Nursing & Midwifery Staffing

Trust Board Seminar – 29th January 2014

Mike Wright - Executive Director of Nursing
Context

- Several sentinel events in the last 12 months with far reaching consequences for the nursing workforce – Francis, Keogh, Berwick, etc.
- Unprecedented scrutiny in this area
- CQC findings = 16% hospitals failing to meet their standards for staffing levels
- RCN poll – 90% nurses believe staffing levels to be inadequate
- Not unique to England, or indeed the UK
Context cont.

- Growing body of evidence of links between RN to patient ratios and risk of increased harm/mortality
- Calls for nationally-mandated minimum nurse staffing levels, which have not been supported by CNO and government
- National ‘minimum’ could become ‘maximum’ in financially-challenged times, when there is a need for nursing/care staffing levels to be flexible sometimes to match patient acuity and flow
- Difference between ‘minimum safe’ and ‘optimum’
Supply and demand issues

- Impending nursing shortfall (Kings Fund) – likely reduction of between 0.6% and 11% between 2013 and 2016.
- Future demand varies from drop by 7% to increase in 23%. Overall = reduction by 2016
- Reduction in university commissions in recent years
- ‘Back and forth’ with international recruitment / ‘Stop-Go’ effect
- This, in the face of reductions in junior doctor numbers
- Increasingly ageing nursing workforce

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Phases of service and workforce growth:

- Wanless – 2002-2005
- Wanless II – 2007-2010
- QIPP – 2010 onwards
- Francis – 2012 onwards
Table 1: Whole-time equivalent and percentage change in the NHS qualified nursing and midwifery workforce, 2002 and 2010 - 2012, four UK countries (September)

<table>
<thead>
<tr>
<th></th>
<th>2002</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>% change 2002 - 2012</th>
<th>% change 2010 - 12</th>
</tr>
</thead>
<tbody>
<tr>
<td>England</td>
<td>268,214</td>
<td>309,139</td>
<td>306,436</td>
<td>305,060</td>
<td>13.7</td>
<td>-1.3</td>
</tr>
<tr>
<td>Scotland</td>
<td>37,260</td>
<td>42,513</td>
<td>41,495</td>
<td>41,159</td>
<td>10.5</td>
<td>-3.2</td>
</tr>
<tr>
<td>Wales</td>
<td>18,766</td>
<td>21,823</td>
<td>21,733</td>
<td>21,779</td>
<td>16.1</td>
<td>-0.2</td>
</tr>
<tr>
<td>Northern Ireland</td>
<td>11,558</td>
<td>13,899</td>
<td>13,649</td>
<td>13,823</td>
<td>19.6</td>
<td>-0.5</td>
</tr>
</tbody>
</table>

Sources: England: non-medical workforce census, excludes bank and agency. The NHS Information Centre. Northern Ireland – DHSSPSNI; data is for March; Scotland data - ISD Workforce Statistics; Wales – StatsWales. Note: per cent figures are rounded. NOTE: Scotland data for 2010-12 is not directly comparable with that from 2002 as data collection was re-calibrated using Agenda for Change bands after 2006. Data for 2012 is for bands 5-9.
Figure 1: NHS England: qualified nursing and midwifery staff, full-time equivalent (FTE), 2001/2 – 2011/12 (2001/2=100)

Source: Health and Social Care Information Centre
Figure 2: NHS England monthly staffing, qualified nursing, midwifery and health visiting staff (FTE), March 2010 – April 2013

Source: Health and Social Care Information Centre

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Figure 3: NHS England: qualified nursing and midwifery staff (2002=100); nurses and finished consultant episodes (FCE) 2002/3 – 2012/13 (2002=100); and mean length of stay in hospital (LOS)

Source: NHS HCHS; Time Series Data from 2000/01 to 2010/11 from publication tables, Health and Social Care Information Centre
Figure 4: Qualified nursing workforce, NHS England: community services; health visitors (HV); district nurses (DN), 2002 to 2012 (full-time equivalent)

Source: NHS non medical workforce census, Table 2b, table 3b. NHS Information Centre

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Figure 5: NHS England: age profile, qualified nursing staff headcount, September 2002 and 2012

Figure 18a: England: number of student places commissioned, 2009/10 to 2013/14

Figure 19a: England: number of student places commissioned, 2009/10 and 2011/12 by Strategic Health Authority


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Figure 19b: England: number of student places commissioned, 2013/14 by local education training board (LETB)

Requirements of NHS Trust Boards

- Ten ‘Expectations’
- 9 for trusts; 1 for commissioners
- Boards must be able to demonstrate to CQC, NTDA, Monitor, patients and the public that robust systems are in place to assure themselves that nursing, midwifery and care staffing resource

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Accountability and 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.

**Expectation 2**: Processes are in place to enable staffing establishments to be met on a shift-to-shift basis.
Evidence-Based Decision Making

- **Expectation 3**: Evidence-based tools are used to inform nursing, midwifery and care staffing capacity and capability

Supporting & Fostering a Professional Environment

- **Expectation 4**: Clinical and Managerial leaders foster a culture of professionalism and responsiveness, where staff feel able to raise concerns
Expectation 5: A multi-professional approach is taken when setting nursing, midwifery and care staffing establishments

Expectation 6: Nurses, midwives and care staff have sufficient time to fulfil responsibilities that are additional to their direct caring duties
Openness and Transparency

- **Expectation 7**: Boards receive monthly updates on workforce information, and staffing capacity and capability is discussed at a public Board meeting at least every six months on the basis of a full nursing and midwifery establishment review.

- **Expectation 8**: NHS providers clearly display information about the nurses, midwives and care staff present on each ward, clinical setting, department or service on each shift.
Planning for future workforce requirements

- **Expectation 9:** Providers of NHS services take an active role in securing staff in line with their workforce requirements

The role of commissioning

- **Expectation 10:** Commissioners actively seek assurance that the right people, with the right skills, are in the right place at the right time within the providers with whom they contract

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The use of ‘accredited’ tools

- No single tool does the ‘whole job’
- They are merely guides and are subjective
- A variety available but not all areas covered e.g. community hospitals and community nursing
- Not all consider ‘non-direct care giving time’ and other activities, e.g. admissions, discharges, theatre activity, admin., student support, etc.
- Assessment criteria e.g. patient acuity scoring is highly subjective
- None consider physical layout of a ward, which has a significant impact

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Publishing staffing numbers

- Requirement to publicise staff on duty on a shift by shift basis – expected versus actual
- Some concerns being raised about heightening patient anxiety by displaying numbers alone
- That the numbers become the focus when it’s the skill mix matched to patient acuity that really matters
- Guy’s & St Thomas’ Hospital NHSFT will not be publishing staffing numbers
- GSTT has increased nursing and HCA staff by 681 wte between June and September 2013 (1,000 beds).

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The CDDFT current position

- This is a complex thing to get right
- In the process of reviewing all areas (hospital and community) and using validated tools where available
- Applying pragmatic professional analysis to determine current requirements
- Establishing a validation panel, chaired by DoN (with Finance and HR) to review analysis work before finalising recommendations to the Trust Board
Other factors to be resolved

- Increments and budget setting – not all set at actual costs; 60% RN/M’s and 63% HCA’s at max. pay point
- Mark up for time-out (annual leave, training, sickness, maternity leave) – different understandings and applications of this (20-22%)
- Supervisory Ward Sister-Charge Nurse/Team Leader
- Establish a ‘risk rating’ – proportion away from desired numbers
Cont.

- DMH v UHND recruitment challenges
- Need to establish Rota Rules (bare acceptable minimum standards), which will alert to any on-going concerns
- Need to agree standardised process for collecting and publishing this information regularly and publically
- Paper to the Trust Board in March 2014, then 6-monthly thereafter
- Work needs to integrate with IBP timelines