The Shrewsbury and Telford Hospital NHS Trust

Board of Directors
10 June 2021

Agenda item	131/21			
Report	Safer Nurse Staffing Bi-annual Report			
Executive Lead	Director of Nursing			
	Link to strategic pillar:		**Link to CQC domain:**	
	Our patients and community	√	Safe	√
	Our people	√	Effective	√
	Our service delivery	√	Caring	√
	Our partners		Responsive	√
	Our governance	√	Well Led	√
	Report recommendations:		**Link to BAF / risk:**	
	For assurance	√	BAF1, BAF 4, BAF 8	
	For decision / approval		**Link to risk register:**	
	For review / discussion		807, 1571, 2058, 1768, 817	
	For noting			
	For information			
	For consent			
Presented to:	Quality & Safety Assurance Committee			
Dependent upon (if applicable)**:**	NA			
Executive summary:	NHS provider boards are accountable for ensuring their organisation has the right culture, leadership and skills in place for safe, sustainable and productive staffing that will support safe, effective, caring, responsive and well-led care. This report provides an update in regards to safer nurse staffing within the Shrewsbury & Telford Hospitals NHS Trust. The Board of Directors is asked to receive and review: • This report in full and **appendix 5** which describes the current gaps in compliance linked to the Developing Workforce Safeguards national document • Decide if any further information, action and/or assurance is required			
Appendices	Appendix 1: **SNCT summary of criteria** Appendix 2: **Summary of data collected January 2021** Appendix 3: **Substantive Unavailability** Appendix 4: **NICE red flags summary** Appendix 5: **Developing Workforce Safeguards gap analysis** Appendix 6: **Priority Wards for Nursing Associate teams**			

1.0 Introduction

1.1 Demonstrating safe staffing is one of the essential standards that all health care providers must meet to comply with Care Quality Commission (CQC) regulation, Nursing and Midwifery Council (NMC) recommendations and national policy on safe staffing. The National Quality Board (2016) guidance and Developing Workforce Safeguards (2018) in particular sets out expectations for Nursing and Midwifery staffing levels to assist local Trust Board decisions in ensuring the right staff, with the right skills are in the right place at the right time.

1.2 It is well documented that ensuring adequate Registered Nurse (RN) staffing levels on acute medical and surgical wards and within other clinical areas in line with national recommendations has many benefits including improved recruitment and retention, reduction in staff stress and thus sickness levels, improved patient outcomes including mortality and improved levels of patient care (Royal College of Nursing, 2021; Rafferty et al 2007).

1.3 Developing Workforce Safeguards (2018) was established from safe staffing work when system leaders identified a gap in support around workforce and builds on the National Quality Board (2016) guidance. It identifies that Trusts must ensure the below three components are used in their safe staffing processes:

- Evidence based tools and data
- Professional judgement
- Outcomes

1.4 This report plus the previous two biannual reports has ensured compliance to the recommendations listed in the above bullet points.

2.0 Nurse to Patient ratios – overview

2.1 Nurse to patient ratios are a useful benchmark for assessing the average amount of patients each Nurse is caring for.

2.2 It should be noted that this method may not always accurately reflect the needs of the individual patient as their dependency on nursing input may differ at various points. Nevertheless, the Royal College of Nursing (RCN) 'Mandatory Nurse Staffing Levels' (2012) and NICE 'Safe Staffing for nursing in adult inpatient wards in acute hospitals' (2014) suggest acute wards must have a planned Registered Nurse (RN) to patient ratio of **no more than 1: 8** during the day. There is no current guidance for nights.

2.3 Table1 shows the average RN: Patient ratio at Shrewsbury and Telford Hospital (SaTH) during the month of January 2021.

Table 1: Actual Average RN: Patient ratio during January 2021

Division	RN : Patient Ratio
Surgical Division	1:7
Medical Division	1:6
Trust	1:6

2.4 This shows that during January 2021 the divisions met the national requirement overall of a ratio of 1:8 maximum.

2.5 This shows an increase since the July 2020 review, where the Medical and Surgical Divisions were both averaging a 1 Nurse to 5 patient ratio. It appears that the Surgical Division has shown the biggest change with nurses averaging an additional 2 patients to care for during the month of January 2021 compared to July 2020.

3.0 Safer Nursing Care Tool (SNCT)

3.1 The SNCT is an evidence based tool that is recommended by NICE to measure individual patient acuity and dependency. It is proposed that using SNCT offers greater understanding in regards to if actual hours match required hours.

3.2 The tool is designed to be used daily for a minimum, 20-day period twice per year (January & July) collecting individual patient acuity. **Appendix 1** details the acuity levels.

3.3 The SNCT allows clinical staff to assess the needs of every individual patient. It is worth noting that as a generic tool, subjective application of SNCT has an expected 10% variation from ward to ward and is not designed to indicate required skill mix. Other variables that should be considered include:

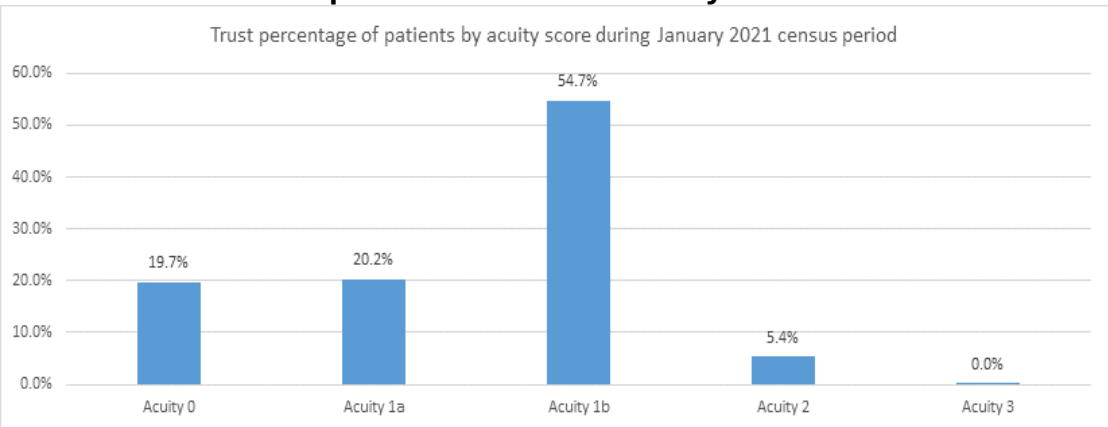
- Clinical speciality
- Staff capacity, capability, seniority and confidence
- Organisational support and support roles such as therapy services
- Geographical layout of a clinical area

Hence why for this review, national standards have been followed and professional judgement and patient outcomes have also been considered.

3.4 It should also be noted that the gold standard should be to have no more than 3 senior staff per clinical area submitting patient acuity and that they should receive annual training. It is recognised that this has not been the case at SaTH and as such there is less assurance in regards to the acuity and dependency figures that has been submitted. This is being rectified with the National Safer Staffing Faculty Team agreeing to provide some additional training in 2021.

3.5 The analysis for all wards acuity in January 2021 is shown in Graph 1, where it can be seen that circa 55% percent of patients are a level 1b.

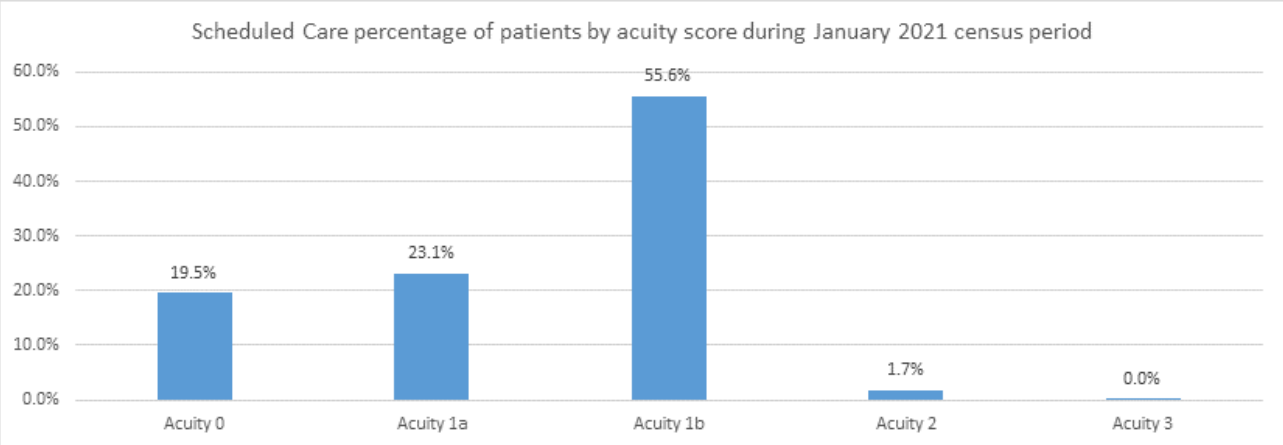
Graph 1 – overall Trust acuity scores



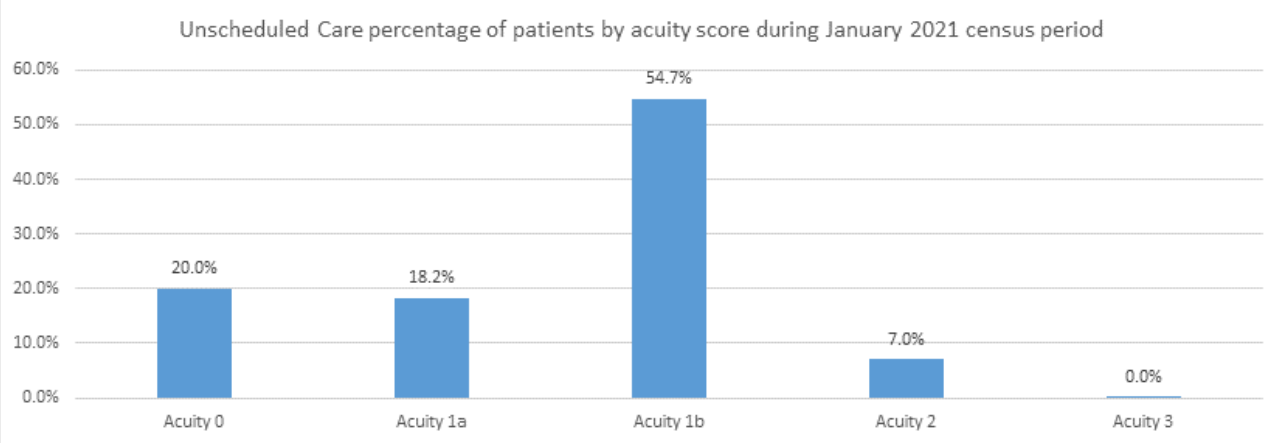
3.6 This shows a similar result to the previous staffing review in July 2020 with the overall majority of patients being measured as a 1b.

3.7 Graphs 2, 3 and 4 show the acuity for January 2021 broken down by Division. It shows that for Surgery and Medicine, the highest proportion of patients fall into the 1b category. For Gynaecology, the majority were classed as a 1a.

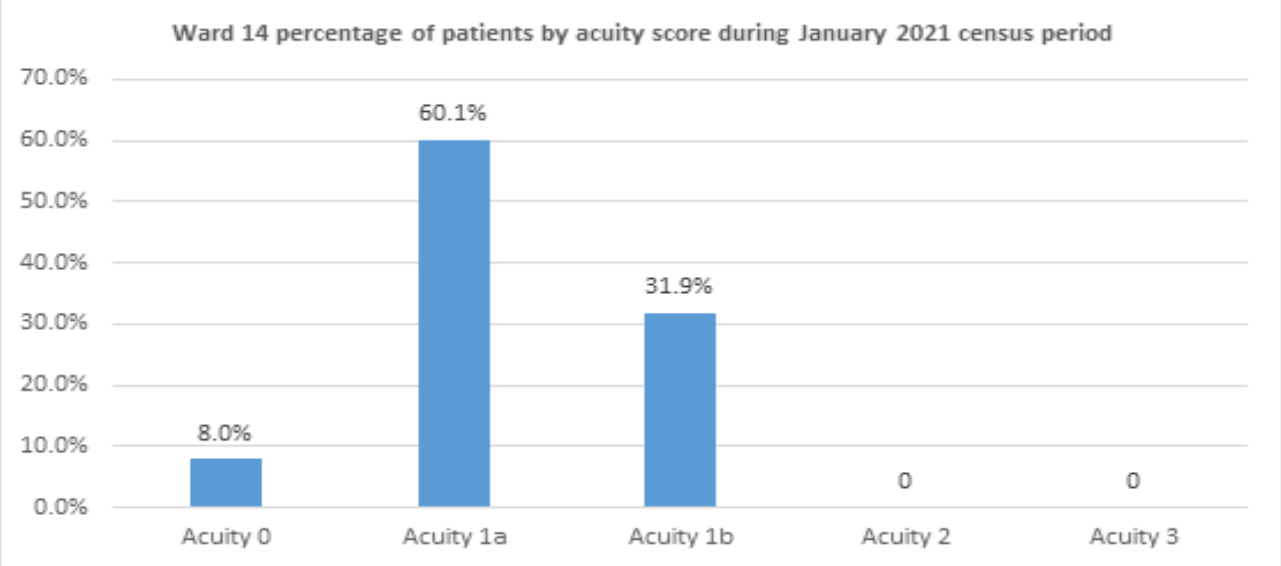
Graph 2 – Surgical Division acuity scores



Graph 3 – Medical Division acuity scores



Graph 4 – Ward 14 (Gynaecology) acuity scores



3.8 It is noted that recognition should be given to the 10% variation that is known to occur when different staff are assessing patients. It should also be noted that this data was collected during the second wave of the Covid-19 pandemic and thus acuity appeared to be higher during this time compared to pre-Covid for the Medical and Surgical areas.

3.9 For the purpose of the bi-annual staffing reviews, a RN: HCA ratio of 65:35 has been utilised within the SNCT.

3.10 It should be noted that the Gold standard would be a mix of 70% RN to 30% HCA linking to evidence suggestive that increasing RNs within a ward skill mix reduces mortality and increases patient safety and quality of care. There is also evidence suggesting that higher numbers of agency Nurses has a similar impact. Aiken et al (2010, 2013, 2016, 2018), Ball et al (2018), Blegan et al (2011), Estabrook et al (2005), Griffiths et al (2016), RCN (2021).

3.11 The analysis of the data collection in January 2021 is shown in **appendix 2**. To aid triangulation the data supplied includes, by ward; the acuity of patients; current budgeted establishments and expected establishments based on acuity (SNCT), CHPPD, RN: HCA ratios and fill rates.

3.12 This data **should be taken with caution** for several reasons:

- The data was collected whilst in the second wave of the Coronavirus pandemic – many Trusts chose not to collect due to the very different range of acuity and dependency away from the norm during this time. It was felt for SaTH that keeping staff mindful of safer staffing requirements was necessary and also the data could help provide some useful insight into the pressures faced during this time and for future potential waves.
- Several ward moves had occurred during the recent pandemic but nursing templates not updated fully, thus there will be significant variation between required staffing and budgeted establishments and as such this data should not be used to make any changes to agreed establishments at this point.

3.13 Changing budgets is **not be** recommended from this report for the reasons outlined above. Additionally, further work is required to enable a disaggregation of the workforce if the ward budget covers more than an in-patient area such as Gynaecology for example.

4.0 Fill rates

4.1 Acute Trusts are required to collate and report staffing fill rates for external data submission to NHSE/I every month. Fill rates are calculated by comparing planned hours against actual hours worked for both RN and HCA.

4.2 The summary position for January 2021 is shown in table 2.

Table 2 – Fill rates

	Registered Nurses		HCA	
	Day	**Night**	**Day**	**Night**
RSH Jan 2021	94.21%	96.45%	78.41%	95.33%
PRH Jan 2021	89.53%	91.14%	85.02%	100.93%

SOURCE: Unify submission January 2021

4.3 Factors affecting fill rates include:

- Sickness (lower if not filled)
- Vacancies (lower if not filled)
- Enhanced Patient Safety requirements (EPS) otherwise known as 1:1 observation (when additional staff above agreed template are rostered on to support)

- Usage of temporary staffing (when fill rates are higher but skill mix may be lower)

4.4 The data from January suggests that fill rates overall on both hospital sites for RNs was circa 90% or above.

4.5 HCA day shifts were lower than expected, often staff were pulled form day shifts to cover the night shifts where there was greater clinical risk.

4.6 It should be noted that there were still some wards where shifts were below expected levels and that the fill rates are based on current expected levels and may not reflect the required numbers from SNCT and professional judgement results. It should also be noted that a low fill rate does not always mean that staffing levels were unsafe as bed occupancy may have been lower.

4.7 The Ward with the lowest fill rate was identified as Ward 36 (42% fill) this was due to the fact that not all beds were open during this time and so staff were mobilised to support other clinical areas in greater need. Ward 36 had 1 patient complaint and 4 category 1 Hospital Acquired Pressure Ulcers. There were no other patient outcome concerns during January 2021. Bed occupancy during this time was only 47.8%.

4.8 The Ward with the highest RN fill rate was Ward 17 which at the time was a Covid Respiratory Ward and thus had greater demand due to the higher acuity.

4.9 This data also does not indicate skill mix and experience and what percentage of this workforce may have been temporary staffing. All of which are contributing factors to quality and safety within the clinical environment.

5.0 Care Hours per Patient Day (CHPPD) – Model Hospital Comparison

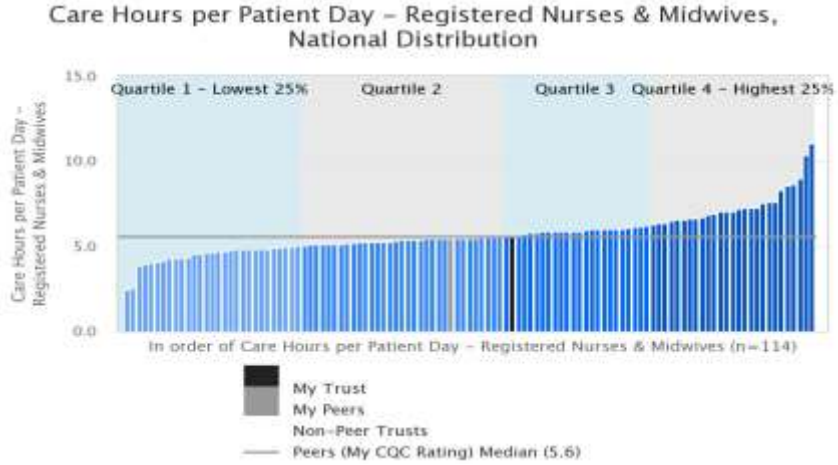
5.1 Care Hours per Patient Day (CHPPD) is a useful means of benchmarking against other NHS Trusts via the Model Hospital website. CHPPD is calculated by dividing the total numbers of nursing hours on a ward or unit by the number of patients in beds at the midnight census. This calculation provides the average number of care hours available for each patient on the ward or unit.

5.2 The area identified with the highest CHPPD was that of Ward 14; this will be due to the Gynaecology Ward having additional staff on duty to cover areas such as GATU. The bed occupancy at this time was only 47.78%

5.3 The lowest Ward area for CHPPD was Ward 7. Ward 7 had 5 patient falls, 1 category 2 Hospital Acquired Pressure Ulcer and 4 datix submissions for inadequate staffing. The bed occupancy in January 2021 for ward 7 was 89.06%.

5.4 Chart 5 shows the most up to date position for SaTH on Model Hospital (February 2021) and indicates that for CHPPD nationally, SaTH are in quartile 3 and in line with the national median of 5.6.

Chart 5 – CHPPD February 2021



Source: Model Hospital, February 2021

6.0 Substantive Unavailability

6.1 Substantive unavailability was high in January 2021 at 32%, in comparison to January 2020 pre Covid which was at 25%. The main reason for the increase appears to be higher sickness levels and other leave at 5% which is likely to be linked to the pandemic. See **appendix 3** for a full breakdown.

6.2 Sickness for Nursing and Midwifery in January 2021 was at 9.88% with 4.28% of this figure linked to Covid absence which shows the unavailability impact of the pandemic.

7.0 Emergency Centre

7.1 The decision was taken at the time not to complete the BEST audit in the Emergency Departments in January 2021 due to staffing and activity pressures, additional staff was required in the Departments due to the change in green and red pathways to avoid Covid transmission. BEST collection is also a very labour intensive process and thus it was not deemed appropriate to add further stress onto this workload.

7.2 It is hoped that an Emergency Department SNCT multiplier will be available at some point during 2021.

8.0 Paediatrics

8.1 Bed occupancy for Ward 19 (Paediatrics) was only at 32.62% in January 2021 and as such the acuity and dependency data collected was not reflective of the usual activity or demographic of patient and as such **should not** be utilised for changing of establishments at this time.

8.2 The data that was collected showed that circa 90% of patients during the monitoring period were relatively low acuity at a level 0. A level 0 paediatric patient is classed as requiring hospitalisation but that all needs are met through normal hospital care.

8.3 The Director of Nursing has asked for a peer review of Paediatrics which will include staffing compliance.

9.0 Incidents

9.1 During January 2021 and the previous 6 months, 52 Nurse staffing related incidents were reported through the Datix reporting system. 12 were recorded as low harm and the remaining 40 were classified as no harm. 20 of these incidents could be identified as potential red flags as defined by NICE (see **appendix 4**) due mainly to delays in patient care including rounding and medications. Whilst these incidents were categorised as no or low harm it should be noted that this will negatively impact on patient and staff experience.

10.0 Considerations

10.1 The review identified many changes to wards and specialties since the January 2020 and July 2020 data captures due to the Covd-19 pandemic. This means that SaTH has not had 2 conclusive reviews performed where data is sufficient to make amendments to staffing establishments.

10.2 An organisational decision needs to be taken on the Band 7 Ward Manager role and if this should be completely supernumerary or a percentage given towards working clinical shifts. Currently there is discrepancies between areas. The Royal College of Nursing recommends this lead role should be supervisory and thus not counted in the roster numbers (RCN, 2021).

10.3 Some Wards have more Band 6 staff than others; from a professional judgement perspective, this resource may not be necessary in the future when vacancies within these specific areas are filled. This will need to be added into the future workforce plan.

10.4 On analysis of budgeted ward splits for RNs and HCAs; the average RN percentage is 55% which is 2% lower than January 2020. This continues to be below national guidance (RCN being 65% registered to 35% unregistered). This is therefore a risk in terms of patient safety, mortality and staff well-being alongside the potential impact financially on addressing this shortfall.

10.5 The SNCT data would suggest that HCA numbers may be able to reduce in some areas however with current temporary staffing requests increasing and fill rates being utilised above 100% for this group of staff, an initial assumption would be that this cannot be the case. Further work is required in regards to enhanced patient care (EPS) requirements across the organisation which **must** include having specific wards for EPS in order to reduce the burden of additional requests and to safely cohort these patients with a richer workforce resource.

10.6 A reduction in HCA posts could be achieved by reviewing additional roles outside of the "nursing workforce" such as Ward Hostesses, Bed Cleaning Teams and Transfer Teams. HCAs appear to be covering some Domestic/Housekeeper duties; this would require a wider workforce review outside of nursing initially but is a recommendation as part of this review.

10.7 As the numbers of Nursing Associates continues to successfully increase, it must be noted that these valuable roles cannot replace a RN. There should be a focussed effort on ensuring as the staff qualify that they are placed within priority wards as outlined in **appendix 6**.

10.8 Currently Ward areas are utilising 12 hour shifts. Given that the workforce at SaTH has a high proportion of staff nearing or at retirement age, careful consideration needs to be given to flexing this approach in order to attract and retain staff and reduce sickness levels. There is a potential financial impact to this approach but it is envisaged these are likely to be small numbers in the near future and likely to be off-set by an anticipated reduction in sickness levels. A suggested approach had previously been muted of 20% to be factored into establishments to allow for this level of flexibility; starting with any new areas that open. It should also be noted that there is growing evidence that 12 hour shifts are unsafe and are no longer recommended (RCN, 2021). The factoring in of a percentage of 7 ½ shifts to each area should be considered in future workforce reviews.

10.9 There needs to be full appraisal and due diligence given to any potential Ward moves by nursing prior to this being agreed in order to ensure that safer staffing is maintained throughout.

10.10 It should be noted that following professional judgement discussions, some areas have a much larger staffing requirements for the bed numbers due to the geographical footprint. This would be true of Ward 36 and if Apley Ward was to open as an inpatient area; there would be similar increased staffing requirements meaning there are elements of inefficiencies that cannot be avoided in order to maintain patient safely.

10.11 None of the tools utilised in this review are able to measure the additional risk of experience of nurses within clinical areas and thus this consideration has been given when utilising professional judgement. Recognising the enhancement to the ward skill mix Nursing Associates could bring if utilised in specific areas as part of a reduction in HCAs would be of benefit form a quality and safety perspective.

11.0 Future plans

11.1 Funding has been agreed for a proof of concept for 2 Band 3 staff to work corporately but out within clinical areas supporting HCA staff and providing further learning opportunities to try and improve retention of this group of staff.

11.2 In order to increase future pipelines of RNs, plans are underway to increase student capacity, Registered Nurse Degree Apprenticeships have started within

SaTH, international recruitment continues but at a slower pace due to the pandemic and consideration is being given to the 2 year Nursing Associate top up programme.

11.3 It has recently been agreed by the Director of Nursing that the Trust should consider the appointment of an Allied Health Professional Chief Lead to support with safer staffing and leadership for non-nursing, non-medical roles.

11.4 It would be beneficial to consider external recruitment of Nursing Associates into the organisation now that these numbers are growing nationally. This would release some of the burden associated with training all staff within the organisation and reduce lead in times of this vital role into some of the identified clinical areas within **appendix 6**.

12.0 Conclusion

12.1 The recommendation from the Director of Nursing is there is some compliance with the Developing Workforce Safeguards (see **appendix 5** for gap analysis). There is an action plan in place to address the remaining gaps.

12.2 The Director of Nursing and Medical Director have confirmed they are satisfied with the plans in place and are moderately satisfied that staffing for Nursing is safe, effective and sustainable.

Deputy Chief Nurse (CH)
May 2021

Appendix 1

SNCT summary of criteria and associated multiplier (adult inpatient wards)

Acuity Level	Multiplier	Criteria
Level 0	0.99	Patient requires hospitalisation Needs met by provision of normal ward care
Level 1a	1.39	Acutely ill patients requiring intervention or those who are UNSTABLE with a GREATER POTENTIAL to deteriorate
Level 1b	1.72	Patients who are in a STABLE condition but are dependent on nursing care to meet most or all of the activities of daily living
Level 2	1.97	May be managed within clearly identified/designated beds, requiring resources with the required expertise and staffing level OR may require transfer to a dedicated level 2 unit
Level 3	5.96	Patients needing advanced respiratory support and/or therapeutic support of multiple organs

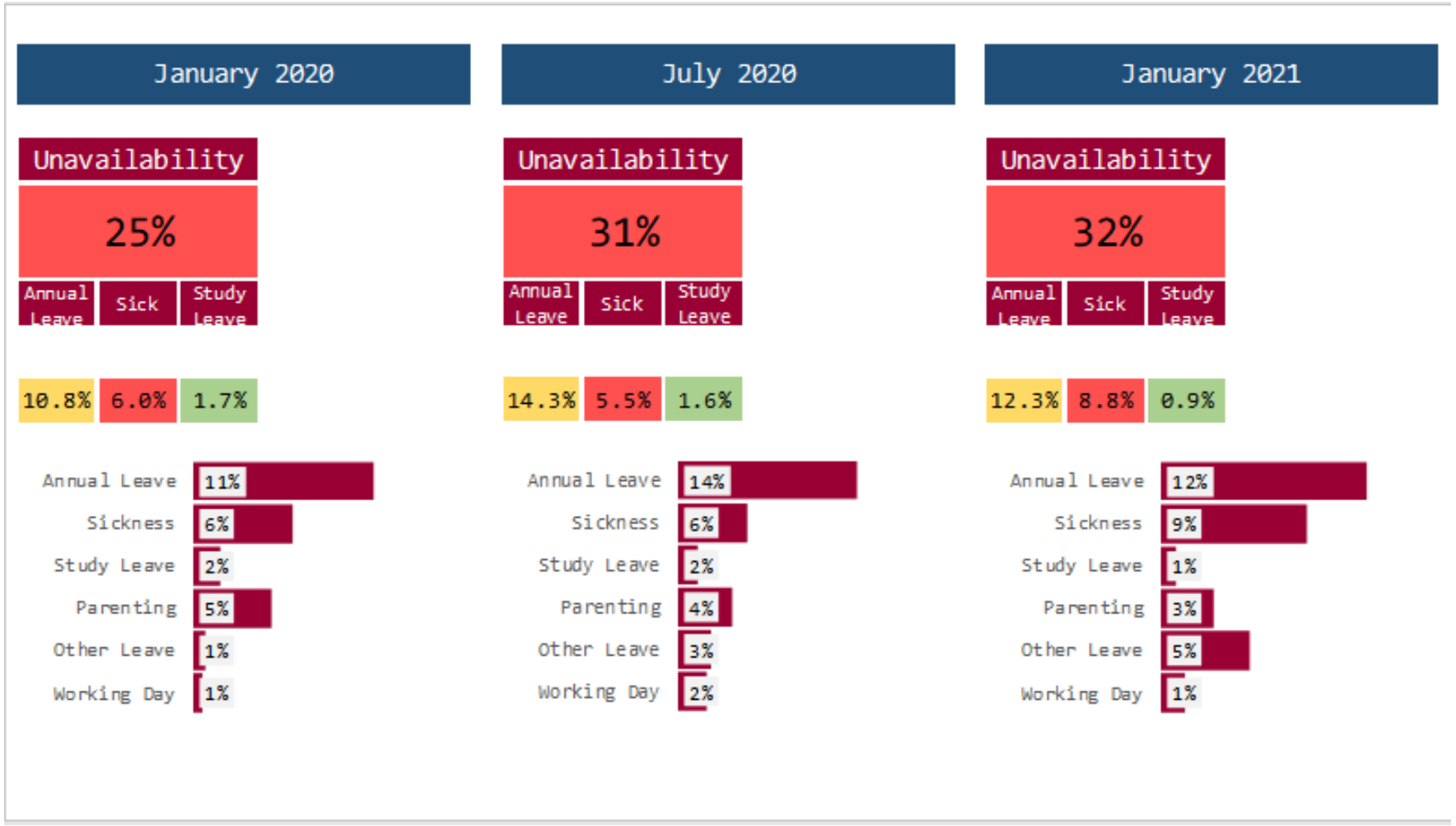
Appendix 2

Data collected – January 2021

Specialty/ Ward	Beds av daily between 4th – 29th Jan 2021	0 %	1a %	1b %	2 %	3 %	Current budgeted substantive FTE		Proposed SNCT		correct or over/under established		Ratio (percentage of RN to non RN day and night) – SNCT	Average Current Number of patients per RN (day) –	Average Current Number of patients per RN (night) –	CHPPD		Fill Rate (RN) – Day	Fill Rate (RN) – Night
							RN – B7, B6,	HCA – B2, B3	RN	HCA	RN	HCA	RN			Required	Actual	(Download Feb 2021)	
Emergency Care																			
AMU PRH	17	0	93	7	0	0	30.85	25.3	16.5	8.9	14.35	16.40	55%	3.7	3.5	7.48	9.95	91%	88%
AMU RSH	20	48	42	10	0	0	39.4	26.81	17.9	9.6	21.50	17.21	59%	5.7	5.3	6.71	12.82	94%	89%
SAU (W33/W34)	38	26	65	9	0	0	34.99	25.73	33.4	51.3	1.59	-25.57	58%	6.7	5.5	7	7.45	112%	105%
(HASU) *(see same data for ward 15 below)*	25						13.08	15.41						3.6	2.8				
Medical																			
Ward 6 *Endinorology* (PRH) Cardiology	20	32	25	38	5	0	30.95	9.52	20.4	11	10.55	-1.48	75%	4.4	4.1	6.22	7.49	89%	102%
Ward 7 Endincrology and Nephrology (PRH)	28	30	1	68	0	0	20.28	15.01	23.7	12.8	-3.42	2.21	57%	4.0	2.5	6.56	5.34	81%	83%
Ward 9 Supported Discharge	29	5	5	90	0	0	10.77	12.5	28	15.1	-17.23	-2.60	53%	4.3	3.0	7.31	5.91	92%	99%
Ward 11 Nephrology (PRH)	29	19	1	80	0	0	18.94	15.01	25.8	13.9	-6.86	1.11	46%	3.2	2.6	6.74	5.64	70%	87%
Ward 10 Frail and Complex Elderly (PRH) increasing by 1	29	5	1	94	0	0	19.81	20.01	26.2	14.1	-6.39	5.91	49%	4.0	2.7	7.38	7.04	88%	91%
Ward 15 *Hyper Acute / Acute Stroke Unit (PRH)*	25	11	4	84	0	0	13.08	15.41	24.9	13.4	-11.82	2.01	50%	3.6	2.8	7.14	6.26	98%	92%
Ward 16 Rehabilitation (PRH)	17	32	1	65	2	0	27.11	15.01	12.9	6.9	14.21	8.11	61%	4.3	2.8	6.46	11.29	95%	92%
Ward 17 Respiratory	28	16	10	33	41	1	21.86	15.01	20.7	11.1	1.16	3.91	53%	5.7	4.3	7.37	10.57	86%	108%
Ward 21(S) Frailty	16	6	19	77	0	0	11.77	12.5	14.4	7.8	-2.63	4.70	43%	2.8	2.7	7.15	10.56	111%	131%
Ward 22SS	26	37	36	27	0	0	17.86	12.5	19.2	10.4	-1.34	2.10	58%	3.7	3.0	5.9	6.32	106%	101%
Ward 22 Respiratory	20	8	21	47	25	0	inc in W32	Inc in W32	21	11.3	Inc in W32	Inc in W32	54%	3.5	3.8	7.28	8.13	88%	95%
Ward 24C+E Cardiology / Endincrology (RSH)	24	13	40	44	3	0	29.67	16.64	28	15.1	1.67	1.54	64%	6.0	4.8	6.59	7.03	93%	95%
Ward 27	39	31	9	59	1	0	26.28	27.23	31.7	17.1	-5.42	10.13	56%	6.2	4.2	6.43	6.24	104%	104%
Ward 28N Nephrology / General Medicine (RSH)	28	20	22	59	0	0	24.27	20.01	24.1	13	0.17	7.01	58%	4.2	4.0	6.63	6.63	75%	98%
Ward 32 Respiratory	24	9	17	9	66	0	33.68	39.26	20.1	10.8	13.58	28.46	55%	4.5	3.1	7.78	8.27	102%	76%
Ward 36 Supported Discharge	19	3	8	89	0	0	24.31	30	9.7	5.2	14.61	24.80	47%	2.0	3.0	7.34	10.75	42%	49%
Ward 35 SD (not on safecare)	19																		
Surgery																			
Ward 25G Colorectal & Gastroenterology (RSH)	38	40	18	41	0	0	26.09	20.76	29.1	15.7	-3.01	5.06	54%	8.2	4.1	6.01	6.66	101%	102%
Ward 26S General Surgery / ICA (RSH)	19	26	7	92	1	0	26.08	18.92	26.7	14.4	-0.62	4.52	61%	6.1	4.1	6.22	6.22	102%	103%
Ward 8 H&N		55	15	30	0	0	13.43	10.12	5.5	3	7.93	7.12	62%	1.9	1.8	5.52	9.95	76%	91%
Muscoloskeletal																			
Ward 4 Trauma and Orthopaedic	27	10	4	77	9	0	19.67	17.59	20.8	11.2	-1.13	6.39	51%	4.2	2.8	7.27	7.43	93%	94%
Ward 8 Medicine (covering period 4th - 13th Jan)	6	17	11	72	0	0	11.01	7.42	2.7	1.4	8.31	6.02	53%	2.4	2.2	6.84	8.8	71%	66%
Ward 22 Orthopaedics	32	1	2	95	1	0	18.47	22.51	32	17.2	-13.53	5.31	43%	3.6	3.1	7.44	5.85	90%	103%
Oncology																			
Ward 23OC Oncology & Haematology	23	0	6	90	4	0	23.97	14.66	23.3	12.5	0.67	2.16	62%	4.2	3.9	7.51	7.57	80%	97%
Womens & Childrens																			
Ward 14 Gynaecology	12	39	9	52	0	0	16.5	7.62	6.8	3.7	9.70	3.92	59%	2.0	2.0	6.4	12.35	95%	85%
Total		539	492	1538	158	1	604.18	488.47			46.6	146.46				184.68	218.52	24.25	25.26
Total without AMU and SAU numbers											-84.49								

Appendix 3

Substantive unavailability



Appendix 4

NICE red flags

• Unplanned omission in providing patient medications.

• Delay of more than 30 minutes in providing pain relief.

• Patient vital signs not assessed or recorded as outlined in the care plan.

• Delay or omission of regular checks on patients to ensure that their fundamental care needs are met as outlined in the care plan. Carrying out these checks is often referred to as 'intentional rounding' and covers aspects of care such as:
– Pain: asking patients to describe their level of pain level using the local pain assessment tool.
– Personal needs: such as scheduling patient visits to the toilet or bathroom to avoid risk of falls and providing hydration.
– Placement: making sure that the items a patient needs are within easy reach.
– Positioning: making sure that the patient is comfortable and the risk of pressure ulcers is assessed and minimised.

• A shortfall of more than 8 hours or 25% (whichever is reached first) of registered nurse time available compared with the actual requirement for the shift. For example, if a shift requires 40 hours of registered nurse time, a red flag event would occur if less than 32 hours of registered nurse time is available for that shift. If a shift requires 15 hours of registered nurse time, a red flag event would occur if 11 hours or less of registered nurse time is available for that shift (which is the loss of more than 25% of the required registered nurse time).

• Less than 2 registered nurses present on a ward during any shift.

Appendix 5

Developing Workforce Safeguards gap analysis

Recommendation		SaTH current position	Action required
1	Trusts must ensure the three components are used in their safe staffing processes: · evidence-based tools (where they exist) · professional judgement · outcomes	**Fully compliant. ↑** As part of the Nurse Establishment Review process which commenced in January 2020; all 3 components can be demonstrated for the last 3 biannual staffing reviews.	SOP under development to confirm process and annual calendar for training, data collection and inter-rater reliability checks being organised.
2	Trusts will be required to confirm their staffing governance processes are safe and sustainable, based on national assessment on the annual governance statement.	**Partially compliant. ↔** Statement from Director of Nursing and Medical Director in staffing report.	Director of Governance and Communications to add statement to annual governance statement noting there is not full assurance.
3	As part of the safe staffing review, the Director of Nursing and Medical Director **must** confirm in a statement that to their Board that they are satisfied with the outcome of any assessment that staffing is safe, effective and sustainable.	**Partially compliant. ↔** Statement available for Board confirming staffing process is satisfactory but staffing cannot be assured is safe.	
4	Trust must have an effective workforce plan that is updated annually and signed off by the Chief Executive and executive leaders. The Board should discuss the workforce plan in a public meeting.	**Partially Compliant ↔** Modelling has taken place via the HTP Team for 5 year plan for nursing. 1 year RN trajectory is updated monthly.	Full plan to be agreed and signed by Chief Executive.

5	The Trust must ensure their organisation has an agreed local quality dashboard that cross-checks comparative data on staffing and skill mix with other efficiency and quality metrics such as the Model Hospital dashboard. Trusts should report on this to their board every month.	**Fully compliant. ↑** Quality dashboard and monthly meetings in place. Further metrics being added to include Workforce. Quality metrics and Model Hospital is discussed within the monthly staffing paper.	
6	An assessment of re-setting of the nursing establishment and skill mix (based on acuity and dependency data and using evidence-based toolkit where available) must be reported to the board by ward or service area twice a year, in accordance with NQB guidance and NHS improvement resources. This must also be linked to professional judgement and outcome.	**Fully compliant. ↑** Reports completed however unable to change budgeted establishments as last 2 data sets collected during the Coronavirus pandemic.	Completion of SOP as stipulated in recommendation 2.
7	There must be no local manipulation of the identified nursing resource from the evidence-based figures embedded in the evidence-based tool used, except in the context of a rigorous independent research study, as this may adversely affect the recommended establishment figures derived from the use of the tool.	**Fully compliant. ↑** No forbidden alteration of the Safe Nursing Care Tool data has occurred.	

8	As stated in CQC's well-led framework guidance (2018) and NQB's guidance any service changes, including skill mix changes, must have a full quality impact assessment (QIA) review.	**Partially compliant. ↑** QIAs for Nursing Associates complete.	To be approved at next Nursing, Midwifery and AHP Workforce Group.
9	Given day-to-day operational challenges, we expect trusts to carry out business-as-usual dynamic staffing risk assessments including formal escalation processes. Any risk to safety, quality, finance, performance and staff experience must be clearly described in these risk assessments.	**Partially compliant. ↑** The Trust holds three times a day site safety meetings which include discussions relating to staffing across the trust based. There is a daily staffing meeting Monday – Friday. Monthly report now requested to Deputy Chief Nurse for oversight of any red flag events linked to staffing. Any formal escalation for gaps is via the Deputy Chief Nurse or an Executive who has access to the local risk assessment, A&D and mitigations already in place prior to making a decision on approving temporary staffing at tier 4 and above agency.	

10	Should risks associated with staffing continue or increase and mitigations prove insufficient, trusts must escalate the issue (and where appropriate, implement business continuity plans) to the board to maintain safety and care quality. Actions may include part or full closure of a service or reduced provision: for example, wards, beds and teams, realignment, or a return to the original skill mix.	**Not compliant.** No set governance process in place.	Added to Safer Staffing Improvement Plan. Phased staffing plan and associated risk assessment in place for inpatient wards in relation to Covid-19. Need set escalation plan for raising staffing concerns.

Appendix 6

Priority Wards for a team of Nursing Associates

- Frailty
- Respiratory
- T&O
- Gastroenterology
- Stroke Rehabilitation

Supporting literature

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