North Bristol NHS
NHS Trust

Report to:	Trust Board	**Agenda item:**	
Date of Meeting:	30th April 2015		

Report Title:	Safe Nurse Staffing – 6 Monthly Assurance Report and Business case for Additional Posts			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
	X		**X**	**X**
Prepared by:	Sarah Dodds, Deputy Director of Nursing (Part A) Lisa Marshall, Interim Director of Midwifery (Part B) Maria Hennessy , Head of Nursing Children's Community Health Partnership (Part C)			
Executive Sponsor (presenting):	Sue Jones, Director of Nursing and Quality			
Appendices (list if applicable):	[Appendix 1 Financial Appraisal]			

Recommendation:
The Trust Board is asked to note this report; the assurance regarding actions already underway and actions planned to ensure staffing levels are safe, effectively monitored and published openly **The Trust Board is asked to Approve:** • **The overarching Business case for the financial budgets within the identified areas to be aligned to the clinical need and posts to be recruited substantively immediately.** • **Approve the funding mechanism for this increase, identified through ensuring posts are funded to the individual increment and through a proposed reduction of up lift from 24% to 21%.** • **Approve the net investment of £528,290.**

Executive Summary:

Further to the Government response to the Francis report the National Quality Board (NQB) published 'How to ensure the right people with the right skills are in the right place at the right time' in November 2013. The NQB guidance set 10 expectations, 9 of which were for Acute Trusts.

Within the NQB guidance the Director of Nursing is responsible for providing the Trust Board with assurance around Safe Nurse Staffing which includes six monthly reports on safe staffing and monthly updates on Workforce Information. This is the fifth of such six monthly reports.

Further to the NQB guidance, NICE has also published its first guidance on safe staffing for nursing in adult inpatient wards in acute hospitals (July 2014). The NICE guidance also makes recommendations about the factors that should be systematically assessed at ward level to determine the nursing staff establishment, recommends on-the-day assessments of nursing staff requirements to ensure that the nursing needs of individual patients are met and recommends monitoring staffing levels and taking action to ensure safe care by adjusting staffing numbers as required.

This report provides assurance against the relevant NQB expectations and NICE recommendations; it details what is currently in place to meet the expectations and recommendations and the plans in place to address any gaps.

Six months post the Move into Brunel and in line with budget setting a review of staff staffing has been completed. This review demonstrates the need for the following additional staff: 60 Registered Nurses, 11 Midwives and 60 Health Care Assistants. The business case developed explains the approach taken to review the nursing skill mix on the wards and the required increases in establishments following this robust review using NICE guidance, Nationally recommended professional guidelines, Acuity and Dependency tool analysis and professional judgment. The results are consistent with CQC findings and requirement to review staffing levels to ensure they meet demand.

The Trust Board is asked to approve:

- The overarching Business case for the financial budgets within the identified areas to be aligned to the clinical need and posts to be recruited substantively immediately.
- Approve the funding mechanism for this increase, identified through ensuring posts are funded to the individual increment and through a proposed reduction of up lift from 24% to 21%.
- Approve the net investment of £528,290

Section 2 of this report specifically covers safe Maternity Unit staffing. There has been investment in Midwifery staffing to address acuity, and the number of unit closures in the last year.
The Trust Board is asked to approve:

- An uplift to the Midwifery establishment to increase by 11 wte

This will enable the Midwife to Birth ratio to benchmark similar to other units in the South West.

Section 3 of this report explains the current position for recruitment of health visitors against the annual plan.

The Trust Board is asked to note:

- Progress made and future workforce projections against the national target.
- Plans to improve retention of the health visiting service going forward.

1. Purpose

The purpose of this paper is to provide the Board with a 6 monthly report on Nursing, Midwifery and Health Visitor staffing and seeks approval for funded increases indicated in establishments to maintain safe staffing.

2. Background

Further to the Robert Francis report, the National Quality Board have published guidance[1] that sets out the expectations of commissioners and providers for safe nursing and midwifery staffing, in order to deliver high quality care and the best possible outcomes for patients.

NICE published its first guidance 'Safe staffing for nursing in adult inpatient wards in acute hospital[2]' (July 2014) and 'Safe midwifery staffing for maternity settings'[3] (Feb 2015). NICE recommends that their guidance is read alongside that of the NQB guidance.

Both the NQB and NICE guidance for Nursing do not set defined staffing ratios with a single ratio or formula. NICE state that *'There is no single nursing staff-to-patient ratio that can be applied across the whole range of wards to safely meet patients' nursing needs. Each ward has to determine its nursing staffing requirements to ensure safe care*.' However they do recommend the use of an evidence based tool to determine the average number of nurses required in order that staffing is geared to patient sickness and dependency as well as numbers of patients.

NICE guidance for Midwifery does recommend a minimum staffing ratio for women in established labour; however, they did not recommend staffing ratios for other areas of midwifery care. This was because of the local variation in how maternity services are configured and therefore variation in midwifery staffing requirements and the lack of evidence to support setting midwife staffing ratios for other areas of care.

A growing body of research shows links between patient sickness and dependency, workload, staffing and quality of care. Low staffing levels and a low proportion of registered nurses on wards have been linked to poor patient outcomes, and there is evidence of increased harm when a registered nurse cares for eight or more patients during day shifts (NICE, 2014).

A nursing skill mix review was undertaken when preparing to move into the Brunel Building at Southmead Hospital in late 2013, this included a new model of care, introduction of 12 hour shifts and additional support roles of administrators and housekeepers to augment the nurse staffing establishment.

Following the move into the new Brunel Building in May 2014 it was soon evident that the staffing levels did not support the nursing requirements to provide safe nursing care, this was evidenced by a substantial increase in the numbers of falls which occurred, in the number of Grade 4 pressure ulcers identified and in the number of patients requiring close observation in a single room environment. In view of this, wards were supported to increase their staffing levels to ensure that patient safety and experience remained a priority.

[1] How to ensure the right people with the right skills are in the right place at the right time, NQB, November 2013

[2] https://www.nice.org.uk/guidance/sg1

[3] https://www.nice.org.uk/guidance/ng4

The CQC inspection in November 2014 reviewed nurse staffing and in their report identified that nurse staffing levels needed to be reviewed in all areas to ensure that they matched demand and to ensure that there are sufficient nurses with the appropriate skills and experience to provide safe and quality care to patients at all times.

Approach taken to review safe staffing

In order to review nurse staffing, triangulation of data has taken place including a review of the patient acuity using the Shelford acuity tool (nationally approved tool) in October 2014, NICE guidance for safe staffing published in July[4] 2014 and Professional knowledge of individual specialties'.

An initial review of the wards was undertaken in September 2014 by the Director of Nursing. The Heads of Nursing presented requirements for increased staffing, at this time there were some approval of increases in establishments supported pending full business cases being generated and fully approved. 10 additional Midwives were approved and appointed in October 2014.

With regard to the benchmarking of skill mix ratios, the plan is to meet the requirement of 1 RN to 8 patients on a day shift and also to have all inpatient wards working to a minimum skill mix of an average RN/HCA ratio of 60/40.
In line with national guidance of 6 monthly reviews and in order to ensure all nurse and midwifery establishments are funded appropriately, In February 2015, a full review of all areas has taken place. This was in the format of a panel review consisting of the new in post Deputy Director of Nursing, Trust Finance Lead for Nursing and Trust Workforce lead. The Heads of Nursing presented their cases for increased staffing requirements which have been supported by business cases. The panel process also included a critical analysis alongside a triangulation of data including Quality metrics, Shelford acuity tool results, QUESTT tool, (Early Warning Trigger Tool) patient and staff feedback and Professional knowledge of the specialty.

Prior to the review there were 2 wards which did not reach the required Registered Nurse ratio of 1:8 on a day shift, following the review and revision of establishments, all wards will now reach a funded ratio of 1:8 or less, exclusive of the Supervisory ward sister. 14 wards do not reach the required average 60/40 split of RN/HCA (table 1), some changes and improvements were made through this review, and validation took place with all the Heads of Nursing, skill mix ratios will continue to be closely monitored against quality indicators and care contact time.

WARDS	%RN/HCA (60/40%)	RN:8 Pts
Gate 6b - Neuro	67/33	1:5
Gate 7a - Neuro	60/40	1:5
Gate 7b - Neuro/Trauma	56/44	1:6
Gate 8a - Medicine/Renal	54/46	1:6
Gate 8b - Renal	59/41	1:5
Gate 9a – Neuro Rehab	55/45	1:6
Gate 9b – Medicine Complex Care	54/46	1:6
Gate 25a - Neuro/Trauma	67/33	1:5

[4] http://shelfordgroup.org/library/documents/130719_Shelford_Safer_Nursing_FINAL.pdf

Gate 25b - MSK Trauma	58/42	1:6
Gate 26a - MSK Ortho	59/41	1:8
Gate 26b - Surgical Admissions/Trauma	69/31	1:5
Gate 27a - Cardiology/CCU	69/31	1:5
Gate 27b - Respiratory/Isolation Suite	63/37	1:5
Gate 28a – Medicine Complex Care	54/46	1:6
Gate 28b – Medicine Complex Care	54/46	1:6
Gate 31a&b - Acute Assessment Unit	63/37	1:5
Gate 32a - Short stay Med	54/46	1:6
Gate 32b - Medicine	57/43	1:6
Gate 33a - Burns and Plastics	76/24	1:6
Gate 33b - Vascular surgery	61/39	1:6
Gate 34a - Colorectal surgery	63/37	1:5
Gate 34b – Urology surgery	61/39	1:6
Rosa Burden Unit – Neuro Psychiatry	67/33	1:5
Cotswold – Gynaecology	80/20	1:8
Elgar 2 - CoE Rehab- 34 Beds	54/46	1:7
Elgar 3 - CoE Rehab	50/50	1:7
Elgar 4 - CoE Rehab	50/50	1:7

(Table 1)

Following a period of training all wards in March 2015 have undertaken a 20 day period of completing and recording acuity using the Safe Care (Shelford) tool with data entry completed twice daily. This data will be reviewed at the Nursing workforce group and all wards are continuing to record acuity twice daily. A version of the Shelford tool for Acute wards for Older People is currently being tested which will better reflect the complexities for managing this group of patients, following evaluation this will be incorporated for use for relevant wards within NBT.

Demonstrating sufficient staffing is one of the essential standards that all health care providers must meet in order to be compliant with CQC requirements and we have been required to publish staffing data since April 2014. The data which we have been providing has been:

- Six monthly Trust Board report Re: Safe staffing
- Board level report detailing planned and actual staffing for the previous month.
- Monthly report published on the Trust's website, and uploaded onto NHS Choices website
- Nursing/Midwifery staffing levels each shift (planned and actual) displayed at ward level.

Boards must, at any point in time, be able to demonstrate to their commissioners that robust systems and processes are in place to assure themselves that the nursing, midwifery and care staffing capacity and capability in their organisation is sufficient to provide safe care. All NHS Trusts are accountable to the NHS Trust Development Authority (TDA) and, as stated in the Accountability Framework 2015-16, will be expected to provide the NHS TDA with assurance that they are implementing the NQB staffing guidance and that, where there are risks to quality of care due to staffing, actions are taken to minimise the risk.

This report will provide assurance against the NQB guidance and expectations for acute Trusts and NICE recommendations,

the purpose of which is to ensure that high quality care can be delivered and the best outcomes can be achieved for patients. All but one expectation (Expectation 10) is targeted at healthcare providers and there is overlap between some of the expectations.

National Quality Board 10 Expectations
Accountability and Responsibility 1. The Board take full responsibility for the quality of care provided to patients and as a key determinant of quality, take full and collective responsibility for nursing, midwifery and care staffing capacity and capability. 2. Processes are in place to enable staffing establishments to be met on a shift by shift basis
Evidence Based Decision Making 3. Evidence based tools are used to inform staffing capacity and capability
Supporting & Fostering a Professional Environment 4. Clinical & Managerial Leaders foster a culture of professionalism and responsiveness, where staff feel able to raise concerns 5. A multi professional approach is taken when setting nursing, midwifery and care staffing establishments 6. Nurses and midwives and care staff have sufficient time to fulfil responsibilities that are additional to their direct caring duties.
Openness & Transparency 7. Boards receive monthly updates on workforce information and staffing capacity and capability is discussed at a public board meeting at least every six months on the basis of a full nursing & midwifery establishment review. 8. NHS providers clearly display information about the nurse's midwives and care staff present on every ward, department or service on each shift.
Planning for Future Workforce Requirements
9. Providers of NHS services take an active role in securing staff in line.
The Role of Commissioners 10. Commissioners actively seek assurance that the right people, with the right skills, are in the right place at the right time.

(Figure 1. National Quality Board expectations Nov 2013)

3. General Factors Influencing Nurse Staffing

The national picture influencing the increased requirement for healthcare and therefore nurses is well documented and includes:

- The ageing population's impact on inpatient dependency and acuity.
- Rapid throughput and shorter inpatient-stays; but of a greater complexity and acuity. Patients with low acuity are no longer found within our acute wards
- Decreasing Registered Nurse direct-care time and the corresponding rise in support worker direct care time
- New roles within the workplace; e.g. Band 4 Assistant Practitioner
- Change in the nursing skill mix e.g. Housekeeper, Supervisory Sister
- The Francis report
- New technologies and treatments
- Changes to pathway delivery i.e. integrated care models
- National Performance measures and CQUIN
- Public expectations regarding quality
- Financial position

4. Nurse Staffing and Nurse Outcomes

The impact of nursing, midwifery and care staffing on the quality of care experienced by patients, and on patient outcomes and experience has been well documented, with studies linking low staffing levels to poorer patient outcomes, and increased mortality rates. Recent reviews by Sir Bruce Keogh and Don Berwick reinforced this with examples of where poor outcomes have been linked to poor nurse to patient ratios. For example, in Professor Sir Bruce Keogh's review, a positive correlation was found between patient to staff ratios and higher Hospital Standardised Mortality Ratios (HSMRs), (Keogh, 2013)[5].

5. Leadership framework in place for Staffing

Each Directorate Nursing Team at NBT is led by a Head of Nursing who is responsible for ensuring that the correct levels of nursing staff are in place on each ward.

A new Matron Leadership structure and Supervisory Ward Sisters were implemented as part of the move into the Brunel Building and additional roles such as Assistant Practitioners, Housekeepers, Ward Administrators and additional Receptionists are all in place.

Since moving to the Brunel Building in May 2014 the ward nursing teams have found it very challenging working in a completely new environment with their new teams which included new staff to the organisation. This was also in the context of problems with the new Building and working closely with other important groups of staff who had also changed their ways of working e.g. Facilities.

To support these issues the Deputy Director of Nursing has been working closely with the Ward Sisters using the 'Productive Ward' methodology to facilitate improved ways of working and efficiencies to release time to care for patients.

There has also been concern with managing patients at high risk of falls with 75% single rooms and the number of 'Specials' being booked are above plan in relation to the ward budgets. In order to manage this and reduce the numbers of 'specials', an 'Enhanced Care' Policy is currently in draft and one Directorate are trialling the use of other groups to staff to provide this level of care. Training for staff in the use of the new policy and risk assessment will take place over the summer, to ensure robust management and implementation. There has been a significant reliance on temporary staff to provide this care in the past and it is planned that through the recruitment of the additional posts identified in the individual business cases and in the training of the staff that this reliance will reduce. There has also been additional recruitment to NBT Xtra to support the increase in requests and to further reduce reliance of agency nursing.

The Trust Falls group has an Action Plan in place to reduce the number of falls and the Dementia Matron is supporting the wards in piloting different ways of working with patients that had cognitive impairment to reduce the risks of falls and dependency on 'Specials'.

[5] http://www.nhs.uk/NHSEngland/bruce-keogh-review/Documents/outcomes/keogh-review-final-report.pdf

6. Meeting the NQB Expectations and NICE recommendations

6.1 Accountability & Responsibility

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Key actions that are in place are:

- Staffing levels 'planned and actual' for each ward, are reviewed on a shift by shift basis and at the daily 'Patient Flow and Leadership' meetings which are managed by a Directorate Matron or Head of Nursing. The accountability for ward staffing levels is with the Ward Sisters and Matrons who escalate concerns to the Heads of Nursing and Deputy/Director of Nursing if required. Staff are supported to complete incident forms when staffing levels are considered to be of concern. There is a plan to implement the 'red flag' reporting alongside the incident reports from June 2015. Examples of 'red flags' on wards (NICE 2014), would be delays or omissions with vital signs or medications and less than 2 RNs present on a ward during the shift.
- A baseline review of NICE guidance SSG1 Safe staffing for nursing in adult inpatients wards in acute hospitals has been undertaken at NBT. The self-assessment undertaken in March 2015 demonstrated 31 recommendations met and 6 partially met. The partially met recommendations all have an action plan in place and will be reviewed again in October 2015. The self-assessment was approved at the March 2015 Nursing, Midwifery and Allied Health Professional Group meeting and will go to the Trust Clinical Effectiveness Committee in May 2015
- The Heads of Nursing also complete a monthly analysis of all of their wards including incident reports for low staffing levels and provide assurance of risk assessments and actions taken when wards are both 10% below or above planned staffing levels.
- Systems for monthly assurance and reporting are in place using nursing metrics, for example QUESTT data and quality metrics
- A staffing establishment review is undertaken six monthly using the Safe Care Tool, an evidence based acuity and dependency tool. The staffing establishment is approved by the Director of Nursing.

Key actions that are being progressed are:

- Standardised processes are being developed to assist in decision-making regarding ward staffing levels on shift by shift basis. This includes a 'Specialling' Policy to support risk assessment and appropriate action to support patients.
- As part of the revised E roster implementation an Escalation Policy for addressing staff shortages on a shift by shift basis will be developed. This will also capture any Wards which identify 'Red Flags' as recommended by NICE.
- The Safe Care acuity tool was completed in March 2015 electronically and will continue to be recorded twice daily on each ward. The results for the March data will be reported and reviewed at the Nursing Workforce Group.
- A baseline review against the Draft NICE Emergency Department safe staffing (February 2015) has taken place with additional posts approved following the CQC warning notice.

6.2 Evidence Based Decision Making

Key actions that are in place are:

- Use of evidence based tools to determine staffing levels is part of the staffing establishment review. This includes the ratio of Registered Nurse (RN) to Health Care Assistant (HCA) and Safe Care Acuity (Shelford) Tool to determine acuity and dependency requirements.

- Triangulation of results from the tools are used in conjunction with professional judgement and local knowledge. The Ward Sisters, Matrons and Heads of Nursing review their skill mix and use nursing metrics to support any decision making.

- Daily reviews of actual staff available in comparison to planned staffing levels is reviewed and recorded at ward level by the Ward Sisters, Matrons and Heads of Nursing. This data is collated and reported monthly on Board reports, NBT Website and NHS Choices for the public. In January 2015 there was a change in the reporting of staffing levels at NBT, this was following a review of the national guidance by the Trust. The changes related to the numbers of additional staff to special patients with 1:1 care. In the past the Trust had included specials in both the planned and actual staffing levels. As noted in the guidance the Trust should only have been reporting these additional staff in the actuals column. As a result of adherence to the guidance, the staffing figures are noted to have increased due the additional staff used to provide specials.

Key actions that are being progressed are:

- E-rostering has been further developed to support all these requirements to enable robust 'live' reporting and monitoring of staffing levels The 'Safe Care' acuity tool which has the functionality to support more immediate staffing deployment has been utilised in March 2015 in 88% of wards.

- The 'Safe Care' tool will now be progressed to be utilised to support the deployment of staff to provide safe staffing levels across the Trust and as a method to fulfil the NICE recommendations with regard to identifying 'red flags' at ward level where there are concerns with staffing levels.

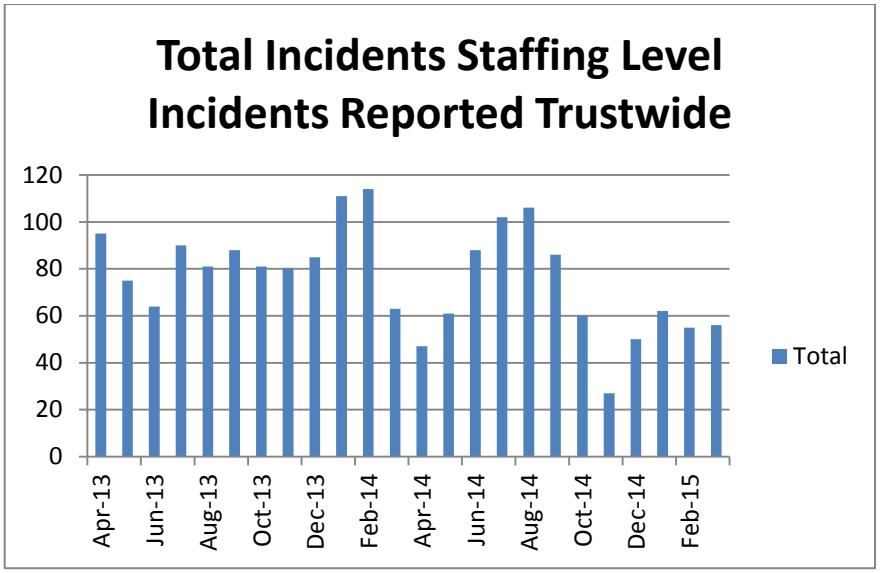
6.3 Supporting & Fostering a Professional Environment

Key actions that are in place are:

- Ensuring that the organisational culture supports staff and ensures that staff are able to raise concerns/ speak up (NBT Whistleblowing Policy 2013)
- The NBT incident reporting system is widely used to support escalation of concerns and facilitate risk management.
- Regular analysis of incident data to identify and respond to trends in relation to safe staffing. Monthly Directorate level data is presently sent to the Heads of Nursing directly from Risk Management.

Key actions that are being progressed are:

- Incident reporting will include guidance for staff completing incident forms with concerns with staffing levels to include 'red flag' reporting.



Graph 1 - Total number of staffing levels incidents

7. Openness and Transparency.

Key actions that are in place are:

- Monthly updates on inpatient staffing 'planned and actual' are made available to the Public on our Website and NHS Choices
- Information about the ward nurses and care staff working on each shift is displayed on each ward and accessible to the public.

Key actions that are being progressed are:

- The ward nurse staffing establishment review took place in February 2015 using evidence based methodologies. Directorates have produced business cases which were submitted as part of an overall nursing business case. This has been approved through the Business planning and Investment Group and the Trust Management Team. The Trust Board is asked to review the proposed increases to establishment and approve the financial investment required with these increases.

The additional staffing requirement by Directorate is as follows:

Directorate	Registered WTE increase	Un-Registered WTE increase	Total WTE Increase
Medicine	24.84	25.75	50.58
Neurosciences	8.10	2.66	10.76
MSK	13.31	7.36	20.67
Surgery	9.26	10.65	19.91
Renal	0.00	0.00	0.00
Core Clinical	4.30	6.86	11.16
W&C	21.00	-6.00	15.00
Sub-Total	**80.81**	**47.27**	**128.08**
Neuro Behavioral HCAs	0.80	12.00	12.80
Overall Total	**81.61**	**59.27**	**140.88**
Non-rec HR Recruitment			3.00
Total	**81.61**	**59.27**	**143.88**

All of these staffing increases have been reviewed and approved by the individual ward sisters, matrons and heads of nursing to ensure that they are fully engaged in their establishment reviews and once in place each directorate has a process in place to manage the budgets. A formal review will take place monthly at the Trust Nursing Workforce Group.

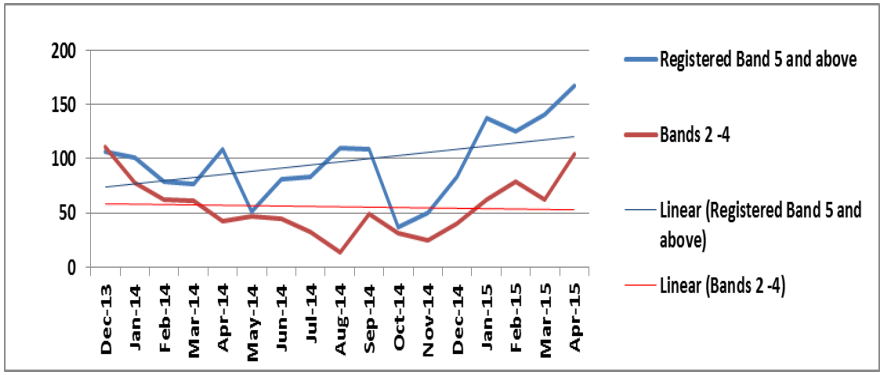
See Appendix 1 for the financial appraisal

8. Planning for future workforce requirements

The Deputy Director of Nursing has been working closely with the Workforce planning and recruitment teams to formulate the nursing workforce plan to fill current vacancies, to manage turnover, and to recruit the staff that will result from the investment.
The Recruitment Plan includes as follows:

- Nurse Recruitment and Retention Manager commences end of April 2015
- All Clinical areas informed to recruit to turnover
- Early advert for newly qualified nurses due to qualify in September 2015 has taken place which will provide job security. This has attracted high number of applicants with interviews planned in Mid April 2015.
- Daily shortlisting of Registered Nurse applicants is in place.
- Overseas recruitment to Spain in April to recruit 60 nurses. 2 cohorts planned to arrive in July 2015 and August 2015. Induction and training programme with Pastoral support underway.
- The targeted areas requiring additional support with recruitment are Anaesthetic staff, Renal, Acute Assessment Unit and Neonatal Intensive Care Unit. Current work is underway with agencies to review supply from non EU countries as adverts within the UK are yielding very little for these targeted areas.
- Review of advertising campaign underway to include annual schedule of recruitment, Open days (3 x year), Job Fair stands.
- NBT extra (Staff Bank) advertising campaign in place for both registered and non-registered staff to attract more staff.
- Trust Recruitment Open day for Registered Nurses on the 24th April
- Values based recruitment to improve retention of staff
- Improved communication with local University to ensure good uptake of Student nurses on Qualification.
- Retention strategies led by the Staff Wellbeing Lead and the Nurse Recruitment and Retention Manager

Census data Nursing Vacancy Level Tracking WTE from 1 Dec 13 – 1 April 2015



Graph 2

The overall trend line for RNs is increasing month on month. This is acknowledged as a concern and a risk to the Trust, it is on the risk register as risk 1158. The current vacancies reported on the 1st April 2015 showed 166 Registered Nurse vacancies with 104 in the pipeline recruited with start dates in the next 3 months and 104 Health Care Assistant vacancies with 68 recruited with start dates in the next 3 months. These figures do not include the additional posts requested within this paper which amount to 60 Registered Nurses, 11 Registered Midwives and 60 Health Care Assistants.

Risks

- There is a real concern that with an increase in the number of vacancies following approval of the increased staffing levels and current turnover rate that the volume of vacancies will be challenging to fill with the current applicants. There is very close working between the nursing, workforce planning and recruitment teams to ensure that data is readily available and risks are regularly reviewed.
- There is a high use of agency and temporary staff on some wards and at times agencies are unable to fill shifts and therefore a risk assessment has to be made in order to manage staffing safely.
- There is a risk for the Trust as the staff being recruited are junior and some are from overseas and will require prolonged period of induction and on-going supervision which in addition will have a training and financial impact.

9. The Role of Commissioners

The NQB guidance sets out clear and specific expectations of commissioners for pro-actively seeking assurance that providers have sufficient nursing and care staffing capacity and capability to deliver the outcomes and quality standards.

We maintain constant assessment and review with Commissioners about any issues relating to safety and staffing levels. We have in place processes to ensure the Medical / Nurse Director review of any Cost Improvement Programmes, ensuring that they are robustly assessed for impact on quality via Quality Impact Assessments.

Staffing Reviews

Undertaken

The CQC inspection in November 2014 reviewed nurse staffing and in their report identified that nurse staffing levels needed to be reviewed in all areas to ensure that they matched demand and to ensure that there are sufficient nurses with the appropriate skills and experience to provide safe and quality care to patients at all times.
The CQC internal Action Plan is reviewed every 2 weeks with assurance against each action to be provided by the Lead (Deputy Director of Nursing) for Improvement Theme 4: Staffing Levels, Well Being and Engagement.

As part of the 2014/15 Annual Audit Plan, the Internal Audit team have undertaken a high level review in March 2015 of the processes in place to ensure that the Trust meets the requirements around staffing levels, results pending**.**

Planned

A visit by the Trust Development Authority on the 5th May 2015 is planned to review the management of nurse staffing within the Trust, this will include visits to the wards to observe and discuss staffing levels with staff and to review mechanisms in place to escalate concerns within the Trust.

10. Recommendations

This report has demonstrated to the Board that the 6 monthly safe staffing reviews have taken place, with this there was a requirement for staffing levels to be increased. The Board is asked to note that the Trust has systems and processes in place that either meet or will meet the 10 NQB expectations and NICE guidance.

The Board is asked to approve:

- The increases in establishments to support the review of the safe staffing levels undertaken in February 2015.
    - Approve the funding mechanism for this increase, identified through ensuring posts are funded to the individual increment and through a proposed reduction of up lift from 24% to 21%.
    - Approve the net investment of £528,290.

- Appendix 1 Financial appraisal

The total increases by Directorate are as follows:

Directorate	Registered WTE increase	Un-Registered WTE increase	Total WTE Increase	Cost £
Medicine	24.84	25.75	50.58	1,888,865
Neurosciences	8.10	2.66	10.76	391,236
MSK	13.31	7.36	20.67	722,605
Surgery	9.26	10.65	19.91	650,883
Renal	0.00	0.00	0.00	0
Core Clinical	4.30	6.86	11.16	289,000
W&C	21.00	-6.00	15.00	853,200
Sub-Total	**80.81**	**47.27**	**128.08**	**4,795,789**
Neuro Behavioral HCAs	0.80	12.00	12.80	404,677
Overall Total	**81.61**	**59.27**	**140.88**	**5,200,466**
Non-rec			3.00	64,500
Total Cost	**81.61**	**59.27**	**143.88**	**5,264,966**

Total cost

The total cost for implementing the proposed staffing increases is £**5,264,966.**

Sources of funding

The existing absence allowance applied to most nursing budgets is 24%. This covers annual leave, bank holiday cover, sickness, study leave and other leave (compassionate/family leave). In addition each Directorate has a Maternity leave budget for nursing. The average absence allowance applied by most Trusts is 21%.

The increased uplift at NBT was in place to support the increase in the additional annual leave requirements in line with agenda for change. It is proposed that the allowances are reduced at NBT to 21%. The reductions will be applied to the annual leave allowance and sickness allowances. Turnover in the last year has been high and resulted in more new starters with lower annual leave allowances which will support this. In addition the Trust has targeted an overall sickness reduction to 3.8% for the 15/16 financial year – therefore allowances have been aligned to this.

The details of the absence allowances are as follows:

Absence type	% Absence applied to 24/7 wards & dept.	% Absence applied to other dept. (not opening on bank holidays)
Existing		
Sickness	4.2%	4.2%
Annual leave	17.5%	12.9%
Study leave	1.8%	1.8%
Other/domestic leave	0.5%	0.5%
Total absence cover	24.0%	19.4%
Revised		
Sickness	3.8%	3.8%
Annual leave	14.9%	11.9%
Study leave	1.8%	1.8%
Other/domestic leave	0.5%	0.5%
Total absence cover	21.0%	18.0%

The saving resulting from this reduction in allowance is £1,834k. In addition there has been a review of the incremental point of scale funding for nursing budgets. A review of the actual average incremental points of the current staff in post by pay band has shown that owing to turnover, and new starters joining near the bottom of the scale, there has been a reduction in the overall funding required. The saving across the nursing budget is £2,904k.

- A summary of the savings by Directorate is detailed below

Directorate	Absence	Incremental	Total saving
Medicine	-515,212	-697,167	-1,212,379
Neurosciences	-219,809	-128,281	-348,091
MSK	-136,689	-139,742	-276,431
Surgery	-149,417	-195,733	-345,149
Renal	-187,948	-391,285	-579,232
Core Clinical	-393,630	-851,074	-1,244,705
W&C	-232,267	-500,422	-732,689
Overall Total	**-1,834,972**	**-2,903,704**	**-4,738,676**

Net investment required

Total cost of staffing	5,264,966
Total saving realized	-4,738,676
Therefore net investment	**526,290**

- Section 2, Maternity Unit Safe Staffing

1. Purpose

To report safe staffing review within the maternity service

2. Background

2014-2015

Midwifery staffing, April 2013-March 2014, and March 2014-September 2014 was funded for 187 whole time equivalent (wte) midwives providing clinical care, In October 2014 there was Trust support to appoint 10 wte midwives into the establishment bringing the total in March 2015 to 197 wte.

5.6 wte of the 197 wte are providing specialist roles and 7.3 wte are providing a sonography service, with an additional 1.6 wte in training for the sonography service. The sonography midwives are not included in the calculation for the birth ratios in line with national guidance. Staffing has been reviewed using Birth Rate Plus and is set at a skill mix ratio of 80:20 trained to maternity support worker,

The total births in 2014/15 were 6313, an increase of 206 births from 2013/14, giving a midwife to birth ratio of 1:35 against the recommended ratio of 1:29.5

1:1 care in labour has improved, the year to date average being 88.2% with a 3 month average January-March 2015 of 92%. Unit closures have shown a decline following improved staffing. (See table 1)

Current Birthplace statistics show 81% of births take place in the high risk delivery suite and 19% in the Birth centres and home. The aim is to change this to 40% in the obstetric unit and 60% in the Birth centres and home locations; this is to promote normality and to reduce interventions.

Community midwifery staffing has been reviewed and is set at a skill mix ratio of 80:20 trained to maternity support worker.

The community midwives work to a midwife to caseload average ratio of 1:100 women and work with Maternity support workers to provide care. There is no clerical support within these teams. The Community service has completed plans to launch a pilot for centralised booking to address some of the clerical requirements; this will reduce booking administration in all areas. The pilot will run for 3 months from June 2015 and will then be evaluated.

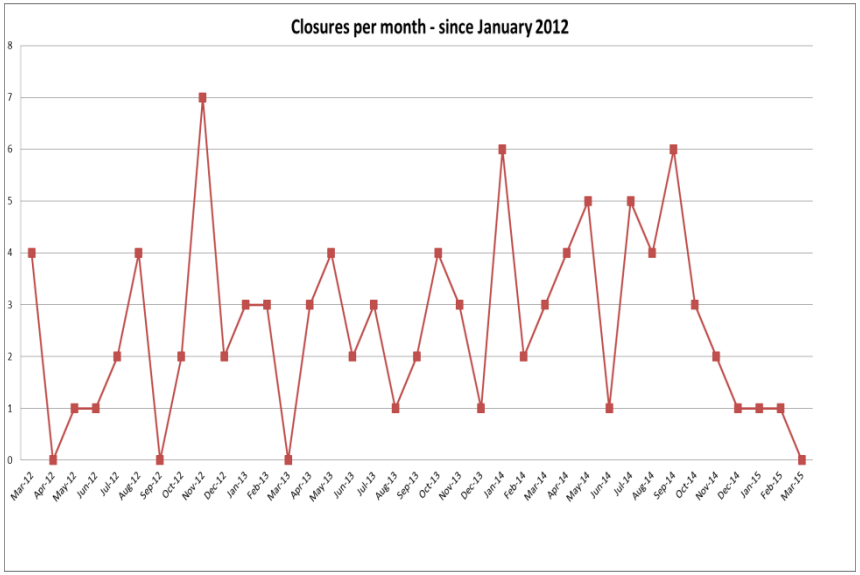


Table 1

3. Report

To validate the closure data and to ensure safe staffing the Directorate purchased the **Birthrate Intrapartum Acuity® System (BRIPAS)**
Data has been collated consistently since the 14th July 2014. February and March data shows an average of 65% of shifts when staffing levels were less than required for the acuity and 35% where staffing levels met the acuity. There has been an average 2% improvement in staffing meeting the acuity using the BRIPAS tool since the October report to the board.

A further break down of the 65%, shows that 59% of this time, the unit was up to 3 midwives short for the acuity and 41% of the time we were more than 3 midwives short for the acuity

BRIPAS is a 'predictive/prospective' tool which enables assessment of real time workforce planning within the delivery suite using clinical indicators. Acuity is a measure of the intensity of need arising from the number and clinical status of women and the infants during labour and delivery.

BRIPAS is informed by clinical indicators and enables a more proactive and prospective approach to management of risk factors and better use of staffing within the delivery suite, as well as informing workforce planning within the wider midwifery service. BRIPAS is based on the Birthrate Plus® tool which is a recognised workforce tool cited by national bodies such as the Royal College of Obstetricians and Gynaecologists, and the Royal College of Midwives.

The BRIPAS showed a deficit in staffing within the unit and showed shortfall in midwifery staffing of 30 wte in September 2014.

The current data was presented to the Deputy Director of Nursing who has undertaken a staffing review for the nursing and maternity teams throughout the whole Trust, who acknowledged the risk of caring for high acuity women being held within the Women and Children's Directorate and the inability to provide 1:1 care to all women.
NICE have published 'Safe midwifery staffing for maternity settings: February 2015 and a tool to interpret the paper is awaited later in 2015.
The Deputy Director of Nursing reviewed the BRIPAS data, used clinical judgement and 1:1 care in labour statistics, and with the Interim Director of Midwifery and identified the requirement to increase midwifery staffing levels by 11 wte. This would bring the establishment to 208 wte.

The increase in staffing would improve the midwife to birth ratio to 1:30. National Guidance is set at 1:29.5.

Consultant presence on delivery suite is recommended as 168hrs per week with >5000 deliveries. NBT currently has 74hrs of consultant presence.

CNST requires trusts to be working towards this standard; it has been difficult to achieve nationally. Benchmarking nationally against units with >6000 deliveries demonstrates that our number of consultant hours on delivery suite is lower than other comparable units (UHBristol 80hrs) However there is only one unit achieving 168hrs cover (St Mary's, Manchester), and we consistently demonstrate that we deliver a safe service as shown in outcome data and the South west dashboard.

Reference: Safer Childbirth standards (Royal College of Obstetricians and Gynaecologists et al 2007) and Standards for Maternity Care (RCOG 2008).

The Maternity Department train in a multi-professional model, using PROMPT training, developed at Southmead Hospital. The training has supported safe emergency care despite increased acuity in the caseload.

1:1 care in labour is currently achieved for 88.2% of labouring women and this has impacted on appropriate care in labour and patient satisfaction. There has been an 8.2% improvement with the previous increase in staffing.

All midwives have personal development opportunities, having an annual appraisal and open access to a Supervisor of midwives (SOM), who also meets with them annually. Each SOM currently has a caseload of 1:16; this has improved to be nearer to the NMC recommendation of 1:15 following the appointment of a new SOM in December 2014.
There is a formal development programme for transition from Band 6 to 7; this programme is in place on the delivery suite, community setting and the ward areas.
All band 5 midwives have a named preceptor and follow a preceptorship package, on completion of the first year they transition to Band 6, and then proceed through the first AFC gateway on completion of competencies outlined in the Band 6 job description.
There is a robust clinical governance process and the maternity dashboard looking at outcomes is reviewed monthly and detailed audits and case review is implemented using dashboard data, to ensure quality and safety of service.

4 Summary

Maternity acute unit staffing has previously been at an unacceptable level to provide 1:1 care in labour for the increased acuity of the women using the service.

An evidence based tool is used to measure acuity and appropriate staffing requirements and there has been an investment in staffing with an initial increase of 10 wte midwives to support the service delivery. **The current paper being submitted is supporting a further 11 wte.**

A Strategic review of working models and skill mix is currently underway, called ‘shaping our future’ to allow a full analysis of working models, to achieve **100%** 1:1 care in labour and to work within the current midwife to birth ratio of 1:35, and with further staffing investment an improvement to a ratio of 1:30.

The previous review of community midwifery services has ensured the caseload ratio of 1:100 with an 80:20 ratio of trained to support staff is in line with recommendations. Clerical support is an identified area needing review. As previously described there will be a pilot centralised booking system launched in May 2015.

Staff at all grades are provided with emergency skills and drills training, and have personal development discussed at annual appraisals, and for midwives also an annual review with their Supervisor of Midwives. Personal development programmes and preceptorship packages are embedded within the Directorate.

5. Recommendations

- Board support for Staffing paper to increase by 11 wte
- Completion of strategic staffing review to be implemented
- Analysis of community booking pilot in the community setting
- Ongoing audit of 1:1 care in labour
- Ongoing use of BRIPAS to inform staffing requirements in relation to acuity
- Promote low risk setting as default birth place for all low risk women

Benchmarking Against Other Trusts

Maternity Unit	Births	Consultant Presence	Midwife:Birth Ratio
Queens Hospital, Romford	7050	98 hours	1:29
Plymouth	4500	98 hours	1:32
UHB	5500	80 hours	1:33
Royal Gloucester	6500	76 hours	1:33
NBT	6300	74 hours	1:35
Birmingham	5700	60 hours	1:28
Nottingham City Hospital	5700	40 hours	1:30
Royal Derby	6100	84 hours	1:27
St Mary's Manchester	8200	112 hours (168)	1:28
Chelsea & Westminster	5800	102 hours	1:30

Section 3, Health Visiting Staffing Update

1. Purpose

To report the staffing position within the health visiting service.

2. Background

The Department of Health's **Health Visitor Implementation Plan 2011–15** *A Call to Action February 2011*[6] set out a call to action to expand and strengthen health visiting services and included a pathway to 2015 which would see:

- More health visitors in training and returning to practice
- Growing numbers of health visitors in post
- A more comprehensive health visiting service locally
- A reviewed and revised commissioning specification that included the Healthy Child Programme (HCP) as set out in the national model specification.(an increase in universal contacts)

3. Main Report

The five year strategy to expand the health visiting workforce set a trajectory of 182.1 wte by March 2015, a total increase of 72.1 wte. The current position at the end of April 2015 is 164.18wte staff in post with a further 17.92 wte required to achieve the target.

A rolling recruitment programme is in place, with pipeline of 8.2 wte health visitors recruited. All new recruits are starting between April to September 2015. This will leave a 9.72 wte gap of which there are 17 health visitor student's being interviewed during May 2015.

Over the past 12 months turnover rate has been 14.5 % which equates to 26 leavers (head count) and workforce data confirms that 1. 3 wte per month are required to mitigate and manage this turnover rate. A review of the reasons for the turnover is now underway and will focus on trends and themes from exit questionnaires.

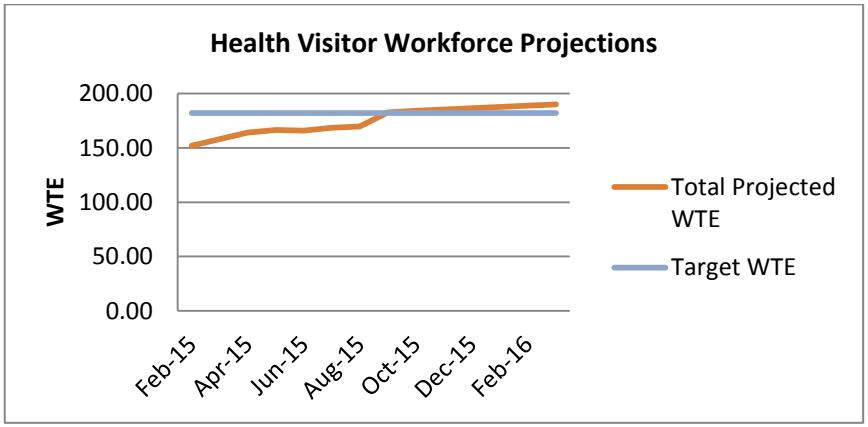
Actions being taken forward to improve recruitment and retention include:

- Review of current advertising to promote Community Child Health's 'Outstanding' CQC judgement and also the unique sub contract with Barnardos and participation strategy.
- Increase our understanding of where the majority of our applicants come from in order to focus future recruitment campaigns.
- Development of professional lead post for health visiting following recent selection process.
- Review of national best practice models regarding caseloads including demand and capacity.
- Review of quality of supervision and support with particular focus on newly qualified staff.

6 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213110/Health-visitor-implementation-plan.pdf

Workforce projections below outline month by month achievement of the target to March 2016.

	Feb-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
Current WTE	152.00	164.18	164.18	164.18	164.18	164.18	164.18	164.18	164.18	164.18	164.18	164.18	164.18
Turnover	0.00	0.00	1.30	1.30	1.30	1.30	1.30	1.30	1.30	1.30	1.30	1.30	1.30
Projected Pipeline	0.00	0.00	0.00	0.00	0.00	2.50	2.50	2.50	2.50	2.50	2.50	2.50	2.50
Newly Qualified Starters	0.00	0.00	0.00	0.00	0.00	0.00	12.00	0.00	0.00	0.00	0.00	0.00	0.00
Confirmed Pipeline	0.00	0.00	3.6	0.8	3.8	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Total Projected WTE	152.00	164.18	166.48	165.98	168.48	169.68	182.88	184.08	185.28	186.48	187.68	188.88	190.08
Target WTE	182.10	182.10	182.10	182.10	182.10	182.10	182.10	182.10	182.10	182.10	182.10	182.10	182.10



Source: NBT HR Department

To deliver the five year strategy to increase the workforce numbers the Community Child Health Partnership (CCHP) have trained and supported a total of 115 student health visitors in the period September 2011 to August 2015. This has met the requirement of commissioned training places from Health Education England. In order to train and support the numbers of students in their practice placements, an increase of 15 Community Practice Teachers was required from within the workforce. 15 existing health visitors were selected and released to undertake a training programme at the University of the West of England in order to undertake the role.

The increase in newly qualified health visitors within the service and the age profile of staff who are at retirement age has led to a junior workforce. There are established induction and preceptorship programmes in place for newly qualified health visitors, as well as standards for 3 monthly child protection supervision. However in response to the increased workforce numbers additional child protection supervisors have been recruited in order to meet the service specification standards and the training and development needs of the workforce. Clinical leadership has been reviewed in CCHP; following this a professional lead for health visiting has been recruited. This key post will support the Head of Nursing and nurse management team to ensure delivery of safe and high quality health visiting practice.

The numbers of student health visitors for 2015/16 and beyond are expected to be 12 annually.

The delivery of the Healthy Child Programme is commissioned in line with the national service specification, with agreed NHS England KPI's for the increased universal contacts following the expansion programme. Historically the service has been delivered via a skill mixed team which has included band 4 community nursery nurses. As a result of the national programme to increase the health visiting workforce there are currently limited opportunities to further review the skill mix within the service post expansion. The impact of this is that 80% of the workforce are band 6. The commissioning of the health visiting service is due to transfer to Local Authorities during 2015.

There is increasing demand on the service: Bristol is a concentrated urban area which has wide variations in health inequalities.[7] Of the 34 wards in the city, 17 are amongst the 25% most deprived wards in England, while eight are amongst the 10% most affluent. The 0-15 population is projected to rise from 80,700 in 2012 to 93,100 in 2022, an increase of 15.4%. South Gloucestershire is an area of diversity and contrast with a variety of communities both urban and rural. In general there are lower levels of deprivation, although one area of Kingswood is in the 10% most deprived area of England. The 0-5 population is projected to rise from 16,300 in 2013 to 17,000 in 2018 (4.29%) but to fall back to 16,400 by 2035. Bristol has a multicultural diversity of the population with BME population for > 15 at 28 %, a rise from 9.8% 2014/14, and 11% in South Gloucestershire.

Health visitors provide a universal family health needs assessment at the initial point of contact, the assessment of need determines the level of service provided. Caseload weighting data is collated for individual health visitors and teams; this determines the level of resource allocated across teams.

During periods of sickness / absence and or vacancies health visitors work to an escalation plan which in linked to assessment of individual needs of children and families and risks for example safeguarding.

4. Recommendation

- To note progress made and future workforce projections against the national target.
- To note plans to improve retention of the health visiting service.
- Ongoing monthly recruitment to support turnover, with planned review in Quarter 3 to ensure no risk of over recruitment.

[7] http://www.bristol.gov.uk/page/adult-care-and-health/health-statistics-evidence-and-intelligence

North Bristol NHS
NHS Trust