Borders NHS Board

NURSING & MIDWIFERY WORKFORCE PLANNING

Aim

This paper provides an overview of the ongoing work being undertaken to ensure that the Nursing & Midwifery Workforce is being effectively planned and managed. It is also a further update to the Board on progress against the 2015/16 Nursing & Midwifery Workforce Planning Tools Implementation Plan and it shares the high level plan for 2016/17.

Background

Nurses and midwives are the largest occupational workforce group within NHS Borders, accounting for 43.84% of the total workforce. Working in specialty areas of adult nursing, midwifery, mental health, learning disabilities, community nursing and paediatrics, NHS Borders employs 1,168.2 whole time equivalent (WTE)[1]/1422 headcount (in-post) nursing and midwifery staff, across all grades, on substantive contracts i.e. excluding bank staff.

As the Board will recall from previous reports there are now twelve different tools in place for adult inpatient, maternity services, community care, specialist nurses, community and specialist nurses, mental health, neonatal, paediatric (SCAMPS™), small wards emergency departments, and professional judgement, which Boards are expected to take account of in planning the nursing workload. These tools consider patient numbers, acuity and actual workload. There are however a number of areas where there are no nationally recommended tools available, for example, out patients and other areas where tools are in development such as single roomed wards.

CEL 32 (2011)[2], which revised the Workforce Planning Guidance issued to Boards, required that Boards take account of the workforce planning tools in the development of workforce plans, specifically ensuring that the tools should be used as part of the triangulation approach incorporating professional judgement with quality measures[3]. In 2013-14, however, Scottish Government mandated both the use and process of utilisation[4], stating that:

"...these tools should form part of a triangulated approach to incorporate professional judgment and quality measures, which enable flexibility in decision making on staffing needs at a local level."

[1] Unless stated otherwise - workforce figures are as at 31st March 2016
[2] CEL 32 (20110 "Revised Workforce Planning Guidance Scottish Government, 19 December 2011 www.shed.scot.nhs.uk
[3] Ibid, Framework, step 3, p10
[4] Mackenzie F (2013) "Nursing & Midwifery Workload and Workforce Planning programme" Agenda paper 2.7, 28 June 2013

NHS Borders has been proactive in the use of the national tools; engaging in early national pilot runs of the Adult In-Patient tool since 2007. Since 2014-15 we have reported progress against the local plan twice per annum to the Board.

Nursing & Midwifery Workforce & Workload Planning Tools

Progress against 2015/16 Plan

Between September 2015 and end of March 2016 we planned to run tools in 15 clinical areas including 4 community hospitals. The plan excluded the application of Paediatrics, Neonatal and Maternity tools as these areas run workforce analysis on a more regular scheduled basis in line with national guidelines. We are reporting that we have completed 11 tool runs as planned.

Mental Health and Learning Disabilities Services are reviewing their workforce using an alternative approach as part of an improvement programme.

Theatres, Critical Care and Margaret Kerr Unit were not reviewed as planned as training needs were identified for staff, and further clarity was required around the most appropriate way to measure workload in these areas. A training event is being planned with the national team to progress these areas and tools will be run in the outstanding areas in line with the 2016/17 plan.

2016/17 Implementation Plan

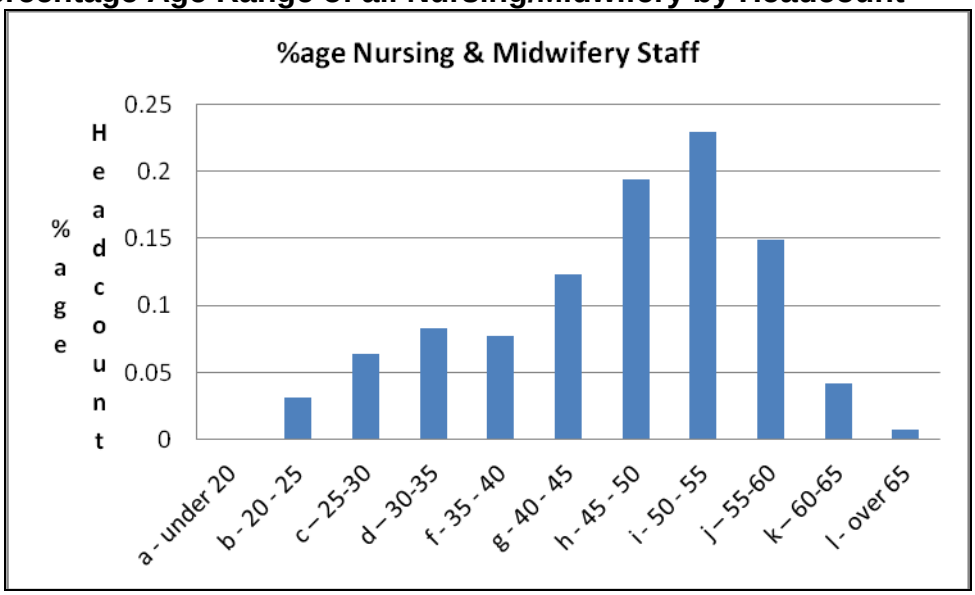
The plan for 2016/17 is to run 18 tools across NHS Borders. At the end of June 2016 4 out of 18 tools had been completed, with the remaining tools planned to be complete by March 2017.

NHS Borders Nursing Workforce Statistics

The nursing & midwifery workforce accounts for 1,168.2 whole time equivalent (WTE)[5]/1422 headcount (in post at 31 March 2016). 91% of the workforce (headcount) is female and only 10% are aged under 30 years, with 20% over age 55 and 43% over age 50. There are more than four times as many nurses over the age of 50 in our workforce (Figure 1), than under the age of 30. 52% of acute nurses work full time, whilst 48% are part-time.

1,168.2 whole time equivalent (WTE)[6]/1422 headcount (in-post)

Figure 1: Percentage Age Range of all Nursing/Midwifery by Headcount



As at 31 March 2016 there were 45.1 WTE vacancies being actively recruited to within the nursing workforce. This is higher than the 2015 (26.2 WTE) level. The level of vacancies is higher than the previous years due to a recruitment event within the period, and filling posts within the Community following a Workforce Review.

The annual turnover for nursing and midwifery is 7% which is slightly below the organisational average of 7.8%. Turnover for nursing and midwifery has increased slightly since last year, which was 6.8%.

NHS Borders is undertaking pre-emptive employment 15 months in advance in an attempt to mitigate some of the risk of potential retirals. We are also considering part time working and creative use of the nurse bank to support staff to work longer as they age.

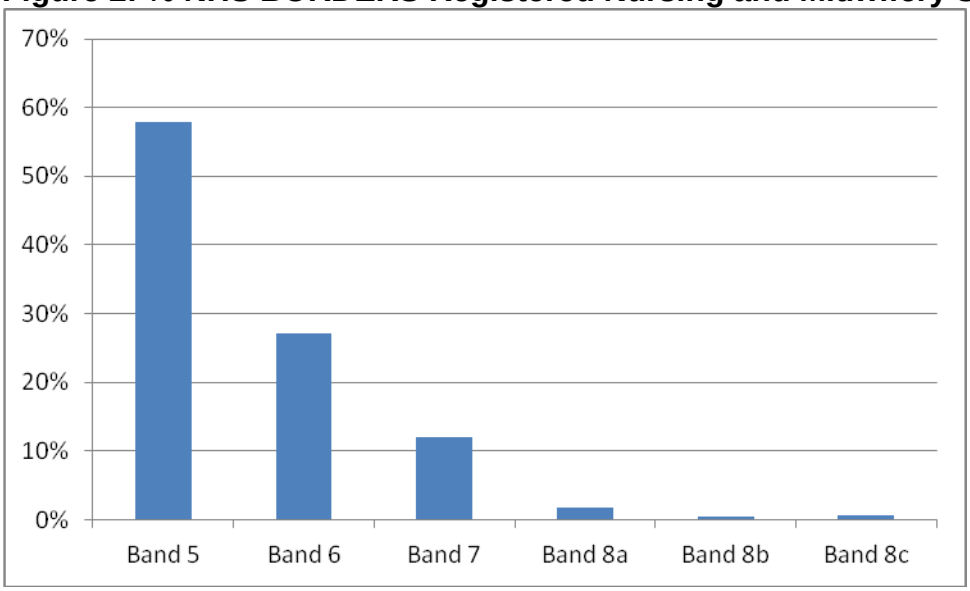
[5] Unless stated otherwise - workforce figures are as at 31st March 2016

Skill Mix Ratios

In 2010, the Royal College of Nursing (RCN)[7] recommended a skill mix of 65% registered to 35% unregistered nursing staff in acute general wards. The skill mix of registered to non-registered staff across the whole of Nursing & Midwifery is 74%:26% (in-post staffing). The skill mix varies across specialties to acknowledge patient complexity and acuity.

In addition to skill mix ratios between registered: non-registered staff, workforce planning also considers skill mix within the workforce. Registered nurses are graded on Agenda for Change (AfC) Bands 5 – 9. In NHS Borders our distribution is 57.99% band 5, 39.09% bands 6 and 7, 2.92% band 8a to 8c. There are no Band 9 Nursing & Midwifery posts (Figure 2). The distribution of bandings shown in Figure 2 is deemed appropriate when considering the skill mix in the NHS Borders registered workforce.

Figure 2: % NHS BORDERS Registered Nursing and Midwifery Staff by Band



Performance against Predictable Absence Allowance

Nursing budgets traditionally within NHS BORDERS have 21% included for predictable absence although there is a national recommendation to build in 22.5%. In NHS BORDERS the predictable absence allocated is: Annual Leave 15%; Sick Leave 4%; Study Leave 2%. Table 4 shows that we are exceeding this in NHS BORDERS.

Table 4: Performance Against Predictable Absence Allowance of 21%

Predictable Absence	NMWWP Tools
Annual leave	14.23%
Sick Leave	6.07%
Maternity leave	1.6%
Study Leave	n/a%
Other	0.46%
TOTAL	**22.36%**

In 2016/17 there will be increased focus on the management of sickness absence.

[7] Guidance on safe Staffing levels (RCN, 2010)

Efficient Rostering

An NHS Borders rostering policy for Nursing & Midwifery was developed and agreed in partnership and implemented in July 2013. This policy supports the principles of effective rostering but is not prescriptive in how rostering should be formulated. Local evidence suggested it was not being applied consistently.

In March 2016 a consistent approach was implemented to scrutinise rosters from 9 wards within the BGH. Throughout the last 3 months regular feedback meetings have been held with the relevant Clinical Nurse Managers (CNM's) and Senior Charger Nurses (SCN's) to implement improvements.

This process has resulted in changes in practice. For example Unscheduled Care has introduced a standard template roster, weekly roster meeting and an approval process for subsequent roster changes. Overall there has been a notable improvement and we continue to focus on providing the SCN's with support to implement the policy effectively.

In 2016/17 we will expand the roster scrutiny into the community hospitals in the coming months and devise a central data base which will be accessible to senior managers.

12 Hour Shifts

A recent literature review on the impact of 12 hour shifts on clinical practice identified that extended shifts or 12 hour working patterns were introduced to the nursing community as early as 1973 and gained prevalence in NHS BORDERS in 2010/11 following expressions of interest from nursing staff to implement.

To date the literature is inconclusive and schools of thought appear to be polarised into economic benefits (additional shifts per budget) and benefits for staff (wellbeing, time off, flexibility for family commitments) to concerns regarding performance in the later stages of the 12 hour shift (concentration, attention to task, irritability, fatigue and sleep deprivation following the shift and its impact on subsequent shifts).

Increasingly there is a body of literature indicating a stronger link with patient safety:

- The Institute of Medicine (2003)[8] indicate a link between longer shift lengths and increased medical errors, increased fatigue and sleep deprivation.
- The USA National Institute for Occupational Safety and Health[9](2004) found that between the 9th and 12th hour of a shift (irrespective of the profession/occupation) staff experience decreased alertness, increased fatigue, decreased cognitive function, decreased vigilance to tasks, increased injuries and that staff work at a slower pace than before.
- The time period of post 9 hours on shift was highlighted in another study[10] as an area of concern. After 9 hours they indicate that neurobehavioural functioning is impaired. Consequently there is a increase in needlestick injuries, increase in musculoskeletal problems and sleep issues between shifts.

[8] IOM(2003) To Err is human

[9] NIOSH (2004) Overtime & extended work shifts Recent findings on Illness, Injuries and health behaviours

[10] Lothshuetz-Montgomery K, Gieger-Brown J (2010) Is it time to pull the plug on 12 hour shifts. Journal of Nursing Administration vol 10 (4) p147 - 149

In NHS Borders the majority of wards have introduced extended shift patterns, with some still operating a mix of traditional shift patterns as well as 12 hour shifts.

In 2013 a local review of Datix incidents v time of day was inconclusive on the impact of long days.

Other Boards have recently reported concerns that 12 hour shifts have reduced staff flexibility and limited staff ability to take statutory breaks thus potentially compromising both patient safety and staff well-being. This experience is also being reported by SCNs locally and is evident in complaints around availability of staff to support patient meal times and drug administration.

Although the evidence is inconclusive, the clinical impact of 12 hour shifts is concerning and NHS BORDERS need to make an informed decision on the future of long shifts.

A short life task and finish group will be convened to review shift patterns in NHS Borders and will make recommendations on future use within the organisation.

Benchmarking

Benchmarking with other boards is challenging. National ISD data provides nursing staff by a range of categories but none correlate precisely with acute nursing or are broken down by specialty.

During 2016/17 we will work with comparable Boards to establish local benchmarking mechanisms.

Additional Supervisory time for Senior Charge Nurse/Midwife (SCN/M)

Following a pilot study undertaken in 2013/14 funding was agreed in 2015/16 to enhance the supervisory status of the Senior Charge Nurse/Midwife within acute inpatient settings. The purpose of this funding was to build on the existing time built into established staffing figures (7.5 hour management activity) to enable the SCN/M to act within a supervisory capacity over 37.5 hours in BGH and Community Hospitals.

In addition a General ward nursing dashboard was developed and implemented, the purpose of which is to support SCN/M's to focus on quality within their ward. The dashboard, which has been demonstrated at the NHS Board, draws data from the SPSP and Leading Better Care measures, Workforce & Finance measures, DATIX, and patient experience measures and is designed to allow the SCN/Midwife to focus on and target areas for improvement within their role during their enhanced supervisory time.

The Board will recall that when the SCN/M Supervisory status was pilot tested the SCN/Ms

- Overwhelming viewed the enhanced supervisory status as a positive change to their role.
- Were committed to working within an enhanced supervisory role and believed that this would enable them to lead positive changes to patient care and experience, improving staff development, supervision and improving team working.

To date not all SCN/Ms are regularly achieving the supervisory status, most often quoting short notice sickness absence and patient dependency as reasons.

Concern has been raised about a lack of clarity and role overload with many competing priorities. The Director of Nursing, Midwifery & Acute Services is hosting monthly Action Learning Sets to help provide direction and focus. In the first instance SCN/Ms are expected to have a daily conversation with patients/relatives/carers to ascertain "Have we done everything we can for you today." Data is being collated weekly and reported back to SCN/Ms on a monthly basis. Community Hospital SCNs are achieving sustainability in having these conversations.

At present it is too early to be able to identify quantifiable improvements correlated to the enhanced supervisory role of the SCN/M.

Recommendation

This paper has provided an overview of the ongoing work being undertaken to ensure that the Nursing & Midwifery Workforce is being effectively planned and managed. It has further updated the Board on progress against the 2015/16 Nursing & Midwifery Workforce Planning Tools Implementation Plan and it shares the high level plan for 2016/17. The Board is asked to **note** the report.

Policy/Strategy Implications	In line with CEL 32 (2011).
Consultation	Requirement from the Scottish Government.
Consultation with Professional Committees	As detailed above.
Risk Assessment	All risks are highlighted within the report.
Compliance with Board Policy requirements on Equality and Diversity	This is an update paper so a full impact assessment is not required.
Resource/Staffing Implications	As detailed above.

Approved by

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