The Future Nursing Workforce Project

Moorfields Eye Hospital
NHS Foundation Trust

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www.moorfields.nhs.uk
Contents

Executive Summary 4

1.  Aims & Objectives 8
2.  Methodology 9
3.  Nursing workforce issues in the UK 10
4.  The service & demand at Moorfields 11
5.  The current nursing workforce at Moorfields 13
6.  Workforce education 26
7.  Retaining, attracting & developing talent-Rethinking the pipeline 29
8.  Working at Moorfields: The staff experience 30
9.  The perception of nursing at Moorfields 34
10.  The future workforce 36
11.  Specific examples from around the Trust 38
12.  References 41

Appendix A 42
Appendix B 44
Appendix C 45

Photography: Thank you to all contributors and Laurence Lane.
Executive summary & recommendations

Moorfields is a world leading ophthalmic centre founded in 1804. The Trust provided around 7% of ophthalmic care in England in 2014/15 (source HSCIC) and has around 30% of the market share in London. The demand for services is increasing with a projected 3% increase in demand for 2016-17 in most areas of activity. The Trust is currently undergoing a transformation process. This report covers the findings from across the Trust with the exception of Moorfields Private, NIHR biomedical research centre, Moorfields Pharmaceuticals and Moorfields UAE.

Key findings

- There is currently a global nursing shortage in the UK & London of registered nurses making recruitment a challenge for the Trust. There is also an increasing demand for ophthalmic services.

- The Trust has had challenges in recruiting registered nurses, particularly the newly qualified. Nurses receive little exposure to the specialism in pre-registration education and development & preceptorship programmes are offered in the acute sector making competition substantial.

- There is a highly skilled nursing workforce at Moorfields and the Trust is heavily reliant on this established, static workforce for its skilled care.

- In common with the nursing workforce generally, the skilled nursing workforce at Moorfields has many registered nurses over the age of 55 (18.1 per cent of registered nurses responding to the local staff survey) creating a potential sudden shortfall in the next five years.

- Using staffing tools based on dependency and acuity has very limited application at Moorfields due to the nature of the work.

- The current business model of acquisition across South East England spreads workforce (particularly the skilled workforce) thinly and exacerbates pipeline/education/succession issues. In addition this model presents peaks in workforce demand at initiation which is not currently managed.

- There has been tremendous progress in education and development in the last few years at Moorfields however this is likely to need increase both in terms of offer and spread to secure the trust position as a market leader in non-physician ophthalmic education.

- There is an appetite at all levels and roles from further education from certificate level to doctoral level education.

- Staff experience is variable. Culture reflects a tall & hierarchical structure resulting varying degrees of satisfaction by staff from baby boomers to millennials.

- The local staff survey conducted as part of this project, found that lower band staff were more likely to feel their future is at the Trust/ophthalmology; 81.3 per cent of staff working below band 5 plan on staying at Moorfields, while 58.4 per cent of registered nurses plan on staying at Moorfields. There is also an appetite within the low band group to pursue registered nurse training; 41.4 per cent of staff working below band 5 expressed an interest pursuing nursing in the future.

- For a world class organisation there is little professional presence outside of Trust as a leader in ophthalmic nursing care, for example the professional press, the literature or at ophthalmic conferences. There is no defined nursing research leadership.
• Capacity issues have been identified by the trust which includes increased demand, higher activity, spread of workforce across multiple sites and longer waiting times. There is a limited understanding of the nature and contribution of nurses at the Trust. This is particularly so of the outpatient workforce and the registered nursing workforce is not working to its full potential when compared to similar organisations.

• Senior nursing leadership is spread thinly and operationally focussed instead of leading and enabling strategy. Expectations around potential contribution of the workforce appear limited and not contemporary.

• Some pockets of advanced practice have developed due to the efforts of individuals and colleagues but these are sporadic. There are examples of non-physician led services but these are very limited and are adjunct services rather than professionally led services.

• Some services appear to focus by necessity on operational work with no capacity for strategic vision. This is reflected in services without strong day to day clinical leadership.

• More detailed modelling proved challenging as many essential items of data are not currently collected. Moorfields has a limited electronic staff record and e-roster is currently being implemented. There is no electronic health record used for intelligence.

• After basic demand modelling of workload we determined that the trust is not over staffed. Although staffing is currently adequate in many areas it will be stretched much further as growth increases. The increased demand that is currently not managed is from site acquisition and longer hours. In some areas there is a small deficit and to some extent this could be address through changes in skill mix. The talent pool could be better utilised to meet changes and nature of demand.
Overarching recommendations

**Detailed recommendations and rationale can be found in each section.**

- Address data deficit by establishing a minimum dataset to allow insight from routinely collected data. This would allow better utilisation of the workforce in future.
- Provide a vision for the nursing workforce through the refreshed nursing strategy.
- Address the spread of the workforce by concentrating expertise and enabling learning—for example a hub and spoke model may be more beneficial.
- Address pipeline issues to improve supply across all bands. Improve talent recruitment and retention across all bands through further opportunities for learning and development, career progression and role recognition.
- Enable further strategic development of teaching and learning, clinical academic careers and research through some protected time and introducing a leadership position to develop research capacity and culture. This could be a senior clinical academic for example a Chair in ophthalmic nursing.
- Strategic development of specialist advanced practice to address capacity issues and make specialism more attractive in long term and aid talent recruitment and retention. Capacity issues & waiting times could be partly addressed by the use of specialist advanced practice nurses using proactive case management for more complex care needs—for example introducing a clinical nurse specialist (and subsequent developmental post) alongside the family support worker post into RDCEC is likely to free up time of both RNs and medical staff.
- Refresh nursing leadership structure to focus on strategic aims and provide leadership in areas which are currently in deficit.
- Understand and address cultural issues, encourage multidisciplinary team working to address capacity issues and aid recruitment and retention.
- Although the Trust is not overstaffed in the current model (there is a small deficit in numbers (WTE 21 RN) once vacancies are filled) a relatively small increase in staff particularly advanced practice and assistant practitioner roles would improve capacity. In addition nursing and other professional staff could be better utilised to deal with some capacity issues.
- Address limited understanding of the nature and contribution of registered and unregistered nurses at the trust. This is particularly so of the outpatient workforce. This includes simplification/aligning job titles and broad competencies and standards of education.
1. Aims and objectives

This project was initiated at the request of the Director of Nursing to align with the refresh of the nursing strategy “Focussing on the Future”.

The aim of this project was initially to build a demand side model and wrap workforce supply around it in common with other safety critical industries. The approach used was to be an emancipatory and data driven one. After an appraisal of data available (Appendix A) it was apparent to the modelling team that such data driven approach would not be feasible in the time available. However there are a number of valuable sources of data within the Trust and through other resources such as the Health & Social Care Information Centre (HSCIC) and the Centre for Workforce Intelligence (CFWI). After discussion with the director of nursing a more descriptive approach was taken utilising different datasets to understand the demand on nursing resource and how the nursing workforce can contribute to the aims of MEH going forward.

The objective of this report is to help inform the nursing vision and the “our people” and “Increasing our productivity and efficiency” enabling themes of the MEH strategy and Vision 2020.

“Work to better understand the current workforce and organisational design in terms of size, skill-mix and potential to recruit and retain staff and preparedness for change”

Our Vision for Excellence

In addition we were asked to examine a number of issues. These were:

- Understanding the pipeline, recruitment & retention issues to ophthalmology nursing (supply) and how this might be improved.
- The assumption that role substitution could take place in out-patients in that an unregistered practitioner could take on the work of a registered practitioner.
- To examine the potential of the unregistered practitioner currently known as a technician based on the model currently in use in the USA.

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This is a bespoke piece of work commissioned by Moorfields NHS Foundation Trust and HENCEL but carried out by an independent team of analysts.
2. Methodology

This work took place over 8 months (August 2015-August 2016). The approach taken was through the identification of issues such as staffing and then synthesis of different sources of data. These data sources & deficits are described in Appendix A. In addition to routine data collection a census of posts and a whole population survey was conducted over the month of January 2016 with an RR of 28% to gain insight into the workforce currently in post including perceptions and intentions. Observations of practice and discussions with approximately fifty staff also took place. These ranged in grade and profession. They were not limited to nursing. No formal interviews with patients took place but observations in clinical areas often meant that patients, families and others would offer an unsolicited opinion. These were noted over the course of the project.

Figure 1: The approach to synthesising data-building a workforce model

Workforce
- Aligning & defining roles
- Right numbers with the right skills
- Addressing the pipeline
- Developing practitioners
- Building on a career framework
- People matter – feeling valued

Education & research
- Developing the right skills
- CPD for everyone
- Clinical academic careers
- A centre of excellence in ophthalmic nursing

Organisational factors
- Nursing leadership for the future
- Developing future leaders at all levels
- Articulating nursing contribution to success
- Culture – Moorfields as an attractive place for generation Y and the Millennials’

The Moorfields way
- Developing expert practice in ophthalmic nursing as a brand across sites
- Nursing Outcomes & KPIs
- World class ophthalmic care
3. Nursing workforce issues in the UK

Health Education England’s (HEE) commissioning and investment plan\(^2\) shows that HEE’s forecasts of future supply show more people are being trained to enter the system than those leaving the system in every profession. This includes people leaving NHS employment to work in the independent and care sectors. However little demand modelling is done in this area and the purpose of this project was to better understand the demands for nursing resource (both registered and unregistered) and how that might be met in the future.

The nursing workforce in London-demand outstrips supply

The current position in England reflects the current global nursing shortage where demand for professional nursing care has exceeded supply. The current shortage in England is a reflection of many factors—not least of which is the consequences of the 2009/10 “Nicholson Challenge” which saw a reduction of numbers of nurses in training by approximately 3,500 (17-18%). Added to the undersupply issue was the “Francis effect” which created a sharp rise in demand\(^3\).

Increasingly both unregistered and registered nurses are being employed outside of NHS organisations on non-NHS, locally negotiated contracts. The increase in qualified providers and the care home sector for example, have increased the number of employers and present a competitive market place. Nursing was to be removed from the Shortage Occupation List and although it has been temporarily restored, this is likely to be another factor that will curtail supply. London and the surrounding areas have high vacancy rates as despite supplemental pay and allowances many workers find the cost of living in the capital prohibitive. Some qualified providers mitigate this by offering higher base rates & increased benefits for skilled staff putting extra pressure on the available talent pool. Other initiatives such as the HENCEL CapitalNurse programme as part of the London Workforce strategy\(^4\) may help with these issues, and represent an opportunity.
4. The service & demand at Moorfields

Moorfields services currently spread from a central hub at City road, through district hubs and satellite centres. There are 23 sites plus a number of smaller satellite sites that number a total around 32. City Road is the principal site which has an adjoined Children’s hospital (RDEC).

Of the approximately 7 million ophthalmology attendances in England in 2014/15, 500,312 were at Moorfields (Source HSCIC) just over 7% of ophthalmic acute care provided in England.

The Trust predicts a 3% growth per annum.

The care provided is primarily ambulatory with a large outpatient service. There were 587,858 outpatient appointments in 2014-15, compared to 512,144 in 2013-14, representing an increase of 75,714 from the previous year. Males accounted for 48.3% (244,154) of all outpatient attendances, while 51.7% (260,966) were female. Those aged 70-79 had the highest proportion of attendances with 19.3% (97,662) (Fig 2). Males accounted for 52.4% (38,126) of all did not attends, while 47.5% (34,557) were female. Those aged 50-59 had the highest proportion of did not attends with 14.1% (10,256).

Overall demand for services is increasing in ophthalmology and this is reflected in the increased demand at Moorfields. The Trust has a number of challenges such as increased demand/wait times, increased use of the emergency department and a rapid expansion into sites across the South east of England.

Figure 2: Outpatient attendance by age-each age demographic has different nursing and care needs.

Source: HSCIC
Of the 2014-15 outpatient activity 49,557 appointments were referred by a general medical practitioner and 24,995 appointments were referred by a known source of referral other than a general medical practitioner or consultant. The increase in demand for ophthalmic services in England means that there is additional demand on the workforce. The Royal College of Ophthalmologists has reported a workforce deficit in terms of meeting this demand.

The average (mean) time waited for the 1st outpatient attendance from general medical practitioner referrals was 56 days, with a median time waited of 51 days. This compares to an average (mean) of 50 days, with a median time waited of 43 days in 2013-14. Increased demand has seen an increase in waiting times. Whilst there was no attrition data, rates of discharge in individual clinics appear relatively low. Staff and patient opinion collected in outpatient areas suggested a long term relationship with the Trust, particularly at City Road.
5. The current nursing workforce at Moorfields

The current overall workforce consists of approximately 2000 staff across the sites. The workforce is varied and ranges in skill, education and expertise. The workforce is multidisciplinary and in common with specialist centres has a specialist allied health professional (AHP) workforce made up of optometrists, orthoptists and other specialist practitioners. The Royal College of Ophthalmologists\(^5\) recommended one full-time equivalent (FTE) consultant for every 55,000 population for a district general hospital (DGH) and one (FTE) consultant for every 50,000 population for a teaching unit although this seems to be based on expert consensus. There is currently no equivalent recommendation for ophthalmic nurses.

The nursing (both registered and unregistered) make up a large proportion of the staff overall-578.64 WTE. A breakdown by band and location is shown in Table 1.

<table>
<thead>
<tr>
<th>Location</th>
<th>Banding</th>
<th>Budgeted WTE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>8A</td>
<td>8B 7 6 5 4 3 2</td>
</tr>
<tr>
<td>Ambulatory City Rd</td>
<td>7.4 1 27.08 48.39 31.95 3 32.88 21.62</td>
<td>173.32</td>
</tr>
<tr>
<td>Barking</td>
<td>0.2 0 0.8 2.05 0.8 0.2 0 0.2</td>
<td>4.25</td>
</tr>
<tr>
<td>Bedford</td>
<td>1 0 3.64 7.6 7.45 1 9.84 2</td>
<td>32.53</td>
</tr>
<tr>
<td>Croydon</td>
<td>1 0 0.4 8.6 6 2 8 2</td>
<td>28</td>
</tr>
<tr>
<td>Darent</td>
<td>0.2 0 2 1 1.68 0 0 1</td>
<td>5.88</td>
</tr>
<tr>
<td>Ealing</td>
<td>0.6 0 3.24 7.4 4.29 0 4.08 2</td>
<td>21.61</td>
</tr>
<tr>
<td>Loxford</td>
<td>0 0 0.43 0.44 0.43 0.2 0 0.2</td>
<td>1.7</td>
</tr>
<tr>
<td>Ludwig</td>
<td>0 0 0.21 0.8 0.53 0.2 0 0.79</td>
<td>2.53</td>
</tr>
<tr>
<td>Mackeller</td>
<td>0 0 1 6.24 7.16 0 0 6.67</td>
<td>21.07</td>
</tr>
<tr>
<td>Mile End</td>
<td>0.2 0 0.79 2.11 1.28 1.4 0 1</td>
<td>6.78</td>
</tr>
<tr>
<td>Northwick Park</td>
<td>1.7 0 0.7 8.1 6.79 0 2.8 4.03</td>
<td>24.12</td>
</tr>
<tr>
<td>Obs bay</td>
<td>0 0 0 1 7 0 0 4</td>
<td>12</td>
</tr>
<tr>
<td>Potters Bar</td>
<td>0.1 0 0.4 2.8 2.65 0 1 0</td>
<td>6.95</td>
</tr>
<tr>
<td>Pre assess</td>
<td>0 0 1 7.3 5.15 0 2 2.52</td>
<td>17.97</td>
</tr>
<tr>
<td>RDEC</td>
<td>1 0 1 11.76 3.6 4.95 2 0.92</td>
<td>25.23</td>
</tr>
<tr>
<td>Sedgewick</td>
<td>0 0 1 5.88 11.45 0 1 5.58</td>
<td>24.91</td>
</tr>
<tr>
<td>SGH clinic</td>
<td>1 0 1.6 4.4 3.94 1.31 13.26 0</td>
<td>25.51</td>
</tr>
<tr>
<td>SGH Theatre</td>
<td>0 0 0 7.52 5.4 0 1.4 1</td>
<td>15.32</td>
</tr>
<tr>
<td>SGH ward</td>
<td>0.3 0 2.42 8.73 5.18 0 4.9 0</td>
<td>21.53</td>
</tr>
<tr>
<td>St Annes</td>
<td>0.4 0 1.2 6.23 3.2 1 1 2.6</td>
<td>15.63</td>
</tr>
<tr>
<td>Theatres</td>
<td>0 0 6 37.31 41.21 0 2.8 4.48</td>
<td>91.8</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>15.1 1 54.91 185.66 157.14 15.26 86.96 62.61</strong></td>
<td><strong>578.64</strong></td>
</tr>
</tbody>
</table>

Vacancy rate at time of writing was 13%.
The spread of nursing workforce is thin away from City Rd (Fig 4) and this is likely to cause significant issues with supply if growth of sites continues at the current rate.

Figures 4 and 5 show the budgeted WTE by location and pay band. The WTE for the largest two – Ambulatory City Road and Theatres – are shown separately in Figure 5 as they would otherwise skew the figures for the remaining locations, which have comparatively small WTEs; note the differences in scales between Figures 4 and 5.
In order to gather more detailed workforce data a local workforce survey took place over the month of January 2016. This had 164 respondents 25% unregistered (n=41) and 75% registered (n=123). This was sent as a link to all staff via the staff bulletin and also via the heads of nursing. Some demographic data was also obtained for example the titles used (Fig 7).
Current workloads

The current demand is from routine, high volume work for the majority of the nursing workforce. There is a significant experienced talent pool in many areas. The current workload overall appears manageable but the rate of expansion means that the workforce is being spread very thinly particularly in terms of leadership and those who, for example, can teach. This is having an effect on the pipeline and retention particularly at band 5. The peaks of work setting up new sites do not seem to be accounted for yet represent considerable peaks in demand. There appears to be little consultation with nursing staff on decisions to set up new sites and the perception is that this work is handed off with no realistic opportunity to challenge. Unpaid overtime appears common from the local survey with just under 40% of respondents stating that they work unpaid overtime. This varies from 1-3 hours per week to over 10 hours a week with an association to grade (the higher the grade the higher the declared unpaid overtime). Some of this demand could be offset with administrative support or HCA/Assistant practitioner support. Administrative support is likely to free up nurse leadership time, improve the quality of data available for intelligence. Although the trust is not overstaffed it does have unfilled vacancies (13%) which have differing impact in the various locations.

Protected time

There is little or no protected time for activities such as administration, audit, data collection, handling/analysis, service evaluation or research. There is leave for study and mandatory training however many participants, particularly at higher grades reported that they had to “catch up” if they took part in other activities. All bands should be expected to lead and teach within competency however one of the most frequently cited reasons for not teaching newer members of staff or supporting teaching in the workplace was time.

Recommendation: Protected Time (administration & service evaluation/development) If administrative help is not available those at band 7 with managerial/leadership responsibilities should have 4 hours per week administrative/service development time to offset the current unpaid overtime (10.6% of 37.5 WTE). In the acute sector this would normally be an “admin
day” for example for a ward sister. To allow 4 hours per week per WTE would equate to almost 6 WTE extra staff and thus lower band administrative staff might be a better return on investment—such posts could provide support to groups of band 7/8a nurses.

Protected time (teaching and learning). Moorfields is a centre of excellence but teaching is seen as primarily the duty of the education team. This is not sustainable unless the education team is vastly expanded. The lack of “on the floor” teaching might also curtail any future business opportunities. Band 6 posts and above have the expertise to teach and should do so. Calculations in this document include 1 hour per week (2.5% of 37.5 WTE) uplift for teaching activity per WTE. It is recognised not all will have such a commitment and for others it might be more thus this is used as an average to calculate deficit.

To allow protected time for such activities would require another 5 band 5/6 posts. Alternatively the introduction of an assistant practitioner could release nursing time.

For the Trust to move forward as a centre of excellence in ophthalmic nursing it essential that attention is paid to education, research and service development and that floor nurses have capacity to do or at least contribute to this work.

The workforce demographic

The workforce that responded to the internal staff survey was predominantly female. 155 people declared a response to the question about sex female 112 (72.26%) male 36 (23.3%) and 7 declined to answer. The age of the workforce (n=153) is shown in Figure 8. This appears representative of the wider workforce when compared with some local data.

Figure 8: The age of the workforce at MEH (n=164)
The current workforce particularly in leadership roles is predominantly from the “baby boomer” and generation X age groups. Future groups such as generation Y and Z (also known as Millennials) are likely to have different expectations of working life and are likely to find the current tall hierarchical structure of the trust a challenging workplace. This was shown to some degree in the freetext responses to the internal staff survey which is explored later in this report (Section 8).

A summary of the characteristics of the generations is shown in figure 10.

Figure 9: The age of the band 7 plus workforce

![Figure 9: The age of the band 7 plus workforce](image)

Figure 10: The characteristics of the different age groups

![Figure 10: The characteristics of the different age groups](image)

<table>
<thead>
<tr>
<th>'Baby Boomers'</th>
<th>'Generation X'</th>
<th>'Generation Y'</th>
<th>'Generation Z'</th>
</tr>
</thead>
<tbody>
<tr>
<td>Motivated and hard working; define self-worth by work and accomplishments.</td>
<td>Practical self-starters, but work-life balance important.</td>
<td>Ambitious, with high career expectations; need mentorship and reassurance.</td>
<td>Highly innovative, but will expect to be informed. Personal freedom is essential.</td>
</tr>
<tr>
<td>25% of the NHS workforce</td>
<td>40% of the NHS workforce</td>
<td>35% of the NHS workforce</td>
<td>&lt;5% of the NHS workforce</td>
</tr>
</tbody>
</table>

Source: HEE

Just under a third of respondents had been at the Trust for less than 2 years. The majority of the respondents had worked at the Trust for many years (Fig 11).
The current unregistered nursing workforce at MEH

The staff in band 1-4 roles make up around 40% of the 1.3 million workers in the NHS (HEE) and are responsible for an estimated 60% of direct patient contact. MEH has a substantial (approx. 164 WTE) unregistered workforce on primarily AFC bands 2-4. The primary groupings are Healthcare Assistants (HCA) and Technicians. Other job titles included Assistant Practitioner (AP) and Senior Healthcare Assistant.

The Band 2-4 workforce has a number of different qualifications and the Trust education team are currently offering the Care certificate and finalising a City & Guilds certificate for healthcare assistants. For technicians there is an in house course.

The band 2-4 workforce is spread throughout the trust but utilised differently in different settings. The satellite centres for example utilise the band 3 healthcare assistant and band 4 assistant practitioner role to a much greater degree and with success in setting such as outpatient services and theatres. On interview there was a preference (all bands) for an assistant practitioner role as an adjunct to the RN as the perception was that this role was more flexible than the technician role and could be used in different settings. The technician role appears to focus on physiological measurement whereas the assistant practitioner role was able to incorporate technical and clinical care skills. After observing the work of clinics a degree of clinical acumen is required-the demand on nursing time is not simply for physiological measurement. It is possible that the assistant practitioner supervised by the RN would be of benefit in many of the clinical areas of the Trust and release RNs to increase capacity in areas such as routine follow up.

This workforce has high potential to address some of the current staffing issues in the trust such as meeting the increasing demand. There is an appetite from the unregistered workforce to pursue further and higher education and even registration. The development of this post could offer such a route (Fig 12).
This unregistered workforce gave a mixture of positive & negative responses to the free text question in the staff survey and in clinical areas; however the majority of responses in both the survey and interviews tended toward negative. This is explored more fully in section 8 but most of the comments fell into the cultural and feeling undervalued categories.

**Developing the unregistered workforce.**

The development of the band 2-4 workforce would be a good option in terms of not only supply in the current model but perhaps also future provision of RNs with more flexible options to registration currently undergoing consultation through HEE.

Although there has been much work in this area (particularly in education) there is a need to align titles and competencies further. This could be done through affirming and extending the definitions and job descriptions already in place. The assistant practitioner role, currently a model in other centres, might best parallel the stated desire for the USA version of a technician⁶.

The USA ophthalmic technician or assistant is a defined product with a core curriculum⁶ and accreditation. On examining the role from the ATPO curriculum, website and a number of job descriptions from the USA, the technician in the USA appears to be a different role to the current technician role at MEH or other ophthalmic centres. The technical role at MEH has a focus on physiological measurement however it would be possible to develop more fully a role similar to the role in the USA as an assistant practitioner role through the use of foundation degrees or higher apprenticeship incorporating the technical and diagnostic specialist skills as well as building on fundamental care skills. It is possible that the RCO developing competencies⁷ may be the framework for this but they are not currently available.

**Recommendation:** The trust undertakes strategic development of this workforce with a defined career structure and pathways part of its OD strategy. This ranges from KSF level 2 (band 2) HCA roles to KSF level 4 & 5 (Band 4) Assistant Practitioners at foundation degree or higher apprentice level. For those who wish it a route to registration should be possible post The Shape of Caring (HEE) review.

An overview of options to develop all roles at MEH is given in Figure 12. This also shows routes to developing the Assistant Practitioner role (which could be used flexibly across the Trust), possible route to registration and aligns academic, CPD and clinical academic careers with the knowledge and skills framework.
Figure 12: A overview of education and professional development options for the nursing workforce at MEH (registered & unregistered)

<table>
<thead>
<tr>
<th>Level</th>
<th>Example role/KSF band</th>
<th>Academic</th>
<th>Professional ^ eg</th>
<th>Clinical academic careers</th>
</tr>
</thead>
<tbody>
<tr>
<td>7 &amp; 8</td>
<td>B7 Specialist adv prac nurse* 8 Consultant 8 &gt;8a</td>
<td>PhD or Professional doctorate</td>
<td>Post-doctoral specialist qualifications</td>
<td>CPD</td>
</tr>
<tr>
<td>7</td>
<td>Senior RN leader/adv prac nurse* i.e. band 7</td>
<td>Postgraduate Diploma</td>
<td>Master's degree</td>
<td>Master's degree (advanced practice)</td>
</tr>
<tr>
<td>5 &amp; 6</td>
<td>Registered nurse i.e. band 5-6</td>
<td>Post Graduate certificate</td>
<td>Degree year 3 &amp; registration</td>
<td>Mentorship</td>
</tr>
<tr>
<td>4 &amp; 5</td>
<td>Assistant Practitioner i.e. band 4</td>
<td>Foundation degree year 2</td>
<td>Degree year 2</td>
<td>NVQ 5 Higher Apprenticeship Intro to Ophthalmology Evidence based practice</td>
</tr>
<tr>
<td>4</td>
<td>Assistant practitioner/ Trainee i.e. band 3</td>
<td>Certificate of Higher Education</td>
<td>BTEC HNC</td>
<td>Foundation degree year 1</td>
</tr>
<tr>
<td>3</td>
<td>Healthcare Assistant/ Senior HCA i.e. band 2-3</td>
<td>14-19 Advanced Diploma/ Principal Learning</td>
<td>City &amp; Guilds</td>
<td>AS/A2 level</td>
</tr>
<tr>
<td>2</td>
<td>Apprentice/ HCA i.e. band 2</td>
<td>14-19 Higher Diploma</td>
<td>BTEC Firsts</td>
<td>GCSE</td>
</tr>
<tr>
<td>1</td>
<td>Apprentice entry level (non-clinical staff)</td>
<td>14-19 Foundation Diploma</td>
<td>BTEC Vocational Qualification</td>
<td>GCSE</td>
</tr>
</tbody>
</table>

Key
HCA Healthcare assistant. AP Assistant practitioner. RN Registered Nurse. SNAP Specialist Nurse in Advanced Practice (e.g. nurse practitioners, clinical nurse specialists (AFC7), consultants (AFC8) etc.) these are the available options from academic providers and in house courses. Posts marked * manage a caseload.

Professional ^ shows some examples but would include leadership, EU programme, CPD Continuing professional development i.e. professional update days, technical competency courses. AOT Asso Ophthalmic Technicians curriculum or UK equivalent. Level is NHS Career framework level not KSF banding which can vary. Programmes highlighted in blue are possible routes to nurse registration post Shape of Caring review. Clinical Academic Careers refers to the NIHR/HEE Career framework for nurses (more details are in Appendix B).
The current registered workforce

The current registered workforce consists largely of bands 5-7 with some posts 8a and above. Registered nurses work across the trust in all settings including a helpline. The current registered workforce has become stretched away from City Rd with a very thin distribution in some areas and it is unlikely that the current model of increasing services by site will be supported in the medium to long term. The distribution of the workforce was seen in Figures 4 & 5.

The current registered workforce has a range of qualifications and experience but forms a rich talent pool. There are a higher proportion of band 6 nurses than usual for the acute sector however it is not uncommon to find a high proportion of band 6 nurses in specialist centres.

Developing the registered workforce

A review of ophthalmic services across the UK has shown how the band 6-7 workforce in particular have increased service capacity with an education at post graduate certificate level. It appears common for this level of nurse to work as part of a multidisciplinary team providing services such as Lid plastic services, Accident & Emergency care, AMD services (including follow up) post-operative cataract discharge, Fluorescein angiography, glaucoma care (for example, one trust has developed a nurse/optometrist glaucoma practitioner) and corneal care. Interestingly many of these posts seem to have developed in district general hospitals, community services and teaching hospitals rather than specialist centres.

There is a great deal of potential to develop this workforce further. There is a significant talent pool and many of the RNs are not practicing to the limit of their qualifications. Some examples of better utilisation are discussed in the later parts of the report but as a general finding the RN workforce could be developed alongside the unregistered workforce to deliver more routine care-this has become more common in other ophthalmic centres. The developing RCO ophthalmic competencies are likely to contribute to this but they are not available for review. Informal feedback is that they focus on the technical aspects of ophthalmic care and would frame technical competence rather than holistic care. An overview of options to develop all roles at MEH is given in Figure 12.

The current specialist and advanced practice workforce at Moorfields

Currently there are few specialist advanced practice nurses at Moorfields. Where there are such posts it has been as the result of a local initiative rather than strategic intent. Some posts also “double up” as management posts for example in outpatient clinics. This causes expert nurses to be pulled away from clinical work to tackle operational management issues and leaves them little time to develop services or increase capacity.

There are currently a number of clinical nurse specialists and advanced practitioners however the number of these seems to vary. They seem to constitute a small proportion of the workforce and there are only two consultant nurse posts. There were few nurse led clinics or services. This is a contrast to other specialist/tertiary centres in the UK where it is not uncommon to find 60-200 of these posts making up a substantial part of the workforce. They have risen in popularity due to their cost effectiveness and conferring the advantage of increased capacity/quality with low risk. In long term conditions they are frequently used to provide follow up and case management functions however there was little evidence of this at MEH apart from pockets of individual practice. This maybe a reflection of the way that advanced nursing practice is viewed nationally in ophthalmology as a technical extension of the physician rather than the more traditional view of advanced practice nursing.
There are nurses performing injection services for AMD but unlike other ophthalmic centres this is primarily the delivery of treatment not the assessment, clinical decision making or follow up.

A functional example of advanced practice at MEH is in the work of Yvonne Kana. Yvonne runs a YAG laser service, has a masters in advanced practice and functions at a high level. Her work also includes oversight of clinic and although she is training to provide follow up in VR, her services are often required to fill gaps in the nursing service giving more routine care and an operational management role in the outpatient clinic. Nurses like Yvonne have a tremendous potential to provide services to patients such as follow up however their talents could be utilised more effectively. Currently Yvonne is only one of a few nurses offering such services but expansion of these roles could see an increase in capacity.

No doctorally prepared nurses were identified in practice although there is an appetite for masters and doctoral level study according to the internal staff survey.

As part of this programme an offer was made to run a development programme but there was little uptake. When asked why a number of answers were given such as not having time, a perception that nurse managers/medical staff would not approve and that service development is not part of the role.

In other organisations nurses at this level are often the drivers or enablers of change alongside medical colleagues. The perception that this is not part of the role at MEH presents a challenge to introducing new models of care.

**Developing the advanced practice workforce.**

Specialist advanced nursing practice has evolved in the UK within the last 30 years and is now common place in many areas of healthcare across the UK, USA, Canada and Australia. In the UK such practice has tended to evolve to meet local need and unusually for a specialist centre there has been no systematic trust wide development of this workforce at MEH.

The terms “specialist” and “advanced” are often used to describe nursing roles in which nurses work to expert level, however there is a lack of clarity in this area. For the purposes of this report and modelling project a specialist nurse is one with an advanced level of expertise and meets the International Council of Nursing definition:

“A registered nurse who has acquired the expert knowledge base, complex decision-making skills and clinical competencies for expanded practice, the characteristics of which are shaped by the context and/or country in which s/he is credentialed to practice. A Master’s degree is recommended for entry level” ICN 2002

Most UK Trusts have a workforce with a considerable number of non-physician roles depending on the services offered. There is a small but growing literature around the return on investment that these posts offer and more robust evidence base on quality, safety and efficiency such as releasing the time of other professionals, increasing access to services, decreasing wait times and admission avoidance work. Other ophthalmology centres have developed such roles as they increase capacity and alongside new ways of working improve efficiency and patient experience. These roles are not limited to nursing but often comprise of different professionals who manage caseloads as part of a multidisciplinary team.

Developing the specialist advanced practice workforce has great potential to develop at MEH. This would require investment in education and mentorship. In addition the development of this level of practice requires strategic planning and leadership. There is already a talent pool to draw on within the Trust and an advanced practice career pathway is likely to attract to posts downstream i.e. aspirational band 5.

**Recommendation:** A leadership position is developed to enable the development of this workforce. Employing 10-20 WTE advanced practice posts across the spread of the trust is likely to have a significant impact. These should include development posts and might not all be new posts but could be created from some existing posts. More detail is given in the sections to follow.
The current nursing leadership at Moorfields

Currently the nursing leadership consists of a Director of Nursing post, no deputy and four senior nurse posts which provide operational day to day leadership across the wide geographic spread of the Trust. There is also a lead nurse for education, a lead nurse for innovation and a lead nurse for patient experience. This senior nursing team faces the challenge of providing leadership in a highly specialist field but across a wide and increasing geographical area.

The senior team have led on operational changes over a number of years but do not have the resources to lead some of the potential areas of growth from a strategic perspective such as the development of advanced practice or nurse led services. Some leadership styles are focussed on the operational which present difficulties given the spread of the trust. The local nursing leadership (Matrons and Sisters) have little or no administrative time or support. In addition the education lead is necessarily focussed on developing the current workforce and curriculum and has made great progress in this area. However for MEH to be a world class provider of ophthalmic care and research, the development of clinical academic careers for non-physicians and the business and talent attraction opportunities for education cannot be met with the current resource.

**Recommendation:** The nursing leadership structure is refreshed to include elements that there is currently no capacity or expertise in. These include **strategic management** across the wide geographical area, **staff development** with a focus on education, practice development, specialist advanced practice roles and clinical academic careers and the development of a world class nursing centre of excellence. A possible new structure is given in Figure 13.

Figure 13: A refreshed nursing leadership structure integrating all levels of ophthalmic nursing including research & education

DDON would be an operational role with particular focus on new models of care.
6. Workforce Education

There is a significant amount of expertise and leadership in professional education at Moorfields. Different pathways and programmes have been developed not only in technical areas such as ophthalmology but also in areas such as leadership. There are established working relationships with several universities and the UCL Institute of Ophthalmology. In addition, the education team provide a variety of programmes including return to practice, the EU nurses programme and introductory courses to ophthalmology.

There is a high demand for education in the Trust and also the expertise offered is a commodity that could be used externally. The current team do not have capacity to exploit business opportunities that come with the brand.

Members of staff who completed the staff census had a range of qualifications (164 respondents offered 868 qualifications). These are shown in Figure 14.

**Figure 14: Qualifications by band**

The most common mode of registration was RGN with a post registration qualification. 39 members of the group held an RN degree. This might preclude opportunities for example Magnet© status, future credentialing schemes or worth on the international market however in the sample group from the internal staff survey there was an expressed desire to study for an RN degree (Figure 15).

Only 4 nurses have a V300 certificate (non medical prescribing)—if this is reflective of the current workforce then advanced practice role might prove challenging. The proposed credentialing of this level of practice by the Royal College of Nursing will be a Masters in advanced nursing practice. The current offer from UCL would not enable advanced practice nurses to credential with the RCN.
Future education provision

It is likely that if new ways of working are established in line with other centres as the services expand and to introduce flexibility, then educational programmes offered may need to broaden. In order to establish the Assistant Practitioner role (a combination of technical and caring work at band 4) it is likely that the City & Guilds currently on offer could be used to step up to foundation degrees or higher apprenticeship. There was an appetite for a route to registration within this group (figure 15).

During interviews senior operational nurses expressed a desire for roles such as practice educators in addition to the teaching provided by the central team. This was despite the high concentration of band 6 & 7 posts across the workforce. Clinical band 6 & 7 posts would normally expect a teaching function as part of practice however a number of reasons were given for clinical areas wanting their “own” practice facilitator or teacher. The reasons given for the desire to have local educators included work pressure/demand on clinical staff thus no time to teach, access to the central team was too sporadic or infrequent and lack of skills to teach. The proportion of the workforce consisting of band 6 & 7 should ensure that the last point is addressed-teaching is usually a function of the band 6 & 7 role. The other factors such as lack of time can be addressed using protected time for example 1-2 hours per week per WTE and adjusting staff numbers upwards to compensate for this. The addition of assistant practitioners would also release nursing time of more senior registered nurses to teach junior staff however RNs will also be supervising the unregistered workforce.

Much of the perceived teaching deficit was in technical ophthalmic skills. This can be addressed in other ways such as simulation and might not only represent a partial solution to the spread of technical skills but also an opportunity to generate income by providing education to external organisations.

There remains an appetite for education past post registration courses Participants expressed an interest in Masters level study and in participants in the local staff survey expressed a desire to study at doctoral level either at PhD or Professional Doctorate.

There was a desire amongst respondents to attain more in terms of education Fig 15.
Figure 15: Future studies by band

**Recommendation:** That the in house practice development team is increased to meet demand for education & training by three WTE as currently the practice education team deliver a large range of taught courses as well as practice education. In addition to provide strategic oversight and enable higher level clinical academic careers some thought should be given to a senior clinical academic (education and practice development) leadership role possibly shared with a university. Currently UCL although part of the same AHSC cannot provide the curriculum required for the band 2-4 workforce, the advanced practice workforce or those that wish to top up to RN. If this cannot be developed relationships should be further developed with a range of other institutions that can offer the education required.

Currently there is no oversight or development of clinical academic careers and a senior research post such as Reader or Chair in ophthalmic nursing/care should be developed with an academic partner. This will develop research capacity for non-physicians. This role could be pump primed but then essentially self-sustaining (income generating or at least cost neutral).
Currently the registered and unregistered workforce appears to be either transient or long stayers. The current workforce is ageing and the same issues of limited supply exist as they do for the wider non specialist nursing workforce. This should be aligned with Trust OD strategy.

The supply issues could be addressed in several ways. To attract new talent and to retain experienced staff a number of approaches are likely to be needed. These could include:

- Work with local universities to **increase the number of pre-registration students on placement**. The liberalisation away from the bursary is intended to increase supply. MEH sites could offer placements for pre-registration students to increase awareness of ophthalmology as a career option by partnering with a number of universities. Many staff during interview said that they welcomed having students, sharing knowledge and that previous evaluations were good.

- Work with universities to increase the number of **return to practice** opportunities. The Trust education team has a track record of success in this area but this could be expanded.

- To attract and retain newly qualified nurses offering **rotational programmes** in different services or even partnering with hosts or community settings might be of benefit. Such programmes have been well evaluated in other specialisms and would allow the development of flexible skillsets.

- Examine the possibility of offering **apprenticeships, higher apprenticeships and foundation degrees** in addition to the current offer of city & guilds to attract the band 2 healthcare assistant to band 4 Assistant Practitioner. This would offer the lower band workforce a career pathway that with the recent changes to funding might allow them to progress to a nursing degree. The census showed an appetite for the RN degree programme from the unregistered workforce.

- To attract experienced nurses and nurse leaders or to retain experienced nurses offering access to the **advanced practice masters programmes (nursing) that are accredited by the Royal College of Nursing** which aims to offer credentialing of advanced practice in the near future. The Trust is currently offering a post graduate certificate in ophthalmology with University College London. This could also be used to attract staff to the specialism. In addition the development of **clinical academic careers** may attract other expert nurses to MEH.

- There is a perception that only nurses trained at Moorfields can lead at Moorfields. Although there is much to value in loyalty to an organisation, this perception is likely to be false given the experience of other specialist centres (where leadership commonly comes from outside the specialism). A lack of diversity can lead to “group think” and is not a feature of high reliability organisation. The trust is likely to benefit from recruiting a **diversity of backgrounds, skills and experience**, not limiting itself to ophthalmic nursing leaders.

- **Leadership development programmes** are already offered and based on the NHS Leadership Academy programmes. This could be expanded to attract senior experienced staff to offers of external leadership development.

- As an organisation MEH may wish to move to more formal credentialing such as **Magnet©** as a workplace and centre of excellence-a number of trusts in England are following this route to attract & retain staff.
8. Working at Moorfields: The staff experience

National Staff survey
The 2015 national staff survey shows overall a good or at least comparable staff experience compared with other similar organisations.

Responses in the 2015 survey for Moorfields were thus:
Registered Nurses – Adult / General n=135 19% of overall response
Registered Nurses – Children n=14 2% of overall response
Midwives 2 0% Other Registered Nurses n=22 3% of overall response
Nursing auxiliary / Nursing assistant / Healthcare assistant n=39 6% of overall response

Although the NHS staff survey was positive overall the bottom five issues were around opportunities for career progression, experiencing discrimination, staff experiencing harassment, bullying or abuse from other staff in last 12 months (27%) percentage of staff experiencing physical violence from staff in last 12 months (2%) and the Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months (24%).

Local staff survey intention
A range of responses were given to the question on intention & future plans by staff who took part in the local survey. Many of the respondents saw their future at the Trust (58 would like to continue their career at the Trust in a higher band post).

Figure 16: Intentions declared on the internal staff survey

- I am undecided about future plans
- I have no plans to move from my current role
- I plan to leave Moorfields in the next 2-5 years for another employer
- I plan to leave Moorfields in the next year for another employer
- I plan to retire in the next 2-5 years
- I plan to retire in the next year
- I would like a different role at Moorfields at a higher band
- I would like a different role at Moorfields at a lower band
- I would like a different role at Moorfields at the same band
- I would like to work at another Moorfields site
Local staff survey conducted in January 2016 free text responses

As part of a data collection exercise staff were invited to submit responses to working at the Trust as part of the online survey. 62 members of staff responded to the Free text question “Is there anything else you would like to tell us about working at the Trust?” These Free text answers word subjected to thematic analysis and given an overall label of mixed, positive or negative. A summary of the coded responses is shown in Figures 17, 18 & 19.

Figure 17: Responses by age group

Figure 18: Responses by banding
Themes emerging from responses

There were a number of broad themes in the 62 responses. These were subjected to thematic analysis but no other analysis. Where clinical areas have been named in responses these have been anonymised. A full list of responses can be found in Appendix C.

The **organisational culture** of the trust was the predominant theme in the freetext responses particularly leadership practices.

“It seems very difficult to challenge decisions from superior/line manager in regard of new ways of working that include increased workload to be carried out, especially if concentrated only on one person rather than being distributed. There is a risk staff might be frustrated and fear an action plan being put in place in case of failure to carry out increased workload, maybe leading to disciplinary action if task are not carried out as requested.”

“It is very difficult to bring new ideas or ways of working as there is some resistance to any creative suggestions. There are some very caring and loyal colleagues but generally it is very hierarchical and old fashioned. Management styles can be very autocratic.

“why does Moorfields do nothing about staff bullying others? Has being reported various times”

“Like the management, recruitment procedures, man power development I have a good working relationship, and a supportive team. I’m happy to be a Moorfield’s employee.”

**Feeling valued**

“I wish the trust would recognise all workers particularly those in lower bands. We do an important job with the patients”

“Not much support in my role. I seem to work on my own. I feel that I am not part of the work force team feel isolated am friendly with all the staff, I do participate in all activities but still feel as if I am a lone body. People ignore me.”
“I don’t feel the trust appreciates how difficult working in a very busy understaffed area. I don’t feel valued by senior management.”

“Don’t feel my opinion would be taken on board.”

“Moorfields is an exciting place to work! As per chief executive message people don’t leave NHS jobs, they leave the management! As the CQC approaches it will be wise to address issues which demotivate employees to work effectively with some managers.”

“Great opportunity to develop are available. What could be improved is to listen about more to frontline staff worries and try to meet them half-way weighing the Trust aims and objectives of course and hopefully, they will be less level staff leaving.”

**Organisational**

“Introduce tele conferencing as travelling from site to site for meetings is very time consuming.”

“Going through many protocols and not implementing right away.”

“Service outgrown the environment and clinics often run over so staff never off on time which is not good for morale.”

**Learning and development**

There is no support at all from the trust towards professional improvement.

There is no future for healthcare assistant where as in general hospital HCA can go up to becoming RN degree depending on your performance. For myself, I would to study nursing to achieve my goal to become RN so that I can do more than they allow me to do. However, I need a disposal income to survive. I hope in the future Moorfields will allow HCA to study and work at the same time.

I enjoy my my role as health care assistant, however, I sometimes feel as HCA, We are very limited to what we can do. I want to do more studying but HCA’s don’t have the chance.
9. The perception of nursing at Moorfields

The role of nursing at Moorfields is perceived differently by different groups. These range as enabler/facilitator of medical care (skilled/technical helper or physician extender) to providers of person centred ophthalmic care including meeting complex information and psycho-social needs such as counselling on sudden sight loss. This diverse range of views is held across professions, including amongst nursing staff.

There is mismatch between perception and function in several areas. These are explored below.

“technicians do the same job as nurses in clinic”

Moorfields nursing workforce is very outpatient focussed. The assumption that RNs could be replaced with lower band technical staff was commonly voiced. To examine this potential solution a number of clinics were observed. Differences were found in the working practices of RNs and technicians & HCA level practitioners.

Technicians on the whole provided a good service that was technically focussed for example visions and physiological measurements. The experienced RN provided a more comprehensive service (brief history, meeting information needs, drug administration & counselling, explanation of investigations, counselling on sight loss and other care functions). From these findings the current RN role is a different function to that of the technical role.

“nursing is not valued”

There was a perception amongst the registered and unregistered staff at all grades that nursing had lost value and was not a respected profession. Some members of staff who had been at the Trust for a long time articulated a view that nursing had decreased in value and had little voice or the ability to self-actualise. Despite this feeling of discontentment, they offered no strategy to change or deal with this situation and appeared to feel powerless despite holding senior or very senior roles. This could be a reflection of the hierarchical culture of the Trust which largely reflects a tall, technocratic organisation.

Incidental observational work

During observational work primarily in clinic settings, other groups such as patients, families and volunteers thought the nurses were caring and compassionate (they did not/could not differentiate between registered and unregistered nurses) the main concerns were waiting times and information needs-some of the patients waiting in clinic had GP cc letters they did not understand or were unsure what they had been told during the consultation.

Different groups exhibited different behaviours. For example during the meetings/observational work medical staff frequently interrupted nursing work with non-urgent needs even if the nurses were speaking to patients.

During this work some issues around governance were revealed such as inconsistencies in charting, communication issues between staff and fear of reporting incidents and near misses.
These were discussed with staff and the Director of Nursing however may point to a more substantial cultural issue which requires exploration.

**Recommendation:** A piece of work could be done to define and promote the value of ophthalmic nursing practice. Alongside the alignment of job titles and role descriptions, this could be used internally to help others understand value of the role and externally for recruitment purposes.

**Recommendation:** The hierarchical structure of the organisation makes innovation a challenge and promotes feeling of disempowerment. Encouragement of multidisciplinary team working and creating an environment where this can thrive for all grades would help promote innovation, evidence based practice, learning and patient safety.

**Recommendation:** A piece of work on effective workplace cultures (for example the recently published DH Culture of care Barometer) should be undertaken to look at effective workplace cultures. This is particularly necessary if the Trust wishes to move to newer more flexible ways of working.
10. The future workforce

If service models remain the same

Current configurations of staffing if all vacancies were filled is likely to be adequate in the short term however if the current model of expansion continues (increases in demand, location and time) a deficit in staffing is likely to occur with the next year, particularly if the 13% vacancy rate is not addressed. This is already being seen in some sections of the Trust for example additional Saturday clinics in the East. The wide geographical spread of the Trust means that mobility/flexibility is an issue—many other acute trusts might fill staffing gaps with lower band workers on a temporary basis if the work is supervised by an RN. Although not ideal this option is not open to MEH due to the spread of the workforce. Allowing for protected time and some uplift for extended hours in the current model there is a deficit of around 21 WTE budgeted RNs.

Changes to skill mix are likely to be beneficial. A high proportion of the workforce is currently in band 6-7 roles. Although this is unusual for an acute Trust it is not particularly unusual in a specialist centre. However in many other specialist Trusts these roles would be utilised more to provide direct multidisciplinary care episodes.

Taking into account future demand based on historical data supplied, the increased role of the assistant practitioner the following staffing model has been calculated as an overview.

Overall in the Trust uplift the Band 4 role to approximately 25 WTE to offset some of the work done by RNs particularly in clinics and theatres. These need not be new posts but development of the band 2-3 workforce in some settings or where a band 5 post is no longer required. An increase in band 4 assistant practitioner posts is likely to release band 5-7 time. There should not be a down drift or whole role substitution but the current workforce should be better utilised.

There are some other deficits in posts across the trust if continuing with the same model—these amount to around an extra 5 RNs to allow for protected time and 16 WTE RNs where there is currently 6 day working. The reason for lack of accuracy in these calculations is primarily lack of baseline data.
If the service models change

The current provision is focussed on procedure based care and high volume outpatient attendance. Although data is available on attendance and activity it is harder to determine the rate of discharge from outpatients’ clinics. Local data and expressed preferences of clinicians indicate that the preferred mode of care delivery is continuous routine follow up with low rates of attrition. Many other providers moved away from this during the introduction of payment by results atomised tariff and subsequent commissioned pathways.

Proactive case management as part of a multidisciplinary team

Proactive case management (PCM) common in both specialist centres and in routine high volume work such as diabetes is not currently the model at MEH. They are mostly physician led although a number of non-physicians lead such teams in other specialist areas. PCM limits the need for follow up appointments. Some providers have also completely dispensed with some outpatient services for routine follow up. Instead they use clinical time to work with patients and the primary care or local specialist community workforce to disseminate expertise and provide care. In proactive case management care is principally delivered by a group of healthcare professionals as part of a multi professional team with specialist nurses or other professionals (for example physiotherapists in musculoskeletal care) taking on the bulk of high volume activity and also some specialist areas of complexity for example psycho-social care and education. This allows consultant level physicians capacity to see complex cases. To deliver this method of care or variant of it, more specialist advanced practice roles would roles will be required (these could be a combination of nursing & other professionals such as optometry). The establishment of high functioning multidisciplinary teams is key to the success of this model.

Some services use nursing time and skilled input such as nurse injectors in the intravetral service however these services, although they offer much potential still rely heavily on medical staff to assess and follow up. In other ophthalmic centres nurses and optometrists as part of a multidisciplinary team manage this patient pathway leaving consultant free to manage complex treatment resistant patients.

The introduction of specialist advanced practice nurses or their development in addition to better utilisation of the current talent pool to deliver routine care is possible.

Nurse led services

Some work has been done at MEH but there has been no systematic, strategic approach to the development of non-physician led services. Such services increase capacity and efficiency whilst maintaining quality and are common in healthcare in all four countries of the UK.

Although there are a few advanced practice nurses at MEH (and a talent pool from which to develop more) it is likely that the addition of a number of these posts (10-20) around the Trust will significantly release capacity following the models of other centres.¹⁰
11. Specific examples from around the Trust

**Surgical services, City Road**
Ward based nursing is recently undergone review and the proposed merger of some functional roles is to be implemented. These have not been examined in this report.

**City Road Theatres**
City Road theatres has a fairly stable workforce and there have been a number of reviews in recent years. There has been a current stretch to 6 day working (including private work) and a proposal to introduce seven day services. The majority of the work is high volume; low risk surgery with patients managed with local anaesthesia and assessed pre operatively.

There is a high concentration of skill in theatres with some practitioners not practicing to the highest level of their registration. Whilst not overstaffed in terms of numbers, the skill mix is biased to this higher skillset. There appear to be three RNs per theatre along with a surgeon, assistant, anaesthetist and ODP. This is a high level of skill compared to similar services.

There has been a recent consultation on staffing in this area and a proposed new model which addresses a number of issues that have been identified. This would include the introduction of a role similar to that of the assistant practitioner. A role such as this has been utilised at other sites successfully.

**Recommendation:** The development of the Assistant Practitioner role which has been successfully implemented in some other areas of the trust theatre structure on other sites. These roles have been used successfully for example in circulating. A development programme from HCA to AP including a possible route to RN for those that might aspire to this.

**Recommendation:** Currently private work is not contributing to establishment figures with high reliance on NHS staffing to cover work. This should be addressed for example moving private work to bank staffing is likely to impact on use of NHS agency.

**Recommendation:** There is considerable scope to develop advanced practice in this setting alongside the development of advanced practice within the trust.

**Accident and Emergency-delivering urgent ophthalmic care across the Trust**
City Road A&E is not currently overstuffed but to run a sustainable service the way such services are provided are likely to need considerable reconfiguration of the service to maximise staff effort. Demand for the service is increasing steadily however demand management has only been recently initiated. There appears to a deficit in overall leadership, particularly in terms of service development. There is operational leadership from the current matron however the workload is increasing, there is a skills deficit in terms of advanced practice, there is little day to day clinical leadership with clinical leadership rotating between different medical staff.
Despite having a number of band 6 and 7 posts there is a deficit in teaching capacity which has prompted the advertisement of a practice educator role. It is likely that A&E is a prime placement of the training of nurses and other professionals in ophthalmic care and any such posts should integrate with the Trust Learning & Teaching and workforce development work. Not to do so risks isolation and the inability to capitalise further on multidisciplinary working and service development opportunities.

**Recommendation City Road:** That a day to day clinical leadership post is created at consultant level (of suitable profession) to provide clinical leadership and drive development of the service. That a comprehensive review of the way emergency ophthalmic care is currently delivered in order to manage demand, address cultural issues and to plan a future workforce and the commissioning the necessary training.

**Recommendation other sites:** The provision of emergency care varies at other sites. Emergency care at other sites (ie Croydon and St Georges) would be well served by the addition of a peripatetic advanced practice workforce for urgent first contact care at those sites who could cover both emergency work, more routine demand from the host organisation (ie emergency inpatient ophthalmic reviews) and follow up alongside medical staff allowing for a flexible workforce.

**Outpatient and diagnostic services, City Road**

**Outpatients & ambulatory care City Road**

Outpatients and ambulatory care at City road provides primarily high volume care with a range of complexity including follow up. There is an increasing demand for nursing in this setting and in the internal staff survey respondents from this group were most likely to work unpaid overtime (3-5 hour and 6-10 hours per week categories). Although RNs at first appearance perform a similar role to technicians in this setting they function differently providing different interventions in addition to technical diagnostic work.

**Recommendation:** Some of the unpaid overtime of this group is likely to be offset by an increase in support workers. Introducing the assistant practitioner role would allow current registered nurses to utilise their skills in supporting unregistered practitioners and increase capacity in clinics or offer other modalities of follow up. The deficit in RNs (once any vacancies are filled) is small but the addition of 4-6 RNs would allow those currently managing services as well as providing advanced practice care to do more care delivery and teaching/staff development.
Richard Desmond Children’s Eye Centre
This service is currently staffed with no deficit however there is an opportunity here to free medical and qualified nursing staff with the introduction of a clinical nurse specialist in paediatric ophthalmology. This would be an advanced practice role specialising in the management of care of children and young adults with complex ophthalmic conditions that require case management and irregular access to services particularly between centres. There are already plans to develop advanced practice for example in emergency care.

St Georges & Croydon
St Georges has 6 beds and takes patients of different levels of acuity including some heavily dependent patients. It shares theatres with the host acute trust (thus not 5 day service). It has an extensive outpatient service, urgent care/walk in (surgery not 5 days theatres used by host trust)
Issues with recording of activity might mean there is less accuracy in activity data. Outpatients are mixed, children & adults and staffed by technicians and RNs.
Croydon also has out patients’ clinics, theatres (10 sessions per week) and urgent care (limited hours).
The development of assistant practitioners (the current technical workforce) is likely to release some nursing time to develop routine high volume services. The aforementioned introduction of an advanced practice workforce particularly in urgent care will offer flexibility & stability plus support to teaching.

Moorfields East
Moorfields East is responsible for the provision of eye care in the eastern part of London
The spread of Moorfields East means that the relatively small deficit in staffing is keenly felt. In addition the leadership position is spread thinly. If further expansion is to occur (days or locations-some services have already expanded to weekend working) this sector will require additional posts depending on the rate of expansion. The sector requires at least 6 WTE RN and 0.5 WTE additional leadership role to complement current leadership.

Bedford and locality
Bedford has done some work on different roles (for example the band 3 HCA in theatres) and has a small deficit of around 2 FTE WTE.

Northwick Park & Locality
NWP and the locality operate as a hub and there was also evidence of advanced practice as part of a multidisciplinary team. NWP have also enabled the assistant practitioner role. It currently has a small deficit (approx. 6 WTE RN at NWP, Potters Bar, Ealing) filling this deficit would allow further development of advanced practice roles.
12. References


Other documents

Sunderland Nurse led injections (service) http://www.magonlinelibrary.com/doi/full/10.12968/ijop.2013.4.2.68
Appendix A

Data available & sources used

Manual headcount from matrons
Demand and capacity data from previous years
Health and social care information centre datasets ie HES
ONS data
Internal staff survey (conducted by team Jan 2016)
Establishments (by directorate) but this is variable in terms of detail/accuracy
Business plan Vision 2020
Patient experience, friends and family (public source NHSE)
Staff experience survey public for 2015 and internal for 2014
Annual reports
Previous CFWI work on the medical workforce
Previous CFWI work on the band 1-4 workforce
Literature
RCN ophthalmic nursing framework
RCO competency statements
COA curriculum.
Internal reports for some areas.
Access to Oriel data was not possible because of commercial confidentiality. Data was obtained from information services and otherwise public datasets were used.

Deficits in data collection

A limited electronic staff record
A partial electronic health record
E roster not yet implemented throughout the trust
Local staffing/establishment records did not tally with Route 66 due to different classification systems. Local records also kept in a variety of formats and styles. These ranged from excel spreadsheets with detailed information to lists kept on Word files. This meant a significant amount of time was dedicated to acquiring and checking baseline data as data from differing sources was contradictory.
## Capacity/activity data distribution as supplied by the Trust

### Outpatients (14/15)

<table>
<thead>
<tr>
<th>Site</th>
<th>Attendances</th>
</tr>
</thead>
<tbody>
<tr>
<td>City Road</td>
<td>290,232</td>
</tr>
<tr>
<td>St George’s</td>
<td>60,473</td>
</tr>
<tr>
<td>Croydon</td>
<td>37,107</td>
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<tr>
<td>Northwick Park</td>
<td>35,952</td>
</tr>
<tr>
<td>Ealing</td>
<td>31,131</td>
</tr>
<tr>
<td>St Ann’s</td>
<td>15,868</td>
</tr>
<tr>
<td>Mile End</td>
<td>9,468</td>
</tr>
<tr>
<td>Barking</td>
<td>9,227</td>
</tr>
<tr>
<td>Potters Bar</td>
<td>7,204</td>
</tr>
<tr>
<td>Loxford</td>
<td>4,641</td>
</tr>
<tr>
<td>Queen Mary’s</td>
<td>1,738</td>
</tr>
<tr>
<td>Teddington</td>
<td>1,386</td>
</tr>
<tr>
<td>Purley</td>
<td>1,202</td>
</tr>
<tr>
<td>Darent Valley</td>
<td>1,160</td>
</tr>
<tr>
<td>Watford</td>
<td>863</td>
</tr>
<tr>
<td>Ludwig</td>
<td>727</td>
</tr>
<tr>
<td>Battersea</td>
<td>476</td>
</tr>
<tr>
<td>Unallocated</td>
<td>166</td>
</tr>
<tr>
<td>Nightingale Nursing Home</td>
<td>14</td>
</tr>
<tr>
<td><strong>Overall</strong></td>
<td><strong>509,035</strong></td>
</tr>
</tbody>
</table>

### Inpatients (surgical) (14/15)

<table>
<thead>
<tr>
<th>Site</th>
<th>Admissions</th>
</tr>
</thead>
<tbody>
<tr>
<td>City Road</td>
<td>18,560</td>
</tr>
<tr>
<td>St Ann’s</td>
<td>4,090</td>
</tr>
<tr>
<td>St George’s</td>
<td>3,774</td>
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<tr>
<td>Croydon</td>
<td>3,422</td>
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<td>Northwick Park</td>
<td>2,462</td>
</tr>
<tr>
<td>Ealing</td>
<td>1,932</td>
</tr>
<tr>
<td>Potters Bar</td>
<td>1,217</td>
</tr>
<tr>
<td>Mile End</td>
<td>1,153</td>
</tr>
<tr>
<td>Darent Valley</td>
<td>321</td>
</tr>
<tr>
<td>Queen Mary’s</td>
<td>221</td>
</tr>
<tr>
<td>Whittington</td>
<td>105</td>
</tr>
<tr>
<td><strong>Overall</strong></td>
<td><strong>37,257</strong></td>
</tr>
</tbody>
</table>
Appendix B

NIHR Clinical Academic Careers for nurses and other healthcare professionals. More information can be found at https://www.hee.nhs.uk/our-work/developing-our-workforce/clinical-academic-careers

NIHR RESEARCH CAREER PATHWAYS

Methodologists

Research Methods Programme

Fellowships for all

NIHR Fellowships, Professorships and other awards

Healthcare Professionals (non-doctors/dentists)

HEE/NIHR Integrated Clinical Academic Programme

Doctors and Dentists

NIHR Integrated Academic Training Programme

Research Professorship

Senior Research Fellowship

Career Development Fellowship

Post-Doctoral Fellowship

Doctoral Research Fellowship

HEE/NIHR Clinical Doctoral Research Fellowship

HEE/NIHR Masters in Clinical Research Studentship

HEE/NIHR Senior Clinical Lectureship

Clinical Lectureship

In-Practice Fellowship

Clinical Scientist Award

Academic Clinical Fellowship

Chair

Senior/Pre-Chair

Post-Doctoral Fellowship

Doctoral Fellowship

Pre-Doctoral Fellowship

Undergraduate

Masters Studentship in Health Economics or Medical Statistics

Systematic Reviews Fellowship and Research Methods Fellowship and Internship

NIHR RESEARCH CAREER PATHWAYS

Source: NIHR 2015
Appendix C

All anonymised responses to the internal staff survey free text question “Is there anything else you would like to tell us about working at the Trust?”

Culture

It seems very difficult to challenge decisions from superior/line manager in regard of new ways of working that include increased workload to be carried out, especially if concentrated only on one person rather than being distributed. There is a risk staff might be frustrated and fear an action plan being putted in place in case of failure to carry out increased workload, maybe leading to disciplinary action if task are not carried out as requested.

I do not like that staff meetings in the unit are done always at different times and are not advertised as it is might be easy to miss those when [they] are happening.

Unfortunately I see MEH treating its staff in a very poor manner more and more and its sad to see longstanding MEH leave under a cloud, as i may well do

I wish the trust would recognise all workers particularly those in lower bands. We do an important job with the patients.

Too many bosses or managers to report to in my department. No room for growth. Recruitment and retention policy is not robust.

It is very difficult to bring new ideas or ways of working as there is some resistance to any creative suggestions. There are some very caring and loyal colleagues but generally it is very hierarchical and old fashioned. Management styles can be very autocratic. why does Moorfields do nothing about staff bullying others? Has being reported various times

Like the management, recruitment procedures, man power development

I have a good working relationship, and a supportive team. I’m happy to be a Moorefield’s employee.

It is not even easy you make a suggestion, I find staff stay in the same areas for too long and become resistant to change.

Working in the Trust, change happens very slowly. staff experience a lot of bullying

Things have changed for the better in the last 2 years- I am happy to be employed at MEH. But I would like further development opportunities for those in lower bands

It is not even easy to make a suggestion, I find staff stay in the same areas for too long and become resistant to change.

Management here seem to be disconnected with the rest of the team

There can be issues with the different groups communicating, e.g clerical managers with nursing managers. There does seem to be a disconnect which we need to change.

It’s very rewarding to work with Moorfields as it has got good reputation on eye care.

Sometimes staff aren’t keen on change. Initially some staff were quite frosty, not sure if that is because the trust has lots of visitors. On a positive, I enjoy working here at Moorfields.

Incredibly challenging organisation to work in. Pockets of exceptional good practice exist but overall Trust is very stuck in an old fashioned way of working. Holistic care of patients is not particularly good. Satellite Units function well but City Road hard to change culture. Too much of a focus on ophthalmology and nothing else - patients are more than just a pair of eyes!!
more team work and more time to see your manager
clinical areas need to take ownership
Understaffed, no admin support for certain roles.
When it comes to promotion other considerations best known to managers are considered.
This trust is not very organised. I have no job satisfaction
There is limited space to work

Feeling valued
I just feel that in my department, female HCA staff are not recognised.
Because Moorfields has so many sites it is an opportunity to work in different sites but due to large
areas to cover staffing the various sites can be challenging.
It would be helpful if certain staffing issues were listened to and addressed more quickly.
i like working at the trust but my immediate teamleader is biased
Not much support in my role. I seem to work on my own. I feel that I am not part of the work
force team feel isolated am friendly with all the staff, I do participate in all activities but still feel as
if I am a lone body. People ignore me.
I don’t feel the trust appreciates how difficult working in a very busy understaffed area. I don’t feel
valued by senior management
Don’t feel my opinion would be taken on board
Hard work is not valued. Senior staff get away with study days, funding. No initiative from senior
staff on clinical activities even clinic are over booked
so far so good
Moorfields are very good employers who listen to and value their staff
With Moorfields – you have a voice and you are heard.
Moorfields is an exciting place to work! As per chief executive message people don’t leave NHS
jobs, they leave the management! As the CQC approaches it will be wise to address issues which
demotivate employees to work effectively with some managers.
Moorfields is a great place to work at, i work within a fantastic team and my ward manager is
equally supportive.
Great opportunity to develop are available. What could be improved is to listen about more to
frontline staff worries and try to meet them half-way weighing the Trust aims and objectives of
course and hopefully , they will be less level staff leaving .
Good place to work but wages very low and extremely busy and sometimes very short staff
I enjoy working at Moorfields and would like to continue working here. However I think it could
be difficult to progress in my career without moving to a different hospital as there does not seem
to be much of a career progression route from my job, and I don’t get the opportunity to find out
about jobs in other departments. It would be nice to have more communication about work going
on in other parts of the hospital, and to have more career progression opportunities.
i honestly feel very at home at Moorfields its just us hca’s / technician are not recognised that much
for our hard work and at the end of every month the money i take home does not make sense
I really enjoy working at Moorfields. I have been well supported by my managers and fellow work colleagues during my time here. There are occasions when staying behind to complete clinics, ensuring that patients have been seen and have left on transport impacts on leaving on time and feels like an expectation that staff will just be able to stay, particularly when clinics are overbooked.

**Organisational**

*Introduce tele conferencing as travelling from site to site for meetings is very time consuming*  
*Going through many protocols and not implementing right away.*

Currently working part time. I would like to increase my hours. But due to lack of flexibility in [named clinical area] it look impossible to do so. Am seriously looking at other department that a a bit flexible to join. Another issue here in [named clinical area] is the Shift pattern. Today you do long day, tomorrow you’re on earlyshift. Plus, no fix day, for example this week you can work Monday and Tuesday next week might be different. It’s very difficult for some of us that have kids/ and other stuff

Service outgrown the environment and clinics often run over so satff never off on time which isnot good for moral

**Learning and development**

*There is no support at all from the trust towards professional improvement.*

*There is no future for healthcare assistant where as in general hospital HCA can go up to becoming RN degree depending on your performance. For myself, I would to study nursing to achieve my goal to become RN so that I can do more than they allow me to do. However, I need a disposal income to survive. I hope in the future Moorfields will allow HCA to study and work at the same time.*

I enjoy my my role as health care assistant, however, I sometimes feel as HCA,  
*We are very limited to what we can do. I want to do more studying but HCA’s don’t have the chance Have more training for other staff except permanent staff*  
*Moorfields is very good in supporting staff with learning opportunities. I get good support from my seniors and nurse manager.*

*Clinical training and development requires evaluation and improving especially for Band 5 nurses [named clinical area] gets little or no allocation for education, most [named clinical area] education for ophthalmology we have to organise ourselves*
Authors of this report

Mr Adrian Swift, Consultant, Centre for Workforce Intelligence (Mouchel)

The Centre for Workforce Intelligence (CfWI) is an independent agency working on specific projects for the Department of Health and is an operating unit within Mouchel Management Consulting Limited. CfWI undertook a stocktake of the ophthalmic medical workforce in 2014.


Prof Alison Leary, Chair of Healthcare & Workforce Modelling London Southbank University.

Much of Alison’s commissioned research and development work is in the area of defining and promoting the value of advanced and specialist practice nursing particularly the cost benefit. She has undertaken several workforce modelling projects at organisational and population level. Recent work has included projects for the third sector, commissioning groups, DH National Cancer Action Team, several NHS Trusts, The RCN, Coloplast Plc. She was included on the Nursing Times Leaders list in 2014 and named as one of The Health Service Journal’s Inspirational Women in Healthcare. She is a Fellow of the Royal College of Nursing (2015) and a Winston Churchill Fellow (2016).