Board of Directors
Meeting Report

Subject: **Six-monthly Nurse Staffing Review – Update Paper**
Date: **April 2015**
Lead Authors: **Michele Platt**
Lead Director: **Susan Bowler – Executive Director of Nursing & Quality**

Executive Summary

This paper presents the second six-monthly review of nursing and care staffing across inpatient wards and the Emergency Department (ED) at Sherwood Forest Hospitals NHS Foundation Trust (SFHT). This review is underpinned by monthly safer staffing reports which have previously presented detailed staffing on a shift-by-shift basis at ward, divisional and Trust level to the Board, triangulated with the bi-annual Safer Nursing Care Tool acuity and dependency audit data.

The review process will be repeated six-monthly and is due for submission again in September 2015.

Recommendation
The Board is asked to

- Receive and consider the information and related risks highlighted in this report
- Note that six-monthly staffing establishment review and progress will be presented again in September 2015.

Relevant Strategic Objectives (please mark in bold)	
Achieve the best patient experience	
Improve patient safety and provide high quality care	
Attract, develop and motivate effective teams	

Links to the BAF and Corporate Risk Register	Staffing risks are contained within the BAF and divisional risk register
Details of additional risks associated with this paper *(may include CQC Essential Standards, NHSLA, NHS Constitution)*	Risk of being assessed as non-compliant against the CQC 5 domains . Potential failure to comply with NICE guidance on staffing when available Individual roles and responsibilities 'identified within 'How to ensure the right people, with the right skills are in the right place at the right time' are not met

Links to NHS Constitution	Principle 2, 3, 4 & 7
Financial Implications/Impact	An investment of £4.25 million over 3 years currently within year 2
Legal Implications/Impact	.
Partnership working & Public Engagement Implications/Impact	This paper will be shared with the CCG Quality Lead
Committees/groups where this item has been presented before	Executive Team, Trust Management Board and Nursing Workforce Forum
Monitoring and Review	This will be monitored through Trust Board, divisional forums and the nursing workforce forum. Reported Monthly via the quality and safety reports.
Is a QIA required/been completed? If yes provide brief details	No

Sherwood Forest Hospitals NHS
NHS Foundation Trust

Nursing Establishment and Staffing Review

Update Report

APRIL 2015

INTRODUCTION

In line with NHS England requirements and National Quality Board recommendations, the Trust Board received the first six-monthly Registered Nursing (RN) and Healthcare Aassistant (HCA) staffing establishment review in November 2014.

This bi-annual review is supported by monthly staffing reports which provide a summary analysis of the actual staffing in the Trust each month. Monthly reports include

- Planned versus actual nursing hours including ward, division and site, triangulated with incidents
- Workforce, vacancies and progress with recruitment
- Organisational capacity and capabilities.

Staffing compliance is scrutinised by the Ward Sisters / Charge Nurses, Matrons, Divisional Matrons and the Executive Director of Nursing and Quality to ensure that safer staffing levels are adhered to. In November 2014 the Trust Board received an initial analysis of information gathered which advised that

- The Registered Nurse to patient ratio was maintained at 1:8
- There was a continued focus on recruitment and retention
- Vacancies had reduced
- There was evidence of a move towards a 60:40 skill mix of Registered Nurses to Healthcare Assistants. .

This paper outlines the changes and actions taken since the November 2014 review and highlights the progress to date.

AIM

To provide a six-month update to the Board, outlining the actions taken and progress made alongside any new or emergent risks and their potential impact on the Trust in conjunction with national guidelines and best practice.

OBJECTIVE

This report will provide

- A summary of monthly fill rate submissions to UNIFY (planned versus actual)
- Analysis of six-monthly acuity and dependency audit data and associated evidence based staffing requirements in whole time equivalents (WTE) by ward, division and site. The Safer Nursing Care Tool (SNCT) is used to this end as recommended by NICE (2014)
- A comparison between calculated and actual staffing levels in WTEs

- A review of vacancies and mitigating actions taken
- Analysis of any correlation between staffing issues and incident rates
- Evidence to support fundamental standards, Regulation 18 from the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, which identifies that

  'Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements of this Part'.

  Alongside the CQC guidance (February 2015) which states that

  '*providers should have a systematic approach to determine the number of staff and range of skills required in order to meet the needs of people using the service.* Furthermore, they indicate that Trusts should consider *the different levels of skills and competence to meet those needs, the registered professional and support workers needed, supervision and leadership requirements'.*

This paper aims to support the Care Quality Commission's (CQC) standard that places a duty on healthcare providers to ensure that they have sufficient numbers of staff that are suitably trained to provide safe and high quality care to patients within their care.

BACKGROUND

The range and nature of services provided across the three sites at SFHT means there is no single ratio or formula that can be used to determine optimum staffing levels for all inpatient areas. For this review, a range of approaches has been used to review establishments underpinned by key publications and recommended methodologies (NICE, 2014; Shelford Group, 2014).

Safe staffing for nursing in adult inpatient wards in acute hospitals (NICE, 2014) supports a 1:8 RN to patient ratio. While this is the aim for all wards areas at SFHT, it is recognised that this ratio must also take account of ward function and specialty, acuity and dependency. The *Safer Nursing Care Tool (SNCT) Acuity and Dependency Audit* (Shelford Group, 2014) directs bi-annual monitoring of patient acuity and dependency levels in all ward areas (January/February and July/August). This data is then used to calculate evidence based recommended staffing levels in WTE.

Key principles that underpin nursing establishments:

- Sisters/Charge Nurses and Matrons are supernumerary to baseline staffing where possible
- Registered Nurse to patient ratio of 1:8 (excluding Sisters/Charge Nurses)
- Alignment of the Registered Nurse to Healthcare Assistant skill-mix ratio of 60:40, with an overall aim for 70:30
- The inpatient wards within the Planned Care & Surgery division are currently transitioning to a 60:40 ratio as of April 2015. This will increase to a 70:30 ratio by September 2015
- The inpatient wards within the Emergency Care & Medicine division are currently established to provide a 50:50 ratio, due to the number of vacancies currently this will

transition to a 60:40 ratio by September 2015 (no stretch-target has yet been agreed thereafter)

- The current process of monitoring a range of safety and nurse-sensitive indicators to inform changes to staffing that will provide consistent safe care.

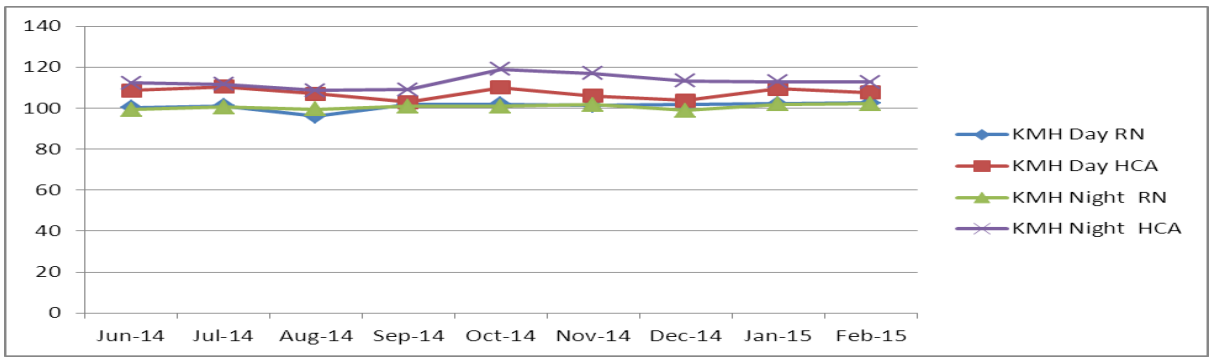
Regular reports have been provided to the Board and focus on the following key areas of practice

- Monthly fill rates (comparing planned with actual staffing on a shift by shift basis)
- Monthly workforce issues including vacancies, sickness and absence reporting and use of additional bank and agency staff
- Monthly incident reporting (initially medications and falls, but now including pressure ulcers and staffing issues) correlated with staffing issues
- Six-monthly SNCT audits of acuity, dependency and associated staffing calculations (Maternity data is provided in Appendix 1)
- Mitigating issues and narrative reports pertaining to specific non-compliance issues.

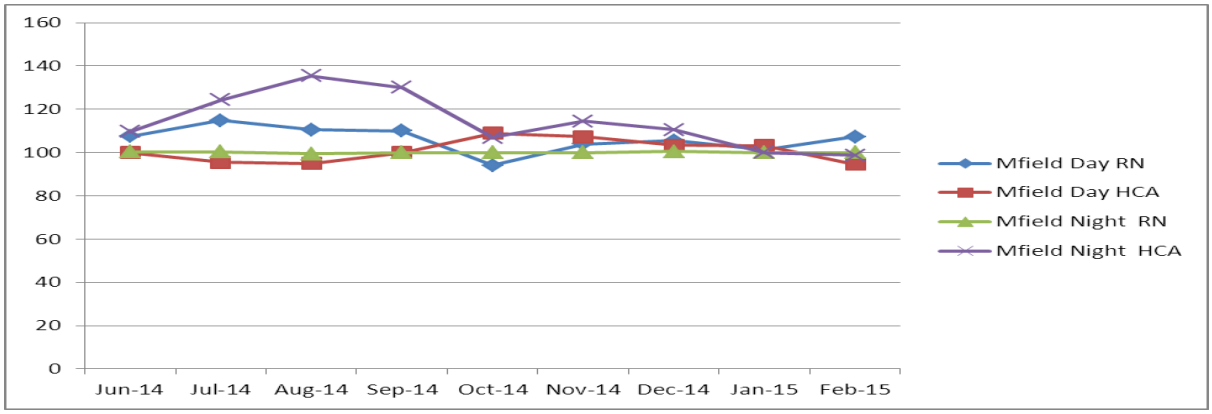
FILL RATES

Fill rates are calculated on a daily shift-by-shift basis and reported monthly via the UNIFY national database. There are currently no national fill rate standards set of which creates difficulties when attempting to compare and contrast performance across organisations. Local monitoring however highlights wards where staffing is either below 90% (under-filled) or above 110% (over-filled). This data identifies the proportion of shift coverage for days and nights by both Registered Nurses and Healthcare Assistants. The run charts below illustrate the percentage (%) coverage for the three sites across SFHT. In all three charts, the purple line indicates that the night Healthcare Assistant (HCA) staffing was over-filled for most months, in the main this was to fulfil enhanced care requirements (for example, using one-to-one care for patients at high risk of falls). Most recent available data (February 2015) indicates that this continues, but only two wards (out of a total 31) were under-filled with Registered Nurses on the day shift and one ward was under-filled with Registered Nurses on the night shift. Ten shifts were overfilled with Healthcare Assistants on the day shift and 15 on the night shift.

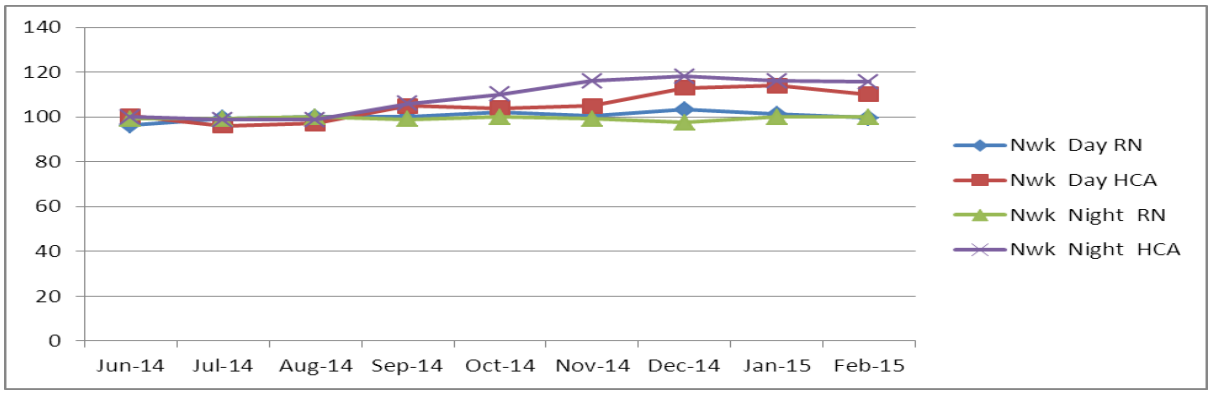
Run Chart 1. Kings Mill Hospital Site



Run Chart 2. Mansfield Community Hospital Site



Run Chart 3. Newark Hospital Site



The Reducing Harms team provide additional staffing support on wards where patients are identified as requiring enhanced care to meet their acuity / dependency needs. The service is currently available during daytime duty periods, current provision of service is currently under review.

Following on from a serious incident and subsequent inquest of which resulted in a Prevention of Future Death notice being issued; the coroner expressed concern regarding the Trust's capacity for the provision of safe care during night duty periods. Specific reference was made by the coroner to the proposed reduction in night time staffing levels (from 3 Registered Nurses and 2 Healthcare Assistants to 3 Registered Nurses and 1 Healthcare Assistant). The case of need for altering the numbers and skill mix on our generic wards identifies how this risk will be reduced / mitigated. A response is currently being formulated for the coroner that explains the rationale for realigning the night numbers whilst managing the risks. It has been stated that we will not be reducing the use of the harms teams or additional staff to support the requirement for enhanced care, as safety will always take precedence within our decision making.

VACANCIES & USE OF TEMPROARY STAFFING SOLUTIONS

In order to accommodate a sustained increase in non-elective activity over the Winter (2014/15) a decision was made to temporarily commission additional bed capacity across four clinical areas; this had a direct impact on overall staffing levels and an increased

requirement temporary staffing solutions. Additional bed capacity was commissioned across the following areas:

- Ward 21 – 24 beds were temporarily commissioned to support non elective activity within the Emergency Care & Medicine division. (The Ward was decommissioned in December 2014 by PC&S)
- Ward 54 – 4 beds were temporally commissioned to support non elective activity within the Emergency Care & Medicine division.
- Emergency Assessment Unit (EAU) – 10 additional beds commissioned
- Day Case Unit (DCU) – an additional 8 beds were commissioned overnight, up to 18 beds at weekends and 10 beds on the 'trolley' side.

Vacancies for both Registered Nurses and Healthcare Assistants are reported in Table 1 below (August 2014 – March 2015). It is important to note that the way in which vacancies are reported and calculated generates some anomalies. Vacancies are recorded as a positive numeral while any over-establishment is recorded as a negative figure. This means that, when summated, the over-establishments negate some of the vacancies. While this is helpful to provide an overall picture of vacancies across the Trust, it does not present a clear indication of the ongoing vacancies where staff cannot always be freely moved between wards and departments. When the data is viewed from this different perspective, using the March 2015 (b) data as an example, a further 15.29 WTE RN vacancies and 10.34 WTE HCAs are identified.

Table 1. Nurse Staffing Vacancies Across SFHT (August 2014 - March 2015)

Month	Registered Nurses (WTE)	Healthcare Assistants (WTE)
Aug 14	129.09	65.94
Sept 14	74.03	39.85
Oct 14	60.87	50.69
Nov 14	67.08	71.65
Dec 14	80.8	76.31
Jan 15*	58	31
Feb 15	79.39	65.15
Mar 15 (a)	91.21	36.31
Mar 15 (b)	*106.5*	*46.65*

Data Source HR Monthly KPI Dashboard

**January 2015 reduction related to decommissioning of Ward 21and redeployment of staff*

Table 2. Use of Additional Healthcare Assistant Shifts Versus The Proportion Provided by Agency Staff

	Additional HCA *shifts* used	
	Total	***Agency***
Aug 14	553	217 (39%)
Sept 14	545	204 (37%)
Oct 14	767	167 (22%)
Nov 14	864	167 (19%)
Dec 14	656	121 (18%)
Jan 15*	743	165 (22%)
Feb 15	708	143 (19%)

Mitigating for the associated risk, any current vacancies have been supported with regular bank staff, agency nurse usage and fixed term contracts. Whilst a decision was made to temporarily halt recruit to Healthcare Assistant positions across the organisation in order to support transition to the new nursing model; the nurse bank have continued to actively recruit to mitigate operational disruption during this time. Table 2 above summarises the associated Trust-wide use of additional HCA shifts, predominantly for enhanced care. This highlights an overall decreasing proportion of agency usage in this staff group.

Table 3 below illustrates the total number of combined Registered Nurse and Healthcare Assistant vacancies by division between September 2014 and February 2015. Again this data is taken from the HR KPI data where under-fills are counterbalanced in part by some over-fills. Total vacancies have however reduced overall.

Table 3. Vacancies By Division (September 2014, February & March 2015).

	PCS		**NWK**	**ECM**	**MCH**	**Maternity**	**NICU**	**TOT**
		Wd 25						
Sept 14	5.74	1.79	7.89	90.79	4.67	9.9	4.15	**128.06**
Feb 15	-4.96*	2.19	7.91	82.9	2.92	5.9	-1.23	**95.63**
Mar 15	-6.37	1.22	8.7	84.32	2.92	7.47	-2.03	**96.23**

**Negative numbers represent no vacancies and an over-establishment*

When individual ward's most recent vacancy data was interrogated for February and March 2015, some 'hot spots' were identified (those wards with five or more Registered Nurse and Healthcare Assistant combined WTE vacancies). The majority of these are within the Emergency Care & Medicine division as illustrated in table 4 below. Again, the anomalies in

the data have been highlighted where over-fills are summated as negative numerals, and 'adjusted' totals are simultaneously reported in the following table.

Table 4. Vacancy 'hot spot' wards (February and March 2015).

	Ward	Sconce	23	24	33	34	52	Stroke	35	EAU
Feb 2015	**RN**	4.42	7.01	4.55	8.45	5.61	7.98	14.94	7.01	11.14
	HCA	3.07	2.23	3.64	(-0.33)	1.35	(-1.12)	1.22	(-0.48)	4.92
	Total	7.49	9.24	8.19	8.12	6.96	6.86	16.15	6.53	16.07
	Adjusted				*8.45*		*7.98*		*7.01*	
Mar 2015	**RNs**	4.42	7.02	5.47	8.45	5.61	8.98	13.94	7.05	11.13
	HCAs	3.86	2.21	2.64	(-1.33)	1.34	(-1.00)	1.22	1.93	5.92
	Total	8.28	9.23	8.11	7.12	6.95	7.98	15.15	8.98	17.06
	Adjusted				*8.45*		*8.98*			

**Adjusted totals use zero for any over-establishment in the summation.*

Mitigating action has been taken in each of the identified aforementioned hot spots.

Sconce ward

Bed capacity has been temporarily reduced to 26 to allow for the existing vacancies. A proposal regarding a future bed model is pending. Acuity and dependency has been recently assessed

Ward 23

The overall nursing establishment has been reduced following a review of service provision and skill mix. Permanent reduction in the establishment has reduced the vacancy rate.

Wards 24, 33, 34, 35 and 52

Internal moves from areas with lower patient dependency to these areas of higher dependency have been implemented to mitigate the risks. Two staff have been transferred from Ward 36 to Ward 33 to support Ward 33 vacancies

Stroke unit

This ward has moved to a 70:30 skill mix of which reflects the hyper acute element of stroke care. Recent recruitment to vacancies has been successful. Since April 2015, 4 beds have been reduced on the Stroke Unit; this helps to mitigate these risks. We have recruited 4WTE but these have not been included within the vacancy factor. Further stroke specific recruitment has commenced with an additional 6 candidates shortlisted for interview. A recent Internal Assurance Visit scored this ward as 'outstanding' within a self-assessment.

Emergency Assessment Unit (EAU)

As of 21st April 2015, EAU have fully recruited into all vacancies. These staff will join incrementally over the next 5 months.

Note: The HCA vacancies have been managed to support the transition to a greater Registered Nurse complement

INCIDENTS

Each month the nurse staffing fill rates are compared against reported incidents for falls, pressure ulcers, medication errors and staffing issues. Table 5 and the associated bar chart below illustrate the number of incidents reported (April 2014 – March 2015) and this indicates an increasing upward trend.

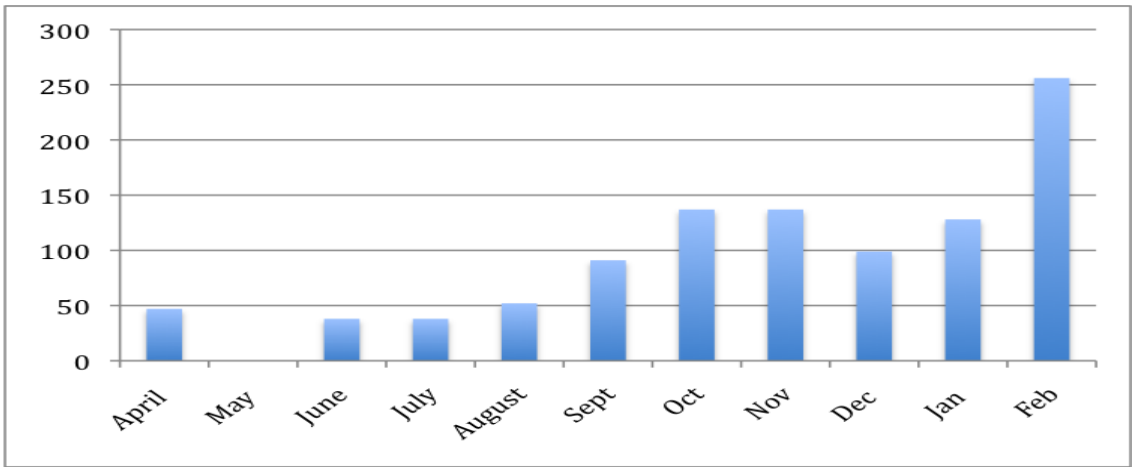
Table 5. Incidents reported by month (April 2014 – February 2015).

Month	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb
No of incidents	47	ND*	38	38	52	91	137	137	99	128	256

**ND no data*

The overall increase in reported incidents is explained in part by a more transparent reporting system and recent improvements to the Trust's risk management reporting system (Datix), but also an increase in types of incidents reported monthly against staffing data. Initially (April – July 2014) medication and falls with harm were reported, with staffing incidents added in August 2014 and pressure ulcers in December 2014. The sudden increase in reported incidents in February is due to a decision to report all falls, not just those that resulted in harm. While there was some concern that staffing issues and incidents might be inter-related, when data were compared there was no clear correlation between the under-filled wards (less than 90% of the planned staffing) and untoward incident rates. Arguably, this is a crude measure and while some association may be identified, cause and effect is difficult to rationalise. For example, in January 2015, 24 incidents occurred on the under-filled wards and 104 on the over-filled wards. In December 2014 however Ward 33 reported a cluster of 12 incidents, sufficient to raise concerns and prompt closer observation. This pattern did not continue into January 2015.

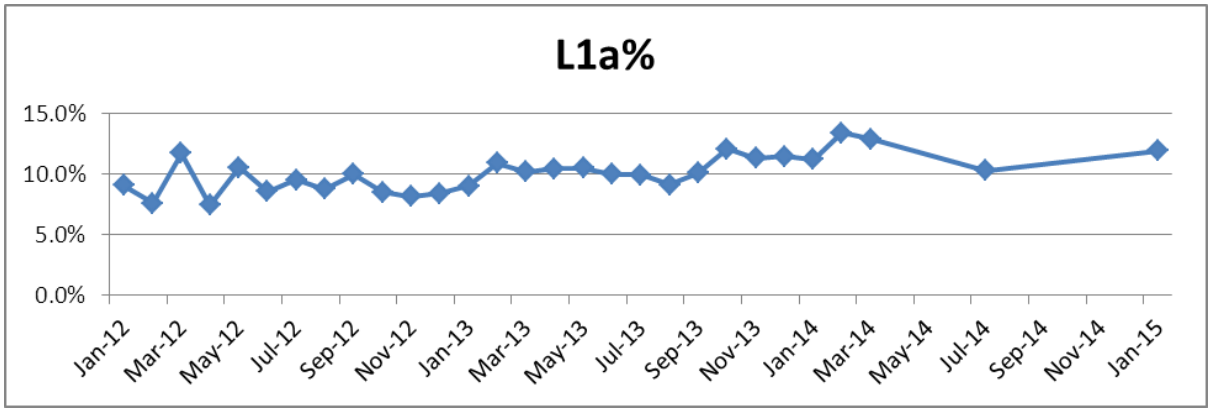
Bar Chart 1. Incidents Reported By Month (April 2014 – February 2015)



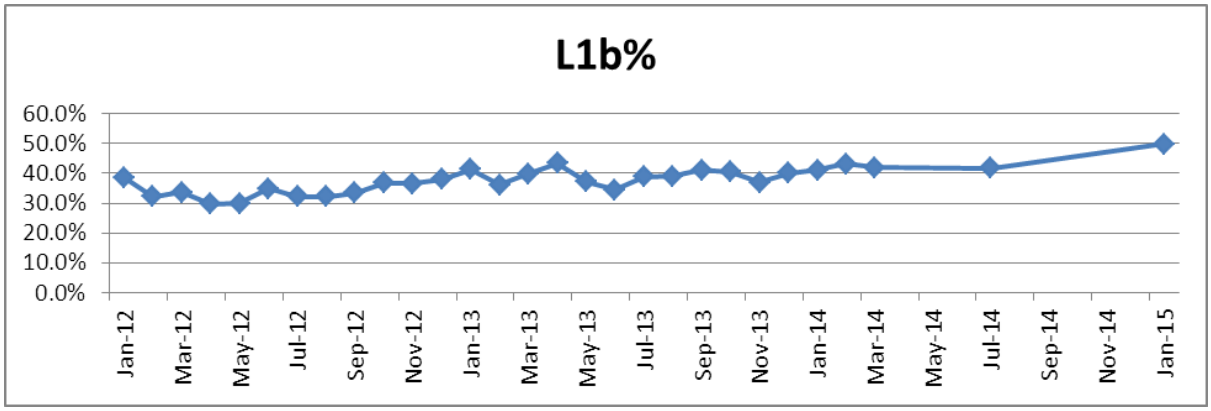
ACUITY, DEPENDANCY AND ASSOCIATED STAFFING: SAFER NURSING CARE TOOL (SNCT)

The SNCT data provides evidence regarding levels of patient acuity (Level 1a), dependency (Level 1b) and high dependency (Level 2 with support for one failing organ) on adult in-patient wards across the Trust. Previously collected monthly, this data is now collected at six-monthly intervals, most recently in July/August 2014 and January/February 2015. For continuity of information and comparison, the run charts below show the Trust wide levels of care from January 2012.

Run Chart 3. Proportion Of Patients (%) Requiring Level 1a Care (Acutely Ill Patients).



Run Chart 4. Proportion Of Patients Requiring Level 1b Care (Highly Dependent On Nursing)



These charts indicate that the proportion of patients requiring higher levels of ward-based care (Level 1a and Level 1b), that is, above normal ward level care (Level 0), has been variable over the last two years, but with an overall upwards trend. Most recent data for January 2014 to January 2015 shows

- Level 1a (acutely ill adults): range 11-13.4%
- Level 1b (highly dependent adults): range 41-49.8%

In the summer, July/August 2015, 8423 (52%) of the 16025 patient episodes audited required more than normal ward level care (Level 0). In winter, January/February 2015, this increased where 9646 (62%) of the 15449 episodes audited required more than normal ward

level care. In short, this data identifies an increasingly complex and acute patient case-mix. This is summarised in table 6 below.

Table 6. Raw Numbers And Proportion Of Patients And Level Of Care Required.

	Level 0	**Level 1a (acuity)**	**Level 1b (dependency)**	**Level 2**	**Empty**	**Total Episodes Audited**
July 14%	6434 *40.1*	1654 *10.3*	6674 *41.6*	95 *0.6*	1168 *7.3*	16025
Jan 15%	5768 *37.3*	1844 *11.9*	7700 *49.8*	102 *0.7*	1285 *8.3*	15449

The SNCT provides a nationally recognised, evidence based method for calculating Registered Nurse and Healthcare Assistant establishments in WTEs. Table 7 below illustrates the staffing levels (WTE) for each ward as calculated from the last two audits (July 2014 and January 2015). It is important to note however that this audit provides a 'snap shot' of patient acuity at 14:00-15:00hrs every day and therefore does not account for considerable changes in patient acuity, dependency or flow through ward areas. The calculated staffing is provided as total nursing WTEs and does not indicate skill-mix; this is set locally. Non-inpatient areas, Day Case Unit, Emergency Department, and Paediatric Wards are excluded from the audit and the tool is only ratified for use in adult inpatient wards. Current establishment is compared with the SNCT calculated WTE and in the main, this is set above the calculated level indicated by the most recent audit data and the tool (colour-coded green and amber). Wards 12, 33, 42 and 22 have current establishments set below the SNCT indicated WTE (colour-coded red).

Of the red-rated wards, wards 12 and 33 have been highlighted as areas of concern and are currently undergoing focussed review. The deficit on Ward 22 may be explained by a shift in patient case-mix and specialty. On Ward 42 the deficit may be rationalised by seasonal variation.

Total WTEs required (including registered and non-registered staff) for the wards participating in SNCT has increased over the last year in conjunction with a rise in both Level 1a and Level 1b care:

	Staffing	Level 1a	Level 1b
• July 2014	**824 wte**	**10.3%**	**41.6%**
• January 2015	**897 wte**	**12%**	**49.8%**

It is anticipated that levels of care will continue to raise with an increasing elderly population, with complex conditions and multiple co-morbidities, further developments in technology,

movement of care into the community and patient expectations, thus nurse staffing levels will need to increase accordingly.

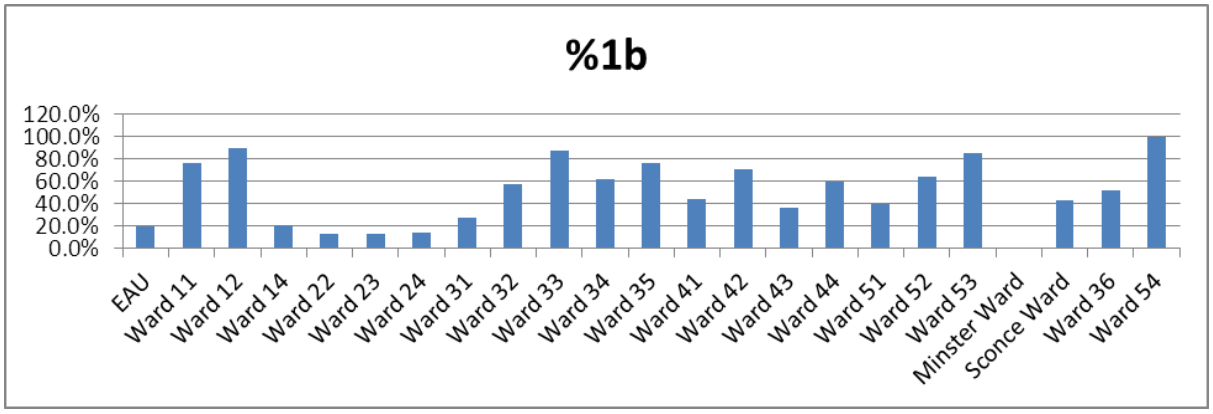
Table 7. SNCT Staffing (WTE) Calculations: A Ward Level Summary.

Ward	SNCT calculated		Current Establishment	Ward	SNCT calculated		Current Establishment
	July 14	Jan 15			July 14	Jan 15	
21	31	NA	**NA**	**23**	28	29	**45.92**
31	30	30	**33.27**	**24**	28	28	**35.24**
32	31	33	**33.59**	**43**	29	31	**38.67**
14*	23	25	**47.35**	**44**	31	31	**34.05**
11	31	36	**39.28**	**33**	36	39	**35.49**
12	37	39	**33.5**	**34**	34	35	**34.69**
				42	36	38	**34.82**
Chatsworth	20	23	**32.92**	**41**	21	31	**34.22**
Lindhurst	25	28	**31.68**	**51**	29	31	**35.86**
Oakham	27	27	**30.09**	**52**	31	35	**42.86**
				53&54	65	72	**75.58**
EAU	70	72	**82.72**	**35**	34	37	**36.37**
Sconce	30	40	**42.24**	**36**	23	31	**35.03**
Minster	ND	6	**14.06**	**22**	40	41	**34.2**

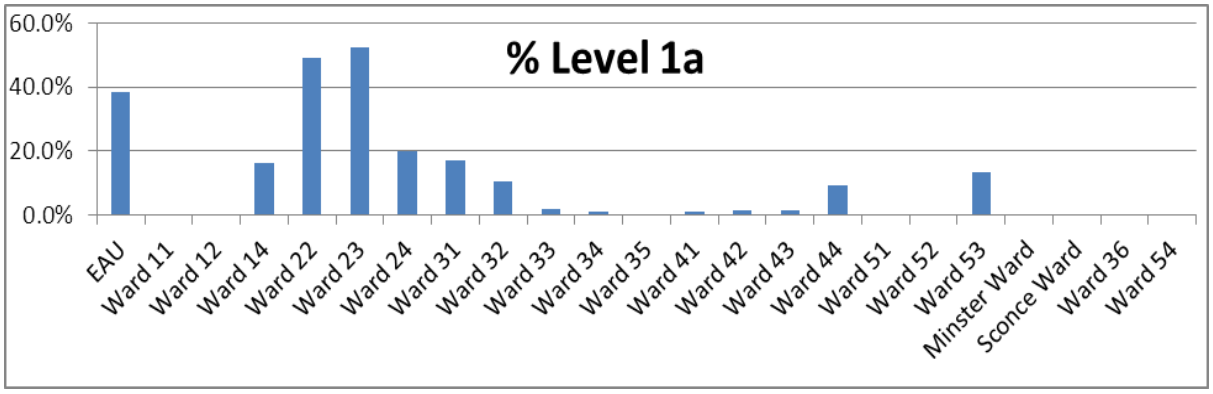
**Configuration changed since audit was carried out*

Bar chart 2 below highlights the wards where the most dependent patients (Level 1b) are being nursed, namely Wards 12, 33 and the Stroke Unit (illustrated here as Wards 53 and 54). Bar chart 3 below illustrates the proportion of acutely ill patients (Level 1a) found on each Ward. As expected, Ward 23 with monitored cardiology patients registered highest, but Wards 14, 22, 24, 31, 32, 44 and 53 all returned data indicating a highly acute patient caseload. It is important to note that Ward 43 appears, in the chart below, eroneously as a low acuity area. This is because the non-invasive ventilation unit patients are not categorised as Level 1a, rather they are identified as the more acutely ill Level 2 care, akin to that delivered in the High Dependency area of the Integrated Critical Care Unit (ICCU).

Bar chart 2. Proportion Of Patients Requiring Level 1b Care (January/February 2015).



Bar chart 3. Proportion Of Patients Requiring Level 1a Care (January/February 2015).



It is hypothesised that low acuity and/or low dependency wards may be better able to carry higher vacancy rates, while the high acuity/dependency areas may not fare so well. When acuity and dependency data (January/February 2015) is triangulated with the vacancy rates (February 2015) it is clear that these wards represent areas of potential high risk. For example, Ward 33 has a high vacancy rate, high patient dependency levels and in December 2014 high number of incidents. This renders it a potentially high risk ward and a focus of attention for prioritised work. Table 8 highlights that the 'hot spot' wards, with high vacancy rates also have a patient case-mix with high acuity and/or high dependency.

Table 8. Vacancy 'Hot Spot' Wards With High Acuity Or Dependency (February 2015).

Ward	Sconce	23	24	33	34	52	Stroke	35	EAU
Vacancy (%)	18	20	23	23	20	18	21	18	21
1a: High acuity (%)		52	52						38.3
1b: High dependency (%)	43	13.5	13.5	87	62.4	63	95	76.4	20.2

Ward 33 has been recommended as one of the wards that is considered for closure under the Ward Closure CIP programme. A new matron has been introduced and a senior nurse has been asked to review the leadership and culture of the ward. During this phase increase support /focus is being given via the Divisional Matron

PROGRESS / NARRATIVE / MITIGATION

Following the last establishment review reported to the Board in November 2014, the key actions that have been progressed are as follows

- Systems are in place and divisional teams continue to provide monthly staffing reports
- Standard systems have been embedded regarding staffing levels capacity and capability on a shift by shift basis, enhanced by E-rostering.
- Monthly updates presented to the Board are available on NHS Choices for transparency, following upload onto the national database UNIFY.
- Information about Registered Nurse and Healthcare Assistant on each shift is now displayed in all inpatient areas. Staffing levels are formally reported three times per day via the capacity and flow bed meetings whereby respective Matrons and on-call teams address gaps in provision to mitigate risk on a daily basis. This is reported daily to the Director of Nursing.
- Staffing compliance is scrutinised monthly by the Divisional Matrons and the Executive Director of Nursing and Quality to ensure standards are adhered to.
- The Registered Nurse to patient staffing ratio is no less than 1:8 in all inpatient areas at the Kings Mill site. Indeed, some areas exceed this minimum, for example specialist areas such as the Integrated Critical Care Unit (ICCU) where a 1:1 nurse patient ratio is achieved for all level 3 patients and 1:2 for all level 2 patients in accordance with national guidance (Faculty of Intensive Care Medicine, 2013). Similarly, in the Non-invasive Ventilation Unit on Ward 43 the ratio is 1:4. The wards at the Mansfield Community Hospital site however are currently staffed at a ratio of 1:12, but are transitioning to the new smaller caseloads as recruitment progresses.
- The skill-mix, that is, the proportion of Registered Nurses to Healthcare Assistants has been monitored on the in-patient wards. In October 2014 the skill mix across these wards was reported as 55.99% RNs to 44.01 HCAs. This is predicted to reach 59.55: 40.45 by September 2015 and subsequently 63.83: 36.1 by March 2016. Implementation of Allocate ‘Health Roster’ which will replace the current SMART system will be completed by 31st March 2016 and this will enable the Trust to monitor skill-mix across all wards and the Trust as a whole. Furthermore, it will facilitate close monitoring of staff movement between wards. The addition of the Safe Care module will enable triangulation of staffing roster data with patient dependency data.
- The SNCT is now collected bi-annually (January/February and July/August) to identify acuity and dependency levels, as recommended by NICE (2014). To date, compliance with data collection has been variable. In the January 2015 dataset however 100% compliance was achieved by all contributing wards and it is anticipated that reducing data collection from daily to bi-annual will help to maintain this level of data input.

- Dashboards, nursing metrics, incidents and complaints are reviewed monthly by Sisters/Charge Nurses, Matrons, Divisional Matrons and the Executive Director of Nursing and Quality. This is scrutinised in conjunction with safer nurse staffing levels to provide assurance to the Board that safety and quality are maintained and appropriate action taken.

This review has identified that

- All wards achieve the required minimum ration of 1:8 (except two wards at Mansfield Community Hospital).
- The majority of wards achieve greater than 90% fill rates during the day shift
- Overall staffing shows a 55.99% RN to 40.45% HCA (October 2015) and a move continues towards an aim of 70:30.
- 19 of the 25 wards monitored with SNCT have a staffing establishment WTE above that indicated by the evidence based tool
- The Trust continues to deliver additional Healthcare Assistant level care in excess of planned staffing to mitigate for associated risks to care and quality. This has resulted in use of bank and agency staff but in February 2015 this did not exceed 20%.

In order to ensure the on-going safety and quality of care of SFHT inpatient wards the current strategy aims to

- Move to a 70:30 skill mix through a transition period of one year (by March 2016).
- A new recruitment and retention strategy is in place for nursing and care staffing with specific focus on :
    - Marketing – with the support of a public relations company, a campaign has been implemented including the use of social media, local radio, East Midlands News and an Open Day planned for 25th April 2015. There are 36 confirmed candidates for interview and another 20 applicants showing an interest. This does not include potential applicants who turn up spontaneously. Stands, refreshments and demonstrations have been arranged. Many Trust staff have volunteered to work Saturday to support this day.
    - On-going advertisements for Band 5 staff nurses and focused speciality recruitment campaigns using journals and local press
    - Cohort recruitment from the local university (next clearing house 30th April 2015). 53 students have applied for interview on Thursday 30th April2015.
    - Flexible family friendly staffing policies
    - Staff feedback response, exit interviews
    - International nurse recruitment plan (including tender to an outside agency for 40 European nurses and 40 non-European nurses, targeting India).

- A return to practice strategy, in line with the national campaign ‘Come Back’, led by Health Education East Midlands (HEEM) to encourage nurses who are currently no longer practicing back to work. This includes a national and local public relations campaign (for example, leaflet drops and a coffee morning) and working more closely with local higher education institutions to facilitate the return to work pathway. An interview day hosted jointly with Derby University resulted in the successful recruitment of six candidates due to start in September and January. Return to practice opportunities are advertised on all recruitment materials and the Trust’s website.
- Providing good support for preceptorship RNs. Recently the Trust has received 35 applications from Lincoln University students. A recruitment fair is planned and clearing house recruitment continues.

- A pilot audit is underway on two Wards at the Kings Mill site and Sconce Ward at Newark to investigate ways in which the SNCT can be used prospectively to identify areas of risk. Currently the data is used retrospectively, but the use of a ‘staffing score’ in real time may augment daily staffing reviews.
- Close additional winter capacity (Phased plan in place from April 2015)
  - Repatriate Trust nursing staff back to their base wards
  - Reduce on-the-day movement of staff (and raise morale)
  - Improve staffing levels on existing wards
  - Reduce use of premium cost temporary staff
- Reduce widespread reliance on temporary staffing
  - Fewer wards pulling on the pool of available bank and agency staff enables wards with vacancies to fill their vacant shifts with temporary staff
  - Reduce the reliance on the Reducing Harm team
  - Facilitate effective management, especially out of hours, for the site coordinators
- Rotation of specialist nurses
  - Specialist nurses have been asked to support their specialty wards, if their job plan allows (not to the detriment of direct patient care and clinical activity).

Michele Platt,

Nurse Consultant Critical Care

Susan Bowler

Executive Director of Nursing

References

NICE (2014) Safe staffing for nursing in adult inpatient wards in acute hospitals found at https://www.nice.org.uk/guidance/sg1 last accessed 13/04/15

FICM (2013) *Core Standards for Intensive Care Units* found at http://www.ficm.ac.uk/news-events/core-standards-intensive-care-units Last accessed 13/04/15

National Quality Board (2013) *How to ensure the right people with the right skills, are in the right place at the right time* found at http://www.england.nhs.uk/wp-content/uploads/2013/11/nqb-how-to-guid.pdf last accessed 13/04/15

Appendix 1.

Staffing Paper for Maternity Staffing (Using Birthrate plus principles)

Total Service Review April – March 2015

Booking, caseload and birth figures obtained from the maternity dashboard April –March 2015.

Total WTE Required 1:42 ratio	Total Funded WTE (Inc. MSW Ex. HOM)	Total WTE in post (Inc. MSW Ex. HOM)
135	127.4	120

Activity	Ratio Applied	WTE Required	Funded WTE
Hospital Births	1:42	77	77.6
Home Birth	1:35	4.8	41.3 (Inc. MSW
Community Caseload	1:98	42.6	
Specialist and management Roles***	9%	11.2	8.5 wte Ex. HOM
Total		135	127.4

Midwife to Birth Ratios

Midwife to birth ratios are calculated more crudely by using those only involved in direct care and would therefore exclude those highlighted as specialist or management roles***. On current birth figures for the year 2014/15 3429, an increase of 4.3% on the same period last year and on current establishment numbers the current ratio would be 1:28.8.

Supervision of Midwifery

Supervision of Midwifery is a statutory function and working caseloads should have a ratio of 1:15. This is not currently factored within the work force or high level birthrate calculation but can be considered as apart of a more detailed review. We currently have nine appointed Supervisors of Midwives and a midwife about to be appointed. Current caseloads range from 1:16 to 1:18 at Sherwood Forest Hospitals. The future of Supervision is as yet undecided but it is thought that the Midwives act will be changed within the next two years.

Alison Whitham, Head of Midwifery, April 2015

Appendix 2. Summary / Raw Data

	December		January		February			March				
Ward	**TOTAL RN**	**HCA**	**RN Vac**	**HCA Vac**	**RN Vac**	**HCA Vac**	**Total**	**RN Budget**	**RN SIP**	**RN Vac**	**HCA Vac**	**Total**
22	2.61	2.66	1.61	2.66	1.61	0.66	2.27	18.4	16.19	2.21	0.66	2.87
23	6.02	2.21	7.02	2.21	7.01	2.23	9.24	33.31	26.29	7.02	2.21	9.23
24	3.76	2.52	6.56	2.84	4.55	3.64	8.19	19.45	13.98	5.47	2.64	8.11
33	8.45	3.80	7.45	1.80	8.45	-0.33	8.12	19.09	10.64	8.45	-1.33	7.12
34	5.61	1.34	5.61	1.34	5.61	1.35	6.96	18.38	12.77	5.61	1.34	6.95
35	6.01	1.16	6.01	-0.48	7.01	-0.48	6.53	20.81	13.76	7.05	1.93	8.98
36	4.56	0.98	2.76	-0.02	2.76	-0.02	2.74	19.41	16.69	2.72	-1.02	1.70
41	4.82	1.53	4.82	-0.47	4.03	-0.47	3.56	18.24	15.22	3.02	-0.47	2.55
42	5.42	1.05	3.42	0.05	3.41	0.05	3.46	18.82	14.40	4.42	0.05	4.47
43	-0.57	1.94	0.47	1.94	1.48	1.94	3.42	22.84	22.37	0.47	3.54	4.01
44	1.94	0.72	-0.06	1.68	-0.06	1.67	1.61	18.58	18.64	-0.06	1.68	1.62
51	4.23	0.00	2.23	0.17	4.08	-0.80	3.28	19.98	15.33	4.65	-0.80	3.85
52	5.98	1.88	6.98	-1.12	7.98	-1.12	6.86	24.38	15.40	8.98	-1.00	7.98
Stroke Unit	13.94	1.38	14.94	1.22	14.94	1.22	16.15	48.83	34.89	13.94	1.22	15.15
Oakham	1.22	6.40	-0.17	6.40	-0.18	6.40	6.22	15.58	15.75	-0.17	1.80	1.63
Lindhurst	-0.62	5.10	-1.22	5.10	-1.22	6.10	4.88	16.18	17.40	-1.22	3.90	2.68
Chatsworth	-1.20	2.10	-2.20	2.30	-2.19	2.30	0.11	14.88	16.08	-1.20	0.30	-0.90
21	-1.53	-0.55	0.00	0.00	-1.00	0.00	-1.00	0	#N/A	0.00	0.00	0.00
31	-2.26	0.95	-1.90	1.67	-0.90	1.67	0.78	17.45	18.05	-0.60	1.67	1.07
32	-0.02	3.32	-3.22	1.32	-2.22	1.32	-0.90	17.58	19.80	-2.22	1.32	-0.90
11	-0.09	3.31	-0.73	1.31	-0.09	1.31	1.23	18.66	19.75	-1.09	1.31	0.23
12	3.02	1.20	-0.94	1.20	-0.98	1.20	0.22	17.62	18.60	-0.98	1.20	0.22
14	2.86	2.95	-1.25	-1.17	-4.85	-2.95	-7.80	24.79	30.64	-5.85	-2.95	-8.80
25	1.64	1.56	1.62	0.56	1.59	-0.21	1.38	38.24	37.62	0.62	-0.21	0.41
Sconce	3.92	2.50	3.92	2.50	4.42	3.07	7.49	19.66	15.24	4.42	3.86	8.28
Fernwood	0.84	-0.86	0.84	-0.86	0.84	-0.86	-0.02	6.64	5.80	0.84	-0.86	-0.02
Day Case Unit	0.20	0.40	0.20	-1.40	0.20	-2.00	-1.80	23.04	23.04	0.00	-1.40	-1.40
EAU	9.33	4.71	10.13	4.92	11.14	4.92	16.07	45.2	34.07	11.13	5.92	17.06
ED	1.82	4.38	1.56	4.02	1.54	4.02	5.56	52.07	48.82	3.25	5.02	8.27
ICCU	3.08	0.06	0.08	0.06	0.08	0.13	0.21	50.53	49.35	1.18	0.13	1.31
MATERNITY	4.80	1.80	5.83	1.19	3.52	1.19	4.71	67.1	63.63	3.47	2.76	6.23
NICU	-1.97	1.47	-1.05	0.05	-1.11	0.05	-1.06	22.81	24.72	-1.91	0.05	-1.86
KTC	1.93	1.12	2.13	1.52	2.68	1.52	4.20	36.68	33.24	3.44	2.12	5.56
MINSTER	0.30	0.00	0.44	0.00	0.44	0.00	0.44	9.33	8.89	0.44	0.00	0.44
MIU	3.88	0.00	3.88	0.00	3.88	0.00	3.88	16.59	12.87	3.72	0.00	3.72