TRUST BOARD IN PUBLIC	**Date: 26 June 2014** **Agenda Item: 2.4**
REPORT TITLE:	Right Staffing Review – Guidance and Current Position for Nursing and Midwifery
EXECUTIVE SPONSOR:	Fiona Allsop Chief Nurse
REPORT AUTHORS:	Fiona Allsop, Chief Nurse Sally Brittain, Deputy Chief Nurse Nicola Shopland, Divisional Chief Nurse, Surgical Division Jamie Moore, Divisional Chief Nurse, Surgical Division
REPORT DISCUSSED PREVIOUSLY: (name of sub-committee/group & date)	Board reports - December 2013, January 2014, March 2014, May 2014

Action Required:		
Approval	**Discussion (√)**	**Assurance (√)**

Summary of Key Issues

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 alongside the subsequent publication of 'Hard Truths Commitments: The Journey to Putting Patients First'. Trust compliance against the recommendations is detailed within.
It is intended to demonstrate progress against the expectations since it was first discussed at Board in March 2014 in line with the nationally set deadline for reporting of June 2014.

Relationship to Trust Strategic Objectives & Assurance Framework:

SO1: Safe -Deliver safe services and be in the top 20% against our peers
SO2: Effective - Deliver effective and sustainable clinical services within the local health economy
SO3: Caring – Ensure patients are cared for and feel cared about
SO4: Responsive – Become the secondary care provider and employer of choice for the catchment populations of Surrey & Sussex
SO5: Well - led

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

Diversity/Communication	
Attachments:	

nqb-how-to-guid.pdf

Staffing letter - 20140331 Hard truths

Appendix A - Fill Rates for Nursing, Midwifery and Care Staff

Appendix 1 – NHS Quality Board -*A guide to nursing, midwifery and care staffing capacity and capability*

Appendix 2 – CQC Letter re publishing of staffing data

TRUST BOARD REPORT – 26TH JUNE 2014
'How to ensure the right people, with the right skills, are in the right place at the right time'. 'Hard Truths: The Journey to Putting Patients First'.

1. 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.

On 20 November 2013 the National Quality Board published guidance on 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'.* 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.

On 31 March 2014 – '*Hard Truths: The Journey to Putting Patients First'* was published with the aim of ensuring patients and the public know how the hospitals they are paying for are being run. The commitments within the paper are linked to the National Quality Board Expectations.

This paper sets out the Trust's current position relative to the guidance and identifies any outstanding actions to meet the requirements of the guidance.

2. Introduction

Key themes from the NQB and the Hard Truths papers 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 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.

3. Expectations

3.1 Expectation 1: *Boards take full responsibility for the quality of care provided to patients, and as a key determinant of quality, take full and collective responsibility for nursing, midwifery and care staffing capacity and capability**.*** *Linked to Hard Truths Expectation A/C/D*

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 – 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 – 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, March and May 2014 detailing staffing ratios, skill mix, plans to display staffing planned versus actual within the ward environment and the Trust mechanism for displaying and escalating to senior nurses and the Executive Team daily staffing and any concerns related to shortfalls. These are available on the Trust Website. The Board was then asked to approve an increase to ward establishments to improved ratios to 1:7 RN/Beds during the day and 1:10 RN/Beds at night in the first instance, this was agreed. The Board was also appraised of the long term plan to work towards improving the night ratio further in order that the ratio of 1:7 RN/Beds was achieved 24/7.

In May 2014 following a review of midwifery staffing utilising the Birthrate Plus staffing tool the Board were asked to approve an addition to the midwifery establishment to work towards a ratio of 1:28 RM/Women. The Board been agreed to recruit up to six additional midwives in 2013/14.

The Chief Nurse Report, May 2014 detailed staffing compliance planned versus actual by ward and staff group for both day and night shifts and as total Trust compliance (April data). The Trust tool allows documentation of clinical concerns and any mitigation put in place to ensure safe staffing on the wards in case of any shortfall in staffing and thus any areas of concern the Board voices with staffing compliance can be presented in daily detail for their review and assurance.

Staffing compliance for May 2014 is available in Appendix A

The next staffing review for general wards and maternity will take place in November 2014 in line with the guidance.

What else do we need to do?

The Board will be appraised of the relevant issues in line with the above guidance as they arise, including specific actions the Board may need to consider.

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

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 as described above for a review of staffing on a shift-by-shift basis which include daily escalation to the Senior Nurses, Executive Team and Site Team. Maternity has a written staffing escalation guide. Nursing has a standard operating procedure for both in hours and out of hours escalation of staffing concerns. Nurse staffing is discussed at each of the three daily bed meetings in addition to the above.

The Trust uses an e-roster system and work is being undertaken regarding the updating of the 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?

Additional training will be undertaken with ward sisters/charge nurses during and following the E-roster upgrade to ensure consistency from e-roster reporting to provide assurance on staffing and trend analysis.

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

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 with the approval of the Trust Board.

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 has been reviewed using the Birthrate Plus Tool as described above.

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.

3.4 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 supports this process.

A recent bid to the Nursing Technology Fund for electronic whiteboards and additional mobile devices was rejected but will be resubmitted in July 2014.

What else do we need to do?

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

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

3.5 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 – 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, Deputy Chief Nurse, Divisional Chiefs, Matrons and Senior Sisters/Charge Nurses have been involved. The Trust Board has received detailed papers relating to nursing and midwifery staffing as referenced within this paper and from May 2014 will receive monthly staffing information. From June 2014 monthly data in relation to staffing compliance is uploaded to Unify and displayed on NHS Choices and on the Trust Website at ward and total Trust level. See below link to Trust website.
http://www.surreyandsussex.nhs.uk/transparency/staffing-compliance/

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.

3.6 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; no Senior Sister is in an entirely supervisory capacity. From May 2014 22% uplift is available in ward establishments to address planned and unplanned leave allowances. 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) ceased in April 2014 when the SHA funding ceased however funding has been identified to recruit to a full time position and in the interim a plan is in place to continue to run preceptorship programmes for newly qualified and junior staff seamlessly.

A leadership development programme has been undertaken for Band 7 Senior Sisters. The Divisional Chief Nurses are working with the Chief and Deputy Chief Nurse to review the service needs in relation to ensuring the appropriate education/training and support for nursing and midwifery staff.

What else do we need to do?

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

3.7 Expectation 7: *Boards receive monthly updates on workforce information, and staffing capacity and capability is discussed at a public Board meeting at least every six months on the basis of a full nursing and midwifery establishment review.* *Linked to Hard Truths Expectation A/C/D*

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 staffing papers as detailed previously within the report in relation to nursing and midwifery establishments. Trust Board papers are available on the Trust website along with monthly staffing compliance at ward level and for the Trust as a whole.

In additional the metric has been added to the monthly Board Performance and Clinical Quality Reports that indicate planned versus actual staffing, and any exceptions to be made available.

What else do we need to do?
Nil at present

3.8 Expectation 8: *NHS providers clearly display information about the nurses, midwives and care staff present on each ward, clinical setting, department or service on each shift.*
Linked to Hard Truths Expectation B
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 – 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 patient's bed.

Where we are now?

Ward Boards displaying the number of staff planned to be on duty vs the actual in a breakdown of registered and unregistered. The Boards also display the name of the Nurse in Charge of the shift, the ward Senior Sister/Charge nurse and Matron for the area. The name

of the Consultant and Nurse caring for each patient on a daily basis is either documented on a board above the patients' bed or where appropriate documented for the bay, this is dependent on speciality. Regardless of method the information is easily accessible to patients and their carers/relatives and staff.

A guide to staff uniforms is displayed on the Trust Website and displayed in ward information packs and on wards of the Trust dependant on which method is most appropriate.

In addition each areas has a quality board which provides information about the care provided on the ward, photographs of the senior sister and matron and communication details such as bleep numbers, contact telephone numbers, consultant clinic dates and time and meet the matron details.

What else do we need to do?

Nil at present

3.9 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 and Finance & Workforce Committee which has received project plan/timelines and processes for recruitment. 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 a nursing 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.

3.10 **Expectation 10**: ***Commissioners actively seek assurance that the right people, with the right skills, are in the right place at the right time within the providers with whom they contract.***

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, these contain the planned versus actual compliance performance.

What else do we need to do?

There is a need to gain agreement and understanding of future staffing levels commissioning and contracting discussions.

4. Conclusion

The Board is asked to note the Trust's compliance against the recommendations and be assured of the progress against the expectations since it was first discussed at Board in March 2014 and is in line with the nationally set deadline for reporting by June 2014.

Fiona Allsop
Chief Nurse
June 2014

Fill Rates for Nursing, Midwifery and Care Staff Appendix A

Reporting Period: May 2014

	Day		Night	
Ward	**Average fill rate – registered nurses/midwives (%)**	**Average fill rate – care staff (%)**	**Average fill rate – registered nurses/midwives (%)**	**Average fill rate – care staff (%)**
Abinger Ward	100%	93.04%	100%	97.87%
Acute Medical Unit	97.9%	91.37%	94.76%	94.17%
Birthing Centre	106.66%	70.61%	100%	N/A
Bletchingley Ward	98.63%	92.89%	100%	100%
Brockham Ward	96.49%	96.21%	98.31%	92.16%
Brook Ward	100%	100%	100%	100%
Buckland Ward	98.02%	97.04%	96.77%	93.55%
Burstow Ward	94%	96.14%	103.33%	70.18%
Capel Ward	94.74%	95.93%	103.23%	101.11%
Chaldon Ward	95.46%	101.65%	101.49%	103.33%
Charlwood Ward	97.53%	96.07%	98.39%	93.33%
Copthorne Ward	100.81%	100%	100%	98.33%
Coronary Care Unit	95.7%	100%	88.71%	87.1%
Delivery	98.92%	98.87%	97.87%	98.31%

Suite				
Discharge Lounge	95.99%	98.04%	103.23%	103.23%
Godstone Ward (Haem)	100%	100%	100%	100%
Godstone Ward (Med)	97.93%	95.65%	100%	98.72%
Hazelwood	94.25%	94.69%	95.16%	96.97%
Holmwood Ward	94.39%	96.77%	87.1%	88.52%
ITU / HDU	96.59%	95.04%	97.17%	93.33%
Leigh Ward	99.3%	98.44%	100%	100%
Meadvale Ward	97.1%	95.95%	100%	100%
Neonatal Unit	91.37%	92.54%	90.55%	96.72%
Newdigate Ward	99.24%	96.62%	100%	104.84%
Nutfield Ward	100.2%	100%	100%	100%
Outwood Ward	89.88%	83.79%	93.51%	88.57%
Rusper Ward	97.83%	68.06%	98.28%	N/A
Surgical Assesment Unit	98.39%	100%	98.39%	100%
Tandridge Ward	99.09%	99.31%	101.61%	100%
Tilgate Ward	100.68%	93.73%	100%	100%
Woodland Ward	97.78%	95.64%	100%	96.77%

Total	97.27%	95.58%	97.54%	96.69%