Board of Directors' Meeting
8 December 2022

The Shrewsbury and Telford Hospital NHS Trust

Agenda item	252/22			
Report Title	Bi-annual Staffing Report			
Executive Lead	Hayley Flavell Director of Nursing			
Report Author	Stephanie Young – Lead Nurse for Workforce			
	Link to strategic goal:		**Link to CQC domain:**	
	Our patients and community	√	Safe	√
	Our people	√	Effective	√
	Our service delivery	√	Caring	√
	Our governance	√	Responsive	√
	Our partners		Well Led	√
	Report recommendations:		**Link to BAF / risk:**	
	For assurance	√	BAF1, BAF2, BAF3, BAF4, BAF8	
	For decision / approval		**Link to risk register:**	
	For review / discussion		327, 247, 220, 192, 1547, 130, 129, 128, 111, 581, 549	
	For noting			
	For information			
	For consent			
Presented to:	*2022.11.23: Quality & Safety Assurance Committee*			
Executive summary:	The purpose of this report is to provide the Board of Directors with an overview of bi-annual nurse staffing review. A paper in full has been presented to the Nursing, Midwifery & AHP Workforce Group and the Quality, Safety and Assurance Committee in November 2022 where a summary of the data collected in July 2022, substantive availability and Red Flags were triangulated and discussed. The Board of Directors is asked to: • Receive and take assurance from this information • Decide if any further information, action and/or assurance is required			
Appendices	Appendix 1: Bi-Annual Staffing Report Appendix 2: Workforce Safeguards Gap Analysis action plan			
Executive Lead				

Bi-Annual Staffing Review 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.

A systematic approach must be employed in determining the number staff and range of skills required to meet the needs patients and maintain their safety. The following three components should be used in safe staffing process:

- Evidenced based tools (where they exist)
- Professional judgement
- Outcomes

The Trust utilises a validated tool to measure staffing twice a year (Safer Nursing Care Tool – SNCT) alongside professional judgement and triangulation of quality data. This is in line with national policy. However, the application of tool used a deployment tool to collect data during census period which would have impacted the reliability of the data. Future reviews will address the process for data collection. The outcomes

Application of the tool requires training and assessment of staff to ensure they are utilising tool correctly. It has been recognised that further training is required will continue as ongoing process to ensure new staff are trained and assessed and there is a yearly reassessment of competence.

Nationally it is agreed that Nurse to patient ratios in the day should be no more than a ratio of 1:8 in adult inpatient ward settings. For January 2022 Medicine Division were at 1:5 and Surgical Division 1:6 thus meeting this national guidance.

When reviewing skill mix establishment planning should ensure Registered Nurse (RN) staffing levels is at least 65% RN compared to unregistered posts. This is known to reduce mortality and increase quality and safety. The data indicates that most wards do not meet this threshold with the average overall being at 53%. Recent establishment reviews have enhanced staffing levels across a number of wards however future establishment reviews must continue to review skill mix and consider ratios to maintain safety. It has been recommended all areas that are currently working with lower percentages of nurse to unregistered post need to complete a Quality Impact Assessment which will be reviewed at the Workforce Steering Group.

Staffing fill rates overall were below 90% for RN/Health Care Assistants (HCA) for days and above both above 90% for Nights. It should be noted fill rate does not account for skill mix and experience and that low fill rates do not always mean that staffing levels were unsafe. Triangulation of staffing with quality and safety data and red flag events should be made. A monthly review of fill rates by the corporate and divisional teams will consider events were staffing levels were below or above thresholds and the impact on patients, staff and safety by triangulation of workforce and quality data.

Care Hours per Patient Day (CHPPD) is a measure of workforce deployment that can be used a ward level, service level and aggregated at Trust level and benchmarked against other Trusts. When comparing Trust data and specifically peers on Model Hospital, it suggests the Trust is above majority of peers and national average.

Following a recent review with support from NHSE, additional areas for development have been identified in line with national policy and developing workforce Safeguards, and updates to ongoing monitoring of action plan made. The oversight of and compliance with workforce safeguards is monitored via the Quality and Safety Assurance Committee quarterly and reviewed monthly at the Nursing Midwifery AHP and Facilities meeting for progress against targets. Following the review additional actions have been added follow a gap analysis process completed. Workforce Safeguards action plan and gap analysis can be found in Appendix 2.

Following recent establishment reviews and changes agreed in budgets and skill mix, there is a real time change in vacancies from RN to Nurse Associate (NA) posts as NA are registrants and recent establishment reviews included NA as part of workforce across a number of wards. SCNT proposes establishments are based on RN and HCA and doesn't currently include NA workforce. Budgeted establishments for registered staff are slightly over compared to SCNT proposed staffing, whereas HCA is much higher than proposed. In the application of SCNT a deployment tool was utilised to support data collection however, caution should be applied to data interpretation as the data would vary from what is required and as such further work is required to provide reliable and validated data for review. Furthermore, SCNT calculations do not account for additional staff required to provide 1:1 care. This data will need to be collected during future staffing reviews to ensure it is available to consider alongside SCNT recommended staffing.

There were 105 incidents over the six-month period up to and including July 2022 for staffing issues, which is lower than the previous 6 months. An increase in reporting of incidents (52) have been identified as potential red flags against NICE safer staffing guidance however this should be interpreted as a positive action as work was done previously to ensure staff were aware of the need to monitor and report 'red flag' events. All the incidents were categorised as no or low harm.

The main risks identified within this review relate to the need to maintain levels of Band 5 RN to offset NA gaps until workforce and NA development pathways addresses current establishment gaps. Due to high unavailability levels, particularly sickness and parenting, the numbers of temporary staff are being utilised to increase fill rates in areas. Plus, additional escalation areas have been opened without mostly without substantive staffing so the reliance on wards providing cover means there is regular movement of staff to cover gaps which helps skill mix of escalation but may reduce the skills and experience of staff in the ward areas.

The use of the SCNT in Emergency Departments is progressing. A planned census period for July was utilised as a test for the application of the tool, as process for ED Data capture is different to wards. Further training and support are required to ensure the effect roll out and application of the tool in 2023.

Paediatrics data was collected for July however, due to the use of the deployment tool there are limitations in the interpretation of the data at this time. This will be address along side the adult wards in the next census periods.

No changes to templates have been made following this census period as recent establishment review was completed. As the application of the SCNT relied on the use of the deployment tool for data collection there are limitations on analysis of the data. This will be addressed in future SCNT use.

A workforce review continues assessing the utilisation of support roles within inpatient areas and how this can help align appropriate duties to non-clinical staff.

The Trust is looking at ways of more flexible working patterns and will look at the possibility of introducing shorter shifts to wards areas that require this. Future establishment reviews will consider all wards area planning some shorter shifts, so staff have more choice.

Appendix 1

Bi Annual Safer Staffing Report – October 2022

1.0 Introduction

1.1 Demonstrating safe staffing is one of the essential standards that all health care providers must comply with to meet 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 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 The 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 there is a systematic approach to determining staffing numbers and skills required to maintain safety of patients in their care. The best practice principles of safe staffing that are to be used in are listed below and must be used in the Trusts safe staffing processes:

- Evidence based tools and data
- Professional judgement
- Outcomes

1.4 This report provides an overview of the above bullet points for inpatient ward areas in July 2022. 26 Adult ward areas and the Paediatric Ward were included in this review. (Appendix 1a)

1.5 Areas excluded in this review include escalation wards or wards with bed base function change in relation to escalation, inpatient and day case function. Due to the variability in function the evidenced based tools would not apply or provide reliable data. The emergency department was also not included and the time allotted was utilised to review process for data collection as the application of the SCNT is new for the department and runs differently to ward processes.

2.0 Nurse to Patient ratios

2.1 Nurse to patient ratios are a useful benchmark for assessing the average amount of patients each Nurse is caring for, but do not accurately reflect the needs of the individual patients, as acuity and dependency needs may vary at different points and as such nurse-to-patient ratios must account for these factors. 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.

2.2 Table1 shows the average RN: Patient ratio at Shrewsbury and Telford Hospital (SaTH) during the month of July 2022. You will see in appendix 1a that NA sit in their own establishment line and are not included in ratio but a registrant and support skill mix needs of wards and departments.

Table 1: Actual Average RN: Patient ratio during July 2022

Division	RN: Patient Ratio
Medicine & Emergency	1:5
Surgery, Anaesthetics & Cancer	1:5

2.3 Table 1 shows that during July 2022 the 2 main adult divisions met the national requirement overall of a ratio of 1:8 maximum with Surgery having the best ratios overall.

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 for whether actual hours match required hours.

3.2 The Adult and Acute Assessment Units tools are designed to be used daily for a minimum, 20-day period twice per year (January & July) collecting individual patient acuity and for ED the period is 12 day and acuity collected twice a day.

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. The tool must be used in conjunction with application of professional judgement and patient outcomes also when determining staffing establishments and skill mix.

3.4 SNCT guidance requires a review of data from three census periods before making changes to establishments/budgets. With multiple changes in ward function, and a number of wards moves the SCNT will have limitations if subsequent census periods do not analyse the same ward functions/locations. Due to this reason, it has been difficult to interpret data with some consistency.

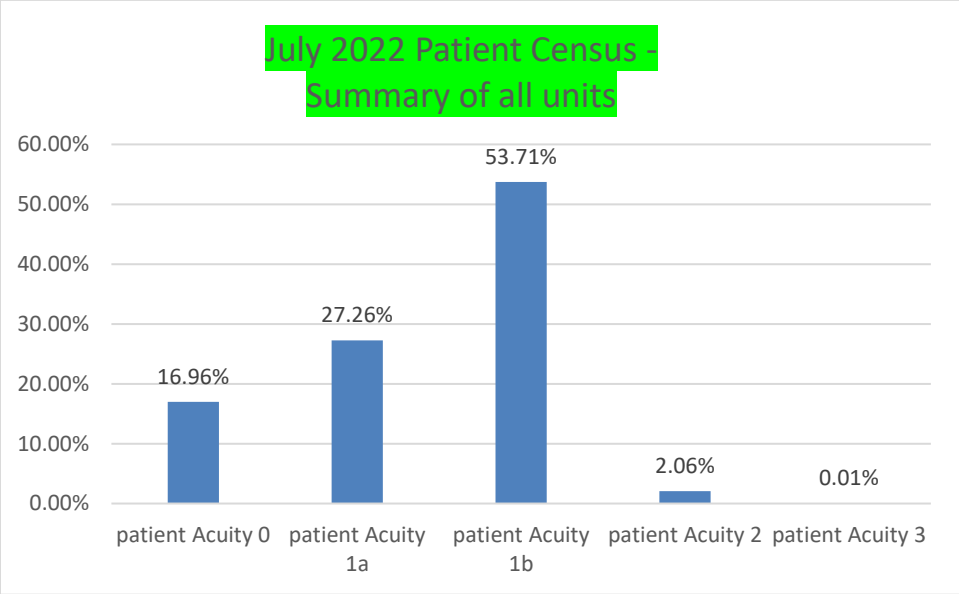
3.5 When applying methodology for safer staffing reviews, the evidence-based tools, outcomes and professional judgement should be considered. To ensure the alignment of template reviews with operation planning in 2023, an increase in census periods to three in total is planned. Baseline data available by the end of 2023 will provide a level of assurance around current establishment and templates that have been implemented in 2022.

3.6 Following a recent review of Census process it was identified the SCNT data has been collated from a deployment tool which will have affected the reliability of the data, as has been the case with this review. A change in data collection process will be applied to future use of the SCNT to ensure reliability of the tool will be planned from January 2023 which is the next planned census period. It was also noted that whilst using a deployment tool no calculation for bed utilisation occurred, which may have led to an underestimated number of acuity scores.

3.7 Further action is required following this review, and ahead of the January 2023 census period, for further training and education of key staff. It is acknowledged having a few core key personnel per ward with an appropriate level of training and competence will reduce variation in scoring and maintain inter-rater reliability. Up to a level of 10% variation expected with the use of SCNT in scores ensuring training and competency is maintained over time will offer greater assurance in regard to data and the associated analysis. Data collection will also take into account bed utilisation as there is a clear separation of use of deployment tool from the SCNT.

3.8 The analysis for all wards acuity in July 2022 is shown in Chart 1, where circa 53.71% percent of patients are a level 1b. This is a slight reduction from January 2022 in the number of 1b patients and an increase in 1a patients from 21% to 27.26% and drop in 0 acuity from 21% to 16.96%. The analysis of this data is limited due to the use of a deployment tool for data collection and variation in training may have impacted the scoring. However, the results are similar to previous census periods which also would have utilised the deployment tool for data collection.

Chart 1 – overall Trust acuity scores



3.8 Charts 2, 3 show the acuity for July 2022 broken down by Division and charts 4 & 5 by specific areas assessed in Women and Children's.

3.9 It shows that for Surgery and Medicine, the highest proportion of patients fall into the 1b category. For Gynaecology ward and Paediatrics, the majority were classed as a 1a or 0. This is similar to the data collected in January 2022.

Chart 2 – Surgery, Anaesthetics and Cancer Divisional acuity scores

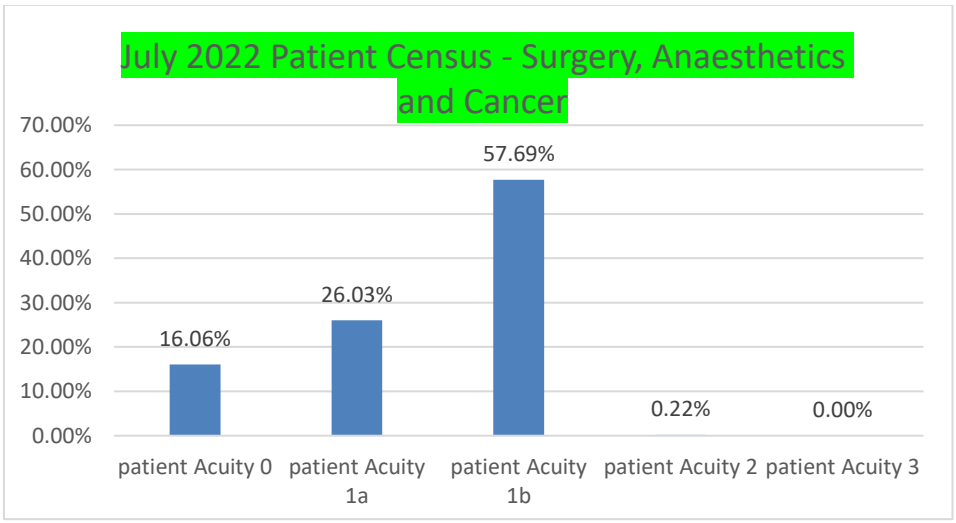


Chart 3 – Medicine and Emergency Divisional acuity scores

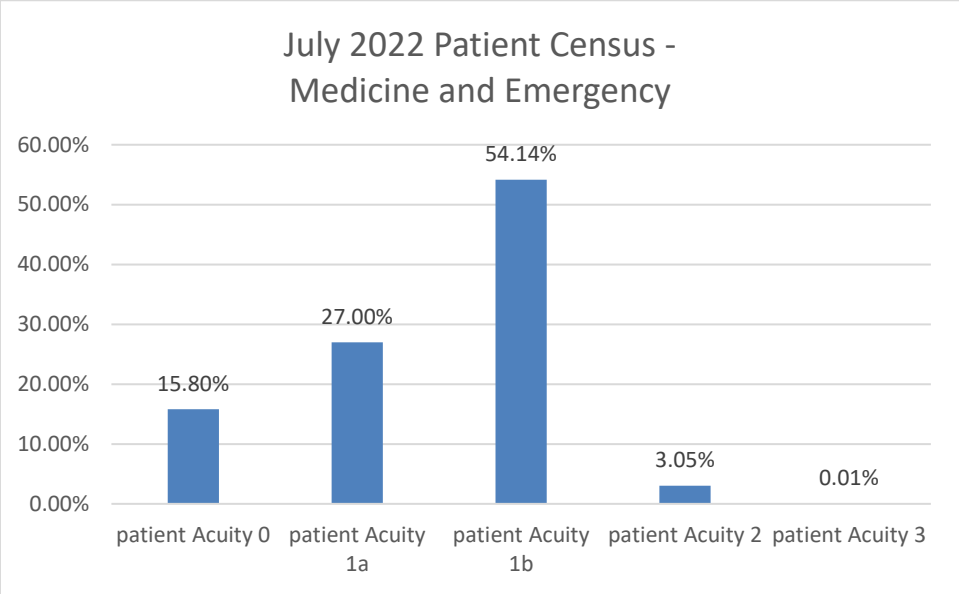


Chart 4 – Ward 14 (Gynaecology) acuity scores

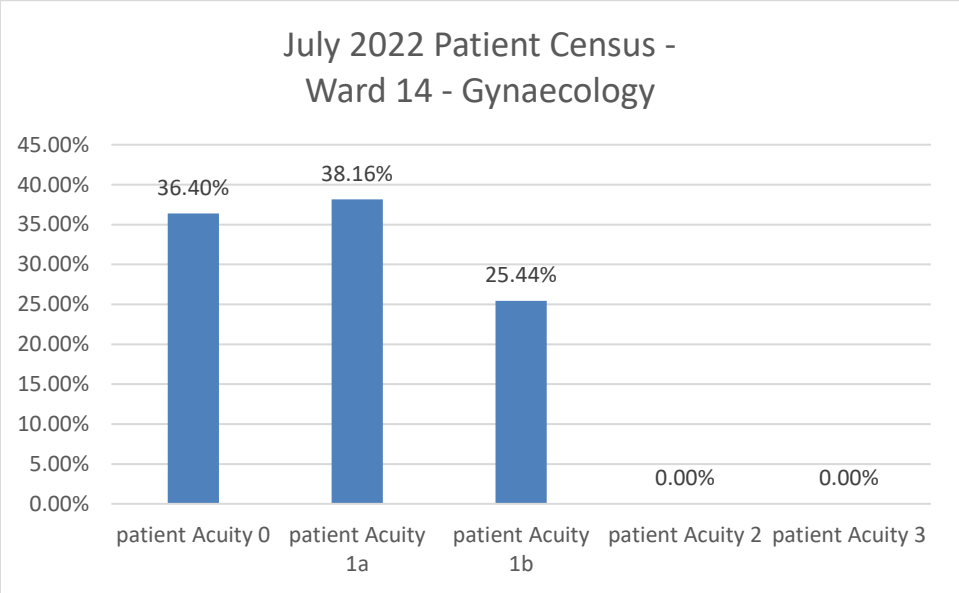
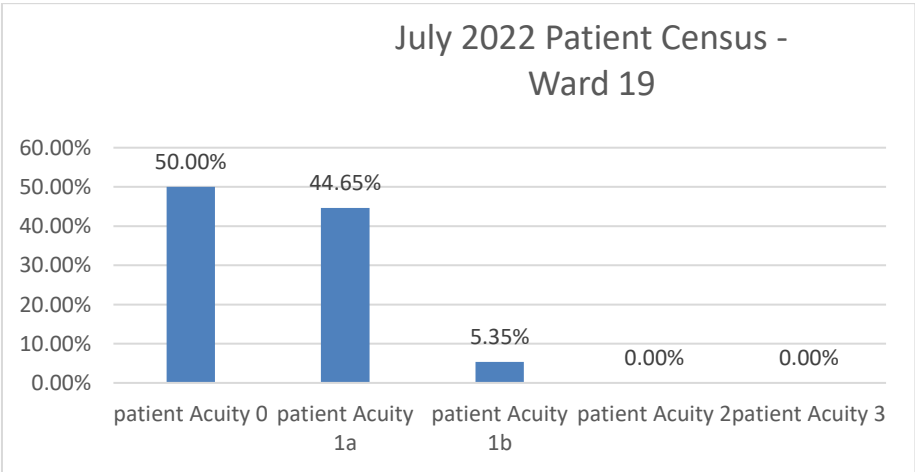
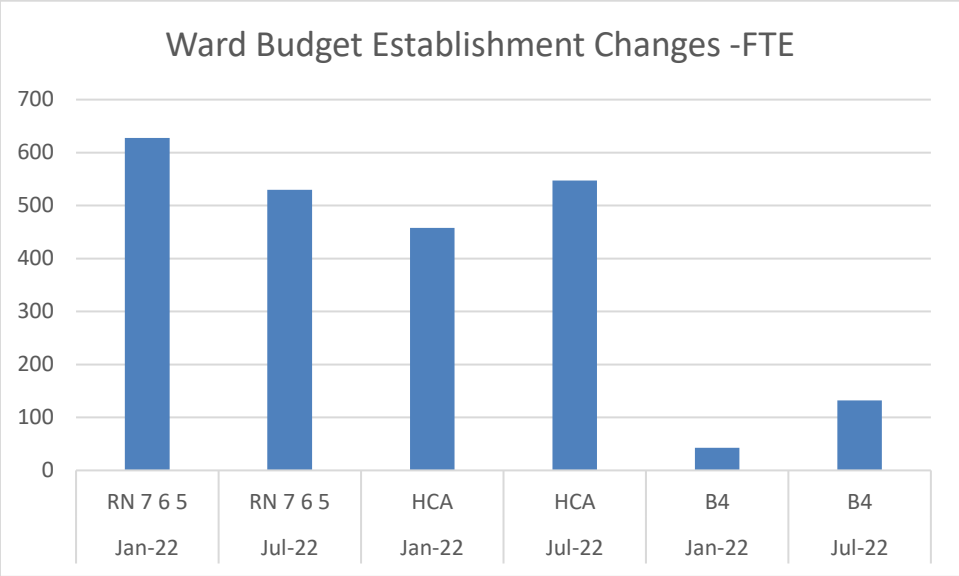


Chart 5 – Ward 19 Paediatrics acuity Scores



3.9 For the purpose of the bi-annual staffing reviews, a benchmark of RN: HCA ratio of 65:35 has been utilised within the SNCT. It should be noted that the Gold standard would be a mix of 70% RN to 30% HCA. Evidence suggests that increasing RNs within a ward skill mix reduces mortality and increases patient safety and quality of care. (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). However, where a ward has a usual higher dependency rather than acuity need, it is accepted the ratio may need change. Current acuity/dependency scoring across medicine and surgery show a higher dependency of patients in July 2022.

Chart 6 – Ward Establishment Changes Jan 2022 compared to Jul 2022 (excluding ward 19)



3.11 The full analysis of the data collection in July 2022 is shown in **Appendix 1a** and summary of changes **chart 6**. 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. However, as previously mentioned the census period used the deployment tool to capture acuity scores and as such analysis of data must take this into account.

3.12 Further work continues to enable a disaggregation of the workforce if the ward budget covers more than an in-patient area such as Gynaecology and Paediatrics for example. Furthermore, during professional judgement discussions where ward teams have additional responsibilities it was discussed how this additional worked should be recorded so it can be taken into account in future census periods.

3.13 It should also be acknowledged that again there have been several ward changes since this data was collected and professional judgement meetings which impacts the relevance of data to current ward functions. In the next calendar year, it is proposed the census periods for adult inpatients wards will be completed on three occasions. This allows for a baseline of data and assessment of recently implemented changes to establishments.

3.14 The area with the highest registered to non-registered ratio was Ward 6 Cardiology Ward at 72%; this is due to the increased RN numbers required for the Coronary Care monitored beds.

3.15 The inpatient ward with the lowest registered to nonregistered patient ratio was Ward 22R at 49%. In July Ward 22R had 1 datix forms submitted regarding staffing, 1 patient fall but nil with harm, I category 2 pressure ulcer (unvalidated), 3 complaints. The ward had 48% acute patient, 20%of patients with a higher dependency and 25% of patients needing level 2 care which as a respiratory ward was likely to be NIV. The skill mix would

not be in line with a ward with higher number of patients needing nursing care. Again, due to deployment tool being used and potential training required to ensure inter-rater reliability is maintained further census periods data is required to understand ward normal acuity/dependency levels. The ward function has now changed and is no longer respiratory following acute floor moves otherwise a quality impact assessment would have been recommended.

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 (rostered) hours against actual hours worked for RN, NA and HCA.

4.2 The summary position for July 2022 Source; (Census period July 4th – July 29, 2022, is shown in table 2).

4.3 Registered staff include NA within the Trust although current overall FTE for Nurse Associates post is 131.89, there are significant vacancies and Band 5 posts are over established. It will take a period of time for recruitment to align with vacancies and as such fill rates will continue to reflect over establishment of RN and under establishment of Band 4 NA.

Table 2 – Fill rates

	Registered Nurses		HCA	
	Day	Night	Day	Night
July 2022	85%	95%	82%	115%

SOURCE: Census period 4th July to 29th July 2022

4.4 The data from July 2022 suggests that fill rates overall on both hospital sites for RNs and HCAs day was below 85% or below and therefore of come concern, however other contributing factors need to be considered as discussed.

4.5 HCA night shifts were higher than planned which is likely to be due to EPS requirements where there tends to be greater clinical risk and template changes not enacted on rosters although changes in establishments had been agreed. This is due to roster already approve and published for staff so changes were made on next roster to be planned.

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. It has also been identified rosters have not always reflecting cover in shifts by ward managers and or other staff. This is an area where improvement is required going forward as rosters should always reflect actual staff who have covered clinically.

4.7 Fill rates also do not take into account the skill mix within an area including what percentage of this fill was temporary staff; all of which are contributing factors to quality and safety within the clinical environment.

4.8 The Ward with the lowest Day RN fill rate was identified as Ward 21 (62.3% fill). This ward also had a vacancy rate RN WTE 5.35 which is 34.9% of registered staff and overall sickness rate 5.6%. Nurse Sensitive indicators did not identify many specific quality issues, with 1 official complaint. Plus, there was a 33% response rate for friends and family with 100% recommendation score. Bed occupancy was 98%.

4.9 The Ward with the highest RN Day fill rate was Ward 14 Gynaecology at 135.5% with a bed occupancy of 80%. Changes in establishment had been agreed but changes to the roster had not been made at this point, hence fill rate was high as coordinator role was included.

4.10 Ward 22 Orthopaedics had the highest Night RN fill rate at 142.4% with a bed occupancy of 91%. The ward has had an agreed temporary uplift due to concerns regards quality and safety concerns on ward, earlier in the year. The ward is due to move to ward 29 so permanent changes to ward 22TO template not required as the will be reflected in the new Acute Orthopaedic Trauma Unit.

4.11 Ward 26S (RSH) had the lowest RN fill rate on Nights at 75.6%, bed occupancy however was only at 94%. There were 6 datix due to lack of staff, 6 falls with no harm, 1 C Diff, 1 Grade 2 Pressure ulcer and 3 official complaints reported.

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.

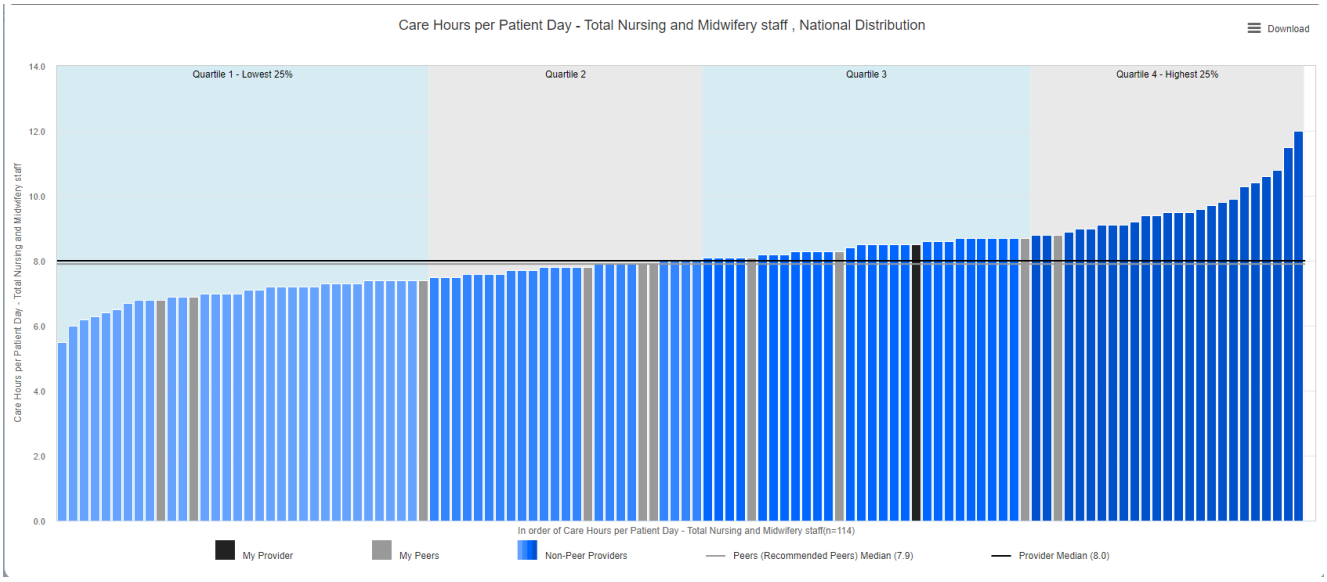
5.2 The inpatient ward area identified with the highest CHPPD (Source; Census period 4th July to 29th July 2022) was Ward 22O (7.34 CHPPD) which is slightly over their actual CHPPD of 7.11; this is likely to be due to this area requiring a rich resource in terms of staffing numbers for the group of patients on the ward during this census period. The bed occupancy at the time was 91%.

5.3 The lowest Ward area for CHPPD excluding Women and Children Division was Ward 26S. Ward 26S had a required CHPPD of 5.39 and only achieved 5.3. The bed occupancy at the time was 94%. Ward 26S SS had 3 patient complaint, 1 SI, 6 patient falls (0 with harm), and 6 datix submissions in relation to staffing.

5.4 Chart 5 shows the most up to date position for SaTH on Model Hospital (May 2022 – Full calendar month) and indicates that for CHPPD nationally, SaTH are towards the middle in quartile 3 at 8.6 and higher than both the peer median (8.5) and the national median of 8.3. (Accessed August 22, 2022).

5.5 The establishment reviews were completed prior to July census period however not all templates were effective on rosters until after July and as such CHPPD would not fully reflect recent establishment changes.

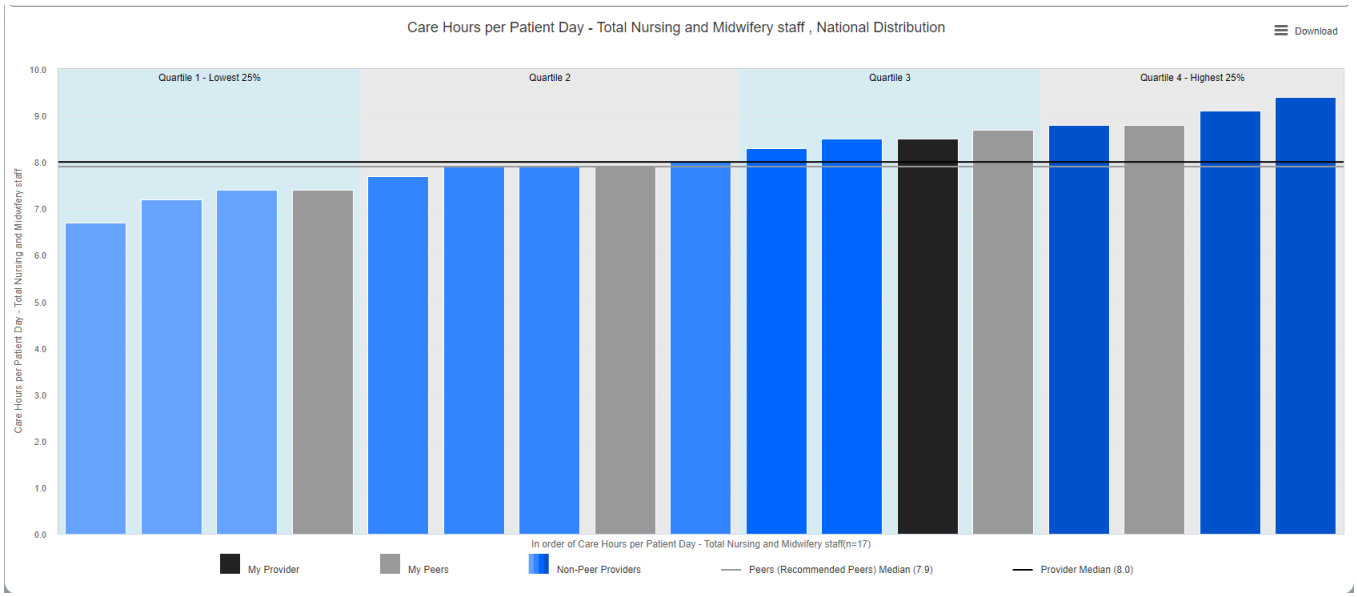
Chart 5 – National Distribution CHPPD August 2022



Source: Model Hospital, August 2022 (Full calendar month)

5.6 When comparing CHPPD to Trusts within the Midlands, it highlights that SaTH are in the upper quartile 3 (**see chart 5 & 6**). One peer at the top of quartile 1 is Wye Valley NHS Trust (7.4), Chesterfield Royal Hospital Foundation NHS Trust (7.9) in quartile 2 and Sherwood Forest NHS Trust (8.7) at the top of quartile 3 and Worcestershire Acute Hospitals NHS Trust (8.8) is in Quartile 4.

Chart 6 – Midlands Distribution CHPPD.



Source: Model Hospital, August 2022 (Full calendar month)

6.0 Substantive Unavailability

6.1 Substantive unavailability remains high in July 2022 at 34%, in comparison to 38% January 2022. Unavailability remains above planned levels due to both sickness (11%), and parenting (6%). This is similar to January 2022. However, other leave has reduced which is likely to lower covid levels and need for isolation.

6.2 There has been an increase in unavailability since pre-Covid. For January 2020 as an example prior to Covid, unavailability was at 25%. The main reason for the increase

since this time appears to be higher sickness levels and parenting which is likely to be linked to the pandemic. See **appendix 2a** for a full breakdown.

7.0 Emergency Centre

7.1 The Trust now has the Emergency Department SNCT multiplier licence. Some training has been completed by the National Team, however further in house training and competency assessment required. The aim will be to complete 3 census periods in 2023 with the first being completed in January/February 2023. Due to department pressures, there may have to some flexibility in this date. As SCNT is new and process for application of tool different to wards, Julys allocated time was utilised to review process and application of tool in practice.

8.0 Paediatrics

8.1 Bed occupancy for Ward 19 (Paediatrics) was only at 51% in July 2022 (Source; Census period July 4 – July 29, 2022) and as such the acuity and dependency data collected was not reflective of the usual activity or demographic of patients, for this reason any analysis of the data at this time is limited. However, bed utilisation should have been considered and applied when using the tool. As the deployment tool was utilised to collated acuity data the opportunity to review bed utilisation was not enabled. It is anticipated Ward 19 will see season variations with future census periods thus bed utilisation will be considered, and recommendations will take this into account following future census periods.

9.0 Incidents

9.1 During July 2022 there were 105 staffing related incidence submitted to the datix system which is second highest month of previous 6 months (see **chart 7**). Due to category being generic not all Datix are ward related and include some workforce groups that are not nursing.

9.2 52 of these incidents could be identified as potential red flags as defined by NICE (2021) due mainly to delays in patient care including rounding and medications. The Divisional Directors of Nursing continue to review these with their teams for confirmation. Whilst these incidents were categorised as no or low harm it should be noted that this will still negatively impact on patient and staff experience.

9.3 The main wards of concern for July SAU (9 Datix), Ward 23 Neonatal (9 Datix) 22 T&O (6 Datix), Ward 28 (6 Datix), and Ward 25 (4 Datix).

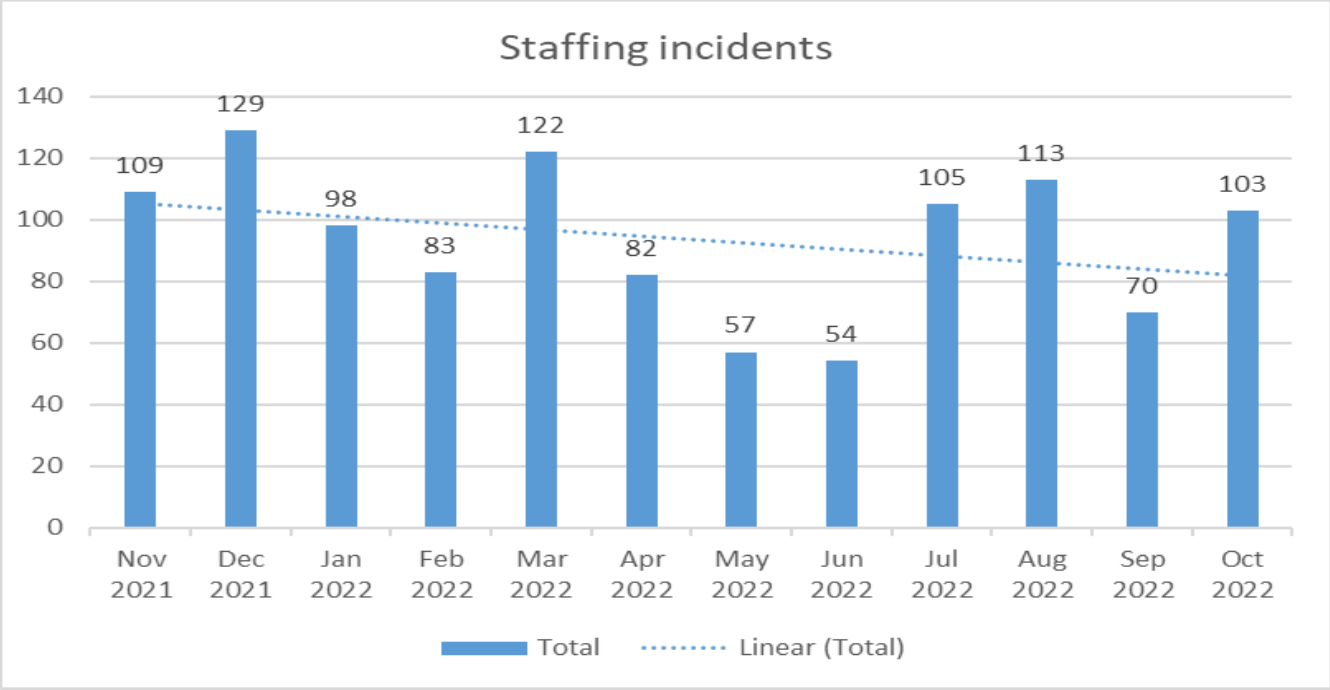
9.4 It should be noted as a caution that the datix submission detail does suggest an element of concern regarding staff understanding of safer staffing which continues to be addressed.

9.5 All datix submissions are now being reviewed monthly by the Lead Nurse for Workforce and the Divisional Directors of Nursing to review for red flags and monthly escalation.

9.6 Further work is planned to ensure there is daily oversite and validation of red flag incidences by Matrons/Divisions to ensure any concerning incidents are escalated at the time of the event.

9.7 Missed breaks and late off shift category was include as a separate category from July 2022. Only ward 28 reported an incident during July. Other areas reporting incidents included Theatres PRH (1 Datix) and CNS Gastro (1 Datix).

Chart 7



10.0 NICE Red Flags

Nursing Red Flags as specified in Safe Staffing for nursing in adult inpatient wards in acute hospitals overvew (NICE 2021).

10.1 Patient vital signs not assessed or recorded as outlined in care plan**.**

ITU/HDU at RSH and PRH are not currently using VitalPac fully as alternative monitoring in place for patients. At RSH compliancy ranges between 86% (AMU RSH) and 98% (Ward 23 Oncology/ Haematology). PRH ranges between 90% (AMU and Ward 10) and 98% (Ward 15 and 16).

10.2 Unplanned omission in providing patient medications.

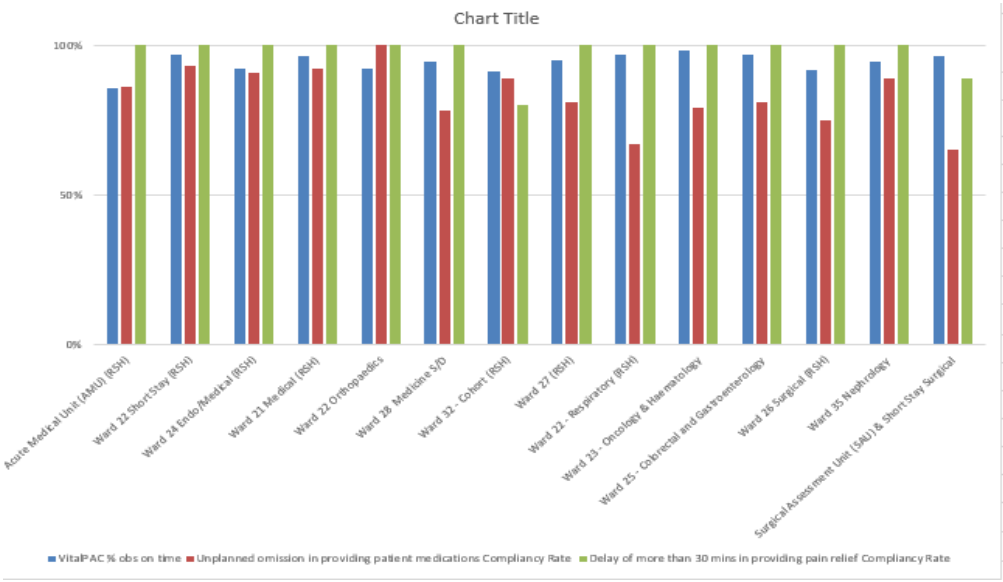
Audit data is taken from the nursing quality metrics audit which reviews 10 patient notes monthly. RSH compliancy rate ranged from 65% (SAU) to 100% (ITU/HDU, Ward 22), and PRH from 54% (ITU/HDU) to 100% (Ward 17,4,8, 9, 14 and 36). Matrons and Ward Managers are working to improve this compliance.

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

Audit data is taken from the nursing quality metrics audit which reviews 10 patient notes monthly. RSH compliancy rate ranged from 80% (Ward 27) to 100% (all other Wards), and PRH from 67% (Ward 11); to 100% (all other Wards). Matrons and Ward Managers are working to improve this compliance.

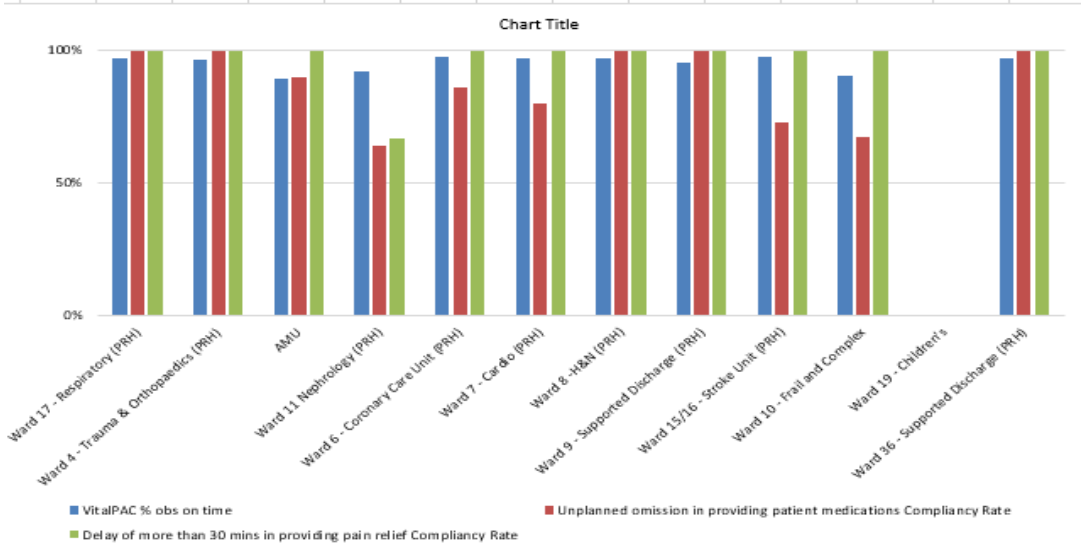
RSH

Nursing Red Flag RSH July 2022 data



Source: Nursing Dashboard July 2022 (Full calendar month)

PRH Nursing Red Flag RSH July 2022 data



Source: Nursing Dashboard July 2022 (Full calendar month)

5.4 A shortfall of more than 8 hours or 25% of registered nurse time available compared with the actual requirement for the shift and fewer than 2 registered nurses present on a ward during any shift. This data captured from E-Roster (July 2022, Full calender month) is illustrated in the graph below. There were no ward areas with less than 2RN on a shift. Assurance was gained from Matrons that this was not the case and on further exploration it was due to the movement of staff not been captured in all cases on E-roster. Work has been ongoing to get the Matrons to highlight its importance to Ward Managers.

	Jul-22			
	Days		Nights	
	Fill Rate <75%	Less than 2 Reg (23 Hrs)	Fill Rate <75%	Less than 2 Reg (23 Hrs)
MEC - Acute Medical Unit (AMU) (PRH)	4	0	3	0
MEC - Acute Medical Unit (AMU) (RSH)	3	0	1	0
MEC - Ward 10 - Frail and Complex	7	0	2	0
MEC - Ward 11 Nephrology (PRH)	7	0	3	1
MEC - Ward 15/16 Stroke Unit (PRH)	7	0	1	0
MEC - Ward 17 - Respiratory (PRH)	2	0	0	0
MEC - Ward 21 - Medicine (RSH)	24	0	9	0
MEC - Ward 22 - Respiratory (RSH)	6	1	3	0
MEC - Ward 22 - Short Stay (RSH)	7	0	1	0
MEC - Ward 24 - Endo/Medicine (RSH)	14	1	0	0
MEC - Ward 27 (RSH)	5	0	0	0
MEC - Ward 28 Medicine & Frailty (RSH)	8	0	1	0
MEC - Ward 32 Cohort (RSH)	5	0	1	0
MEC - Ward 35 Nephrology (RSH)	7	1	4	0
MEC - Ward 6 - CCU/Cardio (PRH)	4	0	0	0
MEC - Ward 7 - Endo/Cardio (PRH)	2	0	0	0
MEC - Ward 9 Medicine (PRH)	1	0	3	0
SAC - ITU/HDU (PRH)	10	0	4	0
SAC - ITU/HDU (RSH)	1	0	0	0
SAC - Surgical Assessment Unit (SAU) & Short Stay Surgical	4	0	0	0
SAC - Ward 22 - Orthopaedics	17	0	1	0
SAC - Ward 23 - Oncology & Haematology	7	0	0	0
SAC - Ward 25 - Colorectal and Gastroenterology	8	0	3	0
SAC - Ward 26 Surgical (RSH)	9	0	2	0
SAC - Ward 36 - Elective Orthopaedic (PRH)	6	0	6	0
SAC - Ward 4 - Trauma & Orthopaedics (PRH)	0	0	3	0
SAC - Ward 8 - Head & Neck (PRH)	5	1	5	0
WAC - Specialist Nurses - Gynaecology (PRH)	5	12	0	0
WAC - Ward 14 - Gynaecology	0	0	2	1
WAC - Ward 19	10	0	4	0
WAC - Ward 21 - Postnatal	19	0	29	1
WAC - Ward 22 - Antenatal	6	0	4	0
WAC - Ward 23 - Neonatal	12	0	8	0
WAC - Ward 24 - Delivery Suite (PRH)	14	0	11	0

Source: E Roster July 2022 (Full calender month)

11.0 Considerations

11.1 The review identified continued changes to wards and specialties to meet the demands of activity and Covid within the Hospitals and this has continued to change across this year with recent changes since the July census period. As previously acknowledged in the report, due to a number of changes in ward locations and functions there will be three planned census periods in 2023. Additional census data will provide considerable data for review of establishments. Establishments will be reviewed after every census period however it is recognised a minimum of two data sets is required before changes to establishments can be made and an annual review of establishments is required.

11.2 Following recent changes to ward establishment reviews that were supported by the Trust Board, it was agreed Band 7 ward managers would be supervisory in their role. This recommendation falls in line with The Royal College of Nursing that the lead role should be supervisory and thus not counted in the roster numbers (RCN, 2021).

11.3 On analysis of budgeted ward splits for RNs and HCAs; the average RN percentage has increased to 56% which is higher than last two census periods (53%). This continues to be below national guidance (RCN being 65% registered to 35% unregistered) and is therefore a risk in terms of patient safety, mortality, and staff well-being, alongside the potential impact financially on addressing this shortfall. It is important to note that overall actual daily ratio of RN to patients was satisfactory, apart from Ward 11 Nephrology (1:8.28) and Ward 22 Short Stay (1:8.04). This is a slightly higher percentage of RN to patients bed than 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) that suggests acute wards must have a planned Registered Nurse (RN) to patient 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. It is recommended a Quality Impact assessment is completed for wards working below recommendations.

11.4 The numbers of non-registered staff have increased from previous census period which has affected the Registered/non-registered ratio. The SNCT data would suggest that HCA numbers may be able to reduce in some areas however with current temporary staffing requests remain high and fill rates being utilised above 100% for this group of staff, an initial assumption would be that this cannot be the case. Work has been undertaken around EPS usage and in previous bi-annual review it was recommended a team was established; recruitment is still ongoing and has been slow to progress, but impact of the team will be considered in future staffing reviews. It is also important to note that SCNT does not calculate for patients requiring 1:1 support and the data should be captured at the time of the census. Due to the use of a deployment tool to collect acuity/dependency data the information on patients requiring 1:1 would not have been captured so this data is not available for review as part of professional judgement conversations. Furthermore, acute medical assessment areas have included staff for ward transfers in establishments and at RSH AMU team covered the RIU which was part of the red covid pathway. With acute floor moves planned and changes in establishments with new locations future reviews should reflect these changes.

11.5 Following recent establishment reviews and changes agreed in budgets and skill mix, there is now a gap in recruitment to Nurse Associate posts rather than RN posts. Until plans for growing the NA workforce are realised, the change in skill mix has meant several areas are over recruited in Band 5 positions. Offsetting Band 5 RN against Band 4 NA gaps leaves a total of 17.1 FTE Band RN over SCNT proposed establishments. As previously commented, due to the use of the deployment tool and not accounting for bed utilisation during the application of the SCNT the interpretation of this data should be limited at this time. A review of process has been completed and a modification in data collection will be made with future census periods.

11.6 Due to higher fill rates in non-registered staff it is evident that health care assistants are still covering other duties. A review of housekeepers has been completed and business case is in development, plus the role out of the enhanced care support team has commenced, however this has been hampered by recruitment into band 2 posts as currently out of a budgeted establishment of 40 FTE only 6 staff have been recruited. A review of role and job description is being completed by the new Band 7 Team Leader to make the role attractive to staff with clear development opportunities. As previously stated, acute admission areas have equated staff in ward teams due to the need to support multiple patient transfers. As such, a reduction in HCA posts could be achieved by reviewing additional roles outside of the “nursing workforce” such as Ward Clerks, Ward Hostesses, Bed Cleaning Teams, and Transfer Teams. This work is being reviewed by the corporate team. Housekeeper roles have recently been reviewed and business case is currently in development.

11.7 Currently Ward areas are utilising 12-hour shifts. It should 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 shorter shifts to each area should be considered in future workforce reviews. This has not been reviewed in the recent template review; however, wards are able to use there templates flexibly to meet the need of their staff and patients. Ward Managers are being encouraged to consider flexible requests for staff, one of which is shorter shifts. Future work will consider options to increase the number of short shifts, so staff have a better choice.

11.8 Nurse Sensitive indicators of quality and red flags do highlight some issues with wards 11, ward 28, SAU and 22R showing a higher level of omissions in medications. Plus 52 datix in total were submitted across several ward areas where the red flag indicators would have applied. Not all wards’ areas are robustly submitting datix in relation to incidences as indicated by fill rates and expected number of datix no. of shifts when staffing is below planned. Further work is required to ensure red flag events are escalated and reviewed by Matron and Senior Nurses and monitored in relation to safety.

Monthly review of Ward Metrics by Divisions and Senior Nurses will review red flag incidences and mitigations actions taken to support safe staffing across organisation.

11.8 Following recent work with NHSE, a review of approach to safe staffing and compliance with NQB standards has identified some areas for action, including the clear separation of deployment tool from SCNT. Further work is required to ensure the use of the deployment tool is embedded in daily practice, daily oversight of red flags and escalation processes is clear, actions taken for mitigation captured. Following meeting with ward managers and matrons in recent professional judgment discussions, it is noted further education and training is required for Ward managers and Matrons regards the application of SCNT and the understanding of workforce safeguards. Processes will be enhanced to ensure there is daily validation of red flags and champions for each division who will support the Lead Nurse with staff knowledge development, training, and oversight of competencies.

12.0 Future plans

12.1 The secondment of AHP workforce lead following successful bid monies from HEE was extended and review of the post to support continued workforce development of non-medical, non-nursing work is being considered. Any continuation of role in the long term will require a business case.

12.2 Consideration of safe staffing across wards and departments where SCNT does not apply will be included in the Safer Staffing Policy and process for review and outcomes included in subsequent staffing papers.

13.0 Conclusion

13.1 There were issues with the application of the SCNT and further areas for development in relation to Developing Workforce Safeguards. There is an action plan in place to address the remaining gaps (Appendix 2 – board paper)

13.2 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.

Lead Nurse for Workforce – Corporate Nursing (SY)

November 2022

Appendix 1a

Data collected – July 2022

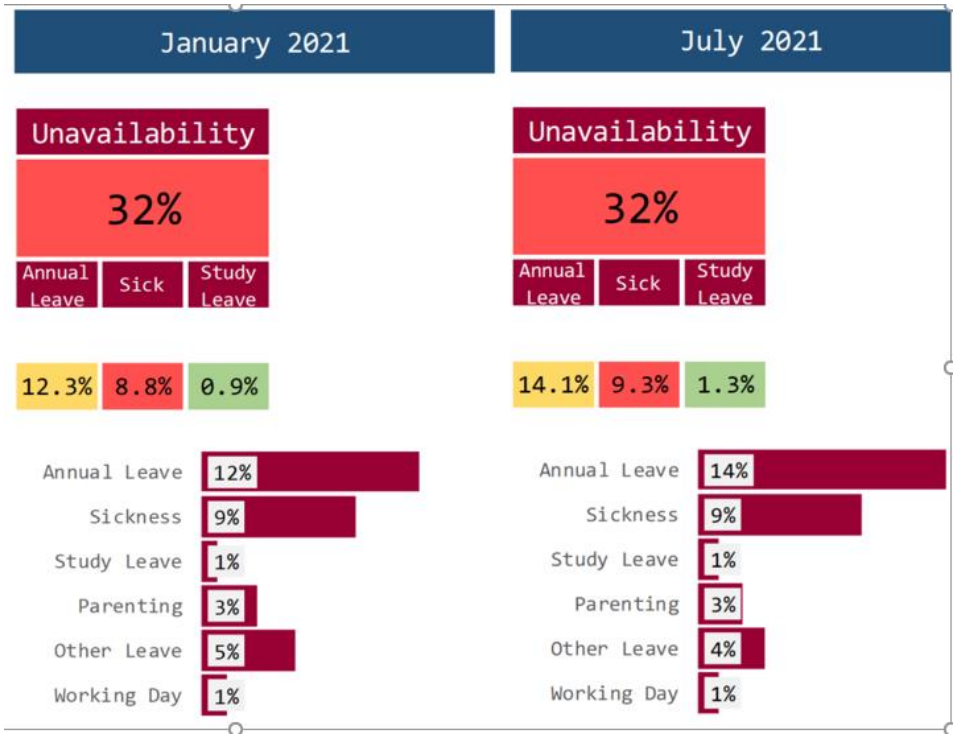
July 2022

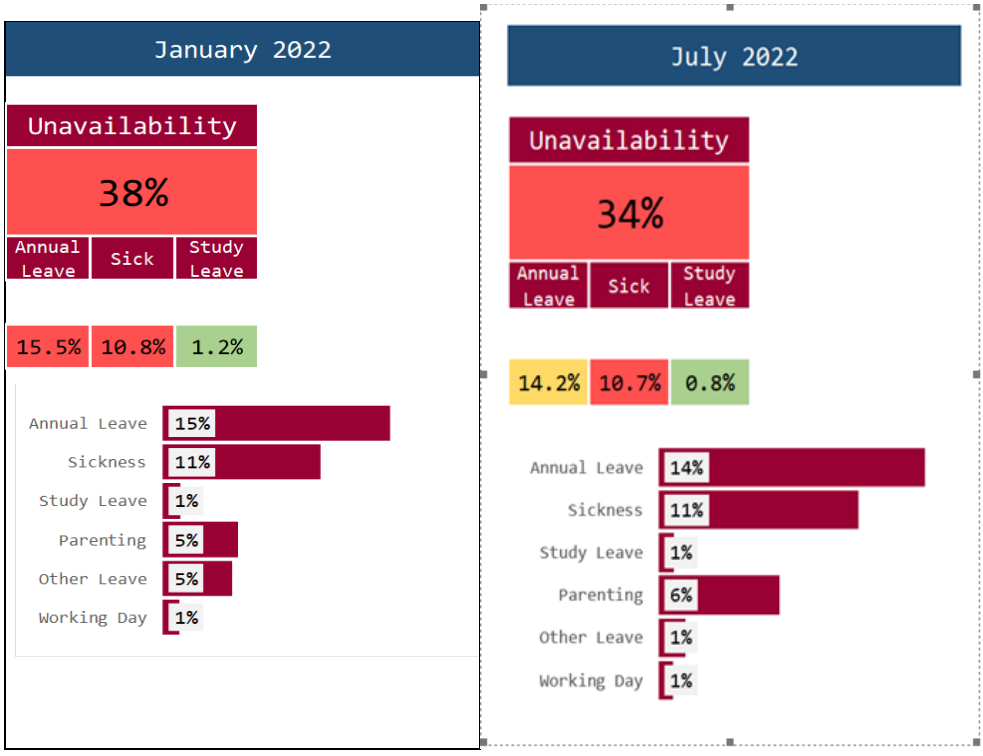
Specialty/ Ward	SitRep Beds av daily between 4th July to 29th July 2022	SitRep Occupancy Rate	0	1a	1b	2	3	Current budgeted substantive FTE			Proposed SNCT		correct or over/under established		Ratio (percentage of RN to non RN day and night) - SNCT	Average Current Number of patients per RN (day) - SNCT	Average Current Number of patients per RN (night) - SNCT	CHPPD		Fill Rate (RN) - Day	Fill Rate (RN) - Night
			%	%	%	%	%	RN - B7, B6, B5	HCA - B2, B3	NA - B4	RN	HCA	RN	HCA	RN:Non Registered			Required	Actual		
		%	Dependency Level Summary / SNCT element																		
Emergency Care																					
AMU PRH	17	83%	0	18.5	1.4	0	0	23.54	28.38	7.08	21.8	11.7	1.74	16.68	67%	3.1	3.5	5.97	10.47	98.0%	93.5%
AMU RSH	20	81%	9.2	10.7	2.6	1	0	35.62	39.55	11.81	24.1	13	11.52	26.55	69%	4.0	3.8	6.99	12.25	86.5%	91.7%
SAU (W33/W34)	38	92%	5.4	24.7	4.4	0	0	38.81	37.86	2.36	37	19.9	1.81	17.96	71%	6.6	5.4	7.31	7.97	93.7%	113.2%
(HASU) *(see same data for ward 15 below)*																					
Medical																					
Ward 6 Cardiology	23	95%	2.1	13	7.1	1.6	0	32.46	14.1	2.36	23.1	12.4	9.36	1.70	85%	4.7	5.5	6.64	6.81	82.4%	105.1%
Ward 7 Endincrology and Nephrology (PRH)	28	93%	3.3	13.1	10.2	0	0	16.03	19.33	4.04	25.4	13.7	-9.37	5.63	71%	6.3	9.2	6.48	6.31	95.6%	101.9%
Ward 9 Medicine	38	97%	2	14.2	13.4	1	0	17.71	19.06	4.72	30.4	16.4	-12.69	2.66	64%	6.2	9.5	6.79	6.63	98.5%	102.8%
Ward 11 Nephrology (PRH)	28	95%	3.7	1	23.30	0	0	17.71	18.85	4.72	29.3	15.8	-11.59	3.05	59%	7.3	9.8	7.11	6.7	87.4%	96.8%
Ward 10 Frail and Complex Elderly (PRH) increasing by 1	28	97%	1.4	2.7	26.7	0	0	17.71	18	4.72	33.2	17.9	-15.49	0.10	72%	5.4	6.3	6.34	5.7	96.4%	128.5%
Ward 15 / 16 *Stroke Unit (PRH) - also includes HASU*	42	94%	4	1	35.4	1.3	0	37.06	37.88	5	44.7	26.1	-7.64	11.78	76%	4.8	5.8	7.24	8.77	88.1%	100.0%
Ward 17 Respiratory	28	93%	7.3	3.2	13.4	3.1	0	22.44	21.77	4.72	26.5	14.3	-4.06	7.47	72%	5.0	7.2	6.68	7.67	95.1%	97.1%
Ward 21 Medicine	16	98%	2.8	5.3	8.5	0	0	15.35	13.06	0	16.1	8.7	-0.75	4.36	73%	4.7	5.2	6.7	6.93	63.5%	93.6%
Ward 22SS	26	91%	9.2	11.7	4.2	1.4	0	17.71	22.01	4.72	23	12.4	-5.29	9.61	61%	7.6	8.7	5.77	7.08	90.8%	103.7%
Ward 22 Respiratory	20	96%	1.4	9.8	4.2	5	0	15.36	16.82	4.72	20.9	11.2	-5.54	5.62	59%	6.3	5.8	7.03	9.24	84.8%	88.4%
Ward 24C+E Cardiology / Endincrology (RSH)	32	96%	3.4	6.7	22	6	0	20.08	20.73	4.72	40.5	21.8	-20.42	-1.07	62%	6.7	8.1	7.06	7.02	80.3%	99.5%
Ward 27	39	95%	18.3	0	19.2	0	0	20.75	27.68	8.77	33.2	17.9	-12.45	9.78	67%	7.1	8.5	5.98	6.14	87.8%	118.4%
Ward 28 Medicine and frailty	34	96%	6.4	2.5	25	1	0	17.71	24.06	9.45	35.6	19.2	-17.89	4.86	68%	6.3	7.5	6.87	6.61	85.6%	92.4%
Ward 32 Respiratory	24	80%	1.4	5	11	2.3	3	18.39	16.81	6.41	32.3	17.4	-13.91	-0.59	66%	6.4	5.5	7.21	8.22	81.3%	95.1%
Ward 35 Renal	16	86%	2.7	5.5	5.6	0	1	13.67	21.17	4.04	16.8	9.1	-3.13	12.07	62%	4.6	4.9	6.37	10.71	80.6%	99.3%
Surgery																					
Ward 25G Colorectal & Gastroenterology (RSH)	37	95%	12	3.9	20.9	0	0	21.47	24.85	8.77	34.6	18.6	-13.13	6.25	64%	6.7	10.1	6.35	6.41	95.3%	95.2%
Ward 26S General Surgery / ICA (RSH)	37	94%	8.1	6.3	21.1	2.2	0	17.71	20.33	7.08	37.3	20.1	-19.59	0.23	67%	5.5	6.6	5.3	5.39	78.7%	75.6%
Ward 8 H&N	13	90%	5.1	5.4	1.8	1.4	0	13.67	8.48	1.69	12	6.4	1.67	2.08	74%	4.6	4.4	5.56	9.32	107.0%	145.4%
Muscoloskeletal																					
Ward 4 Trauma and Orthopaedic	26	94%	1.9	13	22.9	0	0	15.35	19.4	4.72	38.6	20.8	-23.25	-1.40	68%	5.3	8.5	7.28	6.94	99.9%	97.5%
Ward 36 elective orthopaedics	17	81%	1.4	1.8	11.50	0	0	12.99	11.25	2.36	15.4	8.3	-2.41	2.95	75%	4.2	4.6	6.6	10.51	119.0%	138.8%
Ward 22 Orthopaedics	32	91%	1.3	3.5	26.9	1	0	17.71	22.89	7.08	35.4	19	-17.69	3.89	61%	7.6	7.4	7.34	7.11	103.2%	142.4%
Oncology																					
Ward 23OC Oncology & Haematology	22	94%	1.7	10.8	14.5	1	0	20.08	15.36	2.36	28.3	15.3	-8.22	0.06	84%	5.5	5.9	7.05	7.89	76.3%	94.4%
Womens & Childrens																					
Ward 14 Gynaecology	12	80%	4.1	3.8	2.5	0	0	12.54	7.73	3.47	8.90	4.8	3.64	2.93	81%	4.2	5.5	5.8	10.88	135.5%	102.0%
Ward 19	36	51%	9.9	7.7	1.5	1	0	62.08	36.06	9.45	16.3	8.8	45.78	27.26	86%	3.2	3.1	9.23	13.44	76.3%	91.6%
Total			**129.5**	**204.8**	**361.2**	**30.3**	**4**	**493.74**	**477.68**	**131.89**	**740.7**	**401**	**-148.99**	**182.47**	**53%**			**181.05**	**219.12**		

Appendix 2a

Substantive unavailability

[Source ward Dashboards- January and July 2021 Full calendar month, January 2022 Census period January 10 – February 4, 2022. July 2022 4 -28 July includes Ward 19]





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Appendix 2

Workforce Safeguards Gap Analysis and Action Plan