Shropshire Community Health NHS
NHS Trust

SUMMARY REPORT	Meeting Date:	21 November 2013
	Agenda Item:	8.3
	Enclosure Number:	7

Meeting:	Trust Board		
Title:	Community Hospitals Staffing Review		
Author:	Maggie Bayley Director of Nursing, AHP's, Quality, HR, OD and Workforce / Deputy CE		
Accountable Directors:	Maggie Bayley Director of Nursing, AHP's, Quality, HR, OD and Workforce/ Deputy CE		
Other meetings presented to or previously agreed at:	**Committee**	**Date Reviewed**	**Key Points/Recommendation from that Committee**
	None		

Purpose of the report

This paper outlines the findings of the staffing and acuity review of the four community hospitals and details staffing establishments position. It responds to the issues raised in the Francis Inquiry Report, 2013 (cross referenced in the Trusts' action plan) and the key messages of the Keogh Report, 2013, as well as the Compassion in Practice document recommendations in relation to nursing staffing. Outlining the Trusts approach and actions taken.	**Decision/ Approval**	✓
	Assurance	✓
	Discussion	✓
	Information	

Strategic Priorities this report relates to:

To exceed expectations in the quality of care delivered	To transform our services to offer more care closer to home more productively.	To deliver well co-ordinated effective care by working in partnership with others.	To provide the best services for patients by becoming a more flexible and sustainable organisation
✓	✓	✓	✓

Summary of key points in report

- The findings of the Francis Inquiry and the Keogh Review were published during 2013 highlighting the intrinsic link between poor quality care and patient outcomes with low staffing/skill mix ratios. The NHS England document Compassion in Practice: Nursing, Midwifery and Care Staff Our Vision and Strategy has made a number of recommendations regarding the expected Registered Nurse (RN) to patient ratio, RN to Health Care Support Worker ratio and the role of the Ward Sister and there is an expectation that Trust Boards will receive a twice yearly report regarding nursing staffing levels. This will be planned into the board programme.
- A staffing establishment review was undertaken in May 2011 that resulted in an investment of circa £380,000 from commissioners to community hospitals ward staffing.

This was a table top exercise using a national acuity tool designed for acute trusts.

- It was agreed that a further review of staffing levels would take place in June 2013 to enable triangulation of data and supplement this further by reviewing professional judgement and benchmarking with other Community Trusts. This report presents the findings of that review as noted in the Francis action plan.

- Phase two budget setting, seen and approved by the Board has addressed some historical anomalies in ward staffing establishments and invested £633k to align with the professional view of staffing required to meet patient's needs and sustain safety..

- National guidance due to be published by the end of November 2013 will require some reassessment of staffing which will be reviewed with the next data collection in January 2014. The outcome and implications of the national guidance will be reviewed through quality and safety committee structure.

- Further scrutiny and challenge processes have been introduced to ensure that local operations/clinical managers are using the staffing resources in the most effective manner on shift by shift basis, through the development and implementation of a rostering policy.

- Staffing levels are monitored by the quality and safety operational group and reported to the committee on a monthly basis to ensure that the Trust is sited on risk issues and ensuring appropriate mitigation, to keep patients and staff safe.

Key Recommendations

The Board is asked to

- **Note** the process that has been undertaken to review community hospital staffing levels, in 2011 and 2013, to provide assurance of action to mitigate risk.
- **Note** the investment made in 2011 and 2013 as part of phase two budget setting.
- **Support** the on-going use of the safer care nurse staffing tool on a bi-annual basis to ensure staffing levels remain safe. Noting that anticipated national guidance may impact on the current position and will need to be considered by the Board, following review through the quality and safety committee structure.

Is this report relevant to compliance with any key standards? YES OR NO		**State specific standard or BAF risk**
CQC	Yes	All standards
NHSLA	Yes	Learning from Experience, Safe Environment, Clinical Care, Competent and Capable Workforce
IG Governance Toolkit	No	
Board Assurance Framework	Yes	991, Clinical Quality and Patient Safety

Impacts and Implications?	**YES or NO**	**If yes, what impact or implication**
Patient safety & experience	Yes	The report and actions taken and planned developments will provide a basis for assurance on safety, experience and effectiveness
Financial (revenue & capital)	Yes	Resource investment has been made and further may be required
OD/Workforce	Yes	Requirement to ensure appropriate staff and staff fit

		for purpose
Legal	No	

Community Hospitals Staffing Review 2012/13

1. INTRODUCTION

1.1 This paper outlines the actions taken to ensure that the nursing establishments across the four community hospitals provide an appropriate staffing level and skill-mix to support the delivery of safe and effective care to patients. It details how acuity and dependency of patients has been reviewed and outlines the professional judgements reached in relation to staffing establishments required and the cost implications.

1.2 There is now a requirement, post the publication of the Francis Report (2013), that all NHS organisations will take a 6 monthly report to their Board on nursing staffing levels and advise on whether they are adequate to meet the acuity and dependency of their patient population. This paper fulfils that purpose.

2. BACKGROUND

2.1 Prior to the authorisation of the Trust in July 2011 a review of staffing levels for inpatient wards across the community hospitals took place. The review was done in response to a widely held belief that the dependency and number of patients being admitted had increased significantly. This desk top exercise was undertaken using a dependency scoring tool developed by the Association of UK University Hospitals (AUKUH), which includes methodology to review patient acuity and the staff required to meet these needs.

2.2 As a result of the review commissioners provided funding of circa £380k in September 2011 to increase the establishment in the community hospitals working towards providing a skill mix ratio of 65:35 Registered Nurse (RN): Healthcare Assistant (HCA) nursing staff which was the skill mix ratio recommended by the Royal College of Nursing (RCN) in 2006 for acute care wards.

2.3 There are no mandated national, regional or local levels for the number of nurses required to deliver care safely, to meet basic needs, prevent complications and avoid unnecessary deaths or to deliver care to a recognised level of quality (except in a few specialist areas such as intensive care).

2.4 In December 2010 the Royal College of Nursing (RCN) produced a publication titled ‘Guidance on safe nurse staffing levels in the UK and ‘Safer staffing for older people’s wards’ in 2012. This publication does not set targets for staffing per, however sets out the essential elements to planning and reviewing nurse staffing.

2.4 There is a greater focus now on ensuring that Trusts have the right size and shape of its nursing workforce to meet the needs and expectations of its patients. Evidence which was not always available can now directly attribute failings in care and increased mortality rates to poorly staffed wards. Evidence also suggests that poorly staffed wards increase staff sickness, burnout and reduce staff well-being all which have a direct consequence on outcomes of care, including experience. It is not however, just about the numbers of staff. Other factors which underpin safe dignified care include strong, empowered leadership at ward level, resources directed at supporting the ward leaders and the development and use of clinical and patient experience metrics.

2.5 The above findings are further supported by the Francis Inquiry Report, Keogh Report 2013 and the NHS England document Compassion in Practice: Nursing, Midwifery and Care Staff Our Vision and Strategy.

3. INVESTMENT MADE IN 2011

3.1 As a result of the work undertaken in 2011, commissioners provided additional funding to the value of £380,271 which was used to increase the number of registered nursing staff on the wards as detailed in previous Board papers. The additional number of registered nurse (RN) posts to shown in in Table one below:

Table One: Additional Registered Nurse posts

Hospital	Band	Whole Time Equivalent (Wte)
Bishops Castle	Band 5	2.0
Bridgnorth	Band 5	4.0
Whitchurch	Band 5	3.5
Ludlow	Band 5	9.5

3.2 This extra investment resulted in the subsequent budgeted establishments and skill mix shown in Table two below, which demonstrates significant progress towards a 65:35 skill mix.

Table two: Establishments in Community hospitals

Hospital	Budget Wte	Band 7	Band 6	Band 5	Band 2	Skill Mix Ratio
Bishops Castle	18.67	1.0	1.0	9.86	6.81	64:36
Bridgnorth	26.65	0.8	1.8	14.17	9.88	63:37
Whitchurch	36.27	1.0	2.2	19.26	13.81	62:38
Ludlow	44.66	0*	1.6	24.37	18.69	57:43

* error made when Mutually agreed resignation scheme approved by the Board in 2012 removed the funding for the Band 7 ward manager post – post holder still in post.

3.3 This establishment included an uplift of 21% to cover maternity leave, study leave and sickness and it did not include: senior nurse (Band 6 or above) cover across the 24 hour period; any provision for 'specialing' patients on one to one basis. It should be noted that staffing for specialing is approved over and above budgets to meet patient need and safety issues on a daily basis.

3.4 It was evident in 2011 that there was variation across the Community Hospitals in the numbers of staff available and the skill mix ratios and at Ludlow and Bishops Castle traditionally only one RN was on each ward at night. The Director of Nursing in agreement with the Director of Operations advised that as a minimum there must always be two RNs on duty and rotas were to reflect this.

3.5 It was also identified by the Director of Nursing & Quality that there was a need to undertake a more systematic and robust detailed review of the acuity of patients and staffing levels as it was clear from clinical visits that there still appeared to be a gap in requirements.

4. STAFFING AND ACUITY REVIEW METHODOLOGY

4.1 Nursing workload is directly related to patient acuity and dependency. That is, the level of patient need in meeting activities of daily living combined with the complexity of treatment of the medical condition which necessitated admission to hospital. Examples of therapies and treatments which increase nursing workload include supporting patients with complex nursing care needs including altered states of consciousness, complex medication regimes, monitoring and observation for signs of deterioration and escalation of care and patients with dementia or complex communication difficulties associated with mental health or learning disability.

4.2 An essential component of the review involved meetings between the Ward Managers, Clinical Service Managers and the Deputy Director of Nursing & Quality which enabled a discussion of professional judgements on staffing requirements, deployment of the staffing resource, factors impacting on staffing and the impact on quality including patient feedback, safety and effective care indicators within the Trust quality dashboard. Valuable feedback was gained which contributed to the review.

4.3 In order to gain greater assurance around the safety of current staffing levels it was suggested by the Director of Nursing & Quality that a range of data should be reviewed and the findings triangulated. The purpose was to agree a validated position and requirement to meet patients' needs and ensure staff safety. Therefore, the main approaches used to review staffing requirements included:

- Professional Judgement method - involves seeking the views of experienced nurses to assess the number and mix of a nursing team

- Review of benchmarking data - this looks at the numbers and skill mix ratio of staff deployed on similar sized wards across neighbouring Community Trust Hospitals.

- Application of the Association of United Kingdom University Hospitals (AUKUH) tool for measurement of patient acuity, dependency and nursing workload – this tool, known as the Safer Nursing Care Tool, has been widely used in the NHS and was developed in conjunction with the NHS Institute for use within acute NHS hospitals. The tool was modified to include the Barthel Score as a marker of dependency and therefore increase applicability to a non-acute setting and was externally reviewed during 2012 and is now termed the Safer Nursing Care Tool. A data gathering exercise was undertaken across all four community hospitals in November 2012 and repeated in June 2013 using the revised Safer Nursing Care Tool. The data collection measured actual staffing levels per shift for 20 days during the data collection period.

- Comparison of the current numbers of registered nurses per patient and the skill mix ratio of registered nurse to healthcare assistant as recommended by the RCN, (noting that it is guidance only and is not mandated). The guidance states that a ratio of 8 or more patients per registered nurse is associated with patient care on a ward regularly being compromised. The RCN recommend as a minimum 65:35 split of registered nurses (RN) to healthcare assistants (HCA).

- Review of clinical and patient experience measures – this looks at mortality, sickness absence, Infection Prevention & Control, patient safety incidents and safety thermometer data.

5. ANALYSIS OF FINDINGS

5.1 The findings from the professional judgement model demonstrated that there was a gap between the current funded establishment and the requirements of professional judgement perspective.

5.2 Data from other community hospitals showed similar challenges to the trusts data. However, it was not possible to draw exact comparisons due to differences in the organisational structures (several wards in one location is very different to one ward in isolation). The analysis also showed that the skill mix in other organisations is not at the 65:35 split and therefore the Trusts RN to HCA ratio is higher.

5.3 The data is useful in demonstrating the challenges of delivering safe staffing levels for every shift on a day to day basis. Between the planned establishment and the actual staffing levels there is potential 'loss' at different points, due to vacancies, long-term sickness absence, short term sickness absences and staff redeployed or lent to cover shortages elsewhere. RCN guidance identifies that a minimum of 25% should be built into establishments to cover training and sickness absence. At the time of the data collection the Trusts establishments did not meet this guidance as the 'headroom calculation' was approximately 21%.

5.4 The summary of findings from the two data collection periods demonstrates a gap in staffing levels of 29.64 wte in June 2013, which had reduced from 44.54 in November 2013 - the first data collection. It should be noted the tool used advises four data collection periods are used prior to being acted upon. Therefore the results are not seen to be a significant risk for the trust

5.5 Retrospective analysis of the findings against the RCN (2012) guidance that for older people's wards there should be at least one registered nurse on duty for no more than 8 patients shows that there was a gap on some shifts. It is not clear if the national guidance will advise in a similar way, however regional conversations at Director of Nursing level indicate a move towards this. The trust will consider this in the next phase of work.

5.6 Whilst looking at numbers and skill mix of staff on duty it is also important to understand how this correlates to a range of clinical and patient experience measures. We monitor a range of quality indicators to assess the effectiveness of care and support quality and outcome measurement:

- Infection Prevention & Control data - no strong themes emerge in relation to any particular ward.

- Mortality data - in looking at the total number of deaths across each ward during the two data collection periods, the highest number of deaths occurred at Ludlow Community Hospital which also had the second poorest staffing levels. However, this data is not linked to activity or bed numbers so cannot be used as a reliable indicator.

- Safety thermometer data - identifies through a monthly survey of all adult inpatients, the percentage of patients who receive harm free care. Four areas of harm are currently measured; All grades of pressure ulcers whether acquired in hospital or before admission; All falls whether they occurred in hospital or before admission; Urinary catheter related infections and Venous Thromboembolism risk assessment and appropriate prevention. It appears that there may be a link to a lower skill mix and staffing levels at Ludlow hospital since they had the highest recorded incidence of harms during both data collection periods.

- Staff sickness absence data – Ludlow hospital had the highest recorded registered nurse sickness absence and healthcare assistant absence in November 2012. However, in June 2013 Whitchurch hospital had the highest registered nurse sickness absence and healthcare assistant absence. It is not possible to draw firm conclusions from this data.

- Staffing/workload incidents recorded in Datix - any staff member may submit a clinical incident report if they are concerned about unsafe staffing. There are challenges to maintaining core staffing levels at times (as per 5.6 above) when there is an unpredictable call on extra bed capacity and/or the use of specials or sudden staff unavailability. Ludlow hospital does have the highest number of Staffing/workload incidents recorded in Datix which directly links to the fact that they have the poorest numbers and skill mix in current establishments.

- Complaints – it was noticeable that Bishop's Castle hospital has no recorded complaints since July 2011 and this hospital has the strongest establishment in terms of numbers and skill mix, however there was a safeguarding issue.

6. ACTIONS TAKEN

6.1 Phase two budget setting in the trust has realigned budgets, in line with the views of the ward managers of staffing requirements and invested £633k, to employ 18.81 whole time equivalent staff across the community hospitals. Additionally, this includes a 28% uplift to cover sickness, study leave and maternity leave

Hospital	Pre Phase 2 BUDGET WTE	Post Phase 2 BUDGET WTE	VARIANCE WTE	Pre Phase 2 BUDGET £'000	Post Phase 2 BUDGET £'000	VARIANCE £'000
Bishops Castle	18.67	21.19	2.52	613	704	91
Bridgnorth	26.65	29.87	3.22	890	959	69
Whitchurch	36.27	39.00	2.73	1,171	1,305	134
Ludlow	44.66	55.00	10.34	1,390	1,728	338
Total	**126.25**	**145.06**	**18.81**	**4,063**	**4,695**	**633**

6.2 From the table it can be seen that the highest investment is in Ludlow – which should mitigate the issues regarding staffing levels and skill mix and mitigate the risks seen. It should be noted that no areas of concern were raised by the Care Quality Commission review in January 2013.

6.3 Further scrutiny and challenge processes have been introduced to ensure that local operations/clinical managers are using the staffing resources in the most effective manner on shift by shift basis, through the development and implementation of a rostering policy.

6.3 At the operational quality and safety group staffing levels are discussed and divisional managers raise any concerns that require review. These are triangulated against patient safety incidents and complaints to manage any hotspot areas.

6.4 Other systems for providing assurance on nurse staffing levels and care quality are being developed to ensure a dashboard of quality indicators as detailed in the Francis action plan.

6.5 In addition, robust planning for escalation beds with Commissioners has occurred. This has included a systematic approach to staffing which will ensure a dedicated funded establishment is available and recruited ahead of winter pressures, to reduce the reliance on agency and bank staff. This approach will ensure improved quality of care for patients.

6.6 The Trust has implemented a project focused on the reduction of use of agency staff and has entered into a service level agreement with Shrewsbury and Telford Hospitals to use their integrated bank, which has been operational since June. In addition, the Trust is proactively recruiting additional staff to cope with periods of sickness, maternity leave and study leave who will move between different hospitals as required. The purpose of this is to reduce risk and improve quality.

7. SUMMARY

7.1 The investment made in 2011 supported the move towards a 65:35 skill mix ratio of registered to unregistered staff within community hospitals.

7.2 The data collection undertaken in November 2012 was intended to help identify a new base line establishment. After using the AUKUH tool for the first time in November 2012 it was clear that the tool could not be used in isolation and that data would need to be triangulated in order to gain greater assurance around the safety of current and future staffing levels.

7.3 The review of staffing levels in June 2013, using the revised AUKUH Tool (Safer Staffing Tool) also triangulated data against key nurse sensitive indicators. The findings from the range of methods used to review staffing levels all suggested increased establishments were required to meet patient needs. However, it is noted that the safer staffing tool recommends that four cycles of implementation are required to determine appropriate staffing levels and ensure unnecessary changes are not made as a result of seasonal or natural variation.

7.4 The findings of the review suggest that staffing levels needed to be adjusted to meet current demand due to patient acuity and professional guidelines. Phase two budget setting has resulted in the investment of 18.81 wte at a cost of £633k.

8. NEXT STEPS

8.1 In line with best practice the Nursing Directorate will undertake a bi-annual review of dependency using the methodology in the paper, in conjunction with the Operations Directorate. The next review will be undertaken in January 2014, as per the Safer Nursing Care Tool recommendations and the results analysed against the current position. Findings will be shared through Quality and Safety committee structure and any required action recommended.

8.2 As new national guidance is anticipated regarding staffing levels from the Compassion in Practice Action Area 5 (ensuring we have the right staff, with the right skills, in the right place), the recommendations will be reviewed in line with the safe care tool outputs. This will then facilitate a broader discussion as to the requirement for any further investment above phase two budget setting.

8.3 An electronic rostering tool that enables prospective review of staffing on a shift by shift basis is being considered to assist in assurance of staffing levels on a daily basis as detailed in the Keogh report and best practice from Salford.

8.4 Consideration will be given to the amount of supervisory time available for ward managers. Focusing on their ability to have the time to lead, support the staff and act as a role model and be visible to patients and staff. Recognising that effective clinical leadership and management of the ward team is essential for building a well-motivated team and a work-place culture that strives to provide consistently high quality care (person-centred, safe and effective care). This would support our strategic objective of exceeding the expectations of patients and the public and meeting the recommendations made in the Francis (2013) Inquiry.

8.5 A review will be undertaken of the proportion of the current band 6 posts to improve career progression and ensure an adequate number of deputies who can support safe, effective care throughout the 24 hour period.

9. RECOMMENDATIONS

The Board is recommended to:

- **Note** the process that has been undertaken to review community hospital staffing levels, in 2011 and 2013, to provide assurance of action to mitigate risk.
- **Note** the investment made in 2011 and 2013 as part of phase two budget setting.
- **Support** the on-going use of the safer care nurse staffing tool on a bi-annual basis to ensure staffing levels remain safe. Noting that anticipated national guidance may impact on the current position and will need to be considered by the Board, following review through the quality and safety committee structure