REPORT TO:	**STRATEGIC WORKFORCE COMMITTEE**
DATE:	**30th JANUARY 2017**
SUBJECT:	**WARD ESTABLISHMENT REVIEW UPDATE NOVEMBER 2016**
BOARD SPONSOR:	**CHIEF NURSE AND DIRECTOR OF QUALITY**
PAPER AUTHOR:	**ASSOCIATE CHIEF NURSE**
PURPOSE:	**Discussion**

BACKGROUND AND EXECUTIVE SUMMARY

Regular six monthly ward staffing reviews have been undertaken since 2013 to fulfil the requirements set out by the NHS Quality Board to report to the Trust Board.

In July 2016 the National Quality Board published updated guidance, building on the 2013 guidance, to provide an updated safe staffing improvement resource. Annual staffing reviews are required, previously six monthly, and the next full review, reporting April 2017, will be reported to the Strategic Workforce Committee in July 2017.

This report provides:

- A summary of the updated guidance and a gap analysis on current Trust compliance;
- A progress update on the recommendations from the previous ward staffing review (May 2016) reported to the Strategic Workforce Committee in July 2016 specifically:
    a. The key priorities identified from the findings of the review;
    b. The Emergency Departments, Neonatal Intensive Care and Midwifery

Priorities identified from this review update are:

1. Annual staffing reviews are now required with six monthly updates to the Strategic Workforce Committee;
2. Care Hours Per Patient Day (CHPPD) should be included in the ward Quality Heatmap from January 2017;
3. To improve alignment of staffing required to demand by developing the business case aligned to the workforce CIP programme to implement Safe Care. This is underway and external visits are planned to learn from other organisations who are using it to explore realistic and robust benefits realisation.
4. The completion of the 2017/18 Nursing Workforce Plan to inform recruitment and retention planning against current and expected vacancies to support the agency reduction programme;
5. Evaluation of the impact of previous investment through reductions in sickness absence, reductions in use of temporary staff and improvements in patient safety through benefits realisation will be reported to the Strategic Investment Group in February 2017.
6. Successful implementation of the Nurse Associate role to support safe staffing. The pilot is due to commence in April 2017.
7. Phased recruitment to the investment approved into the Emergency Departments and NICU. Further work to be undertaken to explore further investment required into Maternity.

IDENTIFIED RISKS AND MANAGEMENT ACTIONS:	Continued vacancy factor and reliance on temporary staffing will require further innovative recruitment approaches to enable recruitment ahead of turnover.
LINKS TO STRATEGIC OBJECTIVES:	**Patients:** Help all patients take control of their own health. **People:** Identify, recruit, educate and develop talented staff. **Provision:** Provide the services people need and do it well.
LINKS TO STRATEGIC OR CORPORATE RISK REGISTER	SRR8 Ability to attract, recruit and retain high calibre staff to the Trust.
RESOURCE IMPLICATIONS:	Adequate staffing levels impact on the achievement of the of the required performance indicators, non-compliance with contractual obligations attract financial penalties. This includes 2016/17 CQUINs which are valued at 2.5% of actual outturn, or around £10m.
COMMITTEES WHO HAVE CONSIDERED THIS REPORT	Divisional Heads of Nursing meeting

PRIVACY IMPACT ASSESSMENT: *NO**	**EQUALITY IMPACT ASSESSMENT:** *NO*

RECOMMENDATIONS AND ACTION REQUIRED:
The board is asked to note the update and priorities identified.

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WARD ESTABLISHMENT REVIEW UPDATE (November 2016)

1. INTRODUCTION

Regular ward staffing reviews have been undertaken since 2007/08 to ensure they are fit for purpose. Regular six monthly ward staffing reviews have been undertaken since 2013 to fulfil the requirements set out by the NHS Quality Board.

In July 2016 the National Quality Board published updated guidance, building on the 2013 guidance, to provide an updated safe staffing improvement resource.

This report provides:

1. An update on the updated guidance and a gap analysis on current Trust compliance;
2. A progress update on the recommendations from the previous ward staffing review (May 2016) reported to the Strategic Workforce Committee in July 2016 specifically:
    a. The key priorities identified from the findings of the review across all areas
    b. The Emergency Departments, Neonatal Intensive Care and Midwifery

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2. NATIONAL QUALITY BOARD EXPECTATIONS ON WARD STAFFING

2.1 Recommendations for greater transparency of ward staffing levels has followed the Francis report on Mid Staffordshire (2013), the Keogh review (2013), the Berwick report on improving the safety of patients in England (2013) and the NHS England report on Hard Truths; The journey to putting patients first (2013).

As a result, in 2013 the NHS Quality Board published guidance 'How to ensure the right people, with the right skills, are in the right place at the right time' which identified new requirements in providing assurance on safe staffing. The requirements were related to three main areas of action:

- To clearly display information about the nurses, midwives and care staff present and planned in each clinical setting on each shift. Displays should be in an area visible to patients, families and carers and explain the planned and actual numbers of staff for each shift as well as who is in charge of the shift.

  Staffing boards have been in place since April 2014 in all inpatient wards.

- The board should receive monthly reports containing details and summary of planned and actual staffing on a shift-by-shift basis, is advised about those wards where staffing falls short of what is required to provide quality care, the reasons for the gap, the impact and the actions being taken to address the gap.

  Actual against planned staffing hours, by inpatient area, is reported to the Board as part of the monthly Integrated Performance report. This report is accessible to patients and the public on a dedicated area of the Trust website and is published on the relevant hospital profile on NHS Choices.

- The Board should receive a report every six months on staffing capacity and capability which has involved the use of an evidence-based tool (where available), includes the key points set out in the National Quality Board guidance and reflects a realistic expectation of the impact of staffing on a range of factors.

2.2 In July 2016 the National Quality Board (NQB) published updated guidance 'Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time' building on the 2013 guidance to provide an updated safe staffing improvement resource.

The priorities reflect the NQB expectations in three areas; Right staff, right skills and right place. A gap analysis has been undertaken against this recently published guidance and the following key areas of work have been identified:

- Annual staffing reviews, using a triangulated approach (i.e the use of evidence-based tools, professional judgement and comparison with peers), which takes account of all healthcare professional groups and is in line with financial plans, should be reported to Trust Boards. This should be followed with a comprehensive staffing report to the board after six months to ensure workforce plans are still appropriate. There should also be a review following any service change or where quality or workforce concerns are identified.

  The previous requirement was six monthly full reviews. The next review, reporting April 2017, will be reported to the Strategic Workforce Committee in July 2017.

- Care Hours Per Patient Day should be included in the local quality dashboard. This ~~will be included in the Quality heatmap from January 2017~~is reported every month to the Quality Committee and up to the Board of Directors. We are working on including these data in the Quality heatmap.

- The current approach to improve alignment of staffing required to demand focusses on the further development and embedding of live capture, reporting and escalation of staffing status through the dedicated safer staffing tool within Qlikview which enables the capture of daily planned, actual and required staffing linked to acuity and dependency. However, this system is not sufficiently sophisticated to enable live view of patient acuity dependency and skill mix linked to the Healthroster to enable optimised deployment of staff. A business case aligned to the workforce CIP programme to implement Healthroster Safe Care is underway and external visits are planned to learn from other organisations who are using it to explore realistic and robust benefits realisation.

3. PROGRESS IN IMPLEMENTING RECOMMENDATIONS FROM THE PREVIOUS REVIEW

The following key priorities were identified from the findings of the previous review:

3.1 Alignment of staffing required to demand though the Shelford Safer Nursing Care Tool

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

The dimensions of patient dependency and acuity are important variables in determining nursing workload and the SNCT is applied to study current nursing workload in all wards to calculate ward establishment. The updated Shelford SNCT (2013) reiterates the requirement for assessment over a longer period and wards are now capturing daily with quality control provided by matrons who consistency check submissions for all their wards. Further consistency checking is provided by a senior nurse to ensure common understanding and appropriate application of the criteria.

The capture of the dependency and acuity of patients moved from paper-based to electronic in 2015/16 with the development of a dedicated safer staffing tool within Qlikview. This enables capture, reporting and escalation of staffing status with daily planned, actual and required staffing linked to acuity and dependency. However, this system is not sufficiently sophisticated to be linked to Healthroster to readily allow reallocation to staff to areas of high demand.

In May-16 calculation of establishments using the SNCT method taking account of nursing workload associated with patient acuity and dependency demonstrated some correlation between calculated and actual establishment for most wards. However, Cambridge J, Sandwich Bay, St Margarets and Mount McMaster Wards saw an increase in acuity and dependency of patients matched by professional judgement.

Average acuity dependency over quarter 3 (September to December 2016) is seen in figure 1 which indicates that three of these wards have seen no further increase but Mount McMaster saw a further increase in acuity dependency which was linked to caring for a bariatric patient for an extended length of time during this period.

The Shelford tool is not applicable to paediatric wards but has been adapted to enable daily capture of nursing workload in a similar way to the adult wards. For paediatric wards the staffing required is calculated against the current RCN (2013) recommendations of nurse:child ratios of 1:3 for children <2 years of age and 1:4 for children >2 years of age during the day and night. This captures the nursing workload associated with ward beds only and shows acuity dependency in autumn / winter activity over quarter 3 which indicates higher staffing levels may be required. A full review of paediatric wards will be included in the next review in April 2017.

Figure 1. Average acuity dependency Nov-16 compared to May-16

WARD ESTABLISHMENT REVIEW UPDATE NOVEMBER 2016

Nov-16					
Specialty	**Ward**	**Full Est (WTE)**	**Shelford May-16**	**Shelford Nov-16**	**Comments**
CDUs	**CDU WHH**	72.53	58.14	68.57↑	SNCT does not capture bed utilisation and high turnover of patients. The K&C CDU is difficult to assess due to the combined establishment with ECC. Increase in acuity dependency at WHH is seen.
	CDU, QEQM	47.17	42.73	42.19	
	ECC (incl. CDU)	86.16			
Medical	**Cambridge J**	44.64	72.64 ↑	58.31	Increase in acuity dependency is seen on Mount McMaster, St Augustines and Cambridge M1.
	Cambridge K	34.69	32.39	32.33	
	Cambridge M2	27.08	29.66	29.19	
	Minster Ward	31.77	34.41	34.41	
	Oxford	23.91	23.34	23.71	
	Sandwich Bay	27.62	33.73	33.73	
	St Margarets	26.72	42.67 ↑	42.67	
	Deal	35.41	43.13 ↑	43.56	
	Harvey ward	27.50	27.37	27.37	
	Invicta	29.92	30.75	34.14	
	Treble ward	29.41	18.91	22.14	
	Mount McMaster	29.99	39.80 ↑	45.03↑	
	St Augustines	34.03	40.81	43.49↑	
	Cambridge M1	24.60*	25.29	34.3↑	
Stroke	**Fordwich Ward**	37.72	37.43	39.06	Increase in acuity dependency is seen on Kingston but is in line with funded establishment.
	Kingston	40.43	31.76	36.57	
	Richard Stevens Unit	40.63	41.55	39.44	
Frailty	**Harbledown**	35.08	54.45 ↑	55.76	Slight increase in acuity dependency on Harbeldown but professional judgement in May-16 did not indicate insufficient staffing.
	Cambridge L	38.22	43.10	43.62	
Coronary Care	**Taylor KCH**	14.07	7.78	8.57	No change
	CCU QEQM	22.90	18.29	18.39	
	CCU WHH	32.00	17.33	17.36	
Renal & Haematology	**Marlowe**	55.12	27.67	34.61↑	Increase in acuity dependency on Marlowe but inline with funded establishment
	Brabourne	16.26	5.11	9.42	
Gynaecology	**Birchington**	32.71	17.10	18.15	No change
	Kennington ward	23.91	9.56	10.45	
Paediatrics	**Padua**	48.19		54.4	Acuity dependency indicates higher staffing levels required than current
	Rainbow	39.23		46.9	
Surgery	**Rotary**	35.34	16.44	17.04	No change
	Cheerful Sp Female	39.51	30.15	29.54	
	Clarke	44.33	37.26	38.8	
	Cheerful Sp Male	36.72	31.04	28.89	
	Kent	33.28	20.20	23.36	
	Kings B	35.15	36.67	34.63	
	Kings A2	25.26	22.65	23.77	
Trauma & Orthopaedic	**Kings C1**	36.30	42.92 ↑	36.76	No change
	Kings C2	34.97	24.09	24.70	
	Kings D male(1)	62.28	57.08	59.09	
	Kings D female (2)				
	Quex	25.35	19.49	21.35	
	Bishopstone	33.99	34.50	35.87	
	Seabathing	35.73	32.14	35.7	

3.2 Deliver against the trajectory for agency reduction aligned to the EU recruitment programme.

As part of the NHSI Agency Rules and as part of NHSI best practice recommendation a Trust Wide Agency Reduction Programme has been created. This plan describes 31 projects that will reduce Agency Expenditure and usage across the divisions and the wider Trust. The Trust Wide Agency Reduction Programme is comprised of 31 strategic and operational actions.

Part of the plan is the implementation of a SMART Agency Action Plan, by Division, across the Trust. The SMART agency Action Plan identifies the Specific, Measurable, Achievable, Realistic and Targeted activities/work that the divisions are managing in order to reduce the use of agency staff and associated expenditure. In addition the plan presents the forecasted savings and a means to track the expected reduction in expenditure. The SMART Agency Action Plan provides a tool to capture, assess and monitor this work.

The plans will be shared with the Agency Reduction Programme Board (formerly Agency Pay Control Group) and will be reviewed at the Divisional Monthly Executive Performance Review. This provides transparency and the means for critical challenge at Executive Level as well as Senior Management Level.

The SMART plan is owned by the Divisions and is assessed monthly and exception reports generated and escalated to the Executive Performance Review. This commenced in January 2017.

3.3 Further reduce the vacancy levels for registered nurses by continuing the implementation of a robust recruitment and retention plan.

There are currently 176 WTE band 5 vacancies across the organisation.

Planned recruitment initiatives during 2016/17 were developed and implemented to plan for a substantial reduction in vacancies and to reduce agency following modelling of the expected movement and numbers of wte Band 5 nursing staff in late 2015.

In order to be fully established within Band 5 nursing and to keep pace with turnover and maternity cover, recruitment of approximately 160 wte nurses during 2016 over and above the current expected intake of overseas nurses and newly qualified recruitment was planned. Five overseas recruitment trips have been undertaken to Romania and Croatia and 72 employment offers were made. 36 subsequently withdrew and 33 were recruited (21 in July-16, 4 in Aug-16 and 8 in Oct-16). 3 are expected to join us in January / February 2017. A further campaign to India resulted in 112 offers and up to 85 applicants are currently within the recruitment process which includes the requirement to achievement level 7 IELTS before they arrive. A further campaign to the Phillipines is planned for February 2017.

Supply of nurses is influenced nationally and locally and the main challenges are:

- Although % of newly qualified nurses who take up their first post with EKHUFT has fallen since 2013, this improved to 78% in September 2016 but fell to only 38% expected in April 2017.
- Number of applicants to the pre-registration nursing programme has fallen by 20% (and locally by 15%) following bursary removal and the introduction of self funding for students

EKHUFT is leading a partnership for the early implementation of the Nurse Associate (band 4 role) commencing in April 2017 through a grant funded programme. This is expected to convert in to an apprenticeship route from September 2017 through the use of the 0.5% apprenticeship levy.

The nursing workforce plan will inform future recruitment plans and is under development currently.

3.4 Evaluate the impact of the investment into ward staffing and identify if further investment is required:

Evaluation of the impact of previous investment through reductions in sickness absence, reductions in use of temporary staff and improvements in patient safety through benefits realisation will be reported to the Strategic Investment Group in February 2017.

4. PROGRESS IN IMPLEMENTATING RECOMMENDATIONS IN THE EMERGENCY DEPARTMENTS, NEONATAL INTENSIVE CARE AND MIDWIFERY

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4.1 Emergency Departments

A business case was submitted to the Strategic Investment Group in December 2016 and the preferred option 2 was agreed. The aim of the Business Case is to ensure a future proofed robust nursing workforce to enable a patient focussed safe service.

-Emergency Department (ED) attendances have been rising every year since 2001/02, with an increase in conversion to admission. This coupled with overcrowding largely as a result of exit block and significant delays in ambulance handover have had a profound effect on the Emergency Departments and its ability to deliver a timely, safe quality service and maintain adequate flow.

Staffing concerns within the two Emergency Departments (ED) and the Minor injuries Units (MIU) have been highlighted by the Emergency Care Improvement Programme Team (ECIP) who advise that there should be a band 7 Nurse in Charge 24/7. This nurse works alongside the senior doctor to provide a safe quality service and a supervisory role for the nursing staff in all areas of the department.

Additionally they advise Emergency Nurse Practitioners (ENP) should be working at band 7 level and that there should be a stand-alone ENP service. This would provide a minor injuries service in the two EDs staffed by appropriately trained practitioners from 8am to midnight 7 days a week. The benefits of this service would be comparable to those at Kent and Canterbury and Buckland Hospitals minor injuries units.

In order to improve patient flow and streaming at the front door new ways of working are being introduced nationally and locally we have adopted improved assessment pathways for our patients. This is to ensure that they are seen in a timely manner by the most appropriate clinician. These new ways of working also require additional resources.

In order to deliver the above mentioned staffing resource the department relies heavily on agency staff, whilst it is understood the large financial impact of these additional staff it should be noted there are other issues in relying on agency staff in terms of quality, training and the constraints of a transient workforce.

A staffing review was undertaken and it highlighted the following points:

- There is no national tool available to adequately determine appropriate staffing levels, therefore professional judgement and benchmarking with other Ttrusts was undertaken.
- A need to increase the establishment by 30 wte nurses during times of escalation. The UCLTC Division manage this risk by covering the ED's with additional temporary staff.
- The review showed that when benchmarked against similar Trusts we broadly have the correct establishment assuming a business as usual context in relation to nursing staff at bands 6 and below.
- The Review proposed that we need an uplift of the band 7 ENPs and nurse in charge roles in order to bring us in line with other similar Trusts.
- Overcrowding and flow issues are being actively managed internally and also externally through a number of improvement plans and mitigating actions including:
    - 3 times daily site meetings
    - Site situation and risk assessment monitoring
    - Senior support by Site Operations Managers, Matrons, General Managers and a dedicated Head of Nursing for the EDs
    - Roster changes to manage peak attendance patterns
    - New models of ambulatory care led by consultant nurses
    - Ensuring patient safety during overcrowding in the departments
    - Monitoring quality and safety.

The preferred option is to:

1) Increase the establishments at QEQMH and WHH to ensure band 7 available 24/7, it is proposed that this be 6 wte who are able to undertake this role. This is a slight increase to the usual 5.69 wte required for 24/7 cover to take into account the increased training requirements that ED nurses require. This equates to an increase of:
    - Nurse in charge at QEQMH - 3.0 wte
    - Nurse in charge at WHH - 1.0 wte
2) Increase the banding of all ENP's Trust wide to band 7 provided they achieve the appropriate competencies. This will ensure that we are in line with national standards where ENP's are banded at band 7as a minimum and to increase the establishment of ENP posts at QEQMH and WHH only to provide a 8am to midnight service 7 days a week with 3 ENP's covering this time period in a staggered shift pattern. In addition a band 2 technician at BHD MIU to bring this in line with the other MIU's across the Trust. This equates to an increase of:
    - ENP at QEQMH (including increased service cover) increase 3.5 band 6 to band 7 and an additional 1.2 wte band 7
    - ENP at WHH (including increased service cover) increase 3.7 wte band 6 to band 7 and an additional 2.43 band 7 posts
    - ENP at K&CH increase 10.71 wte band 6 to band 7
    - ENP at BHD increase 3.48 wte band 6 to band 7
    - Band 2 technician at BHD 2.80 wte

3) Increased establishment to safely staff the increased demand on the ED service and to ensure appropriate streaming and assessment at the front door. This equates to an increase of :
    - Band 5 at QEQMH of 8.53wte
    - Band 2 at QEQMH of 5.69 wte
    - Band 5 at WHH of 8.53wte
    - Band 2 at WHH of 5.69 wte

It is proposed that the staffing for this option be managed in a phased approach as follows:

Phase 1:

- Ensure band 7 nurse in charge role to cover 24/7 period, likely to take 3-4 months to enable recruitment of new pots to take place. (WHH & QEQMH)
- Recruit to increased ENP posts at band 7 and increase existing band 6 posts to band 7 likely to take approximately 6 months for recruitment to pots and ensuring competencies met to upgrade staff. (All sites)

Phase 2

- Recruit to band 5 and band 2 posts at WHH & QEQMH in a phased way over a period of 1 year.

Phase 3

- Recruit to the band 2 posts at BHD minor injuries unit, this will make this come in line with equivalent staffing levels to the other minor injuries units across the Trust, also taking into account the increasing number of attendances there.

The costs of each option is detailed below. The preferred option 2 was agreed and investment of £1.5m will be off-set by a reduction in nurse agency expenditure of £1.3m with the shortfall met through a reduction in medical staff agency utilisation.

	Op 1	Op 2	Op 3
Capital Investment	£ -	£ -	£ -

Income	£	-	£	-	£	-
Direct Costs	£	720,000.00	£	1,504,565.09	£	635,276.69
Other Costs	£	-	£	-	£	-
Cost Savings	£	-	(£	1,318,000.00)	(£	418,000.00)
I&E Surplus/ (Deficit)	**(£**	**720,000.00)**	**(£**	**186,565.09)**	**(£**	**217,276.69)**

Implementation of Phase 1 has commenced with posts expected to be advertised mid to end of January 2017.

4.2 Neonatal Intensive Care

A comprehensive nurse staffing review was undertaken for Neonatal Services in East Kent and indicated that investment is required in the WHH NICU and the QEQM SCBU. A business case for phased investment has been agreed. Phase 1 will increase the nursing establishment by 6.9 wte at WHH, 4.7 wte at QEQM and additional administrative support to compliment the nursing team and patient care and to enhance parental experience. A further phased increment of staffing levels has been approved over 2017/18 and 2018/19 dependent on a range of operational performance triggers based on unit activity, reduction in frequency of unit closures, reduction in the use of agency staff and improvements in staff sickness levels.

Currently, EKHUFT does not meet national recommendations for staffing levels within its 2 neonatal units. This has an impact on the services' ability to maintain activity and deliver optimum care without the use of expensive agency nurses. Furthermore, the Neonatal Units frequently have to close to admissions because there are insufficient qualified nurses on the units to maintain safe services. As a result, the Trust is losing valuable income and families have to travel further afield to receive the neonatal care they need.

Inadequate neonatal nurse staffing levels have been shown to be associated with increased neonatal mortality. Alongside the potential risk to patient safety, inadequate neonatal nurse staffing also continues to adversely impact on:

(i) Trust finances (through on-going requirement and use of expensive agency nurse staff- figure from year 2015/16 £249,000 and through loss of income by not being able to provide neonatal intensive care services);

(ii) neonatal and maternity unit closure and ability to provide intensive care for local population; and

(iii) staff morale and sickness level.

Without adequate investment in neonatal services, the on-going provision of neonatal intensive care within East Kent is likely to come under threat based on proposed reconfigurations of neonatal services (which will be based, amongst other things on nurse staffing levels and activity).

The business case is predicated on the fact that, within EKHUFT, neonatal staffing levels are inadequate in comparison to national recommendations (British Association of Perinatal Medicine) and national published guidelines (NICE, Department of Health (2009) Toolkit for High Quality Neonatal Services, Bliss (2011) The Bliss Baby Charter Standards).

Three options to address these issues have been considered and appraised.

1) Do nothing – continuing to use off-framework agencies to fill nursing rotas

2) Phased investment in staffing over three years to ultimately achieve BAPM staffing levels with an immediate recognition to staff in alignment with "professional judgement" (preferred option)

3) Cease the use of off-framework agency nursing staff

The cost of each option is detailed below. The preferred option 2 generates an operating surplus of £165,825 per annum.

Following detailed consideration of the possible alternative options, the preferred option sought approval to invest in a phased recruitment programme to increase

nursing establishment by 6.9 WTE at WHH (3.8 Band 6 QIS and 3.1 Band 5) and 4.7 WTE at QEQMH (2.0 Band 6 and 2.7 Band 4) over 2016/17 (numbers based on professional judgement). The preferred option also sought approval to recruit additional administrative support to compliment the nursing team and patient care and to enhance parental experience. In addition, a further phased increment of staffing levels is sought over the following two years to better approximate nurse staffing levels with the BAPM standards.

Implementation of the second phase of recruitment will be dependent upon a range of operational performance "triggers" (based on unit activity, reduction in frequency of unit closures, reduction in the use of agency staff, finances and improvements in staff sickness levels).

	Op 1	Op 2	Op 3
Capital Investment	£ -	£ -	£ -

Income	£ -	£468,873.56	(£227,731.29)
Direct Costs	£249,141.00	£332,367.36	£ -
Other Costs	£ -	£14,280.47	(£578.26)
Cost Savings	£ -	(£43,599.68)	(£145,332.25)
I&E Surplus/ (Deficit)	**(£249,141.00)**	**£ 165,825.40**	**(£81,820.78)**

The activity is funded through NHS England Specialist Commissioning and is not new income to the health economy. This activity is already happening however because we currently do not have the necessary nursing staff to maintain safe clinical services the NICU and SCBU have to close to new admissions. As a result this activity and the income is going to other NHS Trust's in the South East of England.

Recruitment to phase 1 posts is in progress.

4.3 Midwifery

A full Birthrate Plus assessment was reported in May-16 which indicated that current staffing levels meet or exceed recommended levels for clinical midwives and support staff. However, the outcome of the review suggests additional staff are required to provide a sustainable resource for specialist midwifery support roles e.g Safeguarding, bereavement, obesity, ante-natal, per-natal care which are currently undertaken by clinical staff. Priorities are focused currently on up- skilling band 2 and 3 support workers to enable release of midwives to provide greater clinical contact time with women.

Engagement and discussion with midwifery staff was undertaken to seek suggestions and views on adjusting current working patterns and shift times to provide improved cover with the existing resource. A consultation has been completed on working hours that has resulted in releasing 2.9 WTE midwifery time across the acute sites with the change in hours that commences on 1.4.17. These results and the shortfall that was identified in the Birthrate Plus will be reported to the Board to discuss the additional resource that will be required to sustain the specialist roles that are required that are currently still being undertaken in clinical time.

The average Midwife to birth ratio in May-16 was 1:28 but has reduced to 1:32 in December 2016 due to a rise in current vacancy to 21.49 WTE across the Midwifery Bands 5-7.

Midwife:Birth Ratio	
PredictedBirths	7,080
Bands 5-7	216.83
Ratio	1: 32.7

Midwife:Birth Ratio	
PredictedBirths	7,080
Bands 3-7	232.63
Ratio	1: 30.4

An on-going recruitment programme has been successful and there are 5.64 WTE commencing in January 2017. There is also on-going work being undertaken with support worker training in the acute units and five band 3 support workers have transferred into community settings to release midwifery clinical time by providing breastfeeding support and improving national screening compliance with booking blood tests.

5. Priorities identified from this review update are:

1. Annual staffing reviews are now required with six monthly updates to the Strategic Workforce Committee;
2. Care Hours Per Patient Day (CHPPD) should be included in the ward Quality Heatmap ~~from January 2017~~and is being worked up;
3. To improve alignment of staffing required to demand by developing the business case aligned to the workforce CIP programme to implement Safe Care. This is underway and external visits are planned to learn from other organisations who are using it to explore realistic and robust benefits realisation.
4. The completion of the 2017/18 Nursing Workforce Plan to inform recruitment and retention planning against current and expected vacancies to support the agency reduction programme;
5. Evaluation of the impact of previous investment through reductions in sickness absence, reductions in use of temporary staff and improvements in patient safety through benefits realisation will be reported to the Strategic Investment Group in February 2017.
6. Successful implementation of the Nurse Associate role to support safe staffing. The pilot is due to commence in April 2017.
7. Phased recruitment to the investment approved into the Emergency Departments and NICU. Further work to be undertaken to explore further investment required into Maternity.

Appendix 1. Updated NQB 2016 expectations

https://www.england.nhs.uk/ourwork/part-rel/nqb/

	Expectations		Compliance
1	Right staff ➢ Evidence based workforce planning ➢ Professional judgement ➢ Compare staffing with peers	➢ Annual strategic staffing review using a triangulated approach (evidence-based tool, professional judgement and comparison with peers) which takes account of all professional groups and is in line with financial plans. This should be followed by a comprehensive staffing report to the board after six months to ensure workforce plans are still appropriate. ➢ Review of comparative data on actual staffing which provides context for differences in staffing requirements such as case mix, patient movement and acuity and dependency. ➢ Local quality dashboard for sustainable safe staffing which triangulates comparative data on staffing with other efficiency and quality metrics to include Care Hours per Patient Day (CHPPD).	The next full review based on April 2017 will be reported to the SWC July 2017. A triangulated approach will again be used including these methods. CHPPD will be included in the Quality dashboard from January 2017.
2	Right skills • Mandatory training, development and education • Working as a multi-	➢ Staffing establishments take account of the need for staff to undertake mandatory training and continuous professional development. ➢ Sufficient time allocated for team leaders to discharge supervisory responsibilities	Average 22% headroom is included in budgeted establishments currently. Investment in the ward manager assistant role has supported.

	professional team • Recruitment and retention	➢ Commitment to investing in new roles and skill mix to enable nursing and midwifery staff to spend more time using their specialised training to focus on clinical duties and decisions about patient care. A strong multi-professional approach avoids placing demands solely on any one profession. ➢ Flexible and effective strategies to recruit, retain and develop staff as well as managing and planning for predicted loss of staff to avoid over-reliance on temporary staff.	Future Workforce Steering Group has been implemented to take forward standardisation of expectations and education preparation for Advanced Clinical Practice roles.
3	Right place and time • Productive working and eliminating waste • Effective deployment and flexibility • Efficient employment and minimising agency	➢ The organisation uses lean working principles such as the productive ward as a way of eliminating waste ➢ The organisation designs pathways to optimise patient flow ➢ Systems are in place for managing and deploying staff across a range of care settings, ensuring flexible working to meet patient needs ➢ Systems for managing staff use responsive risk management processes, from frontline to board level, which clearly demonstrates how staffing risks are identified and managed. ➢ Clinical capacity and skill mix are aligned to the needs of patients thus making the best use of resources and facilitating effective patient flow ➢ Throughout the day, clinical and managerial leaders compare the actual staff available with planned and required staffing levels, and take appropriate action to ensure staff are available to meet patients' needs	Productive ward principles are embedded within wards. Identification and management of staffing risks are part of the role of the matron. Current system does not enable live view of patient acuity dependency and skill mix to enable deployment of staff. Business case aligned through workforce CIP programme to implement Safe Care is planned.

		➢ Escalation policies and contingency plans are in place for when staffing capacity and capability fall short of what is needed for safe, effective and compassionate care, and staff are aware of steps to take where capacity problems cannot be resolved. Report, investigate and act on red flag incidents. ➢ Meaningful application of effective e-rostering policies is evident. ➢ The annual strategic staffing assessment gives boards a clear medium-term view of the likely temporary staffing requirements. ➢ The organisation is working to reduce and eradicate the use of agency staff in line with NHS Improvement's nursing agency rules.	Daily site situation and escalation report identifies patient flow, bed status and staffing appropriateness. Improvement required to the use of the NHSP interface. To be included in the April 2017 review. Service improvement team led project Smarter Agency Reduction