North Bristol **NHS**

NHS Trust

Report to:	Trust Board	Agenda item:	9
Date of Meeting:	2 June 2016		

Report Title:	**Safe Nurse Staffing** – 6 Monthly Assurance Report			
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)			
Executive Sponsor (presenting):	Sue Jones, Director of Nursing and Quality			
Appendices (list if applicable):	**Appendix 1** **Achievements against National Quality Board Expectations**			

Recommendation:

Part A
   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 in line with the 10 NQB expectations and NICE guidance.
 • The outcome of the Safe staffing reviews undertaken in April/ May 2016
 • Approve the recommendations for changes to establishments.
 • Note planned changes nationally in reporting staffing from May 2016
 Part B
  The Trust Board is asked to note this report;
 • The assurance that a 6 monthly review of staffing across all maternity areas has taken place to ensure safe staffing in line with NICE guidance.
 The outcome of the establishment and budget review has enabled:
 • 1.4 wte midwife to provide a 7 day triage service for Maternity assessment.
 • 3 wte clerical band 2 staff to support centralised booking.
 • Sonography increase of 0.85 wte.

Executive Summary:

Following the Francis report, the National Quality Board (NQB) published guidance[1] that set 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. This was followed by the NICE 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 recommended that their guidance is read alongside that of the NQB guidance.

In June 2015 the Chief Nursing Officer for England confirmed that there would be changes to the safe staffing agenda for all care settings going forward. She emphasised the importance of the NQB expectations and NICE guidance but explained that safe staffing would now be led by NHS Improvement who would work closely with NICE, CQC and Sir Robert Francis, to ensure that there is no compromise on staffing and its impact on patient safety.

The Lord Carter Review (2016)[4] highlights the importance of ensuring that workforce and financial plans are consistent in order to optimise delivery of clinical quality and use of resources. The review described a new nursing workforce metric to be used (Care Hours per Patient Day (CHPPD) along with a model hospital dashboard.

NBT continues to report the following in line with the NQB recommendations:

- 6 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

A full panel review of safe staffing took place of all in patient areas in May 2016 and the methodology and results of this are highlighted within the report and split into 3 components; approved changes to establishment, further review/data required and winter capacity. The Total financial impact of these changes totals £4.2m.

North Bristol Trust (NBT) was one of 12 Trusts who commenced the 90 Day Innovation programme for Enhanced care in September 2015, both the patient experience and financial outcomes are described with the next steps underway in Trust wide roll out to achieve 20% cost

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[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

[4] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/499229/Operational_productivity_A.pdf

avoidance in Enhanced care by September 2016.

The recruitment initiatives, challenges and risks are described, with some planned mitigation to support and ensure safe staffing is in place. With the implementation of the agency rules and pay cap and the tight controls enacted, reduction in agency has been achieved in April 2016.

The Maternity report shows the workforce changes and innovations which have occurred within Community, Assessment Units, Birth centres and the acute unit. Maternity acute unit staffing has previously struggled to provide consistent 1:1 care in labour for the increased acuity of the women using the service. Methodology for reviewing staffing and capacity is based on the Birth rate plus calculating tool, NICE guidance and professional judgment, in conjunction with length of stay and bed modelling.

An evidence based tool is used to measure acuity and appropriate staffing requirements and following panel review and a review of budgets have invested in the following;

- 1.4 wte midwife to provide a 7 day triage service for Maternity assessment.

- 3 wte clerical band 2 staff to support centralized booking.

- Sonography increase of 0.85 wte.

Midwifery are fully recruited and achieving a midwife to birth ratio of 1:30.

1. Purpose

The purpose of this paper is to provide the Board with a 6 monthly report on Nursing and Midwifery staffing and to provide assurance that the Trust has a clear validated process for monitoring and ensuring safe staffing and that a formal 6 month review has been undertaken.

2. Background

Following the Francis report, the National Quality Board (NQB) published guidance that set 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. This was followed by the NICE guidance *Safe staffing for nursing in adult inpatient wards in acute hospital* (July 2014) and *Safe midwifery staffing for maternity settings* (Feb 2015). NICE recommended that their guidance is read alongside that of the NQB guidance.

In June 2015 the Chief Nursing Officer for England confirmed changes to the safe staffing agenda for all care settings going forward. She emphasised the importance of the NQB expectations and NICE guidance but explained that safe staffing would now be led by NHS Improvement who would work closely with NICE, CQC and Sir Robert Francis, to ensure that there is no compromise on staffing and its impact on patient safety.

The Lord Carter Review (2016) highlights the importance of ensuring that workforce and financial plans are consistent in order to optimise delivery of clinical quality and use of resources. The review recommended use of a new metric , Care Hours per Patient Day (CHPPD) to be collected monthly (beginning in April 2016) and for this to be collected daily from April 2017, along with improved efficiency in the use of E-Rostering and implementation of the concepts of Enhanced Care. CHPPD is one part of the nursing workforce component of the model hospital which is being developed with the Carter Trusts and other volunteer trusts. NBT was one of the test sites for monitoring CHPPD and for implementation of the 90 day innovation Enhanced Care Programme.

CHPPD is used to describe both the staff required and staff available in relation to the number of patients. It is calculated by adding the hours of registered nurses to the hours of healthcare support workers and dividing the total by every 24 hours of in-patient admissions (or approximating 24 patient hours by counts of patients at midnight). It can be broken down by grade – initially registered nurses and healthcare support staff, but ultimately bands/grades within these groups and all other staff groups contributing to ward-based care, including Allied Health Professionals. While total CHPPD will be reported, it will be split into registered nurses and healthcare support workers to ensure skill mix and care needs are met.

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:

- 6 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 NHS Improvement and will be expected to provide 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.

See Appendix 1 which demonstrates where NBT benchmarks against the NQB expectations.

3. Approach taken to review safe staffing at North Bristol

The Nursing establishment review undertaken in April 2015 enabled an additional 60 Registered Nurses(RN), 21 Registered Midwives(RM) and 60 Health Care Assistants(HCA)to be recruited, the recruitment process for this has been on going with 304 RN's recruited and 344 HCA's from April 2015- March 2016.

When there is a shortfall in staffing until vacancies have been filled there has been a requirement to utilise agency nurses to ensure patient safety. With the implementation of the agency rules and paycap in October 2015 a significant reduction in cost in Q3 was achieved, however due to significant winter pressures this was not sustainable in Q4.

The nursing and midwifery fill rates for Southmead Hospital for the past 6 months can be viewed in Table 1.

|	Oct	Nov	Dec	Jan	Feb	Mar
RN Day	94.7%	94.7%	94.5%	95.3%	93.3%	93.5%
HCA Day	122.8%	117.2%	118.9%	120.8%	116.7%	114.4%
RN Night	95.0%	96.7%	96.8%	99.5%	96.3%	95.6%
HCA Night	134.6%	130.1%	132.5%	131.9%	130.9%	126.7%

(Table 1)

There has been a noticeable increase in fill rates for January 2016 when there was a significant increase in acuity of patients and additional capacity opened. All wards continue to reach a funded ratio of 1:8 or less for a day shift, exclusive of the supervisory ward sister, and all inpatient wards are working to a minimum skill mix of an average RN/HCA ratio of 60/40.

When there is a shortfall of registered nurses, on occasions unregistered staff are being utilised to ensure safe staffing. In addition the greater than 100% fill rates in HCA numbers are due to the high volume of 'specials' utilised to provide enhanced care. There has been a corresponding drop in the RN to HCA ratio which is predominantly due to the use of HCA's used for enhanced care.

Graph 1 shows the number of safe staffing incidents reported by month, these are all escalated to Heads of Nursing to review with alerts to the Director/ Deputy Director of Nursing when an incident occurs.

Total Staffing Level Incidents Reported Trustwide
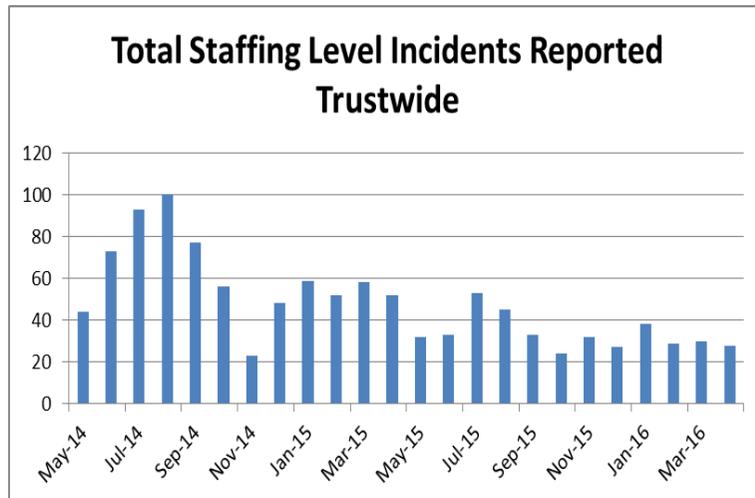
Graph 1 - Total number of staffing levels incidents

6 monthly review – May 2016

A full nursing establishment review was undertaken of all inpatient areas in April/ May 2016. This took the form of a panel review consisting of the Director of Nursing, Deputy Director of Nursing, Director of Finance/Director of Operational Finance and the Finance Business Partner for Nursing. Each Head of Nursing was accompanied by the General Manager, Finance Business Partner and HR Business Partner. They used a triangulation of data to support their reviews, these included:

- a template demonstrating amounts and reasons for staffing over establishment in March 2016

- Knowledge of pressures on wards for the past 6 months and safe staffing incidents

- Safe care data for each ward

- Nursing and Midwifery shift fill rates

- Professional Judgment of Ward Sisters, Matrons, Head of Nursing

The current vacancies for Registered Nurses are 109 wte and Non Registered Nurses are 85 wte as at April 2016.
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Changes in nurse staffing approved by the panel review as part of this 6 monthly review

DIRECTORATE	GATE/WARD	CHANGES
Women and Children	NICU	Increase in 1 registered nurse per shift , 7 days per week
	Cotswold	No change to current funded establishment for 19 beds
Anaesthetics, Surgery and Critical Care	33a	No change
	34a	No change. Monitor high acuity and review in line with any changes in ITU capacity
	34b	No change
Medicine	28a	Increase in 10.4 wte Health Care Assistants to support enhanced care
	28b	Increase in 10.4 wte Health Care Assistants to support enhanced care
	9b	Increase in 10.4 wte Health Care Assistants to support enhanced care
	32a	Increase in 10.4 wte Health Care Assistants to support enhanced care
	Elgar 2	No change required to current establishment
	8a	No change required to current establishment

DIRECTORATE	GATE/WARD	CHANGES
	27b	Increase in Respiratory HDU beds from 4 to 6 beds, required increase in 5.2 wte Registered Nurses
	27b Isolation Suite	Increase in 5.2 wte Registered Nurses and reduction of 5.2 wte Unregistered Nurses
Renal	8b	Increase in enhanced care budget required of 2 wte Health Care Assistants. To be closely monitored using Safe Care
	Outpatients	No additional funding required
	Acute Dialysis	No additional funding required
Neurosciences	25a	Increase in enhanced care budget required of 11 wte Health Care Assistants
	6b	Increase in enhanced care budget required of 1.4 wte Health Care Assistants. Monitor high acuity and review in line with any changes in ITU capacity
	7a	Increase in enhanced care budget required of 1.4 w.t.e Health Care Assistants and increase of 4.2 w.t.e Health Care Assistants for Video Telemetry beds
	9a	Increase in enhanced care budget of 5.2 wte Health Care Assistants.

DIRECTORATE	GATE/WARD	CHANGES
Musculoskeletal	26b	Increase in 0.8 wte Health Care Assistant. Increase in 2 wte Housekeepers as previously unfunded due to speciality change
	7b	Replace previously removed Health Care assistant 1.4 wte
	25b	Internal funding released has funded increase in 1.32 wte Health Care assistant on an early shift 7 days per week
	26a	Increase in 0.64 wte health care assistant

Changes reviewed at Panel – requiring further review

DIRECTORATE	GATE/WARD	CHANGES
Anaesthetics , Surgery and Critical Care	33b	Increase in 2.8 wte Health Care Assistant subject to business case
	ICU	This will be subject to a business case for additional bed capacity when required
	Theatres	Any increases in Theatre staffing will be subject to a business case in line with increased capacity
Medicine	Elgar 1	Increase in 5.2 wte Health Care Assistant proposed, will be reviewed once safe care data completed.

DIRECTORATE	GATE/WARD	CHANGES
	27a	Requires further review of CCU funding and proposal for increase in 5.2 wte Registered Nurses, once safe care data received
	32b	No current increase in staffing , keep under review the requirement for Registered Mental Health Nurse 5.2 wte funding for 1:1 care
Medicine	Acute Medical Unit ,ED, Additional Capacity on Elgar 1 and 2	Additional requirements for these areas to be considered as part of the winter plans by the Directorate. 4.2 wte Registered Nurses 3.5 wte Health Care Assistant
Core Clinical	Interventional Radiology	This requires further review for staffing procedures for Interventional Radiology Additional Capacity for Monday – Friday nights 3.62 wte RN
Women and Children	Cotswold	Additional Capacity for winter planning (6 months) 1.3 wte RN,2.6 wte HCA

Financial Implications of staff changes

- Total staffing change equate to:

		wte
TOTAL	RN	**38 wte**
	HCA	**82 wte**
Approved	RN	18.7 wte
	HCA	64.44 wte
Further review	RN	10.4 wte
	HCA	8 wte
Winter	RN	9.1 wte
	HCA	8.7 wte

	£
TOTAL	**£4.2m**
Approved	£2.4m
Further review	£0.8m
Winter	£1.0m

- Approved changes will cost £2.4m, with further reviews underway not yet approved of £0.8m and winter plans of £1.0m

- This brings the proposed total funding requirement to: **£4.2m**

4. **Enhanced Care 'Specialling' Programme at NBT**

Over the past year the use of additional staff over and above both the funded and specialling establishments has led to a significant Trust financial and staffing concern. NBT was one of 12 Trusts nationally who was asked to join the 90 Day innovation Programme for Enhanced Care in September 2015. This programme was based on learning from work at Salford Royal NHS Foundation Trust where different approaches to delivering specialling care for vulnerable patients were undertaken. This was referenced as an example of good practice within the Lord Carter Review (2016).

There has been a significant reliance on temporary staff to provide this care in the past and through the training and testing of new assessment tools and concepts (firstly on 4 wards) of one to one care this reliance on initially temporary staff and subsequently cost has reduced.

Prior to commencement of the project within NBT the decision to book a 'special' was based on staff intuition and concern that the patient may be at risk of harm. There was no systematic assessment of patients prior to commencing specialling and

patients often continued to be specialled for the duration of their spell in hospital without formal review of whether this was still required. Staff providing the 'special' were often bank or agency staff, who received a limited handover of the patient's needs and expectations of what staff were required to do was also often unclear.

In September 2015, NBT was spending 21% above the funded nursing establishment on specialling, for the first 6 months April to August 2015 Trust wide, this equated to £2.3 Million. When this figure was compared with other Trusts in the innovation project NBT expenditure was 11% higher than any other Trust. Of all the Trust's NBT was unique in the number of side rooms which each ward had.

The Enhanced Care Project Team was led by the Director of Nursing with representatives from each of the pilot wards, Neuroscience Education Lead, Dementia Care Matron, and Finance Partner and there was investment in a Project manager post for 8 months. Staff enthusiastically engaged with the project and attended 4 National workshops from September to January to learn the change methodology, generate new ideas, share NBT experience and bring back the learning to be implemented in their wards. Each ward was required to have the knowledge of, and undertake PDSA cycles, review and undertake assessments on patients receiving enhanced care at least every 24 hours and submit electronic data over the 3 month period on the number of patients receiving enhanced care, the number and type (substantive/agency/bank) of additional staff used to deliver that care and the number of hours of enhanced care used.

Quality Outcomes of Enhanced Care programme

Each wards safety thermometer and friends and family test results were used as quality measures to monitor the impact of implementing the project to ensure that care had not been adversely affected. These measures remained largely unchanged in the pilot wards suggesting no adverse impact on the quality or safety of patient care.

As a result of the project, all patients are now risk assessed prior to initiating Enhanced Care, a care plan is in place, and a senior nurse review is undertaken at least every 24 hours to ensure that they still require the same level of care. Staff complete a 24-hour activity chart detailing any triggers for the patient's behaviour, how the challenging behaviour is exhibited, the interventions used to manage that behaviour and how the patient responded to that intervention.

This approach to enhanced care has increased the confidence of unregistered staff to understand and respond to the patient's need, and enabled registered staff to make a decision to discontinue the use of Enhanced Care based on evidence gathered from the activity charts.

Financial Outcomes of the Enhanced Care programme

For the 4 pilot wards there has been a 13% reduction in expenditure on Enhanced Care from October 2015 to March 2016 when compared to their average Month 1 to Month 6. The second group of wards commenced in January and achieved an 8% reduction in the first month.

The target for each ward is to achieve a 20% reduction in cost by September 2016; this will result in £1m cost avoidance.

The graph below demonstrates how this can be achieved with a reduction in spend on Enhanced Care on one of the pilot wards, Gate 25b (Musculoskeletal), from £34k in November 2015 to £2k in March.

Ward 25B Enhanced Care Expenditure
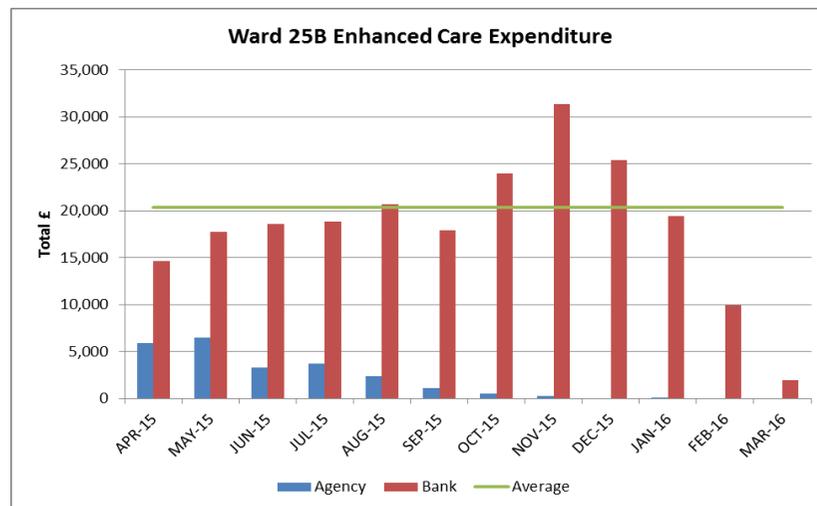
Graph 2 – Enhanced Care expenditure Gate 25B

5. Behaviour and practice changes

- The pilot wards have reduced the number of hours per day that patients receive one-to-one care and

introduced cohorting (more than one) patients where appropriate.

- Patients receiving Enhanced Care are reviewed by a Senior Nurse every 24 hours and discussed at every safety briefing

- Activity Boxes have been introduced to ensure that patients are engaged in meaningful activity when receiving Enhanced Care

- Activity charts and care plans have been developed to assist ward staff to monitor Enhanced Care activity

- Staff undertaking Enhanced Care are easily identifiable to all team members by wearing a yellow lanyard

- Staff participation in the project has contributed to and shaped the Trust policy for Enhanced Care.

The roll out programme for all wards throughout the Trust took place between January and April 2016; this mirrored the process that pilot wards experienced, with the implementation process accelerated as the tools had been rigorously tested and were ready for use.

Learning from the pilot wards demonstrated that it was important to have early involvement of the Ward Sister to ensure all staff engagement. The strength of ward leadership was particularly evident by the Ward Sister on Gate 25b (Musculoskeletal) as demonstrated above, where significant change in practice and culture achieved a reduction with no change in patient group or quality indicators.

NBT was recognised at the end of the national project as being the Trust all the other Trusts on the Programme had learned most from.

6. **Nursing workforce requirements and recruitment**

The Heads of Nursing have 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 retain staff recruited.

The Recruitment Plan includes as follows:

- Nurse Recruitment and Retention Manager for one year fixed term post, this finished in April 2016.

- Three Recruitment Consultants were appointed, who developed high quality recruitment plans for all recruitment across the directorates. Their roles also support a fast and responsive service and supported the Nurse Recruitment Manager with assessment centres and facilitating open days.

- An annual schedule of recruitment is in place, with quarterly Recruitment Open Days for Registered Nurses and Healthcare Support workers. These have been held in November, March and a further one planned for June 2016.The Trust also has Job Fair stands at recruitment events.

- Overseas recruitment to Spain in the past year has yielded 48 new recruits with excellent retention rates and their recruitment has encouraged further migration of Spanish Nurses within the United Kingdom to come

to NBT.

- Theatres have been actively recruiting using a variety of methods and whilst still using agency nurses to replace a short fall in anaesthetics they have seen a marked reduction in agency use.

- Adult Intensive Care Unit has been very actively recruiting and currently there are 42 beds open, a further business case will come as part of the intensive care expansion.

- There are shortages of experienced renal dialysis nurses and recent national adverts have yielded little response, in addition a recent review of age profiles within renal nursing indicate there will be further shortages within the next few years. The directorate is proactively recruiting Registered Nurses and utilise the directorate's inpatient ward areas as a training area for all newly qualified nurses commencing their employment in the area. There is however a need to attract experienced renal nursing staff, this is now going to be part of a Non EU recruitment plan which will be progressed with the lifting of the visa status for nurses which has now occurred. The plan is to recruit 50 Non EU Nurses who will be able to commence work in several areas within the Trust in the next year.

7. **Supernumary status**

The implementation of the supernumary policy for all new starters has ensured that there is a consistent approach utilised across the Trust**.** Each new starters previous experience is now reviewed against the recommended

supernumerary period to ensure optimum efficiency of the induction period.

utilising experienced nurses to work alongside newly registered nurses in a clinical tutor role. Support has also been provided from the Learning and Research clinical training teams.

8.   Risks

- Whilst both registered and unregistered nurse recruitment has been substantial over the past 6 months, with the increase in the number of vacancies following approval of the increased staffing levels and current turnover rate the volume of vacancies may prove difficult to fill with the current applicants. There is very close working between the nursing, workforce planning, finance and recruitment teams to ensure that data is readily available and risks are regularly reviewed.

- The recruitment team will require support with the entire recruitment process once the additional posts are approved to ensure staff commence in a timely way.

- 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 generally have less experience 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. This is being mitigated within individual directorates who are

9.   Agency Reduction

- In October 2015 the Agency Rules5 were implemented and this was followed in November, February and April with the associated introduction of the pay cap. For the first 3 months NBT did well against the national recommendations in reducing the use of non-framework agencies, through collaborative working with staff. The implementation of these rules was within the context of providing safe patient care. Approval for all non-framework agency use has been and continues to be made by the Director/ Deputy Director of Nursing to ensure a robust and safe risk assessment is undertaken. A fortnightly nursing controls and e rostering meeting attended by Heads of Nursing, HR and finance has been instrumental in delivering this reduction.

- April 2016 has seen a reduction in both the use of overall agency use and significant reduction in Non-framework agency use; with the current spend for nurse agency costs at 5.5% of overall nurse staff costs.

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[5] https://www.gov.uk/government/publications/nursing-agency-rules
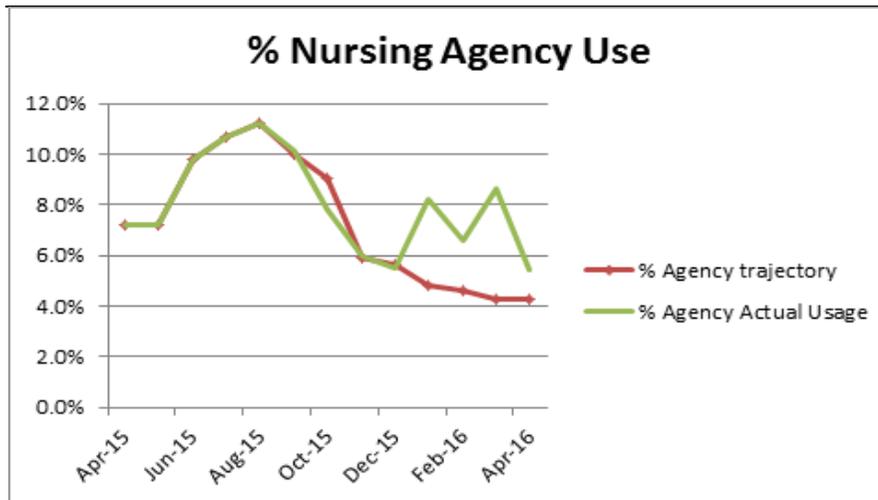
Graph 3 – Nursing agency % use

NHS Improvement has set ceilings on the total amount individual trusts can spend on agency staff in 2016/17. From 1 April 2016 expenditure ceilings for agency nursing will be replaced with expenditure ceilings that apply to all agency staff groups.

10   Conclusion

This paper has reviewed the past 6 months staffing fill rates, demonstrated the outcomes of the actions which have progressed over the past 6 months regarding recruitment and future plans in place to manage vacancies to ensure safe staffing. There has also been a more robust plan of staffing for additional capacity over the winter. There are 3 elements to the safe staffing review – approved changes, changes pending additional data / business cases and changes for winter capacity.

This report has highlighted the quality, patient experience and financial benefits gained as being part of the National Enhanced Care 90 day Innovation Programme. It also has explained the approach taken to manage the supernumerary status of new starters and the controls in place to manage the reduction in agency nursing required. It has described the recruitment and workforce plans in place and the risks with the number of new starters over the next few months.

11   Recommendations

This report has demonstrated to the Board that a robust 6 monthly safe staffing review of the inpatient areas listed has taken place.

The Trust Board is asked to note this report:

- Assurance regarding actions already underway and actions planned to ensure staffing levels are safe, effectively monitored and published openly in line with the 10 NQB expectations and NICE guidance.

- The outcome of the safe staffing reviews undertaken in   April/ May 2016

- Approve the recommendations for changes to establishments and investment of up to £4.2 M.

- Note planned changes nationally in reporting staffing from May 2016.

Midwifery Safe Staffing Report

1.   Purpose:

To provide an update to the Trust Board, of the 6 monthly safe staffing for 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 an additional 10 wte midwives were added into the establishment and appointed bringing the total in March 2015 to 197 wte.

2015-2016

In June 2015 there was Trust Board agreement to further increase Midwifery staffing by 11wte to bring the total wte to 210.67

Staffing has been reviewed using Birth Rate Plus and is set at a skill mix ratio of 80:20 Registered Midwife to maternity support worker, the Registered Midwife staffing has improved the midwife to birth ratio to 1:30, against the SLA with commissioners of 1:32.

1:1 care in labour has improved, the year to date average being 93.9% from an average of 88.2% in 2014/15.

Midwife to Birth Ratio					
Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15
1:34	1:32	1:32	1:32	1:32	1:32
Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
1:32	1:33	1:30	1:29	1:30	1:30

Total Births:

2015/16 showed an increase in births to 6449, an increase of 146 births from 2014/15 and a total increase of 362 births since 2013/14. There is a trajectory of increasing intrapartum activity within the unit following increased bookings for NBT.
(Table 1 and 2)
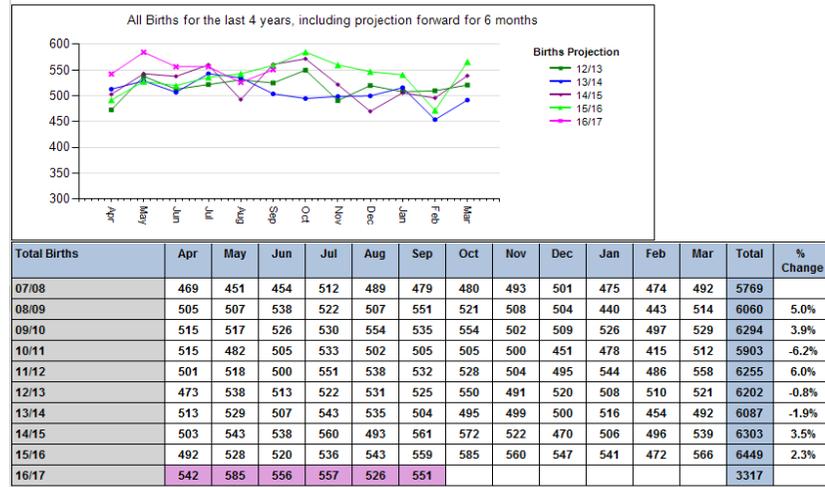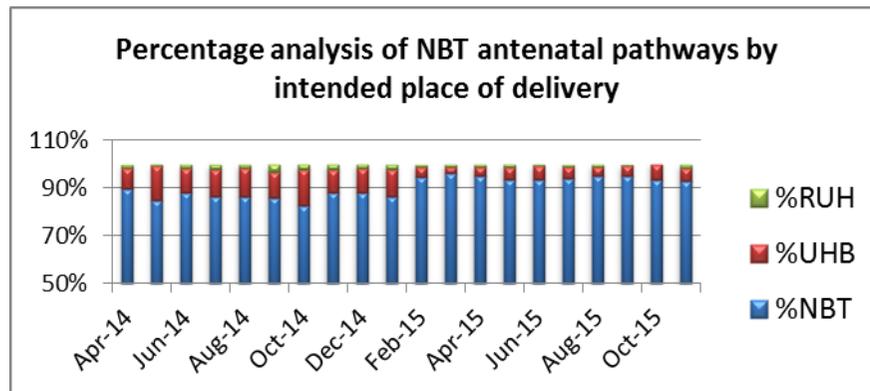
Birth Projection : All

All Births for the last 4 years, including projection forward for 6 months

Births Projection
- 12/13
- 13/14
- 14/15
- 15/16
- 16/17

Total Births	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total	% Change
07/08	469	451	454	512	489	479	480	493	501	475	474	492	5769	
08/09	505	507	538	522	507	551	521	508	504	440	443	514	6060	5.0%
09/10	515	517	526	530	554	535	554	502	509	526	497	529	6294	3.9%
10/11	515	482	505	533	502	505	505	500	451	478	415	512	5903	-6.2%
11/12	501	518	500	551	538	532	528	504	495	544	486	558	6255	6.0%
12/13	473	538	513	522	531	525	550	491	520	508	510	521	6202	-0.8%
13/14	513	529	507	543	535	504	495	499	500	516	454	492	6087	-1.9%
14/15	503	543	538	560	493	561	572	522	470	506	496	539	6303	3.5%
15/16	492	528	520	536	543	559	585	560	547	541	472	566	6449	2.3%
16/17	542	585	556	557	526	551							3317	

Table 1

Unit closures April 14-March 15 were 33 in total (table 3)
Unit closures April 15- March 16 were also 38 in total (table 4)

Closures per month - 2014-15

Table 3

Percentage analysis of NBT antenatal pathways by intended place of delivery

- %RUH
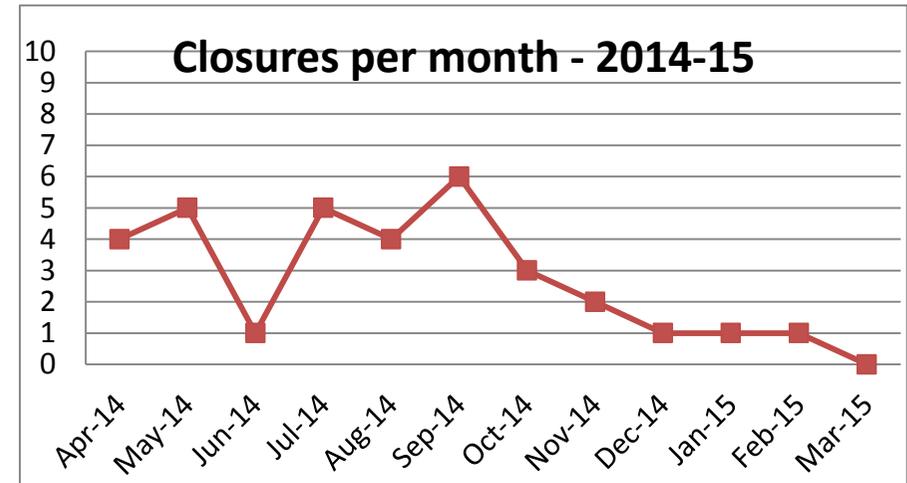- %UHB
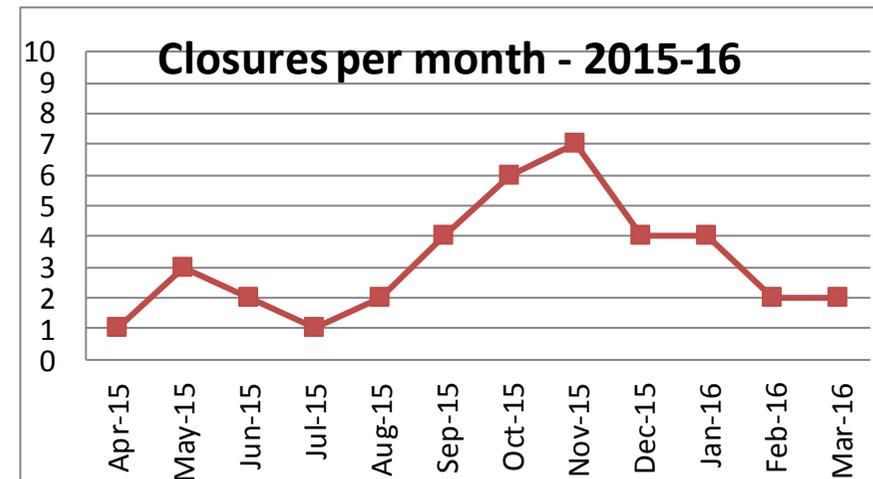- %NBT

Table 2

Closures per month - 2015-16

Table 4

There has been an increase in closures due to the increased number of bookings and intrapartum activity, in conjunction with current bed capacity. If the bookings continue to increase the current staffing would need to be reviewed to prevent closure due to staffing, although bed numbers do have an impact on closure with the increasing birth rate.

Place of Birth

Current Birthplace statistics show 81.5% of births take place in the high risk delivery suite and 16.4% in the Birth centres and home (Table 5). In line with the Place of Birth Study[6], and the Maternity Review ' Better Births' [7]the aim is to change this to 70% in the Delivery Suite and 30% in the Birth centres and home locations; this is to promote normality and to reduce interventions. This will be achieved by telephone triage of all women entering the maternity service and signposting them to the correct place of birth (see below).

Quantock Assessment Unit

Quantock assessment unit is an area used to see women presenting with acute issues related to pregnancy, there are multiple patient episodes per day, and waiting times are often prolonged. A pilot offering telephone triage by an experienced midwife was undertaken to see if attendances could be reduced. Following the audit of piloting telephone triage, it was shown that there was a reduction in unnecessary admissions, staffing has now been allocated within budget, following a staffing and workload review to fulfil this role at Band 6 midwife level. This will commence in June 2016 and will be a 7 day service, 8.30-18.30.

This will undergo evaluation and if continues to be successful will be increased to a 24hour service. Also all community staff screen women for place of birth and sign post to the low risk settings if appropriate.

7 day flow Midwives

The Maternity Department has also implemented 7 day flow midwives to enable patient flow to be managed efficiently, this commenced in October 2015, and the pilot has been successful and has reduced bed issues.

15/16 Births by Month	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Total
Southmead Delivery Suite	406	429	432	424	455	468	473	438	463	439	375	453	5,255
Southmead Birth Suite	42	43	44	64	37	46	46	66	41	62	55	66	612
Home	2	11	11	5	9	12	15	11	6	6	6	9	103
Cossham Birth Centre	39	44	30	40	38	32	51	44	34	28	31	34	445
DAU		1	2								1		4
Other	3		1	3	4	1		1	3	2	1	1	20
Unknown										4	4	2	10
Total	492	528	520	536	543	559	585	560	547	541	472	566	6,449
% Hospital	82.5%	81.3%	83.1%	79.1%	83.8%	83.7%	80.9%	78.2%	84.6%	81.1%	79.4%	80.0%	81.5%
% Birth Suite	16.5%	16.5%	14.2%	19.4%	13.8%	14.0%	16.6%	19.6%	13.7%	16.6%	18.2%	17.7%	16.4%

Table 5

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[6] https://www.npeu.ox.ac.uk/birthplace
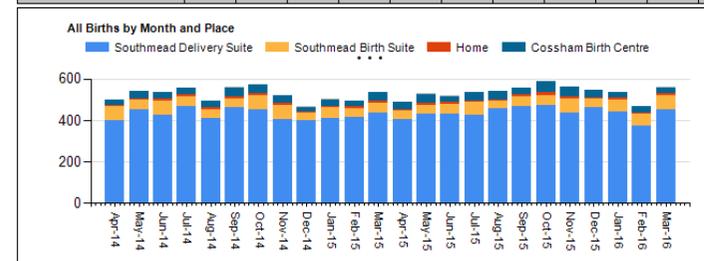[7] https://www.england.nhs.uk/ourwork/futurenhs/mat-review/

Community midwifery

Community staffing is set at a skill mix ratio of 80:20, Registered Midwife 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. The Community service has completed a pilot for centralised booking to address some of the clerical requirements; the pilot has been evaluated and there are now 3 booking clerks in post providing support to the whole community team. To support increased activity within the community setting 2.5 wte midwives have been added to the community setting from adjusting budgets and amending the 21% leave entitlement to 19% which is aligned to a Monday to Friday service with limited weekend working. This allows caseloads to be maintained at 1:100.

3. Safe staffing

In order 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. This tool is for Intra- partum care only. The ward areas are staffed in line with NICE, who published *Safe midwifery staffing for maternity settings* in 2015.[8] All staffing is monitored through the monthly safe staffing returns.

Due to increased activity the acuity tool within the Delivery Suite, continues to show deficits in staffing, however the increase in wte in November 2015 has allowed for more flexibility and movement of staff to be responsive to service needs and to

ensure safety and maintain our midwife to birth ratio at 1:30, benchmarking favorably within the south west region.

Using the birthrate plus tool to model staffing capacity for future growth shows that a further increase of 300 births using current staffing numbers would change the ratios to 1:32. The ratio of 1:32 although in line with the SLA with commissioners does not reflect the 1:29.5 as advocated by NICE; and the Trust achievement of achieving 1:30 in 2016.

To maintain the ratios achieved currently of 1:30, any further booking and birth increases will need 6 monthly monitoring, should there be growth of a further 300 births there would need to be consideration of an increase of 10 wte to maintain the ratios supported by NICE. Each increase in annual bookings and births will need close monitoring and use of the Birthrate plus modelling to ensure capacity and staffing are reflecting each other.

The CQC report in March 2016 rated Maternity Services as Good; an improvement from the previous 2014 rating of requires improvement. This was in direct result of improved investment in staffing and improved ratios from December 2015. Therefore careful monitoring of growth using the Birthrate plus tool will support the model of staffing required going forward.

Although the staffing model allows for consistent growth over the next 6 months the actual bed model and building capacity will impact on the Directorates ability to continue to grow the market share of activity within Bristol. It should also be acknowledged that the growth in bookings and intrapartum care has been absorbed into the current estate and adjusted staffing model, but areas of pressure has been identified within the antenatal clinic and ultrasound service. Sonography has been identified within business planning as an area requiring growth due to forthcoming planned retirements therefore training places, to provide

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

sonographers for the future have been funded for 2016/17. Following panel review approval for an additional 0.85 wte sonographer was approved 4th May 2016.

Consultant presence on delivery suite is recommended by NICE as 168 hours (hrs) per week with >5000 deliveries. NBT currently has 74hrs of consultant presence. [9]

Clinical Negligence Scheme for Trusts (CNST) requires Trusts to be working towards this standard; it has been difficult to achieve nationally due to funding and availability of senior obstetricians. Benchmarking nationally against units with >6000 deliveries demonstrates that our number of consultant hours on delivery suite is lower than other comparable units (University Hospitals Bristol 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 NBT maternity dashboard outcome data and the South West Strategic Clinical Network Maternity Dashboard data. [10]

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 1:18; the NMC recommendation is 1:15. In order to improve this ratio there are currently 2 supervisors in training. This ratio supports development of midwives and will still be required when the NMC expectations regarding supervision change.

Staff Development

There is a formal development programme for transition from Band 6 to 7. This programme is in place on the delivery suite, in the community setting, and within the ward areas. There is also a band 7 to 8a development programme which launched in September 2015.

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 Agenda for Change gateway on completion of competencies outlined in the Band 6 job description.

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. There is a robust clinical governance process and the maternity dashboard looking at outcomes is reviewed monthly in the Directorate Clinical Governance meeting 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 struggled to provide consistent 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 in October 2014. A further 11 wte were approved by the Trust Board in June 2015. The midwives were fully recruited by November 2015, ensuring a midwife to birth ratio of 1:30.

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[9] *Safer Childbirth standards (Royal College of Obstetricians and Gynaecologists et al 2007) and Standards for Maternity Care (RCOG 2008).*

[10] *http://maternitydashboard.swscn.org.uk/*

The new starters were predominately newly qualified band 5 midwives and required a period of 4-6 weeks supernumery status this impacted on the requirement to continue using bank staff in some areas.

A Strategic review of working models and skill mix is currently underway, this review includes medical staffing in obstetrics and gynaecology, and also advanced nursing and midwifery roles. This review will enable 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 1:30.

The previous review of community midwifery services has Community work to a caseload ratio of 1:100 with an 80:20 ratio of trained to support staff is in line with recommendations. Clerical support was an identified area needing review. As previously described the pilot for centralised booking has now been made a permanent model with three clerks in post.

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 are agreed between staff and their appraiser, and preceptorship packages are embedded within the Directorate.

Methodology for reviewing staffing and capacity is based on the Birth rate plus calculating tool, NICE guidance and professional judgement, in conjunction with length of stay and bed modelling.

5. Next Steps:

- Full implementation of strategic staffing review is ongoing with the next phase of 'shaping the future' to be implemented by November 1st 2016, providing integrated working between the Birth Centre's and the community setting. This will allow operational growth within the current staffing numbers through improved efficiency.

- Ongoing audit of 1:1 care in labour.

- Ongoing use of **Birthrate Intrapartum Acuity® System (BRIPAS)** to inform staffing requirements in relation to acuity.

- Promote low risk setting as default birth place for all low risk.

- Review of estates strategy to support further growth of bed capacity would support more activity within current staffing model.

- Audit triage midwife role and increase hours dependent on audit results.

6. Recommendations

- Trust Board to note there has been a 6 monthly review of staffing across all maternity areas to ensure safe staffing in line with NICE guidance.

- Establishment and budget review has enabled:
  - 1.4 wte midwife to provide a 7 day triage service for Maternity assessment.
  - 3 wte clerical band 2 staff to support centralized booking.
  - Sonography increase of 0.85 wte.

Achievements against National Quality Board Expectations

Expectation	What does this mean in practice?	NBT Position –May 2016
1.Boards take full responsibility for the quality of care provided to patients, and as a key determinant to quality, take full collective responsibility for nursing, midwifery and care staffing capacity and capability.	Includes all aspects of board reporting and monitoring of establishments, actual and day to day staffing levels Emphasis on hours monitoring included as part of the NICE guidance and the requirements for uploading information to NHS Choices	In place – Monthly Board report presented since June 2014 which includes NHS Choices monthly submission. Visible on Trust Website and 6 monthly staffing establishment reports presented to Trust Board each year.
2. Processes are in place to enable staffing establishments to be met on a Shift to Shift basis.	Executive team should ensure that policies and systems are in place, such as eRostering and escalation policies.	In place – daily monitoring through staffing meetings within Directorates and Trust wide. eRostering in place for all in patient areas includes 'safe care' module. We do not have Safe Care live Module yet, this would enable real time knowledge of acuity and dependency. Escalation policies in place for use of temporary staffing solutions with Head of Nursing sign off for Framework agency and Executive or Deputy Director of Nursing sign off for non - framework agency.
3. Evidence based tools are used to inform nursing, midwifery and care staffing capacity and capability.	Use of proven methodologies and triangulation with professional judgement for setting staff levels	In place – Benchmarking, Safer Nursing Care Tool, NICE guidance and professional judgement utilised as part of the 6 monthly staffing reviews.
4. Clinical and managerial leaders foster a culture of professionalism and responsiveness where staff feel able to raise concerns	Encourages working in well-functioning teams supported by appropriate infrastructure and support model. Requires an open culture to report shortfall. Staff side organisations have a role.	In place – incidents received, monitored and themed monthly. Staff side review staffing fill rates and ratios monthly and escalate if concerned. Developing real time reporting system to capture safe staffing 'red flag' incidents, staff encouraged to ensure that when incident reporting clear red flags e.g.'Medication given late' are included.

Expectation	What does this mean in practice?	NBT Position –May 2016
5. A multi-professional approach is taken when setting nursing, midwifery and care staffing establishments	Directors of Nursing lead the process of reviewing staffing requirements and ensure that: There is a process in place actively involves sisters, charge nurses, or team leaders. They work closely with Medical Directors, Directors of Finance, Workforce (HR) and Operations. Recognising interdependencies between staffing and other aspects of the organisation's functions.	In place – Deputy Director of Nursing monitors safe staffing and Director of Nursing and Finance undertake staffing review panel. Heads of Nursing present to panel, along with General Manager, HR and Finance Business Partners and are key attendees at Monthly Nursing and Midwifery Workforce group.
6. Nurses, midwives and care staff have sufficient time to fulfil responsibilities that are additional to their direct caring duties	Recommendation on adequate Headroom (no percentages stipulated) Recommendations on supervisory time for ward leaders (no time stipulated)	In place – headroom included in all budgeted staffing levels for wards at 21% exclusive of Maternity Leave. Supervisory ward leader model is in place trust wide for 100% of time, however due to winter pressures and current vacancies this is not achieved at 100%.
7. Boards receive monthly updates on workforce information, staffing capacity and capability is discussed at Public Board meeting at least every 6 months on the basis of full nursing and midwifery establishment review.	Monthly workforce reports go to board detailing actual staffing levels against establishment for the Previous month – highlighting hotspot areas. 6 monthly establishment reviews to go to open board for discussion and debate	In place – Board report presented monthly since June 2014. Hotspot areas listed with actions when fill rates less than 80% and when triggering on QUESTT. 6 monthly review discussed in Public Board Meetings.

Expectation	What does this mean in practice?	NBT Position –May 2016
8. NHS providers clearly display information about the nurses, midwives and care staff present on each ward, clinical setting, department or service on each shift.	Display information of staff present by shifts clearly and visibly for patients.	In place – Every ward displays staffing, trial of new boards in place in Neurosciences.
9. Providers of NHS services take an active role in securing staff in line with their workforce requirements	Robust recruitment and retention plans need to be in place within the organisation Organisations to work with LETB and others to inform commissioning intensions and future workforce planning.	In place – NBT fully engaged with workforce planning cycle at both local and regional level. Increased commissions for undergraduate training agreed for the region, NBT preparing for increased placement of students.
10. Commissioners should seek assurance that providers have sufficient nursing and care staffing capacity and capability to deliver the outcomes and quality standards.	Transparent communication and review with Commissioners about any issues relating to safety and staffing levels. Impact Assessments.	In place- NBT maintain constant assessment and review with Commissioners about any issues relating to safety and staffing levels. Processes are in place 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.