

## ***Delivering Care: Nurse Staffing in Northern Ireland***

### ***Section 2: Using the Framework for general and specialist medical and surgical adult in-hospital care settings***

This Section sets out how the elements of the framework might be used practically by Ward Sisters, Charge Nurses, general and professional managers to facilitate constructive conversations around nurse staffing ranges for a medical and surgical care settings. It includes the following elements:

- Nurse staffing ranges for general and specialist medical and surgical adult care hospital settings
- Factors which influence the point within a staffing range which is appropriate for an individual service or care setting
- Guidance on 'How to Use' the framework.

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## **Preface**

A message from the Minister for Health and Public Safety

I am delighted to introduce, *Delivering Care: Nurse Staffing in Northern Ireland*. The document focuses on General and Specialist Medical and Surgical Adult In-hospital Care Settings and is the first in a series which will in time cover all care settings.

This document is a further step in the modernisation of Health Services within Northern Ireland and it is the first time we will measure the inputs of Nurse Staffing against the outputs of Key Performance Indicators of good quality care and patient experience.

Whether a commissioner or a provider of care, you must draw upon this policy document to assist you to understand the environment of care and how that environment demands the application of a particular range of nurse staffing.

The people of Northern Ireland are rightly demanding that they and their relatives are cared for by a workforce which has sufficient nurses, with the right skills, in the right place to ensure the delivery of a compassionate, person centred, safe and effective service which we can be proud of.

My goal has always been to have a world class nursing workforce able to provide world class care and I believe this document better prepares us to ensure that continues to happen.

Edwin Poots, MLA  
Minister for Health and Public Safety

## Foreword and Acknowledgements

I am pleased to introduce *Delivering Care: Nurse Staffing in Northern Ireland* approved by Edwin Poots, Minister for Health, as the agreed policy direction for formulating the nursing profile of a unit or area. In the Nursing and Midwifery Workforce Planning Project report<sup>1</sup> (SEHDa, 2004), professional judgement was identified as the foundation for nursing and midwifery workload and workforce planning. The approach is subjective and as other objective approaches become available they should be used in conjunction with the *Delivering Care* framework to provide further assurance that the right numbers of staff are available to deliver quality person centred care in Northern Ireland.

This document focuses particularly on medical and surgical units and is the first in a series which will expand to cover a range of major specialties across all programmes of care. As nurses we all have a duty to ensure staffing levels are appropriate and adequate, to provide a high standard of practice and care at all times under the responsibilities outlined within the code of the Nursing and Midwifery Council. This Framework is intended to support Ward Sisters/Charge Nurses, professional and general managers in presenting clearly the need for investment in nurse staffing, within changing service profiles, particularly in response to incremental service growth and in developing new services. Staffing can never be viewed in a vacuum and there is no one perfect tool to define what the staffing profile should be in any particular unit, so it is vital that a number of elements are taken account of such as, the activity within the unit, the requirement to support annual leave, statutory learning and professional regulatory activity, the mix of skill within the workforce, timely recruitment to vacant posts and other factors which might impact on workforce planning, such as the length of stay of patients and the environment. In addition to these elements there must also be an understanding of Key Performance Indicators (KPIs) such as the clinical indicators of good quality care and patient experience. This document should not be viewed in isolation and it will become part of a Nursing KPI Dashboard where the workforce will be one element viewed alongside Clinical Indicators and Patient Experience Indicators. I believe a triangulated approach looking not only at the inputs required to deliver Person Centred Care but also interrogating the outputs which are the quality indicators and the patient experience are essential to improving care within Northern Ireland.

*Delivering Care* sets out principles for commissioners and providers of Health and Social Care services for planning nursing workforce requirements. Securing sufficient numbers of staff with the appropriate skills and deploying them effectively is a highly complex challenge, and one that I recognise is all the more important as we move through one of the most difficult periods in the history of the Health and Social Care sector in Northern Ireland. The publication of this first piece, in a series of work on staffing ranges, is intended to promote a shared understanding between professional, management, finance and human resources colleagues of the essential components to set and review nurse staffing establishments when commissioning new services to ensure safe, effective, person centred care.

The timing of this framework coincides with the implementation of *Transforming Your Care*, the review of Health and Social Care in Northern Ireland, which sets out a range of proposals for the future of services in the region; concluding that there is an unassailable case for change and strategic reform. The Nursing and Midwifery

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<sup>1</sup> Scottish Executive Health Department (2004a) *Nursing and Midwifery Workload & Workforce Planning Project*. Edinburgh: SEHD.

workforce must be ready to meet the challenges of Transforming your Care and I believe this framework will assist in those preparations.

I would like to express my sincere thanks to the members of the Steering Group and Working Group who committed their time energy and expertise in the development of this framework document.

I would also like to thank all of the key stakeholders across the Health and Social Care system who took part in the various consultations and workshops during the development of the Framework. A particular word of thanks goes to the Northern Ireland Practice and Education Council for Nursing and Midwifery (NIPEC) for the significant project management, co-ordination, facilitation, and contribution to drafting of documents provided during the development of the framework.

Finally, I would like to thank Professor James Buchan, School of Health, Queen Margaret University, Edinburgh, for reviewing the documents and providing valuable feedback to support the final production and publication of Sections 1 and 2 of the Framework.

This document should now be shared with Health and Social Care Trust Boards and mechanisms established to ensure workforce planning processes are in place throughout Northern Ireland to support safe, effective, person centred care.

Chief Nursing Officer

## ***Delivering Care: Nurse Staffing in Northern Ireland.***

**The framework is made up of the following constituent elements:**

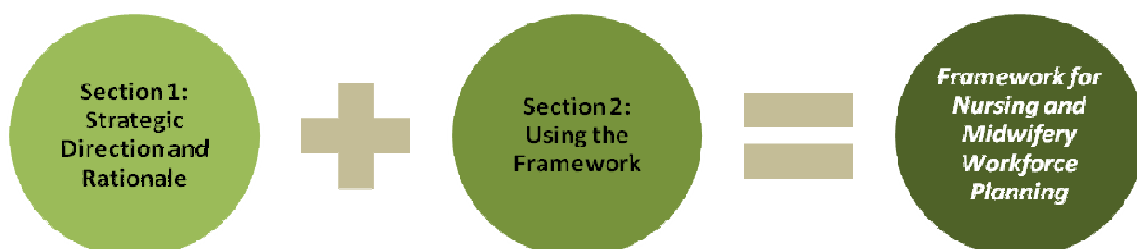


Assumptions of the Framework



Nurse Staffing Ranges

**And is made up of two complimentary documents:**



## GLOSSARY OF TERMS

Term	Meaning
Hospital Care	The utilisation of a hospital bed during an episode of in-patient treatment or care
Regional Services	Specialist services which are provided from one or two hospital sites for people throughout the region
Framework	This document describes a series of steps which incorporate a number of elements that impact on workforce planning such as nursing: bed ratios, Planned and Unplanned Absence Allowance and influencing factors which can be used to describe the optimum workforce required to support safe, effective, person centred care.
Ward	A group of hospital beds, with associated treatment facilities, managed as a single unit. A ward may function for the full 24 hour period in a 7 day week or within a variation of this pattern. This includes for example: day procedure units, elective surgical units, short stay wards.
Professional Regulatory Requirements	Activity within nursing and midwifery roles which is a professional regulatory requirement, but not necessarily an element of direct care provision. This includes: compliance with standards set by the regulatory body, supervision, and compliance with governance arrangements.
<b>Classification of Clinical Care Settings</b>	
Medicine	A general medicine care setting is defined as comprising: adult patients admitted for diagnosis, treatment and/or rehabilitation of medical conditions. This includes, for example: acute general medicine, general respiratory, cardiology, stroke, acute elderly medicine. This does not include, however, short-stay units for example: Medical Assessment Units.
Specialist Medicine	A specialist medicine care setting is defined as comprising: adult patients admitted for diagnosis, treatment and/or rehabilitation of medical conditions, where a higher degree of acuity is anticipated. This includes, for example: specialist respiratory medicine, neurology, coronary care, acute stroke/lysis (general stroke care may often be located within the general medical normative staffing range). This also includes short-stay units, for example, Medical Assessment Units.
Surgery	A general surgery care setting is defined as comprising: adult surgical patients admitted for elective or emergency surgery. This includes, for example: urology, gynaecology, breast and endocrine surgery, orthopaedic surgery, vascular and general surgery.
Specialist Surgery	A specialist surgery care setting is defined as comprising: adult surgical patients admitted for elective or emergency surgery where a higher degree of surgical acuity and/or progressive recovery is anticipated. This includes, for example: neurosurgery, plastics, cardiac and head and neck surgery.

## EXECUTIVE SUMMARY

*Delivering Care: Nurse Staffing in Northern Ireland* has been developed to support the strategic vision identified in *A Partnership for Care: Northern Ireland Strategy for Nursing and Midwifery 2010 - 2015*<sup>2</sup>. This framework will inform the Public Health Agency's duties detailed in the Health and Social Care Framework, the Department of Health Social Services and Public Safety Commissioning Directions and Health and Social Care Board Commissioning Plan.

The framework should inform Health and Social Care Trusts and Commissioners –

- › To promote a shared understanding between professional, management, finance and human resources colleagues of the essential components to set and review nurse staffing establishments and when commissioning new services to provide safe, effective, person centred care
- › To support general and professional managers in presenting clearly the need for investment in nurse staffing, within changing service profiles, particularly in response to incremental service growth
- › As a reference document when developing and agreeing the nurse staffing levels component within investment proposals.

The framework documents incorporate a range of sections that will address a variety of settings across hospital and community care. It should be noted that elements of Section 1 will have relevance to a number of settings and subsequent phases, such as Planned and Unplanned Absence Allowance, Influencing Factors and the requirement to triangulate workforce planning processes with quality information such as Key Performance Indicators (KPIs). In addition, it is anticipated that midwifery staffing levels will be reviewed by the Project Groups as part of the evolving Project Plan.

This framework is based on the best evidence available including a range of recognised workforce planning tools, and has been produced in consultation with a wide range of stakeholders including commissioners and service providers, nurse managers, front-line staff and personal and public involvement, professional and staff side organisations. A core element is the development of a staffing range. This approach has been taken in preference to the simple application of an absolute number or ratio, as individual ward staffing is influenced by a range of factors all of which must be considered.

The importance of this framework is underpinned by regional policy and strategy, evidence base related to staffing levels and patient outcomes, and evidence from public inquiries<sup>3</sup>.

The first phase of publication of the framework includes two sections relevant to nurse staffing levels in the first instance:

### **Section 1: Strategic Direction and Rationale**

This Section sets out the policy context and rationale for the work of the *Delivering Care* Project in Northern Ireland and includes the following elements:

- Background, context and strategic drivers for developing staffing ranges
- Assumptions of the framework
- Nurse Staffing ranges.

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<sup>2</sup> Department of Health Social Services and Public Safety. (2010). *A Partnership for Care: Northern Ireland Strategy for Nursing and Midwifery 2010 - 2015*. Belfast, DHSSPS.

<sup>3</sup> Please see pages 1 - 3 of this document.



The document is a brief summary of the elements of the framework, how they were agreed and how they might be applied in the context of the changing healthcare settings nurses work in currently.

## ***Section 2: Using the Framework for Medical and Surgical Care Settings***

This Section sets out how the elements of the framework might be used practically by Ward Sisters, Charge Nurses, general and professional managers to facilitate constructive conversations around nurse staffing ranges for a particular clinical setting. It includes the following elements:

- Nurse staffing ranges for general and specialist medical and surgical adult care hospital settings
- Factors which influence the point within a staffing range which is appropriate for an individual service or care setting
- Guidance on 'How to Use' the framework.

The products of the *Delivering Care* Project aim to provide all staff, but particularly nurses, both in front line practice, management and commissioning with a framework which will assist workforce planning processes and support constructive conversations about nurse staffing levels in Trusts.

It is anticipated that Health and Social Care Trusts will take account of the recommended staffing ranges contained in this document when developing:

- Proposals to meet the objectives within Transforming Your Care
- New proposals for additional resources to support service innovation and reform
- Developing efficiency and productivity plans for current services.

Over the last number of years changing patterns of service delivery, modernisation of care pathways, increased use of technology, increased patient acuity and higher throughput levels in wards have resulted in changes to staffing levels in Northern Ireland.

The outcome has been a combination of investment in new services and efficiencies in existing services. Executive Directors of Nursing have worked throughout this period of change to ensure staffing levels are maintained at a level that enables the provision of safe, effective person centred care.

This framework will provide a policy context to assist Trusts and commissioners to plan more effectively particularly during this time of transition. Commissioners will as a result, have a regional framework within which they can agree and set consistent ranges for nursing workforce requirements for Health and Social Care Trusts in Northern Ireland.

## SECTION TWO: USING THE FRAMEWORK FOR MEDICAL AND SURGICAL CARE SETTINGS

### 1.0 INTRODUCTION

- 1.1 This document is the second section of *Delivering Care: Nurse Staffing in Northern Ireland*. It is designed to assist all staff, but particularly nurses, both in front line practice, management and commissioning, in the process of nursing workforce planning.
- 1.2 This section contains the following elements of the framework:
- › Nurse staffing ranges for general and specialist medical and surgical adult care hospital settings
  - › Factors which influence the point within a staffing range which is appropriate for an individual service or care setting
  - › Guidance on 'How to Use' the framework.
- 1.3 For further information relating to the background, context and process of the work surrounding the development of the framework please refer to Section 1 of *Delivering Care*.

#### ***Range not Ratio?***

- 1.4 There are a number of questions which could arise in relation to the rationale for defining a range, rather than an absolute number or ratio<sup>4</sup>. This framework describes a range of nurse staffing which would normally be expected in specific specialities. It provides, therefore, a reasonable starting point for discussions about the appropriate staffing in a particular ward. **It does not** prescribe the staff numbers that should be on every ward and at every point in time, as this must be developed in discussion with staff, managers and commissioners and is dependent on a range of factors which influence planning processes. It is also important that planning processes will include the triangulation of findings from recognised workforce planning tools alongside Key Performance Indicators (KPIs) for safe, effective, person centred care.
- 1.5 It is anticipated that on occasion nurse staffing may be outside the normal range. In such cases the Executive Director of Nursing must provide assurances about the quality of nursing care to these patients, and the efficient use of resources through internal and external professional and other assurance frameworks, including KPI dashboards.
- 1.6 It is expected that HSC Trusts will take account of the recommended staffing ranges contained in this framework in developing proposals to meet the objectives within *Transforming Your Care*, in supporting new proposals for additional resources and when developing efficiency and productivity plans.
- 1.7 In addition, commissioners will be able to use the framework within which they can agree and set consistent ranges for nursing workforce requirements for providers of health and social care in Northern Ireland.

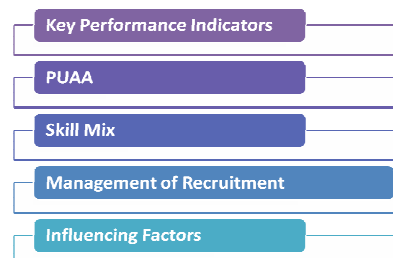
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<sup>4</sup> Buchan, J. (2005). A certain ratio? The policy implications of minimum staffing ratios in nursing. *Journal of Health Services Research and Policy*. 10, 4: 239 – 244. This article reviews the strengths and weaknesses of using an absolute defined ratio, concluding that there are potential inefficiencies if wrongly calibrated, coupled with relative inflexibility.

## ASSUMPTIONS OF THE FRAMEWORK

### 2.0 Introduction

- 2.1 The framework refers to staffing ranges expressed as nursing: bed ratios reflecting the view that the family of nursing comprises both registered and unregistered staff, included collectively within the ratios.
- 2.2 A number of underpinning assumptions must be considered when understanding how a range is set and might be used within the context of this framework. These assumptions are outlined below.



### ASSUMPTION 1: ASSURANCE OF SAFETY, QUALITY AND EXPERIENCE THROUGH KEY PERFORMANCE INDICATORS

- 2.3 The first assumption underpinning the use of the framework is the requirement to provide assurance across a number of quality outcomes for people receiving care and treatment through Key Performance Indicators (KPIs) which have been regionally agreed as sensitive to nursing care. The evidence base referred to at paragraph 2.3, page 2, of Section 1, supports the view that the use of nursing sensitive KPIs can demonstrate either effective workforce planning, or conversely, a need for review of a nursing workforce staff complement.
- 2.4 A regional Project Group in Northern Ireland has led the development of high level KPIs for nursing and midwifery to measure, monitor and evidence the impact and unique contribution the nursing has on the quality of patient and client care. There are three domains within which indicators have been presented for organisations to monitor: Organisational, Safe and Effective Care and Patient Experience. Many organisations in Northern Ireland are currently presenting some of this information via HSC Trust 'dashboard' systems, which allow data sets to be viewed collectively across all wards and departments. It is intended that as more indicators are agreed regionally, they will be added to the existing governance data systems in each Trust. Examples of the current indicators within each domain are:

**Organisational:** absence rates within nursing and midwifery teams; normative staffing ranges which will include vacancy rates.

**Safe and Effective Care:** incidence of pressure ulcers, falls, omitted or delayed medications.

**Patient Experience:** consistent delivery of nursing/midwifery care against identified need; involvement of the person receiving care in decisions made about their nursing care; time spent by nurses with the patient.

It is recognised that such quality information, which is being continuously monitored, will demonstrate the efficacy of staffing levels in a particular clinical area. Where the staffing complement meets the demand of the service being provided, quality indicators should demonstrate that safe, effective, person centred care is being delivered. Should quality indicators begin to fall below the accepted level of

achievement, staffing levels should be reviewed as one of the lines of enquiry of attributable causes.

### ASSUMPTION 2: PLANNED AND UNPLANNED ABSENCE ALLOWANCE

- 2.5 The ranges incorporate a Planned and Unplanned Absence Allowance of 24%. This allowance refers to periods of anticipated absence from work and should, therefore, be factored into the workforce planning process. This includes annual leave, sickness<sup>5</sup>, and mandatory study leave. This element is further defined in *Section 1* of the framework, page 6. It should be noted that the defined percentage will be subject to ongoing review and potential amendment by relevant professional forums, reflecting developments in training requirements and training delivery methods.

### ASSUMPTION 3: SKILL MIX

- 2.6 This term refers to the ratio of registered to unregistered nursing staff working within a complement of staff in an individual care setting. The level of skill mix required for any particular clinical setting may vary. The agreed skill mix for a particular clinical setting must be applied when using this framework. For example, in critical care settings a skill mix comprising mostly registered staff is required to facilitate safe and effective person centred care; this is due to the complexity and acuity of the patient profile of people cared for in such environments. Conversely, where there are high levels of dependency but a lower level of acuity<sup>6</sup>, a skill mix comprising a higher level of unregistered staff may be appropriate.
- 2.7 The Nursing and Midwifery Leaders in Northern Ireland have defined skill mix for an adult hospital-based general medical or surgical care setting as 70:30 registered:unregistered staff, based on best available evidence such as recognised workforce planning tools, related to this care setting. Some flexibility within the stated skill mix in any given area will be tolerated, to maximise the use of support staff, where higher levels of dependency and lower levels of acuity exist and there is evidence to demonstrate that safe, effective, person-centred care is being provided. The skill mix should not, however, fall below 65:35 registered:unregistered staff.
- 2.8 Skill mix should take account of an allocation of 100% of a Ward Sister's/Charge Nurse's time to *'fulfil their ward leadership responsibilities; supervise clinical care; oversee and maintain nursing care standards; teach clinical practice and procedures; be a role model for good professional practice and behaviours; oversee the ward environment and assume high visibility as nurse leader for the ward.'*<sup>78</sup>

An appropriate number of Agenda for Change Bands 6 – 7 within a ward setting is also required to have sufficient grade mix to ensure availability of a senior decision maker(s) – Band 6 or above – over the seven day week.

<sup>5</sup> 'Sickness' refers to both short and long term sick leave, with long term defined as 20 days or over and up to six months.

<sup>6</sup> For definitions of acuity and dependency please see Influencing Factors, *Delivering Care*, Section 2.

<sup>7</sup> Royal College of Nursing. (2009). *Breaking down barriers, driving up standards*. London, RCN. P 18.

<sup>8</sup> Francis, R. (2013). *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, Executive Summary*. London, TSO. Recommendation 195, p 106.

## ASSUMPTION 4: MANAGEMENT OF RECRUITMENT

- 2.9 It is recognised that due process of Human Resources policies and procedures requires a number of weeks to recruit staff. Notwithstanding this process, it is essential that nursing vacancies are filled within a prompt timescale to ensure staffing levels to support safe and effective, person centred care are maintained.
- 2.10 Employers must ensure that a risk-assessed approach is adopted to managing recruitment, taking into consideration the following elements:
- › Maintenance of staffing levels, which support the delivery of safe and effective, person centred care
  - › Avoidance of overuse of temporary staff, for example, bank and agency staff
  - › Matching of staff skill and band mix to patient acuity and dependency within approved guidelines<sup>9</sup>
  - › Timely and ongoing review of risk assessments linked to service reconfigurations.

## ASSUMPTION 5: INFLUENCING FACTORS

- 2.11 It is acknowledged that workforce planning for nursing staff is both complex and diverse<sup>10</sup>. The application of processes or approaches to gauge the number of individuals required with the right level of competence, to provide the appropriate level of care for a particular patient/client group, can be a challenge to those tasked with accurately defining workforce requirements. Triangulation<sup>11</sup> is required of a number of relational factors which impact on the workforce, for example: patient/client dependency, environmental factors, proximity to other services. The Steering Group of the Staffing Ranges Project has defined these factors within four domains:
- › Workforce
  - › Environment and Support
  - › Activity
  - › Professional Regulatory Requirements
- 2.12 It is important, therefore, that these factors are taken into consideration when workforce planning discussions take place, to adopt an appropriate ratio within the defined range for a medical or surgical setting. The tables contained at pages 7 - 13 outline the Influencing Factors within the four identified domains, including the following descriptions:
- › A definition of what the factor means in terms of using the framework
  - › An indication of how the factor impacts on staffing ranges, with related guidance
  - › A list of helpful resources in relation to the factors described.

<sup>9</sup> For information related to skill mix please see assumption 3, page 3.

<sup>10</sup> Ball, J. (2010). *Guidance on Safe Nurse Staffing Levels in the UK*. London, RCN. Page 6.

<sup>11</sup> *Ibid.*

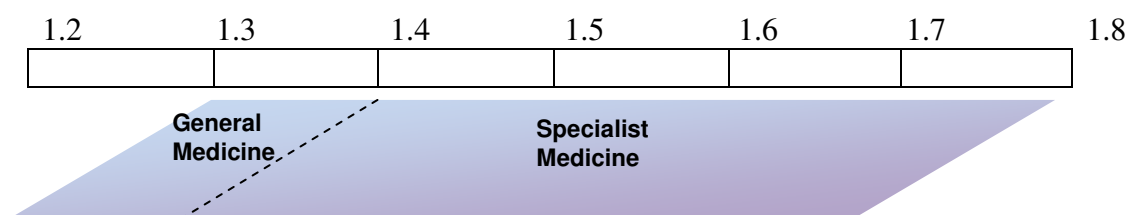
- 5.4 The Influencing Factors should be used to inform service providers, commissioners, and Ward Sisters/Charge Nurses to set or review the point at which a facility falls within the continuum of a nurse staffing range. The factors presented will be used to influence the point at which a facility falls within the continuum.
- 5.5 Two practical examples of how the Influencing Factors might be used to guide workforce planning are included in this document at pages 15 - 16 and 19 - 20 of this document.

**NURSE STAFFING RANGES**

**3.0 Nurse Staffing Ranges for General and Specialist Medicine and Surgery  
MEDICINE**

- 3.1 A **general medical care setting** is defined as comprising adult patients admitted for diagnosis, treatment and/or rehabilitation of medical conditions, including acute general medicine, general respiratory, cardiology, stroke, acute elderly medicine. This does not include, however, short-stay units for example: Medical Assessment Units.
- 3.2 A **specialist medical care setting** is defined as comprising: adult patients admitted for diagnosis, treatment and/or rehabilitation of medical conditions, where a higher degree of acuity is anticipated, including for example: specialist respiratory medicine, neurology, coronary care, acute stroke/lysis (general stroke care may often be located within the general medical normative staffing range). This also includes short-stay units, for example, Medical Assessment Units.
- 3.3 In some general ward areas, existing *in both medical and surgical settings*, a cohort of dedicated beds for specialist services may exist, for example: 8 specialist respiratory care beds within a 24-bed general respiratory ward. As models of care for general medicine move towards specialisms, the number of specialist beds may increase. Where this occurs, a number of calculations will need to be made on two or more cohorts of patients to determine an overall appropriate nursing/bed ratio.
- 3.4 **Figure 1**, below, pictorially represents the range for general and specialist medicine, the majority of general medical wards defined between 1.3 and 1.4, recognising that small number may fall below 1.3 to 1.2 and similarly, a small number existing at the higher end of the range at 1.4. The same representation exists for specialist medicine, fewer wards being defined at the top end of the range (1.8) and lower end of the range. The range stipulated includes an allowance of 24% for Planned and Unplanned Absence Allowance (please see page 6, *Delivering Care, Section 1*). For further information as to how the ranges were described and agreed, please go to page 19 of *Delivering Care, Section 1*.

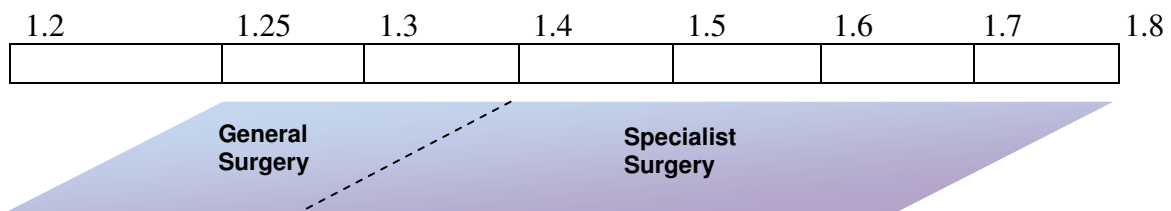
**Figure 1: Nurse Staffing Range for General and Specialist Medicine.**



## SURGERY

- 3.5 A **general surgical care setting** is defined as comprising adult surgical patients admitted for elective or emergency surgery, including for example: urology, gynaecology, breast and endocrine surgery, orthopaedic surgery, vascular and general surgery.
- 3.6 A **specialist surgical care setting** is defined as, comprising adult surgical patients admitted for elective or emergency surgery where a higher degree of surgical acuity and/or progressive recovery is anticipated, including for example: neurosurgery, plastics, cardiac and head and neck surgery.
- 3.7 **Figure 2**, below, pictorially represents the range for general and specialist surgery, the majority of general surgical wards defined between 1.25 and 1.4, recognising that a small number may fall below 1.25 and similarly, a small number existing at the higher end of the range at 1.4. The same representation exists for specialist surgery, fewer wards being defined at the top end of the range and lower end of the range. The range stipulated includes an allowance of 24% for Planned and Unplanned Absence Allowance (please see page 6, *Delivering Care, Section 1*). For further information as to how the ranges were described and agreed, please go to page 19 of *Delivering Care, Section 1*.

**Figure 2: Nurse Staffing Range for General and Specialist Surgery.**



- 3.8 Providing an example: The Ward Sister of a 24 bed medical ward has used a Telford Exercise, coupled with the use of influencing factors to determine that her ward should be staffed at 1.3 on the nursing: bed range.

This equates to:  $24 \times 1.3 = 31.2$  Whole Time Equivalentents (WTE) to provide safe, effective person centred nursing care.

Adding in the requirement for the 100% (1 WTE) allocation of Ward Sister time for supervision/ management responsibilities, this equates to a Funded Establishment of 32.2 WTE, in this example.

With a skill mix of 70:30 this allows for:

- 21.84 WTE registered staff ( $0.7 \times 31.2$ )
- 9.36 WTE unregistered staff ( $0.3 \times 31.2$ )
- 1.0 WTE Ward Sister.



## INFLUENCING FACTORS

### WORKFORCE

Term Used	What does this mean?	How does this impact on a Staffing Range?
Rostering and Shift Patterns	Rosters provide a structured process of matching available staff, and their skills, to the variations in workload to ensure patient safety. Within a roster system, the arrangement of start and finish times known as 'shifts', plus the sequence of working days available per staff members' contract over an agreed period of time, ensure that available numbers of staff are deployed to manage the workload demands.	<p>Optimal rostering of staff supports effective management of the staffing resource available to a manager to deliver on the workload demands of a ward or department.</p> <p>An imbalance in the numbers and skills of staff available to meet the care demands of patients can present greater risks to patient safety.</p> <p>Appropriate shift patterns are key factors in delivering safe and effective care, and maintaining staff morale.</p>
Planned and Unplanned Absence Allowance	Periods of absence from work, which are expected or unexpected and, therefore, factored into the workforce planning process. This includes sickness (both short and long term, with long term defined as 20 days or over and up to six months), study leave, as a minimum for mandatory training, non clinical working, e.g. management time.	<p>Planned and Unplanned Absence Allowance acknowledges that staff have particular requirements and rights that render them unavailable to be rostered.</p> <p>This allowance needs to be agreed and funded to ensure effective workforce planning and efficient deployment of staffing resources.</p>
Ward Sister's/ Charge Nurse's time	An agreed allocation of 100% of a Ward Sister's/Charge Nurse's time to fulfil their ward leadership responsibilities; supervise clinical care; oversee and maintain nursing care standards; teach clinical practice and procedures; be a role model for good professional practice and behaviours; oversee the ward environment and assume high visibility as nurse leader for the ward.	<p>The absence of an agreed allowance of time for Ward Sisters and Charge Nurses to address the management and supervisory responsibilities of their role can result in such essential responsibilities being neglected and failure to provide leadership at ward level.</p> <p>Currently, a ward sister/charge nurse manages a staffing complement in excess of 32 staff with associated appraisal, supervision, regulatory, human resource responsibilities and budgetary management including salaries and wages and goods and services.</p>
Skill mix	The percentage ratio of registered to unregistered nursing staff working within an individual care setting.	An inappropriate skill mix can result in a mismatch of duties and responsibilities to roles. This can present greater clinical risks to patients or, conversely, inefficient deployment of expensive staffing resources.



Management of Recruitment	<p>Due process of Human Resources policies and procedures requires a number of weeks to recruit staff. Notwithstanding this process, it is essential that nursing vacancies are filled within a prompt timescale to ensure staffing levels to support safe and effective, person centred care are maintained. Employers must ensure that a risk-assessed approach is adopted to managing recruitment, taking into consideration the following elements:</p> <ul style="list-style-type: none"> <li>› Maintenance of staffing levels, which support the delivery of safe and effective, person centred care</li> <li>› Avoidance of overuse of temporary staff, for example, bank and agency staff</li> <li>› Matching of staff skill and band mix to patient acuity and dependency within approved guidelines</li> <li>› Timely and ongoing review of risk assessments linked to service reconfigurations.</li> </ul>	Vacancy rates must continue to be carefully managed to avoid destabilising a department or team and increasing the risk to patient care through inappropriate staffing levels and skills.
Management of absenteeism/sickness	The management process through which periods of sickness/absence are managed for all employees, with the aim of maintaining the lowest level achievable.	Effective approaches to the management of periods of staff absence support the continuity of services, provision of safe and effective person centred care, patient safety and good staff morale.
Competence skill set to work flexibly	The level to which the workforce has developed a knowledge base and transferable skill set to enable practice within a particular care setting and be capable of addressing a broad range of demands.	The absence of a core set of transferable skills can limit the capacity of staff to meet a broad range of demands in a given department. To ensure that the essential clinical skills are developed within a team demands careful identification of learning needs and development opportunities for all staff.

### Helpful Resources:

The HSC Trust Roster Policy should provide information on appropriate rostering practice.

Planned and Unplanned Absence Allowance Guidance at page 6 of *Delivering Care: Section 1*.

RCN Publication: *Making the business case for ward sisters/ team leaders to be supervisory to practice*:

[http://www.rcn.org.uk/data/assets/pdf\\_file/0005/414536/004188.pdf](http://www.rcn.org.uk/data/assets/pdf_file/0005/414536/004188.pdf)

Royal College of Nursing. (2009). *Breaking down barriers, driving up standards*. London, RCN.

[http://www.rcn.org.uk/data/assets/pdf\\_file/0009/287784/003312.pdf](http://www.rcn.org.uk/data/assets/pdf_file/0009/287784/003312.pdf)

## ACTIVITY

Term Used	What does this mean?	Impact?
Ward Attendees	Persons who attend a clinical setting for a planned or unplanned visit to seek advice, review or treatment e.g. wound review following surgery.	Ward attendees must be captured as a workload indicator at all times. Incremental growth in ward attendances can place increasing demands on ward nursing teams, without appropriate increases in staffing levels to manage same, and could potentially become an unfunded service development if not appropriately managed.
% Bed Occupancy	<p>A measurement of the percentage of time that beds are occupied, measured at midnight. Day cases and ward attendees are excluded from the calculation.</p> <p><b>Average Daily Occupied Beds</b>            ----- x 100  <b>Average Daily Available Beds</b></p>	<p>Capturing bed occupancy at 12.00 midnight only can result in substantial activity and workload being omitted. Comparing bed occupancy at 12.00 midday and 12.00 midnight can provide valuable management information.</p> <p>The Government's Emergency Services Action Team (ESAT) report in 1997 included analyses showing that in acute hospitals, average bed occupancy rates over 85% are associated with rapidly growing problems in handling emergency admissions<sup>12</sup>.</p>
Throughput	<p>Is the average number of patients per bed during a calendar month. This can include deaths, discharges and transfers to other wards. Day Cases and ward attendees are excluded from the calculation.</p> <p><b>Total Inpatients</b>            -----  <b>Average Number of Available Beds</b></p>	<p>With managed shorter lengths of stay in many hospital beds, throughput is an important workload indicator in the service. In settings where the admissions rate is high e.g. Acute Medical Admissions Units have a high, volume of people being admitted to the care setting, therefore, a high throughput, there is a requirement for higher numbers of staff to support the ongoing care needs.</p>
Patient Dependency/ Acuity	An assessment of the care demands of each patient, incorporating physical and psychosocial needs, using a validated and credible tool.	Appropriate workload measurement tools can lead to appropriate staffing levels for wards and departments, thus supporting safe and effective care.
Length of Stay	<p>A measurement of the average length of time spent in hospital. Day Cases and ward attendees are excluded from the calculation.</p> <p><b>Average Daily Number of Occupied Beds x Days in Year</b>            -----  <b>Total Inpatients</b></p>	<p>The trend in Health and Social Care services has been towards shorter lengths of stay.</p> <p>This also results in more complex discharge processes, as people are provided with ongoing treatment and care in the community setting. These factors ultimately contribute to an increase in the throughput and a resultant increase in the workload demand for staff.</p>

Seasonal Variations	Patients commonly present with a range of conditions and chronic illnesses which may be dependent on the time of the year, or become exacerbated at certain times of the year. This provides a particular case mix of conditions and/or increased volume of admissions which may require more intensive nursing input due to the critical nature of the care required.	Seasonal variations are likely to present a greater workload burden on nursing staff. It is important that increased workload demands are supported by appropriate staffing levels.
Specialities/ Case Mix	The range and variation of patients' health conditions managed in a particular clinical setting	A broader range of specialties and case mix being managed in a care setting presents a greater demand on the nursing team in terms of knowledge, skills and complexity.
Number of Beds	The actual number of beds in a clinical setting.	The number of beds and design of a ward environment can have an impact on the efficiency of a ward or department. There would appear to be an optimal number of beds per ward to maximise efficiencies.
Assessment of Risk	Nurses must assess and manage risk within a clinical environment to ensure the delivery of safe and effective, person-centred care <sup>13</sup> . This includes, risk to people in their care, members of staff and other members of the public.	By adopting an anticipatory approach nurses can proactively support the minimisation of risk and provide a quality service that meets patient/client needs. Opportunities to act on lessons learned and drive improvements in the quality and safety of services ensure that practice is informed and improved. Time is required from the nursing team for this activity to carry out ongoing risk assessments for people within their care environments.
Incremental Service Improvements / Development	This is activity concerned with testing ideas, sustaining and sharing best practice to make a tangible difference in outcomes and experience for staff and service users. (Department of Health, 2008) <sup>14</sup> .	Incremental service improvements are designed to implement improvements in patient care and/or outcomes. This can result in improved working conditions for staff. Alternatively, unrelenting service improvements can also have a disruptive impact on individuals and contribute to low staff morale.

<sup>12</sup> Department of Health (2000). *Shaping the Future NHS: Long Term Planning for Hospitals and Related Services*. London, DoH.

<sup>13</sup> Department of Health Social Services and Public Safety. (2008). *A Partnership for Care: Northern Ireland Strategy for Nursing and Midwifery 2010 - 2015*. Belfast, DHSSPS.

<sup>14</sup> Department of Health (2008). *Making the difference: The Pacesetters beginner's guide to service improvement for equality and diversity in the NHS*. London, DoH.

## ENVIRONMENT AND SUPPORT

Term Used	What does this mean?	Impact?
Technological and Equipment Support	The support provided within a clinical area by Information Technology and other mechanised systems and sufficient equipment maintained and stored appropriately which may assist registrants in caring for people.	Access to available software which links to a range of data systems can enable efficient transfer of information, which assists at many stages of the patient care pathway. Efficient systems may reduce workload requirement and conversely, inefficient systems may add to the workload e.g. staff spending time sourcing equipment.
Geographical Layout/ Room Structure	The arrangement of the physical clinical environment, including whether or not there are single roomed facilities. The physical arrangement of a clinical setting has an impact on workforce planning, in that it may require greater numbers of staff where there are areas of poor visibility or require staff to work in discrete teams.	A well designed/engineered layout for a clinical environment, with optimal employment of relevant technologies, can support enhanced observation of patients and consequently decrease risks to patients/clients, thus reduce the impact upon staffing requirements.  Where single rooms restrict visibility and therefore compromise clinical and care observations this will have an impact on staffing levels in wards.
Ward Size	The 'average' 24-bedded <sup>15</sup> clinical area can be constructed of 24 beds, configured within a mixture of multiple bed areas and/or single rooms.	In clinical settings where the bed complement is substantially smaller, nursing: bed ratios will be significantly higher to support the provision of safe and effective care on a 24 hour basis. Similarly, where a ward is significantly larger than 24 beds, there will be a requirement for appropriate levels of senior staff to support the provision of safe and effective care on a 24 hour basis.
Departmental Adjacencies in relation to Areas for Patient Transfer	The physical distance required to be covered when escorting patients to and from other service areas, e.g. radiology, theatre(s). Where there is likely to be a significant number of patients requiring a nurse escort*, the workforce planning impact needs to be taken into account in determining staffing levels to support safe, effective person centred care.	Nursing staff may be required to escort patients to diagnostic testing/theatre, thus removing the member of staff from the team and the team ability to share the workload.
Supportive Staff Infrastructure	The support provided within a clinical area by other members of staff, who are not registrants or within the family of nursing e.g. administration or housekeeping staff.	There are a range of tasks which can be completed by individuals who are not identified as working within the family of nursing e.g. administrative staff, housekeeping staff.

\***Escorting** refers to the professional role of attending to a patient when in transit from one care environment to another (i.e. the patient requires care).

<sup>15</sup> Ball, J. (2010). *Guidance on Safe Nurse Staffing Levels in the UK*. London, RCN. Page 24. The 'average' NHS ward has 24 beds.

## PROFESSIONAL REGULATORY ACTIVITY

Term Used	What does this mean?	Impact?
Indirect care	This is activity which is linked with care delivery but is not a direct element of the process of care delivery, e.g. multi-professional case meetings.	The level of this activity and requirements for delivery of such can impact on the workload of nursing teams. This requires definition as to what elements are present within the nursing workload and how much time is expended on them.
Compliance with professional regulatory standards	This is activity concerned with ensuring that professional standards issued by the NMC are embedded and maintained within a clinical environment, such as those for learning and assessment in practice/mentorship. This may include ongoing monitoring of these standards.	High ward activity levels without adequate staffing can negatively impact upon the ability of nurses to comply with regulatory standards.
Supervision	This is a process of professional support and learning, undertaken through a range of activities, which enables individual registrant nurses to develop knowledge and competence, assume responsibility for their own practice and enhance service-user protection, quality and safety. (NIPEC, 2007)	An element of the time required to train nurses and those within the family of nursing is included in the Planned and Unplanned Absence Allowance of 24%.
Accountability and governance requirements	<p>The impact of nurse staffing levels on the quality and safety of patient care is well documented. The Executive Director of Nursing is accountable for ensuring that nurse staffing levels are sufficient to deliver safe, effective, high standards of nursing care to all who use services. Governance has been defined as ‘systems, processes and behaviours by which Trusts lead, direct and control their functions in order to achieve organisational objectives, safety and quality of services and in which they relate to patients and carers, the wider community, and partner organisations’ (DoH Integrated Governance Handbook 2006). Accountability embodies three key attributes:</p> <ul style="list-style-type: none"> <li>• recognisably high standards of care</li> <li>• transparent responsibility and accountability for those standards</li> <li>• a constant dynamic of improvement.</li> </ul>	<p>In order to provide safe, effective, person centred care, appropriate staffing levels are required to impact positively upon the professions’ ability to deliver effectively to governance requirements indicated through good performance in Key Performance Indicators.</p> <p>This type of activity can include collecting information about the standard of practice and care through, for example, audit, complaint review and benchmarking practice against an evidence base. Following such activity, action plans are required to enable development of practice or service improvement work to ensure the ongoing delivery of safe, effective, person-centred care. All of this activity requires the time of the team to engage effectively and facilitate ongoing accountability, governance reporting arrangements and improvement of care.</p>

## References and Helpful Resources:

Department of Health (2006). *Integrated Governance Handbook: A handbook for executives and non-executives in healthcare organisations*. Available for download at:

[http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/@dh/@en/documents/digitalasset/dh\\_4129615.pdf](http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4129615.pdf)

Chief Nursing Officer for Northern Ireland (2007). *Standards for Supervision for Nursing*. Belfast, DHSSPS.

Northern Ireland Practice and Education Council (2007). *The Review of Clinical Supervision for Nursing in the HPSS 2006 on behalf of the DHSSPS*. Belfast, NIPEC.

Department of Health Social Services and Public Safety. (2011). *Framework Document*. Available for download at:

[http://www.dhsspsni.gov.uk/framework\\_document\\_september\\_2011.pdf](http://www.dhsspsni.gov.uk/framework_document_september_2011.pdf)

<http://www.nmc-uk.org/Publications/Standards/>

## 6.0 HOW TO USE THIS FRAMEWORK

- 6.1 This framework has been designed to promote a shared understanding of workforce planning principles associated with nurse staffing levels to provide safe effective, person centred care. As Trusts reform and modernise their services, the nurse staffing ranges and planned and unplanned absence allowance outlined in this document must be taken into account prior to releasing funding from nurse staffing for efficiency/productivity savings.
- 6.2 Use of the framework will inform both HSC Trusts and the Commissioner for a range of purposes, some of which are presented below:

### ***HSC Trusts***

- To promote a shared understanding between professional, management, finance and human resources colleagues of the essential components to set and review nurse staffing establishments, and when commissioning new services, to provide safe, effective, person centred care.
- › To support general and professional managers in presenting clearly the need for investment in nurse staffing, within changing service profiles, particularly in response to incremental service growth.
- › As a reference document when developing and agreeing the nurse staffing levels component within investment proposals.

### ***Commissioner***

- To promote a shared understanding between professional, management, finance and human resources colleagues of the essential components to set and review nurse staffing proposals for commissioning general and specialist services to provide safe, effective, person centred care.
  - As a reference document when developing and agreeing the nurse staffing levels component within investment proposals.
- 6.3 Commissioners will as a result have a regional framework in which they can agree and set consistent ranges for nursing workforce requirements for HSC Trusts in Northern Ireland.
- 6.4 Pages 15 - 20 contain a number of practical examples illustrating how to use the Framework to assist nursing workforce planning processes. There is also a worked example of a 'Telford Exercise' at page 17, using the Telford model of nursing workforce planning, which remains the extant nurse workforce planning tool in use in Northern Ireland and the United Kingdom<sup>16</sup>.

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<sup>16</sup> Telford, W.A. (1979). *A Method of Determining Nursing Establishments*. Birmingham, East Birmingham Health District.

## Scenario No. 1

### Preparing for a Discussion

A Ward Sister has been in post for 4 years in an acute adult in-hospital medical care setting in Northern Ireland Health and Social Care Trust (NIHSCT). During this time, the acuity and dependency of the patients her team cares for had increased, along with increased bed occupancy and decreased length of stay. The number of part-time staff within her team complement has also increased significantly.

Sister decides to use *Delivering Care* to have an informed, evidence-based discussion with her Line Manager, about the nurse staffing requirement for her ward to support the provision of safe and effective person centred care.

Steps for discussion:

1. This ward is an acute adult in-hospital medical care setting. Using the Staffing Range for medicine, the lower end of the ratios is 1.3.
2. Sister undertakes a 'Telford' exercise (please see page 17) using her own professional judgement and information from the day-to-day running of the ward, identifying when staff are required to manage optimally the service provided.
3. Sister then looks at the Influencing Factors, pages 7 - 13. Through reading the information, she realises that:
  - it would be helpful to have in place an e-rostering system to assist with the optimum management of the staffing resource
  - the sickness absence rate in the ward she manages is currently 6.5% excluding maternity leave.
4. In order to prepare for the discussion with her line manager, Sister contacts a colleague who contacted her recently to raise awareness regarding the implementation of the e-rostering system within NIHSCT. She is informed that her ward will be included in year two of implementation. She also has a discussion with colleagues within Human Resources and Occupational Health departments to identify if there are any further steps she might take to best manage the sickness absence rate in her ward team.
5. Having identified these areas for action, Sister has several other issues for discussion with her line manager arising from the Influencing Factors:
  - a review of the skill mix within the ward is required as currently it is 68:32 and not the recommended 70:30 registered: unregistered staff
  - the significant increase in part-time staff has a particular relevance in relation to training, as each member of staff, whether full or part-time, requires the same amount of training as regards mandatory and statutory requirements
  - shorter lengths of stay have increased the workload for nursing staff, particularly in relation to complex discharge planning
  - verbal feedback from her team within the last six months has indicated that staff are having difficulty on occasions in finding time to mentor pre-registration nursing students and in meeting the mandatory supervision requirements of two supervision sessions per nurse per year.



### **Meeting with Ward Sister and Line Manager.**

Sister begins the meeting with her Line Manager by talking about the action she has taken in relation to the e-rostering system and enhanced management of sickness/absence rates in her ward as a starting point when considering the staffing complement. Having discussed these issues, the Line Manager identifies a number of other approaches which might help Sister to review the processes within the ward she manages, such as the Productive Ward<sup>17</sup>, or Lean Thinking<sup>18</sup>. Sister agrees that further work could be done within the ward team, in relation to streamlining some of the processes.

She outlines that the ward, being an acute adult in-hospital medical care setting, starts at a ratio of 1.3, using the staffing range for medicine within *Delivering Care Section 2*. The 'Telford' exercise indicated that the complement of staff required was within the lower end of the range; the skill mix required, however, was 70:30, higher than what was currently included in Sister's Funded Establishment (FE). She also identifies that the significant increase in part time staff has a particular relevance in relation to training, as each member of staff, whether full or part-time, requires the same amount of training as regards mandatory and statutory requirements.

She also discusses that shorter lengths of patient stay have increased the workload for nursing staff, particularly in relation to complex discharge planning, and verbal feedback from her team within the last six months has indicated that staff are having difficulty on occasions in finding time to mentor pre-registration nursing students and in meeting the mandatory supervision requirements of two supervision sessions per nurse per year.

Sister and her Line Manager consult with the Assistant Director for Nursing and Midwifery Workforce within the Trust, to reach an agreement that the point within the range at which the FE currently falls: 1.3 is appropriate; there is, however, a question in relation to the skill mix of the FE. There are currently 24 beds in the ward.

This equates to  $1.3 \times 24 = 31.2$  WTE

Using the skill mix of 70:30 registered:unregistered staff, this is calculated as:

$31.2 \times 0.7 = 21.84$  registered

$31.2 \times 0.3 = 9.36$  unregistered

Sister currently has 21.2 registered staff and 10.2 unregistered staff members as part of her team.

She agrees with her Line Manager and Assistant Director of Nursing and Midwifery Workforce that an additional 0.64 WTE registered staff should be added to her staff complement and 0.84 WTE unregistered staff be redeployed to another ward area to provide safe, effective, person centred care.

Factoring in additional time for the Ward Sister leadership/supervisory role at the agreed set level of 100 % WTE of a Band 7; this brings the total funded establishment to be calculated at 32.2 WTE.

<sup>17</sup> The Productive Ward focuses on improving ward processes and environment to help nurses and therapists spend more time on patient care, thereby improving patient safety and efficiency. For further information, please go to: [http://www.institute.nhs.uk/quality\\_and\\_value/productivity\\_series/productive\\_ward.html](http://www.institute.nhs.uk/quality_and_value/productivity_series/productive_ward.html)

<sup>18</sup> Lean thinking is an approach which is about getting the right things to the right place, at the right time, in the right quantities, whilst minimising waste and being flexible and open to change. For further information, please go to: [http://www.institute.nhs.uk/quality\\_and\\_value/lean\\_thinking/lean\\_thinking.html](http://www.institute.nhs.uk/quality_and_value/lean_thinking/lean_thinking.html)

## Example Outline of a 'Telford' Exercise

Please note: the 'Telford' exercise outlined within these pages demonstrates the use of one workforce planning tool which involves a degree of professional judgement. A number of workforce planning tools exist, which use a range of different approaches to the activity, some of which have been referred to in *Delivering Care, Section 1*.

1. Define the length of the shift patterns over a 25 hour period, which includes one hour in total for handover (two half hour periods). For example: that the morning shift is 5 hours long, afternoon shift is 5 hours long, evening shift is 4 hours and night shift 11 hours. These hours are recorded in column **B** in **Table 1**, page 18.
2. Identify the number of registered and unregistered staff required for each shift based on professional judgement; regarding appropriate numbers to provide safe, effective, person centred care.
3. Add up the number of staff for each band to reach a total for the week for each shift – see column **A**.
4. Calculate the number of hours required for each staff group by multiplying columns **A** and **B** to reach the answer located in column **C**.
5. Add all the hours up in column C to provide a total number of staff hours. Multiply this number by 1.24 to add the required 24% Planned and Unplanned Absence Allowance.
6. Divide this number by 37.5 to reach the number of Whole Time Equivalent (WTE) required to staff the ward.
7. You will see from the three columns to the far right of Table 1, it is also possible to calculate numbers by band and therefore calculate skill mix using the same method of:

$$\text{Sub-total of hours} \times 1.24 / 37.5 = \text{Number of WTEs}$$

8. This example provides a total of 31.51 WTEs of all bands. This includes 22.25 of registered staff and 9.26 of unregistered staff. To calculate the skill mix:

Total number of registered staff

Total number of staff

$$= 70.6\%$$

Total number of unregistered staff

Total number of staff

$$= 29.4\%$$

9. Finally, to calculate the nursing to bed ratio, divide the total staff complement by the number of beds:

31.51

24

$$= 1.31 \text{ nursing: bed ratio}$$

10. It should be noted that these calculations do not include the allocated 100% of a Ward Sister's/Charge Nurse's time to fulfil his/her leadership/supervisory role within the care setting. Adding this allocated time brings the Funded Establishment to 32.51

**Table 1**

	Mon	Tues	Wed	Thu	Fri	Sat	Sun	Total for week	hours per shift		Weekly hours per shift per level			
	A								B		C			
<b>Morning</b>											Registered	Band 3	Band 2	
Registered	5	5	5	5	5	4	4	34	5	165.00	165.00			
Band 3	1	1	1	1	1	1	1	7	5	35.00		35.00		
Band 2	2	2	2	2	2	1	1	12	5	60.00			60.00	
<b>Afternoon</b>														
Registered	5	5	5	5	5	4	4	33	5	165.00	165.00			
Band 3	1	1	1	1	1	1	1	7	5	35.00		35.00		
Band 2	1	1	2	2	1	1	1	10	5	45.00			45.00	
<b>Evening</b>														
Registered	4	4	4	4	4	4	4	28	4	112.00	112.00			
Band 3	0	0	0	0	0	0	0	0	4	0.00		0.00		
Band 2	1	1	1	1	1	1	1	7	4	28.00			28.00	
<b>Night Duty</b>														
Registered	3	3	3	3	3	3	3	21	11	231.00	231.00			
Band 3								0	11	0.00		0.00		
Band 2	1	1	1	1	1	1	1	7	11	77.00			77.00	
										Sub total	953.00	673.00	70.00	210.00
										add 24%	228.72	161.52	16.80	50.40
										Total	1194.12	834.52	86.80	260.40
										WTE	31.51	22.25	2.31	6.94
										<b>Total WTE</b>	<b>31.51</b>	<b>22.25</b>		<b>9.25</b>
										<b>Nursing To Bed Ratio</b>	<b>1.31</b>			
										<b>Total Beds</b>	<b>24</b>			
Totals										<b>Skill Mix %</b>		<b>70.62</b>		<b>29.38</b>

## Scenario 2

### **Preparing for a Discussion**

The Assistant Director (AD) for Acute Services, Northern Ireland Health and Social Care Trust (NIHSCT), has been informed that one of the wards within his service group, an acute adult in-hospital general surgical care setting, will be closing 2 beds in the next financial year due to some of the surgical interventions previously carried out as in-patient procedures now being undertaken as day surgery admissions. In addition, two beds currently used for patients returning from surgery and staffed outside of the upper limits of the specialist end of the staffing ranges, are being stepped down to general surgical beds. The care of those patients will be moving to a newly configured unit located elsewhere in the Trust. The AD is aware that this will have an effect on the staffing complement within this ward and decides to use *Delivering Care Part 1* to have an informed, evidence-based discussion with the Lead Nurse for surgery and the Charge Nurse responsible for the ward.

Steps for discussion:

1. The Charge Nurse's ward is an acute adult in-hospital general surgical care setting. There are currently 26 beds, the staffing ratio currently set at 1.25 for 24 of the beds and 2.5 for two of the beds. The Funded Establishment (FE) in his clinical setting is 36.2 Whole Time Equivalents (WTE) with a skill mix of 70:30, registered:unregistered staff.
2. Using the staffing range for surgery, the lower end of the ratios is 1.25. It is likely that this will be applied to all 24 beds, following the service redesign and reconfiguration of bed usage.
3. The AD calculates that this would provide a FE of 30 WTE. Whilst reading through the framework document, he notes that there are a number of areas which need to be considered during the meeting with the Lead Nurse for surgery and the Charge Nurse. He raises the potential use of the framework to guide discussions with the Lead Nurse, and encourages her to have a conversation with the Charge Nurse to think about areas of preparation in advance of the meeting. He also contacts the NIHSCT Nursing and Midwifery workforce lead, to explore possibilities for reconfiguration of the ward team staffing complement using the Delivering Care Framework. Following that discussion, he asks the Workforce Lead to attend the meeting with the Lead Nurse for surgery and Charge Nurse.
4. The Lead Nurse for surgery and Charge Nurse discuss the framework document in order to prepare for the meeting. The Charge Nurse subsequently agrees to carry out a 'Telford' exercise (please see page 17) to estimate the likely need for staff at particular times of the week when the service in his ward area becomes particularly busy.
5. They also consider the Influencing Factors, pages 7 - 13. Through reading the information, they realise that:
  - 3 recently registered staff have joined the team in the last month; they need development of their skill set in relation to the type of service being provided in the ward, and a period of preceptorship
  - Over the last two years, the length of stay of patients in the ward has been decreasing and the throughput increasing
  - The geographical layout of the ward has always presented a difficulty for

- Staff have reported that Key Performance Indicator (KPI) scores collected for nursing and midwifery organisationally have recently fallen compared with previous scores across three out of the five measurements within AHSC Trust. Staff have also reported that there is difficulty in getting time to conduct audits for KPI measurement.

**Meeting with Assistant Director for Acute Services NIHSCT, Assistant Director Nursing and Midwifery Workforce NIHSCT, Lead Nurse for surgery and Charge Nurse.**

The AD begins the meeting by offering an opportunity to the Lead Nurse for surgery and Charge Nurse to present their thinking in relation to identified areas for discussion from *Delivering Care Part 1*. In terms of the geographical layout of the ward, Charge Nurse has identified a need to review the storage systems. The Lead Nurse has offered the opportunity to work with him to implement the Productive Ward<sup>19</sup>, which has successfully helped other areas review ward-based systems and increase efficiency for the ward team.

Charge Nurse outlines the results of the 'Telford' exercise, which indicated that the complement of staff required was within the lower end of the range for general surgery. He acknowledges that the skill mix at which the ward operates is 70:30. The Lead Nurse and Charge Nurse discuss the impact of the decreased length of stay and increased throughput, coupled with a registered staff complement that has a proportion of recently registered staff, who are still within the requirements for induction and preceptorship. The impact of this increased workload on staff is demonstrated through the evidence provided in the falling KPI scores and anecdotal evidence that staff are finding it difficult to find time to collect audit information.

After much debate during the meeting, it is agreed to review the 'Telford' exercise, providing additional staff numbers at busy times in the working week to allow for the extra workload identified. It is agreed that this should be reviewed again in 6 months' time, during which staff will have been provided with some of the required development to build confidence/new competence to provide the service, thus reducing the requirement for extra staffing. When the 'Telford' exercise is repeated, the range is calculated at 1.3. It is also agreed that Charge Nurse will retain the existing Band 6 staff team members, who will not be redeployed in the first instance, to support the development of the ward team.

This equates to  $1.3 \times 24 = 31.2$  WTE

Using the skill mix of 70:30 registered:unregistered staff, this is calculated as:

$31.2 \times 0.7 = 21.84$  registered

$31.2 \times 0.3 = 9.36$  unregistered

Charge Nurse currently has 24.5 registered staff and 10.5 unregistered staff members as part of his team.

He agrees with those attending the meeting that 2.66 WTE registered staff and 1.14 WTE unregistered staff should be redeployed to another ward area to provide safe, effective, person centred care.

Factoring in additional time for the Charge Nurse leadership/supervisory role at the agreed set level of 100% WTE of a Band 7, this brings the total funded establishment to be calculated at 32.2 WTE.

<sup>19</sup> *Op cit*, n 17.

## ABBREVIATIONS

<b>Abbreviation</b>	<b>Meaning</b>
BHSCT	Belfast Health and Social Care Trust
DHSSPS	Department of Health, Social Services and Public Safety
FE	Funded Establishment
HCSW	Health Care Support Worker
HSC	Health and Social Care
HSCB	Health and Social Care Board
KPI	Key Performance Indicator
NHS	National Health Service
NHSCT	Northern Health and Social Care Trust
NI	Northern Ireland
NIPEC	Northern Ireland Practice and Education Council for Nursing and Midwifery
SEHSCT	South Eastern Health and Social Care Trust
SHSCT	Southern Health and Social Care Trust
PHA	Public Health Agency
RCN	Royal College of Nursing
WHSCT	Western Health and Social Care Trust
WTE	Whole Time Equivalent