University Hospitals of Leicester NHS
NHS Trust

Meeting title:	Trust Board **Public Trust Board paper L**					
Date of the meeting:	1st December 2022					
Title:	Annual Nursing and Midwifery Staffing Report October 2022					
Report presented by:	Julie Hogg, Chief Nurse					
Report written by:	Carol Stiles, Clinical Workforce Lead (NHS England) & Debbie McBride, Assistant Chief Nurse					
Action – this paper is for:	Decision/Approval	x	Assurance	x	Update	
Where this report has been discussed previously	Executive Finance and Performance Board Finance Investment Committee					

To your knowledge, does the report provide assurance or mitigate any significant risks? If yes, please detail which

This report provides the Trust Board with an update on the latest UHL nurse establishment reviews that were undertaken in August / September 2022. Nurse establishment reviews must be undertaken by Trusts twice a year and reported to Board in order to comply with the National Institute for Clinical Excellence (NICE) safe staffing, National Quality Board (NQB) standards and the RCN nursing workforce standards. The review must provide the Board with the assurance that the Trust has a nursing workforce with sufficient planned safe staffing resources to meet the patient care requirements.

Impact assessment

The recommended establishment change for 2023/24 is an increase of 248.66 wte posts in the ward-based establishment across 97 wards and/or departments. Appendix 2 details the wte recommendations in full.

ANNUAL NURSING AND MIDWIFERY STAFFING REPORT NOVEMBER 2022

1. Purpose

1.1 The purpose of this paper is to provide the board of directors with the outcome of the 2022 annual staffing reviews which use professional judgement triangulated with outcomes to make recommendations for the inpatient nursing and midwifery establishments for the 2023/24 financial year.

1.2 It provides an overview of nurse staffing capacity and compliance with the National Quality Board (NQB, 2016) standards and Developing Workforce Safeguards (NHS Improvement, 2018). It is a requirement that every Board of Directors receive a report on a six-monthly basis.

1.3 It provides cumulative oversight of care hours per patient day (CHPPD) over the last six months (Mar – Aug 2022). This new metric replaces the previously reported planned and actual staffing and is now published on NHS Choices.

2. Recommendation

2.1 The Board of Directors is asked to note the work currently being undertaken and accept assurance that in the main, there is sufficient nursing and midwifery staffing capacity and compliance with national safe staffing guidance.

2.2 The Board of Directors is asked to endorse the clinical boards proposed establishments, supported, and challenged by corporate nursing for 2023/24.

2.3 Note our efforts to ensure nursing and midwifery pay expenditure remains within budget for the coming year with plans for additional challenge and risk management for enhanced observations.

2.4 Note that with the recommended changes to the establishment the Chief Nurse and Medical Director that planned staffing is safe, effective and sustainable.

3. EXECUTIVE SUMMARY

3.1 The Chief Nurse and Heads of Nursing continue to work with our Medical Director and Clinical Management Groups to ensure our wards and departments are safely staffed and to help identify further opportunities to increase efficiency and reduce costs, whilst monitoring the impact on quality and safety of care relating to the nursing and midwifery workforce.

3.2 At UHL the vacancy rate for nursing and midwifery in August 2022 was 13.7% in totality; 12.4% in ward areas and 20.8% in non-ward areas. We have seen a slight increase in adult and children's nursing vacancies, whilst midwifery vacancies have remained static. We have a strong pipeline of international nurses running alongside further national and local recruitment campaigns. In addition, People Partners are working with nursing and midwifery colleagues on retention plans to reduce increased leavers rates and new Heads of Nursing roles for Recruitment Retention and Pastoral support have been created.

3.8 In our last report, the Chief Nurse and Director of Workforce were content that UHL has good compliance with the National Quality Board (NQB) standards and Developing Workforce Safeguards, and this remains the case. Appendix 1 provides more detail on our compliance with the nursing and midwifery component of Developing Workforce Safeguards (NHS Improvement, 2018).

3.9 Overall staffing levels have fluctuated between 83.07% and 88.76% of our planned hours. Underutilisation of RN hours is related to the flexing of staffing in relation to increased sickness, shielding and self-isolation in relation to Covid-19. This skill-mix adjustment is driving staffing that is more than plan for Health Care Assistants; however, one HCA is not the equivalent of one Registered Nurse. Filling vacant RN posts remains a key focus.

3.10 Alongside this, RMN's and Health Care Assistants are deployed to support the provision of 1:1 care for patients at risk of avoidable harm and those under the mental health liaison team (which are not part of the existing budgets). Corporate nursing continues to lead our strategic approach to managing both the patient safety and financial risks associated focusing on assessing the overall use of specials/enhanced therapeutic observations.

3.12 The recommended establishment change for 2023/24 is an increase of 248.66wte posts in the ward-based establishment across 97 wards and/or departments.

4. NATIONAL NURSING AND MIDWIFERY STAFFING CONTEXT

4.1 Members of the Royal College of Nursing (RCN) have been balloted over strike action and the outcome is awaited. This action has been followed by 6 further trade unions which ballots taking place between November 2022 and February 2023.

4.2 The Health and Social Care Committee has published the Workforce: recruitment, training and retention report, stating that the NHS and social care face the "greatest workforce crisis in their history". The report points to research which suggests that the NHS in England is short of 12,000 hospital doctors and more than 50,000 nurses and midwives. Evidence on workforce projections say an extra 475,000 jobs will be needed in health and an extra 490,000 jobs in social care by the early part of the next decade.
The NHS Confederation also published a member survey outlining the impact workforce shortages in social care are having on NHS services.
The key findings of the survey are:

- More than 9 in 10 NHS leaders warn of a social care workforce crisis in their area which they expect will get worse this winter.
- Nearly all NHS leaders say the lack of capacity in social care is putting the care and safety of patients at risk and is the main reason why medically fit patients are stuck in hospital longer than they should be.
- Almost all NHS leaders say that the most impactful solution would be better pay for social care staff and want the Government to increase investment in social care as a priority.

4.3 The government has outlined details of the NHS pay deal, which will see a million NHS staff get a pay rise of at least £1,400, with lowest earners to receive up to 9.3%. Eligible dentists and doctors will also receive a 4.5% pay rise. In addition, very senior NHS managers (VSM) will receive a 3% increase after they accepted recommendations of the senior salaries review board, which found "well-founded concerns about possible loss of leadership capacity". The pay awards are to be back dated to 1 April 2022. All NHS pay awards are below the current rate of inflation, and the Royal College of Nursing is currently balloting its members on whether to take strike action. In his first interview since taking over as the British Medical Association's chair of council, Professor Philip Banfield has also warned ministers that a doctor's strike is "inevitable". Strikes will most likely happen in spring 2023, he said.

4.4 Research carried out by the Health Foundation's REAL Centre has found that the next decade will see increases in demand for services from rising levels of chronic disease and a rapidly ageing population – putting pressure on hospital services that are already stretched with bed occupancy rates of close to 90%. The analysis finds that even if the NHS continues to reduce

the length of time people stay in hospital, 23,000 to 39,000 extra beds could be needed in 2030/31 to maintain pre-pandemic standards of care – a 20–35% increase.

4.5 The government has published the first ever Women's Health Strategy for England to help tackle the gender health gap. Following a call for evidence, and building on Our Vision for Women's Health, the strategy includes key commitments around new research and data gathering, the expansion of women's health-focused education and training for incoming doctors, improvements to fertility services, ensuring women have access to high quality health information, and updating guidance for female specific health conditions.

4.6 Figures published by the Nursing and Midwifery Council (NMC) reveal that the number of nurses and midwives registered to work in the UK has grown. Statistics show that there were 758,303 nurses, midwives and nursing associates on its register on March 21, up 26,403 from a year earlier. However, the number of people leaving the register has also risen for the first time in five years, with many citing increased workloads and a lack of staff as factors behind their decision. Meanwhile, almost half of those joining the register have trained outside the UK. Andrea Sutcliffe, chief executive and registrar at the NMC, said the high levels of international recruitment should sound "a note of caution". She went on to say that "a future pandemic or global disruption could see history repeat itself, but with an even bigger impact on the overall growth of the register".

4.10 The independent review of maternity services at the Shrewsbury and Telford Hospital NHS Trust carried out by Donna Ockendon and team, published a set of 7 immediate and essential actions to improve safety in maternity services across England. One of its recommendations is that minimum staffing levels should be those agreed nationally or, where there are no agreed national levels, staffing levels should be locally agreed with the local maternity and neonatal system (LMNS). Further, minimum staffing levels must include a locally calculated uplift, representative of the 3 previous years' data, for all absences including sickness, mandatory training, annual leave and maternity leave.

5. LOCAL NURSING AND MIDWIFERY STAFFING CONTEXT

5.1 At UHL the vacancy rate for nursing and midwifery in August 2022 was 13.7% in totality; 12.4% in ward areas and 20.8% in non-ward areas. Adult nursing vacancies have increased slightly to 11.3% as we await the intake of 67 international nurses in September. Plans are on track for the recruitment of a further 70 international nurses prior to December 2022, this is running alongside further national and local recruitment campaigns. There has been a small increase in the numbers of Paediatric Nursing vacancies and HCSW. A number of Paediatric Nurses are expected to be recruited from local training providers and through national recruitment campaigns between October 22 and January 23. There has also been a small intake of Internationally Educated Children's Nurses. Healthcare support worker vacancies have increased slightly and induction events planned for September, October and November are expected to be filled. New Heads of Nursing roles for Recruitment Retention and Pastoral support have been created. Listening events are being held to support an improvement in retention.

5.2 Midwifery vacancies have remained static. A bespoke community midwifery recruitment campaign has led to the appointment of 8 midwives and 28 new midwives are expected to commence to support the two acute units. Maternity HCSW and Support worker vacancy position has remained static with a review of apprenticeship schemes at Band 2 and 3 and funding available to support recruitment and retention. A new development pathway is planned to be in place for March 2023.

5.3 Long term plans are in place to increase the number of registered Nursing Associate roles on

wards. UHL has 64 Registered Nursing Associates and 92 Trainee Nursing Associates (TNAs) across the Trust with a further 19 trainees due to commence the programme in October 2022. All Nursing Associates (NAs) complete preceptorship, alongside newly registered nurses, and international nurses.

5.4 UHL has 18 registered nursing associates on the RN Degree Apprenticeship (RNA) with three due to complete in 2022 and the remaining 15 in November 2023. A further cohort of 10 apprentices is due to commence the degree apprenticeship in October 2022.

5.5 Sickness levels have increased as a result of Covid related absence although early indications are that these are starting to reduce in August 2022. There have been national changes to terms and conditions such that staff who have been off sick with long covid since 7th July will resume normal contractual sickness entitlement with effect from Sept 1st. Staff will continue to be supported if they are absent as a result of Covid with absence not counting towards triggers (with some case by case review) and bank staff receiving payment for pre booked shifts – this will remain in place until March 31st 2023.

5.6 In our last report, the Chief Nurse and Director of Workforce were content that UHL has good compliance with the National Quality Board (NQB) standards and Developing Workforce Safeguards, and this remains the case; UHL is fully compliant with 11 of the recommendations and partially compliant with the remaining 3. Appendix 1 provides more detail on our compliance with the nursing and midwifery component of Developing Workforce Safeguards (NHS Improvement, 2018).

6.0 SETTING EVIDENCE BASED MIDWIFERY ESTABLISHMENTS

6.1 Birthrate Plus was developed in 1986 and is currently used in more than 100 maternity services to plan midwifery staffing requirement, which is expressed as the midwife to birth ratio (Ball, Washbrook and Royal College of Midwives 2018a). Birthrate plus categories women based on clinical indicators that considers the process and outcome of labour for the mother and her baby and is done retrospectively at the point the mother and baby leave the labour ward. Birthrate plus uses five categories ranging from I - V, where category I is of lowest acuity and dependency and category V highest

6.2 The principles underpinning the Birthrate plus methodology is consistent with the National Institute for Health and Care Excellence (NICE 2015) guideline on safe midwifery staffing for maternity settings, which states that Trust should ensure there is a systematic process in place to set midwifery staffing.

6.3 The independent review of maternity services at the Shrewsbury and Telford Hospital NHS Trust carried out by Donna Ockendon and team, published a set of 7 immediate and essential actions to improve safety in maternity services across England. One of its recommendations is that minimum staffing levels should be those agreed nationally or, where there are no agreed national levels, staffing levels should be locally agreed with the local maternity and neonatal system (LMNS). Further, minimum staffing levels must include a locally calculated uplift, representative of the 3 previous years' data, for all absences including sickness, mandatory training, annual leave and maternity leave

6.4 The service is partially compliant with 11 of the 15 IEAs identified by the Ockenden response following the publication of the final report in March 2022 with actions in place for compliance. The majority of actions are expected to be complete by December 2022 .It should be noted however that UHL's compliance is significantly lower than other trusts across the midlands region. There are 3 elements of significant challenge:

- IEA 1: Compliance is demonstrated with the actions specified, however there is still a significant shortfall in midwifery staffing which impacts on service delivery and staff morale.
- IEA 10: Centralised CTG monitoring requires significant investment and redesign of labour wards. Awaiting steer from the national fetal monitoring group
- IEA 14: The risks from the split site neonatal services is on UHL risk register. Reconfiguration pause workstreams set up to mitigate these risks.

6.5 The national response to the Ockendon report included a £95.6m investment into maternity services across England, including funding for, 1200 additional midwifery roles, 100wte equivalent consultant obstetricians, backfill for MDT training, international recruitment programmes for midwives and support to the recruitment and retention of maternity support workers.

6.6 UHL maternity service undertook a systematic midwifery staffing review using the Birthrate Plus tool in April 2021. In line with the Ockenden report recommendation, the department's midwifery funded establishment was amended to reflect that of the Birthrate+ recommendations. Birthrate plus also recommend that specialist midwifery positions accounts for 8-10% of the funded establishment, which the maternity service is appropriately funded for.

7.0 SETTING EVIDENCE BASED NURSING ESTABLISHMENTS

7.1 The Executive board have agreed the process for setting nursing and midwifery establishments. This process includes several important components:

- Using the Safer Nursing Care Tools (SNCT) to assess the acuity and dependency, daily for 1 calendar month across all Adult and Children's and Young Person's inpatient wards and the Emergency Department. The assessment is undertaken by staff trained in the use of the tool. The Birth-rate plus tool is used for midwifery.
- Repeating this exercise twice per year to ensure validity noting no changes if poor data quality.
- External (to the CMG) validation to ensure that the data collection is accurate and robust
- A multi-professional meeting with the Ward/Unit Manager, Matron, Clinical Management Group Heads of Nursing, Finance & Workforce to triangulate the SNCT data with outcomes and professional judgement to make informed establishment proposals. The group ensures that where there is significant seasonality to an individual ward's patient group; professional judgement is applied to ensure we are not staffed beyond activity requirements.
- Sign off by the Board before proposals are fed into the annual planning cycle and budgets.

7.2 Train the trainer sessions for all of the SNCT tools have been provided by NHS England and a comprehensive cascade training plan is in place to ensure all staff using the tool in practice have been assessed as competent to do so. UHL has recruited a lead nurse for safer staffing commencing in post in October 2022 to support the SNCT roll out and support embedding of this process.

7.3 Due to continued ward and staffing challenges relating to the Covid-19 pandemic and elective recovery plan, SNCT audits of patient acuity and dependency would not have provided assurance of staff requirements. This is due to many wards nursing cohorts of patients outside of their speciality, wards changing between blue and green pathways, changes in bed numbers due to IPC precautions and staffing challenges related to increased sickness and self-isolation. UHL could not be assured that data collected would have been an accurate representation of patient acuity and dependency and therefore its use to support establishment setting processes would not be sufficiently robust. Therefore, application of

professional judgement of ward manager, Matrons and Heads of Nursing, alongside review of patient and staff quality outcomes, was used to inform the establishment setting review processes for 2022/23. This is fully supported by the Chief Nurse.

8.0 RECOMMENDED NURSING ESTABLISHMENTS FOR 2022/23

8.1 Boards should ensure there is sufficient and sustainable staffing capacity and capability to always provide safe and effective care to patients, across all care settings in NHS provider organisations. They should ensure there is an annual strategic staffing review, with evidence that this is developed 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 (NQB 2013 and 2016).

8.2 Staffing establishments take account of the need to allow nursing, midwifery and care staff the time to undertake continuous professional development, and to fulfil mentorship and supervision roles. Core principles in determining the nursing and midwifery establishment have been identified, namely:

- The ward sister role is supervisory, and they use their time to direct care, undertake front line clinical leadership, focus on discharges and support unfilled shifts. At UHL the ward manager supervisory time is not allocated.
- 23% 'headroom' is allocated to ward establishments to allow for annual leave, sickness, maternity leave, training and development. The Carter report recommends 25%, however, 22% is the minimum 'headroom' allowed with the SNCT and represents a built-in efficiency.

8.3 The recommended establishment change for nursing in 2023/24 is an increase of 224.66wte posts in the ward-based establishment across 97 wards and/or departments. The Tables below identify by CMG the whole time equivalents and respective costs. Appendix 2 and Appendix 3 details the recommendations in full.

	WTE required						
CMG	Nurse Band 7	Nurse Band 6	Nurse Band 5	Nurse Band 4	Nurse Band 3 (TNA)	Nurse Band 2	Total
RRCV	-	-	24.99	-	-	21.76	46.75
MSS	-	-	22.77	-	-	2.43	25.20
CHUGGS	-	1.89	29.16	-	2.21	4.73	37.99
ESM	-	5.03	45.46	-	-	4.08	54.57
W&C	-	-	49.88	-	-	8.04	57.92
ITAPS	2.31	1.29	22.63	-	-	-	26.23
Total	**2.31**	**8.21**	**194.89**	-	**2.21**	**41.04**	**248.66**

8.4 **University Hospitals of Leicester - UHL:**

Ward Manager: supervisory hours 1.0wte not presently funded needs investment to support leadership and safety within the inpatient wards across areas where not allocated.

RN: The increase in RN is predominantly on nights to increase the RN to patient ratio and ensure the delivery of safe care. In smaller wards the increase of RN has been offset with a skill review and a reduction of HCSW.

HCSW: Areas with high HCSW additional duties to provide increased observation have been some wards recommended to increase HCSW on shifts improve the visibility of patients and increase patient safety and support the harm free care. This has been in some wards with increased establishments however there are wards across UHL that are balancing skill and rotas to ensure the delivery of this agenda.

NA: There are plans in place to build more Nursing Associates into the establishment workforce with particular reference to nights; this obviously needs increased training and time. Areas that have identified these within plans have at present been funded at band 5 due to the lack of supply to meet the required demand. In the future these posts may be able to convert to funded band 4 positions.

8.5 **RRCV: Professional Judgement recommends an increase of 46.75wte**

There are 2 predominant factors impacting on the recommendations for RRCV. Firstly the safety at night and the need to increase the RN workforce and RN to patient safety in particular reference to wards with cardiac monitored patients and the ward layout.

Secondly the renal wards following reconfiguration are delivering an increase in ward attendee services, inpatient treatments alongside the inpatients require specialist treatment presently supported by the LD Nurse in Charge who is not in a supervisory capacity. The recommendation is that renal wards Nurse in Charge should be in a Supervisory capacity on LD to oversee activity and staff education, supervision.

The Clinical Decisions Unit and SDEC review is ongoing in line with the ECIST review and the present Safer Nursing Care Tool review being undertaken. It must be noted that there is no recommended investment at this time but following the reviews a further investment maybe identified to deliver service and altered patient pathways.

8.6 **MSS: Professional Judgement recommends an increase of 25.20wte**

In MSS the establishment reviews have recommended increases across the night shifts in the acute wards for patient safety and an improved RN to patient ratio. This is in addition in wards at the LRI site and as a skill mix review at the LGH site. Furthermore additional HCSW have been recommended on the trauma wards due to the acuity and dependency of patients.

8.7 **CHUGGS: Professional Judgement recommends an increase of 37.99wte**

Reconfiguration has impacted on the recommendations in part for CHUGGS, the environment and services within them have required a review and some recommended RN, HCSW uplifts in particular at the GH site wards and triage area.

The wards across Oncology, Haematology, Surgery, and Urology have recommendations to increase RN on night for patient safety and to increase RN to patient ratio given the high acuity of many specialty patients.

8.8 **ESM: Professional Judgement recommends an increase of 54.57wte**

EM

The ED, GPAU and EM floor is presently being reviewed by ECIST and completing a SNCT audit therefore minimal recommendations to establishments at this time although GPAU is presently staffed at premium spend and will likely need future investment along with the discharge lounge as service changes are confirmed.

The Childrens ED is staffed safely to meet acuity but this does not cover the CSSU area which is increasingly open due to the increase in activity: this will need investment of 22.12 wte.

SM

Specialist Medicine HoN professional judgement has recommended RN increase in specialist areas to increase the RN to patient ratio due to increased acuity. Ongoing SNCT reviews in 2 wards to support this recommendation.

There are 7 wards that are completing a skill mix review within budget to balance the day and night with roster realignment of RN and HCSW to increase the skill mix and observation of patients at night.

8.9 **W&C: Professional Judgement recommends an increase of 57.92wte**

Childrens – 48.88wte recommended within the children's hospital to ensure all commissioned beds are fully established to meet demand. This requires increased RCN/RN predominantly to ensure ongoing compliance of the nurse to child ratios. The children's team are keen to incorporate RN and NA into the present and future workforce as part of the ongoing plan.

Neonates – There are no increased recommendations for Neonates at this time. Ongoing business cases are in place with increasing commissioned cots to meet the BAPM standards.

Gynaecology – Minimal recommendation, supervisory WM only, within gynaecology as skill mix and rota reviews are underway within budget.

Women / Maternity- A review took place in 2022 with midwifery of the establishment; this is pending a full service review in 2023. The Head of Midwifery identified there is Birth rate + compliance. It was discussed that rota need clarity of MAU, wards, delivery suite's, birthing centre. Rota's all to be reviewed with ACN and HoM to ensure templates correct - all changes will be achievable within envelope. Birthrate + MCA band 3 realignment costs from Band 2 with competencies for total compliance in planning. No present investment requested across both Delivery suites and Midwifery at this time.

8.10 **ITAPS: Professional Judgement recommends an increase of 26.23**

Theatres - Theatres has been reviewed against AfPP recommendations and following reconfiguration and the planned roster template changes no uplift to wte or budget is required. This is supported by the Matron and Head of Nursing.

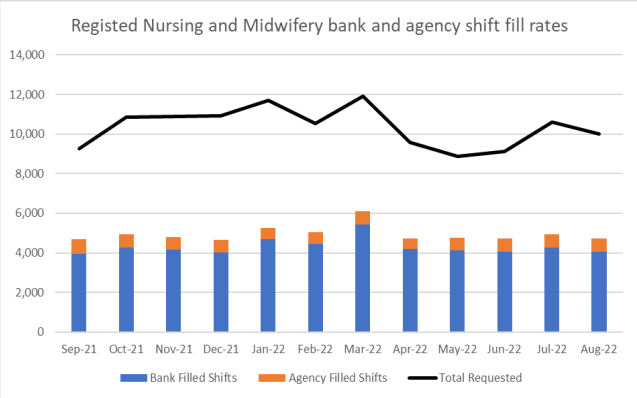
Intensive Care Unit - This ITU has been reviewed against GPICS recommendations and requires an increased in establishment of 12.42wte at LRI ITU and 11.51wte at GH ITU. This is supported by the Matron and Head of Nursing recognising LRI as the priority due to the high occupancy and environment and impacting on the present constant inability to provide GPICS standards.

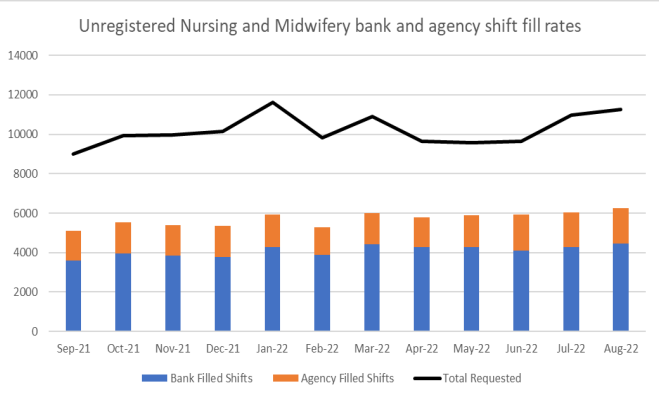
9.0 AGENCY USAGE

9.1 47% of registered nursing and midwifery bank and agency shifts were filled in August 2022 compared to a 55% fill rate for unregistered staff. We are working closely with the bank team to increase staffing fill. There is an embedded programme for existing substantive staff to join the Staff Bank with their manager's support through a recommendation process. Alongside this pay initiatives for all nursing bands with a 20% pay uplift are in place until 31st March 2023.

9.2 Alongside regular recruitment drives for Bank nursing and healthcare assistant roles, there has been a targeted programme for engaging local student nurses as healthcare assistants facilitated between the Trust and university by a dedicated Practice Learning Lead working with the Bank recruitment team. This is also being rolled out for medical students who attend a mandated healthcare skills as part of their first phase of medical training. This is delivered by a dedicated Education team who arrange a small number of clinical placements and encourage joining the Staff Bank to work as a healthcare assistant enhance these skills further. This programme is in its third year of running and it is hoped to reach 100 medical students this year.

9.3 The 'Confirm and Challenge' monthly meetings continue to drive identified benefits and roster efficiencies across the nursing teams. These meetings are led by the Assistant Chief Nurse and Lead Nurse for Rostering with the CMG HoN and identified members of the senior nursing team. These Carter efficiency meetings review and provide assurance that rosters and workforce plans are appropriately managed in line with the roster key performance indicators. Any remedial actions are dealt with and monitored. The HON have identified potential roster efficiency opportunities and are working with their senior nursing teams on ongoing and further improvement strategies.





10.0 MEASUREMENT AND IMPROVEMENT

10.1 The clinical and executive team review workforce metrics, indicators of quality and outcomes, and measures of productivity monthly as a whole and not in isolation from each other.

10.2 During the last 6 months, 1576 safer staffing red flags have been reported across the trust. There have been no reported incidents of Less than 2 registered Nurses present during a shift however, incidents of medication omissions, reports staffing shortfalls and failure to monitor care have increased.

	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22
Less than 2 registered Nurses present on a shift	0	0	0	0	0	0
Medicine Administration Omissions	67	45	63	60	45	63
Staffing shortfalls	75	283	145	88	207	231
Failure to monitor	32	25	34	37	33	43

10.6 Our compliance with Duty of Candour requirements and an annual declaration of our commitment to telling patients if a serious incident has occurred is published in our annual quality account.

10.7 The Board at UHL ensures that they support and enable their executive team to take decisive action when necessary. Commissioners, regulators and other stakeholders are involved any decision to open or close a care environment or suspend services due to concerns about safe staffing.

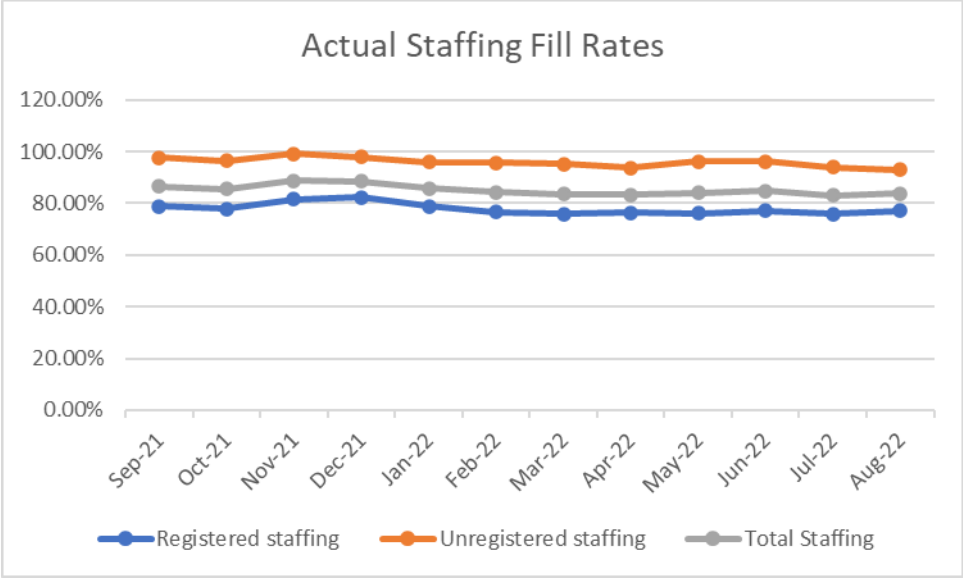
11.0 PLANNED VERSUS ACTUAL STAFFING & CARE HOURS PER PATIENT DAY

11.1 All NHS provider trusts are required to publish nursing and midwifery staffing data monthly. This data shows the planned staffing hours (i.e., those that were planned in the roster) against actual staffing hours (i.e., actual hours worked by substantive and temporary staff). In addition to these, care hours per patient day (CHPPD) are now reportable monthly. Data is published on the trust internet and an exception report is submitted to the SDT every month.

11.2 Overall staffing levels have fluctuated between 83.07% and 88.76% of our planned hours. Underutilisation of RN hours is related to the flexing of staffing in relation to increased sickness, shielding and self-isolation in relation to Covid-19. This skill-mix adjustment is driving staffing that is more than plan for Health Care Assistants; however, one HCA is not the equivalent of one Registered Nurse. Filling vacant RN posts remains a key focus.

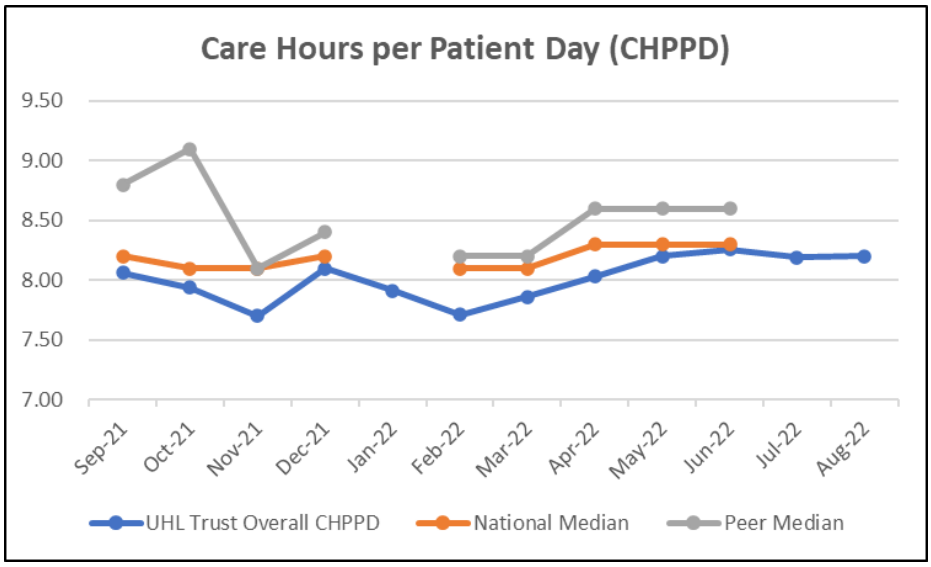
11.3 Alongside this, RMN's and Health Care Assistants are deployed to support the provision of 1:1 care for patients at risk of avoidable harm and those under the mental health liaison team (which are not part of the existing budgets). Corporate nursing continues to lead our strategic approach to managing both the patient safety and financial risks associated focusing on assessing the overall use of specials/enhanced therapeutic observations.

11.4 In addition there is a wider organisational focus assessing the overall of specials/enhanced therapeutic observations staff use with recommendations reporting to the pay review group to reduce the use of specials overall. The graph below demonstrates the actual staffing fill rates over the last year.



Graph 3. Published Nurse Staffing Data (data is substantive and temporary staff combined)

11.5 CHPPD is calculated by adding the hours of registered nurses to hours of healthcare support workers and dividing the total by every 24 hours of inpatient admissions. NHS Improvement began collecting care hours per patient day formally in May 2016 as part of the Carter Programme. Whilst the data remains in its infancy the CHPPD reported at UHL over the last 6 months is stable. This demonstrates that we are flexing our workforce in line with activity. We remain in the lower quartile when compared to our peers.



11.6 Whilst CHPPD is stable internally, preliminary benchmarking data suggests that at a trust level UHL sits below the median (inclusive of critical care units). The median has been derived from the monthly return to NHSI and includes all 132 acute providers. We continue to review and challenge unwarranted ward variation in the coming year using ward level benchmarking data available via the model hospital. This will enable us to identify individual wards that are outside the national median for specialty and to investigate whether it is warranted. This will require ongoing support from the Medical Director as well as the Chief Nurse. It should be noted that due to Covid-19, data exported to the model hospital did not always reflect ward specialities due to ward changes to accommodate blue/green/red pathways during covid, therefore benchmarking against this period is unlikely to provide an accurate reflection of the speciality.

12.0 RECRUITMENT PLAN

The recommended establishment change for 2023/24 is an increase of 248.66 wte posts in the ward-based establishment across 97 wards and/or departments (circa 200 RNs). There will be a staged approach to the recruitment of registrants over a three-year period commencing April 1st 2023.

The national and global challenges of nurse recruitment are well documented but to support our domestic supply of nurses and HCAs, we have two Heads of Nursing who will focus purely on recruitment, retention and pastoral care in partnership with our People Partners. Our Pathway to Excellence® journey will also provide significant opportunities to transform recruitment and retention for nurses and midwives at UHL.

We continue to achieve significant success with international nurse recruitment with over 1000 nurses choosing UHL as a place to work since 2017. We have increased placement capacity for student nurses across the system to support our long-term workforce plan and will be working with our local universities to minimise student attrition and ensure that students choose UHL as a place to commence their NHS career when they qualify.

As part of the operational planning process for 2023/24, we will identify the areas where the impact of increasing establishments will have a positive impact on emergency flow and discharge (i.e. the LRI and in-patient wards at the Glenfield). Key Performance Indicators (KPIs) linked to quality, safety and improved patient flow will also be identified and used to measure the benefits of increasing establishments in terms of quality, safety and produtivity.

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15.0 APPENDIX

Appendix 1 - Compliance with Developing Workforce Safeguards, Nursing and Midwifery October 2022

The Workforce Safeguards published by NHSI in October 2018 are used to assess compliance with the Triangulated approach to staff planning in accordance with the NQB guidance.

The guidance applies to all staff, this paper will outline nursing and midwifery current compliance with the 14 safeguards recommendations and identify any areas of improvement.

Recommendation:	**Compliance:**
Recommendation 1: Trusts must formally ensure NQB's 2016 guidance is embedded in their safe staffing governance.	**Partial Compliant** **Evidence:** SNCT currently not used to inform establishment setting processes, training programme implemented across all adult and paediatric in patient areas and the emergency department and comprehensive plan in place to collect bi-annual data to inform future establishment setting cycles. Our staffing policy was updated to incorporate the revised establishment setting process February 2020. Setting and reviewing nurse staffing establishments SOP approved June 2020.
Recommendation 2: Trust must ensure the three components are used in their safe staffing process.	**Partial Compliant** **Evidence:** SNCT currently not used to inform establishment setting processes, training programme implemented across all adult and paediatric in patient areas and the emergency department and comprehensive plan in place to collect bi-annual data to inform future establishment setting cycles. National guidance and specialty guidance for nurse to patient ratio's is built into SafeCare for analysis. Professional judgement discussions with review of quality outcomes are held bi-annually at establishment review meetings.
Recommendation 3 & 4: Assessment will be based on review of the annual governance statement in which Trusts	**Compliant**

will be required to confirm their staffing governance processes are safe and sustainable.	**Evidence**: Confirmation included in annual governance statement that our staffing governance processes are safe and sustainable.
Recommendation 5: As part of the yearly assessment assurance will be sought through the Single Oversight Framework (SOF) in which performance is monitored against five themes.	**Compliant** **Evidence**: In nursing the monthly data for all workforce metrics and quality indicators is reported and reviewed. Efficiency is driven through confirm and challenge meetings alongside all workforce data, for nursing and midwifery all reviewed not themes in isolation. This all relates to the SOF 5 themes.
Recommendation 6: As part of the safe staffing review the Chief Nurse and Medical Director must confirm in a statement to their Board that they are satisfied with the outcome of any assessment that staffing is safe, effective and sustainable.	**Compliant** **Evidence**: Bi Annual Nursing, Midwifery Staffing Establishment review to board.
Recommendation 7: Trusts must have an effective workforce plan that is updated annually and signed off by the Chief Executive and Executive Leaders. The Board should discuss workforce planning in a public meeting.	**Compliant** **Evidence:** Annual workforce plan with people services support
Recommendation 8: They must ensure their organisation has an agreed local quality dashboard that cross-checks comparative data on staffing and skill mix with other efficiency and quality metrics such as the Model Hospital dashboard. Trusts should report on this to their Board monthly.	**Compliant** **Evidence:** Increased to Monthly Safe Staffing paper with staffing metrics and performance alongside quality metrics. (includes clinical measures dashboard with staffing metrics) Exception reporting within report for executive information and monitoring.
Recommendation 9: An assessment or resetting of the nursing establishment and skill mix (based on acuity and dependency data and using an evidence-based toolkit where available) must be reported to the Board by ward or service area twice a year, in accordance with NQB guidance and NHS Improvement resources. This must also be linked to professional judgement and outcomes.	**Partial Compliant.** **Evidence:** Bi-annual review for nursing is completed across all services; the acuity data is collected daily throughout the year through SafeCare and cycles reported bi annually. Actual biannual audit process under review for implementation and SNCT data analysis. (20 days data, unique weekly validation plan once trained register complete) A bi-annual staffing report is presented to the Nursing, Midwifery Board, Executive People and Culture Board, Executive Quality Board and

	Trust Board. New audit data review and variations of nurse staffing to be presented will change the bi annual paper.
Recommendation 10: There must be no local manipulation of the identified nursing resource from the evidence-based figures embedded in the evidence-based tool used, except in the context of a rigorous independent research study, as this may adversely affect the recommended establishment figures derived from the use of the tool.	**Compliant** **Evidence:** All Nursing and Midwifery staffing tools are implemented as per guidance.
Recommendation 11 & 12: As stated in CQC's well-led framework guidance (2018) and NQB's guidance any service changes, including skill-mix changes and new roles, must have a full quality impact assessment (QIA) review.	**Compliant** **Evidence:** As part of establishment setting process Head of Nursing are required to complete a QIA review for any service change and business cases. UHL utilises a change to establishment document for approval and sign off by the Chief Nursing Officer which ensures governance and confirmation of no local manipulation.
Recommendation 13 & 14: Given day-to-day operational challenges, we expect trusts to carry out business-as-usual dynamic staffing risk assessments including formal escalation processes. Any risk to safety, quality, finance, performance and staff experience must be clearly described in these risk assessments. Should risks associated with staffing continue or increase and mitigations prove insufficient, trusts must escalate the issue (and where appropriate, implement business continuity plans) to the Board to maintain safety and care quality.	**Compliant** **Evidence:** Twice daily tactical staffing meetings. Staffing discussed at the tactical operational meetings throughout the day. Safe Staffing Standard Operating Procedure. Monthly Report for Nursing and Midwifery Safe Staffing.

Appendix 2

Board	Ward (beds)	Current Budget WTE	Suggested WTE from template rotas	Variance to WTE	RN:NA:HCA skill mix
RRCV	GH-CDU (60)	149.68	137.15	-12.53	59:3:38
	GH-CCU (19)	48.76	46.89	-1.87	73:2:25
	GH-SECU (12)	33.34	33.49	0.15	65:11:24
	GH- Wd 15 Cardiology (29)	39.02	46.31	7.29	62:0:38
	GH-Wd 16 Respiratory (30)	38.18	40.58	2.4	63:0:37
	GH-Wd 17 Respiratory (30)	39.7	42.9	3.2	49:2:49
	GH-Wd 20 Respiratory (28)	58.04	59.41	1.37	63:2:35
	GH-Wd 23 (33)	56.84	47.69	-9.15	57:2:41
	GH-Wd 24 Respiratory (25)	38.9	43.32	4.42	51:0:49
	GH-Wd 26 Thoracic (25)	32.06	35.32	3.26	70:0:30
	GH-Wd 27 CAPD Renal (25)	38.08	45.66	7.58	64:0:36
	GH-Wd 28 Cardiology (31)	39.35	43.22	3.87	57:2:41
	GH-Wd 29 Respiratory (25)	33.08	34.49	1.41	59:0:41
	GH-Wd 30 Nephrology (21)	49.92	54.5	4.58	59:2:39
	GH-Wd 31 Cardiac Surgery (25)	35.73	47.92	12.19	69:0:31

	GH-Wd 32 Cardiology Procedures(17)	20.9	27.48	6.58	61:0:39
	GH-Wd 33 Cardiology (29)	37.05	37.94	0.89	65:3:32
	GH-Wd 33a Cardiology (20)	25.63	30.12	4.49	56:0:44
	GH-Wd 37 Renal Transplant (12)	26.04	28.78	2.74	58:0:42
MSS	LRI-ASU (30) now 20 beds	9.06	12.36	3.3	77:1:21
	LGH-Wd 14 Elective Ortho (20)	28.03	29.21	1.18	54:7:39
	LGH-Wd 16 (20)	30.29	30.21	-0.08	56:7:37
	LGH-Wd 18 Elective Ortho (17)	19.02	29.21	10.19	52:3:45
	LRI-Kinmonth Unit Head, Neck, ENT Surg (14)	26.8	32.76	5.96	65:3:32
	LRI-Wd 17 Spinal/Trauma Ortho (24)	43.34	49.49	6.15	52:4:44
	LRI-Wd 18 Trauma (29)	40.53	47.05	6.52	54:6:40
	LRI-Wd 32 Trauma Ortho (29)	42.51	52.38	9.87	49:10:41
	LRI-Wd 9 Spec Surg Admission (17)	30.41	48.3	17.89	53:2:45
	GH- Wd 34 Breast (10)	14.97	11.66	-3.3	100:0:0
CHUGGS	LGH-Wd 20 Surgery (15)	22.33	25.57	3.24	59:0:41
	LGH-Wd 28 (Urology) (25)	35.3	35.9	0.6	59:0:41
	LGH-Wd 29 (Urology) (Brand New Roster) (14)	24.47	~~25.46~~	0.9864	55:4:41
	GH-Wd 35 (HPB) (28)	42.54	44.05	1.51	55:5:44
	GH-Wd 36 (HPB) (24)	35.5824	37.31	1.7276	62:0:38
	LRI-Wd 15 (Surgery) (28)	44.26	44.86	0.6	55:2:43
	LRI-Bone Marrow Transplant Unit (5)	15.32	20.05	4.73	91:0:9
	LRI-Osborne Day Care (0)	13.76	20.19	6.43	76:0:24
	LRI-Wd 16 Surgical Assessment Unit (Prev Wd 8) (30)	58.25	56.9	-1.35	50:4:46
	LRI-Wd 21 Surgery (Prev LRI 22 Surgery) (28)	50.1	50.7	0.6	54:0:46
	LRI-Wd 22 (Surgery) (22)	31.06	31.66	0.6	56:0:44

	LRI-Wd 39 & OAU Onc (18)	38.14	30.27	-7.87	54:7:39
	LRI-Wd 40 Onc (19)	25.85	28.09	2.24	65:4:31
	LRI-Wd 41 Haem (21)	29.41	32.45	3.04	73:0:27
	LRI-Wd 42 Gastro Med (28)	43.22	45.54	2.32	56:2:42
	LRI-Wd 43 Gastro Med/Hepat (28)	43.22	45.54	2.32	55:3:42
	LRI- Chemo Suite	22.35	20.76	-1.59	83:5:12
	LRI-ED (0)				
	LRI-A & E Paeds (0)			22.12	
	LRI-AFU(16)	37.25	37.96	0.71	49:2:49
	LRI-AMU & Wd 7 (70)	159.28	168.73	9.45	54:0:46
	LRI-AMU South(16)	36.90	37.96	1.06	51:0:49
	LRI-EDU(18)	26.80	27.40	0.6	61:0:39
	LRI-GPAU(9)	24.42	28.21	3.79	63:0:37
	LGH-MDCU (Day Case)	12.97	14.69	1.72	67:0:33
	LGH-BIU(9)	28.22	26.38	-1.84	57:0:43
	LGH-NRU(16)	34.36	35.36	1	
	LGH-Wd 1(28)	43.00	44.96	1.96	55:0:45
ESM	LGH-Wd 15 (33)	57.67	59.08	1.41	55:0:45
	LGH-Wd 3 (15)	28.28	27.40	-0.88	52:0:48
	LRI-Hampton (26)	33.91		5.32	62:0:38
	LRI-IDU (18)	25.71	28.63	3.19	59:0:41
	LRI-Stroke/HASU(36)				
	LRI-Wd 23(28)	42.00	41.83	-0.17	50:3:47
	LRI-Wd 24(27)	43.48	44.47	0.99	57:5:38
	LRI-Wd 29(29)	43.25	41.83	-1.42	51:2:47
	LRI-Wd 30(28)	43.00	41.83	-1.17	53:0:47
	LRI-Wd 31(30)	43.00	41.83	-1.17	53:0:47
	LRI-Wd 33 (28)	43.00	41.83	-1.17	50:3:47
	LRI-Wd 34 (26)	43.00	41.83	-1.17	53:0:47
	LRI-Wd 36 (28)	43.29	41.83	-1.46	50:3:47
	LRI-Wd 38 (28)	42.00	44.47	2.47	59:3:38
	LRI-Cardiac PICU (Previously GH-Paed ITU) (7)				
	LRI-Wd 1 Childrens Cardiology (Previously GH-Wd 30) (17)	33.57	46.59	13.02	85:2:13
	LRI-Childrens Day Care Unit (0)	10.96	18.78	7.82	54:0:46
	LRI-Childrens Intensive Care Unit (6)				

W&C	LRI-Wd 10 Childrens Surgery (18)	28.11	33.74	5.63	66:0:34
	LRI-Wd 11 Childrens Med (18)	42.30	45.31	3.01	76:0:24
	LRI-Wd 12 Childrens Med (12)	28.20	40.03	11.83	86:0:14
	LRI-Wd 14 Childrens Med (18)	24.28	38.58	14.3	71:0:29
	LRI-Wd 19 Childrens Surgery (18)	26.00	33.74	7.74	66:0:34
	LRI-Wd 27 Childrens Onc & Haem (12)	31.25	46.00	14.75	71:0:28
	LGH-Delivery Suite (61)	125.90	134.20	8.3	74:0:26
	LGH-GSU (0)	8.40	12.21	3.81	0:7:93
	LGH-NICU Neo-Natal Intensive Care (12)	0.00	0.00	0	
	LGH-Wd 11 Gynae Day Case (8)	6.29	7.70	1.41	50:0:50
	LGH-Wd 31 Gynae (23)	28.70	30.54	1.84	65:0:35
	LRI-Delivery Suite (65)	201.23	224.44	23.21	74:0:26
	LRI-Wd 8 GAU (12)	26.10	23.76	-2.34	58:8:33
	LRI-Neo-Natal Unit (30)				
ITAPS	GH Theatres				70:2:28
	LGH Theatres				70:2:28
	LRI theatres				76:1:23
	TAA (LRI/LGH)				43:0:57
	ITAPS Development Team				40:9:51
	GH- ITU	223.63	209.16		92:0:8
	LGH-ITU	26.08	23.53		74:0:26
	LRI-ITU	172.25	161.64		91:3:7