North Bristol NHS Trust

Report to:	Trust Board	**Agenda item:**	**9.0**
Date of Meeting:	1st February 2018		

Report Title:	**Safe Nurse and Midwifery Staffing**			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
	X		**x**	
Prepared by:	Sarah Dodds, Deputy Director of Nursing (Part A) Rachel Fielding Director of Midwifery/ Head of Nursing, Gina Augarde Senior Matron (Part B)			
Executive Sponsor (presenting):	Sue Jones, Director of Nursing and Quality			
Appendices (list if applicable):	Appendix 1			

Recommendation:

Part A

The Trust Board is asked to note:

1. Assurance regarding current position against the expectations and actions of the NQB expectations, NICE guidance and self-assessment of the NHS Improvement recommendations.
2. The Director of Nursing has undertaken a formal annual review of safe staffing for all inpatient ward areas, detailed within the report with required changes to be included within workforce Business plans for each Division.

Part B

- The implementation of updated Birthrate Plus Acuity Tools from February 2018 in recognition of the acuity and complexity of women with the plan to review the data in June 2018 to identify the appropriate staffing levels/requirements within Maternity Services, as

recommended by NICE guidance.

- The implementation programme for the recommendations of 'Better Births' 2016, to include a new model of Integrated midwifery staffing with the community and Birth Centres. This is in progress, including close working relationships across BNSSG with UHB, the CCGs. and the South West Clinical Network

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).

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 from May 2016 Care hours per Patient Day (CHPPD) along with the model hospital dashboard.

The NQB updated and refreshed their expectations in July 2016[5] to ensure safe, effective, caring, and responsive and well led care on a sustainable basis; Trusts will employ the right staff with the right skills in the right place at the right time. In February 2017 an improvement resource was published by NHS Improvement[6] to support nurse staffing in adult inpatient wards and implementation of the NQB expectations.

This report demonstrates the work underway at North Bristol Trust in line with the 3 expectations of the NQB and a self-assessment of NBT against the NHS Improvement recommendations for safe staffing is provided in Appendix 1. This report details Registered to Non Registered Nurse ratios and the Director of Nursing Annual review of Safe Staffing of all in- patient areas with required changes for each Division.

[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
[5] National Quality Board (July 2016) Supporting NHS Providers to deliver the right staff, With the right skills, in the right place at the right time.
[6] https://improvement.nhs.uk/uploads/documents/Adult_in-patient_safe__sustainable_staffing.pdf

The Maternity report describes the methodology for reviewing midwifery staffing. Birth Rate plus were commissioned in October 2016 and undertook a review at that time. Their report concluded with a requirement for 10 WTE additional Midwives in some care settings, and recommended that a new model of care was implemented called Integration. Subsequent to the above report there had been a small reduction in the number of births and booked births, therefore the decision was made at that time, to purchase an additional acuity tool to measure acuity on CDS (for labour and birth) and the Antenatal and Postnatal Wards more accurately on a daily basis rather than an adhoc audit, and to implement the integration model and to repeat a safe staffing review in 6 months' time.

Since that time, the acuity in maternity has increased by 25% with the Royal College of Obstetrics and Gynaecology (RCOG) endorsement of NICE guidance (Inducing Labour CG70 2008)[7] to offer induction of labour to women with a history of reduced fetal movements at term (a risk factor for stillbirth and part of a national programme of work to reduce the stillbirth rate with the target to reduce the rate by 20% by 2020 and 50% by 2025 as reported to MBRRACE (Mother and Babies Reducing Risk through Audit and Confidential Enquiry)[8]. This has had a significant impact on the workload within maternity whilst the general acuity of women is also increasing, with high BMI, increasing age and comorbidities being the main contributory factors[9].

[7] *https://www.nice.org.uk/guidance/cg70*

[8] https://www.gov.uk/government/news/new-maternity-strategy-to-reduce-the-number-of-stillbirths

[9] https://www.rcm.org.uk/sites/default/files/SoMS%20Report%202016_New%20Design_lowres.pdf

North Bristol NHS Trust

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 in place for monitoring and ensuring safe staffing in line with current national recommendations.
This also reports on the annual review of all inpatient areas which have taken place with recommendations to be supported by workforce business plans.

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.

NICE guidance for 'Safe staffing for nursing in adult inpatient wards in acute hospital (July 2014) and 'Safe midwifery staffing for maternity settings (Feb 2015) was produced and was recommended to be read alongside that of the NQB guidance.

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 Carter review recommended use of a new metric, Care hours per patient day (CHPPD).

All NHS Trusts are accountable to NHS Improvement and are 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. In July 2016 the NQB guidance was refreshed, broadened and re-issued to include the need to focus on safe, sustainable and productive staffing.

In February 2017 an improvement resource was published by NHS Improvement to support nurse staffing in adult inpatient wards. It is aimed at wards that provide overnight care for adult patients in acute hospitals excluding intensive care high dependency, acute admissions and assessment.

This paper will focus on the NQB expectations and assess the Trust's current approach and achievements against these expectations and a self-assessment of the recommendations of the NHS Improvement resource can be found in Appendix 1.

3. NQB Expectations: a triangulated approach to staffing decisions

The NQB expectations support an approach to deciding staffing levels based on patients' needs, acuity and risks, monitored from 'ward to board'. This triangulated approach to staffing decisions rather than making judgments based solely on numbers or ratios of staff to patients is supported by the CQC.

Expectation 1 Right Staff (workforce Plans)	Expectation 2 Right Skills	Expectation 3 Right place and time
Evidence based workforce planning	Mandatory Training, development and education	Productive working and eliminating waste
Professional Judgement	Working as a Multi professional Team	Efficient deployment and flexibility
Compare staffing with Peers	Recruitment and retention	Efficient employment Minimising agency usage

Table 1 NQB Updated Expectations (2016)

Expectation 1 Right Staff (Workforce Plans)

The methodology used for the nursing establishment reviews at NBT includes:
Analysis of actual staffing alongside other metrics; patient acuity (completed 3 times per day), Professional Judgment, ward quality metrics and national tools available such as the NICE guidance (2014) and evidence based guidance from Royal Colleges. The Trust also compares local staffing with staffing provided by an appropriate peer group within the Model hospital dashboard, recognising that the specific ward design for the Brunel Wards also needs to be appropriately benchmarked.

In line with all Trusts NBT reports monthly Care Hours per Patient Day (CHPPD). Over time, this metric enables a review of staff within a specialty and by comparable ward. CHPPD is calculated by adding the hours of registered nurses and the hours of health care assistants and dividing the total by every 24 hours of inpatient admissions or approximating 24 patient hours by counts of patients at midnight. Total CHPPD for NBT for the past 6 months is provided in Table 2.

Divisional Changes

In December 2017 to manage the winter bed base plan there were further bed moves to accommodate increased Medical Admissions. The wards affected by these changes will continue to have their patient acuity and staffing requirements monitored closely to ensure that they are at the correct funded establishment for the change in speciality.

Bed capacity has remained challenging for all wards and has required additional patients to be cared for on some inpatient wards. When this occurs particularly overnight the matrons assess the level of care required on the wards and if required will request additional staff.

A further significant challenge over the past 6 months has been to manage the additional staffing required at times of surge for both AMU and ED in order to care for patients waiting for beds in the corridor. Each day this is assessed and approved by the Head of Nursing for Medicine along with the Director/ Deputy Director of Nursing.

Other areas of bed escalation used are:

Core Clinical Division
Interventional Radiology has been funded to be opened at the weekends over the winter period. The staffing is assessed in line with NICE guidance and professional judgement.

ASCR
Medirooms escalation, staffing is assessed based on both numbers and acuity taking the environment into consideration.

Expectation 2 Right Skills

Mandatory Training, development and education

The Trust is committed to ensuring that clinical staff have the appropriate training and the right competencies to support new models of care. The clinical Induction programme was further reviewed in September 2017 ensuring the relevant level of training provided and where possible this has been completed in the clinical area where the member of staff will be working. The number of Trust inductions per month has increased in order to support the increased recruitment of staff.

The supernumerary guidance for new nurse and midwifery starters is now well embedded to reflect an appropriate timescale for staff to be supernumerary within the workplace.

Working as a Multi Professional Team

The Trust has demonstrated its commitment to investing in new roles and skill mix reviews which enables registered nurses to spend more time to focus on clinical duties and decisions about planning and implementing nursing care.

The 2015 Shape of caring report[10] recommended changes to education, training and career structures for registered nurses and care staff, in light of this NBT has continued with the development of its workforce in support of this report. Training for Assistant Practitioners has been well embedded within NBT and the role is continuing to be developed throughout the hospital.

In April 2017 the Trust as part of the Bristol, North Somerset and South Gloucestershire Sustainability and Transformation Plan along with Bath commenced as a pilot site for the National Nursing Associate role training with 13 candidates commencing at NBT. There are plans in place for a second cohort to commence in 2018.

The NHS Improvement Resource recommends taking account of the wider multidisciplinary team who may or may not be part of the core ward establishment including allied health professionals, advanced clinical practitioners, administrative staff and volunteers. It is recognised that the range of specialist and advanced practitioners at NBT provide expert advice, intervention and support to ward based teams, along with the 'link nurse' model which is in place for certain specialties e.g. Tissue viability, Diabetes.

The delivery of high quality care depends on strong and clear clinical leadership, and well led and motivated staff. In order for this to be achieved at ward level the sisters are

[10] https://hee.nhs.uk/sites/default/files/documents/2348-Shape-of-caring-review-FINAL.pdf

supervisory, this enables them to be visible to patients, staff and visitors and to work alongside staff as role models, monitor performance and deliver training. It has been very challenging to maintain this particularly within the Medical Division when they have been required in reality to work clinically to support wards when there is a shortfall of last minute nursing staff. The administrative requirements of their role are supported by a ward administrator working across 3 wards.

Recruitment and Retention

Over the past 6 months there has been a continued focus in the activity of both Registered and Non Registered Nurse recruitment including:

- Open days for Registered Nurses , these are well led by the Divisions and enable the opportunity for staff to be shown around wards and departments and to be interviewed and offered posts on the day.
- Specialist Divisional adverts.

The process for the recruitment of non-registered nurses has been streamlined and supported by an external administration recruitment team to support an improved recruitment experience. This has enabled high quality and well informed candidates attending the Assessment Centre. This has also shown improvement in start time and an increase in the numbers of non-registered staff in the recruitment pipeline.

Each Division has a detailed understanding of their vacancies and tracks both recruitment and turnover closely to ensure that they are proactively recruiting. Additional recruitment resource is being provided to ASCR given the ongoing use of agency staff in Theatres, Medirooms and Intensive Care to support the filling of vacancies and retention of staff.

Retention programmes are developed more extensively within each Division and include Divisional rotational posts and a Trust Wide staff engagement plan. The use of the staff engagement 'happy app' has been rolled out across a few clinical areas within the Trust. Staff in these areas are engaging well with this method of real time feedback.

A Trust Wide retention steering group is planned for January 2018.

Expectation 3: Right place and time

Each month the Trust submits the ward planned and actual staffing levels including Care Hours Per Patient Day (CHPPD) via Unify.

The nursing and midwifery fill rates and CHPPD for Southmead Hospital for the past 6 months can be viewed in Table 2.

Table 2 Fill Rates and CHPPD

	Jul	Aug	Sep	Oct	Nov	Dec
RN Day	97.1%	94.0%	94.3%	92.7%	96.1%	97.7%
HCA Day	116.7%	112.6%	103.8%	86.9%	91.4%	111.2%
RN Night	97.7%	96.6%	96.4%	94.5%	98.3%	99.3%
HCA Night	122.01	122.4%	114.1%	94.4%	96.2%	120%
CHPPD	8.1	8.2	8.2	8.2	8.3	8.4

****The decrease in HCA's fill rate in October reflected change in establishment in ICU and enhanced care staffing within Neuro being within the rostered establishment***

All wards continue to reach a funded ratio of 1 Registered Nurse: to 8 Patients or less for a day shift, exclusive of the supervisory ward sister.

The night shift is monitored closely depending on the number of patients; this can increase on a ward to 1: 12. The Annual staffing review undertaken however has improved this overnight within most areas.
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.

Current funded Divisional RN: HCA Ratios

Most of the ward establishments using high numbers of enhanced care now include enhanced care Health Care Assistants within the funded establishments which leads to an increased ratio of Unregistered Nursing. This includes Band 4 Assistant Practitioners, many of whom are undertaking competencies previously the domain of the registered nurse.

ASCR

Division	Organisation	Staff Group	Total
339 Anaesthesia, Surgery, Critical & Renal Div	339 14104 Ward 32B	Nursing and Midwifery Registered	58.7%
		Unregistered Nursing	41.3%
	339 14221 Ward 33A Surgical	Nursing and Midwifery Registered	76.4%
		Unregistered Nursing	23.6%
	339 14222 Ward 33B Surgical	Nursing and Midwifery Registered	61.8%
		Unregistered Nursing	38.2%
	339 14230 Critical Care (ICU)	Nursing and Midwifery Registered	94.8%
		Unregistered Nursing	5.2%
	339 14324 Ward 34B (Urology)	Nursing and Midwifery Registered	60.8%
		Unregistered Nursing	39.2%
	339 14325 Ward 34A (Colorectal)	Nursing and Midwifery Registered	61.0%
		Unregistered Nursing	39.0%
	339 14411 Ward 8B (Renal - 38 Bed)	Nursing and Midwifery Registered	59.7%
		Unregistered Nursing	40.3%

Medicine

339 Medicine Division	339 14031 Acute Medical Unit Gate 31A&B	Nursing and Midwifery Registered	65.2%
		Unregistered Nursing	34.8%
	339 14103 Ward 32A	Nursing and Midwifery Registered	43.5%
		Unregistered Nursing	56.5%
	339 14402 Ward 27A	Nursing and Midwifery Registered	67.1%
		Unregistered Nursing	32.9%
	339 14403 Ward 27B	Nursing and Midwifery Registered	65.8%
		Unregistered Nursing	34.2%
	339 14410 Ward 8A (Flex Capacity)	Nursing and Midwifery Registered	58.3%
		Unregistered Nursing	41.7%
	339 14501 Ward 9B Flex Capacity	Nursing and Midwifery Registered	43.2%
		Unregistered Nursing	56.8%
	339 14502 Ward 28A (Complex)	Nursing and Midwifery Registered	43.2%
		Unregistered Nursing	56.8%
	339 14503 Ward 28B (Complex)	Nursing and Midwifery Registered	43.2%
		Unregistered Nursing	56.8%
	339 17002 Elgar Ward 2	Nursing and Midwifery Registered	44.6%
		Unregistered Nursing	55.4%
	339 17003 Elgar Ward 1	Nursing and Midwifery Registered	40.2%
		Unregistered Nursing	59.8%

NMSK

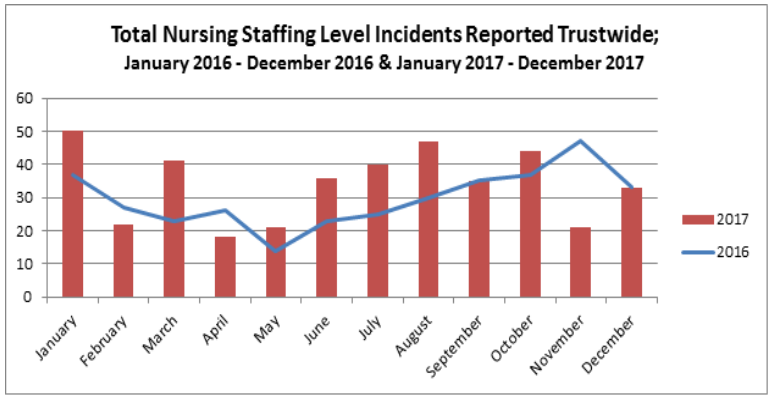
339 Neurosciences & Musculoskeletal Division	339 14211 Ward 6B (Mainly Neuro)	Nursing and Midwifery Registered	67.2%
		Unregistered Nursing	32.8%
	339 14241 Ward 25A Neuro	Nursing and Midwifery Registered	66.5%
		Unregistered Nursing	33.5%
	339 14242 Ward 25B MSK	Nursing and Midwifery Registered	56.7%
		Unregistered Nursing	43.3%
	339 14302 Ward 7A (Neurology/Stroke)	Nursing and Midwifery Registered	54.9%
		Unregistered Nursing	45.1%
	339 14303 Ward 7B (MSK, some Neuro)	Nursing and Midwifery Registered	55.9%
		Unregistered Nursing	44.1%
	339 14311 Ward 26A Musculo	Nursing and Midwifery Registered	55.7%
		Unregistered Nursing	44.3%
	339 14312 Ward 26B Surgery	Nursing and Midwifery Registered	57.1%
		Unregistered Nursing	42.9%
	339 14520 Ward 9A Rehab	Nursing and Midwifery Registered	48.4%
		Unregistered Nursing	51.6%
	339 25000 Neuropsychiatry (non Medical)	Nursing and Midwifery Registered	67.8%
		Unregistered Nursing	32.2%

Women's and Children's

339 Women and Childrens Division	339 01181 Birthing Centre	Nursing and Midwifery Registered	70.6%
		Unregistered Nursing	29.4%
	339 01254 Percy Phillips Ward	Nursing and Midwifery Registered	52.6%
		Unregistered Nursing	47.4%
	339 01255 NICU	Nursing and Midwifery Registered	77.6%
		Unregistered Nursing	22.4%
	339 01259 Central Delivery	Nursing and Midwifery Registered	79.0%
		Unregistered Nursing	21.0%
	339 01269 Cotswold Ward	Nursing and Midwifery Registered	59.6%
		Unregistered Nursing	40.4%

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. These are reviewed monthly at the Nursing, Midwifery and Therapies Leadership Group.

Graph 1 - Total number of staffing levels incidents



The highest reporting Division for 3 months was ASCR. This correlated with an increase in vacancies and reduced fill rate on one ward. This ward was supported by the Matron and has now resolved with vacancies filled. Medicine and Women's and Children's Divisions continue to report when there are decreased fill rates and there are concerns with workload. In Medicine when required to maintain safety at times of increased numbers of patients, staff are moved for short periods of time. Safety has been maintained by the inclusion of an escalation process for Neonatal Intensive Care Unit (NICU) which requires senior non ward based staff responding to support at short notice, the use of both Framework and Non Framework agency for NICU and the Matrons covering clinical shifts.

Productive working and eliminating waste and efficient deployment and flexibility

To ensure that there is an appropriate system and process in place for the deployment of staff and managing the staffing resources on a day to day basis, the Trust uses the Safe Care live Acuity tool. This has now been in use Trust wide however it has been recognised that with staff turnover it does require further education and support for some teams for validation of data to ensure accuracy. Twice daily safe staffing meetings occur when real time data of actual staffing levels and patient acuity can be viewed and staff redeployed as required.

Efficient employment minimising agency usage

NBT has clear plans in place and is working towards an ongoing significant reduction in the use of agency nursing staff in line with the NHS Improvement agency rules. Non-

framework agency nurse approval is via the Director and Deputy Director of Nursing or on call Executive out of hours.

The use of any agency is utilised to ensure patient safety is not compromised by booking in advance following approval for NICU, Theatres / Anaesthetics/ Medirooms and Intensive Care Unit (ICU). Careful control and monitoring of fill rates is maintained by the Heads of Nursing to ensure that there is no negative impact on patient care and safety. All staff are encouraged and supported to complete incident forms if concerns regarding safe staffing are raised. In November 2017 across BNSSG the use of a neutral vendor has been implemented in order to further reduce agency spend through improved rates with framework agencies. This is being closely monitored by Executive level leads across BNSSG.

The recruitment of both registered and non-registered nurses to the temporary staffing bank continues and staff are well supported by the Clinical Lead in ensuring support for new starters, revalidation and monitoring and maintaining high professional standards.

Patient Feedback

Work has commenced on providing an integrated staffing, quality metrics and a patient and staff feedback dashboard. Current analysis of Patient feedback is via complaints, concerns, letters of appreciation and friends and family feedback.

Staff feedback

Staff are encouraged to report unsafe staffing incidents via electronic reporting, the use of the 'happy app' in certain areas and via the 'Freedom to Speak up Guardians'. There are specific questions asked with the Annual staff survey regarding staffing and the results of last year's survey are awaited.

Annual Staffing Review Methodology

A full staffing review of all inpatient wards took place in October / November 2017. This consisted of a formal review chaired by the Director of Nursing, with all ward areas presented by the Head of Nursing supported by Divisional Finance and HR Business Partners. This included assessments of fill rates, CHPPD, triangulated with Ward Quality Metrics, review of e-rostering data, professional judgement and patient and staff feedback.

Annual Staffing Review

Neuro and MSK	Gate 26a	Increase in 1 band 2 per shift 5.2 w.t.e HCA's
	Gate 25a	Assessed – No change
	Gate 26b	Assessed – No change
	Gate 25b	Assessed – No change
	Gate 6b	Assessed – No change
	Gate 7a	Assessed – No change
	Gate 7b	Assessed – No change (change in speciality planned)
	Gate 9a	Increase in 5.2 w.t.e 2.6 w.t.e band 2 and 2.6 w.t.e band 4 Change in speciality and Division planned to be monitored closely.
	Rosa Burden	Assessed – No change
	TOTAL	**7.8 w.t.e Band 2** **2.6 w.t.e Band 4**

ASCR	Gate 32b	Increase in 1 band 5 per shift 5.2 w.t.e and skill mix changes of 0.93 band 5
	Gate 33a	Assessed – No change
	Gate 33b	Assessed- No change
	Gate 34a	Increase in 1 band 2 per shift - 5.2 w.t.e and review for 5.2 w.t.e HCA for enhanced care due to change in speciality, triangulated with patient feedback.
	Gate 34b	Assessed – No change
	Gate 8b	Assessed – No change
	ITU	Assessed – No change
	TOTAL	**6.13 w.t.e Band 5** **10.4 w.t.e band 2**
Medicine	Gate 8a	Increase in 1 band 5 RN per shift 5.2 w.t.e Increase in 1 band 2 per shift 5.2 w.t.e, triangulated with patient feedback.
	Gate 9b	Increase in 1 band 5 Night duty 2.6 w.t.e RN
	Gate 27a	Assessed – No change
	Gate 27b	Assessed – No change
	Gate 28a	Increase in 1 band 5 Night duty. 2.6 w.t.e RN
	Gate 28b	Increase in 1 Band 5 Night duty. 2.6 w.t.e RN
	Gate 31a/b	Change in skill mix increase to 1 band 7 on every shift achieve by reducing Band 6 by 2.6 w.t.e and increase Band 7 by 2.6 w.t.e.
	Gate 32a	Assessed –No change
	Elgar 1	Assessed – No change
	Elgar 2	Assessed – No change
	TOTAL	**2.6 w.t.e Band 6 – 7** **13 w.t.e Band 5** **5.2 w.t.e Band 2**
Women's and Children's	Cotswold	Assessed – see below
	NICU	Assessed – see below

The workforce plan increases for these wards are being included as part of each Divisional Business Operating Plan and where wards have now moved to be managed by the Medical Division they will include the relevant wards i.e. 34A and 9A

Gynaecology - Cotswold Ward

Cotswold Gynaecology Ward is usually staffed for 19 beds. It also has a 10 bed 'Day Case' unit, with the majority of gynaecology procedures being performed as a Day Case or in Outpatients. In times of escalation within the Trust, the ward can increase its bed base to 25 and for the Winter period it has 12 designated medical capacity beds.

Breast and Urology surgical lists are also accommodated on a weekly basis in line with demand. The service also provides a weekly afternoon Emergency Gynaecology Clinic in addition to unpredictable ambulatory ward attendees either as a self-referral or referred by the GP.

The ward is staffed according to the acuity / enhanced care needs of the patient, and increases its staffing numbers accordingly. There is an annual trend of high turnover of

Registered Nurses in the summer months which then require a further recruitment campaign to maintain safe staffing levels. Exit interviews indicate this is due to staff dissatisfaction having been employed as a Gynae/Surgical nurse, but the reality being that they care for women from other specialities with increased acuity and dependency.

In order to support this and ensure the appropriate knowledge and skills are provided, staff from the Medical Division have moved to work on Cotswold for the next few months. There is also a requirement for the use of temporary staffing to be used and if shifts remain unfilled the contingency plan is for the Supervisory Sister and/or Matron to work clinically in support of safe staffing.

The daily safe staffing level of the ward has been reviewed in line with NICE guidance, Professional judgement and using the acuity and dependency tool.

Neonatal Intensive Care Unit (NICU)

There have been concerns regarding the level of registered nurses in NICU over the last few years, also highlighted in a Coroners Report in 2017 and staffing levels in NICU are on the Trust Risk Register. A further concern is increased staff vacancies and in addition, only 58% of all staff are Qualified in Specialty trained.

The Director of Nursing commissioned an external review of NICU staffing and nursing practice in January 2017 and NHS England undertook a peer review in November 2017.

Staffing levels within these reports supported that:

"The funded nursing establishment is below that required for current levels of activity and acuity".

Staffing requirements and current situation

The service specification from NHS England and the British Association of Perinatal Medicine (BAPM) staffing standards, state that the minimum standards for nurse staffing levels for each category for care are:

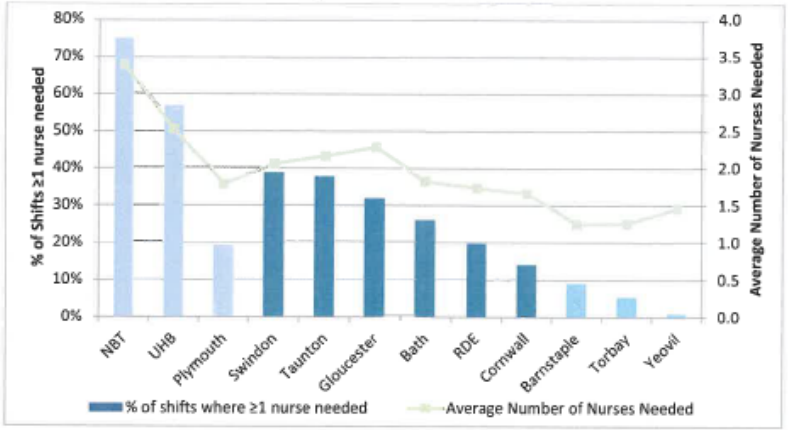
- neonatal intensive care: 1:1 nursing for all babies
- neonatal high dependency care: 2:1 nursing for all babies
- neonatal special care: 4:1 nursing for all babies.

The National Quality Board (edition 1, November 2017) issued 'An improvement resource for neonatal care', this document clearly states that the above are the recognised minimum standards that Trusts should work to.

Nursing Numbers

In 2016/17 a total 550 shifts (75%) were identified in NBT as requiring at least one additional nurse and on average for each of these shifts an additional 3.4 nurses were required to reach BAPM standards. This is well above the network average (see graph below).

Percentage of shifts across 2016/17 where ≥1 nurse was required to reach BAPM standards and the average number of nurses needed for these shifts by unit



To currently maintain safe staffing within NICU the number of cots has been reduced by 4. This is monitored and managed closely by the Divisional Management team. Three times daily an SBAR is completed which manages the staffing requirements in line with acuity of babies. There is an escalation process in place for staff to be used from other areas and the supervisory ward sister and matron provide additional support. The Division submitted a NICU business case to Trust Board which detailed required staffing numbers on NICU in line with BAPM standards with the outcome awaited.

It is recognised that it is challenging to recruit experienced NICU nurses and in view of this the following recruitment and retention plan is in place:

- Ongoing recruitment campaign with consideration of Cross City joint recruitment/interviews
- Rolling Band 5 advert
- NICU open days/Career fairs
- Staffing rotation between Midwifery and gynaecology extended to NICU
- Targeted social media campaign
- Guaranteed interview times
- Staff wellbeing sessions
- Educational support to attend specialist NICU course

4. Risks

Although both registered and unregistered nurse recruitment has been substantial over the past 6 months, with a high number of vacancies and the additional capacity in certain areas it is still challenging 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.

- There remains a high use of agency and temporary staff in NICU, ICU and Theatres/Medirooms and at times agencies are unable to fill shifts and therefore a risk assessment with regards to activity has to be made in order to manage staffing safely.

- The Trust undertook a review of ward specialities to support the winter plan in December 2017. The ward

establishments in place are managed closely and efficiently using the Acuity tool, NICE guidance and professional judgement and will continue to be for the next few months to ensure that the appropriate staffing levels are achieved. There is a risk that there may be a requirement to increase staffing to support some of these changes if the acuity reflects this.

- The Trust holds a significant risk with the increase in acute admissions which has required more patients to be cared for on some wards. The current staffing establishments have been funded for the ward bed base in Brunel of 32 beds, however there are occasions when this is required to increase to 35 patients, including overnight. When required to ensure safety an additional member of staff is booked

- With large numbers of patients requiring enhanced care there is often a high demand for additional Health Care assistants, these shifts particularly during the day are difficult to fill. The risk is managed by moving staff within and across Divisions.

- Staffing the extra capacity and escalation areas at short notice e.g. ED/ AMU/ Interventional Radiology/Cotswold can be difficult as not part of the funded establishment.

- NICU has continued to experience high acuity, high agency usage and a number of unfilled vacancies. Therefore the number of cots continues to be reduced to manage this.

Conclusion

This paper has reviewed North Bristol NHS Trust against the triangulated approach of the NQB expectations (July 2016) for safe staffing. It has 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.

The Director of Nursing Annual staffing review of the inpatient ward areas has taken place and the required increases are highlighted within the ward staffing template. The increases will form part of the workforce business planning for each Division.

There have been some ward specialty changes over the past few months. And ward establishments have been managed closely alongside patient acuity. Once the changes are embedded in each ward a further review of staffing levels with take place.

Next Steps

Over the next 6 months in line with the action required from the self-assessment of the NHS Improvement resource- see appendix 1, a ward level dashboard will be progressed to include quality indicators and staff, patient and carer feedback indicators. This is endorsed within the Chief Nursing Officer Strategy (2016)[11] 'Leading Change, Adding Value: a framework for nursing, midwifery and care staff' with the aim to achieve better outcomes, better patient and staff experience and better use of resources.

[11] https://www.england.nhs.uk/ourwork/leading-change/

Recommendations

This report has demonstrated to the Trust Board that the Annual assessment of nurse staffing in line with business planning and against the triangulated approach to staffing of the NQB expectations has taken place.

The Trust Board is asked to note:

1. Assurance regarding current position against the expectations and actions of the NQB expectations, NICE guidance and self-assessment of the NHS Improvement recommendations.
2. The Director of Nursing has undertaken a formal annual review of safe staffing for all inpatient ward areas, detailed within the report with required changes to be included within workforce Business plans for each Division.

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Midwifery Safe Staffing Report

1. Purpose:

A 6 monthly report, to provide the Trust board with a Safe staffing update for the Maternity service at NBT.

2. Women & Children's Services (W&CS) update on safe staffing

W&CS at NBT, made the decision in June 2017, to introduce the Royal College of Obstetricians & Gynaecologists (RCOG) and NICE Induction of Labour guideline 2008 (IOL). This guideline recommends that all women who are at term and have had two episodes of reduced fetal movements should be given the choice to have an induction of labour. The impact of implementing this recommendation within W&CS has resulted in a significant increase in the associated workload for the clinical team.

NICE Inducing labour CG70 (2008) state 'Induction of labour can place more strain on labour wards than spontaneous labour Traditional induction is carried out during the daytime when labour wards are often already busy' with the onset of labour occurring at any time throughout the 24 hour period.

The guideline has had an impact on safe staffing levels in W&CS due to the increased workload, with the majority of women accepting the offer of IOL. This is a national picture seen in all maternity units offering IOL throughout the UK in response to national work and guidance related to the reduction in the stillbirth rate with a DoH target of a 20% reduction by 2020 and a 50% reduction by 2025.

To monitor the effect on staffing levels, the unit has continued to use the national 'Birthrate Plus (BR+) Acuity tool (an addition to the suite of BR+ maternity workforce tools which were endorsed by NICE in 2016). The BR+ Intrapartum acuity tool is the only model recognised by the Royal College of Midwives (RCM) and NICE. A new Postnatal and Antenatal Acuity tool has recently been developed by BR+ and purchased by W&CS. This is due to be implemented in February 2018, providing further acuity data across all areas within the service in support of safe staffing levels throughout.

The BR+ tools use data from Maternity units around the UK, specific to each unit and the demographics and complexities of women, to demonstrate a validated customised interpretation of safe staffing requirements for each individual unit.

3. Central Delivery Suite (CDS) staffing

CDS is currently the main area of concern with regards to safe staffing due to the above factors. Safety and good clinical outcomes for both mother and baby remain paramount, alongside the patient experience and one to one care in labour as the required standard. Due to the increased complexities and acuity, an increasing number of women are now requiring two to one care in labour and antenatally/postnatally (High Dependency Care) as clinically indicated. One to one midwifery care in labour has remained consistent in 2017 at 96.9%.

As a comparison, and to acknowledge the effect the implementation of the guidance has had on CDS, the following findings have been identified in Table 1.

Table 1. CDS Birthrate Plus Acuity requirements

Time period 2017	April to June	July to Sept	**Oct to Dec**
Staffing levels **less** than acuity requirement as per BR+	43%	49%	**64%**
Staffing levels **meet** acuity requirement as per BR+	57%	51%	**36%**

As of 3rd January 2018 there are 9.71 WTE Midwifery vacancies across the service with a rolling recruitment campaign in order to fill the vacancies and maintain current funded staffing levels.

To support the change in acuity, staffing has been supported in all areas by:

- Use of flow midwives and Matron of the day to ensure that staff are in the correct place and can be moved to the area with the highest acuity as and when required, although moving staff from other areas to support CDS has an impact on the area they are being moved from. The main area of concern is the Mendip Birth Centre. Staff are only moved if there are no women suitable to birth in the birth centre, or the same women can be cared for safely on CDS with the midwives from the Birth Centre. The impact of this is that the woman may not be supported with her chosen place of birth.
- Use of safer staffing tool to identify areas of concern, and ensure that the supervisory ward sisters and Matrons are identifying any areas of concern in a timely manner.
- Development of a new escalation guideline to ensure that the unit has senior support and a robust staffing plan for periods of increased activity and unexpected sickness.
- Purchase of a new BR+ Acuity Tool/ in February 2018 to provide data for a full staffing review in June 2018.
- A business case is being developed to review the role of the scrub midwife in Theatre in consideration of other roles that could potentially fulfil this requirement (Band 5 RN's/Band 4). This also includes the potential for Theatre scrub cover to be provided by the surgical team from ASCR for elective caesarean sections, releasing the midwifery resource to provide midwifery care and capacity in Obstetric Theatres.

Individual units that have undertaken the Birthrate Plus® analysis are advised of the recommended number of clinical midwives required to provide care for the number of births across the whole of the service, regardless of where they are deployed. Ratios are dependent on demographics; case mix, models of care, total number of community cases and the differing complexities of women, with the average ratio ranging between 1:26 at the higher end and 1:34 at the lower end, although more recent reviews across the UK are identifying the need for ratios of 1:21 – 1:23 due to the increased complexity of women. This means a ratio of 1:26 for example, for every 26 births, 1 clinical whole time equivalent midwife is required.

W&CS status is shown in Table 2. This remains a positive ratio for the Division.

Table 2 Midwife to birth Ratios

Midwife to Birth Ratio					
May-16	**Jun-16**	**Jul-16**	**Aug-16**	**Sep-16**	**Oct-16**
1:30	1:30	1:30	1:30	1:30	1:30
Nov-16	**Dec-16**	**Jan-17**	**Feb-17**	**Mar-17**	**Apr-17**
1:30	1:30	1:30	1:30	1:30	1:30
Jun- 17	**Jul-17**	**Aug-17**	**Sep-17**	**Oct-17**	**Nov-17**
1:30	1:30	1:30	1:30	1:30	1:30
Dec-17					
1:30					

Examples of an increase in the complexity of women that impact on acuity is demonstrated in Table 3

Table 3 – Increases in Acuity W&CS 2016 -2017

Increases in Acuity W&CS 2016 – 2017

	2016	2017
Preterm birth rate < 37 wks	6.9%	10.5%
Low birth weight at term	2.0%	2.2%
Stillbirth rate at term	0.1%	0.2%
BMI 50 or more	0.2%	0.6%
Births Under 18 yrs age	0.5%	0.6%
Births over 40yrs	3.3%	4.4%
5 min apgar score< 7 at term	0.8%	1.3%
IOL	29.7%	33.3%
Emergency Caesarean	16%	18.2%
3rd degree tear assisted births	9.1%	11.8%

There is also further guidance awaiting implementation in 2018 regarding women who are large for gestational age. This will have a further impact on the increase in the workload and capacity for the Division.

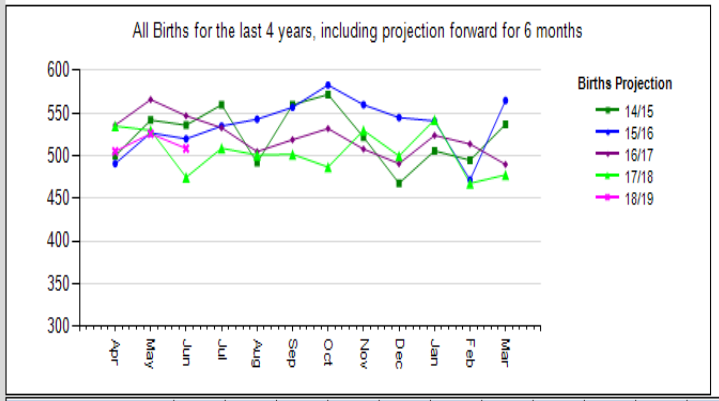
The birth rate for W&CS has not increased (Table 4), in fact the projection demonstrates a slight decrease for 2018/2019. This highlights that the acuity is in fact the main determinant of the increase in workload, and not the number of women accessing Maternity Services and giving birth.

Midwifery staffing numbers cannot be adjusted on a monthly basis in line with predicted births as they need to follow the annual trend and take into consideration the increasing complexity of women accessing maternity services.

There are identified safe staffing numbers per shift for each clinical area that cannot be compromised by the reduction in numbers in a simplistic way. The consideration that needs to be made is in relation to the appropriate skill mix within the service as a whole. The recommendation within Birthrate plus is for an overall Midwife: Support worker (MSW) ratio of 80:20 – with support workers being recognised of value, primarily in the provision of postnatal care within both the hospital and community setting.

Table 4.

Birth Projection : All



Total Births	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total	% Change
09/10	515	517	526	530	554	535	554	502	509	526	497	529	6294	
10/11	515	482	505	532	497	502	502	499	451	476	414	512	5887	-6.5%
11/12	499	517	497	550	533	532	527	504	494	544	485	558	6240	6.0%
12/13	472	535	510	521	530	525	547	491	521	508	507	519	6186	-0.9%
13/14	513	529	507	542	534	504	495	499	498	515	454	489	6079	-1.7%
14/15	500	542	536	560	492	560	572	522	468	506	495	537	6290	3.5%
15/16	491	527	520	535	543	557	583	560	545	541	472	565	6439	2.4%
16/17	536	566	547	533	505	519	532	508	491	524	514	490	6265	-2.7%
17/18	535	530	475	509	501	502	487	530	500	542	468	478	6057	-3.3%
18/19	505	526	509										1540	

Better Births' (2016) a National review of Maternity Services [12]

This review identified seven key recommendations.

1. Personalised care, centred on the woman, her baby and her family, based around their needs and their decisions, where they have genuine choice, informed by unbiased information.

2. Continuity of carer, to ensure safe care based on a relationship of mutual trust and respect in line with the woman's decisions.

3. Safer care, with professionals working together across boundaries to ensure rapid referral, and access to the right care in the right place; leadership for a safety culture within and across organisations; and investigation, honesty and learning when things go wrong.

4. Better postnatal and perinatal mental health care, to address the historic underfunding and provision in these two vital areas, which can have a significant impact on the life chances and wellbeing of the woman, baby and family.

5. Multi-professional working, breaking down barriers between midwives, obstetricians and other professionals to deliver safe and personalised care for women and their babies.

6. Working across boundaries to provide and commission maternity services to support personalisation, safety and choice, with access to specialist care whenever needed.

7. A payment system that fairly and adequately compensates providers for delivering high quality care to all women efficiently,

[12] https://www.england.nhs.uk/wp-content/uploads/2016/02/national-maternity-review-report.pdf

while supporting commissioners to commission for personalisation, safety and choice.

Practice changes are being put in place to reflect the document and the latest Birthrate Plus review:

1. An integrated staffing model for Midwives working in specific community areas, alongside the Birth Centre teams (Cossham and Mendip) commenced in June 2017. This is a pilot (to be reviewed February 2018) with the aim being to improve the flexibility of the workforce in order to be best utilised in areas of greatest need, following the woman through her journey in a responsive way.

2. An integrated staffing model for Maternity Support Workers (MSW's) working in specific community areas integrated with the Birth Centre Teams. This also enables the MSW to be moved to areas of greatest need, following the woman through her journey in a responsive way.

Staff Development

All band 5 midwives have a named midwife Preceptor and follow a formal preceptorship package. The time scale for the programme was recently increased from 12 months to 23 months to better support the Band 5 Midwife to complete the competencies required to be signed off and progress on the accelerated pay scale pathway to fulfil the role of the Band 6 Midwife.

There is a formal development programme to support the transition from Band 6 midwife to Band 7 and from Band 7 to Band 8a. This programme is in place on CDS, in the community setting, and within the ward areas.

PRactical Obstetric Multi-Professional Training (PROMPT)

The Maternity Department train together as a multi-professional team using the internationally renowned PROMPT training package for emergency skills and drills developed at Southmead Hospital in order to reduce harm and improve clinical outcomes for Mothers and Babies. The training has supported safe emergency care despite increased acuity in the caseload. There are robust clinical governance structures and processes in place and the maternity dashboard reports on clinical outcomes, which is reviewed and monitored monthly in the Clinical Governance meeting.

Summary

Since the previous report, a new model of integrated working between the Community and Birth Centre Midwifery Teams has been developed and is to be reviewed in February 2018.

1:1 care in labour has remained stable in 2017 at 96.9%.

A new Birthrate plus acuity tool has been purchased which includes Antenatal and Postnatal care. This will become live at the end of January 2018, when there will provision for a dynamic responsive 'data capture' of Antenatal, Intrapartum (labour and birth) and Postnatal care requirements and acuity. This will enable live acuity monitoring which will provide a more accurate assessment of staffing requirements in line with Safer Staffing, but designed specifically for Maternity Services.

The rise in the acuity and complexity of women and the implementation of guidance in support of reducing the stillbirth rate (linked to IOL) in W&CS has put increased pressure on the workload and staffing levels within Maternity Services as demonstrated by the Birth Rate Intrapartum Acuity tool.

Work is ongoing in the BNSSG Maternity Transformation Programme within the Local Maternity System (LMS), bringing services together in partnership in support of delivering on the recommendations of Better Births as detailed.

Next Steps:

- Ongoing audit of 1:1 care in labour.
- Use of **Birthrate Intrapartum Acuity® System (BRIPAS)** to inform staffing requirements in relation to acuity.
- Full review of the staffing in June 2018 following the introduction of the above tool to include the Antenatal and Postnatal areas.
- Continue to offer women all four options of place of birth as recommended by NICE as clinically appropriate,
  - Home
  - Freestanding Midwifery Unit (FMU – Cossham)
  - Alongside Birth Centre (AMU – Mendip)
  - Obstetric Unit (OU – CDS)
- Consider an 'opt-out' model rather than an 'opt-in' model for women booked for Midwifery Led Care to Mendip Birth Centre (AMU) in accordance with a woman's individual informed choice and preference, ensuring the capacity and care required by 'high risk' women is available on the OU – CDS.
- Develop a robust system to ensure safe staffing levels following the increase in workload from new guidelines related to reducing the stillbirth rate (reduced fetal movements, large for dates and induction of labour RCOG).
- Update W&CS Escalation Policy to support staffing and operational activity, taking into consideration the peaks in activity that are occurring as a result of the introduction of the IOL guideline and rise in acuity of women.
- Bring a 'fresh eyes' review of the old Estate within W&CS, looking at how it is being used and how it could be developed in order to support the increasing demand and complexity of women and the services provided. To also provide a better working environment for staff and become a unit that is 'future proofed' to meet the changing needs of the services both now and in the future.
- Work closely with ASCR to start looking at models of staffing provision, support and skill mix within theatres in W&CS.

4. Recommendations

- Trust Board to note the need to review staffing across all areas within maternity services using the Birth Rate Plus Tools and recommendations and NICE guidance in February 2018 to support the increase in workload.
- The implementation programme for the recommendations of 'Better Births' 2016, to include a new model of Integrated midwifery staffing with the community and Birth Centres. This is in progress, including close working relationships across BNSSG with UHB, the CCGs and the South West Clinical Network

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Appendix 1: Safe, Sustainable and productive staffing – An improvement resource for adult inpatient wards in acute hospitals, Self Assessment

Recommendations	NBT Assessment
A systematic approach should be adopted using an evidence-informed decision support tool triangulated with professional judgement and comparison with relevant peers.	In place, use of Model Hospital Dashboard, National tools and Royal Colleges where relevant.
A strategic staffing review must be undertaken annually or sooner if changes to services are planned.	In place, undertaken 6 monthly with full review annually and at every change to service. Linked going forward to Business planning timescales
Staffing decisions should be taken in the context of the wider registered multi-professional team.	Undertaken where relevant e.g. Elgar 2 ward has registered Multi professional team members on the ward
Consideration of safer staffing requirements and workforce productivity should form an integral part of the operational planning process.	In place
Action plans to address local recruitment and retention priorities should be in place and subject to regular review.	Retention schemes to be further developed with learning shared Trust wide via steering group in January 2018
Flexible employment options and efficient deployment of staff should be maximised across the hospital to limit temporary staff.	Improvement required for deployment using Safe Care live daily. Controls in place for Agency approval. Employment options to be further explored as part of retention.
A local dashboard should be in place to assure stakeholders regarding safe and sustainable staffing. The dashboard should include quality indicators to support decision-making.	Staff staffing reported in line with National requirements, staffing decisions based on review of quality indicators. Trust wide dashboard for review required.
Organisations should ensure they have an appropriate escalation process in case staffing is not delivering the outcomes identified.	Formal staffing reviews include assessment of all metrics and process for escalation to Executive level in place
All organisations should include a process to determine additional uplift requirements based on the needs of patients and staff.	Uplift/ Headroom levels monitored closely each month, recognition that high numbers of part time staff and specialist areas may require increased study leave.
All organisations should investigate staffing related incidents, their outcomes on staff and patients and ensure action and feedback	Robust process in place to review and investigate locally all staffing incidents, reviewed monthly at Nursing and Midwifery Leadership group for themes. Staff encouraged to report unsafe staffing and any impact on patients via electronic incident reporting.