

Board of Directors

27 March 2014

Agenda Item	3.1
Title	Staffing levels and ratio of qualified and non-qualified staff on bedded units
Report for	Information and Monitoring
Report Author	Hilary Shanahan, Compassion in Care Co-ordinator
Responsible Executive Director	Louise Ashley, Chief Nurse and Director of Quality Governance
Contact name and details	Hilary Shanahan hilary.shanahan@clch.nhs.uk
FoI Status	For future publication

Executive Summary

This paper sets out the current National guidance in relation to nurse staffing levels for the bedded rehabilitation areas, nursing homes and community services at CLCH. The Chief Nurse and Director of Quality Governance asks the Committee to review the report in relation to safe staffing numbers in light of current evidence based guidance and the staffing levels within the organisation.

Following the Francis report recommendations and in line with Compassion in Practice Trust Boards are now asked to sign off and publish evidence based staffing levels every 6 months on the basis of a full nursing and midwifery establishment review, linked to quality of care and patient experience.

Trust Boards will receive monthly updates on workforce information, including the number of actual staff on duty during the previous month, compared to the planned staffing level, the reasons for any gaps, the actions being taken to address these and the impact on key quality and outcome measures. This data will also in future, be part of the Care Quality Commission's Intelligent Monitoring of NHS Provider organisations. The reporting to the Trust Board, if not already in place, must be in place by April 2014 and discussed at a Public Board meeting by June 2014 at the latest.

Recommendation to the Committee:

The Board is asked to agree the proposed approach, methodology and reporting timescales that will be taken within the Trust which will be considered by the Quality Committee on 18.03.14.

Trust strategic goals supported by this paper:

Goal

- 1. Embody the best of the NHS for our patients:** delivering great results with compassion and thoughtfulness

- | |
|---|
| <p>2. Support people safely out of hospital: providing safe, high quality value for money alternatives to hospital admissions</p> |
| <p>3. Deliver better value than competitors in our selected markets: securing our sustainability by providing effective and efficient services</p> |
| <p>4. Be responsive to our patients and partners' needs: promoting integration and partnership by demonstrating our capacity, character and competence</p> |
| <p>5. Employ only the best staff: selecting staff who care and supporting them to go the extra mile for our patients</p> |
| <p>6. Be innovation and technology pioneers: leading transformation of out of hospital services to empower staff and improve patient health</p> |

Quality, safety and risks.

The report has described the evidence based recommendations for safe staffing levels within inpatient areas, nursing homes and the community teams. The report has also identified the current staffing levels within CLCH and the difference between the recommendations and the current staffing levels, bedded areas, nursing homes and the community teams.

It is clear that further skill mix reviews are needed across adult community nursing and children's community nursing and the Chief Nurse and Director of Quality Governance will be leading that work.

CLCH is also working with the Queen's Institute and the National Institute of Clinical Excellence to design a user friendly tool to appropriately measure community nursing staffing levels.

Immediate action has been taken forward to rectify staffing levels within the Princess Louise Nursing Home, but these present a cost pressure to the service.

A method is currently being looked at for all in patient areas to report monthly staffing levels against recommended minimum establishments, including the use of temporary staffing.

An escalation policy is currently being written for all staff to ensure they are clear regarding the escalation process for concerns related to staffing and quality of care.

It is proposed that the Quality Committee and Trust Board will receive a six monthly establishment review report on each clinical areas staffing levels and skill mix from the Chief Nurse and Director of Quality Governance from June 2014.

The Quality Committee and Trust Board will receive a monthly report on staffing capacity and capability and the impact that these have had on relevant quality and outcome measures, by the Chief Nurse and Director of Quality Governance from June 2014.

The Quality Committee and Trust Board are asked to agree the proposed approach, methodology and reporting timescales that will be taken within the Trust.

Report on Ward / Team Nurse Staffing Levels at Central London Health Care NHS Trust (CLCH)

1.0 Introduction

- 1.1 This paper sets out the current National guidance in relation to nurse staffing levels for the bedded rehabilitation areas, nursing homes and community services at CLCH. The Chief Nurse asks the Board to review the report in relation to safe staffing numbers in light of current evidence based guidance and the staffing levels within the organisation.

2. Background

- 2.1. Patients have a right to be cared for by appropriately qualified and experienced staff in safe environments. This right is enshrined within the National Health Service (NHS) Constitution, and the NHS Act 1999 makes explicit the Board's corporate accountability for quality. Nurses' responsibilities regarding safe staffing are stipulated by the Nursing and Midwifery Council (NMC), covering every registered nurse in the United Kingdom and in England, demonstrating sufficient staffing is one of the sixteen essential standards that all health care providers (both within and outside of the NHS) must meet to comply with Care Quality Commission (CQC) regulation.
- 2.2. Attention is now focused more sharply than ever on staffing and staffing levels, as public expectations and the quality agenda demand that the disastrous effects of short staffing witnessed at NHS hospitals such as Mid Staffordshire should never reoccur.
- 2.3. Additionally, there is a growing body of research evidence which shows that nurse staffing levels make a difference to patient outcomes (mortality and adverse events), patient experience, quality of care and the efficiency of care delivery. For example, a systematic review in 2007 concluded that there was evidence of an association between increased Registered Nurse staffing and a lower rate of hospital related mortality and adverse events. However, most of the research evidence relates to hospital based care, there is a paucity of equivalent research in primary and community care.
- 2.4. The financial implications of this mean that all services need to be staffed cost-effectively. Many of the identified high impact actions and efficiency measures rely on reducing costs by minimising the expense of avoidable complications such as DVTs (deep vein thrombosis), pressure ulcers, the reduction of falls and UTIs (urinary tract infections). But 'avoidable complications' are only avoidable if effective nursing care is consistently delivered. This relies on having sufficient nurses with the right skills being in the right place at the right time, which depends on robust planning in terms of nursing staff resources (Quality and Outcomes Framework- Griffiths et al, 2010).

- 2.5 At the heart of many of these failures in care provision lie two recurring themes; firstly staffing that cannot sustain care standards, and secondly communication/governance failures that prevent organisations from hearing or responding to problems as these emerge. Indeed, all the available evidence shows that in the current financial climate there is an even greater risk of staffing decisions being made without a sound rational basis, as they are often made arbitrarily in order to reduce costs, without assessing the risk to patient care.
- 2.6 Subsequently, to achieve optimum quality/safety while juggling activity with the Trust's financial commitments each decision should be made on a sound rational basis. Ensuring a safe workforce with the right skill mix that is both fit for purpose and able to adjust to the changing needs of our services must remain a priority.
- 2.7 The Francis Report (2012) recommended that the National Institute for Health and Care Excellence (NICE) develop "evidence based tools for establishing the staffing needs of each service" in the NHS. However, the Government chose not to take that recommendation forward in their official response to the report, instead stating that they believed staff numbers and skill mix should be set locally.
- 2.8 The National Nursing Vision and Strategy, Compassion in Practice (2012) also called for the use of locally set evidence-based tools on staffing. As part of the implementation plan, the Chief Nursing Officer for NHS England and the National Quality Board have both collectively set out the expectations of NHS providers and commissioners for nursing, midwifery and care staffing capacity and capability with ten expectations within the document "How to Ensure the Right People, with the Right Skills, Are in the Right Place at the Right Time (2013)".

2.9 The Ten Expectations

- 2.9.1 The Trust Board will take full responsibility for the quality of care provided to patients, and as a key determinant of quality, take full and collective responsibility for nursing, midwifery and care staffing capacity and capability. Boards will ensure there are robust systems and processes in place to assure themselves that there is sufficient staffing and capacity and capability to provide high quality care on all wards, clinical areas, departments, services or environments day or night, every day of the week. Boards will be actively involved in managing staffing capacity and capability, by agreeing staffing establishments, considering the impact of wider initiatives (such as cost improvement plans) on staffing, and are accountable for decisions made. Boards must, at any point in time, be able to demonstrate to their commissioners, the Care Quality Commission, the NHS Trust Development Authority or Monitor that robust systems and processes are in place to ensure themselves that the nursing, midwifery and care staffing capacity and capability in their organisation is sufficient.
- 2.9.2 Trust Boards will sign off and publish evidence based staffing levels every 6 months on the basis of a full nursing and midwifery establishment review, linked to quality of care and patient experience. Trust Boards will receive monthly updates on workforce information, including the number of actual staff on duty during the previous month,

compared to the planned staffing level, the reasons for any gaps, the actions being taken to address these and the impact on key quality and outcome measures. This data will also in future, be part of the Care Quality Commission's Intelligent Monitoring of NHS Provider organisations. The reporting to the Trust Board, if not already in place, must be in place by April 2014 and discussed at a Public Board meeting by June 2014 at the latest.

- 2.9.3 Processes will be in place to enable staffing establishments to be met on a shift-to-shift basis. The Executive team will ensure that policies and systems are in place, such as e-rostering and escalation policies, to support those with responsibility for staffing decisions on a daily shift to shift basis. The Director of Nursing and their team will routinely monitor shift to shift staffing levels, including the use of temporary staffing solutions, seeking to manage immediate implications and identifying trends.
- 2.9.4 Evidence based tools will be used to inform nursing, midwifery and care staffing capacity and capability, in conjunction with professional judgement and scrutiny, including numbers of staff and skill mix. Senior nursing and midwifery staff and managers will actively seek out data that informs staffing decisions, and will be appropriately trained in the use of evidence based tools and the interpretation of their outputs. Staff will use their professional judgement and scrutiny to triangulate the results of the tools with their local knowledge of what is required to achieve better outcomes for their patients.
 - 2.9.4.1 The evidence base in relation to workforce planning and safe and effective staffing within mental health, community settings and learning, disability services is less established than that for acute settings. Work is underway through Compassion in Practice Action Area 5 to understand what workforce planning tools exist for these care settings and to pilot these tools or develop new tools. CLCH is working with the Queen's Nursing Institute (QNI) in their review of workforce planning tools within community settings and the QNI is due to report at the end of December 2013.
- 2.9.5 Clinical and managerial leaders will foster a culture of professionalism and responsiveness where staff feel able to raise concerns (including about insufficient staffing) and they will seek to ensure that staff feel supported and confident in raising concerns. Where concerns are substantiated, organisations will act on concerns raised.
- 2.9.6 A multi-professional approach is taken when setting nursing, midwifery and care staffing establishments. The Director of Nursing will lead the process of reviewing staffing requirements and ensure there are processes in place to actively involve sisters, charge nurses or team leaders. In working closely with the Medical Director, Director of Finance, Workforce (HR) and Operations, the interdependencies between staffing and other aspects of the organisations' functions will be recognised. Papers presented to the Board will reflect an agreed position.
- 2.9.7 Nurses, midwives and care staff will have sufficient time to fulfil their responsibilities that are additional to their direct caring duties. Staffing establishments will take into

account the need for staff to undertake continuous professional development, and to fulfil mentorship and supervision roles. Likely levels of planned and unplanned leave will be factored into establishments. Establishments will also afford ward or service sisters, charge nurses or team leaders to assume supervisory status and benefits will be reviewed and monitored locally.

- 2.9.8 NHS providers will clearly display information about the nurses, midwives and care staff present on each ward, clinical setting, department or service on each shift. Information should be made available to patients and to the public that outlines which staff are present and what their role is.
- 2.9.9 Providers of NHS services will take an active role in securing staff in line with their workforce requirements. To help determine future workforce requirements, organisations will share staffing establishments and annual service plans with their Local Education and Training Boards (LETBs), and their regulators for assurance. Providers will work in partnership with Clinical Commissioning Groups and NHS England Area Teams to produce a Future Workforce Forecast, which LETBS will use to inform their Education Commissions and the Workforce Plan for England led by Health Education England.
- 2.9.10 Commissioners will actively seek assurance that the right people, with the right skills, are in the right place at the right time within the providers with whom they contract. Commissioners will specify in contracts the outcomes and quality standards they require and actively seek to assure themselves that providers have sufficient nursing, midwifery and care staffing capacity and capability to meet these.

3.0 Methodology

- 3.1 A range of methods exist that enable staffing to be planned at a local level and each method has been used to review the staffing establishments for the inpatient areas, nursing homes and community services within CLCH. This piece of work has been led by the Chief Nurse and Director of Quality Governance.
- 3.2 Most approaches to planning staffing rely on quantifying the volume of nursing care to be provided on the basis of the size of the population, mix of patients and type of service and relating it to the activities undertaken by the different members of the team. The systems vary according to the amount of detail considered, from ratios that relate staffing to numbers of beds or total population, through to more detailed systems based on patient acuity and dependency.
- 3.3 Various evidence based specialism specific guidance from the Royal College of Nursing (RCN), and Safer staffing levels RCN (2012) guidance has been utilised to assist in the planning of staffing levels and skill mix for the identified clinical areas.
- 3.4 Professional judgement and benchmarking have also been used to triangulate the findings of the staffing/skill mix reviews for each identified clinical area.

4.0 Inpatient Areas

4.1 Adults

- 4.1.1 A key theme in the 2006 RCN ward staffing level guidance was the recommendation that skill mix on acute wards should not be more dilute than the benchmark average of 65% registered nurses to 35% health care assistants (RCN 2006). Although valuable, the 65:35 ratio does not address how many patients a nurse should be allocated to care for, despite this being a recognised indicator of lower morbidity and mortality.
- 4.1.2 The 2012 RCN ward staffing level guidance recommends the 65:35 ratio as described in 4.1 and has also recommended the following guidance for specific clinical areas (RCN 2012).

4.2 Care of the Elderly

- 4.2.1 The RCN Safe staffing for older people's wards guidance (2012) recommend for basic safe care
- a 50:50 mix of registered nurses to health care assistants
 - at least one registered nurse per seven patients
 - at least one member of staff per 3.3 to 3.8 patients
 - at least 4 registered nurses for a typical 28 bed ward
 - at least eight nursing staff on duty for a typical 28 bed ward

The recommendations for ideal, good quality care are:

- a 65:35 mix of registered nurses to health care assistants
- at least one registered nurse for every five to seven patients
- at least one member of staff per 3.3 to 3.8 patients
- four to six registered nurses for a typical 28 bed ward
- at least eight nursing staff on duty for a typical 28 bed ward

These numbers exclude the ward sister or senior charge nurse, who is in a supervisory role. The RCN also say that the ward sister or senior charge nurse must be the final arbiter of whether the staffing for each day is appropriate for the specific needs and case mix of patients on the ward (RCN 2012).

4.3 General Rehabilitation Units

- 4.3.1 The RCN Mandatory Nurse Staffing Levels (2012) guidance recommends the mandatory nurse to patient ratios (adapted from NSWNA, 2011):
- the am shift -1 nurse to 5 patient (50:50 skill mix) ratio plus nurse in charge
 - the pm shift- 1 nurse to 5 patient (50:50 skill mix) ratio plus nurse in charge
 - the night shift- 1 nurse to 7patient (50:50) ratio plus nurse in charge

4.4 Nursing Homes

4.4.1 The Regulation and Quality Improvement Authority (2009) produced staffing guidance for nursing homes. The guidance states that there should be a minimum requirement for a skill mix of 35% registered nurses to 65% health care assistants over the 24 hour period.

- Early shift 1 staff to:5 patients
- Late shift 1 staff to :6 patients
- Night shift 1 staff to :10 patients

4.4.2 The Regulation and Quality Improvement Authority (2009) state that the following examples should be used as baseline calculations for any nursing home setting.

4.4.3 For a 30 bedded unit

- Early shift 1 staff to 5 patients. Total number of staff 6. 2 registered nurses and 4 Health Care Assistants
- Late shift 1 staff to 6 patients. Total number of staff 5. 2 registered nurses and 3 Health Care Assistants
- Night shift 1 staff to 10 patients. Total number of staff 1 registered nurse and 2 Health Care Assistants.

This provides a total of 102 available care hours with an average of 3.4 care hours per patient over a 24 hour period with 35% registered nurses and 65% Health Care Assistants over the 24 hour period.

4.4.4 For a 40 bedded unit

- Early shift 1 staff to 5 patients. Total number of staff 8. 3 registered nurses and 5 Health Care Assistants
- Late shift. 1 staff to 6 patients. Total number of staff 7. 2 registered nurses and 5 Health Care Assistants.
- Night shift 1 staff to 10 patients. Total number of staff 4. 2 registered nurses and 2 Health Care Assistants.

This provides a total of 136 available care hours and an average of 3.4 care hours per patient day. The overall grade mix is 38% registered nurses and 62% Health Care Assistants.

4.4.5 For a 60 bedded unit

- Early shift 1 staff to five patients. Total number of staff 12. 4 registered nurses and 8 Health Care Assistants.
- Late shift. 1 staff to 6 patients. Total number of staff 10. 4 registered nurses and 6 Health Care Assistants
- Night shift. 1 staff to 10 patients. Total number of staff 6. 2 registered nurses and 4 Health Care Assistants.

This provides a total of 204 hours of available care over a 24 hour period with an average of 3.4 care hours per patient day. The overall grade mix over the 24 hour period is 35% registered nurses and 65% Health Care Assistants.

5.0 Community Nursing

5.1 Describing staffing levels in the community are far more complex than within hospitals. There are two main means of measuring nurse staffing levels within the community

- Nurses per 1,000 head of population
- Caseloads(patients per nurse)

5.2 Both are fraught with difficulties as none of the parameters are fixed, so it is almost impossible to arrive at consistently defined data that allows averages to be produced and comparisons drawn.

5.3 The Queens Nursing Institute (QNI) is now involved with NHS England and Health Education England to examine the evidence base for good practice in community nursing workforce planning. The QNI have been funded by NHS England to identify and agree the principles upon which District Nurse workforce planning and caseload allocation is based and to make recommendations for the development of this aspect of the service.

6.0 Health Visiting

6.1 There is limited evidence to date to support an RCN position on optimum caseloads for health visitors, particularly where services are evolving in responses to health and social care. In his 2009 progress report on the protection of children in England, Lord Laming recommended a maximum caseload of 300 families (or 400 children) per full time health visitor, with actual numbers being lower depending on caseload competency and other factors(Laming, 2009). The RCN's 2011 position on health visiting in the early years and Cowley et al's recent review recognised that caseloads should be lower depending on the number of vulnerable families the health visitor has on the caseload, deprivation indices, geography of the patch and the team support available, including access to

administrative assistance (RCN,2011b,Cowley et al 2013). Unite/CPHVA (2009) stated that 400 children 'must be the absolute maximum caseload size' and that the 'average and more normal caseload should be no more than 250 children'. They also advise that caseloads for health visitors working in areas of high vulnerability should be much less. The RCN is undertaking further work in this area to inform a clear position on caseload size and complexity and will update its position once this is available. As the dependency of families has increased health visiting teams have developed to include different professional roles and skills, and registered nurses, registered children's nurses and nursery nurses are often key members of the team.

7.0 School Nursing

- 7.1 The RCN guidance, Defining staffing levels for children and young people's services (2013) recommend that each family of schools has a named school nurse responsible for co-ordinating the care across both the primary and secondary schools; and that the school nursing service should be a year round service which incorporates team members of different grades who have a variety of skills and knowledge.
- 7.2 The 2013 guidance recommends that there should be a minimum of one qualified school nurse for each secondary school and its cluster of primary schools. The actual number will vary dependent upon the size and complexity of the school population, the number of vulnerable children, deprivation indices and the geography of the patch. Qualified school nurses will be supported by a skill- mixed team that includes a number of registered nurses, nursery nurses and health care support workers.

8.0 Community Children's Nursing

- 8.1 The RCN guidance, Defining staffing levels for children and young people's services (2013) state that all community children's nursing (CCN) teams must be led by a registered children's nurse who has completed a recognisable community education and development programme.
- 8.2 The 2013 guidance recommends that in the average CCN team the minimum ratio of registered nurse to unregistered staff should not fall below 70:30%, with a minimum of 25% of the registered nurse component being CCNs who have completed a recognisable community education and development programme.
- 8.3 Calculating the dependency of any patient in the community is complex; whilst children and young people often live with their families and have carers around them, it is not always possible for every family/carers to provide the care needed.
- 8.4 The RCN(2013) recommend that for an average –sized district with a child population of 50,000, a minimum of 20 whole time equivalent (WTE) community children's nurses are required to provide a holistic community children's nursing service in addition to any individual child specific continuing care investment (RCN 2009a: 2009b). Workforce

establishments and working patterns must be able to meet the need for 24 – hour end of life care whenever and wherever required (RCN 2013).

9.0 Hospice settings

- 9.1. There is currently no national guidance relating to staffing levels for bedded hospice services. The Pembridge Unit provides a ratio of 1 registered nurse to 3 patients, and this establishment is supplemented by healthcare assistants.

10. Recommendations for Minimum Staffing Levels at CLCH – Continuing Care and Rehabilitation Areas

10.1. Continuing Care Areas

The following tables illustrate current staffing, the national staffing recommendations for continuing care areas, and the related staffing numbers that this would provide per shift. The recommendations are based on guidance, professional judgment and the geography of the buildings.

Athlone House - 25 bed -2 FLOORS					
Shift	Current staffing (RN/HCA)	Recommended staffing ratio	Recommended RN's per Shift	Recommended HCA's per shift	Supervisory RN
Early	2RN 2HCA	1 staff to 5 pts	2	4	1
Late	2RN 2HCA	1 staff to 6 pts	2	3	0
Night	2RN 2HCA	1 staff to 10 pts	2	2	0

Garside House– 43 beds-3 FLOORS					
Shift	Current staffing (RN/HCA)	Recommended staffing ratio	Recommended RN's per Shift	Recommended HCA's per shift	Supervisory RN
Early	4RN 6HCA	1 staff to 5 pts	3	6	1
Late	4RN 6HCA	1 staff to 6 pts	3	6	0
Night	3RN 4HCA	1 staff to 10 pts	3	4	0

Princess Louise – 51 beds-2 FLOORS					
Shift	Current staffing (RN/HCA)	Recommended staffing ratio	Recommended RN's per Shift	Recommended HCA's per shift	Supervisory RN
Early	4RN 8HCA	1 staff to 5 pts	4	8	1
Late	4RN 8HCA	1 staff to 6 pts	4	8	0
Night	2RN 6 HCA	1 staff to 10 pts	2	6	0

10.2. Bedded Rehabilitation Areas

The following tables illustrate current staffing, the national staffing recommendations for rehabilitation areas, and related staffing numbers that this would provide per shift.

Jade Ward – 21 beds					
Shift	Current staffing (RN/HCA) (this includes 7 extra beds open)	Recommended staffing ratio	Recommended RN's per Shift	Recommended HCA's per shift	Supervisory RN
Early	4RN 4HCA 1Supervisory RN	1 nurse to 5 pt ratio 50/50 RN to HCA split	3	3	1
Late	4RN 4 HCA	1 nurse to 5 pt ratio 50/50 RN to HCA split	3	3	0
Night	3RN 3HCA	1 nurse to 7 pt ratio 50/50 RN to HCA split	3	2	0

Marjorie Warren Ward – 34 beds					
Shift	Current staffing (RN/HCA)	Recommended staffing ratio	Recommended RN's per Shift	Recommended HCA's per shift	Supervisory RN
Early	4RN 5HCA	1 nurse to 5 pt ratio 50/50 RN to HCA split	4	3	1
Late	3RN 4-5 HCA	1 nurse to 5 pt ratio 50/50 RN to HCA split	4	3	0
Night	2RN 3HCA	1 nurse to 7 pt ratio 50/50 RN to HCA split	3	2	0

Athlone House Rehabilitation – 23 beds 2 FLOORS					
Shift	Current staffing (RN/HCA)	Recommended staffing ratio	Recommended RN's per Shift	Recommended HCA's per shift	Supervisory RN
Early	2RN 4HCA	1 nurse to 5 pt ratio 50/50 RN to HCA split (due to layout)	3	3	1
Late	2RN 4HCA	1 nurse to 5 pt ratio 50/50 RN to HCA split	3	3	0
Night	2RN 2HCA	1 nurse to 7 pt ratio 50/50 RN to HCA split	2	2	0

Princess Louise Rehabilitation – 11 beds					
Shift	Current staffing (RN/HCA)	Recommended staffing ratio	Recommended RN's per Shift	Recommended HCA's per shift	Supervisory RN
Early	1RN 2RSW	1 staff to 5 pt ratio 50/50 RN to HCA split	1	2	1
Late	1RN 2RSW	1 staff to 5 pt ratio 50/50 RN to HCA split	1	2	0
Night	1RN 1RSW	1 staff to 7 pt ratio 50/50 RN to HCA split	1	1	0

10.3 Nurse in Charge Role

10.3.1. The nurse in charge of each shift must be a band 6 nurse if the ward manager is not on duty.

10.3.2. The ward manager will be supervisory on each shift and work 9-5 weekdays, unless there is a need to work a clinical shift and in emergency situations.

11.0 Current Staffing Levels in Community Nursing

11.1 During April and May 2013, the 4 District Nursing Services within CLCH undertook a comprehensive review of their caseloads to gain an in-depth understanding of all patients currently on their caseloads. They looked at each patient being seen and applied a complexity/dependency tool rating to each one, using the complexity/dependency tool created by the Interim Service Manager for District Nursing.

11.2 Each patient was rated first as to the use of the service, low, medium or high. The parameters that constituted this were decided and agreed upon by the Professional Lead for Adult Nursing and two Clinical Leads.

11.3 Each patient was then rated as to their dependency on the service, low, highly or intensively dependent which indicated the band of staff that was most appropriate to undertake the intervention.

11.4 The combined score gave the complexity and dependency score for each patient. The patients were scored on the primary intervention they were being seen by the service

for, but additional medical, social or mental health needs were also taken into account and altered the score of the patient if appropriate.

- 11.5 The caseload analysis was undertaken by the Team Leads in all 41 of the District Nursing teams across Barnet, Hammersmith and Fulham, Kensington and Chelsea and Westminster. They were supported in the process by working with a peer who challenged decisions as and when necessary.
- 11.6 As a consequence, it was identified that CLCH had just over 6,000 active patients on their caseloads during the review period. However, in some teams continence / equipment reviews were not included which may account for an additional 1,000- 1,500 additional patients.
- 11.7 Once completed, service and senior managers were given a good snapshot in time of the number of high, medium and low patients on each caseload. It demonstrated how many patients were on each caseload and how many calculated visits per week each team had. It also demonstrated the complexity and dependency of patients on all caseloads across CLCH, with the ability to shift resources if necessary from team to team. In addition, in order to start to understand future demand on those teams, patients were categorised into age brackets. This demonstrated that the higher percentage of patients in each caseload were patients aged 75 years and above, closely followed by 64-74year olds. Palliative care patients were also identified as a high percentage of patients on caseloads with increased demand on teams as their condition deteriorated to end of life care. As these could be mapped to specific teams, team leaders and managers were able to make realistic and informed decisions regarding increased staff resource allocation as and when required.

12.0 Recommendations for Community Nursing

- 12.1 The complexity and dependency tool becomes a live document that can be used in real time through RiO, which enables team leaders and managers to manage the demand and complexity of patients as an additional tool to manage staffing levels within the community.
- 12.2 There is a need for a further staffing and skill mix review.
- 12.3 CLCH is represented at the QNI National review of staffing within Community Nursing and would like to become a pilot site for the implementation of the new National tool that is developed.

13.0 Current Staffing Levels in Health Visiting and School Nursing

- 13.1 A CLCH workforce formula guided by a funding model described by Sarah Crowley, Professor of Community Practice Development, Kings College London has been used to identify the numbers of children in the population, service volumes and public health

indices of local deprivation to calculate hours needed to deliver a safe service to each child. The principle shows that areas of deprivation require twice the number of health visiting hours and supports earlier research by Rowe (1995).

13.2 CLCH have developed a unique model for delivering Children's services in line with current evidence base. Key principles for service delivery have been undertaken through conversations with parents and a wide range of children's health professionals, commissioners, education and children's services. The service focus is children and young people from 0 to 19 years (inclusive of related aspects of pre-birth) living and/or schooled within Barnet, Hammersmith and Fulham, Kensington and Chelsea, and Westminster boroughs.

13.3 The approach to understanding and organising the provision of services is based on the London Continuum of Need Framework that defines levels of need. Three broad areas of need are identified:

UNIVERSAL	The needs of every child
TARGETED/VULNERABLE	For children with an identified need or those at risk
COMPLEX /SPECIALIST	For children who have complex care needs, disability, special educational needs, safeguarding plan or 'Looked after Children'

13.4 The service approach includes:

13.5 Management of need - a service framework for understanding needs and organising services and required interventions

13.6 Practice by pathways - utilisation of multi-disciplinary care pathways across agency and provider boundaries

13.7 Continuity of care – the management and collaborative working for a seamless experience that demonstrates value for money

13.8 Partnership working - collaborative and joint working across pathways and service activity

13.9 Service delivery - the effective arrangement of interventions which includes joint working and co-location

13.10 Workforce flexibility - value and effectiveness of resources

13.11 At the centre of the Model of care is the stratification of care according to need, universal, targeted and specialist. A part of every assessment with children, young people and their families is the assessment of their need which determines the pathway they will follow.

- 13.12 The continuity of care management approach assures multi-disciplinary teams around the child/family which follow agreed pathways and practices, and integrate service activities. This enables a seamless user experience, effectiveness, quality, and value for money and appropriate staff and skill mix.
- 13.13 CLCH has a named school nurse for each school although those named for primary schools will not have the specialist public health school nurse qualification.
- 13.14 The teams consist of Band 7 team leaders, Band 6 Specialist public health nurse (School nursing), Band 5 register nurses, band 4 School Health Technicians/support workers and administrative support.
- 13.15 There are some full time nurses in each borough to cover the service in the holidays but the majority of staff are term time only.
- 13.16 There are some band 6 employees who do not have the qualification but have had many years of experience at a band 5 in school nursing. The service is working towards all band 6 staff having the qualification.

14.0 Recommendations for Health Visiting and School Nursing

- 14.1 All of the recommendations of the CLCH Health Visiting Workforce formula group outputs have been agreed by the Executive Management Team, with a view to review the implementation plan to evaluate its effectiveness in 6 months.
- 14.2 It is proposed that the school nursing service is reviewed in light of the evidence based guidance from the RCN. and considered as part of the next six month review within the service.

15.0 Current Staffing Levels in Childrens' Community Nursing

- 15.1 The Childrens' Community Nursing (CCN) Service is led by two Registered Children's Nurses who hold post registration specialist practitioner qualifications.
- 15.2 The Inner CLCH CCN Service covers the three boroughs of Hammersmith and Fulham, Kensington and Chelsea and Westminster, which has a child population of 0 to 18 year olds of 100,302.
- 15.3 For the CCN Team specifically there are 9.72 WTE CCNs. In addition there is 1.0 WTE for Palliative Care and continuing care and special school provision.

- 15.4 Barnet has a child population of 90,646. Barnet does not have a generic CCN Service but does have a continuing care and special school provision.
- 15.5 The CCN Service as a whole (all 4 boroughs) has an establishment of 22.4 WTE registered nurses and 18.88 WTE unregistered care workers. In addition the service has 2.00 WTE qualified play specialists and has 1.5 WTE of administrative support.
- 15.6 The CCN Service has a skill mix of 54% registered nurses to 46% unregistered care workers.
- 15.7 The Inner Borough's Home Care Support Team (currently 22% registered nurses to 78% unregistered care workers, reduces in March 2014 to 17% registered nurses to 83% unregistered care workers); the Barnet Children's Complex Care Team has a skill mix of 26% registered nurses to 74% care workers and the Special Schools skill mix is 40% registered nurses to 60% care workers.
- 15.8 6.76 WTE of the registered nurses have completed a community qualification. This equates to 30% of the registered nurses. 1.0 WTE is currently doing the Advanced Nurse Practitioner Course, and a 0.8 WTE registered nurse is retiring in March 2014.

16.0 Recommendations for Children's' Community Nursing

- 16.1 It is recommended that the CCN service nursing establishment and skill mix is reviewed in line with evidence based practice and professional judgement, as part of the 6 monthly Health Visitor and School Nurse review.

17.0 Conclusions and Way Forward

- 17.1 The report has described the evidence based recommendations for safe staffing levels within inpatient bedded areas, nursing homes and the community teams. The report has also identified the current staffing levels within CLCH and the difference between the recommendations and the current staffing levels.
- 17.2 It is clear that further skill mix reviews are needed across adult community nursing and children's community nursing and the Chief Nurse and Director of Quality Governance will be leading that work. CLCH are also working with the Queen's Institute and the National Institute of Clinical Excellence to design a user friendly tool to appropriately measure community nursing staffing levels.
- 17.3 Immediate action has been taken forward to rectify staffing levels within the Princess Louise Nursing Home, but these present a cost pressure to the service.

- 17.4 A method is currently being looked at for all in areas to report monthly staffing levels against recommended minimum establishments, including the use of temporary staffing.
- 17.5 An escalation policy is currently being written for all staff to ensure they are clear regarding the escalation process for concerns related to staffing and quality of care.
- 17.6 It is proposed that the Quality Committee and Trust Board will receive a six monthly establishment review report on each clinical areas staffing levels and skill mix from the Chief Nurse and Director of Quality Governance from June 2014.
- 17.7 The Quality Committee and Trust Board will receive a monthly report on staffing capacity and capability and the impact that these have had on relevant quality and outcome measures, by the Chief Nurse and Director of Quality Governance from June 2014.
- 17.8 The Trust Board are asked to agree the proposed approach, methodology and reporting timescales that will be taken within the Trust.

18.0 References

NHS Act (1999)

Department of Health (2009) The NHS Constitution: the NHS belongs to us all, London:DH Available at [www.dh.gov.uk\(internet\)](http://www.dh.gov.uk/internet)

Nursing and Midwifery Council (2013) The code: standards of conduct, performance and ethics for nurses and midwives, London: NMC

Griffiths P, Murrells T, Maben J, Jones S and Ashworth M (2010) Nurse staffing and quality of care in UK general practice: cross-sectional study using routinely collected data, British Journal of General Practice, 60 (570), pp.e36-e48(13)

The Mid-Staffordshire NHS Foundation Trust (2013) Public Inquiry chaired by Robert Francis QC

Compassion in Practice (2012) Nursing, Midwifery and Care Staff: Our vision and Strategy NHS England-Department of Health

Royal College of Nursing (2012) Mandatory Nurse Staffing Levels Policy Briefing 03/12 Royal College of Nursing London

Royal College of Nursing (2006) Setting appropriate ward staffing levels in NHS Acute Trusts: an exploration of the Issues, London: RCN (Policy guidance 15/2006)

Royal College of Nursing (2012) Safe staffing for older people's wards, RCN summary guidance and recommendations, London

New South Wales Nurses' Association (2011) The offer on ratios, The Lamp, 68(1)

The Laming Report (2009) HMSO-London

Royal College of Nursing (2011b) Congress 2011 agenda - 8 Safe staffing levels. Available at www.rcn.org.uk/newsevents/congress/congress2011/congressagenda/8.safestaffinglevels (accessed 05/03.012)(Web)

Cowley S et al (2013) Why Health Visiting? A review of the literature about key health visitor interventions, processes and outcomes for children and families London: Kings College London National Nursing Research Unit

Unite/CPHVA (2009) Unite/CPHVA Statement: What size caseload should a health visitor have? Available at <http://archive.unitetheunion.org/accessed> 3 April 2013)

Royal College of Nursing (2013) Defining staffing levels for children and young people's services RCN standards for clinical professionals and service managers RCN London

Royal College of Nursing (2009a) Submission to the Prime Minister's Commission on Nursing and Midwifery, London: RCN

Royal College of Nursing (2009b), A child's right to care in the home, London: RCN

Staffing guidance for Nursing Homes (2009) The Regulation and Quality Improvement Authority

How to ensure the right people, with the right skills, are in the right place at the right time (2013) A guide to nursing, midwifery and care staffing capacity and capability