1. Introduction

This report was commissioned by the Director of Nursing and Modernisation and lays the foundation for regular establishment reviews to build on, to ensure all stakeholders including patients, staff and the Trust Board understand the risks and assurances associated with current nurse staffing levels and the actions required to ensure care is provided safely.

The report recommendations will need to be fully examined, and when judgements are reached, the timescales will be agreed to inform when the changes to establishments will be implemented.

2. Summary

In summary, the nurse establishment review included all the inpatient wards and the summary recommendation of the review is included at page 19. The review also included the NRU who completed the audit of activity and dependency over the same period; using the same methodology as the other wards, but also using their specific audit tool, Northwick Park, to triangulate results.

This review used the evidence based Safer Nursing Care Tool (SNCT- Shelford Group), the Professional Judgement Model (Telford), the safe staffing alliance principles where appropriate and compared these to the funded and actual establishments of the Trust. Nurse sensitive indicators are also incorporated for triangulation, but it should be noted that there was no evidence of concern from these indicators when undertaking the review.

The acuity SNCT review took place during May 2014. The project included training for the ward staff, two weeks’ of data collection, data analysis, national benchmark review and report writing. This report focuses on the nursing staff alone and it should be remembered that the efficiency of a nursing team will be influenced by the way in which they are led, the
way in which they work with other healthcare professionals including AHP, pharmacists and medical staff. The support to the ward/unit by other non-clinical staff including clerical, portering and housekeeping staff is essential.

3. Background

The national focus on safe staffing on wards has been increasing since the publication of three important national reviews, Francis, Keogh and Berwick. All three reports shared a common purpose and that was to review patient safety either specifically at certain organisations or more generally in the NHS.

All three reports stress the importance of adequate nurse staffing levels and add to the importance of this review at the Walton Centre NHS Foundation Trust. The methodology will be described later in the report but the most recent RCN guidance should be noted as it supports the need for a nurse staffing review. In 2011 the RCN called for all ward leaders (Band 7) to hold supervisory status, this means they are not ‘counted in’ the staffing numbers on clinical shifts, rather they have the time to develop their staff, set standards and monitor the quality of care in their areas. Although there are currently no mandated minimum nurse staffing levels in the UK for adult general wards or neurosciences, the Berwick review and National Quality Board 2013 note the direction of travel for NICE to take this forward. NICE Guidance is currently out for consultation by invitation and there are best practice guidelines for some areas such as the safe staffing alliance principles 2013 and these will be referred to in the results section.

The National Quality Board published in 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)’ The report detailed 10 Expectations in relation to nurse staffing and have been agreed principles in this report namely;

**Expectation 1.** *Boards take full responsibility for the quality of care provided to patients and as a key determinant of quality, take full and collective responsibility for nursing and care staffing capacity and capability.* At the Walton Centre, the Board have received previous reviews of nurse staffing and agreed in May 2014 to reviewing the patient acuity and nurse staffing levels on a biannual basis. This report is the first biannual review with a
further review being presented to the Board of Directors in January 2015 (noting there is no trust board meeting in December).

**Expectation 2.** *Processes are in place to enable staffing establishments to be met on a shift by shift basis.* The Walton Centre has robust escalation procedures in place undertaken throughout the day to ensure staffing meets patient need on a shift by shift basis. The board of directors receive an exception report monthly reviewing actual staffing against planned on a shift by shift basis, and identifying any issues.

**Expectation 3.** *Evidence-based tools are used to inform nursing and care staffing capacity and capability reviews.* This report details the triangulation of evidence based tools, including SNCT, Telford and nurse sensitive indicators.

**Expectation 4.** *Clinical and managerial leaders foster a culture of professionalism and responsiveness, where staff feel able to raise concerns.* Nurses utilise the NMC raising concerns approach within the organisation to complement existing Trust processes. The Trust is also in the process of joining the RCN ‘speak out’ campaign to build on these foundations further and ensure staff feel supported and encouraged to raise any concerns.

**Expectation 5.** *A multi-professional approach is taken when setting nursing and care staffing establishments.* At the Walton Centre, representatives of finance, HR and management have been part of the project group in relation to the safe staffing review.

**Expectation 6.** *Nurses and care staff have sufficient time to fulfil responsibilities that are additional to their direct caring duties.* This paper recommends Ward Managers are allocated supervisory status to support ward staff, furthermore the organisation has a 22% uplift built in nurse staffing to ensure time for training and staff development.

**Expectation 7.** *Boards receive monthly updates on workforce information, and staffing capacity and capability is discussed at a public Board meeting at least every six months on the basis of a full nursing establishment review.* In May 2014 the Walton Centre Trust Board agreed to the presentation of a biannual safe staffing review and a monthly staffing exception report, which builds on previous foundations. Detail of the staffing on a daily basis
across the Trust can also be found on the Trust website with links from NHS Choices and Unify.

**Expectation 8.** *NHS providers clearly display information about the nurses and care staff present on each ward, clinical setting, department or service on each shift.* The Trust has an initial system in place since April 2014. The displays have been enhanced following feedback from patients and staff and after a further month’s trial the Trust will invest in purpose built display boards for all areas.

**Expectation 9.** *Providers of NHS services take an active role in securing staff in line with their workforce requirements.* The Trust has systems in place in relation to this and is continuing to strengthen its recruitment processes in particular. The Trust has taken its recruitment activity in house in recent months and is increasing the hospitals presence at recruitment fairs and commenced a recruitment campaign on the website with the development of trust videos.

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

4. **Terms of Reference**

The review has been undertaken to determine the safe nurse staffing levels required and support the Trust in:-

- Benchmarking WCFT wards against ‘best practice’ wards and services in other Health Trusts by reviewing:-
  - Patient dependency/acuity (acuity levels are detailed in appendix 1)
  - Staff activity
  - Service quality
  - Staffing data
  - Professional Judgement
- Nurse Sensitive Indicators

- Recommending safe, quality ward and staffing establishments, based on current workloads and anticipated workloads for future planning on all wards within the Trust.

- Enabling the correct skill mix and staffing levels to ensure patient acuity and the Trusts service requirements are taken into account on a regular basis within the manpower plan of the Trust.

- Oversee the collection and reporting of data from the wards to help provide accurate reporting of present staffing and skill mix structure and processes.

- Ensure that when collected, the data in the reports is used to review and update staffing levels and skill mix on the relevant wards and support them in being able to provide safe, quality patient care.

- Ensure on-going sustainability of the correct staffing and skill mix on the wards and to ensure patient acuity is taken into account in:
  
  - Patient assessment
  - Personalised care planning and risk assessments
  - Implementing and reviewing personalised care plans
  - The safety and quality of patient care services.

- Consider patient safety and clinical governance issues that are relevant to staffing levels, skill mix and patient acuity.

Additional evidence and guidance will be used to support the review; for example the 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). This review included by ward; professional judgement model, SCNT model, benchmarking, safe staffing alliance principles where relevant, funded and actual establishments, agreed clinical indicators and ward activity (admissions, discharges,
transfers and deaths). Recommendations are being made based on the overall picture for each ward.

It is recognised that safe staffing workforce reviews need to occur biannually to ensure up to date staffing that is as dynamic and reflective of the current wards status and patient acuity. Software options need to be explored going forward to ensure the best system to support the ward managers to review their ward team size and skill mix is appropriate and safe.

5. Supported by internal project group and staff:-

Director of Nursing and Modernisation
Deputy Director of Nursing
Lead Nurses
Unit Matrons
Ward Managers
Finance representative
Human Resources representative
Divisional Manager - Medicine

6. Methodology

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

6.1 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, however the tool is not neuroscience specific.
• Used in conjunction with 9 Nurse Sensitive Indicators (NSI) (patient falls, infection rates, pressure ulcer incidence, patient safety incidents, non patient safety incidents, sickness, staff turnover, medication errors and complaints) which can all be linked to staffing.

• Able to support benchmarking activity in organisations when used across Trusts. This will assist in facilitating consistent nurse-to-patient ratios in line with agreed standards across similar care settings in England.

• It can be accessed on http://shelfordgroup.org/library/documents/130719_Shelford_Safer_Nursing_FINAL.pdf

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 ‘Leeds Acuity-Quality’ 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 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. Hurst to review the tool and 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;
• 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 (* includes HCAs/Assistant Practitioner).

This required that the dual scoring exercise was repeated.
• 40,000 dual assessments were undertaken in October 2012 using the Leeds Dependency tool and Safer Nursing Care Tool to update the staffing Multipliers.
• 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, experience, seniority, educational level 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 (Royal College of Nursing, 2010, National Quality Board 2013). 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.

This review has used the SNCT, Professional Judgement and Registered Nurse (RN) to Bed Ratio.

6.3 Caution with the SNCT data

The SNCT should be used to assess patient dependency and acuity at least twice a year (results being presented at January and July board meetings, noting that there is no board in December). The model is very clear that decisions should not be taken on one set of data alone and that ideally trusts should have three sets of data before making significant changes to the workforce. It is widely recognised that the first set of data may not be as robust as subsequent sets, due to staff knowledge and application of the tool. Clearly, if the SNCT results and other assessments, for example Registered Nurse to Bed ratio and
clinical indicators demonstrate there is a significant problem, prompt action should be taken. The Trust has taken the approach to triangulate the SNCT information as previously described with Telfords, safe staffing alliance and nurse sensitive indicators to improve the reliability of the first set of data – however where the information is conflicting the review has noted this and advised monitoring trend to inform the next 6 monthly review of those areas before any staffing changes are recommended.

7 Evidence to support safe staffing ratios

There is a body of evidence (Rafferty et al, Griffiths et al 2013, Kane et al 2007, Needleman et al 2011, Ball et al 2012) to support the assertion that on general wards (including elderly care) during the daytime, a ratio of more than 8 patients per registered nurse (RN) significantly increases the risk of harm and constitutes a potential breach in patient safety. This ratio should not be viewed as an acceptable minimum but as an alert to potential patient safety concerns. This is referred to as the Safe Staffing Alliance Principle in the report.

The skill mix is also crucial to ensuring safe staffing levels. The RCN guidance (2010) advocates a skill mix of no less than 65:35 (RN: NonRN) for general wards and that Ward Managers have supervisory status. This skill mix is a useful reference point however it is noted that depending on the acuity of patients and ward speciality skill mix may be more appropriate at a higher RN/HCA or lower RN/HCA mix. The SCNT references the skill mix based on the best practice for the speciality, and has been considered as part of this review.

In 2004, the British Association of Neuroscience Nurses (BANN) set out in their strategy expectations about staffing ratios, this has been reviewed in 2013 in BANNs Neuroscience Safe Staffing Benchmarking and suggested that there should be 1.25 wte registered nurses per bed for neuroscience patients. Having reviewed this with other trust data in neuroscience specialist trusts;

- Trust A in 2013 had 1.10 wte registered nurses per bed
- Trust B in 2013 had 0.93 wte registered nurses per bed
- Trust C in 2013 had 0.86 wte registered nurses per bed
Trust D in 2013 had 1.42 wte registered nurses per bed (however note this Trust lacked economies of scale as low bed numbers on ward).

Further acuity reviews by these organisations could have seen these ratios change in 2014. In most organisations recent staffing reviews have led to an increase in staffing levels. This review recommends between 0.92 to 1.63wte registered nurses per bed depending on the acuity of patients nursed on the wards speciality, the wards size and layout. It is recognised that on some wards this is less than the BANN suggested staffing ratios however the Trust has a number of senior nursing roles that as part of their core duties provide care to patients on the wards and these nurses provide an additional resource not included in the ward staffing numbers. These roles are clinical coordinators, neuroscience outreach team and some of the advanced nurse practitioner posts in the organisation, it is therefore considered appropriate to set staffing levels at this level. The subsequent safe nurse staffing biannual review will note how these roles are functioning and the impact on patient care on the wards and ward staffing, being undertaken as part of the post deanery visit actions. The next review will also examine the role of the assistant practitioners within the Trust.

For nurses to provide safe and compassionate care and treat patients with dignity and respect consistently; staffing levels should not breach the recommended 1:8 (trained nurse to patient ratio) for those areas applicable. Each clinical area should have its staffing determined by experienced and knowledgeable senior nurses and within the WCFT expertise of the ward manager, matron and lead nurse for the area and Deputy Director of Nursing was utilised and approved by the Director of Nursing and Modernisation.
8 Report

The review for each ward brings together the SCNT information, Telfords (professional judgement), safe staffing alliance principles where appropriate and the clinical nurse indicators for May, followed by the recommendation.

8.3 Neurosurgical Wards

Cairns Review

Following the analysis of the data from the staffing tool, SNCT notes the ward has a higher number of staff when compared with 150 general surgical wards, however the acuity of neurosurgery patients was noted to be higher (see table below) and so a decrease in staff numbers is not recommended. The level of experience of trained nurses on the ward has reduced with a higher number of newly qualified staff than previously; in recognition of the change in experience an additional practice facilitator role is recommended to support the newly qualified staff. The professional judgement model has also recognised a recent increase in need of HCA at night, it is proposed that this is monitored over the coming months to inform the next review and determine whether this is a trend that requires additional staffing for HCA on nights or not.

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<th>Acuity</th>
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<tr>
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</tr>
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<td>22%</td>
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</tbody>
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The review identified current funded establishment meets safer staffing alliance principles. The nine nurse sensitive indicators indicate insignificant/low harm with sickness being above the trust average.

Recommendation:
Following budgetary realignment the investment required is
- RNs to increase by 0.28 wte, which would include the practice facilitator post.
- HCA to increase by 1.07 wte
- Review HCA need on nights following further monitoring

**Caton Review**

Following the analysis of the data from the staffing tool, SNCT notes that the ward has a lower number of trained staff and a higher number of support staff when compared with 150 general surgical wards. It should be noted that the acuity for Caton Ward patients was lower during the two weeks measured than expected and therefore is less reliable as a platform for change. This may be due to a misinterpretation of the tool, which is new to staff, as referenced in section 6.3 as a potential caution to making changes. The professional judgement model has recognised the ward needs an increase in trained staff to enable the ward manager supervisory status and recognising activity levels on a Saturday. The level of experience of trained nurses on the ward has reduced with a higher number of newly qualified staff than previously; in recognition of the change in experience an additional practice facilitator role is recommended to support the newly qualified staff.

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<th>150 General Surgery</th>
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The review identified current funded establishment meets safer staffing alliance principles. The nine nurse sensitive indicators indicate insignificant/low harm with the exception of one grade two pressure ulcer. Sickness is below the trust average.

**Recommendation:**

Following budgetary realignment the investment required is
- Increase RNs by 1.44wte which would include the practice facilitator post.
- Decrease of HCA by 0.65wte

**Dott Review**

Following the analysis of the data from the staffing tool, SNCT recommends a slight increase in current RN staffing when compared with 150 general surgical wards. The acuity modelling demonstrates a significantly higher level of acuity of patients which was reflective of the period in May. Further reviews will establish if this is a consistent level of acuity. This is supported when using the Telford model of professional judgement, which recommends an increase of registered nurses and health care assistants. The level of experience of trained nurses on the ward has reduced with a higher number of newly qualified staff than previously; in recognition of the change in experience an additional practice facilitator role is recommended to support the newly qualified staff. The professional judgement model has also recognised a recent increase in need of HCA at night, it is proposed that this is monitored over the coming months to inform the next review and determine whether this is a trend that requires additional staffing for HCA on nights or not.

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</tbody>
</table>

The review identified current funded establishment meets safer staffing alliance principles. The nine nurse sensitive indicators show low harm with sickness above the trust average.

**Recommendation:**
Following budgetary realignment the investment required is

- RNs to increase by 0.79wte which includes the practice facilitator post
- An increase of 0.57wte HCA
- Review HCA need on nights following further monitoring

Sherrington Review

Following the analysis of the data from the staffing tool, SNCT notes the ward has a higher number of staff when compared with 150 general surgical wards, however the acuity of neurosurgery patients was noted to be higher and a decrease is not recommended. This is supported when using the Telford model of professional judgement, which recommends an increase of RN. The level of experience of trained nurses on the ward has reduced with a higher number of newly qualified staff than previously; in recognition of the change in experience an additional practice facilitator role is recommended to support the newly qualified staff.

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<th>Acuity</th>
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The review identified current funded establishment meets safer staffing alliance principles. The nine nurse sensitive indicators identify low or minor harm, with the exception of one moderate harm fall. Sickness is at the trust average.

Recommendation

Following budgetary realignment the investment required is

- RNs to increase by 0.79wte which includes the practice facilitator
- HCA to reduce by 1.2wte
8.4 Neurology Wards

Chavasse Review

Following the analysis of the data from the staffing tool, SNCT notes that staffing is higher when compared with 98 Neurology wards. Although the benchmark group used is based on neurology wards, these are spread across general hospital services and do not have the geography associated with Chavasse Ward or the acuity of patients in a specialist Trust. However this first acuity review has demonstrated patients on Chavasse Ward were a lower dependency than expected and therefore caution in interpreting this data is needed. It is recommended that no change is made on this first set of data and will require further reviews (ref section 6.3). Chavasse Ward has a telemetry facility on the ward which needs a higher proportion of support staff than other neurology wards. The professional judgement model recommends an increase of RNs. The level of experience of trained nurses on the ward has reduced with a higher number of newly qualified staff than previously; in recognition of the change in experience an additional practice facilitator role is recommended to support the newly qualified staff.

<table>
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The review identified current funded establishment meets safer staffing alliance principles. The nine nurse sensitive indicators indicate insignificant harm with sickness at the trust average.

Recommendation

Following budgetary realignment the investment required is

- RNs to increase by 0.47 wte, this includes the practice facilitator post
- HCA to increase by 0.09wte
Lipton Review

Following the analysis of the data from the staffing tool, SNCT notes that staffing is higher than compared with general rehabilitation wards. Although the benchmark group used is based on 26 neuro rehabilitation wards, these are across general hospital services and do not have the acuity or the specialised care requirements of patients that are seen on Lipton Ward as a specialist Trust. The table below identifies a significant increase in patient’s acuity on Lipton Ward when compared to other Neuro rehabilitation areas. This is supported when using the Telford model of professional judgement, which recommends an increase of RN and HCA. The level of experience of trained nurses on the ward has reduced with a higher number of newly qualified staff than previously; in recognition of the change in experience an additional practice facilitator role is recommended to support the newly qualified staff.

<table>
<thead>
<tr>
<th>Acuity</th>
<th>Lipton</th>
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<td>Level 1a</td>
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<td>Level 1b</td>
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<td>Level 2</td>
<td>5%</td>
<td>7%</td>
</tr>
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<td>0%</td>
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</table>

The review identified current funded establishment meets safer staffing alliance principles. The nine nurse sensitive indicators indicate insignificant harm and there is currently no sickness on the ward.

Recommendation

Following budgetary realignment the investment required is

- RNs to increase by 0.52wte, which includes the practice facilitator
- HCA to increase by 2.71wte.
NRU Review

Following the analysis of the data from the staffing tool, SNCT notes the ward has a higher number of staff when compared with 26 neuro rehabilitation wards, however the acuity of neurosurgery patients was noted to be significantly higher and a decrease is not recommended, furthermore these are spread across general hospital services and do not have the acuity of the patients on NRU as a specialist hospital. The table below identifies a significant increase in patient’s acuity on NRU when compared to other Neuro rehabilitation areas. This is supported when using the Telford model of professional judgement, which recommends an increase of just over 4.0 wte RN. The HCA has been slightly reduced in recognition of the richer skill mix with increased trained staff causing an over establishment of 1.38wte. The level of experience of trained nurses on the ward has reduced with a higher number of newly qualified staff than previously; in recognition of the change in experience an additional practice facilitator role is recommended to support the newly qualified staff. The professional judgement model has also recognised a recent increase in need of HCA at night, it is proposed that this is monitored over the coming months to inform the next review and determine whether this is a trend that requires additional staffing for HCA on nights or not. It is anticipated with the increase in trained staff on night duty that this level of usage would be unlikely to continue.

<table>
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<tr>
<th>Acuity</th>
<th>NRU</th>
<th>26 Neuro Rehab</th>
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<tbody>
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<td>Level 1a</td>
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<td>Level 1b</td>
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<td>Level 2</td>
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<td>7%</td>
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<td>Level 3</td>
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The unit in the past did not have the level of patient acuity it now experiences which was demonstrated in the review to be a high dependency – it is therefore appropriate going forward to benchmark this with acute wards and the safe staffing alliance principles. The nine nurse sensitive indicators indicate low harm and there is currently no sickness on the ward.
Recommendation
Following budgetary realignment the investment required is

- RNs to increase by 4.56wte this includes the practice facilitator
- HCA to reduce by 1.38wte

8.3 Neuroscience Staffing Ratios

The BANN suggest 1.25 wte per registered nurse per bed for neuroscience patients and the investment above would bring us to ratios:

- Cairns 0.92 wte per bed
- Caton 0.95 wte per bed
- Dott 0.96 wte per bed
- Sherrington 1.03 wte per bed (needs higher due to spinal and cranial trauma)
- Lipton 1.68 wte per bed (hyper acute and lacks economies of scale as 10 beds)
- Chavasse 1.03 wte per bed (increased staffing per bed within the Trust in recognition of the wards layout)
- NRU 0.94 wte per bed

Whilst it is recognised these wte are less than the BANN, it is in line with 2 of the 4 benchmarking Trusts in neurosciences and the Walton Centre has a number of roles that support the ward staff and patient care within the Trust namely clinical coordinators, neuroscience outreach team, and advanced nurse practitioners who are present on the wards and units throughout the day (clinical coordinators are also present on nights). It is therefore proposed that future reviews look at these wider roles and the support to patient care on the wards before any further trained staff recommendations are made.
9 Overall Recommendations

The Director of Nursing and Modernisation and Deputy Director of Nursing acknowledge the findings and recommend that the Trust Board staffs the wards to the recommended levels. They note that no concerns have been raised from the results of the nurse sensitive indicators or from patient feedback on the patient’s experience at the Trust with the current establishments, and identify discussions will need to take place to prioritise and decide the timescales of when the changes are to be implemented. Proposed establishments, nurse shift patterns and nurse to patient ratios are identified in appendix 2.

The recommendation, in summary, is that the Trust fund an additional 8.83 wte Registered Nurses, and 1.18 wte Health Care Assistants over and above existing funding at a cost of £347,299. This will be further offset by recurrent funding of £75,000 identified in NRUs budget from January in recognition of the new unit staffing changes which will be reviewed in light of the earlier investment proposed. It is recognised that the review includes the budgetary realignment that has taken place reducing 10 study days per wte to 8 study days per wte and therefore only outlines the budgetary wte increase rather than the actual increase in wte which has been offset financially by this reduction. Supporting financial information is in appendix 2.

The review has identified on some wards the need to monitor HCA usage at night over the coming months as recent usage has been higher, this will inform the next review and determine whether this is a trend that requires additional staffing for HCA on nights or not.

9.1 Ward Managers Supervisory Status

The ward manager’s principle of supervisory time per week is recommended by Francis, Berwick principles and the National Quality Board; they suggest that ward managers should have complete supervisory status. The senior team will monitor the effectiveness of this in having this supervisory status it is anticipated that the ward would see a reduction in the nurse sensitive indicators used to inform this review (complaints, HCAI, pressure ulcers, slips trips falls with harm, medication incidents, patient and non-patient safety incidents, staff turnover and sickness). Furthermore it is anticipated it will have a positive effect on
length of stay and timely discharge. We will review the impact of the supervisory status on these metrics at the January review and through measuring for improvement principles across the year.

9.2 Practice Facilitators

These new roles are recommended in recognition of the changes in workforce planning and the decline in availability of senior staff nurses at ward level. The number of opportunities for staff nurses with experience has increased over recent years with the reduction of junior doctors and emergence of new roles and NHS roles that see a clinical qualification as desirable. This has impacted on the level of experience of staff nurses in wards across the NHS with a higher proportion of staff being newly qualified and in preceptorship or their first year post qualification.

In recognition of this dilution of neuroscience experienced staff nurses it is recommended that each ward has an additional band 6 post that for half of their time work alongside the less experienced staff modelling the way and demonstrating how to deliver excellent care acting as a personal coach and mentor. This would require an investment across the Trust of 4 wte band 5 staff nurses to back fill the time spent working with the newly qualified and no longer being counted in the staffing numbers. These posts would also be attractive in retaining staff that would otherwise look to move away from the wards for a more senior position so retain experienced staff and would be an additional support for newly qualified staff and enhance recruitment.

9.3 Further Reviews

This report has focussed on the ward areas as Horsley Intensive Care Unit was reviewed in February 2014, and changes implemented as per the recommendations. The impact of reviews of roles following the post deanery visit actions and also Jefferson Ward Staffing will be noted in the next biannual review.
10 References


Francis, R (2013) the Mid Staffordshire NHS Foundation Trust Public Inquiry, London


Keogh, B., (2013) Review into the quality of care and treatment provided by 14 hospital trusts in England

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.


Royal College of Nursing, making the business case for ward sisters / team leaders to be supervisory to practice, (2010), RCN, London


Appendix 1

SNCT Classification System (for scoring patient’s care level)

**Level 0:** requires hospitalisation and needs met by providing normal ward care. Care requirements may include:
- Elective medical or surgical admission – e.g. routine micro disc
- May have underlying medical condition requiring on-going treatment
- Patients awaiting discharge
- Post-operative/post-procedure care – observations recorded half-hourly initially then four-hourly.
- Two to four hourly observations
- Early Warning Score is within normal threshold.
- Fluid management
- Oxygen therapy less than 35%
- PCA
- Confused patients not at risk, (pleasantly confused)
- Patients requiring assistance with some daily living activities requiring one person to mobilise, or one experiencing occasional incontinence

**Level 1a:** Acutely ill patients requiring intervention or those who are unstable with a greater potential to deteriorate. Care requirements may include:
- Increased observation and therapeutic interventions
- Early Warning Score – trigger point reached and requiring escalation
- ECG monitoring
- 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 two to six hourly
- Arterial blood gas analysis – intermittent
- Twenty-four hours after tracheostomy or extra ventricular drains, lumber drains
- Severe infection or sepsis
- Pain Control – titration regime
Level 1b: Patients are stable but are dependent on nurses to meet most or all daily living activities. Care requirements may include:

- 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 two carers or more
- Complex intravenous drug regimens – including those requiring prolonged preparatory/administration/post-administration care. e.g. ketamine
- Patients and/or carers requiring enhanced psychological support owing to poor disease prognosis 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 daily living activities
- Potential for self-harm and requires constant observation
- Facilitating a complex discharge where this is the ward nurse’s responsibility

Level 2: May be managed within clearly identified, designated beds, resources with the required expertise and staffing level OR may require transfer to a dedicated Level 2 facility/unit. Care requirements may include:

- 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
- Requires several 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, GTN) or potassium, magnesium, pain management – intra-thecal analgesia
- CNS depressed airway and protective reflexes
- Invasive neurological monitoring

Level 3: Patients needing advanced respiratory support and/or therapeutic support of multiple organs. Care requirements may include:

- Monitoring and therapy for compromised/collapse involving two or more organ/systems
- Respiratory or CNS depression/compromise requires mechanical/invasive ventilation
### Professional Judgement - Ward Staffing Establishments

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<tr>
<th>Ward</th>
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<th>Early Sat - Sun</th>
<th>Late</th>
<th>Night</th>
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## Supporting Financial Information

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| Cost (£)             |                      |                  | **321,207**             | **26,091**        |

| Total Requirement (£)|                      |                  | **347,299**             |