The Nursing and Midwifery Workforce

Background

On 26th January 2018 the House of Commons Health Committee published its inquiry into **the nursing workforce**. At the same time the National Quality Board published a series of improvement resources on safe sustainable staffing guidance. The resources relevant to Sherwood Forest Hospitals (SFH) include **Adult inpatient wards in acute hospitals** and **Maternity services**. In addition, Children and Young people, Neonatal and Urgent and Emergency care are in the process of being reviewed following consultation prior to their final approval. This paper will provide an overview of these reports alongside a gap analysis of the recommendations in relation to the position at SFH.

1) The Nursing Workforce[i]

In January, the House of Commons Health Committee published its inquiry into the NHS workforce. Although the number of hospital nurses has increased the figures show that 11% of posts in England remain unfilled. The inquiry held several focus groups across the UK and reported their findings and recommendations. The key themes have been highlighted below and the recommendations have been captured within appendix 1 alongside the gap analysis against SFH.

There is no agreed measure of shortfall in the nursing workforce in England. Health Education England (HEE) states there are 36,000 nursing vacancies in the NHS in England, equating to a vacancy rate of 11%, while the Royal College of Nursing (RCN) give a figure of 40,000. Vacancy rates mean that posts are not substantively filled, but they may be being filled by bank or agency staff on a temporary basis. HEE estimates that 33,000 of the 36,000 nursing vacancies are being filled by the temporary workforce, which leaves an overall rate of 3,000 (1%) remaining unfilled.

Vacancy rates vary between nursing specialities and regions. The highest rate is within learning disability nursing at 16.3%. Adult nursing is 10.1% and children's nursing 10.9%. For adult nursing the highest vacancy rate is in South London at 15.7%, with the East Midlands at 10.1%.

The significant vacancy rate has in part been driven by the NHS's response to the public inquiry into poor care at Mid Staffs, following which many new nursing posts were created, but without a matching supply of new nurses to fill them.

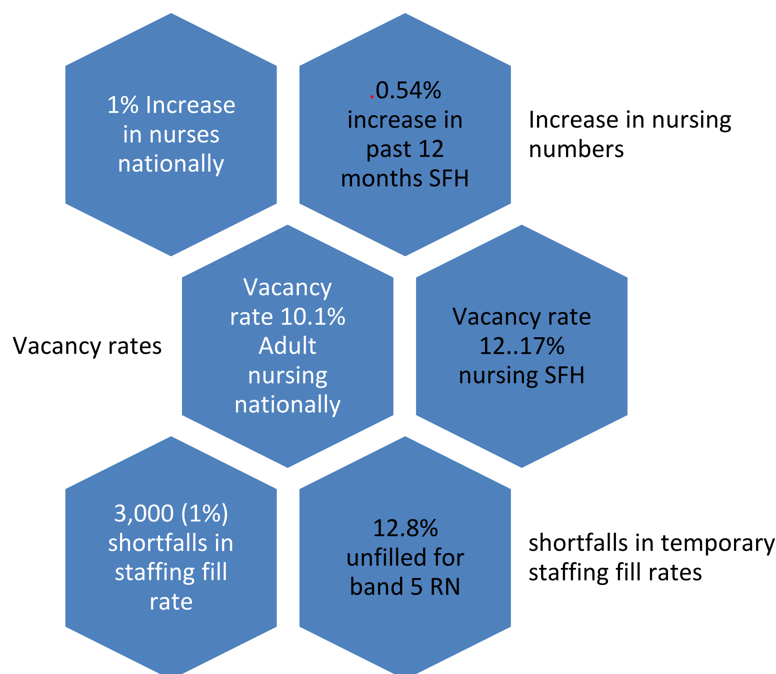
The UK has fewer nurses relative to the population than the OECD average, and it is also below many EU countries.

Turnover has increased from 12.3% in 2012-13 to 15% in 2016-17. The total number of nurses working in the NHS fell by 1,000 in the year June 2016 to June 2017. Increasing numbers of UK nurses are leaving the profession each year. Just over 29,000 UK nurses and

midwives left the NMC register in 2016-17, up 9% from the previous year with around 33% being over the age of 60.

There is currently a crisis in the nursing workforce. This has been affected by the major changes made over the past 12 months, including the removal of bursaries, reduction in access to continuous professional development (CPD), pay restraint and the UK decision to leave the EU, alongside changes to the language testing has had an impact on recruitment and retention.

Nursing workforce



Recruitment

Workforce planning has historically been short termism and lacked a strategic approach. HEE have a draft workforce strategy currently out for consultation which intends to address this shortfall at a national level.

The inquiry highlighted concerns raised around recruitment of the EU workforce and language testing. This is at times a significant barrier to nurses coming to work in the UK. However, reliance cannot be made on recruitment from overseas.

The inquiry was positive around the introduction of new roles within nursing, including the nursing associates and apprenticeships. In addition the introduction of fast track schemes and return to practice. The Government has committed to funding an additional 5,000 (25%) nursing placements for 2018-19.

Student funding and financial support for students is now through the student loans scheme rather than NHS bursary. There is no intention of this changing over the next three years.

Applications to undergraduate nursing courses in England in 2017-18 have dropped by 23% in the past year following these changes. The average age of students applying for undergraduate programme has fallen which suggests that the number of the mature entrant students has dropped due to funding changes through the student loan route. The nursing bursary has been reduced for the last 2 years which means that newly qualified nurses will leave university with about a £30k student loan which will put some people off applying for nursing places compared to a few years ago.

Nursing associates provide a bridge between registered nurses and health care assistants. They will provide direct patient care, including some tasks usually performed by nurses. They will complete a two year programme, whilst working as a member of the healthcare team as opposed to a student on a supernumerary basis. Within SFH we are part of the first wave programme and currently have 13 trainee nursing associates who are due to complete their training in April 2019. Nursing associates are intended to supplement nurses rather than replace them but will ease pressure from the registered nurse through taking on some of their tasks. A final consultation document is due to be released in April 2018 outlining the roles and responsibilities of the Nursing associates.

Retention

Growing numbers of UK nurses are leaving the profession - around 29,000 (5%) UK nurses and midwives left in 2016-17 compared to 3.6% in 2012-13. Although not enough research has been done to understand why nurses are leaving, difficult working conditions, exacerbated by staffing shortfalls, are likely to be playing a significant part, which is supported by the Nursing and Midwifery Council (NMC) findings. The main issues identified that have been highlighted that are reported to contribute to nurses leaving include:

- Working conditions (staffing levels, workload)
- Change in personal circumstances
- Disillusionment with the quality of care provided to patients
- Concerns about being able to meet revalidation requirements
- Leaving the UK
- Poor pay and benefits

Overall, this does correlate with the information that we collect at SFH. However, our exit interviews do not currently provide enough richness around the reason for exit. In addition to this, it is well written that staff do not always give the real reason for leaving. One or two organisations have started to introduce an exit questionnaire six months after the staff have left and this is felt to provide a richer source of information, but the response rate is not always that high. This is something as part of our retention work we can consider.

For nurses returning to practice, HEE highlight lack of flexibility as the main reason for them initially leaving the profession.

Pay

The ongoing pay restraint was reported as having an impact on both recruitment and retention. During the course of the inquiry and more recently, the removal of the 1% pay cap and the proposed pay award reviewed. However, the inquiry highlights that pay is not the sole solution to the retention problem but only one element of it.

Working conditions

During the inquiry key areas of concern were expressed by nurses as the need for '*more hands on deck*'. Nurses are reported to be concerned that the increasing pressure is having an impact on their ability to deliver safe care, for which nurses bear personal professional responsibility. Some nurses reported preferring to carry out bank or agency work as it gives them greater flexibility and higher rates of pay. However, this does impact on continuity of care.

Nurses described arriving early for their shifts and finishing late, and not being able to take breaks because there are too few staff on duty. The RCN raised concerns that the nursing shortages are impacting on the handover between nurses at the beginning and end of their shifts, potentially affecting the quality of care on their patients.

Nurses reported the lack of facilities and time to take their breaks.

Reduction in funding for nurse education and training

The evidence within the inquiry showed that reductions in the availability of funding for continuing professional development (CPD) is a major issue contributing to nurses leaving the profession. The national budget for nurses' CPD has fallen from £205 million to £84 million in two years.

For the last 2 years SFH have received £140k of Learning beyond Registration Funding (LBR) but this is to support multi-professional training as well as nursing as it's utilised on an organisational training needs priority basis. Approximately 70% is spent on nursing on areas such as advanced clinical practice development, mentorship and non-medical prescribing.

In 15/16 the Trust received £180k of LBR funding so we have seen a reduction by £40k in the last 2 financial years. We have not had our allocation for 18/19 as yet but are anticipating a further reduction.

NHS Employers report that this is a fundamental priority for national action as not only does it limit the opportunities for advanced practice but impacts on the standard way of ensuring ongoing CPD to carry out specialist roles such as critical care or urgent and emergency care courses.

2) An improvement resource for adult inpatient wards in acute hospitals

This improvement resource is part of a suite of specialty resources which underpin the overarching NQB staffing improvement resource. The resource outlines a systematic approach for identifying the organisational, managerial and ward factors that support safe staffing. It makes recommendations for monitoring and taking action if not enough staff are available on the ward to meet patient's needs. There is a recognition that local wards vary in makeup that local factors such as ward layout, geography and estate need to be considered when calculating staffing needs.

A transparent governance structure, including ward to board staffing requirements, should be in place for determining staffing numbers and skill mix, and monitoring its effectiveness.

Boards should carry out a strategic staffing review annually and should be assured that the key elements of planning are followed:

- Use of a systematic, evidence based approach to determine the number and skill mix of staff required
- Exercising professional judgement to meet specific local needs
- Benchmarking with peers
- Taking account of national guidance

On a monthly basis, actual staffing data should be compared with expected staffing and reviewed alongside quality of care, patient safety and patient and staff experience data.

Establishments should be reviewed annually and should include an uplift to allow for the efficient and responsible management of planned and unplanned leave and to ensure absences can be managed effectively. This would include: annual leave, study leave, parenting leave, sickness absence and compassionate leave.

The ward sister / charge nurse is critical to ensuring the delivery of safe and effective care in adult inpatient wards, and for ensuring that staffing meets locally agreed levels. The post holder is responsible for setting the culture of compassionate care and team working. The extent of supervisory time is determined locally and needs to reflect both administrative work and clinical leadership. Ward sisters / charge nurses should make themselves visible to patients and staff and be available to discuss concerns with all, including relatives. They should work alongside staff as role models and developing clinical competencies and leadership skills amongst their teams.

Lord Carter's report (2016) recommends the use of e rostering systems for effective staff utilisation. Factors to consider when rostering clinical staff include:

- In charge capability / competence
- Skill / band mix

- Admission / discharge profile
- Day attenders
- Theatre schedule
- Patient focused activity (case conferences and team huddles)
- Opportunities to spend increased time providing direct patient care

Flexible working within and between wards is essential to ensure patient care needs are met. Flexible working is important in retaining staff and may include:

- Part time working
- Compressed hours
- Job share
- Self rostering
- Annualised hours
- Flexible retirement schemes

Temporary staff are a valuable and valued part of the workforce, and can be a useful contingency for filling both anticipated and unanticipated staff shortages. Ideally, recruited from in house banks. Temporary staff should receive local training and indication to ensure they are familiar with how the organisation works.

Within SFH temporary staff local induction is monitored on a monthly basis and reported back to the ward sisters. Bank staff are included within the Trust induction programme and each nurse on the bank who has a substantive post with a neighbouring organisation is reviewed on an individual basis to minimise duplication of mandatory training.

Organisations should have a protocol for escalation of concerns about the safety and effectiveness of care by frontline staff to a senior level.

Trusts should collect ward and organisation metrics to monitor the impact of staffing levels on the quality of care and outcomes. Evidence informed ward metrics may focus on:

- Patient and staff outcomes (infections, falls, pressure ulcers)
- Patient and staff experience (patient and staff survey, FFT and complaints)
- Staffing data
- Process measures (hand hygiene)
- Training and education

Trusts should actively encourage staff to report an occasion where a less than optimal level of suitably trained or experienced staff harmed or seemed likely to have harmed a patient.

In early 2017 SFH introduced staffing safeguards SOP which is monitored three times daily. Against this SOP are ‘Tipping points’ to measure safety and effectiveness. This work is recognised a best practice and has been shared with NHSI.

3) An improvement resource for maternity services

Maternity services in the NHS have had significant change and development in the last decade, driven by an ambition and vision to deliver the best care to women, babies and families. Critical to delivery of this is safe, sustainable and productive staffing of maternity services.

The vision for maternity services across England is ' for them to become safer, more personalised, kinder, professional and more family friendly; where every woman has access to information to enable her to make decisions about her care; and where she and her baby can access support that is centred around their individual needs and circumstances. This is called 'woman centred care'.

Maternity staffing is central to delivering the triple aim of health and well being, care and quality, and funding and efficiency, as described in the five year forward view. It is increasingly evident that personalised care leads to safer care and better outcomes. It is also well recognised that when staff work in well led positive environments and are supported to take pride in their work, outcomes for women and babies improve.

Using Birthrate + and the Royal colleges staffing guidance should be sued in planning workforce requirements in maternity to ensure the right staff with the right skills are in place.

Use of professional judgement in assessing and planning safe staffing levels to cover the clinical workload. As this is subjective it should not be used in isolation but as a component alongside workforce tools. It may be necessary to consider local factors when assessing safe staffing, such as the ward layout and geography, distance/ proximity and access to facilities such as labour wards, theatre delivery suites, ant and post-natal wards and the neonatal unit.

Establishments should include an uplift to allow management of planned and unplanned leave for all staff and to ensure the effective management of absences.

Organisations must have robust mandatory training, development and education programmes for multi-disciplinary teams. Boards must assure themselves that sufficient staff have attended such training and are competent to deliver safe maternity care.

Conclusion

The report summarises the key points for consideration relating to the recently published national documents on staffing within the nursing and midwifery workforce. Within the appendix a gap analysis highlights those recommendations that are relevant to acute trust organisations.

The gap analysis shows that we have 4 amber rated and 1 red rated area for improvement across all three reports.

For those areas where there are areas for development these will be incorporated within the Nursing Taskforce Steering Group work stream as part of the programme of work and progress against them will be monitored on a monthly basis and reported through the Nursing, Midwifery and AHP Board.

Appendix 1

Gap Analysis on the recommendations from the following reports:

- House of Commons Health Committee – The nursing workforce - January 2018
- National Quality Board – An Improvement resource for adult inpatient wards in acute hospitals - January 2018
- National Quality Board – An Improvement resource for maternity services - January 2018

House of Commons Health Committee – The nursing workforce			
No.	**Recommendation**	**SFH Position**	**RAG**
1	Facilitation of nurse transfers between departments / wards to avoid lengthy application process	The Trust has a system in place for staff to transfer from department/ward in a timely manner. It is important to note that in areas which are difficult to recruit to, the process for transfer will be within the timescales laid down by Agenda for Change	G
2	Funding allocated to Trusts should be ring fenced for CPD for nurses	The Deputy Director of Human Resources – Training & Development ensures that all funding is allocated to the appropriate workforce group and that is fairly allocated. However, funding which is allocated to the Trust has been reduced	A
3	Nurses should be able to hand over patients to colleagues safely, without routinely staying late and have time to take their breaks	Nursing staff are able to hand over patients to colleagues safely, but will on occasions remain on the ward late due to acuity of the patients, or the busyness of the ward. All staff are encouraged to take regular breaks	A
4	There should be a greater focus on staff wellbeing	The Trust offers staff benefits, such as, My Car schemes, bikes and computers from salary sacrifice schemes. There are Yoga classes on two of the three sites. The Trust has a Staff Benefit Officer who works at the main site, but visits all three sites regularly. The Trust has recently employed two Promoting Wellbeing Leads to	G

		support the Trust in the Wellbeing agenda for our patients and staff. The Chief Nurse is keen to establish a workstream for helping women through the menopause. The Trust offers an Occupational Health service on the main site daily and on the other sites at regular intervals.	
5	Ensure Trusts communicate the role of Nursing Associates as it becomes available from Health Education England	As one of the pilot sites for trainee nursing associates the Trust and has hosted several information and engagement event over the past year. The Trust has in place a dedicated clinical educator for nursing associates. Part of the remit of this role is to work directly with clinical teams to ensure that they are aware of the role and remit of this new role.	G

NQB – An improvement resource for adult inpatient wards in acute hospitals			
No.	**Recommendation**	**SFH Position**	**RAG**
1	Annual staffing establishment review including professional judgement and decision support tool	Annual establishment reviews are undertaken within the divisions, and confirm and challenge with the Chief Nurse and the Deputy Chief Nurse.	G
2	Plans for recruitment and retention of nursing workforce	Nursing recruitment and retention is a driver in the Nursing Taskforce Steering Group, and is a standing agenda item. The Trust has developed a workforce group which is chaired by the Director of Human Resources, and drives the initiatives across all workforces including nursing. Nursing Band 5 Assessment Days are held monthly within the Trust, and these are planned to December 2018.	G
3	SOP for efficient deployment of staff to limit the use of temporary staffing	The Trust does not have a Standard Operating Procedure for the deployment of staff to reduce the use of temporary staffing. This will be captured within a refreshed staffing safeguards SOP.	R
4	Dashboard for safe staffing in use	Minimum of twice daily staffing template is shared with on-call managers and clinical managers within the Trust. This is RAG rated on the number of agency against the number of Trust nurses. Divisional Matron ensures that appropriate mitigation is available to provide assurance.	G
5	Escalation process for staffing shortfalls	Staffing shortfalls are escalated through the divisional Head of Nursing and to the Chief Nurse and Deputy Chief Nurse in hours. Out of hours the escalation of staffing shortfalls are through the Gold on-call. At times of extreme pressure, a	G

		Divisional Head of Nursing will remain on site to ensure safe staffing.	
6	Measures for recording staffing acuity and process for informing staffing safeguards	The Trust utilises 'Safe Care' module on Allocate, however this has not been embedded sufficiently, and a group of Matrons are currently undertaking some work on relaunching and embedding	A
7	Process for investigating and reporting staffing related incidents alongside feedback	The Trust utilises a mini-Root Cause Analysis documentation to report and undertake deep dives in to staffing shortfalls or the use of Tier 3 agency. Staffing related incidents that are reported through the DATIX incident reporting system are investigated as per policy	G

NQB – An improvement resource for maternity services			
No.	**Recommendation**	**SFH Position**	**RAG**
1	Boards are assured that NICE recommended Birthrate + tool for midwifery staffing is used to assess multiprofessional staffing requirement	Our twice yearly staffing papers are based on Birthrate + and cover all aspects of the maternity service and the use of skill mixing at a 90:10 ratio.	G
2	Boards are assured that results from workforce planning tools are cross referenced with professional judgement	We always apply professional Judgement when applying ratios based on our knowledge of local health needs	G
3	Boards review midwifery staffing annually	I prepare and share a midwifery staffing paper twice yearly this was last prepared in November 2017	G
4	Boards are assured that staffing reviews use the RCOG, RCoA and OAA guidelines on effective maternity staffing resource	O&G and Anaesthetic Consultant cover for maternity services is in line with recommendations in these staffing resources.	G
5	Boards are assured that sufficient staff have attended training and development and are competent to deliver safe maternity care	We are above expectation on our mandatory training currently at 93% and are just completing the extra training in Fetal Monitoring and Human factors training sourced from HEE funding	G
6	Action plans are in place to address local recruitment and retention priorities, which are subject to regular reviews	We are still very successful with recruitment and have minimal vacancies within the service. We have 2.1 WTE in the acute maternity service and 2WTE in the community which are in the active stages of recruitment.	G
7	Flexible employment options and efficient deployment of trained staff should be maximised across the hospital to limit numbers of temporary staffing	We deliver flexible working opportunities in line with service delivery with 16 staff either having a template rota or flexible working agreement. We have commenced a midwifery bank which currently has 43 midwives enrolled 40 of which do or have all worked within our services. We have minimal usage of	G

		Agency staff not having used any since January 2018.	
8	Local dashboard in place to assure stakeholders re safe and sustainable staffing, which should include quality indicators	We have a maternity dashboard which includes MW: Birth ratios and quality indicators that are shared with Stakeholders as appropriate there are no areas of concern currently – this has been supported by the recent outcomes from the national Maternity and perinatal audit.	G
9	Clear escalation processes are in place to respond to unpredicted service needs and concerns about staffing	We have a clear escalation policy for unpredicted service needs which is effectively used by all staff groups when required. The Trust uses Datix which staff can use to escalate concerns re staffing and this is monitored monthly. There are also whistle Blowing policies and freedom to speak Guardians if staff were concerned.	G
10	Establishments should include an uplift to allow for the management of planned and unplanned leave to ensure absences can be managed effectively	There is a 21% built in uplift within the Birthrate + tool	G
11	Trusts must have programmes in place for mandatory training and development for the multidisciplinary team and establishments must allow for the staff to be released for this training	We are above expectation on our mandatory training currently at 93% and are just completing the extra training in Fetal Monitoring and Human factors training sourced from HEE funding	G
12	Services should review red flag events and feedback from women, regarding them as an early warning system	We currently have a red flag audit on meridian – this is soon to be removed however we are looking to get the Birthrate acuity tool for the unit to commence in April 2018 when the Meridian audit ceases. We monitor monthly FFT results as well as compliments, concerns and complaints for emerging themes. Our current Divisional FFT average	A

		performance is 98.26% We have recently received the 2017 results of Women's experience of maternity care at Sherwood Forest which were really positive. There were some areas of concerns re timeliness and awaiting medicines prior to discharge from the inpatient ward which the team are reviewing.	
13	Trusts must investigate staffing related incidents, outcomes on staff and patients and ensure action, learning and feedback	We have a robust governance structure within women and Children's and the trust and various mechanisms for investigating incidents and sharing learning. Maternity Unit Memo's, newsletter (MUM's) goes to all staff and we support this with LIM alerts – learning in maternity. Governance meeting s are held monthly both for speciality and division – escalations are monthly to the Patient Safety Quality Board.	G