendations of safer childbirth. The figures are based on the first six months data which has seen a 5.3% increase on the same 6 months last year.

1. Midwifery, Nursing and Support staff utilised by the Maternity Service.

1.1 Midwives.
Midwives form the largest number of staff within the maternity service. In the hospital setting there is a core of midwives based in each clinical area with others 'rotating' through the areas. Community midwives are allocated to geographical teams. Teams work a traditional model of community care offering community based antenatal and post natal care and home births. Community midwives are rostered to work on SBU on a regular basis and form part of the hospital establishment on these days.

1.2 HCA Band 2
Health Care Assistants support midwives in all clinical areas within the hospital setting and have a specific role as runner in maternity theatres.

1.3 Maternity Assistants Band 3
HCA Band 3 work within the maternity ward and Community setting. These support staff have distinct roles separate to those of the midwife. They have had enhanced training and support with early postnatal care.

1.4 Admin and Clerical staff and the Housekeepers.
Receptionists provide a front of house service to both the Birthing Unit and the Maternity Ward. They meet and greet patients and visitors and answer telephone queries from patients, relatives and staff in other areas of the hospital. This role enables clinical staff to concentrate on direct patient care. Similarly the housekeepers ensure patients receive meals and refreshments as required and that the kitchen areas are maintained hygienically.

2. Staffing Levels.

The figures detailed in this paper are based on the Birthrate Plus Workforce Planning tool[3] cited in Safer Childbirth[2] which was undertaken in October 2008[4.] These figures have been updated for 2014/15 using the Midlands and East Strategic Health Authority Midwifery Staffing tool, and are in line with the recommendations in 'How to ensure the right people, with the right skills, are in the right place at the right time'[5]

2.1 From a midwifery skill mix perspective we currently operate a 90% Midwife - 10% Unqualified Support Staff Ratio. The unqualified support staff ratio comprises of a

combination of Band 2 and 3 staff, the level of supervision required within their role is reflected in the banding awarded.

2.2 Midwifery staff.[2,3,4,5,,6]

Optimum Midwifery **staffing applying birth ratios**[3,4]:

The following graph illustrates our current midwife – birth ratio

Activity	Number	Ratio Applied**	WTE Required
Hospital Births	3378	1:42	80
Home Birth	110	1:35	3.14
Community Caseload	4190	1:98	42.7
Specialist and management Roles**		9%	11.3
Total			137.14

* To cover the additional roles required managing and providing maternity services, over & above that of clinical care (general/strategic management, governance/risk, screening, infant feeding, education), 9% of the total clinical midwifery WTE is added.

**Birthrate Plus Workforce Tool

2.3 Support Staff (Nursing, HCA)

The following are the WTE numbers of support staff required within the hospital.

2.3.1 Clinic, Birthing Unit and Maternity ward

Clinic, Birthing Unit and Maternity ward	WTE
HCSW band 2	24.33

Staffing levels for

Birthing Unit, Maternity ward and community	WTE
HCSW Band 3	9.48

Optimum midwifery (Hospital Births) staffing applying up to 90% midwife: 10% Band 3 skill mix. Using 1:42 ratio in table above**.**

	WTE requirement for the provision of direct care (excludes specialist & management roles)		Current WTE	
HCSW Band 3	125.84	12.43	9.48	8.5%
Midwives		111.87	114.56	92.5%

3. Process for conducting six monthly review.

An established biannual review in October and April each year is made against the Midwifery, Nursing and Support staffing levels in all care settings comparing the optimum staffing ratios will be conducted by the Head of Midwifery to establish whether they are in line with the recommendations of safer childbirth cited in this document. The results and recommendations are presented to the Maternity and Gynaecology Clinical Governance group where action plans are agreed and monitored

4. Process for the development of a contingency plan to address staffing shortfalls.

4.1 Short term staffing shortfalls

In the event of increased workload or unplanned sickness the Midwifery Shift Coordinator is informed and the Maternity Service Escalation Policy: management of staff shortage / management of bed pressures is available to assist in resolving the problem.

4.2 Ongoing staffing shortfalls

Ongoing staffing shortfalls are identified through regular monitoring by operational managers and through monthly review as part of the Maternity Dashboard at the Maternity and Gynaecology clinical governance group.

Unresolved staffing shortfalls prompt a review of services and existing recourses to enable development of a contingency plan in order to ensure the safety of maternity care.

Long-term staff shortages will be formally risk assessed and entered onto the Risk Register. A review of local staffing needs will be conducted[1,3] and a business case will be submitted.

5. Process for monitoring progression of business and contingency plans.

The progression of contingency plans and Business plans to address both short term and ongoing staffing shortfalls will be monitored through the Maternity and Gynaecology Clinical Governance group.

Where it is identified that progression is not timely this will be reported to the Planned Care and Surgery Division Clinical Governance group where further progression will be monitored.

6. Monitoring Compliance

Compliance is monitored through the Maternity & Gynaecology Clinical Governance group on a monthly basis. Results of the annual audit are presented to the Maternity and Gynaecology Clinical Governance group where action plans are agreed and monitored. Following a successful midwifery campaign we have successfully appointed to our vacancies, those individuals have now commenced in post enabling us to declare that we are compliant against the midwifery staffing standards.

7. References

1. NHS Litigation Authority (2013) Clinical Negligence Scheme for Trusts. Standard 1:3

2. RCOG (2007) Safer Childbirth. Minimum Standards for the Organisation and Delivery of Care in Labour. LONDON: RCOG Press

3 Ball J. A & Washbrook M. (1996) Birthrate Plus; A Framework for Workforce Planning and Decision making in Maternity Services; Books for Midwives Press/Elseivier

4. Ball J. A & Washbrook M. SFHT NHS Trust Ratios Summary 081008

5. NHS England. 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.

6 Royal College of Midwives. (2009) Staffing Standards in Midwifery Services. Guidance Paper no 7. LONDON: RCM

Using Birthrate plus principles

Six monthly review October 2014

Booking, caseload and birth figures obtained from the maternity dashboard April – September 2014.

Total WTE Required 1:42 ratio	Total WTE Required 1:45 ratio	Total Funded WTE(Inc. MSW Ex. HOM)	Total WTE in post(Inc. MSW Ex. HOM)
137.14	133.6	131.9	128

Activity	Ratio Applied	WTE Required	Funded WTE	Ratio Applied	WTE Required	WTE in Post
Hospital Births	1:42	80	78.1	1:45	76.8	79.8
Home Birth	1:35	3.14	46.2(Inc. MSW	1:35	3.14	46.2(Inc. MSW
Community Caseload	1:98	42.7		1:98	42.7	
Specialist and management Roles***	9%	11.3	7.6 wte Ex.HOM	9%	11	7.6 wte Ex. HOM
Total		137.14	131.9		133.6	131.9

Midwife to Birth Ratios

Midwife to birth ratios are calculated more crudely by using those only involved in direct care and would therefore exclude those highlighted as specialist or management roles***. On current birth figures we estimate that our birth for the year 2014/15 will be 3488, an increase of 5.3% on the same period last year and on current establishment numbers the current ratio would be 1:28.

Supervision of Midwifery

Supervision of Midwifery is a statutory function and working caseloads should have a ratio of 1:15. This is not currently factored within the work force or high level birthrate calculation but can be considered as apart of a more detailed review. We currently have nine appointed Supervisors of Midwives and a midwife undertaking the preparation course. Current caseloads range from 1:16 to 1:18 at Sherwood Forest Hospitals.

Alison Whitham

Head of Midwifery Nov 2014