CHESTERFIELD ROYAL HOSPITAL NHS FOUNDATION TRUST

BOARD OF DIRECTORS – 28 APRIL 2014
EXECUTIVE SUMMARY

AGENDA ITEM:	**Nurse Staffing Review**
AUTHOR:	Lynn Andrews Director of Nursing and Patient Care Steve Hackett Director of Finance and Contacting

PURPOSE:	To provide the Board with a report on the ward based staffing levels and to seek approval for additional costs and to revise budgets associated with the uplift in ward staffing To seek approval for a revised number of staff per shift To identify the progress the Trust is making in reaching the expectations outlined in the National Quality Boards latest guidance on safe staffing levels for our patients.

KEY POINTS FOR THE BOARD:	1. The current budgeted establishment for the ward environment is £24.4m. The Trust has overspent against this budgeted establishment by £4.4m in the financial year 2013/14 2. The additional costs of increasing the budgeted staffing levels amount to £1.692m. 3. The Trust contingency for Ward Nursing spend will be £27.204m, this therefore leaving £1.009m for increased costs of using Agency staff 4. The Trust is making progress against the National Quality Board expectations

ACTION REQUIRED OF THE BOARD:	To **Note** the contexts of the report and expectations for reporting staffing capability and capacity to the Trust Board To **Note** the analysis of shift patterns to achieve safe staffing levels and the considered changes to skill mix and increase in whole time equivalent numbers of registered To **Approve** the additional costs and revised budgets associated with the uplift in ward staffing establishments To **Approve** the revised numbers of staff per shift

RELATED STRATEGIC OBJECTIVE(S):	To provide high quality, safe and person centred care Deliver sustainable, appropriate and high performing services Manage our money wisely

FINANCIAL IMPACT:	The additional costs of increasing the budgeted staffing levels amount to £1.692m.

EQUALITY IMPACT:	

ENVIRONMENTAL IMPACT:	

PARTNERSHIP WORKING:	

BOARD OF DIRECTORS – 28 April 2014

NURSE STAFFING REPORT

1. Introduction

1.1 The report focuses on ward based staffing levels in adult and children's services and the Trust Boards accountability and responsibilities for staffing capacity and capability to provide safe, high quality compassionate care.

1.2 The paper also identifies the progress the Trust is making in reaching the expectations outlined in the National Quality Boards latest guidance on safe staffing levels for our patients.

2. National context and Board reporting

2.1 The focus on nursing, midwifery and healthcare staffing as a key determinant of the quality of care experienced by patients has become increasingly sharp over recent months. Recent reports including Robert Francis's report into the events at Mid Staffordshire Hospital, Professor Sir Bruce Keoghs review into hospitals with elevated mortality rates, and Professor Don Berwick's review into patient safety, all highlighted the importance of ensuring appropriate nurse staffing capacity and capability and outlined the need to do some further work.

2.2 As the impact of understaffing on patient safety has become clear, many trusts have started to reverse earlier cuts and alter plans by investment in the nursing workforce. The investment in the nursing workforce has been welcomed however there is still some way to go in determining the right staff with the right skills are in the right place.

2.3 There has also previously been a dilution of skill mix, as more senior nursing staff have been disproportionately targeted for workforce cuts and found their roles increasingly devalued. There is evidence that the recent renewed recruitment or the 'Francis effect' has had an impact on the availability of nurses nationally leading to many trust seeing an increase in their vacancy levels and a rising bank, overtime and agency costs.

2.4 More recently the Health Select Committee called for transparency around staffing levels recommending that hospitals should clearly display the actual number of nurses and healthcare assistants on duty versus the numbers that should be present.

2.5 This recommendation is laid out in The National Quality Board guidance issues in November 2013 placing emphasis on openness and transparency about staffing and the responsibility of the trust to ensure it is operating with

safe, high quality staffing levels. Annex 1 outlines the Boards key areas of responsibility.

Expectation 1 – *Boards take full responsibility for the quality of care provided to patients and as a key determinant of quality, take full and collective responsibility for nursing, midwifery and care staffing capacity and capability.*

2.6 This includes managing capacity and capability, agreeing establishments, considering the impact of wider initiatives (cost improvements plan) on staffing and demonstrating accountability for decisions made about nurse and midwifery staffing.

2.7 Expectation 1 introduces new requirements for Boards to monitor staffing capacity and capability through regular and frequent reports on actual staff on duty on a shift to shift basis versus planned staffing levels. Alongside this Boards are expected to review trends in relation to key quality and outcome measures, recruitment, training and management of nurses, midwives and healthcare staff.

2.8 The involvement of staff to support ward to board reporting is key to ensuring that the organisation is open and supports staff in escalating potentially unsafe staffing levels and implementing steps to maintain patient safety. It is expected that Boards will be able to provide assurance to commissioners, the Care Quality Commission and Monitor.

3. The Board Reports

3.1 There are two elements to this reporting.

1. A six monthly report
2. A monthly report

3.2 The six monthly reporting

Boards should receive papers on establishment reviews which should focus on an evaluation of staffing capacity and capability over the previous six months. This should include a forecast of likely staffing requirements for the next six months based on the use of evidence based tools and a discussion with the ward, matron and senior nursing leaders.

3.3 The Board may consider more frequent reporting if there are recognised patient outcome concerns or if staff raise issues in relation to staffing levels. In addition Boards may wish to seek assurance if there are significant cost improvement programmes being implemented which could impact on staffing and subsequent quality of care.

3.4 The criteria for inclusion outlined for six monthly report includes:

- Current establishment/skill mix and recommendations following use of the evidence based tools
- Details around how gaps in staffing will be covered and resourced
- Allowances included for planned and unplanned leave (annex 3)
- Supervisory allowance for sisters/Matrons
- Triangulation between tools and professional judgement and scrutiny
- Plans to financial any additional staff
- Workforce metrics
- Key quality and outcome measures

3.5 The monthly report

These should be published monthly and provide regular updates to the Board providing the following:

- Actual staff available on a shift to shift basis versus planned staffing levels
- Impact on relevant quality and outcome measures
- Wards where staffing capacity and capability frequently falls short of what is required, reasons for the gaps, the impact and actions taken to deal with this

3.6 Monthly Trust Board reports should commence no later than June 2014. It is intended that this Board will start to receive these reports from May 2014.

4.0 National work streams

4.1 The National Institute for Health and Care Excellence (NICE) are in the process of reviewing the evidence and best practice regarding safe staffing levels with the aim of producing national guidance. Initially this will focus on acute inpatient settings and extend to other areas. It is expected that the guidance will cover nursing and midwifery staffing levels and skill mix but is not set to recommend a national minimum staffing level.

4.2 The national website on which staffing information is to be published is expected to be launched in the summer of 2014. Until such time organisations are expected to publish their information through Board reports and NHS Choices.

5. Previous investment in staffing capacity and capability

5.1 The Trust has undertaken a nursing and midwifery staffing review each year since 2012. In 2012 the nurse staffing review demonstrated that inpatient nursing establishment had not altered since 2009 and did not reflect the acuity, dependency of the changing patient needs or the skill mix requirements for each specialty. A significant investment was made at that time (see Figure 1). In October 2013 a review of staff for the Emergency Department was considered by the Board with agreement to invest £419K split between 2013 and April 2014.

Figure 1. The investment committed by the Board of Directors in 2012 and 2013.

	2012/13	**2013/14**	**April2014**
Midwifery	£ 300,000		
Medicine	£1,044,440		
Surgery	£ 264,100		
Orthopaedics	£ 128,000		
Emergency Department		£189,000	£230,000
TOTAL	**£1,736,540**	**£189,000**	**£230,000**

6. Current work streams to aid safe staffing levels

6.1 A number of recruitment initiatives have been implemented to assist in reaching the safe staffing levels agreed in previous Board papers.

The Trust has recruited 122 registered nurses through recruitment campaign activity over the past 18 months – combination of newly qualified and experienced staff (table 1.). This is from 'campaign' activity and does not include the ad hoc recruitment for individual vacancies.

Activity	Date	No. of Registered Nurses recruited
Recruitment campaign	November 2012	34
Recruitment campaign	May 2013	22
External recruitment campaign	July 2013	8
Career Fair/Open Day	October 2013	33
External recruitment campaign	January 2014	15
Overseas recruitment in Portugal	February 2014	10
Overseas recruitment in Italy	April 2014	21 potential
	TOTAL	**122 (plus 21 potential)**

Table 1. Number of Registered Nurses appointed through Recruitment Campaigns

6.2 A managed service for bank and agency staff has been secured with NHS Professionals. The contract was signed at the start of April with an implementation date of July 2014. This service will ensure that staff supplied to the trust all meet agreed minimum standards in training, development and appropriate behaviours in delivering compassionate care. By using the managed service to cover for additional staffing needs this will reduce or negate the high costs associated with agencies.

6.3 The roll out of E-Rostering programme has continued. A revised implementation plan has been considered at Project Board due to capacity issues as a result of vacancies within the project team. The programme continues to roll out across clinical areas and recruitment into the project team is in progress. As the E-Rostering facility embeds efficiencies in staff usage across the shape of the working week will improve. In addition the systems data information has been used to support intelligence on effective staff allocation.

7. What constitutes good staffing levels and skill mix?

7.1 What is the optimum level and mix of nurses required to deliver quality care is a perennial question. Currently there is no nationally defined minimum safe staffing level. There are however recommendations on skill mix and the number of registered nurse to patient ratios.

7.2 The Royal College of Nursing (RCN 2010) suggest that staffing levels between one Registered Nurse to six patients (1 RN:6 patients) and eight patients per registered nurse (I RN:8 patients) is associated with good care. The recommended skill mix split is 65:35 qualified nurses to healthcare

assistants however Trusts are finding this increasing difficult to achieve with many Trusts aiming for a 70:30 split (Royal College of Nursing 2012).

7.3 The Keogh report published in July 2013 highlights significant concerns around staffing levels where the skill mix at 50:50 was considered low on general wards.

7.4 Suggested minimum registered nurse staffing levels for children's wards is for under 2 years of age 1 children's nurse to 3 children and other ages (day and night) 1 nurse to 4 children (Royal Colleague of Nursing 2013).

8. Benchmarking

Information from other acute trusts (where known) is shown below:

Trust	Skill Mix Split (range) RN:HCA	Ratio RN: patient
Chesterfield Royal Hospital NHS Trust	55:45 to 67:33	1:6 to 1.8 (based on overall bed numbers)
Nottingham University Hospitals	56:34 to 84:16	-
Mid Cheshire Hospitals NHS Trust	45:55 to 70:30	-
Northampton General Hospital	-	1:8 (based on overall bed numbers)

9. Proposal for increasing staffing requirements for Chesterfield Hospital

9.1 In October 2013 the new Divisional structures had recently been implemented and the Heads of Nursing had just been appointed. An assessment of the staffing levels made at the time were based on minimal staffing information data and limited understanding of the ward based nurse staffing needs. A dependency/acuity tool was not in use to aid staffing level calculations.

9.2 The nurse staffing levels, shift pattern and skill mix has been reviewed by the Matron and senior nursing staff within the Clinical Divisions and with the Director of Nursing and Patient Care. The activities, considered dependency, nature of patients' clinical needs and the layout of the ward environment have all been taken into account during this review. The Heads of Nursing and Senior Matrons have also been in post for 6 months and have a stronger sense of the care needs on the wards. This has led to the proposal for additional staffing levels.

9.3 Since October 2013 the E-Rostering system has been rolled out more widely and the data analysis from this system has identified that there are a number of wards employing staffing levels over and above the agreed position in October 2013. This has also been bourne out in the rising costs associated with the Bank and Agency usage.

9.4 A snap shot analysis of the E-Rostering data undertaken between the 1 April 2013 and 14 April 2013 has confirmed that additional staffs have been rostered for a range of reasons namely:

- Additional bed usage
- Clinical workload
- To provide one to one care to prevent high risk patients falling, patients posing a safety risk due to mental health concerns, patients at risk of wandering
- Vacancies
- To cover sickness
- Maternity leave cover

9.5 The use of additional staff in this uncoordinated way is of financial and quality concern.

9.6 Children's services were not considered in the October 2013 review therefore a local review of nursing capacity and capability was undertaken in preparation for this staffing paper. The review identified that the current ward establishment was implemented on an activity model with has grown in volume and complexity. The number of admissions, day case activity and interventions have led to recommendations to increase the establishment to provide safe staffing levels. The new proposal for Children's ward is attached as a separate annex (annex 4)

10. Additional considerations

10.1 When considering potential investment in nursing establishments the wider context of overall bed capacity and nursing demand is required to identify the opportunity to redistribute the workforce and therefore to inform discussion as to the likely potential for permanent trust cover to the rosters.

10.2 The trust is working in partnership with local commissioners on demand management schemes as well as a number of efficiency projects as part of the trust overall transformation strategy. Combined these schemes have the potential to have a significant impact on the bed capacity of the trust over the next 12 to 24 months and will therefore impact on nurse staffing levels. It is for these reasons that a nursing and midwifery staffing capacity and capability review should be undertaken on a six monthly basis.

10.3 There are workforce plans in place to improve recruitment through overseas nurse recruitment, reviewing recruitment processes and making the Royal the first choice for nursing staff in the region to work, this has the potentially to improve our position to fill vacancies.

10.4 The proportion of newly registered staff has increased through the recent recruitment drives. They warrant a period of preceptorship while they develop their capability as a registered nurse. In addition a number of overseas nurses have been recruited and will require socialisation to healthcare in England. These groups of staff will need good education and personal development support to ensure they feel valued and can make a positive contribution to the workforce. Ensuring we recruit to a permanent position fosters the team ethos and an ability to work more flexibly among team members.

10.5 The champion roles have not been considered separately within the new establishment proposals. It is the view of the Director of Nursing and Patient Care and senior nursing colleagues that nursing establishments should be correct for the care of patients, this includes as part of the nurses role the day to day on the job training and to champion topic interests in relation to essential elements of care.

10.6 Population demographics are constantly under review and pose challenges for the nursing and midwifery workforce. Increasing numbers of patients with complex care requirements, challenging behaviours, mental health and CAHMS patients all add to the complexity and demands placed on nursing teams.

10.7 Annex 3 describes the nature of care on the wards requiring additional investment.

11. Financial position

11.1 The current budgeted establishment for the ward environment is £24.4m. Board will recognise the Trust has overspent against this budgeted establishment by £4.4m in the financial year 2013/14. This is due to increased staffing used to support additional clinical needs over and above usual inpatient ward acuity and the use of Agency Nursing.

11.2 The proposal will seek to staff the wards to an equivalent level of Registered Nurses to those currently being deployed, but over time will be staffed from our clinical workforce rather than use of Agency.

11.3 The financial model allows for some use of Agency Nursing but the costs will be controlled through the newly implemented Managed Service Contract with NHS Professionals.

11.4 The additional costs of increasing the budgeted staffing levels amount to £1.692m. Clearly if we cannot release costs through the implementation of the NHS Professional contract this would increase the financial risk. Our assessment though is that the control mechanism of one central point of access to authorise an Agency Nurse will mitigate financial risk.

11.5 In total the increased ward staffing establishment will amount to £26.1m, the Trust contingency for Ward Nursing spend will be £27.204m, this therefore leaving £1.009m for increased costs of using Agency staff.

11.6 The ambition is to maintain and if possible reduce nurse staffing turnover. If, however, turnover rates increase this will add further financial risk and may deem the staffing skill mix unaffordable. One way of mitigating this risk would be to reduce bed base stock and thereby using less Agency.

11.7 Annex 4 provides an overview of the shift patterns prior to the investments made in 2012 and 2013. The new proposal for the shift patterns and whole time equivalent (WTE) are also outlined.

Fig.1 Ward budgeted before and after proposed investment

Division		Agreed Staffing Levels Oct 2013 £m	New Investments Proposed £m	Total Budget Required £m
Medicine	Qualified	9.137	0.615	9.752
	Un Qualified	4.099	0.407	4.506
	Medicine Total	**13.236**	**1.022**	**14.259**
Surgery	Qualified	7.271	0.291	7.561
	Un Qualified	2.466	0.065	2.531
	Surgery Total	**9.737**	**0.355**	**10.092**
W&C	Qualified	1.198	0.208	1.406
	Un Qualified	0.238	0.107	0.344
	W&C Total	**1.436**	**0.314**	**1.751**
Trust Total	Qualified	17.606	1.114	18.720
	Un Qualified	6.803	0.578	7.381
	(a) Grand Total	**24.409**	**1.692**	**26.101**

12. Next Steps

12.1 The National Quality Board (2013) guidance sets out the requirements for all inpatient areas including acute and maternity services. There are a number of commitments outlined which the Trust is already achieving. The table below outlines the additional actions and next steps the Trust will take to meet the remaining expectations before the end of June 2014.

The overarching areas are outlined below:

NQB Expectation	Progress to date	Further actions
For the Board to receive a report every six months on staffing capacity and capability, following an establishment review using evidence based tools where possible	The Board of Directors has received a review of nurse staffing in October 2013 and April 2014	To implement an evidence based monitoring tool in May to establish patient acuity/dependency and safe staffing numbers using a recognised methodology
For the Trust to display information about the nurses, midwives and care staff present and planned in each clinical setting on each shift	Since the beginning of April 2014 each inpatient ward has displayed information about the staff that are planned on the duty rota and those who are present on duty.	In May the Trust will enhance the presentation style of the displayed information about staff attendance boards to ensure they are more visible, clear and

		meaningful for patients
For the Trust to review the actual versus planned staffing on a shift by shift basis and have plans in place to address the risks and gaps associated with shortages	A daily report of the nursing, midwifery and children's services staffing is collated and reviewed by the Heads of Nursing and Senior Matrons	In April the Trust will commence a daily review of the staffing position using a shift by shift, planned versus actual attendance records. A risk assessment and authorisation will be completed where identified gaps are realised and plans developed and implemented to ensure safe care is delivered
For the Trust to have in place systems like E-Rostering, escalation and contingency plans to make the most of resources and optimise care	The Trust has introduced E Rostering into medicine and surgery wards. It continues to roll out in children's services	To continue to roll out E Rostering in Women's and Children's services. In April to review the escalation process to ensure that it clearly identifies when additional staffing can be authorised for clinical reasons within budget and shift levels In July the Trust will commenced the Managed Services contact
For the Board to receive an update containing details and a summary of planned and actual staffing on a shift by shift basis	The nurse staffing review paper will be discussed in the public board meeting in April 2014.	From May a monthly summary of planned and actual staffing by shift will be reported to the Board on a monthly basis
For the Trust to ensure that the published monthly update report is available on the Trusts website but also the relevant hospital profiles on NHS Choices	The nurse staffing review Board paper for April 2014 will be made available on the Trust website following the Board meeting	In May the monthly staffing update shift by shift summary will be published on the Trust website and NHS Choices

13. Training and Development

13.1 During the review of the nurse staffing within the Trust it has become clear that additional training and education is required to support Matrons develop a clear understanding of their management responsibilities in relation to good roster management and financial controls. A training programme will be developed and introduced in May.

13.2 In conjunction we will implement the following control mechanisms:

- E-rostering will be revised to the final agreed establishment
- Budgetary control, in addition to E-rostering will be applied at ward level and performance managed
- Financial and HR support will be provided at Matron level where greatest level of control can be maintained
- Escalation processes to agree temporary staff over and above ward establishment will be scrutinised prior to any approval by Divisional Management Team prior to Executive level sign off
- Board reports will contain monthly run rates showing variance to budget and planned verses actual staffing by ward and shift
- If variation occurs Divisions will be accountable for mitigation plans to address the finical risk
- An acuity tool will be deployed to inform dependency at ward level
- Director of Nursing and Patient Care will monitor safety measures in conjunction with the acuity tool and staff deployment, this will in turn be reported to Board.

14. Proposal

14.1 To introduce the new staffing levels and subsequent investment proposed

14.2 To work towards a 1:8 nurse to patient ratio or better (dependant on nature of ward speciality) and a 70:30 Registered Nurse to Healthcare assistant skill mix.

14.3 In line with national guidance continue with the systematic approach to review nurse staffing capacity and capability and undertake a further review within six months.

15. Recommendations

15.1 The Board of Directors is asked to:

- **Note** the contexts of the report and expectations for reporting staffing capability and capacity to the Trust Board
- **Note** the analysis of shift patterns to achieve safe staffing levels and the considered changes to skill mix and increase in whole time equivalent numbers of registered
- **Approve** the additional costs and revised budgets associated with the uplift in ward staffing establishments
- **Approve** the revised numbers of staff per shift.

15.2 The Board of Directors is requested to:

- **Advise** on further assurances required in relation to staffing capability and capacity and content of future board reports

Lynn Andrews
Director of Nursing and patient Care

Steve Hackett
Director of Finance and Contracting

April 2014

References

National Quality Board (2013)	How to ensure the right people, with the right skills, are in the right place at the right time
NHS Employers (2010)	Flexible workforce: strategic planning to reduce costs and improve quality.
Royal College of Nursing RCN(2010)	Guidance on safe nurse staffing levels in the UK
Royal College of Nursing RCN(2012)	Safe Staffing for Older People's wards. Summary guidance and recommendations
Royal College of Nursing (2013)	Defining staffing levels for children and young peoples services.
The Shelford Group (2013)	Safer Nursing Care Tool

NON-EXECUTIVE DIRECTORS OF THE BOARD

- Ensure there are robust systems and processes in place across the organisation to make informed and accurate decisions concerning workforce planning and provision.
- Review data on workforce, quality of care and patient safety on a regular basis and hold Executive Directors to account for ensuring that the right staff are in place to provide high quality care to patients
- Ensure that decisions being taken at a board level, such as implementing cost improvement plans, have sufficiently considered and taken account of impacts on staffing capacity and capability and key quality and outcomes measures
- Understand the principles which should be followed in workforce planning, and seek assurance that these are being followed in the organisation

CHIEF EXECUTIVE

- Ensure that the organisation has the right number of staff with the required knowledge and skills to provide safe and effective patient care
- Ensure that there is an agreed nursing and midwifery establishment for all clinical areas
- Ensure there are robust systems and processes in place across the organisation to make informed and accurate decisions concerning workforce planning and provision.
- Ensure that appropriate escalation policies are in place and action is taken when staffing falls below that expected
- Ensure workforce plans are clinically and financially viable, and that they inform education commissioning process in place through the Local Education and Training Board (LETB) and Health Education England (HEE)
- Ensure that the Executive Team have SMART objectives (specific, measurable, achievable, realistic, timely) aligned to staffing and that these are reviewed and performance tracked regularly.

EXECUTIVE BOARD MEMBERS

- Report to the Board on nursing, midwifery and care staffing capacity and capability, highlighting concerns and making recommendations where necessary. Workforce data should be triangulated with data on quality of care
- Where staffing capacity and capability is insufficient to provide safe care to patients and cannot be restored, undertake a full risk assessment and consider the suspension of services and closure of wards in conjunction with the Directors of Operations, Chief Executive and Commissioners
- Foster a culture of openness and honesty amongst staff, supported by nursing and midwifery leaders, where staff feel able to raise concerns, and concerns are acted upon

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DIRECTOR OF NURSING

Develop the nursing and midwifery leadership team to ensure that they understand the principles of workforce planning and can use evidence based tools informed by their professional judgement to develop workforce plans and make staffing decisions on a day to day basis

Assure the Board that there are nursing and midwifery workforce plans in place for all patient care areas/pathways

On a monthly basis, report workforce information to the Board on expected vs actual staff in post on a shift-to-shift together with information on key quality and outcome measures

Ensure there is an uplift in planned establishments to allow for planned and unplanned leave and ensure absence is managed effectively

DIRECTOR OF WORKFORCE (HR)

Ensure that human resources support and policies are available to secure sufficient staffing capacity and capability to provide high quality care to patients

Ensure that there are systems and processes in place to capture accurate data on establishment, staffing levels and skill mix, staff movements, training and turnover to inform decisions on workforce planning

Develop and implement policies that support all staff working within areas of competence

Develop and implement a strategic recruitment plan to provide the required resources and fill current and future vacancies

CHIEF OPERATING OFFICER/DIRECTOR OF OPERATIONS

Ensure that the management of the organisation supports delivery of the workforce plan and there is sufficient staffing capacity and capability to provide high quality care to patients

Ensuring that there are systems and processes in place to capture accurate data on quality of care, patient pathways and volume to inform decisions on workforce planning

DIRECTOR OF FINANCE

Ensure that finance decisions which could have an impact on staff capacity and capability and patient outcomes are taken with consideration of staffing and workforce planning implications, and that these are reflected in any advice provided for decision to the Board, linking proposals to patient outcomes and quality

Ensure there are staff recruitment and retention strategies in place, and regularly review the effectiveness of these

Ensure that there are systems and processes in place to capture accurate data on establishment, staffing levels and skill mix, to inform decisions on workforce planning

Annex 2

Reasons for the proposed changes to skill mix and staffing levels following the proposed investment

Ward	Reason for proposed changes
Nightingale	• to enable the day case patients to be cared for in a safe environment during post operative recovery under observation and supervision (separate area) • to respond to volume, intensity and dependency of clinical needs of patients • support immediate response to patients clinical needs overnight. • Facilitate increased support to the emergency department with caring for paediatric patients (ED do not have a paediatric nurse on nights).
Elmton	• Major surgery/ high number of observations and acuity/dependence post operatively e.g colorectal cases • Multiple interventions and high dependency/acuity of patients • To enable a twilight shift to support drug rounds, High IV antibiotics administration on medication rounds • Volume of complex dressing including Vac Pumps • Tube feeding either PEG or NG (no. of feeds high) • Geographical layout of the ward leads to dispersed staffing and feeling of isolation for patients within the single rooms
Holywell	• High volume of activity on the early shift
Robinson	• Complex patients with increased dependency and cognitive impairment • High number of direct admissions from ED can be 5 to 6 a day • Complex/co morbidity patients
Portland	• Complex patients with increased dependency and cognitive impairment • High number of direct admissions from ED • Complex/co morbidity patients
Ashover	• Acute non invasive ventilation care (take all acute directly to Ashover) • Step down facility from critical care for all medical patients requiring respiratory care e.g. tracheostomy • Dependency levels of the frail, elderly patients with LTC severe COPD • Increase of patients requiring invasive procedures e.g. chest drains.
Markham	• Frail elderly care ward – predominately patients with cognitive impairment who have an increased dependency on nursing care, interventions and supervision. • Patients with acute on chronic diseases, e.g. delirium. • The investment along with the change in environment will reduce the need for additional 1:1 care.
Durrant	• Acute frailty unit which increases a higher MDT involvement with a reduced LOS focusing on rapid assessment, intervention • Stroke rehabilitation patients who are on-going rehabilitation and require increased nursing intervention in particular for ADLs and complex feeding regimes (NG/PEG/Trials) – issue identified via CQC.

Eastwood	• The band 6 duty 24/7 is within the rostered numbers however they provide stroke specialist reviews to patients via ED and if appropriate support 24/7 stroke thrombolysis. • MRA/TIA pathway lead for ward attendees attending for MRA and TIA assessment and treatment (Monday – Friday) • Leads the TIA Doppler service for high risk patients on Saturday and Sunday. • Focuses on discharge planning, focusing on the acute and rehab patients - daily huddles and the three times MDT. • Approximately 20 rehab patients who need support with ADLS and attend activities and rehab at 10am each day. • Complex feeding regimes NG, PEG and trials (issues picked up via CQC.)
EMU/CDU	• Increased through put of emergency patients both medical and surgery via GP. • High levels of activity which has increased with the new 7/7 day senior decision making rota. • Unpredictable/management of spikes of activity. • Increased acuity and dependency
Hasland	• Increase in complex cancer treatments which require specific treatment management • Increased frequency and monitoring of blood transfusions which often due to the treatment regimes are into the late evening • Increase in the neutropenia patients who require acute intervention • Unpredictable workload.
Manvers/CCU	• 23 cardiology and 8 CCU patients (92% occupancy) • CCU increased acuity and dependency. • Reduced path way times from tertiary centres. • Acuity and dependency.
Pearson	• Frail, elderly dependent patients with chronic conditions. • Acute DKA patients. • Increase in complex diabetes associated ulcerations.
Ridgeway	• Increased acuity/dependency • Unpredictable workload in relation to acute alcohol detox and eating disabilities.

Annex 3

Allowances

Figure 2 below outlines the allowances used when calculating the budgeted whole time equivalent. Some specialities have previously agreed to reduce allowance allocated for sick leave as part of previous years cost improvement programmes which reduces the overall allowances for that group of staff.

	Percent (%)	No. of Days	EMU/CDU & Orthopaedics Percent (%)	No of Days
Annual Leave cover	14.4	38 (30 plus 10 BH)	14.4	38
Sickness cover	5.2	13.5	3.75	
Training	2.0	5	2.0	5
Sub Total	21.6	63.5	20.15	52.1
Additional allowances on top of initial allowance	4.6	12	4.06	10.6
Total allowances included in budget	**26.2**	**68.5**	**24.21**	**62.7**

Medicine Ward Reconcilliation with Investment at Current Sickness Levels

Ward	Number of Beds			Pre Original Investment Shifts Early	Late	Night	Other	Rota WTE	Post Original Investment Shifts Early	Late	Night	Other	Rota WTE	New Proposal Shifts Early	Late	Night	Other	Rota WTE	Post Original Ratio of RGNs:Beds Early	Late	Night	Overall	New Proposal Ratio of RGNs:Beds Early	Late	Night	Overall	Variance between New Proposal and Post WTE	£	Notes
Ashover	33	Qualified	Band 5/6	4	3	2		16.31	5	5	3		23.57	6	5	3		26.28	1:6.6	1:6.6	1:11.0	1:7.6	1:5.5	1:6.6	1:11.0	1:7.1	2.71	105,643	Night shift has increased from 10 hours to 11.5 hours
		Unqualified	Band 2	4	3	2		16.25	4	3	2		16.263	4	3	2		16.97									0.71	17,993	5th RN until 2:30
		Percentage Qualified						50%					59%					61%											
		Percentage Unqualified						50%					41%					39%											
Basil	34	Qualified	Band 5/6	4	3	2		16.31	5	4	2		19.563	5	5	2		21.92	1:6.8	1:8.5	1:17.0	1:9.3	1:6.8	1:6.8	1:17.0	1:8.5	2.36	91,863	Night shift has increased from 10 hours to 11.5 hours
		Unqualified	Band 2	4	3	2		16.26	3	3	2		14.613	4	3	3		19.68									5.07	128,947	
		Percentage Qualified						50%					57%					53%											
		Percentage Unqualified						50%					43%					47%											
Durrant	32	Qualified	Band 5/6	4	3	2		16.3	5	4	2		19.563	5	5	2		21.92	1:6.4	1:8.0	1:16.0	1:8.7	1:6.4	1:6.4	1:16.0	1:8.0	2.36	91,863	Night shift has increased from 10 hours to 11.5 hours
		Unqualified	Band 2	3	3	2		14.61	3	3	2		14.613	3	3	2		15.32									0.71	17,993	
		Percentage Qualified						53%					57%					59%											
		Percentage Unqualified						47%					43%					41%											
Eastwood	36	Qualified	Band 5/6	6	5	3		25.65	6	5	3		25.219	6	6	3		26.87	1:6.0	1:7.2	1:12.0	1:7.7	1:6.0	1:6.0	1:12.0	1:7.2	1.65	64,304	
		Unqualified	Band 2	3	2	2		12.96	3	2	2		12.963	3	2	2		12.96									0.00	0	
		Percentage Qualified						66%					66%					67%											
		Percentage Unqualified						34%					34%					33%											
Elizabeth Ward	28	Qualified	Band 5/6						3	3	2		14.61	2	2	2		11.31	1:9.3	1:9.3	1:14.0	1:10.5	1:14.0	1:14.0	1:14.0	1:14.0	-3.30	-128,608	
		Unqualified	Band 2						5	4	2		19.563	6	5	2		22.86									3.30	83,966	
		Percentage Qualified											43%					33%											
		Percentage Unqualified											57%					67%											
EMU/CDU	60	Qualified	Band 5/6	9.4	0	6		39.8	11	0	7		47.995	11	0	7		47.99	1:5.5		1:8.6	1:7.0	1:5.5		1:8.6	1:7.0	0.00	0	E-roster rota shows 3 shift system but only earlys' and nights in operation
		Unqualified	Band 2	5.3	0	4		24.7	5	0	3		21.331	5	0	4	1.413	25.41									4.08	103,816	On Erostering Earlys' 6 hr shift afternoons 6 hour shift actual one 11.5 hr shift
		Percentage Qualified						62%					69%					65%											removed Ambulatory Care Qualified 2.0 Wte Unqualified 1.0 WTE as funded 2014/15
		Percentage Unqualified						38%					31%					35%											Removed Transfer Team Qualified 1.76 WTE Unqualifed 1.76 WTE
Hasland	32	Qualified	Band 5/6						5	5	2		21.213	6	5	4		27.81	1:6.4	1:6.4	1:16.0	1:8.0	1:5.3	1:6.4	1:8.0	1:6.4	6.60	257,217	Night shift has increased from 10 hours to 11.5 hours
		Unqualified	Band 2						4	3	2		16.263	4	4	2		17.68									1.41	35,985	
		Percentage Qualified											57%					61%											
		Percentage Unqualified											43%					39%											
Manvers	31	Qualified	Band 5/6	5	4	3		22.75	5	4	3		21.92	5	5	3		23.45	1:6.2	1:7.8	1:10.3	1:7.8	1:6.2	1:6.2	1:10.3	1:7.2	1.53	59,711	Night shift has increased from 10 hours to 11.5 hours
		Unqualified	Band 2	3	3	2		14.61	3	3	2		14.613	3	3	2		14.61									0.00	0	
		Percentage Qualified						61%					60%					62%											
		Percentage Unqualified						39%					40%					38%											
Pearson	33	Qualified	Band 5/6	4	3	2		16.42	5	4	2		19.563	5	5	2		21.92	1:6.6	1:8.3	1:16.5	1:9.0	1:6.6	1:6.6	1:16.5	1:8.3	2.36	91,863	Night shift has increased from 10 hours to 11.5 hours
		Unqualified	Band 2	3.3	3	2		15.2	3	3	2		14.613	3	3	2		15.32									0.71	17,993	
		Percentage Qualified						52%					57%					59%											
		Percentage Unqualified						48%					43%					41%											
Ridgeway	32	Qualified	Band 5/6	4	3	2		16.3	5	5	2		21.213	5	5	2		20.74	1:6.4	1:6.4	1:16.0	1:8.0	1:6.4	1:6.4	1:16.0	1:8.0	-0.47	-18,373	Night shift has increased from 10 hours to 11.5 hours
		Unqualified	Band 2	4	3	2		16.25	4	3	2		16.263	4	3	2		16.26									0.00	0	with one night twilight shift of 6 hours
		Percentage Qualified						50%					57%					56%											
		Percentage Unqualified						50%					43%					44%											
Total Investment for Medical Wards	**351**																										**31.77**	**1,022,175**	

Surgery Ward Reconcilliation with Investment at Current Sickness Levels

Ward	Number of Beds			Pre Original Investment Shifts Early	Late	Night	Other	Rota WTE	Post Original Investment Shifts Early	Late	Night	Other	Rota WTE	New Proposal Shifts Early	Late	Night	Other	Rota WTE	Post Original Ratio of RGNs:Beds Early	Late	Night	Overall	New Proposal Ratio of RGNs:Beds Early	Late	Night	Overall	Variance between New Proposal and Post WTE	£	Notes
Surgical Wards																												
Devonshire	33	Qualified	Band 5/6	4	4	2		17.91	5	5	2		21.21	5	5	2		21.21	1:6.6	1:6.6	1:16.5	1:8.3	1:6.6	1:6.6	1:16.5	1:8.3	0.00		
		Unqualified	Band 2/3	4	2	2		14.14	4	2	2		14.14	4	2	2		14.14									0.00		
		Qual W/E	Band 5/6	4	4	2			5	5	2			5	5	2			1:6.6	1:6.6	1:16.5	1:8.3	1:6.6	1:6.6	1:16.5	1:8.3			
		Unqual W/E	Band 2/3	3	2	2			3	2	2			3	2	2													
		Percentage Qualified						56					60					60											
		Percentage Unqualified						44					40					40											
Elmton	32	Qualified	Band 5/6	4	4	2		17.91	4	4	2		17.91	5	5	2		21.21	1:8.0	1:6.4	1:16.0	1:9.6	1:6.4	1:6.4	1:16.0	1:8.0	3.30	128,608	
		Unqualified	Band 2/3	4	2	2		14.14	4	2	2		14.14	4	3	2		16.26									2.12	53,978	
		Qual W/E	Band 5/6	4	4	2			4	4	2			5	5	2			1:8.0	1:6.4	1:16.0	1:9.6	1:6.4	1:6.4	1:16.0	1:8.0			
		Unqual W/E	Band 2/3	3	2	2			3	2	2			4	3	2													
		Percentage Qualified						56					56					57											
		Percentage Unqualified						44					44					43											
Barnes	32	Qualified	Band 5/6	4	4	2		17.44	5	5	2		21.21	5	5	2		21.21	1:6.4	1:6.4	1:16.0	1:8.0	1:6.4	1:6.4	1:16.0	1:8.0	0.00		
		Unqualified	Band 2/3	3	2	2		12.76	3	2	2		12.96	3	2	2		12.96									0.00		
		Qual W/E	Band 5/6	4	3	2			5	5	2			5	5	2			1:6.4	1:6.4	1:16.0	1:8.0	1:6.4	1:6.4	1:16.0	1:8.0			
		Unqual W/E	Band 2/3	3	3	1			3	2	2			3	2	2													
		Percentage Qualified						58					62					62											
		Percentage Unqualified						42					38					38											
Holywell		Qualified	Band 5/6	4	3	0		8.75	4	3	0		8.75	5	3	0		9.93									1.18	35,378	26 Trolleys used on ward change in shift cover over the week results in an average
		Unqualified	Band 2/3	4	3	0		7.01	4	3	0		7.01	4	3	0		7.43									0.42	10,687	additional of 2.5 hours per day above budget
		Percentage Qualified						56					56					57											
		Percentage Unqualified						44					44					43											
Orthopaedic Wards																												
Murphy	28	Qualified	Band 5/6	4	4	2		17.62	4	4	2		17.62	4	4	2		17.62	1:7.0	1:7.0	1:14.0	1:8.4	1:7.0	1:7.0	1:14.0	1:8.4	0.00		
(was Hasland)		Unqualified	Band 2/3	4	2	2		13.91	4	2	2		13.91	4	2	2		13.91									0.00		
		Qual W/E	Band 5/6	4	4	2			4	4	2			4	4	2			1:7.0	1:7.0	1:14.0	1:8.4	1:7.0	1:7.0	1:14.0	1:8.4			
		Unqual W/E	Band 2/3	3	2	2			3	2	2			3	2	2													
		Percentage Qualified						56					56					56											
		Percentage Unqualified						44					44					44											
Robinson	28	Qualified	Band 5/6	4	3	2		16.00	4	3	2		16.00	4	4	2		17.62	1:7.0	1:7.0	1:14.0	1:9.3	1:7.0	1:7.0	1:14.0	1:8.4	1.62	63,257	
(was Elizabeth)		Unqualified	Band 2/3	3	2	1	1	12.06	3	3	2		14.38	3	3	2		14.38									0.00	0	
		Percentage Qualified						57					53					55											
		Percentage Unqualified						43					47					45											
Portland	27	Qualified	Band 5/6	4	3	2		16.00	4	3	2		16.00	4	4	2		17.62	1:6.8	1:6.8	1:13.5	1:9.0	1:6.8	1:6.8	1:13.5	1:8.1	1.62	63,257	
(was Murphy)		Unqualified	Band 2/3	3	2	1	1	12.06	3	3	2		14.38	3	3	2		14.38									0.00	0	
		Percentage Qualified						57					53					55											
		Percentage Unqualified						43					47					45											
Critical Care																												
ITU	7	Qualified	Band 5/6	8	8	8		45.21	8	8	8		45.21	8	8	8		45.21	1:0.9	1:0.9	1:0.9	1:0.9	1:0.9	1:0.9	1:0.9	1:0.9	0.00		
		Unqualified	Band 2/3	3 wte works across 7 days				3.00	3 wte works across 7 days				3.00	3 wte works across 7 days				3.00									0.00		
		Percentage Qualified						94					94					94											
		Percentage Unqualified						6					6					6											
HDU	8	Qualified	Band 5/6	4	4	4		22.62	4	4	4		22.62	4	4	4		22.62	1:2.0	1:2.0	1:2.0	1:2.0	1:2.0	1:2.0	1:2.0	1:2.0	0.00		
		Unqualified	Band 2/3	3 wte works across 7 days				3.00	3 wte works across 7 days				3.00	3 wte works across 7 days				3.00									0.00		
		Percentage Qualified						88					88					88											
		Percentage Unqualified						12					12					12											
Total Investment for Surgical Wards	**195**																										**10.27**	**355,166**	

W&C Ward Reconcilliation with Investment at Current Sickness Levels

Ward	Current Number of Beds	Proposed Number of Beds			Current Budgeted WTE Shifts Short Day	Shifts Long Day	Shifts Night	Shifts Other	Rota WTE	Current Rota Shifts Short Day	Shifts Long Day	Shifts Night	Shifts Other	Rota WTE	New Proposal Shifts Short Day	Shifts Long Day	Shifts Night	Shifts Other	Rota WTE	Current Rota Ratio of RGNs:Beds Short Day	Long Day	Night	Overall	New Proposal Ratio of RGNs:Beds Short Day	Long Day	Night	Overall	Variance between New Proposal and Post WTE	£	Notes
Nightingale summer	28	28	Qualified	Band 5/6					20.74		5	3		21.36		5	4		26.07		1:5.6	1:9.3	1:7.0		1:5.6	1:7.0	1:6.2	5.33	207,738	20 beds plus 2 HDU beds plus 6 day case beds
			Unqualified	Band 2					5.11		1	1		5.54		2	1		9.30									4.19	106,619	
	22	22	Qual W/E	Band 5/6							4	3				4	4				1:5.5	1:7.3	1:6.3		1:5.5	1:5.5	1:5.5			20 beds plus 2 HDU beds
			Unqual W/E	Band 2							1	1				1	1													
			Percentage Qualified						80%					79%					74%											
			Percentage Unqualified						20%					21%					26%											
Nightingale winter	28	32	Qualified	Band 5/6							5	3				6	4				1:5.6	1:9.3	1:7.0		1:5.3	1:8.0	1:6.4			24 beds plus 2 HDU beds plus 6 day case beds
			Unqualified	Band 2							1	1				2	2													
	22	26	Qual W/E	Band 5/6							4	3				5	4				1:5.5	1:7.3	1:6.3		1:5.2	1:6.5	1:5.8			24 beds plus 2 HDU beds
			Unqual W/E	Band 2							1	1				2	2													
WHU			Qualified	Band 5/6					10.01	2.8	2.2	1		11.79	2.8	2.2	1		11.79											
			Unqualified	Band 2					4.23	2	2			6.40	2	2			6.40											
			Qual W/E	Band 5/6							2	1				2	1													
			Unqual W/E	Band 2																										
			Percentage Qualified						70%					65%					65%											
			Percentage Unqualified						30%					35%					35%											
Total Investment for Women & Children's Wards																												**9.52**	**314,358**	