

**Paper for submission to the Board of Directors on 5<sup>th</sup> December 2013**

<b>TITLE:</b>	How to ensure the right people, with the right skills, are in the right place at the right time		
<b>AUTHOR:</b>	Denise McMahon Director of Nursing	<b>PRESENTER:</b>	Denise McMahon Director of Nursing
<b>CORPORATE OBJECTIVE:</b>			
SGO1: Quality, Safety & Service Transformation Reputation - To become well known for the safety and quality of our services through a systematic approach to service transformation , research and innovation			
SGO2: Patient experience - To provide the best possible patient experience			
SGO5: Staff Commitment - To create a high commitment culture from our staff with positive morale and a “can do” attitude			
<b>SUMMARY OF KEY ISSUES:</b>			
<p>This is the new guidance which was published last week and has been developed by the Chief Nursing Officer with the National Quality Board and seeks to support organisations in making informed decisions about staffing levels that allow for high quality and compassionate care. The report covers 10 expectations; these are explicit requirements for Trust Boards.</p> <p><b><u>ACCOUNTABILITY &amp; RESPONSIBILITY</u></b></p> <p><b>Expectation 1:</b> Boards take full responsibility for the quality of care provided to patients and as a key determinant of quality, take full and collective responsibility for nursing, midwifery and care staffing capacity and capability. <i>It will be a responsibility of the Board to assure and be accountable to the public that staff levels are safe.</i></p> <p><b>Expectation 2:</b> Processes are in place to enable staffing establishments to be met on a shift-to-shift basis. <i>There must be an escalation process to inform on shortages and this must be visible to the Board.</i></p> <p><b><u>EVIDENCE-BASED DECISION MAKING</u></b></p> <p><b>Expectation 3:</b> Evidence-based tools are used to inform nursing, midwifery and care staffing capacity and capability. <i>Staff must be trained to use these tools but also soft intelligence.</i></p> <p><b><u>SUPPORTING AND FOSTERING A PROFESSIONAL ENVIRONMENT</u></b></p> <p><b>Expectation 4:</b> Clinical and managerial leaders foster a culture of professionalism and responsiveness, where staff feel able to raise concerns. <i>Staff must be supported to speak out if they can't deliver care within the staffing levels allowed.</i></p> <p><b>Expectation 5:</b> A multi-professional approach is taken when setting nursing, midwifery and care staffing establishments. <i>This includes AHP, Clerical and Management.</i></p> <p><b>Expectation 6:</b> Nurses, midwives and care staff have sufficient time to fulfil responsibilities that are additional to their direct caring duties. <i>This includes clinical, admin, leading and mentoring.</i></p> <p><b><u>OPENNESS AND TRANSPARENCY</u></b></p> <p><b>Expectation 7:</b> Boards receive monthly updates on workforce information, and staffing capacity and capability is discussed at a public Board meeting at least every six months on the basis of a full nursing and midwifery establishment review.</p> <p><b>Expectation 8:</b> NHS providers clearly display information about the nurses, midwives and care staff present on each ward, clinical setting, department or service on each shift. <i>This must be visible to patients.</i></p> <p><b><u>PLANNING FOR FUTURE WORKFORCE REQUIREMENTS</u></b></p> <p><b>Expectation 9:</b> Providers of NHS services take an active role in securing staff in line with their workforce requirements.</p> <p><b><u>THE ROLE OF COMMISSIONING</u></b></p> <p><b>Expectation 10:</b> Commissioners actively seek assurance that the right people, with the right skills, are in the right place at the right time within the providers with whom they contract.</p> <p>National Institute for Health and Care Excellence (NICE) are taking forward this guidance and</p>			

will publish it by July 2014. This will be followed by specific guidance on Accident and Emergency (A&E), Mental Health, Community and Paediatrics.

This report is welcomed to give structure to the National position on nurse staffing. As a Trust, we have undertaken much of this work already but still await results from the AUKUH Safer Staffing Tool, which at present Ruth May has instructed that a bespoke data entry should be made for us to satisfy the requirements of the Keogh inspection actions. She has suggested Ann Coley, an expert from University College London Hospital, undertakes this process for us.

I will advise the Board at the January 2014 meeting of our specific actions against each of our recommendations.

**IMPLICATIONS OF PAPER:**

<b>RISK</b>	<b>Y</b>		<b>Risk Score and Description:</b> Nurse staffing levels are sub-optimal (20) Loss of experienced midwives (15)
	<b>Risk Register: Y</b>		
<b>COMPLIANCE and/or LEGAL REQUIREMENTS</b>	<b>CQC</b>	<b>Y</b>	<b>Details:</b> 13: Staffing
	<b>NHSLA</b>	<b>N</b>	<b>Details:</b>
	<b>Monitor</b>	<b>Y</b>	<b>Details:</b> Compliance with the Risk Assessment Framework
	<b>Equality Assured</b>	<b>Y</b>	<b>Details:</b> Better Health Outcomes for all Improved patients access and experience
	<b>Other</b>	<b>N</b>	<b>Details:</b>

**ACTION REQUIRED OF BOARD:**

<b>Decision</b>	<b>Approval</b>	<b>Discussion</b>	<b>Other</b>
✓		✓	

**RECOMMENDATIONS FOR THE BOARD:**

To be cognisant of the Board responsibilities within the new guidance and agree.  
To approve the proposed actions.

# **How to ensure the right people, with the right skills, are in the right place at the right time**

*A guide to nursing, midwifery and care staffing capacity and capability*



# Contents

- Foreword ..... 3
- 1 Expectations relating to nursing, midwifery and care staffing capacity and capability..... 4
- 2 Introduction and purpose of this guide ..... 8
- 3 Accountability and responsibility for staffing capacity and capability ..... 10
- 4 Evidence-based decision-making ..... 18
- 5 Supporting and fostering a professional environment ..... 28
- 6 Openness and transparency for patients and the public ..... 44
- 7 Planning for future workforce requirements..... 52
- 8 The role of commissioning ..... 54
- 9 Next Steps..... 56

## Foreword

High quality, compassionate care is about people, not institutions. In every ward and clinic, in every hospital, health centre, community service and patient's home across the country, nursing, midwifery and care staff work to provide care and compassion to people when they need it – whether it is at the beginning, or end of their life; in times of illness or uncertainty; or as part of helping people with long term conditions to stay as healthy and live as independently as possible.

However, there have been examples of care in recent times which have been unacceptable. These have been as a result of individual and organisational failings. We must all find the provision of sub-standard and unsafe care to patients intolerable. We must do all we can to support our staff to provide high quality, compassionate care. And we must support organisations to be able to make the right decisions about their staffing needs and to create an environment within which staff are supported to care.

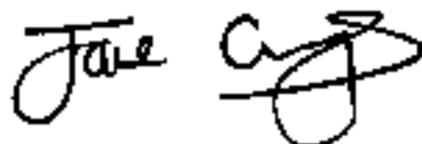
This guidance, which I have developed with my colleagues from the National Quality Board, seeks to support organisations in making the right decisions and creating a supportive environment where their staff are able to provide compassionate care. It sets out expectations of commissioners and providers in relation to getting nursing, midwifery and care staffing right so that they can deliver high quality care and the best possible outcomes for their patients. To a large extent, these expectations are about common sense and good leadership. We expect that all organisations should be meeting these currently, or taking active steps to ensure they do in the very near future.

There has been much debate as to whether there should be defined staffing ratios in the NHS. My view is that this misses the point – we want the right staff, with the right skills, in the right place at the right time. There is no single ratio or formula that can calculate the answers to such complex questions. The right answer will differ across and within organisations, and reaching it requires the use of evidence, evidence based tools, the exercise of professional judgement and a truly multi-professional approach. Above all, it requires openness and transparency, within organisations and with patients and the public. This guidance helps organisations to make those decisions by identifying tools, resources and examples of good practice. NICE will soon review the evidence and accredit evidence-based tools to further support decision-making on staffing.

Getting the right staff with the right skills to care for our patients all the time is not something that can be mandated or secured nationally. Providers and commissioners, working together in partnership, listening to their staff and patients, are responsible and will make these expectations a reality. As national organisations we pledge to play our part in securing the staffing capacity and capability you need to care for your patients.

I am grateful to my NQB colleagues for their commitment to this challenge and for working with me in setting out these expectations. I look forward to our continued work together and to seeing this guidance implemented across England for the benefit of our patients and staff.

**Jane Cummings, Chief Nursing Officer for England**

A handwritten signature in black ink, appearing to read 'Jane Cummings', written in a cursive style.

# 1 Expectations relating to nursing, midwifery and care staffing capacity and capability

Nursing, midwifery and care staff, working as part of wider multidisciplinary teams, play a critical role in securing high quality care and excellent outcomes for patients.

There are established and evidenced links between patient outcomes and whether organisations have the right people, with the right skills, in the right place at the right time. *Compassion in Practice*<sup>1</sup> emphasised the importance of getting this right, and the publication of the report of the Mid-Staffordshire NHS Foundation Trust Public Inquiry,<sup>2</sup> and more recent reviews by Professor Sir Bruce Keogh into 14 trusts with elevated mortality rates<sup>3</sup>, Don Berwick's review into patient safety,<sup>4</sup> and the Cavendish review into the role of healthcare assistants and support workers<sup>5</sup> also highlighted the risks to patients of not taking this issue seriously.

That is why members of the National Quality Board, which brings together the different parts of the NHS system with responsibilities for quality, alongside patients and experts – and the Chief Nursing Officer, England, have come together to set out collectively the expectations of NHS providers and commissioners in this area.

---

<sup>1</sup> *Compassion in Practice*, NHS England, December 2012. Available at <http://www.england.nhs.uk/wp-content/uploads/2012/12/compassion-in-practice.pdf>

<sup>2</sup> *Report of the Mid-Staffordshire NHS Foundation Trust Public Inquiry*, The Mid-Staffordshire NHS Foundation Trust Public Inquiry, February 2013. Available at <http://www.midstaffpublicinquiry.com/>

<sup>3</sup> *Review into the quality of care provided by 14 hospital trusts in England: overview report*, Prof. Sir Bruce Keogh, NHS England, July 2013. Available at: <http://www.nhs.uk/NHSEngland/bruce-keogh-review/Documents/outcomes/keogh-review-final-report.pdf>

<sup>4</sup> *A promise to learn, a commitment to act: improving the safety of patients in England*, Don Berwick, Department of Health, August 2013. Available at: <https://www.gov.uk/government/publications/berwick-review-into-patient-safety>

<sup>5</sup> *The Cavendish review: an independent review into healthcare assistants and support workers*, Camilla Cavendish, Department of Health, July 2013. Available at: [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/236212/Cavendish\\_Review.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/236212/Cavendish_Review.pdf)

## ACCOUNTABILITY & RESPONSIBILITY

**EXPECTATION 1: Boards take full responsibility for the quality of care provided to patients, and as a key determinant of quality, take full and collective responsibility for nursing, midwifery and care staffing capacity and capability.** Boards ensure there are robust systems and processes in place to assure themselves that there is sufficient staffing capacity and capability to provide high quality care to patients on all wards, clinical areas, departments, services or environments day or night, every day of the week.

Boards are actively involved in managing staffing capacity and capability, by agreeing staffing establishments, considering the impact of wider initiatives (such as cost improvement plans) on staffing, and are accountable for decisions made. Boards monitor staffing capacity and capability through regular and frequent reports on the actual staff on duty on a shift-to-shift basis, versus planned staffing levels. They examine trends in the context of key quality and outcome measures. They ask about the recruitment, training and management of nurses, midwives and care staff and give authority to the Director of Nursing to oversee and report on this at Board level.

Board papers are accessible to patients and staff working at all levels, and boards seek to involve staff at all levels and across different parts of the organisation, facilitating a strong line of communication from ward to Board, and Board to ward. Boards ensure their organisation is open and honest if they identify potentially unsafe staffing levels, and take steps to maintain patient safety.

Boards must, at any point in time, be able to demonstrate to their commissioners, the Care Quality Commission, the NHS Trust Development Authority or Monitor that robust systems and processes are in place to assure themselves that the nursing, midwifery and care staffing capacity and capability in their organisation is sufficient.

**EXPECTATION 2: Processes are in place to enable staffing establishments to be met on a shift-to-shift basis.** The Executive team should ensure that policies and systems are in place, such as e-rostering and escalation policies, to support those with responsibility for staffing decisions on a shift-to-shift basis. The Director of Nursing and their team routinely monitor shift-to-shift staffing levels, including the use of temporary staffing solutions, seeking to manage immediate implications and identify trends. Where staffing shortages are identified, staff refer to escalation policies which provide clarity about the actions needed to mitigate any problems identified.

## EVIDENCE-BASED DECISION MAKING

**EXPECTATION 3: Evidence-based tools are used to inform nursing, midwifery and care staffing capacity and capability.** As part of a wider assessment of workforce requirements, evidence-based tools, in conjunction with professional judgement and scrutiny, are used to inform staffing requirements, including numbers and skill mix. Senior nursing and midwifery staff and managers actively seek out data that informs staffing decisions, and they are appropriately trained in the use of evidence-based tools and interpretation of their outputs. Staff use professional judgement and scrutiny to triangulate the results of tools with their local knowledge of what is required to achieve better outcomes for their patients.

## SUPPORTING AND FOSTERING A PROFESSIONAL ENVIRONMENT

**EXPECTATION 4: Clinical and managerial leaders foster a culture of professionalism and responsiveness, where staff feel able to raise concerns.** The organisation supports and enables staff to deliver compassionate care. Staff work in well-structured teams and are enabled to practice effectively, through the supporting infrastructure of the organisation (such as the use of IT, deployment of ward clerks, housekeepers and other factors) and supportive line management.

Nursing, midwifery and care staff have a professional duty to put the interests of the people in their care first, and to act to protect them if they consider that they may be at risk, including raising concerns. Clinical and managerial leaders support this duty, have clear processes in place to enable staff to raise concerns (including about insufficient staffing) and they seek to ensure that staff feel supported and confident in raising concerns. Where substantiated, organisations act on concerns raised.

**EXPECTATION 5: A multi-professional approach is taken when setting nursing, midwifery and care staffing establishments.** Directors of Nursing lead the process of reviewing staffing requirements, and ensure that there are processes in place to actively involve sisters, charge nurses or team leaders. They work closely with Medical Directors, Directors of Finance, Workforce (HR), and Operations, recognising the interdependencies between staffing and other aspects of the organisations' functions. Papers presented to the Board are the result of team working and reflect an agreed position.

**EXPECTATION 6: Nurses, midwives and care staff have sufficient time to fulfil responsibilities that are additional to their direct caring duties.** Staffing establishments take account of the need to allow nursing, midwifery and care staff the time to undertake continuous professional development, and to fulfil mentorship and supervision roles. Providers of NHS services make realistic estimations of the likely levels of planned and unplanned leave, and factor this into establishments. Establishments also afford ward or service sisters, charge nurses or team leaders time to assume supervisory status and benefits are reviewed and monitored locally.

## OPENNESS AND TRANSPARENCY

**EXPECTATION 7: Boards receive monthly updates on workforce information, and staffing capacity and capability is discussed at a public Board meeting at least every six months on the basis of a full nursing and midwifery establishment review.** Boards receive monthly updates on workforce information, including the number of actual staff on duty during the previous month, compared to the planned staffing level, the reasons for any gaps, the actions being taken to address these and the impact on key quality and outcome measures. At least once every six months, nursing, midwifery and care staffing capacity and capability is reviewed (an establishment review) and is discussed at a public Board meeting. This information is therefore made public monthly and six monthly. This data will, in future, be part of CQC's Intelligent Monitoring of NHS provider organisations.

**EXPECTATION 8: NHS providers clearly display information about the nurses, midwives and care staff present on each ward, clinical setting, department or service on each shift.** Information should be made available to patients and the public that outlines which staff are present and what their role is. Information displayed should be visible, clear and accurate, and it should include the full range of support staff available on the ward during each shift.

## PLANNING FOR FUTURE WORKFORCE REQUIREMENTS

**EXPECTATION 9: Providers of NHS services take an active role in securing staff in line with their workforce requirements.** Providers of NHS services actively manage their existing workforce, and have robust plans in place to recruit, retain and develop all staff. To help determine future workforce requirements, organisations share staffing establishments and annual service plans with their Local Education and Training Board (LETBs), and their regulators for assurance. Providers work in partnership with Clinical Commissioning Groups and NHS England Area Teams to produce a Future Workforce Forecast, which LETBs will use to inform their Education Commissions and the Workforce Plan for England led by Health Education England (HEE).

## THE ROLE OF COMMISSIONING

**EXPECTATION 10: Commissioners actively seek assurance that the right people, with the right skills, are in the right place at the right time within the providers with whom they contract.** Commissioners specify in contracts the outcomes and quality standards they require and actively seek to assure themselves that providers have sufficient nursing, midwifery and care staffing capacity and capability to meet these. Commissioners monitor providers' quality and outcomes closely, and where problems with staff capacity and capability pose a threat to quality, commissioners use appropriate commissioning and contractual levers to bring about improvements. Commissioners recognise that they may have a contribution to make in addressing staffing-related quality issues, where these are driven by the configuration of local services or the setting of local prices in contracts.

## 2 Introduction and purpose of this guide

In recognition of the ever increasing focus on nursing, midwifery and care staffing capacity and capability as a key determinant of the quality of care experienced by patients, the Chief Nursing Officer in England, members of the National Quality Board, and a cross-sector professional steering group have come together to set out system-wide expectations of providers and commissioners in this area. This 'How to' guide outlines these expectations and considers each one in detail, outlining why it is important, and providing some practical advice on how it can be met. This guidance has been written with providers and commissioners of NHS funded acute services, maternity, mental health, learning disabilities and community services, in mind.

Meeting the expectations outlined in the guide will go a long way to ensuring that organisations have nursing, midwifery and care staffing capacity and capability that is consistent with the provision of high quality care. However, establishing and maintaining adequate staffing capacity and capability is an inherently challenging process, and we recognise that not all organisations will be meeting the expectations set out in this document at the moment. Where this is the case, we expect organisations to have discussions at Board level as a matter of urgency about the actions that could be taken to meet these expectations. Chapter 9 – Next Steps, sets out how national regulatory and oversight organisations will take account of this guidance.

In the longer term, this guidance will be built upon by the work of the National Institute for Health and Care Excellence (NICE). NICE will be reviewing the evidence in this area, and will produce further guidance, and accredit tools to support staffing capacity and capability that is commensurate with high quality care.

There is no 'one size fits all' approach to establishing nursing, midwifery and care staffing capacity and capability, and this guide does not prescribe the 'right way', or a single approach, to doing so. Similarly, the guide does not recommend a minimum staff-to-patient ratio. It is the role of provider organisations to make decisions about nursing, midwifery and care staffing requirements, working in partnership with their commissioners, based on the needs of their patients, their expertise, the evidence and their knowledge of the local context. Rather, this guide aims to support providers and commissioners in meeting the expectations of people using their services by:

- suggesting some practical steps that organisations can take to meet the expectations and providing examples of good practice;
- signposting readers to existing tools and resources; and
- outlining the individual roles and responsibilities of different professionals involved in establishing and maintaining nursing, midwifery and care staffing capacity and capability.

In order to ensure that the nursing, midwifery and care staffing workforces can deliver the best care possible, a range of factors must be considered – simply having the right numbers of staff in place is not enough. To maximise the effectiveness of the workforce, organisations need strong and effective leadership, and to foster a culture that encourages people to take pride in their work. Staff need adequate training and development, and the organisation needs to support them to maintain their health and wellbeing. At a time when finances remain constrained, yet demand and public expectations of the health system are rising, it is vital that organisations look at how they use their available resources and workforce, and consider how things can be done more efficiently. Whilst this guide focuses on staffing capacity and capability, the importance of other factors in supporting a capable and effective workforce must not be overlooked.

Though this guide is focussed on nursing, midwifery and care staffing capacity and capability – following recent reports that identified particular issues with these professional groups – the principles outlined in this guide are applicable when assessing the appropriateness of clinical staffing in its broadest sense. Nurses, midwives and care staff make a unique and vital contribution to high quality patient care – but they are part of a much wider clinical team, and staffing needs must be considered in the round to ensure high quality care is delivered.

Throughout this guide, the following certain terms are frequently used:

- **High quality** – the accepted definition of ‘quality’ in the NHS comprises three components; care that is safe, care that is clinically effective; and care that provides as positive an experience for the patient as possible.
- **Wards** – we recognise that care is delivered in a variety of settings, such as wards, departments, clinical services, community settings. Throughout this document we have used the term ‘ward’ to denote all settings.
- **Capacity** – by this we mean the ability of staff present on any ward at any one time to provide care to patients.
- **Capability** – here we mean the skills, experience, knowledge and training of those staff present providing care to patients.
- **Care staff** – this includes assistant/associate practitioners, healthcare support workers, healthcare assistants, nursing assistants, auxiliary nurses and maternity support workers.

### 3 Accountability and responsibility for staffing capacity and capability

#### Expectation 1

**Boards take full responsibility for the quality of care provided to patients, and as a key determinant of quality, take full and collective responsibility for nursing, midwifery and care staffing capacity and capability.** Boards ensure there are robust systems and processes in place to assure themselves that there is sufficient staffing capacity and capability to provide high quality care to patients on all wards, clinical areas, departments, services or environments day or night, every day of the week.

Boards are actively involved in managing staffing capacity and capability, by agreeing staffing establishments, considering the impact of wider initiatives (such as cost improvement plans) on staffing, and are accountable for decisions made. Boards monitor staffing capacity and capability through regular and frequent reports on the actual staff on duty on a shift-to-shift basis, versus planned staffing levels. They examine trends in the context of key quality and outcome measures. They ask about the recruitment, training and management of nurses, midwives and care staff and give authority to the Director of Nursing to oversee and report on this at Board level.

Board papers are accessible to patients and staff working at all levels, and boards seek to involve staff at all levels and across different parts of the organisation, facilitating a strong line of communication from ward to Board, and Board to ward. Boards ensure their organisation is open and honest if they identify potentially unsafe staffing levels, and take steps to maintain patient safety.

Boards must, at any point in time, be able to demonstrate to their commissioners, the Care Quality Commission, the NHS Trust Development Authority or Monitor that robust systems and processes are in place to assure themselves that the nursing, midwifery and care staffing capacity and capability in their organisation is sufficient.

#### Why is this important?

- Boards of organisations are ultimately responsible for the quality of care they provide, and for the outcomes they achieve. The impact of nursing, midwifery and care staffing capacity and capability on the quality of care experienced by patients, and on patient outcomes and experience has been well documented, with multiple studies linking low staffing levels to poorer patient outcomes, and increased mortality rates.
- One study estimated that an increase of 1 registered nurse full time equivalent per patient day could save 5 lives per 1000 patients in intensive care, 5 lives per 1000

medical patients, and 6 per 1000 surgical patients.<sup>6</sup> In Prof. Sir Bruce Keogh's review of 14 hospitals with elevated mortality rates, he found a positive correlation between in-patient to staff ratios and higher hospital standardised mortality ratios (HSMRs)<sup>7</sup>

- Staffing capacity and capability can have a profound impact on patient safety - Don Berwick's recent review into patient safety emphasised the role of Boards and leaders of provider organisations in relation to staffing capacity and capability, stating that they should take responsibility for ensuring that clinical areas are adequately staffed in ways that take account of varying levels of patient acuity and dependency, and that are in accordance with scientific evidence about adequate staffing.<sup>8</sup>
- Patients need care every day of the week – not just Monday to Friday. Evidence shows that the limited availability of some services at weekends can have a detrimental impact on outcomes for patients, including raising the risk of mortality.<sup>9</sup> Appropriate nursing, midwifery and care staffing capacity and capability, together with other clinical staff, needs to be sustained 24 hours a day, 7 days of week, to maintain patient care and protect patient safety.

## What does this mean in practice?

### Board reporting

- **Boards request and receive papers on establishment reviews.** Carried out at least every six months, establishment reviews are critical to ensuring that the right people, with the right skills, are in the right place at the right time. They provide the opportunity to evaluate staffing capacity and capability over the previous six months, and to forecast the likely staffing requirements of wards for the next six months, based on the use of evidence based tools, and a discussion with ward, service and team leaders. Boards should sign off establishments for all clinical areas, articulate the rationale and evidence for agreed staffing establishments, and understand the links to key quality and outcome measures.

---

<sup>6</sup> Kane RL, Shamliyan TA, Mueller C, Duval S, Wilt TJ. *The association of registered nurse staffing levels and patient outcomes: systematic review and meta-analysis.* *Med Care.* Dec 2007;45(12):1195-1204

<sup>7</sup> *Review into the quality of care provided by 14 hospital trusts in England: overview report*, Prof. Sir Bruce Keogh, NHS England, July 2013. Available at: <http://www.nhs.uk/NHSEngland/bruce-keogh-review/Documents/outcomes/keogh-review-final-report.pdf>

<sup>8</sup> *A promise to learn, a commitment to act: improving the safety of patients in England*, Don Berwick, Department of Health, August 2013. Available at: <https://www.gov.uk/government/publications/berwick-review-into-patient-safety>

<sup>9</sup> N Freemantle, M Richardson, J Wood, D Ray, S Khosla, D Shahian, WR Roche, I Stephens, B Keogh and D Pagano, *Weekend hospitalization and additional risk of death: An analysis of inpatient data.* *Journal of the Royal Society of Medicine*, February 2012 vol. 105 no. 2 74-84. Available at: <http://jrs.sagepub.com/content/105/2/74>

Papers to the Board on establishment reviews should aim to be relevant to all wards and cover the following points:

- the difference between current establishment and recommendations following the use of evidence based tool(s) (further detail provided under **expectation 3**);
- what allowance has been made in establishments for planned and unplanned leave (further detail provided under **expectation 6**);
- demonstration of the use evidence based tool(s) (further detail provided under **expectation 3**);
- details of any element of supervisory allowance that is included in establishments for the lead sister / charge nurse or equivalent (further detail provided under **expectation 6**);
- evidence of triangulation between the use of tools and professional judgement and scrutiny (further detail provided under **expectation 3**);
- the skill mix ratio before the review, and recommendations for after the review (further detail provided under **expectation 3**);
- details of any plans to finance any additional staff required (further detail provided under **expectation 9**);
- the difference between the current staff in post and current establishment and details of how this gap is being covered and resourced;
- details of workforce metrics - for example data on vacancies (short and long-term), sickness / absence, staff turnover, use of temporary staffing solutions (split by bank / agency / extra hours and over-time); and
- information against key quality and outcome measures - for example, data on: safety thermometer or equivalent for non-acute settings, serious incidents, healthcare associated infections (HCAIs), complaints, patient experience / satisfaction and staff experience / satisfaction.

The paper should make clear recommendations to the Board, which would be considered and discussed at a public Board meeting. Actions agreed by the Board should be detailed in the minutes of the meeting, and evidence of sustained improvements in the quality of care and staff experience should be considered periodically.

- **Regular updates to the Board** on staffing capacity and capability. Published monthly, these updates should provide details of the actual staff available on a shift-to-shift basis versus planned staffing levels, and the impact that this has had on relevant quality and outcome measures. These reports would highlight those wards where staffing capacity and capability frequently falls short of what is required to provide quality care to patients, the reasons for the gap, the impact and actions being taken to address it and to improve care.

## Evaluating the risks

- Ensuring that adequate staffing capacity and capability is maintained can be a challenging and complicated process, and there will inevitably be times when it falls short of what is needed to provide high quality care to patients. Even where there appears to be enough staff, the skills of the workforce must be considered: a very dilute skill mix of registered nurses/midwives to care staff can compromise patient safety. In Professor Sir Bruce Keogh's review of 14 hospitals with elevated mortality rates, an over-reliance on non-registered staff and temporary staff was reported as a particular problem, and there were often restrictions in place on the clinical tasks temporary staff could undertake.<sup>10</sup>
- Boards should seek assurance that there are processes in place to highlight risks to patient care caused by insufficient staffing capacity and capability. They should seek assurance that escalation policies and contingency plans are in place for those times where staffing capacity and capability falls short of that required to provide a high quality service to patients. Further detail on the use of escalation policies is provided under **expectation 2**.
- Organisations should actively encourage all staff to report any occasions where any lack of suitably trained or experienced staff could have, or did, harm a patient. Because we know that staff under pressure are more liable to make errors, these locally reported incidents should be considered as patient safety incidents rather than solely staff safety incidents, and be routinely uploaded to the National Reporting and Learning System<sup>11</sup>.

## Being able to take decisive action

- Boards should ensure that the Executive Team is supported and enabled to take decisive action when necessary. Where potentially unsafe staffing capacity and capability is identified, escalation policies are important in outlining mitigating actions as part of contingency plans. In those situations where all potential solutions are exhausted, Directors of Nursing and the Executive Team should have the knowledge and expertise required to form a judgement on the course of action that best protects the safety of patients in their care. The closure of a ward or suspension of services as a final resort should always be carefully considered with alternative arrangements for patients identified as a priority.

---

<sup>10</sup> *Review into the quality of care provided by 14 hospital trusts in England: overview report*, Prof. Sir Bruce Keogh, NHS England, July 2013. Available at: <http://www.nhs.uk/NHSEngland/bruce-keogh-review/Documents/outcomes/keogh-review-final-report.pdf>

<sup>11</sup> More information on how to report incidents can be found at: <http://www.nrls.npsa.nhs.uk/patient-safety-data/>

## CASE STUDY 1: University College London Hospitals (UCLH)

At UCLH the Executive Board receives regular updates about nursing and midwifery staffing and patient care.

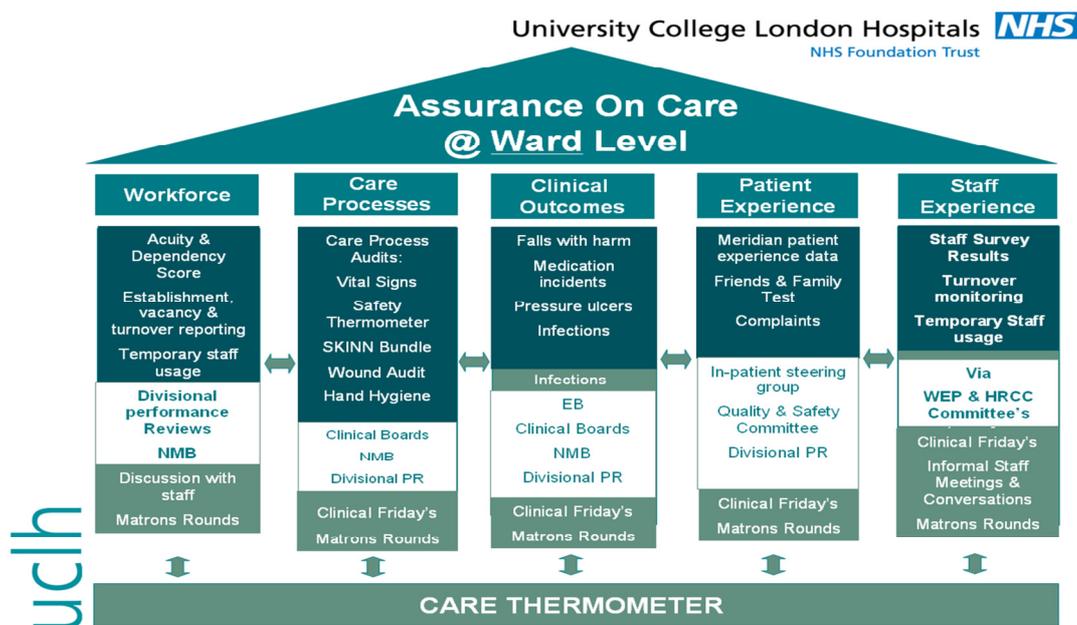
Ward establishments are set through a process agreed by the trust board and which utilises the Safer Nursing Care Tool to ensure that staff numbers are based on evidence based assessment of acuity and dependency.

Data are collected three times per year which is followed by a review of the data by the Head of Nursing, Head of Finance, Head of Workforce and Divisional Manager. This review triangulates professional judgement and ensures that the establishments are set at the right level for a particular ward.

Where an adjustment to the establishment is required this is then reflected in the following year's ward budget and is updated on the e-rostering system.

Staffing numbers are measured at the beginning of each shift and are displayed on the ward quality board at the entrance to each ward. Where the number of staff on duty is more than 1 nurse less than rostered, or each nurse has more than 7 patients to care for, the nurse in charge follows a standard escalation procedure which includes escalation to the chief nurse or one of her deputies over the full 24 hour period.

Nurse sensitive outcomes are measured and monitored via the care thermometer which is challenged at monthly meetings of the matrons and the nursing and midwifery board. This mechanism allows the leadership team to monitor process and outcomes measures that are sensitive to nurse staffing levels and provide assurance that the mechanisms for setting establishments are robust and effective.

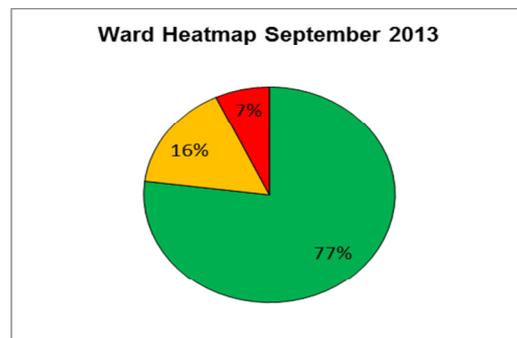
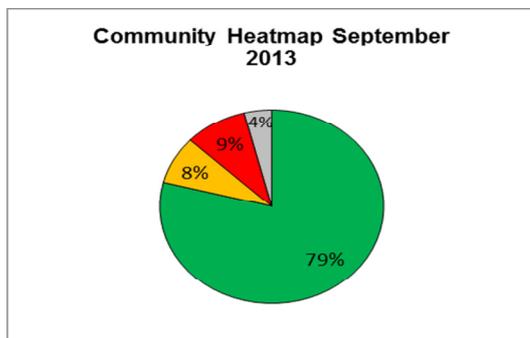


**Contact:** Katherine Fenton, Chief Nurse – [Katherine.fenton@uclh.nhs.uk](mailto:Katherine.fenton@uclh.nhs.uk)

## CASE STUDY 2: Lincoln Partnership NHS Foundation Trust

### Board Reporting - Use of a Heat Map, Cultural Barometer and Staffing Benchmarks'

For the last 18 months Lincolnshire Partnership NHS Trust has been developing and using a set of indicators that pull together reporting against CQC standards, patient experience, staff experience, and more recently the benchmarking of staffing. These indicators cover all clinical services (including wards and community services) and are in use from the ward to the Board. The 'Heat Map' report informs the Board and all staff within the organisation of the performance of the wards and community services utilising both pictorial and written methods. The report acts as an early warning tool and complements an 'under the skin' approach to support services that need support and is also used to highlight improvement and exemplary practice.



Key: ■ Outcome met ■ Outcome mostly met ■ Risk of outcome not being met ■ no data

Underpinning the Heat Map the Trust uses the framework of the Provider Compliance Assessment (PCA) tool developed by the CQC. The Trust measures compliance across 16 outcomes which includes staffing measures which are presented to the Board and throughout the organisation using both pie charts and tables, showing compliance across individual outcomes for each ward/clinical area. Recently this internal regulation approach has been enhanced by the use of an internal cultural barometer, including questions about support, leadership, staff development and satisfaction, whether people feel able to raise concerns and transparently reported staffing ratios.

The report and approach highlights the requirement for listening to patients, staff and the public, a culture of open and honest communication, leadership at every level and not relying on one single process of assurance about care standards and quality. The approach supports the Board level requirement to monitor the quality of its services, to challenge poor performance and variation, and to incentivise high quality and performance improvement. Its use has supported the leadership development at all levels that is required to underpin good governance and high quality care.

**Contact:** Dr Julie Hall, Director of Nursing and Operations - [julie.hall@lpft.nhs.uk](mailto:julie.hall@lpft.nhs.uk)

## Expectation 2

### **Processes are in place to enable staffing establishments to be met on a shift-to-shift basis.**

The Executive team should ensure that policies and systems are in place, such as e-rostering and escalation policies, to support those with responsibility for staffing decisions on a shift-to-shift basis. The Director of Nursing and their team routinely monitor shift-to-shift staffing levels, including the use of temporary staffing solutions, seeking to manage immediate implications and identify trends. Where staffing shortages are identified, staff refer to escalation policies which provide clarity about the actions needed to mitigate any problems identified.

### Why is this important?

- Agreeing staffing establishments is the first part of an important process. Ensuring that establishments are met on a shift-to-shift basis is a vital step in ensuring that there is sufficient capacity and capability to care for patients on wards.
- Professor Sir Bruce Keogh highlighted this as a particular problem in his recent review into hospitals with elevated mortality rates; whilst staffing establishments in organisations appeared adequate in many instances, there were occasions when establishments were not met on wards on a shift-to-shift basis, compromising patient care.<sup>12</sup>
- Temporary staff form a key part of the nursing, midwifery and care staffing workforces. Using temporary staffing solutions when establishments cannot be met on a shift-to-shift basis can be an effective way of maintaining patient care, where the skills and capabilities of temporary staff match the requirements on the ward. However, an over reliance on temporary staffing can be costly, and lead to a lack of continuity in patient care. Ideally, substantive staff should be recruited to establishments, with temporary staffing solutions used to fill short term gaps only.

### What does this mean in practice?

- **Daily reviews of the actual staff available on a shift-to-shift basis versus planned staffing levels** should occur between Sisters, Matrons and Heads of Nursing (and equivalent posts). Where shortages are identified, they work together to seek a solution – such as the pooling of staff from other clinical areas, or the deployment of bank or agency staff.

---

<sup>12</sup> *Review into the quality of care provided by 14 hospital trusts in England: overview report*, Prof. Sir Bruce Keogh, NHS England, July 2013. Available at: <http://www.nhs.uk/NHSEngland/bruce-keogh-review/Documents/outcomes/keogh-review-final-report.pdf>

- **E-rostering policies** can be an effective way of making the most of existing resources. NHS Employers has produced guidance that provides all the information an organisation will need to successfully implement an e-rostering system, which will allow them to embrace efficient and safe staffing by releasing more time for staff to deliver higher quality services, as well as helping to reduce expenditure on temporary staffing. E-rostering brings together management information on shift patterns, annual leave, sickness absence, staff skill mix and movement of staff between wards. This enables managers to quickly build rotas to meet patient demand. Employees are able to access the system to check their rotas and make personal requests, which should be balanced with service requirements. The guidance explains why e-rostering is beneficial, and explains how organisations can secure agreement to and implement an e-rostering programme.

The guidance can be found at:

<http://www.nhsemployers.org/planningyourworkforce/flexible-workforce/agencyworkers/reducingagencyspend/e-rostering/Pages/e-Rostering.aspx>

- **Using escalation policies and contingency plans** can provide a source of clarity at times of increased pressure (for example, when there are unusually high workloads, a particularly high level of patient dependency, exceptionally high staff sickness levels, or unfilled vacancies), and when staffing capacity and capability cannot be met on a shift-to-shift basis. Staff should be aware of the escalation policies in place, flag where they think staffing capacity and capability falls short of what is required (further detail is provided under **expectation 4**), and be able and prepared to use the escalation policies in place.
- Escalation policies should outline actions to be taken, the people who should be involved in decisions, in short, medium and long term staffing shortages, and outline the contingency steps where capacity problems cannot be resolved. Escalation policies are helpful in flagging capacity problems at an early stage, allowing organisations to adopt a proactive rather than a reactive response to problems identified.

## 4 Evidence-based decision-making

### Expectation 3

**Evidence-based tools are used to inform nursing, midwifery and care staffing capacity and capability.** As part of a wider assessment of workforce requirements, evidence-based tools, in conjunction with professional judgement and scrutiny, are used to inform staffing requirements, including numbers and skill mix. Senior nursing and midwifery staff and managers actively seek out data that informs staffing decisions, and they are appropriately trained in the use of evidence-based tools and interpretation of their outputs. Staff use professional judgement and scrutiny to triangulate the results of tools with their local knowledge of what is required to achieve better outcomes for their patients.

### Why is this important?

- Determining nursing, midwifery and care staffing requirements is a complex process, requiring input from all levels within the nursing and midwifery staffing structure. Using an evidenced-based tool is a critical part of making staffing decisions, and will ensure that these decisions are based on patient care needs and expert professional opinion.
- Using such tools is only one part of an approach to making staffing decisions; professional judgment and scrutiny is critical in evaluating the results from evidence-based tools, in light of patients' needs and knowledge of the local context.
- Simply determining the number of nurses, midwives or care staff required is only one part of the equation. The skill mix of the workforce should reflect patient care needs and local requirements, considering the experience and capabilities of the workforce employed. Evidence suggests that where there are lower levels of registered nurses, there are higher rates of errors in care<sup>13, 14</sup> and care is more likely to be 'left undone' when there are fewer registered nurses on a ward.<sup>15,16</sup>
- The right number and skill mix of staff alone will not ensure that high quality patient care is delivered; this depends upon a range of other factors, such as the leadership of an organisation, the management culture, the culture and team working on the ward, the

<sup>13</sup> McGillis Hall L, Doran D, Pink GH. *Nurse staffing models, nursing hours, and patient safety outcomes*. Journal of Nursing Administration. Jan 2004;34(1):41-45

<sup>14</sup> Blegen MA, Goode CJ, Reed L. *Nurse staffing and patient outcomes*. Nurse Researcher. Jan-Feb 1998;47(1):43-50.

<sup>15</sup> Kalisch B, Tschannen D, Lee H. *Does missed nursing care predict job satisfaction?* Journal of Healthcare Management. Mar-Apr 2011;56(2):117-131; discussion 132-113.

<sup>16</sup> Kalisch BJ, Tschannen D, Lee KH. *Do staffing levels predict missed nursing care?* International Journal for Quality in Health Care. Jun 2011;23(3):302-308.

level of education and training available to staff, and the organisational environment. Further detail is given under **Expectation 4**.

## What does this mean in practice?

- **Using evidence-based tools** - there are a range and variety of tools available for use at present. Some of the tools that are currently in use, and a guide as to their use, is given in the table below. This is not intended to be a comprehensive list of the tools in use, and in the longer term, NICE will be reviewing the evidence base and accrediting tools in this area.

### ACUTE SETTINGS

#### Safer Nursing Care Tool™

The SNCT was originally developed in conjunction with the Association of UK University Hospitals (AUKUH), when it was known as the *AUKUH Patient Care Portfolio*. It has been widely used across the NHS, private sector and in some overseas hospitals. The Shelford Group commissioned a review of the tool and it has recently been relaunched as the *Safer Nursing Care Tool* (SNCT). It is available on the Shelford website at: <http://shelfordgroup.org/resource/chief-nurses/safety-nursing-care-tool>

The tool comprises two parts:

- An Acuity and Dependency Tool – this has been developed to help acute NHS hospitals measure patient acuity and/or dependency to inform evidence-based decision making on staffing and workforce. The tool sets out how to measure acuity and dependency of patients in a ward, what rules to follow to ensure that data are captured accurately, how to use this information to calculate total staff needed in a particular ward using nursing multipliers, and provides an example database which organisations can adapt for their own purposes.
- Nurse Sensitive Indicators (NSIs) – these have been identified as quality indicators of care with specific sensitivity to nursing intervention or lack of intervention. They can be used alongside the information captured using the Acuity and Dependency Tool to develop evidence-based workforce plans to support existing services or the development of new services. The Safer Nursing Care Tool demonstrates how NSI outcome data can be used alongside acuity and dependency information. If the SNCT and NSIs are used concurrently then it will be possible to relate ward staffing and nursing outcomes.

Work is underway to develop Safer Nursing Care tools for children's in-patient wards, acute assessment units, elderly acute care and elderly rehabilitation.

## MATERNITY SETTINGS

### **Birthrate Plus®**

Birthrate Plus® is the only national tool available for calculating midwifery staffing levels. It was developed 24 years ago and has now been applied in the majority of NHS Trusts in the UK and Ireland, being modified and developed to reflect changing models of care and working patterns.

- Using Birthrate Plus® enables individual Trusts to calculate their staffing requirements based on their specific activity, case mix, demographics and skill mix.
- It enables commissioners to compare the staffing, skill mix and models of care in their local providers with neighbours or units of a similar size.
- It provides workforce planners with robust data on which to commission student midwife numbers and advise on workforce establishments.

At its simplest Birthrate Plus® can provide any given service with a recommended ratio of clinical midwives to births in order to assure safe staffing levels. The methodology is based on an assessment of clinical risk and the needs of women and their babies during labour, delivery and the immediate post-delivery period. From these quantifiable needs of women Birthrate Plus® provides insights and intelligence to inform decisions about staffing numbers, staff deployment, models of care and skill mix.

Birthrate Plus® is available at <http://www.rcm.org.uk/college/policy-practice/joint-statements-and-reports/>

## PAEDIATRICS

### **Great Ormond Street Hospital Paediatric Acuity and Nursing Dependency Assessment tool (PANDA)™**

Developed by Great Ormond Street Hospital, the PANDA tool measures patient dependency and calculates nursing staff requirements based on the actual acuity and dependency of children.

Previously paper based, the new PANDA software version has been supported by NHS Innovations London and developed by Genisys Group.

It is available at: <http://rfdesign-uk.com/testsite/panda/>

## CLINICAL NURSE SPECIALISTS PROVIDED SERVICES

### **Cassandra™**

Cassandra™ allows specialist advanced practice nurses to draw on a representative sample of their work and was a response to diary care exercise/time and motion studies in common use which did not adequately capture the complexity of the work. The Cassandra™ tool was developed by Dr Alison Leary by clustering data from a more complex dataset (Pandora). It has been used in several national studies and is now free to download as a spreadsheet from [www.alisonleary.co.uk](http://www.alisonleary.co.uk)

### **Alexa Caseload Tool™**

The Alexa Caseload tool™ was developed by Dr Alison Leary with the National Cancer Action Team (NCAT) quality in nursing group. It is used to determine the optimum caseload of a specialist nurse against best practice. It is based on the work of lung Clinical Nurse Specialists but the methodology can be applied to Clinical Nurse Specialists who manage patients with other long term conditions. It uses previously modelled activity and national data to calculate a recommended caseload.

It is available at: [www.alisonleary.co.uk](http://www.alisonleary.co.uk) or [www.cancertoolkit.co.uk](http://www.cancertoolkit.co.uk)

## ACUTE AND MENTAL HEALTH IN-PATIENT SETTINGS

### **Nursing Hours per Patient Day (NHPPD)™**

Developed in Western Australia the Nursing Hours per Patient Day tool is a nursing workload monitoring and measuring system that provides a guide to the number of nurses required for service provision in a specific clinical area. The model relies on clinical judgement to assess adequate staffing to deliver care on a day-to-day basis. The model is used to calculate the number of direct nursing hours required to provide patient care and can offer a framework to develop a nursing roster.

It can be found at: [http://www.nursing.health.wa.gov.au/planning/workload\\_man.cfm](http://www.nursing.health.wa.gov.au/planning/workload_man.cfm)

## ACUTE, MENTAL HEALTH, LEARNING DISABILITIES AND COMMUNITY SETTINGS

**Tools developed by Dr Keith Hurst** - Dr Keith Hurst has developed a variety of tools to determine nursing requirements:

### **Professional Judgement Software™**

A quick and easy method: an expert group (clinical, workforce and finance) decides each ward's team size and skill mix using local intelligence.

### **Ward Staff Per Occupied Bed™**

Another quick and easy method; ward managers draw relevant staff to occupied ratios from the national database and multiply occupied beds in their wards by the staffing multiplier. Separate multipliers are available for nurses and healthcare support workers. This method does not consider patient dependency/acuity.

### **Patient Dependency / Acuity Specialty Specific Tool™**

Ward managers assess every patient at least daily for two weeks using the ADL dependency criteria. Daily averages are entered into software (selected according to clinical speciality). Ward staffing, therefore, reflects a clinical speciality's current workload and can be adjusted at any time. The software covers 28 clinical specialties. Managers also conduct an activity analysis and service quality audit. Ward workload index, staffing recommendations, ward staff activity and service quality can be benchmarked against same-specialty wards in the UK.

A community nursing tool with community care levels and multipliers is also available for use.

The software is available from [keithhurst.research@yahoo.co.uk](mailto:keithhurst.research@yahoo.co.uk)

A list of professional guidance is provided at **Appendix A**.

### **Evidence-based tools for mental health, learning disabilities and community settings**

- The evidence base in relation to workforce planning and safe and effective staffing within mental health, learning disability and community settings is less established than that for acute care settings. Work is under way through *Compassion in Practice* Action Area Five to understand what workforce planning tools exist for these care settings and to pilot these tools or develop new tools.
  - **Mental Health** - A critical issue in mental health services is the therapeutic relationship and skilful interaction between staff and individual patients. The ethos, models of care and philosophy are also important factors in determining staffing establishments in mental health. The composition of the multi-professional team in mental health settings, for example the presence of occupational therapists and psychologists, will have a direct impact upon nurse staffing requirements.

- The guiding principles of workforce planning are applicable for all care groups, and some tools, for example the methodology developed by Dr Keith Hurst, are applicable to mental health services. Work is underway to pilot the Mental Health tool developed in NHS Scotland alongside Dr Keith Hurst’s mental health / learning disabilities tool in mental health in-patient settings in England.
- **Learning Disabilities** - A UK-wide review of learning disabilities nursing supported by the four Chief Nursing Officers in the UK published in 2012<sup>17</sup> made recommendations related to workforce planning. Subsequent to this report a number of work streams and actions have commenced across the UK to influence workforce planning and education commissioning decisions in relation to learning disability nursing. All of the work streams report to the UK steering group chaired by Dr Ben Thomas. The Centre for Workforce Intelligence also undertook a strategic review of the learning disability nursing workforce.
- Through *Compassion in Practice* Action Area Five work is underway to pilot the NHS Scotland mental health tool and Dr Keith Hurst’s tool for mental health and learning disabilities in learning disability in-patient settings. It is however recognised that the vast majority of learning disabilities care takes place in the community and work is also being taken forward to develop a tool for use in community settings. This work will consider the close working relationship between the nursing and social care workforce.
- **Community services** - The Community Nursing Strategy Programme brings together multiple organisations, including NHS England, the Department of Health, Health Education England, Public Health England and Queens Nursing Institute within a national programme led by the Chief Nursing Officer for England. Within the next two years, it aims to:
  - strengthen innovation;
  - support the workforce and improve commissioning practice for community, district and general practice nursing that enables care to be delivered closer to home; and
  - improve the outcomes for people with long term conditions, whilst simultaneously improving the experience of patients, carers and staff.
- The Queen’s Nursing Institute is undertaking a review of workforce planning tools in community settings which is due to report at the end of December 2013.

---

<sup>17</sup> *Strengthening the commitment, The Report of the UK Learning Disabilities Nursing Review, 2012*, available at: <http://www.scotland.gov.uk/Resource/0039/00391946.pdf>

## Interpreting results of tools and using professional judgment and scrutiny

- **Triangulation of results** from evidence-based tools is a vital step in establishing safe nursing, midwifery and care staffing capacity and capability. Staff should use professional judgement and scrutiny to interpret results from evidence based tools, taking account of the local context and patient needs. Some factors which can affect staffing requirements include:
  - The layout and design of the ward. For example, wards with multiple single rooms or bays may require higher staffing capacity and capability;
  - The number of ward clerks/ housekeepers and other support staff available;
  - Employing ward clerks and housekeepers on wards can reduce the pressure on nurses, midwives and care staff in undertaking administrative tasks;
  - Any travel requirements. For example, in community settings, staff may have distances to travel between visits. Establishments should include a proportion of time allocated to travel where necessary. Clinical visits should be planned to make most effective use of travel time;
  - The technological support available on wards. The adoption of new technological solutions can reduce the amount of time that nurses, midwives and care staff spend on paperwork, freeing them up to focus on direct caring duties;
  - The dependency and acuity of patients. High patient dependency will require higher capacity and capability of registered nurses and midwives; and
  - Patient throughput is another factor which needs to be considered when planning nursing, midwifery and care staff establishments.
  
- Professional judgment and knowledge of the local context and patient needs should also inform the **skill mix** of staff. Simply determining the numbers of staff required for each ward is not sufficient – it is important that the skill mix between registered and non-registered staff reflects the likely workload and skills required to care for patients locally. Healthcare Support Workers, Maternity Support Workers and Assistant / Associate Practitioners are key members of the nursing and midwifery team, and the skill mix used should maximise the potential contributions of all parts of the workforce. The considerations outlined above are equally relevant when considering the skill mix of staff.
  
- Employer organisations should have robust systems in place to govern the practice of all members of the nursing and midwifery workforce, including the accountabilities of Registered Nurses and Midwives in relation to the appropriate delegation of care. It is essential that all members of the nursing and midwifery team receive training for their role.

- Healthcare Assistants<sup>18</sup>/Support workers now make up around a third of the caring workforce in hospitals, and research suggests that they now spend more time than nurses at the bedside.<sup>19</sup> Health Education England (HEE) is leading work nationally to maximize the capabilities and contribution of Healthcare Assistants/Support Workers, which includes:
  - establishing minimum training standards for Healthcare Assistants / Support Workers
  - progression routes for Healthcare Assistants / Support Workers to enter nurse training
  - increasing the number of healthcare apprentices
- The Royal College of Midwives has published guidance on the role and responsibilities of Maternity Support Workers available at: <http://www.rcm.org.uk/college/your-career/maternity-support-workers/roles/>

### **CASE STUDY 3: Hertfordshire Partnership University Trust - 'Safe Staffing: Managed entry and exit policy for acute mental health services'**

Hertfordshire Partnership University NHS Foundation Trust acute mental health services updated its managed exit and entry policy, focusing on correct and safe staffing on acute admission wards for Informal patients entitled to leave the unit and Formal patients detained under the Mental Health Act.

The policy introduced the following principles:

- All service users admitted are screened and risked assessed for their potential to abscond from the unit based on their status under the Mental Health Act and their profile risk is combined with clinical judgement.
- 'Patient Status' at a glance boards for high risk absconders are utilised at handover and team meetings.
- A range of evidence-based tools interventions are available for use to assess acuity and risk, enabling staffing needs to be adjusted, these include including the Nursing Observed Intensity Sickness Scale and the Brøset Violence Checklist.

Early feedback suggests this policy is leading to safer services for both service users and staff.

**Contact:** Oliver Shanley, Deputy Chief Executive/ Executive Director of Quality,  
[Oliver.shanley@hpft.nhs.uk](mailto:Oliver.shanley@hpft.nhs.uk)

<sup>18</sup> Some organisations use the terms Nursing Auxiliaries, Nursing Assistants, Healthcare Support Workers and Healthcare Assistants.

<sup>19</sup> *The Cavendish review: an independent review into healthcare assistants and support workers*, Camilla Cavendish, Department of Health, July 2013. Available at: [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/236212/Cavendish\\_Review.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/236212/Cavendish_Review.pdf)

**CASE STUDY 4: Derbyshire Community Health Services NHS Trust - 'Staffing for Quality: Joint Review of Community Nursing on behalf of Derbyshire Community Health Services NHS Trust and North Derbyshire CCG'**

A review was established between Derbyshire Community Health Services DCHS and North Derbyshire CCG (NDCCG), as lead commissioner, to assess community nurse staffing levels following the publication of the Francis Inquiry report, and in light of national and local priorities in relation to community nursing and the delivery of integrated care models.

In March 2013 following a review of staffing levels in their community hospitals, the DCHS Board approved increased funding. The review 'Staffing for Quality' was undertaken utilising an evidence-based tool (Hurst) and assessed against recent recommendations by the Royal College of Nursing (RCN) and national reports on the provision of elderly care.

A locally developed tool based on a model used in Central Essex to determine community nursing workload and dependency has been in use within DCHS for a number of years. Currently it is mainly used by the District Nursing sister to manage the weekly and daily work load of their teams (planned and urgent work), matching skills/competency to patient need. In some localities the Integrated Team Leaders use it across a number of teams to ensure efficient use of resources and manage their workforce. Recent development work has supported linking the tool with electronic patient records. DCHS is developing this further, linking with a Hurst review process, and e-rostering, system which will include a patient acuity tool.

Contact: Kathryn Henderson, Senior Clinical Advisor, Nursing and Quality,  
[Kathryn.henderson@northderbyshireccg.nhs.uk](mailto:Kathryn.henderson@northderbyshireccg.nhs.uk)

**CASE STUDY 5: Cumbria Partnership NHS Foundation Trust - 'Safer Nursing Care Tool: Community Hospital Review and District Nurse Services Review'**

In Summer 2012 the tBoard requested a review of two Community Hospital in-patient units which resulted in a recommendation to undertake a review across all 14 in-patient units. It was also agreed that the District Nursing team should be reviewed.

This review was commissioned in November 2012. The Safer Nursing Care Tool was used for the inpatient review and the audit results were benchmarked against 145 comparable best practice wards within England. In April 2013 all forty-six district nursing teams were audited.

The results of the reviews has enabled the Trust Board to understand the dependency and acuity of patients on each ward and in the community, the quality of care delivered and the staffing numbers, skill mix and competency required to care for the patient mix compared with the actual staffing levels. This has provided the Board and clinicians with an evidence base against which to allocate resources and has resulted in Ward Managers becoming supervisory and a Band 5 Registered Nurse post appointed on each ward in replacement (13 in total); there have also been additional Health Care Assistant's and Band 6 Registered Nurse roles appointed.

Contact: Esther Kirby, Deputy Director of Nursing, Quality and Patient Experience,  
[Esther.kirby@cumbria.nhs.uk](mailto:Esther.kirby@cumbria.nhs.uk)

### **CASE STUDY 6: Staffordshire and Stoke on Trent Partnership NHS Trust - 'Workforce Planning Toolkit'**

Staffordshire and Stoke on Trent Partnership NHS Trust has developed an innovative Workforce Planning Toolkit to support its strategic workforce planning and operational deployment. Using a bottom up approach, it enables managers to work through an integrated workforce planning methodology in a systematic way using population/demographic demand, competency frameworks to match demand and a caseload management tool.

Features of the toolkit include a triangulation of multiple methods to establishing demand, and include business tools to link workforce planning with the Trust's overall strategic direction, as well as indications for improvements to the current deployment of staff and possibilities for workforce redesign.

The development of robust competency frameworks across the Trust is a key enabler to this toolkit which will ensure that staff are appropriately placed with the right skills, knowledge and competences to deliver the Trust's person-centred model.

**Contact:** Tina Cookson, Director of Operations (Adult Services) - [tina.cookson@ssotp.nhs.uk](mailto:tina.cookson@ssotp.nhs.uk)

### **CASE STUDY 7: 'The Role of Maternity Support Workers**

The Royal College of Midwives (RCM) describes Maternity Support Workers (MSW) 'as any non-registered employee providing support to a maternity team, mothers and their families who work specifically for a maternity service' and who, with training and supervision, can provide information, guidance and support.

In Wrightington, Wigan and Leigh NHS Foundation Trust (WWL) MSW's deliver one to one practical parenting support and education to the 2% most vulnerable pregnant women and their families as part of the Integrated Health Service Team. These pregnant women can have complex needs, which may include safeguarding or mental health concerns. Support commences early in pregnancy and continues both on the maternity ward and for six weeks post natal. The MSWs provide training and support across a range of areas including baby bathing, breastfeeding, artificial feeding and associated sterilisation and safe sleep.

At Southend University Hospital Foundation Trust Infant Feeding MSWs are trained and empowered with the skills and knowledge to support women to continue to breastfeed for as long as possible. The MSWs were trained in the UNICEF Baby Friendly Initiative Breastfeeding Management and provide post-delivery support of up to six weeks by making contact with breastfeeding mothers upon transfer to the community. Within three months of introducing MSWs the continuation rate for breastfeeding had improved.

Although MSWs do not make clinical judgments their input under the direction of the midwife supports mother and baby.

## 5 Supporting and fostering a professional environment

### Expectation 4

**Clinical and managerial leaders foster a culture of professionalism and responsiveness, where staff feel able to raise concerns.** The organisation supports and enables staff to deliver compassionate care. Staff work in well-structured teams and are enabled to practice effectively, through the supporting infrastructure of the organisation (such as the use of IT, deployment of ward clerks, housekeepers and other factors) and supportive line management.

Nursing, midwifery and care staff have a professional duty to put the interests of the people in their care first, and to act to protect them if they consider that they may be at risk, including raising concerns. Clinical and managerial leaders support this duty, have clear processes in place to enable staff to raise concerns (including about insufficient staffing) and they seek to ensure that staff feel supported and confident in raising concerns. Where substantiated, organisations act on concerns raised.

### Why is this important?

- In general terms, the more positive the experience of staff within a Trust, the better the outcomes for patients and the organisation. Staff engagement has many significant associations with patient satisfaction, mortality, and infection rates. The proportion of staff working in well-structured teams, receiving well-structured appraisals and experiencing supportive leadership from line managers are all linked to patient mortality.<sup>20</sup>
- A key part of supporting staff is ensuring that the organisational culture encourages them to perform their job to the best of their abilities. For example, advances in technology can have a huge impact on the workload of nursing, midwifery, and care staff, enabling them to deliver effective care and freeing up their time to care for patients. Embracing such developments will allow staff the opportunity to fulfill roles to their maximum potential, and could affect the staffing establishments required.
- Being listened to, respected, and treated with the compassion and dignity they deserve has a huge impact on patients' experience of care, and contributes to higher quality care. It is vital that leaders and managers at every level create supportive, caring cultures, within teams and within organisations as a whole. As outlined in *Compassion in Practice*,

---

<sup>20</sup> Michael A West, Jeremy F Dawson. *Employee engagement and NHS performance*, 2012. Available at: <http://www.kingsfund.org.uk/sites/files/kf/employee-engagement-nhs-performance-west-dawson-leadership-review2012-paper.pdf>

nurses, midwives and care staff have a responsibility to demonstrate six key values – the 6Cs - in everything they do. These are care, compassion, competence, communication, courage and commitment.<sup>21</sup>

## What does this mean in practice?

### Supporting staff

- **Organisational culture** is key to ensuring that staff feel supported and enabled to fulfill their role to their maximum potential, and are able to raise concerns where necessary. Those with line management responsibilities seek to ensure that staff are managed effectively, with clear objectives set, constructive appraisals carried out, resulting in a workforce that feels valued. Teams should be well-structured, with supportive line management at every level of the organisation.
- The adoption of technological advances can enable nurses and midwives to deliver care more effectively, and can free up staff time to focus on delivering patient care. The Nursing Technology Fund has been established with this aim - £100 million of funding over two years will be available uniquely for new technology that will support safe, effective care. The new technology could include digital pens and other handheld mobile devices that allow staff to access the latest information about a patient's treatment whenever, wherever they are. These technologies will enable a swifter, more comprehensive understanding of a patient's care and conditions, reducing the time spent on form filling and bureaucracy, freeing up time for face-to-face patient care and contributing to safer care and better outcomes.

### Ensuring staff are able to speak up

- Nurses, midwives and care staff are under a professional duty to put the needs of their patients first, and to speak out when they have concerns. This is made clear in the Nursing and Midwifery Council's (NMC) code. The Code is the foundation of good nursing and midwifery practice, and a key tool in safeguarding the health and wellbeing of the public. It highlights that the people in the care of Registered Nurses and Midwives must be able to trust them with their health and wellbeing, and that to justify that trust, nurses and midwives must:
  - make the care of people their first concern, treating them as individuals and respecting their dignity;
  - work with others to protect and promote the health and wellbeing of those in their care, their families and carers, and the wider community;
  - provide a high standard of practice and care at all times; and

---

<sup>21</sup> *Compassion in Practice*, NHS England, December 2012. Available at <http://www.england.nhs.uk/wp-content/uploads/2012/12/compassion-in-practice.pdf>

- be open and honest, act with integrity and uphold the reputation of their profession.

The code continues to apply to operational managers who keep their nursing or midwifery registration. The code is available at: <http://www.nmc-uk.org/Nurses-and-midwives/Standards-and-guidance1/The-code/>

- The NMC has also recently refreshed and re-launched guidance on raising concerns. This provides guidance for nurses and midwives on raising concerns, setting out broad principles that will help them think through the issues and take appropriate action in the public interest. The new edition includes information on recent legislation that offers protection to whistleblowers as well as updated information on where nurses and midwives can go to for further information. It is available at <http://www.nmc-uk.org/Nurses-and-midwives/Raising-and-escalating-concerns>
- **Whistleblowing policies** should be in place within providers of NHS services, supporting staff to raise concerns as and when they arise. NHS Employers provides guidance to support employers to implement and develop policies and procedures that are targeted at enabling NHS staff to report concerns appropriately. NHS Employers work closely with the National Whistleblowing Helpline launched in December 2011 which provides free, independent advice and support to staff within the NHS and Social Care.<sup>22</sup> The Helpline can be reached by calling 08000 724 725.
- Organisations should be open and honest when things go wrong. All providers of NHS services must adhere to **Duty of Candour requirements**, which require organisations to publish an annual declaration of a commitment to telling patients if something has gone wrong with their care.<sup>23</sup> The Duty of Candour has also been strengthened in the recently published Government response to the Report of the Mid-Staffordshire NHS Foundation Trust Public Inquiry, available at: [https://www.gov.uk/government/publications?departments\[\]=department-of-health](https://www.gov.uk/government/publications?departments[]=department-of-health)
- **Staff side representatives** working in organisations can provide support in ensuring that staff views are considered, for example through staff survey feedback, and can support them in raising concerns – including concerns around staffing capacity and capability. They can act on behalf of staff and represent staff views and concerns during regular meetings with the organisation’s management team.

---

<sup>22</sup> Guidance produced by NHS Employers can be found at:

<http://www.nhsemployers.org/employmentpolicyandpractice/ukemploymentpractice/raisingconcerns/pages/whistleblowing.aspx>

<sup>23</sup> Guidance on the Duty of Candour can be found at:

<http://www.nhsemployers.org/EMPLOYMENTPOLICYANDPRACTICE/UKEMPLOYMENTPRACTICE/Pages/DutyofCandourconsultation.aspx>

### **CASE STUDY 8: The Royal Wolverhampton Hospitals NHS Trust - 'SafeHands' Programme supports safer staffing levels using real time information**

SafeHands is a Department of Health part-funded innovation project using Real time locating software (RTLS) to improve patient safety.

RTLS uses infra-red and radio-frequency technology to monitor and measure real time patient and staff interaction based on RTLS badge co-location. It provides real time locating and visibility of patients with on screen alerts and audible alarms when a patient is leaving the ward unaccompanied or alone in an isolated area and can generate a live bed state. The hospital can understand the true dependency of patients allowing staff to prioritise and improve individual patient care.

The RTLS also monitors Hand Hygiene index (similar to compliance) by ward and real time locating of equipment across the Trust ensuring planned equipment gets to the patient in a timely manner allowing prompt commencement of treatment.

All of the data can be reported on including hours of care given to individual patients, by individuals or groups of staff and triangulated with patient condition, acuity, falls risk etc. This will support accurate costing of service provision, predicting and planning for future staffing levels and informed dialogue with commissioners.

The programme is being rolled out across all in-patient areas of the hospital.



“Virtual walls” mark out individual bed spaces to identify real time locations of badges.

The Badges attach to patients, staff, hand gels, soaps and equipment to track location, movement, interaction, passage of time and hand hygiene compliance.



Staff, patient, gel and equipment badges send radiofrequency signals indicating their current location to the virtual walls. Messages are sent to the software which interprets the messages and triggers rules and reports including patient staff interaction, equipment tracking and patient “Last Seen” timer.

**Contact:** Clare.Nash, Programme Manager – SafeHands, [Clare.nash@nhs.net](mailto:Clare.nash@nhs.net)

### **CASE STUDY 9: Stockport NHS Foundation Trust - Stockport District Nursing and the Dominic System (Domiciliary in the Community Care System)**

In 2010 the District Nursing Service in Stockport moved forward to produce an electronic scheduling system tailor made to staff requirements. The system, later called 'Dominic', was initially developed to reduce medication errors, duplication of visits, ensure continuity of visit by the right nurse with the right skills and promote visits at the patient's choice of time

The system was fully launched in 2012, and all caseloads are visible to all staff. It can now:

- schedule visits weeks in advance;
- enable management of workload pressures by moving staff;
- predict peaks in demand enabling managers to forecast pressures;
- monitor the performance of the service by measuring outcomes for CQUINS/KPIs and local targets;
- reduce the amount of bank required; and
- introduce improved skill mix resulting in efficiency savings.

Further development in 2014 will include incorporating the Specialist Nursing Team so that communication and referrals are fully electronic.

**Contact:** Tina Roebuck, Clinical Lead - [tina.roebuck@nhs.net](mailto:tina.roebuck@nhs.net)

### **CASE STUDY 10: King's College London - 'Culture of Care Barometer'**

Caroline Alexander, Chief Nurse, NHS England (London) is leading the work on Action Area 4 of Compassion in Practice and the Culture of Care Barometer is part of this work. The National Nursing Research Unit at King's College London have been commissioned to develop and pilot the tool.

The Barometer aims to:

- be short and quick to complete;
- complement, not duplicate, other measures or quality programmes;
- allow "ward to board" communication;
- act as an early warning system to identify care culture problems; and
- prompt reflection, to help identify actions required.

The Barometer is a short survey which captures staff views of resources to deliver quality care, support needed to do a good job. It aims to gauge whether the culture of care in different parts of an organisation is conducive to delivering compassionate patient centred care, signalling where there are opportunities to develop and improve.

**Contact:** Professor Anne Marie Rafferty - [ann\\_marie.rafferty@kcl.ac.uk](mailto:ann_marie.rafferty@kcl.ac.uk)

## CASE STUDY 11: University Hospital Southampton NHS Foundation Trust - 'A Staff Compact: Roles and Responsibility Discussions'

The Director of Nursing and Organisational Development has developed with staff a compact which sets out her own responsibility to staff and their responsibility within the organisation and to the nursing profession.

The staff compact is utilised to stimulate discussions in training sessions around professional behaviours and how every action or intervention with a patient should reflect their role as a caring and compassionate nurse or midwife. It also sets out a clear commitment that the Director of Nursing and Organisational Development will champion high quality patient care from Board to Ward.

### A Moment In Time Every Time

#### My Responsibility To You

- I will continually champion high quality patient care from Board to Ward
- I will continue implementing our strategies to fill our vacancies, enable Ward Leaders to be fully supernumerary and ensure there are regular staffing reviews
- I will support anyone who has the courage to escalate concerns
- Working with you, I will ensure nursing and midwifery is valued and is high profile in the organisation
- I want to actively listen to new ideas and your views on how the nursing, midwifery and carer workforce can feel fully engaged in the Quality Improvement agenda

**Judy Gillow, Director of Nursing and Organisational Development**

University Hospital Southampton   
NHS Foundation Trust

### A Moment In Time Every Time

#### Your Responsibility To Your Profession and the Organisation

- Remember every action/intervention/communication you undertake with patients, should reflect your role as a caring, compassionate nurse/midwife, and as a member of UHS
- At every level you should be a role model in behaviour and practice and demonstrate pride in your job
- You are the advocate for patients and must ensure they are receiving the best care
- You should act professionally at all times and treat your colleagues with respect

University Hospital Southampton   
NHS Foundation Trust

Contact: Judy Gillow, Director of Nursing and Organisational Development - [Judy.gillow@uhs.nhs.uk](mailto:Judy.gillow@uhs.nhs.uk)

**CASE STUDY 12: Maidstone and Tunbridge Wells NHS Trust - 'Safer Staffing; Changes made to a respiratory ward following the use of the Safer Staffing methodology'**

Key quality indicators are reviewed monthly at performance meetings and at the Clinical Governance Overview Committee utilising the Quality, Effectiveness and Safety Trigger Tool (QuESTT). Two consecutive low QuESST scores, along with a further infection case, instigated an internal review of Whatman ward, a 28 bedded medical ward focused on respiratory care and providing non-invasive ventilation support (NIV), using the CQC Dignity And Nutrition Inspection methodology. The review included a matron external to the Directorate and a patient representative.

Demand for NIV support had increased and had not been reflected in staffing levels. Discussions with operational management resulted in one bay (6 beds) being closed; staffing levels were adjusted to improve the Registered Nurse:Patient ratio. A bespoke training programme ensured all staff were competent and confident with NIV management.

Data from Safer Staffing was reviewed daily and progress was monitored weekly by the Directorate, the Infection Prevention Committee, Chief Nurse and up to the Board via the Quality & Safety Committee. A Risk Summit chaired by the Chief Executive allowed the Directorate to identify what Corporate/Organisation level support was required.

Improvements include a decrease in the number of complaints, improved patient satisfaction and a reduction in the number of incidents. There has also been a reduction in staff sickness and turnover. All of these improvements have been sustained over the last 6 - 9 months.

Contact: John Kennedy, Deputy Chief Nurse - [john.kennedy5@nhs.net](mailto:john.kennedy5@nhs.net)

## Expectation 5

**A multi-professional approach is taken when setting nursing, midwifery and care staffing establishments.** Directors of Nursing lead the process of reviewing staffing requirements, and ensure that there are processes in place to actively involve sisters, charge nurses or team leaders. They work closely with Medical Directors, Directors of Finance, Workforce (HR), and Operations, recognising the interdependencies between staffing and other aspects of the organisations' functions. Papers presented to the Board are the result of team working and reflect an agreed position.

### Why is this important?

- There are many complex interdependencies between nursing, midwifery and care staffing capacity and capability, and other parts of an organisation's structure and functions. A multi-disciplinary approach to reviewing and establishing staffing capacity and capability will help to identify these interdependencies and to ensure that decisions are not taken in isolation.
- Whilst responsibility for nursing, midwifery and care staffing capacity and capability resides with Directors of Nursing (or equivalent), other Directors – such as Workforce (HR), Finance, Operations and Medical – also have responsibilities in this area. For example, it is important to ensure that the impact on nursing, midwifery and care staffing of changes to the provision of medical care are discussed between the Medical Director, the Director of Nursing and Director of Operations before being implemented. It would also be important to consider the impact of issues such as medical, allied health professional or pharmacy vacancies on the nursing, midwifery and care workforce, together with the use of administrative staff to support the non-clinical aspects of the workload.

### What does this mean in practice?

- Staff should be clear on individual **roles and responsibilities** in terms of nursing, midwifery and care staffing capacity and capability. Whilst recommendations on staffing capacity and capability presented to the Board should be the result of joint working and joint ownership of the issues, there are some distinct roles and responsibilities for different parts of the organisation involved in the staffing process, as outlined below. These are not intended to be comprehensive and will also change as innovation occurs and new roles develop.

### **NON-EXECUTIVE DIRECTORS OF THE BOARD**

- Ensure there are robust systems and processes in place across the organisation to make informed and accurate decisions concerning workforce planning and provision.
- Review data on workforce, quality of care and patient safety on a regular basis and hold Executive Directors to account for ensuring that the right staff are in place to provide high quality care to patients
- Ensure that decisions being taken at a board level, such as implementing cost improvement plans, have sufficiently considered and taken account of impacts on staffing capacity and capability and key quality and outcomes measures
- Understand the principles which should be followed in workforce planning, and seek assurance that these are being followed in the organisation

### **CHIEF EXECUTIVE**

- Ensure that the organisation has the right number of staff with the required knowledge and skills to provide safe and effective patient care
- Ensure that there is an agreed nursing and midwifery establishment for all clinical areas
- Ensure there are robust systems and processes in place across the organisation to make informed and accurate decisions concerning workforce planning and provision.
- Ensure that appropriate escalation policies are in place and action is taken when staffing falls below that expected
- Ensure workforce plans are clinically and financially viable, and that they inform education commissioning process in place through the Local Education and Training Board (LETB) and Health Education England (HEE)
- Ensure that the Executive Team have SMART objectives (specific, measurable, achievable, realistic, timely) aligned to staffing and that these are reviewed and performance tracked regularly.

### **EXECUTIVE BOARD MEMBERS**

- Report to the Board on nursing, midwifery and care staffing capacity and capability, highlighting concerns and making recommendations where necessary. Workforce data should be triangulated with data on quality of care
- Where staffing capacity and capability is insufficient to provide safe care to patients and cannot be restored, undertake a full risk assessment and consider the suspension of services and closure of wards in conjunction with the Directors of Operations, Chief Executive and Commissioners
- Foster a culture of openness and honesty amongst staff, supported by nursing and midwifery leaders, where staff feel able to raise concerns, and concerns are acted upon

### **DIRECTOR OF NURSING**

Develop the nursing and midwifery leadership team to ensure that they understand the principles of workforce planning and can use evidence based tools informed by their professional judgement to develop workforce plans and make staffing decisions on a day to day basis

Assure the Board that there are nursing and midwifery workforce plans in place for all patient care areas/pathways

On a monthly basis, report workforce information to the Board on expected vs actual staff in post on a shift-to-shift together with information on key quality and outcome measures

Ensure there is an uplift in planned establishments to allow for planned and unplanned leave and ensure absence is managed effectively

### **DIRECTOR OF WORKFORCE (HR)**

Ensure that human resources support and policies are available to secure sufficient staffing capacity and capability to provide high quality care to patients

Ensure that there are systems and processes in place to capture accurate data on establishment, staffing levels and skill mix, staff movements, training and turnover to inform decisions on workforce planning

Develop and implement policies that support all staff working within areas of competence

Develop and implement a strategic recruitment plan to provide the required resources and fill current and future vacancies

### **CHIEF OPERATING OFFICER/DIRECTOR OF OPERATIONS**

Ensure that the management of the organisation supports delivery of the workforce plan and there is sufficient staffing capacity and capability to provide high quality care to patients

Ensuring that there are systems and processes in place to capture accurate data on quality of care, patient pathways and volume to inform decisions on workforce planning

### **DIRECTOR OF FINANCE**

Ensure that finance decisions which could have an impact on staff capacity and capability and patient outcomes are taken with consideration of staffing and workforce planning implications, and that these are reflected in any advice provided for decision to the Board, linking proposals to patient outcomes and quality

Ensure there are staff recruitment and retention strategies in place, and regularly review the effectiveness of these

Ensure that there are systems and processes in place to capture accurate data on establishment, staffing levels and skill mix, to inform decisions on workforce planning

### **NURSING LEADERS: HEAD OF NURSING / MATRON / SENIOR MIDWIFE**

- Review and approve rosters submitted from wards
- Reallocate staff and authorise the use of temporary staffing solutions if necessary and where required
- Continuously review and monitor nursing, midwifery and care staffing capacity and capability across areas of responsibility
- Produce data / information to inform the Board and management of the organisation, and to inform workforce planning
- Hold Service Managers to account for having appropriate staffing capacity and capability on a shift to shift basis, and following escalation procedures where necessary

### **SISTER / CHARGE NURSE/TEAM LEADER**

- Produce and manage safe and efficient staff rosters
- Measure quality of care and outcomes achieved for patients and the capacity and capability of staff on a ward-to-ward basis
- Respond in a timely manner to unplanned changes in staffing, changing patient acuity / dependency or numbers, including the request for and use of temporary staffing where nursing/midwifery shortages are identified
- Escalate concerns to line manager where staffing capacity and capability are inadequate to meet patient needs
- Understand the evidence based methodology used to determine the nursing and/or midwifery staffing in your area of responsibility

### **OTHER HEALTH AND CARE STAFF**

- Complete data returns where requested about the staffing in your workplace to inform workforce planning decisions
- Participate in discussions and decisions regarding staffing in your clinical area
- Understand the agreed staffing capacity and capability are for your clinical area on a shift by shift basis
- Raise concerns regarding staffing and/or the quality of clinical care within your organisation when they arise

These roles and responsibilities only seek to cover responsibilities related to nursing, midwifery and care staffing capacity and capability, and are not exhaustive. They are not mandatory and should be read in the context of each organisation and its governance and management structures. It is important to empower ward Sisters/Charge Nurses to take responsibility for their clinical areas with delegated authority to act, supported by their organisations.

Roles will, over time, evolve and change as new innovations come into practice and these guidelines will need to be updated to take this into account.

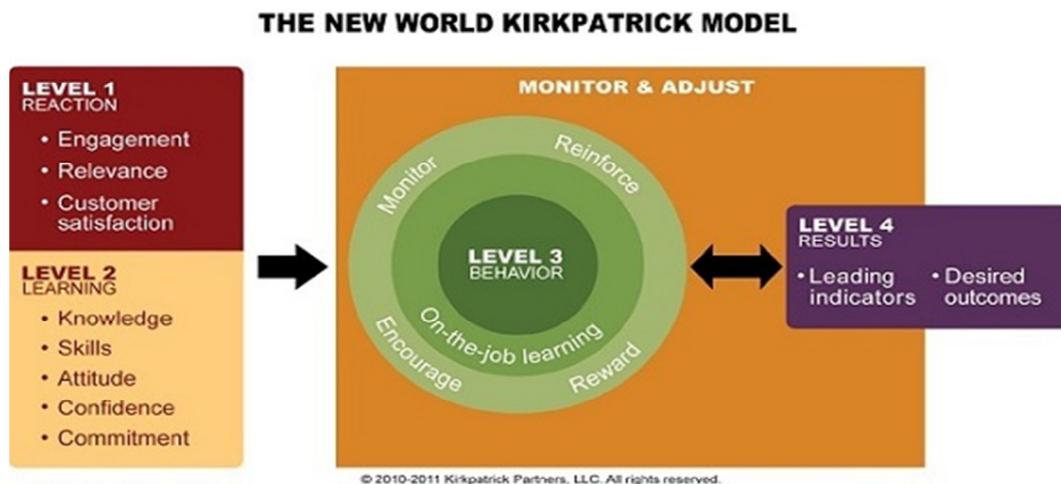
### CASE STUDY 13: NHS England – North - ‘Investing in Behaviours’

The ‘Investing in Behaviours’ programme was funded by the Health Foundation for the North East of England and is being taken forward as part of Action Area 3 of the Compassion in Practice Programme, which is led by Gill Harris, Chief Nurse, NHS England (London)

Conceived in July 2012, it is a product of the need to address issues raised by the Francis Inquiry; to underpin safety and quality improvement work with actions that address Human Factors and Behaviours.

During the 3 year improvement programme, ‘Safer Care North East’ clinicians leading improvement work recognised that focussing on systems and processes alone could only deliver improvements to a point – there was a need to address the fact that human error exists. A faculty of Human Factors was established and clinical teams worked with pioneers from the airline industry to develop the knowledge base of human factors in patient safety. It includes a new perspective on working as part of a team; the benefit this can have in terms of leadership, patient focus and utilisation of staff. Funded by the Health Foundation, an educational package was published in March 2013 including e-learning, workbook and trainers manual.

‘Investing in Behaviours’ has two elements; firstly it is underpinned by the Kirkpatrick evaluation model, which ensures that any action, intervention or training, delivered to support improvement, delivers behaviour change rather than just the acquisition of a technical or theoretical skill. The Kirkpatrick evaluation model is shown below:



Secondly individuals and clinical teams are supported with ‘Insights Discovery – Discovering Investing in Behaviours’, a programme that delivers self-awareness and facilitates changes in individuals, in teams and organisations, focusing on engaging ‘hearts and minds’.

The programme involves an assessment of organisational culture and Quality Indicators and identification of area(s) to change; Board Level expectations are set as a result of this and a multi-disciplinary corporate team leading the implementation of an improvement plan based upon Kirkpatrick model and facilitated by Human Factors awareness and ‘Insights Discovery (Discovering Investing in Behaviours)’ workshops. A reassessment of leading indicators during and following implementation to measure impact is undertaken.

There are currently eight acute organisations involved in the 'Investing in Behaviours' programme and they are seeing improvements in their projects.

Board level Insights 'Discovery (Discovering Investing in Behaviours)' workshops allow Boards to see that differences in individual personalities can lead to constructive as well as destructive behaviours in the Board room, which can impact on patient care.

**Contact:** Teresa Fenech. Deputy Director: Quality Assurance, NHS England (North) - [t.fenech@nhs.net](mailto:t.fenech@nhs.net)

Emma Nunez. Quality and Safety Manager, NHS England (North) [emma.nunez@nhs.net](mailto:emma.nunez@nhs.net)

## Expectation 6

**Nurses, midwives and care staff have sufficient time to fulfil responsibilities that are additional to their direct caring duties.** Staffing establishments take account of the need to allow nursing, midwifery and care staff the time to undertake continuous professional development, and to fulfil mentorship and supervision roles. Providers of NHS services make realistic estimations of the likely levels of planned and unplanned leave, and factor this into establishments. Establishments also afford ward or service sisters, charge nurses or team leaders time to assume supervisory status and benefits are reviewed and monitored locally.

### Why is this important?

- Undertaking continuous professional development is a key part of developing staff capability. It can improve the quality of care provided to patients, as staff who undertake continuous professional development are more likely to have up to date knowledge, skills and judgement. In order to maintain registration with the Nursing and Midwifery Council (NMC), nurses and midwives need to declare that they have completed:
  - 450 hours of registered practice in the previous three years; and
  - 35 hours of learning activity (continuing professional development) in the previous three years.<sup>24</sup>
- Fulfilling supervision and mentorship roles effectively is key to training the next generation of nursing, midwifery and care staff, and ensuring that student nurses and midwives are adequately supported throughout their training.
- Allowing staff the time to undertake these activities, whilst not compromising patient care, is likely to contribute to an increase in staff engagement and productivity. Patient and organisational outcomes are better where staff engagement is higher.<sup>25</sup>
- Strong and clear nurse leadership is central to the delivery of high quality care, and to ensuring that staff are well led and motivated. Allocating time for the Lead Sister/Charge Nurse/Senior Midwife/Community Team Leaders to assume supervisory

---

<sup>24</sup> Further information about staying on the NMC's register can be found at: <http://www.nmc-uk.org/Registration/Staying-on-the-register/>

<sup>25</sup> Michael A West, Jeremy F Dawson. *Employee engagement and NHS performance*. . Available at: <http://www.kingsfund.org.uk/sites/files/kf/employee-engagement-nhs-performance-west-dawson-leadership-review2012-paper.pdf>

status can help to ensure that leaders have sufficient time to co-ordinate activity on the ward, manage and support staff, and ensure standards are maintained.

## What does this mean in practice?

- **Establishment uplifts** should reflect a realistic expectation by the organisation of the impact on staffing requirements of a range of factors:
  - **staff training and development:** the amount of time that staff may reasonably be expected to be absent from direct caring responsibilities to undertake mandatory training and continuous professional development;
  - **supervision and mentorship roles:** the amount of time that staff would realistically need to spend fulfilling mentorship roles (for example, of students) or supervision roles. Where new staff are recruited, or new/bank agency staff are used, time should be allowed for permanent staff to conduct a thorough induction;
  - **planned and unplanned leave:** based on the number of staff in post and the annual leave, maternity and paternity leave entitlements, realistic estimations of the number of staff likely to be absent at any one time should be made and reflected in establishment figures. Establishments should also have flexibility to allow for unplanned leave, such as sickness absence and carer leave; and
  - a realistic assessment of the time required by the lead sister / charge nurse or team leader to assume **supervisory status**. Many trusts have supported these staff to be supervisory full time. The NHS Trust Development Authority provides support, oversight and governance for all NHS Trusts on their journey to delivering what patients want; high quality services today, secure for tomorrow – and they expect that the lead sister, charge nurse or team leader should spend a minimum of two shifts per week assuming supervisory status. Cost Improvement Plans and other initiatives should enable the lead sisters/charge nurses or team leaders time to assume supervisory status.

### CASE STUDY 14: Heart of England NHS Foundation Trust - 'Introducing Supervisory roles'

At Heart of England NHS Foundation Trust Sam Foster, Chief Nurse has undertaken a review of the ward sister/charge nurse role. A paper was shared with the Board setting out options for nursing including the creation of the ward sister/charge nurse supervisory role. This was endorsed by the Board who supported investment of £1.4m, creating an additional 60.48 full time equivalent(FTEs) which allowed for the ward sister/charge nurse to become supervisory.

To support the transition new job descriptions were produced and a training needs analysis was undertaken with ward sisters/charge nurses with a complementary development programme introduced to provide them with the skills required to undertake their roles.

In order to be able to measure success Key Performance Indicators (KPIs) were agreed and each ward sister/charge nurse is expected to report against these, the head nurses hold monthly performance meetings whereby the delivery of these are monitored.

#### Supervisory Ward Sister/ Charge Nurse

- KPI 1: 1% Reduction in short term sickness
- KPI 2: Implementation of e- JONAH and discharge CQUIN
- KPI 3: 100% Compliance with ADTs
- KPI 4: 0% Prevalence of hospital acquired pressure sores
- KPI 5: Demonstrable improvement in patient experience
- KPI 6: Sustained achievement of > 95% for nursing metric scores
- KPI 7: Implementation of nursing quality review bundle
- KPI 8: Sustained nursing staffing to agreed levels
- KPI 9: 100% Compliance with Infection Control policies and procedures
- KPI 10: To be set for each clinical area around Harm Free Care Reduction

The extensive preparation which has led to 'go live' in October 2013 is already yielding results – for example doctors are more engaged with ward sisters/charge nurses about the management of their patients creating a 'team' around the patient and the ward sisters/charge nurse feels more confident in challenging operational aspects to ensure they support best patient care.

Contact: Sam Foster, Chief Nurse [sam.foster@heartofengland.nhs.uk](mailto:sam.foster@heartofengland.nhs.uk)

## 6 Openness and transparency for patients and the public

### Expectation 7

**Boards receive monthly updates on workforce information, and staffing capacity and capability is discussed at a public Board meeting at least every six months on the basis of a full nursing and midwifery establishment review.** Boards receive monthly updates on workforce information, including the number of actual staff on duty during the previous month, compared to the planned staffing level, the reasons for any gaps, the actions being taken to address these and the impact on key quality and outcome measures. At least once every six months, nursing, midwifery and care staffing capacity and capability is reviewed (an establishment review) and is discussed at a public Board meeting. This information is therefore made public monthly and six monthly. This data will, in future, be part of CQC's Intelligent Monitoring of NHS provider organisations.

### Why is this important?

- Transparency should be at the heart of the NHS, and is a key mechanism for holding organisations to account for the outcomes they achieve with their available resources. As outlined in **expectation 1**, Boards are accountable for the patient outcomes they achieve with the staffing capacity and capability in place.
- As outlined earlier in the document, meeting establishments on a shift-to-shift basis can present difficulties at times of increased pressure. Boards are ultimately responsible for staffing capacity and capability, and must ensure that there are systems in place to regularly assure themselves that there is sufficient nursing, midwifery and care staffing capacity and capability on a shift-to-shift basis.

### What does this mean in practice?

#### Board level discussions

- As outlined in **expectation 1**, establishment reviews should be carried out every six months. Components of papers to the Board on the establishment reviews were also set out under expectation 1.
- At least twice per year, all nursing, midwifery and care staffing levels, and key quality and outcomes measures should be discussed at Trust Board level in a public meeting.

This recommendation was made in *Compassion in Practice*<sup>26</sup>, published in December 2012, so we expect Trusts to be doing this already. Where they are not, we expect them to start this process by April 2014 and discuss at a Public Board meeting by June 2014 at the latest.

### Monthly reporting

- As outlined in **expectation 1**, on a monthly basis, the Board should receive a report on workforce information, outlining the actual staff available on a shift-to-shift basis versus planned staffing levels. The report should outline areas where there are gaps between these figures, the impact of this, and the steps being taken to address the issue. This report should be published in a form accessible to patients and the public.
- By summer 2014 this data will be collated alongside an integrated safety dataset that will provide information down to ward level where appropriate. This will be available via a single website covering the key aspects of patient safety and in a form accessible to patients and the public.
- Information published in this way will provide close to real time information of staffing at organisational level. It is not intended to replace established statistical publications by the Health and Social Care Information Centre on a monthly, quarterly and annual basis, which are official statistics that go through a rigorous validation process.

---

<sup>26</sup> *Compassion in Practice* is available at <http://www.england.nhs.uk/wp-content/uploads/2012/12/compassion-in-practice.pdf>

**CASE STUDY 15: Avon and Wiltshire Mental Health Partnership Trust - 'Board to Ward Quality Information System'**

The Avon and Wiltshire Mental Health Partnership Trust (AWP) has created a 'Ward to Board' quality information system, known as 'IQ'. Every ward and team completes a monthly self-assessment on key quality indicators which includes compliance with Care Quality Commission standards including a declaration on the 'suitability of staffing' outcome. Although minimum staffing requirements are known, managers are asked to assess against their professional judgement and to declare compliance or not.

The IQ system is accessible by every part of the Trust, including all Board members, and is reviewed in real time every fortnight by the Senior Management Team. Staffing issues are visible and addressed as required.

Contact: Hazel Watsons, Director of Nursing, Hazel.watson@awp.nhs.uk

**CASE STUDY 16: Guy's and St Thomas' NHS Foundation Trust - 'Board Update on Safe Staffing'**

In April 2013 the Chief Nurse and Director of Patient Experience presented a paper to the Board of Directors. It highlighted previous Board reports, the need to report 6 monthly on nursing and midwifery levels and whether they are adequate to meet patient acuity and dependency.

The Board paper set out the approach to assuring safe staffing levels in acute adult wards and Evelina Children's Hospital using both professional judgement and a range of tools including:

- Safer Nursing Care tool
- RCN guidance 'Defining Staffing levels for Children's and Young People's Services'
- Paediatric Intensive Care services.
- Birth-rate plus tool (for maternity services)

Directorate teams were asked to provide an assurance statement to the Chief Nurse that staffing levels were safe. In addition the Chief Nurse met all ward sisters/charge nurses individually to discuss staffing, their concerns and whether what was being reported to the Board was accurate.

The Board paper also details how the Trust utilises its staffing resource effectively and the Board of Directors was asked to assure itself that staffing levels were robust, recognise that further work relating to the community workforce was to take place and the recruitment challenges.

Contact: Professor Eileen Sills CBE, Chief Nurse and Director of Patient Experience

[Eileen.sills@gstt.nhs.uk](mailto:Eileen.sills@gstt.nhs.uk)

### **CASE STUDY 17: NHS England – North - ‘Open and Honest Care: Driving Improvement’**

‘Open and Honest Care: Driving Improvement’ uses data on quality of care, such as the Safety Thermometer and Friends and Family Test. It enables an organisation to understand what data is telling them about clinical safety and patient experience. Initially launched in the North West as the ‘Transparency pilot’ in September 2011 following a challenge by Jane Cummings (then Chief Nurse, North West) to a group of Directors of Nursing: ‘What can nursing do to further improve quality, safety and patient experience and justify pride in the profession?’.

The transparency pilot measured the quality of nursing care delivered together with patient and staff experience in the area where harm occurred. The incidence of harm was published monthly together with the action taken to prevent a recurrence. This collaborative work identified pressure ulcers and falls as areas where an immediate, lasting impact could be made.

Nurses recognised that publishing the data they collected on pressure ulcers and patient falls would bring even stronger focus on patient safety, resulting in staff and patients in open, honest conversations about the quality of care. It offers the opportunity to make further improvements, by looking at things differently; enabling the organisation to be open and honest about care and how they are working to improve the quality of services provided.

The ‘Open and Honest Care: Driving Improvement’ process begins with a Trust Board signing a compact that endorses its involvement and commitment to openness; an agreement that it will use common data definitions and reporting templates, publish data in agreed formats at agreed times and proactively share with stakeholders (internal and external) and that the publication will form part of routine quality reporting in Part One of Trust Board meetings. There is also a commitment to publish further metrics as developed and agreed and to focus on the capacity and capability for improvement, not to apportion blame.

On a monthly basis there is a publication on the Trust website utilising a standardised template that has been designed with service users. Staff views about the harm events are collected and a future ambition is to identify the staffing levels that should have been deployed at the time compared with actual staff available. The first publication of Open and Honest Care: Driving Improvement takes place in November 2013.

Organisations involved in the transparency pilot have been able to demonstrate a reduction in pressure ulcers and falls. In addition they have demonstrated that this framework can easily shift to new priority areas.

Contact: Teresa Fenech Deputy Director: Quality Assurance NHS England North  
(t.fenech@nhs.net)

Hazel Richards, Programme Director. [Hazel.Richards1@nhs.net](mailto:Hazel.Richards1@nhs.net)

## Expectation 8

**NHS providers clearly display information about the nurses, midwives and care staff present on each ward, clinical setting, department or service on each shift.** Information should be made available to patients and the public that outlines which staff are present and what their role is. Information displayed should be visible, clear and accurate, and it should include the full range of support staff available on the ward during each shift.

### Why is this important?

- In other industries, it is common practice for the people serving customers to be visible. If you travel on an aeroplane, you are clear that there is a pilot in charge of flying the plane, and a first officer there to assist the pilot. Air stewards and stewardesses introduce themselves, and make their role in serving passengers, and protecting their safety, known.
- When people use the NHS, they are often at their most vulnerable stage in life. By the very nature of healthcare, patients, their families, friends and carers place trust in the professionals looking after them, and rely on them to put their interests first. There is a strong argument that, in this unique environment and at the time of greatest need and vulnerability, transparency should be more important than in any other setting.
- Displaying information about the staff present on each ward on each shift is part of the broader agenda around improving transparency in health care. Other actions underway include displaying the name of the lead clinician and nurse in charge of patients' care above their beds, and ensuring that people outside of hospitals have a named clinician who is responsible and accountable for the care of that patient.

### What does this mean in practice?

- Providers should have information on staffing on a shift-to-shift basis that is available, and accessible to patients. Organisations should display the numbers of staff in post on a shift-to-shift basis, piloting an approach to this. Plans should be implemented subject to evaluation of pilots.
- The information displayed should be helpful and accessible to patients, and could include: the numbers of staff present on the ward, department, service or setting; who is in charge; and what the different roles and responsibilities of staff on the ward are.
- It may be helpful to outline additional information that is relevant locally, for example, the significance of different uniforms worn by staff, and titles used, mean.

### *Case study 18: #Hellomynameis*

During 2013, Dr Kate Granger, a senior registrar specialising in the care of older people, and who is also terminally ill, was an in-patient in NHS care and she noticed that only some members of the healthcare team looking after her introduced themselves. Kate wondered why this fundamental element of good communication (the introduction) seemed to have failed. She noted how members of healthcare staff know much about the patients in their care, but that this is not always reciprocated, and she pointed out that this tends to push the balance of power in favour of the healthcare worker. Given that people receiving treatment and care often feel vulnerable already, this imbalance creates an unhelpful and unfortunate gap.

Kate shared her views via twitter and suggested that getting to know people's names is the first rung on the ladder towards providing compassionate care. It is getting the simple things right that means that the more complex things follow more easily and naturally. As a result, the idea of #hellomynameis was born.

Since then people have taken steps in all manner of ways to ensure that this key bit of compassionate care; the introduction, happens. Some organisations have created name boards in their clinical areas headed 'Hello My Name Is...' and others have used it as they start their speeches at conferences and other events or placed it on name badges.

There is further work to do however. As Kate has pointed out, the NHS employs many, many people and a significant number of these people interact directly or indirectly with patients at some level. Influencing practice in this small way could have a major impact on the outcomes of care and treatment, especially the patient's experience of that care.

### **CASE STUDY 19: 'Implementing Safe Nurse Staffing Salford Royal NHS Foundation Trust'**

At Salford Royal NHS Foundation Trust (SRFT) the Safer Nursing Care tool is used to determine nursing establishments to deliver safe quality care. The qualified nurse to patient ratio at SRFT of 1:8 is never breached. Sub specialty wards have a ratio higher than this. All wards in addition have a nurse in charge on all shifts.

The Safe Staffing Steering Group considers how SRFT shares information with patients and families in an open and transparent way, including the numbers of nursing staff on wards at each shift. To support this staffing boards have been introduced onto every ward/department.

The board identifies the coordinator for the area and the numbers of registered and non-registered nurses that the ward should have and the numbers they actually have for the shift. The board is displayed at the entrance to every ward and visible to patients/family and carers.

A senior nurse teleconference is held daily at 8.30am, chaired by the Deputy Director of Nursing to address any nurse staffing concerns. To support this, a daily nursing rota is produced and staffing is discussed at capacity meetings held four times daily.

SRFT will expand the project to look at staffing with community nursing.

**Contact:** Elaine Inglesby, Executive Nurse Director – [elaine.inglesby@srft.nhs.uk](mailto:elaine.inglesby@srft.nhs.uk)

### CASE STUDY 20: Writhington, Wigan and Leigh NHS Foundation Trust (WWL) – ‘Using Staffing Display Boards’

An element of WWL’s Nursing and Midwifery Strategy includes the need for transparency, and white boards at the entrance to wards have been introduced. These boards display the funded staffing establishment and the actual staffing levels on each shift and are visible to patients and visitors.

An escalation process means that should staffing levels fall below establishment this is picked up by the Ward Sister and Matron immediately. Two wards ‘buddy’ each other and will work together to resolve the staffing issue initially across the two wards with Matron reviewing all nurse staffing across the directorate. The Duty Matron has access to staff across the organisation and will move nursing staff as appropriate to ensure safe levels in all areas, in addition to securing additional nurses by utilising bank and agency.

Board papers include details of any staffing breaches to ensure the team are aware of issues and actions taken, offering an opportunity for further challenge and support.



**Contact:** Pauline Jones, Director of Nursing, [pauline.m.jones@wwl.nhs.uk](mailto:pauline.m.jones@wwl.nhs.uk)

## 7 Planning for future workforce requirements

### Expectation 9

**Providers of NHS services take an active role in securing staff in line with their workforce requirements.** Providers of NHS services actively manage their existing workforce, and have robust plans in place to recruit, retain and develop all staff. To help determine future workforce requirements, organisations share staffing establishments and annual service plans with their Local Education and Training Board (LETBs), and their regulators for assurance. Providers work in partnership with Clinical Commissioning Groups and NHS England Area Teams to produce a Future Workforce Forecast, which LETBs will use to inform their Education Commissions and the Workforce Plan for England led by Health Education England (HEE).

### Why is this important?

- It is first and foremost an employer responsibility to ensure they have enough staff to provide a safe and high quality service for current and future patients. As outlined in this document, providers are required to produce establishment reviews and Annual Service Plans which set out the number and mix of staff that providers intend to employ that year, (including fill and vacancy rates and planned spend on temporary staffing). It is an employer responsibility to ensure that they have robust plans in place to recruit, retain and develop their staff, as well as managing and planning for any potential loss of staff through, for example, turnover, retirement and maternity leave.
- In order to make services sustainable, organisations have a key role to play in determining future workforce demands. It can take fifteen years to train a Consultant, and three years to train a nurse – so the NHS has to plan not just for the needs of patients today, but the needs of patients tomorrow.

### What does this mean in practice?

#### Managing the current workforce

- It is the responsibility of Health Education England to secure the future supply of workforce through commissioning education and training places. The workforce plans that HEE will publish later this year will result in nurse training places commencing in September 2014, completing in 2017. It is then the responsibility of the providers of health care services to ensure they have sufficient supply (nurses and midwives) to meet patient demand. As well as recruitment, this requires providers to have effective

strategies in place to retain and develop the staff they employ, in order to reduce the numbers of qualified staff who leave the service. Without effective employment strategies in place, providers are forced to demand yet more supply (either from other parts of the UK or abroad), which takes time and money to produce. This is potentially an inefficient use of taxpayers' money, and a poor use of the investment we have made in people who have expressed a desire to work with patients.

### **Shaping the future workforce**

- Each provider of NHS services is required to be a member of, or be represented on, their Local Education and Training Board, (LETB) which are committees of Health Education England. It is the role of the Governing Body of LETBs to ensure that education and training commissions reflect local need and national priorities, by directly involving employers and commissioners in these decisions. In order to enable LETBs to ensure that their plans reflect local needs, employers need to:
  - Share establishment reviews with their LETB so that they have a sound understanding of the current situation upon which to base any future investments, and with regulators (NTDA, Monitor and CQC) for assurance; and
  - Produce a future workforce forecast that sets out their anticipated needs, which will form the basis of LETBs education and training commissioning plans and strategies. These forecasts should be developed in partnership with local commissioners to ensure that they reflect local visions for services, and submitted to LETBs as set out in HEE's Workforce Planning Guidance. Further information is available at: <http://hee.nhs.uk/work-programmes/workforce-planning/>
  - Local LETBs will assess and aggregate the forecasts submitted by local providers, triangulate with local partners including commissioners and Health and Well Being Boards and submit to Health Education England; and
  - Health Education England will assess and aggregate the 13 investment plans from its LETBs and develop a Workforce Plan for England, ensuring that the £5 billion pounds that is spent on workforce reflects both local and national priorities as set out in by their Mandate.

## 8 The role of commissioning

### Expectation 10

**Commissioners actively seek assurance that the right people, with the right skills, are in the right place at the right time within the providers with whom they contract.**

Commissioners specify in contracts the outcomes and quality standards they require and actively seek to assure themselves that providers have sufficient nursing, midwifery and care staffing capacity and capability to meet these. Commissioners monitor providers' quality and outcomes closely, and where problems with staff capacity and capability pose a threat to quality, commissioners use appropriate commissioning and contractual levers to bring about improvements. Commissioners recognise that they may have a contribution to make in addressing staffing-related quality issues, where these are driven by the configuration of local services or the setting of local prices in contracts.

### Why is this important?

- Commissioners are responsible for ensuring that they commission high-quality services. The impact that nursing, midwifery and care staffing capacity and capability can have on patient safety has been well documented and should therefore be a key focus for commissioners. Commissioners should continually hold providers to account for ensuring that they deliver high-quality services, ensuring that they maintain sufficient staffing capacity and capability to do this at all times.
- Commissioners must commission high-quality care whilst also delivering value for public money. Where prices for the services they commission are set through local negotiations, rather than by national tariffs, commissioners have a responsibility to ensure that the local prices agreed mean that provision of safe, effective services remains viable.

### What does this mean in practice?

- Commissioners set clear standards for quality and outcomes in their contracts, through services specifications and incorporating quality standards.
- As outlined in *Everyone Counts: Planning For Patients 2013/14*,<sup>27</sup> commissioners actively review and discuss the cost improvement programmes proposed by their major

---

<sup>27</sup> *Everyone Counts: Planning for Patients 2013/2014* is available at: <http://www.england.nhs.uk/everyonecounts/>

providers, ensuring that these have clinical ownership within the provider and do not threaten service quality.

- Commissioners have mature discussions with providers about local prices and efficiency requirements so that commissioner financial constraints do not inadvertently encourage providers to operate unsafe staffing levels.
- Commissioners monitor service quality and outcomes, alongside expenditure and activity levels, using the monitoring information which providers are required to supply under the NHS Standard Contract; this covers quality standards, complaints, serious incidents and Never Events, infections rates, clinical audit reports and patient and staff surveys. Commissioners maintain a constant and close dialogue with providers about any issues relating to service safety and staffing levels.
- Commissioners triangulate this data on service quality with provider reports on actual staff available on a shift-to-shift basis versus planned staffing levels. The NHS Standard Contract for 2014/15 is expected to set out new requirements on providers to report on this to commissioners.
- In liaison with regulators and NHS England Area Teams through Quality Surveillance Groups, commissioners use the levers set out in the NHS Standard Contract to address any provider issues with service quality and safe staffing. These levers include the ability to:
  - require remedial action plans to be agreed and implemented
  - report formally to the provider's Board and levy financial sanctions where such actions plans are not implemented
  - suspend services temporarily or terminate them permanently.
- In deciding whether to suspend or terminate services, commissioners balance risks and benefits carefully and work closely with providers to ensure that sufficient service provision can be maintained and that delivery of the normal service can be re-established as soon as possible, if necessary through a new provider.
- Commissioners share information and intelligence with their local commissioning and regulatory partners through their Quality Surveillance Group.

## 9 Next Steps

This document has set out expectations of providers and commissioners in respect of nursing, midwifery and care staffing capacity and capability and how those expectations can be met. Similar guidance may need to be developed for other parts of the health and care workforce.

This chapter sets out how the different organisations with responsibilities for regulating and supervising the system will reflect these expectations as they discharge their statutory responsibilities. This guidance has been developed in advance of further, evidenced based work which is being taken forward by NICE, more detail on which is set out at the end of chapter.

### **Leadership in provider organisations**

These expectations are designed to support providers in taking the complex and difficult decisions that they must take to secure safe staffing to care for their patients and service users.

We would expect that each provider organisation would consider these expectations explicitly, and have a board discussion to assure itself that the systems and processes within the organisation met these expectations.

Establishing and maintaining adequate staffing capacity and capability is an inherently challenging process, and we recognise that not all organisations will be meeting the expectations set out in this document at the moment. Where this is the case, we expect boards to identify as a matter of urgency the actions that could be taken to meet these expectations.

### **Care Quality Commission (CQC)**

The **CQC** is the regulator of the quality of health and care services in England. It is currently developing a new approach to monitoring, inspecting and rating providers. Staffing capacity and capability will be central to this new approach, and the expectations set out in this guide will be used to inform the development of their new approach to inspections, and subsequently, to inform their judgements and ratings for providers.

## **Monitor**

Monitor is the sector regulator for health services in England. Their role is to protect and promote the interests of patients by ensuring that the whole sector works for their benefit. They have the ability to exercise a range of powers in relation to the licences issued to NHS-funded providers.

Monitor expects that NHS foundation trusts and aspirant foundation trusts should have the right people, with the right skills, in the right place at the right time. They should take the necessary steps to assure themselves and others that they do so. Monitor will act where the CQC identifies any deficiencies in staffing levels for foundation trusts.

## **NHS Trust Development Authority**

The NHS Trust Development Authority (NHS TDA) provides support, oversight and governance for all NHS Trusts on their journey to delivering what patients want; high quality services today, secure for tomorrow. As part of this drive for sustainable quality across all NHS trusts the NHS TDA will support trusts to develop a constructive approach towards meeting the expectations set out in this guide.

Trusts will also be encouraged to continue to work in a transparent manner in sharing data and to liaise with Commissioners in the delivery of the expectations.

## **NHS England**

NHS England has a dual role in respect of staffing capacity and capability: it is a commissioner of certain services (specialised, primary care, health and justice and veterans care); and it oversees the local commissioning system, supporting Clinical Commissioning Groups to meet their statutory responsibility for improving the quality of services and delivering the best possible outcomes for their communities.

NHS England will reflect relevant elements of these expectations in the NHS Standard Contract which is used by all commissioners for contracts with providers (other than for primary care services). In relation to its own commissioning, NHS England will design and commission services with a view to meeting the expectations in this guide, and particularly in line with expectation 10 on commissioning. Through assurance, NHS England will ensure that both statutory duties and delivery plans are being met by CCGs with challenge through evidence and agreed support where improvement is found to be required.

## **National Institute for Health and Care Excellence (NICE)**

NICE will shortly begin work to develop evidence-based guidance that sets out safe staffing capacity and capability for the NHS. This guidance will be for use within NHS provider organisations, and to inform any practical tools that help calculate staffing capacity and capability.

It will begin by reviewing the evidence-base underpinning existing products, plus any new or additional relevant evidence, to develop staffing guidance. This guidance will enable existing tools and related products used in the NHS in England to be updated, if required.

By June 2014, NICE will have produced guidance on safe staffing in adult in-patient settings, including its view of existing staffing tools. This initial phase will be followed by further work to develop full accreditation of staffing tools against the evidence based guidance, and work on safe staffing in other settings, including maternity, A&E non-acute settings such as mental health, community services and learning disabilities settings. The focus of the work will be nursing and maternity staffing levels, but it will also take into account the wider context of other workforce groups and the importance of multi-disciplinary working in modern healthcare.

-----

This guidance has set out some core expectations of providers and commissioners in respect of getting nursing, midwifery and care staffing right. They are based on available evidence, good practice and common sense. They aim to support and reinforce the ability and judgement of healthcare professionals and managers in making what are difficult decisions both on a daily basis, and with a longer term perspective. In using this guidance, working in the NHS, we must recognise that the roles staff perform, and the capacity and capability of staffing needed to provide care, like any other components of healthcare delivery, can and should be components for constant innovation. Across the NHS we must make sure that current approaches to staffing do not stifle bold ideas and innovation, such as the development of new healthcare professional roles; new forms of delivery of care that might significantly alter the patterns of needs and staffing requirements; and new ways to empower patients and carers to use their own skills and expertise to improve their care. Similarly, we must constantly look to the future, understanding how we can improve our care through the skills and expertise of our staff, not just those we currently employ, but the young professionals in training and as they enter their careers.

## Appendix A: Professional Guidance

Below is a list of some known professional guidance on nursing, midwifery and care staffing capacity and capability. This list is not intended to be definitive or exhaustive.

**The British Association of Critical Care Nurses (2009):** *Standards for nurse staffing in critical care.* Available at:

[http://www.baccn.org.uk/about/downloads/BACCN\\_Staffing\\_Standards.pdf](http://www.baccn.org.uk/about/downloads/BACCN_Staffing_Standards.pdf)

**The Paediatric Intensive Care Society Standards for the Care of Critically Ill Children (4<sup>th</sup> ed) 2010.** Available at:

[http://www.ukpics.org.uk/documents/PICS\\_standards.pdf](http://www.ukpics.org.uk/documents/PICS_standards.pdf)

**The Association for Peri-operative Practice (2008):** Available at:

<http://www.afpp.org.uk/books-journals/books/book-119>

**BAPM Service Standards for Hospitals Providing Neonatal Care 3<sup>rd</sup> edition (2010).** Available at:

[http://www.bapm.org/publications/documents/guidelines/BAPM\\_Standards\\_Final\\_Aug2010.pdf](http://www.bapm.org/publications/documents/guidelines/BAPM_Standards_Final_Aug2010.pdf)

### RCN Guidance

RCN (2006) *Setting appropriate ward nurse staffing levels in NHS acute trusts.* Available at: [http://www.rcn.org.uk/\\_data/assets/pdf\\_file/0007/287710/setting\\_appropriate\\_ward\\_nurse\\_staffing\\_levels\\_in\\_nhs\\_acut.pdf](http://www.rcn.org.uk/_data/assets/pdf_file/0007/287710/setting_appropriate_ward_nurse_staffing_levels_in_nhs_acut.pdf)

RCN (2010a) *Guidance on safe nurse staffing levels in the UK.* Available at: [http://www.rcn.org.uk/\\_data/assets/pdf\\_file/0005/353237/003860.pdf](http://www.rcn.org.uk/_data/assets/pdf_file/0005/353237/003860.pdf)

RCN (2010b) *RCN policy position: evidence based nurse staffing levels.* Available at: [http://www.rcn.org.uk/\\_data/assets/pdf\\_file/0007/353239/003870.pdf](http://www.rcn.org.uk/_data/assets/pdf_file/0007/353239/003870.pdf)

RCN (2012a) *Safe staffing for older people's wards: RCN full report and recommendations.* Available at: [http://www.rcn.org.uk/\\_data/assets/pdf\\_file/0009/476379/004280.pdf](http://www.rcn.org.uk/_data/assets/pdf_file/0009/476379/004280.pdf)

RCN (2013) *Defining staffing levels for children and young people's services.* Available at: [http://www.rcn.org.uk/\\_data/assets/pdf\\_file/0004/78592/002172.pdf](http://www.rcn.org.uk/_data/assets/pdf_file/0004/78592/002172.pdf)