East and North Hertfordshire NHS
NHS Trust

Agenda Item: 10.1

Trust Board Part 1 - January 2018

Nursing and Midwifery Establishment Review

PURPOSE	To provide the Board with the bi-annual review report for ward establishments for October 2017
PREVIOUSLY CONSIDERED BY	Elements of content previously considered by the Nursing and Midwifery Executive Committee (NMEC) and Ward Sisters and Matrons Committee and the Risk and Quality Committee (RAQC)
Objective(s) to which issue relates *	☑ **Keeping our promises about quality and value** – embedding the changes resulting from delivery of Our Changing Hospitals Programme. ☐ **Developing new services and ways of working** – delivered through working with our partner organisations ☐ **Delivering a positive and proactive approach to the redevelopment of the Mount Vernon Cancer Centre**
Risk Issues(Quality, safety, financial, HR, legal issues, equality issues)	Poor quality patient experience Impact on safety Impact upon annual assessment ratings Non-compliance with regulatory and legislative requirements Trust reputation
Healthcare/ National Policy (includes CQC/Monitor)	CQC standards, NICE Guidance Safe Staffing for nursing in adult in patient wards in acute hospitals (2014). NICE Guidance Safe midwifery staffing for maternity settings (2015). National Quality Board – How to ensure the right people, with the right skills, are in the right place at the right time. (2013) NHSI-Model Hospital Dashboard (2017)
CRR/Board Assurance Framework * * tick applicable box	☑ **Corporate Risk Register** ☐ **BAF**
ACTION REQUIRED * For approval: x For discussion: ☐ For decision: ☐ For information: ☐	

DIRECTOR:	Director of Nursing and Patient Experience / DIPC
PRESENTED BY:	Director of Nursing and Patient Experience / DIPC
AUTHOR:	Acting Director of Nursing and Patient Experience / DIPC
DATE:	January 2018

We put our patients first we work as a team we value everybody we are open and honest
We strive for excellence and continuous improvement

East and North Hertfordshire NHS
NHS Trust

Nursing and Midwifery Establishment Review

October 2017

Nursing and Midwifery Establishment Review – Trust-wide

1. Executive Summary

The data collection for the nursing and midwifery establishment review was undertaken in October 2017. Actual staffing, along with patient acuity and dependency data, was collected over a 20 day period. This was then analysed using a recognised evaluative framework, and was benchmarked against other Trusts - **Appendix 1.** Triangulation of this data along with nationally recognised recommendations are used to assess appropriate nurse staffing levels for each inpatient ward. The Trust uses a flexible and pragmatic approach to safe staffing, using evidence-based tools and appropriate skill mix to assess and meet the overall need in all departments. This establishment review outlines the work undertaken since the last review, provides an update on any continuous or on-going initiatives and outlines any future options to be undertaken in relation to maintaining safe and productive nurse staffing levels.

Summary of additional options reviewed:-

- Review of staffing shift plan and skill mix on Ashwell Ward
- Review of staffing shift plan and skill mix on the Short Stay Unit (SSU)
- Review of staffing and skill mix on Ward 10B
- Review of staffing and skill mix on Barley
- Review of staffing and skill mix in Critical Care
- Review of staffing and skill mix on Swift
- Review of staffing and skill mix on Bluebell
- Review of 5 day ward manager supervisory time on the Acute Medical Unit Ward (AMUW)
- Review of proposed introduction of a supportive care pathway at Mount Vernon Cancer Centre (MVCC)
- Update on non-ward based nursing (NWBN) project
- Update on Trainee Nurse Associates (TNA)
- Establishment alignment
- Enhanced nursing care team update

2. Introduction

Trust Boards have a duty to ensure safe staffing levels are in place and patients have a right to be cared for by appropriately qualified and experienced staff in a safe environment. These rights are set out within the National Health Service (NHS) Constitution, and the Health and Social Care Act (2012) which make explicit the Board's corporate accountability for quality.

The Nursing and Midwifery Council (NMC) sets out nurses responsibilities in relation to safe staffing levels. Demonstrating safe staffing is one of the six essential standards that all healthcare providers must meet to comply with the Care Quality Commission (CQC) regulation. This is also incorporated within the NICE guidelines 'Safe Staffing for nursing in adult inpatient wards in acute hospitals' (2014). The Carter report (2015) recommends the implementation of care hours per patient day (CHPPD) as the preferred metric to provide NHS trusts with a single consistent way of recording and reporting deployment of staff working on inpatient wards.

Although not directly referenced within this report, other quality indicators have been taken into consideration, i.e. red flags, red triggered shifts and the Nursing and Midwifery Quality Indicators. These indicators are considered and reported within the monthly safe staffing report.

3. Purpose

This establishment review was undertaken for a number of reasons, including:-

- The need to provide assurance, both internally and externally, that ward establishments are appropriate to provide safe care to patients.
- To provide establishment data that will inform the Trust's Workforce Strategy and People Strategy 2014-19.
- To deliver Care Quality Commission requirements under the Essential Standards of Quality and Safety, including outcomes 13 (staffing) and 14 (supporting staff).
- To support implementation of the Trust's annual and strategic objectives, the Nursing and Midwifery Ambitions and Patient and Carer Experience Strategy.

4. Establishment review methodology

A full review of the data, collection processes and methodologies can be found in **Appendix 2.**

5. Current assumptions – Skill Mix and Registered Nurse to bed ratio

The nurse to patient ratio describes the number of patients allocated to each registered nurse. Nurse patient allocations are based on the acuity or needs of the patients on the ward. In critical care the ratio may be 1:1 for the sickest patients or 1:2 or 1:3 for patients who are acutely ill but stable. On general wards the nurse to patient ratio is higher, for example 1:6 or 1:8 depending on the type of service delivered and the needs of the patients. This type of nurse patient ratio is based on guidelines from professional organisations and accreditation bodies, but also reflects the needs of the individual patients at a given point in time.

A full ward breakdown of the service model skill mix and the actual worked skill mix for the reference period can be found in **Appendix 3.**

The Royal College of Nursing (RCN) 'Mandatory Nurse Staffing Levels' (2012) and NICE 'Safe staffing for nursing in adult inpatient wards in acute hospitals' (2014), suggest wards have a planned registered nurse to patient ratio of no more than 8 patients to one registered nurse on day shifts. Table 1 below indicates the service model average target 'registered nurse to patient' ratio for the Trust; the table indicates that no division has a model registered nurse to patient ratio of more than 1 to 8.

Table 1
Registered Nurse to Patient ratio per division

Division	RN to Bed Ratio		
	Early	Late	Night
Medicine	1/6	1/6	1/7
Surgery (Excluding Critical Care)	1/7	1/6	1/7
Women's and Children's	2/9	2/9	2/9
Cancer	2/9	2/9	1/6

6. Data Triangulation

6.1 Care Hours per Patient Day (CHPPD)

At ENHT care hours per patient day (CHPPD) is a productivity model that has been used, in triangulation with other methods, to set the nursing and midwifery establishments.

The review of NHS productivity, chaired by Lord Carter, highlighted CHPPD as the preferred metric to provide NHS trusts with a single consistent way of recording and reporting deployment of staff working on inpatient wards. The methodology for calculating CHPPD used in this review can be found in **Appendix 4.**

CHPPD includes elements of care time that are categorised as direct and indirect clinical care time, these include:

Direct patient care time	Indirect patient care time
▪ All hands-on care (for example assistance with eating and drinking, patient hygiene, administering medication, taking clinical observations) ▪ Providing one-to-one observation or support to patients (for example, taking them to or from theatre) ▪ All direct communication with patients	▪ Patient documentation ▪ Professional discussions to plan patient care ▪ Discharge planning ▪ Communication with patients relatives and friends ▪ Ordering investigations ▪ Shift handovers

CHPPD is used prospectively to identify the likely care time required for expected patient type for a service; this can then be compared to the required CHPPD for actual patients using the service. This can then be compared to the actual CHPPD provided by staff on the ward to asses if wards were appropriately staffed for actual patients.

Table 2 below shows the three dynamics of the continuous linear CHPPD cycle. A full breakdown per ward can be seen in **Appendix 5.** The analysis of outlier wards are discussed further in this report.

Table 2
Care Hours per Patient Day service model, required, and actual worked per division

Division	Service Model CHPPD	Required CHPPD	Actual worked CHPPD
Medicine	5.80	6.82	6.13
Surgery (Excluding Critical Care)	5.21	5.73	5.32
Women's and Children's	6.96	6.94	8.50
Cancer	7.23	6.51	7.93

6.2 Safer Nursing Care Tool (SNCT)

The SNCT is an evidence-based tool developed to help NHS hospitals measure patient acuity and dependency to inform decision making on staffing and workforce, this tool has an expected 10% variation.

Table 3 below shows the occupancy information for each division for the sample period; the SNCT recommended establishment (whole time equivalent - WTE) adjusted to include 17% headroom, current recruitable establishment and the variance between the two metrics. The table shows the cumulative divisional position.

Table 3
Divisional bed occupancy, SNCT, recruitable establishment and variance

Division	Bed Occupancy %	Recommended SNCT recruitable WTE based on occupancy (headroom adjusted to 17%)	Recruitable Establishment (17% headroom)	Variance from actual funded WTE
Medicine	96%	430.19	411.30	-18.89
Surgery (Excluding Critical Care)	93%	218.24	224.64	6.40
Women's and Children's	86%	23.23	42.01	18.78
Cancer	76%	38.73	67.11	28.38

As the SNCT has an expected variation of 10% Medicine and Surgery fall within this expected range. Women's and Children's and Cancer have variations of 45% and 42% respectively, this is further explored in section 9 below. A full breakdown of the data for each ward can be found in **Appendix 6.** When using this tool, other variables should also be taken into consideration:

- Clinical speciality
- Ward size and layout
- Staff capacity, capability, seniority and confidence
- Organisational support and support roles
- Ward manager supervisory time

The outlying variances are discussed per individual unit further in the report.

6.2.1 SafeCare

SafeCare has been used since October 2015 to provide the safer nursing care data for the establishment review. Acuity/dependency is measured on all inpatient wards three times a day and recorded on SafeCare. SafeCare allows nursing staff to capture actual patient numbers by acuity and dependency and asses if staffing levels are appropriate. SafeCare provides visibility across wards and areas transforming rostering into an acuity based daily staffing process that unlocks productivity and safeguards safety. SafeCare has been awarded an endorsement statement by NICE as an effective tool to support Safe Staffing. The Trust is a national leader in the use of SafeCare for safer staffing; having hosted over 50 Trusts to observe and share the Trusts practices and processes to ensure wards are staffed safely.

6.2.2 Data Validation

To validate data collection for the establishment review, the following actions were taken:

- Inter-rater reliability training - To ensure that the SNCT data is validated and consistent, inter-rater reliability exercises have been undertaken with the nursing teams to ensure consistent application of the acuity multipliers.
- Comparing recommended establishment for both CHPPD and SNCT **Appendix 6.**
- Matron Acuity Audits - Throughout the data collection period Matrons audited their wards on a weekly basis to validate data inputs. Any discrepancies in the acuity data scoring were corrected and Matrons worked with nurses to ensure consistent application of the tool.
- External benchmarking with other organisations using the NHS Improvement (NHSI) Model Hospital Dashboard.

6.2.3 Nursing and Midwifery Quality Indicators

The Trust uses information and statistical tools to examine indicators of care. These indicators include; pressure ulcers, complaints, patient falls, drug administration errors, *Clostridium-difficile* rates, MRSA rates. Standardising these metrics by occupancy and length of stay creates a statistical tool that highlights outlying areas whose indicators are higher than anticipated.

Any indicator triggering above established threshold is subject to detailed analysis and an action plan developed where appropriate to improve patient safety and experience. A summary of the nursing and midwifery quality indicators for October 2017 can be seen in **Appendix 7.**

6.2.4 Red Triggered Shifts

The Trust monitors and reports shifts that fall below minimum staffing levels (red triggered shifts) on an on-going basis. **Appendix 8** shows the percentage of shifts that fell below minimum levels during the establishment review period. Proactive mitigating action is taken by nursing team to balance risk across the organisation.

Factors affecting red triggering shifts include:

- Patient numbers, dependency and acuity
- Staffing number and skill mix
- Temporary Staffing fill rate
- Vacancy Rate
- Sickness
- Enhanced Nursing Care requirements (Specialling)

7. Aligning budgets to clinical models

There is an on-going piece of work to align funded establishments to the safe staffing levels outlined in this paper. Although this work is not yet completed, there are some process improvements that have been identified that should prevent the misalignment of service requirement to budget. These are outlined below and will take immediate affect across the organisation:

- No change to clinical staffing budgets will be made without approval from the director of nursing or medical director.
- Where these areas are on e-roster any change must be identified on a shift plan and any budgetary change must align to the agreed shifts plan.
- Each shift plan must be signed by the clinical service lead, finance manager and appropriate clinical director before any service change or budget adjustment is made.
- An audit log of all changes must be included with each shift plan update.

8. Departmental Reviews

8.1 Critical Care

The Critical Care unit at East and North Hertfordshire NHS Trust (ENHT) has 20 beds spread over 3 areas, there are currently 93 staff in post in total equating to 88 whole time equivalent (WTE), and the unit currently has a 17.48% vacancy rate. The unit has a high degree of senior staff on duty with a band 7 overseeing each shift and band 6s working as nurse in charge of each patient area.

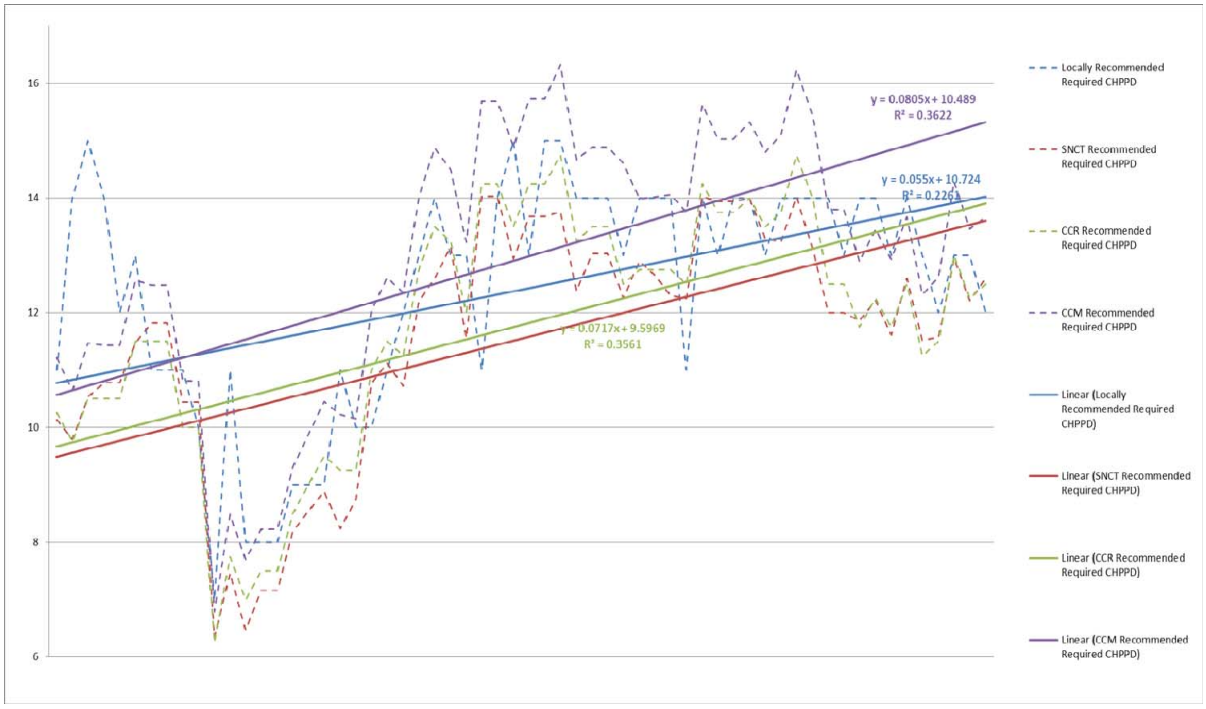
There are generally between 9-20 staff on shift at any time, this variation is due to the highly unpredictable nature of the demand. The unit plans staffing levels on expected activity at the time and flexes as service need dictates which is in line with the "Guidelines for the Provision of Intensive Care Services" (GPCIS) see **Appendix 9**. The unit cares for the most acutely ill patients which are broken down by patient levels, as per the GPCIS guidelines, these patients are scored according their acuity and dependency. Level 0 patients require the least clinical care, level 1 patients have a suggest 1 RN to 4 patient ratio, level 2 have a recommended 1 RN to 2 patients ratio and level 3 patients requiring constant 1-1 or 1-2 care. The patient profile and occupancy is subject to a high degree variation, making planning in the unit particularly complex.

Based on an extensive review carried out in the organisation earlier this year the unit had an average occupancy of 85.42%, with an expected range at 2 standard deviations of between 59.13% and 100% occupancy. The patient profiles for this research found that patients needed on average 18.13 care hours per patient day (Direct Clinical Care), for the acuity and dependency of the patients on the unit.

On this basis, factoring in the nurse in charge element outlined in GPCIS guidelines, the unit should have no less than 97.6 WTE and no more than 109 WTE establishment to provide the direct clinical care needs for patients.

The research carried out also reviewed how staff flexed based on the care needs of the patients in the department, comparing the locally recommended CHPPD levels to GPICS, SNCT and SafeCare recommended CHPPD. Chart 1 below shows the CHPPD comparison across the days of the review period, and suggests the ward does flex CHPPD based on patient need and was generally appropriately staffed to the recommended level. See chart 1 below.

Chart 1



This suggests that staffing levels are appropriate for the unit throughout the review.

To ensure the unit has the appropriate funded skills mix for the service, benchmarking of banding profile was carried with five other acute trusts. This data can be found in **Appendix 10**. This shows the critical care unit had a slightly lower level of senior nurses compared to other organisations.

Triangulating all the available data would suggest that the critical care department's establishment is appropriate for the service and is flexed effectively based on patient need. The benchmarking data would suggest our banding profile is lower than surrounding trusts but the unit has indicated they do not feel this needs adjusting at this time.

8.2 Bluebell Children's Ward

Children's services have always flexed the nursing and support staff on Bluebell ward in relation to patient numbers and acuity. Bluebell ward works closely with the children's emergency department and outpatient services to support the whole paediatric unit ensuring all areas are safely staffed. From April 2017, operational beds on Bluebell ward have been reduced to 16 open beds/cots (from 20). This is for a number of reasons:

- Reduced bed occupancy over the summer period
- Vacancies across children's services
- Change in acuity and dependency of patients
- Staff in the pipeline starting in September 2017

The service has continued to monitor patient activity and has recruited into a number of posts successfully. The staffing shift plan for the winter period has been reviewed due to increased patient activity and acuity. Staffing levels continue to be flexed to support any reduction of inpatient numbers, staffing ratios remain within paediatric guidelines and the service is able to flex the team across the unit to maintain safe staffing levels.

8.3 Mount Vernon Cancer Centre (MVCC) - Wards 10 and 11

Following the reduction in inpatient bed numbers from 45 to 36 at the beginning of this year, there has been further scoping done at MVCC to review their models of care.

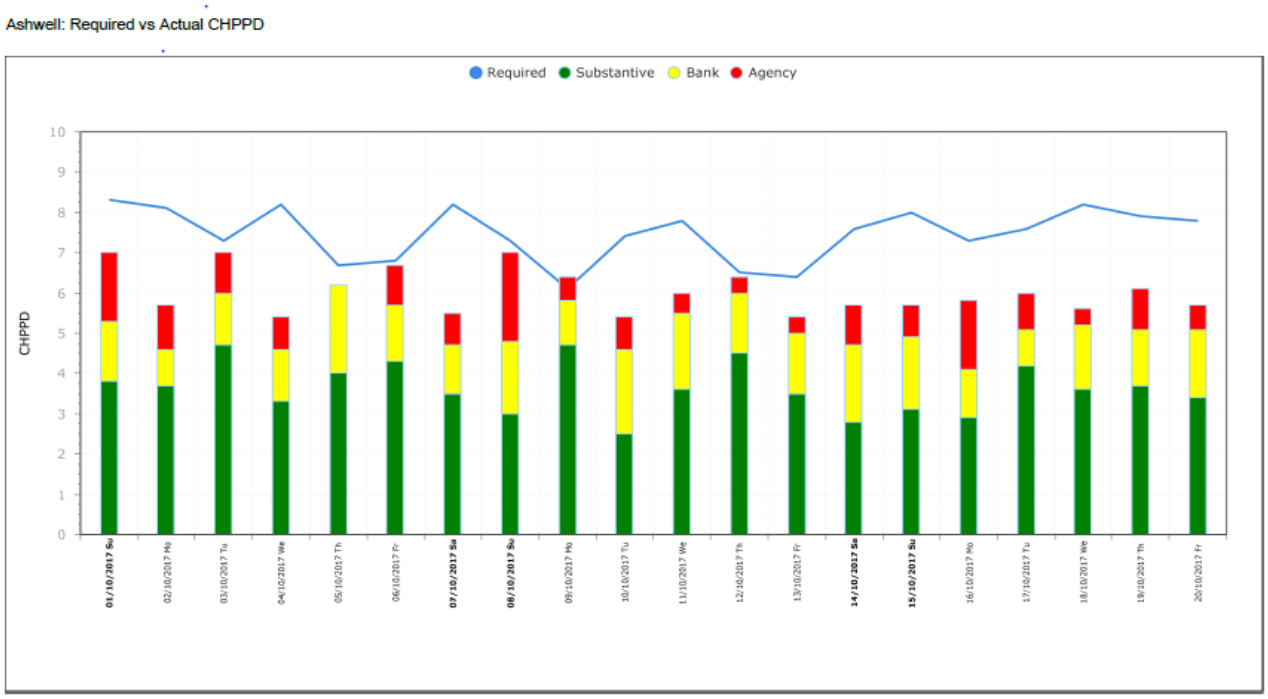
The proposed plan is to further reduce the inpatients beds down to 22 across both ward 10 and 11 and to create a Supportive Oncology Care Day Unit in the old Marie Curie Day Unit, which will be known as the John Bush Supportive Oncology Unit. This unit would be staffed Monday to Friday providing care on an outpatient basis to patients requiring assessment, observation, consultation, treatment, interventions and rehabilitation services. During the weekends, the 7 day elements of the supportive care model will be managed in a dedicated room on Ward 11 to ensure that the patient pathway remains consistent. This plan has been proposed by the Cancer Division and shared with operational, financial and nursing teams at an Executive level.

Role	Total	Total	WTE Saving	Financial Saving
Nurse band 7	2.00	2.00	0	£0
Nurse band 6	14.84	14.07	0.77	£39,660
Nurse band 5	13.47	12.60	0.87	£35,830
Nurse band 4	1.16	1.16	0	£0
Nurse band 3	4.26	3.48	0.78	£24,420
Nurse band 2 (CSW)	7.91	7.13	0.78	£22,260
Admin & Clerical band 2	1.69	1.69	0	£0
Ancillary band 2	1.36	1.36	0	£0
Total	**47.70**	**43.49**	**3.2**	**£122,170**

8.4 Ashwell Ward

Ashwell ward is a 24 bed frailty ward that flexes to 28 beds when escalation beds are required. The ward has been running at 28 beds and this plan will continue through to April 2018 when this will be reviewed. Chart 3 shows the CHPPD for Ashwell ward had less care hours than were required for the acuity and dependency of their patients.

Chart 3 - Ashwell: Required vs Actual CHPPD



This ward had a higher than expected number of patients requiring enhanced care during the data collection period, which is reflected in the SNCT data.

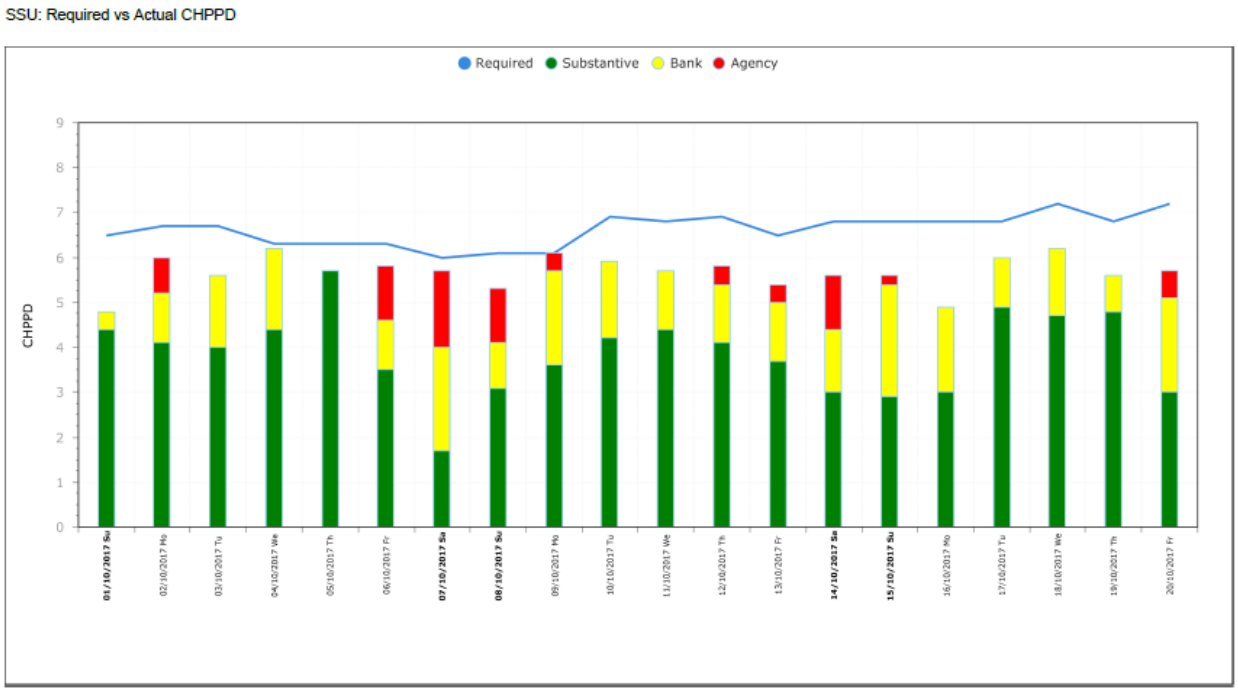
The previous review recommended a 'wait and watch' approach in Ashwell, using the flex and reactive support process. However it was highlighted that Ashwell required uplift prior to this review to support the acuity and dependency of patients on the ward. It was agreed that an additional band 2 CSW for the late and the night shift have been introduced and the ward will continue to be monitored.

Skill Mix Change	Cost
Uplift 4.1 WTE Band 2 CSW	£99,780

8.5 Short Stay Unit (SSU)

SSU had a higher than expected number of patients requiring enhanced care for the data collection period. This ward also has frequently longer stay patients admitted due to continuing bed pressures within the trust. There will need to be some work done to look at the modelling for the short stay unit to ensure they are receiving the right patient group for the model of care. SSU will continue to be monitored, with continuing support for high acuity patients requiring 1-1 from the enhanced care team.

Chart 4 - SSU: Required vs Actual CHPPD



This spike in acuity is not consistent with the continuous data collected over the last 6 months and therefore this review recommends a 'wait and watch' approach, focusing on acuity and dependency to ensure these results are not part of a trend change in the service.

8.6 10B

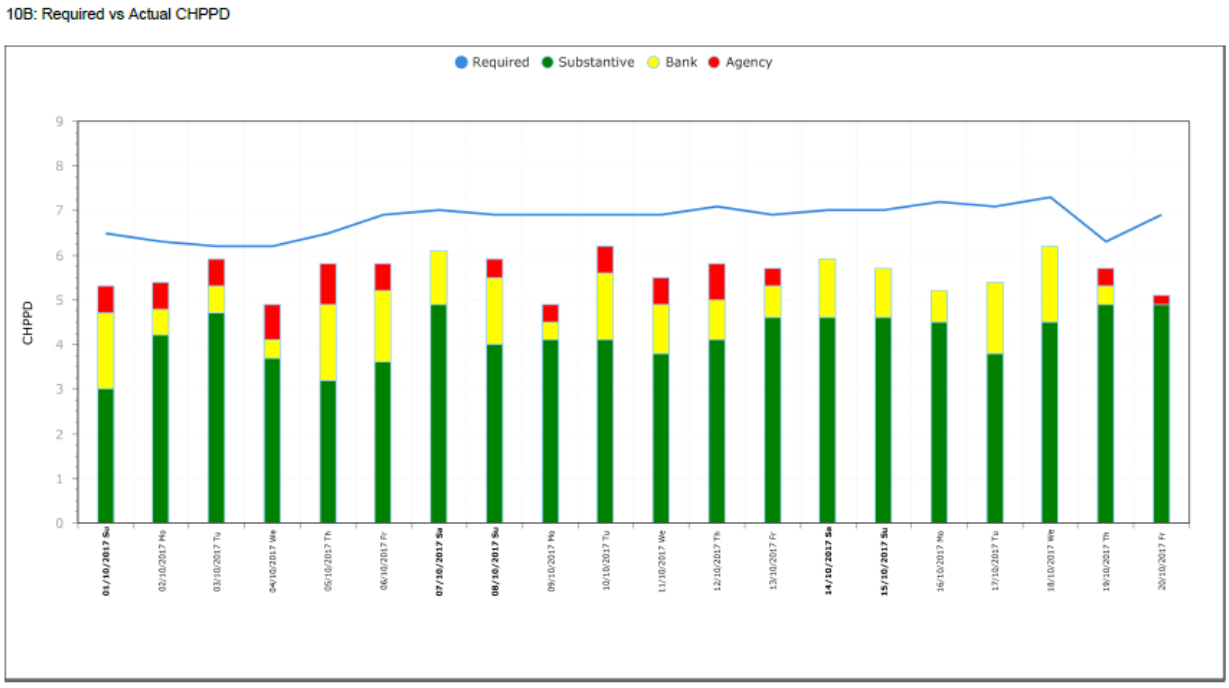
10B is a 30 bedded diabetic ward. The acuity and dependency shows on a daily basis that the care hours do not meet the required demand. Chart 5 shows the required care hours do not meet the actual care hours. This is for a number of reasons such as;

- High number of unfilled shifts
- High sickness levels
- Higher than expected patient acuity and dependency for the ward model.

A deep dive project is being undertaken into the patient type on the ward. Currently the ward receives repatriated neurological patients which are not reflected in the model of care for the ward. The ward also has a large number of patients with numerous co morbidities due to their diabetes and the nurses are required to deal with a high level of complex dressings and IV drug regimes. The ward has an action plan in place with the senior nursing team which includes;

- Ward improvement programme
- Nurse Education Support
- Long line Agency staff
- Ongoing Recruitment
- Extra support from Human Resources to manage sickness absence
- Consideration by the site team when placing complex patients
- Looking at new models of care

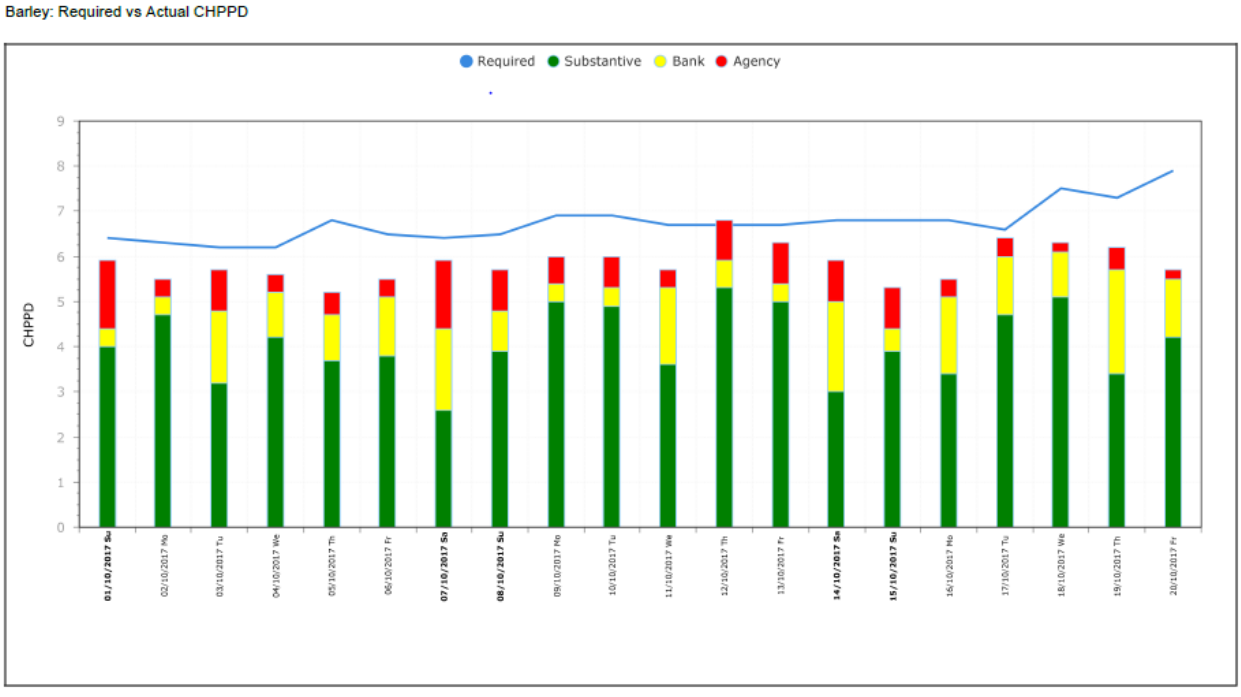
Chart 5 10B: Required vs Actual CHPPD



8.7 Barley

Barley is a 26 bedded rehabilitation stroke ward and the acuity and dependency of patients on Barley therefore is often high. Chart 6 shows that the required CHPPD is lower than the actual worked. However therapists work on the stroke wards providing one hour of therapy for all stroke patients on a daily basis. This care is not included in the CHPPD for this ward. The CHPPD is also being impacted by the number of vacancies due to the challenges associated with unfilled temporary staffing shifts.

Chart 6- Barley: Required vs Actual CHPPD



The stroke service is looking at new models of care and how therapists can be captured in care hours. Therefore it is recommended that Barley will be on a watch and wait review with support from:

- Long line Agency staff and focus on improving temporary staffing fill rates
- Matron acuity and dependency monitoring
- Human resources for ongoing Recruitment and retention support
- Looking at new models of care in the stroke unit

8.8 Acute Medical Unit Ward (AMUW)

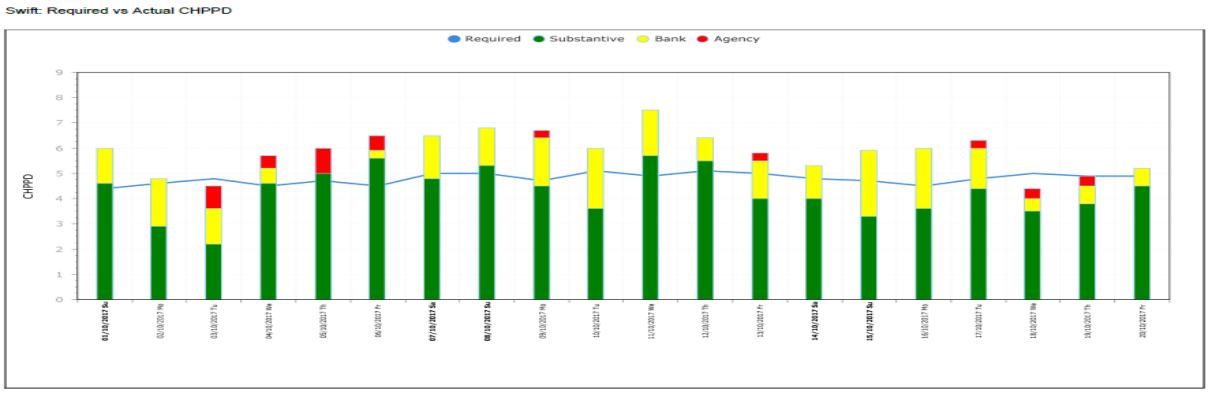
The risk assessment completed following the introduction of the TNA role, highlighted that the skill mix in this area, on the days that the ward manager is not supervisory, is not adequate. This is largely due to the admission criteria, high turnaround of patients and the geographical layout which consists of 100% side room accommodation. It is therefore recommended that the ward manager remains supervisory five days a week instead of three to ensure the unit is staffed safely. This will be reviewed again in six months.

Skill Mix Change	Cost
Uplift 0.39 WTE Band 5	£13,600

8.9 Swift

Swift is a 26 bedded elective Orthopaedic ward. The ward layout is over two areas and consists of all side rooms. This is not taken into account when using the SNCT so professional judgement needs to be used when looking at Swifts staffing levels. Due to their occupancy they remain over on their care hours shown in chart 7. This review recommends that Swift staffing remain the same over the winter period due to a plan to increase elective admission rates. If occupancy drops staff will be flexed to support other areas when required. This will be reviewed again in 6 months.

Chart 7- Swift: Required vs Actual CHPPD

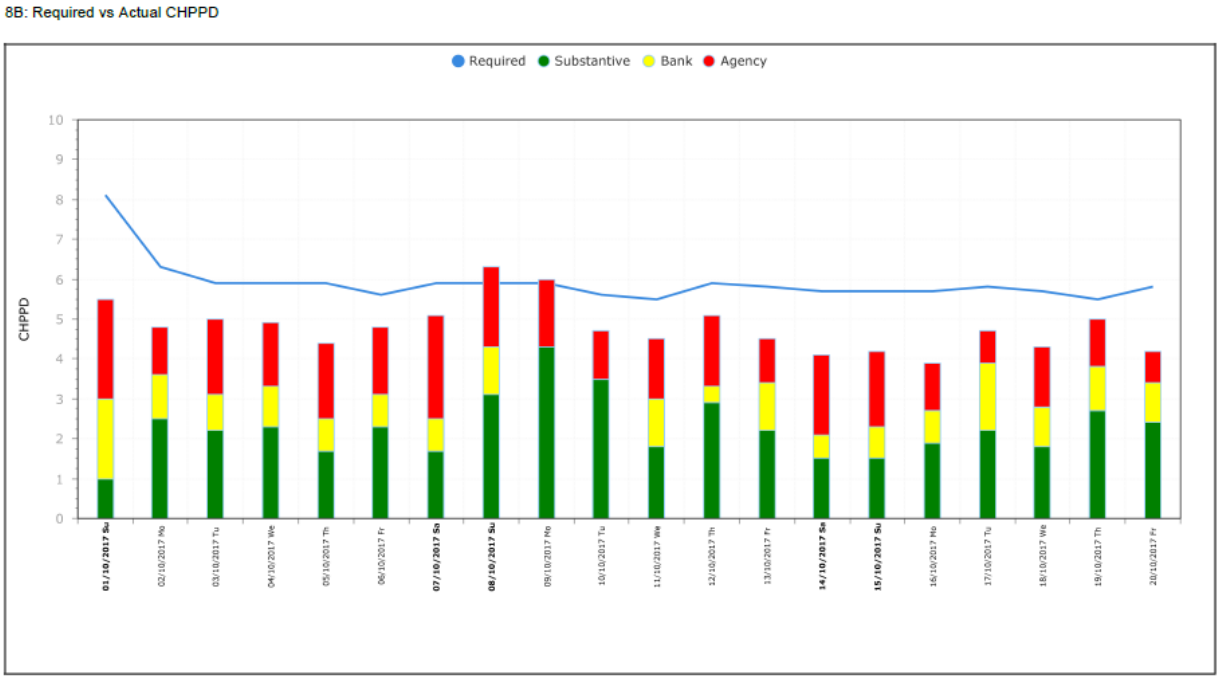


8.10 8B

8B is a 30 bed general surgical and vascular ward. During the establishment review the SCNT and CHPPD indicated the funded establishment was within the agreed parameters. The April 2017 review agreed that 8B would have an uplift of 1 band 2 CSW on a night shift. Chart 8 shows that the required CHPPD compared to the actual CHPPD is not meeting the requirement. This is for a number of reasons which were;

- High level of vacancy
- Shifts not being filled by temporary staffing
- Higher than average sickness levels

Chart 8- 8B: Required vs Actual CHPPD



This review therefore recommends the following actions:

- Ward improvement plan to replicate the work carried out on ward 10B
- Watch and wait approach
- Support from Human Resources with sickness management, recruitment and retention
- Introduce Agency long line staff and movement of skilled staff from other areas within the Surgical Division

9. Trainee Associate Nurse (TNA) Pilot

This new nursing support role works alongside healthcare support workers and registered nurses to deliver hands on care, ensuring patients continue to get the compassionate care they deserve. Nursing associates support nurses to spend more time using their specialist training to focus on clinical duties and take more of a lead in decisions about patient care.

The NMC (2017) stated “The intention is for nursing associates, who will have foundation degrees, to contribute to the delivery of patient care. The registered nurse will still have responsibility as the primary assessor, planner and evaluator of care. Nursing associates will support, not replace, registered nurses.” The NMC have agreed to regulate this role.

Hertfordshire and West Essex STP became a pilot site for the new Trainee Nursing Associate (TNA) programme. Across the STP 53 Trainees have commenced this programme, of which 17 are from ENHT. The TNA programme is a two year work based learning programme with one day a week attendance at University. The TNA works under supervision of the registered nurse delivering effective, safe and responsive care. On successful completion of the course the Nursing Associate will be able to work independently, within defined parameters of practice.

Our 17 TNA’s are progressing well and have completed their first external placement which provided learning experiences for the TNA’s in a variety of settings for a period of four weeks which included: the Mental Health Trust, Community, Private sector and an Acute Trust. Facilitated meetings take place monthly with the TNA’s and an in-house educational rolling programme will feature in these meetings commencing in 2018. Ward managers and mentors support sessions will also be commencing in 2018.

10. Enhanced Nursing Care Team

The Enhanced care team have embedded best practice for patients in our trust that require enhanced care (specialling).

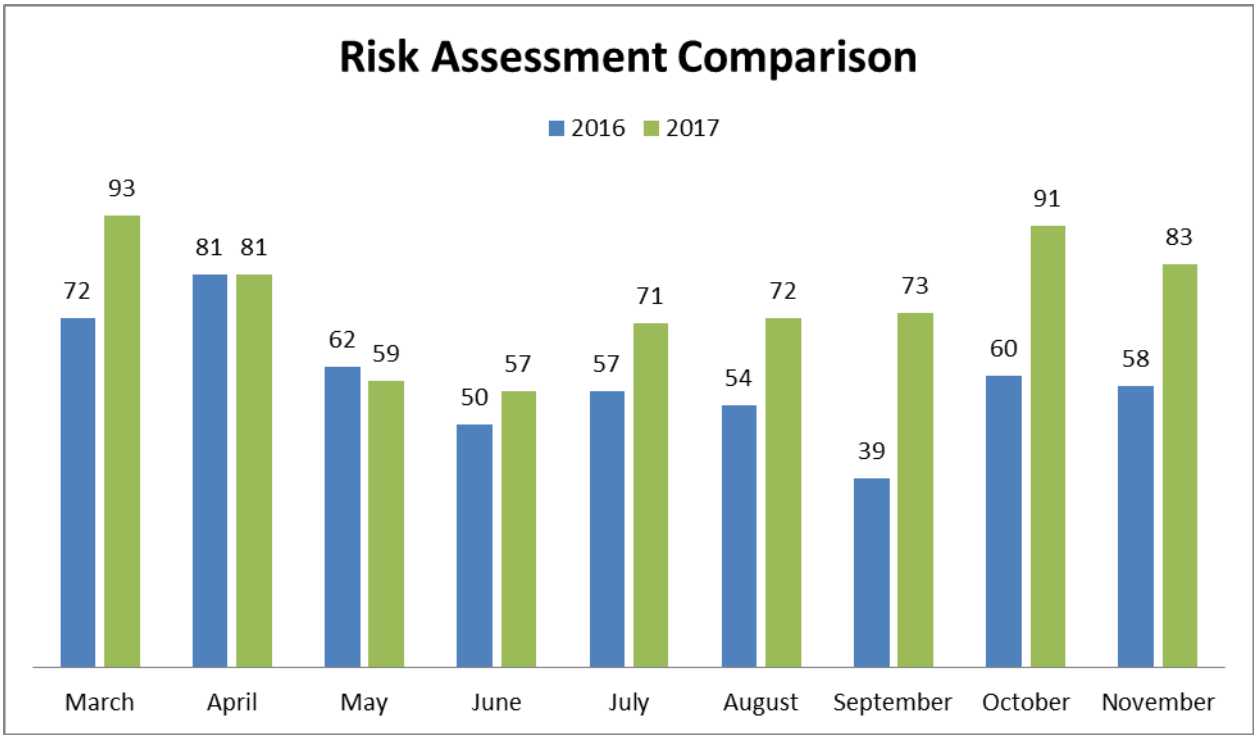
The team has contributed to the following benefits:

- More hours of care at reduced costs
- Reduction in agency spend
- Falls reduction
- Harms reduction
- Higher level of care for vulnerable patients
- Preventing deconditioning
- Robust process for enhanced care
- Rotation of staff to most high risk patients
- Specialist training
- Involving carers
- Promoting independence
- Reduced length of stay
- Improved compliance with MCA and DOLs
- Use of volunteers for enhanced care
- Least restrictive care requirement for vulnerable patients
- Introduction of Bay watch

The Enhanced Care Team has now introduced the band 4 shift leaders to manage and coordinate the team out of hours. In addition the team are working with Hertfordshire Partnership Foundation Trust (HPFT) supporting adult and paediatric mental health patients requiring enhanced care whilst in the acute trust. Additional training has been delivered to support this collaborative work.

The team is now supporting a much larger cohort of patients with varying care needs, demand continues to remain high; Chart 9 shows the risk assessments received for patients requiring enhanced care 2017 compared to 2016. The demand for the service has increased and temporary staff are being used to support the increased demand and ensure patient safety. The mental health enhanced care will be reviewed in December with a view for uplift in the team to support the mental health demand.

Chart 9



The team has received very positive feedback for the quality of care and support they are providing for patients. They have also hosted numerous visits to share the good practice with other Trusts who are keen to implement a similar model. The team have written a case study for NHSI about how the best practice team works. They have also won an Award for "care needs first" at the national Allocate awards in October 2017 and were finalists in the RCNI awards in May 2017.

11. Non Ward Based Nursing Project

Non-ward based staff form a large part of the organisation and have, historically, been developed through organic growth. This staff base can now benefit from an in-depth review to align the current workforce against the changing clinical and organisational requirements. The project was initiated in July 2017 with several qualitative and financial objectives. These included a review and evaluation of roles and activities, supporting ward activity, and maximising income generation.

The immediate aim was to support and contribute to the Trust CIP programme by delivering sufficient non-ward based staff shifts to wards to achieve a financial contribution target of £12k per month. This was achieved, as planned, in October of this year. August saw the launch of the diary exercise with the first tranche of over 50 diaries issued. These were reviewed collectively on return and contributed to the delivery of the financial target. Diaries continue to be issued in tranches with nearly 300 issued to date. These include a whole range of non-ward based services, with the final tranche to be issued to outpatients in November.

The culmination of the exercise will inform the proposed in-depth review of the roles and activities of non-ward based nurses, and will allow for a more objective approach to meeting the clinical and organisational demands.

12. Summary of proposed changes from establishment review

WTE movement	MVCC Ward	Ashwell	AMUW	Total WTE Movement
Nurse band 7	0	0	0	0
Nurse band 6	-0.77	0	0	-0.77
Nurse band 5	-0.87	0	0.39	-0.48
Nurse band 3	-0.78	0	0	-0.78
Nurse band 2 (CSW)	-0.78	4.1	0	3.32
Admin & Clerical band 2	0	0	0	0
Ancillary band 2		0	0	0
Total	-3.2	4.1	0.39	1.29

£ movement	MVCC Ward	Ashwell	AMUW	Total £ Movement
Nurse band 7	0	0	0	0
Nurse band 6	-39,660	0	0	-39,660
Nurse band 5	-35,830	0	13,600	-22,230
Nurse band 3	-24,420	0	0	-24,420
Nurse band 2 (CSW)	-22,260	99,780	0	77,520
Admin & Clerical band 2	0	0	0	0
Ancillary band 2	0	0	0	0
Total	-122,170	99,780	13,600	-8,790

13. Summary and Recommendations for Executive Approval

On balance, reviewing all available information, this review suggests that current funded establishments are appropriate to provide safe nursing care on most inpatient wards. However, based on the information in this report, the following recommendations should be considered:-

- Reduction of inpatient beds at MVCC to open a supportive care unit.
- Uplift of 1 band 2 CSW on late and night shift on Ashwell Ward
- Watch and Wait approach on SSU
- Watch and Wait approach and support ward improvement program on 10B and 8B
- Watch and Wait approach on Barley
- Staffing on Swift ward to remain higher to support elective programme during winter with a review in spring.
- Ward manager to remain supervisory 5 days per week on AMUW and to review in 6 months
- Review of Enhanced Nursing Care team and mental health requirement
- Prepare for the next cohort of TNA in April 2018
- Complete the NWBN project

14. Next Steps

The Board are asked to approve the recommendations in this report.

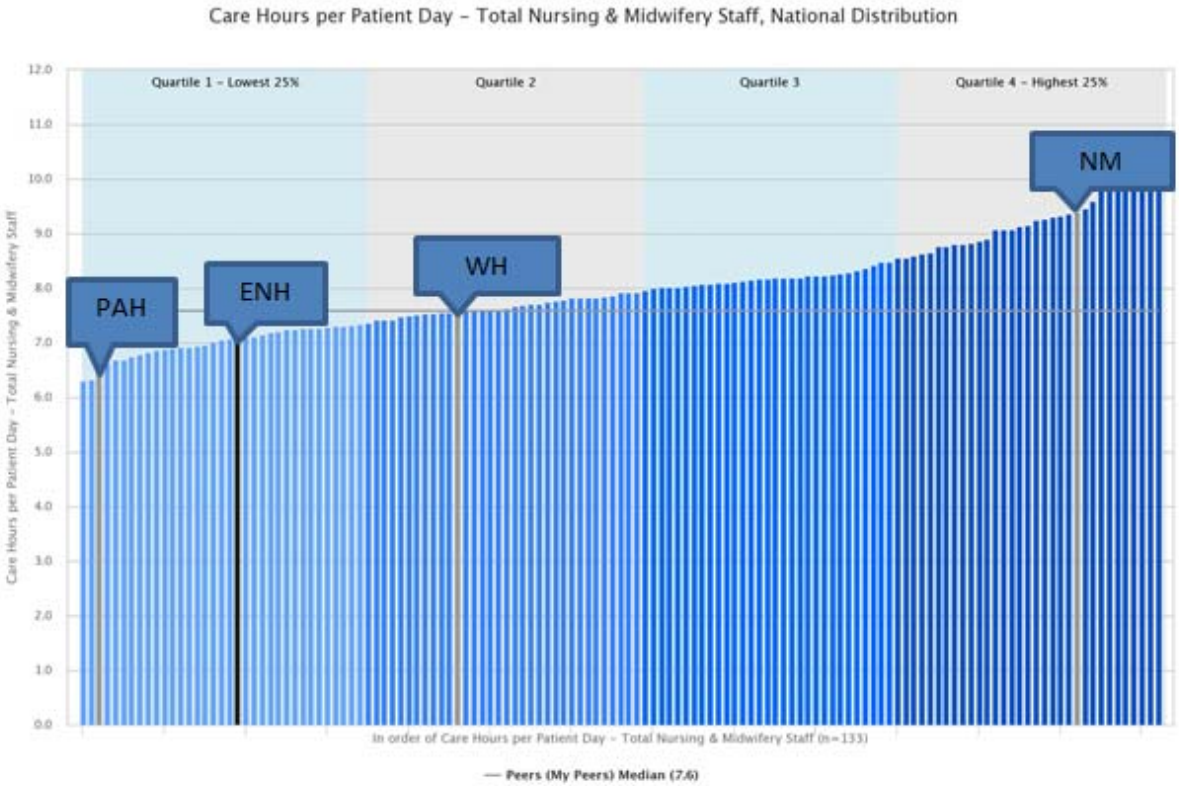
References:

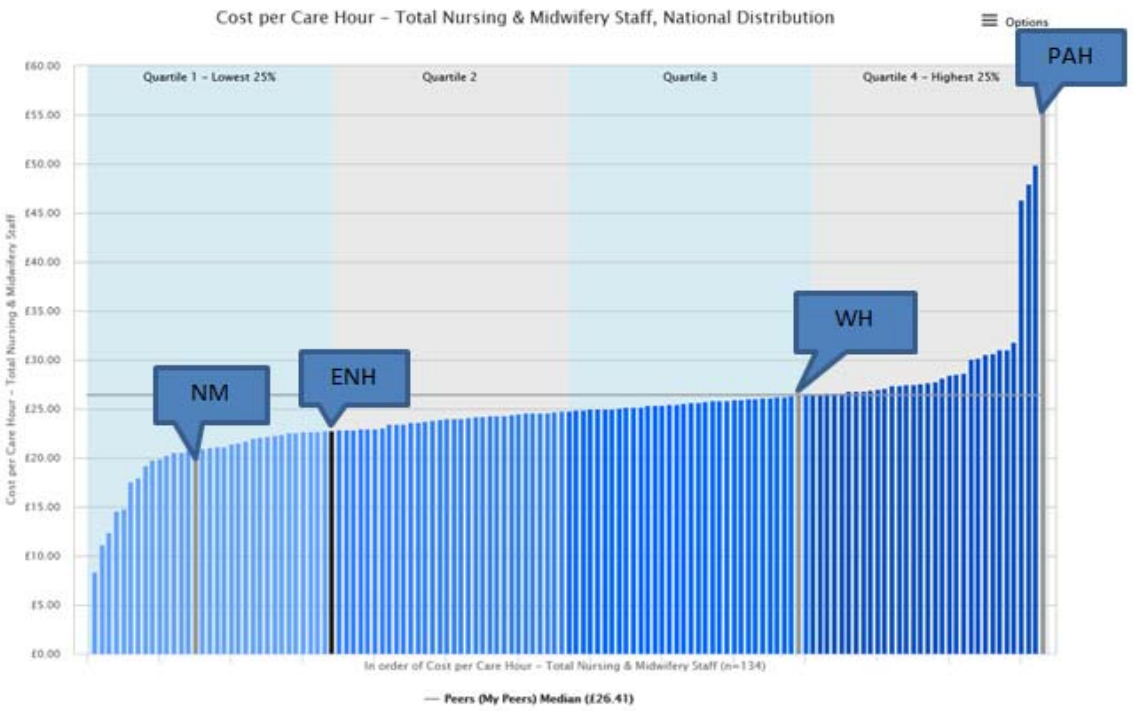
- Carter (2015). Productivity in NHS Hospitals. London: Department of Health.
- Francis R (2013) Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry. London: Stationery Office
- NHS England (2016). Leading Change and Adding Value: A framework for nursing, midwifery and care staff. London: NHS England
- NICE (2013) Safe Staffing for nursing in adult inpatient wards in acute hospitals.

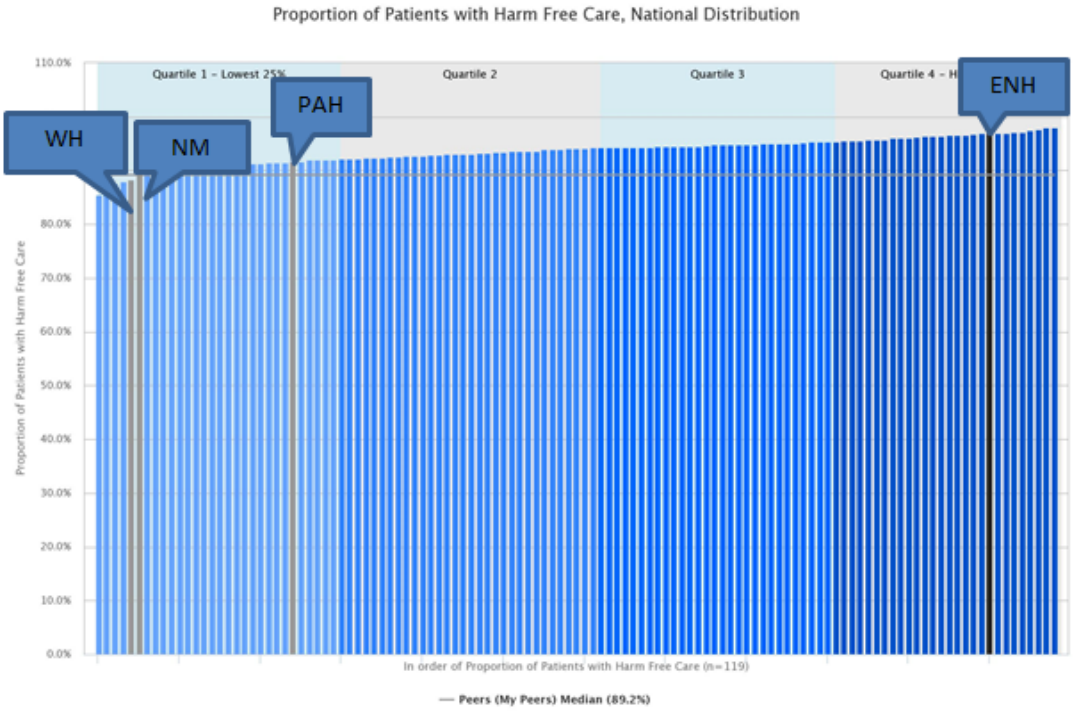
Appendix 1

Benchmarking data comparing local peers From The NHSI Model Hospital Dashboard – latest data available August 2017

East & North Hertfordshire NHS Trust (ENH), Princess Alexandra Hospital (PAH), West Herts Hospitals Trust (WH) North Middlesex University Hospitals Trust (NM)




Cost per Care Hour – Total Nursing & Midwifery Staff, National Distribution
Options
Quartile 1 – Lowest 25%
Quartile 2
Quartile 3
Quartile 4 – Highest 25%
PAH
WH
ENH
NM
£60.00
£55.00
£50.00
£45.00
£40.00
£35.00
£30.00
£25.00
£20.00
£15.00
£10.00
£5.00
£0.00
Cost per Care Hour – Total Nursing & Midwifery Staff
In order of Cost per Care Hour – Total Nursing & Midwifery Staff (n=134)
Peers (My Peers) Median (£26.41)


Proportion of Patients with Harm Free Care, National Distribution
Quartile 1 – Lowest 25%
Quartile 2
Quartile 3
WH
NM
PAH
ENH
110.0%
80.0%
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
Proportion of Patients with Harm Free Care
In order of Proportion of Patients with Harm Free Care (n=119)
Peers (My Peers) Median (89.2%)

Appendix 2

Methodology

The following information was also collected and reviewed; a review of all relevant literature and guidelines was undertaken prior to commencement of this review, these included:

- NICE Guidance on Safer Staffing for nursing in adult inpatient wards in acute hospitals (2012)
- Compassion in Practice, NHS England (2012)
- Safer Nursing Care Tool
- Nurse sensitive indicators
- Safer Staffing Guidance, Trust Development Authority (2015)
- Leading Change Adding Value (2016)
- Lord Carter Report (2016)
- Lord Willis Report (2015)

As part of this review all calculations were carried out in line with the national guidance associated with these tools. This document details the assumptions, methods of data collection, calculation and evaluation as applied in the establishment review. These are set out for each information process below:

Skill Mix:

Data for this metric is collected from the approved shift plans defining each service model and actual hours worked on the roster system. It is assumed that the roster template is an accurate representation of the shift plan, that the shift plan is an accurate representation of the service model and that the hours worked on the roster are true reflection of what was worked. The calculations for this metric are:

Service model skills mix:

Total number of clinical hours available on shift plan for registered/unregistered staff

/

Total number of clinical hours available on shift plan

Actual skills mix:

Total number of clinical hours worked for registered/unregistered staff for the reference period

/

Total number of clinical hours worked for the reference period

Registered nurse to bed ratio:

The data for this metric is collected from the daily staff sheet and the shift plan, it is assumed that the number of available beds on the daily staffing return is correct and the number of registered nurses on shift on the shift plan is an accurate representation of what could be rostered to work. The calculations for this metric are:

Number of registered nurse on shift

/

Number of available beds for reference period

Care Hours per patient day (CHPPD)

The data for this metric is collected from the service model shift plans, the Trusts e-roster system and SafeCare. It is assumed that the service model shift plan is an accurate representation of the service, the roster is an accurate reflection of the hours worked and SafeCare has accurate patient acuity and dependency scores input for each patient. As SafeCare uses an external formula to calculate the required and actual CHPPD values, it is assumed that this formula is correct and the Shelford Acuity and Dependency model is appropriate for the service. The calculations for this metric are:

Service Model CHPPD:

Total service model care hours (clinical care hours for registered and unregistered staff)
/
Total beds

Required CHPPD:

Required hours of work based on standardised SNCT model
/
Average patients per 24 hours in reference period (Patient days)

Actual CHPPD:

Actual Hours Worked
/
Average patients per 24 hours in reference period (Patient days)

Cost of Care Hours per Patient Day:

The data for this metric is taken from the same sources as detailed in CHPPD calculations above, along with financial information from the budgeted and actual cost in month for the reference period. In addition to the assumptions made in the CHPPD calculation, it is assumed that the financial information is an accurate account of what is spent in month and that the budget is representative of the nursing spend for inpatient activity.

Target cost of care hours:

Budget per bed day (Total monthly budget/number of inpatient beds)
/
Service model CHPPD

Required cost of care hours:

Target cost of care hours
X
Variance factor of CHPPD (Target model CHPPD/Required CHPPD)

Actual cost of CHPPD:

Spend per bed day (Total monthly budget/number of inpatient beds)
/
Actual worked CHPPD

Cost distribution of CHPPD:

This metric builds on the actual worked CHPPD and breaks this down by how it was funded, highlighting the substantive, bank and agency proportions of how CHPPD is provided.

Safer Nursing Care Tool:

Calculations for this metric follow the SNCT national guidelines; data collection for this metric is taken from the roster and SafeCare systems. It is assumed that the roster is an accurate reflection of the work carried out and that SafeCare has accurate patient acuity and dependency scores input for each patient. Calculations for this metric are:

Bed Occupancy:

Total bed days in reference period
/
Total available beds in reference period

SNCT WTE required:

Sum of [**Total number of patient of a specific acuity**
X
SNCT specific multiplier]

Required SNCT is then adjusted to include 17% headroom

Variance from actual funded WTE:

Funded WTE – Adjusted SNCT Recommended WTE

Supervisory Shifts:

Data for this metric is taken from the shift plans and the roster system, it is assumed that the shift plan accurately represents the number of supervisory days available for managers to work, and that the data in the roster system is correct. Calculations for this metric are:

Supervisory hours worked
/
Supervisory hours available

Table 1

The table below shows the registered and unregistered nurse % for each ward:

Div	Speciality	Ward	Service model registered nurse %	Service model unregistered nurse %	Actual registered nurse %	Actual unregistered nurse %
Medicine	Care of the Elderly	9B	60.00	40.00	56.40	43.60
		Ashwell	54.00	46.00	47.30	52.70
		9A	57.00	43.00	53.70	46.30
	Stroke	Pirton	67.00	33.00	67.70	32.30
	Stroke	Barley	61.00	39.00	58.00	42.00
	General	6A	56.00	44.00	54.90	45.10
	General	10B	56.00	44.00	52.10	47.90
	Respiratory	11A	71.00	29.00	70.00	30.00
		7AN				
	Cardiology	ACU	67.00	33.00	74.60	25.40
	Acute	AMU Ward	56.00	44.00	49.90	50.10
		SSU	60.00	40.00	62.00	38.00
	Renal	6B	58.00	42.00	64.70	35.30
Surgery	General	8A	59.00	41.00	58.70	41.30
		8B	63.00	37.00	69.70	30.30
	Surgical Spec	11B *	55.00	45.00	57.40	42.60
		7B	64.00	36.00	66.80	33.20
	T&O	5A	61.00	39.00	66.70	33.30
		Swift	61.00	39.00	59.10	40.90
		5B	57.00	43.00	56.60	43.40
	ATCC	Critical Care	90.00	10.00	88.90	11.10
W&C	Gynae	10A Gynae*	67.00	33.00	68.90	31.10
	Paeds	Bluebell	80.00	20.00	76.50	23.50
Cancer	Inpatient	Ward 10	75.00	25.00	77.50	22.50
		Michael Sobell House	59.00	41.00	61.60	38.40

Table 2

The table below shows the available staff on shift as per the agreed shift plan and the Registered Nurse to bed ratio

Div	Speciality	Ward	RN to Bed Ratio Early	Late	Night
Medicine	Care of the Elderly	9B	1/6	1/7	1/7
		Ashwell	1/7	1/7	1/9
		9A	1/7	1/7	1/7
	Stroke	Pirton	2/9	2/9	1/7
	Stroke	Barley	1/5	1/6	1/9
	General	6A	1/7	1/7	1/7
	General	10B	1/7	1/7	1/7
	Respiratory	11A	1/6	1/5	1/6
		7AN			
	Cardiology	ACU	1/5	1/5	1/5
	Acute	AMU Ward	1/8	1/5	1/5
		SSU	1/7	1/7	1/7
	Renal	6B	1/5	1/5	1/8
Surgery	General	8A	1/7	1/7	1/7
		8B	1/6	1/7	1/7
	Surgical Spec	11B *	1/7	1/5	1/7
		7B	1/7	1/7	1/7
	T&O	5A	1/7	1/7	1/7
		Swift	1/6	1/6	1/9
		5B	1/7	1/7	1/7
	ATCC	Critical Care**	6/7	6/7	8/9
W&C	Gynae	10A Gynae*	1/5	1/5	1/5
	Paeds	Bluebell	1/4	1/4	1/4
Cancer	Inpatient	Ward 10	1/4	1/4	1/5
		Michael Sobell House	1/5	1/5	1/8

* Denotes the number of staff allocated to the inpatient ward areas

** Critical Care staffing is dependant on the patient number and acuity and therefore the available shifts is not representative of required staff

Appendix 4

Care Hours per Patient Day service model, required, and actual worked

Div	Speciality	Ward	Service Model CHPPD	Required CHPPD	Actual worked CHPPD
Medicine	Care of the Elderly	Ward 9B Elderly Care	5.28	5.73	5.47
		Ashwell ward	5.36	7.48	6.04
		Ward 9A Elderly Care	5.29	6.8	5.94
	Stroke	Pirton HASU	6.18	6.94	6.7
	Stroke	New Barley	5.48	6.75	5.87
	General	Ward 6A	5.51	6.43	5.78
	General	Ward 10B	5.44	6.8	5.61
	Respiratory	Ward 11A Respiratory	6.07	6.78	6.12
		7AN			
	Cardiology	Acute Cardiac Unit	6.19	6.83	6.52
	Acute	Acute Medical Unit	7.08	8.74	7.75
		Short Stay Unit - SSU	5.5	6.62	5.66
	Renal	Ward 6B	6.17	5.93	6.04
Surgery	General	Gen Surgery Ward 8A	5.12	5.56	5.01
		Gen Surgery Ward 8B	5.12	5.88	4.75
	Surgical Spec	Ward 11B Plastics & ENT	6.09	5.99	5.9
		Urology Ward 7BN	4.69	5.57	5
	T&O	T&O Ward 5A	5.05	5.64	4.95
		Swift Ward	5.02	4.77	5.77
		T&O Ward 5B	5.38	6.68	5.84
	ATCC	Critical Care Unit	23	18.11	19.05
W&C	Gynae	Gynaecology Ward 10A	6.79	5.09	7.69
	Paeds	Children Bluebell Ward	7.13	8.78	9.3
Cancer	Inpatient	MV Ward 10	7.55	4.73	5.81
		MV M.S.H Inpatient Unit	6.9	8.29	10.05

Division	Service Model CHPPD	Required CHPPD	Actual worked CHPPD
Medicine	5.80	6.82	6.13
Surgery (Excluding Critical Care)	5.21	5.73	5.32
Women's and Children's	6.96	6.94	8.50
Cancer	7.23	6.51	7.93

Appendix 5

The table below shows the recommended recruitable WTE based on the benchmark for the service and the average occupancy for the reference period compared to the actual funded recruitable WTE for the period

Div	Speciality	Ward	Bed Occupancy %	Recommended SNCT recruitable WTE based on occupancy (headroom adjusted to 17%)	Recruitable Establishment (17% headroom)	Variance from actual funded WTE
Medicine	Care of the Elderly	**9B**	97.5%	35.99	36.13	0.14
		Ashwell	97.9%	39.38	34.25	-5.13
		9A	98.2%	34.50	36.18	1.68
	Stroke	**Pirton**	90.9%	30.57	31.07	0.50
	Stroke	**Barley**	98.7%	37.59	32.57	-5.02
	General	**6A**	99.3%	40.64	37.67	-2.97
	General	**10B**	97.7%	43.26	37.19	-6.07
	Respiratory	**11A**	95.7%	40.75	38.76	-1.99
		7AN				
	Cardiology	**ACU**	86.1%	28.37	31.12	2.75
	Acute	**AMU Ward**	98.8%	28.75	26.49	-2.26
		SSU	98.8%	39.83	35.14	-4.69
	Renal	**6B**	95.4%	30.56	34.73	4.17
Surgery	**General**	**8A**	96.0%	34.72	35.05	0.33
		8B	95.3%	37.13	35.05	-2.08
	Surgical Spec	**11B ***	99.0%	19.60	21.05	1.45
		7B	91.0%	32.80	32.13	-0.67
	T&O	**5A**	95.3%	33.99	34.59	0.60
		Swift	82.7%	22.39	29.94	7.55
		5B	89.3%	37.61	36.83	-0.78
	ATCC	**Critical Care**	79.3%	62.67	100.78	38.11
W&C	**Gynae**	**10A Gynae ***	96.0%	10.64	15.37	4.73
	Paeds	**Bluebell**	76.6%	12.59	26.64	14.05
Cancer	**Inpatient**	**Ward 10**	89.0%	22.05	43.21	21.16
		Ward 11				
		Michael Sobell House	63.1%	16.68	23.9	7.22

* Denotes the number of staff allocated to the inpatient ward areas

Appendix 6

The table below shows the CHPPD Benchmark Recommended WTE compared to the SNCT Recommended WTE.

Div	Speciality	Ward	CHPPD Bench Marking Data			SNCT Recommended Data		
			Recommended CHPPD recruitable WTE based on occupancy	Recruitable Establishment Oct 2017	Variance form actual funded WTE	SNCT recommended WTE	Recruitable Establishment Oct 2017	Variance of operation establishment to SNCT recommended
Medicine	Care of the Elderly	9B	33.73	36.13	2.40	35.99	36.13	0.14
		Ashwell	32.09	34.25	2.16	39.38	34.25	-5.13
		9A	34.04	36.18	2.14	34.50	36.18	1.68
	Stroke	Pirton	26.99	31.07	4.08	30.57	31.07	0.50
	Stroke	Barley	30.71	32.57	1.86	37.59	32.57	-5.02
	General	6A	35.85	37.67	1.82	40.64	37.67	-2.97
	General	10B	34.82	37.19	2.37	43.26	37.19	-6.07
	Respiratory	11A	36.79	38.76	1.97	40.75	38.76	-1.99
		7AN						
	Cardiology	ACU	25.61	31.12	5.51	28.37	31.12	2.75
	Acute	AMU Ward	24.44	26.49	2.05	28.75	26.49	-2.26
		SSU	33.23	35.14	1.91	39.83	35.14	-4.69
	Renal	6B	32.14	34.73	2.59	30.56	34.73	4.17
Surgery	General	8A	32.20	35.05	2.85	34.72	35.05	0.33
		8B	31.97	35.05	3.08	37.13	35.05	-2.08
	Surgical Spec	11B *	19.75	21.05	1.30	19.60	21.05	1.45
		7B	27.96	32.13	4.17	32.80	32.13	-0.67
	T&O	5A	31.53	34.59	3.06	33.99	34.59	0.60
		Swift	23.57	29.94	6.37	22.39	29.94	7.55
		5B	31.48	36.83	5.35	37.61	36.83	-0.78
	ATCC	Critical Care	79.67	100.78	21.11	62.67	100.78	38.11
W&C	Gynae	10A Gynae *	14.24	15.37	1.13	10.64	15.37	4.73
	Paeds	Bluebell	19.08	26.64	7.56	12.59	26.64	14.05
Cancer	Inpatient	Ward 10	24.15	43.21	19.06	22.05	43.21	21.16
		Michael Sobell House	15.21	23.9	8.69	16.68	23.9	7.22

* Denotes the number of staff allocated to the inpatient ward areas

Division	CHPPD Bench Marking Data			SNCT Recommended Data		
	Recommended CHPPD recruitable WTE based on occupancy	Recruitable Establishment Oct 2017	Variance form actual funded WTE	SNCT recommended WTE	Worked WTE	Variance of operation establishment to SNCT recommended
Medicine	31.70	34.28	2.57	35.85	34.28	-1.57
Surgery (Excluding Critical Care)	28.35	32.09	3.74	31.18	32.09	0.91
Women's and Children's	16.66	21.01	4.35	11.62	21.01	9.39
Cancer	19.68	33.56	13.88	19.37	33.56	14.19

NURSING & MIDWIFERY QUALITY INDICATORS: Oct 17

East and North Hertfordshire NHS NHS Trust

*** Bed Totals & Occupancy figures taken from SafeCare data*

SUMMARY		Trust	Medicine	Surgery	Women & Children	Cancer
Beds	Total Beds (based on Wards within this report)	606	317	211	26	52
	Bed occupancy % (at Midnight)	89.78	95.80	90.21	78.04	54.34
e-Rostering	% E-roster Deadline Met	0.7	0.5	0.8	0.9	0.4
	Net Hours %	0.0	0.4	-0.4	-0.7	0.3
	Net Hours Position	-795.4	19.5	-20.9	-30.6	7.9
	% of Actual Annual Leave	12.6	11.5	12.2	12.6	7.7
Staffing	Funded WTE	1702.3	710.3	406.7	350.0	74.5
	Actual WTE	1265.8	505.0	281.5	280.8	57.8
	Vacancy rate %	13.6	13.5	19.3	11.5	13.4
	RN Fill Rate (day shifts)	92.6	93.2	93.2	93.9	57.3
	Sickness %	6.5	5.5	7.7	7.9	9.0
	Agency usage %	5.1	6.8	10.0	2.6	0.7
	Bank usage %	15.2	15.4	15.1	12.4	4.1
	Staff Appraised % (rolling 12 months)	73.0	70.5	77.4	68.6	88.9
	Nursing Overtime	0.6	0.0	0.0	0.6	0.0
	Statutory Mandatory Training Overall Coverage %	58.0	49.6	54.1	62.3	69.0
	% Shifts Triggered Red in Month - Initial	12.2	14.9	13.4	7.8	1.6
	% Shifts Triggered Red in Month - Final	0.8	1.2	0.2	1.1	0.0
Patient Safety	Inpatient falls (rate per 1000 bed days)	4.21	4.27	4.89	2.48	1.86
	Inpatient falls resulting in harm (rate per 1000 bed days)	0.00	0.20	0.15	0.00	0.00
	Hospital Acquired Pressure Ulcers (rate per 1000 bed days)	0.11	0.00	0.15	1.24	0.00
	% News Score Completion	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable
	News Escalation	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable
	No. Medication Reported errors	58	23	19	14	2
	% Medication administered as prescribed	98.0	99.6	95.5	100.0	Not Provided
	% Analgesia administered as prescribed	97.0	96.0	99.3	100.0	Not Provided
	Intentional rounding completed	94.0	98.3	90.5	100.0	Not Provided
	Patient Identification	93.0	96.5	93.8	95.0	Not Provided
	Safety Thermometer Patients with harm	31	22	6	2	1
	% of Compliance with Hand Hygiene	96.1	97.2	98.5	89.2	99.4
Patient Experience	% Response to Inpatient Survey	39.5	53.3	50.9	26.1	18.4
	Help to eat meals/Infant Feeding	93	94.2	88.6	93.0	96.5
	Enough nurses on duty	77	73.6	76.3	92.7	90.5
	Respond to call bell	89	88.9	85.9	80.0	100.0
	Pain Control	94	94.8	92.5	93.0	100.0
	Understand answers from nurses	92	91.9	90.4	95.3	98.0
	Someone to talk to about worries and fears	86	85.4	82.3	78.3	98.0
	Enough emotional support from staff	89	88.8	86.5	93.5	96.0
	Know named nurse	80	82.0	80.0	84.3	99.0
	Inpatient FFT - % of patients would recommend	97.0	97.0	97.2	94.8	97.2
	Inpatient FFT - % of patients would not recommend	0.6	0.7	0.5	1.7	0.0
	FFT Response Rate %	46.0	58.9	43.7	37.8	32.7
	No.of Complaints	16	7	8	1	0

Appendix 8

Period	01/10/17-20/10/17	Days in Month	20

Division	Speciality	Ward	INITIAL REDS						FINAL REDS				
			Total no. of shifts available	Early	Late	Night	Number of shifts where staffing initially fell below agreed levels	%of shifts where staffing fell below agreed levels and triggered a Red rating	Early	Late	Night	Number of shifts where staffing initially fell below agreed levels	%of shifts where staffing fell below agreed levels and triggered a Red rating
Medicine	Care of the Elderly	9A	60	5	6	0	11	18.33	0	0	0	0	0.00
		9B	60	3	4	0	7	11.67	0	0	0	0	0.00
	Stroke	Barley	60	7	5	0	12	20.00	0	0	0	0	0.00
		Pirton	60	1	5	2	8	13.33	0	0	1	1	1.67
	General	6A	60	3	4	0	7	11.67	0	0	0	0	0.00
		10B	60	8	4	1	13	21.67	0	0	0	0	0.00
	Respiratory	11A	60	4	3	0	7	11.67	0	0	0	0	0.00
		7AN	60	0	0	0	0	0.00	0	0	0	0	0.00
	Cardiology	ACU	60	3	10	1	14	23.33	0	0	0	0	0.00
	Acute	AMU-A	60	2	3	0	5	8.33	0	0	0	0	0.00
		SSU	60	2	3	0	5	8.33	0	0	0	0	0.00
		AMU-W	60	8	2	0	10	16.67	0	0	0	0	0.00
	Renal	6B	60	1	6	0	7	11.67	0	0	0	0	0.00
	DTOC / gastro	Ashwell	60	10	9	3	22	36.67	0	0	0	0	0.00
	ED	A&E	60	3	3	1	7	11.67	0	1	1	2	3.33
		UCC	60	0	0	0	0	0.00	0	0	0	0	0.00
Total			**960**	**60**	**67**	**8**	**135**	**14.06**	**0**	**1**	**2**	**3**	**0.31**
Surgery	General	8A	60	4	5	0	9	15.00	0	0	0	0	0.00
		8B	60	7	7	6	20	33.33	0	0	0	0	0.00
		SAU	60	2	10	1	13	21.67	0	0	0	0	0.00
	Surgical Spec	11B	60	2	1	0	3	5.00	0	0	0	0	0.00
		7B	60	5	4	2	11	18.33	0	0	0	0	0.00
	T&O	5A	60	5	0	1	6	10.00	0	0	0	0	0.00
		5B	60	4	4	0	8	13.33	0	0	0	0	0.00
		Swift	60	5	5	3	13	21.67	0	0	0	0	0.00
	ATCC	Critical Care 1	60	0	0	1	1	1.67	0	0	0	0	0.00
		ASCU	60	0	0	0	0	0.00	0	0	0	0	0.00
Total			**600**	**34**	**36**	**14**	**84**	**14.00**	**0**	**0**	**0**	**0**	**0.00**
Women's & Children	Gynae	10A Gynae	60	4	8	2	14	23.33	0	0	0	0	0.00
	Paeds	Bluebell	60	0	0	2	2	3.33	0	0	0	0	0.00
		Child A&E	60	0	1	1	2	3.33	0	0	0	0	0.00
		NICU	60	0	0	0	0	0.00	0	0	0	0	0.00
	Maternity	Dacre	60	0	1	0	1	1.67	0	0	0	0	0.00
		Gloucester	60	1	5	0	6	10.00	0	0	0	0	0.00
		Mat MLU	60	0	0	0	0	0.00	0	0	0	0	0.00
		Mat CLU 1	60	3	5	3	11	18.33	0	0	1	1	1.67
Total			**480**	**8**	**20**	**8**	**36**	**7.50**	**0**	**0**	**1**	**1**	**0.21**
Cancer	Inpatient	Ward 10	60	0	0	0	0	0.00	0	0	0	0	0.00
		Michael Sobell House	60	2	1	0	3	5.00	0	0	0	0	0.00
Total			**120**	**2**	**1**	**0**	**3**	**2.50**	**0**	**0**	**0**	**0**	**0.00**
		TRUST TOTAL	**2160**	**104**	**124**	**30**	**258**	**11.94**	**0**	**1**	**3**	**4**	**0.19**

	Total no. of shifts available	Early	Late	Night	Number of shifts where staffing initially fell below agreed levels	%of shifts where staffing fell below agreed levels and triggered a Red rating	Early	Late	Night	Number of shifts where staffing initially fell below agreed levels	%of shifts where staffing fell below agreed levels and triggered a Red rating
Medicine	960	60	67	8	135	14.06%	0	1	2	3	0.31%
Surgery (Excluding Critical Care)	600	34	36	14	84	14.00%	0	0	0	0	0.00%
Women's and Children's	480	8	20	8	36	7.50%	0	0	1	1	0.21%
Cancer	120	2	1	0	3	2.50%	0	0	0	0	0.00%

Critical Care Guidelines

Standard		Additional rationale/consideration	References
1.2.1	Level 3 patients (level guided by ICS levels of care) require a registered nurse/patient ratio of a minimum 1:1 to deliver direct care	A greater ratio than 1:1 may be required to safely meet the needs of some critically ill patients, such as unstable patients requiring various simultaneous nursing activities and complex therapies used in supporting multiple organ failure. Enhanced Level 3 patient status takes in to account severity of illness and the related nursing demands	Williams G, Schmollgruber S, Alberto L. *Crit Care Clin.* 2006 Jul;22(3):393-406 The European Federation of Critical Care Nursing Associations, 2007
1.2.2	Level 2 patients (level guided by ICS levels of care) require a registered nurse/ patient ratio of a minimum 1:2 to deliver direct care	The 1:2 ratios may need to be increased to 1:1 to safely meet the needs of critically ill patients, such as those who are confused/delirious requiring close monitoring and/or those being nursed in single rooms.	The European Federation of Critical Care Nursing Associations, 2007
1.2.3	Each designated Critical Care Unit will have a identified Lead Nurse who is formally recognised with overall responsibility for the nursing elements of the service e.g. Band 8a Matron	This person must be an experienced critical care nurse with detailed knowledge and skills to undertake the operational management and strategic development of the service. This person will have: • undertaken leadership/management training • be in possession of a post registration award in Critical Care Nursing • be in possession or working towards post graduate study in relevant area This person will be supported by a tier of Band 7 sisters/charge nurses who will collectively manage human resources, health & safety, equipment management, research, audit, infection prevention & control, quality improvement and staff development.	Williams G, Schmollgruber S, Alberto L. *Crit Care Clin.* 2006 Jul;22(3):393-406

Appendix 10

Critical Care Staffing and skill mix benchmarking data

Trust A = Bedford Hospital NHS Trust
Trust B = Epsom and St Hellier University Hospitals NHS Trust
Trust C = East Sussex Hospitals NHS Trust
Trust D = Cambridge University Hospitals NHS Foundation Trust
Trust E = West Hertfordshire Hospitals NHS Trust

	Trust A	Trust B	Trust C	Trust D	Trust E	Average for Bench Mark	ENHT	Var from Benchmark
Band 8	1.74%	0.96%	0.94%		1.04%	1.17%	0.98%	-0.19%
Band 7	10.45%	15.45%	20.77%	7.11%	7.33%	12.22%	7.83%	-4.39%
Band 6	25.55%	42.80%	26.67%	9.23%	22.02%	25.26%	14.48%	-10.77%
Band 5	53.13%	34.36%	43.31%	73.64%	62.34%	53.36%	69.86%	16.51%
Band 4								
Band 3		6.43%	5.48%			5.95%		-5.95%
Band 2	9.13%		2.83%	10.01%	6.24%	7.05%	6.85%	-0.20%