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CHESTERFIELD ROYAL HOSPITAL NHS FOUNDATION TRUST REDESIGNING CARE DELIVERY: BUILDING THE TEAM AROUND THE PATIENT

Background

Chesterfield Royal Hospital NHS Foundation Trust (Chesterfield Royal) employs 3,900 staff and serves a population of over 400,000 people from the communities of North Derbyshire and the surrounding area.

In recent years the trust has experienced a shortage in the number of registered nurses across its workforce. Despite a concerted effort, including proactive recruitment campaigns, it had exhausted all available options to recruit to nursing posts.

In addition to the recruitment challenges, the organisation also recognised that development opportunities for those in band 2 and band 3 roles were limited and so the trust wanted to explore opportunities to improve this.

This case study reflects on how Chesterfield Royal has piloted an approach to redesigning its team structure, how it addressed the issues this process presented, and the organisation's current position: where other wards are looking to adopt the new team structure.

What the trust did

As the organisation was unable to make up for the shortfall in nursing, Chesterfield Royal decided to explore the possibility of introducing a new workforce model to ensure the best use of the staff and the skills already available in teams. In redesigning the care delivery, the trust looked at how it could introduce band 4 roles, such as the nursing associate and the assistant practitioner, to build a team around patient needs, based on identifying the skills needed to deliver the best care.

First steps

The proposal started with a conversation in the senior leadership team which was shared with the board to gain support. The heads of nursing and therapies had this on their respective agendas and discussions were held with professional standards groups.

Recognising that a new staffing model would require a cultural, as well as a structural change for the wards involved, the leadership team was keen to ensure that staff were involved in the process from the outset. There was a clear message that this would not be forced onto any ward or team and only introduced where there was an appetite to do so.

Project leaders knew that staff engagement would be key to embedding the roles of assistant practitioner, and later the nursing associate, if they were to extend the scope of roles below band 5. Group sessions were held specifically for the ward matrons who were asked for their thoughts about the work the band 2 and band 3 staff were currently doing, and explore the art of the possible to understand whether and how staff could be used differently to help support the work of the wider team.

Information about the pilot was cascaded by the matrons to their teams, and those wanting to hear more were encouraged to attend open forum sessions that were arranged discuss the proposals. Eight sessions were held over two months, with two additional sessions held for the therapy services.

Staff were encouraged to talk openly about any worries or concerns they had, and to ask questions so that the sessions could be used to address these. The use of email was deliberately kept to a minimum with the project leaders preferring to meet with staff and discuss any issues directly.

How they did it

Once participating pilot wards had been identified, multi-professional team days were arranged. These were structured, and started by setting the context and introducing the vision of building a team around the patient. From the outset it was made clear that the main driver for this change was not about finance, or introducing top-down change, but wanting to do something that would provide best care for patients while also making things better for the staff.

Staff were rostered to attend the workshops and each day had a mix of staff, including registered nurses, healthcare assistants and therapists.

The matrons ran these sessions to talk about how the model would work in practice and answer any questions. The overall approach was not to try and create a full model from beginning to end, but to break this down into small chunks with lots of discussion. For example, an idea would be presented, staff would then think about why it might be good, identify concerns, and then make any adjustments needed.

A task analysis exercise was used splitting the staff into small groups with each group being asked to list the different aspects of care that patients on their ward need. They were then asked to map these against the skills and knowledge required to deliver that care. Through this exercise the staff identified that while a lot of the team had the skills to deliver many aspects of care, there are certain elements that can only be done by a registered nurse or therapist.

Applying this to a model of care delivery, the team identified that having someone who could undertake tasks such as moving and handling, administering

medication, or assessing a patient for a walking aid, would free up senior members of the team to focus on doing the things that only they could do.

Overcoming challenges

When the trainee assistant practitioners were first appointed there was some resistance from nursing staff and healthcare assistants. On reflection, it is possible that these staff felt their own roles were under threat. The first six months of the pilot were the most difficult, but staff have since come to realise the longer-term potential of having these new roles within the teams.

A focus group was established for the trainees during the pilot to help unpick issues they experienced and offer peer support. They also used this to raise any issues with the matrons, who in turn hosted information sessions for the other staff.

Being mindful of the impact on the ward, management tried to ensure there was only one learner on rota in each of the areas, however, as the programme rolled out this wasn't always possible. With some individuals needing extra educational support, each ward was reviewed separately with a view to vacancies, learners, and gaps on the rota.

Outcome

Once qualified, the use of these roles within the team structure will provide capacity for the band 5 staff to work to the top of their licence and utilise the full extent of their education and training, which is important for the model to work. Going forward the model will also provide a career pathway for healthcare assistants looking to further their development.

The numbers involved have helped to establish a peer support model and maintain momentum. The trust introduced 19 trainee assistant practitioners in 2016, followed by 10 trainee nursing associates the following year. In February 2018, a further 19 trainee nursing associates were appointed from 120 applications.

Conclusion and lessons learned

The approach taken by Chesterfield Royal to engage its staff redesign care delivery as part of the pilot has enabled the trust to successfully introduce trainee assistant practitioners and trainee nursing associates. The trainees are employed at band 3, and upon qualification will progress into their respective roles at band 4.

Staff were involved through workshop sessions co-facilitated with the head of practice and professional development and the head of nursing. Having this mix of expertise on how the model could work in practice, and the authority to make decisions to help make this work, helped to maintain momentum. Involving staff in the process from the outset has also instilled a sense of ownership among the teams involved.

Top tips

- Gain strategic support from board members and senior leaders.
- Involve staff from the beginning to instill a sense of ownership.
- Support ward matrons to run sessions with their teams.
- Discuss how the model will work in practice and answer any questions.
- Listen to concerns – be willing to reflect and change.
- Be clear the driver is about improving things for patients and staff - not financial savings.

Find out more

For more information about how this model was implemented please contact Maxine Simmons, head of practice and professional development, via

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