REPORT TO THE TRUST BOARD 31 July 2014

Paper Title:	Nursing and Midwifery Establishment Review: Review of Progress
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Purpose:	To update the Board regarding progress
Action required by the board:	To note the actions taken since the Board's consideration of the staffing establishment review at its meeting in May 2014
Document previously considered by:	N/A

Executive summary

The report has outlined the steps taken since May 2014 and the approach to deliver the recommendations in a timely manner. There has been some slippage against some of the timescales outlined within the recommendations, however the project now has a clearly understood timetable and the first programme board will be held in the next two weeks.

Work continues to finalise work regarding the detailed funding approach to support delivery of the revised establishments.

Key risks identified: None

Related Corporate Objective: *Reference to corporate objective that this paper refers to.*	
Related CQC Standard: *Reference to CQC standard that this paper refers to.*	

Equality Impact Assessment (EIA): Has an EIA been carried out? No

1.0 Introduction:

In May 2014 the Board received a paper outlining the findings of a Nursing and Midwifery establishment review undertaken between February and May 2014 for 49 clinical inpatient areas within the Trust. At the meeting in May the Board agreed to endorse the recommendations made within the body of the report.

The purpose of this paper is to provide an update to the Board about the approach and progress made in relation to the implementation of the recommendations arising from the review and to highlight any key areas of risk.

2.0 Background to the Establishment Review:

A key external driver for the review was the expectation set by the National Quality Board in December 2013 (as a consequence of the Mid Staffordshire Public Inquiry) that all hospital trusts should review their nursing & midwifery establishments twice annually and reports the findings to a public trust board.

Guidance published in July 2014 by the National Institute of Clinical Excellence for inpatient Ward Staffing has restated that trusts must review staffing every 6 months, an element of a wider framework a trust must adopt to ensure safe staffing.

The report outlined the importance of ensuring that staffing is appropriate, referring 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.

The review was undertaken over a number of months and covered 49 inpatient areas. A robust methodology was employed and a large number of staff were involved from band 7 upwards to Divisional Director of Nursing & Governance level.

Metrics to gauge safe, high quality care were used throughout triangulating results using acuity data, national guidelines, Hurst tool and the trust safe Staffing policy.

Requirements according to these metrics were compared to budgets and were compared to peer wards within the divisions.

Following senior professional challenge and scrutiny from the Head of Nursing DDNG and Deputy Chief Nurse any gap between requirement and existing WTE resource was identified.

Within the report detail was provided about estimated costs in the event that the recommendations were accepted.

The report had a number of recommendations which can be found at appendix A. These were split into two key areas, namely recommendations for the Divisional Directors of Nursing will take forward, others for Corporate Directors.

The original report to the Board highlighted an anticipated timetable for the implementation of some of the recommendations.

3.0 Progress with Implementation of the Review Recommendations:

To ensure that the implementation of the recommendations occurs in a timely and effective manner this will be undertaken using a project management approach. A Project Initiation Document has been written and agreed with clear sight of the timetable for implementation of the individual recommendations and owners for action.

This project will sit within a wider programme of work regarding Nursing and Midwifery Staffing which is going to be reviewed and coordinated by the Corporate Nursing Team. The programme of work will focus on key areas building on and supporting existing work programmes that the Divisions are taking forward and current corporate initiatives. HR Colleagues will be fully involved in this work. The key areas will be:

- Development of a High level milestone plan to encompass future service development plans and to ensure forward planning of workforce.
- Work regarding substantive recruitment focussing on the approaches to local and overseas recruitment ensuring VFM and good coordination of initiatives. In addition focus on recruitment of students trained within the Trust.
- Temporary Staffing and supporting the TSU function in the securing of staff and the training/ support of staff within the Trust.
- Innovative approaches to recruitment and new roles to support service delivery
- Retention of staff and approaches to change the current profile in some areas.
- Support of the ongoing 6 monthly establishment reviews.

In relation to the establishment review presented in May 2014 there has been some slippage against timescales for some recommendations due to the change of personnel within the nursing Directorate and a need to develop the PID. However there are now clear agreed timescales and the first project board will meet in early August.

Work has also commenced to scope the second and third phases of the establishment review to capture areas of the Trust that have not been reviewed.

4.0 Progress regarding Funding of the Nursing and Midwifery Establishment Review:

A key element of the project is confirming the position of nursing budgets in relation to the establishment review paper (May 2014) and agreeing an approach to funding from 14/15. An outline of the position is given below:

*Summary of Nursing Budgets 2013/14***:** In 2013/14 the Trust's nursing budget was £155m against which it showed a small adverse variance of £0.2m. The table below shows the position by Division

Table 1 – Divisional Position Nursing expenditure 2013/14

Division	Budget £m	Spend £m	Variance £m
CWDT	49.4	49.9	0.5
Community	29.2	29.3	0.1
Medcard	43.1	42.2	-0.8
SNT	29.6	30.4	0.8
Overheads & R&D	3.6	3.3	-0.3
	155.0	155.2	0.2

In year additional non-recurring budgets were added to cover winter pressures, compliances issues in Medcard, the impact of specials, the acuity of patients on Mary Seacole and the impact of agency premiums in Critical care. These issues were then reviewed and included in budgets for 2014/15 where appropriate.

*Business Planning and Budget Setting 2014/15***:** As part of business planning divisions were asked to identify any costs pressures they were facing to be presented to the Business planning steering group. These pressures were reviewed by a group led by the Medical director and including the DDO's.

Based on the pressures put a decision was taken to establish a reserve to cover any nursing pressures this reserve was set at £1m and has yet to be allocated to divisions as at month 3.

As shown in the finance risk paper as part of budget setting divisions received £16.5m to clear any legacy issues they had from previous years. At the time of setting budgets the guidance to divisions was to use this funding as part of exercise to re set their baselines in line with their spend in 13/14. At this point no specific guidance was given on nursing.

*Financial Impact of the Nursing Review***:** In parallel with business planning the nursing review was undertaken. The impact of the review over the 13/14 budget was an additional £3.1m.The review didn't cover all areas of nursing spend and the 13/14 position for the areas included was an adverse variance of £2.4m compared to the overall nursing variance of £0.2m shown in table 1

In terms of budgets the review covered 55% of nursing spend and the table below shows the position by division for the areas included.

Table 2 – Divisional Position Nursing expenditure 2013/14 For Areas in Nursing Review

Division	Budget £m	Spend £m	Variance £m	Nursing Review compared to 13/14 Budget
CWDT	37.5	38.2	0.7	0.9
Community	5.0	5.7	0.6	0.2
Medcard	23.4	24.2	0.8	2.2
SNT	19.4	19.6	0.2	-0.2
Overheads & R&D	0.0	0.0	0.0	-0.1
	85.3	87.7	2.4	3.1

Since the review was published work has been carried out between the author of the review and finance. The aim of this was to understand the impact on nursing budgets and to allow the required budgets changes to be identified and agreed.

*Divisional Engagement***:** The full analysis behind the tables above has been shared with divisions and a series of meetings have been held and are planned with the DDO's, DDNG's and the ADF for Financial management. The aims of these meetings are:

- To gain a common understanding between the division and finance as to the impact of the review
- To explore how much of the additional spend was incurred in 13/14 and would be covered in the legacy funding each division received

*Next Steps***:** The intention had been to close these meetings off by the time month 3 was reported but due to problems arranging the meetings there are still two divisions to meet. Once these meetings are complete the ADF will summarise for the Nursing director and Finance director the outcome of these meeting and draw up a proposal for the allocation of the £1m reserve and how this achieves the divisions being able to update their budgets to reflect the nursing review.

5.0 Summary:

The report has outlined the steps taken since May 2014 and the approach to deliver the recommendations in a timely manner. There has been some slippage against some of the timescales outlined within the recommendations, however the project now has a clearly understood timetable and the first programme board will be held in the next two weeks.

Work continues to finalise work regarding the detailed funding approach to support delivery of the revised establishments.

Appendix A: Recommendations

The following recommendations were agreed by the Board in May 2014.

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. Stroke.
   - Risk register entries related to ward staffing.
   - Historical/known/agreed cost pressures related to ward staffing.

   For each ward, the direct care 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 Manager and Matron, who respectively are accountable for writing and approving the electronic roster, each ward will be expected to demonstrate compliance with the Annual Leave, Sick Leave and Study Leave thresholds in the uplift across three consecutive rosters (12 weeks). 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 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, Parental, Suspensions) are to be monitored at Divisional level. Roster tolerances can be reset by the E-rostering Team to ensure the parameters of the roster guide the writing and approval process within the uplift limits. Tackling unaffordable absence will increase staff availability and offset bank and agency usage.

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 (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 period to demonstrate uplift adherence, the ward is required to benchmark their estimated WTE requirement with comparable ward(s) in other Trust(s). The metrics provided by this review 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 Manager 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 it's 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 Managers, Matrons and Heads of Nursing must receive budget statements from June 2014 onwards. A programme of mandatory masterclasses in how to interpret and manage the budget, 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 Managers, 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:

    a. Ward budgets are on a 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.

14. 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.

15. 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.

16. It is recommended that across the 2014/15 financial year, this impact 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. There are 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 trust wide 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.