TRUST BOARD IN PUBLIC	**Date: 27 March 2014** **Agenda Item: 2.4**
REPORT TITLE:	**Right Staffing Review – Guidance and Current Position for Nursing and Midwifery** **PART ONE**
EXECUTIVE SPONSOR:	Fiona Allsop, Chief Nurse
REPORT AUTHOR:	Fiona Allsop, Chief Nurse Sally Brittain, Deputy Chief Nurse Angela Stevenson, Associate Director, Medical Division Jamie Moore, Divisional Chief Nurse, Surgical Division
REPORT DISCUSSED PREVIOUSLY: (name of sub-committee/group & date)	Board reports - December 2013, January 2014

Purpose of the Report and Action Required:		**(√)**
To update the board on the current position in relation to the National Quality Board paper regarding *How to ensure the right people, with the right skills, are in the right place at the right time.* **For the Board to review and approve.**	**Approval**	√
	Discussion	√
	Assurance	**(√)**

Summary: (Key Issues)

Part 1: This report provides an outline of the key components of the guide to nursing, midwifery and care staffing capacity and capability - *How to ensure the right people, with the right skills, are in the right place at the right time,* developed by the Chief Nursing Officer, Jane Cummings, and published by the National Quality Board on November 2013, in response to the Francis Inquiry.

Part 2: Provides information about current/future staffing requirements for discussion and approval at Private Board prior to submission to Public board in April 2014

Relationship to Trust Corporate Objectives & Assurance Framework:

Central to the delivery of safe and quality patient care.

Corporate Impact Assessment:	
Legal and regulatory implications	Yes
Financial implications	Yes
Patient Experience/Engagement	Yes
Risk & Performance Management	Yes
NHS Constitution/Equality & Diversity/Communication	Yes

Part One - How to ensure the right people, with the right skills, are in the right place at the right time'

Executive Summary

On 19 November 2013 the Government issued its full response to the Francis Inquiry which included a requirement for increased transparency in the way in which Trusts determine and meet nursing, midwifery and care staffing levels. It did not mandate minimum staffing levels.

On 20 November 2013 the National Quality Board published guidance on nursing, midwifery and care staffing capacity and capability ï ó*How to ensure the right people, with the right skills, are in the right place at the right time'.* This guidance contains ten expectations in the setting, monitoring and achievement of nursing, midwifery and care staffing, nine of which are pertinent to provider organisations; and 1 for commissioning organisations.

The guide states that it is the role of provider organisations to make decisions about nursing, midwifery and care staffing requirements, working in partnership with their commissioners, based on the needs of their patients, their expertise, and knowledge of the local context. It also recognises that simply having the right number of staff in place is not enough, as leadership, training and development, and a supportive and caring culture is necessary for staff to provide high quality and compassionate care.

This paper sets out the Trustôs current position relative to the guidance and identifies actions to meet the requirements of the guidance.

Introduction

Key themes from the NQB paper are that changes or deficiencies in the nursing & midwifery workforce can have a profound impact on the quality of patient care and that patient outcomes and particularly safety are improved when organisations have the right people, with the right skills, in the right place at the right time.

In November 2013 the Government issued its full response to the Francis Inquiry which included a requirement for increased transparency regarding how Trusts determine and deliver nursing, midwifery and care staffing levels. It stopped short of mandating minimum staffing levels. Following this the National Quality Board published guidance on nursing, midwifery and care staffing capacity and capability ï ó*How to ensure the right people, with the right skills, are in the right place at the right time'.*

The guidance states that it is the role of provider organisations to make decisions about nursing, midwifery and care staffing requirements, working in partnership with their commissioners, based on the needs of their patients, their expertise, and knowledge of the local context. It recognises that there is not a ôone size fits allô approach to establishing nursing, midwifery and care staffing capacity and capability. It does not prescribe the ôright wayô or a single approach, to doing so and importantly, also does not mandate minimum staffing levels.

In the longer term, this guidance will be supplemented by the work of the National Institute for Health and Care Excellence (NICE). NICE will be reviewing the evidence in this area, and will

produce guidance, and accredit tools to support staffing capacity and capability that is commensurate with high quality care.

This guidance has been endorsed by the CQC and NHS England. The CQC will use the guidance to inform their inspections and subsequently to inform their judgements and ratings for providers.

Expectations

The guidance contains ten expectations in total, nine for provider organisations and one for commissioners. This section details the requirements of each expectation, describes the Trustõs current position and describes future actions to comply with the expectations.

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 capacity and capability***.

The Board is ultimately responsible for the quality of care and outcomes achieved and for decisions regarding nursing, midwifery and care staffing. It must be able to demonstrate that systems and processes are in place to assure that nursing, midwifery and care staffing capacity and capability is sufficient. Specifically:

- Monthly reporting to the Board on staffing capacity and capability ï providing details of actual staff on duty shift to shift versus planned. Exception reporting should highlight wards which frequently fall short of what is required, stating the reasons, impact and actions to address the issues.
- Establishment reviews should be carried out every six months ï evaluating the previous six months performance and forecasting the likely requirements for the next six months
- Boards should sign off establishments for all clinical areas, articulate the rationale and evidence for agreed staffing establishments, and understand the links to key quality and outcome measures
- Boards should seek assurance on the processes in place to highlight risks caused by insufficient staffing capacity and capability.

Where we are now?

The Board received reports on the nursing & midwifery establishment in January 2014 and therefore already has an understanding of the importance of nursing, midwifery and care staffing and its impact to patient care. This paper provides further clarity.

What else do we need to do?

The Board will be appraised of the relevant issues in line with the above guidance, including specific actions the Board may need to consider. A measure(s) of actual versus planned staffing will be added to the monthly performance and clinical quality reports. These will include exception reports as outlined above.

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

This expectation sets out the requirement that systems and processes are in place to support shift-to-shift staffing decisions, monitoring and actions to mitigate any identified problems. Key issues to note:

- Daily reviews of actual staffing on a shift-by-shift basis versus planned staffing levels should take place between Sisters, Matrons, Divisional Chief Nurses and any identified variance should be managed.
- Escalation policies and contingency plans, including clear actions to be taken, should be in place to manage times of increased pressure (e.g. high staff sickness; unfilled vacancies; increased dependency).
- Temporary staffing solutions should only be used to fill short term gaps.
- E-roster is seen as an enabler.

Where we are now?

There are processes in place within the Trust for a review of staffing on a shift-by-shift basis and escalation processes are developed and utilised. Maternity has a written staffing escalation guide.

The Trust uses an e-roster system and work is being undertaken regarding the updating of the system or procurement of an alternative system which includes a work-based staffing module.

The Trust has established the elimination of agency staff as a corporate objective (14/15) in order to reduce the overall cost of temporary staffing and to improve quality through preferred use of permanent staff and has stipulated that bank staff, rather than agency, should be used when temporary staff are required.

What else do we need to do?

Further work is required with ward sisters/charge nurses to ensure consistency from e-roster reporting to provide assurance on staffing and trend analysis.

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

This expectation recognises the complexity of determining nursing, midwifery and care staffing requirements and recommends that the numbers and skill mix is determined through triangulation of evidence based tools, in conjunction with professional judgement, patient experience data and other workforce indicators. Key issues to note:

- There are no evidence based tools currently available for some areas (e.g. ED, AMU, SAU).
- Determining numbers is not enough and professional judgement and local knowledge should also inform decisions made about skill mix.
- Senior nursing and midwifery staff should be appropriately trained in the use of evidence

based tools and interpretation of their outputs.

- Leadership, management culture, team working, levels of education and training are also essential factors.
- Patient needs and local contexts (e.g. other support staff, technology in place) should be considered.
- NICE will be reviewing the evidence base and accrediting tools in this area.

Where we are now?

Nursing Capacity

Nursing headcount is broadly determined by the type of care being delivered, patient acuity and dependency, patient throughput, the level and extent of other multi-professional input and the level of direct clinical care delivered by more senior members of the nursing team at bands 6 and 7. There are three broad principles that determine nursing capacity. These are the ratio of registered to unregistered nursing staff, the ratio of registered nurses to patients and the level of direct clinical care that is provided by those nurses.

Information gathered at Trust Development Authority (TDA) events, published articles and research indicates that the nursing skill mix nationally should be at a ratio of no less than 65% registered staff to 35% unregistered staff (65:35). This ratio has been used in the nursing review at SaSH.

It is widely accepted that patient outcomes are likely to be worse as the registered nurse to patient ratio increases above a base of one registered nurse to eight patients (1:8) in a general ward setting. This ratio varies nationally and internationally depending on the type of care being delivered. Currently the TDA and the CNO are indicating that levels at or below 1:8 should be the standard twenty four hours, seven days per week. The ward configuration at SaSH indicates that a 1:7 ratio is optimal and has been used as the base for day time staffing. At night a figure of 1:10 has been determined as a first step from which the organisation will transition to 1:7.

The senior ward sisters in the Trust are generally delivering direct clinical care coordination 50% of the time with the remaining time being used for managerial activities.

They are supported by nine clinically based matrons.

Nursing Capability

There is limited direct educational or practice development support in the general ward areas.

Evidence based tools are being used within the adult ward areas with the exception of those identified above, and where guidance exists for other areas such as paediatrics, neonates, maternity, and ITU. These tools have informed the decision-making process within skill mix reviews. There are some areas which require tools to be introduced which are in development nationally.

A limited number of senior nursing & midwifery staff have expertise in the use of evidence

based tools within the organisation. Paper based systems are being used to collect large volumes of acuity/dependency information which are required in using evidence based tools such as the Safer Nursing Care Tool (SNCT). This does not encourage maximum efficiency.

Midwifery staffing is being reviewed using the Birthrate Plus Tool and will be presented to the Board following validation within the Women's and Children Division.

What else do we need to do?

As skill mix reviews will be undertaken every six months further work is required to define and develop this process to ensure it is conducted consistently and effectively. . This will mean the information collected and reviewed is triangulated and sense checked against tools such as professional judgement, nurse sensitive indicators, workforce and patient experience data. The Trust is currently undertaking acuity and dependency assessments using the SNCT on a rolling basis as part of this process.

Going forward the accurate and efficient use of evidence based tools like the SNCT, will require electronic systems to support data collection and analysis. These will need to be procured as funding is identified. The Trust will need to review the use of evidence based tools when the NICE guidance is received.

See expectation 6 in regards to nursing training and support.

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

This expectation highlights the impact that staff engagement has on patient outcomes and that the organisational culture encourages and listens to staff. Key issues to note:

- Clear process in place to raise concerns including whistleblowing policies.
- Providers must comply with Duty of Candour requirements.
- Teams should be well structured with supportive line management at every level.
- Line managers ensure staff are managed effectively with constructive appraisals and clear objectives.
- Staff side representatives provide support to ensure staff views are considered.
- Technological advances free up staff time to focus on delivering patient care.

Where we are now?

Staff are encouraged to raise concerns. The Trust has a whistleblowing policy in place which has been reiterated to staff recently as part of the Trust's response to the Francis Inquiry. Manager feedback is part of the appraisal process for all line managers, and appraisal rates are monitored on a regular basis. The GE development work will support this process.

A recent bid to the Nursing Technology Fund for electronic whiteboards and additional mobile devices was rejected but will be resubmitted at later date. The use of technology will result in increased time for direct patient care.

What else do we need to do?

Deployment of electronic records and prescribing solutions will support release of time to care.

Further work is required to ensure that mechanisms exist to ensure that concerns and risks raised and actions taken are known and discussed at all levels of the organisation

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

This expectation sets out the roles and responsibilities for nursing, midwifery and care staffing capacity and capability, recognising the complex interdependencies between this group and other parts of an organisations structure and functions. Key issues to note:

- Directors of Nursing lead the process of reviewing staffing requirement and ensure there are processes to actively involve sisters, charge nurses or team leaders.
- Papers to the Trust Board are as a result of team working and reflect an agreed position.
- Other Directors ï Medical, Finance, Workforce and Operations have responsibilities in this area recognising the clear interdependencies between professions to support non-clinical aspects of the nursing, midwifery and care staffing workload.
- Ward sister/charge nurses should be empowered to take responsibility for their clinical areas with delegated authority to act, supported by their organisations.
- Non-Executive Directors must ensure robust systems and processes are in place to make informed and accurate decisions regarding workforce planning and provision; review data on workforce, quality of care and patient safety and hold Executive Directors to account for ensuring right staff in right place to provide high quality care and ensure quality and outcomes measures.

Where we are now?

The Chief Nurse leads the nursing and midwifery staffing review processes and Divisional Chief Nurses, Associate Directors, Divisional Chiefs, matrons and ward managers have been involved. A programme of development for ward sister/charge nurses is in place to encourage empowerment and authority to act. The Trust Board has received a detailed paper in January 2014 and will receive monthly staffing information from the date of this paper.

What else do we need to do?

Ensure that the tools and professional judgement that supports the nursing establishments are clearly understood and shared with other members of the multi-professional team at ward, divisional, executive and board level.

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

This expectation sets out the need to ensure that establishments take account of the requirement for nurses, midwives and care staff to undertake continuous professional

development, and to fulfil mentorship and supervision. Key issues to note:

- Strong nursing leadership is central to the delivery of high quality care.
- Establishments should enable time for ward sister/charge nurses or team leaders to assume supervisory status.
- Establishment uplifts should allow for staff training and development; supervision and mentorship roles, including for students and for periods of induction of new staff; planned and unplanned leave.
- These uplifts should be determined by Trusts based on realistic estimations.

Where we are now?

Ward Senior Sisters/Charge Nurses have allocated supervisory time which varies from ward to ward and no Senior Sister is in an entirely supervisory capacity. An 18% uplift is available in ward establishments to address planned and unplanned leave allowances, however, this does not completely cover the rota and discussion is underway to agree a 22% uplift to the Divisional establishments to address this issue. The Trust does not have a practice development team is in place for nursing and midwifery to provide supervision and training of staff at ward level. The Preceptorship Nurse post (0.6 WTE Band 6) will cease in April 2014 when the SHA funding ceases and will significantly impact on the ability to run preceptorship programmes for newly qualified and junior staff.
A leadership development programme has been undertaken for Band 6 & 7 nurses. This needs to be evaluated particularly in regard to future plans for this programme.

What else do we need to do?

The six-monthly reports to the Trust Board will need to include assurance on the establishment uplifts that are in place and how they have been achieved.

A review of nursing educational support, including the role of preceptorship, at ward level needs to be undertaken. Consideration needs to be given to future leadership development needs for nursing and midwifery staff.

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.***

This expectation aligns to the first expectation and reiterates the Boards accountability. Key issues to note:

- Boards are accountable for patient outcomes they achieve within the staffing capacity and capability in place.
- Boards must assure themselves that there is sufficient nursing, midwifery and care staffing capacity and capability on a shift-by-shift basis and care staffing levels and key quality outcomes measures should be discussed at Trust Board level in a public meeting. For those Trusts not already doing so they must start this process by April 2014 and discuss at a Public Board meeting by June 2014.
- The Board should receive monthly reports on actual versus planned staffing on a shift-by-

shift basis and outline areas where there are gaps, the impact and steps taken to address the issue.

- Reports should be published in a form accessible to patients and the public.
- By summer of 2014 it is expected that this information is collated alongside an integrated safety data set that provides information at ward level where appropriate..

Where we are now?

The Trust Board has received a staffing paper in January 2014 primarily focused on ward nursing. However a formal maternity staffing review was undertaken as part to the Trust maternity CNST assessment in February 2014. The maternity service has been awarded CNST Level 2 status following this assessment.

What else do we need to do?

The six-monthly reports to the board will need to ensure that all areas of nursing, midwifery and care staffing are referenced ï which includes areas beyond wards.

Additional metric(s) to be added to the monthly Board Performance and Clinical Quality Reports that indicate planned versus actual staffing, and any exceptions to be made available.

Once information is available regarding reporting requirements via the single website in summer 2014, the Trust will need to ensure it complies with these requirements and is fully aware of risks that comparison with other organisations presents, particularly as Trusts are not all working at the same baseline.

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.***

The drive for transparency of staffing information is central to this expectation, which sets out requirements for display of information to patients and the public. Key issues to note:

- Information should be displayed to patients and the public, which outlines which staff are present and their roles.
- Information displayed should be visible, clear, accurate and helpful.
- Additional information such as a guide to uniforms and titles should also be considered for display ï appropriate to local needs.
- It should be clear who is in charge of the ward, the named clinician and nurse in charge of a patients care displayed above the patientôs bed.

Where we are now?

Laminated displays on the wards identify the number of staff planned to be on duty vs the actual in a breakdown of registered and unregistered. This sheet also displays the name of the Nurse in Charge of the shift, the ward sister/charge nurse and matron for the area. Some wards display the name of the consultant for that area.

Boards are currently being sourced to place above patient beds to highlight the name of the

clinician and nurse in charge of the patient and will be trialled in two ward areas. There are a variety of methods that can be used to convey this information. The principle should be that it assists patients and their families or carers to be assured that there is a clinician responsible for care planning and providing relevant information and support. .

What else do we need to do?

The photographs of nursing, midwifery and medical leaders will need to be kept up-to-date and available for display. A guide to staff uniforms is also required to be displayed.

The Trust should consider its website as another vehicle for publishing information on staffing. Each ward could have a web page which would provide another opportunity for ward level display of information.

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

This expectation sets out the responsibilities on providers, Local Education and Training Boards (LETBs), and Health Education England (HEE). Key issues to note:

- Providers must actively manage their existing workforce and have robust plans in place to recruit, retain and develop all staff.
- Providers share staffing establishments and annual service plans with their LETB in order to inform education and training commissioning plans and strategies.
- Staffing establishment and annual service plans shared with regulators for assurance.
- Each provider must be a member, or represented on their LETB.
- HEE is responsible for developing a Workforce Plan for England.

Where we are now?

An active programme of recruitment and retention of nursing, midwifery and care staff is in place with workforce being monitored within the Divisions and corporately by the Recruitment & Retention Group. The Trust responds to all workforce-forecasting requests from the LETB and has responded to ad-hoc requests resulting from the impact of Francis on future requirements for nurses, midwives and care staff.

What else do we need to do?

The Trust should consider developing and implementation of the Education & Training Strategy. Furthermore, although interventions are in place to reduce the turnover of nurses and care staff specifically, it is yet too early to determine their impact. Reports to the Trust Board will need to continue to monitor turnover in the nursing, midwifery & care staff group, to provide assurance that interventions are effective.

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.***

This expectation, although primarily aimed at commissioners, has implications for provider organisations. Key issues to note are:

- When setting local prices in contracts due consideration to impact on staffing should be made.
- Commissioners must monitor maintain a close dialogue regarding any issues related to service safety and staffing levels.
- Commissioners should seek assurance that Cost Improvement Programmes have clinical ownership within providers and do not threaten service quality.
- The 2014/15 standard NHS contract is expected to set out requirement for providers to report data on actual versus planned staff available on a shift-to-shift basis.
- Commissioners share intelligence with regulatory partners.

Where we are now?

The monthly Clinical Quality Performance Monitoring Group (CQPM) between the Trust and commissioners is the forum where nursing & midwifery staffing is discussed. The monthly Performance and Clinical Quality Report are also shared and presented monthly.

What else do we need to do?

Revised monthly metrics that report planned versus actual staffing will need to be provided to commissioners via the CQRG. These will need to be in line with the additions to the monthly performance reports. There is a need to gain agreement and understanding of future staffing levels commissioning and contracting discussions.