

NURSE STAFFING

Assumptions:

1. The affect of MMC changes has still to be quantified but a general presumption is that the number of junior doctors will be less and they will not be as experienced or skilled as their predecessors. This will affect the in-patient areas but its affect on A&E Nurse staffing will be more explicit and profound.
2. While Nurses are assuming much greater responsibility for the minor injuries service, junior doctors make significant contributions to processing minor injuries as well as major illnesses and injuries. Any reduction will require replacement by other types of medical staff, Nurses or new roles such as Physicians Assistants.
3. Medical staff cannot be replaced in their entirety even in the minor injuries service. Even where they are replaced by Consultant Medical staff on a one-for-one basis the reality is that the Consultant will not be deployed to deal with minor injuries services or personally “work-up” cases, therefore the demands on Nurse (or other) staffing will increase.
4. The Nurse staffing in A&E is already under strain and is probably at a point where additional resource is required to meet current volumes and configuration before the impact of MMC is taken into account.
5. Option A, and variants (no medical receiving); have a greater impact on HECT Nurse staffing because greater resources will be needed at Wishaw and Hairmyres Hospitals and there will be a minimum level of staffing required at Monklands Hospital.
6. Option E and variants (full A&E service, medical receiving, status quo) will have only marginal impact in total although there may be significant changes in the type of nursing service from the current. Essentially this assumes that the same total services are redistributed between three hospitals but each remains roughly the same size.
7. If the consultant medical staff base is to be increased to improve sustainability and rotas (option G), then staffing in nursing and the other disciplines will need uplifting because:
 - Like medicine the Nursing and AHP base is some 25% lower than one would expect it given our population size (and Arbutnott share) and it is spread over more acute sites than other Health Boards

- Consultant Medical staff will wish to pursue their own career interests, have their own out-patient clinics and theatre or lab (cardio, endoscopy) sessions. There is no spare capacity to accommodate these, e.g. the theatre staffing is based on a 45 week year.
 - When Wishaw and Hairmyres Hospitals were opened the zero-based method of calculating the ward staffing removed some 190 wte posts. The ward based staffing has therefore been at one of the lowest comparative levels in Scotland. This is further impacted upon by an assumption that the occupancy level of receiving wards would be an average of 85% occupancy, but in reality the occupancy levels exceed 95%.
 - The number of Consultants each Ward Sister has to relate to may increase considerably
8. Throughout the assumption is that the bed base will not be increased even though its configuration changes according to the options.

Conclusions:

9. The Nurse staffing of A&E is problematic for all options in terms of its current base, the impact of MMC and the configuration of the options. The closer the options are to the status quo the less difficulty there will be however MMC has the potential to be more significant than the service configuration options
10. The staffing of HECT will require marginal additions the closer Monklands is to the PoH options and less so as the options are closer to the status quo, however the impact of MMC on the medical members of the HECT team and on the support they may be asked to give to general wards (particularly at weekends in Wishaw) as junior doctor cover is reduced may be considerable.

11. The Nurse staffing of all the hospitals would have to rise if the Consultant Medical Staff increased particularly (but not exclusively) in out-patients, clinical labs and theatres¹

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1. ¹ As a crude measure and based on current staffing an additional 10 nursing staff may be needed for each additional consultant post, however, if the assumption holds good that no extra beds will be created then an element of the 1:10 ratio would be reduced (e.g. ward nursing staff) but not all because of the anticipated increase in throughput and greater intensity of medical demands (e.g. ward rounds).