St George's Healthcare NHS
NHS Trust

Name and date of meeting: **Trust Board** **30 January 2014**
Document Title: **Nursing & Midwifery establishments and skill mix – maintaining safety.**
Action(s) for the quality and risk committee: To note the updated report and support the proposed changes/actions.
Summary: **To provide a progress report to the Board on recommendations made to the Trust Board in a detailed staffing paper in September 2013.** This paper covered a range of topics relating to staffing in nursing and midwifery. It is important to note that setting establishments, skill mix and monitoring acuity is complex and a variety of methods and tools exist in England and abroad. There is no agreement yet on any one method and although there are recommendations, professional guidance and suggested ratios not all of these are evidence based. **To outline the recommendations from the recent National Quality Board (NQB) report in December 2013.** This is a detailed report with a number of expectations (recommendations) that the trust will be expected to comply with. Key points will be 6 monthly establishment reviews and new monthly workforce reporting to the board. **To outline the proposal for undertaking a trust wide review of nursing & midwifery establishments.** The proposal is to triangulate the approach using a recognised tool, professional guidance and local knowledge. This needs to be complete and reported to the May 2013 public board meeting. The report will be presented by Vikki Carruth, Deputy Chief Nurse
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Nursing & Midwifery staffing establishments and skill mix; maintaining safety

Introduction

In September 2013 a detailed paper went to the trust board covering a range of topics relating to staffing in nursing and midwifery. The Chief and Deputy Chief Nurse undertook a review of existing processes for reporting on nursing and midwifery staffing, establishment and skill mix. The paper contained details relating to skill mix, nurse to bed ratios and details of new real time systems for recording and monitoring staffing. It is important to note that setting establishments, skill mix and monitoring acuity is complex and a variety of methods and tools exist in England and abroad. There is no agreement yet on any one method and although there are recommendations, professional guidance and suggested ratios not all of these are evidence based. The purpose of this paper is to provide an update on recommendations from that paper and also to provide an overview of a recent report from the NQB and the recommendations that the trust will be expected to adhere to.

Below are the actions/recommendations from the Sept 2013 board report with updates.

1. There should be an agreed, standardised process preferably using evidence based approaches and triangulation for the review of all nursing and midwifery establishments.
   Please see detail in this paper regarding the National Quality Board (NQB) report and recommendations.
2. Review of establishments and indications for change should be incorporated into the annual business planning process. All establishments must be signed off by the DDNG. Also all in year changes to establishments must be discussed with the matron, approved by the Head of Nursing and ratified by the DDNG.
   As above re NQB paper.
3. No significant changes should be made to nursing & midwifery establishments without the agreement of the Chief Nurse.
   In line with recommendations in the Francis Inquiry.
4. A decision should be taken regarding whether or not to purchase the next version of the electronic rostering tool.
   Yet to be agreed.
5. All clinical areas should complete the establishment tool to enable simple, more real time reporting until or unless electronic rostering can provide suitable information.
   No longer in use but will be replaced by monthly workforce reporting to board as per NQB report.
6. The trust board will receive six monthly situation reports and any significant risks/issues will be flagged via the Chief Nurse's quality report. The nursing board will also receive quarterly reports.
   Please see detail later in this paper regarding the National Quality Board (NQB) report and recommendations.

Since the September board paper, another report was published in December 2013 by the National Quality Board (NQB) supported by the Chief Nursing Officer (CNO) entitled "How to ensure the right people, with the right skills, are in the right place at the right time". This is the latest in a long line of reports recently post the Mid Staff's inquiry that refer to staffing and skill mix but it is important to note that many of these reports highlight that leadership is also a key factor in ensuring patients receive safe, high quality care. It is also important to consider other staff groups as many other professionals and support services influence patients' experience such as therapists, doctors, ward clerks, porters and many others. Gaps in one area/staff group can often adversely affect nursing who may have to undertake roles that are not essentially theirs. It is important therefore that reviews are not undertaken in isolation and do not just involve nurses/midwives.

This NQB paper also highlights that there is no one size fits all approach and it does not recommend a minimum staff to patient ratio, albeit many other recent reports do and one registered nurse to seven patients (with a supernumery nurse in charge) is the most common suggestion. There is still a lack of clarity/guidance about staffing at night and at weekends. As we move to a 24/7 model establishments will need to be reviewed in line with clinical/service changes to ensure it is appropriate at all times.

The paper outlines the expectations/recommendations with details of what is required, by whom and timelines where detailed. Please note that where the term Director of Nursing is used this should be interpreted as Chief Nurse in the case of the trust.

The NQB paper is quite explicit in some areas (less so in others) regarding what is expected in reports and processes to support safe staffing. Some time scales are outlined (e.g. “by June”) although some simply refer to summer 2014. The next stage of this process will involve a detailed action plan with dates that will need to be signed off by the executive management team in February and then by the trust board in March. The following narrative provides more detail of what is expected.

Board reporting

Papers to the Board on establishment reviews should aim to be relevant to all wards and cover the following points:

- the difference between current establishment and recommendations following the use of evidence based tool(s)
- what allowance has been made in establishments for planned and unplanned leave
- demonstration of the use evidence based tool(s)
- details of any element of supervisory allowance that is included in establishments for the lead sister / charge nurse or equivalent
- evidence of triangulation between the use of tools and professional judgement and scrutiny
- the skill mix ratio before the review, and recommendations for after the review details of any plans to finance any additional staff required
- the difference between the current staff in post and current establishment and details of how this gap is being covered and resourced;
- details of workforce metrics - for example data on vacancies (short and long-term), sickness / absence, staff turnover, use of temporary staffing solutions (split by bank / agency / extra hours and over-time) and information against key quality and outcome measures - for example, data on: safety thermometer or equivalent for non-acute settings, serious incidents, healthcare associated infections (HCAIs), complaints, patient experience / satisfaction and staff experience / satisfaction.
- the paper should make clear recommendations to the Board, which would be considered and discussed at a public Board meeting. Actions agreed by the Board should be detailed in the minutes of the meeting, and evidence of sustained improvements in the quality of care and staff experience should be considered periodically.

Regular updates to the Board

Published monthly, these updates should provide details of the actual staff available on a shift-to-shift basis versus planned staffing levels, and the impact that this has had on relevant quality and outcome measures. These reports would highlight those wards where staffing capacity and capability frequently falls short of what is required to provide quality care to patients, the reasons for the gap, the impact and actions being taken to address it and to improve care. The details of who will produce these and what they will look like are being worked through at the moment with a review of existing workforce information.

Evaluating the risks

Ensuring that adequate staffing capacity and capability is maintained can be a challenging and complicated process, and there will inevitably be times when it falls short of what is needed to provide high quality care to patients. Even where there appears to be enough staff, the skills of the workforce must be considered: a very dilute skill mix of registered nurses/midwives to care staff can compromise patient safety. In Professor Sir Bruce Keogh's review of 14 hospitals with elevated mortality rates, an overreliance on non-registered staff and temporary staff was reported as a particular problem, and there were often restrictions in place on the clinical tasks temporary staff could undertake. Boards should seek assurance that there are processes in place to highlight risks to patient care caused by insufficient staffing capacity and capability. They should seek assurance that escalation policies and contingency plans are in place for those times where staffing capacity and capability falls short of that required to provide a high quality service to patients. The trust safe staffing policy has just been reviewed in light of the NQB report and recent developments. Organisations should actively encourage all staff to report any occasions where any lack of suitably trained or experienced staff could have, or did, harm a patient. These locally reported incidents should be considered as patient safety incidents rather than solely staff safety incidents, and be routinely uploaded to the National Reporting and Learning System. The trust has a system of monitoring staffing daily albeit there are still some gaps in compliance of submitting the information daily.

Being able to take decisive action

Boards should ensure that the Executive Team is supported and enabled to take decisive action when necessary. Where potentially unsafe staffing capacity and capability is identified, escalation policies are important in outlining mitigating actions as part of contingency plans. In those situations where all potential solutions are exhausted, Directors of Nursing and the Executive Team should have the knowledge and expertise required to form a judgement on the course of action that best protects the safety of patients in their care. The closure of a ward or suspension of services as a final resort should always be carefully considered with alternative arrangements for patients identified as a priority.

Processes are in place to enable staffing establishments to be met on a shift-to-shift basis.

The Executive team should ensure that policies and systems are in place, such as e-rostering and escalation policies, to support those with responsibility for staffing decisions on a shift-to-shift basis. The Director of Nursing and their team routinely monitor shift-to-shift staffing levels, including the use of temporary staffing solutions, seeking to manage immediate implications and identify trends. Where staffing shortages are identified, staff should refer to escalation policies which provide clarity about the actions needed to mitigate any problems identified. Professor Sir Bruce Keogh highlighted this as a particular problem in his recent review into hospitals with elevated mortality rates; whilst staffing establishments in organisations appeared adequate in many instances, there were occasions when establishments were not met on wards on a shift-to-shift basis, compromising patient care.

Daily reviews of the actual staff available on a shift-to-shift basis versus planned staffing levels

This should occur between Sisters, Matrons and Heads of Nursing (and equivalent posts). Where shortages are identified, they work together to seek a solution, such as the pooling of staff from other clinical areas, or the deployment of bank or agency staff. The trust will also be required to display details of staffing outside every ward updated every shift and plans are underway to roll this out. The trust has also been piloting the use of an acuity/dependency tool in a number of areas since December. The information is yet to be analysed but it is hoped this will support the establishment reviews with a decision to be made about roll out trust wide.

Electronic rostering policies

These can be an effective way of making the most of existing resources. NHS Employers has produced guidance that provides all the information an organisation will need to successfully implement an e-rostering system, which will allow them to embrace efficient and safe staffing by releasing more time for

staff to deliver higher quality services, as well as helping to reduce expenditure on temporary staffing. E-rostering brings together management information on shift patterns, annual leave, sickness absence, staff skill mix and movement of staff between wards. This enables managers to quickly build rotas to meet patient demand. Employees are able to access the system to check their rotas and make personal requests, which should be balanced with service requirements. The guidance explains why e-rostering is beneficial, and explains how organisations can secure agreement to and implement an e-rostering programme. The trusts e-rostering policy is currently being reviewed in light of the NQB report.

Using escalation policies and contingency plans

This can provide a source of clarity at times of increased pressure (for example, when there are unusually high workloads, a particularly high level of patient dependency, exceptionally high staff sickness levels, or unfilled vacancies), and when staffing capacity and capability cannot be met on a shift to shift basis. Staff should be aware of the escalation policies in place, flag where they think staffing capacity and capability falls short of what is required (further detail is provided under expectation 4), and be able and prepared to use the escalation policies in place. Escalation policies should outline actions to be taken, the people who should be involved in decisions, in short, medium and long term staffing shortages, and outline the contingency steps where capacity problems cannot be resolved. Escalation policies are helpful in flagging capacity problems at an early stage, allowing organisations to adopt a proactive rather than a reactive response to problems identified.

Summary

The NQB report has a number of expectations/recommendations and the trust is expected to comply with these accordingly to the timescales described, broadly by Summer 2014.

The proposed monthly reporting to trust board details what will be reported including metrics/indicators to be reviewed alongside the workforce data. Work is underway to determine who will undertake this reporting with attempts to use as much existing information as possible. It is envisaged that existing metrics (nursing scorecard) can be used.

Although there is already a considerable amount of work on-going in relation to this, to ensure compliance with the NQB expectations, this will be a considerable piece of work going forward in terms of reporting and the 6 monthly establishment reviews will also be a significant challenge given the size of the organisation.

A small group comprising of senior leads from nursing, workforce and finance have started to meet and will be suggesting a methodology for the reviews. In essence this will consist of the use of an approved/recognised tool (the suggested tool is called the Hurst model) and triangulating that with professional guidance (such as Royal Colleges) and local judgement/discussion. Information has already been sent out to divisional senior teams with more information about the tool and proposed approach. The tool is based on thousands of hours of observations in hundreds of clinical settings over many years. In essence the tool calculates required numbers and skill mix of staff for a number of different speciality areas. It also takes into account a number of non-patient facing demands with estimates of impact in terms of time needed including indirect care such as documentation, communication, cleaning and many others.

The suggestion is that this review process starts imminently in the clinical areas via meetings/workshops with ward/team leaders, Matrons, Service Managers and relevant HR and finance reps working together to review the current establishment.

Next steps will then involve more senior staff in the division (Heads of Nursing and General Managers or equivalent) reviewing this with submission with a final report from the Divisional Directors of Nursing and Governance and the Divisional Directors of Operations being submitted to the Chief Nurse for final oversight. Details of these reports and any suggested changes should then be reported to the executive management team and ultimately to the trust board. The NQB report outlines timelines for the first

establishment review and implementation of monthly reporting and therefore the first submission to the board should be in May 2014 as this will be the last public board before the June deadline.

It is recognised that business planning and budget setting has already been undertaken in the divisions but these reviews must be undertaken and any proposed changes considered and discussed as necessary.

Another key point for discussion and decision making relates to the pilot of 50% supervisory time for ward leaders and how this will move forward as it is mentioned in a number of reports. This has not yet been rolled out and is in place in only 8 areas. It is proposed that this is discussed again at EMT in February with a decision about how to proceed.

Progress against the expectations/recommendations will be monitored via the Workforce Efficiency Group chaired by the Director of HR who will report to the executive management team meetings and also discussed at a number of other groups and committees including divisional meetings. It will also be reported to the board every month as part of the new monthly reporting.

Vikki Carruth
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Jan 2014