Title	Open and Honest Care April 2016: Staffing Levels across Nursing and Midwifery inpatient settings.
Meeting	Executive Board
Date	20th June 2016

Executive Summary

In November 2013 the National Quality Board (NQB) published a guidance document which set out ten core expectations of providers and commissioners with respect to getting nursing, midwifery and care staffing right. STFT has remained compliant with these guidelines which include monthly open and honest staffing reports to Board and biannual reviews of staffing establishments across the acute inpatient bed base. These reports are uploaded to our website for the public to access. It is expected that the NQB will publish revised guidance in the summer of 2016 however until this is published the requirement to publish staffing fill rates, as we have been since May 2014, remains in place.

From May 2016 all Trusts are required to also report Care Hours Per Patient Day (CHPPD). This is a new staffing metric based on the number of nursing and care staff hours available on each ward divided by the number of patients on the ward at midnight. The metric has been devised by NHS Improvement to give a simple consistent measure of nursing and healthcare support workers deployment on inpatient wards and units. Trusts will be able to see how their CHPPD relates to other Trusts with the same speciality by ward in order to identify how they can improve their staff deployment and productivity. STFT is now submitting CHPPD each month as required.

This report will indicate how in time each Trust will be given access to the same data from "peer" Trusts in order to benchmark their information with that of similar Trusts and gauge whether STFT is within the range of CHPPD for individual specialist areas or an outlier. STFT has purchased the Safer Nursing Care Tool (SCNT) module which allows data to be entered at ward level 3 times per day at each shift change. This intelligence, when added to the CHPPD data, adds a level of detail which enhances CHPPD and makes the data set more useful in determining whether staffing levels are appropriate to meet patient's needs at that time; examples of CHPPD information have been included in the report for areas of exception.

The staffing data for the period 1st April to 30th April 2016 was uploaded via UNIFY in a template provided by NHS England on 17th May 2016. This information was published in early June 2016 on NHS Choices along with a number of safety indicators. These safety indicators are colour coded on the NHS Choices website giving a clear signal to the public as to how they should be interpreted. There is a link on the NHS Choices website connecting the reader to the Trust "Open and Honest Staffing" webpage where detail of staffing for each inpatient area is available for the public. The information provided will include this paper.

The fill rate analysis for April indicates that three areas experienced staffing

numbers below the 80% minimum threshold or above 150% maximum threshold – Wards 6, Acute Stroke Unit and ITU/HDU. Reasons and mitigating actions have been given and assurance sought that all wards were safely staffed with local escalation and monitoring of safety, quality and experience indicators.

In the coming weeks a new Directorate structure will be implemented along with a revised integrated performance report that will underpin the approach to clinical governance from team to Board. The workforce and quality indicators referred to within this paper will be part of the future performance reporting framework both internal to the Trust and aligned to the NHSI nursing and midwifery dashboard that will contain CHPPD and a range of other indicators.

Recommendation

The Executive Board is asked to review the staffing data for the inpatient areas of South Tyneside NHS Foundation Trust during April 2016 and consider areas of exception with regard to staffing shortfalls, the reasons why these have occurred, any impact on quality and actions taken or being taken to address gaps.

Report Author	Louise Burn, Deputy Director of Nursing and Patient Safety
Executive Director/ Sponsor	Dr Bob Brown, Executive Director of Nursing, Allied Health Professions and Patient Safety.

Purpose of paper	**Information**	√	**Discussion**	√
	Decision	√	**Assurance**	√
	Specific action	√		
Implications	**Staffing**		√	
	Finance		√	
	Legal		√	
	Public engagement		√	
	Partnership			
	Communication		√	
	Equality & Diversity		√	
	Clinical		√	
	Patient Safety		√	

Risk assessment and mitigation (include risk register reference if appropriate)

Link to STFT Business Plan	Patient Safety, Patient experience, Safe Staffing
Link to CQC outcome	All
Link to Board Assurance Framework	Workforce requirements
Link to Strategic Risk Register	Clinical Staffing

SOUTH TYNESIDE NHS FOUNDATION TRUST

REPORT TO EXECUTIVE BOARD
20th June 2016

Open and Honest Care - Staffing Levels - Nursing and Midwifery

1. BACKGROUND

The National Quality Board (NQB) requires that each month a board staffing report is produced which, by exception, advises on areas where staffing capacity and capability falls short of what is planned, the reasons why, any impact on quality and the actions taken to address gaps in staffing. This monthly report is also required to be published on the Trust website for the public.

This exception report meets the requirement by publishing staffing fill rates (actual versus planned) in hours on the NHS Choices website each month with a link through to the Trust website for detailed staffing information by ward. A clear steer as to where the rating ranges should lie can be taken from the fact that in May 2014 NHS England requested further information and mitigating actions on all wards with staffing fill rates below 80% or above 150% and highlighted fill rates below 90% or above 125%. No further guidance has been issued since.

From May 2016 all Trusts are required to also report Care Hours Per Patient Day (CHPPD). This is a new staffing metric devised by NHS Improvement to give a simple consistent measure of nursing and healthcare support workers deployment on inpatient wards and units. CHPPD can be used to describe both the staff required and staff available in relation to the number (but not the acuity and dependency) of patients. It is expected that the NQB will publish revised safe staffing guidance in the summer of 2016 and streamline reporting to the new system. However until this is available the requirement to publish staffing fill rates, as we have been since May 2014, remains in place.

CHPPD is calculated by adding the hours of registered nurses to the hours of healthcare support workers and dividing the total by every 24 hours of in-patient admissions (or approximating 24 patient hours by counts of patients at midnight). It can be broken down by grade – initially registered nurses and healthcare support staff, but ultimately to bands/grades within these groups and eventually all other staff groups contributing to ward-based care, including AHPs and medical staff. While total CHPPD will be reported monthly via Unify, the metric will be available to Trusts split into registered nurses and healthcare support workers through the model hospital portal which will enable benchmarking with “peer” Trusts. The portal, an output of the Lord Carter of Cole report, will enable Trusts to see how their CHPPD compares to

other Trusts within the same speciality by ward in order to identify how they can improve their staff deployment and productivity.

STFT has purchased the Safe Nursing Care Tool (SNCT) module of eRoster which gives wards the ability to enter the acuity and dependency of each of their patients at the beginning of each shift and to update staff availability in real-time. Although this information is not required as part of the CHPPD data set it adds important patient acuity detail to the information making it more specific to determine whether or not there are enough CHPPD and registered:non-registered skills mix to meet the needs of the patients on each ward and on each shift.

TRUST STAFFING FILL RATE FOR APRIL 2016

STFT	DAYS		NIGHTS	
	Average fill rate RNs and RMs	**Average fill rate care staff**	**Average fill rate RNs and RMs**	**Average fill rate care staff**
Overall Trust Summary	**90.7%**	**106.0%**	**103.3%**	**103.0%**
STDH	90.5%	106.8%	103.6%	103.3%
Monkton Hospital	95.6%	95.2%	100.0%	100.0%
St Benedict's Hospice	92.8%	104.0%	100.0%	100.0%

2. TRUST STAFFING FILL RATE FOR APRIL 2016 BY WARD.

The fill rates for each of the wards are available at Appendix A. The table below reports by exception, wards with fill rates below 80% or above 150% for either registered nurses or care staff on day or night duty.

Hospital	Ward	Day		Night	
		RN/RM fill rate	**Care staff fill rate**	**RN/RM fill rate**	**Care staff fill rate**
STDH	ITU / HDU	79.5%	N/A	99.3%	N/A
STDH	WARD 6	75.7%	133.2%	102.1%	100.0%
STDH	ASU - ACUTE STROKE UNIT	77.3%	103.9%	98.3%	127.5%

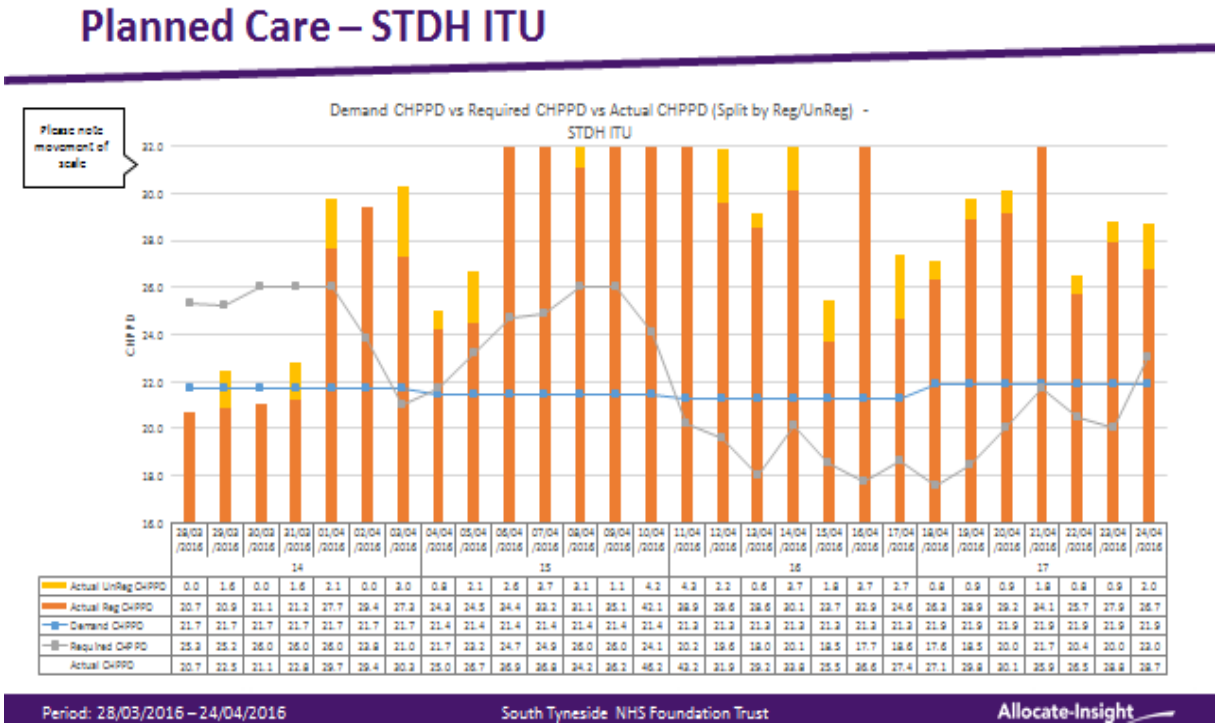
There are three wards reporting fill rates below 80% for April 2016 these are ITU/HDU, Ward 6 and Acute Stroke Unit (ASU). The graphs for CHPPD for each of these areas are included in this report. The time frame of the CHPPD graphs is 28th March to 24th April which is broadly comparable to the timeframe for fill rates which is 1st April to 30th April 2015. The two staffing metrics are defined differently:

- Staffing 'fill rates' refer to the number of nursing and care hours planned for, compared to how many were actually available on the day or night shift. These are combined together to give a monthly figure for the ward or team.
- CHPPD is the number of hours worked by nursing and care staff combined and then divided by the number of patients on the ward at midnight. It can be disaggregated to give nursing hours and care staff

hours and can be translated into staffing ratios e.g., 12 CHPPD is a staffing ratio of 1 nurse or carer to every 2 patients and 8 CHPPD is a staffing ratio of 1:3.

Neither of these metrics alone can determine whether staffing levels are safe but CHPPD, in combination with the SNCT patient acuity and dependency staffing measure, is more useful in determining appropriate levels of staffing levels for ward areas on a shift by shift basis.

2.1 ITU/HDU – Care Hours Per Patient Day



ITU/HDU is reported as an area of exception in April as the fill rate on day duty for registered nurses is 79.5% which is just below the 80% threshold. The graph of CHPPD for a similar time frame demonstrates that at the end of March there were four days when the required CHPPD was below both the planned level and that required, when patient acuity was considered, by four to five hours each day. The April CHPPD data shows that there was an excess of registered nursing hours available to meet the needs of patients which is demonstrated by the variable (grey) “required” CHPPD line on the graph.

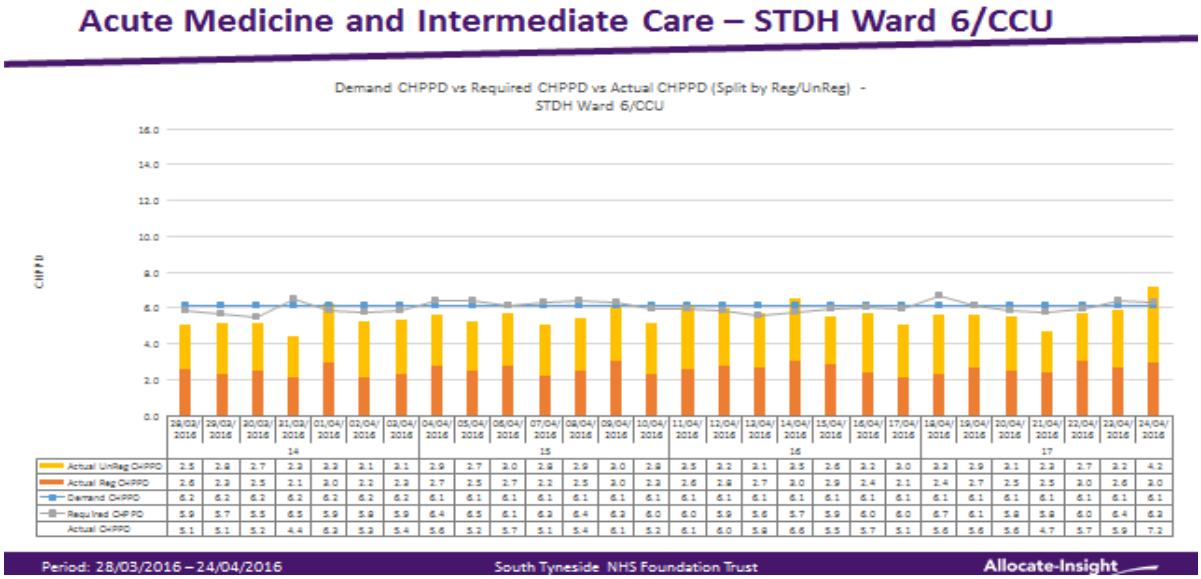
2.1.1 Mitigating actions

ITU/HDU: ITU/HDU had a low fill rate on day duty in April based on planned versus actual numbers. However the CHPPD data, enhanced by information on patient dependency and acuity, demonstrates that during April there was sufficient registered nurse hours available to meet the variable demand from the patient case load. For four days at the end of March there were not enough CHPPD to reflect the patient demand as generated by the SNCT. The normal staffing ratios for critical care areas is 1:1 for level 3 patients and 1:2 for level 2 patients representing 24 CHPPD and 12 CHPPD respectively. The

shortfall in March reflects between 4 and 5 CHPPD. Critical care nurses work flexibly to meet the needs of their patients at all times working between patients as necessary when acuity and dependency are high.

There was one level 2 pressure ulcer developed on ITU/HDU in April which generated an open and honest report, however patient experience was not captured as part of this process as patients were not well enough to be interviewed. Staff interviewed expressed very low staff satisfaction levels with comments around the future of hospital services, working environment and shift patterns named as sources of low morale.

2.2 Ward 6 – Care Hours Per Patient Day



Ward 6 is an area of exception in April as the fill rate for registered nurses on day duty is 75.7%. The graph of CHPPD for end of March and April demonstrates that Ward 6 is consistently 1 to 2 hours below both the required and planned care hours except on four or five days when care hours required is met by the hours available. The staffing skill mix between registered and none registered nurses is low at best achieving 50:50 rather than the recommended skill mix of 60% registered nurses to 40% non-registered nurses.

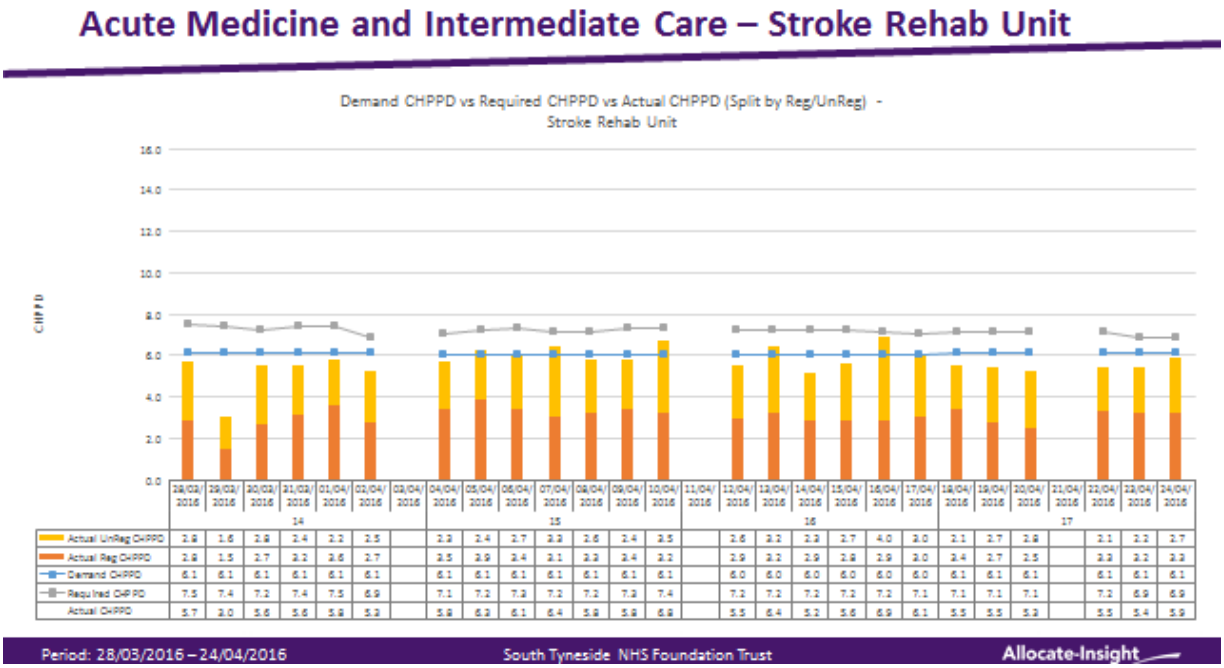
2.2.1 Mitigating actions

Ward 6 had in excess of five full time registered nurse vacancies in April and there were also a number of staff on short term sickness which led to a reduced fill rate for registered nurses on day duty. These shifts were backfilled with care staff and the Clinical Operational Manager provided assurance that minimum numbers for registered nurse staff was always met. The need to fill registered nurse duties with care staff is reflected in the low skill mix demonstrated on the CHPPD graph.

There was one category two pressure ulcer reported on the ward in April which triggered an open and honest care report. Feedback from patients was 100% positive across all eight key questions, staff satisfaction was also high

with nurses indicating being satisfied with the standard of care they were able to give.

2.3 Acute Stroke Unit – Care Hours Per Patient Day



Acute Stroke Unit is highlighted as an exception in April as the fill rates reported for registered nurses on day duty is 77.3%. The CHPPD graph demonstrates that there were reporting gaps in April on three days when the data was not captured. On the days that were reported the CHPPD is either just below or just meets planned levels but is consistently below required levels with the exception of 16th April when there were enough CHPPD to meet patient's needs. On March 23rd the CHPPD was 50% less than planned and approximately 60% less than required.

2.3.1 Mitigating actions

ASU had 6.55 WTE registered nurse vacancies in April, one registered nurse on secondment to Ward 2 and some short and long term sickness/absence. Care staff provided extra shifts to ensure the ward remained safely staffed. The high fill rate for care staff on nights represents extra shifts worked to provide enhanced staffing to patients who required one to one care. There are monthly recruitment panels to fast track new staff through the recruitment process to medical and older person wards, in addition to international recruitment, however uncertainty of the future of acute stroke services at STFT is reported to be causing low staff morale and prompting nurses to leave and seek posts in other locations. There were no patient harms reported on ASU in February and therefore no open and honest care report was generated.

3.0 IMPACT OF STAFFING

During the data collection period from April 1st to April 30th our safety thermometer data tells us that 89% of patients did not experience any of the

four harms whilst an inpatient in our hospitals. The safety thermometer looks at four harms: pressure ulcers, falls, blood clots and urine infections for those patients who have a urinary catheter in place.

3.1 Nursing Workforce Review Group

As a sub-group of the Nursing Workforce Committee, this group of senior managers meets twice monthly to assess progress with recruitment and retention of nursing staff, to monitor progress against key performance indicators such as agency and bank usage, and take mitigating actions. The challenge is to ensure wards are safely staffed by driving effective rostering practice while ensuring that efficiency savings are being met. Three times daily patient flow meetings are also undertaken, each of which includes a focus on maintaining safe staffing informed by a daily report on the planned v actual registered and non-registered nursing number and skill mix per ward.

4.0 Model Hospital Vision

STFT has been part of the Lord Carter efficiency programme since August 2015 and having been a pilot site for CHPPD is now part of a national project to develop and test a Model Hospital. The overall vision for this is to provide a nationally available data information system relating to metrics of productivity, efficiency and quality of care.

The Model Hospital will provide information in support of Trusts developing a greater understanding of their performance and how it compares nationally as well as with smaller peer groups. The aim of each compartment of the Model Hospital will be to provide areas of the hospital with information from which decisions can be made as to how they might improve productivity and efficiency, whilst ensuring quality outcomes are met.

As good practice, services and structures change to provide new models of care, it will be critical that the Model Hospital can adapt to these and therefore a structured review and revise programme will be set in place.

It is envisaged that the achievement of this vision will provide acute trusts with a common platform by April 2017 through which they are able to:

- review their Trust level data against the most important metrics in relation to productivity and efficiency and understand their progress against plan or target;
- understand how they perform in comparison to their peers;
- understand how they perform in comparison to ‘what good looks like’ nationally;
- access to case studies and guides of good practice that provide detail of how other acute trusts have achieved levels of performance and good practice in line with ‘what good looks like’;
- Review unwarranted variation in order to understand where efficiencies can be made.

5.1 The Nursing & Midwifery Dashboard in context

The nursing and midwifery dashboard will form one part of the model hospital framework. It will contain a subset of the population of collected metrics and is designed to allow all staff, from Directors of Nursing through to Ward Managers, to review nursing productivity against safety and staffing metrics in order to achieve a holistic view of the nursing workforce. The indicators that will be reported will include CHPPD, sickness absence, turnover, skills mix, safety metrics, bank and agency use, and headroom. STFT has been developing a reporting process for these metrics and will complete this in line with the national programme with the aim of commencing a report to Board from the onset of revised operational restructuring from July 2016.

In order to ensure the nursing and midwifery dashboard is fit for purpose and allows trusts and their staff to effectively manage their services and staff, the components of the dashboard are being further tested with a number of stakeholders including STFT. The intention is to ensure that the dashboard becomes the single centre for nursing information, and allowing the interdependencies between quality and finance to be considered.

6.0 CONCLUSION

This paper by exception reports on nursing/midwifery and care staff fill rates which supports the monthly publication of staffing on NHS Choices and staffing fill rates by ward on our Trust website. In this paper we have now reported CHPPD for areas of exception.

Areas with low staffing fill rates have been identified and where this has been due to substantial staffing shortfall, rather than to process issues, mitigating actions have been identified and implemented to assure safe, high quality patient care and good patient experience.

This report is part of a national requirement to publish safer staffing alongside other safety indicators and which will allow patients and the public access to a greater range of more detailed information in one place in order to compare Trusts.

Louise Burn
Deputy Director of Nursing and Patient Safety
June 2016

Appendix A: Staffing Information April 2016
South Tyneside Foundation Trust

		Day		Night	
Hospital site	**Ward**	**Average fill rate - registered nurses/midwives (%)**	**Average fill rate - care staff (%)**	**Average fill rate - registered nurses/midwives (%)**	**Average fill rate - care staff (%)**
STDH	ASU - ACUTE STROKE UNIT	77.3%	103.9%	98.3%	127.5%
STDH	DELIVERY SUITE	88.8%	87.8%	99.5%	100.0%
STDH	EAU	88.2%	113.0%	103.3%	105.0%
Monkton	ELMVILLE	95.6%	95.2%	100.0%	100.0%
STDH	ITU / HDU	79.5%	N/A	99.3%	N/A
STDH	PRIMROSE WARD	93.5%	110.0%	125.0%	133.7%
STDH	SPECIAL CARE BABY UNIT	108.0%	95.1%	110.0%	#DIV/0!
ST BENEDICT'S HOSPICE	ST BENEDICTS	92.8%	104.0%	100.0%	100.0%
STDH	WARD 1	105.5%	90.4%	100.0%	101.7%
STDH	WARD 10	91.5%	90.5%	100.0%	100.0%
STDH	WARD 19	98.7%	86.6%	101.7%	95.7%
STDH	WARD 2	87.6%	125.9%	100.0%	103.3%
STDH	WARD 22	104.1%	85.1%	100.0%	100.0%
STDH	WARD 3	83.2%	142.2%	100.0%	100.0%
STDH	WARD 5	108.5%	102.8%	133.1%	99.6%
STDH	WARD 6	75.7%	133.2%	102.1%	100.0%
STDH	WARD 7	87.7%	118.9%	100.2%	106.7%
STDH	WARD 9	104.0%	102.9%	100.0%	100.0%