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Meeting:	**Brighton and Sussex University Hospitals NHS Trust** **Board of Directors**
Date:	**27th October 2016**
Board Sponsor:	**Helen O'Dell Interim Chief Nurse**
Paper Author:	**Helen O'Dell Interim Chief Nurse**
Subject:	**Safer Nursing Staffing levels**

Executive summary

This report, alongside the monthly reports on Safer Staffing, form part of the Chief Nurse's assurance to the Board that the Trust's commitments to Safe Staffing are being delivered through our leadership and with the support of our internal processes and governance arrangements. The Chief Nurse provides a detailed report on the nursing workforce to the Board every six months.

This report builds on the previous reviews of the nursing workforce reported to the Board in September 2013, when the Board approved prioritised investment in nursing; and the report to the Board in April 2014, which described the requirements in relation to nurse staffing and the publication of nurse to patient ratios which followed the Francis Inquiry and Government response to the Francis Inquiry, *Hard Truths.*

This report follows the last detailed report in March 2016, which reviewed national guidance for nursing and midwifery staffing and the current position of the Trust.

This report has focused on:

1. Intensive care staffing – neurology
2. Emergency departments – RSCH & PRH
3. Care Hours Per Patient Day
4. Nursing & Midwifery revalidation
5. Nursing & Midwifery work stream work
6. Issues raised by care quality commission in relation to nursing and midwifery staffing
7. Future plans

Action required by the Board

The Board of Directors is asked to note the six-monthly report on nursing & midwifery staffing; the current position of the Trust and the further work planned.

Links to corporate objectives	Safe staffing levels support the Trust objectives of: ***excellent outcomes; great experience; empowered skilled staff; and high productivity***
Identified risks and risk management actions	Safe staffing levels are key to ensuring patient safety and high quality patient experience.

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Resource implications	As reported to the Board of Directors any shortfalls in staffing levels will be addressed, through the development of business cases.
Report history	Previous reports on nurse staffing have been made to the Board monthly since April 2014.
Appendices	Appendix 1 – Summary tables form March 2016 Nursing & Midwifery staffing Appendix 2 – neurology ICU staffing escalation July 2016 Appendix 3 - Monthly monitoring of Nursing & Midwifery workforce Appendix 4 - NHS Choices version of BSUH Safer Nurse Staffing: September 2016

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Report to the Board of Directors, 27th October 2016
Nursing & Midwifery Workforce

1. Introduction

This report details current staffing at BSUH benchmarked against National Nursing & Midwifery Staffing guidance The report provides the Board with an overview of Nursing and Midwifery staffing levels in inpatient areas as outlined in the Nurse Staffing Guide "How to ensure the right people, with the right skills, are in the right place, at the right time" (National Quality Board and NHS Commissioning Board).

The key external driver is the expectation set by the National Quality Board that all hospital trusts should review their nursing & midwifery establishments twice annually and report the findings to a public trust board meeting. The National Quality Board report has a number of other recommendations, 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.

Determining staffing requirements is complex and determining the number is only one part of the process. The skill mix of the staff is vital and the Keogh 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 depends on a range of other factors including leadership, culture, team working, environment and training & development.

In addition to baseline establishments each area requires an additional uplift to cover some absences such as annual leave and training as well as some provision for sickness. 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.

Appropriate staffing can be monitored in several ways, safer staffing filled and unfilled shifts, acuity and dependency, bank and agency usage, vacancies, turnover, sickness levels, overtime, patient feedback, patient voice, friends and family test, falls, pressure ulcers, medication errors, complaints, staff feedback on missed breaks, attendance at mandatory training and number of appraisals completed

In March 2016 a detailed report was shared with the Board benchmarking Nursing and Midwifery establishments to National guidance - see summary tables in Appendix 1.

Following the March report, a further review of staffing has taken place and this report will cover the following areas:

1. Intensive care staffing – neurology
2. Emergency departments – RSCH & PRH
3. Care hours per patient day
4. Nursing & Midwifery revalidation
5. Nursing & Midwifery work stream work
    - Agency
    - Acuity & dependency
    - Nursing & Midwifery Consultation
    - International recruitment

6. Issues raised by care quality commission in relation to nursing & midwifery staffing
7. Future plans

1. Intensive care staffing

Intensive care units nationally are struggling to recruit experienced nurses with intensive care qualification. At Brighton & Sussex University Hospitals NHS Trust (BSUH) we have been training our own nurses but when they have completed the programme several leave to develop their careers at other units. The national shortage of ICU nurses has been compounded with the transfer of neurological ICU to RSCH in June 2015.

A number of actions have been taken to help to integrate the neurology nurses into the RSCH team, to ensure skills and knowledge are shared, to ensure good practice education and to strive for safe, quality care.

- The neurology and general nursing rotas have been joined together.
- There is now a single shift leader on Level 5 rather than two.
- As nursing numbers allow, there is a supernumerary senior nurse with neurology skills available as a neurology expert 24/7, to support and coach the bedside nurses in caring for the neurosurgical critically ill.
- Twice-weekly multidisciplinary bedside teaching sessions – one neurology and one general – led by the critical care nurse consultant.
- Weekly staff meetings introduced.
- Three-monthly rotations for the nurses currently without neurology skills so that they can learn to care for the neurosurgical patients and complete competency booklets to record learning.
- Secondment of previous neurology practice educator to support for one day a week.
- Neurosurgical Senior Band 6 to work non-clinically to support the neurology education.
- An optional rotation for the neurology nurses to the general side to gain broader experience and support team working.
- Work commenced with the Values & Behaviours coach to arrange team building strategies.

The number of neurology patients requiring ICU is greater than anticipated (eight patients but up to 15 patients) which is causing even more pressure on the nursing staff.

In July 2016 a paper was presented to the senior management team, which included:

Areas of concern:

- Staffing of Critical care to allow safe care of Neurosurgical patients
  Staffing of Critical Care to allow safe care of Head injury patients
- Staffing to allow support for Nurses obtaining Neurosurgical Critical Care Skills
- Escalation policy

Rationale for this Policy

- To state a safe level of nursing cover for Neurosurgical patients
- To state a safe number of neurosurgical patients
- To provide an escalation and contingency plan
- To allow controlled increase in capacity for Neurosurgical Critical Care patients as training and recruitment advance

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A base 'safe' staffing level is:

- 2 experienced Neurosurgical Critical Care nurses
- 2 rotational Neurosurgical Critical Care nurses
- 2 other Critical Care Nurses

Base patient cover:

- The above staffing level will cover 7 patients
- 3 L3 patients in D Bay L5 ICU
- 4 L2 patients in C bay L5 ICU

Policy Monitoring will be by:

- Continued audit of case cancellation and reasons
- Audit of transferred cases (stage F)
- Audit of declined cases
- Audit of nursing ratios and failures at stage A

A flow chart of actions to be taken (Appendix 2) has been implemented. This paper and flow chart clearly indicates that 7 patients can be safely staffed with current staffing levels. The flow chart explains actions to be taken if the demand is higher. When neurological staffing numbers increase the number of patients cared for will also increase.

Recruitment of registered nurses has been successful and 9 band 5's started in September further recruitment is taking place, in addition 2 neurology skilled ICU nurses started. Nurses who would like to work in ICU can be recruited, experienced nurses with ICU experience is more challenging.

2. Emergency Departments

BSUH has four Emergency departments: RSCH, PRH, Eye Hospital and Children's.

Staff requirements for Emergency Department are calculated using '*NICE guidance for staffing emergency departments',* taking into account RSCH ED is a major trauma centre.

NICE recommend that there is one registered nurse to one cubicle for triage, one registered nurse to 4 cubicles for minors and majors, one registered nurse to 2 cubicles in resus.

RSCH number of cubicles:

- Ambulance triage /Cohort area - 1 triage cubicle
- Resus – 5 cubicles
- Majors 2A – 14 cubicles
- Majors 2B – 12 cubicles
    - (2A and 2B run as two areas due to the geography of the department)
- UCC – 8 rooms and a waiting room
- SSW/CDU – 13 bed spaces- 7 female, 6 male

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Table 4: nurse staffing requirements RSCH ED

Area	Staff required	Comments
Shift leader	1 Band 7	NICE Recommendation
Ambulance triage/ PAT (2^{nd} amb triage nurse)	1 band 6 1 band 5 1 HCA	NICE recommendation 2^{nd} triage nurse (essential to meet turnaround times)Acts as cohort nurse when necessary to release crews
Resus – 5 cubicles	1 band 6 2 band 5	NICE recommendation Ratio 1:2/1:2/1:1
Majors 2A – 14 cubicles	1 band 6 coordinator 4 band 5 nurses 2 HCA's	Often very high acuity and resus step Ratio 1:4/1:4/1:4/1:2
Majors 2B – 12 cubicles	3 band 5 nurses 1 HCA	As above Ratio 1:4
UCC – 8 rooms	1 band 6 Triage Nurse 1 band 7 Triage Nurse – front door 1 band 5 treatment nurse 1 HCA	Vital to have a coordinator to manage this very busy area. ENP's present as manage own workload
SSW/CDU – 13 beds	1 band 6 1 band 5 2 HCA's	Ratio 1:6 / 1: 7
Total per shift	19 trained and 7 HCAs	
Additional staff	Band 7 x 3 • Management nurse • Practice educator • Resus/trauma lead nurse	

This would require 19 trained staff and 7 HCAs per shift 24/7.

This number is essential to:

- Staff all cubicles and assessment areas safely
- To manage a safe and efficient minors and primary care flow
- To meet ambulance turnaround times

Current staffing funded template

Day – 17 trained band 6 HCAs
Night – 16 trained band 5 HCAs

Current template worked but not funded

Additional two staff - cohort nurse and triage UCC
Day – 19 trained band 6 HCAs
Night – 18 trained band 5 HCAs

Additional staff required to meet NICE recommendations:

15.52 wte - £601k

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Princess Royal Emergency Department

PRH number of cubicles:

- Ambulance triage - 1 triage cubicle
- Resus – 3 cubicles
- Cubicles – 10 cubicles
- CDU – 6 bed spaces

Additional rooms: Children's, Gynae, quiet room

Table 5: Nurse staffing requirements PRH ED

Area	Staff required	Comments
Shift leader	1 Band 7	NICE Recommendation
Ambulance triage	1 band 6	NICE recommendation 2nd triage nurse (essential to meet tu times)
Resus - 3	1 band 6 1 band 5	NICE recommendation Ratio 1:2/1:2/1:1
Cubicles - 10	1 band 6 1 band 5 1 HCA's	Ratio 1:4/1:4/1:4/1:2
CDU – 6 beds	1 band 5 1 HCA's	Ratio 1:6
Total per shift	7 trained and 2 HCAs	
Additional staff	Band 7 Management nur	

Current staffing funded template

Day – 7 trained band 2 HCAs
Night – 5 trained band 2 HCAs

Current template worked but not funded

Additional one staff night (Alert support)

Day – 7 trained band 2 HCAs
Night – 6 trained band 2 HCAs

Additional staff required to meet NICE recommendations;

Additional two staff at night, however the activity reduces significantly after midnight and does not often pick up until after 11.00am so a twilight shift should be considered to reflect activity.

Day - 6 trained band 2 HCAs and twilight start midday
Night – 6 trained band 2 HCAs and twilight finish a round midnight.

Additional resources - 5.17 WTE £168k

Summary

Emergency Department RSCH: 15.52 WTE
Emergency Department PRH: 5.17 WTE

3. Care Hours Per Patient Day (CHPPD)

In Lord Carter's final report, Operational productivity and performance in English acute hospitals: unwarranted variations, better planning of staff resources is crucial to improving quality of care, staff productivity and financial control. The Carter Team found there is not a consistent way to record and report staff deployment, meaning that trusts could not measure and then improve on staff productivity.

The report recommended that all Trusts start recording Care Hours per Patient Day (CHPPD) – a single, consistent metric of nursing and healthcare support workers deployment on inpatient wards and units. This metric will enable trusts to have the right staff-mix in the right place at the right time, delivering the right care for patients.

From 1 May 2016, all Trusts were requested to report back monthly CHPPD data to NHS Improvement so that they can start to build a national picture of how nursing staff are deployed. Also enabling trusts to see how their CHPPD relates to other trusts within a speciality and by ward in order to identify how they can improve their staffing.

BSUH has areas where the CHPPD are higher as expected e.g. ITU, HDU. Our medical and surgical wards vary between 6.5 hours and 8.8 hours. The internet was used to search other Trusts' information to date and minimal information was available. It is difficult to do a comparison as Trusts would need a similar profile, e.g. number ICU, Neonatal ICU, renal, number of sites, etc. NHS Choices website and The Model Hospital were searched, but there did not appear to be any information available to enable comparisons.

Western Sussex Hospitals NHS Trust CHPPD have displayed as:

- Registered – average 3.8 to 4.1
- Care – average 2.4- 2.7
- Overall – average 6.2 – 6.8

Table 6: Average Care Hours Per Patient Day

Average Care Hours Patient Day (CHPPD)	Registered Nurses / Midwives	Care staff	Overall
May	6.4	2.8	9.2
June	6.6	2.9	9.5
July	6.6	2.9	9.5
August	6.5	2.9	9.4
September	6.5	2.9	9.3

CHPPD have been recorded since May 2016 so further analysis needs to take place as more data becomes available.

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4. Nursing & Midwifery revalidation

The Nursing & Midwifery Council (NMC) implemented revalidation for all registered staff from 1st April 2016. Nurses and Midwives re-register every three years and revalidation is now the enabler to do this. In preparation for NMC revalidation the Head of Nursing and Midwifery Education facilitated training sessions for 1652 nurses & midwives. In addition revalidation has been discussed at; Professional Improvement Meetings, Nursing & Midwifery Board and regular flyers, newsletters, message of the week have been circulated raising the requirements for NMC Revalidation.

The NMC send registrants several reminders by email starting 6 months before re-registration is required. Revalidation can be completed in advance of re-registration and the template completed 60 days before re-registration is due. Revalidation is required every three years but the majority of nurses pay an annual fee £120 so there continues to be some confusion. All nurses and midwives have been requested by the NMC and BSUH to ensure they sign up for an NMC account on line this enables each registrant to clearly see their revalidation date and annual payment date.

The information required for revalidation is in the following table. Each registrant is required to complete all the work, gather the evidence and take to a confirmer for sign off. The NMC website has very clear guidance of what is required and in what format, the NMC templates have to be used for the majority of information. When revalidating information does not have to be uploaded to the NMC but it needs to be ready as it could be called upon for audit purposes and it is expected to be provided quickly if requested. The Chief Nurse has successfully completed revalidation in September.

Table 7: Revalidation Requirements

	Revalidation	Revalidation requirements
	**Practice hours**	You must practise a minimum of 450 hours (900 hours for those with dual registration) over the three years prior to the renewal of your registration.
	**Continuing professional development**	You must undertake 35 hours of continuing professional development (CPD) relevant to your scope of practice as a nurse or midwife, over the three years prior to the renewal of your registration. 20 hours of CPD must be through participatory learning.
	**Practice-related feedback**	You must obtain five pieces of practice-related feedback over the three years prior to the renewal of your registration.
	**Written reflective accounts**	You must prepare five written reflective accounts on what you learnt from your CPD, practice-related feedback or an event or experience in your practice, and explain how this is relevant to the Code.
	**Reflective discussion**	You must discuss these reflective accounts with another NMC-registered nurse or midwife as part of a reflective discussion.
	**Health and character**	You must provide a health and character declaration, including declaring any cautions or convictions.
	**Professional indemnity arrangement**	You must declare that you have, or will have when practising, appropriate cover under an indemnity arrangement.
	**Confirmation**	You will need to demonstrate to an appropriate person that you have met the revalidation requirements.
	**Keeping a portfolio**	We strongly recommend that you keep evidence that you have met these requirements in a portfolio. This does not have to be an e-portfolio.

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5. Nursing & Midwifery Work Stream

The Nursing and Midwifery work stream has continued to meet weekly and is attended by Deputy / Chief Nurse, Senior HR Business Partner – Workforce Efficiencies, Clinical Lead eRostering, Clinical Lead Nursing Bank, Finance Lead, Senior Analyst Clinical Information Unit. This meeting enables nursing and midwifery to focus on the CIP for 2016/17 and monitor closely N&M spend, plan future changes to reduce costs. The group continues to work closely with the interim financial support teams. The work stream has focused on:

1. Synchronise the start of all in patient rota areas.
2. All rotas to be issued at least 6 weeks in advance of start date.
3. Annual leave must be allocated in hours, not days or weeks.
4. Regularly check, review and amendment of Rotas against KPI data including:
    - Appropriate allocation of Annual Leave
    - Appropriate allocation of Study Leave
    - Allocation of full contracted hours, to name a few
5. Ensure all Rota's are reviewed by the Directorate Lead Nurse/Matron.
6. Review of the Rostering Policy draft document.

5.1 Agency Nursing

Weekly agency data is discussed, number from previous week, what is planned, high user/ high risk areas, further plan for reducing. Monthly statistics Appendix 3**.** The agency nursing use has tended to stay at 120-140 shifts a week. The cost has reduced from £900k in May 2015 to under £200k for the last 5 months. This is at risk as the vacancies have been rising for the last 6 months.

5.2 Acuity and dependency

Acuity and dependency of all patients was measured on wards, (excluding ED, maternity, children's) in June 2016 with the support of McKinsey team.

The safer nursing care tool (SNCT) measures acuity and dependency is based on the critical care patient classification (comprehensive Critical Care, DH 2000). These classifications have been adapted to support measurement across a range of wards/specialities. The tool outlines what aspects of care clarifies the patient as level 0, 1a, 1b, 2 or 3 being the highest dependency. The recording of all patients is taken at the same time every day as it is recognised patients change as does their acuity and dependency. The information is manually collected and then reported onto a spread sheet and analysis undertaken.

The data needs to be undertaken for a minimum of 20 days to gain an average and undertaken 6 monthly.

The data suggests that some ward staffing ratios appear higher than might be expected; this is mostly due to the environment, e.g. nine beds, two registered nurses, ratio 1:4.5. This is the size of the ward – we have to have two nurses for safety, but we would not choose or plan that ratio.

Looking forward it is really important to consider the size of wards / departments as they have staffing implications. A further acuity and dependency exercise will be carried out in December / January 2016/17 then a comparison can be made

5.3 Nursing & Midwifery Consultation

In July 2016 the Nursing & Midwifery consultation commenced the aim of the consultation was to:

- Standardisation of shift start and finish times and breaks across all wards across all sites
- Breaks – no paid breaks
- Families Working Together – avoid potential conflict, Full compliance with declaration of interests
- Rota Management – no changes unless authorised by ward/department manager / deputy
- NMC Registration – accountability of all registrants to maintain registrations – breach of contract if lapses
- Fixed Working Patterns – all to be reviewed to ensure meet the needs of the service
- Minimum Contract Hours – 23 hours (2 x 11.5 hrs)
- Day only and/or Night only Working Contracts – to include some day/night shifts
- Study leave – equity and fairness
- Annual leave – to be taken throughout the year except in exceptional circumstances agreed with line manager
- Agency use – reduce the need
- Overtime – to be agreed prior to working with DLN/Matron

Trust Council and Staff side have been involved. The aim is to close the consultation by the end of November 2016 so new rotas and rostering policy can be in place for the New Year. The above changes will support the wards/departments to work within their budgets.

5.4 International recruitment

In 2015/16 international recruitment took place from Europe and Philippines. Some of the recruitment took longer than we would have liked but in the last financial year, 2015/16 - 249 nurses started employment with BSUH. All nurses undertook a 3 week induction supported by two facilitators. The induction period included;

- Housekeeping; bank accounts, national insurance numbers, introduction to letting agents, registering with GP etc.
- All mandatory and statutory training
- Simulation exercises to support clinical skills and working in the UK.
- The nurse's from the Philippines in addition have had to undertake Adaptation programme / OSCE's.
- After the induction programme nurses then have a local induction in the wards/departments
- Additional free English lessons are available
- The facilitators visit nurses on the wards/departments.
- Each induction programme is evaluated and the induction programme changed to support ideas from nurses

In 2016/17 we have not actively recruited international nurses through agencies to date. Agencies have been making contact as they have nurses who want to work at BSH because their friends do. We have had some nurses start who were recruited in 2015/16 but have been delayed in starting.

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Reviewing the starters and leavers for 2015/16 it was the international nurses starting that helped close the gap otherwise the starters and leavers almost matched. In 2016/17 the leavers are currently higher than the starters. Winter additional capacity plans for 2016/17 require additional staff so discussions are taking place hoping for authorisation to do some further international recruitment.

In country sourcing for non-European nurses was considered but BSUH with its current challenges is not in a position to do this at the moment.

6. Issues raised by Care Quality Commission

The Care Quality Commission (CQC) completed an agreed inspection of BSUH in April 2016. Immediate areas of concerns were noted and immediate action taken. A Section 29 notice was received in May 2016. A quality improvement programme was established and the actions satisfied the CQC in September. In July a quality summit with CQC and wider stakeholders of BSUH as well as the executive team were told that the Trust was going to be put in special measures. A robust quality improvement programme has been established and a lot of work has taken place to improve services for patients and staff.

The CQC report makes reference to the nursing & midwifery staffing issues in the following table:

Table 8: Nursing issues from CQC findings

Page No.	Regulation	Domain	Theme	Requirements	Issue
160	Reg 12 (1) Safe care and treatment	Safe	Patient safety	Should do	The provider should ensure that there are sufficient staff available to offer a full seven-day service across all directorates and support services.
Full review of all nursing and midwifery areas taking place on 11th November 2016; Budgeted templates, nurse to patient ratios, safer staffing, care hours per patient day, acuity and dependency, skill mix					
34 214 159	Reg 18 Staffing	Safe	Safer staffing	Must do	Ensure that there are sufficient numbers of staff with the right competencies, knowledge, qualifications, skills and experience to meet the needs of patients using the service at all times.
Full review of all nursing and midwifery areas taking place on 11th November 2016; Budgeted templates, nurse to patient ratios, safer staffing, care hours per patient day, acuity and dependency, skill mix					
34 214 160	Reg 18 Staffing	Safe	Safer staffing	Must do	Ensure that newly appointed overseas staff have the support and training to ensure their basic competencies before they care for and treat patients.
International induction is reviewed and evaluated monthly. Undertake a review from wards that have received international nurses to understand any additional training required. International facilitators work closely with ward managers and change induction programme as they receive feedback.					
159	Reg 18 Staffing	Safe	Safer staffing	Must do	Implement an action plan to reduce further nurse sickness absence and attrition through a transparent, sustainable programme of engagement that must include a significant and urgent improvement in staff training.
HR Manager – Engagement and Wellbeing appointed and leading on several programmes to promote wellbeing. Appointed Programme Manager, Newly Qualified Practitioners Project – reviewing how newly qualified nurses adapt to					

Page No.	Regulation	Domain	Theme	Requirements	Issue
new roles, why nurses stay, support in place and why they leave					
159	Reg 18 Staffing	Safe	Safer staffing	Must do	Adhere to RCN guidelines that the nurse coordinator remains supernumerary at all times.
Full review of all nursing and midwifery areas taking place on 11th November 2016; Budgeted templates, nurse to patient ratios, safer staffing, care hours per patient day, acuity and dependency, skill mix. Wards all have ward managers in supernumerary roles but they often work clinically especially when short notice sickness occurs					
160	Reg 18 Staffing	Safe	Safer staffing	Should do	Review the nurse staffing levels to ensure all areas are adequately staffed.
Full review of all nursing and midwifery areas taking place on 11th November 2016; Budgeted templates, nurse to patient ratios, safer staffing, care hours per patient day, acuity and dependency, skill mix Reviewing currently vacancy numbers, numbers who have been recruited and considering international recruitment					
	Regulation 29A	Effectiv e	Safer staffing	Warning notice	Review staffing and skills mix on ICU and cardiac ICU
Full review of all nursing and midwifery areas taking place on 11th November 2016; Budgeted templates, nurse to patient ratios, safer staffing, care hours per patient day, acuity and dependency, skill mix					
34 214 159	Reg 18 Staffing	Safe	Safer staffing	Must do	Must undertake an urgent review of staff skill mix in the mixed/neuro ICU unit and this must include an analysis of competencies against patient acuity.
Full review of all nursing and midwifery areas taking place on 11th November 2016; Budgeted templates, nurse to patient ratios, safer staffing, care hours per patient day, acuity and dependency, skill mix See section 1 of this report – ensuring safe care					
159	Reg 18 Staffing	Safe	Safer staffing	Must do	Review and improve medical and nursing cover to meet relevant CEM and RCPCH standards and reflect/review activity rates relating to paediatric for the unit.
In 2013 there was a lot of discussion around children attending PRH A&E and how we ensure safe services for children at PRH A&E in the absence of any on site paediatric medical presence. The Trust has previously made a commitment to maintain an A&E service on the PRH site which did not attempt to formally restrict the service for children. There is an arrangement with SECAMB that all children are brought to RACH if they require ambulance transfer. Local GPs are aware of the scope of paediatric services available at PRH and do not generally refer unwell children to PRH A&E, rather referring to RACH directly Paediatric attendances at PRH A&E are therefore mainly walk-ins. The service is able to deal with minor injuries in otherwise well children effectively. The service is not best placed to manage unwell children although it can of course do so if and when necessary, with urgent transfer to the RACH Maternity and Health Visitors advise parents of this and provide a leaflet explaining emergency services for children Nurses from PRH ED receive training from the Children's ED Nurse Consultant and several have completed a rotation to the RACH ED One of the senior nurses has taken on a coordinator role for children and has made several improvements and supports training and updating at PRH is also in regular communication with the RACH ED and Consultant Nurse for support.					
160	Reg 18 Staffing	Safe	Safer staffing	Should do	Review the workload of the nurse practice educators and assess the impact on their availability for bedside learning and teaching.
Review to be undertaken, practice educators have completed job plans need to be reviewed so confirm bedside teaching time.					

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7. Future plans

Following the publication of the CQC report in August 2016 BSUH is now in special measures and last week it was announced that BSUH is now in financial special measures. There is a need to review in detail all aspects of nursing and midwifery staffing:

- National guidance
- Nurse to patient ratio
- Safer staffing
- Care hours per patient day
- Acuity and dependency
- Vacancies
- Rosters
- Bank and agency usage

On 11th November NHS Improvement are meeting with the Chief Nurse to undertake a detailed workforce review.

Further work needs to be undertaken to review nursing and support staff in all outpatient areas and theatres. To date most of the focus has been on ward areas.

Helen O'Dell
Interim Chief Nurse
August 2016

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Appendix 1

National Guidance

Directorate	National Guidance
Abdominal medicine & surgery	No specific National Guidance
Acute floor	Emergency Department Intensive Care Unit
Cancer	Guidance
Cardiovascular	Cardiac Renal
Children's	Children's Neonatal
Head & Neck	No specific National Guidance
Musculoskeletal	No specific National Guidance
Neurosciences & Stroke	Stroke Rehabilitation
Perioperative	Perioperative
Speciality Medicine	Dementia and Alzheimer's Older people General medicine Respiratory HIV
Women's	Birth rate plus – 2014, Safer Childbirth Minimum Standards for the Organisation and Delivery Care in Labour - 2007 Staffing Obstetric theatres 2009 Staffing In Maternity Units The Kings Fund - 2011 NICE Safe Midwifery Staffing - 2015

Appropriate staffing can be monitored in several ways, safer staffing filled and unfilled shifts, acuity and dependency, bank and agency usage, vacancies, turnover, sickness levels, overtime, patient feedback, patient voice, friends and family test, falls, pressure ulcers, medication errors, complaints, staff feedback on missed breaks, attendance at mandatory training and number of appraisals completed.

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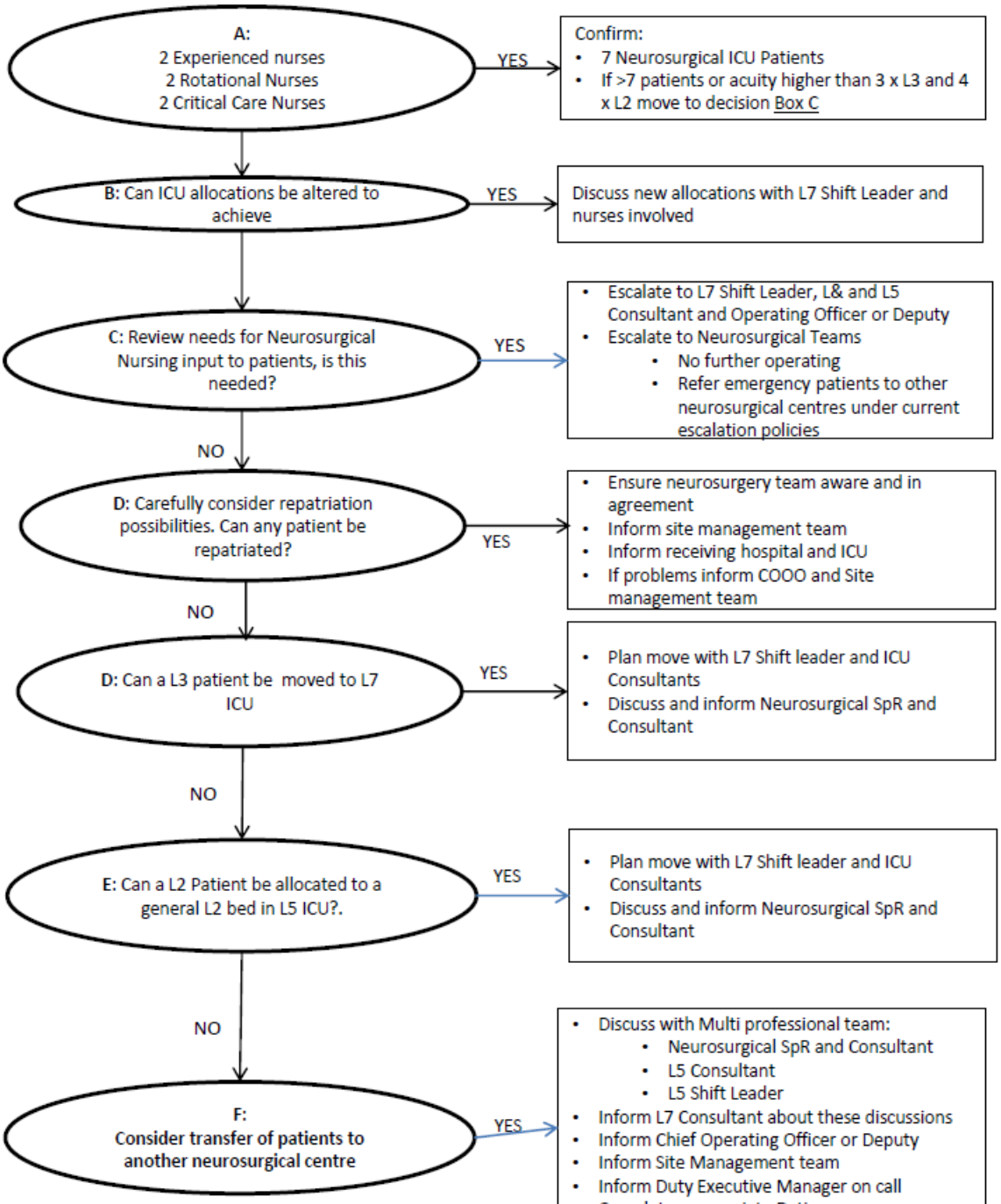
Summary of Directorates and National Guidance

Directorate	Position to National Guidance
Abdominal medicine & surgery	Working within National Guidance
Acute floor (New Directorate Lead Nurse nee opportunity to review)	ICU RSCH and PRH – 39.54 WTE, trained ED RSCH; 18.2 WTE trained staff and 2.6 HCA's ED PRH; 7.8 WTE trained
Cancer	Working within National Guidance
Cardiovascular	Renal Trafford ward -2.6 WTE HCA Cardiac -11.82 trained and untrained
Children's	Children's – 15.7 WTE Neonates – 8.7 WTE
Head & Neck	Working within National Guidance
Musculoskeletal	Working within National Guidance
Neurosciences & Stroke	Neurosciences -29.73 WTE trained and untrained
Perioperative	Working within National Guidance
Speciality Medicine	Working within National Guidance Catherine James Egremont - = 7.8wte trained
Women's	Working within National Guidance

Appendix 2



ICU **Neurosurgical Staffing Policy August 2016 –Boyd, ratified** by SMT 5th Sept 2016

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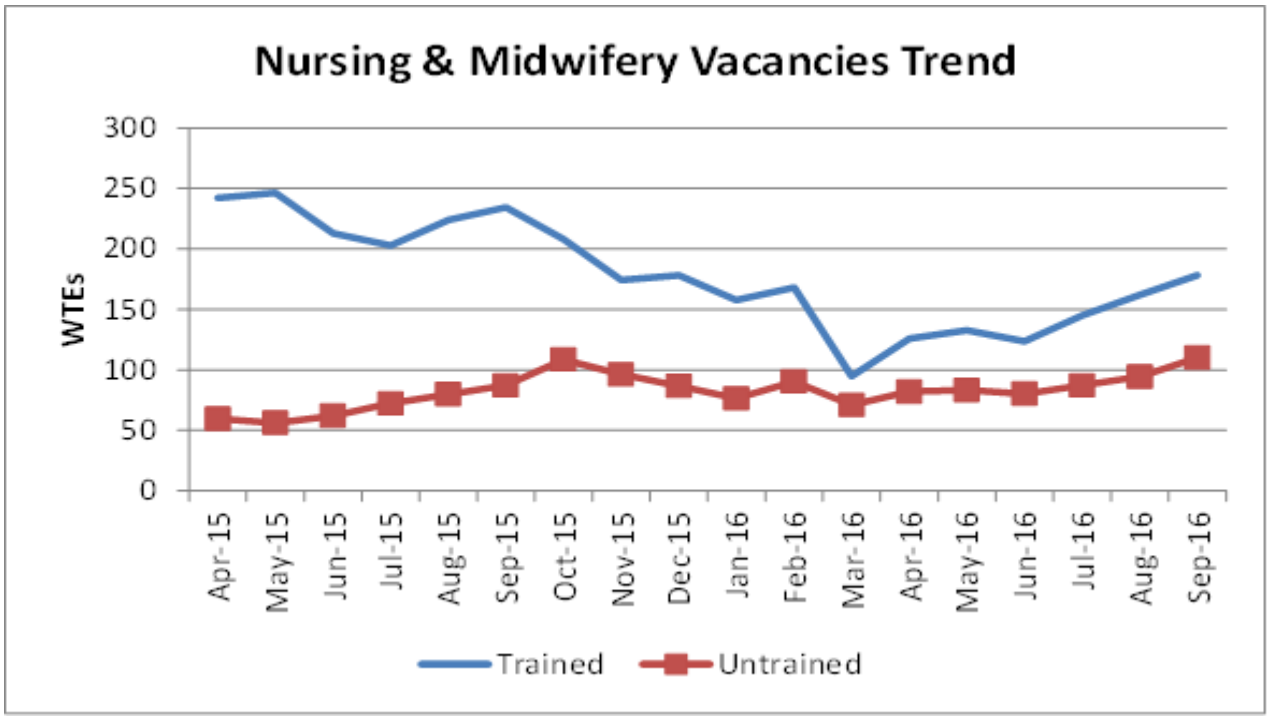
Appendix 3

Monthly Monitoring of Nursing & Midwifery Workforce

Nursing & Midwifery Vacancies

Nursing & Midwifery Vacancies WTE	Dec 2015	Jan 2016	Feb 2016	March 2016	April 2016	May 2016	June 2016	July 2016	Aug 2016	Sept 2016
Nursing & Midwifery	178	158	168	95	126	133	124	145	162	178
Non-registered	87	77	90	71	82	83	80	87	94	110
Total WTE	265	235	258	166	208	216	204	232	256	288

Nursing & Midwifery Vacancies Trend



Both Registered and non-registered vacancies increased in September as budget increased by 14.1 WTE and leavers exceeded joiners by 17.9 WTE.

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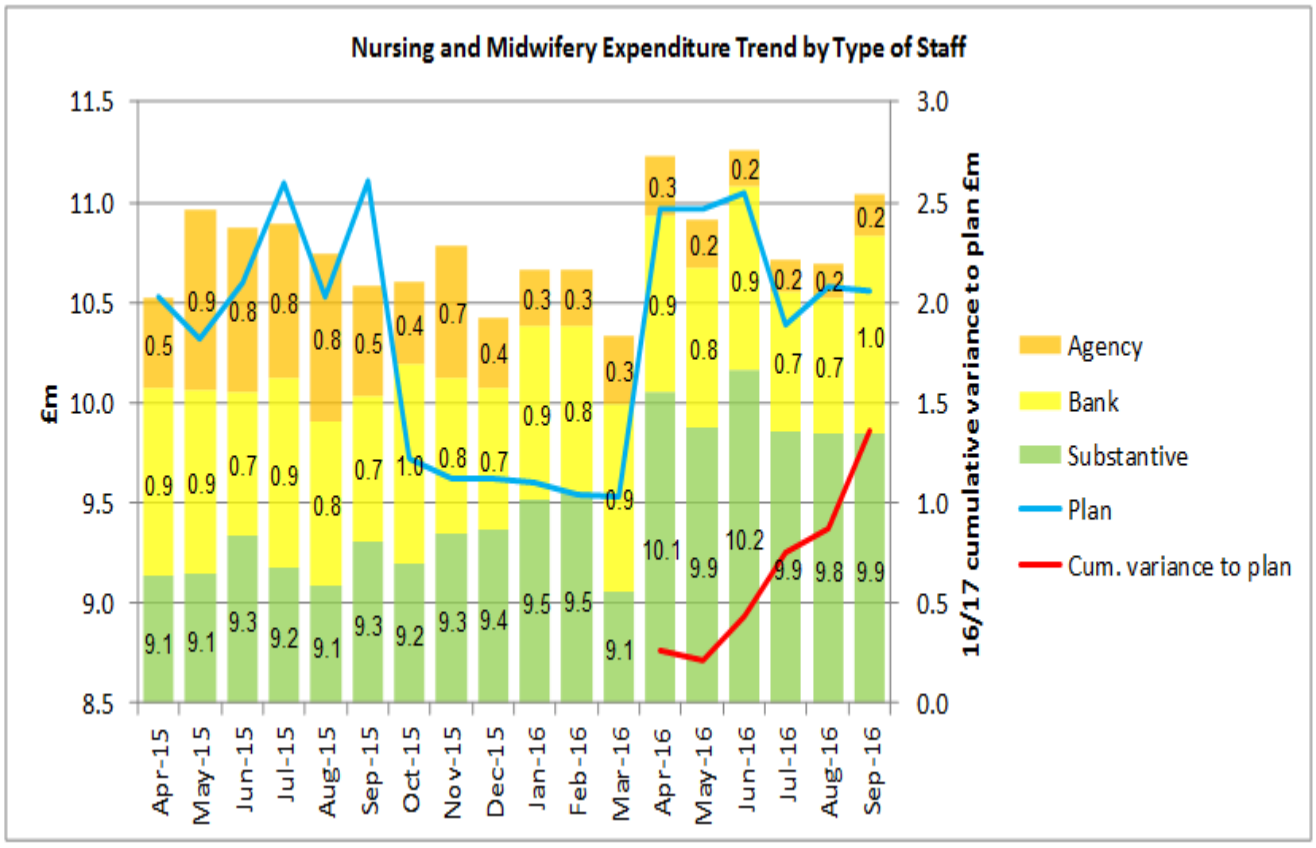
Substantive, Bank and Agency Spend 2015/16



Bank use did increase by 11wte in-month, much of the expenditure increase relates to August actual costs, paid September, being greater than was estimated.

The year-to-date over spend increased to £1.36m.

Nursing and Midwifery staffing fill rates (%)

2014	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
Day								
Trained	92	92	93	92	91	92	93	90
Un-trained	90	91	90	92	95	93	92	91
Night								
Trained	95	94	94	93	93	95	94	92
Un-trained	104	106	109	105	106	106	106	102

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2015	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
Day												
Trained	92	89	91	92	93	94	91	92	90	93	94	93
Un-trained	89	91	95	94	98	97	95	96	98	96	95	99
Night												
Trained	94	92	93	93	95	96	94	94	93	92	93	95
Un-trained	106	106	109	104	107	105	106	108	107	106	112	113

2016 / 17	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Day												
Registered	93	95	92	92	92	92						
Non-Registered	97	99	104	96	97	97						
Night												
Registered	95	96	95	93	94	89						
Non-Registered	115	116	118	114	114	116						

Table 3: Filled and Unfilled Hours 2015/16

	May 15	Jun 15	Jul 15	Aug 15	Sept 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	March 16
Total number of actual staff hours (includes registered and un-registered)	221,384	217,149	228,012	248,634	241,353	252,200	242,145	255,832	256,823	239,958	254114
%	96	96	95	95	94	95	96	97	95.8	95.1	94.5
Total number of hours un-filled (includes registered and un-registered)	9,408	8,176	13,043	12,929	14713	14,191	10,453	7,597	11,133	12,462	14893
%	4	4	5	5	6	5	4	3	4.2	4.9	5.5
Total Hours	230,792	225,325	241,055	261,563	256,066	266,391	252,598	263,429	267,956	252,420	269,007

	April 16	May 16	Jun 16	Jul 16	Aug 16	Sept 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	March 17
Total number of actual staff hours (includes registered and un-registered)	251326	261955	253063	257258	259112	247145						
%	96.8	98.3	98.2	96.8	96.1	95						
Total number of hours un-filled (includes registered and un-registered)	8210	4405	4566	10156	10509	13650						
%	3.2	1.7	1.8	3.8	3.9	5.1						
Total Hours	259,536	266,360	257,629	267,414	269,620	260,794						

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Areas with fill rates of 80% or less

2015	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
No of wards 80% or less	13	16	7	16	9	7	5	7	10	5	4	6
2016	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**
No of wards 80% or less	8	10	5	1	7	5	8	8	7			

Starters and leavers

Registered Nurses (Band 5,6,7)	Apr-15	May-1	Jun-15	Jul-15	Aug-1	Sep-15	Oct-15	Nov-1	Dec-15	Jan-16	Feb-16	Mar-1	
Starters Local/ National	30	23	35	31	24	23	27	52	11	21	21	14	312
International starters	7	41	12	10	9	27	22	21	0	32	38	30	249
Leavers	25	26	21	20	45	17	27	42	25	19	17	31	315

Registered Nurses (Band 5,6,7)	Apr-16	May-1	Jun-1	Jul-1	Aug-1	Sep-1	Oct-16	Nov-1	Dec-1	Jan-1	Feb-1	Mar-1	TOTAL to date
Starters Local/ National	26	19	18	10	20	22							115
International starters	11	4	5	5	7	3							35
Leavers	26	20	26	32	35	32							171

There are 55 band 5 nurses in the recruitment process and 105 HCAs.

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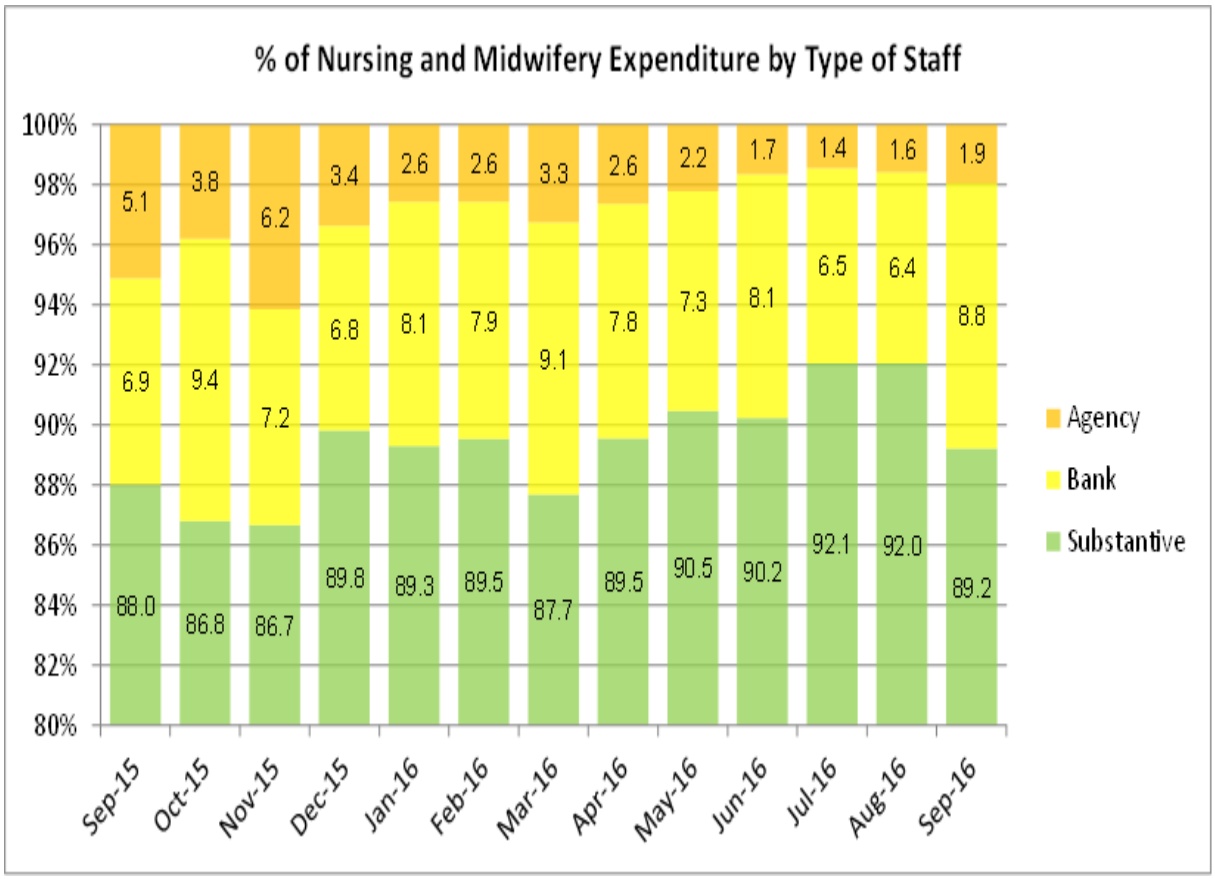
% of Nursing and Midwifery Expenditure



Agency expenditure increased in September by £45k up to £215k, 1.9% of the total.

The increase in Bank costs means they represented 8.8% of expenditure.

An issue has also been identified of some Bank staff costs being coded as Substantive costs; this means Bank costs are understated by £345k year-to-date. Amendments are being made in ESR to resolve this problem.

Numbers of Nurses & Midwives revalidating 206/17

	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Numbers of Nurses & Midwives	127	286	145	193	42	237	88	83	63	49	65	83
Lapsed	1	0	2	2	0	7						