Trust Board Meeting: Wednesday 10<sup>th</sup> September 2014  
TB2014.94

| Title                                                                 | Nursing and Midwifery staffing (June & July 2014)  
The acuity and dependency review and Nurse Sensitive Indicators (May/June 2014) |
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<td>Status</td>
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| History                                                              | • Trust Board Seminar 21<sup>st</sup> October 2013  
• Trust Board Seminar 27<sup>th</sup> November 2013  
• Trust Management Executive 9<sup>th</sup> January 2014  
• Trust Board (Part II) 22<sup>nd</sup> January 2014  
• Trust Management Executive 23<sup>rd</sup> January 2014  
• Trust Management Executive 13<sup>th</sup> February 2014  
• Trust Board 12<sup>th</sup> March 2014  
• Quality Committee 9<sup>th</sup> April 2014  
• Trust Board 14<sup>th</sup> May 2014  
• Trust Board 9<sup>th</sup> July 2014  
• Quality Committee 13<sup>th</sup> August 2014  
• Trust Management Executive 14<sup>th</sup> August 2014 |

<table>
<thead>
<tr>
<th>Board Lead(s)</th>
<th>Catherine Stoddart, Chief Nurse</th>
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<tbody>
<tr>
<td>Key purpose</td>
<td>Strategy Assurance Policy Performance</td>
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## Executive Summary

|   | **Nursing establishments and skill mixes across the divisions**  
Sisters, matrons and divisional nurses have undertaken a 14 day audit of the acuity levels and dependency levels of patients within their wards/departments in May/June 2014 using a modified and updated single combined Safer Nursing Care Tool. |
|---|---|
| 2 | **NICE Safe Staffing guidance July 2014** – This document was published in July 2014 and provides guidance on determining nursing establishments and monitoring of safe staffing levels.  
The main principle being that establishments are determined locally by senior nursing ward staff, using evidence based data and Professional Judgement, according to the needs of the patients.  
In the majority of instances these will be less than a 1:8 ratio of registered nurses to patients, according to the skill set and level of staff required for the patients within the clinical specialty. |
| 3 | **Nurse Sensitive Indicators**  
The inclusion of Nurse Sensitive Indicators is considered advisable given that overall quality of patient care within wards may be affected by differences in overall numbers of staff and their skill mix.  
The indicators used include Datix derived incidents, as recommended in the NICE guidance. The Trust will also continue to develop specialty sensitive indicators. |
| 4 | **Electronic acuity measurement tool**  
The Trust is exploring the possibility of the use of a specific application that can record each patient’s acuity at least daily. |
| 5 | **Recommendations**  
- To approve the revised presentation of the data together with the Nurse Sensitive Indicators.  
- To note the recommendations related to the adjustments to nurse establishments in 3 clinical areas. |
Purpose of this paper

1. The purpose of this paper is to present the six monthly review of the acuity and dependency of patients against nursing staff establishments and skill mixes.

2. The Trust is committed to ensuring that there is the appropriate level and skill mix of nursing and midwifery staff, and is compliant with the national guidance provided via the National Quality Board in 2013 (‘How to ensure the right people, with the right skills, are in the right place at the right time’ National Quality Board November 2013), in reviewing the capability and capacity of these staffing levels.

Background

3. This exercise of data measurement is undertaken manually six monthly, with the use of an evidence based tool, the Safer Nursing Care Tool. The process of data collection was undertaken in late May, but repeat measurements were undertaken for accuracy in the Emergency Assessment Units with a modified multiplier (due to the level of acuity and the turnover of patients). Additionally some clinical areas for elective surgery repeated the exercise due to the reduced activity in late May, as this was not representative during a period of half term and bank holidays.

4. The data has been validated by the senior nursing team, against a suite of Nurse Sensitive Indicators and analysed using professional judgement surrounding the level of activity, and any variations and changes is service.

5. This provides an overview of the Trust’s current status for the provision of appropriate nurse staffing levels, and the capability and capacity of the nursing establishments across the Trust, in relation to the patients’ acuity and dependency.

6. Additionally, this paper presents an initial iteration of the use of Nurse Sensitive Indicators, which are indicators that are recognised internationally for the correlation between levels and skill mix of nursing and midwifery staff, and deterioration in these indicators if the skill mix or staffing level reduces.

Update on the national guidance

The NICE Safe Staffing Advisory Committee published The NICE Safe Staffing Guidance in July 2014

https://www.nice.org.uk/Guidance/SG1/chapter/recommendations#organisational-strategy

7. The recommendations that relate to the determination of correct adult in-patient nursing establishments include these key points:

   Nurse ratios to patients – the evidence base

   7.1 ‘There is no single nursing staff-to-patient ratio that can be applied across the whole range of wards, to safely meet patients’ nursing needs. Each ward has to determine its individual nursing staff requirements to ensure safe patient care.

   7.2 This guideline therefore makes the recommendation that in most cases patients’ nursing needs, as determined by the implementation of the NICE guidance recommendations, will require in the majority of acute clinical areas a registered nurse to patient ratio of fewer than 8 patients i.e. 1:6 or 1:5. This reinforces the use of nursing to patient hours for accuracy purposes.
7.3 This is an important factor that is often misinterpreted by non-clinical staff, in a drive to reduce the common denominator of ratio of registered nurses to patients down to 1:8. This is not the case, and is a reference to well documented international research evidence undertaken in the USA, Australia and the UK, (as referenced in previous papers) that the tipping point at which harm will occur is a ratio > 8 patients per registered nurse.

7.4 However, the NICE guidance is clear and stipulates that in the majority of wards where registered qualified staff are required to undertake technical skills as well as risk assessments, plan and implement care, this ratio is required to be far less, due to the nature of the skill set required, without harm occurring.

Developing the nursing establishments

7.5 ‘Develop procedures to ensure that ward nursing staff establishments are sufficient to provide safe nursing care to each patient at all times’.

7.6 ‘Ensure that the final ward nursing staff establishments are developed with the registered nurses who are responsible for determining nursing staff requirements at ward level and approved by the Chief Nurse. The Board should retain organisational responsibility’.

7.7 ‘This (the establishment) should include capacity to deal with planned and predictable variations in nursing staff available, such as annual, maternity, paternity and study leave.’ The Trust currently has an ‘uplift’ of 18-20% and when benchmarked against other Shelford Trusts, is the lowest against 24%.

7.8 Establishments need to have the ‘capacity to accommodate to fluctuations in patients’ nursing needs (such as seasonal variations indicated by historical records of nursing staff requirements) and staff unplanned leave or absences’.

7.9 All of the above must be considered and taken into account, and the guidance suggests that this ‘could’ be expressed as nursing hours per patient to ensure that ward staff establishments are derived from individual patient’s needs. This is currently not a system that is widely used in the UK although in some other countries utilise it.

7.10 The determination of nursing establishments through the calculation of nursing hours per patient is a mechanism for assessing a more accurate patient to nurse contact ratio.

Determining the skill mix

7.11 ‘When agreeing the skill mix of the ward nursing staff establishment, this should be determined through the appropriateness to patients’ needs, and take into account evidence that shows improved patient outcomes are associated with care delivered by registered nurses.

7.12 ‘Use informed Professional Judgement to make a final assessment of nursing staff requirements. This should take account of the local circumstances, variability of patients’ nursing needs, and previously reported nursing “red flag events”.

7.13 These are t incidents of delays in providing pain relief, regular checks on patients such as ‘intentional rounding’, vital signs not being assessed or recorded according to their care plan, less than two registered nurses on a ward
during any shift, a shortfall of 8 hours or 25% whichever is met first, taken from the registered nurse time availability, compared to the planned requirement for the shift.

7.14 There are recommendations to take into account patient factors i.e. dependency needs, difficulties in cognition or confusion, end of life care, as well as ward factors such as turnover of patients in a 24 hour period, unscheduled admissions, ward layout and size.

7.15 Nursing factors and activities are also cited as requiring consideration i.e. communication with relatives and carers, managing the nursing team, care planning, direct contact activities, assisting with food and drink, medication administration, mobilisation, vital signs and observations, discharge planning, patient and carer education, toileting needs, skin and pressure area care, washing, dressing and oral care.

7.16 Identify the appropriate knowledge and nursing skill mix required in the team to meet the nursing needs of the wards’ patients, with registered nurses remaining accountable for the overall care of patients, and as such their supervision of Care Support Workers. The establishment should be based on the registered nurse hour requirements, and consider which activities can be safely delegated to trained and competent Care Support Workers.

Outcome measures

7.17 ‘Improved patient outcomes are associated with a higher proportion of registered nurses in the ward nursing establishment’.

It is notable that the hospitals with the highest quality and safety associated with patient care have the higher ratios of registered nurses, and in addition to this they are educated to a higher level. This forms an integral part of the accreditation of ‘Magnet Hospitals’ in countries such as in the USA and Australia.

7.18 The guidance highlights that data can be collected to measure outcomes in the form of:

* Patient reported outcome measures* including adequacy of pain management or communication with the nursing team.

* Safety outcome measures (OUH refers to these as Nurse Sensitive Indicators)*, such as falls, pressure ulcers and medication administration errors.

* Staff reported measures* including missed breaks and nursing staff who have worked additional hours (both paid and unpaid).

Review of the nursing establishment using the Safer Nursing Care Tool (SNCT) in May/June 2014

8. The six monthly measurement of the acuity/dependency of the patients during a 14 day period was undertaken in late May. An updated tool with adjusted multipliers specifically for Emergency Assessment Units was utilised for the EAUs, although this doesn’t fully represent the amount of turnover in these clinical areas, and an alternative tool is being researched, including for the Emergency Department.

9. The SNCT has been revised following an updated national data collection, in order to adjust the multipliers to account for the higher level of dependency experienced in caring for increasing levels of elderly frail and those with cognitive impairment.
10. The Trust has now utilised a single combined updated tool for this data set.

11. The Trust is developing a reliable suite of Nurse Sensitive Indicators, which include relevant Datix clinical incidents that can potentially be attributed to, and are sensitive to variations in skill mix and staffing levels.

Those used have been suggested by the national NICE guidance, but the Trust intends to expand on them to include specialty specific indicators, that can we triangulated with the professional judgement of senior nursing staff and staffing levels.

12. The results of the measurement of the acuity/dependency is presented in a detailed format and relates to individual in-patient clinical areas (Appendix 5).

**Staffing Levels June & July 2014**

The levels of staffing by ward and by shift are demonstrated graphically in (appendices 1-4). These show the levels of staff according to the RAG (Red Amber Green) Safe Staffing system the Trust utilises to enable senior staff to escalate and address short notice deficits in real time. This is either done through moving staff from areas where the activity is less or deploying pool bank nurses, or considering a number of actions to support the staff during fluctuations in activity or acuity of patients.

**Conclusion**

13. The results of the acuity/dependency data collection highlighted that the majority of clinical areas have appropriate establishments of nursing staff or are able to make internal adjustments in relation to skill mix.

The Acute General Medical wards at the JR and Horton Hospital are still continuing to recruit to the previous investment business case (approved February 2014). The organisation and infrastructure on these wards are being reviewed in relation to the level of support for sisters, senior supervision out of hours, and Practice Development support, in order to enhance retention strategies.

14. Nurse Sensitive Indicators are being used to triangulate with the acuity review results and validated through Professional Judgement.

15. There are three wards within the Surgery and Oncology Division where the acuity tool has indicated a need for a review of staffing establishments as a result of increased activity and levels of acuity.

16. It is recognised that in some areas such as the Emergency Assessment Units, this tool is not as sensitive to the turnover and acuity and an alternative method is being considered.

17. The intermittent manual collection of data is resource intensive, and does not provide real time data on patient acuity and dependency levels or reflect day to day or seasonal changes in activity.

The identification of an application that can support live data recording is a priority

**Recommendations:**

The Trust Board is asked:
18. To comment on the more detailed presentation of the data following the acuity review of patients triangulated against the Nurse Sensitive Indicators and the Professional Judgement of the senior nursing team.

19. To note that the Trust Management Executive will consider a business case based on the findings of the acuity review for the 3 ward areas highlighted in the report.

20. To note that the Trust Management Executive approved the early deployment of an electronic acuity tool that provides detailed data for the Trust to meet the national NICE guidance for safe staffing.

Executive Lead
Catherine Stoddart
Chief Nurse

The paper has been prepared by
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Deputy Chief Nurse

1 September 2014