

REPORT TO:	CLINICAL EXECUTIVE MANAGEMENT GROUP
DATE:	15 AUGUST 2018
SUBJECT:	WARD ESTABLISHMENT REVIEW MAY 2018
BOARD SPONSOR:	CHIEF NURSE AND DIRECTOR OF QUALITY
PAPER AUTHOR:	ASSOCIATE CHIEF NURSE
PURPOSE:	Discussion
APPENDICES	Appendix 1. Compliance with NQB / NHSI expectations on safe staffing Appendix 2. Current funded establishments and staff in post

BACKGROUND AND EXECUTIVE SUMMARY

Annual ward staffing reviews are required and are reported to the Strategic Workforce Committee. This review took place in May 2018.

The findings from the review are:

1. The NHS Quality Board (2016) and NHS Improvement (2018) requirements in providing assurance on safe staffing are currently being met;
2. To improve alignment of staffing required to demand the implementation of Safe Care was completed in January 2018 and is now embedded;
3. The impact of previous investment into ward staffing has increased WTE per bed across most areas;
4. Average skill mix is slightly lower in most specialties since the previous review. This is due to the impact of associate practitioners and is reflected in a slightly reduced skill mix over the last three years in most specialties where the role has been implemented to support specific patient pathways and reduce the impact of registered nurse vacancies. The over-recruitment of support workers where registered nurse vacancies are high has also contributed to the fall in skill mix;
5. The vacancy rate across all wards is 13.9%, an increase from the previous review (10.28%). Registered nurse vacancies in wards are 226 WTE, an increase from 148 WTE in the previous review, with the majority at band 5. Support worker vacancies are 39 WTE, similar to the previous review (34 WTE);
6. Overall average sickness absence rate across all 49 wards at 4.58% in May-18 has remained similar over the last two years (4.47% in May-16, 4.40% in May-17). During May-18 Registered Nurse sickness was 3.57% and HCA sickness was 6.11%.
7. The absence associated with maternity leave in May-18 across the 49 wards is significant, at 41 WTE (2.09%), similar to May-17 (1.96%). Ward managers are able to recruit to posts and this has significantly reduced the impact of maternity leave;
8. Overall turnover of registered nurses and midwives has increased from 13.0% in 2016/17 to 13.6% in 2017/18. The turnover of healthcare assistants remains stable at 13.2%;
9. Improvement in roster quality has been sustained with the average achievement of % time clinically effective (% time worked) across all the wards reviewed, within E-Rostering for May-18 at 77.7%, similar to May-17

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- (78.7%). Most (38 out of 49) wards achieved more than the optimum 75%;
10. Details and summary of planned and actual staffing on a shift-by-shift basis, continues to be published monthly. Reported data is derived from the E-Rostering and NHS-Professionals systems and aggregated fill rates in May-18 were 101.7% and reflects the national trend in performance over time. Low fill rates were seen on several wards due to a combination of high sickness, maternity leave and vacancies (Minster, Coronary Care QE, Treble, Critical Care K&C, Kingston, Richard Stevens and Fordwich stroke units, Kings C2 and Birchington).
 11. Work to ensure that roster templates closely reflect the budgeted establishments and include shifts necessary for additional beds has supported the increased fill rates seen over time. However, the bank line within ward budgets is not reflected in roster templates, which has the effect of slight over-inflation of %filled hours against planned. Since the previous review 15 wards have converted the bank line in to funded establishment but most ward budgets (29 out of 49) have not, which represents over 20 WTE not included in roster templates.
 12. Most ward managers reported an increased move from 7.5 to 12 hour shift patterns, thereby reducing staffing handover overlap times, to provide greater staffing numbers on each shift.
 13. The application of modelling methods has identified that there is alignment between current funded establishments and modelling tools applied (Professional Judgement, Hurst and the Shelford SNCT) for some wards. However, acuity and dependency appeared higher in May-18 than in Nov-17 for some wards not reflecting the expected variation in nursing workload between winter and spring. There has been an increase in acuity dependency over time on some wards.

Evaluation of the triangulation of the modelling methods is summarised as:

CDUs	Current establishments show alignment to Shelford (SafeCare) and Hurst but less so to Professional Judgement (PJ). PJ at QEQMH is higher than current due to the need to staff contingency beds. <u>Consideration should be made to providing substantive staffing for these contingency beds to enable a more reliable resource for provision of safe and effective care.</u>
Medical wards	<p>Alignment to PJ and Hurst for most wards but establishments below that are suggested by Shelford on CJ, Minster, Sandwich Bay, St Margarets, Invicta, Mount McMaster, CM1 and Quex where acuity and dependency indicates higher staffing than currently in the establishment.</p> <p>PJ and Shelford indicate higher staffing requirement than actual, particularly CJ and Invicta which report 7-8 patients per day requiring specialling. Shelford for Mt McMaster is capturing workload of additional beds.</p> <p><u>Funded establishments may require adjustment on Minster, CM1 and St Margarets due to increased acuity and dependency and on Mount McMaster to fund contingency beds. A resource to support consistency in specialling should be developed.</u></p>
Stroke Units	Alignment for all wards (*SEC Network Stroke Model). Shelford does not capture stroke thrombolysis nursing work outside the ward. Wide variation in the use of 1:1 specials with significantly

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	higher on Fordwich. <u>Staffing appears appropriate but a resource to support consistency in specialling should be developed.</u>
HCOOP/Frailty	PJ and Shelford indicate higher staffing requirement but no increase in acuity & dependency. High need for specialling on Harbeldown but not St Augustines. <u>A resource to support consistency in specialling should be developed.</u>
Coronary Care Units	Alignment of modelling methods except Shelford does not capture the intensity of pPCI work on the Bartholomew Unit. <u>Staffing appears appropriate.</u>
Renal & Haematology	Alignment on both wards with Professional Judgement and Hurst but less so with Shelford as it does not fully capture the work of the acute dialysis or day case beds on Marlowe. <u>Staffing appears appropriate.</u>
Gynaecology	Alignment of PJ at WHH but less so on Birchington due to contingency beds. Hurst and Shelford do not capture all activity, only inpatient beds. <u>Consideration should be made to providing substantive staffing for these contingency beds to enable a more reliable resource for provision of safe and effective care.</u>
Paediatrics	*RCN and Professional Judgement suggest higher establishments to cover day surgery & relocated outpatients particularly on Padua. Shelford is not relevant to Paediatrics.
Surgery	Alignment of modelling methods for most wards. Increase in acuity & dependency on CSF linked to heavily dependent patients requiring specialling. Shelford does not capture trolley activity on Clarke & Kent nor outpatient activity on Rotary. <u>A resource to support consistency in specialling should be developed.</u>
Trauma and Orthopaedics	Some alignment of modelling methods. Increase in acuity & dependency on Seabathing reflecting high numbers of patients identified as requiring 1:1 specialling. Shelford does not capture high throughput on KC2. <u>A resource to support consistency in specialling should be developed.</u>
Emergency departments (EDs)	A business case for the Rapid Assessment and Treatment area has been recently approved. A two phase workforce plan is currently underway to match services to demand and assess workforce needs against new models of care.
Neonatal services (NICU)	A business case is under development in response to the Oct-17 Neonatal Services Peer Review for a phased improvement to staffing.
Maternity services	A further Birth Rate Plus Review is underway. Sickness and vacancies rates are improving and midwife to birth ratio and 1:1 care in labour is being sustained.

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IDENTIFIED RISKS AND MANAGEMENT ACTIONS:	Continued vacancy factor and reliance on temporary staffing will require further innovative recruitment approaches to enable recruitment ahead of turnover.
LINKS TO STRATEGIC OBJECTIVES:	Patients: Help all patients take control of their own health. People: Identify, recruit, educate and develop talented staff. Provision: Provide the services people need and do it well.
LINKS TO STRATEGIC OR CORPORATE RISK REGISTER	SRR8 Ability to attract, recruit and retain high calibre staff to the Trust.
RESOURCE IMPLICATIONS:	Adequate staffing levels impact on the achievement of the required performance indicators, non-compliance with contractual obligations attract financial penalties. This includes 2018/19 CQUINs which are valued at 2.5% of actual outturn, or around £4.8M.
COMMITTEES WHO HAVE CONSIDERED THIS REPORT	Divisional Heads of Nursing meeting.
PRIVACY IMPACT ASSESSMENT: NO	EQUALITY IMPACT ASSESSMENT: NO

RECOMMENDATIONS AND ACTION REQUIRED:

1. Closely monitor acuity and dependency trends monthly particularly on medical wards where higher staffing levels may be required, to determine appropriateness of current staffing;
2. Undertake bi-monthly detailed analysis of acuity and dependency to provide assurance on reliability of data and support consistency in the use of the Shelford tool (SafeCare);
3. Develop and implement a specialising policy to provide clarity in the application of criteria and promote consistency in approach;
4. Introduce a nursing pool of HCAs to improve support to wards for patients who require specialising and explore the feasibility of expanding this to include registered nurses;
5. Progress the work programme within the 2018/19 recruitment strategy to drive recruitment and retention planning against current and expected vacancies to support the agency reduction programme;
6. Plan further implementation of the Nursing Associate role to support safe staffing;
7. Plan re-skill mixing on a selection of appropriate wards to incorporate a wider range of roles and skills appropriate to the patient group.
8. Recruit to the additional resource approved in the ED business case and implement the workforce plan.
9. Complete the business case for NICU and submit for approval.
10. Participate in the Birth Rate Plus Review for maternity services.

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1. INTRODUCTION

Regular ward staffing reviews have been undertaken since 2007/08 to ensure that the ward nursing establishments provide an appropriate staffing level and skill-mix to support the delivery of safe and effective care to patients. Ward staffing reviews now take place annually, with a six monthly update, to fulfil the requirements set out by the NHS Quality Board.

In January 2018 NHS Improvement (NHSI) published updated guidance, building on the 2016 guidance, to provide an updated safe staffing improvement resource.

This report provides:

1. An overview of the updated national guidance;
2. A progress update on the recommendations from the previous ward staffing review update (Nov-17) reported to the Strategic Workforce Committee in February 2018;
3. The May 2018 review including all wards across the Trust including:

UC<C	Medicine Clinical Decision Units Coronary Care Stroke Health Care of the Older Person (HCOOP) / Frailty
Surgical Services	Surgery Trauma & Orthopaedics Critical Care
Specialist Services	Renal Haematology / Oncology Gynaecology Paediatrics Midwifery Neonatal Intensive Care (NICU) Emergency Departments

This paper provides information on the findings of the review and outlines a number of recommendations to the Board of Directors.

2. NATIONAL QUALITY BOARD AND NHS IMPROVEMENT EXPECTATIONS ON WARD STAFFING

2.1 The National Quality Board (NQB) publication *Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time: Safe, sustainable and productive staffing (2016)* outlines the expectations and framework within which decisions on safe and sustainable staffing should be made to support the delivery of safe, effective, caring, responsive and well-led care on a sustainable basis.

The NHSI resource *Safe, sustainable and productive staffing (2018)* underpins the NQB expectations and framework and focuses on nurse staffing within adult inpatient

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wards in acute hospitals and maternity services and is aligned with Commitment 9 of *Leading change, adding value*: 'We will have the right staff in the right places and at the right time' (NHSE 2016). It also builds on National Institute for Health and Excellence (NICE) guidelines on safe staffing and is informed by NICE's comprehensive evidence reviews focusing specifically on staffing levels and outcomes, flexible staffing and shift work. More recently (June 2018) resources have been published for urgent and emergency care, children's and young people's inpatient wards and neonatal care.

2.2 The NHSI recommendations include:

- 2.2.1 Boards should carry out a strategic staffing review at least annually, aligned to the operational planning process, or more frequently if changes to services are planned or workforce concerns are identified. Reviews should include the use of a triangulated approach (i.e the use of evidence-based tools, professional judgement and benchmarking with peers as well as national guidelines). NHSI do not indicate the requirement for a six monthly update to boards.

Review of planned ward establishments has taken place since the previous Nov-17 update to inform required staffing levels in relation to:

- The movement of Cambridge K (combined CCU and cardiology ward) to the Bartholomew unit in May/June 2018;
- The proposed merger of stroke rehabilitation and neurology at K&CH and;
- The planned creation of a 'hot floor' at QEQMh following the move of Quex ward to the Minster footprint.

The last full review was undertaken in May 2017 and an update was reported to the Strategic Workforce Committee in February 2018.

- 2.2.2 On a monthly basis, actual staffing data should be compared with expected staffing and reviewed alongside quality of care, patient safety, and patient and staff experience data. This will ensure that improvements are learned from and celebrated, and areas of emerging concern are identified and addressed promptly.

Actual against planned staffing hours, by inpatient area, is reported to the Board as part of the monthly Integrated Performance report and is incorporated within the quality heatmap. This report is accessible to patients and the public on a dedicated area of the Trust website and is published on the relevant hospital profile on NHS Choices.

Current compliance against NQB (2016) and NHSI (2018) expectations is summarised in Appendix 1.

A suite of specialty improvement resources, detailed in figure 1, which underpin the overarching NQB staffing resource have been developed with NHSI and were published during 2018. This review follows the guidance within these resources.

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Figure 1. NQB Improvement Resources

Specialty Improvement Resource	Draft publication date	Final version publication date
Adult Inpatient wards in acute hospitals	June 2017	30 January 2018
Urgent and Emergency Care	November 2017	27 June 2018
Maternity Services	June 2017	30 January 2018
Children and Young People's Inpatient wards in acute hospitals	November 2017	27 June 2018
Neonatal Care	November 2017	27 June 2018

3. PROGRESS IN IMPLEMENTING PRIORITIES IDENTIFIED FROM THE PREVIOUS REVIEW

1. The Healthroster SafeCare system was implemented from June-17 to Jan-18, is now embedded and provides a live view of patient acuity dependency and skill mix linked to the Healthroster to enable optimised deployment of staff. Additional training and competence assessment has been undertaken with nurses who have access to SafeCare to maximise consistency and reliability of data.
2. High turnover of staff and increased activity within the Emergency Departments (EDs) required further work to review required staffing. Progress of this work is included in this paper.
3. Phased recruitment into the Neonatal services (NICU) investment was suspended pending further review of staffing requirements following the Neonatal Services Peer Review undertaken in October 2017. Further work has been undertaken to review staffing and is included in this paper.
4. Further work has been undertaken to review Maternity services staffing following the Birthrate Plus Review undertaken in 2016, and is included in this paper.
5. A Recruitment Strategy has been implemented and the work programme is progressing. Further detail is included in this paper.

4. CURRENT WARD ESTABLISHMENTS

A summary of current funded establishments and staff in post is provided in Appendix 2. This includes the detail, by ward, of funded registered nurse, support worker, administrative support posts and actual staff in post at May-18.

The structure of most (60%) ward budgets (29 out of the 49 reviewed) still includes a separate bank line which provides a resource as part of the funded WTE to manage peaks and troughs in activity and flexible replacement for sickness. Most ward managers have chosen not to convert an element of this resource to substantive posts due to the flexibility it provides. Converting this budget into WTE represents an additional 20.59 WTE across the 49 wards, and it is this 'uplifted' total funded establishment that has been used as the baseline when making comparisons with the modelling methods within this review. However, operationally this component of the budget is not included in the establishment for E-Rostering and is utilised by requesting additional shifts within the system to provide additional cover for long-term sick leave.

Since the previous review 15 wards have formerly converted the bank line into funded establishment, which has contributed to an increase in the vacancy factor.

Additional average allowance or percentage headroom within funded establishments is 22% which includes a 3% allowance for sickness, 30 days annual leave plus bank

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holidays and study leave of around 4 days per year. This is in line with NHSI (2018) recommendations.

5. SKILL MIX AND WHOLE TIME EQUIVALENT PER BED (WTE)

Average skill mix is represented including those providing direct patient care only, excludes administrative staff (ward clerk and ward manager assistant roles) and ranges from 53/47 in T+O to 77/23 in Paediatrics (% registered nurses to support workers). Most specialties have seen a reduction in average skill mix since the previous review, shown in figure 2. Contributing factors include:

- The impact of associate practitioners is reflected in a slightly reduced skill mix in stroke, orthopaedic and some medical wards, over time, where the role has been implemented to support specific patient pathways and reduce the impact of registered nurse vacancies. Associate Practitioners are highly trained support staff who undertake a Foundation Degree, equivalent to diploma level, and are able to undertake much of the work previously within the domain of the registered nurse.
- The Coronary care average relates to only one unit since the temporary move of Taylor ward from K&CH and the combination of the WHH CCU into the new Bartholomew unit since Spring 2018.
- The fall in the stroke unit average skill mix reflects the movement of the thrombolysis nurses away from Kingston ward at K&CH following the sites changes that took place in June-17.
- The over-recruitment of support workers to support wards where registered nurse vacancies are high (Minster, Oxford, Deal, Invicta, Treble, Mount McMaster, Kingston, St Augustines, both CDUs and EDs, Cheerful Sparrows female, Kent, Kings D, Seabathing and Birchington).

Figure 2. Skill-mix including registered nurses / support staff

Skill-mix - Direct patient care							
Specialty	Mar-14	Oct-14	Apr-15	Oct-15	May-16	May-17	May-18
Medical	59/41	59/41	59/41	59/41	58/42	59/41	58/42
CDU	69/31	67/33	70/30	69/31	66/34	66/34	66/34
CCU	82/18	82/18	83/17	83/17	83/17	83/17	66/34
Stroke	63/37	59/41	57/43	58/42	58/42	58/42	55/43
Acute frailty	57/43	57/43	58/42	56/44	57/43	56/44	55/45
Surgery	60/40	59/41	59/41	59/41	60/40	59/41	54/46
T+O	58/42	57/43	57/43	57/43	57/43	57/43	53/47
Gynaecology	65/35	65/35	65/35	63/37	67/33	67/33	65/35
Paediatrics	80/20	77/23	77/23	80/20	80/20	80/20	77/23

The impact of previous investment into ward staffing has increased WTE per bed across most areas, seen in Figure 3.

Figure 3. Average ward staffing WTE per bed from 2007 to 2018

Average WTE per bed												
Specialty	2007/08	2008/09	2011/12	2012/13	Mar-14	Oct-14	Apr-15	Oct-15	May-16	May-17	May-18	Hurst
Medical	1.14	1.19	1.28	1.33	1.29	1.29	1.34	1.36	1.36	1.38	1.41	1.43
CDU	NR	NR	NR	2.18	1.54	1.92	1.61	1.81	1.87	1.75	2.04	1.94
CCU	2.2	2.2	2.42	2.76	2.62	2.68	2.69	2.56	2.54	2.54	1.91	2.00
Stroke	1.19	1.52	1.57	1.75	1.79	1.84	1.85	1.84	1.84	1.84	1.81	2.04
HCOOP/frailty	1.1	1.18	1.29	1.47	1.33	1.34	1.51	1.38	1.46	1.45	1.37	1.34
Surgery	1.09	1.28	1.46	1.38	1.45	1.5	1.57	1.53	1.50	1.50	1.54	1.43
T+O	1.12	1.17	1.21	1.32	1.36	1.37	1.40	1.41	1.41	1.42	1.47	1.42
Renal				1.5	1.81	1.81	1.83	1.91	1.90	2.09	1.88	1.71
Haematology				1.38	2.09	2.09	2.08	2.06	2.03	2.20	2.27	1.82
Gynaecology				1.96	1.93	1.93	2.02	1.97	2.09	2.31	2.18	1.53

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6. WORKFORCE METRICS

The total budgeted establishment across the wards reviewed has increased over time, seen in Figure 5, following previous investment into ward staffing. The impact of current vacancy levels, sickness and maternity leave across the 49 wards is 20.57%, an increase from 16.75% in May-17, summarised in figure 4.

Figure 4. Wards staffing vacancy, sickness and maternity leave May-18

Workforce indicators								
	Dec-12	Mar-14	Oct-14	Apr-15	Oct-15	May-16	May-17	May-18
Total budgeted establishment across 46 wards (WTE)	1514.90	1514.01	*1620.02	1680.86	1728.21	1746.45	1774.64	*1960.74
Registered Nursing vacancies (WTE)	44.00	73.88	37.66	124.71	120.58	91.43	148.06	226.77
HCA and other support staff vacancies (WTE)	28.00	5.13	36.44	12.55	38.72	32.9	34.48	39.6
Vacancy (%)	4.75	5.21	6.08	8.16	9.20	9.00	10.28	13.90
Sickness (%)	4.96	4.90	4.60	5.15	3.80	4.47	4.51	4.58
Maternity leave (%)	3.28	2.38	2.53	3.89	3.00	2.01	1.96	2.09
* Oct-14 - includes 82.9 wte ECC/CDU which was not included in previous reviews								
* May-18 - includes 213.8 wte ED which was not included in previous reviews								

The majority of maternity leave is recruited to, in accordance with guidance issued to ward managers, but further work is required to ensure that the process of recruitment is undertaken in a timely fashion to ensure availability of replacement staff to reduce gaps.

6.1 Vacancies

The vacancy rate across all wards is 13.9%, an increase from the previous review (10.28%). Registered nurse vacancies in wards are 226 WTE, an increase from 148 WTE in the previous review, with the majority at band 5. Support worker vacancies are 39 WTE, similar to the previous review (34 WTE).

Several issues have contributed to the rise in vacancies in EKHUFT:

- There is a national shortage of registered nurses;
- The shortage of candidates with the right skills and experience has created a competitive market and EKHUFT also suffers from a unique geographical position on a peninsula with 'fast transport links' into London;
- We compete with the London Healthcare Market and Private Healthcare Providers and other NHS providers in areas where the NHS High Cost Area Supplement (London Weighting) applies;
- There was a gradual fall in % newly qualified nurses who take up their first post within EKHUFT since 2013 with only 55% of the Canterbury Christ Church University (CCCU) newly qualified cohort taking up a band 5 post within EKHUFT in Apr-17. This is due to many factors including relocation back to home and taking up posts in London. Following feedback from students, cohort recruitment one year before qualifying and rotational opportunities are being created to improve retention and some improvement has been seen with 72% of the Apr-18 cohort taking up their first post within EKHUFT;

It is a critical time for the nursing workforce

- There has been a 12% fall in the numbers of applications to undertake nurse training since 2017 and an overall decline of 32% since March 2016, the last year students received bursary support;
- The number of nurses on the UK Nursing and Midwifery Council Register is lower than last year largely due to a decline in EU nurses joining;

- There have been delays in the arrival of overseas nurses recruited in 2016/17 due to challenges in achieving the required IELTS level 7 English language qualification.

A nursing and midwifery workforce recruitment strategy was implemented in 2017/18 and refreshed for 2018/19 and the work programme is progressing. This includes:

- Increasing local open days to 5 per site per year which, although attracts low numbers of registered nurses, is a useful method of recruiting large numbers of support workers;
- Updating the Return to Practice process to enable placements without the need for employment as a support worker and this has led to a rise in applicants. 3 are currently completing the programme and a further 3 will commence in the autumn;
- Small numbers of overseas nurses from the 2016/17 India and Phillipines campaigns are joining EKHUFT in 2018/19 following successful achievement of the IELTS level 7 standard (5 from India and 20 from the Phillipines. 11 have already commenced in post and 5 have successfully achieved the NMC OSCE requirement and are awaiting their NMC PIN no.);
- A rigorous OSCE preparation programme is in place to support overseas nurses to successfully undertake the OSCE;
- 48 of our support workers have been identified as overseas nurses and a programme of support is planned to enable them to gain registration with the NMC, starting with tailored support, commencing in October, to undertake the Occupational English tests as an alternative to IELTS.
- A recruitment event was undertaken in Australia in June 2018 and 39 offers were made although 7 have since withdrawn;
- A marketing project is due to commence in August 2018 focused on attracting more nurses to EKHUFT
- EKHUFT are leading the East Kent partnership, along with Kent Community Healthcare Trust, in the early implementation of the Nursing Associate role with 13 trainees due to complete the programme in March 2019. From 2018/19 the programme is funded through the apprenticeship levy. The procurement for provider selection was completed in April 2018 and the contract awarded to Canterbury Christ Church University. A cohort of 10 apprentices commenced in April and a further 10 have been recruited for a September start.

6.2 Sickness absence

ESR data demonstrates that average sickness absence rate across the wards at 4.58% in May-18 has remained similar over the last two years (4.47% in May-16, 4.40% in May-17). During May-18 Registered Nurse sickness was 3.57% and HCA sickness was 6.11%.

Average rates in excess of 5% were seen in some stroke, medical, frailty, surgical and orthopaedic wards with higher rates in excess of 10% on three wards. This reflects the high physical and emotional demands of ward work in some areas, particularly for HCAs, and also significant opportunity for further improvement.

6.3 Maternity leave

The absence associated with maternity leave in May-18 across the 49 wards is significant, at 41 WTE (2.09%), similar to May-17 (1.96%). Following investment into ward staffing this element of absence is now recruited to thus reducing the impact of maternity leave. The majority of maternity leave is recruited to, in accordance with guidance issued to ward managers, but further work is required to ensure that the process of recruitment is undertaken in a timely fashion to ensure availability of

replacement staff to reduce gaps. Ward managers report that this has had a very positive impact.

6.4 Staff turnover

Turnover figures include only staff who have left the employment of the organisation and do not include staff who are internally promoted. ESR data (excluding TUPE staff) demonstrates that our overall turnover of registered nurses and midwives has increased during 2017/18 to 13.6%, seen in figure 5. The turnover of healthcare assistants has remained similar since 2015/16 at 13.1%. The combined turnover of registered nurses / midwives and support staff was 13.3% during 2017/18.

Figure 5. Average turnover of nursing, midwifery and care staff 2011 to 2018

	Turnover (%)						
	2011	2012	2013/14	2014/15	2015/16	2016/17	2017/18
Nursing & Midwifery	7.5	9.5	11.2	12.8	8.9	13	13.6
HCA and other support staff	12.6	10.6	10.6	14.2	12.8	13.2	13.1

7. Roster performance, actual against planned filled hours and Care Hours per Patient Day (CHPPD)

7.1 Roster performance

Improvement in roster quality has been sustained with the average achievement of % time clinically effective (% time worked) across all the wards reviewed, within E-Rostering for May-18 at 77.7%, similar to May-17 (78.7%), from just 72% In Oct-15 following implementation of the Healthroster system. A large proportion of wards (38 out of 49) wards achieved more than the optimum 75%.

Meeting the 75% time worked measure requires effective annual leave planning to ensure it is evenly spread, effective sickness management, fair allocation of training days and effective use of management time.

7.2 Actual against planned filled hours

Revised National Quality Board guidance published in May 2014 outlined the requirement for % fill of planned and actual hours to be identified by registered nurse and care staff, by day and by night, and by individual hospital site. Reported data is derived from the E-Rostering and NHS-Professionals systems and aggregated fill rates in May-18 were 101.7%.

Low fill rates were seen on several wards due to a combination of high sickness, maternity leave and vacancies (Minster, Coronary Care QEOMH, Treble, Critical Care K&CH, Kingston, Richard Stevens and Fordwich stroke units, Kings C2 and Birchington).

Actions in place include:

- Matrons and non-ward-based staff often cover the shifts that are short of staff. This is not reflected in the filled hours as it is not captured on the E-Roster currently;
- Safecare (utilising the Shelford acuity and dependency tool) allows the live capture of patient acuity dependency and improved matching of staffing to demand. This allows staff movement to areas of highest need on a shift by shift basis;
- Skill-mix changes are made, such as using a healthcare assistant if a registered nurse is not available. This explains why some fill rates are high for 'Care Staff';
- Recruitment campaigns continue both locally and overseas;

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- Retention is being addressed with wards and teams with support from the HR Business Partners.

Work to ensure that roster templates closely reflect the budgeted establishments and include shifts necessary for additional beds has supported the increased fill rates seen over time. However, the bank line within ward budgets is not reflected in roster templates, which has the effect of slight over-inflation of % filled hours against planned. 29 out of the 49 wards have a bank line which represents 20.59 WTE not included in roster templates. Filling these shifts requires an 'additional shift' to be created in templates which should in reality be already included in the available staffing.

Many ward managers report creative use of their roster templates to further reduce the early and late shift overlap to create improved cover for night shifts.

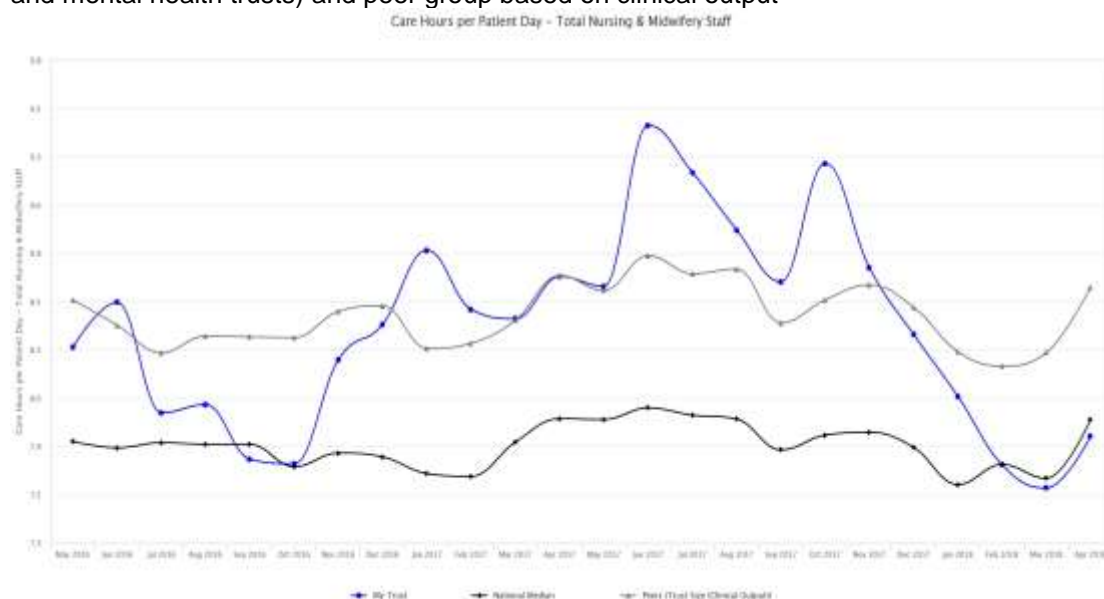
7.3 Care Hours Per Patient Day (CHPPD)

Care Hours per patient day (CHPPD) is one of the key staffing measures, highlighted by the NQB and NHSI, that are used to evaluate the safety of staffing levels and relates actual staffing to patient numbers and includes registered staff and care staff hours against the cumulative total of patients on the ward at 23.59hrs each day during the month. CHPPD have been reported since May-16 and has been included in the Quality Heatmap, by ward, since Feb-17. CHPPD represents the average number of hours of care provided to each patient on the ward per day.

Average CHPPD in May-18 was 8.2. The range is from around 5.5 hours of care per patient on medical wards to over 25 within critical care areas where one to one care is required.

NHSI recommend benchmarking with peers and the Model Hospital dashboard makes it possible to compare with peers that are close comparators. Comparative data within the Model Hospital Dashboard for Apr-18 (the latest available data) shows EKHUFT average CHPPD is in the mid to low 25% (Quartile 2) and in line with our recommended peer group and peer median based on spend and clinical output, shown in figure 6. This indicates that appropriate staffing is available to provide safe and effective care to our patients.

Figure 6. CHPPD EKHUFT compared to national median (all acute trusts, community trusts and mental health trusts) and peer group based on clinical output



8. Triangulation between evidence based tools and professional judgement and scrutiny

There is no single nursing staff to patient ratio that can be applied across all wards to safely or adequately meet the nursing care needs of patients. A range of tools, outlined in table 1 are available for use in evaluating individual specialties.

Table 1. Methodologies used to evaluate specialties

Area	Methodology
Wards	The Shelford Safer Nursing Care Tool (Shelford Group 2013), Professional Judgement, Hurst Nursing Workforce Planning Tool (2014).
Stroke Units	SEC Cardiovascular Strategic Network Stroke and TIA Service & Quality Standards (2014)
Critical Care Units	British Association of Critical Care Nursing (2009)
Paediatrics	Royal College of Nursing (RCN 2013) guidelines
Emergency Departments	Baseline Emergency Staffing Tool (BEST - RCN)
Midwifery	Birthrate Plus (RCM)
NICU	Department of Health Toolkit for High Quality Neonatal Services 2009. British Association of Perinatal Medicine 2011. Dinning tool (2016)

There are advantages and disadvantages to the different methods and tools used to model staffing levels, and also a view that none of them capture the communication aspects of nursing work (nurse-patient, nurse-family, nurse-doctor, nurse-other healthcare professionals and departments, nurse-other agencies). Different systems applied to the same care environment can produce different results, and so combining two or more methods is recommended to improve reliability and validity.

8.1 Professional judgement

A component of the Hurst workforce planning tool includes a method of calculating required establishments using professional judgement. The feedback from ward managers on required staffing levels across the 24 hour period was utilised and there was a close correlation between calculated establishments and actual for most wards. Higher than existing establishments were identified in four wards which have additional contingency beds:

- Birchington (7 contingency beds)
- CDU QEQM (6 contingency beds)
- Cheerful Sparrows female (3 contingency beds)
- Harbeldown (2 contingency beds)

Higher than existing establishments were also identified in several wards where a significant number of patients requiring specialising were identified through the analysis of SafeCare (acuity and dependency) data for May 2018. These wards were Minster, Harbeldown, Cambridge J, Invicta and Kings A2.

Most ward managers reported an increased move from 7.5 to 12 hour shift patterns, thereby reducing staffing handover overlap times, to provide greater staffing numbers on each shift.

8.2 Hurst Workforce Planning Tool

The Hurst Nurse per Occupied Bed (NPOB) formulae (Hurst 2014) were applied to the main specialties. These formulas are unique because they are derived from data collected in same specialty wards. The wards providing these data (across the UK) passed a quality test, that is, none fell below a pre-determined quality standard to avoid projecting from inadequately staffed wards. Hurst formulae are available for a

wide range of specialties and all wards were benchmarked against the most appropriate 'fit'. The tool provides a calculated establishment in relation to number of beds and NPOB guidance per specialty.

Calculation of establishments using the NPOB method suggested that most ward establishments are near recommended Hurst levels except Sandwich Bay and Marlowe (due to a best fit model for these wards not being available). However, the calculated establishments were significantly lower than current for Rotary, Birchington and Kennington wards as the tool does not enable capture of trolley, ward attender and outpatient activity.

The current establishments for the stroke units (Richard Stevens, Fordwich and Kingston) are in line with the SEC Cardiovascular Strategic Network Stroke standards.

The current establishments for the Paediatric wards are in line with RCN (2013) standards for Rainbow but less so for Padua.

8.3 Alignment of staffing required to demand though the Shelford Safer Nursing Care Tool (via SafeCare Healthroster)

The Shelford Safer Nursing Care Tool (SNCT) is based on the critical care patient classification (Comprehensive Critical Care 2000). These classifications have been adapted to support measurement across a range of wards and specialties. The dimensions of patient dependency and acuity are important variables in determining nursing workload and the updated Shelford SNCT (2013) is now used twice daily via the SafeCare interface within the healthroster to capture acuity and dependency at two census points during the day. Matrons provide quality control and consistency check submissions for all their wards. This allows matrons to evaluate the appropriateness of staffing across wards and make decisions about movement of staff to areas of higher nursing workload where necessary.

The Shelford group reiterate the requirement for assessment over a longer period and so for the purpose of this review the average acuity and dependency from May 1st to 21st was calculated from the SafeCare data and applied to study current nursing workload in all wards to calculate ward establishment. Further consistency checking was provided by a senior nurse to ensure common understanding and appropriate application of the criteria and to challenge where necessary.

Average May-18 calculation of establishments using the Shelford method taking account of nursing workload associated with patient acuity and dependency demonstrated some correlation between calculated and actual establishment for some wards. However, 19 wards saw an increase in acuity and dependency of patients and on 12 wards this was matched by professional judgement. For most of these 12 wards the higher staffing levels indicated were linked to an high number of patients identified through SafeCare data as requiring specialising (Cambridge J, Invicta, Harbeldown and Seabathing). Similar wards (Cambridge L, St Augustines and Kings C1) did not identify such high numbers of specialising required, indicating higher use of cohorting patients. Further work will be undertaken to explore the criteria in use for specialising to ensure more consistency in the way that the safety needs of these patients are met across our wards.

Some ward managers have reported some variation in interpretation of the levels within the Shelford tool particularly over the past year as the proportion of highly dependent and acutely ill patients has increased. Drivers of nursing workload related to acuity and dependency are outlined in table 2, but additional workload is presented with increased throughput of patients for example taking drug charts to pharmacy

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and collecting take home medications which can mean significant time away from the ward for nursing staff. Further experience in the use of the tool and continued consistency checking has led to increased confidence in the use of the Shelford tool particularly as Safecare roll-out was completed in Jan-18 and is now embedded. Safecare now provides more sophisticated information to enable staff to be available to meet patients' needs.

The deteriorating patient group report to the Patient Safety Board in March 2018 highlighted that analysis of Early Warning Scores within VitalPac from Oct-17 to Mar-18 showed a steady increase of acuity of patients particularly at WHH and QEOMH during January and February. The capacity of the respiratory wards was exceeded and some patients requiring Non-Invasive Ventilation or High Flow Humidified Nasal Oxygen were cared for outside these specialist wards. The move of acute medicine from K&CH is a contributing factor to the increase in acuity and dependency on these sites.

Table 2. Drivers of nursing workload

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 treatment which increase nursing workload include the care of patients requiring non-invasive respiratory support such as Non Invasive Ventilation or High Flow Oxygen, caring for patients requiring enteral or parenteral nutrition, management of central venous lines, tracheostomy care, complex medication regimes including oral and intravenous therapy, neurological assessment, monitoring and observation for signs of deterioration and escalation of care. Nursing workload is further increased when supporting patients with complex nursing care needs including altered states of consciousness, patients with dementia, complex mental health needs or complex communication difficulties associated with learning disability. Increasing the throughput of patients and decreasing length of stay generates additional nursing work related to assessment on admission, and planning safe discharges to tight time-frames.

The Nursing and Midwifery Council (NMC), the regulator for nurses and midwives whose main purpose is to protect the public, have set standards for the supervision and assessment of students and learners in practice which produces another level of work which is conducted without additional resource to the budgeted ward establishments. Mentors with responsibility and accountability for making the final sign-off in practice must have the equivalent of an hour per student per week allocated during their final period of practice learning. With around 150 students alone undertaking this assessment within EKHUFT annually, this represents a significant workload that is also absorbed at ward level.

The application of modelling methods (summarised in figure 7) has identified that there is alignment between current funded establishments and modelling tools applied (Professional Judgement, Hurst and the Shelford SNCT) for some wards. However, acuity and dependency appeared higher in May-18 than in Nov-17 for some wards not reflecting the expected variation in nursing workload between winter and spring. There has been an increase in acuity dependency over time on some wards.

8.4 Evaluation of the triangulation of the modelling methods

Evaluation of the triangulation of the modelling methods is summarised as:

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CDUs	<p>Current establishments show alignment to Shelford (SafeCare) and Hurst but less so to Professional Judgement (PJ). PJ at QEQMH is higher than current due to the need to staff contingency beds. <u>Consideration should be made to providing substantive staffing for these contingency beds to enable a more reliable resource for provision of safe and effective care.</u></p>
Medical wards	<p>Alignment to PJ and Hurst for most wards but establishments below that are suggested by Shelford on CJ, Minster, Sandwich Bay, St Margarets, Invicta, Mount McMaster, CM1 and Quex where acuity and dependency indicates higher staffing than currently in the establishment.</p> <p>PJ and Shelford indicate higher staffing requirement than actual, particularly CJ and Invicta which report 7-8 patients per day requiring specialising. Shelford for Mt McMaster is capturing workload of additional beds.</p> <p><u>Funded establishments may require adjustment on Minster, CM1 and St Margarets due to increased acuity and dependency and on Mount McMaster to fund contingency beds. A resource to support consistency in specialising should be developed.</u></p>
Stroke Units	<p>Alignment for all wards (*SEC Network Stroke Model). Shelford does not capture stroke thrombolysis nursing work outside the ward. Wide variation in the use of 1:1 specials with significantly higher on Fordwich. <u>Staffing appears appropriate but a resource to support consistency in specialising should be developed.</u></p>
HCOOP/Frailty	<p>PJ and Shelford indicate higher staffing requirement but no increase in acuity & dependency. High need for specialising on Harbeldown but not St Augustines. <u>A resource to support consistency in specialising should be developed.</u></p>
Coronary Care Units	<p>Alignment of modelling methods except Shelford does not capture the intensity of pPCI work on the Bartholomew Unit. <u>Staffing appears appropriate.</u></p>
Renal & Haematology	<p>Alignment on both wards with Professional Judgement and Hurst but less so with Shelford as it does not fully capture the work of the acute dialysis or day case beds on Marlowe. <u>Staffing appears appropriate.</u></p>
Gynaecology	<p>Alignment of PJ at WHH but less so on Birchington due to contingency beds. Hurst and Shelford do not capture all activity, only inpatient beds. <u>Consideration should be made to providing substantive staffing for these contingency beds to</u></p>

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enable a more reliable resource for provision of safe and effective care.

Paediatrics

*RCN and Professional Judgement suggest higher establishments to cover day surgery & relocated outpatients particularly on Padua. Shelford is not relevant to Paediatrics.

Surgery

Alignment of modelling methods for most wards. Increase in acuity & dependency on CSF linked to heavily dependent patients requiring specialling. Shelford does not capture trolley activity on Clarke & Kent nor outpatient activity on Rotary. A resource to support consistency in specialling should be developed.

Trauma and Orthopaedics

Some alignment of modelling methods. Increase in acuity & dependency on Seabathing reflecting high numbers of patients identified as requiring 1:1 specialling. Shelford does not capture high throughput on KC2. A resource to support consistency in specialling should be developed.

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Figure 7. Triangulation between professional judgement and evidence based tools.

Specialty	Ward	Full est (WTE) May-18	Prof judgment (PJ) May-18	Hurst NPOB or other appropriate model	Shelford May-16	Shelford Nov-16	Shelford May-17	SafeCare Dec-17 Required staffing (+ admin)	SafeCare May-18 Required staffing (+ admin)	CHPPD Nov-17 Actual staffing	Comments
CDUs	CDU WHH	71.80	66.19	72.79	58.14	68.57↑	66.09	67.79	71.30	12.4	Alignment to Shelford and Hurst but less so to P.J. PJ at QEQM reflects additional beds.
	CDU, QEQM	47.48	61.34	44.7	42.73	42.19	43.14	38.84	44.95	8.7	
Medical	Bartholomew	65.48	65.7	59.1	NA	NA	NA	NA	46.79	11.3	Alignment to professional judgement and Hurst for most wards but establishments below that suggested by Shelford on CJ, Minster, Sandwich Bay, St Margarets, Invicta, Mount McMaster, CM1 and Quex where acuity and dependency indicates high staffing than current. PJ and Shelford indicate higher staffing requirement than actual, particularly CJ and Invicta which report 7-8 patients per day requiring specialising. SafeCare for MtMcMaster capturing workload of additional beds.
	Cambridge J	44.57	54.7	46.0	72.64 ↑	58.31	54.61	49.73	64.24	6.1	
	Cambridge K	46.63	43.6	45.4	32.39	32.33	33.83	33.49	43.05	7.0	
	Cambridge M2	27.02	28.5	28.3	29.66	29.19	27.53	30.39	28.97	5.8	
	Minster Ward	31.72	37.9	32.8	34.41	34.41	33.79	37.66	35.84	6.1	
	Oxford	23.87	25.5	20.9	23.34	23.71	24.01	27.40	24.14	7.6	
	Sandwich Bay	27.58	30.6	30.6	33.73	33.73	33.73	34.89	31.66	5.8	
	St Margarets	31.07	33.2	35.0	42.67 ↑	42.67	32.45	37.00	35.09	5.7	
	Deal	34.02	34.7	38.4	43.13 ↑	43.56	43.78	48.00	36.53	5.3	
	Harvey ward	27.89	27.4	24.6	27.37	27.37	27.37	26.30	26.91	5.3	
	Invicta	29.88	33.0	33.9	30.75	34.14	34.14	36.00	38.58	6.0	
	Treble ward	29.63	29.1	27.2	18.91	22.14	23.31	28.11	27.52	7.4	
	Mount McMaster	30.42	31.6	33.9	39.80 ↑	45.03↑	50.57		41.63	5.2	
	Cambridge M1	27.06	28.9	27.2	25.29	34.3↑	44.47	32.66	32.48	5.8	
Quex	35.46	37.4	38.4	NA	NA	NA	NA	42.29	6.2		
Stroke	Fordwich Ward	44.99	44.57	43.45*	37.43	39.06	39.06	52.27	43.20	8.8	Alignment of modelling methods. Wide variation in the use of 1:1 specials with significantly higher on Fordwich.
	Kingston	37.56	34.6	31.7*	31.76	36.57	36.82	43.17	44.98	6.5	
	Richard Stevens	43.25	41.1	44.8*	41.55	39.44	39.95	49.06	46.39	8.2	
HCOOP/Frailty	Harbledown	34.53	37.8	34.4	54.45 ↑	55.76	64.87	44.12	44.05	5.7	PJ and Shelford indicate higher staffing requirement but no increase in acuity & dependency. High need for specialising on Harbledown but not St
	Cambridge L	38.15	39.4	37.18	43.10	43.62	43.84	42.87	44.05	6.5	
	St Augustines	35.71	38.6	37.4	40.81	43.49↑	48.12	54.20	44.12	5.6	
Coronary Care	CCU QEQM	22.97	25.7	22.5	18.29	18.39	17.77	20.80	22.38	7.8	Alignment of modelling methods except Shelford does not capture the intensity of pPCI work (Bartholomew)
Renal & Haematology	Marlowe	54.76	52.2	58.9	27.67	34.61↑	30.19	27.00	30.67	7.9	SafeCare does not capture all activity (acute dialysis or day case)
	Brabourne	15.93	19.9	13.1	5.11	9.42	10.02	5.60	11.86	10.5	
Gynaecology	Birchington	33.40	38.7	17.4	17.10	18.15	17.20	25.27	25.19	6.1	Alignment of PJ at WHH but less so on Birchington due to contingency beds. Hurst and Shelford do not capture all activity, only IP beds.
	Kennington ward	23.69	24.2	12.8	9.56	10.45	10.45	15.90	11.28	6.8	
Paediatrics	Padua	47.80	53.7*			54.4		33.70	NA	8.2	*RCN and Professional Judgement suggest higher establishments to cover day surgery & relocated outpatients particularly on Padua.
	Rainbow	39.30	39.1*			46.9		23.50	NA	12.8	
Surgery	Rotary	35.46	33.7	30.5	16.44	17.04	17.62	23.73	23.55	7.8	Alignment of modelling methods. Increase in acuity & dependency on CSF linked to heavily dependent patients requiring specialising. SafeCare does not capture trolley activity on Clarke & Kent nor outpatient activity on Rotary.
	Cheerful Sp Fem	30.18	34.4	32.4	30.15	29.54	29.98	26.40	36.64	6.9	
	Clarke	46.02	43.0	50.0	37.26	38.8	28.41	44.40	37.74	7.8	
	Cheerful Sp Male	34.92	35.4	29.8	31.04	28.89	28.89	25.90	40.54	6.7	
	Kent	33.14	33.3	29.8	20.20	23.36	22.95	22.50	27.00	7.9	
	Kings B	35.41	33.4	38.7	36.67	34.63	34.63	38.00	34.12	5.3	
Kings A2	25.25	31.0	29.8	22.65	23.77	23.68	36.40	29.11	6.1		
Trauma & Orthopaedic	Kings C1	35.36	37.6	37.4	42.92 ↑	36.76	39.59	45.41	39.86	5.5	Alignment of modelling methods. Increase in acuity & dependency on Seabathing reflecting high numbers of patients identified as requiring 1:1 specialising. Shelford does not capture high throughput on KC2.
	Kings C2	35.05	36.8	36.7	24.09	24.70	25.97	27.19	24.09	6.2	
	Kings D male(1)	61.75	65.1	66.4	57.08	59.09	57.64	66.56	65.58	6.3	
	Bishopstone	34.07	28.3	31.2	34.50	35.87	28.61	38.22	24.65	7.4	
	Seabathing	35.93	39.6	38.9	32.14	35.7	38.14	34.70	50.96	6.3	
Critical Care	ITU WHH	63.09						48.75	NA	28.1	Shelford is not relevant to ITUs.
	ITU QE	46.64						23.40	NA	22.7	
	ITU KCH	39.06							NA	27.7	
*Stroke	SEC Network Stroke Standards										
*Paediatrics	RCN (2013)										

9. THE EMERGENCY DEPARTMENTS, NEONATAL INTENSIVE CARE, MIDWIFERY AND CRITICAL CARE

9.1 Emergency Departments

Since the last workforce review in November 2017, a number of developments have taken place:

Approval of a business case for nursing in the RAT (rapid assessment and treatment area). The additional staff approved were 5 band 6s and 3 band 5s on each site.

A separate business case for ED paediatric nursing was developed in order to provide 24/7 paediatric nursing cover in ED, but has not yet been approved. The recommendation was for 3 band 6s, 19 band 5s and 5.69 band 3s on each site, plus 1 band 7 at WHH.

As reported in the last staffing review, there is no validated tool on staffing emergency departments and the NQB document 'Safe, sustainable and productive staffing: An improvement resource for urgent and emergency care' (Nov, 2017) stated 'There is no evidence base to support a specific ratio; instead staffing requirements should be decided using patient acuity and dependency data alongside throughput, and the skills and experience of the wider multi-professional team'. Currently, a 1 nurse to 4 patient ratio is used in majors, and 4 patients an hour for ENPs in minors.

The workforce plan for EDs is being worked up in two phases:

Phase 1 is matching staffing to demand using the current workforce model mapping workforce against demand currently and planned against projected activity. The Head of Nursing developed a plan for ward nursing staff to come to ED to care for patients once they have been handed over to a medical team. This was aimed at improving the transfer to ward from ED time for patients needing admitting, but has had limited success.

Phase 2 involves assessing workforce needs to match new models of care. The models of care are currently being finalised, following which a series of workshops involving all staff groups will be held to come up with several options for the future workforce model. The workshop will focus on what patients need at each stage of the pathway, what skills and competence that requires, then which roles could demonstrate those skills and competence. Tools already developed that will support this process are; a workforce redesign toolkit and workforce redesign six-stage process; competency framework for emergency ambulatory care developed by the Associate Director of Transformational Research and Practice Development and colleagues, and a career framework developed by the Workforce redesign working group. From these options, supply factors will be taken into account to ensure that the final plan is realistic in terms of filling roles. The STP workforce team have a dynamic workforce modelling tool and have agreed to use our EDs as a case study for a workshop in September which will be able to model a number of scenarios in order to help us make a decision on the workforce plan.

In addition, a bid for 2 band 7 practice development nurses has been submitted to HEE KSS with a positive response pending funding confirmation.

9.2 Neonatal Intensive Care

A comprehensive nurse staffing review was undertaken for Neonatal Services in East Kent and indicated that investment was required in the WHH NICU and the QEQMH SCBU. A business case for phased investment was predicated on the fact that, within EKHUFT, neonatal staffing levels were inadequate in comparison to national recommendations (British Association of Perinatal Medicine) and national published guidelines (NICE, Department of Health (2009) Toolkit for High Quality Neonatal Services, Bliss (2011) The Bliss Baby Charter Standards) and was agreed in July-16.

Following the successful implementation of phase 1 neonatal nurse staffing business case nursing numbers have increased over the last year. Further phased increment of staffing levels was approved over 2017/18 and 2018/19 dependent on a range of operational performance triggers based on unit activity, reduction in frequency of unit closures, increased income from activity, reduction in the use of agency staff and improvements in staff sickness levels. Unfortunately there was insufficient progress against these operational performance criteria in order for the second phase of the Business Case to be released.

Evaluation of appropriate staffing was one of the clinical indicators included in benchmarking as part of the Neonatal services Peer review, undertaken in October 2017 by the Quality Surveillance team NHS England and there were some concerns raised about the appropriateness of current staffing.

On a daily basis, total number of nurses and number of Qualified in Specialty (QIS) nurses are recorded on Badger.net (Clevermed, Edinburgh) along with number of ITU, HDU and SC babies. On an annual basis nursing numbers are reviewed using the South East Coastal ODN's agreed reference tool which is based on Dinning as recommended by the NQB "Safe, Sustainable & Productive Staffing, An improvement resource for neonatal care" 2017.

The SEC ODN have recognised that based on 2017 activity data NICU require 17 additional staff members overall and that they require 24 additional (QIS) nurses. This will be addressed by ongoing development of current staff to achieve QIS status and by increasing staff numbers over the next 2 years to ensure sustainability of this QIS training. SCBU at QEQMH do not require additional staff but they do require additional QIS nurses – this will be addressed by on going training of existing staff to achieve QIS.

EKHUFT are not outliers with regards to the shortfall of QIS nurses as this is a national problem which other units in the SEC ODN also have. However EKHUFT did receive a serious concern notification following the Neonatal services Peer review in October 2017 "At times activity exceeds the budgeted capacity of the unit, when this occurs there are regularly insufficient numbers of appropriately trained nursing staff to meet the intensive care and high dependency care nurse to baby ratios. As a consequence, the reviewers were seriously concerned that the situation compromises the ability of the unit to deliver specialist care locally and undermines the NICU's role within the network and can affect the quality of patient experience and patient outcomes". Therefore it is vitally important that we continue to train staff to QIS level and to continue to recruit new members of the teams.

Neonatal Services are currently working on a second business case that will focus on the need for additional resource and recruitment in order to train QIS nurses and maintain the safety and sustainability of Neonatal Services in East Kent. The business case will outline a phased approach over 2 years.

9.3 Midwifery

In 2016 a Birth Rate Plus review was conducted for EKHUFT Maternity Services which suggested additional staff were required to provide a sustainable resource for specialist midwifery roles. These included safeguarding, obesity, bereavement and diabetes for example. Some of these roles are covered currently with midwives working clinically and having a specialist interest. There are few that are designated leadership specialist roles. The Kent and Medway Local Maternity System (LMS) which was set up following the National Maternity Review and has supported the funding for a further Birth Rate Plus review for the four maternity units, Maidstone and Tunbridge Wells, Darent Valley, East Kent and Medway Maternity services. A meeting will be held with each provider to explain the methodology and discuss the clinical profile and configuration of services. Data is currently being collected and the draft staffing data will be presented to each provider for discussion and clarification. We anticipate this will be completed by September 2018.

Professional Midwifery Advocates (PMA)

Following the removal of Statutory Midwifery Supervision in 2017 the A-EQUIP; an acronym for 'Advocating for Education and QUality ImProvement', model of clinical supervision was developed. The A-EQUIP model of clinical supervision is employer led and non-regulatory; it does not involve investigating practice concerns; imposing interim orders; specifying and monitoring local programs or any regulatory matters relating to the NMC.

A number of midwives formally Supervisors of Midwives undertook the short programme for conversation to the new model of clinical supervision. The PMA team have developed a strategy document. The scope of this strategy is designed to clearly identify how professional midwifery advocates (PMAs) will undertake their role within EKHUFT.

The Professional Midwifery Advocate aims to promote the safety of all women and babies by supporting staff to support women. The professional midwifery advocate will facilitate the development of woman focused, safe and effective care, provided by the staff within EKHUFT.

Sickness Absence

Previous sickness levels have been reported as over 5% impacting on staffing levels and workload. Regular meetings are held with the midwifery matrons to ensure all sickness absence is managed appropriately. This has resulted in the reduction of sickness absence seen particularly over the last five months (Table 3)

Table 3. % Sickness levels in midwifery 2018

Feb 18	March 18	April 18	May 18	June 18	5 month Total
3.9%	4.0%	5.0%	4.4%	4.7%	4.7%

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Vacancy rates had increased last year and the team worked proactively with Kent and Canterbury University to attract newly qualified midwives to work within maternity services. The Maternity Transformation Programme which began last year was an incentive to their choice of place to work. We continue to have a number of staff leaving for personal reasons and taking retirement with a few returning on a flexi retirement option. Active recruitment continues and monitoring of staff vacancy levels.

Table 4. % Vacancy levels in midwifery 2018

Feb 18	March 18	April 18	May 18	June 18	5 month Total
10.7%	9.6%	10.6%	9.2%	9.3%	9.9%

The priority of staffing the midwifery services is to deliver 1:1 care in labour (Table 5). This data excludes women who undergo an elective caesarean section. This is reported on our Trust Maternity Dashboard. Performance has remained stable with a midwife to birth of 1:28 this is a worked ratio calculated as per actual worked WTE hours versus births.

Table 5. 1:1 midwifery care in labour

Feb 18	March 18	April 18	May 18	June 18	Average
98.3%	93.8%	96.2%	93.5%	95.4%	94.6%

A specialist post for an Infant Feeding Midwifery Coordinator, funded from the existing establishment, has recently been successfully recruited to. A band 7 Risk and Governance post, funded through additional resource, following the identification of increasing workload within the Risk and Governance team for Maternity Services has also been recruited to and both are due to commence in September 2018.

A Band 2 development programme was commenced last year and has been running successfully. This provides a portfolio of additional competencies to staff to support their application for a Band 3 maternity support worker role. A 2 day workshop has been developed to support the Band 7 midwifery cohort to focus on a Women's Health Leadership Development, to include resilience training, conflict and leadership. This is to be coordinated for October and November with a number of dates available.

9.4 Critical Care

The capacity of the WHH critical care unit currently exceeds the 11 funded beds and 2 additional beds have been utilised within the footprint of the former coronary care Unit for the past 18 months. Further escalation into theatre recovery is undertaken when further capacity is required.

The capacity of the QEQMH critical care unit regularly exceeds the 8 funded beds and an additional bed is in regular use.

WARD ESTABLISHMENT REVIEW MAY 2018

A business case for investment into additional staffing has been developed with planned phasing over 2018/19 and 2019/20, has been considered by the Strategic Investment Group and will be presented to the Clinical Executive Management Group in August.

10. Recommendations from this review are to:

11. Closely monitor acuity and dependency trends monthly particularly on medical wards where higher staffing levels may be required, to determine appropriateness of current staffing;
12. Undertake bi-monthly detailed analysis of acuity and dependency to provide assurance on reliability of data and support consistency in the use of the Shelford tool (SafeCare);
13. Develop and implement a specialising policy to provide clarity in the application of criteria and promote consistency in approach;
14. Introduce a nursing pool of HCAs to improve support to wards for patients who require specialising and explore the feasibility of expanding this to include registered nurses;
15. Progress the work programme within the 2018/19 recruitment strategy to drive recruitment and retention planning against current and expected vacancies to support the agency reduction programme;
16. Plan further implementation of the Nursing Associate role to support safe staffing;
17. Plan re-skill mixing on a selection of appropriate wards to incorporate a wider range of roles and skills appropriate to the patient group.
18. Recruit to the additional resource approved in the ED business case and implement the workforce plan.
19. Complete the business case for NICU and submit for approval.
20. Participate in the Birth Rate Plus Review for maternity services.

Appendix 1 – National Quality Board (2016) and NHS Improvement (2018) expectations on safe staffing

Expectations		Compliance	
1	<p>Right staff</p> <ul style="list-style-type: none"> ➤ Evidence based workforce planning ➤ Professional judgement ➤ Compare staffing with peers 	<ul style="list-style-type: none"> ➤ Annual strategic staffing review using a triangulated approach (evidence-based tool, professional judgement and comparison with peers) which takes account of all professional groups and is in line with financial plans. This should be followed by a comprehensive staffing report to the board after six months to ensure workforce plans are still appropriate. NHSI do not include the requirement for a six monthly update to Trust boards but highlight that reviews should be undertaken sooner than annually if changes to services are planned. ➤ Review of comparative data on actual staffing which provides context for differences in staffing requirements such as case mix, patient movement and acuity and dependency. ➤ Local quality dashboard for sustainable safe staffing which triangulates comparative data on staffing with other efficiency and quality metrics to include Care Hours per Patient Day (CHPPD). ➤ Action plans to address local recruitment and retention priorities should be in place and subject to regular review. 	<p>Annual staffing reviews have been undertaken since 2007/08 and have included six monthly updates since 2016. Comparison with peers is undertaken through the Model Hospital Dashboard comparators.</p> <p>A triangulated approach is used including these methods.</p> <p>CHPPD was included in the Quality dashboard from February-17.</p> <p>A recruitment and retention action plan has been in place since 2017/18 and is progressing to plan.</p>
2	<p>Right skills</p> <ul style="list-style-type: none"> • Mandatory training, development and education • Working as a multi-professional team • Recruitment and 	<ul style="list-style-type: none"> ➤ Staffing establishments take account of the need for staff to undertake mandatory training and continuous professional development. ➤ Sufficient time allocated for team leaders to discharge supervisory responsibilities ➤ Commitment to investing in new roles and skill mix to enable nursing and midwifery staff to spend more time using their specialised training to focus on clinical duties and decisions about patient care. A strong multi-professional approach avoids placing demands solely on any one profession. 	<p>Average 22% headroom is included in budgeted establishments currently.</p> <p>Investment in the ward manager assistant role has supported.</p> <p>Future Workforce Steering Group has been implemented to take forward standardisation of</p>

	retention	<ul style="list-style-type: none"> ➤ Flexible and effective strategies to recruit, retain and develop staff as well as managing and planning for predicted loss of staff to avoid over-reliance on temporary staff. 	<p>expectations and education preparation for Advanced Clinical Practice roles.</p>
3	<p>Right place and time</p> <ul style="list-style-type: none"> • Productive working and eliminating waste • Effective deployment and flexibility • Efficient employment and minimising agency 	<ul style="list-style-type: none"> ➤ The organisation uses lean working principles such as the productive ward as a way of eliminating waste ➤ The organisation designs pathways to optimise patient flow ➤ Systems are in place for managing and deploying staff across a range of care settings, ensuring flexible working to meet patient needs ➤ Systems for managing staff use responsive risk management processes, from frontline to board level, which clearly demonstrates how staffing risks are identified and managed. ➤ Clinical capacity and skill mix are aligned to the needs of patients thus making the best use of resources and facilitating effective patient flow ➤ Throughout the day, clinical and managerial leaders compare the actual staff available with planned and required staffing levels, and take appropriate action to ensure staff are available to meet patients' needs ➤ Escalation policies and contingency plans are in place for when staffing capacity and capability fall short of what is needed for safe, effective and compassionate care, and staff are aware of steps to take where capacity problems cannot be resolved. Report, investigate and act on red flag incidents. ➤ Meaningful application of effective e-rostering policies is evident. ➤ The annual strategic staffing assessment gives boards a clear medium-term view of the likely temporary staffing requirements. ➤ The organisation is working to reduce and eradicate the use of agency staff in line with NHS Improvement's nursing agency rules. 	<p>Productive ward principles are embedded within wards.</p> <p>Identification and management of staffing risks are part of the role of the matron.</p> <p>The implementation and embedding of SafeCare enables live view of patient acuity dependency and skill mix to enable deployment of staff. Daily site situation and escalation report identifies patient flow, bed status and staffing appropriateness.</p> <p>Improvement has been made to the use of NHSP interface in booking NHSP shifts but further improvement is required.</p> <p>Service improvement team led project Smarter Agency Reduction and work is now led through the agency taskforce group.</p>

