To:	Trust Board
From:	Michelle Rhodes – Director of Nursing
Date:	December 2017
Essential Standards:	Standard 13 NICE Safer Staffing Guidance-- NQB Guidance
Title:	Nursing & Midwifery Establishment Review December 2017

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Purpose of the Report:
This paper provides the findings of the Trust's six monthly nursing and midwifery establishment review

The Report is provided to the Board for:

Decision	Discussion	Information
✓	✓	✓

Summary/Key Points:

- The establishment review was carried out across the Trust in all ward areas
- Midwifery establishment reviews have been included in this report
- The review was undertaken using the nationally recognised Safer Nursing Care Tool
- The Birth Rate Plus Toll was used for the maternity review
- Patient acuity data was collected through the Safe Care module of Health Roster
- Professional judgement has been applied along with benchmarking data from a peer Trust
- The next review will be presented to the Trust Board in April 2018.

Recommendations:

The Trust Board is asked to:

- Note the progress made to ensure compliance with national guidance in relation to maintaining safe nursing and midwifery staffing levels
- To endorse the recommendations and proposed actions highlighted within the report

1. INTRODUCTION

Executive Summary

The Trust board is committed to ensuring that the levels of nursing staff, which includes registered nurses, midwives and healthcare assistants, are correct to meet the care requirements of our patients across our adult inpatient wards. This paper sets out the detail behind the reviews and provides assurance to the Trust Board that safer staffing establishment levels currently reflect best practice.

There is a growing body of evidence to support the relationship between patient acuity, and dependency, staffing and the quality of care delivered to patients.

In November 2013 the Chief Nurse for NHS England published the National Quality Board: A guide to support providers and commissioners in making the right decisions about nursing, midwifery and care staffing capacity and capability (2013). In July 2014 the National Institute for Care Excellence (NICE) published recommendations for safe staffing for adult inpatient areas. The recommendations in latest publications 'Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time' (NQB July 2016) and 'Safe, sustainable and productive staffing – an improvement resource for adult in patient wards in acute hospitals' (NQB December 2016) support, alongside the other listed documents, the blueprint for this review.

The Safer Nursing care Tool (SNCT) was utilised for the nursing review, this is a nationally agreed tool for measuring the acuity and dependency of patients in adult ward areas over a 4 week period. It is based on the Keith Hurst model and is widely accepted by Chief Nurses as the tool of choice for informing ward establishments. The model needs to be supplemented by professional judgement, local patient conditions such falls, pressure ulcers and staffing levels.

The Royal College of Nursing (RCN) suggest that harm is likely to occur at a nurse to patient ratio of more than 1:8 during the day. The RCN further suggest that an increase in harm may be seen if the level rises to more than 1:11 at night. It is generally accepted that these ratios are a good start to supporting the professional judgement element of establishment reviews. These ratio's are applied to the reviews.

The Midwifery establishment has been reviewed by the Birthrate Plus® team and their findings have been included in this report.

Key areas to note

1. A Skill mix of 70/30 has been set for specialty wards and 60/40 for base wards (RCN suggest 70/30 and 65/35 , the corporate nursing team have applied professional judgement with regard to base wards)
2. Some wards have a lower skill mix than the above, professional judgement has been applied in most areas whereas an increase in skill mix is required in a number of areas as indicated in appendix 1.

3. Base wards require a RN ratio of 1:8, speciality wards is higher depending on the specialty but typically 1:6, ITU require higher still, 1:1 - 1:2
4. No wards have a nurse/patient ratio of more than 1:8 during the day which is the level recognised at which harm is likely to occur.
5. Ward Sister allocation remains at 1.0 wte supervisory
6. The establishment review is set on 503 beds at Lincoln and Louth, 340 beds at Pilgrim and 96 beds at Grantham

2. PROCESS

Each ward area submits is required to submit data 3 times a day through the safercare tool on health roster system. This data reflects the acuity of the patients on the ward, this information is used along with professional judgement and other elements to determine the establishment. (Further work is underway to ensure that all wards are submitting accurate data in a timely fashion. For the purposes of this report 28 days data for the month of October 2017 has been used.)

The Ward Sister/Charge Nurse, Matron and the Head of Nursing (HoN) from each ward area meet with Deputy Chief Nurse (DCN), Finance and Head of Rostering for a confirm and challenge session. These sessions consider the acuity data, quality data, bed numbers and the ward layout to determine the correct establishment. These initial results were discussed within the Corporate Nursing team and with a buddy Trust, and the final confirm and challenge was held between the HoN for each area, the DCN and Director of Nursing.

3. FINDINGS & RECOMMENDATIONS

3.1 Surgery and Critical Care, Lincoln

- Fotherby ward could reduce its establishment once an agreement is finalised on whether the ward will be open for 5 or 7 days
- Clayton ward has been classified as a specialist ward based on the recognition that tracheostomy patients are cared for on this ward. However, the October data suggest that the acuity has lowered therefore an activity review is required.
- Both Hatton and Neustadt Welton wards have supernumerary co-ordinator roles in their establishment. This role requires reviewing to understand the contribution it is makes to patient experience, quality of care, flow and outcomes.
- The establishment on SEAU appears rich. There are however, high numbers of newly qualified nurses on the area. A reduction in establishment should be considered at the next review.
- ICU will review their need to have more than one HCSW on duty on a long day shift. In reducing the current establishment to this it has the potential to release 2.73 wte resulting in a saving of £53.2K per year. A full impact assessment has been requested to support this suggestion.

  Potential saving of £53.2K per year

3.2 Medicine Lincoln

- Waddington ward is not established for 32 beds, yet these beds are open for the majority of time. In order to support these beds, a further 5.25wte band 5 registered nurses and 5.25wte band 2 HCSW are required, which will result in the need for a £382.9K investment. A business case is required for this investment.
- The establishment following the merger of MEAU and Alex bay may need to change once acuity and dependency data is collected following the change. This will be reviewed at the next establishment review.

Investment required of £382.9K to support 32 beds remaining open on Waddington ward

3.3 Surgery and Critical Care, Boston

A significant amount of work has been undertaken to remodel medicine and surgery across the Pilgrim site. Until this work has been completed limited changes can be recommended:

- The current numbers of RN's could support an additional 4 open beds (vacancies permitting).
- Bostonian ward have proposed a change to their template. This will need an investment of 2.5 wte HCSW and a reduction of 2.6wte registered nurses, releasing a net saving of £18.3K per annum. A full Quality Impact Assessment has been requested to support this.
- ICU to review their need to have more than one HCSW on duty on a long day shift. In reducing the current establishment to this it has the potential to release 1.72 wte resulting in a saving of £41.5K per year.

Potential savings of £59.8K per year

3.4 Medicine Boston

The 6th floor has reviewed the model of care delivered across wards 6A and 6B and have suggested the following to make efficient use of the establishment it currently has. This piece of work has been supported by the Deputy Chief Nurse leading on Dementia and Patient Experience.

- Explore the development of the dementia practitioner role across site from within current vacancies
- Identify and protect the clinical educator role for both wards
- Encourage the use of Registered Mental Health nurses across the wards
- Explore the option of creating a ward administrator post to reduce the bureaucratic pull on the ward sister role
- Review the frailty service and model of frailty pathway
- Explore introduction of rotational posts

There is the opportunity to reduce the establishment on the stroke unit if the 8 beds remain closed as part of the re-configuration.

3.5 Grantham

- The bed base on ward 6 at Grantham could be increased with no further investment to the nursing establishment. This would have the potential to assist the other main sites with patient flow.
- ACU at Grantham is rich in staff. The unit needs to complete a full service review to establish the patient population that it will care for going forward. This has the potential of reducing the nursing establishment significantly.

3.6 Women & Children's Services

- The findings for Branston and 1B (gynaecology) are not reflective of the activity that is undertaken on the wards from ward assessments and GP referrals, hence no changes are proposed at this time. (SNCT does not pick this up)
- It is proposed that the templates and establishments for both children's wards be examined further and harmonised to reflect the same bed base and patient acuity data.

3.7 Review of Midwifery Staffing

Process

The review of midwifery staffing has been undertaken in several stages. Initially the Head of Midwifery commissioned an external review of midwifery staffing using the Birthrate Plus® (BR+) tool. The Tool has been endorsed by both the Royal College of Midwives [RCM] and Royal College of Obstetricians and Gynaecologists [RCOG]. More recently, NICE guidance for midwives working the maternity settings (2015) included the principles set out in BR+ and the NQB safe, sustainable and productive staffing: An improvement resource for maternity services (2017) again endorsed the use of Birthrate Plus® as a mean of reliable method of informing Trust Boards of the staffing requirements of their local maternity service.

BR+ calculates the total number of wte required to deliver a safe maternity unit at two levels one just clinical staff and two the managerial and specialist roles that are required to meet all the needs of the service such as breastfeeding specialist midwives.

The next stage of the review involved the Deputy Chief Nurse (who has previous Head of Midwifery experience) and the current Head of Midwifery reviewing the draft BR+ findings, triangulating them with the clinical outcomes reported in the Trust's Maternity Dashboard, funded staffing establishments and skill mix options.

Despite the reduction in birth rate there is an increase in complex women (E.g. high BMI, diabetes) and there is a variation in the level of obstetric intervention compared to the national picture.

The Trust's Maternity Dashboard reports a year to date caesarean section rate of 26% with the two of last three months reporting rates just under 30% (National average of 26%) and an induction of labour rate of approx. 29.5% which is an increasing trend not only locally but also nationally. There was a 5% reduction in the number of women on midwifery led pathways, which could be related to the absence of midwifery led birthing units.

The increased acuity is also related to higher numbers of women who are obese or have medical issues such as diabetes which place more resource pressure on maternity services.

The GIRFT project reports that the service is an outlier for both elective and emergency caesarean sections for first time mothers.

Findings
These factors are driving the demand for higher numbers of staff as indicated in the BR+ report.

The BR+ review recommended the following staffing levels for ULHT across all sites

- Total number of midwives (clinically, specialist nurses, midwifery management): 222.67wte
- This includes a recommended 206.33wte clinical midwives

This figure givens an overall 1:26 midwife to birth ratio as it includes 22% for annual, sick and study leave allowance as well as an additional 15% for community midwives for travel related to postnatal care.

The currently funded *total* midwifery establishment is 204wte which excludes the Head of Midwifery (as the post holder is also responsible for paediatric and women's health services). To meet the BR+ recommendation; an additional 18wte Band 6 midwives would be required if the preferred staffing model is a 100% registered workforce.

To adopt a 90:10 skill mix, the birth rate recommended clinical component of the midwifery establishment would be the starting point (206.33 wte.). This would mean 90% registered midwives would equate to 185.90wte and 10% maternity support workers 20.43wte. Including unsocial hours, this would be at **cost pressure** of approximately £45K.

Option 1
BR+ staffing levels with a 90% / 10% split between Registered Midwives and New Maternity Support worker

Maternity Services Workforce

Planning (BR+)

BIRTH RATE PLUS RECOMMENDATION			
Description	**Total**	**Skill Mix**	**Funding**
Clinical wte (Inc. A-Equip)	206.33		
90% RMs		185.90	
10% MSWs in P/N Care		20.43	
Non-clinical Midwifery	16.34		
TOTAL WTE per Unit	**222.67**		
ULHT CURRENT FUNDING			
Description	**Total**	**Skill Mix**	**Funding**
Clinical wte (Inc. A-Equip)	201.44		
RMs		200.44	9,630,800
MSWs in P/N Care		1.00	23,700
Non-clinical Midwifery	12.40		646,200
TOTAL WTE per Unit	**213.84**		**10,300,700**

VARIANCE			
Description	**Total**	**Skill Mix**	**Funding**
Clinical wte (Inc. A-Equip)	4.89		
RMs		-14.54	-681,900
MSWs in P/N Care		19.43	551,800
Non-clinical Midwifery	3.94		175,300
TOTAL WTE per Unit	**8.83**		**45,200**

To implement 90:10 skill mix, visits to other maternity providers who have completed clinical pathway redesign should be undertaken and a workforce improvement project is required regarding roles and responsibilities.

Some units have progressed to an 80:20 skill mix, but this would be dependent on reducing the level of obstetric intervention and the further development of the MSW workforce that adds value. It is possible that the service works towards this goal.

Option 2
BR+ calculations with a 80% / 20% split between Registered Midwifes and New Maternity Support worker

Maternity Services Workforce Planning (Br+ move to 80%/ 20%)

BIRTH RATE PLUS CALCULATION - 80% / 20% SKILL MIX			
Description	**Total**	**Skill Mix**	**Funding**
Clinical wte (Inc. A-Equip)	206.33		
80% RMs		165.06	
20% MSWs in P/N Care		41.27	
Non-clinical Midwifery	16.34		
TOTAL WTE per Unit	**222.67**		

ULHT CURRENT FUNDING			
Description	**Total**	**Skill Mix**	**Funding**
Clinical wte (Inc. A-Equip)	201.44		
RMs		200.44	9,630,800
MSWs in P/N Care		1.00	23,700
Non-clinical Midwifery	12.40		646,200
TOTAL WTE per Unit	**213.84**		**10,300,700**

VARIANCE			
Description	**Total**	**Skill Mix**	**Funding**
Clinical wte (Inc. A-Equip)	4.89		
RMs		-35.38	-1,659,100
MSWs in P/N Care		40.27	1,143,600
Non-clinical Midwifery	3.94		175,300
TOTAL WTE per Unit	**8.83**		**-340,200**

Saving of £340,200

Recommendations

- The service must develop plans to address the increased intervention as highlighted in the GIRFT review of obstetric services which will assist in reducing the demand on staffing.
- It is recommended that the maternity unit add the follow red flag data to the maternity dashboard to ensure that there is sufficient oversight of whether the following recommendations can be supported/ continued:
- The Board are asked to support the BR+ recommendations for the introduction of support workers at 90:10 skill mix with a step change to 80:20 over a period of 2 years
- It is recommended that the Head of Midwifery starts to develop job roles and job descriptions for the introduction of maternity support workers within the hospital and community setting following a visit to Portsmouth which would be implemented from April 2018.
- The current vacancies would fund the introduction of the maternity support workers within the existing budget.

4. CONCLUSION

The requirement to meet safer staffing standards is an ongoing and significant challenge for many service providers. The recommendations in this review set out what is required to continue our journey of Quality Improvement.

Full details of the staffing requirements per ward and site are presented in Appendix 1 which accompanies this paper.

The figures below include the Band 7 ward sisters / charge nurses, but these have been counted as 100% supernumerary within staffing levels / templates.

The figures **do not** include any supernumerary time for clinical educators on the ward, which is an issue that needs reviewing as a separate piece of work.

The opportunity to 'do things differently' is both exciting and challenging and delivery of the nurse staffing action plan is crucial to the sustainability of a successful nursing/professional workforce.

Actions to address any immediate staffing issues are dealt with by the nursing and management teams on a day by day, shift by shift basis.

The next nursing and midwifery establishment review will be presented to Trust Board in April 2018

The Board are asked to:

- Agree the recommendations from the midwifery review

- Support the recommendations from the nursing review to allow for a longer collection of data that is more representative of patient acuity
- Note that any changes proposed to the current nursing and midwifery establishments will need to be supported by a full transformational plan and quality impact assessment prior to being implemented
- Support the re-introduction of nursing red flags to assist with professional judgement
- Support further work to be taken on the impact of supernumerary roles on the quality of patient care and the contribution that these roles make to the patient journey and flow.
- Recognise that the current model of delivering clinical education from within establishment budgets is not working due to the number of vacancies and that this needs urgent review going forward.