Adult Ward Nursing
Establishment review

using the Safer Nursing care tool
(Hurst & Shelford group of Hospitals, 2013)

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www.cddft.nhs.uk
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EXECUTIVE SUMMARY

The last report on this topic was presented to the Trust Board in January 2015.

That report advised the Trust Board of the latest developments in relation to the National Quality Board’s¹ Ten Expectations in relation to nursing and midwifery staffing levels, specifically expectations 7 and 8.

The purpose of this report is to confirm on-going compliance with the requirement to publish monthly aggregated nursing and care assistant staffing levels (Expectation 7), in accordance with NHS England’s, The NQB’s and the CQC’s requirements and present the findings of a review of Adult Ward Nursing establishments (Expectation 8) undertaken in June 2015.

In January 2015, the Trust Board agreed establishment uplifts in a number of areas. The effect of this and next steps of work in this area are explained.

CDDT has agreed an approach for ward based nursing staffing levels, which reflect the advice of the Chief Nursing Officer, NHS England’s, The NQB’s and the CQC’s requirements This includes:

- Twice a year review of ward based staffing using an evidence based tool
- Staffing reviews consistently use the same triangulated methodology (acuity/dependency tool; professional judgement; benchmarking with comparators)
- Implement where possible supervisory time for ward leaders
- Support ward leaders with administrative support, where possible
- Skill mix to reflect the needs of the patients in line case mix and activity

This paper continues the work begun with a full review of the ward based nursing staffing levels in the ward based staffing review against 8:1 ratio (patients to registered nurse) in September 2014. This report comprises the findings of a review of all Adult Ward settings using the Safer Nursing care tool (SNCT) conducted in June 2015.

The SNCT is:

- An evidence based tool that enables nurses to assess patient acuity and dependency, incorporating a staffing multiplier to ensure that nursing establishments reflect patient needs in acuity / dependency terms.
- Appropriate for use in any acute hospital within the UK (although further work is underway to refine the tool for use in particular clinical environments, see below on ongoing development of the tool)
- Used in conjunction with Nurse Sensitive Indicators (NSI) such as patient falls and pressure ulcer incidence, which can be linked to staffing
- Able to support benchmarking activity in organisations when used across Trusts. This will facilitate consistent nurse-to-patient ratios in line with agreed standards across similar care settings in England.

Following extensive training Ward staff collected data on the acuity and dependency of every adult in-patient in the trust at 1300 every weekday afternoon for four weeks in June 2015. Quality control was fundamental to ensuring a robust approach to data

¹ National Quality Board 2013 - How to ensure the right people, with the right skills, are in the right place at the right time - A guide to nursing, midwifery and care staffing capacity and capability
A process to ensure that accurate, quality controlled data was collected included:

- Nominating the E-Rostering manager to quality control the data collection.
- Identifying no more than three leaders per ward to complete the scoring daily for the duration of the data collection period.
- Patient flow data was collected for the 24-hour period leading to the data collection time; e.g., all admissions / discharges between 1300hrs that day and 1300hrs the previous day.
- Nurse Sensitive Indicator data could be collected retrospectively by a senior nurse or directly pulled from the electronic incident reporting system (Safeguard).
- Data collection tools were then transcribed onto prepared spreadsheets, and collated on a shared drive for analysis. Dependency scores were compared to national benchmarks for similar specialty wards in the pilot testing sites and further discussion was had with ward staff to ensure a consistency of approach. Ward staff, Matrons and Lead nurses were also encouraged to ‘sense check’ their ‘scores’ with neighbouring wards in their division or other community hospitals. Workforce variables such as non-productive time were adjusted to produce accurate data to predict nursing requirements for each ward / department.
- Validation with the Finance department to compare predicted nursing requirements with actual budgeted nursing establishments.
- Feedback of results to Sisters and Charge Nurses, Matrons and Lead nurses will commence after publication at board.

This will allow nursing staff to understand not only the levels of patients on wards, but also enable this information to be allied to other key data including:

- **Nurse Sensitive Indicators** are quality indicators linked to nursing care. These inform nurses of good and poor patient outcomes, enabling good practice to be shared and poor practice to be rectified. (See Appendix 1)
- **Patient Flow information** was collected to enable nurses responsible for nursing workforce reviews to consider issues such as throughput, including numbers of admissions, discharges, transfers, ward attenders, deaths and transfers away from the ward / department, occupancy and staffing levels. The multipliers account for normal patient-flow levels, however when there is a high throughput of patients, an additional staffing uplift may be considered appropriate - see example in section 11.
- Nurse Sensitive Indicators and patient flow allied to acuity and dependency support professional judgement and enable appropriate nursing establishments for meeting the patients’ needs to be agreed.

Preliminary findings were shared with Lead Nurses in October 2015. The resulting analysis is a combination of the presented data with a triangulation of professional judgement, nursing sensitive outcome data and observations on the utility of the service model going forward.

Where possible, Lead Nurses have tried to “consume their own fire” in their respective divisions, i.e. make adjustments between over- and under- staffed areas before seeking investments or offering up savings. Recommendations for change have been offered to take a view regarding investment plans, service redesign, skill mix changes and cost improvements.

The key recommendations relate to:
• Understaffing of Orthopaedic Ward 12, UHND.

• Internal adjustments to the establishment and capacity of the Surgery and Diagnostics care group, with a particular review of ward sizes and configurations.

• Staffing establishments in Emergency Medicine and Elderly care approximate closely to need in most areas, however Acute Medical assessment and Elderly Medicine carry the greatest risk related to high vacancy levels.

• Surgery appears slightly over staffed creating the opportunity to reassign resources to understaffed Ward 12 and further refinement of the bed model followed by a repeat exercise this winter.

• Underutilisation in the Orthopaedic unit at Bishop Auckland Hospital reinforces the imperative for strategic centralisation of Orthopaedic services at this site.

• A high patient flow in Gynaecology suggests consideration should be given to a mixed day case / in patient bed model across the trust cf. to the current mirror image traditional Gynaecology wards at DMH and UHND.

• A longer term view regarding some community hospitals where utilisation is variable and skill mix is rich but appear to remain understaffed with high use of temporary staff.

• The review of Community hospitals should be expedited in order to implement agreed budget uplifts and recruit to new establishments in order to avoid budget overspends on temporary staff to support patient demand.

• There should further refinement of the repeat study later in the year through the introduction of variant tools for assessment areas and long stay elderly wards.

It is recommended that the Care groups study this report in order to create an action plan of changes to sustain patient safety, improve staff utilisation, make targeted investments, adjust budgets and change the configuration of services to more closely meet the needs of patients in the trusts hospitals.

The Trust Board is requested to:

• Receive this report,
• Decide if any if any further actions and/or information are required.
1. PURPOSE OF THIS REPORT

The last report on this topic was presented to the Trust Board in January 2015. That report advised the Trust Board of the latest developments in relation to the National Quality Board’s\(^2\) Ten Expectations for nursing and midwifery staffing levels, specifically expectations 7 and 1.

The purpose of this report is to confirm on-going compliance with the requirements to:

- publish monthly aggregated nursing and care assistant staffing levels, in accordance with NHS England’s, The NQB’s and the CQC’s requirements; and
- evaluate Nursing establishments in Adult wards twice each year and report these findings to the Trust board.

At its meeting in January 2015, the Trust Board approved uplifts to nursing establishments. An update on the impact of this is provided in the report.

The Trust Board is requested to:

- Receive this report, and;
- Decide if any further actions and/or information are required.

2. EXPECTATION 7

Expectation 7 of the NQB’s standards requires Trust Boards to receive monthly updates\(^3\) on workforce information, and that staffing capacity and capability is discussed at a Trust Board meeting in public at least every six months on the basis of a full nursing and midwifery establishment review.

The first specific requirement of Expectation 7 is for provider Trusts to upload the staffing levels for all in-patient areas on a monthly basis into the national reporting database. These are then published via the NHS Choices Website alongside other quality indicators for each Trust, with a hyperlink to each Trust’s web page for more specific information.

The Trust Board is advised that the Trust continues to comply with the requirement to upload and publish the aggregated monthly nursing and care assistant (non-registered) staffing data for in-patient areas. These can be viewed via the following hyperlink address on the Trust’s web-page: `http://www.cddft.nhs.uk/about-the-trust/safer-staffing.aspx` and in the attached Safe staffing report under separate cover.

\(^2\) National Quality Board 2013 - How to ensure the right people, with the right skills, are in the right place at the right time - *A guide to nursing, midwifery and care staffing capacity and capability*

\(^3\) Where Trust Boards do not meet in public monthly, this is to be presented at every Trust Board meeting in public when they occur.
2.1 Revised Nursing & Midwifery Establishment Reviews – December 2014

At its meeting in January 2015, the Trust Board agreed the following uplifts to nursing and midwifery establishments:

Table 1: Additional establishment requirement (headcount wte) - Basic cost

<table>
<thead>
<tr>
<th></th>
<th>WTE - RGN</th>
<th>WTE - Non RGN</th>
<th>WTE Total</th>
<th>£000 - RGN</th>
<th>£000 - Non RGN</th>
<th>£ Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>ALTC</td>
<td>53.44</td>
<td>63.76</td>
<td>117.2</td>
<td>£1,537,415</td>
<td>£1,168,593</td>
<td>£2,706,009</td>
</tr>
<tr>
<td>S&amp;D</td>
<td>12.93</td>
<td>2.00</td>
<td>14.93</td>
<td>£371,983</td>
<td>£36,656</td>
<td>£408,639</td>
</tr>
<tr>
<td>CCTH</td>
<td>40.22</td>
<td>16.87</td>
<td>57.09</td>
<td>£1,157,089</td>
<td>£309,193</td>
<td>£1,466,283</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>106.59</strong></td>
<td><strong>82.63</strong></td>
<td><strong>189.22</strong></td>
<td><strong>£3,066,488</strong></td>
<td><strong>£1,514,443</strong></td>
<td><strong>£4,580,930</strong></td>
</tr>
</tbody>
</table>

Table 2: With headroom mark up for sickness, annual leave etc. at 21% and with an estimate for unsocial hours (overall extra budgeted wte)

<table>
<thead>
<tr>
<th></th>
<th>WTE - RGN</th>
<th>WTE - Non RGN</th>
<th>WTE Total</th>
<th>£000 - RGN</th>
<th>£000 - Non RGN</th>
<th>£ Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>ALTC</td>
<td>64.66</td>
<td>77.15</td>
<td>141.81</td>
<td>£3,028,879</td>
<td>£245,405</td>
<td>£3,274,284</td>
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<td>S&amp;D</td>
<td>15.65</td>
<td>2.42</td>
<td>18.07</td>
<td>£486,759</td>
<td>£7,698</td>
<td>£494,457</td>
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<tr>
<td>CCTH</td>
<td>48.48</td>
<td>20.41</td>
<td>68.89</td>
<td>£1,709,281</td>
<td>£64,931</td>
<td>£1,774,212</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>128.78</strong></td>
<td><strong>99.98</strong></td>
<td><strong>228.77</strong></td>
<td><strong>£5,224,919</strong></td>
<td><strong>£318,033</strong></td>
<td><strong>£5,542,952</strong></td>
</tr>
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</table>

Table 2 details the overall budgeted wte impact of the establishment uplifts. However, these are not pure headcount vacancies. Therefore, in order to clarify this, the following principles have been agreed between executive directors and with senior nurses and midwives. These include:

1. Baseline budgets are to be re-set from 1st April 2015 to include additional posts (extra headcount wte required) and the allowance for annual leave/bank holidays (circa. 15%).
2. The allowance for study leave and sickness (circa. 6%) is to be placed on a ‘flexi-line’ in budget reports. This will allow budget holders greater flexibility to cover periods of sickness and other workload pressures.
3. Work is underway to look at improved and more regular management information to support this. This will include looking at how the e-rostering system can support this.
4. There is an explicit accountability requirement for budget holders to manage within the available financial envelope. The Trust's Standing Financial Instructions require this. The agreement has to be for budget holders to remain within the available money.
5. Lead Nurses, Associate Chief Operating Officers and Care Group Accountants are required to review this a minimum of monthly and take any appropriate corrective actions to ensure that all quality and financial duties are and continue to be met.
6. The six-monthly establishment reviews will need to consider past and current performance, by area, as part of this work. This report comprises the June review of Adult Ward Nursing establishments.
7. There will be the opportunity to move budget within sphere of responsibility to flex for unforeseen circumstances. However, movement of any budget needs to be justified and be explicit and auditable.
8. Exceptional requirements (exceptional leave or maternity leave) will be required to be managed/mitigated within overall care group resources. However, the establishment review work does not cover any costs associated with running extra bed capacity over and above established baselines. This will require specific funding if it needs to happen.

9. Nursing and midwifery budget holders are accountable for nursing and midwifery spend at each respective level.

10. Lead Nurses and Matrons may operate flexible skill mix arrangements within the available budget. However, these must be safe and retain appropriate staffing and skill mix ratios and, also, be explicit.

11. Every opportunity has to be taken to reduce and, where possible, remove agency spend and dependency.

3. **EXPECTATION 1**

The National Quality board set out an expectation that Boards request and receive papers on establishment reviews. Carried out at least every six months, establishment reviews are critical to ensuring that the right people, with the right skills, are in the right place at the right time. They provide the opportunity to evaluate staffing capacity and capability over the previous six months, and to forecast the likely staffing requirements of wards for the next six months, based on the use of evidence based tools, and a discussion with ward, service and team leaders. Boards should sign off establishments for all clinical areas, articulate the rationale and evidence for agreed staffing establishments, and understand the links to key quality and outcome measures.

Papers to the Board on establishment reviews should aim to be relevant to all wards and cover the following points:

- the difference between current establishment and recommendations following the use of evidence based tool(s) (further detail provided under expectation 3);
- what allowance has been made in establishments for planned and unplanned leave (further detail provided under expectation 6);
- demonstration of the use evidence based tool(s) (further detail provided under expectation 3);
- details of any element of supervisory allowance that is included in establishments for the lead sister / charge nurse or equivalent (further detail provided under expectation 6);
- evidence of triangulation between the use of tools and professional judgement and scrutiny (further detail provided under expectation 3);
- the skill mix ratio before the review, and recommendations for after the review (further detail provided under expectation 3);
- details of any plans to finance any additional staff required (further detail provided under expectation 9);
- the difference between the current staff in post and current establishment and details of how this gap is being covered and resourced;
- details of workforce metrics - for example data on vacancies (short and long-term), sickness / absence, staff turnover, use of temporary staffing solutions (split by bank / agency / extra hours and over-time); and
- information against key quality and outcome measures - for example, data on: safety thermometer or equivalent for non-acute settings, serious incidents, healthcare associated infections (HCAIs), complaints, patient experience / satisfaction and staff experience / satisfaction.
The paper should make clear recommendations to the Board, which would be considered and discussed at a public Board meeting. Actions agreed by the Board should be detailed in the minutes of the meeting, and evidence of sustained improvements in the quality of care and staff experience should be considered periodically.

3.1 In-patient areas with staffing pressures and quality concerns

The Trust continues to be under significant and sustained capacity/activity pressures in both emergency departments and in-patient wards. This includes having extra bedded capacity open in some medical wards on both acute sites, some of which remains open still.

This has placed the Trust in the challenging position of having to balance patient care needs, scheduled and unscheduled care activity, rising and complex patient acuity alongside securing safe staffing levels for its in-patient areas and emergency departments. This is all with the ultimate priority requirement to deliver safe and high quality patient care. This has resulted in the Trust incurring significant agency spends in these areas.

The main pressure areas for staffing remain medical and acute assessment wards, particularly at The University Hospital of North Durham. The main pressurised wards are Wards 1, 2, 3 (AMU) and 14 at UHND and Wards 32, 33, 43, 51 and 52 at Darlington Memorial Hospital. Staffing levels and ratios are reviewed on a shift by shift basis and bed numbers and staff are flexed as far as is possible to keep patients safe.

4. SAFER NURSING CARE TOOL NURSING ESTABLISHMENT REVIEW

4.1 Introduction

CDDT has agreed an approach for ward based nursing staffing levels, which reflect the advice of the Chief Nursing Officer, NHS England’s, The NQB’s and the CQC’s requirements. This includes:

- Twice a year review of ward based staffing using an evidence based tool
- Staffing reviews consistently use the same triangulated methodology (acuity/dependency tool; professional judgement; benchmarking with comparators)
- Implement where possible supervisory time for ward leaders
- Support ward leaders with administrative support, where possible
- Skill mix to reflect the needs of the patients in line case mix and activity

This paper continues the work begun with a full review of the ward based nursing staffing levels in the ward based staffing review against 8:1 ratio (patients to registered nurse) in September 2014. This report comprises the findings of a review of all Adult Ward settings using the Safer Nursing care tool (SNCT) conducted in June 2015.

Issues such as Ward leader supervisory allocation are considered elsewhere. Current budgets recognise a 0.8WTE Band 7 contribution to supernumerary Ward leadership. This work follows the 10 recommendations of NHS England / National Quality Board publication (“How to ensure the right people, with the right skills, are in the right place at the right time: a guide to nursing, midwifery and care staffing capacity and capability” November 2013)
Note: the focus of this review is upon the adult in-patient facilities including community hospitals. The Emergency departments, Critical care and Paediatric settings, Non-ward based staffing and Maternity are not covered in this paper, but, are the subject of other reviews which are currently in train.

5 WARD STAFFING

5.1 Establishment review

January’s paper to the Board on establishment reviews (thereafter to be reported every six months as a minimum) aimed to be relevant to all wards and cover the following points:

- information against key quality and outcome measures - for example, data on safety thermometer or equivalent for non-acute settings, serious incidents, healthcare associated infections (HCAIs), complaints, patient experience / satisfaction and staff experience / satisfaction.
- details of workforce metrics - for example, data on vacancies (short and long-term), sickness / absence, staff turnover, use of temporary staffing solutions (split by bank / agency / extra hours and over-time)
- details of any plans to finance any additional staff required
- evidence of triangulation between the use of tools and professional judgement and scrutiny
- details of any element of supervisory allowance that is included in establishments for the lead sister / charge nurse or equivalent
- the difference between then current staff in post and current establishment and details of how this gap is being covered and resourced
- the skill mix ratio before the review, and recommendations for after the review
- the difference between current establishment and recommendations following the use of evidence based tool(s)
- allowances to be made in establishments for planned and unplanned leave
- demonstration of the use of evidence based tool(s)

This review follows on from January’s Board paper and establishes a pattern for a biennial review of Nurse staffing capacity.

5.2 Current Patient to Registered Nurse Ratio

Recent research by the Florence Nightingale School of Nursing and Midwifery at King’s College London found operating a general medical or surgical acute hospital ward with more than eight patients per registered nurse increased the risk of harm (HSJ August 2013). New published safer staffing recommends that the nurse to patient ratio is more appropriate to use as a general guide and local professional judgement must be used when reviewing ward staffing levels skill mix and ratios, taking account of local ward activity and case-mix requirements. Nationally the focus has identified specific issues within adult in-patient ward areas, which this report covers. However there is also an on-going need to complete full staffing reviews on paediatric (using an acuity/dependency tool ward areas or national network guidance for Neonatal Intensive Care), community settings, emergency departments and maternity areas (using midwife to birth ratios).

The full updated ward based reviews are located in the results section of the document.
The output from the September 2014 ward based staffing review was followed by budget resetting, including a revised forecast. Therefore a further review was required based upon the updated position and any service changes. This commenced in June 2015.

6  SETTING THE CONTEXT FOR THE SAFER NURSING CARE TOOL (SNCT)

6.1  Background and description

Ensuring we have the right staff, with the right skills in the right place is Action Area 5 within Compassion in Practice (NHSCB, 2012). This emphasises the need for developing evidence-based, patient need-driven staffing levels in all care settings. The strategy also advocates that there is a twice yearly public Board level discussion to ratify and agree nurse staffing levels.

The Safer Nursing Care Tool (SNCT) is one method that can be used to assist Directors of Nursing to determine optimal nurse staffing levels.

The SNCT is:
- An evidence based tool that enables nurses to assess patient acuity and dependency, incorporating a staffing multiplier to ensure that nursing establishments reflect patient needs in acuity / dependency terms.
- Appropriate for use in any acute hospital within the UK (although further work is underway to refine the tool for use in particular clinical environments, see section on ongoing development of the tool)
- Used in conjunction with Nurse Sensitive Indicators (NSI) such as patient falls and pressure ulcer incidence, which can be linked to staffing
- Able to support benchmarking activity in organisations when used across Trusts. This will facilitate consistent nurse-to-patient ratios in line with agreed standards across similar care settings in England.

6.2  Developing and validating the tool

The tool was validated by Dr. K. Hurst, (then based at the University of Leeds). This included recalibrating the tool using the UK Nursing Database, which at that time included 1,000 best practice wards (those achieving a pre-determined quality rating) and some 119,000 nursing interventions delivered to almost 2,800 patients in 14 care groups over two years.

The SNCT tool was tested in Teaching and District General Hospitals in England (Appendix 1) and across NHS Scotland, to confirm that the tool was easy to use.

In 2012 the Shelford Chief Nurses Group commissioned an expert working group including Dr. Keith Hurst to review the tool, its definitions and multipliers to ensure the SNCT is still current and applicable. A full review was undertaken taking into consideration changes such as:
- The ageing population’s impact on inpatient dependency and acuity;
- Rapid throughput and shorter patient-stays;

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4 The Shelford Group is an organisation comprising the Chief Executives of ten of the leading NHS multi-specialty academic healthcare organisations in England. The Chief Nurses of each of these NHS Trusts belong to a Sub-Group of the organisation and they meet every two months to share best-practice, benchmark and work towards improving standards in nursing.

Noel Scanlon, Executive Director of Nursing
Ged Whitfield, E-roster manager
- Decreasing Registered Nurse direct-care time and the corresponding rise in support worker direct care time.
- New roles and support staff; e.g. Band 4 Nursing Assistants and Band 1-3 housekeepers
- This required that the dual scoring exercise was repeated. 40,000 dual assessments were undertaken in October 2012 using the UK Nursing Database and Safer Nursing Care Tool to update the staffing Multipliers.

6.3 Using the tool in conjunction with other methods to increase assurance

Nursing workload and the ability to provide good care is influenced by many variables including patient acuity and dependency and other issues known to influence nursing workload more locally; e.g.:
- The clinical model
- The labour market
- Staff capacity and capability, seniority and confidence
- Organisational factors; i.e. support roles, support external to the ward, ward layout
- Senior Sister / Charge Nurse supervisory time and leadership capability
- No national workforce tool can incorporate all factors and so combining methods (triangulation) is recommended to arrive at optimal staffing levels. This should include quantitative assessments such as those encapsulated in the SNCT and other more qualitative and professional judgement methods to increase confidence in recommended staffing levels and provide balanced assurance.
- The Royal College of Nursing report (RCN 2010) also advocates triangulating different methods for calculating nurse staffing levels. BHT has explored other methods available to help determine nurse establishments, which can be used for triangulation purposes most especially in relation to Critical care, Community nursing, Paediatric nursing and Midwifery. Triangulation is a key principle of the approach used by the Office of the Chief Nurse is estimating the size and mix of nursing teams in the trust.

6.4 Are we getting the results we want? Monitoring Nurse Sensitive Indicators

Links between patient acuity and dependency, workload, staffing and quality have been established in recent years. Evidence in the literature links low staffing levels and skill mix ratios to adverse patient outcomes (Rafferty et al. 2007; NPSA 2009; NICE 2014). Monitoring Nurse Sensitive Indicators (NSIs) such as infection rates, complaints, pressure ulcers and falls is therefore recommended to ensure that staffing levels determined in the ways described above, deliver the patient outcomes that we aim to achieve. Within the SNCT these data are converted into a rate per 1,000 occupied bed days, thus allowing consistent comparison across wards and Trusts to help ensure optimum staffing levels. If the NSIs are adverse then staffing levels require prompt review to test if the initial recommendations remain appropriate. It is important to exclude factors that may compromise workforce numbers, such as high turnover, sickness, leave or unfilled vacancies. Alternatively, there may be other factors that compromise workforce efficacy including competence, inadequate leadership, poor morale and poor compliance with good practice all of which will require redress through other action.

5 Includes HCAs / Assistant Practitioner
The adult, generic Safer Nursing Care Tool has only recently been validated for use in Acute Medical Unit / Medical admission / Surgical admission wards. The tool has also been further developed to better reflect the complexities of caring for older people in acute care wards and long stay elderly wards, such as community hospitals.

Additionally, a similar tool has been developed for use in Accident and Emergency Departments, though the practicalities of its use require careful consideration as will be discussed later.

7 OVERVIEW OF THE SNCT

The Safer Nursing Care Tool (SNCT) is based on the critical care patient classification (Comprehensive Critical Care, DH 2000). These classifications have been adapted to support measurement across a range of wards / specialties. The full SNCT is outlined below.
The Safer Nursing Care Tool (SNCT) is based on the critical care patient classification (Comprehensive Critical Care, DH 2000). These classifications have been adapted to support measurement across a range of wards/specialties.

<table>
<thead>
<tr>
<th>Levels of Care</th>
<th>Description</th>
</tr>
</thead>
</table>
| Level 0 (Multiplier = 0.99*) | Care requirements may include the following:
  - Elective medical or surgical admission
  - May have underlying medical condition requiring on-going treatment
  - Patients awaiting discharge
  - Post-operative/post-procedure care - observations recorded half hourly initially then 4 hourly
  - Regular observations 2 - 4 hourly
  - Early Warning Score is within normal threshold
  - ECG monitoring
  - Fluid management
  - Oxygen therapy less than 35%
  - Patient controlled analgesia
  - Nerve block
  - Single chest drain
  - Confused patients not at risk
  - Patients requiring assistance with some activities of daily living, require the assistance of one person to mobilise, or experiences occasional incontinence |

<table>
<thead>
<tr>
<th>Level 1a (Multiplier = 1.39*)</th>
<th>Acutely if patients requiring intervention or those who are UNSTABLE with a GREATER POTENTIAL to deteriorate.</th>
</tr>
</thead>
</table>
| Care requirements may include the following:
  - Increased level of observations and therapeutic interventions
  - Early Warning Score - trigger point reached and requiring escalation.
  - Post-operative care following complex surgery
  - Emergency admissions requiring immediate therapeutic intervention.
  - Instability requiring continual observation/invasive monitoring
  - Oxygen therapy greater than 35% +/- chest physiotherapy 2-6 hourly
  - Arterial blood gas analysis - intermittent
  - Post 24 hours following tracheostomy insertion
  - May require transfer to a dedicated Level 2 facility/unit |

<table>
<thead>
<tr>
<th>Level 1b (Multiplier = 1.72*)</th>
<th>Patients who are in a STABLE condition but are dependent on nursing care to meet most or all of the activities of daily living.</th>
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</thead>
</table>
| Care requirements may include the following:
  - Complex wound management requiring more than one nurse or takes more than one hour to complete.
  - VAC therapy where ward-based nurses undertake the treatment.
  - Patients with Spinal Instability/Spinal Cord Injury
  - Mobility or repositioning difficulties requiring the assistance of two people
  - Complex Intravenous Drug Regimes - (including those requiring prolonged preparatory/administration/post-administration care)
  - Patient and/or families requiring enhanced psychological support owing to poor disease progress or clinical outcome
  - Patients on End of Life Care Pathway
  - Confused patients who are at risk or requiring constant supervision
  - Requires assistance with most or all activities of daily living
  - Potential for self-harm and requires constant observation
  - Facilitating a complex discharge where this is the responsibility of the ward-based nurse |

<table>
<thead>
<tr>
<th>Level 2 (Multiplier = 1.97*)</th>
<th>May be managed within clearly identified, designated beds, resources with the required expertise and staffing level.</th>
</tr>
</thead>
</table>
| Care requirements may include the following:
  - Deteriorating compromised single organ system
  - Post operative optimisation (pre-op invasive monitoring) extended post-op care.
  - Patients requiring non-invasive ventilation/respiratory support; CPAP/BiPAP in acute respiratory failure
  - First 24 hours following tracheostomy insertion
  - Requires a range of therapeutic interventions including:
    - Greater than 50% oxygen continuously
    - Continuous cardiac monitoring and invasive pressure monitoring
    - Drug Infusions requiring more intensive monitoring e.g. vasoactive drugs (amiodarone, inotropes, gnr or potassium, magnesium)
    - Pain management - intrathecal analgesia
    - CNS depression of airway and protective reflexes
    - Invasive neurological monitoring |

<table>
<thead>
<tr>
<th>Level 3 (Multiplier = 3.76*)</th>
<th>Patients needing advanced respiratory support and/or therapeutic support of multiple organs.</th>
</tr>
</thead>
</table>
| Care requirements may include the following:
  - Monitoring and supportive therapy for compromised/collapse of two or more organ/systems
  - Respiratory or CNS depression/compromise requires mechanical/invasive ventilation
  - Invasive monitoring, vasoactive drugs, treatment of hypovolaemia/haemorrhage/sepsis or neuro protection |

* This multiplier allows a 22% (time out) uplift for annual leave / study leave, etc. The software allows this to be adjusted for skill mix and the precise 'time-out' or non-productive time ratios of the trusts qualified nurses and unqualified staff. A RfA or Ready for Action time is the proportion of non productive time observed in working nurses in a given speciality during the validation of the tool. This proportion is fixed by the tool.
7.1 Measurement of acuity and dependency

Following extensive training, coaching and a pilot testing week Ward staff collected data on the acuity and dependency of every adult in-patient in the trust at 1300 every weekday afternoon for four weeks in June 2015.

In order to facilitate benchmarking with other users of the tool ward staff collected data at the same time. Acuity and dependency measurement currently takes place at least twice yearly (e.g. January and June). Over time, it is anticipated that this acuity and dependency measurement will identify seasonal trends in response to changing demographics and healthcare needs. Ultimately, this evidence base will support workforce plans for nursing that should accurately predict and enable resources to be identified to support nursing establishments that meet patient and service needs.

Acuity and dependency measurement must be consistent. Consequently all relevant data was collected during the same period. Data was collected on every patient on participating wards / units at 1300 hrs, daily Monday to Friday for 20 days as a minimum.

Quality control was fundamental to ensuring a robust approach to data collection. A process to ensure that accurate, quality controlled data was collected included:

- Nominating the E-Rostering manager to quality control the data collection.
- Identifying no more than three leaders per ward to complete the scoring daily for the duration of the data collection period.
- Patient flow data was collected for the 24-hour period leading to the data collection time; e.g., all admissions / discharges between 1300hrs that day and 1300hrs the previous day.
- Nurse Sensitive Indicator data could be collected retrospectively by a senior nurse or directly pulled from the electronic incident reporting system (Safeguard).
- Data collection tools were then transcribed onto prepared spreadsheets, and collated on a shared drive for analysis. Dependency scores were compared to national benchmarks for similar specialty wards in the pilot testing sites and further discussion was had with ward staff to ensure a consistency of approach. Ward staff, Matrons and Lead nurses were also encouraged to ‘sense check’ their ‘scores’ with neighbouring wards in their division or other community hospitals. Workforce variables such as non-productive time were adjusted to produce accurate data to predict nursing requirements for each ward / department.
- Validation with the Finance department to compare predicted nursing requirements with actual budgeted nursing establishments
- Feedback of results to Sisters and Charge Nurses, Matrons and Lead nurses will commence after publication at board.

This will allow nursing staff to understand not only the levels of patients on wards, but also enable this information to be allied to other key data including:

- **Nurse Sensitive Indicators** are quality indicators linked to nursing care. These inform nurses of good and poor patient outcomes, enabling good practice to be shared and poor practice to be rectified. (See Appendix 1)
- **Patient Flow information** was collected to enable nurses responsible for nursing workforce reviews to consider issues such as throughput, including numbers of admissions, discharges, transfers, ward attenders, deaths and transfers away from the ward / department, occupancy and staffing levels. The multipliers account for normal patient-flow levels, however when there is a high throughput of patients, an additional staffing uplift may be considered appropriate - see example in section 11.
Nurse Sensitive Indicators and patient flow allied to acuity and dependency support professional judgement and enable appropriate nursing establishments for meeting the patients’ needs to be agreed.

Preliminary findings were shared with Lead Nurses in October 2015. The resulting analysis is a combination of the presented data with a triangulation of professional judgement, nursing sensitive outcome data and observations on the utility of the service model going forward.

The final section of the report comprises a set of recommendations to Care groups to sustain patient safety, improve staff utilisation, make targeted investments, adjust budgets and change the configuration of services to more closely meet the needs of patients in the trusts hospitals and departments.

8 SAFER NURSING CARE TOOL RESULTS

The Safer Nursing Care Tool is used to calculate nurse staffing requirements based on the acuity and dependency of patients. During June 2015 over a period of 28 days data from 30 Wards was submitted to the Safer Nursing Care Tool.

The SNCT requires a number of inputs to generate the scores, these are;
- Number of inpatients on the census wards at 1pm
- The acuity score for each patient a 1pm
- Number of staff on each duty; split into Registered & Unregistered and further subdivided into Bank and Agency
- Patient flow data; number of admissions, discharges, transfers in, transfers out, ward attenders, deaths and escort episodes per day.
- Number of budgeted beds
- Number of budgeted Whole Time Equivalent Staff (WTE)
- The SNCT generates;
  - Average recommended WTE’s which is based on the acuity scores averaged out
  - Recommended WTE’s which is based on the highest scoring days being applied right across the census period
  - Patient flow episodes
  - Bed occupancy levels

The SNCT is a nationally recognised and validated approach to guaging nurse staff requirements however has a number of issues that need to be considered;
- The acuity scores are liable to a degree of subjectivity; to minimise this risk it was advised that the Band 7’s and Band 6’s whenever possible score the acuity levels
- The tool requires the staffing levels to be segregated into Registered/Unregistered and Bank/Agency, the output is a combined staffing figure which doesn’t indicate the required skill mix
- The patient flow data does not affect the ‘Average’ or ‘Recommended’ WTE figure – so the tool does not factor the workload required for managing discharges, admissions etc.
- The tool was designed for ‘Acute’ wards not Community Hospitals or Critical Care settings, although variants of the tool for Community hospitals and Assessment areas are now available
- The tool is not as reliable in relation to smaller / specialist areas as the multipliers will recommend staffing levels which are unfeasible for such small numbers of beds
- The Recommended WTE is generated from the highest scoring day and applied across the census period e.g. a Ward could score all ‘0’s for 27 days however on the
28th day score 10 ‘1b’s, the 10 ‘1b’s’ would then generate across the whole 28 days massively inflating the staffing requirement.

- Census period is 28 days and excludes weekend activity
- Census timing (mid-afternoon) for patient acuity does not adequately capture the initial post-operative period for surgical patients

The Safer Nursing Care Tool ‘Average’ WTE’s was the measurement utilised for the recent staffing uplift.

8.1 Results
The following graphs illustrate the findings from the SNCT. The figures being compared are:

- Budgeted WTE – number of both Registered Nurses and Health Care Assistants budgeted to a ward
- Actual WTE – number of WTE Registered Nurses and Health Care Assistant on duty; this is inclusive of Bank and Agency staff. This number is influenced by vacancies, sickness, maternity leave etc.
- SNCT’s Average WTE – number of WTE Registered Nurses and Health Care Assistant the SNCT recommends when the acuity is average out.
- SNCT’s Recommended WTE – number of WTE Registered Nurses and Health Care Assistant the SNCT recommends based on period of greatest acuity
- Negative numbers represent the shortfall between the budgeted/actual and the SNCT’s average/recommended; positive numbers illustrates where the tool has calculated over staffing.
- The WTE’s represent ‘pure’ clinical time with headroom, break times etc. stripped out
- The initial graphs display the full Trust results followed by breakdown by Care Group.
Trust Comparisons; Budgeted/Actual compared to SNCT’s Average & Recommended

<table>
<thead>
<tr>
<th>Trust Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td>-47.84</td>
</tr>
<tr>
<td>-18.57</td>
</tr>
<tr>
<td>46.91</td>
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<tr>
<td>-66.51</td>
</tr>
</tbody>
</table>

- Sum of Budgeted WTE's Compared to Actual WTE's
- Sum of Budgeted WTE's Compared to SNCT's Average
- Sum of Budgeted WTE's Compared to SNCT's Recommended WTE's
- Sum of Actual WTE's Compared to SNCT's Average WTE's
- Sum of Actual WTE's Compared to SNCT's Recommended WTE's
Bed Occupancy

Bed Occupancy %

Noel Scanlon, Executive Director of Nursing

Ged Whitfield, E-roster manager
Budgeted & Actual WTE's Per Bed Ratio
Total Patient Flow Episodes

The chart shows the total patient flow episodes for each ward. The highest number of episodes is in Ward 3 and Ward 4, with numbers ranging from 1335 to 210. The lowest number of episodes is in Ward 17 and Ward 18, with numbers ranging from 4 to 12.
Difference Between Budgeted WTE's and Actual WTE's

[Bar chart showing the difference between budgeted and actual WTE's for various wards and units at UHND and AMU DMH.]
Difference Between Budgeted WTE's and SNCT's Average WTE's

- Ward 2, UHND (0002)
- Ward 3, Acute Medical Unit (0282)
- Ward 17, Lady Eden BAGH (0249)
- Ward 16, DMH (0206)
- Ward 42, DMH (0211)
- Ward 52, DMH (0233)
- Ward 51, UHND (0005)
- Ward 14, UHND (0006)
- Ward 11, UHND (0004)
- Ward 43, DMH (0207)
- AMU DMH (1203)
- Ward 44, DMH (0208)
- Ward 5, UHND (0010)
- Ward 4, Stroke Rehab Unit BAGH (0248)
- Ward 41, DMH (0205)
- Ward 6, UHND (0001)
Difference Between Budgeted WTE's & SNCT's Recommended WTE's

The diagram above illustrates the difference between the budgeted whole-time equivalents (WTE's) and the SNCT's recommended WTE's for various units. The units include Lady Eden Unit (0282), BAGH (0249), DMH (0206), Ward 42 (0233), Ward 51 (0211), Ward 52 (0211), Ward 3 Acute Medical Unit Short Stay UHND (0003), Ward 14 UHND (0005), Ward 1 UHND (0006), Ward 11 UHND (0004), Ward 43 DMH (0207), Ward 2 UHND (0002), Ward 44 DMH (0208), AMU DMH (1203), Ward 5 UHND (0100), Ward 41 DMH (0205), Ward 4 Stroke Rehab Unit BAGH (0248), and Ward 6 UHND (0001). The values represent the difference in WTE's, with positive values indicating a surplus and negative values indicating a deficit.
Difference Between Actual WTE's & SNCT's Average WTE's

Noel Scanlon, Executive Director of Nursing
Ged Whitfield, E-roster manager
Bed Occupancy

<table>
<thead>
<tr>
<th>Ward</th>
<th>Bed Occupancy %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ward 17 Lady Eden Unit (0282)</td>
<td>117.33%</td>
</tr>
<tr>
<td>Ward 44 DMH (0208)</td>
<td>111.11%</td>
</tr>
<tr>
<td>Ward 51 UHND (0233)</td>
<td>111.11%</td>
</tr>
<tr>
<td>Ward 1 UHND (0006)</td>
<td>111.11%</td>
</tr>
<tr>
<td>Ward 11 UHND (0004)</td>
<td>111.11%</td>
</tr>
<tr>
<td>Ward 5 UHND (0300)</td>
<td>111.11%</td>
</tr>
<tr>
<td>Ward 14 DMH (0211)</td>
<td>111.11%</td>
</tr>
<tr>
<td>Ward 52 UHND (0001)</td>
<td>111.11%</td>
</tr>
<tr>
<td>Ward 6 UHND (0002)</td>
<td>111.11%</td>
</tr>
<tr>
<td>Ward 42 DMH (0206)</td>
<td>110.00%</td>
</tr>
<tr>
<td>Ward 4 Stroke Rehab Unit BAGH (0248)</td>
<td>108.83%</td>
</tr>
<tr>
<td>Ward 16 BAGH (0249)</td>
<td>108.83%</td>
</tr>
<tr>
<td>Ward 41 DMH (0205)</td>
<td>108.83%</td>
</tr>
<tr>
<td>Ward 43 DMH (0207)</td>
<td>108.83%</td>
</tr>
<tr>
<td>AMU DMH (1203)</td>
<td>100.00%</td>
</tr>
<tr>
<td>Ward 2 UHND (0002)</td>
<td>97.76%</td>
</tr>
<tr>
<td>Ward 3 Acute Medical Unit Short Stay UHND (0003)</td>
<td>88.89%</td>
</tr>
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</table>
Total Patient Flow Episodes

<table>
<thead>
<tr>
<th>Unit Short Stay UHND (0003)</th>
<th>Total Patient Flow Count</th>
</tr>
</thead>
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<tr>
<td>Ward 3 Acute Medical</td>
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</tr>
<tr>
<td>AMU DMH (0203)</td>
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<tr>
<td>Ward 1 UHND (0006)</td>
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<td>Ward 41 DMH (0205)</td>
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<tr>
<td>Ward 14 UHND (0005)</td>
<td>862</td>
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<tr>
<td>Ward 11 UHND (0004)</td>
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<tr>
<td>Ward 51 DMH (0233)</td>
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<tr>
<td>Ward 43 DMH (0207)</td>
<td>210</td>
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<tr>
<td>Ward 5 UHND (0300)</td>
<td>201</td>
</tr>
<tr>
<td>Ward 2 UHND (0002)</td>
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<tr>
<td>Ward 44 DMH (0208)</td>
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<tr>
<td>Ward 52 DMH (0211)</td>
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<td>Ward 6 UHND (0001)</td>
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<td>Ward 16 BAGH (0249)</td>
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<tr>
<td>Ward 42 Stroke Rehab Unit</td>
<td>132</td>
</tr>
<tr>
<td>Lady Eden Unit (0282)</td>
<td>111</td>
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<tr>
<td>BAGH (0248)</td>
<td>83</td>
</tr>
<tr>
<td>DMH (0206)</td>
<td>61</td>
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<tr>
<td>Lady Eden Unit (0282)</td>
<td>54</td>
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</table>
Surgery & Diagnostics
Difference Between Budgeted WTE's and Actual WTE's

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<th></th>
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<tbody>
<tr>
<td>9.24</td>
<td>0.28</td>
<td>-0.99</td>
<td>-0.42</td>
<td>-0.7</td>
<td>-1.14</td>
<td>-1.2</td>
<td>-1.23</td>
<td>-2.05</td>
<td>-2.35</td>
</tr>
</tbody>
</table>
Difference Between Budgeted WTE's and SNCT's Average WTE's

[Bar chart showing the difference between budgeted WTE's and SNCT's average WTE's for various wards.]

- Ward 18 BAGH (1409): 9.29
- SAU UHND (1106): 6.8
- Ward 15 UHND (1305): 6.18
- Ward 34 DMH (1402): 5.7
- Ward 16 UHND (1105): 5.57
- Ward 13 UHND (1104): 5.01
- Ward 32 DMH (1205): 3.36
- Ward 33 DMH (1401): -0.72
- Ward 31 DMH (1204): -0.87
- Ward 12 Orthopaedic Unit UHND (1303): -5.27
Difference Between Budgeted WTE’s & SNCT’s Recommended WTE’s

<table>
<thead>
<tr>
<th>Ward</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>SAU UHND (1106)</td>
<td>5.93</td>
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<td>Ward 18 BAGH (1409)</td>
<td>5.87</td>
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<tr>
<td>Ward 15 UHND (1305)</td>
<td>5.65</td>
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<tr>
<td>Ward 13 UHND (1104)</td>
<td>5.01</td>
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<tr>
<td>Ward 16 UHND (1105)</td>
<td>4.8</td>
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<tr>
<td>Ward 34 DMH (1402)</td>
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<tr>
<td>Ward 32 DMH (1205)</td>
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<td>Ward 31 DMH (1204)</td>
<td>-5.27</td>
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<td>Ward 33 DMH (1401)</td>
<td>-5.34</td>
</tr>
<tr>
<td>Ward 12 Orthopedic Unit UHND (1303)</td>
<td>-8.06</td>
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</tbody>
</table>
Difference Between Actual WTE's & SNCT's Recommended WTE's

<table>
<thead>
<tr>
<th>Ward</th>
<th>Difference</th>
</tr>
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<tbody>
<tr>
<td>SAU UHND (1106)</td>
<td>4.73</td>
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<td>Ward 13 UHND (1104)</td>
<td>4.59</td>
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<tr>
<td>Ward 15 UHND (1305)</td>
<td>4.42</td>
</tr>
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<td>Ward 16 UHND (1105)</td>
<td>4.41</td>
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<tr>
<td>Ward 18 BAGH (1409)</td>
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<td>Ward 12 Orthopaedic Unit UHND (1303)</td>
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<td>Ward 84 DMH (1402)</td>
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<td>Ward 82 DMH (1205)</td>
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<td>Ward 81 DMH (1204)</td>
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<td>Ward 83 DMH (1401)</td>
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</table>
Difference Between Budgeted WTE’s and Actual WTE’s
Difference Between Budgeted WTE's and SNCT's Average WTE's

- Weardale Community Hospital (5001)
- FWU Sedgefield Community Hospital
- Ward 62 DMH (0705)
- Lowson Ward Richardson Community Hospital
- Ward 1 C-L-S (0307)
- Ward 9 UHND (0605)
- Starling Ward Richardson Community Hospital
- Ward 6 BAGH (0243)

Values:
- 9.59
- 8.78
- 7.58
- 6.75
- 5.78
- 4.57
- 4.05
- 14.73
Difference Between Budgeted WTE's & SNCT's Recommended WTE's

Weardale Community Hospital (5001)
FWU Sedgefield Community Hospital
Ward 1 C-L-S (0307) Ward 6 DMH (0705)
Lowson Ward Richardson Community Hospital
Ward 9 UHND (0605)
Starling Ward Richardson Community Hospital
Ward 6 BAGH (0243)

<table>
<thead>
<tr>
<th></th>
<th>Difference Between Budgeted WTE's &amp; SNCT's Recommended</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weardale</td>
<td>7.77</td>
</tr>
<tr>
<td>FWU Sedgefield</td>
<td>6.97</td>
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<tr>
<td>Ward 1 C-L-S (0307)</td>
<td>4.83</td>
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<tr>
<td>Ward 6 DMH (0705)</td>
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<tr>
<td>Lowson Ward</td>
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<td>Starling Ward</td>
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<tr>
<td>Ward 6 BAGH (0243)</td>
<td>-7.86</td>
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<tr>
<td></td>
<td>-16.66</td>
</tr>
</tbody>
</table>
Difference Between Actual WTE's & SNCT's Average WTE's

- Lowson Ward Richardson Community Hospital: 10.68
- Ward 62 DMH (0705): 9.02
- Ward 9 UHND (0605): 4.75
- Weardale Community Hospital (5001): 3.36
- Ward 1 CLS (0307): 2.99
- NWU Sedgefield Community Hospital: -0.08
- Starling Ward Richardson Community Hospital: -3.66
- Ward 6 BAGH (0248): -14.95
Difference Between Actual WTE's & SNCT's Recommended WTE's

<table>
<thead>
<tr>
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<th>Difference</th>
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<tbody>
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Total Patient Flow Episodes

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<tr>
<th>Total Patient Flow Count</th>
<th>Ward 9 UHND (0605)</th>
<th>Ward 62 DMH (0705)</th>
<th>Starling Ward Richardson Community Hospital</th>
<th>Ward 6 BAGH (0243)</th>
<th>FIWU Sedgefield Community Hospital</th>
<th>Lowson Ward Richardson Community Hospital</th>
<th>Weardale Community Hospital (5001)</th>
<th>Ward 1 C-L-S (0307)</th>
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<tr>
<td></td>
<td>450</td>
<td>285</td>
<td>66</td>
<td>55</td>
<td>55</td>
<td>51</td>
<td>47</td>
<td>44</td>
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</tbody>
</table>
9 ANALYSIS

An analysis of the Trust wide comparisons between budgeted, actual, average and SNCT recommended Nursing workforce requirements expressed in whole time equivalents (page 18) should show a close alignment between these values if Staffing matches demand. However, for the following areas there is not close alignment between budget, actual staff in post, average demand and the requirements recommended by the Safer nursing care tool:

- AMUs, Durham & Darlington
- Lowson & Starling wards, Richardson Hospital
- Wards 16 & 18, BAH
- Ward 4 Stroke BAH
- Wards 41 & 52 DMH
- Ward 6, BAH
- Ward 6, UHND
- Ward 12, UHND.

This indicates that these areas may be under-staffed or under-established or both. A comparison of budgeted against SNCT recommended establishments points to a shortfall of 18.67 wte (page 20).

Bed occupancy (page 21) across the trust was reported as extremely high during the reporting period. Only one ward – Ward18 BAH – had less than 80% occupancy and most areas reported in excess of 100% due to the high throughput of patients and rapid turnover.

An analysis of budgeted v. actual WTEs per bed ratio (page 22) shows overstaffing on Ward 5 UHND which has since been corrected during phase 1 of the paperless rostering roll out. Ward 12 Orthopaedic appears to be the most understaffed and overspent ward in the trust with an actual WTE per bed ratio of 0.83 cf. spend of 1.11. This compares to it’s sister Orthopaedic ward at DMH, Ward 33 with a budgeted ratio of 1.08 closely aligned to it’s actual spend of 1.00 wte.

Total patient flow episodes (page 23) on the Medical assessment units (Ward 3, UHND & AMU DMH) and Surgical assessment unit, DMH Ward 31 are predictably high. However the Gynaecology wards also have a throughput of 450 and 285 patients / month indicating that the Gynaecology pathway should be reviewed with a greater emphasis on day case work to reduce cost and improve efficiency.

9.1 Acute & Long term conditions.

When looking for correlations between budgeted, actual utilisation and recommended nursing requirements (page 24) the lack of correlation for Ward 6 should be investigated further.

The difference between budgeted and actual WTEs (page 25) shows over rostering on Wards 5, 6 and 14 at UHND which has now been corrected following phase 1 of the paperless rostering roll out and the introduction of new policies on “Cohorting and specialising” (Supervision) of vulnerable patients - particularly the confused elderly and those suffering from detoxification for alcohol related illness. These policies have objectively assessed risk and for the first time introduced the notion of de-escalation when risk profiles change.

The difference between budgeted and average WTEs (page 26) shows the limitations of the tool as it applies to small bed complement areas such as Neuro-Rehabilitation Ward 17, BAH; Elderly Rehab. Ward 42 Oncology DMH which only 8 beds. Professional judgement does not substantiate the need for 10 additional staff on Ward 41 DMH or Ward 6 UHND.
9.2 Surgery & Diagnostics.

When looking for correlations between budgeted, actual utilisation and recommended nursing requirements (page 33) the lack of correlation for many of the Surgical wards highlights the need to consider consolidating wards of 16-18 beds to more economic bed complements, notably Wards 13 and 16 UHND and Ward 18 BAH. Development of the Orthopaedic centre of excellence may enable a greater use of assets at BAH. Making economies of the existing staffing arrangements within these complements would be counter productive as minimum safe staffing levels would be breached.

There is also a variant of the SCNCT tool for assessment areas which might better capture the utilisation and demand of these high throughput short stay areas. This should be considered for the next study at the end of 2015.

The difference between budgeted and actual WTEs (page 34) shows over spending on Ward 12, Orthopaedic at UHND which has less than 1 wte per bed compared to its sister ward as has been mentioned earlier. This indicates the highest level of unmet need in the trust with spend on agency to compensate. The establishment should be corrected through internal reassignment of resources within the care group, such as the reassignment of 8 wte taken from Wards 13 and 16 UHND and Ward 34 at DMH. The difference between budgeted and SNCT recommended WTEs (page 38) reinforces the need for 8 additional staff on Ward 12 UHND.

Bed occupancy (page 39) on Ward 18 BAH (Orthopaedic) is the most flexible but least well utilised in the trust showing an average occupancy of 62%.

Ward 12 Orthopaedic appears to be the most understaffed and overspent ward in the care group (page 40) with an actual WTE per bed ratio of 0.83 cf. spend of 1.11. This compares to it’s sister Orthopaedic ward at DMH, Ward 33 with a budgeted ratio of 1.08 closely aligned to it’s actual spend of 1.00 wte.

9.3 Care closer to Home

Analysis of SNCT data in long stay elderly wards within the Community hospitals (page 42) has been made very difficult by two factors:

- The utility of the SNCT tool which is designed for acute hospitals, which makes sensitive scoring of patient dependency difficult. A variant of the tool for long stay elderly wards within Community hospitals is now available and should be utilised for the Winter 2015 study.
- The failure to apply agreed budget uplifts pending a review of Community hospitals. This is manifest as budget overspends on temporary staff to support patient demand and makes interpretation of the data less reliable.

Conversely, Gynaecology wards 62, DMH and 9, UHND appear over staffed because the tool does not adequately capture the high volume of day case activity – perhaps indicating that consideration should be given to changing the model of care away from mirror image in patient facilities towards a mixture of day case and in patient provision across the trust.

Professional judgement does not therefore support the need for 8 additional WTE at Sedgfield community hospital (page 43) or circa 15 wte at Ward 6 BAH (pages 44-47).

10 RECOMMENDATIONS

The SNCT tool has highlighted fluctuations in staff utilisation, patient flow and the demand for nursing services which reinforce actions currently being undertaken to bring nursing costs under control through more disciplined rostering and more objective evaluation of the need
for temporary nursing cover to meet unexpected demand such as the specialising of vulnerable at risk patients.

The study has also highlighted very levels of bed occupancy and close alignment of budgets against nursing requirements given that significant levels of vacancy are being across very many areas.

Inefficiencies in the current bed model are also highlighted especially in Surgical settings.

It is therefore recommended that the Surgery and Diagnostics care group:

- reassign resources to meet a shortfall of 8 wte in Ward 12, e.g. from Wards 13 and 16 UHND and Ward 34 at DMH
- re-examine the utilisation of Elective Orthopaedic Ward 18, BAH given that this is associated with the Development of the Orthopaedic centre of excellence and the upgrading of some operating theatres at BAH which is already in train
- consider consolidating wards of 16-18 beds to more economic bed complements, notably Wards 13 and 16 UHND and Ward 18 BAH
- consider a new model of care for Gynaecology away from mirror image in patient facilities at DMH and UHND towards a mixture of day case and in patient provision across the trust.

There should further refinement of the repeat study later in the year through the introduction of variant tools for assessment areas and long stay elderly wards.

The review of Community hospitals should be expedited in order to implement agreed budget uplifts and recruit to new establishments in order to avoid budget overspends on temporary staff to support patient demand.

Lead nurses, Matrons and Ward sisters should review the findings of this study carefully in order to understand the relationship between patient demand, nursing requirements and current utilisation of budgeted resources. A broader discussion of the use of this and other tools in the Nursing community should take place in order to drive greater efficiency in both staffing arrangements, bed modelling and organisational capacity to meet patient demand.

11 SUMMARY

The Trust continues to meet its obligations as set out by NHS England, the CQC and the National Quality Board to review and report nursing staffing levels. The first of the bi-annual reviews of establishments has taken place for this financial year.

The key recommendations relate to:

- Understaffing of Orthopaedic Wards 12, UHND.

- Internal adjustments to the establishment and capacity of the Surgery and Diagnostics care group, with a particular review of ward sizes and configurations.

- A longer term view regarding some community hospitals where utilisation is variable and skill mix is rich but appear to remain understaffed with high use of temporary staff.

- Staffing establishments in Emergency Medicine and Elderly care approaches closely to need in most areas, however Acute Medical assessment and Elderly Medicine carry the greatest risk related to high vacancy levels.
• Surgery appears slightly over staffed creating the opportunity to reassign resources to understaffed Ward 12 and further refinement of the bed model followed by a repeat exercise this winter.

• Underutilisation in the Orthopaedic unit at Bishop Auckland Hospital reinforces the imperative for strategic centralisation of Orthopaedic services at this site.

• A high patient flow in Gynaecology suggests consideration should be given to a mixed day case / in patient bed model across the trust cf. to the current mirror image traditional Gynaecology wards at DMH and UHND.

It is recommended that the Care groups study this report in order to create an action plan of changes to sustain patient safety, improve staff utilisation, make targeted investments, adjust budgets and change the configuration of services to more closely meet the needs of patients in the trusts hospitals.

12 KEY ISSUES
Trust board has been asked to consider a review of Ward nursing safer staffing levels undertaken in the Summer of 2015 using the Safer Nursing care tool, that enables care to be provided of acceptable quality and safety standards. This has been highlighted as a key concern from the Francis report, Keogh Reviews and CQC inspections. This is part of a biannual process to review Nursing capacity in all settings in order to highlight areas of risk and the potential for improvements in utilisation and the patient pathway in each of the trusts nursing settings.

Having presented these findings to the board, further scrutiny and discussion with key stakeholders will now take place in order to offer both an evidence based appraisal of the capacity of nursing services in Adult wards and an indication of the response of the Executive and Clinical leaders of the Trust. This will be reported in future board reports as part of the Ward establishment review cycle and as part of the monthly safe staffing levels monitoring currently presented to the board as part of Expectation 7 of NQB guidance.

13 OPTIONS AND DECISIONS REQUIRED
This paper asks Trust Board :
• To note the current situation on Adult ward staffing capacity in light of the national expectations of service providers.
• To review the current approach for workforce planning, resource utilisation and quality and safety performance monitoring for Adult ward based nursing staff.

14 NEXT STEPS / WAY FORWARD:
Depending upon the outcome of the Trust Board’s discussion the current approach for workforce planning, resource utilisation and quality and safety performance monitoring for Adult ward based nursing staff will be implemented or further adjusted with a view to reviewing the impact of these decisions with a further study in December or January. This will take account of any changes and seasonal variations in workload.

The outcomes of further reviews of :
• Midwifery
• Childrens Nursing services
• Critical care
• Emergency department Nursing can be expected in the coming months.
A decision on any review of Community Nursing will be made pending the outcome of research into evidence based tools currently under way.

The Trust Board has agreed staffing establishment uplifts. Most of these were placed into budgets formally from 1st April but recruitment efforts to try and fill as many of these posts as possible and displace agency spend in the process has been an ongoing challenge.

The investment levels are significant and there needs to be robust controls in place supported by good and regular management information and action. Every effort now needs to take place through this work to reduce significantly the Trust’s use of agency staff.

Further work is needed to try and improve recruitment and retention and the nursing recruitment group is making progress in this area.

15 ACTION REQUESTED OF THE TRUST BOARD

The Trust Board is requested to:

- Receive this report, and;
- Decide if any if any further actions and/or information are required.

Noel Scanlon
Executive Director of Nursing
October 2015
16 REFERENCES


RCN (2010) Guidance on safe nurse staffing levels in the UK. London: Royal College of Nursing

16.1 Bibliography


Department of Health and Human Services (2011) Safe Staffing - User Manual Nursing Hours per patient day Model. Tasmania: Department of Health and Human Services


