Paper 3

Reporting to:	**Trust Board - 28 November 2013**
Title	Improving Quality and Safety - A review of nurse staffing levels across adult inpatient wards
Sponsoring Director	Acting Director of Nursing and Quality
Author(s)	Acting Director of Nursing and Quality
Previously considered by	Quality and Safety Committee
Executive Summary	Following the publication of the Francis, Keogh and Berwick reports there has been considerable debate over safe nurse staffing levels and how assurance can be gained that these are set and maintained appropriately. A review of nurse staffing levels across the Trust's adult inpatient wards was conducted using an evidence based, layed methodology in order to ensure both scrutiny, evaluation and challenge. As a result of this review a significant increase in nursing establishments is recommended plus improved robustness to assurance arrangements relating to nurse staffing.
Strategic Priorities ☒ Quality and Safety ☒ Healthcare Standards ☐ People and Innovation ☐ Community and Partnership ☐ Financial Strength	**Operational Objectives** QS1 Reduce avoidable deaths QS2 Improve the nutritional status of patients and hydration and fluid management QS3 Enhance communication and information for all patients and their carers QS4 Eradicate all avoidable grade 3 and 4 pressure ulcers QS5 Reduce the number of RIDDOR reportable falls HS2 Improving the timely flow of patients from admission to discharge HS3 Deliver all key performance targets
Board Assurance Framework (BAF) Risks	☒ Deliver Safe Care or patients may suffer avoidable harm and poor clinical outcomes and experience ☒ Implement our falls prevention strategy to help prevent patients suffering serious injury ☒ Achieve safe and efficient Patient Flow or we will fail the national quality and performance standards ☐ Clear Clinical Service Vision or we may not deliver the best services to patients ☒ Good levels of Staff Engagement to get a culture of continuous improvement or staff morale and patient outcomes may not improve ☐ Appoint Board members in a timely way or may impact on the governance of the Trust ☐ Achieve a Financial Risk Rating of 3 to be authorised as an FT

Care Quality Commission (CQC) Domains	☒ Safe ☒ Effective ☒ Caring ☐ Responsive ☐ Well led
☐ **Receive** ☐ **Review** ☐ **Note** ☒ **Approve**	**Recommendation**

Improving Quality and Safety - Nurse Staffing Review of Adult Inpatient Areas

Background and context

Following the publication of the Francis (2013) and Keogh (2013) reports, safe nursing staffing levels have been ever more highlighted as being of critical importance in delivering high quality, safe and effective care. As further clarity has been provided by these recent publications around a framework for reviewing such levels, the acting Director of Nursing and Quality, supported by senior operational nurses, has conducted a review of the current Trust position, and using a variety of supporting evidence has reached a number of recommendations for consideration by the board.

In addition to providing appropriate numbers of staff it is also necessary in line with action area 5 of Compassion in Practice (2013), the Chief Nursing Officer's vision for nurses, midwives and care givers, to ensure that the "right staff with the right skills are in the right place." Hence while this staffing review focuses on ensuring that our numbers and ratios of staff are safe and appropriate, further work on supporting our nursing staff to have the right skills, education and training must continue.

There are several nurse staffing tools in existence, many of which are based on acuity and dependency measurement and whilst there is no absolutely objective tool, the importance of setting staffing levels supported by such tools was recognised by the Keogh report (2013); Ambition 6 - "Nurse staffing levels and skill mix will appropriately reflect the caseload and the severity of illness of the patients they are caring for and be transparently reported by trust boards". This is further supported by the aforementioned Compassion in Practice (2013) which specifically asks Trusts to use such evidence based tools and to publish through Trust Boards staffing levels and their impact on care on a six monthly basis.

More detailed guidance is provided by the Royal College of Nursing and Safe Staffing Alliance who recognise the impact that registered nurse:bed ratios can have on quality and safety of care. Both support the findings of Ball and Pike (2009) which evidence the likelihood that care will be compromised if these ratios climb above 1:8, although there is an absence of clarity on the suggested requirements for night shift staffing which historically has been lower than daytime staffing largely due to lower activity levels. Due to this widely recognised issue, very few wards would require the same ratio across a 24 hour period, however in some cases such as 24 hour assessment areas and Intensive Therapy Units this may be indicated.

The publication on 20th November 2013 of the paper "How to ensure the right people, with the right skills are in the right place at the right time – A guide to nursing, midwifery and care staffing capacity and capability" by the National Quality Board has provided much needed guidance and clarity on expectations of provider and commissioner organisations on setting safe staffing levels. The report sets out 10 clear expectations and contains explicit information regarding the roles and responsibilities of boards in ensuring firstly that safe staffing levels are set and consequently that appropriate staff are in place to meet these levels. Considerable additional requirements focus on areas such as assurance, transparency, workforce planning and supporting our staff to ensure that we are continuously striving to improve the quality of safe care provided within the organisation.

Methodology

This review has taken into account a variety of recommended methods for reviewing and setting safe staffing levels all of which have influenced the recommendations in this paper, namely;

- Use of the Sheldon model Safer Nursing Care Tool
- Nurse sensitive indicators
- Registered Nurse:bed ratio modelling
- Benchmarking
- Literature review
- Professional scrutiny
- Registered Nurse:HCA ratio
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The wider group of senior nurses within the Trust have had input and influence throughout this review via the Head's of Nursing for the care groups. Quality dashboards have been developed across all inpatient areas (outpatient and speciality areas currently being developed) which triangulate a wide variety of nurse sensitive indicators including those recommended by the Safer Nursing Care Tool. Dashboards also include workforce metrics such as appraisal rates and sickness absence in order to enable mapping of quality performance against workforce factors. Following the recent publication by the Quality Board (p1), these dashboards will be reviewed to ensure that the recommendations for monitoring staffing levels are reflected and then the corporate level dashboard will be included in subsequent nurse staffing board reports.

By triangulating the many layers of information and evidence above alongside professional scrutiny and organisational knowledge, all adult inpatient nurse staffing templates have been revised and proposals for change detailed below.

Results

Detailed information by ward of current and proposed nurse:bed ratios alongside proposed increases to nursing establishments can be found in the appendix to this paper. The overall findings of the above applied methodology indicated that a further 45.42 Registered Nurses and 33.88 Health Care Assistants are required to make the recommended improvements to nurse staffing levels in these areas. This equates to a total of 79.3wte additional nursing staff before the application of uplift cover (see below).

The proposed increases to wards ensure the required improvements to RN:patient ratio are in place in line with current research and guidelines discussed above. The above ratios include the nurse in charge or ward coordinator where present as this gives parity of comparison across the Trust.

Uplift to nursing pay budgets

The Trust currently applies an uplift of 20.7% to nursing pay budgets which is broken down into the following areas;

- Annual leave – 14.1%
- Sick leave – 3.9%
- Maternity leave – 1.5% (held centrally to ensure appropriate distribution)
- Study leave – 1.2%

Due to the low turnover within the Trust a higher proportion of staff have longer periods of service and therefore are entitled to the maximum period of annual leave which may exceed the current funded amount. In addition to this as acuity and dependency increases along with the evidence base for care, training requirements for nursing staff have increased significantly. In order to be able to release staff for quality and safety related training and ensure that leave entitlement is

given it is recommended that nursing uplift be increased to 22% in line with the majority of other providers.

Supervisory status of Ward Managers

In addition to providing safe staffing levels it is essential to also have the right clinical leadership in place and supported with time to fulfil this critical role. The Trust currently funds 60% supervisory time for all Ward Managers with the exception of the Emergency Departments and Acute Medical Units which receive 80% supervisory time in reflection of the acuity and high patient flow of these clinical areas. Many reports including Francis and the recent National Quality Board report have highlighted the need for supervisory status for Ward Managers which enables closer monitoring and scrutiny of quality and safety in the ward area. It is also essential for nurse leaders to maintain clinical skills and work within the ward template at times to ensure an accurate understanding of ward culture and to demonstrate positive leadership behaviours.

It is recommended that the supervisory status of Ward Managers is reviewed within the current financial template to consider applying a sliding scale of supervisory time dependant on bed numbers and establishment of staff being managed.

Recruitment

If the recommendations of this report are approved then the Trust will incur a significant vacancy factor. Uptake for interview of a recent national advert for registered nurses was poor although a further recruitment day in November following readvertisement was more successful. However, even taking this into account would leave a significant shortfall which will require consideration of short and medium term options such as overseas recruitment for registered nurses. Further discussion and agreement is required around a strategy for filling the vacancy gap including a trajectory for how long this is likely to take. There is a currently national movement by provider organisations to review staffing levels and improve RN:patient ratios which has the potential to create a substantial recruitment problem for nursing in the UK.

Ongoing strategies such as ongoing interaction with Higher Education Institutions have been put in place in order to encourage and support the student nurses we train to come and work within the Trust. In relation to long term planning, consideration to the commissioning of preregistration nursing places has already been considered by the Workforce Director.

Finance

The proposed increases to staffing templates detailed above, clearly present a significant cost implication to the Trust. The total increase to current templates equates to 95 wte following the application of the increased uplift to revised nursing budgets, the estimated cost of which is an additional £3.578 million against current nursing ward pay budgets. Although not within budget, the current spend on nursing bank is significant and an equitable reduction in usage should be expected once vacancies are filled. Future work should be completed in order to quantify savings from improvements in quality that may result from improved staffing levels.

The current average nursing bank usage across the Trust is 167 wte, which if calculated as an annual cost amounts to £5.0m. In addition to this the same measurement of agency usage equates to 110 wte per month with an annual cost of £4.8m. It is expected that with recruitment to proposed templates and improved structures around financial management that agency and bank use will reduce in line with recruitment to substantive posts.

This review does not include escalation areas such as ward 32 from a funding perspective although it has considered nurse staffing templates in these areas to be adequate. It is planned that these escalation beds will be funded through the winter funding scheme.

Evidently, this is a significant requirement for investment proposed at a time of financial difficulty. However, given the recent trend in expenditure on temporary nursing staffing above budgeted templates in relation to EPS, high utilisation factor and escalation requirements, it is proposed that the recommendations of this review are a sustainable method of providing safe staffing levels and reducing temporary staffing spend.

Robust processes of accountability will be embedded to ensure that absolute clarity is provided for Ward Managers around nursing pay budget management and that this is followed to ensure a sustainable position is maintained for nursing pay moving forward.

During the review it has become apparent that a robust process for agreeing and implementing nurse staffing templates has been absent. In addition to this, variability in the application of consistent financial management to ward pay budgets has been present. Improvements proposed in this area will not only cover improvements to nurse staffing levels but also support robust and supportive financial management of pay budgets in a sustainable way to ensure financial as well as clinical maturity in relation to delivering excellent nursing care.

In the course of this review the number of Enhanced Patient Support (EPS) shifts used has also been considered. These shifts are commonly used to provide one to one care for patients who may be confused and wandering, therefore at risk of absconding or falling and sustaining injury. Because these shifts are in addition to the current ward templates they are frequently filled by agency workers who are not permanent staff and come at a premium cost to the Trust. The Trust has seen a considerable increase in the use of such shifts over the last year and would expect to see a substantial reduction following implementation of revised nursing templates if the recommendations of this report are accepted, due to improved availability of permanent ward staff to care for patients. In addition to this the process for obtaining EPS has recently been revised to provide clarity around clinical risk.

Conclusion

This paper provides an opportunity for discussion and agreement around proposed nurse staffing levels by the board. Considerable evidence to support this review methodology is available and the recent publication by the National Quality Board serves to provide the more granular detail on safe nurse staffing that has been much needed following the Francis, Keogh and Berwick reports. It also sets the scene for the future by proposing the framework by which nurse staffing should be continuously reviewed and suggests robust methods for the board to gain assurance that these levels are both being met, and are supporting the provision of safe, high quality care.

Recommendations

- Proposed changes to nursing templates are approved and implemented
- Proposed increase to nursing pay budget uplift is approved and implemented
- That the Trust Board receives a monthly report demonstrating the actual vs funded staffing levels by ward following metric development. (National Quality Board requirement)
- That the Trust Board receives a report reviewing the Trust nurse staffing position on a 6 monthly basis. (National Quality Board requirement).

Appendix

The below summary outlines current position (left hand side) by ward in relation to speciality, bed numbers and RN:patient ratio compared to the recommended position (right hand side) following triangulation of the above methods of review.

Ward	Beds	RN:patient ratio days current	RN:patient ratio nights current	RN:patient ratio days proposed	RN:patient ratio nights proposed	RN:HCA Ratio	WTE Increase
AMU (S) Assessment	20 beds 9 CDU + ambulatory care clinic	1:4.1 Exc RN ambulatory care *	1:4.8	1:4.1	1:4.8	62:38	4.51 HCA
AMU (T) Assessment	25	1:5	1:6.25	1:5	1:5	59:41	RN 2.02 HCA 3.46 amb care increase
22s/r Stroke/rehab	40	E 1:5.7 Inc stroke bleep holder – rarely leaves ward * L 1: 6.6 *	1:8	E 1:5.7 * L 1: 6.6	1:8	55:45	1.0 RN 1.71 HCA
23N Nephrology		1:6	1:9	1:6	1:9	63:37	0.86 RN (w/e coord)
24E Endocrine	12	1:6	1:12	1:6	1:6* (Ward combines night staffing with 24C)	65:35	3.62 RN
24C Cardiology	12	1:6	1:12	1:6	1:12* (combined ratio = 1:8)		
CCU (S) Cardiac Care	8	1:4 Exc cardiac cay case services - delivered off the ward *	1:4	1:4	1:4		
27 Respiratory	38	E 1:6.33 Inc NIV RN-does not leave ward area * L 1:9.5 *	1:9.5	E 1:6.33 * L 1:7.6 *	1:9.5	51:49	0.68 RN 2.83HCA

28 General and short stay medicine	34 (rev for 38)	1:6.33	1:9.5	E 1:6.3 L 1:7.6	1:9.5	51:49	4.89 RN 4.67 HCA
32E** Escalation area	10	1:5	1:10	1:5	1:10 (Ward combines night staff with Gynae Ward)	59:41	No change
4 Frail and complex	27	E 1:6.75 L 1:9	1:13.5	1:5.4	1:9	57:43	5.46 RN 3.91 HCA
6 Cardiology	20 Inc cardiac day case services	E 1:5 L 1:7	1:10	E 1:5 Inc w/e to support CCU	1:5 (see below)	69:31	3.82 RN 2.59HCA
CCU (T) Cardiac care	5	1:5	1:5	1:5 Supported by ward 6	1:5 CCU and ward 6 working together		
7 Gastro	28	1:5.6	1:14	1:5.6	1:9.3	58:42	2.0 RN 1.46 HCA
9 Respiratory	28	1:5.6 Inc NIV nurse who is also co-ordinator infrequently leaves ward base*	1:9.33	1:5.6	1:9.3	60:40	1.49RN (w/e coord) 0.46 HCA
12 Short stay medicine	21	1:5.25	1:10.5	E 1:5.25 L 1:7	1:10.5	58:42	0.8 RN 1.28 HCA
15 Rehabilitation	25	E 1:6.25 L 1:8.3	1:12.5	E1:5 L1:6.25	1:8.3	60:40	5.5 RN
16 Acute Stroke	24	1:4.8 Exc stroke bleep holder -frequently off ward *	1:12	1:4.8	1:8	61:39	3.98 RN
DSU (S) Short stay surgery	12 (SS)	1:6	1:6	1:6	1:6	68:32	None
21 Oncology	16	E 1:5.3 L 1:8	1:8	1:6.7	1:8	60:40	None

22O Orthopaedic	25	E 1:5 L 1:6.3	1:12.5	E 1:5 L 1:6.3	1:8.3	60:40	3.04 RN
23H Haematology	12	E 1:4 L 1:6	1:6	1:5	1:6	64:36	None
25 Colorectal/ Gastro	38	1:6.3	1:9.5	1:6.3	1:9.5	58:42	2.56 HCA
26 Urology/ICA/ Vascular	36 (ICA)	1:6	1:9	1:6	1:9	60:40	None
SAU Assessment area	14+amb care	1:4.7	1:7	1:4.7	1:7	50:50	None
SSS Short stay surgery	23	E 1:5.8 L 1:7.7	1:11.5	E 1:5.8 L 1:7.7	1:7.7	69:31	No increase but skill mix change
8 Head and Neck	14 (ICA)	1:4.7/1: 7 When ICA open	1: 4.7/ 1:7 When ICA open	1: 4.7/ 1:7 When ICA open	1:4.61: 4.7/ 1:7 When ICA open	70:30	None – some funding already removed May further reduce dep FCHS
10 Trauma Ortho	28	E 1:7 L 1:9.3	1:14	E 1:5.6 L 1:7	1:9.3	60:40	4.59 RN 1.89 HCA
11 Elective Ortho	22	1:7.3	1:11	E 1:5.5 L 1:7	1:11	54:46	1.67 RN 2.55 HCA (further 6.01 to fund 28 beds)
Apley Private patients/ surgery	10	1:5	1:5	1:5	1:5	77:23	None
Total							45.42 RN 33.88 HCA **79.3 wte**

Where there appears to be no change to RN:Bed ratio but an increase in wte this is due to an increase in weekend staffing which is currently reduced in comparison to weekdays.

References

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