The Royal Wolverhampton NHS Trust	

Trust Board Report

Meeting Date:	Monday 25 November 2013
Title:	Nursing Workforce Review
Executive Summary:	For the Trust Board to approve the principle findings of the workforce review to enable discussions to take place regarding the source of funding.
Action Requested:	For approval
Report of:	Cheryl Etches, Director of Nursing & Midwifery
Author: **Contact Details:**	Charlotte Hall, Deputy Chief Nursing Officer
Resource Implications:	£3.6M recurring
Public or Private: **(with reasons if private)**	Public
References: **(eg from/to other committees)**	TMC, Contract & Commissioning Group, Divisional Core groups.
Appendices/ **References/** **Background Reading**	CQC Registration Hurst 2012
NHS Constitution: **(How it impacts on any decision-making)**	In determining this matter, the Board should have regard to the Core principles contained in the Constitution of: - Equality of treatment and access to services - High standards of excellence and professionalism - Service user preferences - Cross community working - Best Value - Accountability through local influence and scrutiny

1. Introduction

In 2011 a phased approach to workforce review was agreed within the nursing quality directorates, the three phases are:

- Phase 1 band 7 supervisory status this was completed in February 2012 and funding agreed February 2013
- Phase 2 Adult inpatient wards excluding midwifery
- Phase 3 Paediatrics, outpatients, specialist nurses, theatres

There are a number of national drivers for organisations to assure themselves of their clinical staffing levels e.g, Care Quality Commission, Francis Report, the pending Safer Staffing Guidance etc. Many organisations have already completed skill mix reviews these are either being funded or are in the process of being presented to Trust Boards.

It is acknowledged that the dependency of outpatients and their care needs is ever more complex demanding more face to face care time. Skill mix requirement can no longer rely on purely a ratio of bed to nurse number because complexity and turnover impacts significantly on the manpower required to deliver safe and effective care. RWT is experiencing cost pressures within ward budgets to enable safe and effective care to be delivered.

The attached skill mix review is a summary of detailed work and methodology that has been completed over a number of months and contains a professional view of the senior leaders of the work force requirement when good quality patient experiences. The Trust Board is asked to approve the principle findings of the workforce review to enable discussions to take place regarding the source of funding.

The Royal Wolverhampton NHS
NHS Trust

Business Case

TITLE: Phase Two: Workforce review of adult nursing inpatient wards excluding Midwifery and Paediatric inpatient services	
DIRECTORATE **Led by corporate in conjunction with Divisions 1 & 2**	**PROJECT LEAD (ACCOUNTABLE OFFICER):** **Cheryl Etches, Chief Nursing Officer** Author: **Charlotte Hall, Deputy Chief Nurse** **Rose Baker, Head of Nursing Div 2** **Zena Young Head of Nursing Div 1** **Debra Hickman Head of Midwifery**

BACKGROUND INFORMATION

1.0 Following publication of the second Francis Report (2013) and the new nursing vision: 'Compassion in Practice' (2013), there is a recommendation for all NHS organisations to take a six monthly report to Trust Board detailing the nursing and midwifery staffing levels together with an assurance that they meet the acuity and dependency of the patient population based on sound methodology..

1.1 There is now a far greater focus on ensuring Trusts have the right size and shape of nursing and midwifery workforce to meet the needs and expectations of patients. Evidence is now available that directly attributes failings in care and increased rates of harm to poorly staffed wards. Evidence also suggests that poorly staffed wards impact on staff morale, turnover, burnout and a reduction in staff wellbeing, all of which have a direct consequence on outcomes of care.

1.2 From a demographic perspective the Trust needs to prepare for the future; Wolverhampton was more deprived in 2010 than in 2007 (Indices of Deprivation). This represents a relative decline, from the 28th most deprived Local Authority to the 20th most deprived (out of 326 local authorities). The wider implications of poverty and consequential state dependency are a cause for concern. In late 2012, the city featured as the most exposed area, outside London, for threatened homelessness with 1 in 65 households having a (landlord) possession notice in place. Poor health already features in several wards. Key facts about the population are shown below:

- Wolverhampton's employment rate is 61.2%; below the England average of 70%
- Local people do not always have the right skills to benefit from local jobs and earnings are below the national average
- The current unemployment rate in Wolverhampton is 5.4% higher than the national average.
- Citizens' Advice Bureau estimates that the total amount of welfare income coming into the city is £615 million.
- Total debt in the city is estimated at £125 million
- One in three children living in poverty, and in some areas is over 40%

Life expectancy and birth rates in the city are on the increase. This will lead to an increasing proportion of the city's population being at or beyond retirement age as well as a growing younger population. With an increasing birth rate, extended life expectancy and international inward migration the population is projected to continue increasing to 260,200 in 20212.

2.0 Workforce review

2.1 **Supervisory ward sisters**: In June 2012, the Board received a business case seeking support to fund senior ward sisters and charge nurses as supervisory , the implications of this are that senior ward sisters who predominantly work five days a week, no longer need to not take a caseload of patients on shift and are available to supervise and monitor care and speak with patients and relatives.

The business case formed **Phase One of the workforce review** and was funded as part of a quality initiative by the commissioners in **February 2013**. The funding provided an additional 29.24 WTE (£922,793) which has being used to employ Band 5 staff nurses to backfill the existing Band 7 ward sisters enabling them to work differently and now, with foresight, fulfilling the recommendation by Francis for all senior ward sisters to be supervisory within the nursing establishment.

2.2 Nationally over the last 15 years, there has been considerable development in terms of Trusts having the right size and shape of workforce and a range of approaches to support professional judgement exists.. There is no single recommended method however consensus has moved to using an acuity based model (supported by the RCN, NHS England and the Francis Report) which measures patient acuity and dependency.

This however needs to be triangulated with professional judgement which takes into account the complexities of a hospital ward: turnover of patients, geographical proximity ie. additional single rooms, increasing numbers of infection outbreaks necessitating cohort nursing. The Trust has examples within a surgical ward where up to 3 patients move through a bed in 24 hours which adds to the nursing workload and is not necessarily able to be captured using an acuity study.

The measure of 'uplift, in line with other Trusts is 20%. This consists of a planned additional staff compliment and enables the ward establishment to absorb planned (annual/study) leave and unplanned (sick leave, maternity, compassionate) leave.

2.3 To determine acuity, all adult inpatient wards have used the Association of UK University Hospitals (AUKUH) Dependency Tool which measures the individual dependency of every patient over 20 days then uses generic multipliers to calculate staffing required.

Each ward first completed this in January 2012 and most recently again in June 2013. This methodology is advocated as best practice by the RCN, NHS England and is cited within the Francis Report.

Moving forward the Trust will be able to identify acuity on a shift by shift basis using SafeHands technology making this methodology very robust and transparent and supporting 'intelligent redeployment' of staff in preference to working on usual numbers of staff routinely counted on every shift.

2.4 Midwifery staffing is measured using 'Birthrate Plus' and this has been funded through a separate business case and was excluded from this review. Phase 3 of the workforce review encompasses outpatients, clinical nurse specialists, and community and paediatric services.

3.0 Assuring safe staffing at RWT on in - patient wards - June 2012

3.1 Phase 2 of the workforce review identified what staffing is required on each in patient ward spanning the 24 hour/ 7 day week. The Trust used two methodologies; collection and

analysis of ward acuity data over 20 days, triangulated with the second method, ward sister/charge nurse professional judgement of staffing and skill required per shift coupled with final agreement with the head of nursing and CNO. Thus the methodology is tested out using triangulated data.

3.2 **Skill mix:** Whilst the RCN (2010) recommend a minimum of 65:35 split, increasingly, in line with other Trusts, this in now seen as a minimum. Hurst evidence (2012) supports a skill mix of **70:30** in acute wards. The decision to move to a skill mix ratio of less than this in acute wards, and in the absence of national guidance, is made by the CNO who carries ultimate accountability for the standard of nursing care.

Hurst recommends 70:30 because of the increasing complexity and volume of patients. As length of stay reduces, ward turnover rises and medication regimes, as an example, become more complicated. A number of CIPs relate to reduced length of stay. In order to achieve these, therefore, length of stay must reduce which is a multi-disciplinary challenge. Whilst lengths of stay remain longer than the national averages meeting these CIPs whilst maintaining quality will therefore remain a significant challenge.

3.3 **Professional judgement**: Hurst data cannot be looked at in isolation and must be tempered with experience and judgement of those who run the wards and who know and understand the experience and ability of the staff. Professional judgement needs to be challenged with external scrutiny in order to avoid the pitfalls of accepting mediocrity as the norm.

RWT has taken a balanced line where Hurst exceeds professional judgement and has agreed staffing between the two measures. Evidence supports running Hurst three times before making adjustments based on acuity data alone because staff need to become experienced at using it. However to validate the data in June, the validation was completed by the matron or HoN. Where anomalies exist between Hurst data and professional judgement, the variability has been challenged. An example is where Hurst will dictate x WTE but professional judgement supports a higher number of staff, this has highlighted challenges due to complexities of geography of the ward, bed turnover; a surgical ward can routinely accommodate 3 different patients in 24 hours, change of sex from male to female as wards flex capacity to accommodate same sex accommodation and increased complexity of treatments such as chemotherapy. A middle ground has been agreed based on valid reasons for not just using acuity data alone.

3.4 Hurst evidence supports the reduction in harm and improvement in quality indicators where skill mix of 70:30 exists as well as improved performance indicators such as earlier discharge, reduced length of stay, infection rates and patient satisfaction encompassing the other two domains of quality: clinical effectiveness and experience. The Trust can demonstrate where this ratio of skill mix achieves success:

Continual improvement in reducing all pressure ulcers

Reduction in incidences of patients being discharged with unnecessary catheters

Improved and sustained escalation of the deteriorating patient and reduction in cardiac arrests

Improving mortality

Improving patient experience with continued reduction in complaints and increasing friends and family score

Increased activity with a reduction in length of stay

Improved training, education and appraisal to maintain standards achieved through NHSLA L3

3.5 The recent announced CQC report, cited out of hours staffing as a priority to be addressed. This needs to include 7 day working.2

4.0 Methodology and Analysis of data

3.1 The data has been assimilated using electronically completed dependency studies completed in June and triangulated with professional judgement using a simple spreadsheet. Further detailed work has taken place challenging areas with a lower Hurst dataset to professional judgement. Each individual ward has been finally reviewed by the CNO.

4.0 Recommendations:

4.1 The review has identified some staffing levels of immediate concern which need to be addressed as a matter of urgency around night time staffing on medical, trauma/orthopeadic and elderly care wards. A list of actions must be prioritised in line with stepped recruitment

CASE FOR IMPROVEMENT

Proposal:

1 To invest £3.4M in nursing staff. This would consist of 135 WTE posts: 8.4 WTE x Band 6; 75.82 x Band 5; 51 x WTE Band 2

2 CNO to advise Trust Board on the state of nursing and midwifery staffing levels twice a year including the nursing Trust wide vacancy and sickness position

3 Maximise current staffing through the use of Electronic Rostering to manage the 20% uplift and scope the use of intelligent redeployment through SafeHands

4 Monitor acuity dependency on a daily basis through SafeHands

BENEFITS OF CASE

The overall benefits to the organisation of this business case would be thus:

1 Investment in improving safety and quality of care to particularly vulnerable groups of patients by increasing nurse to patient number based on acuity and need.

2 Maintaining the current bed capacity will meet the needs of the population presenting at the emergency portals

3 Reduction in healthcare related harm and continued success in quality and safety indicators.

4 Local population's confidence in local health care provision improves (patient satisfaction) supporting reputation because of the CQC inspection report

5 Achieve the staff ratio of nurse to patient need using the acuity model of staffing supported by the Francis Report (Feb 2013) and NHS England.

RESOURCE IMPACT *(Staffing, time, costs -capital and revenue, source of funding)*
Attach financial proforma (Add hyper-link for Financial Proforma)

RISKS AND DEPENDENCIES *(Partners, other projects in progress, availability of resource/people, Service Improvement capability within team, contingency plans & mechanism to stop the improvement if benefits can not be delivered i.e. exit strategy, Risk Register implications)*

Risk	***Grade (R,A,G)***
No further investment in nurse staffing levels with existing bed capacity will mean continued reliance on additional staffing (bank and overtime) which is not funded and is an annual cost pressure	*4A*
Difficulty in recruiting will require a stepped approach to recruitment over 12months	*3B*
Wards not working within 20% uplift resulting in further over expenditure on nursing establishments	*3B*
Loss of public confidence following CQC report due to be published publically November 2013 states RWT have significant risks around poor nurse staffing.	*4A*

PUBLIC CONSULTATION Not required

EQUALITY IMPACT ASSESSMENT Not required

HIGH LEVEL IMPLEMENTATION PLAN

Key Actions	**Person responsible**	**Timescale**
Agree BC with Divisional teams	DCOO/HoN	Nov 2013
Confirm BC with Directors and NEDs	Directors NEDs	Nov 2013
Agree source of funding	FD	Nov 2013
Agree stepped recruitment with priority areas	Heads of Nursing with CNO	Dec 2013
Agree dedicated recruitment plan	Heads of Nursing with DHR Director	Dec 2013

SUBMITTED BY:

Clinical Director ……Matron……Dir. Mgr……

Date……..

APPROVED BY: **Divisional Director…… Divisional Manager ……..** **Divisional Accountant…….. Head of Nursing ……..** **Date……..**
FOR CAPITAL INVESTMENT ONLY **Director of Estates Development ……..** **Date……..** **(On behalf of Capital Review Group)**