St George's Healthcare **NHS**
NHS Trust

REPORT TO THE TRUST BOARD

Paper Title:	Establishment review – Nursing and Midwifery Staffing (inpatient areas)
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Purpose:	To present to the board a review of ward establishments, as directed by the National Quality Board.
Action required by the board:	To receive the report, understand the methodology undertaken to inform the review and agree next steps.
Document previously considered by:	This document was circulated to the Executive Management team and discussed in detail at the Operational Management Team. The Senior Sisters/Charge Nurses, Matrons and Heads of Nursing have been fully involved in the development of this paper. The outputs and recommendations have been agreed with and supported by the Divisional Directors of Nursing.

Executive summary

1. The Francis report on Mid Staffordshire (2013) resulted in the publication of a number of documents focussing on the importance of safe staffing levels in nursing and midwifery.

- 'How to ensure the right people, with the right skills, are in the place at the right time. A guide to nursing, midwifery and care staffing capacity and capability' (National Quality Board 2013).
- 'Hard truths. The journey to putting patients first' (DH, 2013)
- 'Safe staffing for Nursing in adult inpatient wards in acute hospitals' (NICE consultation document 2014)

2. The NQB has stipulated that Boards must receive a report every 6 months on staffing capacity and capability which draws on expert professional opinion and demonstrates insight into local clinical need and context. The report must be presented to the public trust board where recommendations are considered and discussed.

3. This report covers 49 inpatient wards at St George's Hospital and Queen Mary's Hospital.

4. Determining staffing requirements is complex and determining the number is only one part of the process. Skill mix is also vital as evidence suggests that where there are lower levels of registered nurses there are higher rates of errors in care and poorer outcomes. High quality care also depends on a range of other factors including leadership, culture, team working, environment, training and development.

5. This report results from a significant piece of work which incorporated many hours of discussion with

Sisters, Charge nurses, Matrons, Heads of Nursing and Divisional Directors of Nursing. The methodology included a) ward level engagement, b) triangulation, c) comparison, d) a comment on standardisation.

6. The establishments were broken down in a number of different ways – whole time equivalents, skill mix, patients per registered nurse or midwife, nurse to bed ratio.

7. What is important to understand is that each ward establishment has been reviewed on an individual basis and recommendations agreed in terms of what is right for that clinical area, it's speciality, the case mix, acuity and dependency of the patients and their nursing needs.

<u>**Findings**</u> (summary)

1. Taking October, 2013 – February 2014 as sample months (excluding December) Trust wide, the nursing and midwifery budget was significantly overspent, with a lack of clarity on reasons why in all areas.

Monthly average overspend against budget (all areas)	293 WTE (9%)
monthly average overspend in 49 ward areas	176.37 WTE
WTE of bank and agency were used (allocated)	634 WTE
WTE of bank and agency were used in 49 areas	398 WTE
Gap between WTE requirement and existing budget	137.59 WTE
Known/historical gap previously agreed (cost pressure)	49.98 WTE
Cost of Gap (mid point, on costs outer London weighting)	£3,061,266

NB not included – special requirement of 1:1 nursing and parenting leave.

2. It can be seen in many of the areas that this paper supports the divisions decisions already made where it has been agreed to increase ward staffing numbers but the budget has not been adjusted to reflect the increase.

Some areas where a shortfall is identified are also known and are on the risk register, whilst in other areas work is underway to recognise changes to patient case mix, acuity and dependency and recalculate staffing requirements.

3. In terms of current use of bank and agency to supplement existing establishments, no ward area was found to be fundamentally unsafe and putting patients at risk. As previously reported the trust has a safe staffing and escalation policy in place with daily alerts if clinical areas are concerned about staffing levels and patient safety.

<u>**Next Steps**</u>

1. Agreeing and setting realistic ward establishments, recruiting to vacancies and effectively rostering the ward teams will lead to efficient, cost effective and safe, high quality care.

2. It is however recognised that the difference between the current ward budget WTE and the suggested requirement is significant (although this represents only a 2% increase on the total nursing and midwifery workforce spend) a considered approach must be taken and the following should be considered in terms

of priority.

- Outcomes/indicator scores for patient safety (NB the need to develop and implement an automated, ward level nursing scorecard is now critical).
- Non-compliance with national standards and guidelines.
- Risk register entries related to ward staffing
- Historical/known/agreed cost pressures related to ward staffing.

3. The paper contains a number of recommendations which, if agreed and implemented, will further strengthen the processes by which we can ensure we are making the best use of our nursing and midwifery workforce, obtaining value for money and, most importantly, providing safe patient care.

Key risks identified:

That the findings and recommendations in this paper are not implemented.

Related Corporate Objective: *Reference to corporate objective that this paper refers to.*	Strategic aim 1 – provide outstanding quality of care
Related CQC Standard: *Reference to CQC standard that this paper refers to.*	Underpin the delivery of all CQC standards.

Equality Impact Assessment (EIA): Has an EIA been carried out? (Yes)

If yes, please provide a summary of the key findings

If no, please explain you reasons for not undertaking and EIA.

Appendix A:

1. EQUALITY IMPACT ASSESSMENT FORM – INITIAL SCREENING

Headline outcomes for the Equality Delivery System (EDS)

- Better health outcomes for all
- Improved patient access and experience
- Empowered, engaged and well-supported staff
- Inclusive leadership at all levels

Service/Function/Policy	Directorate / Department	Assessor(s)	New or Existing Service or Policy?	Date of Assessment

Who is responsible for this service / function / policy?

Chief Nurse

Describe the purpose of the service / function / policy?

To improve patient safety, patient experience and patient outcomes

Are there any associated objectives?

There are a variety of associated objectives relating to this subject

1.4 What factors contribute or detract from achieving intended outcomes?

Not implementing the findings and recommendations of this report.

1.5 Does the service / policy / function / have a positive or negative impact in terms of the protected groups under the Equality Act 2010. These are Age, Disability (physical and mental), Gender-reassignment, Marriage and Civil partnership, Pregnancy and maternity, Sex /Gender, Race (inc nationality and ethnicity), Sexual orientation, Religion or belief and Human Rights

The function is aimed at improving the care for all of our patients in bed based services.

1.6 If yes, please describe current or planned activities to address the impact.

1.7 Is there any scope for new measures which would promote equality?

1.8 What are your monitoring arrangements for this policy/ service

1.9 Equality Impact Rating [low,]

2.0. Please give you reasons for this rating

Nursing and Midwifery Establishment Review - Introduction and Rationale

The external driver for this review was the expectation set by the National Quality Board (NQB) in December 2013 (as a consequence of the Mid Staffordshire Public Inquiry) that all hospital trusts should review their nursing and midwifery establishments twice annually and report the findings to a public trust board. The report has a number of other recommendations and outlines the importance of ensuring that staffing is appropriate and refers to multiple studies that link low staffing levels to poorer patient outcomes and increased mortality rates. Professor Sir Bruce Keogh's (2013) review of 14 hospitals with elevated mortality rates also found a positive correlation between inpatient to staff ratios and higher hospital standardised mortality ratios.

There had been some previous establishment reviews undertaken in the Trust but these were not systematic and were localised to some specific care groups. Often, they were focused on finance, rather than nursing input. In addition, over recent years there has been a significant number of changes in how services are delivered, with some areas moving location and changing bed numbers and activity. Establishments were not always updated accordingly.

Determining staffing requirements is complex and determining the number is only one part of the process. The skillmix of the staff is vital and the Mid Staffordshire report refers to evidence that suggests that where there are lower levels of registered nurses there are higher rates of errors in care. High quality care also depends on a range of other factors including leadership, culture, team working, environment and training and development.

As well as the baseline establishment, each area requires an 'uplift' to cover absence such as Annual Leave and training as well as some provision for Sick Leave. If this is not realistic it is very difficult to have robust budgetary control and to be able to hold relevant staff to account for managing their resources effectively.

In addition to the meeting the external requirement to evaluate our establishment, the trust review was an opportunity to address some internal areas for attention. These included:

- Trust wide, the nursing and midwifery budget was significantly overspent, with a lack of clarity on reasons why in all areas. A review of payroll and bank and agency spend from October 2013 to February 2014 (excluding December) showed a monthly average of:
    - A 293 WTE overspend against a budget of 3,440 WTE (equivalent to 9%).
    - 634 WTE of bank and agency staff were used (equivalent to 17% of all WTE paid). Bank and agency staff are more expensive than substantive employees.

    'WTE' is the abbreviation for Whole Time Equivalent and describes staff hours in relation to the standard NHS working week. 1 WTE is 37.5 hours per week, or 150 hours in a four-week roster, and is the contracted hours for a staff member that works full time. The WTE of part-time staff is pro-rated accordingly, e.g. a staff member contracted for 30 hours per week would be shown as 0.8 WTE. WTE is the unit of measurement throughout this review, as our focus is on the quantity of nursing and midwifery care provided. WTE can be translated into a financial value by multiplying it with salary or bank/agency costs.

- The value of the 'uplift' in ward budgets to cover staff absence was not entirely clear, and understanding of the uplift concept was variable amongst some Ward Sisters/Charge Nurses. Anecdotally, 22% had been factored into budgets to provide cover for Sick Leave, planned Annual Leave and a small amount of training. However, this could not be confirmed and it was reported that a minority of areas had no uplift in their budget to cover absence. Subsequent changes to ward budgets and Cost Improvement Plans (CIPs) have further complicated the picture. In addition, the value of the uplift was not shown separately in budget statements and was not always apparent to those who write the rosters and manage absence cover. This led to

some wards recruiting to the extent of their total budget, leaving no flexibility to afford unplanned absence. Conversely, wards that aimed to keep some budget in reserve to cover absent staff were often challenged on having 'vacancies' they could afford to release.

- In taking a snapshot of ward budgets and rosters in October 2013, there was a general disparity between the funded WTE resource provided in the budget, and the WTE required to populate the roster. Roster data for January-March 2014 indicates that a significant number of wards had levels of Annual Leave, Study Leave and Sick Leave that were higher than their budgets could affordably cover (see Appendix I). Generally, bank and agency staff appeared to be filling these gaps (where possible), at a cost to the ward in addition to its substantive pay bill.

- Understanding and visibility of pay costs by those who write and approve the rosters (and hence control spend) was variable. A number of Ward Sisters/Charge Nurses and even some Matrons advised that they were unclear about their budgets (some had not had sight of them), had not been involved in the establishment setting, and the finance information and concepts discussed in review meetings were new to some of them.

- Use of tools, benchmarking, or internal/external comparison in measuring St George's staffing against other trusts was variable, and staff did not have easy access to the data and contacts to attempt this.

- On discussion, there were varying levels of visibility around skillmix, patients per registered nurse on shift, and nurse to bed ratios, and assurance regarding staffing levels was not always as robust as it could be.

Under the governance of the Deputy Chief Nurse, supported by an external consultant with experience in implementing nurse rostering and establishment planning, a review of 49 inpatient ward establishments commenced in late February 2014 and concluded in mid-May.

As stipulated by the NQB, this process is to be repeated every six months. As the focus of this review is inpatient areas, we propose that the next review revisits the inpatient areas but focuses more on non-ward nursing. By alternating the main focus between ward and non-ward nursing, all nursing teams will receive a thorough annual review.

Methodology

This was an iterative process over a number of months and a significant number of changes were made over time during the review, both increases and decreases to WTE requirements. There was considerable rigour and scrutiny of establishments looking at each area in detail, their activity, acuity and any changes. Meetings were held with a large number of staff from Band 7 Ward Sisters and Charge Nurses to Divisional Directors of Nursing & Governance. The approach was based on four core principles; ward-level engagement, triangulation, comparison and standardisation.

1) Ward-level Engagement

Ward Sisters/Charge Nurses and Matrons were included from the outset, so they could contribute a realistic assessment of current staffing needs and be central to estimating the WTE requirement and specific uplift for their areas. This was to develop a common understanding at ward level of establishments, the use of staffing metrics to inform safe and affordable care, and the imperative to manage staff leave (and bank & agency cover) within agreed thresholds that were specific to their area.

As part of this, each ward completed a data return, entering their shift requirements, typical Study Leave requirements, and the actual Annual Leave entitlements of their staff. A drop-in session, workforce briefings for Band 7s, and support via email assisted this process. The data return was used to estimate the WTE requirement of the ward, which consisted of:

- Shifts providing direct (hands on) patient care.
- Specialist roles, e.g. Discharge Coordinators, Practice Educators, Housekeepers.
- Nurse-in-Charge (NIC) time.
- Supervisory/management time for Ward Sister/Charge Nurses (when not working as the NIC) – typically 50% of their working time (options for offsetting this cost are presented in Recommendation 6).
- Non-clinical duties of Band 6s, e.g. Safety Thermometer returns, Infection Control audits, writing the roster, appraisals etc. Typically this was 2-4 shifts in a 4-week roster.
- Any other shifts or roles specific to the ward.
- Note that ad hoc 'special' shifts for 1:1 care were not included, as these are not part of a routine, substantive establishment.

Shifts were identified as whether they needed uplift, to ensure they could be covered when the individual(s) that may deliver them were on leave. Generally, daily direct care, hands-on shifts attracted uplift, and non-clinical or certain specialist roles (e.g. Practice Educators) did not. An extract from a data return is below (Benjamin Weir, Cardiac Surgery):

Shift type	Shift Start	Shift End	Duration (hours)	Unpaid Break	Hours Paid	Mon		Tues		Wed	
						Reg	Unreg	Reg	Unreg	Reg	Unreg
Long Day	07:00	19:30	12.5	1	11.5	6	2	6	2	6	2
Night	19:00	07:30	12.5	1	11.5	4		4		4	
NIC Early Mon-Fri	07:00	15:00	8	0.5	7.5	1		1		1	
NIC Late Mon-Fri	14:30	19:30	5	0	5	1		1		1	
NIC LD Weekend	07:00	19:30	12.5	1	11.5	0		0		0	

Key: *Reg: Registered Nurse or Midwife; Unreg: Unregistered support staff, e.g. Healthcare Assistant.*

As mentioned, the concept and practice of uplift was variably understood. To build an uplift with the Ward Sisters/Charge Nurse, they were asked for 1) the breakdown of actual Annual Leave entitlements across their in-post staff (27, 29 or 33 days annually, according to length of service), and; 2) an estimate of the Study Leave requirements for their specialty in the course of a year. Together with eight days of bank holiday entitlement, plus the Trust's sickness absence threshold target of 3.5%, the expected hours that a full-time member of staff would need to be covered for in a year was estimated and converted to a percentage. An example of this is below (Mary Seacole Ward, Senior Health):

Leave / absence category	Days	Registered hours	Unreg hours
Average Annual Leave entitlement per staff	29.6	222	222
Public Holidays 2014/15	8	60	60
Study Leave: Registered staff	13	98	
Study Leave: Unreg staff	4		30
Target sickness	3.5%	68	68
Total contracted hours unavailable for duty		**448**	**380**

The % of contracted hours that the staff member is unavailable:	22.9%	19.5%
Blended rate based on the Reg/Unreg split of WTE that requires uplift	**21.3%**	

Please note that Parenting Leave (maternity, paternity and adoption) is not included in the uplift and has not been to date but is a cost that needs to be considered. Uplift is designed to meet the typical absence expected for every member of staff over a 12 month period, so is in effect

'business as usual' cover. Parenting, Carers and disciplinary leave (and any other types of paid, special leave) are additional costs to this and are not as predictable albeit they are not uncommon in a workforce of our size. An estimate of how much WTE Parenting Leave is taken/paid for at Trust level, based on data from the electronic system 'Healthroster', was estimated and is supplied in Appendix II.

The data return was entered into an analysis model that had been checked as fit for purpose for the review. The model uses the information from the data return to generate a suggested WTE requirement and uplift.

Meetings were then held with each ward (typically the Ward Sisters/Charge Nurse, Matron and Head of Nursing) to validate the data return and review the suggested outputs. Challenge and senior professional judgement was provided by the Deputy Chief Nurse (or Head of Nursing for Workforce) throughout, regarding numbers on shift, specialist roles and Study Leave requirements. This ensured a consistent approach across the Trust.

2) Triangulation

In addition to the data return, the review used inputs from four other sources, both internal and external to the Trust. These were gathered before the meeting and were used to triangulate the WTE requirement suggested by the data return, and judge whether the estimated WTE was in the 'correct' range. Between one and three of these inputs were used for each ward, as all four were not entirely relevant or available for every specialty given the size of the Trust and scale of the review. The triangulation options were:

i) Ward Sisters/Charge Nurses completed the 2013 **Hurst Model**; a research-based tool developed by Dr Keith Hurst that suggests the amount of WTE a specialty will need, based on the number of beds and his historical workload observations at various UK trusts.

ii) **Acuity and Dependency** data from the Trust's RaTE system was obtained for March 2014. On participating wards, RaTE records the acuity and dependency of each patient according to the category assigned by the nurse completing the daily record. The Shelford Group, a collective of Chief Nurses leading on the national quality agenda, have updated the tool recently and suggest WTE multipliers for each acuity category. These were applied to the daily ward records to calculate how much WTE the ward would need to meet the reported acuity.

   The Trust's **Safe Nursing Staff Escalation Policy 2014** contains agreed minimum staffing levels for day, night and weekend shifts on each ward. These shift numbers were converted into a WTE figure. The review identified a need for this policy to be revisited in some cases as some areas had changed their templates even since January.

iii) Where available, **national guidelines** for the number of nurses per patient, such as those offered by the Royal College of Nursing for critical care or paediatrics, informed the results and provided a check on whether sufficient WTE was in place.

The WTE suggested by the data return and by the above inputs was presented using the following recognised metrics, to facilitate a discussion on appropriate levels of care. Because uplift varies from ward to ward, and because uplift is a budget provision to ensure care levels can be maintained, all metrics in this review exclude uplift to avoid double counting of the uplift as care time. Where triangulation inputs included a built-in uplift, this was removed.

The charts that follow are real examples from review meetings, picked from a cross section of wards, to illustrate the process. Each DDNG holds the confirmed shift template and review outputs for their wards.

a) WTE

The first chart for discussion was a simple comparison of the WTE (with no uplift applied), to the WTE suggested by other methods. The Direct Care (hands-on) Requirement is the figure calculated from the ward's data return. The dashed green line reads across to aid comparison between this figure and the triangulation options.
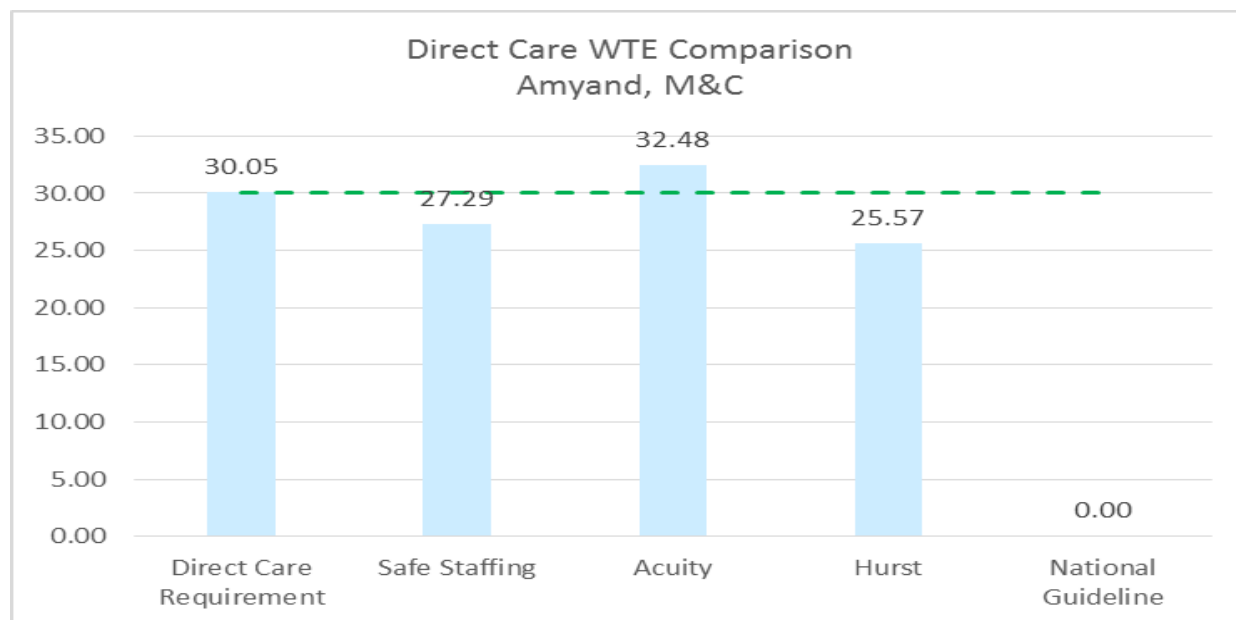

b) Skillmix

The skillmix is the percentage of staff providing direct care that are Registered Nurses or Midwives. For example, a skillmix of 60% indicates that 60% of the WTE requirement is for Registered Nurses and the remaining 40% of nursing time is provided by Healthcare Assistants (HCAs). Broadly, this may look like three Registered Nurses (60%), supported by two HCAs (40%) on a typical shift. If three Registered Nurses were supported by three HCAs, the skillmix would change to 50%. Skillmix is therefore not an indicator of nursing quantity, but rather the ratio of registered to unregistered staff.

In general, the RCN recommends a minimum skill mix of 65% for generic wards albeit this varies across the Trust and across the country. For example intensive care areas typically have 100% and rehabilitation settings may have nearer to 50% due to the types of patients and the care they need. It should be noted that as a tertiary centre, often with quite complex patients, it is reasonable and appropriate for the skillmix to be higher in many areas. In addition, the income associated with the care of such patients should reflect this, so affording the correct staffing should not be a significant issue. That said, the review did highlight some areas (notably in cardiac) where skillmix is higher than expected for a non-critical care environment and it is recommended that this is revisited in the subsequent review in six months' time. As these areas are not attracting a level 2 or 3 tariff (similar to critical care) the cost of staffing these areas is unlikely to be covered. There may be a case for reviewing the levels of care these patients receive and ensuring that activity is coded accordingly (see Recommendation 14). The chart below demonstrates the skillmix in an area compared to the Trust's Safe Staffing policy and what would be recommended by the Hurst tool.

Skillmix of bedside nursing - Belgrave, M&C
(Excludes uplift. Includes Unreg.)
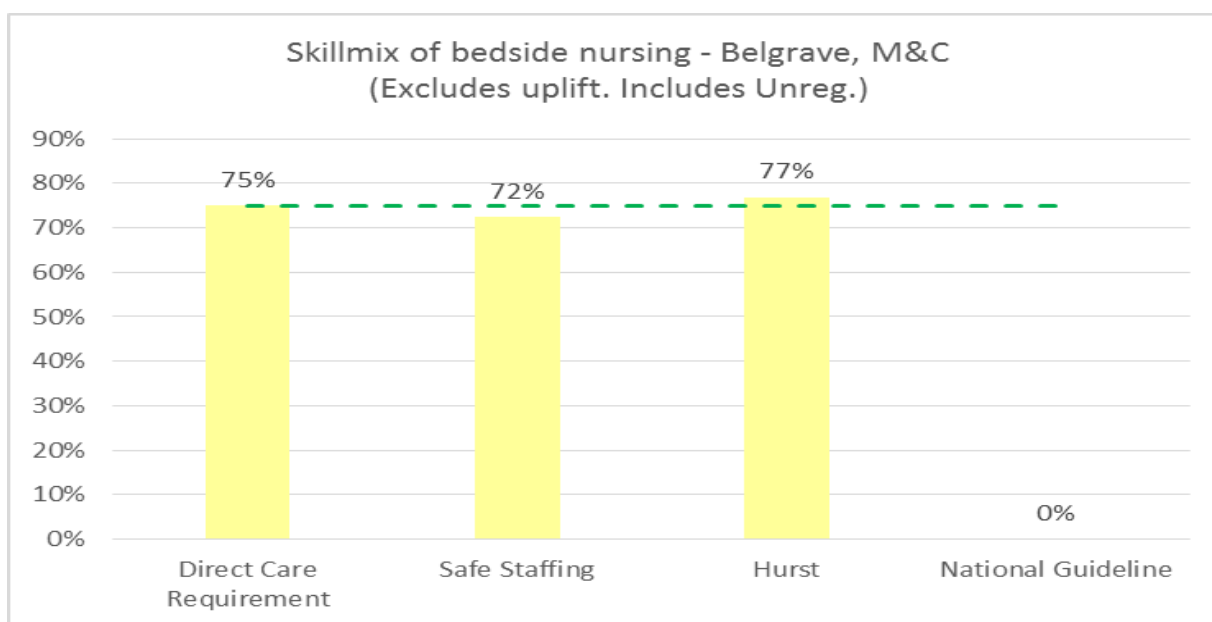
c) **Patients per Registered Nurse or Midwife**

This is the number of beds on the ward, divided by the number of Registered staff on each type of shift. Healthcare Assistants are not included in this metric and are additional to the Registered staff. This is possibly the most commonly used ratio. The ratio varies greatly across the Trust and there is still no nationally mandated ratio, and less clarity and guidance for ratios at night. In recent years, the RCN recommended ratios for older people and paediatrics, and at the time our review concluded, made the suggestion that the number of patients per registered nurse should not exceed 8. After the review concluded the draft NICE guidance for consultation was published. An overview of this, our response and a comparison of St George's wards to the 1:8 suggestion is in Appendix III.

Patients per Registered Nurse on Shift
SC&N - Neuro
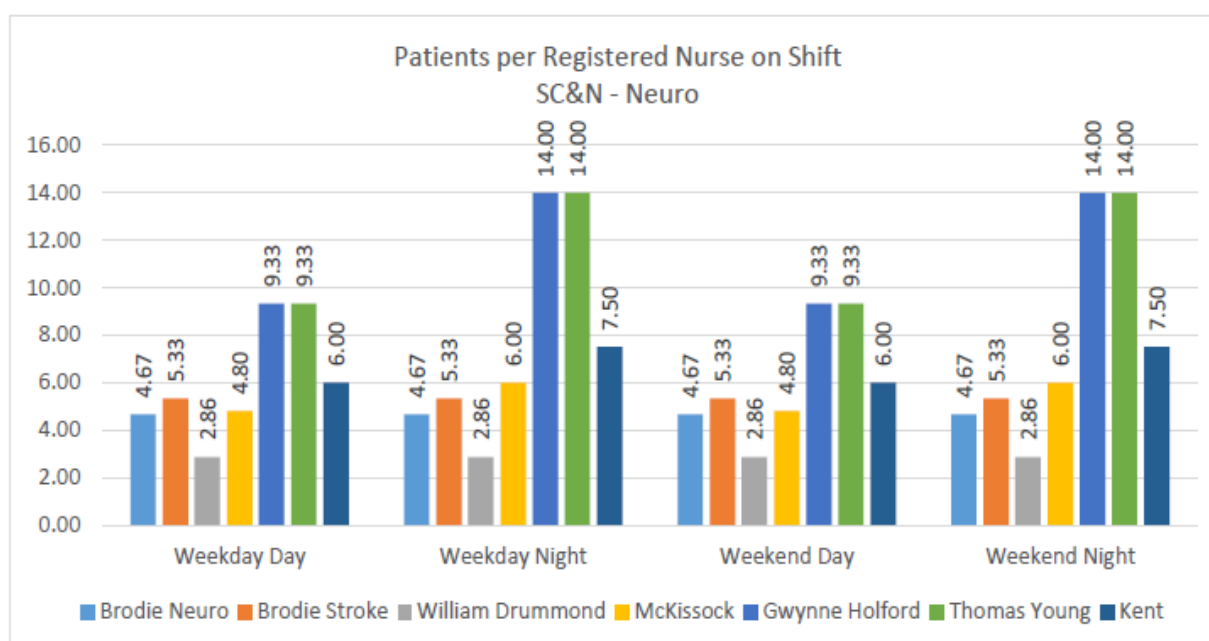
When viewing Patients per Nurse and other metrics, it should be noted that although national minimum thresholds can be useful, they are not specific to different types of hospital. As a teaching

hospital, tertiary services provider and major trauma centre covering a large catchment area and receiving complex patients, St George's often requires a richer staffing profile than hospitals of different portfolios and size. Related to this is that activity at St George's can attract higher value tariffs to support the care required.

d) Nurse WTE to Bed Ratio

This is the WTE of all nursing and midwifery staff delivering direct care, divided by the number of beds on the ward. It is a less common comparator in the NHS but is being used more in reports and benchmarks. Typically, a general ward would be expected to have a Nurse WTE to Bed ratio in the region of 1:1.0 This is based on WTE over 24 hours and does not indicate the number of nurses or midwives on a particular shift. Again, no uplift is included in the calculation. Our review confirmed that the WTE requirement of some cardiac areas had a combination of some of the highest skillmixes in combination with some of the lowest nurse to bed ratios in the 49 areas reviewed. This illustrates the importance of professional judgement and a robust process that can validate the accurate needs of each ward.
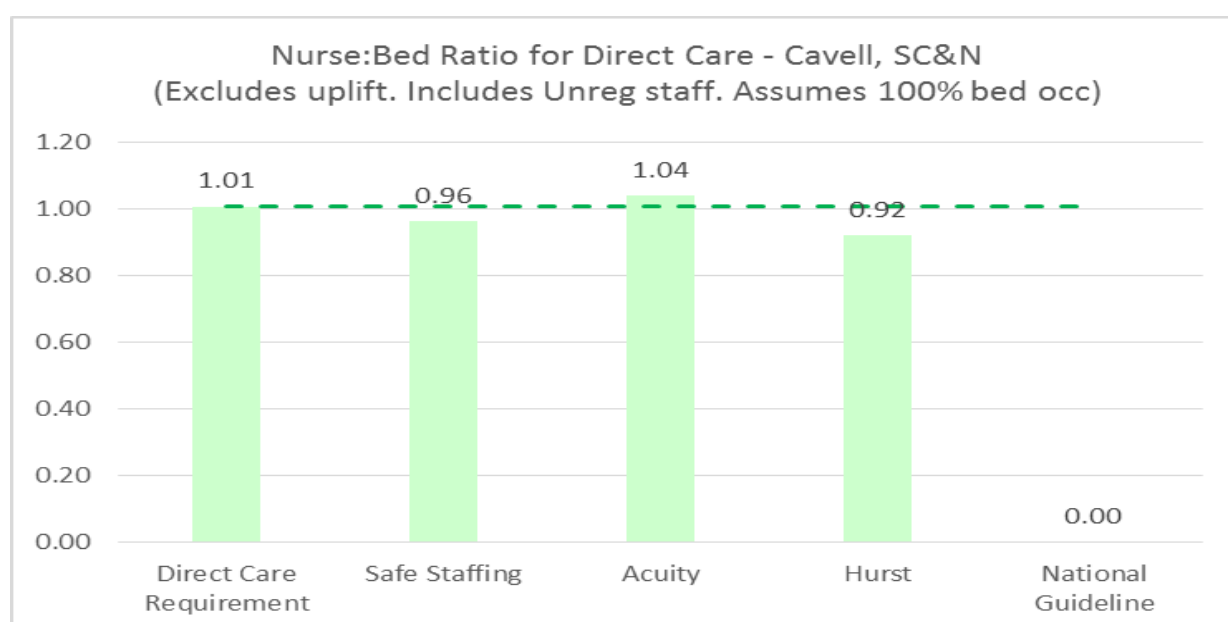
Because each of these inputs have limitations and it is not possible to assure the data quality of these sources, they were used for discussion in the meetings only, and are not presented as part of the outputs of this review.

3) Comparison

The final stage of the meeting was to compare the calculated requirement and uplift against the existing WTE budget for the ward. The existing WTE budget was shown as having 22% uplift.

Any differences were discussed, challenged and reviewed in the context of the average over/underspend as between October 2013 – February 2014 (excluding December). Budgeted WTE and Actual WTE paid per ward was provided by Finance.

An example of a comparison between one ward's WTE requirement against their existing WTE budget is below:
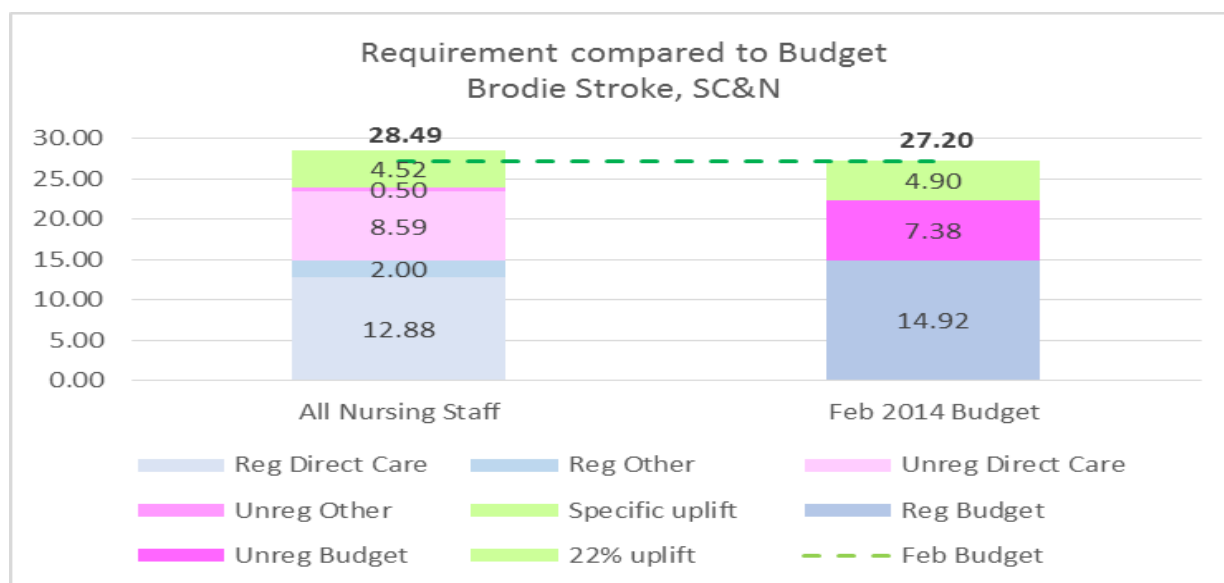
In this example, the difference between budgeted WTE and suggested requirement WTE is a gap of -1.29 WTE. Some gaps were historical and were not because of any suggested changes as part of the review. The reasons for historical gaps vary but some may be due to changes in bed numbers and an increase in staffing which were agreed in principle but not substantively funded accordingly.

The outputs for each ward were presented in summary packs for Heads of Nursing to review the individual ward outputs and compare wards across their group to check if the relative ranking of the wards for each metric was in the order they would expect. For example, the comparison of skillmix for the wards in a Directorate group is shown below. Skillmix does vary but this may for a number of reasons, for example the type of ward, the number of beds (small numbers can result in large changes), the acuity of patients or there may be a commissioning requirement or guideline e.g. as in Intensive Care.
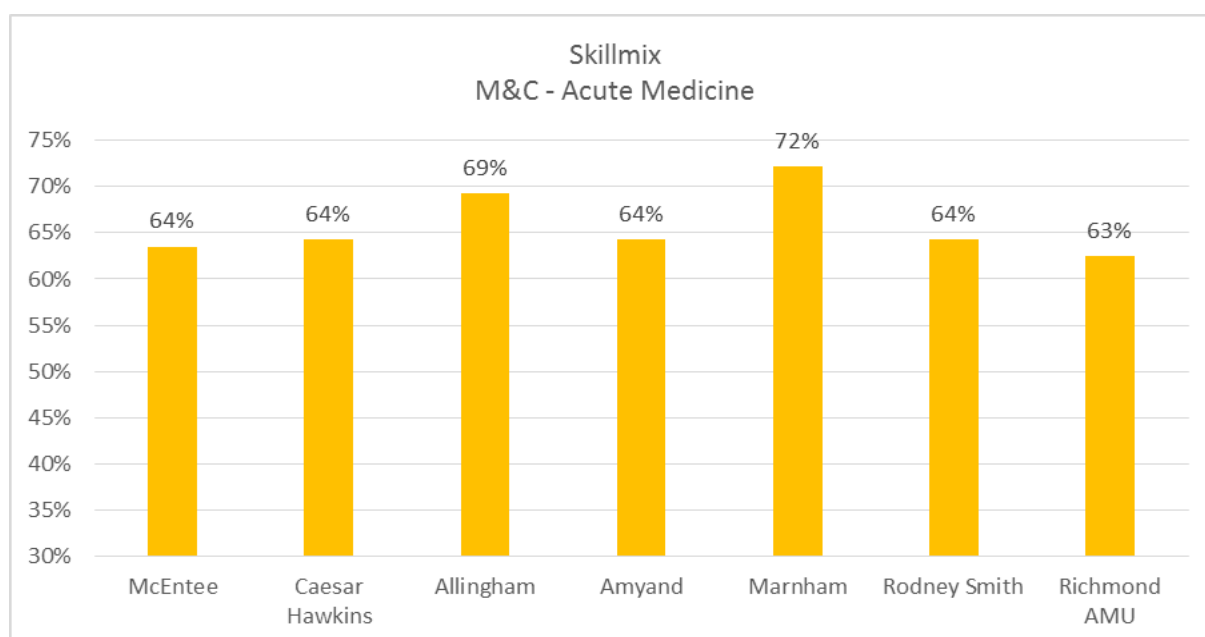
A comparison of differences between budgeted WTE and estimated requirement WTE was also provided as shown in the chart below. The bars above the line are surplus and those below show a gap. In each case, the average monthly WTE over/under-spend (the 'Actual') is shown next to the WTE difference. This helps to place the size and the nature of the difference (i.e. surplus or gap) in the context of actual spending.
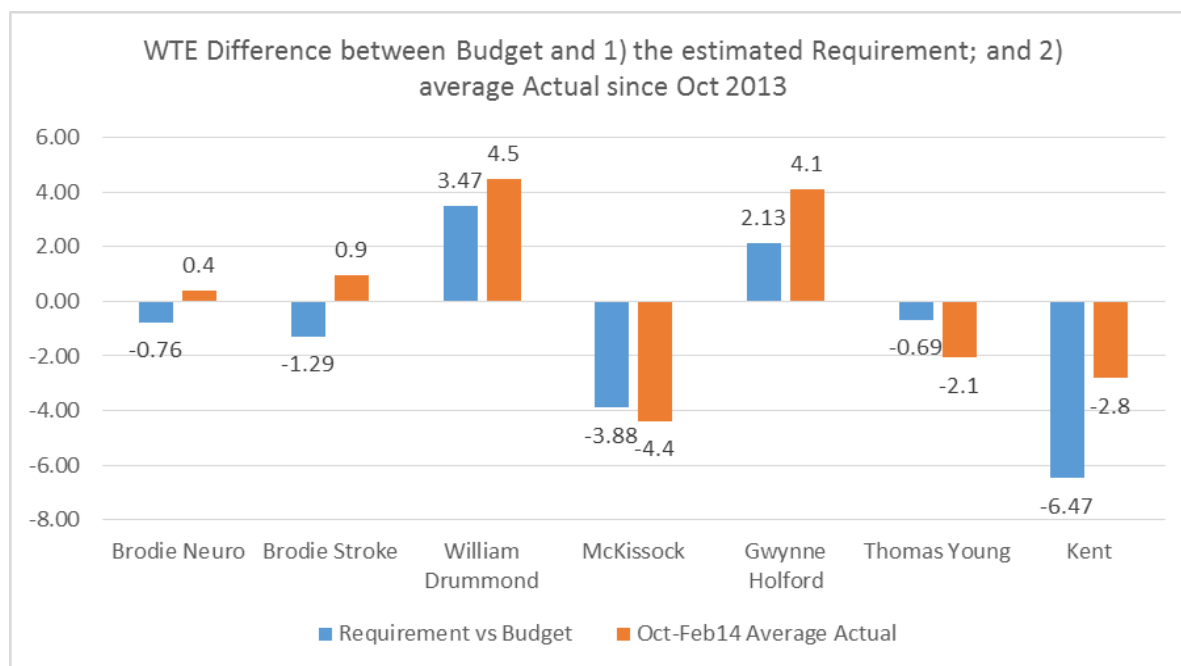
Following any amendments, the packs were reconfirmed (some several times) and provided to the Head of Nursing and DDNG ahead of a meeting with the Deputy Chief Nurse to scrutinise the outputs for the group. This also provided an opportunity for consistency on areas that had been more difficult to articulate, e.g. allocation of time for Band 6 non-clinical duties, amount of Study Leave provision, etc. The chart below shows the range of Study Leave across Neurology:
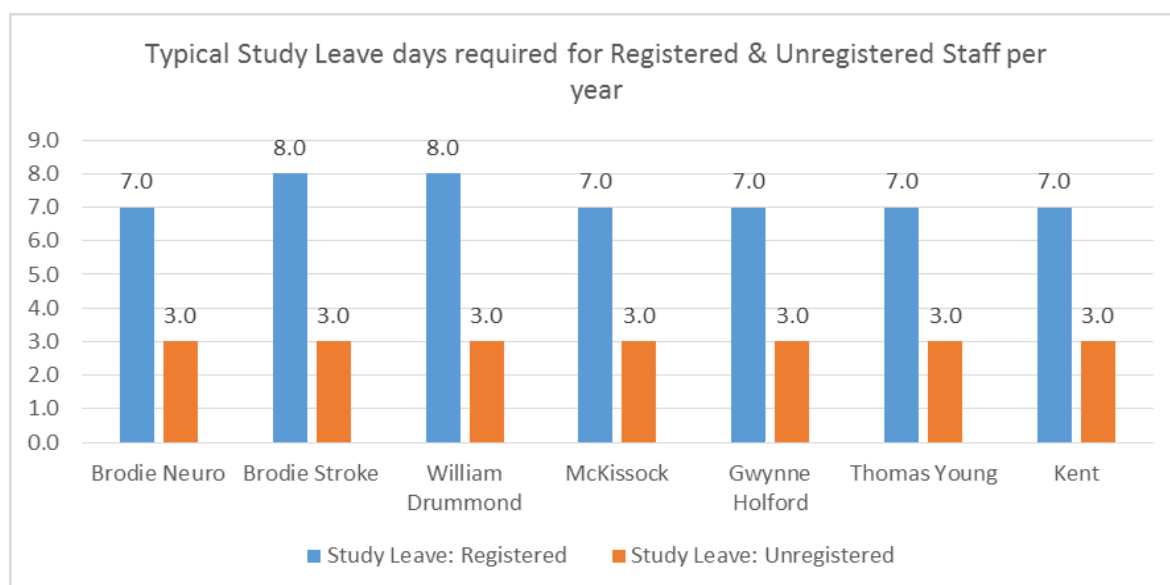
Study leave requirements do vary (therefore so does uplift) and may be a condition of a commissioning requirement (e.g. Stroke) or be part of a national recommendation from the RCN. Many areas did provide considerable details to calculate actual requirements and not simply give a

professional estimate. It should be noted that induction time for new staff is not considered in this and should be part of overall recruitment "costs". This is covered under Recommendation 17.

4) Standardisation

During the review we identified that the shift durations and timings on some wards offered a two-fold opportunity for standardisation and saving:

i)   Avoidance of unsocial hours

Time worked after 20:00, Monday to Friday attracts an unsocial hourly rate enhancement of 44% for Band 2 staff, 37% for Band 3 staff and 30% for Band 4 and above.

Sixteen wards have shifts that finish at 20:15 or 20:30. If it is possible to retime there shifts to start earlier and finish at or before 20:00, the total annual saving will be £74, 321.

ii)   Standardisation to 11.5 hours

Six wards operate a 12-hour day shift (13 hours duration with a one hour unpaid break) and an 11 hour night shift (12 hours duration with a one hour unpaid break). Standardising the shift time to 11.5 hours for day and night shifts saves WTE, because the overall number of staff working the day shift (which reduces by 30 minutes) is greater than the number of staff working the night shift (which increases by 30 minutes). Across the wards identified, this presents a total saving of 1.25 WTE, or £43,720 based on gross salary and on-costs.

In total, these two opportunities represent a spend saving of £118,041.

There are a further two wards where a standardisation opportunity exists to bring them in line with the rest of the Trust, although there would be no direct financial benefit.

Outputs

A summary of the outputs of this review for each Directorate follows. The DDNGs hold detailed, agreed packs that provide a breakdown of these summary results. The number of patients per registered nurse/midwife for each of the wards is in Appendix II.

Explanation of terms:

- **The average monthly over/underspend:** This is the average overspend (shown as a negative number in red type) or average underspend (shown in black type) across the four months of October and November 2013, and January and February 2014. These were the most recent months of confirmed pay data at the start of this review. December 2013 was omitted, as the effect of Christmas holidays can skew the average. The information was provided by the Chief Management Accountant and is the difference between the WTE Budget for the ward and the Actual WTE spent by the ward. The Actual WTE spent is the WTE of substantive staff (including time away on any type of paid leave) and any bank and agency WTE that the ward used. Note that not all vacant shifts sent for bank and agency fulfilment are able to be covered; if a ward had a low 'fill-rate' during that period, the actual spend may have been higher. The figure relates to ward staff on nursing pay lines only; doctors and ward clerks etc are not included. We present this as context and refer to this in point (e) below.

- **Historical/known cost pressures:** some gaps between budgeted WTE and required WTE are already known, in full or in part, if the ward has been running at a recognised cost pressure. Where this is the case, this is noted here.

- **Ward staffing entries on Trust risk register:** where a staffing-related risk is currently held on the Trust's risk register, this is noted here.

- **Difference between budgeted WTE and requirement WTE (Gap):** this is the key finding of the review. As outlined in the Approach, the Ward Sister/Charge Nurse, Matron, Head of Nursing, DDNG and Deputy Chief Nurse have collectively agreed what they professionally recommend as the WTE requirement for their ward. This was compared to the WTE budget for the ward, and this column is the difference between the two. Where the requirement WTE exceeded the budgeted WTE, the difference is shown as a gap, as a negative number in red type. Where the requirement WTE was less than the budget WTE, this indicates a surplus and is shown in black type. It is helpful to compare this figure to the average monthly over/underspend column; for example, has the ward historically overspent, and is this to a similar value of the gap identified?

- **Estimated Cost:** We have applied sample pay costs to the gap or surplus. We obtained mid-point salary values from Finance that include on-costs, unsocial hours allowance and the Outer London Pay Weighting. Registered Nurse WTE was costed at Band 5 (£36,000), Registered Midwife WTE at Band 6 (£45,000) and Healthcare Assistants at Band 2 (£27,000). A breakdown of the Registered/Unregistered split is held by the DDNGs.

Intended use of the Outputs, and note on Uplifts:

The outputs are intended to articulate the required staffing for the ward and any gaps / surplus related to meeting this. Where gaps were already identified as cost pressures or risks, this work may help to articulate why overspends have occurred and offer a more cost effective way of substantively meeting the workload (rather than supplementing with expensive, transient bank and agency). Some Divisions show a significant gap between requirements and budget, and an associated significant cost to meet this. Realistic expectations of budgetary control, value for money and appropriate care can be enabled by realistic, professionally-led budgets that provide appropriate nurse to patient ratios with the required skill mix and necessary uplift.

It is worth reiterating that the ward requirements were formed using an uplift that was built from scratch for each ward, and selectively applied to only those shifts that were confirmed as needing cover at all times. For example, uplift was typically applied to direct care WTE, almost never applied to supervisory WTE, and variably applied to supporting roles according to local cross-cover arrangements. The majority of the bespoke uplifts were less than the Trust's approximate figure of 22%; the average uplift is 21.7%. The uplifts for each ward are in Appendix I, with a detailed breakdown held by DDNGs.

Overall Summary:

Directorate	Average Monthly Over/Under-spend WTE	Difference between Budgeted WTE and Requirement WTE (Gap)	Estimated Cost £	Historical/known cost pressures and agreed funds	Ward staffing entries on Trust Risk Register
M&C – Acute Medicine	-41.42 WTE	-37.67 WTE	-£ 935,869	- 12.46 WTE	Yes: Directorate-wide risk MC4 – staffing levels across the Division. There is also a recognised need for a business case for staffing to meet the increase in non-invasive ventilation patients on Marnham ward.
M&C – Renal, Haem, Onc, Cardiovascular	-29.27 WTE	-37.62 WTE	-£1,249,091	-17.43 WTE	Yes: Directorate-wide risk MC4 –

					staffing levels across the Division; MC25 – Haematology Day Unit staffing levels (6); MC39 - Trevor Howell staffing (9); MC26 – Buckland ward staffing levels (9) (also noted by CQC); MC21 – Caroline ward staffing levels (12) (also noted by CQC).
Senior Health	-43.30 WTE	-30.41 WTE	-£218,285*	- 19.23 WTE	Yes: CSW1018 – incorrect establishment/ skillmix on rehab ward (6)
SC&N – Surgical	-20.17 WTE	+ 5.78 WTE	+£286,740	n/a temp winter monies rec'd	No
S&CN – Neurosciences	+ 0.66 WTE	-7.49 WTE	-£122,805	-0.86 WTE	No
Women's	-2.16 WTE	-2.92 WTE	-£69,498	n/a	No
Children's	-21.81 WTE	-24.94 WTE	-£825,220	n/a – extra requirements due to compliance with RCN guidance	Yes: Directorate-wide risk CW056 – Paediatric nursing staffing levels (12)

Critical Care	-15.6 WTE	+ 7.66 WTE**	+£314,127**	n/a	No
Neonatal	-3.3 WTE	-9.98 WTE	-£359,406	n/a	Yes: CW049 – NNU staffing levels (12)
Sub Total	**-176.37 WTE**	**-137.59 WTE**	**-£3,179,307**	**-49.98 WTE**	
Shift Standardisation Cost Saving			**+£118,041**		
Total			**-£3,061,266**		

* Includes the agreed recurring funds of £730,000

** This is likely to change in May 2014 subject to realignment so will not be a surplus

Observations and Recommendations

This report presents the following recommendations for the Board's consideration and endorsement. This report is the first of an on-going, twice annual cycle. The opportunity and discussion to improve and adjust nursing establishments is therefore continuous, rather than a one-off occurrence.

The recommendations are two-fold; there are recommendations for Nursing & Midwifery (DDNGs) to improve governance, create efficiencies and release spend savings, and there are recommendations at a management/operational level (DDOs) for supporting the case for adequate WTE funding to meet safe, good quality levels of care. The Deputy Chief Nurse will assign ownership and due dates upon approval of these recommendations by the Board.

i)   Recommendations for Nursing and Midwifery:

It is recognised that the difference between current ward budget WTE and suggested requirement WTE is significant and challenging in the context of major cost improvement programmes. Therefore the following is proposed before extra WTE provision is considered.

1. In recognition of financial pressures across the Trust, wards for which a gap between budget WTE and requirement WTE is indicated should be prioritised in order of attention. Prioritisation can be informed by a combination of:
   - Outcomes/indicator scores for patient safety, such as pressure ulcers, falls, serious incidents, complaints and other items directly or indirectly related to ward staffing.
   - Non-compliance with national standards for patients per nurse e.g. CCU.
   - Risk register entries related to ward staffing.
   - Historical/known/agreed cost pressures related to ward staffing.

   For each ward, the direct care element of the WTE gap should be prioritised over the WTE gap for any supporting roles (e.g. Practice Educator, Housekeeper etc). Where possible, supporting roles may be rationalised and combined where proximity of neighbouring wards allows.

2. Now that an accurate uplift has been calculated with the involvement of the Ward Sister/Charge Nurse and Matron, who respectively are accountable for writing and approving the electronic roster, each ward will be expected to demonstrate they can manage absence for Annual Leave, training and Sick Leave within the uplift, evidenced by Healthroster reports, over a continuous 12-week reference period. Appendix I shows historical performance for the 12 weeks preceding this report. The reference period can include historical performance if the ward has demonstrated compliance during this time. An average across the 12 weeks can be taken, to allow for small fluctuations from roster to roster. The roster should not be approved unless planned Annual Leave and Study Leave are within tolerance. Regarding unused contracted hours, no roster should be approved if a member of staff holds enough unused hours to deliver a standard shift and this must not be carried over to the next month. When the roster has been worked and is finalised for payroll, adherence to the planned levels of Annual and Study Leave must be re-checked, and Sick Leave (which is largely unplanned) should be compared to the 3.5% threshold. This is to mitigate the risk of building in more WTE that is then not managed within affordable limits.

3. Other types of leave not covered by the uplift (e.g. Carers, Special, Parenting, Suspensions) are to be monitored at Divisional level. The effect of leave not covered by the uplift must be reviewed for each roster period and monitored quarterly, with actions

to mitigate and reduce the impact. We recommend the Head of Nursing Workforce leads this process.

4. Roster templates and parameters should be reviewed and reset to support affordable and safe absence management. This can be done on the current version of Healthroster (version 9.5). The forthcoming version 10 can accommodate specific uplifts per ward and these should be set according to the uplifts calculated in this review.

5. Within the 12-week reference period to demonstrate uplift adherence, ward for which a requirement gap was identified are required to benchmark their estimated WTE requirement with comparable ward(s) in other Trust(s). The metrics provided to DDNGs from this review will enable comparison. The Head of Nursing for Workforce can assist with finding comparator trusts, or alternatively the RCN or national bodies relevant to the specialty could be approached for suggestions on peer trusts. Wards for which national mandatory ratios exist (e.g. critical care level 2 and 3 patients) are exempt from this requirement, in agreement with the Chief Nurse. The Deputy Chief Nurse and DDNGs will review the benchmarking findings.

6. For wards that operate an Early Nurse in Charge shift (7.5 hours of paid time within a duration of 8 hours), where this shift is followed by a Late Nurse in Charge shift, the Late shift could be a shorter shift of 5 hours of paid time. This would prevent a 3.5 hour overlap between the Early and Late Nurse in Charge shifts. In doing so, each week, this will save 12.5 hours of time, which can be used offset the majority of the 18.75 hours protected for Ward Sister/Charge Nurse supervisory time. It is critical that this and similar efficiencies are implemented wherever possible as this is also supported by the NTDA and would be expected going forward. Alternatively, where a Nurse in Charge is required for the whole day, this could be worked as a Long Day shift of 11.5 hours of paid time, which requires less WTE.

7. To realise the £118,041 benefit from shift standardisation and avoidance of unsocial pay enhancements on day shifts, relevant ward staff will be consulted on proposed shift standardisation measures. The consultation could start in June 2014, with the objective of implementing this in the first roster that is written after the consultation concludes. This saving will be used to offset agreed costs from implementing additional WTE as recommended by this review.

8. Rosters should be written for 8 weeks at a time (currently 4) and must be approved and published at least 4 weeks before the roster start date. This will require the roster writing process to begin no later than twelve weeks before the start date. This will provide greater notice of working schedules, allow more time for vacant shifts to be filled by the bank, and give more time for remedial action if roster metrics indicate risks.

9. The Safe Staffing & Workforce Group (SsAW) will review its terms of reference and update policies to support improved establishment management. These include the Safe Staffing and Escalation Policy, E-rostering Policy, and the Study Leave Policy. Policies for update will be identified by end of July 2014 and updates completed by end of September 2014. All relevant staff will be briefed on adherence to the updated policies.

10. The use of 'specials' for one-to-one care is to be reviewed, including reasons, patient outcomes and value for money. The objective will be to reduce costs, introduce clear protocols, and reduce harm and length of stay of specialled patients.

11. To enable on-going checks of establishment levels relative to Acuity and Dependency, the Shelford Safer Nursing Care Tool multipliers (without uplift – or with the uplift specifically calculated for each ward) should be built into the Trust's RaTE system, so that recording patient-level acuity and dependency data generates a suggested establishment WTE figure to deal with the workload. This can be used as a thermometer to check staffing levels, and give greater clarity regarding over/underspends, cost pressures or risks.

12. Proficiency in planning and managing establishment budgets varies across nursing and midwifery. All Ward Sisters/Charge Nurses, Matrons and Heads of Nursing must receive budget statements from June 2014 onwards. A programme of mandatory master classes in how to interpret and manage the budget, and refresher training in safe and efficient rostering will be held. The roles of each member of each level of staff in the process will be formalised. There are some good examples of strong establishment planning and control across the Trust (e.g. Surgery, Neurosciences, Critical Care, Women); good practice from these areas will be shared and staff will be offered 'buddies' from these areas for advice and support.

ii)   Corporate Recommendations:

The Board is asked to review the information indicated in this review and consider the following recommendations;

13. Ward budgets should be presented in a format that is easy to understand and nursing staff should be accountable and responsible for the nursing budgets in their areas. They should work in collaboration with other colleagues but be given the authority to suggest and make changes and take responsibility for this. It is essential that Ward Sister/Charge Nurses, Matrons, Heads of Nursing and DDNGs should be consulted on the redesign of budgetary information/reports. The budget statements should show how much of the budget is uplift, so the difference between baseline budget WTE and uplift WTE is clear, so the nursing team can decide whether to recruit into their uplift and to what extent. It is not recommended that areas recruit into all of their uplift as it significantly reduces flexibility. It should however not be seen as a vacancy or way to reduce cost. Ward budgets should be reorganised so that:

14. Ward budgets are on a totally separate budget to day units, where applicable (e.g. James Hope, Trevor Howell, Ruth Myles). This will allow greater visibility, easier rostering and better control. The current situation of aggregated budgets is confusing and is difficult to relate to roster templates. There is consistency on the inclusion of non-direct care posts, e.g. Matrons, Medical Support Assistants etc.

15. Concern was expressed that in some areas (including respiratory and some cardiac areas) patient acuity and complexity has increased (and therefore nursing workload and specialling requirements have increased) but that this may not be reflected in clinical coding to achieve the correct income and thereby make the required nursing input affordable. Anecdotally, there is no mechanism to match extra income for more complex patients with the cost of extra nursing input; this is borne as either an overspend, or the patients per nurse ratio drops for other patients on the ward. A review of coding and income for a sample of patients of relatively higher acuity, dependency and co-

morbidities is recommended for areas where this is suspected (e.g. Marnham, Acute Medicine). Trialling a programme where extra nursing or specialling costs are matched to the extra income generated by a more complex patient may also be of value.

16. Parenting leave (maternity, paternity and adoption) is not accommodated in the uplift, as it is not a routine category of leave that applies to every staff member in a year. It does however present an additional operational challenge: Parenting Leave that is covered can present an extra cost (often met through expensive bank and agency cover); Parenting Leave that is not covered can affect staff to patient ratios. It is estimated that approximately 3.5% of the nursing and midwifery workforce is on Parenting Leave at any time. This is indicated by monthly data from the Trust's Healthroster system and an estimate of the impact of this in WTE is presented in Appendix II. Note that provision for covering Parenting Leave is not included in the ward requirements presented in this review.

   It is recommended that across the 2014/15 financial year, the impact of Parenting Leave is quantified by Divisions. It is further recommended that this impact and sustainable, affordable options to mitigate it are presented to the Board in 12 months. During the review, we observed measures in Critical Care nursing to meet this challenge in a cost-effective way, by providing contingency WTE in the budget for specific use against maternity leave. Further work is required to profile the workforce in terms of age and gender to more accurately determine likely requirements. Due to size and timescales it was not possible to complete this as part of the initial review but is recommend for the subsequent one in 6 months' time.

17. Future projects and trustwide training programmes (e.g. such as clinical documentation training), which require nursing and midwifery time away from patient care, must identify the impact this will have in hours and WTE. There should not be an assumption that wards have the capacity to absorb extra tasks. Costs of nursing/midwifery time should be factored into the net benefits estimate of the project. Ward-level nursing and midwifery time must be quantified and agreed with the Chief Nurse before implementation. If the (cumulative) requirement is significant, the Chief Nurse may recommend that provision is made for this time to be backfilled. Not doing so may cause overspends or affect nurse to patient ratios.

18. Ward data returns and subsequent discussions highlighted that some wards have a high requirement for supernumerary and induction time for new staff. This typically applies to specialist areas (e.g. Neonatal) where there is a defined time period of supervised supernumerary working as part of the accreditation to work in that speciality. Due to difficulties in recruiting Band 6s to St George's (anecdotally, this is a London-wide problem), many wards are focusing on recruiting newly qualified Band 5s, and growing existing Band 5s into Band 6 positions. A consequence of this is increased supernumerary and induction time. This is another cost that is not budgeted for and can affect budgetary control.

   In calculating the uplift, we did not include supernumerary time in the Study Leave element, as uplift should cover 'business as usual' absence, and avoid building in temporary peaks in training demand. However, the costs of supernumerary and induction time are necessary and real, and need to be met in the most cost effective way possible. We recommend that the wards requiring higher amounts of supernumerary time are identified, that the cost of this time is quantified, and these costs are at least

acknowledged as part of recruitment drives. Where recruitment is motivated by increased bed numbers, the costs of the associated supernumerary and induction time must be included in the business case.

Finally the reviewers would like to note that there have been a number of other benefits to the organisation as part of undertaking this review. A considerable amount of learning and development has taken place from Band 7 nurses upwards in relation to establishment setting, skillmix review, calculating uplift requirements, managing within realistic budgets, and others. There has also been considerable discussion and sharing of ideas and good practice.

This process will hopefully ensure that going forward staff are better equipped and prepared to undertake subsequent reviews and with support will be able to manage resources efficiently and effectively.

Appendix I

Comparison of uplift per ward against absence recorded in the roster

The agreed uplift per ward, which was calculated using the specific Annual Leave allowances of in-post staff (plus 8 days in lieu for public holidays), the Study Leave requirements for the specialty, and the Trust's Sick Leave threshold of 3.5%, was compared to the absence recorded in the electronic roster for the same categories of leave. Instances where actual absence exceeded the uplift limit by more than 2% are highlighted.

Ward	Agreed Uplift %	Jan - Feb 2014 Roster		Feb - March 2014 Roster		March - April 2014 Roster		Average	
		Annual Leave, Study and Sickness Absence %	Difference between Uplift % and Actual Absence %	Annual Leave, Study and Sickness Absence %	Difference between Uplift % and Actual Absence %	Annual Leave, Study and Sickness Absence %	Difference between Uplift % and Actual Absence %	Annual Leave, Study and Sickness Absence %	Difference between Uplift % and Actual Absence %
Allingham Ward HJG	20.4%	19.1%	1.3%	31.4%	-11.0%	28.5%	-8.1%	26.3%	-5.9%
Amyand Ward HJE	21.0%	18.7%	2.3%	23.4%	-2.4%	20.7%	0.3%	20.9%	0.1%
Belgrave Ward AMW HKM	21.2%	12.8%	8.4%	21.3%	-0.1%	27.8%	-6.6%	20.6%	0.6%
Benjamin Weir Ward AMW HKL	21.8%	19.0%	2.8%	16.9%	4.9%	24.5%	-2.7%	20.1%	1.7%
Brodie Stroke Rehab HAJ	19.7%	24.4%	-4.7%	23.7%	-4.0%	26.6%	-6.9%	24.9%	-5.2%
Brodie Ward HAA	19.9%	22.0%	-2.1%	29.5%	-9.6%	23.3%	-3.4%	24.9%	-5.0%
Buckland Ward HLO	21.6%	25.9%	-4.3%	28.1%	-6.5%	26.6%	-5.0%	26.9%	-5.3%
Cardiothoracic Intensive Care Unit (CTICU) HKJ	25.6%	22.4%	3.2%	25.1%	0.5%	27.6%	-2.0%	25.0%	0.6%
Carmen Suite JMA	25.4%	28.9%	-3.5%	37.6%	-12.2%	34.1%	-8.7%	33.5%	-8.1%
Caroline Ward HKH	22.1%	18.4%	3.7%	18.4%	3.7%	24.3%	-2.2%	20.4%	1.7%
Cavell Surg Ward HJM	20.9%	26.5%	-5.6%	23.9%	-3.0%	20.5%	0.4%	23.6%	-2.7%
Cheselden Ward HJF	22.6%	22.6%	0.0%	26.3%	-3.7%	22.6%	0.0%	23.8%	-1.2%
Coronary Care Unit JKA	22.2%	15.0%	7.2%	15.3%	6.9%	12.1%	10.1%	14.1%	8.1%
Dalby Ward (Senior Health) HKC	20.3%	20.6%	-0.3%	22.3%	-2.0%	20.7%	-0.4%	21.2%	-0.9%
Delivery Suite JLB	25.3%	28.6%	-3.3%	28.0%	-2.7%	25.6%	-0.3%	27.4%	-2.1%
Florence Nightingale Ward HLE	20.2%	17.5%	2.7%	17.6%	2.6%	24.4%	-4.2%	19.8%	0.4%
Fred Hewitt Ward HLH	21.3%	29.2%	-7.9%	36.0%	-14.7%	26.9%	-5.6%	30.7%	-9.4%
General Intensive Care Unit (Gen ICU HDU) JJB	25.6%	21.4%	4.2%	25.5%	0.1%	28.7%	-3.1%	25.2%	0.4%

Gray Short Stay Ward HJJ	20.0%	17.0%	3.0%	21.7%	-1.7%	22.6%	-2.6%	20.4%	-0.4%
Gunning Ward HJH	20.1%	16.5%	3.6%	24.6%	-4.5%	21.7%	-1.6%	20.9%	-0.8%
Gwillim Ward HLI	25.2%	25.5%	-0.3%	26.3%	-1.1%	26.3%	-1.1%	26.0%	-0.8%
Gwynne Holford Ward QHL	19.7%	19.6%	0.1%	25.8%	-6.1%	28.6%	-8.9%	24.7%	-5.0%
Heberden HKA	20.5%	15.9%	4.6%	18.9%	1.6%	24.9%	-4.4%	19.9%	0.6%
Holdsworth Ward HJI	20.1%	20.2%	-0.1%	26.0%	-5.9%	15.9%	4.2%	20.7%	-0.6%
James Hope Ward HKK	21.6%	13.4%	8.2%	15.1%	6.5%	25.3%	-3.7%	17.9%	3.7%
Jungle Ward HLJ	22.8%	22.2%	0.6%	20.8%	2.0%	15.3%	7.5%	19.4%	3.4%
Keate Ward HLC	20.3%	18.8%	1.5%	26.3%	-6.0%	26.2%	-5.9%	23.8%	-3.5%
Kent Ward HAC	19.8%	24.6%	-4.8%	29.4%	-9.6%	20.1%	-0.3%	24.7%	-4.9%
Marnham Ward HJK	21.2%	19.9%	1.3%	22.6%	-1.4%	24.7%	-3.5%	22.4%	-1.2%
Mary Seacole Ward QHG	21.3%	20.6%	0.7%	29.5%	-8.2%	26.7%	-5.4%	25.6%	-4.3%
McEntee Ward HJL	20.8%	16.2%	4.6%	19.7%	1.1%	20.2%	0.6%	18.7%	2.1%
Mckissock Ward HAD	20.1%	22.0%	-1.9%	20.4%	-0.3%	27.1%	-7.0%	23.2%	-3.1%
Neo Natal Unit (NNU) JLF	24.5%	20.4%	4.1%	25.6%	-1.1%	24.3%	0.2%	23.4%	1.1%
Neuro Intensive Care Unit (Neuro ICU) JAD	25.6%	18.7%	6.9%	23.6%	2.0%	31.9%	-6.3%	24.7%	0.9%
Nicholls Ward HLK	21.5%	29.1%	-7.6%	35.8%	-14.3%	41.2%	-19.7%	35.4%	-13.9%
Paediatric Intensive Care Unit (PICU) JLH	25.4%	25.2%	0.2%	28.4%	-3.0%	28.7%	-3.3%	27.4%	-2.0%
Pinckney Ward HLM	23.7%	25.0%	-1.3%	31.6%	-7.9%	28.6%	-4.9%	28.4%	-4.7%
Richmond Ward HJR	20.4%	21.9%	-1.5%	21.9%	-1.5%	19.1%	1.3%	21.0%	-0.6%
Rodney Smith Med Ward HJB	20.9%	19.7%	1.2%	20.0%	0.9%	20.7%	0.2%	20.1%	0.8%
Ruth Myles Ward HJN	21.9%	36.5%	-14.6%	33.2%	-11.3%	28.0%	-6.1%	32.6%	-10.7%
Trevor Howell Ward HJA	21.7%	12.2%	9.5%	21.8%	-0.1%	20.4%	1.3%	18.1%	3.6%
Vernon Ward HJO	20.9%	19.6%	1.3%	18.6%	2.3%	26.8%	-5.9%	21.7%	-0.8%
William Drummond HASU HAS	20.4%	23.6%	-3.2%	23.9%	-3.5%	22.3%	-1.9%	23.3%	-2.9%
Wolfson Centre JAE	19.2%	20.1%	-0.9%	28.0%	-8.8%	27.8%	-8.6%	25.3%	-6.1%
Caesar Hawkins (Winter Ward)	19.9%	18.2%	1.7%	20.1%	-0.2%	35.1%	-15.2%	24.5%	-4.6%
Averages	**21.7%**	**21.2%**	**0.5%**	**24.7%**	**-3.0%**	**25.0%**	**-3.3%**	**23.6%**	**-1.9%**

Appendix II

Effect of Parenting Leave on Ward Staffing

Further to Recommendation 15, the estimated effect of Parenting Leave on each Directorate is below. Based on Healthroster data, approximately 3.5% of the workforce on Parenting Leave (maternity, paternity and adoption) at any time.

Directorate	WTE Requirement excluding uplift	Estimated WTE of staff on Parenting Leave, based on 3.5%
M&C – Acute Medicine	297.16	10.40
M&C – Renal, Haem, Onc, Cardiac	238.74	8.36
Senior Health	124.07	4.34
SC&N – Neurosciences	212.89	7.45
SC&N – Surgical	209.45	7.33
Women	152.65	5.34
Children	150.94	5.28
Critical Care	257.23	9.00
Neonatal	124.75	4.37
Total	**1,767.88**	**61.97**

Appendix III

A note on Nurse to Patient ratios, draft NICE guidance and the RCN's perspective

On 12th May 2014, NICE issued draft guidance for consultation on how to design, implement and monitor safe nurse staffing in adult wards. This was released on the day our establishment review reported its findings.

The draft NICE guidance does not specify a minimum ratio for patients per registered nurse, but the Royal College of Nursing, in response to the draft guidance, advises that:

'…*a registered nurse caring for more than eight patients is a cause for concern and that in many cases considerably more nurses will be needed. The College has additionally emphasised the importance of providing an adequate staffing skill mix in order to allow for supervision from ward sisters and other senior staff.'*

Registered nurse to patient ratios, for every day and night throughout the week, were the foundation of our approach and a main theme in discussions on the appropriate level of care to meet the demand of each ward.

The nurse to patient ratio on the shifts of St George's wards varies, with the majority within the RCN's 1:8 suggestion, and a minority outside of this. We reached these ratios through a standardised process of ward-level data collection, modelling, triangulation with other tools (e.g. Hurst) and national standards (e.g. critical care), internal comparisons within Divisions, and professional judgement from Ward Sisters/Charge Nurses, Matrons, Heads of Nursing, DDNGs and the Deputy Chief Nurse.

In retrospectively reviewing the draft NICE guidance, we are confident that our review meets its key principles. For example:

- We used a locally-agreed approach, with informed professional judgement to make a final assessment.
- Limiting factors presented by ward layout and size were considered.
- Ward-level supervision has been included.
- An 'uplift' for planned and unplanned absence has been designed on a ward-by-ward basis, and the impact of Parenting Leave is also considered.

The summary of the Trust's current and proposed nurse to patient ratios is below. Our current ratios are based on the Safe Nursing Staff Escalation policy (Jan 2014) – Appendix B of this is also pasted below. Links to the RCN and NICE sources are provided.Note that:

- The ratios include only those registered nurses that 'take' patients and provide direct care.
- Where a shift has a Nurse in Charge (which may be the Band 7 Ward Sister/Charge Nurse, or deputy) this is excluded. Aside from known exceptions, we have assumed that the staffing levels in the Safe Nursing policy include one Nurse in Charge on weekday day shifts.
- Registered nurses in specialist roles are not counted towards the ratio, e.g. Discharge Coordinators, Practice Educators, Clinical Nurse Specialists, Matrons, etc.
- Unregistered ward staff such as Healthcare Assistants and Housekeepers are not included.
- Registered mental health nurses drafted in for ad hoc one-to-one supervision of a patient ('specialling') are also not counted.

Patients per Registered Nurse/Midwife ratios

CURRENT agreed ratio:

This is based on the Safe Nursing Staff Escalation Policy, Jan 2014.

It is assumed that, aside from known exceptions, one RN in the number for Weekday Days is the Nurse in Charge, does not take patients and therefore does not contribute towards the patients pr RN ratio.

The 'current' numbers are approximate and for guidance only. They may not reflect actual staffing levels.

PROPOSED ratio:

This is the ratio presented by the establishment review, based on professionally agreed staffing requirements.

Key:

	The ratio exceeds the RCN's 1:8 maximum patients per RN suggestion
	Proposed ratio is lighter than Safe Nursing Staff Escalation Policy (i.e more patients per RN) - this applies to shifts on 13 wards
	Proposed ratio is richer than Safe Nursing Staff Escalation Policy (ie less patients per RN) - this applies to shifts on 23 wards

Ward	No. of beds	CURRENT Number of patients per RN				PROPOSED Number of patients per RN				DIFFERENCE			
		Weekday Days	Weekday Nights	Weekend Days	Weekend Nights	Weekday Days	Weekday Nights	Weekend Days	Weekend Nights	Weekday Days	Weekday Nights	Weekend Days	Weekend Nights
McKissock	24	4.8	6.0	4.8	6.0	4.8	6.0	4.8	6.0	0.0	0.0	0.0	0.0
Wolfson	28	9.3	14.0	9.3	14.0	9.3	14.0	9.3	14.0	0.0	0.0	0.0	0.0
Cavell	28	5.6	7.0	6.2	9.3	5.6	7.0	5.6	7.0	0.0	0.0	-0.6	-2.3
Gunning	28	5.6	9.3	5.6	9.3	5.6	7.0	5.6	7.0	0.0	-2.3	0.0	-2.3
Holdsworth	22	5.5	7.3	5.5	7.3	5.5	7.3	5.5	7.3	0.0	0.0	0.0	0.0
Vernon	32	5.3	8.0	5.3	8.0	5.2	7.8	6.2	7.8	-0.2	-0.3	0.9	-0.3
Keate	20	5.0	6.7	5.0	6.7	5.0	6.7	5.0	6.7	0.0	0.0	0.0	0.0
Florence Nightingale	22	4.4	5.5	4.4	5.5	4.4	5.5	4.4	5.5	0.0	0.0	0.0	0.0
William Drummond	20	2.9	2.9	2.9	2.9	2.9	2.9	2.9	2.9	0.0	0.0	0.0	0.0
Kent	30	6.0	7.5	6.0	7.5	6.0	7.5	6.0	7.5	0.0	0.0	0.0	0.0
Brodie neurosurgery	14	4.7	4.7	4.7	4.7	4.7	4.7	4.7	4.7	0.0	0.0	0.0	0.0
Brodie stroke	16	5.3	5.3	5.3	5.3	5.3	5.3	5.3	5.3	0.0	0.0	0.0	0.0
Gray	32	5.3	8.0	5.3	8.0	5.3	8.0	5.3	8.0	0.0	0.0	0.0	0.0
Gwynne Holford	28	9.3	14.0	9.3	14.0	9.3	14.0	9.3	14.0	0.0	0.0	0.0	0.0
Richmond AMU	58	4.8	6.4	4.8	6.4	5.8	6.4	5.8	6.4	1.0	0.0	1.0	0.0
James Hope	10	2.5	NA	NA	NA	2.5	2.5	0.0	0.0	0.0	NA	NA	NA
Ruth Myles	13	4.3	6.5	4.3	6.5	3.3	4.3	3.3	4.3	-1.1	-2.2	-1.1	-2.2
Rodney Smith	28	7.0	9.3	7.0	9.3	7.0	7.0	7.0	7.0	0.0	-2.3	0.0	-2.3
Marnham	28	4.7	5.6	4.7	5.6	4.0	4.7	4.0	4.7	-0.7	-0.9	-0.7	-0.9
Trevor Howell	19	4.8	6.3	4.8	6.3	3.8	6.3	3.8	6.3	-1.0	0.0	-1.0	0.0

McEntee	18	6.0	9.0	6.0	9.0	4.5	9.0	4.5	9.0	-1.5	0.0	-1.5	0.0
Allingham	24	6.0	8.0	6.0	8.0	6.0	6.0	6.0	6.0	0.0	-2.0	0.0	-2.0
Caroline	24	6.0	8.0	6.9	8.0	6.0	6.0	6.0	6.0	0.0	-2.0	-0.9	-2.0
Benjamin Weir	32	5.3	7.1	5.3	7.1	5.3	8.0	5.3	8.0	0.0	0.9	0.0	0.9
Buckland	20	6.7	6.7	6.7	6.7	5.0	6.7	5.0	6.7	-1.7	0.0	-1.7	0.0
Belgrave	30	6.0	7.5	6.0	7.5	5.7	8.5	5.7	8.5	-0.3	1.0	-0.3	1.0
Amyand	28	7.0	9.3	7.0	9.3	7.0	7.0	7.0	7.0	0.0	-2.3	0.0	-2.3
CCU	10	2.0	2.0	2.0	2.0	1.8	1.8	1.8	1.8	-0.2	-0.2	-0.2	-0.2
Cheselden	22	5.5	7.3	6.3	7.3	5.5	7.3	5.5	7.3	0.0	0.0	-0.8	0.0
Nicholls	25	4.2	4.2	3.8	4.2	3.1	5.0	3.1	5.0	-1.0	0.8	-0.7	0.8
Freddie Hewitt	17	4.3	4.3	4.3	4.3	3.4	3.4	4.3	4.3	-0.9	-0.9	0.0	0.0
Champneys	18	4.5	9.0	4.5	9.0	4.5	9.0	4.5	9.0	0.0	0.0	0.0	0.0
Jungle	15	3.8	NA	NA	NA	3.8	3.0	0.0	0.0	0.0	NA	NA	NA
GICU	20	1.0	1.0	1.0	1.0	1.1	1.1	1.2	1.1	0.1	0.1	0.2	0.1
CT ICU	18	1.0	1.0	1.0	1.0	0.9	0.9	0.9	0.9	-0.1	-0.1	-0.1	-0.1
NICU	13	1.0	1.0	1.0	1.0	1.2	1.2	1.2	1.2	0.2	0.2	0.2	0.2
PICU	8	0.9	0.9	0.9	0.9	1.0	1.0	1.0	1.0	0.1	0.1	0.1	0.1
Neonatal Unit	21	1.2	1.2	1.2	1.2	1.3	1.3	1.3	1.3	0.2	0.2	0.2	0.2
Special Care	18	3.3	3.3	3.3	3.3	3.0	3.6	3.0	3.6	-0.3	0.3	-0.3	0.3
Pinckney	15	3.3	3.3	3.3	3.3	2.5	3.0	2.5	3.0	-0.8	-0.3	-0.8	-0.3
Gwillim	32	4.6	8.0	6.4	8.0	6.4	8.0	6.4	8.0	1.8	0.0	0.0	0.0
Carmen	15	4.3	4.3	4.3	4.3	5.1	5.1	5.1	5.1	0.8	0.8	0.8	0.8
Delivery	19	1.9	1.9	1.9	1.9	2.1	2.1	2.1	2.1	0.2	0.2	0.2	0.2
Mary Seacole	42	8.4	8.4	8.4	8.4	7.0	7.0	7.0	7.0	-1.4	-1.4	-1.4	-1.4
Heberden	24	8.0	8.0	8.0	8.0	6.0	6.0	6.0	6.0	-2.0	-2.0	-2.0	-2.0
Dalby	24	8.0	8.0	8.0	8.0	6.0	6.0	6.0	6.0	-2.0	-2.0	-2.0	-2.0

Links:

Draft NICE guidance: http://www.nice.org.uk/media/E18/ED/StaffingForNursingInAdultInpatientWardsDrafForConsultationMay2014.pdf

RCN statement: https://www.rcn.org.uk/newsevents/news/article/uk/new_nice_guidelines_are_a_step_towards_improving_staffing_levels

From the Safe Nursing Staff Escalation Policy (Jan 2014):

<u>Agreed Staffing Levels for wards and departments 2013</u>
Appendix B

Division	Ward	No of beds	Days	Nights	Weekends
Surgery, Cancer & Neurosciences	McKissock	24	6 RN, 3 HCA (early) 6 RN, 2 HCA (late)	4 RN	5 RN, 2 HCA
	Wolfson	28	4 RN, 4 HCA	2 RN, 2 HCA	3 RN, 4 HCA
	Cavell	28	6 RN 2 HCA	4 RN 1 HCA (mon to thu) 3RN 1HCA (fri to mon)	6 RN, 2HCA (sat) 5 RN 2 HCA (sun)
	Gunning	28	6 RN, 3 HCA (drop one HCA for the afternoon)	3 RN, 2 HCA	6 RN, 3 HCA (drop one HCA for the weekend)
	Holdsworth	22	5 RN 2 HCA	3 RN, 2 HCA	5 RN 2 HCA
	Holdsworth (if D bay reopens and beds increase to 26/28	26/28	6 RN 2 HCA (plus one extra HCA for early shift)	3 RN, 2 HCA	6 RN 2 HCA (Plus one extra HCA for early shift)
	Vernon	32	7 RN 2 HCA	4 RN, 2 HCA	7 RN 2 HCA
	Keate	20	5 RN 2 HCA (4+1pm)	3 RN	5 RN 2 HCA
	Florence Nightingale	22	6 RN, 2 HCA	4 RN,	6 RN, 2 HCA
	William Drummond	20	8 RN, 2 HCA	8 RN 2 HCA	8 RN, 2 HCA
	Kent	30	6 RN, 3 HCA	4 RN, 1 HCA	5 RN, 1 HCA
	Brodie neurosurgery	14	4 RN, 2 HCA	3 RN	3 RN,1 HCA
	Brodie stroke	16	3 RN, 2 HCA	3 RN, 1 HCA	3 RN,2 HCA
	Gray	32	7RN 2 HCA	4 RN + 2 HCA	7 RN + 2 HCA
Medicine & Cardiothoracic	Gwynne Holford	28	4 RN (early) 3RN (late, 3 HCA	2 RN, 2 HCA	3RN, 3 HCA
	Richmond AMU	58	16 RN, 8 HCA	11 RN, 7 HCA	15 RN, 8HCA
	James Hope	10+4 chairs	4 RN	0	0
	Ruth Myles	13	4 RN, 1 HCA	2 RN, 1HCA	3 RN, 1 HCA
	Rodney Smith	28	5 RN, 3 HCA	3 RN, 2 HCA	5 RN, 3 HCA
	Marnham	28	7 RN, 2 HCA	5 RN, 1 HCA	6 RN, 2 HCA

	Trevor Howell	19	5RN, 2 HCA	3 RN, 1 HCA	4 RN, 2 HCA
	McEntee	18	4 RN, 2 HCA	2 RN 2 HCA	4 RN 2 HCA
	Allingham	24	5 RN, 2 HCA	3 RN, 2 HCA	5 RN, 2 HCA
	Caroline	24	5 RN 1 HCA	3 RN 1 HCA	5/4 RN
	Benjamin Weir	32	7 RN 1 HCA	5/4 RN	7 RN
	Buckland	20	4 RN, 2 HCA	3 RN, 1 HCA	4 RN
	Belgrave	30	6 RN plus an early or a late 3 HCA	4 RN 1 HCA	6 RN 3 HCA
	Amyand	28	5 RN, 3 HCA	3 RN, 2 HCA	5RN, 2 HCA
	CCU 1 & CCU 2	6 + 4	6 RN	5 RN	5 RN
	Cheselden	22	5 RN, 1 HCA	3 RN	4/5 RN, 1 HCA
	Nicholls/Ocean	25	9 (7RN + 2HCA)	6 RN, 1 HCA	7-8 RN, 1 HCA
	Freddie Hewitt	17	5 RN, 1 HCA	4 RN, 1 HCA	4 RN , 1 HCA
	Champneys	18	5 RN, 1HCA	2 RN, 1 HCA	4 RN, 1 HCA
	Jungle	15	5 RN	Closed	Closed
	General Intensive Care Unit (incl Holdsworth HDU beds)	20	20 RNs per shift (Monday to Saturday pm and then 17 per shift once Holdsworth HDU shuts on Saturday afternoon)		
	Cardiothoracic Intensive Care Unit (incl Benjamin Weir HDU beds)	18	18 RNs per shift		
	Neuro Intensive Care Unit	13	13 RNs per shift		
	Paediatric Intensive Care Unit	5 +3	9 RN , 2 HCA per shift and 9 RN and 1 HCA on nights		
	Neonatal Unit	21	18RN	18RN	18RN
	Special Care	18	6 RN or 5 RN + 1 NN	6 RN or 5 RN + 1 NN	6 RN or 5 RN + 1 NN
	Pinckney	15	5-6 RN, 1 HCA	5-6 RN	5-6 RN
	Gwillim (postnatal)	32	7 RM, 1 RN, 2HCA	4 RM, 1/2 HCA	5 RM, 1/2 HCA
	Carmen Suite –birth unit & antenatal	3 birth, & 12 AN	3/4 RM, 1 HCA	3/4 RM, 1 HCA	3/4 RM, 1 HCA
	Delivery rooms, HDU,x2, triage	19	10RM, 2 HCA	10RM, 2 HCA	10RM, 2 HCA
Community	Mary Seacole	42	5 RN, 6 HCA	5 RN, 5 HCA	5 RN, 5 HCA
	Heberden	24	4 RN, 4 HCA	4 RN, 4 HCA	3 RN, 2 HCA
	Dalby	24	4 RN, 4 HCA	4 RN, 4 HCA	3 RN, 2 HCA